

**Practice of Maternal Health Care Among Married
Women Aged (15-49)
(A Case Study of Dodhara VDC in Kanchanpur District)**

**A Thesis Submitted to
The Central Department of Population Studies
Faculty of Humanities and Social Sciences
For Partial Fulfillment of
Master's Degree in Population Studies**

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RECOMMENDATION LETTER

This is to certify that Miss. Debaki Kumari Joshi has completed the dissertation entitled “**Practice of Maternal Health Care Among Married Women Aged (15-49)**”: A Case Study of Dodhara VDC in Kanchanpur District, under my guidance and supervision. The dissertation is original and embodies the result of her empirical investigation based on field work. Therefore, I recommend this dissertation for final evaluation.

.....

Prof. Dr. Ram Sharan Pathak
(Supervisor)

APPROVAL SHEET

This Dissertation entitled “**Practices of Maternal Health Care Among Marred Women Aged (15-49): A Case Study of Dodhara VDC Kanchanpur District**” by Debaki Kumari Joshi has been accepted as partial fulfillment of the requirement for Master Degree of Arts in population studies.

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ABSTRACT

The study on **“Maternal Health Care Practices Among Married Women Aged (15-49): A Study of Dodhara VDC in Kanchanpur District”** has been carried out using primary source of data obtained from 120 respondents of reproductive aged women.

The study is conducted at Dodhara VDC of kanchanpur district in month 2009. There are various problems to achieve the goal of Maternal Health Care in society. The main purpose of this study is: To examine the socio –economic and demographic status of married women aged 15-49 years and to find out the Practice of Maternal health care of married women aged 15-49 years.

In the study area it has found that socio-economic status of study population was very low. Most of the people in that area are engaged in agriculture and housework. The mean age at marriage of women in the study area is very low. The majority of women are delivered at home .It has found that literate (Intermediate level) women are delivered at Hospital while illiterate women are delivered maximum at home. Women yet have to face many complications during the time of delivery.

During pregnancy labour and complication Nepali women follow traditional techniques which have harmful effects on health moreover women are more likely to have infections because of anatomical structures one of the regions in the quality and accessibility to maternal health care services in that most of the Nepali women risk in rural areas. In these areas only basic health services are available in very limited areas though some community based services are provided by trained birth attendants, female community Health Volunteer.

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ACRONYMS

ANC	:	Antenatal Care
ANM	:	Auxiliary Nurse Midwife
AHW	:	Assistant Health Worker
CBS	:	Central Bureau of Statistics
CDPS	:	Central Department of population Studies
DC	:	Delivery Care
DFID	:	Department for International Development
HA	:	Health Assistant
HH	:	House Hold
HMG	:	His Majesty of Government
IEC	:	Information Education and Communication
IMR	:	Infant Mortality Rate
ICPD	:	International Conference on Population and Development
INGOS	:	International Non- Governmental Organizations
MCHW	:	Maternal and Child Health Worker
MMR	:	Maternal Mortality Rate
MOH	:	Ministry of Health
MOPE	:	Ministry of population and Environment
NDHS	:	Nepal Demographic Health Survey
NGOS	:	Non – Governmental organizations
PNC	:	Postnatal Care
PRB	:	Population Reference Bureau
RH	:	Reproductive Health
SAARC	:	South Asian Association for Regional cooperation
SLC	:	School Leaving Certificate
TU	:	Tribhuvan University
TUCL	:	Tribhvan University Central Library
TT	:	Tetanus Toxid
TBA	:	Traditional Birth Attendant
UN	:	United Nation
UNFPA	:	United Nations Population Fund
UNICEF	:	United Nations Children Fund
VDC	:	Village Development Committee
W H O	:	World Health Organization

CHAPTER - ONE

INTRODUCTION

1.1 Background to the Study

Health is one of the most important factors for the fulfillment of human needs and improvement of the quality of life. A healthy person is always cheerful and can do full day's work without exhaustion. Even poor man having good health can improve his living standard. So, health of the people is considered to be the wealth of nation. Maternity care implies the provision of essential care for pregnant women to ensure safe delivery postnatal care and termination of complication of the mother and new born. Maternity care starts from the time of pregnancy diagnosis and continuous through delivery and postnatal period (MOH, 1998).

Maternity care is one of the most important components of reproductive health. Reproductive health is defined as "A state of complete physical, mental and social well- being not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and process." Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have to the capability to reproduce and the freedom to decide when and how often to do so (UN, 1994).

Maternal health care is defined as the care that women reviewed during pregnancy.

The maternal health care covers the several aspects.

-) Antenatal care (ANC)
-) Delivery care (DC)
-) Postnatal care (PNC)
-) New born care (NBC)

ANC, DC and PNC can improve the maternal health of women. ANC includes the question such as pregnancy checkup and tetanus toxic injection during pregnancy. The delivery care is related to the place of child delivery and help received from the

health personal at the time of delivery such as delivery by doctor' s and nurse midwife or different health facilities during the period of delivery (Pradhan , 1997).

Safe motherhood goal and objectives are to be achieved through the implementation of the following strategies:

1. Promoting inter-sectoral collaboration by ensuring advocacy for and commitments to reproductive health, including safe motherhood, at the central, regional, districts and community levels;

) Ensuring the commitment to SM initiative at all levels by promoting collaboration between sectors like health, education and social welfare, legal and local development (strengthening RHSC, RHCC district RHCC and SMSC).

) Mobilizing national authorities, district health management committee (DHMC), community leaders and community members to play active roles in creating suitable environment for promoting safe motherhood.

2. Strengthening and expanding delivery by skilled health workers, basic and comprehensive obstetric care services (including family planning) at all levels. Interventions include the following:

) Developing the infrastructure for delivery and emergency obstetric care.

) Standardizing basic maternity care and emergency obstetric care at appropriate level of the health care system.

) Strengthening human resource management.

) Establishing functional referral system and advocating emergency transport system and funds from communities to district hospital for obstetric emergencies and high risk pregnancies.

) Strengthening community based awareness on birth preparedness and complication readiness through FCHVs and MCHWs, and

) Increasing access of all relevant maternal health information and service.

) Supporting activities that raise the status of women in society.

Promoting research on safe motherhood to contribute to improved planning, higher quality services, and more cost effective intervention. (DOHS, 2004/05).

According to NDHS 2006, Forty- four percent of mothers received antenatal care from skilled birth attendants (SBAS) that is from doctor, nurse or midwife for their most recent birth in the five years preceding the survey. 28 percent of mothers received antenatal care from trained health worker such as health assistant or auxiliary health worker, maternal and child health worker, maternal and child health worker less than 2 percent of women received antenatal from a traditional birth attendant or a Female Community Health Worker (FCHW). 26 percent of women received no antenatal care for births in the five years before the survey (NDHS, 2006).

1.2 Statement of the Problem

A large proportion of the population in the Twenty first century in Nepal is still below in the poverty line. Generally, people do not pay attention towards health and health practices. Especially the women do not reveal or to tell their health problems even in serious conditions because of shyness and oppressive as well as patriarchal cultural norms.

Dodhara VDC is situated in the Far western development region of kanchanpur district across the Mahakali River of our country. This VDC is back regarding the all round development in comparison to the other parts of kanchanpur district. But newly made suspension Bridge has hightited this VDC all over the country and linked with the district head quarter. Women of this VDC get little bit relief because of the bridge. But still maternal health care practice is very poor because of the lack of education, Health post, Health worker, traditional approach etc. Most of the women are the house hold worker and delivery at home and assisted by TBA so the main target of this study is to provide reliable and valid information on various aspects of maternal health care practice of Dodhara VDC's women.

In Nepal , More than nine out of every ten births occurred at home , and many women even delivery alone , traditional birth attendant both trained and untrained are sometimes called in to attend the majority of the women receive help only from

relatives or friends use of clinical services in clearly low. In addition to cultural factors which prevent women from seeking clinical come a number of others factors influence the use of services few facilities provide essential practice of maternal health care, health services are often of poor quality. Access appropriate facilities are poor long distance; poor roads and lack of transportation also keep women from using the facilities.

Thus, this study attempts to find out maternal health care practices in DodharaVDC of kanchanpur district. It is believed that these women have normal maternal health practices because this community is low socio- economic status. So the main target of this study is to provide reliable and valid information on various aspects of practice of maternal health of Dodhara VDC Kanchanpur.

1.3 Significance of the Study

This study will be very useful for those individuals and institutions, who are interested to know the maternity health care. It will be also useful to formulate and implement appropriate policies, plans and programs focusing the issue of maternal health care. It may be helpful for the research persons and the personal interested in maternity health care studies. The study also helps to formulate the safe motherhood policy and more useful for the effective implementation of future development and various maternal health programmed for Dodhara VDC.

1.4 Objective of the Study

The general objective of the study is to identify socio-economic and cultural determinants of maternal health care practice among reproductive age women (15-49) for their last birth. However, this study has aimed to bring out the following specific objectives:

1. To Examine, the socio-economic and demographic status of among women of reproductive age.
2. To find out of antenatal check up and delivery check up among Women.
3. To find out practice of ANC, Delivery care among women.

1.5 Limitation of the Study

1. This study is limited in Dodhara VDC 3, 4 and 6 of kanchanpur so findings may not representation for the others areas of Nepal.
2. This study is limited to the currently married reproductive age's women (15 – 49 years) who have at least one child less than 5 years age for their last birth.
3. In this study, only socio-economic and demographic variables considered in an analysis of maternal health such as education, occupation women's age at marriage, age at first child birth etc considered in the analysis of maternal health.
4. This study focuses on the antenatal and delivery services, use of clean delivery kits.

1.6 Location of the Study Area

The study area, Dodhara VDC is situated in kanchanpur district of Mahakali Zone with geographical location $80^{\circ}5' 00''$ E and $28^{\circ}52' 30''$ N. Its western Northern part, Southern touches with India and estern part Chandani VDC and Mahakali River. Since, it is away from Mahakali River so it is famous.

CHAPTER - TWO

LITERATURE REVIEW

2.1 Situations in the Nepal

Health is important for all most of the women especially in health sectors is neglected. The physical and mental health of women is treated as discrimination in a predominant patriarchal society and their status is also seen as a secondary class. Women are undervalued through their lives and discrimination starts even before birth.

With an estimated about 4800 maternal deaths occur annually or 13 perday one women die every two hours in Nepal. The UNFPA has ranked Nepal as the worst affected country in south Asia. Most of women, who are in the prime of their lives, die as a result of pregnancy and child birth. This has serious social and economic consequences for the family the community and country. When a mother dies the new born faces 10 times higher risk of death and even older children. (UNICEF, 2006)

There has been little improvement in maternal mortality in developing countries. A maternal death related to pregnancy of childbirth is a rare event in more developed countries. Just 9 women died for every 100000 births in these countries in 2005, according to new estimates from the world health organization, UNCEF, the UN population fund and the World Bank. But the ratio of maternal deaths to birth in very high in sub - Saharan Africa and south Asia. Even more worrisome, there has been little improvement over the past 15 years in developing regions as a whole, despite concerted efforts to improve mother's health. Public health experts emphasize the importance during childbirth, including the availability of emergency care to deal with complications such health care in after lacking in countries with poor infrastructure and inadequate health facilities (PRB, 2008).

The overall MMR for the eight districts was found to be 229 per 100,000 live births, ranging from 153 in Okkaldhunga to 301 in Rasuwa. Maternal deaths accounted for 93 % of pregnancy related deaths, so that the pregnancy related mortality rationally slightly higher at 247 per 100,000 live births, making this a good proxy indicator for maternal mortality. Just over one in ten deaths (11%) among women of reproductive

age were due to maternal causes, making it the third major cause of death, an improvement on the 1998 study, in which maternal deaths were the leading cause of WRA deaths, accounting for one in five 21% percent .This MMR result is consisted with the 2006 NDHS figure of 281 deaths per 100,000 live births. Although this MMR study only covered eight districts, they were chosen to reflect the diversity across Nepal and it is anticipated that a national estimate modeled using these data⁵ would fall within similar range to the NDHS, although the NDHS was based on an earlier reference period (1999-2005) had a smaller sample size, was a national estimate used the direct sisterhood method and measured pregnancy related rather than maternal deaths. The 2008/2009 MMR study results for pregnancy related mortality ratio (247) and MMR (229) both fall within NDHS 95% Confidence interval of 178-384 ,supporting the NDHS estimates. The findings are in stark contrast to the much higher revised and unpublished 2005 world Health organization figure of 670 per 100,000 live births (Maternal mortality and morbidity study, 2008/09).

2.1.1 Antenatal Care

Antenatal care (ANC) is the health care and education provided to women during pregnancy. The aim of antenatal care is to screen for and identify high risk factors or keep the mother healthy until delivery is over.

There are four main component of ANC:

1. Maintenance of maternal health.
2. Health education about pregnancy and safe delivery.
3. Risk screening for early recognition and management of complication if present.
4. Detection and management of associate diseases.

Women who suspect pregnancy or are referred for high –risk care at district Hospital, should be seen in the antenatal clinic by a doctor at the first visit. In the first antenatal care visit, personal and medical history is taken, complete physical examination performed and findings are recorded in the antenatal card. The objective is to record any condition or abnormality which may affect the present pregnancy. This

information is essential and must be obtained as the objective is to discover any previous abnormalities that may recur or influence the present pregnancy (HMG/UNICEF, 1996).

Forty- four percent of mothers received antenatal care from skilled birth attendants (SBAS) that is from doctor, nurse, or midwife for their most recent birth in the five years preceding the survey, 28 percent of mothers received antenatal care from trained health workers such as health assistant or auxiliary health worker, maternal and child health worker or a village health worker. Less than 2 percent of women received antenatal from a Traditional Birth Attendant (TBA) or a Female Community Health Volunteer (FCHV), 26 percent of women received no antenatal care for birth in the five years before the survey (NDHS, 2006).

2.1.2 Delivery Care

The objective of the safe delivery care services is to protect the life and health of the mother and her children by ensuring the delivery of baby safely. An important component of efforts to reduce the health risk to mother and children is to increase the proportion of babies' delivered under the supervision of health professionals. Proper medical attention under hygienic conditions during delivery can reduce the risk of complication and infections that may cause death or serious illness either to the mother or the baby or both. Nevertheless, the national safe motherhood program encourages, women to delivery at facilities are upgraded and providers are trained to minimize complications (Pathak, 2006).

However, at the national, only 8 percent of births are delivered in health facilities. This is a slight improvement since 1991 when the comparable figure was 6 percent (MOH,1993), 9 percent birth were delivered under the supervision of a doctor, 6 percent or trained nurse or midwife 3 percent (NFHS,1996).

About 18 percent of births take place in a health facility, 13 percent are delivered in a public sector health facility, 4 percent in a non – government facility, less than 1 percent in private facility and 81 percent take place at home. Delivery in a health facility also varies by ecological region, being lowest in the mountains (6%), high in the hills (21%), and moderately high (17%) in the terai. The proportion of deliveries

in a health facility is only 8 percent among births to uneducated mothers, compared with 67 percent among births to mothers with SLC and higher education (NDHS, 2006).

2.1.3 Postnatal Care

Most of women did not receive postnatal care from a trained medical professional. Only 7 percent were seen by doctors, 2 percent by nurse or midwife and 4 percent by an unskilled worker, 24 percent by a traditional birth attendant, 40 percent were visited by relatives or friend and once in five women did not received post partum care from anyone (NDHS,1996).

Postnatal care is not common in Nepal. Nearly 80 percent of mothers who delivered outside a health facility do not receive any postnatal checkup. Less than one in five mothers receive postnatal care within the first two days after delivery (NDHS, 2001).

Similarly, Nineteen percent of mothers received postnatal care from an SBA, and 3 percent of mother's received care from a health assistant, auxiliary health worker, and MCHW or VHW. One in ten mothers received postnatal care from a traditional birth attendant. Mothers of first order births, mothers with SLC and higher education, those from the wealthiest households, and those in urban areas are more likely to have received postnatal care from an SBA than other mothers (NDHS, 2006).

2.2 Situations in the World

All countries, with the support of all sections of the international community, must expand the provision of maternal health services in the context of primary health care. These services based on the concept of informed choice, should include education on safe motherhood prenatal care that is focused and effective maternal nutrition programs, adequate delivery assistance that avoids excessive recourse to caesarean and provides for obstetric emergencies, referral services for pregnancy child birth and abortion complication, postnatal care and family planning. All birth should be assisted by at least by trained birth attendants. The underlying causes of maternal morbidity and mortality morbidity should be identified and attention should be given to development of strategies to overcome them and for adequate evaluation and

monitoring mechanism to access the progress being made in reducing maternal mortality and morbidity to enhance the effectiveness of maternal health and safe motherhood should be developed (ICPD, 1994 UN) .

Maternal health is the output of total life time investment in women in any society. In this context men are partner for change supporting for human rights and safe motherhood i.e.

1. Support pregnant wife
2. Care for baby
3. Educate daughter
4. Share parenting

(UNFPA, 2007)

Abortion complication is a major health problem in Nepal because 20 percent of mother's deaths in health facilities are due to complication of abortion. The maternal mortality and morbidity study 1998 shows that in the community 5 percent of the deaths are due to abortion (MOH, 2003/04).

Complication related to pregnancy and child birth is the main causes of maternal death in developing countries. Women in developing countries are much more likely to die from such complication than women of developed countries. These complications can lead the cause of death and disability among women of reproductive age. Maternal death is highest in region where women do not receive basic maternity care including prenatal, delivery and postnatal care. At least 35 percent women in developing countries did not receive antenatal during pregnancy. 50 percent women give birth by a skilled attendant and 70 percent did not receive postnatal care after delivery (WHO, 1996).

According to WHO 2001 over one third of all the healthy life lost among adult women in poor countries because of reproductive health problems as compared to only 12 percent among men. Nearly 600,000 women die every year from complication of pregnancy or delivery. Out of this 48 percent occurs in Africa 31

percent south East Asia, 4 percent in Latin America and Caribbean, and less than 1 percent in the world's more developed regions (WHO, 2001)

Complication of pregnancy and childbirth are major causes of disability and death among women of reproductive age in less developed countries. More than 500000 women die each year from pregnancy related causes. More than 95 percent of this death occurs in the less developed countries, particularly in Africa and Asia. All of the adult health statistics by the WHO, maternal death rates shows the largest discrepancy between more developed and less developed countries. Maternal deaths are strongly associated with substandard health services and lack of medical care during and immediately after child birth. Most birth in less developed countries about 60 percent maternal death occur outside health facilities (UNFPA, 1997).

There has been little improvement in maternal mortality in developing countries. A maternal death related to pregnancy or childbirth is a rare event in more developed countries. Just 9 women died for every 100,000 births in their countries in 2005, according to new estimates from the World Health Organization, UNICEF, the UN population fund and the World Bank. But the ratio of maternal deaths to births is very high in sub-Saharan Africa and South Asia. But, there has been little improvement over the past 15 years in developing regions because of despite concerted efforts to improve mother's health. Public health experts emphasize the important once of prenatal care and skilled medical assistance during child birth, including the availability of emergency care to deal with complications (WHO, 2005).

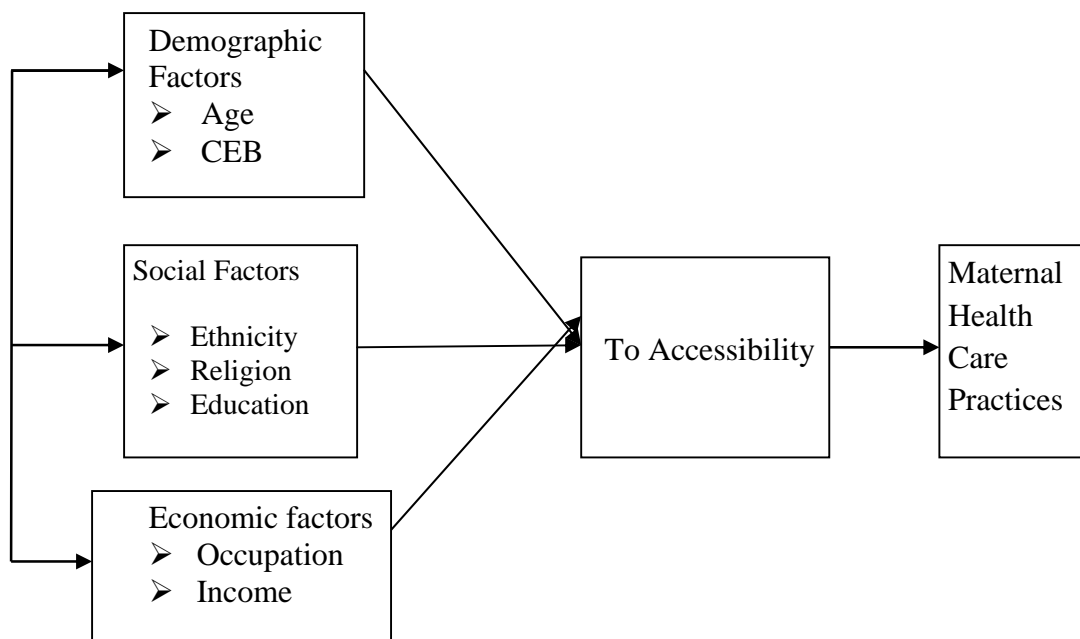
2.3 Conceptual Framework

There is relationship among various variable and maternal health care practice. We can see that social factors, demographic factors, economic factor, and educational factor are independent variables and maternal health care practice is the dependent variable. Accessibility is one of the intermediate variables, which is directly affected by independent variables as well as maternal care practice. Social like ethnicity religion have direct bearing on maternal health care practice. Ethnicity and religion have different norms and values. Similarly, educational level of the population is an important indicator of social development. Educational level is also affecting the reproductive behavior of mothers. Educational factors is perhaps the most important

to insure maternal health care practices. It is expected that literate women has better knowledge about pregnancy, its complication and implication than illiterate women. Other variables like current age, marriage are directly related with pregnancy. The age of mothers group; the possibility if antenatal care services slowly goes down. Economic factors like income and occupation are also the factors that directly affect woman's maternal health care practices.

All above mentioned variables are linked with accessibility which becomes the most important factors in changing a women's attitude towards maternal health care practice. If the health institutions are the nearby with all facilities available, people would readily go for delivery services than if the distance is very far away.

Conceptual Framework



CHAPTER - THREE

METHODOLOGY

This chapter deals with the research methodology. Research methodology is used to collect quantitative and qualitative data for research work. Further chapter discuss about study area, sources of data sample selection, questionnaire design and method of data analysis.

3.1 Study Area

This study concentrated on the women of the reproductive ages (15-49). The Dodhara V.D.C situated in Kanchanpur district of far western Nepal. It is near India and Kanchanpur District of Mahakali River with geographical location 80⁰5' 00" E and 28⁰52' 30" N. Most of the part of this region touches Mahendranagar municipality and some part touches India. In Dodhara V.D.C with the different cast of people from different caste ethnicity like Brahman, Chhetri, Tharu, Kami, Gurung and Giri etc. It is separated by Mahakali River from Nepal side and is known as part of Nepal across the Mahakali River. The study area was purposively conducted in Dodhara VDC of Kanchanpur district which lies in the Mahakali zone, southern part of Nepal. According to the 2001 census, the total population of this VDC was enumerated 18,556 among them 9,447 were males and 9,109 females. The census report shows there were 2932 households and 6.33 average household sizes. Agriculture is the main occupation of people and most of cultivated land is irrigated paddy, maize, sugarcane and wheat are main agriculture products of this VDC.

3.2 Source of Data

The primary information base study usually stands on primary information using the different method. Therefore primary source information collected by using prestructured questionnaire from the method study area though direct interview with respondents. The secondary information also used for reference of the study collection from the published or unpublished related documents (CBS 2001, NDHS 2006) is used to compare and analyze the result.

3.3 Sample Size and Sampling Procedure

The study area concerned with the Dodhara VDC about maternal health care practices. This study is based on the 15-49 years age group married women to find out their maternal health conditions. These women asked about their last child only which occurred in the last five years preceding of the survey. Only women with at least one child below five years age at the time of survey enumerated as the individual respondents. The sample is taken of 40 respondents out of 275 household from ward no 6. Similarly, 40 respondents from ward no.4. Only women with at least one child below five years age at the time of survey enumerated as the individual respondents. Leaving three houses and taking next 1 each, there were 40 respondents altogether in one ward. Any three selected to find out the delivery condition of village women. There are economically and educationally backward. Household information and individual questionnaire used as instrument in this study. The total population in the households was 648 among them the male was 303 and female was 345.

3.4 Questionnaire Design

For the survey two types of questionnaires developed which as follows:-

1. The household questionnaires collect information on age, family size, and caste, ethnicity age at marriage, educational status and occupation.
2. Individual questionnaire designed for all women of reproductive ages.
3. Who have experienced child birth, Information on the maternal health care practice like ANC, Delivery care and opinion of delivery place, numbers of CEB, age at first pregnancy, type of problem, access to health post and type of household amenities and sources of drinking water etc.

3.5 Data Processing and Analysis

This dissertation mainly based upon the primary data collected from the Dodhara VDC. The collection of data needs to be aggregated into a form that present the summary of answers from respondents. The data are thus transformed in to information. Thus process of transforming data is called analysis. The raw data collected from the study area are process by using computer software, then the data analyzed by simple table presentation, frequency tables.

CHAPTER - FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF HOUSEHOLD POPULATION AND RESPONDENTS

4.1 Characteristics of Household Population

A household is defined as a person or group of persons who live and eat together. This chapter presents the socio-economic and demographic characteristics of respondents and households populations. Demographic and socio-economic characteristics play important role in the development of society. It provides valuable input for social and economic development planning and is also useful in understanding and identifying the major factors that determines or influence the basic demographic indicators of the population. These characteristics include household composition, education attainment, and occupation. Demographic characteristics include age sex structure of household population, marital status and age at marriage of respondents.

4.1.1 Ethnicity of the Household

Table 4.1: Ethnicity Distribution by Household

Ethnicity	Number	Percent
Brahmin	150	23.15
Chhetri/thakuri	200	30.86
Kami/Damai	148	22.84
Giri/puri/Nath	120	18.52
Gurung/Magar	30	4.63
Total	648	100

Source: Field Survey, 2009

The above Table 4.1 shows that ethnic group Chhetr/ thakuri contributed highest as 30.86 percent where as Brahmin, Kami / Damai, Giri/Puri/Nath, Gurung/magar contribute 23.15, 22.84, 18.52, and 4.63 percent respectively.

4.1.2 Educational Status

It is important to know the educational status of the study population because education affects of all the aspects of human's life like occupation income and living standards.

Table 4.2: Literacy above 5 Years Distribution by Household

Literacy status	Number	Percent
Literate	396	61.9
Illiterate	252	38.9
Total	648	100

Source: Field Survey, 2009

The Table 4.2 shows the educational status of the population of 5 and above years. Out of the total, 61.9 percent were literate and 38.9 percent were illiterate.

4.1.3 Occupational Status

People of working age in any society or area are usually involved or engaged in any types of productive work. Generally, occupation is defined as the work done by person at least 6 months in a year. Occupation is another factor which influences the social, economic, cultural, political and religious variables occupational status and quality of life has positive relationship with demographic indicators

Table 4.3: Occupation Distribution by Household

Occupation	Number	Percent
Agriculture	298	45.99
Service	20	3.09
Business	80	12.35
Daily wages	88	13.58
House work	162	25
Total	648	100

Source: Field Survey, 2009

The Table 4.3 total number of household was 648, among all the households major occupation was agriculture. The number of households having occupation agriculture was 45.99 percent, followed by Housework with number 25 percent, daily wage 13.58 percent, Business 12.35 percent and Service 3.09 percent.

4.2 Demographic Characteristics of the Household

The demographic characteristics of the household's population such as and sex composition, population pyramid and marital status are presented in this section.

4.2.1 Age and Sex Composition of the Household Population

Age and sex composition play an important role in determining the population distribution. The total population in this study was recorded 648 of which 45.36 percent were male and 54.69 percent were female i.e. the sex ratio was (82.94 males per 100 female) which lower than national sex 99.8 in 2001 (CBS, 2004).

In young age group, the sex ration was high because young lady work in other home than young boy in the study area and in older age group the sex ratio was high it may be due to the life expectancy of female was less than male.

The population below 14 years of age was 45.06 percent. Similarly, the population age 15-59 was 53.9 percent and 60 year above age was 1.1 percent.

Figure population pyramid study population, 2009

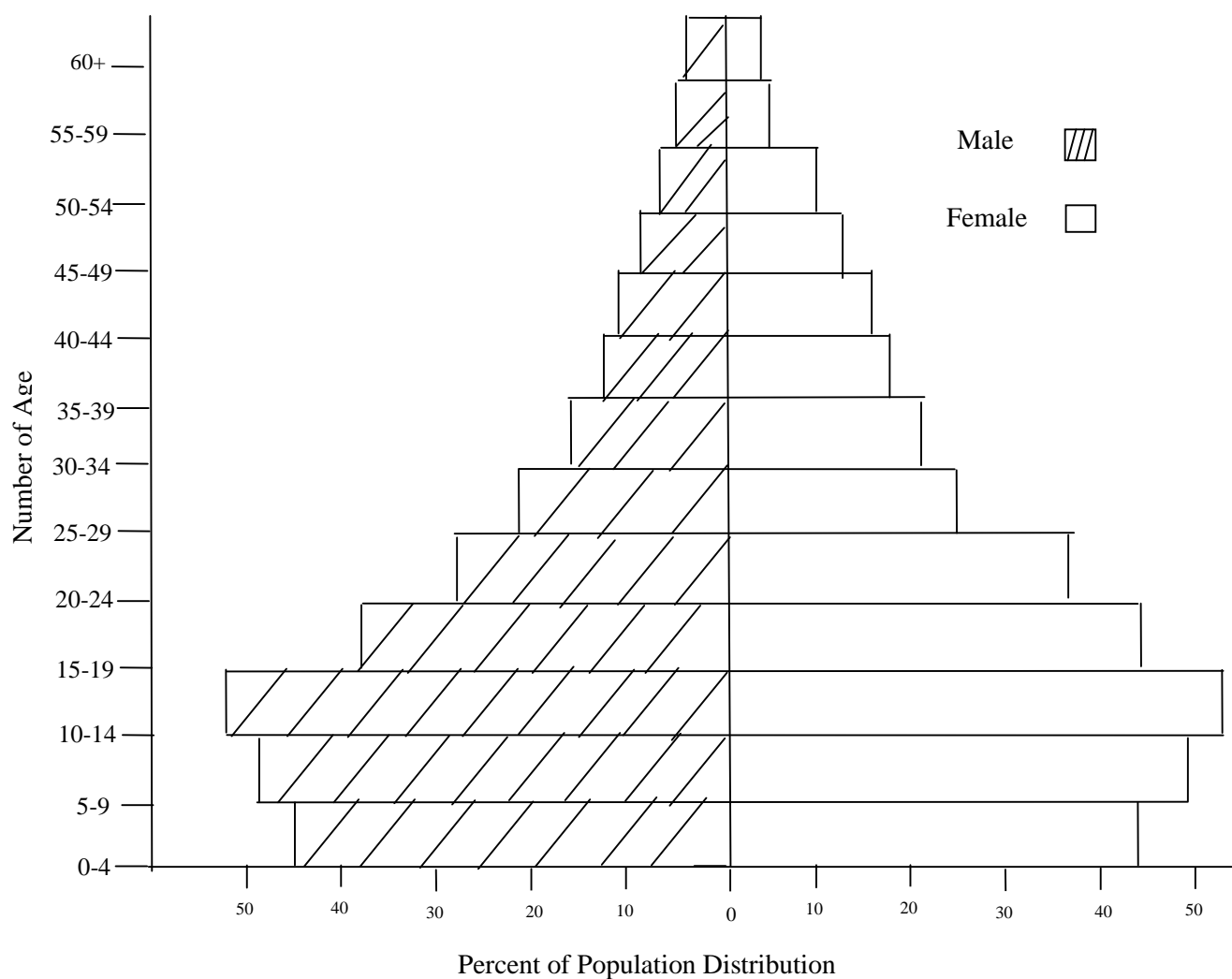


Table 4.4: Broad Age Group and Sex Distribution by the Household population

Age	Male		Female		Total	
	N	%	N	%	N	%
<14	130	42.90	162	46.96	292	45.06
15-59	170	56.11	179	51.88	349	53.86
60+	3	0.99	4	1.16	7	1.08
Total	303	100	345	100	648	100

Source: Field survey, 2009

The Table 4.4 out of 648 populations below 14 years was 292 and old age population was 7 and working age population was 349. The depends ratio in the study population is 85.6 percent. The male dependency ratio and female dependency ratio of the study population seems 78.24 and 92.74 respectively.

4.2.2 Marital Status of the Household Population

Marriage is one of the main components of population dynamics. Marriage in Nepal Universal and early marriage marks the point in women’s life at which child bearing becomes socially acceptable. Women who marry early in average have, a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing and higher fertility.

Table 4.5: Marital Status Distribution by the Household population

Marital Status	Number	Percentage
Unmarried	316	48.77
Married and living together	229	35.34
Widow/Separated/divorced	9	1.59
Married but not living together	94	14.51
Total	648	100

Source: Field survey, 2009

The Table 4.5 shows that among the total population 48.77 percent population is unmarried, married and living together population is 35.34 percent, 1.59 percent population widow/separated/Divorced and 14.51 percent population married but not living together.

4.3 Socio-Economic Characteristics of Respondents

The purpose of this chapter is to provide a descriptive summary of the demographic and socio-economic characteristics of respondents. Information on the basic characteristics of women in the survey is essential for the interpretation of the

findings and serves as an approximate indicator of the representativeness of the survey.

4.3.1 Educational Status

It is considered that educated women are more aware of family and own health care significantly. Education represents better position of women in terms of their socio-economic status. This study, however show that majority of the respondents were literate.

Table 4.6: Educational Distribution by Respondents

Literacy Status	Respondents	
	N	%
Literate	80	66.7
Illiterate	40	33.3
Level of education		
Primary	45	56.3
Lower secondary	22	27.5
Secondary	8	10
Intermediate	5	6.3
Total	120	100

Source: Field survey, 2009

The Table 4.6 shows that among the 120 respondent were 33.3 percent population were illiterate and 66.7 percent were literate. Out of 80 literate respondents, 56.3 percent respondents got the primary level, 27.5 percent respondents received Lower secondary level, 10 percent respondents received secondary level , 6.3 percent received the intermediate level.

4.3.2 Occupational Status of Respondents

Income is another important part of life. It determines the level of households. In the context of Nepal main source of income is agriculture, service, business, work in India, gulf countries such as Qatar and Malaysia.

Table 4.7: Occupational Distributions by Respondents

Occupation status	Number	percent
Agriculture	60	50
Service	4	3.3
Business	7	5.8
Daily wages	9	7.5
House work	40	33.3
Total	120	100

Source: Field Survey, 2009

The Table 4.7 shows that in agriculture 50 percent respondents were engaged in agriculture, 33.3 percent respondents were engaged in house work. That is in study area, directly or indirectly 50 percent respondents were engaged in agriculture. About 8 percent respondents were Daily wages, 5.8 percent respondents were engaged in Business, and 3.3 percent respondents were engaged in service.

4.4 Economic Characteristics of Respondents

The economic Status of the Respondents of agriculture respondent's husband such as income, wages, business, service.

4.4.1 Monthly Income

Income determines the saving and investment capacity of households. High income facilities result high quality of life of the people.

Table 4.8: Income per Month Distribution by Respondents Husband

Income in RS	Number	Percent
Less 500	-	-
500-1000	12	10
1000-2000	54	45
2000-3000	31	25.8
3000+	23	19.2
Total	120	100

Source: Field Survey, 2009

The Table 4.8 shows that it was that 45 percent respondent's husband had earned monthly RS 1000 to 2000 and following by 19.2 percent households with monthly income 3000+.

4.4.2 Home Facility of Respondents

Home facility reflects the social and economical status of the households, which is useful to analyze the general socio-economic condition of study population. In this study, the variables like Electricity, Television, Radio, Telephone, Biogas and types of house was discussed.

Table 4.9: Home Facility Distribution by Respondents

Home facility	Number	Percent
Electricity	70	39.3
Television	23	12.9
Radio	79	44.4
Telephone	6	3.4
Biogas	-	-
Total	120	100

Source: Field survey, 2009

Table 4.9 provide the information of selected home facility .Out of total 120 respondents only 39.3 percent respondents used electricity, only 44.4 respondents have radio 12.9 percent have television only 3.4 percent have telephone facility in this area.

4.4.3 Types of House

House is the basic and fundamental requirement of human being. It is one of the basic measures of quality of life of people. Good housing means good living standard and also makes life comfortable. Here, the houses are categorized in three groups as thatched, wood, brick/stone, cement /brick and others.

Table 4.10: Type of House Distribution by Respondents

Types of House	Number	Percent
Thatched	97	80.8
Wood	2	1.7
Brick/Stone	4	3.3
Cement/Brick	13	10.8
Others	4	3.3
Total	120	100

Source: Field Survey, 2009

The Table 4.10 shows that almost 80.8 percent households were made by thatched and 1.7 percent households were made by wood, 3.3 percent housed make by brick and stone. Similarly 10.8 percent house make by cement/ brick in this study area.

4.4.4 Toilet Facilities

Some of the people don't know the human excrete is means of communicable disease due to lack of awareness. There may not be proper use of toilet this study has tried to get information from respondents about use and non-use and types of toilet facilities.

Table 4.11: Toilet Facilities Distributions by Respondents

Toilet facility	Number	Percent
Open toilet/bush	39	32.4
Flush toilet	-	-
Water supplied	3	2.5
Pit with finch	78	65
Total	120	100

Source: Field Survey, 2009

The Table 4.11 shows that, the condition of toilet facility seems to be poor. Most of the households have pit with Finch 65 percent followed by water supplied toilet 2.5 percent, open toilet /bush 32.4 percent.

4.4.5 Source of Drinking Water

Water is essential for everyday for various purposes. Life is impossible without water. There are various sources of water in the earth: ocean, river, well spring steam, pond, and snow e.tc. Human being use different sources of water according to access and availability for their basic needs as drinking, cooking, washing e.t.c pure and germless Water is important for better health. The main sources of drinking water in the study area are hand pump. It is found that 100 percent Households use hand pump to get underground water.

4.4.6 Radio Listening

In study area, 60 respondents have radio but all the respondents may not listen to the radio. Radio listening habit increases the awareness about the maternal health care. So, it is essential to analyze the maternal health care practices with radio listening.

Table 4.12: Listening Radio Distribution by Respondents

Listing Radio	Number	Percent
Yes	36	30
No	84	70
Total	120	100

Source: Field survey, 2009

The Table 4.12 shows that out of the total 120 respondents, 30 percent respondents were radio listening and 70 percent respondents were not radio. It may be due to low social and economical status of respondents.

4.5 Demographic Characteristic of Respondents

4.5.1 Age

Age is demographic character of any population .age plays an important role in any aspect of life. Therefore, it was important from the study population.

Table 4.13: Age Distributions by Respondents

Age group	Number	Percentage
15-19	40	33.3
20-24	18	15
25-29	24	20
30-34	20	16.7
35-39	10	8.3
40-44	5	4.2
45-49	3	2.5
Total	120	100

Source: Field Survey, 2009.

Table 4.13 Shows that the highest proportion of respondent was found to be in the age group of 15-19. Which was 33.3 percent followed by 25-29 age groups(20%), 30-34 age group (16.7%), 20-24 age group (15 %), 35-39 age groups (8.3 %), 40-44 age group (4.2 %) and the lowest no. of respondents from the 45-49 age group 2.5 percent.

4.5.2 Age at Marriage of Respondents

Age at marriage is the most important facture in determining maternal health care practices. The age at marriage in study area of respondents was found low. The main

reason of early marriage in study area was social, religion, cultural and economic of respondent.

Table 4.14: Age at Marriage Distribution by Respondents

Age	Number	Percent
15-19	69	57.5
20-24	17	14.2
25-29	25	12.5
30-34	4	8.3
35-39	4	7.5
40-44	-	-
45-49	-	-
Total	120	100

Source: Field Survey, 2009

Table 4.14 shows that about 57.3 respondents were married between 15-19 years. Only the 14.2 percent respondents married after 20-24 years. Early marriage pattern seems higher in this area.

4.5.3 Children Ever Born

A child ever born is another demographic characteristic of any population. In this study most of women interviewed below the age of years. Number of parity is inversely related to the health status of mother and infant as well as better health is inversely related to the number of children.

Table 4.15: Children Ever Born Distribution by Respondents

No. of CEB	Number	Percent
1-2	82	68.3
3-4	31	25.8
5-6	6	5.0
7+	1	0.8
Total	120	100

Source: Field Survey, 2009

Table 4.15 shows that, the CEB for the highest percent respondents about 68.3 percent is 1 to 2, followed by 3 to 4 children 25.8 percent, 5 to 6 children 5.0 percent and 0.8 percent have 7 children till the date of interview.

CHAPTER-FIVE

ANALYSIS OF MATERNAL HEALTH CARE PRACTICE

This chapter examines the practice of maternal health care such as antenatal care, TT vaccination, receiving iron, Vitamin ‘A’ tablets. Also this chapter discusses the type of antenatal services used by respondents during her pregnancy period through trained and untrained health personnel, TT –Vaccination, place of delivery, delivery assistance and the basic of selected socio- economic and demographic characteristics of respondents.

5.1 Practices of Antenatal Services

Antenatal care includes the care of mother during pregnancy or before delivery. It is essential for the good health of both mother and fetus. It helps to reduce the maternal mortality as well as the death of new born baby.

Table 5.1: Practices of Antenatal Care Distribution by Respondents

Antenatal care received	Number	Percent
Yes	102	15
No	18	85
Total	120	100

Source: Field Survey, 2009

Table 5.1 explains that only 15 percent respondents don't get antenatal services. In the study area, there are not more facilities in health sector. So people cannot achieve health service at any time they need. About 85 percent of women have received and utilized antenatal service.

5.1.1 Antenatal Check up by Respondent's Age

Mostly, younger respondents were associated with better antenatal check than the older respondents. The respondents of age 15-19 and 20-24 had received 5.3 and 85.7 percent antenatal checks. Similarly, the respondents of age 25-29, 30-34, 35-39, 40-44 had received 70.6, 40, and 25 percent antenatal check up respectively in health

post. There were no respondent between (45-49) for the antenatal check up, in any health institution.

Table 5.2: Antenatal Checks up Distribution by Respondents Age

Age	Hospital		Private clinic		Health post/others		None		Total	
	N	%	N	%	N	%	N	%	N	%
15-19	-	-	-	-	5	5.3	-	-	5	100
20-24	-	-	-	-	60	85.7	10	14.3	70	100
25-29	1	3.3	-	-	24	80	5	16.7	30	100
30-34	-	-	-	-	-	-	5	100	5	100
35-39	-	-	3	60	2	40	-	-	5	100
40-44	-	-	-	-	1	25	22	4	5	100
45-49	-	-	-	-	-	-	-	-	-	-
Total	1	8.3	3	2.5	92	76.7	42	35	120	100

Source: Field survey, 2009

The Table 5.2 shows that, out of total (120) respondents the higher percent of antenatal check up in health post by 85.7 percent respondents of age group 20-24 and followed by 80 percent of age group 25-29. The lowest percent of antenatal check up in health post had found zero percent for 45-49 age group respondents and 5.3 percent for 15-19 years age group respondents.

5.1.2 Antenatal Check up by Respondent's Education

Education has made difference in antenatal check up. Educated women are more aware about maternal health care. All the illiterate respondents have found Antenatal check up in health post where as all the respondents having intermediate level education antenatal check in Hospital.

Table 5.3: Antenatal Check up Distribution by Educational Respondents

Respondents education	Hospital		Private clinic		Health post		Don't know		Total	
	N	%	N	%	N	%	N	%	N	%
Literate	10	12.5	6	7.5	60	75	4	5	80	100
Illiterate	-	-	-	-	15	37.5	25	62.5	40	100
Total	10	8.3	6	5	65	54.2	29	24.2	120	100
Educational Level										
Primary	-	-	-	-	8	72.7	3	27.3	11	100
Lower secondary	1	6.7	2	13.3	12	80	-	-	15	100
Secondary	5	29.4	1	5.9	10	58.8	1	5.9	17	100
Intermediate	4	10.8	3	8.1	30	81.1	-	-	37	100
Total	10	12.5	6	7.5	60	75	4	5	80	100

Source: field Survey, 2009

The Table 5.3 shows out of the total literate respondents, 75 percent received ANC service in health post whereas only 37.5 percent illiterate respondents received this checkup. When we see the educational level and practices of ANC of only literate women, there are vast difference literate and illiterate respondents. As educational level, from health post 81.1 percent, 80 percent, 72.7 percent, and 58.8 percent had got antenatal check up as Intermediate, Lower secondary, primary, and secondary level respectively. The respondents who did not have the antenatal check up as educational status were 27.3 and 5.9 for Primary and Secondary. From the above table, it was found that, the antenatal check up was not only depending on literate and illiterate, but it also strongly depends on educational level.

Table 5.4: Antenatal Checks Distribution by Respondent's Occupation Status

Occupational Status	Hospital		Private clinic		Health post		None		Total	
	N	%	N	%	N	%	N	%	N	%
Agriculture	1	1.1	-	-	70	77.8	20	22.2	90	100
Service	4	80	-	-	2	40	-	-	5	100
Business	-	-	-	-	4	66.7	-	-	6	100
Daily wages	-	-	-	-	1	25	3	75	4	100
House work	-	-	-	-	10	66.7	3	33.3	15	100
Total	5	4.2	-	-	87	72.2	28	23.3	120	100

Source: Field Survey, 2009

Mostly, all the respondents were related with Agriculture, Service, Business, Daily wages and House work occupation in study area. Table 5.4 shows that, out of the total respondents almost 72.5 percent received antenatal checkup from Health post, 23.3 percent did not received the antenatal check up, 4.2 percent received the antenatal check up. About 80 percent respondents who are engaged in service are received antenatal check up at Hospital, 77.8 percent respondents who are engaged in agriculture are received antenatal check up at Health post. Only one 1.1 percent respondents who are engaged in Agriculture who are received antenatal check up at Hospital. The respondents, who did not have the antenatal check up was higher in Daily wages.

5.1.3 Antenatal Checkup to Listen Radio by Respondents

Communication is the act of exchanging news, views, feeling, ideas, and information etc from one individual to another. It helps to settle dispute to know about another and to get suggestions from others. The medium of communication must be simple and understand by other easily.

Table 5.5: Antenatal Checkup Distribution by Listening Radio of Respondents

Listen Radio	Hospital		Private clinic		Health post		None		Total	
	N	%	N	%	N	%	N	%	N	%
Yes	31	88.6	-	-	4	11.4	-	-	35	100
No	1	1.2	-	-	64	75.3	20	23.5	85	100
Total	32	26.7	-	-	68	56.7	20	16.7	120	100

Source: Field survey 2009

Most of the Radio listener goes Hospital non listener goes Health post for them ANC. The Table 5.5 shows that, Out of the 120 total respondents 35 percent respondents were radio listener and 85 respondents were radio non listener. Total radio listener 35 respondents received the antenatal check up from hospital and health post /other respectively. Similarly, the 85 total radio non listener respondent's 1.2 percent and 75.3 percent respondents received the antenatal check up from Hospital, Health post. Radio non listeners 16.7 percent are not use any health facility for their ANC.

5.1.4 The Number of ANC Visits and Age of Respondents

The respondents receiving antenatal checkup with on times, two times, three times and not know were 45.8, 22.5, 9.7 and 21.7 percent respectively. The respondents receiving two and three times antenatal check up belonging to age,15-19,20-24,25-29, 30-34 and 35-39 where 16.7, 30.8, 18.5,30 and 21.4 Percent respectively. Similarly the antenatal check up receiving only one time was 60, 38.5, 44.4, 40, 42.9 and 33.3 percent respectively. The respondent of age group 15-19 had highest 60 percent antennal check up and followed by 25-29 had highest 44.4 percent antenatal check up.

Table 5.6: The Number of ANC Visits Distribution by Age of Respondents

Age of Respondents	One time		Two times		Three times		None		Total	
	N	%	N	%	N	%	N	%	N	%
15-19	18	60	5	16.7	2	6.5	4	13.3	30	100
20-24	10	38.5	8	30.8	3	11.5	5	19.2	26	100
25-29	12	44.4	5	18.5	4	14.8	6	22.2	27	100
30-34	8	40	6	30	-	-	6	30	20	100
35-39	6	42.9	3	21.4	2	14.3	3	21.4	14	100
40-44	1	33.3	-	-	-	-	2	66.7	3	100
45-49	-	-	-	-	-	-	-	-	-	-
Total	55	45.8	27	22.5	11	9.2	26	21.7	120	100

Source: Field Survey, 2009

This Table concluded that younger women are more likely to ANC visits than older women this may be due to the younger respondents were more aware to health.

Table 5.7: ANC Visits Distribution by Educational Status of Respondents

Educational Status	One times		Two times		Three times		None		Total	
	N	%	N	%	N	%	N	%	N	%
Literate	40	50	18	22.5	10	12.5	12	15	80	100
Illiterate	7	17.5	8	20	-	-	26	65	40	100
Total	47	39.2	26	21.7	10	8.3	38	31.7	120	100
Educational Level										
Primary	9	45	3	15	1	5	7	35	20	100
Lower secondary	10	50	5	25	2	10	1	15	20	100
Secondary	8	47.1	4	23.5	3	17.6	2	11.8	17	100
Intermediate	13	56.5	6	26.1	4	17.4	-	-	23	100
Total	40	50	18	22.5	10	12.5	12	15	80	100

Source: Field Survey, 2009

The Table 5.7 shows that , Among the total 40 illiterate respondents 17.5 percent respondents had received one time antenatal check up, 20 percent respondents had received two times antenatal check up,65 percent respondents do not received antenatal check up. Generally, the respondents, who had got primary, lower secondary, Secondary and Intermediate had 45, 50, 47.1, and 56.5 percent one time respectively. This data concluded that the level of education high and antenatal check up also high.

5.2 Coverage of Tetanus Vaccination

Tetanus Taxied is another component of antenatal care. It protects both mother and new born baby from tetanus infection. It is taken twice or thrice times during delivery period.

5.2.1 TT-Vaccination by Age of Respondents

TT Vaccination protects both mother and new born baby from tetanus infection. It is also an important component of antenatal care. TT Vaccination taken is also affected by age of respondents. The respondents of age 20-24 and 25-29 have more practice of TT Vaccination in the study area.

Table 5.8: Tetanus Vaccination Distribution by Age of Respondents

Age Group	One does		Two does		Three does		Don't know		Total	
	N	%	N	%	N	%	N	%	N	%
15-19	15	50	5	14.3	2	5.7	3	8.6	35	100
20-24	25	71.4	12	40	3	10	2	6.7	30	100
25-29	16	64	6	24	2	8	1	4	25	100
30-34	8	53.3	2	13.3	-	-	5	33.3	15	100
35-39	4	50	1	12.5	-	-	3	37.5	8	100
40-44	-	-	-	-	-	-	5	100	5	100
44-45	-		-	-	-	-	2	100	2	100
Total	71	59.2	26	21.7	7	5.8	21	17.5	120	100

Source: Field Survey, 2009

The Table 5.8 shows that the 17.5 percent respondents did not receive TT-Vaccination. Out of 59.2 percent got only one does, 21.7 percent got two does and 5.8 percent get full does TT- Vaccination. This data concluded that younger women are more likely to take TT-Vaccination than older women this may be due to the younger respondents were more aware to health , more educated and know the benefits of TT-Vaccination than older women.

5.2.2 TT- Vaccination and Listening Radio

In maternal health care can improve on the basis of related information from media. Therefore, the respondents, who listen to radio, received better TT-Vaccination than radio non listener respondents.

Table 5.9: TT Vaccination Distribution by Listen to a Radio by Respondents

Listening Radio	One dose		Two dose		Three dose		None		Total	
	N	%	N	%	N	%	N	%	N	%
Yes	40	47.6	20	23.8	10	11.9	14	16.7	84	100
No	20	55.6	6	16.7	4	11.1	6	16.7	36	100
Total	60	50	26	21.7	14	11.7	20	16.6	120	100

Source: Field Survey, 2009

From the above Table 5.9 shows that 11.9 percent radio listener respondents had got the full does of TT-Vaccine. Where 11.1 percent radio non listeners respondents had got full does of TT-Vaccine. The one dose of TT-Vaccine receiving was found higher in 55.6 percent of non listener than listener. We can conclude that, the radio listener respondents were more aware about maternal health care than radio non listener.

5.3 Age Group

5.3.1 Age group and Iron Tablet

Iron tablets helps to keep better health of pregnant women. Age of the respondents also make difference in taking Iron tablets. Women of age group 20-24 have more Practices than age 15-19.

Table 5.10: Iron Tablets Take Distribution by Age Group

Age Group	Receiving Iron Tablets				Total	
	Yes		No			
	N	%	N	%	N	%
15-19	4	21.1	15	78.9	19	100
20-24	44	88	6	12	50	100
25-29	11	34.4	20	62.5	32	100
30-34	5	62.5	3	37.5	8	100
35-39	2	66.7	1	33.3	3	100
40-44	1	16.7	5	83.3	6	100
45-49	-	-	2	100	2	100
Total	67	55.8	52	43.3	120	100

Source: Field Survey, 2009

The Table 5.10 shows the respondents by age group and Iron tablet. Among the total 50 respondents of age group 20-24 years, 88 percent respondent's received iron tablets and followed by 66.7 percent respondents of age group 35-39 years. The lowest percent of iron tablets receiving were found in age group 45-49 with zero percent followed by 16.7 percent of 40-44 age groups.

5.3.2 Education and Iron Tablet

Education of respondents plays the vital role in taking Iron tablets. Educated women have better knowledge about maternal health care than uneducated. To protect the health from iron deficiency, a mother should take iron tablet during pregnancy.

Table 5.11: Iron Tablet Distributions by Education

Education of Respondents	Receiving Iron Tablets				Total	
	Yes		No		N	%
	N	%	N	%		
Literate	45	56.3	35	43.8	80	100
Illiterate	15	37.5	25	62.5	40	100
Total	60	50	60	50	120	100
Educational Level						
Primary	4	10	15	35.5	40	100
Secondary	10	55.6	8	44.4	18	100
Lower Secondary	6	46.2	7	53.8	13	100
Intermediate	25	62.5	5	55.6	9	100
Total	45	56.3	35	43.8	80	100

Source: Field Survey, 2009

Table 5.11 shows the education and Iron tablets. Among the total 80 literate respondents, 56.3 percent had received iron tablets. Similarly, out of the total 40 illiterate respondents, 37.5 percent had received iron tablets, so the difference between literate and illiterate iron tablets receiving was 18.8 percent. The higher 62.5 percent iron tablets receiving were found in intermediate level followed by the respondents having Secondary level by 55.6 percent. This table concluded that educated respondents are expected to take high and better iron tablets than uneducated respondents.

Table 5.12 Receiving Vitamin 'A' Distribution by Respondents

Receiving vitamin 'A'	Number	Percent
Yes	50	41.7
No	70	58.3
Total	120	100

Source: Field Survey, 2009

The Table 5.12 shows that the 41.7 percent respondents received the vitamin A and majority 58.3 percent respondents did not receive the vitamin 'A'.

Table 5.13: Vitamin ‘A’ Distribution by Age Group

Age Group	Yes		No		Total	
	N	%	N	%	N	%
15-19	4	15.4	22	84.6	26	100
20-24	12	38.7	19	61.3	31	100
25-29	25	55.6	20	44.4	45	100
30-34	4	44.4	5	55.6	9	100
35-39	3	75	1	25	4	100
40-44	2	50	2	50	4	100
45-49	-	-	1	100	1	100
Total	50	41.7	70	58.3	120	100

Source: Field Survey, 2009

The Table 5.13 shows that the level of receiving vitamin ‘A’ was ranging from 15.4 to 75 percent. The highest percent was contributed by age group 35-39 years with 75 percent and followed by 25-29 years age group with 55.6 percent. The lowest percent was shared by age group 15-19 with 15.4 percent and followed by 40-44 years age group with 50 percent. The younger age group with 15-19 had shared 15.4 percent and the younger age group 20-24 had shared 38.7 percent in receiving vitamin ‘A’.

Table 5.14 Receiving Vitamin ‘A’ by Education of Respondents

Education of Respondents	Receiving Vitamin ‘A’				Total	
	Yes		No		N	%
	N	%	N	%		
Literate	35	43.8	45	56.3	80	100
Illiterate	15	37.5	25	62.5	40	100
Total	50	41.7	70	58.3	120	100
Educational Level						
Primary	7	21.9	5	26.3	19	100
Secondary	9	52.9	8	47.1	17	100
Lower Secondary	5	41.7	7	58.3	12	100
Intermediate	14	43.7	5	78.1	32	100
Total	35	43.8	45	56.3	80	100

Source: Field Survey, 2009

The Table 5.14 shows that the use of vitamin 'A' and by educational level depicted that 43.8 percent respondents of the total literate had received vitamin 'A' and 37.5 percent of the total illiterate respondents had receive vitamin 'A' . Similarly, who had got Primary, Lower secondary, Secondary and Intermediate had 21.9, 52.9, 41.7, 43.7 percent respondents had receiving Vitamin 'A'.

5.4 Delivery Practices

In this section we deal about place of delivery types of delivery assistance and use of clean delivery kits.

5.4.1 Place of Delivery

Place of delivery is one of the most important factor affecting maternal health. Most of the Nepalese women give birth at home with the help of untrained birth attendants i.e. relatives, friend and family member. The home deliveries take place in extremely unhygienic condition which is dangerous for mother and new born child. A large proportion of maternal deaths occur at home. Very little proportion of mothers dies at health facilities.

5.4.2 Education and Place of Delivery

Education has made difference in place of delivery .Education women are more aware about maternal health care. All the illiterate respondents have found delivered at home where as all the respondents having higher Secondary above education has delivered at hospital.

Table 5.15: Place of Delivery Distribution by Educational Respondents

Literacy Status	Home		Hospital		Clinic		Health post		Total	
	N	%	N	%	N	%	N	%	N	%
Literate	60	75	16	20	2	2.5	2	2.5	80	100
Illiterate	38	95	2	5	-	-	-	-	40	100
Total	98	81.7	18	15	2	1.7	2	1.7	120	100
Educational Level										
Primary	40	90.9	3	6.8	-	-	2	2.5	45	100
Lower Secondary	15	78.9	4	21.0	-	-	-	-	19	100
Secondary	3	50	3	50	-	-	-	-	6	100
Intermediate	2	22.2	6	60	2	22.2	-	-	10	100
Total	60	75	16	20	2	2.5	2	2.5	80	100

Source: Field Survey, 2009

Table 5.15 shows that, out of 80 literate respondents 75 percent delivered at home where as more than 95 percent illiterate respondents delivered at home. When we see the educational level and practice of place of delivery only literate and women, there is vast difference literate and illiterate respondents. As educational level, from home 90.9 percent, 78.9 percent, 50 percent and 22.2 percent had got delivered at home as primary, lower secondary, and intermediate level respectively. The above data concluded that education level high than women are more conscious hands they go to Health Institution for delivery and when women are not educated they are not conscious have their delivery at Home.

5.4.3 Place of Delivery and Occupational Status.

Occupation of the respondents has made difference in the place of delivery. Most of the respondents having non- agricultural occupation have delivered at health facility

Table 5.16 Place of Delivery Distribution by Occupation Respondents

Occupational Status	Home		Hospital		Health post		Private clinic		Total	
	N	%	N	%	N	%	N	%	N	%
Agriculture	65	81.3	5	6.3	10	12.5	3	16.7	80	100
Services	5	27.8	8	44.4	2	11.1	3	30	18	100
Business	5	50	2	20	1	10	-	-	10	100
Daily wages	4	100	-	-	-	-	-	-	4	100
House work	6	75	-	-	2	25	-	-	8	100
Total	92	76.7	15	12.5	15	12.5	6	5	120	100

Source: Field survey, 2009

Table 5.16 Shows that out of the total 120 respondents, almost 76.7 percent delivered at home, 12.5 percent at hospital, 12.5 percent at health post, and 5 percent at private clinic. About 44.4 percent respondents who are engaged in service are delivered at hospital more than 81.3 percent respondents who are engaged in agriculture are delivered at home. Only 30 percent respondents who are engaged in business who are delivered in private clinic.

5.5.1 Birth Assistance during Delivery

Information about delivery assistance has collected in the survey. The topics discusses on assistance during child birth of respondents. Assistance is important for mother and child for healthy and safe delivery through which the women receive medical personnel during delivery.

Table 5.17: Birth Assistance During Delivery Distribution by Respondents

Birth Assistance	Number	Percent
Doctor	3	2.5
Nurse	26	21.7
H.A	2	1.7
TBA	19	15.8
Family members	70	58.3
Total	120	100

Source: Field Survey, 2009

The Table 5.17 shows that among the 120 respondents, 58.3 percent respondents are assisted by family member / relatives /Friends, 21.7 percent respondents are assisted by Nurse, 15.8 percent by TBA. 2.5 percent by Doctor and 1.7 more than half percent birth is assisted by untrained relatives, family member and friends in the study area.

5.5.2 Age Group and Birth Assistance

Birth assistance during delivery is an important factor for maternal health care. All birth should assisted by health personal to reduce maternal mortality and morbidity. Age group of respondents has made difference in birth assisting during delivery. Most of the respondents in the age group 20-24 and 25-29 have assisted by health personal.

Table 5.18: Birth Assistance During Delivery Distribution by Age Group of Respondents

Age group	Birth Assistance											
	Doctor		Nurse		H.A		TBA		Family member		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
15-19	-	-	3	37.5	-	-	2	25	3	37.5	8	100
20-24	3	7.7	5	12.8	4	10.3	8	20.5	19	48.7	39	100
25-29	3	10.3	13	44.8	2	6.9	3	10.3	8	27.6.	29	100
30-34	-	-	4	14.3	-	-	3	10.7	21	75	28	100
35-39	3	23.0	-	-	2	13.3	-	-	8	61.5	13	100
40-44	-	-	-	-	-	-	-	-	2	100	2	100
45-49	-	-	-	-	-	-	-	-	1	100	1	100
Total	9	7.5	25	20.9	8	6.7	16	13.3	59	49.2	120	100

Source: Field Survey, 2009

The Table 5.18 shows that most of the births are assisted by family member .The percent respondents in the age group 40-44 and 45-49 reported that their birth is assisted by family member which is followed by the respondents 75 percent of 30-34 age groups. Most of the respondents in the age group 25-29 are assisted by Nurse i.e. 44.8 percent. Most of the respondents, in the age group 20-24 are assisted by TBA i.e. 20.5 percent. In total 120 respondents only 7.5 percent respondents are assisted by

the Doctors. From this situation we conclude that most of the respondents are assisted by family members, in an unhygienic place which is the responsible cause of maternal mortality and morbidity.

5.5.3 Education and Birth Assistance

Educations of the respondents have made difference in birth assisting during delivery. Out of the 80 literate respondent's more than half birth are assisted by health personal.

Table 5.19 Birth Assistance during Delivery Distribution by education of Respondents

Education Status	Birth Assistance											
	Doctor		Nurse		HA		TBA		Family Member		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Literate	8	10	14	17.5	9	11.3	22	27.5	27	33.8	80	100
Illiterate	-	-	-	-	-	-	15	21.2	34	40	40	100
Total	8	6.7	14	11.7	9	7.5	37	30.8	52	43.3	120	100
Education Level												
Primary	-	-	1	3.6	2	7.1	10	35.7	15	53.6	28	100
Lower secondary	1	5.3	15.8	20	1	5.3	6	31.6	8	42.1	19	100
Secondary	2	12.5	4	25	2	12.5	4	25	4	25	16	100
Intermediate	5	29.4	6	35.3	3	17.6	2	-	11.8	1	17	100
Total	8	10	14	17.5	9	11.3	22	27.5	27	33.8	80	100

Source: Field Survey, 2009

The Table 5.19 shows that among the literate respondents, 10 percent is assisted by doctor. 17.5 percent are assisted by Nurse, 11.3 percent are assisted by Health Assistance, 27.5 percent by Traditional Birth Attendance (TBA) and 33.8 percent by Family member. All respondents who are illiterate are assisted by untrained assistance by during delivery. We can see that birth assistance by Health Personal.

The respondents are increasing with the level of education. The respondents who have got higher education have high rate of birth assistance by health personal.

Table 5.20: Birth Assistance During Delivery Distribution by Occupation of Respondents

Occupation	Birth Assistance											
	Doctor		Nurse		HA		TBA		Family member		Total	
	N	%	N	%	N	%	N	%	N	%	N	%
Agriculture	1	1.3	3	3.8	2	2.5	14	17.5	60	75	80	100
Services	4	40	3	30	2	20	1	10	-	-	10	100
Business	2	16.7	6	50	-	-	-	-	4	33.	12	100
Daily wages	-	-	-	-	-	-	3	37.5	5	62.5	8	100
House work	-	-	-	-	-	-	4	40	6	60	10	100
Total	7	5.8	12	10	4	3.3	22	18.3	75	62.5	120	100

Source: Field Survey, 2009

The Table 5.20 we can see that all the respondents who are engaged in service and business. 40 percent are assisted by Doctor who is engaged in Service and 16.7 percent are assisted by Doctor who is engaged in Business. Out of 80 respondents who are engaged in Agriculture 1.3 percent are assisted by Doctor, 17.5 assisted by Traditional Birth Attendance and 75 percent by Family member. Daily wages and House work respondents totally assisted by Traditional Birth Attendance and Family Member.

5.6.1 Coverage of Use of Clean Delivery Kits

A clean delivery kit is an especially prepared kit, containing a razorblade a cutting surface, a plastic sheet, a piece of soap, a string and pictorial instruction, assembled by maternal and child health product pvt.ltd for safe delivery practices.

Table 5.21: Distribution of Respondents by Use of Clean Delivery Kits

Use of clean delivery kits	Number	Percent
Yes	9	7.5
No	90	75
Don't know	21	17.5
Total	120	100

Source: Field Survey, 2009

The Table 5.21 shows that the respondents using the clean delivery kits for safe delivery in study area were found 9 i.e. 7.5 percent and 90 respondents did not use clean delivery kits. Out of the total 120 respondents, 7.5 percent respondents used clean delivery kits for safe delivery and 75 percent respondents do not know about clean delivery kits. But most of the respondents use new blade and shop in delivery as the experience of respondents.

5.6.2 Use of clean Delivery Kits and Respondents Education

There is relationship between education and clean Delivery kits .Education plays the role to increase the practice of delivery kits.

Table 5.22: Use of Clean Delivery kits Distribution by Education of Respondents

Education Respondents	Yes		NO		Don't know		Total	
	N	%	N	%	N	%	N	%
Literate	20	25	50	62.5	10	12.5	80	100
Illiterate	5	12.5	20	50	30	75	40	100
Total	25	20.8	70	58.3	40	19.4	120	100
Educational Status								
Primary	2	8.3	18	75	4	16.7	24	100
Lower secondary	4	17.4	17	73	2	8.7	23	100
Secondary	6	42.9	8	57.1	1	7.1	17	100
Intermediate	8	47.1	7	43.8	3	18.8	16	100
Total	20	25	103	62.5	10	12.5	80	100

Source: Field Survey, 2009

The Table 5.22 shows that among the total 120 respondents, literate 80 respondents, uses more clean delivery than illiterate 40 respondents. Out of total illiterate 40 respondents, 12.5 percent respondents used clean delivery kits and in the study area. Likewise, out of the total literate 80 respondents, 25 percent respondents used the clean delivery kits and 62.5 percent respondents did not used clean delivery kits. The respondents taking Primary, Secondary, Lower secondary, and Intermediate level used the clean delivery kits where 8.3 percent ,17.4 percent, 42.9 percent, and 47.1 percent respectively .From this data, it was clear that the education might have significant role in enhancing the use of clean delivery kits for safe delivery, in study area.

5.6.3 Use of Safe Delivery Kits by Occupation

Safe delivery kit is important medical box used at the time of delivery. It is hygienic for both mother and new child. The respondents who are engaged in non –agricultural occupation have better use clean delivery kits who are engaged in agriculture occupation.

Table 5.23: Safe Delivery Kits Distribution by Respondents’ Occupation

Respondents occupation	Safe Delivery							
	Yes		No		Don’t know		Total	
	N	%	N	%	N	%	N	%
Agriculture	22	31.4	15	21.4	33	47.1	70	100
Services	10	83.3	3	37.5	-	-	8	100
Business	5	62.5	-	-	2	16.7	12	100
Daily wages	3	18.8	5	27.8	8	50	16	100
House work	4	28.6	3	25	7	58.3	14	100
Total	44	36.7	26	21.7	50	41.7	120	100

Source: Field Survey, 2009

The Table 5.23 shows that all respondents who are engaged in Service and Business have used have use of clean delivery kits. Only one 31.4 percent respondents who are engaged in agriculture have use of delivery kits. Out of total 120 respondents 44.9 Percent have practice in about delivery kits. Out of total 120 respondents 27.9 percent have not practice of delivery kits during delivery. Out of total 120 respondents 43.0

percent have do not know practice of delivery kits during delivery. In this data concluded the increase the occupational level than already high use of clean delivery kits.

5.6.4 Problem of Faced at the Time of Delivery

During the period of child delivery, mothers will have complicated physiological and psychotically prolonged labour, retained placenta, excessive bleeding etc.

Table 5.24: Face any Problem During Deliver Distribution of Respondents

Face any problem	Number	Percent
Yes	102	85
No	18	15
Total	120	100

Source: Field Survey, 2009

Table 5.24 Shows that about 85 percent of the respondents have faced problem during delivery. While 15 percent respondents do not have faced problem during delivery.

Table 5.25: The Problem Distribution by Respondents

Types of problem faced	Number	Percent
Excessive bleeding	65	63.7
Prolonged labour	25	24.5
Lack of milk	12	11.8
Total	102	100

Source: Field Survey, 2009

The Table 5.25 shows that, during delivery time 63.7 percent respondents Excessive bleeding faced, 24.5 percents respondent prolonged labour of problem, 11.8 percent respondents faced the lack of milk problem. This data concluded that Dodhara VDC respondents are low economic condition they are depend on agriculture, they have not trained health worker.

CHAPTER - SIX

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 Summary

This study has analyzed the maternal health care practice, socio-economic and demographic status among married women of reproductive ages having at least one child of Dodhara VDC of Kanchanpur. This study is based on primary data from purposive sampling method in (3, 4, and 6) of this VDC. In order to meet the objectives of the study, the study considers qualitative and quantitative information from the respondents. The major findings of this study are as follows:

-) Out of 648 total populations of 120 households, 303 male populations and 345 female populations. The highest proportion of population is found in 15-59 years of (56.11%).
-) Average number of respondent's size Brahmin, Chhetri, Kami/ Damai , Giri/puri/Nath and Magar/Gurung/ is found to be 23.15%, 30.86%, 22.84%, 18.52% and 4.63% respectively.
-) This study shows that out of 120 respondents about 33.3 percent are illiterate where as literate respondents about 56.3 percent are primary level, 27.5 percent are lower secondary, 10 percent are secondary and about 6.3 percent are Intermediated level.
-) In study area 100 percent respondents found using hand pump to get underground water.
-) Among total population about 48.77 percent are unmarried, 35.34 percent are married and living together, 1.59 percent widow /separated /divorced, 14.51 percent are married but not living together.
-) The highest percent of respondents are belonging to age group 15-19 (33.3%) and lowest percent to age group 45-49 (2.5%).
-) The majority of respondents have got married in the interval of age group 15-19 (57.5%). Only (14.2%) respondents have got marriage in the age 20 above.
-) Nearly 68.8 percent of the respondents have reported that average number of CEB is 1 to 2.

- J Perspective of occupation 50 percent have engaged in agriculture, about 33.3 percent respondents are in house work , only 3.3 percent have engaged in service and 5.8 percent have engaged in business and 7.5 percent have engaged in daily wages.
- J Among the 120 houses, 80.0 percent have thatched house, about 10.8 percent have cement/stone house, 3.3 percent have Brick/Stone house, 3.3 percent have other house and 1.7 percent have wood houses.
- J About 65 percent household has managed the pitch and finch toilet facilities. There are also 32.4 percent people who use open place as a toilet and 2.5 percent have use water supplied.
- J An overwhelming majority about 44.4 percent respondents have reported to have radio. About 39.3 percent have electricity, among them, 12.9 percent have television and 3.4 percent telephone respectively.
- J It is found that literate respondents (college level) use maternal health practice whereas, maximum illiterate are not practice of maternal health care.
- J On the basis of occupation, it has found that who's involved in service used practice of maternal health Care whose in housework used not practice of maternal health care.
- J Overall respondents, more than 59.2 percent utilized the TT vaccine during delivery. And overall TT vaccine receive three does is 5.8 percent.
- J Overall 55.8 percent respondents reported they had received iron tablet during delivery.
- J Overall respondents, only 15 percent take ANC services and 85 percent don't take ANC.
- J Of those who received the ANC services 12.5 percent from hospital, 75 percent from health post and 7.5 percent from private clinic.
- J Out of 120 respondents, 80 percent literate respondents taking ANC and 40 percent have not taking ANC.
- J Out of 120 respondents, one time ANC visit 45.8 percent, two times 22.5 percent, three times 9.2 percent, none of them 9.2 percent respectively.
- J Overall respondents, 43.8 percent receiving vitamin 'A' and 56.3 percent have not receiving vitamin 'A' for both literate and illiterate.

-) Among the 75 percent are delivered at home, 20 percent at Hospital, 2.5 percent private clinics, 2.5 percent Health post respectively.
-) At the time of delivery, 62.5 percent respondents are birth assisted by family member, 5.8 percent by Doctor, and 3.3 percent by HA, 10 percent by Nurse and 18.3 percent by TBAs respectively.
-) Overall respondents, only 7.5 percent use of clean delivery kits, 75 percent have not use and 17.5 percent don't know use of clean delivery kits.
-) Out of total respondents, about 85 percent faced problem at the time of delivery and 15 percent have not faced problem.
-) It is observed that about 85 percent respondent's complication during the delivery whereas 15 percent have not any complication. There are some kinds of problem faced at the time of delivery. About 63.7 percent respondents have faced excessive bleeding, 24.5 percent have prolonged labour and 11.8 percent respondents have faced with lack of milk.

6.2 Conclusions

This study is conducted to find out the practice of maternal health care services among women in ward 3, 4 & 6 Dodhara VDC of Kanchanpur district. On the basis of above analysis & results, the study has concluded that practice of maternal health care is not satisfactory. Practices of antenatal care delivery care are not satisfactory in the study area. There practices are found better among educated respondents then uneducated. There is positive relationship between educations. There is positive relationship between education and practices of maternal health care services. Study reflects that those respondents who have low level of education have got early marriage, early age pregnancy but less use of antenatal care, delivery care services. This shown that practices of maternal health care services in increased by level of education. The occupation of mothers also affects on the practices of maternal health care services. The practice of their services is low among those respondents who are engaged in house work and agriculture.

6.3 Recommendations

The finding of the study shows that practices of maternal health care are unsatisfactory in this area. To increase the level of practices on maternal health care service, the related policies & programmes should be implemented by the government.

-) Government should make policies to expand NGOs, INGO & other agencies to make maternal health care services available up to the grass root level.
-) Economic crisis is one of the major problem low level of maternal & child health. So, income generating programme should be launched for them.
-) Basic awareness programme (education, trainings) should be implemented.
-) Maternal health care practices are highly influenced by education socio-economic status, age at marriage & media different programs like seminar, pictorial demonstrative programme should be carried.
-) Due to lack of information many women are not found practicing maternal health care. So information, education and communication (IEC) programme should be implemented.
-) Focus to establish health institution especially in rural areas by the government in necessary.
-) Status of women should be raised by supporting on their health, economics, and educational, social sectors as well as increasing their decision making role on family & society.

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