CHAPTER ONE
INTRODUCTION

1.1 General Background

Child loss is measured by the difference between children ever born and surviving children of a couple. The CEB roughly indicates the fertility and child loss depicts the mortality. Child loss experience is the prevalence loss of live born child or children during and after the reproductive life of a woman. Fertility and mortality, the two major components of demography are thus associated with each other. These components are directly related to change in structure and composition of population. Fertility and mortality are inevitable biological processes of a woman. These two components are also directly related to reproductive health. In demographic studies child loss experience is one of the important concerns along with fertility and safe motherhood. Fertility is related to mother's health and mortality is related to the both health of both mother and the child.

Reproduction is a most essential part for the existence of human being and propagating generation. The sexual activities are the prerequisite for reproduction. Therefore concerns of sexuality are important while dealing with reproductive health and even mortality. Reproductive health is defined as state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its function and processes (UN, 1994:45). Reproductive health therefore, assumes that people have a satisfying and safe sex life, and they have the capability to reproduce; and the freedom to decide if, when and how often to do so. Reproductive health and rights are also key stones for meeting the Millennium Development Goals (MDGs). Men and women must have the rights to be informed and to have access to safe, effective affordable methods of family planning of their choice for regulation of fertility which are not against the law as well as the rights of access to appropriate health care services for safe pregnancy and child birth (UN,1994:45).

Reproductive health and child loss are interrelated to each other. Socio-economic, demographic and psychological variables affect the level of fertility. Reproductive

health directly or indirectly related to social norms, values, and practice and these all collectively determine child survival. Maternal health care is one of the major components of the reproductive health, which is very close life style and living standard of the women. Maternal health is an important part of the health care system aimed at reducing morbidity and mortality related to pregnancy. The health care that a woman receives during pregnancy at the time of delivery, and soon after delivery is important for the survival and well-being of both the mother and the child. The prevailing high morality is related to low access to antenatal care, inadequate emergency obstetric care and postnatal care. Mainly low access to antenatal care is occurring by three different delays (Safe Mother Programme, Family Health Division: 6-7).

- Delay in deciding to seek the care
- Delay in reaching a health Institutions
- Delay in receiving cares at the health personals.

Thousand of mother and children in developing countries like Nepal are dying and suffering from different health problems. The problems prevailing are as malnutrition, lack of health facilities, lack of parent's education, and attacked of many diseases. Maternity care, one of the components of SRH, implies the provision of essential care of pregnant women to ensure safe delivery including postnatal care and termination of complication of the mother and new born. Maternity care starts from the pregnancy and continues through delivery to postnatal care. Maternal and child health care is the important to fulfill primary health care. Though, there are many programs conducted from government and non-government sides but still no satisfactory improvement in the health status of mother and child.

There is a problem of child loss all over the world. More children die in least developing countries compare to the developed countries. In 2011, as NDHS observed, one in every 22 Nepalese children died before reaching age 1, while one in every 19 does not survive to her or his fifth birth day. It was differs by place of residence. Infant and child mortality is higher in rural areas (55 deaths per 1,000 live births) than in urban areas (38 deaths per 1,000 live births) and it is differing from development region also. Infant mortality is highest in the far- western development region (45 deaths per 1,000 live births) lowest in the eastern development region (47 deaths per 1,000 live births) (MOHP, New Era, 2012:113-114).

The child mortality is related to educational level. Education is one of the most influential factors affecting an individual's attitude, knowledge and behavior in various factors of life. Educational attainment in Nepal is very low for women, who are disadvantaged than men. The overall literacy rate in 2001 was 54.1 percent for both sexes, 65.5 percent for males and 42.8 percent for females (CBS, 2001:146). Education has been found to influence reproductive behavior, the use of contraceptives, the health of mothers and children and hygienic habits. The lower literacy rates among females are the result of a variety of historical, economic and social reasons. Social prejudices against female education, restriction on mobility of female, low social status granted to the females, the system of early marriage and low participation of females in formal education are the main reasons for low female literacy rate. But now the situation is rapidly changing. Females have now greater access to primary as well as upper levels of education. There is wide gap between urban and rural areas in educational attainment. 15.4 percent of males and 42.8 percent of females in rural areas have never attended school compared with 6 percent of male and 22 percent of females in urban areas (MOHP, New Era, 2012:44-45).

Female education is important in determining reproductive behavior. Generally the CEB of uneducated women is higher than educated women. Education helps to girls' age at marriage. So it decreases the reproductive span of women on the one hand and they will not believe unnecessary traditional norms, values and cultural restriction about sex of their children on the other hand. This situation helps to reduce the number of fertility of a woman. The rises in educational level from one group to another helps to the increased age at marriage, in use of contraception, time of breast feeding. As a result it effects directly to the fertility of o woman. Varies studies showed that a shift in educational status of women from illiterate to primary, secondary and higher level of educational attainment was found to be contributory aspect to the reduced level of fertility and child loss experience of women indirectly.[1]

There is positive association between educational attainment and age at marriage because educated boys and girls may also consider early age at marriage as an

[1] Acharya, **Bidhan (2006), class note in Principles of Demography, CDPS.**

obstacle to achieve social and economic mobility and therefore may postpone their marriages until they have a stable career path and a permanent source of income. And this process could delay the age at marriage of educated boys and girls. For men the singulate mean age at marriage is 21.2 for the illiterate and 23.6 for the literate. The corresponding figures for women are 17.6 and 20.8 respectively (CBS, 2001:187)

In Nepalese society, maternal health care practice is very poor because of poverty, illiteracy, poor social structure and living far from the health facilities. Likewise, traditional values and norms and second position of women in society are the major causes of maternal health problems. Most of the health practices are concentrated in urban areas and have frequently unhappy outcomes for rural inhabitants. The provision of care for women during pregnancy and child birth is essential to ensure healthy and successful outcomes of pregnancy for mother and her born infants. Many women in developing countries like Nepal don't have the privilege to basic health care services during pregnancy and child birth. Women often deliver in unhygienic surrounding with the risk of both mother and new born baby resulting high risk for them and the children.

Overall the situation of women health and child loss in Nepal is problematic. Both are interrelated in programme and policy level which need to be focused in interlinked way. In practice most of the women and their family members are suffering from the problem of SRH. Women in young age are compelled to give birth to child while they are unknown about caring and raring of children. Thus there are economic, social, and demographic factors that influence RH and CLE. These are to be carefully examined before adopted policy measures to improve the behaviors.

1.2 Statement of the Problem

Child health is based on knowledge and practice of mother. If women have no access to education, health facilities, pregnancy check-up, food intake etc there would be high risk of maternal mortality and child mortality. Maternal mortality reflects the level of socio-economic development of the country. Being a predominant of male supremacy in society so women are dominated suppressed in Nepalese society. Though women are the inevitable part in the process of reproduction but the people and state have not been careful about women's physical and mental health. They are

not allowed to take an active role in decision making process in the family. As a result, it directly affects to the child health. Maternal health care is one of the burning problems in Nepal. Maternal health care practice aims to save the mothers' life and to improve the health status of women in several with special emphasis on reducing maternal and neonatal mortality and morbidity. The main strategies of this programme focuses on improving the quality and coverage of maternity health is services to all women. Women who are empowered are in a better position to access information, make decisions, and act effectively to address their own and their children's health.

Proper medical attention and hygienic conditions during delivery can reduce the risk of child loss. Although 58 percent of mothers received antenatal care from a doctor or nurse/midwife for their most recent birth there was also a significant number of mothers who had not received such services. Some fifty percent of pregnant women make four or more ANC visits during their entire pregnancy. Among them 72 percent women were in urban and only 48 percent were from rural women (MOHP, New Era, 2012:121). Recently 35 percent of births took place in a health facility. Among them 26 percent were delivered in public sector health facilities, 2 percent in a non government facility and 7 percent in a private facility. Still in 2011 some 63.1 percent of births took place at home (MOHP, New-Era, 2012:124-125).

Nepalese women pass through the situation of over work which caused negative impact on their health status, especially on maternal health issues. Hence the majority of women do not have access to maternal health care services due to social, economic and political reasons. The offspring's of the people who are highly addicted are also liable to suffer from chronic disease and are pushed in the mouth of death. The women who are suffering from domestic violence by their in – laws are also in risk to the loss of child. The women who have active exposure to the media, those who are politically powerful are less prone to child loss.

Far-western Development Region is one of the backward areas of Nepal. Among them Pachanali VDC in Doti is also supposed to have wider gap between men and women. There is dearth of information based on VDC level research that helps in policy making and designing the programme implemented in local level. Therefore, the need of study of child loss experience in such local areas that collectively contributes to national level policy making.

1.3 Objectives of the Study

The general objectives of this study are to examine the child loss experience of women in Pachanali VDC, Doti District. However the specific objectives of the study are followings.

- To evaluate the status of child loss experience by social variables
- To examine the status of child loss experience by economic variables
- To assess the status of child loss experience by demographic variables

1.4 Significance of the Study

This study is important to pullout the fact about knowledge, awareness, practice and behavior of reproductive health, child care practice and child mortality among Dalits and Non-Dalits Community so it can be compared one community to another and can understand the ethnic variation by selected variables.

This study will be beneficial for planners, policy makers, social researchers, GOs, NGOs, and INGOs and administrative purpose related to the reproductive health and child care practices. Similarly, this study will provide valuable information to those who are interested to study ethnicity based reproductive health and child care practice. The major significance of the study is as follows;

- The finding of the study will be helpful for local NGOs, INGOs and government to formulate the policies and plans regarding health care.
- It will be useful to the local people to develop awareness towards their health problem in their community.
- The result of the study will be helpful to women to care their own health and their children.
- It will be useful as a guideline for further researchers in similar studies.
- It will be beneficial to the students.
- It will be highly influential to the people of VDC for their further planning.
- Other women in that village will be benefitted by the data so that they could improve their further planning.
- The males will be aware of the reality of their own society.

1.5 Limitations of the Study

This study carried out in Pachanali VDC of Doti district as a sample survey. Some of the especial limitations of this study are as follows:

- This study is limited to Pachanali VDC of Doti district.
- This study covers broadly two communities as Dalits and Non Dalits.
- The sample size of this study is only170 (85 sample respondents each from selected communities).
- This study considered only women, who had at least one child birth.

1.6 Organization of the Study

This dissertation is divided into eights chapters. The first chapter is introductory, which includes background of the study, statement of the problem, objectives, significance of the study, limitation and organization of the study. Similarly, the second chapter deals with literature review that includes theoretical and empirical literature review and formulation on framework.

In the same way, third chapter is devoted to methodology of the study that includes the research design, nature and source of data, selection of the study area and sample, date collection, processing and method of analyses. Likewise chapter four provides the introduction to study population. It includes socio-economic and demographic and other characteristics of the respondent. The chapter five includes the analysis of data discussing on the child loss experience of women in the sample area. In the similar way chapter six summarize qualitative information. Chapter seven presents summary, conclusion, and recommendations.

CHAPTER TWO
LITERATURE REVIEW

This chapter deals with some selected studies relevant to the reproductive health, maternal and child health care practices. The socio-economic and literacy status of women and traditional practices play important role in maternal and child health care practices. Some of the facts, opinions, principles and empirical studies are reviewed to streamline the research in this section. These discussions are segregated into two larger frames. The literature that deals the theories, approach, norms and values are discussed under the theoretical segment and the findings of the previous studies are arranged in empirical segment.

2.1 Theoretical Literature

2.1.1 Theoretical Perspective Related to Child Loss

There are so many theories propounded in fertility and mortality. One of them is demographic transition theory. The transformation from a state of high fertility and mortality to a state of low fertility and low mortality is a demographic transition. The major features of transition theory as below-

- Societies remain in the high fertility and high mortality stage in the beginning.
- Mortality declines rapidly and the rate of natural increase becomes larger insuring a high population growth.
- Social values, norms and systems do not permit fertility decline rapidly but fertility also declines in the long run and meets mortality at a lower stationary state.
- These all changes in demographic characteristics are possible only with the change in socio economic status of the country.
- The course of demographic transition takes time differently in different countries or societies.

In general, the demographic transition could be presented in three stages: High stationary stage, high expanding stage and low stationary stage. The second or expanding stage consists of two phenomena that are expanding with increasing growth rate and decreasing growth rate. Therefore, it would be easier to understand population dynamics if the second stage is further segregated in two stages. Thus the

standard of demographic transition is able to represent the transformation of fertility and mortality in almost all societies.

Mosley and Chen (1948) developed a model of mortality framework in consisting the both social science and medical science approaches and also known as a perfect model for the analysis of mortality study. The model includes five major proximate determinants and its interplay with the life and death which are as below-

- In an optional setting over 97 percent of new born infants can be expected to survive through the first five years of life.
- The reduction in above survival probability society is due to the operation of social economic, biological and environmental factor.
- Socio economic determinants must operate through the more basic proximate determinants that intern influence the risk of disease and the outcome of disease processes.
- Specific disease and nutrient deficiencies observed in a surviving population may be viewed as biological indicator of the operations of the proximate determinants.
- Growth faltering and ultimately mortality in children are the cumulative consequences of multiple disease processes.

The epidemiological transition theory is another theory to describe mortality and morbidity analysis. This theory focuses on the complete change in patterns of health and biological determinants and consequences. During the transition pandemic of infection are gradually displaced as a cause of mortality and morbidity by degenerative, stress- related and manmade diseases. This transition is associated in varying degrees with social, economic and medical development. These changes in the patterns of diseases resulted in the shift in the average age at death, from infancy, childhood and young adulthood to older ages with corresponding increase in life expectancy. Such improved survival was more favorable to young than old and women than man resulting in changes in the age and sex structure of the population. The decline in mortality could have been observed due to change in fertility levels.

In conclusion, RH and CS are related to each other. Better RH and CS knowledge provides better RH and CS practice that direct shape amount of child loss Therefore, the concept of Demographic Transition, Mosley and Chen model and Epidemiological Transition advocate that improvement in socio- economic status of society leads forwards declining mortality. Development could be measured by education, life

expectancy and income. The use of media and other related variables are associated with mortality level of children too. So, the experience of child loss has close association with development level of the society or community. The backward community of Dalits and their counterpart Non–Dalits are examined in this research considering their experience regarding the death of their children.

2.1.2 International Conventions

In 1979, UN General Assembly adopted a resolution as Elimination of all Forms of Discrimination Against Women and it urged all state the parties to take best possible and appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning and they should ensure to women appropriate services in connection with pregnancy, confinement and the postnatal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation (Khanal, 2010: 26).

The International Conference on Population and Development (ICPD in 1994) focused on reproductive health to enable women to go safely through pregnancy and child birth and to provide couple with the best opportunity of having a healthy baby. The ICPD policy document says that both mother and child have the right of access to appropriate health care service (United Nations, 1994:30).

The ICPD Programme of Action was a watershed for safe motherhood for the first time. A UN document defined maternal health as a core component of reproductive health. It set out a time-bound and measurable goal: to reduce maternal deaths worldwide by 75 percent by the year 2015. Maternal health was situated within the context of comprehensive rights based approach to RH. Since them the commitment has been reaffirmed by several measure global agreement including the platform for action of the fourth world conference on women, the outcome documents from the UN General Assembly Special Session on HIV/AIDS, the UN General Assembly Special Session on children, and the Millennium Declaration (Khanal,2010:26).

The United Nations convened the fourth world conference on women in September 4-15,1995 in Beijing, China that clearly advocated an integrated approach, including health services, family planning and women's empowerment as the immediate and

most effective means to deal with the health and population problems. The Principal theme of this convention was the advancement and empowerment of women in relation to 12 critical areas. Among them women in relation to health was one of the concern areas of this convention.

In 1999, on the occasion of the 50th World Health Day, the World Health Organization (WHO) announced for the 'Safe Motherhood'. It paid special attention to improve the health of mothers and children. The WHO mentions that the safe motherhood is a matter of human rights and social justice as well as vital social and economic investment. All pregnant and delivery women should get equal opportunities to receive medical treatment for mother's and child's health (Shakya, 2006:33).

The UNFPA supported safe motherhood initiatives in 89 countries. It supported programmers emphasized capacity development in maternal care, especially the strengthening of needed human resources. The UNFPA also sought to make motherhood as safe as possible during crisis situations that compound women's vulnerability. In 2008, the fund, along with a number of partners, established a Thematic Fund for Maternal Health to increase the capacity of health system to provide a broad range of quality maternal health services, reduce health inequalities, and empower women to exercise their right to maternal health. Other key initiatives to accelerate progress in making motherhood safer include the Global Program on Reproductive Health Commodity Security and the Campaign to End Fistula (Khanal, 2010:28).

2.1.3 The Context of Nepal

The RH education was an educational experience which was aimed at developing capacities of the adolescent to understand their sexuality in the context of biological, physiological, socio-cultural and reproductive dimension and to acquire skills in making responsive decisions. The level of awareness' among woman and young girls was to be enhanced in the area of sexual and reproductive health behavior particularly protecting themselves from unwanted pregnancies, sexually transmitted diseases, unsafe sex, sexual abuse and unsafe abortion. Reproductive health education provides knowledge about suitable age for marriage, birth spacing, contraceptive use, family

size, safe sex, breast feeding, antenatal and postnatal care which are very important for the women. If girls have knowledge about them they can take care of their health themselves and of their children too. RH education is closely related to RH and CL.

On the other hand child survival practice and knowledge is always in reproductive health. Countless number of children dies each year from epidemics communicable diseases supplemented by malnutrition and micronutrient deficiencies which are easily prevented by simple treatment and preventive measure. To control the exceptionally high morbidity and mortality among children under five, the Ministry of Health and Population (MOHP) initiated several child survival intervention strategies; the Expanded Program of Immunization (EPI) began in 1979; the control of Diarrheas Disease Program began in 1982; and the control of Actuate Respiratory Infections program was initiated in 1987. Later these two programs were merged into the Community-Based Integrated Management of Childhood Illness (CB-IMIC) in 1998. This child survival intervention brought under the umbrella of Child Health Division of MOHP in 1995. The current health sector of reform strategy recognizes the management of childhood illness as a core component of the essential health care strategy (Mainali, 2011:12).

The ANC is a care of the woman during pregnancy and child birth. There are different components of maternal health care services and the health care facilities that a woman gets during her pregnancy period. Under antenatal health care TT immunization, receiving iron tablets, food intake and physical work are included. Men in the form of husband, in- laws, father, brother, family member, co-workers, seniors, juniors have to involvement is also necessary in good child health (Acharya, 2007:17) In our society woman are always dominant in society but men's involvement and participation can make all the difference in women's lives. The UNFPA chose the slogan as "Men as Partner in Maternal Health" for World Population Day activities (Acharya, 2007:14) .Men involvement is very important in safe motherhood. In developing countries like Nepal the majority of woman delivers their babies without skilled assistance helped only by untrained traditional birth attendants or family members. A trained attendance presence during childbirth can make difference between life and death. Complications related to pregnancy and child birth was found among the leading cause of mortality and morbidity of woman.

The ICPD, as well as, WHO defined reproductive health 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 function and processes. In this context the government of Nepal has recognized that the couple and individual should have the basic right to decide freely and responsibly the number and spacing of their children have the information, education and means to do so. Reproductive health therefore implies that people should be able to have satisfying, safe sex life and that they have capability to reproduce and also the freedom to decide it, when and how often to do so. There is the right of the man and woman to be informed to have access to safe, effective, affordable and acceptable methods of family planning of their choice. Moreover, their choice for regulation of fertility which is not against the law of the land and the rights of access to appropriate supportive , services that will enable woman to go safely through pregnancy and child birth.

Reproductive rights embrace certain human rights, reproductive rights, essentially rest on recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so and to attain highest standard of sexual and reproductive health. The new paradigm of RH that emerged through the ICPD 1994 has put human rights, human development and individual well beings at the center of programmed policies

The goal IV of MDGS aims to reduce child mortality by two third by 2015. It also indicated the indicate for reducing child mortality under 5 mortality by increasing access to safe water, better sanitation facility and improved education, especially for girls and mothers are closely linked to reduced child mortality.

Furthermore, MDGs indicated that among the childhood vaccine – preventable diseases measles is the leading cause of child mortality, over half a million death in 2000. Hence, for achieving the MDGs targets needed to improve new born care practice in most of the rural community.

To improve maternal health MGDs set the goal for three- forth reduction of maternal mortality by 2015 from the 1990s lead through presence of skilled birth attendant during pregnancy, delivery and postnatal period. The MDGs strategy for reducing maternal mortality by presence of SBA likely to improve the knowledge about

hygiene, baby feeding and child caring practice which directly contribute to reduce the maternal mortality, morbidity and child too (Dahal,2011:18-19).

2.1.3.1 Chhaupadi Tradition

Chhaupadi tradition is a tradition in which women are asked to live in a cow shed or on a hut during their menstruation period which a man even from the family should not see she and she should not even see the rising sun.

This tradition prevailing in the far western region in Nepal is mainly women dominated. During the menstruation the females have to live in small huts separate from their family more than one week because they are considered impure during the time. It is unsafe for women to live in the shades. There are many reports of snakebites, sexual assaults and attacks by wild animals, infectious disease and malaria. So became of this practice the health conditions of women were going to poor condition. As a result it is directly related to their children health. So, Chhaupadi tradition is a one cause of child loss of women.

2.1.3.2 Governments Efforts towards Chhaupadi Tradition

The ministry of women, children and social welfare has disclosed that it will begin a joint campaign along with Save the Children Norway to combat the Chhaupadi system rampant in the far western region.

The schools in affected areas, community healers and vulnerable groups need to be emerged as catalytic agents for reform through involvement in awareness, which may drive out the negative impact of the age-old social practice. Teachers, young and adolescent population have to be educated to discourage the practice of Chhaupadi traditional healers who have influence over the community have to be made aware of the ills of the system and the vulnerable groups and adolescent girls are needed to be helped directly to overcome the system and its side effects[2].

[2] www.ethicsinaction.asia. , www.farwesternnepal.com/district/doti.html.

Various advocacy and awareness programs will be conducts to check the instances of the practice and as a curative step of the programs, legal provision and penalty system will be introduce to discourage the practice.

When women get menstruation they have to live in a small hut or cow shed. In this time their youngest child also goes to with their mother. This place is not hygienic for women and child. Because of this trained, the health of mother and their children suffer different diseases like pneumonia, common cold, malnutrition etc. This is the main cause of morbidity of mother and child, which is the main cause of child death.

Eventhough various advocacy and awareness programme were lunched to mitigate the Chhaupadi tradition, still the tradition is alive in community that in turn affecting to accelerate the death of children.

2.2 Empirical Literature

2.2.1 Global Situation

Hundreds of millions of women every year suffer from pregnancy complications, and more than half of a million die due to pregnancies and childbirth, or following unsafe abortion. Almost all of these deaths are preventable. Every minute, other woman died in pregnancy or childbirth. Every minute, the loss of mother shatters a family and threatens the well-being of surviving children. Women died various kinds of complications and chronic infections. Such deaths are happens between the haves and haves not both within and between countries. More than 500,000 women who die during pregnancy or childbirth, 90 percent occur in Africa and Asia. The majority of women are dying from severe bleeding, infection, eclampsia, obstructed labor and the consequences of unsafe abortion. Working for the several of mothers is human rights imperative. It also has enormous socio- economic ramifications and is a crucial international development priority. Both the international Conference on Population and Development and Millennium Development Goals called for a 75 percent reduction in maternal mortality between 1990 and 2015 (Khanal, 2010:35).

In countries such as China, Cuba, Egypt, Malaysia, Sir Lank, Thailand and Tunisia, significant decline in maternal mortality have occurred as more women have gained access to family planning and skilled birth attendance with backup emergency

obstetric care. Many of these countries have halved their maternal deaths in the space of a decade. Cadres of professionally trained midwives have been critical to these successes. Services shortages of trained health providers with midwife skills are holding back progress in many countries (Khanal, 2010:35).

About 97 percent of the unsafe abortion occurred in developing countries. Adolescent's girls are at greater risk of reproductive ill health. Almost 15 million adolescent girls become mothers every year. Among women who became mother under 20, infant mortality rates are almost double the ratio among older women. Women and adolescents girl continue to die and suffer from disabilities during pregnancy and childbirth. The estimates of maternal mortality worldwide indicate that there were about 535,900 deaths in 2005. Among it 270.500 deaths occurred in Sub-Saharan Africa and 240,600 deaths in Asia (WHO et al., 2007:7).

2.2.2 The Nepali Context

Maternal health care has been a serious problem for most of the developing countries like Nepal. After ICPD Cairo conference most of the studies related to health have focused on reproductive health including maternal health. The government of Nepal initiated the safe Delivery Incentive Program to reduce maternal mortality and morbidity. Safe motherhood program was initiated in 1997 with the objective of reducing maternal mortality in Nepal. It has brought significant improvement in maternal health by reducing maternal mortality ratio to 281 per 100,000 live births in 2006 (MOHP, New Era, 2007:133). Utilization of the maternal health services are however not encouraging. Nepal Demographic and Health Survey 2011 showed that 58 percent pregnant women received antenatal care from a skilled provider, only 35 percent births delivered in a health facility and 45 percent of women received postnatal care for their last birth within the critical first two day following delivery. One in three women received postnatal care within four hours of delivery, 7 percent received care within 4-23 hours, and 4 percent were seen 1-2 days following delivery. More than one in two (54 %) women did not receive a check-up within the recommended time. Difference by mother's age, birth order, and place of residence, wealth quintile and education are pronounced. Young mothers less than 20 years of age, mothers of first births, urban women, women in the highest wealth quintile, and highly educated mothers are much more likely to have received post natal care within

the first 24 hours than their counterparts. Women living in the Tarai zone, women living in the central region, and women from the Central Tarai and central hill sub regions are more likely to have received postnatal care within the first 24 hours following delivery then mothers living elsewhere.

Promote maternal and child health the concept of maternal health and child health (MCHW's) was introduced in Nepal by focusing the people of rural areas. These MCHWs are responsible for the tasks related to antenatal and postnatal care and manage some simple gynecological problem in the remote areas. Therefore an effort is done to measure their knowledge and skills regarding these subjects.

A large proportion of maternal and neonatal deaths occur during the 24 hours following delivery. In addition, the first two days following delivery are critical for monitoring complications arising from the delivery. A postnatal care visit is also an ideal time to educate a new mother on how to care for herself and her newborn. Safe motherhood programs emphasize the importance of postnatal care, recommending that all women receive at least two postnatal checkups and iron supplementation for 45 days following a delivery (MOHP, New Era, 2012:131).

There is large difference in the use of antenatal care services between urban and rural women. Eighty-eight percent of urban mothers received antenatal care from a skilled provider, compared with only 55 percent of rural mothers. Sixty-three percent of mothers living in the Tarai received antenatal care from a skilled provider, compared with 53 percent of mothers in the hill zone and 52 percent of mothers in the mountain zone. About 60 percent of mothers living in the Far –Western, Eastern and Western region received antenatal care from a skilled provider. The proportion of women who received antenatal care from a skilled provider was lowest in the Mid- Western hill sub region (43 %) and highest in the Western Tarai (73 %) and Far-Western Tarai (74 %) sub regions (MOHP, New Era, 2012:120-121).

Proper medical attention and hygienic conditions during delivery can reduce the risk of complication and infection that may cause the death or serious illness of the mother and the baby or both. Hence an important component in the effect to reduce the health risk of mothers and children is to increase the proportion of babies delivered in a safe and clean environment and under the supervision of health professionals. NDHS, 20011 presents the percent distribution of live births in the five year preceding the

survey by place of delivery, according to back ground characteristics. Thirty-five percent of births take place in health facility: 26 percent are delivered in a public sector health facility, 2 percent in a non-government facility and 7 percent in a private facility. Still two-third of birth (63 %) takes place at home. Delivery in a health facility is more common among younger mothers less than age 34 (35-41) and mothers of first-order (54 %). Children in urban areas are more than twice as likely (71 %) to be delivered in an institutional setting as children born in rural areas (32 %). Institutional deliveries range from a low of 29 percent in the Far-Western and Mid-Western region to a high of 40 percent in the Eastern region. There is a strong association between health facility deliveries, mother's education. The proportion of deliveries in a health facility is nearly four times higher among births to mother with an SLC and higher education (75 %) than among births to mother with no education (19 %).

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Likewise scheduled vaccination also vitally influence the child loss case according to the World Health Organization, a child is considered fully vaccinated if he or she has received a BCG vaccination against tuberculosis, three doses of the DPT vaccine to prevent diphtheria, pertussis, and tetanus, at least three doses of the polio vaccine, and one does of the measles vaccine. Similarly, all women of childbearing age should complete five doses of TT vaccine during their reproductive life (MOHP, New Era, 2012:149).

The information on vaccination coverage for children 12-23 months who should have been fully vaccinated against the major preventable childhood illness was that 87 percent in total aged were immunized. It was not a matter of coverage of full vaccination for 87 percent but was a question of remaining 13 percent. About 97 percent of the children received BCG and DPT 1, with polio 1 received by 96 and 97

percent respectively. However, the proportion of children the third dose of DPT and polio is lower (92% and 93% respectively), as is the proportion receiving the measles 88 percent. Now only 3 percent of children 12-23 months did not receive any vaccine at all. Vaccination coverage varies significantly by mother's education, 78 percent of children whose mothers have no education were fully vaccine compared with 92 percent of children whose mothers have SLC or higher level education (MOHP, New Era, 2012:150-151).

There are so many factors like, reproductive and biological factors, lower age at marriage, low education, lower age at first birth and maternity service which are leading to maternal and child death in Nepal. Slimily, factors include place and attendant of antenatal care and delivery, unsafe abortion, hemorrhage, anemia, obstetric fistula and uterus prolapsed are other cause of maternal and child health. Large no. of people was residing in rural areas. They are suffering from poverty, illiteracy, lack of awareness, unhygienic behavior, traditional values and norms. Position of women in rural society and less access to health facilities results high maternal and child mortality, contrary to this the facilities provided to them are very low. Agriculture is the dominant sector of the economy of Nepal. More women than men are involved in this sector (75% and 35%, respectively). As expected, rural women are more likely than urban women to be employed in the agricultural sector. Residence has a significant effect on type of occupation. Eighty percent of rural women compared with 33 percent of urban women are involved in the agricultural sector (MOHP, New Era, 2012:58-59).

The issue of children was not of the greater importance to Nepalese government till 1980s. Children as a development concern was only included for the first time in the seventh plan (CBS, 2001:296) Nepalese children are facing various difficulties due to social beliefs, poverty, gender discrimination and illiteracy relating to their development. Traditional beliefs have contributed significantly in many Nepalese families as a result of which sons are more preferred. Religious, social and economic compulsions regard son as not only valuable but also indispensable asset whereas daughter are taken as financial burden to their parents. Due to poverty children labor forms part of the family support for their subsistence. According to 2001 census about

29 percent of the children within the age group 10-14 are economically active and among which about 62 percent are engaged in agricultural and related activities.

Nepal has high mortality. About 31 percent people are lying below poverty line. Nepal is facing geographical barriers for delivering maternal health care services.

2.3 Variables Identified

On the basis of above theoretical discussion following variables have been identified to carry on the research.

2.3.1 Independent variables

- Caste/ ethnicity
- Religion
- Social norms and values
- Place of Residence
- Physical and Emotional factors

2.3.2 Intermediate Variables I

2.3.2.1 Social variables

- Education
- Gender Role
- Status of family
- Chhaupadi Tradition

2.3.2.2 Economics Variables

- Occupation
- Income
- Personal Property
- Household Amenities

2.3.2.3 Demographic Variables

- Age
- Marital Status
- Family Size
- Number of CEB

2.3.3 Intermediate Variables

- Knowledge on Safe motherhood
- Antenatal care
- Delivery care
- Postnatal care
- Newborn care

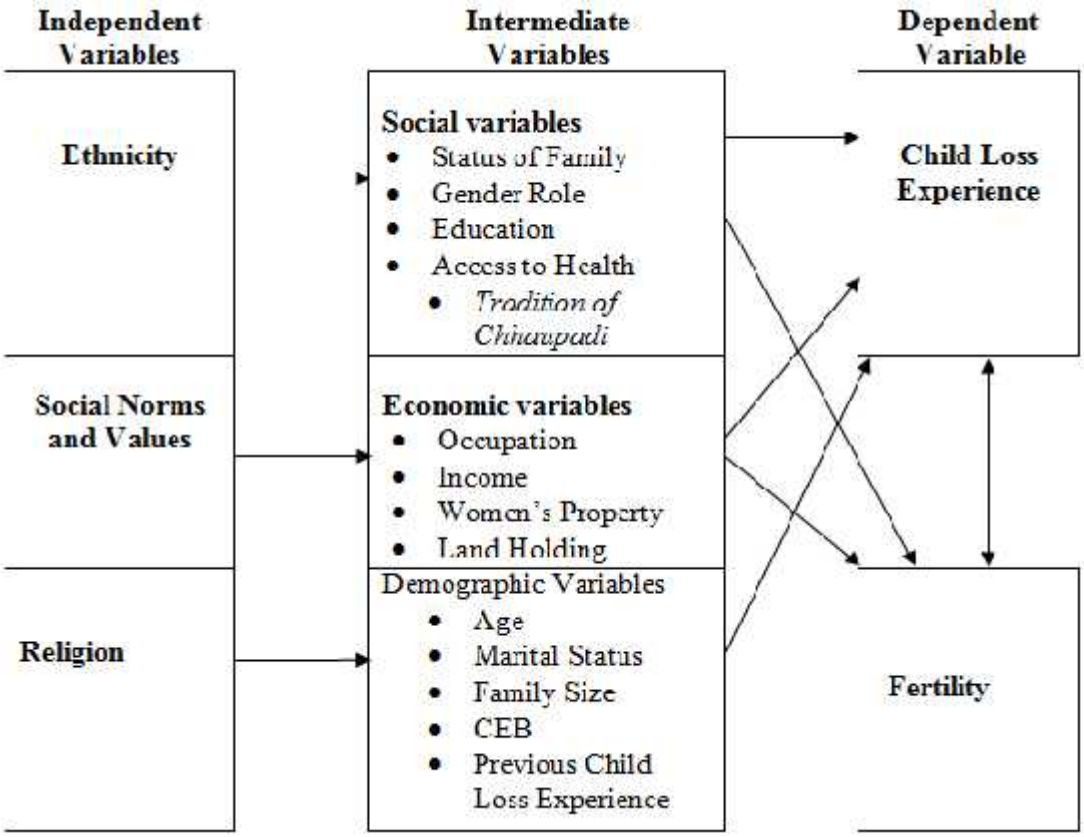
2.3.4 Dependent Variables

- Child loss experience
- Fertility

2.4 Conceptual Framework

People are segregated by the cultural as well as caste/ethnic related behavior. There are social variables like education, health, social status and norms Chhaupadi tradition; demographic variables like age at marriage, CEB, previous child loss experience; economics variables like occupation, income, amenities, employment and land holding; participatory variables like gender roles sharing of household burden and participation in local level that are affected by caste/ethnicity. Therefore, caste/ethnicity has been identified as independent variable. Knowledge affects antenatal care, delivery care, postnatal care, and combination of all above mentioned variables determine child loss experience and its results determine the fertility. So child loss experience and fertility has been identified as dependent variables.

Conceptual framework



CHAPTER- THREE
METHODOLOGY

3.1 Research Design

Descriptive method is applied to describe the findings. It is a cross-sectional study that attempted assessing the mother's knowledge and practice of maternal health through a cross examination with their reported child loss experience. The research was designed as a comparative study of Dalits and Non-Dalits with equal number of households covered.

3.2 Sample Design

3.2.1 Selection of Cluster

The study covered all households of Dalits and Non–Dalits community in Pachnali VDC, because the numbers of the Dalits were nearly one third of the whole population and the rest of the households were of Non-Dalits. The study did use the census type method for collection of information regarding maternal health and child loss experience.

The area of four wards namely 3, 4, 5 and 6 in Pachnali VDC of Doti district was considered as the selected cluster. This is in the Far-western Development Region of Nepal. Sample VDC also lay in western part of Doti district. Various ethnic communities like Brahmin, Chhetri, Kami, Damai, Sarki, etc are residing permanently. Majority of population residing in the VDC are higher castes. However, as is the objectives of this research the sample population covers only Dalits and Non-Dalits communities.

3.2.2 Selection of Households

The researcher selected the area of Dalits first to cover the whole area and gathered data and information related to the child loss and maternal health. During the research the researcher consulted the respondent who has at least one child birth. The researcher went to the community of Non-Dalits and collected the information. Based on research objectives 85 households were selected from each ethnic community.

3.2.3: Selection of Respondents

Women of reproductive age (15-49) years were eligible to be the respondent and only one respondent was eligible from a single household who have one child birth. Total 170 respondents were selected for interview. Out of 170 respondents, 85 respondents from each ethnic community were interviewed. In case of more than one eligible woman available at home during survey time, those women who have child loss experience were selected for the interview. For this study male were excluded and only females who have at least one child birth were selected.

3.3 Instrumentation

3.3.1 Quantitative Tools - Questionnaire Design

The questionnaire was designed based on conceptual framework and as per the suggestion and guideline of the researcher supervisor and it was fully guided by the study objectives. The household questionnaire was designed to obtain the demographic, socio- economic and other information about household and individual questionnaire was formulated to obtain the information and date of maternal health and child loss experience among married women of reproductive age who had at least one child birth. The whole set of questionnaire was divided into eight aspects:

- General knowledge among individual and household.
- Economics status of the family.
- Gender role at community and family.
- Knowledge of RH, concept and behavior of adolescent and period of menstruation
- Questionnaire related with sexual health.
- Questionnaire related with access to health.
- Questionnaire related with pregnancy, pregnancy test and abortion practice.
- Questionnaire related with CEB, child survival and child loss.

3.4 Data Collection and Processing

3.4.1 Pre-test of Tools

The questionnaires were prepared in simple Nepali language. The pre-test of questionnaire was done for checking the wording, sequence and the use of language whether that was understandable or not for the respondent. Ten sample questionnaires were pre- tested in the different community beyond the sample area. The questions which were not suitable to ask in community were left and the most essentials were added for the perfection of the survey. After finishing that the researcher went in her own community for the final survey.

3.4.2 Field Operation

The researcher herself was the interviewer to respondents. Among them 85 Dalits and 85 non-Dalits who had one child birth until the time of survey.

3.4.3 Data Entry and Processing

The field questionnaire was edited thoroughly. The entire questionnaire was edited to see if there was any mistake or error. After completing the manual edition the researcher entry data in EPI date entry program and copied it in SPSS. Finally, the latest developed SPSS program was used to the data. Frequency distribution and cross table analysis was the main output of the analysis.

3.5 Data Quality

The age heaping problem always occurred in this research. The age always concentrated on the terminal digit 0 and 5. For measuring and correcting the data quality and age heaping, researcher used Myer's Blended index is one of the popular measures of age misreporting in demography. Myer's index measures the digit preference of age between ranges of 10- 89 years. This index may range from zero to ninety. If the index appears approximate to zero indices there is no age heaping in the given age data and ninety shows the absolute misreporting of age data. The Myers' index calculated in this research is 0.01. That appears to zero; meaning that there is very few heaping occurred in this research.

3.6 Methods of Analyses

The analysis was simply based on descriptive type of analysis. The frequency tables, cross tabulation and percentage were utilizing for data analysis and interpretation. Data were edited and coded and analyzed by using SPSS. Frequency tables, mean tables, and cross tabulation were the analytical tools for the examination of the relationship between the variables. Necessary tables were generated using the same software. Statistical tool such as co- relation, regression coefficient are supposed to be used for data analysis.

3.7 Consideration of Ethical Issues

Researcher visited the household personally. Since they were known and familiar already, there were no disagreements regarding the data collection. Moreover, the respondents were persuaded in a friendly manner and made sure that they could answer to the questions they want. The information collected only for the research purpose was well communicated to them and they were also assured of the no possibility of misuse of data. The respondents were not threatened and they were easily attained to the interview.

CHAPTER FOUR
INTRODUCTION TO STUDY POPULATION

This chapter has covered the background characteristics of Dalits and Non- Dalits household. This chapter has consist of age-sex composition, marital status, age at marriage, family size, children ever born, caste/ ethnicity, religion, education status, occupational status, own- income, type of house, household facilities, family status, property entitlement, major decision at family, opportunity of opinion in family decision, and gender role in household errands.

The study area, Pachanali VDC, is situated in Doti District- Far Western region of Nepal. This study includes 170 households from four wards of Pachanali VDC. The study population was from Dalits and Non- Dalits community. Among them 85 households from each of these were selected.

4.1 Demographic Characteristics

4.1.1 Age and Sex Distribution of Population

The total population of the 170 households of respondents was 824. Out of total population (824) of locality, there are 49.6 percent were male and 50.4 percent are female. Among them 18.3 percent were male and 14.4 percent were female in 0-4 years age group. Similarly 18.1 percent were male and 16.1 percent female in the age group of 5-9 years, 14. 4 percent male and 14.7 percent were female, 5.4 percent were male and 8.7 percent were female, 5.9 percent were male and 7.5 percent were female, 7.8 percent were male and 10.1 percent were female, 6.1 percent were male and 6.5 percent were female, 6.6 percent male and 6.5 percent were female,6.8 percent were male and 6.5 percent were female, 4.4 percent were male 1.9 percent were female, 1.2 percent were male and female, 1.7 percent male and 2.4 percent were female, 2.0 percent were male and 1.0 were female, 0.2 percent were male and 1.0 percent were female, 0.5 percent were male and 0.2 percent were female in age group of 10-14, 15-19, 20-24, 25-29, 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70 plus respectively. The majority of the age was 0-4 years of male and 5-9 years of female of

the total population. The age-sex composition of Dalits and Non-Dalits of the study area is found as rather fluctuated in various categories of age (Table1).

Table 1: Age Distribution of Total Population by Age and Sex in Pachanali VDC, Doti District, Nepal, 2012

Age Group	Sex					
	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
0 – 4	75	18.3	60	14.5	135	16.4
5 – 9	74	18.1	67	16.1	141	17.1
10 – 14	59	14.4	61	14.7	120	14.6
0 – 14	208	50.9	188	45.3	396	48.1
15 – 19	22	5.4	36	8.7	58	7
20 – 24	24	5.9	31	7.5	55	6.7
25 – 29	32	7.8	42	10.1	74	9
30 – 34	25	6.1	27	6.5	52	6.3
35 – 39	27	6.6	30	7.2	57	6.9
40 – 44	28	6.8	27	6.5	55	6.7
45 – 49	18	4.4	8	1.9	26	3.2
50 – 54	5	1.2	5	1.2	10	1.2
55 – 59	7	1.7	10	2.4	17	2.1
15 – 59	188	45.9	216	52	404	49.0
60 – 64	8	2	4	1	12	1.5
65 – 69	1	0.2	4	1	5	0.6
70 – 74	2	0.5	1	0.2	3	0.4
75 Plus	2	0.5	2	0.5	4	0.5
60 and Above	13	3.2	11	2.7	24	2.9
Total	409	100	415	100	824	100

Source: Field Survey, 2012

4.1.2 Age Distribution of Sample Population

The age group 25-29 constitutes the highest percent 23.5 followed by the age group 35-39 with 18.8 percent (Table2).

Table 2: Age Distribution of Respondents in Pachanali VDC, Doti District, Nepal 2012

Age group	Cases	Percent
15-19	9	5.3
20-24	27	15.9
25-29	40	23.5
30-34	26	15.3
35-39	32	18.8
40-44	26	15.3
45-49	10	5.9
Total	170	100.0

Source: Field Survey, 2012

4.1.3 Marital Status

Marital status was one of the major components for the increase the family size. Among 170 respondents, 157 (92.4%) respondents married and living together with their husband. Similarly 10 (5.9%) and respondents widow, 3 (1.8%) respondent separated (Table 3).

Table 3: Percent Distribution by Respondents by Marital Status in Pachanali VDC, Doti District, Nepal 2012

Marital Status	Cases	Percent
Currently Married	157	92.4
Widow	10	5.9
Separated	3	1.8
Total	170	100.0

Source Field Study, 2012

4.1.4 Age at Marriage

Among 170 respondents, all respondent were married. Among them 72.9 percent respondents were married between 15-19 years, 18.8 percent respondent were married at the age of 10-14 years, 7.1 percent respondents were married at the age of 20-24 years and only 1.2 percent respondent were married at the age of 25-29 (Table4).

Table 4: Distribution of Respondents by Age at Marriage of Pachanali VDC Doti District, Nepal 2012.

Age At Marriage	Cases	Percent
10-14	32	18.8
15-19	124	72.9
20-24	12	7.1
25-29	2	1.2
Total	170	100.0

Source: Field Survey, 2012

4.1.5 Family Size

Family size is another important demographic factor. Generally, in large family it may be difficult to provide all type of facilities. The data on family size indicate most of the respondents (64.70 %) had 4-6 family members, 20 percent of the respondent had less than three family members and 15.29 percent of the respondent had 7-9 family members in their households (Table5).

Table 5: Respondents by Family Size of Pachanali VDC, Doti District, Nepal 2012

Family Size	Cases	Percent
Less than 3	34	20.0
4-6	110	64.70
7-9	26	15.29
Total	170	100.0

Source: Field Survey, 2012

4.1.6 Children Ever Born

CEB is the directly related to the child loss experience. Out of 170 respondents 51 (30.0%) respondents had given 1-2 child births ,65 (33.0%) respondents had given 3-4 child births, 38 (22.4%) respondents had given 5-6 child births, and 25 (14.7%) respondents had given 7-9 child births in their life time (Table6).

Table 6: Respondents by CEB of Pachanali VDC, Doti District, Nepal2012

CEB	Cases	Percent
1-2	51	30.0
3-4	56	33.0
5-6	38	22.4
7-9	25	14.7
Total	170	100.0

Source: Field Survey, 2012

4.2 Social Characteristics

4.2.1 Caste/ Ethnicity

In this study, the 170 respondents were from two major ethnic groups. They were Dalits (Kami, Sarki, Tamrakar, Tamata etc.) and Non-Dalits (Brahmin, chhetri) community of Pachanali VDC.

Among total household population, majority of sample populations 52.1 percent were Dalits, 26.1 percent were Brahmin and 21.8 percent were Chhetri respectively (Table7).

Table 7: Total Population of Sample Households by Caste/Ethnicity of Pachanali VDC, Doti District, Nepal 2012

Caste/Ethnicity	Cases	Percent
Brahmin	215	26.1
Chhetri	180	21.8
Dalits	429	52.1
Total	824	100.0

Source: Field Survey, 2012

4.2.2 Religion

Among total household population, majority of population (99.8%) were Hindus and second religion was Buddhism with 0. 2 percent in the sample population of Pachanali VDC (Table8).

Table 8: Percent Distribution of Household Population by Religion of Pachanali VDC, Doti District, Nepal 2012

Religion	Cases	Percent
Hindus	822	99.8
Buddhism	2	0.2
Total	824	100

Source: Field Survey, 2012

4.2.3 Educational Status of Respondent

Education is very important factor of peoples' well-being. It helps behavioral change of the peoples' knowledge and many other attitudes. The level of education of respondents was different which shows the here in table 8.

Among total respondents, only 25 (14.7 %) respondents level of education was SLC and above. Out of 170 respondents, 24 (14.1%) respondents level of education was secondary level. Similarly, 63 (37.0) respondents were complete primary level and 58 (34.1%) respondents are illiterate (Table9).

Table 9: Percent Distribution of Respondents by Educational Status of Pachanali VDC, Doti District, Nepal 2012

Educational Status	Cases	Percent
Illiterate	58	34.1
Primary	63	37.0
Secondary	24	14.1
SLC and above	25	14.7
Total	170	100.0

Source: Field Survey, 2012

4.3 Economic Characteristics

The economic condition shows their real figure of purchasing power of goods and services. The economics statuses of the respondents determine whether they are poor or rich. If the income of a respondent's family is high, their living status is also high; if their income is low their living status is also low. This situation affects the whole life of people.

4.3.1 Occupational Status of Respondent

The occupation of respondents was divided into nine categories. Occupation of respondents was also an important factor that determines their knowledge, attitude and practice on maternal health and child loss experience of women

Out of total respondents, 64.1 percent reported that they were engaged in agriculture. However 18.2 percent of the respondents reported that they were engaged in labor (agriculture, domestic work). Similarly 9.4 percent respondents reported that they were engaged in job sector (government and non- government sector), 2.9 percent of the respondents reported that they were engaged in business sector, 1.8 percent of the respondents reported that they were engaged in labor (except agriculture), 2.4 percent of the respondents reported that they were seeking the job, o.6 percent of the respondents reported that they were dependent and 0.6 percent respondents reported that they were engaged in only house maker sector (Table10).

Table 10: Respondent by Their Occupation of Pachanali VDC, Doti District, Nepal 2012

Occupation	**Cases**	**Percent**
Agriculture	109	64.1
Business	5	2.9
Job	16	9.4
Labor	31	18.2
Labor (expert agriculture)	3	1.8
Dependent	1	0.6
Job seeker	4	2.4
House maker	1	0.6
Total	170	100.0

Source: Field Survey, 2012

4.3.2 Own- Income of Respondent

Income determines their economic status. If there is much income, there is more chance of economic prosperity. Income helps to fulfill need of family member.

The respondents were divided into five categories of income level as presented in the following table. Out of 170 respondents 18.82 percent respondents' monthly income

was less than 1000. Similarly 16.47 percent respondents' monthly income was between Rupees 1,001 to 3000, only 6.47 percent respondents' monthly income was above 9000 , 4.7 percent respondents' monthly income was between 3001 to 6000 and 1.17 percent respondents' monthly income was between 6001 to 9000 (Table11).

Table11: Respondents by Their Own Income in Pachanali VDC, Doti District Nepal, 2012

Own Income	**Cases**	**Percent**
No income	90	52.94
Less than 1000	32	18.82
1001 – 3000	28	16.47
3001-6000	7	4.11
6001-9000	2	1.17
9000+	11	6.47
Total	170	100.0

Source: Field Survey, 2012

4.3.3 Type of House

Type of house, usually, indicates economic status of any family. Among 170 respondents, most of them 98.8 percent had rough mudstone (made by mud and stone) house and 1.2 percent respondents reported that they were homeless at the time of survey (Table12).

Table 12: Respondents by Household Type of Pachanali VDC Doti District, Nepal 2012

Type of house	**Cases**	**Percent**
Rough mudstone	168	98.8
Homeless	2	1.2
Total.	170	100.0

Source: Field Survey, 2012

4.3.4. Household Facilities

Household facility indicates the economic status of the household. The respondents were asked to specify whether they had the household facilities, such as electricity,

radio, TV, motorcycle, bio-gas, mobile, phone, bus, jeep etc. or not. Availability of these types of facilities helps to increase the knowledge of maternal and child health. Out of 170 respondents, 80 respondents had Radio, 161 had electricity, 137 had mobile phone, 17 had CDMA phone, 41 had television, 3 had motorbike, 2 had bio-gas, 2 had cycle, 1 had solar, 1 had jeep and no one had bus, truck, and tractor at the time of survey (Table13).

Table13: Respondents by Household Facilities of Pachanali VDC, Doti District, Nepal 2012

Household Facilities	Yes		No		Total
	Number	Percent	Number	Percent	Number
Radio	80	47.1	90	52.9	170
Cycle	2	1.2	168	98.8	170
Solar	1	0.6	169	99.4	170
Electricity	161	94.7	9	5.3	170
TV	41	24.1	129	75.9	170
Bio-gas	2	1.2	168	98.8	170
Phone	17	10.0	153	90.0	170
Mobile	137	80.6	33	19.4	170
Motorbike	3	1.8	167	98.2	170
Car, Jeep	1	0.6	167	99.4	170
Bus, Truck, Tractor	0	0	170	100.0	170

Source: Field Survey, 2012.

4.3.5 Perception Regarding the Family Status

By comparing availability of HH facility, economic condition, family income, occupation, etc. are determine the status of the family. The respondents were categorized into six groups of the level of family status.

Out of the total 170 respondents, majority of the respondents (49.4) had low income and low facility. Slimily, 17.1 percent respondents had average level of family status, 14.7 percent respondents' reported that their status was under the average, 12.9 percent respondents reported that they had no income and facility. Only 4.1 percent

respondents' reported that they had above the average level of family status and 1.8 percent respondents' were from sophisticated in their society (Table14).

Table 14: Respondents by Family Size of Pachanali VDC, Doti District, Nepal

Family status	Cases	Percent
Sophisticated	3	1.8
Above the average	7	4.1
Average	29	17.7
Under the average	25	14.7
Low income and facility	84	49.4
No income and facility	22	12.9
Total	170	100.0

Source: Field Survey, 2012.

4.3.6 Property Entitlement

Ownership of the personal properties such as land, house, animal, ornaments, bank balance etc. by respondents and their family is included in this section.

Out of 170 respondents, 143 had different types of ornaments as their personal property, 115 respondents had kept animal, 26 respondents had only land in their name, 17 respondents had share, bank balance, 9 respondents had land with house, 2 respondents had shop/Ghatta and only one respondent had Rickshaw or mill (Table15).

Table15: Respondents by Personal Property of Pachanali VDC, Doti District, Nepal 2012

Property	Yes		No		Total
	Cases	Percent	Cases	Percent	Total Cases
Land with house	9	5.3	161	74.7	170
Only Land	26	15.3	144	84.7	170
Animals	115	67.6	55	32.4	170
Rickshaw, Mills	1	0.6	169	99.4	170
Share, bank balance	17	10.0	153	90.0	170
Shop	2	1.2	168	98.8	170

Source: Field survey, 2012.

4.4 Participatory Characteristics

4.4.1 Major Decision Maker at Family

Major household decision maker at the family of the responds were categorized into four groups and they are tabulated.

Out of the 170 respondents, 72.9 percent respondents reported that their husbands made main decision at their family. Similarly 14.7 percent respondents claimed that they would make their own decision at home. 5.3 percent reported that their father were the major HH decision maker at home,4.1 percent reported that their mother were the major HH decision maker at home and 2.9 percent respondents reported that there were other family members such as brother, sister, uncle, brother in low, sister in law etc. who would make decision in important family matters (Table16).

Table 16: Respondents by Decision Maker at Family in Pachanali VDC, Doti Nepal2012

Major HH decision maker	Cases	Percent
Self	25	14.7
Husband	124	72.9
Father	9	5.3
Mother	7	4.1
Others	5	2.9
Total	170	100.0

. Source: Field Survey, 2012.

4.4.2 Opportunity of Opinion in Family Decision

The response taken from 170 respondents, huge 50.6 percent respondents reported that their advice is always taken. Similarly, 35.9 percent said that their advice was taken only in usually, 9.4 percent said that their advice was taken sometimes. However, 2.9 percent respondents reported that their advice was never taken and 1.2 percent respondents reported that their advice was usually not taken in making family decisions (Table17).

Table 17: Respondents by Household Decision Making Role in Pachanali VDC, Doti, Nepal 2012

Role in family decision	Cases	Percent
Always	86	50.6
Usually	61	35.9
Sometimes	16	9.4
Usually not taken	2	1.2
Never taken	5	2.9
Total	170	100.0

Source: Field survey, 2012.

4.4.3: Gender Role in Household Errands

In our society, the HH works are mostly done by female and the outdoor works are mostly done by male once. These activities surveyed included cooking, water fetching, animal rearing, mill work, and fuel management, pay bills, daily shopping and selling of family products.

Among 170 respondents, around 70.6 percent said that only females would cook in their house, 24.7 percent said that it was mostly done by females, 2.9 percent said that it was equally done by both gender and 1.2 percent said that it was done by mostly male and 0.1 percent said that it was done by male. The percentage of the respondents reported that the job of water collection was under taken always by female, mostly by female, equally by both male and female, mostly male were 60.6, 22.9, 15.9, 0.6 percent respectively. In the same way, 60.0, 21.8, 11.8, 6.3 percent were the percentage of respondents that answered that the job of mill work was done always by female, mostly female, equal both, mostly male respectively. As per the role of fuel management 45.9 percent, 28.8 percent, 14.7 percent, 10.0 percent, and 0.6 percent were the percentage of the respondents that replied that it was done always female, mostly female, equal both, mostly male, and always male. In the same way, 57.7 percent, 27.4 percent, 14.3 percent, 0.6 percent were the respondent of respondents that answered that the job of animal rearing was done always female, mostly female, equal both, mostly male respectively. Similarly, the percent of the respondents that reported that the job of paying bill was done by always by female, mostly female, equal both, mostly male, always male were 37.1 percent,6.5 percent,

5.3 percent, 47.1 percent, and 4.1 percent respectively. Among the total respondent, 42.2 percent, 15.9 percent, 26.5 percent, 12.9 percent, and 1.8 percent responded that daily shopping was done always by female, mostly female, equal both, mostly male and always by male. And finally, 58.3 percent, 19.0 percent, 13.1 percent, 8.9 percent and 0.6 percent of the total respondents replied that family products would be sold always by female, mostly by female, equally by both male and female, mostly by male, and always by male respectively The degree of gender role of the respondents in HH errands is summarized here (Table18).

Table 18: Distribution of Respondents by Gender Role in Pachanali VDC, Doti District, Nepal 2012

Household Errands	Always female		Mostly female		Equal Both		Mostly Male		Always male		Total
	Number	Percent	Number	Percent	Number	Percent	Number	Percent	Number	Percent	
Cooking	120	70.6	42	24.7	5	2.9	2	1.2		0.1	170
Supply of water	103	60.6	39	22.9	27	15.9	1	0.6	0	0	170
Mill work	102	60.0	37	21.8	20	11.8	11	6.3	0	0	170
Management of fuel	78	45.9	49	28.8	25	14.7	17	10.0	1	0.6	170
Animal rearing	97	57.7	46	27.4	24	14.3	1	0.6	0	0	170
Billing	63	37.1	11	6.5	9	5.3	80	47.1	7	4.1	170
Daily shopping	73	42.9	27	15.9	45	26.5	12	12.9	3	1.8	170
Selling HH products	98	58.3	34	19.0	22	13.1	15	8.9	1	0.6	170

Source: Field survey, 2012.

In conclusion, most of the respondents had followed Hindu religion. A large proportion of female population is found involve in agriculture sector and HH works. Similarly almost respondents' houses were made by mud and stone. Among total respondents, primary completed respondents are found more than secondary, SLC and above. Most of the respondents were married between 15 to 19 years.

CHAPTER FIVE

ASSESSMENT OF CHILD LOSS EXPERIENCE OF NON-DALITS AND DALITS

5.1 Child Loss Experience by Social Variables

5.1.1 Child Loss Experience by Education

5.1.1.1 Child Loss Experience by Education of Respondents

The illiterate respondents who, had the highest mean child loss experience that was 0.96, which is higher than the Dalits. Likewise for primary level Dalits's mean of child loss 0.77 which is the higher index which in comparison to the non-Dalits. Furthermore, in secondary level the index of Non- Dalits 0.24. In higher level Dalits respondents have high child loss experience (0.75) compared to Non- Dalits women (0.24). In total on the basis of their educational level the highest child loss experience (0.91) in illiterate respondents (Table19).

Table 19: Child Loss Experience by Education of Respondents, of Pachanali, Doti 2012

Education	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD.	Mean CLE	Cases	SD.	Mean CLE	Cases	SD.
Illiterate	0.96	23	0.767	0.89	35	0.678	0.91	58	0.756
Primary	0.50	24	0.590	0.77	39	0.706	0.67	63	0.672
Secondary	0.24	21	0.436	0.00	3	0.000	0.21	24	0.415
Higher	0.24	17	0.437	0.75	8	0.886	0.40	25	0.645
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.1.1.2 Child Loss Experience by Education of Husbands of Respondents

The educational level of husbands showed that the illiterate husbands had (0.91) index of child loss experience in Dalits community which compared to high in Non-Dalits community (0.85). Likewise child loss experience was high in Non-Dalits community (1.11) comparatively to Dalits community (0.80) in the level of primary education .The child loss experience in Dalits community (0.65) was high compared to Non-Dalits community (0.48) in secondary level of education. Likewise it high in Dalits community (1.00) compared to Non- Dalits community (0.13) in the level of higher education. In total the child loss experience was high (0.89) of the illiterate husbands (Table20).

Table 20: Child Loss Experience by Husbands Education of Respondents, of Pachanali, Doti 2012

Education	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Illiterate	0.85	13	0.689	0.91	12	0.750	0.89	35	0.718
Primary	1.11	9	0.782	0.80	45	0.757	0.85	54	0.769
Secondary	0.48	40	0.599	0.56	16	0.727	0.50	56	0.632
Higher	0.13	23	0.344	1.00	2	0.000	0.20	25	0.408
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.1.2 Child Loss Experience by Gender Roles in Family

Most of the males are in India for their livelihood. So most of respondents are shown as a decision maker in their households but their child loss still high. According to the gender role, the child loss experience index was high in Non-Dalits community compared to Dalits community (0.77) whom respondents were self decision maker. Likewise those respondents which households' decision makers were their households had 0.80 index of child loss in Dalits community and 0.53 indexes in Non-Dalits community. The child loss experience index high in Dalits community (0.80) compared to Non-Dalits community (0.25), the household respondents who were the

decision maker was their father or father in law. Likewise the child loss experience index was high in Non-Dalits community 0.50 and 0.29 and it was not in Dalits community which household decision maker were others and mother in law respectively. In total the child loss experience index was high and equal in (0.68) which most of the decisions were taken by respondents and her husband's equally (Table21).

Table 21: Child Loss Experience by Gender Role in Family, Pachanali, Doti 2012

Decision Making in Household	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Self Decision	0.58	12	0.669	0.77	13	0.832	0.68	25	0.748
Husband	0.53	58	0.681	0.80	66	0.684	0.68	124	0.693
Father/father in Law	0.25	4	0.500	0.80	5	1.304	0.56	9	1.014
Mother/ Mother in law	0.29	7	0.488	00	0	000	0.29	7	0.488
Others	0.50	4	0.577	00	1	-	0.40	5	0.548
Total	0.51	85	0.648	0.79	85	0.65	0.65	170	0.708

Source: Field Survey, 2012

5 .1.3 Child Loss Experience by Status of Family

The rich Non-Dalits community, 3 respondents had 0.00 child loss experience, which family status was above average they had 0.86 index of child loss and there were no rich and above average status of family in Dalits community .In the average the child loss experience index was high in Dalits community (0.330) compare to the Non-Dalits community (0.23).Under the average the child experience index was high in (0.75) in Non-Dalits community compared to Dalits community (0.46). Likewise the child loss experience index was high (0.90) in Dalits community compared to Non-Dalits community (0.58) which family status had the low income and low facility. In the same way the child loss experience index was high in Dalits community (0.78) compared to the Non-Dalits community (0.75), which family had none of facilities. In total the child loss experience index was high in above average status of family (0.86) (Table22).

Table 22: Child Loss Experience by Status of Family, Pachanali, Doti 2012

Status of Family	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Rich	0.00	3	0.000	0.00	00	0.00	0.00	3	0.000
Above average	0.86	7	0.690	0.00	00	0.00	0.86	7	0.690
Average	0.23	26	0.430	0.33	3	0.577	0.24	29	0.435
Under average	0.75	12	0.965	0.46	13	0.660	0.60	25	0.816
Low income and facilities	0.58	33	0.614	0.90	51	0.781	0.77	84	0.734
None of them	0.75	4	0.500	0.78	18	0.647	0.77	22	0.612
Total	0.51	85	0.649	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.1.4 Child Loss Experience by Chhaupadi Tradition

The people who follow Chhaupadi tradition appropriately (those who say this tradition is absolutely good) had high (0.83) child loss experience index in Non-Dalits community in comparison to Dalits (0.73). Those who followed the tradition normally had high index in Dalits (0.88) compared to Non-Dalits (0.56). On the same way those who don't follow that tradition have higher index on Non-Dalits (0.08) in comparison to Dalits (0.00). Among 170 respondents, those who thought this tradition irrelevant or incorrect there was 1 respondent from Non-Dalits had 0.00 index of child loss experience and in Dalits the index was naught. The same was the case with the person who thought it strictly incorrect. In total the index of child loss experience was the highest (0.75) who said Chhaupadi tradition was good and they should strictly follow it (Table23).

Table 23: Child Loss Experience by Chhaupadi Tradition, Pachanali, Doti, 2012

Chhaupadi Tradition	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Appropriate	0.83	2	0.577	0.73	44	0.727	0.75	56	0.690
Normally	0.56	57	0.682	0.88	40	0.757	0.69	97	0.727
Don't follow tradition	0.08	12	0.298	0.00	1	-	0.08	13	0.177
Think it incorrect	0.00	1	-	0.00	00	-	0.00	1	-
Think it strictly incorrect	0.00	3	0.000	0.00	00	0.00	0.00	3	0.000
Total	0.51	85	0.647	0.79	85	0.740	0.67	170	0.708

Source: Field Survey, 2012

5.2 Child Loss Experience by Economic Variables.

5.2.1 Child Loss Experience by Occupation of Respondents

The Non-Dalits respondents with occupation as agriculture had higher child loss experience (0.96) compared to the Dalits (0.79) of same occupation. The respondents who were engaged in business had 1.00 index of child loss experience in Dalits where there was naught in Non-Dalits. The respondents who were engaged in some kind of jobs have 0.25 child loss index in Non-Dalits which was naught in Dalits community. Likewise, the respondents who were engaged in wage labor had higher (0.85) child loss experience index in Dalits community compared to Non-Dalits community (0.73). The respondents who follow wage labor except farming had higher child less experience index which was 1.00 in Non-Dalits community compared to Dalits community who had naught. The respondents who were dependent had equal index of child loss experience in both Dalits and Non-Dalits community that was 0.00. Likewise the Non-Dalits respondents who were seeking job had 0.50 index of child loss experience, whereas in Dalits respondents it was naught. Those who were only housewives hadn't any child loss experience index both in Dalits and in Non-Dalits community. In total the child loss experience index is was the highest (0.81) in the respondents who follow waged labor including farming (Table24).

Table 24: Child Loss Experience by Occupation of Respondents, Pachanali, Doti 2012

Occupation of Mother	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Agriculture	0.96	48	0.712	0.79	61	0.798	0.69	109	0.766
Business	0.00	3	0.000	1.00	2	0.000	0.40	5	0.548
Job	0.25	16	0.447	0.00	0	-	0.25	16	0.447
Wage Labor	0.73	11	0.467	0.85	20	0.587	0.81	31	0.543
Wage Labor Except Farming	1.0	2	1.414	.00	1	-	.67	3	.155
Dependent	0.00	1	-	0.00	00	-	0.00	1	-
Seeking Job	0.50	4	0.577	0.00	00	-	0.50	4	0.577
Housewife	0.00	00	-	0.00	1	-	0.00	1	-
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.2.2 Child Loss Experience by Income

Among170 respondents, as the data was taken on the basis of amount of their income, the highest index of child loss experience (0.63) in Non-Dalits, who had income less than 1000 rupees was less than Dalits (0.78). Likewise the respondents who had the income between 1001-3000 had the index of child loss experience in Dalits is 0.47 which is less than non Dalits who had the higher index (0.78). Again those respondents who had the income between 3001 -5000, the index of child loss experience in Dalits was double (1.00), in comparison to Non-Dalits (.50). Likewise the respondents who had their income more than 5000, in Dalits they had higher index of child loss experience (1.00) and in Non-Dalits the index were low (0.13). In total those who had their income between 3001-5000 is the highest index (.75) of child loss experience. And the lowest index of child loss experience (0.19) is of the respondents who had their income above 5000 (Table25).

Table 25: Child Loss Experience by Income of Respondents, Pachanali, Doti, 2012

Income Level	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Less than 1000	0.63	49	0.698	0.78	73	0.731	0.72	122	0.719
1001-3000	0.47	19	0.612	0.78	9	0.972	0.57	28	0.742
3001-5000	0.50	2	0.707	1.00	2	0.000	0.75	4	0.500
Above 5000	0.13	15	0.352	1.00	1	-	0.19	14	0.403
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.2.3 Child Loss Experience by Personal property

On the basis of personal property the child loss experience among 170 respondents, the index of child loss experience who had the land in their own name was (0.46) which was less than the respondents who didn't have land in their name in Non-Dalits (0.53). The respondents who had land with houses in their own name had the higher index (0.50) of the child loss experience in Non-Dalits which was very much higher than the Dalits (0.03). The respondents who had ornaments in their own name had the higher index of the child loss experience in the Dalits (76). In total the least index of the child loss is those who have the land in their own name (0.46), and the highest index of the child loss experience were those who had ornaments in their own name and land with house (0.78), which was the equal index in both (Table26).

Table 26: Child Loss Experience by Personal Property, Pachanali, Doti 2012

Personal Property	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Land									
Yes	0.46	26	0.761	00	00	00	0.46	26	0.761
No	0.53	59	0.598	0.79	85	0.742	0.68	144	0.696
Land with House									
Yes	0.50	8	0.535	0.03	1	-	0.78	9	0.972
No	0.51	77	0.661	0.76	84	0.705	0.64	161	0.694
Ornaments									
Yes	0.50	76	0.600	0.76	67	0.698	0.62	143	0.659
No	0.56	9	1.014	0.89	18	0.900	0.78	27	0.934
Animals									
Yes	0.57	61	0.694	0.74	54	0.650	0.65	115	0.676
No	0.33	24	0.482	0.87	31	0.885	0.64	55	0.778
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.2.4 Child Loss Experience by Household Amenities

Among the 170 respondents who had their household amenities on the basis of availability and the use, the child loss index was higher (0.85) in Dalits community had the radio compared to the non- Dalits (0.56). The child loss index was high (0.43) in Dalits compared to Non-Dalits (0.39), who used TV. Likewise the child loss experience index was high (0.76) in Dalits community compared with non- Dalits (0.49) who had the electricity in their households. Likewise the child loss experience index was high (0.68) in Dalits community compared with Non- Dalits (0.44) who had the mobile with themselves. In total the respondents, who didn't have TV in their households, had the highest index of child loss experience (0.74) (Table27).

Table 27: Child Loss Experience by Household Amenities, Pachanali, Doti, 2012

Household Amenities	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Radio									
Yes	0.56	54	0.691	0.85	26	0.784	0.65	80	0 .731
No	0.40	31	0.564	0.76	59	0.727	0.64	90	0.692
Television									
Yes	0.39	34	0.544	0.43	7	0.787	0.37	41	0.581
No	0.61	51	0.695	0.82	78	0.734	0.74	129	0.724
Electricity									
Yes	0.49	81	0.635	0.76	80	0.706	0.55	137	0.674
No	0.57	4	0.957	1.20	5	0.707	1.03	33	0.728
Mobile									
Yes	0.44	72	0.606	0.68	65	0.731	0.55	137	0.674
No	0.85	13	0.801	1.15	20	0.671	1.03	33	0.728
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.3 Child Loss Experience by Demographic Variables

5.3.1 Child Loss Experience by Age

Among 170 respondents the child loss experience index was high in Dalits community (0.25) compared to Non-Dalits community (0.00) from the age of 15-19 years. Likewise the child loss experience index was also high in Dalits community (0.50) compared to Non-Dalits community (0.20) from the age of 20-24 years. Same way the index of child loss experience is high in Dalits community (0.71) compared to Non-Dalits community to age group of 25-29 years. In the age group of 30-34 years the index of child loss experience was equal in both community Dalits and Non-Dalits. In similar way in the age group of 35-39 years the index of child loss experience was high in Dalits community (0.92) compared to the Non-Dalits community (0.35). The index of child loss experience was high in Dalits community (1.18) compared to Non-Dalits community (0.80) to the age group of 40-45 year. Likewise the index of child loss experience was high in Non-Dalits community (1.20)

compared to the Dalits community (0.80) to the age group of 45-49 years. In total the index of child loss experience was high and equal in the age group of 30-34 and 45-49 years (Table28).

Table 28: Child Loss Experience by Age of Respondents, Pachanali, Doti 2012

Age	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
15-19	0.00	1	-	0.25	8	0.463	0.22	9	0.441
20-24	0.20	15	0.414	0.50	12	0.674	0.33	27	0.555
25-29	0.26	19	0.452	0.71	21	0.644	0.50	40	0.599
30-34	1.00	10	0.943	1.00	16	0.816	1.00	26	0.849
35-39	0.35	20	0.489	0.92	12	0.793	0.56	32	0.669
40-44	0.80	15	0.676	1.18	11	0.874	0.96	26	0.774
45-49	1.20	5	0.447	0.80	5	0.447	1.00	10	0.471
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.3.2 Child Loss Experience by Marital Status

Among 170 respondents, 157 were married and living with husbands had the highest index of child loss experience in Dalits community (0.78) compared to Non-Dalits community (0.48). Likewise the respondents, who were separated, had the equal index (1.00) of child loss experience in Non-Dalits community. The respondents, who were widow of Non-Dalits community, had the 1.00 index of child loss experience which was high compared to the Dalits community (0.86). In total the child loss experience was high in Dalits community (0.79) followed by Non-Dalits community (0.51) as the condition of marital status (Table29).

Table 29: Child Loss Experience by Marital Status of Respondents of Pachanali, Doti 2012

Marital Status	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Married and living with Husband	0.48	81	0.654	0.78	76	0.723	0.62	157	0.702
Separated	1.00	1	-	1.00	2	0.000	1.00	3	0.000
Widow	1.00	3	0.000	0.86	7	1.069	0.90	10	0.876
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.3.3 Child Loss Experience by Family Size

Among170 respondents the index of child loss experience was different. The respondents whose family size was between1-3 had higher index (0.79) of child loss experience in Dalits community *compared* to Non-Dalits community (0.45). Likewise the index of child loss experience was high in Dalits community (0.82) compared to Non-Dalits community (0.51), whose family size was 3-5 members. Similarly the index of child loss experience was also high in Dalits community (0.82) compared to the Non-Dalits community (0.69) which family size between 5-7 members. Likewise the index of child loss experience was high in Dalits community (0.25) compared to Non-Dalits community which family member was above 7 members. In total the index of child loss experience was high (0.78) which had the 5-7 family members (Table30).

Table 30: Child Loss Experience by Family Size of Respondents of, Pachanali, Doti 2012

Family Size	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
1-3	0.45	20	0.605	0.79	14	0.802	0.59	34	0.701
3-5	0.51	45	0.695	0.82	34	0.716	0.65	79	0.717
5-7	0.69	16	0.602	0.82	33	0.769	0.78	49	0.715
Above 7	0.00	4	0.000	0.25	4	0.500	0.13	8	0.354
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.708

Source: Field Survey, 2012

5.3.4 Child Loss Experience by Number of CEB

Among 170 respondents which had 0.32 index of child loss experience was high in Dalits community compared to the Dalits community (0.17) which CEB was below 3. Likewise the index of child loss experience is high in Dalits community (0.95) compared to the Dalits community (0.93) which CEB was 4-6. Similarly the index of child loss experience was high in Dalits community (1.17) compared to Non-Dalits community (0.88). In total the index of child loss experience was high (1.08) who had above seven, of CEB (Table31).

Table 31: Child Loss Experience by Number of CEB, Pachanali, Doti, 2012

Number of CEB	Mean Number of Child Loss								
	Non-Dalits			Dalits			Total		
	Mean CLE	Cases	SD	Mean CLE	Cases	SD	Mean CLE	Cases	SD
Below 3	0.17	47	0.380	0.32	28	0.476	0.32	75	0.421
4-6	0.93	30	0.640	0.95	39	0.724	0.94	69	0.684
7+	0.88	8	0.835	1.17	18	0.786	1.08	26	0.796
Total	0.51	85	0.648	0.79	85	0.742	0.65	170	0.706

Source: Field Survey, 2012

CHAPTER SIX
ANALYSIS OF QUALITATIVE INFORMATION

6.1 Case Studies

There were various cases observed during the field visit. Among them two cases are presented bellow.

6.1.1 Case One

Puni was Dalits woman of 49 years. She had got married at the age of 11 years. Her husband has been working in India as a security guard till now. She had one daughter and two sons alive now. She did not give birth only three children but she had child loss experience as well. According to her, her first girl child had died within seven days of birth and a son had died at the age of 25 years, due to HIV/AIDS. Her dead son used to work at hotel of Mumbai. He had a wife and two sons. At the time of research her daughter in law was not at home. There had not good relation between mother in law and daughter in law. So her daughter in law went to her birth place with her two sons.

Puni was living in Pachanali VDC ward number 6 since two years. Before that she used to live in India with her husband. She had five years old son then. She had not her own land for farming and she was living in her neighbor's house at the time of survey.

By the date of survey she had three times miscarriage and she had undergone abortion six times in hospital in India. She had been pregnant fifteen times in her lifetime. Her frequent miscarriage and the abortion was cause of backside pain and belly pain. She could not do her work very well. She had felt that she became very weak due to regular pregnancy and regular abortion. She said, "Lack of awareness and education I gave birth to more child and I am facing various kinds of health problems." She suggested her relatives and neighbors not to get married in early age and to give birth one or two child only so that we will get happy life.

6.1.2 Case Two

Haru Tamata was a Dalits woman with two years son. She was just 31 years of age and mother of seven children. Among them six were daughters and last one was son. All of them were unmarried at the time of survey. Her eldest daughter was of age 14 years. All daughters went to school. Her family had two Ropani of dry land. Food production is sufficient hardly for three months. Rest of nine months they depended on her husband income. She had one pregnancy loss and no child loss experience yet. Though there was radio in her home, she had little knowledge about safe motherhood and maternal care. She had two ANC visit for her last pregnancy, took TT vaccination and iron capsule. She delivered her last baby at home and her senior daughter helped her during and after delivery. Used blade was the tool for cutting umbilical cord. She did not have PNC visit. She had taken nutritious food like ghee, meat up to 12 days after delivery.

She had felt that she became very weak due to regular pregnancy. She also felt about difficulty to rearing and caring seven children. They had desire for son, so she had giving birth almost yearly. She reports as “Though I wish to use any method of family planning, I have fear of society but that time I have not son, but now my dreams are fulfilled. So I would make operation as soon as possible.” In case of her husband due to responsibility of nine members of family, he had to do hard work daily. So they did not have desire for vasectomy.

So, there was higher chance of checking higher number of children in future.

6.4: Researcher's Observations

The Pachanali VDC is one of the hilly areas of Doti District. During the field visit, the researcher had to travel on foot. Almost all parts of VDC were visited. Majority of the people were engaged in agriculture. So, the researcher had to wait for respondent for some minutes because they were engaged in cutting grass, raring animals, fetching water etc. Most of the houses old age women are only in the house. The women had lack of time to go in the non sense sitting of the males which is still prevalent in that society. They were always busy within their household activities.

Especially, in poor households when researcher reached to their home, the available family member of that home demanded to fulfill their needs. They had great demand

from government. The great demand was employment for survival and education for children.

Majority of Dalits Households had very little fertile land. So their male members had gone to India for raring and caring of wife and children. Most Dalits had only two rooms of their house including kitchen. Almost all had toilet facility in their home but they had no water facility in their house. They reported that they had taken at least 15 to 30 minutes to bring water. They are very much deprived of irrigation, and if they are deprived of these things how can we expect the better agro product? They were always dependent on the rainfall. Most of the households' works were done by women.

There were various experiences gathered by researcher during field visit. At the Chhudi village of the ward number 3, the researcher saw a woman with three days delivery was cooking for their family, her husband was not home, and he was India.

At the Aakhada village of ward number 4, the researcher saw women with one day delivery was caring a huge clothes and a pot of water on her head. At the Rithavowa village of ward number 5, twenty seven days baby was playing with her elder sister and her mother had gone to bring water. At the Pachanali village of ward number 6, in a Dalits household a baby was sitting on the window, he was fully covered with mud; his face was covered by house-flies. In some villages, the researcher observed pregnant or recently delivered women were doing hard works.

Due to lack of time, they had not managed their children well. The people had more confidence about health services available at sub-health post. They gained absolute services from health-posts. Mothers and child workers of the VDC were observed more active. The people of the VDC were aware about health care facilities and used in practicing.

CHAPTER SEVEN

SUMMARY, CONCLUSION AND RECOMMENDITION

7.1 Summary

This study has attempted to examine the status of child loss experience by social, economic and demographic variables among Dalits and Non-Dalits women in Pachanali VDC of Doti district. The study primarily concentrated on child loss experience of women aged 15-49 who had one child birth at the time of survey by social, economic and demographic variables.

The following are the major findings of this study:

7.1.1 Summary of Basic Characteristics of Respondents

- Out of 824 sample population, 409 (49.6%) were male and 415 (50.4%) were female.
- There were 170 respondents, 156 were currently married, 10 were widow and 4 were separated at the time of survey.
- In total respondents 5.3 percent were age of 15-19, 15.9 were age of 20-24, 23.5 percent were age of 25-29 years, 15.3percent were age of 30-34 and 18.8,15.3, 5.9 percent were age of 35-39, 40-44, 45-49 years respectively.
- Among 170 respondents 18.8 percent were married between the age of 10-14 years, 72.9 percent were married between the age of 15-19 years, 7.1 percents were married between the age of 20-24 years and only 1.2 percents were married between the age of 25-29 years.
- Likewise 64.70 respondents had 4-6 family members, 20.0 respondents had less than 3 member, 15.29 respondents had 7-9 family member.
- Among 170 respondents 33.0 percent respondents had 3-4 CEB, 30.0 respondents had 1-2 CEB, 22.4 percent respondents had 5-6 CEB and 14.7 percent respondents had 7-9 CEB in their family.
- Among total sample size 52.1 percent were Dalits, 26.1 percent were Brahmin and 21.8 percent were chhetri.
- Likewise 99.8 percent were Hindu and only 0.2 percent was Buddhist.
- The 14.7 percent respondents were SLC and above education status, 14.1, 37.0and 34.1perccent respondents were secondary, primary and illiterate respectively.
- Most of the respondents (63.7%) had depended on agriculture.
- Likewise 52.94 percent respondents had no income.

- The 95.88 percent respondents were living in non pitched house.
- Among total respondents 47.1 percent had radio ,1.2 percent had cycle, 0.6 percent had solar 94.7 percent had electricity 24.1 had TV 1.2 had bio- gas, 10 had phone, 80.6 had mobile phone, 1.8 had motorbike, 0.6 had car /jeep and none of them had bus truck and tractors.
- The 49.4 percent respondents had low income and low facilities.
- The 5.3 percent respondents had land with house as their own personal property, 15.3 percent had only land, 67.6 percent had animals 0.6 percent had rickshaw/mills, 10 percent had share/ bank balance and only 1.2 percent respondents had shop as their personal property.
- The 14.7 percent respondents were self decision maker in their households.
- The 50.6 percent respondent's advice taken always in their households.
- The 70.6 percent respondents were always cooking.

7.1.2 Findings of Child Loss Experience

- The total non-Dalits had 0.51 and Dalits had 0.79 mean of child loss experience.
- By education the child loss experience were 0.96 in non- Dalits and 0.89 in Dalits community who were illiterate.
- The child loss experience was high (0.77) in Dalits community compare to the non-Dalits community (0.50), who had primary, education.
- The respondents who had secondary level education of Non- Dalits community had 0.24 and Dalits had no child loss experience at the time of survey.
- Likewise the child loss experience ware 0.75 in non- Dalits community compare to the Dalits community (0.24), who had higher level of education.
- The child loss experience had high in Dalits community (0.91) compare to the non- Dalits community (0.83) whose husbands' were illiterate.
- Among 170 respondents Non-Dalits community had more child loss experience (1.11) than Dalits community (0.80) by husbands who had primary education of respondents.
- Whose husbands had secondary and higher level of education had high child loss experience in Dalits community compared to Non-Dalits.
- The child loss experience were high in Dalits community (0.77) compared to the Non-Dalits community (0.58) who were self decision maker in their households.
- Among 170 respondents there were no child loss experiences in the rich family.
- The child loss experience had high in Dalits community (0.90) compared to Non-Dalits (0.58), responds who had low income and low facility.

- Likewise the child loss experience had high in Non-Dalits community (0.83) compared to the Dalits community (0.73) who says the Chhaupadi tradition is absolutely good.
- The Non-Dalits respondents had higher child loss experience (0.96) compared to the Dalits (0.79), those occupations had agriculture.
- Among 170 respondents the highest index of child loss experience (0.78) in Dalits community compared to Non-Dalits community (0.63), who had less than 1000 rupees, income per months.
- There were no child loss experiences in Dalits community compared to Non-Dalits community, who had the land in their own name.
- The child loss experiences were high (0.85) in Dalits community compared to the Non-Dalits community (0.56) respondents who had radio in their households.
- There were no child loss experiences in Dalits community compared to Non-Dalits community who age between15-19.
- In Dalits community child loss experience were high (0.92) between the age of 35-39 and in Non-Dalits it were high (1.00) between the age of 30-34 years of age.
- The child loss experience was high in Dalits community (0.78) compared to non –Dalits community (0.48), respondents who were married and living with husbands.
- The child loss experiences were high in Dalits community (0.82) whose family members were between 3-5 and 5-7.
- Likewise child loss experiences were high in Non-Dalits community whose family members between 5-7(0.69).
- The child loss experience were high in Dalits community (0.32) compared to the Non-Dalits community (0.17), respondents whose CEB below 3.
- Likewise the child loss experience were high in Dalits community (1.17) compared to the Non-Dalits community (0.88), those respondents had above 7 CEB.

7.2: Conclusions

This study was conducted to find out the child loss experience among women of Dalits and Non- Dalits community was included on the various independent, intermediate and dependent variables relationship. The intermediate variables like education, gender role, status of family, Chhaupadi tradition. The intermediate variables directly affected on the dependent variables which were child loss experience and fertility. The ethnicity directly affecting on the intermediate variables

which was directly related on dependent variables. The other independent variables were social norms and values and religion. This was closely related on dependents variables mainly the relationships between both all variables are related to each other.

High level of educational status showed one of strong variable for determining the child loss experience of respondents. When the level of education increased, the child loss experience of respondents' was decreased. It means that education is most important role for reduce the child loss experience. It brings awareness to all people in different ethnicity and society. As a result it determines women's fertility too. Likewise household facility, level of HH income, property in their own name and caste/ethnicity also played vital role to determine child loss experience of a respondents. Respondents who had high income have less child loss experience and vice-versa. This means high level of income supported for less number of child loss experience. So, these facilities and CLE have negative relationship.

The child loss experience was also determined by Chhaupadi tradition. It had positive relationship with CLE of respondents of Dalits and Non- Dalits community. The CEB were also found to be other prominent variable in determining child loss experience. It's relation with CLE have positive relationship.

7.3: Recommendation

On the basis of summary of findings and conclusions the recommendation for policy implementation and further area for research suggested.

7.3.1: Recommendation for Future Area of Research

- This study is limited only in 170 households of Pachanali VDC, one of the rural are of Doti district. Therefore these types of research should be done in whole VDC and other urban and semi-urban areas in different time.
- This study covered broad two ethnic communities (Dalits and non-Dalits); other researches should be conducted comparative study within an ethnicity (Kami, Damai and Sarki).
- This method has utilized simple method for analysis like frequency tables, mean tables, cross tables. So it is recommended for using advanced statistical tools to obtain precise information.
- This study is based on primary information. So it is recommended to conduct another research by using secondary information.

7.3.2: Recommendation for Policy Implications

- Education observed one of the significant variables in relations to child loss experience, so child and maternal health programmes need to be oriented towards uneducated women.
- The economic condition was associated with the child loss experience; there should be the opportunity to enhance economic status for the women.
- All the children and adolescents of school going age should be enrolled in school.
- Government should establish the health facility center and trained female staff in each ward of the VDC.
- Government should lunch the girl related programmes for reducing the child loss experience.
- Nutrition insuffencicy observed a one of leading cause of child loss in study areas. So various incentive programmes for nutritious food are necessary for mother and children.
- Chhaupadi tradition had also contributed to child loss, so government should lunched the various programmes towards Chhaupadi tradition to improve mother and child health.
- Government should provide employment, which was unemployment.
- Government had formulated the strong policy and programmes towards the unemployment persons.

APPENDIX-ONE : QUESTIONNAIRE

TRIBHUVAN UNIVERSITY

CENTRAL DEPARTMENT OF POPULATION STUDIED KIRTIPUR, KATHMANDU

CHILD LOSS EXPERIENCE AMONG WOMEN IN DALIT AND NON-DALIT COMMUNITY IN PACHANALI VDC DOTI, NEPAL

RESPONDENTS: WOMEN AGDES 15-19 AND HAD EXPERIENCE AT LEAST ONE CHILD BIRTH

Student Researcher: Pavitra Bhatta

The letters written in italic is instruction. No tick mark please only circle, don't write more than one number in one box.

General Information

G1.Interviewers' Name……G2.Starting time of interview…….
G3.Date of interview……G4.Times of the interview……
Q1: Name of respondent (optional)…….
Q2: District Q3: VDC Q4: Ward no.
Q5: Mother tongue of respondent……..
Q6: Cast of Respondent ……..
Q7: Religion of the Respondents

1. Buddha 2. Hindu 3.Muslim 4.Christain 5.Kirat 6.Jain 7.Others 8.Others 9.Don't know 10. Not stated

Q8: caste structure of the family: Is all members of your households are of same Caste/ethnicity?

1. Yes 2. No 8.Don't know 9.Not stated

Q9: Religious structure of the family: Are all member of your household are a same religion?

1. Yes. 2. No 8.Don't know 9.Not stated

Q10: Which languages do the most of the members of your family use? ……

Q10a	Q10b	Q10c		Q10d	Q10e	Q10f	Q10g	Q10h
SN	Name	Age		Sex	Education	Occupacition	Birth place	Survey identity
1				1 2 3			1 2	1 2 3
2				1 2 3			1 2	1 2 3
3				1 2 3			1 2	1 2 3
4				1 2 3			1 2	1 2 3
5				1 2 3			1 2	1 2 3
6				1 2 3			1 2	1 2 3
7				1 2 3			1 2	1 2 3
8				1 2 3			1 2	1 2 3
9				1 2 3			1 2	1 2 3
10				1 2 3			1 2	1 2 3

Ask only respondent below here

Q11: Mention your complete age?
Q12: What is your marital status?
1. Unmarried 2.Married and living together 3.Married and separated now 4.Married but has done divorce. 5. Married but husband died. 6. Unmarried but living with boy friend. 7. Married but not started to live with husband. 8. Others….
Q13: Who is your head of family?

1. Yourself. 2. Husband. 3. Father/father in law 4. Mother / Mother in law. 5. Brother / brother in law. 6. Sister /sister in law 7. Others male. 8. Others female.

Q 14: What is your academic qualification……

Q15: What is your husband's academic qualification?

a. Illiteratriate b. passed class……

Q16: What is your main occupation?

1. Agriculture 2.Business 3.Job (government and non-government) 4.Lobor (agriculture animal HH works) 5.Labor (except agriculture). 6. Students. 7. Dependent. 8. Seeking job. 9. House wife. 10. Domestic worker. 11. Others…..

Q17: How is your monthly Income……...?

Economic status of family

Q18: How much land do you have in the name of your family member? Write three unit e.g. if 8 aana be, 0-8-0.
Q18A: Bihga, kattha/ dhur……..
Q18B: Ropani, aana, pasia……
Q18C: Halko melo, muri, pathi, mana ……
Q19: Is the food production sufficient for your family?
1. Yes. 2. No. 8. Don't know 9. Not stated.

Q20: If not how many months do it sufficient?
1 2 3 4 5 6 7 8 9 10 11
Q21: How many numbers of domestic animals do you have in your family?
A: Cow, Buffalo, Ox B: Goat, sheep, Pig C: Chicken, Duck
D: Bee, Fish E: Others…….

Q22: What type of your house?
1. House of plastic roof and walls of woods, etc. 2. Temporary house with thatched roof. 3. Thatched roof and clay walls 4. Clay wall and roof of tin. 5. Stone walls and thatched roof. 6. Stone walls and roof of tin. 7. Concrete wall and roof of tin 8. Concrete temporary wall and concrete roof 9. No own house 10.Others
Q23: Total Income of your family. ……
Q24: Where do your family members go for the toilet?

1. Own toilet 2. Open place 3. Around the spout 4. Inside the jungle 5. Others (specify)……..

Q25: How many years do you have in your own toilet in your family? ……years
Q26: Is water sources available at your house? 1. Yes-31 2. No
Q27: What amount of time is required to bring water (minutes)?

Q28 Who does the work fetching water?

1. Male 2. Female 3. Children-boys 4. Children-girls 5.male/ female both 6. Both boys and girls 7. others

Q29: What following facilities are available in your family?
A: Radio B: Cycle C: Solar D: Electricity E: TV
F: Bio gas G: Telephone H: Mobile Phone I: Motorbike
J: Jeep, Pickup K: Bus, Truck, and Tractor L: Others
Q30: Compare to others neighbors, Status of Your family according to income and facility?

Gender role in family and community

1. Rich 2. Above the average 3. Average 4.under the average 5.low income and facility 6.none of above 8. Don't know 9. Not stated

Q31: Who makes the main decision in your family?

1. Myself 2. Husband 3. Father/ father in law 4. Mother /mother in law 5. Brother/ brother in law 6. Sister/ sister in law 7. Other male 8. Other female 9. Other……

Q32: How often your advice taken when main family decision is made? 1.
Daily 2. Usually 3. Sometimes 4. Usually not taken 5 never taken
Q33: Who decide of your marriage?

1. Myself 2. Husband 3. Father/ father in law 4. Mother /mother in law 5. Brother/ brother in law 6. Sister/ sister in law 7. Other male 8. Other female 9. Other……

Q34: Is your under 14 years' children going to School in your family?
1. all are school
Q35:In your family among boy and girl whose study is expensive?

1. Boy 2. Girl 3. Equal to both 4. Don't know 5. Not stated

Q36: Among following what properties in your name?

A: House with land B: Land C: Livestock D: Ornaments
E: Riksa, mill, Machine F: Shear, Bank balance G: Shop, Water mill
H: Others
Q37: Among followings, who does daily works in your family?

a. Cooking

1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male

Fetching water

1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male

b. Kutani pesini (mill work)

1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male

c. Managing the gas

1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male

d. Raring animals
   1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male
e. Pay the bills of water and electricity
   1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male
f. Household purches
   1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male
g. Sell demostrict products
   1. Always female 2. Mostly female 3. Equal both 4. Mostly male 5. Always male

Q38: Permission for spent money for your neceassaricities things?
1. No need to ask 2. No need to ask, just inform 3. Spend separately
4. Ask and spend when given 5. Other purchase needed things
6. No one given money.

Q39: To whom do you ask to spend your own money?
1. None 2. Husband 3. Other men in family 4. Other women in family 5. Other.

Q40: Do your any family members have involve in any organization?
   1. Yes 2. No→48 8. Don't know

Q41: Are you involved of any Organization?
   1. Yes 2. No→48

Q42: If yes which level do you lead?
1. Ward 2. VDC 3. District 4. National

Q43: who is your family member to involved organization?
a. Community forestry committee
b. Road consumer committee
c. Drinking water committee
d. School and collage management committee
e. Mother group
f. Government committee
g. FPAN/NGOs, and club
h. Community committee or institution
i. Woman group
j. Goats farming group
k. Short credit group
l. Vegetable, milk and fruits production group
m. Others.

Q44: What is your role where do you involve yourself?
1. Decision maker 2. Simple member 3. Only participant

Information about reproductive health, concept and behavior adolescents and menstruation

Q45: What do you know about Physical and mental changes among male and females during the adolescence period?
a. Well know b. know a lot c. know a little d. less knowledge e. don't have any knowledge.

Q46: Which age group indicates adolescence period?
   A….to …..B.

Q47: Similarly which age group indicates adulthood period?
   a….to…b.

Q48: Generally form which age group menstruation starts in the female?

Q49: How old were you, when your first menstruation started? Complete age... …?

Q50: When one female starts to be adult what Physical changes appears on female?
A. Breast enlargement. 1. Yes 2. No 8. Don't know 9. Not stated.
B. Growth on sexual organs. 1. Yes 2. No 8. Don't know 9. Not stated.
C. Hair growth around the sexual organs. 1. Yes 2. No 8. Don't know 9. Not stated.
D. Enlargement of hip. 1. Yes 2. No 8. Don't know 9. Not stated.

E. Change in voice. 1. Yes 2. No 8. Don't know 9. Not stated.
F. Others. 1. Yes 2. No 8. Don't know 9. Not stated.

Q51: What are the female reproductive organs?

a. Ovaries 1. Yes 2. No 8. Don't know 9. Not stated.
b. Fallopian. 1. Yes 2. No 8. Don't know 9. Not stated.
c. Uterus. 1. Yes 2. No 8. Don't know 9. Not stated.
d. Vagina. 1. Yes 2. No 8. Don't know 9. Not stated.
e. Breast. 1. Yes 2. No 8. Don't know 9. Not stated.
f. others. 1. Yes 2. No 8. Don't know 9. Not stated.

52: What kinds of felling appear in the female when they appear to adolescent period?

a. Likes to be beautiful and attractive. 1. Yes 2. No 8. Don't know 9. Not stated.
b. Attractive towards boys. 1. Yes 2. No 8. Don't know 9. Not stated.
c. Curiosity about sex. 1. Yes 2. No 8. Don't know 9. Not stated.
d. Desire to follow her thought by others. 1. Yes 2. No 8. Don't know 9. Not stated.
e. Wish somebody to love her. 1. Yes 2. No 8. Don't know 9. Not stated.
f. Others/wish of lovingness. 1. Yes 2. No 8. Don't know 9. Not stated.

Q53: Generally between how many days dose menstruation appears in the females…….days.

Q54: Dose you menstruation takes place in the exact period?

Q55: How often do you clean the body during the period of menstruation?

a. Too much.
b. Maximum.
c. Little bit.
d. Not too much/never clean.

Q56: During menstruation period how often do you take bath?

a. At the end of menstruation.
b. To take bath after a single day.
c. To take bath daily.
d. Thought I don't take bath I daily clean my sexual organs.

Q57: How do you manage your bleeding during menstruation period?

1. Using pad, towel.
2. Use new clothes.
3. Old clothes.
4. Do nothing.

Q58: Usually where do you live and sleep during menstruation period?

1. Use place and bed.
2. Inside home but different place.
3. Outside of home.
4. Shed.
5. Others home, others.

Q59: Do you any problem during the menstruation period?

1. Yes.
2. No.

Q60: What problem appears?

a. Pain in the belly. 1. Yes 2. No 8. Don't know 9. Not stated.
b. Too much bleeding. 1. Yes 2. No 8. Don't know 9. Not stated.
c. Fever. 1. Yes 2. No 8. Don't know 9. Not stated.
d. Felling weakness. 1. Yes 2. No 8. Don't know 9. Not stated.
e. Nausia. 1. Yes 2. No 8. Don't know 9. Not stated.
f. Vomiting. 1. Yes 2. No 8. Don't know 9. Not stated.
g. Body Pain. 1. Yes 2. No 8. Don't know 9. Not stated.
h. Others. 1. Yes 2. No 8. Don't know 9. Not stated.

Q61: How much do you house work during the menstruation period?

1. More than usually.
2. Like usual.

3. Less than usual.
4. I don't remember.
5. Don't want to say.

Q62: Who helps you during the menstruation period?

A. Husband. 1. Yes 2. No 8. Don't know 9. Not stated.
B. Father/father in law. 1. Yes 2. No 8. Don't know 9. Not stated.
C. Brother/brother in law. 1. Yes 2. No 8. Don't know 9. Not stated.
D. Mother/mother in law. 1. Yes 2. No 8. Don't know 9. Not stated.
E. Sister/sister in law. 1. Yes 2. No 8. Don't know 9. Not stated.
F. Others. 1. Yes 2. No 8. Don't know 9. Not stated.

Q63: Do you have live separately during the menstruation period?

1. Yes.
2. No.

Q64: What do you do during the menstruation period?

A. Worship the god/go to the temple. 1. Yes 2. No 8. Don't know 9. Not stated.
B. To cook meal. 1. Yes 2. No 8. Don't know 9. Not stated.
C. Drink milk and eat fruits. 1. Yes 2. No 8. Don't know 9. Not stated.
D. Towards in the garden and vegetable garden. 1. Yes 2. No 8. Don't know 9. Not stated.
E. To care cattle's. 1. Yes 2. No 8. Don't know 9. Not stated.
F. To wear casual dress. 1. Yes 2. No 8. Don't know 9. Not stated.
G. To touch boys. 1. Yes 2. No 8. Don't know 9. Not stated.
H. Sitting separately during travel time. 1. Yes 2. No 8. Don't know 9. Not stated.
I. To make sexual contact. 1. Yes 2. No 8. Don't know 9. Not stated.
J. Others. 1. Yes 2. No 8. Don't know 9. Not stated.

Q65: How do you fell about living separately during menstruation period?

1. Absolutely.
2. Right.
3. Doesn't matter living separately or not.
4. Wrong/absolutely wrong.

Q66: Felling about work during the menstruation period?

1. More than usual 2. As usual 3. Less than usual 4. Don't know 5. Not stated

About sex

Q67: According to your view which age will be best for of sexual contact for girls? …

Q68: According to your view which age will be best for of sexual contact for boys?..

Q69: How old were you when you had your first sexual contact? .....

Q70: How old was your sex partner when you had your first sexual contact? .....

Q71: when you had your first sexual contact and with women?

1. Boy's friends.
2. Husband.
3. Blood relation.
4. Known person.
5. Unknown person.
6. Others.

Q72: What was the cause of that sexual contact?

1. Love/own desire.
2. Curiosity.
3. Fear/threaten/obligation.
4. Rape/forcefully.
5. Others.

Q73: How many best friends do you have in the present situation?

1. A lot.
2. A few.
3. Less.

4. Nobody.

Q74: Among them how many of them are males? ……

Q75: Do you know the safe period during the menstruation cycle?

1. Yes.
2. No.

Q76: Have you ever adopected any method for unwanted pregency?

1. Yes.
2. No.

Q77: which methods have you adopected? (These are the knowledge and practice so one option chosen is necessary)

Natural Method

a. Withdrawal 1. Yes 2.know but not use 3. Don't know
b. Safe period 1. Yes 2.know but not use 3. Don't know
c. Tested vaginal mucus method 1. Yes 2.know but not use 3. Don't know

Mechanical method

d. Use of male condom 1. Yes 2.know but not use 3. Don't know
e. Method use cupper-t 1. Yes 2.know but not use 3. Don't know
f. Use of femi-dom (female condom) 1. Yes 2.know but not use 3. Don't know

Chemical method

g. Daily use pills 1. Yes 2.know but not use 3. Don't know
h. Use Norplant 1. Yes 2.know but not use 3. Don't know
i. Use Depo-Provera (Sengini) injection 1. Yes 2.know but not use 3. Don't know
j. Use emergency contraceptive tablet 1. Yes 2.know but not use 3. Don't know
k. To use vigional tablets 1. Yes 2.know but not use 3. Don't know

Operational method

l. Minilap or remove uterus 1. Yes 2.know but not use 3. Don't know
m. Vasectomy use of male partner 1. Yes 2.know but not use 3. Don't know
n. Other…… 1. Yes 2.know but not use 3. Don't know

Q78: Do you have any experience about side effect after using devices of family planning?

1. Yes 2. No 3. Don't know 4. Not stated---96

Q79: If yes, devices. ……

Q80: What was the Side effect? . ……

Q81: What would be the best Method for controlling sexual diseases?

a. Condom
b. Cupper T
c. Pills
d. Inter-utrine Pills
e. Depo
f. Norplant
g. Natural Method
h. Others

Q82: Why do you think so? .....

a: Prevents pregency and sexual desires.
b: No minimization in the sexual satisfaction
c: No doubt
d: No side effect
e: Even the sex partner likes it
f: Others.

Q83: Have you ever checked sexual diseases.

1: Yes
2: No

Excess to health

Q84 How long time does it takes to take health service for you & your baby? Minutes……

Q85: Can you take these services when of needed?
1: Yes
2: No

Q86: Do you manage yourself transportation & other expenditure for services?
1: Yes
2: No

Q87: How do you manage expenditure for FP & sexual health if needed ?
a: Own income
b: Family income
c: Husband/buy friend's income

d: Borrowing
e: From the help of the hospital/institution
f: Relatives/others

Q88: Have you given vaccine against TB to your child?
1: Yes
2: No
3: Don't know
4: Don't share

Q89: How many times have you given polio drops to your child? .....times.

Q90: Have you given DPT vaccine to your child?
1. Yes 2. No 8.don‘t know 9. Not stated

Q91: Have you given miseals vaccine to your child?
1. Yes 2. No 8.don‘t know 9. Not stated

Q92: Have you given JE vaccine to your child who is given from 12 to 23 months in the arms?
1. Yes 2. No 8.don‘t know 9. Not stated

Q93: Have you given these eatable things to your child

a. Plain water 1. Yes 2. No 8. Don’t know
b. Juice 1. Yes 2. No 8. Don’t know
c. Milk 1. Yes 2. No 8. Don’t know
d. Lactogin, 1. Yes 2. No 8. Don’t know
e. Other liquid things 1. Yes 2. No 8. Don’t know
f. Curd 1. Yes 2. No 8. Don’t know
g. Ceralic 1. Yes 2. No 8. Don’t know
h. nestem Rice Millet WheatBarely 1. Yes 2. No 8. Don’t know
i. Pumpkin, Carrot, Sweet potatoes, 1. Yes 2. No 8. Don’t know
j. Potatoes, Green vegetables 1. Yes 2. No 8. Don’t know
k. Banana, Apple mango, Papaya, Orange, 1. Yes 2. No 8. Don’t know
l. Liver, Kidney, Heart, Lungs 1. Yes 2. No 8. Don’t know
m. Chicken, Mutton, Buff, 1. Yes 2. No 8. Don’t know
n. Eggs, 1. Yes 2. No 8. Don’t know
o. Fish, 1. Yes 2. No 8. Don’t know
p. Dal, groundnut others. 1. Yes 2. No 8. Don’t know

Pregnancy and Pregnancy Test

Q94: From where do you get the knowledge about FP, pregency and other information?

a. Radio
b. TV
c. Newspaper
d. Books
e. Teachers
f. Friend circle
g. FPAN

h. Health worker
i. Husband
j. Female or male sex partner
k. Other male members of the family female members of the family
l. others.

Q95: How old were you when you had had your first pregency? .....years

Q96 Have you ever had your miscarriage automatically? 1. yes 2. No.
a. How many times…..?

Q97: How much knowledge do you have about abortion if female is not mentally prepared to give birth?
1. Well-known
2. A little knowledge
3. Don't know

Q98: Did you go for the check up for the last time when you were pregnant? 1. yes
2. No →111

Q99: Where did you go for the checkup?
1: Governmental Hospital
2: FPAN clinic
3: Private clinic
4: FCHV
5: Knowledgeable lady of the village
6: Others.

Q100: How many times have you checked up? .....times.

Q101: Have you taken any vaccine during the period of pregnancy?
1: Yes 2: No

Q102: Have you taken Iron Pills?
1: Yes 2: No

Q103: Have you ever done abortion in the case of unwanted pregency?
1: Yes 2: No ‖ 111
a: If yes how many times.....

Q104: What was the case of abortion?
a: Due to the suggestion pressure from the family.
1. Yes 2. No 8. don't know 9. Not stated.
b: Due to under age
1. Yes 2. No 8. don't know 9. Not stated.
c: Pressure from husband or boyfriend
1. Yes 2. No 8. don't know 9. Not stated.
d: Pressure from Friend circle
1. Yes 2. No 8. don't know 9. Not stated.
e: Due to health Problem
1. Yes 2. No 8. don't know 9. Not stated.
f: Due to the suggestion from Doctors
1. Yes 2. No 8. don't know 9. Not stated.
g: Due to the pregnancy from rape
1. Yes 2. No 8. don't know 9. Not stated.
h: Due to the Pregnancy from own synling
1. Yes 2. No 8. don't know 9. Not stated.
i: Due to the pregnancy before marriage
1. Yes 2. No 8. don't know 9. Not stated.
j: Due to the problem of work and take care
1. Yes 2. No 8. don't know 9. Not stated.
k: Due to the unwanted of child at that time
1. Yes 2. No 8. don't know 9. Not stated.
l: Others

1. Yes 2. No 8. don't know 9. Not stated.

Q105: Before abortion from where & whom did you get the suggestion?
- 1: Governmental Hospital
- 2: FPAN clinic
- 3: Private clinic
- 4: FCHV
- 5: Knowledgeable lady of the village
- 6: Others.

Q106: From where & whom did you get the abortion?
- 1: Governmental Hospital
- 2: FPAN clinic
- 3: Private clinic
- 4: FCHV
- 5: Knowledgeable lady of the village
- 6: Others.

Q107: How much did you paid in Hospital & clinic? Rs…....

Q108: Did you have any health problem after abortion?
- 1: Yes
- 2: No | 111

Q109: What health problems appear?
- a: Too much bleeding
  1. Yes 2. No 8. don't know 9. Not stated.
- b: Infection in the uterus
  1. Yes 2. No 8. don't know 9. Not stated.
- c: Not able get to be pregnant later?
  1. Yes 2. No 8. don't know 9. Not stated.
- d: To much pain sexual during contact
  1. Yes 2. No 8. don't know 9. Not stated.
- e: Due to the weakness
  1. Yes 2. No 8. don't know 9. Not stated.
- f: Unable to work
  1. Yes 2. No 8. don't know 9. Not stated.
- g: Fever and other diseases
  1. Yes 2. No 8. don't know 9. Not stated.
- h: Other health problem
  1. Yes 2. No 8. don't know 9. Not stated.

Q110: What do you think the pregnant lady should do when she does not want to be pregnant?
- a: To give birth
  1. Yes 2. No 8. don't know 9. Not stated.
- b: To get abortion in the acceptance of mother
  1. Yes 2. No 8. don't know 9. Not stated.
- c: Suggestion from family 1. Yes 2. No 8. don't know 9. Not stated.
- d: Suggestion from Doctors 1. Yes 2. No 8. don't know 9. Not stated.
- e: Others 1. Yes 2. No 8. Don't know 9. Not stated.

Demographic particular

Q111: How many members are in your family?

Q112: How old were you when you get married?

Q113: How old your husband when he get married?

Q114: Have you ever give birth to the child?

Q115: How many sons do you have with you now?

Q116: How many daughters do you have with now?

Q117: How many of your son lives far from you?

Q118: How many of your daughters live far from you?

Q119: Did you any child died after the birth? 1: yes 2: No
Q120: What was the number of that baby? ……child.
Q121: What was the cause for the deaths of you're that child...? cause….
Q122: How many of your son died after birth?
Q123: How many daughters died after birth?
Q124: Till now you have given birth .....children.
Q125: How old were you when you given birth to a first child? Complete year…
Q126: Did you have a child during the period of 12 months? 1. Yes 2. No
Q127: How old is the youngest child? complete age…

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