

CHAPTER-ONE

INTRODUCTION

1.1 Background

Maternal health care is defined as the care that women received during pregnancy, delivery and after delivery. Maternal health care is the major component of reproductive health. The provision of care for women during pregnancy and child birth is essential to ensure healthy and successful born infant. The maternal health care covers the several aspects. Antenatal care, Delivery care, Postpartum care.

Maternity care is the major contributing factor for reducing maternal mortality rate. The maternal mortality rate (MMR) is an effective index to the quality of maternity care services in any given country. The most common direct causes of maternal deaths are hemorrhage, sepsis, toxemia, obstructed labour and consequences of abortion.

Four elements are essential to maternal death prevention. First, prenatal care. It is recommended that expectant mothers receive at least four antenatal visits to check and monitor the health of mother and fetus. Second, skilled birth attendance with emergency backup such as doctors, nurses and midwives who have the skills to manage normal deliveries and recognize the onset of complications. Third, emergency obstetric care to address the major causes of maternal death which are hemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour. Lastly, postnatal care which is the six weeks following delivery. During this time bleeding, sepsis and hypertensive disorders can occur and newborns are extremely vulnerable in the immediate aftermath of birth. Therefore, follow-up visits by a health worker to assess the health of both mother and child in the postnatal period is strongly recommended.

Prenatal care is an important part of basic maternal health care. It is recommended expectant mothers receive at least four antenatal visits, in which a health worker can check for signs of ill health – such as underweight, anemia or infection – and monitor the health of the foetus. During these visits, women are counseled on nutrition and hygiene to improve their health prior to, and following, delivery. They can also develop a birth plan laying out how to reach care and what to do in case of an emergency Globally, more than eight million of the 136 million women giving birth

each year suffer from excessive bleeding after childbirth.(WHO 2005). In many developing countries Most maternal deaths and injuries are caused by biological processes, not from disease, which can be prevented and have been largely eradicated in the developed world — such as postpartum hemorrhaging, which causes 34% of maternal deaths in the developing world but only 13% of maternal deaths in developed countries. (WHO 2010)

According to a UNFPA report, “A woman’s chance of dying or becoming disabled during pregnancy and childbirth is closely connected to her social and economic status, the norms and values of her culture, and the geographic remoteness of her home. Generally speaking, the poorer and more marginalized a woman is, the greater her risk of death. In fact, maternal mortality rates reflect disparities between wealthy and poor countries more than any other measure of health. A woman’s lifetime risk of dying as a result of pregnancy or childbirth is 1 in 39 in Sub-Saharan Africa, as compared to 1 in 4,700 in industrialized countries.” (UNFPA 2013)

Among the indirect causes of maternal mortality, the quality and accessibility to maternity care services stand ahead. Most women in Nepal reside in rural areas where only basic health care services are available at the Health Post and Sub Health Post plus some community based services provided by trained TBAs or FCHVs. Maternity care services available at all these levels are usually inadequate in quality and accessibility. The knowledge and skills of health care provider are most significant in the provision of quality of care, essential to respond to the needs of pregnant woman. However, the capacity of the various health workers categories differ considerably but mostly are weak and unable to respond to women's needs effectively. Furthermore, accessibility to health facilities is very limited due to difficult terrain, lack of roads and facilities.

The United Nations Population Fund (UNFPA) estimated that 289,000 women died of pregnancy or childbirth related, These causes range from severe bleeding to obstructed labour, all of which have highly effective interventions. As women have gained access to family planning and skilled birth attendance with backup emergency obstetric care, the global maternal mortality ratio has fallen from 380 maternal deaths per 100,000 live births in 1990 to 210 deals per 100,000 live births in 2013. This has resulted in many countries halving their maternal death rates.(UNFPA 2013)

Women constitute more than half of the total population in our country. However, females are dominated in various ways within a family or society. They do not have control over their own fertility. Female literacy rate is poor compared to male. Women's status has a direct effect on the health and nutritional status of women and children. Since women are the primary caregivers, their status can impact the health status and survival of the children. 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.

The safe Motherhood Program in Nepal has adopted two major strategies to improve maternal health provide around the clock essential obstetric services and ensure the presence of skilled attendants at deliveries, especially at-home delivers . In recognizing that the majority of women do not have access to maternal health care services due to social, economic and political reasons, the Ministry of Health is emphasizing a multi-sectoral approach that encompasses medical interventions and non health programme that promotes access to and utilization of services.

Poor countries like Nepal are suffering from various reproductive health complication or problem, low level of practice of anti natal care, delivery care and postnatal care which are the major problems of maternal morbidity and mortality. The major responsible causes for such problems are lack of education, poor access of health services, water sanitation facilities, low per capita income and gender discrimination. In Nepal a strong emphasis was placed on providing family planning to rural regions and it was shown to be effective. Increasing contraceptive usage and family planning also improves maternal health through reduction in numbers of higher risk pregnancies. (Engel 2014)

Nepal has committed to the Millennium development goal (MDGS) and has developed various policies and strategies to maternal health care. The MDG targets for a there fourths reduction in maternal mortality by the year 2015. The Ministry of Health and Population is working together with WHO, UNICEF, UNFPA, DFID, USAID, GTZ and other NGOs toward better access and higher quality service to improve (SSMP) is designed to improve infrastructural development through comprehensive emergency obstetric care, basic emergency obstetric care, birthing centers and human resource development and upgrade the skills of SBAs. A maternity

incentive scheme has been adopted since 2005 to increase the demand for maternity services along with a focus on improving access to such services.

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 mortality 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.

1. Delay in deciding to seek the care
2. Delay in reaching a health situation
3. Delay in receiving cares at the health facility

Nearly 10 percent of maternal death is caused by above three delay in Nepal. It has been stated that currently married women in general tend to receive more antenatal care compared to older women. The proportion of currently married women seeking antenatal care is lowest in Pakistan (26%) followed by India (35%) and highest in Nepal (44%)

The average number of children born per woman group 45-49 year has decreased from 5.3 in 1995/96 to 4.2 in 2010/11 while total fertility rate (TFR-adjusted) declined from 5.10 to 3.4 during the same period. The proportion of woman (15-49 year) who have knowledge of at least one family planning method has increased by 23 percentage points from 60% in 1995/96 to 83% in 2010/11. On the other hand, the proportion of married couples using some form of family planning methods has increased from 15 to 39% in the last 15 years. The proportion of women receiving prenatal care is 78% and receiving post-natal care 20% in 2010/11 (Choudhary, 2000)

Education is one of the most influential factors affecting an individual's attitude, knowledge and behavior in various factors of life. Not surprisingly, educational attainment in Nepal is very low among women, who are much more disadvantaged than men. Overall Literacy rate (5 years and above) has increased 54.1 percent in 2001 to 65.9 percent in 2011. Male literacy rate is 75.1 percent compared to female literacy rate of 57.4 percent (CBS, 2011). 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. 20 percent of males and 57 percent of females in rural areas have never attended school compared with 10 percent of male and 30 percent of females in urban areas. (NDHS, 2006)

The quality of ANC can be assessed by the type of provider, the number of ANC visits, and the timing of the first visit. 44 percent of mothers received antenatal care from skilled birth attendants (SBAs), that is, from a doctor, nurse or midwife. 28 percent of mothers received ANC from trained health workers such as a health assistant, MCHW or VHW. Less than 2 percent of women received ANC from TBAs or FCHV. 26 percent of women received no antenatal care for births in the five years before the survey. (NDHS 2011)

Among mothers who received ANC 58 percent reported that they were informed about pregnancy complications during their antenatal care visits 80 percent took iron tablets and 55 percent took intestinal parasite drugs while pregnant with their last birth. Nearly four out of five mothers with a live birth in the five years preceding the survey were protected against neonatal tetanus. However, more than 2-3(70%) of pregnant women received two or more tetanus injections during their last pregnancy. 35 percent of birth take place in health facility. 26 percent in public sector. 2 percent NGO facility 26 percent private. still 2-3 of birth(63%) take place in home. The % of birth taking place in health facility has doubled in the past 5 years (from 18% in 2006 to 35% in 2011) One third of women received post natal care. (NDHS 2011).

According to NDHS 2011, 86 percent women aged 15-49 have heard of AIDS. Education and wealth are strongly associated with AIDS awareness. Knowledge of AIDS is universal among women with SLC and higher level of education compared with just half of women with no education. HIV/AIDS prevention programs focus

their messages and efforts on three important aspects of behavior: delaying sexual debut (abstinence), limiting the number of sexual partners, staying faithful to one uninfected partner and use of condoms. The 2011 NDHS shows that one quarter of female have comprehensive knowledge of HIV/AIDS transmission. 13 percent of sexually active women and 3 percent of sexually active men reported that they had had an STI and STI symptoms in the 12 months prior to the survey.

The 2011 NDHS indicates that there has been unprecedented decline in fertility from 4.6 in 1996 to 2.6 births per women in 2011. Fertility is considerably higher in rural (2.8 births per woman) than in urban areas (1.6 births per woman). Fertility has declined in every age group over the past 15 years. (NDHS 2011). The TFR for the three years preceding the 2011 NDHS is 2.6 birth per woman. Fertility is considerably higher in rural areas (2.8 birth per woman) than in urban areas (1.6 birth per woman) NDHS (2011).

Women of Nepalese society have higher work burden compared to men. But 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 (91% and 64%, respectively). As expected, rural women are more likely than urban women to be employed in the agricultural sector. Ninety percent of rural women compared with 47 percent of urban women are involved in the agricultural sector (NDHS, 2006).

At current mortality levels, one in every 22 Nepalese children dies before reaching age one, while one in every 19 does not survive to the fifth birth day. Data from the 2011 NDHS show that infant mortality has declined by 42% over the last 15 years, while under five mortality has declined 54% over the same period. The neonatal mortality rate in the past 5 years is 33 death per 1000 live births which is two and half times the post neonatal rate the perinatal mortality rate is 37 per, 1000 pregnancies. In the past five years there have been only minimal changes Neonatal, postnatal and infant mortality. (MOHP 2004)

In regarding with the study area, the socio-economic status and literacy status of women is very poor. During delivery and postnatal visits are comparatively lower here with respect to others. Overwhelming majority of the births are delivered at home and very little of births are assisted by health professionals. Most of these people are dependent on agriculture followed by labour.

The Muslim is one of the major marginalized caste groups of Nepal. Their settlements are found in the Terai of Nepal. Most of them are settled in Morang, Sunsari, Siraha, Sarlahi, Dhanusha, Rautahat Bake etc. They have started to settle in Terai region since seven centuries ago.

1.2 Statement of the Problem

Maternal health care problem is one of the burning issues in Nepal. Maternal health care practice is an important component, which aims to save the mother life and to improve the health status of women with special emphasis on reducing maternal and neonatal mortality and morbidity.

Maternal health care practice of Muslim community is influenced by their cultural practices. They have their own kind of perception about maternal care. They worship to their god for the better health of pregnant women and unborn child. They believe that this kind of worshipping keep the pregnant women and the unborn child healthy and secure. Even by the religion they believe that procreation of the children is supposed to be a religious duty and culture. Children are supposed to be the blessing of god. They have the concept that their children will take care of them in their old age.

Thus, this study attempts to find out level of knowledge, perception and utilization of maternal health care practices of Muslim women in Biratnagar sub-municipality of Morang district. It is believed that these women have normal level of knowledge, perception and utilization of maternal health care practices because this community is socially marginalized and have low socio-economic status. Not any research has been done in this field. Therefore, Muslim community is selected for the study. Such studies are likely to play an important role in improving maternal health and reduce maternal mortality rate in Muslim community.

1.3 Objectives of the Study

The overall objectives of this study are to identify the status of maternal health care practices in Muslim community. The specific objectives of this study are as follows:

1. To find out the socio-economic and demographic characteristics among Muslim community.

2. To find out the status of maternal health care practices in terms of behavior, practices and attitudes of the community.
3. To examine the relationship between maternal health care practices and educational status of Muslim women of Biratnagar sub-municipality of Morang district

1.4. Research Questions:

On the basis of above discussion made in statement of the problems and objective following research question can be formulated. This study will attempt to provide the answers of the following research questions.

1. What are the socio-economic and demographic characteristics of Muslim community that is likely to influence maternal health care practices ?
2. What is the condition of maternal health care practices in terms of behavior, practices and attitudes of Muslim community ?
3. What kind of relationship can we find between maternal health care practices and educational status of Muslim women of Biratnagar sub-municipality of Morang district ?

1.5. Significance of the Study:

Main aim of this study is to identify the maternal health care practices of muslim women in Biratnagar municipality. This study is important to extent general awareness among reproductive age women of this community.

Some significances of the study are as follow:

1. This study will help to explore the situation of pregnant women.
2. This study will help to find health problems of pregnant women.
3. The findings of the study will be useful for policy makers and planners of different kinds of INGOs, NGOs, government to plan and implement the programmers.
4. This study will help to know the status of maternal health care practices and it's affect in Muslim women

1.6 Delimitation of the Study

Following are the delimitation of the current study:

1. This study is limited to the Muslim community. The results cannot be generalized to other communities.
2. This study is based on sample population of Muslim community of Biratnagar sub-municipality ward no. 7 of Morang district So, it may not represent for all areas of Nepal.
3. The target population of this study will be married women aged 15-49 years who have had a child or currently pregnant.
4. This study will cover only some variables of maternity care. Therefore, predictions for all components of reproductive health cannot be made from this study.

1.7 Definition of the terms used

2. **Age at marriage:** the age which female gets married and reproductive period life
3. **Antenatal care:** Care of mother and her fetus during pregnancy.
4. **Breast feeding:** The mother feeds milk from her breast to her infant/child
5. **Community:** A group of person in social interaction in a certain geographical and seeking common social and cultural life.
6. **Colostrums:** The first coming fluid from the mothers breasts after child birth which Contains more protein but less fat and sugar than true milk.
7. **Contraceptive:** method or tools for prevention of conception.
8. **Delivery:** The process by which the fetus and the placenta are expelled from the uterus.
9. **Postnatal care:** care of mother and her baby since delivery to 42 days.
10. **Pregnancy:** A physical condition of women during reproductive period in which development of fertilized ovum occurs within the maternal body.
11. **Reproductive:** A process of birth.
12. **Knowledge:** A clear and certain mental perception understanding, the fact of being aware of something experience of acquaintance or familiarity with in for motion of learning that which is known, facts learned or acquired.

CHAPTER: TWO

LITERATURE REVIEW

This chapter attempts to present some literatures related to maternal health practices in Nepal as well as global reference. Maternal health care is one of the major issues related to the maternal morbidity and mortality. After the initiation of world motherhood strategy 1987, this topic has got worldwide emphasize. Nepal established special safe motherhood task force in 1993 to develop a national plan of action.

2.1 Theoretical Review

The international conference on population and development (ICPD) held in Cairo in 1994 intensified worldwide focus on the reproductive health. So, ICPD is a mile stone to guide the efforts regarding the reproductive health of women. According to the ICDP document, the reproductive health is defined as:- "A state of complete physical, mental and social well being and not merely the absence of diseases or infirmity in all matters relating to its functions and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and the freedom to decide if when and how often to do so." (UN, 1994-95)

Maternal deaths and illness not only affect women but it also affects her spouse, children and communities in many ways. The economic cost of mother's death includes her lost contributions to the family and its survivals. It increases mortality among her children, increased burdens of home maintenance and child care to the survivors and additional impact on communities and society, children are more likely to die if their parents die but much more likely if it is the mother. (UNFPA, 1995)

Improving maternal health is the fifth of the United Nations' eight Millennium Development Goals (MDGs), targeting a reduction in the number of women dying during pregnancy and childbirth by three quarters by 2015, notably by increasing the usage of skilled birth attendants, contraception and family planning. The U.S. Joint Commission on Accreditation of Healthcare Organizations calls maternal mortality a "sentinel event", and uses it to assess the quality of a health care system. Maternal mortality data is said to be an important indicator of overall health system quality

because pregnant women survive in sanitary, safe, well-staffed and stocked facilities. If new mothers are thriving, it indicates that the health care system is doing its job. If not, problems likely exist.

The World Bank estimated that a total of 3.00 US dollars per person a year can provide basic family planning, maternal and neonatal health care to women in developing countries.(improving maternal health "millennium Development Goals. UNICEF). Many non-profit organizations have programs educating the public and gaining access to emergency obstetric care for mothers in developing countries. In South Africa alone there is one maternal death every two minutes. Over 80 percent of pregnant women in South Asia are anemic, severe anemia increase a women's vulnerability to infection during pregnancy and birth and increase her risk of death due to obstetric hemorrhage (UNFPA, 1997).

The Maternal Health Task Force (MHTF) is a global project focused on improving maternal health through better coordination, communication, and facilitation between existing maternal health organizations, as well as with experts in related fields. The Task Force serves as a catalyst to address one of the most neglected areas in global health. Maternal morbidity and mortality rates remain unacceptably high across the developing world. Every minute, a woman dies from complications related to childbirth or pregnancy. While most maternal deaths are preventable, poor health services and scarce resources limit women's access to life-saving, high-quality care. Although there have been some notable advances, efforts to adequately address maternal health remain fragmented, and the political will remains insufficient to effectively tackle the issues. Material Health Task Force (2009)

The maternal mortality ratio (MMR) in Nepal decreased substantially between 1996 and 2006 from 539 to 281 death per 1000,000 births (Ministry of Health and population (MOPH).To reduce maternal mortality rates the government of Nepal has run many policy and programs .The national safe motherhood program has made significant progress in term of development policies and protocols as well as expansion of the role of service provider such as staff nurse and auxiliary nurse midwives. The target for maternal health is to reduce the MMR by three quarters between 1990 and 2015.The policy on birth attendance ,endorsed in 2006 by the MOHP ,specifically identifies the importance of skilled birth attendance (SBAs) at

every birth and embodies the government's commitment to training and developing doctors, nurse and auxiliary nurse midwives with required skills across the country .in order to ensure focused and coordinated efforts among various stake holders involved insane motherhood and neonatal health programming. The national safe motherhood(2002-2007) program has been revised with wider participation by the government and nongovernmental, national and international institution. By the end of 2008-2009, the birth pre parchedness package (BPP) had been rolled out in all 75 district. Similarly a maternal incentive scheme was adopted in 2005 to encourage women health facilities for maternity care and improve access to maternity care services.(MOHP,2011)

2.2 Empirical Review

Maternal Mortality in Nepal has drastically came down to 229 per hundred thousand live birth. Obstetric hemmorrhage, pregnancy induced hypertension obstructed labour,abortion,complication,sepsis are the major causes of maternal death worldwide.

According to Maternal Health task Force, Maternal mortality ratio was 310/100,000 live births. Among the eight maternal deaths, seven were referred from other health facilities and one directly came from home. Four of them were illiterate and above all, they were essentially less parity young women Of the eight maternal deaths three resulted from induced unsafe abortion and five were direct obstetric death. Even today the abortion is legalized, Still women continue to die from complication, which could have been avoided by safe abortion. According to article provision of safe abortion services is still not available to many women despite of legalization of abortion in Nepal quality antenatal care services would be helpful in avoiding maternal mortality in many situation by dictating and managing medical complication of pregnancy. Ghimire (2012)

Sharma (1999) has conducted his study on fertility amongst Muslim women in Siraha. The main objectives of the search were to identify the factors affecting fertility in Muslim community. He has conducted research applying purposive sampling method from 100 households representing from Muslim ethnic group. He has concluded that educated Muslim women have less number of children in compared to illiterate

women. Similarly, the fertility of women is decreasing with increment in gross household income. Prevalence of son preference plays major role of decision-making power of women in reducing fertility.

L. Vaiva (2005) has given the description about the social, economic and cultural situation of the Muslim of Amudaha VDC of Sunsari. The Muslim of this VDC are totally landless and they are compelled to settle at the land given by their Malik (landlord) such land is called Girat. Vaiva has also presented some causes of poverty of the Muslim of this VDC. He has concluded that landlessness, low level of income, illiteracy, caste system, and population growth are the major causes of poverty of the Muslim of this VDC.

Limbu, D, conducted a study (2004) "To examine on Maternal Health care practices of Limbu Community" identified the status of maternity health care practices. The study area is Ambung VDC Teherathum. It's sample size 100 women and sampling procedure was purposive sampling. She found that out of total woman population of the area 42 percent women born first baby before 19 years. 22 percent mothers took TT vaccine, 18 percent took tablets. 76 percent respondents had drinking and 35 percent had smoking habit.

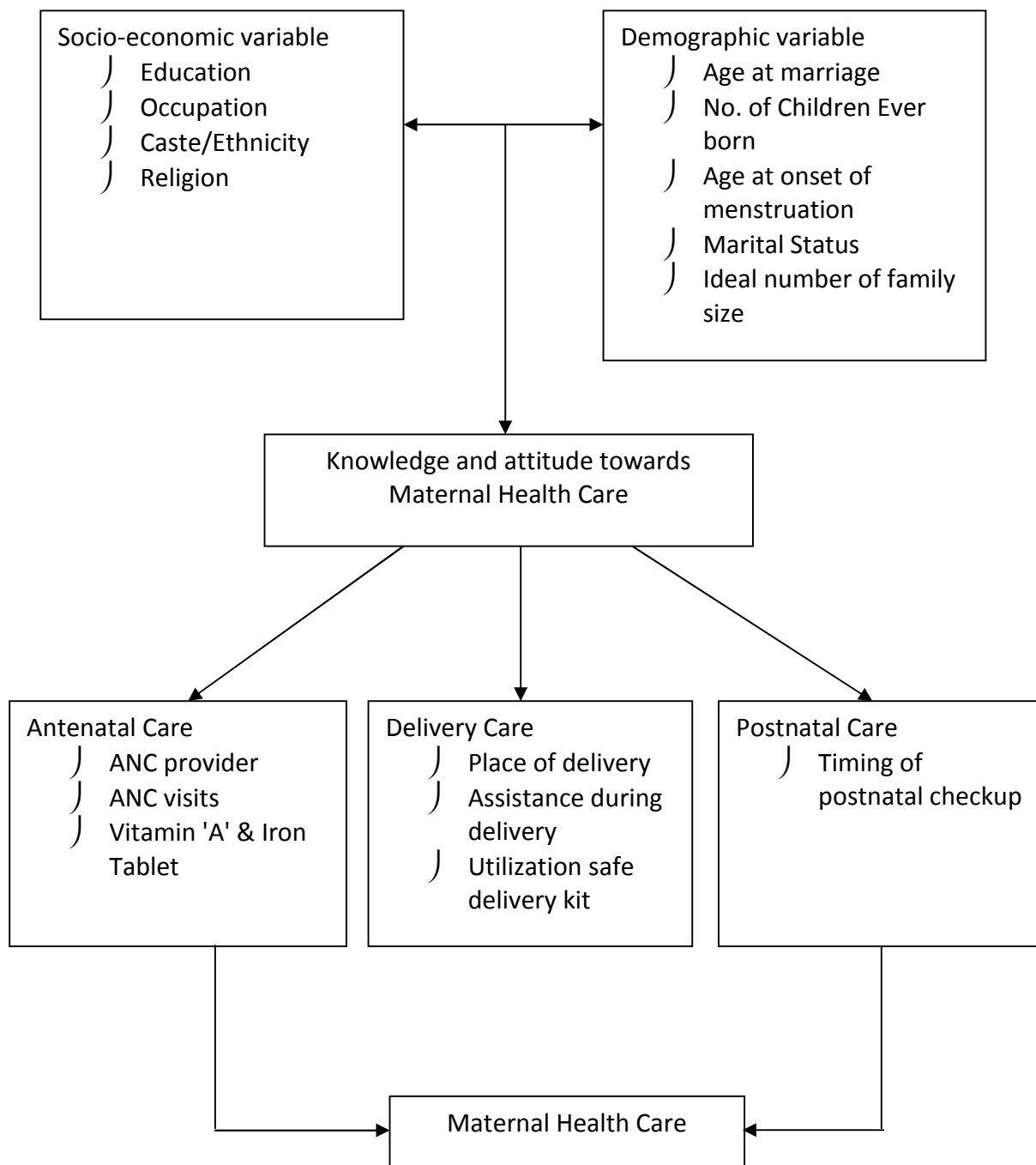
Subedi, V Prasad, research (2009). "Material and child Health Care Practices with relation to the education of the mothers" has shown that the main objective of the study is to assess maternal and child health practices with relation to the education of mothers. It's population is 7290 persons. Study area is Tilahar VDC Parbat. Sample size is 112 mothers. Sampling procedure is purposive sampling. It's conclusion are as follows: Majority of the respondents were married at the age of 18 to 21 years. 54.46 percent of respondents were literate. Majority 18-21 years. Only 10.71 percent of respondents used to eat additional food during pregnancy > Home was common place for delivery.

The above mentioned studies are either from urban area or from remote of Nepal they are away from the actual condition of awareness and practice of Maternal Health. Therefore, it is important to conduct the research on this topic focusing the factual of Muslim caste of the locality.

2.3 Conceptual Framework

The conceptual framework includes socio-economic and demographic variables as independent variables for determining the person's attitude towards maternal health care (dependent variable). It should be noted that the effect of these two variables on maternal health care practices through the knowledge and access of health services.

Conceptual Framework for the study of Maternal Health Care in Nepal



CHAPTER-THREE

METHODOLOGY OF THE STUDY

Researcher can use various types of research methods to collect reliable data from research area. Methods may be different from one problem to another. This is descriptive type of research design. The following section describes the methodology adopted in the study.

3.1. The Study Area

The Muslim community living in Biratnagar Sub-municipality ward no 7 of morang district is purposively selected which lies in Koshi zone, eastern part of Nepal.

The main caste/ethnic composition of this ward are Muslim . This study has been conducted specially in Muslim community in order to identify the maternity care practices, behaviours and determinants variables. There is 1 muslim schools. Business and wage labour is the main occupation of the people living in the study area.

3.2. Site selection and Target population:

Biratnagar Sub-municipality except ward no. 7 was the main study area. The study is based on the information from ever married women of age group 15-49 years who have experienced child birth or pregnancy- specially of Muslim community at Biratnagar Sub-municipality Morang district.

3.3. Sources of Data

The source of the data for this study is based on the primary data. This data was found by using direct interview among married women having at least one child of reproductive age of the above mentioned Muslim community.

The survey was conducted through structured interview, the household type information was collected from the member of the household who had at least one child. The individual questionnaires were administered among women of reproductive age having at least one child and living with their husband and these questionnaire cover the information about antenatal, delivery and postnatal care as well as age, marital status, number of children they had, their age at child bearing and marriage and many other demographic and socio-economic characteristics.

3.4. Sample Design

The data for this study have been collected from "Muslim" women of age group 15-49 years who had at least one child. There are 452 households throughout the 16 ward of Biratnagar Sub-Municipality. The total sample of the study was 25 percent of total households of Muslim whereas the total household of Muslim is 452 of the total households of that ward.

The simple random sampling procedure was used for sample selection of respondents. The respondents for the study were selected from different households in each interval of 4. For this, households were imaginatively numbered and respondents were ranked in the interval of 4. If there was either of respondents in the ranking households, or respondents not living with their household, the nearest, household was taken for interview.

3.5. Data Collection

Quantitative techniques of data collection have been used. Interview schedule is the main tool of obtaining the information from research area and respondents. So, questionnaire is designed to obtain two types of information i.e. household information and individual information. These two types of questionnaire were administered among the respondents. Individual questionnaire was designed to obtain the information on maternal health care practices and educational status of women. on the other hand, household questionnaire was designed to obtain the information on age, sex, education and demographic characteristics of the household members.

In the field survey a few case histories have been conducted to obtain in depth information on their past and present experiences of maternal health care practices faced in their life. And some key informant interview was also done for information on how social norms and behavior affect towards maternal health care practice in Muslim community and to know the attitude and behavior towards maternal health care practices

3.6 Data Presentation Analysis & Interpretation

The study is based on primary data. Quantitative data have been used to complete this study. Data for this study have been collected from field observation. After completion of information collection from field visit, the collected information was processed myself without using computer. It was very tedious and time consuming work to manage the collected questionnaires. Different types of dummy tables were used for the data analysis. Data were classified and tabulated in the designed model and then interpretation of tables was done based on cases count, percentage distribution and frequency tables.

CHAPTER - FOUR

RESULT AND DISCUSSION

DEMOGRAPHIC AND SOCIO-ECONOMIC CHARACTERISTICS OF THE STUDY POPULATION

This chapter presents the socio-economic and demographic characteristics of Muslim Community at Biratnagar Sub-municipality of Morang district. Demographic and socio-economic characteristics play vital role in the development of society. Socio-economic characteristics include household composition, educational attainment, occupation and size of land holding. Demographic characteristics include age-sex structure of household population marital status, age at marriage of respondents.

4.1 Demographic Characteristics

4.1.1 Age of Respondents

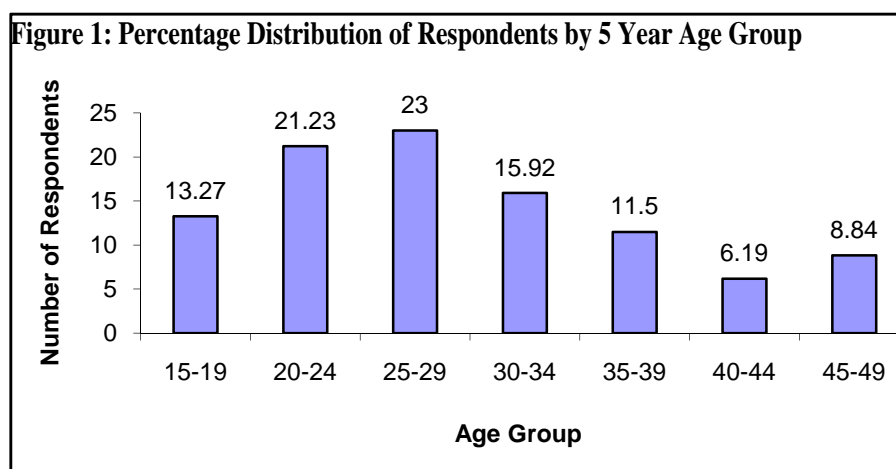
The respondents of this study are currently married women of reproductive age (15-49 years). This age composition of female population is one of major demographic indicators for fertility performance. If the population is higher in the middle age group 20-35 the fertility rate might be higher because it is considered as the most fertile period of reproductive span.

Table 1: Percentage Distribution of Respondents by Age

Age group	No. of Respondents	Percentage
15-19	15	13.27
20-24	24	21.23
25-29	26	23.00
30-34	18	15.92
35-39	13	11.50
40-44	7	6.19
45-49	10	8.84
Total	113	100

Table 1 shows that the highest proportion of respondents were found in age group 25-29. The percentage of the respondents of this age group was 23 percent. It is

followed by 20-24 age group i.e. (21.23%), 30-34 age group (15.92%), 15-19 age group (13.27%), 35-39 age group (11.5%).



4.1.2 Age at marriage of Respondents

Age at marriage for women is another important factor which affects fertility performance as well as the use of maternal health care practices. Still Nepalese society practices early marriage. The mean age at marriage of women under study population was found very low i.e. 15 years. This low age at marriage may be due to various social, cultural and economic background of the community.

Table 2: Age at Marriage of Respondent Women (15-49 yrs)

Age at Marriage	No. of Respondents	Percent
< 15 yrs	23	20.36
15-19 yrs	74	65.47
20 + yrs	16	14.27
Total	113	100.00

Table 2 presents that the mean age at marriage of respondents was found almost 15-19 years which is lower than the national average of 2011 CBS. This shows that most of the marriage occurred around 17 years age. Out of total respondents 20.36 percent were married before the age of 15 years, 65.47 percent were married within the age 15-19 years. Similarly, 14.27 percent were married above the age 20+.

4.1.3 Children Ever Born

CEB is another demographic characteristic of any population. In this study most of the women were interviewed below the age of 40 years.

Table 3: Number of Children Ever Born

No. of CEB	No. of Respondents	Percent
1 TM 2 children	38	33.6
3-4 children	59	52.2
5+ children	16	14.1
Total	113	100.00

Table 3 shows that 33.6 percent women had ever born 2 children. It is followed by 14.1 percent women had ever born 5 or more than 5 children. Majority of women (52.2%) had ever born 3-4 children.

4.2 Socio-Economic Characteristics

4.2.1 Educational Status of Respondents

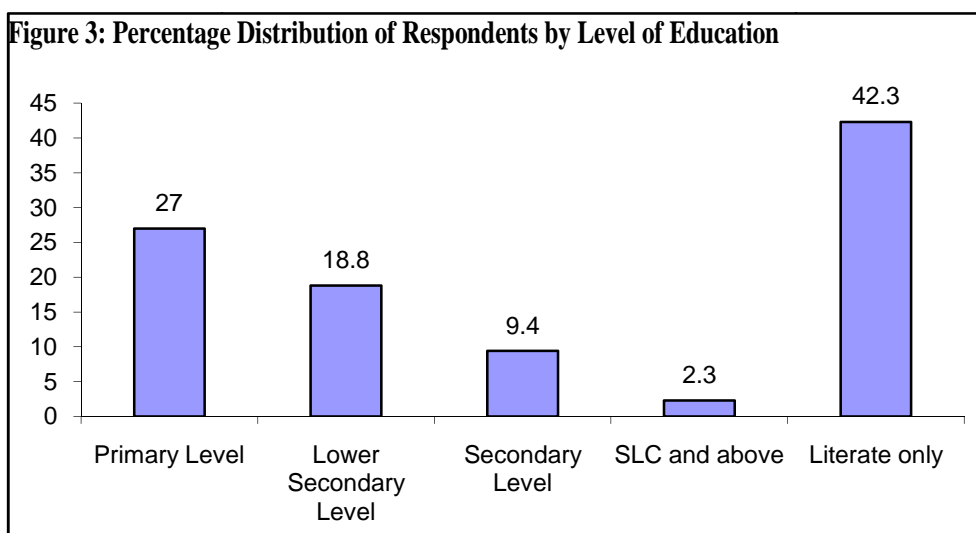
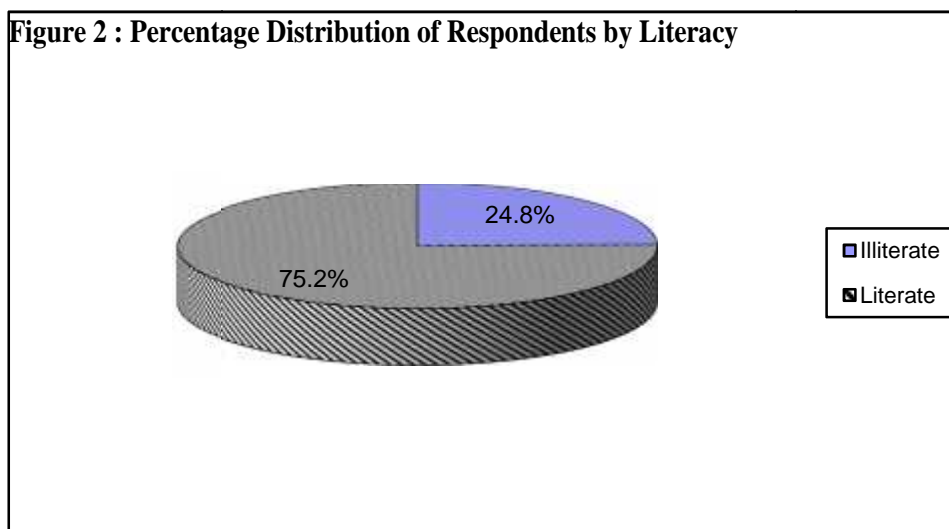
It is very important to examine the educational status of respondents because it effects to the personal perception of the mother. Many mothers are unknown about their personal hygienic activities. It is considered that educated mothers are more aware on the issue of maintaining the quality of their health and their children than non-educated.

Table 4 shows that higher percent of respondents are (75.2%) are literate followed by primary level of education (27%) and lower secondary level (18.8%). We conclude that as the level of education increases the no. of respondent decreases. Number of respondents varies inversely with the level of education.

Table 4: Percentage Distribution of Educational Status of Respondents

Educational Status	No. of Respondents	Percentage
Illiterate	28	24.8
Literate	85	75.2
Total	113	100.0
Level of Education		

Primary Level	23	27.0
Lower Secondary Level	16	18.8
Secondary Level	8	9.4
SLC and above	2	2.3
Literate only	36	42.3
Total	85	100.0



4.2.2 Distribution of Respondents by Source of Income

Occupational status of households and quality of life has positive relationship with demographic indicators. Occupation is important factor which influence the social, economic, cultural, political and religious variables. Occupational status is

associated with the life standard of individual. Occupational status plays vital role in promotion and protection of individual health as well as community health.

Table 5: Percentage Distribution of Household Population aged 10 Years and Above by Major Occupation

Major occupation	No. of Respondents	Percent
Agriculture	25	22.13
Service	11	9.73
Business	21	18.58
Daily wages (labour)	41	36.29
House Wife	15	13.27
Total	113	100.00

Table 9 shows that highest percent of respondent (i.e. 25%) depend on agriculture. Although this figure is remarkably less than the national average. Muslim community is living very near from the market area agriculture dependency is being decreased. The first largest source of income for 41 percent respondents is daily wages as labor force. 18.58 percent people are dependent on Business.

4.2.3 Language

Nepal is a multi-religious and multi-ethnic society. Data on language spoken at home is usually analyzed through mother tongue. A mother tongue is defined as one spoken by a person in his/her early childhood. According to the interview results all enumerated household members used Muslim language as their mother tongue but almost all of them can communicate Nepali fairly as well.

4.2.4 Religion

After 2nd revolution in Nepal, the kingdom of Nepal has not any it's own religion. Each people are free to select the religion. From the field survey in the study area, all the households in the sample are reported to have been Muslim religion.

4.2.5 Size of Land Holding

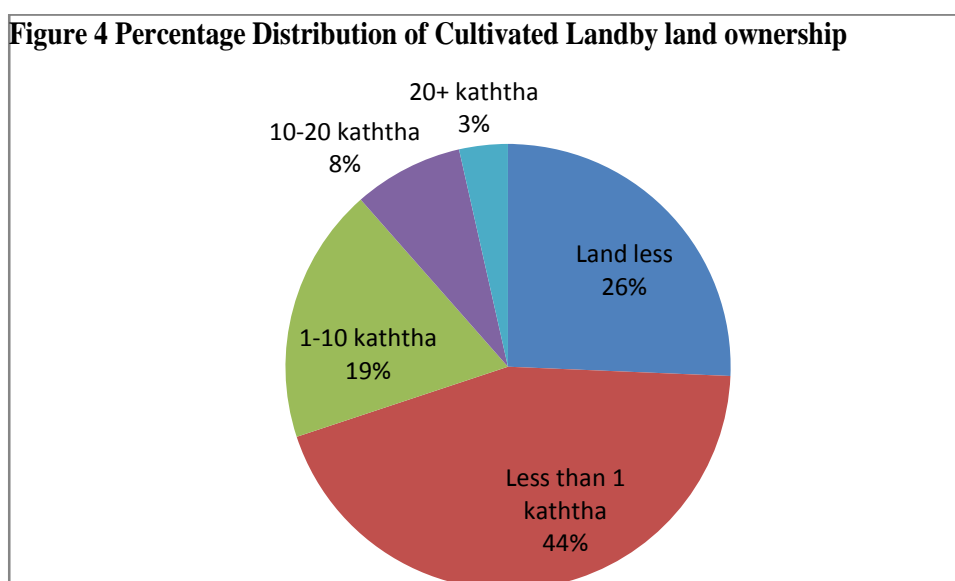
Nepal is a agricultural country where almost 80 percent people are dependent in agricultural sector (CBS 2011). Hence the size of the land holding also represents the level of economic status of people. Being marginalized from the major fertile land holding some of the caste/ethnic group Muslim community has hardly been able to safe their land. It is seen that majority of the household have been changed into landless people. The size of the land holding by the household under study is presented in the table.

Table 6: Percentage Distribution of Cultivated Land among the Respondents

Size of Land	No. of Respondents	Percent
Land less	29	25.67
Less than 1 kaththa	50	44.25
1-10 kaththa	21	18.58
10-20 kaththa	9	7.96
20+ kaththa	4	3.54
Total	113	100.0

Table 6 shows that 25.47% of the total respondents were landless. 44.25 percent people had land 1 kaththa or less than 1 kaththa where they had built their small house made of bamboo, mud and wood. It is seen that majority of the people are still facing with poverty

Figure 4 Percentage Distribution of Cultivated Landby land ownership



4.2.6 Maternal Health Care Practices

The provision of care for women during pregnancy and child birth is essential to ensure healthy and successful outcome of pregnancy for the mother and her new born infant. Many women in the developing world do not have the privilege or the access to basic health care services during pregnancy and child birth. Women often deliver in unhygienic surroundings without the help of trained birth attendant, increasing the risk to both the mother and the new born baby, resulting frequently in unhappy outcomes.

Maternal health care practices mean maintenance and promotion of maternal health status. This concept includes antenatal, delivery and postnatal cares. This chapter deals with the major aspects of maternal health care in the study area.

4.2.7 Age of Respondents at Onset of Menstruation

Only women can conceive and give birth to children within the certain age limits. A female is considered biologically capable of bearing a child after menstruation. Her capacity to bear children comes to an end with onset of menopause.

Table 7: Percentage Distribution of Respondent by Age at Onset of Menstruation

Age at onset of menstruation	No. of respondents	Percentage (%)
12	18	15.9
13	69	61.0
14	24	21.2
15+	2	1.7
Total	113	100.00

Table 7 shows that 61 percent respondents had their menstruation at the age of 13 which was followed by 21.23 percent respondents at the age of 14 and 15.9 percent respondents at the age of 12. Very few (1.76%) respondents got their menstruation at the age of 15 and above.

4.3 Antenatal Care Practices

There are different components of maternal health care. Among them antenatal care is the important one. Antenatal Health Care Services are the health care facilities that a women gets during her pregnancy period. It can be defined as the care of mother before the delivery. Under antenatal health care, TT immunization receiving iron tablets, quality and frequency of food intake and physical work are included in this section.

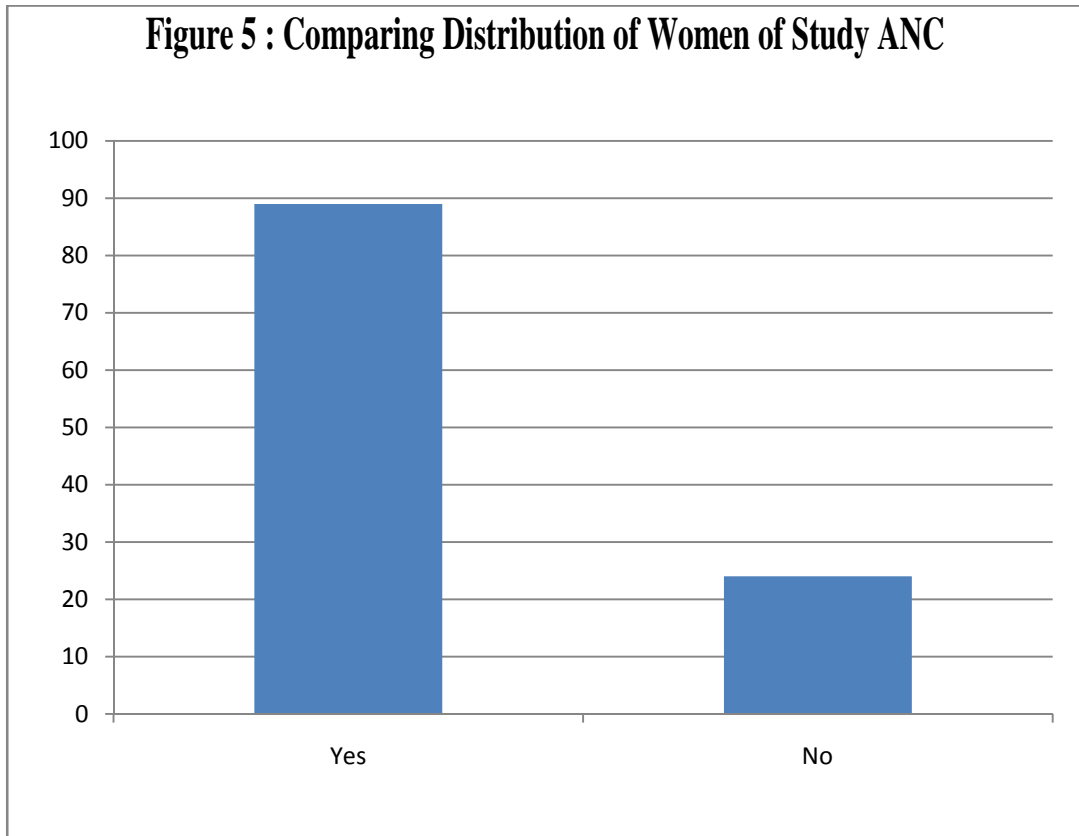
4.3.1 Utilization of Antenatal Care Services

In this survey, 113 married women in age group 15-49 who had at least one child were eligible respondents and individual questionnaire was asked about the utilization of antenatal care services. Younger women are more likely to use antenatal services than older women. The utilization of antenatal care services is positively associated with mother's level of education. Antenatal care can be more effective in avoiding adverse pregnancy outcomes.

Table 8: Percentage Distribution of Respondents by Utilization of Antenatal Care Services

Utilization of ANC	No. of Respondents	Percentage (%)
Yes	89	78.7
No	24	21.3
Total	113	100.0

Table 8 shows that 78.7 percent respondents received antenatal service during pregnancy period. Similarly, 21.3 percent respondents did not receive antenatal care during pregnancy period. The study shows that there is some improvements in the utilization of antenatal services compared with the national average (50%). Observation indicates that most women who receive antenatal care get it at a relatively late stage in the pregnancy and do not make the minimum recommend number of antenatal visits.



4.3.2 Utilization of Antenatal Care by Education

Education is an important factor which motivates people to receive maternal care to protect them from arising danger sign. The utilization of antenatal care services is positively associated with mother's level of education. The different components of antenatal care received vary with women's level of education, with educated women much more likely to have received all components of antenatal care than uneducated women.

Table 9 shows that 75.2 percent respondents are literate. Among them 61.1 percent received ANC services out of 25 percent illiterate respondents 17.7 percent respondents received ANC. In total out of 113 respondents, 89 (i.e. 78.7%) respondents received ANC which is higher than national average (i.e. 74%) from NDHS 2006. Since, most of the illiterate respondents are residing very near from health post their percentage is higher than literate respondents regarding ANC visit.

Table 9: Percentage Distribution of Respondents by Utilization of ANC and Level of Literacy Education

Literacy and Education	Utilization of ANC				Total	
	Yes		No		Number	Percent
	No.	Percent	No.	Percent		
Literate	69	61.1	16	14.2	85	75.2
Illiterate	20	17.7	8	7.1	28.0	24.8
Total	89	78.8	24	21.3	113	100
Level of Education						
Primary	18	21.2	5	5.8	23	27.0
Lower Secondary	12	14.1	4	4.7	16	18.8
L. Secondary +	10	11.7	-	-	10	11.8
Literate Only	29	34.1	7	8.3	36	42.4
Total	69	81.1	16	18.8	85	100

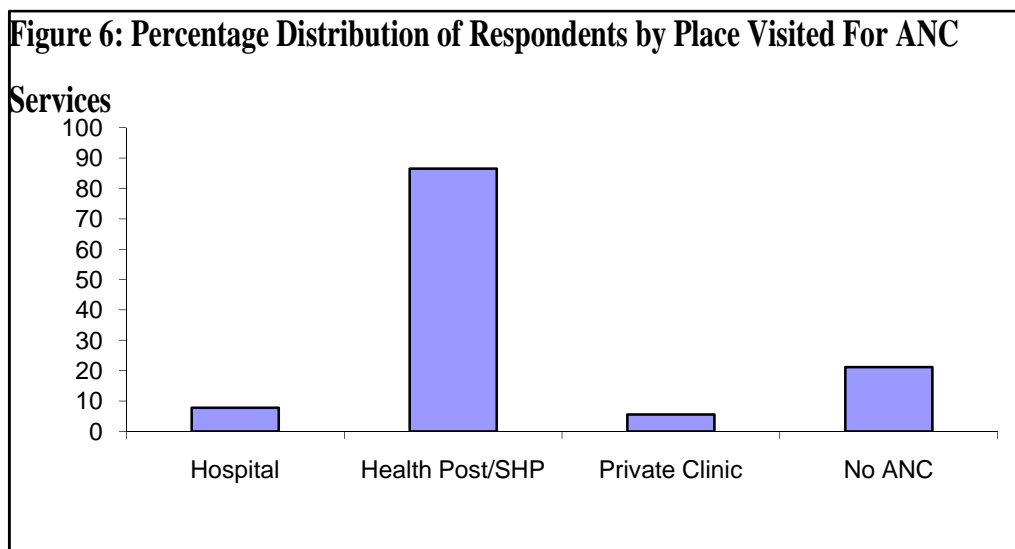
4.3.3 Place Visited for ANC Services

Institutional deliveries are not common in Nepal. Antenatal Care Service can be received from hospital, primary health care centre, health post, sub-health post and private clinic. Nepalese children are delivered at home either without assistance or with the assistance of TBAs or relatives and friends..

Table 10: Percentage Distribution of Respondents by Place Visited For ANC Services

Place of ANC Services	Respondents	Percent
Hospital	7	7.8
Health Post/SHP	77	86.5
Private Clinic	5	5.6
No ANC	24	21.2
Total	113	100.0

Table 10 shows that out of 113 antenatal care receivers 7.8 percent had received ANC from Hospital and 5.6 percent from private clinic. Majority of respondents (86.5%) had received the services from the HP/SHP. 21.2 percent respondents had received no antenatal care.



4.3.4 ANC Care Provider

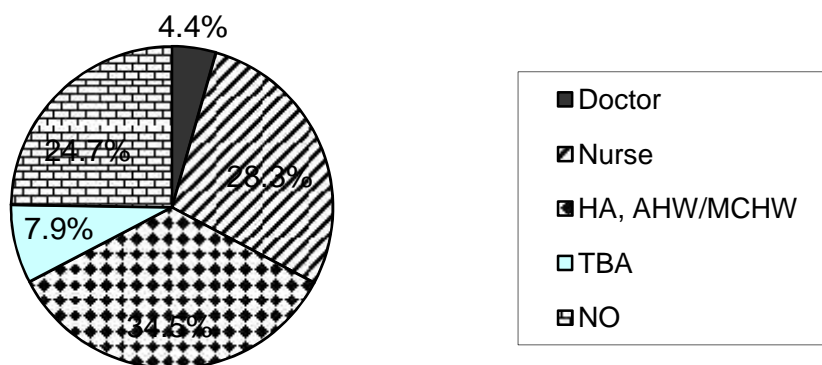
Institutional deliveries are not common in Nepal. Assistance by skilled health personnel during delivery is considered to be effective in the reduction of maternal and neonatal mortality. Births delivered at home are usually more likely to be delivered with assistance from a health professional, whereas births delivered at health facility are more likely to be delivered by health personnel with at least minimal training in the provision of normal delivery services.

Table 11: Percentage Distribution of Respondents by ANC Provider During Pregnancy

Service Provider	No. of Respondents	Percent
Doctors	5	4.4
Nurse/ Midwife	32	28.3
HA, AHW/ MCHW	39	34.5
TBAs	9	7.9
No one	28	24.7
Total	113	100.0

Table 11 shows that 28 out of 113 respondents (i.e. 24.7%) of women received no antenatal care. 4.4 percent of mothers only received antenatal care from doctors in the study area which is lower than the value recorded by NDHS, 2011. Most of the women have received ANC from Nurse/midwife and HA, AHW/MCHW (i.e. 28.3% and 34.5% respectively).

Figure 7 : Percentage Distribution of Respondents by ANC Provider During Pregnancy

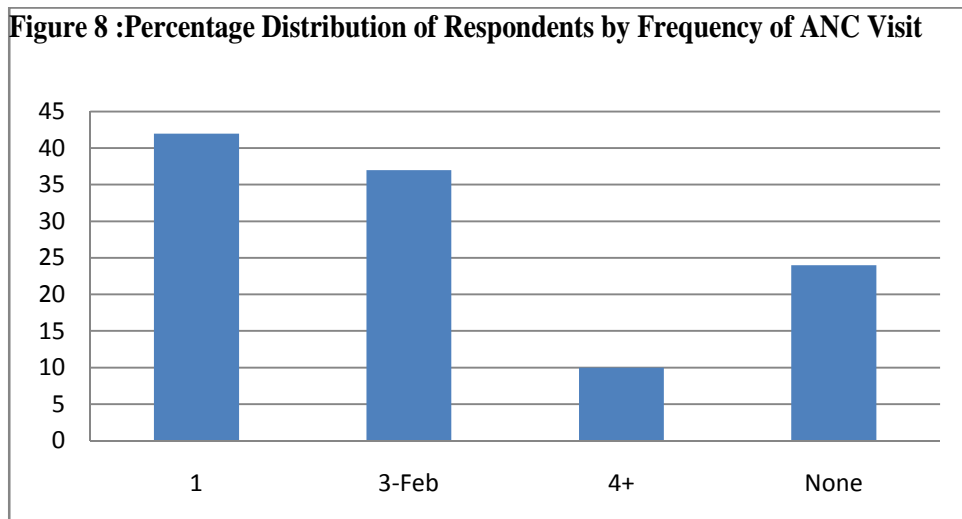


4.3.5 Frequency of ANC Visit

Table 12: Percentage Distribution of Respondents by Frequency of ANC Visit

Frequency of ANC visit	No. of Respondent	Percentage
1	42	37.3
2-3	37	32.7
4+	10	8.8
None	24	21.2
Total	113	100.00

Table 12 shows that very few no. of pregnant (i.e. 8.8%) women make four or more antenatal care visit during their entire pregnancy which is lower. About 37 percent women made their first antenatal care visit before the fourth month of pregnancy. The result shows that mothers should be encouraged to make the minimum recommended number of ANC visits because the vast majority of women believe that it is not necessary to visit twice, thrice and more unless they feel any difficulty.



4.3.6 Coverage of Iron Tablets

Iron prevents mother from diseases like anemia and malnutrition. Iron deficiency anemia has remained a public health problem in Nepal. In the study area, respondents were asked whether they had received iron tablet during pregnancy. Among total respondents 71.6 percent had received iron tablet and 28.3 percent have not received during their pregnancy period in the study area.

Education of mothers is strongly associated with the coverage of Iron Tablets. Educated women were expected to be more exposed to iron tablet acceptance.

Table 13: Percentage Distribution of Iron Tablets Coverage by Educational Status

Iron Tablet Consumption						
Literacy of Respondents	Yes		No		Total	
	No.	Percent	No.	Percent	No.	Percent
Literate	60	70.5	25	29.4	85	75.2
Illiterate	21	75	7	25	28	24.8
Total	81	71.6	32	28.3	113	100.00

Table 13 shows that among the literate, 70.5 percent received iron tablet but only 75 percent respondents among the illiterate received iron tablet and 25 percent did not receive iron tablet. While distributing the mothers according to their education level, 38.8 percent respondents still are not receiving iron tablets among literate only.

4.3.7 Food-intake during pregnancy

Women's nutritional status is important both as an indicator of overall health and as a predictor of pregnancy outcome for both mother and child. Malnutrition is a direct result of insufficient food intake or repeated infectious diseases or combination of both. Balanced diet plays important role for the physical, mental and social well being for both pregnant mother and child. A pregnant woman needs more extra nutritious food than normal women.

In the study area, respondents were asked whether they had taken extra nutritious food during pregnancy. Only 57.5 percent respondents had taken extra nutritious food and other 42.5 percent had taken usual food during pregnancy.

Table 14: Percentage Distribution of Respondents by Type of Food Intake during Pregnancy

Type of food intake	Respondents	Percent
Usual Food	65	57.5
Extra-Nutrious food	48	42.5
Total	113	100.00

4.3.8 Smoking and Alcohol Habit during Pregnancy

Tobacco smoking and alcoholism during pregnancy increases the risk of having a small or low birth weight baby. It may cause miscarriage a fetal loss during pregnancy. The use of smoking at other times also adversely affects women's health and may increase respiratory illnesses among children. Smoking is more prevalent among older women than among younger women.

Table 15: Percentage Distribution of Respondents by Smoking and Alcoholism during Pregnancy

	Respondents	Percentage
No	91	80.5
Yes	22	19.5

Table 15 Shows that 80.5 percent respondents neither smoked nor drank alcohol. Only 19.0 percent respondents had taken smoke and alcohol.

4.3.9 Complication during Pregnancy and Its Solution

Due to weak and unhygienic practices women of rural area are prone to complications during pregnancy. Such complications may be minor or major. complications during pregnancy is a social, economic and demographic problem in any community.

The study showed that out of total respondents, 25.6 percent replied that they faced complication during pregnancy. Other 74.4 percent had no any complication during pregnancy.

Table 16: Percentage Distribution of Respondents by Complication during Pregnancy and its Solution

Complication during pregnancy	Respondents	Percentage
Yes	29	25.6
No	84	74.4
Total	113	100.0

4.4 Delivery Practices

This objective of providing safe delivery services is to protect the life and health of the mother and her child by ensuring the delivery of a baby safely. Proper medical attention under hygienic conditions during delivery can reduce the risk of complications and infections that may cause death or serious illness either to the mother or the baby or both. This section includes the information on place of delivery, assistance during delivery and utilization of safe delivery kit during pregnancy.

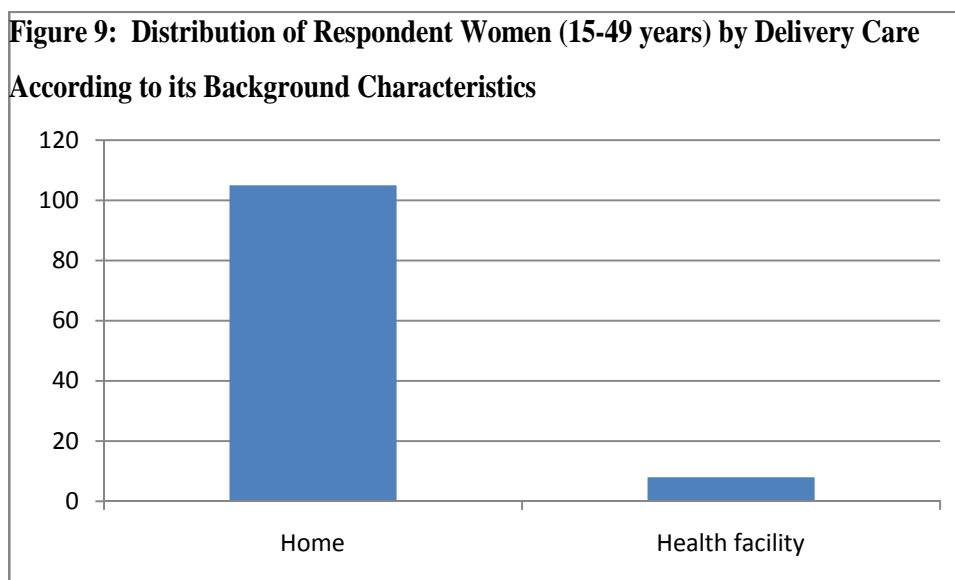
4.4.1 Place of Delivery

Place of delivery practice is a major component of maternity health care practice. Traditionally, Nepalese children are delivered at home either without assistance or with the assistance of TBAs or relatives and friends. Despite an increase in the number of health facilities offering delivery services, use of health facilities during deliveries is still minimal among most Nepalese women.

Table 17: Percentage Distribution of Respondent Women (15-49 years) by Delivery Care According to its Background Characteristics

Background characteristics		
Place of delivery	Number of respondents	Percentage
Home	105	93.0
Health facility	8	7.0
Total	113	100.0

Table 17 shows that only 7 percent deliveries are assisted by health professionals, that is, doctor, nurses or ANMs, HAs or AHWs, MCHWs and VHWs. Other 93 percent of respondents deliveries in home.



4.4.2 Utilization of Safe Delivery Kit during Pregnancy

The safe home delivery kit is very important component for safe and effective delivery to safe life of mother and newly born baby from tetanus and other infections. Since most babies are delivered at home with the assistance of elders or relatives and TBAs, use of clean home delivery kit could play an important role in reducing neonatal tetanus and other infection.

Table 18: Percentage Distribution of Respondents by Use of Safe Delivery Kit by Literacy Status

Utilization of safe delivery kit	Respondents	Percent
Yes	49	43.4
No	64	56.6
Total	113	100.0

The study shows that it has still not reached the bulk of Nepali mothers. Only 43.4 percent respondents used safe delivery kit. And other 56.6 percent were not use delivery kit. Comparative study indicates that the use of clean delivery kits in home deliveries has improved over these days.

4.5 Postnatal Care Service

The postnatal care is uncommon in Nepal. The aim of postnatal care is to ensure the physical and psychological well being of the mother and the new born child in the 1st six weeks after delivery. The national safe motherhood program recommends that mothers should have a postnatal check up within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery. The normal postnatal care includes care of the mother during immediate postnatal period and care during postnatal period, up to 6 weeks.

Table 19: Percentage Distribution of Respondents who Received Postnatal Care by Educational Status

	Postnatal Coverage	
	Respondents	Percent
Yes	18	15.9
No	95	84.1
Total	113	100.0

Postnatal care is higher for literate than illiterate respondents. Table 19 shows that 15.9 percent respondents had postnatal check up and 84.1 percent didn't receive postnatal care

CHAPTER - FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

This study is based on both quantitative and qualitative data. Primary data have been used to complete this study. Data for this study have been collected from field observation. This study has been designed to find out the status of maternal health care practices among the Muslim community of Biratnagar Municipality ward no 7 of Morang District. The main purpose of this study was to find out the impact of awareness ,practice and complication during pregnancy of respondent in maternal health, Maternal health care practices is serious matter of overall reproductive health care practices.

5.2 Summary of Findings

Following are the major findings of the study.

1. The majority of respondents had got married in the interval of age group 15-19 (i.e.65.47%)
2. Nearly 52 percent of the respondents reported that average number of CEB is 3-4
3. Nearly75.2 percent respondents were illiterate in the study area and 24.8 percent were literate.
4. The major occupation of this community is Daily wages (36.29%) followed by Agriculture (i.e.22.13%).
5. All the respondents were reported to have been Islam.
6. About 26 percent people in the study area are landless 44.25 percent people had land less than 1 Kaththa 3.54 percent people had more than 20 kathatha of cultivated land.
7. Highest percent of respondents (61%) had their first menstruation at the age of 13 years ,it is followed by 14 years (21.2%) .12 Years (15.9%) and 15 years and above (1.7%).
8. Majority of respondents (78.7% received antenatal visit during pregnancy.

9. Out of 89 antenatal care receivers 7.8 percent received ANC from hospital 5.6 percent from private clinic and majority of respondents (86.5%) from the HP or Sub HP.
10. 4.4 percent respondent received ANC from doctors, 28.3 percent from Nurse/midwife 34.5 percent from HA , AHW , MCHW.
11. Nearly one in ten (8.8 %) pregnant women made four or more ANC visit where as 37.3 percent women made first visit only before the four month of pregnancy .
12. Out of 113 respondents 71.6 percent received iron tablets but out of 85 literate respondents only 70.5 percent received iron tablets but out of 28 illiterate respondents 75 percent respondents received iron tablet.
13. Out of 113 respondents 19.5 percent respondents had habit of smoking and alcoholism 80.5 percent respondents had no habit of smoking and alcoholism.
14. Out of 113 respondents 25.6 percent had faced complication during pregnancy. And 74.4 percentage has not faced any complication.
15. An overview helping majority (93%) delivery are delivered at home. Only 7 percent deliveries are delivered at public health facility.
16. Out of 113 respondents 43.4 percent respondents used safe delivery kit.

5.3 Conclusions

The study focused on maternal health care practices in Muslim community at Biratnagar Sub municipality concluded that the utilization of maternal health care practices is not satisfactory even the result in some background characteristics is better than national level. Muslim community has its own culture and tradition. It is one of the disadvantaged ethnic groups residing in the Terai of Nepal. This community is socially and economically disadvantaged ethnic group. They have strong beliefs on traditional activities. Daily Wages and Agriculture is their main occupation. They have been still following the wage as their occupation for many years. Socio-economic and characteristics (Age-Sex structure, literacy, occupation, age at marriage) are poor. However satisfactory changes in the various aspects of life (i.e. political, academic and socio-economic aspects) have not been possible. The slogan of the government "education for all" is very limited here. No one student has

entered into the bachelor level till now. There is less than one percent studying in the higher education. All round development of Muslim community is not possible unless level of education increases. No bright future can be observed in different fields of life unless their tradition beliefs are modernized.

Following conclusions are drawn from the study:

1. Socio- economic status of an individual plays a strong role in determining the health status and perception.
2. A positive relationship is observed between the level of education and maternal health care services. Educated women are much more likely to have the advantage of medically supervised delivery and antenatal care services.
3. The regular care during pregnancy would also increases chances of giving birth to a healthy child. Prenatal care can reduce maternal and prenatal morbidity and help to prevent complication from becoming life threatening emergencies.
4. It is necessary to educate mother to care herself and for her newborn about the importance of postnatal care. safe motherhood programme recommends that all women should receive at least two postnatal checkup and iron supplementation for 45 days following a delivery.
5. Nearly all Nepalese women and men know of at least one method on contraception. Injeciontablets, female sterilization condoms male sterilization and the contraceptive pills are known to most currently married women.
6. Early marriage plays a significant role in increasing the number of CEB but level of education is inversely co-related with number of CEB.
7. Higher the level of income lower the CEB, which helps to improve maternity care.

5.4 Recommendation

Following are the recommendations for the policy makers and planners:

Practice Level :

1. Muslim women are much more sensitive towards their culture. Therefore, planers should be careful while preparing plans. The cultural aspects should be positively addressed.

2. It is found that people of the study are much deprived of physical facilities .Therefore, planning should be made to increase such facilities.
3. Early marriage prevailing in this society. It leads to early pregnancy and bring many risk. so early marriage should be controlled by giving health education.
4. In the pregnant period, the respondents nutritional condition is very poor so that to aware their about local available food and low costly food and should be discourage in superstitious believes.
5. There is prevailing low birth interval it is complicated condition of women for own an baby's health care. Therefore, they should be aware of birth interval.
6. Early pregnancy and low birth interval invites many dangerous problems. Contraceptive devices can help their problems. There for be aware for contraceptive device.

Planning and Policy related Recommendation:

1. The government should implement the marriage law which can help to control the early marriage.
2. Government should make the national policy. So a strong programme implementation policy should be emphasized by concern department and ministry.
3. Awariness of the main component of changing behavior .Education status is near about national level, but it is essential to take initiation to give emphasis in education and to raise public awareness about M.H
4. Unemployment and poverty are prevalent in this community .So job opportunity should be provide for increasing income.
5. Economic crises is one of the problem for low level of maternal and child health, Therefore, income generating activities should be launched for them.
6. Public awareness programmes to the parents of the study area should be launched seriously and the government should support economically to their child for study period. Different Programme like seminar training and pictorial demonstrative programmes should be carried out by responsible authorities.
7. The poverty allevation programme should be launched . At least one member from each house hold should be guarnted for the job as this community.

Further Study related Recommendation:

1. This study is delimited in Biratnagar Sub-metropolitan city. this study cannot explore the actual situation of Maternal Health so the detail study in national level is necessary to invoke the actual situation of maternal health in Nepal .
2. This study is covers (related) only female gender. This study has not been exploring details about maternal health related issues so researchers will explore about the topic.
3. It is recommended that other study could be done comparatively in other place in caste either urban in rural area.
4. There must be reservation system in local level in every aspect of development including employment opportunities until they are assimilated into the main stream of the country with equal strength.

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Questionnaires

A survey Questionnaire for Material Health Care Practices and Educational Status of Muslim Women

Group 'A' General Information

Name Respondent	Age	Cast	Religion

1. Have you ever attended school?
A. Yes B) No
2. If yes, what was the highest grade you completed?
A. Primary Level B. Secondary Level C. SLC
D. IA\+2 E. Bachelor F. Above
3. If not, what was the main reason, you stopped attending school?
A. Got Pregnant B. Family needed help on Agriculture
C. Could not pay fees (poverty) D. School not accessible too far
E. Others
4. How old were you at menarche? Years
5. How old were you, when you get (first) married? years
6. Are you currently pregnant?
A. Yes B. No.
7. How much land does your family have?
A. < 20 Kattha B. 20-40 Kattha
C. > 40 Kattha D. Not at all

Group 'B' Reproduction

8. Have you ever heard about safe motherhood?
A. Yes B. No
9. If yes, Which services does it include?
A. Regular checkup during pregnancy B. Regular TT- vaccination
C. Receiving vitamin 'A' & Iron Tab D. Use of clean delivery kits
E. Delivery Assistance by trained medical personnel
F. Advice/counseling services
10. Do you think it is necessary to utilize safe motherhood services (explained as above) by pregnant women?
A. Yes B. No

27. Where did you give birth to?
 A. Home B. In health facility
28. Did you smoke during pregnancy?
 A. Yes B. No
29. What kind of food did you take at the time of pregnancy?
 A. Usual food B. Extra nutritious food C. Others
30. Did you do the following activities during pregnancy?
 A. Measure weight B. Check blood pressure C. Measure height
31. Did you face any complication during pregnancy?
 A. Yes B. No

Group 'F': Delivery Care

32. Where did you go to give birth to?
 A. Hospital B. Private clinic C. Health post
 D. Home E. Other's home F. Others
33. Was a special safe delivery kit used?
 A. Yes B. No C. Don't know
34. Did you face any problem during delivery?
 A. Yes B. No
35. If yes, what were the problems?
 A. Prolonged labour B. Obstructed labour C. Excessive bleeding D. Others
36. What was the size of baby at birth?
 A. Very big B. Big C. Normal D. Small E. Very small

Group 'G' :Postnatal Care

37. Did you take postnatal care service?
 A. Yes B. No
38. Where did you visit for PNC?
 A. Home B. Hospital C. Health post D. Others
39. What was the frequency of meal per day after delivery?
 A. Two times B. Three times C. Four and more times
40. Did you receive a checkup within 6 weeks following delivery of your last child?
 A. Yes B. No
41. Are you still breast feedings?
 A. Yes B. No

