CHAPTER – I

INTRODUCTION

1.1 Background of the Study

Maternal health refers to the health of women during pregnancy, safe delivery and the postpartum (antenatal, natal and postnatal) period. These three periods play vital role to determine the maternal health. Pregnancy period is the care before birth. This includes regular check up, nutrition diet, taking of iron calcium and TT (Tetanus Toxoid) immunization. And safe delivery refers to delivery at hospital or by trained person. Postnatal period refers to after delivery providing nutrition diet for mother and breast feeding to child, sanitation and other related facilities with child and mother.

Maternal health is an important part of the health care system aimed at reducing mortality and morbidity related to pregnancy. According to Nepal Demographic Health Survey 2006, the health care that a woman receives during pregnancy and at the time of delivery is important for the survival and well being of both the mother and child. Antenatal care also is an important time for women to establish a relationship with health care services and for health care professionals to deliver key messages to women on health problems more generally, especially relating to the upcoming birth but also relating to sexual health, family planning, HIV/ AIDS and the care of the newborn and child.

The 2006 Nepal Demographic Health Survey (NDHS) also revealed that the maternal mortality rate in Nepal is 281 deaths per 100,000 live births and infant mortality rate is 48 death per 1000 live births. All Nepal only 29 percent women have had four or more antenatal care contact with skilled professional. 52 percent women of urban areas and 26 percent women of rural areas have had four or more antenatal care contact. And all Nepal 74 percent women who have had at least one antenatal care contact. 88 percent of urban and 72 percent of rural areas' women have had at least one antenatal care contact. Women who have had attended by a skilled professional when they give birth is only below 20 percent. And the proportion of women who have received TT (Tetanus Toxiod) vaccination is 63 percent. TT

injections are given during pregnancy for the prevention of neonatal tetanus, a major cause of death among infants. For full protection, a pregnant woman should receive at least two doses during each pregnancy. If a woman has been vaccinated during a previous pregnancy or during maternal and neonatal tetanus vaccination campaigns, she may only require one dose for the current pregnancy. Five doses are considered to provide lifetime protection.

Traditionally, pregnancy is considered to be natural in Nepal. Thus, some women of Nepal they thought regular checkups is unnecessary, particularly in rural areas, unless there are complications. Some groups of women in Nepal do not seek prenatal care (PC) because they think infants were more likely to die if they do so while these infants were in the womb. Such norms were found in rural area of Nepal and other developing countries as well (Suwal 2001). And many Nepalese people, especially in rural areas believe that the complication is created by an evil eye and thus seek help from traditional healers (*Shamans)* before seeking medical help. Also, many women do not seek prenatal care because they are unaware of its benefits. And they are not aware of pregnancy complications. It is just a normal thing for them and that they can deliver at home and they are not aware of the consequences that pregnancy can bring.

The factors for high Maternal Mortality are the 'three delays' - delay in taking the decision to seek medical assistance, delay in accessing appropriate care and delay in receiving care at health centers. Delay in seeking help due to cultural beliefs, problems of finance, transportation, and decision-making has been reported by a number of studies in Nepal (Shrestha, 2012). Furthermore, many district hospitals are unable to cope with obstetric emergencies. Among other problems, drugs are not always readily available in the pharmacy and if available, the poor families are unable to buy. In addition, the health care staffs in the rural health posts are often reported as being unreliable, hostile towards local patients, and absent from the care centers; the major probable causes of not seeking medical care by rural women even when medical care was available. Furthermore, most women in rural areas of Nepal are forced to perform daily household chores and fieldwork that demands physical strength. Also, sanitation, a factor that affects maternal mortality, is extremely poor in home, where almost all the deliveries take place.

According to Nepal Demographic and Health Survey (2011), the proportion of women who have received antenatal care contact with skilled professional (doctor, nurse or midwife) is 58.3 percent. Here percentages of women who have received four or more antenatal care contact during their pregnancy has increased by 50 percent during five year (2006 to 2011) period with pronounced increase in Nepal. And 36 percent of deliveries have attended by a skilled provider. So the deliveries have attended by a skilled provider has increased by 10 percent during the five years (2006 to 2011). The proportion of women who have received TT (Tetanus Toxiod) vaccination is 76.9 percent which increased by 13 percent.

From the above data we can realize that the condition of maternal health is going to improve but still maternal mortality rate and infant mortality rate is high in Nepal. Only 36 percent women give birth to child by presence of trained person (Nepal Demographic and Health Survey 2011). Still around 64 percent women give birth to child at home without presence of trained person. When they cannot give birth to child at home for long time and then she is brought to the hospital. Mainly it is practice in rural areas due to many factors such as socio cultural factors, lack of proper knowledge etc.

The number of women who get medical help during pregnancy and delivery is even lower. According to Nepal Demographic Health Survey (2011), in Nepal 58.3 percent women have received antenatal care contact with trained person. Still around 42 percent women do not regular check up during their pregnancy. In rural areas everyone used to works during pregnancy and soon after delivery (Chaudhari 2067 BS). Most of pregnant women do not go regular check up to the health facilities and they do not take iron, calcium tablets and also TT immunization. To decrease the mortality rates of mothers and children, it is important to have at least four check-ups during pregnancy (Gautam, 2009). World Health Organization (WHO) also recommends that four antenatal visits are necessary.

Attitudes and practices relating to pregnancy and childbirth in Nepal are influenced by social, cultural and religious factors. These are often so strong that, at times, they can seem to be insurmountable barriers to reducing maternal mortality using rational methods. In addressing these complex areas, the Nepal Safer

Motherhood Project (NSMP) had developed a strong understanding and appreciation of local beliefs and practices in order to reinforce positive aspects and help to transform others. Both project staff and partners make continual and concerted efforts to study local antenatal, childbirth and neonatal practices (DFID, 2006).

The lives of mothers and children are still in danger due to many factors like; geographic structure, lack of proper knowledge about safe motherhood, lack of health post, trend of not seeing a doctor during pregnancy, our socio- cultural practices etc. Lack of nearest health facilities is one of the major problems in our country. To reach nearest hospital for safe delivery it takes at least one day by foot. So these causes also create problems which are related with a maternal health. Still women are not aware of pregnancy complication it is just a normal thing and that they can deliver at home and they are not aware of the consequences that pregnancy can bring (Mishra, 2009).

For the improvement of maternal health, Nepal is committed to the MDGs and has developed various policies and strategies to this end. Together with multilateral and bilateral organization and other international and national Non Governmental Organization (NGOs) is working towards better access and higher quality service to improve maternal health. The Support for Safer Motherhood Program (SSMP) is designed to improve infrastructure development (through comprehensive emergency obstetric care, basic emergency obstetric care and birthing centers) and human resources development and upgrade the skills of skilled birth attendants.

In recently, the government of Nepal has taken new steps to develop programs geared toward helping pregnant women. One program offers financial incentives to women if they give birth in health posts or other medical facilities. The government is providing money to women in all 75 districts of Nepal in hopes of attracting pregnant women to deliver in safer conditions. Women are given different amounts according to the region where they live in and the distance and difficulty required reaching a health post. Women from the Himalayan regions get 1,500 rupees, while women from hill of Nepal get 1,000 rupees, and women from the Terai of Nepal, earn 500 rupees. Throughout Nepal there are 27 hospitals capable of providing comprehensive obstetric services and a few thousand health posts capable of providing basic or emergency obstetric care (Gautam, 2009).

1.2 Statement of the Problem

Maternal health refers to the health of women during pregnancy, child birth and the post partum period. It is one of the major problems of Nepal. Many women still die in pregnancy or childbirth. According to Nepal Demographic and Health Survey (2011), only 58.3 percent women have visited the trained persons for antenatal care during their pregnancy period. Still around 42 percent women do not visit the trained persons during their pregnancy period. And around 64 percent women do not attended skilled provider during their delivery period.

There are many factors for such result. Nepalese socio-cultural practices, lack of proper knowledge about maternal health services, lack of nearest health-post, geographic structure, trend to not seeing a doctor during pregnancy, male dominant society etc. but this research have tried to find out main cause which associate with maternal risk.

Health seeking behavior includes individual habits, dietary intake etc. This research tries to find out the behavior of using health services within existing health system and food habit during the three periods (prenatal, natal and postnatal). Health seeking behavior is a usual habit of a people or a community that is resulted by the interaction and balance between health needs, health resources, and socio-cultural practices as well as national/ international contextual factors.

In the Nepali society the utilization of maternal health care services are going to increase. But most of the women do not have knowledge that they should adopt these services. According to Nepal Demographic and Health Survey (2011), around 42 percent of women in Nepal do not visit the doctor during the pregnancy and only 36 percent women give birth to child by trained persons. So this study attempts to find out the level of knowledge, perception and practices of safe motherhood by respondent who live in Lekhani VDC of Baglung District. It is believed that these women have low level of knowledge on maternal health because most of the women they work hard during pregnancy and soon after delivery and they give birth to child at home. In case women cannot give birth to child at home for long time then only she is taken to the hospital.

This research has focused on the following questions:

- Which factors play an important role to increase maternal health problems?
- Do pregnant women have proper knowledge about danger sign and symptoms during pre-natal, natal and postnatal periods?
- In which conditions pregnant women taken to the hospital for delivery?
- How is present condition of health seeking behavior of mother?
- How is present condition of the level of knowledge in maternal health of mothers?

1.3 Objectives of the Study

Generally this study has examined the knowledge, practices, perception and present condition about maternal health. And it has focused on women who have children below five years.

The specific objectives are following:

1) To describe basic knowledge of pregnant women and mother about ante-natal, natal and postnatal checkup.
2) To find out main factor which play an important role to increase maternal health problems?

1.4 Significance of the Study

Maternal mortality is a social as well as economic problem which depends on maternal health. In Nepali society the condition of maternal health is one of the problems which support to increase maternal morality.

This study has collected information about the knowledge, practices, health seeking behaviors of mothers with children below five years who have been living in Lekhani VDC of Baglung District. Therefore this study has helped to know present condition about knowledge level, practices and health seeking behaviors of rural areas' women of Baglung district. And this study also has provided baseline information about such conditions which support to make suitable program for programmer planner, policy makers and other who have interest in this field. And it is applicable for whole Baglung district.

1.5 Organization of the Study

In this study, the researcher has divided into six chapters which are organized consistently as appropriate status on which the first chapter is the introduction; the second chapter is literature review. Similarly the third chapter is research methodology which is the backbone of field work and data analysis. The fourth chapter is study area and population which generally has identified the recommendation of existing study site. The five chapters is presentation of findings which is the main body of this study and the six chapter represents summary and conclusion which end to the present study.

CHAPTER – II

LITERATURE REVIEW

The 2006 Nepal Demographic and Health Survey revealed that the provision of antenatal care to increasing proportions of women, although not direct linked to improvements in maternal survival, is important to track because of the opportunity that it provides to relay health messages to women. Some complications can be addressed during pregnancy (although most occur at the time of birth or in the hours afterwards). Indeed a substantial proportion of maternal deaths – perhaps as many as one in four – occur during pregnancy. Women who seek antenatal care also tend to seek a skilled professional at childbirth. Antenatal care is an important time for women to establish a relationship with health care services and for health care professionals to deliver key messages to women on health problems more generally, especially relating to the upcoming birth, but also relating to sexual health, family planning, HIV/AIDS, and the care of the newborn and child.

According to Nepal Demographic and Health Survey (2006) the maternal mortality rate in Nepal is 281 deaths per 100,000 live births and infant mortality rate is 48 death per 1000 live births. All Nepal only 29 percent women have had four or more antenatal care contact with skilled professional. 52 percent women of urban areas and 26 percent women of rural areas have had four or more antenatal care contact. And all Nepal 74 percent women who have had at least one antenatal care contact. 88 percent of urban and 72 percent of rural areas' women have had at least one antenatal care contact. Women who have had attended by a skilled professional when they give birth is only below 20 percent. And the proportion of women who have received TT (Tetanus Toxiod) vaccination is 63 percent. TT injections are given during pregnancy for the prevention of neonatal tetanus, a major cause of death among infants. For full protection, a pregnant woman should receive at least two doses during each pregnancy. If a woman has been vaccinated during a previous pregnancy or during maternal and neonatal tetanus vaccination campaigns, she may only require one dose for the current pregnancy. Five doses are considered to provide lifetime protection.

According to Nepal Demographic Health Survey (2011), among births in the past five years, 58.3 percent of women had antenatal care from a skilled provider (doctor, nurse, or midwife) but only 36 percent of deliveries were attended by a skilled provider and only 28.1 percent took place in a health facility. That is well short of the 60 percent target set by the UN Millennium Development Goals for deliveries in a facility for 2015. These proportions have increased since the 2006 DHS, however. Among the most recent births, 76.9 percent were protected against neonatal tetanus, but that has remained unchanged since the 2006 DHS. All of these measures were the highest in the *Terai*, or lowland zone bordering India where a little over half of Nepalese live, compared with the Mountain and Hill zones. Childhood mortality has been declining slowly. The infant mortality rate in the five years before the survey decreased to 46 infant deaths below age one per 1,000 live births from 60 five to nine years before the survey. The current level is similar to that in India. Mortality under age 5 showed a similar decline. Nepal has a ways to go on child nutrition. The survey found that 40.5 percent of children had stunted growth, 28.8 percent were underweight, and 10.9 percent were wasted (weight-for-height).

The risk associated with each pregnancy and delivery is higher for women in the developing countries and very few women in developed countries die during pregnancy and child birth. The main cause for this is less availability of health care services in developing countries. Among who die 99 percent live in developing countries and of the 585000 death each year from maternal care and nearly 40 percent of them are from the south East Asian countries. The number is exceptionally high in Bangladesh, Bhutan, India, Indonesia, Nepal and Maldives (WHO, 1999).

In rural area still they are not aware of pregnancy complications. It is just a normal thing for them and that they can deliver at home and they are not aware of the consequences that pregnancy can bring. Because traditionaly, pregnancy is considered to be natural in Nepal. Thus, regular check-ups are thought to be unnecessary, particularly in rural areas, unless there are complications. A study by Suwal (2001) unveiled an interesting finding related to prenatal medical visits and infant mortality in Nepal. Infants were more likely to die if their mothers sought prenatal medical care while these infants were in the womb than those who did not seek prenatal care. This

indicated an association between pregnancy complications and seeking prenatal medical care. Such norms were found in other developing countries as well.

There are so many factors to increase maternal related problems such as lack of proper knowledge, lack of near health facilities and socio cultural practices etc. Furthermore, The study by the Shrestha (2012) shows, the factors for high Maternal Mortality are the 'three delays' - delay in taking the decision to seek medical assistance, delay in accessing appropriate care and delay in receiving care at health centers. Delay in seeking help due to cultural beliefs, problems of finance, transportation, and decision-making has been reported by a number of studies in Nepal. Sometime, Zonal hospitals of the Baglung headquarter is also unable to cope with obstetric emergencies due to absence of Doctor and Nurse. Among other problems, drugs are not always readily available in the pharmacy and if available, the poor families are unable to buy. In addition, the health care staffs in the rural health posts are often reported as being unreliable, hostile towards local patients, and absent from the care centers; the major probable causes of not seeking medical care by rural women even when medical care was available. Furthermore, most women in rural areas of Nepal are forced to perform such almost all the deliveries take place at home.

Births at not necessarily unsafe if mother's home are family and her birth attendant can recognize the sings of complications during the labor and delivery and if complications occur can promptly carry her to the health facilities with adequate facilities .Families may not be able to transport her to a medical centre in time or they may not take her because they fear patronizing high fees or poor quality. Deliveries in health facilities can still be risky because of poor medical care .All pregnancies involve some risk even for healthy women .An estimated 15 percent of pregnancies result in complications requiring medical care .In life-threatening cases women need emergency obstetric care (UNFPA-2001).

Before few years ago, the government of Nepal has taken new steps to develop programs geared toward helping pregnant women. One program offers financial incentives to women if they give birth in health posts or other medical facilities. Guatam revealed on her article Nepal's Infant, Maternal Mortality Rates worst in South Asia 2008, the government is providing money to women in all 75 districts of Nepal in hopes of attracting pregnant women to deliver in safer conditions. Women

are given different amounts according to the region where they live in and the distance and difficulty required toreach a health post. Women from the Himalayan regions get 1,500 rupees, about $21, while women from the eastern part of Nepal get 1,000 rupees, about $14, and women from the Terai region, the plains in the southern part of Nepal, earn 500 rupees, or $7. Throughout Nepal there are 27 hospitals capable of providing comprehensive obstetric services and a few thousand health posts capable of providing basic or emergency obstetric care.

Attitudes and practices relating to pregnancy and childbirth in Nepal are influence by social, cultural and religious factors. These are often so strong that, at times, they can seem to be insurmountable barriers to reducing maternal mortality using rational methods. In addressing these complex areas, the Nepal Safer Motherhood Project (NSMP) has developed a strong understanding and appreciation of local beliefs and practices in order to reinforce positive aspects and help to transform others. Both project staff and partners make continual and concerted efforts to study local antenatal, childbirth and neonatal practices (DFID 2006).

Maternal Mortality is high in Nepal among Developing country. Still women are dying due to pregnancy related complications in our country. Misra (2009) shows on her article, Women are not aware of pregnancy (complications) it's just a normal thing and that they can deliver at home and they are not aware of the consequences that pregnancy can bring.

In Nepal, the lives of mothers and children are still in danger due to the geographic structure of the country. According to Gautam (2009), at some places it takes about four to five hours (on foot) to bring (a) pregnant women to health posts and some die on the way. So it is possible to construct a good hospital, but we cannot change the geographic structure of the country.

2012 March 26, the Ministry of Health and Population, Government of Nepal and the U.S. Agency for International Development (USAID/Nepal) jointly released the findings of the 2011 Nepal Demographic and Health Survey (NDHS), highlighting the health, social and economic status and trends in the country. At the seminar, authors of the survey presented key findings, underlining the changes in the most

important demographic and health indicators over the past decade and factors contributing to the startling changes.

Some key findings include –

- Decline in fertility over the past fifteen years. Currently, women have an average of 2.6 children during their lifetimes. This represents a steady decline since 2006 when women were having an average of 3.1 births.
- Family planning use has remained essentially the same since 2006. Use of female sterilization has dropped slightly, from 18% in 2006 to 15% in 2011, while male sterilization has increased, from 6% in 2006 to 8% in 2011. Use of traditional methods has also increased, from 4% in 2006 to 7% in 2011, mostly due to an increase in the use of withdrawal. The 2011 NDHS also reveals that 27% of married women have an unmet need for family planning – 10% for birth spacing and 17% for limiting.
- Infant mortality rate is 46 deaths per 1,000 live births for the five-year period before the survey, just two deaths below the infant mortality reported in 2006. Under-five mortality is 54 deaths per 1,000 live births, down from 61 deaths per 1,000 in 2006.
- Immunization coverage among children has slightly increased during this period. Currently, 87 percent of children aged 12-23 months are immunized against the six major childhood diseases whereas 83% of children were fully immunized in 2006.
- Nepalese children are better nourished than in the past. In children under five years of age, 41% are chronically malnourished, as measured through stunting, and 11% are wasted, a measure of acute malnutrition. While still high, these statistics represent a reduction from 2006 when 49% were stunted and 13% were wasted. Furthermore, the data show 29% of Nepalese children under age five are underweight in 2011, which is a decrease from 39% in 2006.
- Knowledge on HIV/AIDS has increased in the past 5 years with 86% of women and 97% of men in Nepal having heard of it.

Women's health has improved over the last five years. In 2011, 58% women \received antenatal care from a skilled provider, compared to 44% women in 2006,

and more than one in three (36%) births are delivered with the assistance of a skilled birth attendant currently compared with less than one in five births (19%) five years ago. Similarly, institutional delivery has also increased from 18% in 2006 to 35% in 2011.

There are many factors to bring such types of positive changes like increase in female education, the role of government, NGOs and INGOs to bring maternal health related programmed and awareness through Radio, Television etc. According to Joshi 1994, schooling equips women with specific skills and disposition or identity which significantly predict two principles, domains of Health-care behavior: Use of medical services; and change in household health behavior. It was also found that women with schooling had healthier children using height for-age as an indicator of Health.

The main objectives of this study were to examine knowledge and practice on maternal health and to find out main factor which support to increase maternal problem. For the fulfillment of my objectives, I have reviewed above literature particularly Nepal Demographic Health Survey (2011) had helped to know present condition of women about using maternal health services. And I have got some idea from Shrestha's article Maternal Mortality in Nepal: Adrressing the Issue (2012) and Gautam's article Nepal's Infant, Maternal Mortality rates worst in South Asia (2008) to fined out factors which support to increase maternal risk. Other important literatures had also related with my study which helped to fulfill my objectives.

CHAPTER – III

METHODOLOGY

3.1 Rational of the Site Selection

When I went to Lekhani village after my marriage, I found most of the women had given birth to child at home and they had worked hard during pregnancy and soon after delivery as a result some of them have suffered from maternal related problems. And also I have shown that a woman had given birth to her child on the path between Lekhani village and Baglung headquarter because she was being taken to the Zonal Hospital of Baglung District for the delivery case when she was unable to give birth to child at home. There are many factors for the selection to lekhani as a study area. But the main reasons behind the selection of this area are given below:

1. During my living period I found that most of women they have worked hard during pregnancy period and soon after delivery.
2. Most of women used to give birth to child at home. If they cannot give birth to child at home for long time and then she is taken to hospital by their family.

3.2 Research Design

Research design is the most important element of any social research. It is a logical and systematic planning which directs the research.

This research has involved descriptive design on the basis in quantitative data. This design for detailed study about knowledge and practice of mothers about safe motherhood and such designs help to know knowledge about maternal health (antenatal, natal, postnatal) and others related factors associated with it which support to increase maternal risk. The study populations are mothers with children below five years.

3.3 Sampling Procedure

The study area is Lekhani VDC of Baglung District. In this village, the population is heterogeneous such as Brahmin, Kchhetri, Newar, Chhantyal, Magar, Thakali and other lower caste Dalits. Therefore sample has selected by purposive/judgment sampling method. From the sample the required information or objectives has collected through interview schedule and observation. The interview schedule has provided information about level of knowledge of the antenatal, natal and postnatal periods. A total of 50 women among 149 women were interviewed to collect the required information. And I have interviewed to women in the day of immunization for the cover all wards of VDC. Observation has supported to find out the main factor which related with maternal risk.

3.4 Nature of Data

The main focus of the study has to collect quantitative data, although some qualitative data have also used. The main part of the research has depended on the primary data. It has taken different techniques and tools namely: interview schedule and observation.

3.5 Techniques of Data Collection

3.5.1 Interview Schedule

Interview schedule is one of the major tools of the data collection which is list of questions where Interviewer asks questions to the respondents and respondents give answer. The interview schedule has collected the information about maternal health among 50 women of the Lekhani VDC.

3.5.2 Observation

Observation as a tool has used comprehends the present situation of the mothers what they have been doing in practice particularly I have observed: what types of clothes are using for newly child? And who help her after delivery?

3.6 Data Analysis

To make the research meaningful there is very necessary of data analysis. Only data collection is not sufficient. So the collected quantitative data were edited and coded carefully for the computer entry. The edited and coded data were processed and analyzed in SPSS software. The frequency tables were reviewed and description of the information was prepared. The primary analysis was done based on frequency and percentage using tables. Throughout the data processing and analysis, the current status of knowledge and practice of women of the Lekhani VDC were examined. Then the main cause of increase problems related with maternal health was identified.

3.7 Limitation of the Study

Every study/research does have its own limitation, and this research is no exception either. The limitation of the study is as follows:

1) This study has covered only Lekhani VDC of Baglung District and the study has centralized over the mothers with children below five years.
2) The research has conducted in specific area i.e. Lekhani VDC of Baglung District. Therefore result may not be applicable and relevant to multiple places and context.
3) This study has conducted as a study of Lekhani VDC of Baglung District for the partial fulfillment of the master level degree requirement in sociology. So it is not feasible for detailed intensive research due to the lack of sufficient resources collection with such short span of time.

CHAPTER – IV

THE STUDY AREA

4.1 General Background of the Study Area

The study area is one of a rural village located in a hilly area of Baglung district of Western region of Nepal. The name of the village where the study is conducted and researched is Lekhani. It is only 10 km far to the west from the district headquarter of Baglung. The study area is consisted of 9 wards. The total population of village is 2473. Male population is 994 and female population is 1479 (National Population Survey, 2068). It has got hills and mountains with subtropical temperature and wide variation in vegetation and animal life. It is truly a rural hilly area where we can notice a true rural natural lives, language, culture, people, costume and different types of cultural practices because the study area is inhabited of different local indigenous people like Magar, Gurung, Newar, Thakali, Chhantyal, Brahmin, Kshetri, and other lower caste Dalits.

Most of the people are farmers. Rice, corn, barley, potatoes, beans etc and other crops are main crops. The village is surrounded by Resha VDC in East, by Damek VDC in South, by Bihun in North and by Galkot region in the West which is consisted of several villages and also known as one of a *Chaubise Rajya* at ancient historical period. Geographically, the village is famous for Gaja Hill which at the top of the village. It is 2500 ft high from the surface level of the sea. Religiously, people have adopted Buddhist, Hindus and Christian religion in the village. Culturally, people celebrate their own festival as per their own religion and local cultural practices. They share their joy and wish for peace and prosperity of one another on this occasion. Different indigenous people have their own cultural practices to follow that guide them to be honest, patient, laborious, and helpful and disciplined with one another. Gaja Youth Club is one of the leading NGO of the village which is also a leading NGO in the district as well. The club has taken part in various fields like education, health, sanitation, irrigation, social awareness and natural resource management of the village. Recently, the organization has conducted *Suaahar* project

in the village it is mainly focus on the health condition and nutritional food of pre-natal and post-natal period of women and children which is sponsored by UNICEF.

The village has got a kind of homogenous society like Mager, Gurung, Thakali, Newar, Chhantyal, Brahmin, Kchetri and Dalits. People of different ethnic group are given equal opportunities and take part in every developmental work in very co-operative manner. Villagers have formed various co-operatives institutions like Gaja Bachat Tatha Hrin Sahakari Sanstha, Laligurans Multi-Purpose Co-operative Institute, Dugdha Sahakari Sanstha, Kadesh Sahakari Sanstha and Jadibuti Sahakari Sanstha etc. to make village, people and community financially strong. Village has got a Local Paper Industry and its commodities like bags, photo frame and album, copies, diaries etc. are supplied to market. It has provided employment mainly for women and economically supports them and village. Furthermore, the village has got beautiful hills, green zones, view points, various traditional culture and costumes and there many more cultural heritages which have made the village culturally rich. Villagers have kept it secure by forming committees and managed home stay for the tourists who wish to visit the village.

4.2 Education

The study area has got one Higher Secondary School, one Secondary School, two Lower Secondary School, four Primary Schools which have been providing education in English medium for decades of years. There is a private institutional school named Little Paradise Academy which is also providing English medium education. For further education students select and join universities and other academic institution of their own interest in established in district headquarter or in other cities. There is only one high school for whole VDC, 7 primary schools and 2 lower secondary schools.

4.3 Health and Sanitation

Regarding health facilities, the study area has a sub-health post established in 2052 B.S. It is duly providing good health services and facilities. An HA, ANM and other female community health volunteer are providing the health services as

announced by the government. The habitants of the study area take first aid services and other immediate treatment of an injury or diseases from the sub health post then they follow-up to zonal hospital for further treatment as prescribed by the HA. Sub-health conducts regular vaccination, nourishment, follow-up and family planning for child and mother. It also regularly conducts health awareness program such as about sanitation, sexual abuse, pregnancy, child care and nourishment and provides other numerous health facilities. According to the Health Assistant Lakshmi Prasad Neure mostly the patients of respiration visit the sub health post and among them mostly women patients frequently visit. He also said that in comparison to prior health condition of the local villagers the number of pneumonia and diarrhea has been decreased due to health awareness program and practices.

4.4 Transportation and Communication

The study area is easily accessible from the district headquarter which takes only one hour in vehicles and takes around 3 hour on foot. It is situated besides the Maddhay Pahadi Lokmarg but the road has not been built up through the village which is only 1.5 km far from the border of the village. It remained untouched from the highway but the villagers have linked the village with the highway by building the road at their own investment which has made the lives of villagers easier than before. Both heavy and light vehicles can easily run on the road but during rainy season mud and landslide creates problems in transportation because the road is not graveled. The means of communication is very easy. Everyone have their own mobile. And electricity is available.

4.5 Economy

The main occupation of the study area is agriculture. About 95% of the livelihood depends on agriculture which has made the lives of villagers independent remaining 5% has adopted occupations like business and others. Mainly the women work for agricultural work because usually men go to foreign country. Village has a Local Paper Industry and its commodities like bags, photo frame and album, copies, diaries etc. are supplied to market. It has provided employment mainly for women and economically supports them and village.

CHAPTER – V

KNOWLEDGE AND PRACTICES ON MATERNAL HEALTH OF WOMEN

In this section, knowledge, practice and present conditions so far as the maternal health of women in Lekhani VDC concerned are discussed in four sub-chapters.

5.1 General Background of the Respondents

In the study area the female population is 1479 (National Population Survey, 2068). Most of women their occupation is agriculture as well as they work inside the house. Most of women they work during pregnancy and soon after delivery. Majority of the respondents are below S.L.C. they have low level of knowledge on danger sign and symptoms during three periods (pre natal, natal and post natal).

5.1.1 Education

The use of antenatal care services is strongly related to the mother's level of education. It has found that majority of the respondents are under SLC. 68 percent of respondents are still under SLC and 18 percent of respondents are with SLC. Rest 14 percent are with IA. According to data majority numbers of respondents with under SLC have found low level of knowledge about danger symptoms during three periods (pre natal, natal and post natal).

Table 1: Education Level of the Respondents

Education Level of the Respondents	Frequency	Percent
Below S.L.C.	34	68.0
S.L.C.	9	18.0
I.A.	7	14.0
Total	50	100.0

Source: Field Survey 2012

Studies have shown that education is one of the major factors that influence a person's behaviour, knowledge and attitudes. In general, the higher the level of education of a woman, the more knowledgeable she is about the use of health facilities. The knowledge about maternal health such as use of ANC services from Skilled Birth Attendants (SBA), danger symptoms during three periods (pre natal, natal and postnatal) and sanitation related with mother and child etc are strongly related to the mother's level of education. According to table 5.1.1 the respondents with under SLC are less knowledgeable about maternal health than the respondents with SLC and IA.

5.1.2 Age of the Respondents

In this study the target group is the women who are with below 5 years child. Age is the important demographic variable in this study among the pregnant women. Pregnancy is directly related to the age of the woman because it determines the health of mother and new born baby too. Majority of the women give birth to child after maturity (after 20 years). Only 3 percent of the young women gave birth before their maturity which means there may have dangerous effect and high risks for both mother and child.

Table 2: Age of the Respondents

Age of the Respondents	Frequency	Percent
15-19	3	6.0
20-24	17	34.0
25-29	24	48.0
30-34	2	4.0
35-49	3	6.0
Above 40	1	2.0
Total	50	100.0

Source: Field Survey 2012

5.1.3 Caste/ ethnicity of the Respondents

The study area is inhabited of different local indigenous people like Magar, Gurung, Newar, Thakali, Chhantyal, Brahmin, Kshetri, and other lower caste Dalits. The respondents have chosen by purposive/judgment sapling method. 18 percent respondents are from Brahmin, 4% are from chhetri, 40% are from Janjati and 38% are from Dalit.

Table 3: Caste/ Ethnicity of the Respondents

Caste/ Ethnicity of the Respondents	Frequency	Percent
Brahmin	9	18.0
Kchetri	2	4.0
Janjati (Chhantyal, Magar, Newar, Gurung)	20	40.0
Dalit	19	38
Total	50	100.0

Source: Field Survey 2012

5.2 Pre-Natal Care/Antenatal

This sub-chapter is concerned about the knowledge and practices of pre-natal care/antenatal care of the study area. It further describes the implementation of services provided by the government and local authorities such as regular checkup during pregnancy, having iron tablets, TT vaccination, and food pattern and delivery preparation etc for the pregnant women.

5.2.1 Antenatal Care during Pregnancy

Prenatal/antenatal care is a period of pregnancy which falls after conception and before live birth. A woman at this age is supposed to get regular health check up, have nutrition diet, get relief hard from physical work, and take iron, calcium and vitamin A tablets and TT immunization. The table 4 describes antenatal care received by respondents of Lekhani VDC.

Table 4: Antenatal Care during Pregnancy

ANC Check-up(At least one time)	Frequency	Percent
Yes	49	98.0
No	1	2.0
Total	50	100.0

Source: Field Survey 2012

Table 4 shows that majority 98.0 percent of respondents had received antenatal care during their pregnancy. Only 2.0 percent respondents had not received any medicinal and familial checkup during their pregnancy. The respondents who had received regular check up during their pregnancy period they answered "antenatal care is compulsory. We need to know baby's condition, position and need to find out up coming problems if there is any abnormality." And rest of the 2.0 percent respondent had not received any antenatal care due to shyness and hesitation. According to Nepal Demographic Health Survey (201)1, still all over Nepal, 42.0 percent women had not received any checkup which is needed to both mother and child. Women's health has improved over the last five years. In 2011, 58% women received antenatal care from a skilled provider, compared to 44% women in 2006, and more than one in three (36%) births are delivered with the assistance of a skilled birth attendant currently compared with less than one in five births (19%) five years ago. Similarly, institutional delivery has also increased from 18% in 2006 to 35% in 2011.

5.2.2 Number of ANC Visits

Pregnancy complications are the major cause of maternal and child morbidity and mortality, so the teaching and education for pregnant women about the dangerous signs associated with pregnancy should be given. They should learn the appropriate action to take at the time of abnormity is essential component of antenatal care. It is only possible to know for the most of the rural pregnant women during ANC visits to detect health problems associated with a pregnancy. In the event of any complications and necessities, more frequent visits are advised and may be necessary. Also, the World Health Organization (WHO) recommends that a woman without any

complications should also have at least four ANC visits to provide sufficient antenatal care. The table 5 shows that majority percent women of Lekhani VDC had taken antenatal care for 4 times or more than 4 times during their period of pregnancy.

Table 5: Number of ANC Visits by Respondents

Number of ANC visits	Frequency	Percent
2 times	2	4.0
3 times	11	22.0
4 times	19	38.0
More than 4	17	34.0
Not Done	1	2.0
Total	50	100.0

Source: Field Survey 2012

Table 5 shows frequency of checkup of both mother and child by respondents in the study area. World Health Organization recommends that four antenatal visits are necessary and in the Lekhani VDC, 38.0 percent of women have visited four times for antenatal care and 34.0 percent women have visited more than 4 times for antenatal care. Respondents who had visited 4 or more than 4 times for antenatal care, they answered "more frequent visits are necessary to know the position of child and physical condition of mother too." (ulto or sulto). 22.0 percent women had visited 3 times only. Likewise, other 4.0 percent women had visited only 2 times during pregnancy period. Respondents who had visited 2 or 3 times for antenatal care, they replied that there had not been any problem in the health of both child and mother and remaining 2.0 percent women did not have any checkup due to socio-cultural boundary, shyness and hesitation.

Table 6: Antenatal Care with Different Health Person

ANC Check Up	Frequency	Percent
Doctor	5	10.0
Nurse	41	82.0
Both	3	6.0
Nobody	1	2.0
Total	50	100.0

Source: Field Survey 2012

Table 6 demonstrates the majority of respondents (82.0 percent) who have received antenatal care with nurse/ANM of sub-health post of Lekhani VDC. Only 10.0 percent respondents had received suggestion about antenatal care from the doctors of zonal hospital located in district headquarter of Baglung district which is only 10 km far from Lekhani VDC and other 6.0 percent have receive with both doctor and ANM. Rest 2.0 percent did not take any checkup. 82.0 percent respondent who had been checked by ANM of sub-health of VDC, they replied that the Nurse had advised the condition is normal, it was not necessary to go to headquarter for further check up so most of the respondents took prenatal care at the local sub-health post of VDC but 10.0 percent respondents who had followed the doctor's suggestion do many more procedures like video x- ray, ultrasound, medication etc.

5.2.3 Coverage of Iron/Calcium

Pregnant women must take iron tablets for the growth of fetus and this also prevents mother from disease like Anemia. And it is important to take from first month of pregnancy up to 45 days after delivery.

Table 7: Consume Iron/ Folic Acid

Consume Iron/ Folic Acid	Frequency	Percent
Yes	48	96.0
No	2	4.0
Total	50	100.0

Source: Field Survey 2012

Table 7 shows that majority number of women reported that they had taken iron/folic acid to be safe from anemia and 96.0 percent respondents had taken iron or folic acid. Only 4.0 percent respondents had not taken it due to carelessness. It means they have not gone for ANC checkup.

Table 8: Number of Days of Consumed Iron/ Folic Acid

Number of days of consumed Iron/ Folic	Frequency	Percent
Less than 200	14	28.0
200-249	11	22.0
250-300	15	30.0
More than 300	8	16.0
Not taken	2	4.0
Total	50	100.0

Source: Field Survey 2012

Table 8 shows the number of days that consumed iron/ folic acid by respondents. 28 percent respondents had taken iron/ folic acid less than 200 days, 22 percent respondents had taken between 200- 249 days, 30 percent respondents had taken between 250-300 days and 16 percent respondents had taken more than 300 days. Rest 4 percent respondents had not taken iron/folic acid. In study area, 70.0 percent respondents had taken iron everyday and 26.0 percent respondent had taken but remaining rest of 4.0 percent respondents had not taken any.

5.2.4 Coverage of TT Vaccination

TT vaccination that women receive during the period of pregnancy is an important indicator of antenatal care. It prevents them from tetanus disease to both mother and child. All over Nepal, the proportion of women who have received TT injection is 79.9 percent (Nepal Demographic health Survey, 2011). The status of study area is as following.

Table 9: Number of Received TT Injection

Number of Receive TT Injection	Frequency	Percent
One	5	10.0
Two	29	58.0
Three	14	28.0
Not taken	2	4.0
Total	50	100.0

Source: Field Survey 2012

In the study area, it was found that 96.0 percent of women had received TT vaccine and 4.0 percent had not received during their period of pregnancy. 96.0 percent of women who had received TT vaccine they replied "TT vaccine is good for mother and child." Most of them have known that it prevents both mother and child from tetanus disease but some of them did not know the positive effects of taking TT vaccination though they believe in taking it. Rest 4.0 percent respondents had not received TT vaccine because they had not heard and been familiar about TT vaccination and its beneficiations so they gave birth to child without any TT vaccination.

Table 9 also shows that the frequency of receiving TT injection. The proportion of women who had been injected 2 times is 58.0 percent. And the proportion of women who had been injected 3 times is 28.0 percent. Others 10.0 percent women had been injected only once and rest 4.0 percent women had not taken any.

5.2.5 Food Pattern/Diet

Good food pattern/balance diet including fresh fruit, vegetable, milk, meat, fish, etc plays an important role during pregnancy to make both baby and mother healthy. It supports to grow baby properly. So, good food pattern is desperately needed for a mother during pregnancy and after delivery.

Table 10: Food Pattern during Pregnancy

Food Taken during Pregnancy	Frequency	Percent
Same as usual	22	44.0
More as usual	25	50.0
Less as usual	3	6.0
Total	50	100.0

Source: Field Survey 2012

Table 10 shows the food pattern of respondents in study area which they had had during pregnancy period. 50.0 percent respondents answered that they had food more than usual because adequate food amount and nutrition help baby to grow properly and it makes mother strong too (their opinion). Other 44.0 percent respondents answered that they had had same as usual because of their lack of desire to have appetite, economic condition and joint family. Rest 6.0 percent respondents answered they had had food less than usual because of less desire to have food.

The Table 11 shows the relation between education level of the respondent and food pattern during pregnancy by respondents. 18 respondents with Under SLC had taken food same as usual, 13 respondents with Under SLC had taken food more as usual and 3 respondents with Under SLC had taken less usual. And 3 respondents with SLC had taken same as usual, 6 respondents with SLC had taken more as usual. All respondents with IA had taken food more as usual. There are no respondents with SLC and IA had taken food less as usual. It means education level of respondents affect on food pattern of the respondents.

Table 11: Education of the Respondents and Food Pattern during Pregnancy

Education level of the Respondents	Food Pattern during Pregnancy			Total
	Same	More	Less	
Under SLC	18	13	3	34
SLC	3	6	0	9
I.A	0	7	0	7
Total	22	25	3	50

Source: Field Survey 2012

5.2.6 Knowledge of Respondents on Dangerous Sign and Symptoms during Pregnancy

High bleeding, swelling on legs Arms and Face, high fever, failure to gain weight, anemia, high blood pressure and blurred vision etc are dangerous sign and symptoms during pregnancy. Somehow, these dangerous symptoms can be appeared during the period of pregnancy which may lead to death of both mother and fetus. Most of rural area's women still are unknown and unaware about the dangerous sign and symptoms of diseases that appear during pregnancy due to illiteracy and carelessness. The table 12 shows the knowledge of women of Lekhani VDC about the dangerous sign and symptoms that may occur during pregnancy.

Table 12: Knowledge of Respondents on Dangerous Sign and Symptoms during Pregnancy

Knowledge on Dangerous sign and symptoms	**Yes**	**Percent**	**No**	**Percent**
Bleeding	32	64.00	18	36.00
Swelling on Legs, Arms and Face	10	20.00	40	80.00
High Fever	2	4.00	48	96.00
Failure to gain weight	1	2.00	49	98.00
Anemia	0	0.00	50	100.00
High blood pressure	0	0.00	50	100.00
Blurred vision	0	0.00	50	100.00

Source: Field Survey 2012

High bleeding is one of the danger symptoms during pregnancy. In the study area 64 percent of women they have known about bleeding is the danger for health of mother and fetus during pregnancy. Still 36 percent of women they did not know

about bleeding is danger for health of mother and fetus. Swelling on legs, arms and face also is a danger for health of mother and fetus during pregnancy. In the study area only 20 percent respondents have known that swelling on legs, arms and face during pregnancy is the danger for health of mother and fetus. Others 80 percent respondents they were unknown about that swelling on legs, arms and face during pregnancy is the danger for health of both mother and fetus. From this data it is clear that more numbers of the women are still unknown about it. And only 4 percent respondents have known about high fever is one of the danger sign and symptom during pregnancy. Others 96 percent respondents they did not know about high fever is danger symptom during pregnancy. That means more women are still unknown about it. In the study area, only 2 percent respondent have known about failure to gain weight during pregnancy is one of the danger symptom. Others 98 percent respondents they did not know about that failure to gain weight during pregnancy is danger symptom. In the study area, more numbers of women they have still unknown about danger symptoms which associate with maternal health. And it is found that all respondents were unknown about anaemia, high blood pressure, blurred vision which is also the danger symptom during pregnancy.

Now, the level of education status has increased the knowledge of respondent about the dangerous signs that may occur during pregnancy.

Table 13: Level of Education and Knowledge on Dangerous Symptoms during Pregnancy

Education of the Respondents	**Knowledge on Danger Symptoms during Pregnancy**			
	Yes	Percent	No	Percent
Below SLC	23	46.o	11	22.0
SLC	6	12.0	3	6.0
IA	7	14.0	0	0.0
Total	36	72.0	14	28.0

Source: Field Survey 2012

Table 13 shows increased knowledge level about the dangerous symptoms in response with education level. 11 and 3 respondents who are under S.L.C. and passed SLC had low level of knowledge about danger symptoms. Respondents with IA are known with it.

Table 14: Caste/Ethnicity and Knowledge on Danger Symptoms during Pregnancy

Caste/ Ethnicity	Knowledge on Danger Symptoms during Pregnancy			
	Yes	Percent	No	Percent
Brahmin	8	16.0	1	2.0
Chhetri	1	2.0	1	2.0
Janjati	15	30.0	5	10.0
Dalit	12	24.0	7	14.0
Total	36	72.0	14	28.0

Source: Field Survey 2012

Table 14 denotes the proportion of women who were unknown about the dangerous symptoms that may occur during pregnancy. The proportion of women having no knowledge about dangerous symptoms was 5 from Janajati, from Dalit community there was 7, only one from chhetri and from Brahmin also only one.

5.2.7 Delivery Preparation

It is important that needed materials for the delivery such as Birth kit, materials for newly baby (soft, clean clothes), transportation, money, inform to nurse/ANM beforehand, blood (in difficult) etc should be managed before delivery for the safety of the baby and mother. In the rural area still it is not in practice due to many causes such as lack of education, culture, economic condition etc. The following data shows the present condition of the study area's women about delivery preparation.

Table 15: Delivery Preparation by Respondents

Delivery Preparation	Yes	Percentage	No	Percentage
Informing the skilled Attendant for Delivery beforehand	1	2.00	49	98.00
Arrangement of delivery materials for newly born child	12	24.00	38	76.00
Arrangement of money	27	54.00	23	46.00
Arrangement of transportation	3	6.00	47	94.00
Arrangement of Birth kit	15	30.00	35	70.00
Blood	0	0.00	50	100.00

Source: Field Survey 2012

Informing the skilled attendant for delivery beforehand is important task for safety of mother and child because skilled attendant can solve coming problem beforehand and if necessary she also advise to go hospital. But in study area women they do not inform beforehand first family members/ neighbors support her or when women start labor pain during long time and then family member brought to the skilled attendant at home. In the study area it is found that only one woman have informed to the skilled attendant for safe delivery beforehand. Others 49 respondents they did not inform to the skilled attendant for delivery beforehand. Because culturally they have been giving birth to child at home without skilled attendant only the situation of women is not good during period of delivery then only they search to the health person and further processes. According to Nepal Demographic health survey 2011, in our country only 36 percent of deliveries were attended by a skilled provider and only 28.1 percent took place in a health facility.

In the study area only 24 percent respondents have arranged needed material for child and mother (clean and warm clothes) to prevent from infections. Others 76

percent respondents did not any preparation to prevent from infection for both mother and child. In the study area it is found that more numbers women they have used old and wastes clothes (old saari, lungi and old bed cover) for child to prevent from cold. And 54 percent respondents have arranged of money to solve the coming problems and 46 percent respondents they did not arrange of money. The respondents who did not any preparation they answered that " je parchha tyhi tarchha". In the study area it is found that When problems become such as pro long labour, high bleeding, mal presentation, placenta not expel within 30 min. etc and then they borrow money from neighbours and only she is taken hospital for further treatment. And only 6 percent respondents they have arranged of transportation. Others 94 percent respondents they did not arrange of transportation for emergency. The respondents who did not arrange of transportation they try to give birth to child at home if women cannot give birth to child at home only then they search phone number of driver for the management of transportation to bring hospital for delivery of headquarter.

A safe delivery kit is a small medical box which is used at the time of delivery. This is a small well-prepared and well-composed kit box which contains a razor, blade, cutting surface, plastic sheet, a piece of soap, string and pictorial instruction. And it prevents from infection and others diseases. If there is home delivery it should be manage beforehand for safety of mother and child. In the study area, only 30 percent respondents have managed of it beforehand others 70 percent respondents they did not manage of it. The respondents they manage of safe birth kit they answered that it should be used in the period of delivery because its material is clean and it prevent from diseases. And the respondents they did not manage of safe birth kid they answered that they did not know about safe birth kid. In the study area it is found that nobody have managed of blood.

5.3 Natal Care

This section presents the knowledge and current practices which are performed at the time of the natal care of women of Lekhani VDC i.e. birth place or place of delivery, person who assisted at the time of delivery, use of safe birth kit etc. And it, further describes their knowledge on dangerous sign and symptoms that may harm or take the life of both mother and child during delivery like prolonged labor,

excessive bleeding, high fever, mal presentation, placenta not expelled within 30 minutes, convulsion etc.

5.3.1 Delivery Practices of Respondents

Safe delivery refers to the process of delivering the child safely under the supervision of doctors, nurses, ANM, HA, AHW, Midwife or TBAs either at health post, home or at hospital. This process also deals with the application equipments that are used at the time duration of labor. The forceps delivery and operation are also the major ways of safe delivery. In our society, most of the deliveries take place at the home and are assisted by untrained birth attendants. According to Nepal Demographic Health Survey 2011, still around 64 percent women give birth to child at home without the presence of trained person. Only 36 percent women give birth to child at the presence of trained person. For most of the women of study area the place of delivery is their own home and get proper help by birth attendants, local midwife, HA and ANM.

Table 16: Birth Place for Delivery

Place of Delivery	Frequency	Percent
Home	33	66.0
Hospital	17	34.0
Total	50	100.0

Source: Field Survey 2012

Table 16: shows 66.0 percent of the women had given birth to their child at home and 34.0 percent of the women had given birth to their child in the hospital. Above data indicates that more respondents give and are giving birth to child at their own home in the study area.

5.3.2 Assistants who help during the Period of Delivery

According to Nepal Demographic Health Survey 2011, Women's health has improved over the last five years. In 2011, 58% women received antenatal care from a

skilled service provider in comparison to 44% women in 2006, and more than one in three (36%) births are delivered with the assistance of a skilled birth attendant which was currently compared with less than one in five births (19%) five years ago. Similarly, institutional delivery has also increased from 18% in 2006 to 35% in 2011. The following table shows that majority percent of women who have delivered their child with the assistance of a skilled birth attendant.

Table 17: Assistants during Period of Delivery

Assistants during period of Delivery	**Frequency**	**Percent**
Doctor	4	8.0
Nurse	17	34.0
HA	7	14.0
TBA	9	18.0
Family Member/ neighbours	13	26.0
Total	50	100.0

Source: Field Survey 2012

Above data shows that, the proportion of women who are assisted by a skilled birth attendant during the period of delivery is 74.0 percent. Among them only 8.0 percent women are assisted by doctor, 34.0 percent women are assisted by nurses and 14.0 percent women by HA (Health Assistant) and others 18.0 percent women by TBA (Traditional Birth Attendant). And the proportion of women who are not assisted by a skilled birth attendant during their period of delivery is 26.0 percent. From the above data, it is clear that a vast majority percent of women prefer to deliver the child with the help of a skilled birth attendant.

5.3.3 Safe Delivery Kit

A safe delivery kit is a small medical box which is used at the time of delivery. This is a small well-prepared and well-composed kit box which contains a razor, blade, cutting surface, plastic sheet, a piece of soap, string and pictorial instruction. It is assembled by maternal and child health product private limited for

the safe delivery practice. The following table describes the use of safe delivery kit by women of the study area.

Table 18: Use of Clean Safe Delivery Kit

Use of Safe Delivery Kit	Frequency	Percent
Yes	42	84.0
No	8	16.0
Total	50	100.0

Source: Field Survey 2012

In the study area, the proportion of women who had used of safe delivery kit is 84.0 percent and the proportion of women who did not use the safe delivery kit is 16.0 percent that means a vast majority percent of women had used safe delivery kit.

5.3.4 Knowledge of Respondents on Danger Symptoms during Delivery

Sometimes, dangerous symptoms can be seen during the period of delivery such as excessive bleeding, mal presentation, placenta not expel within 30 minutes, prolong labour, convulsions, high fever etc. These may cause death. In our society, still some of the women are unknown about it due to illiteracy and carelessness. The following data shows that still some of the women in the Lekhani VDC are unknown about dangerous symptoms during delivery.

Table 19: Knowledge on Dangerous Sign and Symptoms during Delivery

Having knowledge on Dangerous sign and symptoms	Yes	Percent	No	Percent
Prolong labour	5	10.00	45	90.00
Excessive bleeding	31	62.00	19	38.00
High fever	3	6.00	47	94.00
Mal presentation	14	28.00	36	72.00
Placenta not expelled within 30 minutes after delivery	2	4.00	48	96.00
Convulsion	0	0.00	50	100.00

Source: Field Survey 2012

Prolonged labour is one of the dangerous symptoms during delivery. The women cannot get help of trained health person in right time that may cause of death of both mother and child. In the study area it is in practice, first women try to give birth to child at home without help of trained person when she cannot give birth to child during long time and then only they search alternative ways (to bring trained health person at home, to take headquarter).

The table 19 shows that more number of women they did not know that the prolong labour is the one of dangerous symptoms during delivery. Because only 10 percent respondents have known that the prolonged labour is the dangerous symptoms during delivery others 90 percent are unknown about that the prolonged labour is the dangerous symptoms during delivery. In the study area, it is found that 62 percent respondents have known that excessive bleeding is one of the dangerous symptoms during delivery others 38 percent respondents they did not have knowledge that excessive bleeding is dangerous symptom during delivery. That means most of women they are known about it. High fever is also abnormal condition during delivery. It is also a dangerous symptom. In the Lekhani VDC it is found that only 6 percent respondents have known that high fever is dangerous symptom during delivery others 94 percent respondents they are unknown about it. From this data it is clear that still more number of respondents did not have knowledge about the high fever is one of the dangerous symptom during delivery.

According to table 19 more number of women did not have knowledge that mal presentation is dangerous symptom during delivery. Because only 28 percent respondents have answered that mal presentation is dangerous symptom others 72 percent respondents have answered do not know about it. That means 72 percent women are unknown about that mal presentation is danger for both mother and fetus. And it is found that only 4 percent respondents have answered that placenta not expelled within 30 minutes after delivery is dangerous symptoms. Others 98 percent respondents have not answered. It means majority numbers of women are unknown about it.

5.3.5 Education Level of the Respondents and Knowledge on Dangerous Sign and Symptoms during Delivery

Higher education enlightens people, enhances and broadens the knowledge so people naturally get ideas to get rid of problems hence; there is a relationship between education and knowledge. The following data also shows there is a relation between education and knowledge level in response with the dangerous symptoms that occur during delivery. The following table below displays how education and knowledge are interlinked with each other and their relation.

Table 20: Education Level and Knowledge of the Respondents about Dangerous Symptoms in the Following Cross Tabulation

Education of the Respondents	Knowledge Level of Respondents on Dangerous Symptoms during Delivery				Total
	One	Two	Three	Don't know	
U.S.L.C.	12	9	1	12	34
S.L.C.	2	5	0	2	9
I.A	1	4	2	0	7
Total	15	18	3	14	50

Source: Field Survey 2012

Regarding the cross tabulation between education of the respondents and knowledge of the respondents on dangerous symptoms during delivery, 12 respondents with under SLC has no knowledge about dangerous symptoms during delivery similarly 2 respondents with SLC are also unaware about it too. But the respondents with IA are aware about the dangerous symptoms which may harm and take life during delivery that means all respondents with IA education they are known and well aware with dangerous symptoms which may occur during delivery. This table proves that the education level of women play vital role to decrease maternal mortality.

5.4 Post Natal Care

Post natal care is a health care service which a mother and her newly born baby receive after the delivery of the child. In our society, acceptance and practice of postnatal care is rare because of socio-cultural aspects and issues. In the study area, around 50.0 percent respondents had not received postnatal care after delivery and when the baby or the mother gets problems then only taken to health post or then only they were given medicinal care at home. The following table tells the responses of respondents in regards of medicinal treatment they got at the period of post natal time.

5.4.1 Health Checkup of the Mother and Child after Delivery

Health check up of the mother and child after delivery is not in practice in many rural areas due to different causes. But it is necessary to check up of both mother and child after delivery to know health condition. In the study area it is found that around 50 percent women they have check up their health after delivery.

Table 21: Checkup of Mother's Health after Child Born

Check-up of mother after child born	Frequency	Percent
Yes	26	52.0
No	24	48.0
Total	50	100.0

Source: Field Survey 2012

Table 21 depicts the checkup of physical condition of the mother after delivery. The proportion of women who have checked their health after delivery is 52.0 percent and who have not checked their health after delivery is 48.0 percent. That means around 50 percent women still do not do any checkup or medicinal treatment after delivery.

Table 22: Checkup with Different Health Persons by Respondents after Delivery

Check Up by Respondents	Frequency	Percent
Doctor	7	14.0
Nurse	12	24.0
Other	7	14.0
Not Done	24	48.0
Total	50	100.0

Source: Field Survey 2012

According to table 22, 14.0 percent respondents had got checked up their health with doctor so they have given birth to child safely at hospital of headquarter of Baglung district. Other 24.0 percent respondents had got checked up with nurse and rest 17.0 percent respondents had got checked up with the local midwife because some of them are found to have been suffered from high bleeding, high blood pressure etc after delivery. Other 48.0 percent respondents did not follow any check up procedure to know their health condition. The respondents who did not get checked after delivery, their condition was normal too. Both mother and child are found to be in good condition. But according to the respondents who did not check followed it they viewed that it is necessary to checkup the health and condition of both mother and child in the problem at stage of post natal time but not necessary in normal condition. So around 50 percent respondents did not have any checkup after their delivery in the study areas.

Table 23: Status of Baby's First Health Check Up

First Health Check up of Child	Frequency	Percent
Not Done	7	14.0
Within 3	16	32.0
Within 7	4	8.0
After 7	23	46.0
Total	50	100.0

Source: Field Survey 2012

Table 23 shows that 32.0 percent respondents they have checked the health condition of their baby within 3 days and 8.0 percent respondents they have checked their baby within 7 days and other 46.0 percent respondents they have done it after 7 days. But still rest 14.0 percent respondents they did not check the health condition of their baby sooner after delivery.

5.4.2 Knowledge of Respondents on Essential Care of Baby

To wipe with soft clean and dry cloth and keep baby wrapped with clean cloth, hours after delivery etc are essential care of newly born child. In the study area most of women are still unaware about it. They have been using old clothes such as saari lungi and old bed cover for newly child. They did not have any manage such as soft, clean and dry clothes for child and mother. The table 24 describes the knowledge of respondents about essential care of baby.

Table 24: Knowledge of the Respondents about Essential Care of Baby

Knowledge on Essential care of baby	Yes	Percent	No	Percent
To wipe with soft, clean and dry cloth and keep baby wrapped with clean cloth	20	40.00	30	60.00
To feed colostrums within an hour of birth	22	44.00	28	56.00
Keep baby warm	45	90.00	5	10.00
Not to bathe till 24 hours after delivery	15	30.00	35	70.00

Source: Field Survey 2012

According to table 24, 40.0 percent respondents have had knowledge about that soft, clean and dry clothes is needed for child others 60.0 percent respondents did not have knowledge about it. During my observation period I found that a few child were wrap with old and dirty clothes and their clothes was made from old saari which is not good for child of health. The respondents were questioned about it but they replied that new clothes will make only after nwaran. And 44.0 percent respondents have known that colostrums should be feed to child as soon as fast of birth. Others 56.0 percent respondents did not have knowledge about it. 90.0 percent respondents have answered that baby should keep in warm others 10.0 percent did not have

answered. And only 30.0 percent respondents have answered not to bathe till 24 hours after delivery others 70.0 percent have not answered about it.

5.4.3 Breast Feeding to Child

In our society, colostrums are not good for newly born baby. So most of the women do not feed colostrums to newly born baby after delivery. In the study area, some women replied that it was not good for the health of baby and for sure mother-in-low did not do it to her children too. So it has become tradition not to feed colostrums to newly born baby. But it is very important that colostrums should be fed to newly born baby as soon as after delivery because colostrums contain a lot of antibodies which helps baby to resist against diseases. In the study area, the majority is of the women who are aware about the advantages of colostrums. The following table shows that more women fed colostrums to their child after delivery. So, in the study area, majority women have known about advantage of the colostrums for baby.

Table 25: Throw the Colostrums before Feeding to Child

Feeding Colostrums to Child	Frequency	Percent
Yes	14	28.0
No	36	72.0
Total	50	100.0

Source: Field Survey 2012

Above table shows that 72.0 percent women had fed their (colostrums) breast milk to child. That means they did not throw their first colostrums and well about the benefits of it. Other 28.0 percent women had thrown colostrums before the first breastfed of newly born baby. That means they didn't know about the advantages of the first breastfed (colostrums) to new born child.

There are many advantage of immediately breast feeding such as child get nutrients soon, prevent breast abscess and help to shrunk uterus etc. The following table describes the knowledge about advantage of immediately breast feeding.

Table 26: Knowledge of Respondents about Immediately Breast Feeding to Child

Having Knowledge of Immediately Breast Feeding to Child	Frequency	Percent
Yes	26	52.0
No	24	48.0
Total	50	100.0

Source: Field Survey 2012

According to table 26, there were 52 Percent respondents who have knowledge about advantage of immediately breast feeding to child. And it is found that 48 percent respondents did not have knowledge about it. Still around 50 percent women are unknown about its advantage. The respondents who have knowledge about it were asked, they answered that immediately breast feeding prevents breast abscess and child get nutrition soon. The following table describes detail data about it.

Table 27: Knowledge level of Respondents about immediately Breast Feeding to Child

Having Knowledge on Immediately Breast Feeding	Yes	Percentage	No	Percentage
Prevent Breast Abscess	22	44.00	28	56.00
Get Nutrients Immediately	11	22.00	39	78.00
Immediate flow of milk	0	0.00	50	100.00

Source: Field Survey 2012

The table 27 shows that 44 percent respondents have knowledge that, immediately breast feeding prevents breast abscess. Others 56 percent respondents did not have knowledge that, immediately breast feeding prevents breast abscess. It means more numbers of women are unknown about it. And only 22 percent respondents have knowledge about immediately breast feeding provides nutrients soon to newly born child. And others 78 percent respondents are unknown about it.

All respondents are unknown about immediately breast feeding help to come out milk soon.

5.4.4 Vitamin A Capsule

It is very important to take Vitamin A Capsule within 45 days of delivery which prevents mother from disease like, night blindness, malnutrition etc. According to table 28, majority 86.0 percent respondents had received Vitamin A Capsule within 45 days after delivery provided by Female Community Health Worker (FCHW) but 14.0 percent respondent they did not receive Vitamin A Capsule. Because they didn't know about the capsule and nobody suggested to them about it.

Table 28: Taken Vitamin A Capsule within 45 Days of Delivery

Taken Vitamin A	Frequency	Percent
Yes	43	86.0
No	7	14.0
Total	50	100.0

Source: Field Survey 2012

Most of the Nepalese women in rural area have to work soon after delivery. Particularly, after 11 days, because they are supposed to be freed or purified within 11 days by doing *nwaran* of the newly born baby. After then, she has to cook, tidy house, and look after pets and so on. She has to manage all household tasks as a result more of women in rural areas are suffering from uterus prolepsis. The table 29 shows that present condition or practices of women of Lekhani VDC when they start to work after delivery.

Table 29: Start to Work after Delivery

Start to work	Frequency	Percent
After 15 days	24	48.0
After 20 days	6	12.0
After 1 month	13	26.0
After 2 months	7	14.0
Total	50	100.0

Source: Field Survey 2012

Above table shows that 48.0 percent respondents had started to work after 15 days of delivery because of the absence of assistant at home due to separation from joint family and some their husband were gone to foreign country for job. During my observation it is found that a woman with 6 days child she was alone in the partition house only her mother in law used to come on the time of giving food and making food. A few days after the delivery, they get supported by other family members and simultaneously they have to start working. And 12 percent respondents have started to work after 20 days. 26.0 percent have started to work after 1 month because they were helped by other members in joint family. Rest 14 percent respondent they start to work after 2 months of delivery because they have brought to mother's house after few days of delivery.

5.4.4 Immunization for Children

According to Nepal Demographic Health Survey 2011, Immunization Coverage among children has slightly increases during this period. Currently, 87 percent of children aged 12.23 months are immunized against the six major childhood diseases whereas 83 percent of children were fully immunized in 2006. The following table describes the data of immunization of the study area.

Table 30: Immunization of Children

Immunization for children (against five vaccine preventable diseases such as BCG 1, Polio, DPT 3, Measles 1)	Frequency	Percent
Complicit	42	84.0
Not complete	8	16.0
Total	50	100.0

Source: Field Survey 2012

In the study area, 84 percent children have completed their all vaccination such as BCG (single dose), DPT (three doses), and against measles (single dose) polio and all respondent's children received Vitamin A Capsule. 84.0 percent children have completed their immunization and still 16 percent children are receiving

immunization. That means they have not completed due to under age some of them are 2 months age of children and some are 3 months age etc. In the study area all the respondents are aware about the immunization of their baby.

5.4.5 Start Giving Food and Liquid to Child

According to Nepal Demographic Health Survey 2011, Nepalese children are better nourished than in the past. Children under five years of age, 41% are chronically malnourished, as measured through stunting, and 11% are wasted, a measure of acute malnutrition. While still high, those statistics represent a reduction from 2006 when 49% were stunted and 13% were wasted. Furthermore, the data shows 29% of Nepalese children under age are underweight in 2011 which is decreased from 39% in 2006.

Table 31: Start Giving Food and Liquid to Child in Addition to Breast Milk

Start Giving Food and Liquid to Child	Frequency	Percent
From 5 month	9	18.0
From 6 month	36	72.0
From 7 month	3	6.0
above 7 month	2	4.0
Total	50	100.0

Source: Field Survey 2012

According to table 31, 72.0 percent respondent they have started to give food and liquid to child after 6 months in addition to breast milk. They answered that "after 6 months we have to feed adequate food and liquid to the baby because only mother's milk is not sufficient for growing baby and cannot fulfill nutrition to baby." And 18.0 percent respondents have started to give food and liquid after 5 months because their breast milk was not sufficient to baby. Rest 8.0 percent respondents have started to give food and liquid to baby after 7 months of age. Respondents who have started to give food and liquid to children after 7 months they answered "breast milk was sufficient to children". And they are also unknown about the fact after 6 months a

baby needs good adequate food and liquid in addition breast milk. During my observation period I found that a child with 11 months who had suffered from malnutrition because he was unable to sit properly without assistance of other person. It may be due to lack of proper knowledge of the mother toward adequate food for child. According to Joshi R. Arun, schooling equips women with specific skills and disposition or identity which significantly predict two principles, domains of Health-care behavior: Use of medical services; and change in household health behavior. It was also found that women with schooling had healthier children using height for-age as an indicator of Health.

5.4.6 Family Planning

According to Nepal Demographic Health Survey 2011, it has noted the decline in fertility over the past fifteen years. Currently women have an average of 2.6 children during their lifetimes. This represents a steady decline in fertility since 2006 hereafter women are giving an average birth of 3.1. The trend of fertility has been changed due to various aspects such as education, awareness programs organized and implemented by NGO, INGOs, employment of husband in foreign and use of different contraceptives etc.

The trend of family planning has remained essentially the same since 2006. Use of female sterilization has dropped slightly, from 18% in 2006 to 15% in 2011, while male sterilization has increased, from 6% in 2006 to 8% in 2011. Practice of traditional methods of family planning has also increased, from 4% in 2006 to 7% in 2011, due to an increase in the use of withdrawal. The 2011 NDHS also reveals that 27% of married women have an unmet need to family planning – 10% for birth spacing and 17% limiting. (Nepal Demographic health Survey, 2011). This data shows that trend of family planning has not increased rapidly but women are having an average of 2.6 children during their lifetimes. Likewise the following data shows that a vast majority of respondents doesn’t use contraceptives and aware about family planning.

Table 32: Using Family Planning

Use of Family planning	Frequency	Percent
Yes	12	24.0
No	38	76.0
Total	50	100.0

Source: Field Survey 2012

Table 32 demonstrates that only 24.0 percent respondents have used different contraceptives and planned family planning at the post natal period. And other 76.0 percent respondents had not used contraceptives and made family planning. The respondents who used different contraceptives and kept birth spacing, they answered they had used contraceptives "to stop unwanted pregnancy" and the respondents who did not use any means of family planning, they answered "Husband is not with me or husband is in foreign country for the job." From the above data it is clear that more respondents haven't made family planning, used contraceptives and aware about birth spacing. The respondents who used contraceptives, kept birth spacing between children and made family planning were only 24.0 percent.

Among them 6.0 percent respondents had used means of family planning within 2 months after delivery. And 18% respondents have used temporary means of family planning after 3 months of delivery. Rest 16 % had used means of family planning after 4 months of age of baby others 76 % did not have used any means of family planning due to different causes.

Table 33: Age of Baby of Starting Family Planning

Age of baby of starting Family Planning	Frequency	Percent
After 2 month	3	6.0
After 3 month	1	2.0
Above 4 month	8	16.0
Did not use	38	76.0
Total	50	100.0

Source: Field Survey 2012

The table 33 shows that 6.0 percent respondents had used means of family planning within 2 months after delivery. And 18% respondents have used temporary means of family planning after 3 months of delivery. Rest 16 % had used means of family planning after 4 months of age of baby others 76 % did not have used any means of family planning due to different causes.

Table 34: Knowledge about Advantage of Birth Spacing

Knowledge of Birth Spacing	**Frequency**	**Percent**
Yes	46	92.0
No	4	8.0
Total	50	100.0

Source: Field Survey 2012

Table 34 shows that 92.0 percent respondents have knowledge about advantage of birth spacing. Only 8.0 percent respondents did not have any knowledge about it. Because they have not given any answer. The respondents were asked about advantage of the birth spacing they answered that it makes us healthy and happy. From the above data it is clear that in Lekhani VDC majority percent of women they have knowledge about birth spacing.

5.4.7 Habit to Wash Hand with Soap

Habit to wash hand with soap is important before preparing food, having food, feeding child to prevent from diseases such as diarrhea, warm and vomiting. But in the rural area it is not in practice due to many causes. The following data shows the habit to wash hand of the women of the study area.

Table 35: Habit of Respondents to Wash Hand with Soap

Habit to wash Hand with Soap	Yes	Percentage	No	Percentage
Before preparing and having Food	16	32.00	34	68.00
Before Feeding Child	30	60.00	20	40.00
After Defecation	45	90.00	5	10.00

Source: Field Survey 2012

According to table 35 only 32 percent respondents have habit to wash hand with soap before preparing and having food. Others 68 percent respondents did not have habit to wash hand with soap. From this data it is clear that majority percent respondents they do not have habit to wash hand with soap before preparing and having food. In the study area, 60 percent respondents have habit to wash hand with soap before feeding child others 40 percent respondents did not have habit to wash hand with soap before feeding child. From this data it is clear that majority percent respondents have habit to wash and with soap before feeding child. And majority percent respondents have habit to wash hand with soap after defecation. 90 percent respondents have habit to wash hand with soap after defecation only 10 percent respondents did not have habit to wash hand with soap after defecation.

5.4.8 Knowledge of the Respondents on Dangerous Sign and Symptoms after Delivery

Excessive bleeding, vaginal discharge with foul smell, weak and pale, convulsion, lower abdominal pain etc are dangerous sign and symptoms after delivery. Somehow, these dangerous sign and symptoms can be appeared after delivery which may lead to death of both mother and fetus. Most of rural area's women still are unknown and unaware about the dangerous sign and symptoms of diseases that appear after delivery due to illiteracy and carelessness. The table 36 shows the knowledge of women of the study area about the dangerous sign and symptoms that may occur after delivery.

Table 36: Knowledge on Dangerous Sign and Symptoms after Delivery

Knowledge of Respondents on Dangerous sign and symptoms	Yes	Percent	No	Percent
Excessive bleeding	35	70.00	15	30.00
Vaginal discharge with foul smell	2	4.00	48	96.00
Lower abdominal pain	6	12.00	44	88.00
Convulsion	4	8.00	46	92.00
Pale and weak	2	4.00	48	96.00

Source: Field Survey 2012

Excessive bleeding is one of the dangerous symptoms after delivery. If women get late to rich hospital in right time it may cause of death. In the study area it is found that more number of women they have had knowledge that excessive bleeding is danger for mother. The following table shows that only 30 percent women they did not know about it or they did not have answered. Others 70 percent women they have answered that excessive bleeding is danger for health of mother.In the Lekhani VDC, only 4 percent respondents have known that vaginal discharge with foul smell is a dangerous symptom. Others 96 percent respondents are unknown about that vaginal discharge with foul small is danger. It means more number of respondents have unknown about it.

In the study area, only 12 percent respondents have known that lower abdominal pain is dangerous symptoms after delivery. Others 88 percent respondents they did not have answered that lower abdominal pain is a dangerous symptom. Form this data it is clear that more respondents have not knowledge about it. And only 8 percent respondents have known with convulsion is a danger symptom after delivery others 92 percent respondents they are unknown with convulsion is a danger. It means more numbers of respondents are unknown about it.

When women become weak and pale after delivery it is also abnormal condition. In the study area it is found that only 4 percent respondents have known that pale and weak condition of women after delivery is a dangerous symptom. Others 96 percent respondents did not know that weak and pale condition of women is danger. It means the proportion of unknown women about it is more than known women.

Health education level increased the knowledge level of people. It means there is a mutual relationship between education and knowledge. In the study area, it is found that the respondents with high level of education have known the dangerous symptoms that may occur after delivery. And the respondents with low level of education are little aware about it.

Table 37: Education Level of the Respondents and Knowledge on Danger Signs and Symptoms after Delivery

Education of the Respondent	Knowledge Level of Respondent on Danger Symptoms after Delivery					Total
	One	Two	Three	Four	Don't Know	
U.S.L.C.	17	6	1	0	10	34
S.L.C.	6	1	0	0	2	9
I.A	4	1	1	1	0	7
Total	27	8	2	1	12	50

Source: Field Survey 2012

Above cross tabulation between education level of respondents and knowledge level of respondents about dangerous symptoms that occur at post natal period shows that 10 respondents with under SLC and they did not know about any dangerous symptoms and 2 respondents with SLC were also not aware about dangerous symptoms after delivery but all respondents with I.A. had known about danger symptoms which may occur after delivery, that means all respondents with I.A. have known and aware of dangerous symptoms that mostly occur at the post natal period. From this data it is clear that education level increases knowledge level. Education determines knowledge and understanding level woman during prenatal and postnatal period.

CHAPTER –VI

SUMMARY AND CONCLUSION

6.1 Summary

This study analyzed the knowledge, practices and perception of women of the Lekhani VDC. Main objectives of this study were to examine knowledge and practice and to find out main factor which play an important role to increase problems of the maternal health.

Judgmental/purposive sampling method had used for the selection of the respondents and the data was collected through interview schedule and observation. The collected quantitative data were edited and coded carefully for the computer entry. The edited and coded data were processed and analyzed in SPSS software. The frequency tables were reviewed and description of the information was prepared. The primary analysis was done based on frequency and percentage using tables. Throughout the data processing and analysis, the current status of knowledge and practice of women of the Lekhani VDC were examined. Then the main cause of increase problems related with maternal health was identified.

The respondents were selected who have below 5 years child. It has found that majority of the respondents are under SLC. 68 percent of respondents are still under SLC and 18 percent of respondents are with SLC. Rest 14 percent are with IA. According to data majority numbers of respondents with under SLC have found that lack of knowledge about danger symptoms during three periods (pre natal, natal and post natal). Majority of the respondents they have given birth to child after maturity (after 20 years). The study area is inhabited of different local indigenous people like Magar, Gurung, Newar, Thakali, Chhantyal, Brahmin, Kshetri, and other lower caste Dalits. The respondents have chosen by purposive/judgment sapling method. 18 percent respondents are from Brahmin, 4% are from chhetri, 40% are from Janjati and 38% are from Dalit.

In the study area, more numbers of respondent have had knowledge on maternal health such as ANC visits; receive iron/folic acid, TT vaccination, Diet etc. But still less than 50 percent respondents are unaware about dangerous sign and symptoms of three periods (pre natal, natal and post natal). Particularly, Respondents with under SLC are unknown about it. And it is found that their knowledge and practice have been affecting by socio-cultural practice because more numbers of respondent have given birth to child at home without trained person.

In the study area, it is found that more numbers of respondent have visited for ANC. Only 2% respondents did not visit due to carelessness. 75% women have visited more than 4 times for ANC check up with trained person. Still 25% women have visited less than 4 times for ANC check up. And 96% respondents had taken iron or folic acid rest 4% had not taken it. 50% women have received iron/folic acid more than 250 days. Others 50% have taken it less than 250 days.96% women they have taken TT vaccination rest 4% women did not taken it. And 90% women have taken TT vaccination more than 2 times rest 10% have taken it only once. 50% women they have had food more as usual and 44% have had same as usual rest 6% have had less as usual. It means majority percent women are aware about maternal health.

In case of dangerous sign and symptoms, majority percent of women were unknown. 80% women were unknown with swelling on legs, arms and face on pregnancy, 96% were unknown with high fever during pregnancy, 98% women were unknown with failure to gain weight during pregnancy and 36% were unknown with bleeding during pregnancy. All respondents were unknown with anaemia, high blood pressure and blurred vision. From this data it is clear that more numbers of women are unknown about dangerous sign and symptoms during pregnancy. Particularly women with under SLC were unknown with these sign and symptoms.

In the study area, 66.0 percent of the women had given birth to their child at home, among them 26% women had given birth to child without assisted by trained person, and 34.0 percent of the women had given birth to their child in the hospital. Above data indicates that more respondents give and are giving birth to child at their own home in Lekhani VDC. It means practice and perception of respondents have been affecting by their socio culture. And 84% respondents had used of safe delivery

kit rest 16% did not use of it. It means majority percent women they have known with safe delivery kit. The respondents have less knowledge about dangerous sign and symptoms during delivery because only 10% women have known with prolong labor, 28% women have known with mal presentation, 62% have known with excessive bleeding, only 6% women have known with high fever and only 4% women have known with placenta not expelled within 30 minutes after delivery.

The proportion of women who have checked their health after child born is 52 rest 48% women they did not check any. And 72% women had fed their colostrums to child after soon delivery others 28% women had thrown colostrums before the first breastfed of newly born child. It means still some women they did not know about the advantage of colostrums to new born child. It is also the result of socio cultural practice because some respondents were answered mother in law suggested to throw colostrums. And 14% women they did not taken vitamin A capsule because they did not know about it and nobody suggested to them about it. Around 50% women they have started to work after 15 days of delivery due to separation from join family and some their husband were gone to foreign country for job. But they have known with women must take rest at least 2/3 months.

In the study area, it is found that all women have known with immunization of their child. Still 10% women they had not known that after 6 months child needs good adequate food and liquid in addition breast milk of mother. In case family planning, 76% women they had not used contraceptives and made family planning because their husband is in foreign country. 92% women they have knowledge about the advantage of birth spacing. Still more than 50% women they did not have habit to wash hand with soap before feeding to child due to proper knowledge and awareness.

In case of dangerous sign and symptoms after delivery, 30% women were unknown with excessive bleeding, 96% women were unknown with vaginal discharge with foul smell, 88% women were unknown with lower abdominal pain, 92% women were unknown with convulsion and 96% women were unknown with pale and weak. It means majority proportion of women they are unknown with dangerous sign and symptoms after delivery.

In the study area, more numbers of respondent have had knowledge on maternal health such as ANC visits; receive iron/folic acid, TT vaccination, Diet etc. But still less than 50 percent respondents are unaware about dangerous sign and symptoms of three periods (pre natal, natal and post natal). Particularly, Respondents with under SLC are less knowledgeable about it. And it is found that their knowledge and practice have been affecting by socio-cultural practice because more numbers of respondent have given birth to child at home without trained person.

6.2 Conclusion

It was found that majority of the respondents have visited for the ANC check up. Almost all the women have easy access to SHP for ANC. It may be because of all health care services are free of cost and in the study site there are no other private medicals or clinics so people have no other options. Also some women seek ANC in Zonal Hospital of the Baglung District and other private clinics. Most of the mothers 98 per cent received antenatal care and 72 percent respondents have visited at least 4 times or more than 4 times for ANC check up. Those respondents who received antenatal care were mostly aware by Television, Radio etc. The acceptance of iron tablets, TT-Vaccination and Vitamin 'A' was high among these women. So it shows that mobility of women in accessing health care is going to increasing.

The delivery practices of more women has been affecting by their socio cultural practice because still 66 per cent of the deliveries had taken place at home. Among them 26 percent deliveries had without the assistance of trained medical personnel. The main person who assisted during the delivery was family members. But the use of clean delivery kit was high. The postnatal care of those women was not satisfactory because majority of the women they have been giving birth to child at home in help of family member/neighbor and they have started to work after 15 days of delivery.

From the above result, we can conclude that more number of women they are aware or have knowledge about maternal health but less number of women has knowledge about dangerous sign and symptoms during three periods (pre natal, natal and post natal). And also we can conclude that the main cause of increasing problems

of the maternal health is their socio cultural practice such as no preparation for the delivery (Transportation, soft and dry clothes for mother and child, safe delivery kit, inform to trained person beforehand and no checkup of physical health of mother after delivery etc), home delivery without trained person, physical load on the pregnancy and starting work after soon delivery etc.

REFERENCES

Baker, Therese L. (1999) *Doing Social Research* (3rd ed.). MacGraw Hill, Inc., New York,

Chaudhari,P. (2067BS) *Pisab Chuhine Samasya* Naari Magazine (mansir), Kantipur Complex, Subidhanagar, KTM, Kantipur Publication (Pra).li.

Gautam, T.R. (2066) *Social Research Methodology.* Vidyharthi pustak vandar bhotahity, KTM.

Gautam, Kamala. (2009) *Nepal's Infant, Maternal Mortality Rates worst in South Asia*

Joshi, R.Arun. (1994) *Maternal Schooling and Child Health: Preliminary analysis of the intervening mechanisms in rural Nepal*, Health Transition Review Vol.4.no.1. JSTOR, National Center for Epidemiology and Population Health (NCEPH) The Australian National University

LeVine, RA., LeVine SE., Rome ML. (2004) *Maternal literacy and health behavior: a Nepalese case study*

Misra, Sangeeta. (2009) *Women's Health in Nepal* http://www.nhttp://www.pri.org/stories/health/global-health/womenhealth

Nepal Demographic Health Survey, 2006. Ministry of Health and Population, Government of Nepal, Kathmandu, New Era, Macro International Inc. Calverton, Maryland, U.S.A., Nepal Demographic and Health Survey 2006, Adult and Maternal mortality; P102, P137, P 190

Nepal Demographic Health Survey, 2011. Population Division Ministry of Health and Population, New ERA, MEASURE DHS and U.S. Agency for International Development (2011)

Regional Health Forum WHO South-East Asia Region: Volume 6, Number 1, Geneva

Shrestha, Roman. (2012) *Maternal Mortality in Nepal: Adrressing the Issue.* Student pluse,4 (10). Retrieved from http://www.studentpulse.com/a?id=708

Suwal V. Juhee. (2001) *Maternal Mortality in Nepal: Unraveling the complexity,* Department of Family Medicine, University of Alberta Edmonton, Alberta, Canada T6G2C8

http://www.globalpressinstitute.org/print/199
nepal422.htmlsmp.org/pregnancy_childbirth_nepal/index.html
Pdf.usaid.gov/pdf-docs/PNADM572.pdf.PDF file
www.infoforhealth.org/elearning/antenatalcare.shtml
www.moh.gov.np/safemotherhood
www.who.int/making_pregnancy_safer/
www. Safemotherhood.com

INTERVIEW SCHEDULE

Identification

Interviewer's Name: Interview Date:

District: VDC/Municipality:

Ward No:

-Information about Respondent

Name: Age:

Ethnicity:

Antenatal care

1) Did you see anyone for antenatal care while you were pregnant with baby? If yes/no why?

O. no a. yes

……

……

……

2) Whom did you see?

a. Doctor b.ANM/Nurse

c. MCHW x. Others (specify)

3) During your antenatal care were you counseled on the following?

a. Delivery preparation
b. Breast feeding
c. Family planning
d. Immunization
e. Danger signs of pregnancy
f. Nutrition
g. No counseling
x. Others(specify)

4) How many times did you see someone for care during the pregnancy? and why?

a. 2 times b. 3 times

c. 4 times d. More than 4 times

……

……

…….

5) Before you gave birth to child did you receive an injection TT (vaccine) in the arm? If yes/no why?

O. don't know a. yes

b. no

……

……

……

6) How many times did you receive such an injection?

0. don't know a. Once

b. Twice c. more than two times

7) During pregnancy did you consume Iron/ folic acid? If yes/no why?

O. don't know a. yes

b. no

……

……

……

8) For how long did you consume iron/ folic acid?

Number of……..days

9) During pregnancy what was your food pattern same as usual, more of less than usual? If more or less than usual why?

a. same as usual b. more than usual

c. less than usual x. others(specify)

……

……

……

10) What danger symptoms require immediate medical assistance during pregnancy?

O. don't know a. fast and difficult breathing

b. bleeding c. swelling on legs, arms, face

d. high fever e. high blood pressure

f. anemia g. blurred vision

h. persistent vomiting i. failure to gain weight during pregnancy

11) What preparations did you do for delivery?

O. don't know a. arrangement of money

b. arrangement of person for blood transfusion in case of emergency

c. arrangement of transportation

x. others (specify)

12) What preparations did you do for home delivery? And why?

O. don't know

a. informing the skilled attendant for delivery beforehand

b. arrangement of delivery materials for delivery to prevent newborn from infections (clean thread, blade, plastic, coin, cloth)

x. others(specify)

……

……

……..

13) Was it pre decided on where to go for delivery? If yes/ no why?(if no skip 15)

a. Yes b. no

……

……

……

14) If pre decided what was the decision?

a. To take the help of sudeni (TBA)
b. To arrenge expenses for delivery
c. Where to go in difficulty
d. Helping person for transportation
e. Others (specify)

Natal Care

15) Where did you give birth to child? If home/ hospital/PHC/private clinic why?

a. home b. hospital

c. primary health care d. private clinic

16) Who assisted you in your delivery period?

a. doctor b. nurse/ANM

c. HA/AHW d. TBA

e. female community health volunteer

f. family member

17) What instrument was used to cut the cord?

O. don't remember a. new razor blade

b. old blade c. sickle/knife

d. bamboo blade e. others (specify)

18) Was a safe birth kit used during this delivery of baby? If yes/ no why?

O. don't know

a. yes b. no

……

……

……..

19) What danger symptoms require immediate medical assistance during delivery?

O. don't know a. prolonged labor

b. convulsions c. excessive beading

d. high fever e. lower abdominal pain

f. mal-presentation g. placenta not expelled within 30 minutes after delivery

x. others(specify)

20) After (baby) was born, did anyone cheek on your health? If yes/ no why?(If no skip 22)

a. yes b. no

……

……

……

21) By who were you cheeked?

a. doctor b. nurse/ANM

c. MCHW d. others (specify)

Postnatal care

22) How many days after the delivery of baby did the first cheek take place?

O. don't know a. within first three days

b. between 4-7 days c. after seven days

23) At that time, did the person cheek on baby's health as well? If yes/no why? (If no skip 25

a. yes b. no

……

……

……

24) If cheeked what advice was given?

a. keep the baby clean

b. bathe the baby timely

c. visit health facility if child is sick

d. breast fed within one hour and continue breast feeding for 6 months

e. keep the baby warm

f. immunize fully

g. family planning

x. others (specify)

25) How long after birth did you first put (baby) to the breast?

a. during the first hour of delivery

b. during 1to 8 hours of delivery

c. More than 8 hours of delivery

d. don't remember

x. others (specify)

26) Before putting the baby to the breast, did you throw the breast milk? if yes/no why?

a. yes b.no.

c. don't remember

……

……

……..

27) What are the advantages of breast-feeding immediately an hour after birth?

O. don' know a. Milk comes out immediately

b. prevents breast abscess c. gets nutrients immediately

x. others (specify)

28) Was baby weight at birth? if yes/no why? (If no skip 31)

O. don't know a. yes

b. no

……

……

…….

29) What was his/her birth weight?

O. don't know

……gm

30) Was the weight of baby at birth appropriate?

O. don't know a. smallest in size

b. bigger in size c. normal

31) What are the essential cares for new born? and why?

O. don't know

a. to wipe with soft, clean and dry cloth and keep baby wrapped with clean cloth.

b. to feed colostrums within an hour of birth.

c. keep baby warm

d. not to bathe till 24 hours after delivery

x. others (specify)

……

……

…….

32) What are the danger symptoms of new born?

0. Don't know a. fever or cold

b. unable to suck breast c. fast breathing of blue lips

d. Infection of stump or redness around stump

e. low birth weight –less than 2.5 kg

x. others (specify)

33) How long after delivery was baby bath for first time? Why?

…… hours.

……

……

……

34) What types of immediate care was gives to the new born (baby)?

O. don't know a. bathed

b. wrapped with warm cloth c. fed the newborn immediately

d. cleaned face/ nose

35) What danger symptoms require medical advice after delivery?

O. don't know a. fever

b. excessive bleeding c. vaginal discharge with foul smell

d. lower abdominal pain e. convulsions

f. redness around the breast g. pale and weak

h. repeated vomiting x. others (specify)

36) Did you take a vitamin A capsule within 45 days of delivery of child?

o. don't know

a. yes b. no

37) Do you have a card where (baby) vaccinations are written down? (If no skip 41)

o. don't know

a. yes b. no

38) Record information exactly as it appears on baby's vaccination card?

BCG	O	1		
DPT	O	1	2	3
Polio	O	1	2	3
Measles	O	1		
Vitamins A	O	1		

39) At what age of child should receive an injection to prevent measles?

o. don't know a. 6 month

b. 9 month c. above 9 month

40) Are you currently breast feeding to baby? If yes/no why? (if no skip 45)

a. Yes b. no

……

……

……..

41) For how long did you breast feed to baby?

Number of months……

42) Does baby eat or drink anything else besides breast milk? (if no skip 46)

a. Yes b. no

43) When did you start giving food and liquids to child in addition to breast milk?

Age of child……

44) At what age of child should a mother start giving her child foods or liquids in addition to breast milk? And why?

0. don't know a. after 4 months

b. after 5 months c. after 6 months

d. above 6 months

……

……

……..

45) When do you wash your hands with soap/ash?

a. never

b. before preparing and having food

c. before feeding child

d. after defecation

x. others (specify)

46) When did you start to work after delivery? And why?

a. after 15 days b. after 20 days

c. after 1 month d. after 2 months

……

……

……..

47) Are you currently using family planning? If yes/no why? (if no skip 47)

a. Yes b. no

……

……

……

48) If yes at what age of baby did you start family planning?

……months

49) What are the advantages of birth spacing?

0. don't know

a. for mother's health

b. for child's health

c. to prevent unwanted pregnancy

d. to have happy family

x. others (specify)

50) Have you any problem now which associated with maternal health? If yes/no why?

a. yes b. no

……

……

……..

51) If yes, from which disease you are suffering?

Name of disease…….

End