

CHAPTER ONE

INTRODUCTION

1.1 General Background of the Study

Health is one of the most important factors for the fulfillment of human needs and improvement of the quality of life. A healthy person is always cheerful and can do a full day's work without exhaustion. Even a poor man having good health can improve his living standard. The health of the people is considered the wealth of the nation.

According to Oxford English Dictionary (1989), "health is the state of being well and free from illness". The definition indicates that health is soundness of body and mind. It is the condition in which all the functions are duly and efficiently discharged. WHO has defined health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Two of the most important indicators of health situation of a country are life expectancy and infant mortality rate. The bleak health situation in Nepal with respect to maternal and child healthcare can be assessed by the single fact that until the 2001 Census reported for the first time that female life expectancy in Nepal was slightly higher than male life expectancy (60.7 years for women, 60.1 years for men), Nepal was one of the few countries in the world where a woman's life expectancy was lower than that of a man. Another indicator of female vulnerability in Nepal is the persistence of higher infant and under-five mortality rates for girls than for boys. According to Central Bureau of Statistics' (CBS) Nepal in Figures 2009, infant mortality rate is 48 and mortality rate under five is 61.

Nepal's child mortality declined during the 1990s, putting it on track for achieving the MDGs of reducing child mortality by two thirds by 2015. Infant mortality has also decreased. Nevertheless, this is still extremely high, as is

Nepal's maternal mortality, and there are sharp disparities between different groups that are related not only to economic status, rural/urban residence and region but also to gender, caste and ethnic identity.

There are many interrelated factors, cultural, religious and social beliefs and norms (especially those that reflect the entrenched gender, caste and ethnic hierarchies), as well as economic, institutional and location-related specificities behind these differential health outcomes. Women's health outcomes are directly affected by their subordinate status vis-à-vis the men and the senior women in the family. In addition, females tend to be less valued than males, and this is reflected in poorer female performance on all indicators, especially education and health.

Health outcomes are the worst for women because of biology, specifically their reproductive roles. The biological risks associated with childbirth can be compounded by cultural practices including early marriage and childbearing and food restrictions during pregnancy and during menstruation. Girls aged 15 to 19 are twice as likely to die in childbirth as are women in their 20s. Childbirth is seen as a normal occurrence not ordinarily requiring medical attention, so pre- and postnatal care may be considered unnecessary in many families. Compounding all of this is the sense of *laaj* or "shame" about their own body and reproductive functions that make it difficult for women to communicate their symptoms even within the family (MOH, 2006).

The use of professional help for deliveries is also low; over six of 10 births are unassisted. Almost 95 percent of Nepal's Emergency Obstetric Care (EOC) needs remain unmet. The combined effect of these factors is at least 12 daily deaths from pregnancy-related complications (MoH/DFID 2004). Among rural women, Newars and Brahman/Chhetris have the highest access to trained assists during child delivery and Janajatis and Dalits have the least. The same trend is seen for antenatal care. Maternal mortality also includes deaths caused by unsafe abortions. According to the Ministry of Health (2002), at least 20

percent of maternal deaths are caused by unsafe abortions. The demand for safe abortion rose after abortion was legalized by the 11th amendment of the Muluki Ain in 2002.

Maternal mortality in Nepal is still high relative to many developed countries. However for each age group maternal deaths are relatively rare occurrence. As such, age specific pattern should be interpreted with caution. The maternal mortality rate which is the annual number of maternal death per 1000 women age 15-49 for period, 1991-2005 is 0.33. Maternal death accounted for 18 percent of all death to women age 15-49; in other words about one in five. Nepali women who died in the seven year preceding the survey died from pregnancy or pregnancy related causes (NDHS, 2006).

There is a high correlation between educational attainment and health outcomes. The total fertility rate for uneducated women is 8.4, whereas for women with some secondary education is 2.3 (NDHS, 2001). The under- five mortality rates for children of uneducated mothers in Nepal is 121 per 1,000 births: this is 64 percent higher than that for children of mothers with some primary education and nearly double that of children whose mothers have some secondary education (ibid). The risk of death among children of uneducated mothers is eight times higher than the risk for children of mothers with SLC and above education. Similarly, the prevalence of underweight children is 78 percent higher, and the prevalence of stunting is 62 percent higher among children whose mothers do ibid.

Child health practice differs from community to community. Women residing rural area are supposed to have poor child health practice in the context of Nepal. Dhupoo a VDC of Shankhuwa Sava district is a rural area. Being a rural area, lack of proper awareness to the people, poor health services facilities and social taboos are the key lacking factor to contribute considerable status of maternal and child health practice. Therefore, these typical characteristics deserve special consideration on the study on maternal and child care practice.

1.2 Statement of the Problem

Inadequate health service is a major problem of the world. Maternal and child health care problem is one of the burning problems in Nepal. Poverty, lack of proper education and poor health practices are the major causes of maternal mortality and morbidity. Whooping cough, diphtheria, tetanus and other communicable disease are the major causes of infant mortality and morbidity.

Maternal and child mortality is one of the major problems. Every minute of every day, somewhere in the world a women dies as a result of complications arising during pregnancy and childbirth. Around the world, 5, 00,000 women died annually in 1980s from pregnancy-related causes, and for 1990 it was closer to 6, 00,000 per year. In developed countries, the maternal mortality ratio is 27 deaths per 1,00,000 live births but in developing countries the ratio is 20 times higher and 480 deaths per 1,00,000 birth in magnitude, and may be high as 1,000 per 1,00,000 in some ethnic settings (UNFPA ,1999).

Maternal and childcare services are insufficient in Nepal due to minimal level of education or low literacy of women, low economic status and lack of adequate knowledge about healthcare practices. Teenage pregnancy, excessive childbearing tradition, and other socio-cultural factors contribute to increased population growth as well as fertility rate, which decrease the health status of the mother and children. Due to early marriage, traditions, beliefs and superstitions, low economic status, low women literacy, unhygienic health behavioral practices, maternal and child health status is not improved. Most of the rural women do not utilize the available health facilities as they are not sufficient. Low social status of the women is the main cause of their ignorance.

So, it is needed to find out maternal and child health care problems and solve these problems definitely. That is why this topic has been selected for the present study, which is stated as “Maternal and Child Health Care Practices in Dhupoo VDC.”

1.3 Objectives of the Study

The general objective of the study is to assess overall mother and child health care practice in Dhupoo VDC of Shankhuwa Sava. The specific objectives are:

- a) To find out the socio economic and demographic characteristics of the family,
- b) To assess the antenatal, delivery, and postnatal care practices of rural women and;
- c) To examine out the practice of colostrums feeding, breast- feeding, child immunization, and additional food feeding to the women.

1.4 Significance of the Study

Health is one of the most important issues of life. There is no value of life without healthy life. “Health for All and All for Health” is today’s slogan of the world. The slogan cannot be materialized without active participation and cooperation of all people.

Children are future stars. They are facing many health problems which are essential to find and solve for their harmonious development. The aim of the study is to find maternal and child health care practices including antenatal, delivery and postnatal care of the mother.

Maternal and child health care practice is one of the most important factors for the improvement in health condition of mother and children. If mothers are aware of their health, they will not give birth too many children and their babies will be healthy, and this awareness helps reduce the rate of child mortality and morbidity.

So, the significance of the study can be listed as follows:

- a) The result of the study will be useful for strengthening the maternal and child health care services because the people of study area know their condition and they mobilize to use of the available health services.
- b) The Study result will be helpful for the people to develop awareness on maternal and child mortality because they regular contact their health services.
- c) It will be useful to guide planners, educators, volunteer agencies for improving women and child health status through education of the female,
- d) It will be helpful to the women to understand the importance of education for girls and to care their own health and of their children and;

It will be useful as a guideline for further researchers in the similar field.

1.5 Delimitation of the Study

The study is limited in Dhupoo VDC. And other limitations are followings:

- a. The women having one or more children below the age of five years are included in this study,
- b. The study is limited to maternal and child health care practice only, i.e., antenatal care, delivery practices, and postnatal care practices,
- c. Mothers staying at temporary residence in the study area are not included in the study and because they did not real population of study area.
- d. Due to being a partial fulfillment, the study is done under limited time, budget and manpower.

1.6 Definition of used terms

Age at Marriage: The age at which a female marries and enters reproductive period of life.

Antenatal care: Care of mother and her fetus during pregnancy.

Child Mortality: The death of child due to poor health practices and other health-related matters but not from accidental causes.

Delivery: The period of giving birth to a child.

Dhami/Jhakri: The person who treats the sick through traditional methods.

Jaulo: The food for the baby prepared by cooking of rice, ghee, milk, *dal*, etc.

Maternal Care: Care taken from pregnancy until postnatal period to uplift the health status of mothers.

Maternal mortality: Death of mother while pregnant or within 42 days of termination of the pregnancy.

Postnatal care: Care of mother and child after delivery within 42 days.

CHAPTER TWO

LITERATURE REVIEW

Literature review is one of the important parts of any research work. It is done to find out the research gap in the related issues reviewing previous studies done by different scholars.

2.1 Theoretical Frame Work

According to the World Summit for Child 1990, it is reported that child survival is closely linked to the timing, spacing and number of births, and to the reproductive health of mother. Early, late, numerous, and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially where health care facilities are searched (ICPD 1994).

Devkota, B, (1994), who had done a study on “Knowledge, Attitude and Practices of the Maternal and Child Health Care at Pandrun Village, Gorkha District,” reported that about one-third of the total respondents mothers reported that food should be taken more than usual during pregnancy; about 67.2 percent of respondents had reported to have done two or more health checkups during pregnancy period; eight in ten of the mothers knew more than two dangerous signs in pregnancy; and 36.0 percent of the respondents had taken two or more doses of TT vaccine during their last pregnancy.

Mr. Devkota also found that family members were the main birth attendants and razor blade was the main cord-cutting instrument. He also reported that maternal and child health care practices, family planning, child immunization practices are influenced by the caste structure of the mothers.

Shrestha, (1994) in her study “A Study on Child Health Care Practice of Different Ethnic Groups in Baglung Bazaar” found that most of the pregnant women (87.72%) had done antenatal checkup and 58.77 percent of

respondents' delivery took place in a hospital. She also reported that 93.86 percent of respondents used buffalo milk to feed as supplementary food. Among the different ethnic groups, 48.82 percent of households began weaning baby from the age of 4-6 months, 29.4 percent from the age of 7-12 months, and 22.14 percent women wean after 2 years.

Government of Pakistan and UNICEF, (1999) reports that every year 529,000 women worldwide die due to pregnancy and childbirth complications, 12.99 percent of these deaths claimed by developing countries. Far too often, this desperate face of maternal death is buried under poverty and low status without its story being told. Their silenced voices linger unburdened with a beseeching message, move beyond complex definition, and voices to take action to prevent maternal deaths, and let no another woman die untimely and unnecessarily. The South Asian region is home to 1.25 billion people or 22 percent of the world's population. It also disproportionately accounts for 30 percent of the world's maternal deaths. In this region, every three minutes one woman dies from complications of pregnancy and childbirth. This translates into an estimated 425 deaths each day and approximately 155,000 deaths annually.

According to WHO Bulletin 2000, prenatal mortality studies points to the link between the health of the mother and birth outcome. The high prenatal mortality rate in India reflects the poor status of women, including poor nutritional status, low rates of literacy, and early marriage and childbirth.

UNICEF and MIRA, (2000), in "Low Birth Weight Prevalence and Associated Factors in Four Regions of Nepal," mentioned low maternal weight and body mass index, birth of a previous preterm infant, and a birth interval of less than two years as the top five factors associated with LBW. Primarily adolescent motherhood, maternal illiteracy, rural residence and minimal antenatal care were also the implications.

UNICEF (1998), in its study on “Health Seeking Behavior Study,” Nepal, mentioned that education is associated with greater use of health services, in general. The study showed that the highest proportion of women who used health services/sought care (antenatal as well as care during pregnancy, childbirth and during the postnatal period) were the majors who had the highest level of literacy, among women in the study population. About 70 percent of the major women in study were literate. The study showed that the highest proportion of women who did not seek care were the Tamang women, who had the highest illiteracy rate among women in the study population.

UNFPA’s (2001) Expanded Program on Immunization (EPI) is a priority program of His Majesty’s Government of Nepal. EPI is considered as one of the most cost-effective health interventions. Vaccine-preventable diseases (VPDs) are routinely reported through the HMIS system complemented by appropriate surveillance and outbreak response. The immediate objectives of the EPI program are to eliminate neonatal tetanus (NNT), to reduce measles morbidity and mortality, and to eradicate poliomyelitis.

Analysis of the report from all 75 districts of the country for FY 2057/58 shows that overall coverage level for BCG vaccination is 95%, measles vaccination is 75%, DPT3 and OPV3 is 80%, and for tetanus toxoid (TT2+) is 65%, using number of expected pregnant women as the denominator. However, coverage for various vaccinations is not uniform within the country, with some districts achieving more than 100% coverage, and others far behind. Reported morbidity for some VPDs is decreasing, whereas for others it is on rise, especially measles.

DHS (2001) reported that one in every 11 children born in Nepal dies before reaching age five. Slightly more than two in three under-five deaths occur in the first year of life- infant mortality is 64 deaths per 1,000 live births. During infancy, the risk of post neonatal death (39 per 1000) is one and half times as high as the risk of post neonatal death (26 per 1000)

According to Costello and Manandhar, (2002) newborn care is of immense importance for the proper development and healthy life of a baby. Although childhood and infant mortality in South Asia has reduced substantially during the last decade, the rate of neonatal mortality is still high.

Paul and Beorari (2002) reports that estimated 11 million children in South Asia are born each year at weights less than 2500 grams, amounting for over 50 percent of all LBW neonates in the world. Infants born with low birth weight rate suffer from extremely rate of morbidity and mortality from infectious disease and are underweight, stunted, or wasted beginning in the neonatal period through childhood.

Adhikari (1994) had done “A Study of Child Health Problem and Their Treatment Practice” at Besisahar VCD, Lamjung District. He found that about 57 percent of the children were found ill during one year. Prevalence rate of disease was found influenced by many factors like age of the children, ethnicity, parent education, and occupation.

Panta (1995), who rendered a study “Socioeconomic Status and Maternal and Child Health Care Practices with Relation to Fertility in Pokhara,” noted that about one-third of the total respondents used to take additional food during pregnancy. She noted that maternal and child health practices were influenced by the caste structure of the mothers.

Khanal (2001) reported that 72 percent of the mothers delivered at their homes and the rest went to either hospitals or in health posts for delivery. In Gaine and Poda communities, the family members are found to have acted as the main birth attendants at home delivery. About 35 percent of the total respondents were found to have used MCH kit during delivery period. Similarly, 21.67 percent of the mothers who delivered babies at homes indicated that they suffered from bleeding complications.

(UNFPA, 2008) unveils that care in remote districts was inadequate before civil war began and worsened during the decade of conflict. Reproductive health problems are the leading cause of ill health and death among Nepalese women of childbearing age. The country's maternal mortality ratio, 281 deaths per 100,000 live births, is one of the highest in South Asia.

(UN, 2009) identified in The United Nations Millennium Declaration, the reduction of child mortality as a critical challenges for the twenty first century. Every year millions of young children die of preventable causes. Mortality in child is highest in least developed countries where infant mortality averages 82 deaths per 1000 live birth in 2005-2010 and 132 children out of every 1000 born alive are expected to die before age of 5.

Child mortality in most countries has been decreasing in past decades, however, both neonatal and maternal mortality have largely remained the same. Neonatal mortality accounts for almost 40 per cent of estimated 9.7 million children under-five deaths and for nearly 60 per cent of infant (under-one) deaths. This means that a child is about 500 times more likely to die in the first day of life than at one month of age. The largest absolute number of newborn deaths occurs in South Asia – India contributes a quarter of the world total – but the highest national rates of neonatal mortality occur in sub-Saharan Africa. A common factor in these deaths is the health of the mother. ([www.unecef.org/health/idex/-maternal health .html](http://www.unecef.org/health/idex/-maternal%20health.html))

Thus, different scholars and reports say condition of maternal and child health care is very poor. Different approaches were used by conducting different programs for improving maternal and child health. Various types of research were conducted regarding this topic. But nobody more or less has conducted any research in such rural area especially targeting maternal and child health care practice. So, my study will fulfill this gap.

2.2 Empirical Framework

Different scholars have done research on child care and maternal health practices. They found dismal condition of child care and maternal health practices especially in rural areas. They have given own type of recommendations.

Adhikari (1994) says that government should initiate awareness program to use hospital as delivery place. Training should be given to local midwife.

Shrestha (1994) focuses that in rural areas mother should be encouraged to feed their own milk to baby rather than of cow, buffalo and flour. Women health volunteers must be mobilized to make hospital going practices at the time of pregnancy.

Panta (1996) focuses that in rural areas for nutritious food to baby, concept should be given to make sarbottam pitho by locally available food to child mother through women health volunteers.

Khanal (2001) stresses that special health programs should be launched for rural areas for improving the nutritional status and personal hygiene that helps to reduce child mortality and morbidity. INGOs and NGOs must be encouraged to launch their program in rural areas.

Maharian (2006) gives prescriptions that early marriage has been one of the drawbacks of women of rural areas, so they should be encouraged for late marriage. Higher priority should be given to education to them.

2.3 Conceptual Framework

The literature review provides sufficient background to conceive a conceptual framework of the study by establishing relationship among various socio-economic variables to maternal and child health care practices. In this study the socio-economic variables (education, health institution, family size and

occupation) which have direct influence on other variables (postnatal care practices, delivery practices and antenatal care practices). And these variables determine the level of maternal and child health care practices. Combination of these three practices is maternal and child health care practices. This framework includes health institution, family size, occupation and education as independent socio-economic variables and others are independent i.e. postnatal care practices, delivery practices and antenatal care practices. So ultimately maternal and child health care practices is dependent variable. The conceptual frame work deals with different selected variables relating with maternal and child health care practices of women Dhupoo VDC which is presented in below as:

Maternal and child health care practice is determine by social and economic variable. Lack of education, person doesn't adjustment of occupation. Lack of occupation income source is poor. When income sources is poor family doesn't fulfillments of his wants and needs. Education occurs occupation, occupation

occurs income source, income source occurs high living standard and living standards shows all things. Other side lack of education family doesn't fulfillments of. Religion and culture are other determine material and culture. Like Muslim family their family size is big which is influencing by their religion and culture. As a whole maternal child health care practice is influencing by social and economic variables size is not control.

Where the facilities are available like primary Health Care, Health Post, Hospital, People of this area are awareness and their Health behavior are good. But where not available of those facilities people of this area are ignorance of health behavior, Health services and other Health attitude.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Research Design

To achieve the goal of this study, a descriptive as well as explorative method of research design has been adopted. The study has attempted to assess overall mother and child health care practice.

3.2 Population:

The study area total house holds were 802. Out of 802 households 120 (15%) has been selected for the study. Therefore the study population is 120.

3.3 Source of Data

Both qualitative and quantitative has used to fulfill the research objectives. Primary as well as secondary sources of data have been used. Primary source of the data have been collected from the household information (interview and observation), mainly derived from field survey, within the help of questionnaire; and the necessary secondary sources of data have been collected from various books, journals, research reports, magazines, newspapers, documentary, periodicals, and related websites from the internet.

3.4 Sample Size and Sampling Procedure.

There are 802 households' with 5,143 populations in the Dhupoo VDC. Among them, 2610 are women and 2533 are men. Out of 802 households, 120 (15%) has been selected for the study. The selection of the study households has been done by using simple random sampling. Therefore the sampling procedure adopted during study has been given below. On the basis of simple random sampling to selected the 15% (120) households from total households.

3.5 Data Collection Tools and Techniques

Structured questionnaire, observation, key informants' interview and focus group discussion are taken as tools and techniques for the collection of required data.

3.6 Standardization and validation of research tools

Before uses the tools of this study they used other similar community in Savapokhari V.D.C. ward – 2, Otkten and valid them. They are taken of other thesis paper and put it in this study and put it here suggestion of expert.

3.7 Data Analysis and Interpretation

After processing and analyzing the data, they have been presented with the help of simple formulas and simple statistical tools like percentage, ratio, average, table, chart, diagrams, etc.

CHAPTER FOUR

ANALYSIS AND INTERPRETATION OF DATA

4.1 Age of Respondents

For the study, active reproductive age group between 15 and 45 was purposively selected, which is directly related to maternal and child healthcare practice. Those respondents were further divided into 6 groups. The distribution of respondents in each group is shown in Table 4.1 below.

Table 4.1
Distribution of Respondents by Age Group

S. No.	Age Group	Respondents	
		No.	Percent
1	15-19yrs	15	12.5
2	20-24 yrs	33	27.5
3	25-29 yrs	36	30
4	30-34 yrs	20	16.6
5	35-39yrs	12	10
6	40-44yrs	4	3.33
Total		120	100

In the above table and figure, all the respondent mothers are distributed according to their ages and the distribution is shown at five-year intervals, ranging from 15-45 years of age for all 120 interviewed mothers. In this study, 30 percent of mothers belong to the age group of 25-30 years, each 12.5 percent belong to the age group of 15-20 and 27.5 percent to 20-25 years, and each 16.66 percent of mothers belong to the age group of 30-35years. Each 4 percent of mothers belong to 40-45 years. One fourth mothers are not fit to be mother on the basis of the year in terms of their health.

4.1.1 Respondents by Age of Marriage

Marriage is one of the most important aspects of life, so it is meaningful for the whole life. Marriage is an institution which admits a man and a woman to lead a family life. In Hindu culture, there are various types of marriage. Due to religious and culture practices, early marriage is still prevalent in Nepal. Most of the Nepali women are married before they reach 18 years of age. The practice of early marriage is quite usual in this community as seen in the following table.

Table 4.2
Distribution of Respondents by Age of Marriage

S. No.	Age Group	Respondents	
		No.	Percent
1	15-19yrs	35	29.16
2	20-24yrs	53	44.16
3	25-29yrs	32	26.66
Total		120	100

These table and figure shows that 29.15 percent girls are married between 15-20 years. 44.16 percent of mothers got married between 20-25 years. And 26.66 percent of mothers got married between 25-30 years. Data show early marriage is still prevalent in this village which indicates poor health condition of mothers.

4.1.2 Occupational Status

Occupation is a key factor for determining the social status of a person in society. People are engaged in different occupations to live their life comfortably. Without occupation, people cannot meet the increasing demands

of family and society. The classification of respondents based on their occupation is given below.

Table 4.3
Distribution of Respondents and Their Husbands' Occupation

S.N.	Occupation	Respondents			
		Respondent	Percent	Husband	Percent
1	Agriculture	35	29.16	67	58.83
2	Housewife	62	51.66	0	0
3	Govt. Employee	6	5	25	20.83
4	Others	17	14.16	28	23.33
Total		120	100	120	100

The above table shows that 29.16 percent of respondents and 58.83 percent of their husbands are involved in agriculture, 51.66 percent of respondents are housewives, 5 percent respondents are government employees and 25 percent of respondents' husbands are government employees, and 14.16 percent of respondents and 28.33 percent of their husbands are doing others occupations. Half of the respondents are housewives.

4.1.3 Literacy Status of Respondent and Their Husbands'

Education is an integral part of human life. It is an indicator of socio-economic development and is considered as a lamp of intelligence of human life. Education plays a significant role in every aspect of human life. Maternal and child health care is directly related to educational status of the mother and father. Educated women are more aware of the issues related to health and children than uneducated women are. For intensive study of the topic, educational status is categorized only in two headings i.e. literate and illiterate.

The following table shows educational status of respondent mothers in comparison to their husbands.

Table 4.4
Education of the Respondents and Their Husbands

S. No.	Education	Number of Respondents			
		Respondents	Percent	Husband	Percent
1	Illiterate	41	34.16	17	14.16
2	Literate	79	65.84	103	85.84
Total		120	100	120	100

The table shows that out of 120 respondents, 34.16 percent of respondents and 14.16 percent of respondents' husbands are illiterate, and 65.84 percent respondents and 85.84 percent of their husbands are literate. Thus, the result shows that most of the respondents and respondents' husbands are literate.

4.1.4 Land Ownership

Land is the major factor of production. In an agrarian economy, the extent of ownership of land is the main indicator of relative economic status of people. The possession of land shows both prestige and source of wealth in Nepal. In case of women land ownership, it is one of the yardsticks for the measurement of their social position and degree of their empowerment. But it is interesting to unveil the reality that most of the respondents have no land. Only 30 percent women have land which is not more than 5 ropani.

4.1.5 Type of Family

Family is the most important primary group in society. It is considered both as an association and as institution. There are mainly three forms of family according to size: nuclear, joint and extended. However, for our purpose, we

define only two types: nuclear and joint/extended. Distribution of respondents by the type of family is presented in the following table.

Table 4.5
Distribution of Respondents by the Type of Family

S. No.	Type of family	Respondents	
		No.	Percent
1	Nuclear	88	73.34
2	Joint/ Extended	32	26.66
Total		120	100

Among the 120 respondent, 88 (77.33 percent) were living in the nuclear family system and remaining 32 (26.66 percent) were in the joint family system. Joint family system has friendly environment for good maternal and child health care practice as there are so many other members to take care baby and mother.

4.1.6 Number of Children

Nowadays the concept of small family is growing. Accesses to family planning devices are available at the community level, as well as health education and family planning advocacy is growing. Distribution of respondents by their number of children is given in the table.

Table 4.6
Distribution of Respondents by Their Number of Children

S. No.	Number of Children	Respondents	
		No.	Percent
1	One	16	13.34
2	Two	56	46.66
3	Three	36	30
4	Four	12	10
Total		120	100

The above table shows that out of the total respondents, 13.33 percent have one child, 46.66 percent have two children, 30 percent have three children, and 10 percent have four children. The figure shows that tendency of having one to two children is growing and three to four children is decreasing. It must have positive effect on maternal and child health care practices.

4.2 Maternal and Child Healthcare Practice

Maternal and child health care practice means progression, promotion and protection of health of mother and children who are under 5 years of age. It includes antenatal care, delivery, and postnatal care practices.

4.2.1 Antenatal Care Practice

Antenatal care is care given for women during pregnancy. Better antenatal care practice is necessary throughout the pregnancy period to achieve a healthy child and healthy mother. This section deals with antenatal health care practices such as health checkups during pregnancy, additional food during pregnancy, TT immunization, breastfeeding and knowledge about dangerous signs and symptoms that may be associated with pregnancy and pregnancy complications.

4.2.1.1 Health Checkup during Pregnancy

Health checkup here means checkup of the pregnant mother's health during pregnancy period. It is very important for the health of the mother and the fetus. The following table presents the report of health checkup during pregnancy as expressed by the women of this VDC.

Table 4.7
Distribution of Respondents by their Antenatal Checkup Practice

S. No.	Health Checkup	Respondents	
		No.	Percent
1	Yes	108	90
2	No	12	10
Total		120	100

The above table and figure shows that 90 percent of pregnant women had checkups during pregnancy period whereas 10 percent women had no checkup.

Thus, we can know that health checkup practice in this village's mothers is found better. It means that mothers of this village are conscious about maternal and child health care practice.

4.2.1.2 Time Duration of Health Checkup during Pregnancy

Regular health checkup is necessary from the time of conception up to the time of delivery. Starting from conception, monthly checkup is necessary until the period of 28 weeks of pregnancy. After that, fortnightly checkups are necessary up to 36 weeks. After 36 weeks of pregnancy, weekly health checkups are necessary to keep the mother's health in good condition and to achieve a healthy baby at the end. At least four antenatal visits for checkup are required for normal pregnant women for safe delivery. The researcher asked questions

about the frequency of health checkup practice during pregnancy. The responses are presented below.

Table 4.8
Distribution of Respondents by Frequency of Checkup during Pregnancy

S. No.	Frequency	Respondents	
		No.	Percent
1	Once	8	6.66
2	Twice	5	4.17
3	Thrice	5	4.17
4	Monthly	42	35
5	Whenever Necessary	60	50
Total		120	100

The above table shows that 6.66 percent of respondents had checkup once, 4.17 percent had twice and another 4.17 had thrice, 35 percent had monthly, and 60 percent of the mothers had checked up if necessary. It indicates most of the mothers are not conscious of their health in time of pregnancy. Those having regular health checkups have good awareness of checkup for entire length of pregnancy. The national norm for the frequency of health checkup practice is four times.

4.2.1.3 Tetanus Toxioid Injection

Tetanus toxiod (TT) injection is given to the mother and child to prevent tetanus. Usually, two or three doses of tetanus toxiod injections are given at the first antenatal visit. The second dose is given in pregnancy not less than 6 weeks after the first dose. The third dose is given in the last trimester of pregnancy. The results are presented in the table given below.

Table 4.9
TT Vaccine Practice of Pregnant Women

S. No.	TT Vaccine	TT Vaccination dose	Respondents	
			No.	Percent
1	Yes	One dose	8	6.66
		Two dose	32	26.66
		More than two dose	68	56.86
2	No		12	10
Total			120	100

The table show that 108 mothers had TT injection and 12 mothers did not have. 56.68 percent of mothers have taken more than two doses of TT injection, 26.66 percent mothers have taken two doses of TT injection, and 6.66 percent of mothers have taken one dose of injection during their pregnancy period.

4.2.1.4 Additional Food during Pregnancy

In the pregnancy period, supplementary food is necessary for growth and development of the fetus, normal delivery, and to prevent anemia and malnutrition in the mother. So, balanced and adequate diet with intake of protein, vitamins and minerals is necessary. Mothers in good nutritional status are better equipped for the strain of labor and for lactation. Poor nutrition before and during pregnancy period results in a baby with low birth weight and can lead to pregnancy complications such as abortion, death of the mother, or death of the infant. In this study, the researcher asked questions about additional food during pregnancy. The information obtained in this area is given below. Table no. 4.10

Table 4.10
Distribution of Respondents by Additional Food Intake during Pregnancy

S.N.	Additional food	Once a week	Twice week	Thrice week	Daily	Occasional	Total
1	Green Vegetable	25	5	5	55	30	120
2	Meat	55	27	15	6	17	120
3	Milk/Curd	12	24	21	41	22	120
4	Ghee	7	8	3	12	90	120
5	Fruit	17	10	15	13	65	120

4.2.1.5 Work during Pregnancy Period

It is widely accepted that pregnant women should not work hard and need to get enough rest. In some cultures, hard work and weightlifting is avoided during pregnancy, but some cultures prefer women to do hard work during pregnancy. Distribution of respondents by their practices regarding work during pregnancy is given in the table below.

Table 4.11
Distribution of Respondents by Amount of Work during Pregnancy

S. No.	Type of work	Respondents	
		No.	Percent
1	Same as Usual	72	60
2	Less	35	29.17
3	More	5	4.17
4	Do not do	8	6.66
Total		120	100

Sixty percent of respondents replied that they worked the same as usual, 29.17 percent replied that they worked less than usual, 6.66 percent replied that they

did not work at all, and 4.17 percent replied that they worked more during pregnancy period. As to the amount of work pregnant mothers should do, most at the participants replied that pregnant women should work same as usual to manage delivery easily, and they have to do so because of nuclear family.

4.2.2 Place for Delivery

Determination of place of delivery is important for safe labor. Understanding about maternal health, availability of services, and socio-economic condition of the family determine the choice of place for delivery, i.e., home or hospital. The preference for place of delivery is given here for the study area.

Table 4.12
Distribution of Respondents by Preference of Place for Delivery

S. No.	Delivery at	Respondents	
		No.	Percent
1	Hospital	82	68.33
2	Home	38	31.67
Total		120	100

The above table and figure shows that among the total respondent mothers, 68.33 percent of them delivered their babies in a hospital and 31.67 percent of them at home. Giving incentives to do delivery in hospital by government, there is not used hospital. Modern facilities for maternity can be found only in Khandabari which is three hour far from the village. Lack of awareness is also the main reason for not using hospital as delivery places.

4.2.2.1 Types of Delivery Assistants

Delivery assistants are necessary for safe delivery and to get emergency help during labor. The helpers for this period are called delivery assistants, health personals, traditions birth attendants (TBA), and family members, usually the

mother- in-law. The following table shows what types of delivery assistants were generally employed in this village at the time of delivery.

Table 4.13
Assistants during Delivery Periods

S. No.	Delivery	Respondents	
		No.	Percent
1	TBA	79	65.84
2	Family Member	41	34.16
Total		120	100

The above table shows that among the total mothers, majority of them (65.84percent) are delivered with the help of TBA, and in remaining 34.16, delivery was attended by family members. It is concluded that majority of the mothers delivery cases were assisted by trained TBA rather than a family member. It shows the bad practices for doing delivering.

4.2.2.2 Home Delivery Complications

Home delivery complications are a major cause of maternal mortality and morbidity. This means that a substantial number of women suffered serious complications such as abortion, bleeding, etc., which directly affect fertility, pregnancy, birth and breast-feeding of the mothers (World Bank Report 1989). The highest risk arises when the mother needs cesarean section due to, say, breech position, which cannot be provided at home. The available information about home delivery complications during pregnancy is presented below.

Table 4.14
Distribution of Respondents by Home Delivery Complications

S. No.	Complications	Respondents	
		No.	Percent
1	Bleeding	6	16.66
2	Fever	6	16.66
3	Anemia	7	16.68
4	Others	19	50
Total		38	100

The above table and figure shows that the majority, 50 percent, of respondent mothers had other complications during home delivery practices. Among them, 16.66 percent of the mothers had bleeding, 16.66 percent of the mothers had fever, and 16.68 percent had anemia as home delivery complications. This shows the home delivery is not good practices for the health of mothers and baby.

4.2.2.3 Cord-Cutting Practices

It is important to cut the cord after the birth of a baby. But it should be done carefully to avoid risks of different kinds of infectious diseases. Neonatal tetanus has been associated with the use of unsterilized cord-cutting instrument. The use of sterilized cord-cutting technique is very important for safe delivery and to save the mother as well as the child's life.

The effective cord cutting practice depends on the condition of the equipment used. The equipment which has not been properly disinfected may invite different kinds of infectious diseases. It is therefore necessary to ensure the condition of the equipment before it is used to cut the cord. In this, both the cord-cutting person and cord-cutting instruments are included. Obviously, in the hospital setting, the doctor or health professional is the cord-cutting person.

Table 4.15
Status of Cord-Cutting Practices

S. No.	Cord-Cutting Person	Respondents	
		No.	Percent
1	Family Member	8	6.67
2	Health Professional	82	68.33
3	TBA	27	22.5
4	Doctor	3	2.5
Total		120	100

The above table shows that in 68.33 percent of the total respondent mothers, the cord-cutting practice was done by doctor or other health professional in a hospital, 22.5 percent of them by TBA, 6.67 percent by a family member, and remaining 2.5 percent of cord-cutting practices were done by health personals.

Table 4.16
Cord-Cutting Instruments

S. No.	Cord-Cutting Instrument	Respondents	
		No.	Percent
1	Sterilized	76	63.33
2	Razor blade	44	36.67
Total		120	100

The table and figure shows that in the majority of cases (63.33 percent), a sterilized cord-cutting instrument was used, and in 36.67 percent of cases, a razor blade was used as cord-cutting instrument.

4.2.3 Postnatal Care Practices

The six-week period after delivery is called postnatal period. It is the time required to revolute the uterus and to regain personal health as well as to

maintain neonatal baby care. The main aim of postnatal care is to prevent complications of the postnatal period, to check adequacy of breastfeeding, and to provide adequate nutrition to the baby. Such practices include first milk feeding practices, breastfeeding practices, weaning practices, and child immunization practices.

4.2.3.1 Breastfeeding Period

Breast milk is the best food for an infant. It is necessary to feed mother's milk until the child reaches two years of age. In breast milk, all types of necessary nutritious substances and antibodies are present to help protect the infant against diarrhoea and respiratory disease in the first few months. It also prevents malnutrition and reduces child mortality. The longer a woman breast-feeds; the lower is her chance of conceiving a baby.

Though breast-feeding in Nepal is common, cultural pattern and rituality sanction its prolonged use (Paneru, 1980). Breast-feeding is affected by the age of women's education and working status, place of residence, and death of child (Risal and Sharma, 1989). The information collected regarding the duration of breast-feeding practice in the study area is tabulated below.

Table 4.17
Distribution of Respondents by Duration of Breast-feeding Period

S. No.	Period	Respondents	
		No.	Percent
1	12-18 months	12	10
2	18-20 months	20	16.66
3	More than two years	88	73.34
Percent		120	100

A large percent of respondents in the study area fed breast milk until they did not have another baby. About 73.34 percent fed breast milk for more than two

years, 20.00 percent were fed for 18 to 20 months, and only 6.66 percent said that they fed for 12 to 18 months. Here is still more than 25 percent mothers feed less than two years. Mothers are still less conscious about proper breast feeding.

4.2.3.2 Weaning Practices

Weaning practices differ in different communities and societies. Supplementary food—semi-solid and liquid—is started after 4 months, which increases the risk of diarrhea and other illnesses. Appropriate supplementary food starting age is 4 to 6 month after childbirth.

Table 4.18
Age of Weaning Practices

S. No.	Weaning Age	Respondents	
		No.	Percent
1	Earlier than 4 months	16	13.33
2	Between 4-6 months	28	23.35
3	After 6 months	32	26.66
4	After 9 months	8	6.66
5	After 1 year	36	30
Total		120	100

A good aspect of the people of this village is that they do weaning practice after four months. However, 26.66 percent of mother began weaning practice after 6 months, 23.35 percent between 4 to 6 months, 13.33 percent began earlier than 4 months, and only 6.66 percent said that after 9 months they began

weaning practice. They are explain likes – Breast feedings, weaning practices are given below of this topics.

4.2.3.3 Type of Water Used for Bathing

It is necessary to bathe a baby from time to time. It is important to ensure that the water is clean. Since newborn infants are susceptible to cold and their skin is very sensitive, the temperature of the water should be moderate. The following table provides the condition of water for bathing babies in the study area.

Table 4.19
Type of Water Used for Bathing

S. No.	Water	Respondents	
		No.	Percent
1	Hot Water	24	20
2	Lukewarm Water	96	80
Total		120	100

The table and figure shows that 80 percent of the mother used lukewarm water for bathing their babies, and 20 percent mother used hot water for bathing their babies.

CHAPTER FIVE

CONCLUSION FINDING AND RECOMMENDATIONS

5.1 Summary

Maternal and child health is an important indicator of social well-being of a country. But status of health in Nepal is not impressive. Like in many least developed countries, Nepal also has many problems concerning health and health services. The major health problems are high maternal mortality and morbidity, child mortality, prevalence of communicable disease, high fertility rate, unsafe motherhood, malnutrition and poor health practice.

The purpose of the study was to find out the socioeconomic and demographic characteristics of family residing in Dhupoo VDC, to assess the antenatal care, delivery and postnatal care practice of colostrums feeding, child immunization, and additional food feeding to the women of this village.

To fulfill the objectives, 120 respondents were selected by simple random sampling method and both quantitatively and qualitative techniques have been used. Both primary and secondary data have been used to analyze the present social status of the maternal and child health care. The primary data has been collected from structured questionnaire, key informant interview and focus discussion, whereas secondary data has been collected from internet, books, relevant literature, journal and other available sources about related subjects.

5.2 Findings

Based on the survey, focus group discussion and informant interview, the major findings have been presented:

1. According to the study, the majority of the respondents 30% are in the 25-30 year age groups.

2. Most of respondents 51.66% mothers are housewives and 5 percent are engaged in government services. The education status of the mothers is very low in comparison to their husbands.
3. Out of 120 respondents 34.16 % women and 14.16% of their husband are found to illiterate.
4. Majority, 73.34 %, of the respondents belong to the nuclear family.
5. Majority, 46.66 %, of the respondents have two children.
6. 90 % of the respondents had continuously had health checkup during their pregnancy period.
7. Majority 56.86 % of the respondents have taken more than two doses of the TT injection during pregnancy period.
8. Majority, 60% of the respondents work the same as usual during pregnancy period.
9. 68.33% respondents delivered at hospital and 31.67% respondents delivered their babies in their homes.
10. 65.84% respondents were delivered by TBA and remaining 34.16 % of the respondents delivered attained by family members.
11. In home delivery, razor blade was the main instrument for cord cutting.
12. All of the mothers fed their infants with colostrums immediately after the baby was born, and about 73.34 % respondents had breastfed their children more than two years.
13. Out of the 120 respondents, 23.35 % respondents have weaning practices their children between 4-6 months.
14. 46.68% of the respondents have Rice plus *dal* as supplementary food practice to the babies.
15. All of the respondents have immunized their children.
16. 30% of the respondents child have health problems after birth such as ART, diarrhea, dysentery, pneumonia and others diseases.
17. Those who are jobholders went to their work two and a half months after the postnatal care.

18. Most of the respondents have family support during postnatal period.
19. Three of the respondents' children were dead because of pneumonia.
20. Most of respondents use tap water for drinking.

5.3 Conclusion

Dhupoo VDC is one of the rural areas of the Shankhuwa Sava district. People of there are on the way of being consciousness in the area of maternal and child health care practices. Women are also being made consciousness in term of their health in time of pregnancy. Due to not involving effective income generating job, they are not coping their health problem in proper way.

Lack of Education, Health service, Health awareness and Low income source, women of this study area are did not show the good performance of maternal and child Health Care Practice. They take Immunization but not fulfill of dose. Low economic status they didn't take enough food at time pregnancy, delivery and postnatal period. Lack of education they did not develop their awareness of good health behaviours. As a group the study area were the status of all things are poor.

5.4 Recommendations

Based on the findings of the study, the following recommendations can be made:

- a) Early marriage has been one of the drawbacks of these caste groups, so women should be encouraged for delay marriage.
- b) Higher priority should be given to education for girls. And women not getting education must be given non- formal education.
- c) Developmental programs should be launched targeting women to improve their performance in health, education, and political participation so as they are better aware of their own socioeconomic states and can change it.

- d) Special health programs should be launched for such village to improve the nutritional status and personal hygiene that help to reduce child mortality and morbidity. The present study is limited to maternal and child health care practice in Dhupoo VDC, and the further researcher could also be done on this village with regard to occupational health and consumer's health.

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www.unifem.org

Appendix I

Questionnaire for Household Survey**MATERNAL AND CHILD HEALTH CARE PRACTICES IN DHUPOO VDC****Respondent: Female (Mother)**

Name:

Age:

Age of Marriage:

I. Socio-economic and Demographic Characteristics

1. Occupation of the Mother (Respondent):

- (a) Agriculture (b) Government Employee
 (c) Housewife (e) Others (Specify)

2. Occupation of Husband:

- (a) Agriculture (b) Government Employee
 (c) Business (d) Others (Specify)

3. Do you have your own land?

- (a) Yes (b) No

If yes, how much?

- (a) Ropani (b) Anna

4. Education of the Respondent:

- (a) Illiterate (b) Literate

5. Type of family

- (a) Nuclear (b) Joint/Extended

6. Number of Family Members:

S. No.	Name	Sex	Age	Occupation	Education

7. Religion:

- (a) Hindu (b) Buddhist
 (c) Christian (d) Others (Specify)

II. Antenatal Care Practice

1. When was your first pregnancy?

- (a) Year... .. Month... .. Day

2. During pregnancy and lactation, how much food should be taken?

- (a) More than usual (b) Same as usual
 (c) Less than usual (d) Do not want to say

3. Did you take additional foods during pregnancy?

- (a) Yes (b) No

If yes, how often?

Additional Food	Once a Week	Twice a Week	Thrice a Week	Daily	Occasionally
Green Vegetables					
Meat/Egg					
Milk/curd					
Fruit					
Others					

4. Would you tell me the most dangerous signs you had during the pregnancy period?

- (a) Leg swelling (b) Anemia
 (c) Bleeding (d) High blood pressure
 (e) Fever (e) Other (Specify)

5. Did you go for health checkup during pregnancy period?

- (a) Yes (b) No

If yes, how many health checkups did you make during the pregnancy period?

- (a) Once (b) Twice
(c) Thrice (d) Monthly
(e) Whatever Necessary

If no, why?

- (a) Lack of time (b) Lack of Knowledge
(c) By the shame (d) Lack of Health facilities
(e) Others (Specify)

6. Did you take TT injection during pregnancy period?

- (a) Yes (b) No

If yes, how much?

- (a) One dose (b) Two dose
(c) None

7. Who supported you when you were pregnant?

- (a) Husband (b) Family
(c) Others (Specify)

8. How much did you work during pregnancy period?

- (a) Same as usual (b) Less
(c) More (d) Do not work at all

III. Delivery Practice

1. Where was the baby delivered?

- (a) Hospital (b) Clinic
(c) Home (d) Others

2. If at home, who attained the delivery?

- (a) Health personnel (b) TBA
(c) Family member (d) Others (Specify)

3. What were the home delivery complications?

- (a) Bleeding (b) Fever
(c) Anemia (d) Others (Specify)

4. At the delivery time, who cut the cord and tied?
- (a) Family member (b) Health personnel
(c) TBA (d) Doctor
(e) Others (Specify)

5. What instrument was used for cutting the cord?
- (a) Sterilized (b) Razor blade

IV. Postnatal Care Practice

1. Did you feed colostrums to your newborn baby?
- (a) Yes (b) No
2. How long did you breast feed to your child?
- (a) Less than 6 months (b) 12-18 months
(c) 18-20 months (d) More than 2 years
3. Did you wash/clean your breasts before feeding?
- (a) Yes (b) No
- If yes, what do you use?
- (a) Water (b) Water and soap
(c) Other (Specify)
4. When did you start weaning your child?
- (a) Earlier than 4 months (b) Between 4-6 months
(c) After 6 months (d) After 9 months
(e) After 1 year
5. What type of supplementary food do you used to feed?
- (a) Lito (b) Jaulo, soup, fruit juice, and milk
(c) Rice and dal (d) Others (Specify)
6. Do you think it is necessary to eat additional food by breast-feeding mothers?
- (a) Yes (b) No
7. How often did you bathe your child?
- (a) Daily (b) Once a week
(c) Twice a week (d) Once a month
8. What type of water did you use to bath your child?
- (a) Hot water (b) Lukewarm water
9. Did you immunize your children?
- (a) Yes (b) No

If yes, what type of immunizations do you give to your child?

- (a) DPT (b) Polio up to 5 year
(c) B.C.G. (d) Measles

If not, what are the reasons?

- (a) Ignorance (b) Lack of immunization
(c) Negligence (d) Superstition

10. After the birth of baby, did you get any health problems on your child?

- (a) Yes (b) No

If yes, what is the most prevalent disease that affected your child?

- (a) ART (b) Malnutrition
(c) Diarrhea/Dysentery (d) Others (Specify)

11. What measures have you done to prevent from such disease?

- (a) Curing at home (b) Help of Dhami/Jhakri
(c) Help of Doctor (d) Others (Specify)

12. After how many months did you go for work after postnatal care?

.....

13. Do you have family support during postnatal care?

- (a) Yes (b) No

14. Have any of your children died?

- (a) Yes (b) No

15. What was the main disease that caused the death?

.....

16. Where do you take them for care?

- (a) Hospital (b) Clinic
(c) Health Post (d) Dhami/ Jhak
(e) Others (Specify)