# CHAPTER- ONE

# INTRODUCTION

## 1.1 Background of the study

Nepal is one of the least developed countries in the world. About 38 percent of people are living below poverty line. Here are multi religious, multi ethnic, multi linguistic and multi cultural people. Specially, 12.9 percent Dalit are inhabitant in different part of the country (HDR 2004). It is necessary to bring Dalit in main stream of development .Musahar is also a cast of Dalit.

Women are illiterate especially in Dalit cast. They don't know what health is and how can preserve it. So many people of some community believe "It is better to make early marriage for their daughter as soon as possible." They don't know early marriage leads early pregnancy; early pregnancy is a health risk for young woman. When girl marry with one young male before 20 years can be termed as early marriage. According to health science, before 20 female may be harmful for child as well as mother. After 20 years reproductive health implies that all women are also to have satisfaction from safe sex life and they have capacity to reproduce and free to decide it ,when and how often to do so with her husband's participation. Health has been recognized as crucial to human development. This includes sexual health also; enhance life and personal relation also.

Early marriage is taken as normal thing in many parts of the world .It usually leads to early motherhood. Girls under 15 are five times more likely to die of pregnancy related complications than women over 20 and pregnancy is leading cause of death for 15-19 years old girls around the world. In many developing countries, at least 20 percent of women give to their first birth before age of 18. Expectation of parents-in-laws and society are reasons to compel mothers to produce a child soon after marriage many young wives feel pressure to bear sons. This result in pregnancies being spaced to closely in addition to occurring soon in the young mother's life. (UNFPA, 2000)

Good health is essential to live easily and to do anything .According to WHO "Health is a state of complete physical, mental and social wellbeing not merely the absence of disease or infirmity." Health is one of the most important for the fulfillment of human desire of long and easy life which can improve the quality of life. Early marriage invites many

kinds of serious problem in women's life and to their new born baby. So it should be dropped through the forceful effort by the society as well as by the nation by providing sufficient knowledge about health and marriage.

According to UNICEF's innocent research centre" practice of marriage girls at a young age is most common in Sub-Sahara African and South Asia." In many places of earth marriage before puberty are not unusual. However, the centre also notes that marriage shortly after puberty is common among those living traditional life styles in the Middle East, South Africa and other parts of Asia. Marriage of female adolescents between 16 to18 is common in the parts of Latin America and Eastern Europe.

As women are married early and generally becomes pregnant in adolescent ages greater risk is associated with pregnancy and child birth. (Agrawal and Shrestha, 1994)

Human health needs to understand not only from the biophysical point of view but also from cultural and social point of view. The death of each of us is very much influenced by our life style, the kind of a community we live and by our natural environment. It is by examining these and other dimension of socio-cultural context makes a distinction contribution to the understanding of health issues. Therefore, this study will be tried to assess the affects of early marriage in reproductive health status of Musahar community in Biratnagar municipality.

Biratnagar municipality is the head quarter of Morang district. It is situated in the east-southern part of country. It is near from Jogbani (India). It has extended from 26˚20’ to 26˚53’ in eastern longitude and from 87˚16’ to 87˚41’ in northern altitude. There are Singhya khola in eastern part, Sunsari district in western part, Tankisinuwari VDC in northern part and Jogbani (India) in southern part of this municipality. The population of Biratnagar municipality is made of different castes groups: Brahmin, Kshetri, Newar, Yadav, Madwari, Mushar, Dom, Rai, Limbu, Bantar, Satar, Mallaha, Rajbanshi, Muslim, Dusad, Baniya, Teli, Tharu, Dhanuk, Kayastha, Haluwai, Nuniya, Magar, Kewat, Sudi, Kurmi, Kauri, Gurung Jhangar, Dhobi, Sarki, Sherpa, Badhai, Thakuri etc. Mushar, Bantar, Satar, Dom ,Dusad Sarki, Kami etc are backward(Dalit) castes. Especially Dalits involve in many sector of labor occupation for their livelihood.

**1.2 Statement of the problem**

Early marriage invites the growth of population. Population growth has appeared as a threatening challenge to the very development and prosperity of human race like high birth rate and low death rate in the world especially in under developed and developing countries as our country Nepal.

Among different castes and ethnic groups Mushar, Banter, Sarki, Dusad and other lower castes accounts for the significant population as well as wide spread across the southern part of country. The population of Mushar community has occupied significant percentage of total research area, which is associated with research about women early marriage and affect in their reproductive health.

In Nepal, comparison between female and male life expectancy, female life expectancy is low and have high maternal mortality rate (539\100000 live birth). Private and government agencies have been formulating different policies and spreading sound proportion budget in health sector but due to lack of proper implementation, satisfactory result have not been achieved. As the result of early marriage everyday, a woman dies due to the complication of pregnancy of child birth and many more suffering from illness or disability. Risk of death is 100 times higher in developing country. Every six second a baby is born so weak that death comes within one month and many more infants are born disabled (UNFPA 2000). Due to lack of knowledge a large proportion of the birth delivered at home, outside the health facilities.

In the Terai, it is common for 10 or12 years old married girls to suffer sex related injuries, pain and sickness. Undergo girls who are disadvantage by childhood deprivation give birth to weak and underdeveloped offspring. The risk of complications during child birth is greater because the body of girls under 18 is not fully developed. The ammonic fluid needed for the survival and growth of the fetus might not be mature enough and the underdeveloped uterus can not provide a full protection shield. Similarly because of the critical dilations (lack of elasticity in the cervix), the child may suffocate to death at the time of birth. Also pregnant adolescents are less likely to receive early and adequate prenatal care. Thus leading to higher rates of maternal and child mortality Pregnancy related complications are the main cause of death in 15-19 years old girls world wide. The women who begin child bearing at an early age are also more likely to a pattern of

having babies in quick succession which is not conducive to good health of the girl and their babies. It also means that they will have larger families over all, which leads to higher maternal and child mortality. So, this study is based on health problems of early marriage.

### 1.3 Significance of the study

Main aim of this study is to identify the health problems of early married women in Biratnagar municipality. This study is important to extent general awareness among reproductive age women of this municipality.

Some significances of the study are as follow:

(a) This study will help to explore the situation of early marriage.

(b) This study will help to find health problems of early married women.

(c) The findings of the study will be useful for policy makers and planners of different kinds of INGOs, NGOs, government to plan and implement the programmers.

(d) This study will provide knowledge to researchers with related field and further study.

(e) This study will help to know the status of early marriage and it's affect in Mushar women

### 1.4 Objectives of the study

The specific objectives are as follow:

(a) To find out the knowledge of early marriage.

(b) To find out the age at marriage and at first child bearing.

(c) To identify the causes of early marriage.

(d) To find out the effects of early marriage on reproductive health

### 1.5 Delimitation of the study

This study has following delimitations:

(a) The study is based on Biratnagar municipality ward no 16 Morang district only.

(b) The respondents were married women who have got married before 18 years.

(c) Only selected socio economic and demographic variables are analyzed relating at the early marriage practices.

### 1.6 Definition of terms

**Age at marriage:** the age which female gets married and reproductive period life.

**Anemia:** Low level of hemoglobin in blood.

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

**Breast feeding:** The mother feeds milk from her breast to her infant/child

**Community:** A group of person in social interaction in a certain geographical and seeking a common social and cultural life.

**Colostrums:** The first coming fluid from the mothers breasts after child birth which Contains more protein but less fat and sugar than true milk.

**Contraceptive:** method or tools for prevention of conception.

**Delivery:** The process by which the fetus and the placenta are expelled from the uterus.

**Early marriage:** Women who married below eighteen years.

**Postnatal care:** care of mother and her baby since delivery to 42 days.

**Pregnancy:** A physical condition of women during reproductive period in which Development of fertilized ovum occurs within the maternal body.

**Reproductive:** A process of birth.

**Knowledge:** A clear and certain mental perception understanding, the fact of being aware of something experience of acquaintance or familiarity with in for motion of learning that which is known, facts learned or acquired.

## CHAPTER-TWO

## REVIEW OF RWLATED LITERATURE

There are various theoretical literatures regarding to the study of early marriage. The early writers concerned that there exists a practice of having early marriage. Later the demographic transition theory also supported such views.

Generally, early marriages are determined by the cultural, social and economic factors. So there are various theoretical and empirical literatures regarding the study of early marriage. This chapter will attempt to review the various relevant literature based as theoretical as well as empirical studies.

"Child marriage is prohibited by law and normally, it is assumed that there is no presence of child marriage in educated, modern and urban communities." (Acharya, 1979)

'A study of the Age at Marriage, the Reason for Marriage at Different Ages, the Age at First Birth and Pregnancy Outcome' found that about one third women marriage in early age. The impact of marriage on health of women was negative. The proportion of women's good health condition was significantly decreased after marriage. Only half of the women in early age got medical check up and importance of medical check up was not known by the most of the women, the use of family planning device was very low and more among the women of early age. More than one third of babies in sample were low birth babies, majority of low birth weight baby were born to women who are under 17 years of age (Pokhrel Nita 1989).

Thapa Krishna (1990) had studied child health care practice of Gopali community of Makwanpur district, covering three VDC's. Mother who had concluded that inappropriate child feeding practice was the main cause of malnutrition. It was also found that the practices of personal hygiene, sanitation and oral re-hydration were poor. He also mentioned that maternal and child health care practices were poor. The umbilical cord cutting practices were unhygienic. Tetanus was the highest child-killer disease and the Kwashiorkor and Marasmus were major problems in the community.

Early pregnancy is not of course, found only in the developing world. The teenage pregnancy rate has been called a major public health problem in the United States. It has been estimated that over half of the 21 million adolescent aged between 15 and 19 in the

united states have been sexually active and more than a million teenage girls become pregnant early year, at least two third of them without planning to and while unmarried. Thirty thousand of those pregnancies affect girls under 15 and about 430000 teenagers have induced abortion each year (UNSCO 1991).

Early marriage is most common in developing countries like Nepal. Research in Nepal shows that 22.05 percent girls are married before 14th birthday. Pregnancy adolescent below the age of 18 years is 2-3 times more likely to die than the pregnant women between 18 and 25 years. Low birth weight is more common among babies born to adolescent than the adult women. The high maternal death rates 539 in 100000 live birth which contributed by early child bearing and pregnancy complications (UNICEF 1992).

According to Aryal (1995), age at marriage is an especially important variable affecting fertility in a society. Where fertility out of wedlock is strongly disapproved at and marital dissolution is insignificant. Marriage is not a biological event like birth and death; rather it is a social event that is determined by the society within it occurs. Therefore it is an especially important variable shaping the fertility level in Nepal wherever few birth take place outside of marriage and maternal dissolution is in significance.

Birth spacing is one of the most powerful ways of improving the health of women and children. Birth which are too many or too close or to close or to women who are below 18 years and past 35 years old one responsible for approximately one third of all infants deaths world wide children born close together as well as two years apart do not usually develop mentally and physically (UNICEF, 1995).

40 percent of all women are marriage before the age of 10 years and they give first child even by the age of 14 years. Abortion obstructed labour, hemorrhage infections are some of the highly prevalent health risk among the girls below age of 18 years. UVF (Uterine Valve Fistula) is one of the leading long term health problem, because of contracted pelvis resulting from incomplete development of adolescent mothers, low birth weight, high infant neonatal and prenatal mortality are some of risk to infant and teenage mothers (Graver Deepa, 1995).

According to 'Muluki Ain Civil Act, 2052', the legal age of marriage is 16 years for girls and 18 years for boys with the consent of parents. It is without consent the age should be 18 and 21 respectively for girls and boys. There is a provision of legal punishment for

both couples as well as guardians, if they marry against the law, punishment may be imprisonment of 3 months to 3 years or cash payment or both according to the marriage in different age.

Panta Indira (1996) had found that 53.80 percent of the mother had done colostrums feeding practices whereas 34.76 percent of the mothers were against colostrums feeding and 11.42 percent mother had not known about first milk practice. She also wrote that only 10.47 percent mothers' breast feed their babies for one year, 30.65 percent for second year, 37.14 percent for three and remaining 21.42 percent mothers feed until the next pregnancy. She found that 70 percent of mothers start weaning their children in between the age of 4-6 months while 8.37 percent start in after 6 months.

According to WHO (1996), the life risk of dying of pregnancy or child birth is one in twenty in some developing countries. Compared to one in ten thousand in some developed countries, the age at which women being to start child bearing, the interval between each birth, total number of life time pregnancy and socio-cultural and economic circumstances in which women's life influence maternal morbidity and mortality.

According to UNFPA (2000) report, females aged between 15 and 19 are twice as likely to die during child birth. Just about percent of women received assistance from doctor, nurse or midwife during delivery, and percent of women given birth at home under the supervision of traditional birth attends or family members. In many remote areas, none of the pregnant women have ever been in contact with health workers. Poor maternal nutrition and health, short birth intervals, and the lack of accessibility of obstetrical (emergency) services contribute to Nepal's high levels of maternal and neonatal mortalities and morbidity. The situation is worsened by the practice of early marriage. Among the 2.5 million girls aged between 15 to 19, half are already married and nearly a quarter are mothers or pregnant with their first child. The UNFPA report states that 60 percent of girls marry before they turn 18 in Nepal. The young rural girls, who are usually unprepared for pregnancy and motherhood and are under-nourished and under - fed, have a higher chance of dying as a result of their pregnancy. UNFPA report stresses the need to invest in girls' education. The report shows that 76 percent of female above 15 years are illiterate against 43 percent of the male population group. Maternal mortality and morbidity are closely related to literacy.

Rural people generally do not visit the health centre and 70 percent of birth happens without any contact with a trained health practitioners. Health services in most of the rural areas are provided by village health worker (VHWs), maternal child health workers (MCHWs), female community health volunteers (FCHVs) and traditional health practitioners (population monograph of Nepal 2003)

According to annual report department of health service global evidence shows the all pregnancies are at risk, and complications during pregnancy, delivery and the postnatal period are difficult to predict. (Annual report of department of health service Nepal 2066).

According Mahara (2005) it is clearly seen that, new member of females who are accessed to school education are in increasing trend than the elders. Due to the lack of education older generation are playing their attention only for marriage to their young girl. So it can be considered that education is necessary to reduce early marriage trend and its bad impact to the women's health. Income also plays a vital role in family health and education. Most of the people are suffering from low income and its impact in their lives is very painful. They cannot fulfill their fundamental needs due to the unproductive and insufficient land, lack of job opportunities and in scientific agricultural system of the country.

According to Adhikari (2008) after crossing adolescent, they begin to know what are marriage and its importance and the wrong response of her husband. Due to age factor, the husband and wife cannot understand to each other's.

On the basis of above reviewing related literature it is disclosed that early marriage is the health risk for women. Many health problems such as poor maternal and child health, high fertility and high level of maternal and infant mortality are arise from early marriage practice.

Different studies, in this way, have shown different findings about regarding early marriage. It was found that some of the researchers about knowledge, attitudes and practice surveys where as some others are about comparative studies of knowledge, attitude, and practice of maternal and child care. But no research found regarding the

effect of early marriage on Mushar women's reproductive health in Biratnagar -16. So, the researcher wanted to study about this topic.

# CHAPTER -THREE

# RESEARCH METHOLOGY

The investigator applied the descriptive type of research method in this study. This study tried to assess the early marriage among reproductive ages before 18 years married women of Biratnagar Municipality ward no 16, Morang district. The given methodological procedures apply in this study.

## 3.1 Research design

In this study the researcher has expressed all the obtained information truly. So it follows descriptive research design. The nature of the study is also qualitative and quantitative.

## 3.2 Source of data/ population

This study was based on primary source of data. The primary source of data were taken to develop the interview schedule form and collection information from married women relating to reproductive age group before 18 years women of Biratnagar Municipality ward no16 of Morang district. The secondary data are collected from different booklets, bulletins, census data, survey reports, and journal. And further research works etc.

## 3.3 Sampling procedure and sample size

This study was based on purposive sampling survey method. Among the total population; respondents of the study were married women of reproductive age group before 18 years. In total 78 married women are in Biratnagar Municipality, ward no 16, Mahalanuwa Tole. Among them 54 are interviewed as key information of the study, they had early marriage and had at least one child within 5 years at the time of survey. For this at first the researcher visited communities' member for informal talking, after that interview schedule had used for data collection.

## 3.4 Tools for data collection

The researcher applied field survey technique in order to collect data. Interview schedule was the main tool for the study; it was included close open types of questions. For the development of the tool, the researcher had consulted reference sources as previous research report, journals etc. and got advice from the adviser, in course of preparing the tools to cover the objectives of the study.

### 3.5 Validation of tools

After constructing the interview schedule was submitted to the supervisor. After that, to improve it form administered as a trial to 5 percent similar woman in Ramgunj VDC of Sunsary district and compared with the reproductive age group before 18 years women of Biratnagar Municipality ward no 16 for the required validity and objectivity. According to the supervisor's suggestion and pre-test result, necessary and revision had made before making them final.

### 3.6 Data collection procedure

The researcher had the good rapport with the concerned members of the related Municipality, SHP as well as respondents. Than it was applied the purposive method to collect information from each. After that the researcher administered the interview schedule to the target respondents for the needed information.

### 3.7 Method of data analysis and interpretation

After completion of data, the researcher had tabulated the data on different headings according to the objectives of the study for the analysis and interpretation of data. The researcher had presented in table, charts and figures. The data were calculated by using simple statistical method, like frequency consist, percentage distribution makers etc. Percentage was used to interpret the data.

# CHAPTER 4

# ANALYSIS AND INTERPRETATION OF DATA

## 4.1 Demographic characteristics of the study site

Population means the number of people living in a defined area, which is important in every aspect of development of community. The percentage of population according to age sex structure of the study area is presented in table no 1 below.

Table no.1: Demographic characteristics of the study area

| S.N | Age group | Male | Percentage | Female | Percentage | Total | Percent |
|---|---|---|---|---|---|---|---|
| 1 | 0-5 | 23 | 17.82 | 21 | 14.89 | 44 | 16.29 |
| 2 | 6-14 | 33 | 25.58 | 47 | 33.33 | 80 | 29.62 |
| 3 | 15-24 | 16 | 12.40 | 34 | 24.11 | 50 | 18.51 |
| 4 | 25-34 | 31 | 24.03 | 24 | 17.02 | 55 | 20.37 |
| 5 | 35-44 | 12 | 9.30 | 11 | 7.80 | 23 | 8.51 |
| 6 | 45-54 | 8 | 6.20 | 4 | 2.83 | 12 | 4.4 |
| 7 | 55-64 | 4 | 3.10 | 0 | - | 4 | 1.48 |
| 8 | above 65 | 2 | 1.55 | 0 | - | 2 | 0.74 |
| total | | 129 | 100 | 141 | 100 | 270 | 100 |

The table no 1 shows that the percent of below 5 years population is 16.29%, 6-14 years is 29.62%, 15-24 years is 18.51%, 25-34 years is 20.37%, 35-44 years is 8.51%, 45-54 years is 4.4%, 55-64 years is 1.48% and above 65 years is 0.74% .

Above data shows that there are more children less than 15 years age group, whereas elder people seem less. From this situation we know that there is high fertility rate and low number of working manpower in that community. There are not female of above 65 years age. Average age is also less than national average age.

## 4.2 Educational level of respondent:

Educational background of a person is directly affected by the financial background of the family, family traditions and occupation. Education is important, which makes the skill better, attitude clear, increase the knowledge in mind and helps to be gentle in the social, political and economic behavior. Without education it would be hardly possible to modernize to rural agriculture, social change, industrial and health sectors of the rural

life. Educational condition of community reflects the level of awareness of people. Therefore it is important to know the level of education of the study area. The educational status of the study area is shown in the following figure.

Figure no 1:

Educational level of respondents

The above figure no 1 shows the educational level of Musahar community. In this community, despite under schooling, the educational level has been classified into four categories, i.e. illiterate, literate, school going and S.L.C level. Among 270 numbers of population 64 female and 30 male are illiterate and 25 female and 48 male are literate. 51 female and 50 male are going to school and 1 female and 1 male have passed S.L.C.

It is concluded that the literacy rate is unsatisfactory and miserable in comparison with national level. Majority of the people are illiterate, they can not get chance to study due to the cause of poverty, low income source and their traditional thinking.

### 4.3 Age at marriage

According to health survey 2006 A.D in Nepal about 60% of women adolescent had married at the age up to 18. The data below shows the distributions of respondents by age at marriage.

Table no 3: Age at marriage

| s.n | Marriage age | Respondents | Percentage |
|---|---|---|---|
| 1 | 10-12 | 5 | 9.26 |
| 2 | 13-15 | 21 | 38.89 |
| 3 | 16-18 | 28 | 51.85 |
| | total | 54 | 100 |

Where, extra marital relation is social unacceptable. Marriage means the point in women's life at which child bearing becomes socially acceptable. Women who has got married early, have a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing and also their health risk to mother.

In this study the age of respondents are classified in different four groups that are 10-12 years, 13-15 years, 16-18 years above 18 years. The table no 3 shows that 9.2% of the respondents women get marriage between age of 10-12, 38.89%of the respondents women get marriage between ages of 13-15, 51.85%of the respondents women get marriage between ages of 16-18.

According to the above table it is concluded in this study that early marriage is prevailing in Mahalanuwa, Biratnagar-16 Morang and their tradition and lack of education are the main causes of early marriage.

### 4.4 Early marriage practices

Marriage is also dependent on nature of community and their socio-culture traditional. Such as, somewhere or some cast there is practices of marriage by their self decision, in some cast by pressure or force. There also asked to respondent that how did you get marriage? They said that some of they had married by their self decision but most of them had married by parent decision.

Out of total respondents 10 women married by self decision, 29 women married by parent decision and 15 by other process. It is right to decide to do her own marriage by herself, it is also necessary to know about marriage and its meaning. But in study area they are still unknown about the consequences of early age marriage. Parents are uneducated. They want to earn religion by daughter's early marriage. They don't know it is very harmful to be pregnant before eighteen for the mother and new born.

### 4.5 Occupational status of early married women

About 80% of the Nepalese population depends on agriculture for their livelihood. But most of respondents of this study have not their own land.

The below figure shows that maximum 38 of the total respondents are engaged in housework, 12 are engaged in wage labour and only 4 are engaged in agriculture. Due

to lack of their own land, poverty and education most of the respondents are engaged in housework and wage labour.

Figure no.2:

Occupational status of early marriage women

Poor economic condition is not enough for fulfillment of basic needs and other activities. So occupational status of that community is not good for reproductive health.

### 4.6 Knowledge and causes of early marriage

#### 4.6.1 Knowledge about early marriage

Marriage below 18 years is called early marriage. The knowledge about early marriage helps to control it. Those parents, who have knowledge about early marriage and complications, can help to stop it practice. In order to access the knowledge about early marriage among early married women they were asked in your opinion "what do you mean by early marriage?" responses of the respondents are presented in table no 4 below.

Table no 4: Knowledge about early marriage

| s.n | Meaning of marriage | Respondents no | Percent |
|---|---|---|---|
| 1 | marriage below 18 years | 6 | 11.11 |
| 2 | marriage in childhood age | 9 | 16.67 |
| 3 | marriage before getting menstruation | 10 | 18.52 |
| 4 | don't know | 24 | 53.70 |
| | total | 54 | 100 |

The above table no 4 shows that 29(53.10%) respondents don't know about early marriage, 9(16.67%)respondents know that early marriage is that marriage which getting

in childhood age.10(18.52%) said that marriage getting before menstruation is called early marriage and only 6(11.11%) gave right answer They said early marriage is marriage below eighteen years. Above table shows that most of the respondents don't know about early marriage. So we know that little knowledge is one of the reasons of early marriage practice.

### 4.6.2 Knowledge about legal age at marriage

According to Muluki Ain Legal age of marriage is 16 years for girls and 18 for boys with the consent of the parents. The age respectively should be 18 for girl and 21 years for boys with out consent of the parent. There is provision of legal punishment for illegal/early marriage for both couple as well as guardian. Punishment is imprisonment of 3 years 3 months or cash payment or both according to the case. The respondents were asked "do you know about legal age of marriage?" They answered that all of them don't know about the legal age of marriage. If they had the knowledge about legal age for marriage and punishment for early marriage they should be control in early marriage practice. Thus there is the lack of knowledge in the respondents about early marriage.

### 4.6.3 Causes of early marriage

There are many reasons of early marriage such as socio-cultural, tradition, poverty, lack of education, discrimination towards son and daughter. To access the reasons of early marriage respondents in the study asked a question on "what is the reason of early marriage?" Their responses are presented in figure 2 below:

Figure no 3:

Causes of early marriage

Above figure no.2 shows that 30 respondents are married in early age due to their tradition.15 respondents are married due to discrimination 6 respondents are married due to poverty and 3 respondents are married to love. It shows that cultural, economic status, lack of educational characteristics of the study population also plays an important role for determining the age of marriage.

## 4.7 Health problems of early marriage

### 4.7.1 Age at first pregnancy

By the reproductive health point of view, women age at first pregnancy is at least 20 years. Low age at first pregnancy invites the risk of complications and increases the maternal and child mortality rate. In the context of Nepal, 24% adolescent have been pregnant at the age of 15-18 (Demographic health survey 2006). The collected information about age at first pregnancy from respondents is presented in table 5 below:

Table 5: Age of first pregnancy

| s.n | Age at first pregnancy | Respondents | Percent |
|---|---|---|---|
| 1 | Below 15 years | 23 | 42.59 |
| 2 | 15-19 | 31 | 57.41 |
| | Total | 54 | 100 |

The above table no.5 shows that, the majority of the age of first pregnancy was 15-19 years age group.23 respondents had first pregnancy below 15 years.

The women who have children below 20 years of age are mostly illiterate. There is tradition of early marriage and child birth just after marriage .The main reason behind it is found that they and their parents may have strong desire to be father and mother and grand father -grand mother. They don't know it is considered an unsafe age for child birth.

### 4.7.2 Antenatal care practice

Pregnancy is a special period. There are many chances of danger in any time. It is essential health check up for mother and her fetus on antenatal period at least 4 times for normal pregnant women for safe delivery .The following table no 6 shows the practices of antenatal check up of the study population

Table 6: Antenatal check-up practice

| s.n | Times of checked | No. of respondents | percent |
|---|---|---|---|
| 1 | 1 time | 16 | 29.63 |
| 2 | 2 times | 11 | 20.87 |
| 3 | 3 times | 2 | 3.70 |
| 4 | 4 times | 1 | 1.86 |
| 5 | never | 24 | 44.44 |
| | Total | 54 | 100.00 |

Table 6 indicates that most of study respondents 24(44.44%) have never visited for antenatal check-up. Only 1(8.86%) women had checked 4 times during pregnancy .16(29.63%) had checked one time, 11(20.8%) had checked 2 times and 2(3.70%) had checked 3 times during pregnancy.

Most of none checked up women are illiterate. Nepal demographic and health survey (2009) reported backward community women never visit for check up during pregnancy. They go for check up only when they feel uneasy or critical problems. Likewise rural and upward community women do have made four or more ANC visits.

According to the respondent's causes of antenatal check up is lack of knowledge, shyness, lack of time, lack of money, carelessness etc.

### 4.7.3 Delivery place

Places of delivery also affect maternal and child health too. Unhygienic delivery practices lead to the women. So many problems like bleeding, tetanus, and uterine rapture. Usually in backward community there delivery practices is at home at cowshed and at kitchen with support of mother in law, sudden and other experienced women .Table no 7 shows delivery place of respondents below:

Table no.7: Delivery place

| S.n | Place | number of respondents | percentage |
|---|---|---|---|
| 1 | at home | 22 | 40.74 |
| 2 | at kitchen | 17 | 31.48 |
| 3 | at cowshed | 14 | 25.93 |
| 4 | at hospital | 1 | 1.85 |
| | Total | 54 | 100 |

Table no.7 indicates delivery practices among respondents which shows most of respondents 22(40.14%) delivery occurred at home, 17(31.48%) at kitchen, 1(1.85%) at hospital. They give birth to their baby anywhere; they don't manage the place of delivery. From it we know delivery practice of Mushar community is very poor.

**4.7.4 Assisting personnel during delivery**

Assistance by skilled health personnel during delivery is considered to be effective in the reduction of maternal and child health problem. Delivery at home one usually more likely to deliver without assistance from health professional. Following table shows about assisting person during delivery in Musahar community.

Table no.8: Assisting personnel during delivery

| s.n | Assisting personnel | Number of respondents | Percent |
|---|---|---|---|
| 1 | Elder women of community | 26 | 48.15 |
| 2 | Sudheni (Midwife) | 9 | 16.66 |
| 3 | Husband | 4 | 7.40 |
| 4 | Mother-in-law | 14 | 25.93 |
| 5 | Clinical personnel | 1 | 1.86 |
| | Total | 54 | 100 |

This shows that delivery practice of Mushar community is not safe. It is risky for mother and neonate babies.

### 4.7.5 Complications during pregnancy

Early marriage and pregnancy can have severe implication for the health and well being of mother whose bodies are not sufficiently develop to withstand the period of pregnancy and pain of child birth. The status of mother and child health in Nepal is very low due to economic, socio-cultural barriers. Pregnancy complication is one of the main challenges to improve maternal health in Nepal.

Table no.9 Situation of complication

| s.n | complications | number of respondents | Percent |
|---|---|---|---|
| 1 | stomach pain | 15 | 27.77 |
| 2 | Swelling | 26 | 48.55 |
| 3 | Bleeding | 11 | 20.37 |
| 4 | miscarriage before 3 months | 2 | 3.70 |
| | Total | 54 | 100 |

Table no.9 shows 15(27.77%) had suffered stomach pain during pregnancy, 26(48.15%) had suffered from foot swelling, 11(20.37%) had suffered bleeding and 2(3.70%) had suffered miscarriage before 3 months during pregnancy.

### 4.7.6 Complications after delivery

Most complications seemed after delivery like anemia, bleeding, weakness, some kinds of complication lead to the main causes of women morbidity and mortality.

Table 10: complication after delivery

| S.n | completions | number of respondents | Percent |
|---|---|---|---|
| 1 | anemia | 24 | 44.44 |
| 2 | bleeding | 11 | 20.37 |
| 3 | weakness | 14 | 25.93 |
| 4 | malnutrition | 5 | 9.26 |
| | total | 54 | 100 |

Above table no 8 shows24 (44.44%) respondents had suffered from anemia, 11(20.37%) from bleeding 14(25.93%) weakness and 5(9.26%) had suffered from malnutrition after Delivery. Many of Musahar community women in reproductive age are anemic. This high proportion of anemic among Nepalese women results in high maternal morbidity as well as mortality. Moreover the days lost due to sickness were found to be greater for women then men. High bleeding after delivery is one of the main causes to maternal death.

**4.8 Breast feeding (colostrums) practice after giving birth**

It is said that the breast feeding should be immediately after the birth. Breast feeding is the primary source of baby food but it cannot be found in reality in research population. The following table no 11 shows the condition of breast feeding practice

Table no 11: Breast feeding practice:

| s.n | particulars | no. of respondents | percent |
|---|---|---|---|
| 1 | just after birth | 13 | 24.07 |
| 2 | after 6 hours | 19 | 35.18 |
| 3 | after 12 hours | 15 | 27.18 |
| 4 | after 24 hours | 7 | 12.96 |
| | | 54 | 100 |

Table no 11 shows that 19(35.18%) respondent mothers feed breast after 6 hours, 15(27.18%) after 12 hours and 7(12.96%) after 24 hours. Its reason was they had not sufficient breast milk only 13(24.07%) respondents feed colostrums just after the birth of baby.

**4.9 Condition of baby health when birth within one years age**

Children condition is poor in Nepal .Every one in four children is born with less than 2.5 kg of weight. A mother status during pregnancy is important both for the child's intrauterine development and for protection against maternal morbidity and mortality (NDHD2006). Low pregnancy weight is often associated with pregnancy outcomes. The table no.12 shows the types of health problem when birth took place.

Table no. 12: condition of baby health

| s.n. | health problem | respondent child before one year | percentage |
|---|---|---|---|
| 1 | low birth weight | 10 | 47.62 |
| 2 | Disabled | 1 | 4.76 |
| 3 | suffering from disease | 4 | 19.04 |
| 4 | healthy | 6 | 28.57 |
| | total | 21 | 100 |

Table 12 shows 10 (47.62%) babies were low birth weight.1 (4.76%) was disable. 4 (19.04%) were suffering from disease. Only 6 (28.57%) babies were healthy. Site of the baby at birth and mortality are negatively associated. For example, children who have regarded as very small or small have an infant mortality rate that is 60% higher than that for average children (NDHS 2006).

**4.10 Practice of post natal service**

After birth of baby, mothers need to check up her health at least 3 times according to specified schedule: six hours, six days, and six week by trained health person. On that time, she receives vitamin A capsule, advice for food and nutrition, hygiene, immunization and family planning. In the study area they don't care for the mother after the delivery. If they had critical problem they use to go to medicine shop near community. Thus Musahar community's women have faced many problems on post delivery period. They had faced many kinds of health problem after marriage during pregnancy and after delivery today.

**4.11 Family planning practice**

**4.11.1 Knowledge about using contraceptive method**

Family planning is a scheme of family pleasure and sound family life. It is an important aspect of reproductive health. The knowledge of family planning determines the safe motherhood and child care. It helps mother to keep birth spacing and child born on preferred time. The respondents they were asked if they had ever heard various methods of contraceptives devices that the couple could use to delay or stop getting pregnancy. Respondent's responses are presented in following table no 13 below:

Table no 13**:** Knowledge about using contraceptive method

| methods | | number of respondents | percentage |
|---|---|---|---|
| 1. | permanent | 3 | 5.55 |
| 2. | temporary | | |
| I | condom | - | - |
| ii | oral pills | 8 | 14.86 |
| iii | depo provera | 3 | 5.55 |
| iv | others | 2 | 3.70 |
| v | none | 38 | 70.37 |
| | total | 54 | 100 |

The above table no.13 shows that among 54 respondents many of respondent mother have not use any kinds of contraceptive. Among them only 3(5.55%) mother practices permanent method.8 (14.86%) have used oral pills, 3(5.55) have used depo provera and 2(3.70%) have used other e.g. natural method. They used to buy contraceptives from near medicine shop.4.38 (70.37%) have not used any kind of method or devices. They had not use any kind of family planning method or devices .They had not gone to hospital or any health service center to take advices or contraceptive.

In this way we concluded that family planning practice in Musahar community is very weak .Male people are not responsible for family planning and female are reluctant to use long terms temporary method .Only four types of family planning method or devices are found to have been used .The main reasons of not using contraceptives are religious belief, ignorance, fear of side effects, uneasiness etc.

**4.12 Activities done by mother on unwanted pregnancy**

More Nepalese mother becomes pregnant without their interest. On that period they want to be free from pregnancy. Abortion is illegal. Though it is allowed in some condition, like if the doctor comes to the decisions that the pregnancy is dangerous, if the embryo is under 12 weeks, if it is married pregnancy, if pregnant women is mentally disturbed etc.

Question asked about their activities with answer followed by them is shown in table no 14 below

Table 14: Activities done by respondent an unwanted pregnancy

| s.n | activities done by mother | number of respondents | percentage |
|---|---|---|---|
| 1 | Consult with Sudheni | 2 | 3.70 |
| 2 | Consult with elder women | 2 | 3.70 |
| 3 | Consult with health worker | 1 | 1.85 |
| 4 | Gave birth annually | 49 | 90.74 |

The above figure indicated among 54 respondents only 9.25% mother had aborted their unwanted pregnancy consulting with elder women, sudheni, and health worker etc otherwise they gave birth child annually.

This result clarifies that Mushar women do not have good knowledge about the safe removal process of unwanted pregnancy. Abortion service is legalized now days but they have not received this service in their necessary time.

# CHAPTER 5

# SUMMARY, FINDINGS, CONCLUSION AND RECOMMENDATIONS

## 5.1 Summary

The study is descriptive type in nature. Data was collected from the census type. Survey site was Biratnagar sub metropolitan ward no 16 Mahalanuwa, Morang district. Questionnaire was the major tool used for data collection. Information about early marriage practice and reproductive health was collected from 54 respondents who had married before 18 years age and they had children up to 5 years age at the time of data collection.

Mushar are dalits, religiously Hindu, backward community in various aspects and poor. Most of the families have no land and other any kind of property. Education status is very low. Early marriage practice is high in their community. Reproductive health or safe motherhood practice is very bad.

In this study data about the necessary information was collected from Mushar community by visiting door to door and then it was tabulated in master chart. After that it was analyzed and interpreted with the help of table and figures. At last findings conclusion and recommendation have been presented to achieve the objective of the study.

## 5.2 Findings

The researcher has derived the following major findings in this study:

1) Early marriage is still remarkable problem
2) Out of total respondents (54) Mushar women as well as their husband are illiterate.
3) Out of total household of study area 54 respondents were early married.
4) Mushar of study area don't have their own land.
5) The respondents had no land, no education and no skill. Economic condition seems very poor. The land they are occupying is not enough for fulfill their basic needs.
6) 29 early married women had not any kind of knowledge about early marriage.
7) Tradition (parents will), poverty, discrimination and falling in love are the main causes of early marriage.

8) Repeated childbirths and short spaces between the births, less care of own health, lack of nutrient food during pregnancy and after delivery makes Mushar women more susceptible to diseases.
9) The situation was a major problem in Musahar women to express and share their reproductive problems.
10) 54 respondents got first pregnancy between ages of 15-19 years.
11) Most of Mushar women (about 98%) gave birth to their babies at home assisted by old women, sudheni and mother in law. Among 54 respondents only 1.85% went to hospital to take delivery service.
12) Out of total, only 1 respondent's children were delivered in hospital.22 at home, 17 at kitchen and 14 at cowshed.
13) Out of the total respondent 48.15% had suffered from feet swelling, 27.77% had suffered from stomach pain, 3.70% had miscarriage before 3 month and 20.37% had bleeding problem during pregnancy.
14) After delivery 44.44% respondent mothers had suffered from anemia, 20.37%had suffered from bleeding problem 9.26%, became malnourished and 25.93% had felt other weakness.
15) Out of total respondents 24.07% have been found feeding colostrums and 75.93% not feeding colostrums because of thinking that infant may be sick, ignorance and some are advised by others not to feed.
16) After delivery out of total respondents 16.66% rest less than 7 days, 37.03% rest up to 15 days 25.93% rest up to 22 days and only 20.37% rest more than 22 days. Because of lack of time, poverty of their mother, most of babies had low breast feeding. So they had many complications.
17) Within one year age, at the time of birth health condition of the children not found so good. Out of 21 birth 47.62% were low weight, 4.76% were disable 19.04% were suffering from disease and 28.57% were healthy.
18) None of the respondent mothers received postnatal service. If they had critical problem they had consulted in medical shop near their community.
19) Among 54 respondents 70.37% had not knowledge about family planning. 5.55% had done permanent sterilization.14.86% used oral pills.5.55% have used

depoprovera.3.70%have done other practice. They had used temporary devices buying from near medical shop. They had not gone to take advice, to check up their health condition before using contraceptive.

20) Out of 54, 5 respondent mothers to abort their unwanted pregnancy, 3.70 had consulted with Sudheni, 3.70 had consulted with elder women, and only 1.85% had consulted with health worker. 8.88% gave birth annually their unwanted pregnancy.

**5.3 CONCLUSIONS**

On the basis of the study, the following conclusions are drawn:

Practice of safe motherhood in Musahar community is very poor. They have no registered land, educational and economic status seems weak. Agriculture and wage labour are the main occupations.

Early marriage (below 18), pregnancy and low birth space are prevailing in Mushar community. Illiteracy, ignorance and fear of side effects are the main reasons for not using contraceptive. Only 3 mothers have done sterilization but the number is very low in that period.

Most of the mothers don't check up their pregnancy, such as they do not take proper food, T.T. injection, and iron tablet and quality health service from trained health person. Most of the babies were delivered at home with assistance of their family member, sudheni and elder women of community. On complicated cases, most of them consult with Dhami, Jhankri. If they cannot manage the problem, they decide to take mother to health centre. It becomes too late for the delivery. Postnatal care is also poor in the study population. Some complication are also occurring in the study area, e.g. anemia, bleeding, weakness etc. Children are suffering from low birth, weight and diseases. They want more number of sons than daughter. Early marriage, early pregnancy, multiple pregnancy, low birth space, complications during and after pregnancy are the most prevailing problems in Musahar community.

After considering all of findings the study indicates that early marriage practice of Musahar community is highly influencing by lack of education, low socio-economic status, traditional believes, no knowledge about early marriage and legal age at marriage and awareness about health education.

## 5.4 RECOMMENDATIONS

On the basis of findings of this study, Musahar women have unhealthy practice on caring of mother and neonate due to the lack of knowledge and proper health care service. It is not declining phase till now. For the same improvement of this challenging situation some points are given here as recommendation.

1) This study is mainly focused on health problems of early married women. So it is also necessary to conduct study on other problems e.g. social, economical, educational etc. It should discourage early marriage practice.
2) Awareness to the mother about safe motherhood practice by government and non-government sector.
3) Many mothers believe in elder women of community. Dhami, Jhakri, mother-in-law. So they should be oriented to safe motherhood practice.
4) Mainly husband and mother-in-law are to be made responsible for caring in pregnancy, neo natal and postnatal period.
5) Community should be oriented about prevention and treatment of abortion complications besides its legalization to control unwanted birth.
6) Study area of this research is only based on Biratnagar-16 Mahalanuwa. So it is complicated to generalize on all districts and on other caste and community.
7) Any type of death of mother and child should be classified immediately and reported to the district health office.
8) A comparative study should be carried out on early marriage practices and its effects on maternal child health between high caste and other disadvantage castes.
9) Economic status of that community should be raised for this purpose. Special vocational training, micro-business should be conducted.
10) To support this community on safe motherhood, antenatal, natal and post natal service should be provided without taking any cost anywhere for these group.
11) Mobile health centre should be established among these community focusing provide service to safe motherhood practice to provide advice and service of family planning.

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# APPENDIX

**Interview Schedule**
**Department of Health Physical and Population**
**Kirtipur, Kathmandu**
**"Effect of Early Marriage on Reproductive Health of Musahar Women in Biratnagar, Morang"**
**Interview Schedule for the Study**

**Group**
**A. Individual Information**

District: Ward No:
Municipality: Tole:

1. Name of respondents:
2. Marriage age: Present age:
3. Education:

   a).....b).....c).....

4. If literate:

   a) Primary b) Secondary c) Higher Education

5. What the major source of income of your family?

   a) Agriculture b) Business c) Service d) Others

6. What is per family income?

   a) Below 10 thousand b) 10-20 thousand c) 20-30 thousand

   d) More than 30 thousand

**B. Question about knowledge and causes of early marriage**

1. In your opinion what is early marriage?

   a).....

2. Do you know about legal age at marriage?

   a) Yes b) No

3. If yes what is the age?

   a).....

4. Are you early married?

   a) Yes b) No

**5.** How old were you when you got married?

a).....

6. What is the reason of early marriage?

a) It is our tradition b) Poverty c) Discrimination d) Others

7. Do you feel that early marriage is good?

a) Yes b) No

8. If yes, give reason.....

9. If no, give reason.....

10. How old were you when you gave birth to your first child?

a) ..... years.

11. What is right age for giving birth?

a)..... Years

**C. Health problems of early marriage practices.**

1. How was your age when you bore your first pregnancy?

a) Below 15 years b) 15-19 years c) 20 above d) others

2. Have ever take care your health in first pregnancy?

a) Yes b) No

3. Where did your baby take birth?

a) At home b) At hospital c) others

4. Was your first child healthy when birth?

a) Yes b) No

5. If not, what was the problem?

a) Low birth weight b) disabled c) others

6. Did you check your health in pregnancy period?

a) Yes b) No

7. If yes, how many times?

a) Once b) Twice c) Three times d) More than four times

8. Did you go for postnatal check up to health centre after delivery?

a) Yes b) no

9. If yes, how many times after delivery?

a).....

10. Did you give colostrums (first milk) to the newly born baby?

a) Yes b) NO

11. If not why?

a) Afraid of child being sick b) Advised by others not to feed c) others.....

12. During the period of breast feeding, was your breast milk sufficient to Your baby or not?

a) Yes b) No

13. Did you suffer from any disease in pregnancy?

a) Yes b) No

14. If yes, what type of disease?

a) Anemia b) Jaundice c) back pain d) swelling e) others.....

15. Do you know dangerous signs of pregnancy period?

a) Yes b) No

16. If yes, what are they?

a) Anemia b) swelling c) Bleeding d) Bad smelling of vaginal discharge e) Other

17. Had you have any complication during pregnancy, delivery and after delivery?

a) Yes b) No

18. If yes, when?

a) During pregnancy b) Delivery c) after delivery

19. What kind of problem had occurred?

a) Anemia b) weakness c) bleeding d) others.....

20. Are you getting miscarriage on pregnancy period?

a) Yes b) no

21. What is the reason of miscarriage?

.....

22. What is the difference in your health status before marriage?

a) Good b) Fair c) Bad

23. What is the difference in your health status after marriage?

a) Good b) Fair c) Bad

**D. Family planning**

1. Have you ever heard the various methods of contraceptives?

   a) Heard b) Not heard

2. Have you or your husband ever used any contraceptive methods to delay or stop getting pregnancy?

   a) Yes b) no

3. If yes, which method or devices have been used?

   a) Pills b) Copper-T c) Norplant d) Depo-Provera e) others....

4. If no, what is the main reason that you are not using?

   a) Ignorance b) Fear of side effect c) uneasiness d) religious belief e) others.....

5. Who first advised you to use this method?

   a) Doctor/nurse b) MCHW c) neighbor e) others....