CHAPTER- ONE
INTRODUCTION

1.1 Background of the Study

Nepal is one of the developing countries in the world. It has to face various socio-economical as well as health problems. The major health problem of Nepal is due to lack of awareness, lack of nutritional foods, prevention of communicable disease, lack of health services and the lack of the physical facilities etc. In Nepal most of the people live in rural and remote areas and lack of adequate health and sanitary facilities. The provision of care for women during pregnancy and child birth is essential to ensure healthy and successful outcome of pregnancy for the mother and her newborn infant. Many women in the developing world do not have the privilege or the access to basic health care services during pregnancy and child birth. Women after delivery in unhygienic surrounding, without the help of a trained birth attendant, increasing the risk to both the mother and the newborn baby, resulting frequently unhappy outcomes.

The Maternal Mortality Rate (MMR) is an effective index to the quality of maternity care services in any given country. A national survey conducted in 1991 estimated the MMR per at 515 per 100,000 live births. A National Demography Health Survey (NDHS) in 2006 estimated the MMR at 281 per 100,000 live birth. However small community based studies in some remote areas of Nepal shown MMR covers twice this figure. The most common direct causes of maternal deaths are hemorrhage, sepsis, toxemic obstructed labour and consequences of abortions (Ministry of Health, 1996).

Maternity care is the major contributing factor for reducing maternal mortality rate. Most of the women in developing countries do not have the privilege of the access to basic health care services during pregnancy and childbirth. Many women give birth to child in home with unhygienic surrounding and some of the delivery cases are assisted by none.

The demographic indication do not present healthy picture of women and that is reevaluated by several surveys. The maternal mortality rate in Nepal is one of the highest in the world. Infant Mortality Rate (IMR) and Child Mortality Rate (CMR) reported as 539 per hundred thousands female 64.4 per 1000 live births and 91.2 per 1000 live births respectively (CBS, 2001). (NDHS, 2006) reported MMR as 281 per hundred thousand female, CMR as 61 per 1000 live births and IMR as 48 per 1000 live births. In Nepalese societies women are considered as second grade people. Though women in Nepal are main food distributor in every household, she should have only remaining food at last. Thus nutrition status of women in low compared to men. The life expectancy at birth as 60.1 male, 60.7 female (CBS, 2001). The status of women in Nepal is very poor. Literacy rate of women is only 42.5 percent compare to male 65 percent (CBS, 2001).

Family Planning helps to reduce fertility by spacing and limiting childbirth. Maternity care (antenatal care, delivery care, and postnatal care) contributes for the safe motherhood and hence reduction in maternal mortality. Neonatal care contributes for the reduction in IMR and CMR improving their health status. IMR, CMR and MMR are positively related to the fertility. So the reduction in these mortality rates result in the reduction in fertility.

According to NDHS 2006, 35percent women did not receive antenatal checkup, 65 percent women have ANC check up to health center. Only about 20 percent women visited the health center four and more times. Only about 22 percent women received the delivery care.

Poor countries like Nepal are suffering from various reproductive health complication or problem. Low level of practice of antenatal care, delivery care and postnatal care which are the major problems of maternal morbidity and mortality. The major responsible causes for such problem are lack of education, poor access of health services, water sanitation facilities, low per capita income and gender discrimination.

1.2 Statement of the Problem

Maternal health problem is the main problem of the world. Maternal health care problem is one of the burning problem in our country. Poverty, lack of proper education, lack of proper nutrition, lack of sanitation, drinking water facilities and poor practice are the major causes of high maternal mortality in rural areas.

Maternity is not a disease, it is women's privilege yet over large number of women continue to die each year from pregnancy related, complications, and child birth.

In Nepal, every day, twelve women die due to pregnancy related causes. Poor maternal health not only affects maternal mortality, but also has a severe impact on neonatal mortality rates. Even year almost 8 million babies die globally late in pregnancy, at birth or soon after birth due to poor maternal care and inadequate management of pregnancy related complications (Safe Motherhood Network 2000).

Maternal health care services are insufficient in Nepal due to minimum level of education or low literacy rate of women, low socio-economic status and lack of adequate knowledge about health care practices. Teenage pregnancy, low birth interval, high birth order, excessive child earning traditional and other socio-cultural norms and values contribute to increase population growth as well as fertility rate which decrease the health status of mothers and children.

In Nepal, marriage and child bearing for many women still occur at an earlier age than the legal age at marriage. The civil act of marriage with consent in male and female in 18, 18 years old, with out consent marriage in 21, 21 years in female and male. Only 49 percent of women receive ANC, out them 17 percent from doctor, 11 percent from nurse/ ANM and AHW and 5 percent from SBA, 6 percent from VHW and 5 percent from traditional birth attendant (TBA) (MHO, 2000).

More than 90 percent of women occurred delivery at home, assistance during delivery by doctor is only 8 percent.

Due to the came of early marriage, superstitions belief, low women literary, unhygienic health behavioral practices, maternal and child health status is not improved. Most of the women do not utilize health services properly and they are not aware of the available health services in this Manpur VDC. Thus, this study thrust on developing short and long term strategies plan on maternal health care programme. Which is important for the Manpur VDC of Dang district. Wards no. 6 and 7 of this VDC have very poor condition women. So, maternal health care practice and education status of women of these wards are taken to seek the answer of the following research questions.

- What is the socio-economic and demographic characteristics of the mother ?
- What is the status of maternal health care of 15-49 years age group of mother?

1.3 Objectives of the Study

The general objectives of this study is to know the maternal health care practice and educational status in Manpur VDC, ward no. 6 and 7 of Dang District. The specific objectives of the study are as follows.

- To explore the Socio-economic and demographic characteristics of the study area.
- To explore the maternal health care status of the 15-49 years age group of mothers.
- To identify the relationship between maternal health care practices and educational status of women.

1.4 Limitation of the Study

- The Study is limited with in the 6 & 7 wards of Manpur VDC of Dang district. So, it may not represent for all area of Nepal.
- This study is limited to child bearing married women aged 15-49 years at least having one child.
- Maternal health care practices include only ANC, delivery, postnatal care and family planning.
- This study analysis the knowledge and practice of maternal health care services in terms of socio-economic and demographic variables.

1.5 Significance of the Study

Maternal health care is important factor for the improvement of mother status. A nation can not progress without healthy people. So the present study is try to find out the important factor for maternal health care services of Manpur VDC. It is hope that the significance of this study are as given belows.

- ❖ This study is useful to the women to care their own health of this Manpur VDC.
- ❖ This is useful to the VDC and district to organize and conduct various such programmes in the VDC.
- ❖ This research is useful to educate local women to care for their own health during the pregnancy period.
- ❖ The finding of this study is useful for planners and policy maker to improve the health status of mother and to reduce maternal mortality rate in Manpur VDC of Dang district.
- ❖ The result of the study is useful for the GOs, NGOs for designing policies and programmes to launch in the grass roots level.

1.6 Organization of the Study

This report is organized into seven chapter. The first chapter includes background of the study, statement of the problem, objective of the study, limitation of the study, significance of the study and organization of the study. The second chapter deals with the literature review. The third chapter is concerned with methodology of the study which includes the study area, source of data, sample design, tools of data collection and techniques of data analysis. Similarly, chapter four provides the background characteristics of household, which includes demographic and socio-economic characteristics. Chapter five deals about the maternal health care practices. Chapter six analysis the relationship between educational status and maternal health care practices. The final chapter has been used to present the findings, conclusions and recommendations.

CHAPTER- TWO

LITERATURE REVIEW

This chapter covers the general review of literature on maternal health care practice globally and Nepalese context. Though the world already entered into a new millennium along with the advanced medical technology and scientific invention, pregnancy childbirth and abortion continue to be unnecessary hazards for the majority of the world's women. Maternal health care is one of the major issues related to the maternal morbidity and mortality. After the initiation of world safe motherhood strangely 1987, this topic has got world wide emphasize. Based in the same strategy many countries have made national policy to integrate the issues of safe motherhood to ensure the life of mother and child.

The assembly of world health organization in 1948 has accepted that maternal and child health are important and put it as one of the six big priorities of the organization. By the year 1995, WHO was strongly advising against the further establishment of the tradition. "MCH center" with general health services aimed at forming a basic of more elaborate and more effective care.

The World Health Organization introduced the mother baby package in 1994 to improve maternal and neonatal health. The mother baby package describes each intervention needed to achieve safe motherhood in short term. It represents the synthesis of activities at different level of health care system and defines as a basic set of health system and defines a basic set of healthy system interventions and activities and describes simple interventions needed before and during pregnancy, during delivery and after delivery for the mother and new born (WHO, 1998).

In developing countries, each year more than half a million women die from maternal causes since nearly all of these deaths could be prevented. Efforts to prevent maternal deaths from one major cause, i.e. complications of unsafe abortion are crucial but inadequate in most of the world. Providing appropriate medical care immediately could save many thousand of woman's lives. Offering family planning could prevent many future unintended. Pregnancies and unsafe abortions (population Reports, 1997).

The movement for improving women's status all over the world has emphasized the role of education. It is believed that education will bring about a reduction in the inequalities between sexes and uplift women's subjugated position in the society. Educated woman have a higher status in the society and family size becomes smaller as the education is low in Nepal and lowest in SAARC countries for instance adult female illiteracy is 88 in Nepal which is high compared to India (71), Pakistan (81), Bangladesh (78) (World Bank, 1990).

In International Labour Organization's Maternity protection convention (adopted in 1919 and last revised in 2000) sets a minimum standard for what should be included in national legislation in this regard. The convention provides for protection against dismissal of woman during pregnancy, maternity leave and the pres feeding period, and also for cash benefits. It encamp passes coverage of antenatal, childbirth and postnatal care and hospitalization care when necessary, and working hours and takes that are not determinant to mother of children or child. It which six weeks must be postnatal leave to safeguard the health of mother and child. This aspect of the convention covers all married and unmarried employed woman including those in unusual forms of dependent work. This can be interpreted broadly to cover woman in all sectors of the economy, Including the informal sector, but in practice legislation usually cover only women who are employed in the formal sector. with increasing urbanization and the development of the formal economy, compliance with these minimum standards is increasingly becoming an issue, in developing as we well as developed countries (WHO, 2005).

International conference on population and development (Cario, 1994), the fourth world conference on woman (Beijing, 1995) and the safe motherhood technical consultation (Colombo, 1997) have helped to focus the attention of the international community on the need for accelerated action to achieve the world summit for children (New York; 1990) goal of reducing maternal mortality in the context of human right, even governments use their political, legal and health system to fulfill the obligation imposed by their endorsement of various international human right instruments.

The most obvious impediments to the use of maternal health care services re physical barriers such as distance and lack of communication transport. In rural setting women

may find it difficult to pay for transport where roads are poor and vehicles rare, such physical barrier render even the sue of routine prenticed care services complicated use of services for complications and emergencies is made that much worse because speed of the essence, no matter the time of day or night, women in there, in most rural setting lives more than five kilometers form the nearest facility and amount 80 percent live more than five Kilometers from nearest hospital (Abuser, 1998).

Nowadays maternal health care is taking a global attention with how name "Safe Motherhood: Unbeknownst to each other at first the safe motherhood initiative was launched at a international consolation of UN agencies, government, donors and large NGOs, in Naribio Kenya in 1987. The second was the international day of action for women's health on 28th May 1988 lunched by the women's Global Network for Reproductive Rigths (Marge et. al. 1999).

In industrialized countries, delivery assistance with trained birth attendance in almost universal. Thee is a significant variation of use of Tabs in various places. For examples, It ranges between 55 to 98 percent in Latin American and Caribbean between 2 to 77 percent in Sub- Haran Africa and between 16 to 97 percent in North African and West Africa. The variation is even wider in Asian countries. In south central Asia, very few women receive delivery assistance from trained birth attendance. Poor nutrition in childhood and adolescence, for example, is a major came of poor health of women during pregnancy and child birth. This poor health status influences to their bates, especially when batsies are low birth weight, pregnancy and child birth, including unsafe abortion account for the largest health burden for women in their reproductive years. complications of pregnancy and children birth are major causes of disutility and death among women of reproductive age in less developed countries. More than 500,00 women die each year from pregnancy related causes. More than 95 percent of these deaths occur in the less developed countries, particularly in Africa and Asia of the adult health statistics by the WHO, maternal death rates shows the largest discrepancy between more developed and less developed countries. Maternal deaths are strongly associated with substandard health services and a lack of medical care during and immediately after child birth. Most births in less developed countries about 60 percent maternal deaths occur outside health facilities (UNFPA, 1997).

The tragedy of maternal mortality is not simply another manifestation for the differential in mortality between developed and less developed countries. Maternal mortality in rich and poor countries shows a much greater disparity than any other public health indicators. The life time risk for a women to die because of pregnancy and child birth is estimated to range between countries from 1 in 7 to 1 in 9200. The light level of maternal mortality can not be considered a direct outcome of poor socio-economic development. The scale of maternal mortality varies widely between countries at the same economic level and several developing countries at the same economic level and several developing counties with a low or lower middle income economy have broth down their maternal mortality to low levels (Fathalla, 1998)

UNFPA supports a variety of measures in over 100 countries to reduce high rates of maternal mortality from educating communities on safe to training health care providers it emergency obstetrics and equipping health faculties with proper supplies cooperating closely with WHO, UNICEP and world Bank. UNFPA is a key member of the safe motherhood imitative which has been working programmes to protect women during pregnancy and child birth. It is also a member of the interagency group convened a meeting with leading experts on maternal mortality to develop key strategies to provide skilled attendance at delivery. In November, the group organized an international conference in Tunisia "Saving lives skilled attendance at child birth" which brought together country teams from sub-sahara Africa and South Asia to Share experiences and develop national strategies (UNFPA, 2000).

Estimates of maternal mortality in South Africa vary between 150 and 250 deaths per 100,000 births for white women most pregnant women in South Africa receive same form of antenatal care during pregnancy. White women however are more likely to undertake their first visit early in pregnancy, be seen by a medical practicaioner and receive care in the private sector than African women. In a 1994 household survey 22 percent of African women had delivered their last infant at home, a factor which was strongly associated with educational status and geographical location. 58 percent and 43 percent of women who had received no formal education and worked on formal respectively delivered their last infant without the support of the health service (Schneider et. al, 1998).

Most pregnant women hope to give birth safely to a baby that is alive and well and to see it grow up in good health. Their chances of doing so are better in 2005 than ever-before not least because they are becoming aware of their rights with today's knowledge and technology, the vast majority of the problem that threaten the world's mothers and children can be prevented or treated. Most of the millions of untimely deaths that occur are avoidable, as is much of he suffering that comes with ill-health. A mother's death is a tragedy unlike others, because of the deeply held feeling that no one should die in the course of the normal process of reproduction and because of the divesting effects on her family. In all cultures, family and communities acknowledge the need to cover for mothers and children and try to do so the best of their ability (WHO, 2005)

Chaudhary (1999) has stated that currently married adolescent women in general tend to receive more antenatal care compared to older women. The majority of the still do not seek antenatal care in Pakistan and Bangladesh. The proportion of currently married women seeking, antenatal care in lowest in Pakistan 26% followed by India 38% and highest in Nepal 44% Pakistan, only 29 percent of pregnant women are immunized against tetanus. The proportion of pregnant adolescent women immunized against is highest in Bangladesh 80% followed by India 63%.

About sixty percent women receives at least one antenatal care in Nepal, with 15.4 percent receiving care form a doctor, 64.6 percent receiving care from a nurse, 9.2 percent receiving care from a health Assistance, 10.8 percent receiving care from 9 AHW and SBA. 48 percent of mother received ANC from skilled attendants birth (SBA) 28 percent trained health workers such as HA or AHW etc. (NDHS, 2006)

In Nepal pregnancy and delivery is viewed as natural conditions requiring no health care interventions. Child bearing women and their families only seek care when a condition becomes life threatening. Nearly 92 percent of deliveries at home and birth is considered to be polluting. Traditionally, child birth takes place in a cowshed and dirty materials and used for delivery and cord core. Strong religious and cultural beliefs and practices regarding reproduction are deeply embedded in the traditional societies of Nepal (Levitte et al., 1998).

Poudel (2001) shows a study on safe motherhood that 25.2 percent mother received maternal care and 78 percent women not received ANC only 78.5 percent of women received TT vaccine, deliver in health facilities is only 9.7 percent and only 21.3 percent received postnatal care.

The situation clearly indicates that most of pregnant women are still far from delivery and antenatal services. More than 74 percent women do not use maternal health facilities for ANC and 12 percent of deliveries taken place at home without a trained birth attendant (MOH, 1998). An important reason for this is that pregnant women have no decision making power in the households that would enable them to obtain delivery and antenatal services (Pradhan et al. 1996).

According to the census report 2001 maternal mortality rate was 539 per hundred thousand female. Infant mortality rate was 64 per 1000 live birth and child mortality rate 91 per 1000 live birth. In this way the status of women and children with reference to their health care service is much considerable now. Female literacy rate is only 42 percent and women have less decision making power in family. Maternal and child health care is not sufficient for them. Due to lack of knowledge women cannot utilize health services properly. Pregnant women immunized against tetanus were only 13 percent in 1990-1993 and percentage of birth attended by trained health personnel was only 9 percent (UNICEF, 1991).

CHAPTER- TRHEE

METHODOLOGY

Methodology is a way of solving systematically about research problems. It is a general plan of how the researcher is going about answering the research questions the researcher has set. It is also the clear process or method applied from data collection, processing and analysis of finding conclusions. This section deals with the methods employed while conducting the research study in order to achieve the research objectives.

3.1 Selection of the Study Area

The study area "Manpur VDC word no. 6 & 7 Dang district" is chosen for study. Dang district is situated in western southern part of Nepal. Dang district consists of 3 valleys such as Dang, Deukhuri, and Tuidang. Manpur VDC lies in Dang valley. The total population of the Dang district 5,21529 in 2006. Among them 258942 males and 262587 are females (Project from CBS, 2001 to 2021)

3.2 Research Design

The study is based on quantitative data. It is hoped that it help to investigates the maternal health care and educational status of women. Besides, the study make an attempt to describe the things related to maternal health and also related to educational status of women such as socio-economic status, occupation and interest in education.

3.3 Sampling Procedure

The sample population is selected purposive sampling from Manpur VDC, ward no. 6 & 7 of Dang district. This study have been collected data from women of age group 15-49 who had at least one child. This study has covered 105 household. Out of total household, 105 respondents one from each household are selected as sample population.

3.4 Source of Data

3.4.1 Primary Data

The primary data has been collected from the direct field visit (personal interview, household survey, observation and group discussion)

3.4.2 Secondary Data

Similarly, the secondary data has collected from the published or unpublished written documents, articles, journals and related to the subject, register of health post concerned offices and village profile.

3.5 Method of Data Collection

The required information for this study is collect through direct interview with respondents by using well prepared questionnaires. One hundred five individuals ask to obtained information. The researcher himself visit the field, the study area and personally involved to fill up the individual questionnaires for all respondents. According to needs, the researcher used the other techniques such as interview schedule, observation.

3.5.1 Household Survey

Questionnaire is prepared to acquire the realistic and accurate data from household survey. Researcher himself conducted interview with household head as well as women age 15-49. A set of semi-structure of questionnaire is used for interview purpose.

3.5.2 Key Information Interview

The primary data also is collected from key informations using the semi-structured interview method. The interview is taken as cross checking for data obtained from household survey (HHS) questionnaire. The informants is interviewed on the attitudes and perceptions towards education. There informants is people.

3.6 Data Processing, Presentation and Analysis

After collection of data, data processing is done for drawing meaningful results. The researcher gets raw data from the field. So, it needs to be analyzed to get fruitful results. The collected data are analyzed by using the methods such as frequency distributions average and percentage distribution. The collected data has been carefully edited, checked and coded before its entry into the computer and tabulation.

CHAPTER- FOUR

BACKGROUND CHARACTERISTICS OF HOUSEHOLD POPULATION

This chapter presents the socio-economic and demographic characteristics of women in Manpur VDC in Dang district. Demographic and Socio-economic characteristics play important role in the development of society. These characteristics include household composition, educational attainment, occupation, sources of drinking water and size of land holding. Demographic characteristics include age-sex structure of households population, marital status and age at marriage of respondents.

4.1 Characteristics of Household Population

4.1.1 Age-Sex Structure of Household Population

Age-sex composition plays an important role in determining the population dynamics. In the study area, Manpur VDC, 105 household were selected and total recorded population is 517 out of them 54.9 percent were male and 45.1 percent were female.

The sex ratio of this study population was 121.9 which is higher than the national sex ratio i.e. 99.8. The distribution of population according to age group and sex which indicated highest i.e. 14.8 percent of male 13.3 percent for female in age group 5-9. The lowest percent of male and female were in the age group 60-64 i.e., 0.4 percent for male and 0.9 percent for female. The sex ratio according to age group was highest for age group 70+ which were 350 and lowest for the age group 60-64 which was 50. The sex ratio of 70+ age group is very high compare to national cases and global cases this may be the poorest of women compare to men in the study area;

Table 4.1 : Distribution of Household Population by Age and Sex

Age of Group	Male		Female		Total		Sex Ratio
	No	%	No	%	No	%	
0-4	40	14.1	25	10.7	65	12.6	160.0
5-9	42	14.8	31	13.3	73	14.1	135.5
10-14	28	9.9	31	13.3	59	11.4	90.3
15-19	35	12.3	21	9.0	56	10.8	166.7
20-24	27	9.5	24	10.3	51	9.9	112.5
25-29	30	10.6	20	8.6	50	9.7	150.0
30-34	15	5.3	16	6.9	31	6.0	93.8
35-39	16	5.6	14	6.0	30	5.8	114.3
40-44	16	5.6	13	5.6	29	5.6	123.1
45-49	11	3.9	20	8.6	31	6.0	55.0
50-54	6	2.1	5	2.1	11	2.1	120.0
55-59	6	2.1	6	2.6	12	2.3	100.0
60-64	1	0.4	2	0.9	3	0.6	50.0
65-69	4	1.4	3	1.3	7	1.4	133.3
70+	7	2.5	2	0.9	9	1.7	350.0
Total	284	100.1	233	100.1	517	100.0	121.9

Source:- Field Survey, 2010.

4.1.2 Educational Status of Household Population

Education is one of the most important means of empowering women with the knowledge, skill and self confidence necessary to participate fully in the development process. It determines the level of life of a person and level of education and the process of nation too. It involves with qualitative aspect of any society and it directly affected the various aspect of life like, civilization of nation and other aspects of an individual or community and the nation.

Table 4.2 : Distribution of Population Aged 5 Year Above by Educational Status

Educational Status	Number	Percent
Literate	380	84.1
Illiterate	72	15.9
Total	452	100.0
Only literate	38	10.0
Primary	110	28.9
Lower Secondary	85	22.4
Secondary	98	25.8
SLC & above	49	12.9
Total	380	100.0

Source:- Field Survey, 2010.

Among 105 household and of 452 population of aged 5 years and above, 84.1 percent were literate and 15.9 percent were illiterate. The survey further reveals that 10 percent people were Literate but not attending schooling, 28.9 percent had attended primary, 22.4 percent were with lower secondary, 25.8 percent with secondary and 12.9 percent were with SLC and higher level of education.

4.2 Characteristics of Respondents

4.2.1 Age of Respondents

Age is another demographic characteristics of any population. Age plays an important role in any aspect of life. Therefore, it is important to know age of respondents from the study population. The age of respondents is presented in table 4.3

Table 4.3: Distribution of Respondents by 5 Years Age Group

Age of Group	No. of Respondents	Percentage
15-19	4	3.8
20-24	15	14.3
25-29	32	30.5
30-34	22	20.9
35-39	18	17.2
40-44	10	9.5
45-49	4	3.8
Total	105	100.0

Source:- Field Survey, 2010.

Above table revels that the highest proportion of respondents were found in age group 25-29. The percent of this age group was (30.5%). This is followed by 30-34 age group (20.9%), 35-39 age group (17.2%), 20-24 age group (14.3%), 40-44 age group (9.5%), 45-49 Years age group (3.8%) and 15-19 age group (3.8%).

4.2.2 Age at Marriage of Respondents

Age at marriage for women is another important factor which determines the utilization maternal health care practices. The mean age at marriage of women under study was very low i.e. 17.8 years. This low age at marriage may be due to various social, cultural and economic background of the community.

Table 4.4: Distribution of Respondents by Age at Marriage

Age Group	No. of Respondents	Percentage
Below 18 years	35	33.3
18-21	45	42.9
21+	25	23.8
Total	105	100

Source:- Field Survey, 2010.

Above tables presents the distribution of Respondents by their age at first marriage. Out of total respondents, 33.3 percent were married before the age of 18 years, 42.9 percent were marriage within 18-21 years. 23.8 percent were married within 21+ years.

4.2.3 Children Ever Born

Children ever born (CEB) is another demographic characteristics of any population. In this study most of the women were interviewed below the age of 40 years. CEB is mentioned table 4.5 on the basis of live birth that the women given in her life history preceding the survey period.

Table 4.5 : Distribution of Respondents by CEB to Currently Marred Women

No. of Children Ever Born	No. of Respondents	Percentage
1	12	11.4
2	42	40.0
3	31	29.6
4	16	15.2
5	2	1.9
6	2	1.9
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that 40 percent women have 2 children, Likewise 29.6 percent women have 3 children, 15.2 percent have 4 children, 11.4 percents have 1 children. 1.9 percent have 5 children, 1.9 percents 6 children.

4.2.4 Educational Status of Respondents

It is important to examine the educational status of respondents, which is given by following table.

Table 4.6 : Distribution of Educational Status of Respondents

Educational Status	Number	Percent
Illiterate	31	29.5
Literate	74	70.5
Total	105	100.0
Level of Education		
Literate only	32	43.4
Primary	21	28.4
Lower Secondary	11	14.9
Secondary	8	10.6
SLC & above	2	2.7
Total	74	100.0

Source:- Field Survey, 2010.

The table shows that among the total respondents, 29.5 percent were illiterate and 70.5 percent were Literate which was higher than nationally reported figure of 53.7 percent (CBS 2001). Among Literate respondents, 43.4 percent were literate only but they had no schooling, 28.4 percent were primary, 14.9 percent were lower secondary, 10.6 percent were secondary level of education and 2 percent had SLC and above educational attainment.

4.2.5 Occupational Status of Respondents

Level of income determines the level of living standard of households and economic capacity of any households. In the context of Nepal, the main source of income is agriculture. Besides agriculture, services, business, cottage industries and foreign employment. The real occupational status of my respondents are as given below.

Table 4.7 : Distribution of Occupational Status of Respondents

Occupation	No. of Respondents	Percent
Agriculture	48	45.7
Business	22	21.0
Service	25	23.8
Cottage Industry	10	9.5
Total	105	100.0

Source:- Field Survey, 2010.

The table shows that main source of income of the respondents was agriculture (45.7%). It was followed by service (23.8%) business (21%) and cottage industry (9.5%).

4.2.6 Income Level of Respondents

Level of income determines the level of living standard and economic capacity of any households. The income level of respondents of my study area is as given below.

Table 4.8: Distribution of Income Level of Respondents

Occupation	No. of Respondents	Percent
Rs. < 2000	30	28.6
2000-4000	35	33.3
4000-6000	25	23.8
6000+	15	14.3
Total	105	100.0

Source:- Field Survey, 2010.

The table shows that there are 28.6% respondents who have less than 2000 rupees monthly income while it is Rs. 2000-4000 among 35 respondents whose percentage is 33.3, similarly 23.8% respondents have Rs. 4000-6000 monthly income. Only 14.3% respondents have more than 6000 rupees income in every month. The income level shows the very low status of the respondents.

4.2.7 Religion

Table 4.9: Distribution of Respondents by their Religion

Religion	No. of Respondents	Percent
Hindu	85	81.0
Buddhist	10	9.5
Muslim	6	5.7
Christian	2	1.9
Others	2	1.9
Total	105	100.0

Source:- Field Survey, 2010.

The table shows that 81.0 percent of the respondents were Hindu, 9.5 percent of the respondents were Buddhist, 5.7 percent of the respondents were Muslim, 1.9 percent of the respondents were Christian, 1.9 percent of the respondents were other.

4.2.8 Caste/Ethnicity

Table 4.10: Distribution of Respondents by Caste/Ethnicity

Caste	No. of Respondents	Percent
Brahamin	27	25.7
Chettri	30	28.6
Tharu	18	17.1
Kami	15	14.3
Damai	10	9.5
Sarki	5	4.8
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that the caste/ethnicity composition of the respondents was hetrogeneous. The majority of the respondents were Chettri. Respondents from Brahamin, Tharu, Kami, Bamai, Sarki were taken. About 28.6 percent the respondents reported they were Chettri, 25.7 percent reported Brahmin, 17.1 percent were Tharu, 14.3 percent were Kami, 9.5 percent were Damai, 4.8 percent reported Sarki.

4.2.9 Source of Earner in the Family

Table 4.11: Distribution of Respondents by Earner in the Family

Earner in the Family	No. of Respondents	Percent
Husband	88	83.8
Self	7	6.7
Father/mother in law	10	9.5
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that distribution of respondents by earner of the family. 83.8 percent of the respondents reported husband as the main earner in the family. Father or mother in-low are earner for 9.5 percent of the respondents. 6.7 percent respondents reported themselves as the earner.

4.2.10 Size of Land Holding

Nepal is a agricultural country where 80 percent people are engaged in agricultural sector (CBS, 2001). But economics growth has not improved marked over time to over take population growth. The size of land holding also respond the level of economic status of people. The size of landholding by the household study is given below.

Table 4.12: Distribution of Landholding Status Among the Respondents

Size of Land	No. of Respondents	Percent
Land Less	4	3.8
1-10 Katha	25	23.8
11-20 Katha	58	55.2
More than 21 Katha	18	17.2
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that there were 55.2 percent household who had (11-20) Kattha as their own cultivate land. There were 23.8 percent households who had (1-10) Kattha

cultivate land. Similarly, 17.2 percent household had more than 21 Kattha cultivated land and only 3.8 percent household did not have their own land.

4.2.11 Source of Drinking Water

Water is essential for every day for various purposes. Life is impossible without water in the earth ocean, rivers, well spring, stream, pound, piped water etc. Human beings use different sources of water according to access and availability for their basic needs as drinking, cooking, washing, etc. Pure and germless water is important for better health. The sources of water is important for better health. The source of water that the households use for drinking are mentioned below.

Table 4.13: Distribution of Respondents under Study by Sources of Drinking Water

Source of drinking water	No. of Respondents	Percent
Well	20	19.0
Piped water	70	66.7
Stream/river	5	4.8
Tube well	10	9.5
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that main sources of drinking water in the study area were piped water. It was found that 66.7 percent of households under studying used piped water and 19 percent of households used well for drinking water, 9.5 percent of household used tube well for drinking and other purposes. Only 4.8 percent of household used stream/river water for drinking and other purposes.

CHAPTER- FIVE

ANALYSIS OF MATERNAL HEALTH CARE PRACTICES

Maternal care implies the provision of essential care for pregnant women to ensure safe delivery including postnatal care are termination of complication of the mother and the new born. Maternal care starts from the time of pregnancy diagnosis and continuous through delivery and post-natal period.

5.1 Age of Respondents at Onset of Menstruation

Only women can conceive and give birth to children and that too, within certain age limits. A women becomes biologically fecund (capable of bearing a child) with the onset of menstruation. Her capacity to bear children comes to an end with onset of menopause (Bhende Asha and Kanit Kar Tara, 1999).

Generally menarche starts between the age of 12 to 15 but biologically it may be exception to some women table 5.1 provide the distribution of respondents by age at onset of menstruation.

Table 5.1: Percentage Distribution of Respondents by Age at Onset of Menstruation

Age at onset of menstruation	No. of respondents	Percent
12	20	19.0
13	64	61.0
14	20	19.0
15 +	1	1.0
Total	105	100.0

Source:- Field Survey, 2010.

Above table presents that menarche of the respondents was started at the age of 13 is 61 percent and 19 percent respondents had their first menstruation at the age of 14 similarly, 19 percent respondents had their first menstruation at the age of 12 and 1 percent got their menstruation at the age of 15 and above.

5.2 Age of Respondents at First Conception

Women are capable to conception after menarche because their is ovulation in every month. Conception is possible during ovulation if there is unprotective sexual intercourse with opposite sex. Even women are biologically capable to conceive after menarche, they are not physically matured before age of 20. Hence, conception before age 20 is risky to both women and infant. Various studies also prove first conception after age of 35 is also risky to the both mother and her infant. Table 5.2 shows the distribution of respondents by age at their first conception in the concerned field.

Table 5.2: Distribution of Respondents by Age at First Conception

Age	No. of Respondents	Percent
Below 15	8	7.6
15-16	12	11.4
17-18	24	22.9
19-20	34	32.4
21-22	17	16.2
23+	10	9.5
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that the highest percent of respondents (32.4%) reported that they had their first conception in the age group 19-20. Others 22.9 percent respondents reported that they had first conception in the age group 17-18. There were 7.6 percent respondents who had first conception below the age of 15. About 11.4 percent respondents had their first conception in age group 15-16 and 16.2 had conception in 21-22. Only 9.5 percent respondents had their first conception at the age 23 and above.

5.3 Antenatal Care

Antenatal health care services are the health care facilities that a women gets during her pregnancy period. It can be defined the care of mother before the delivery. Antenatal check up plays important role in the health of mother and new born child.

Under antenatal care, TT immunization, receiving iron tablets, quality and frequency of food intake and physical work are included in this section.

5.3.1 Utilization of Antenatal Care Services

In this survey, 105 married women in age group 15-49 who had at least one child were eligible respondents. Individual questionnaire was asked about the utilization of antenatal care services for those only.

Table 5.3: Distribution of Respondents by practice of Antenatal visit for last birth preceding the survey

Practice of ANC	No. of Respondents	Percent
Yes	65	61.9
No	40	38.1
Visited place		
Hospital	24	36.9
Private	31	47.7
Health Post	10	15.4
Total	65	100.0

Source:- Field Survey, 2010.

Above table presents that, 61.9 percent respondents had practiced antenatal service during their pregnancy period. Similarly, 38.1 percent had not practiced antenatal care during their pregnancy period at all. About 47.7 percent had received ANC from private clinic, 36.9 percent from hospital.

5.3.2 ANC Service Provider

Table 5.4: Distribution of Respondents by ANC Services Providers

Service Provider	No. of Respondents	Percent
Doctor	10	15.4
Nurse	42	64.6
Health Assistance	6	9.2
SBA/AHW	7	10.8
Total	105	100.0

Source:- Field Survey, 2010.

The table shows that according to the respondents, 64.6 percent women got ANC service from nurse, 15.4 percent got the service from doctor, 10.8 percent got the service from AHW and TBA/SBA and 9.2 percent got the service from doctor.

5.3.3 Frequently of ANC Visit

According to WHO standard, a mother should visit health facilities for health check up at least four times per birth. Frequency of antenatal visits often should the carefulness of mother towards her reproductive health. Table 5.5 shows the frequency of ANC visit of respondents in the study area.

Table 5.5: Distribution of Respondents by Frequency of ANC Visit for last birth preceding the survey

Frequency of ANC visit	No. of Respondents	Percent
Two	5	7.7
Three	25	38.5
Four & above	35	53.8
Total	65	100.0

Source:- Field Survey, 2010.

Above table shows that among ANC receivers, 53.8 percent respondents had three visits for ANC visit for last birth preceding the survey. Similarly 7.7 percent respondents had two visits for ANC visit for last birth preceding the survey.

5.3.4 Reasons for not taking ANC

The main reasons for not taking ANC services were poor economic condition, cultural value and lack of knowledge about the services.

Table 5.6 : Distribution of Respondents by Cause of Not Taking ANC Services

Causes	No. of Respondents	Percent
Poor Economic Condition	21	52.5
Cultural Value	15	37.5
Lack of Knowledge	4	10.0
Total	40	100.0

Source:- Field Survey, 2010.

The table presents that 52.5 percent of the respondents did not have ANC service because of poor economic condition. In the case of 37.5 percent respondents, they did not have ANC service due to cultural values of the society which society suffered from conservation norms and vales and 10.0 percent respondents did not receive any service because of lack of knowledge about ANC service.

5.3.5 Coverage of TT Vaccination

Tetanus Toxide (TT) injection, an important component of antenatal care, in given to women during pregnancy primarily for the preservation of neonatal tetanus. Neonatal tetanus is one of the major cause of infant death in Nepal. For protection, it is recommended that a pregnant women should received at least two does of Tetanus Toxide during her first pregnancy administrated one months apart from a boster shot during each subsequent pregnancy. Five does of Tetanus toxide injection are considered to provide life time protection.

Table 5.7 : Distribution of Respondents by Tetanus Toxide

TT Coverage	No. of Respondents	Percent
Yes	95	90.5
No	10	9.5
Total	105	100.0
Frequency (In dose)		
1	12	12.6
2	50	52.6
3	25	26.3
4 & more	8	8.5
Total	95	100.0

Source:- Field Survey, 2010.

The table shows that 90.5 percent of women had received TT vaccine in different doses and 9.5 percent had not received. Among those who had received TT vaccination 52.6 percent had injected Two times, 26.3 percent had injected three times, 12.6 percent had injected one times, and 8.5 percent had injected four and more times.

5.3.6 Coverage of Iron Tables

Iron prevents mother from diseases like anemia and malnutrition. In the study area, respondents were asked whether they had received Iron Tablet during pregnancy. It can be easily understood from the table 5.8

Table 5.8 : Distribution of Respondents by Coverage of Iron Tablets

Iron Coverage	No. of Respondents	Percent
Yes	65	61.9
No	40	38.1
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that among total respondents 61.9 percent had received Iron Tablets and 38.1 percent did not receive during their pregnancy period. (Table 5.8)

5.3.7 Types of Work During Pregnancy

A pregnancy women needs more rest than normal women. Heavy and risky work during pregnancy is risky for health. Most essentially, Simple and worming up exercises are needed for health and maintenance but heavy works are dangerous. the table shows the real condition of the respondents.

Table 5.9 : Distribution of Respondents by Work During Pregnancy

Work during pregnancy	No. of Respondents	Percent
Hard Work	27	25.7
Normal Work	68	64.8
No Work	10	9.5
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that majority of respondents (64.8%) reported that they worked normal during pregnancy, 25.7 percent respondents reported they worked hard and only 9.5 percent did not work during pregnancy.

5.3.8 Food Intake During Pregnancy

Balanced diet plays important role for the physical, mental and social well being and is a predictor of pregnancy outcome for both mother and child. Balanced diet always consists of vitamin proteins, carbohydrates, mineral, fats and water. A pregnant women need more extra nutritious food than normal women.

Table 5.10 : Distribution of Respondents by Type of the Food in Take During Pregnancy

Type of Food	No. of Respondents	Percent
Normal & regular food	72	68.6
Rich food	28	26.7
Other food	5	4.7
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that a large percent of respondents (68.6%) reported that they took normal and regular food where as 26.7 percent respondents reported that they took rich food and only 4.7 percent reported that they took other types of food during pregnancy.

5.3.9 Smoking and Alcohol Habit

Smoking and Alcoholism during pregnancy increase the risk of having small or low birth weight baby. It may cause abortion during pregnancy. The use of smoking at other times also adversely affects women's health and may increase respiratory illness among children.

Table 5.11 : Distribution of Respondents by Drinking and Smoking Habits During Pregnancy

Drinking Habit	No. of Respondents	Percent
Yes	5	4.8
No	100	95.2
Total	105	100.0
Smoking		
Yes	20	19.0
No	85	81.0
Total	105	100.0

Source:- Field Survey, 2010.

Above table indicates that only 4.8 respondents drink alcohol during pregnancy. 19 percent reported they have smoking habit.

5.4 Complication During Pregnancy and its Solution

Complication during pregnancy is a social, economic and demographic problem in any community. Maternal and child death can be related with the complication during pregnancy.

Table 5.12 : Distribution of Respondents by Complication During Pregnancy and Place of Treatment

Complication during pregnancy	No. of Respondents	Percent
Yes	88	83.8
No	17	16.2
Total	105	100.0
Place of Treatment		
Visited Hospital	42	47.7
Additional Local Treatment	37	42.1
Dhami/Jhankri	1	1.1
No Treatment	8	9.1
Total	88	100.0

Source:- Field Survey, 2010.

Above table showed that out of total respondents 88 percent replied that they faced complication during pregnancy. Among the total respondents who faced complication during pregnancy, they solved their problems by visiting hospital 47.7% additional local treatment 42.1% and Dhami/Jhankri 1.1%. While 9.1% respondents did not visit for any service.

5.5 Place of Delivery

Place of delivery is a major component of maternity health care practice. Many maternal and infant deaths occur due to lack of safe delivery place. Home is common place of delivery in Nepal. The place of delivery of this study is given below;

Table 5.13 : Distribution of Respondents by Place of Delivery

Place of delivery	No. of Respondents	Percent
Home	85	81.0
Hospital	18	17.1
Health Post	2	1.9
Total	105	100.0

Source:- Field Survey, 2010.

The table shows that out of total respondents in survey area, 81 percent delivery occurred at home, 17. 1 percent occurred at hospital and only 1.9 percent occurred in health post.

5.6 Assistance During Delivery

Assistance by skilled health personnel during delivery is considered to be effective to reduce. The mortality. Births delivered at home is usually more likely to be delivered at home with out assistance from a health personal. Whereas birth delivered at health facilities are more likely to be delivered by health personnel.

Table 5.14 : Distribution of Respondents by Delivery Assistance

Delivery Assistance	No. of Respondents	Percent
Doctor	6	5.8
Nurse	14	13.3
Health Assistance	2	1.9
TBAs/SBA	37	35.2
Relatives	44	41.9
No one	2	1.9
Total	105	100.0

Source:- Field Survey, 2010.

Above table indicates that among total respondents 41.9 percent delivery were assisted by relatives. 35.2 percent were assisted by TBAs/SBA, 13.3 percent were assisted by Nurses, 5.8 percent were assisted by doctors 1.9 percent were assisted by health assistants and 1.9 percent were assisted by any one in the study area.

5.7 Utilization of Safe Delivery Kit During Delivery

Table 5.15: Distribution of Respondents by Use of Delivery Kit

Use of Delivery Kit	No. of Respondents	Percent
Yes	77	73.3
No	28	26.7
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that majority of women 73.3 used safe delivery kit, whereas 26.7 percent did not use safe delivery kit. (Table 5.15)

5.8 Postnatal Care

The aim of postnatal care is to ensure the biological and physiological well being of mother and new born child in the first weeks after delivery postnatal care indicates all the health services, after delivery for the care of mother and newly born baby.

Table 5.16: Distribution of Respondents by Postnatal Care Services

Postnatal Care Services	No. of Respondents	Percent
Yes	88	83.8
No	17	16.2
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that among the total respondents 83.8 percent mother had received postnatal care in study area whereas 16.2 percent respondents did not receive postnatal care.

5.9 Place of Utilization of PNC Service

Table 5.17: Distribution of Respondents by Place of Utilization of PNC Services

Place	No. of Respondents	Percent
Home	66	75.0
Hospital	14	15.9
Health post	8	9.1
Total	88	100.0

Source:- Field Survey, 2010.

Above table shows that respondents utilized the home based on PNC services were 75.0 percent, 15.9 of respondents utilized that services from hospital and only 9.1 percent of respondents utilized this services from health post. There are 17 respondents also have not taken PNC services in the study area.

5.10 PNC Services Provider

Table 5.18: Distribution of Respondents by PNC Service Provider

Service provider	No. of Respondents	Percent
HA/AHW	66	75.0
Nurse	11	12.5
Doctor	5	5.7
TBAs/SBA	6	6.8
Total	88	100.0

Source:- Field Survey, 2010.

Above table shows that among the total respondents who utilized PNC services 75 percent has received from HA/AHW. 12.5 percent Nurse, 5.7 percent from doctors and only 7 percent TBAs/SBA in the study population.

5.11 Family Planning and Contraceptive Use

Family Planning (FP) is an important aspect of reproductive health. It helps to reduce maternal mortality and improving women's reproductive health and it also help to reduce the unwanted and high risk pregnancies as well as unsafe abortion.

Table 5.19: Distribution of Ever Married women by Use of Contraception

Use	No. of Respondents	Percent
Yes	98	93.3
No	7	6.7
Total	105	100.0
Contraceptives Method		
Depo-Provera	45	45.9
Condom	31	31.6
Pills	14	14.3
Sterilization	8	8.2
Total	98	100.0

Source:- Field Survey, 2010.

Above table shows that 93.3 percent couples had utilized either sterilization or temporary contraceptives method and 6.7 percent did not utilized any method of contraceptives at all.

Among the total users 45.9%, 31.6%, 14.3% & 8.2 percent couples had utilized Depo-Provera, condom, pills and sterilization respectively.

5.12 Healthy in General Till Now

Table 5.20: Distribution of Respondents by Healthy in General Till Now

Health in General till now	No. of Respondents	Percent
Yes	85	81
No	20	19
Total	105	100.0

Source:- Field Survey, 2010.

Above table shows that among the total respondents 81 percent were said healthy in general till now and 19 percent respondents were said not healthy in general till now.

CHAPTER- SIX

RELATIONSHIP BETWEEN EDUCATIONAL STATUS AND MATERNAL HEALTH CARE PRACTICES

Maternal health care is the outcome of various socio-economic demographic and cultural factors. All factors should play a positive role in order to enhance the status of maternal health. This chapter examines the possible association of various factors with maternal health care practices. The relationship analyzed in this chapter is not so wide so as to discover all the facts but the most common and strong factor such as age and education are used to interpret the relationship with ANC service and TT vaccine coverage and intake of Iron tablet.

6.1 Utilization of Antenatal Care by Education

Education is an important factor which motivations people in several ways. On the other hand, among literate (31.2%) have not utilize the ANC services. The percent among illiterate in 48.8% and 51.2%. This means 48.8 percent illiterate are also utilized the ANC service while (51.2%) are not utilized this service. Majority of women utilized ANC services who are Literate i.e. 68.8 percent.

Table 6.1: Distribution of Respondents of Utilization of ANC by Education

Education	Utilization of ANC				Total	
	Yes		No			
	No.	%	No.	%	No.	%
Literate	44	68.8	20	31.2	64	100.0
Illiterate	20	48.8	21	51.2	41	100.0
Total	64	61.0	41	39.0	105	100.0
Level of Education						
Literate only	4	66.7	2	33.3	6	100.0
Primary Level	4	50.0	4	50.0	8	100.0
Lower Secondary	7	58.3	5	41.7	12	100.0
Secondary	17	65.4	9	34.6	26	100.0
SLC & above	12	100.0	0	0.0	12	100.0

Source:- Field Survey, 2010.

Above table show that, among the total only literate 66.7 percent respondents were found to have utilized antenatal service and only 33.3 percent had not. Similarly above table show that the utilization of care by level of education. It give the result that all respondents with SLC and above used of ANC. Likewise, 65.4 percent women with secondary and 50.0 percent women with primary education had utilized the ANC services. It was also prevails that who had lower secondary education (58.3%).

6.2 Food Intake During Pregnancy Education

Table 6.2: Distribution of Respondents of Utilization of ANC by Education

Education	**Food Intake**							
	Normal & Regular Food		**Rich Food**		**Others**		**Total**	
	No.	%	No.	%	No.	%	No.	%
Literate	34	53.1	27	42.2	3	4.7	64	100
Illiterate	40	97.6	0	0	1	2.4	41	100
Total	74	70.5	27	25.7	4	3.8	105	100%
Level of Education								
Literate only	5	83.3	1	16.7	0	0	6	100.0
Primary	2	25.0	4	50.0	2	25.0	8	100.0
L. Secondary	10	83.3	2	16.7	0	0	12	100.0
Secondary	17	65.4	8	30.8	1	3.8	26	100.0
SLC +	0	0	12	100.0	0	0	12	100.0

Source:- Field Survey, 2010.

Above table shows that out of total illiterate respondents 97.6 percent were found to have eaten normal and regular food and 2.4 percent eat other. This study also reveals that out of total Literate respondents 42.2 percent respondents were found to give rich food.

CHAPTER- SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

This study analyzed maternal health care practices and education status among the married women of reproductive ages having at least one child of women of Manpur VDC Dang. This study is based on primary data from purposive sampling method in 6 & 7 wards of Dang VDC. In order to meet the objectives of the study is considers quantitative information from the respondents.

7.1 Summary

The major findings of the study are as follows.

7.1.1 Demographic and Socio-Economic Characteristics of Households and Respondents in Study Area

- Out of 5.7 total population of 105 households, 55 percent were males and 45 percent were females. The sex ratio was 121.9. The sex ratio of the age 70+ is found significantly higher (i.e. 350 male per 100 female) but the national and international figure is just opposite and smaller in size. This may be the causes of higher mortality among women in the study area. The highest proportion of population was found in age in group 5-9 (14.8 %)
- The highest percent of respondents belonged to age group 25-29 (30.5%) and the lowest percent and age group 45-49 (3.8%)
- The highest percent of aged at married 18 - 21 age group (i.e. 42.9 %) and lowest percent to age 21 and above (i.e. 23.8)
- Nearly 40 percent of the respondents reported that average number of child born was 2.
- Furthermore, in this study areas the literary rate had been found 74 percent.
- Among the total respondents, the major occupation in agriculture is found 45.7 percent. it is followed by service 23.8 percent business 21 percent and 9.5 percent households depend on daily wages in cottage industry.

- ❖ Highest income level of respondents for per months is 2000-4000 (33.3%). The lowest income level of respondent is 6000+ (14.3 %)
- ❖ The major religion of this community is Hindu (81.0%). It is followed by Buddish (9.5 percent), Muslim (5.7 %) , Christian (1.9 %) and other (1.9 %).
- ❖ The major caste of this community is Chhetri (28.6%). It is followed by Brahmin (25.7 %), Tharu (17.1 %) and Kami (14.3 %).
- ❖ 84 percent respondents reported husband as the main earner in the family.
- ❖ Overall 17 percent households are found more than 21 Kattha land and 4 percent found landless
- ❖ Out of total households, 66.7 percent households use piped water.

7.1.2 Maternal Health Care Practices

- ❖ The highest percent of respondents (61 %) had their first menstruation at age 13 years. It is followed by age 14 years (19 %), 12 years (19 %) and 15 above (1 %) .
- ❖ Overall respondents, 32. 4 percent reported that they had first conception at age (19-20) years. Likewise, 22.9 percent respondents had their first conception (17-18) years. Respondents who reported they had first conception below the age 15 years were 7.6 percent.
- ❖ Out of total respondents 61.9 percent respondents reported they had antenatal visits.
- ❖ The majority of respondents visited ANC services from private Clinic (47.7%). Some respondents received such services from hospital (36.9%) and health post (15.4 %). Among the ANC service receives, 15.4 percent received from doctors, 64.5 percent received from nurses and 9.2 percent received from health assistance.
- ❖ Of those who received ANC services, 53.8 percent respondents visited four and above time of ANC services. 38.5 percent had three ANC visits and 7.7 percent had two time ANC visit.
- ❖ Among total respondents, 90.5 percent respondents reported they had utilized T.T vaccine during pregnancy. Overall T.T vaccine receivers, only 8.5 percent had utilized four and more times.

- Overall 61.9 percent respondents reported they had received Iron tables during pregnancy.
- Out of total respondents 25.7 percent has done hard work during pregnancy and only 9.5 percent respondents did not worked during pregnancy.
- Out of total respondents, 26.7 percent had taken rich food during pregnancy, 68. 6 percent had taken normal and regular had during pregnancy and only 4.7 percent respondents had taken other types of nutritious food during pregnancy.
- Among the total respondents, only 4.8 parent respondents drinking and only 19.0 percent respondents smoked during pregnancy.
- Out the total respondents 83 percent faced complication during pregnancy. 16.2 percent responded did not faced complication during pregnancy.
- Most of women 81 respondents had delivered their last child at home had preceding the survey, 17. 1 percent delivery were hospitalized.
- Among the total delivers, 41.9 percent assisted by relatives, 35.2 percent assisted by SBA/VHW, 13 percent were assisted by nurses. Six percent were assisted by doctor respectively.
- 73 percent of respondents used safe delivery kit during delivery 26.7 percent respondents did not used safe delivery kit during delivery.
- 84 percent respondents reported they had postnatal care service after delivery whereas 16 percent respondents did not received postnatal care after delivery.
- Among total respondents, 75% percent of PNC receivers got services from home, 15.9 percent got from hospital and 9.1 percent got from health post. Similarly, among PNC receivers 75 percent from HA/HAW and 5.7 percent took the services from doctors.
- Ninety-three percent of respondents were used temporary contraceptive method and 7 percent did not used any contraceptive method. The majority of contraceptives users were Depo-Provera users (45.9 %).
- Out of the total Illiterate respondents 97.6 percent were fond to have eaten normal and regular food and out of total literate 42.2 percent were found to have eaten rich food.
- Literate 68.8 percent and illiterate 48.8 percent women of respondents utilization of ANC by education.

7.2 Conclusions

This study was conducted to find out the maternal health care practice in women in Manpur VDC, Dang. On the basis of data analysis the study on the utilization of maternal health care practice is not satisfactory even though it is better than national level. Socio-economic characteristics (Housing, literacy, occupation , age of marriage etc.) are poor but it is some what satisfactory, than the national level. Sources of drinking water and light facilities are found more accessible in study area.

The main components of maternal health care practices (Antenatal care, delivery and postnatal care) are poor in study area. These practices are found better among educated respondents than compared to illiterate. TT vaccination, Iron Tablet vitamin 'A' capsulate utilization are much better than national level but all respondents haven't utilize these services. Smoking and alcoholism prevalent rate is low in the study area. More than 80 percent delivery occurred at home assisted by family members relatives and SBAs. The sex ratio of age 70+ is found very high, similarly among age group 25-29, 40-44 and 65-69. The sex ratio is found 150.0, 123.0, and 133.3 respectively. It may the causes of maternal mortality high in the study area because male does not faced the maternal mortality.

7.3 Recommendation

- ❖ It is found that the study area population is deprived from the basic infrastructure i.e. employment education. To develop the development of the basic infrastructure for community not only the government of Nepal alone but also In GOs' and NGO's should carry out vertical and horizontal development
- ❖ Economic crisis is one of the problem of low level of maternal and child health. So income generating activities should lunch for them.
- ❖ Maternal health care practices are highly influenced by education, socio-economic status, age at marriage and role of media. These all indicator are used at low level. So, different programmes like training, seminar and pictorial demonstrative programmes should be carried.

- ❖ Sterilization should be made universal to these couples satisfied by children and use of contraceptives should be focused for spacing the births. Therefore family planning programmes should be actively enhanced.
- ❖ Due to lack of information many women were not found practicing safe maternal health care. So information, education and commutation (IEC) programmes should be lunched.

7.4 Area for Further Research

Following are the areas for the further research.

- ❖ This research includes very few limited variables. A wider research containing several variable are needed.
- ❖ Further study should be carried out including other aspects of reproductive health such as STD, HIV/AIDS.
- ❖ The sex ratio in different age group found comparatively high so, it is recommended to research the causes of this in the future study.

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Maternal Health Care Practices and Educational Status of Women (A Case Study in Manpur VDC Dang)

CDPS (T.U.) Kirtipur, Kathmandu

Survey for obtaining master's degree in Population Studies 2010

Questionnaire for the study

A. Household Information

1. Name of the Respondents:
2. Religion: a) Hindu
   b) Buddhist
   c) Muslim
   d) Islam
3. Total size of children
   a) Male b) Female
4. Income level of household.
   a) Rs. < 2000 b) Rs.2000 - 4000
   c) Rs.4000 - 6000 d) Rs.6000 +
5. Educational level
   a) Literate b) Illiterate
6. Occupation of the household
   a) Agriculture b) Business
   c) Service d) Others
7. What main sources of income in your family ?
   a) Agriculture b) Business
   c) Services d) Cottage industry
   e) Others
8. Who is the main earner of your family ?
   a) Husband b) Self
   c) Father/mother-in-law d) Others
9. How much cultivable land does your household own ?
   a) Bigha b) Kattha c) No land
10. What type of house do you have ?
    a) Brick and mortar b) Store made
    c) Wooden d) Cottage

11. Which source of light do you use in your households ?

a) Electricity c) Kerosene c) Fire

d) Others .....

12. Do you have following communication facilities ?

a) Ratio b) T.V.

c) Telephone d) Mobile

13. What is the source of drinking water ?

a) Well b) Piped water

c) Stream/river water d) Tube well

e) Others

14. Distance to water source (meter) .....

15. Is your kitchen separate than other room ?

a) Yes b) No

16. What type of toilet facility does your household have ?

a) Modern b) Traditional c) No toilet

B. Individual Information

17. Income level of respondents.

a) Rs. < 2000 per moth b) Rs.2000 - 4000 per month

c) Rs.4000 - 6000 per month d) Rs.6000 + per month

18. Age at married of respondents.

a) less than < 18 years b) 18-21 years c) 21 + years

19. Do you usually listen radio ?

a) Yes b) No

20. How old were you at the onset of menstruation ? ..... years

21. How many live births have you had ? (specially total number)

22. What was your age at first conception ?

..... years

23. Are you currently pregnant ?

a) Yes b) No

24. Did you smoke during pregnancy ?

a) Yes b) No

25. Did you drink alcohol during pregnancy ?

a) Yes b) No

26. What type of work did you do during pregnancy ?

a) Usual period b) Short period

c) No work

27. What kind of food did you take at the time of pregnancy ?

a) Usual food b) Extra nutrition food

28. Did you take antenatal care service ?

a) Yes b) No

29. If yes, where did you visit ?

a) Hospital b) Private clinic

c) Health post d) Other .....

30. How many times did you receive ANC per birth ? .....

31. What is the distance to the nearest health facility ?

.....

32. Who provide the service ?

a) Doctor b) Nurse

c) Health assistance d) TBA/SBA

e) Others

33. What is the main reason of not taking ANC service ?

a) Poor economic condition b) Cultural values

c) Lack of knowledge d) Others

34. Did you face any complication during pregnancy ?

a) Yes b) No

35. If yes, how was complication solved ?

a) Visited hospital b) Traditional local treatment

c) Dhami/Jhakri d) No treatment

e) Other .....

36. Did you receive TT vaccine ?

a) Yes b) No

37. Did you take iron table ?

a) Yes b) No

38. Have you ever used any contraception to avoid conception ?

a) Yes b) No

39. If yes, which method have you used ?

a) Pills b) Condom

c) Depo-Provera d) Sterilization

e) Others .....

40. Where did you deliver your last child ?

a) Home b) Hospital

c) Health post d) Relatives home

d) Other .....

41. Did you are delivery kit ?

a) Yes b) No

42. Who assisted during the delivering ?

a) Doctor b) Nurse

c) Health assistance d) TBA/SBA

e) Relatives f) No one

43. What was the frequency of meal per day after delivery ?

a) Two times b) Three times

c) Four and more times

44. Did you take postnatal care service ?

a) Yes b) No

45. Where did you visit for PNC ?

a) Home b) Hospital

c) Health post d) Other .....

46. Whom did you visit ?

a) Doctor b) Nurse

c) HA/AHA d) Other .....

47. Are you healthy in general till now ?

a) Yes b) No