CHAPTER I
INTRODUCTION

1.1 Background of the Study

Urbanization refers to the process of growth in the proportion of population living in urban areas. Historically, the concept of urbanization has been related to the specialization, industrialization and the consequent economic development. Although the form of this relationship has remained contested, there is a general consensus among scholars that a fundamental characteristic of urbanization is the structural shift in employment from agriculture to non- agriculture pursuits. In other words, urbanization is a territorial response to structural change in the economy. A distinctive division of labour, technology based production of goods, trade of a variety of goods and service, high level of spatial and economic interaction, and relatively high density and diversity of population are basic tenets associated with urbanization (Population Studies in Health Sector, Ministry of Health and Population Nepal, 2008).

The distinction between town and country is not merely a distinction based on the nature of settlements, it is a distinction rooted in the economic structure and social relations of production and reproduction, and in the process of social and political consciousness and its articulation. Therefore, urbanization is often taken as a proxy for the level of development in general (Sharma, 2003). Urbanization is the process of people moving to cities or other densely settled areas (PRB, 2005).

The 1952/54 census provides data on 10 *prominent* settlements with a population of over 5,000 but refrained from defining an urban area. The 1961 census for the first time defined an Urban area or '*Sahar*' "as an area with a population cluster of 5,000 and over and having urban environment such as high school, college, judicial and administrative offices, bazaar,

communication facilities, mills, factories etc," but also indicated that the definition was not strictly followed (Bastola, 1995).

Embedded with urbanization, migration is the geographic movement of people across a specified boundary for the purpose of establishing a new permanent or semi- permanent residence. Along with fertility and mortality, migration is a component of population change. The terms" immigration" and emigration" are used to refer to the moves between countries (international migration). The parallel terms *"in migration"* and *"out – migration"* are used for movement between areas within a country in the form of internal migration and it is these sorts of migration which is embedded with the health related behavior of the people (Population Studies in Health Sector, 2008).

Likewise, the issue embedded with health issue is *breastfeeding.* Breastfeeding is the feeding of an infant or young child with breast milk directly from mothers breasts, not from a baby bottle or other container. Babies have a sucking reflex that enables them to suck and swallow milk. It is possible for most mothers to nourish their infant (or infants in the case of twins and multiple births) by breastfeeding for the first six months, if not longer, without the supplement of infant formula milk or solid food.

In most situations human breast milk is the best source of nourishment for human infants, preventing disease, promoting health and reducing health care costs (exceptions include situations where the mother is taking certain drugs or is infected with tuberculosis or HIV). There exists disagreement about how long to breastfeed to gain the greatest benefit, and about the risks of using artificial formulas. In both developing and developed countries, artificial feeding is associated with more deaths from diarrhoea in infants.

The World Health Organization (WHO) recommends breastfeeding for up to two years or beyond and exclusive breastfeeding for the first six months of life. The American Academy of Pediatrics (AAP) recommends at least one year of breastfeeding and exclusive breastfeeding for the first six months of the infant's life. Exclusive breastfeeding for the first six months of life "provides continuing protection against diarrhea and respiratory tract infection" that is

more common in babies fed formula. The WHO and AAP both stress the value of breastfeeding for mothers and children. While recognizing the superiority of breastfeeding, regulating authorities work to make artificial feeding safer when it is not used.

According to a WHO (2001), alternatives to breastfeeding include:

- *expressed breast milk from an infant's own mother.*
- *breast milk from a healthy wet-nurse or a human-milk bank.*
- *a breast-milk substitute fed with a cup, which is a safer method than a feeding bottle and teat.*

Migration and Urbanization plays a vital role in breastfeeding practices and behaviors, because women's habitation, occupation, socio economic status are changed with migration. Migrant people assimilate their culture, behavior, and practice on the basis of residual society. Urbanization affects their traditional behaviors, they ought to behave as a civilized society like using bottle, can (container) feeding e.g. artificial feeding to their child due to the cause of professional, occupational situations, as they don't have time to breastfeeding. Another fact is that, many women feel that they will lose their beauty with their *loose hanging* breast if they breastfed to their infants.

A meeting point of people from diverse backgrounds, the Pokhara sub-metropolitan city in particular, emerged from a minor beginning. Construction of two highways viz, the Sunauli Pokhara highway (1969) and the Prithvi highway (1972) linked with the Terai and Kathmandu designation of Pokhara as the headquarters of the Western Development Region of Nepal in 1972 contributed to upgrade it into the present status of sub- Metropolitan city in 1996.

The total population of Pokhara in 2008 (CBS, mid term evaluation) is 2, 19, 215 having 3, 970 per Sq km population density, 71.9 percentage literacy rate, 7.41 population growth rate and 55.66 Sq. kilometer coverage area of land. Households by type of ownership of housing unit in use of percentage are that 46% have own house and 49% have rented, 4% institutional, 0.83% rent free and 0.33% have others (Municipality Profiles of Nepal, 2008). According

to the DPHO, Kaski (District Public Health Office, 2008), there are 4839 infants with less than one years population, 9572 below 2 years and 23, 422 under five populations.

There is one NGO working in Pokhara sub metropolitan office named as UBS (Urban Basic Services) which was implemented as a joint venture of Nepal Government ministry of local development and UNICEF in 15 municipalities of the country since 1992. During the period of 1992- 1997 UNICEF had also actively participated to construct the physical facilities which stopped and diverted to the various trainings such as MCH (Maternal and Child Health), Child Development Center, Child Literacy Program, Child Development, Child Rights, Female Rights and Gender.

Since 2002, UNICEF had started the DACAW (Decentralized Action for Child and Women) program through DDC (District Development Committee) to implement the child and female development in Government and non Government Institutions. The agreement was for 5 years e.g. since 2002 to 2006 in municipalities of Nepal. Pokhara base UBS (Urban Basic Services) program is the one Institution. At the end of 2006 the UNICEF supported child development and all programs have been phased out; however UBS Pokhara has been continuing the service of MCH (Maternal and Child Health) clinic in 1-18 wards of municipalities including Sidhartha Club, Rato Pahiro Kaski (Lalteen Bazaar), Abhiyan community Hospital, Female Asylum and Landfield site in 24 clinics.

Likewise the *Sansthagat* clinic of DPHO (District Public Health Office) Kaski is attached in the WRH (Western Regional Hospital) building since B.S. 033/34 providing family planning, MCH, EPI (Expanded Programme on Immunization) services regularly which are Male/Female sterilization, Contraceptives distribution/ Counselling, Antenatal examination, Postnatal examination, Immunization clinic.

Similarly UBS (Urban Basic Services) has been serving Immunization, Maternal and Child Health (MCH), primary treatment to the children who have been attending the clinics in each wards of the Municipality. Immunization serves to the Infants (0-1 years), mothers are having breastfeeding practices as

well as complementary feeding after the age of 6 months later. Even in MCH Clinic mothers come to exam Antenatal, Postnatal, general health examination to their child. Hence, the Health workers can observe breastfeeding practices of mothers and their cultural practices. Although medically regarded best, many mothers used to say that *colostrums* which is the first, yellow, bulky milk is not fed to their children. It is due to the cultural practices in the community. Culturally *colostrums* (immunity) is indigestible and impure to their new born child, so few mothers say they don't fed immediately after birth. Among the mothers low socio economic status, backward caste/ethnicity, migrant mothers, uneducated are reluctant to feed colostrums to the newly born babies. But most mothers practice colostrums feeding to newly born babies.

1.2 Statement of the Problem

Due to the urbanization and migration (seasonal as well as occupational), the Growth rate of Pokhara is too high as compared to other cities of the country. The Growth rate of the city is 7.41 percent and having 4839 less than one year children. (Pokhara sub-metropolis, 2008). Housing, feeding, clothing are the basic needs of human being. So, house occupying mothers are 46 percentage who have their own house in the city but 49 percentage do not have their own house and they are living in few rooms paying rent in others house. Household by type of ownership of house/housing unit in use of percentage are 46% who have their own house and 49% have rented. It shows that occupational, professional population is greater than permanent residential, squatting is considered as a problem for the society in general and particularly a major problem in urban area. But in deep study and the approaches to clear out such settlements showed a need to look into such matters in a different ways (Pokhara Municipality, 2008). There are however, examples found in middle East, Brazil etc, where national and local governments joined forces to treat urban problems in its totality (Thapa, 1994).

It has been deduced that in Nepal 48 deaths per 1000 live births and 61 per 1000 live births infants are under five respectively. Infant Mortality Rate (IMR) is the ratio of deaths under 1 year of age in a given year to the total

number of live births in the same year; usually expressed as a rate per 1000 live births (MOHP, 2008). It is one of the most universally accepted indicators of health status not only of infants, but also of whole population and of the socio economic conditions under which they live.

Mother's level of education is strongly associated with child mortality. Children born to woman who have completed secondary education upto the bachelor level experienced an infant mortality rate of 13 deaths per 1000 live births compared with 69 deaths per 1000 live births for those whose mothers are not educated at all (Nepal Demography Health Survey, 2006).

Infant mortality rate is the highest among children born to mothers under age 20 and over 40 years. First birth and birth of over seven and higher also suffer significantly higher rates of mortality than births of order two to six. Spacing children at least 36 months apart is safest and healthiest for the mother and the child. WHO has recommended only around half of children under six months (53%) are exclusively breast fed. The average duration of breast feeding in Nepal is 34.3 months (MOH&P, 2008).

The causes of Infant mortality are Acute Respiratory Infection (ARI), Diarrhoea and Malnutrition. Malnutrition starts at pregnancy and after birth while a child fed breast. Breast feeding plays a vital role to reduce malnutrition and mortality of Infants. (Training Manual of IYCF, 2008).

No doubt all Nepalese Women (98%) feed their breast after child birth. But the problem is the lack of knowledge of proper position and attachment of breast feeding. Another problem is weaning, few mothers feed their children before the age of 6 months and some do not feed after the age of one year. All nutrients, calories are not fulfilled after 6 months of age of the child even mother feel that breast milk is much excreting.

Even though breast feeding to the child, there are 2,3 hours intervals of breast fed, it means at least 8 times in a day (24 hours). And time of breastfed at once is not less than 10-20 minutes. Exclusive breast feeding below 6 months child, appropriate time, duration of breast fed, proper position, attachment are the clues for breastfeeding norms recommended by WHO as

CB-IMCI (Community Based Integrated Management of Childhood Illness) protocols which plays the role of reducing Infant Mortality and decreasing trend of breast cancer in mothers. But mothers of Pokhara valley have not attained above clues due to poverty, jobs, social-cultural norms and feeling of beautiless to some fashionable women.

Among babies, stunted underweight and wasted has been increasing after the age of 6 months completion which indicates that inadequate complementary feeding (weaning) in quality, times and hygienic practices (MOH&P, 2008). On the behalf of breastfeeding practices, 35.4 percent child have been breastfeed within one hour after birth, 85% have been fed within 24 hours and 36.5% have been fed prelacteal (lactogen, can milk etc) food. Among the 6-9 months child 96% children have been fed cereals food and only 50% are fed vegetables and fruits. Only 29.6% have been eating meat and animal proteins. In Nepal, infants are fed three times a day, where as WHO (2008) has suggested 4-6 times launch with snacks between the meals (IYCF manual 2008).

The problems related to the breast feeding behaviours are also complex and concerned with economic, educational, social and cultural status of breast feeding mothers. On one hand, breast feeding mothers are becoming the victim of malnutrition in the lack of proper diets, on the other hand, their breast feeding behaviours are also not free of complexities. Ignorance, lack of health cautions, barriers of social, cultural norms, education are influencing the breast feeding behaviour of mothers. This study will ponder on all the issues related to the practices of breastfeeding among the breastfeeding mothers in Pokhara. Even though Nepal Government, (MOH & P) has been appreciating one most crucial intervention eg. CB-IMCI package program through out the country. But municipalities have not included it in policy, so the problem is in the cities or municipalities where more people come from out side for various options. So one joint venture has to be merged through local Governance and Nepal Government Ministry of Health & Population and Ministry of Local Development to implement the reducing Infant Mortality and through

nutritional Intervention initiating exclusive breast feeding which has been guided by MOH& P, Department of Health Services, Child Health Division following rules as CB IMCI protocols which is in WHO guidelines.

1.3 Objectives of the Study

Breast feeding is not only a pure health issue but rather embedded with social, cultural and economic contexts. The general objective of the study is to find out the practices of breastfeeding among the breastfeeding mothers in Pokhara. The specific objectives of the research are as follows:

i) To find out the cultural practices of breastfeeding.

ii) To find out the antenatal and postnatal phenomenon.

iii) To find the duration of breast feeding after childbirth and age up to discontinue.

iv) To find out the importance, intervals and duration of breast feeding at once.

v) To find out the proper position, attachment of breast feeding as following IMCI protocols.

To meet the objectives the following research questions have been raised

i) What are the prevailing cultural practices on breast feeding in our society?

ii) How early the infants are breast fed and what its importance after birth?

iii) Do mothers know the proper position and attachment of breast feeding?

iv) What are the composition and immunity role of the breastfeeding?

v) At what age complementary feeding is needed and what its role in nutrition?

1.4 Rationale and Significance of the Study

Pokhara is the city of Western development region, having rich and poor, educated, illiterate and diverse ethnic groups. The one of the Intervention of reducing IMR implemented by Ministry of Health is CB-IMCI programme which is running since 1995 and more than 50 districts have managed it. This current study has illustrated the effect of CB-IMCI programme in Pokhara and

has also indicated the status of breast feeding and bottle feeding practices. A comparative study has been done to urban and rural population on their breast feeding practices.

Proper position of breast feeding, attachment, time, duration, knowledge and practices of *Colostrums* feeding as well as exclusive breastfeeding, complementary feeding are vital part of infants health. Nutrition plays a vital role in breast feeding; Colostrums feeding is the main intervention which reduces Infant Mortality Rate (IMR). Colostrums is the nutritious food for infant which comes immediate after birth, containing energy (carbohydrate), protein, vitamins, and minerals. Colostrums provide immunity to the child as an innoculing vaccine to prevent against various communicable diseases.

Likewise, in the same manner, exclusive breastfeeding provides energy, proteins food, vitamins, minerals and liquids. Even though water and medicines except in the diseased conditions are not necessary to the child breast feeding for babies less than 6 months of age is prerequisite. Breast milk is easily digestible, pathogen free, nutritious and also helps in binding mother to child in cognitive relationships, which plays vital role in future in society and community. Thus, given the vitality of breast feeding of the health of infants who are the future citizens of the nation, this study is fully significant and rationale in the sense that the outcomes of the study will be vital. The study will find out the actual status of breastfeeding practices of mothers among educated, illiterate, richer and poorer, urban and slum dwellers. It will also specify that the bottle feeding to the child is due to the lack of time for professionals and job holders. Professionals (workers) go to field early in the morning; hence their child fed prelacteal foods, animals' milk practicing bottle feeding. Using bottle, there may be chances of bacterial growths in teeth and container, which leads diarrhoea to the children.

Many experiences have shown that communicable diseases like measles, mumps, pneumonia, diarrhoea are rampant to bottle feeding children. Such prevalence of communicable diseases leads malnutrition. Malnutrition leads low immunity, low immunity leads communicable diseases. Low immunity,

prevalence of communicable diseases, malnutrition is the leading causes of high Infant Mortality Rate. Bottle feeding practices have to be discouraged by exclusive breastfeeding laws but time, money and support have to be facilitated by the Government. Finally the research work will empower the researcher, policy maker, planner to find out the differences in rural and urban society of the community, especially in Pokhara Municipality.

This study will find out the gender discrimination of infants by their mother and spacing between the older and younger kids. In our society male children are more facilitated as well as served by their parents than female children. It is gender discrimination behaviour. In our cultural practices male child is fed complementary feeding (weaning) after 6 months completion and female child at 5 months completion. After completing six months age, there may be difference in complementary foods. Male child may get nutritious foods; where as female child may not be getting as male child.

The outcome of attitude and practices of Nutrition especially breast feeding as well as complementary feeding to child may reduce the Malnutrition proportion of existing 50% and Infant Mortality Rate of 48/1000 existing status. The findings of the study will help not only in exploring the breast feeding practices of mothers but will also be helpful in tracing the malfunctions and the socio-cultural barriers of perfect breast feeding which in future will pave the ground for the policy makers to make appropriate laws, rules and regulations related to the breast feeding for making a healthy nation of tomorrow. Thus, this study is fully rationale and significant.

1.5 Operational Definitions of Key Terms used in the Study

Abandon - If someone does something and make time pass in an enjoyable way: childhood amusement.

Asylum - Prisoner's residence.

Atopic -Atopic eczema is an allergic eczema.

Begetter - A causes something or makes it happen: Hunger begets crime.

Caste ridden and priest ridden society: A society where there is a prime role of caste based norms reinforced by orthodox *Brahministic rite de passage*, values and actions.

Circumvented- To avoid a problem or rule that restricted you especially in a cleaver or dishonest way – used to show disapproval.

Culture of Poverty- Sociologists believe that the stage of acute poverty, backwardness and suppression for a long time, used to produce a *culture of poverty*-- that is a culture shared by the poor and the backwards of the same group. The term culture of poverty was first used by An American Sociologist Oscar Lewis in 1968 while conducting study on the blacks of Central America. The culture of poverty, thus, is a design or a style for living, which is transmitted from one generation to next and which influences all aspects of individual's life.

Contested - A competitions or a situation in which two or more people or groups are completion with each other.

Consensus - An opinion that everyone in a group agrees with or accepts.

Colostrums - Yellowish, bulky milk immediate after birth.

Dyspnoea - Difficult in breathing.

Inferred - To form an opinion that something is probably true because of information that you have.

Nurturing - Feeding nutritiously.

Pursuits - When someone tries to get, achieve or find something in a determined way.

Procreate - Formal to provide children or baby animals: (reproduce procreation)

Paradigm - Technically a model or example that shows how something works or is produced, formal a very clear or typical example of something.

Prelacteal - A substitution feeding ingredients except breast milk e.g. lactogen etc.

Refrained - Formal not to do something that you want to do.

Stunted - Relating less than normal age.

Spatial - Relating to the position, size, shape etc of things.

Social, Cultural factors: These factors are associated with society's social realities and cultural factors viz. norms, values, customs, gender balance, Casteism, elitism etc.

Tenets – A principle or belief, especially one that is part of a larger system of beliefs.

Under weight - Weight less than normal.

Weaning - Complementary feeding after the age of six months completion.

Wasted - Muscle wasting, owing to lean and thin.

Wheezing - A typical sound heard during respiration.

CHAPTER II

REVIEW OF LITERATURE

For tracing and identifying the problems in any research work it is essential at first to have a literary evaluation of the matter to be dealt with. It helps to stay away from the possibility of duplication in research works and gives the work a literary authenticity. Without any regard to the past, it is unreasonable to pass away judgment on the present. Hence, the importance of the review of literature in any research work remains crucial. In this study, beyond others, a perusal has been made of theoretical perspectives embedded with nutritional anthropology and medical anthropology, conceptual overview etc. Side by side theoretical and conceptual framework espoused for this study will provide incentive for guiding the study.

Nutritional Anthropology

Nutritional anthropology has emerged as a new branch of applied anthropology over the past 15 years, and its methods are having an important influence on the methods of nutrition survey and nutritional epidemiology. The field of nutritional anthropology has continued to develop rapidly since the original workshop and the subsequent period in which the chapters were written. Nevertheless, the methodological guidance is not available elsewhere for applying anthropological methods to the conventionalizing (Beaton, Milner, P. Corey, et al. 1979).

During the past decade many nutritional scientists have become interested in multidisciplinary approaches to problems of malnutrition. At the same time, there has been a growing recognition among other social scientists of their potential role in research and programme development with respect to nutritional issues in the modern world. Increasingly, anthropologists and other

social scientists have become involved in research and applied activities in nutrition. From such collaboration, new directions for research are emerging. Among these, the comparatively new sub discipline of nutritional anthropology is beginning to generate a body of data and theory on the relationships of nutrition to socio-cultural, economic, and ecological processes (Burke, 1947).

Medical Anthropology

Medical anthropology is a subfield of social and cultural anthropology. It is a term which has been used since 1963 (Scotch & Norman, 1963). Medical anthropology is a label for empirical research and theoretical production by anthropologists into the social processes and cultural representations of health, illness and the nursing/care practices including the breast feeding practices associated with these. Furthermore, in Europe the terms “anthropology of medicine”, “anthropology of health” and “anthropology of illness” have also been used, and “medical anthropology”, was also a translation of the nineteenth century Dutch term "*medische anthropologie*". This term was chosen by some authors during the 1940s to refer to philosophical studies on health and illness (Laín Entralgo, Pedro 1968)

The relationship between anthropology, *medicine* and medical practice goes back a long way and is well documented (Comelles & Martínez, 1993). General anthropology occupied a notable position in the basic medical sciences (which correspond to those subjects commonly known as pre-clinical). However, medical education started to be restricted to the confines of the hospital and medicine in general adopted a reticent attitude towards the empiricism gained by doctors working in their daily practices among the people.

Furthermore, its basic source of knowledge was experimental medicine in the hospital and laboratory, and these factors together meant that over time doctors abandoned ethnography. This abandonment happened when social

anthropology adopted ethnography as one of the markers of its professional identity and started to depart from the initial project of general anthropology. The divergence of professional anthropology from medicine was never a complete split. The relationships between the two disciplines remained constant during the twentieth century, until the development of medical anthropology in the 1960s and 1970s.

For much of the twentieth century the concept of *popular medicine*, or *folk medicine*, has been familiar to both doctors and anthropologists. Doctors, anthropologists and medical anthropologists used these terms to describe the resources, other than the help of health professionals, which European or Latin American peasants used to resolve any health problems. The term was also used to describe the health practices of aborigines in different parts of the world; with particular emphasis on their ethno botanical knowledge. This knowledge is fundamental for isolating alkaloids and active pharmacological principles. Furthermore, studying the rituals surrounding popular therapies served to challenge Western psychopathological categories, as well as the relationship in the West between science and religion. Doctors were not trying to turn popular medicine into an anthropological concept, rather they wanted to construct a scientifically based medical concept which they could use to establish the cultural limits of biomedicine.

If every culture had its own specific popular medicine based on its general cultural features, it would be possible to propose the existence of as many medical systems as there were cultures and therefore develop the comparative study of these systems. Those medical systems which showed none of the syncretic features of European popular medicine were called primitive or pretechnical medicine according to whether they referred to contemporary aboriginal cultures or to cultures predating Classical Greece. Those cultures with a documentary corpus, such as the Tibetan, traditional Chinese or Ayurvedic cultures, were sometimes called *systematic medicines*.

The comparative study of medical systems is known as ethnomedicine or, if psychopathology is the object of study, ethnopsychiatry (Park, 2002)

Under this concept, medical systems would be seen as the specific product of each ethnic group's cultural history. Scientific biomedicine would become another medical system and therefore a cultural form which could be studied as such. This position, which originated in the cultural relativism maintained by cultural anthropology, allowed the debate with medicine and psychiatry to revolve around some fundamental questions:

1) The influence of culture on what a society considers being normal, pathological or abnormal.

2) The verification in different cultures of the universality of the nosological categories of biomedicine and psychiatry.

3) The identification and description of diseases belonging to specific cultures which have not been previously described by clinical medicine.

These are known as ethnic disorders and, more recently, as culture bound syndromes, and include the *evil eye* and tarantism among European peasants, being possessed or in a state of trance in many cultures, and nervous anorexia, nerves and premenstrual syndrome in Western societies.

All these earlier studies are prone to prepare the background for conducting the current study on the breast feeding behavior of mothers of the infants.

Theoretical Perspectives

The Theory of Planned Behavior (TPB)

The theory of planned behavior (TPB) is used to explain breastfeeding behaviors in different cultures. This theory is helpful to evaluate cross-cultural

application of breastfeeding duration among mothers (Nursing Research Journal, Hong Kong, 2003).

Three predictive models proposed under TPB are: (a) a strict interpretation of the TPB with two added proximal predictors of breastfeeding duration; (b) a replication with modification of the TPB-based model for more fully employed breastfeeding mothers and (c) a model that posited perceived control (PC) as a mediating factor linking TPB motivational variables for breastfeeding with breastfeeding intentions and behavior. Cross-cultural measurement issues and the need for prospective designs are continuing challenges in breastfeeding research.

The General Theory of Primal Seduction

French psychoanalyst Jean Laplanche (2004) has mounted a return to Freud's officially abandoned theory of seduction and its reformulation as a general theory of primal seduction, emerging out of a decade's long critical archaeology of the Freudian conceptual field.

Primal seduction is the fundamental anthropological situation of the human being, and the primacy of the other it entails, Laplanche proposes, is the basis for the formation of the unconscious and the organization of human sexuality. They address the topics of sublimation and cultural production, psychosis, female sexuality, the function and fantasy of breast-feeding, the structure and cultural effects of fantasy, and the question of hermeneutics. They are striking testimony to the productivity of Laplanche's proposed 'new foundations' as a vital and developing research programme for psychoanalysis. Laplanche's formulation of is called the 'fundamental anthropological situation' of the human infant. He conceives this as a dual situation involving the infant's need and dependency on the care and nurture given by the adult other (an inter-subjective situation marked by bilateral communication as described by attachment theory), on the one hand, and as well the implantation of enigmatic messages in the primitive body-ego of the infant via the adult's gestures of care and expressions of feeling, both verbal and non-verbal (a unilateral transmission that is enigmatic because derived from the adult's unconscious sexuality in a situation of primal seduction), on the other.

As well as developing this model of primal seduction, the work of resituating and relocating classical concepts and debates also continues with a path-breaking meditation by Laplanche himself on the theory of sublimation, unfinished and unsatisfactory in Freud, even in his rich and productive text on Leonardo and his art; with a reformulation of the problematic of parental 'primal scenes' in relation to the mother-child couple and the experience of breast-feeding with a return to the classical debates on female sexuality and a reconsideration of the question of precocious vaginal eroticism and a critique of the orthodox thesis of phallic primacy, in order to articulate the presence in

Freud's work of a subordinated counter-thesis that emphasizes a primordial and repressed femininity, legible through the lens of the theory of seduction and implantation. Laplanche's short set of theses on narratives and hermeneutics reflects on the primal anthropological situation of the human infant, to emphasize the centrality of interpretation and translation in that situation, indicating briefly an important affinity with the philosophy of Martin Heidegger in order to question the retrospective 'constructivism' and relativism of the 'narrativist' current in contemporary psychoanalytic thought.

The data and theory of nutritional anthropology reflect anthropological methodologies, including some of the basic, traditional features of the discipline such as community studies and participant observation. But there are also some research procedures that have been developed recently to address new research questions. The accent is on applied research, on investigations that are carried out for the purposes of general nutrition planning and specific programme development, as well as evaluation of ongoing programmes. At the same time, the discussions of research tools and issues will also be of use to theory-oriented researchers working at some remove from applied projects, since many areas of theoretical concern are closely intertwined with applied, practical aims (Burke, 1947).

The work of nutritional anthropologists, like that of other anthropologists, covers a broad spectrum of theoretical perspectives, utilizing a wide range of research techniques. Some investigators focus on the cultural context, seeking to understand the meaning of food in cultural and symbolic terms. Others are interested primarily in identifying the linkages between local conditions and national and international political and economic forces. Biological anthropologists emphasize the interactions of genetics, physiological processes, population characteristics, and a wide variety of nutrition-related diseases. Medical anthropologists working in community health projects are usually concerned with the interrelationships among community health programmes, dietary patterns, and other aspects of local and regional cultures.

While there are a number of commonalities among these different approaches, especially the commitment to a "holistic," multifactor analysis, the research techniques that could be included are many and varied. One criterion was to exclude those aspects of methodology that have been extensively examined by nutritional scientists, including food intake measurement, anthropometry, and other measures of nutritional status assessment. These are topics on which there is an extensive literature. However, some comments about the use of ethnography to improve dietary intake measurements are put forward in this introduction because this matter has received little attention (Beaton, Milner, P. Corey, et al. 1979).

A second criterion by which the scope of discussion was narrowed was to exclude socio-cultural issues and concepts that have been well covered in the standard literature of anthropology. For example, details of measuring "socio-economic status" or "family organization" are not addressed, even though they are often of major importance in nutritional anthropological research. A third criterion was that special attention should be given to the problems of transforming qualitative, descriptive information, e.g. about food-use patterns, social factors, and activity patterns, into quantifiable observations that can be used in statistical analyses. The rationale for this criterion involves the assumption that one of the important strengths of the anthropological contribution to nutrition research is the description of cultural processes. To be useful in practical application, these descriptions often have to be focused at the level of individual or household units - the same units that are used for measurements of nutrition and health variables.

A fourth criterion was an emphasis on problems of research design and data analysis, a feature that becomes particularly critical in multidisciplinary research. Finally, we felt it would be important to include some discussion of the types of issues that are encountered when research designs meet the realities of field situations.

Anthropological traditions place emphasis on the importance of long-term residence in a community, with many months of descriptive research as an essential prerequisite to focused, quantitative data gathering for purposes of hypothesis testing. However, intensive ethnographic field-work is often seen by other researchers in a multidisciplinary way.

Anthropologists should undertake to develop guidelines that are regionally and ecologically specific for key domains of ethnographic data relevant to nutritional anthropology. For example, in most areas of intensive agriculture, modes of land ownership and cropping patterns are nearly always relevant to an understanding of local and household differences in food availability. In urban areas, information on the organization of commercial food distribution and transportation networks is essential to understanding food-use behavior.

Likewise, the current study on the breast feeding behaviors of mothers of Kaski will also provide information and help in breast milk suckling behaviors of babies as well as the practices of mothers.

The influence of religious beliefs and practices are quite peripheral to food-intake patterns in some regions, while they play a large role in other cultural settings. A general overview of the key factors affecting food production, distribution, and consumption could help direct nutrition researchers' attention to potentially important data-collection activities.

At the heart of much research in applied human nutrition and nutritional anthropology is the matter of *food* (may be breast milk for baby) intake. Food is, after all, the carrier for most nutrients consumed by humans, and the specification of nutrient intake requires quantitative data on food consumption.

Given its central place in nutrition, one would expect to find a long tradition of methodological research on food intake measurement within nutritional science. Indeed, the literature is massive (Marr, 1971; Todd, Hudes,

and Calloway, 1984), and decades of research, albeit of varying quality, have provided a quantity of information about the problems of dietary intake measurement. In recent years methodological research on food intake has become increasingly sophisticated (Beaton et al., 1979); our understanding of measurement problems and of sources of error and variation continues to grow.

In the literature on food-intake measurement, there is considerable ambivalence about whether it is legitimate to base the choice of measurement in part on the population being studied and not only on the kinds of questions being asked. In this context, ethnographic data can be useful in providing information on the cultural factors that could be expected to facilitate or distort the validity of different methods of dietary data collection.

Anthropological methods do not provide a panacea for the problems of food-intake measurement. However, ethnographic research can improve data quality with respect to two primary aspects of intake measurement (Beaton, Milner, P. Corey, et al. 1979):

1. The selection of a method for food-intake measurement most suited to the particular population studied.
2. The selection of a sampling frame to generate a representative dietary record for an individual or household.

The degree of precision in the specification of nutrient intake outside of a closed metabolic unit depends on the accuracy of the food-intake record. The extent to which a highly accurate record, based on observation and weighing, can be obtained for a single day will vary from one cultural setting to another. The extent to which a representative sample of intake over a period of time can be obtained through weighing is also highly dependent on cultural factors, which are not necessarily isomorphic with the factors that affect precision for a single day.

Ideally, the selection of a method for obtaining food-intake data should be based on a series of criteria, including information on the potential sources of error and problems that may occur because of socio-cultural characteristics. Such information is even more critical for the development of specific data-collection protocols, since many of the potential problems can be circumvented with effective interview modes.

The significant temporal variables can be placed into two categories, "factors that directly affect food availability, including the effects of seasons, marketing practices and cash flow," and "factors that indirectly affect food availability through cultural regulation, including the effects of work schedules and the calendar of sacred and secular ceremonials" (Jerome and Pelto, 1981).

Ethnographic data provide vital information about social and cultural sources of temporal variability in food intake. While these sources are not the only components to consider in setting up a "sampling frame" for food-intake measurement, it is very important to have such data during the critical period when the research design is "fitted to" the local research scene.

May be the breast feeding of an infant or the quest for food by an adult, the need of food has shaped the development of human society. In his search for sustenance, man has influenced population growth and urban expansion, has dictated economic and political theory, and has inspired wars. Food and the science of food touch our lives in numerous ways. Many religions follow strict dietary laws –may be eating food or sucking of breast milk by a baby. Some of the earliest observations in the world of chemistry came from the preparation and cooking of food. Food has influenced technology, too. The water wheel, developed for the milling of grain, became a primary tool during the Industrial Revolution. Even class distinctions in some societies are determined by what foods are put on the table.

No doubt, the technological explosion will continue to affect why we eat what we eat but the infants' most ideal food—the milk is a *matter* which needs serious study (UCLA center for human nutrition, 2006).

2.1. Nutrition and Health

"What people eat is not calories but food, and consideration of fads; flavours and variations of appetite can make nonsense of the dietician's theories" (Park, 2002)

Nutrition may be defined as the science of food and its relationship to health. It is concerned primarily with the part played by nutrients in body growth, development and maintenance. (Park, 2002)

Classification of Foods

There are many ways of classifying foods:

1. Classification by origin:
   a) Animal origin foods. b) Vegetable origin foods.
2. Classification by Chemical Composition:
   a) Proteins b) Fats c) Carbohydrates
   d) Vitamins e) Minerals
3. Classification by predominant function.
   a) Body-building foods, e.g. milk, meat, poultry, fish, eggs, pulses, groundnuts, etc.
   b) Energy- giving foods, e.g. cereals, sugars, roots and tubers, fats and oils.
   c) Protective foods, e.g., vegetables, fruits, milk.
4. Classification by nutritive value:
   a) Cereals and millets. b) Pulses (legumes)
   c) Vegetables d) Nuts and oilseeds e) Fruits f) Animal foods.
   g) Fats and oils. h) Sugar and jaggery.
   i) Condiments and spices. j) Miscellaneous foods (Park, 2002).

There are 50 different nutrients which are normally supplied through the foods we eat. Each nutrient has specific functions in the body. Most natural foods contain more than one nutrient. These may be divided into:

i) Macro nutrients: These are proteins, fats and carbohydrates which are often called "Proximate principles" because they form the main bulk of food.

ii) Micro nutrients: These are vitamins and minerals. They are called micro nutrients because they are required in small amounts which may vary from a fraction of a milligram to several grams.

(Park, 2002)

Nutrition of Children and Women:

The poor nutritional status of children and women has been considered a serious problem in Nepal for many years. The most common forms of Malnutrition in the country are Protein Energy Malnutrition (PEM), Iodine Deficiency Disorder (IDD), Vitamin A Deficiency (VAD) and Iron Deficiency Anaemia (IDA). (Nepal Demographic Health Survey 2006).

Initiatives have been underway for more than three decades with national nutritional strategies developed in 1978 (National Nutrition Strategy), 1986(National Nutrition Strategy for Nepal), and 1998 (Nepal National Plan of Action). Several programs with an explicit nutrition component have been launched in Nepal under the initiative of the Nutrition Section of the Ministry of Health and population. It was in 2004-05 that a National Nutrition Policy and Strategy was compiled and approved, which provided a comprehensive documentation on nutrition policy and strategy (Ministry of Health and Population, 2006). The major partners in initiating programs to address the problem of malnutrition the United Mission to Nepal, World Food Program, Save the Children Alliance, and USAID. Additionally, UNICEF – Nepal and the Micronutrient Initiative- Nepal have also played important roles. (Nepal Demographic Health Survey 2006).

Since fiscal year (2060/061), Child Health Division decided to celebrate February as "the month to create general awareness about the use of iodized salt' by conduction different activities with the help of different partner agencies like UNICEF, WHO and Salt Treading Corporation Ltd. This advocacy campaign is expected to further contribute in the prevention of Iodine Deficiency Disorders (IDD).

Micronutrient Initiative (MI), in 2005 conducted the survey to track the progress towards elimination of IDD in Nepal. Two main indicators for the IDD- Urinary iodine excretion and Salt iodine of household level were assessed in the Survey. The survey has revealed improved iodine status in Nepal as the median Urinary Iodine Excretion (UIE) among school- aged children increased from 144 microgram / litre in 1998 to 188 microgram/ litre in 2005, both of the

levels being over the minimum level designated by WHO to indicate the adequacy of iodine intake, i.e. 100 microgram/ litre. Nepal has however yet to achieve the goal of Universal Salt Iodization, which requires that at least 90% of households should be consuming adequately iodized salt. (Annual Report, Department of Health Services 2062/63)

Initiation of Breastfeeding:

Early initiation of breastfeeding is encouraged for a number of reasons. Mothers benefit from early suckling because it stimulates breast milk production and facilities the release of oxytocin, which helps the contraction of the uterus and reduces post partum blood loss. The first breast milk contains colostrums. Which is highly nutritious and has antibodies that the newborn prevents from diseases. Early initiation of breastfeeding also fosters bonding between mother and child. (Nepal Demographic Health Survey, 2006). Based on these literatures this study is prone to unearth the real practices of initiation of early breastfeeding and feeding colostrums.

Nutrition for Health and Development

Nutrition is an input to and foundation for health and development. Interaction of infection and malnutrition is well-documented. Better nutrition means stronger immune system, less illness and better health. Healthy learn better. Healthy people are stronger, are more productive and more able to create opportunities to gradually break the cycles of both poverty and hunger in a sustainable way. Better nutrition is a prime entry point to ending poverty and a milestone to achieving better quality of life (WHO, 2002).

As in Department of Nutrition, World Health Organization, Geneva, Switzerland Abstract Research has not provided unequivocal support for the recommendation to continue breast feeding until children reach at least age 24 months. In many circumstances, breast feeding duration is chosen or conditioned by factors other than scientific evidence and recommendations. Even in communities where breast feeding into the second year is a significant of toddlers are weaned before the recommended age (Springer Link, 2008). It was found from WHO study in Kenya in 2002 that breast feeding was

positively associated with growth in a manner that we inferred to be causal, the effect being stronger on linear growth than on weight gain. This was despite the fact that in a cohort where 95% were breastfeeding at baseline, the prevalence of stunting (height- for-age below-2 standard deviations of the WHO-NCHS reference) was already 48% (Springer Link, 2008). This study by WHO examined the socioeconomic characteristics, sanitation, morbidity and complementary feeding practices that define the context of this apparently contradictory relationship. The population was poor, no household had running water and malaria is endemic in the study area. Complementary feeding was initiated for 93 percentage of the cohort before age 3 months. The weaning diet was bulky (77% energy from carbohydrate), and high in phytate content (phytate): (zinc) molar ratio, 28. Diet quality, judged by diversity and animal source food intake, was low. Several micronutrient intakes were below current recommendations, including riboflavin (63%), niacin equivalents (64%), calcium (72%), iron (74%) and zinc (33%). Based on a locally defined socioeconomic status scale, children in higher SES households were breastfed for a shorter duration than were children from poorer households. Sanitation and water consumption modified the effect of breastfeeding duration on growth: the effect was stronger in the absence of a pit latrine and at low water consumption.

As based on the guidelines from above literature, the current study will find out the facts, behaviour and practices of mothers, cultural practices of nutrient and behaviours, drinking water, waste disposal, using sanitary toilets etc. These earlier studies will guide this study as a pioneer and comparatively weighing the weightage of the findings.

2.2 KENYA: Breast is best, even for Mothers with HIV

The risk of HIV-positive mother infecting child through breast feeding can be significantly reduced by antiretroviral treatment (ART), say health officials in Kenya (Plus News East Africa, 2008).

Recent clinical trials have found that putting nursing HIV-positive mothers on ART can suppress viral load and minimize the chances of transmission. East Africa, Great Lakes, Horn of Africa, Southern Africa, West African countries the nutritional and other health benefits of breast feeding over formula feeding have generally been thought to out weight the risks of HIV infection(UNICEF).

According to the WHO (World Health Organization), every year 10 million children younger than five die worldwide, often as a result of malnutrition. (19th September/ GLOB Plus/ News 2008). Promoting breast feeding is vital to achieving the Millennium Development Goal of a two-thirds reduction in childhood mortality rates by 2015.

For Park's (2002) on under any circumstances, breast milk is the ideal food for the infant. No other food is required by the baby until 4-5 months after birth. Under normal conditions, Indian mothers secrete 450 ml to 600 ml of milk daily with 1.1 gm protein per 100 ml. The energy value of human milk is 70 kcals per 100 ml. A child is breast-fed has greater chances of survival than a child artificially fed. Prolonged breast feeding does protect the infant from early malnutrition and some infections. The data suggest that infant mortality rates in developing countries are 5-10 times higher among children who have not been breastfed or who have been breastfed for less than 6 months. Despite the marked advantages of breast-feeding, its popularity has declined significantly in many parts of the world. Among the advantages of breast milk are the following (Park, 2002):

a) It is safe, clean, hygienic, cheap and available to the infant at correct temperature.
b) It fully meets the nutritional requirements of the intent in the first few months of life.
c) It provides considerable protection not only against diarrhoeal diseases and necrotizing entercolitis, but also against respiratory infections in the first months of life.

d) It is easily digested and utilized by both the normal and premature babies.

e) It promotes 'bonding" between the mother and infant.

f) Sucking is good for the baby-it helps in the development of jaws and teeth.

g) It protects babies from the tendency to obesity.

h) It prevents malnutrition reduces infant mortality.

i) It provides several biochemical advantages such as prevention of neonatal hypocalcaemia and hypomagnesaemia and

j) It helps parents to space their children by prolonging the period of infertility.

The mother's importance of breastfeeding exclusively up to the age of 6 months has been advocated in the above mentioned points. Advising the benefits of breast milk mothers may motivate and discontinue the bottle feeding practices. Knowledge, attitude, practices may change by counseling the mother's with suitable examples. All these will prepare the ground for the current study on breast feeding mothers of Kaski.

2.3 Benefits of Breastfeeding for Baby:

- Breast milk provides the right balance of nutrients to help an infant grow into a strong and healthy toddler. (Wikipedia, the free encyclopedia 2008)
- Breast fed infants, and those who are fed expressed breast milk, have fewer deaths during the first year and experience fewer illnesses than babies fed formula.
- Some of the nutrients in breast milk also help protect an infant against some common childhood illnesses and infections, and certain long infections.
- Some recent NICHD-supported research also suggests that breast milk contains important fatty acids (building blocks) that help an infant's brain development. Two specific fatty acids, known as

DHA and AA, may help increase infants's cognitive skills. Many types of infant formulas available in the all formula available with DHA and AA, and fortified with these fatty acids. (Health and Nutrition Breastfeeding , 2008)

For Mother

- In response to the baby's sucking, the mother's body releases a hormone that makes her uterus contract and get smaller.
- Many mothers also get emotional benefits from breastfeeding because of the closeness of this interaction with the baby and from the satisfaction of helping to nourish their babies. (Health and Nutrition Breastfeeding, 2008)
- Some research suggest that mothers who breastfeed their babies have fewer episodes of post-delivery depression. (Health and Nutrition Breastfeeding , 2008)
- There is evolving evidence to indicate that certain types of cancer (such as breast, uterus, and ovarian cancer) occur less often in mothers who have breastfed their babies.
- Many societies and cultures also encourage mothers to breastfeed, which can offer support to a new mother.

Are there cases in which it is better not to breastfeed?

In some situations, health care provides advice to a woman not to breastfeed (Health and Nutrition Breastfeeding, 2008)

- A woman with certain health conditions, such as HIV or active tuberculosis, should not breastfeed because she risks giving the infection to her infant through her breast milk.
- Women who actively use drugs or do not control their alcohol intake, or who have a history of these situations, may also be advised not to breastfeed.

- Certain medicine, including some mood stabilizers and migraine medicines, can also pass through the breast milk and cause harm to the infant.
- Women with certain chronic illnesses may be advised not to breastfeed, or to take special steps to ensure their own health while breastfeeding. For example, women who have diabetes may need to eat slightly more food while they breastfeed to prevent their blood sugar levels from dropping.
- Women who have had breast surgery in the past may face some difficulties in breastfeeding.

If a mother stops breastfeeding before the child is a year old, then she should feed her infant iron fortified commercially available formula. Health care provides advice women not to give their infants' cow's milk if the child is at least a year old (Park, 2002).

2.4 Venezuela-Excessive Motherhood

The Venezuelan family consists of a group of women and children. It is a family without where women only need men to procreate. The mother is worshipped at the expense of this excessive motherhood, fatherhood and conjugal relations occur only in ritual forms mother-child relationship with its overprotecting nucleus is the paradigm. (Venezuela – Excessive Motherhood Journal, 2008)

To be a mother defines the paradigmatic relationship. Scholarly studies (Vethen court 1981, 1982; Moreno 1993, 1994; Lopez 1980, 1993; Hurtado 1998, 1999), looking at sociological symbol, characterize the mother figure according to a fundamental threefold shape, or the models; a mother is begetter, a virgin, and a martyr. Data for these studies are obtained methods but rather by qualitative methods- for example, large interviews, life stories, by fieldwork. Each part of this threefold shape is explained as follows:

1. The belief that a woman is a mother because she gives birth involves a cultural destiny constitutes the begetter archetype. If the woman begets,

she becomes respectable; other culture qualifies her as an embittered person. Motherhood is always emphasized. Pregnant welcomed with joy and celebrated by rubbing the future mother belly. Ideally, a male expected for it reaffirms motherhood, even though a baby girl is desired. Part of this and of motherhood is a long period of breastfeeding. Samuel Hurtado (1998) has found that breastfeeding continues for one to two years (24 women), as long as the child wanted or until another baby is born (3 woman). Any pediatric advice against this long of breastfeeding is ignored under the intervention of the mother's mother (Torres, 1998).

2. The virgin in mother defines the second archetype. The grandmother is the virgin mother children. She has not borne. The grandmother wants and seeks more for her grandchildren for her own children. The mother-son structural axis continues in the grandmother-great relationship. The grandmother develops a feeling of ownership on the grandchildren stronger than her daughter's. A mother that never becomes a grandmother does not feel happily realize her motherhood. This is similar to the phenomenon of the woman who more devotion to an adopted child than to her biological off spring. This symbolic *trans* is inherent in every woman because Venezuelan culture makes her a mother from the true conception. (Venezuela – Excessive Motherhood 2008)

3. From indulgence and abandonment emerges the third archetype: The martyr mother. Venezuelan radically despire men. The mother suffers because she has to let her son as a male leave home. Husbands are almost an unnecessary burden. In the reciprocal husband-wife system is only a provider, whom society calls family father. It he abandons his wife but gives in his children, he is not considered irresponsible. The passage to manhood is very hard, means that the young male will be removed from his mother's concern. A mother expects her son will leave the home in search of amusement with other women and yet never feel

him for being born male. The marital process has a similar logic. Separation means that woman expels the man from the house.

Separation is not necessarily preceded by the interference of another woman. In spite of say, Venezuelan women accept that the man has another woman. The explanation that in offered is that another woman stood in their way-his mother, even though this may not be. (Venezuela – Excessive Motherhood 2008)

But in Nepalese context male child is having great importance than female due to the patriarchal society. Culturally male are the genotype who serves their parents, grandparents generation to generation. After marriage, female are detached with their parents biologically, culturally and sociologically. In few society e.g. Thakalis, Gurungs, Tamangs have importance of female child in comparison to Brahmins, Chettries. More or less in all Nepalese Communities accepting behavioral patriarchal types of cultural practices are rampant.

2.5 Breastfeeding a Phenomenon

Breastfeeding is the feeding of an infant or young child with breast milk directly from a woman's breasts, not from a baby bottle or other container. Babies have a sucking reflex that enables them to suck and shallow milk. It is possible for most mothers to nourish their infant (or infants in the case of twins and multiple births) by breastfeeding for the first six months, if not longer, without the supplement of infant formula milk or solid food. (Breastfeeding Wikipedia, the free encyclopedia 2008)

According to a 2001 World Health Organization (WHO) report, alternatives to breastfeeding include;

- Expressed breast milk from an infant's own mothers.
- Breast milk from a healthy wet-nurse or a human milk bank.
- A breast-milk substitute fed with a cup, which is a safer method than a feeding bottle and teat.

In most situations human breast milk is the best source of nourishment for human infants, preventing disease, promoting health and reducing health care costs (exceptions include situations where the mother is taking certain drugs or is infected with tuberculosis or HIV). In both developing and developed countries, artificial feeding is associated with more deaths from diarrhea in infants. The WHO recommends a minimum of two years of breastfeeding and exclusive breastfeeding for the first six months of life.

***Lactation*:**

The production, secretion and ejection of milk are called lactation. It is one of the defining features of being a mammal. (Breastfeeding- Wikipedia, the free encyclopedia, 2008)

Breast milk:

Breast milk is made from the nutrients in the mother's bloodstream and bodily stores. Some studies estimate that a woman who breastfeeds her infant exclusively uses 400-600 extra calories a day in producing milk. The composition of breast milk changes depending on how long the baby nurses at each session, as well as on the age of the child. (Breastfeeding- Wikipedia, the free encyclopedia, 2008)

Research shows that the milk and energy content of breast milk actually decreases after the first year. Breast milk adapts to a toddler's developing system, providing exactly the right amount of nutrition at exactly the right time. In fact, research shows that between the ages of 12 and 24 months, 448 million of a mother's milk provides these percentages of the following minimum daily requirements. (Breastfeeding- Wikipedia, the free encyclopedia, 2008).

Benefits for the infant:

Researches shows that during breastfeeding nutrients and antibodies pass to the baby and the maternal bond can also be strengthened (Breastfeeding- Wikipedia, the free encyclopedia, 2008). The benefits of breastfeeding to an infant are as follows:

a) Superior nutrition

b) Less Diarrhea

c) Greater immune health

d) Higher Intelligence

e) Long Term Health Effects

f) Fewer Infections

g) Less Atopy

h) Less necrotizing enter colitis

Exclusive breast feeding:

Exclusive breastfeeding is when an infant receives no other food or drink besides breast milk. National and international guide line recommends that all infants be breastfed exclusively for the first six months of life. It is generally accepted that newborns should be exclusively breastfed for around 6 months. Breastfeeding may continue with the addition of appropriate foods, for two years or more. Exclusive breast feeding has dramatically reduced infant deaths in developing countries by reducing diarrhoea and infectious diseases. (Breastfeeding- Wikipedia- the free encyclopedia, 2008).

While it can be hard to measure how much food a breastfed baby consumes, babies normally feed to meet their own requirements. Babies that fail to eat enough may exhibit symptoms of failure to thrive. If necessary, it is possible to estimate feeding from wet and soiled nappies (diapers): 8 wet cloth or 5-6 wet disposable and 2-5 soiled per 24 hours suggests an acceptable amount of input for new born older than 5-6 days old. After 2-3 months, stool frequency is a less accurate measure of adequate input as some normal infants may go up to 10 days between stools. Babies can also be weighted before and after foods (Breastfeeding- Wikipedia- the free encyclopedia, 2008)

Expressing breast milk:

When direct breast feeding is not possible, a mother can express (artificially remove and store) her milk. With manual massage or using a breast pump, a woman can do squeezing her breast milk manually and keep it in

freezer storage bags, a supplemental nursing system or a bottle ready for use. Breast milk may be kept at room temperature for up to ten hours, refrizerated for up to eight days or frozen for up to four to six months. Research suggests that the antioxidant activity in expressed breast milk decreases over time but it still remains at higher levels than in infant formula. If a sick baby is unable to feed, expressed milk can be fed through a nasogastric tube (Park, 2009)

Mixed feeding:

As mixed breastfeeding is feeding breast milk along with infant formula, baby food and even water, depending on the age of the child. Babies feed differently with artificial teats from a breast (Breastfeeding- Wikipedia- the free encyclopedia, 2008)

Tandem breastfeeding:

Breastfeeding two children at the same time is called *Tandem breastfeeding*. The most common reason for tandem breastfeeding is the birth of twins, although women with closely spaced children can do continue to nurse the older as well as the younger (Breastfeeding- Wikipedia- the free encyclopedia, 2008).

Tandem breastfeeding may also occur when a woman has a baby while breastfeeding an older child. During the late stages of pregnancy the milk will change to colostrums, and some older nurslings will continue to feed even with this change, while others may wean due to the change in taste or drop in supply. Feeding a child while being pregnant with another can also be considered a form of tandem feeding for the nursing mother, as she also provides the nutrition for two. (Breastfeeding- Wikipedia- the free encyclopedia, 2008)

Embedded with this current study, in Nepalese Society, tandem breastfeeding is very common because frequently child birth tendency due to lack of using family planning contraceptives. The situation is mostly in low socio economic status, uneducated, slum area, rural community than Urban and educated, civilized society and the current study will explore these phenomenon.

Extended breastfeeding:

Breastfeeding past two years is called "extended breastfeeding" or "sustained breastfeeding". Supporters of extended breastfeeding believe that all the benefits of human milk, nutritional, immunological and emotional, continue for as long as a child nurses. Often the older child will be nursed infrequently or sporadically as a way of bonding with the mother.

Shared breastfeeding:

It used to be common Worldwide, and still is in developing nation such as those in Africa, for more than one woman to breastfeed a child. Shared breastfeeding is a risk factor for HIV infection in infants. Woman who is engaged to breastfeed another's baby is known as a wet nurse. Islam has codified the relationship between this woman and the infants she nurses and also between the infants when they grow up, so that milk siblings are considered as blood siblings and cannot marry. American feminist activist Jennifer Baumgardner (2008) has written about her experiences in New York with this issue.

Weaning:

Weaning is the process of introducing the infant to other food and the supply of breast milk. The infant is fully weaned once it relies on other food for all its nutrition and it no longer receives any breast milk. Most mammals stop producing the enzyme lactase at the end of weaning and become lactose into learnt. In the past, bromocriptine sometimes used to reduce the engorgement experienced by many women during weaning. However, it was discovered that when used for this purpose, this medication posed serious health risks to women, such as stroke and the U.S. FDA withdraw this indication for the drug in 1994. (Breastfeeding- Wikipedia- the free encyclopedia, 2008)

2.6 Sociological and Anthropological Factors Embedded with Breastfeeding

There exists several social and cultural factors that correlate with differences in initiation, frequency and other factors affecting a mother's choice whether or not to breastfeed and how long she breastfeeds her child.

Education

According to Singh, Kogan and Lee (2008) more mothers with higher education levels correlate breastfeeds and these mothers breastfeed for longer.

Race and culture

Singh et al (2008) found that African American Women are less likely than white women of similar socioeconomic status to breastfeed and Hispanic women are likely to breastfeed. This may be evidence that breastfeeding acceptability is based on cultural acceptance and that acceptance is related to socioeconomic status in the mother's cultural acceptance and that acceptance is related to socioeconomic status in the mother's culture. The center of Disease control U.S. used information from the National Immunization Survey to determine the proportion of Caucasian and African American children that were ever breast fed. They found that 71.5% of Caucasians had breastfed their child while only 50.1% African Americans had breast fed. At six months of age this fell to 53.9% of Caucasian mothers who were still breastfeeding.

Women in higher status jobs are more likely to have access to a lactation room and suffer less social stigma from having to breastfeed or express breast milk excreted breast milk by manually at work. In addition, women who are unable to take an extended leave from work following the birth of their child are less likely to continue breastfeeding when they return to work.

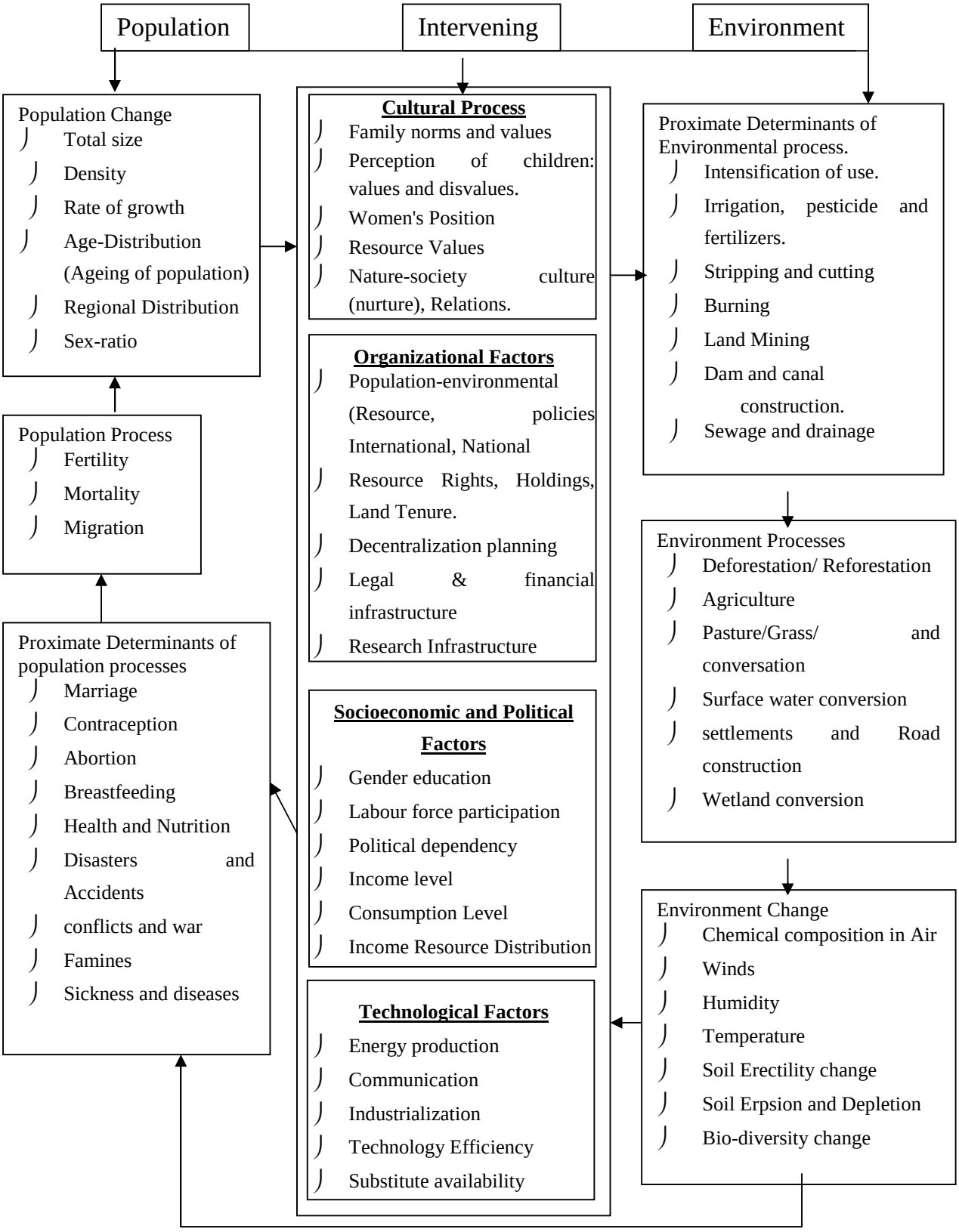
Other factors effecting breastfeeding are "household composition, metropolitan/non-metropolitan residence, parental education, household income or poverty status, neighbourhood safety, families support, maternal physical and household smoking status." (Breastfeeding, Wikipedia ,2008)

Economic Factors of Breastfeeding

As women who are less likely to breastfeed are more likely to incur medical bills because their babies lack the protection that breast milk provides. In the case of poor mothers this combined with the extra cost of artificial feeding could result in more debt and even worse poverty. The birth of a child puts an economic burden on parents, but this is exacerbated if the baby is not breastfed. This is also linked to Michael Marmot's theory of *status syndrome*, in which status level, determined by education, wealth, occupation and social prestige, determines how healthy people are (Breastfeeding – Wikipedia, the free encyclopaedia –, 2008).

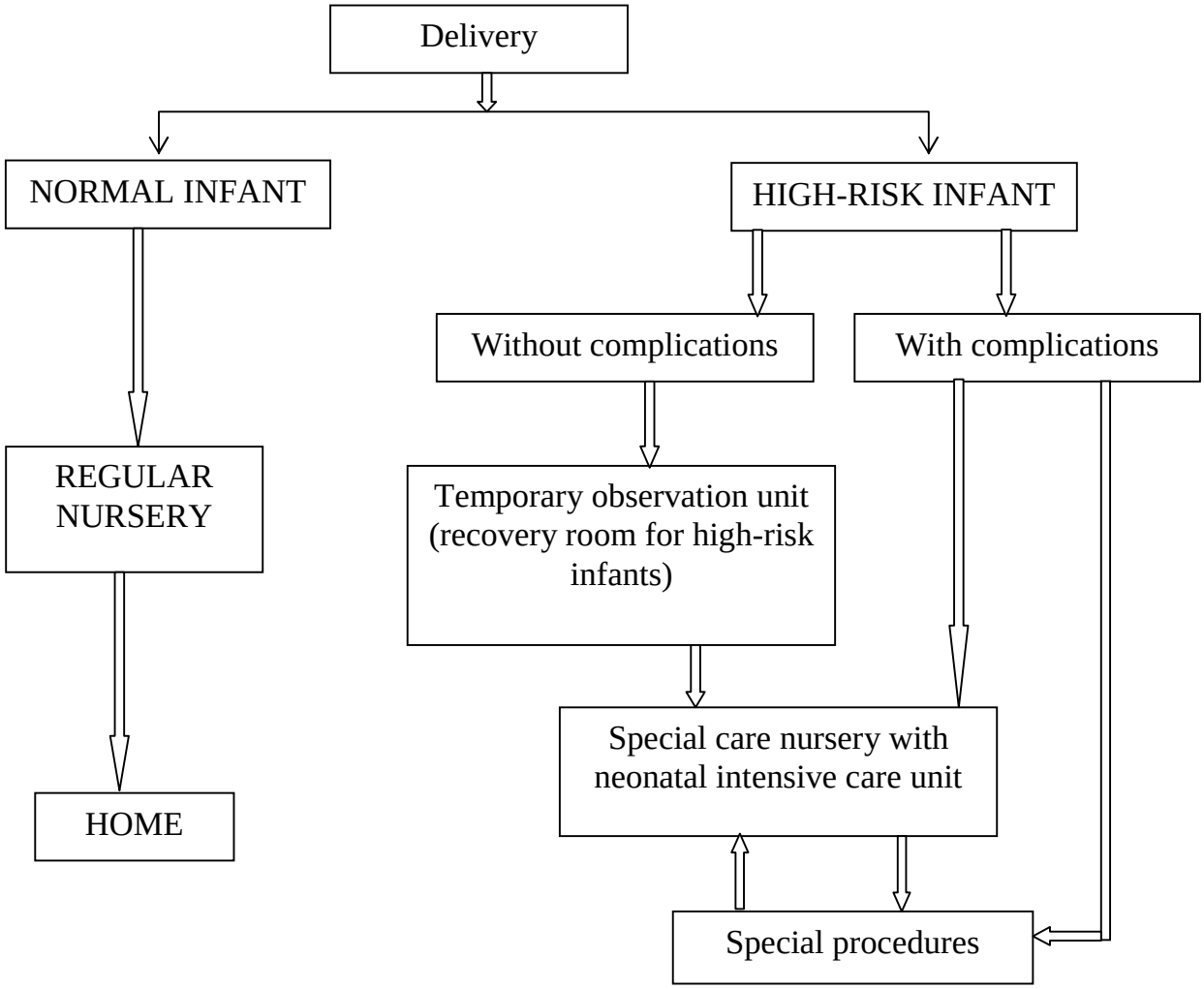
2.7 Conceptual Review

The following chart of conceptual framework is a simplified depiction of population and resource relationships. It demonstrates that all these demographics and environmental factors as well as the intervening factor such as cultural, organization, socioeconomic and technological affect one another. In the framework, changes in population and environmental characteristics are linked with changes in cultural, organizational, socioeconomic and technological factors. In any society or any region, these factors continually interact with each other and labelled by intervening factors (Population Studies in Health Sector, 2008).



Source: Population Studies in Health Sector, Ministry of Health, Nepal 2008

The first week of life is the most crucial period in the life of an infant. In India, 50-60% of all infant deaths occur within the first month of life. Among this 50-60 percent death, more than half may die during the first week of birth. The risk of death is the greatest during the first 24-48 hours after birth. The problem is more acute in rural areas where expert obstetric care is scarce, and the home environmental conditions in which the baby is born, are usually unsatisfactory (Park, 2002). A flow chart of the optimum care of the new born is shown below:



Source: Park, 2002

2.8 Review of Earlier Works

2.8.1 Child Nutrition and Feeding Practices in "SAARC" Countries

South Asian Association for Regional co-operation (SAARC) has common nutritional problems and child feeding practices. Prevalence of malnutrition is very high in SAARC countries. In this regard, Gopalan (1987) stated that the nutrition survey of 1981-82 in Bangladesh indicate that 46 percent of children suffered "from second degree" malnutrition (60-75 percent of the international reference standard) and 15 percent had "Third degree" malnutrition (less than 60 percent of the international reference standard).

Child feeding practices have significant impact on study conducted by Ahmed et-al (1996) indicated that many factors influence feeding practices in Bangladesh and prelacteal feeding is one of them. This study highlighted that the type and duration of prelacteal feeding had significant negative influence on breast-feeding practices.

In Bhutan, though child-feeding practice was found to be similar, the nutritional status of the young children was better. Gopalan (1987) stated that a report from Thimpu MCH clinic indicated that 22% of children's weight was found to be more than the median Harvard Standard weight for age and only 2% was found to be below 60 percent. The figures indicated that childhood nutritional status was better in Bhutan as compared to other SAARC countries. Breast-feeding was universal and babies start receiving supplementary food like cooked rice and butter as and when needed as complementary food in Bhutan.

In India, the National Nutrition Monitoring Bureau (NNMB) (1975) had computed that the percentage of severely malnourished children between 1969 and 1975 ranged from 18.0 to 21.8 percent. This study highlighted that many factors were responsible for child malnutrition and the *breast feeding practice* was one of them. A study conducted on breast-feeding practices in a tribal community of Melghat region in Maharastra by Zodpey et al (1965) indicated that the tribal mothers of 462 children received their first breast feed after 54 hrs of birth. The exclusive breast feeding rate was 0.22 and the predominant

breast-feeding rate was 0.79. The continued breast-feeding rates as 1 years and 2 years were 0.88 and 0.64 respectively. Timely complementary feeding rate was 0.22. This study confirms that breast-feeding and complementary feeding practices have great role in the Indian community.

In the same way to assess the prevailing breast feeding and infant feeding practices in rural areas, a community based study conducted in central Karnataka in India by Banapurmath et al (1996) indicated that all the infants received prelacteal feeds. Colostrums were rejected by 29% of the mothers. Delayed initiation of breast-feeding was common, 35% of babies were not breast-fed even after 48 hours of birth. Exclusive breast-feeding was noted in 94% and timely complementary feeding rate was 57.7% among infants from 6 to 10 months of age. This study indicated that bottle-feeding is quite prevalent even in rural areas and the infant feeding practices are for from satisfactory.

A study was conducted to identify the cost of infant feeding in exclusively and partially breastfed infants in urban slums of South Delhi, India by Bhatnagar et al (1996). The findings of the study indicated that there was a decline of exclusive breast-feeding from birth to six months. The mean cost of infant feeding was Rs.204 per month in partially breast-fed as compared to Rs.106 in exclusively breast fed at 6 months of age. The increased cost was largely attributable to supplementary food and the cost of the feeding bottles. In conclusion, the main cost of the infant feeding is substantially higher in partially breast-fed children.

A study conducted in Melghat region, India by Despaired et al (1996) indicated that out of 494 infants none were breast fed within 2 hours of delivery, 36% infants received first breast feed only after 24 hours of delivery, 91.2% of the mother used perfect feeds. Only 31.06% of the infants were weaned, out of these only 7% received the complementary feeds between 4-6 months. This study concluded that though breast-feeding was practiced by all mothers complementary food should be introduced in time.

In Maldives, the nutrition problem is very common in less than 3 years old children. In this regard Gopalan (1987) highlighted that the data collected

by the mobile team in Maldives in 1985 indicated that nearly 52 percent of the children less than three years of age suffered from moderate degree and 4 percent from severe degree of malnutrition. According to the 1981 household Income and expenditure survey, average calorie intake in different groups was found to be in the range of 1935-2058 kcal per head, which was less than the recommended allowances.

Gopalan further stated that in Sri Lanka, Surveys carried out in 1975-76 and 1980-82 indicated that nearly 40 to 70 percent of the children between one to 5 years were found stunted e.g. height for weight less than 90 percent of the standard. Child feeding practices are similar to other SAARC countries.

In Pakistan, malnutrition is found to be a serious problem. Gopalan (1987) highlighted that thousands of children die every years simply due to the lack of adequate nutrition. Micronutrient survey of Pakistan (1976-77) indicated that over half of the children under 5 years of age were suffering from serious malnutrition, and 13% had signs of chronic nutrition deprivation. Lack of proper feeding practices was found to be one of the significant causes of the nutritional problem.

A study conducted by Badruddin et al (1997) to find out constraints to adoption of appropriate breast feeding practices in a squatter settlement in Karachi, highlighted that out of 102 children 87 infants received prelacteal feeds of honey as a *'quasi'- religious ritual*, 16 received *ghutti (Liquid to swallow)* for "dancing of stomach," other prelacteal feeds were given as substituted for breast feeding. Out of 102 mothers, 29 initiated breast-feeding within 4 hours after birth, supplementary milk and work load of mothers were the main reasons for supplementation.

A study conducted by Kulsoom et al (1997) regarding beliefs and practices related to the feeding of 52 infants of an urban community of Lahore of Pakistan indicated that 98% mothers started breast feeding within the 1st week and 54.3% continued until 12 months, weaning occurred earlier in infants of the upper socio-economic class and literate mothers. The working women reported problems in feeding their children exclusively on breast during early

infancy. This study recommended that health education interventions are needed to promote breast feeding and complementary feeding practices.

2.8.2 Child Nutrition and Feeding Practices in Nepal

As in the literature of Malla (2002) named "Child Complementary feeding in urban areas of Nepal" breast feeding is widespread in Nepal. According to the Nepal Fertility Study (1996), 82.0% mothers breast-feed their children for more than 2 years. The lengths of breast-feeding vary only slightly between the urban and rural areas. A study conducted by Acharya (1985) in four districts, Tanahu, Siraha, Bajhang and Nuwakot, revealed that breast feeding was the normal way of feeding infants and it continued up to two years or more. Nothing was given to the child except breast milk before *Annaprasan*, the rice-feeding ceremony. Furthermore the same studies indicated that breast-feeding was well practiced by all the lactating mothers. It is believed that cow milk aggravates diarrhoea and buffalo milk stops it. In Nuwakot, feeding practices were slightly different. If breast milk is not sufficient for the child, *'Lito'*, made of rice flour, is given. In Tanahu, semi solid salted food like '*Dal'* was given after Annaprasan. Generally, *'Dal-bhat'* is the main weaning food. Acharya states that leafy vegetables are not given to the children in the study areas. In most of the Nepalese communities, children are not fed green leafy vegetables. In this regard, a study conducted by Benister et al in Chitwan (1985) district indicated that 53% of the households fed green leafy vegetables only once or twice a week to young children.

A study conducted by Krantz (1999) in two villages of Lalitpur district in 1973 revealed that one in nearly every four children between one to 3 years of age suffered from protein energy malnutrition due to the lack of knowledge on child nutrition.

In most of the communities it was found that a child's nutritional status is influenced due to mother’s awareness. Boulden (1976) stated that in the Kathmandu valley, if anything goes wrong the mothers do not ascribe it to malnutrition and it is commonly believed that the symptoms are caused by the

child's contact with a pregnant woman. In Nepal, weaning starts generally at the age of 5-6 months of the child's life. Traditionally, girls at 5 months and boys at 6 months are introduced solid food during the time of *Annaprasan* which is also called *pasni* or rice feeding ceremony. This ceremony has a great influence on child feeding practice. In this regard a study conducted by Malla (1991) indicated that a large number of children (79%) in Walling Village Development Committee of Syangza district found to be introduced supplementary food only after Annaprasan. This study further indicated that the mothers who did not introduce their children to complementary foods before "*pasni"* were found influenced by the traditional beliefs.

Child feeding practice is very much influenced by mothers' knowledge and traditional belief in many communities. A study by Malla (1991) in the Walling Village Development Committee of Syangza district revealed that 80% of the mothers were found breast-feeding their children up to two years because they believed that breast milk was sufficient for children. Among the samples 58% children were receiving supplementary food whereas 42% of the children were not introduced to such foods. Mothers, who do not introduce supplementary foods, expressed the view that breast milk was enough to young children up to 2 years and nothing should be given in addition to breast milk. These findings also indicated that 'Lito' made from rice was the more preferred complementary food in Walling followed by rice and pulses (Dal-bhat) and 'Jaulo' was the third common food given to the children in addition to breast milk.

Many of these earlier studies focused on the medical and community related nutritional issues embedded with breast feeding practices, thus ignoring the anthropological and sociological implications of breast feeding practices in a *caste ridden and priest ridden* traditional society like that of Nepal. Hence this current study in Sansthagat clinic of Pokhara will fill up this lacuna.

2.9 Empirical Review

In a research study Dhakal, Mira Devkota (2007) in her dissertation on "Educated Women in Government Employment" about gender discrimination in professional work between male and female concluded that various research studies have been made in the area of gender discrimination between male and female. But enough study has not been made about gender situation in the case of educated and professional women. The study is important that the educated women are suffering from the discrimination in our patriarchy society.

Lamichhane Khim Bahadur (2007) in his study on *Woman and Depression; a study of psychiatry OPD in Manipal teaching hospital and western regional hospital,* Pokhara explored the relation between women and depression. He concluded that women in reproductive age group (15-45) are more sufferer than other age group women and women suffer more than men. The study showed that increasing socio-economic status has substantially decreased depression in women. Similarly, low income level has made high depression in women. He had experienced that Aryans (Brahmins/ Chettries) women are highly suffering from depression because of the cultural and traditional practice of the society. More depressive women are seen in rural areas than in urban society. In ethnic groups like Gurungs, Magars, Tamangs women are suffering less in number because of their life style and liberal behaviour in their society. As his experience arranged marriage couple are more sufferer than love marriage because they do not know each other before marriage.

As a dissertation submitted by Sapkota (2006) about "A Sociological Study among the youths reintegrated from social organizations and living in Kathmandu valley" has found that socialization in the child and reintegration homes seems to be a very serious problem. He has concluded that these child or reintegration homes have provided high degree of religious freedom. The reintegrated youth have more attachment to their friends than to their family or relatives. They are grown-up in an environment where there is very big

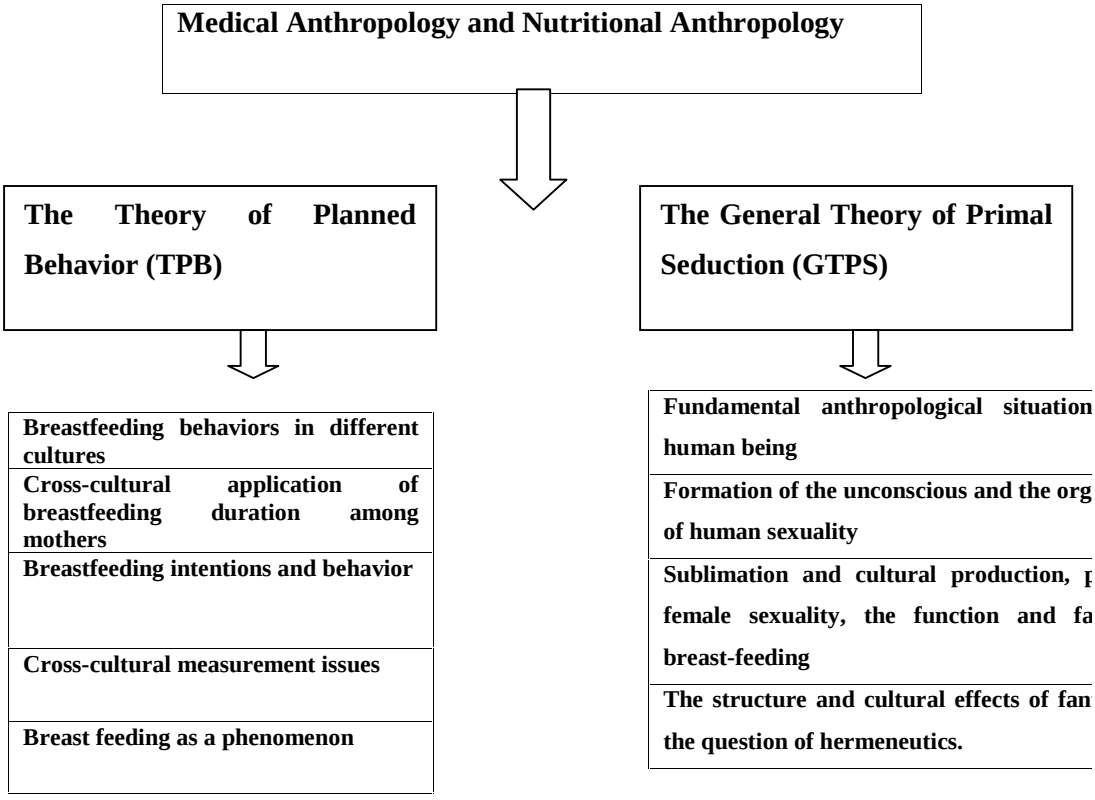
importance and respect to friends. This is also a subject of sociological study which has direct relation to cultural development and socialization of a child.

"Perception about abortion and family planning among married Muslim women of Miapatan Pokhara" a dissertation submitted by Sandhya Shrestha (2007) has analysed that age group, education, marriage and marital status, occupation, family structure and during in family, birth place of the child and problem during pregnancy, knowledge about family planning and abortion. Regarding the occupation of the respondent majority (63%) of the respondents has been only doing domestic works and (15%) are involved in domestic as well as business. Culturally they do not accept red clothes and ornaments, but in the process of cultural assimilation, the Muslim women of Miapatan have started accepting these features of other culture. In the religious practice, they do not believe in family planning contraception and accepting permanent sterilization e.g. Vasectomy, minilap operations but many of them have been found adopting family planning devices and permanent sterilization.

"Child care and socialization among the squatters of Peepaldali Village of Sarangkot Village Development committee- 9 of Kaski" a dissertation submitted by Bedhari Adhikari (2005) has presented and emphasized on the child care and socialization process among the squatters children of Peepaldali Village. Socio cultural features have provided important mechanism for the socialization. As in conclusion, he has presented that the growing squatter infant in the family is the major socio-cultural context in which they learn existing norms and values. Child care is the responsibility of elders or older siblings, so that the working parents can go for labour or other outside job to earn income. Although boys and girls enjoy equal amounts of parental love and care while growing, parental goals and expectations for them is different according to their sex. The child care center has proved to be especially useful to the parents as it provides care and nourishment to the children. Squatter parents feel that the school is now relieving them of some of their responsibilities, which affords them more time to invest in other productive activities.

Under the guidance of these earlier studies, the current study addresses the actual practices of mothers in breast feeding in Sansthagat clinic of Pokhara.

2.10 Theoretical Framework adopted in the study



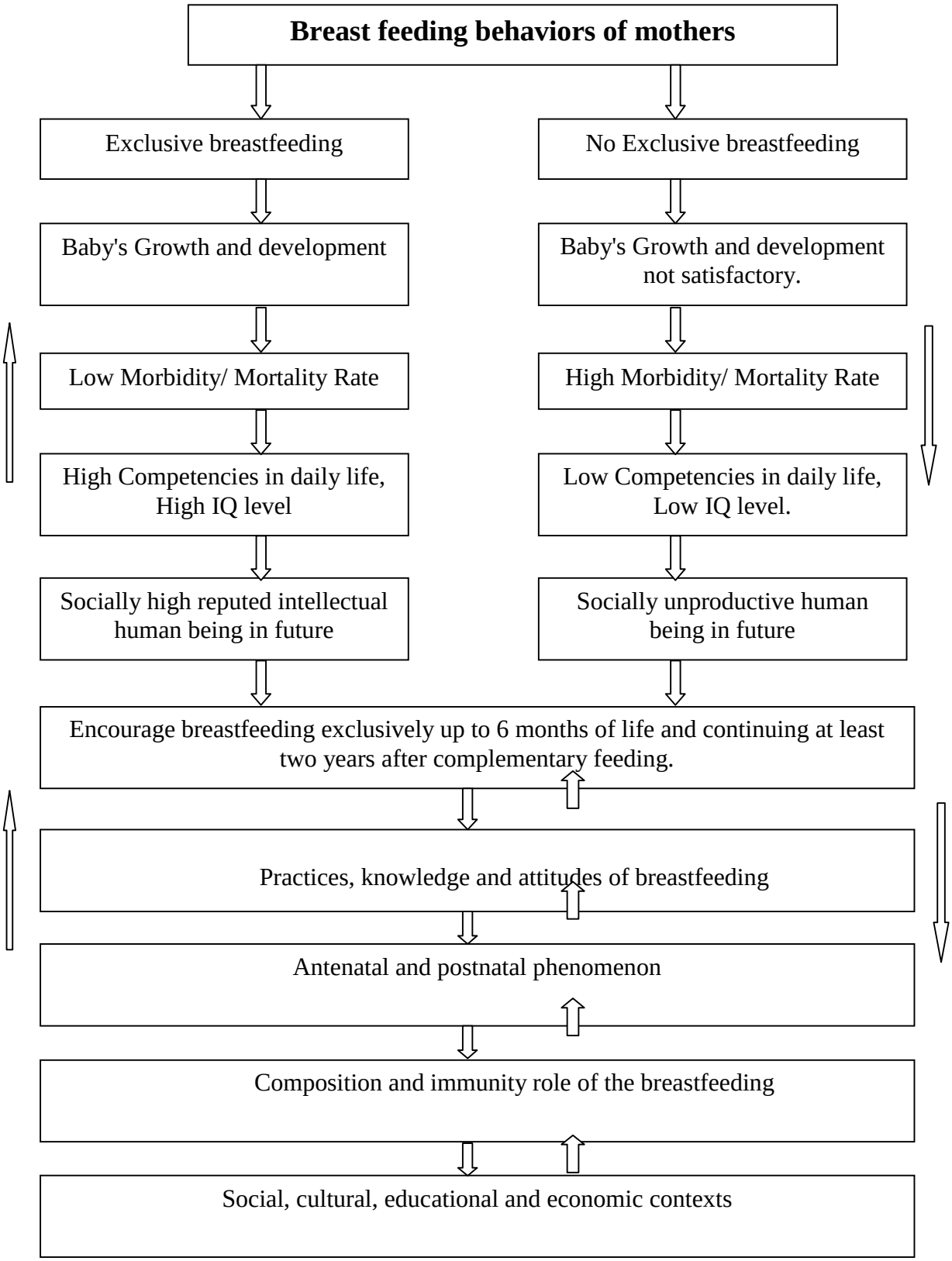
This research has espoused the theoretical base of TPB and primal seduction theory for providing the theoretical guidance to this study. The theory of planned behavior (TPB) is used to explain breastfeeding behaviors in different cultures. This theory is helpful to evaluate cross-cultural application of breastfeeding duration and practices among mothers.

They address the topics of sublimation and cultural production, psychosis, female sexuality, the function and fantasy of breast-feeding, the structure and cultural effects of fantasy, and the question of hermeneutics. They are striking testimony to the productivity of Laplanche's proposed 'new foundations' as a vital and developing research programme for psychoanalysis. Laplanche’s formulation of is called the ‘fundamental anthropological situation’ of the human infant. He conceives this as a dual situation involving the infant’s need and dependency on the care and nurture given by the adult other (an inter-subjective situation marked by bilateral communication as described by attachment theory), on the one hand, and as well the implantation of enigmatic messages in the primitive body-ego of the infant via the adult’s gestures of care and expressions of feeling, both verbal and non-verbal (a unilateral transmission that is enigmatic because derived from the adult’s unconscious sexuality in a situation of primal seduction), on the other.

As well as developing this model of primal seduction, the work of resituating and relocating classical concepts and debates also continues with a path-breaking meditation by Laplanche himself on the theory of sublimation, unfinished and unsatisfactory in Freud.

2.11 Conceptual Framework Adopted for the Study

In this study the conceptual frame work adopted is as follows:



Conceptual framework explains that Antenatal and postnatal phenomenons are vital for mothers. Likewise crucial are Composition and Immunity role of the breastfeeding. The proper position, attachment, time, duration, knowledge and practices of Colostrums feeding as well as exclusive breastfeeding, Complementary feeding are related to breast feeding behaviour. Reducing Infant Mortality Rate (IMR), nutrition plays a vital role in breastfeeding, Colostrums feeding is the main intervention. Colostrums is the nutritious food for infant which comes immediate after birth, containing energy (Carbohydrate), protein, vitamins, minerals. Colostrums provide immunity to the child as an inoculing vaccine to prevent against various communicable diseases.

In the same manner, exclusive breastfeeding provides energy, proteins food, vitamins, minerals and liquids. Even though water and medicines except in the diseased conditions do not necessary suit to the child while breast feeding less than 6 months age is mandatory. Breast milk is easily digestible, pathogen free, nutritious and also helps in binding mother to child in cognitive relationships, which plays vital role in future in society and the community. In general practices and attitudes related to breast feeding differs and it is influenced by factors as social, cultural, educational and economic.

CHAPTER III

RESEARCH METHODOLOGY

3.1 Research Design

The study focuses on obtaining knowledge, attitude and behaviours of mothers in breast feeding to their Infants. It is based on the study of Pokhara Sub-metropolitan city in Family Planning Sansthagat clinic of District Public Health Office, Kaski situated in Western Regional Hospital complex. The research is based on comparative study of CB-IMCI pattern in breast feeding as well as the status of socio-economic, cultural, educational, caste/ethnical, urban as well rural background mothers. The study has adopted both exploratory as well as descriptive research design. The study is exploratory because it exposes the knowledge, attitude and practices of breast feeding mothers. The study is descriptive as it describes different aspects of breast feeding practices.

The total population of Pokhara in 2008 (CBS, mid term evaluation) is 2,19,215 and 4839 infants with less than one years population, 9572 below 2 years and 23,422 under five populations.

3.2 Location of the Study Area

The study has been conducted in Family Planning Sansthagat clinic of DPHO (District Public Health Office) of Kaski district and the immunization clinics of various wards of Pokhara viz. 8, 11, 13, 14, 15, and 17 because all breast feeding mothers do not come to Sansthagat clinic all day for immunization .

3.3 Sampling Procedure

Breast feeding practices of mothers among the mothers of Pokhara Valley as well as outside the valley who come to Sansthagat Clinic for immunization to their infants especially receiving DPT first are the main target

of study. Most of the mothers having less than one year or mostly less than 6 months child need immunization for their child. DPT first (Diptheria Pertusis, Tetanus) + hep B (Hepatitis B) is needed to receive at the age of one and half month.

As DPT first (Diptheria, Pertussis, Tetanus) accepters have been selected, the target in first quarter, DPT first immunized is only 293 in number. Out of 293, this study has selected the 155 mothers according to the sample in 52.90 proportionate basis.

3.4 Units of Analysis

Individual level and group level; Breast feeding mothers have been taken in consideration under individual level and mothers with the baby have been considered as group level.

3.5 Nature and Sources of Data

The nature and sources of data are primary data collection method but secondary source has also been used.

3.6 Primary data Collection Techniques

The research needs to collect necessary and reliable data; essential techniques used for the data collection should be precise and accurate. Therefore best appropriate tools and techniques such as interview schedule has been used to collect the required information. During the procedure, observation has been done and recorded as in questionnaire scheduled formats.

3.6.1 Interview Schedule

This is the main technique in the research work which has been carried out in field procedure. The questionnaire has been prepared in English but was translated into Nepali language before they were used in actual field work. The questions were pre- tested in "Shishuwa P.H.C (Primary Health Center) of Lekhnath Municipality" of Kaski in MCH (Mother & Child Health) day, before using in Sansthagat clinic" of D.P.H.O. (District Public Health Office) Pokhara. Modifications were made in the points which were not in sequential

order and added extra questions as needed in variables. It has been experienced that time taken was not more than 15 minutes because some open ended questionnaire takes longer time. The interview schedule was constructed in unstructured as well as structured pattern. Key informants were selected in field work as on the basis of education, occupation, economic status and those giving answer satisfactorily. Key informants for this study are one medical doctor, nurse and a person who have already completed the thesis and three breast feeding mothers having general background as repliers.

3.6.2 Observation

Observation has three components, namely, impression, attention, and perception and it is one of the important methods of data collection. For this study, direct overt **participant** observations method was used to collect relevant data. Participant Observation included, establishing rapport with the breast feeding mothers, and direct collection of primary data from the site. Personal Observation is crucial for the immediate study of the events. In this study, personal observations were made in the field with certain behaviors and different aspects of breast feeding mothers i.e. their physical fitness, health status, behavioral conditions etc. Proper position, attachment observed during breastfeeding to their child and adopted in interview schedule where already arranged, hence there is no observation checklist have been used.

3.7 Data Analysis and Presentation

After completion of data collection from the respondents, encoding, coding and tabulation was done manually. Likewise the computer software program, the statistical package for social science (SPSS) was used in assistance of opportunity. All the collected data have been analysed both qualitatively as well as quantitatively. Statistical tools such as mean, percentage, tables, charts have been used for analysis of the data; photographs at the field site have been pasted as assets of the findings of the research work.

3.8 Problems Faced During Fieldwork

Field work in "Sansthagat Clinic" of D.P.H.O at Western Regional Hospital was full of complexities but required numbers of respondents used to be absent from the clinic on Tuesday of every week. Hence, I moved toward immunization clinics of Municipality to fulfill the required numbers of respondents. So, data was collected from ward no. 8 Srizana Chowk, ward no.11 Ranipauwa, ward no.13 Miyapatan, ward no.14 Chouthe, ward no.15 lower Rambazar, ward no.17 Rato Pahiro and Pardi Birouta respectively.

Field is different from theory, in the field all respondents were not co-operative, even though I explained about questionnaire before conducting the session but some rejected and some asked the questions that for *what purpose you are asking? And some asked that may we get job?* I replied that it is my research for the program and will be presented in the Sociology/Anthropology Department, P.N.Campus, Tribhuvan University.

CHAPTER IV

ANALYSIS AND INTERPRETATION OF SOCIO-ECONOMIC PROFILE

This chapter converses on the general demographic features like caste/ethnicity age, permanent and temporary address, occupational status, educational status, husband's occupation, child birth and death etc.

It is notable that the social, cultural and economic structures of the society are important themes in sociological and anthropological studies. They are very closely related to the issues of growth and any sort of issues related to human being. Unless and until the cultural and social structures as well as economic structure are not comprehended, it is not easy to solve any kind of problem or any kind of human -allied issues or problems.

The society is a social web of social relationship, human behaviors and their consequences. Generally, society is a system where people live with their culture in a fixed geographical environment, along with a fixed social structure; social barriers and well-defined social relationships. The conception of culture is undeniably influential in shaping concepts and practices related to physical environment. Social, cultural and economic phenomenon’s have differing roles to play in this complex process and therefore must be researched separately. Culture shapes or determines people’s use of surroundings and their behavior and different sorts of practices (Bhusan, 1999).

At the same time different components of culture, in different conditions and circumstances and at different time influences all behavior pattern. Human behavior is multipotential, at any point in the life cycle of individuals the number of possible responses to a given situation is in fact constrained by previous learning, standardized responses, and conventional values. Hence, it is never possible to rule out the role and value of cultural and social structure in influencing behavior of breast feeding mothers related to their breast feeding

practices. Likewise, the role of economy in shaping the destiny of cannot be disproving.

4.1 The Setting

Pokhara is a natural paradise on earth and "Sansthagat Clinic" of D.P.H.O. Kaski is situated at the heart of Pokhara Sub Metropolitan city. It is in ward no.9 Ramghat of the Sub Metropolitan city. The clients come to this clinic from the surrounding area, the Western Regional Hospital area and all parts of the city. Women having the permanent settlement outside Pokhara but currently the residents in Pokhara sub-metropolis also used to come to Sansthagat Clinic.

4.2 Religion

Faith is a part of world religion. World's main religions, for example are Islam, Hinduism, Buddhism, Judaism, or Christianity.

William P. Scott (1999) defined religion in Dictionary of Sociology *as a system of beliefs, practices, and philosophical values concerned with the definition of the sacred, the comprehension of life, and salvation from the problems of human existence*. Religion is essentially an institutionalized or traditional path to salvation. All men in all societies ultimately must face life's problems essentially alone, despite all efforts of others to help. Religious traditions are the result of man's attempt to capture and enshrine his philosophical and spiritual insights so that they are available to the individual as he faces life and its stresses, confusions, and complexities.

Religion is a social phenomenon (as well as a psychological one) because it necessarily stresses fellowship in the development, teaching, and perpetuation of religious insight and knowledge. It is concerned with the common plight of all people at all times, regardless of age, sex, or status within society. The concept of the supernatural path of salvation bind man to the dictates of limited contemporary social values and social groups, or it may serve to provide the wisdom and techniques by which man may free himself from contemporary groups and values- it may give him periodic freedom to

achieve values transcend the demands of the social present. The religion is both intensely personal and intensely social but it used to create deep influence on the behavior of the people as well as on different sorts of practices (Scott, 1999).

Religious composition is one of the important social characteristics of population. Significant economic, social and cultural differences are associated with the major religious groups of the country, which is important because it often determines the national loyalty. Ethics of certain groups also plays an important part in making decision in health related and nutritional issues.

Religion is also an important thing in health seeking behaviours. Circumcision in Muslims, thread sacred in Hinduism, Lama and *Jhuma* (being unmarried due to cultural, religion) in Buddhism are related to their Religion. Eating pork, cows, goats, vegetarians, no vegetarians, norms, beliefs, and values depend on the base of religious practices of the community

As religion is one of the factors of culture influencing different sorts of practices of the society, this research explores the native religion of the sampled population. Table 4.1 shows the status of religion of sampled breast feeding mothers as follows:

TABLE 4.1: RELIGIONS OF BREAST FEEDING MOTHERS

S.No.	Religion	No.	Percentage
1.	Hinduism	109	70.32
2.	Buddhism	39	25.16
3.	Muslim	4	2.58
4.	Christian	3	1.93
5.	Other	0	0.00
	Total	155	100.00

Source: Field Research, 2008.

It is explored that majority of respondents are Hindus among the sampled population. Buddhists are in second category and Muslim, the third and Christian the fourth. Hindus belong to the caste/ethnic groups of Brahman, Chhetri, Magars, Kami, Damai, Sarki, Rai, Kumal, Newars. Budhists are Gurungs and Tamangs. Christians and Muslims are very few in numbers among the sampled mothers. Majority of Muslims are from Miyapatan, ward no. 13 Pokhara, the birth place of late poet Ali Miya and the area consists of the largest concentration of hill Muslims in Pokhara.

4.3 Caste/Ethnic Background of Breastfeeding Mothers

Nepal is a country with multi-ethnic, multi-language, multi-cultural, multi-religious and caste society. This study based on sampled 155 breast feeding mothers is also not an exception of this general pattern. Caste, ethnicity, and cultural factors reserves special position in influencing behavior of the people, hence, the caste, ethnic and linguistic distribution of the sampled population stood vital. Pokhara is the biggest and densely populated city of Western Development region.

As shown in the presentation in table 4.2, the sampled breast feeding mothers are from 16 caste/ethnicities background. Highest number of sampled breast feeding mothers is of Brahmin caste followed by Gurung, Kami, Chhetri and Magars respectively. The lowest Population is of Rai, Kumal, Gaine,

Tibetan, Gharti, Muslim, Thakuri, Newars and Damai, Tamang, Sarki respectively. The table no 4.2 is as follows:

TABLE 4.2: CASTE/ETHNICITY OF BREAST FEEDING MOTHERS

S.No.	Ethnicity/Caste	No.	Percentage
1.	Brahmin	30	19.35
2.	Gurung	27	17.41
3.	Kami	23	14.83
4.	Chhetri	18	11.61
5.	Magar	14	9.03
6.	Tamang	9	5.80
7.	Sarki	9	5.80
8.	Damai	6	3.87
9.	Newar	4	2.58
10.	Thakuri	4	2.58
11.	Muslim	4	2.58
12.	Gharti	3	1.93
13.	Rai	1	0.64
14.	Kumal	1	0.64
15.	Gaine	1	0.64
16.	Tibetian	1	0.64
Total		**155**	**100.00**

Source: Field Research, 2008

4.4 Age Distribution

According to the age distribution, the highest number of mothers represent 20-25, 25-30 years and 18-20 years having 41.93, 30.32, 14.19 percentage simultaneously. The age group 15-18 years have 3.87 and 35-40 years have 2.58 percent which belongs in danger sign of delivery. Even age group 18-20 have 14.19% which may be in danger alarm. The finding shows

that the highest age of married are 20-25 after then 25-30 and 18-20 in hierarchy.

TABLE 4.3: AGE DISTRIBUTION

S.No.	Age Group	Numbers	Percentage
1.	15-18 years	6	3.87
2.	18-20 years	22	14.19
3.	20-25 years	65	41.93
4.	25-30 years	47	30.32
5.	30-35 years	11	7.09
6.	35-40 years	4	2.58
7.	40 +	0	0.00
Total		**155**	**100.00**

Source: Field Research, 2008

4.5 Permanent Address and Housing Ownership Pattern

In this research 60% of respondents are from Kaski district and rest 40% are from other districts. Among the other districts Syangja, Lamjung, Tanahu, Dhading, Nawalparasi and Chitwan have been represented orderly in number. The representing districts are 25 in number and one from India also is presented. Pokhara is the second largest city in hills, so most of the people come to do job, study, service in this city. The rising trend of migration and urbanization has helped a lot to augment the population of Pokhara at the same time it has also brought changes in the living standard of the people. The table 4.4 representing the depiction in number and percentage of breast feeding mothers follows.

TABLE 4.4: PERMANENT ADDRESS OF THE BREAST FEEDING MOTHERS

S.No.	Name of the district	No.	Percentage
1.	Kaski	93	60.00
2.	Syangja	10	6.45
3.	Lamjung	7	4.51
4.	Tanahu	6	3.87
5.	Dhading	5	3.22
6.	Nawalparasi	4	2.58
7.	Chitwan	4	2.58
8.	Kavrepalanchok	3	1.93
9.	Baglung	2	1.29
10.	Parvat	2	1.29
11.	Sindhuli	2	1.29
12.	Ramechhap	2	1.29
13.	Dhankuta	2	1.29
14.	Palpa	1	0.64
15.	Myagdi	1	0.64
16.	Dhanusa	1	0.64
17.	Kathmandu	1	0.64
18.	Jhapa	1	0.64
19.	Kapilbastu	1	0.64
20.	Gorkha	1	0.64
21.	Makwanpur	1	0.64
22.	Udayapur	1	0.64
23.	Dolakha	1	0.64
24.	Okhaldhunga	1	0.64
25.	Sankhuwa Sabha	1	0.64
26.	India	1	0.64
Total		**155**	**100.00**

Source: Field Research, 2008

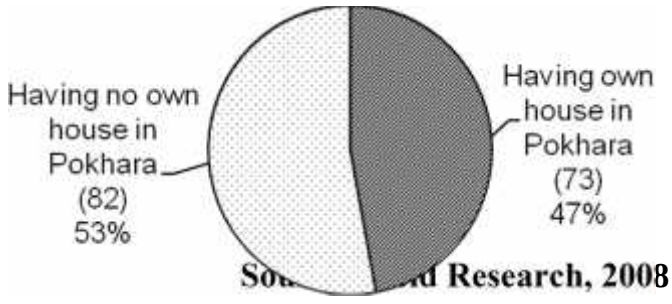
An Expert Committee of the WHO (2002) recommended the criteria for healthful housing similar to the basic principles of Healthful Housing published by the American public Health Association, viz:

1. Healthful housing provides physical protection and shelter;
2. It provides adequately for cooking, eating, washing and excretory functions;
3. It is designed, constructed, maintained and used in a manner such as to prevent the spread of communicable disease;
4. It provides for protection from hazards of exposure to noise and pollution;

Park (2002) has argued that healthful housing is free from unsafe physical arrangements due to construction or maintenance, and from toxic or harmful materials; and to encourage personal and community development promotes social relationships, reflects a regard for ecological principles and by there means promoting mental health.

But all the people are not lucky all as they do not house their own in urban area as Pokhara. Especially the migrating people have multiple problems, likewise rising urbanization has also added to their problems. People having houses are also lacking healthful housing. The housing ownership pattern of the breast feeding mothers is as follows-

FIGURE 4.1: OWN HOUSE IN POKHARA



Sou[illegible]d Research, 2008

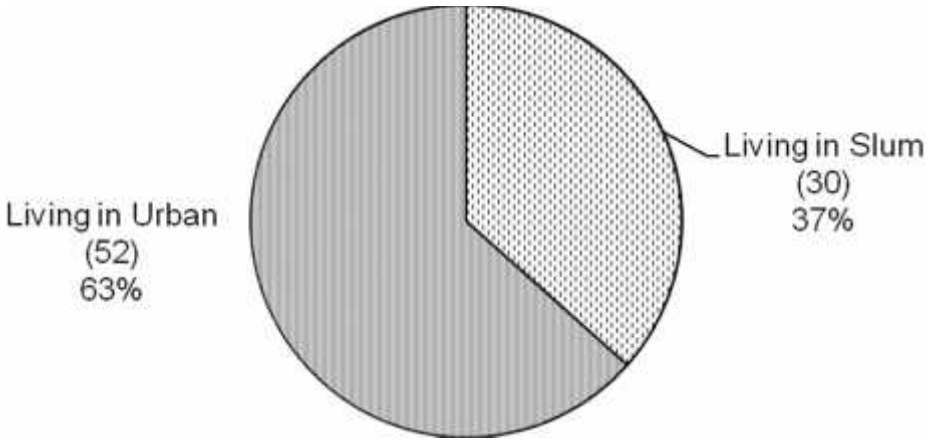
The above figure shows that among 155 respondents 73 have their own house in Pokhara and 82 do not their have own house. It shows the trend of migration (occupational/seasonal) which is too high in Pokhara.

"*Housing"* in the modern concept includes not only the physical structure providing shelter, but also the immediate surroundings and the related community service and facilities. It has become part of the concept of human "settlement" which is defined as *all places* in which a group of people reside and pursue their life goals; the size of the settlement may vary from a single family to millions of people.

A WHO expert Group (1961) on public health aspects of housing prefers to use the term "*residential environment*" which is defined as the physical structure that man uses and the environment of the structure including all necessary services. But the residential environment differs depending on *urban vs. rural* as well as slum background of the people.

In the present research among the respondents the following are living in urban and slum.

FIGURE4.2: LIVING IN URBAN/SLUM



Source: Field Research, 2008

Among the respondents, 82 respondents (53%) have no house in Pokhara and 73 respondents (47%) have their house in Pokhara. Likewise, 63.41% (52) are living in urban 36.58% (30) are in slum area. Most of them are having occupations, service, business etc.

TABLES 4.5: RENTAL CATEGORIES OF THE BREAST FEEDING MOTHERS

S.No.	Description	No.	Percentage

1.	Rental more than Rs. 1000.00	43	52.43
2.	Rental less than Rs. 1000.00	24	29.26
3.	Rental less than Rs. 500.00	3	3.65
4.	Rent Free	12	14.63
	Total	**82**	**100.00**

Source : Field Research, 2008

Above table shows that among the 82 number of houseless respondents are living in rented houses for various purposes, 43 are paying Rs. 1000.00 and more than 1000.00 Rs. per month. Most of them are occupational and job holders, service holders. One respondent has paid more than 7000.00 Rs. per month, having business of Gold ornaments. One has paid Rs. 4000.00 per month, her husband has job in Medicine Company as a Medical Representative (MR). Rest of all are labourers, occupational workers and rent free are government, non government job holders as well as some are living in own relative's home as a guest for short period. It has been deduced that most of them have low socio-economic status except few which has already been described above.

4.6 Occupations

People’s occupation determines the status, position, rank or grading of both male and female. United Nation has defined the status in the context of people's access to the economic resources, knowledge and political power, as well as their personal autonomy in the process of decision making inside the home and outside in the society .

Based on the notion of *status*, Socio-economic status is a system of stratification, a combination of various social and economic indexes of rank that are used in research studies. The term is often used to deal with stratification in a society without the need of the assumption that there are distinct social classes. Social characteristics (family background, education values, prestige of occupation, etc.) and economic status (income) are combined into SES (Socio-economic Status) rating. Age, gender, caste and

ethnicity, religion, family background, educational status, marital status etc are social aspects and occupation, income, living standard etc are the economic aspects that determine the health related status of an individual (Dictionary of Sociology, 1999).

Given the vitality of occupation in determining the status of people, in this study an attempt has been made to trace the occupations of both sampled breast feeding mothers and their husbands. The study shows that most of the respondents (72.25%) are housewives, though they had jobs before delivery, being left after child birth. In occupational hierarchy second is the business, third agriculture, fourth private sector, five students and sixth labour and Government service.

Sociologist like Vidya Bhusan (1999) have used occupation widely as a means of determining the level of social standing of an individual in a community, because occupation has an enormous importance in all societies for understanding human behaviours. In urbanised and industrialised communities, where there is a substantial division of labour, occupation is a major determinant of (1) Economic rewards; that is income and wealth which can promote or achieve health easier. (2) Extent of authority: That occupation is an important determinant of authority which the individual has over other people; it spills over into his life itself, his pleasures and other activities, through control of purchasing power. Those who receive higher economic rewards are fed to be verged with greater authority. (3) Extent of obligations: The extent of obligations demanded of individuals by the rest of the community is determined by the occupation he holds, one who holds a high place occupationally has greater obligations. (4) Degree of status: Closely allied with the occupational role is the degree of status and position of the individual in the community. For example, medical practitioners in India enjoy a higher status in society than others.

Likewise, the occupation of an individual varying largely will determine many of the values the individual has, the things he feels worth pursuing, his

life goals, and his life style; his pleasures, friendships, health behaviour and relationships with others (Park, 2002).

Given the vitality of occupation, the occupational tabulation of sampled breast feeding mother respondents has been given in table 4.6:

TABLE 4.6: OCCUPATIONS OF BREASTFEEDING MOTHERS

S.No.	Occupational Backgrounds	No.	Percentage
1.	Housewives	112	72.25
2.	Business	12	7.74
3.	Agriculture	11	7.09
4.	Private Sector	7	4.51
5.	Student	5	3.22
6.	Labour	4	2.58
7.	Government Service	4	2.58
8.	Other	0	0.00
	Total	**155**	**100.00**

Source: Field Research, 2008

The table clarifies that out of 155 sampled mothers, 112 mothers making a percentage of 72.25 are housewives followed by 12 women involved in business and agriculture 11. Some of the women are students and few are labourers and the least are government service holders. This trend shows that majority are housewives and tare dependent on their husbands occupation.

4.7 Husband's Occupation

This research explores that among 155 respondents 109 women's husbands are having their occupations in Nepal and 46 are abroad. National occupation holders are higher in number especially in labour, business, non Government service, agriculture, as drivers, Government Service, teacher, Nepal Army, students.

Husband's occupations in Nepal are as follows in table 4.7:

TABLE 4.7: HUSBAND'S OCCUPATION IN NEPAL

S.No.	Description	No.	Percentage
1.	Labour	26	23.85
2.	Business	18	16.51
3.	Non Government Service	11	10.09
4.	Agriculture	10	9.17
5.	Heavy Driver	7	6.42
6.	Light Driver	7	6.42
7.	Government Service	5	4.58
8.	Motor Garage work	5	4.58
9.	Teacher	5	4.58
10.	Nepal Army	5	4.58
11.	House Construction	3	2.75
12.	Student	2	1.83
13.	Job in project	2	1.83
14.	Tailor	1	0.91
15.	Teacher far from home	1	0.91
16.	Trekking	1	0.91
	Total	**109**	**100.00**

Source: Field Research, 2008

Among the abroad service holders, highest number of people are in Saudi Arabia, Qatar, U.A.E., Malaysia, Indian Army, Private sector in India, Iraq, a little number in Hong Kong, Japan, German, Australia, U.K., France, Macau. The table 4.8 depicts the husband's jobs in foreign countries.

TABLE 4.8: HUSBAND'S EMPLOYMENT IN FOREIGN COUNTRIES

S.NO.	Country	No.	Percentage
1.	Saudi Arabia	8	17.39
2.	Qatar	8	17.39
3.	U.A.E	7	15.21

4.	Malaysia	5	10.86
5.	Indian Army	5	10.86
6.	India	2	4.34
7.	Iraq	2	4.34
8.	Oman	2	4.34
9.	Japan	1	2.17
10.	German	1	2.17
11.	Australia	1	2.17
12.	Hong Kong	1	2.17
13.	U.K.	1	2.17
14.	France	1	2.17
15.	Macau	1	2.17
	Total	**46**	**100.00**

Source: Field Research, 2008

4.8 Education

Education is the transmission of knowledge by either formal or informal methods. According to Dictionary of Sociology (1999), the concepts of socialization and learning are related to, in fact often inseparable from, the concept of education. Although education is often thought of in terms of schooling (formal education), effective training for the individual role as both a group member and an autonomous person is a constant process. The main function of the educative process is to pass down knowledge from generation to generation- a process that is essential to the development of culture. Formal education is primarily designed to inculcate crucial skills and values central to the survival of the society or to those who hold effective power. Inherent in education, in all periods of man's history, is a stimulus to creative thinking and action, which accounts in part for culture change, culture change itself being a powerful stimulus to further innovation (Dictionary of Sociology, 1999).

Education is one of the most important factors determining social, economic, and educational status. Qualification is also the most important

profile for better job and employment. Education contributes to personal and professional development, bringing opportunities in life. Education is said to be a path not only for a better living but also for prestige is a bright future of every human being. The literacy rate of Nepal according to the census of 2001 is 53.7 %. Over 40% people are illiterate yet in present day Nepal (CBS, 2001).

Although education in the Nepal context of may be playing prime role in strengthening patriarchal relationship, there exists no doubt that education is an important attribute for the development of human personality and leadership skill so that to work in any kind of works. The level of education is related to higher social and economic status in the Nepalese context. A positive attitude towards any sort of attitudes and practices by the educated people can make it successful and handy. Education is a variable, which inhibits/motivates people in diverse programmes. Hence, the nature and acclaim of --*literate vs. illiterate* is vital to be comprehended for the comprehension of attitude and behaviors of breast feeding mothers.

Education status of sampled respondents is varied. The higher number of the education is the people with lower secondary level, second high school level, third no reading writing (illiterate) four primary levels, fifth Intermediate level, sixth Diploma/Degree level and seventh literate only. Around 20% (1/5) are illiterate, 16% are primary level, 20% have lower secondary level around 20% have High school level, 14% have Intermediate level and 11% have degree/diploma. Educational status has been presented in table 4.9.

It is veracity that education embedded with socio economic conditions has long been known to influence human health status in determined primarily by their level of socio economic development e.g, per capital GNP, education, nutrition, employment, housing, the political system of the country etc. A second major factor influencing health status is education (especially female education). Studies indicate that education, to some extent, compensates the effect of poverty on health, irrespective of the availability of health facilities. Kerala state of India has an estimated infant mortality rate of 14 compared to 71 for all- India in 1999. A major factor in the infant mortality of Kerala is its

highest female literacy rate of 87.86 percent compared to 54.16 percent for all-India. (Park, 2002)

Researches in Nepal clarify that more than one in two (53 percent) women age 15-49 have never been to school, 12 percent of woman have only some primary education, 5 percent have completed primary, 21 percent have only some secondary education, and less than 10 percent have completed secondary or higher level of education. Women who are older and reside in rural areas are more likely to have no education. The urban-rural difference in the level of education is pronounced at the secondary or higher levels. For example four times as many women in urban areas as in rural areas have completed secondary or higher level of education (24 percent and 6 percent respecting). Literacy is widely acknowledged as benefiting the individual and the society and is associated with a number of positive out comes for health, nation, and the overall well-being of both men and women (Nepal Demographic and Health Survey, 2006).

Among the respondent mothers the educational status has been presented in the table 4.9 which follows:

TABLE 4.9: EDUCATIONAL STATUS OF MOTHERS

S.NO.	Description	No.	Percentage
1.	Lower Secondary level	31	20.00
2.	High School level	30	19.35
3.	Illiterate	26	16.77
4	Primary level	25	16.12
5.	Intermediate level	22	14.19
6.	Diploma/Degree	17	10.96
7.	Literate only	4	2.58
	Total	**155**	**100.00**

Source: Field Research, 2008

The table depicts that 31 mothers (20%) have lower secondary level qualifications followed by 30 (19.35) mothers having high schools level school education. 26 (16.77) women are illiterate. Women with intermediate degree

are 22 (14.19) in number followed by diploma/degree 17(10.96). This trends shows that more women are literate.

4.9 Child birth and Sex Discrimination

Research has shown that the trend of child birth is highest in one child, category that is having only a child (Nepal Demographic and Health Survey, 2006). It shows that young mother below 25 years old is having two children. The age range of mothers in this range is 25-30 (Nepal Demographic and Health Survey, 2006).

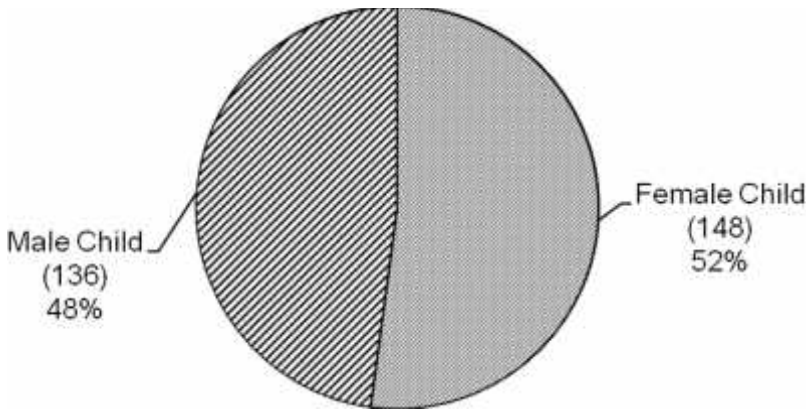
In this study among sampled 155 mothers finding shows that no one has five children but three have six children, it was in the case of women's from Rato Pahiro of ward no. 17 in Pokhara city. Rato pahiro belt is the *Sukumbasi* (squatter*)* inhabited area where people migrated from various parts of the country to this region of Pokhara in search of job and occupational activity and also having the urbanizational quest.

TABLE 4.10: CHILD BIRTH NUMBER

S.NO.	No. of child	No.	Percentage
1.	Only one child	70	45.16
2.	Two child	59	38.06
3.	Three child	20	12.90
4.	Four child	3	1.93
5.	Five child	0	0.00
6.	Six child	3	1.93
	Total	**155**	**100.00**

Source: Field Research, 2008

FIGURE 4.3: CHILD BORN AND SEX DISCRIMINATION



Source: Field Research 2008

As shown in fig. 4.3, Female child born occupy 52.11% (148) and male child 47.88% (136) among the sampled mothers, thus, it differs by 4.23%. Female child birth has high ratio than male child birth. The social fact is that couple may desire male child hence the number of female child have been increasing among the sampled mothers. It shows the trend of discrimination that prevails in the society as well as the want and priority for male child and negligence to female child.

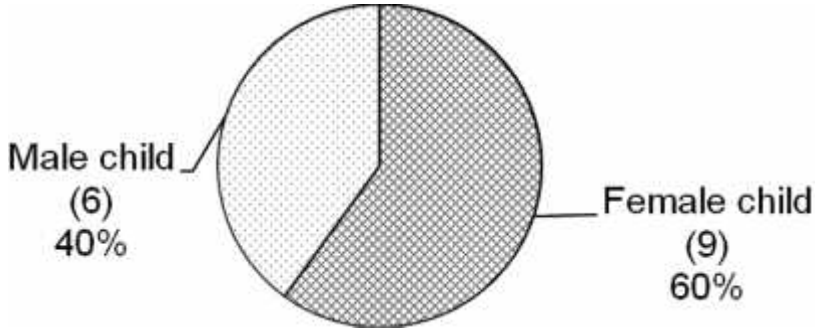
4.10 Death Records

In Nepal the IMR (Infant mortality rates) is 48/1000 in national record (Nepal Demographic and Health Survey, 2006). But this research study explored from field study that the total number of infant death is 15 and total live birth in the year 2008 is 284 among sampled mothers, thus making a total IMR of 52.8 per thousand. So, it is traced in this study that IMR (Infant mortality rates) is higher in Pokhara than national statistics as more babies are dying. It is because of the lack of good health facilities and the low socio-economic status of the mothers and comparatively fragile standing in this urban locality. In fact growth rate in Pokhara is more than as compared to national records. It has been basically based on migration, poverty and literacy rate.

This research study found that among the sampled mothers, there have been 9 abortions and I assumed that lack of nutrition and risk in pregnancy is high. The sex wise death records follows.

Figure has been presented as follows:

FIGURE 4.4: SEX WISE DEATH RECORDS



Source: Field Research, 2008

TABLE 4. 11: ABORTION, INFANT DEATH AND IMR

S.NO.	Description	No.	Percentage
1.	No. of Abortion	9	-
2.	No. of Infant death	15	-
3.	IMR	-	-
	Total	**-**	**-**

Source: Field Research, 2008

The table clarifies that the number of male child death is six and female nine, the total infant death is fifteen, 15 children which shows 52.81 IMR which is relatively higher than national trend of other areas. It also shows that the better health facilities are not available and the sampled mothers comparatively do not high social, economic and educational status. It also presents the plight of mothers who are the migrants and are surrounded by problems of various sorts; s*ocial, economic and cultural*.

CHAPTER V

PRENATAL AND POSTNATAL BEHAVIOURS OF MOTHERS

A preliminary overview of options in nutritional anthropology and strategies provides a background for the more specialization, which deals with methods for studying nutritionally related social behavior and household functioning, the determinants of food intake, the analysis of energy and even prenatal and postnatal activities of mothers viz the knowledge related to colostrums and other cultural behaviors of breast feedings.

This chapter converse on prenatal and postnatal activities of mothers after the deliveries, birth place of infants, the knowledge related to colostrums and other cultural behaviors of breast feedings and colostrums use by sampled mothers , feeding other foods, types of feeding Aids, Weaning (Complementary Feeding), nutrition immediately after delivery, and cares after delivery etc.

5.1 Birth Place

People's place of birth differs. Some may be born in hospitals and some in home or elsewhere. Likewise, process and treatment process also differs. Family Health Division **(**FHD), Department of Health Services (DOHS) (2007) depicts the total Deliveries, Caesarean sections and Referrals in 60 Districts of Nepal under the Maternity Incentives Scheme. FHD, DOHS report clarifies that national rate of delivery at health institutions are 74.8%, and 25.2% home delivery.

However, in the current research, it has been explored that 78.06 percentage of women had institutional delivery in health institutions viz. hospitals and only 21.93 are not having institutional delivery as they had their deliveries viz. at home. It differs 3.27% from the national average of 60 districts of Nepal. The table makes it more lucid:

TABLE 5.1: BIRTH PLACE

S.NO.	Place	No.	Percentage
1.	At Health institutions	121	78.06
2.	At home	33	21.29
3.	On the way	1	0.64
	Total	**155**	**100.00**

Source: Field Research, 2008

The accessibility of Western Regional Hospital, Manipal Teaching Hospital, Abhiyan Community (maternity) Hospital, Various nursing homes and polyclinics have been assisting the performance and thus making easy the deliveries. Embedded with the birth is the vital issue of prenatal and post natal behaviours of the breast feeding mothers viz the use of colostrums and its cultural implications.

5.2 Meaning of Colostrums

This research study has found out that 85.16% respondents gave the meaning of colostrums correctly. Rest 9.67% was unknown about the colostrums, 3.22% said nutritious food and 1.93% said immunity. Table showing the trend is given in table 5.2:

TABLE 5.2: KNOWLEDGE OF COLOSTRUMS

S.NO.	Description	No.	Percentage
1.	Yellowish bulky first milk	**132**	**85.16**
2.	Nutritious	**5**	**3.22**
3.	Immunity	**3**	**1.93**
4.	Unknown	**15**	**9.67**
	Total	**155**	**100.00**

Source: Field Research, 2008

5.3 Cultural Behaviours on *Colostrums* use and Breast Feeding

Before the initiation of any kind of programme it is prerequisite that local social and cultural structure, people's sentiments should be taken into proper consideration .As people are themselves sensitive subject of study, they are self conscious having individual personality, motives, emotions, sentiments, norms and values and because of this, they are self capable of choosing their

own course of action or in deciding when to participate and how to participate in any kind of activity and all these course of actions are to a great extent determined by the social and cultural structure.

A society where there is a prime role of caste based norms reinforced by orthodox *Brahministic rite de passage,* values and actions, cultural norms ought to be considered. Similarly, the Cultural features that define *"food"* and *"drink"* and distinguish categories of edibles are vital. Such sequences are vital for methods that depend on verbal elicitation of recalled consumption. For example, Fleuret (1979) found that several dietary studies in East Africa failed to report consumption of wild greens and fruit, not because the people were not eating these foods but because they were not considered "food" in the local cultural vernacular and hence were not same to colostrums milk in the cultural context of Nepal. Cultural perceptions of specific foods in terms of their social acceptability, prestige value, flavor, quality, and other characteristics consciously and unconsciously affect people's use of these foods and their ability or willingness to report their use.

Similarly, the influence of religious beliefs and practices are quite peripheral to food-intake patterns in some regions, while they play a large role in other cultural settings. A general overview of the key factors affecting food production, distribution, and consumption could help direct nutrition researchers' attention to potentially important data-collection activities.

Different socio-cultural institutions play influential role in shaping the social destiny of the people (Abrams, 2003). No doubt, Nepalese culture is diverse, reflecting different caste/ethnic origins of the people; however, the role of diverse socio-cultural organization and institutions in shaping the life style and behavior of people including the breast feeding behavior has been less comprehended in the present.

Nepal is particularly rich in cultural diversity; they observe many taboos, well known for their traditions. Likewise, there exists different socio-cultural norms and institutions of different sorts in the present influencing the taboos and diverse norms and specific identities of the people.

In the current study, the cultural behavior on breast feeding has been presented in table 5.3:

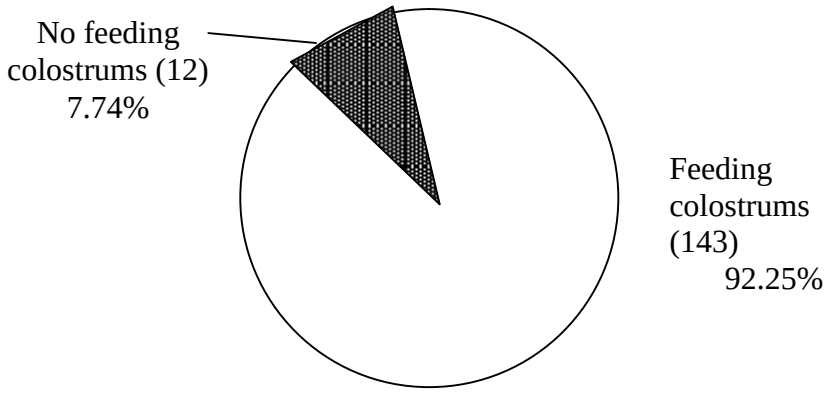
TABLE 5.3: CULTURAL BEHAVIOURS ON BREAST FEEDING

Conventional Knowledge of breast feeding	Number	Percentage
	143	**92.25**
Unknown to breast feeding and not fed colostrums squeezing culturally	**12**	**7.74**
Total	**155**	**100**

Source: Field Research, 2008

This trend has been depicted in figure 5.1 also

FIGURE 5.1: FEEDING COLOSTRUMS



Source: Field Research, 2008

Among the respondents 143 (92.25) have the conventional knowledge of breast feeding as they explained clearly about need, importance and qualities of nutrients in breast milk. Few respondents 12(7.74%) have replied that they are unknown about breast feeding at all and they have not fed colostrums (initial nutrients breast milk) initially after child birth.

The indication is cultural practices of breast feeding in their community which is hindering them from feeding *colostrums* to their infants. Some remarked that it is their belief that colostrums is indigestible to child and they believe that the pure milk comes after squeezing the first bulky milk e.g. colostrums.

This study helped in understanding that the heart of much research in applied human nutrition and nutritional anthropology is the matter of food (may be milk for infant) intake. Food is, after all, the carrier for most nutrients consumed by humans, and the specification of nutrient intake requires quantitative data on food consumption. Even when public interests are on patterns of food consumption, rather than on nutrients per se, some type of behavioral record of consumption, beyond a formal respondent's summary of "typical food intake," is a practical necessity.

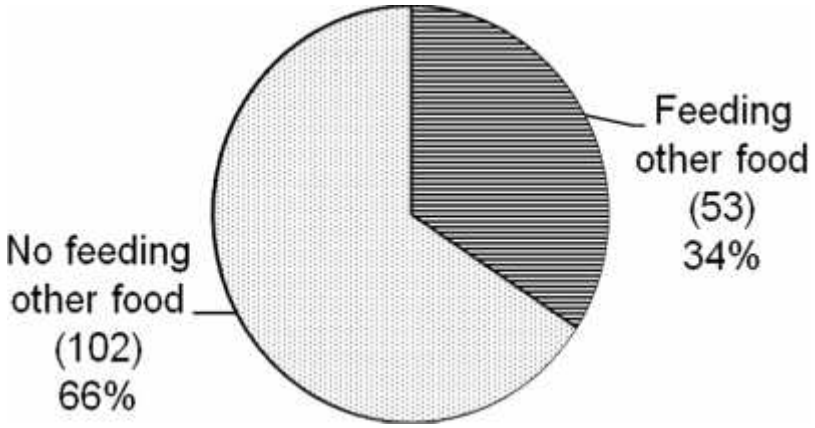
5.4 Feeding other Foods, Types of Feeding Aids

Among 155 respondents 53 have fed other food except breast feeding and 102 have used exclusive breast feeding to their infants below 6 months of age thus making a percentage of 65.8. %. It is higher than national percentage of 53% --thus having 12.8% difference in Pokhara. Probably the cause of higher percentage of breast feeding to infants is due to higher socio, economic, educational status of permanent residence of Pokhara city. In this study, it has been deduced that the causes of other food feeding are service, labour, job holders. Nevertheless, one respondent in Srizana Chowk reported that no breast is secreting completely in her breast since child birth and hence she fed lactogen, and cow's milk these days. But her socio economic status is quite higher than other because she is graduate teacher and family background is sound. She was advised of her proper position, attachment of breast feeding but she replied no success even by means. It was exceptional case may be *Sehan's syndrome* (no secretion of prolactin hormone).

In this research among 53 other food feeding, 6 have been applying more than one food. Among 53 had been feeding lactogen/container milk, 13 had other food, 7 buffalo and 1 have been fed cow's milk to the infants below 6 months of age.

Using aids (pot) are bowl/spoon and bottle but highest is of bowl/spoon users whose number is 39 and bottle using are 14. Figure following presents the breast feeding behaviour of sampled mothers which is as follows.

FIGURE 5.2: FEEDING OTHER FOODS, YES/NO



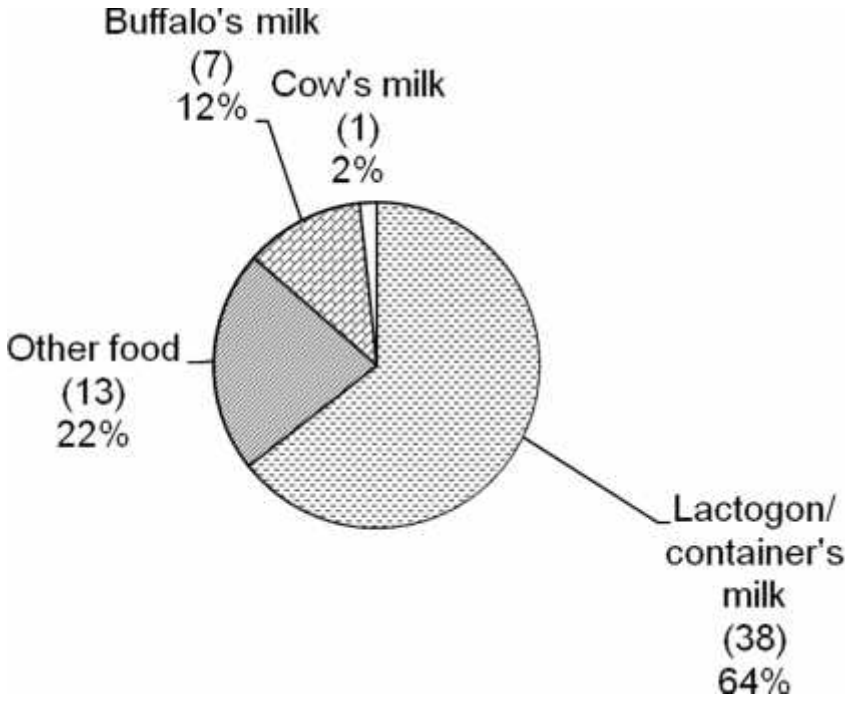
Source: Field Research, 2008

Case study of a breast feeding medical doctor mother

Nutrition is essential for all creatures to survive as no creature can survive without nutrition. So as human beings and their infants. Breast feeding is necessary for all babies. Breastfeeding is the feeding of an infant or young child with breast milk directly from human breasts, not from a baby bottle or other container. Babies have a sucking reflex that enables them to suck and swallow milk. It is possible for most mothers to breastfed their infant by breastfeeding for the first six months, if not longer, without the supplement of infant formula milk or solid food.

In most situations breast feeding is the best source of nourishment for human infants, preventing disease, promoting health and reducing health care costs. However, breast feeding a phenomenon which is quite complex and embedded with different situations. Likewise, women from all situations used to face the problems related to breast feedings. But, it is not only the common women who are facing difficulties with breast feeding. Even a medical doctor her name is Dr. Saraswati Pandey, aged 27 years old who served at Fewa city Hospital and Research Center at Srizana Chowk has not been following exclusive breast feeding. The lady doctor as a mother reported and lamented that she is unable to go for proper feeding to her infant who is only few months old. She told that her child had been fed lactogen since 3 months and then followed by cow's milk after 4 months because she has to do duty in hospital, at so time her baby needs to be fed other food except her breast milk. She also told that private hospital rules are very strict and she has no option but to attend the duty than to give priority to breast feeding her baby. This shows the plight of breast feeding even in the case of a medical practitioner who is feeding other food to her baby and the economic factor is the responsible factor behind this.

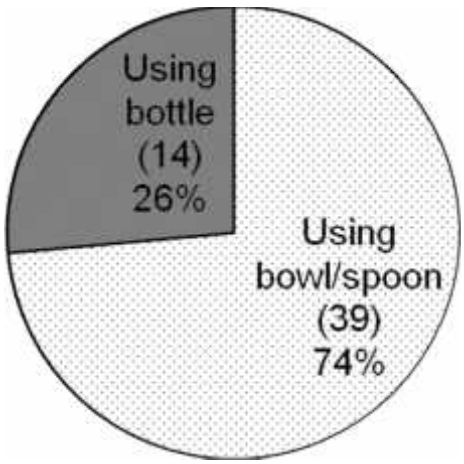
FIGURE 5.3: TYPES OF OTHER FOODS



Source: Field Research, 2008

Types of other food shown in fig. 5.3 as above using feeding Aids (Pot) are presented in fig. 5.4 below which depicts the trends of feeding Aids (pot) to the infants:

FIGURE 5.4: FEEDING AIDS (POT)



Source: Field Research, 2008

5.5 Weaning (Complementary Feeding)

After completion of 6 months, a child does not fulfill him/her nutrition as needed to the body from breast feeding only. Even though breast feeding is continuing, soft cereals foods like *jaulo, lito* are needed for child's physical growth and development. This research has explored the complementary feeding before 6 months of age which has been already described earlier. In spite of vitality of complementary feedings, few mothers have not been starting complementary feeding even after 6 months of age of their babies. They have believed that it is sufficient from breast feeding but it is their fault which may result to illness of child, lack of energy, indigestion and malnourishment in the long run.

In Nepal complex, majority of malnutrition belongs at the age below 2 years old. The cause is that proper time and quality of complementary feeding to child is lacking and also owing to the tradition of *culture of poverty*. Sociologists believe that the stage of acute poverty, backwardness and suppression for a long time, used to produce a *culture of poverty*-- that is a culture shared by the poor and the backwards of the same group. The term culture of poverty was first of all used by Oscar Lewis in 1968 while conducting study in Central America. The culture of poverty, thus, is a design or a style for living, which is transmitted from one generation to next and which influences all aspects of individual's life. In case of poor mothers *culture of poverty* has imparted a very adverse effect on the breast feeding behavior of the mothers, thus preparing the background for ignorance and apathy.

The complementary feeding practices found in this research have been presented in table below which depicts the reality that it is highest in 6 month completion and lowest in 9 month completion. The table clarifies that 128 mothers are adopting complimentary feeding at 6 months completion of their infant's age.

TABLE 5.4: COMPLEMENTARY FEEDING

S.NO.	Months	No.	Percentage
1.	5 months	20	12.90
2.	6 months	128	82.58
3.	7 months	5	3.22
4.	9 months	2	1.29
	Total	**155**	**100.00**

Source: Field Research, 2008

5.6 Assist and Conduct During Child Birth

Childbirth is a complex event embedded not only with the health issue but with the social, cultural, economic and educational status of mothers and the society as a whole. Society is a network of relationship and different factors and agents play a pivot role in pregnancy and delivery in an *oriental* society like ours. The table given below clarifies who assisted and helped in giving birth to a baby among the sampled mothers.

TABLE 5.5: ASSIST AND CONDUCT DURING CHILD BIRTH

S.NO.	Assistance	No.	Percentage
1.	Doctor/Nurses	122	78.70
2.	Sister	12	7.74
3.	Sasu/ Mother in Law	10	6.45
4.	Neighbours/TBA	8	5.16
5.	Own mother	3	1.93
	Total	**155**	**100.00**

Source: Field Research, 2008

The study has shown that highest numbers of deliveries were conducted at Hospital e.g.78.70%, conducted by Doctors/Nurses. Rest 21.3% have home delivery which varies 7.74% conducted by sister (own + husbands), 6.45% by own *sasu* (husband's mother), 5.16% by neighbours/TBAs and 1.93% by own mother. It shows the trends of institutional delivery which is safety; protect the chances of maternal mortality. Now-a-days Government has stressed

institutional delivery to the people, providence of free health service rupees 500 in Terai, rupees 1000 in hills and rupees 1500 in the mountains for maternal incentives programme.

5.7 Care after Delivery at Home.

Most of the respondents were cared by own *Sasu (Mother in law)* after delivery at home. Care after delivery is most important factor in maternal death. Due to the rising education, awareness, modernization and urbanization husbands were sensitive to take care of their wives after her delivery. Table below has been presenting the trend as follows:

TABLE 5.6: CARE AFTER DELIVERY

S.NO.	Care takers	No.	Percentage
1.	*Sasu* (Mother in Law)	49	31.6
2.	Husband	45	29.00
3.	Own sisters	36	23.22
4.	Mothers	19	12.25
5.	Neighbour	5	3.22
6.	Son's wife	1	0.06
	Total	**155**	**100.00**

Source: Field Research, 2008

The table clarifies that out of 155 sampled mothers 49 women were assisted and taken care after delivery by *Sasu* thus making a percent of 31.6. Likewise 45 women were supported by their husbands. Own sisters took care of 36 women. Likewise women's own mothers took care of 19 women, 5 women were given care by neighbours and 1 by another sons wife. This trend shows that in Nepalese society a major bulk of delivery and post natal care starts from women's own home and it also shows the internal mechanism and network of Nepalese society which is based on mutual care and solidarity.

5.8 Nutrition Immediately after Delivery

Nutrition of lactating mothers is the most important thing in breast feeding practice. Liquid, nutritious items, fruits, vegetables, protineous food (meat, fish, milk) are essentials for mothers. It has been deduced that among the sampled women majority have taken more than one type of food immediately after delivery for few days. It shows that 89 mothers have taken more than one type of food. In all together meat, rice consumer are the highest in number, then Ghee rice, *jwanoko Jhole, Dal* rice, animal's milk, fruits, bread respectively . The table given below clarifies the situation which depicts the nutrition taken and the number of time it has been taken:

TABLE 5.7: NUTRITION IMMEDIATELY AFTER DELIVERY AND TYPES OF FOOD INTAKE

S.No.	Types of food	Types of food intake	Percentage
1.	Meat Rice	97	44.31
2.	Ghee Rice	63	23.86
3.	Jwanoko jhole	58	21.96
4.	Dal Rice	13	4.92
5.	Animal's milk	9	3.40
6.	Fruits	3	1.13
7.	Bread	1	0.37
8.	Wine	0	0.00
	Total		100.00

Source: Field Research, 2008

The table clarifies that meat and rice has been taken by 97 mothers followed by ghee rice 63 mothers, and the *Jwanoko jhole* 58 mothers and plain Dal rice 13 mothers, animal milk 9 mothers, fruits 3 mothers and bread 1 mother. Wine was not taken at any time by any women which shows that Nepalese society is still *caste ridden and priest ridden* where wine is culturally regarded polluted specially by Brahmins and Chettries. Wine drinking cultures of ethnic group's viz. *Matawali* groups like Gurung, and even Dalits was also restricted and influenced by the dominating Brahmin-Chettri cultures.

CHAPTER V

PRENATAL AND POSTNATAL BEHAVIOURS OF MOTHERS

A preliminary overview of options in nutritional anthropology and strategies provides a background for the more specialization, which deals with methods for studying nutritionally related social behavior and household functioning, the determinants of food intake, the analysis of energy and even prenatal and postnatal activities of mothers viz the knowledge related to colostrums and other cultural behaviors of breast feedings.

This chapter converse on prenatal and postnatal activities of mothers after the deliveries, birth place of infants, the knowledge related to colostrums and other cultural behaviors of breast feedings and colostrums use by sampled mothers , feeding other foods, types of feeding Aids, Weaning (Complementary Feeding), nutrition immediately after delivery, and cares after delivery etc.

5.2 Birth Place

People's place of birth differs. Some may be born in hospitals and some in home or elsewhere. Likewise, process and treatment process also differs. Family Health Division **(**FHD), Department of Health Services (DOHS) (2007) depicts the total Deliveries, Caesarean sections and Referrals in 60 Districts of Nepal under the Maternity Incentives Scheme. FHD, DOHS report clarifies that national rate of delivery at health institutions are 74.8%, and 25.2% home delivery.

However, in the current research, it has been explored that 78.06 percentage of women had institutional delivery in health institutions viz. hospitals and only 21.93 are not having institutional delivery as they had their deliveries viz. at home. It differs 3.27% from the national average of 60 districts of Nepal. The table makes it more lucid:

TABLE 5.1: BIRTH PLACE

S.NO.	Place	No.	Percentage
1.	At Health institutions	121	78.06
2.	At home	33	21.29
3.	On the way	1	0.64
	Total	**155**	**100.00**

Source: Field Research, 2008

The accessibility of Western Regional Hospital, Manipal Teaching Hospital, Abhiyan Community (maternity) Hospital, Various nursing homes and polyclinics have been assisting the performance and thus making easy the deliveries. Embedded with the birth is the vital issue of prenatal and post natal behaviours of the breast feeding mothers viz the use of colostrums and its cultural implications.

5.2 Meaning of Colostrums

This research study has found out that 85.16% respondents gave the meaning of colostrums correctly. Rest 9.67% was unknown about the colostrums, 3.22% said nutritious food and 1.93% said immunity. Table showing the trend is given in table 5.2:

TABLE 5.2: KNOWLEDGE OF COLOSTRUMS

S.NO.	Description	No.	Percentage
1.	Yellowish bulky first milk	**132**	**85.16**
2.	Nutritious	**5**	**3.22**
3.	Immunity	**3**	**1.93**
4.	Unknown	**15**	**9.67**
	Total	**155**	**100.00**

Source: Field Research, 2008

5.3 Cultural Behaviours on *Colostrums* use and Breast Feeding

Before the initiation of any kind of programme it is prerequisite that local social and cultural structure, people's sentiments should be taken into proper consideration .As people are themselves sensitive subject of study, they are self conscious having individual personality, motives, emotions, sentiments, norms and values and because of this, they are self capable of choosing their

own course of action or in deciding when to participate and how to participate in any kind of activity and all these course of actions are to a great extent determined by the social and cultural structure.

A society where there is a prime role of caste based norms reinforced by orthodox *Brahministic rite de passage,* values and actions, cultural norms ought to be considered. Similarly, the Cultural features that define *"food"* and *"drink"* and distinguish categories of edibles are vital. Such sequences are vital for methods that depend on verbal elicitation of recalled consumption. For example, Fleuret (1979) found that several dietary studies in East Africa failed to report consumption of wild greens and fruit, not because the people were not eating these foods but because they were not considered "food" in the local cultural vernacular and hence were not same to colostrums milk in the cultural context of Nepal. Cultural perceptions of specific foods in terms of their social acceptability, prestige value, flavor, quality, and other characteristics consciously and unconsciously affect people's use of these foods and their ability or willingness to report their use.

Similarly, the influence of religious beliefs and practices are quite peripheral to food-intake patterns in some regions, while they play a large role in other cultural settings. A general overview of the key factors affecting food production, distribution, and consumption could help direct nutrition researchers' attention to potentially important data-collection activities.

Different socio-cultural institutions play influential role in shaping the social destiny of the people (Abrams, 2003). No doubt, Nepalese culture is diverse, reflecting different caste/ethnic origins of the people; however, the role of diverse socio-cultural organization and institutions in shaping the life style and behavior of people including the breast feeding behavior has been less comprehended in the present.

Nepal is particularly rich in cultural diversity; they observe many taboos, well known for their traditions. Likewise, there exists different socio-cultural norms and institutions of different sorts in the present influencing the taboos and diverse norms and specific identities of the people.

In the current study, the cultural behavior on breast feeding has been presented in table 5.3:

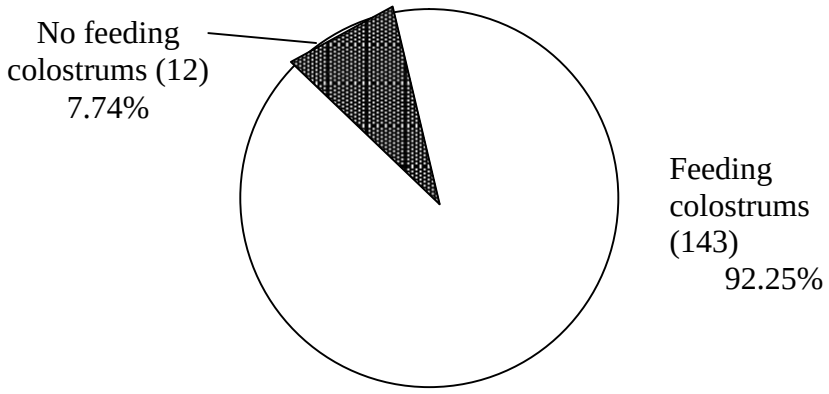
TABLE 5.3: CULTURAL BEHAVIOURS ON BREAST FEEDING

Conventional Knowledge of breast feeding	Number	Percentage
	143	**92.25**
Unknown to breast feeding and not fed colostrums squeezing culturally	**12**	**7.74**
Total	**155**	**100**

Source: Field Research, 2008

This trend has been depicted in figure 5.1 also

FIGURE 5.1: FEEDING COLOSTRUMS



Source: Field Research, 2008

Among the respondents 143 (92.25) have the conventional knowledge of breast feeding as they explained clearly about need, importance and qualities of nutrients in breast milk. Few respondents 12(7.74%) have replied that they are unknown about breast feeding at all and they have not fed colostrums (initial nutrients breast milk) initially after child birth.

The indication is cultural practices of breast feeding in their community which is hindering them from feeding *colostrums* to their infants. Some remarked that it is their belief that colostrums is indigestible to child and they believe that the pure milk comes after squeezing the first bulky milk e.g. colostrums.

This study helped in understanding that the heart of much research in applied human nutrition and nutritional anthropology is the matter of food (may be milk for infant) intake. Food is, after all, the carrier for most nutrients consumed by humans, and the specification of nutrient intake requires quantitative data on food consumption. Even when public interests are on patterns of food consumption, rather than on nutrients per se, some type of behavioral record of consumption, beyond a formal respondent's summary of "typical food intake," is a practical necessity.

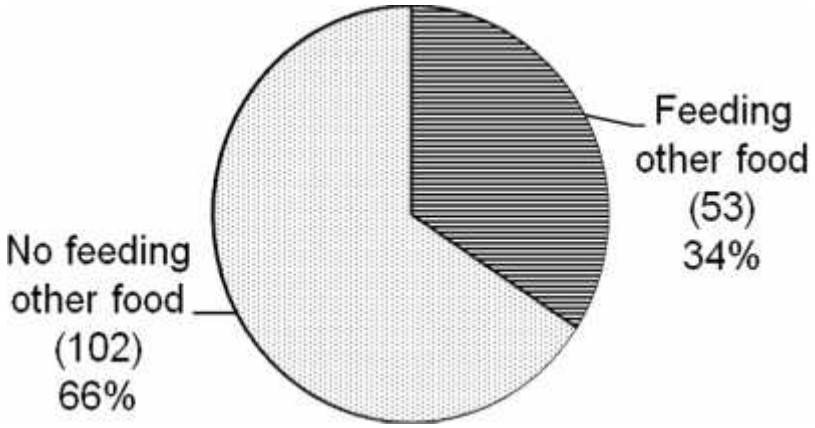
5.4 Feeding other Foods, Types of Feeding Aids

Among 155 respondents 53 have fed other food except breast feeding and 102 have used exclusive breast feeding to their infants below 6 months of age thus making a percentage of 65.8. %. It is higher than national percentage of 53% --thus having 12.8% difference in Pokhara. Probably the cause of higher percentage of breast feeding to infants is due to higher socio, economic, educational status of permanent residence of Pokhara city. In this study, it has been deduced that the causes of other food feeding are service, labour, job holders. Nevertheless, one respondent in Srizana Chowk reported that no breast is secreting completely in her breast since child birth and hence she fed lactogen, and cow's milk these days. But her socio economic status is quite higher than other because she is graduate teacher and family background is sound. She was advised of her proper position, attachment of breast feeding but she replied no success even by means. It was exceptional case may be *Sehan's syndrome* (no secretion of prolactin hormone).

In this research among 53 other food feeding, 6 have been applying more than one food. Among 53 had been feeding lactogen/container milk, 13 had other food, 7 buffalo and 1 have been fed cow's milk to the infants below 6 months of age.

Using aids (pot) are bowl/spoon and bottle but highest is of bowl/spoon users whose number is 39 and bottle using are 14. Figure following presents the breast feeding behaviour of sampled mothers which is as follows.

FIGURE 5.2: FEEDING OTHER FOODS, YES/NO



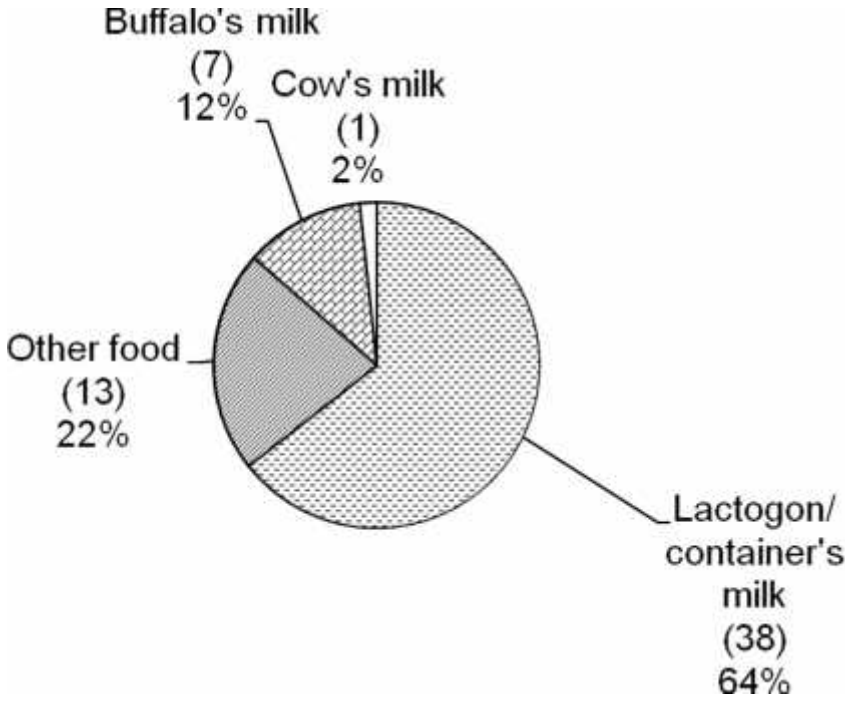
Source: Field Research, 2008

Case study of a breast feeding medical doctor mother

Nutrition is essential for all creatures to survive as no creature can survive without nutrition. So as human beings and their infants. Breast feeding is necessary for all babies. Breastfeeding is the feeding of an infant or young child with breast milk directly from human breasts, not from a baby bottle or other container. Babies have a sucking reflex that enables them to suck and swallow milk. It is possible for most mothers to breastfed their infant by breastfeeding for the first six months, if not longer, without the supplement of infant formula milk or solid food.

In most situations breast feeding is the best source of nourishment for human infants, preventing disease, promoting health and reducing health care costs. However, breast feeding a phenomenon which is quite complex and embedded with different situations. Likewise, women from all situations used to face the problems related to breast feedings. But, it is not only the common women who are facing difficulties with breast feeding. Even a medical doctor her name is Dr. Saraswati Pandey, aged 27 years old who served at Fewa city Hospital and Research Center at Srizana Chowk has not been following exclusive breast feeding. The lady doctor as a mother reported and lamented that she is unable to go for proper feeding to her infant who is only few months old. She told that her child had been fed lactogen since 3 months and then followed by cow's milk after 4 months because she has to do duty in hospital, at so time her baby needs to be fed other food except her breast milk. She also told that private hospital rules are very strict and she has no option but to attend the duty than to give priority to breast feeding her baby. This shows the plight of breast feeding even in the case of a medical practitioner who is feeding other food to her baby and the economic factor is the responsible factor behind this.

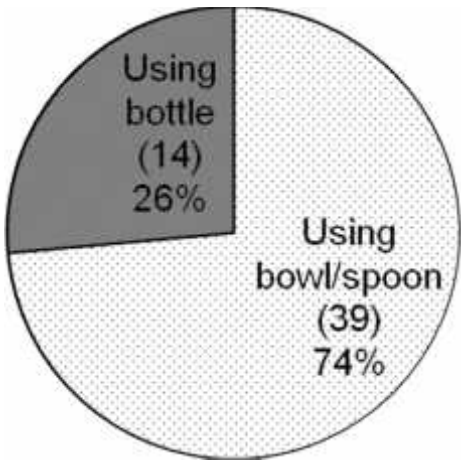
FIGURE 5.3: TYPES OF OTHER FOODS



Source: Field Research, 2008

Types of other food shown in fig. 5.3 as above using feeding Aids (Pot) are presented in fig. 5.4 below which depicts the trends of feeding Aids (pot) to the infants:

FIGURE 5.4: FEEDING AIDS (POT)



Source: Field Research, 2008

5.5 Weaning (Complementary Feeding)

After completion of 6 months, a child does not fulfill him/her nutrition as needed to the body from breast feeding only. Even though breast feeding is continuing, soft cereals foods like *jaulo, lito* are needed for child's physical growth and development. This research has explored the complementary feeding before 6 months of age which has been already described earlier. In spite of vitality of complementary feedings, few mothers have not been starting complementary feeding even after 6 months of age of their babies. They have believed that it is sufficient from breast feeding but it is their fault which may result to illness of child, lack of energy, indigestion and malnourishment in the long run.

In Nepal complex, majority of malnutrition belongs at the age below 2 years old. The cause is that proper time and quality of complementary feeding to child is lacking and also owing to the tradition of *culture of poverty*. Sociologists believe that the stage of acute poverty, backwardness and suppression for a long time, used to produce a *culture of poverty*-- that is a culture shared by the poor and the backwards of the same group. The term culture of poverty was first of all used by Oscar Lewis in 1968 while conducting study in Central America. The culture of poverty, thus, is a design or a style for living, which is transmitted from one generation to next and which influences all aspects of individual's life. In case of poor mothers *culture of poverty* has imparted a very adverse effect on the breast feeding behavior of the mothers, thus preparing the background for ignorance and apathy.

The complementary feeding practices found in this research have been presented in table below which depicts the reality that it is highest in 6 month completion and lowest in 9 month completion. The table clarifies that 128 mothers are adopting complimentary feeding at 6 months completion of their infant's age.

TABLE 5.4: COMPLEMENTARY FEEDING

S.NO.	Months	No.	Percentage
1.	5 months	20	12.90
2.	6 months	128	82.58
3.	7 months	5	3.22
4.	9 months	2	1.29
	Total	**155**	**100.00**

Source: Field Research, 2008

5.6 Assist and Conduct During Child Birth

Childbirth is a complex event embedded not only with the health issue but with the social, cultural, economic and educational status of mothers and the society as a whole. Society is a network of relationship and different factors and agents play a pivot role in pregnancy and delivery in an *oriental* society like ours. The table given below clarifies who assisted and helped in giving birth to a baby among the sampled mothers.

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S.NO.	Assistance	No.	Percentage
1.	Doctor/Nurses	122	78.70
2.	Sister	12	7.74
3.	Sasu/ Mother in Law	10	6.45
4.	Neighbours/TBA	8	5.16
5.	Own mother	3	1.93
	Total	**155**	**100.00**

Source: Field Research, 2008

The study has shown that highest numbers of deliveries were conducted at Hospital e.g.78.70%, conducted by Doctors/Nurses. Rest 21.3% have home delivery which varies 7.74% conducted by sister (own + husbands), 6.45% by own *sasu* (husband's mother), 5.16% by neighbours/TBAs and 1.93% by own mother. It shows the trends of institutional delivery which is safety; protect the chances of maternal mortality. Now-a-days Government has stressed

institutional delivery to the people, providence of free health service rupees 500 in Terai, rupees 1000 in hills and rupees 1500 in the mountains for maternal incentives programme.

5.7 Care after Delivery at Home.

Most of the respondents were cared by own *Sasu (Mother in law)* after delivery at home. Care after delivery is most important factor in maternal death. Due to the rising education, awareness, modernization and urbanization husbands were sensitive to take care of their wives after her delivery. Table below has been presenting the trend as follows:

TABLE 5.6: CARE AFTER DELIVERY

S.NO.	Care takers	No.	Percentage
1.	*Sasu* (Mother in Law)	49	31.6
2.	Husband	45	29.00
3.	Own sisters	36	23.22
4.	Mothers	19	12.25
5.	Neighbour	5	3.22
6.	Son's wife	1	0.06
	Total	**155**	**100.00**

Source: Field Research, 2008

The table clarifies that out of 155 sampled mothers 49 women were assisted and taken care after delivery by *Sasu* thus making a percent of 31.6. Likewise 45 women were supported by their husbands. Own sisters took care of 36 women. Likewise women's own mothers took care of 19 women, 5 women were given care by neighbours and 1 by another sons wife. This trend shows that in Nepalese society a major bulk of delivery and post natal care starts from women's own home and it also shows the internal mechanism and network of Nepalese society which is based on mutual care and solidarity.

5.8 Nutrition Immediately after Delivery

Nutrition of lactating mothers is the most important thing in breast feeding practice. Liquid, nutritious items, fruits, vegetables, protineous food (meat, fish, milk) are essentials for mothers. It has been deduced that among the sampled women majority have taken more than one type of food immediately after delivery for few days. It shows that 89 mothers have taken more than one type of food. In all together meat, rice consumer are the highest in number, then Ghee rice, *jwanoko Jhole, Dal* rice, animal's milk, fruits, bread respectively . The table given below clarifies the situation which depicts the nutrition taken and the number of time it has been taken:

TABLE 5.7: NUTRITION IMMEDIATELY AFTER DELIVERY AND TYPES OF FOOD INTAKE

S.No.	Types of food	Types of food intake	Percentage
1.	Meat Rice	97	44.31
2.	Ghee Rice	63	23.86
3.	Jwanoko jhole	58	21.96
4.	Dal Rice	13	4.92
5.	Animal's milk	9	3.40
6.	Fruits	3	1.13
7.	Bread	1	0.37
8.	Wine	0	0.00
	Total		100.00

Source: Field Research, 2008

The table clarifies that meat and rice has been taken by 97 mothers followed by ghee rice 63 mothers, and the *Jwanoko jhole* 58 mothers and plain Dal rice 13 mothers, animal milk 9 mothers, fruits 3 mothers and bread 1 mother. Wine was not taken at any time by any women which shows that Nepalese society is still *caste ridden and priest ridden* where wine is culturally regarded polluted specially by Brahmins and Chettries. Wine drinking cultures of ethnic group's viz. *Matawali* groups like Gurung, and even Dalits was also restricted and influenced by the dominating Brahmin-Chettri cultures.

CHAPTER VI

ATTITUDES AND BREAST FEEDING BEHAVIOURS OF MOTHERS

Every culture has its own specific popular health related beliefs based on its general cultural features hence it is possible to propose the existence of as many medical systems and health related beliefs as there are cultures and therefore develop the comparative study of these systems. Likewise, medical systems as well as breast feeding systems and the knowledge of breast feeding are the specific products of each caste/ethnic group's cultural history. Based on these notions, this chapter converse on the knowledge of Breast feeding, early breastfeeding after child birth, exclusive breastfeeding, continuing breast feeding after complementary feeding, antenatal examination and post natal care examinations etc among the sampled mothers from diverse socio-cultural, economic and ethnic backgrounds.

6.1 Knowledge of Breast feeding

This research study traced that most of the respondents (breast feeding mothers) replied breastfeeding is baby's ideal food, for nutrition, and immunity. But two of the breast feeding mothers said that they are unknown to this reality. Most of the respondents 65.8% (102) have described briefly the scientific definition of breast feeding. The cumulative differentiation of breastfeeding knowledge of mothers has been presented in table 6.1:

TABLE 6.1: KNOWLEDGE OF BREAST FEEDING

S.NO.	Mother's responses	No.	Percentage
1.	Baby's food	102	65.80
2.	Nutrition	38	24.51
3.	Immunity	13	8.38
4.	Unknown	2	1.29
	Total	**155**	**100.00**

Source: Field Research, 2008

6.2 Early Breastfeeding After Child birth

Breast feeding is the very important practice after child birth. It prevents uterine bleeding of mothers, helps to secrete protection hormone to form milk in mother's body. Sucking stimulates the ducts of milk collecting from the body. No other things even water do not feed child except breast feeding. Hence, it is vital to explore the early breastfeeding after child birth among the sampled mothers. The variations of breast feeding intervals are in table 6.2:

TABLE 6.2: EARLY BREAST FEEDING AFTER CHILD BIRTH

S.NO.	Hours	No.	Percentage
1.	Within ½ an hour	43	27.74
2.	Within 1 hour	49	31.61
3.	Within 3 hour	30	19.35
4.	Within 4 hour	6	3.87
5.	After 6 hours or more	22	14.19
6.	After 3,4 days	5	3.22
	Total	**155**	**100.00**

Source: Field Research, 2008

Above presentation has shown most of the mothers breastfed within one hour after child birth, but 22 had fed after 6 hours and more. In the same manner 5 mothers had breast fed even after 3, 4 days after child birth because they were caesarean cases (operative child birth).

6.3 Exclusive Breastfeeding

The meaning of exclusive breastfeeding is not to give any food, liquids to child except breast feeding till six months of life. The dangerous consequences of early complementary feeding are diarrhoea, acute respiratory tract infections, and various illnesses to child. WHO has recommended that breast feeding till 6 months of life is sufficient nutrition value to child then after needed complementary feeding. This study traced that 83.87% (130) mothers have had breast fed exclusively. Only 6.45% (10) had breastfed till 3months. Among the 155 mothers, 13 had breastfed more than 6 months. Table 6.3 has been presenting the eminence of exclusive breast feeding among the mothers:

TABLE 6.3: EXCLUSIVE BREAST FEEDING

S.NO.	Breastfeeding months	No.	Percentage
1.	Till three months	10	6.45
2.	Till six months	130	83.87
3.	Till nine months	6	3.87
4.	Till twelve months	7	4.51
5	Unknown	2	1.29
	Total	**155**	**100.0**

Source: Field Research, 2008

6.4 Times of Breast feeding in a Day

WHO/UNICEF has recommended 8 times breast feeding in a day as the best. In this research study among 155 sampled mothers, only 15 respondents have breast fed less than 8 times in a day. It has been found that 21.29% (33) have breastfed 8 times, 40.64% (63) have ten times, 28.38% (44) have more than fifteen times in a day. This study deduced that the breast feeding times in a day for the mothers dwelling in the city is satisfactory, but all are not alert as they are migrants lacking awareness and having multifaceted socio-economic problems with rural background and low economic and educational status. The table showing below is as follows which exposes the times of breast feeding in a day.

TABLE 6.4: TIMES OF BREAST FEEDING IN A DAY

S.NO.	Breastfeeding time	No.	Percentage
1.	Four times in a day	6	3.87
2.	Six times in a day	9	5.80
3.	Eight times in a day	33	21.29
4.	Ten times in a day	63	40.64
5.	Fifteen times or more	44	28.38
	Total	**155**	**100.00**

Source: Field Research, 2008

6.5 Causes of Feeding other food

This study traced that 53 mothers are feeding other food except their breast milk to their babies. Among the 53 breast feeding mothers giving complimentary feeding except breast milk, more than 50% (50.94) children were more than 6 months of age. They need complementary feeding as needed extra calorie to require growth and development. Breast feeding is sufficient till 6 months of age only and it is not adequate for the children above 6 months of age.

Except the complementary feeding 49.05% (26) children below 6 months of age were breastfed and most of the mother says baby is not satisfied on breast feeding.

The table 6.5 shows the description and variations of causes on feeding other food.

TABLE 6.5: CAUSES OF FEEDING OTHER FOOD

S.NO.	Description	No.	Percentage
1.	Baby is more than 6 months	27	50.94
2.	Baby need to satisfy	14	26.41
3.	No breast milk	6	11.32
4.	Mother goes to service	3	5.66
5.	Mother goes to Labour	1	1.88
6.	Twins baby	1	1.88
7.	Neonatal/jaundice	1	1.88
	Total	**53**	**100.00**

Source: Field Research, 2008

Few mothers are feeding other food due to the cause of service, labour work, twin baby and neonatal jaundice. It seems that mothers need proper counselling about breastfeeding position, attachment, psychosocial support from their family and community.

6.6 Continuing Breast feeding after Complementary Feeding

The health and nutrition theme has approved that breast feeding needs continuation up to two years after complementary feeding. As feeding complementary food, breastfeeding is needed for immunity, calorie, and various forms of elements are needed mentally, for physically growth and development of a child. Following table 6.6 showing different versions of mothers have been presented as follows:

TABLE 6.6: CONTINUATION OF BREAST FEEDING AFTER COMPLEMENTARY FEEDING

S.NO.	Year	No.	Percentage
1.	Up to one year	3	1.93
2.	Up to two year	64	41.29
3.	Up to three year	46	29.67
4.	Up to four year	40	25.80
5.	Up to five year	0	0.00
6.	Unknown	2	1.29
	Total	**155**	**100.00**

Source: Field Research, 2008

Breastfeeding up to two years or more is satisfactory after complementary feeding. Above table has shown only 1.93% (3) mothers have left breastfeeding after one year. Nevertheless, American Association of paediatrics (AAP) had recommended that one year continuation of breast feeding is sufficient.

In this research study among the 155 sampled breast feeding mothers, most of the women replied that their breastfeeding practice is continuing up to next baby born. The two out of 155 mothers said that they are unknown about the issue and concept of the continuation of breast feeding after complementary feeding, but they have to breast fed till next baby is born and conception. From this, it is deduced that continuation of breastfeeding after complementary feeding is satisfactory among the sampled breast feeding mothers.

6.7 Antenatal Care Examination

It has been endorsed that four times ANC (antenatal examination or check up) visit is helpful in reducing maternal mortality rate. As written in annual reports of MOHP (2007), in Nepal the national rate of antenatal examination is 4 times and ANC visit is 48% on the part of mothers in national context.

In this research it has been found that only 25.16% (39) mothers have not examined or gone for four times ANC visit. However, 116 mothers visited the clinic for **Antenatal examination** hence making a percentage of 74.83% which has been presented in table below.

TABLE 6.7: ANTENATAL EXAMINATION

S.NO.	Times of ANC	No.	Percentage
1.	No examination at all	10	6.45
2.	One time examination	6	3.87
3.	Two time examination	19	12.25
4.	Three time examination	4	2.58
5.	Four time examination	37	23.87
6.	Five time examination	34	21.93
7.	Six time examination	45	29.03
	Total	**155**	**100.00**

Source: Field Research, 2008

The table clarifies that Antenatal examination by sampled mothers is around 27% higher than national standard. The reason is that HDI; GDI is in highest level in Kaski district (Central bureau of statistics report, 2001). This trend in Pokhara has been satisfactory as compared to the other parts of the country.

6.8 Post Natal Care Examination

Child birth is a complex phenomenon likewise postnatal care examination is also very vital task to be taken on the part of the mothers which will improve their best feeding capacity and the health of both infant and the mother. 24 hours after child birth or within 3 days is the best time for first post natal care examination. For second examination, 3-7 days after delivery is the best time. 7-42 days after delivery is the best time for third examination (MOH&P, 2007).

Post natal care is imperative in the absence of which there prevails the risk of death of both the mother and baby. As such it has been deduced that the

Post Natal Care Examination of the mothers is a vital task which has been highlighted in the table below.

TABLE 6.8: PNC (POST NATAL CARE) EXAMINATION

S.NO.	Description	No.	Percentage
1.	No examination	64	41.29
2.	One time examination	65	41.93
3.	Two time examination	19	12.25
4.	Three time examination	5	3.22
5.	Four time examination	2	1.29
	Total	**155**	**100.00**

Source: Field Research, 2008

From this table it becomes lucid that, post natal care at least one time after child birth among the sampled mothers is 41.93% (65) as compared to national average of 37.3%. It is a little better than national standard. Most of the cases were admitted in hospital before delivery and examined after delivery. But three times is very nominal in Post Natal Care Examination.

6.9 Immunization/Complete Immunization

Immunization or inoculation is one of the interventions which prevents against various communicable diseases such as tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, hepatitis. The researcher observed EPI cards of child and find out almost all have been routinely immunized. The table 6.9 has shown the number of times the babies have been served in EPI clinic.

TABLE 6.9: IMMUNIZED BY BCG, DPT, POLIO, HEP B.

S.NO.	Description	No.	Percentage
1.	One time	39	25.16
2.	Two time	32	20.64
3.	Three time	55	35.48
4.	Four time	7	4.51
5.	B.C.G. only	22	14.19
	Total	**155**	**100.00**

Source: Field Research, 2008

The table clarifies that the number of one time immunized is 39 with a percentage of 25.16. The number of two time immunized is 32 with a percentage of 20.64. Three times immunized number is 55(35.48) and four time immunized is 7 (4.51) in number.

6.10 Breast Feeding time at Once

Health literature and WHO (IYCF training manual, 2008) has recommended that the best breast feeding time at one occasion is 10-20 minutes. The time longer than this is not a problem but the problem occurs in less time which may deteriorate and affect the health of the infant. All details of the breast feeding time have been exposed below in the table which is as follows:

TABLE 6.10: BREAST FEEDING TIME

S.NO.	Description	No.	Percentage
1.	Five minutes	46	29.67
2.	Ten minutes	65	41.93
3.	Fifteen minutes	33	21.29
4.	Twenty minutes	11	7.09
	Total	**155**	**100.00**

Source: Field Research, 2008

This research has discovered that 65 mothers that is 41.93% of sampled mothers have fed more than 10 minutes, 33 mothers (21.29%) fed fifteen minutes, 11 mothers (7.09%) fed 20 minutes, 46 mothers (29.67%) have fed five minutes. In total more than 10 minutes breast feed mothers were 109 in number which is 70% and less than 10 minutes breast feed mothers were 46 which is 30%.

6.11 Knowledge of Breast feeding Position

Breastfeeding in correct position helps better secretion of milk with prolactin hormone stimulating. Best position described is as follows:

1. *Sitting upright position with flexing both thighs having no tension at the moment.*

2. *Hold the baby with both hands, using one below the head and one below the buttock of a child.*
3. *Holding baby at 45° L from the surface.*
4. *Attached baby with mother's body closely has been described as the best position* (World Health Organization Report, 1994).

Among the sampled mothers the knowledge of breast feeding positions differs which is as follows: out of 155 mothers 62 breast feeding mothers making a total of 40.00 percentages reported of attached baby in upright while feeding milk to a baby. 49 mothers (31.6) reported of breast feeding her baby at 45°L one hand below head and one on buttock. Likewise, 44 breast feeding mother said that they have no knowledge of actual or the real breast feeding position. The table 6.11 exposes it as follows:

TABLE 6.11: KNOWLEDGE OF BREASTFEEDING POSITION AMONG SAMPLED MOTHERS

S.NO.	Description	No.	Percentage
1.	Attached baby in upright	62	40.00
2.	At 45°L one hand below head and one on buttock	49	31.6
3.	No knowledge	44	28.38
	Total	**155**	**100.00**

Source: Field Research, 2008

This table clarifies that the breast feeding mothers sitting upright position with flexing both thighs having no tension at a moment and holding the baby with both hands, using one below the head and one below the buttock of a child and holding baby at 45° L from the surface attaching baby with mother's body closely as revealed as best position in WHO report has been achieved very least in the sampled breast feeding mothers in the study site of Pokhara.

6.12 Knowledge of Breast feeding Attachment

According to the report of World Health Organization (1994) proper breast feeding attachment is:

- Hold areola of the breast fully inside the baby's mouth.
- Baby's mouth is fully opened and wide.
- Backwards lower lip during breastfeeding.
- Chin of the baby touches to the breast while breast feeding.
- Cheeks of the baby protused while breast feeding.
- Awareness of breastfeeding policy in written form ought to be provided in all health institutions.
- Training for all health workers to fulfil breast feeding policy.
- Informed to all pregnant women about importance of breastfeeding and procedure.
- Assist to mothers, breastfeeding within an hour after child birth immediately.
- Counsel to mothers, how to do breastfeeding, how to increase breast milk production.
- Except in the diseased conditions advised by medical doctors no other food, even water is not fed to child unless breastfeeding till 6 months of age.
- Attachment of the baby with his/her mothers.
- Artificial teat or other chewing aids do not provide to breastfeeding Infant.
- Advise to form mother groups which promotes, advise to mother’s breastfeeding and after working hours from institutions, mothers have to consult about breast feeding.

In the case of this study the breast feeding mothers knowledge of breast feeding has been presented in the table 6.12 as follows:

TABLE 6.12: KNOWLEDGE OF BREAST FEEDING ATTACHMENT

S.NO.	Description	No.	Percentage
1.	No knowledge	119	76.77
2.	Fully open the mouth	5	3.22
3.	Backwards lower lip	5	3.22
4.	Areola fully inside baby's mouth	20	12.90
5.	Baby's chin attached to breast	6	3.87
	Total	**155**	**100.00**

Source: Field Research, 2008

Related to the knowledge on breast feeding *attachment* among the 155 respondents, more than 75% mothers have no knowledge of proper attachment of breastfeeding as defined in CB-IMCI protocol as 119 women reported that they have no knowledge of breast feeding attachment. Without proper attachment there is no chances of effective suckling, if no effective suckling no chances of emptying all milk retaining in the breast of mother. At the last it has been deduced from this study that breastfeeding offers numerous health advantages to children, mothers, and society. From obstetrics to pediatrics, breast feeding mothers come in contact with healthcare providers as Sansthagat clinic. Health workers support breastfeeding enthusiastically and for all children to have a proper breast feeding but ***this study*** identified gaps in breastfeeding knowledge, counseling skills, and professional education and training given to a mother that's why the percentage of breast feeding mothers having a proper knowledge of breast feeding positions, attachment is very low. Likewise the breast feeding practices, knowledge and behaviors of mothers is also not scientific and adequate. Breast feeding mothers *cultures and attitudes* also affect breastfeeding promotion and support. Breast feeders used their own breastfeeding experiences to replace evidence-based knowledge and recommendations for proper breastfeeding provided by the health clinic. There

is also the lack of proper communication between health service providers and breast feeding mother. Likewise, it has been deduced that health clinic as *Sansthagat* clinic overestimated their own, and underestimated others' (culture, society, social norms, values) influence on breastfeeding behavior. In a *caste ridden and priest society* where there is a prime role of caste based norms reinforced by orthodox *Brahministic rite de passage,* values and actions, there exists a major role of social and cultural factors than *medical* in determining the breast feeding practices of mothers.

CHAPTER VII

SUMMARY, CONCLUSION AND RECOMMENDATIONS

7.1 Summary of Findings

This study presents the behaviours of breast feeding mothers in Pokhara, especially women visiting *Sansthagat* clinic and EPI clinics of sub metropolitan city of Pokhara. The study focuses on the practices of mothers in breast feeding to their Infants. The research is based on comparative study of CB-IMCI pattern in breast feeding. The study has adopted both exploratory as well as descriptive research design. The study is exploratory because it exposed the attitudes and practices of breast feeding mothers. The study is descriptive as it describes different aspects of breast feeding.

For data collection, observation method was adopted and questionnaire schedule about general information as name, age, case, address (permanent, temporary), religion, occupation, education, occupation of husband (national, abroad), number of total children born, alive and death etc has been made. Relevant questions were of weaning, bottle feeding, continuation of breast feeding after weaning, ante-natal, postnatal examination, places of childbirth, immunization and complete immunization knowledge and practices, proper position and attachment of breast feeding, socio-economic, cultural practices of breastfeeding etc.

Among all the mothers who have attended EPI clinic to immunize their infants, only 155 mothers were interviewed and observed on first come first serve basis. The mothers are from different wards of sub-metropolitan city 8 Srizana Chowk, ward no.11 Ranipauwa, ward no 13 Miapatan, ward no 14 Chouthe, ward no 15 Tallo Ram Bazar, ward no 17 Rato Pahiro and ward no 17 Pardi Birouta respectively. Among 155 sampled breast feeding mother respondents, the number represents as Brahmins 30, Gurung 27, Kami 23, Chhetri 18, Magar 14, Tamang 9, Sarki 9, Damain 6, Thakuri 4, Newar 4,

Muslims 4, Gharti 3, Rai 1, Kumal 1, Gaine 1 and Tibetan 1 respectively. No Himalayans and Terai origin women were enumerated. On the religious aspect of sampled mothers, Hindus represent highest number 109, Buddhist 39, Muslims 4 and Christians 3 respectively.

The highest number of age distribution of breast feeding mothers range on 20-25 years, then 25-30 years, 18-20 years, 30-35 years. Age ranging 15-18 years are 6 in number and 35-40 are 4 in number. On total, below age 20 women are 28 in numbers and 35-40 years are 4 in number which is the danger precipitating factor of maternal death due to complicated delivery.

This Research study has shown that among 155 respondents, 47.09% (73) have their own house in Pokhara where as 52.90% (82) has no house in the city. It shows that migrant population is higher than residents in Pokhara sub-metropolitan city which depicts the trend of migration and rising urbanization.

This research has shown that on the basis of occupational status 122 mothers are house wives, 12 business holders, 11 Agricultural, 7 have job in private sector, 5 students, 4 labours, 4 Government service holders. It has been deduced that some had jobs before child birth but detached after child birth and are being housewife yet.

On the basis of educational status, 31 women have completed lower secondary which is the highest number in ranking all together, 30 have completed high school level, 17 have degree/diploma and 4 literate only. But illiterate number of mothers is 26 which represents third position in ranking. It indicates that illiterate mothers are having immense space in total number of mother which leads low performance in health seeking behaviours.

This study reveals that 109 husbands of the sampled breast feeding mothers are employed in Nepal. 46 of them are working abroad specially in Golf Countries. Among the 109 employers in Nepal, the highest number is in labour and second in business, third non Governmental services.

This research has shown that among the total child birth, 52.11% is of female child and 47.88% is male child. It shows the social value of male in our

society which is the major reason behind the increasing number of female on the demand of male child.

This study has depicted IMR as 52.81/1000 where as national average is 48/1000, which indicates the condition of health service practices in Pokhara sub-metropolitan city. A new concept, vision is required for better implementation of infant health related facilities.

The summary of major findings is as follows:

- The highest number of the mother that has knowledge about colostrums ranges 85.16 percent and knowledge of feeding is 90.96 percent and the mothers not feeding colostrums is 9.03 percent only.
- Among 155 respondents 53 have fed other food except breast feeding and 102 have used exclusive breastfeeding 65.80%, which is higher than national exclusive breastfeeding rate e.g. 53 percentage.
- The study has shown that highest number of delivery has been conducted at Hospital e.g. 78.70%, rest 21.3% have home delivery assisted and conducted by their sisters, *Sasu* (mother–in-law), neighbours and own mothers which depicts the traditional dependency based structure of Nepalese society.
- This research deduced that most of the respondents that is 102 mothers replied breastfeeding is baby's ideal food, nutrition (38); immunity (13) and two of them said they are *unknown*.
- Most of the mothers that is 92, have breastfed within one hour after delivery, 36 mothers have breast fed after 3,4 hours, 22 mothers breast fed after 6 hours and even after 3,4 days were 5 cases because they were *caesarean* cases.
- Among 155 mother, 130 (83.87%) have exclusive breastfeeding, 10 mothers have exclusive breastfed till three months, only rest 15 have breastfed more than 6 months as exclusively.
- The research has found that 140 mothers had breastfed more than 8 times and 15 had less than 8 times in a day (24 hours).

- Mothers with knowledge of complete immunization is 93.54%, rest are 6.44% which shows that knowledge about immunization is quite high among the mothers.
- Culture, norms, rituals and traditions are to a great extent hindering the lactation of first milk *colostrums* by the babies as it is popular belief among different case/ethnicities not to offer colostrums milk to the baby on the wrong fallacy that colostrums is indigestible and impure.
- Out of 155 sampled mothers 49 women were assisted and taken care after delivery by *Sasu* thus making a percent of 31.6. This shows the traditional bond and the family structure of the women and the Nepali society. Likewise, 45 women were supported by their husbands. Own sisters took care of 36 women. Similarly women's mothers took care of 19 women, 5 women were given by neighbours and 1 by another sons wife. This trend shows that in Nepalese society a major bulk of delivery and post natal care starts from women's own home.
- Among the sampled mothers, the knowledge of breast feeding positions differs which is as follows; out of the sampled 155 mothers 62 breast feeding mothers (making a total of 40.00 percentages) reported of attached baby in upright while feeding milk to a baby. 49 mothers (31.6) reported of breast feeding her baby at 45°L one hand below head and one on buttock. Likewise, 44 breast feeding mother said that they have no knowledge of actual or the real breast feeding position. Proper position, attachment of breastfeeding knowledge, behaviour is very low as compared to rural mothers on the principle of CB-IMCI protocol. It is the challenge of breastfeeding knowledge of mothers in Pokhara sub-metropolitan city.
- Related to the knowledge on breast feeding attachment among the 155 respondents, more than 75% have no knowledge of proper attachment of breastfeeding as defined in CB-IMCI protocol. 119 women reported that they have no knowledge of breast feeding attachment. Without proper attachment there is no chances of effective suckling, if no effective

suckling no chances of emptying all milk retaining in the breast of mother.

At last, it has been deduced from this study that breastfeeding offers numerous health advantages to children, mothers, and society. From obstetrics to pediatrics, breast feeding mothers come in contact with healthcare providers as Sansthagat clinic. Health workers support breastfeeding enthusiastically and for all children to have a proper breast feeding but ***this study*** identified gaps in breastfeeding knowledge, counseling skills, and professional education and training given to a mother that's why the percentage of breast feeding mothers having a proper knowledge of breast feeding positions, attachment is very low. Likewise, the breast feeding practices, knowledge and behaviors of mothers is also not scientific and adequate. Breast feeding mothers cultures and attitudes also affect breastfeeding promotion and support. Breast feeders used their own breastfeeding experiences to replace evidence-based scientific knowledge and recommendations for proper breastfeeding provided by the health clinic. There is also the lack of proper communication between health service providers and breast feeding mother. Likewise, it has been deduced that health clinic as *Sansthagat* clinic overestimated their own, and underrated others' (culture, society, social norms, values) influence on breastfeeding behavior by adopting very little the suggestions of breast feeding mothers.

7.2 Conclusion

This study deduced that the heart of much exploration in applied human nutrition and nutritional anthropology is the matter of food intake-- may be breast milk for a baby or the average food for mothers. Food is, after all, the carrier for most nutrients consumed by humans, and the specification of nutrient intake requires quantitative food consumption. Food intake as breast milk is a practical necessity which will help in regulating the life breath and health of a baby. Likewise, the knowledge related to breast feeding is also prerequisite.

This Research has explored that most of the mothers know about colostrums and the knowledge about colostrums immediately after birth is also high. This study deduced that the mothers who fed colostrums are educated; socio economic status is higher than non fed mothers. Most of the non colostrums fed mothers are of low socio economic status and illiterate. This research also explored that cultural practices of breast feeding in communities is hindering mothers from feeding their infants the *colostrums*. Likewise norms, rituals and traditions of a culture are to a great extent hindering the lactation of first milk colostrums by the babies as it is popular belief among different caste/ethnicities not to offer colostrums milk to the baby.

This study explored that exclusive breast feeding is higher among sampled mothers which is higher than national percentage of exclusive breastfeeding. The probability of higher percentage is due to higher socio economic, educational status of permanent residences of mothers.

It has been found that other food feeding causes are due to service, labour, job holders, and *culture of poverty (poor attitude and thinking)*. Even a medical doctor is also unable to follow exclusive breastfeeding in the lack of time. This shows the plight of breast feeding which is due to the economic factor. Even educated graduate mothers lack technical knowledge of breast feeding. Consequently, this study concludes that as even highly educated women are ignorant about scientific technical knowledge and are based on traditional cultural knowledge and concepts of breast feedings, the need of the time is to give proper technical scientific knowledge to all the breast feeding mothers---may be educated , highly educated or illiterate.

This study explored that *Weaning* (complementary feeding) practices are quite high but child needs complementary feeding with continuation of breastfeeding. Early weaning causes bacterial infection, indigestion leading to diarrhoea leading to consequences of malnutrition and even death. Late weaning causes nutritional deficiency which leads to being malnutrition. The problem is owing to low economic status, so mothers have to leave their

children at home and go for labour, especially in case of migrant mothers, using other food to their infants at time.

The study explored that most of the delivery (child birth) were at hospital and care after delivery at home was taken by their *Sasu* (husband's mother), husbands, own sisters, own mothers. This depicts the traditional bond and norms of Nepalese society where the birth giving women is given high significance. This also presents the solidarity (unity) of the society. Based on the cultural practices of nutrition after delivery, most of them had eaten meat rice, Ghee rice, *jwanoko jhole* but very few have eaten animal's milk, fruits, bread. The clue is that nobody had used drinking alcohol. This food practice also illustrates the cultural norms of nutritional anthropology where the food habits are determined by the caste/ethnic, social, cultural norms and the economic backgrounds of the mothers.

Most of the mothers had fed their breast milk within one hour after child birth, but rest have fed after one hour of child birth. This shows that early breast feeding practice is good but we have to encourage all mothers. This Research also explores that exclusive breastfeeding practice is satisfactory among sampled mothers. Continuation of breast feeding after complementary feeding up to two years of age is also reasonable which is very good practice in medical ethics. However, the time of breastfeeding is not satisfactory. Knowledge and practices of proper breast feeding position, proper attachment is very low. The cultural norms, rituals and traditions, popular beliefs existing among different caste/ethnicities are to a great extent hindering the attitude and behaviour of breast feeding mother and the their breast feeding activities.

At last this study identifies key problems for a model medical home as Sansthagat clinic in fostering continuous, comprehensive, coordinated, culturally effective, and evidence-based breastfeeding promotion and support by incorporating the breast feeding mothers of all backgrounds—social-cultural, ethnic/caste, economic and educational.

7.3 Recommendations

- Most of the mothers have no knowledge of proper attachment and position of breast feeding as CB-IMCI protocol guideline. CB-IMCI training is needed to FCHVs of Pokhara Municipality, they can educate, aware of proper breast feeding procedure to mothers.
- Breast feeding counselling is needed to mothers while they have been visiting EPI clinic. It will be an advantage if they manage separate room for counselling, because it is too crowded at EPI clinic. It will be better to show audio, visual pictures about breast feeding in each EPI clinic session. Visual slides of colostrums feeding, malnourished child due to weaning before 6 months and delaying beyond 6 months, will be better to display in session.
- Child care centers are needed in slum areas of the sub-metropolis such as Rato Pahiro and other slum areas, strengthening support and continuing nutritional, educational, medical treatment service etc. Mother group orientation trainings are needed in such slums where exclusive and proper breast feeding practice is very low.
- Income generating vocational trainings are needed in slum areas with co-ordination, collaboration of line agencies, NGOs, INGOs.
- Assessing the knowledge, attitude, behaviours in slum, rural, urban areas as cross cutting manners and preparing, presenting reports periodically, analytically of breast feeding practices.
- Providing posters, pamphlets, brochures, booklets, photo albums of proper position, attachment of breast feeding.
- Arranging monthly, bimonthly, quarterly competition of healthy babies who have been practicing properly exclusive breast feeding with providence of prizes.
- Awareness of family, stakeholders, caretakers, and community also needs proper and exclusive breast feeding procedures which support mothers for exclusive breast feeding and increasing awareness of exclusive breast

feeding and procedure of proper position, attachment guided as in CB-IMCI guideline through media viz. News letter, FM, Radio, TV etc.

- Focus ought to be given on other aspects of breast feeding beyond medical aspects. Focus should be on caste/ethnicity, culture, traditions, norms, values, social economic, cultural, economic backgrounds of the breast feeding mothers, in comprehending the thesis of *culture of poverty* prevailing among mothers with an extensive use of the notions of *Nutritional anthropology* and *Medical anthropology* in comprehending the sentiments and breast feeding practices of mothers.

BIBLIOGRAPHY

Adhikari, Jagannath (2002): *Urban context of environmental justice-* A study in Pokhara. Martin Chautari and social development and research center, Kathmandu.

Annual reports of MOH & P, Department of health services, Nepal (2062/63, 2063/64).

An information sheet of Pokhara municipality (2007, 2008).

Beaton, G. H., I. Milner, P. Corey, et al. (1979): Sources of Variance in 24-hour Dietary Recall Data: Implications for Nutrition Study Design and Interpretation. Am. J. Clin. Nutr., 24: 304. Heymay, New York.

Bhusan, Vidya (1999): *An Introduction to Sociology*. Published by Kitab Mahal, New Delhi.

Booklets and protocols of CB-IMCI (2005-2006): Programmes, published and distributed from child Health Division, Department of Health services, Kathmandu.

Breast Feeding Training Manuals of (IYCF 2008): Nutrition section, Child Health Division, Kathmandu.

Burke, B. S. (1947): *The Diet History as a Tool in Research*. J. American Dietetic Assoc., 23: 1014-1046. Washington.

Canadian Community Health Survey, Cycle Nutrition (2004): Demography and Health Survey, Nepal 2006.

Center Bureau of Statistics (CBS) 2001. Kathmandu. Nepal.

Central Bureau of Statistics (CBS) 2002: Kathmandu, Nepal.

Dhakal, Mira Devkota (2007) : *Educated Women in Government Employment*. M.A. dissertation submitted to the department of Sociology/Anthropology, P.N. Campus, Pokhara.

Health and nutrition breast feeding/ Health and nutrition USA (2008)*:* A Journal of US society of nutrition, Washington.

Horton S. Sanghi T, Philips M, etal (1996) : Health and nutrition breast feeding/ Springer link, New York.

Jean, Laplanche (2004): *Narrativity and hermeneutics*: some propositions. Darren Publishers, Paris.

Kramer M, Kakuma R (2002): *Optimal duration of exclusive breast feeding*. Cromwell publications, Philadelphia, USA.

Marshall's Dictionary of Sociology (1999) : Oreint Publisher,New Delhi.

Mishra, Atul (2008): *Restriction in Chinese milk ingredients*. New Delhi Publishers.

Municipality profile of Nepal 2008. Kathmandu.

Nepal Health sector programme implementation plan (2004). Kathmandu, Nepal.

Nepal Demography Health Survey 2006. Kathmandu.

Nursing Research Journal, Hong Kong, 2003

Park Andrew (2002): Text book of preventive and social medicine. California Publishers, United states.

Pokhara Municipality Profile of Nepal-2008.

Pokhara Sub-metropolitan city UBS programme (2008).

Population Studies in Health Sector, Ministry of Health, Nepal 2008.

Pratibha, singhi, Sumit Singhi and Prabhaiot Mathi (2007): Socialization and child development. Orient publishers, India.

Second long terms health plan (1997-2017): Ministry of Health and Population, Kathmandu, Nepal.

Strategy on Health sector reform (2004): Ministry of Health and Population, Kathmandu, Nepal.

Training Manual of IYCF, (2008), Infants and young child Nutritional counselling Training manuals for Health workers published by

Ministry of Health and population, National Health Training center Teku, Kathmandu.

T.S. Saraswati (2007): Culture, Socialization and Human Development. New Delhi Publishers.

UCLA Center for human nutrition, (2006): Vethen court 1981, 1982; Moreno 1993, 1994; Lopez 1980, 1993; Hartado 1998, 1999. Cohen books New York.

WHO reports on World Child Health 1994. Geneva.

WHO programmes and projects nutrition 2008. Geneva.

Websites

Breast feeding- Wikipedia, the free encyclopedia.www.enclo.com 26/6/2007

Malla, Sushila (2002): Child complements any feeding in urban areas of Nepal. (Practices and nutritional implication). www. M-Nutrition plus/ news 4/7/2008

Plus News East Africa- www. Plus News- 9/2/2008

Plus News Global HIV/ AIDS-www. Plus News- 23/3/2008.

Springer link-Book (2008): Quality of life in Health care and medical ethics. www.springler link 4/6/2008

Venezuela's Excessive motherhood 2008. News letter.www.Amazon.com-12/3/2008

Wikipedia, the free encyclopaedia 2008. www. Amazon.Com. 15/4/2008.

World Health Organization (2001-11-24): "Infant and young child nutrition: Global strategy for infant and young child feeding, (http:// www.who.int/gb/ebwho/pd-files/eb/loa/eeb 10912.pdf)"

William P. Scott (1999): Defined religion in Dictionary of Sociology

www. GLOB Plus/News 5/4/2008

ANNEX I

BREAST FEEDING PRACTICES OF MOTHERS

General information

1. Name: 2. Age: 3. Caste
4. Address:
   a) District: b) V.D.C/municipality c) Ward no:
   d) Tole: e) House no:
5. Is your home in Pokhara?
   a) Yes b) No
6. If no, where do you live?
   a) Name of the *Tole*:
   b) House rent/month:
   c) No's of room occupied:
7. Religion:
   a) Hindu b) Buddha c) Christian
   d) Muslim e) Other
8. Occupation:
   a) Agriculture b) Housewife c) Labour
   d) Service e) Business
9. Educational status:
   a) Can read and write. b) Can't read and write.
10. If you can read and write, your educational status?
    a) Literate only b) Primary c) Middle school
    d) High School e) Intermediate f) degree/diploma
11. Is your husband at home?
    a) Yes b) No
12. If your husband at home, what is his occupation?
13. If your husband is not at home, where is he?

14. Along this latest child how, many children have you born?

    1 2 3 4 5 6

15. Number of male /female children are:

    a) Total Female no: b) Total male no:

16. Had any child died?

    a) Yes b) No

17. If any child had died, description as below:

S.No.	Male	Female	Total
1.			
2.			
3.			

Concept of breast feeding

18. What do you mean by breast feeding? Describe.

19. Since how early did you start breast feeding after birth?

    a) Within half an hour b) 1 hour c) 3 hours

    d) 4 hours e) 6 hours or more

20. What do you mean by ***colostrums*****?** Describe in brief.

21. Did you feed colostrums to your child?

    a) Yes b) No

22. Exclusive breast feeding months.

    a) 3 months b) 6 months c) 9 months d) 12 months

23. How many times do you breast feed in a day? (24 hours)

    a) 4 times b) 6 times c) 8 times

    d) 15 times or more

24. For how many minutes do you breast feed in one sitting?

    a) 5 minutes b) 10 minutes c) 15 minutes d) 20 minutes

25. Do you feed other food except breast feeding?

    a) Yes b) No

26. If you are feeding other food, what are they?
    a) Cow's milk b) buffalo's milk
    c) Container milk/lactogen/cereals d) others
27. If you are feeding animal's milk using container; what is it ?
    a) Bottle b) bowl/spoon c) Other
28. If you have been applying the things given question number 27, what is your problem? Explain in brief.

29. At what age you have starting weaning?
    a) 3 months b) 5 months c) 6 months d) 7 months
    e) 9 months
30. After weaning, continuation of breast feeding age/period?
    a) One year b) Two year c) three years d) four years
31. Sacred days after child birth?
    a) Three days b) 5 days c) 7 days d) 9 days
    e) 11 days
32. Did you examine antenatal at health institutions?
    a) Yes b) No
33. If you have examined antenatal, can you suggest times of examination?
    a) Once at time b) 2 time c) Four times d) Five times
    e) 6 time
34. Place of child birth?
    a) Health Institution b) Home
    c) On the way d) Ambulance

35. Time of post natal examination after child birth.
    a) No examination b) At once
    c) Two times d) Three times e) Four times.
36. Who assisted you during the child birth ?
    a) Doctor/nurse b) Sasu
    c) Mother d) sister e) TBAs

37. Who have served you at home after delivery?
    a) Own sister b) Sasu c) Own mother d) Husband
    e) Neighbour
38. What types of food did you take after delivery?
    a) Animal's milk b) wine
    c) Meat rice d) Ghee rice e) *jwano ko jhole*
39. How many times did you immunize this child?
    a) Once b) 2 times
    c) 3 times d) 4 times e) None
40. To complete immunization, how many times have you taken this child in EPI clinic?
    a) Two times b) Three times c) Four times d) Five times
41. Do you know proper position of breastfeeding?
    a) Yes b) No
42. If yes, provide it clearly in brief.

43. Do you know proper attachment of breast feeding?
    a) Yes b) No
44. If yes, provide it clearly in brief.

Thanks

ANNEX I I

Key Respondents

S.NO.	Name	Age	Address	Description in detail	Remarks
1.	Shushila Adhikari	36	Amarapuri Nawalparasi, temporary in Damside Pokhara	Previously she had worked in women's vocational club (NGO) but now engaged in business at Damside Pokhara.	
2.	Kalpana Sharma	24	Bharat Pokhari Kaski, temporary in Damside Pokhara	Job in Hotel Blue Bird Pokhara	
3.	Kabita Neupane	20	Purkot Tanahun, temporary in Birauta Pokhara.	She had been doing business of Fancy, cosmetic paying house rent of Rs. 6500 per month.	
4.	Sumitra Gurung	23	Pokhara ward no. 11 Foolbari	She had written thesis in breast feeding for completion of B.Ed. Health in Bachelor level	
5.	Tarana Magar	21	Ramechhap, temporary in Fulbari, Pokhara.	She is wife of Military man, her Husband has been employing in Fulbari Barrack Pokhara.	

6.	Sharmela Rai	22	Sitamadhi, Dumaraha, Mohanpur, India.	Now she has been in her own mother's home at Majheripatan Pokhara. She explained breastfeeding position, attachment correctly among all 155 respondents.	
7.	Srijana Ghimire	27	Jita V.D.C Lamjung	She has been working in Western Regional Hospital Ramghat Pokhara as staff Nurse.	
8.	Arpana Timilseena	28	Shiva Marga Pokhara Ramghat.	She has been working in Abhiyan Community Hospital at Bus park Pokhara as an ANM post.	
9.	Dr. Saraswati Pandey	27	Gharipatan ward No. 17, Pokhara.	She has been working in Fewa city Hospital and Research center at Srijana Chowk Pokhara.	

ANNEX: III

LIST OF THE RESPONDENTS

S.N.	Name	Age	Address	
			Permanent	Temporary
1.	Shreedhari Aryal	28	Syangja	Pokhara
2.	Bhim Maya Lama	28	Sindhuli	Pokhara Chouthe
3.	Gita Subedi	23	Syangja	Birauta
4.	Rekha Pariyar	25	Pokhara, Ranipuwa	Birauta
5.	Munni Nesha	27	Pokhara, Kundahar	-
6.	Rajmati Nepali	32	Fulbari, Pokhara	-
7.	Durga Lama	24	Pokhara, Banjhapatan	-
8.	Gou Maya Gurung	25	Pokhara, Nayagaun	-
9.	Anjum Khan	24	Pokhara, Tersapatti	-
10.	Meem Maya Thapa	24	Pokhara, Shantideep	-
11.	Meena Gurung	29	Chitwan	Ghale Chowk, Pokhara
12.	Devi Sunar	19	Pokhara, Hospital Chowk	-
13.	Teeka Maya Pariyar	20	Kaski	Bajhapatan Pokhara
14.	Chandrakala Adhikari	25	Lekhnath Kaski	-
15.	Geeta Sunar	26	Malepatan Pokhara	-
16.	Joona Sunar	23	Lumjung	Miyapatan, Pokhara
17.	Ram Laxmi Gurung	31	Adarsamarga, Pokhara	-
18.	Neesha	20	Sankhuwasabha	Ranipouwa, Pokhara
19.	Sun Kumari Gurung	31	Lamjung	Hospital chowk,

				Pokhara
20.	Kusum Gurung	20	Dhading	Rambazar, Pokhara
21.	Meethu Bajracharya	31	Syangja	Rambazar, Pokhara
22.	Kalpana Bhandari	21	Airport, Pokhara	-
23.	Laxmi Chapagain	27	Indra chowk Pokhara	-
24.	Tara Kumal	26	Nawalparasi	Srizanachowk, Pokhara
25.	Jyoti Shahi	24	Tanahun	Srizanachowk, Pokhara
26.	Bishun Ranabhat	25	Airport, Pokhara	-
27.	Susmeeta Pariyar	30	Lamjung	Feerke, Pokhara
28.	Beena Sunar	21	Nawalparasi	Sabhagriha Pokhara
29.	Sunita Thapa	20	Lekhanath Kaski	Srizanachowk, Pokhara
30.	Amreeta Bhujel	20	Tanahun	Shivalaya Chowk, Pokhara
31.	Kamala Gurung	35	Lamjung	Shivalaya Chowk, Pokhara
32.	Shushila Dhungana	24	Bagar, Pokhara	-
33.	Bindra Nepali	27	Dhading	Purandhara, Pokhara
34.	Malati Koirala	21	Okhaldhunga	Fulbari, Pokhara
35.	Tarana Lamichhane Magar	21	Ramechhap	,,
36.	Sarita Khadka	20	,,	,,
37.	Lal Devi Tamang	34	Dolakha	,,
38.	Neesha Gurung	24	Ranipauwa, Pokhara	-

39.	Meethu B.K.	24	Phoolbari, Pokhara	-
40.	Susmeeta	29	Lekhnath, Kaski	-
41.	Phoolmaya Nepali	24	Parvat	Phoolbari, Pokhara
42.	Shanti Sunar	23	Phoolbari, Pokhara	-
43.	Neermal Tamang	26	Udayapur	Phoolbari, Pokhara
44.	Aanu Tamang	20	Hemja, Kaski	-
45.	Renu Thapa	25	Lamachour, Kaski	-
46.	Manu Nepali	19	Phoolbari, Pokhara	-
47.	Kopila Shrestha	20	Ranipouwa, Pokhara	-
48.	Madina Khatoon	19	Miyapatan, Pokhara	-
49.	Indira Gurung	36	B.B.Marga, Pokhara	-
50.	Mamata B.K.	18	Lekhnath, Kaski	Nayabazar, Pokhara
51.	Laxmi Shrestha	27	Miyapatan, Pokhara	-
52.	Shusma B.K.	22	Yangakot, Kaski	Gaundako Mukh, Pokhara
53.	Susma Gurung	20	Banjhapatan, Pokhara	-
54.	Jiya Gurung	21	Lamjung, Besishahar	Bajhapata, Pokhara
55.	Yasoda nepali	25	Syangja	Miyapatan, Pokhara
56.	Seeta Gayak	19	Lekhnath, Kaski	Industrial area, Pokhara
57.	Sanu Gurung	32	Pokhara	-
58.	Pravati K.C.	26	Banjhapatan, Pokhara	-
59.	Salma Khatoon	20	Miyapatan, Pokhara	-
60.	Mansuba Gurung	35	Tangting, Kaski	Gaundkomukh, Pokhara

61.	Jamuna B.K.	34	Pokhara, Sangam tole	-
62.	Tulasi Dhungana	24	Pokhara, Majheripatan	-
63.	Ganga Sunar	23	Pokhara, chauthe	-
64.	Devi Sunar	27	,,	-
65.	Kamala Gurung	27	Kaski, Mijuredanda	-
66.	Radha Baral	30	Pokhara, Majheripatan	-
67.	Natasa Parajuli	23	,,	-
68.	Raj Kumari Sunar	26	Pokhara, Chhorepatan	-
69.	Sangeeta Thapa	21	Pokhara, BanCampus	-
70.	Sharmeela Raya	22	Sitamadhi, India	Majheripatan, Pokhara`
71.	Laxmi Nepali	23	Kaski, Kalika V.D.C.	Talchowk, Lekhnath
72.	Jamuna B.K.	25	Pokhara, Majheripatan	-
73.	Anita Pariyar	20	,,	-
74.	Geeta Poudel	22	Kaski, Lekhnath	-
75.	Maya Lama	20	Kavrepalanchowk	Chouthe, Pokhara
76.	Sukmaya B.K.	33	Kaski, Bharatpokhari	Near Radhe Temple
77.	Reeta Gurung	25	Bahakot, Syangja	Pokhara
78.	Bindu Neupane	23	Laxmi Tole, Pokhara	-
79.	Narayani Kandel	24	Bhimda, Tanahun	Ram Bazar, Pokhara
80.	Lalmaya Subedi	24	Syanipatan, Pokhara	-
81.	Kho maya Gurung	30	Laxmi Tole, Pokhara	-
82.	Heera Maya Gurung	25	Bhedifarm, Pokhara	-

83.	Pavitra Soti Magar	23	Jhirubas, Palpa	Phalepatan, Pokhara
84.	Kumari Gharti Magar	20	Kawaswoti, Nawalparasi	Naya Gaun, Pokhara
85.	Salu Gurung	37	Laxmi Tole, Pokhara	-
86.	Suk maya Magar	37	Pokhara	-
87.	Chandra B.K.	22	Hetaunda, Makwanpur	Ghalechowk, Pokhara
88.	Srijana Gautam		Batulechour, Pokhara	-
89.	Sumeetra Gurung	23	Sindure, Lamjung	Laxmi Tole, Pokhara
90.	Mankala Thapa	34	Pokhara, Kaski	-
91.	Kalpana Baniya	27	Kantipur Marga, Pokhara	-
92.	Sumeetra Gurung	23	Fulbari, Pokhara	-
93.	Sapana Magar	34	Mukundapoor, Chitwan	Neerajan Chowk, Pokhara
94.	Meena Pun	27	Fulbari, Pokhara	-
95.	Jamuna Gurung	28	Bhedi Form, Pokhara	-
96.	Sanjeeta Shrestha	24	Borlang, Gorkha	Syanipatan, Pokhara
97.	Beemala Thapa	30	Chitwan	Eye Hospital, Pokhara
98.	Bhagawati Nepali	17	Birauta Pokhara	-
99.	Durga Sharma	30	Pokhara	-
100.	Ram Maya Nepali	40	Monali Bhajyang, Dhading	Eye Hospital, Pokhara
101.	Tara Adhikari	21	Lwangghalel, Kaski	Near Himalaya Boarding School,Gharipat

				an
102.	Binita B.K.	20	Kapilbastu	,,
103.	Meena Sunar	21	Kheelung Deurali, Syangja	Gahripatan, Pokhara
104.	Urmeela Rokka	21	Pumdi Bhumdi, Kaski	,,
105.	Teeka Bhandari	24	Topgachhi, Jhapa	,,
106.	Meena Tamang	24	Muga, Dhankuta	,,
107.	Drameela Magar	20	Kathmandu	,,
108.	Kabita Gurung	23	Gharipatan, Pokhara	-
109.	Rama Nepali	21	Lamachaur, Pokhara	-
110.	Manju Khatri	26	Gajarkot, Tanahun	Gharipatan, Pokhara
111.	Jyoti Sunar	20	Chapakot, Kaski	Ratopahiro, Pokhara
112.	Shanta Thing	16	Dobilla, Kaski	-
113.	Laxmi Acharya	24	Bharatpokhari, Kaski	Gharipatan,Pokhara
114.	Manisha Pariyar	20	Gharipatan, Pokhara	-
115.	Rewati Mohani Subedi	29	Kavrepalanchowk	Ratophiro, Pokhara
116.	Devi Thapa	24	Pokhara	-
117.	Koushila Sharma	27	Phedikhola, Syangja	Gharipatan, Pokhara
118.	Sirmaya Thapa	24	Baglung	Ratopahiro, Pokhara
119.	Susma Karki	21	Himali Tole, Pokhara	-
120.	Anita Pariyar	18	Pokhara-17	-
121.	Laxmi	26	Damside, Pokhara	-
122.	Kalpana Chapagain	28	Mustang Chowk, Pokhara	-

123.	Jyoti Bhujel	20	Bhimad, Tanahun	Davis fall, Pokhara
124.	Sakuntala Bhandari	30	Pokhara, Kaski	-
125.	Pooja B.K.	24	Chhorepatan, Pokhara	-
126.	Susma Bhujel	24	Dangchuri, Sindhuli	Birouta, Pokhara
127.	Chha Maya Gurung	27	Chorepatan, Pokhara	-
128.	Chandra Thapa	22	Chungmang, Dhankuta	Birouta, Pokhara
129.	Kavita Neupane	20	Purkot, Tanahun	,,
130.	Dil maya Pun	26	Bharatpokhari, Kaski	Mustang Chowk, Pokhara
131.	Sarswoti Sharma	24	Chhorpatan, Pokhara	-
132.	Samundari Gurung	27	Oraste, Syangja	Birouta, Pokhara
133.	Pratichhya Acharya	21	Nirmalpokhari, Kaski	,,
134.	Seeta Shahi	27	Birouta, Pokhara	-
135.	Man Maya Gurung	30	Hanuman Tole, Pokhara	-
136.	Yami Khan	35	Powerhouse, Pokhara	-
137.	Shushila Thakuri	21	Machhapuchhre Tole	-
138.	Yanu Maya Gurung	27	Hanuman Tole, Pokhara	-
139.	Kalpana Acharya	24	Bharatpokhari, Kaski	Damside, Pokhara
140.	Sarswoti Regmi	23	Ghatikula, Pokhara	-
141.	Shushila Adhikari	36	Amarapuri, Nawalparasi	Damside, Pokhara
142.	Devi Kumari Dong	27	Khoula, Parbat	,,
143.	Laxmi Ranabhat	29	Bhat khola, Syangja	Balodaya Marga, Pokhara
144.	Aasha Gurung	21	Neelknatha, Dhading	Himali Tole,

				Pokhara
145.	Ambika Lamsal	29	Bharatpokhari, Kaski	,,
146.	Neermala Darlami	21	Kumpur, Dhading	Ranipouwa, Pokhara
147.	Mangala Nepali	25	Bhadure, Tamagi, Kaski	Gharipatan, Pokhara
148.	Anita Pyakurel	23	Bairi, Chitwan	Chouthe, Pokhara
149.	Meera Pyakurel	29	Janakpur, Dhanusha	Ranpauwa, Pokhara
150.	Reeta Sunchouri	22	Tersapatti, Pokhara	-
151.	Arpana Timilsina	28	Ramghat Shiva Marga Pokhara	-
152.	Man Kumari Tamang	27	Kavrepalanchowk	Tallo shantiban, Pokhara
153.	Srijana Ghimire	27	Jita, Lamjung	Hospital Quarter, Pokhara
154.	Dr. Saraswati Pandey	27	Gharipatan, Pokhara	-
155.	Kavita Gurung	22	Mijuredanda, Kaski	Matepani, Pokhara

ANNEX: IV

PHOTO GALLERY

Nurses of Pokhara Sub-Metropolitan City, U.B.S.
Program are in Ward Immunization Clinic

Researcher Mr. Bhim Bahadur Thapa
Interviewing to the Respondent mother seriously

Researcher asking some clues of Breastfeeding to the Respondent mother on the basis of Interview schedule


कार्क्रो
आगत क्लिनिक

Health workers are on duty at Sansthagat
Clinic in Immunization day on each Tuesday

Researcher in a contended mood
after the completion of the interview schedule