

CHAPTER – ONE

INTRODUCTION

Demography is the scientific study of human population especially dealing with three different variables such as fertility, mortality and migration. Among them fertility is considered to be most important one. Fertility is the biological variables which are directly related to female population. Reproductive health is the major one and maternal and child health is one of the major components of reproductive health. Maternity is the provision of care for women during pregnancy and child birth. It ensures healthy and successful outcome of pregnancy for the mother and her new born babies. Maternity care also provides the provision of essential care for pregnant women to ensure safe delivery including post-natal and treatment of complication of new born. It starts from the time of pregnancy diagnosis and continuous through delivery and postnatal care.

The International Conference on Population and Development (ICPD) held in Cairo in 1994 intensified worldwide focuses on the reproductive health. So, ICPD is milestone to guide the efforts regarding the reproductive health of women. According to ICPD document the reproductive health is defined as, "A State of complete physical mental and social well being and not merely the absence of diseases or infirmity in al matters relating to its function and process. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and they have capability to reproduce and the freedom to decide if, when and how often to do so." (UN, 1994:43).

1.1 General Background of the Study

Maternal and child health care is one of the important component of primary health. The World Health Organization (WHO) defines health as a state of complete physical, mental and social well being and not merely the absesnce of diseases or an infirmity in all matters relating to the reproductive system and to its function and successful family planning programme is always contextual and combined with maternal and child health activities.

Globally, safe motherhood programme was adopted as a strategy to reduce maternal mortality and morbidity in 1987 at 'Safe Motherhood Convention' held in Nairobi. The main aim was to draw world's attention to the thousands of death and millions of serious illness suffer by women every year. This commitment reinforced ICPD held to reduce maternal mortality to one half of 1990s, level by 2000 and further reduced one half by 2015 (ICPD, 1994).

In Nepal, Until the early 1950s, health care was provided by family members and indigenous herbalists and spiritualists which were traditional. There were not organized health programmes. In early 1950s a government health system was organized and expanded by the newly formed Ministry of Health (MOH). All health programmes were implemented under the ministry of Health, Department of health services and other health division. During 1960s International attention focused on the rapidly growing need to extend basic health services, both preventive and curative to more people, especially, to rural population in developing countires. During the late 1970s, health care programme was gradually transformed into primary health care later, a few organization and units were formed to implement health programmes in Nepal, that is MOH,

Department of Health and other health division. Beside the MOH, there are many local NGOs, INGOs and donor organizations implementing health programmes (UNDP/OPS, 1993 cited in Adhikari).

A recent study in Nepal found that the decision to seek care for pregnant or post partum women was most often made by husbands followed by mother in law, the women themselves are seldom involved in the decision (UNFPA, 2000).

It is categorized that 24 percent of adolescent girls in the rural areas have given birth to at least one child while only 10 percent of all women receive antenatal care. Women in many remote communities have virtually no contact with health worker during pregnancy. Only 6 percent of child birth are attended by trained birth attendants. Due to poor maternal health, around 29 percent of newly born infants are under weight (UNISCO, 1999:16). In Nepal maternal and Child health practices are insufficient due to minimal level of education, poor economic status and lack of knowledge about health care facilities. Maternal mortality estimates in Nepal is comparatively high 415 per 100,000 live births Compared to other SAARC Countries because maternal services, especially in rural areas often deficient and in- appropriate to women situation (NDHS, 2006).

The health Care practices differ from Community to Community, one group to another and one individual to other. Nepal has been considered as a multi-ethnic and multi-lingual Country. there are more than 53 different tribal groups speaking about 75 language in Nepal. Except the Raute almost all other tribal groups are settled agriculturalists. The Ruates are one of the indigenous tribal, nomadic, hunter and gather roaming through forest to forest in Mid and Far-Western Development Region (Singh, 1997).

1.2 Statement of the Problem

Maternal and child health service are available more widely than ever before, but the task of making them universally available is bigger than any one expected (UNFPA, 1997).

When reviewing the status of women's health in Nepal, it seems unrealistic to separate a women's physical and mental health from her expected role in the society. In a predominant patriarchal society, women have a secondary status to man, women are undervalued through out their lives and discrimination starts even before birth.

Nepal is one of the countries where the maternal mortality rate is highest in the world. It is estimated that 415 per 100,000 live births (NDHS, 2006). High infant and maternal mortality rates are inadequate safe motherhood practices. High infant and maternal mortality is also a product of unhygienic traditional birth practices.

According to NDHS, 2006, 44 percent of women who gave birth in the five year preceding the survey receive antenatal care from a health professional. 72 percent of women had their last birth protected against neonatal tetanus. Similarly, 59 percent of all pregnant women received iron supplementation during pregnancy.

Proper medical attention and hygienic conditions during delivery can reduce the risk of complication and infections that can cause the death of serious illness of the mother and the baby. Although 44 percent of mothers received antenatal care from a doctor or nurse/midwife for their most recent birth, only 19 percent of babies are delivered by a doctor or nurse/midwife, and only 14 percent are delivered at a health facility. (MOH at al., 2002 as cited in NDHS, 2006)

According to the World Health Organization, a child is considered fully vaccinated if he or she has received a BCG vaccination against tuberculosis, three doses of the DPT vaccine to prevent diphtheria, pertussis, and tetanus, at least three doses of the polio vaccine, and one dose of the measles vaccine (NDHS, 2006).

The information on vaccination coverage for children 12-23 months who should have been fully vaccinated against the major preventable childhood illness. There are four in five (93 percent) children were fully immunized. About 93 percent of the children received BCG and DPT 1, with polio 1 received by 97 percent children. However, the proportion of children the third dose of DPT and polio is lower (89 percent and 91 percent respectively), as is the proportion receiving the measles 95 percent. As expected, full vaccination coverage varies significantly by mothers education from 74 percent among children of mothers with no education to 99 percent among children of mothers with SLC or higher level education (NDHS, 2006).

Worldwide, more than 200 million female become pregnant, most pregnancies end with the birth of live baby to a healthy mother. For some, however, child birth is not the joyous events, it should be but a time of pain, fear, suffering and even death. Each year about 529 thousands or one in every minute women die as a result of pregnancy and childbirth, and almost all 99 percent of these event occurs in developing countries. A women in a developing counties has one in 61 chance of dying pregnancy or child birth compared with just one in 28000 in developed countries. In case of Nepal one in every 10 women die due to the complication of pregnancy and childbirth (NDHS, 2006).

Similarly, one in every eleven children born in Nepal dies before reaching age five. Slightly more than two in three under five deaths occur in the first five years of life. Infant mortality is 64 deaths per 100 live births, and child mortality is 29 deaths per 1000 live births. During infancy, the risk of neonatal death (29 per 1000) is one and a half times as high as the risk of post neonatal death 26 per 1000 live births (NDHS, 2001).

There are however, various types of programmes are implemented to improve the maternal and child health and to reduce the child and maternal mortality rate. But still we are facing the risk of high maternal and child health problem in Nepal. So that, the following questions are still left to answer, especially for the Raute community.

1. What is the socio economics characteristics of mother?
2. What are the maternal and child health care practice i.e. antenatal, delivery and post natal care?

To get the answer of this problem, a Raute community is selected which is the illiterate voiceless as well as poorest of the poor in all respect of the development stream.

1.3 Objective of the Study

The prime objective of the study is to access maternal and child health care practices in Raute Community (i.e. antenatal care, postnatal care, and delivery care).

The specific objectives of the study are;

1. To access socio-economic and demographic characteristics of the Rautes.

2. To examine the status of maternal and child health care practices among Rautes, and
3. To examine the differential in maternal and child health care practices among background characteristics of the Rautes.

1.4 Significance of the Study

This study mainly focuses on the demographic and socio-economic status of Rautes and its contribute on maternal and child health. The maternal and child health care practice includes antenatal care, delivery care practices to the mothers and breast feeding, supplementary food and immunization practices to the child.

The major significance of the study are as follows;

- The finding of the study will be helpful for local NGOs, INGOs and government to formulate the policies and plans regarding health care.
- It will be useful to the local people to develop awareness towards their health problem in their community.
- The result of the study will be helpful to women to care their own health and their children.
- It will be useful as a guideline for further researchers in similar studies.

1.5 Limitation of the Study

- This study is limited to the currently married women aged 15-49 years who have children under three years of age.
- This study is also limited only to the Raute community in Ampani-1, Jogbudha and Rajyuda – 6, Sirsha VDC of Dadeldhura district. So, it

may not be representative for whole nation as well as other community.

- Only the selected socio-demographic variables are considered in the analysis of maternal and child health care practice.
- Maternal and child health includes only antenatal care, delivery care and post natal care.

CHAPTER – TWO

REVIEW OF LITERATURE

2.1 Studies on Maternal and Child Health Practices

This chapter attempts to present some literatures related to the maternal and child health care practices previously done in Nepal as well as in other countries of the world. Some of the facts, opinion principles, and study reports directly and indirectly related to this study are reviewed and presented here.

The 1991/92 Yeman Demographic and maternal and child health survey provides an information from nationally representatively sample of ever marrid. Women aged 15-49 years and children aged under 5. Lifetime fertility was 7.7 children; 8.2 in rural areas and 8.1 for women without any formal education. Elimination of unwanted pregnancy would result in life time fertility of 6 births. First births before the age of 20 years amounted to almost 50 percent of reproductive age of women. Education impacts on early age at marriage; women with more than a primary education had a median age at war, age of almost 23 years. About 6 percent of currently married women were in polygynous unions. Infant mortality was 82/1000 births and child mortality was 116 in urban areas and 142 in rural sanitation and hygiene. Health (about 4 out of 5 deliveries) and 20 percent of deliveries were assisted by a birth attendant and 16 percent by a doctor or nurse (Yemen Central Statistical Organization, 1995, cited in Timilsina).

According to WHO, the life time risk of dying from pregnancy or child birth related causes is 1 in 20 in some developing countries, compare to 1 in 10,000 in some developed countries. The age at which child bearing

begins or stops the interval between each birth, the total number of life the pregnancies and the socio-cultural and economic circumstances in which women live all influence maternal morbidity and mortality. The death of the mother increases the risk to the survival of her young children, especially, if the family is not able to provide a substitute for the reproductive health needs of female adolescent and young women could prevent the major share of maternal morbidity and mortality through prevention of unwanted pregnancies and may subsequent poorly managed abortion. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality (ICPD, 1994).

Serbanescu and Morries (1995), provided variety of information from the 1993 Romanian Reproductive Health Survey on attitude, knowledge and beliefs about child bearing modern contraception, abortion, women's decision making and family and reproductive roles. In this study, 54 percent of total respondents correctly reported that the greatest chance of pregnancy occurs mid way between menstrual periods. Knowledge of the menstrual cycle is lowest among rural women, women under 20 years old and never married women. Knowledge increases with the level of education and socio-economic status. 75 percent of women under 25 years old, 38 percent of women aged 35-39 years and 21 percent of women in age 40-44 years old desire more information on the subject. 74 percent have trust is an obstetrician or gynecologist for reliable information on contraception. 33 percent of women do not know a women can get pregnant at first intercourse. 78 percent agree that it is acceptable for a women not to bear children.

UNFPA, (1997) reported that the birth with the help of trained attendant is nearly universal in the industrialized counties but varies widely elsewhere;

in countries of Latin America and the Caribbean between 55 and 98 percent; between 2 and 77 percent in Sub-Saharan Africa; between 16 and 97 percent in North Africa and West Asia. The variation is even wider in Asian countries. In South Central Asia, very few women receive trained birth assistance; like Nepal 6 percent, Bangladesh 10 percent, Pakistan 19 percent, Bhutan 20 percent, and India 33 percent.

UNICEF, (1993) estimated that global coverage of measles immunization is 77 percent as a world average where as it is highest 80 percent for ESCAP region, 80 percent which is for both industrialized countries and South America, 79 percent for South Asia, 75 percent for Middle – East and North America and least for Sub-Saharan Africa 48 percent regarding the South Asian countries India has the highest 86 percent and Afghanistan has lowest 29 percent coverage of measles immunization.

Nepal Family Health Survey, (1996) mentioned as, for 24 percent of births, mothers received antenatal care from a doctor, 15 percent or trained nurse mid wife 11 percent. For 10 percent of births mothers received antenatal care from a village health workers (VHW), maternal and child worker (MCHW) 4 percent or other health professional 2 percent. Women received antenatal care form traditional birth attendant, (TBA) for only one percent of births. For the majority of births in Nepal 56 percent mother did not receive any antenatal care. Report showed that younger women are more likely to use antenatal services then older women. For about one third 33 percent of births, mother received two or more doses of tetanus toxoid during pregnancy, while 13 percent received one dose of TT injection. For well over half of birth 54 percent mothers did not receive a single dose of tetanus toxoid.

Report also showed that 9 percent of births were delivered under the supervision of a doctor 6 percent or trained nurse of midwife 3 percent TBA assisted in 25 percent of births, while relative and friends provided primary assistance for 56 percent of births. 11 percent of births were delivered without any assistance.

According to this survey 73 percent of children received the BCG vaccine by 12 months of age. Coverage for the first doses of DPT and polio is 76 percent and 77 percent respectively. 26 percent of children had experienced diarrhea at some time in the two weeks preceding the survey, 6 percent of children had experienced bloody diarrhea probably indicating dysentery. Diarrhoea prevalence increases with age to peak at age 6-25 months 35-36 percent then falls again at older ages. A similar pattern is observed for bloody diarrhea. Nearly two thirds 63 percent of children sick with diarrhea were given less food during the illness and 31 percent were given less to drink.

According to the Chaudhary, R.H. (1999), currently married adolescents women in general tend to receive more antenatal care, compared to older women, the majority of the still do not seek antenatal care in Pakistan and Bangladesh. The proportion of currently married women seeking antenatal care is lowest in: Pakistan (26 percent) followed by Bangladesh (29 percent) and highest in Nepal (44 percent) followed by India (33 percent). In Pakistan only (29 percent) of pregnant adolescent women were immunized against tetanus. The proportion of pregnant adolescent women immunized against tetanus was highest in Bangladesh (80 percent) followed by India (63 percent). Nepal occupies the intermediate position with (56 percent) of pregnant women immunized Tetanus.

Chaudhary also explain that small proportion of births of currently married adolescent women are delivered at health facilities, accounting for 3 to 11 percent in Bangladesh, Nepal and Pakistan, and 24 percent of births in India. Consistent with this findings, it is also observed that over 70 percent of births by women of all age groups still remain unattended by health worker in all counties of the region. The proportion of births of currently married women attended by health worker is lowest in Nepal and Bangladesh (both 14 percent) where this is highest in India (34 percent) followed by Pakistan.

The study in Nepal found that illiterate women are 1.4 times likely to bear a baby with low birth weight than literate mothers, who did not go for antenatal care (ANC) are 1.29 times likely to bear a baby with low birth weight than those who have 3 or more ANC visits (Pant, 1997).

Ministry of Health, Nepal Family Health Survey, (1996) has explained a substantial difference in the use of antenatal care services between urban and rural areas. For instance percentage of women using antenatal services in rural areas as 10.5, 10.2, 10.7 and 0.8 from the doctor nurse (ANM, VHW, MCHW and TBA) respectively and the figures for urban area are 45.7, 20.5, 0.0, 0.8 and 0.0 from the doctors nurses/ANM, VHW, MCHW and TBA respectively. Overall utilization is 79 percent higher in urban areas than in rural areas and urban women are using doctors, nurses and midwives much more frequently than rural women. Rural women are more likely to use VHWs and MCHWs for antenatal care. Utilization of antenatal services is higher in the Terai than in Hill and Mountain regions. The western mountain, sub – region is especially underserved. In the eastern, central and western terai sub region, the situation is somewhat better some antenatal care was received for more than half of birth.

Singh (1997) indicates that 40 percent of pregnant women are not receiving benefits of the safe motherhood program. Other status presented in the paper are that 44 percent of pregnant women receive only prenatal care services, 92 percent of deliveries are performed at home, 3 percent of women are attended by physician, 33 percent of pregnant women receive 2 or more dose of Tetanus Toxoid, 19 percent of newly married non pregnant use contraception, 539 women out of 100,000 deliveries die due to unsafe motherhood, and 5000 women die each year due to pregnancy related problems.

Birthing practices and maternity care system is beside on socio-cultural environment. In Nepalese context, we can see different pregnancy is usually diagnosed symptomatically by the women are shy about discussing pregnancy and it becomes known to outsider only when they are visible Singh. UNICEF (1996) reported that, antenatal health care has traditionally not been practices in Nepal. The majority of community members recognize pregnancy with the cessation of the menstrual period and symptoms such as nausea – vomiting and loss of appetite. Shyness, shame and fear are main reason of problem for pregnancy and related complication, management. Shy or shyness is important component of much aspect of pregnancy women's lives. In the course of their child bearing women undergo several physiological process, which are regarded as shame or embarrassment (Laj). Pregnancy is considered as a matter of Laj, because it draws attention to the pregnancy women's sexual activity. A report of FHD, DHS, MOH (1996) shows that the vast majority of births in Nepal (92.5 percent) continue to occur within the home with a assistance from relatives TBAs or without any attendant present. It is reported in reference of the Nepal Family-Health Survey 1996 [cited in DHS, 1997].

Only 9.4 percent of the total deliveries in the country are attended by doctor or Nurse ANM.

Overall, only 9 percent of births are delivered in health facilities, compared with 89 percent at home. This is a slight improvement since 1996, when 8 percent of births were delivered in health facilities. The hill and Terai zones health facility delivered system is higher than mountain (NDHS, 2001).

Poudel, Meena conducted, "A Study on Utilization of Maternal health Services provided by different category of health personnel in Pida VDC of Dhading District." The sample size occupied of 50 mothers who had delivered at least one child under five years. The main purpose of the study was to find out the utilization of health services by mothers in community. During the interview they found 100 respondents had some delivery in normal neighbour but 20 respondents took assistance from health personnel's due to complication. The study has revealed that most of them were illiterate. They had lack of awareness of utilization of health services during antenatal, and postnatal period. The data revealed the picture of very low health status of female population of Pida VDC. The major causes this was ignorance of the mothers in safe motherhood concept and they did not utilize existing health services when the condition becomes services. Only during emergency condition they consult with health personnel for a special medical care to overcome the dangerous situation.

More than 200 million female became pregnant and 585,000 or over women are die each year from causes related to pregnancy. For each death at least 13 women suffer form a less serious threat to their health. According to World Health Organization (1996) estimates that each year about 529 thousands or one every minute women die as a result of

pregnancy and child birth, and almost all 99 percent of these even occurs in developing countries. There is wide difference in maternal death between developed and developing countries. A woman dying in pregnancy or child birth compared with just one in 28000 in developed countries. In case of Nepal, one in every ten women die due to the complication of pregnancy and child birth.

World Health Organization Bulletin, 2000 also showed that, prenatal mortality studies points to the link between the health of the mother and births outcomes. The high prenatal mortality rates in India reflect the poor status of women including poor nutritional status, low rate of literacy, early marriage and child birth. Improving female education and nutrition and increasing the use of health services during pregnancy and delivery are all important for reducing childhood mortality rates.

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

The International Labour Organization's Maternity Protection Convention (adopted 1919 and last revised in 2000) states of minimum standard for what should be included in national legislation in this regard. The convention provides protection against dismissal of women during pregnancy, maternity leave and the breast feeding period and also for cash benefits. It encompasses coverage of antenatal care and postnatal care and hospitalization care when necessary and working hours and tasks that are not detrimental to mother or child it call for 14 weeks of maternity leave, of which six weeks must be postnatal leave to safe guard the health of mother and child. This aspect to the convention covers all married and unmarried employed women including those in unusual forms of dependent work. This can be interpreted broadly to cover women in all sectors of the economy, including the informal sector, with increasing urbanization and the development of the formal economy, compliance with these minimum standards is increasingly becoming an issue in developing as well as developed countries (WHO, 2005).

Maternal deaths are highest in regions where few women receive basic maternity care, including prenatal, delivery and postnatal care. At least 35 percent of women in developing countries give birth without a skilled attendant and 70 percent receive no post natal care in the six weeks following delivery (WHO, 1997). In the context of Nepal for majority of birth, mother's received two or more doses of tetanus toxoid during pregnancy (Pathak and Gurung, 2007).

In developing countries, each year more than half a million women die from maternal causes. Since, nearly all of these death could be prevented. Efforts to prevent maternal death from one major cause complication of unsafe abortion care crucial but inadequate in most of the world. Providing

appropriate medical care immediately could save many thousands of women's lives. Offering family planning could prevent many future unintended pregnancies and unsafe abortions (population report, 1997).

Overall, out of two pregnant women only one received antenatal care. The proportion of mothers who received antenatal care is 28 percent either from a doctor 17 percent or a nurse or auxiliary nurse/midwife 11 percent. Another 11 percent of mothers received antenatal care from a health assistant (HA) or auxiliary health workers (AHWs). Village Health Workers (VHWs) provided care to 3 percent of mothers and Traditional Birth Attendants (TBAs) provided antenatal care to less than one percent of mothers (NDHS, 2001).

Similarly, according to NDHS, (2006) 44 percent of women who gave birth in the five years preceding the survey received antenatal care from a health professional that is a doctor or nurse/midwife, at least once. Education has a direct impact on access to antenatal care from a health professional which ranges from 29 percent among women with no education to 90 percent among those with SLC and higher level of education.

Women had their last birth protected against neonatal tetanus that is 72 percent. Similarly, 59 percent of all pregnant women received iron supplementation during pregnancy. The likelihood of receiving tetanus toxoid injection increases with education attainment from 63 percent among women with no education to 95 percent among mothers with SLC or higher level of education. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and the baby. Although 44 percent of mothers received antenatal care from a doctor or nurse/midwife for their most recent birth, only 19 percent of

babies are delivered by a doctor, nurse/midwife and 14 percent are at a health facility. However, it is encouraging to note that the proportion of babies delivered by a health professional over the last five year has increased by 72 percent from 9 percent in 2001. while the proportion of babies delivered in a health facility increased by 54 percent from 9 percent in 2001 (MOH, et al. 2002). Similarly, the children aged 12-23 months who should have been fully vaccinated against the major preventable childhood illness NDHS, (2006) estimated that, four in five (83 percent) children are fully immunized. About 93 percent of the children received BCG and DPT-1, with polio 1 received by 97 percent children. However, the proportion of children receiving the third doses of DPT and polio is lower (85 percent and 91 percent respectively), as is the proportion receiving measles vaccination 85 percent. As expected, full vaccination coverage varies significantly by mothers education from 74 percent among children of mothers with no education to 99 percent among children of mothers with SLC or higher level of education (NDHS, 2006).

There are large difference in the use of antenatal care services between urban and rural women. Eighty-five percent of urban mothers received antenatal care from an skilled birth attendant (SBA), compared with only 38 percent of rural mothers. Nearly one in two mother living in the hills received antenatal care from an SBA, compared with 32 percent of mothers from the mountains and 43 percent of mothers from the Terai. About twice as many mothers living in the Western, Central and Eastern region received antenatal care from an SBA as mothers living in the Far-Western region. Antenatal care from an SBA ranged from a low of 25 percent in the Far Western hill sub region to a high of 64 percent among women in the central hill and mid – western Terai sub region (NDHS, 2006).

Proper medical attention and hygienic conditions during delivery can reduce the risk of complication and infection that may cause the death or serious illness of the mother and the baby or both. Hence an important component in the effort to reduce the health risk of mothers and children is to increase the proportion of babies delivered in a safe and clean environment and under the supervision of health professionals. NDHS, (2006) presents the percent distribution of live births in the five year preceding the survey by place of delivery, according to background characteristics. Eighty percent of births take place in health facility: 13 percent are delivered in a public sector health facility. Four percent in a non-government facility and less than 1 percent in a private facility, four out of five births (81 percent) take place at home. Delivery in a health facility is more common among younger mother (21 percent), mothers of first ordered births (32 percent), and mothers who have had at least four antenatal visits (41 percent). Almost half (48 percent) of the children in urban areas are born in a health facility, compared with 14 percent in rural areas. Delivery in a health facility also varies by ecological region, being lowest in the mountains (6 percent) high in the hills (21 percent), and moderately high (17 percent) in the Terai. Delivery in a health facility varies from a low of 9 percent among births in the Far-Western region to a high of 24 among birth in the central region and is highest in the central hill sub region, where two-fifth of mother have a facility-based delivery. The proportion of deliveries in a health facility is only 8 percent among births to uneducated mothers, compared with 67 percent among births to mothers with SLC and higher education (NDHS, 2006).

A large proportion of maternal and neonatal deaths occur during the 24 hours following delivery. In addition, the first two days following delivery are critical for monitoring complications arising from the delivery. A

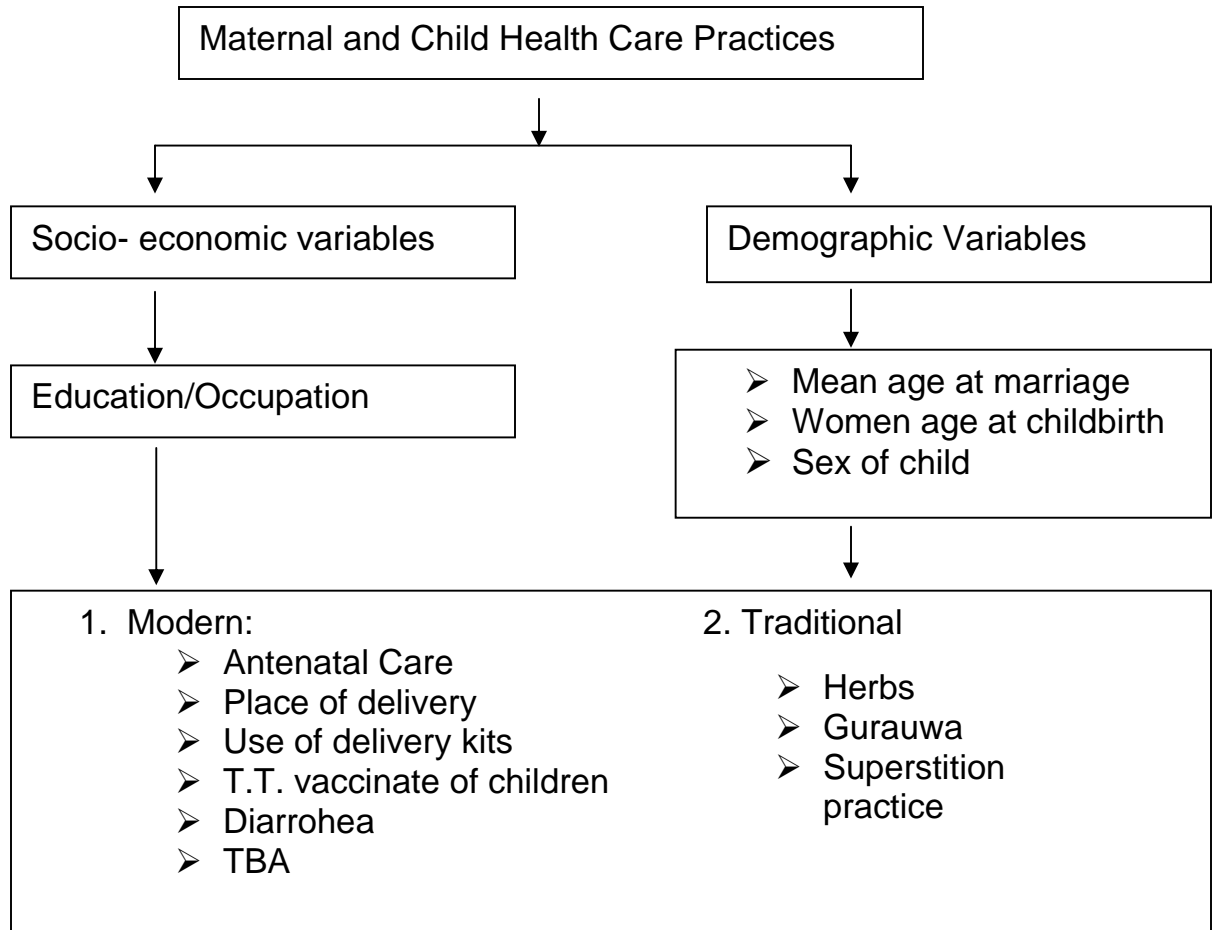
postnatal care visit is also an ideal time to educate a new mother on how to care for herself and her newborn. Safe motherhood programs emphasize the importance of postnatal care, recommending that all women receive at least two postnatal checkups and iron supplementation for 45 days following a delivery (Department of Health Service, 2006 cited in NDHS, 2006).

Nepal Demographic Health Survey (NDHS, 2006) shows that in the five years preceding the survey, one-third (33 percent) of women receive postnatal care for their last birth. One in five women received postnatal care within four hours of delivery more than one in four (27 percent) received care within the first 24 hours, and 4 percent of women were seen 1-2 days following delivery. Difference by mother's age, birth order, place of residence, wealth quintile and education are pronounced. Young mothers less than 20 years of age, mothers of first births, urban women, women in the highest wealth quintile, and highly educated mothers are much more likely to have received post natal care within the first 24 hours than their counterparts. Women living in the Terai zone, women living in the central region, and women from the Central Terai and central hill sub regions are more likely to have received postnatal care within the first 24 hours following delivery than mothers living elsewhere.

2.2 Conceptual Framework

Conceptual framework for "Maternal and Child Health Care Practices" among Raute community in Jogbudha and Sirsha VDCs, Dadeldhura district.

Figure 1: Conceptual Framework for Maternal and Child Health Care Practices



This analytical frame work is suitable for the study, since the maternal and child health care practice is influenced by different socio-economic and demographic variables. For the study two types of socio-economic variables like education and occupation are selected. These variables affect the maternal and child health care practices. Similarly, there are also different demographic variables like age at marriage, women’s age at child birth, sex of the child and so on. Age at marriage plays the vital role for mothers and child health. Thus the given all variables help to have condition of maternal and child health practices among Raute women.

CHAPTER – THREE

METHODOLOGY OF THE STUDY

3.1 Selection of the Study Area

Jogbudha and Sirsha VDC lies in Dadeldhura district and is located in Far Western Development region. The district shares its border with Doti (east), Baitadi and India (West), Baitadi (north), and Kanchanpur district in the east. The district is divided into 20 VDCs and one Nagarpalika (Amargadhi). It is basically a hilly district (mid-hill 73%) with very few inner terai and valleys.

The main reason for selection of the study area are as:

- i) There have not been found researched document related with maternal and child health care practice among Raute Community.
- ii) Dadeldhura is the main district of settlement place of Raute.
- iii) Researcher's self – interested to study, their usual practices regarding with maternal and child health care.

3.2 Population of the Study Area

According to the census record 2001, the total population of Jogbudha and Sirsha VDCs are 33,840 in which 16313 are males and 17527 are females. Out of whole population 378 are Rautes (192 males and 186 females) reside in that study area, who are main ethnic and endanger group of people.

3.3 Sources of Data

The research is based on primary sources of data and the information were collected from field survey in Jogbudha and Sirsha VDCs of Dadeldhura district. Respondents of the study included married women of reproductive age group (15-49 years.) altogether 71 women were interviewed as key informants of the study who had at least one child within the 3 years at the time of survey.

3.4 Sample Size and Sample Design

The study covers all households of Raute community in Jogbudha and Sirsha VDCs, because the total number of Rautes households are 65 and total population are 378 (192 male and 186 female). The study didn't use the sample size and census type method was used in the study time for collection of various information regarding with maternal and child health care.

3.5 Questionnaire Design

The questionnaire was designed to obtain information on various aspect of maternal and child health care status of Raute Community in Jogbudha and Sirsha VDC. The purpose of the questionnaire is also to assess basic socio-economic and demographic information like age, sex, education, occupation, marital status and relationship with head of the household to each member of the household.

Questionnaire is used as a major tool of primary data collection. There were two types of questionnaire used namely household questionnaire and individual questionnaire.

- a) **Household questionnaire:** The household questionnaire is mostly asked with the head of the household. It was designed to cover information about household including their socio-economic and demographic characteristics.
- b) **Individual questionnaire:** An individual questionnaire was asked only to ever married women of reproductive ages (15-49 years) and who had at least one child during the time of survey. The main objectives of an individual questionnaire was to obtain detail information of maternal and child health care status from the study area of respondents.

3.6 Method of Data Collection

The questionnaire was originally drafted in English and then translated into Nepali, and the Researcher visited the Jogbudha and Sirsha VDC office to obtain the necessary information about the study area. Then, door to door visit to fill up the household and individual questionnaire. First of all fill up the household questionnaire and then on the basis of this questionnaire fill up the individual questionnaire by the direct interview.

3.7 Tabulation and Data Analysis

- One way tabulation (Frequency distribution)
- Two way classification (Cross tabulation)

In this study, the data were tabulated by making the tally bar on the basis of filling questionnaire. Then, the data were analyzed by simple table, cross tabulation, graphical presentation and pie-chart.

CHAPTER – FOUR

SOCIO-ECONOMIC AND DEMOGRAPHIC CHARACTERISTICS OF THE HOUSEHOLD POPULATION

The socio-economics and demographic characteristics of household population are explained in this chapter. The demographic and socio-economic characteristics includes age and sex structure, marital status, occupational and educational status of the study population.

4.1 Age and Sex Composition

Age group	<u>Male</u>		<u>Female</u>		<u>Total</u>		<u>Sex ratio</u>
	N	%	N	%	N	%	
0-4	41	21.4	39	20.9	80	21.2	105.1
5-9	34	17.7	36	19.4	70	18.5	94.4
10-14	28	14.6	31	16.7	59	15.6	90.3
15-19	17	8.8	12	6.5	29	7.7	141.7
20-24	11	5.7	13	6.9	24	6.3	84.6
25-29	12	6.2	16	8.6	28	7.4	75.0
30-34	20	10.4	14	7.5	34	8.9	142.9
35-39	9	4.7	8	4.3	17	4.5	112.5
40-44	6	3.1	3	1.6	9	2.4	200.0
45-49	3	1.6	5	2.7	8	2.1	60.0
50-54	4	2.1	2	1.1	6	1.6	200.0
55-59	3	1.6	4	2.2	7	1.9	75.0
60+	4	2.1	3	1.6	7	1.9	133.3
Total	192	100	186	100	378	100.0	103.2
		(50.8%)		(49.2%)			

Source: Field Survey, 2007

The population of study area has been classified into five year age groups. According to table 1 the total population of the study area is 378 and 192 are male (50.8%) and 186 are female (49.02%).

The sex ratio is found to be 103.2 which is higher than the national sex ratio 99.8 in 2001 (CBS). The age group below 10 years consists the highest percent compared with than other age group both male and female. The table also shows that, the population age of group 5-9 and 10-14 years the female population is greater 19.4 percent and 16.7 percent. Then male population 17.7 and 14.6 percent. In this way, the female population of age group (20-29 years) are slightly higher than male population in lower age group indicates the higher fertility rate in that community and the male population on age 55 years and above is also found slightly same between male and female population.

4.2 Educational Status

Education is basic requirement for enhancing the social, political and economic development. Therefore, it is important to know the situation of educational status of study population.

Educational Status	<u>Male</u>		<u>Female</u>		<u>Total</u>	
	Number	Percent	Number	Percent	Number	Percent
Literate	50	33.1	43	29.3	93	31.2
Illiterate	101	66.9	104	70.4	205	68.8
Total	151	100.0	147	100.0	298	100.0

Source: Field Survey, 2007.

Table 2, shows that the distribution of population of the study households who are above 5 years age by sexwise and educational status. Out of total 298 population, only 33.1 and 29.3 percent male and females are literate respectively. Where as the total literacy rate is 31.2 percent which is lower than the national literacy rate 53.7 percent (CBS, 2001). Similarly, the

figures also clear that the illiterate male population are 66.9 percent and 70.4 percent female population are illiterate in the study area.

4.3 Marital Status

Marital Status	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
Currently Married	95	81.2	94	84.7	189	82.9
Unmarried	20	17.1	14	12.6	34	14.9
Widowed/ Widower	2	1.7	3	2.7	5	2.2
Divorced/ Separated	-	-	-	-	-	-
Total	117	100.0	111	100.0	228	100.0

Source: Field Survey, 2007.

According to the table 3, out of total population of ages 10 years and above 82.9 percent are married population in the study area. Among them, 95 male (81.2%) and 94 female (84.7%) are currently married. The female currently married percentage (84.7%) is higher than with the male currently married percentage (81.2%) in the study area.

The percent of unmarried and widowed/widower population is slightly difference between male and female (17.1%), (12.6%), (1.7%) and (2.7%) respectively. Divorced and separated population were not found in the study area at the survey time.

4.4 Occupational Status

Occupational Status	<u>Male</u>		<u>Female</u>		<u>Total</u>	
	Number	Percent	Number	Percent	Number	Percent
Agriculture	15	12.8	25	22.5	40	17.5
Daily Wages	88	75.2	49	44.1	137	60.1
Housewife	-	-	11	9.9	11	4.9
Students	14	12.0	26	23.4	40	17.5
Total	117	100.0	111	100.0	228	100.0

Source: Field Survey, 2007

The table number 4, out of total 228 household population, only 12.8 percent and 22.6 percent male and female are engaged in agriculture sector respectively. In total, very few 17.5 percent household population are involved in agriculture sector. In the study area, half and above household population are involved in daily wages work (60.1%). Where 75.2 percent and 44.1 percent male and female are engaged in this sector respectively. Similarly, out of total population 17.5 percent are students and only 9.9 percent female population are engaged in housewives.

4.5 Landholding Status of Household

Description	No. of HH	Percent
Land Lessness	26	40
Less than 1 Bigha	23	35.4
1 Bigha and above	16	24.6
Total	65	100.0

Source: Field Survey, 2007.

Table 5 shows that the distribution of household by their land ownership. Out of total 65 household, only 35.4 percent have one Bigha and above land. Highest percent household 35.4 percent have reported to their own land less than one Bigha. And 40 percent household population is reported landlessness.

4.6 Physical Facilities

Description	No. of HH	Percent
<u>Drinking Water</u>		
River	7	10.8
Piped Water	58	89.2
<u>Type of Toilet</u>		
Kachhi Toilet	4	6.2
Open Filed/Jungle	61	93.8
<u>Type of House</u>		
Ardha Pakki	9	13.8
Kachhi	56	86.2
<u>Have Radio</u>		
Yes	3	4.6
No	62	95.4
Total	65	100.0

Source: Field Survey, 2007.

In the table 6, the distribution of respondents by physical facility available in their household. Respondents were particularly asked the sources of drinking water, type of house, toilet, electricity facility and communication. But electricity facility is not available in the study area at the time of survey. According to table 6 almost 89.2 per cent house have access to piped water but not available easily and still, 10.8 percent house have using river water.

Similarly, toilet facility is not so good in the study area. There are among 93.8 percent households reported to have no toilet facility and only 6.2 percent households reported to have Kachhi toilet facility.

In the study area, type of houses are also poor. The data percented only, 13.8 percentage of household is living in Ardha Pakki and almost 86.2 percent of household have Kachhin (temporary) type of house. Almost, 62 (95.4 percent) household have no radio facility and only 4.6 percent household have radio. This is an indicator of poor health and sanitation condition in the study area.

CHAPTER – FIVE

SOCIO-ECONOMIC AND DEMOGRAPHIC STATUS OF RESPONDENTS

Demographic and socio-economic characteristics of mother such as age, age at marriage, educational attainment, occupational status as well as age and sex structure of children under three years of age are observed in this chapter.

5.1 Age Composition of Respondents

The study was done mainly to obtain a reliable information on maternal and child health care practices among Rautes which is directly related to the mothers aged between (15-49 years) having children under three years of age. This age composition of female population is one of the major demographic indicators for fertility performance.

Age	No. of Respondents	Percent
15-19	12	16.9
20-24	13	18.3
25-29	16	22.5
30-34	14	19.7
35-39	8	11.3
40-44	3	4.2
45-49	5	7.1
Total	71	100.0

Source: Field Survey, 2007

The table 7 shows that the age distribution of mothers by conventional five year interval ranging from 15-49 years. In this study, majority of mothers is

higher in age group (25-29 years) which is 22.5 percent. This is followed by age group (30-34 years) 19.7 percent and then by (20-24 years) 18.3 percent. In this way, more than 60 percent of the total mother belongs to most fertile age group 20-34 years.

5.2 Age at Marriage of Respondents

Marriage is universal and one of the major social factors affecting fertility performance. It is an important factor for maternal health care status. Early age at marriage has been prevailing in Nepal due to various religions and cultural practices. Most of the Nepali women are married before they reach twenty.

Table: 8 Distribution of Respondents by Age at Marriage		
Age at Marriage	No. of Respondents	Percent
Below 15	16	22.5
15-19	46	64.8
20-24	7	9.9
25+	2	2.8
Total	71	100.0

Source: Field Survey, 2007

Table 6 shows that more than two-third (64.8 percent) of total mothers are married between age 15-19 years. Table also presents the information that almost 97.2 percent of respondents were married before age 24 years and only 2.8 percent belong to the marriage age of 25 and above. From this study, it is concluded that the early age at marriage was prevailing in the Raute Community.

5.3 Age and Sex Composition of Children

Out of total children, only 76 children were found under three years of age in the survey. The age and sex composition of those children are categorized into three groups as shown in the table 9.

Age Group (in month)	<u>Male</u>		<u>Female</u>		<u>Total</u>	
	Number	Percent	Number	Percent	Number	Percent
Below 12	14	35.9	11	29.7	25	32.9
12-25	12	30.8	16	43.2	28	36.8
24-35	13	33.3	10	27.1	23	30.3
Total	39	100.0	37	100.0	76	100.0

Source: Field Survey, 2007

In the table 9, observed that the sex ration of the children is 105 males per 100 females. The proportion of children is highest for those who are aged 24-35 months (36.8 percent). This is followed by aged below 12 months (32.9 percent) and children age 24-35 months is found to (30.3 percent). When the distribution of children is examined according to sex males are found to be slightly higher then females (51.3 percent and 48.7 percent) respectively.

5.4 Educational Attainment

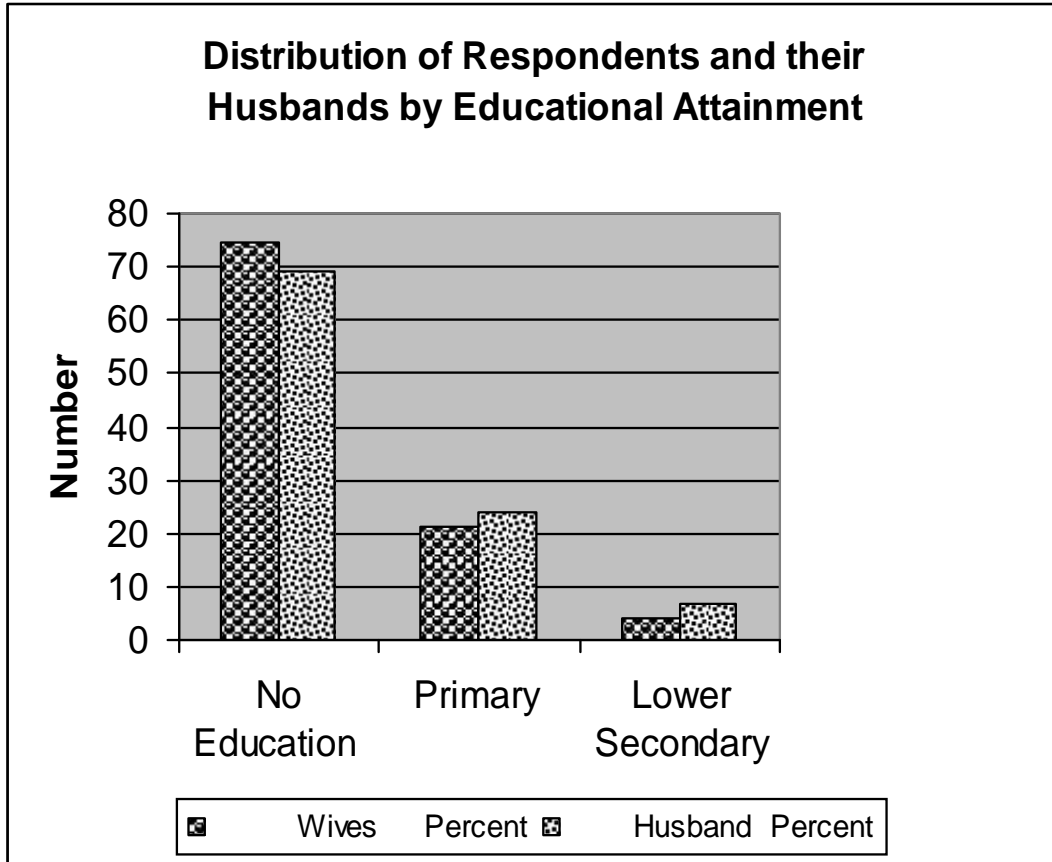
Education is the most important factors for the socio-economic development of an individual. Educated women are more aware of the issue of quality of health and children than that of non-educated.

Educational Status	<u>Wives</u>		<u>Husband</u>	
	Number	Percent	Number	Percent
No Education	53	74.6	49	69.1
Primary	15	21.2	17	23.9
Lower Secondary	3	4.2	5	7.0
Total	71	100.0	71	100.0

Source: Field Survey, 2007

Table 9 indicates that the educational status of the study population is very poor where more than 74.6 percent of women and 69.1 percent of husbands are illiterate and both women and husbands are not having higher level of education. There were only 25.4 percent women belong to primary level and above educational status. In this study, it is concluded that the respondents educational status is slightly lower than their husbands' educational status.

Figure 2: Educational Level of Respondents and Their Husbands



5.5 Occupational Status of Respondents and their Husbands

Occupational status plays vital role in promotion and protection of individual's health as well as community health. Here, table 12 presents the distribution of occupational status of respondents and their husbands' occupational status which is associated with the standard life of an individual.

Table 11: Distribution of Respondents and their Husbands by Occupational Status				
Occupational Status	<u>No. of husband</u>		<u>No. of respondents</u>	
	Number	Percent	Number	Percent
Housewife	-	-	29	40.8
Agriculture	8	11.3	18	25.4
Daily wages	63	88.7	24	33.8
Total	71	100.0	71	100.0

Source: Field Survey, 2007

More than 88 percent of the husbands were reported that they were involved in daily wages work and only 11.3 percent of husbands were involved in agriculture sector. Similarly, 33.8 percent women were involved in daily wages work and 40.8 percent and 25.4 percent women were involved in Housewives and agriculture sector respectively.

CHAPTER – SIX

MATERNAL AND CHILD HEALTH CARE PRACTICES AMONG RAUTES

Maternal and child health care practices means maintenance and promotion of maternal and child health status. Maternal and child health care includes all necessary cautions in order to improve and protect the health of mother and child. The main aim of the maternal health care services is reducing maternal and child mortality and morbidity. This concept includes antenatal, delivery and postnatal cares.

6.1 Antenatal Care Practices

Antenatal care includes the care of mother before the delivery. The maternal health care service that a mother receives during their pregnancy and at the time of delivery is important for the well being of the mother and her child.

This section presents the analysis on health check-up, TT immunization, receiving additional food and iron tables during pregnancy.

6.1.1 Age of Women and Received Antenatal Care Services

According to NDHS (2001), one in two pregnancy women received antenatal services then older women. Utilization of antenatal care services is higher in the Terai, urban and in the western, eastern and central development region than in other region.

Age of Women	<u>Yes</u>		<u>No</u>		<u>Total</u>	
	Number	Percent	Number	Percent	Number	Percent
<20	6	23.1	6	13.3	12	16.9
20-24	5	19.2	8	17.8	13	18.4
25-29	6	23.1	10	22.2	16	22.5
30-34	5	19.2	9	20.0	14	19.7
35+	4	15.4	12	26.7	16	22.5
Total	26	100(36.6)	45	100 (63.4)	71	100.0

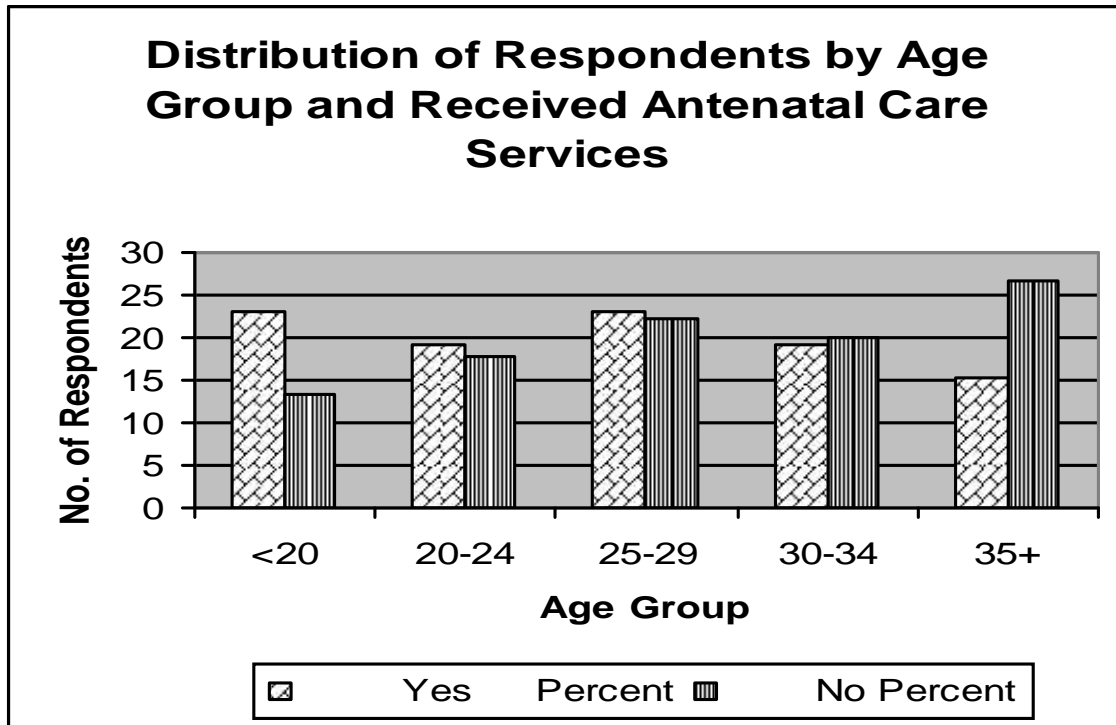
Source: Field Survey, 2007

From the table 11, we observe the information on antenatal services according to women's age group and received antenatal care services during pregnancy. In this study, antenatal care services includes the services of trained health personnel and traditional birth attendants to mother during their pregnancy. Table 12 shows that, out of total 71 respondents only 26 (36.6 percent) women have received antenatal care services during pregnant period. Similarly, 45 (63.4 percent) women did not receive antenatal care during pregnancy period. This data shows that, still antenatal care services are low in the study area during the pregnancy period.

According to table 12, out of total 26 respondents highest 23.1 percent respondents received antenatal care services of the age below 20 and 24-29 years of age respectively, and then, followed by 19.2 from the age group 20-24 and 30-34 years respectively. Only, 15.4 percent women's received antenatal care services from the age 35 and above. From this table, it is concluded that the younger women are more likely to use antenatal services then older women. Beside this, the majority of age

group in Rautes during pregnancy did not receive any antenatal care indicating very low level of the practices of antenatal services.

Figure: 3 Antenatal Checkup



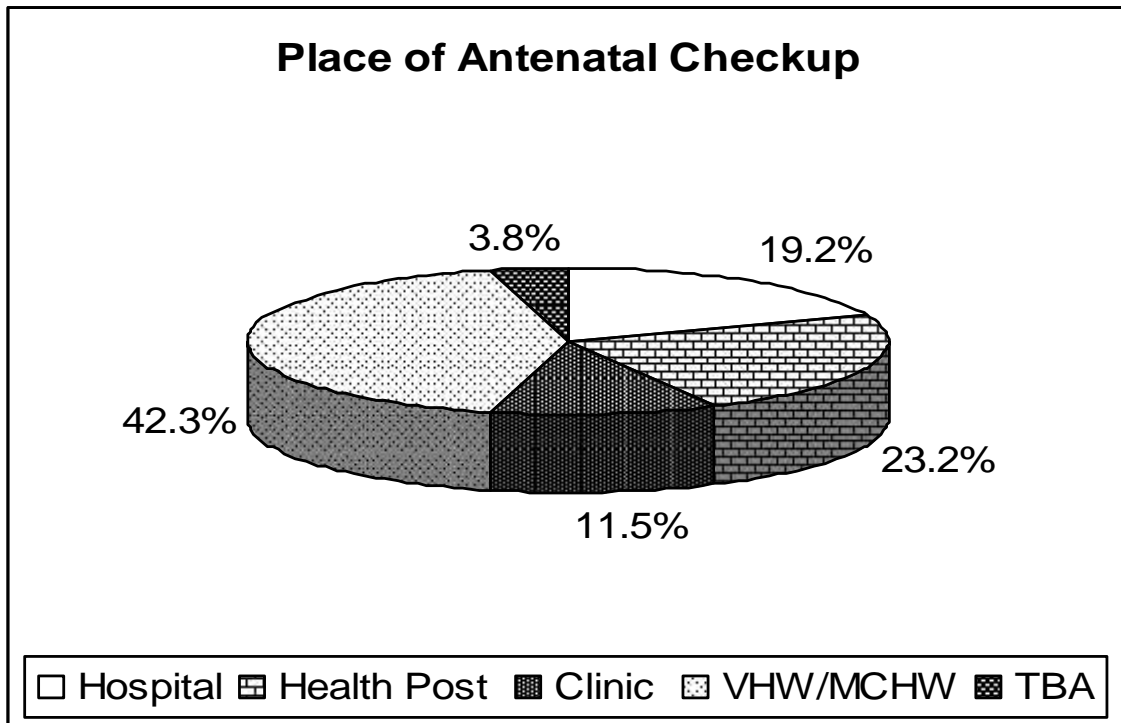
6.1.2 Place of Antenatal Checkup

Antenatal checkup is most important in order to maintain the health of mother. Antenatal visits have various beneficial for both mother and her new born child. Table 12 shows that the highest percentage of respondents 42.3 are going to antenatal checkup in VHW/MCHW, and then followed by going to antenatal checkup in health post 23.3 percent. Similarly, 19.2 percent and 11.5 percent respondents are going to antenatal checkup in hospital and clinic respectively. Only, 3.8 percent respondents are found to antenatal checkup in TBA.

Place of Checkup	Number of Respondents	Percent
Hospital	5	19.2
Health Post	6	23.2
Clinic	3	11.5
VHW/MCHW	11	42.3
TBA	1	3.8
Total	26	100.0

Source: Field Survey, 2007

Figure 4: Place of Antenatal Checkup



6.1.3 Frequency of the ANC visit

The number of ANC visits is important for pregnant women and their child. The number of antenatal visits recommended by the safe motherhood programme in Nepal is 3 times. Obstetricians generally recommended that antenatal visits be made on a monthly basis to the seventh months, fortnightly to the eight months and then weekly until birth. It means a woman should be more than 10 times visits.

No. of Visit	Number of Respondents	Percent
Once	9	12.7
Twice	12	16.9
Three or more	5	7.1
None	45	63.3
Total	71	100.0

Source: Field Survey, 2007

Highest percentage of the respondents who received the antenatal service, 16.9 percent reported that they received antenatal care twice during pregnancy and 7.1 received three or more times. 12.7 percent respondents visit to the antenatal care by once. Remaining 63.1 percent of the births mother did not make any visits during pregnancy period. According to the table 14 we can be concluded that the Rautes mothers are less conscious about antenatal checkup.

6.1.4 Antenatal Checkup and Respondents' Educational Status

Educational status of women and antenatal checkup is closely related. If the level of women education is higher, the level of antenatal checkup is also higher.

Educational Status	Antenatal Checkup				Total	
	<u>Yes</u>		<u>No</u>			
	Number	Percent	Number	Percent	Number	Percent
Illiterate	12	22.6	41	77.4	53	74.6
Literate	14	77.8	4	22.2	18	25.4
Total	26	36.6	45	63.4	71	100.0

Source: Field Survey, 2007

Table 19 indicates the distribution of the relation of women's education level and antenatal checkup. Out of total 26 respondents 22.6 percent illiterate women are received antenatal checkup but 77.4 percent illiterate women are not receiving antenatal checkup. Similarly, 77.8 percent literate women are reported to antenatal checkup but 22.2 percent literate women are not receiving antenatal care. Therefore this table shows that higher the level of education, higher the chances of antenatal checkup during pregnancy.

6.1.5 Receiving Iron Tables and Vitamin 'A' Tablets

During the pregnancy period, additional food, vitamins and minerals are necessary for growth and development of the foetus and to prevent anemia and malnutrition for mothers. In this study, a question was asked to

the respondents about vitamins and iron tables. The information is shown in the table 16.

Table 16: Distribution of Respondents by Receiving Iron Tablets		
Receiving Iron Tablets	Number of Respondents	Percent
Yes	31	43.7
No	40	56.3
Total	71	100.0

Source: Field Survey, 2007

According to the table 20, out of 71 respondents 43.3 percent are receiving iron tablets during her pregnancy period. Similarly, 56.3 percent respondents are not received iron tablets during their pregnancy period. In the study, the number of respondents who have not received iron tablets is still high.

Table 17: Distribution of Respondents by Receiving Vitamin 'A' Tablet		
Receiving Vitamin 'A'	Number of Respondents	Percent
Yes	33	46.5
No	38	53.5
Total	71	100.0

Source: Field Survey, 2007

According to table 17, out of total 71 respondents only 46.5 percent women are received, Vitamin 'A' tablets during their pregnancy. On the other hand 53.5 percent respondents did not received vitamin 'A' tablets during their pregnancy. Receiving the vitamin 'A' tablets at the time of pregnancy of women is still low in the study area, because of low awareness and no access the facility.

6.1.6 Tetanus, Toxoid Injections and Doses

A pregnant woman should receive two doses of the toxoid for full protection of neonatal tetanus. However, if a woman has been vaccinated during a previous pregnancy, she may only require one dose during current pregnancy (NDHS, 1996). In this context, the collected data during the study period are presented in table 18.

Received TT Injection	No. of Respondents	Percent
Yes	46	64.8
No	25	35.2
Total	71	100
No. of TT Injection dose		
One	16	34.8
Two	19	41.3
Three	11	23.9
Total	46	100.0

Source: Field Survey, 2007

Table 18 shows that, 64.8 percent respondents reported to take TT vaccine. Those who received TT vaccine, highest percent 41.3 percent of respondents received two doses and followed by three doses 23.9 percent and then only one doses of TT vaccine received 34.8 percent of respondents.

Received TT Injection	<u>Literate</u>		<u>Illiterate</u>		<u>Total</u>	
	Number	Percent	Number	Percent	Number	Percent
Yes	15	83.3	31	58.5	46	64.8
No	3	16.7	22	41.5	25	35.2
Total	18	100.0	53	100.0	71	100.0

Source: Field Survey, 2007

Women's literacy status and receiving tetanus toxoid injection are interrelated. Table 19 shows that out of total 18 literate respondents, 83.3 percent received TT injection. Only 16.7 literate women did not received TT injection at the time of pregnancy. Out of total 53 illiterate women 58.5 percent received TT injection. So, higher the level of education higher chances of receiving TT injection during the pregnancy.

6.2 Delivery Practices

The section of the study deals about place of delivery, types of delivery assistance, and use of delivery kits.

6.2.1 Place of Delivery

Place of delivery is one of the most important factors affecting maternal health. A large proportion of maternal deaths occur at home, only a little proportion of mother's delivery at health facility. In Nepal, (90 percent in 2001 and 81 percent in 2006) mothers delivery at home.

Place of Delivery	No. of Respondents	Percent
Own Home	64	90.1
Hospital	4	5.6
Health Post	3	4.2
Total	71	100.0

Source: Field Survey, 2007

Table 20 shows that, highest 90.1 percentage of respondents are delivered at home. Only 9.9 percent of women are delivered at health facilities in the study area. Which of them, 5.6 percent and 4.2 percent are delivered at hospital and health post respectively. This data shows that women of the study area passing through miserable condition. Major reason behind it is possibly the illiteracy and ignorance and lack of reliable.

6.2.2 Use of Clean Delivery Kits

A clean delivery Kits means specially prepared kit, containing a razor, blade a cutting surface, a plastic sheet, a piece of soap, a string and practical instructions assembled by maternal and Child Health Pvt. Ltd. for safe delivery practices. The mothers were asked the questions about uses of clear delivery kits. The available information is presented in the table 21.

Clean Delivery Kit Used	No. of Live Births	Percent
Yes	4	5.3
No	72	94.7
Total	76	100.0

Source: Field Survey, 2007

Table 21 shows that, a clean delivery kit was used only for 5.3 percent of home deliveries. Similarly, 94.7 percent respondents were not used this instruments in home deliveries. The low use of these specific clean deliveries kits may be due to the fact that they are not yet widely available and lack of access to safe delivery kit and traditional systems women do not use them and as a result they suffer various health problem.

6.2.3 Assistance with the Delivery Period

Assistance during delivery is an important component for a health and safe delivery for mother and new born baby. If women receive assistance from a medical person during delivery, she will not face any sign and symptoms to complication during delivery.

Assistance	No. of Respondents	Percent
Family Member/Relatives	40	56.3
MCHW/Nurse	3	4.2
VHW	4	5.6
TBA	7	9.9
Doctors	2	2.8
None	15	21.2
Total	71	100.0

Source: Field Survey, 2007

Mainly delivery assistance were divided into three types; Health personnel (i.e. Doctor, MCHW/Nurse, TBA, VHW etc.), traditional births attendants and family members or relatives which are given in the table 22. The table 22 shows that the family member or relatives are the highest percentage 56.3 percent for delivery assistance and them assisted followed by traditional birth attendants 9.9 percent of births. Where as only 12.7

percent of births were delivered by trained health personnel. Remaining 21.2 percent of were delivered without assistance.

6.2.4 Place of Delivery and Literacy of Women

Place of Delivery	<u>Literacy Status</u>				<u>Total</u>	
	<u>Literate</u>		<u>Illiterate</u>		Number	Percent
	Number	Percent	Number	Percent		
Own Home	12	18.8	52	81.2	64	90.2
Hospital	3	75.0	1	25.0	4	5.6
Health Post	3	100.0	0	0.0	3	4.2
Total	18	25.4	53	74.6	71	100.0

Source: Field Survey, 2007

Table 23 shows that out of 18 literate respondents 18.8 percent have delivered in own home, 75.0 percent have delivered at hospital and cent percent literate respondents were delivered at health post. On the other hand out of 53 illiterate respondents 81.2 percent have delivered at own home and similarly 25.0 percent have illiterate respondents have delivered at hospital. It means literate women have delivered more in hospital then illiterate women.

6.2.5 Post Partum Care

Women were asked if they had received a check-up from anyone with in 24 hours following the delivery of any child born in the three years preceding the survey.

Table 24: Percentage Distribution of Live Births to Women Received Health Check-up from Post-Partum Care Provider within 24 Hours of Delivery

Post Partum Care Provider	No. of Live Births	Percent
Doctor	1	1.4
TBAs	3	3.9
MCH/Nurse	2	2.6
Friend/Relatives	47	61.8
VHW	2	2.6
None	21	27.7
Total	76	100.0

Source: Field Survey, 2007

Table 24 provides the information that the majority of women didn't receive post partum care from trained medical personnel. Only 1.4 percent of births were visited by doctor, 3.9 percent by TBAs, 2.6 percent by MCHW/Nurse, and 2.6 percent births were visited by VHW. Similarly, 61.8 percent of births were visited by relatives or friends and 27.7 percent of mother did not receive post partum care from any one.

6.3 Post-natal Care Practices

This section deals with the Post-natal care among Rautes. It means care of mothers and new born child after delivery. In this study, post-natal care practices including first milk practices, duration of breast feeding period, nutritional status of children, immunization practices and common health problem of children and their treatment practices.

6.3.1 First Milk Practices

Breast feeding is nutritious, food for children specially, during infancy period. It consists of antibodies and other substances which protects the

baby against diseases. First milk is known as Colostrum, prepared on mother's breast immediately after delivery. It carries immunity to diseases and high nutritive value to the infant (Pant, 1994).

The respondents were asked the question about first milk practices. The collected data are given in table 25.

Table 25: Percent Distribution of the Live Births in Three Years Preceding the Survey by First Milk Practices, and by Mothers Literacy Status				
Educational status	<u>First Milk Practices</u>			No. of Live Births
	Yes	No	Total	
Literate	72.7	27.3	100.0	11
Illiterate	44.6	55.4	100.0	65
Total	48.7	51.3	100.0	76

Source: Field Survey, 2007

Table 25 indicates that the majority of the women made colostrums feeding for their births, that is 48.7 percent. The literate mothers made the first milk practices for the 72.7 percent of births and illiterate made for the 44.6 percent of births. It means mother's education plays important role to first milk practices for their births.

6.3.2 Duration of Breast Feeding

Breast feeding is the best form of nutrition for children up to six months, and which provides immunological protection against common childhood diseases such as diarrhea and Acute Respiratory Infectious (ARI). The survey collected information on breast feeding practices for all children born in the three years preceding the survey, but the analysis has been carried out only for those who have completed breastfeeding.

Table 26: Percent Distribution of the Live Births in Three Years Preceding the Survey Weaning Breast Milk by Literacy Status of Mothers

Educational status	<u>Duration of Breast Feeding</u>			No. of Children
	One Year	Two Year	Three Year	
Literate	-	66.7	33.3	9
Illiterate	15.9	57.9	26.3	38
Total	12.8	59.6	27.6	47

Source: Field Survey, 2007

Table 26 shows that the majority of the respondents breast feed their children for two years, that is 59.6 percent. Among them 66.7 percent were literate and 57.9 percent were illiterate. There is 15.8 percent of illiterate women had breast feeding practiced up to one year and no literate mothers who fed their children less than one year. Breast feeding practices up to three years were 33.3 percent and 25.3 percent of literate and illiterate mothers respectively.

6.3.3 Nutritional Status of Child

This study attempts to find out the frequency of supplementary food feeding practices to children under three years of age. The children generally received rice, Jaulo and animal milk as supplementary food.

Table 27: Percent Distribution of Living Children who Received only Breast Milk, and who Received Supplementary Food in Three Years Preceding the Survey by Child's Sex

Children's Sex	Only take Mother's Milk	Frequency Of Supplementary Food Feeding Daily			No. of Living Children
		Two	Three	Four	
Male	12.8	23.1	43.6	20.5	39
Female	10.8	27.1	40.5	21.6	37
Total	11.8	25.0	42.1	21.1	76

Source: Field Survey, 2007

Table 29 shows that the 11.8 percent of total children take only mothers milk and 25.0, 42.1 and 21.1 percent of children received supplementary food two, three and four times per day respectively. The data shows that most of the children took supplementary food three times per day.

6.3.4 Child Immunization Practices

Immunization is the most important component which helps to reduce high child mortality. The World Health Organization (WHO) has set the following programs for the child vaccinations. In order to be considered fully vaccinated, a child should receive the following vaccines: one doses of BCG, three doses each of DPT and polio, and one dose of measles vaccine. BCG which should be given at birth or first clinical contact, protects against tuberculosis, DDT protects against diphtheria, pertussis and tetanus. DPT and Polio should be given approximately six, ten, and fourteen weeks of age. Measles should be given at or soon after reaching nine months. It is recommended that children receive the complete schedule of vaccinations before twelve months of age.

In this survey, information on vaccination coverage also collected for all children born in three years preceding the survey, but the analysis has been carried out only for those who have completed one years of age, because child could receive full doses of vaccines up to twelve months.

Vaccines	Yes		No		Total	
	Number	Percent	Number	Percent	Number	Percent
BCG	53	69.7	23	30.3	76	100.0
DPT	41	53.9	35	46.1	76	100.0
Polio	57	75.0	19	25.0	76	100.0
Measles	22	28.9	54	71.1	76	100.0

Source: Field Survey, 2007

Table 28 shows that the highest proportion 75.0 percent reported that the child was immunized by polio, and then followed by 69.7 percent child was vaccinated by BCG. The children are vaccinated by DPT and measles are found to be 53.9 percent and 28.9 percent respectively. The study suggested that the more than 40 percent and above children did not receive any vaccines with in the proper time.

6.3.5 Diarrhoea

Dehydration caused by severe diarrhea is a major cause of morbidity and mortality among children in Nepal. A simple and effective response to child's dehydration is a prompt increase in fluid intake that is Oral Rehydration Therapy (ORT), rehydration therapy may include the use of solution prepared from packets of Oral Rehydration Salts (ORS) or Recommended Home Fluids (RHF) such as sugar – salt – water – solution.

6.3.5.1 Prevalence of Diarrhoea

Child's Sex	All Diarrhoea		Number of Live Births
	Number	Percent	
Male	9	23.1	39
Female	11	29.7	37
Total	20	26.3	76

Source: Field Survey, 2007

Table 29 presents data on prevalence of diarrhea among children under three years of age. Twenty six percent of children had experienced diarrhea some time in the two weeks preceding the survey. Among them 29.7 and 23.1 percent male and female child was suffered from diarrhea in the two weeks preceding the survey time.

6.3.5.2 Knowledge and use of ORS (Jeevan Jal)

Educational Status	Know about ORS	Ever Used	No. of Women
Literate	100.0	38.9	18
Illiterate	94.3	15.1	53
Total	95.8	21.1	71

Source: Field Survey, 2007

Table 30 shows the 100 percent of literate women and 94.3 percent of illiterate women know about ORS, however, 38.9 percent of literate women ever used ORS while only 15.1 percent of literate women ever used it. From this information it is concluded that the literate women is more likely to use ORS then illiterate women.

6.3.5.3 Treatment of Diarrhoea

Respondents reported that they had provided two types of treatment for their children during diarrhea. Such as, oral rehydration therapy (Jeevan Jal) and other treatment (i.e. health facility, Baidhya, home made herbal, dhami/Jhakri etc).

Table 31: Percentage of Children Under Three Years who had Diarrhoea in the Two Weeks Preceding the Survey had Received ORS and Taken Other Treatment, according to the Mothers Literacy Rate

Educational Status	ORS (Jeevan Jal) Treatment	Other Treatment	No. of Children
Literate	100.0	75.0	4
Illiterate	50.0	31.3	16
Total	60.0	40.0	20

Source: Field Survey, 2007

Table 31 shows that almost 60.0 percent of women provided treatments by ORS and 40.0 percent of women provided other treatments. The cent percent children of literate women received ORS and 75.0 percent of the children have experienced other treatment. While only 50.0 percent children of illiterate women received ORS and 31.3 percent of the children have got other treatment. It means the literate mothers are more conscious about child health problem then illiterate mothers.

CHAPTER – SEVEN

SUMMARY, CONCLUSION AND RECOMMENDATION

7.1 Summary

The study had been carried out to examine the health status of mothers and children among Rautes based on a primary data. Raute community at Jogbudha and Sirsha VDC in Dadeldhura districts was selected for the study. In total, there are 65 household were covered of Rautes in this study. The detail study was limited to the currently married women aged 15-49 who have children under three years of age.

The main objectives of the study are:

- To assess the socio-economic and demographic characteristics of Rautes mothers.
- To examine the status of maternal and child health care practices among Rautes, and
- To examine the relationship of MCH with background characteristics among Rautes.

To fulfill the objectives of this study, some selected socio-demographic variables are taken as main influencing variables on antenatal, delivery and post-natal care practices.

The major findings of the study are as follows:

7.1.1 Demographic and Socio-Economic Characteristics of the Respondents

- The majority of the mothers belonged to age group 25-29 years and least numbers belong to 40-44 years.
- Almost 97.2 percent of respondents were married before age 20 and only 2.8 percent married at age 25 and above.
- The highest number (36.8 percent) of children belonged to age group 12-23 months and then followed by age below 12 months and 24-35 months.
- Around the 80 percent of women are illiterate and only 4.2 percent mothers have passed the primary level education and there were no mothers who passed the lower secondary level of education.
- More than 68 percent of respondent's husbands were illiterate. Only 7 percent of respondent's husbands passed the lower secondary level of education.
- More than 88 percent of respondent's husbands were involved in daily wages work and only 11.3 percent of respondent's husbands were involved in agriculture sector.

7.1.2 Maternal and Child Health Care Practices

- Around the one third (36.6 percent) of the total respondents were received antenatal services during pregnancy. Among those who have received antenatal services, the highest proportions of women were served by VHWs/MCHWs (42.3 percent). The least proportion of respondents received antenatal care from TBAs (3.8 percent).
- Majority of mother did not receive full doses of TT injection. Only (23.9 percent) of mothers received three doses of TT injection, while 34.8 percent respondents reported that they receive single

dose and 35.2 percent did not received any doses of TT injection during pregnancy period.

- More than 55 percent of Raute mothers could not get any extra protein, vitamins and mineral salts during pregnancy.
- Ninety percent and above children were delivered at home and remaining 9.8 percent were delivered at health facility.
- Family member or relative (56.3 percent) were the main birth attendance in the study area. Only 20 percent of delivery was assisted by trained health personnel.
- The majority of the women made colostrums feeding for their births. That is only 48.7 percent.
- The majority of the respondents their children for two years, that is 59.6 percent. And most of the children took supplementary food three times per day that is 42.1 percent.
- Children were immunized by BCG, DPT and polio that is only 50 percent and measles coverage was only 28.9 percent. Children had experienced all diarrhea, that is 26.3 percent.
- The general knowledge of ORS is wide spread among respondents (95.8 percent). Similarly, a use of Jeevan Jal is only 21.1 percent respondents.

7.2 Conclusion

On the basis of the above main findings of the study, the following conclusions are drawn:

In this study area, the majority of respondents belonged to age group 25-29, which is considered as highly fertile age group. Early age at marriage is most prevailing in the Raute community. The study shows that all the respondents were engaged in daily wages activities and educational status

of respondents and their husbands was very low in comparison with their husbands.

Antenatal care practice was very poor of the study population only one-third of the total respondents used antenatal services during pregnancy. From this study, it is observed that the younger women were more likely to use antenatal services than older women. This is specially true with regard to care from MCHWs and VHWs. Similarly, lower birth order is associated with greater use of services provided by medially trained health workers. Perhaps this pattern occurs because younger women tend to be literate than older women. Similar pattern is observed from those who have tetanus toxoid injection.

Most of the children were delivered at home with the assistance of friends/relatives and TBAs of the community. The major finding of the study were the younger women and women with some education are more likely to receive assistance during delivery. Similarly, the women with lower birth order are more likely to receive better care during delivery.

Post-natal care practices in the study area was found some satisfactory than antenatal and delivery care practices. The colostrums feeding practices was found so not better in the community. Similar pattern is observed in breast feeding and supplementary food practices. The frequency of receiving supplementary food practices was higher for male children than female children. Immunization practices for children under three years of age found so poor than national average. Though, the general knowledge of ORS is wide spread among mothers about specific eating and drinking for sick children, the findings are less encouraging. There is positive relationship between child health care practices and mother's education.

7.3 Recommendation

- i. The socio-economic status of the community is very poor. So, the respondents are unable to receive payable medical facilities. Therefore the free and mobile medical facilities could be effective to improve the maternal and child health status in the community.
- ii. Most of the people in the community involved in daily wages activities. So, development programmes should be launched for improving socio-economic status, which will be positive and preventive check for maternal and child health.
- iii. Maternal and child health care practices in the Raute community were highly influenced by education, since antenatal, delivery and post-natal care practices were a little satisfactory for literate women than that for illiterate women. So, the priority should be given in education in order to enhance more antenatal, delivery and post-natal care practices.
- iv. In this study, very limited socio-demographic variables (education, age of respondents, age and sex of child, and birth order) were used as influencing variable on maternal and child health care practices. These variables may not sufficient for the study. So, the further study could be done by using other approaches like social, economic, cultural, geographic regional and other multi-dimensions.
- v. This study has been carried out by using simple descriptive analysis. This type of study could be done by using correlation, regression and other statistical controls.
- vi. The present study does not estimate the indirect effect of the selected variables. So, the further study could be done by estimating indirect effects of the independent variables on maternal and child health care practices.

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TRIBHUVAN UNIVERSITY

Central Department of Population Studies (CDPS)

**A Questionnaire on Maternal and Child Health Care Practices
among Raute Community in Jogbudha and Sirsha VDCs of
Dadeldhura Districts**

ANNEX - 1

Household Schedule

District VDC.....

Religion.....

Name of Respondent

ID No.	UR	RTHHH	SEX	AGE	ED	MS	OCC	EG
01								
02								
03								
04								
05								

Note: UR = Usual Residents, RTHHH = Relation to Head of Household
ED = Education, MS = Marital Status, OCC = Occupation, EG = Eligibility

SECTION 1: RESPONDENT'S BACKGROUND

1. In what month and year were you born?
i) Month ii) Don't know month.....
iii) year..... iv) Don't know year.....
2. How old were you at your last birth?
i) Age in completed years.....
3. Have you ever attended school?
i) Yes..... ii) No.....
4. What is the highest grade you completed?
i) Grade

5. Can you read and understand a letter or new paper?
 - i) Yes
 - ii) No

6. What is your current marital status?
 - i) Currently married
 - ii) Widowed
 - iii) Divorced
 - iv) Separated

7. How old were you when you (first) got married?
 - i) Age.....

8. What is the main source of drinking for members of your household?
 - i) Piped Water
 - ii) Well water
 - iii) Spring/Kuwa.....
 - iv) Other

9. What kind of toilet facility does your household have?
 - i) Pit toilet
 - ii) Traditional pit toilet
 - iii) No facility
 - iv) Other

10. Have you usually listen radio?
 - i) Yes.....
 - ii) No

SECTION 2: REPRODUCTION

11. Now, I would like to ask about all the births you have had during your life, have you ever given birth?
 - i) Yes
 - ii) No

12. Do you have any sons or daughter to whom you have given birth who are living with you?
 - i) Yes
 - ii) No

13. How many sons and daughter live with you?
 - i) Sons
 - ii) Daughters

.....

14. How many sons and daughters are alive but do not live with you?
 - i) Sons
 - ii) Daughters

.....

15. Have you ever given birth to son or daughter who was born alive but later died?

i) Yes ii) No

16. How many boys and girls have died?

i) Sons ii) Daughters

17. Now I would like to ask you about live births within three years.

A	B	C	D	E	F	G
Name of child	Was that a single or multiple pregnancy?	Is a boy or girl?	In what month and year was born?	Is still alive?	How old was at his/her last birth day?	How old was when he/she was died?
01a. Name	Single Multiple.....	Son Daughter....	Year..... Month.....	Yes..... No	Age	Day..... Month..... Day.....
01 b. Name (if multiple)	Single Multiple.....	Son Daughter....	Year..... Month.....	Yes..... No	Age	Day..... Month..... Day.....
02 b. Name.....	Single Multiple.....	Son Daughter....	Year..... Month.....	Yes..... No	Age	Day..... Month..... Day.....
02 b. Name.....(if multiple)	Single Multiple.....	Son Daughter....	Year..... Month.....	Yes..... No	Age	Day..... Month..... Day.....

18. Are you pregnant?

i) Yes ii) No

19. How many months of pregnant are you?

i) Months

20. At the time your became pregnant did you want to became pregnant or did you want to wait until later, or you did not want to become pregnant at all?

i) Then ii) Later
 iii) Not at all

SECTION 3: CONTRACEPTION

21. Which ways or method of FP have you heard about?
- i) Pill
 - ii) IUD
 - iii) Injections
 - iv) Norplant
 - v) Diaphragm Foam, Jelly.....
 - vi) Condom
 - vii) Female sterilization
 - viii) Rhythm
 - ix) Withdrawal
22. Have you ever used anything or tried in any way to delay or avoid getting pregnant?
- i) Yes
 - ii) No
23. How many living sons did you have at the time you first used contraception (family planning), if any?
- i) Number of sons
 - ii) Numbers of daughter
24. Are you or your husband currently doing something or using any method to delay or void your getting pregnant?
- i) Yes.....
 - ii) No..... if no go to Q. 30
25. Which method are you using?
Name of the method.....
26. Where did you obtain (method) the last time?
Name of the place.....
27. Is it easy or difficult to get there?
- i) Easy
 - ii) Difficult
 - iii) Don't know
- Go to section 4A.
28. What is the main reason you are not using a method of contraception to avoid pregnancy?

Mention reason

SECTION 4 A: PREGNANCY AND BREAST FEEDING

Now I would like to ask you some questions about the health of all your children born in the three years.

We will talk about one child at a time.

29. At time you become pregnant with (Name), did you want to become pregnant, then did you want to wait until later, or did you want to no more children at all?

- i) Then
- ii) Later.....
- iii) No more

30. At the time you became pregnant with (Name) how much longer would you like to have waited?

- i) Months
- ii) Year
- iii) Don't know

31. When you were pregnant with (Name), did you see anyone for antenatal care for his pregnancy?

- i) Doctor
- ii) Nurse/A.N.M.....
- iii) TBA
- iv) MCHW.....
- v) Other.....
- vi) No one

32. How many months pregnant were you when you first received antenatal care?

- i) Months
- ii) Don't know

33. How many times did you receive antenatal care during this pregnancy?

- i) No. of times
- ii) Don't know

34. When you were pregnant with (Name), were you given an injection in the arm to prevent the baby from getting tetanus, that is, convulsions after birth?

- i) Yes ii) No.....
- iii) Don't know.....
35. During this pregnancy, how many times did you get this injection?
- i) No. of times ii) Don't know
36. With (Name), did you receive any iron tablets/extra food?
- i) Yes ii) No.....
- iii) Don't know
37. Where did you give birth to (Name)?
- i) Home ii) In health facility
-
38. Was a special safe delivery kit was used?
- i) Yes ii) No
- iii) Don't know
39. Who assisted with the delivery of (Name)?
- i) Doctor ii) Nurse /A.N.M.....
- iii) TBA..... iv) MCHW.....
- v) Relatives/Friends..... vii) No one
40. Did you ever breastfeed (Name)?
- i) Yes..... ii) No.....
41. For how many months did you breastfeed (Name)?
- i) No. of months
42. Did (Name) ever receive following vaccines?

Vaccines	Ever received	
	Yes	No
BCG		
DPT 1		
DPT 2		
DPT 3		
Polio 1		

Polio 2		
Polio 3		
Measles		

43. Did (Name) receive vitamin A during the last 6 months?
i) Yes ii) No.....
44. Did (Name) receive iodine capsules during the last 6 months?
i) Yes ii) No.....
45. Has (Name) been ill with a fever at any time in the last 2 weeks?
i) Yes ii) No.....
46. When a child is sick with diarrhea, what signs of illness would tell you that he or she should be taken to health facility or health worker?
Record all Mentioned
47. No child received ORS or question not asked.
No child received ORS.....
48. Have you ever heard of a special product called ORS such as Jeevan Jal you can get for treatment of diarrhea?
i) Yes ii) No.....
49. Did you prepare the whole packet at once or only part of the packet?
i) Whole packets at one..... ii) Only part of the packet
.....
50. How much water did you omit with a packet of Jeeven Jal?
i) Liter ii) Mana
iii) Tea Glass..... iv) Other.....
v) Don't know.....
51. Where can you buy or obtain a packet of ORS like Jeeve Jal?
Record all mentioned

SECTION 5: FERTILITY PREFERENCES

52. a) Not pregnant or unsure

Would you prefer not to have any (more) children?

b) Pregnant

After the child you are expecting now like to have another child or would you prefer not to any more.

- i) Have (another) child
- ii) No more.....
- iii) Says she can't get pregnant.....
- iv) Undecided/Don't know.....

53. a) Not pregnant or unsure

How long would like to wait from now before the birth of (a/another) child?

b) Pregnant

After the child you are expecting now, how long would you like to wait before the birth to another child?

- i) Months
- ii) Years
- iii) Soon/now.....
- iv) Says she can't get pregnancy.....
- v) Other.....

54. Do you think you will use a method of family planning at any time in the future?

- i) Yes
- ii) No.....
- iii) Don't know

55. Which method would you prefer to use?

Name of the Methods.....

56. What is the main reason that you think you will never use a method?

Mention reason.....

SECTION 6: HUSBAND'S BACKGROUND AND WOMAN'S WORK

57. How old was your husband on his last birthday?
Age.....
58. Did your (last) husband ever attend school?
i) Yes ii) No.....
59. What was the highest grade he completed?
i) Grade ii) Don't know.....
60. What (is/was) your (last) husband's occupation? That is, what kind of
work (does/did) he mainly do?
.....

*****The End*****