Chapter One

1.Introduction

1.1 Background of the Study

Reproductive Health is a crucial part of over all health. It affects everybody and involved intimate and highly valued aspects of life. It reflected not only health in infancy, childhood, and adolescent but also it sets stage for health beyond the reproductive years both women and men. It has also sound effects for one generation to another.

Reproductive health is define as “a state of complete physical, mental and social well being and not merely the absence of disease or infirmity in terms of reproduction (ICPD,1994).

Among the various component of reproductive health, maternity care is an essential and central component. Maternal health is an important part of the health care system aimed at reducing morbidity and mortality related to pregnancy. Maternity care refers to the provision of care for women during pregnancy and child birth. It ensures healthy and successful outcome of pregnancy for the mother and her newborn. It says that, it starts form the time of pregnancy diagnosis and continue through delivery and postnatal care (MOH, 1998). In order to get healthy reproductive life one should take care of a women of age group (15-49) because this period is considered as reproductively active period. So maternity care should be provided through the beginning up to the end.

Every year more than 200 million females become pregnant in the world. Most pregnancies end with the birth of live babies to a healthy mother. However child birth is not a joyous event. Mother of developing world has says “ I am going to

sea to fetch the baby, the journey is so long and dangerous, I may not return"(UNFPA, 2000).

World wide more than 60 millions women delivered at home with out skilled care. About 530,000 women die from pregnancy related complications, with some 68,000 of those deaths resulting from unsafe abortion. About 4 million babies die with in the first month of life. And more than 3 millions die as still births. Moreover, nearly 99 percent maternal, new born and child death occur in low and middle income countries (PRB,2006). Many women in the developing world do not have the privilege of the access to basic health care services during pregnancy and child birth. Women often delivered in unhygienic surroundings, with out help of trained birth attendant, which increases the risk to both mother and new born baby, resulting unhappy outcomes.

Maternity health is one of the major issue of reproductive health. Maternal mortality is the reflector of the socio-economic development of the country and is an effective index to the quality of maternity care services in any given country. In south central Asia, the high rate of maternal mortality ratio(MMR) are estimated for Afghanistan (1,900), Nepal (740) and India (540) where as the ratio for Japan is 10 (UNFPA 2004:103).

A national survey conducted in 1996 estimated the MMR at 539 per 100,000 live birth. In Nepal. Significant proportion (18.9) of maternal deaths occurs in adolescent age groups and there is also high prevalence of chronic energy deficiency among adolescent girls. Most of the teenager mother die due to the causes of child birth (MOH,1998). In Nepal, about 89 percent of all women deliver babies at home and a nurse or doctor attends only 11 percent. The child bearing age (15-49) years constituted 2 percent of the total population. Nepali women suffering from pregnancy complications are very high and consequently this risk increase as these women under go multiple pregnancies during their reproductive

age (MOH, New ERA and Orc Macro,2002). The disease anemia is a serious problem through out the Nepalese life cycle. More than 78 percent of pre school children and 75 percent of pregnant women suffer from anemia in rural area of Nepal (Helen Keller International, 1998).

Nepal has one of the highest maternal mortality rate in the world, many of the mother die because they don't get basic treatment before, during and after delivery. The matter male involvement in safe mother hood is the most crucial aspect for surviving women life.

Maternity care practice depend upon the place of residence, level of education, availability of health facility, traditional believes, socio-economic condition and caste/ethnicity of the people. Maternity care practice is likely to higher in upper caste ethnic groups then that of lower caste/ethnic group. The high fertility is also more pronounced in backward and depressed communities i.e; Dalit Janajati. Communities which are backward in the context of economic, social, cultural and education are known as Dalit community and are supposed to be so called untouchable (Manab Maryada, 1999).

In it's etymological definition, Dr. Harka Gurung says " the term Dalit has close relationship with Nepali words dalai or dalnu which means to crush, exploit, oppress or suppress" that expression can be applied to the people who have been oppressed. The basis of such oppression, exploitation and exclusion of Dalit is caste discrimination (Gurung, H. 2005). Dalit are the groups of people who are religiously culturally, socially and economically oppressed who could belong to different language and ethnic groups (Koirala,1996). However, from the constitution of Nepal, there is no any caste discrimination. The status of dalit is still lower in Nepalese society and are dominated by other caste and ethnic groups socio-economically, religiously and politically.

In Nepal many sub-caste/ ethnic groups such as Damai, Kami, Sarki, Kumal, Meche, Mushar Chamar, Badhee, Khatwe, Dusadh, Gaine, etc are with in the dalit community (CBS,2001). Among them Damai, Kami and Sarki have the larger number than other dalit in Nepal. For the national development, the socio-econonic status should be up graded and behaviorally the discrimination should be ended. Hence this study tries to expose the maternal health care practice of dalit and non dalit community which shows the contributing factors to determine the high fertility behavior, lower socio-economic status, lack of awareness, lower status of maternal and child health care services and practices.

Women of dalit community, especially in reproductive age, are more vulnerable than non dalit women. In Nepal, women are far from education, health facility empowerment and participation of decision making even about their own life. In case of dalit women, they are just passed their life with poverty, illiteracy and dependency. In, Nepal, the major health problems comprises high maternal and child mortality, prevalence of communicable diseases, environmental pollution, high fertility rate, rapid population growth and poor health care status. Majority of the people are deprived from safe drinking water and modern health facility. Women strongly desire to have son for the socio-economic security and prestige in the society (Dahal,1999).

In Nepal most people are illiterate. They do not know about the maternity care and its importance, so fertility as well as mortality rate is high. due to lack of knowledge and awareness regarding maternity health care. Ultimately they suffer from morbidity and mortality. Nepalese mothers have many traditional believes, habits, norms, values and customs regarding the maternal and child health care. Their practice are not safe because they don't go for regular antenatal check-up, attend delivery at home without septic precaution, cut the cord with unsafe instrument and post natal period. The Nepalese mother has very low educational

status and directly or indirectly, it has adverse effect on colostrum feeding, immunization against communicable diseases and use of contraceptives.

In Nepal many of the women are compelled to die because of three delays such as: delay in seeking care, delay in reaching care, and delay in receiving care, particularly postnatal visit is lower than anti-natal visit. Based on this fact, it is necessary to investigate the involvement of men in maternal health. Husband are the nearest supporter for wives and almost of the time they live together (pokhrel,2003) .

The maternal health covers the following aspects:

Anti natal Care (ANC)

Anti natal care is one of the important parts of maternity care. It assures for the well being of the mother and her child. Anti-natal care includes all type of care of pregnant mother before delivery.

Delivery Care (DC)

Delivery care means care during delivery or child birth. It also known as infrontal care or intra-partum care. Fundamental objective of delivery care is to protect the life and health of mother and her child by ensuring the delivery of a baby safely and healthy.

Post-natal Care (PNC)

Post natal care means care of baby or mother after delivery. The fundamental objective of the postnatal care is to ensure physical and psychological wellbeing of mother and child in the first six weeks of the delivery.

ANC, DC, and PNC can improve the maternal health. But Nepal, it is uncommon. Still 51 percent mother do not receive ANC by any other means. DC also not better. 55 percent women give birth with the help of relatives or friends and 9

percent give birth at home. Nearly 80 percent of mother delivers out side the health facilities. Less than one in 5 mother receives post natal care. Most of the deaths of the mothers and baby occur during 48 hours after delivery (NDHS 2001). Each year about 529 thousand or one every minute women die as a results of pregnancy and child birth, all most all 90% of these events occurs in the developing countries. Haemorrhage, sepsis, complication of abortion, preeclampica and eclampsia, and prolong labour are the major cause of maternal death.. There are considerable variation between countries and even in the individual communities countries. In the developing countries women has one in 61 chance of dying in pregnancy and child birth. In developed countries just one in 28,000 and in case of Nepal one in every 10 women die due to the complication of pregnancy and child birth(WHO 2001.

1.2 Statement of the Problem

UNFPA, 2003 estimated the MMR for the world is 400 and 20 for the developed region and 440 for the developing regions. In many developing countries maternal death account for 25 to 33 percent of death of women of child bearing age. It is estimated that 585,000 women die in developing countries to every year because of pregnancy and child birth (UNFPA, 2003).

In some developing countries like Afghanistan, Bhutan, Bangladesh, India, Nepal, Pakistan, Shrilanka etc, the situation of maternal health is not satisfactory. Maternal mortality problem is the most important indicator that, life is extra ordinarily difficult for women in Afghanistan.

The maternal mortality studies in 2002 shows a MMR of 16000 per 100,000 live birth. in Bangladesh. There is seen pregnancy complications being unable to meet the cost annunciated with seeking care and being ignorant about health care, facing a death without medicines, equipments and health personnel.

In Pakistan, there is a lacking access to good medical facilities and care for pregnant women. Every 20 minutes a women losses her life while giving birth. due to lack of .knowledge and skills of the health provider. There was extreme shortage of essential supplies and equipment. The record keeping was very poor and referral system was not in place.

Shrilanka has the MMR 124 per lakh live birth in 1996. The common causes of MMR has been haemorrhage , including hypertension and abortion (UNICEF, 2004).

Nepal has one of the highest maternal mortality ratio in the world. Coverage of ANC, DC, and PNC services throughout the country is still low but at increasing trend. There are many problems of safe mother hood due to lack of sufficient staff (doctors, nurse, ANM, MCHW), pregnancy among <20 years age group. Home delivery conducted by HW is not increased satisfactorily and not fully recorded. In addition, poor practice of referral services of EOC, hospital, nursing home, deliver records not in corporate fully in Nepal. 4rth visit still low in comparison to ANC first visit as well as PNC visit, low coverage of ANC, DC, and PNC services. In most of the district inadequate EOC and insufficient health facilities (DOH,2060/61).

In Hetauda municipality ward no. 11, of Makawanpur districts, there is a tole of a community containing both dalit and non dalit families. Especially dalit women, are far from education and modernization. IEC has not been able to produce satisfactory result among dalit community. There are limited facilities and services in urban area, so dalit women are deprived from the maternity care services compared to non dalit women .Maternity care is most important aspect of human life, but most of the studies and research left out of this issues and maternity care services couldn’t reach to the socio-economically and politically deprived group which is known as dalit.

The chosen area is economically fragile, socially backward, agricultural based and 5 Km away from urban area. Forther more, the minority people are really outreach from the modern resource in the every steps. The main purpose of this study is to investigate the accessibility of maternity care services and their utilization as well as difference between anti-natal and post-natal care practice among the backward people of study area.

1.3 Significance of the study

Reproductive health issues are the burning issues in all over the world. Various research have been made at international level focusing on the situation and the problems regarding maternal health.. In Nepal very little researches are conducted in this issue. Annually lots of mother die at reproductive span and some may suffer from reproductive health problem. The study is most important for the practice of maternal health and present health condition of reproductive age group of dalit and non dalit mother. The study designed to obtained the level of education, economic condition, knowledge and practice about maternity care services including the ANC, DC and PNC, condition and relationship with impact on other demographic event. During study it is found that there are some conflicts with pregnant women that they are suffering from iron deficiency, lack of nutrition food behavior during the time of ANC, DC and PNC. In this area, women have to do hard work in gestation period and have no sufficient nutrition too. Hence, this study focus on the situation of maternity care practices including ANC, DC, and PNC in dalit and non-dalit women of reproductive age. This study is comparative study on caste/ethnical base. The study tries to focus on situation differential of utilization of maternity care practices among dalit and non dalit community.

Some of the studies were made previously in Nepal but each of them either has focused on lower caste perspective and sometime higher caste but none of the study has tried to compare between the caste/ ethnical characteristics. This studies

has produced useful information for the national RH strategy. This study also endorses the completeness of the national health program. Therefore, the study will be useful to all level of people. The result will be applicable in both community level and national level. The research will provide further way out for other researchers. The main sprit of this research is to access the level of knowledge and practice of maternity care among dalit and non dalit women age (15-49) years.

1.4 Objective of the Study

This research is focused on the maternity care practice of dalit and non dalit ever married women aged (15-49) years.

The study incorporates the following objectives.

- To evaluate the knowledge and practice of maternity care among dalit and non dalit women age (15-49) years.
- To examine the accessibility of maternity care services at study area.
- To examine the difference between Anti-natal and Post-natal care among Dalit and non dalit women age (15-49) years.

1.5 Limitation of the study

This study has following limitations;

- The study is based on maternity care practice of dalits and non dalit women of Makawanpur district only, there fore, the whole national scenario may not be represented.
- The respondents of this study are married women of reproductive age (15-49) years.
- In this study, post natal period is regarded as one month after delivery, there fore it may not be appropriate to analyze for whole postnatal period.

1.6 Organization of the study

This study is organized in to six chapters. The first chapter covers introduction, which includes general background of the study, statement of the problem, objective of the study significance of the study, limitation of the study and organization of the study.

The second chapter deals with literature review, and conceptual framework. The third chapter is about methodology, under this chapter background of the study area, research design, sampling procedure of sample size, sources of data, research tools, data collection technique, data tabulation and analysis and selection of variables.

Chapter four describes about the house hold population, where socio-economic and demographic composition are presented and describe about the socio-economic and demographic characteristics of respondents. Here is detailed information of ever married women age (15-49) years.

Chapter five describes about maternity care practices of the respondents with various socio-economic and demographic variables that affect the ANC, DC and PNC in reproductive age of ever married women of the study area.

Chapter six of availability and accessibility of health facility.

Chapter seven consists maternal health behavior and selected variables.

Chapter eight consists of summary of findings, conclusions, recommendation and further research issues.

Chapter Two

2.1 Literature Review

This chapter deals with review of some selected studies relevant to the maternal health care practice in Nepal. The economic and education of women and traditional practices and customs have played and important role on maternal health. Some of the fact, opinions, principles and study reports directly and indirectly related to the study are reviewed and presented here.

The safe motherhood program in Nepal has adopted two major strategies to improve maternal health provide around the clock essential obstetric services and ensure the presence of skilled attendants at delivery, especially at home setting and promoting birth preparedness and complication readiness by preparing for blood, transpiration and money deliveries (MOH, 2002)

In 1987, WHO,UNICEF,UNFPA, the World Bank and other organization directly concerned with maternal health, launch the safe motherhood initiative. Although strong commitment is for government and development partners and implementing many activities has been achieved. More efforts are needed to further reduce MMR and IMR as state in the Millennium Development Goals (MDGs).

In the Millennium Development Goals framework to indicators, have been purposed to monitor improvement in maternal health, namely, the maternal mortality ratio and the proportion of birth attendant by a skilled health care provider with the target of 90 percent by 2015. The concept of skilled attained should be well understood, to allow effective implementation we all lead to ensure that the millennium development goals to reduce MMR and IMR and improve maternal and new born health are placed at the center of national planning.

In order to achieve the targets set in the MDGs, including improving the quality of maternal health services, partnership among all stake holders are crucial, coordinated activities among programs and plans will provide more productive results.

More collaboration should be sought among government institution, professional organization, development partners and NGOs. We will be straightened in order to improve the implementation of the maternal and new born health programs in which member country (EHO, Regional Office for South East Asia, New Delhi,2004). South Asia present a paradoxical picture in level of maternal mortality. On one hand, it has the dubious distinction of having countries with some of the highest level of maternal mortality in the world and on the other hand it has a country like Srilanka with a low level of maternal mortality ratio in the world is part of west Asia. The top 5 causes of death and disability are the same (in varying proportions) in all countries and they are haemorrhage, sepsis, eclampsia, preeclampsia, obstruct labour and unsafe abortion. It is well known that for every women who dies another thirty suffer injuries, injection and disabilities during pregnancy and child birth. tn the region, obstetric fistula and uterine prolapsed are increasing being recognized as an important RH problem (UNFPA,2002).

For a women to obtained antenatal care, she most be able to leave her duties which include child care, house work and other task. Some programs have attempted to build support for women's temporary absence from household and professional and to inform women, their families and community about the importance of seeking antenatal care. An evaluation of motherhood information, education and communication program in Pakistan eg there was a market improvement in knowledge regarding preventive measures that women should take during pregnancy, because of high prevalence of pregnancy related domestic violence, some experts content that all women attending antenatal care should also be screen

domestic violence (By Elizabeth, I Ranson Nancy V. Yinger;Making Motherhood Saffer: February, 2002; Population Reference Bureau, page no.12-13).

Nepal has a high maternal mortality all over the world. According to chaudhari R.H (1999), currently married adolescents women in general tend to receive more antenatal care, compared to older women. The majority of them still don't seek antenatal care in Pakistan and Bangladesh. The proportion of currently married women seeking antenatal care is lowest in Pakistan(26%),followed by Bangladesh (29%) and highest in Nepal (44%), followed by India (35%0. In Pakistan only 29percent adolescent women were immunized against tetanus. The proportion of pregnant adolescent women immunized against tetanus was highest in Bangladesh(80%), followed by India (63%). Nepal occupies the intermediate position with (56%) of pregnant women immunized Tetanus.

Chaudhari 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 countries of the region. The proportion of births of currently married women attended by health of workers in lowest in Nepal and Bangladesh where this is highest in India followed by Pakistan.

Ministry of Health, Nepal Family Health Survey(1996), has explained a sub stantial differences in the use of antenatal care services between urban and rural areas. Over all utilization in 79 percent higher in urban areas than in rural areas, and urban women are using doctors , nurse and midwifes much more frequently than rural women. Utilization of antenatal services is higher in the terai than hill and mountain regions. The western mountain, sub-region, is especially

underserved. In the eastern central and western terai, sub-regions, the situation is some what better than previous year(MOH,NFHS;1996).

In Nepal ANC is not satisfactory, over all one in two pregnant mother received ANC. 28 percent mother received ANC either from doctor(17%), Nurse/ANM(11%). Another (11%) mother received anti-natal care from HA or AHWS. VHW provided a anti-natal care to (6%) women. And MCHW provided care to (6%) of mother. TBA provided anti-natal care to less than 1% of mothers. (51%) mothers did not receive any anti-natal care. (45%) women receive two or more TT injection during pregnancy. While (9%) mother received one dose of TT injection and (45%) mother did not received even single dose of TT injection(NDHS,2001). It also reveled that total ANC coverage of Nepal is 49 percent.

According to NDHS,2006, 44 percent of mothers received antenatal care from skilled birth attendants (SBAs),that is , from a doctor, nurse or midwife, for their most recent birth in the five year preceding the survey. In addition, 28 percent of mother received antenatal care from trained health workers such as a heath assistant or auxiliary health worker, a maternal and child health worker, or a village health worker. Less than 2 percent of women received antenatal or a female community health volunteer. 26 percent of women received no ANC for births in the five years before the survey.

Younger mothers (less than 20 years) are more likely to receive ANC from SBAs than older mother (20-49). Mothers are also much more likely to receive care from SBAs for their first birth (59%) than births of six and higher (17%).

There are large differences in the use of ANC services between urban and rural women. 85 percent of urban mothers received ANC from SBA, compared with only 38 percent of rural mothers. Nearly one in two mothers living in the Hills

received ANC from SBA, compared with 32 percent of mother from the mountains and 43 percent of mothers living in the far-western region. ANC from SBA ranged from low 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.

The use of ANC services from SBA is strongly related to the mother's level of education. Women with SLC and higher level of education are three times more likely to receive ANC from SBA(90%) than women with no education(29%). Similarly, women in the highest wealth quintile were five times more likely to receive care from SBA (84%) than women in the lowest wealth quintile (18%). More than one fourth (29%) of m pregnant women make four or more ANC visits during their entire pregnancy. Urban women (52%) are twice as likely as rural women (26%) to have received four or more antenatal visits.

Nearly four out of five mothers (78%) with a birth in the five years preceding the survey were protected against neo-natal tetanus. However, less than two- thirds (63%) of pregnant women received two or more tetanus injections during their last pregnancy.

Younger mother less than 20 years of age and mothers of lower order births are more likely to have received two or more tetanus injections during their last pregnancy then older mothers age 35-49 (38%) mothers of higher order births (40%).88 percent of the mothers with SLC or higher education received at least two injections during their last pregnancy, compared with 55 percent of mothers with no education. Similarly 79 percent of mothers received at least two doze of tetanus toxoid injection, compared with 39 percent mother in the lowest quintile. (NDHS,2006). Proper medical attention and hygienic conditions, during delivery can reduce the risk of complications and injections that may cause the death or serious ill ness of the mother and baby or both.

Skilled health professionals a person who has mid-wife skills and skill health include doctor, nurse, and other health workers who can diagnose and manage complication during child birth, it is important because millions of women and new born develops complications, during or immediately after delivery. How ever, there is shortage of these professionals especially in developing countries, where 60 million live birth each year with out help of skilled health professional (WHO, 1997). Prenatal mortality studies points to the link between the health of mother and the birth outcomes. The high prenatal mortality rate 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 child hood mortality rates(WHO Bulletin,2000).

Due to socio-cultural norms, traditional behavior and practices, mass illiteracy, delivery care is not better in Nepal.

Still percent women give birth with the help of relative or friend and about 9 percent give birth alone. 9 percent delivered under health facilities compare with 89 percent at home. 1 percent by MCHWs, 23 percent TBAS, while 11 percent birth took place with out assistance. The 2001 NDHS data indicates that about one in 5 births(21%) was reported as being very small or smaller than average. Nearly 80 percent of mothers report that heir baby was of average size or larger at birth.

Now a days, Nepal is promoting safe motherhood through various activities, especially, delivery by skilled birth attendants, as a result the proportion of delivery care is increasing order than previous, NDHS 2006, revealed that 18 percent of births take place in a health facility 13 percent are delivered in a public sector health facility, 4 percent in non government facilities and less than 1 percent in a private facility. Four out of 5 birth (81%) take place at home. Delivery in a health facility is more common among younger mother (21%), mother of first birth

order birth (32%) and mothers who have had at least four ANC visits (41%). Almost half (48%) of the children in urban areas are born in a health facility compared with 14 percent in rural areas. Obstetric care from a trained provider during delivery is recognized as critical for the reduction of maternal and neonatal mortality. Less than one- fifth (19%) of birth take place with the assistance of SBAs, health assistant or health assistant in delivery at 4 percent of births, FCHVS assistant in 2 percent of deliveries, and traditional birth attendants assistance from a relative or some other person for nearly one in two births , while 7 percent of births take place with out any type of assistance at all.

SBAs are more likely to attend births to young mothers (22% and 33% respectively). One in two urban births(51%) is assisted by SBA, compared with 14 percent of births in rural areas. Birth in the hill zone, in the central region and especially in the central hill sub-region are most likely to be attended by SBA.

There is strong relation ship between mother's education and delivery by SBA. Births to highly educated women (SLC or Higher education) are nearly nine times (71%) as likely as birth to uneducated mother (8%) to receive assistance from SBA. Birth preparedness by the pregnant women and her family is important in ensuring appropriate care during delivery. More over birth preparedness is also believed to reduce two out of three delays in getting delivery services (Department of Health Services, 2006). More than one in three women (37%) saved money for delivery, 9 percent bought a home delivery kit, 4 percent contacted a health workers and about 26 percent arranged for food and clothing for new born. Man's response different some what from women's responses. 54 percent of men mentioned that they saved money for the birth, 10 percent of men said they bought a home delivery kit, 9 percent contacted a health worker and 6 percent of men said they did not make any preparation for the birth of their youngest child(NDHS2006).

Uterine prolapsed occurs when the uterus has moved from it's normal position in the abdominal cavity, usually in to a lower position. Prolapsed uterus may occur because of underlying weak muscles, or simply as a result of repeated term pregnancies. Uterine prolapsed is considered a major cause of maternal morbidity among women in Nepal. The UNFPA estimates that there may be around 600,000 women with uterine prolapsed in Nepal(UNFPA,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. Safe mother hood programs emphasize the important 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 Services, 2006).

In most of the developing countries, most maternal death took place after delivery. The mother should have a post natal checkup with in to days of delivery, because large number of maternal and neonatal death are occurs during 48 hour after delivery.

In Nepal, nearly 80 percent of mother who delivered out side the health facilities do not receive post-natal check up. Less then one in five mother receive post-natal care after the delivery. As in Nepal most of the death of mother accrue after delivery. It account 62 percent in urban and 86 per cent in rural area. 17.1 percent mother received postnatal care with in 2 days of delivery and 3-6 days after delivery 0.8 percent mother received post natal care and 2.7 percent mother received post natal care 7-41 days after delivery. And 79 percent mother did not receive post natal checkup after delivery (NDHS,2001).

One third (33%) of women received postnatal check care for their last birth. One in five mother received postnatal care within four hours of delivery, more than

one in four (27%) received care with in the first 24 Hours and 4 percent of women were seen 1-2 days following delivery. Differences by mother's age birth order, place of resident , wealth quintile and education are pronounced. Younger mothers less than twenty 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 postnatal care with in the first 24 hours than their counterparts. 19 percent of mothers received postnatal care from SBA, and 3 percent of mothers received postnatal care from a traditional birth attendant. Mothers of first order births, mother with SLC and higher education, those from the wealthiest household, and those in urban areas are more likely to have received post natal care from SBA than other mothr . 22 percent of mothers had a pelvic examination during their postnatal checkup (NDHS,2006).

Many factors can prevent women from getting medical advise or treatment for themselves when they are sick. Information on such factors is particularly important in understanding and seeking care, reaching care and receiving care during pregnancy at the time of delivery and after delivery.

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 then ever before not lest because they are becoming aware of their rights. With today's knowledge and technology, the vast majority of the problem that threaten the worlds mother and children can be prevented and treated. Most of the millions of death's that occur are avoidable, as each much of suffering that comes with ill health. In all cultures, family and communities knowledge the need to care for mother and children and try to do so to the best of their ability(WHO,2005).

2.2 Safe mother hood Policy and Major Strategies.

Nepal Safe mother hood Policy (SMH),1998 is one of the several new post ICPD national policy developed and adopted after HMG/N endorsed the Cairo ICPD program of action. The Family Health Division of the MOH is identified as the agency responsible for the implementation and collaboration of all maternal health related activities under the SMH program. HMGs policy statement regarding safe mother hood indicates that;

- The Ministry of Health's Safe mother hood program will be HMG's main thrust to reduce maternal and neonatal mortality in Nepal.
- The program main focus will be on the improvement of maternity care services including family planning, at all levels of the health care delivery system and in the community.
- In conjunction with the MOH's programs efforts will also be made to improve the general status of women by promoting program aimed at bringing about attitudinal, behavioral and social changes regarding women's health concerns.

Major strategies

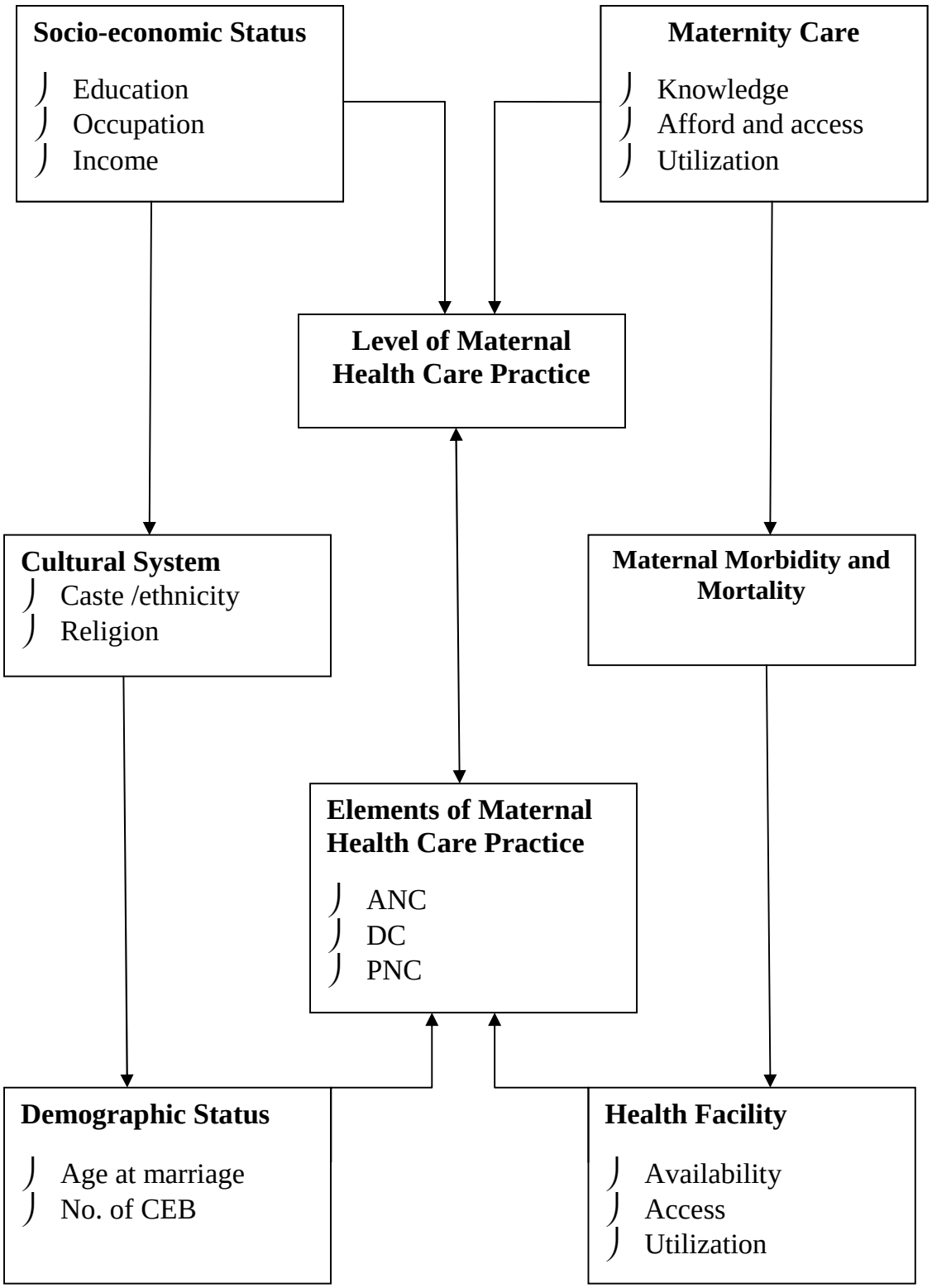
- Promoting inter sectoral collaboration in order to attain the aims of safe mother hoods.
- Strengthening and expanding basic maternity care services, including family planning, at all institutional levels,
- Raising the status of women so that maternal morbidity and mortality will be reduced: and
- Promoting research on safe motherhood.

2.3 Conceptual frame work

Maternity care is one of the prime element of the reproductive health and it is directly associated with maternal, infant, child morbidity and mortality rate. There

are four pillars of maternity care such as: Anti natal care, Delivery care postnatal care and over all maternal care.

Figure 1: Conceptual framework for maternal health care practices



Chapter- Three

3. Research Methodology

This is the field based study which incorporates the most talking issues of today's life. This study has been made to compare the maternity care practice among dalit and non-dalit women aged (15-49) years. The study has been based in primary data.. Data for this study were collected from the field survey with the help of structured questionnaire.

3.1 Research design

Descriptive research design has been used to identify the phenomenon of the study and has been made on the event which has been already put into existence. It is comparative study, which identifies the differential in maternity care practice among dalit and non dalit community. Comparison of the respondents have made on caste/ ethnical bases.

3.2 Study area

The study area was purposively selected. and was carried in the two caste group of communities – dalit and non-dalit of Hetauda municipality ward no. 11, Makawanpur district which lies 5 km away from Hetauda Municipality. According to 2001 census , the total population of ward no. 11 is 5765, among them female 2,828 and male 2,937 (CBS,2001). Many caste/ethnic group of people have their residence in the study area such as Brahman, Chhetri, Gurung, Magar, Newar, Damai, Kami and Sarki.

3.4 Sample size

100 households with at least one ever married female with in ward no. 11 of Hetauda municipality were randomly selected out of which 50 house hold (out of 97 household) were from dalit group in the ratio of 1:2 and 50 household (out of1133 household) were from non dalit group in the ratio of nearly 1:23 by using simple random sampling method. In total 100 respondents were selected for the interview as follows:

Target population	Sample size
Dalit women	50
Non-Dalit women	50
Total	100

3.5 Data collection

The study is totally based in the primary data. The 100 respondents selected for the interview were the main source of the information. The structured and semi structured questionnaires were used for collection of data. Direct personal interview method was applied with the help of structure questionnaire to collect the information from the respondents.

3.6 Data Analysis

After completion of field work, the raw information were checked, edited, coded and entered in computer analysis and managed by using SPSS soft were. Percentage distribution, frequency and cross tables have been used to manage the raw data which interprets the tables and cases count and comparing with other variables.

3.7 Study variables and issues

In this study, maternity care practice of ever married women of reproductive age (15-49) is dependent variables. The socio-economic status, cultural system and demographic status are independent variables. Knowledge afford, access of maternity care, maternal morbidity and mortality and factor related to health facilities are intermediate variables.

Chapter Four

4. Socio- economic and Demographic characteristic

Socio-economic and demographic distribution is the major way of characterizing of the population. The way of distribution produces an aggregate tool for over all analysis of the objectives in social research problems. Most common and major aspects of the socio- economic and demographic perspective such as age, religion, caste/ ethnicity, literacy status, house hold facilities and occupation are enumerated under this chapter. Therefore, this chapter is organized to provide a descriptive knowledge on the mentioned characteristics of the respondents.

4.1 Distribution of respondents by age

Age structure plays an important role in over all demographic structure, therefore, age composition of the population is one of the major consideration of the demographic analysis. For the survey, total 30 percent respondent of both cast are reported in age group 25-29 and 30 –34. Among non dalit the highest percentage of respodents are in age group 25-29 followed by 35 + and 30- 34 years. Among dalits, the highest percentages of respondents are in age group 35+ followed by 30-34 years and lowest percentage are in age group up to 24 years. (Table 1).

Table 1 Percentage distribution of the respondents by age group of the respondent

Age group	Non-dalit	Dalit	Total
Up to 24		14.0	7.0
25-29	40.0	20.0	30.0
30-34	32.0	28.0	30.0
35 +	28.0	38.0	33.0
Median age	32.5	32.0	32.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.2 Distribution of Respondent by religion

The population census 2001 has shown that over 80 percent of the Nepalese are Hindu. This character is well applied in this survey also. Hindu is the major religion in both dalit and non dalit caste. Forty six percent dalits and 60 percent non dalit respondents are reported to be Hindu. The second religion is Buddhist and third comes to be Christian in both caste which is 44 percent and 10 percent in dalit and 28 and 12 percent in non dalit caste respectively (Table 2).

Table 2 Percentage distribution of the respondents by religion

Religion	Dalit	Non dalit	Total
Hindu	46.0	60.0	53.0
Buddhist	44.0	28.0	36.0
Christian	10.0	12.0	11.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.3 Distribution of Respondents by caste/ethnicity

Caste/ethnicity is one of the major components to determine the demographic characteristic of a particular area. It is one of the major social characteristics that has an effective role over the total attitudinal perspective.

The largest caste is reported to be Brahman(48.0%) in non dalit and Kami (54.0%) in dalit respectively followed by is Chhetri (22.0%) for non dalit and Sarki (24%) for dalit. Twenty two percent respondents are reported as Damai,, Magar (10.0%), Newar(6.0%) and Gurung (14.0%) respectively.

Table 3: Distribution of Respondents by caste/ethnicity

Caste of the respondents	N	Total
Brahman	60.0	30.0
Chhetri	36.0	18.0
Magar	4.0	2.0
Damai	24.0	12.0
Kami	74.0	37.0
Sarki	2.0	1.0
Total	100.0	100.0
N	100.0	100.0

Source: Field survey 2007

4.4 Distribution of respondent by type of family

One of the major effects of modernization is the concept of nuclear family from joint family. Nuclear family is more famous in non dalit community than dalit.

Table 4 Percentage distribution of the respondents by type of family

Type of family	Dalit	Non dalit	Total
Nuclear	24.0	68.0	46.0
Joint	76.0	32.0	54.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

Among non-dalit , the highest percentage of families are reported to be nuclear and among dalits the highest percentage of families are reported to be joints.

4.5 Distribution of respondent by literacy status

Literacy is the major factor to bring change in people's attitude. Impact of literacy status in reproductive health issue is more evaluated. Out of total 100 respondents, 76 percent are reported to literate and 24 percent are illiterate in both

community. Among non dalits the highest percentages of literate is 94.0 and among dalits highest percentages of literate is 58.0.

Table 5 Percentage distribution of the respondents by education status

Education Status	Non-dalit	Dalit	Total
Literate	94.0	58.0	76.0
Illiterate	6.0	42.0	24.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.6 Distribution of respondents by complete level of education

Among non dalits, the highest percentage of respondents have completed secondary level of education followed by S.L.C, lower secondary, non formal, 10+2, and primary level of education. Among dalits the highest percentage of respondents have completed lower secondary level of education followed by primary, secondary and non formal. None of the dalit respondents have completed 10+2 level of education..

The proportion of lower level of education is higher in dalit community and higher level of education is higher in non dalit community. This disparity shows that very little people of dalit community have completed their higher study.

Table 6 Percentage distribution of the respondents by complete classes loower se

Complete class	Non-dalit	Dalit	Total
Primary	4.3	34.5	15.8
Lower secondary	19.1	41.4	27.6
Secondary	27.7	20.7	25.0
S L C	25.5	-	15.8
10+2	10.6	-	6.6
Non formal	12.8	3.4	9.2
Total	100.0	100.0	100.0
N	47	29	76

Source: Field survey 2007

4.7 Distribution of respondent by occupation.

Economic activities is one of the strong indicators of economic development of the country. Economic development is linked with the overall development of the area. Occupation is linked with the level of educational attainment and with the total change of life standard.

Out of total 100 respondents, three fourth are reported to engaged in agriculture and daily wages compared to other occupation. The major occupation of dalit is daily wages (34.0%) but agriculture comes to the top for non dalit (44.0%). The second major occupation for non dalit respondents is daily wages (36.0%) where as agriculture (28.0%) is the second major occupation of the dalit. Ten percent of the dalit respondents are engaged in business and 6 percent are in trade. Sixteen percent dalit respondents are engaged in iron pot making. None of the non dalit respondents are engaged in services. About12 percent and 8 percent non dalit respondents are engaged in business and trade respectively which is larger than dalit

Table 7 Percentage distribution of the respondents by occupation

Occupation	Dalit	Non dalit	Total
Agriculture	28.0	44.0	36.0
Business	10.0	12.0	11.0
Trade	6.0	8.0	7.0
Service	4.0		2.0
Daily wages	34.0	36.0	35.0
Iron pot maker	18.0		9.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.8 Distribution of the respondents by food sufficiency

Out of 100 total respondents 21 percent respondents are reported to have sufficient food and 79 percent respondents from both caste are reported to have no sufficient food diet. In comparison to dalits, non dalits have good sufficient food which is due to the cause of sound socio-economic condition of non-dalit community.

Table 8 Percentage distribution of the respondents by food sufficiency

Food sufficiency	Dalit	Non dalit	Total
Yes	16.0	26.0	21.0
No	84.0	74.0	79.0
Totals	100.0	100.0	100.0
N	50	50	100

Source: Field survey 200

4.9 Distribution of respondents by Household facilities

Household facilities indicate the economic status of the family. Economically sound family may be better in other aspects too.

4.9.1: Type of House

Out of total 100 respondents, 30 percent respondents have concrete house, 17 percent have stone with concrete joint, 27 percent have stone with mud joint and 26 percent have bamboo joint in both caste. Among non-dalits, highest percentage of respondents have concrete houses followed by stone with concrete joint, stone with mud joint and bamboo joint houses. Among dalits, highest percentage of respondents have bamboo joint houses followed by stone with mud joint , stone with concrete joint and concrete houses. It shows that majority of the pakki house is found in non dalits than dalits.

Table 9 Percentage distribution of the respondents by type of house

Type of house	Dalit	Non dalit	Total
Concrete	2.0	58.0	30.0
Stone with concrete joint	8.0	26.0	17.0
Stone with mud joint	42.0	12.0	27.0
Bamboo joint	48.0	4.0	26.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.9.2 Type of Toilet

Hundred percent respondents are reported to have toilet facility. The highest percentage of respondents are reported to have open toilet in both castes. Among non dalits 44 percent respondents have pit toilet followed by bush/field toilets. Among dalits, 26 percent respondents have pit toilet followed by bush/field toilets. Two percent dalit respondent are using flush toilets but none of the non dalit respondents have used such toilets.

The table reveled that every respondent have had the knowledge of sanitation and personal hygiene because availability of toilet facilities is one of the major indicator of sanitation.

Table 10 Percentage distribution of the respondents by type of Toilet

Type of toilet	Dalit	Non dalit	Total
Pit toilet	26.5	44.0	35.4
Open toilet	69.5	52.0	60.6
Bush/field toilet	2.0	4.0	4.0
Flush toilet	2.0		1.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.9.3 Distribution of respondents by house hold facilities

Highest percentage of respondents have electricity, radio and television in both castes Followed by electricity and radio and radio only. Comparatively bio-gas and telephone users are less percentage in both castes .

Table 11 Percentage distribution of the respondents by household facilities

Household facilities	Dalit	Non dalit	Total
Radio	14.0	16.0	15.0
Bio-gas	4.0	8.0	6.0
Telephone	2.0	6.0	4.0
Electricity	4.0	2.0	3.0
Electricity, radio, television.	30.0	32.0	31.0
Electricity, radio	32.0	22.0	27.0
All of above	14.0	14.0	14.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.9.4 Source of Fuel

More than one third of the respondents are used both kerosene and fire wood as well as bio-gas and kerosene together as a source of fuel.

Out of total 100 respondents 16 percent respondents are using bio-gas as a sources of fuel. Among non-dalits, kerosene and fire wood users have highest percentage followed by bio-gas, fire wood and cylinder gas users. Among dalits, firewood users have highest percentages followed by kerosene and firewood, bio-gas, and cylinder users.

Table 12 Percentage distribution of the respondents by source of fuel

Source of fuel	Dalit	Non dalit	Total
Bio-gas	10.0	22.0	16.0
Cylinder	4.0	12.0	8.0
Kerosene	-	2.0	1.0
Fire wood	54.0	20.0	37.0
Kerosene, fire wood	32.0	42.0	37.0
Bio-gas, kerosene	-	2.0	1.0
Total	100.0	100.0	100.0
N	50	50	100

Source :Field survey 2007

4.10 Distribution of respondents by age at marriage

Marriage occurs relatively early in Nepal. More than 50 percent respondents got married between the age 17-20 years. Among non-dalits,the highest percentages of marriage age is 17-20 years followed by 13-16 years and 21 and above years. Among dalits, the highst percentages of marriage age is 13-16 years followed by 17-20 years and 21 and above years. Comparatively Dalit respondents gets marriage in earlier age.

Table 13 Percentage distribution of the respondents by age at marriage

Age at marriage	Dalit	Non Dalit	Total
13-16	52.0	36.0	44.0
17-20	42.0	60.0	51.0
21 and above	6.0	4.0	5.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

4.11 Distribution of respondent by total number of children

Out of total 100 respondents the highest percentageof respondents have given 3 birth in their reproductive life in both castes. Among non-dalits 20 percent mother have given 2 birth followed by 12.0 percent mother have given 4 birth,8.0 percent mother have given 6 birth, 6.0 percent mother have given one birth and 4.0 percent mother have given 7 birth in their reproductive life.

Among dalits, 22 percent mother have given 2 birth followed by 18.0 percent mother have given 4 birth, 12.0 percent mother have given 5 birth, 10.0 percent mother have given 6 birth and 8.0 percent have given one birth and 6.0 percents mother have given 7 birth in their reproductive life. In comparison to non dalit women, dalit women have given higher number of birth (6 and 7) in their reproductive life.

Table 14 Percentage distribution of the respondents by CEB

CEB	Dalit	Non dalit	Total
1	8.0	6.0	7.0
2	22.0	20.0	21.0
3	24.0	30.0	27.0
4	18.0	12.0	15.0
5	12.0	20.0	16.0
6	10.0	8.0	9.0
7	6.0	4.0	5.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

Chapter Five

5. Maternal Health

Maternal health is one of the major issues of reproductive health. Maternal mortality is the reflector of the socio- economic development of the country. Nepal has one of the highest maternal mortality rates in the world. Many of the mother die because they don't get basic treatment before, during and after delivery. Many of the women are compelled to die because of late transportation to health facility when they are in delivery problem. Similarly antenatal and postnatal visit also comparatively lower in Nepal. Particularly, post natal visit is lower than antenatal visit. Still IEC could not play active role to provide information about utilization of maternal and child health. Lower female literacy rate is one of the major cause of maternal and child morbidity and mortality. The chapter aims to provide information of the maternal health of women relating antenatal care ,delivery care, and post natal care.

5.1 Distribution of respondent by knowledge of maternity care

A question, "Have you ever heard about maternity care?" was asked to assess the knowledge of maternity care. 'Yes' was consider as knowledgeable and 'No' was not having knowledge.

Out of total 100 respondents 66 percent have knowledge about maternity care and 34 percent have no knowledge about maternity care. Among non- dalit highest percentage of respondents have knowledge about maternity care and among dalits highest percentage of respondents have no knowledge about maternity care. The results are some what controversial, more of the non dalits have more knowledge about maternity care compared to dalits.

Table15Percentage distribution of the respondents by knowledge of maternity care

Knowledge of maternity care	Dalit	Non dalit	Total
Yes	46.0	86.0	66.0
No	54.0	14.0	34.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.2 Source of knowledge

Communication is one of the infrastructures to develop the sense of people. Radio is the major and most popular communication media. It has integral role in enhancing the knowledge of maternity care.

Out of 100 total respondents 54 percent have heard about maternity care from radio. Among non- dalits, the highest percentage of respondents have heared about maternity care from radio followed by radio/television, family/dfriend private clinicand own self. Among dalits, the highest percentage of rspondents have heard about maternity care from radio followed by radio/television, family/friend, telivision and health workers.

Table 16 Percentage distribution of the respondents by source of knowledge

Source of knowledge	Dalit	Non dalit	Total
Radio	66.7	46.5	53.7
Television	4.2	4.7	4.5
Private clinic		9.3	6.0
Family		7.0	4.5
Friend	4.2		1.5
Radio, Television	12.5	14.0	13.4
Health workers ,	4.2		1.5
Family, Friend	8.3	11.6	10.4
Own self		7.0	4.5
Total	100.0	100.0	100.0
N	24	43	67

Source: Field Survey 2007

5.3 Knowledge Of TT

A question, “Have you ever heard about TT?” was asked to assess the knowledge of tetanus toxoid . ‘Yes’ was consider as knowledgeable and ‘No’ was not having knowledge.

Out of 100 respondents 72.0 percent have knowledge about TT and 20.0 percent have no knowledge about TT. Among non-dalits 94.0 percent respondents have knowledge about Tt and among dalits, 50 percent respondents have knowledge about TT.

Table 17 Percentage distribution of the respondents by knowledge of TT

Knowledge of TT	Dalit	Non dalit	Total
Yes	50.0	94.0	72.0
No	50.0	6.0	28.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.4 TT dose taken before delivery

Majority of the respondents have taken two or more dose of TT for both castes. Among non-dalits, the highest percentages of respondents have taken 2 dose of TT followed by one dose of TT. Among dalits, sthe highest percentages of responents have taken 2 dose of TT followed by 3 dose, one dose and 4 and above dose of TT.

Table 18 Percentage distribution of the respondents by dose taken before delivery

Dose taken before delivery	Dalit	Non dalit	Total
1dose	11.5	12.8	12.3
2dose	53.8	59.6	57.5
3 dose	30.8	27.7	28.8
4dose and above	3.8		1.4
Total	100.0	100.0	100.0
N	26	47	73

Source: Field survey 2007

5.5 Knowledge of Iron Tablets

A question, “Have you ever heard about Iron Tablets ?” was asked to assess the knowledge of Iron Tablets. ‘Yes’ was consider as knowledgeable and ‘No’ was not having knowledge.

Among non-dalits, 84.0 percents respondents have knowledge about iron tables and among dalits, 78.0 percent respondents have knowledge about iron tablets.

Table 19 Percentage distribution of the respondents by knowledge of iron tablets

Knowledge of iron tab	Dalit	Non dalit	Total
Yes	78.0	84.0	81.0
No	22.0	16.0	19.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.6 Knowledge of Anemia

A question, “Have you ever heard about anemia?” was asked to assess the knowledge of anemia. ‘Yes’ was considered as knowledgeable and ‘No’ was not having knowledge.

Highest percentage of respondents have no knowledge about anaemia in both castes. In comparison, the proposition of having knowledge is higher in non dalit community than dalit community.

Table 20 Percentage distribution of the respondents by knowledge of anemia

Knowledge Of Anemia	Dalit	Non dalit	Total
Yes	36.0	42.0	39.0
No	64.0	58.0	61.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.7 Antenatal care

The quality of ANC can be assessed by the number of ANC visit, mothers level of education and kind of information's that mother has gained during their visits.

5.7.1 ANC visit

A question, "Have you ever been to visit ANC?" was asked to measure the visit for Antenatal Care. 'Yes' was consider as visit ANC and 'No' was not visiting ANC. Out of total 100 respondents, 85 percent have visited ANC and 15 percent have never visited ANC. Highest percent of respondents have visit ANC in both caste. The proportion of visiting ANC is higher in non dalits compared to dalits.

Table 21 Percentage distribution of the respondents by visit for ANC

Visit for ANC	Dalit	Non dalit	Total
Yes	82.0	88.0	85.0
No	18.0	12.0	15.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.8.2 Frequency of ANC visit

The frequency of ANC visit ranges from one to over four times in an average pregnancy cases.

Among non-dalits, 38.6 percent respondents have visited ANC 4 times followed by 29.5 percent have visited visited 2 times, 15.9 percent have visited 3 times, 11.4 percent have visited one time and 4.0 percent have visited ANC 4 times and above. Among dalits, 39.0 percent respondentsd have visited ANC one time followed by 26.8 percent have visited 2 times, 19.5 percent have visited 3 times, 9.8 percent have visited 4 times and 4.9 percent have visited 4 times and above. The frequency of four times visit ANC is higher in non dalit than dalit respondents.

Table 22 Percentage distribution of the respondents by time of visit ANC

Frequency of ANC	Dalit	Non dalit	Total
1 time	39.0	11.4	24.7
2time	26.8	29.5	28.2
3time	19.5	15.9	17.6
4 time	9.8	38.6	24.7
4 time and above	4.9	4.5	4.7
Total	100.0	100.0	100.0
N	41	44	85

Source: Field survey 2007

5.8.3 Purpose to visit ANC

Out of total 100 respondents 21 percent respondents have visited ANC to get idea about the position and incensement of foetus and 32 percent respondents have visited ANC to get advice about maternal and child health. Among non-dalits, The highest percentage of respondent have visited ANC to get idea about the position and incensement of foetus and among dalits, the highest percentage of respondents have visited ANC to know the position and incensement of foetus and to get advice from health personnel about maternal and child health.

Table 23 Percentage distribution of the respondents by purpose to visiting

Purpose to visit	Dalit	Non dalit	Total
To know the position and incensement of foetus	19.5	22.7	21.2
To get advice	26.8	36.4	31.8
Both of above	53.7	38.6	45.9
Others		2.3	1.2
Total	100.0	100.0	100.0
N	41	44	85

Source: Field survey 2007

5.8.4 Sexual intercourse after conceive

Out of 100 respondents, the highest percentage of respondents have reported continued sexual intercourse till three months of pregnancy. Among non- dalits, 30.0 percent respondents have continued sexual intercourse till 4 month of pregnancy followed by 5 month (24.05) and 6 month(6%) of pregnancy. Among dalits, 20 percent respondents have reported continued sexual intercourse till 4 months of pregnancy followed by 5 month (18.0%) and 6 month(16.0%), 7 month (12.0%) and 8 month (2.0%)of pregnancy. The proportion of continued sexual intercourse till 5 month is higher in non dalit couple where as till 7 months is higher in dalit couple.

Table 25 Percentage distribution of the respondents by sexual intercourse during pregnancy.

Month	Dalit	Non dalit	Total
3	32.0	36.0	34.0
4	20.0	30.0	25.0
5	18.0	24.0	21.0
6	16.0	6.0	11.0
7	12.0	2.0	7.0
8	2.0	2.0	2.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.9 Delivery care

Proper medical attention and hygienic condition during delivery can reduce the risk of complication and infections 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 mother and children is to increase the proportion of babies delivered in a safe and clean environment and under the supervision of health professionals.

5.9.1 Knowledge of safe delivery kit.

A question, "Have you ever heard about safe delivery kit?" was asked to assess the knowledge of safe delivery kit. 'Yes' was consider as knowledgeable and 'No' was not having knowledge.

Among non- dalits highest percentage of respondents have knowledge about safe delivery kit. And among dalits, highest percentage of respondents have no knowledge about safe delivery kit.

Table 26 Percentage distribution of the respondents by knowledge of safe delivery kit

Knowledge of safe delivery kit	Dalit	Non dalit	Total
Yes	30.0	82.0	56.0
No	70.0	18.0	44.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.9.2 Place of Delivery

Place of delivery is one of the major component to determine the morbidity and mortality pattern of mother and children. In Nepal most of the birth are delivered at home.

Out of total 100 respondents 47percent respondents were delivered at home and 45 percents respondents were delivered in hospital. Among non-dalits, highest percentage of respondents were delivered in hospital followed by 26.0 percent at

home and 14.0 percent in private clinic. Among dalits 68 percent respondents were delivered at home followed by 30 percent in hospital and 2.0 percent in health post.The proportion of respondents delivered at home is higher in dalit community than non dalits and the proportion of respondents delivered at hospital is higher in non dalit.

Table 27 Percentage distribution of the respondents by place of delivery

Place of delivery	Dalit	Non dalit	Total
Home	68.0	26.0	47.0
Health Post	2.0	-	1.0
Hospital	30.0	60.0	45.0
Private clinic	-	14.0	7.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.9.3 Presence of assistant during child birth

Delivery assistance plays an important role in reducing the maternal and child morbidity and mortality. Many mother die due to unsafe delivery and lack of presence of proper assistant during delivery time.

Among non-dalits, 46 percent respondents were assisted by doctors followed by AHW/HA/Nurse (26.0%), house hold member (20.0%),TBA (6.0%)and friend/relatives (2.0%). Among dalits, 62.0 percent of respondent were assisted by household members followed by doctors (30.0%), AHW/HA/Nurse(6.0%) and friends/relatives (2.0%).. In comparison, higher percentage of dalits respondents were assisted by household member than non dalit and higher percent of non dalit respondents were assisted by doctors compared to dalits.

Table 28 Percentage distribution of the respondents by assistant of child birth

Assistant	Dalit	Non dalit	Total
TBA		6.0	3.0
Household member	62.0	20.0	41.0
AHW/HA/Nurse	6.0	26.0	16.0
Doctor	30.0	46.0	38.0
Friends/ Relatives	2.0	2.0	2.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.9.4 Problem at the time of birth

A question, “Have you ever got the problem at the time of birth ?” was asked to know the problem at the time of birth. ‘Yes’ was consider as have problem and ‘No’ was not having problem.

Out of total 100 percent respondents, 62.0 percent had problem at the time of birth and 38.0 percent had not having problem at the time of birth. Among non-dalit, 34.0 percent respondents had problem at the time of birth and among dalit and 90.0 percent respondents had problem at the time of birth. Comparatively most of the dalit respondents had problem at the time of birth than non dalits.

Table 29 Percentage distribution of the respondents by problem at the time of birth

Problem at the time of birth	Dalit	Non dalit	Total
Yes	90.0	34.0	62.0
No	10.0	66.0	38.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.9.5 Kinds of problem at the time of birth

Among non-dalits, 50 percent respondents had problem i.e. excessive bleeding. And fever at the time of birth and among dalits, 37.3 percent had excessive bleeding followed by bad smelling of vaginal discharge (31.6%) and fever (31.1%).

Table 30 Percentage distribution of the respondents by kinds of problem at the time of birth

Kinds of problems	Dalit	Non dalit	Total
Excessive bleeding	37.3	50.0	41.7
Fever	31.1	50.0	36.1
Bad smelling of vaginal discharge	31.6	-	22.2
Total	100.0	100.0	100.0
N	45	17	62

Source: Field survey 2007

5.10 Postnatal Care

A large propotion of maternal and neonatal deaths occurs during the 24 hours follwing delivery. In addition, the first two days are critical for monitoring complications arising from 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 emphasizes the importance of post natal care, recommending that all women should receive at least two post natal check up and iron supplementation for 45 days following a delivery (Department of Health Services,2006a)

Compared to ANC the tendency of taking PNC is very low in Nepal. Postnatal care has an optimistic role in reducing maternal and child health vulnerability and morbidity pattern. In this study one month period after delivery is regarded as post natal period.

5.11 Problem After Delivery

In Nepal most of the women die due to puerperal cause. Most of the women get problem after delivery. In the study area, rational placenta is the major causes of maternal morbidity and mortality.

Out of total100respondents, 88 percent respondents had problems after delivery and 20 percent respondents had no problems after delivery. Among non- dalit 78 percent respondents had problems after delivery and among dalits, 98.0 percent respondents had problems after delivery. The proportion of having problem is higher in dalit community than non dalits.

Table31Percentage distribution of the respondents by problem after delivery

Problem After Delivery	Dalit	Non dalit	Total
Yes	98.0	78.0	88.0
No	2.0	22.0	12.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.12 Type of Problem

Out of total100 respondents, rational placenta is the main problem for both caste. , among non-dalits, 19.5 percent respondents reported for stomach paining and foot soiling (14.6%) followed by Obstructed labuor (19.5%), accessive bleeding (17.1%),and fever (9.8%). Among dalits, 22.4 percent respondents reported for stomach paining followed by Obstructed labuor (16.3%), Fever (14.3%), excessive bleeding (10.2%) and foot swelling (6.1%). than dalit after child birth.

Table 32 Percentage distribution of the respondents by type of problem

Type of problem	Dalit	Non dalit	Total
Stomach paining	22.4	14.6	18.9
Foot soiling	6.1	14.6	10.0
Fever	14.3	9.8	12.2
Rational placenta	26.5	24.4	25.6
Obstructed labuor	16.3	19.5	17.8
Excessive bleeding	10.2	17.1	13.3
Others	4.1		2.2
Total	100.0	100.0	100.0
N	49	41	90

Source: Field survey 2007

5.13 Receive of Postnatal Care services

Out of total 100 respondents,84.0 percent had received PNC services in both castes. Among non dalits, 92.0 percent had receive PNC after delivery and among dalits, 76.0 percent respondents had received PNC after delivery. Comparatively most of the non dalits received PNC services than dalit.

Table 33 Percentage distribution of the respondents by PNC receive

PNC receive	Dalit	Non dalit	Total
Yes	76.0	92.0	84.0
No	24.0	8.0	16.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

5.14 Timing for PNC services

Out of total100 respondents, 13 percent respondents had obtained PNC services within two days of delivery and 19 percent respondents had obtained PNC services within first week of delivery . Among non-dalits, the highest percentage

of obtaining PNC services is before 15 days of delivery (30.4%) followed by before one month (21.7%), with in first week 919.6%), with in two days (15.2%) and after one month (13.0%). Among dalits, the highest percentage of obtaining PNC services is after one month (28.9%) followed by before 15 days and one months (21.1%), with in first week (18.4%) and with in two days (10.5%) of delivery..

Table 34 Percentage distribution of the respondents by timing for PNC services

Timing for PNC services	Dalit	Non dalit	Total
With in two days	10.5	15.2	13.1
With in first week	18.4	19.6	19.0
Before 15 days	21.1	30.4	26.2
Before one month	21.1	21.7	21.4
After one month	28.9	13.0	20.2
Total	100.0	100.0	100.0
N	38	46	84

Source: Field survey 2007

Chapter Six

6. Availability and accessibility of health services

Availability and accessibility of health services is an important factor for reducing maternal and child morbidity and mortality. Most of the Nepalese mother die because of lack of proper health services. Still 81 percent birth delivered at home and may be the result of lacking health facilities (NDHS 2006).

6.1 Health services

A question, "Is there any health facility near by your locality?" was asked to assess the availability of health services. 'Yes' was consider as available and 'No' was not available.

Out of total 100 respondents, 58 percent are reported having health facility and 42 percent respondents reported not having health services. Among non dalit highest percentage of respondents (84%) percent respondents reported having health facility and among dalit, highest percentage of respondents reported not having health services. Comparatively non dalits were more familiar with health facilities than dalits.

Table 35 Percentage distribution of the respondents by Available of Health services

Health Facilities	Dalit	Non dalit	Total
Yes	32.0	84.0	58.0
No	68.0	16.0	42.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

6.2 Distance between house and health facility

"Delay in reaching" is one of the most important cause of maternal death which is determined by distant of health facility from their resident.

Out of total 100 respondents, 57 percent respondents reported that they have availability of health facility in less than 1 km distance from their residence and 9 percent respondent are reported to have health facility about 2 km far from their residence. Among non-dalits, 76.0 percent reported that they have availability of health facility in less than 1 km followed by 2km. 3km,and 4km. among dalits, 38.0 percent respondents reported that they have availability of health facility in less than 1 km distance from their residence followed by 4 and more km (28.0%), 3 km (24.0%), and 2km (10.0%). Comparatively non dalit respondent have near by health facility than dalit.

Table 36 Percentage distribution of the respondents by distant from house

Distant from house	Dalit	Non dalit	Total
<1km	38.0	76.0	57.0
2km	10.0	8.0	9.0
3km	24.0	8.0	16.0
4km+	28.0	8.0	18.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

6.3 Accessibility of transportation facility

Transportation facility also determines the morbidity and mortality rate of both mother and her child. Due to vague geographical structure, transportation facility is not available every where in Nepal.

Out of total 100 respondents, 57.0 percent respondents reaches in health facility by on foot and 43.0 percent respondents reaches in health facility by buses. Among non-dalit highest percentages (60.0%) of respondents reaches in health facility by buses and among dalits, highest percentages (74.0%) of respondents reaches in health facility by on foot.

Table 37 Percentage distribution of the respondents by transportation

Transportation	Dalit	Non dalit	Total
On foot	74.0	40.0	57.0
By bus	26.0	60.0	43.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

6.4 Nutritional food behavior

Nutrition is major factor to determine the sound health of both mother and child. Due to lack of nutritional food more than 75 percent mother and her child suffer from malnutrition.

Out of total 100 respondents, 51.0 percent respondents reported that they have good nutritional food behavior, 44.0 percent reported that they had not bad nutritional food behavior and 5.0 percent reported that they had bad nutritional food behavior at the time of post natal period . Among non-dalits, 56.0 percent respondents reported that they have good nutritional food behavior at the time of post natal period followed by 40.0 percent reported that they had not bad nutritional food behavior and 4.0 percent reported that they had bad nutritional food behavior at the time of post natal period . Among dalts, the highest percentage (48.0%) reported that they they had not bad nutritional food behavior followed by good (46.0%).and bad (6.0%) nutritional food behavior at the time of

post natal period. Comparatively non dalits respondents had batter nutritional food behavior than dalits.

Table 38 Percentage distribution of the respondents by nutritional food behavior at the time of PNC period

Nutritional food behavior	Dalit	Non dalit	Total
Good	46.0	56.0	51.0
Not bad	48.0	40.0	44.0
Bad	6.0	4.0	5.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

6.5 Immunization services

Out of total100 respondents, 79 percent respondents reported that they provided immunization services for their children and 21 percent respondents reported that they have never provided immunization services for their children. Among non-dalits,highest percentage (98.0%) of respondents reported that they provided immunization services for their children and among dalits, 60 percent reported that they provided immunization services for their children . Where 40 percent dalits and 2 percent non-dalits reported that they have never provided immunization services for their children. Comparatively nearby cent percent non-dalits mother had provided immunization services for their children.

Table 39 Percentage distribution of the respondents by immunization services for child at the period of PNC

Immunization service	Dalit	Non dalit	Total
Yes	60.0	98.0	79.0
No	40.0	2.0	21.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

6.6 Sexual Intercourse after Delivery

Among non-dalits, highest percentages(40%) of respondents had started sexual intercourse after2 month of delivery followed by 3 month (20.0%), 6month (12.0%), 5 month, 7 month (6.0%) and 8 month (2.0%). Among dalits, 40.0 percent of respondents had started sexual intercourse after 3 month of delivery followed by 2 month (22.0%), 4month (12.0%), 5 month (10.0%), 6 month (4.0%) and 8 month (2.0%)..The proportion of starting sexual intercourse after delivery is relatively higher in dalit couple than non dalits.

Table 40 Percentage distribution of the respondents by sexual intercourse after delivery

Sexual intercourse after delivery(M)	Dalit	Non dalit	Total
1	10.0	8.0	9.0
2	22.0	40.0	31.0
3	40.0	20.0	30.0
4	12.0	6.0	9.0
5	10.0	6.0	8.0
6	4.0	12.0	8.0
7		6.0	3.0
8	2.0	2.0	2.0
Total	100.0	100.0	100.0
N	50	50	100

Source: Field survey 2007

Chapter Seven

7. Maternal health behavior of the respondents

The main objective of this chapter is to deal with socio-economic and demographic factors that can affect the maternity care in reproductive age in ever married women. Antenatal care, delivery care and post natal care are the major component of maternal health and is measured in terms of socio-economic and demographic characteristics .

7.1 Age group of mother and timing For ANC Visit

ANC is more beneficial is preventing adverse pregnancy outcome when it is sought early in the pregnancy and is continued through delivery. WHO recommended that a women with out complications should have at least 4 times ANC visit to provide sufficient antenatal care.

Table 41 Percentage distribution of the respondents by timing for ANC visit by age group of respondent

Caste	Age group	Timing for ANC visit					Total	
		1 time	2 time	3 time	4 time	4 time and above	%	N
Non-dalit	25-29	6.3	50.0		37.5	6.3	100.0	16
	30-34	20.0	20.0	33.3	20.0	6.7	100.0	15
	35+	7.7	15.4	15.4	61.5	-	100.0	13
	Total	11.4	29.5	15.9	38.6	4.5	100.0	44
Dalit	Up to 24	57.1	-	14.3	-	28.6	100.0	7
	25-29	33.3	33.3	22.2	11.1	-	100.0	9
	30-34	27.3	36.4	18.2	18.2	-	100.0	11
	35+	42.9	28.6	21.4	7.1	-	100.0	14
	Total	39.0	26.8	19.5	9.8	4.9	100.0	41

Source: Field survey 2007

Younger mothers are more likely to visit ANC than older. But here the result is somewhat controversial, i.e non-dalit mother of age group 35+ is more likely to visit ANC than other age group. Out of total 7 dalit respondents 57.1 percent mother visited ANC once at a time and 28.6 percent mother visited ANC more than 4 times. Non dalit women of age group 25-29 likes to visit three times more ANC than dalit .

7.2 Complete level of education and timing for ANC visit

Timing for ANC visit is strongly related to the mother's level of education. Non dalit women with 10+2 level and secondary level education are more likely to visit ANC 4 times and above than lower level of education where as dalit women with primary level is more likely to visit ANC 4 times and above than higher level of education.

Table 42 Percentage distribution of the respondents timing for ANC service by complete class

Caste	Complete class	Time of visiting ANC					Total	
		1 time	2 time	3 time	4 time	4 time and above	%	N
Non-dalit	Primary	100.0	-	-	-	-	100.0	1
	Lower secondary	12.5	37.5	12.5	37.5	-	100.0	8
	Secondary	18.2	9.1	18.2	45.5	9.1	100.0	11
	S l c	9.1	36.4	18.2	36.4	-	100.0	11
	10+2	-	25.0	25.0	25.0	25.0	100.0	4
	Non formal	-	33.3	-	66.7	-	100.0	6
	Total	12.2	26.8	14.6	41.5	4.9	100.0	41
Dalit	Primary	50.0	12.5	-	12.5	25.0	100.0	8
	Lower secondary	45.5	9.1	45.5	-	-	100.0	11
	Secondary	40.0	60.0	-	-	-	100.0	5
	Non formal	-	-	100.0	-	-	100.0	1
	Total	44.0	20.0	24.0	4.0	8.0	100.0	25

Source : Field survey 2007

7.3 Age group and place of delivery.

There is a strong relationship between delivered in health facility and age group of women. Younger mother are more likely to deliver in health facility than their counter parts.

Non-dalit women of age group 25-29 are more likely to deliver in hospital than dalit mother. Similarly, older mother are more likely to deliver at home than their counterparts. Twenty nine percent non dalit mother of age group 35 and above do not like to deliver at home than dalit mother (78.9%).

Table 43 Percentage distribution of the respondents by place of delivery by age group of respondent

Caste	Age group	Place of delivery				Total	
		home	health center	hospital	private clinic	%	N
Non-dalit	25-29	25.0	-	62.0	15.0	100.0	20
	30-34	25.0	-	60.5	12.5	100.0	16
	35+	28.6	-	57.1	14.3	100.0	14
	Total	26.0	-	60.0	14.0	100.0	50
Dalit	Up to 24	57.1	-	42.9	-	100.0	7
	25-29	40.0	10.0	50.0	-	100.0	10
	30-34	78.6	-	21.4	-	100.0	14
	35+	78.9	-	21.1	-	100.0	19
	Total	68.0	2.0	30.0	-	100.0	50

Source Field survey 2007

7.4 Education status and place of delivery.

Place of delivery is strongly related to the mother's education level. Educated women are more likely to deliver in health facilities than their counterparts. Women with lower secondary and secondary level education more likely to deliver in hospital. Non-dalit women with SLC (58.0%) and 10+2 (80.0%) level

education more likely to deliver in hospital. Out of total 15 percent non dalit mother 22 percent (out of 9) lower secondary level followed by 15percent (out of 13) secondary level and 17 percent (out of 12) SLC level delivered in private clinic and non of the dalit respondents had delivered in private clinic.

Comparatively, dalit women are more likely to deliver at home than non dalit women. Fifty percent non dalit women with non formal education had delivered at home where as all dalit mother with non formal education had delivered at home. Hence delivery in health facility is strongly related with socio- economic condition of the concerned mother.

Table 44 Percentage distribution of the respondents by place of delivery by Complete class

Caste	Complete class	Place of delivery				Total	
		home	health center	hospital	private clinic	%	N
Non-dalit	Primary	50.0	-	-	50.0	100.0	2
	Lower secondary	11.1	-	66.7	22.2	100.0	9
	Secondary	23.1	-	61.5	15.4	100.0	13
	S L C	25.0	-	58.3	16.7	100.0	12
	10+2	20.0	-	80.0	-	100.0	5
	Non formal	50.0	-	50.0	-	100.0	6
	Total	25.5	-	59.6	14.9	100.0	47
Dalit	Primary	70.0	-	30.0	-	100.0	10
	Lower secondary	50.0	8.3	41.7	--	100.0	12
	Secondary	33.3	-	66.7	-	100.0	6
	Non formal	100.0	-	-	-	100.0	1
	Total	55.2	3.4	41.4	-	100.0	29

Source: Field survey 2007

7.5 Age group of mother and timing for PNC service

In non dalit community, younger mother (age group 25-29) prefere to receive PNC within two days of delivery than their counterparts but in dalit community mother of age group 30-34 prefere to receive PNC within two days of delivery and the proportion of receiving PNC services is higher in before 15 days of delivery in non-dalit community where as it is higher in after one month of delivery in dalit community. Frequency of PNC visit is higher (32.0%) in non- dalit women (age group 25-29) before one month of delivery where as it is higher (38.0%) in dalit mother (age group 25-29) with in first week of delivery.

Table 45 Percentage distribution of the respondents by timing for PNC services by age group of respondent

Caste	Age group	Timing for PNC services					Total	
		with in two days	with in first week	before 15 days	before one month	after one month	%	N
Non-dalit	25-29	21.1	10.5	26.3	31.6	10.5	100.0	19
	30-34	21.4	21.4	35.7	14.3	7.1	100.0	14
	35+		30.8	30.8	15.4	23.1	100.0	13
	Total	15.2	19.6	30.4	21.7	13.0	100.0	46
Dalit	Up to 24		20.0		20.0	60.0	100.0	5
	25-29	12.5	37.5	25.0		25.0	100.0	8
	30-34	18.2	18.2	9.1	27.3	27.3	100.0	11
	35+	7.1	7.1	35.7	28.6	21.4	100.0	14
	Total	10.5	18.4	21.1	21.1	28.9	100.0	38

Source: Field survey 2007

7.6 Education and timing for PNC service

Timing for PNC services is strongly related to the level of mother's education. Dalit women with secondary level (20.0%) more likely to receive PNC within two days of delivery than non-dalit women (17.0%). The proportion of receiving PNC services is higher in dalit mother with secondary level education (40.0%) before 15 days of delivery where as it is higher in non-dalit women with 10+2 level education (60.0%) within first week of delivery.

Table 46 Percentage distribution of the respondents timing for PNC service by complete class

Caste	complete class	Timing for PNC services					Total	
		with in two days	with in first week	before 15 days	before one month	after one month	%	N
Non-dalit	Primary			50.0	50.0		100.0	2
	Lower secondary		22.2	33.3	22.2	22.2	100.0	9
	Secondary	16.7	8.3	33.3	33.3	8.3	100.0	12
	S L C	30.0	10.0	20.0	20.0	20.0	100.0	10
	10+2		60.0	40.0			100.0	5
	Non formal	16.7	33.3	33.3		16.7	100.0	6
	Total	15.9	20.5	29.5	20.5	13.6	100.0	44
Dalit	Primary		25.0	12.5	37.5	25.0	100.0	8
	Lower secondary	33.3	22.2			44.4	100.0	9
	Secondary	20.0	20.0	40.0	20.0		100.0	5
	Non formal		100.0				100.0	1
	Total	17.4	26.1	13.0	17.4	26.1	100.0	23

Source: Field survey 2007

Chapter Eight

8. Findings, conclusion and recommendations

This study has been organized to find out the level of maternity care practices among ever married dalit and non dalit women of reproductive age group (15-49). Only selected components of maternity care have been taken into account because of interest and limitations. This is comparative study examining the differences of maternity care practices between dalit and non dalit women. The study is based on the primary data obtained from 100 respondents,50 from each dalits and non dalits.

8.1 Summary Findings

The following are the major findings of the study.

1. Background characteristic of respondents

The highest percentage of the respondent is in age group 35+ (38.0%) for dalit and age group for 25-29 (40.0%) for non-dalit respondents where as lowest percentage of the respondents are in age group upto 24 (14.0%) for dalit and age group 35 + (28.0%) for non dalit respondents. Over all median age for both caste is 32 years.
Hindu is the major religion for both castes with around 50 percent for each of the castes.
The major caste for non dalit - Brahman (60.0%) followed by Chhetri (36.0%) and Magar (4.0%) and for dalit -Kami (74.0%) followed by Damai (24.0%) and Sarki (2.0%).
Sixty eight percent families are nuclear in non dalit community where as 24 percent families are nuclear in dalit community. Seventy six percent families are joint in dalit community where as 32 percent are in non-dalit.

Differences observed between non dalit and dalit respondents in terms of literacy status, highest percent of non dalit respondents (94.0%) are literate where as highest percent of dalit respondents, 58 percent are literate. Highest percent of non-dalit respondents (28.0%) have completed secondary level education where as 21 percent dalit respondents have completed secondary level education level.

Agricultural is the major occupation for non dalit respondents (44.0%) where as daily wages is the major occupation for dalit respondents (34.0%).

Non-dalit respondents(26.0%) have got sufficient food compared to dalit respondents (16.0%).

Most of the non dalit respondents (58.0%) have concrete house where as most of the dalit respondent (48.0%) have bamboo joint houses.

Open toilet is the main toilet facility for both castes. About 52 percent non dalit respondents and 70 percent dalit respondents are using open toilets.

About 32 percent non dalit respondents have electricity, radio, and television facilities where as 32 percent dalit respondents have only electricity and radio facility.

Kerosene and fire wood is the main source of fuel for non dalit respondents where as only fire wood is the main source of fuel for dalit respondents.

Highest percent of non dalit respondents (60.0%) got married between the age of 17-20 years where as dalit respondents (52.0%) got married between the age of 13-16 years.

Higher percentage of mothers had given three birth in both castes- 30 percent non dalit and 24 percent dalit.

2. Maternal Health

Knowledge of maternity care is more pronounced in non dalit community than dalit community. About 86 and 46 percent non dalit and dalit mother have the knowledge of maternity care respectively.

Radio is the most commom source of information for both dalit and non dalit respondents . About 46 percent non dalit and 67 percent dalit mother have heard about maternity care from radio. Comparatively, non dalits have more knowledge about maternity care practices than dalits and also revealed that non dalit are more familiar with modern source of information than dalits.

Nearly three fourth of the total respondents from both castes have knowledge about TT. The results showed that higher percentage of non dalits have more knowledge about TT compared to dalits.

About 28 percent non dalit mother and 31 percent dalit mother had taken 3 dose of TT and only 3 percent dalit mother had taken four dose of TT.

More than 80 percent respondents for both castes have the knowledge about Iron tablets.

Less than 50 percent respondents for both castes have the knowledge about Anemia.

3. Antenatal Care

Highest percent of both respondents are reported to visit ANC before delivery. Equal percentage (5.0%) of both non dalit and dalit respondents have visited ANC more than 4 times where as 39 percent non dalit and 10 percent dalit respondents have visited to ANC for four times.

Highest percentage of dallit mother (54.0%) have visited ANC for the purpose to know the position and incensement of foetus and to get advise from the health personnel's as compared to non dalit mother (39.0%).

Highest percent of both dalit (20.0%) and non dalit (30.0%) mothers have continued sexual intercourse during the period of 4 month pregnancy.

4. Delivery Care

In total more than 50 percent respondents have the knowledge about safe delivery kits. Eighty two percent non dalit and 30 percent dalit respondents have the knowledge about safe delivery kits.

Highest percent of non dalit women (60%) delivered in hospital as compared to dalit(30.0%). Sixty eight percent dalit women delivered at home as compared to non-dalit (26.0%).

Forty six percent non dalit mother are reported to assisted by doctor as compared to dalit (30.0%).Sixty two percent dalit mother assisted by household member as compared to non-dalit (20.0%).

Thirty four percent non dait mother and 90 percent dalit mother had the problem at the time of child birth.

Excessive bleeding is the main problem for both non dalit (50.0%) and dalit (38.0%) mother at the time of child birth.

Highest number of mother from both castes have reported that they had problem after child birth, i.e. 78 percent non dalit mother and 98 percent dalit mother respectively.

Rational placenta (prolapse) is the major problem after child birth for both castes,i.e. 24 percent in non dalit mother and 27 percent in dalit mother respectively.

5. Postnatal Care

Over 80 percent mother received PNC service, i.e. 92 percent non dalit mother and 76 percent dalit mother respectively.

Highest percentage of both dalit and non dalit respondents reported that they received PNC before 15 days of delivery, i.e. 30 percent non dalit and 21 percent dalit mother respectively.

Eighty four percent non dalit mother reported to have health facility as compared to dalit (32.0%).

In total more than 50 percent mother reported that they have health facility less than 1 km far from their house.

Forty percent non dalit mother and 74 percent dalit mother use to avail their health facility by on foot. Sixty percent non dalit mother and 20 percent dalit mother use to avail their health facility by buses.

Non dalit mother (56.0%) reported to have good nutritional food behavior than dalit mother (46.0%).

Non dalit mother (98%)and dalit mother (60%) reported that they have provided immunization services for their children at the period of PNC.

Forty percent non dalit mother reported that they started their sexual intercourse after 2 month of delivery as compare to dalit (22.0%). Forty percent dalit mother reported that they started their sexual intercourse after 3 month of delivery as compare to non-dalit (20.0%).

6. Maternal Health Practice and Selected Variables.

Younger mothers are more likely to visit ANC than older. Out of total 7 dalit respondents 57.1 percent mother visited ANC once at a time and 28.6 percent mother visited ANC more than 4 times. Non dalit women of age group 25-29 likes to visit three times more ANC than dalit.

Timing for ANC visit is strongly related to the mother's level of education. Non dalit women with 10+2 level and secondary level education are more likely to visit ANC 4 times and above than lower level of education where as dalit women with primary level is more likely to visit ANC 4 times and above than higher level of education.

Non-dalit women of age group 25-29 are more likely to deliver in hospital than dalit mother. Similarly, older mother are more likely to deliver at home than their

counterparts. Twenty nine percent non dalit mother of age group 35 and above do not like to deliver at home than dalit mother (78.9%).

Non-dalit women with SLC (58.0%) and 10+2 (80.0%) level education more likely to deliver in hospital. Out of total 15 percent non dalit mother 22 percent (out of 9) lower secondary level followed by 15percent (out of 13) secondary level and 17 percent (out of 12) SLC level delivered in private clinic and non of the dalit respondents had delivered in private clinic.

Comparatively, dalit women are more likely to deliver at home than non dalit women. Fifty percent non dalit women with non formal education had delivered at home where as all dalit mother with non formal education had delivered at home. Hence delivery in health facility is strongly related with socio- economic condition of the concerned mother.

In non dalit community, younger mother (age group 25-29) prefer to receive PNC within two days of delivery than their counterparts but in dalit community mother of age group 30-34 prefer to receive PNC within two days of delivery and the proportion of receiving PNC services is higher in before 15 days of delivery in non-dalit community where as it is higher in after one month of delivery in dalit community.

Frequency of PNC visit is higher (32.0%) in non- dalit women (age group 25-29) before one month of delivery where as it is higher (38.0%) in dalit mother (age group 25-29) with in first week of delivery.

Dalit women with secondary level (20.0%) more likely to receive PNC within two days of delivery than non-dalit women (17.0%). The proportion of receiving PNC services is higher in dalit mother with secondary level education (40.0%) before 15 days of delivery where as it is higher in non-dalit women with 10+2 level education (60.0%) within first week of delivery.

8.2 Conclusion

This study is primarily responsible for differentiating the characteristics of the respondents on the basis of caste/ ethnicity. Generally, this study takes into views

that non-dalit women are simultaneously more serious in the case of maternity care as they have better knowledge because of advancement in development and understanding system. Therefore, this study is targeted to identify the degree of maternity care practices. The investigations have been made with the selected variables of maternal health.

Over all median age for both castes is 32 years. Hindu is the major religion for both castes with around 50 percent for each of the castes .The major caste for non-dalit - Brahman(60.0%) followed by Chhetri (36.0%) and Magar (4.0%) and for dalit - Kami (74.0%) followed by Damai (24.0%) and Sarki (2.0%).

Two children family is being popular among non-dalit respondents and similarly, the family size is being reduced in dalit community also. It may be because of affect of modernization.

Differences observed between non dalit and dalit respondents in terms of literacy status, highest percent of non dalit respondents (94.0%) are literate where as highest percent of dalit respondents, 58 percent are literate. Highest percent of non-dalit respondents (28.0%) have completed secondary level education where as 21 percent dalit respondents have completed secondary level education level.

The proportion of complete primary level of education is higher in non-dalit community than dalit.

More of the non-dalit respondents are still depends on the Agriculture where as dalit respondents are dependent in daily wages.

Non-dalit mother have more sufficient food than dalit mother.

Most of the non-dalit respondents have concrete houses where as dalit respondents have bamboo joint houses.

Open toilet is the main toilet facility for both castes. More of the dalit respondents are using open toilets then non-dalit respondents.

Non-dalit respondents are using more household facilities than their counterparts. Kerosene and fire wood is the main source of fuel for non-dalit respondents where as only fire wood is the main source of fuel for dalit respondents.

Early marriage is more pronounced in dalit community than non dalit.

Number of total birth is comparatively higher in dalit community than their counter parts.

Knowledge of maternity care is more pronounced in non-dalit community than dalit community.

Radio is the most common source of information for both dalit and non dalit respondents. Comparatively, non dalits have more knowledge about maternity care practices than dalits and also revealed that non-dalit are more familiar with modern source of information than dalits.

Nearly three fourth of the total respondents from both castes have knowledge about TT.The results showed that higher percentage of non dalits have more knowledge about TT compared to dalits.

About 28 percent non-dalit mother and 31 percent dalit mother had taken 3 dose of TT and only 3 percent dalit mother had taken four dose of TT.

More than 80 percent respondents for both castes have the knowledge about Iron tablets.

Less than 50 percent respondents for both castes have the knowledge about Anemia.

Highest percent of both respondents are reported to visit ANC before delivery. Equal percentage (5.0%) of both non-dalit and dalit respondents have visited ANC more than 4 times where as 39 percent non dalit and 10 percent dalit respondents have visited to ANC for four times.

Highest percentage of dalit mother (54.0%) have visited ANC for the purpose to know the position and incensement of fetus and to get advise from the health personnel's as compared to non dalit mother (39.0%).

Highest percent of both dalit and non dalit mothers have continued sexual intercourse during the period of 4 month pregnancy.

In total more than 50 percent respondents have the knowledge about safe delivery kits.

Highest percent of non dalit women delivered in hospital as compared to dalit. Forty six percent non-dalit mother are reported to assisted by doctor as compared to dalit (30.0%).Sixty two percent dalit mother assisted by household member as compared to non-dalit (20.0%).

Thirty four percent non dalit mother and 90 percent dalit mother had the problem at the time of child birth.

Excessive bleeding (RAKTA TALIKA) is the main problem for both non-dalit and dalit mother at the time of child birth.

Highest number of mother from both castes have reported that they had problem after child birth. Rational placenta (prolapse) is the major problem after child birth for both castes.

Comparatively PNC visit is lower than ANC visit in both castes. Non-dalit mother are more likely to visit PNC than dalit mothers. More non-dalit mothers are utilizing the health facilities than dalit mothers. Generally on foot is the main transportation is to reach to health facilities for dalit mother where as non-dalit mothers are using bus facilities too.

Non-dalit mother have good nutrition food behavior than dalit mother at the PNC period.

Non-dalit mothers are more conscious to provide immunization services for their children than dalit mothers, it may be due to the result of higher level of education and awareness.

Younger mother of both castes are likely to visit ANC more than 4 times than older mothers . Non-dalit mother with higher level of education are more likely to visit ANC than lower level education. But in dalit mother with lower level education are likely to visit ANC more than 4 times than higher level education. Though education is necessary but from the result it shows that uneducated women's are also equally concious about the PNC visit and this may be due to awareness.

Younger mothers are more likely to deliver in hospital compare to older mothers and non dalit mothers with higher level of education are more likely to deliver in

hospital than lower level of education. But in dalit mother with lower level education are likely to deliver in hospital than higher level education. This also may be the result of awareness as well as modernization.

Mothers age group 30-34 is more likely to visit PNC within two days of delivery than younger mothers and age group 35+ are more likely to visit PNC after one month of delivery. Mothers with SLC level education are more likely to visit PNC with earlier days of deliver compare to lower level education. This showed that education is one of the necessary factor for consciousness.

8.3 Recommendations and Research Issues

8.3.1 Recommendations.

On the basis of the above findings and conclusions the following recommendations can be made.

The level of education of dalit respondents is very low which directly affect the participation of women's in their personal hygienic and sanitation as well as over all health of their children and their family. So non formal education should be launched in this area for the illiterate women. Awareness program should be conducted in order to bring the positive behavioral changes among women of reproductive age.

Low age at marriage is more pronounced in dalit community, so, effective program should be lunched to rise the status of women and avoid early marriage norms.

Most of the people are engaged in agriculture and daily wages work in the study area, therefore, effective program should be lunched to create employment opportunity for them which helps to increase their economic status and improve their quality of life.

Most of the respondents are suffering from different problem during and after delivery, it may be due to cause of non hygienic behavior, lack of health education and delivery at home, low frequency of ANC and PNC visits. In order to avoid this problem, health volunteers, MCHWS and health campaign and other

health awareness programs should be implemented among the reproductive aged women.

Policy makers should be more conscious about maternal health care practices before launching any awareness programs.

8.3.2 Research issues

Only limited components of maternity care are included in this study. Further more detail research is needed to include the components other than studied.

This is just descriptive type of study. An analytical type of study is necessary for reaching to logical end.

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Maternity care practice :A Comparative Study among Dalit and Non -Dalit women age (15-49)years

District :Makawanpur
Village/ Tole : **Respondent (Named):**
Caste :
Age : **Numbers of family member:**
Religion ;
Type of House hold

Part-1

Background characteristics of household:

SN	Questions	Description	coding	Remarks
1	Do you have toilet facility?	Yes No	01 02	Go to 2
2	What type of toilet does your family use?.	Pit toilet Open toilet Bush/field Flush toilet 0thers	01 02 03 04 05	
3	What type of house do you have?	Concrete Stone with concrete joint Stone with mud joint Bamboo joint Others	01 02 03 04 05	
4	Does your household have facilities?	Electricity(solar) Bio-gas Telephone Radio Television others	01 02 03 04 05 06	
5	What is the sources of fuel in your house?	Bio-gas cylinder Gas kerosene fire wood	01 02 03 04	
6	What is your main occupation?	Agriculture Trade	01 02	

		Business Services Daily wages Iron pot making	03 04 05 06	
7	What is your occupational status in terms of food sufficiency?	Good Bad Not bad	01 02 03	
	Part- 2 **Personal Background Information**			
1	What is your date of birth?	Years ……		
2	What is your educational status?	Literate Illiterate	01 02	
3	If literate which class did you passed ?			
6	How many children do you have?(including Dead)	1 2 3 4 5 6 7+	01 02 03 04 05 06 07	
7	What was your age when you got married?	……..years		

Knowledge on Maternity care

SN	Questions	Description	coding	Remarks
1	Have you ever heard about maternity care?	Yes No	01 02	Go to 4
2	What services does it include?	Regular check up during pregnancy Receiving TT Receiving Vit. A Iron tablets Delivery assistance by training medical personal Use of home delivery kits Advise counseling services others	01 02 03 04 05 06 07 08	
3	What are the sources of your knowledge?	Radio Television Health workers	01 02 03	

		Private clinic doctor Family Friend others	04 05 06 07	
4	Did you know about TT?	Yes No	01 02	Go to 8
5	Do you know , how many doze it is necessary before delivery?	1 doze 2 doze 3 doze 4 doze above unknown	01 02 03 04 05	
7	Do you know about iron tablet?	Yes No	01 02	
8	Do you know the Anaemia?	Yes No	01 02	
11	Have you ever heard about safe delivery kits ?	Yes No	01 02	
12	Do you know the treditional methods of treatment of prolong labour?	Yes No	01 02	
13	If yes, what is that?	Dhami/ Jhakri Pani phukera khane Chamal phukera khane Others	01 02 03 04	
Practice of maternity care **Section-1 Antinatal care practices**				
SN	Questions	Description	coding	Remarks
1	Did you visit fpr Anti natal care?	Yes No	01 02	Go to 5
2	How many times during pregnancy?	…….Times	01	
3	What is the purpose to visit there ?	To know the position and incensement of foetus To get advice Both of above Don’t know	01 02 03 04	
4	Who suggested you to get there services?	HW/Nurse/Doctor FCHV Husband Mother inlaw Other family members Friends/ Neighbor	01 02 03 04 05 06	

		others	07	
5	Did you get help during pregnancy?	Yes No	01 02	Go to 7
6	If yes, to whom?	Mother inlaw Husband others	01 02 03	
7	How long you continued sexual intercourse after pregnancy?			

Section-2 delivery care practice

SN	Questions	Description	coding	Remarks
1	Where did you deliver your baby?	Home Health center Hospital Private clinic Others	01 02 03 04 05	
2	Who had assisted with the birth of the baby?	TBA Household member AHW/HA/Nurse Doctor Friends/ relatives Others	01 02 03 04 05 06	
3	Around the time of birth of child, did you have any problem?	Yes No	01 02	
4	If yes,what kinds of problems ?	Excessive bleeding Fever Bad smelling of vaginal discharge others	01 02 03 04	
5	Have you ever heard about the safe delivery kits?	Yes No	01 02	Go to 7
6	Did you use a safe delivery kit for the birth?	Yes No	01 02	
7	What was the cord- cut?	Sterilized blade Non Sterilized blade Others Don’t know	01 02 03 04	

Section –3 post natal care practice

1	Did you rceivePNC check	Yes	01	Go to 3

	up ?	No	02	
2	If yes, when did you receive the check up ?	With in two days of delivery With in first week of delivery Before 15 days of delivery Before one month of delivery After one month of delivery.	01 02 03 04 05	
3	Did you get any health problem after the delivery of your last child?	Yes No	01 02	Go to 5
4	If yes, what were the problems?	Stomach paining Foot soiling Fever Headache Rationed placenta Abstracted labour Accessive bleeding Others	01 02 03 04 05 06 07 08	
5	Did you visit any health facility for check up?	Yes No	01 02	Go to 7
6	If yes, where did yougo for check up?	Hospital Health post Sub –health post Private clinics TBA FCHV Others	01 02 03 04 05 06 07	
7	When did you started sexual intercouse after delivery?	…….. days …… month		
Services for Maternity Care 1. Available and Accessible of Safe motherhood Services				
1	Are there any health facilities in your lokacity?	Yes No	01 02	
2	Distant from house to health center?	<1 KM 2KM 3 KM 4 KM + Others	01 02 03 04 05	

3	What types of health facilities is available?	Hospital Health post/Sub –health post Private clinics TBA FCHV Dhami/Jhakri Others	01 02 03 04 05 06 07	
4	What type of transportation is available there?	On foot By bus By jeep By stature Other	01 02 03 04 05	
5	What types of Maternity care services are provided in that health facility?	Regular check up during pregnancy TT vaccination Availability of vitamin A and Iron Tablets Deliver assistance by trained medical personnel's Others	01 02 03 04 05	
11	What is your nutritional food behaviour during the post-natal period?	Good Not bad Bad	01 02 03	
12	Did you provide immunization services to your child in 1st month after delivery?	Yes No	01 02	