

**MATERNAL AND CHILD HEALTH CARE PRACTICES IN PODE
COMMUNITY
(A Case Study of Kirtipur Municipality)**

Thesis

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**Submitted By:
Roshani Maharjan**

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LETTER OF RECOMMENDATION

This is to certify that Ms. Roshani Maharjan has completed this thesis on ‘**Maternal and Child Health Care Practices in Poda Community: A Case Study of Kirtipur Municipality**’ under my guidance and supervision. I therefore recommend it for final approval and acceptance.

.....

Yogendra Bista
(Research Supervisor)

LETTER OF APPROVAL

This thesis submitted to the Central Department of Rural Development, Tribhuvan University, by Ms. Roshani Maharjan, entitled “**Maternal and Child Health Care Practices in Pode Community: A Case Study of Kirtipur Municipality,**” has been approved by the undersigned members of thesis committee.

Approved by

.....

Prof. Dr. Pradeep Kumar Khadka
(Head of Department)

.....

(External Examiner)

.....

Yogendra Bista
(Internal Examiner)

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ABBREVIATION / ACRONYMS

ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
BCG	Bacillus Calmette-Guerin
CDD	Control of Diarrheal Diseases
DFID	Department for International Development
DPT	Diphtheria, Pertussis and Tetanus (Vaccine)
ICP	International Classification of Disease Code
ICPD	International Conference of Population
LBW	Low Birth Weight
MDGs	Millennium Development Goals
MoH	Ministry of Health
NDHS	Nepal Demographic and Health Survey
NPC	National Planning Commission
TBA	Traditional Birth Attendant
TT	Tetanus Toxoid
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nation Children's Emergency Fund
VDC	Village Development Committee
WHO	World Health Organization

GLOSSARY

Maternal Care: Care taken from pregnancy until postnatal period to uplift the health status of mothers.

Maternal mortality: Death of mother while pregnant or within 42 days of termination of the pregnancy.

Child Mortality: The death of child due to poor health practices and other health-related matters but not from accidental causes.

Age at Marriage: The age at which a female marries and enters reproductive period of life.

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

Delivery: The period of giving birth to a child.

Postnatal care: Care of mother and child after delivery within 42 days.

Jaulo: The food for the baby prepared by cooking of rice, ghee, milk, *dal*, etc.

Dhami/Jhakri: The person who treats the sick through traditional methods.

ABSTRACT

The study, “Maternal and Child Health Care Practice in Pode Community,” has been carried out to assess the healthcare practices of an untouchable Newar caste of Kirtipur. It tries to find out the socioeconomic and demographic characteristics; to assess the antenatal care, delivery and postnatal care practices; and to examine the practice of colostrum feeding, breastfeeding, child immunization, and additional food feeding by the women of the Pode community. A total of 30 respondent mothers were interviewed on maternal and child health care, and 14 respondents were taken for focus group discussion. For key informant interview, the chairperson of health post, volunteers, social worker, TBA, etc., were consulted.

In the study area, ages of the respondents are between 15-35 years. Among them, the 25-30 age group women were married at early age (15-20 years), and literacy rate of the women has been found low. All of the respondents are landless and most of the respondents are job holders. Regarding health care practices, around 55.55 percent of the respondents indicated that they went for health checkup more than two times during pregnancy, and 56.68 percent of the total mothers have taken more than two doses of TT injection during their pregnancy period. The study has confirmed that around 63.33 percent of the mothers delivered their babies in hospital and 36.67 percent mothers delivered at their own homes. All of the respondents had fed colostrum and 73.34 percent respondents have breastfed for more than two years.

Overall, although the findings suggest that these practices are satisfactory from a national level point of view, their performance can be said below par if we compare it to other communities of Kirtipur and if we consider the proximity of health centers. Their social exclusion as Dalits—more specifically Dalit women, along with their low economic and political status as well as their occupations per se, are seen to be responsible for their somewhat low performance on maternal and child health care.

INTRODUCTION

1.1 General Background

Health is one of the most important factors for the fulfillment of human needs and improvement of the quality of life. A healthy person is always cheerful and can do a full day's work without exhaustion. Even a poor man having good health can improve his living standard. The health of the people is considered the wealth of the nation.

According to Oxford English Dictionary (1989), "health is the state of being well and free from illness". The definition indicates that health is soundness of body and mind. It is the condition in which all the functions are duly and efficiently discharged. WHO has defined health "as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."

Two of the most important indicators of health situation of a country are life expectancy and infant mortality rate. The bleak health situation in Nepal with respect to maternal and child healthcare can be assessed by the single fact that until the 2001 Census reported for the first time that female life expectancy in Nepal was slightly higher than male life expectancy (60.7 years for women, 60.1 years for men), Nepal was one of the few countries in the world where a woman's life expectancy was lower than that of a man. Another indicator of female vulnerability in Nepal is the persistence of higher infant and under-five mortality rates for girls than for boys.

Nepal's child mortality declined during the 1990s, putting it on track for achieving the MDGs of reducing child mortality by two thirds by 2015. Infant mortality has also decreased. Nevertheless, this is still extremely high, as is Nepal's maternal mortality, and there are sharp disparities between different groups that are related not only to economic status, rural/urban residence and region but also to gender, caste and ethnic identity.

There are many interrelated factors, cultural, religious and social beliefs and norms (especially those that reflect the entrenched gender, caste and ethnic hierarchies), as well as economic, institutional and location-related specificities behind these differential health outcomes. Women's health outcomes are directly affected by their subordinate status vis-à-vis the men and the senior women in the family. In addition, females tend to be less valued than males, and this is reflected in poorer female performance on all indicators, especially education and health.

Health outcomes are the worst for women because of biology, specifically their reproductive roles. The biological risks associated with childbirth can be compounded by cultural practices including early marriage and childbearing and food restrictions during pregnancy and during menstruation. Girls aged 15 to 19 are twice as likely to die in childbirth as are women in their 20s. Childbirth is seen as a normal occurrence not ordinarily requiring medical attention, so pre- and postnatal care may be considered unnecessary in many families. Compounding all of this is the sense of *laaj* or "shame" about their own body and reproductive functions that makes it difficult for women to communicate their symptoms even within the family.

The use of professional help for deliveries is also low; over six of 10 births are unassisted. Almost 95 percent of Nepal's Emergency Obstetric Care (EOC) needs remain unmet. The combined effect of these factors is at least 12 daily deaths from pregnancy-related complications (MoH/DFID 2004). Among rural women, Newars and Brahman/Chhetris have the highest access to trained assists during child delivery and Janajatis and Dalits have the least. The same trend is seen for antenatal care. Maternal mortality also includes deaths caused by unsafe abortions. According to the Ministry of Health (2002), at least 20 percent of maternal deaths are caused by unsafe abortions. The demand for safe abortion rose after abortion was legalized by the 11th amendment of the *Muluki Ain* in 2002.

Regarding healthcare access to Dalits, caste discrimination by health service providers is a major barrier to health seeking behavior among Dalit women. Similarly, disrespectful attitude of service providers toward those beneath them in the caste hierarchy was a major reason that many women did not seek either pre- or

postnatal care or emergency obstetric care. Moreover, due to the nature of service occupations, some involving handling of waste, the health outcome of Dalits are poor, compounded by their higher poverty levels and lower education levels.

There is a high correlation between educational attainment and health outcomes. The Total Fertility Rate for uneducated women is 8.4, whereas for women with some secondary education is 2.3 (NDHS, 2001). The under-five mortality rate for children of uneducated mothers in Nepal is 121 per 1,000 births: this is 64 percent higher than that for children of mothers with some primary education and nearly double that of children whose mothers have some secondary education (ibid). The risk of death among children of uneducated mothers is eight times higher than the risk for children of mothers with SLC and above education. Similarly, the prevalence of underweight children is 78 percent higher, and the prevalence of stunting is 62 percent higher among children whose mothers do. Even with controlling for income and other compounding variables, Dalit, Terai Middle Caste, and Muslim children had a significantly higher prevalence of both stunting and underweight.

There are significant variations in access to healthcare between women from different castes and ethnic groups. Data from the 2001 NDHS show that access to and use of a range of health and family planning services for rural women is lowest among Dalit and Terai Middle Caste women. Knowledge levels of Dalit women are also very low compared to Newars, Brahman/Chhetris and Hill Janajatis. Contraceptive use among married rural women is lowest for Dalits (28%) and Muslims (15), while Newars and Terai Janajatis have the highest contraceptive use. There is still significant unmet contraceptive need, most notably among Muslims (45%), but also among many other groups. The national average stands at 30 percent.

Although Nepal implicitly recognizes healthcare as a basic citizenship rights, the effort to reorient policy and health services along the rights-based approach remains ad-hoc and immature.

Child health practice differs from community to community and from one ethnic group to another. Some ethnic groups have good healthcare practice. Newars are the indigenous people of the Kathmandu valley, and among Newars, there are also different castes. One of the important Newar towns of Kathmandu is Kirtipur. Kirtipur municipality is situated in the southern side of Kathmandu. There are 19 wards. Newars, Brahmins and Chhetris are the main castes living there. Besides, there are *Gandarva* (Gaine), *Pode*, *Dami*, *Sarki*, *Kami* castes in Kirtipur. Among Newars, there are different caste groups arranged in vertical hierarchies. Their caste system is based on occupation. Podes are one of the untouchables of Newar community who are placed at the bottom of the hierarchy. Podes use *Pode*, *Dyahla*, *Deopala*, *Pujari*, *Pujawari*, *Devja* and *Nepali* in the surnames. Their occupations are executing, sweeping, fishing, skinning dead animals, and weaving cane baskets and *kharpan*. They are grouped in the Dalit, oppressed class. Due to the nature of their service occupations, health outcome of these groups are poor, compounded by their higher poverty levels and lower education levels. Therefore, these all typical characteristics deserve special consideration on the study on maternal and child care practice.

1.2 Statement of the Problem

Inadequate health service is a major problem of the world. Maternal and child healthcare problem is one of the burning problems in Nepal. Poverty, lack of proper education and poor health practices are the major causes of maternal mortality and morbidity. Whooping cough, diphtheria, tetanus and other communicable disease are the major causes of infant mortality and morbidity.

Maternal and child mortality is one of the major problems. Every minute of everyday, somewhere in the world a women dies as a result of complications arising during pregnancy and childbirth. Around the world, 5, 00,000 women died annually in 1980s from pregnancy-related causes, and for 1990 it was closer to 6, 00,000 per year. In developed countries, the maternal mortality ratio is 27 deaths per 1,00,000 live births but in developing countries the ratio is 20 times higher and 480 deaths per 1,00,000 birth in magnitude, and may be high as 1,000 per 1,00,000 in some ethnic settings (UNFPA, 1999).

Maternal and childcare services are insufficient in Nepal due to minimal level of education or low literacy of women, low economic status and lack of adequate knowledge about healthcare practices. Teenage pregnancy, excessive childbearing tradition, and other socio-cultural factors contribute to increased population growth as well as fertility rate, which decrease the health status of the mother and children. Due to early marriage, traditions, beliefs and superstitions, low economic status, low women literacy, unhygienic health behavioral practices, maternal and child health status is not improved. Most of the rural women do not utilize the available health facilities as they are not sufficient. Low social status of the women is the main cause of their ignorance.

So, it is needed to find out maternal and child health care problems and solve these problems definitely. That is why this topic has been selected for the present study, which is stated as “Maternal and Child Health Care Practices in Poda Community.”

1.3 Significance of the Study

Health is one of the most important issues of life. There is no value of life without healthy life. “Health for All and All for Health” is today’s slogan of the world. The slogan cannot be materialized without active participation and cooperation of all people.

Children are future stars. They are facing many health problems which are essential to find and solve for their harmonious development. The aim of the study is to find maternal and child health care practices including antenatal, delivery and postnatal care of the mother.

Maternal and child health care practice is one of the most important factors for the improvement in health condition of mother and children. If mothers are aware of their health, they will not give birth to many children and their babies will be healthy, and this awareness helps reduce the rate of child mortality and morbidity. So, the significance of the study can be listed as follows:

- a) This study is useful for strengthening the maternal and child health care services.

- b) It is helpful for the people to develop awareness on maternal and child mortality.
- c) It is useful to guide planners, educators, volunteer agencies for improving women and child health status through education of the female.
- d) It is helpful to the women to understand the importance of education for girls and to care their own health and of their children.
- e) It is useful as a guideline for further researchers in the similar field.

1.4 Objectives of the Study

The general objective of the study is to assess overall mother and child health care practice in Pode community of Kirtipur. The specific objectives are:

- a) To find out the socioeconomic and demographic characteristics of the family.
- b) To assess the antenatal, delivery, and postnatal care practices in the Pode families.
- c) To examine out the practice of colostrum feeding, breast-feeding, child immunization, and additional food feeding to the women of the Pode Community.

1.5 Limitations of the Study

Due to the limitation of time and budget, the study is limited to the Pode families.

- a) The study is limited within ward no. 17 of Kirtipur municipality.
- b) The women having one or more children below the age of five years are included in this study.
- c) The study is limited to maternal and child health care practice only, i.e., antenatal care, delivery practices, and postnatal care practices.
- d) Mothers staying at temporary residence in the study area are not included in the study.

REVIEW OF LITERATURE

2.1 Conceptual Studies

According to the World Summit for Child 1990, it is reported that child survival is closely linked to the timing, spacing and number of births, and to the reproductive health of mother. Early, late, numerous, and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially where healthcare facilities are scarce (ICPD 1994).

According to WHO Bulletin 2000, prenatal mortality studies points to the link between the health of the mother and birth outcome. The high prenatal mortality rate in India reflects the poor status of women, including poor nutritional status, low rates of literacy, and early marriage and childbirth. Improving female education and nutrition, and increasing the use of health services during pregnancy and delivery are all important for reducing childhood mortality rates.

UNICEF and MIRA (2000:37), in “Low Birth Weight Prevalence and Associated Factors in Four Regions of Nepal,” mentioned low maternal weight and body mass index, birth of a previous preterm infant, and a birth interval of less than two years as the top five factors associated with LBW. Primarily adolescent motherhood, maternal illiteracy, rural residence and minimal antenatal care were also the implications. The effects of some factors such as adolescent pregnancy and maternal illiteracy were substantially reduced. Overall, the strongest effects on LBW were seen for maternal weight, previous preterm delivery, short birth interval, and paternal employment in agriculture.

UNICEF (1998:33), in its study on “Health Seeking Behavior Study,” Nepal, mentioned that education is associated with greater use of health services, in general. The study showed that the highest proportion of women who used health services/sought care (antenatal as well as care during pregnancy, childbirth and during the postnatal period) were the majors who had the highest level of literacy,

among women in the study population. About 70 percent of the major women in study were literate. The study showed that the highest proportion of women who did not seek care were the Tamang women, who had the highest illiteracy rate among women in the study population.

The study also showed that the use of doctors, hospital, and health posts was highest among women 18 to 35 years (57%) compared to women 35 years and above (23%). TAB/ANM-assisted deliveries were also highest (25%) among women in the 18-35 age group who were literate (32%) compared to women 35 years and above (14%).

According to UNICEF (1988: 26), birth spacing is one of the most powerful ways of improving the health of women and children. Births that are too many and too close to women who are below 20 years and past 35 years are responsible for approximately one third of all infant deaths.

According to ICPD, United Nations (1994:10), important progress has been made in reducing infant and child mortality rates everywhere. Improving the survival of children has been the main components of the overall increase in average life expectancy in the world over the past century, first in the developed countries and over the past 50 years in the developing countries.

UNFPA's (2001:21) Expanded Program on Immunization (EPI) is a priority program of His Majesty's Government of Nepal. EPI is considered as one of the most cost-effective health interventions. Vaccine-preventable diseases (VPDs) are routinely reported through the HMIS system complemented by appropriate surveillance and outbreak response. The immediate objectives of the EPI program are to eliminate neonatal tetanus (NNT), to reduce measles morbidity and mortality, and to eradicate poliomyelitis.

Analysis of the report from all 75 districts of the country for FY 2057/58 shows that overall coverage level for BCG vaccination is 95%, measles vaccination is 75%, DPT3 and OPV3 is 80%, and for tetanus toxoid (TT2+) is 65%, using number of expected pregnant women as the denominator. However, coverage for various

vaccinations is not uniform within the country, with some districts achieving more than 100% coverage, and others far behind. Reported morbidity for some VPDs is decreasing, whereas for others it is on rise, especially measles.

“Nepal Micro Nutrition Status Survey,” conducted in 1998 by UNFPA (2001:29), showed that 54 percent of children below 5 years of age are affected by stunting (short for their age), which can be a sign of early chronic under nutrition. The survey also found that 47 percent of the children are underweight (low weight for age). In addition, the survey reported that 7 percent of the children below 5 years are wasted (thin for their height), an indicator of acute malnutrition.

Similarly, as per the finding of the 1998 Nepal Micro Nutrition Status Survey (NMSS), Iodine Deficiency Disorder (IDD) is no longer a significant problem of public health in Nepal. The median urinary iodine excretion (UIE) was 114.0 ug/L among women and 143.8 ug/L among school-aged children, For both the groups this is just above the cut-off point designated by WHO to indicate adequate iodine (100 ug/L). In spite of this overall good situation, 43.6 percent of the women and 38.3 percent of the school-aged children showed UIE below 100 ug/L, indicating further improvement is required in their iodine status.

“Reduction of Maternal Mortality,” WHO (1999:40), a joint statement, mentioned that the first estimates of the extent of maternal mortality around the world were made in the late 1980s. It indicated that globally some 500,000 women die each year from pregnancy-related causes. In 1996, WHO and UNICEF revised the estimates for 1990 and they indicated that maternal deaths closer to 600,000 occur each year, with the overwhelming majority of them in developing countries. In developed countries, the maternal mortality ratio averages around 27 maternal deaths per 100,000 live births; in developing countries the ratio is nearly 20 times at 480 and may be as high as 1000 per 100,000 in some regions.

DHS (2001) reported that one in every 11 children born in Nepal dies before reaching age five. Slightly more than two in three under-five deaths occur in the first year of life-infant mortality is 64 deaths per 1,000 live births. During infancy, the risk of post neonatal death (39 per 1000) is one and half times as high as the risk

of post neonatal death (26 per 1000). According to data collected in the 2001 by NDHS, mortality levels have declined rapidly since the early 1980s. Under-five mortality in the five years before the survey is 58 percent of what it was 10-14 years before the survey. Comparable data for child mortality (50 percent) and infant mortality (60 percent) indicate that the pace of decline is somewhat faster than for infant mortality. The corresponding figure for neonatal and postnatal mortality is 61 percent and 58 percent, respectively. This decline in childhood mortality level is confirmed from the data from other sources.

Sixty percent of the children are fully vaccinated by 12 months of age, 83 percent have received the BCG vaccination, and 64 percent have vaccinated against measles. Coverage for the first dose of DPT is 83 percent, but this drops to 77 percent for the second dose and further to 71 percent for the third dose. Polio coverage is much higher at 97 percent for the first dose, 96 percent for the second dose, and 90 percent for the third dose. The percentage of children aged 12-23 months fully immunized by age has increased in the last five years by 67 percent. The corresponding increase in the third dose of DPT and polio are 39 percent and 87 percent, respectively, while BCG coverage increased by 13 percent and measles vaccination increased by 41 percent.

The prevalence of symptoms of acute respiratory infection (ARI) among children under five years of age in the two weeks before the survey was 23 percent, while 32 percent of children below five had a fever in the preceding two weeks. Use of a health facility for the treatment of symptoms of ARI and/or fever is low, with less than one in four children taken to a health facility.

One in five children suffered from diarrhea at some time in two weeks before the survey. Among those children, only one in five was taken to a health facility for treatment. Nearly one in two children receives oral rehydration therapy, with 32 percent treated with oral rehydration salts and 27 percent receiving increased fluids. Nevertheless, more than one-third of children with diarrhea were not given any treatment at all.

The survey further reveals that one in two pregnant women receives antenatal care in Nepal, with 28 percent receiving care from doctor or nurse, midwife, or auxiliary nurse midwife. In addition, 11 percent of women receive antenatal care from a health assistant or auxiliary health worker. Most Nepalese women who receive antenatal care get it at a relatively late stage in their pregnancy and do not make the minimum recommended number of antenatal visits. Only seven women (14 percent) makes four or more visits during their entire pregnancy, while 16 percent women report that their first visit occurred less than four months of pregnancy. About half of mothers who received antenatal care report that they were informed about the signs of pregnancy complications, while three in five women report that their blood pressure was measured as part of antenatal care checkup. Forty-five percent of women receive two or more doses of tetanus toxoid during their most recent pregnancy.

Institutional deliveries are not common in Nepal. Less than ten percent births in five years preceding the survey took place in a health facility. Thirteen percent of births were attended at delivery by medical professional, with only 8 percent of births attended by a doctor and 3 percent attended by a nurse, midwife, or auxiliary nurse midwife. Nearly one-four of births were attended by a traditional birth attendant. Safe delivery kits were used in 9 percent of births delivered at home.

Only 17 percent of mothers receive postnatal care within the first two days after delivery. Even more troubling is that nearly four in five mothers did not receive postnatal care at all.

According to Costello and Manandhar (2002:1) newborn care is of immense importance for the proper development and healthy life of a baby. Although childhood and infant mortality in South Asia has reduced substantially during the last decade, the rate of neonatal mortality is still high. According to one source, 60 percent of all neonatal death and most of the world's burden of prenatal deaths occur in Asia (Paul and Beorari 2002). Further, although most of infant deaths occur in the first month of the life, the policymakers and health professionals in developing countries, until recently, neglected newborn care.

Nepal Micro Nutrition Status Survey (1998:16) reported that 84.2 percent of children of 6-11 months were breastfed. Likewise, 90.7 percent of children of 12-23 months age, 60.2 percent of 24-35 months, 33.6 percent of 36.47 months and 15.9 percent of 48.59 months age group of children were breastfed.

UNFPA (2001:21) National Tradition Birth Attendant (TBA) program aims to improve the quality and utilization of community-level TBA services to support the reduction of maternal mortality from 539 per 100,000 live births to 400 per 10,000, and neonatal mortality from 49.9 per 1000 to 40 per 1000 by the end of the Ninth Five-Year Plan period.

International Encyclopedia of women (1998:331). The maternal mortality has been estimated by the World Health Organization that worldwide at least one-half million women die every year from causes related to pregnancy and childbirth and 99 percent of these deaths occur in the developing countries (World Health Organization 1991).

Paul V.K. and Beorari, A. (2002:5-6) reports that estimated 11 million children in South Asia are born each year at weights less than 2500 grams, amounting for over 50 percent of all LBW neonates in the world. Infants born with low birth weight rate suffer from extremely rate of morbidity and mortality from infectious disease and are underweight, stunted, or wasted beginning in the neonatal period through childhood. Low birth weight infants have higher mortality rates during the postnatal period, and in some cases, their risk may be greater than those at low birth weight infants during the neonatal period. Infants weighing 2000-2499 grams at birth and weighing 2500-2999 grams are ten times more likely to die than infants weighing 3000-34999 grams are.

WHO (1994:13). The worldwide data had recommended that newborns with birth weight less than 2500 grams may be considered to fall in the low birth weight (LBW) category, carrying relatively greater risks of prenatal and neonatal morbidity and mortality and substandard growth and development in later life. The validity of this definition of the “cut-off point” of 2500 grams has been occasionally challenged, but it has by and large now gained general acceptance (Gopalan 1994).

The latest WHO recommendation (WHO 1995, de oris and Hachicht 1996) has retained this “cut-off point” of 2500 grams to define LBW and recommended an additional demarcation of 1500 grams to define very low birth weight (VLBM) babies.

UNICEF (1999:110). Several decisions were taken aimed at prevention. Most maternal deaths are due to hemorrhage. These are highlighted at all levels of the health care provision of basic EmOC facilities, at least 4 per system, which contributes to sensitizing all health 500,000 population and comprehensive EmOC personnel into taking action for preventing such fatalities, at least 1 per 500,000 deaths.

UNICEF (1999:2). Every year over 150 million children under the age of five are vaccinated in South Asia. Immunization is essential to save children’s lives. It is also an affordable means of protecting whole communities, and it reduces poverty. Immunization has achieved real success in the past 20 years. Smallpox was eradicated in 1979, a massive human endeavor, and today polio is set to become another scourge of the past.

Today vaccines protect nearly three-quarters of the world’s children against major diseases. In Afghanistan, women, some dressed in *burka*, and children stand in line outside a village health center awaiting vaccinations during the UNICEF-supported immunization campaigns against childhood illnesses. UNICEF and WHO have been instrumental in assuring increased access of developing countries to high quality affordable vaccines. All EPI vaccines supplied by UNICEF are from WHO-recommended sources. Through a process of prequalification, WHO advises UN procurement agencies on the quality, efficiency, and safety of vaccines available in the market.

Government of Pakistan and UNICEF (1999:7) reports that every year 529,000 women worldwide die due to pregnancy and childbirth complications, 12.99 percent of these deaths claimed by developing countries. Far too often, this desperate face of maternal death is buried under poverty and low status without its story being told. Their silenced voices linger unburdened with a beseeching message, move beyond

complex definition, and voices to take action to prevent maternal deaths, and let no another woman die untimely and unnecessarily. The South Asian region is home to 1.25 billion people or 22 percent of the world's population. It also disproportionately accounts for 30 percent of the world's maternal deaths. In this region, every three minutes one woman dies from complications of pregnancy and childbirth. This translates into an estimated 425 deaths each day and approximately 155,000 deaths annually.

Nepal Demographic and Health Survey (2001:2-3) data shows that only 28 percent of the children under three years of age consumed fruits and vegetable rich in vitamin A at least once in the seven days prior to survey. Thirty-seven percent of urban children as compared to 28 percent of rural children consumed fruits and vegetable rich in vitamin A. However, the proportion (four out of five) of rural children who received the direct vitamin A supplementation exceeds the proportion (three out of four) of children in urban area.

The percent and prevalence for underweight and wasted children of under five years are 48.3 and 10 percent. Around 50 percent of the under-five children are stunted. Children in rural areas are more likely to be stunted (52%) than in urban area (37%). Nepal Micro Nutrition Status Survey 1998 (6-59 months) indicate that 54.1 percent were stunted, 6.7 percent showed wasting, and 47.1 percent were underweight. National Family Health Survey (NFHS 1996) in a nationally representative sample of children (6-36 months) showed that overall 54.8 percent were stunted, 12.7 percent showed wasting, and 54.2 percent were underweight. The first National Nutritional Survey in 1975 also showed similar findings of 48.1 percent stunted, 2.8 percent wasted, and 50 percent underweight. The data suggest that there is no improvement in the nutritional status in the country, although per capita energy consumption showed an upward trend of 2270 kcal per day.

Studies have showed that breastfeeding has positive effect on the nutritional status. Early initiation of breastfeeding is vital because the first breast milk (colostrum) is full of nutrients and antibodies that protect the newborn from infections. Around 31 percent of the children in Nepal are breastfed within one hour and 64.9 percent of them receive it within one day of birth. More urban children are breastfed within

one day (72.3%) as compared to rural children with 30.9 percent and 64.4 percent respectively. Around 69 percent of the children are fed with the first breast milk.

2.2 Related Studies in Nepal

Adhikari D.B (1994:4) had done “A Study of Child Health Problem and Their Treatment Practice” at Besisahar VCD, Lamjung District. He found that about 57 percent of the children were found ill during one year. Prevalence rate of disease was found influenced by many factors like age of the children, ethnicity, parent education, and occupation.

He also found that nearly 6 percent of the children under one year of age were not breastfed due to next pregnancy of the mother. Most of the delivery cases were handled by traditional healers at their homes, 65 percent of the mothers had examined their health during pregnancy, and more than 80 percent of the children received vaccines like DPT, BCG, polio and measles.

Shrestha (1994:26) in her study “A Study on Child Health Care Practice of Different Ethnic Groups in Baglung Bazaar” found that most of the pregnant women (87.72%) had done antenatal checkup and 58.77 percent of respondents’ delivery took place in a hospital. She also reported that 93.86 percent of respondents used buffalo milk to feed as supplementary food. Among the different ethnic groups, 48.82 percent of households began weaning baby from the age of 4-6 months, 29.4 percent from the age of 7-12 months, and 22.14 percent women wean after 2 years.

Panta (1995:18), who rendered a study “Socioeconomic Status and Maternal and Child Health Care Practices with Relation to Fertility in Pokhara,” noted that about one-third of the total respondents used to take additional food during pregnancy. About 50 percent of respondents reported that they had made two or more times antenatal visit during pregnancy; 18 percent of respondents had done only one time health checkup; and 31.0 percent of respondents had not taken any antenatal visit during pregnancy. She found that majority of the respondents had not taken the full dose of TT injection. Only 22.67 percent of the respondents had taken two or more doses of TT injection, whereas 42.0 percent reported only one dose and 34.7 percent had not taken any dose of TT injection during pregnancy.

Ms. Panta also reported that about 60 percent of the respondents delivered in their homes, 36.19 percent in hospital, and only 3.30 percent of them delivered in the private clinics and other places. About 50.47 percent of respondents were delivered with the attendance of their family members, 42.38 percent of delivery was assisted by trained health personal, and the remaining 7.14 percent were assisted by TBAs.

She also noted that about 70 percent of the respondents started weaning foods between the age of 4 to 6 months, and only 20 percent of the respondents used *Sarbottam Pitho ko Lito*, whereas 70.9 percent of respondents used *dal* and rice and milk. And she noted that maternal and child health practices were influenced by the caste structure of the mothers.

Devkota, B. (1994:7), who had done a study on “Knowledge, Attitude and Practices of the Maternal and Child Health Care at Pandrun Village, Gorkha District,” reported that about one-third of the total respondents mothers reported that food should be taken more than usual during pregnancy; about 67.2 percent of respondents had reported to have done two or more health checkups during pregnancy period; eight in ten of the mothers knew more than two dangerous signs in pregnancy; and 36.0 percent of the respondents had taken two or more doses of TT vaccine during their last pregnancy.

Mr. Devkota also found that family members were the main birth attendants and razor blade was the main cord-cutting instrument. He also reported that maternal and child health care practices, family planning, child immunization practices are influenced by the caste structure of the mothers.

Khanal (2001:11) reported that 72 percent of the mothers delivered at their homes and the rest went to either hospitals or in health posts for delivery. In Gaine and Poda communities, the family members are found to have acted as the main birth attendants at home delivery. About 35 percent of the total respondents were found to have used MCH kit during delivery period. Similarly, 21.67 percent of the mothers who delivered babies at homes indicated that they suffered from bleeding complications.

He found that breastfeeding is common in rural Nepal. About 45 percent of the respondents were found to have practiced breast-feeding for two years, and 78.33 percent have fed colostrum to their babies. Immunization of the newborn babies was a common practice among respondents. More than 83 percent of total respondent mothers were found to have immunized their children.

RESEARCH METHODOLOGY

3.1 Rationale of the Selection of the Study Area

The study is conducted in Kirtipur. In Kirtipur, we can see the mixed (rural/urban) life patterns. It is one of the oldest and most interesting Newar towns, only a few miles from the centre of Kathmandu, located along the hill south to Tribhuvan University. Kirtipur is famous for its long resistance against the Gorkhas.

The municipality is divided into 19 wards with 9487 households altogether. The total population is 40,835, in which 53.10 percent are males and 46.9 percent are females. Among the total population, 27582 (67.54%) are literate, in which 17152 males and 10431 are females. About 7910 cannot read and write in which 1846 are males and 6064 are females (CBS, 2001).

This study was conducted in “Pode community” of Ward No. 17, Dhokasi tole. Podes are untouchable castes (Dalits) and they are educationally, socially, economically backward. A large number of Podes live in Dhokasi tole. There are 55 Pode households in the ward and 273 people live in this tole. The researcher herself also lives in same locality. Due to this reason, the researcher selected this area for getting qualitative and quantitative data.

3.2 Research Design

To achieve the goal of this study, descriptive as well as explorative methods of research design have been adopted. The study has attempted to assess overall mother and child health care practice in the Pode community.

3.3 Nature and Source of Data

Both qualitative and quantitative data have been used to fulfill the research objectives. Primary as well as secondary sources of data have been used. Primary source of the data have been collected from the household information (interview and observation), mainly derived from field survey, within the help of

questionnaire; and the necessary secondary sources of data have been collected from various books, journals, research reports, magazines, newspapers, documentary, periodicals, and related websites from the Internet.

3.4 Sampling Procedure

The researcher has applied purposive sampling method. In ward no.17, there are 55 Poda households and 273 people live in this tole. Out of 55 households, 30 mothers have children who are under 5 years of age; they all have been kept under study.

3.5 Data Collection Tools and Techniques

Structured questionnaire, observation, key informants' interview and FGD have been taken as tools and techniques for the collection of required data.

3.5.1 Questionnaire

Various reference instruments have been consulted while formulating the semi-structured questionnaire. The questions were asked to the respondents and answers had been filled up by the researcher herself. The questionnaire includes four parts: socioeconomic and demographic characteristic, antenatal care practice, delivery practice, and postnatal care practice. The questionnaires were administered only to women who have children less than five years of age.

3.5.2 Observation

Observation is one of the most important methods of data collection in social research. It is probably the oldest method used in scientific investigation. I have used the non-participation observation method for their various activities, especially household size, sanitation, food, dress pattern, habitation and behaviors.

3.5.3 Key Informants Interviews

Interview of key informants was conducted with the involvement of chairperson of health post, health volunteers of municipality, TBA and social workers. These key informants interview provided some useful qualitative as well as quantitative data regarding maternal and child health care practices. The information from key informants was helpful in crosschecking the field data.

3.5.4 Focus Group Discussion

Qualitative information such as expression capacity, decision-making and implementation has been obtained from focus group discussion. For this study, approximately a dozen of women were involved in each group involved in the program.

3.5.5 Data Analysis and Interpretation

After processing and analyzing the data, they have been presented with the help of simple formulas and simple statistical tools like percentage, ratio, average, table, chart, diagrams, etc.

ANALYSIS AND INTERPRETATION OF DATA

4.1 Demographic and Socio-economic Characteristics

Nepal is suffering from one of the highest maternal deaths. The inadequate maternal and child healthcare practice is closely linked to the high maternal and infant deaths. So, it was felt necessary to study maternal and child healthcare practices. The demographic and socio-economic characteristics of the respondents such as age, age of marriage, occupation, literacy status, family structure, and number of children are presented in this section.

4.1.1 Age Category of Respondents

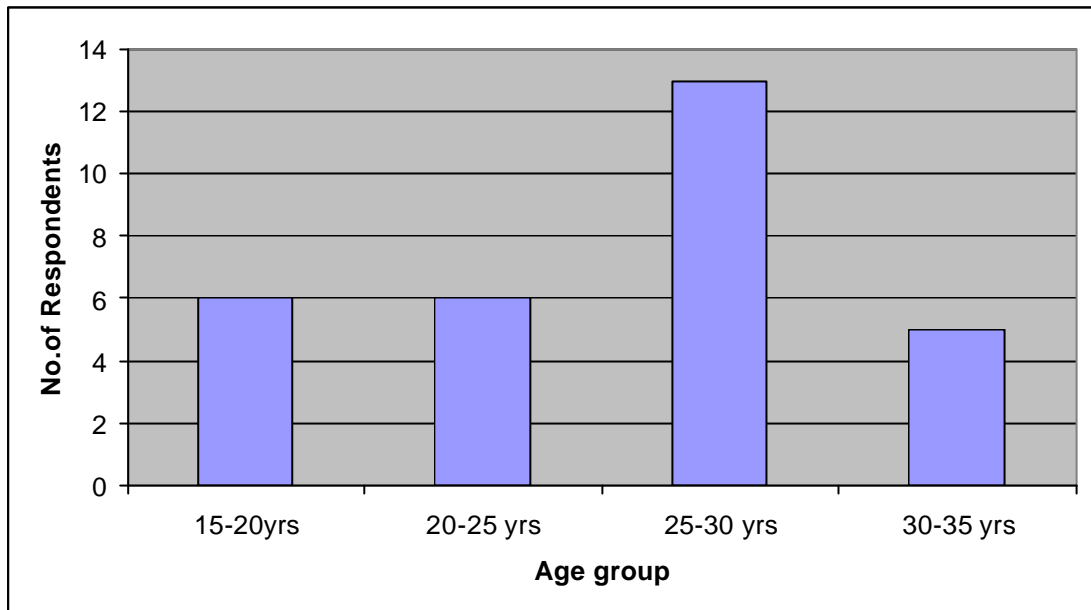
For the study, active reproductive age group between 15 and 49 was purposively selected, which is directly related to maternal and child healthcare practice. Those respondents were further divided into 7 groups. The distribution of respondents in each group is shown in Table 4.1 below.

Table 4.1
Distribution of Respondents by Age Group

S. No.	Age Group	Respondents	
		No.	Percent
1.	15-20yrs	6	20.00
2.	20-25 yrs	6	20.00
3.	25-30 yrs	13	43.34
4.	30-35 yrs	5	16.66
Total		30	100.00

Source: Field Survey, 2006

Figure 4.1
Respondents by Age Group



Source: Field Survey, 2006

In the above table and figure, all the respondent mothers are distributed according to their ages and the distribution is shown at five-year intervals, ranging from 15-35 years of age for all 30 interviewed mothers. In this study, 43.34 percent of mothers belong to the age group of 25-30 years, each 20 percent belong to the age group of 15-20 and 20-25 years, and each 16.66 percent of mothers belong to the age group of 30-35years.

4.1.2 Respondents by Age of Marriage

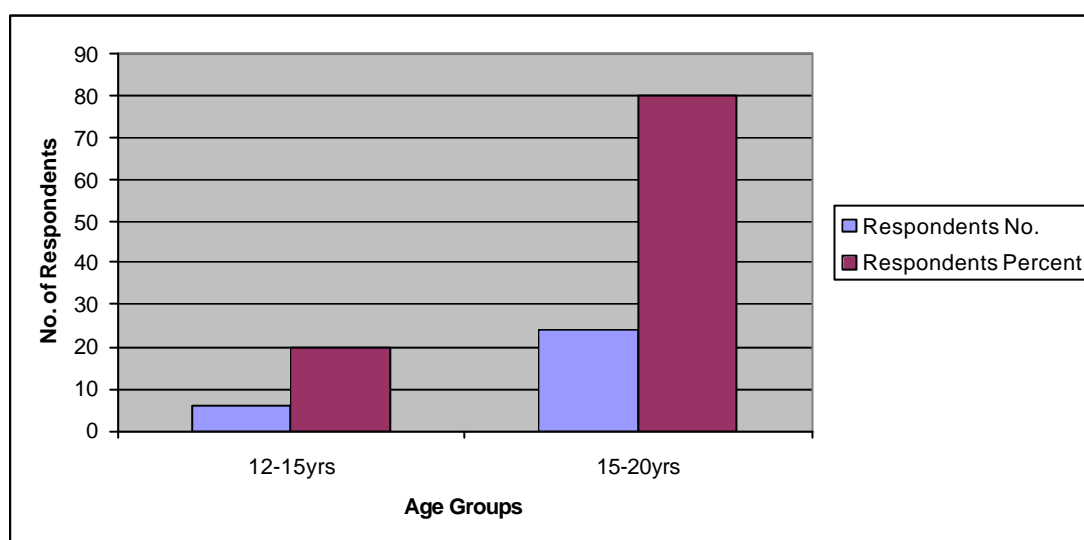
Marriage is one of the most important aspects of life, so it is meaningful for the whole life. Marriage is an institution which admits a man and a woman to lead a family life. In Hindu culture, there are various types of marriage. Due to religious and culture practices, early marriage is still prevalent in Nepal. Most of the Nepali women are married before they reach 18 years of age. The practice of early marriage is quite usual in Pode community as seen in the following table.

Table 4.2
Distribution of Respondents by Age of Marriage

S. No.	Age Group	Respondents	
		No.	Percent
1.	12-15yrs	6	20
2.	15-20yrs	24	80
Total		30	100

Source: Field Survey, 2006

Figure 4.2
Respondents by Age of Marriage



Source: Field Survey, 2006

These table and figure shows that 80 percent girls are married between 15-20 years, and 20 percent of mothers got married between 12-15 years. This result shows that most of the females from Pode caste get early married, with all married when they reached 20 years of age.

4.1.3 Occupational Status

Occupation is a key factor for determining the social status of a person in society. People are engaged in different occupations to live their life comfortably. Without occupation, people cannot meet the increasing demands of family and society. The classification of respondents based on their occupation is given below.

Table 4.3**Distribution of Respondents and Their Husbands' Occupation**

S. N.	Occupation	Respondents			
		Respondent	Percent	Husband	Percent
1.	Sweeper	17	56.66	17	56.66
2.	Housewife	11	36.67	0	0.00
3.	Wastage collector	0	0.00	3	10.00
4.	Others	2	6.67	10	33.34
Total		30	100.00	30	100.00

Source: Field Survey, 2006

The above table shows that 56.66 percent of respondents and their husbands work as sweepers, 36.67 percent of respondents are housewives, 10 percent of respondents' husbands are wastage collectors, and 6.67 percent of respondents and 3.34 percent of their husbands are doing others occupations.

4.1.4 Literacy Status

Education is an integral part of human life. It is an indicator of socio-economic development and is considered as a lamp of intelligence of human life. Education plays a significant role in every aspect of human life. Maternal and child health care is directly related to educational status of the mother and father. Educated women are more aware of the issues related to health and children than uneducated women are. The following table shows educational status of respondent mothers in comparison to their husbands.

Table 4.4
Occupation of the Respondents and Their Husbands

S. No.	Education	Number of Respondents			
		Respondents	Percent	Husband	Percent
1.	Illiterate	20	66.66	13	43.33
2.	Literate	10	33.34	17	56.67
Total		30	100.00	30	100.00

Source: Field Survey, 2006

The table shows that out of 30 respondents, 66.66 percent of respondents and 43.33 percent of respondents' husbands are illiterate, and 33.33 percent respondents and their husbands are literate. Thus, the result shows that most of the respondents and respondents' husbands are illiterate.

4.1.5 Type of Family

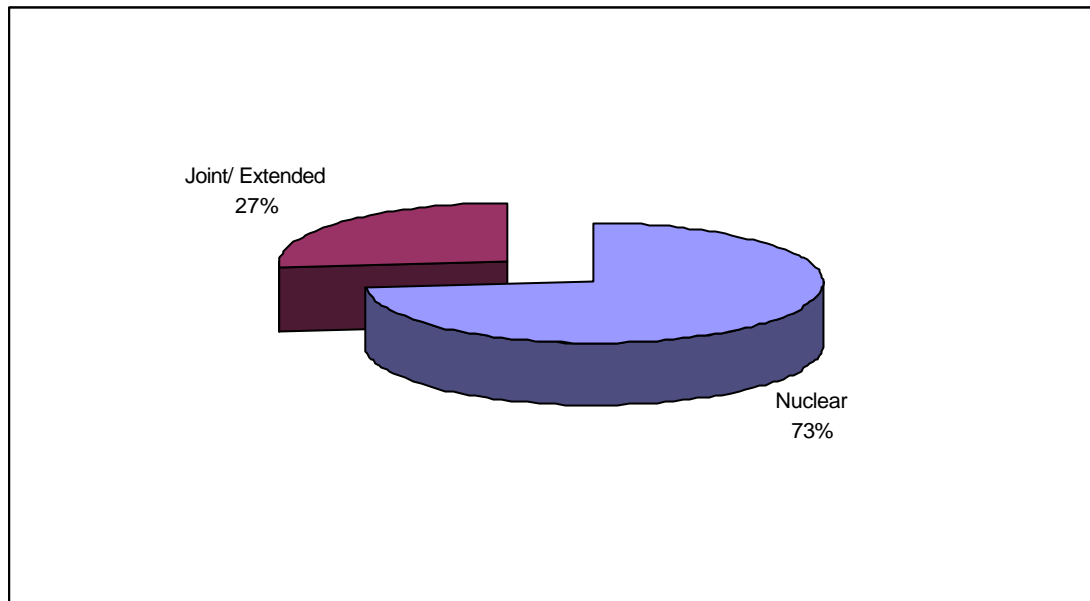
Family is the most important primary group in society. It is considered both as an association and as institution. There are mainly three forms of family according to size: nuclear, joint and extended. However, for our purpose, we define only two types: nuclear and joint/extended. Distribution of respondents by the type of family is presented in the following table.

Table 4.5
Distribution of Respondents by the Type of Family

S. No.	Type of family	Respondents	
		No.	Percent
1.	Nuclear	22	73.34
2.	Joint/ Extended	8	26.66
Total		30	100.00

Source: Field Survey, 2006

Figure 4.3
Respondents by the Type of Family



Source: Field Survey, 2006

Among the 30 respondent, 22 (77.33 percent) were living in the nuclear family system and remaining 8 (26.66 percent) in the joint family system.

4.1.6 Number of Children

Nowadays the concept of small family is growing. Accesses to family planning devices are available at the community level, as well as health education and family planning advocacy is growing. Distribution of respondents by their number of children is given in the table.

Table 4.6
Distribution of Respondents by Their Number of Children

S. No.	Number of Children	Respondents	
		No.	Percent
1.	One	4	13.34
2.	Two	14	46.66
3.	Three	9	30.00
4.	Four and more	3	10.00
Total		30	100.00

Source: Field Survey, 2006

The above table shows that out of the total respondents, 13.33 percent have one child, 46.66 percent have two children, 30 percent have three children, and 10 percent have four children. The table and figure shows that although one third of the respondents were illiterate; on average, they have only two children.

4.2 Maternal and Child Healthcare Practice

Maternal and child health care practice means progression, promotion and protection of health of mother and children who are under 5 years of age. It includes antenatal care, delivery, and postnatal care practices.

4.2.1 Antenatal Care Practice

Antenatal care is care given for women during pregnancy. Better antenatal care practice is necessary throughout the pregnancy period to achieve a healthy child and healthy mother.

This section deals with antenatal health care practices such as health checkups during pregnancy, additional food during pregnancy, TT immunization, breast-feeding and knowledge about dangerous signs and symptoms that may be associated with pregnancy and pregnancy complications.

4.2.1.1 Health Checkup during Pregnancy

Health checkup here means checkup of the pregnant mother's health during pregnancy period. It is very important for the health of the mother and the fetus. The following table presents the report of health checkup during pregnancy as expressed by the women of Poda castes.

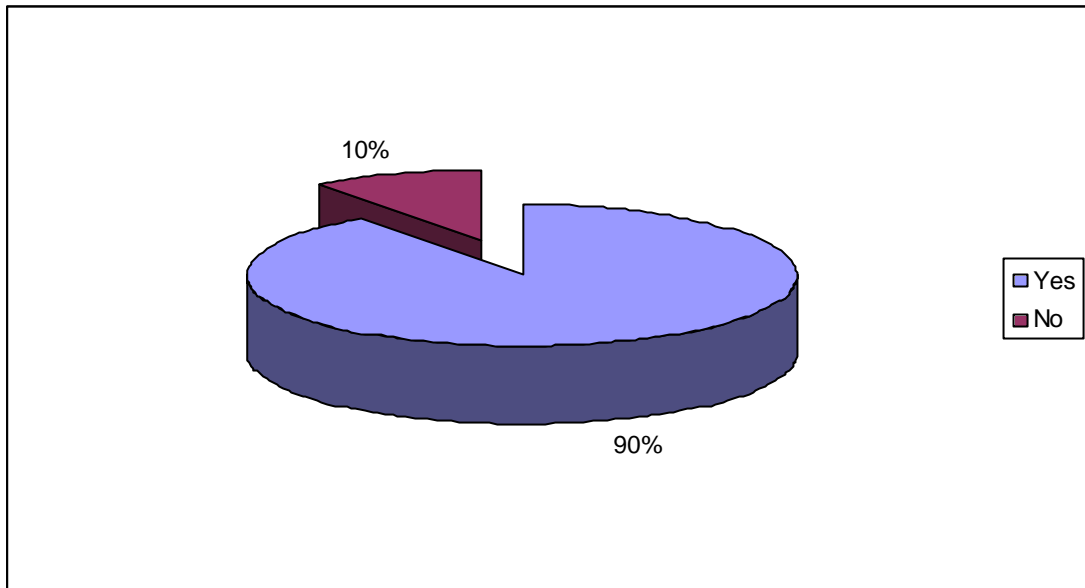
Table 4.7

Distribution of Respondents by their Antenatal Checkup Practice

S. No.	Health Checkup	Respondents	
		No.	Percent
1.	Yes	27	90
2.	No	3	10
Total		30	100

Source: Field Survey, 2006

Figure 4.4
Respondents by Antenatal Checkup Practice



Source: Field Survey, 2006

The above table and figure shows that 90 percent of pregnant women had checkups during pregnancy period whereas 10 percent women had no checkup.

Thus, we can know that health checkup practice in Pode caste mothers is found better. It means that the Pode caste mothers are conscious about maternal and child health care practice.

4.2.1.2 Time Duration of Health Checkup during Pregnancy

Regular health checkup is necessary from the time of conception up to the time of delivery. Starting from conception, monthly checkup is necessary until the period of 28 weeks of pregnancy. After that, fortnightly checkups are necessary up to 36 weeks. After 36 weeks of pregnancy, weekly health checkups are necessary to keep the mother's health in good condition and to achieve a healthy baby at the end. At least four antenatal visits for checkup are required for normal pregnant women for safe delivery. The researcher asked questions about the frequency of health checkup practice during pregnancy. The responses are presented below.

Table 4.8

Distribution of Respondents by Frequency of Checkup during Pregnancy

S. No.	Frequency	Respondents	
		No.	Percent
1.	Once	2	7.40
2.	Twice	1	3.70
3.	Thrice	1	3.70
4.	Monthly	8	29.65
5.	Whatever Necessary	15	55.55
Total		27	100.00

Source: Field Survey, 2006

The above table shows that 7.40 percent of respondents had checkup once, 3.70 percent had twice and another 3.70 had thrice, 29.65 percent had monthly, and 55.65 percent of the mothers had checked up if necessary.

Those having regular health checkups have good awareness of checkup for entire length of pregnancy. The national norm for the frequency of health checkup practice is four times.

4.2.1.3 Tetanus Toxioid Injection

Tetanus toxiod (TT) injection is given to the mother and child to prevent tetanus. Usually, two or three doses of tetanus toxiod injections are given at the first antenatal visit. The second dose is given in pregnancy not less than 6 weeks after the first dose. The third dose is given in the last trimester of pregnancy. The results are presented in the table given below.

Table 4.9**TT Vaccine Practice of Pregnant Women**

S.No.	TT Vaccine	TT Vaccination dose	Respondents	
			No.	Percent
1.	Yes	One dose	2	6.66
		Two dose	8	26.66
		More than two dose	17	56.68
2.	No		3	10.00
Total			30	100.00

Source: Field Survey, 2006

The table show that 27 mothers had TT injection and 3 mothers did not have. 56.68 percent of mothers have taken more than two doses of TT injection, 26.66 percent mothers have taken two doses of TT injection, and 6.66 percent of mothers have taken one dose of injection during their pregnancy period.

4.2.1.4 Dangerous Signs during Pregnancy

Although pregnancy and child bearing is a normal natural process, there are certain risks. Swelling of feet and hands, anemia, bleeding, high blood pressure, fever, etc., are some of the dangerous signs during pregnancy. A woman herself and her family should be familiar with these dangerous signs to prevent them and to minimize morbidity and mortality of the mother and the baby and to seek care in time.

Table 4.10**Dangerous Signs during Pregnancy as Mentioned by Respondents**

S. No.	Dangerous Signs	Respondents	
		No.	Percent
1.	Swelling of Legs	1	3.33
2.	Swelling of Legs/ High BP	1	3.33
3.	Swelling of Legs/Others	1	3.33
4.	High BP	5	16.66
6.	Fever	2	6.66
7.	Nothing	20	66.69
Total		30	100.00

Source: Field Survey, 2006

The above table shows that 3.33 percent of Pode caste women had swelling of legs, 3.33 percent of women had swelling of legs/high BP, 3.33 percent of women found swelling of legs/others, 16.66 percent women found they had fever, and 66.69 percent of women found no dangerous signs during pregnancy. It shows that most of women had normal condition in the pregnancy period.

4.2.1.5 Additional Food during Pregnancy

In the pregnancy period, supplementary food is necessary for growth and development of the fetus, normal delivery, and to prevent anemia and malnutrition in the mother. So, balanced and adequate diet with intake of protein, vitamins and minerals is necessary. Mothers in good nutritional status are better equipped for the strain of labor and for lactation. Poor nutrition before and during pregnancy period results in a baby with low birth weight and can lead to pregnancy complications such as abortion, death of the mother, or death of the infant. In this study, the researcher asked questions about additional food during pregnancy. The information obtained in this area is given below.

Table 4.11**Distribution of Respondents by Additional Food Intake during Pregnancy**

S.No.	Additional food	Once a week	Twice a week	Thrice a week	Daily	Occasional	Percent
1.	Green Vegetable	7	1	1	14	7	30
2.	Meat	15	5	2	7	1	30
3.	Milk/Curd	3	8	9	10	-	30
4.	Daily	-	-	3	-	27	30
5.	Fruit	6	2	4	3	15	30

Source: Field Survey, 2006

4.2.1.6 Work during Pregnancy Period

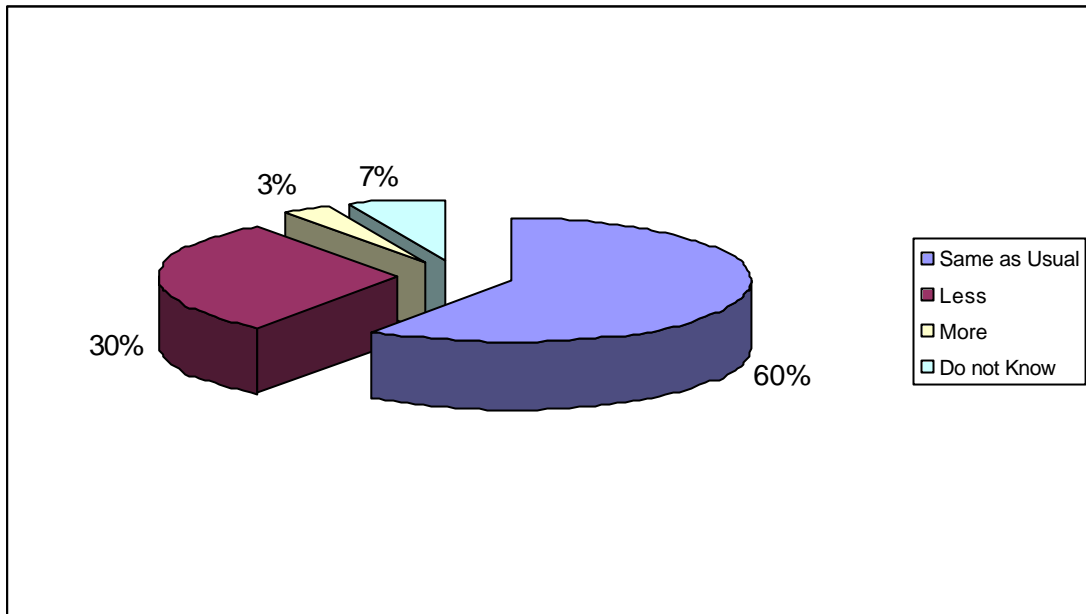
It is widely accepted that pregnant women should not work hard and need to get enough rest. In some cultures, hard work and weightlifting is avoided during pregnancy, but some cultures prefer women to do hard work during pregnancy. Distribution of respondents by their practices regarding work during pregnancy is given in the table below.

Table 4.12**Distribution of Respondents by Amount of Work during Pregnancy**

S. No.	Type of work	Respondents	
		No.	Percent
1.	Same as Usual	18	60
2.	Less	9	30
3.	More	1	3.34
4.	Do not Know	2	6.66
Total		30	100.00

Source: Field Survey, 2006

Figure 4.5
Respondents by Amount of Work during Pregnancy



Source: Field Survey, 2006

Sixty percent of respondents replied that they worked the same as usual, 30 percent replied that they worked less than usual, 6.62 percent replied that they did not work at all, and 3.34 percent replied that they worked more during pregnancy period.

As to the amount of work pregnant mothers should do, most of the participants replied that pregnant women should work same as usual to manage delivery easily, and they have to do so because of nuclear family.

4.2.2 Delivery Practice

4.2.2.1 Place for Delivery

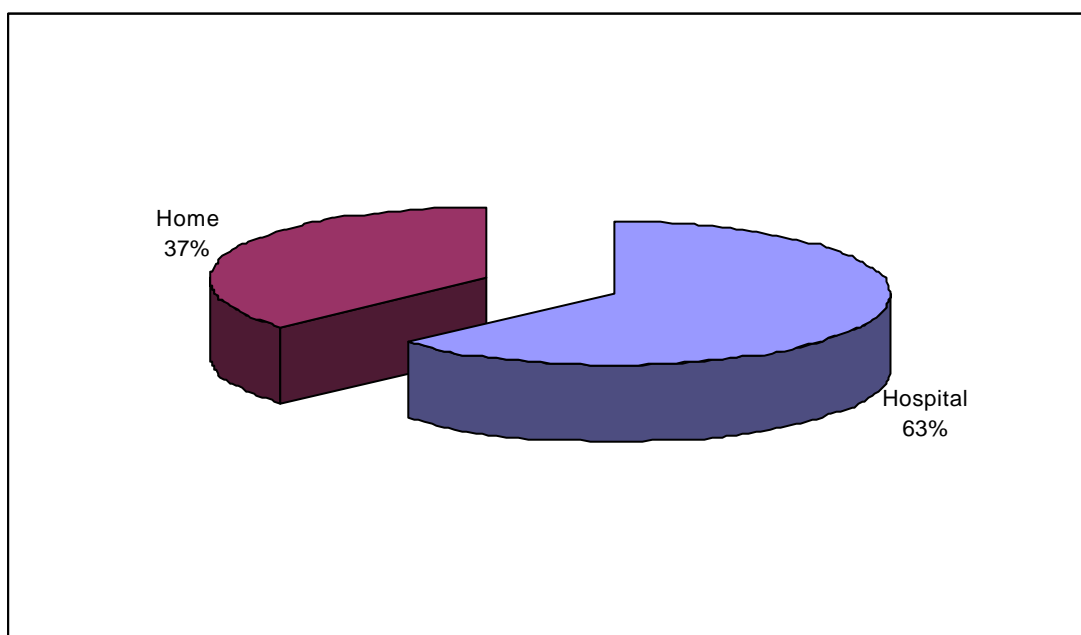
Determination of place of delivery is important for safe labor. Understanding about maternal health, availability of services, and socio-economic condition of the family determine the choice of place for delivery, i.e., home or hospital. The preference for place of delivery is given here for the study area.

Table 4.13
Distribution of Respondents by Preference of Place for Delivery

S. No.	Delivery at	Respondents	
		No.	Percent
1.	Hospital	19	63.33
2.	Home	11	36.67
Total		30	100.00

Source: Field Survey, 2006

Figure 4.6
Respondents by Preference of Place for Delivery



Source: Field Survey, 2006

The above table and figure shows that among the total respondent mothers, 63.33 percent of them delivered their babies in a hospital and 36.67 percent of them at home. Although Kirtipur is not so far from Kathmandu and Patan, where modern facilities for maternity are located, a significant number of women delivered at home.

4.2.2.2 Types of Delivery Assistants

Delivery assistants are necessary for safe delivery and to get emergency help during labor. The helpers for this period are called delivery assistants, health personals, traditions birth attendants (TBA), and family members, usually the mother-in-law. The following table shows what types of delivery assistants were generally employed in Poda caste people at the time of delivery.

Table 4.14
Assistants during Delivery Periods

S. No.	Delivery	Respondents	
		No.	Percent
1.	TBA	9	81.82
2.	Family member	2	18.18
Total		11	100.00

Source: Field Survey, 2006

The above table shows that among the total mothers, majority of them (81.82 percent) delivered with the help of TBA, and in remaining 18.18, delivery was attended by family members. It is concluded that majority of the mothers delivery cases were assisted by trained TBA rather than a family member.

4.2.2.3 Home Delivery Complications

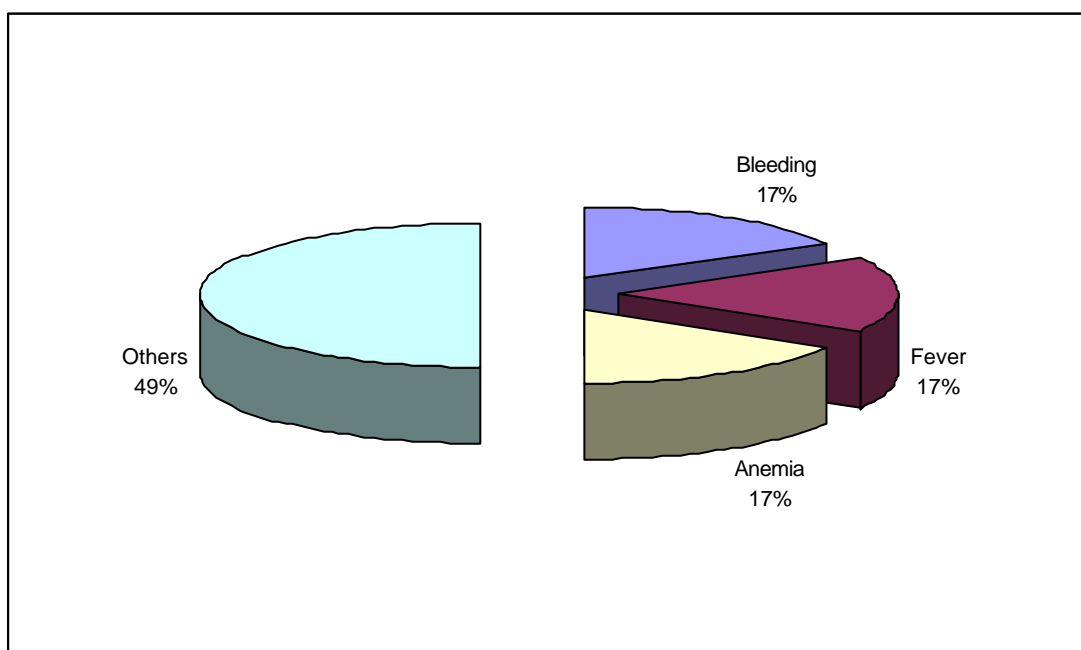
Home delivery complications are a major cause of maternal mortality and morbidity. This means that a substantial number of women suffered serious complications such as abortion, bleeding, etc., which directly affect fertility, pregnancy, birth and breast-feeding of the mothers (World Bank Report 1989). The highest risk arises when the mother needs cesarean section due to, say, breech position, which cannot be provided at home. The available information about home delivery complications during pregnancy is presented below.

Table 4.15
Distribution of Respondents by Home Delivery Complications

S. No.	Complications	Respondents	
		No.	Percent
1.	Bleeding	1	16.66
2.	Fever	1	16.66
3.	Anemia	1	16.68
4.	Others	3	50.00
Total		6	100.00

Source: Field Survey, 2006

Figure 4.7
Respondents by Home Delivery Complications



Source: Field Survey, 2006

The above table and figure shows that the majority, 50 percent, of respondent mothers had other complications during home delivery practices. Among them, 16.66 percent of the mothers had bleeding, 16.66 percent of the mothers had fever, and 1 percent had anemia as home delivery complications.

4.2.2.4 Cord-Cutting Practices

It is important to cut the cord after the birth of a baby. But it should be done carefully to avoid risks of different kinds of infectious diseases. Neonatal tetanus has been associated with the use of unsterilized cord-cutting instrument. The use of sterilized cord-cutting technique is very important for safe delivery and to save the mother as well as the child's life.

The effective cord cutting practice depends on the condition of the equipment used. The equipment which has not been properly disinfected may invite different kinds of infectious diseases. It is therefore necessary to ensure the condition of the equipment before it is used to cut the cord. In this, both the cord-cutting person and cord-cutting instruments are included. Obviously, in the hospital setting, the doctor or health professional is the cord-cutting person.

Table 4.16
Status of Cord-Cutting Practices

S. No.	Cord-Cutting Person	Respondents	
		No.	Percent
1.	Family Member	2	6.66
2.	Health Professional	1	3.33
3.	TBA	8	26.66
4.	Doctor	19	63.35
Total		30	100.00

Source: Field Survey, 2006

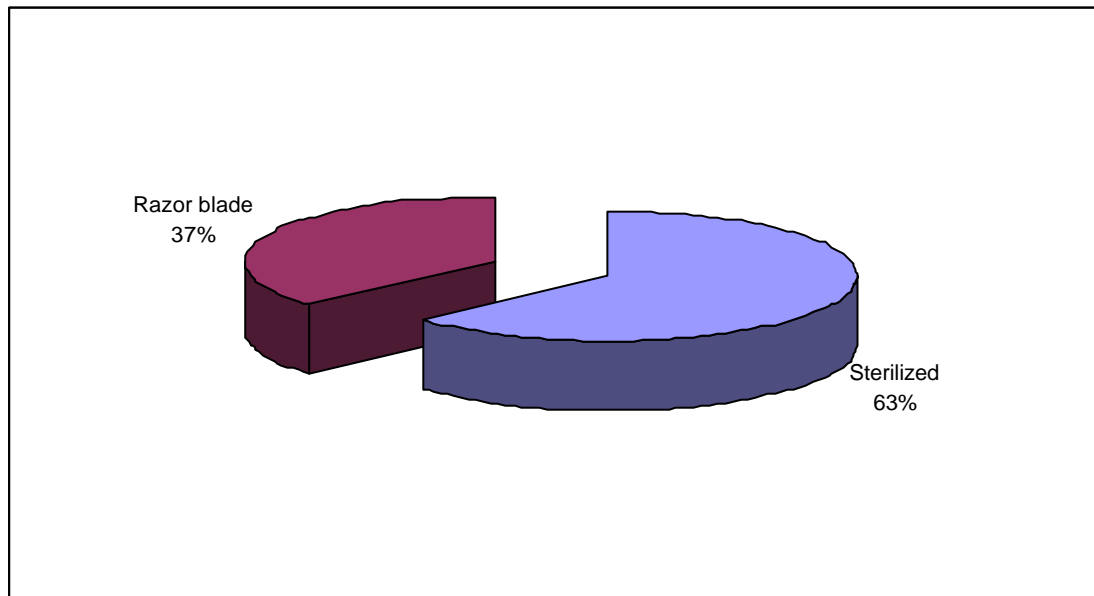
The above table shows that in 63.35 percent of the total respondent mothers, the cord-cutting practice was done by doctor or other health professional in a hospital, 26.66 percent of them by TBA, 6.66 percent by a family member, and remaining 3.33 percent of cord-cutting practices were done by health personals.

Table 4.17
Cord-Cutting Instruments

S. No.	Cord-Cutting Instrument	Respondents	
		No.	Percent
1.	Sterilized	19	63.33
2.	Razor blade	11	36.67
Total		30	100.00

Source: Field Survey, 2006

Figure 4.8
Cord-Cutting Instruments



Source: Field Survey, 2006

The table and figure shows that in the majority of cases (63.33 percent), a sterilized cord-cutting instrument was used, and in 36.67 percent of cases, a razor blade was used as cord-cutting instrument.

4.2.3 Postnatal Care Practices

The six-week period after delivery is called postnatal period. It is the time required to revolute the uterus and to regain personal health as well as to maintain neonatal baby care. The main aim of postnatal care is to prevent complications of the

postnatal period, to check adequacy of breastfeeding, and to provide adequate nutrition to the baby. Such practices include first milk feeding practices, breast-feeding practices, weaning practices, and child immunization practices.

4.2.3.1 Breastfeeding Period

Breast milk is the best food for an infant. It is necessary to feed mother's milk until the child reaches two years of age. In breast milk, all types of necessary nutritious substances and antibodies are present to help protect the infant against diarrhea and respiratory disease in the first few months. It also prevents malnutrition and reduces child mortality.

The longer a woman breast-feeds, the lower is her chance of conceiving a baby. Though breast-feeding in Nepal is common, cultural pattern and ritual sanction its prolonged use (Paneru, 1980). Breast-feeding is affected by the age of women's education and working status, place of residence, and death of child (Risal and Sharma, 1989). The information collected regarding the duration of breast-feeding practice in the study area is tabulated below.

Table 4.18
Distribution of Respondents by Duration of Breast-feeding Period

S. No.	Period	Respondents	
		No.	Percent
1.	12-18 months	2	6.66
2.	18-20 months	6	20.00
3.	More than two years	22	73.34
Total		30	100.00

Source: Field Survey, 2006

A large percent of respondents in the study area were feeding breast milk until they did not have another baby. About 73.34 percent were feeding breast milk for more than two years, 20.00 percent were feeding for 18 to 20 months, and only 6.66 percent said that they fed for 12 to 18 months.

4.2.3.2 Weaning Practices

Weaning practices differ in different communities and societies. Supplementary food—semi-solid and liquid—is started after 4 months, which increases the risk of diarrhea and other illnesses. Appropriate supplementary food starting age is 4 to 6 month after childbirth.

Table 4.19
Age of Weaning Practices

S. No.	Weaning Age	Respondents	
		No.	Percent
1.	Earlier than 4 months	4	13.33
2.	Between 4-6 months	7	23.35
3.	After 6 months	8	26.66
4.	After 9 months	2	6.66
5.	After 1 year	9	30.00
Total		30	100.00

Source: Field Survey, 2006

A good aspect of the Pode families was that they do weaning practice after four months. However, 30 percent of mother began weaning practice after 6 months, 23.33 percent between 4 to 6 months, 13.33 percent began earlier than 4 months, and only 6.66 percent said that after 9 months they began weaning practice.

4.2.3.3 Supplementary Food Practices

Supplementary foods are those that in terms of quality and quantity meet the nutritional requirements for the development of the child. Therefore, additional meal must be fed to the child after four or five months for adequate calories, protein, and vitamins. The main foods are rice, pulses, vegetable, *jaulo*, milk, soup, fruits, and *lito*. The practice of using supplementary feeding to a weaned child is presented below.

Table 4.20
Types of Supplementary Food for Weaning Babies

S. No.	Supplementary Food	Respondents	
		No.	Percent
1.	<i>Lito</i>	3	10.00
2.	<i>Lito, Jaulo</i> , Soup, Fruit, Juice and Milk	3	10.00
3.	<i>Jaulo</i> , Soup, Fruit Juice and milk/rice+ <i>Dal</i>	5	16.66
4.	Rice + <i>Dal</i>	14	46.68
5.	Rice + <i>Dal</i> and others	2	6.66
6.	Others	3	10.00
Total		30	100.00

Source: Field Survey, 2006

It was found that 46.68 percent of Pode women use usual rice plus *dal* as their supplementary food; whereas 16.66 percent of them use *jaulo*, soup, fruit juice, and milk/rice plus *dal*; 10 percent of them use *lito*, *Jaulo*, soup, fruit juice, and milk; 3 percent of them use rice plus *dal* and other; and 2 percent of them use other foods for supplementary their children.

4.2.3.4 Type of Immunization Practice

Immunization is one of the most important components to protect children from various diseases, such as tuberculosis, whooping cough, tetanus, diphtheria, poliomyelitis, and measles. These six types of child killer diseases can be prevented by immunization. These practices of immunization are given is the table below.

Table 4.21
Type of Immunization

S. No.	Type of Immunization	Respondents	
		No.	Percent
1.	Only BCG	2	6.66
2.	BCG/DPT	3	10.00
3.	BCG/DPT/Polio	2	6.66
4.	BCG/DPT/Polio /Measles	23	76.68
Total		30	100.00

Source: Field Survey, 2006

Table 4.21 indicated that 23 (76.68%) had immunized their children against six types of child killer disease. Likewise, 10 percent of the mothers had immunized their children with BCG/DPT; where as 6.66 percent of the mothers had immunized BCG/DPT/Polio.

4.2.3.5 Type of Water Used for Bathing

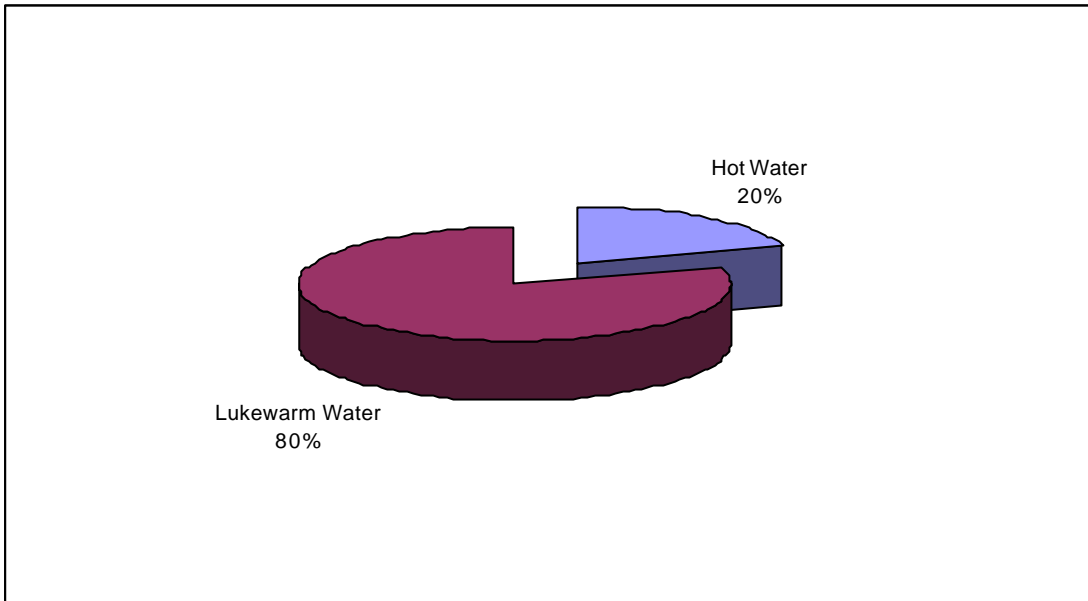
It is necessary to bathe a baby from time to time. It is important to ensure that the water is clean. Since newborn infants are susceptible to cold and their skin is very sensitive, the temperature of the water should be moderate. The following table provides the condition of water for bathing babies in the study area.

Table 4.22
Type of Water Used for Bathing

S. No.	Water	Respondents	
		No.	Percent
1.	Hot Water	6	20
2.	Lukewarm Water	24	80
Total		30	100

Source: Field Survey, 2006

Figure 4.9
Type of Water Used for Bathing



Source: Field Survey, 2006

The table and figure shows that 80 percent of the mother used lukewarm water for bathing their babies, and 20 percent mother used hot water for bathing their babies.

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary

Maternal and child health is an important indicator of social well-being of a country. But status of health in Nepal is not impressive. Like in many least developed countries, Nepal also has many problems concerning health and health services. The major health problems are high maternal mortality and morbidity, child mortality, prevalence of communicable disease, high fertility rate, unsafe motherhood, malnutrition and poor health practice.

The purpose of the study was to find out the socioeconomic and demographic characteristics of the Pode community, to assess the antenatal care, delivery and postnatal care practice of colostrum feeding, child immunization, and additional food feeding to the women of the Pode community.

To fulfill the objectives, 30 respondents were selected by purposive sampling method and both quantitatively and qualitative techniques have been used. Both primary and secondary data have been used to analyze the present social status of the maternal and child health care. The primary data has been collected from structured questionnaire, key informant interview and focus discussion, whereas secondary data has been collected from internet, books, relevant literature, journal and other available sources about related subjects.

Based on the survey, focus group discussion and informant interview, the major finding has been presented:

- According to the study, the majority of the respondents 46.66 percent are in the 25-29 year age groups. Similarly, the majority of the respondents 26.67 percent are in between ages 15-19 years.
- Most of respondents 56.66 percent mothers are sweepers and 36 percent are engaged in household activities. The education status of the mothers is very low in comparison to their husbands.

- Out of 30 respondents 66.66 percent women and 43.33 percent of their husband are found to illiterate.
- Majority, 73.33 percent, of the respondents belong to the nuclear family.
- Majority, 46.66 percent, of the respondents have two children.
- All of the respondents are landless.
- 90 percent of the respondents had continuously had health checkup during their pregnancy period.
- Majority 62.96 percent of the respondents have taken more than two doses of the TT injection during pregnancy period.
- Majority, 60 percent, of the respondents work the same as usual during pregnancy period.
- About 30 respondents (63.66 percent) delivered at hospital and 11 (36.64 percent) respondents delivered their babies in their homes.
- Out of 11 respondents, 81.82 percent were delivered by TBA and remaining 2 (18.18 percent) of the respondents delivered attained by family members.
- In home delivery, razor blade was the main instrument for cord cutting.
- All of the mothers fed their infants with colostrum immediately after the baby was born, and about 73.34 percent respondents had breastfed their children more than two years.
- Out of the 30 respondents, 30 percent respondents have weaning practices their children between 4-6 months.
- 46.68 percent of the respondents have Rice plus *dal* as supplementary food practice to the babies.
- All of the respondents have immunized their children.
- 30% of the respondents child have health problems after birth such as ART, diarrhea, dysentery, pneumonia and others diseases.
- Most of the respondents take meat daily as their additional food during pregnancy period.
- Those who are jobholders went to their work two and a half months after the postnatal care.
- Majority, 70 percent, of the respondents have family support during postnatal period.
- Three of the respondents' children were dead because of pneumonia.

- All respondents use tap water for drinking.
- The size of the houses in Poda community is normal and sanitation system is not so good.

5.2 Conclusion

The Podas are untouchable groups or Dalits, and their economic, social, educational, and other status are low compared to other castes. This difference is indicated in the present study also. Although we have no data on other groups in the Kirtipur municipality area, the prevalence of delivery at birth indicates lack of knowledge and resources because healthcare services can be obtained in the Kathmandu city proper, which is not far away. Due to the poor educational status of women as well as their husbands and low economic level, pregnant women could not afford to eat healthier and nutritious diet during pregnancy. Moreover, due to the nature of their occupations, such as sweeping, handling waste, and poor sanitation, the health risk of this community is higher, which is the reason of observed infant deaths. The early age of marriage of women also seems to have compounded the maternal and child health care practice among them. Although these practices are satisfactory from a national level point of view, it lags far behind if we consider the proximity of the numerous hospitals and health centers in the vicinity of Kirtipur and if we compare it to other groups. Thus, various social, economic, educational factors are contributing to their not up-to-par performance in the maternal and child health care practices.

5.3 Recommendations

Based on the findings of the study, the following recommendations can be made:

- a) Early marriage has been one of the drawbacks of these caste groups, so women should be encouraged for late marriage.
- b) Higher priority should be given to education.
- c) Developmental programs should be launched to such Dalit groups for improving their performance in health, education, and political participation so they are better aware of their own socioeconomic states and can change it.
- d) Special health programs should be launched for such communities for improving the nutritional status and personal hygiene that help to reduce

child mortality and morbidity. The present study is limited to maternal and child health care practice among Poda community, and the further researcher could also be done on them with regard to occupational health and consumer's health.

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www.unicef.org

www.unief.org/immunization

Appendix I
Questionnaire for Household Survey
MATERNAL AND CHILD HEALTH CARE PRACTICES IN PODE
COMMUNITY

Respondent: Female (Mother)

Name:

Age:

Age of Marriage:

I. Socio-economic and Demographic Characteristics

1. Occupation of the Mother (Respondent):

- | | |
|-----------------|----------------------|
| (a) Agriculture | (b) Sweeper |
| (c) Housewife | (e) Others (Specify) |

2. Occupation of Husband:

- | | |
|----------------------|-----------------------|
| (a) Agriculture | (b) Wastage Collector |
| (c) Business | (d) Sweeper |
| (e) Others (Specify) | |

3. Do you have your own land?

- | | |
|---------|--------|
| (a) Yes | (b) No |
|---------|--------|

If yes, how much?

- | | |
|------------|----------|
| (a) Ropani | (b) Anna |
|------------|----------|

4. Education of the Respondent:

- | | |
|----------------|--------------|
| (a) Illiterate | (b) Literate |
|----------------|--------------|

5. Type of family

- | | |
|-------------|--------------------|
| (a) Nuclear | (b) Joint/Extended |
|-------------|--------------------|

6. Number of Family Members:

S. No.	Name	Sex	Age	Occupation	Education

7. Religion:

- (a) Hindu (b) Buddhist
(c) Christian (d) Others (Specify)

II. Antenatal Care Practice

1. When was your first pregnancy?

- (a) Year... .. Month... .. Day

2. During pregnancy and lactation, how much food should be taken?

- (a) More than usual (b) Same as usual
(c) Less than usual (d) Do not want to say

3. Did you take additional foods during pregnancy?

- (a) Yes (b) No

If yes, how often?

Additional Food	Once a Week	Twice a Week	Thrice a Week	Daily	Occasionally
Green Vegetables					
Meat/Egg					
Milk/curd					
Fruit					
Others					

4. Would you tell me the most dangerous signs you had during the pregnancy period?

- (a) Leg swelling
- (b) Anemia
- (c) Bleeding
- (d) High blood pressure
- (e) Fever
- (e) Other (Specify)

5. Did you go for health checkup during pregnancy period?

- (a) Yes
- (b) No

If yes, how many health checkups did you make during the pregnancy period?

- (a) Once
- (b) Twice
- (c) Thrice
- (d) Monthly
- (e) Whatever Necessary

If no, why?

- (a) Lack of time
- (b) Lack of Knowledge
- (c) By the shame
- (d) Lack of Health facilities
- (e) Others (Specify)

6. Did you take TT injection during pregnancy period?

- (a) Yes
- (b) No

If yes, how much?

- (a) One dose
- (b) Two dose

(c) None

7. Who supported you when you were pregnant?

- (a) Husband (b) Family
(c) Others (Specify)

8. How much did you work during pregnancy period?

- (a) Same as usual (b) Less
(c) More (d) Do not work at all

III. Delivery Practice

1. Where was the baby delivered?

- (a) Hospital (b) Clinic
(c) Home (d) Others

2. If at home, who attended the delivery?

- (a) Health personnel (b) TBA
(c) Family member (d) Others (Specify)

3. What were the home delivery complications?

- (a) Bleeding (b) Fever
(c) Anemia (d) Others (Specify)

4. At the delivery time, who cut the cord and tied?

- (a) Family member (b) Health personnel
(c) TBA (d) Doctor
(e) Others (Specify)

5. What instrument was used for cutting the cord?

- (a) Sterilized (b) Razor blade

IV. Postnatal Care Practice

1. Did you feed colostrum to your newborn baby?

- (a) Yes (b) No

2. How long did you breast feed to your child?

- (a) Less than 6 months (b) 12-18 months
(c) 18-20 months (d) More than 2 years

3. Did you wash/clean your breasts before feeding?

- (a) Yes (b) No

If yes, what do you use?

- (a) Water (b) Water and soap
(c) Other (Specify)

4. When did you start weaning your child?

- (a) Earlier than 4 months (b) Between 4-6 months
(c) After 6 months (d) After 9 months
(e) After 1 year

5. What type of supplementary food do you used to feed?

- (a) *Lito* (b) *Jaulo*, soup, fruit juice, and milk
(c) Rice and *dal* (d) Others (Specify)

6. Do you think it is necessary to eat additional food by breast-feeding mothers?

- (a) Yes (b) No

7. How often did you bathe your child?

- (a) Daily (b) Once a week
(c) Twice a week (d) Once a month

8. What type of water did you use to bath your child?

- (a) Hot water (b) Lukewarm water

9. Did you immunize your children?

- (a) Yes (b) No

If yes, what type of immunizations do you give to your child?

- (a) DPT (b) Polio up to 5 year
(c) B.C.G. (d) Measles

If not, what are the reasons?

- (a) Ignorance (b) Lack of immunization
(c) Negligence (d) Superstition

10. After the birth of baby, did you get any health problems on your child?

- (a) Yes (b) No

If yes, what is the most prevalent disease that affected your child?

- (a) ART (b) Malnutrition
(c) Diarrhea/Dysentery (d) Others (Specify)

11. What measures have you done to prevent from such disease?

- (a) Curing at home (b) Help of *Dhami/Jhakri*
(c) Help of Doctor (d) Others (Specify)

12. After how many months did you go for work after postnatal care?

.....

13. Do you have family support during postnatal care?

- (a) Yes (b) No

14. Have any of your children died?

- (a) Yes (b) No

15. What was the main disease that caused the death?

.....

16. Where do you take them for care?

- (a) Hospital
- (c) Health post
- (e) Others (Specify)

- (b) Clinic
- (d) *Dhami/ Jhak*

Appendix II

PHOTOS



Photo 1. Because nervous system of a newborn is immature, it sleeps a great deal.



Photo 2. A mother holding her six-day old infant. After the birth of a baby, the parents are encouraged to hold their newborn.



Photo 3. The Researcher collecting primary data with respondents.



Photo 4. The Researcher along with respondents for Focus Group Discussion.