CHAPTER-ONE

INTRODUCTION

1.1 Background of the Study

Maternal health refers to the health of women during pregnancy, childbirth and the postpartum period. While motherhood is often a positive and fulfilling experience, for too many women it is associated with suffering, ill-health and even death. Maternal and child health care practice means the maintenance and promotion of maternal and child health status. Maternal and child health care includes taking all necessary cautions in order to improve and protect health of mother and child. The main aim of maternal health care services is reducing maternal child mortality and morbidity. This concept includes (a) antenatal care practice (b) delivery practices and (c) postnatal practices (Adhikari, 2000).

Antenatal care includes the care of the mother before the delivery. The maternal health care service that a mother receives during her pregnancy and at the time of delivery is important for the wellbeing of the mother and child (Adhikari, 2000).

The place of delivery at the place of their living (home) or health facility, types of delivery assistance, and use of delivery kits are important for health and well-being of the mothers and their child. Rituals of disposing the placenta, traditional practices of shaping the head of the newly born baby, and in the case of a child's death, the ritual of death procession are important to explore. These practices vary from place to place, among cultural group and over time.

Place of delivery is one of the most important factors affecting maternal health. A large portion of maternal deaths occur at home. In Nepal many deliveries take place at home and only a few children are delivered at hospital and health post (Timilsina, 2004). While delivering babies at home is a practice that has continued since ancient periods, and women giving birth to the child at home often report feeling very safe, in complicated cases modern hospitals and health posts can be the lifesavers (Timilsina, 2004).

Assistance during delivery is an important component for a healthy and safe delivery for both mother and a newly born baby. If women receive assistance from a medical person during her delivery, she will face fewer complications (Timilsina, 2004).

Breast feeding is nutritious food for children, especially during their infancy period. It consists of antibodies and other substance which protect the baby against disease. First milk is given as colostrum, prepared by the mother immediately after delivery. It carries, immunity to fight the disease and high nutritive value for the infant (Timilsina, 2004).

Maternal health is the health status of women during pregnancy, childbirth and the post-partum period, which incorporates the health care dimension of family planning preconception, and prenatal and postnatal care to reduce maternal mortality (Mahara, 2016).

Maternal mortality (MM) is one of the major health issues in Nepal. In 1996, the Nepal family Health survey estimated maternal mortality ratio (MMR) to be 539 per 100,000 live births, which was the highest among the south-Asia countries at that time. The Demographic Health survey (DHS) 2006 showed Nepal MMR as 281 per 100,000 live births, a decrease by almost 50% (Suwal, 2008).

The Maternal Mortality ratio (MMR) in Nepal decreased from 539 maternal deaths per 100,000 live births to 239 maternal deaths per 100,000 live births between 1996 and 2016. In 2016, roughly 12% of deaths among women of reproductive age were classified as maternal death (Banstola, 2017).

The use of maternal health services (MHS) depends on several enabling factors such as a) availability of health services, b) accessibility of health services in terms of distance from a woman's place of domicile; cost of services to be rendered, cost of transport, in the context of this study, it means certain biological (age and parity),cultural (religious beliefs, ethnicity, female autonomy) and socioeconomic characteristics (education, income levels, place of domicile, marital status) will predispose some women to use or not to use MHS which could positively or negatively influence the outcome of pregnancy (Anderson & Newman, 2005). Although, this work has focused on predisposing factors at individual level, the model caters for predisposing factors at community level that are known to influence the use of MHS. These community level factors include the demographic profile of the community, collective and organizational values, cultural beliefs and political viewpoints. The cultural characteristics of a woman included the expected stereotype behavior of a pregnant woman in a given community, tribe or

religion to pregnancy and her use of MHS. Those with appropriate knowledge, positive attitude and effectiveness of MHS are likely to use these services (Umar,2016).

The Mushahar community, in Terai Nepal is socially and economically one of the most marginalized communities in Nepal and they are poorest amongst poor. The Mushahar community falls under the category of Dalit. The Mushahar, they famous named by “Rat eaters”. It is considered the worse of Dalit groups which are the most segregated communities in Nepal. They are discriminated for their skin color, religion, and traditions. They belong to the Hindu religion (Shah, 2016, pp.1). This thesis focuses on maternal health service practices in Mushahar community.

1.2 Statement of the Problem

Traditionally, pregnancy is considered to be natural in Nepal. Thus, regular check-ups were thought to be unnecessary, particularly in rural areas, unless there were complications. One study unveiled that some groups of women in Nepal still do not seek antenatal care (ANC) because they think infants would more likely to die if they do so while these infants are in the womb (Suwal, 2008).

According to Nepal Demographic and Health Survey 2017, eighty-four percent of women who gave birth in the 5 years before the survey received antenatal care (ANC) from a skilled provider, a 25-percentage point increase from 2011. Sixty-nine percent of women had at least four antenatal care visits, fifty-eight percent of deliveries are conducted by skilled birth attendants, and 57% of deliveries take place in a health facility and percentage of live births in the 5 years before the survey that were delivered in a health facility, women who did not deliver their most recent birth at a health facility were asked why? The most commonly reported reason was that it was not necessary to deliver in a health facility (56%) followed by the birth taking place before reaching the facility (18%) and the facility being too far away or not having transportation (17%) Notably, 80% of mothers in province 2 said they felt that it was not necessary to deliver in a health facility. In province 7, 38% of mothers said the birth took place before reaching the facility (NDHS, 2017).

According to national population census 2011, the total population of indigenous community is 13.33% of the total population of Nepal. Maternal health care knowledge and practice of indigenous community is influenced by their cultural practices. They have

their own kind of perception about maternal care. They worship to their God for the better health of pregnant women and unborn child, they believed that, this kind of worshiping keep the pregnant women and the unburned child healthy and secure. Due to traditional superstitions, cultural values. They usually do not go to hospital for the check up during pregnancy period (Khanal, 2001).

Suwal (2008) In rural areas, early marriage is traditional. The mean age at marriage for Nepalese women is as low as 19.5 years (CBS, 2006), was even lower at 18 years a decade ago (CBS, 1995). Early marriage also means early pregnancy and childbirth, both of which are harmful to very young women as their body may not be physiologically ready to bear children. Frequent births, then, entail repeated life–threading process (pp.4).

Maternal mortality in Nepal is mainly due to three delays: delay in seeking care, delay in reaching care and delay in receiving lifesaving interventions once reaching the health facilities (Bhusal, 2015. pp.68).

The further analysis of the 2006 NDHS revealed that 28 percent of the country's population consist Dalits, Muslims, Terai/Madhesi and other groups who had consistently low levels of most indicators regarding health. In terms of maternal health, there was a consistent pattern of disparities among the different groups in the use of ANC, delivery by an SBA, and delivery in a health facility. Less than 35 percent of Muslims, Terai Janjati, and Hill Janjati women received ANC from an SBA; an even lesser percentage delivered in a health facility supported by an SBA. Likewise, Terai/Madhesi Dalits had lowest percentages delivering in a health facility as well as poorest nutritional status. The study by Suvedi and colleagues found much higher maternal mortality ratio (MMR) among Muslims, Terai/Madhesi and Dalits compared with the Brahman/Chhetri and Newar (Bhusal, 2015. pp.68).

Poorer women have other financial barriers. Research in other low-and middle-income countries such as Nigeria show that acquiring money was one of the three major barriers for women, in addition to long distance and unavailability of transport to ANC services (Fagbamigbe and Idemudia, 2015). Previous studies, including the 2011 NDHS results, show that the odd of completing four or more ANC visits is higher among richer women (Pandey et al., 2013). This finding is supported by other small-scale studies from Nepal, which found richer women had higher odds of using ANC services and higher levels of

autonomy associated with being a member of an advantaged ethnic group (Deo et al.,2015). This suggest that poor economic status continues to be a barrier to utilizing ANC services in Nepal because although ANC care is free, associated costs, for Example those related to the travel to health facilities, are barriers to ANC services utilization (Aryal, 2019, p.36).

Bhusal (2015) Underutilization of health services are big challenges for Nepal. Different factors such as lack of awareness, cost involved in availability of health facilities, prohibition by head of family, less education and low family income are reasons of not delivering children in health institutions. Deliveries at home by unskilled birth attendants are still common, even in a rural area relatively close to capital city of Nepal. Key factors associated with the uptake of skilled delivery care included. Age, ethnicity, occupation and education of women as well as their husbands, number of pregnancies and children, use of ANC, and experience of problems during pregnancy. The main teenagers die each year because they are pregnant before they are physically mature enough for successful motherhood. Therefore, teenage pregnancies and births are considered as great challenges (pp.69-70).

In the Nepali society, the utilization of maternal health care services is going to increase. But still most of the women do not have knowledge that they should adopt these services. According to Nepal Demographic and Health survey (2016), there were large socioeconomic disparities in this area as well. While 90% women in the highest wealth quintile delivered in a health facility, the same was true for only 34% of women in the lowest quintile. 89% of the wealthiest women delivered with an SBA, but only 34% of the poorest women did so. The main reason for insufficient MCH care practice in Nepal is due to minimal level of education or low economic status and lack of adequate knowledge about health care practices. Teenage pregnancy, excessive child bearing tradition and other socio-cultural factors contribute to increase population growth as well as fertility rate which decrease the health status of mother and children.

This research has focused on the following questions:

1. Which factors play an important role to use maternal health services?
2. What are the challenges faced by Mushahar women during their pregnancy?

1.3 Importance of the Study

Because of high level of early marriages and early child bearing in most of the Mushahar community, pregnancy and child birth are the two leading causes of deaths among women and children. Use of skilled antenatal and delivery care improves maternal outcomes through the prevention, management and treatment of obstetric complications and infant immunizations prevent many childhood diseases. Maternal mortality is a social as well as economic problem which depends on maternal health. In Nepali society the condition of maternal health is one of the problems which support to increase maternal mortality.

This study has collected information about the knowledge, practices, health seeking behaviors of mothers with children who have been living in Mushahar community, Motigada -7, Udayapur. Therefore, this study has helped to know present condition about knowledge level, practices and health seeking behaviors of rural areas women and this study also has provided baseline information about such conditions which support to make suitable program for program planner, policy makers and other who are interested in this field.

CHAPTER-II

LITERATURE REVIEW

This chapter highlights the Maternal and Child Health varies in different sectors. The limited numbers of books, articles, research report have been consulted and reviewed the shed light on the subject under study.

2.1 Theoretical Review

Kevin White explains medical knowledge is also shaped and produced out of economic and racial practices contradictor. White further adds Marxist approaches emphasize the causal role of economics in the production and distribution of disease, as well as the role that medical knowledge plays in sustaining the class structure (White 2002, p.6). He emphasizes the role of medicine in maintaining social harmony, pointing to the non-market basis of professional groups. At the same time its critical sociological edge is maintained by the way it highlights the social control function of medicine in enforcing compliance with social roles in modern society (White 2002, p. 3).

In mean time since sociologists do not accept the medical model of disease and illness as simply biological events, they then examine the social functions of medical knowledge. That is, they examine the way medical and biological explanations of disease function in our society. Medical knowledge is produced in and reflects structural features of society. It explains as 'natural' what, from a sociological perspective, are social phenomena. Why the working class is sicker and dies earlier? why women are diagnosed sick more than men? Why ethnic groups do not receive the services they need? Requires a sociological explanation and not a biological one (White 2002, p.13).

Medical knowledge is not disinterested, objective, scientific knowledge, but is both shaped by and shapes the social structures within which it is embedded. There is little evidence that disease is caused by purely biological factors, operating separately from social organization. It is also the argument that individual lifestyle choices are socially shaped, and that a focus on them as an explanation of the cause of disease misses the social factors involved in producing individual actions. Rather, there are a wide range of mediating social factors that intervene between the biology of disease, individual lifestyle,

and the social experience shaping and producing disease. These range from standards of living and occupational conditions, to socio-psychological experiences at work and at home, of men and women social roles, and of hierarchical status groups based on ethnicity (Barry 2002, p.46).

A unique strength of the sociological perspective is the focus on underlying social structural mechanisms of phenomena that ostensibly occur at the individual level (McKinlay 1996). Sociologists have long conceptualized medicine as a social institution, highlighting the influence of macro factors on help-seeking and the practice of health care in everyday life (Freidson 1970; Mechanic 1975; Parsons 1951). The institution of medicine is characterized by a powerful set of social norms, rules, values, and practices that provides a blueprint for the behavior of individuals and organizations (e.g., physicians, patients, hospitals, HMOs, etc) and systematically structures the relationship between them. Sociologists have contributed much to our understanding of the way that culturally and historically shaped institutional forces constrain the behavior of health care providers and consumers, reproducing health care inequalities across social groups (Wright, 2010).

The social study of health and illness set upon an ambitious topic matter but explicitly excluded biology and disease as research foci. The point of this discussion paper is to argue that the genesis of medical sociology is not deterministic and that we may be the richer for studying disease in addition to illness and health. We aim to open a research space for the sociology of disease, not to replace the rich scholarship that sociologist have produced but to include fundamental research questions that now remain unformulated. Sociologists of disease are interested in the dialectic interaction between social life matters for morbidity and mortality and vice versa. Rather than viewing the broad field of health as a unique case of social organization, social forces, or identity formation, the sociology of disease focuses on how social processes affect the severity or course of diseases and how, in turn, specific stages of disease affect social relationships, work, neighborhood, or family life (Timmermans, 2008, pp.661).

The range of shops available is generally more limited in poorer areas and the range of foods available is also more limited. The difficulty of procuring food in poor neighborhoods has led to them bring described as ‘food deserts’ (Cummins, 2003) and it has been shown that ‘healthier’ choice in poorer areas is illustrated by a study which

showed that deprived neighborhoods in Glasgow were more poorly supplied with parks and sports centers than wealthier neighborhoods (Macintyre and Ellaway, 1998). This brings us to the fourth explanatory mechanism listed in the Black Report, namely the influence of material or structural factors, whereby social class determines health through social class differences in the material circumstances of life. The concern which nineteenth century campaigners showed for the housing conditions, recreational opportunities, diet and stimulant-use of the urban poor remains relevant in terms of understanding poor health outcomes among deprived groups. The merit of disaggregating the independent health effects of various aspects of structural constraint, such as unemployment, living on benefits and living in a poor area, is the subject of ongoing debate among researchers (Bradby, 2009. pp.78-79).

2.1.1 Empirical Review

Unfortunately, infant mortality is not equal for all people. The mortality rate for African American infants, for example, is almost 15%. This difference in infant deaths is thought to be related to the higher proportion of births to young African American mothers, unequal provision of health care, and the higher percentage of low-birth-weight babies born to African American women: 12%, compared with approximately 5% for white and Asian women. Because teenage pregnancy leads to increased premature births, this can result in infants being born who are not as well prepared as others to face extra uterine life (Pillitteri, 2010).

We believe that post-reconstruction authorities should focus health resources on stabilizing maternal and infant health, with all of the tasks associated with that goal, such as ensuring access to potable water and improving sanitation. By stabilizing maternal and infant health, the most basic sector of society would be secured first, allowing women to maintain their families and provide an anchor for reconstructing other elements of their communities (Benard, 2008).

Adhikari (2013) found that the majority i.e. 94.66 percent of the respondents reported that their wives attended for ANC visits during pregnancy and 5.34 percent of the respondents had told that their wives did not go for antenatal check-ups.

A study by Khanal (2001) On maternal and child health care practices of Gandarba (Gaine) and Pode castes of Kaski district, shows that out of total respondents 40 percent

of the mothers have been found to be married at the age less than 16 and 51.67 percent of them married in between 16-20 years of age. About 71.67 percent of the total respondent mothers delivered babies in their homes and this indicates that might be dangerous for their health.

Superstition and indigenous practice is one of the barriers for not utilizing the services. In different areas of Nepal, still there is the tradition that the first baby should be delivered at home. A large amount of straw an ideal insulation material is brought into the house to from the birth bed. In some villages, women are still forced to give birth in cow shed. Besides these certain fruits are not given during pregnancy like papaya, pineapple, mango that leads early labour sometimes leading to abortion. Vitamins are also not given because they believe that vitamins are 'strengthening' so it will make the fetus grow big resulting in difficult delivery (Bhusal, 2015. pp.70).

Shrestha, Sunita (2018) who has done a study on 'Knowledge and practice of antenatal care among Chepang women from Chitwan' reported that The antenatal visit by literate and illiterate group, more than half of the literate group of targeted community (61.8%) had more than 4 antenatal visit while only less than one third (31.8%) of the illiterate had less than 4 antenatal visit. This shows that the number of antenatal visit is dependent on the literacy level which means that literate women have more antenatal visits compared to illiterate women (pp.9).

The findings from this review suggest that poverty causes inequality all over India. However, the review also reflects that residency is less important than economic status. Both the population living in urban slums and the poor living in rural areas have less access to maternal and reproductive health compared to the non-poor living in the same areas. The findings from this review also suggest that caste and economic status are closely interlinked, with women from marginalized caste groups often also being poor, and the doubly disadvantaged (Saxsena, 2013.pp.2).

Traditional birth attendants (TBAs) are also factor affecting maternal health in Nepal. They are not well trained to conduct delivery safely in the context of a quality health care service. They use traditional methods to conduct the delivery at home, and that practice puts the health of women in danger. However TBAs have been playing a vital role in the community during antenatal care, delivery, and the postnatal period. Women can benefit

easily from them in the community and the cost of their service is also less than the cost of other private or government health workers. TBA can be found everywhere in Nepal. TBAs are source of maternal care during pregnancy and delivery because of insufficient trained professionals in rural parts of the country. The services are different according to cast and culture among the TBAs. They have been providing traditional and culturally suitable services to women in the community for many years. The family Health Division has been providing basic delivery skills training to TBAs to reduce the complications experienced by women during pregnancy through the safe Motherhood and Newborn Health program. In this way, skills birth attendants (after being trained) have been using a safe delivery technique instead of the traditional method. However, there is still a long way to go to reduce maternal mortality in Nepal because only 36 % of pregnant women have been receiving the delivery service from skilled birth attendants during pregnancy. And A lack of education and a lack of essential knowledge about maternal health are key factors affecting maternal mortality and education are key factors of affecting maternal health and that these factors also determine the health care seeking behavior of women. Different studies have shown that increasing women's education is the best way to encourage antenatal care visits in Nepal. Educated women are more motivates to use health care facilities in comparison with those who are not educated. Education gives women power to use the maternal health care services, which can also be helpful to increase their capacity of interacting with other people and personal development. Education helps to improve the decision- making power and confidence of women and laterally empowers women. However, the literacy - rate of women in Nepal was very low (25%) in 1991, although it had increased by 57.9% in 2011. Because of lack of education, women have not been using health care facilities, which are provided by the government (Mahara, 2016 pp.32-33).

In Nepal, utilization of maternal health services depends on the socio-economic status (SES) of women. Higher SES women in terms of education level, wealth and urban residence utilize better health care services including maternity care. Dalit are defined as untouchables and marginalized groups within the Hindu caste system. Often the social, economic, and health status and political conditions among these population are lowest compared to other groups in Nepal. Women from Dalit community suffer from not only discrimination based on their gender but also caste identity and consequent economic

deprivation. Dalit women face numerous barriers in accessing maternal healthcare services due to their lower status in the society and, in Nepal, women with disabilities and women from Dalit caste groups are with low rates of maternal health services utilization. A study done in Bara district in the same community found that 41.6% of mothers did not receive any antenatal checkup while only 28.0% completed all four ANC visits, more than 55.0% had not taken vaccine, and 48.3% had not taken folic acid during pregnancy period (Awasthi, 2018. pp.2).

The most recent survey in Nepal analyzed delivery care by the place of delivery. Only 18% of births take place in a health facility, of whom 13% delivered their babies in a public facility and less than one percent in non- government facilities. Four out of five birth (81%) take place at home in Nepal. Delivery in a health facility is more common among younger mothers, mothers of first order and mothers who have attended the recommended four antenatal visits in a facility. Almost half (48%) of babies in urban areas are born in a health facility, compared to 14% in rural areas of Nepal. Likewise, Delivery in a health facility also varies by ecological region. The facility- based births are lowest in the mountains (6%), highest in the hills (21%), and moderately high (17%) in the Terai. Similarly, delivery in a health facility varies according to development region, 24% in the Central region and highest in the Central hill sub region, where two-fifths of mothers have a facility-based delivery. There is a strong association between a health facility delivery according to the mother's education and economic status. The proportion of deliveries in a health facility is only 8% among uneducated mothers, compared with 67% among mothers with SLC and higher qualifications. A similar pattern is seen in terms of wealth quantiles: delivery at a health facility is significantly lower among births to women lowest quantile, 4%, compared to 55% of those in the highest quantile. In Nepal the number of facility-based births has doubled in the past ten years, and several changes can be seen in the period 1996 to 2006 but utilization of delivery care is still minimal in most rural areas (Baral, 2012. pp. 624).

CHAPTER-THREE

RESEARCH METHODOLOGY

Research methodology is necessary for any research work in every field. It explains the procedure of the study from beginning to the end. It includes many tools and techniques which are applied as the skeleton and favor of the study. The basic qualitative analysis has been implied to accomplish this research study which studies the experiences and perceptions of the respondents. This study is aimed at the study of challenges and factors of maternal and child health in Mushahar community. It is descriptive research design has employed to find the problems faced by Mushahar women. Its appropriateness is justified by saying-Baden and Major (2013) who write,"….When studying individuals, the best the researchers can do is learning about, describe and explain them from the perception of those involved" (p.6). Interpretive approach is o after employed for learning how individual experience and interact with their social world, the meaning it has for them (Merriam, 2002, p.4). My research issues also indicate the need of interpretation of the experience of the Mushahar women who faced different circumstances while pregnancy period.

3.1 Research Design

Based on objectives, this research attempted to describe the maternal and child health in Mushahar community in Triyuga Municipality-7, Motigada, Udayapur. Mainly, this research had followed qualitative approach with description. The ideas and information collected from the respondents were discussed, analyzed and described accordingly.

3.2 Rationale of the Site Selection

To grab the objectives of this research, Triyuga -7, Motigadha is selected as study area purposefully.

Most of the researches on maternity are concentrated in the national level. Research on maternity of this area has not been carried out till now. That is why; I have planned to study about the maternal health. The reasons behind the selection of this area were as followings; According to local people in questionnaire period, many women of Triyuga-7 were being hospitalized in last stage into the mouth death increasing day by day so this

research is relevant and representative to find out causes and consequences of maternal health in the context of Triyuga-7. There had been changed in the income, profession, and living standard of Mushahar and its impact had been seen in the society. While asking according to my objective with some daily activities, Mushahar women added their life for further and past period including the answer of my question. The thesis researcher is the permanent resident of this area so it would be easier to collect the information.

3.3 Nature and Sources of Data

This is a qualitative research. However, some background variables of the study participants like the age of respondents, education status, age during marriage, age at first pregnancy and TT vaccine practice of pregnant are quantitate. In qualitative data, concept of Mushahar women regarding various aspects, views, opinions, feelings, thoughts, experiences regarding maternal health are collected.

The data has been collected from both primary and secondary sources. The primary data has collected in the presence of the researcher herself reaching to research area. For this the techniques as; semi structure in-depth interview has applied, whereas for the secondary data collection, different types of books, journal, magazines, articles, etc. where consulted which are related to the subjected matter and are helpful for the research of the topic.

3.4 Selection of the Study Participants

The study area is Triyuga-7of Udayapur District. In this village, the population is homogeneous such as Mushahar. Therefore, the study participants were selected by purposive sampling method. From the sample the required information or objectives were collected through interview schedule and observation. The interview schedule has provided information about level of knowledge of the antenatal, natal and postnatal periods. A total 30 were interviewed to collect the required information. And I have interviewed women in the day of immunization to cover all respondents. Observation has supported to find out the main factors which are related with maternal risk.

3.5 Primary Data Collection Tools and Techniques

The following techniques were used for the fulfillment of aim of this research analyzing its primary sources as per nature type of the research.

3.5.1 Observation: All those maternal health matters that the researcher personally observes can be presented as the primary data in their presentation and explanation. The research area of the study itself was the settlement area of the required population. The observation is the qualitative method, which used in social science research.

Observation is beneficial to get actual information and the lifestyle and situations of the respondents which I also used it. I also got the opportunity to observe how they are manifesting their daily life during pregnancy period. The Mushahar community is located close to my home, so I observe them in my daily life. While interviewing the Mushahar community up to 1 week also, I observed that most of the pregnant women were found working all the time like collecting firewood, household works and other field works as well. Also it was found that they didn't have time to take rest during pregnancy. I have seen that many women were facing difficulties during pregnancy." Observation is a way for a researcher to document everyday practices of participants and to better understand their experiences (Savin-Baden & Major, 2013, p.392).

3.5.2 In-Depth Interview

I used semi-structured in-depth interview to explore their experiences more freely in order to gather more information related to subject matter. I applied all procedures before taking interview as reading consent, provide brief purpose about my study purpose and told them about the rights to leave the interview process anytime and free to answer any questions. I have told them about the time duration and the confidentiality about our conversation which is only used for data collection and discarded after completion of my master study. For the easiness of my respondents, I asked them in our mother language; Nepali and later on, I transcribed and translated most part of it into English language.

I had prepared a list of open-ended questions for my reference organized in the bordered themes for the participants as possible as to capture their daily life condition and perceptions. This list helped me to stay focused on my research objectives. It was through this interview process that my data emerged. All of these procedures help me in order to

make my study qualitatively stronger and to present lived experiences of the participants in their own words.

3.5.3 Secondary Data Collection

To make the research more effective, secondary data was collected basically by means of reviewing related literature, report, journals, and articles. Related literatures reviews in selected issue guided the research to find out new findings and provide information about the past in related topic which also helped my research study.

3.6. Field Work

I chose Triyuga-7, Motigada of Udayapur district. It is easy to collect the information from the respondents. The fieldwork had concluded in July 2019. I requested the participants to have interviews by saying a brief introduction and purpose of my research study. They were so kind and helpful towards me and gave me their time and shared their maternal health experiences.

Often the location and situation at the time of the interview had a great impact on the interview process, researchers and participants. When I went to interview, I requested the participants to have interview in personal and they were so kind and energetic that they gave me a very comfort level by understanding what I want for my study. During interview, two participants didn't agree to give interview and some women were unable to understand Nepali language. It was a difficult situation for me.

While transcribing interviews, I could see that I spoke in a different manner possibly from initial to up-gradation that I have reached in course of the interview, to that of the women of Mushahar community. However, due to the fact that our experiences and life stories were spartanly different, I could not draw upon my experience as a common platform to discuss issues and condition of the maternal and child health of Mushahar community.

3.6.1 Data Analysis

Analysis is necessary for the data interpreting and analyzing which is a continuous process of reviewing the information as it has been collected, classified, formulated, additional questions, verifying information and drawing conclusion.

To make my respondents easy and understandable, I took my interview into Nepali language and after the completion of interview. I transcribed and translated most parts of my interview into English language.

Then, the categorized data is described, analyzed and interpreted. The interview is transcribed and highlighted the most part of it. The meaning of these words is provided in the bracket with it. Collected data have been analyzed qualitatively. However, the efforts are made to maintain the objectively and avoid the error by analyzing the recorded interview and the field note various times and comparing them with each other.

3.6.2 Research Problem in the Field

The sample size of the study has encountered small area of Udayapur but still various problems had been encountered from respondents in the field. Since the topic is based on the maternal and child health in Mushahar community, some respondents hesitated to express themselves and feel shy and didn't open-up. It took time to be frank and share their experience and perceptions towards me as it was my second interaction with them as taking interview where I also felt quite afraid.

During the process of data collection, I faced different obstacles. Due to the personal topic, the major challenges face in the field is that respondent felt shy and some women were unable to understand Nepali language while taking interview. Two respondents didn't agree to give interview and the situation was difficult to handle.

3.7 Limitation of the Study

Every study/research does have its own limitation, and this research is no exception either. The limitation of the study is as follows:

1. This study has covered only Triyuga-7of Udayapur District and the study has centralized over the mothers with children below five years.
2. The research has been conducted in specific area i.e. Triyuga-7ofUdayapur District. Therefore, result may not be applicable and relevant to multiple places and context.
3. This study has conducted as a study of Triyuga-7of Udayapur District for the partial fulfillment of the master level degree requirement in Sociology. So, it is not feasible for detailed intensive research due to the lack of sufficient resources collection with such short span of time.

CHAPTER-FOUR

MUSHAHARI WOMEN AND MATERNAL HEALTH SERVICES

The Mushahar is one of the major marginalized cast groups of Nepal. Their settlements are found in the Terai and inner Terai of Nepal. Most of them are settled in Morang, Sunsari, Udayapur, Siraha, Sarlahi, Dhanusha, Rautahat. According to the population Census 2001, there are 1, 72,434 Mushars in Nepal. It represents 0.76 per cent of total population. In Morang, there are 17,852 Mushahars including 9,195 Male and 8657 Female (CBS, 2001). Mushahars are the nomad which can be proved by the type of the houses or huts they construct for dwelling, which are small and low in height and clustered together in 20-25 houses-groups in a single community. Their houses are light and constructed from locally available materials such as bamboo and straw. The house of Mushahars is comprised of single large central room. In one corner, they keep their livestock; in another they cook their meals (Ghimire, 2009).

The main aim of this chapter is to present and examine the data that provide a detailed overview which I have collected from my respondents. I analyzed it on the base of maternal and child health of Mushahari woman. Here, I have indicated that the Mushahar women are unknown about maternal and child heath who are my target group for this research study. In this study, the entire respondent has been taken from Triyuga Municipality–7, Udayapur. To make anonymous, I gave the number to the respondent's name accordingly I, II, IV, V, …., XXX; so that their identity can be kept confidential.

I have presented and analyzed the collected data through the participants' interview and observation in this chapter. In my interview and observation process, my participants have articulated their stories, experiences, opinion and their real-life long experiences which I have classified based on its thematic nature. I have categorized six major themes as: Background information of study participation, occupation description and educational status, marriage description, food description during maternal periods and maternal health (prenatal, natal and postnatal). I have also provided detailed information in my annex part in my formats.

4. Background Information of Study Participants

This section includes a brief background of study participants. The time durations of the pregnancy, marital status and education level also have been mentioned in this section. RI, who is uneducated, 40 years old, married woman, takes pregnancy as usual. She goes to forest, does selling of wood because she asserts that she is poor. Similarly, RII, who is 60 years old and married, is also getting the same problem as of R1. She says" I am poor and I used to work in bricks house and paddy cultivation and also used to do all types of works. She has got *ProudhSikshya*. Another young married woman of 26 years old (R3 who has finished her *ProudhSikshya*also facing that "when I was first pregnant, that time I used to filter pebbles and stones." RIV, aged 21 years old, did all types of works such as gathering woods and all household works. She studied up to primary level. RV, aged 30 years old, who is uneducated, did not do any types of work except cooking food at home during their pregnancy. RVI, who is uneducated, 45 years old, married woman, did gathering woods and farming in others land. RVII, who is uneducated, 50 years old, married woman, did all types of works such as gathering woods. RVII, who is uneducated, 45 years old married woman, did all types of work during pregnancy. RIX, who is uneducated, 20 years old, married woman, did only household work and always stayed at home. RX, who is uneducated, 20 years old, married woman, did household work and sometime she went to forest. RXII, who is uneducated, 18 years old, married woman, did not have to do any works but only had to cook food. RXII, who is uneducated, 35 years old, married woman, did all types of work. RXII, who is uneducated, 50 years old, married woman, did all types of work. RXIV, who is uneducated,45 years old, married woman, did all types of work such as gathering of woods. RXV, who had studied up to primary level, 24 years old, married woman, did not do any works except household works. RXVI, who is uneducated, 50 years old, married woman, did all types of work such as gathering woods and taking it to sell and farming in others land. RXVI, who is uneducated, 35 years old, married woman, did all types of work. RXVII, who is uneducated, 35 years old, married woman, did all types of work. RXIX, who had studied up to primary level, 28 years old, married woman, did all types of work. RXX, who is uneducated, 40 years old, married woman, did all types of works such as gathering of woods and taking it to sell in the market. RXXI, who is uneducated, 20 years old, married woman, did all types of works and taking it to sell in the market and

farming in others land. RXXII, who is uneducated, 50 years old, married woman, did all types of work such as gathering woods. RXXIII, who had studied up to *proudhsikshya*, 30 years old, married woman, did all types of work. RXXIV, who is uneducated, 20 years old, married woman, did all types of work. R25, who had studied up to primary level, XXV years old, married woman, did not do any works except household works. RXXVI, who is uneducated, 23 years old, married woman, did all types of works and did farming in others land. RXXVII, who is uneducated, 40 years old, married woman, did all types of wok. RXXVIII, who is uneducated, 60 years old, married woman, did all types of work. RXXIX, who is uneducated, 19 years old, married woman did all types of work. RXXX, who is uneducated, 21 years old, married woman, did all types of work.

TableNo.1

Characteristics of Respondents

Respondents	**Age**	**Education**	**Occupation**
RI	40	Not studied	Labour
RII	60	Adult education	Labour
RIII	26	Adult education	Labour
RIV	21	Primary level	Labour
RV	30	Not studied	Labour
RVI	45	Not studied	Labour
RVII	50	Not studied	Labour
RVIII	45	Not studied	Labour
RIX	20	Not studied	Labour
RX	20	Not studied	Labour
RXI	18	Not studied	Labour
RXII	35	Not studied	Labour
RXIII	50	Not studied	Labour
RXIV	45	Not studied	Labour
RXV	24	Primary level	Labour
RXVI	50	Not studied	Labour
RXVII	35	Not studied	Labour
RXVIII	35	Not studied	Labour
RXIX	28	Primary level	Labour
RXX	40	Not studied	Labour
RXXI	20	Not studied	Labour
RXXII	50	Not studied	Labour
RXXIII	30	Adult education	Labour
RXIV	22	Not studied	Labour
RXV	25	Primary level	Labour
RXVI	23	Not studied	Labour
RXVII	40	Not studied	Labour
RXVIII	60	Not studied	Labour
RXIX	19	Not studied	Labour
RXXX	21	Not studied	Labour

Source: Field Survey, 2020

4.1 Factors Supportive to Mushahar Women to Use Maternal Health Service

From the study of maternal and child health practices, following are the factors that play important role in Mushahhar community.

4.1.1 Age of Respondents

In my research, there is an important role of age. This is because age affects the maternal status a lot. Due to backwardness in the entire field, it is very important factor for Maternal health care in Mushahar community. In the context of Nepal, the percentage for child bearing is 20-30. So, age is very important in my research.

Table No. 2

Age of Respondents

Age of Respondents	Number of Respondents	Percentage
Below 20 years	2	6.6
20-24	8	26.6
25-29	3	10
30-34	2	6.6
35-39	3	10
40-44	3	10
45-49	3	10
50-54	4	13.3
55-59	0	0
60 years and above	2	6.6
Total	30	100

Source: Field Survey, 2020

This table shows that, as the study has been based on life histories of the individual respondent and their experiences in course of difficulties in law. I focused maternal and child health in Mushahar community. Age group, below 20 years, consisted of two participants, 20-24 consisted of 8, 25-29 consisted of 3 participants, 30-34 consisted of 2 participants, 35-39 consisted of 3 participants, 40-44 consisted of 3 participants, 45-49 embraces 3, 50-54 comprise 4 participants and there were 2 respondents 60 years old.

Looking at the age distribution of people with married age group of 20-24 from the highest number.

4.1.2 Education Status

Education is the way to the bright from the dark. Education is the most essential and important part of our daily life. We are like a blind person without education. Education makes our daily work very easy. Similarly, my survey on Mushahar community's maternal health practices, education plays an important role.

In case of Mushahar community, they are back in politics, cultural values, education etc. Due to lack of education, Mushahar communities are having a lot of problem about Maternal and child health care practices. Therefore, there is an important role of education for the better improvement of Maternal and child health care practices.

Table No. 3

Education Status

Education Status	**Number of Respondents**	**Percentage**
Illiterate	23	76.6
Just read and write	3	10
Primary level	4	13.3
Total	30	100

Source: Field Survey, 2020

This table shows that, Education of Respondents was mostly (76.6%) illiterate, 10% just read and write and 13.3% primary level. So that Mushahar women got married below 20 years and they don't know about maternal health. It is because Mushahar community is a Dalit community which is socially, politically and religiously backward. Due to poor economic condition parents are unable to give good education to their children and are forced to go to work. According to NDHS, 2017, 47% of Nepal's women are still no education and only 39.2% of Terai women have been shown no education and 11.5% some primary education. This means that according to my research and NDHS, 2017, women in Nepal and even more in the Terai are not educated.

4.1.3 Age at Marriage

The culture of any society or ethnicity has its roots deep down in times immemorial some of their cultural habits or positive while some are negative. Those habits go a long way in affecting the health status of the community directly or indirectly.

In Nepal, marriage marks an important transition on a person's life. The marriage pattern according to the constitution standard is minimum 20 years legal marriage for women and 20 years but the 'Mushahari' culture has the following marriage pattern: -

Table No. 4

Age at Marriages

Age group of Respondents	Number of Respondents	Percentage
Below 20 years	29	96.6
20-25 years	1	3.3
Total	30	100

Source: Field Survey, 2020

From the above table, we can conclude that age at marriage of Mushahar women was found less than 20 years (96.6%). The average age at marriage of Nepali women is 17.9 years. (NDHS, 2017).It can be concluded that the increasing level of education of women helps to decrease the early age marriage of women. It is because women with more education usually marry later, wants smaller families and more likely to use contraceptives than illiterate women.

From my study about the Mushahar community it is found that though the average age of marriage for Nepalese women is 17.9 years but still the early marriage is taking place it is because of their own cultural practices and due to illiteracy among the members of the community.

4.1.4 Age at First Pregnancy

A girl in Nepal may bear her first child when she is 14 or 15, while the period between 20 and 30 years is generally considered to be the safest period of child bearing.

According to the reproductive health point of view, an women's age of first child bearing should at least be 20 years. Otherwise the complication may also lead to her death. In order to assess the age of similar child bearing a question was asked, the finding is given below:

Table No. 5

Age at First Pregnancy

Age group of Respondents	Number of Respondents	Percentage
Below 20 years	26	86.6
20-24 years	4	13.3
Total	30	100

Source: Field Survey, 2020

The above table shows that the highest percentage of mothers being pregnant is of the age group below 20 years 86.6% and the age group 20-25 years is 13.3%.

Although the percentage of child bearing age of below 20 years is higher than 20-25 years age group. The main reason behind it was found to be either be ignorant themselves or due to early marriage and due to the socio-culture values and norms. They are forced to marry early; child is born earlier. According to NDHS,2017, the median age at first birth among women age 25-49 in Nepal is 20.4 years. Median age at first birth has changed little over the decades (19.8 years in 1996 and 20.4 years in 2016). But Most of the research I have done has found her to be the first pregnant below 20 years. This means that it has not improved yet.

4.1.5 Maternal Health Practice and Seeking Services

Maternal health is the health status of women during pregnancy, childbirth and the post-partum period, which incorporates the health care dimension of family planning preconception, and prenatal and postnatal care to reduce maternal mortality (Mahara, 2016).

The health statistics reveals fair utilization of health care services provided by government of Nepal in recent years. Annual health report of 2069/2070 B.S. (2013/2014 AD) claims more than three quarters of the people of Nepal had used public health

services in 2069/70. Eighty one percent of registered morbidity cases used free health care services and ninety one percent of the population who used free health care services did so at health posts and sub health post, 5% at hospital and 4% at PHCCs. There are different types of health care delivery systems in Nepal. They are Allopathic, Ayurvedic, Homeopathic, Acupuncture, Unani, Yoga, Meditation, and various indigenous system of treatment and healing systems of treatment in health care besides modern allopathic system. The treatment satisfaction of these traditional systems is substantial in Nepal. (Bhattarai, 2015, p.8).

4.1.6 Immunization During Pregnancy

Tetanus Toxoid injection is given to pregnant women and children to prevent them from tetanus. TT injection, an important component of antenatal care in Nepal ensuring that pregnant women and children are adequately protected against tetanus. Usually, two or three dose of TT injection are given during pregnancy. The first dose is 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 at the last phase of pregnancy.

Table No. 6

TT Vaccine Practice of Pregnant Women

TT Dose	**Number of Respondents**	**Percentage**
Not taken	17	56.6
One dose	2	6.6
Two doses	2	6.
More than two doses	9	30
Total	30	100

Source: Field Survey, 2020

The table shows that 56.6% of women are found to have not taken TT dose and 6.6% of women are found to have taken two doses of TT injection. Similarly, 6.6% of respondents were found taken only one dose of TT injection during pregnancy period, 30 % of respondents were found taken more than two doses of TT injection during pregnancy period. From the above information, it can be concluded that though they have

health facilities, all the women have not taken TT vaccine due to negligence and lack of awareness about the importance of TT vaccine. So, in the table above, the percentage of women having more than two doses is higher than that of two doses and one dose respectively.

Majority of women in our country hardly practice health checkup due to various reasons. In same Mushahar community, women have not good awareness of taking full dose of TT vaccine. Those women who had not taken TT vaccine were from the poor and uneducated family. They had good effect of their old generation, so they had taken it as unnecessary. According to NDHS,2017, percentage receiving two or more injections during last pregnancy in Terai 63.9% and percentage whose protected against neonatal tetanus 91.6% but my research has found that most women(56.6%) still do not have an injection.6.6% one doses and 6.6% two doses, and 30% more than two doses. This means that there is still a lack of education or training on maternal health practices in the Mushahar community.

4.1.7 Access to Information

None of the women from my respondent get any information about Maternal and Child Health (MCH). Now the government and Non-government have given various training on maternal health practices and in the community where I have researched, even though the training on maternal health practices is their main occupation, they are always in the forest all day long. And there is still a feeling of shame in the women who cannot speak openly about pregnancy. Therefore, all the women there have said that they have not received any information in this regard.

4.2 Challenges Faced by Mushahar Women During Pregnancy

Following are the challenges faced by Mushahar community women during pregnancy:

4.2.1 Selection of Health Facility

Overally, Mushahar community is back in all aspects such as political, economic, cultural, social and educational. In my research, mostly respondents (76.6%) are uneducated and are labour worker but their official work is selling firewood due to which they are economically in same condition. Thus, despite the same economic situation, forty percent (40%) of the women, including the young and the uneducated, have been

found to have gone to the private hospital due to the laziness of going to a government hospital far from home forty-six (46%) percent of women who have received adult educated and most of the elderly have gone to government hospital because it is cheaper. 13.3% of respondents still believe in Dhami, so they go to Dhami initially and go to a government hospital only if they are not well.

4.2.2 Work Activities During Pregnancy

Work is necessary to survive. While giving interview, many respondents reacted that work is a medium to survive at any time at any cost. Concerning to work while a woman is pregnant in Mushahar community: Agricultural and working in other's physical job is compulsion to have food, and continuing the life is basic rules. Among of thirty respondents, collecting woods, working in construction are means of earning money. Some examples from my respondent has been taken who had worked during pregnancy.

RII, aged 60 years old, shared her experiences about work while pregnant.

"I'm poor, I used to work in bricks house (Itta Bhatta) and paddy cultivation and also used to do all types of works."

Similarly, RIII, aged 26 years old, said, *"When I was pregnant for the first time; I used to filter pebbles and stones. I used to do the same things after giving birth to the child, we are poor, this is our life."*

Similarly, RXII, aged 35 years old, said, *"All types of works such as gathering woods, farming others land, cooking rice etc."*

RXIX, aged 28 years old, said, *"All types of works such as gathering woods and taking it to sell and farming others land. Didn't take too much rest as it is not that good for health as well. But did some normal works so, I did all types of household works and other works"*.

According to RXXVI, aged 23 years old, said, *"I used to do all the household works, work in the paddy cultivation and gathering woods."*

Most of the respondent that all types of works such as gathering woods, farming others land and all households work.

In this way, some of the respondent focused that they had to work just to survive in these times. If there is no work, there is no money. They answered, *"In pregnancy period, even when every work was not possible, the easier work of household like cooking can be done."*Also, RV, aged 30 years old, shared her experiences about work while pregnant as: *"Did not do any works except cooking food."*

Similarly, RIX, aged 20 years old, said, *"Only household works, I did not go anywhere, I always stayed at home."*

Similarly, RXI, aged 18 years old, says, "*Didn't do any works except household works*."

Though a pregnant woman suffers from troubles, they have to work in order to earn money. In this way, the health is kept at risk.

Out of the representative figure; According to RXX, aged 40 years old said, *"I did all types of works such as gathering woods and taking it to sell in the market and farming others land so I didn't get time to take rest. If I took rest, then who would give food to eat. So, I had to work."*

Similarly, RXXII aged 50 years old, said, *"I did all types works such as gathering woods and taking it to sell in the market and farming others land. I didn't have anyone and I didn't live with mother-in-law. We had a lot of troubles."*

Similarly, RXXIII aged 30 years old, said, "*Gathering woods and take it to sell in the market. If I didn't work, there was no food to eat."*

From the study it was found that most of the women were found doing various households works during pregnancy also. It is because the whole community is deprived of good education, quality of life, poor economic condition, primitive cultures. Due to these all reasons in today's world also they are still backward and are compelled to do the works, otherwise it's really hard to survive.

4.2.3 Visit of Health Institution for Checkup

Health institution is a place where the health condition is checked. During pregnancy, most of the women even did not go to the hospital for health checkup. But, some of the respondents went to government hospital. Some examples from my respondents who did not go to hospital are: -

RVIII, aged 45 years old, shared her reason of why she didn't go to the hospital as: "*No, I thought it was not that necessary to visit."*

According to RXIII, aged 50 years old, "*Earlier neither there was practice nor we had knowledge that we should checkup."*

Similarly, RXIV, aged 45 years old, said, "*No, I didn't know that we have to do a health checkup and had labor while working and give birth at home. Then, how should I go to the hospital if there was no practice of going to the hospital and also unknown about it at that time. I gave birth to 3 children but I never went to hospital during that period."*

Similarly, XVII, aged 35 years old, said, "*No I did not have that much issue, so didn't go for checkup."*

Similarly, RXXII, aged 50 years old, said, "*No, earlier there was no practice of going hospitals for checkup. All the time, I was busy in doing work, so had no time. Then, how could I go to the hospital for checkup."*

RXXIII, aged 30 years old did not go to the hospital because she thought going to hospital is shameful. She said, *"I didn't go to the hospital because I felt shy to go for a checkup. Also, I had no money."*

Similarly, RXXVII, aged 40 years old, said, *"No, my mother-in-law (saus) didn't allow me to go for checkup. She (saus) used to tell, "I gave birth at home so no need to go to the hospital."*

Similarly, RXXIV, aged 22 years old, said, "*Didn't go anywhere. I didn't have any problems so why should I go?"*

Similarly, RXXX, aged 21 years old, said, "*No, I thought that it was not necessary to visit."*

From the study it was found that most of the respondents were found not visiting health institutions during pregnancy. It is because of illiteracy and lack of awareness about the maternal health and mostly they are bounded by their culture as they have belief that pregnancy is a normal process.

4.2.4 Workload During Pregnancy

Pregnancy is a period to take a rest and intake nutrition food items. In this period every pregnant woman should care own self. They should have idea of their body condition and every development of organ of baby. While talking with my respondents, mostly answered as usual that some women are aware of health so, they used to take rest. Some examples from my respondents are given below: -

RXIX, aged 28 years old, shared her experiences, "*I didn't get time to take rest. All the time I had to work. I used to go to the forest in the morning. While returning back, always I used to be late and become evening."*

According to RXXII, aged 50 years old, "*I didn't get time to take rest. If I took rest, then who would give the food to eat, so had to work."*

According to RXXIV, aged 22 years old, "*I didn't get time to take rest. I used to go to the forest all the day."*

Similarly, RII, aged 60 years old, said, "*When I was pregnant, I used to work in others land as farmer and also in bricks factory. All day I used to work and did not get time to take rest."*

In most of the respondent case, if they don't work then they used to have food problem, so they had to work all the time due to which they don't get time to take rest.

RXX, aged 40 years old, said, "*I didn't get time to take rest. All the time, I had to work. If I took rest, then who would give food to eat. So, I had to work. We had a lot of trouble."*

Similarly, RXXIII, aged 30 years old, said, "*I didn't get time to take rest. I always used to go to the forest. If I didn't go to the forest, then who would give food to eat.*

From the study it was found clearly that the pregnant women don't get enough time to take rest during pregnancy. Due to poverty and traditional belief they are compelled to do the work all the time for their daily survival, if they don't do the work it's really hard to survive.

4.2.5 Food Intake During Pregnancy

During pregnancy, additional food is necessary for the growth and development of the fetus and respondents used to take same as usual food due to their low economic condition and they have not good educational background. So, they have not knowledge to take additional food during pregnancy. Likewise, the mother who had used to eat as usual food has knowledge about the necessity but poor in practice due to their negligence or poverty and due to their large family size. Some examples from my respondents are: -

RIII, aged 26 years old, shared about her food intake as; "*What to tell about food, we are poor, sometimes we may or may not get food to eat but also sometimes salt and rice or pearls or vegetables."*

Similarly, RVII, aged 50 years old, said, "*I did not like to eat rice when I had big stomach because I could not work so I used to work in hungry stomach. When I finish all my works, then at night I used to eat a little rice and sleep"*.

During pregnancy, additional food is necessary for the growth and development of the fetus and malnutrition in the mother. In general, more than usual food stuff should be taken during pregnancy to fulfill the required protein, vitamins and minerals. Mothers in good nutritional status are better equipped for the strain of labor and lactation poor nutrition before and during pregnancy period result in a baby with a low birth weight (below 2.5 Kg) and leads to pregnancy complication, like abortion, infra-uterine death, premature delivery, etc. A pregnant woman must gain about 11 Kg of weight during pregnancy. Thus, it is necessary to have additional food by the women during this period. Some respondents used to eat the food that are available in their own houses (i.e. Meat, Fish, Pearls, Green vegetables, Fruits, etc.) but most of the respondents did not used to eat food like meat, fish, fruits, even they like to eat. They used to eat salt, rice, pulse, and chilly. Some examples from my respondents are;

RII, aged 60 years old, shared about her foods during her pregnancy as;

"Who gives to poor? I used to eat spinach, vegetables, edible snail (Ghonghi), salt and chilly."

Similarly, RIII, aged 26 years old, said, *"I never got fruits, meat, fish to eat but in hilly region. During pregnancy, pregnant women used to get fruits, meat, fish in order to make the baby healthy. Although, healthy food should be provided but we never ate it."*

Similarly, RXVI aged 50 years old, said, *"I never used to eat meat, fish and fruits. But nowadays people eat all the nutritious foods."*

According to RXVII, aged 35 years old, said, "*Fish, meat, curd and milk. I didn't eat fruits as no one used to give me. Then also, who gives fruits to a poor?"*

According to RXX, aged 40 years old, said, *"Pulse, rice and vegetables. I didn't eat what I liked because I had no money."*

Similarly, RXXII aged 50 years old, said, *"I ate pulse, rice, salt, chilly because we were poor."*

Similarly, RXXIII, aged 30 years old, said, *"I ate pulse, rice, fish, vegetables but didn't eat all other foods that I liked to eat."*

Similarly, RXXVI, aged 26 years old, said, *"I used to eat spinach, pulse, fish, meat but I never ate fruits."*

According to RXXVII, aged 40 years old, said, '*I used to eat salt, rice and chilly."*

From the study it was found that most of the pregnant women don't get nutritious food during pregnancy due to their poor economic condition and traditional belief. They just get usual daily foods like Daal, Bhaat, Tarkari only. But in some rare cases it was found they get better foods also. But comparatively most of them are deprived of good nutritious foods.

4.2.6 Complication During Pregnancy

Any women can have complications during pregnancy, delivery and postnatal period. Although, some pregnancies carry more risks than others predicting complication in the individual women is uncertain, therefore, pregnancy should be viewed as a special period and in my study most of the respondents didn't face any complications during pregnancy. and Some respondents did face complications during pregnancy but they didn't go anywhere for treatment. Some examples from my respondents who did face complications even they didn't go anywhere for treatment are:

RII, 60 years old, shared her health complications during pregnancy as;

"What can I do? Legs were swollen but I did not go for treatment. I stayed in home and tolerated it."

Similarly, RIII, aged 26 years old, said, "*During pregnancy, I used to feel dizziness. At my home only mother-in-law and my husband were there, so I did not go anywhere for checkup. I tolerate it."*

Similarly, RVIII, aged 45 years old, said, "*Yes, swelling of legs. Did not go anywhere for treatment, it got better after giving birth to the child."*

Similarly, RXXII, aged, 50 years old, said, "*Swelling of legs. Didn't go anywhere for treatment. It got better after giving birth to the child."*

According to RXXIV, aged 22 years old, said, "*Swelling of legs but didn't go anywhere for treatment. People said that it gets better after child birth."*

It was found that majority of the women under study were unaware about the risk factors of pregnancy although they have the facilities for antenatal checkup and early detection of health problem during pregnancy. The reason is due to a greater number of illiterate women and busy in their work (occupation).

4.2.7 Place of Delivery

Traditionally, Nepalese women are delivered at home with the attendants of family members or Traditional Birth Attendants (TBAs). An important component of effects to reduce the health risk of mothers and children is to increase the proportion under medical supervision. Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that can cause the death or serious illness of the mother and baby (NFHS, 1996).

Delivery place affects maternal and child health. Safe delivery practices are essential because it reduces delivery complications and saves mothers as well as child's health.

Though home is the most common place for delivery of babies in Nepal, but in this study, most of the respondents gave birth to at home. Some examples from my respondents are given below:

RI, age 40 years old, shared about where she gave birth to child and why as;

"At home I gave birth to a child because of our poor economic condition."

Similarly, RII, aged 60 years old, said, "*I gave birth to a child at home. I did not go to hospital. At hospital, they do different things and I get shy of it."*

Similarly, RX, aged 20 years old, said, "*I gave birth to a child at home. I had the labor itself while working."*

According to RXII, aged 35 years old, said, "*I gave birth to my first child at home even I had labor of five days but I gave birth to my second child at hospital. I gave birth to my first child at home because I was unknown about it as well at that time and after that I went to another place where I met to different people and there, I knew about delivery is done in hospital."*

Similarly, RXIII, aged50 years old, said, "*I gave birth to all the children at home. I did not go hospital; the birth took place while I was working. One child got birth while I was working in yard (oshra)."*

Similarly, RXV, aged 24years old, said, "*I bear the first child at home. I gave birth at home itself but I gave birth to my second child at hospital because home delivery was not possible at that time."*

Similarly, RXVI aged 50 years old, said, "*I did not go to the hospital. I gave birth to three children at my home. I did not go anywhere because at that time, child birth to take place while working at home itself."*

According to RXVII, aged35 years old, said, "*At home. The birth took place at home itself, so there was no necessity to take hospital."*

It was found that among the most of women were delivered at home by self while working and few women were delivered at hospital. The women who went to hospital had a good knowledge about safe delivery but those who didn't go to hospital for delivery had less knowledge so they are not conscious about safe delivery. Other main factor for this is that their guardians (mother in law) do not think it is necessary to go to hospital, they took this as natural process, they do not know about MCH care and other reason is a greater number of illiterate women and busy in their occupation.

4.2.8 Assistance During Delivery

Assistance to pregnant woman is compulsory in Mushahar community. In most of the cases, mother-in-law of the respondents had taken care. Since her husband had to go out for work, so he can't take care of her. In some case, No one took care pregnant women too. In the caring family, mother-in-law helped and mother assisted to pregnant women. A few numbers of respondents' husband also helped woman. In same family, sometimes by Mother-in-law (Saus) and sometimes by husband, she is taken care and helped.

From the study it was found that all the males have to go to work outside but household work is divided among the females. But mostly during pregnancy period mother-in-law (Saus) takes care of the delivery women. As it is not possible for husband to take care of their pregnant women all the time as he has to go to work for survival also so during this period (Saus) is the one who should take care of. Due to poverty and traditional beliefs in the community they are backward and hence can't take proper care during delivery.

4.2.9 Post Natal Care: Food Consumption Practice

Nepal is the country with ethnic and cultural diversity and many religious cultural traditions. But a number of social norms which are based on the religious cultural tradition are found partially responsible for health problems of women. Mushahar community is ethnic and marginalized group of Nepal, so they have their own culture, social norms and values. Health of the mother affects the health of her baby too, so the mother needs additional food at the time of lactation not only for her sound health but also for her baby. Here the additional food includes: Meat, Fish, Egg, Milk, Ghee, Green vegetables, High protein diet, etc. But in Mushahar culture, ginger, raw sugar, kurthi's Daal, salt, and chilly are prioritized. Some respondents answer that:

RII, age 60 years old, shared her post pregnancy food according to culture practice as:

"Salt and chilly, another person give rice and used to eat, that's my problem and sometimes I ate Kurthi's Daal."

Similarly, RVI, aged45 years old, said, *"Had adequate money. Local Hens meat as provided otherwise broiler hens with Kurthis Daal and Ginger's pickle."*

Similarly, RVII, aged 50 years old, said, *"Only ginger (aadi), salt and rice."*

Similarly, RXII, aged35 years old, said, *"Before I was only provided with salt and chilly but now right from the time of giving birth I'm provided with fish and meat."*

According to RXV, aged24 years old, said, *"In the early days there was the tradition of eating salt, chilly and rice but from the time of giving birth I was provided local hen's meat."*

According to RXVI, aged50 years old, *"Salt was only provided. If other food was given also, they used to say u should not eat this, that as it is not good for health and so on*."

According to RXVIII, aged 35 years old, said, *"Raw sugar (gund) and ginger (Aadi)."*

Similarly, RXX, aged40 years old, said, *"First, Ginger, pickles, salt, chilly was provided and then if had adequate money meat was provided otherwise KurthisDaal and rice was provided."*

Similarly, RXXI, aged 20 years old, said, *"Before salt, gingers, chilly were provided. Nowadays local hen's meat is provided if available otherwise broiler hen's meat with Kurthis Daal."*

Similarly, RXXIV, aged22 years old, said, *"First, salt, ginger pickle, Kurthis Daal, rice was provided but I ate meat from local hen's meat from the beginning."*

Similarly, RXXVII, aged 40 years old, said, *"First, salt, ginger pickles and raw sugar was provided. After six seven days Kurthis Daal, salt and rice were provided. If u eat all types of foods child gets sick so they didn't let me to eat."*

Similarly, RXXX, aged 21years old, said, *"First, salt, ginger pickles and raw sugar was provided. After six seven days Kurthis Daal, salt and rice were provided. If had adequate money, meat was provided."*

Some women reported that they took extra nutritious food during the postnatal period and most of the women reported that they could not take the extra nutritious food during the postnatal period due to the lack of money, illiterate and due to awareness also.

4.2.10 Post Natal Care: Daily Work Activities

In my research study, most of the women in Mushahar community are found who had not taken rest. Since the source of income for this community people is gathering woods and

take it to sell in the market. So, in order to eat and have shelter and run daily life they are depended on this work. Here, they have to work all the day, so they don't get time to take rest even if they are in any condition. Some sayings of my respondents are reported below: -

RI, age 40 years old, shared her rest period days as:

"Did not take rest. I went to the forest in the day to gather woods and gave birth during night."

According to RIV, aged 21 years old, "*I did not get time to take rest. All the times of giving birth. I worked until the days before birth."*

Similarly, RVI, aged 45 years old, said, "*How to say, today I went to sell woods and tomorrow I gave birth to a child."*

Similarly, RVIII, aged 45 years old, said, "*Did not get time to take rest. All the times of giving birth I worked until the day before birth."*

According to RXII, aged 35 years old, said, *"Idid not get enough time to take rest as it is not that good for health as well as had to do some normal works also."*

According to RXIX, aged 28 years old, said, *"Ididn't get time to take rest. I went forest in the day and gave birth during night."*

Similarly, RXXX, aged 21 years old, said, "*No. I didn't get time to take rest. I Sold the woods the day before and the next day I gave birth."*

From the study, it was found that most of the respondents don't get enough time to take rest during pregnancy. It is because they are not aware of their maternal health, due to illiteracy and societal norms. And due to lack of health awareness programs also they don't have proper knowledge about health-related problems. They are forceful to work every day as if they don't work it's really hard for them to survive.

Most of the women from my respondent couldn't do rest. It is observed that due to poor economic condition and illiteracy, most of the women from my respondent had to do household and external works. Also, it is observed that due to lack of knowledge about Maternal and Child Health and poor economic condition, most of the women from my

respondents had worked in few days of delivery. Only few women were found to do work after 2-3 months of delivery.

In my survey, according to the women of Mushahar community, most of them worked within 10-12 days of delivery from which it is found that some women did washing clothes, cooking food, etc. It is also found that some women, in 10-12 days of delivery, did both household as well as external works. Some of the works that my respondent reported are: -

RI, age 40 years old, shared about work she did after delivery: -

"Sometimes I had to go to forest for gathering woods, and households works like cooking food."

Similarly, RIII, aged 26 years old, said, *"I used to work all the household works and then after I used to go to give food to my husband in his working place (Filtering pebbles and stone work)."*

Similarly, RXIV, aged 14 years old, said, *"All types of works such as gathering woods and taking it to sell and farming others land."*

According to RXVII, age 35 years old, said, "*I did all types of works such as gathering woods and household works."*

According to RXXIII, aged 30 years old, said, "*Did all types of works such as gathering woods and selling those for daily breads because we are poor."*

From the study it was found that after the delivery of 10-12 days, they are compelled to do every kind of household works and outside works also such as going forest, washing clothes, cooking foods. It is because for their daily foods also they have to go to work as they are economically backward and if they don't go to work it's really hard to survive.

4.2.11 Post Natal Care: Service Received From the Health Workers

The postnatal period is important for mothers, as evidence has shown that they are more likely to develop life- threatening complications such as postpartum hemorrhage during this period. Postnatal visits from health personnel can help to prevent or treat most of these conditions. In addition, this period is important for counseling mothers on how to care for themselves and their newborns. It is recommended that a woman receive at least

three postnatal checkups, the first within 24 hours of delivery, the second on the third day following the delivery, and third on the seventh day after delivery. Proper care for newborns is essential to reduce neonatal problems and death. According to the World Health organization, postnatal care services for newborns should start as soon as possible after birth because many neonatal deaths occur within the first 48 hours of life. To identify, manage, and prevent complications, the government of Nepal recommends at least three postnatal checkups for newborns within 7 days of delivery, which is days of delivery, which is considered a critical time period for neonates and mothers (NDHS, 2017) but, in Mushahar community most of the women did not consult with doctor at any period. Few women decided to consult to doctor if the child becomes sick and very few women decided to consult with doctor after 1-2 months of delivery due to the lack of money, cultural norms and values and awareness also.

CHAPTER-FIVE

SUMMARY, CONCLUSION

5.1 Summary

In this chapter, I present the summary of the research findings of my study project. It entails of various constrains of research, recommendations for further research and recommendation for the stakeholders specially who want to study in the Maternal and child health in Mushahar community. Maternal and child health care practices play a vital role in the health of Mothers and children. Inadequate Maternal and child health care practice results in Maternal and child mortality and morbidity. Maternal and child health care practices have been improving but still many Dalit communities have not knowledge about it. Therefore, an attempt was made to study the Maternal and child health care practice of Mushahar community of Motigadha 7, Udayapur.

The main objectives of the study were to find out the factors of increase maternal health problems and the challenges of the respondents and to identify the Maternal and child health practice of Mushahar community of Motigadha 7.For this study,30 respondents using as a purposive sampling from Mushahar community of Motigadha 7.Data used in this study were primary and secondary in nature and they were collected through various tools as semi-structured, open-ended questionnaire, in-depth interview and observation. The data were analyzed using descriptive method of analysis with qualitative analysis methodology. And main findings conclusion are presented below.

5.2 Conclusion

Finally, it may be concluded from my study of Mushahar community that; this community is one ethnic and marginalized group in Nepal. And, this community is back in socio-culture, economic condition, politics, etc. These community groups have their own culture, rituals, lifestyle, activity, etc. According to this community, they survive and live their life. They live separately in one own group and have unity, feeling of brotherhood, etc. From my survey of these group women, it has been found that many women are uneducated and unemployed and some women are able to read and write only. Their work is to go to the forest, collect woods, take it to sell in the market and

work in others land and from these works they survive. Now also many women of this group are backward due to less knowledge about MCH. Because of this reason, it has been found that many women of this group hadn't gone for checkup to hospital and now also they feel shy to go hospital for checkup. Most of the women from this group has given birth to a child while working easily and comfortably, so they think going hospital is unnecessary. Also, it is found that due to poorness some women were unable to go to the hospital even the condition was critical, so they have to forcedly stay at home. Here, it is found that the main reason of avoiding MCH by the women of this group is due to lack of people who have knowledge about MCH. It has also been found that the present generation of this group is also unknown about MCH and they are following the same rituals and culture and also, they are giving birth to a baby in home bearing the labor pain. In case of food, it is found that due to poorness they are unable to eat nutritious food instead of which they have to eat chilly, salt, rice, pulse, etc. Due to poor nutrition, it is found that many children after the birth are dying and in some cases mother and child both are died. After the delivery, the women most take rest but, in my survey, it is found that most of the women started working after 10-12 days of delivery due to the requirement of food.

REFERENCES

Adhikari, K. (2013). *Role of Husband in Safe Motherhood of Wives*. A Study of *and Pod Castes of Kaski District.* Department of Sociology/Anthropology.

Adhikari, R. H. (2000). *Maternal Health Care Practice among Fisher Women in Rapti and Narayani River in Chitwan and Nawalparasi Districts Specially around the Chitwan National Park:* An M.A. Dissertation Submitted to Central Department of Population Studies, Tribhuvan University (Kathmandu: Central Department of Populations Studies).

Aryal, K.K.(2019). *Maternal Health Care in Nepal: Trends and Determinants*. Ministry of Health and Population.

Awasthi, M. S, et al. (2018). *Utilization of Antenatal Care Services in Dalit Communities in Gorkha, Nepal: A Cross- Sectional Study*. Journal of Pregnancy, Vol. 2018, pp.1-8.

Banstola, A. (2017). *The Current State of Maternal Health in Nepal.* Maternal Health Task Force, Center of Excellence in *Maternal and Child Health.* Harvard Chan School.

Baral, Y.R, et al. (2012). *Maternal Health Services Utilization in Nepal: Progress in the New Millennium.* Health Science Journal, Vol. 6(4), pp.618-633.

Barry Anne Marie, and Yuill, Chris (2002). Understanding Health, A Sociological Introduction. Sage Publications, London.

Benard, Cheryl, et al. (2008). *"Planning and Implementing Programs for Women's Health and Education: Building Indicators of Success"*. Women and Nation building. Rand Corporation.

Bhattarai, S, et al. (2015). *Health Seeking Behavior and Utilization of Health Care Services in the Village Development Committees of Ilam District of Nepal.* Journal of College of Medical Sciences Nepal, Vol.11(2), pp.8-16.

Bhusal, C., Bhattrai, S., and Bhaskar, R.K. (2015). *Maternal Health in Nepal Progress, Challenges and Opportunities.* International Journal of Medical and Health Research, Vol. 1 (3), pp. 68-73.

Bradby, Hannah (2009). *Medical Sociology: An Introduction.* Sage Publication, London.

Ghimire, K.P. (2009). *Livelihood Strategy of Mushahar Community. A Case Study of Baijanathpur VDC, Morang.* A Dissertation Submitted to Faculty of Humanities and Social Science, T.U., Kirtipur.

Khanal, M. K. (2001*). Maternal and Child Health Care Practices at Gandarva (Gaine) and Pod Castes at Kaski Districts*. Unpublished Department, FOE, Kirtipur.

Mahara, G. et al. (2016). *Maternal Health and its Affecting Factors in Nepal*. Medicine and Community Health, Vol. 4 (3), pp.30-34.

Merriam, S.B. (2002), *Introduction to Qualitative Research*", Qualitative Research in Practice: Examples for Discussion and Analysis (pp.3-17). San Francisco, CA: Jossey-Bass.

Ministry of Health, Nepal, New ERA and ICF (2017).*Nepal Demographic Health Survey 2016*. Kathmandu Nepal*:* Ministry of Health, Nepal.

Pillitteri, Adele. (2010). *Maternal and Child Health Nursing: Care of the Child Bearing and Child Bearing Family*. Walnut Street, Philadelphia.

Savin-Baden, M., Major, C. H. (2013), "Qualitative research: The essential guide to theory and practice", New York: Routledge.

Saxena, D., Vangani, R., Mavalankar, D.V., and Thomsen, S. (2013). *Inequality in Maternal Health Care Service Utilization in Gujrat: Analyses of District Level Health Survey Data*. Global Health Action, 13, 6. Doi: 10. 3402/ gha. V6io.19652.

Shah, S.K. et al. (2016). *Prevalence of Under Nutrition among MushaharChildren Aged between 12 to 59 Months in Urban SirahaDistrict, Nepal.*MojPublic Health, Vol,4(5), pp.146-152.

Shrestha, S., et al. (2018). *Knowledge and Practice of Antenatal Care among Chepang Women from Chitwan, Nepal.* ARC Journal of Public Health and Community Medicine, Vol,3(2),pp.7-11.

Suwal, J. (2008). *Maternal Mortality in Nepal: Unravelling the Complexity*. Canadial Studies in Population, Vol. 35(1), 1-26.

Timilsina, Umesh (2004). "A *Study of Indigenous Practices of Maternal and Child Health Care in Majhi Community"*, An Unpublished Dissertation Submitted to Central Department of Population Studies, T.U. (Kathmandu: CDPS).

Timmermans, Stefan & Steven, Haas (2008). Towards a Sociology of Disease. *Sociology of Health and Illness. Vol. 30 (5). pp.659-676.*

Umar, Abubakar Sadiq. (2016). *Use of Maternal Health Services and Pregnancy Outcomes in Nigeria.* Walden Dissertation of Doctoral Studies, Walden University.

White, Kevin (2002). *An Introduction to the Sociology of Health and Illness.* Sage Publications, London.

Wright, R., Eric and Perry, L., Brea (2010). Medical Sociology and Health Services research: Past Accomplishments and Future Policy Challenges. *Journal of Health and Social Behavior.51 (S), S(107-S119).*

APPENDIX-I

Guideline Questions

Namaste and welcome to our conversation.

Can we start Now?

I would like to welcome you again and thank you for taking part in this conversation.

1) What is your age? Occupation: Religion:

2) Your education?

……..

3) Which age did you get married?

……..

4) Where do you go for check-up when your family members get any types of sickness?

……

5) What types of work were you required to do while you were pregnant?

……. ……

6) What was your age during your first childbirth?

……..

7) Did you go to a health institution for a health checkup? If not why? If not, why? if yes where did you go for checkup?

……

8) How many hours a day did you have rest during your pregnancy?

…….

9) How was your food intake during your pregnancy?

…….

10) What kinds of foods did you eat during your pregnancy?

……

11) Did you face any complications during pregnancy? If yes, what types of problems did you face? Where did you go for treatment? Who helped you to get the treatment?

……

….

12) Where did you give birth to your child? Why?

……

13) According to your religion and culture, what types of food are provided post-pregnancy?

……..

14) How many days prior to your child birth did you got to take rest?

……..

15) Who assisted / took your care during your delivery?

…….

16) After how many days post-delivery, did you continue your work?

……..

17) What kinds of works did you do after delivery?

……..

18) During your postnatal period, what types of foods did you eat?

…….

19) Did you take TT Vaccine during pregnancy? If yes, how many times did you take the vaccine?

…….

20) After delivery at home, when did you consult to doctor? And where did you take your child for the first health checkup?

…….

21) Did you get any health- related information during pregnancy?