A Study of Educational Status, Social Awareness and Safe Motherhood Practices among Dalit and Janajati Women of Nepal

THESIS
Submitted to
JAIPUR NATIONAL UNIVERSITY
for the
Degree of Doctor of Philosophy
in
EDUCATION
By

OM PRASAD BARAL
Reg. No. JNU.jpr/PhD/Edu/2013/011

Under the Supervision of
Prof. Kamla Vashisth

SCHOOL OF EDUCATION
JAIPUR NATIONAL UNIVERSITY, JAIPUR, INDIA
2015

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the dissertation entitled “A Study of Educational Status, Social Awareness and Safe Motherhood Practices among Dalit and Janjati Women of Nepal" has been submitted by Om Prasad Baral, School of Education, Jaipur National University for the Degree of Doctor of Philosophy is a record of work carried out by his during the period from May 2013 to May 2015 under the guidance of Prof Kamla Vashisth and has not formed on the basis for the award of any degree,, diploma, associate-ship, fellowship, titles in this or any other university or the other similar institution of higher learning.

_____

Prof. Kamla Vashisth, Ph.D.
Director
School of Education
Jaipur National University, Jaipur
Rajasthan, 332001 (INDIA)

CERTIFICATE OF THE SUPERVISOR

This is to certify that the dissertation entitled "A Study of Educational Status, Social Awareness and Safe Motherhood Practices among Dalit and Janjati Women of Nepal" has been submitted by Om Prasad Baral, School of Education, Jaipur National University for the Degree of Doctor of Philosophy is a record of bona-fide research work. He has carried this dissertation under my guidance and supervision, which has fulfilled the requirements stated for the submission of this dissertation.

The results contained in this dissertation have not been submitted in part or full by the candidate to any other university for the award of degree.

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Prof. Kamla Vashisth, Ph.D.

Supervisor

DECLARATION OF CANDIDATE

I, Om Prasad Baral hereby declare that the thesis entitled **"**A **study of educational status, social awareness and safe motherhood practices of Dalit and Janajati women of Nepal"** submitted for the degree of Doctor of Philosophy of Education in the research work carried out me under the supervision of Prof. Kamla Vashisth , Director, School of Education, Jaipur National University, Jaipur and has not formed on the basis for the award of any degree, diploma, associate-ship, fellowship, titles in this or any other university or the other similar institution of higher learning.

Place: Jaipur, India

Date:

Om Prasad Baral

ACKNOWLEDGEMENT

I am greatly indebted to the School of Education Jaipur National University, Jaipur for giving me the opportunity to carry out this study for the partial fulfillment of Doctor of Philosophy in Education.

A large number of individuals and institutions have co-operated and contributed to accomplish this study. First of all I would like to express my deep sense of gratitude to my supervisor Prof. Kamla Vashisth, Ph.D. for her valuable time, generous guidance, co-operation and continuous support throughout the study. This work has been completed under her academic guidance and inspirational supervision.

I am very grateful to Prof. Lokendra Sherchan Ph.D. Head of Health, Physical and Population Education Department, Tribhuvan University Nepal for his valuable feedback and suggestions in overall aspects of this study. Similarly, I am grateful to Prof. Abdul Quaiyum, Ph.D. Head of Mathematics Education Department, Tribhuvan University Nepal for his observations and comments on this research work regardless of his own academic preoccupations.

I would like to thank Prof. Shubha Vyas, Ph.D., School of Education, Jaipur National University for providing me co-operation and continuous support for this study. I wish to express my deep sense of gratitude to Prof. Rita Arora, Ph,D., School of Education, Jaipur National University, Jaipur for her valuable feedback and suggestions in this study. I am thankful to all other faculty member and administrative staffs of Jaipur National University, who directly or indirectly co-operated with me for the completion of present research work.

I am highly grateful to Prof. Shyam Krishna Maharjan, Ph.D. Chairman of Health and Population Education Subject Committee, Tribhuvan University Nepal for his co-operation and continuous encouragement and to Assistant Prof. Pabitra Raj Baral for his language correction and valuable suggestions. My acknowledgement also goes to Faculty of Education, Tribhuvan University, Kathmandu, Nepal for granting me study leave to carry out this study.

Last but not the least, I am grateful to the respondents of different VDCs of Parsa and Kaski districts for their encouraging participation as interviewees and valuable personal information during the period of data collection.

Om Prasad Baral

Researcher

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

LIST OF ACRONYMS

AMTSL	:	Active Management of Third Stage of Labour
ANC	:	Antenatal Care
APH	:	Ante-partum Haemorrhage
ANM	:	Auxiliary Nurse Midwife
BF	:	Breast Feeding
BEDOC	:	Basic and Emergency Obstetric Care
C/S	:	Caesarian Section
CAC	:	Comprehensive Abortion Care
CEOC	:	Comprehensive and Emergency Obstetric Care
CBS	:	Central Bureau of Statistics
CMA	:	Community Medical Assistant
DFID	:	Department for International Development
DoE	:	Department of Education
DoHS	:	Department of Health Services
DPHO	:	District Public Health Office
EU	:	European Union
FCHV	:	Female Community Health Volunteer
FHD	:	Family Health Division
FP	:	Family Planning
GoN	:	Government of Nepal
GER	:	Gross Enrollment Rate
HA	:	Health Assistant
HIV/AIDS	:	Human Immuno-deficiency Virus/Acquired Immuno-Deficiency Syndrome
HDI	:	Human Development Index
HP	:	Health Post
ICPD	:	International Conference on Population and Development
ILO	:	International Labour Organization
INGO	:	International Non-Governmental Organization
MCH	:	Maternal and Child Health
MDGs	:	Millennium Development Goals
MG	:	Mother's Group
MoES	:	Ministry of Education and Sports
MoH	:	Ministry of Health

MMR	:	Maternal Mortality Ratio
MoHFW	:	Ministry of Health and Family Welfare
MoHP	:	Ministry of Health and Population
NSMP	:	National Safe Motherhood Plan
NEFIN	:	Nepal Federation for Indigenous Nationalities
NMIS	:	National Management Information Center
NFFHS	:	Nepal Fertility, Family Planning and Health Survey
NDHS	:	Nepal Demographic and Health Survey
NER	:	Net Enrollment Rate
NGO	:	Non-Governmental Organization
NLSS	:	Nepal Living Standard Survey
NHTC	:	National Health Training Center
NNHP	:	Nepal's National Health Policy
NPC	:	National Planning Commission
PN	:	Postnatal
PNC	:	Postnatal Care
PHC	:	Primary Health Center
PPH	:	Post Partum Haemorrhage
PCI	:	Per Capita Income
PMR	:	Prenatal Mortality
RCH	:	Reproductive Child Health
SMNS	:	Safe Motherhood Network Secretariat
RH	:	Reproductive Health
SA	:	Social Awareness
SAARC	:	South Asian Association of Regional Co-operation
SBA	:	Skill Birth Attendance
SCs	:	Scheduled Castes
SDIP	:	Safe Delivery Incentive Program
SHP	:	Sub Health Post
SLC	:	School Leaving Certificate
SM	:	Safe Motherhood
SMNH	:	Safe Motherhood National Health
SMNHLTP	:	Safe Motherhood National Health Long Term Plan
SMNS	:	Nepal's National Health Policy
SSMP	:	Support for Safer Motherhood Program
SSRP	:	School Sector Reform Program

STs	:	Scheduled Tribes
TBA	:	Traditional Birth Attendance
TT	:	Tetanus Toxiod
UN	:	United Nations
UK	:	United Kingdom
UNESCO	:	United Nations Education and Socio-cultural Organization
UNFPA	:	United Nations Fund for Population Activities
UNICEF	:	United Nations Children Fund
UP	:	Uterus Prolapsed
USAID	:	United States Aid for International Development
VDC	:	Village Development Committee
WHO	:	World Health Organization
GTZ	:	Germany's Gesellschaft for Technical Zusammenarbeit

CHAPTER-I

INTRODUCTION

1. Background of the Study

Nepal is multi-cultural, multi-lingual, multi-ethnic, multi-religious and Federal Democratic Republic. There are 125 castes/ groups and 123 languages (CBS, 2011) spoken as mother tongue. Nepal is preparing to bring marginalized and excluded communities in social inclusion and new nation building process. Dalits and Janajatis are among the most marginalized groups at present in Nepal. Dalits, for instance, are traditionally denied their own means of production and access to land ownership, and are amongst the poorest in the country. Likewise, the small ethnic groups that figure among the 54 listed still remain on the edge of Nepali society. Exclusion affects many of life: education, health, standard of living, at participation in public life. The difference must be recognized within these two large categories. The level of exclusion for Dalits, for instance is more extreme in Tarai than in the Hills. The Nepal Federation for Indigenous Nationalities (NEFIN) has further broken down their list of 54 Janajati into five categories based on the level of development: advanced, disadvantaged, marginalized, highly marginalized and endangered. This sub classification implies that not all indigenous should be ranked at the same level (Toffin, 2014)[1].Dalits and Janajatis are facing difficulties in education, health and economy. The government's intervention is needed to uplift the Dalits and Janajatis in all these aspects.

1.1 Policy and Programs to Increase Literacy Level of Dalit and Janajatis

In line with the Millennium Development Goals (MDGs), the Nepal government is implementing the National Action Plan 2001-2015 in the education sector with the slogan "Education For All". Its major focus is on universal access to basic and primary education. The target is to increase the literacy rate in 6 years and above

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[1]Toffin (2014).The inclusive state: A philosophy and sociology of social inclusion. In Gurung,O.,Tamang,MS.and Turin,M.(Eds). *Perspective on social inclusion and exclusion in Nepal* PP 219-234.

population to 85 percent by the year 2012 and 90 percent by 2015. To achieve this target, the government is committed to a socially inclusive policy of improved access to education such as the elimination of gender disparity in primary and secondary education and improvement of the quality of education (MoES, 2003). There is a remarkable difference in the literacy rate between the boarder social group and the social subgroups. According to the 2011 census, 65.94 percent of the population of 5 years and above is literate. About 50 percent of VDCs/ Municipalities in the country have higher literacy rate than the national average. Among the broader social groups, Brahman/ Chhtrees have the highest literacy rate (76.03%) while Musalmans have the lowest (43.56%). The literacy rate for Janajati is just above the national average (66.79%). This is followed by Madhesi caste (55.49%), and Dalits (52.48%). Among the social subgroups, literacy rate varies. For example, among Hill Brahmans, the rate is 81.89% for Newar it is 80.07 percent. These groups are followed by Hill Chhetrees (72.17%), Hill Janajaati (68.45%), Tarai Janajati (62.48%), Hill Dalit (61.93%), and other Madhesi castes (53.88%). The literacy rate for Madhesi Dalits (34.50%), is well below the national range (CDS/A, 2014).[2]

Because of political instability and a decade long conflict, Nepal achieved an adult literacy rate (15 years and above) of only 56.5 percent with huge variation between men (71.6 percent) and women (44.5 percent). There are noticeable differences in literacy rates based on gender, caste and ethnicity, location and income of people. With adult literacy rates at only 51 percent (men 67 percent versus females 39 percent) the people living in rural areas are far behind their urban counterparts with literacy rates at 76 percent (men 87 percent versus women 66 percent). The most miserable situation prevails for the poorest 20 percent of population compared to the richest 20 percent of population with an enormous literacy gap of more than 40 percentage point. In some of the poorest and remote districts of Nepal, the above figure drops to less than 25 percent with literacy rates for adult women even lower. Adults without basic education are more likely to be extremely poor, malnourished, and are less likely to know about basic human rights to protect them. The children of illiterates are more likely to die before seeing their fifth birthday and have higher rates

[2]CDS/ A, T.U. (2014). Nepal *Social inclusion survey 2012*. Kathmandu: CDS/A,T.U. Pp 42-51.

of malnutrition which hampers their mental, emotional and physical development (CBS, 2011)[3]

The Government of Nepal (GoN) has made significant progress over the last decade in getting children into primary school. According to the GoN, Ministry of Education the current net enrolment rate for children in primary school is 95.6 percent with gender parity almost achieved. The GoN has been particularly effective at increasing the number of girls in school. The Flash Report 2010 showed that the participation of girls improved significantly. The gender parity index in primary, lower secondary and secondary education in net enrolment rate is 0.98 at all levels (DoE, 2011)[4].

However, more progress to improve internal efficiency still needs to be made. Drop out and retention rates for children in primary school are worrisome with only 66 percent of children completing primary education (grade 8). About 27.1 percent of student's complete secondary education (grade 12). There are large disparities between the enrolment and completion rates in rural areas and urban areas. Children from marginalized communities and those living in rural areas often receive poor quality education. Rural schools struggle to find and keep good teachers. Many schools have poor infrastructure facilities. In some schools there are no desks or toilets for children (MoE, 2013).

Nepal has prioritized both basic primary and secondary education as an important contribution to the national goal of poverty reduction. GoN should focus more on improving all children's access to education, enhancing the quality of public school education.

Education is a high priority for poverty reduction in Nepal and the Nepal Government is allocating nearly twenty percent of its public budget on education and skills. SSRP is the latest in a series of Government-led national programs on education. Previous programs have succeeded in improving access and inclusion at the primary level: the net enrolment rate at the primary level is now 92 percent. Girl's enrolment has increased dramatically from 33 percent in 1983 to about 67 percent in 2003 and to 87 percent in 2008 – Nepal has nearly achieved parity of girl: boy enrolment in primary education. Despite this, Nepal is still some distance away from achieving the MDG goals on education and gender: gender discrimination, inequality and social exclusion constrain progress. And achievements in access (enrolment, attendance, retention and

[3]Central Bureau of statistic (CBS) (2011) Nepal living standard survey statistical report, vol. I p28.
[4]Department of Education (2011). Flash report I, 2011-12. Government of Nepal p9.

completion) are undermined by poor quality of schooling (relevance and achievement)(MoE,2010).[5]

Addressing gender and social inclusion GoN has had most success in promoting equality and rights while acting at national sector level. Considerable monitoring, evaluation and research activities have taken place for social goals and social disaggregation is embedded in most social programs. The commitment to gender equality in education and to a target of 50 percent women teachers in SSRP by 2015, including women from Dalit and Janajati groups, will make a significant contribution to gender and social inclusion. Demand-side financing through scholarship programs for girls, Dalits, Janajatis and other disadvantaged children are combined with increased local accountability through school management committees to strengthen the relationship between children, schools and policy makers. Sector instruments alone are not sufficient to reach the most excluded.

For the better governance in the education sector DFID and EU's supported and technically engaged through the development partners' forum has helped shape SSRP, contributing significantly to the development of processes and timelines for strengthened financial management and improved governance and results.

1.2 Educational Status of Dalit and Janajati Communities

Education is a foundation on which the destiny of a nation is laid. Most of the developing countries like Nepal which despite allocating a sizable of meager resources to the education sector every year is still facing the challenge of bringing the light of education to all it people, mainly the female.

Table 1.1: Educational status of Dalit and Janajati communities, 2011

SN	Description	Total percent	Janajati	Dalit
1	Total literates	65.9	66.79	52.48
2	Basic level education	64.99	72.21	24.56
3	Secondary level education	30.82	26	14.8
4	Higher secondary education	4.19	1.58	0.63

Sources: Population Monograph of Nepal Vol.2, 2014

NSIS, 2012

[5]MoE (2010). *Ministry of Educaiton: A glimpse 2010.* Kathmandu: MoE/Monitoring, Evaluation and Supervision Division Pp. 14-15.

Table 1 reveals that 67.79 percent of Janajati and 52.48 percent of Dalit were literate in comparison to average national literacy rate of 65.9 percent. Accordingly only 26 percent of the Janajati and 14.8 percent of Dalit acquired secondary level education. However, only 1.58 percent Janajati and 0.63 percent of Dalits acquiredHigher secondary education. It is clear that educational status of Dalits and janajatis which much low in comparison to another communities of Nepal.

1.3 Social Awareness Context of Nepal

The concept of social awareness entered into Nepali national debate through various mediums and resonates the conceptualization and application elsewhere as discussed. Social and political movement against exclusion by historically excluded groups, intellectual analysis of Nepali society (Gurung, 1998) and initiatives of the Nepali state and the international and development community (DFID and the World Bank, 2006) all contributed to deepening the agenda of social awareness and social inclusion in Nepal. Concept of social awareness and social inclusion also has been extensively discussed in the context of new constitution making in Nepal (Tamang, 2012).[6]

The government of Nepal introduced social awareness and social inclusion as one of the four pillar of the tenth five years plan also known as poverty reduction strategy in 2003. The interim constitution 2007, subsequently promulgated, reflects further work on institutionalizing the concepts, and states in Article 33 (d) that the state shall have responsibility to carry out on inclusive, democratic and progressive reconsturing of the state by eliminating its existing form of centralized and unitary structure in order to address the problems related to women, Dalits, Janajatis, Madhesi, oppressed and minority communities and other disadvantaged groups, by eliminating class, caste, language, gender, cultural, religious and regional discrimination.

According to Nepal Social Inclusive Survey(2012), there is 25 percent social awareness situation here. The characteristics of social awareness regarding government facilities, rights and reservations in Nepal are 20 percent, 24 percent and 30 percent respectively.

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[6]Tamang (2012). The politics of developing Nepali women in state of Nepal *edited by Kanak M. Dixit and S.Ramachandran*. Kathmandu: Himal Books Pp27-31.

1.3.1 Social Awareness and Social Inclusion of Dalits

The Dalit community in Nepal is not only deprived of the use of and access to public utilities and places, but also excluded from the legal system and public policies. Through laws and plans (e.g. the local-self Government Act) which have made affirmative provisions for Dalit participation in local bodies, and the 10th five year plan aiming for the enhancement of Dalits limited accessibility of natural resources, the government of Nepal has been intervening to increase the participation of Dalits in local and central governance. Yet the results of such nominal polices have been proved as tokens and can be labeled as formally inclusive only. Often Dalit activists and people/ institutions working for Dalit raise their voices on pertinent issues like untouchability discrimination, poverty, social prejudice and cultural barriers, inaccessibility of resources, and lack of representation in governance and the political system.

1.3.2 Social Awareness and Social Inclusion of Janajati Communities

The Nepal state recognized 61 Janajati communities only in 1999 (DFID and World Bank, 2007).[7] However, the state has defined the communities conservatively by dividing them into groups that face socio-economic and cultural backwardness. Social scientists believe that there are more Janajatis people/ communities that should be recognized by the state. Janajati people face consequences in terms of discrimination because of their small population and also historic and current inequitable treatment by the state and society. Some of the pressing problems relevant to the Janajati group are: linguistic discrimination, religious domination and cultural imperialism, abolishment of land rights, access to resources and inadequate recognition of indigenous traditional knowledge endowment, exclusion in political participation and migration.

1.4 Social Awareness and Social Inclusion in India and Nepal

In India, exclusion/ inclusion themes were adopted in the 1980s. They were applied to social categories such as the disabled. Scheduled Castes (SCs) Scheduled Tribes

[7] DFID & et.al (2006). *Unequal citizens: gender caste and ethnic exclusion in Nepal*. Kathmandu: DFID and the World Bank, 42-45.

(STs), identified (i.e. ex-criminal) and Nomadic tribes minority religious groups, and other marginal and excluded section of society. Some areas in which these themes were experimented which include empowerment projects, access to basic services including water, sanitation and hygiene education, reservation and quotas, mechanism of social protection, preservation of cultural diversity while promoting communal harmony, and many other so-called good practices relevant to a particular time and space. In India, affirmative action was legally adopted in the early 1950s and even before in some regions. Multicultural values are perceived to be as central to the Indian. Constitution as equalitarian values, despite persistent Islam phobia high-caste consciousness in some sections of the Hindu Populations. The India constitution has granted linguistic minorities the right to establish separate institutions to promote their culture and languages, and the national commission adopted inclusion in its 12th plan 2012-2017 (Tripathy& et.al, 2013).[8]

The philosophy behind such action in India is to construct more inclusive society by countering discrimination and providing better economic facilities, better schooling, improved school protection, and wider political representation for the underprivileged. Nevertheless, some societal issues have been violently contested, such as the extension of affirmative action to OBCs (Other Backward Classes) and the process of detribalizing ethnic groups to integrate them fully into mainstream society. In this respect, it is worth remembering that Prime Minister V.P Singh's decision to implement the recommendations of the Mandal Commission, which largely extended the caste reservation policy from scheduled castes to OBCs, brought about a number of self-immolation in 1990. That year, 159 young people attempted to commit suicide by setting fire to themselves in protest against the new policy, but only 63 of them succeeded (Dirks, 2001).[9]

Young people with upper-caste backgrounds saw in the decision the prospect of losing their own employment opportunity in various state administrations. In some

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[8]Tripathy & et.al (2013).*The democratic predicament: cultural diversity in Europe and India.* Delhi: Routledge Pp 231-241.

[9]Dirks (2001).*Castes mind: colonialism and the making modern India.* Princeton: Princeton University press Pp139-148.

cases, self-assertiveness, revivalism, and identity preservation can run counter to the dynamic of inclusion (Toffin, 2014). The repertoires of inclusion have met with similar success in Nepal.It was rapidly adopted by the authorities and became part of political agenda (Inclusive democracy). Even before the ending of monarchy in Nepal (2008), the concept of inclusion had been adopted as one of the four pillar of the 10^{th} five year plan in 2003 (Rawal, 2008). The first Constituent Assembly (2008-2013) similarly laid emphasis on social awareness/inclusion and asserted its commitment to respecting the social, economic, cultural, and political rights of excluded communities. As a case in print, from now on, Constituent Assembly members have the right to use their mother tongue in the swearing-in ceremony at the beginning of their mandate (The Kathmandu Post, 18 February, 2014)). This is remarkable in a country where 123 distinct languages (2011 census) have been officially recognized and only half of the population uses Nepali as their native language. The Constituent Assembly also stipulated that at least one third of its members should be women. The notion of social awareness and inclusive state has thus become an essential instrument for building a republican democracy in Nepal. It aims to dismantle the inequalities associated with caste and helps to rally government agencies behind issues of equality. Mechanisms of social awareness/ inclusion are based on an assumption that society is unable to make up for its own failings.

1.5 Brief History of Safe Motherhood

1.5.1 Global movements for safe motherhood: major landmarks.

1946: The commission on the status of women in formed.

1975: Celebration of International women's years is held in Mexico City. It is the first global conference to be held on women's issues, with 138 government's representation.

1976–1985: United Nationals Decade for women.

1979: UN General Assembly adopts the convention for the Elimination of All Forms of Discrimination against Women.

1985: The world conference on the UN Decade for women takes place in Copenhagen with delegations from 145 member state.

1985: The third UN women's conference to review and appraise the achievement of the UN Decade for women's is held in Nairobi, with delegations form 157 members

states. The Nairobi Forward Looking Strategies for the Advancement of Women is adopted, outline measures to improve the status of women by the end of the century.

1987: International conference on Better Health for women and children through FP held in Nairobi.

1992: The Rio Declaration (Agenda 21) adopted by the UN conference on Environment and Development in Rio De Janeiro affirms that women have a vital role to play in environment management and sustainable development.

1993: The UN conference on Human Right in Vienna adopts the Vienna Declaration and Program of Action, which urges Governments and the United Nations to ensure equal rights of women and stresses the importance of the elimination of violence against women.

1994: The ICPD in Cairo affirms that there are four requirements for any program of population and development: gender equality, empowerment of women, the ability of women to control their fertility, and the elimination of violence against women.

1995: The fourth world conference on women is held in Beijing. The Beijing Declaration and platform for Action, adopted by representatives from 189 countries, identifies 12 critical areas of concern which reflect the main obstacles to women's advancement, including poverty, health and violence against women.

2000: Millennium Declaration.

2007: Women Deliver conference in London.

2010: Millennium Declaration summit in New York USA.

International Conference on Population and Development (Cairo, 1994), the fourth world conference on women (Beijing, 1995) and the Safe Motherhood Technical Consultation(Colombo, 1997) have helped to focus the attention of the international community on the need for accelerated action to achieve the World Summit for Children (New York, 2000) goal of reducing maternal mortality in the context of human right, even governments use their political, legal and health system to fulfill the obligation imposed by their endorsement of various international human rights instruments.

Global safe motherhood initiative was launched at an International Conference held in Nairobi, Kenya in 1987. Its aim was to draw attention to the dimension and consequences of poor maternal health in developing countries and to mobilize action to address high rate of death and disability caused by complication of pregnancy and child-birth. The goal set out by initiative, and later adopted at several United Nations

conferences, was to reduce maternal mortality by half by the year 2000. In this particular issue, commitment was done to strive for reducing the mortality and morbidity related to pregnancy and child-birth. This commitment was reinforced in the ICPD Conference held in Cairo in 1994 where in addition to the call to reduce maternal mortality and morbidity by at least 50 percent by the turn of century. Safe motherhood was recognized as one of the key components of Reproductive Health. Attention was also drawn to creating an enabling environment, enhancing gender equality, equity and empowerment of women. It also gave priority to promoting reproductive health, including family planning and sexual health and reproductive rights. ICPD also emphasized the need for strengthening partnership and mobilizing and monitoring resource, which made a significant contribution to these deaths. Nepal as the signatory of ICPD conference has endorsed the plan of action of the ICPD. Moreover, the 1995 UN fourth world conference on women in Beijing have clearly, advocated an integrated approach, including health services, family planning and women's empowerment, as the immediate and most effective means to deal with health and population (UN, 1996).[10]

The practice and knowledge about safe motherhood is very poor in developing countries because of inaccessibility of facilities and lack of proper awareness of it. The short term strategy emphasizes improving attitude of FP and maternity care services. Child on a long term enhancement of status of women is important and play vital role for practicing the safe motherhood (Tinker & et. al 1995).[11]

The World Health Organization (WHO) introduced the mother-baby package program and describes it as each intervention needed to achieve safe motherhood in short term. It represents the synthesis of activities at different levels of health care system and defines as a basic set of health system, intervention and activities that cannot be further reduced. The package describes simple interventions needed before and during pregnancy, delivery and after delivery for the mother and new born (WHO, 1995).

These are important but it is one of the 'six big' priorities of the organization. By the year 1995, WHO was strongly advising against the further establishment of the

[10]UN (1996).*Program of action: International conference on population and development* (ICPD) New York: UNFPA 229-231.

[11]Tinker & et.al (1993). *Making motherhood safe World Bank Discussion Paper 202* Washington DC: The World Bank.

tradition "MCH center" but it was also advising instead of integration of "Maternal and child activities" with general health services aimed at forming a basis for more effective care.

In developing countries, each year more than half a million women die from maternal causes since nearly all of these deaths could be prevented. Efforts to prevent maternal deaths from one major cause, i.e. complications of unsafe abortion are crucial but inadequate in most of the world. Providing appropriate medical care immediately could save many thousands of women's lives. Offering family planning could prevent many future unwanted pregnancies and unsafe abortions (MoPE, 1997).

The most obvious impediments to the use of maternal health care services are physical barriers such as distance and lack of communication and transport. In rural setting, women may find it difficult to pay for transport, where roads are in poor conditions and vehicles are rare. Such physical barrier render even the use of routine prenatal care services, complicated use of services for complications and emergencies is made much worse because speed of the essence, no matter the time of day or night, women in there, in most rural setting lives more than five kilometers from the nearest facility and around 80 percent lives more than five kilometers from nearest hospital (Abouzahr, 1998).[12]

The International Labour Organization's Maternity Protection Convention (adopted in 1999 and last revised in 2000) sets a minimum standard for what should be included in national legislation in this regard. The convention provides for protection against dismissal of women during pregnancy, maternity leave and the breastfeeding period, and also for cash benefits. It encompasses coverage of antenatal, childbirth and postnatal care and hospitalization care when necessary, and working hours and tasks that are not detrimental to mother or child. It is called for 14 weeks of maternity leave, of which six weeks must be postnatal leave to safeguard the health of mother and child. This aspect of the convention covers all married and unmarried employed women including those in unusual forms of dependent work. This can be interpreted broadly to cover women in all sectors of the economy, including the informal sector, but in practice legislation usually cover only women who are employed in the formal sector. With increasing urbanization and the development of the formal economy,

[12]Abouzahr (1998).*Improving access to quality maternal health service*s.London: IPPC Pp 6-9

compliance with these minimum standards in increasingly becoming an issue, in developing as well as developed countries (WHO, 2005).

Despite a lot of effort in maternal health, health status of women is very tragedy. In mid-1980s, it was estimated that half a million women died each year from pregnancy-related causes. In 1996, WHO, UNICEF, UNFPA and the World Bank revised the estimate and reported 576 maternal deaths globally in 1990 and 536, 900 in 2005- a 0.48 percent yearly rate of decline. The MMR was estimated at 400 per 100000 live births and a life time risk of one maternal death in 92. In 2008, it was estimated every year 358, 000 women and girls die from pregnancy related causes. Recent data in 2010 showed further decrease in number of maternal deaths in the world (WHO, 2010).

Safe motherhood has been an issue of growing importance in Nepal over the past decade. Following the conference in Nairobi, Government of Nepal formulated the National health policy in 1991, which identified the safe motherhood as a priority program and institutionalized safe motherhood as a primary health care. Similarly the establishment of safe motherhood task force and development of the National Safe Motherhood Plan of Action (1994-1997) demonstrated a step towards, improving maternal health status in Nepal. In 1998, MoH published the RH strategies, which included SM in integrated RH care package. This was followed by a SM policy document that related already contained in the plan of action 1994-97 and also givesvery high priority to improve maternal and neonatal health status of the nation (FHD, 2001)[13].

1.6 Goal of Safe Motherhood and Newborn Health in Nepal

The goal of the national safe motherhood program is to reduce maternal and neonatal mortalities by addressing factors related to various morbidities, death and disability caused by complications of pregnancy and childbirth. Since its initiation in 1997, the safe Motherhood program has made significant progress in terms of the development of policies and protocols as well as expansion in the role of service providers such as staff nurses and ANMs in life saving skills. The policy on skilled birth attendants endorsed in 2006 by MoHP specially indentifies the importance of skilled birth attendance at every birth and embodies the government's commitment to training and deploying doctors and nurses/ ANMs with the required skills across the country.

[13]FHD (2001).Safe motherhood news letter, maternal situation in Nepal Pp2-3.

In order to ensure focused and coordinated efforts among the various stakeholders involved in safe motherhood and neonatal health programming, government and non-government, national and international, the National Safe Motherhood Plan (2002-2017) has been revised with wide participation of partners. The revised Safe Motherhood National Health Long Term Plan (SMNHLTP, 2006-2017) includes recent development not adequately covered in the original plan. These include recognition of the importance of addressing neonatal health as an integral part of safe motherhood programming: the policy for skilled birth attendants; health sector reform initiatives; legalization of abortion and the integration of safe abortion services under the safe motherhood umbrella, addressing the increasing problem of mother to child transmission of HIV/AIDS; and recognition of the importance of equity and access efforts to ensure that most needy women can access the services they need(DoHS,2011)[14].

1.7 Strategies of Safe Motherhood in Nepal

Following strategies have been taken to achieve the goals of safe motherhood program as related to 10th plan.

1.7.1 Promoting inter-sectoral collaboration by insuring advocacy for and commitments to reproductive health, including safe motherhood at central, regional, district and community levels focusing on poor and excluded groups,

- Ensuring the commitment to SMNH initiative at all levels by promoting collaboration between sectors like health, education, and social welfare, legal and local development.
- Mobilizing national authorities, district health management committee, community leader and community member's to play active roles increasing suitable environment for promoting safe motherhood.

1.7.2. Strengthening and expanding delivery by skilled birth attendant, basic and comprehensive obstetric care service (including family planning) at all levels. Interventions include the following:

- Developing the infrastructure for delivery and emergency obstetric care.

[14]DoHS (2011). Annual report 2010/011.Government of Nepal p66.

- Standardizing basic maternity care and emergency obstetric care at appropriate levels of the health care system.
- Strengthening human resource management.
- Establishing functional referral system and advocating for emergency transport system and funds from communities to district hospitals for obstetric emergencies and high risk pregnancies.
- Strengthening community based awareness on birth preparedness and complication readiness through FCHVs increasing access of all relevant maternal health information and service.
- Supporting activities that raise the status of women in society.
- Promoting research on safe motherhood to contribute to improved planning higher quality services, and more cost effective interventions.

1.8 Major Activities of Safe Motherhood in Nepal

Nepal government, MoHP has been implementing safe motherhood program all over the country on the basis of following activities:

1.8.1 Birth Preparedness Package and MNH Activities at Community level

Family Health Division (FHD) continued support for expansion and maintenance of MNH actives at community level which includes revised Birth Preparedness Package (Jeevan suraksha Flip chart and Jeevan Suraksha Card) and Matri Suraksha Chakhi (Misoprostol) distribution for prevention of Post Partum Haemarrhage (PPH) at home delivery focusing continuum of care from pregnancy, through birth and post partum period, including the newborn. Such community level activities promote strengthening birth preparedness and complication, readiness (Preparedness of money, SBA/ health facilities, transport and blood donors), promotion of ANC/PNC service (Iron, T.T, Albendazole), Self-care in pregnancy and post partum period (Food, rest, no smoking and no drinking alcohol), identification and prompt care seeking for danger signs in pregnancy, delivery and post-partum period and education and distribution of Matri Suraksha chakki for prevention of PPH at home delivery.

These community level interventions have increased the demand of and access to information and service at the community level. This has contributed to increase the service utilization in pregnancy, delivery and post partum care including essential new born care.

1.8.2 Rural Ultrasound Program

The objective of this program is to identify the complication during pregnancy referral to the appropriate health faculty for complication, management. This program is being piloted in two Districts, Mugu and Dhading. The preliminary finding shows the increment in ANC cases and increased timely referral to higher centers. In this program attained nurse use a portable ultrasound machine for scan purpose only.

1.8.3 Uterine prolapsed

Uterine prolapsed (UP) relates to nearly every aspect of mandate in the area of RH and Rights of gender equality, and empowerment of women. The main factors that directly and indirectly cause this morbidity have the potential to serve as an entry point for improving women's RH and reproductive rights. Uterine prolapsed is one of the priority programs of GoN. In the last four years separate fund has been allocated for uterine prolapsed. Uterine prolapsed treatment and surgery operational guideline 2008, first revision 2009 has been development and one focal person has been identified in the FHD.

1.8.4 Human Resource

Coordinating with NHTC,FHD provides SBA training to doctors and staff nurses. Since in-service SBA training was initiated in 2007.

1.8.5 Emergency Referral Fund

It is very important to have referral services to the pregnant woman in the remote districts. To address this issue FHD has launched emergency referral fund program to facilitate referral services in 14 districts namely Bhojpur, Khotang, Sunsari, Rasuwa, Manag, Mustang, Dolpa, Humla, Jajarkot, Mugu, Rolpa, Rukum, Bajang and Darchula. A total sum of two hundred thousand rupees has been allocated as seed money for each district to be used by a locally formed committee as per the guidelines. The main objective of this program is to provide the referral services to women from poor, Dalit, Janapati, geographically disadvantages, socially and economically disadvantage communities who need caesarean section (ClS) or complication management during pregnancy.

1.8.6. Safe Abortion Services

Preventing unwanted pregnancies through a quality family planning services is a first step towards addressing women's reproductive health needs, and increasing access to safe abortion service has been considered as a missed opportunity to prevent unwanted pregnancy. However, there is a dearth need to make this service available in

order to prevent mortality and morbidity from unsafe abortion. A comprehensive approach needs to be integrated between three services; family planning, safe abortion and post abortion care. This means ensuring the availability of comprehensive abortion care (CAC) that refers to termination of unwanted pregnancies through safe technique with effective pain management, post procedure family planning information and service to ensure that women are able to plan when to have children and avoid further unwanted pregnancies. Only trained doctors or health workers can provide safe abortion services at the government approved health facilities, with the consent of women and according to the national standard.

1.8.7. Aama Program

Aama program has four components: (i) the safe delivery incentive program (SDIP), a cash incentive scheme, which was initiated in July 2005, (ii) free institutional delivery care, which was launched in mid-January 2009, (iii) incentive to health worker for home delivery and (iv) incentive to women for four ANC visits. The Aama program has following provisions and it has been practically implemented in the communities.

i. Incentives to women on institutional delivery. A cash payment is made to women immediately following institutional delivery: NRS 1,500 in mountain, NRS 1000 in hill and NRs. 500 in tarai region.

ii. Free institutional delivery services : A payment to the health facility for the provision of free delivery care: For a normal delivery service health facilities with less than 25 beds receive NRs 1000; health facilities with 25 or more beds receive NRs 1,500.For complicated deliveries health facilities receive NRs 3000, for each C/S NRs 7,000.

iii. Incentive to women for four ANC visits: A cash payment of NRs 400 is made to women on completion of four ANC visits at the 4,6,8 and 9 months of pregnancy following institutional delivery.

iv. Incentives to health worker for home deliveries: A cash payment of NRs 100 is made to health worker for home deliveries. Copies of birth registration or death certificate need to be produced to claim incentives for home deliveries (DoHS, 2012)[15].

[15]DoHS (2012).Annual report 2011/012.Government of Nepal Pp67-69.

1.9 Situation of Safe Motherhood in Nepal

While 89 percent of all mothers received ANC services, less than 56 percent had four ANC check up indicating that more than 44 percent of mother did not complete the recommended fourth check up. Forty five percent of deliveries assisted by SBA, 55 percent have followed for postnatal check up and 45 percent had institutional deliveries in 2012/13. Forty six percent pregnant mother were benefited from free institutional delivery care under the Aama program and almost same percentage received transportation incentive in 2012/13 While 89 percent of all mothers received ANC services, less than 56 percent had four ANC check up indicating that more than 44 percent of mother did not complete the recommended four check up. Forty five percent of deliveries assisted by SBA, 55 percent have followed for postnatal check up and 45 percent had institutional deliveries in 2012/13. Forty six percent pregnant mother were benefited from free institutional delivery care under the Aama program and almost same percentage received transportation incentive in 2012/13(DoHS, 2013)[16].

In spite of the above mentioned attempts, majority of inhabitants, particularly married women of Dalit and Janjati communities are facing a number of safe motherhood related complication like maternal and child death due to the number of reasons such as lack of education, poor health services, deeply rooted superstition, unemployment, low income, rapid population growth, lack of environmental sanitation and malnutrition.

1.10 Statement of the Problem

Women of Nepal have very poor social awareness and educational status. Majority of rural women are illiterate and do not know the danger sign of pregnancy, delivery and post natal period. Nepalese women are bounded with too many traditional and cultural barriers as compared to men.

The maternal mortality is an effective index to the quality of maternity care services in any given country. A National Survey conducted in 2001 estimated the MMR at 539 per 100000 live births. However, small communities based in some remote areas of Nepal have shown MMR of over twice this figure. The most common direct causes

[16]DoHS (2013). Annual report 2012/013 .GoN.Kathmandu. Pp66-75

of maternal deaths are hemorrhage, sepsis, toxemia, obstructed labour and consequences of abortion. Nepalese mothers have many traditional beliefs, habits, norms, values and customs regarding the maternal and child health care. Their practices are not safe because they do not go for regular antenatal check-up; they attend delivery at home without septic precaution, cut the cord with unsafe instrument, and certain food during the antenatal and postnatal period. The Nepalese motherhas very low educational status and directly or indirectly, it has adverse effect on colostrums feeding, immunization against communicable disease and the use of contraceptives (Acharya, 2004).

Maternal mortality ratio of Nepal for the period 1996- 2011 is recorded as 229 deaths per 100000 live births or alternately nearly 3 deaths per 1000 live births. Causes of death are PPH (17.5%), obstructed labor (5.6%), eclampsia (21.3%), abortion (6.9%), puerperal sepsis (5%) and APH (6.5%) (MoHP, 2012).[17]

Among the death cases, 28 percent occurred during pregnancy, 61 percent during post natal period and 10 percent during labor. Most of the deaths (41%) occurred at home, 7 percent death occurred on the way to heath facilities and 4.2 percent occurred in health institution (Pradhan & et.al, 2009). The highest proportion of death at home shows the reality of the poor safe motherhood care services by the mothers.

Utilization of the health facility is very low in Nepal. Only 35 percent women deliver under health facility. Sixty three percent births take place at home. Children delivered at home are usually more likely to be delivered without assistance from a health professional. Assistance during delivery is 36 percent by SBA (NDHS, 2011). Similarly, the indicators of educational status, social awareness, ANC visit, place of delivery, PN check up of Dalit and Janajati women of Parsa and Kaski Districts are lower and poorer than the national status. Therefore, there is huge gap between the educational status and safe motherhood care users of Dalit and Janajati women of Parsa and Kaski Districts of Nepal.

Thus, the problem is stated as " A STUDY OF EDUCATIONAL STATUS, SOCIAL AWARENESS AND SAFE MOTHERHOOD PRACTICES AMONG DALIT AND JANAJATI WOMEN OF NEPAL".

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[17] MoHP&et.al (2012) *Nepal demographic and health survey 2011*.Kathmandu : MoHP/New ERA and ICF Pp 233-257.

1.11 Rationale

Nepal is an agricultural based country where sixty-five percent of the population is involved in semi-traditional agriculture. Twenty five percent of the population falls below the poverty line and Nepal has the highest maternal death rate among all of the south Asian countries (CBS, 2011). In general, women in Nepal have remained economically poor as a result of their traditional social values, superstition, poverty and lack of knowledge. Women also do not have access to property, despite the hard work they put into its keeping and maintenance. Instead they are pressured to give birth to healthy sons, though they are ironically deprived of nutritious food and appropriate care during pregnancy. They are often deprived of safe motherhood services and they do not have access to family planning methods.

Most of the women living in the rural setting have many different responsibilities including looking after the household, cutting wood, fetching water, washing dishes and cloths, cooking, farming, looking after the animals ,taking care of children etc. Dalit and Janajati Nepali Women's reproductive health is severely affected by their low familial and social status, patriarchal perspectives, traditional values, illiteracy, poverty etc.

Safe pregnancy, safe delivery and safe birth of new born infants are the major components of safe motherhood. This can be accomplished through increasing access to effective antenatal, delivery and postnatal care and through a massive health education awareness activity in respective community. The results of the study may be used as guideline for governmental and non-governmental organizations to modify and adopt new polices. The finding may be helpful for the concerned experts and designers to frame curriculum accordingly in the area of safe motherhood. It may provide guidelines for improving safe motherhood programs and activities. The findings of the study will be useful to the local agency to develop awareness of safe motherhood program in Dalit and Janajati communities of Nepal. It may be useful as a guide for further research in similar areas.

Women are the corner stone's of the family and assume responsibility for many of its most vital functions, not only in regards to health and education but also in food production and income generation. Therefore, the health of women is a pre requisite for the health of the whole family and by extension of communities and societies.

Pregnancy and the birth of a child-daughter or son are life giving events. It is our ethical obligation as individuals, familiar, communities and nation to uphold every woman's right to life enhancing pregnancy and birth.

1.12 Objectives of the Study

The following are the objectives of this study:

1.12.1 To identify the educational status of Dalit and Janajati women of Nepal.

1.12.2 To find out social awareness situation ofDalit and Janajati women of Nepal.

1.12.3 To assess safe motherhood practices ofDalit and Janajati women of Nepal.

1.12.4 To study the association of educational status and safe motherhood practices of Dalit and Janajati women of Nepal.

1.12.5 To find out the association of social awareness and safe motherhood practices of Dalit and Janajati women of Nepal.

1.13 Operational Definition

Educational Status: Educational Status refers to formal and non-formal educational background of Dalit and Janjati women of Nepal.

Dalit women: The women belonging to the indigenous community (Kami, Sarki, Damai, Chamar, Dom and Dushad) in Nepal who lag far behind in their income, education and other human development indicators.

Janajati women: The women belonging to ethnic groups (Gurung, Magar, Tharu and Dhanuk) who have been excluded from the main stream and as such most of these women are living in abject poverty.

Safe motherhood: In this study safe motherhood means ensuring that all women receive the care they need to be safe and healthy throughout pregnancy, delivery and postnatal period.

Antenatal Care:Care of mothers and her foetus during pregnancy as recommended by the government of Nepal.

Delivery Care: In this study care of mother during delivery period at recommended health institution.

Postnatal Care: Care of the mother and her baby since delivery to six week as adopted by the government of Nepal.

Social Awareness: Social awareness refers to the consciousness-raising on legal rights, reservation and facilities provided by the government to the Dalit and Janajati women of Nepal.

1.14 Research Hypotheses

The following are the research hypotheses:

1. **Main Hypothesis**

   The educational status of Dalit and Janajati women is significantly associated with the practice of safe motherhood.

   Hypotheses

1. The educational status of Dalit and Janajati women is significantly associated with the practice of Ante Natal Care (ANC) visit.
2. The educational status of Dalit and Janajati women is significantly associated with the practice of having Tetanus Toxiod vaccine.
3. The educational status of Dalit and Janajati women is significantly associated with the practice of having iron tablet and vitamin A capsules .
4. The educational status of Dalit and Janajati women is significantly associated with the practice of place of delivery.
5. The educational status of Dalit and Janajati women is significantly associated with the practice of assistance during delivery.
6. The educational status of Dalit and Janajati women is significantly associated with the practice of umbilical cord cutting instrument.
7. The educational status of Dalit and Janajati women is significantly associated with the practice of postnatal check up.
8. The educational status of Dalit and Janajati women is significantly associated with the practice of work during postnatal period.
9. The educational status of Dalit and Janajati women is significantly associated with the practice of colostrums feeding.
10. The educational status of Dalit and Janajati women' spouse is significantly associated with the practice of ANC visit.
11. The educational status of Dalit and Janajati women's spouse is significantly associated with the practice of place of delivery.

12. The educational status of Dalit and Janajati women's spouse is significantly associated with the practice of postnatal check up.
13. The educational status of Dalit and Janajati women's father-in-law is significantly associated with the practice of place of delivery.
14. The educational status of Dalit and Janajati women's mother-in-law is significantly associated with the practice of ANC visit.
15. The educational status of Dalit and Janajati women's mother-in-law is significantly associated with the practice of postnatal check up.
16. The educational status of Dalit and Janajati women's mother-in-law is significantly associated with the practice of food intake during pregnant period.

2. Main Hypothesis

The social awareness of Dalit and Janajati women is significantly associated with the practice of safe motherhood.

Hypotheses

1. The social awareness regarding facilities provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visits.
2. The social awareness regarding facilities provided by the government to the Dalit and Janajati women is significantly associated with the practice of postnatal checkup.
3. The social awareness regarding rights provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visits.
4. The social awareness regarding rights provided by the government to the of Dalit and Janajati women is significantly associated with the practice of postnatal checkup.
5. The social awareness regarding reservation provided by the government to the of Dalit and Janajati women is significantly associated with the practice of ANC visits.
6. The social awareness regarding reservation provided by the government to the Dalit and Janajati women is significantly associated with the practice of postnatal checkup.

1.14 Variables

The following are the variables of the study:

1. Dependent Variable: Safe Motherhood Practices (Antenatal care, Delivery care and postnatal care).
2. Independent Variable: Educational Status (Respondents, Spouse, Mother – in –law, Father- in- law, Mothers and Fathers) and Social Awareness (Facilities, Rights and Reservation of Government of Nepal).

1.15 Research Framework of Educational Status, Social Awareness and Safe Motherhood Practices

The research framework includes the variables of educational status, social awareness and safe motherhood practices and their influencing factors. An ideal research framework should consist of strong relationship in between independent and dependent variables with the range of highest degree of clarity. Manipulation of each and every independent variable has close impact upon the dependent variable. Realizing this norm of research, present study attempts to show the bond of educational status and social awareness of Dalits and Janajatis upon the safe motherhood practices. The effect of these variables on safe motherhood practices can be summarized in the following research framework. This research framework is based on safe motherhood and maternal health care as established by WHO in 1999 as well as the State of World Children2009 and Maternal Health Supplement 2011.

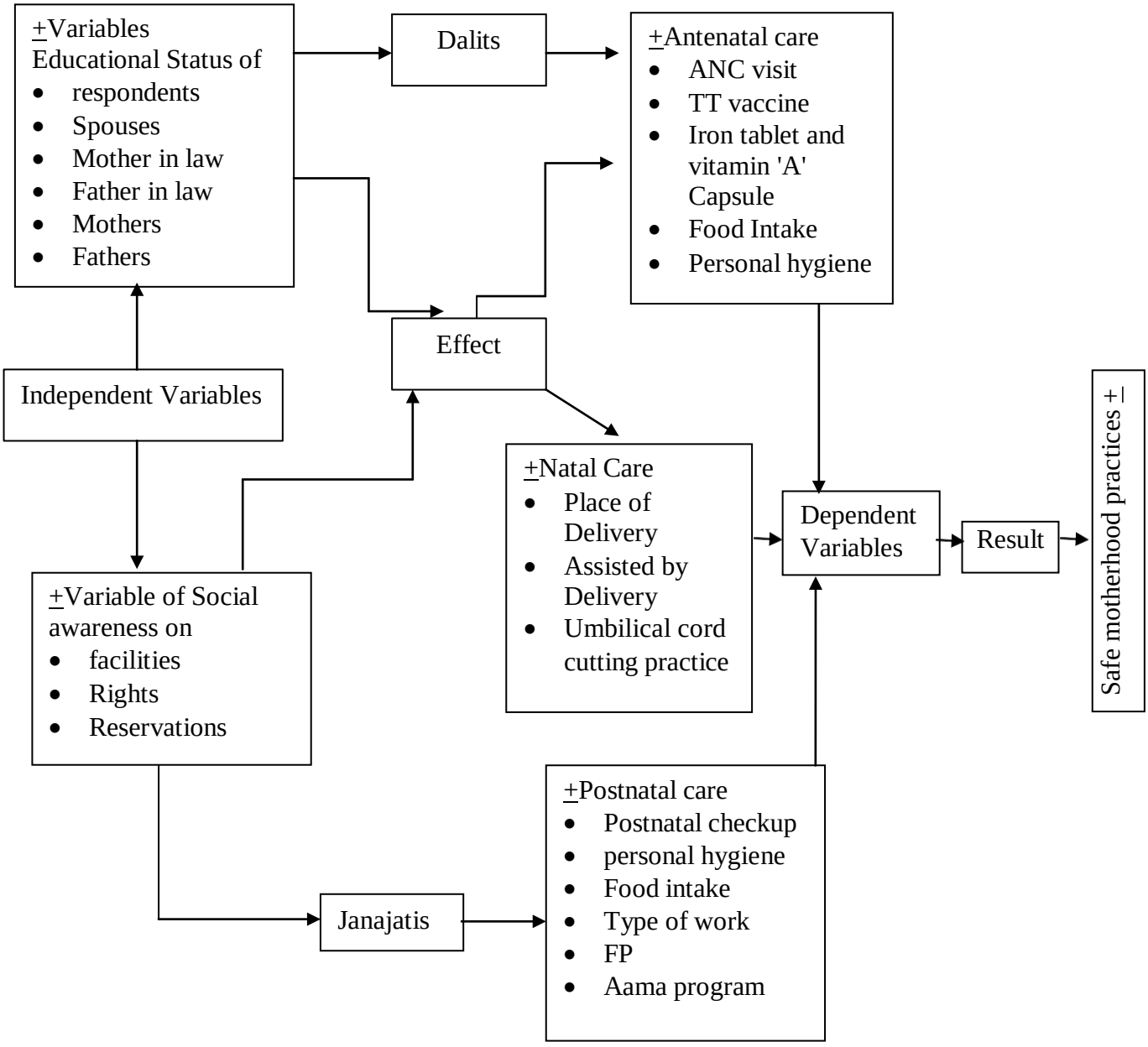

Figure No. 1.1: Research framework of Educational status, social awareness and safe motherhood practices

It is depicted from above sketched diagram that two variables such as educational status and social awareness are main independent variables of this study. Furthermore, educational status is comprised of respondents' own educational level and her close relatives such as spouses, mother in law and father in law, fathers and mothers educational status. This study is sought to link and explore the impact of both poor and better educational status of respondents and their relatives with utilization of safe motherhood practices. It is universally assumed that if educational status of respondents themselves and their relatives remained good then it would create positive impact upon the utilization of safe motherhood practices and vice a versa. Since, poor educational status acts as main barrier for utilization of services. Furthermore, receiving antenatal, natal and post natal care is not only influenced by respondent's own educational status but equally or more strongly afflicted by her close relative's educational level. It is because at the time of demand of those cares, she cannot manage herself since she needs help from others at that time. And dominance of their relative's educational status would obviously reflect upon the service utilization. For example, respondents may offer traditional healer to assist the respondent at the time of delivery if their educational status is found poor otherwise the seek the help of SBA at the moment. These issues are highlighted by this present study.

Social awareness is second independent variable of this study which includes government facilities, rights and reservation to under privileged women. Some international level of researches showed the favorable positive impacts of social awareness upon the safe motherhood practices. It was proven that along with the increment of social awareness among the service utilize the rate of neonatal, infant, child and maternal deaths had also been simultaneously reduced. In case, if these components are sacked then it would negatively impact upon the improvement of safe motherhoodness of Nepalese women. Hence considering this fact, this research attempts to explore the relationship of education status and social awareness with safe motherhood practices of Dalit and Janajati women of Nepal.

1.16 Delimitation

This study has been delimited to:

- Kaski district (one VDC) in Hill and Parsa district (two VDCs) in Tarai.

- The Dalits (Kami, Sarki, Damai, Dom, Chamar and Dusad) and Janajatis (Gurung .Magar, Tharu and Dhanuk).
- Married women from Dalit and Janajati community having at least one child.

CHAPTER- II

REVIEW OF RELATED LITERATURE

Review of related literature enables to know how much and what type of work has taken place in the field of proposed study. Review of literature makes aware about techniques and methods adopted by others investigators for their research work.

The key to the vast storehouse of published literature may upon door to sources of significant problems and explanatory of hypothesis and proved helpful orientation for definition of the problem, background or selection of procedure and comparative data for interpretation of result. In order to creative and original one must read extensively and exotically as a stimulus to thinking (Good & et al, 1986).Man is only the creative that does not have to begin new in every generation, but can take the advantage of the knowledge, which has been accumulated through the centuries. This fact is of particular interest in research which operates as a continuous function of every closer approximation to the truth. The investigator can be sure that this problem does not exist in a vacuum and that considerable work has been done already on problem which are directly related to his proposed investigation. The success of his efforts will depend in no small measure on the extent to which he capitalizes on the advance made by previous investigator.

For the knowledge emerging from the investigations would enable the investigator to avoid unintentional duplication, as well as it would also provide the understanding and insight for development of a logical framework for the present problem under investigation. Moreover, studies that have been done would provide for formulating research hypotheses an indicating what needs to be done will form the basis for the justification of the study under investigation. In this a glance at the previous investigations in the related areas will evidently through a light and make the path of the investigator illuminated with abundant information. These previous investigations will deliberately help the investigator to pursue the research.

A review of the relevant literature is presented and discussed in this research in order to be informed about previous studies, to identify gaps in the literature and to address the issue of educational status, social awareness and safe motherhood practices. The major purpose of this review of the available literature is to determine the significant facts, which are essentially related to the problem under investigation. Brief resume of

the work done in Nepal and abroad related to educational status, social awareness and safe motherhood practices of Dalit and Janajati women has been presented below:

2.1 Review of Literature Related to Educational Status

Women's education also directly affects their health through its influence on demographic variables. For example, there is consistent evidence from all regions of the world that an increase in the number of years of schooling for girls is usually associated with an increase in the age at marriage. To the extent that marriage associated with initiation of sexual activity, later marriage would prevent early initiation of sexual activity and early child bearing, the health risks of which are well known. Education also contributes to better health for women through its influence on improved child survival. Child mortality has been found to decline with higher levels of maternal education (Cohrane, 1982). Improved survival of children, through its association with lover fertility, has a positive impact on women' health.

Education also equips women to better resist pressures from the patriarchal family. Together, these capabilities would have an impact on women' health status, by affording better access to resources and information to avoid health risks, to recognize when she needs health care, and to seek health services when necessary. Women would also be able to form more equitable marital (and hence sexual) relationships, and to make choices regarding reproduction. The effects of women's education on fertility levels have been established by a number of studies examining cross-sectional data for many countries (UN, 1987).

Uneducated women tend to be less productive, and employed in low paid jobs, than educated women. They are less able to protect their environment and keep their children healthy. They marry younger and are less likely to use FP. There are an estimated 600 million illiterate women in the world-out numbering men by nearly two to one (Taylor, 1993).[18]

The education effect has often been pointed that educating women is the single most important step. Governments can take to improve the health of their citizens and their economies. This is because educated women are more productive. Literacy and

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[23]Taylor, DC. 1993). The most influential investment. *Journal of People and Planet. Special Report: Educating Girls* Vo1.2 p 197.

numeracy among women is associated with the adoption of improved farming methods. Data from 70 developing countries suggested that increasing girls' of secondary schooling varying from 4 to 16 percent would increase women participation in the labor force by over 12 percent. In Morocco, an additional year of education is associated with a 15.8 percent increase in women's earning. In Thailand, and additional year of women's schooling is associated with a 26 percent increase in their hourly wages (Summer, 1993). [24]

Educated women are more confident. Studies from Nepal, Nigeria and India found literate women expected and received better treatment at clinics and hospitals. Research in Nigeria, Bangladesh and Mexico found educated women communicate more with their husband and have a greater say in family decision than uneducated women. Research from Uganda showed that educated women expect to be less dependent on their children in old age. Educated women marry later. The world fertility survey found that women with over 7 years of schooling married around 4 years later than uneducated women. Data from 77 developing countries found later marriage was associated with enhanced access to resources. Information from 21 developing countries found later marriage was linked to women' greater economic independence (Summer, 1993).

Educated women use FP. Uneducated women in Brazil have three times as many children as women who have graduated from secondary school. The increase in education of women in four Latin American countries is estimated to be responsible for 40-60 percent of fertility decline in those countries. It has been estimated that giving 1000 girls an extra one year of education would avert up to 500 births. Educated women have healthier children. Data from 33 less-developed countries reveals that every additional year of mother schooling is associated with an additional 7-9 percent drop in child mortality. The children of educated women in Srilanka, Colombia, Mali, Senegal and Liberia have fewer episodes of diarrhea that those of uneducated women. A study of four Latin American countries found educated women are more likely to attend antenatal clinics, have their birth supervised by a trained person, and take their babies to the clinic to be immunized (Summer, 1993).

Education confirms strong tools to upgrade women skills for grabbing market opportunities through exposure on their knowledge, getting confidence and decision making power (Jejeebhoy, 1996).[19]

The assembly of World Health Organization in 1948 has accepted maternal and child health. The movement for improving women's status all over the world has emphasized the role of education. It is believed that education will bring about a reduction in the inequalities between sexes and uplift women's subjugated position in the society (WHO.1999).

Low maternal education level compared to those with Higher secondary education was a significant risk factor for a home delivery (Bolam, 1997). A cross sectional descriptive study with sample size 496 which was done in semi urban settlement revealed that mothers with formal education tend to deliver at the hospital while those with no formal education tend to deliver at home (Idris, 2006). A study done in India shows the illiterate women were more likely to deliver a baby at home relative to hospital as compared with the literate women (Navaneetham &et.al 2000).[20]

Use of a health facility for delivery increases sharply with maternal education from 4 percent of births among women with no education to 55 percent among children of women with an SLC or higher level of education (MoH, 2001).[21]

The utilization of ANC services is positively associated with mother's level of education. Ninety-five percent of women with an SLC and above received ANC services, compared with 39 percent of women with no education. Use of a doctor for ANC increases from 10 percent among uneducated women to 66 percent among women who have completed then SLC (MoH, 2001).

Women's education was associated with use of maternal health care in Ethiopia, with the use of maternal health care increasing linearly with education. The odds of utilizing such services were four and a half times and eight times higher for women

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[19]Jejeebhoy (1996) *Women's education, fertility and the proximate determinats of fertility.* New York: UN Population Division Pp 171-175.

[20]Nawaneetham & et.al (2000).*Utilization of maternal health care services in South India*. India: Authors P 18

[21]MoH.(2001).*Nepal demographic health survey* USA; MoH, NEW ERA and ORC Macro Pp 139-169.

with primary and secondary or higher levels of education respectively, when compared with women with no education (Mekonnen& et.al 2002)[22].

UN Secretary General Kofi Annan stated the millennium development goals (MDGs), particularly the eradication of extreme poverty and hunger, cannot be achieved if questions of population and reproductive health are not squarely addressed. And that means stronger efforts should be made to promote women's right and greater investment in education and health, including reproductive health and family planning (UN,2002).

The study shows that increasing maternal education status was closely associated with a significant decrease in the chance of home delivery. Women who had at least primary education had higher incidence of hospital delivery as compared to those women with no education. It was seen that some education (primary education) had greater impact on urban slum women in choosing hospital delivery care. No education women, only 6 percent were utilized hospital delivery from primary education 21.7 percent slum women utilized hospital facility (Hossain, 2005)[23.]

Investing in women's education is therefore important for their well-being. While significant achievements have been made with respect to schooling for girls in all countries of the South East Asia Region, there are wide disparities across countries in the proportion educated and in the levels of education achieved. The region has the unenviable distinction of making the largest contribution to the number of illiterate women in the world. The movement for improving women's status all over the world has emphasized the role of education. It is believed that education will bring about a reduction in the inequalities between sexes and uplift women's subjugated position in the society. Educated women have a higher status in the society and family size becomes smaller. As the education is low in Nepal and lowest in SAARC countries,

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[22]Mekonnen& et.al (2002).Utilization of maternal health care services in Ethiopia.*Ethiopian Health and Nutrition Research Institute* Pp7-12.

[23]Hosssain & et.al (2005). Determinants of choice of delivery care in some urbanslums of Dhaka city. *Pakistan Journal of Social Sciences* Vol 3 Pp 469-475.

for instance, adult female literacy is 88 in Nepal which is high compared to India (71), Pakistan (81), Bangladesh (78) (World Banks 2007).[23]

The proportion of deliveries in a health facility was only 8 percent among birth to uneducated mother, compared with 67 percent among births to mothers with SLC and Higher secondary education. The use of antenatal care services from an SBA was strongly related to mothers' level of education. Women with SLC and higher level of education were three times more likely to receive antenatal care from and SBA (90%) them women with no education (29%) (MoH &et.al, 2007).

2.2 Review of Literature Related to Social Awareness

For centuries, Dalits have suffered social exclusion and domination of state and so-called higher caste in Nepal. Nevertheless, multi party democratic system has put forward some important amendments in order to end untouchable practice and provision Dalit reservation. Nevertheless, country is again in the constitution making process. So the strong voice should be raised for Dalits reservation in new constitution. The study found that India has provisioned 15percent seats of parliaments for Dalits along with reservation of various scales in other areas. Same percentage is not sufficient for Dalit in Nepal because the state and non-state actor has higher tortured the Dalits sometimes also like animals. The study highlighted that the reservation policies are not implemented by words and it will also recommend on the necessary revision of Dalit reservation policy (Purkoti, 2009).[24]

The study found that: most of the Dalits are in poor conditions. They have limited access to income generating opportunities. Illiteracy is rampant in Dalits (40% literacy) and they have limited land possession. In terms of employment, most Dalits are engaged in non-agriculture works due to limited the agriculture opportunity. It has been observed that the reservation actions have not been implemented by word. So Dalits are not able to improve their status (Pariyar, 2009). [25]

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[23]World Bank (2007).*Education status of women in SAARC countries*. Editor Caglar Ozden. Mawrice Schiff pp 91-95

[24]Purkoti &et.al .(2009). Study of reservation for Dalit in Nepal[Abstract]. Social Inclusion and National Building in Nepal P 123.

[25]Pariyar (2009). A study an reservations/ affirmative action of Dalit in Hulma district . [Abstract]. Social Inclusion and National Building in Nepal P 91.

Education is the main vehicle for participating in different sectors of the society. The poor economic status of indigenous nationalities hinders them from participating actively in local/ national governance and other social activities. There are wide gap of leadership skill and knowledge in indigenous and the physical representation of indigenous nationalities in local governance limits the representative voice (Magar, 2009)[26]

Nepal is in the state of restructuring for proportional representation of excluded class which includes Dalits, Madhesi, Janajati and women. The study found that the constitution of country and other supplements policies and legal documents provision for social inclusion of all class of Nepali including Janajatis in development process. Janajatis are excluded in terms of political participation, education, economic upliftment and health. The study concluded that the constitutional and legal provisions are still not inclusive and the legal provision and policy document should be implemented by words (Rai, 2009).[27]

Representation is below one percent in state governance and symbolic in non-state sectors. Likewise, constitutional and legal provisions for Dalits are deficient. Existing laws related to Dalits have loop holes in term of implementing process. The political parties and civil society organizations seem sensitized on the material inclusions of Dalits. The research concluded with the remarks for restructuring of the state make its organs, structure, mechanism, institutions, agency and agents more inclusive as well as Dalits motive. Secondary, the government has to make special provisions to Dalits in order to increase their representation in policy making and implementation at the state and non-state level. Lastly, the constitutional, legal and procedural provisions have to be amended and the prejudices, perception, beliefs, attitude and behavior need to be changed (Kisan, 2009).[28]

The study shows that mothers' group (MG) primarily focus on social awareness of child care, primary health care, nutrition, sanitation, cleaning-up programs and family

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[26]Magar (2009). Issues of representation of indigenous nationalities in local governance: practice and obstacles. Social Inclusion and National Building in Nepal p 123.

[27]Rai .(2009). Evaluation of government policies towards excluded groups: A case study of Janajati. Social Inclusion and National Building in Nepal P 142.

[28]Kisan, (2009) A study of Dalits inclusion in Nepali state governance .Social Inclusion and National Building in Nepal P 89.

planning. Nevertheless self induced MG seems more active and creative. Additionally, the study found that MG play significant role in increasing participation of women in school management committee and forestry user's groups. Fifty four percent of the MG members have informed that they have been involved in such institutions with self motivation. MG could not play effective role towards capacity building of mothers as they are less equipped in terms of education, self-confidence and entrepreneurial skills. Further, MG face financial constraint as well as less support from social leaders (Lingden, 2009).[29]

Social exclusion hurts disadvantaged people and educational attainment is one of the most crucial indicators to measure the extent of social exclusion prevailed in the country. The preliminary findings of the study revealed that the high dropout is observed in disadvantaged children. Poverty and discrimination social customs have come out as primary factors responsible for high droop out (Yadao, 2009).[30]

The study found that dowry, traditional culture poverty, illiteracy and prestige are the causes of early marriage. Health effects are seen due to early marriage are different types of gynecological problems including uterus and other health problems like anemia, backache and so forth. The study recommended for effective and result oriented special provision for women inclusions in development(Sah, 2013).[31]

The study showed that Dalit women are lowly educated. Most of the married women are confined in household work or employed in lowly-paid jobs such as wage labors, sweepers etc. Their role in household decision making is considerably guided by the level of education. Education, however, has an indirect effect on their occupation and income, and the income affects their role in decision making. They enjoy decisive role in day to day household stuffs such as kitchen stuffs, selling of cattle but have a substantially weaker role in control over property while buying/selling valuable things like gold ornaments, land, and house. The research found that the decision on marriage is mostly taken by Dalit women themselves, irrespective of their education.

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[29]Lingdel (2009).Energizing social mobilization of women through mothers' group.Social Inclusion and National Building in Nepal P 41.

[30]Yadao (2009). Social exclusion in education: A study on school dropout in tarai and hill district of Nepal .Social Inclusion and National Building in Nepal P 189.

[31]Sah (2013).Impact of early marriage on women's' status in tarai.Social Inclusion and National Building in Nepal P 45.

Most of them do not have an income source during marriage. Dalit women also have significant low role in deciding numbers of children to be born and their education. However, the level of awareness has risen among them. Furthermore the research revealed that there is visible influence of education and income in their decisive role and control over self-mobility and career decision and procreation activities. Higher the educational attainment stronger the decisive role observed in the study. The research found a positive relationship between education level, income and decision making of Dalit women (Shrestha, 2013).[32]

2.3 Review of Literature Related to Safe Motherhood Practices

A study showed that the pregnant women in rural areas in Indonesia that prenatal mortality is highest in mothers under the age 20 and also that the risk of prenatal mortality increase again in mothers of 35 years of age and above the prenatal mortality (PMR) also rise with increasing birth order short birth intervals (less than 18months) and long intervals also increase the risk of mortality some extent (Alissaban, 1990).[33]

The complications related to pregnancy and childbirth are among the leading causes of mortality for women of reproductive age in many parts of the developing world. At the global level, it has been estimated that about half a million women die each year of pregnancy-related cause, 99 percent of them in developing countries. The gap in maternal mortality between developed and developing regions is wide: in 1988, it ranged from more than 700 per 100,000 live births in the least development countries to about 26 per 100,000 live births in developed regions. According to WHO, the life time risk of dying from pregnancy or childbirth – related causes in 1 in 20 in some developing countries, compared to 1 in 10,000 in some developed countries. Safe motherhood has been accepted in many countries as a strategy to reduce maternal morbidity and mortality. The objectives are: to promote women's health and safe motherhood, to improve the health and nutritional status of women especially of

[32]Shrestha (2013).Role of education, occupation and income on Dalit women's decision making. A case study of Pokhara Submetroplitan City.Social Inclusion and National Building in Nepal P 66.

[33]Alisiabana (1990).*The implementation of risk approach in maternal and child health services: health care of women and children in developing countries.* California: Third Party Publishing Pp 382-392.

pregnant and nursing women. The actions should strive to effect significant reduction in maternal mortality by the year 2015: reduction in maternal mortality by one half of the 1990 levels by the year 2000 and a further one half by 2015(UN, 1994).

All countries, especially developing countries, with the support of the international community, should aim at further reductions in maternal mortality through measures to prevent, detect and manage high-risk pregnancies and births, particularly those to adolescents and late – parity women. Adolescent females and males should be provided with information, education and counseling to help them delay early family formation, premature sexual activity and first pregnancies, maternal health and safe motherhood programs should include counseling and FP information (UN, 1996).

In industrialized countries, delivery assistance with trained birth attendance is almost universal. There is a significant variation of use of TBAs in various places. For example, it ranges between 55 to 98 percent in Latin American and Caribbean, between 2 to 77 percent in sub-Saharan Africa and between 16 to 97 percent in North Africa and West Africa. The variation is even wider in Asian countries. In south central Asia, very few women receive delivery assistance form trained birth attendance. Poor nutrition in childhood and adolescence is a major cause of poor health of women during pregnancy and child birth. This poor health status influences their babies, especially when babies are low birth weight. Pregnancy and childbirth, including unsafe abortion account for the largest health burden for women in their reproductive years. Complications of pregnancy and childbirth are major causes of disability and death among women of reproductive age in less developed countries. More than 500000 women die each year from pregnancy related causes. More than 95 percent of these deaths occur in the less developed countries, particularly, in Africa and Asia. Of all the adult health statistics by the WHO, maternal death rates shows the largest discrepancy between more developed and less developed countries. Maternal deaths are strongly associated with substandard health services and a lack of medical care during and immediately after child birth. Most births in less developed countries about 60 percent maternal deaths occur outside health facilities. (UNFPA, 1997).

The UN world population conference in Bucharest in 1974, eight of the ten countries of the Region adopted national population policies aimed at reducing fertility levels. The exceptions were DPR Korea, where the government considers the fertility level as satisfactory, and Myanmar, where-despite acknowledging the fertility levels is

high-the policy is not to intervene directly to bring about fertility reduction. All 10 countries supported family planning programs that made contraceptive services widely available at affordable costs (UN, 1998).

The global SM initiative was launched in 1987. It is led by a unique partnership of international organizations, including the UNICEF, the UNFPA, the World Bank, the WHO, the IPPF and the Population Council. These agencies worked together to raise awareness, set prioritize, stimulate research, mobilize resources, provide technical assistance and shared information according to each organization's mandate. There co-operation and commitment enabled governments, and non-governmental partners from more than 100 country is to take their own actions to make motherhood safe (WHO, 1998).

The tragedy of maternal mortality is not simply another manifestation for the differential in mortality between developed and less developed countries. Maternal mortality in rich and poor countries shows a much greater disparity than any other public health indicators. The life time risk for a woman to die because of pregnancy and child birth is estimated to range between countries from 1 in 7 to 1 in 9200. The high level of maternal mortality cannot be considered a direct outcome of poor socio-economic development. The scale of maternal mortality varies widely between countries at the same economic level and several developing countries at the same economic level and several developing countries with a low or lower middle income economy has brought down their maternal mortality to low levels (Fathalla, 1998).

Estimates of maternal mortality in South Africa vary between 150 and 250 deaths per 100,000 births for white women. Most pregnant women in South Africa receive same form of antenatal care during pregnancy. White women, however, are more likely to undertake their first visit early in pregnancy, to be seen by a medical practitioner and receive care in the private sector than African women. In a 1994 household survey, 22 percent of African women had delivered their last infant at home, a factor which was strongly associated with educational status and geographical location. Fifty eight percent and 43 percent of women who had received no formal education and worked on farms respectively delivered their last infant without the support of the health service (Schneider& et.al., 1998).[34]

[34]Schneider& et.al (1998).*The impact of maternal health care in South Asia. Safe motherhood initiatives critical issue.*USA: UNFPA. Pp 41-44.

Almost all countries in the region have made a commitment to safe motherhood. Specific targets have been set for the reduction of maternal mortality and for better coverage with maternal health services. For example, the government of Bangladesh adopted a declaration in 1997, and Indonesia has enacted safe motherhood legislation (MoHFW, 1999).

In 1997, India launched its Reproductive and Child Health (RCH) program. This program aims to provide need based, client centered, demand-driven, high quality and interested RCH services to the beneficiaries. The program incorporates the components relating to the earlier child survival and safe motherhood programs (Gopalan, 1999).

Bhutan's eighth five year plan seeks to reduce mortality rates from 3.8 to 1.5 maternal deaths per 1000 live births, increase coverage with antenatal care from 51 percent to 80 percent, and raise the proportion of pregnant women with access to safe delivery to 40 percent (MoH, 1998). The health master plan in the Maldives (1996-2000) has also set target to increase the contraceptive prevalence rate from 15 to 50 percent and to significantly increase the number of women with a birth interval of more than three years (MoH, 2000).

UNFPA supports a variety of measure in over 100 countries to reduce high rate of maternal mortality form educating communities on safe motherhood to training health care providers in emergency obstetric and equipping health facilities with proper supplies co-operating closely with WHO, UNICEF and World Bank. UNFPA is a key member of the safe motherhood initiative which has been working since 1987 to develop policies and programs to protect women during pregnancy and child birth. It is also a member of the inter-agency group convened a meeting with leading experts on maternal mortality to develop key strategies to provide skilled attendance at delivery. In November, the group organized an international conference in Tunisia "Saving lives skilled attendance at child birth" which brought together country teams from sub-Saharan Africa and South Asia to share experiences and develop national strategies (UNFPA, 2000).

Coverage by maternal health services varies widely across countries of the region. The majority of pregnant women (70% and above) appears to receive tetanus vaccination during pregnancy in all countries except Nepal. A much smaller proportion of women see a trained health worker during pregnancy in Bangladesh, Bhutan and India than are covered by vaccination, which pints to the difficulties in

making professional care available to pregnant women. The situation with respect to trained attendance at delivery is a cause for serious concern. In two countries- Bangladesh and Nepal less than 10 percent of the births are attended by a trained person, and in another two Bhutan and India, the proportions are 15 percent and 34 percent respectively. Indonesia has made major strides since 1989 in coverage of maternity care, when the government started the community midwives training program as described in the box on community midwives in Indonesia. Indonesia and Myanmar are better in comparison to the four countries mentioned above. All the same, nearly half the births in these countries are not attended by a trained person. It is ironic that more than 10 years after the launching of the safe motherhood initiative, one of the fundamental requirements for safe motherhood - trained attendance at delivery has remained a distant dream for women in many countries of the region (WHO, 2000).

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

A cross sectional quantitative study with sample size 974 shows that the utilization of antenatal care services was universal. Almost all (99.8%) of mothers attend at least one antenatal check up during their last pregnancy. At ANC period women receive appropriate advice, Tetanus Toxiod vaccination, counseling on birth planning and iron supplementation. However, only 46.7 percent delivered at health institution (Mpembeni & et.al 2007).[35]

[35]Mpembeni& et.al (2007). Use pattern of maternal health service and determinants of skilled care during delivery in Southern Tanzania. *BMC Pregnancy and Childbirth Journal* Vol. 7 P 29.

A cross sectional study done in Northern Ghana with sample size 4060 shows that the use of antenatal care was almost universal (98%) with 81 percent of women receiving antenatal care at least four times. All most all pregnant women who went for antenatal care were advised at antenatal care to deliver with a health professional while 70 percent were aware that they could deliver free of charge at the health facilities. However, 38 percent women were delivered with health professionals and 37 percent in health facilities. An additional 3 percent of women were delivered on the way to a health facility (Mills&et.al ,2008). [36]

An estimated 209,000 women die annually due to pregnancy and child birth related complication in Bangladesh, India, Nepal and Pakistan. Most countries in this region failed to achieve the ICPD goal of MMR. To achieve the ICPD goal of MMR at 100 per 100000 live births by 2005 all require its reduction from highest 8 percent for Nepal to lowest 50 percent for the Maldives and averaging 71.7 percent from rest of the SAARC countries. The maternal mortality ranges from 539 in Nepal to 440 in Bangladesh, 408 in India, 380 in Bhutan, 340 in Pakistan, 200 in Maldives and 23 in Sri Lanka. In the context of Asia at least two fifth of pregnant women were anemic in most countries of South Asia. The proportion of pregnant women who are anemic ranges form 45-47 percent in Pakistan and India to 58-62 percent in Bangladesh, SriLanka and Maldives and 73-75 percent in Bhutan and Nepal. Nearly 80 percent of women in reproductive ages were reported to be suffering from vitamin 'A' deficiency in Nepal (Chaudhary, 2008).

The worldwide, nearly 60,000 women between the age of 15 and 49 die every year as a result of complications arising from pregnancy and childbirth. This means, almost every minute of every year, there is a maternal death, 99percent of which occurs in the developing countries. Majority (80%) of these deaths are preventable. The tragedy is that these women die not from disease but during the normal, life enhancing process of procreation. Most of these deaths could be avoided if preventive measures were taken and adequate cares were available. For every woman who dies, many more suffer from serious conditions that can affect them for the rest of their lives (Park,2010).

[36]Mills & et.al.(2008) Use of health professionals for delivery following the availability of free obstetric care in Northern Ghana.*Maternal Child Health Journal* Vol 12 Pp 509-518

Maternal mortality is an indicator of disparity and inequality between men and women and to great extent a sign of women's place in society and their access to social, health, nutrition service and economic opportunities. The poor health and nutrition of women and the lack of care that contributes to their death in pregnancy and childbirth also compromise the health and survival of the infant and children they live behind. It is estimated that nearly 2/3 rd of the 8 million infant death that occur each year result largely from poor maternal health and hygiene, inadequate care, insufficient management of delivery and lack of essential care of the newborn . In developed countries, the maternal mortality ratio is around 27 per 100,000 live births and in developing countries the ratio is 20 times higher. The life time risk of dying from pregnancy related complications for a woman of developing country is one in 11 to one in 5000 in developed countries (Chitrakar, 2010).

Out of 900 women investigated for antenatal coverage 90 percent women had at least one visit. Only 11 percent of the investigated women had more than or equal four antenatal visits, while 10 percent had not attended at all. Out of 90 percent women who attended at least one visit, 59.6 percent, 37.4 percent, 37.4 percent and 3.1 percent women attended antenatal care in the first, second and third trimester, respectively(Ali& et.al ,2010). [37]

Most of the rural women did not have regular medical check-up during their pregnancy, which constituted 88.1 percent of the total. Only 11.9 percent women did have medical checkup during pregnancy. So, it may be said that regular medicalcheckup during pregnancy is not a common phenomenon for women in rural areas (Shirini, 2012).[38]

Over 80 percent of urban women are delivering in institutions. Similarly over 80 percent of the non-poor attended at least three ANC visits (the recommended minimum in India) during their last pregnancy. Educational levels also show an apparent dose-response relationship with use of all maternal health services studied

[37]Ali& et.al (2010). Use of antenatal care services inKassala, Estern Sudan: *BMC Pregnancy and Childbirth,* 10-67.

[38]Shirina.(2012).Health care seeking behavior for safe motherhood findings from rural Bangladesh. *Bangladesh e-Journal of Sociology.*Vol.9 N.2, pp 62-63.

her. That is the more education one has more likely one is to use ANC, institutional delivery, and modern methods of contraception (Saxena & et.al,2013).[39]

2.3.1 Review of Literature Related to Safe Motherhood Practices in Nepalese Context

The knowledge, attitudes and practices about safe motherhood including prenatal care, TT injection during pregnancy, delivery services and type of assistance during delivery which was conducted by Ministry of health, FP/MCH Division. The outcome of the study was only 18 percent delivery were taken place under the supervision of trained health personnel (11 percent Doctor, 42 percent Nurse and 2.3 percent TBA) only 24 percent of women received TT injection during pregnancy including 15 percent single dose and 27 percent double dose. More than 90 percent delivery cases were observed at home (NFHS, 1991)). But, National Conference on Safe Motherhood reports that 8 percent girls are literate and 92 percent girls are illiterate in Achham district. Majority of the mothers (91%) did not received TT vaccine and Iron tablet during pregnancy.

Nepal's National Health Policy (NNHP), adopted since ICPD, recognizes the reproductive and sexual health rights of women, adolescents and youth. A comprehensive reproductive health strategy has been developed and is being implemented through a multi sectorial, incremental approach to strengthen the existing safe motherhood and FP programs (SMNS, 1998).

In Nepalese Society, mothers-in-law and family member play an important role in the utilization of maternal health care facilities. It is because mothers-in-law is the key person in the family and responsible for making household division about health care. The mother-in-law is often found to be a source of assistance in delivery (Khanal, 1998).

The fact that 67 percent of maternal deaths take place at home and a further 11 percent on the way to hospital, coupled with that fact that 47 percent of deaths are due to postpartum hemorrhage, strengths the case for skilled attendants both in the community and in accessible institutions (Pathak& et al. 1998).[40]

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[39]Saxena,& et.al (2013).In equity in maternal health care service utilization in Gujarat: analysis of district health data. *Global Health Action 6.10.*

[40]Pathak & et.al (1998).*Maternal mortality and morbidity study* Kathmandu: Family Health Division, Department of Health Service Pp 115-121.

The study found that currently married adolescent women in general tend to receive more antenatal care compared to older women. The majority of them still do not seek antenatal care in Pakistan and Bangladesh. The proportion of currently married women seeking antenatal care is lowest in Pakistan (26%), followed by India (35%) and highest in Nepal (44%). In Pakistan, only 29 percent of pregnant women are immunized against tetanus. The proportions of pregnant adolescent women are immunized against tetanus. The proportion of pregnant adolescent women immunized against tetanus toxoid is highest in Bangladesh (80%) followed by India (63%)(Chaudhary,1999).

Nearly 17 Percent mother received ANC from doctors, 11 percent from nurses, 3 percent from HA/CMA and 50 percent from health personnel and 1 percent form TBAs. Similarly, regarding the place of delivery, 90 percent mothers delivered at home, 7 percent at hospital, 1 percent at NGO sector and rest of them (2%) at other places (NDHS,2001).

Safe motherhood is highlighted as a priority in the Nepal from Tenth National Development Plan (2002-2007). The goal of reducing maternal mortality and improving maternal, neonatal health is in line with Millennium Development Goals and embodied in the National Safe Motherhood Plan (2002-2017). To this end SSMP inputs will be designed in collaboration with the Ministry of Health (MoH), Department of Health Services (DoHS) and other governmental departments and non-government partners. SSMP will also support health systems strengthening through the national health sector reform agenda in recognition of the importance of the wider health system context in enhancing the quality and quantity of safe motherhood services (MoH, 2004).

Abortion complication is a major health problem in Nepal because 20 percent of mothers' deaths in the health facilities are due to complication of abortion. The maternal mortality and morbidity study 1998 showed that in the community 5 percent of the deaths are due to abortion (DoHS, 2004).

Safe motherhood services are that which provide the protection and maintenance of child and maternal health. In 1992 the national commitment starship to provide the safe motherhood by the leadership of health secretary in 1994. Its history is not long. In March 9, 1997 the formal program, started by Family Health Division, Nepal

Government. First of all, this program, which is donated by UK, started in three districts such as Kailali, Baglung and Surkhet. Ministry of Health, Family Health Division conduction a long-term health plan (1997-2017 A.D). Now this program is to be conducted in other districts of the country soon. In safe motherhood, the following areas will be included such as safe motherhood, education and services for healthy pregnancy, safe delivery and postnatal care including breast feeding, responsible parenthood for individual couples and adolescent (Karki, 2005).

Table 1.2: Causes of Maternal Death in Nepal

Pregnancy or delivery related women death per day (in person)	Deliveries related death per 2 hour	Under one year mortality per 1,000	Less than one month mortality per 1,000 live births
12	1	64	63

Source: WHO, 2005

In Nepal, per day 12 person women die due to the complication of delivery. Every two hours 1 woman die due to pregnancy complication Nepal. Sixty four percent child die per 1,000 live births less than one year and 63 children die per 1,000 live births less than 1 month (MoHP, 2006).

National Planning Commission (2002) reported that 14.3 percent have attained four ANC visit during pregnancy, 45.3 percent delivered by trained health personnel. Meanwhile, a study reported that 98.49 percent mother have not received postnatal service and only 1.51 percent have received postnatal service by the health worker(Kandel ,2005).

A study revealed that more than 90 percent deliveries occurred in own house and were assisted by TBAs and household members, 67.1 percent deliveries were assisted by household members and 21.3 percent helped by TBAs and remaining (8.2 percent) were occurred at health center and only 3.5 percent were supervised by health professionals. Almost 90 percent women did not use delivery kit during delivery but more than 93 percent used sterilized blade to cut umbilical cord. Nearly 64 percent women had begged for help during labour period. Only 21 percent women followed postnatal check up after delivery (Khatri,2005).

WHO recommends pregnant women to have at least four ANC visit. Following WHO Recommendation, MoHP Nepal has recommended to conduct at least four ANC visits

in; first in four months, second in six months, third in eight months and fourth in nine months (DoHS, 2010).

Fifty eight percent of women who gave birth in the 5 years preceding the survey received antenatal care by a skilled provider. This was 24 percent in 1996, 28 percent in 2001 and 44 percent in 2006. There has been a five-fold increase in the percentage of women with four or more antenatal visits during pregnancy (from 9% in 1996 to 50% in 2011)(NDHS, 2011).

Due to enormous effort of MoHP, practice of delivery at health facility has doubled in the past five years between 2006 to 2011. It showed that 35 percent of birth take place in a health facility, 26 percent are delivered in a public-sector health facility, 2 percent in a non-government facility and 7 percent in a private facility. Practice of delivery at health facility was 18 percent in 2006. However, still 63 percent of births took place at home in 2011. It further revealed that nearly 36 percent of birth took place with assistance of a skilled birth attendant, which includes. doctor, nurse: HA/CMA assist in 4 percent, FCHVs assist 3 percent and TBAs assist in 11 percent moreover 45 percent of women with a live birth in the two years before the survey received a postnatal check up within two days of delivery one in three women received postnatal care within four hours of delivery, 7 percent received care within 4-23 hours and 4 percent were seen 1-2 days following delivery (NDHS, 2011).

DoHS reported that while 89 percent of all mothers received ANC services, less than three fifths had four ANC check-ups indicating that more than two fifths of mother did not complete the recommended four checkups. There was a minor increase in skilled birth attendance at deliveries from 44 percent in 2012 to 45 percent in 2013. There was also a slight increase in institutional deliveries from 44 percent in 2012 to 45 percent in 2012/013. Postnatal care checkups were reposted with slight decrease previous fiscal year i.e. 56 percent in 2012 to 55 percent in 2013. More than two fifths of pregnant women (46%) benefited from free institutional delivery care under the Aama program(DoHS ,2013).

A study found that 99percent of pregnant women did not check up their health during pregnancy, 95 percent of mothers gave birth to their babies at home, 88 percent fed colostrums to new born babies and 85 percent children have not taken any vaccine (Subedi, 2002). In the same fashion, 60 percent women had visited ANC checkups,

83.3 women had taken TT vaccine and 76.66 percent women had practiced of iron tablet and vitamin ‘A’ capsule during pregnancy (Karki ,2013).

2.3.2 Antenatal Care

The maternal health care services that a mother receives during her pregnancy and at the time of delivery are important for the well being of the mother and her child. Overall, one in two pregnant woman receive ANC. Twenty-eight percent of mothers receive ANC either form a doctor (17percent) or a nurse or auxiliary nurse midwife (11percent). Another 11 percent of mothers receive ANC from a HA or AHW. VHWs provided antenatal care to 6 percent of women and MCHWs provide care to 3 percent of mothers. TBAs provide ANC to less than 1 percent of mothers (MoH, 2001).

Comparison with the 1996, NFHS results showed that there are some improvements in the utilization of antenatal services during at last five years. The percentage of women receiving antenatal services from a doctor, nurse or ANM has increased from 24 percent in 1996 to 28 percent in 2001. At the same time, the percentage of mothers receiving ANC from a HA or AHW increase from 2 percent to 11 percent. The percentage of mothers who did not receive any ANC dropped from 56 percent to 51 percent over same period. There are large differences in the use of ANC services between urban and rural women. Overall, 82 percent of women form urban areas utilize ANC services, compared with 47 percent of their rural counterparts (MoH, 2001),

2.3.3 Delivery Care

The objectives of providing safe delivery services are to protect the life and health of the mother and her child by ensuring the safe delivery of the baby. Traditionally, Nepalese children are delivered at home either without assistance or with the assistance of TBAs or relatives and friends. At the national level, only 9 percent of births are delivered in health facilities compared with 89 percent at home. This is a slight improvement since 1996, when 8 percent of births were delivered in health facilities. A child birth in an urban area is six times more likely (45 %) to be delivered at a health facility than a child from a rural area (7%). Children living in the mountain ecological zone are less likely to be delivered under a health facility than children living in the hill and Tarai zones (MoH, 2001).

Although TBAs are considered to be less effective in reducing maternal deaths, TBAs continue to play a prominent role in assisting deliveries, especially in rural area. The

contribution of TBAs is providing delivery care remained almost the same over the last ten years i.e. about 23 percent. More than half of births are assisted by relatives, friends and other non health personnel, while about one in ten births are delivered without any assistance at all (MoH, 2001).

Increasing the percentage of births delivered in health facilities or in the presence of an SBA reduces deaths from complications of pregnancy. Nationally, the percentage of women who delivered with assistance from a SBA is low, i.e. 36 percent in 2011 (MoHP, 2012). Although, increasingly, women are delivering in health facilities, a majority of Nepali women continue to deliver their babies at home. Once again, the more privileged Newar and Hill Brahman women have the highest percentage of delivery in a health facility and supported by an SBA, while Tarai/Madhesi and Dalit have the lowest levels for both service. Delivery by cesarean section, one indicator of access to safe delivery techniques of complications arise during delivery, also is highest for Newar and Hill Brahmin women.

2.3.4 Postnatal Care

The situation clearly indicates that most of pregnant women are still far from delivery and antenatal services. More than 74 percent women do not use maternal health facilities for ANC and 12 percent of deliveries take place at home without trained birth attendant (MoH, 1998). An important reason for this is that pregnant women have no decision making power in the households that would enable them to obtain delivery and antenatal services (Pradhan, A.& et. al., 1996).[41]

In Nepal pregnancy and delivery are viewed as natural conditions requiring no health care interventions. Child bearing women and their families only seek care when a condition becomes life threatening. Nearly 92 percent of deliveries at home and birth is considered to be polluting. Traditionally, child birth takes place in a cowshed and dirty materials are used for delivery and cord care. Strong religious and cultural beliefs and practices regarding reproduction are deeply embedded in the traditional societies of Nepal (Livett & et.al,1998).

The Health Ministry's safe motherhood program is the Nepal's government main thrust to reduce maternal and neonatal mortality by addressing the high rate of death

[41]Pradhan,A. et.al (1996).*Nepal family health survey* Kathmandu: MoH, NEW ERA, and Macro International Inc. PP. 91-135.

and disability caused by the complications of pregnancy and childbirth. The main target of safe motherhood program is to reduce MMR form the estimated rate of 539 per 100000 live births to 400 by the end of tenth plan (2006) and 250 by 2017 and to reduce neonatal mortality rate from 39 per 1000 to 32 by end of tenth plan (2006) and 15 by 2017. Similarly, it aims to increase delivery by health workers to 18 percent by end of tenth plan (2006) and 40 percent by 2017 and to increase the percent of women attending care service 4 times to 25 percent by end of tenth plan (2006) and 40 percent by 2017 (MoH, 2001).

A study showed that the safe motherhood that 25.2 percent mothers have received maternal care and 78 percent women have not received ANC. Only 78.5 percent of women have received TT vaccine, delivery in health facilities is only 9.7 percent and only 22.3 percent have received postnatal care (Poudel,2001).

The National Safe motherhood program recommends that mother should have a postnatal checkup within two days of delivery. This recommendation is based on the fact that a large number of maternal and neonatal deaths occur during the 48 hours after delivery. PNC is uncommon in Nepal. Seventy-nine percent of mothers who delivered outside a health facility do not receive any post-natal checkup. Less than one in five mothers receives PHC within the first two days after delivery. PNC utilization varies by place of residence. Rural women are slightly more likely to receive PNC within two day of delivery, compared with urban women (17 percent and 13 percent respectively) (MoH, 2001)

The 2006 Nepal Demographic and Health Survey data revealed that 70 percent of women in the mountains saw lack of a service provider as a key barrier to accessing health care, compared with 61 percent in the hills and 52 percent in the tarai. In the mountains 55 percent of women were also reluctant to go to a facility due to the distance to be travelled, compared with 44percent in the hills and 36 percent in the tarai. The result is that only 6 percent of mountain women deliver in a health facility, compared with 21 percent in the hills and 17 percent in the Tarai (MoHP, 2007).

The Government of Nepal has implemented various strategies to reduce maternal deaths. One of the primary causes of maternal deaths in Nepal is postpartum hemorrhage (PPH). The 2008-2009 Maternal/Mortality Survey indicated that 24 percent of maternal deaths were due to postpartum hemorrhage (however, this was a reduction from 41 percent in 1998) (Pradhan & et al., 2009). WHO reports that postpartum hemorrhage is responsible for one quarter of maternal mortality

worldwide. In response to the high incidence of postpartum hemorrhage, the Government of Nepal has initiated use of prophylactic oxytocine immediately after birth under the Active Management of Third Stage of Labour (AMTST) intervention program. The intramuscular oxytocine dose of 10 milligrams soon after delivery prevents postpartum hemorrhage (DoHS, 2006). Similarly, a national free delivery policy was launched in Nepal in January 2009 to address the financial barriers women face in accessing health facilities for delivery and to encourage institutional deliveries. This is known as the Aama program. It covers all of the districts in the country. Similarly, a cash incentive scheme, the safe delivery incentive program (SDIP), was initiated in 2005. This program provides cash payments (differing by ecological region to women who deliver in health facilities and incentive payments for health worker who undertake home deliveries.

Nepal has still high maternal deaths although there was drastic decline in 2006 as compared to 1996. Maternal Mortality ratio (MMR) declined from 539 to 281 per 100000 live births over 10 years. Nepal still experiences around 2000 maternal deaths per year among 690000 births. To reach Nepal's MDG 5 target of 134 per 100000 by 2015, the maternal mortality ratio must continue to decline by 13 percent per year. 2066 maternal death were found in 2007, which indicates 6 deaths per day and 1 death in every 4 hours (Pant & et.al 2008).[42]

The overall MMR for the eight study districts was 229 per 100000 live births, ranging from 153 to 301 by district. This is consistent with the national figure calculated by the 2006 NDHS, which were 281 per 100000 live births. The MMR was high among adolescents, Muslims, Tarai/Madhesi and Dalits. This study revealed that there were significant improvements over the past 10 years in access to routine live saving care and prevention of maternal deaths. The findings also align with the NDHS 2006 MMR estimate, which indicates Nepal is on track to meet the 5th millennium development goal (Pradhan & et.al, 2009).[43]

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[42]Pant,& et.al (2008).*Investigating recent improvements in maternal health in Nepal: Further analysis of the 2006 NDHS.* USA: Macro International Inc. pp. 231-271.

[43]Pradhan & et.al. (2009).*Nepal maternal mortality and morbidity study 2008/09: Summary of preliminary findings.*Kathmandu : FHD/DoHS. pp. 235-261,

Among, key findings of maternal health, about 6 in 10 mothers receive antenatal care from a skilled provider, a significant improvement from 24 percent in 1996. Fifty percent of the women make four or more antenatal care visits during pregnancy, a five-fold increases in the past 15 years. The median duration of pregnancy for the first antenatal visit is 3.7 months. Eighty two percent of mothers with a birth in five years preceding the survey are protected assisted by a skilled provider; skilled birth attendance had doubled over this period. In two years before the survey, 45 percent of women receive postnatal care for their last birth in the first two days after delivery. Only 38 percent women are aware that abortion is legal in Nepal. In their knowledge of the specific circumstances under which abortion is legal is poor. (MoHP, 2011).

Fifty-eight percent of mothers receive antenatal care form a skilled provider (a doctor, nurse, or midwife) for their most recent birth in the five years preceding the survey. In addition, 26 percent of mothers receive antenatal care from trained health workers such as a health assistant or auxiliary health worker (AHW), a maternal and child health worker (MCHW), or a village health worker (VHW). Less than 1 percent of women receive antenatal care from a female community health volunteers (FCHV). Fifteen percent of women receive no antenatal care for births in the five years before the survey (MoHP, 2011).

Younger mothers (less than age 20) are more likely to receive antenatal care form a skilled provider than older mothers (age 35-49). Mothers are also much more likely to receive care from a skilled provider form their first births (73 percent) than for births of order six and higher (20 percent). There are large differences in the use of antenatal care services between urban and rural women. Eighty-eight percent of urban mothers receive antenatal care form a skilled provider, compared with only 55 percent of rural mothers. Sixty-three percent of mothers living in the Tarai receive antenatal care from a skilled provider, compared with 53 percent of mothers in the hill zone and 52 percent of mothers in the mountain zone. About 60 percent of mothers living in the Far-western, Eastern, and western regions receive antenatal care from a skilled provider. Less than 55 percent of mothers living in the Mid-western region receive antenatal care form a skilled provider. The proportion of women who receive antenatal care form a skilled provider is lowest in the Mid-western hill sub-region (43 percent) and highest in the Western Tarai (73 percent) and Far western Tarai (74 percent) sub regions. The use of antenatal care services from a skilled provider is strongly related to the mother's level of education. Women with a school leaving

certificate (SLC) and Higher secondary education are more than twice as likely to receive antenatal care from a skilled provider (89 percent) as women with no education (42 percent). Similarly, women in the highest wealth quintile are almost three times as likely to receive care from a skilled provider (92 percent) as women in the lowest wealth quintile (33 percent)(MoHP, 2011).

Thirty-five percent of births take place under a health facility: 26 percent are delivered under a public-sector health facility, 2 percent in a nongovernment facility, and 7 percent under a private facility. Still two-thirds of births (63percent) take place at home. Delivery under a health facility is more common among mothers less than age 34 (35-41 percent) and mothers of first-order births (54percent). Children in urban areas are more than twice as likely (71percent) to be delivered in an institutional setting as children born in rural areas (32 percent). Delivery under a health facility varies wildly by ecological region, being lowest in the mountain zone (19 percent) and highest in the Tarai (41percent). Institutional deliveries range from low of 29 percent in the Far-western and Mid-western region, and they are most frequent in the Eastern Tarai-sub-region, where one of two mothers has a facility-based delivery. There is a strong association between health facility delivery, mother's education, and wealth quintile (MoHP, 2011).

Overall, direct causes accounted for 69 percent of all maternal deaths while indirect causes accounted for 31 percent. The main direct maternal cause of death was hemorrhage, accounting for 24 percent of maternal deaths (10% PPH without retained placenta, 8% PPH with retained placenta and 6% APH). Eclampsia was the second leading direct cause of death, accounting for 21 percent of maternal deaths. Abortion was the third highest direct cause, accounting for 7 percent of deaths, with half of these being induced and half being spontaneous. The other direct causes included obstructed labour 6 percent puerperal sepsis 5 percent, retained placenta without hemorrhage 1 percent, ruptured uterus 1 percent and inversion of uterus 1 percent, pulmonary embolism 1 percent, and one woman died from a primary hemorrhage from a caesarean section and another from a blood transfusion reaction. The leading indirect maternal cause of deaths was heart disease at 7 percent followed by anemia 4 percent and gastroenteritis 4 percent. The remaining indirect causes were hepatitis, pneumonia, septicemia, typhoid, epilepsy, malaria, renal pulmonary edema etc. This study found 42 percent of deaths occurred in a facility, 41 percent occurred at a home of the decreased or their relatives, 7 percent in transit to a facility and 5 percent in

transit from a facility 2 percent at a medicine shop and 1 percent occurred at a home of service provider. Thirty four percent of maternal deaths occurred in the ante partum period, 38 percent occurred during the intra partum period and 28 percent occurred in the postpartum period (MoHP, 2011).

In Nepal, despite of importance of Skill Birth Attendants (SBA) is reduction of maternal mortality, currently only 36 percent women are attended by a SBA during delivery. So a lot of improvement in this area is needed to get near to international target. SBA national policy of Nepal has also set target to increase proportion of birth attended by a SBA of 60 percent by 2015(DoHS, 2011).

Fifty percent women receive at least one antenatal care in Nepal, with 28 percent receiving care form a doctor or nurse, mid wife or auxiliary nurse mid wife. Most Nepalese women who receive antenatal care get it at a relatively late stage in their pregnancy and do not make the minimum recommended number of antenatal visits. Only one in seven (14%) women make four or more visits during their entire pregnancy while 16 percent of women report that their first visit occurred at less than four month of pregnancy. Forty-five percent of women receive two or more doses of tetanus toxiod injection during their most recent pregnancy. Thirteen percent of births are attended at delivery by a medical professional, with only 8 percent of births attended by a doctor and 3 percent attended by a nurse, mid wife or auxiliary nurse mid wife. Nearly a TBA attended one in four births. Safe delivery kits were used in 9 percent of birth delivery at home. Only 17 percent of rural mothers receive postnatal care within the first two days after delivery and nearly four in five mothers did not receive postnatal care at all (MoHP,2012).

In Nepal, there are delays in seeking care, reaching care and receiving care for mother to get appropriate health services. Still 35 percent of pregnant mother do not prepare anything for delivery (Vashisth & et.al 2013).[44]

Thapa (2010) conducted research study on safe motherhood practice of Tharu mother's Rupandehi district of Nepal. Objectives of this study are to describe the practice of safe motherhood in Tharu community. Based on quantitative data collected from 100 mothers who were randomly included in the study. Majority of mothers got married at the age of 16-19 years and 52 percent mothers gave birth to their first baby

[44]Vashistha & et.al (2013) Goal, activities and strategies of safe motherhood situation in Nepal.*Journal of Academic Voices* Vol. I pp. 19-23.

at the age of 16 to 19 years. Nearly two third (64%) of respondents' mothers had antenatal check up and 20 percent them received antennal check up 4 times.

Only one fourth of them delivered their new babies at health institutions. A few of them received postnatal check up and proper rest during post-partum period. Mothers who have better knowledge about safe motherhood are more likely to receive antenatal check up three to four times and deliver births at health institution compared to those who have poor knowledge. It can be concluded that education and level of knowledge positively influence the safe motherhood practices. Utilization of maternal health care service and safe mother practices is still poor among the marginalized ethnic groups like Tharu of Nepal. Poor socio-economic condition and lack of awareness in Tharu community may have negative impact on women health and safe motherhood practices.

Prassad (2012) carried out a research paper on the title Safe Motherhood Practice in Dalit community, Bara district of Nepal. This paper describes the practice of safe motherhood in the Dalit community based on quantitative data collected from 120 mothers. The respondents were interviewed by using interview schedule. It is concluded that lack of education and awareness, low socio-economic condition teenage marriage and early pregnancy, improper antenatal care service, unsafe delivery at home, improper postnatal checkup and traditional attitude indicate that safe motherhood practice is not satisfactory in the Dalit community.

Sharma (2012) carried out a research study on the title antenatal, natal and postnatal care and existing health problem of the women among rural community. The study was of descriptive nature, purposive sampling method was applied to select the respondents. This study mainly based on primary data. It was limited to the mothers who had a child under one year. The total number of respondents were 112 from Keshavtar VDC,Tanahun district of Nepal. The interview and observation were the major tools for data collection. The essential information regarding the demographic characteristics, antenatal; delivery and postnatal care practice were obtained from the study. Antenatal check up is very important for newborn and mother's health but study show that most of the mother's did not have knowledge about antenatal checkups, some of the respondents said that it was not necessary. Majority of respondents visited less than four times to have checked up during pregnancies. In all scenarios there were no consciousnesses about on antenatal, natal and postnatal care and practice.

It is undeniable fact that study on safe motherhood practice so far done in Nepal is not complete in all respects. The study carried out by Thapa (2010)[45]included safe motherhood practices of Tharu mothers only but this study does not cover women of other communities. Similarly, Prasad (2012)[46] studied safe motherhood practice of women of Dalit community. More surprisingly, the recent study done by Sharma(2012)[47]on antenatal, natal and postnatal care of rural community of Nepal tried to point out significant information but the study does not touch important aspects of the problem in Hill and Tarai. The following conclusions are drawn from the review of related literature in the field of educational status, social awareness and safe motherhood practices. It is found that no work is done on this problem. So it is an effort to identify and fill up the gap.

As motherhood is the foundation of upbringing and nurturing future generation. Present study is inspired with the facts that education plays an important role in adopting practices of safe motherhood and might be more cautious regarding pre and post natal care.

This study focuses on:

1 Educational status of respondents, their mother- in- law, father- in-law, mothers, fathers and spouses.

2 Social awareness of respondents regarding facilities, reservations and rights provided by the government of Nepal.

3 The existing pattern of antenatal care, natal care and postnatal care practiced in Hilly and Tarai Region of Nepal.

4 The similarities and differences among Dalits and Janajatis of the target area in matter of education, social awareness and safe motherhood practices.

5 The interrelationship between the educational status and safe motherhood practices.

6 The association between the social awareness and safe motherhood practices.

[45]Thapa (2010).Safe motherhood practice of Tharu mothers. Journal of health promotion vol. 3,Pp39-45.

[46]Prasad.(2012). Safe motherhood practice of Dalit community.Journal of academic voices vol 2, Pp63-68.

[47]Sharma (2012).Antenatal, natal and postnatal care practice and knowledge.Journal of shikhya sandesh vol 2, Pp61-65.

CHAPTER –III

METHODOLOGY

This chapter deals with the methodology and procedure used in this study. Research methodology is a way to systematically solved research problem (Kothari, 1990). Webster's dictionary defines that methods indicates that systematic way of procedure adopted in scientific investigation. Proper method leads to systematic proceedings and finally leading to fruitful results. Research method, study area, sources of data, population, sample size, sampling technique, research tool, process of data collection and scheme of data analysis.

3.1 Research Method

Descriptive survey method was used in this study. Descriptive survey is the form of the survey which describes the characteristics of the sample. It provides opportunities of describing, studying and interpreting. It is concerned with the conditions, relationships, practices, belief, values that prevail the processes and the trends that are developing. Descriptive survey method attempts to describe systematically a situation, problem, phenomenon, service or program, and provides information about living condition of a community, or describes attitudes towards an issue (Best & et.al, 2008). The investigator used descriptive survey method for accomplishment of this work. Here the descriptive survey method was found more appropriate for the present study as it was also aimed to describe the characteristics which explored from the various cluster of the sample of Dalit and Janajati communities of Nepal. Looking to the nature of work, qualitative research inputs were also employed. Hence, the components of qualitative and quantitative methods were mixed matched to obtain and interpret the data.

3.2 Study Area

Located in the central Nepal, Kaski and Parsa districts represent the Hilly and Tarai region respectively. There are 2 Municipality and 43 Village Development Committee (VDC) in Kaski district. Kaski district is surrounded by Tanahun and Lamjung in the east, Parbat and Syangja in the west, Manang and Myagdi in the north, Nawalparasi and Tanahun in the south. Mostly Dalit and Janajati communities are permanent

residents in Kaski district. The total population of Kaski district is 492098 as per the census of 2011. Among the total population, the male population is 236358 and female population is 255713. Similarly, total Dalit female population is 69581 and total female Janajati population is 67082. The population of Dalit and Janajati women having at least one child is 5181 and 4818 respectively. Since it is densely populated by Dalit and Janajati, Pumdi Bhumdi VDC has been selected as the study area from Kaski district.

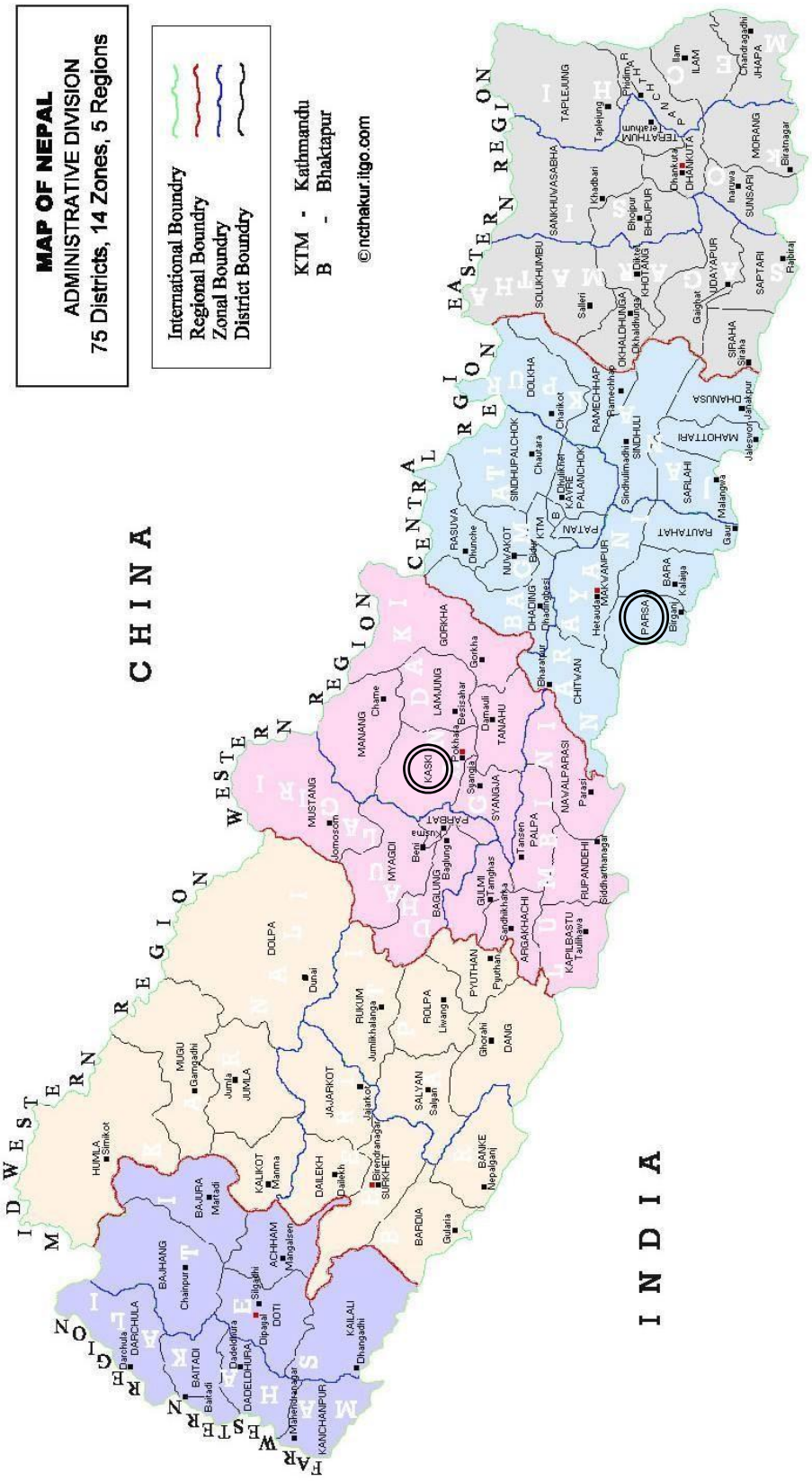
Regarding Parsa district, there are 83 VDCs andone Municipality located in this district. Like Kaski, Parsa distict also inhabited by a high population of Dalit and Janajatis. Parsa district is surrouned by Bara district in the east, Chitwan district in the west, Makwanpur district in the north and Bihar Province of India in the south.The total population of Parsa district is 601017 as per the census of 2011. Among the total population, the male population is 312358 and female population is 288659. Similarly, total female Dalit population is 56585 and total female janajati population is 27802. The population of Dalit and Janajati women having at least one child is 3489 and 3150 respectively. Since Bishrampur and Bageswori Titrauna VDCs are densely populated by Dalit and Janajati, they were selected as the study area from Parsa district.

The main reasons behind selecting these districts as study areas are: they represent cultural and geographical diversity in Nepal and mostly Dalit and Janajati people live these districts. The researcher believes that both of these districts really represent the entire geography of Nepal (ref. Fig 2).

3.3 Sources of Data

Dalit and Janajati women with at least one child of these two districts were the main sources of data for this study. The study was based on primary sources of data. Primary datawere collected from field survey. The primary data were obtained from the selected samples of Dalit and Janajati women of three VDCs of Parsa and Kaski districts of Nepal.

Map of Study Area



3.4 Population

Population is the universe group of people from which sample size is selected, and the results of the study can be generalized (Best &et.al, 2008). In any investigation the interest usually lies in studying the various characteristics relating to individuals belonging to population. The population of this study consists of all women having at least one child belonging to Dalit and Janajati community from Pumdi Bhumdi VDC of Kaski district and Bishrampur and Bageswori Titrauna of Parsa district Nepal (ref.Appendix-VII). According to district profile (2013) the population of such Dalit and Janajati women in Kaski district were 5181 and 4817 whereas in Parsa district Dalit and Janajati women were 3489 and 3150 respectively. The population of this study comprised of 16637 (9998 at Kaski and 6639 at Parsa) women of Dalit and Janajati.

3.5 Sample Size

The individuals selected from a population in such a way that they represent the larger group from which they were selected comprise a sample (Karlinger, 2008). The purpose of selecting a sample is to gain information about a population. The sampling frame was list of women who have at least one child from selected VDCs of both Kaski and Parsa districts belonging to Dalits and Janajati.

Desired Sample size was calculated by using following formula;

$$n = PQ\left(\frac{Z_{\frac{\alpha}{2}}}{E}\right)^2 = 500$$

Where, P= Proportion literate population of Dalit and Janajati=52%

Q= Proportion illiterate population of Dalit and Janajati=48%

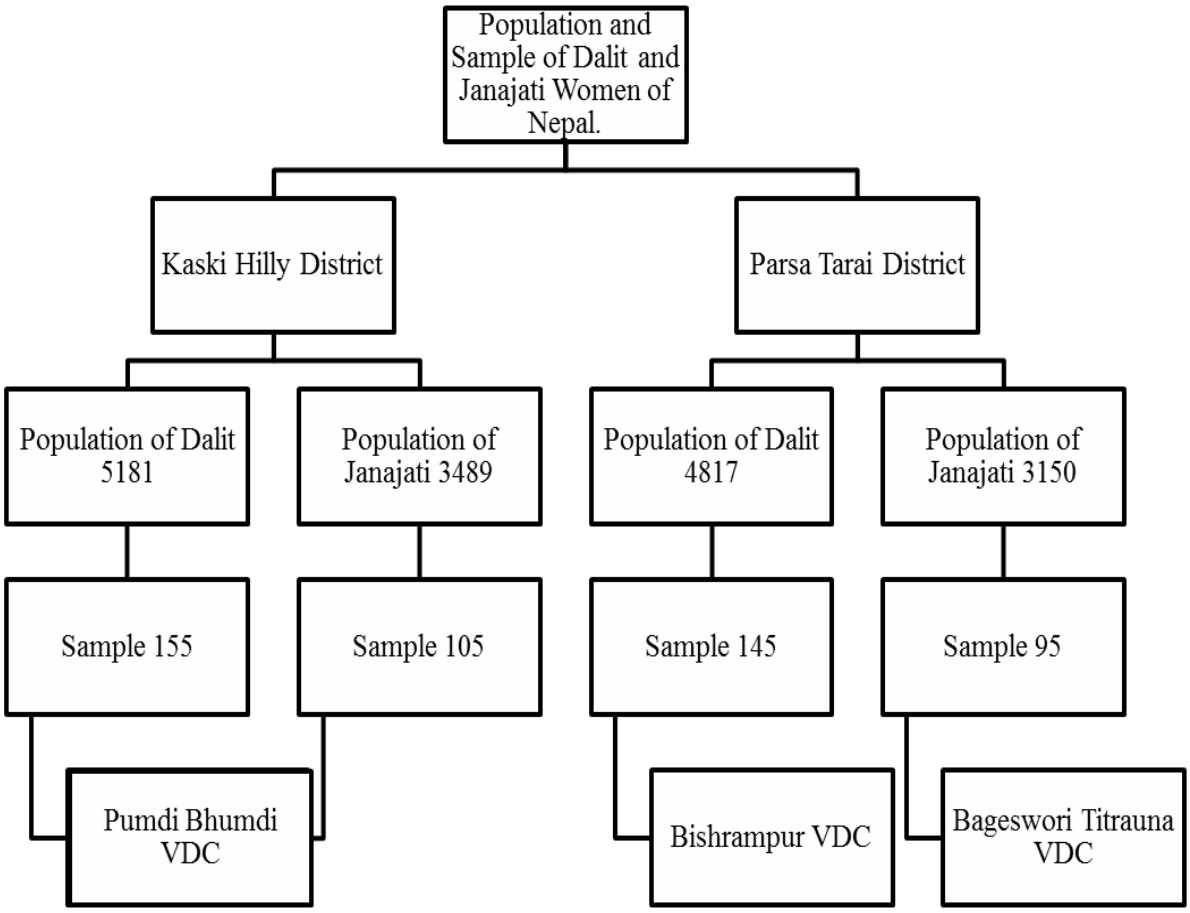
E= 4.38% (Tolerable error)

Source: *Patel, 2013*

3.6 Sampling Techniques

Cluster sampling is a variation of simple random sampling. It is used when the population under study is infinite where a list of units of the population (sampling frame) does not exist, when the geographic distribution of units is scattered (Koul, 2009). In the present study, cluster sampling technique was used in the selection of

Dalit and Janajati women having at least one child from the study area- Parsa and Kaski district of Nepal. In the first stage, three VDCs-Bishrampur and Bageswari Titraunafrom Parsadistrict andPumdi Bhumdi VDC from Kaski district were randomly selected. In the second stage, two VDCs Dalits and Janajatis women were randomly selected from each of the selected three VDCs. Thus, from the sample consisted of 500 women (300 Dalit and 200 Janajati). Bishrampur VDC- 145 Dalit and from Bageswari Titrauna VDC -95 Janajati women were selected randomly. In the same way, 155 – Dalit and 105 – Janajati women were selected from Pumdi Bhumdi VDC of Kaski district. The selection of sample is based on the Krejcie and Morgan (1970) table of determining sample size.
(ref.Fig:3).



From this a sample of 3% was drawn by using Krejcie and Morgan (1970) table for determining sample size.

3.7 Research Tools

Structured questionnaire and unstructured interview schedule were the main tools to collect necessary data for this research work. In order to fulfill the objectives of the study, two types of tools viz. structured questionnaire and unstructured interview schedule were developed and used for the collection of data/information for this study.

3.7.1 Questionnaire

The investigator reviewed the related questionnaire specially developed by NDHS (2011) to survey the education and Health status of Nepalese women. On the basis of this review, items related to educational status, social awareness and safe motherhood practices of women were prepared. The initial draft of items for questionnaire consisted of eight items on educational status, ten items on social awareness and forty one items on safe motherhood practices. This draft questionnaire was distributed to three experts of related field to comment on the items of the questionnaire. On the basis of suggestions from experts, one item on educational status, two items on social awareness and five items on safe motherhood practices were removed from the questions and rest of the items were finalized with necessary modification. The feedback offered by the supervisor was considered and the questions were further improved for its administrative practicability and reliability.

Try out first:

The questionnaire consisting of seven items on educational status, nine items on social awareness and thirty six items on safe motherhood practices was piloted on a group of thirty women of Dalit and Janajati of Tanahun District of Nepal. The data obtained from the first tried out were analyzed and five items on social awareness and eleven items on safe motherhood practices were rejected due to overlapping of items.

Try out second:

A second try out research questionnaire was conducted on the same group of thirty women of Tanahun District. The data obtained from the second tried out were analyzed and no modifications were made in the items of questionnaire.

Thus, the final form of questionnaire consisted of thirty four items-seven items on educational status, four items on social awareness and twenty three items on safe

motherhood practices (ref. Appendix-I). Nepali version of questionnaire was also constructed with the help of language expert (ref. Appendix-II).

Validity of Questionnaire

Validity of a test means truthfulness. Validity refers to the accuracy of an assessment-whether or not it measures what it is supposed to measure. The investigator adopted the following validity.

Content Validity

Content validity refers to the degree to which an instrument measures what it is intended to measures. Content validity warrants that an overall sample of the content being measured is represented. A panel or grouping of content expert is consulted to identify a broad spectrum of content.

During the process of development of questionnaire three experts (Prof. Lokendra Sherchan, Prof. Abdul Quaiyum and Prof. Shyamkrishna Maharjan) were consulted to check educate and representative coverage of educational status, social awareness and safe motherhood practices. On the basis of suggestions and try out research the items of the questionnaire were finalized. Thus, content validity was achieved by making professional judgment about the relevance and sampling of the content of the questionnaire to the particular dimension.

Consequently questionnaire seems to be highly valid. The questionnaire has already content validity therefore it has face validity.

Reliability of Questionnaire

Reliability is one of the most important characteristics of a tool which denotes how accurately the tool measures whatever it measures. The reliability of the questionnaire is determined by test-retest method. Test-retest method is based on testing the same subjects twice with the same test and then correlating the result. In piloting the questionnaire, it was administered twice on the same group of 30 women in and interval of two weeks and similar responses to questionnaire were obtained. The data obtained from the test-retest were compared and a gap of 20 percent was found in the responses. Thus, the questionnaire seems to be highly reliable.

3.7.2 Unstructured Interview schedule

Unstructured interview schedule is an extremely useful method of data collection that provides complete freedom in terms of content and structure. As a researcher you are free to order these in whatever sequence you wish, keeping in mind the context you also have complete freedom it terms of what questions you ask of your respondents, the wording you use and the way you explain them to your respondents. You usually formulate questions and raise issues on the spur of the moment, depending upon what occurs to you in the context of discussion (Kumar, 2014).

The investigator has developed interview schedule after reviewing related research studies and discussion with respective experts. The purpose of conducting this interview was to focus practices related to ANC visit, place of delivery, postnatal checkup and social awareness of Dalit and Janajati mothers. This interview schedule consisted of nine open questions (ref. Appendix-III) .Nepali version of the interview schedule was also constructed with the help of language expert (ref. Appendix-IV).

3.8 Data Collection Procedure

The researcher himself visited the secretary of the selected VDCs to take permission for collection of data. The researcher made a door to door visit to the selected respondents of the three VDCs of Parsa and Kaski districts .The purpose of the visit was made clear to the respondents and they were asked to provide information without any hesitation and confidential and name of respondents were not associated with their answer. The questionnaire were filled by the researcher himself. Personal questions were not asked and refusal right of the participants was respected. Questionnaire were filled by the selected sample of Dalit and Janajati community women from13July to 5 September 2014. Furthermore, interview schedule were held after the questionnaire were filled out by the respondents. By winning the consent and favor of the respondents, the researcher asked the respondents questions as per the interview schedule and kept on asking tactfully unless the satisfactory response didn't come. The researcher conducted the interview schedule with the eight selected educated and uneducated respondents and elicited the necessary information about safe motherhood practices and social awareness from them.

3.9 Data Analysis Procedure

The quantitative data collected through questionnaire were edited, summarized and tabulated by using statistical package for social sciences (SPSS) 20.0 version. Keeping in view the objectives of the study, following techniques such as cross tabulation and pie-chart were constructed to analyze the data.

Chi-square test

The Chi-square test is an important test amongst the several tests of significance developed by statisticians. As a non-parametric test, it can be used to determine if categorical data shows dependency or the two classification are independent. It can also be used to make comparisons between theoretical populations and actual data when categories are used. Thus, the Chi-square test is applicable in large number of problems. The test is, in fact, a technique through the use of which it is possible for all researchers to (i) test the goodness of fit; (ii) test the significant of association between two attributes, and (iii) test the homogeneity or the significance of population variance.

The investigator applied non-parametric Chi-square test to ascertain the association between independent and dependent variables. The investigator used the following formula to calculate the Chi-square value.

$$\chi^2 = \sum \frac{(f_o - f_e)^2}{f_e}$$

Where, f_o = The observed frequency

f_e = The expected frequency

$\sum$ = Sum of the resulting value

Percentage

A percentage is a number or ratio expressed as a fraction of 100. It is often denoted using the percent sign "%". A percentage describes how many parts there are out of one hundred parts of a particular thing. In the present research, percentages of respondents regarding educational status, social awareness and safe motherhood

practices were computed and compared between Dalit and Janajati respondents under study.

Furthermore, the qualitative information obtained from the interview schedule were contextually analyzed and interpreted on social awareness and safe motherhood practices. All together eight mothers were interviewed to study their views upon social awareness and safe motherhood practices. The age of the participants ranged from the twenty to thirty-one years. Likewise, both uneducated as well as educated Dalit and Janajati women having at least a child were selected for the interview. Out of the total interviewees; four Dalit women comprised of two educated and two uneducated and four Janajati women comprised of two educated and two uneducated were selected as participants to obtain information and their opinions regarding social awareness and safe motherhood practices prevalent in the selected study areas.

CHAPTER- IV
ANALYSIS AND INTERPRETATION OF DATA

The next important step in research, after the collection of data, is to analyze and interpret the collected data scientifically and methodical. Scientific analysis means a systematic observation and classification of collected data. The process of interpretation is essentially one of stating what the result shows. What do they mean? what is their significance? That all the limitation of the data must enter into become a part of interpretation of result (Good & et al, 1959).

This chapter presents analysis and interpretation of qualitative and quantitative information on the following heads; educational status, safe motherhood practices and social awareness; association between educational status and safe motherhood practices, and social awareness and safe motherhood practices.

4.1 Educational Status

Education is one of the very important aspects of human life. It directly affects the overall sectors of life including occupation, income, health and social status, standard of quality of life and civilization of a nation, an individual, or community. Educated people have growing awareness of the health of an individual, of family and the entire society.

4.1.1 Educational Status of Dalit and Janajati Respondents

It is crucial and essential to find out the educational status of the respondents so as to conduct the research. To a greater extent, education of the respondents affects safe motherhood practices in the target community.

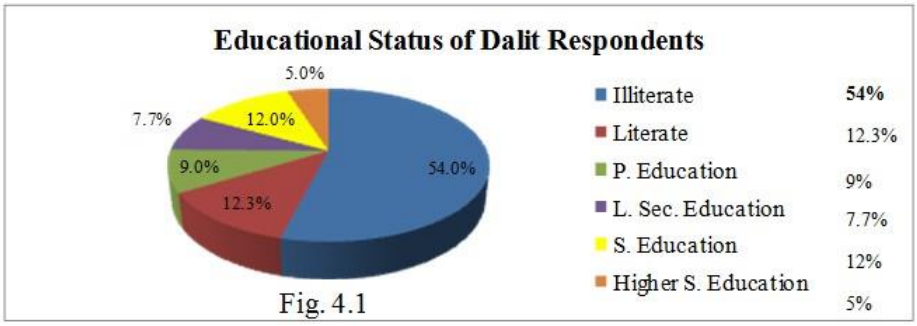


Fig. 4.1

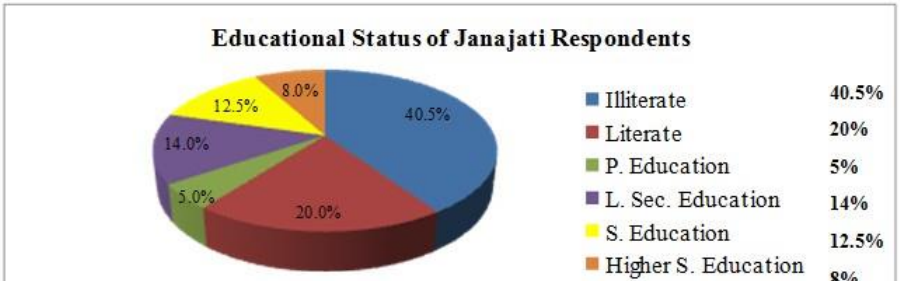


Fig. 4.2

Figure 4.1 shows that among Dalit respondents, 54 percent were illiterate, 12.3percent were literate whereas 9 percent were of primary education, 7.7 percent of lower secondary, 12 percent of secondary and 5 percent only of higher secondary education. On the other hand, figure 4.2 indicates that among Janajati respondents,40.5 percent were illiterate, 20 percent were literate where as 5 percent were of primary education, 14 percent of lower secondary, 12.5 percent of secondary and 8 percent only of higher secondary education.

It is further discovered that Janajati respondents were more literate than Dalits.

4.2 Antenatal Care

Antenatal health care services are those health care services that a woman gets during her pregnancy. Information technology can be defined as the care of mother after the date of conception and before date of delivery. Antenatal check up plays a vital role in promotion of role the health of the mother and her fetus. Under antenatal health care: frequency of antenatal care (ANC) visit, assistance during ANC, food intake during pregnancy, frequency of bath during pregnancy, smoking and alcoholic habit, problem faced during pregnancy, TT immunization, receiving iron tablets and vitamin 'A' capsule are included.

4.2.1 Frequency of ANC Visit

According to World Health Organization's standard, a mother should visit health center for health check up at least four times per birth. Frequency of ANC visit often shows the carefulness of mother towards her reproductive health.

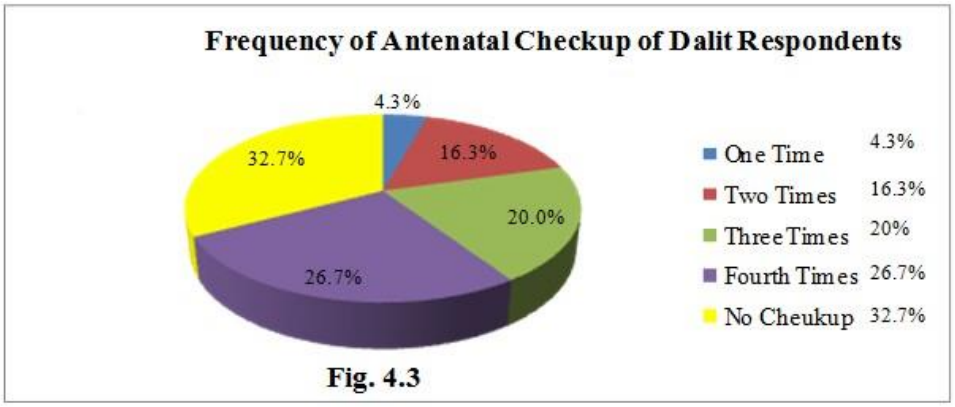


Fig. 4.3

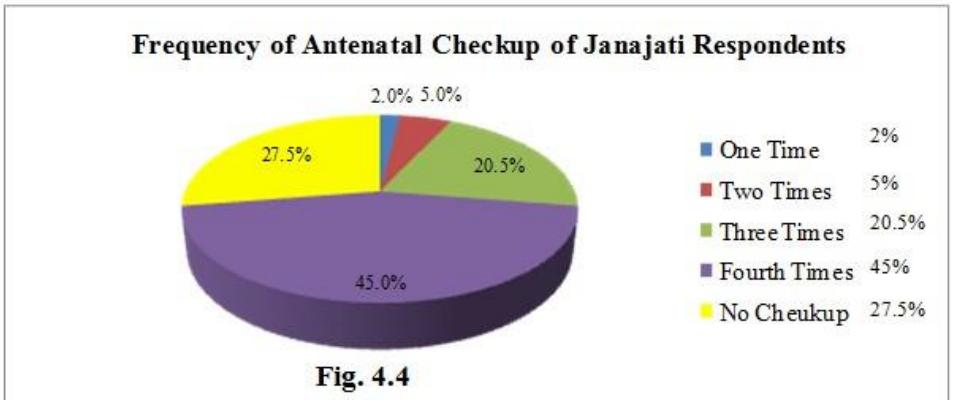


Fig. 4.4

Figure 4.3 and 4.4 shows that 26.7 percent of the Dalits and 45 percent of Janajati mothers followed ANC visit four times during pregnancy period. However, 20 percent of each of them (Dalits and Janajatis) had three times ANC visit during the same period. In contrast, 32.7 percent of the Dalit and 27.5 percent of the Janajati mothers never had their health check up during pregnancy.

The data reveals that Dalits mother had less frequency of ANC visits than that of Janajati mothers. The utilization of ANC visit is positively association with the respondents' level. Lack of knowledge about safe motherhood and low educational status was one of the causes for absence of ANC visit.

Hypothesis 1 was examined on the basis of its different dimensions in form of sub hypothesis the analysis is given in preceding tables from 1.1 to 1.16.

H 1.1 The educational status of Dalit and Janajati women is significantly associated with the practice of Ante Natal Care (ANC) visit.

Table 4.1: Association between Educational Status and Frequency of ANC visit

Respondents Educational Status.		Frequency of ANC Visit			
	one time	Two times	Three times	Four time	No check up
Illiterate	14 5.8%	41 16.9%	65 26.7%	23 9.5%	100 41.2%
Literate	2 2.6%	8 10.4%	7 9.1%	18 23.4%	42 54.4%
Primary education	0 0%	8 21.6%	9 24.3%	12 32.4%	8 21.6%
Lower secondary education	1 2%	1 2%	12 23.5%	35 68.6%	2 3.9%
Secondary education	0 0%	1 1.6%	4 6.6%	55 90.2%	1 1.6%
Higher secondary education	0 0%	0 0%	4 12.9%	27 87.1%	0 0%
Total	17 3.4%	59 11.8%	101 20.2%	170 34%	153 30.6%

χ^2=55.56**, df**=20**, p**=.005

Table 4.1 shows that among the illiterate respondents, 5.8 percent had ANC visit once, 16.9 percent twice, 26.7 percent thrice, 9.5 percent visited four times but 41.2 percent had no ANC visit during pregnancy. Among the literate respondents, 2.6 percent had ANC visit once, 10.4 percent twice, 9.1 percent thrice, 23.4 percent four times but 54.5 percent did not have ANC visit during pregnancy. Among those having primary education, 21.6 percent had ANC visit twice, 24.3 percent thrice, 32.4 percent four times, whereas 21.6 percent had no ANC visit. Among the respondents having lower secondary education, 2 percent had ANC visit once and 2 percent twice respectively, 23.5 percent thrice, 68.6 percent four times and 3.9 percent did not have ANC visit. Among the respondents having secondary education, 1.6 percent had ANC

visit twice, 6.6 percent thrice, 90.2 percent four times and 1.6 percent did not have ANC visit. Regarding the respondents having higher secondary education, 12.9 percent had ANC visit thrice whereas 87.1 percent had ANC visit four times during pregnancy period.

The significance of association between educational status and frequency of ANC visit was tested statistically by applying Chi-square test. The computed Chi-square value is $\chi^2 = 55.56$ which is not less than the table value 31.41, so the association between educational status and frequency of ANC visit during pregnancy is significant at the

0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and frequency of ANC visit is retained. It may be interpreted that educated women have more ANC visit during pregnancy than that of uneducated women.

Interview held with one educated Janajati mother and uneducated Dalit mother regarding ANC visit has been presented here:

A **23-year-old educated Janajati mother** of two children shared her experience regarding the problems she faced during pregnancy, *"I went for antenatal check up after four months. At that time I was injected TT, offered Vitamin A Capsules and Iron Tablets and also recommended for four times' checkups. I followed the advice exactly."* It was firstly interesting to note that educated mothers were more aware of antenatal checkup and its importance for the health of a pregnant women. The mother shared that they went for antenatal checkup regularly during pregnancy but they didn't go for postnatal checkup. Secondly, it was found that educated mother had some kind of awareness of ANC checkup.

A **26-year-old uneducated Dalit mother** of three children expressed her experience after delivering third child, *"My legs got swelled after six months of pregnancy. My spouse saw that and advised me to go to the health post for treatment. Accordingly, I went to the health post. The nurse examined health condition and gave various types of medicines. I took up them as per the advice and I recovered from swelling legs."* It firstly shows that uneducated pregnant women paid very less visits to health institutions for checkup. Secondly, it was interesting to notice that some of the uneducated women's spouses were aware of ANC checkups but they ignored it unless their pregnant wives get serious problems.

Analyzing the two views of respondents, it may be said that safe motherhood practice in the sense of antenatal care of educated mother more ANC visit than that of uneducated mothers.

4.2.2 Antenatal Care Service Provider

Pregnancy is a special period. It needs best care nutrition, rest, hygiene and psychological support of husband and family member. Basically, antenatal care is necessary to reduce the risk of growing maternal and infant motility. Antenatal care service can be received from Doctor, Nurses, FCHVs, and health workers.

Table 4.2: Antenatal Care Service Provider

Caste/Ethinic group	ANC Service Provider				
	Doctor	Nurse	FCHV	Health worker	No consult
Dalits	76 25.3%	95 31.7%	28 9.3%	3 1%	98 32.7%
Janajati	77 38.5%	48 24%	19 9.5%	0 0%	56 28%
Total	153 30.6%	143 28.6%	47 9.4%	3 0.6%	154 30.8%

Table 4.2 presents that out of 500 respondents, 69.2 percent got ANC service from doctor, nurse, FCHV and health workers whereas 30.8 percent never consulted health personnel. Among Dalit respondents, 25.3 percent got services from doctors, 31.7 percent from nurses, 9.3 percent from FCHVs, only one percent from health worker but 32.7 percent never consulted any health professionals. Regarding Janajati respondents, 38.5 percent got service from doctors, 24 percent from nurses, 9.5 percent from FCHVs whereas 28 percent never consulted any health personnel.

In the study area, it is found that more Janajatis received antenatal care service from health personnel as compared to Dalits. The main causes behind these effects were traditional faith, their culture, lack of facilities like transportation, money and effective services and irregularities of health personnel and unavailability of trained professional.

4.2.3 Reasons for Not Taking ANC

The principal reasons for respondents' inability to take ANC services include poor economic condition, cultural and social barriers and lack of time and awareness about the ANC services.

Table 4.3: Reasons for Not Taking ANC

Caste/Ethinic group	Reason for not Taking ANC		
	lack of awareness	Lack of time	Lack of money
Dalits	32 33.68%	28 29.47%	35 36.84%
Janajati	20 34.48%	20 34.48%	18 31.04%
Total	52 34%	48 31%	53 35%

Table 4.3 presents that out of total respondents, 34 percent did not receive ANC services due to lack of awareness and 31 percent lack of time. Likewise, 35 percent respondents did not receive ANC service due to lack of money. Among Dalit respondent, 33.68 percent did not receive antenatal care service due to lack of awareness, 29.47 percent due to lack of time and 36.85 percent due to lack of money. In case of Janajati respondents, 34.48 percent did not receive antenatal care service owing to lack of awareness and time, and 31.04 percent due to lack of money.

The data reveals that Dalit respondents received a lower degree of ANC services than Janajati respondents did. Dalit mothers were not aware of importance of ANC visit and had lack of time, guidance and money for check up.

4.2.4 Food Intake during Pregnancy

Needless to repeat that nutritious and balanced diet plays a vital role in developing physical, mental and social well-being for both pregnant mother and the baby. Nutritious and balanced diet always consist of required amount of vitamins, proteins, carbohydrates, minerals, fats and water. A pregnant woman needs additional and extra nutritious food than normal woman does.

Table 4.4: Food Intake during Pregnancy

Caste/Ethinic group	Food intake during pregnancy		
	Normal food	Additional food	Special food
Dalits	227 75.7%	72 24%	1 0.3%
Janajati	196 98%	4 2%	0 0%
Total	423 84.6%	76 15.2%	1 0.2%

Table 4.4 indicates that out of total respondents, 84.6 percent were found to have taken normal food, 15.2 percent additional food and hardly 0.2 percent took special food during pregnancy. Among Dalit respondents, 75.7 percent received normal food, 24 percent additional food and only 0.3 percent took special food. As regard Janajati respondents, 98 percent took normal food and 2 percent took additional food during pregnancy period.

The data reveals that Janajati mothers had less intake of additional food than the Dalits mothers had. The data shows one more interesting fact that both Dalit and Janajati women hardly took special food during their pregnancy. In most of the families, it was common practices to give normal food to pregnant women as other members of family. It seems that these communities were unknown about importance of additional foods during pregnancy due to ignorance, poverty and traditional beliefs.

4.2.5 Frequency of Bath during Pregnancy

Personal hygiene helps the individuals preserve and improve both the body and mind. The main objective of personal hygiene is to maintain a higher standard of an individual. Illness can be prevented from the proper personal hygiene practices by pregnant mothers. Since the skin is more sensitive during pregnancy, pregnant mother need better personal hygiene and sanitation.

Table 4.5: Frequency of Bath during Pregnancy

Caste/Ethinic group	Frequency of bath during pregnancy			
	Daily	Alternate day	Twice a week	Once a week
Dalits	10 3.3%	153 51%	93 31%	44 14.7%
Janajati	96 48%	14 7%	24 12%	66 33%
Total	106 21.2%	167 33.4%	117 23.4%	110 22%

Table 4.5 presents that out of total respondents, only 21.2 percent pregnant mothers took bath daily, whereas 33.4 percent of the respondents took bath on every alternate day. Likewise 23.4 percent of the respondents bathed twice a week and remaining (22%) once a week, Among Dalit respondents, 3.3 percent took bath daily, a higher 51 percent on every alternate day, 31 percent twice a week and 14.7 percent once a week. Among Janajati respondents, 48 percent took bath daily, 7 percent on every alternate day, 12 percent twice a week and 33 percent one a week.

The data indicates that Dalit respondents maintained a better hygiene than that of the Janajati respondents. It can be concluded that Janajati women did not have the proper consciousness about personal hygiene during pregnancy.

4.2.6 Smoking and Alcoholic Habit during pregnancy

A noted fact is that smoking and alcoholism during pregnancy increase the risk of having a small or low-birth-weight baby. It causes the higher chance of abortion during pregnancy. The habit of smoking adversely affects women's health and may also increase respiratory problems. Smoking and alcohol taken in pregnant period is ultimately harmful to mother herself and her fetus.

Table 4.6: Smoking and Alcoholic Habit during Pregnancy

Caste/Ethinic group	Smoking and Alcoholic Habit			
	Smoking	Alcohol	Both Alcohol and Smoking	Neither Alcohol nor Smoking
Dalits	105 35%	39 13%	69 23%	87 29%
Janajati	23 11.5%	24 12%	55 27.5%	98 49%
Total	128 25.6%	63 12.6%	124 24.8%	185 37%

Table 4.6 indicates that out of total respondents, 37 percent neither smoked nor took alcohol. In the same way, 25.6 percent had smoking habit whereas 12.6 percent went for only alcohol. On the other hand, 24.8 percent were reported to have habit of both smoking and drinking. Among Dalit respondents, 35 percent were reported smoking and 13 percent drinking. Similarly, 23 percent went for both smoking and alcohol whereas 29 percent were reported neither to be smoking nor drinking. Regarding the Janajati respondents, 11.5 percent were reported to be smoking, 12 percent drinking, 27.5 percent both alcohol and smoking and 49 percent neither did smoking nor they took alcohol.

The data reveals that Dalit respondents had a lower degree of both smoking and alcoholic behavior than that of Janajati respondents. Dalit respondents were aware of harmful effect of alcohol and smoking but Janajati were found to be neglecting.

Therefore, it is estimated that Janajati women had more chance of various problems related to smoking and alcohol.

4.2.7 Complication during Pregnancy

Complication during pregnancy is a growing health, social, economic and demographic problem in any community. To an extent, maternal and child mortality can be related with complication during pregnancy. Women have to fight many problems such as vomiting, swelling leg, accidental bleeding, anemia and backache during pregnancy.

Table 4.7: Complication during Pregnancy

Caste/Ethinic group	Complication during pregnancy					
	Vomiting	Swelling leg	Sometimes bleeding	Anemia	Backache	No problem
Dalits	148 49.3%	90 30%	15 5%	9 3%	29 9.7%	9 3%
Janajati	111 55.5%	55 27.5%	3 1.5%	1 0.5%	17 8.5%	13 6.5%
Total	259 51.8%	145 29%	18 3.6%	10 2%	46 9.2%	22 4.4%

The study in survey areas shows that out of total respondents, 51.8 percent faced vomiting, 29 percent swelling leg, 3.6 percent sometimes bleeding, 2 percent anemia, 9.2 percent backache problem whereas 4.4 percent faced no problems at all. Among Dalit respondents, 49.3 percent faced vomiting, 30 percent swelling leg, 5 percent accidental bleeding, 9 percent anemia, 29 percent backache and 9 percent faced no problems. Regarding Janajati respondents, 55.5 percent faced vomiting, 27.5 percent swelling leg, 1.5 percent accidental bleeding 0.5 percent anemia, 8.5 percent backache and 6.5 percent faced no problems during pregnancy.

It is found that Janajati respondents faced more frequent degree of vomiting problems as compared to Dalit respondents. This data concludes that most of the Dalit women were not aware of complications during pregnancy due to lack of illiteracy and social awareness.

4.2.8 Practice of Having TT Vaccine during Pregnancy

Tetanus Toxiod (TT) vaccine is an importantly required component of antenatal care and is given during pregnancy, primarily for the prevention of neonatal tetanus. Different studies show that neonatal tetanus is one of the major causes of infant deaths in Nepal. For full protection, it is recommended that pregnant women should receive at least two doses of tetanus toxiod during her first pregnancy, administered one month apart and a booster shot during each subsequent pregnancy. Five doses of TT injections are considered to provide life time protection.

Table 4.8: Practice of Having TT Vaccine during Pregnancy

Caste/Ethinic group	Practice of TT vaccine during pregnancy		
	One	Two	Never
Dalits	19 6.3%	165 55%	116 38.7%
Janajati	6 3%	135 67.5%	59 29.5%
Total	25 5%	300 60%	175 35%

Table 4.8 presents that out of total respondents, 5 percent received TT vaccine once, 60 percent two times, whereas 35 percent received no TT vaccine during pregnancy period. Among Dalit respondents, 6.3 percent received TT vaccine once, 55 percent two times, but 38.7 percent received no TT vaccine. In case of Janajati respondents 3 percent received TT vaccine at once, 67.5 percent two times but 29.5 percent received no TT vaccine during pregnancy.

The data reveals that more Janajati respondents received two times TT immunization as compared to Dalit respondents. The respondents who did not take TT vaccine were due to lack of awareness and education. They did not know what would be the result after taking TT vaccines. This study also shows that the practice of having TT vaccine between Dalit and Janajati respondents was satisfactory.

H 1.2: The educational status of Dalit and Janajati women is significantly associated with the practice of having Tetanus Toxiod vaccine.

Table 4.9: Association between Educational Status and Practice of TT Vaccine during Pregnancy

Respondents Educational Status.	Practice of TT vaccine during pregnancy		
	One time	Two times	No use
Illiterate	20 8.2%	107 44%	116 47.8%
Literate	2 2.6%	29 37.7%	46 59.7%
Primary education	1 2.7%	27 73%	9 24.3%
Lower secondary education	0 0%	49 96.1%	2 3.9%
Secondary education	2 3.3%	58 95.1%	1 1.6%
Higher secondary education	0 0%	30 96.8%	1 3.2%
Total	25 5%	300 60%	175 35%

χ^2=47.49**, df**=10**, p**=.000

Table 4.9 shows that among illiterate Dalit and Janajati mothers, 8.2 percent reported to have taken TT vaccine once, 44 percent twice and rest of them (47.8%) not to have taken TT vaccine during pregnancy. Similarly, among the literate respondents, 2.6 percent reported to have taken TT once, 37.7 percent twice but 59.7 percent not to have taken TT vaccine. In the same way, among the respondents having primary education, 2.7 percent reported to have taken TT once, 73 percent twice whereas 24.3 percent not to have taken TT vaccine. Among the respondents having secondary education, 3.8 percent reported to have taken once, 95 percent twice and 1.6 percent not to have taken TT vaccine. Among those having higher secondary education, 96.8

percent reported to have taken twice but only 3.2 percent not to have taken TT vaccine during pregnancy.

The significance of association between educational status of Dalit and Janajati women and practice of having TT vaccine during pregnancy was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=47.49, which is not less than the table value 18.3, so the association between educational status and practice having TT vaccine during pregnancy is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational

status and practice of having TT vaccine is retained. It may be interpreted that the educated women more practice of TT vaccine during pregnancy than that of uneducated women.

4.2.9 Practice of Having of Iron Tablets and Vitamin 'A' Capsule during Pregnancy

Needless to say that iron prevents mother from health problems like anemia and malnutrition. Vitamin 'A' prevents pregnant women from night blindness and helps for the development of fetus.

Table 4.10: Practice of Having of Iron Tablets and Vitamin 'A' Capsule during Pregnancy

Caste/Ethinic group	Practice of having Iron Tablet and Vitamin 'A' Capsule during pregnancy		
	Regular	Irregular	No Use
Dalits	19 6.3%	165 55%	116 38.7%
Janajati	6 3%	135 67.5%	59 29.5%
Total	25 5%	300 60%	175 35%

Table 4.10 shows that out of total respondents, 5 percent received iron tablets and vitamin 'A' capsule regularly during pregnancy and 60 percent received irregularly whereas 35 percent never received the iron and capsule. Among Dalit respondents,

6.3 percent received iron tablets and vitamin 'A' capsule regularly during pregnant period, 55 percent received irregularly but 38.7 percent never received any tablets and

capsule. Regarding Janajati respondents, 3 percent received regular basis, 67.5 received on irregular basis but 29.5 percent never received any tablets and capsule during pregnancy.

The data concludes that Dalit respondents received iron tablets and vitamin 'A' capsule more regularly than the Janajati respondents did. It is because they did not have knowledge about importance of regular using iron tablets and vitamin 'A' capsules during pregnancy. Even they did not have awareness and had negligence about it.

H 1.3: The educational status of Dalit and Janajati women is significantly associated with the practice of having iron tablet and vitamin A capsules.

Table 4.11: Association between Educational Status and Practice of having Iron Tablet and Vitamin 'A' Capsule during Pregnancy

Respondents Educational Status.	Practice of having Iron Tablet and Vitamin 'A' Capsule during pregnancy		
	Regular	Irregular	No Use
Illiterate	20 8.2%	107 44%	116 47.8%
Literate	2 2.6%	29 37.7%	46 59.7%
Primary education	1 2.7%	27 73%	9 24.3%
Lower secondary education	0 0%	49 96.1%	2 3.9%
Secondary education	2 3.3%	58 95.1%	1 1.6%
Higher secondary education	0 0%	30 96.8%	1 3.2%
Total	25 5%	300 60%	175 35%

χ^2=47.49**, df**=10**, p**=.000

Table 4.11 indicates that among illiterate respondents, 8.2 percent were found to have taken iron tablet and Vitamin 'A' capsule regularly, 44 percent irregularly and rest of them (47.8%) not to have taken tablet and capsule. Among the literate respondents, 2.6 percent were found to have taken tablet and capsule regularly, 37.7 percent irregularly and 59.7 percent not to have taken at all. Among the respondents having primary education, 2.7 percent were found to have taken tablet and capsule regularly, 73 percent irregularly and 2.7 percent not to have taken at all. Among the respondents having secondary education, 3.3 percent were found to have taken tablet and capsule regularly whereas 95.1 percent irregularly. Among the respondents with higher secondary education, 96.8 percent were found to have taken irregularly but 3.2 percent not to have taken at all.

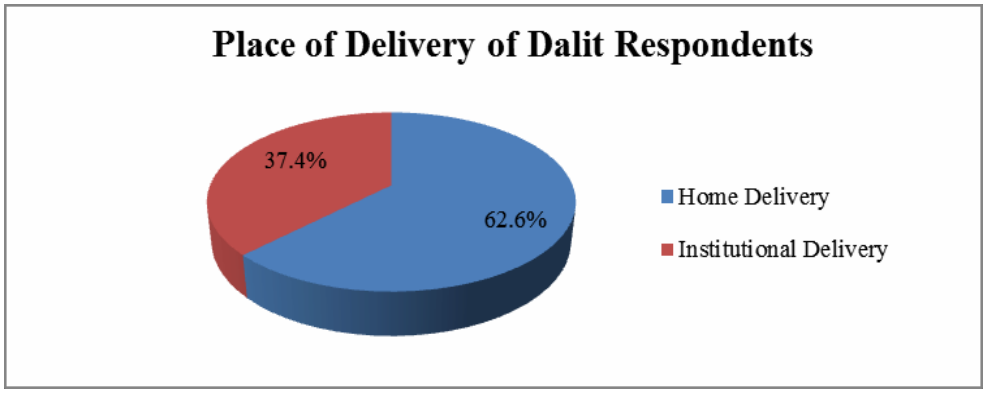
The significance of association between educational status of Dalit and Janajati women and practice of having Iron tablets and Vitamin 'A' capsule intake during pregnancy was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=47.49which is not less than the table value 18.31, so the association between educational status and practice having Iron tablets and Vitamin 'A' capsule intake during pregnancy is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and practice of having Iron tablets and Vitamin 'A' capsule intake during pregnancy is retained. It may be interpreted that the acceptance of Iron tablets and Vitamin 'A' capsule is positively associated with the educational status of Dalit and Janajati women i.e. educated women are expected to be more exposed to iron tablets and Vitamin 'A' capsule acceptance.

4.3 Delivery Service

The aim of providing safe delivery services are to protect the life and health of the mother and her child by ensuring the delivery of baby safely. This section includes the information on place of delivery, assistance during delivery, mode of delivery; feel after delivery and umbilical cord cutting instruments.

4.3.1 Place of Delivery

Place of delivery is a major component of safe motherhood practices. Many maternal and neonatal deaths occur due to lack of safe delivery place. Home/ maternal home is common place of delivery in Nepal**.**



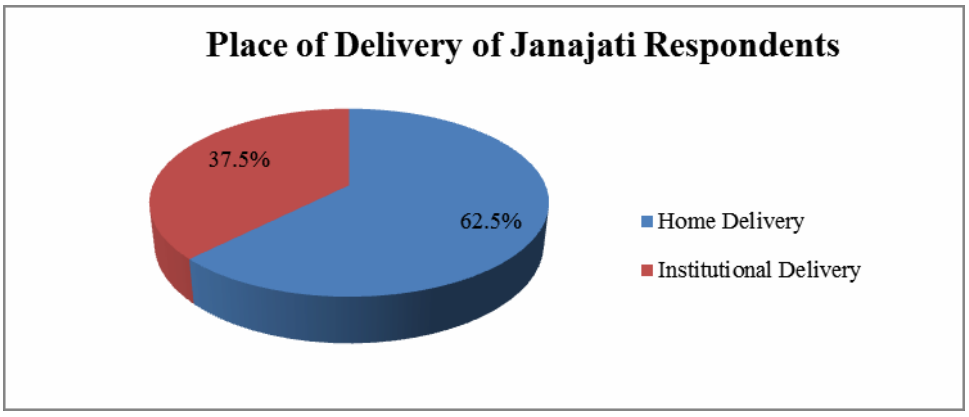


Figure 4.5 indicates that among Dalit respondents, 62.6 percent deliveries occurred at home and 37.4 percent deliveries at health institutions. Figure 4.6 shows that among Janajati respondents, 60.5 percent deliveries occurred at home but 37.5 percent deliveries at health institutions.

The data clarifies that the percentage of Dalits safe delivery at health institution was the same as that of Janajatis' safe delivery at health institutions. It further reveals that both Janajati and Dalits women gave more births to their babies at home than they did it at the health institutions. Among the Dalit and Janajati mothers who delivered at home, the reasons not going to health institutions for delivery were being alone with home, delivered on way, no time to go to health facility felt easy on home, facility not at the time of need etc. This means there was not safer for both mother and baby.

H 1.4: The educational status of Dalit and Janajati women is significantly associated with the practice of place of delivery.

Table 4.12: Association between Educational Status and Place of Delivery

Respondents Educational Status.	Place of delivery	
	Home Delivery	Health Institutional Delivery
Illiterate	179 83.1%	41 16.9%
Literate	62 80.5%	15 19.5%
Primary education	21 56.8%	16 43.2%
Lower secondary education	16 31.4%	35 68.6%
Secondary education	10 16.4%	51 83.6%
Higher secondary education	2 6.5%	29 93.5%
Total	313 62.6%	187 37.4%

χ^2=42.89**, df**=5**, p**=.000

Table 4.12 reveals that among the illiterate respondents, 83.1 percent delivered at home whereas 16.9 percent delivered at health institutions. Among the literate respondents, 80.5 percent delivered at home but 19.5 percent delivered at health institutions. Among the respondents having primary education 56.8 percent delivered at home and rest of them 43.2 percent delivered at health institutions. Among the respondents having lower secondary education, 31.4 percent delivered at home but 68.6 percent delivered at health institutions. Among the respondents having secondary education, 16.4 percent delivered at home and 83.6 percent delivered at health institutions. Among the respondents having higher secondary education, 6.5 percent delivered at home and 93.5 percent delivered at health institutions.

The significance of association between educational status and place of delivery was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=42.89, which is not less than the table value 11.07, so the association between educational status and place of delivery is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and place of delivery is accepted. It may be said that the preference of respondents making delivery at home was higher among illiterate group. Regarding the literate, frequency of delivery at health institution was higher among the mother who had secondary or higher secondary education.

The information also provides some reasons for not obtaining health facilities for delivery services. Some verbatim of the mothers are quoted below which shows that the mothers think delivery is a normal process and do not know that every pregnancy may face higher risk. They went to health institution for check up when they face complications.

A **25-year-old uneducated Janajati mother** who delivered at home shared, *"If delivery takes place normally at home, it is the easiest place for delivery. If any complication and difficulties arise then only hospital is preferred."* It firstly shows that uneducated women generally delivered their babies at home. Secondly, they were found to go to hospital only after some serious problems occurred in delivering babies.

A **27-year-old educated Dalit mother** of a child expressed, *"we were on the way to hospital but there the delivery occurred before we reach the hospital. So we returned home from there."* Firstly, it was found that educated mothers tended to go to hospital for delivery of the baby. Secondly, it was found that they were not much serious about the urgency of time.

Now, on the basis of above cited two different views of respondents, it is concluded that there was notable difference between the educated and uneducated mother's for safe motherhood practices in the sense of delivery care. Hence, it is furthermore proven that higher the education status is better the safe motherhood practices and it's vice versa.

4.3.2. Mode of Delivery

Mostly the women deliver their babies normally. Very rare cases of prolong and operation delivery occur.

Table 4.13: Mode of Delivery

Caste/Ethinic group	Mode of delivery		
	Normal delivery	Operation	Prolong delivery
Dalits	283 94.3%	13 4.3%	4 1.3%
Janajati	198 99%	2 1%	0 0%
Total	481 96.2%	15 3%	4 0.8%

Table 4.13 shows that among total respondents, 96.2 percent were found to have normal delivery, 3 percent operation (cesarean section) whereas 0.8 percent underwent prolonged labour. Among Dalit respondents, 94.3 percent were found to have normal delivery, 4.3 percent operation and 1.3 percent prolonged labor. Regarding Janajati respondents, 99 percent were found to have normal delivery and only 1 percent operation during delivery period. More interestingly, no Janajati respondents underwent prolonged labor during delivery period.

The data reveals that majority of the respondents had normal delivery and very less percentage had cesarean section (operation) at delivery period. The result obtained concludes that mode of delivery between Dalit and Janajati were satisfactory.

4.3.3 Assistance during Delivery

Assistant by skilled health personnel during delivery is considered to be effective in the reduction of maternal and neonatal mortality. Births delivered at home is usually more likely to be delivered without assistance from a health personnel, whereas birth delivered at health facilities are more likely to be delivery by health professional.

Table 4.14: Assistance during Delivery

Caste/Ethinic group	Assistance during delivery			
	Doctor	Nurse	FCHV	Family member
Dalits	16 5.3%	92 30.7%	2 0.7%	190 63.3%
Janajati	26 13%	52 26%	3 1.5%	119 59.5%
Total	42 8.4%	144 28.8%	5 1%	309 61.8%

Table 4.14 indicates that among total respondents, 61.8 percent deliveries were assisted by family members. In the same way, one percent assisted by FCHVs 28.8 percent were assisted by nurses and only 8.8 percent assisted by doctors.

In the study area delivery assisted by family members was more common among Dalit and Janajati respondents due to traditional and cultural values. Safe delivery practice in mother reduces delivery complications and save the mother as well as baby health. As a result, high maternal and mortality ratio might have occurred during that period.

H 1.5: The educational status of Dalit and Janajati women is significantly associated with the practice of assistance during delivery.

Table 4.15: Relationship between Educational Status and Assistance during Delivery

Respondents Educational Status.	Assistance during delivery			
	Doctor	Nurse	FCHV	Family member
Illiterate	5 2.1%	36 14.8%	1 0.4%	201 82.7%
Literate	5 6.5%	11 14.3%	1 1.3%	60 77.9%
Primary education	1 2.7%	15 40.5%	1 2.7%	20 54.1%
Lower secondary education	6 11.8%	29 56.9%	1 2%	15 29.3%
Secondary education	14 23%	36 59%	1 1.6%	10 16.4%
Higher secondary education	11 35.5%	17 54.8%	0 0%	3 9.7%
Total	42 8.4%	144 28.8%	5 1%	309 61.8%

χ^2=87.46**, df**=15**, p**=.001

Table 4.15 indicates that among the illiterate respondents, 2.1 percent deliveries were assisted by doctors, 14.8 percent assisted nurses, 0.4 percent assisted by FCHVs and 82.7 percent assisted by family members during delivery period. Among the literate respondents, 6.5 percent assisted by doctors, 14.3 percent assisted by nurses, 1.3 percent assisted by FCHVs and 77.9 percent delivers were assisted by family members. Among the respondents having primary education, 2.7 percent assisted by doctors, 40.7 percent assisted by nurses, 2.7 percent assisted by FCHVs and 54.1 percent deliveries assisted by family member. Among the respondents having lower

secondary, 11.8 percent were assisted by doctors, 56.9 percent assisted by nurses, 2 percent assisted by FCHVs and 29.4 percent deliveries were assisted by family members. Among the respondents having secondary education, 23 percent assisted by doctors, 59 percent assisted by nurses, 1.6 percent assisted by FCHVs and 16.4 percent deliveries were assisted by family members. Among the respondents having higher secondary education, 35.5 percent were assisted by doctors, 54.8 percent assisted by nurses and 9.7 percent deliveries were assisted by family members during delivery period.

The significance of association between educational status and assistance during delivery was tested statistically by applying Chi-square test The computed Chi-square value is χ^2=87.46 which is not less than the table value 24.99, so the association between educational status and assistance during delivery is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and assistance during delivery is retained. It may be said that the

assistance during delivery is varies on educational status of the respondents.

4.3.4 Feeling after Delivery

After having delivered her baby, the mother feels happy, painful, sad, weak or normal. Generally, most women feel happy and satisfied right after they have delivered their babies.

Table 4.16: Feeling after Delivery

Caste/Ethinic group	Feeling after delivery				
	Happy feel	Pain feel	Sad feel	Weak feel	Normal feel
Dalits	87 29%	141 47%	2 0.7%	17 5.7%	53 17.7%
Janajati	40 20%	82 41%	0 0%	4 2%	74 37%
Total	127 25.4%	223 44.6%	2 0.4%	21 4.2%	127 25.4%

Table 4.16 presents that out of total respondents, 44.6 percent reported to have felt pain but 25.4 percent felt happy and normal. Similarly, 4.2 percent felt weak and only 4 percent felt sad after delivery. Among Dalit respondents, 47 percent reported to

have felt pain, 29 percent felt happy, 17.7 percent felt normal, 5.7 percent felt weak and 0.7 percent felt sad. Regarding Janajati respondents, 41 percent reported to have felt pain, 20 percent felt happy, 37 percent felt normal and only 2 percent felt sad.

It is found that a higher percentage of Dalit respondents felt pain immediately after delivery than that of Janajati respondents.

4.3.5 Umbilical Cord Cutting Instrument

After the baby comes out of the womb, it needs to be separated from the mother. In this process, the umbilical cord should be cut with sterile blade/instrument. If instruction is unsafe, there may appear the chances of neonatal tetanus that is the main cause of neonatal death.

Table 4.17: Umbilical Cord Cutting Instrument

Caste/Ethinic group	Umbilical cord cutting instrument		
	Sickle/ knife	Blade	Sterile blade
Dalits	93 31%	92 30.7%	115 38.3%
Janajati	38 19%	78 39%	84 42%
Total	131 26.2%	170 34%	199 39.8%

Table 4.17 reveals that out of the total respondents, 26.2 percent mother cut their baby's umbilical cord with sickle/ knife. In the same way, 34 percent of mother cut their baby's umbilical cord with blade. Similarly, 39.8 percent of mother cut their baby's umbilical cord and with sterile blade.

It clearly shows that majority of Dalits and Janajatis were unaware of sterilized instruments for a safe cutting of umbilical cord. Thus, it is estimated that the study area had a higher chance of neonatal tetanus and other kinds of infection.

H 1.6: The educational status of Dalit and Janajati women is significantly associated with the practice of umbilical cord cutting instrument.

Table 4.18: Association between Educational Status and Practice of Umbilical Cord Cutting Instrument

Respondents Educational Status.	Umbilical cord cutting instrument		
	Sickle/ knife	Blade	Sterile blade
Illiterate	72 29.6%	125 51.4%	46 18.9%
Literate	37 48.1%	22 28.6%	18 23.4%
Primary education	12 32.4%	6 16.2%	19 51.4%
Lower secondary education	7 13.7%	8 15.7%	36 70.6%
Secondary education	3 4.9%	7 11.5%	51 83.6%
Higher secondary education	3 4.9%	7 11.5%	51 83.6%
Total	131 26.2%	170 34%	199 39.8%

$\chi^2$81.38**, df=**10**, p=**.369

Table 4.18 illustrates that among the illiterate respondents, 29.6 percent mother cut their babies' umbilical cord with sickle / knife, 51.4 percent cut their baby's cord with blade and 18.9 percent cut their baby's cord with sterile blade. Among the literate respondents, 48.1 percent cut their baby's' umbilical cord with sickle/knife, 28.6 percent cut their baby's cord with blade and 23.4 percent cut their baby's cord with sterile blade. Among the respondents having primary education, 32.4 percent cut their baby's umbilical cord with sickle/knife, 16.2 percent cut their baby's cord with blade and 51.4 percent cut their baby's cord with sterile blade. Among the respondents having secondary and higher secondary education, 4.9 percent cut their baby's

umbilical cord with sickle/knife, 11.5 percent cut their baby's cord with blade and 83.6 percent cut their baby's cord with sterile blade.

The significance of association between educational status of Dalit and Janajati women and umbilical cord cutting instrument was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=81.38which is not less than the table value 18.31, so the association between educational status and umbilical cord cutting instrument is not significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and umbilical cord cutting instrument is rejected. It may be interpreted that educational status of Dalit and Janajati women do not have significant association with the practice of umbilical cord cutting instrument. It seems that they are not so much aware regarding the instrument used for cutting umbilical cord and still they follow traditions using these instruments are still playing significant role at their home.

4.3.6 Frequency of Clean Privacy Part after Delivery

From the point of view of health, it is better to clean the injured privacy part after delivery applying antiseptic solution. If possible, it is recommended that the privacy part should be cleaned at least once a day using the antiseptic solution.

Table 4.19: Frequency of Clean Privacy Part after Delivery

Caste/Ethinic group	Frequency of clean privacy part after delivery			
	Daily	Alternate day	Twice a week	Once a week
Dalits	98 32.7%	106 35.3%	88 29.3%	8 2.7%
Janajati	31 15.5%	90 45%	67 33.5%	12 6%
Total	129 25.8%	196 39.2%	155 31%	20 4%

Table 4.19 shows that out of total respondents, 25.8 percent mothers were found to clean privacy part daily, 39.2 percent on every alternate day, 31 percent twice a week and only 4 percent once a week after delivery. Among Dalit respondents, 32.7 percent were found to clean daily, 35.3 percent on every alternate day, 29.3 percent twice a

week and 2.7 percent once a week. Regarding Janajati respondents, 15.5 percent were found to clean the privacy part daily, 45 percent on every alternate day, 33.5 percent twice a week and 6 percent once a week after delivery.

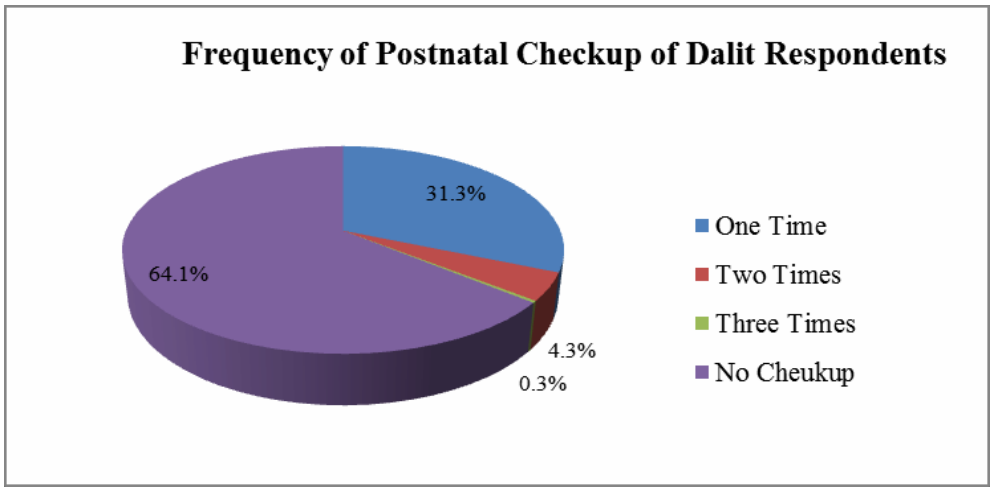
The data reveals that more Dalit respondents were found to clean privacy part daily after delivery as compared to Janajati respondents. The result shows that Janajati women did not have the appropriate knowledge of personal hygiene after delivery.

4.4 Postnatal Care

The aim of the postnatal care is to ensure the physical and psychological well being of mother and the new born baby in the first six weeks after delivery. Postnatal care indicates all the health services after delivery for the care of mother and newly born baby. In the context of Nepal the three-time post-natal check up is not practically maintained. In the study area, it is further discovered that the frequency of postnatal checkup is lower than national average. Under postnatal care: frequency of postnatal checkup, problems faced during postnatal period, type of work, frequency of meal and clean of baby after birth are included.

4.4.1 Frequency of Postnatal Checkup

All mothers and family member must know about postnatal check up during postnatal period. After delivery both mother and infant, need to be checked by health professionals to maintain their health status. Postnatal mother should receive at least three postnatal checkups; the first being within 24 hours of delivery, second visit on the third day following delivery and the third being on the seventh day after delivery (DoHS, 2010).



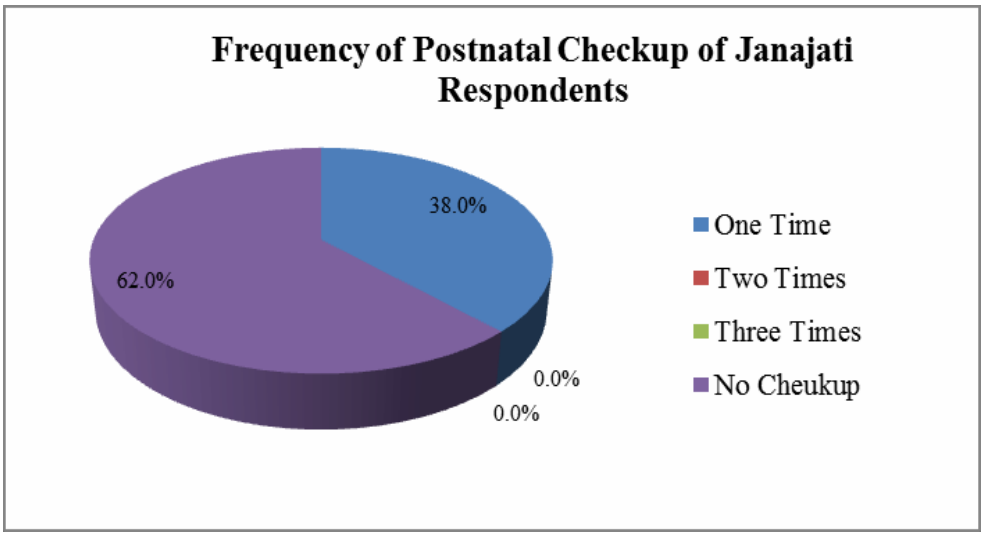


Figure 4.7 presents that among Dalit respondents, 31.3 percent had checked once, 4.3 percent two twice, only 0.3 percent thrice whereas a higher 64.1 percent had no postnatal check up during post-natal period.

Figure 4.8 shows that among Janajati respondents, 38 percent had checked once and 62 percent had no postnatal check up during post-natal period.

Post-natal checkup is less frequently conducted practice in the present context of Nepal. It is concluded that the respondents' postnatal check up is less frequent and irregular than the national level check up status. In comparing Dalit and Janajati respondents, Janajati had their postnatal check up conducted more frequently than that

of Dalits. The result shows that most of Dalit respondent did not obtained postnatal visit because of low importance for postnatal check up and unawareness of postnatal checkup visit.

H 1.7: The educational status of Dalit and Janajati women is significantly associated with the practice of postnatal check up

Table 4.20: Association between Education Status and Frequency of Postnatal Check Up

Respondents Educational Status.	Frequency of Postnatal Check Up			
	one time	Two times	Three times	No check up
Illiterate	36 14.8%	1 0.4%	1 0.4%	205 84.4%
Literate	14 18.2%	3 3.9%	0 0%	60 77.9%
Primary education	14 37.8%	2 5.4%	0 0%	21 56.8%
Lower secondary education	31 60.8%	2 3.9%	0 0%	18 35.3%
Secondary education	48 78.7%	4 6.6%	0 0%	9 14.8%
Higher secondary education	27 87.1%	1 3.2%	0 0%	3 9.7%
Total	170 34%	13 2.6%	1 0.2%	316 63.2%

χ^2=78.73**, df**=15**, p=.**001

Table 4.20 shows that among the illiterate respondents, 14.8 percent reported to have gone for check up only once, 0.4 percent two times and the same 0.4 percent three times whereas the highest 84.4 percent attended no postnatal check up. Among the literate respondents, 18.2 percent reported to have gone for check up only one, 3.9 percent two times, whereas 0 percent was found to have had attended three times but the highest 77.9 percent have not attended any checkup. Among the respondents

having primary education, 37.8 percent reported to have gone for check up only once, 5.4 percent two times, 0 percent was found to have had attended three times and 56.8 percent attended no checkup. Among the respondents having secondary education, 58.7 percent reported to have gone for check up only one, 6.6 percent two times, remaining (14.8%) attended no checkups. Among the respondents having higher secondary education, 87.1 percent reported to have gone for check up only one, 3.2 two times but 9.7 percent attended no checkup during postnatal period.

The significance of association between educational status of Dalit and Janajati women and frequency of postnatal check up was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=78.73which is not less than the table value 24.99, so the association between educational status and frequency of postnatal check up is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and frequency of postnatal check up is accepted. It may be said that the higher secondary educational status of the respondents had more frequent postnatal check up visit they attended during postnatal period than that of uneducated women.

Interview held with one uneducated Janajati mother and educated Dalit mother regarding postnatal checkup has been presented here:

A **25-year-old educated Janajati mother** who delivered at home shared, *"If the baby is safely delivered, then why do we need a checkup? if any health problem arises then only it is necessary to go hospital for checkup."* Hence, the view of women towards postnatal care can be grouped around two themes. The first view is that postnatal period is relatively safe in comparison to pregnancy and delivery period and home care is sufficient. The second view is that postnatal checkup is only required if there is serious health problem. These views towards postnatal care play vital role in availing of postnatal care by mothers.

A **20-year-old uneducated Dalit mother** of a child who delivered at home probed into the health problem, *"I delivered at home and I didn't go for checkup as there was no any serious health problem that. The only problem I faced was a continual bleeding for about a month and I had to change pad many times in a day but it was normal during postnatal period. Nobody told me about postnatal checkup either."* It firstly indicates that uneducated women did not know anything about postnatal

checkup and they did not go for checkup. Secondly, it signifies that even the educated women did not go for postnatal checkup unless the serious problems arise.

Analyzing the two views of respondents, it may be said that safe motherhood practice in the sense of postnatal care of educated mothers more postnatal checkup than that of uneducated mothers.

4.4.2 Problem Faced during Postnatal Period

A study on maternal mortality and morbidity, done in 1998 in Nepal by the family health division, department of health service showed that the majority of maternal deaths are due to postnatal complication which are preventable (MoH, 2003). Postnatal care is one of the critical stages of maternal and child health in postnatal period when women may develop serious complication after delivery that might threaten their life. Evidence has shown that a large proportion of maternal deaths occur during this period, with postpartum hemorrhage being an important cause.

Table 4.21: Problem Faced during Postnatal Period

Caste/Ethinic group	Problem faced during postnatal period			
	Heavy bleeding	Lower abdominal pain	Weakness and shivering	No problem
Dalits	1 0.3%	69 23%	54 18%	176 58.7%
Janajati	0 0%	6 3%	24 12%	170 85%
Total	1 0.2%	75 15%	78 15.6%	346 69.2%

Table 4.21 shows that among the total respondents, 0.2 percent faced heavy bleeding, 15 percent lower abdominal pain, 15.6 percent weakness and shivering, 69.2 percent weakness and shivering, but 69.2 percent faced no problem during postnatal period.

The data reveals that Dalit respondents faced more problems than that of the Janajati respondents during postnatal period. The main reasons behind that was general and hard working during pregnancy, lack of additional food in delivery and unawareness about safe motherhood.

4.4.3 Types of Work during Post-natal Period

A post-natal mother needs more rest than normal women. After delivery mother need complete rest for at least 3 weeks for her physical fitness. Most essentially, simple warming up exercise is need for health maintenance. Light work below three hours a day is normal and is also required but if work is more, and then it becomes vulnerable.

Table 4.22: Types of Work during Post-natal Period

Caste/Ethinic group	Type of work during postnatal period		
	Light	General	Hard
Dalits	132 44%	165 55%	3 1%
Janajati	86 43%	114 57%	0 0%
Total	218 43.6%	279 55.8%	3 0.6%

Table 4.22 indicates that among total respondents, 43.6 percent reported that they undertook light work, 55.8 percent general work but only 0.6 percent worked hard during postnatal period. Among Dalit respondents, 44 percent reported that they undertook light work, 55 percent general work and only 1 percent hard work. In case of Janajati respondents, 43 percent reported that they undertook light work and 57 percent general work during postnatal period.

In the study area, it is found that Dalit respondents handled lighter work than the Janajati respondents did. It is because Janajati respondents had lack of awareness about the light type of work during postnatal period. Even they thought that they could perform light work after 21 days of delivery and they did not know the demerits.

H 1.8: The educational status of Dalit and Janajati women is significantly associated with the practice of work during postnatal period

Table 4.23: Association between Educational Status and Type of Work during Postnatal Period

Respondents Educational Status.	Type of work during postnatal period		
	Light	General	Hard
Illiterate	70 28.8%	171 70.4%	2 0.8%
Literate	38 49.4%	39 50.6%	0 0%
Primary education	16 43.2%	21 56.8%	0 0%
Lower secondary education	33 64.7%	18 35.3%	0 0%
Secondary education	42 68.9%	18 29.5%	1 1.6%
Higher secondary education	19 61.3%	12 38.7%	0 0%
Total	218 43.6%	279 55.8%	3 0.6%

χ^2=54.26**, df**=10**, p=.**000

Table 4.23 shows that among total illiterate respondents, 28.8 percent undertook light work, 70.4 percent general work but only 0.8 percent worked hard during postnatal period. Among the literate respondent, 49.4 percent they undertook light work and 50.6 percent had general work during postnatal period. Among the respondent having lower secondary education, 64.7 percent undertook light work and 35.3 percent had general work during postnatal period. Among the respondents having secondary education, 68.9 percent undertook light work; 29.5 percent undertook general work and only 1.6 percent worked hard during post-natal period. Among the respondents

having higher secondary education, 61.3 percent undertook light work and 38.7 percent had general work during postnatal period.

The significance of association between educational status of Dalit and Janajati women and type of work during postnatal period was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=54.26 which is not less than the table value 18.31, so the association between educational status and type of work during postnatal period is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and type of work during postnatal period is retained. It may be interpreted that the type of work during postnatal period is varies on educational status. The higher secondary educational status level of the respondents had more light work they undertook during postnatal period.

4.4.4 Frequency of Food Intake during Postnatal Period

A woman needs nutritious food more frequently after delivery for lactating milk. An infant fully depends on breast feeding for a normal survival. So, nutritious food and higher frequency of meal for the postnatal mother is highly recommended.

Table 4.24: Frequency of Food Intake during Postnatal Period

Caste/Ethinic group	Frequency of Food Intake		
	At least two times	Three times	Four times
Dalits	117 39%	172 57.3%	11 3.7%
Janajati	28 14%	169 84.5%	3 1.5%
Total	145 29%	341 68.2%	14 2.8%

Table 4.24 shows that among total respondents, 29 percent received food at least two times per day, 68.2 percent three times and only 28 percent four times per day during postnatal period. Among Dalit respondents, 39 percent received food at least two times per day, 57.3 percent three times per day and only 3.7 percent four times per day during post-natal period. Regarding Janajati respondents, 14 percent received

food at least two times per day, 84.5 percent three times whereas only 1.5 percent received food four times per day.

The data reveals that Dalit respondents had less frequent food intake than Janajati respondents did, because of lack of importance of food intake at regular interval during postnatal period.

4.4.5 Clean of Baby after Birth

After the baby is born, first of all it should be cleaned using safe method particularly through mop-up with clean cloth. It is further suggested that the newly born infant be bathed only after 24 hours of birth.

Table 4.25: Clean of Baby after Birth

Caste/Ethinic group	Clean of baby after birth			
	Wash with Luke warm water	Wash with water	Mop of with cloth	Mop with clean cloth
Dalits	165 55%	10 3.3%	11 3.7%	114 38%
Janajati	65 32.5%	30 15%	22 11%	83 41.5%
Total	230 46%	40 8%	33 6.6%	197 39.4%

Table 4.25 presents that out of total respondents, 39.4 percent reported to have cleaned their baby with a mop of clean cloth. Among them 38 percent Dalits and 41.5 percent Janajatis reported to have cleaned the baby mop of clean cloth. Similarly, 46 percent mothers reported to have cleaned their baby with Luke warm water. Among them 55 percent, Dalits and 32.5 percent Janajatis reported to have cleaned the baby with lukewarm water. In the same way, 8 percent mothers reported to have cleaned their baby with only water whereas 3.7 percent Dalits and 15 percent Janajatis reported to have cleaned their baby with water. Likewise, 6.6 percent mothers reported to have cleaned their baby mop of cloth whereas 3.3 percent Dalits and 11 percent Janajatis reported to have cleaned the baby I mop of cloth after birth.

It also shows that more Janajati respondents cleaned their baby mop of clean cloth than Dalit did. This further reveals the fact that majority of the respondents had wrong cleaning practices after baby birth. On the basis of above data Janajati were more educated and aware than Dalits, so Dalits had unscientific baby cleaning practice after birth.

4.4.6 Colostrums Feeding Practice

In postnatal care, first milk is essential for the child as a nutritious food because it has colostrums. It is also baby's first immunization. Breast feeding should be initiated soon after delivery ideally within thirty to sixty minutes after giving birth to the child. The yellow thick milk called colostrums should be fed to the baby. Colostrums consist of antibodies and other substances which protect the body against diseases. It carries immunity power against diseases and it has high nutritive value to the infant. Breast feeding (BF) practice is on the rise and in most countries. A relatively small percentage of mothers practice option breast feeding behavior that reduce infants' risk of morbidity and mortality, including initiation of BF in the first hour after birth and exclusive breastfeeding for the first six months of life (Aryal, 2005).

Table 4.26: Colostrums Feeding Practice

Caste/Ethinic group	Colostrums feeding practice			
	Threw out	I fed after throwing first	I fed	I didn't care
Dalits	156 52%	93 31%	42 14%	9 3%
Janajati	71 35.5%	108 54%	14 7%	7 3.5%
Total	71 35.5%	108 54%	14 7%	7 3.5%

Table 4.26 presents that out of total respondent, 35.5 percent threw out colostrums, 54 percent fed after throwing first, 7 percent fed and 3.5 percent didn't care for feeding colostrums to newly born baby. Among Dalit respondents, 52 percent threw out colostrums, 31 percent fed after throwing first, 14 percent fed and 7 percent didn't care for feeding colostrums. Regarding Janajati respondents, 35.5 percent threw out

colostrums, 54 percent fed after throwing first, 7 percent fed and 3.5 percent didn't care for feeding colostrums. Among Dalit respondents, only 7 percent fed colostrums whereas 7 percent of Janajati respondents fed colostrums.

It is found that large number of Dalits conducts colostrums feeding practice as compared to Janajati respondents. Most of the respondents did not fed colostrums due to lack of awareness and its value from the scientific and health point of view with traditional culture.

H 1.9: The educational status of Dalit and Janajati women is significantly associated with the practice of colostrums feeding

Table 4.27: Association between Educational Status and Colostrums Feeding Practice

Respondents Educational Status.	Colostrums feeding practice			
	Threw out	I fed after throwing first	I fed	I didn't care
Illiterate	137 56.4%	70 28.8%	34 14%	2 0.8%
Literate	38 49.3%	21 27.3%	14 18.2%	4 5.2%
Primary education	12 32.4%	7 18.9%	16 43.2%	2 5.5%
Lower secondary education	14 27,5%	12 23.5%	25 49%	0 0%
Secondary education	4 6.6%	9 14.8%	47 77%	1 1.6%
Higher secondary education	0 0%	2 6.5%	29 93.5	0 0%
Total	205 41%	121 24.2%	165 33%	9 1.8%

χ^2=75.34**, df**=15**, p=.**000

Table 4.27 shows that among illiterate respondents, 56.4 percent threw out colostrums, 28.8 percent fed after throwing first, 14 percent fed and 0.8 percent didn't

care for feeding colostrums. Among the respondents having primary education, 32.4 percent threw out colostrums, 18.9 percent fed after throwing first, 43.2 percent fed and 5.4 percent didn't care for feeding colostrums. Among the respondents having secondary education, 6.6 percent threw out colostrums, 14.8 percent fed after throwing first, 77 percent fed and 1.6 percent didn't care for feeding colostrums. Among the respondents having secondary education, no one threw out and didn't care for feeding colostrums, 6.5 percent fed after throwing first and 93.5 percent fed colostrums.

The significance of association between educational status of Dalit and Janajati women and practice of colostrums feeding was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=75.34 which is not less than the table value 24.99, so the association between educational status and practice of colostrums feeding is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status and practice of colostrums

feeding is accepted. It may be said that colostrums feeding practice was higher among literate mothers as compared to illiterate ones. Educational status plays significant role in using the colostrums feeding practices of Dalit and Janajati mothers.

4.4.7 Family Planning Practices

Family planning (FP) is an important aspects of reproductive health. It helps to reduce maternal mortality and improving women's reproductive health, prevent unwanted and high risk pregnancies, reduce the need for unsafe abortion and space the birth.

Table 4.28: Family Planning Practices

Caste/Ethinic group	FP practices		
	Pills	Depo	No use
Dalits	49 16.3%	105 35%	146 48.7%
Janajati	39 19.5%	59 29.5%	102 51%
Total	88 17.6%	164 32.8%	248 49.6%

Table 4.28 reveals that among total respondents, 49.6 percent did not use any method of family planning. Among Dalit respondents, 16.3 percent were reported to have used pills, 36 percent Depo and 48.7 percent were reported to have not used any method of family planning. Regarding Janajati respondents, 19.5 percent were reported to have used pills, 29.5 percent Depo and 51 percent were reported to have not used any method of family planning.

The data shows that Janajati respondents used less family planning devices than that of the Dalit respondents. This further reveals the fact that family planning practices in study community was very poor and weak. Males were responsible for family planning and females were recurrent to use long time temporary methods.

4.4.8 Facilities Provided by Aama Program

The government of Nepal has launched of Aama program to provide an attractive incentive for those who utilize safe motherhood services. Aama program has four components: a. incentives to women on institutional delivery, b. free institutional delivery, c. Incentive to women for four ANC visits and d. Incentives to health worker for home deliveries. Its primary goal is to reduce maternal and neonatal mortality.

Table 4.29: Facilities Provided by Aama Program

Caste/Ethinic group	Facilities provided by Amma program			
	Free delivery service	Incentive for ANC Visit	Free delivery with cash payment	I Don't know
Dalits	11 3.7%	8 2.7%	70 23.3%	211 70.7%
Janajati	0 0%	6 3%	55 27.5%	139 69.5%
Total	11 2.2%	14 2.8%	125 25%	350 70%

Table 4.29 indicates that out of total respondents, 2.2 percent received free delivery service, 2.8 percent incentive for ANC visit, 25 percent free delivery with cash payments and 70 percent received no facilities provided by Aama program. Among

Dalit respondents, 3.7 percent have been received free delivery service, 2.7 percent incentive for ANC visit, and 23.3 percent received no facilities by Aama program. Regarding Janajati respondents, 0 percent was found to have received free delivery service, 3 percent incentive for ANC visit, 27.5 percent free delivery with cash payments and 69.5 percent received no facilities by Aama program.

The study presents the fact that a higher number of Dalits women received the facilities provided by the Aama program in comparison to the number of Janajati women. Based on the results, it is recommended that the mother who came on antenatal check up should be provided with adequate information about availability of safe delivery incentive and free health services facilities provided by Aama program.

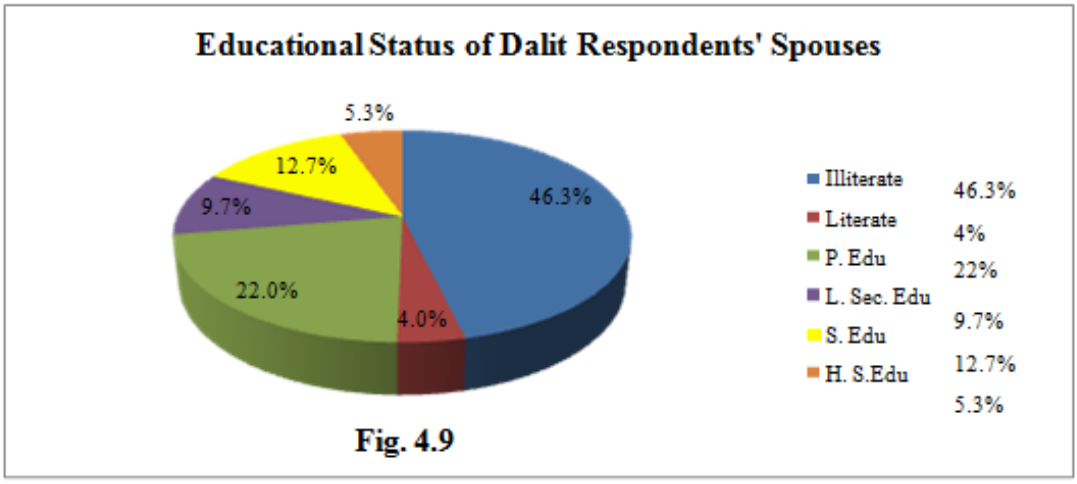


Fig. 4.9

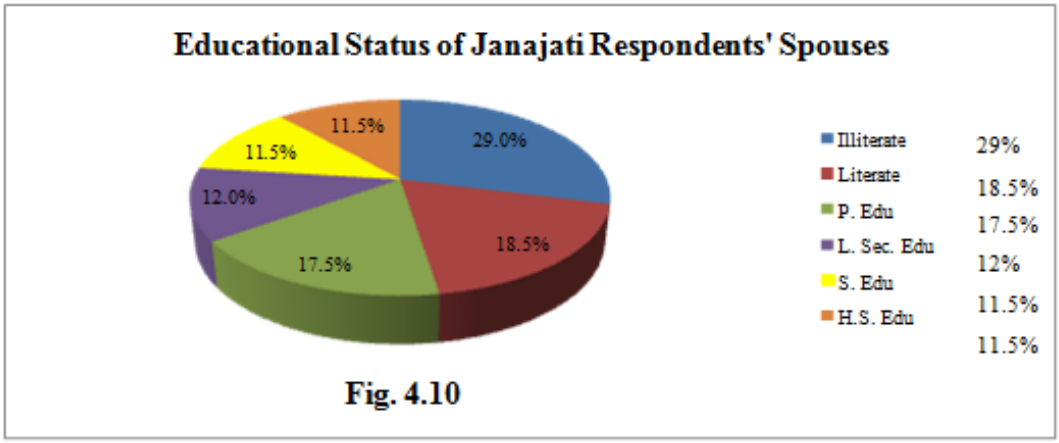


Fig. 4.10

Figure 4.9 shows that out of total Dalit respondents' spouses, 46.3 percent were illiterate,4 percent were literate whereas 22 percent were of primary education, 9.7

percent of lower secondary, 12.7 percent of secondary and 5.3 percent only of higher secondary education. On the other hand, figure 4.10 shows that out of total Janajati respondents' spouses, 29 percent were illiterate, 18.5 percent were literate whereas 17.5 percent were of primary education, 12 percent of lower secondary, 11.5 percent of secondary and 11.5 percent only of higher secondary education.

The data indicates that there was lower educational status of spouses than national level of literacy status. Thus, the studies reveal that the Dalits spouses were more illiterate than Janajati spouses.

H 1.10: The educational status of Dalit and Janajati women' spouse is significantly associated with the practice of ANC visit

Table 4.30: Association between Educational Status of Respondents Spouses and Frequency of ANC Visit

Spouses Educational status	Frequency of ANC				
	one time	Two times	Three times	Four time	No check up
Illiterate	15 7.6%	42 21.3%	52 26.4%	20 10.2%	68 34.5%
Literate	0 0%	0 0%	4 8.2%	10 20.4%	35 %71.4
Primary	1 1%	12 11.9%	21 20.8%	29 28.7%	38 37.6%
Lower Secondary	0 0%	4 7.5%	10 18.9%	34 64.2%	5 9.4
Secondary	1 1.6%	0 0%	10 16.4%	44 72.1%	6 9.8%
Higher Secondary	0 0%	1 2.6%	4 10.3%	33 84.6%	1 2.6%
Total	17 3.4%	59 11.8%	101 20.2%	170 34%	153 30.6%

χ^2=90.54**, df**=20**, p**=.000

Table 4.30 shows that among the illiterate respondents of spouses, 7.6 percent wives had ANC visit once, 21.3 percent twice, 26.4 percent thrice, 10.2 percent visited four

times but 34.5 percent had no ANC visit during pregnancy. Among the respondents of spouses having primary education, 1percent had ANC visit once, 11.9 percent twice ,20.8 percent thrice, 28.7 percent four times but 37.6 percent did not have ANC visit during pregnancy. Among the respondents of spouses having secondary education, 1.6 percent had ANC visit once, 0 percent had twice, 16.4 percent thrice, 72.1 percent four times and 9.4 percent had no ANC visit at all. Regarding the respondents of spouses having higher secondary education, 0 percent ANC visits once, 2.6 percent twice, 10.3 percent thrice whereas 84.6 percent had four times during pregnancy period.

The significance of association between spouse's educational status and frequency of ANC visit was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=90.54 which is not less than the tale value 31.41, so the association between spouses educational status and frequency of ANC visit is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between spouses' educational status and frequency of ANC visit is retained. It may be interpreted that educated spouses' responsibility have more ANC visit than that of uneducated spouses' respondents.

H 1.11: The educational status of Dalit and Janajati women's spouse is significantly associated with the practice of place of delivery

Table 4.31: Association between Educational Status of Respondents' Spouses and Place of delivery

Respondents' Spouses Educational Status.	Place of delivery	
	Home Delivery	Health Institutional Delivery
Illiterate	162 82.2%	35 17.8.%
Literate	40 81.6	9 18.4%
Primary education	70 69.3%	31 30.7%
Lower secondary education	18 34.%	35 66%
Secondary education	15 24.4%	46 75.4%
Higher secondary education	8 20.6%	31 79.4%
Total	313 62.6%	187 37.4%

χ^2=83.90**, df**=5**, p**=.000

Table 4.31 reveals that among the illiterate respondents' spouses, 82.2 percent women delivered birth at home whereas 17.8 percent delivered at health institutions. Among the literate respondents of spouses, 81.6 percent women delivered birth at home and 17.8 percent delivered at health institutions. Among the respondents of spouses having primary education, 69.3 percent women delivered birth at home and 30.7 percent delivered at health institutions. Among the respondents of spouses having secondary education, 24.6 percent women delivered birth at home and 75.4 percent delivered at health institutions. Among the respondents of spouses having higher secondary education, 20.6 percent delivered at home whereas 79.4 percent women delivered birth at health institutions.

The significance of association between educational status of respondents' spouses and place of delivery was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=83.90which is not less than the table value 11.07, so the association between educational status of respondents' spouses and place of delivery is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status respondents' spouses and place of

delivery is retained. It may be interpreted that the higher secondary educational level of the respondents' spouses education more frequent ANC visit during pregnancy than that of uneducated spouses. In Nepal study shows that spouse has a significant role in deciding place of delivery during delivery period (DoHS, 2009).

H 1.12: The educational status of Dalit and Janajati women's spouse is significantly associated with the practice of postnatal check up

Table 4.32:Association between Educational Status of Respondents' Spouses and Frequency of Postnatal Checkup

Spouses Educational Status	Frequency of Postnatal Checkup			
	one time	Two times	Three times	No check up
Illiterate	32 16.2%	3 1.5%	1 0.5%	161 81.7%
Literate	9 18.4%	1 2%	0 0%	39 79.6%
Primary education	29 28.7%	2 2%	0 0%	70 69.3%
Lower secondary education	30 56.6%	2 3.8%	0 0%	21 39.6%
Secondary education	41 67.2.%	4 6.6%	0 0%	16 26.2%
Higher secondary education	29 74.4%	1 2.6%	0 0%	9 23.1%
Total	170 34%	13 2.6%	1 0.2%	316 63.2%

χ^2=76.81**, df**=15**, p**=.000

Table 4.32 shows that among the respondents of illiterate spouses, 16.2 percent were found to have gone for check up only once, 1.5 percent twice and the same 1.5 percent thrice whereas a higher 81.7 percent not to have attended any postnatal check up. Among the respondents whose spouses had primary education, 28.7 percent were found to have gone for check up only once, 2 percent twice, 0 percent thrice but 69.3 percent not attend any check up. Among the respondents whose spouses had secondary education, 67.2 percent were found to have gone for check up only one, 6.6 percent twice, and remaining (26.2%) not to have attended any checkup. Among the respondents whose husbands had higher secondary education, 74.4 percent were found to have gone for check up only one, 2.6 percent twice and 9.7 percent not to have attended any checkup during postnatal period.

The significance of association between educational status of respondents' spouses and frequency of postnatal checkup was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=76.81 which is not less than the table value 24.99, so the association between educational status of respondents' spouses and frequency of postnatal is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status respondents' spouses and frequency of postnatal is accepted. It may be said that the adoption of postnatal check up is positively associated with educational status of spouses i.e. educated respondents' spouses are aware of more frequency of postnatal check up than that of uneducated respondents' spouses.

H1.13: The educational status of Dalit and Janajati women's father-in-law is significantly associated with the practice of place of delivery

Table 4.33: Association between Educational Status of Respondents' Father- in-law and Place of Delivery

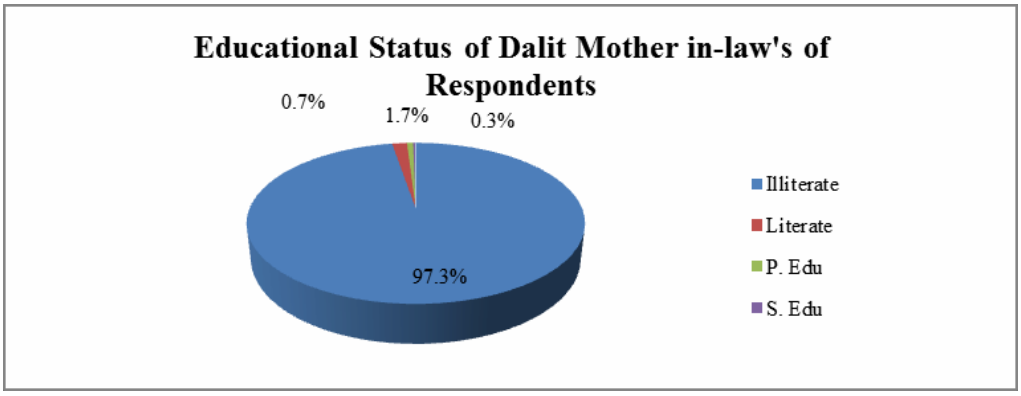
Father- In-law Educational status	Place of delivery	
	Home Delivery	Health Institutional Delivery
Illiterate	264 69.9%	114 30.1%
Literate	45 57.7%	33 42.3%
Primary education	4 14.8%	23 85.2%
Lower secondary education	0 0%	3 100%
Secondary education	0 0%	10 100%
Higher secondary education	0 0%	4 100%
Total	313 62.6%	187 37.4%

χ^2=85.55**, df**=5**, p**=.000

Table 4.33 indicates that among the respondents' father- in-law had lower secondary and higher secondary education, 100 percent utilized health institutional delivery. The health institutional delivery was utilized by 30.1 percent, 42.3 percent and 85.2 percent respondents whose father-in-law had illiteracy, literacy and primary education respectively.

The significance of association between educational status of respondents' father-in law and place of delivery was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=85.55which is less than the table value 11.07, so the association between educational status of respondents' father-in law and place of

delivery is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status respondents' father-in law and place of delivery is retained. It may be interpreted that the institutional delivery was higher among literate father-in law as compared to among illiterate ones.



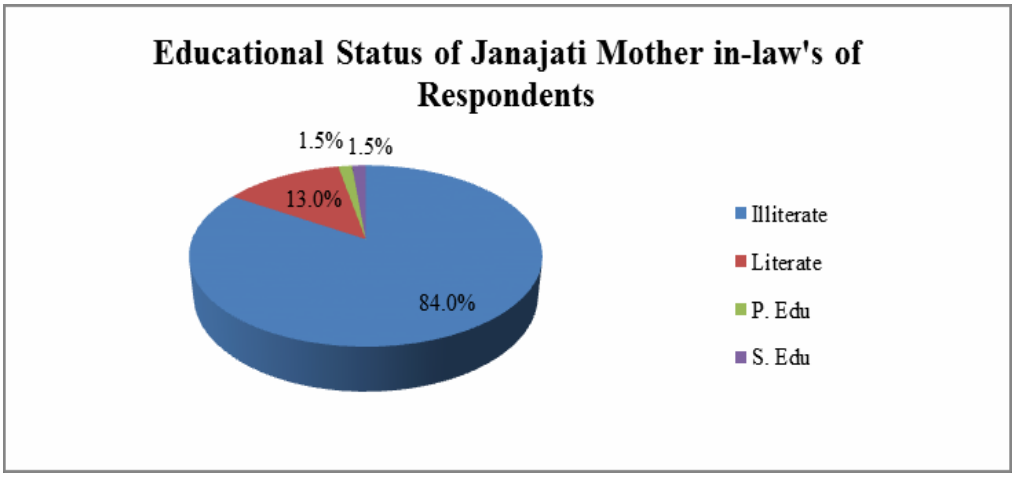


Figure 4.11 indicates that among Dalit respondents' mother-in-law, 97.3 percent were illiterate, 1.7 percent were literate whereas 0.7 percent were of primary education and 0.3 percent of secondary education. Similarly, figure 4.12 shows that among Janajati respondents' mother-in-law, 84 percent were illiterate, 13 percent were literate and 1.5 percent of primary as well as secondary education.

It is clarified that a large numbers of mother-in law of Dalits and Janajatis were uneducated.

H 1.14: The educational status of Dalit and Janajati women's mother-in-law is significantly associated with the practice of ANC visit

Table 4.34: Association between Respondents Mother-In-law Educational Status and Frequency of ANC Visit

Mother-In-law Educational status	Frequency of ANC Visit				
	one time	Two times	Three times	Four time	No check up
Illiterate	17 3.7%	58 12.6%	100 21.7%	139 30.2%	146 31.7%
Literate	0 0%	0 0%	1 3.2%	23 74.2%	7 22.6%
Primary	0 0%	1 20%	0 0%	4 80%	0 0%
Secondary	0 0%	0 0%	0 0%	4 100%	0 0%
Total	17 3.4%	59 11.8%	101 20.2%	170 34%	153 30.6%

χ^2=41.43**, df**=12**, p**=.000

Table 4.34 reveals that among respondents' mother-in-law were illiteracy, 3.7 percent had ANC visit once, 12.6 percent two times, 21.7 percent three times, 30.2 percent visited four times but 31.7 percent had no ANC visit during pregnancy. Among the respondents 'whose mother-in-law had primary education, 0 percent had ANC visit once, 20 percent two times and a higher 80 percent four times. Among those whose mother-in-law had secondary education, 100 percent pregnant women had ANC visit for four times during pregnancy.

The significance of association between mother-in law educational status and frequency of ANC visit was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=41.43 which is not less than the tale value 21.04, so the association between mother-in law educational status and frequency of ANC visit is

significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between mother-in law educational status and frequency of ANC visit is accepted. This may be due to fact that as increase the level of education, the level of utilization of ANC visits also increases.

H1.15: The educational status of Dalit and Janajati women's mother-in-law is significantly associated with the practice of postnatal check up

Table 4.35: Association between Educational Status of Respondents' Mother- In-Law and Frequency of Postnatal Check Up

Mother- In-law Educational status	Frequency of postnatal check up			
	1Time	2 Times	3 Times	No check up
Illiterate	147 32%	11 2.4%	1 0.2%	301 65.5%
Literate	15 48.4%	2 6.5%	0 0%	14 45.2%
Primary	4 80%	0 0%	0 0%	1 20%
Secondary	4 100%	0 0%	0 0%	0 0%
Total	170 34%	13 2.6%	1 0.2%	316 63.2%

χ^2=18.82**, df**=9**, p**=.027

Table 4.35 shows that among the illiterate respondents' mother-in-law, 32 percent were found to have gone for check up only once, 2.4 percent two times and the same 0.2 percent three times whereas a higher 65.4 percent not to have attended any postnatal check up. Among the respondents whose mother-in-law had primary education, 80 percent were found to have gone for check up only once and 20 percent not to have attended any checkup. Among the respondents whose mother-in-law had secondary education, 100 percent had attained postnatal checkup for once.

The significance of association between educational status of respondents' mother-in law and frequency of postnatal checkup was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=18.82which is not less than the table value 16.91, so the association between educational status of respondents' mother-in law and frequency of postnatal is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status of respondents' mother-in law and frequency of postnatal is retained. It may be interpreted that the educational status plays significant role in attending the postnatal checkup practices. Frequency of postnatal check up practice was higher among literate mother-in-law as compared to illiterate.

H 1.16: The educational status of Dalit and Janajati women's mother-in-law is significantly associated with the practice of food intake during pregnant period

Table 4.36: Association between Educational Status of Respondents' Mother- In Law and Frequency of Food Intake during Pregnancy

Mother- In- Law Educational status	Frequency of Food intake during pregnancy		
	Two times	Three times	Four time
Illiterate	390 84.8%	69 15%	1 0.2%
Literate	26 83.9%	5 16.1%	0 0%
Primary education	4 80%	1 20%	0 0%
Secondary education	3 75%	1 25%	0 0%
Total	423 84.6%	76 15.2%	1 0.2%

χ^2=.51**, df=6, p=**.583

Table 4.36 indicates that among the illiterate respondents' mother-in-law, 84.8 percent were found to take food twice a day, 15 percent thrice and only 0.2 percent four times during pregnancy. In the same way, among the literate respondents' mother-in-law,

83.9 percent were found to take food twice a day, 16 percent thrice whereas 0 percent was found to have had four times a day during pregnancy. Similarly, among the respondents whose mother-in-law had primary education, 80 percent had taken food twice per day, 20 percent thrice and 0 percent had taken four times a day. Among the respondents whose mother-in-law had secondary education, 75 percent had taken food twice per day and 25 percent had taken thrice during pregnancy period.

The significance of association between educational status of respondents' mother-in law and frequency of food intake during pregnancy was tested statistically by applying Chi-square test. The computed Chi-square value is $\chi^2 = .51$, which is less than table value 12.59, so the association between respondents' mother- in-law and frequency of food intake during pregnancy is not significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between educational status of respondents' mother-in-law and frequency of food intake during pregnancy is rejected. It may be said that educational status of respondents' mother-in-law do not have significant association with the food intake during pregnancy.

Table 4.37: Educational Status of Respondents' Mothers

Caste/Ethinic group	Educational status				
	Illiterate	Literate	Primary	Secondary	Higher secondary education
Dalits	296 98.7%	2 0.7%	2 0.7%	0 0%	0 0%
Janajati	180 90%	16 16%	1 0.5%	2 1%	1 0.5%
Total	476 95.2%	18 3.6%	3 0.6%	2 0.4%	1 0.2%

Table 4.37 indicates that among the total respondents' mothers, 95.2 percent were illiterates. Their literacy rate was much lower than national level female literacy rate. Among mothers of Janajati respondents, 16 percent were literate, 0.5 percent had

primary, 1 percent secondary and 0.5 percent higher secondary education. On the other hand, among mothers' of Dalit respondents, 0.7 percent was literate as well as primary education. Surprisingly, 0 percent had received secondary and higher secondary education.

It is concluded that the educational status of respondent's mothers were very poor.

Table 4.38: Educational Status of Respondents' Fathers

Caste/Ethinic group	Educational status					
	Illiterate	Literate	Primary	Lower Secondary	Secondary	Higher secondary education
Dalits	272 90.7%	4 1.3%	12 4%	8 2.7%	4 1.3%	0 0%
Janajati	153 76.5%	35 17.5%	3 1.5%	3 1.5%	4 2%	2 1%
Total	425 85%	39 7.8%	15 3%	11 2.2%	8 1.6%	2 0.4%

Table 4.38, reveals that among total respondents' fathers, 85 percent were illiterate and 15 percent were literate. The literacy rate was very lower to national level male literacy status. Among literate Dalits and Janajatis communities, educational status of respondents' fathers were 1.3 percent and 17.3 percent in primary education, 2.7 percent and 1.5 percent in lower secondary, 1.3 percent and 2 percent in secondary and nil percent and 1 percent respectively in higher secondary education.

The data clearly shows that respondents' father educational status was very poor and weak.

4.5 Social Awareness

Social awareness along with inclusion is a composite and highly flexible concept. It describes a wide range of phenomena and processes. It incorporates the socio cultural context as well as an individual and a collective dimension Moreover, the repertoire of social awareness and inclusion has undergone massive changes over time and space. Novel prizewinner and Indian economist, Amartya Sen (2000) defines social exclusion as the deprivation of basic capabilities rather than merely as low income. In

Sen's views, the concepts of capability failure, social awareness and inclusion must be interlinked. In this research work, social awareness refers to raising consciousness on legal rights, reservations and facilities provided by the government to the Dalit and Janajati women of Nepal.

4.5.1 Social Awareness regarding Government Facilities

Government of Nepal has provided scholarship and other facilities to Dalits and Janajatis in the fields of education and health sector after 2008. It has helped a lot in safe motherhood practice and also improved their quality of life.

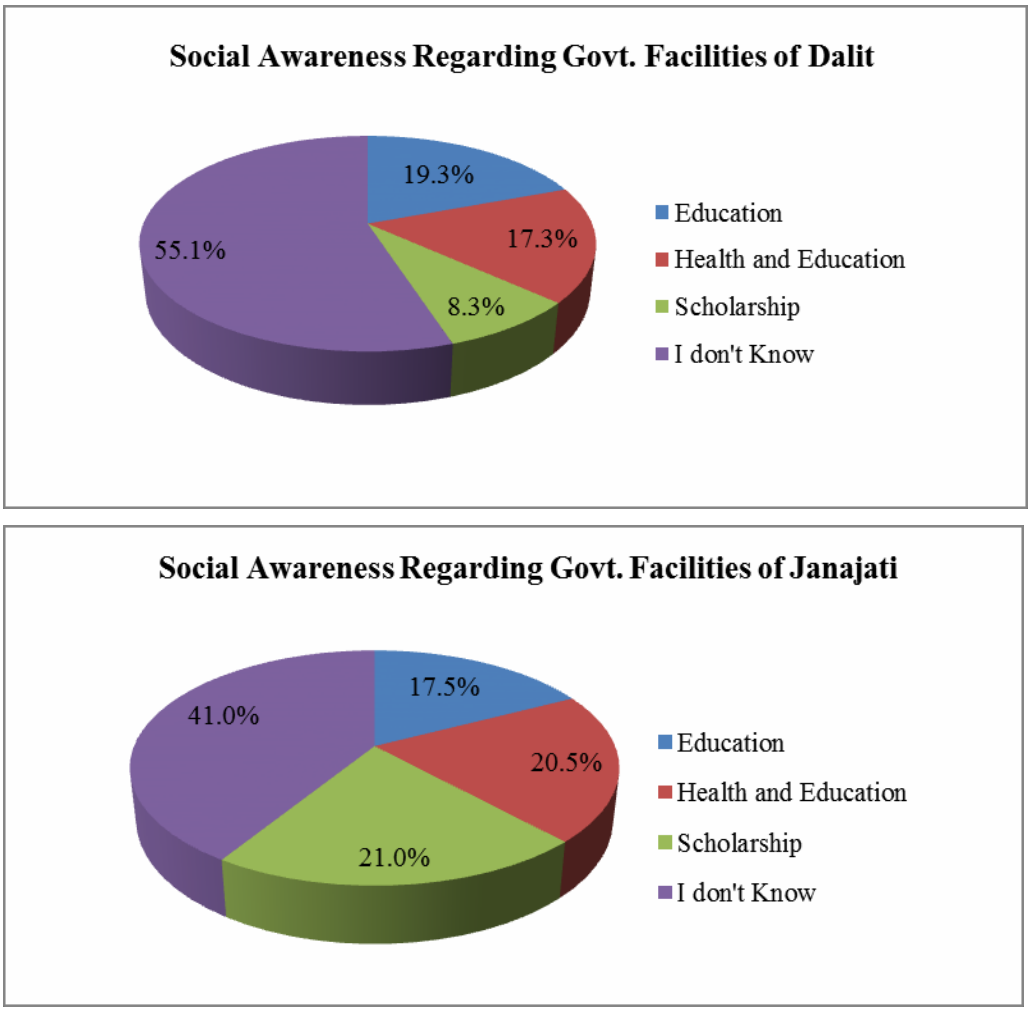


Figure 4.13, shows that among Dalit respondents, 19.3 percent were reported to be aware of education, 17.3 percent health and education, 8.3 percent scholarship whereas 55 percent didn't mention any facilities being provided with. Similarly, figure

4.14, indicates that among Janajati respondents, 17.5 percent were reported to aware of education, 20.5 percent health and education, 21 percent scholarship whereas 41 percent didn't mention any facilities being provided with.

As the data presents that Janajatis received higher degree of education, health and scholarship facilities provided by the government than the facilities the Dalits received. Janajati communities utilize the available health facilities and their safe motherhood practice was better. However, Dalit communities did not fully utilize available health and other facilities that resulted in poor safe motherhood practices in society.

Hypothesis 2 was examined on the basis of its different dimensions in form of sub hypothesis the analysis is given in preceding tables from 2.1 to 2.6.

H 2.1: The social awareness regarding facilities provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visit

Table 4.39: Association between Social Awareness regarding Facilities Provided by Government and Frequency of ANC visit

Facility provided by Govt. to Dalits and Janajatis	Frequency of ANC				
	one time	Two times	Three times	Four time	No check up
Education	2 2.2%	11 11.8%	12 12.9%	28 30.1%	40 43%
Health and education	1 1.1%	6 6.5%	14 15.1%	63 67.7%	9 9.7%
Scholarship	0 0%	1 1.5%	7 10.4%	57 85.1%	2 3%
I don’t know	14 5.7%	41 16.6%	68 27.5%	22 8.9%	102 41.3%
Total	17 3.4%	59 11.8%	101 20.2%	170 34%	153 30.6%

χ^2=71.05**, df**=12**, p=.**008

Table 4.39, shows that among the respondents having social awareness of government facilities reported on education, 2.2 percent had ANC visit once, 11.8 percent had twice whereas 43 percent did not have ANC visit. Similarly, among the respondents reported on health and education, 1.1 percent had ANC visit once, 6.5 percent twice, 15.1 percent thrice, 67.7 percent four times and rest of them (9.7%) had no ANC visit at all. In the same way, among the respondents reported on scholarship, no one had ANC visit once, 1.5 percent twice, 10.4 percent thrice, 85.1 percent four times and only 3 percent did not have ANC visit. Among the respondents who didn't mention their social awareness of government facilities, 5.7 percent had ANC visit once, 16.6 percent twice, 27.5 percent thrice, 8.9 percent four times but 4.3 percent did not have ANC visit.

The significance of relationship between social awareness regarding facilities provided by government and frequency of ANC visits was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=71.05 which is not less than the table value 21.03, so the association between social awareness regarding facilities provided by government and frequency of ANC visits is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between social awareness regarding facilities provided by government and frequency of ANC visits is retained. It may be interpreted that the ANC visits varies on social awareness regarding facilities provided by government to the Dalit and Janajati women.

H 2.2: The social awareness regarding facilities provided by the government to the Dalit and Janajati women is significantly associated with the practice of postnatal checkup

Table 4.40: Association between Social Awareness regarding Facilities Provided by Government and Frequency of Postnatal Check up

Facility provided by Govt. to Dalits and Janajatis	Frequency of Postnatal Check up			
	one time	Two times	Three times	No check up
Education	25 26.9%	8 8.6%	0 0%	60 64.5
Health and education	55 59.1%	3 3.2%	0 0%	35 37.6%
Scholarship	53 79.1%	0 0%	0 0%	14 20.9%
I don't know	37 15%	2 0.8%	1 0.4%	207 83.8%%
Total	170 34%	13 2.6%	1 0.2%	316 63.2%

χ^2=49.09**, df**=9**, p=.**000

Table 4.40, shows that among the respondents having social awareness of government facilities on education, 26.9 percent had post-natal check up once, 8.6 percent twice, 0 percent had thrice and the highest 64.5 percent had not conducted any postnatal check up. Similarly, among the respondents reported on health and education, 59.1 percent had check up once, 3.2 percent twice, no one has had thrice and 37.6 percent had not conducted any check up. In the same way, among the respondents reported on scholarship, 79.1 percent had postnatal checkup once, 0 percent had two and three times; and rest of them (20.9 percent) had not conducted postnatal check up. Among the respondents who did not mention, 15 percent had check up once, 0.8 percent twice, 0.4 percent thrice and a higher 83.8 percent had not conducted any check up.

The significance of association between social awareness regarding facilities provided by government and frequency of postnatal check up was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=49.09 which is not less than the table value 16.92, so the association between social awareness regarding facilities provided by government and frequency of postnatal check up is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between social awareness regarding facilities provided by government and frequency of postnatal check up is retained. It may be interpreted that the social awareness regarding government facilities depends on frequency of postnatal check up.

4.5.2 Social Awareness regarding Government Rights

Government of Nepal has provisioned for the Dalits and Janajatis a reservation as their privileges in the interim constitution. As a result, the Dalits and Janajatis have an access to different level of state mechanism through the state policies of inclusive democracy and empowerment of the marginalized communities. In one or the other way, it has contributed to the safe motherhood practices.

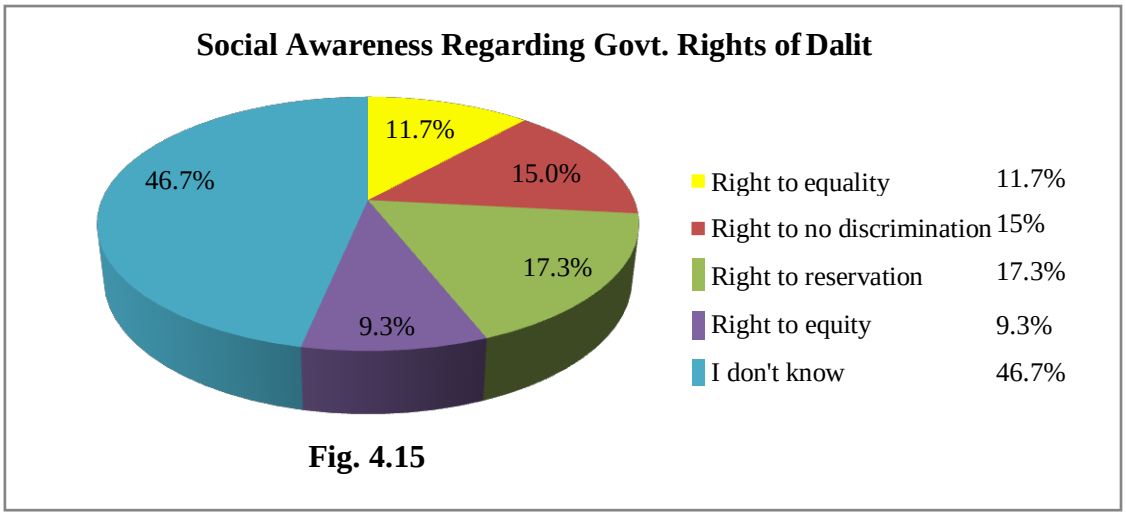


Fig. 4.15

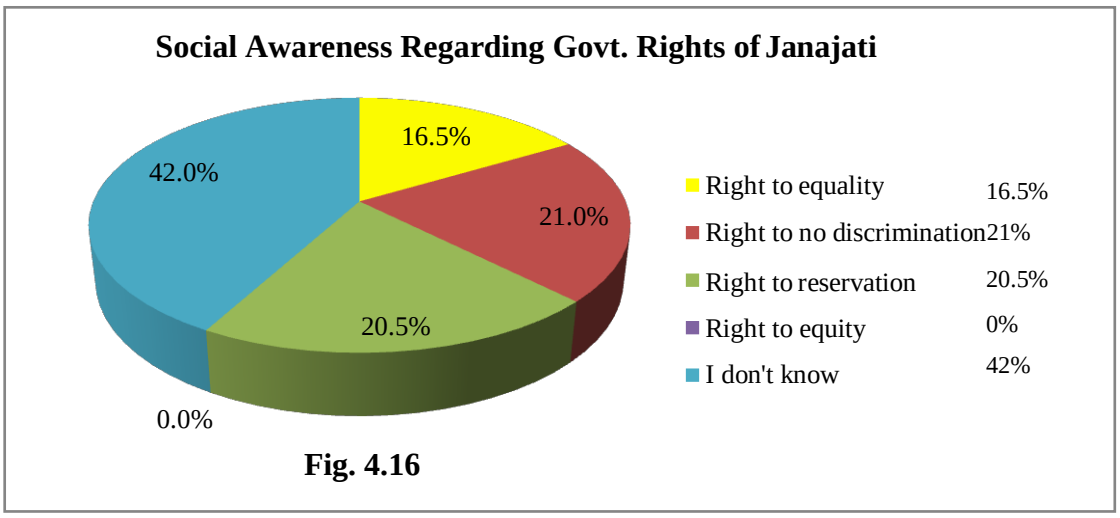


Fig. 4.16

Observing the figure 4.15, it is found that among Dalit respondents, 11.7 percent were reported on right to equality, 15 percent right to no discrimination, 17.3 percent right to reservation, whereas 9.3 percent respondents that they had no idea on the rights to equity provided to them by the government. Similarly, figure 4.16 shows that among Janajati respondents, 16.5 percent were reported on right to equality, 21 percent right to no discrimination, 20.5 percent right to reservation and no one had have got discrimination.

It is concluded that Janajatis secured a higher degree of rights provided to them by the government than the degree Dalits had been provided with. Since Janajatis were socially more aware than Dalits, Janajatis were shown to have got a higher access to the rights provided by government than the Dalits have got. Consequently, Janajatis' safe motherhood practice was better than that of Dalit.

H 2.3: The social awareness regarding rights provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visits

Table 4.41: Association between Social Awareness regarding Rights Provided by Government and Frequency of ANC Visits

Rights provided by Govt. to Dalits and Janajatis	Frequency of ANC Visits				
	one time	Two times	Three times	Four time	No check up
Right to equality	0 0%	7 10.3%	14 20.6%	27 39.7%	20 29.4%
Right to no discrimination	3 3.4%	6 6.9%	13 14.9%	37 42.5%	28 32.2%
Right to reservation	0 0%	4 4.3%	9 9.7%	79 84.9%	1 1.1%
Right to equity	1 3.6%	9 32.1%	2 7.1%	0 0%	16 57.1%
I don't Know	13 5.8%	33 14.7%	63 28.1%	27 12.1%	88 39.3%
Total	17 3.4%	59 11.8%	101 20.2%	170 34%	153 30.6%

χ^2=96.02**, df**=16**, p=.**023

Among the respondents reported their social awareness of the rights provided by government on right to equality, no one had ANC visit once, 10.3 percent twice, 20.6 percent thrice, 39.7 percent four times and 29.4 percent did not have ANC visit. In the same way, among the respondents with awareness of right to no discrimination, 3.4 percent had ANC visit once, 6.9 percent twice, 14.9 percent thrice, 42.5 percent four times and 32.2 percent did not have ANC visit. Among the respondents with awareness of right to reservation, no one had ANC visit once, 4.3 percent twice, 9.7 percent thrice, 84.9 percent four times and 1.1 percent did not have ANC visit. Among the respondents with awareness of equity, 3.6 percent had ANC visit once, 32.1 percent twice, 7.1 percent thrice, no one had ANC visit four times and 57.1 percent did not have ANC visit. Among the respondents who did not mention, 5.8

percent had ANC visit once, 14.7 percent twice, 28.1 percent thrice, 12.1 percent four times and remaining (39.3%) did not have ANC visits

The significance of relationship between social awareness regarding rights provided by government and frequency of ANC visits was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=96.02 which is not less than the table value 26.29, so the association between social awareness regarding rights provided by government and frequency of ANC visits is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association betweensocial awareness regarding rights provided by government and frequency of ANC visits is retained. It may be interpreted that the number of ANC visits depends on the social awareness regarding rights provided by government.

H 2.4: The social awareness regarding rights provided by the government to the of Dalit and Janajati women is significantly associated with the practice of postnatal checkup

Table 4.42: Association between Social Awareness regarding Rights Provided by Government and Frequency of Postnatal Check up

Rights provided by Govt. to Dalits and Janajatis	Frequency of Postnatal Check up .			
	one time	Two times	Three times	No check up
Right to equality	21 30.9%	4 5.9.%	0 0%	43 63.2%
Right to no discrimination	34 39.1%	3 3.4%	0 0%	50 57.5%
Right to reservation	74 79.6%	4 4.3%	0 0%	15 16.1%
Right to equity	1 3.6%	0 0%	0 0%	27 96.4%
I don't Know	40 17.9%	2 0.9%	1 0.4%	181 80.8%
Total	170 34%	13 2.6%	1 0.2%	316 63.2%

χ^2=49.95**, df**=12**, p=.**000

Table 4.42 reveals that among the respondents with social awareness of right to equality, 30.9 percent had postnatal check up once, 5.9 percent twice, 0 percent had thrice and a higher 63.2 percent had not had postnatal check up. Similarly, among the respondents with social awareness on the right to no discrimination, 39.1 percent had checkup once, 3.4 percent twice, 0 percent had postnatal check up four times and remaining (57.5%) had no postnatal check up. Among the respondents with social awareness of right to reservation, 79.6 percent had postnatal check up once, 43 percent twice, 0 percent had thrice and 16.1 percent have not had postnatal check up. Among the respondents with social awareness on equity, 3.6 percent had postnatal check up once, no one has had twice and thrice; and remaining (96.4%) have not had postnatal check up. Similarly, among the respondents, who did not mention, 17.9 percent have had check up once, 0.9 percent twice and 0.4 percent had no postnatal checkup.

The significance of relationship between social awareness regarding rights provided by government and frequency of postnatal check up was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=49.95which is not less than the table value 21.03, so the association between social awareness regarding rights provided by government and frequency of postnatal check up is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between social awareness regarding rights provided by government and frequency of postnatal check up is retained. It may be interpreted that the social awareness regarding rights has positive effect on postnatal checkup.

4.5.3 Social Awareness regarding Government Reservation

Interim constitution of Nepal has provisioned the reservation for Dalits and Janajatis from government service to the political sector. This provision has contributed to their education and health improvement. More significantly, it has brought remarkable changes in safe motherhood practices.

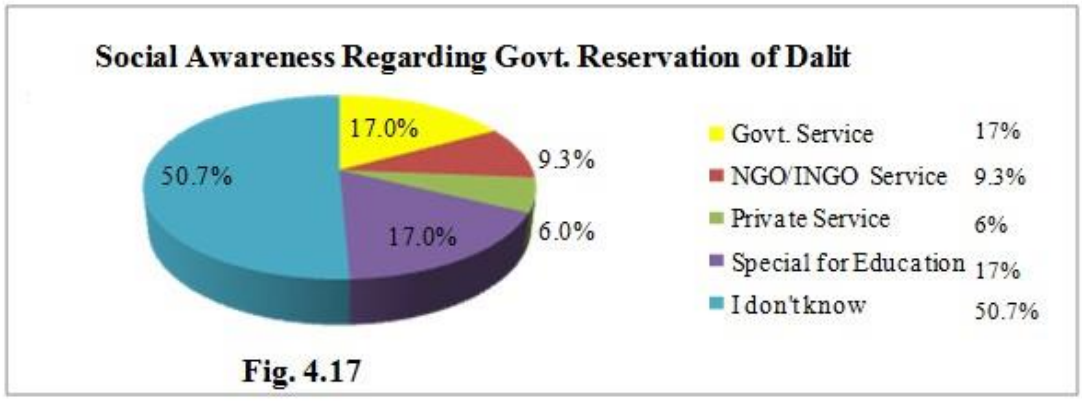


Fig. 4.17

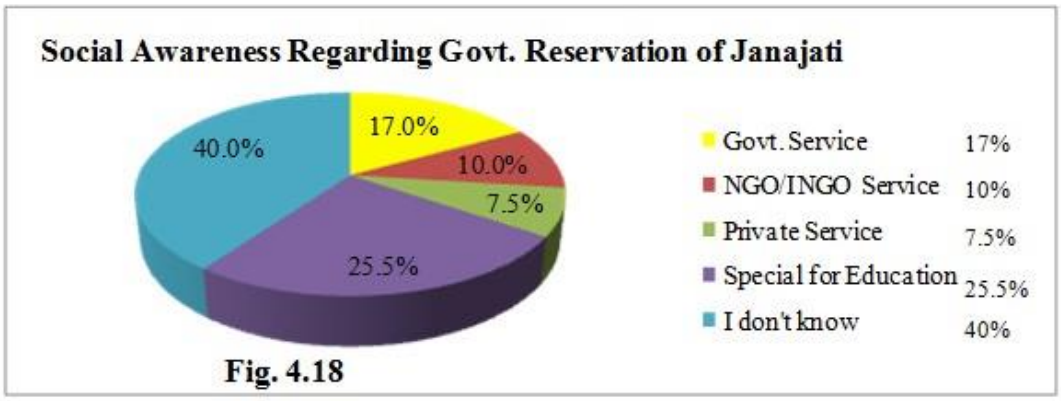


Fig. 4.18

Figure 4.17 illustrates that among Dalit respondents, 17 percent knew about reservation on government services, 9.3 percent NGO/INGO services, 6 percent private's services, 17 percent special for education whereas 50.7 percent didn't want to remark on the reservation facilities provided by the government. Similarly, figure 4.18 shows that among Janajati respondents, 17 percent knew about reservation on government services, 10 percent NGO/INGO services, 7.5 percent private services, 25.5 percent special for education whereas 40 percent didn't want to remark on the reservation facilities provided to them by government.

The data reveals that both Dalit and Janajati respondents had the almost similar degree of awareness of reservation facilities provided by government to them. In Nepal, government reservation for marginalized communities was introduced only after 2008 AD. So both Dalits and Janajatis' social awareness of this reservation is not fully satisfactory and effective. Thus, government reservation has an equal degree of influence on safe motherhood practices of both Dalits and Janajatis.

H 2.5: The social awareness regarding reservation provided by the government to the of Dalit and Janajati women is significantly associated with the practice of ANC visits

Table 4.43: Association between Social Awareness regarding Reservation Provided by Government and Frequency of ANC Visit

Types of Reservation provided by Govt. to Dalits and Janajatis	Frequency of ANC Visit				
	one time	Two times	Three times	Four time	No check up
Government service	1 1.2%	3 3.5%	11 12.9%	67 78.8%	3 3.55%
NGO/INGO service	1 2.1%	3 6.2%	7 14.6%	10 20.8%	27 56.2%
Private service	1 3%	5 15.2%	5 15.2%	7 21.2%	15 45.4%
Special for Education	0 0%	11 10.8%	15 14.7%	61 59.8%	15 14.7%
I don't Know	14 6%	37 15.9%	63 27.2%	25 10,8%	9340.1%
Total	17 3.4%	59 11.8%	101 20.2%	170 34%	153 30.6%

χ^2=89.47**, df**=16**, p=.**019

As per the response of those with social awareness of government reservation reported on government service, 1.2 percent had ANC visit once, 3.5 percent twice, 12.9 percent thrice, 78.8 percent four times and only 3.5 percent conducted no ANC visit. Among the respondents reported on NGO/INGO service, 2.1 percent had ANC visit once, 6.2 percent twice, 14.6 percent thrice, 20.8 percent four times and 56.2 percent conducted no ANC visit. Similarly, among the respondents reported on private service, 3 percent had ANC visit once, 15.2 percent twice and thrice, 21.2 percent four times and remaining(45.5%) conducted no ANC visit. Among the respondents reported on special service for education, no one has had ANC visit once,

10.8 percent twice, 14.7 percent thrice, 59.8 percent four times and 14.7 percent conducted no ANC visit. Similarly, among the respondents who didn't mention, 6 percent had ANC visit once, 15.9 percent twice, 27.2 percent thrice, 10.8 percent four times and rest of them (40.1 percent) conducted no ANC visit.

The significance of association between social awareness regarding reservation provided by government and frequency of ANC visits was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=89.47which is not less than the table value 26.29, so the association between social awareness regarding reservation provided by government and frequency of ANC visits is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between social awareness regarding reservation provided by government and frequency of ANC visits is retained. This may be said that an ANC visit is affected to the reservation provided by the government.

H 2.6: The social awareness regarding reservation provided by the government to the Dalit and Janajati women is significantly associated with the practice of postnatal checkup

Table 4.44: Association between Social Awareness regarding Reservation Provided by Government and Frequency of Postnatal Check up

Types of Reservation provided by Govt. to Dalits and Janajatis	Frequency of postnatal check up			
	1 Time	2 Times	3 Times	No check up
Government service	61 71.8%	5 5.9%	0 0%	19 22.4%
NGO/INGO service	13 27.1%	0 0%	0 0%	35 72.9%
Private service	6 18.2%	2 6.1%	0 0%	25 75.8%
Special for Education	52 51%	4 3.9%	0 0%	46 45.1
I don't Know	38 16.4%	2 0.9%	1 0.4%	191 82.3%
Total	170 34%	13 2.6%	1 0.2%	316 63.2%

χ^2=42.12**, df**=12**, p=.**000

Table 4.44 shows that among the respondents having social awareness of reservation on government service, 71.8 percent were found to have attended postnatal check up once, 5.9 percent twice, 0 percent had thrice and rest of them (22.4%) attended no postnatal check up. Among the respondents responding to NGO/INGOs service, 27 percent had postnatal check up once, no one has had twice and thrice; and remaining (72.3) had not attended postnatal check up. Similarly, among the respondents familiar with private service, 18.2 percent were found to have attended postnatal check up once, 6.1 percent twice, no one had check up thrice but 75.8 percent attended no postnatal check up at all. Among the respondents with reported on special service for education, 51 percent had check up once, 3.9 percent twice, 0 percent had check up thrice whereas 45.1 percent attended no postnatal check up. Similarly, among the respondents who did not mention, 16.4 percent have had check up once, 0.9 percent twice, 0.4 percent thrice and a higher 82.3 percent attended no postnatal check up at all.

The significance of association between social awareness regarding reservation provided by government and frequency of postnatal check up was tested statistically by applying Chi-square test. The computed Chi-square value is χ^2=42.12which is not less than the table value 21.03, so the association between social awareness regarding reservation provided by government and frequency of postnatal check up is significant at the 0.05 level of significance. Thus, the hypothesis that there exists significant association between social awareness regarding reservation provided by government and frequency of postnatal check up is retained. It may be interpreted that the social awareness regarding reservation has positive effect on postnatal checkup.

Government of Nepal had laid provision with various special facilities, rights and reservations to Dalit and Janajati of Nepal in order to bring those marginalized in the mainstream of the state. Those Dalit and Janajatis who have been aware of utilizing such special facilities, rights and reservations, have also been obtaining the essential facilities on safe motherhood practices. On the other hand, those Dalit and Janajatis who are not aware of those facilities rights and reservations have been deprived of the essential facilities provided by government in matters of safe motherhood. In the course of interview, a **25-year-old uneducated Dalit mother** having three children responded, *"I did not know anything about government facilities, rights and reservations because I am uneducated and my role is only to look after children, to*

handle the household affairs and to involve in agricultural activities. If you want to know further about it you can ask my spouse. He knows better than I do".

This interview extract firstly disclose that those women who had higher secondary education level, they also had higher social awareness level. Likewise, those with lower education level had lower social awareness level. Consequently, due to their lower social awareness level had poor level of safe motherhood practices. Secondly, it is further explored that uneducated women are dependent upon their spouses. They maintain their livelihood as per the directions and suggestions of the spouses.

Another **31-year-old educated Janajati mother** with two children opined, *"I know very little about the government facilities, rights and reservations. I have received few facilities, rights and reservations as mentioned in the interim constitutions of Nepal since 2009. I believe these kind of facilities helped me for a better safe motherhood practices."* It firstly illustrates that educated mothers' awareness level was found higher. Secondly, it showed that those educated mothers' social awareness to safe motherhood practice was also found significantly better.

Now, on the basis of above cited two different views of respondents, it is concluded that there was notable difference between the educated and uneducated mothers safe motherhood practices in the sense of social awareness regarding the government facilities, rights and reservations. Hence, it is furthermore proven that higher the social awareness regarding facilities, rights and reservation provided by government better the safe motherhood practices and it's vice versa.

4.5.4 Response on Traditional patters of Safe motherhood practice

There are both satisfactory and unscientific traditional patterns of safe motherhood practice. Therefore, good practices should be accepted and adopted while the bad ones should be avoided.

Table 4.45: Response Related to Traditional Patterns of Safe Motherhood Practice

Caste/Ethinic group	Response Related to Traditional Patterns of Safe Motherhood Practice			
	Traditional patterns as satisfactory	Traditional patterns as mixed views	Traditional patterns as unscientific	I don't know
Dalits	122 40.8%	99 33.1%	78 26.1%	0 0%
Janajati	59 29.5%	63 31.5%	77 38.5%	1 0.5%
Total	181 36.3%	162 32.5%	155 31.1%	1 0.2%

Table 4.45 shows that among Dalits respondents, 40.8 percent believed traditional patterns as satisfactory, 26.1 percent believed traditional patterns as unscientific, 33.1 percent believed traditional patterns as mixed views whereas nil percent showed their anonymity to traditional patterns of safe motherhood practices. On the other hand, among Janajati respondents, 29.5 percent believed traditional patterns as satisfactory, 38.5 percent believed traditional patterns as unscientific, 31.5 percent believed traditional patterns as mixed views and only 1 percent showed their anonymity to traditional patters of safe motherhood practices.

The conclusion of the table 4.45 is that more Dalits were satisfied with traditional patterns of safe motherhood practices than Janajatis were. Janajatis' avoidance of traditional patterns of safe motherhood practices was slightly higher than that of Dalits because Janajatis' social awareness and educational status were better than those of Dalits. This phenomenon had a positive influence on Janajatis' safe motherhood practices.

CHAPTER –V

SUMMARY, FINDINGS, DISCUSSION ON RESULTS, EDUCATIONAL IMPLICATIONS AND RECOMMENDATIONS

5.1 Summary

Nepal is a country of geographical and cultural diversity where health facilities and services are not equally distributed. Availing of safe motherhood facilities and services are influenced by education, awareness, economical status, religion, socio-cultural aspects, etc. Presently **literacy** percentage in **Nepal** is **65.94** but it is **57.4** percent in **female folk**. For comprehensive development and growth of future generation, the health programs of mother and child are of crucial importance. **Caring** and **nurturing of mother and child** plays important **role in every sphere of life** including enhancing **education** achievements.

Recent studies by Ministry of Health and Population (2014) shows that**89 percent** of Nepalese mothers received **antenatal checkup** (ANC) services of which 56 percent mothers had four ANC checkups. It indicates that 44 percent mothers did not complete the recommended four checkups. Forty five percent of deliveries were assisted by Skill Birth Attendance, **55 percen**t followed **postnatal checkups** and **45 percent** had **institutional deliveries** in 2014. **Forty six percent** pregnant mothers were benefitted from **free institutional delivery** care under the **Aama program** and almost same percentage of mothers received transportation incentive in 2014. One of the major public health problems of Nepal is associated with maternal and child health care practices. Maternal mortality is still unacceptably high. Out of one hundred thousand live births, 229 mothers die due to the complication of pregnancy, childbirth and postnatal period. Low utilization of health services during delivery is one of the major factors contributing to maternal mortality. Nearly 41 percent of maternal deaths occur at home while 7 percent deaths occur on the way to health facilities. The highest mortality at home shows the reality of low utilization of health services. The level differential between maternal mortality ratio (MMR) in entire country and MMR at the sub-region suggest that Nepal's safe motherhood program

should recommit and focus on increasing the availability and access to utilization of quality safe motherhood care for women across the country, particularly women in the Hilly and Tarai sub-region.

The research problem under investigation is "**Study of Educational Status, Social Awareness and Safe Motherhood Practices among Dalit and Janajati Women of Nepal".** The objectives of study were; to identify the educational status, social awareness and safe motherhood practices, to study the association of educational status and safe motherhood practices and to find out the association of social awareness and safe motherhood practices of Dalit and Janajati women of Nepal.

The investigator used descriptive survey method for accomplishment of this work. Here the descriptive survey method was found more appropriate for the present study as it was also aimed to describe the characteristics, which explored from the various cluster of the sample of Dalit and Janajati communities of Nepal. Looking to the nature of work, qualitative research inputs were also employed. Hence, the components of qualitative and quantitative methods were mixed matched to obtain and interpret the data.

The main reasons behind selecting Kaski and Parsa districts as study areas are: they represent cultural and geographical diversity in Nepal and mostly Dalit and Janajati people live these districts. Dalit and Janajati women with at least one child of these two districts were the main sources of data for this study. The population of this study consists of all women having at least one child belonging to Dalit and Janajati community from **Pumdi Bhumdi VDC of Kaski** district and **Bishrampur and Bageswori Titrauna VDC of Parsa** district Nepal. **Cluster sampling technique** was used in the selection of Dalit and Janajati women having at least one child from the study area- Parsa and Kaski district of Nepal. In the first stage, three VDCs- Bishrampur and Bageswari Titraunafrom Parsadistrict andPumdi Bhumdi VDC from Kaski district were randomly selected. In the second stage, two VDCs Dalits and Janajatis women were randomly selected from each of the selected three VDCs. Thus, from the **sample** consisted of **500** women (300 Dalit and 200 Janajati. Bishrampur VDC- 145 Dalit and from Bageswari Titrauna VDC -95 Janajati women were selected randomly. In the same way, 155 – Dalit and 105 – Janajati women were selected from Pumdi Bhumdi VDC of Kaski district. The selection of sample is based on the **Krejcie** and **Morgan** table of determining sample size.

Structured questionnaire and unstructured interview schedule were the main **tools** to collect necessary data for this research work. The researcher himself visited the secretary of the selected VDCs to take permission for collection of data. The researcher made a door to door visit to the selected respondents of the three VDCs of Parsa and Kaski districts .The purpose of the visit was made clear to the respondents and they were asked to provide information without any hesitation and confidential and name of respondents were not associated with their answer. The questionnaire were filled by the researcher himself. Personal questions were not asked and refusal right of the participants was respected. Questionnaire were filled by the selected sample of Dalit and Janajati community women from13July to 5 September 2014. Furthermore, interview schedule were held after the questionnaire were filled out by the respondents. By winning the consent and favor of the respondents, the researcher asked the respondents questions as per the interview schedule and kept on asking tactfully unless the satisfactory response didn't come. The researcher conducted the interview schedule with the eight selected educated and uneducated respondents and elicited the necessary information about safe motherhood practices and social awareness from them.

The **quantitative data** collected through **questionnaire** were edited, summarized and tabulated by using statistical package for social sciences (SPSS) 20.0 version. Keeping in view the objectives of the study, following techniques such as cross tabulation and pie-chart were constructed to analyze the data. The investigator applied **non-parametric Chi-square test** to ascertain the association between independent and dependent variables. Percentages of respondents regarding educational status, social awareness and safe motherhood practices were computed and compared between Dalit and Janajati respondents under study. Furthermore, the **qualitative information** obtained from the **interview schedule** were contextually analyzed and interpreted on social awareness and safe motherhood practices.

The **major findings** of this study have been as follows;

i. The findings shows that literacy rate of the respondents (51.4%), their mother-in-law's (8%), father-in-law's (24.4%), mothers (4.8%), fathers (15%) and spouses of respondents(61.6%) was very low than the national level literary status (65.9%) of Nepal. Similarly, educational status of women of Dalit and Janajati were found not satisfactory and is lower than national level education status.

ii. Out of the total respondents in survey area, 26.7 percent Dalits and 45 percent Janajatis have followed ANC visit four times during pregnancy. ANC visit of respondents is less frequent than the national level ANC checkup (56%).

iii. Educational status of Dalit / Janajati women and frequency of ANC visit during pregnancy is found statistically significant at the 0.05 level of significance. It means educated women have more ANC visit during pregnancy than that of uneducated women.

iv. Educational status of Dalit / Janajati women and practice of having TT vaccine during pregnancy is found statistically significant at the 0.05 level of significance. It means the educated women more practice of TT vaccine during pregnancy than that of uneducated women.

v. Educational status of respondents' mother-in law and frequency of food intake during pregnancy is not found statistically significant at the 0.05 level of significance. It means educational status of respondents' mother-in- law do not have significant association with the food intake during pregnancy.

vi. Educational status of Dalit / Janajati women and place of delivery is found statistically significant at the 0.05 level of significance. It means the preference of respondents making delivery at home was higher among illiterate group. Regarding the literate, frequency of delivery at health institution was higher among the mother who had secondary or higher secondary education.

vii. Educational status of Dalit / Janajati women and umbilical cord cutting instrument is not found statistically significant at the 0.05 level of significance. It means educational status of Dalit and Janajati women do not have significant association with the practice of umbilical cord cutting instrument. It seems that they are not so much aware regarding the instrument used for cutting umbilical cord and still they follow traditions using these instruments are still playing significant role at their home.

viii. Out of total respondent's postnatal checkup (36%) is less frequent and irregular than the national level checkup (55%). In comparing Dalit and Janajati respondents, Janajati had their postnatal check up conducted more frequently than that of Dalits.

ix. Educational status of Dalit / Janajati women and frequency of postnatal check up is found statistically significant at the 0.05 level of significance. It means the higher secondary educational status of the respondents had more frequent postnatal check up visit they attended during postnatal period than that of uneducated women.

x. Social awareness regarding reservation provided by government and frequency of ANC visits is found statistically significant at the 0.05 level of significance. It means the social awareness regarding reservation has positive effect on ANC visit.

xi. Social awareness regarding reservation provided by government and frequency of postnatal check up is found statistically significant at the 0.05 level of significance. It means the social awareness regarding reservation has positive effect on postnatal checkup.

xii. The social awareness of respondents regarding safe motherhood facilities, rights and reservations provided by the government was found 17 percent which is lower than the national level (25%) . The findings reveals that both Dalit and Janajati women had almost similar level of social awareness.

Based on findings, it is recommended that the mothers, who came for antenatal check up, should be provided with adequate information about availability of safe delivery incentive and free health services provided by government of Nepal. Formal and non-formal education and awareness program should be focused on girls, women and decision maker of the family. Health post/sub health post, primary health center and district public health office should emphasize the importance of institutional delivery through community awareness program with strong monitoring and evaluation mechanism to improve the situation of safe motherhood practice in Dalit and Janajati communities in Nepal.

5.2 Findings

Followings are the major findings of the study

5.2.1 Educational Status

i. Out of the respondents, 51.4 percent are literate and 48.6 percent are illiterate which is much lower than nationally reported figure. Among Dalit respondents, 54 percent are illiterate, 12.3 percent are literate, 9 percent, 7.7 percent, 12 percent and 5 percent have completed primary, lower secondary ,secondary and higher secondary education respectively. Regarding Janajati respondents, 40.5 percent are illiterate, 20 percent are literate, 5 percent completed primary education, 14 percent completed lower secondary education, 12.5 percent secondary and 8 percent higher secondary education.

ii. Out of total spouses, 61 percent are literate and 39 percent are illiterate whereas 53.7 percent Dalits and 61 percent Janajatis are found literate.

iii. Among total respondents' father–in –law, 24.4 percent are literate and 75.6 percent are illiterate but 14 percent Dalits and 40 percent Janajatis father–in –law are literate.

iv. Out of total respondent's mother- in –law, 8 percent are literate and 92 percent are illiterate. Likewise, 2.7 percent Dalits and 16 percent Janajatis respondents' mother- in –law are literate.

v. Among total respondents' mothers, 95.2 percent are illiterate and 4.8 percent are literate.

vi. Out of total respondents' fathers, 85 percent are illiterate and 15 percent are literate. Among them 9.3 percent Dalits and 23.5 percent, Janajatis are literate. In summing up, the literacy rate of the respondents, spouses, mother-in-law, father-in-law, mothers and fathers is very low and poorer than the national literacy status of Nepal.

5.2.2 Social Awareness

i. Out of the total respondents, 50.6 percent are socially aware of education, health and scholarship facilities provided by government whereas 49.4 percent didn't report about any facilities being provided with. Similarly, 45 percent

Dalits and 59 percent Janajatis are provided with different facilities by government.

ii. Among the total respondents, 49.6 percent reported to have secured right to equality, no discrimination and right to reservation facilities provided by government but 50.4 percent reported that they didn't secure rights provided by government. Besides, 44 percent Dalits and 58 percent Janajatis are provided with different rights by the government. Similarly, 53.6 percent had awareness of reservation on government, NGO/INGO, private and special service for education whereas 46.4 percent are unaware of reservation provided by government. Furthermore, 49.3 percent Dalits and 60 percent Janajatis are provided with government reservation on different sectors.

iii. Among Dalit respondents, 40.8 percent believed traditional patterns of safe motherhood satisfactorily, 26.1 percent believed unscientific and 33.1 percent had mixed views regarding traditional patterns. In the case of Janajati respondents, 29.5 percent believed traditional patterns satisfactorily, 38 percent believed unscientific, 31.5 percent mixed views and only one percent showed their anonymity to traditional patterns of safe motherhood.

iv. It is found that there exists significant association between social awareness regarding facilities provided by government and frequency of ANC visits is retained. It means the ANC visit varies on social awareness regarding facilities provided by government to the Dalit and Janajati women.

v. It is clear from the data analysis revealed that there exists significant association between social awareness regarding facilities provided by government and frequency of postnatal check up is retained. It means the social awareness regarding government facilities depends on frequency of postnatal check up.

vi. Analysis of data revealed that there exists significant association between social awareness regarding rights provided by government and frequency of ANC visits is retained. It means the number of ANC visits depends on the social awareness regarding rights provided by government.

vii. It is found that there exists significant association between social awareness regarding rights provided by government and frequency of postnatal check up is retained. It means the social awareness regarding rights has positive effect on postnatal checkup.

viii. The analysis revealed that there exists significant association between social awareness regarding reservation provided by government and frequency of ANC visits is retained. It means the ANC visit is affected to the reservation provided by the government.

ix. It clearly shown by the analysis of data revealed that there exists significant association between social awareness regarding reservation provided by government and frequency of postnatal check up is retained. It means the social awareness regarding reservation has positive effect on postnatal checkup.

5.2.3 Safe Motherhood Practices

5.2.4 Antenatal Care

i. Out of total respondents, 26.7 percent Dalits and 45 percent Janajatis followed ANC visit four times during pregnancy period. In contrast, 32.7 percent of the Dalits and 27.5 percent of the Janajatis never had their health check up during pregnancy.

ii. Among total respondents, 67.3 percent Dalits and 72 percent Janajatis got ANC service from health personnel. In opposition, 32.7 percent of Dalits and 28 percent of Janajatis never consulted from health personnel during their antenatal period.

iii. Among the Dalit respondents, 33.68 percent did not receive antenatal care service due to lack of awareness, 29.47 percent due to lack of time and 36.85percent due to lack of money respectively. Regarding Janajati respondents, 34.48 percent received no antenatal care service owing to lack of awareness and time, and 31.04 percent due to lack of money.

iv. Out of total respondents, 24.3 percent Dalits and 2 percent Janajatis took additional and special food during pregnancy. In contrast, 75.7 percent of Dalits and 98 percent Janajati had normal food intake during their pregnancy.

v. Among Dalit respondents, 3.3 percent pregnant mother took bath daily, 51 percent on every alternate day, 31 percent twice a week and 14.1 percent once a week. In case of Janajati respondents, 48 percent took bath daily, 7 percent on every alternate day, 12 percent twice a week and 3.3 percent once a week during pregnancy.

vi. Out of total respondents, 71 percent Dalits and 51 percent Janajatis had smoking and alcoholic habits during pregnancy. In opposition, 29 percent of Dalits and 49 percent Janajatis neither did smoking nor they took alcohol.

vii. Among the total respondents, 97 percent Dalits and 93.5 percent Janajati mother faced complications like vomiting, swelling leg, sometimes bleeding and backache during pregnancy whereas 3 percent of Dalits and 6.5 percent of Janajati mother faced no problems during the same period.

viii. In the study area, out of the total respondents, 61.3 percent Dalit and 71.5 percent Janajati received T.T. vaccine of different doses whereas 38.7 percent Dalit and 29.5 percent Janajati mothers received no T.T. Vaccine during pregnancy.

ix. Among Dalit respondents, 6.3 percent took iron tablets and vitamin 'A' capsules regularly, 55 percent took irregularly but 28.7 percent never took any tablets and capsule during pregnancy. Regarding Janajatis respondents, 3 percent took tablets and capsules on regular basis, 67. 5 percent on irregular basis but 29.5 percent took no iron tablets and vitamin 'A' capsules at all.

x. It is found that there exists significant association between educational status and frequency of ANC visit is retained. It means educated women have more ANC visit during pregnancy than that of uneducated women.

xi. It is clear from the data analysis revealed that there exists significant association between educational status and practice of having TT vaccine is retained. It means the educated women more practice of TT vaccine during pregnancy than that of uneducated women.

xii. Analysis of data revealed that there exists significant association between educational status and practice of having Iron tablets and Vitamin 'A' capsule intake during pregnancy is retained. It means the acceptance of Iron tablets and Vitamin 'A' capsule is positively associated with the educational status of Dalit and Janajati women i.e. educated women are expected to be more exposed to iron tablets and Vitamin 'A' capsule acceptance.

xiii. It is found that there exists significant association between spouses' educational status and frequency of ANC visit is retained. It means educated spouses' responsibility have more ANC visit than that of uneducated spouses' respondents. This may be due to fact that as increase the level of education, the level of utilization of ANC visits also increases.

xiv. Analysis of data revealed that there exists significant association between educational status of respondents' mother-in-law and frequency of food intake during pregnancy is rejected. It means educational status of respondents' mother-in- law do not have significant association with the food intake during pregnancy.

5.2.5 Delivery Service

i. Out of total respondents, 37.4 percent Dalits and 37.5 percent Janajatis' deliveries took place at health institutions whereas 62.6 percent Dalit and 62.5 percent Janajatis deliveries took place at home.

ii. Among Dalit respondents, 94.3 percent had normal delivery, 4.3 percent had operational and 1.3 percent underwent prolonged labour. In case of Janajati respondents, 99 percent had normal delivery and only one percent had operational delivery.

iii. Similarly, 36.7 percent Dalit and 40.5 percent Janajati deliveries are assisted by health personnel (Doctors, Nurses and FCHVs) whereas 63.3 percent of the Dalits and 59.5 percent of the Janajatis deliveries are assisted by family members.

iv. Among Dalit respondents, 47 percent, 29 percent, 17.7 percent, 57 percent and only 0.7 percent felt pain, happy, normal, weak and sad immediately after delivery respectively. Regarding Janajati respondents, 41 percent felt pain, 20 percent happy, 37 percent normal and only 2 percent sad after delivery.

v. In the study area, 38.3 percent Dalits and 42 percent Janajati mothers cut their baby's umbilical cord with sterile blade. In contrast, 31 percent of Dalits and 19 percent Janajati mothers cut their baby's umbilical cord with sickle/knife.

vi. Among Dalit respondents, 32.7 percent cleaned privacy part daily, 35.3 percent on every alternate day, 29.3 percent twice a week and 2.7 percent once a week after delivery. In case of Janajati respondents, 15.5 percent cleaned the privacy part daily, 45 percent on every alternate day, 33.5 percent twice a week and 6 percent cleaned once a week after delivery.

vii. It is found that there exists significant association between educational status and place of delivery is accepted. It means the preference of respondents making delivery at home was higher among illiterate group. Regarding the

literate, frequency of delivery at health institution was higher among the mother who had secondary or higher secondary education.

viii. It is clear from the data analysis revealed that there exists significant association between educational status and assistance during delivery is retained. It means the assistance during delivery is varies on educational status of the respondents.

ix. Analysis of data revealed that there exists significant association between educational status and umbilical cord cutting instrument is rejected. It means educational status of Dalit and Janajati women do not have significant association with the practice of umbilical cord cutting instrument. It seems that they are not so much aware regarding the instrument used for cutting umbilical cord and still they follow traditions using these instruments are still playing significant role at their home.

x. It is found that there exists significant association between educational status respondents' spouses and place of delivery is retained. It means the higher secondary educational level of the respondents' spouses education more frequent ANC visit during pregnancy than that of uneducated spouses.

xi. The analysis revealed that there exists significant association between educational status respondents' father-in law and place of delivery is retained. It means the institutional delivery is higher among literate father-in law as compared to among illiterate ones.

xii. It is clear from the data analysis revealed that there exists significant association between educational status respondents' father-in law and place of delivery is retained. It means the institutional delivery is higher among literate father-in law as compared to among illiterate ones.

5.2.6 Post-natal Care

i. Out of total respondents, 31.5 percent Dalits and 38 percent Janajatis followed post-natal check up one time during pregnancy. In opposition, 64 percent Dalits and 62 percent Janajatis never had their checkup during post-natal period.

ii. Among total respondents, 41.3 percent Dalit and 15 percent Janajati mothers faced complications like heavy bleeding, lower abdominal pain, weakness and

shivering during pregnancy. In contrast, 58.7 percent Dalit and 85 percent Janajati mothers faced no any problems during post-natal period.

iii. In the study area, among Dalit respondents, 44 percent performed after light work, 55 percent general work and only one percent worked hard during post-natal period. Regarding Janajati respondents, 43 percent performed light work and 57 percent reported they had general work during post-natal period.

iv. Among Dalit respondents, 39 percent took food at least two times in a day, 57.3 percent three times in a day and 3.7 percent four times in a day during post-natal period. In the case of Janajati respondents, 14 percent took food at least two times in a day, 84.5 percent took three times and only 1.5 percent four times in a day during post-natal period.

v. Out of total respondents, 39.4 percent cleaned their baby with a mop of clean cloths. Among them, 38 percent Dalits and 41.5 percent Janajatis cleaned the baby with mop with clean cloth.

vi. Among the total respondents, 4.2 percent only mothers fed colostrums to newly born baby. Among them, 14 percent Dalits and 7 percent Janajatis have fed colostrums to newly born baby.

vii. In the study area, 51.3 percent Dalit and 49 percent Janajati mothers utilized temporary contraceptive devices (Pills and Depo) where as 48.7 percent Dalit and 51 percent Janajati mothers did not utilize any devices to avoid probable pregnancies.

viii. Among Dalit respondents, 3.7 percent received free delivery service, 2.7 percent had incentive for ANC visit, 23.3 percent had free delivery with cash payments and 70.3 percent did not receive any facilities provided by Aama program. In the case of Janajati respondents, 3 percent received incentive for ANC visit, 27.5 percent got free delivery with cash payments and remaining 69.5 percent received no facilities provided by Aama program which showed poor performance in safe motherhood practice.

ix. It is found that there exists significant association between educational status and frequency of postnatal check up is accepted. It means the higher secondary educational status of the respondents had more frequent postnatal check up visit they attended during postnatal period than that of uneducated women.

x. The analysis revealed that there exists significant association between educational status and type of work during postnatal period is retained. It means the type of work during postnatal period is varies on educational status. The higher secondary educational status level of the respondents had more light work they undertook during postnatal period.

xi. It is clear from the data analysis revealed that there exists significant association between educational status and practice of colostrums feeding is accepted. It means colostrums feeding practice was higher among literate mothers as compared to illiterate ones. Educational status plays significant role in using the colostrums feeding practices of Dalit and Janajati mothers.

xii. It is found that there exists significant association between educational status respondents' mother-in law and frequency of postnatal is retained. It means the educational status plays significant role in attending the postnatal checkup practices.

5.3 Discussion on Result

The results obtained from the analysis and interpretation of data has been discussed and presented in the following paragraphs.

Safe motherhood is one of the important programs of government of Nepal. Antenatal care, place of delivery, delivery conducted by skilled birth attendants and postnatal care are key components of safe motherhood program. Government of Nepal has target of reducing maternal mortality through institutional delivery at health incentive facility since 2005. The major indicators of safe motherhood are ANC visits, place of safe delivery and postnatal check up in government recommended and supported sub health posts, health posts, primary health centers and birthing centers established in hospitals. Study is aimed to explore whether literacy and education level of Dalit and Janajati women is associated with adoption of safe motherhood practices offered by Nepal government.

As per figure 4.3 and 4.4, it is clear that Dalit mothers had less frequency of ANC visits than that of Janajati mothers. However, lack of knowledge on safe motherhood and low educational status was one of the causes for absences of ANC visit for both Dalit and Janajati women. Furthermore, on the basis of table 4.1, it is observed that there is significant association between educational status and ANC visit. The data reveals that the higher secondary educational levels of the respondents more frequent

ANC visit take place during pregnancy. The result of the present study are corroborated by Pradhan & et.al (2013). This study revealed that women with low educational level are less likely to use recommended number of ANC visits. Education of mother is found significantly associated with the ANC service utilization in this study. Educated mothers are about three times more likely to have four recommended ANC visit than that of mother who did not have formal education in Kaski and Parsa districts. NDHS 2011 showed that 25 percent of illiterate mothers had less ANC visit while one percent mother having SLC or above education had one visit (MoHP, 2012). Different studies conducted in Nepal as well as abroad showed that there is an association of level of mother education with ANC visit (Joshi, 2014).[48]It can be concluded that increased education could bring increased knowledge and awareness among respondents in health services. Similarly, they had health related information and better communication with their spouses and possessed more decision making power, negotiating skills, and ability to demand adequate services in the concern communities.

Mothers with secondary or above (6.2%) level of education are three to four times more likely to make four recommended ANC visits than illiterate (48.6%) mothers with primary education (7.4%). The findings revealed that women's education status is significantly associated with the ANC visits and service utilization which is similar to the findings shown by national study (MoHP &et, al, 2011). Mothers from Janajatis are found to have four recommended visits than mothers of Dalits. The finding of the Janajati mothers is more likely to make four ANC visits as per guidelines of NDHS 2011 (Meheta, 2012).[49]It means Janajati mothers are having better safe motherhood practices than that of Dalit mothers in the study area.

Consequently, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of ANC visit, has been retained.

As per table 4.8, it is observed that more Janajati respondents received two times TT immunization as compared to Dalit respondents .However, the coverage rates of Dalit and Janajati women appears to be somewhat low. Furthermore, on the basis of table 4.9, it is found that there is significant association between educational status and

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[48]Joshi ,& et.al.(2014). Factors associated with the use and quality of antenatal care in Nepal: a population based study using the demographic and health survey data, BMC.

[49]Meheta&et.al, S.(2012). Nepal household survey.Kathmandu:MoHP/GoN.

practice of having TT vaccine during pregnancy. It may be concluded that the number of TT vaccine varies on the level of educational status. This result has been partially supported by Sharma (2012). He observed that mother's education is associated with the practice of TT vaccine and TT vaccine increasing linearly with education.

Consequently, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of having TT vaccine, has been retained.

From table 4.10, it is clear that Dalit respondents received iron tablet and vitamin 'A' capsule more regularly than the Janajati respondents did. It is because they didn't have knowledge about importance of regular using iron tablet and vitamin 'A' capsules during pregnancy. However, the consuming rate of iron tablet and vitamin 'A' capsule of both Dalit and Janajati women is very low. Moreover, from table 4.11, it is observed that there is association between educational status and practice of having iron tablet and vitamin 'A' capsule intake during pregnancy. It is found that the acceptance of iron tablet and vitamin 'A' capsule is also positively associated with educational status of Dalit and Janajati women. This result has been substantiated by walker (1996). He illustrated that educated women are expected to be more exposed to iron tablets and vitamin 'A' capsules acceptance during pregnancy period.

Thus, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of iron tablet and vitamin 'A' capsule ,has been retained.

As per figure 4.5 and 4.6, it is observed that the percentage of Dalits safe delivery at health institution is the same as that of Janajatis safe delivery at health institutions. It further reveals that both Janajatis and Dalits women prefer home delivery instead of health centers. Moreover, from table 4.12, it is found that there is positive association between educational status and place of delivery. It may be concluded that both Dalit and Janajati mothers who delivered at home, the reason not going to health institution for delivery are being alone at home, delivered on way, no time to go to health facility, felt easy on home, facility not at the time of need etc. This result has been corroborated by Hossain & et.al (2005).The study shows that (48.6%) mothers are illiterate and (51.4%) literate. Delivery at home is found higher among illiterate group. Delivery at health institution is higher among the mothers who have secondary or higher secondary education. This may be because education provides a wide range of favorable behavior. In contrast 16.9 percent births of uneducated mother deliveries took place in health facility. Ninety-four percent mothers with higher secondary

education took place in health facility. A study done in Kathmandu revealed that low maternal education level compared to those with higher secondary education is a significant risk factor for home delivery (Bolam, 1997).[50] Mothers' education is associated with the use of maternal health care, increasing linearly with education (Abbas, 1986).[51] A study done in Dhaka also supported the study, which shows that increasing maternal education status is closely associated with significant decrease in the chance of home delivery. Mother who had at least primary education had higher incidence of hospital delivery as compared to those with no education (Hossian, 2005).[52]

Therefore, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of place of delivery, has been accepted.

On the basis of table 4.14, it is found that the delivery assisted by family members is more common among Dalit and Janajati women. Moreover, as per table 4.15 revealed that the educational status depends on assistance during delivery. This result has been corroborated by MoH & et.al (2007). They found that almost half deliveries are assisted by relatives or family members and 7 percent birth took place without any assistance by family members.

Consequently, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of assistance during delivery, has been accepted.

From table 4.17, indicated that majority of Dalit and Janajati are unaware of sterilized instruments for a safe cutting of umbilical cord. Furthermore, as per table 4.18, it is clear that there is no significant association between educational status and umbilical cord cutting instruments. It is found that they were not much aware regarding the instrument use for cutting umbilical cord and still they believed on traditional instrument for cutting umbilical cord. Cultural traditions using these instruments are still playing significant role at their home. This result has been partially supported by

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[50]Bolam& et.al (1997). Factor affecting home delivery in the Kathmandu valley Nepal. *The Journal of Nepal Medical Association* ,35,122-129.

[51]Abbas & et.al.(1986). Determinants of the utilization of maternal and child health service in Jordan.*International Journal of Epidemiology*.12, 404-407.

[52]Hossain,&et.al. (2005). Determinants of choice of delivery care in some urban slums of Dhaka City. *Pakistan Journal of Social Sciences*.3, 469-475.

Prasad (2012). He illustrated that the higher secondary education of the respondents have the more safely and healthy practice they adopt for cutting umbilical cord during delivery.

Thus, the hypothesis, the educational status of Dalit and Janajati women is not significantly associated with the practice of umbilical cord cutting instrument, has been rejected.

As per figure 4.7 and 4.8, it is found that the respondent's postnatal check up is less frequent and irregular than the national level check up status. In comparing Dalit and Janajati respondents Janajati had their postnatal checkup conducted more frequent than that of Dalit. Moreover, on the basis of table 4.20, it is observed that there is significant association between educational status and frequency of postnatal checkup. It is clear that the frequency of postnatal checkup visit is significantly depends on educational status. The higher secondary educational status of the respondents had more frequent postnatal checkup visit they attended during postnatal period The finding of the study showed that about one third (36.8%) of the mothers had utilized postnatal check up services. A similar study conducted in Nepal by Dhakal & et al. in two VDCs of Kathmandu valley in 2007 showed similar results (34%) and another study done in Nigeria revealed that 31 percent of mother received postnatal check up services (Rai, 2012).[53] A study done in India showed 37.4 percent women received postnatal check up services within two weeks of delivery (WHO, 2012). The finding is lower in comparison to results of NDHS (2011) which showed a postnatal check up utilization rate of 45 percent. Another study by Neupane & et al. in 2013 showed that only 21 percent of new mothers received postnatal check up services (Neupane & et al., 2013).[54] Respondents are literate to use more postnatal check up services than those illiterate ones.

Therefore, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice postnatal checkup, has been retained.

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[53]Rai,& et.al. (2012). Utilization of maternal health care service among married adolescent women: inside from the Nigeria demographic and health survey 2008. Women's Health Issues,4(22): 407-414.

[54]Neuapne& et.al.(2013). Utilization of postnatal care among Nepalese women.*Maternal and Child Health Journal*, 36-42

On the basis of table 4.22, it is found that Dalit respondents handled lighter work than the Janajati respondents did. It is because Janajati respondents had lack of awareness about the right type of work during postnatal period. Furthermore, from table 4.23, it is clear that there is significant association between educational status and type of work during postnatal period. It may be concluded that the higher secondary educational level of the respondents had the more light work the under took during postnatal period.

Thus, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of type of work, has not been rejected.

As per table 4.26, it is found that large numbers of Dalits conduct colostrums feeding practice as compared to Janajati respondents. Most of the respondents did not feed colostrums due to lack of awareness and its value from the scientific and health point of view with traditional culture. Moreover, on the basis of table 4.27, it is clear that there is significant association between educational status and colostrums feeding practice. Colostrums feeding practice was higher among literate mothers as compared to illiterate ones.

Therefore, the hypothesis, the educational status of Dalit and Janajati women is significantly associated with the practice of colostrums feeding, has been accepted.

From table 4.30, it is clear that there is positive significant association between spouse's educational status and ANC visit. It may be concluded that frequency of ANC visit highly depends on educational status of spouses. Education of spouse is found strongly associated with ANC visit during pregnancy in this study. A mother whose spouse is educated is about twice to have ANC visit and service utilization than counterpart. In this regard, a national level study NDHS 2011 showed similar result. A study conducted in Ethiopia also showed that higher secondary education of spouse was positively associated with the skilled ANC attendants (Tarekegn, 2014).[55] This may be explained on the basis that educated spouses are aware of the benefits of ANC services. The women have more freedom for mobility and decision making and capable to communicate with health workers for appropriate health care.

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[55]Tarekegn,&et.al.(2014).Determinants of maternal health service utilization of Ethiopia: analysis of 2011 Ethiopian demographic and health survey. BMC pregnancy and child birth,14 (1): 61.

Therefore, the hypothesis, the educational status of respondents' spouse is significantly associated with the practice of ANC visit, has been accepted.

Table 4.31, reveals that there is significant association between educational status of respondents' spouses and place of delivery. The preference of delivery at health institution was higher among the respondents whose spouses have secondary or higher secondary education. This result has been corroborated by DoHS (2009). This study shows that spouses have a significant role in deciding place of delivery during delivery period. This study revealed that increasing maternal educational status was closely associated with significant decrease in the chance of home delivery. Mothers who had at least primary education had higher incidence of hospital delivery as compared to those with home delivery.

Thus, the hypothesis, the educational status of respondents' spouses is significantly associated with the practice of place of delivery has not been retained.

From table 4.32, it is observed that there is significant association between spouse's educational status and postnatal check up. The adoption of postnatal check up is positively associated with educational status of spouses i.e. educated spouses are aware of more frequency of postnatal check up. The educational status of respondents' spouses is also significant associated with postnatal check up. Respondents who are literate are twice more likely to use postnatal checked up than those who are illiterate and this is similar to findings from other study done in Nepal (Dhakal and et al. 2007).[56] Consequently, the hypothesis, the educational status of respondents' spouse is significantly associated with the practice of postnatal check up, has been accepted.

From table 4.33, it is found that there is significant relation between educational status of respondents' father-in law's and place of delivery. The data shows that father-in-law educational status has direct effect on women utilization of place of delivery. Institutional delivery is higher among literate father-in-law as compared to illiterate ones.

Therefore, the hypothesis, the educational status of respondents' father-in-law is significantly associated with the practice of place of delivery has been accepted.

[56]Dhakal and et al. (2007).Utilization of Postnatal care among rural women in Nepal. BMC Pregnancy and Child birthd , 7 (1): 19.

From table 4.34, it is clear that frequency of ANC visit depends on educational status of mothers- in- law. This may due to fact that with increased level of education, the level of utilization of ANC services also increases.

Thus, the hypothesis, the educational status of respondents' mother-in-law is significantly associated with the practice of ANC visit, has not been rejected.

As per table 4.35, it is clear that there is significant association between mother-in-law educational status and schedules postnatal check up. Frequency of postnatal check up is higher among literate mothers-in-law's as compared to illiterate.

Therefore, the hypothesis, the educational status of respondents' mother-in-law is significantly associated with the practice of postnatal check up, has been retained.

On the basis of table 4.36, it is found that there is no significant association between respondents' mother –in- law's educational status and frequency of food intake during pregnancy. The result has been corroborated by Thapa (2010). He found that there is no significant association between educational status of respondents' mother- in –law and frequency of food intake during pregnancy. Mothers-in-law have no positive attitude towards food intake of their sister-in-law. Despite some level of education, they have not yet changed their attitude toward food intake during pregnancy.

Thus, the hypothesis, the educational status of Dalit and Janajati respondents' mother – in – law is significantly associated with the practice of food intake during pregnancy, has been rejected.

On the basis of figure 4.13 and 4.14, it is found that Janajati received higher degree of education, health and scholarship facilities provided by the government than the facilities the Dalits received. The available health facilities are utilized by Janajati communities and the safe motherhood. Moreover, as per table 4.39, it is illustrated that significant association between social awareness regarding facilities provided by the government and frequency of ANC visit. It is found that social awareness towards government facilities plays vital role in promoting safe motherhood practices (ANC visits).

Consequently, the hypothesis, the social awareness regarding facilities provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visit, has been retained.

On the basis of table 4.40, it is found that the social awareness regarding government facilities is depends on frequency of postnatal check up of Dalit and Janajati mothers.

Consequently, the hypothesis, the social awareness regarding facilities provided by

the government to the Dalit and Janajati women is significantly associated with the practice of postnatal check up, has been accepted.

From figure 4.15 and 4.16, it is observed that the Janajati secured a higher degree of rights provided to them by government than the degree had been provided with. Since Janajati are socially more aware than Dalits, Janajatis are shown to have a higher access to the rights provided by government than the Dalits have got. Furthermore, as per table 4.41, it is found that there is significant association between social awareness regarding rights provided by the government and frequency of ANC visit. In other words, the number of visits depends on the social awareness regarding government rights.

Therefore, the hypothesis , the social awareness regarding rights provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visit has been accepted.

As per table 4.42, it is found that there is significant association between the respondents' social awareness regarding rights provided by the government and frequency of postnatal check up. The result obtained from analyzed concludes that government should make citizen aware of their fundamental rights in promoting quality of mother and their children of both Dalit and Janajati communities.

Thus, the hypothesis, the social awareness regarding rights provided by the government to the Dalit and Janajati women is significantly associated with the practice of postnatal check up, has been retained.

As per figure 4.17 and 4.18, it is clear that both Dalits and Janajati respondents had almost similar degree of awareness regarding reservation facilities provided by government to them. Thus, government reservation has an equal degree of influence of safe motherhood practices of both Dalits and Janajatis. Moreover, on the basis of table 4.43, it is revealed that there is significant association between social awareness regarding government reservation and ANC visit. This may due to the fact that reservation provides more aware towards their ANC visit.

Thus, the hypothesis, the social awareness regarding reservation provided by the government to the Dalit and Janajati women is significantly associated with the practice of ANC visit, has been retained.

From table 4.44, it is observed that the frequency of postnatal check up depends on social awareness regarding government reservation. The study shows the fact that

government should increase the awareness regarding the reservation of their respective sector of development among Dalit and Janajati communities.

Therefore, the hypothesis, the social awareness regarding reservation provided by the government to the Dalit and Janajati women is significantly associated with the practice of postnatal check up, has been accepted.

5.4 Educational Implications

Education is the most important factor in every aspect of human being. More specifically, it is applicable for women welfare from the point of view of safe motherhood. This is an important means, which can avoid all the unwanted problems occurring in the reproductive age of women. Effective education the prerequisite for sustainable human development and investigates the ways for attitudinal and behavioral changes in terms of safe motherhood practices. Education institutions can provide their values and can be important vehicle in all societies for installing gender, child spacing, ANC, delivery care, postnatal care including sexual and reproductive behavior. People can achieve general knowledge and be careful about problems related to safe motherhood practices. However, Nepal government has formulated different policies in-terms of safe motherhood services and allocating sound proportion of budget in health sector. But due to lack of proper implementation, government's efforts are not carried out effectively. Maternal and infant mortality ratio is still high in the study areas due to lack of basic health services at the time of antenatal, natal and postnatal period. No adequate facilities are provided for safe motherhood services. Women's educational status is very miserable in most of the remote areas of the country. Therefore, women need skills oriented education and employment to solve their problems related to reproductive health in the field of safe motherhood practices. The research work may be utilized for generating the Dalits and Janajati women's awareness about the fundamental right, facilities and reservation provided to them by the government through different campaigns. This also may be a useful guideline for introducing educational status, social awareness and safe motherhood practices in the school level curriculum so as to promote these aspects in the marginalized communities of Nepal. This study may help to solve the reproductive health problem of the women by conducting awareness programs about the utilization of health services from the conception to the birth in Parsa and Kaski districts of Nepal. The study also provides information about recent status of

education, social awareness and safe motherhood practices to policy makers, planners, researchers, NGOs/INGOs and government organizations.

5.5 Recommendations

i. Utilization of safe motherhood practices is highly influenced by education and social awareness. These all indicators need to be used at grass root level. Different programs like training, seminar, pictorial, demonstratives etc, may be carried out by concerned authorities.

ii. Due to lack of information, many women are not able to practice the safe motherhood services properly. Information, education and communication (IEC) programs may excel adoptions.

iii. Formal and non-formal education with massive awareness campaign is needed to promote safe motherhood practices (Antenatal care, Delivery service and post-natal care) between both communities (Dalit and Janajati) in Nepal.

iv. Promotion of participation of women in different agencies and institutions should be carried out effectively in the improvement of decision making and better use of safe motherhood services.

v. Education of the spouse and mother in law's is one of the important components of safe motherhood practices. Thus, spouses and mothers in law are to be involved in antenatal, natal and post-natal awareness programs.

vi. Existing government strategy for providing incentive for ANC visit and health institutional delivery should be continued and additional incentive may be imperative to improve uptake of safe motherhood practices. .

vii. To enhance the health status of the women, it is necessary to raise the literacy status before planning and implementing for better utilization of antenatal natal and postnatal (Safe motherhood) care services.

viii. The utilization of safe motherhood services should be made easily accessible for the poor specially government facilities (Hospital, PHC, HP and SHP) with reliable services.

ix. Mothers who came for antenatal check up should be provided adequate information about availability of safe delivery incentive and free health

service. Thus, effective campaigns may be organized for diffusion, adoption and follow-up practices related to women education, health and wellbeing.

5.5.1 Suggestions for Further Research

Following Suggestions are given for researchers who are interested to study the educational status, social awareness and safe motherhood practices in the area in the future:

i. The present status of national level management of educational status and safe motherhood services (Antenatal, natal and postnatal period).
ii. Monitoring process on policy and program implementation of education and safe motherhood services.
iii. Social awareness of women seeking for safe motherhood services.
iv. Comparative study of different caste/ Ethnicity for social awareness and safe motherhood practices.
v. Educational status and care of new born baby.
vi. There are many issues related to gender based violence, family planning services, education and empowerment of women, social awareness and unsafe abortion, education and uterus prolapsed and others.

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APPENDIX - I

Questionnaire/Schedule on educational status, social awareness and safe motherhood practices.

Researcher

Om Prasad Baral

Research Scholar (Ph.D)

Jaipur National University

Jaipur

Supervisor

Dr. Kamla Vashisth

Director School of Education

Jaipur National University

Jaipur

General Instructions

1. There are total two sections- A and B in this questionnaire/schedule. You have to answer all sections and all questions.
2. Section –A is relating to demographic profile of the respondents.
3. Section- B contains 34 questions relating to the educational status, social awareness and safe motherhood practices.
4. Please tick ( ) the suitable answer

I am …….. I am here to collect data related Educational status, social awareness and safe motherhood practice of Dalit and Janajati women of Nepal. As you meet the criteria. I will invite you in the research. However, your participation is voluntary and your information will be kept confidential. Your are not compel to answer all question(Interview schedule) and can quit any time whenever you feel uncomfortable. It will neither harm nor benefit you but it can provide good information for planning and implementing programs in similar communities you are living. Can I start interview schedule?

Yes ..…… Signature

No……. Date on interview of questionnaire

Interviewer Name

VDC Name

Ward No.

Name of the Respondent:

Age : Occupation:

Type of Family: Caste :

No.of Total Family: No. of Son/Daughter:

Religion :

Educational Status:

1. Level of education
    1. Literate
    2. Illiterate
2. Education Status:
    1. Literate
    2. Primary education
    3. Lower secondary education
    4. Secondary education
    5. Higher secondary education
3. Spouse's Educational Status
    1. Literate
    2. Primary education
    3. lower secondary education
    4. Secondary education
    5. Higher secondary education
4. Father- in- law educational status
    1. Literate
    2. Primary education
    3. lower secondary education
    4. Secondary education
    5. Higher secondary education
5. Mother- in- law educational status
    1. Literate
    2. Primary education
    3. lower secondary education
    4. Secondary education
    5. Higher secondary education

6. Father's educational status

    1. Literate
    2. Primary education
    3. lower secondary education
    4. Secondary education
    5. Higher secondary education

7. Mother's educational status

    1. Literate
    2. Primary education
    3. lower secondary education
    4. Secondary education
    5. Higher secondary education

Social Awareness:

8. What are the facilities provided by government to Dalit and Janajati ?

    1. Education
    2. Health
    3. Health and education
    4. Scholarship
    5. I don't know

9. What rights have been provided by government to Dalit and Janajati ?

    1. Right to equality of Dalit and janajati
    2. Right to no discrimination of dalit and janajati
    3. Right to reservation of Dalit and Jananati
    4. Right to equity of Dalit and janajati
    5. I don't know

10. In which sectors has the government given reservation to Dalit and Janajati ?

    1. Government service
    2. NGO/INGO service
    3. Private Service
    4. Special for Education
    5. I don't know

11. What is your response related to traditional patterns of safe motherhood?

    1. Satisfactory as traditional patterns
    2. Unscientific as traditional patterns
    3. Traditional patterns as mixed views

Safe motherhood practices:

Antenatal care practice:

12. How many times have you done antenatal checkup during pregnancy?
    1. I
    2. II
    3. III
    4. IV
    5. more than four
13. Who did you go for ANC (Antenatal Checkup) during pregnancy?
    1. Doctor
    2. Nurse
    3. FCHV
    4. Health worker
14. Why did you not go for antenatal Checkup?
    1. Lack of awareness
    2. Lack of time
    3. Lack of money
    4. Others …….
15. Who is your best helper during pregnant period?
    1. Husband
    2. Mother in law
    3. Friends
    4. Any family member
    5. Others
16. Which food did you take during pregnancy period ?
    1. Normal food
    2. Additional food
    3. Special food
    4. Others ……
17. How many time did you take TT vaccine during pregnancy?
    1. 1 time
    2. times
    3. 3times
    4. times
    5. Never

18. How often do you have a bath?
    1. Daily
    2. In alternate day
    3. Twice a week
    4. Once a week
    5. Others …

19. Smoking or Alcohol did you take during pregnancy period ?
    1. Smoking
    2. Alcohol
    3. Both alcohol and smoking
    4. Neither smoking nor alcoholic

20. What problem do you face mainly in pregnant period :
    1. Vomiting time to time
    2. Swelling leg
    3. Sometimes bleeding
    4. Anemia
    5. Others…

Natal care Practice:

21. Where did you have delivery :
    1. At home
    2. At hospital

22. Who helped you to deliver the child ?
    1. Doctor
    2. Nurse
    3. FCHV
    4. Family member
    5. Others……

23. What was the mode of your delivery?
    1. Normal delivery
    2. Vacuum delivery
    3. Operation
    4. Others…

24. How did you feel immediately after the delivery?

    1. Happy feel
    2. Pain feel
    3. Sad feel
    4. Normal feel

25. Which instrument did you use to cut umbilical cord ?

    1. Sickle / knife
    2. Blade
    3. Sterile blade
    4. Others…….

Postnatal Care:

26. How many times did you clean privacy part per day?

    1. I
    2. II
    3. III
    4. IV

27. Was there any health problem after delivery?

    1. Heavy bleeding
    2. Delay placenta discharge
    3. Lower abdomen pain
    4. Weakness and shivering

28. How many times did you medical checkup (Post natal checkup) in the postnatal period?

    1. One time
    2. Two times
    3. Three times
    4. Never

29. What kind of work do you do in postnatal period?

    1. Light
    2. General
    3. Hard
    4. Others…….

30. How many times did you have meal a day?
    1. Two
    2. Three
    3. Four
    4. others …….
31. After the birth of baby how you clean it ?
    1. Wash with Luke warm water
    2. Wash with water
    3. Mop up with cloth
    4. Mop up with dry and clean cloth
32. How did you use your colostrums to new born baby ?
    1. I threw out
    2. I fed baby after throwing first
    3. I fed
    4. I didn't care
33. What family planning devices did you use after delivery ?
    1. Pills
    2. Depo injection
    3. Norplant
    4. Copper –T

34. What facilities have been provided by Amma program of Nepal ?
    1. Cash payment
    2. Free delivery services
    3. Incentive for ANC visit
    4. I don't know

APPENDIX –II

Interview Schedule for Dalit and Janajati Women of Nepal

Participants: **Educated** and **Uneducated** Dalit and Janajati Mothers of Study Area .

1. Are you aware about antenatal checkup? Do you think it is important to go for antenatal checkup? In your view, what are the advantages of going for antenatal checkup?
2. Did you ever go for checkup during antenatal period? If yes, what enabled you to go for check up?
3. If no, what are the reasons for not going for checkup? What, in your view are, the barriers to availing of antenatal services?
4. Are aware about postnatal check up? Do you think it is important to go for postnatal checkup? In your view, what are the advantages of going for postnatal checkup?
5. Did you ever go for checkup during postnatal period? If yes, what enabled you to go for check up?
6. If no, what are the reasons for not going for checkup? What, in your view are, the barriers to availing of postnatal services?
7. What changes in community and health facility would enable you to use antenatal and postnatal care services?
8. In your view, why is the home delivery is more frequent and common than institutional delivery in your area?
9. In your view, what facilities, rights and reservations have been given to Dalits and Janajatis for safe motherhood program of Nepal?

APPENDIX –III

प्रश्नावली परिचय तथा स्वीकृति

मेरो नाम .....हो । म नेपालमा दलित र जनजाति महिलाहरूको शैक्षिक अवस्था, सामाजिक चेतना र सुरक्षित मातृत्वको अभ्यास विषयमा तथ्याङ्क संकलन गर्न यहाँ आएको छु । तपाई यसको लागि छनौटमा पर्नु भएकोले यहाँलाई सहभागी गराउन चाहन्छु । तपाई सहभागी हुन स्वतन्त्र हुनुहुन्छ र यहाँबाट प्राप्त सूचनाहरू गोप्य रहने छन् । तपाईको शैक्षिक अवस्था, सामाजिक चेतना र गर्भवति, सुत्केरी र सुत्केरी पछिको स्याहारको अनुभव लगायतका व्यक्तिगत प्रश्नहरू सोध्न सक्नेछु । तपाईलाई उत्तर दिन वाध्य पारिने छैन साथै नचाहेको खण्डमा अन्तरवार्ता कुनै पनि समयमा छाड्न सक्नुहुन्छ । यो अन्तरवार्ताबाट तपाईलाई कुनै फाइदा वा घाटा छैन तर यो अध्ययनले तपाई र तपाई जस्तै समुदायलाई फाइदा पुग्न सक्छ । के तपाई यो अन्तरवार्तामा भाग लिन मञ्जुर हुनुहुन्छ ?

मञ्जुर छु .....१ हस्ताक्षर

मञ्जुर छैन .....२ अन्तरवार्ता मिति:

फाराम नं.

अन्तरवार्ता लिनेको नाम: गा.वि.स.को नाम: टोलको नाम:

उत्तरदाताबाट आएको मिल्ने उत्तरको ठाउँमा (☐) ठिक चिन्ह लगाउनुहोस् । उत्तरदाताको नाम:

उमेर : पेशा :

परिवारको किसिम: जात:

परिवारको संख्या: छोरा/छोरीको संख्या: धर्म:

शैक्षिक अवस्था

१. शैक्षिक स्तर

क. साक्षर ख. निरक्षर

२. शैक्षिक अवस्था

क. अनौपचारिक शिक्षा (विद्यालय विना साक्षर) ख. प्राथमिक शिक्षा

ग. निम्न माध्यमिक शिक्षा घ. माध्यमिक शिक्षा

ङ. उच्च शिक्षा

३. पतिको शैक्षिक अवस्था

क.साक्षर ख. प्राथमिक शिक्षा

ग. निम्न माध्यमिक शिक्षा घ. माध्यमिक शिक्षा

ङ. उच्च शिक्षा

४. ससुराको शैक्षिक अवस्था

क.साक्षर

ख. प्राथमिक शिक्षा

ग. निम्न माध्यमिक शिक्षा

घ. माध्यमिक शिक्षा

ङ. उच्च शिक्षा

५. सासूको शैक्षिक अवस्था

क.साक्षर

ख. प्राथमिक शिक्षा

ग. निम्न माध्यमिक शिक्षा

घ. माध्यमिक शिक्षा

ङ. उच्च शिक्षा

६. बुवाको शैक्षिक अवस्था

क.साक्षर

ख. प्राथमिक शिक्षा

ग. निम्न माध्यमिक शिक्षा घ. माध्यमिक शिक्षा

ङ. उच्च शिक्षा

७. आमाको शैक्षिक अवस्था

क.साक्षर

ख. प्राथमिक शिक्षा

ग. निम्न माध्यमिक शिक्षा

घ. माध्यमिक शिक्षा

ङ. उच्च शिक्षा

सामाजिक चेतना

८. दलित र जनजातिलाई सरकारले प्रदान गरेका सुविधाहरू के के हुन् ?

क. शिक्षा

ख. स्वास्थ्य

ग. स्वास्थ्य र शिक्षा

घ. छात्रवृत्ति

ङ. थाहा छैन

९. दलित र जनजातिलाई सरकारले प्रदान गरेका अधिकारहरू के के हुन् ?

क. समानता

ख. विना भेदभाव

ग. आरक्षणको अधिकार

घ. समता

ङ. थाहा छैन

१०. दलित र जनजातिका लागि सरकारले कुन क्षेत्रमा आरक्षणको व्यवस्था गरेको छ ?

क. सरकारी सेवा

ख. गैरसरकारी/अन्तराष्ट्रिय गैर सरकारी संस्थाको सेवा

ग. निजी संस्थाको सेवा

घ. विशेष शिक्षाको लागि

ङ. थाहा छैन

११. सुरक्षित मातृत्व सम्बन्धमा परम्परागत धारणाप्रति तपाईको प्रतिक्रिया के छ ?

क. परम्परागत धारणाप्रति सन्तुष्त

ख. परम्परागत धारणा अवैज्ञानिक

ग. परम्परागत धारणाप्रति मिश्रित प्रतिक्रिया

सुरक्षित मातृत्व अभ्यास गर्भवति हेरचाह अभ्यास

१२. तपाईले गर्भवस्थामा कतिपटक स्वास्थ्य परीक्षण गर्नुभयो ?

क. प्रथम

ख. दोस्रो

ग. तेस्रो

घ. चौथो

ङ. गरिन

१३. गर्भावस्थामा तपाई कोसँग स्वास्थ्य परीक्षण गराउनु भयो ?

क. चिकित्सक

ख. परिचारीका

ग. महिला स्वास्थ्य स्वंयसेविका

घ. स्वास्थ्य कार्यकर्ता

१४. तपाई के कारणले गर्भावस्थामा स्वास्थ्य परीक्षण गराउनुभएन ?

क. चेतनाको कमिले

ख. समयको अभावले

ग. पैसाको कमिले

घ. अन्य .....

१५. गर्भावस्थामा तपाईको उत्तम सहयोगी को हुनुहुन्थ्यो ?

क. पति

ख. सासू

ग. संगिनी

घ. कुनै पनि पारिवारिक सदस्य

ङ. अन्य.....

१६. तपाईले गर्भावस्थामा कुन किसिमको खाना लिनुहुन्थ्यो ?

क. सामान्य खाना

ख. थप खाना

ग. विशेष खाना

घ. अन्य .....

१७. तपाईले गर्भावस्थामा कति पटक धनुष्टंकार विरुद्धको खोप लिनुभयो ?

क. एक पटक

ख. दुई पटक

ग. तीनपटक

घ. चार पटक

ङ. लिएकी छैन ।

१८. तपाई कहिले कहिले सरसफाइमा ध्यान दिनुहुन्छ ?

क. दैनिक

ख. एक दिन विराएर

ग. हप्तामा दुइपटक

घ. हप्तामा एक पटक

ङ. अन्य .....

१९. गर्भवती हुँदा तपाईले धुम्रपान र मद्यपान सेवन गर्नुभयो कि ?

क. धुम्रपान
ख. मद्यपान
ग. दुवै सेवन गरेको
घ. कुनै पनि सेवन नगरेको

२०. तपाईले गर्भावस्थामा कुन किसिमको समस्या भोग्नुभयो ?

क. समय समयमा वान्ता हुने

ख. खुट्टा सुनिने

ग. कहिले काहि रक्तश्राव हुने

घ. रक्तअल्पता हुने

ङ. अन्य .....

सुत्केरी स्याहारको अभ्यास

२१. तपाईले सुत्केरी कहाँ गराउनु भयो ?

क. घरमा

ख. स्वास्थ्य संस्थामा

२२. तपाईलाई सुत्केरी गराउँदा कसले सहयोग गर्नुभयो ?

क. चिकित्सक

ख. परिचारीका

ग. महिला स्वास्थ्य स्वंयसेविका

घ. परिवारका सदस्य

ङ. अन्य ....

२३. तपाईलाई सुत्केरी गराउँदा कुन विधि अपनाइयो ?

क. साधारण तरिका

ख. साधनको प्रयोग

ग. शल्यक्रिया

घ. अन्य ....

२४. तपाईले सुत्केरी हुनासाथ कस्तो अनुभूति गर्नुभयो ?

क. खुशिको अनुभूति

ख. दुखाइको अनुभूति

ग. दुखद अनुभूति

घ. सामान्य अनुभूति

२५. तपाईको बच्चाको नाभीकाट्दा कस्तो साधन प्रयोग गर्नुभयो ?

क. हसिया ,चक्कु

ख. पत्ति

ग. सफा पत्ति

घ. अन्य .....

सुत्केरी पछिको हेरचाह

२६. तपाईले दिनमा कतिपटक गुप्ताङ्ग सफा गर्नुभयो ?

क. एकपटक

ख. दुईपटक

ग. तीनपटक

घ. चारपटक

२७. तपाईलाई सुत्केरी भएपछि कुनै समस्या देखापऱ्यो ?

क. अत्याधिक रक्तश्राव

ख. सालनाल ढिलो खस्नु

ग. तल्लो पेट दुख्नु

घ. काम्नु र कमजोर हुनु

ङ. समस्या देखिएन

२८. तपाईले सुत्केरी भइसकेपछि कति पटक स्वास्थ्य परीक्षण गर्नुभयो ?

क. एक पटक

ख. दुई पटक

ग. तीन पटक

घ. परीक्षण गरिन

२९. तपाई सुत्केरी भइसकेपछि कुन किसिमको काम गर्नुभयो ?

क. हल्का

ख. सामान्य

ग. गह्रौं

घ. अन्य .....

३०. तपाई सुत्केरी भएपछि दिनमा कति पटक खाना खानुहुन्थ्यो ?

क. दुईपटक

ख. तीन पटक

ग. चार पटक

घ. अन्य .....

३१. वच्चा जन्मि सकेपछि के ले सफा गर्नु भयो ?

क. मनतातोपानीले

ख. पानीले मात्र

ग. कपडाले पुछ्ने

घ. सफा कपडाले पुछ्ने

३२. तपाईले विगौती दुधलाई के गर्नुभयो ?

क. फालिदिएं

ख. एकपटक फालेर खुवाएं

ग. खुवाएं

घ. ख्याल गरिन

३३. तपाईले सुत्केरी पछि कुन परिवार नियोजनको साधन प्रयोग गर्नुभयो ?

क. खाने चक्की

ख. तीन महिने सुई

ग. नरप्लान्ट

घ. कपर टि

ङ. अन्य ....

३४. नेपालको आमा कार्यक्रमले कुन कुन सुविधाहरू उपलब्ध गराउँदै आएको छ ?

क. नगद प्रदान

ख. निशुल्क सुत्केरी सेवा

ग. गर्भवति परीक्षण गरेवापत नगद प्रदान

घ. थाहा छैन

APPENDIX-IV

Interview Schedule for Dalit and Janajati Women of Nepal

(१) के तपाईलाई गर्भवती जाँचबारे थाहा छ ? के गर्भवती जाँच गराउन जरुरी छ ? गर्भवती जाँच गराउन किन जरुरी छ ? यसका फाइदाहरु के के हुन ?

(२) के तपाई गर्भवती जाँच गराउन जानु भयो ? यदि जानु भयो भने के के कुराले प्रोत्साहन गऱ्यो ?

(३) यदि जानु भएन भने के कारणहरुले गर्दा जानु भएन ?

(४) के तपाईलाई सुत्केरी जाँचबारे थाहा छ ? के सुत्केरी जाँच गराउन जरुरी छ ? सुत्केरी जाँच गराउन किन जरुरी छ ? यसका फाइदाहरु के के हुन ?

(५) के तपाई सुत्केरी जाँच गराउन जानु भयो?यदि जानु भयो भने के के कुराले प्रोत्साहन गऱ्यो ?

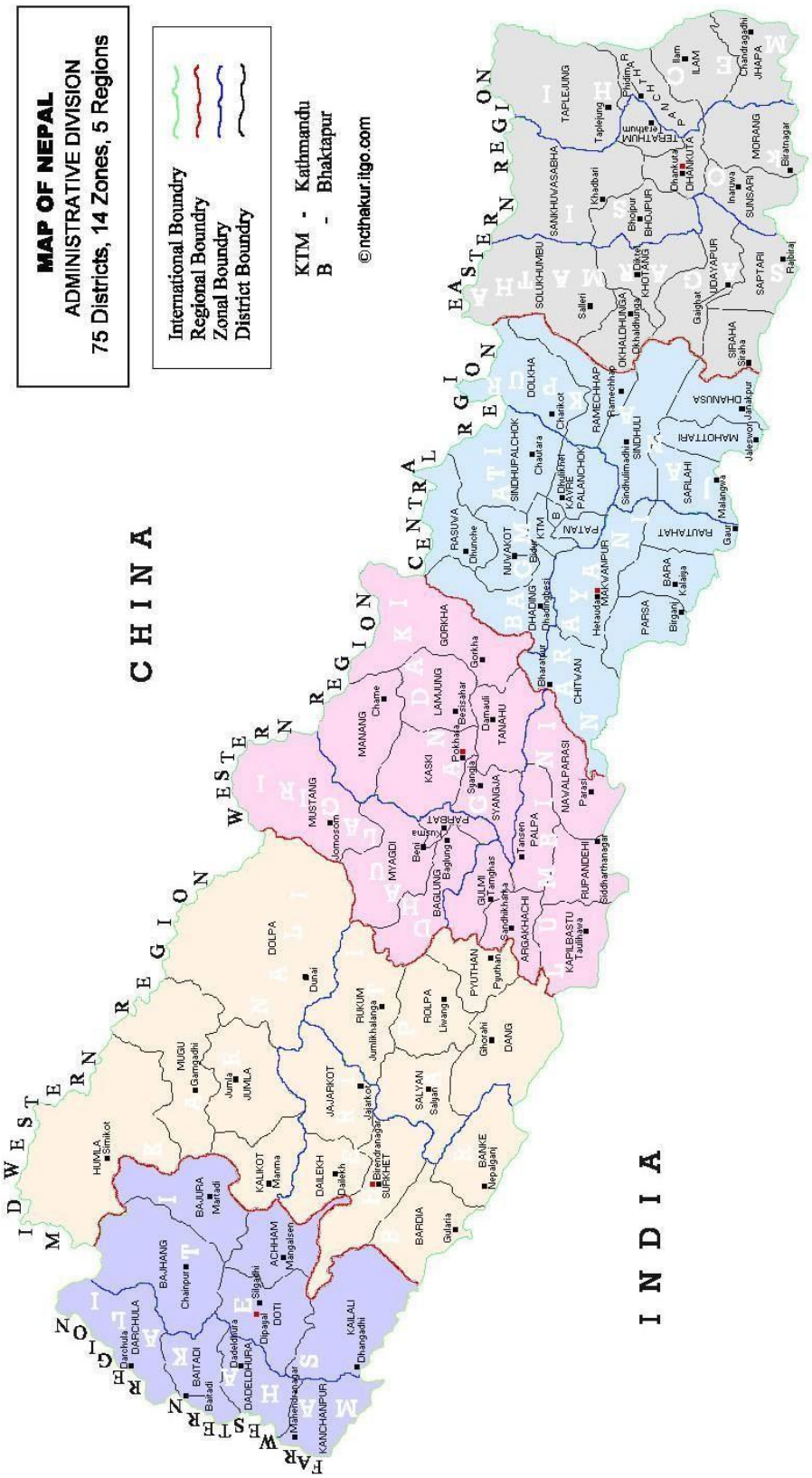
(६) यदि जानु भएन भने के कारणहरुले गर्दा जानु भएन ?

(७) घर परिवार वा समुदाय वा स्वास्थ्य सस्थामा कस्ता परिवर्तन आए भने गर्भवती र सुत्केरी जाचलाई बढाउन सकिएला ?

(८) तपाईको विचारमा घरमा वढी र स्वास्थ्यमा सुत्केरी कम किन गराइरहेका छन ?

(९) तपाईको विचारमा नेपालको सुरक्षित मातृत्व कार्यक्रम दलित र जनजातिका लागि सरकारले प्रदान गरेका सुविधा, अधिकार र आरक्षणहरु के के छन ?

APPENDIX –V


MAP OF NEPAL
ADMINISTRATIVE DIVISION
75 Districts, 14 Zones, 5 Regions
International Boundry
Regional Boundry
Zonal Boundry
District Boundry
KTM - Kathmandu
B - Bhaktapur
©ntchakur.itgo.com
CHINA
INDIA
FAR WESTERN REGION
MID WESTERN REGION
WESTERN REGION
CENTRAL REGION
EASTERN REGION

APPENDIX – VI
Pictures of Conducting interview schedule
Participant : Dalit and Janajati (Educated and Uneducated) Women of Nepal.

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