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A RESEARCH REPORT  
ON  
A STUDY ON KNOWLEDGE AND PRACTICE OF TRADITIONAL BIRTH  
ATTENDANTS REGARDING DELIVERY CARE IN DHANUSHA DISTRICT



SUBMITTED TO:  
NEPAL HEALTH RESEARCH COUNCIL  
SINGHDARBAR, KATHMANDU



SUBMITTED BY:  
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BPH 14<sup>TH</sup> BATCH  
2003



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APPROVAL CERTIFICATE:

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This is to certify that Mr. Sanjay Kumar Das has prepared this research report entitled " A Study on knowledge and practice of TBAs regarding delivery care in Dhanusha district" under my guidance and supervision.

This report is prepared as partial fulfillment of the requirement for Bachelor of public health. This report is in the form prescribed by the University and is recommended for acceptance.

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- Sanjay Kumar Das.

## ACRONYMS:



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ANC:	Antenatal Care.
BPH:	Bachelor of Public Health.
CPR:	Contraceptive Prevalent Rate.
DCMFH:	Department of community medicine and Family Health.
DPHO:	District public health office
DPHO:	District public health officer
Dr.:	Doctor
FP:	Family Planning
FHD:	Family Health Division.
GO:	Governmental Organization.
HMG:	His Majesty the Government.
HOD:	Head of department.
HP:	Health Post.
IMR:	Infant Mortality Rate
MCH:	Maternal and Child Health.
MMR:	Maternal Mortality Rate
NFHS:	Nepal Family Health Survey
NGO:	Non-Governmental Organization.
PNC:	Post-Natal Care.
PHCC:	Primary Health Care Centre.
RH:	Reproductive Health.
Sr.:	Senior
TBA:	Traditional Birth Attendant
TTBA:	Trained Traditional Birth Attendant
UNICEF:	United Nations Children Fund.
UTBA:	Untrained Traditional Birth Attendant
WHO:	World Health Organization.



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### **Abstract:**

Because of the widely recognized importance of quality of care in the provision of delivery care, a study was conducted in Dhanusha with the objective of assessing the knowledge and practice of TBAs regarding delivery care.

Taking the sample size 35 percent and TBAs as a study population, a cross-sectional descriptive research was conducted. Structured & semi-structured questionnaires were used and interview, focus group discussion technique were adopted for data collection.

All the TBAs were illiterate. Majority of delivery were conducted by washing hands, in clean separate room. New blades were used for cord cutting and placenta were removed by pressing the lower abdomen by the majority of TBAs.

Nothing was applied on the cut part of cord by about 72% TTBA and 50% UTBA whereas cow dung was applied by some TBAs (TTBA 10% and UTBA 29%).

After birth, newborn was covered with clean clothes by about 100% TTBA and 92% UTBA and colostrums feeding were also done by 100% TBAs and 93% UTBA.

Breast feeding was started after 1 hour and before breast feeding mouth and water was fed by majority of TBAs.

Abnormal delivery was referred by about 79% TTBA while referred only by 62% UTBA.

To conclude, the quality of delivery conducted by TTBA was better than UTBA. To improve the quality of delivery conducted by UTBA, Proper training should be given to them.

**CONTENTS:**

Approval Certificate  
Acknowledgement  
Acronyms  
Abstracts  
Contents



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<b>Chapter-1: Introduction</b>	<b>1-3</b>
1.1 Background of the study	1
1.2 Statement of the problem	2
1.3 Justification/Rationale of the study	3
<b>Chapter-2: Objectives of the study</b>	<b>4-5</b>
2.1 General Objective	4
2.2 Specific Objectives	4
2.3 Research Question	4
2.4 Conceptual Framework	4
2.5 Operational Definition	5
<b>Chapter-3 Literature Review</b>	<b>6</b>
<b>Chapter-4 Research Design and Methodology</b>	<b>7-9</b>
4.1 Study Area and Study Population	7
4.2 Research Method	7
4.3 Study Variables	7
4.4 Type of Study	7
4.5 Sampling Method	8
4.6 Sampling size	8
4.7 Sampling Frame and Sampling Process	8
4.8 Tools and Techniques of Data Collection	8
4.9 Validity and Reliability	9
4.10 Data Processing and Analysis	9
4.11 Limitation of the study	9
4.12 Biases	9
4.13 Ethical Consideration	9
<b>Chapter-5 Finding And Analysis</b>	<b>10-13</b>
<b>Chapter-6</b>	<b>14-15</b>
6.1 Discussion	14
6.2 Conclusion and Recommendations	15
<b>Annexes</b>	<b>16-19</b>
<b>Annex-1 Work Plan</b>	<b>16</b>
<b>Annex-2 Budget</b>	<b>17</b>
<b>Annex-3 Questionnaire</b>	<b>18-19</b>
<b>References</b>	<b>20</b>



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**CHAPTER – ONE**  
***INTRODUCTION***

## **1.INTRODUCTION:**

### **1.1 Background of the study:**

Maternal mortality is still the leading cause of death among women of reproductive age in most developing countries. Women from developing countries face greater risk during pregnancy, childbirth and postpartum period because they are most likely to deliver without health worker and have limited access to adequate medical care in the event of complication. The result is not only a tragedy for the women concerned, but also for their entire family.

The most common causes of maternal deaths are hemorrhage, sepsis, toxemia, obstructed labor and septic abortion. In addition to women dying from obstetric complications, many also suffer from serious chronic disabilities resulting from pregnancy and childbirth. In developing countries like Nepal these obstetric complications and chronic disabilities are aggravated by number of socio-cultural factors.

The maternal mortality rate (MMR) is an effective index to the quality of maternity care services in any given country. Two different estimates of maternal of maternal mortality ratios have been quoted for Nepal.

- ❖ WHO/UNICEF revised 1990 estimates released in 1996: 1500/100,000 live births.
- ❖ NFHS 1996: 539/100,000 live births.

The women in developing countries bear many children and obstetric care is poor. Their lifetime risk of maternal death is much higher almost 40 times higher than in the developed countries.

Women's lifetime risk of dying from pregnancy related complications globally.

<b><u>Region</u></b>	<b><u>Risk of dying</u></b>
Africa	1 in 16
Asia	1 in 65
Latin America	1 in 130
Europe	1 in 1400
North America	1 in 3700
All developing countries	1 in 48
All developed countries	1 in 1800

Women's lifetime risk of dying from pregnancy related complications in South Asia countries.

<b><u>Countries</u></b>	<b><u>Risk of dying</u></b>
Nepal	1 in 10
India	1 in 37
Bangladesh	1 in 21
Bhutan	1 in 9
Sri Lanka	1 in 230
Pakistan	1 in 38



The provision of care for women during childbirth is essential to ensure healthy and successful outcome of pregnancy for the mother and her newborn infant. Many women in developing world do not have the privilege or the access to basic health care services during their pregnancy and childbirth. Women often deliver in unhygienic surroundings, without the help of a trained birth attendant increasing the risk to both the mother and the newborn baby, resulting frequently in unhappy outcomes. Women's health is major health problem in the World.

In the new National Health Policy approved by His Majesty's Government of Nepal(HMG/N) in 1991, Safe-motherhood has been identified as a priority program. HMG/N developed a National Safe-motherhood Plan of action (SMPA) for the period 1994-1997.

In Nepal women of childbearing age (15-49yrs.) constitute 23% of total population. The Nepal Family Health Survey (NFHS) and other research findings have confirmed the leading immediate cause of maternal deaths to be due to hemorrhage, sepsis, toxemia, and obstructed labor, most of which are preventable with the provision of adequate antenatal care, safe delivery practices, timely referral and well organized and accessible family planning services.

Pregnant and birthing women do not always have ready access to medical treatment during pregnancy and delivery because of various social, economic and cultural factors or lack of access to health facilities. Prenatal and obstetric care has been shown to have the greatest impact in the neonatal period.

Untrained relatives or friend who may use unsafe delivery practice conducts Fifty to sixty percent of total births. Tetanus is a major consequence of miss-management of home delivery, which contributes to high levels of neonatal mortality in developing countries.

In Bangladesh, babies are likely to be delivered on to an unclean surface, the cord usually is cut with unclean razor, blades or piece of bamboo and tied with dirty threads and cows dung or ash is smeared on the cord and same processes are at home delivery in Nepal. In Nepal, 91.7% delivery is conducted at home.

The six clean required during delivery are:

- |                       |                   |
|-----------------------|-------------------|
| a. Clean finger       | b. Clean hands    |
| c. Clean place        | d. Clean perineum |
| e. Clean cord cutting | f. Clean thread   |

### **1.2 Statement of the problem:**

The World Health Organization (WHO) estimates that each year about six lakhs women die as a result of pregnancy and childbirth and almost 99% of these deaths occur in the developing countries.

There are only 9 countries in the world having a maternal mortality ratio of 1500/lakh live birth or higher, of which Nepal is one. However the figure for Nepal ranges from 539 to 1500 shown different sources have different estimates. In Nepal, somewhere around 3000 to 9000 women is dying yearly due to pregnancy and

childbirth. The NFHS of 1996 indicates that 91.7% of all women deliver at home and a nurse or a doctor attend only 7.8%. The chances of Nepalese woman suffering from pregnancy complications are very high and consequently the risk increases as these women undergo multiple pregnancies during their reproductive age. In addition to women dying from obstetric complications, many also suffer from serious chronic disabilities resulting from pregnancy and childbirth. In general, experts estimate that about 100 maternal morbidity occur for each maternal death.

Out of every 11 children born in Nepal dies before reaching the age of 5 years. Slightly over 2 in 3 under 5 deaths occur in the first year of life. Infant mortality rate (IMR) is 64/1000 live births whereas under 5 mortality rate is 91/1000 live births. During infancy, the risk of neonatal deaths (39/1000) is one and half times higher than the risk of post-neonatal deaths (26/1000).

### **1.3 Justification/Rationale of the study:**

Over the years, increasing attention has been given to strengthening and improving the quality of maternity care services worldwide. If quality is poor, the services received could result in complications, which in turn affect the health of the mother and neonates. Likewise, the quality of services has direct bearing on whether people return to facility and advise other about the quality of services.

International studies throughout the world have clearly demonstrated that there is a direct relationship between qualities of care use of services.

Most of the delivery (92%) is conducted at home, out of which about 25% are attended by a TBAs, though trained traditional birth attendants (TTBA) are available in every two hours of walk.

Maternal mortality ratio (MMR) of Nepal is very high. Majority of maternal deaths (62%) occurred after delivery and 10% died during childbirth.

During infancy, the risk of neonatal deaths (39/1000) is one and half times higher than the risk of post neonatal death (26/1000).

Therefore, the provision of proper care for women during pregnancy and child birth is essential to ensure healthy and successful outcome of pregnancies for the mother and her new born infant. About 70% of maternal deaths can be prevented through early antenatal care, treatment of existing health conditions and availability of medical care and hospitalization in time.

Pregnancy is neither a health problem nor a disease, this is just a natural process because for reproduction women should be pregnant and give birth. A woman faces various risks during her pregnancy period. In countries like Nepal where traditions of early marriage, son preference and consideration of childbirth as divine gifts, assumed to be responsible for high fertility leading the mother to the death.

**CHAPTER – TWO**  
**OBJECTIVES OF THE STUDY**

## **2.OBJECTIVES:**

### **2.1 General Objective:**

To access the knowledge and practice of TBAs regarding the delivery care in the Dhansha district.

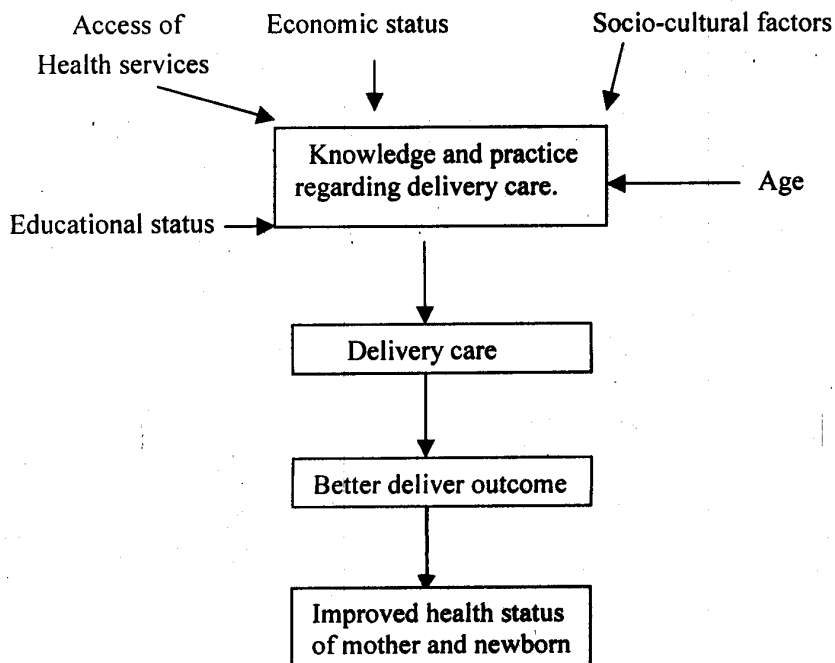
### **2.2 Specific Objectives:**

- ❖ To access the knowledge and practice of TBAs about the clean fingers and hands
- ❖ To understand their knowledge about the place where delivery should be conducted.
- ❖ To explore their knowledge and practice about the use of safe delivery kit and the removal of placenta during delivery.
- ❖ To access the knowledge and practice regarding the maintenance of body temperature of baby.
- ❖ To know their knowledge and practice about colostrum and breast feeding.

### **2.3 Research Questions:**

- ❖ What is their knowledge and practice about six clean during delivery?
- ❖ How do they remove the placenta during delivery?
- ❖ How do they maintain the body temperature of the baby?
- ❖ What is their knowledge and practice regarding colostrum feeding?

### **2.4 Conceptual Framework:**



## 2.5 Operational Definitions:

- **Community:** Place where TBAs live and conduct delivery at the village level.
- **Knowledge:** It is the storage of information in the brain of TBAs regarding delivery care.
- **Practice:** Activities TBAs do before, during and <sup>after</sup> delivery.
- **TBA:** One who conducts delivery at the village level.
- **TTBA:** One who has taken 15 days basic training of TBAs.
- **UTBA:** One who has not taken 15 days basic training of TBAs.



**CHAPTER - THREE**  
**LITERATURE REVIEW**

### 3. LITERATURE REVIEW:

# UNICEF, 1991 stated that the health and wellbeing of the newborn infant is based on four principles of care:

- a) Non-traumatic delivery.
- b) Maintenance of body temperature.
- c) Initiation of spontaneous respiration and
- d) Initiation of breast-feeding shortly after birth.

# According to Ebrahim G.J. 1978, stated that for the fulfillment of basic needs of newborn, we should consider the baby's chief needs which are respiration, protection from injury and infection, nutrition, adequate warmth and comfort.

# In the workshop jointly organized by WHO, UNICEF, IPA in 1992 at Brazil on the topic "Global Priorities in newborn health" had the objective to identify issues for research into developing countries improving perinatal and neonatal health and to identify global priorities in the new born health. (International Child Health, 1993)

One survey study in Sindhupalchok has suggested those factors like competency of health workers being responsible for the use of health services. Low competency decreases the flow of patients.

Maternal mortality is estimated as 1300/100000 live births in remote areas and 120/100000 for hospital deliveries in our country. About 99% of Nepal's population has no access to roads, electricity and appropriate health care. A TBA attends 90% of deliveries.

Dr. Rita Thapa, in her research in "Reproductive Health" mentions that the main research concerns relate to improving the access of women, men and adolescents to quality reproductive health services.

With approximately 840,000 live births during 1996 in Nepal it is estimated that 42000 newborns died before completing their 1 month of life and that 4500 women died of pregnancy and delivery related causes.

Sound knowledge of health workers and good performance to detect high risk pregnancy and refer to proper person and place are crucial measures to save the mothers as well as babies life.

Safe motherhood program was initiated in Nepal in 1993 in 10 districts. Women did not attain local health posts due to their unreliability and lack of staffs.

**CHAPTER – FOUR**  
**RESEARCH DESIGN AND METHODOLOGY**



## **4. RESEARCH DESIGN AND METHODOLOGY:**

### **4.1 Study area and study population:**

The study was carried out in Dhanusha district. It was one of the Terai district of Nepal, the flat strip of lands. Its population inhabitants consist mainly of people originating from the Terai like Kaisth, Bahun, Yadav, Sah, Muslim, and other Terai castes.

Female literacy rate was very low. They did not go for antenatal care and did not intend to get assisted by male health workers. Untrained female population conducted most of the delivery.

The target population of my study was TBAs of Dhanusha district.

### **4.2 Research Method:**

Quantitative method.

### **4.3. Study Variables:**

#### **A. Dependent variables.**

- ◆ Hygiene during delivery
- ◆ Place of delivery
- ◆ Delivery technique
- ◆ Use of safe delivery kit
- ◆ Wrapping of the baby
- ◆ Colostrum feeding
- ◆ Breast feeding

#### **B. Independent variables.**

- ◆ Age
- ◆ Economic status
- ◆ Educational status
- ◆ Access of health services
- ◆ Socio-cultural factors:
  - Ethnicity
  - Religion
  - Values
  - Beliefs

### **4.4. Type of study:**

Descriptive cross-sectional study.

#### 4.5. Sampling method:

Probability proportionate systematic random sampling.

#### 4.6. Sample size:

$N = Z^2PQ / L^2$  where N = Desired sample size

P = The proportion in the target population estimated to have specific character.

Q = 1-P Degree of accuracy at 95% confidence interval.

L = Allowance error at 5%.

Among 14 health institutions (PHCC-5 & HP-9) I took five health institutions (PHCC-2 & HP-3), which represent the sample size 35.7%.

My sampled area –wise number of TTBA's & UTBA's were as follows.

AREAS	Number of TTBA's	Number of UTBA's
Mahendranagar	20	24
Dhanusha Dham	28	27
Parwaha	36	32
Kathpulla	20	25
Tarapattee	21	17

#### 4.7 Sampling frame and sampling process:

The name list of health institutions was taken from DPHO. According to the sample size, health institutions were selected by probability proportionate systematic random sampling method.

#### 4.8 Tools and Techniques for data collection:

##### A. Tools:

- Questionnaire: Structured and semi-structured questionnaires were used to collect the required information. The questionnaires were pre-tested before the data collection.
- Focus Group Discussion (FGD) Guidelines: Some FGD guidelines were prepared to explore the knowledge and practice regarding delivery care.

##### B. Techniques:

- Interview: Interview technique was used, using structured and semi-structured questionnaires to obtain the information. Interviews were taken from the sampled TTBA's and UTBA's.

- b. Focus group discussion: It was done to obtain descriptive information regarding delivery care.

#### **4.9. Validity and reliability:**

For the validity and reliability of the data, strong emphasis was given to make questionnaire standard, pre-testing was done in neighboring Mahottari district. Local dialect was used so that they can really understand the questions and give proper answer.

- Data editing was done on the same day as the information collected.
- FGD summary points were written on the same day.
- Local interviewers were used for the information collection so that they could easily understand and use the local dialect when required.
- An orientation was conducted to the interviewers on the questionnaire and data collection techniques.

#### **4.10 Data Processing and Analysis:**

- Row Data was properly edited and coded
- Data was analyzed in terms of percentage and chi-square test by using EPI-INFO program.

#### **4.11. Limitation of the Study:**

The study was limited only to the Dhanusha District

#### **4.12. Biases:**

There might be biases while interviewing with trained and untrained TBAs.

#### **4.13. Ethical Consideration:**

First of all, DPHO was consulted and detail information was given regarding the purpose of research and the procedures to be used. Thus consent was obtained to carry out the research activities. To the TBAs, as well after clarifying aim and objective of the study, consent was obtained. The respondents were convinced that any information gathered would be used for the groups of the individuals and the result was presented such that the information from the single individual can not be identified separately. The access to the individual informant was limited to researcher only. No blame on the practice of respondents was kept on.

**CHAPTER – FIVE**  
**FINDING AND ANALYSIS**

## **5.FINDINGS AND ANALYSIS:**

This chapter deals with obtained different levels of knowledge and practice of TBAs regarding delivery care.

A total of 125 trained TBAs and 125 untrained TBAs were participated in study.

### ❖ **AGE:**

The age range of the TBAs were found 18years to 45 years. The mean age of TBAs was 27 years and almost one half of the TBAs were aged 24-35. The age patterns of respondents were similar across both trained and untrained TBAs.

Table No.1. Age Distribution of Respondents.

Categories	TTBAs	UTBAs
Age Range	18-42	18-45
Mean Age	26	29

### ❖ **EDUCATIONAL LEVEL:**

All the TBAs were found illiterate.

### ❖ **MAIN SOURCE OF INCOME:**

Main source of income of all the TBAs was labor.

### ❖ **HANDWASHING BEFORE DELIVERY:**

Hand washing before conduction of delivery was found more in TTBAs than UTBAs, but most of them used to wash hands only with water.

Table No.2.

Hand washing before delivery	TTBAs	UTBAs
Yes	63%	59%
No	37%	41%

Out of 63 percent TTBAs who washed hand before delivery, 86 percent said that they used to wash hands to prevent from infection while out of 59 percent UTBAs only 11 percent said that they used to wash hands to prevent from infection. Rests were unknown about reasons of washing hands before delivery.

❖ **PLACE FOR CONDUCTING DELIVERY:**

It was found that all the TBAs conduct delivery in clean residing room.

❖ **CORD CUTTING PRACTICE:**

Cord cutting practice was found satisfactory. All the TTBAAs and UTBAAs used to cut cord by sterilized blades, but only 88% TTBAAs and 52% UTBAAs were able to say that it prevents from Tetanus Toxoid infection.

❖ **REMOVAL OF THE PLACENTA:**

Most of the both TTBAAs and UTBAAs used to remove placenta by pressing the lower abdomen while some (4%) UTBAAs said that placenta was removed by natural process.

Table No.3.

Techniques	TTBAAs	UTBAAs
By pressing the lower abdomen.	79%	84%
By pulling slowly	21%	12%
By natural process	0%	4%

❖ **THINGS USED AFTER CORD CUTTING:**

It was found that most of the TBAs use nothing after cord cutting but some use to apply cow dung and oil on the cut part of cord.

But using cow dung is very dangerous.

Table No. 4.

Things	TTBAAs	UTBAAs
Cow dungs	10%	29%
Oil	18%	21%

Nothing	72%	50%
---------	-----	-----

❖ **COVERING OF THE CHILD AFTER BIRTH:**

It was found that 100 percent TTBA's and 92 percent UTBA's use to cover the new borne, out of which only 49 percent TTBA's and 18% UTBA's were able to say that it prevents from hypothermia.

Table No.5

Covering of the newborne	TTBAs	UTBAs
Yes	100%	92%
No	0%	8%

❖ **COLOSTRUM FEEDING:**

Colostrums feeding were found satisfactory. It was found that 100 percent TTBA's and 97percent UTBA's use to feed colostrums, but out of these only 82 percent TTBA's and 26 percent UTBA's were able to say that it provides immunity and strength to the child.

Table No 6.

Colostrum	TTBAs	UTBAs
Should be fed	100%	93%
Should not be fed	0%	7%

❖ **TIME FOR STARTING BREAST FEEDING:**

It was found that most of the TBAs use to start breast feeding only after one hour.

On deep interview most of the TBAs said that the family members of the delivered mother did not allow allow them to conduct breast feeding as soon as possible.

Table No.7.

Time of starting breast feeding	TTBAs	UTBAs
As soon as possible	18%	8%
After one hour	56%	42%

After one day	16%	24%
After >= two days	10%	26%

❖ **THINGS FED BEFORE BREASTFEEDING:**

It was found that most of the TBAs use to feed maudh and water before breast feeding. They said that they didn't accept to start breast feeding without feeding maudh and water. Some also use to feed goat milk or milk of other woman before starting breast feeding.

Table No. 8.

Things fed before breast feeding	TTBAs	UTBAs
Goat milk	34%	36%
Maudh and Water	60%	61%
Milk of other women	6%	3%

❖ **ABNORMAL DELIVERY:**

It was found that most of the TBAs refer abnormal delivery but some TBAs use to deliver abnormally presented fetus by moving it in the uterus of the mother.

It was found that abnormal delivery was mostly conducted by UTBAs in comparison to TTBAs.

Table No.9

Abnormal delivery	TTBAs	UTBAs
Refer	79%	62%
No refer	21%	38%

❖ **PROCEDURE FOR CONDUCTING DELIVERY:**

It was found that more TTBAs use to follow the proper procedure for delivery conduction in comparison to UTBAs.

Table No. 10.

Use proper procedure	TTBAs	UTBAs
Yes	62%	41%
No	38%	59%



**CHAPTER – SIX**  
***DISCUSSION, CONCLUSION AND***  
***RECOMMENDATION***

### **6.1. DISCUSSION:**

This study was conducted in Dhanusha with limited number of TBAs, so the result of this study can't be generalized. However, finding suggested that interview and FGD using short, simple questionnaires and FGD guidelines can successfully identify areas of dissatisfaction and areas to be improved.

The respondents in this study were both TTBAAs and UTBAAs. The age of the respondents were ranging from 18-45 yrs and the mean age was 27 yrs. All the TBAs were illiterate and the educational status of community was very lower.

All the TBAs of that areas were from lower caste like chamar whose economic status was very lower and so, personal hygiene and environmental sanitation were also very poor.

Most of the TBAs used to wash hand before delivery conduction but they wash only with water. Some UTBAAs said that

“ चमरा चमैनीके सक्कुछ लागले रहे है तैयो सदरे ।”

Cord was cut with clean blades and placenta was removed by pressing the lower abdomen by most of the TBAs. Cow dungs were used on the cut part of cord by some of the TBAs ( 10% TTBAAs and 29% UTBAAs) which was very dangerous practice.

Covering of the child and colostrum feeding were found satisfactory. About 100% TTBAAs and 92% UTBAAs used to cover new borne with clean clothes.

Breast feeding was conducted only after 1 hour by most of the TBAs (56% TTBAAs and 42% UTBAAs) while some used to start breast feeding only after  $\geq 2$  days. During this period, they used to feed Maudh and water by most of the TBAs (60% TTBAAs and 61 % UTBAAs). Some also used to feed goat milk (34% TTBAAs and 36% UTBAAs ) and milk of other women (6% TTBAAs and 3% UTBAAs). Most TTBAAs said that the guardian of the family didn't allow them to start breast feeding as soon as possible.

## **6.2. CONCLUSION AND RE COMMENDATION**

### **6.2.1. Conclusion:**

Interviews and Focus group discussion should always be considered should always be considered to be just few part of an over all quality evaluation effort. Qualing is a broad concept that no few approaches adequately and fully measured. Alone any one of the approaches can address only a piece of the total quality picture.

Results of this study concludes that place of delivery, cord cutting practice, covering of the child after birth and colostrums feeding practice are very satisfactory but some parts like application of cow dung on the cut part of cord, breast feeding only after two days and removal of the placenta by pressing on the lower part of abdomen are very dangerous practice.

Most of the delivery in that area were found to be conducted TBAs due to lack of hospital and absence of female health workers in the local level health institutions.

### **6.2.2 Recommendations:**

- All the TBAs should be trained.
- There should be regular practical exposure of TTBA's to the hospital.
- Refresher training at least twice a year.
- It will be better to give TBAs training to literate women of the community.
- Proper awareness programme should be conducted in the community about the cause and preventive measures of high IMR and MMR.

**ANNEX-1**

• **WORK PLAN:**

*Plan of Action chart.*

S.No	Activities to be undertaken	Responsible Person	Bhadra of 2060			
			1 <sup>st</sup> week	2 <sup>nd</sup> week	3 <sup>rd</sup> week	4 <sup>th</sup> week
1	Identification of the problem	Researcher	****			
2	Selection of topic	"	**			
3	Literature Review	"	*	***		
4	Preparation of research proposal			***		
5	Presentation of the research proposal.			*		
6	Determine the sample size.			*		
7	Design the questionnaires.				*	
8	Recruit and train interviewers				**	
9	Pretest and finalize questionnaires.				**	
10	Collect data				**	**
11	Tabulate and Analyze data					**
12	Write Report					**
13	Print and submit report					**

\*=1 day.

**ANNEX-2**

**BUDGET EXPENSED FOR THE STUDY.**

S.No.	Activities.	Unit Cost.	Total cost.
<b>1.</b>	<b>Proposal development</b>		
a	Literature search		1000.00
b	Proposal typing and printing		1500.00
c	Stationary and photocopy		2200.00
	<b>Sob Total</b>		<b>4700.00</b>
<b>2</b>	<b>Orientation, pre-testing and instrumentation</b>		
a	Orientation to the Interviewers (2 persons for two days)	200*2*2	800.00
b	Questionnaire pre-testing (2 persons for one days)	200*2	400.00
c	Final typing and printing of questionnaire		800.00
d	Stationery (Files, Pencils, Erasers)		200.00
	<b>Sub Total</b>		<b>2200.00</b>
<b>3</b>	<b>Data collection and field visit</b>		
a	Daily allowance for the interviewers	200*2*7	2800.00
b	Travelling cost for researcher	150.00	150.00
c	Communication (Phone, fax)	150.00	150.00
	<b>Subtotal</b>		<b>3150.00</b>
<b>4</b>	<b>Report writing and dissemination</b>		
a	Typing and printing of report		1000.00
b	Photocopy of the report		200.00
c	Information dissemination and seminar		3900.00
d	Miscellaneous		500.00
	<b>Subtotal</b>		<b>5600.00</b>
<b>5</b>	<b>Grand Total</b>		<b>15600.00</b>

ANNEX -3

• QUESTIONNAIRE:

Tribhuwan University  
Institute of Medicine  
Department of community medicine and Family Health  
Maharajgnj, Kathmandu

VDC:  
Name of the respondent:  
Religion:

Date:  
Ward No:  
AGE:

1. Have you taken training?  
a. Yes                      b. No
2. Educational status?  
a. Illiterate                b. Literate  
c. Primary                 d. Secondary
3. What is your main source of income?  
a. Agriculture             b. Service  
c. Labor                    d. Other
4. For how many months your income is sufficient?  
a. 3 month                b. 6 months  
c. 12-month               d. >12month
5. What is the distance of health institution from your house?  
a. <30-minute            b. 1 hour  
c. 1-2 hour                d. >2 hour
6. Is it necessary to clean the hand before conducting delivery?  
a. Yes                      b. No
7. If yes, then why?  
a. To prevent infection    b. Don't know            c. Others
8. Where the delivery should be conducted?  
a. Cattle shed             b. Residing Room        c. Separate Room        d. Others
9. Why in that place?  
.....
10. What should be used for cord cutting?  
a. Clean Blade            b. Seacle or knife        c. Old Blades            d. Others
11. How the placenta should be removed?  
a. By pulling forcefully after birth    b. Leaves by time stone

- c. By pulling slowly                      d. By natural Process
12. What should be used on the cut part of cord?  
a. Dung      b. Mud      c. Oil or Ghee   d. Nothing
13. Is it necessary to cover the baby with clothes after birth?  
a. Yes      b. No      c. Don't know
14. If yes, then why?  
.....
15. Should the clostrum be fed?  
a. Yes      b. No
16. If yes, then why?  
.....
17. If no, then why?  
.....
18. When the breast-feeding should be started?  
a. As soon as possible      b. After one hour      c. within a day  
d. after 2 or more days
19. What do you do when the pregnancy is abnormal?  
a. Refer      b. No refer
20. How do you conduct delivery?  
a. Sterilize all the instruments  
b. Clean the room  
c. Clean hand with soap water  
d. Clean the perineum  
e. Cut the cord with clean blade  
f. Tie the cord with sterile thread  
g. Remove the placenta properly  
h. Wrap the baby with clean cloth  
i. Clostrum feeding and breast feeding are started as soon as possible

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श्री ५ को सरकार

फोन नं. ५२०६२८

फ्याक्स नं. ५२०६२८

स्वास्थ्य मन्त्रालय, स्वास्थ्य सेवा विभाग  
मध्यमाञ्चल क्षेत्रीय स्वास्थ्य सेवा निर्देशनालय

# जिल्ला जन स्वास्थ्य कार्यालय, धनुषा

पत्र संख्या :

२०६७ (६)

चलानी नं.:

३१५

स्वास्थ्य मन्त्रालय  
स्वास्थ्य सेवा विभाग  
जिल्ला जन स्वास्थ्य कार्यालय

जनकपुरधाम  
मिति २०६७/५/२३

विषय :- जानकारी गराउन भन्ने बारे ।

श्री.....

मान प्रमुख ज्यू

नि.शा.संस्थान, महाराजगंज, काठमाण्डौ ।

महोदय,

उपरोक्त सम्बन्धमा ~~सम्बन्धमा~~ जिकित्सा शास्त्र अध्ययन संस्थान महाराजगंज मा जनस्वास्थ्य विद्याको स्नातक (बि.बि.स्न) तेश्रो बर्गमा अध्ययनरत श्री संजय कुमार दास ले आफ्नो कुटुमीको ज्ञान र अभ्यास सम्बन्धी अध्ययन र अनुसन्धानको लागि महेन्द्रनगर, धनुषा जिल्ला, बाब्राहा, कडुपुला र तारापट्टी गा.बि.स. हनुवाट आवस्यक कुनै भन्नु भएको कुरा जानकारी गराउने बर्गको उत्तरांतर व्यातिको कामना गर्दु ।

( **हनुवत दास** )  
प्रमुख  
जिल्ला जन स्वास्थ्य कार्यालय