DELIVERY PRACTICES AMONG RAJBANSHI

Nawa Raj Subba, MPH

Ministry of Health and Population
khatiwadasom@yahoo.co.in

Abstract

This is a cross-sectional study with the objective of uncovering home and hospital delivery practices among Rajbansi of Nepal. Quantitative tools semi-structured questionnaires, check lists were used covering 375 samples of its resident districts Morang, Jhapa and Sunsari districts. Among Rajbanshi population 69.33% has done hospital delivery and 30.67% has home delivery. Home delivery is practiced by economic condition very poor (18.87%), poor (8.8%) and rich (4%). Hospital delivery is practiced by economic condition very poor (20.53%), poor (20.27%) and rich (28.53%). Similarly, home delivery is higher by occupation labour (24.27%), by education illiterate (10.67%), by geography rural (34.28%). Hospital delivery is increasing and home delivery is decreasing in trend. Status of hospital delivery of Rajbanshi is better than the levels of Morang district and country Nepal, but which is significantly lower among very poor, illiterate, labour and rural Rajbanshi population.

Keywords: Home delivery, hospital delivery, Rajbansi

Background

In Nepal, there are 59 indigenous people dwell in the country. Rajbanshi is one of the indigenous people of their habitat Terai region. People speaking the Rajbanshi language was 85,559 in census held in 1991, which increased to 1, 29,829 in 2001's census. In addition, according to census 2011 there is 122,214 in numbers speaks Rajbanshi language. Rajbanshis are found to have settled in most of the villages in

Jhapa and Morang. They are agro-based people but now they are working in different occupation like labour, service and business.

Nepali society is multi-cultural, multiethnic and of heterogenic type Rajbanshi people have their own tradition and culture and practices. They have their own traditional knowledge, attitude and practices in caring mother and child. Concepts of health and hygiene, disease and illness also differ from culture to culture. However, very few focused studies are done on specific ethnics in Nepal. Dualism refers to the existence of two sectors, one modern and other traditional, that coexist in the same community (Maghaddam F, 1993).

Traditional system does not explain everything by logic and it ignores modern practices. Every culture is characterized by a unique set of concepts, images system of values and specific type of perception of the world (Lomov B.F. et al, 1993). Scientific investigation of indigenous knowledge is still in its infancy. There can be multitude of perspectives within a particular society with dualism and parallelism. Dualism describes a situation where one sector of society is developed and "Westernized" and the other sector remains "traditional" (Kim U., Berry J.W., 1993). Even within a particular culture, these two sectors have limited interactions and operate parallel to each other. In addition, the existence of cultural diversity within a particular society could produce the different types of explanations and interpretations (Moghaddam F.M., 1986). The traditional perception of Jajarkot people in illness is deeply rooted and embedded in their local culture and religion. Illnesses are categorized into three categories: (1) a natural cause (roga), (2) a supernatural cause (dokh), and according to (3) the severity of the illness (Subba, S., 1999).

Methods

1. Household Survey: general information taken from head of household and detailed questionnaire filled with mother's interview (n=375). 2. Observation: of housing and traditional practices Tools: 1. Questionnaire (Semi-structured), 2. Check list for Observations. Study Sites: (1) Jhapa and (2) Morang and (3) Sunsari districts. Data entered and analyzed with SPSS 20 software in computer.

Findings

Table 1. *Delivery Practice and Economic Status*

Practices in Last Delivery and Economic Status (n=375)				
Economic	Traditional	Modern	Total	p-value
Very poor	67	77	144	p= <0.0001 x^2= 58.99
Poor	33	76	109	
Rich	15	107	122	
Total	115	260	375	

Table No. 1 shows the practices of delivery (last) based on economic status. Among 375 samples 115 (30.67%) practiced traditional system and 260 (69.33%) practiced modern system. Among very poor (144) samples 67 (18.87%) practiced traditional and 77 (20.53%) practiced modern system. Likewise, among poor (109) samples 33 (8.8%) practiced traditional and 76 (20.27%) practiced modern system. Among rich (122) samples 15 (4%) practiced

traditional and 107 (28.53%) practiced modern system. They are statistically highly significant (p= <0.0001).

Delivery Practices by Occupation (n=375)				
Occupation	Traditional	Modern	Total	P-value
Agriculture	10	51	62	
Service	9	56	56	p= <0.0001
Labor	91	117	221	x^2=38.05
Business	5	33	33	
Other	0	3	3	
Total	115	260	375	

Table 2. *Delivery Practice and Occupation*

Table No. 2 shows the practice of traditional and modern system based on occupation. Among 375 samples 115 (30.67%) practiced traditional system and 260 (69.33%) practiced modern system. Among agriculture occupation (62) samples 10 (2.67%) practiced traditional and 51 (13.6%) practiced modern system. Likewise, among (56) service occupation 9 (2.4%) practiced traditional and 56 (14.93%) practiced modern system. Among labour occupation (221) samples 91 (24.27%) practiced traditional and 117 (31.2%) practiced modern system. Among busibess occupation (33) samples 5 (1.33%) practiced traditional and 33 (8.8%) practiced modern system. They are statistically highly significant (p= <0.0001).

Table 3**.** *Delivery Practice and Education Level*

Delivery practice by Education Level (n=375)

Education	Traditional	Modern	Total	P-value
Illiterate	40	30	70	
Literate NS	39	68	107	p= <.0001
Class 1-10	25	86	96	x^2= 43.14
SLC/IA	6	60	66	
BA+	5	16	36	
Total	115	260	375	

Table No. 3 shows the delivery practices (last) on the basis of education status of head of household. Among 375 samples 115 (30.67%) practiced traditional system and 260 (69.33%) practiced modern system. Among illiterate (107) samples 40 (10.67%) practiced traditional and 30 (8%) practiced modern system. Likewise, among 107 non-schooling literate 39 (10.4%) practiced traditional and 68 (18.13%) practiced modern system. Among class 1-10 (96) samples 25 (6.67%) practiced traditional and 86 (22.93%) practiced modern system. Among SLC/IA (66) samples 6 (1.6%) practiced traditional and 60 (16%) practiced modern system. Among BA+ (36) samples 5 (1.33%) practiced traditional and 16 (4.27%) practiced modern system. Rajbanshi by education who were illiterate to Class 10 used traditional practices by 26.93% and who were SLC and above used to traditional practices by only 2.93%. They are statistically highly significant (p= <0.0001).

Table 4. *First Delivery Practices in Urban-Rural Setting*

Urban-Rural Setting: First Delivery (n= 375)

	Delivery	Delivery	Total
	Home	Hospital	
Urban	33	14	47
Rural	232	96	328
		Total	375

Table 5. *Last Delivery Practices in Urban-Rural Setting*

Urban-Rural Setting: Last Delivery (n= 375)			
	Delivery	Delivery	Total
	Home	Hospital	
Urban	6	51	57
Rural	109	209	318
		Total	375

Table Numbers 4 and 5 are illustrating first and last delivery practices in urban and rural setting. According to findings 70.21% urban mothers and 70.73% rural mothers reported their first birth was done as home delivery. It's almost same. But during their last baby birth 10.53% urban mothers and 34.28% rural mothers have done home delivery. According to the tables 89.47% urban mothers and 65.72% rural mothers had hospital deliveries of their last baby birth. Delivery practice is gradually changing towards hospital delivery from home delivery both in urban rural setting but degree is higher in urban setting.

Discussion

Studies have concluded that around ninety-nine percent of maternal deaths occur in the developing world (IAGSM, 1997) and it is noted that maternal mortality rate is 229 per 100,000 live births in Nepal (NDHS, 2011) due to hemorrhage, sepsis, unsafe abortion, AIDS, eclampsia, and obstructed labor ((MoH, 2001). Despite the evidences that Maternal mortality ratio of Nepal has reduced from 539/100,000 (NDHS, 1996) to 281/100,000 (NDHS, 2006), everyday six women die from pregnancy-related causes. Unclean delivery conditions and improper care for mothers and their newborns bear numerous risks to the wellbeing of thousands of mothers and babies each day.

In Rajbanshi there is 69.33% had hospital delivery or modern practice and 30.67% had home delivery or traditional practice (n=375). There is significant change observed in delivery practices. Home delivery was conducted by 70.21% in urban and 70.73% in rural during first birth. It's almost same. But during their last baby birth it has been declined to10.53% in urban mothers and 34.28% in rural. So, 89.47% urban mothers and 65.72% rural mothers had hospital delivery during their last delivery. Delivery practice is gradually changing towards hospital delivery from home delivery both in urban rural setting but degree was higher in urban setting. According to annual report of District Public Health Morang Report of FY 2068/69, the institutional or hospital delivery rate is 56% among expected number of deliveries in Morang (HMIS/DPHO Morang, 2068/69). And Annual Report of Department of Health Services had noted institutional delivery in FY 2067/68 is 37% in Nepal (DOHS, 2067/68). Therefore, proportion of hospital delivery among Rajbanshi is better than mean of Morang district (56%) and of country Nepal (37%).

Most mothers felt that communication with language is also a barrier to take modern care, which is not felt during taking traditional care. (Subba, N.R. 2003). Some Rajbanshi clusters still have tradition of shaving of new born hair and cutting umbilical cord only by specific caste caused infection, delay and bleeding which is are major causes of neonatal and maternal deaths. Tradition of son preference culture and practice of more trial babies and low value of girl child delivery has affected more maternal and child mortality.

Conclusion

Practice of hospital delivery among Rajbanshi is 69.33% and home delivery is 30.67%. Hospital delivery is increasing and home delivery is decreasing in trend. Status of hospital delivery of Rajbanshi is better than the levels of Morang district and country Nepal, but which is significantly lower among very poor, illiterate, labor and rural Rajbanshi population.

References

DOHS. (2067/68). *Annual Report of FY 2067/68*, Department of Health Services, Teku, Kathmandu, Nepal

HMIS/DPHO, Morang. (2068/69). *Annual Report and District Profile FY 2068/69*, District Public health Office Morang, Nepal

IAGSM. (1997). Inter-Agency Group for Safe Motherhood, *The Safe Motherhood Action Agenda: Priorities for the Next Decade; Report on the Safe Motherhood Technical Consultation*, 18-23 October 1997. Colombo, Sri Lanka, and New York: Family Care International, 1997.

Kim, U., Berry, J.W. (1993). Kim U. & Berry J.W.(1993). *Indigenous Psychologies: Research and Experience in cultural Context,* New Delhi, SAGE Publication 2-3.

Lomov, BF. & etal. (1993). Psychological thought within the Russian culture, Indigenous Psychology: *Research and experience in cultural context;* SAGE publications New Delhi India

Maghaddam, F. etal. (1993). *Social psychology in cross-cultural perspective*, New York, NY, US: W H Freeman/Times Books/ Henry Holt.

MoH. (2001). *Integrated Reproductive Health Curriculum Safe Motherhood Module*, Ministry of Health, Reproductive Health Division, Uganda.

Moghaddam, F.M. (1986). *Traditional and Modern Psychologies in competing cultural Systems*: Lessons from Iran 1978-1981, Indigenous Psychologies: *Research and Experience in cultural context*, SAGE Publication, New Delhi. 118-131.

NDHS. (1996, 2006, 2011). Nepal Demographic and Health Survey, *Preliminary Report*, Ministry of Health and Population, Department of Health Services, Kathmandu, Nepal.

Subba, N.R. (2003). *Assessment of Health Status in Eastern Development Region Nepal*, HMG/ MOH/ Eastern Regional Health Directorate and Britain Nepal Medical Trust, Nepal.

Subba S. (1999). *Perception of disease and illness among health providers and health seekers in Jajarkot district, Nepal*, The University of Copenhagen.