

**Child Delivery Practices Among Married Women Aged (15-49)  
(A Case Study of Dodhara VDC in Kanchanpur District)**

**A Dissertation**

**Submitted to Central Department of Population Studies Faculty of  
Humanities and Social Science for Partial Fulfillment of  
Masters' Degree of Arts in Population Studies**

**Submitted by  
Parbati Upreti**

**Tribhuvan University  
Kathmandu, Nepal  
March 2010**

## **RECOMMENDATION LETTER**

This is to certify that miss Parbati Upreti has completed the dissertation entitled “**Child Delivery Practices Among Married Women Aged (15-49)**”: A Case Study of **Dodhara VDC in Kanchanpur District**, under my guidance and supervision. The dissertation is original and embodies the result of her empirical investigation based on field work. Therefore, I recommend this dissertation for final evaluation

.....  
**Mr. Sunil Kumar Acharya**  
**(Supervisor)**

March 2010

## **APPROVAL SHEET**

This dissertation entitled “**Child Delivery Practices Among Married Women Aged (15-49)**”: A Case Study of Dodhara VDC Kanchanpur District, by Parbati Upreti has been accepted as partial fulfillment of the requirement for the Master’s Degree of Arts in Population Studies.

**Approved by:**

.....

**Prof.Dr. Prem Singh Bisht**  
**Head of CDPS**  
**Kirtipur**

.....

**Mr. Bhumidatta Poudel**  
**(External Examiner)**

.....

**Mr. Sunil Kumar Acharya**  
**(Supervisor)**

## **ACKNOWLEDGEMENTS**

This dissertation is submitted to the Central Department of Population studies, faculty of Humanities and social sciences, Tribhuvan University for the partial fulfillment of master's degree in Art. This dissertation came in its shape and reality by the help, support and guidance from several people. Hence, I am very much privileged to express my sincere thanks and gratitude to the women of Dodhara VDC, kanchanpur, who generously shared their feeling and provided their valuable time during the field work.

I am grateful to my supervisor Mr. Sunil Kumar Acharya for his valuable and constructive input in the way of guidance and supervision at the time of study. I would like to express gratitude Prof. Dr Prem Singh Bisht for providing mean opportunity to conduct this study on the subject of my interest. I am indebted to the library of the department (CDPS) to support and provide the necessary and useful materials. I am grateful to my brother Meen Raj Bhatt and Basant Upreti for his honest help of handling all the computer concerns of entire dissertation.

Finally, I would like to thank my friends (Sushila and Debaki) who helped me to collect the information in the field operations. I would also like to thank my brother Madan Raj Upreti who helped me for the preparation of this dissertation. I am extremely delighted to my parents and my entire family member where continuous financial support and expectation of my bright future inspired me continuously.

Parbati Upreti

March 2010

## ABSTRACT

The study on “**Child Delivery Practices Among Married Women Aged (15-49)**”: **A Case Study of Dodhara VDC in Kanchanpur District**, has been carried out using primary sources of data obtained from 120 respondents of reproductive aged women. The study was conducted at Dodhara VDC of Kanchanpur district in month 2009. There are various problems to achieve the goal of Child Delivery in society. The main purpose of this study are: To examine the Socio-economic and demographic status of married women aged 15-49 years and to find out the safe delivery practices of married women aged 15-49 years.

In the study area it has found that socio-economic status of study population was very low. Most of the people in that area are engaged in agriculture and housework. The mean age at marriage of women in the study area is very low. The majority of women are delivered at home. It has found that literate (college level) used safe delivery while illiterate used unsafe delivery maximum at home. Women yet have to face many complications during the time of delivery.

During pregnancy labour and complication Nepali women follow traditional techniques which have harmful effects on health moreover women are more likely to have infections because of anatomical structures one of the regions in the quality and accessibility to maternal care services in that most of the Nepali women risk in rural areas. In these areas only basic health services are available in very limited areas though some community based services are provided by trained birth attendants, female community Health Volunteers.

## ACRONYMS

ANM	Auxiliary Nurse Midwife
ANC	Antenatal care
CBS	Central Bureau of Statistics
CDPS	Central Department of Population Studies
CEB	Child Ever Born
DC	Delivery Care
FP	Family Planning
HA	Health Assistant
HH	Household
IEC	Information Education and Communication
IMR	Infant Mortality Rate
ICPD	International conference on Population and Development
INGOs	International Non-Governmental Organizations
MCHW	Maternal and Child Health Worker
MMR	Maternal Mortality Rate
MOH	Ministry of Health
MOPE	Ministry of Population and Environment
NDHS	Nepal Demography Health Survey
NGOs	Non-Governmental Organizations
PNC	Postnatal Care
PRB	Population Reference Bureau
RH	Reproductive Health
RHSC	Reproductive Health Steering Committee
RHCC	Reproductive Health Co-ordination Committee
SLC	School Leaving Certificate
SMSC	Safe Motherhood Sub- Committee
TU	Tribhuvan University
TBA	Traditional Birth Attendant
UN	United Nation
UNFPA	United Nations Population Fund
VDC	Village Development Committee
VHW	Village Health Worker
WHO	World Health Organization.

# CONTENTS

	<b>Page No.</b>
Letter of Recommendation	
Approval sheet	
Acknowledgement	
Abstract	
Acronyms	
<b>Chapter- One: Introduction</b>	<b>1-4</b>
1.1 Background of the status	1
1.2 Statement of the problem	2
1.3 Objective of the study	3
1.4 Significance of the study	4
1.5 Limitation of the study	4
<b>Chapter- Two: Literature Review</b>	<b>5-13</b>
2.1 Theoretical Literature	5
2.2 Empirical literature	9
2.3 Conceptual framework	12
<b>Chapter-Three: Methodology</b>	<b>14-15</b>
3.1 The study area	14
3.2 Source of data	14
3.3 Sample size and sampling procedure	14
3.4 Questionnaire Design	15
3.5 Data processing and Data Analysis Techniques	15
<b>Chapter-Four: Data Analysis</b>	

<b>4.1 Household Characteristics</b>	<b>16-31</b>
4.1.1 Age-sex structure	16
4.1.2 Educational Status	17
4.1.3 Occupational status	17
4.1.4 Marital status	18
4.1.5 Family size	19
<b>4.2 Respondent's Characteristics and Status</b>	
4.2.1 Educational status	19
4.2.2 Caste/Ethnicity	20
4.2.3 Religion	20
4.2.4 Occupational status	21
4.2.5 Household Amenities	22
4.2.6 Type of house	23
4.2.7 Toilet facility	23
4.2.8 Sources of drinking water	24
4.2.9 Media habit	24
4.2.10 Age	25
4.2.11 Age at first marriage	26
4.2.12 Age at first pregnancy	26
4.2.13 Children ever born	27
<b>4.3 Heard of Safe Delivery</b>	<b>28</b>
4.3.1: Knowledge of Safe Delivery	29
4.3.2: Source of Knowledge	29
4.3.3: Preparations for Safe Delivery	30
4.3.4. Availability and Accessibility of respondent's local area.	31



<b>Chapter- Five: Safe Delivery Among Women</b>	<b>32-44</b>
5.1 Mean Table	32
5.2 Place of delivery	33
5.2.1 Educational level and place of delivery	34
5.2.2 Occupational and place of delivery	35
5.2.3 Mass media and place of delivery	35
5.3 Assistant in delivery	36
5.4 Safe Delivery Kits	40
5.5 Complication during delivery and solve complication	40
5.6 Accompanied	41
5.7 Transportation	42
5.8 Status of currently pregnant women	42
5.9 CEB and currently pregnant women	43
<b>Chapter- Six: Summary, Conclusion and Recommendations</b>	<b>45-50</b>
6.1 Summary	45
6.2 Conclusion	48
6.3 Recommendation	48

## **References**

## LIST OF TABLES

Table No.	Page No.
Table 4.1: Distribution of Households population by age and sex	16
Table 4.2: Distribution of household population aged 5 years and above By education status.	17
Table 4.3: Distribution of household population by occupation.	18
Table 4.4: Distribution of household population by marital status.	18
Table 4.5: Distribution Family Size.	19
Table 4.6: Distribution of respondents by educational attainment.	19
Table 4.7: Distribution of Respondents by caste.	20
Table 4.8: Distribution of Respondents by religion.	20
Table 4.9: Distribution of respondents by occupation status.	21
Table 4.10: Distribution of Respondent's by husband occupation.	21
Table 4.11: Distribution of respondent by husbands' income.	22
Table 4.12: Distribution of Respondents by household Amenities.	22
Table 4.13: Distribution of households by the type of house.	23
Table 4.14: Distribution of households by toilet facilities.	23
Table 4.15: Distribution of respondents by listening radio and watching Television.	24
Table 4.16: Distribution of Respondents by type of usually Program Listen.	24
Table 4.17: Distribution Respondents by type of usually Program Watching.	25
Table 4.18: Distribution of age of respondents.	25
Table 4.19: Distribution of respondents by age at marriage.	26
Table 4.20: Distribution of respondents by age at first pregnancy.	27
Table 4.21: Distribution of Respondents by CEB.	27
Table 4.22: Distribution of Child loss experience.	28
Table 4.23. : Distribution of respondent by reason of safe delivery.	30

Table 5.1: Mean Number of CEB and Mean age at marriage According to Background characteristics.	32
Table 5.2: Distribution of respondents by place of delivery and Caste/Ethnicity in Dodhara VDC.	33
Table 5.3: Percent distribution of respondent place of delivery and Educational level in Dodhara VDC.	34
Table 5.4: Percent distribution of respondent place of delivery and Occupation in Dodhara VDC.	35
Table 5.5: Distribution of respondents by place of delivery and exposure to Mass media in Dodhara VDC.	36
Table 5.6: Distribution of respondents by delivery assistance at home.	37
Table 5.7: Distribution of respondents by person providing assistance During delivery according to educational level in Dodhara.	37
Table 5.8: Distribution of women by person providing assistance during Delivery, According to occupation in Dodhara VDC.	38
Table 5.9: Distribution of women by person providing assistance during Delivery, According to exposure to mass media in Dodhara VDC.	39
Table 5.10: Distribution of respondents by use of delivery kit.	40
Table 5.11: Distribution of respondents by complication during delivery and Solve the complication.	41
Table 5.12: Distribution of accompanied to the Health Facility at the Time of Delivery.	41
Table 5.13: Distribution Transportation used to go to health facility centre at Time of delivery.	42
Table 5.14: Distribution of respondent by currently pregnant.	42
Table 5.15: Distribution of respondent by month of currently pregnant.	43
Table 5.16: Distribution of respondent by plan to deliver.	43
Table 5.17: Distribution of number of CEB and currently pregnant women in Dodhara.	44

## **LIST OF FIGURE**

Fig.4.3: Distribution of respondents by heard about safe delivery.	28
Fig 4.3.1: Distributions of respondents by knowledge of safe delivery.	29
Fig 4.3.2. Distribution of sources of knowledge.	30
Fig 4.3.3: Distribution of Respondents by preparation for safe delivery.	31

# CHAPTER ONE

## INTRODUCTION

### 1.1 Background of the Study

Women have child bearing power gifted by nature. The child bearing power is a biological process. Which depends on women's pregnancy and also the pain of giving birth but every women can not get a chance for giving birth and attending good health maternal care is the care of women doing pregnancy, delivery and after delivery. It is important for the survival and well being of both of mother and new born child. Pregnancy is the state of developing a baby insides women's womb. It is a natural process giving continuation of human generation the earth. In other words, it is reproductive function in women that begins at menarche and ends in menarche (15-49 yrs).

Care of safe delivery begins soon after conception until the birth takes place. The provision of care during pregnancy and child birth is essential to ensure healthy and success outcomes of pregnancy for the mother and her new born. The status of women is lower in most of the developing countries like Nepal. Low literacy rate, high fertility rate, high maternal mortality rate, high infant and child mortality rate are some indicators of lower status of women. Due to the lower status and inaccessibility empowerment, opportunities to get education to have nutritional food or to make decision to represent at various social sectors. In developing countries like Nepal, this position of woman exists not only in pregnancy period but also during the time of pregnancy through delivery to postnatal period. It is obvious that women are less aware of their civil rights. Few numbers of women is aware and is struggling for their rights and is required services but it can't spread all over the country and village, as for remote and rural areas. The total fertility sate is 4.1 per women in Nepal that was reported by 2001 census but is slightly decline, now it is 3.1 per women due to the lack of family planning knowledge unwanted pregnancy. This is accepted as on additional burden by the mother. The percentage of economically active population of female age 10 year and above is seen 46.2, 45.5 and 55.3 in 1981, 1991 and 2001 census respectively (CDPS, volume11: 75). Child delivery is related with the national health, maternal health is an important part of the health care system amid at seducing morbidity and mortality related to pregnancy. The health care at time of delivery and soon after delivery is important for the survival and well-being of both the mother and child, The support for safe motherhood program (SSMP) is designed to improve infrastructural

development (through comprehensive emergency obstetric care, basic emergency obstetric care and birthing centers) and human resource development and up grade the skills of skilled birth Attendants.

Nepal is developing country. It is located between India and china and ecologically, it is divided in to three belts, namely the Mountain, Hill and terai. Almost 84% of 23.2 million people live in the Nepal area. The growth rate of population is 2.27%. These are various obstacle and hardship entangled with education. The literacy status of women in Nepal is very low at 42 percent only. The literacy is not significant to improve the health status. Socio cultural customs and traditions are also responsible for affecting the health status of women and newborns. The Maternal mortality rate and Neo-natal mortality rate are preventable by applying the following appropriate approaches.

- Increase women level of education
- Improve social and culture factors which have negative effects on health.
- Use available resources
- Focus on the management of poverty in national health policy (Dura,2005:2)(cited in Bhatt Shanker Datta)

In the context of Nepal 90% of maternal death occurs in rural areas because of the complications during delivery. Similarly every hour in Nepal 3.4 neonatal deaths occur because of the complication of safe delivery practices. Poor countries like Nepal are suffering from various reproductive health complication or problem, low level of practice of antenatal care, delivery care and postnatal care which the major problems of maternal are morbidly and mortality. The major responsible causes for such problems are lack of education poor access of health services water sanitation facilities, low per capita income and gender discrimination.

## **1.2 Statement of the Problem**

A large proportion of the population in the twenty first century in Nepal is still below in the poverty line. Generally, people do not pay attention towards health and health practices. Especially the women do not reveal or to tell their health problems even in serious conditions because of shyness and oppressive as well as patriarchal cultural norms.

Dodhara VDC is situated in the far western development region of kanchanpur district across the Mahakali River of our country. This VDC is back regarding the all round development in comparison to the other parts of kanchanpur district. But newly made suspension Bridge has highlighted this VDC all over the country and linked with the district head quarter. Women of this VDC get little bit relief regarding their health issue because of the suspension Bridge. But still child delivery practice is very poor because of the lack of education, health post, health worker, tradition approach etc. most of the women are the house hold worker and delivery at home and assisted by TBA and others(relative & friends).

In Nepal, More than nine out of every ten births occurred at home, and many women even deliver alone, traditional birth attendant both trained and untrained are sometimes called into attend the deliveries but the majority of the women receive help only from relatives or friends use of clinical services is clearly low. In addition to cultural factors which prevent women from seeking clinical come a number of others factors influence the use of services few facilities provide essential obstetric care, health services are often of poor quality. Access to appropriate facilities is poor long distance; poor roads and lack of transportation also keep women from using the facilities.

Thus, this study attempts to find out level of knowledge and safe delivery practices in Dodhara VDC of kanchanpur district. It is believed that these women have normal level of knowledge and delivery practices because this community is low socio-economic status. So the main target of this study is to provide reliable and valid information on various aspects of child delivery practices of Dodhara VDC, kanchanpur.

### **1.3 Objective of the Study**

The general objective of the study is to assess safe delivery practices in Dodhara VDC. The Following are the specific objectives.

1. To examine the Socio-economic and demographic status of married women aged 15-49 years.
2. To find out the safe delivery practices of married women aged 15-49 years.

### **1.4 Significance of the Study**

The MM and NMR is higher in Nepal in the comparison of developed countries. So, women health is a relevant topic of study. Not only the illiteracy but also the different cultural, social, economic political geographical and religions beliefs are the factors effecting to the status of women health. This study is based on the data collected in Dodhara V.D.C ward no.3, 4 and 6 Mahendranagar, Kanchanpur District.

The major significance of the study area as follow:-

- This study will provide basic knowledge about their safe delivery.
- This study will be useful to create awareness for women to care their own health.
- It will help to formulate the safe motherhood programs.
- This study will provide baseline information about the recent status of Safe delivery.

### **1.5 Limitation of the Study**

The study attempts to analyze perception towards the safe delivery of Mahendranagar Kanchanpur district of Dodhara VDC the following are the limitation of the current study.

1. This study is limited to Dodhara VDC of kanchanpur district.
2. This study would not represent whole nation but only representative study area.
3. This study is limited to child bearing married women aged 15-49 years having at least one child under five years



## **CHAPTER TWO**

### **LITERATURE REVIEW**

This chapter deals with review of some selected studies relevant to the child delivery practices globally and Nepalese context. Literature review means the act of presenting past activities as reference. Some of the facts and study report related to the study are reviewed in this chapter. We are unaware with the subject-matter then our research would be meaningless. Hence, once the problem is formulated an extensive review of the literature is very much essential. Some of the facts, opinions, principles, and study report directly or indirectly related to this study are review and presented here.

#### **2.1 Theoretical Literature**

Reproductive health is a state of complete, physical, mental and social well-being and not merely the absence of disease of infirmity in all matters relating to the reproductive system and its functions and process (UN, 1994:45)

Delivery care refers to the place for delivery and under where supervision the delivery occurred. Pregnant women should never be left alone to delivery by her. The family members should request help from a trained health worker. Trained birth attendant auxiliary nurse midwife and maternal and child health workers as soon as labour beginnings if a trained health worker is unavailable, the family planning members should assist the mother child birth when labour begins (MOH, 1996).

Many women prefer to give birth at home because they like the friendship and support from female relatives and neighbors. The government has committed itself to safe motherhood, however of women dying pregnancy and child birth aware among mother groups in the some communities women are isolated in livestock, seeds during child birth due to the belief that blood particularly the blood of child birth is impure and it leads to tetanus and other infections (WHO, 2000).

In Nepal, the family plays a critical roles in prompting health pregnancies reducing the chance of high risk pregnancies seeking routine maternity care and recognizing and taking immediate action for obstetric emergencies. The family should make sure the women risk during her pregnancy provide her with adequate food and help poor seeking assistance from a trained health

worker during pregnancy and labour community leaders and health workers should promote the importance role of family in ensuring health pregnancy and child (MOH 1996).

The three elements of maternal health services according to world Health Organization are antenatal care delivery care and postpartum care each element should consist of the following services as prescribe by WHO.

1. Antenatal Care: WHO recommends pregnant women to get 4 ANC visits for health promotion, assessment, prevention and treatment
2. Delivery Care: WHO are recommends a skilled or trained birth attendant at every birth W.H.O. can provide good quality care to the mother and child such a TBA is expected to perform hygienic. Safe and sympathetic services and able to recognize and manage complications and refer promptly if more care is needed.
3. Post Partum Care: WHO recommends integrated postpartum care which included identification and management of problem in mother and new born, counseling information and services for family planning and health promotion forth new born and mother (W.H.O. 1998:3) Sharma (2001).Summarized on that there is influence of distance availability of proper transpiration facility mother education level, financial conditions of Nepalese mother and family decision maker.

Another study conducted by WHO and UNICEF showed that women play an important role in society and as mother from the nuclear and backbone of the family. Despite this role women were, still accorded a low status in society in most developing countries like Nepal and their needs continue to remain unfulfilled, (Dital,1999).

According to world summit for children 1990, it is reported that child survival is closely linked to the reproductive health of mothers. Early, late, numerous and closely spaced pregnancies are major contributors to high infant and child mortality and morbidity rates, especially, where health care facility are scare (ICPD,1994).

Making motherhood much safer will require improvement in the socio-economic and political status of girls and woman. Such status would include high quality family planning, prenatal and delivery care for all women a skilled obstruct care for high risk and emergency cases. The 1987 sm initiative had goals set to improve women's health and reduce maternal mortality by half by the year 2000(UNFPA, 1995).

UNFPA supports a variety of measures in over 100 countries to reduce high rates of maternal mortality from educated communities on safe motherhood to training health care providers, emergency obstetric and equipping health facilities with proper supplies co- operating closely with WHO, UNICEF and World Bank. UNFPA is key member of the safe motherhood which has been working since 1987 to develop policies and programs to protect women during pregnancy and child birth. It is also member of the interagency group convened a meeting with leading experts on maternal mortality to develop key strategies to provide skilled attendance at delivery. The group of organized international conference on 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)(Cited in Poudel Yak Raj, 2007).

Many women in rural area of Nepal lose their lives mainly because of lack of adequate access to quality maternal health care and lack of awareness. Medical health care during pregnancy and delivery is not considered necessary and it is considered as natural process of giving birth to women. Lack of health care practice is the main cause of high motility and that is related to the high fertility. The health care practices during pregnancy, delivery and after delivery are varied by different caste and ethnic group and community in Nepal (Khanal, 2001).

Educated women are likely to marry later, have their first pregnancy later and fewer children. They are more likely to know about contraceptives and to attend for antenatal, delivery and postnatal care. The increasing level of education of women help to decrease the early age of marriage and the first pregnancy age is late for higher educated women than secondary and primary level educated mothers (Subedi,2001)(Cited in Poudel Yak Raj, 2007).

More adolescent’s girls die from pregnancy related causes than from any other cause because they have not completed their growth. Adolescent girls are at greater risk of obstruct labor (when the birth canal is blocked), which can lead to permanent injury or death for both mother and infant. In many countries the risk of death during the first year of life is half times higher for infants born to mothers under age 20 than for those born to mothers aged 20 to 29 years because adolescents have less experience, resource, and knowledge about maternal health care than older women(WHO,2002).

Safe motherhood goal and objectives are to be achieved through the implementation of the following strategies:

1. Promoting inter-sectoral collaboration by ensuring advocacy for and commitments to reproductive health, including safe motherhood, at the central, regional, districts and community levels;
  - Ensuring the commitment to SM initiative at all levels by promoting collaboration between sectors like health, education and social welfare, legal and local development (strengthening RHSC, RHCC district RHCC and SMSC).
  - Mobilizing national authorities, district health management committee (DHMC), community leaders and community members to play active roles in creating suitable environment for promoting safe motherhood.
  
2. Strengthening and expanding delivery by skilled health workers, basic and comprehensive obstetric care services (including family planning) at all levels. Interventions include the following:
  - Developing the infrastructure for delivery and emergency obstetric care.
  - Standardizing basic maternity care and emergency obstetric care at appropriate level of the health care system.
  - Strengthening human resource management.
  - Establishing functional referral system and advocating emergency transport system and funds from communities to district hospital for obstetric emergencies and high risk pregnancies.
  - Strengthening community based awareness on birth preparedness and complication readiness through FCHVs and MCHWs, and
  - 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 intervention. (DOHS 2004/05).

## **2.2 Empirical Literature Review**

Worldwide around 600,000 women die every year from complications of pregnancy and child birth for every maternal death. It is estimated that so to 40 women suffers from disabilities (Manadhar, 2005 Vol. 6:6)

Young women below 15 and older women above 40 years are especially at high risk level that may be 10 to 15 times higher than women in their 205 MMR is supposed to be the only "the single biggest inequity in global public health statistics"(W.H.O 1992:28).

Overall, one in two pregnant women received antenatal care. Twenty eight percent of mothers received antenatal care either from a doctor (17 percent) or a nurse or auxiliary nurse mid wife (11 percent). Another 11 percent of mothers received antenatal care from a health assistant or auxiliary health worker (AHW). Village health worker (VHWs) provided antenatal care to 6 percent of women and maternal and child health workers (MCHWs) provided care to 3 percent of mothers. Traditional birth attendants (TBAs) provided antenatal care to less than 1 percent of mothers. Traditionally Nepalese children are delivered at home either without assistance or with 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 slight improvement since 1996, when 8 percent of births were delivered in health facilities. This suggests that despite an increase in the number of health facilities offering delivery services, use of health facilities during deliveries is still minimal among most Nepalese women. Only 13 percent of deliveries are assisted by health professionals, that is, doctors, nurses or ANMs, HAs or AHWs, MCHWs, and VHWs of these, 8 percent are doctors and 3 percent are nurses or ANMs. Postnatal care is uncommon in Nepal. 79 percent of mothers who delivered outside a health facility do not receive any postnatal check up. Less than one in five mothers receive postnatal care within the first two days after delivery. (NDHS, 2001)

The percent distribution of mothers in the five years preceding the survey by ANC, Delivery care and PNC. 44% of mothers received antenatal care from skilled birth attendants (SBAs) that is from a doctor nurse or midwife, for their most recent birth in the five years preceding the survey. In addition, 28% of mothers received antenatal care from trained health workers such as a health assistant or auxiliary health worker, a maternal and child health worker (MCHW), or a village health worker (VHW) less than 2% of women received antenatal care from a traditional birth attendant or a female community health volunteer (FCHV). Twenty six percent of women received no antenatal care for births in the five years before the survey. Less than one-fifth (19 percent) of birth take place with the assistance of an SBA (doctor, nurse, or midwife). Health

assistants or health workers assist in delivery at 4 percent of births, FCHVs assist in 2 percent of deliveries and traditional birth attendants assist in 19 percent of deliveries. Women receive assistance from a relative or some other person for nearly one in two births, while 7 percent of births take place without any type of assistance at all. Five years preceding the survey, one-third (33 percent) of women received postnatal care for their last birth. One in five women received postnatal care within four hours of delivery, more than one in four (27 percent) received care within the first 24 hours, and 4 percent of women were seen 1-2 days following delivery. (NDHS, 2006).

Birth at home are not necessarily unsafe if the mother's family and her birth attendant can recognize the signs of complications during the labour and delivery and if complications occur can promptly carry her to the health facilities with adequate facilities. Families may not be able to transport her to a medical centre in time, or they may not take her because they fear patronizing treatment high fees or poor quality. Deliveries in health facilities can still be risky because of poor medical care. All pregnancies involve some risks even for healthy women. An estimated 15 percent of pregnancies result in complications requiring medical care. In life-threatening cases women need emergency obstetric care (UNFPA, 1997).

The maternity service factors relate to place and attendant of antenatal care and attendance of delivery relative to the period of pregnancy when death occur about 28 percent women die during pregnancy 9.9 percent women die undelivered during labour and 62 percent die after delivery. The "High Risk" pregnancies are too early or too late while low risk of maternal death occurs in age group 20-39 years of age (MOH, 1998).

In the world Health Report 2005, WHO estimates that out of total 136 million birth in a year world wide, less than two third of woman in less developed countries and only one third in the least developed countries, have their babies delivered by a skilled attendant. The report says this can make the difference between life and death for mother and child if, complications arise (WHO, 2005).

Almost 50 percent woman used delivery kits during delivery but the placenta of 86 percent children was cut by sterilized blade. About 38 Percent of woman were suffering from different problems during delivery and 73.07 percent woman has begged help during labour period (Dhungel, 2000).

In industrialized countries, delivery attendance with trained birth attendance is the most universal. There is a significant variation in various places. For example, it ranges between 55 to 98 percent in Latin America, Africa and Caribbean, 2 to 77 percent in sub-Saharan Africa and between 16 to 97 percent in North Africa and West Africa more than 500,000 women die each year from pregnancy related causes more than 95 percent of these deaths occurs in less developed countries, particularly in Africa and Asia (UNFPA, 1997).

Maternal deaths are highest in regions where few women received basic maternity care, including prenatal, delivery and post-partum care. At least 35 percent of women in developing countries give birth without skilled attendant and 70 percent receive post-partum care in the six weeks following delivery (WHO, 1997). In the context of Nepal for majority of birth mothers receive two or more doses of tetanus toxoid during pregnancy (Pathak and Gurung, 2002) (Cited in, Bhatt Shanker Datt).

Delays at the facility: community and providers agreed on the three main delays at facilities that may lead to maternal death, although the order differed slightly. These were (1) inability to treat the problem at the facility where she died; (2) inability to treat the problem at the previous (referring) facility; (3) inadequate clinical expertise lack of transport from the referring facility and lack of blood were perceived delay by providers identified lack of blood as an avoidable factor in 19% of facility based deaths, but this had dropped to 12% in 2008/09. (Maternal mortality and morbidity study, 2008/09).

Overall, 69% of maternal deaths were due to direct causes and 31% to indirect, compared with 80% and 20% respectively in 1998. Omitting Rasuwa, Jumla and Okhaldunga, where sample sizes were very small, the percentage of direct causes of death ranged from 63% in Kailali to 73% in Baglung. Hemorrhage remains the leading direct cause of maternal deaths, but with a reduced percentage contribution, at 24%, compared with 41% in 1998. This reflects a reduction in postpartum (PPH), down to 19% from 37%, rather than ante partum (APH). Eclampsia was the second leading direct cause (21%, increased from 11% in 1998); complication related to abortion third (7%, increased from 4% in 1998), with half due to induced and half to spontaneous abortion other direct causes included obstructed labors (6%, down from 13% in 1998), puerperal sepsis (5%, down from 11% in 1998). The leading indirect maternal cause of death was heart disease, at 7%, which did not feature at all in 1998; followed by anemia (4% up from 3% in 1998) and gastroenteritis (4%, up from 2% in 1998). A total of 57 maternal deaths were identified in hospital (through the MDR process) within the study

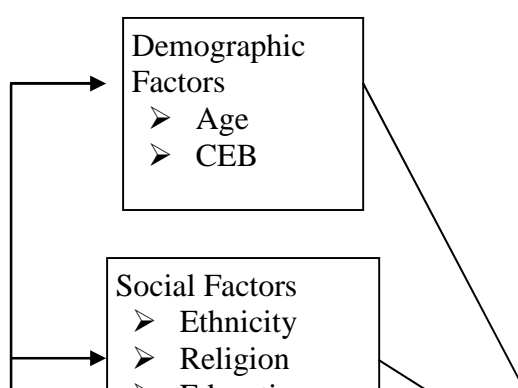
catchments area, giving an overall hospital based MMR of 267 per 100,000 live birth. In the EOC (emergency obstetric care) facilities the overall MMR was 218 per 100,000 live births for direct causes only, the MMR Was 14 per 100,000 live births. There is a good deal of district variation, but the sample sizes are too small to make robust district level comparisons. (Maternal mortality and morbidity study, 2008/09).

### 2.3 Conceptual Framework for the Study

There is relationship among various variable and safe delivery practice. We can see those social factors, demographic factors, economic factor, and educational factor are independent variable and safe delivery practice is the dependent variable. Accessibility is one of the intermediate variables, which are directly affected by independent variables and which are directly affected by safe delivery. Social like ethnicity religion have direct bearing on safe delivery. Each ethnicity, each religion has a different norms and value different from one another. Similarly, educational level of the population is an important indicator of social devilmnt. Educational level is also affecting the reproductive behavior of mothers. Educational factors is perhaps the most important to insure safe delivery practices. It is expected that literate women has better knowledge about pregnancy, meaning, delivery, it's complication and implication than illiterate women. Another variable as current age, marriage, children ever born is also directly associated with delivery. It is obvious that the age of mothers group; the possibility if antenatal care services slowly goes down. Economic factors as income and occupation are also the access and available service and facilities which facilities woman's safe delivery practices.

Furthermore media expose as radio and television are also playing great role to adopt safe delivery practices. People who are benefited from these Medias have significant knowledge about healthy pregnancy and outcome. All above mentioned variables are linked with accessibility which becomes the most important factors in changing a women's attitude towards safe delivery. If the health instutitutions are the near by with all facilities available, people would readily go for delivery services than if the distance is very far away.

#### Conceptual Framework





## **CHAPTER THREE**

### **METHODOLOGY**

This chapter deals with the research methodology. It is used to collect quantitative and qualitative data which is need for the study especially this chapter discusses the study area, sources of data sample selection, questionnaire design and method of data analysis.

#### **3.1 Study Area**

This study concentrated on the women of the reproductive ages (15-49).The Dodhara V.D.C situated in Kanchanpur district of far western Nepal. It is near India and Kanchanpur district of mahakali river with geographical location  $80^{\circ}5' 00''$  E and  $28^{\circ}52' 30''$  N. most of the part of this region touches mahendranagar municipality and some part touches India. In Dodhara VDC with the different trench of people from different caste ethnicity like Brahman, Chhetri, Tharu, kami, gurung and Giri etc. It is separated by Mahakali River from Nepal side and well known as the part of Nepal across the Mahakali River. This lies in the mahakali zone, southern part of Nepal. According to the 2001 census, the total population of this VDC was enumerated 18,556 among

them 9,447 were males and 9,109 females. The census report shows there were 2932 households and 6.33 average household sizes. Agriculture is the main occupation of people and most of cultivated land is irrigated paddy, maize, sugarcane and wheat are main agriculture products of this VDC.

### **3.2 Source of Data**

There are mainly two types of data sources; one is primary source and another being secondary. Therefore this primary sources information collected by using prestructured questionnaire from the prementioned study area through direct interview with respondents. The secondary information also used for reference of the study collection from the published or unpublished related documents (CBS 2001, NDHS 2006) is used to compare and analyze the result.

### **3.3 Sample Size and Sampling Procedure**

This research is based on primary data collection from three wards of Dodhara VDC of kanchanpur district in mahakali zone. It is based on the 15-49 years age group married women to find out their child delivery conditions. These women asked about their last child only which occurred in the last five years preceding of this survey. This study is based on the lottery method of random sampling. Total VDC equally numbered on small pieces of paper of equal size and selected on number at time until the desired sample size is obtained. The sample is taken of 40 respondents out of 275 household from ward no 6. Similarly, 40 respondents out of 395 households from ward no. 3 and 40 respondents from ward no. 4. Only women with at least one child below five years age at the time of survey enumerated as the individual respondents. Leaving three houses and taking next 1 each, there were 40 respondents altogether in one ward. Household information and individual questionnaire used as instrument in this study. The total population in the households is 648 among them the male are 316 and female are 332.

### **3.4 Questionnaire Design**

In the study area was used one set questionnaire. It was divided into two parts

Which as follows:-

1. The household questionnaires collect information on age, family size, and caste, ethnicity age at marriage, educational status and occupation.
2. Individual questionnaire designed for all women of reproductive ages who have experienced child birth, Information on the safe delivery, services like knowledge of safe

delivery, delivery kits, opinion of delivery place, numbers of CEB, age at first pregnancy, type of problem, access to health post and type of household amenities and sources of drinking water etc.

### **3.5 Data Processing and analysis**

This dissertation mainly based upon the primary data collected from the Dodhara VDC. The collection of data needs to be aggregated into a form that present the summary of answers from respondents. The data are thus transformed into information. This process of transforming data is called analysis. The raw data collected from the study area are process by using computer software, then the data analyzed by simple Table, graphical presentation, pie chart, bar diagrams and frequency tables.

## **CHAPTER FOUR**

### **DATA ANALYSIS**

#### **4.1 Household Characteristics**

A household is defined as a person or group of persons who live and eat together. This chapter presents the socio-economic and demographic characteristics of respondents and households populations. Demographic and socio-economic characteristics play important role in the development of society. It provides valuable input for social and economic development planning and is also useful in understanding and identifying the major factors that determines or influence the basic demographic indicators of the population. These characteristics include household composition, education attainment, and occupation. Demographic characteristics include age sex structure of household population, marital status and age at marriage of respondents.

##### **4.1.1 Age- sex Structure**

Age-sex composition plays an important role in determining the population dynamic. In the study area, 120 Households of Dodhara VDC are selected and total recorded population is 648, out of them, about 49 percent male and 51 percent are female. The sex ratio of this study population is 95.2 which are lower than that of national i.e.99.8. (census2058). Table 4.1 shows, the distribution of population according to age group and sex which indicated highest i.e. about

53 percent of male and 54 percent of female in the age group 15-59. The lowest percent of male and female are in the age 60 and above i.e. about 2 percent of male and 1 percent of female. The sex ratio according to age group was highest for the age above 60 year which is 150 and lowest for age group 15-59 which is about 94.

**Table 4.1: Distribution of Households population by age and sex**

Age	Male		Female		Total		Sex ratio
	No	%	No	%	No	%	Male/female%
<14	143	45.3	150	45.2	293	45.2	95.3
15-59	167	52.8	178	53.6	345	53.2	93.8
60+	6	1.9	4	1.2	10	1.5	150.0
<b>Total</b>	<b>316</b>	<b>100.0</b>	<b>332</b>	<b>100.0</b>	<b>648</b>	<b>100.0</b>	<b>95.2</b>

*Source: Field Survey, 2009.*

#### 4.1.2 Educational Status

Education is very important aspects of human life. It determines the level of life of a person and level of education represents the progress of nation too. It is one of the most important means of empowering women with knowledge skill and self confidence and helps to involve fully participate in development process.

**Table 4.2: Distribution of household population aged 5 years and above by education status**

Educational status	No.	%
No education	113	22.3
Primary(1-5)	230	45.5
Lower secondary(6-8)	111	22.0
Secondary(9-10)	28	5.5
College level(+2)	24	4.7
<b>Total</b>	<b>506</b>	<b>100</b>

*Source: Field Survey, 2009.*

In this study, out of 120 households and 506 populations aged 5 years and education status. About 22 percent are illiterate and 77 percent are literate. Among the literate population, about 46 percent have passed primary level, 22 percent have passed lower secondary, 6 percent have passed secondary level and 5 percent have passed college level (+2).

#### 4.1.3 Occupational Status

People of working age in any society or area are usually involved or engaged in any types of productive work. Generally, occupation is defined as the work done by person at least 6 months in a year. Occupation is another factor which influences the social, economic, cultural, political and religious variables occupational status and quality of life has positive relationship with demographic indicators.

**Table 4.3: Distribution of household population by occupation**

<b>Occupational</b>	<b>No.</b>	<b>%</b>
Student	161	33.0
Housework	131	26.8
Agriculture	102	20.9
service	56	11.5
Trade/business	21	4.3
Daily wage	17	3.5
<b>Total</b>	<b>488</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Table 4.3 shows, that the majority of the population is base on housework and agricultural occupation. The household populations under study are involved in agricultural sector about 21 percent in Housework in 27 percent, in service 12 percent, in Trade 4 percent, Daily wage in about 3 percent, and 33 percent are student.

#### **4.1.4 Marital Status**

Marriage is one of the main components of population dynamics. Marriage in Nepal Universal and early marriage marks the point in women’s life at which child bearing becomes socially acceptable. Women who marry early in average have, a longer exposure to the risk of becoming pregnant and therefore early age at marriage often implies early age at child bearing and higher fertility. About 2% respondents were found living separate after being married due to foreign job.

**Table 4.4: Distribution of household population by marital status**

<b>Marital status</b>	<b>No.</b>	<b>%</b>
Unmarried	325	50.2
Married and living together	242	37.3
Married but not living together	71	10.9
Widow	9	1.4
Divorce/ Separated	1	0.15
<b>Total</b>	<b>648</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

The table 4.4 shows that unmarried population is more in comparison to other. Whereas divorced population find very less nearly 1 percent. Similarly 37 percent find living together, 1.4 percent find widow women and nearly 11 percent women find being separated due to foreign job.

**Table 4.1.5 Distribution of Family Size**

<b>Family size</b>	<b>No.</b>	<b>%</b>
3-5	73	60.8
6-8	36	30.0
9-11	9	7.5
11+	2	1.7
<b>Total</b>	<b>120</b>	<b>100.0</b>

Table 4.5 shows that most of the respondents, about 61 percent have 3 to 5 family sizes, lowest is 11+. Similarly 30 percent have 6 to 8 family and 8 percent have 9-11 family sizes. About 2 percent have highest family sizes (11+).

## **4.2 Respondent's characteristics and status**

The purpose of this chapter is to provide a descriptive summary of the demographic and socio-economic characteristics of respondents. Information on the basic characteristics of women in the survey is essential for the interpretation of the findings and serves as an approximate indicator of the representativeness of the survey.

### **4.2.1 Educational Status**

It is important to examine the educational status of respondents. Because of education of respondents affect the level of safe delivery practices.

**Table 4.6: Distribution of respondents by educational attainment**

<b>Educational status</b>	<b>No.</b>	<b>%</b>
No education	55	45.8
Primary(1-5)	37	30.8
Lower secondary(6-8)	21	17.5
Secondary(9-10)	5	4.2
College level(+2)	2	1.7
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Table 4.6 shows that the proportion of women who have never attended school ranges about 46 percent to high 31 percent in primary level education, about 18 percent of women completed lower secondary school. Similarly, about 4 percent and 2 percent of women completed secondary level and college level respectively

#### **4.2.2 Caste/Ethnicity**

**Table 4.7: Distribution of Respondents by caste**

<b>Caste</b>	<b>No.</b>	<b>%</b>
Chhetri	58	48.3
Damai/kami	24	20.0
Magar/Gurung/Rai	17	14.2
Brahmin	8	6.7
Tharu	7	5.8
Geri/ Nath	6	5.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

It has found that the caste of the respondents is also determining factor safe delivery. There are 6 caste groups of respondents. Among total no. of respondents Chhetri is 48 percent, Damai/kami is 20 percent, Magar/Gurung/Rai is 14 percent Brahmin about 7 percent, Tharu about 6 percent and Geri/Nath is 5 percent.

#### **4.2.3: Religion**

**Table 4.8: Distribution of Respondents by religion**

<b>Religion</b>	<b>No.</b>	<b>%</b>
Hindu	108	90.0
Christian	12	10.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Nepal is legally declared as secular nation as per interim constitution of 2063. No individual compelled to follow the particular religion by any tribes or religion group. Although, majority group of people are the follower of Hinduism. Table 4.2.3 shows that the large proportion of respondents 90 percent are the Hindu and 10 percent are Christian.

#### **4.2.4: Occupational Status**

Income is another important part of life. It determines the level of households. In the context of Nepal main source of income is agriculture, service, business, work in India, gulf countries such as Qatar and Malaysia.

**Table 4.9: Distribution of respondents by occupation status**

<b>Occupational status</b>	<b>No.</b>	<b>%</b>
Housework	90	75.0
Agriculture	10	8.3
Daily wages	9	7.5
Trade/Business	7	5.8
service	4	3.3
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

The Table 4.9 shows, that 75 percent women have engaged in housework. About 8 percent respondents are in agriculture, 7.5 percent in daily wages. Similarly, about 6 percent in trade/business and 3 percent have engaged in service.

**Table 4.10: Distribution of Respondent's by husband occupation**

<b>Occupational status</b>	<b>No.</b>	<b>%</b>
Agriculture	60	50.0



Foreign employment	20	16.7
Trade/Business	16	13.3
Service	10	8.3
Others	14	11.7
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Table 4.10, shows that the main source of income of respondent's husband 50 percent is agriculture, foreign employment is 16.7 percent, Trade/business is 13.3 percent, others 11.7 percent, in service sector 8.3 percent, the main source of income is agriculture.

**Table 4.11: Distribution of respondent by husbands' income**

Monthly income	No.	%
Less than 2,000	66	55.0
2,000-5,000	30	25.0
5,000-10,000	19	15.8
10,000 and above	5	4.2
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Income determines the saving and investment capacity of households. High income facilities result high quality of life of the people. Above table shows that monthly income in cash 55 percent respondents' husband income is less than 2,000. Similarly 25 percent respondent's husband's income level is Rs 2,000-5,000. Whereas about 16 percent and 4 percent respondents husband income level is recorded is 5,000-10,000 and above.

#### **4.2.5: Household Amenities Status**

**Table 4.12: Distribution of Respondents by household amenities**

Household amenities	No.	%
Radio	79	65.8
Electricity	70	58.3
Television	23	19.2

Telephone	6	5.0
None	31	25.8
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

The respondents are asked to specify whether they have used any type of household facility such as electricity, telephone, television, radio. It has found that maximum number of respondents have by of availability of the household facility. It has seen that nearly 66 percent of respondents have radio at their household and 58 percent have electricity. Similarly 26 percent have no any facility at their home whereas about 19 percent have television and 5 percent have telephone at their home.

#### 4.2.6: Type of House

House is the basic and fundamental requirement of human being. It is one of the basic measures of quality of life of people. Good housing means good living standard and also makes life comfortable. Here, the houses are categorized in three groups as pakki, half pakki and kachhi. Where, the houses made by using cement and iron rod are in pakki group, the houses made by using tiles for roof and cement wall are in half Paki group and mud covered wall are in kachhi group.

**Table 4.13: Distribution of households by the type of house**

Types of house	No.	%
Pakki	9	7.5
Half pakki	21	17.5
Kachhi	90	75.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

Table 4.13 shows that, the large proportion of households are kachhi house (75%) and only (7.5%) households are pakki. The properties of half pakki house are (17.5%).

#### 4.2.7 Toilet facilities

Some of the people don't know the human excreta are means of communicable disease due to lack of awareness. This study has tried to get information from respondents about use and non-use and types of toilet facilities.

**Table 4.14: Distribution of households by toilet facilities**

Types of toilet	No.	%
Pit toilet	75	62.5
Bush/Open	30	25.0
Ordinary toilet	15	12.5
Flush toilet	-	-
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Table 4.14 Shows that, large proportion of respondents have pit latrine (62.5%), (23.0%) respondents have neither pit latrine nor ordinary toilet, they are using Bush/ open place as their toilet.

#### **4.2.8 Sources of Drinking Water**

Water is essential for everyday for various purposes. Life is impossible without water. There are various sources of water in the earth: ocean, river, well spring stream, pond, snow e.t.c. Human being use different sources of water according to access and availability for their basic needs as drinking, cooking, washing e.t.c. Pure and germless water is important for better health. The main sources of drinking water in the study area are hand pump. It is found that 100 percent Households use hand pump to get underground water.

#### **4.2.9: Media habit**

Communication is the act of exchanging news, views, feeling, ideas, and information e.t.c. from one individual to another. It helps to settle dispute to know about another and to get suggestions from others. The medium of communication must be simple and understand by able other easily.

**Table 4.15: Distribution of respondents by listening radio and watching television**

Media	Yes		No		Total	
	No.	%	No.	%	No.	%
Radio	58	51.7	62	48.3	120	100.0

Television	18	15	102	85.0	120	100.0
------------	----	----	-----	------	-----	-------

Source: Field Survey, 2009.

Media is the most important determining factor of safe delivery. Communication plays vital role to determine safe delivery. It is found that about 52 percent respondent listen radio and 48 percent respondent have not listen radio where as 85 percent respondents have not watched television and 15 percent respondents watch television.

#### 4.16: Distribution of Respondents by type of usually Program Listen

Program listen	No.	%
Musical	40	69.0
Health program	10	17.2
News	8	13.8
<b>Total</b>	<b>58</b>	<b>100.0</b>

Source: Field Survey, 2009.

Table 4.16 presents that, 69 percent women have listen musical program and 17 percent women listen health program. Similarly, about 14 percent women have listen news.

#### 4.17: Distribution Respondents by type of usually Program Watching

Program watching	No.	Percent
Nepal television	7	38.9
Kantipur	-	-
Sagarmatha	-	-
Others	11	61.1
<b>Total</b>	<b>18</b>	<b>100.0</b>

Table 4.17 shows that there is much type of TV channels. Most of the respondent's watch others channels like Hindi about 61 percent and 40 percent respondents watch Nepal television.

#### 4.2.10: Age

Age is demographic character of any population and it plays an important role in any aspect of life. Therefore, it is important the view of population. The age of respondent in the study is presented in Table 4.2.10.

#### Table 4.18: Distribution of age of respondents

Age group	No.	%
15-19	3	2.5
20-24	55	45.3
25-29	46	38.3
30-34	9	7.5
35-39	6	5.0
40-44	1	0.8
45-49	-	-
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

Table 4.18 reveals that the highest proportion of respondent are found in the age group of 20-24. The percentage of this age group is (45.8%). This is followed by 25-29 age groups which are (38.3%), 30-34 age group is (7.5%), 35-39 age group is (5.0%), 15-19 age group is (2.5%) and the lowest no. of respondents from the age group 40-44 (0.8%).

#### 4.2.11: Age at Marriage

Age at marriage for women is another important factor which determines the utilization of safe delivery practices. The median age at marriage of women under study is very low i.e. 16.74 years. This low age at marriage may be due to various social, cultural and economic background of community.

**Table 4.19: Distribution of respondents by age at marriage**

Age at marriage	No.	%
12 to14	37	30.8
15 to 17	37	30.8
18 to 20	41	34.2
21+	5	4.2
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

$$\text{Median age at marriage} = L + \frac{N/2 - c.f}{f} \times h$$

Where,

L = the lower limit of the class interval

N= total number of cases

c.f= cumulative frequency

f= frequency and

h =class interval

4.19. Table shows that most of the marriage occurs around 17 years of age. About 31 percent of respondents have reported that they have married at the both age of 12 to 14 and 15 to 17 years. Similarly, about 34 percent respondents and 4 percent respondents have married at 18 to 20 and 20+ at the age respectively.

#### **4.2.12: Age at First Pregnancy**

As marriage is universal in Nepal first pregnancy within one of marriage is also universal. In many societies being parent is considered as an entire goal. They give priorities for birth right after the marriage. From the reproductive point of view, the age group 20-35 years is considered as the appropriate for childbearing. Table 4.2.12 shows the distribution of respondent's first pregnancy.

**Table 4.20: Distribution of respondents by age at first pregnancy**

<b>Age at pregnancy</b>	<b>No.</b>	<b>%</b>
12 to14	11	9.2
15 to 17	31	25.8
18 to20	68	56.7
21+	10	8.3
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

The Highest, number of percent of respondents nearly 57 percent have reported that they have had their first pregnancy in 18 to 20 years age group, the age group 15 to 17 years follow 26 percent, about 8 percent respondents have reported to have had first pregnancy at the age 21 years and above and about 9 percent have reported to have pregnancy at the age of 12 to 14 years.

#### **4.22: Children Ever Born**

A child ever born is another demographic characteristic of any population. In this study most of women have interviewed below the age of 40 years. CEB mentioned Table 4.2.13 on the basis of live birth that the women given in her life history preceding the survey period. Number of parity

is inversely related to the health status of mother and infant as well as better health is inversely related to the number of children.

**Table 4.21: Distribution of Respondents by CEB**

No. of CEB	No.	%
1-2	83	69.2
3-4	30	25.0
5-6	6	5.0
7+	1	0.8
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

$$\text{Mean CEB} = \frac{\sum Fx}{n}$$

Where, x =mid point of the class

F = Frequency

n= Total number of cases.

Table 4.21.shows that the CEB for the highest percent respondents about 69 percent is 1 to2, followed by 3 to 4 children is 25 percent, 5 to 6 children is 5 percent and 0.8 percent have 7 children till the date of interview. The mean CEB of married women is 2.3.

#### 4.22. Child loss experience

Child loss experience	No.	%
No experience	114	95.0
Four son loss experience	4	66.7
Two daughter loss experience	2	33.3
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

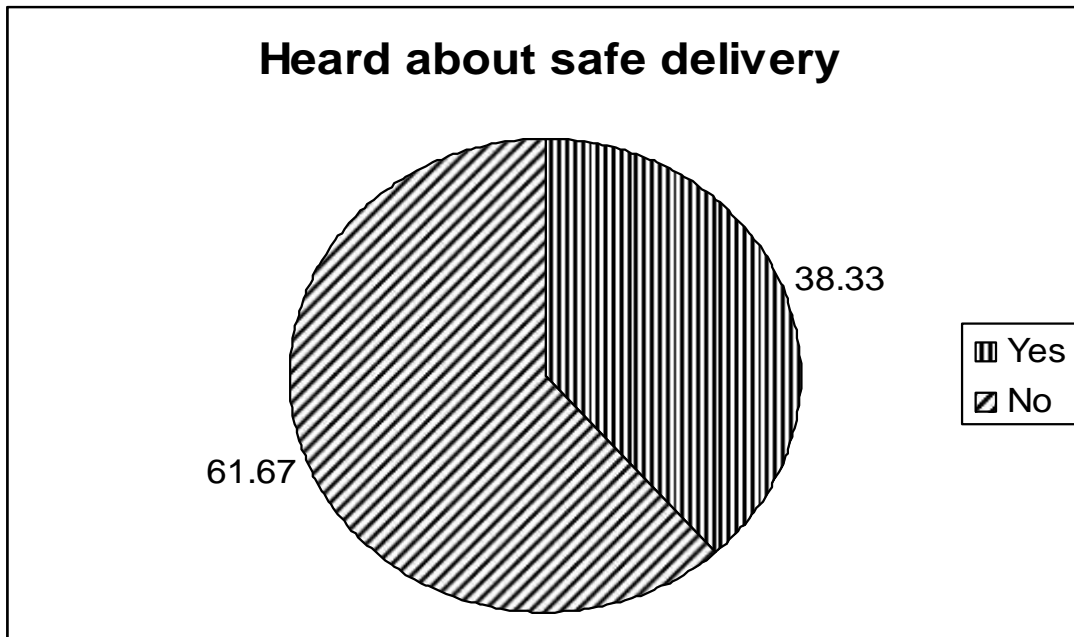
Out of the 120 respondents, 95.0 percent respondents have no son and daughter loss experience. In study area respondents have more son loss experience than daughter. On other hand, according to field observation; it shows that, the sex preference have given to son than daughter. So the low experience of daughter loss may be due to high survival of daughter than son in study area.

#### 4.3: Heard about safe delivery

Acquiring knowledge of safe delivery is an important precondition of safe life. In the study area out of the 120 Respondents about 38 percent respondents have heard about safe delivery whereas

62 percent have not heard about safe delivery.

**Fig.4.3: Distribution of respondents by heard about safe delivery**

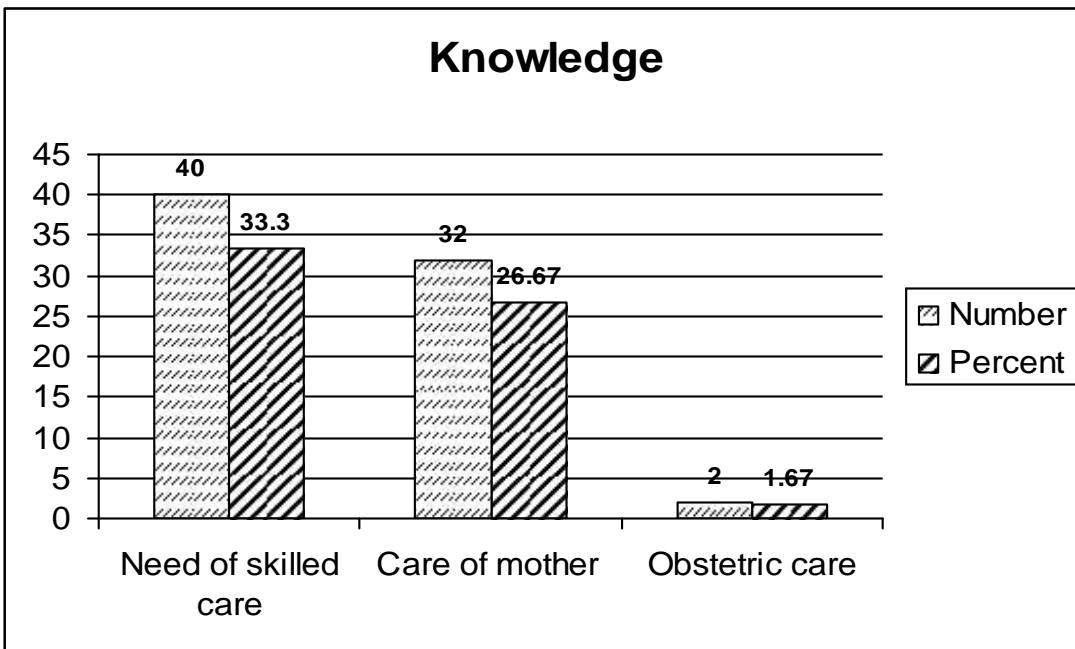


**4.3.1: Knowledge of Safe Delivery**

Knowledge of safe delivery is essential for mother (respondents) and the mother should take, it they have asked the reason to take safe delivery service. This question asked in order to explore the actual knowledge with them about safe delivery service. The Highest percent of respondents 33 percent have reported that it is necessary for need of skilled care, where as about 27 percent followed by care of mother and about 2 percent obstetric care.

**Figure 4.3.1: Distributions of respondents by knowledge of safe delivery**

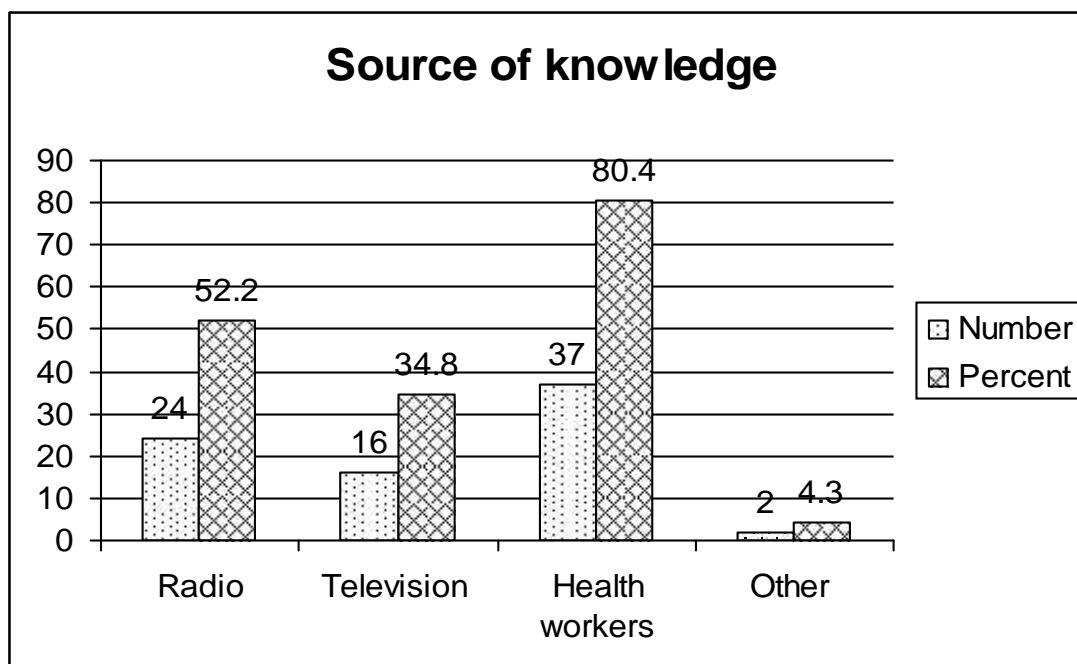




#### 4.3.2: Source of Knowledge

As we know that, the means of communication can play vital role for safe delivery of mother. Here the following number of respondents has got knowledge from difference means of communication and from health service worker.

### 4.3.2. Distribution of sources of knowledge



Above figure shows, that, about 52 percent respondents have got at knowledge about safe delivery from radio, 35 percent respondents from television, 80 percent from health workers and 4 percent from others like friends.

### 4.23: Distribution respondent by (why safe delivery) reason of safe deliver

Reason	No.	%
For the health of mother and new born	23	19.17
To avoid risk of complicated	43	35.83
Don't know	2	1.67
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

Here, about 19 percent respondents have found seeking reasons in order to safe delivery for the health of mother and new born, about 36 percent respondents have told to avoid risk of complicated delivery and about 2 percent respondents have told don't know regarding safe delivery.

### 4.3.3: Preparations for Safe Delivery

Preparation is one of the most important factors affecting safe delivery. Delivery kits, money food, transportation, etc these are the important thing during the delivery. Those women who

make preparation for safe delivery, their delivery have found safe. The preparation for safe delivery reduces the maternal mortality and child mortality rate.

**Figure 4.3.4: Distribution of Respondents by preparation for safe delivery**

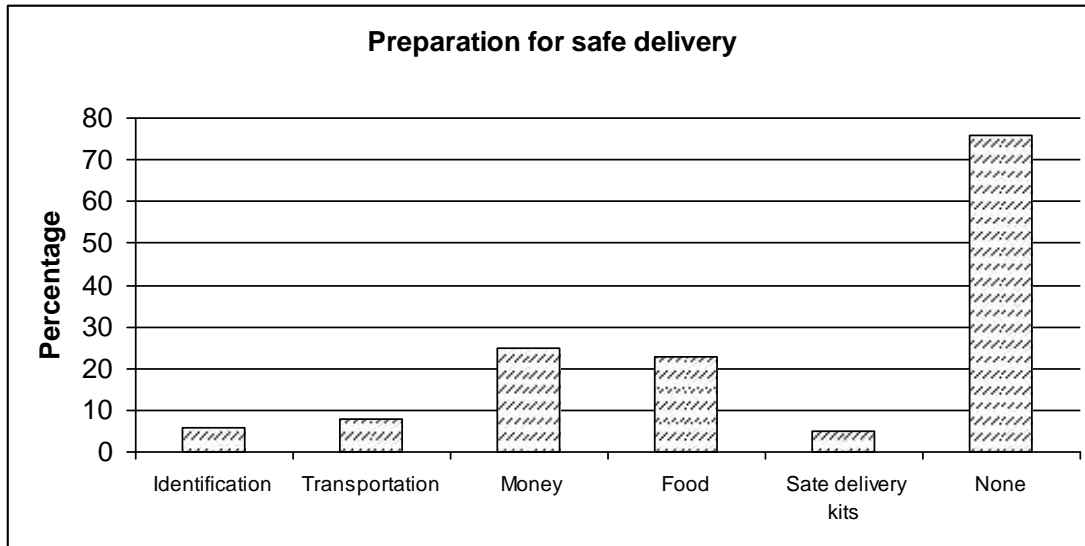


Figure 4.3.4 shows that majority of women 25 percent are here who have used to make preparation for safe delivery. Minor women group found using safe delivery kits for safe delivery. Whereas, about 23 percent respondents and 8 percent respondents have prepared food and transportation respectively and 6 percent identification (health person).

**4.3.4. Availability and Accessibility of respondent’s local area.**

Availability and accessibility are the most important factors affecting safe delivery. Because of the available health facility, women feel easy at the time of their delivery period. Health post is as a main health service providing centre in their locality which is the means of health facility centre at delivery period of women. Majority of women, who have delivery at hospital, have gone to the India at their complicated delivery period

## CHAPTER FIVE

### SAFE DELIVERY AMONG WOMEN

Safe delivery care begins soon after conception till the birth takes place. The provision of care during pregnancy and child birth is essential to ensure healthy and successful outcomes of pregnancy for mother and her new born infant. The maternal infant mortality, morbidity and significance indicates of maternal and child health status. This chapter deals with the major aspects of safe delivery care in the study area.

#### 5.1 Mean Table

**Table 5.1: Mean Number of CEB and Mean age at marriage According to Background characteristics.**

Background characteristics cast/ ethnicity	Mean CEB	Mean age at marriage	Total	
			No.	%
Brahman	2.7	17.1	8	6.7
Chhetri	2.3	16.4	58	48.3
Giri Nath	1.6	19.1	6	5
Magar gurung rai	2.0	17.4	17	20.0
Damai kami	3.1	14.4	24	14.2
Tharu	2.1	15.4	7	5.8
<b>Educational Level</b>				
No Education	2.9	15.5	55	45.8
Primary level(1-5)	2.8	15.7	37	30.8
Lower secondary(6-8)	2.2	16.5	21	17.5
Secondary (9-10)	1.9	17.5	5	4.2
College level(+2)	1.5	18.1	2	1.7
<b>Occupation</b>				
Agriculture	2.7	16.5	10	8.33
Trade /Business	1.9	15.6	7	5.8
Service	1.6	18.4	4	3.3
Daily wages	2.5	17.2	9	7.5
House work	2.8	15.8	90	75
<b>Media exposure</b>				
Radio				
Yes	1.9	17.1	58	48.33
No	2.7	16.3	62	51.6
Television				
Yes	1.8	17.5	18	15
No	2.8	15.9	102	85
<b>Total</b>	<b>2.3</b>	<b>16.74</b>	<b>120</b>	<b>100.0</b>

After analysis of the above data we have found that the Giri/Nath has the highest mean age at marriage i.e. 19.1 and Damai/kami have found to be the lowest mean age at marriage i.e. 14.4. It has found that mean CEB Giri/Nath has the lowest where as Damai/Kami has highest CEB. Likewise, the educated person has high mean age at marriage and uneducated person has low mean age at marriage.

5.1 Table shows that, person involve in agriculture find about 8 percent with 16.5 mean age at marriage and 2.7 mean CEB. Similarly about 6 percent respondents find involving in trade having 1.9 mean CEB and 15.6 mean age at marriage. As a result, respondents involve in housework have the highest mean CEB and respondents involve in service have the lowest mean CEB. Analyzing data with the person listening to the radio and watching television we have found that persons who listen radio and TV have the highest mean age at marriage i.e. 17.1 and 17.5 respectively and they have low mean age at marriage i.e. 1.9 and 1.8 respectively. Person who don't listen to radio and TV have lower mean age at marriage and high CEB.

## 5.2 Place of Delivery

Health center/doctors clinic etc is considered as the best places to visit for health checkup status as well pregnancy. The places and person have essential equipments and knowledge for such services. Total respondents are shown in the following table as per their castes following by them.

**Table 5.2: Distribution of respondents by place of delivery and caste/Ethnicity in Dodhara VDC**

Ethnicity/ Caste	Place of delivery					
	At home		At health facility		Total	
	No.	%	No	%	No	%
Brahmin	5	62.5	3	37.5	8	100.0
Chhetri	46	79.3	12	20.7	58	100.0
Giri/Nath	6	100.0	-	-	6	100.0
Magar/Gurung	14	82.4	3	17.6	17	100.0
Damai/Kami	21	87.5	3	12.3	24	100.0
Tharu	5	71.4	2	28.6	7	100.0
<b>Total</b>	<b>97</b>	<b>61.3</b>	<b>23</b>	<b>38.7</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

It is found that 79.3 percent Chhetri women have delivered at home and only 20.7 percent only delivery at the hospital. Similarly 37.5 percent Brahmin women have had their delivery at hospital. Total 6 women (Giri/Nath) totally have had their delivery at home. Similarly, out of 24 Dalits, only 12.3 percent have had their delivery at health facility. Magar/Gurung women 82.4 percent have delivery at home and out of 7 Tharu women, only 2 percent have their delivery at health facility.

### 5.2.1: Educational Level and Place of Delivery

There is close interrelation between education level and place of delivery. So, the respondents have asked their educational status and the place of delivery at the time of survey. The following Table includes education level of respondents and their place of delivery.

**Table 5.3: Percent distribution of respondent place of delivery and educational level in Dodhara VDC**

Educational level	Place of delivery					
	At home		At health facility		Total	
	No.	%	No.	%	No.	%
No education	43	78.2	12	21.8	55	100.0
Primary(1-5)	33	89.2	4	10.8	37	100.0
Lower Secondary(6-8)	18	85.7	3	14.3	21	100.0
Secondary(9-10)	3	60.0	2	40.0	5	100.0
College(+2)	-	-	2	100.0	2	100.0
<b>Total</b>	<b>97</b>	<b>61.3</b>	<b>23</b>	<b>38.7</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Out of the, 55 illiterate women nearly 22 percent have delivery at health facility and majority of the illiterate women delivery at home. Women, who have got primary and lower secondary education have their delivery at health facility but very less, i.e. 4 and 3 respondents respectively out of total. It is found that 2 women out of 3 having secondary level education delivery at health facility and 100 percent women having college level education found delivery at health facility.

### 5.2.2: Occupation and Place of Delivery

Occupation is another determine factor of safe delivery. It is found that who are involved in any service, they have had safe delivery. The Table5.2.2 shows the status of occupation and their place of delivery.

**Table 5.4: Percent distribution of respondent place of delivery and occupation in Dodhara VDC**

Occupation	Place of Delivery				Total	
	At home		At health facility			
	No.	%	No.	%	No.	%
Agriculture	7	70	3	30	10	100
Trade/Business	7	100	-	-	7	100
Service	1	25	3	75	4	100
Daily wages	8	88.9	1	11.1	9	100
House hold	74	82.2	16	17.8	90	100
<b>Total</b>	<b>97</b>	<b>73.2</b>	<b>23</b>	<b>26.8</b>	<b>120</b>	<b>100</b>

*Source: Field Survey, 2009.*

It is found that majority of respondent's place of delivery at health facility. Out of 120 respondents, 10 respondents have involved in agricultural occupation. Among them 7 women have delivered at home and 3 have delivered at health facilities. Similarly, among 7 women who are in trade/ business, majority of the respondents delivery at health facility. Likewise, majority of the respondent's occupation is household work. Out of 120 respondents, 90 respondents have involved in house job. Among them largest number of respondents have delivered at home which percent is about 82 percent. Similarly only 4 women have involved in service occupation. Among them, 75 percent have delivered at health facilities whereas 25 percent at home.

### **5.2.3 Mass Media and Place Delivery**

Mass media is the most important determining factor of safe delivery. Communication plays vital role to determine safe delivery. Therefore, respondents have asked question about mass media and their place of delivery. While taking the information about mass media, different options are observed at the time of survey. Respondents have asked, about the means of communication which they have used.

**Table 5.5: Distribution of respondents by place of delivery and exposure to mass media in Dodhara VDC**

Exposure	Place of delivery					
	At home		At health facility		Total	
Radio	No.	%	No.	%	No.	%
Yes	37	63.8	21	36.2	58	100.0
No	60	96.8	2	3.2	62	100.0
<b>Total</b>	<b>97</b>	<b>80.3</b>	<b>23</b>	<b>19.7</b>	<b>120</b>	<b>100.0</b>
Television						
Yes	15	83.3	3	16.7	18	100.0
No	52	80.4	20	19.6	102	100.0
<b>Total</b>	<b>97</b>	<b>81.9</b>	<b>23</b>	<b>18.2</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

It was found that 58 percent respondents had radio facility. Among the respondents about 64 percent women have delivered at home and 36 percent women were delivery at health facility as they have at least radio facility at home. Likewise another determining factor of safe delivery is television facility at home. Out of them, majority of respondents used safe deliver or, were delivery 17 percent at hospital but who haven't television facility at their house, they haven't used safe delivery. Significantly, majority of the respondents delivered at home who haven't television facility at home about 80 percent. Hence, it is clear that mass media is the most important determining factor of safe delivery.

### **5.3: Assistance in delivery**

To minimize the complication at the time of delivery, trained health professional are needed. Situation of birth attended at the time of survey is presented by following Table.



**Table 5.6: Distribution of respondents by delivery assistance at home**

<b>Delivery assistance by</b>	<b>No.</b>	<b>%</b>
ANM	6	6.2
FCHV	11	11.3
TBA	26	26.8
Friends\Neighbours	54	55.7
<b>Total</b>	<b>97</b>	<b>100.0</b>

Source: Field Survey, 2009.

Table 5.6 shows, Out of the 97 respondents of women about 56 percent are delivery assistance by friends and neighbour about 27 percent women by TBA. Similarly 11 percent by FCHV and only 6 percent women is delivery assistant by ANM.

**Table 5.7: Distribution of respondents by person providing assistance during delivery according to educational level in Dodhara VDC**

Educational Level	Delivery-Assistant at home									
	ANM		FCHV		TBA		Relative and friends		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
No education	-	-	5	11.6	9	20.9	29	67.4	43	100.0
Primary(1-5)	2	6.1	3	9.1	10	30.3	18	54.5	33	100.0
Lower secondary(6-8)	3	16.7	2	11.1	6	33.3	7	38.9	18	100.0
Secondary(9-10)	1	33.3	1	33.3	1	33.3	-	-	3	100.0
College level	-	-	-	-	-	-	-	-	-	-
<b>Total</b>	<b>6</b>	<b>14.0</b>	<b>11</b>	<b>16.3</b>	<b>26</b>	<b>29.5</b>	<b>54</b>	<b>40.2</b>	<b>97</b>	<b>100.0</b>

Source: Field Survey, 2009.

Out of, the 120 respondents, 97 respondents who have delivery at home. Again out of 97 respondents, 43 respondents are illiterate. Among the literate respondents, 33 respondents have primary level (1-5), 18 respondents have lower secondary and 3 respondents have secondary level. Among the illiterate respondents are about 12 percent delivery assistance by FCHV, 21 percent by TBA and 67 percent by relative and friends.

Similarly, among 97 respondents who have completed grade 1-5, about 6 percent delivery assistance by ANM, 9 percent by FCHV, 30 percent by TBA and 55 percent by relative and friends. Like wise, the respondents who have their educational level 6-8, about 18 percent by ANM, 11 percent by FCHV, 33 percent by TBA and 39 percent by relative an friends. similarly respondents who have completed secondary level about 33 percent have took delivery by ANM, also 33 percent by FCHV, 33percent by TBA and the college level respondent have not deliver at home.

Finally, the respondents who have educational level received delivery assistance in health service centre assisted by doctor and nurse. This table clearly shows that as education level goes higher, the birth attendance turns safe and safety.

**Table 5.8: Distribution of women by person providing assistance during delivery, according to occupation in Dodhara VDC**

Occupation	Delivery-Assistant at home									
	ANM		FCHV		TBA		Relative & friends		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
Agricultural	-	-	-	-	2	28.6	5	71.4	7	100.0
Trade/Business	2	28.6	1	14.3	2	28.6	2	28.6	7	100.0
Service	1	100.0	-	-	-	-	-	-	1	100.0
Daily wage	1	12.5	-	-	3	37.5	4	50	8	100.0
Housework	2	16.9	10	13.5	19	25.7	43	58.1	74	100.0
<b>Total</b>	<b>6</b>	<b>31.6</b>	<b>11</b>	<b>5.6</b>	<b>26</b>	<b>24.1</b>	<b>54</b>	<b>41.6</b>	<b>97</b>	<b>100.0</b>

Source: Field Survey, 2009.

The majority of respondents have household job. Out of, the 97 respondents, 74 involve in household job. Total respondents; have found involving in different occupations. Respondents who have involve in agriculture delivery assistance by TBA. About 29 percent and 71 percent have delivery assistance by relative and friends. Who have involved in trade/business about 29 percent delivery assistance by ANM, 14 percent by FCHV, 29 percent by TBA and also 29 percent by relative and friends.

Similarly, among the 97 respondents who have delivery at home among them only the 1 respondent delivery assistance by ANM. Likewise who have involved in daily wage, about 13

percent delivery assistance by ANM, 38 percent by TBA, 50 percent by relative and friends. At last who have engage in housework, about 17 percent delivery assistance by ANM, 14 percent by FCHV, 26 percent by TBA and 58 percent by relative and friends.

Table 5.8, clearly shows that, who have involved in service received safe delivery and not takes safe delivery assistance by others. Who have involved in agriculture they are totally assistance by TBA and relative and don't take safe delivery assistance.

**Table 5.9: Distribution of women by person providing assistance during delivery, According to exposure to mass media in Dodhara VDC**

Exposure	Delivery-Assistant											
	Doctor		Nurse		TBA		Health worker		Relative and friends		Total	
Radio	No.	%	No.	%	No.	%	No	%	No	%	No.	%
Yes	9	15.5	12	20.7	8	13.8	6	10.3	23	39.7	58	100.0
No	3	4.8	1	1.6	12	19.4	15	24.1	31	50.0	62	100.0
Total	12	10.2	13	11.2	20	16.7	21	17.2	54	44.9	120	100.0
Television												
Yes	2	11.1	1	5.6	5	27.8	5	27.8	5	27.8	18	100.0
No	10	9.8	12	11.8	15	14.7	16	15.7	49	48.0	102	100.0
Total	12	10.5	13	8.7	20	21.3	21	21.8	54	37.9	120	100.0

Source: Field Survey, 2009.

It has found that majority of the respondents have radio facility at home are 58 in number. Among them, 15.5 percent have received delivery assistance by doctor, 20.7 percent by nurse, 13.8 percent by TBA, 10.3 percent by health worker and similarly 39.7 percent delivery assistance by relatives and friends. Majority of the respondents are assisted during delivery by relatives and friends nearly 50 percent.

Among them who have used television nearly 11 percent take delivery assistance by doctor, 5.6 percent by nurse, 27.8 percent each assisted by TBA, health worker and relative and friends. Out of 120 respondents, 102 respondents haven't this type of facility at their home.

#### 5.4: Use of Delivery Kits

Use of safe delivery kits is very important ideal techniques to save and serve the mother and child. Therefore the question is asked about the use of delivery kits at the time of survey.

**Table 5.10: Distribution of respondents by use of delivery kit**

Use of delivery kit	No.	%
Yes	6	5.0
No	114	95.0
<b>Total</b>	<b>120</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Table 5.10 indicates that out of the 120 respondents only 5 percent respondents use safe delivery kits whereas 95 percent respondents do not use safe delivery kits.

#### 5.5: Complication during Delivery and Solve Complication

Complication during delivery is social, economic and demographic problem in any community. Maternal death is related with the complication during delivery. The study in survey area shows that out of total respondents, about 15 percent have replied that they faced the problem during delivery. Out of 15 respondents about 53 percent respondents are faced prolong labour, 33 percent suffered from retained placenta and 13 percent from excessive bleeding. To solve their problem about 13 percent have visited hospital, 67 percent have visited health post, about 19 percent have visited to other like FCHV etc and no respondents have found to visit Dhami/Jhakri to solve their problem.

**Table 5.11: Distribution of respondents by complication during delivery and solve the complication**

<b>Complication During delivery</b>	<b>No.</b>	<b>%</b>
Yes	31	25.8
No	89	74.2
<b>Total</b>	<b>120</b>	<b>100.0</b>
<b>Faced problem</b>		
Prolong lab our(above 8 hour)	8	53.3
Retained placenta	5	33.3
Excessive bleeding	2	13.3
<b>Total</b>	<b>15</b>	<b>100.0</b>
<b>Place where help was sought</b>		
Hospital	10	32.3
Health post	15	48.4
Dhami/ Jhankri	0	0.0
Others	6	19.4
<b>Total</b>	<b>31</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

### **5.6: Accompanied**

Delivery period is the complicated period. Without the proper care and help of their own family member being delivery is quite difficult and dangerous so they need to be cared in every complicated step at their delivery period.

**Table 5.12: Distribution of respondents Accompanied to the Health Facility at the Time of Delivery**

<b>Person</b>	<b>No.</b>	<b>%</b>
Alone	-	-
Mother in law\ father in law	10	43.5
Husband	8	34.8
Others	5	21.7
<b>Total</b>	<b>23</b>	<b>100.0</b>

Table 5.12 shows that the highest number of respondents about 44 percent accompanied with mother in law/father in law, 35 percent by husband and 22 percent by others like friends.

### 5.7: Transportation

As we know that means of transportation is necessary at the time of delivery. To, save the life of mother as well as infant, the means of transportation must be available easily and quickly as per the need of situation in delivery time.

**Table 5.13: Distribution of respondents Transportation used to go to health facility centre at time of delivery**

Transportation	No.	%
Ambulance	-	-
Car	2	8.7
Tampoo	-	
Walked	11	47.8
Bike( Motor cycle)	10	43.5
<b>Total</b>	<b>23</b>	<b>100.0</b>

Source: Field Survey, 2009.

Table 5.13 shows that among 23 respondents, about 9 percent respondents use car, nearly 48 percent respondents walk and about 44 percent use bike(Motor cycle).

### 5.8: Status of Currently Pregnant Women

The level of currently pregnant is one of the most important indicators for health and family planning policy makers and professionals in Nepal because of it is direct relevance to the population policy and programs.

**Table 5.14: Distribution of respondent by currently pregnant**

Currently pregnant	No.	%
Yes	7	5.8
No	113	94.2
<b>Total</b>	<b>120</b>	<b>100.0</b>

Source: Field Survey, 2009.

Above table 5.14 shows that, out of 120 respondents about 6 percent are currently pregnant where as, 94 percent are not pregnant till the date of interview.

**Table 5.15: Distribution of respondent by month of currently pregnant**

<b>Month</b>	<b>No.</b>	<b>%</b>
1-3	4	57.1
4-6	2	28.6
7-9	1	14.3
<b>Total</b>	<b>7</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Table 5.15 shows that, about 57 percent respondents found being 3 month pregnancy where was nearly 57 percent, similarly 2 and 1 respondents found having 4-5 and 7-9 months of pregnancy respectively out of total which clearly mentioned in above table.

**Table 5.16: Distribution of respondent by plan for deliver**

<b>Plant for deliver</b>	<b>No.</b>	<b>%</b>
Hospital	1	14.3
At home	-	-
Don't know	6	85.7
<b>Total</b>	<b>7</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

It is found that out of the 7 women most of the women i.e. About 86 percent reply that they don't have any plan for their delivery where as nearly 14 percent reply to go hospital.

### **5.9: CEB and Currently Pregnant**

It is considered that lower the number of CEB women are more pregnant. The following. Table is also clearly shows this type of vision.

**Table 5.17: Distribution of number of CEB and currently pregnant women in Dodhora**

<b>No of CEB</b>	<b>No.</b>	<b>%</b>
1-2	4	57.1
3-4	2	28.6
5-6	1	14.3
7+	-	-
<b>Total</b>	<b>7</b>	<b>100.0</b>

*Source: Field Survey, 2009.*

Here, lower the CEB indicates higher number of pregnant women. The highest, 4 pregnant women are having 1-2 children. Similarly 2 women are pregnant being 3-4 children. Nearly 1 woman is pregnant being 5-6 children and 7 children women are not have pregnant till the date of interview.



## CHAPTER SIX

### SUMMARY, CONCLUSION AND RECOMMENDATION

#### 6.1 Summary

This study has analyzed the child delivery practice, socio-economic and demographic status among married women of reproductive ages having at least one child of Dodhara VDC of Kanchanpur. This study is based on primary data from random sampling method in (3, 4, and 6) of this VDC. In order to meet the objectives of the study, the study considers qualitative and quantitative information from the respondents. The major findings of this study are as follows:

- Out of 648 total populations of 120 households, 316 male populations and 332 female populations. The highest proportion of population is found in 15-49 years of (53.2%).
- Average number of respondent's size Brahmin, Chhetri, Tharu, Magar/Gurung/Rai, Dalits, and Giri/Nath is found to be 6.7%, 48.3%, 14.2%, 20.0% and 5.0% respectively.
- This study shows that out of 120 respondents about 46 percent are illiterate where as literate respondents about 31 percent are primary level, 18 percent are lower secondary, 4 percent are secondary and about 2 percent are college level.
- In study area 100 percent respondents found using hand pump to get underground water.
- Among total population about 50 percent are unmarried, 37 percent are married and living together, 1 percent widow, 2 percent divorce and 11 percent are married but not living together.
- The highest percent of respondents are belonging to age group 20-24(45.8%) and lowest percent to age group 40-44 (0.8%).

- The majority of respondents have got married in the interval of age group 18-20 (34.3%). Only (8.3%) respondents have got marriage in the age 21 above.
- Nearly 69 percent of the respondents have reported that average number of CEB is 1 to 2.
- Perspective of occupation 75 percent have engaged in housework, about 8 percent respondents are in agriculture, only 3 percent have engaged in service and 6 percent have engaged in business.
- 90 percent respondents are follower of Hindu religion and 10 percent are the followers of Christian religion.
- Among the 120 houses, 75.0 percent have kachhi house, about 18 percent have half pakki house and 8 percent have Pakki houses.
- About 63 percent household has managed the pit latrine facilities. There are also 25.0 percent people who use open place as a toilet and 13 percent have ordinary latrine.
- An overwhelming majority about 66 percent respondents have reported to have radio. About 58 percent have electricity, among them, 19 percent, 5 percent have television and telephone respectively and 26 percent haven't any thing.
- Among the respondents, 25.0 percent respondents prepare Money for safe delivery, about 23 percent food, 8 percent transportation, 6 percent identification, 5.0 percent safe delivery kits and 75 percent respondent aren't any preparation for safe delivery.
- It is found that literate respondents (college level) use safe deliveries where as, maximum illiterate are used unsafe delivery at home.
- On the basis of occupation, it has found that who's involved in service used safe delivery and whose in housework have used unsafe delivery.

- It is found that only 5 percent respondents have used safe delivery kit whereas 95 percent did not use.
- Among the 97 respondents who have delivery at home, about 6 percent with ANM, 11 percent with FCHV, 27 percent with TBA and large proportion 56 percent with friends\neighbour.
- Respondents who have delivery at home, on the basis of occupation, engaged in agricultural they are delivery assistant about 29 percent with TBA and 71 percent with relative and friends.
- Respondents who are in contact of mass media used safe delivery- assistant while others used unsafe delivery assistance.
- It is observed that about 26 percent respondent have complication during the delivery whereas 74 percent have not any complication. There are some kinds of problem faced at the time of delivery. About 53 percent respondents have faced prolong labour, 33 percent have faced with retained placenta and 13 percent respondents have faced with excessive bleeding.
- Out of total respondents, about 26 percent faced problem at the time of delivery. Such problem has solved by hospital 32 percent, by health post 48 percent and 19 percent others.
- About 52 percent respondents have got source knowledge about safe delivery from radio, 35 percent respondents are knowledge from television, 80 percent respondents are from health workers and 4 percent respondents from others like friends.
- Out of 120 respondents, 7 respondents are currently pregnant. Among them 4 respondents have found being 3 month pregnancy where as 2 and 1 respondents have found having 4-5 and 7-9 months of pregnancy respectively.

## 6.2 Conclusion

This study has conducted to find out of the health concern child delivery practices in to different ethnicity in Dodhara VDC. On the basis of above analysis and results the study has concluded that child delivery practices are not satisfactory. Socio –economic characteristics (housing , literacy , occupation ,age at marriage) are poor sources of water (Hand pump) are found accessible in the study area women ,who are literate involved in profession have found in better situation with compare to illiterate women in the study area. In study area, it has found that, maximum numbers of respondents are the delivery at home having no any knowledge about the safe delivery practice. 97 number respondent's delivery occurs at home assisted by relatives and friends. Similarly a large number of respondents are found involving in house work. Education attainment is positively related to health and every aspect of human life. Educated woman are found more careful than uneducated woman.

## 6.3 Recommendation

- In the study area the majority of women have delivered at home. So awareness program about safe delivery raising the participation of women should be done. Women should be taught about the benefits and easiness of delivery being at hospital. Priority should be given in women's education.
- The mean age at marriage of women in the study area is very low, which in high fertility and bad reproductive health status of women. So to reduce early age at marriage practice public awareness program lunch in this study area.
- Women in the study area are engaged in agriculture and house work only, so they should be provided different kind of skillful training and to involve them in different social sector.
- Due to lack of information many women found not practicing safe child delivery, so information education communication (IEC) programs should be implemented.

- Status of women should be raised by supporting on their health, economic, educational, social sector as well as increasing their decision making role on family and society.
  
- In the study area, majority of women have used Bush/Open place as a toilet, so awareness program should be launched for such women by NGOs and Ingo's

## References

- Bhatta, Shanker Datta, 2006, *Status of Child Delivery, A Case Study of Mahendranagar Municipality*, an Unpublished M.A Dissertation (Kathmandu: CDPS T.U).
- Department of Health Services (DOHS), 2004/05, *Annual Report*. (Kathmandu: MOH/New Era).
- Dhungel, Sanjib, 2000, *Utilization of Motherhood Services in Nepal*, Unpublished, MA Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).
- Dithal, Malla, 1999, *Safe Motherhood Practice: A Study of Selected Slum Areas along Bishnumati river in Kathmandu*, Unpublished M.A. Dissertation (Kathmandu: CDPS T. U.).
- F.H.D. UNICEF 1996, *National Maternity Care Guidelines Nepal* (Kathmandu: Family Health Division (F.H.D) Ministry of Health (MOH) United Nations Children Fund (UNICEF).
- ICPD 1994, "Reproductive Rights and Reproductive Health" Program of Action (ICPD 1994) pp. 46.
- Khanal, M.K, 2001, *Maternal and Child Health Care Practice of Gandarva and Poda Castes of Kaski District*, An Unpublished Dissertation Submitted to Central Department of Population Studies (Kathmandu: CDPS).
- Mandhar, Vijay 2005, *Make Every Mother and Child Count*, "Safe Motherhood Newsletter" Vol. 6 Kathmandu, MOH.
- Ministry of Health (MOH), 1998, *Maternal Mortality and Morbidity Study*, (Kathmandu: Family Health Division).
- Ministry of Health (MOH) 2006, "Nepal Demographic Health Survey", (Kathmandu: MOH).
- , 2001, "Nepal Demographic Health Survey" (Kathmandu: MOH).

- Poudel Yak Raj, 2007, *Maternal Health Care Practice and Educational Status of Women*.  
An Unpublished M.A Dissertation, (Kathmandu: CDPS T.U).
- United Nations Population Fund (UNFPA), 2008/09, Maternal Mortality and Morbidity  
Study, *Summary of Preliminary Findings*. (Katmandu: New Era).
- United Nations Population Fund (UNFPA), 1997, “Rights for Sexual and Reproductive  
Health: *The State of World Population*, (New York, UN).
- United Nations Population Fund (UNFPA), 1995, “Reproductive Health and Family  
Planning”, in Alex Marshall (ed.), *Report on the State of World Population, 1995*  
(UK, NIPL) pp.31 to36.
- United Nations Populations Fund, 2000, “The State of World Population, 2000” (UNFPA,  
2000).
- World Health Organization (WHO), 2005, *Mothers and Children Matter so Does their  
Health*, (WHO report), Chapter 1, pp.1 of 9.
- , 2002, “Making Pregnancy Safer,” *Research on Reproductive Health*  
(Geneva: WHO).