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Child Delivery Practices among Married Women in Kohalpur Banke

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Abstract

This study employs a descriptive research design to examine socio-economic and demographic factors influencing safe delivery practices. Both primary and secondary data were utilized. Primary data were collected from 120 women aged 15–49 years across three wards of Kohalpur Municipality, Banke District, Nepal, using structured interviews. Respondents were selected through random sampling, focusing on women with at least one child under five years. Secondary data were obtained from municipal profiles and health posts. Data collection tools were validated by experts and finalized under the guidance of an advisor. Simple statistical tools were used for analysis, with findings presented in tables, graphs, and percentages. The study underscores the impact of education, awareness, and accessibility to healthcare facilities in improving maternal health outcomes and promoting safe delivery practices.

Key words: Safe Delivery Practices, Maternal Health, Socio-economic Factors, Demographic Influences, Reproductive Health

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Introduction

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 rate is 2.5 per women in Nepal that was reported by 2011census but is slightly decline. 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 1991, 2001 and 2011 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 26.4 million people live in the Nepal area. The growth rate of population is 1.35%. These are various obstacle and hardship entangled with education. The literacy status of women in Nepal is very low at 57 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. In the context of Nepal 90% of maternal death occurs in rural areas because of the complications during delivery. Similarly, every hour in Nepal 2.4 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. The general objective of the study was to assess safe delivery practices in Kohalpur Municipality. The study aimed to assess safe delivery practices in Kohalpur Municipality by examining the socio-economic and demographic status and identifying the safe delivery practices of married women aged 15-49 years.

Review of Related Literature

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 tradition 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 with in four hours of delivery, more than one in four (27 percent) received care with in the first 24 hours, and 4 percent of women were seen 1-2 days following delivery. (NDHS, 2006).

Birth at home are not necessary unsafe if the mother's family and her birth attendant can recognize the sings of complications during the labour and delivery and if complications occur can promptly carry her to the health facilities with adequate facilities. Families may nit 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 significance 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 with out skilled attendant and 70 percent receive post- partum care in the six week following delivery (WHO, 1997). In the context of Nepal for majority of birth mothers receives two or more doses of tetanus toxoid during pregnancy (Pathak and Gurung, 2002) (Cited in, Bhatt Shanker Datt).

Delays at the facility: community and provides 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 blood were perceived delay by providers

identified lack of blood as an avoidable factors in 19% of facility based deaths, but this had dropped to 12% in 2008/09. (Maternal mortality and morbidity study, 2008/09).

Methodology

Design and Method of the Study

The study was based on descriptive types of research design. Primary and secondary data information will be use, descriptive and simple statistical interpretation procedure was adapted in this study.

Population Sample and Sample Strategy

This research was based on primary data collection from three wards of Kohalpur Municipality of Banke district in Lumbini provision. It is based on the 15-49 years age group married women

to find out there child delivery conditions. These women asked about their last child only which occurred in the last five years proceeding of this survey. This study was based on the lottery method of random sampling. Total equally numbered on small pieces of paper of equal size and selected on number at time until the desired sample size in obtained. The sample was 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.

Study Area / Field

This study was concentrated on the women of the reproductive ages (15-49).The Kohalpur Municipality situated in Banke district of Lumbini provision. It is near India and Baijanath most of the part of this touches Kohalpur municipality and some part touches Bardiya District. In Kohalpur Municipality with the different trench of people from different caste ethnicity like Brahman, Chhetri, Tharu, kami, gurung Yogi and Giri etc. This lies in the Veri zone, southern part of Nepal. According to the 2068 census, the total population of this area 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 RMUC.

Data Collection Tools and Techniques

For the purpose of data collection, the researcher was used interview schedule. Tools were defined, developed and checked up by exports before using them. After checking, the tools and finalized by suggestion and guideline of the advisor, final tools were developed and used for data collection.

Data Collection Procedure

For the collection of the primary data, the researcher was consulted the Municipality members to obtain information about married women from Kohalpur Municipality of Banke District. Secondary data were collected from the concerned agencies like as Rural Municipality profiles, health post.

Data Analysis and Interpretation Procedure

Once the researcher completed data collection, they will be tabulated in the master chart. The data were tabulated systematically and sequenced according to the need of the study. Simple statistical tools were used to analyze and interpret the collected data. They were graphically presented in tabular forms and even in percentage.

Result and Discussion

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

Educational status	**No.**	percent
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
Total	**120**	**100.0**

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

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 1.

Table 1 Distribution of age of respondents

Age group	**No.**	percent
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	-	-
Total	**120**	**100.0**

Table 1 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%).

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 2 Distribution of respondents by age at marriage

Age at marriage	**No.**	percent
12 to14	37	30.8
15 to 17	37	30.8
18 to 20	41	34.2
21+	5	4.2
Total	**120**	**100.0**

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.

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 3 Distribution of respondents by age at first pregnancy

Age at pregnancy	**No.**	percent
12 to14	11	9.2
15 to 17	31	25.8
18 to20	68	56.7
21+	10	8.3
Total	**120**	**100.0**

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.

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 hared about safe delivery.

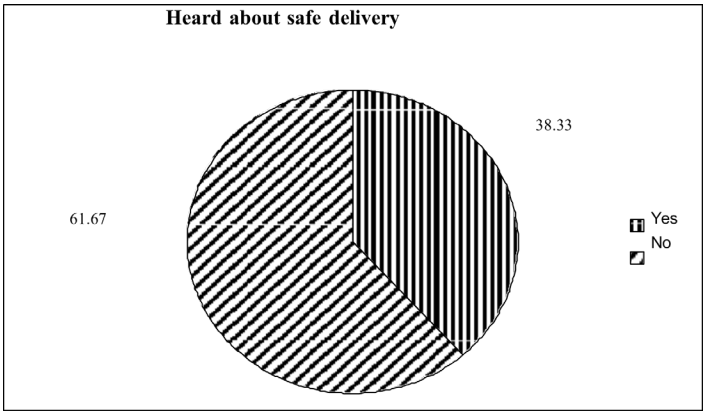

Fig.1 Distribution of respondents by heard about safe delivery

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.

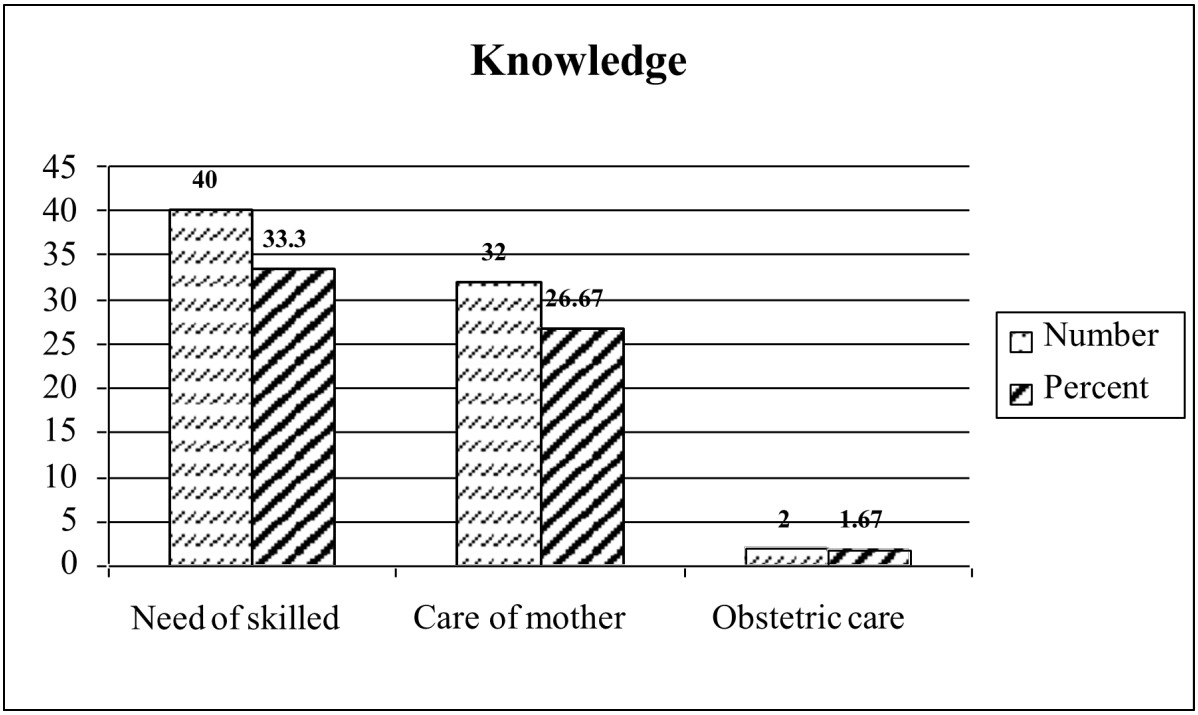

Figure 2 Distributions of respondents by knowledge of safe delivery

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.

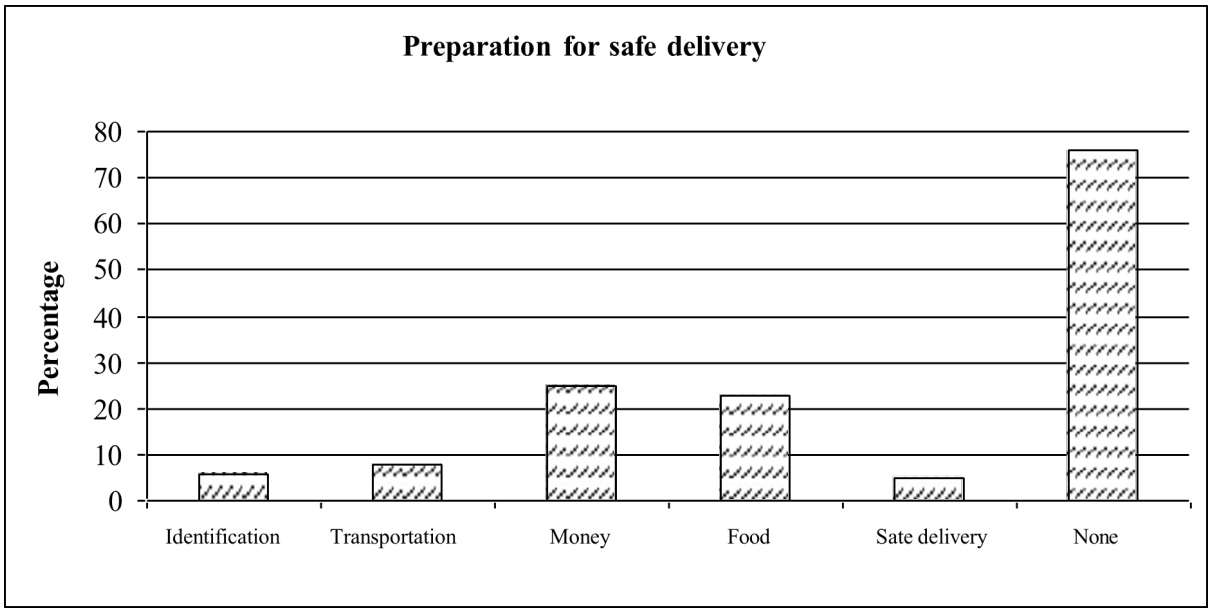

Figure 3 Distribution of Respondents by preparation for safe delivery

Figure 3 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).

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.

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: Distribution of respondents by place of delivery and caste/Ethnicity

Ethnicity/ Caste	**Place of delivery**					
	At home		**At health facility**		**Total**	
	No.	percent	**No**	percent	**No**	percent
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
Total	**97**	**61.3**	**23**	**38.7**	**120**	**100.0**

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.

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 6 Percent distribution of respondent place of delivery and educational level

Educational level	**Place of delivery**					
	At home		**At health facility**		**Total**	
	No.	percent	**No.**	percent	**No.**	percent
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

Educational level	Place of delivery					
	At home		At health facility		Total	
	No.	percent	No.	percent	No.	percent
Secondary(9-10)	3	60.0	2	40.0	5	100.0
College(+2)	-	-	2	100.0	2	100.0
Total	**97**	**61.3**	**23**	**38.7**	**120**	**100.0**

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.

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 Table 7 shows the status of occupation and their place of delivery.

Table 7 Percent distribution of respondent place of delivery and occupation

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, it is clear that mass media is the most important determining factor of safe delivery.

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 8 Distribution of respondents by delivery assistance at home

Delivery assistance by	**No.**	percent
ANM	6	6.2
FCHV	11	11.3
TBA	26	26.8
Friends\Neighbors	54	55.7
Total	**97**	**100.0**

Table 8 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 perent women is delivery assistant by ANM.

Table 9 Distribution of respondents by person providing assistance during delivery according to educational level

Educational Level	Delivery-Assistant at home									
	ANM		FCHV		TBA		Relative and friends		Total	
	No.	P.	No.	P.	No.	P.	No.	P.	No.	P.
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	-	-	-	-	-	-	-	-	-	-
Total	**6**	**14.0**	**11**	**16.3**	**26**	**29.5**	**54**	**40.2**	**97**	**100.0**

Note: P= Percent

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 10 Distribution of women by person providing assistance during delivery, according to occupation

Occupation	**Delivery-Assistant at home**									
	ANM		**FCHV**		**TBA**		**Relative & friends**		**Total**	
	No.	P.	No.	P.	No.	P.	No.	P.	No.	P.
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
Total	**6**	**31.6**	**11**	**5.6**	**26**	**24.1**	**54**	**41.6**	**97**	**100.0**

Note: P=Percent

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 11 Distribution of women by person providing assistance during delivery, According to exposure to mass media

Exposure	Delivery-Assistant											
	Doctor		Nurse		TBA		Health worker		Relative and friends		Total	
Radio	No.	P.	No.	P.	No.	P.	No	P.	No	P.	No.	P.
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

Note : P=Percent

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.

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 12 Distribution of respondents by use of delivery kit

Use of delivery kit	**No.**	percent
Yes	6	5.0
No	114	95.0
Total	**120**	**100.0**

Table 4.30 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.

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 13 Distribution of respondents by complication during delivery and solve the complication

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

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 4.32 Distribution of respondent by currently pregnant

Currently pregnant	**No.**	percent
Yes	7	5.8
No	113	94.2
Total	**120**	**100.0**

Above table 4.32 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 14 Distribution of respondent by month of currently pregnant

Month	**No.**	percent
1-3	4	57.1
4-6	2	28.6
7-9	1	14.3
Total	**7**	**100.0**

Table 4.33 shows that, about 57 percent respondents found being 3 month pregnancy where was nearly 57 percent, similarly 2 and1 respondents found having 4-5 and 7-9 months of pregnancy respectively out of total which clearly mentioned in above table.

Table 4.34 Distribution of respondent by plan for deliver

Plant for deliver	**No.**	percent
Hospital	1	14.3
At home	-	-
Don’t know	6	85.7
Total	**7**	**100.0**

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.

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 15 Distribution of number of CEB and currently pregnant women

No of CEB	**No.**	percent
1-2	4	57.1
3-4	2	28.6
5-6	1	14.3
7+	-	-
Total	**7**	**100.0**

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.

Conclusion

This study has conducted to find out of the health concern child delivery practices in to different ethnicity in Kohalpur Municipality. 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.

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