MATERNAL AND CHILD HEALTH CARE PRACTICES IN THARU COMMUNITY

(A Study of Tharu Community in Chandranagar VDC, Sarlahi District)

By

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A Dissertation Submitted to the Central Department of Population Studies, Faculty of Humanities and Social Sciences for the Partial Fulfillment of the Degree of Master of Arts in Population Studies

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Recommendation

The dissertation work entitled "Maternal and Child Health Care Practices: A Study of Tharu Community in Chandranagar VDC, Sarlahi District," by Mr. Raj Kumar Chaudhary is prepared under my supervision for the partial fulfillment of the requirement for the Degree of Master of Arts in Population Studies. To the best of my knowledge, the study is original and carries useful information on maternal and child health. Therefore, I recommend it for evaluation to the Dissertation Committee.

August 2008

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This dissertation entitled "Maternal and Child Health Care Practices: A Case Study of Tharu Community in Chandranagar VDC, Sarlahi District," by Mr. Raj Kumar Chaudhary has been accepted as partial fulfillment of requirement for the Degree of Master of Arts in Population Studies.

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ABSTRACT

The study on "Maternal and Child Health Care Practices in Tharu Community" is carried out based on primary data collected from the Chandra Nagar VDC, Sarlahi district. The main objectives of the study are to examine the knowledge and practices of maternal and child health care among the Tharu community, to examine the modern as well as traditional maternal and child health care practice among the Tharu community and to assess the socio-economic and demographic characteristics of the Thru community.

The total population in this study is 713 of which 390 are males and 323 are females. The sex ratio is found to be 120.7. Among 138 respondents, 89.1 percent females are illiterate as against 79.7 percent among their husbands. The main occupation of husband and wife is agriculture. Almost all of their husbands are involved in agriculture. Age at marriage of respondents was early age which was most prevailing in the community.

In the case of maternal health care, the age group 20-24 years received antenatal services most during last pregnancy (31.2%). The coverage of TT is 23.2 percent only. Most of the children are delivered at home (94.2%) with assistance of TBA which comprises 52.2 percent among persons assisted during delivery. Majority of respondents use usual food (99.3%). Most of the respondents breastfed for one to two years, that is 67.4 percent.

Most of the Tharu women (98.6%) used herbs to treat disease. Onion, garlic, ginger are very popular among Tharu women. Child immunization practice is good but measles and polio are less common than BCG and DPT. Even though, most of the Tharu women used herbs to treat diarrhoea, they used the Jeevan Jal also. The overall observation of the study revealed that the MCH care practice is related with mother's age, education and knowledge of use of medicine. In Tharu society, 64.5 percent respondents used contraceptive methods.

ABBREVIATIONS

AHW	:	Auxilliary Health Worker
ANC	:	Antenatal Care service
ANMHA	:	Auxilliary Nurse Midwife Health Assistant
ARI	:	Acute Respiratory Infection
CBS	:	Central Bureau of Statistics
DHS	:	Demographic Health Survey
FP	:	Family Planning
FPAN		Family Planning Association of Nepal
GON	:	Government of Nepal
ICPD	:	International Conference on Population and Development
IMCI	:	Integrated Management of Childhood Illness
INGO	:	International Non-Governmental Organization
MCHW	:	Maternal Child Health Worker
MMR	:	Maternal Mortality Rate
MOH	:	Ministry of Health
NFHS	:	Nepal Fertility Health Survey
NGO	:	Non Governmental Organization
ORS	:	Oral Rehydration Salt
PAHO	:	Pan American Health Organization
RH	:	Reproductive Health
SAARC	:	South Asian Association for Regional Cooperation
TBA	:	Traditional Birth Attendance
TFR	:	Total Fertility Rate
TT	:	Tetanus-Toxoid
TU	:	Tribhuvan University
UN	:	United Nations
UNDP	:	United Nations Development Programme
UNFPA	:	United Nations Population Fund
VDC	:	Village Development Committee
VHW	:	Village Health Worker
WHO	:	World Health Organization

CONTENTS

LIST OF TABLES

Page No.

CHAPTER - ONE

INTRODUCTION

1.1 General Background

Maternal and child health care is one of the important components of primary health. The World Health Organization (WHO) defined "health is a state of complete physical, mental and social well-being and not merely the absence of disease or an infirmity in all matters relating to the reproductive system and to its functions and process." Successful family planning programme is always contextual and combined with maternal and child health activities.

Status of health in Nepal is poor. Therefore, as in many least developed countries, Nepal has many problems concerning health and health services. The major health problems of Nepal are high maternal and child morbidity and mortality, prevalence of communicable diseases, environmental pollution, high fertility rate and poor health care practices (Khoj-Bin, 1997).

According to the World Health Organization, the risk of dying from pregnancy of childbirth related cases is 1 in 20 in some developing countries compared to 1 in 10,000 in some developed countries (ICPD, 1994).

A recent study in Nepal, for example, found that the decision to seek care for pregnant of postpartum woman was most often made by husbands followed by mother in law, the women themselves are seldom involved in the decision (UNPF, 1999). It is categorized that 24 percent of adolescent girls in the rural areas have given birth to at least one child while only 18

percent of all women receive ante-natal care. Women in many remote communities have virtually no contact with health worker during pregnancy. Only 6 percent of child birth are attended by trained birth attendants. Due to poor maternal health around 29 percent of newly born infants are under weighted (UNESCO, 1999:16). In Nepal, maternal and child health care practices are insufficient due to minimum level of education poor economic status and lack of knowledge about health care facilities. Maternal morbidity and mortality estimate in Nepal is comparatively high (515 per 100,000 births) compared to other SAARC countries because maternal services, especially in rural areas, are often deficient and inappropriate to women situations (Panta, 1994).

Government of Nepal has fully endorsed the ICPD programme of action as well as the 1995 WHO Global Reproductive Health strategy both of which are bound to serve as a basis for Nepal National Reproductive Health strategy. Nepal has recognized that an effective family planning programme will lead to reduction of fertility as well as safe motherhood programme. In this context, Government of Nepal, as a signatory of the Cairo Declaration is committed to provide reproductive health services to all over Nepal in conformity with goals as set out by the Cairo Plan of Action 1994. The strategy is in line with the 1991 health policy and 1997-2017 second long-term health plan (MOH.1998).

1.2 Statement of the Problem

The high maternal mortality are not only the problems of women but are affecting everyone. Through supports of families, health care provides care of young and alike, farmers, traders, the key educators of children (UNFPA,1999).

Nepal is one where the maternal mortality rate is highest in the world. The major cause of maternal and infant mortality is reproductive complications. The maternal mortality rate (MMR) is found to be 281 per 100,000 live birth (MOHP et al., 2007).

In our earth, every minute one women die as a result of complications during pregnancy or child birth. Similarly, every minute eight babies die because of poorly managed pregnancies and deliveries. Most of these deaths occur where there is poverty and where women's health needs are neglected. Of the global annual total of 500,000 maternal deaths, 494,000 are in the developing world (WHO, 1993).

A primary means of improving child survival is expanding childhood vaccination coverage. About 76 percent of Nepalese children aged 12-23 months have been vaccinated against TB, DPT and Polio. Similarly, diarrhoea and respiratory illnesses are common for childhood deaths in Nepal. Only 14 percent of children with diarrhoea and 18 percent of children with symptoms of Acute Respiratory Infection (ARI) were taken to health facility (Pradhan, 1996).

One in every 11 children born in Nepal dies before reaching age five years. Slightly more than two in three under five deaths occur in the first year of life. Infant Mortality Rate is 48 per 1000 live births, and child mortality is 61 per 1000 live births. During infancy, the risk of neonatal death (34 per 1,000) is nearly one and a half times as high as the risk of post neonatal death 26 per 1,000) (MOHP/New ERA/Macro Int'l, 2007).

- What are the maternal and child health care practices, i.e. antenatal, delivery and post natal are practices?
- What is the socio-economic characteristics of mother?

- To get the answer of these problems, a Tharu Community is selected which is the poorest of the poor in all respects of the development stream of the country.

1.3 Objectives of the Study

The main objectives of this study are to assess maternal and child health care practices in Tharu community. The specific objectives of this study are as follows:

- To assess the socio-economic and demographic characteristic of Tharu community.
- To examine the knowledge and practices of maternal and child health care among the community.
- To examine the traditional as well as modern maternal and child health care practices among Tharu of Chandranagar VDC

1.4 Significance of the Study

The study is to examine the maternal and child health care practices among Tharu community in Chandranagar VDC. The indigenous practices of maternal and child health care including antenatal delivery and post-natal care practices to the mothers and breast feeding and other sanitary practices.

The major significance of the study are as follows:

- The findings of the study will be helpful for planners and policy makers of different kinds of non-governmental organization, International non governmental organization and Government to formulate the policies and plans regarding health care

- The result of the study will be helpful to women to care their own health and their children.
- This study helps to the local people to develop awareness towards their health problem in their community.
- The study will be useful as a guideline for research in similar studies.

1.5 Limitations of the Study

- This study is limited to the currently married women aged 15-49 years having children under five years of age.
- The study will also be limited only to the Tharu community of Chandranagar VDC in Sarlahi.
- Only selected socio-demographic variables are considered in the analysis of maternal and child health care practices.
- Maternal and child health includes only antenatal care, delivery care and postnatal care practices.

CHAPTER-TWO

REVIEW OF LITERATURE

This chapter attempts to present some literature related to the Maternal and child health care practices previously done in Nepal as well as in other countries of the world.

UNICEF (1993) estimates that global coverage of measles immunization is 77 percent as a world average where as it is the highest 80 percent for ESCAP region, 80 percent which is for south Asia, 73 percent for Middle East and North America and least for Sub-Saharan Africa (48%). Regarding the South Asian countries, India has the highest (86 %) and Afghanistan has lowest (92 %) coverage of measles immunization.

Beker et al. (1993) conducted a study based on data of 8,000 women in Metro Cebu, the Philippines using polygamous logistic regression methods. They tried that the level of maternal and child education was most consistent and important determinant of the use of family planning, pre-natal care, childhood immunization and Oral Rehydration Salt (ORS) services in both urban and rural areas. The most effective way of reducing the risk of death among pregnant women is by increasing accessibility and use of essential obstetric services (WHO, 1991) Pudasaini (1994) says that a mother is a foundation of life. It is tragic that so many of them lose their own life while in the process of giving birth to a new living-being. Women deserve best possible health care to go through a happy, and healthy pregnancy and child birth. But they have less access to quality health care. Maternal mortality continues to be a leading cause of death among women of reproductive age.

Devkota, (1994) who conducted a study on "Knowledge, Attitude and Practices of Mothers on Maternal and Child Health Care at Pandrung Village" in Gorkha district noted that about one third of the total mothers said that food should be taken more than usual during pregnancy. About 67.2 percent of the mothers had reported to have done two or more health check-ups during pregnancy. Almost 36 percent of the mothers had taken two or more doses of TT Vaccine during their last pregnancy.

Shrestha, (1994) had done a study of Baglung district of Baglung Bazar on "Child Health Care Practice in Different Ethnic Groups" She has found that most prevalent health problems of children were cold (50.8%) and diarrhoea (24.5%) compared to other health problems. She concluded that cold and diarrhoea were seen as a major health problems of children. Oral rehydration therapy practices were done by the majority of the mothers. She also found that about 75.4 percent children were normal by observation however, severe malnutrition was seen in spite of the majority of the mothers being careful of their children. She concluded that the nutritional status was higher for literate mother than that of illiterate. The children from women of higher family were having better nutritional status than children from lower family.

Children spend their life with their parents, sometimes with their siblings and grand parents. The growth and development of a child depend upon the care of the parents. If parents fail to look after their children properly, to give balance diet and consult the doctor to check up, the improvement of child will be difficult. Educated parents become more able to understand childhood disease and adopt good treatment practices. So it is believed that the prevalence rate of childhood disease in educated mothers must be lowered than the uneducated mothers (Adhikari, 1994)

1991/92 Yamen Demographic and Maternal and Child Health Survey provides information from a nationally representative sample of ever married women aged 15-49 years and children aged under 5. Lifetime fertility was 7.7 children, 8.2 in rural areas and 8.1 for women without any formal education. Elimination of unwanted pregnancy would result in lifetime fertility of 6 births, first births before the age of 20 years amounted to almost 50 percent of reproductive age of women. Education impacts on early age at marriage; Women with more than a primary education had a median age at marriage of almost 23 years. About 6 percent of currently married women were in polygyrious unions. Infant mortality was 83/1000 births and child mortality was 166 in urban areas and 142 in rural areas. However, rates of mortality were associated with better sanitation and hygiene. Health (about 4 out of 5 deliveries) and 20 percent of all deliveries were assisted by a birth attendant and 16 percent by a doctor or nurse (Yamen Central Statistical Organization, 1995).

It is noted that wide spread poverty, lack of knowledge and poor health infrastructure have resulted high child morbidity and mortality in Nepal. The most common diseases involved are respiratory diseases; diarrhoea, malnutrition and other infections though they are largely preventable (Karki and Thapa 1985, cited in Pant (1995: 46).

The percentage of births to women receiving pre-natal services from a doctor, nurse or midwife has increased from 15 percent in 1988-91 to 24 percent in 1995/96, and the percentage of receiving no pre-natal care dropped from around 80 percent to 56 percent over the same period. Report showed that younger women took pre-natal services than older women. For about one third (33 %) of births, mothers received two or more doses of Tetanus Toxoid (TT) during pregnancy, while 13 percent

received one dose only. For about half of births (54%) mothers did not receive a single dose of TT Vaccine (MoH, 1996).

Nepal Family health Survey (NFHS) 1996 mentioned as, for 24 percent of births, mothers received antenatal care from a doctor (13%) or trained nurse midwife (11%). For 10 percent of births, mothers received antenatal care from a village health workers (VHW), (4%) maternal and child health (MCHW) worker (4%) or other health professional 2 percent. Women received antenatal care from a traditional birth attendant (TBA) for only one percent of births. For the majority of births in Nepal 56 percent, mothers did not receive any antenatal care.

More than 585,000 women die each year from causes related to pregnancy. For each death, at least 13 women suffer from a less serious threat to their health. In some countries, emergency care is more accessible and only fewer women die there. Over 3000 women may suffer ill-health from pregnancy related causes for each maternal death. Complications of pregnancy are found everywhere, but nearly all maternal deaths are in developing countries: an African woman is 500 times more likely to die of pregnancy related causes than her counterpart in one of the Scandinavian countries.

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

The target of safe motherhood programme is to reduce maternal mortality at 400 death per 1,00,000 live births by the year of 2000 and is fulfilled by making family planning and maternal health care services more accessible and increasing quantity and quality of service outlets. Government has extended the health facilities up to village level by the end of the Ninth Five year plan (MOH, 1997).

UNFPA, (1997) has published a report noted that women's social empowerment and economic security clearly contribute to, and depend on good reproductive health. But their access to reproductive health services is constrained by their lack of resources, restrictions on social participation, and limited access to information due to illiteracy.

UN (1998) concludes that the maternal mortality is one of the leading causes of death among women of reproductive age in many developing countries. Pregnancies that are too many too early, too frequent, too late or unplanned pregnancies are associated with levels of child and maternal morbidity and mortality.

The Integrated Management of Childhood Illness(IMCI) initiative has been introduced by UNICEF and the WHO/Pan American Health organization (PAHO) in Latin America and other regions to improve the knowledge and skills of health workers and parents. Rather than concentrating on the treatment of specific diseases, it emphasizes the overall care of sick children. For example, a child with fever needs to drink more fluids. The end of 1997 had piloted IMCI in 20 countries around the world.

Overall, out of two pregnant women, only one received antenatal care. The proportion of mothers who received antenatal care is 28 percent either from a doctor (17 %) or a nurse or auxiliary nurse midwife (11 %).

Another 11 percent of mother received antenatal care from a health assistant (HA) or auxiliary health worker (AHW). Village health workers (VHWs) provided antenatal care to 6 percent 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 mother (MOHP/New ERA/Macro Int'l, 2002).

Women who have been immunized with tetanus toxoid (TT) during pregnancy was 32.6 percent (WHO, 1999).

Vaccination coverage has improved significantly over the last five years. The percentage of children aged 12-23 months who are fully immunized by 12 months of age increased by 67 percent, from 36 percent in 1996 (Pradhan et. al. 1997) to 60 percent in 2001. Coverage with all three doses of DPT increased from 51 to 71 percent of children, while complete Polio coverage increased from 48 to 90 percent of children. BCG coverage increased from 73 to 83 percent and measles vaccination increased from 45 to 64 percent.

The prevailing high maternal mortality is related to low access to antenatal and postnatal care and inadequate emergency obstetric care service. A large proportion of birth still remains unattended by trained health worker. In most countries of South Asian region, except in Sri Lanka and Maldives a large proportion of pregnant mother did not seek antenatal care. The proportion of pregnant mother seeking antenatal care was highest for Sri-Lanka, followed by Maldives and India and the lowest in Bangladesh (Chaudhaary, 2000).

Globally 585,000 women died from the complications of pregnancy and labour (WHO 1996). More than 99 percent of deaths occurred in developing countries. Over the past few years there has been a steady

improvement in many of the health indicators in Nepal, but maternal mortality in Nepal is still a subject of great concern. The maternal mortality rate, which stands at 281/100000 live births is one of the highest in the South East Asia region and the world. The highest causes of maternal mortality rate are the issue of poverty, malnutrition and lack of access to adequate maternity care. Nearly 90 percent of women are delivered at home without any assistance from trained medical personnel. Further more, Nepal has special problem. The main causes of maternal mortality are postpartum haemorrhage (47 %), obstructed labour (60 %), eclampeia (14 %), puerperal sepsis (12%) and abortion 5 percent (Shrestha, 2002).

According to Nepal Demographic Health Survey Report 2006 A.D. the infant mortality rate is 48 and under five morality is 61 thousand (MOHP et al., 2007).

More than 500,000 women die every year from causes related to pregnancy, child birth and abortion. Ninety-nine percent of those deaths occur in less developed regions, particularly in Africa and Asia. The ratio of maternal death to live births varies greeting throughout the world from fewer then 10 maternal deaths per 100,000 live births in many European Countries to more than 1,400 deaths per 100,000 live births in some countries in sub-Saharan Africa. In addition for every women who die, the World Health Organization (WHO) estimates that about 30 suffers form long-term health problems such as infertility and damage to the reproductive organs (PRB, 2002).

Malnutrition is not overly prevalent out in Nepal. Indeed, there is wide variation in both ecologically and regionally through Nepal. Stunting under weight and wasting are more common in the common in the

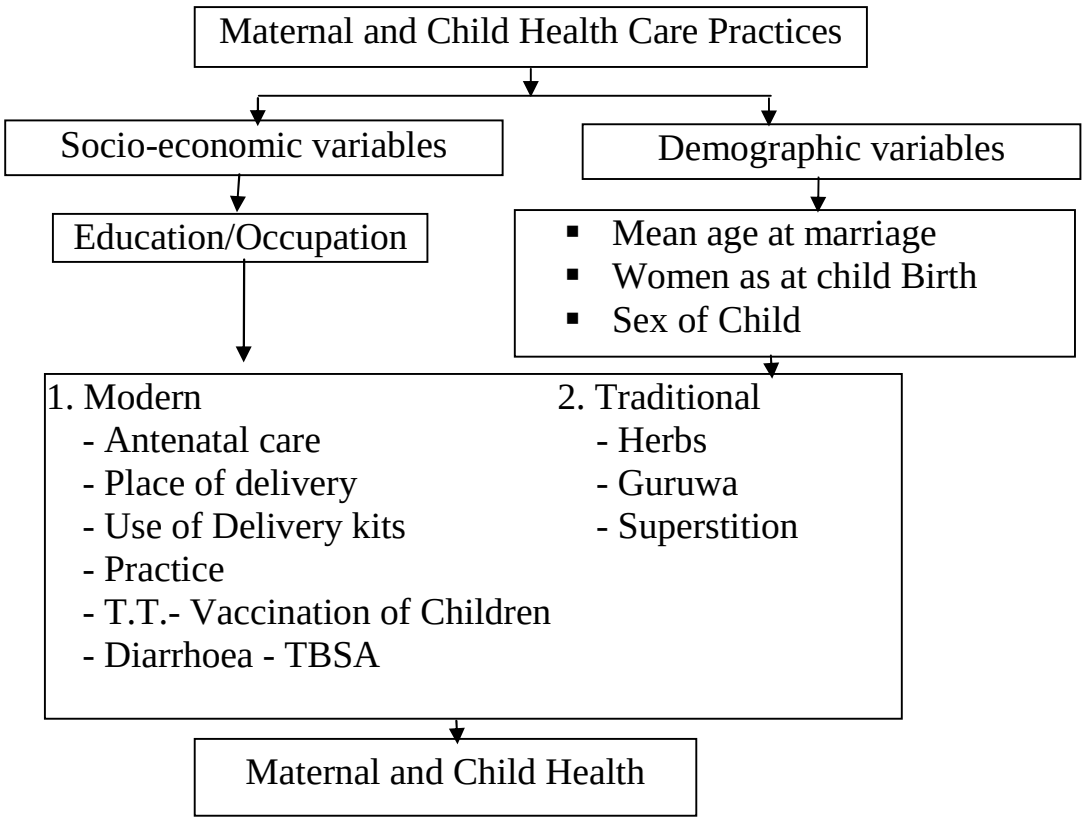
mountain areas than in the Terai. There is also a marked geographical trend, with the rates for all three indicators being particularly high in the mid-western and far-western hills, as well as the whole mountain region. In addition urban children are less likely to be stunted (36%) than their rural counter parts (56%) (MOH, 2000/2001).

2.1 Conceptual Framework

Conceptual framework for "maternal and child health care practices " among Tharu community in Chandra Nagar VDC. Sarlahi district is presented in fig. 1.

Fig. 1

Conceptual Framework for Maternal and Child Health Care Practices



This analytical framework is suitable for the study, since the maternal and child health care practice is influenced by different socio-economic and demographic variables. For the study two types of socio-economic variables like education and occupation are selected. These variables affect the maternal and child health care practices. Similarly, there are also different demographic variables like age at marriage, women's age at childbirth, sex of the child and so on. Age at marriage plays the vital role for mother's and child's health. Thus, the given all variables help to have condition of maternal and child health practices among Tharu women.

CHAPTER-THREE

METHODOLOGY

3.1 Selection of the Study Area

Main study area of this research is the Chandranagar VDC. Sarlahi. According to census 2001. Nepal, the total population of this VDC is 6,915 of which 3,503 are males and 3,412 are females. This study covered a total of 150 households with 713 population from Tharu community. In addition to Tharu, main ethnic groups residing in this VDC are Danuwar, Teli, Mushar, and Mallah.

3.2 Source of Data

The source of data for this study is based on the primary data and this is obtained by using direct structural interview among women of reproductive age group of 15-49 years who are married ones and have a baby at breast.

3.3 Sampling

Sample was taken in the Chandranagar VDC, where the concentration of Tharu population is mainly concentrated in ward 1 to 9. All the households were not taken for the study due to short duration of time. However, the intention was to collect rich data on practice of maternal and child health status of Tharu. Among households in the VDC, purposively 150 Tharu households were choosen for the sample. From these households, 138 respondents are selected to carry out the study of maternal and child health care practices.

3.4 Research Tools

To know the knowledge on maternal and child health care practices based on primary data, the questionnaires were as follows:-

Household Questionnaire

These questionnaires included the information on age, sex, marital status and relation of household member.

Individual Questionnaire

As its name represents this questionnaire deals with the individual women of reproductive age (15-49 years) and collected personal information specially about antenatal, delivery and postnatal care. It also collected information about number of child ever born, age at child bearing and marriage, and other socio-economic and demographic characteristics.

3.5 Method of Data Analysis

The collected information were processed with the help of computer using computer statistical package. Data were analyzed using required frequency and cross-tabulation. Similarly, data are presented in pie-chart, bar diagram etc.

CHAPTER-FOUR

BACKGROUND CHARACTERISTICS OF STUDY POPULATION

This chapter deals with background characteristics of the study population. It analyzes the socio-economic and demographic characteristics.

4.1 Demographic and Socio-economic Characteristics

The study covers a total of 713 population from 150 households of Tharu community in Chandranagar VDC. The age and sex distribution is shown in Table 1.

Table 1:

Age-sex structure of study population

Age group (in years)	Male		Female		Sex Ratio	Total	
	No.	%	No.	%	-	No.	%
0-4	49	12.6	41	12.7	119.5	90	12.6
5-9	59	15.1	52	16.1	113.4	111	15.6
10-14	42	10.8	35	10.8	120.0	77	10.8
15-19	48	12.3	43	13.3	111.6	91	12.8
20-24	45	11.5	38	11.8	118.4	83	11.6
25-29	32	8.2	23	7.1	139.1	55	7.7
30-34	40	10.3	32	9.9	125.0	72	10.1
35-39	28	7.2	25	7.7	112.0	53	7.4
40-44	21	5.4	17	5.3	123.5	38	5.3
45-49	13	3.3	9	2.8	144.4	22	3.1
50-54	6	1.5	4	1.2	150.0	10	1.4
55-59	5	1.3	3	0.9	166.7	8	1.1
60+	2	0.5	1	0.3	200.0	3	0.4
Total	390	100.0	323	100.0	120.7	713	100.0

Source: Field survey, 2008.

Age-sex structure plays an important role in determining the population distribution of the study area. The study showed that for both sex a higher proportion of population was in early age group. Of the total population 54.7 percent were males and 45.3 percent were females. The sex ratio of this area was 120.7 which is higher than the national average (99.8 males per 100 females). Table showed the distribution of population according to age group and their sex which indicated higher of 16.1percent female and 15.1 percent male were in age group 5-9. The lowest percentage of males and females were in the age group 60 years and above which was 0.5 percent male and 0.3 percent female. According to age group the sex ratio was highest for the age group 60 above which was 200 and lowest for the age group 15-19 which was 111.6.

4.2 Marital Status

Among the total population of age 10 years and above, only 39.64 percent were unmarried. The percentage of currently married was more than 57 percent and the percentage of widow/widower and separated is relatively low. Of the total 282 male and 230 females, 56.8 %age of males and 58.9 percent age of females were currently married. The proportion of unmarried males (40.2%) was higher than that of female (39.64%).

Table 2:

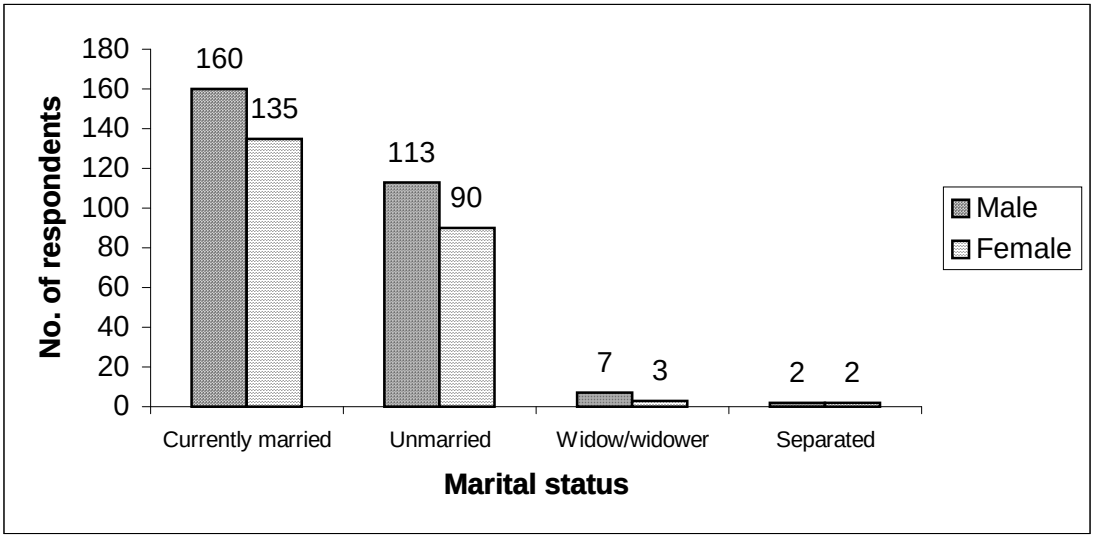
Distribution of population aged 10 years and above by marital status

Marital status	Male		Female		Total	
	No.	%	No.	%	No.	%
Currently married	160	56.8	135	58.9	295	57.61
Unmarried	113	40.2	90	39.1	203	39.64
Widow/widower	7	2.5	3	1.4	10	1.95
Separated	2	0.5	2	0.6	4	0.80
Total	282	100.00	230	100.0	512	100.0

Source: Field survey, 2008.

It can be shown in bar diagram as:

Fig. No. 2:
The Marital Status



4.3 Occupational Status

Occupational status is another important factor, which determines the socio-economic condition of a society. Differential in occupational status is observed in the study of population. Most of the respondents replied that they are engaged in agricultural sector in about 62 percent of the total population. Very few population are engaged in services (0.7%), 16.3 percent populations are labourers whereas 21percent populations are students. Out of total, 58.2percent male populations engaged in agriculture. Only 1.2percent male populations are engaged in services, whereas no any female is found service holders.

Table 3:
Distribution of population aged 10 years and above by occupational status

Occupational status	Male		Female		Total	
	No.	%	No.	%	No.	%
Agriculture	164	58.2	154	67.1	318	62.1
Labour	49	17.4	34	14.8	83	16.2
Student	66	23.2	42	18.1	108	21.0
Service	3	1.2	-	-	3	0.7
Total	282	100.0	230	100.0	512	100.0

Source: Field survey, 2008.

4.4 Educational status

Education is one of the important factor which affects all aspects of human life. It is important requirement for enhancing the social, political and economic development. Therefore, it is believed that educated people are more aware of their family and health.

Table 4:

Distribution of population aged 6 years and above by literacy status

Literacy status	No.	percent
Literate	150	31.6
Illiterate	325	68.4
Total	475	100.0

Source Field survey, 2008.

Table 4 shows that more than 68 percent of Tharu are illiterate whereas only 31.6 percent are literate. It can be shown in the pie-chart as:

Fig. 3:

The Literacy Status

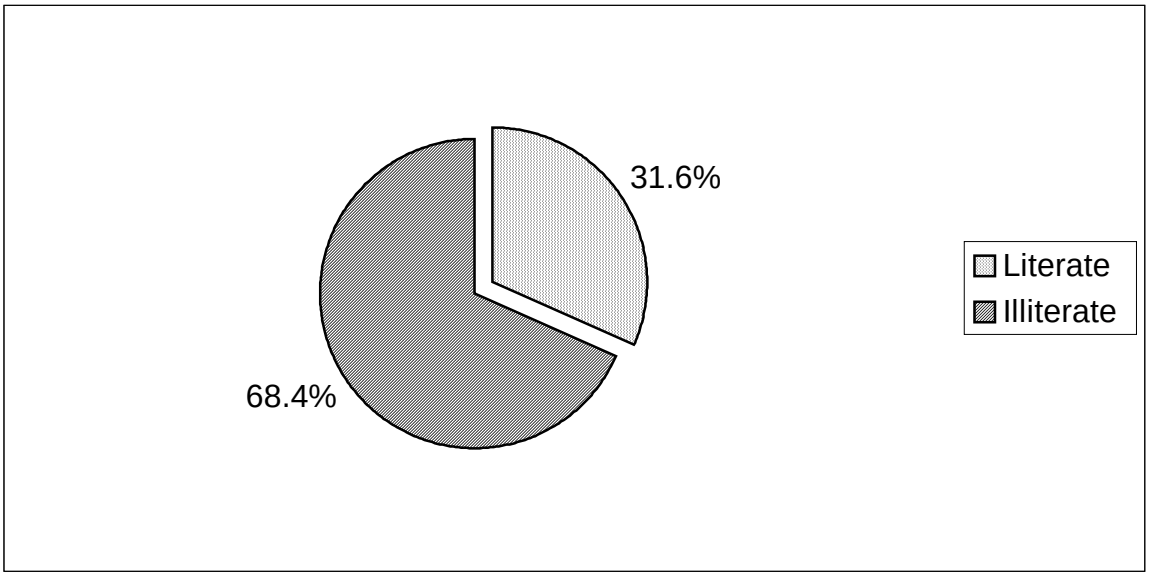


Table 5:

Distribution of population aged 6 years and above by educational status

Educational status	Male		Female		Total	
	No.	Percent	No.	Percent	No.	Percent
Primary (1-5)	45	9.5	26	5.5	71	15.0
L. secondary	32	6.7	12	2.5	44	9.2
SLC	18	3.8	8	1.7	26	5.5
Intermediate and above	7	1.5	2	0.4	9	1.9
	102	21.5	48	10.1	150	31.6

Source: Field survey, 2008

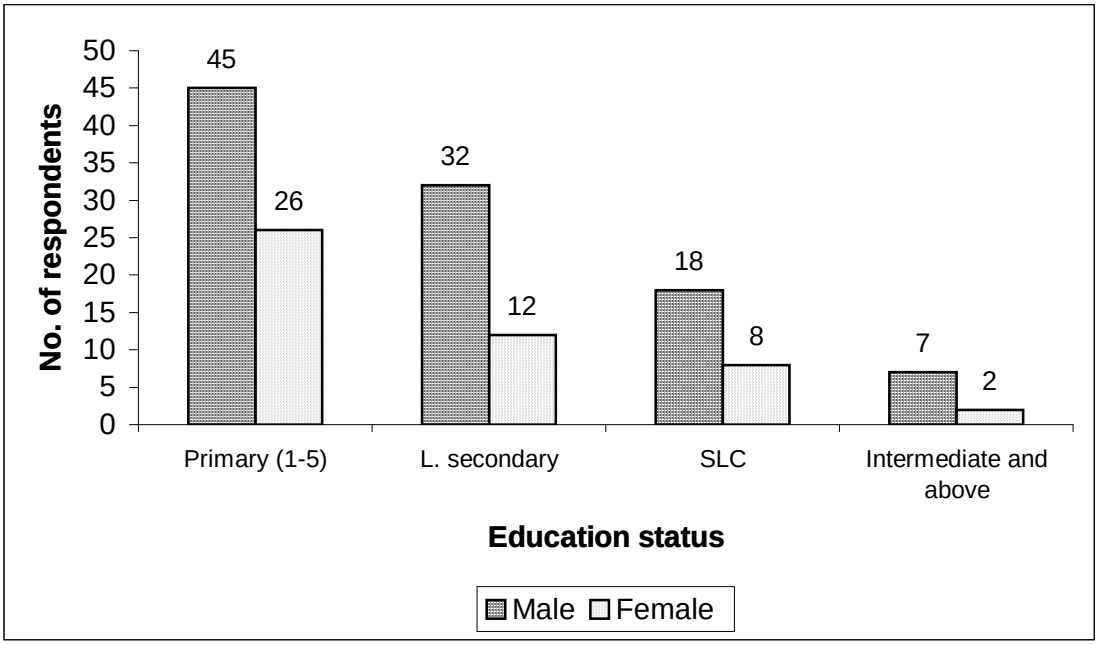
Table 5 shows that among total literate population, 15 [percent have primary level of education, 9.2 percent have lower secondary education and only 5.5% have passed SLC. The proportion of higher level of education (Intermediate and above) is lower. It is 1.9 percent.

Regarding the sex, more than 9 percent of males have primary level of education as against 5.5 percent of females. The proportions of males having secondary level of education and higher level of education (3.80%0 and 1.5%) respectively are greater than that for females. (1.7% and 0.4% respectively). It clarifies that females are back in education in Tharu community.

Table 5 can be presented in bar diagram as:

Fig. 4:

The Educational Status



4.5 Socio-economic and Demographic Characteristics of Respondents

In this section, demographic and socio-economic characteristics of mother such as age, age at marriage, educational attainment, occupational status as well age and sex structure of children under five years are presented.

4.5.1 Age Composition of Respondents

In this study the women of reproductive age 15-49 years of 138 households were taken as target population and these respondents were distributed in five years age group.

Table 6:

Distribution of respondents by age group

Age group (years)	No. of respondents	Percent
15-19	13	9.4
20-24	34	24.6
25-29	40	29.0
30-34	26	18.8
35-39	16	11.6
40-44	6	4.3
45-49	3	2.3
Total	138	100.0

Source: Field survey, 2008

Table 6 shows that the largest number of respondents were in the age group 25-29, which is 29 percent, followed by age group 20-24 with 24.6 percent, 30-34 with 18.8 percent age group 35-39 with 11.6 percent, age group 40-44 with 4.3 percent and the lowest in age group 45-49 (2.3 %).

4.5.2 Age at Marriage of Respondents

Age at marriage is the most important factor determining maternal health care practice. Nearly universal and early marriage is being practiced in Nepal. It is mainly due to various religious and cultural reasons. Most of the women in the sample are married before they reach twenty.

Table 7:

Distribution of respondents by age at marriage

Age of marriage (years)	No. of respondents	Percent
<14	34	24.6
15-19	77	55.8
20-24	24	17.4
25+	3	2.2
Total	138	100.0

Source: Field survey, 2008.

Table 7 shows that more than 55 percent respondents had married between ages 15-19. The lowest percentage i.e. 2.2 percent of respondents had married while reaching 25 year of age. About one fourth (24.6 %) of respondents had married before reaching 15 years of age. This study shows that the early age at marriage is common in Tharu communities.

4.5.3 Age and sex composition of children

In this study, there were 76 children under 5 years. The age composition of these children were categorized into three groups as shown in the table.

Table 8 :

Age and sex composition of the children under age five

Age group (in years)	Male		Female		Total	
	No.	%	No.	%	No.	%
0-1	8	20	7	19.4	15	19.7
1-2	10	25	8	22.2	18	23.7
2-3	9	22.5	6	16.7	15	19.7
3-4	7	17.5	9	25	16	21.1
4-5	6	15	6	16.7	12	15.8
Total	40	100.0	36	100.0	76	100.0

Source: Field survey, 2008.

The table can be presented in bar diagram as:

Fig. No. 5:

Distribution of Children Under 5 Years of Age by Sex to the Respondents

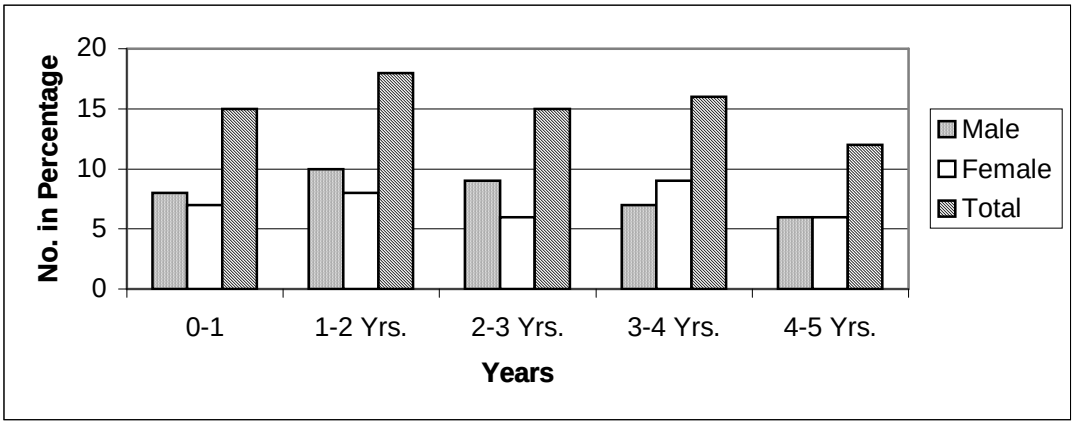


Table 8 shows that the sex ratio of the children is 75 males per 100 females. The proportion of children is highest for those who are aged below 1year (27.7%). This is followed by children those aged 1-2 years (25%), 2-3years (21.4%) and the children those aged 3-4 years (16.1%). According to table, females are found higher than males.

4.5.4 Literacy Status of the Respondents and Their Husbands

Education is one of the most important factor, which affects all aspects of human life. It is believed that educated people are more aware of their family and health. Although, more people in the rural area are not educated, the literacy also may have positive influence in socio-economic background of the respondents. Similarly husband's education is also important for maternal and child health.

Table 9:

Distribution of respondents by their and their husband's educational attainment

Literacy status	Respondents		Husbands	
	No.	Percent	No.	Percent
Literate	15	10.9	28	20.3
Illiterate	123	89.1	110	79.7
Total	138	100.0	138	100.0

Source: Field survey, 2008.

Table 9 shows the educational status of wives and their husbands. From the table, it was found that 10.9 percent respondents were literate and that of husband is 20.3 percent. Similarly, about 89 percent respondents and 79.7 percent respondent's husbands were illiterate.

4.5.5 Occupational Status of the Respondents and Their Husbands

Occupational status plays vital role in the promotion and protection of individual health as well as community health. The occupation is divided into two group: agriculture and non-agriculture.

Table 10:

Distribution of respondents by their and their husbands' occupational status

Occupational status	Respondents		Husbands	
	No	%	No	%
Agriculture	138	100.0	133	96.4
Non agriculture	-	-	5	3.6
Total	138	100.0	138	100.0

Source: Field survey, 2008.

Table 10 shows that more than 96 percent of the respondents reported that their husbands were involved in agriculture. Only 3.6 percent of respondents' husbands were involved in non-agricultural. All the women were involved in agricultural sector in Tharu communities.

CHAPTER-FIVE

MATERNAL AND CHILD HEALTH CARE

In this section, the maternal and child health care practices such as antenatal, delivery and post-natal cares are discussed. It further describes such as, TT-vaccination, place of delivery, delivery assistance, etc.

5.1 Antenatal Care Practices

Antenatal care services are the health care facilities that women get during her pregnancy. This includes health check up, TT immunization and receiving additional food.

5.1.1 Health Check-up During Pregnancy

Health check-up during pregnancy means to check-up pregnant mothers health during the pregnancy period.

Table 11:

Distribution of respondents who received ANC during their last pregnancy by age group

Received ANC Health Check-up	No. of respondents	Percent
Yes	32	23.2
No	106	76.8
Total	138	100.0
Age group (years)	No of respondents	Percent
15-19	5	15.6
20-24	10	31.2
25-29	6	18.8
30-34	4	12.5
35-39	3	9.3
40-44	2	6.2
45-49	2	6.2
Total	32	100.0

Source: Field survey, 2008.

Table 11 shows the information on antenatal services according to women's age. Among the total respondents, 32 checked up at any health facilities. The highest proportion (31.2%) of respondents received the health check up during pregnancy in 20-24 age group. It is followed by 18.8 percent who received health check in 25-29 age group. The lowest (2.4%) proportion of respondents received health check up in 40 above age group.

Table 12:

Distribution of respondents who received antenatal care during their last pregnancy according to their occupation and persons visited

Occupational Status	Farmer		Labour		Service		Total	
	No.	%	No.	%	No.	%	No.	%
Doctor	10	31.3	-	-	2	6.3	12	37.5
Baidhaya	7	22.0	-	-	-	-	7	21.9
Guruwa	5	16.0	-	-	-	-	5	15.6
TBA	2	6.3	-	-	-	-	2	6.3
Midwife	6	19.1	-	-	-	-	6	18.8
Total	30	93.7	-	-	2	6.3	32	100.0

Source : Field survey, 2008.

Table 12 shows the number of respondents who received any type of antenatal services during their last pregnancies. According to table, about 94 percent women were engaged in agriculture. Only 6.3 percent women were in service. From the total number of women, 37.5 percent received ANC services from doctor, about 22 percent from Baidhya. Similarly about 19 percent women received ANC services from midwife.

Table 13:

Distribution of respondents who received antenatal care during last pregnancies according to their age

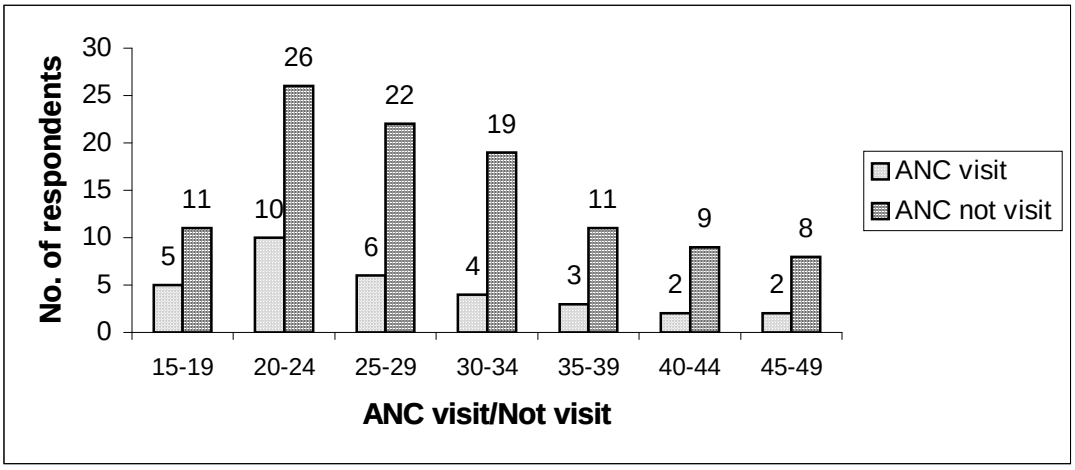
Age Group (in years)	ANC visit		No visit	
	No.	Percent	No.	Percent
15-19	5	15.6	11	10.4
20-24	10	31.2	26	24.5
25-29	6	18.7	22	20.8
30-34	4	12.5	19	17.9
35-39	3	9.3	11	10.4
40-44	2	6.3	9	8.5
45-49	2	6.3	8	7.5
Total	32	100.0	106	100.0

Source : Field survey, 2008.

Table 13 shows the information of an antenatal care services according to women's age. In this study, doctor, baidhya, guruwa, midwife and TBAs are included on the study of antenatal services. Out of the total women about 77 percent respondents did not receive any type of antenatal cares. Only 23 percent respondents have received ANC. Among them, the highest percentage of respondents are in age group 20-24 (31.2%) the lowest percentage in age groups 40-44 and 45-49 years (6.3%) each. Table 13 can be presented in bar diagram.

Fig. No. 6:

Antenatal Care Receivers



5.1.2 Tetanus Toxoid Coverage

TT vaccination that women must receive during the period of pregnancy is an important indicator of antenatal care. The prescribed normal course of TT vaccine was the dose during the period of pregnancy.

Table 14:

Distribution of respondents by coverage of TT vaccination

Received TT Vaccination	No. of women	Percent
Yes	32	23.2
No	106	76.8
Total	138	100.0

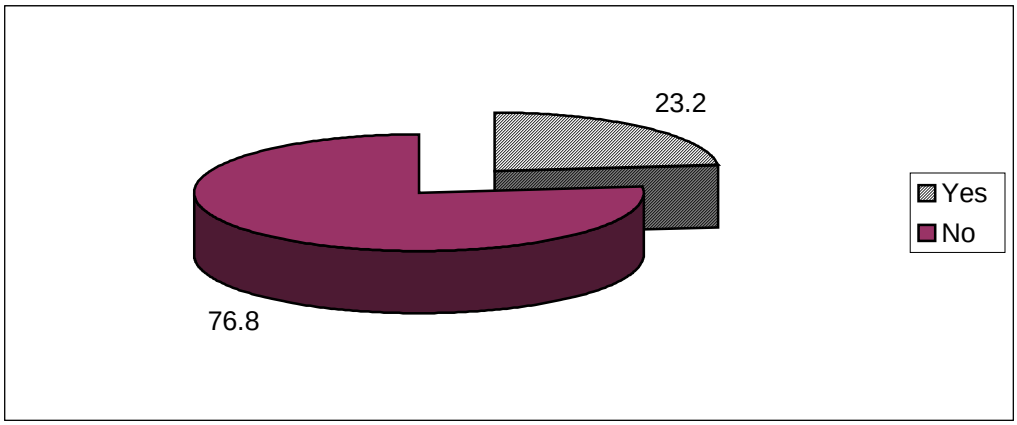
Source : Field survey, 2008.

Table 14 shows that of total women only 23.2 percent got TT vaccines against 76.8 percent women who did not get TT Vaccines during their pregnancies. So Tharu women have poor knowledge of modern medicine.

Table 14 can be presented in pie-chart as:

Fig. 7:

Coverage of TT Vaccination



5.1.3 Additional Food

Additional foods are necessary for growth and development of foetus and to prevent anaemia and malnutrition for mother. In the survey, a question was asked to the respondents about additional food. The information is shown in Table 15.

Table 15:

Distribution of respondents who have any additional food during pregnancy period

Types of food	No. of Respondents	Percent
Usual	137	993
Others	1	0.7
Total	138	100

Source : Field survey, 2008.

Table 15 shows that 99.3 percent respondents have usual food during pregnancy. They did not have additional food for good health in pregnancy period. Only 0.7 percent respondents have other food. This type of condition is found due to the lack of knowledge about maternal health care and poor economic condition.

5.2 Delivery Practices

This section presents the information on the place of delivery, person who arrested at the time of delivery and utilization of safe delivery kit.

5.2.1 Place of delivery

In our society most of the deliveries take place at home and are arrested by untrained birth attendants or elderly women of the home or neighborhood. These home deliveries take place in extremely unhygienic

condition. This is a dangerous procedure for both the mother and her new-born baby. Delivery place for most of the women of this Tharu community was home.

Table 16:

Distribution of respondents by place of delivery

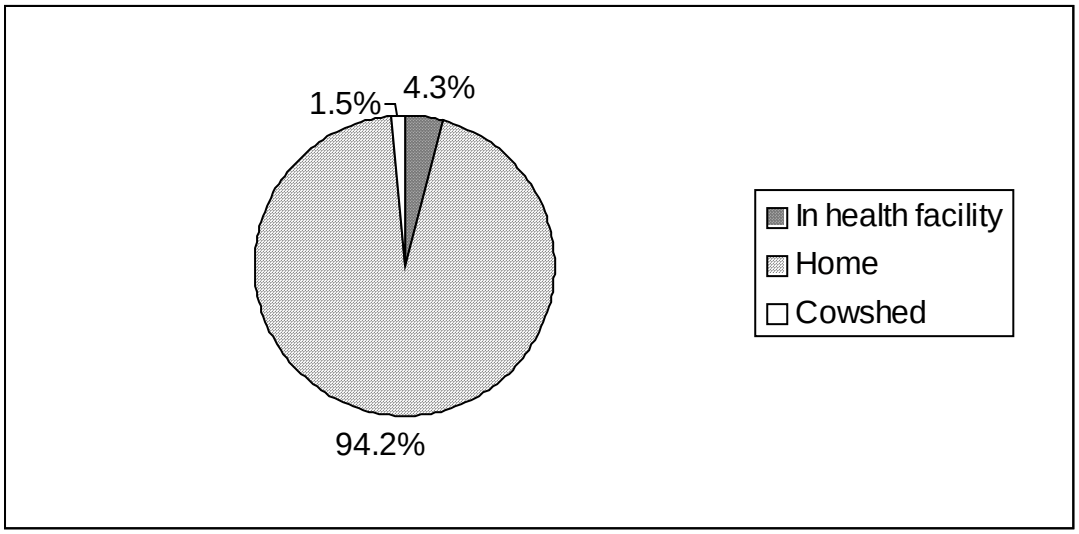
Place of Delivery	Number	Percent
In health facility	6	4.3
Home	130	94.2
Cowshed	2	1.5
Total	138	100.0

Source: Field survey, 2008.

Table 16 shows that 94.2 percent of the women had given birth to her child at home, followed by 4.3 percent in the health facility and 1.5 percent in the cowshed. So the place of delivery of Tharu community is also traditional and unsafe. It can be presented in pie-chart as:

Fig. 8:

Place of Delivery



5.2.2 Assistance during Delivery

The assistance during the delivery of a child plays an important role on the survival of the new born child and the mother. The delivery assistance is categorized into 5 types i.e. Baidhya, Midwife, TBA, doctor/nurse, neigbours.

Table 17:

Distribution of respondents by assistance during delivery

Persons who assisted	No of women	%
Baidhya	2	1.4
Doctor/Nurse	5	3.6
Midwife	37	26.8
TBA (Sudeni)	72	52.2
Neighbours	22	15.9
Total	138	100.0

Source: Field Survey, 2008.

Table 17 shows the highest (52.2%) proportion of respondents were assisted by TBA. The proportion of delivery arrested by Baidhya was found to be only 1.4 percent. About 3.6 percent respondents were assisted by doctor/nurse, 26.8 percent of mothers were delivered by midwife and 15.9 percent of mothers were delivered by neighbours. From the table, it is concluded that majority were delivered by TBA in Tharu community.

5.2.3 Safe Delivery Kits

A safe delivery kit is a small medical box used at the time of delivery. This is a small prepared kit and contains a razer, a blade, a cutting surface, a plastic sheet, a piece of soap, a string and pictorial instruction, assembled by maternal and child health for safe delivery practices.

Table 18:

Distribution of respondents by use of safe delivery kit

Use of safe deliver kit	**No. of respondents**	**%**
Yes	3	2.2
No	135	97.8
Name of equipment	**Number of Respondent**	**%**
Blade string	85	61.6
Blade, string, oil	50	36.2
Sutkeri samgri	3	2.2
Total	138	100.0

Source: Filed survey, 2008.

Table 18 shows that a safe delivery kit was used only for 2.2 percent of delivery. About 98 percent mothers did not use safe delivery kit. Among those who did not use safe delivery kits, they used different kits. Table shows that the highest proportion of mothers (61.6%) used blade and string. Similarly, 36.2 percent mothers were found using blade, string and oil during their delivery. The lowest use of safe delivery kit is due to the lack of education and knowledge about safe delivery kits. From the survey it is found that the message of using safe delivery kit during delivery has not reached adequately to Tharu women.

5.3 Postnatal Care Practice

Health care services, the women received after the delivery of a child is defined as postnatal care. Sharma (1985:31) has mentioned that the major cause of death in children in Nepal are meningitis, measles, malnutrition, diarrhoea and respiratory disease. Programmes to combat these include immunization, primary healthcare, improvement in nutrition of mother and child health. In Tharu society acceptance of postnatal care is very low.

Table 19:

Distribution of respondents by postnatal care

Post-natal care	No. of women	Percent
No	135	97.8
Yes	3	2.2
Total	138	100.0

Source: Filed survey, 2008.

Table 19 shows that out of total 138 respondents, only 3 women (2.2%) responded that they had received postnatal care. The percentage of women who did not received was 97.8 percent.

5.3.1 Breast Feeding

Breast feeding is the best form of nutrition for children up to six months, and which provides immunological protection against common childhood diseases such as diarrhoea and acute respiratory infections (ARI).

Maternal nutritional status has important implications for health of the mother as well as of her children. A woman who is in poor nutritional health has a greater risk of having an adverse pregnancy out come and is more likely to be births to under weight baby (NFHS, 1996).

Table 20:

Distribution of respondents who breastfed their child by duration

Period	No of Respondent	%
Below 12 month	18	13.0
12-24 month	93	67.4
25-36 month	25	18.1
None	2	1.5
Total	138	100.0

Source : Field survey, 2008.

Table 20 shows that 67.4 percent of mothers breastfeed their children for 12 to 24 months. Similarly, 18.1 percent of mothers breastfeed their children for *25* to 36 months. Nearly 13.0 percent of mothers breastfeed their children for below 12 months and 1.5 percent mothers did not breast feed their children. Finally, it can be said that breast-feeling is better experiencing among Tharu mothers.

5.3.2 Use of Herbs to Treat Child Disease

In the survey, it is found that the Tharu women always use many herbs to treat child disease. They use different types of herbs like Turmeric, Garlic, Ginger, Guava's skin, Neem, Bhringaraj, Nutmeg, Titepati, Caraway, basil asafetida etc.

Table 21:

Distribution of respondents who used herbs to treat child Disease

Using the Herbs	No. of women	%
Yes	136	98.6
No	2	1.4
Total	138	100.0

Source, Filed survey, 2008.

Table 21 shows that more than 98 percent women used the herbs to treat child diseases. Less than 2 percent women did not use any herbs for their children. The table 21 shows that highest proportion of women used any herbs to treat diseases.

5.3.3 Child Immunization Practices

Immunization is the most important component which helps to reduce high child mortality. The world health organization (WHO) has set the following programmes for the child vaccinations. In ordered to be considered fully vaccinated, a child should receive the following vaccines: one dose of BCG, these doses each of DPT and Polio, and one

dose of measles vaccine. BCGs which should be given at birth to protect against tuberculosis. DPT protects against diptheria, pertussis and tetanus and polio against the lame. All of the vaccinations are necessary before twelve month of age.

Table 22:

Distribution of respondents by the birth receiving specific vaccines

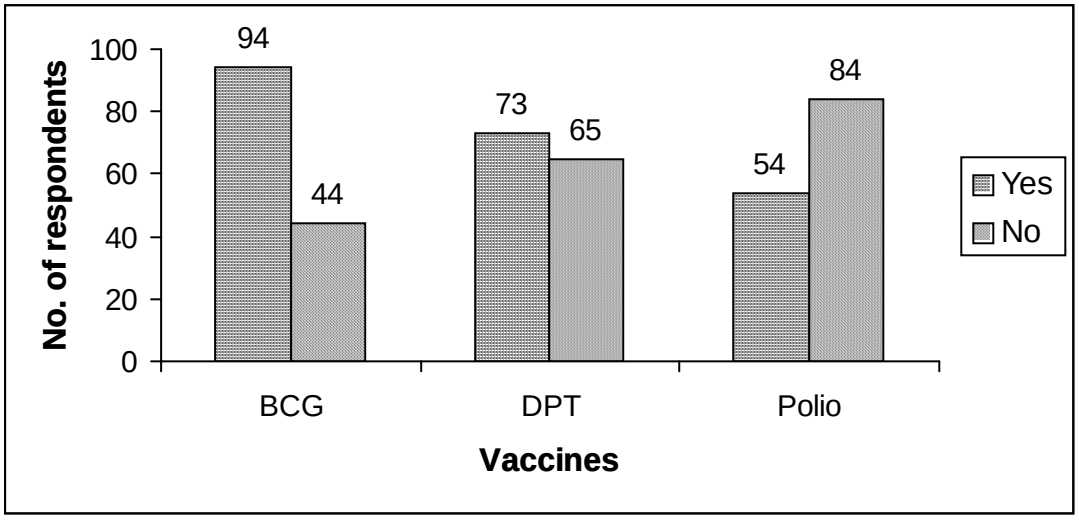
Vaccines	Yes		No	
	No.	Percent	No.	Percent
BCG	94	68.2	44	31.8
DPT	73	52.9	65	47.1
Polio	54	39.2	84	60.8
Measles	28	20.3	110	79.7

Source: Field survey, 2008.

Table 22 shows that the highest proportion of mothers reported that their children were immunized by BCG by (68.2%) followed by 53 percent mothers giving vaccines of DPT. The polio and measles are found to be less common to Tharu women. Among the total respondents only 39.2 percent mothers gave polio to their child it is followed by those who gave measles (20.3%) to their child. The table 22 can be presented in bar diagram as:

Fig. 9:

Vaccines Receivers



5.3.2 Diarrhoea

Dehydration caused by severe diarrhoea is a major cause of morbidity and mortality among children in Nepal. A simple and effective response to child's dehydration is a prompt increase in fluid intake, that is oral dehydration therapy Dehydration therapy may include the use of solution prepared from packets of oral dehydration salts of recommended home fluids such as sugar-salt-water solution.

5.3.2.1 Use of herbs to treat diarrhoea

Table 23:

Distribution of respondents who used herbs to treat diarrhoea

Name of herbs	Number of respondents	Percent
Neem, Bhangariya, asafetida	72	52.17
Basil, Guava's skin, Caraway	66	47.83
Total	138	100.00

Source: Filed survey, 2008.

Table 23 shows that 51.5 percent women used Neem, Bhangariya, and asafetida during the diarrhoea. Only 48.5 percent women used basil, Guava's skin and caraway to treat diarrhoea. The Tharu women other child diseases use any herbs to treat.

5.3.2.2 Jeevan Jal

Oral rehydration therapy can be used successfully in treating acute diarrhoeas in all age groups, in all country not only for children. Once the infant is rehydrated breastfeeding is continued along with oral rehydration solution given after each liquid stool. Not only breast milk helps the infant to recover form an attack of diarrhea both in terms of the nutrients it supplies and its rehydrating effect.

Table 24:

Distribution of respondents who fed Jeevan Jal during diarrhoea

Fed Jeevan Jal	Number of Respondents	Percent
Yes	123	89.1
No	15	10.9
Total	138	100.0

Source: Field survey, 2008.

Table 24 shows that more than 89 percent respondents fed the Jeevan Jal to their children during diarrhoea. Similarly, only 10.9 percent respondents had never fed Jeevan Jal to their children during diarrhoea.

5.3.2.2.1 Place for Jeevan Jal

Packets of "Oral rehydration mixture" are how freely available at all primary health centers, sub centers and hospitals. The contents of the packet are to be dissolved in one liter of drinking water. The solution should not be boiled.

Table 25:

Distribution of respondents by places visited for Jeevan Jal services

Place for Jeevan Jal services	No of Respondents	%
Hospital	28	22.8
Medical	40	32.5
Shop	55	44.7
Total	123	100

Source : Field survey, 2008.

Table 25 shows that more than 44 percent respondent had visited shop for the Jeevan Jal services. After shop, medical was place at 2nd position for Jeevan Jal services by (32.5 %). About 22.8 percent of respondents have

taken Jeevan Jal from hospital. So, it is concluded that majority of the respondents take Jeevan jal from the shop.

5.4 Family Planning

Family planning means not only reducing but mainly planning a family. A mother of family planning methods help maintain derive family size then, desire family size help the maternal and child health care with directly or indirectly.

WHO defined family planning as "a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country."

Table 26 :

Distribution of respondents who used the contraceptives method

Family planning method	No. of women	%
Yes	89	64.5
No	49	35.5
Total	138	100.0

Source: Filed survey, 2008.

Table 26 shows that there are 35.5 percent women who had never used the contraceptives as against 64.5 percent women who have used the contraceptives method. The popular contraceptive method used by Tharu community was Depo-Provera (Three month injections)

5.5 Sources of Family Planning Method

The government sector is the major source of contraceptive methods in Nepal. The largest governmental supplier of contraceptives is the Family

planning Association of Nepal (FPAN). One in four users obtain these methods from governmental hospitals/clinics, sub-health post, medical centers.

Table 27:

Distribution of respondents by sources of contraceptive methods

Sources of Contraceptive	No of Respondents	Percent
SHP	80	89.9
Hospital	9	10.1
Total	89	100.0

Source: Field survey, 2008.

Table 27 shows that more then 90 percent respondents obtained their methods from sub-health post (SHP) and 10 percent respondents visited hospitals for the contraceptive methods.

CHAPTER-SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

The study is based on a primary data. According to the census 2001, national population of Tharu is 12,21,546. The total population of Thru in Sarlahi district is 37,047. This study covers the population of Tharu community at Chandranagar VDC in Sarlahi district where 138 respondents are taken from population having 713. The population of children in Tharu community of this VDC is higher. The detail study was limited to currently married women aged 15-49 years who had ever given live birth. To fulfill the objective of this study, some selected socio-economic and demographic variables are taken as main influencing variables such as antenatal, delivery and postnatal care practices.

Among the total population 57.78 percent were married and only 39.69 percent were unmarried. Agriculture is the main backbone of Nepalese economy. So, more than 61 percent of total population are engaged in agriculture as against 58.19 percent of their husbands are involved in some occupation. The percent of landless formers is also high i.e. 16.27 percent in whole community. More than sixty-eight percent of total population are illiterate and only 31.56 percent people are literate. School-going population is higher than no school going population in total, primarily school-going population is 68.44 percent and higher-schooling population is 2 percent in community. The majority of the mothers belonged to age group 25-29 years and least numbers belonged to 40^{+} years.

The majority of women age at marriage belonged to age group 15-19 years and least numbers belonged to above 25 years age group. More than 79 percent of respondents' husbands and more than 89 percent of wives were illiterate. Among the total population of respondents, all respondents and more than 96 percent of their husbands are involved in agriculture.

In this study, out of 83 respondents 33.73 percent mothers received health case belonging to 20-24 years age group. Only 41 percent of mothers have received health checkup lying 40 years above. The urban women are using Doctors, nurses and midwives much more frequently than rural women. Rural women are more likely to use VHWS and MOH workers for antenatal care. Out of 138 women 11.59 percent mothers have received antenatal services who have involved in agriculture and only 0.72percent mothers received antenatal services who have involved in other occupation such as domestic servant and labour. Among the total respondents only 23.19percent got TT vaccines during pregnancy period. It is noticed that the Tharu women are most poor in the knowledge toward the modern medicine during the pregnancy period. It is found that 94 percent mothers gave birth at home and 4.35 percent mothers gave birth in the place of health facility.

It is found that the mothers are interested towards that facility which is easily available in their own areas i.e. more than 52 percent of mothers were delivered by TBA. Only 1.45 percent of mother were associated with Baidhya. In this study only 2.17 percent mothers used safe delivery kits. Most of the Tharu women used the unsafe kits. The majority of the women (67.40%) had-breast feed their children until 2 years. Only about 2 percent respondents had breast fed their children for 4 years. More than 98 percent women used that herbs such as onion, garlic, Neem, Bhargair etc. the highest proportion of mothers had given the BCG to their children that is 68.12 percent and 20.29 percent children get the vaccines of

measles. Majority of women i.e. more than 89 percent had given Jeevan Jal to their children to treat the diarrhoea. In the Tharu society, about 99 percent of women used only one contraception method i.e. Depo-Provera.

6.2 Conclusion

The study area is selected at Chandranagar VDC in Sarlahi district. In this VDC 150 households were chosen for sample, among these households 138 respondents were interviewed. Those respondents belonged to age group 15-49 years. Early age at marriage is roost prevailing in the Tharu community. The study shows that most of the respondents were engaged in agricultural sector and education status of respondents was very low in comparison with their husbands.

Antenatal care practices were poor in study population. Only 60.14 percent respondents have got antenatal services during pregnancy. From this study, it is observed that the younger women were more likely to use anteatal services than older women. Doctor, midwife, Baidhya, Guruwa and TBA are antenatal service providers. Only 23.19 percent women got full dose of TT vaccines during the pregnancy period Tharu women did not have additional food for good health in pregnancy period. Only 0.72 percent mothers used additional food during delivery.

Most of the children are delivered at home with the assistance of TBAs or neighours of the community. The younger women have received health personnel and other facilities like TBA, Midwife and relatives during delivery. More than 97percent women did not use safe delivery kits. They used traditional method such as knife, blade, string oil etc.

The lowest use of these specific safe delivery kits may be due to the fact that they are not available and there is not knowledge about safe delivery kits among Tharu women.

Generally Tharu women always use various herbs to treat diarrhoea. More than 98 percent women used the herbs to treat diarrhoea. Immunization practices were found better. The highest proportions are found using polio. The coverage of DPT and BCG are also good. The prevalence of ARI is seemed in better situation. Users of Jeevan Jal are highest than other method. The knowledge of ORS is widely spreader among mothers about specific drinking regimes for sick children.

The knowledge about the family planning are found very poor among mothers of Tharu community. More than 35 percent respondents are found at the situation of not using contraceptive due to lack of proper knowledge about it. More than 64 percent mothers are in favor of using contraceptive in future.

6.3 Recommendation

Recommendation for the Policy

The following are the suggestions for further research work and the socioeconomic and health conditions of the Tharu population of Chandranagar VDC, Sarlahi district.

- Tharus are very poor in socio-economic status. So maternal and child health care services should be free in target area to improve the level.
- Tharu women have no knowledge with respect to maternal and child health care services. For this, educational programme should be need. It has been observed that services provided by midewives, VHW, TBA and other health worker by Government and NGO, INGO program mobilized for the maternal and child health care for Tharu community.
- The economic condition is worse in Tharu community. So government should provide facilitated loan trough bank, agricultural development bank and other sources.

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