CHAPTER-I

INTRODUCTION

1.1 Background of Study

Nepal is landlocked country which is situated between China and India. China lies in the north and India lies in east, west and south. Nepal's total area is 1,47,181 Sqkm. According to census report 2001, Nepal's total population is 23151423 where the number of male is 1156392 (49.95%) and female is 11587502 (50.05%). Among total population 82% of Rural Population, Similarly total fertility rate is 2.82, birth with skilled attendant 19 percent (the state of world population data sheet-2009).

At present situation our country Nepal has facing many maternal and child health problems. The infant mortality rate is 48 per 1000. It is estimated that 42 percent children under five years are suffering from moderate malnutrition. The maternal mortality rate 415 in per 100000. Crude date rate is 6.4 per 1000, age specific fertility rate (15-49) is 98 per 1000 married woman. The annual growth rate is 1.8 percent and infant with low wt. 21% (ESCAP-2009). So there is a great need for to improvement the vulnerable group consisting of woman of reproductive age and the children below five year.

According to Nepal demographic health survey 2006, the status of maternal health are follows: ANC checkup by health worker (all) 71.8 percent, ANC checkup by SBA 43.7 percent, ANC4+visit 29.4, Iron supplementation to pregnant mother 59.3, TT2 or more 63.2 and deliver conducted by health workers only 22.8 percent of Nepalese Women.

Similarly the status of child health services percent of fully immunized coverage 82.8 percent (BCG 93.4%), DPT 3 86.6%, Polio -3 91.1%, HEPB 69.4% and measles 85% and nutritional status of children are malnourished as height for age 49.3%, Malnourished for weight for height 12.6% and malnourished as weight for age 38.6%. So we can easily say that maternal and child health is not good in our country Nepal. (DHS, 2007/08)

Nepal is decorated with villages. Nearly 82% people live in rural areas; similarly the rural population of Nepal consists of several ethnic groups. Some groups are far ahead socially and economically than the other groups. There is intra as well as inter diversity in living conditions and income level among different social groups. In Nepal, one hundred and three casts or ethnic groups live throughout the country. Among them Sardar is the small ethnic cast of Nepal (CBS, 2003).

Sardar originally came from India and are found primarily in Sunsari district of the southeastern of Nepal. Their traditional occupation is brick making and other kinds of labor associated with construction. They have not any fix occupation. They are thought to be untouchable; The Sardars are the indigenous people dwelling found in the Tarai belt of Nepal from very beginning as an indigenous group. In the traditional Hindu caste hierarchy they belong to shudhar class and they are treated as untouchable. They eat rats; speak Maithali, Hindi, Bhojpuri, and Nepali also.

The Sardars had no land registered under their name. Their main source of subsistence is working in other land on lease and as hard labors. The Sardar's women also work hard as a labour in the field and contribute to the family's income. They are employed on daily wages basis by land owners for various domestic works such as making cow dung cake, planting paddy, millet, harvesting corps threshing and so forth. The Sardar are so poor that they do not have sufficient food to eat and clothes to wear. They do not have shelter to live in and have no sufficient money to educate their children. They do not have basic health facilities too.

The socio-economic condition of the country is depending on the health status of the people and vice versa. The socio-economic condition of the country is shaped by the variety of factors, such as the level of income and standard of living, housing, sanitation, occupation, education, employment health consciousness, personal hygiene, environmental hygiene and coverage and accessibility to health care delivery services.

Sardars are those people who have been almost isolated and neglected by the government. The neglected segments of society facing many problems and becoming poorer and poorer day by day the migrated people from hills "Pahadiyas" are highly influencing the life style of Sardars. The Sardar communities are affected by

transportation, education, telecommunication, migration and modernization and seem many changes in their economic and social life.

For most of the people, their own tradition, customs and culture are very important as these reveal their own originality. The constitution of Nepal also gives direction of the government in the article 26 (r) as “the state shall, while maintaining the cultural diversity of the country, pursue a policy of strengthening the natural unity by promoting healthy and cordial social relations among the various religious, castes, tribe communities and linguistics groups and by helping in the promotion of their language, literature, scripts and culture.

The Sardars are the less studied ethnic groups of Nepal and are inhabitants of Terai, inner Terai, the indigenous group up to people living in different places from east to west of the country. The settlement of Sardars in Sunsari district is in considerable number in comparison to the other districts the Sardar living in Kaptanganj VDC are illiterate, suppressed and backward in socio-economic condition.

Many girls under 18, especially in poorer countries, are physically immature and at higher risk for obstetric complications and children born by these young mothers are at higher risk for illness and death than children born to mothers in their 20s. Some countries have reduced the prevalence of early child bearing by keeping girls in school and changing community norms and national policies about early marriage (ESCAP, 2009).

In Nepal maternal and child health care services are insufficient due to minimal level of education or low literacy rate of women, poor economical status and lack of knowledge about health care facilities. In this period governmental and non governmental organizations have started many mothers and child centered health programs to improve maternal and child health status. But very low women literacy rate and poor economic status which is product of superstitions and insufficient maternal and child health care services are the main factors which directly affect the mortality rate and increase fertility rate as well as.

Among the direct causes of maternal mortality, the quality and accessibility to maternity care services stand ahead. Mostly common people in Nepal reside in rural areas, where only basic health care services are available at the health post and sub health post. Another hand, people have no a lot of money to spend at Private health clinic. Plus some community based services provided by trained TBAs or FCHVs Maternity care services available at all these levels are usually inadequate in quality, uniformity and accessibility.

The knowledge and skills of the health care provider are most significant in the provision of quality of care, essential to respond to the needs of the pregnant women. However, the capacities of various health workers categories differ considerably. But most are weak and unable to respond to women's needs effectively, furthermore, accessibility to health facilities is very limited due to difficult terrain, lack of roads and transport facilities.

The health status of Sardar's women and child are highly affected. Therefore Knowledge, Attitude & Practice of maternal and child health services is one of the most important subject matter of discussing among the Sardar community who are facing a lot of maternal and child health problems. So this study has focused to find out the Knowledge, Attitude & Practice of maternal and child health service in Sardar community.

1.2 Statement of the Problem

In our country Nepal, Many Health Problems has challenging to us. Our country recognize in world in another name like "high maternal and child mortality country." So our effort always goes to control the maternal and child mortality. In my view something which are the cause of the major problem for maternal & child health like lack of education, poor economic status, poor access of basic need and facilities.

Sardar community of Kaptanganj VDC has been selected as study area which is in southern part of Sunsari district, Although Kaptanganj VDC of inhabitant of different castes, Sardar community has been living here a humiliated, ethnic and backward Dalit Caste, specially women and children of sardar community in out of reach of minimum health service. So the study has been

concentrated to find out the reason for in assessable maternal and child health services. Sardar are Dalit and Backward. They are deprived of basic needs and facilities. They are very far from the access of amazing exploration of modern world, science and technology, they are still victim of social superstitions conservative tradition, culture even today.

So, Education, Economic Status, Poverty, Conservative Tradition, Superstitions, Cultural beliefs, concept and beliefs on health etc may be the possible causes of maternal and Child health problem of Sardar Community at Kaptanganj VDC which is the selected for the study.

In the selected area neighter and report nor any research was carried out to find such barriers of this community in the past. So necessity is felt to carry out a research to find out the main KAP of the maternal and child health service. Specially in Sardar Community, So, I have selected this topic as my research and also following problem of this community attracts to me for research.

a. This community is very backward community.
b. In this community different kinds of maternal and child health problem will available.
c. This community beliefs on superstition, Dhami, Boxi also.
d. This community have not taken the benefit by government health organization.
e. In this community not good educational status.

1.3 Objectives of the Study

The general objectives of this study is KAP of Maternal and Child Health services of Sardar community at Kaptanganj VDC of Sunsari district.

The specific objectives are as follows:

a. To find out socio-economic condition and its affects prenatal, natal and post natal care.
b. To identify the knowledge about Maternal and child health service.
c. To assess the health beliefs and cultural practices of maternal and child health in Sardar community.

d. To find out the practices of maternal and child health Sardar community.

1.4 Significance of the Study

This study will identify the KAP of maternal and child health service of Sardar people in Kaptanganj VDC Sunsari where there is lack of health service, especially maternal and child health service. There fore; this study will help to explore the provide health service (especially maternal and child health service) in backward (Dalit; Sardar, Chamar, Dom etc.) community and promote health status of these community's people.

This research will significantly contribute the following areas:

a. The result of study will be helpful to Ministry of Health to plan and implement maternal and child health programs in the remote VDC of Nepal

b. The findings of the study will be useful to the district development committee to develop awareness towards health problems in Sardar community.

c. It will create awareness in community about the consequences of Maternal and Child health service.

d. This study will give ideas and bases about proved system of health service for the health planners, policy makers, health workers and related NGOs and INGOs.

e. This study will give solution of reduce risk factors of maternal and child health service from backward community.

f. It will be useful as guide line for further researchers in similar study.

1.5 Delimitations of the Study

As the study is an academic research, there are limited time and economic factor. So, delimitations of the study are as follows:

a. This study was delimited only Sardar Community of Kaptanganj VDC of Sunsari district.
b. Only married women of 15-45 years of age and their children at the age of 0 to 5 years was taken in the sample population.
c. This study was based on "KAP of Maternal and Child Health Service in Sardar Community" at Kaptanganj VDC, Sunsari
d. This study was based on Sub-health post, Privet clinic, and Health workers of Kaptanganj VDC.
e. This research was mainly designed on the bases of descriptive method and only simple statistical tools and techniques such as numerical, percentage and average was used in data analysis process.

1.6 Definition of Important Terms Used

Some terminologies are used in this thesis proposal to describe the study procedures and findings. These terminologies bear different meaning in different contexts. But in this thesis these used terminologies bear following meanings:

Age at marriage: Normally after 18 years of old age and before 35 years of old age suitable age for marriage.

Birth attendants: A person who help them during delivery period of women.

Barriers: An enclosure, an obstacle, a boundary

Community: A community is a group of people living together in a particular area who have recognized them to meet common interest and problems.

Complication: Complication is a serious effects/ condition of any problems or disease.

Contraceptive: Contraceptive (hormonal preparation) is a family planning device for female.

Delivery: The process by which the fetus and the placenta are expelled from the uterus.

Early Pregnancy: Pregnancy below eighteen years is called early pregnancy.

Female sterilization: It is a permanent method of family planning for female.

Fertility: Fertility means the actual bearing of children. Woman's child period is roughly from 15-45 years.

Health: Health is a state of complete physical, mental and social well being

Not merely the absence of disease or infirmity (WHO, 1948)

Household: It is defined as one of the people related to blood or adoption that are lived together and joint kitchen.

Immunization: Immunization is a mean of protection against the result (germs) of infectious disease with in the human body (Helen Hag 29:1968).

IMR: It refers to the death of child less than one year.

Malnutrition: The condition caused by improper balance between what an individual eats and what he/she requires maintaining health.

MMR: A maternal mortality is defined as the death of a woman while pregnant or within 42 days of termination of pregnancy from any caused related to or aggravated by the pregnancy or its management but not form accidental or incidental causes.

Miscarriage: Become abortion up to 28 weeks of fetus without any medication.

Pregnancy: The condition of having a developing embryo or fetus in the body, after union of an ovum and sperm. In women, duration of pregnancy is about 280 days.

Prevalence: Number of total affected cases (new and old cases) of specific disease in specific population during a specific time/ year.

Reproductive Health: It is state of complete physical, mental and social well being not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and process. (WHO)

CHAPTER-II

REVIEW OF THE RELATED LITERATURE

Literature review of related topic in research has important and more information about research can be fond by literature review. This chapter deals with the related literature of health service as well as maternal and child health service. When we analyze the historical background of maternal and child health we should start from general health. The term 'health' defines not only health problems or health services; it includes all the aspects of development of human life i.e. social, economic, political, physical, environmental, and biological and Interrelation to totally (NHRC, 1997). "In response to the Alma Ata declaration, Nepal formulated its first documents on "Planning for provision of basic minimum needs 1900-2000 in 1981" (Upaddhaya, 1993).

In order to develop the "health status" the concept of basic health service and provision of basic minimum needs were included during the period of 6^{th} and 7^{th} five years plans (1980-90).In this connection , necessary attention was given to launch several programs like nutritive food, safe drinking water, public hygiene, environmental health and appropriate health education (Ibid, 1993).

To achieve the targeted health status, since 1^{st} five year plan , the process establishing Health Posts (Hps) and Sub Health Posts (SHPs) are still continuing and special attention have been given to strengthen primary health care service through the establishment of Sub Health Posts in each VDC throughout the country within the 8^{th} five year plan period. Therefore, present health policy has targeted to establish one SHPs in each VDC in order to facilitate the rural people with all primary health care services.

There are many Governmental Organization (GOs), Non Governmental Organizations (NGOs) and International Non Governmental Organization (INGOs) working in the field of health system as well as the Primary Health Care Project (PHCP) , Family Planning/ Maternal and Child Health Services and so forth. Very few researches have been done on the KAP health service of the Sardar women and children.

Health status of women is directly affected by fertility, and fertility is influenced by various social and economic factors such as education, age at marriage, occupation, income, preference for sons and decision making power (Dhakal, 1995).

Further more, when we discuss about maternal and child health, we have no ignored the reproductive health. Reproductive health has been defined at the international conference on population and development (ICPD) in Cairo as "a state of complete physical mental and sexual well being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its function and process. Reproductive health therefore, implies that people are able to have a satisfying and safe sex life and they have the capacity to reproduce and the freedom to decide, when and how to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, effort able methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law of access top appropriate health care services that will unable women to go safely through pregnancy and child birth and provide couples with best chances of having a healthy infant (Mehta, 2008).

WHO (2005) discussed about maternity protection convention (adopted 1919 and last revised in 2000) to sets of minimum standard for what should be included in national legislation in this regard. The convention provides protection against dismissal of women during pregnancy, maternity leave and the breast feeding period, and also for cash benefits. It encompasses coverage of antenatal child birth and postnatal care and hospitalization care when necessary and working hours and tasks that are not determined to mother or child. It called for 14 of maternity leave of which six week must be postnatal leave to safeguard the health of mother and child. This aspect to the convention covers all married and unmarried employed women including those in unusual forms of dependent work. This can be interpreted broadly to cover women in all sectors of the economy, including the informal sector, with these minimum standards is increasingly becoming an issue in developing as well as developed countries (Mehta, 2008).

The solution clearly indicates that most of the pregnant women are still far from delivery and antenatal services. More than 74 percent women do not use maternal health facilities for ANC and 12 percent of deliveries takes place at home without a

trained both attendant (MOH, 1998). An important reason for this is, that pregnant women have no decision making power in the household that would enable them to obtain delivery and antenatal services. (Palikhe, 2001:18).

Yadav (2003) found that educational status of the community is very poor. No one has any own land to cultivation and gardening. Cent-percent people were still illiterate and most of the Musahar engaged in wages labour. Most of the respondent hadn't taken additional food during pregnancy period. 96% mothers delivered babies in their home with assistance of family numbers and TBAs. Duration of breast feeding practice in Musahar community is satisfied because 86 percent mothers did it up to two years duration. 50 percent Musahar consume alcohol and 75 percent used smoking. The majority of the people of Musahar caste visit Wizards (Dhami-Jhankri) first for the treatment when they get sick. They have strong belief in superstition idea, traditional methods and they also pray god and goddess for the recovery of sickness.

NEW ERA (2000) mentioned that an important component of HMG efforts to reduce the health risk of mothers and children are to increase the proportion of babies delivered under medical supervision. Proper medical attention and hygienic condition during can reduce the risk of complication and infections that can cause the death of the mothers and the babies.

Socially and economically excluded groups are also the hardest to reach because, in addition to their poverty and low education levels, they often live in areas that are geographically remote and /or severely affected by the armed conflict. These groups will be identified through equity and access programmes and community based volunteers and organization, and innovative approaches used to priorities them in planning appropriate SMNH activities, such as cost sharing and subsidy systems, which increase their access to services. The use of facilities by socially excluded groups will be monitored and the results used in programme planning (linked with output 1, Equity and Access).NSMNH-LTP (2006-2017)

This study seeks to establish the relative importance of service access and quality on utilization of preventive health services in the western and middle-western Hill region of Nepal. Access was measured in terms of travel time to the nearest health post and coverage by outreach workers. The quality of static services was defined in structural terms: physical infrastructure, number of staff, availability of drugs and holding of special maternal and child health clinics. The initial analysis showed that no single

indicator of quality was of overriding importance and therefore an overall quality index was constructed. After adjustment for access and for socioeconomic characteristics of families and communities, a very pronounced relationship between overall structural quality of the nearest health post and service uptake persisted. The adjusted odds of using some form of antenatal service were 6.6 times higher in the catchment areas of high quality posts than in areas served by low quality posts. The corresponding figure for receipt of BCG vaccination is 8.1. By comparison, the effects of travel time to the nearest health post are modest. Uptake of services is about twice as high when there is a health post in the community. Regular monthly visits by outreach workers also had a marked effect on service utilization. These results suggest that investment in the quality of health posts is more important than further increases in their number and that a further expansion of outreach services is a priority. (Acharya and et. al., 2000AD)

Nepal's Safe Motherhood Programme has failed to deliver expected gains in maternal and child health. Nepalese mothers and their children continue to dispense with (or be denied) antenatal care, experience high maternal mortality rates and suffer chronic malnutrition. We address the correlates and consequences of antenatal care utilization in Nepal by applying two-stage least squares, binomial logit and Heckman selection bias estimates to data drawn from the Nepal Health and Demographic Surveys of 1996 and 2001. Results indicate that maternal education, even at low levels, significantly increases the use of antenatal care; paternal education plays a more important role in the use of routine antenatal care than the conventional wisdom suggests; and when mothers use routine professional antenatal care and maintain good health their children tend to stay healthy through infancy and early childhood. Since health-seeking behaviour is circumscribed by patriarchal gender norms in Nepal, health policies should not only focus on female education and women's status, but also involve husbands in the process of maternal care utilization. (Halim and Et. al., 2011AD)

Maternal and neonatal mortality rates are highest in the poorest countries, and financial barriers impede access to health care. Community loan funds can increase access to cash in rural areas, thereby reducing delays in care seeking. As part of a participatory intervention in rural Nepal, community women's groups initiated and

managed local funds. We explore the factors affecting utilization and management of these funds and the role of the funds in the success of the women's group intervention. We conducted a qualitative study using focus group discussions, group interviews and unstructured observations. Funds may increase access to care for members of trusted ‘insider’ families adjudged as able to repay loans. Sustainability and sufficiency of funds was a concern but funds increased women's independence and enabled timely care seeking. Conversely, the perceived necessity to contribute may have deterred poorer women. While funds were integral to group success and increased women's autonomy, they may not be the most effective way of supporting the poorest, as the risk pool is too small to allow for repayment default. (Morrision and et. al., 2010)

CHAPTER - III

RESEARCH METHODOLOGY

3.1 Research Design

The research design had descriptive. The study mainly focused on obtaining information about KAP of Maternal and child Health Service in Sardar community of Kaptanganj VDC, Sunsari, Nepal.

3.2 Population of the Study

The study carried out in Sardar community of Kaptanganj VDC. Sardar married women of age-group 15-45 years and children below five years old with KAP of maternal and child health services of Kaptangaj VDC are the target population of the study. In whole VDC there are 65 household found which has one baby under five years. The primary data was collected from interview with interviews schedule. and secondary data by Population record, VDC report, District development profile, related books, journal and hospital records have used as secondary sources of information.

3.3 Sampling Procedure

All the households with married women have at least one child under five of Sardar community in Kaptanganj VDC was included in the study. There were 65 Sardar women which has one child of under five years. Therefore census method was used to include the married women from Sardar community.

3.4 Tools of Data Collection

Following tools and techniques was used for the study:

Interview schedule:-

Questionnaire:-

3.5 Standardization of Tools

After completion of construction the questionnaire, it was submitted to the health, education department. After getting necessary suggestions from the adviser, improved tools were administered as trial testing among 10 mothers who have in 15-45 years married women among the Sardar community in Kaptanganj VDC of Sunsari district for its objectivity and practicability, by collecting pre test result necessary changes and revisions were made before making to them final shape.

3.6 Data Collection Procedure

The researcher consulted the VDC members to obtain information about the married women who had children under five. The researcher visited the selected members of the VDC for the collection of necessary information. Data was collected in the appropriate time for both party conveniences. The question was asked to the respondents by visiting. Before starting the interview, the researcher was introduce himself to the respondents and had share the purpose of the study. After building rapport the researcher had start filling the interview schedule. The researcher was provide adequate support to respondents during questioning period such as language, friendly environment and so on.

3.7 Data Analysis and Interpretation

After collecting the necessary data from the respondent. The data was analyzed through tables, percentages, chart, and they had used for processing analyzing and interpreting the result. Since this is a descriptive study the quantitative information had interpreted and explained in detail. Possible discussion had added to clarify the collected information from the respondents. Some simple statistics rules (i.e. number and percentage) had also follows to make presentation more clear.

CHAPTER - IV

ANALYSIS AND INTERPRETATION OF DATA

This chapter deals with analysis and interpretation of the data which were collected from field survey. The data have labialized and kept in sequential order according to the need of the study. Then information has analyzed on the basis of percentage, tables, graphs and diagrams are used to make the presentation clearer and more meaningful. The analysis and interpretation of data have presented as follow:

4.1 Demographic, Socio-Cultural and Economic Status

Demographic characteristics have an important role in the level of knowledge, attitude and practice of a person. Socio cultural and economic statuses directly play vital roles in the development of family, society, country as well as in the life status of people and their health. Lack of education, poverty, superstition of the society and lack of health awareness lead to high mortality and morbidity.

In this study to analyzes the demographic, socio- cultural and economic status they has marriage before the age 15 years, many respondents has no land and only a few respondent has above ten katha land, as like only a few respondents has more than 75 thousand annually income. move than more respondents has less than 75 thousand annually income. as like more than more respondents were illiterate so the respondents KAP of antenatal care, natal care and postnatal care not good. Such as health check ups during pregnancy are low respondents has no knowledge, as like respondents has knowledge about extra food but lack of money then didn't eat extra food. As like less than less respondents delivered her delivery in hospital became of low socio- economic and cultural status.

4.1.1 Age and Sex Structure

Age and sex structure of the population directly influence the fertility, marriage and mortality of any society. Table 1 shows age and sex composition of the study population.

Table 1: Age and Sex Structure

Age Group	Male		Female		Total	
	Number	Percent	Number	Percent	Number	Percent
0 - 5	48	32.65	39	31.97	87	32.34
6 - 15	38	25.85	35	28.69	73	27.14
16 - 30	31	21.09	23	18.85	54	20.07
31 - 45	21	14.28	16	13.11	37	13.75
46 - 60	7	4.47	6	4.93	13	4.84
60+	2	1.36	3	2.45	5	1.86
Total	**147**	**100**	**122**	**100**	**269**	**100**

Table 1 indicates that 0-5 years population is high (32%) in study area. 27 percent of total population was schooling age population and one third was reproductive age population in the study area. There was very low (about 34) percentage of working population and remaining (about 66) percent was dependent population in the study area. The table also shows that there was low (near about 2) percent of population over sixty age group.

It is concluded that fertility rate is high because of the unawareness of the family planning method and lack of family planning devices in local level of health organizations and higher percent of dependent population is the reason of being more poverty or low economic status of that community. It is indicated that their life style and life expectancy is not good, due to higher percent of dependent and lower percent of independent population.

4.1.2 Educational and Occupational Status of Respondent

Status of female education and occupation play vital role in their family health status. A literate woman cares her children and family members properly but illiterate women can not care their babies and own health properly because they have not good knowledge about family care and child immunization. So housewife should be literate for good health status of all family members. Educational and Occupational status of the respondent have been shown in Table No.2 below.

Table 2 : Educational and Occupational Status of the Respondents

Education levels	Number	Percent	Occupation	Number	Percent
Literate	11	16.92	Daily wages	41	63.07
Illiterate	54	83.07	Agriculture	12	18.46
Total	**65**	**100**	Housewife	12	18.46
Primary	5	45.45	Service	-	-
Lower Secondary	2	18.18	-	-	-
Formal/Non-Formal	4	36.36	-	-	-
Total	**11**	**100**	**Total**	**65**	**100**

According to the table 2, most of the respondents (83.07%) were illiterate, 16.92 percent was literate and among literate 45.45 percent respondents have primary level education. Similarly, most of the respondent (63.07%) has occupation on daily wages, 18.46 percent was involved in agriculture and no any respondent was involved governmental job in study area.

It is concluded that maternal education is very poorer in Sardar community and they have not other option of occupation expect daily wages. Due to the above reasons their family health status was not so good.

4.1. 3 Marital Status of Respondents

Marriage is a legal union of two members where one is male and another female but many causes affect of the married couple.

Table 3 : Marital Status of Respondents

Status	Female	Total	Percent
Single	1	1	1.5
Married	61	61	93.84
Divorced	1	1	1.5
Widow	2	2	3.07
Separated	-	-	-
Other	-	-	-
Total	**65**	**65**	**100**

Table 3 shows that 93.84% has married, 3.07% widow, 1.5% single, 1.5% Divorce. It is concluded that Divorce and separated problem has not in this community.

4.1.4 Size of Land Holding

The land reflect that the status of economics. In our countries distribution of land is unequal only a few person has capture the land property but they could not cultivate the land.

Table 4: Size of land holding

Response of land holding		**Percent**
Response	**No. of Respondents**	
Yes	48	73.84
No	17	26.15
Total	**65**	**100**
Distribution of Respondent by Size of Land Holding		
Size of land	**Number**	**Percent**
Less than 1 Kattha	17	35.41
1 to 4 Kattha	19	39.58
5 to 10 Kattha	8	16.66
More than 10 Kattha	4	8.33
Total	**48**	**100**

Table 4 shows that among total respondent only 73.48 percent have land and 26.15 percent have not land and they live in Alani land and also among land holding 35.41 percent have less than 1 Kattha, 29. 58 percent have 1-4 Kattha, 16.66 percent have 5-10 Kattha and 8.33 percent have more then 10 Kattha.

Thus, it is concluded that catchments of land property have not very well. They cultivate other land they have not own much land. So they has economically poor.

4.1.5 Annul Income and Its Sources of the Households

Income plays a vital role in increase and decrease of family health status. Low income decreases the health status and high income increase the health status of people.

Annul income and their sources of the households have been presented in Table-3 below.

Table 5: Income and its Sources of the Households and main expenditure

Yearly Income	**Frequency**	**Percentage**
5000-25000	16	24.61
25000-50000	19	29.23
50000-75000	14	21.53
75000 +	16	24.61
Total	**65**	**100.00**
Sources of Income	-	-
Laborers/ Wages	25	38.46
Agricultural Farm	19	29.23
Service	-	-
Earn by Panjab	21	32.30
Total	**65**	**100.00**
Item for expenditure	-	-
Food	48	73.84
Cloth	6	9.23
Medicine	10	15.38
Other	1	1.5
Total	**65**	**100.00**

(Note: Percentage exceeds 100 due to multiple responses.)

Table 5 shows that 24.61 percent of the respondents had income 5000-25000 thousand rupees as yearly income, it shows that 29.23 percent had 25000-50000 thousand on their yearly income, but only 21.53 percent respondents had 50000-75000 thousand rupees their yearly income and 24.61 percent had more than 75000 thousand rupees on there early income. So the maximum respondents (about 75%) had survived in very low income and very difficult to fulfill their fundamental needs.

This Table also shows that all most all (38.46%) households depends on laborer/wages for their income, it shows that 29.23 percent households have earned money from agricultural and 32. 30 percent household earn money by Panjab and

main expenditure of it in 73.84 percent had in food, 15.38 percent had medicine, 9.23 percent had in cloth.

It is concluded in this study that most of the people have been suffering from low income and its impact in their life is very painful and their main source of income is daily wages. So they have very difficult to the utilization of health service due to low income.

4.2 Knowledge and Practices of Maternal and Child Health Care

4.2.1 Age at Marriage

Marriage is a natural phenomenon of human beings. Marriage is a process in women's life when child bearing becomes socially acceptable. Most of the women in rural area of Nepal marry before the age of 15 years. Before reaching 20, they often give birth to two or three children. Most of the adolescents get pregnant before their reproductive and sexual organs become fully developed. As a result, the rate of maternal and child mortality and morbidity results high in Nepal. In this regards, the age of marriage. Respondents were asked about age at marriage her and their responses have been presented in Figure No.1

In this study the age of marriage of respondents are classified in different four groups. That is under 15 years, 15-19 years, 20-24 years, and 25 years above. The above

figure shows that most of respondents (40%) have got married at the age of under 15 years 32.30 percent got married at the age of 15-19 years. Similarly, there were only few (18.46%) percentage of respondent who get married at the age of 20-24 years, and (9.23%) respondent got married above 25 years. According to the above figure, it can be concluded in this study that early age marriage is prevailing in Sardar community and their tradition is the main cause of teenage marriage as well as lack of education.

4.2.2 Age of First Child of Respondents

On the reproductive health point of view, a woman's age of bearing child should be 20 years, otherwise more complications can be seen in this period which may also lead to the death and different types of complications might come in different ages of mother and affect their child health at the beginning. In this regard, the respondents were asked "How many old do you have first child"? Their answers have been presented in Figure 2.

In this study, the age of respondents is classified in four different groups. Those are of 15 to 18 years, 19 to 22 years and 23 to 25 years and 26+. The above figure shows that 27.69 percent of respondent were first child at the age of 15 to 18 years and same (43.07) percent of respondents had got at the age of 19 to 22 years. Similarly, 23.07 percent of respondents had got first child at the age of 23 to 25 years and 6.15 percent respondent had got first child at the age of 26 + years. The teenage pregnancy percent has declined markedly from 31% to 26% in 2001 and to 19% in 2006. In national

wide, the proportion of teenage pregnancies has declined from 24% to 21% in 2001 and to 17% in 2006 (Source: NDHS, 2006).

It is concluded that early pregnancy is prevailing in the Sardar community. It is a sign of higher maternal and child mortality, morbidity and health risk. The main causes of early pregnancy are social belief like child as the gift of God; illiteracy as well as lack of awareness.

4.2.3 Additional Food During Pregnancy and Causes of not Taking Additional Foods During Pregnancy

A mother's nutritional status during pregnancy is important for both the child's intrauterine development and for protection against maternal morbidity and mortality. Night blindness is indicators of severe vitamin 'A' deficiency and pregnant women are especially prone to suffer from it. Additional food refers to either the extra food i.e. milk, eggs, meat, fish, fruits, varieties of leafy vegetables etc. In this context, the respondent was asked "In your last pregnancy period what are the extra food taken"? Their responses have been presented in Table No.6.

Table 6: Intake of Additional Food During Pregnancy

Additional Foods	**Frequencies**	**Percentage**
Fruits	19	40.42
Green vegetable	8	17.02
Meat/ fish	11	23.40
Other	9	19.14
Total	**47**	**100**
Causes of not Taking Additional Foods During Pregnancy		
Causes		
Lack of money	6	33.33
No one give/bring	11	61.11
Didn't know about it	1	5.55
Total	**18**	**100**

As shown in Table 6, majority of respondents (about 72%) had taken additional foods in pregnancy period. Only 28 percent respondent had not taken additional foods during pregnancy. Thus 40.42 percent had taken fruits, About 17.02 percent had taken green vegetable, 23.40 percent had taken meat/ fish, 19.14 percent had taken others foods as an additional food during pregnancy.

The above table shows reasons for not having additional foods during pregnancy period. It is clearly seen from the above table that most of respondents (61.11%) have not taken additional food due to no one give or bring, and 33.33 percent respondent has not taken due to lack of money and 5.55 percent have not taken due to lack of knowledge. Additional food was given to pregnant women for sometimes by a few families but not regularly. It was commonly practiced in most of the families to give pregnant women to eat what ever they prepared in their kitchen.

One of the findings of study is that 27.69% women of Sardar community do not take additional foods during pregnancy because of low level of economic status as well as lack of proper knowledge about health education.

4.2.4 Awareness and Health Checkup During Pregnancy

Maternal health is an important part of the health care system aimed at reducing morbidity and mortality related to pregnancy. The health cares of a woman that a woman receives during pregnancy, at the time of delivery, soon after delivery is important for the survival and well-being of both the mother and the child. Nepal is committed to millennium development goals (MDGs) and has developed various policies and strategies to this end. The target of three and fourth’s fifth’s year plan was reduction in maternal mortality by the year 2015.

Health checkup during pregnancy means the checkup of pregnant mothers during pregnancy period. If the pregnant mother goes for regular checkup during pregnancy the risk of child birth can be drastically reduced and will have a safe and healthy birth. In this context, the respondents were asked "How many times should be check up and how many times did you check up in last pregnancy period?" Their answer has been presented in below Table No. 7.

Table 7: Knowledge and Health Check up during Pregnancy Period

Awareness of pregnancy check up of Respondent		**Percent**
Response	**Number**	
Yes	55	84.62
No	10	15.38
Total	**65**	**100**
Health Check up During Last Pregnancy		
One time	14	25.45
Two time	11	20
Three time	9	16.36
Four time	21	38.18
Total	**55**	**100**

The Table 7 shows that (15%) respondent was not awareness of pregnancy check up and 85 percent of respondent had awareness. Thus 38.18 percent respondent were four time ANC check up, only 14 percent respondent were one time ANC check up. This is good but not sufficient matter.

It is concluded that knowledge and practice of antenatal care fully dependents on status of maternal education. Antenatal practice is no satisfactory in Sardar community. The main reason for this is lack of awareness, lack of knowledge, lack of time and lower economic status of that community people.

4.2.5 Centers for Check up and Reason for not Checking During Pregnancy

The support for safer 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 upgrade the skills of skilled birth attendants (SBAS). In this regard respondents were asked, "Where did you go for check up?" and "Why did you not go for check up?" Their responses about centers for checkup and causes for no check up have presented in the Table 8.

Table 8: Centers for Antenatal Checkup and Reason for not check up

Service provide centers	**No. of respondent**	**Percent**
Sub-Health post	36	65.45
Hospital	3	5.45
Private Clinic	-	-
ORC Clinic	16	29.09
Total	**55**	**100**
Causes of not Antenatal Check up During Pregnancy		
No free check up service	1	10
Lack of money	2	20
No permission for checkup from house member	3	30
Lack of knowledge about check up	4	40
Total	**10**	**100**

In this study, services provided by centers are classified in different four categories, namely; sub- health post; hospital, private clinic and ORC clinic. The table 10 shows that only 5.45 percent respondents visited hospital for antenatal checkup and 65.45 percent visited sub-health post. Similarly, majority of respondents (29.09%) visited ORC clinic and no any respondent visited private clinic.

The above table also shows the reasons for not checking up during pregnancy. There were different causes for not checking. Fifty percent respondent had not checked due to lack of knowledge about it, 20 percent respondent had lack of money and 30 percent respondent had no permission for check up by house member during pregnancy. The study shows that no any Sardar mother visited private clinic for antenatal checkup.

It is concluded that sub-health post and ORC clinic are the resource centers for antenatal service in the rural areas. Because they have not a lot of money and sufficient time, they have not good knowledge about different governmental health organization. So they have much difficult to utilize of maternal and child health service during pregnancy period.

4.2.6 Receiving TT Injection and Iron Tablets During Pregnancy

Tetanus taxied injections are given during pregnancy for the prevention of neonatal tetanus which may be a major cause of death among infants. For full protection, pregnant women should have at least two doses during each pregnancy. Five doses are considered to provide life time protection. Iron tablets are also given during pregnancy for prevention of anemia and malnutrition. In this regard, the collected data during the study period have presented in the Table No 9.

Table 9: Receiving TT Injection and Iron Tablets During Pregnancy

Frequency(TT)	Number	Percent	Frequency (I.T.)	Number	Percent
One time	21	46.66	Yes	38	58.46
Two times	18	40	No	11	16.92
More two times	6	13.33	Insufficient	16	24.61
Total	**45**	**100**	**Total**	**65**	**100**

The Table 9 shows that majority of the respondents (69.23%) received TT injection during pregnancy and rest of all didn't receive. Similarly, 83 percent of them received iron tablets and near about 17 percent of the respondent did not receive. Some of the respondents about 24.61 percent received insufficient dose of iron tablet.

In this study, it is concluded that mothers of younger age were associated with better knowledge of iron tablets and tetanus vaccine coverage. About 30 percent mother did not received TT injection. The study also concluded that large number of Sardar mothers did not receive iron tablets during their preceding pregnancy, which might lead to iron deficiency anemia and high risk of neonatal tetanus.

4.2.7 Reason for not Getting TT Injection and Iron Tablet

There are so many causes of not receiving TT injection and Iron tablet in the study area’s women. Such as lack of knowledge, lack of time, unawareness on health and ignored by health workers. The government provides all kinds of medicine and immunization for mother and children. But rural population has not receiving those services easily. Backward ethnic communities have so difficulty to utilization of

governmental services. In this regard respondents were asked, "Why did you not receive TT injection and Iron tablet?" Their responses about not receiving TT injection and Iron tablet during pregnancy period have been presented in the Table 10.

Table 10: Reason for not Getting TT Injection and Iron Tablet

Reason for not getting TT injection	**No. of Respondent**	**Percent**
Didn't give by health worker	-	-
Didn't come to give in our community	8	40
Go to in work during time	5	25
Lack of knowledge about it	7	35
Total	**20**	**100**
Reason for not getting Iron Tablet		
Not to give free	-	-
Have no money	2	18.18
No information about it	2	18.18
Because of Drug side effect	7	63.63
Total	**11**	**100**

The above Table 10 shows that one third of the respondents did not receive TT injection during pregnancy period due to lack of knowledge about it. Near about 40 percent of the respondents said that TT injection was not provided in their community and 25 percent of the respondents have not sufficient time to receive TT injection.

Above Table also shows the reasons for not receiving Iron Tablet during and after pregnancy. Most of the respondent (63.63%) said that the drug side effect 18.18 percent respondent did not receive due to lack of knowledge about importance of Iron Tablet. And also 18.18 percent have said that lack of money for buying by medical. In this study, it is concluded that mothers have not good knowledge about the place of receiving TT injection and Iron Tablets. And other causes of not receiving TT and Iron are that the local health workers also ignored them. So Sardar women are far from utilization of maternal and child health services.

4.2.8 Suffered by Health Problem in Last Pregnant Period and Their Management

Pregnant time is most important time for pregnant women and her family. Any problem bring the maternal and child high risk of life.

Table 11: Status of Health problem and management

Response	**No. of respondent**	**Percent**
Yes	30	46.15
No	35	53.84
Total	**65**	**100**
Management of problem		
Domestic treatment	7	23.33
Dhami	9	30
Check up by health worker	12	40
Check up by Quack	2	6.66
Total	**30**	**100**

In this study 46 percent respondent suffered in pregnant period such as backache, vomiting, abdomen pain, diarrhea, cough etc. and 54 percent has not any health problem. Among the problematic respondent about 24 percent have manage by domestic treatment, 30 percent take help by Dhami, 40 percent take help by health worker and about 7 percent take help by quack.

Thus, it is concluded that this community believe in Dhami so, the traditional believe already present. So that is not happy matter this community need the safe motherhood education.

4.3 Knowledge and Practices of Maternal and Child Health Care

Knowledge and practices play vital role in utilization of health service. Rural population can not use available health service due to lack of knowledge and their traditional practice. There are many facilities available at local level health organization but it's not very useful because their population has not perfect

knowledge about it. Traditional culture, unawareness on health, lack of time and money are major problem to utilization of health service in rural areas of Nepal.

4.3.1 Place of Delivery

Proper medical attention and hygienic conditions during delivery can reduce the risk of complications and infections that may cause the death or serious illness of the mother and the baby or both. Hence, an important component in the effort to reduce the health risks of mothers and children is to increase the proportion of babies delivered in a safe and clean environment and under the supervision of health professionals (NDHS, 2006). In this survey, respondents were asked, where do you have last delivery? Their responses has presented in Figure No. 3.

The above Figure shows the all most all (76.92%) of respondents delivered their children at home without receiving any health facilities. Only 23.07% percent respondents were delivered in hospital become a labour is so long. Who were delivered at home, helped with mother in low, mother and experienced lady (neighbor).

In this study, it is concluded that vast majority of mothers are delivered at home without health facilities, due to their tradition, lack of awareness, lack of money and lack of delivery facilities in nearest governmental health institution.

4.3.2 Complication during Delivery Period and its Treatment

Safe delivery is an important to protect the life and health of mothers to ensure the birth of healthy baby. Traditionally Nepalese rural area's children are delivered at

home with the assistances of TBA (Traditional birth attendant) or older women of the community. In that condition, many mothers face different types of complication during their delivery period, which creates high risk on mother and child's health. In this regard respondents were asked, "During their delivery period did they have any complication?" If yes, what have they done for treatment? Their responses have been presented in Table No. 12.

Table 12: Complication during Delivery Period and its Treatment

Complication During Delivery Period		**Percent**
Response	**Number**	
Yes	48	73.85
No	17	26.15
Total	**65**	**100**
Solution for Treatment of Complication During Delivery Period		
Call to the experience woman	18	37.5
Call to the health worker	20	41.66
Call to the TBA	7	14.58
Call to the traditional healer/Dhami	3	6.25
Total	**48**	**100**

The above Table shows that most of the respondents (74%) reported about different complications during pregnancy period. Except 26 percent of the respondent. Similarly, majority of the respondents (41.66%) said that they called health worker when they had any complication during pregnancy. Near about 38 percent respondent said they had called experienced woman of the community, 6 percent respondent had called traditional healer (Dhami/ Jhankri) and about 15 percent respondent had called TBA.

According to above table, for treatment of their delivery complication, almost all the households of the study area have not gone to hospital and consulted with doctor. Most of them who were economically better called to the mobile doctor (CMA) of this community. In one question of the researcher as to why they do not go to hospital or health post and why they do not call to the doctor, the respondents had answered

like this, they have not a lot of money for fees of the doctor and buy medicine, the hospital is so far from their community and the doctor also dislike to come in their home and cause of no any vehicle so they usually do not call to the doctor.

It is concluded that vast majority of Sardar community women are facing dangerous complications during their delivery period. But they have not got utilization of available maternal and child health facilities because of lack of money, lack of knowledge about health facilities and so many causes. Mainly, they have delivered at home without any health facilities.

4.3.3 Knowledge, Health Check up and Complication After Delivery and Place of Treatment of Complication

Risky pregnancy is the one of the main cause of maternal and child mortality. Early pregnancy may create some complications during delivery period. Every mother should have good knowledge about health check up after delivery and appropriate place for check up. In this regard respondents were asked 'Do you know about health check up, any complication at present time due to pregnancy and place of check up?' Their answers has presented in Table 13 and Figure 4.

Table No.13: Knowledge, Complication and Health Check up After Delivery

Knowledge About Health Check up			**Complication After Delivery**	
Response	**Number**	**Percent**	**Number**	**Percent**
Yes	9	13.85	45	69.23
No	56	86.15	20	30.77
Total	**65**	**100**	**65**	**100**

As shown in Table 13, Eighty six percent of respondent mentioned that they did not have knowledge of check up after delivery and only few percent (14) have knowledge about it. Similarly, majority of respondent (about 69%) mentioned that they suffered different types of complications and only, 31 percent mentioned that they did not have any complication after delivery at present time.

The above Figure has clearly shown the places of treatment where problematic women went after delivery. The majority of the respondents (51.11%) found to be gone to private clinic, near about 28.88 percent went to hospital or sub health post for their treatment of problematic mother.

According to the table shown above most of the delivery women of the study area have not gone to hospital and sub-health post although they have complication after delivery. The question asked with respondent to find out its reason "why do you not go to hospital or sub-health post for treatment of complication after delivery?" their answers show many different causes. Most of respondent (60%) reported that due to no permission by their member, some respondent said that they have not appropriate vehicle. Similarly, some respondents had due to the lack of money. So it is clear that due to above mentioned reasons they could not utilize of these facilities.

It is concluded that most of mother and her baby were high risk for death in this post natal period. And miner negligence them life threatening. So, mother were need orient the importance of PNC check up.

4.4 Practices About Nutrition and Immunization

4.4.1 Practice About Colostrums Feeding.

The first milk comes from breast of mothers soon after the child birth which is seemed thin and yellow is known as colostrums. Colostrums are more nutritious food for children, specially during infancy period. It consists of antibodies and other substances which protects the body against many kinds of disease. The practice of respondent about colostrums feeding is presented with Figure 5.

Figure 5 has shown the practice of colostrums feeding. Most of the respondents (69.23%) had practiced colostrums feeding, 23 percent of the respondent have fed milk of cow or buffalo to their newborn baby, and 6.15 percent have feed other like water and 1.53 percent have fed goat milk. The researcher asked the question why they had not fed mother's milk. The maximum respondent said that "Milk dose not come in mother breast so I can't feed to own newborn baby."

It is concluded that vast majority of Sardar community women were feeding colostrums her baby except of problematic mothers.

4.4.2 Knowledge about Immunization Practice of children at Study Area

In May 1974, the WHO officially launched a global immunization programme, known as expended programme on immunization (EPI) to protect all children of the world against six vaccine preventable diseases, namely diphtheria, whooping cough, tetanus, polio, tuberculosis and measles by the year 2000 (Park, 2005).

Immunization is one of the most important things which indicates child's health and helps to reduce child mortality. Data about knowledge and immunization practices found in the study areas is the presented in Table No.14.

Table 14: Knowledge and Immunization Status of Children at Study Area

Knowledge about Child Immunization of Respondents						
Response	**Respondent**		**Literate**		**Illiterate**	
	Number	Percent	Number	Percent	Number	Percent
Yes	39	60	11	100	28	51.85
No	26	40	-	-	26	48.15
Total	**65**	**100**	**11**	**100**	**54**	**100**
Practice about Child Immunization of Respondents						
Yes	30	76.92	11	100	19	67.86
No	9	23.08	-	-	9	32.14
Total	**39**	**100**	**11**	**100**	**28**	**100**

The Table 14 shows that 60 percent of mothers have knowledge of immunization and rest 40 percent had no clear idea about it. Twenty three percent mentioned that they didn't immunize their children and 76.92 percent mentioned that they immunized their children completely. Nationally, 83 percent children are immunized. According to NDHS report 2006. Similarly, majority of illiterate (52%) respondents had also idea about immunization for their children but whole of the literate respondent had good knowledge about it and they were fully immunized their children.

It is concluded in this study that immunization status was satisfactory but not so better. The main reasons of not immunizing their children are not to come health worker, go to work during immunization time, not information about it.

It is concluded that, male population is almost out of home and women are out of home for earning money during the day time. Most of the children are deprived of immunization because there is no body at their home to take the children to immunization center. So the immunized baby has more chances of communicable diseases.

4.4.3 Sickness and Its Treatment of Children at Last 3 Month (under 5 year)

There is most important role of mother to make healthy their Childs. The children can not express theirs health problems in word. In this period mother and father can understand their health problems from feelings or activities. So, health point of view, it is most critical age of children and guardians to be alert about their child health status. In this regard respondents were asked "Did you child fall ill at last three months. If yes, where did you get their treatment?" Their answers have been presented in Table No. 15.

Table No.15: Sickness and Place of Treatment

Child Sickness Within Three Months		**Percent**
Responses	**No. of Respondents**	
Yes	30	46.15
No	35	53.85
Total	**65**	**100**
Places of Treatment	-	-
Governmental hospital/SHP	4	13.33
Quack	4	13.33
Medical hall	13	43.34
Traditional healer (Dhami)	9	30.00
Total	**30**	**100**

Above Table 15 shows that status of the child health is not good in the study area. Forty-six percent children having some health problems and only 54 percent was healthy at last three months in total number under five years children. The above table also shows that trends of child treatment. Only few percent (13.33) of respondent have to go to hospital or sub-health post for treatment of their children. The highest percent (43.34) of respondent have gone to medical hall and second highest (30) percent of respondent have gone to traditional healer for treatment, Similarly 13.33 percent have gone to Quack among all of respondent who have sacked children.

It is concluded in this study that health status is not satisfactory but not very bad. And the trend of treatment of their child is not good.

4.4.4 The Reason for Not Going to Hospital or Sub-health Post for Treatment Their Children

According to the above mentioned result of child treatment trend, there was only few percent of respondent have to gone hospital or sub-health post and the highest percent of respondent have gone to medical hall or house of traditional healer for treatment for their sick children. The researcher asked a question "why do you not go to hospital or sub-health post for treatment your baby?" to find out its main reasons. Their responses has presented in Table No.16.

Table 16: The Causes of No Going to Hospital or Sub-health Post

The Causes	No. of Respondents	Percentage
To think about more expenditure	10	38.46
No information about hospital	7	26.92
Think not good check up in government organization	4	15.38
Far from here	5	19.23
Total	**26**	**100**

The above Table 16 shows the causes of no going to hospital or sub-health post. Highest (38.46) percent of respondent showed the think about more expenditure, 15 percent said not good check up, 27 percent said not information about right hospital. Similarly 19 percent said there was far from here.

4.4.5 Facilities and Utilization of Health Service

Utilization of health service is fundamental right of human and facility of health service is basic requirement of the every society. People's health status depends on available health facilities in their community in which communities has good facility of health service and know proper utilization than automatically increasing health status of these community's people. Nature of this community is first, they go to the nearest health institution at the time of illness. If there do not get any treatment there, they go to other proper place. In this regard they were asked, "Which is the nearest health institution from your community and where do you go for treatment at first?" Their answer has been presented in Table No. 17.

Table 17: Nearest, trend of sickness and First going Health Institution for Treatment

Nearest Places for Treatment	**No. of Respondent**	**Percent**
Sub-health post	11	16.69
Medical hall/Private Clinic	50	76.92
Hospital	-	-
India	4	6.16
Total	**65**	**100**
Trend of Sickness Response	**No. of Respondents**	**Percent**
Yes	37	56.92
No	28	43.07
Total	65	100
The Places, Where go for Treatment at first of All		
Health Post	26	70.27
Domestic Treatment	5	13.51
Quack	4	10.81
Dhami	2	5.40
Total	**37**	**100**

Above Table 17 shows the condition of the nearest health institution of study area, according to respondent. Most of the respondents (77%) reported that they sought help form medical Hall when they become sick. Similarly, 17 percent said that their nearest health institution is sub-health post and only 6 percent have reported that go to India as nearest place for their treatment in the entire respondent. Most of the study population 71 percent visited the SHP, about 13.51 percent people have in domestic treatment. 10.8 percent visited by Quick and 5.40 percent have visited by Dhami in the study population.

It is clear that by this study, they feel easy to treat by sub health post compare of other. It means Quack and Dhami Services also present. So, good education need of this society.

4.4.6 Concept of the Respondent About on Sub-Health Post

A concept is the form of a mental image denotes a generalization idea about the things, persons or events. In simple term we can define that a concept is an idea or understanding of what a things is. We have need of concept to understand any matter,

to take decision and to utilization of any service. In this regard respondents were asked "Who checked up, how did you feel theirs behavior and did you receive any medicine?" Their responses have been presented in Table 18.

Table 18: The concept of About on Sub-health post

Health examiners	**No. of Respondents**	**Percentage**
ANM	5	19.23
CMA	7	26.92
VHW	14	53.85
Total	**26**	**100**
Behave of Health Examiners	-	-
Fine	2	7.69
Not so well/Bad	15	57.69
Not Fine/Normal	9	34.62
Very good	-	-
Total	**26**	**100**
Receiving Medicines	-	-
Yes	13	50
No	13	50
Total	**26**	**100**

The above Table 18 shown that information about health examiners who checked up the patients in sub-health post, theirs behave with respondent and receiving medicines. Most of the respondent (54%) have been checked by VHW, near about 27 percent have been checked by CMA and only 19 percent have been checked by ANM is the total number of respondents. Similarly, majority of the respondents (58%) reported that the health workers have not behaved so well with them. Near about 35 percent said that they have not been behaved well and only lowest (8) percent said that they have been behaved finely with them. The above table also shows that only half of the respondent have received medicine at all of the (26) respondent who have gone to sub-health post for their treatment.

It is concluded that health workers do not show good behavior with Sardar and did not provide sufficient medicine to them. So, they have established negative concept about sub health post.

4.4.7 Maternal Problem and their management

The disease, which is not, cured by simple treatment then they consult with disease specialist or any good governmental hospital for curing properly. Many people die everyday due to lack of appropriate treatment in developing country. Especially, backward or rural people have not good facility of health service, lack of information about health services, lack of transportation service and due to poverty, they are deprived to consume health facilities. In this regard respondents were asked "Do you have any maternal Problem? If yes what do you do?

Table 19: Maternal Problem and Their Management

Consult with Doctor/Hospital			**Management**	**Number of Respondent**	**Percent**
Response	**No.**	**Per.**			
Yes	14	21.53	Domestic Treatment	2	14.28
No	51	78.46	Checkup by Health worker	6	42.85
-	-	-	Dhami	2	14.28
			Quack	4	28.57
Total	**65**	**100**	**Total**	**14**	**100**

The Table 19 shows that 78.46 percent mentions that they have not any maternal problem. Only 21.53 percent mentions have maternal problem. Thus, in management 42.85 percent responded have consult the health worker, similarly 28.57 percent have management by quack., 14.28 percent have take domestic treatment and same percent have management by Dhami.

It is concluded by this study that majority of sick respondent who could consult the health worker is positive matter.

CHAPTER – V

SUMMARY, FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Summary

The present study entitled 'knowledge, attitude and practice of maternal and child health service in Sardar community in Kaptanganj VDC Sunsari District" was based upon the obtaining information about KAP of maternal and child health service in Sardar community.

The objectives of this study were to find out socio- economic condition, to identify the knowledge about maternal and child health service available at local level, to access the health beliefs and cultural practices of maternal and child health and to find out existing practices of maternal and child health services.

In this study Sardar community of Kaptanganj VDC was selected. Only married women of 15- 45 years of age and their children at the age of 0-5 years was taken. This study was based on "KAP of maternal and child health service". This research was mainly designed on the bases of descriptive method. To collect the necessary information regarding the study purpose, different sets of structured interview schedule were made. The interview was done face to face and the required information was collected.

To examine the relationship among various variables, the available information was managed manually in master chart. Data were analyzed and interpreted accordingly. From analysis and interpretation of data, the findings and conclusion were drawn and appropriate recommendations were made.

5.2 Major Findings

The major findings of the study are as follows:

5.2.1 Demographic, Socio-Culture and Economic Status

a. There was very low (about 34) percent of working population and rest (about 64) percent were dependents population in the study area.

b. Among the total respondents 31.57 percent had engaged in daily wages and 30.52 worked in Panjab (the state of India).

c. Among the total household 24.61 percent have 5 to 25 thousands and 24.61 percent have over 75 thousands of yearly income.

d. Majority of the household (38.46%) was depends on laborers/wages for their income and 29.23 only 5 percent has been earning money from agricultural farm plus wages and 32.30 has been earning by Panjab (India).

e. There was majority of (61 .86%) population were illiterate and only 38.14 percent literate.

5.2.2 Knowledge and Practices of Maternal and Child Health Care

a. Among the total respondents 27.69 percent have got their first delivery at the age of 15-18 years, 43.07 percent have got 19-22, 23.07% have got 23-25 year and 6.15% got 26+ years age.

b. Majority of respondents (about 27.69%) had not taken additional foods in pregnancy period .

c. Most of respondents (15.38%) have not knowledge about how many times should be checked up in pregnancy period.

d. Among the total respondents, 15.38 percent respondents have not health checked up and only 55 percent have checked three or more times in pregnancy period.

e. Out of the total respondents, 69.23 percent received TT injection and 83% of the total has received iron tablet.

f. All most all (77%) respondents delivered their children at home without receiving any health facilities.

g. The majority of the respondents (41.66%) call to the health worker. Among all of compliant after the delivery.

h. More than 23 percent respondents didn't immunize their children completely.

i. Most of the women (70.27%.) visited health post for their treatment at first.

j. Majority of the respondents (58%) said that, the sub-health post's workers do not behave well.

k. Majority of the respondents (76.92%) has home delivery and only (23.07%) has hospital delivery.

l. Majority of the respondents (73.85%) among home delivery has complication. among complicated delivery and to manage them 41% by call health worker, (37%) call experience women, 14% call TBA and (6.25%) call Dhami.

m. Majority of the respondents (86%) has not knowledge about post natal check ups.

n. Among (14%) which has knowledge for post natal check ups 51% has checked in private clinic, 28% has checked in health post, 15% Dhami.

o. Majority of the respondents (69.23%) mother milk or colostrums milk, (23%) feeding her child cow milk.

p. Majority of the child immunized (76.92%) and 23% child has not immunized.

5.3 Conclusion

On the basis of findings of it is concluded that KAP of maternal and child health service in Sardar community at Kaptanganj VDC. The socio-economic condition of Sardar people is very poor. More than 68.13 percent mothers are still illiterate. Daily wages are the main occupation of the community people.

It can be concluded that there are no hospitals facilities established yet. Due to remote hospital and lack of money, local people do not go for checking up at the time of illness and go to mobile doctor because they are available nearby the village and they go to their house to house but don't take money immediately. Governmental hospital and primary health care services do not sufficiently facilitate. Therefore, they are deprived to consume health facilities.

socio, economic and cultural status is poor in this Sardar community. For antenatal care early marriage in even present maximum respondents were intake additional food except some respondents. Maxmum respondents have checked her ANC except some

respondents. majority delivery delivered in home. It is a major problem. Maximum respondents have not knowledge and practices about post natal care. Maximum respondents feeding her child colostrums milk. Except some respondents.

Analyzing all the findings, it is concluded that women and children are out of the reach of the services provided by different governmental health institutions, providing maternal and child health service, private services for them, carelessness of health, poverty, ignorance, social discrimination, traditional culture, lack of time and they are major hindrances of their health facilities.

5.4 Recommendations

On the basis of findings of this study the following recommendation are suggested:

a. Most of the people depend on daily wages, so government should conduct different types of skill development training and job opportunity to maintain their quality of life.

b. The socio-economic condition of the community is very poor; they are unable to receive payable medical facilities, so government should provide free medical services for them.

c. Most of the Sardar women are illiterate so, it is necessary to provide non-formal education such as Proudha Kaksha.

d. Socio-cultural values, lack of awareness, low educational status poverty are the main causes of deprivation to consume health facilities. So government should launch different types of awareness programs here.

e. The government should start mobile health clinic service which seems to be much more effective.

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