CHAPTER -ONE

INTRODUCTION

1.1 Background of the Study

Nepal is a landlocked country in South Asia. It is located in the Himalayas and boarded to the north by the People's Republic of china, and to the south, east and west by the republic of India. With the area of 1, 47,181square kilometers (56,827 sq. ml) and a population of approximately 30 million, Nepal is the world's 93rd largest country by land mass (world Fact book, 2010) and the 41st most populous country. Nepal is a country of highly diverse and geography, culture and religions. The mountainous north has eight of the world's ten highest mountains, including the highest *Sagarmatha*, known in English as Mount Everest. It contains more than 240 peaks over 20,000 ft (6,096 m) above sea level (Shaha, 1992). Economically Nepal is an Agriculture based country. Where, about 80 percent of the population, most of them self-employed depend on agriculture as the primary source of employment. Disparities in landholding and income result in the bottom 20 percent of the population getting just 3.7 percent of the national income while the top ten percent claim 50 percent (CBS, 2003/04). With inequality intrinsic to social organization, endemic poverty is the result.

Geographically Nepal is divided in to 3 regions named Mountainous region, Hilly region and the Terai region. Since long time ago Tharu people used to live in Terai region in Nepal. The Tharu people are an Asian ethnic group indigenous to the Terai, the southern foothills of the Himalayas in Nepal and

India (Rajaure, 1981). The Tharus are recognized as an official nationality by the government of Nepal (Lewis, 2009).

According to Nepali author Subodh Kumar Singh, a series of invasions by the other races, from north India across the border and from hills and mountains of Nepal, eroded the influence of the indigenous Tharus. In 1854 Jung Bahadur the first Rana prime minister of Nepal, developed the Mulki Ain, a codification of Nepal's indigenous legal system, which divided society into a system of casts. The Tharus were placed at next to the bottom (lowest touchable, above untouchables) of the social hierarchy. Their land was taken away, disrupting their community and displacing the people. In the 1950s, the World Health Organization helped the Nepalese government eradicate malaria in the Terai region. This resulted in immigration of people from other areas to claim the fertile land, making many Tharus virtual slaves of the new landowners and developing the Kamaiya system of bonding generations of Tharus families to labor (World Organization against Torture, 2006).

Kamaiya, a form of bonded labor system, used to practice in Dang, Banke, Bardiya, Kailali and Kanchanpur - before July 17, 2000. The Tharu population, one of the indigenous peoples of Nepal, is densely settled in these areas. Kamaiya (bonded labor) was an age old practice of the Tharu people within their community (Banerjee, 2008).

The Kamaiya system develops within Tharu communities to ensure an effective supply of labor. In the 19th century Rana rulers allow local Tharu headman and later high cast people from the hills to collect revenue for the crown from the Tharu people. Despite the national and international efforts

opposed to slavery to fulfill growing demand for agricultural labor the local revenue collectors, some clever Tharus and high cast immigrants from different hill regions who started to hire labors from indigenous Tharus, ultimately the labor relation converted in to Kamaiya as a new forms of slavery. The literary meaning of term 'Kamaiya' in Tharu language is "kamkaruiya" meance hardworking man. Nepali dictionary defines the term "Kamaiya" as follows a hard tiller of land earner, mainly persons one who learn along with his family in others land by borrowing in cash or kind from the land owner or a peasant equivalent to him. The kamaiya is, in fact, a worker; he is a bonded on a slavery system prohibited all over the world including Nepal (INSEC, 1992).

Health is a condition of the body free from physical and mental illness. Health is the state when one feels well as long, well and smoothly. Health is a multicultural condition, which is determined by the interaction of biological and environmental factors. 'Besides poverty, the World Bank Health Sector Policy has categorized demographic factors, malnutrition and unhealthy environment as three main causes responsible for the poor health of developing countries (Mathema 1987)

Health service has provided services one people as well as to society to aid health progress. The main objectives are to improve the health condition of the people. For example immunization of children is to decrease the attack of communicable diseases. Looking after the pregnant women and children helps to decrease the rate of maternal as well as infant mortality and morbidity. Primary health care services include health post, sub health posts and primary health outreach clinics. The general structural of Nepalese primary health care system depicts that health posts are the primary level

unites of the Nepalese health service system to provide primary health care at the local level through the country. There are 67 district hospitals, 180 primary health care center, 13 health center, 711 health post, 3179 sub health posts and 15548 primary health care outreach clinic (MOH, 2002)

1.2 Statement of the Problem

Kamaiya is a traditional system of bonded labor in southern Nepal. The people affected are also called Kamaiya or Kamaiyas. Various forms of forced labor and bondsman system existed since the 17th century. Traditionally, people without land or work could get loans from landowners allowing them to sustain a minimum livelihood. In exchange to this, they had to live and work on the landowner's land as aqua's-slaves. Exorbitant debts were charged and whole families were forced to slave labor for years and even generations, bonded by indebtedness to the landowner and bonded by unequal social relations to sell labor in lieu of the loan taken. Following the eradication of malaria in Terai region in the 1950-60s, the large influx of hill migrants marginalized traditionally landowning Tharu people by occupying their lands. While the Tharus had no records of the land they were cultivating, the settlers registered the land in their name forcing the Tharus to work as agricultural laborers. The customary practice of obtaining a "helping hand for family business" was gradually replaced by the forced labor system called Kamaiya, which in Tharu Parlance is tantamount to hardworking hired farm labor (World Organization against Torture, 2006).

After the abolition of Kamaiya before ten years they are said to be *Mukta Kamaiya* (Free labor) but their liberation is not enough due to the their miserable status. Since long period they were working as bounded labor in

result they had nothing as an asset on the time of abolition. Along with asset they have no any opportunity of Health and Sanitation. They are still struggling for their livelihood. So, they did not get any better facility along with Health and Sanitation.

Mukta Kamaiya's were taken as vote bank of various political parties but no one is caring for their social status. In addition Government of Nepal also neglected about their health and sanitation situation and so on and so forth with these broad perspectives, this study has been conducted to find out the Kamaiyas access on Health and Sanitation facilities in the context of Ex-Kamaiya of Bardiya district. Considering above issues this study has been focused on the following research questions:

I. What is the condition of Health and Sanitation of Ex-Kamaiyas?
II. Which is the major health problem of Ex-Kamaiyas?
III. How much time and duration they have to spend for Health facilities?
IV. How much population using the toilet in their daily life.
V. Is there any support for betterment of Health and Sanitation facility from any institutions?

1.3 Objective of the Study

a) The general objective is:
   1. To find out the Status of Kamaiyas' access on Health and Sanitation facility.
b) The specific objectives are
   1. To find out the major health problem of Kamaiyas.
   2. To find out type of access to health facility.
   3. To assess the condition of toilets and Drinking water facility.

4. To assess the institutional support for their Health and sanitation facility.

1.4 Significance of the Study

Nepal was being defamed in the world by Kamaiya system. Ex-kamiyais resettled in the forest land or in the bank of the river. So, there are prone to natural hazard like flood also provides the nature of their settlement. Tharu ethnic community covers 6.75 percent of the total population. Socio economic status of the Tharus is very low so that their health and sanitation status is poor.

Freed kamaiya families are highly food unsecured. Therefore there health and sanitation condition is being worsened. There is a great challenge to the nation to improve the health and sanitation condition of Kamaiya

There are many studies about the socio economic status of kamaiya but there are not studies conducted to the health and sanitation sector. The present study is justifiable in order to have information of study area. Finally, it may be helpful to the government to design health program for the study area.

Academically for others interested in Ex-Kamaiyas issues especially related to Kamaiyas' access on health and sanitation facility of the Bardiya District of Midwestern Nepal. In addition, this study would provide useful information, suggestions and recommendation to various INGOs, NGOs, CBOs, G and other agencies working in this sector.

1.5 Limitation of the Study

The studies have been undertaken with in a fixed time-frame. Similarly, the studies based on the field works of possibly sample area of Ex-Kamaiyas. Findings of the field may not be generalized for other systems. Primarily, this study focused on existing Ex-Kamaiyas' access on health and sanitation facility. Thus it not cover other aspect of Ex-Kamaiyas and their others sectors.

CHAPTER- TWO

LITERATURE REVIEW

The Tharu people themselves say that they are a people of a forest. In Chitawan, they have lived in the forests for hundreds of years practicing a short fallow shifting cultivation. They planted rice, mustered, corn and lentils, but also collected forest products such as wild fruits, vegetables, medicinal plants and materials to build their houses; hunted deer, rabbit, wild boar and went fishing in the rivers and oxbow lakes (Mclean, 1999).

Having lived in the malaria-infested jungle of the Terai for centuries, they were reputed to have an innate resistance to malaria. Following the deforestation and malaria eradication program using DDT in the 1960s, thousands of the people from the mid-hills settled in the area. Recent medical studies among the Tharu and non-Tharu population of the Terai yielded the evidence that the prevalence of cases of residual malaria is nearly seven times lower among Tharus. The basis for their resistance to malaria is most likely a genetic factor (Terrenato, Shrestha, Dixit, Luzzatto, Modiano, Morpurgo and Arese, 1998).

The Tharus are the largest and most important of the various tribal groups occupying the Terai Zone of Nepal (The Terai is the lowest [300 to 800 meters above sea level] of the four ecological zones that run across the country from west to east). In 1985 the Tharus numbered about 5,00,000 in Nepal, with a considerably smaller population in Uttar Pradesh, India (67,994 in 1971). The Tharus are sometimes described as containing two fairly distinct geographical subgroups, the *Bhoksa*in in the west and the Mechi in the east. From the perspective of their high cast *Pahari* and *Newar*

neighbors, the Tharus are Untouchables, though higher than the official "unclean" Untouchable casts.

Contemporary Tharus are mainly wet-rice agriculturalists who live in permanent settlements, integrated through kin ties and mutual economic obligations. Each village is governed by a council and a headman who collects taxes for the central government. There is some evidence that permanent settlements and wet-rice agriculture represent a shift from an earlier reliance on shifting horticulture. Traditionally, the Tharus were subdivided into two major groups of unequal status, each composed of a number of endogamous units called *kuri*. Today, the high-status group forms single endogamous unit, while the low-status group continues to have a number of distinct endogamous units. Tharu religion is an amalgam of beliefs involving traditional supernatural, Hindu deities and Moslem saints, with the shaman as the central religious figure, calling on the power of supernatural forces from all three belief system to exorcise evil spirits and cure the sick (Srivastava, 1958).

The term “Kamaiya” refers to agricultural indentured laborers lacking land or property that are required to serve the single *Jamindar* (landlord) to whom they are financially indebted until the debt is repaid. Typically, the Kamaiya and other family members work for a single and in return get payments in kind, or in-kind payments plus a wage. But in most cases, the earnings are so small that the Kamaiya is unable to pay back the *Sauki* (loan) and ends up serving their *Jamindar* for a lifetime, and in some cases, from one generation to another. The Kamaiya problem is most prevalent among the Tharu (Indigenous) community that inhabits the Mid- and Far-Western Terai where landlessness, low levels of human capital development, and lack

of employment opportunities have contributed to this exploitative form of employment. On 17th July 2000, the Government of Nepal made the landmark decision to outlaw bonded labor. Thus, forcing another person to work under the Kamaiya system is now punishable by law. While this is a positive development, in order to actually terminate the Kamaiya system, the authorities must be prepared for difficult battles, both on the legal and political fronts.

According to *'Kamaiya Labor Prohibition Act, 2001'- "* Unless otherwise meant with reference to the subject or context in this Act, (a) Kamaiya Labor means the labor or service to be provided by a person to his creditor without any wages or at low rates of wages for the following reasons. (1) To repay loans obtained by him or any member of his family or to pay interest thereon. (2) To repay loans obtained by his ancestors, or to pay interest thereon. (3) To repay the Kamaiya loans of Kamaiya laborer for whom he had provided surety to the creditor. (b) Kamaiya Laborers means persons who provide Kamaiya labor as Bhainsbar, Gaiwar, Vardikar, Chhekarbar, Haruwa, Charuwa, Hali, Gothalo, Kamalariya or under similar other names. (c) Kamaiya loans mean cash, goods, or commodities obtained by a Kamaiya laborer from his creditor the term includes Sauki or other loans. (d) Creditor means a person who has provided a loan to a Kamaiya laborer. (e) Family includes father, mother, husband, wife, son or unmarried daughter, the term includes coparceners of an undivided family headed by a person who is himself working as a Kamaiya laborer. (f) Freed Kamaiya means a Kamaiya who has been freed under section 3. (g) Committee means the Freed Kamaiya Rehabilitation and Monitoring Committee formed under section 8. (h) Welfare Officer means the Welfare Officer mentioned in

section 10. (i) Fund means the fund mentioned in section 12. (j) Agricultural Laborer means a person who performs functions prescribed by HMG by notification in the Nepal Rajpatra. (k) Proscribed or as prescribed means prescribed or in the manner prescribed in the rules framed under this Act."

The Kamaiya is in fact a worker mostly bonded because of different reasons. The Term Kamaiya is derived from the *Kamuiya* of Tharu word, which means hard workingman (GoN, 1995). Likewise another general meaning of the word Kamaiya is person who cultivates the land of others. The word Kamaiya also reflects the economic, social and political exploitation of the poor Tharu families (GEFONT and Siddique2008).

The Kamaiya system refers to human power exploitation for agricultural work and other related works however, the fundamental secret behind the Kamaiya system lies in the way and terms of conditions on which *Sauki*are given and how their account maintained. The aforesaid implication, underlying the word Kamaiya, though apparently positive in sense, expressing implicitly it a tell of human exploitation injustice as a Kamaiya is presented as a slave or bonded worker (INSEC and Siddiqui, 2008)

INSES (1992) attempted to identify the existence of bounded labor under Kamaiya system in Nepal based on a sample study of three districts viz. Bardiya, Kailali, and Kanchanpur. The study analyzed the genesis of the Kamaiya system and its causes, procedure for employing Kamaiyas, working hour and facilities reasons to borrow *Sunki* (loan). Socio economic condition of Kamaiyas based on the sample study established the fact there exist the situation of bounded labor within the Kamaiya system. It also

concluded that the Kamaiya had been working for about 18 hours a day and reserving extremely low remuneration for their work.

Subedi (1999) has studied on Bounded Labor in Nepal: Sociological Study of Kamaiya System in Khairi Chandapur VDC of Bardiy District. This dissertation has been done to submit to the central department of Sociology/Anthropology, T.U. The objectives of this study were to determine the socio economic and ethno political condition of Kamaiya. Both exploratory and descriptive research design were chosen for the study.55 households were selected the sample hhs by using purposive random sampling method. He has found that education attainment with Kamaiya families was very low. Health and Sanitation condition in Kamaiya families ever also very poor. The women of Kamaiya families were also poor. Some of women of kamaiya families often faced sexual abuse from their masters (the landlords). No kamaiya has a primary income source other than farming. Out of the total only 11 sampled families had a small plot of land and 38 families kept small livestock like hens, pings and boars? Kamaiyas' children from the age of 7-8 years started to the work as cowherds, shepherds, firewood collection etc. to manage the affairs of their families and masters. The Kamaiya had not formed any sort of power group to influence decision in their favor. The interface with the hill migrant had resulted in a loss of Tharu's land and positive impact caused by the interaction was the development of education and health sectors.

After the abolition of the system in 2000, the civil society organization created a massive pressure for re-identifying Kamaiyas in five districts as the 1995 record were outdated. Government of Nepal again conducted a survey in 2000 and identified 18,400 Kamaiyas. As not all Kamaiyas were

homogeneous in term of bondage and asset ownership, Kamaiya were grouped according to the land and house ownership. Out of the total 8,030 were categorized as "A" having neither home or land, and 1,517 were categorized as "B" having either a homestead plot or small parcel of land. The rest of the identified Kamaiyas were categorized as "C" and "D", defined as those having land in their name or were farming government land. Government of Nepal also set up a high level committee at a central level to indentify, monitor and co-ordinate the rehabilitation work as well as to ease the implementation of rehabilitation activities at grass root level (Cheria, 2005).

In Bardiya district only 9.2 percent of Ex-Kamaiyas have toilet facilities at their premises. Remaining 90.8 percent of Ex-Kamaiya use bank of the river, forest and open space for disposal. Comparisons of toilet facilities by grade "A" Ex-Kamaiyas have better toilet facilities with 11.5 percent households having toilet. Similarly, toilet facility is slightly better in Kanchanpur district where 10 percent Ex-Kamaiyas having toilet facilities (ILO and Siddique, 2008).

The average daily wage rate of Kamaiyas in Bardiya district was Rs 64.03 and daily average working hour was 10.98. It seems that this rate is higher than the minimum rate fixed by the government for agricultural labor, but for this wage they have to work for 10.98 hours instead of 8 hours fixed by the government under minimum wage law. Adjusting the rate and the time Ex-Kamaiyas are getting about 6 percent less than what they should have got under minimum wage provision (ibid).

MOH (2002) developed a 20 years Second Long Term Health Plan (SLTHP) for fiscal year (1997-2017). The main objectives of HLTHP are to improve health status of vulnerable groups (Children, women, rural poor), underprivileged, extent essential and cost effective health service to the district, provide appropriate health personnel for quality health care and increase efficiency and effectiveness of health care service system. The SLTHP is to guide health sector development in the improvement the health of population particularly those whose health needs are not often met. The SLTHP addresses disparities in the health care, assuring gender sensitivity and equitable community access to quality health care services.

WHO (2002) has mentioned that all countries in the South-East Asia region have made considerable gains in the health sector. However, daunting challenges are still ahead. With careful strategies planning these challenges can be met and people can look forward to and better healthier life in the future.

In many studies and researches more than 20 organizations found that major problem of Kamaiyas is lack of better livelihood and employment opportunities for the income generation. So far, here we will discuss about the steps taken by the various institutions and agencies for their access on health and sanitation facility. This provides us important information about Ex-Kamaiyas access on health and sanitation facilities status. Hence, most of the literatures are unable to touch the specific case of Bardiya District.

CHAPTER - THREE

RESEARCH METHODOLOGY

3.1 Selection of the Study Area

There are more than 40 thousand of Ex-Kamaiyas living in 5 districts they are Dang, Banke, Bardiya, Kailali and Kanchanpur. Among them, 20 thousands of Ex-Kamaiyas are in Bardiya District which can represents all the command area of Ex-Kamaiyas who were resettled in 5 districts and other more.

3.2 Research Design

In this research descriptive design have been adopted to describe the prevalent of Bardiya District, to develop better understanding of Ex-Kamaiyas' access on health and sanitation facility to explore an action plan for the betterment of health and sanitation facilities by collecting primary data with field survey, focus group discussion and interview. In addition, secondary data have been used to make Comparisons and draw conclusions. The research has been both qualitative and quantitative in nature.

3.3 Nature and Sources of Data

Qualitative and quantitative information collected to present in the thesis. Primary data have been collected from the field by group interview, personal interview and key informants interview with the real victim of such System. Similarly, focus group conducted with the health posts, hospitals, sanitation offices and health institutions nearby the sample area. In addition, the secondary data have been collected by Review - previous studies, published book, journals, case studies, news, articles, document and other related

materials under the secondary sources and use both formal and informal methods for the collections of both quantitative and qualitative data.

3.4 Universe and Sampling

The Total Ex-Kamaiyas of this District constitute (31 VDC) the sample universe of the study. In which mostly their prevalence is on 12 VDC's (Action aid, 2006). I will take 2 VDCs among these 12 VDCs as sample unit. It based on judgment sampling and lottery system used to select 2 wards of each 2 VDC's as a sample. 25 households of each ward have been sampled using judgment sampling methods.

3.5 Data Collection Technique

Several data collection methods and tools used for study such as participant observation, key informant interview, focus group discussion and interviews and with some related agencies. Secondary sources and existing records have also use for clarification of collected and supplemented data. Secondary sources including NGOs, INGOs, CBOs and government policy and rule related to Kamaiyas, various journals and research articles of various organizations along with Ex-Kamaiyas used.

3.6 Key Informants Interview

Interview have been conducted with those institutions and individuals related to the Ex-Kamaiyas' welfare and development. Key informants of the study could be the Local leaders, Social mobilizes, personnel of I/NGOs, CBOs and government agencies, who have been directly or indirectly involved in the Ex-Kamaiyas issue.

3.7 Method of Data Analysis

Field notes and field diary used for recording and organizing field data. The purpose of the field notes is to flesh out and to conceptualize what researcher could and observed during the field. Field notes have been maintained in chronological order. On the regular basis field notes have been written in detail expanded form, which can guide me for further what information should collected and what has been already collected. The collected data entered in to the computer and I used Excel to generalize it. Personal feelings, opinion and observed documented in the field in the field diary Presentation of the data done in tables analysis and examining its appropriateness in the particular situation of the presentation.

CHAPTER-FOUR

PRESENTATION AND ANALYSIS

This chapter analysis of primary as well as secondary data focusing on access to health and sanitation of ex-kamaiya in Bardiya District .The chapter begins with discussion about Bardiya District and then goes on to describe about its population and their access to health and sanitation. The chapter then goes on to describe about the selected VDCs for study. The chapter ends with the explanation for the rational of selection of the study side.

4.1 Background of the study area

4.1.1 Bardiya District:-

Bardiya district, which has been selected for this study, lies towards the west of Nepal, and falls in the mid-western development region. Banke district lies towards its east, Kailali in the west, Surkhet and Salyan in the north and the open border of India towards the south. The district is divided in to 31 VDC and 1 municipality for its agricultural productivity.

Bardiya has a total area of 203,553 hectares of which 62.72% (CBS 2001) is forest area. The resulting area is used for agriculture.

Bardiya was initially a Royal Hunting reserve of Nepal's Rana rules from 1846 to 1960s opened the Tarai for settlement, and transformed about 75 percent of the native Tarai to agricultural land. A part of Bardiya was declared a wildlife reserve in 1976.which in 1988became the Royal Bardiya National Park (Wikipedia.2007)

The Bardiya National Park which lies towards the North East of Bardia. Is the largest and most undisturbed wild area of the tarai region of climate and more remote location, Bardiya encompasses 1000kmsquire of reverie grassland and Sal Forest (Wikipedia,2007) Bardiya has a total population of 3,83,720,out of which 1,93,041 are males and 1,90,679 are females (CBS,2001). The population density lies at 189kmsquire .which according to the CBS is slightly higher than the national average population density. In terms of ethnic composition, the Tharu, are the majority in the district, their number amounting to 2, 01,276 (52.60% of the total population of the district according to CBS 2001. In compliance with the population Tharu language spoken by majority of the population with regard to literacy, Bardiya does not boast of a largely literate population, and literacy rate in Bardiya is only 45.41% (CBS2001) whereas the national level average is 59.9% Bardiya falls behind the other districts in education. It is regrettable that female literacy rate is still lower at 26.3%.

4.1.2 The people of Bardiya

Tharu ethnic group which fall under the *janjati* (Ethnic) group, comprise the majority of Bardiya population at 52.60%of the total population. it is followed by Chhetri, then 9.45 percent of hill Brahmin, 3.36 percent of Kami, 3.02 percent of Muslims , 2.81 percent of Dhami, 1.56 percent of Sunar, 1.06 percent Yadav and 0.82 percent Tarai Brahmins (CBS,2001)

The major religion followed by people of Bardiya according to the CBS 2001, is Hinduism with 95.17 percent followers, Islam follows with 2.79 percent of followers, and Buddhism has 1.57 percent and other religion accounts for the remaining 0.27 percent.

- **Tharu**

Tharu who are the dominant ethnic population have been living in Bardiya district are the longest standing residents of the Nepal's fertile Tarai area. They are also Nepal's second largest ethnic group, with over 6.75percent of the national population, about 1,500,000 persons. (Gersony, 2003)

According to Nepali author Subodh Kumar Singh (as quoted by Wikipedia online encyclopedia), Junga Bahadur Rana, and the then prime minister of Nepal's indigenous legal system which divided the society in to a system of castes. The Tharus were placed at the bottom of the social hierarchy and their community disrupted. The land grant after the eradication of the malaria in 1960s, contributed to the movement of the other parts of the country to the Tarai, making the Tharus slaves of the new land owners and developing Kamaiya system bonding generations of Tharu families to labor.

4.1.3 Rajapur

Rajapur is also situated in the Rajapur delta with total households of 1876, out of which 1009 are landless people. With 6437 males and 6220 females the VDC has a total population of 12,657. The majority of the population is Tharu numbering at 7519 of the total population, followed by Muslim at 1157, the remaining others belong to various other cast and religious groups. The main economy activity of the VDC as quoted by the people is agriculture. (Data source: Oxfam and National Labor Organization, 2003)

4.1.4 Dhadawar

Dhadabhar VDC is the less developed village. This village largely populated by poor groups like Mushar, Kami, Dami, Yedav, Tharu, Kewat Doom and it is situated western part of the Bardiaya District.

The total population 4616 and the total households is 788.Out of the total population 2363 is male and 2252 are female. The main economy activity of the VDC as quoted by the people is agriculture. (Data source: Oxfam and National Labor Organization, 2003).

4.2 Distribution of ex-Kamaiya in Nepal

Various survey conducted by different I/NGOs and governmental records reported that the Kamaiya system was concentrated in five districts of mid and far western Regions of Nepal. So that Ex-Kamaiyas are also naturally distributed within the same districts i.e. in Dang, Banke, Bardiya, Kailali and Kanchanpur. The data of freed Kamaiyas distribution reported by the government and NGOs are found different Table 4.2 revels that the government and the NGOs are varied.

Table 4.1:

Distribution of Ex-Kamaiyas household in Nepal

District	Government Information					NGOs Information (Total HHs)
	Homeless and landless	Having house but Landless	Having(≤2 Kattha Land)	Other (<2 Kattha Land)	Total HHs	
Dang	175	230	371	351	1127	3,030
Banke	165	736	21	420	1,342	1,432
Bardiya	2,691	1,203	1,019	2,066	6,979	8,756
Kailali	2,647	2,477	199	350	5,673	6,157
Kanchanpur	2,453	482	137	98	3,170	3,302
Total	8,131	5,128	1,747	3,285	18,291	22,677

Source: Department of Land Reform, 2000Action aid Nepal, 2001.

The comparison government and NGOs data on Ex-Kamaiya revels difference of 23.9 percent in total. The NGOs figure seems closer to reality. Thus about 22 thousand Ex-Kamaiyas households are distributed in the five districts on Nepal. The distribution pattern of Ex- Kamaiya with respect to five districts, Bardiya is found more populated, followed by Banke, Kailali, Kanchanpur and Dang respectively.

4.3 Age and Sex Structure of Sample Household

Out of the total of 50 households surveyed, the total number of resettled EX-Kamaiyas at present at two villages (Rajapur and Dhadawar) was recorded 238. Numerically males were found to be slightly larger (117 or 49.16 percent of the total population) than females (121 or 50.84 percent of the total population). Table 4.3 shows the population composition population composition of sample resettled Ex-Kamaiyas according to age and sex structure.

Table 4.2:

Age and Sex Structure of Resettled Ex-Kamaiya

Age group(in year)	Population				Total	
	Male		Female		No	Percent
	No	Percent	No	Percent		
0-9	19	16.24	31	25.62	50	21
10-19	33	28.20	27	22.32	59	24.79
20-29	24	20.51	31	25.62	57	23.55
30-39	17	14.53	16	13.22	32	13.45
40-49	13	11.11	10	8.26	23	9.66
50-59	2	1.71	3	2.48	5	2.10
60-above	9	7.69	3	2.48	12	5.04
Total	117	100	121	100	238	100

Sources: Field Survey, 2011

In the above table 4.2, for simplicity total sample population 238 has divided in7 different age group. About 21 percent are below 10 years of the age. The ageing population (i.e. above 60) is only 5.04 percent compare to high population of 6.5 percent national average. It indicates the low life expectancy among the Ex-Kamaiya.

4.4 family and households size

The resettled freed kamaiya of the study area are live as nuclear families. Usually, the old couples live one of their eldest or youngest son's families. If they have more than one married son who decide to be separated from the family, the property is divided as equally as possible. Now a day, they prefer nuclear family rather than going and extended family because of their changing socio-economic reason. Table 4.3 shows the households size and population of surveyed households.

Table 4.3:

Sample Households Distribution by Family Size

Family Size	No. of Households	Percent	Population				Total	
			Male		Female			
			No.	Percent	No	Percent	No	Percent
1-2 or <2	7	10	3	2.57	4	3.31	7	2.94
3-4	10	20	15	12.82	16	13.22	31	13
5-6	23	50	60	51.28	58	47.93	118	49.58
7-8	5	8	15	12.82	20	16.53	35	14.71
9-10	4	10	18	15.39	18	14.88	36	15.13
11& above (≥11)	1	2	6	5.13	5	4.13	11	4.62
Total	50	100	117	100	121	100	238	100

Source: Field Survey, 2011

Above table 4.3 shows that most of the Households i.e. 50 percent have 5-6 no. of family members. The households who have 2-4 members in their family are just separated from their parents; in the study area 33 households have more than 4 members. And 17 households have small size i.e. below 4 members of family.

4.5 Occupation

Main occupation of Ex-Kamaiya is agriculture. But they do choose other occupation like wages labor, service, Business and agriculture production. Following table gives the actual figure of occupation done by them.

Table 4.4:

Occupation Status of Sample Households

Occupation	No. of households	Percent
Agriculture Labor	40	60
Service(government office)	2	4
Business(shop)	3	6
Other (driving, hotel etc)	5	10
Total	50	100

Source: Field Survey, 2011

According to this table, it is shows that which is the unskilled farm labor. Most of these households are naturally unskilled. The agriculture labor has the highest percent. This indicated that Tharu ethnic communities are skill working as agricultural labor. Though agricultural, in this district as the rest district in the main area for the occupation of the unskilled labor are farm labor.

In the study area 40 head of the respondent households are agriculture labor. I.e. 60 percent, 4 percent households are Service, 6 percent households are business, and 10 percent are other.

4.6 Education Status of Ex-Kamaiya

Education is one of the major means of change in any community. So, it has an important role for development of any society. The literacy rate of resettled Kamaiyas is less in comparison to other caste/ethnic groups of surrounding community. How, they are being attracted towards formal and informal education, which are provided by government and non-government sector. Their poor economic condition, work load, lack of opportunity does not support to get the education for all the children. Education status divided into two groups Literate and Illiterate. The education status of sampled population is presented in the table 4.5 given below.

Table 4.5:

Education Status of Ex-Kamaiyas of Study Area

Education Status	Population				Total	
	Male		Female		No	Percent
	No	Percent	No	Percent		
Literate	61	57.55	63	53.85	124	55.61
Illiterate	45	42.45	54	56.15	99	44.39
Total	106	100	117	100	223	100

Source: Field Survey, 2011.

*Note: Children (15) have not been considered by literate or illiterate.

Among the total of 223 people, 124 (55.61%) are literate population and 99(44.39%) are Illiterate population. The data shows that illiterate population is less as compared to literate population. This is contributed by the informal education program and increase in awareness.

4.7 Shelter Status:

Health and Sanitation was affected by shelter status. Out of the 50 households 30(60%) have used of Goth (shelter).According to data most of the Kamaiyas are uses Goth. And 18(36%) households not uses of Goth (shelter) 2 (4%) households have not bear animal. (Table4.6)

Table 4.6:

Shelter Status of X- Kamaiyas

Descriptions	No. of Households	Percent
Uses of *Goth* (shelter)	30	60
Not uses of Goth(Shelter)	18	36
No animal	2	4
Total	50	100

Source: Field Survey, 2011

4.8 Having Room of Ex-Kamaiya

Sanitation has exploited by congested room. Out of the 50 households 26(52%) households have used one room. And 22(44%) households have used two rooms. And 4% households use more than 3 rooms. (Table 4.7)

Table: 4.7:

Having Room of Ex- Kamaiya

No of Room	No of households	Percent
One	26	52
Two	22	44
More than 3	2	4
Total	50	100

Sources: Field Survey, 2011

4.9 Drinking water and Sanitation

Pure drinking water is the most necessary things for sanitation and healthy life. Drinking water is one of the main affecting factors of health and sanitation. On in the past, the rural people used spring and public well for drinking water but now public taps and tube well are in their villages. Therefore, the sources of drinking water are taken as an indicator to find out the health situation of the study area the detail is given in the table below.

Table 4.8:

Sources of Drinking Water of Sample Households

Sources	No of Households	Percent
Public Tap	34	68
Tube Well	16	32
Total	50	100

Source: Field Survey, 2011

From the above table among 50 households, 68 percent of households used the public tap for pure drinking water, 22 percent used private tube well used water for daily use.

4.10: Toilet Condition of Ex-Kamaiya

In the past, there was no tradition of making toilets and using them in rural areas. So they go nearby bushes and streams for excretion for excretion. Now, some households of the rural area are using *Kachhi* toilet. Table 4.9 shows the toilet using of Households.

Table 4.9:

Toilet condition of EX-Kamaiya

Attributes	No of Households	Percent
Kachhi Toilet	28	56
No Toilet	22	44
Total	50	100

Source: Field Survey, 2011

In the above table 4.9, among 50 households the majority i.e. 56 percent used the *Kachhi* toilet and 44 percent have no toilet. So they used the nearby Khet, Nahar and where their suitable open area. Toilet using practice is increased by governmental and non-governmental promotion to the people to build the toilet.

4.10.1 Place Use for Toilet

Most of the respondents have not their toilets. They go to Khet, Nahar, and open field for toileting. The following table shows the place used for toileting in the study area.

Table 4.9.1:

Place Use for Toilet

Description	No. of Households	Percent
Khet	9	40.90
Nahar	6	27.27
Open Field	5	22.72
Way	2	9.09
Total	22	100

Sources: Field Survey, 2011

According to the above table, among the total 22 respondents who did not use toilet, 40.90 percent of the respondents used Khet in study are.27.27 percent used toileting in Nahar, 22.72 percent used open field and 9.09 percent of respondents used way for toileting.

It is concluded that majorities of family use for toilet khet. This practice is harmful for their Health and Sanitation condition. It is due to lack of importance of toilet, health knowledge and poor economic condition.

4.11 Garbage Disposal

Household's waste material/garbage is the root cause of making environment dirty and unhygienic for health. Most of the rural villagers are still not aware about their surrounding environment and they throw wastages everywhere. But, now by taking different trainings about homemade wastage maintains, they are practicing to make compost, fertilizer and keep the surrounding areas clean. Therefore the detail about practice of disposal of sample households is shown in the table.

Table 4.10:

Practice of Garbage Disposal of Sample Households

Attributes	No. of Households	Percent
Pilling on open space	30	60
Pilling in fixed area	15	30
Other place	5	10
Total	50	100

Source: Field Survey, 2011

The table shows that 60 percent households were pilling waste materials into an open space, 30 percent pilling in fix place.10 percent throwing other place.

4.12 Immunization status of child

Immunization is the most important components which help to reduce high child mortality. According to the World Health Organization (WHO), a child should be given one dose of BCG, three doses each of DPT and Polio and one does of Measles as complete doses of vaccine. All these vaccines should be completed to a child within twelve month of age. Immunization of Ex-kamaiya children is presented in the following table.

Table 4.11:

Immunization status of Ex-Kamaiya Children

Description	No. of vaccination of Children	Percent
Yes	47	94
No	3	6
Total	50	100

Source: Field Survey, 2011

It is shows that the immunization status of children of Ex-Kamaiya community is very good. It is found that 94 percent people had immunized their baby and 6 percent people had not immunized their baby. There was a cause of drop-out and not take any doses of vaccine, mainly the cause was lack of knowledge about immunization.

4.13 Use of Family Planning measures by MWRA among Ex-Kamaiya

Family planning means to avoid unnecessary birth and to maintain size of family according to need and want. Family planning practice refers to the practices that help couple to avoid unwanted birth and determined the number of children in the family. Family planning status divided into two

group's uses of family planning and no uses of family planning .The number of family planning measures users by MWRA (Married women of Reproductive Age) is given below table 4.12

Table 4.12:

Number of Family Planning Measures Users by MWRA

Description	No. of MWAR Ex-Kamayas	Percent
Uses of Family planning	44	80
No uses of Family planning	11	20
Total	55	100

Source: Field Survey, 2011.

According to the data mentioned in the above table 80 percent MWRA had applied family planning measures and remaining 20 percent MWRA had not applied any contraceptives.

It is concluded that majority women of reproductive age (MWRA) used family planning methods.

4.14 Delivery, Location and Assistance

Traditional Nepalese children are delivered at home with the assistance of Sudeni or elders of the community. If the children are delivered at home, there is high health risk or mother and children because of lacking medical attention and hygienic condition during delivery. In the study, only one child was born in hospital and other all at home.

Assistance during delivery is also the most important factor of determine the prenatal health care. In Nepal, family member and Sudeni (traditional birth

assistant) are the main persons involving in delivery assistance. *Guruwa* (Traditional healers) are also the main persons involving in delivery assistance of Tharu community. It has been observed in the Ex-Kamaiya families that deliveries have been assistance by health workers or doctors only when mothers are in serious condition like heavy bleeding, the body can't come out and placenta won't come out. The detail information is presentation in the table below.

Table 4.13:

Assistance during delivery in Sample Households

Assistance during Delivery	No. of Children	Percent
Own HHs member	7	4.83
Sudeni and Doctor	1	0.67
Nurse	1	0.67
Sudeni and Guruwa	9	6.21
Sudeni	127	87.89
Total	145	100

Source: Field survey, 2011

Above table clearly shows that in 145 deliveries of the sample households, 87.89 percent deliveries by *Sudeni* and family members and4.83 percent deliveries at home of the sample households.

4.15 Choice of health service among Ex-Kamaiya

In rural society health is the synonyms of *Dhami/Jhankri*. The people still believe in Lago, Boksi etc. when anyone falls sick, the patient is sent firstly to their own Guruwa. If the patient does not recover than the patient is carried to the nearby health Centre and hospital. But treatment practice during illness is directly related to the health situation of human being. Therefore, the practice of treatment during illness of sample households also studied. The table given below describes the treatment practice of sample households in first priority basis.

Table 4.14:

Choices of Health Services among Ex- Kamaiya

Treatment practice	No. of households	Percent
Guruwa	22	44
Health Post	20	40
Both	8	16
Total	50	100

Source: Field Survey, 2011

In the above table 4.14, the majority 44 percent of sample households have beloved that people become sick because of Bhutta (Ghost, witches), so Guruwa involves the deities of his patient to protect from illness. Some of them maintain that they would take ill persons to their own Guruwa at first because they are available at every settlement and provide free treatment. 40 percent of the samples households have maintain that they have beloved in doctor and nurse, doctor but not in Guruwa, so they would take ill persons at

health post first. According to them, they would take ill persons to the Guruwa also if the illness is not cured. Similarly 16 percent visit both Guruwa and health post.

4.16 Washing Hands after Toileting

Washing hand after toileting is the most important. If anybody does not wash hands after toileting, it is dangerous for health. It creates various health problems, such as diarrhea, cholera, dysentery etcetera's. People's habit of washing hands after toileting of the study area is given in the following table.

Table No.4.15:

Habit of Washing Hands after Toileting

Description	No. of Respondent	Percentage
Washing hands after toilet	40	80
No washing hands after toilet	10	20
Total	50	100

Source: Field Survey, 2011

The above table shows that among the 50 respondent still 20 percent people does not wash their hands after toileting and 80 percent people wash their hands after toileting.

It is concluded that some people still do not wash their hands after toileting. So, it can be said that wrong health care practice in one of the cause of spreading diseases in this community. This kind of practice affects the health of the people and community too.

4.17 Major Health Problem among Ex-Kamaiyas

Ex-Kamaiya is more illiterate, exploited and poorest indigenous segments of the Nepalese people. They believe and follow their own tradition. They mostly consult their witch doctor (*Guruwa)*. Than believe and follow their own tradition. They mostly consult their witch doctor. Many Ex-Kamaiya are also again going to the trap of indebt nets for fulfilling food deficiency and basic needs. The condition of resettle in terms of health and sanitation is also found not satisfactory. The major health problems of the freed Kamaiyas are given in the following table.

Table 4.16:

Major Health Problem of Ex-Kamaiya

Diseases	No of Households	Percent
Diarrhea	25	50
Fever	16	32
Dysentery	4	8
Malaria	3	6
Skin Diseases	2	4
Total	50	100

Source: Field Survey, 2011

The above table shows that 50 percent households expressed diarrhea is the most common problem in summer season,32 percent households were suffered from fever,8 percent households were suffered from dysentery,6 percent suffered from malaria and 4 percent suffered from skin diseases. It was found that majority of the people among Ex-Kamaiya were suffered

from diarrhea, fever and dysentery. Due to lack of neat and clean their houses and surrounding, most of them faced such problems. These are also leaded due to reasons of education and economic condition.

4.18 Situation of Health Awareness among Ex-Kamaiya

Kamaiya were those who were primarily landless and who lacked access to means of subsistence. They were completely dependent upon their landlords. They were forced to do whatever they were asked to do because their bread butter was in the hand of their landlord. After the declaration of their freedom and redistribution of land to them their situation in not so improved because they are mostly resettled in the public and closer to forest area or in the bank of water. Generally in the initial phase of their freedom, they were less conscious about their health and they were not habituated to adopt modern medical facilities because of their illiteracy, poverty and superstitions belief. Because of their lack of adequate food, clothes, safe drinking water supply and condition of house and sanitation facilities, they were suffered from illness and severe disease.

But with the passing of time, Ex-kamaiyas are becoming more conscious to adopt new alternatives of traditional practices. During the field observation, they are found in the initial stage of charge in socio-economic as well as their views regarding health. The degree of awareness on education, health and sanitation is increasing among them. Now, to some extent they have been more health conscious with their public contact. Their awareness about health is increasing because of their access to health centers and health education compared to the earlier situation.

4.18.1 Satisfaction of awareness Trainings

Regarding the training availability, only 8% have got opportunity of training related to health and sanitation while 32% have got training facility which is not sufficient. It means they have got only basic training.60% households have no opportunity of training (Table 4.17)

Table 4.17:

Satisfaction of awareness Training

Particulars	No of Households	Percent
Trained	4	8%
Partially trained	16	32%
No training	30	60%
Total	50	100

Sources: Field Survey, 2011

4.18.2 Awareness about Malnutrition among Ex-Kamaiya

Good nutrition is a fundamental right of people. It remains a serious obstacle to survival, growth and development to poor people. Mostly rural poor are affected from it. In Nepal, 18.3 percent of the children had suffered from malnutrition in FY 2000/1 (Economy Survey, 2001/02). Malnutrition places enormous burden open children and women in Nepal. Evan mildly and modernly malnourished children are more likely to die from common childhood diseases than adequately nourished. It is also closely associated with impaired child development.

The population of Ex-Kamaiya is the most marginalized in the country. They are poor, illiterate and lack of balanced diet. Their settlement are characterized by high population densities, lake of sanitation facilities, lake of health services and facilities help to make confect malnutrition among Ex-Kamaiya families. Awareness about malnutrition among Ex- Kamaiya is shown in table (4.17.1)

Table4.17.1:

Awareness of Malnutrition among Ex-Kamaiyas

Description	No. of Households	Percent
Knowledge about Malnutrition	26	52
Unknown about Malnutrition	24	48
Total	50	100

Source: Field Survey, 2011

From the above table, it is clear that among 50 households, 48 percent are not aware on malnutrition and other 52 percent have mentioned that it is one type of disease and only children are affected from it. According to them, lake of balanced diet and green vegetables are the main causes of malnutrition. From the field visit, it is observed that they have given much priority to their work then their children, so children have not get proper care from their parent. All Ex-Kamaiya family are facing food defect, member of family may feel insecure and their entire activities revolve around the struggle for two meals a day. To get balanced diet by Kamaiya families seems impossible. So only vitamin A and vaccination program to their children can't be succeed to solve the problem of malnutrition in Kamaiya family. Therefore, awareness programmed on malnutrition and programmed

to solve food grain of freed Kamaiya families should be launched by different sectors.

4.19 Access to Nearest Health post

They have to depend on the sub health post of their village as there are no private clinics too. It is about 30 minutes far from where they stay. They face a lot of problems taking their patients to the sub health post because they don't have proper transportation facilities and most of them believe in *Guruwas*. They have been filled with traditional beliefs which cause lots of troubles to the patients. In some cases these beliefs lead the patients to death because they hang around the *Guruwa* even in serious diseases.

CHAPTER-FIVE

FINDINGS, CONCLUSIONS AND RECOMMENDATION

5.1 Major findings of the Study

Health and Sanitation is most important to improve the quality of life. A healthy person is a pillar of nation's development. So, we know popular dictum 'Health is Wealth'. If the people are not healthy, the development of citizens and nations is quite impossible. In Nepal high fertility is one of the major problems for population growth. Low literacy rate, low economic status, lack of employment opportunity, ignorance about health and health care services are the major factors affecting the health status of the ex-kamaiyas people.

Since, agriculture is central to the employment issues in Nepal, the landless and marginal families are mainly subsisted on wage income particularly on farm wage. The Kamaiya system is a form of permanent labor relationship. The Kamaiya farm labor arrangement was mainly practiced in five mid and Far Western Terai district of Nepal. With restoration of democracy they got complete liberation for their age- old bondage relation on 17th July 2002. Though, Kamaiya system is abolished; it may raise other social evils such as child labor, illegal earning activities etc.

This study attempts to explain the access to health and sanitation of Ex-Kamaiya families in Bardiya district. Especially this study focus that toilet using practice, Garbage disposal, Drinking water facilities, Awareness about health and sanitation, Family planning condition and major health problem. For this study, 50 sample households from total households of Rajapur VDC are taken by simple random sampling technique. To analyses this study, the

primary sources of data information is taken into account, which is collected by researcher himself with the help of structured questionnaire. And different techniques such as field visit, household's survey, interview, observation and focus group discussion were used to collect primary data. For data analysis descriptive as well as quantitative statistical methods have been used.

The main findings of the study are as follow:

- 22 thousand Ex-Kamaiyas households are distributed in the five districts on Nepal. Bardiya is found more populated, followed by Banke, Kailali, Kanchanpur and Dange respectively.
- Total sample population of male is 117, which is less than female i.e. 121.
- The average household size of the study area is 5.5 where as the national average households size is 5.44.
- The analysis of occupation structure of Ex-Kamaiyas shows that 80 percent engaged in agriculture labor and other 20 percent engaged service, business and other field.
- The field survey clearly shows that only 55.61 percent Ex-Kamaiya family members were literate other illiterate.
- The 48 households have pets only 6o percent households have Shelter (Goth) and 36 percent household's have-not Shelter (Goth).
- Out of the 50 households 52 percent have used only one room, 44 percent have used 2 room and 4 percent households use more than 3 rooms.
- 68 percent households have got drinking water in common near their house.
- Among 50 households 56 percent used the Kachhi toilet and 44 percent have no toilet. Majority of the Kamaiyas people used open field this practice is harmful for their health and sanitation.

- Out of sample households 60 percent households were pilling waste materials into an open space, only 30 percent pilling fix place and 10 percent throwing other place.
- Immunization status of children of Ex-Kamaiyas is good. It is found that 94 percent people immunized their baby and 6 percent people had not immunized their baby.
- 80 percent married women of reproductive age have applied family planning and 20 percent had not applied any contraceptives.
- 145 deliveries of the sample households, 87.89 percent deliveries by Sudeni and family members and 4.83 percent deliveries at home.
- More than 40 percent were taken at health post to treatment at first but 44 percent Ex-Kamaiyas have given answer that they would take ill persons at the Guruwa.
- Out of 50 respondent still 20 percent people does not wash their hands after toileting and other 80 percent people wash their hands after toileting. This kind of practice affects the health of the people.
- Majority of the people among Ex-Kamaiyas were suffered from diarrhea, fever, dysentery, and malaria and skin diseases problem in the study area.
- Only 8 percent have got opportunity of training related to health and sanitation while 32 percent have got training facility which is not sufficient and 60 percent households have no opportunity of training.
- Out of 50 households 48 percent are not aware on malnutrition and other 52 percent people aware on malnutrition.
- In overall the health and sanitation status of Ex-Kamaiyas people of Rajapur and Dhadawar VDC is very poor and they have been living in miserable condition such as early marriage, lack of health knowledge, lack of

sanitation knowledge, unscientific treatment practice, poor economic condition, lack of hard work, less conscious about health care practice etc.

5.2Conclusion

A healthy person is a pillar of nation's development. Among factors in the factors affection in the determination of health or disease health care practice is major one. Especially the health and sanitation status of people depend on health care practice.

Now Ex-Kamaiyas are becoming conscious to adopt new alternatives of traditional socio-economic and cultural practice. So they are in initial stage of social-economic change. The degree of awareness on education, health and sanitation is increasing among them. They are not consulting traditional healers only when they become sick. Some ex-kamaiyas did not believe on *Guruwa*. They are utilization modern health services. But also most of the ex-kamaiyas people are labor. They are physically and economically very poor. They have to depend on sub health post of their village there are no private clinic too. It is about 30 minutes far from where they stay. So they face a many problems. They do have very difficult to solve morning, evening eating problem they are busy for this. So that they do not have time for sanitation and they suffered from sick.

5.3 Recommendation

This research study on ex-kamaiyas in Rajapur and Dhadawar VDC has found major health problem due to the lack of proper health care practice. On the basic of the above findings, conclusion and the researcher field survey experiences, the following recommendation have been presented for the future improvement of the existing situation.

1. Awareness is the most important factor for maintain the sanitation and health status. There for awareness classes should be managed by the government.
2. Government has helped them for the toilet. There will be good sanitation if they have biogas with joining toilet. So that they need not to fire wood and the house will not be black and it is not harmful for their health.
3. Ex-kamaiyas are very poor so that I/NGOs should start skill development program and income generation activities on the basis of market and capacity of ex-kamaiyas.
4. Special packages of programs should be made by government as well as private organizations and agencies in this backward community to uplift their health status as well as overall their living standard.
5. Lack of proper management of drinking water and toileting is one of the major health and sanitation problems. Therefore, provision of safe drinking and sanitary toilet should be managed by both of the government and non-government sectors.

6. In the study area, there is no health Centre so government should be opened health clinics in each ex- kamaiyas settlement and provide freed medical treatment.
7. As most of them are involved in agriculture they should be well trained with knowledge of using fertilizer, seeding, and manage west to made compost manure production for their improvement in agriculture product.
8. Regular health services should be provided in free of cost by card system for the betterment for the health.
9. In the study area untrained traditional birth assistance are the main persons involved in delivery assistance. Therefore, proper training should be given government to this service providing.
10. The government should develop strong policies for promotion of health service.
11. In the study area, there is lack of infrastructure, low income, and low level of employment opportunity. Therefore the poverty situation in the area is very serious. So, it is recommended that government should be created employment opportunity and developed infrastructure in the study area.

Finally, the findings, conclusions and recommendations, derived above are expected to be a useful feedback to the concerned.

BIBLOGRAPHY

Banerjee, M (2008). Freed Kamaiya Society in Nepal. *I-Volunteer Overseas*, October 7, 2008.

Central Bureau of Statistics, (2003/04).*Nepal Living Standards Survey 2003/04*(Kathmandu: Central Bureau of Statistics).

Cheria, Anita (2005). *Liberation is not enough*: The Kamaiya Movement in Nepal. Action aid Nepal, Kathmandu.

CIA, (2010). *The world Fact book*. The Central Intelligence Agency The Work of a Nation.

CBS: 2001/2*: District Demographic Profile of Nepal*, Central Bureau of Statistics.

GEFONT, (2001). *Impacts of Intervention on Kamaiya Study,* Study Report submitted to ILO/IPEC, Kathmandu, Nepal

Gersony, 2003, Sowing the winds*: History and Dynamics of the Maoist Revolt in Nepal's Rapti Hills*: Mercy Crops International.2003.

Government of Nepal, (2001).*KamaiyaLabour Prohibition Act,* 2001. Informal Sector Service Centre, (1992).*Bonded Labour in Nepal*:Under KamaiyaSystem.Pp.34.Kathmandu, Nepal.

International Labour Organization, (2003).*Baseline Study for Nepal* (Final Draft) October 2003, South Asian Debt Bondage Project.

Lewis, M.P. (ed) (2009). *"Tharu, Chitwania- a language of Nepal"*. Ethnologies: Languages of the World, Sixteenth edition. Dallas, Texas. Retrieved 2010-07-03.

McLean, J. (1999). *"Conservation and the impact of relocation on the Tharus of Chitwan, Nepal"*.Himalayan Research Bulletin, XIX (2): 38-44.

Mathema, Padam (1987), *PrimaryHealth Care in Nepal*. Kathmandu: Publisher VijayaMathama.

MOH (2002), *Second Long Term Health Plan (1997-2012)*, Annual Report. Department of Health Service 2001/02, Kathmandu: UNEPA.

Rajaure, D.P. (1981). *"Tharus of Dang: The people and the social context"*. Kailash- Journal of Himalayan Studies, Volume 8, Number 3 and 4: 155-185. Retrived 2010-07-04.

Shiddiqui A. Rafeaque (2008). *Socio-Economic Status of Ex-Kamaiyas in Nepal.* An unpublished dissertation submitted to Central Department of Rural Development Faculty of Humanities and Social Sciences, Tribhuvan University, Kirtipur, Nepal.

Shaha, Rishikesh (1992). *Ancient and Medieval Nepal.* New Delhi: Manohar Publications.

Srivastava, S.K. (1958). *The Tharus: A study in Cultural Dynamics*. Agra: Agra University Press.

Subedi, Tejprakash (1999), *Boundedlabour in Nepal: A sociological Study of Kamaiya System in Khairichandanpur VDC of Bardiya District*. An unpolished M.A. Dissertation, Submitted to the Central Department of Sociology/Anthropology. T.U.,Kathmandu.

Terrentato L., Shrestha S., Dixit K.A., Luzzatto L., Modiano G., Morpurgo G., Arese P. (1988) *"Decreased malaria morbidity in the Tharu people compared to sympatric populations in Nepal"*. Annals of tropical medicine and parasitology 1988 Feb; 82(1):1-11. Retrived 2006-12-07.

World Organization Aagainst Torture (2006). *"The Kamaiya System of Bonded Labour in Nepal"*. A study prepared by World Organization against Torture for the International Conference Poverty, Inequality and Violence: is there a human rights response? Geneva, 4-6 October 2005.