

A STUDY ON KNOWLEDGE AND CARE PRACTICE OF MOTHERS REGARDING CSOM IN NAWALPARASI DISTRICT



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Submitted in partial fulfillment of
the requirements for the degree of
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Bachelor of Nursing Program from
Tribhuvan University, Institute of Medicine,
Nursing Campus, Maharajgunj.

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April 2002

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ABSTRACT

This small-scale study is conducted in Kumarvarti VDC, Nawalparasi district, during the month of April-June 2000. The subject of study entitled is Knowledge and Care Practice of Mothers regarding CSOM.

This study was carried out using a descriptive exploratory methodology. Maintaining of the validity and reliability of instrument, sample size taken was 50, out of which 25 were the mothers of Tharu children and 25 were mothers of Pahadiya children. Data were collected using very comprehensive semi-structured interview schedule maintaining ethical consideration. The collected data were analyzed by using a descriptive statistical process.

The findings of the study are consistent with the set hypothesis. Low socio-economic status, practice of using mustard oil or instillation of various types of liquid in the ear, ear pricking habit, blowing nose, entrance of water during bathing or swimming, laying down position during breast feeding, and recurrent URTI are the common factors in the causation of CSOM.

This study recommends that the problems of Ear infection should be controlled and cured by proper medical and surgical management. Proper health education and precautions could prevent a vast majority of cases.

CSOM was found to be common in both Tharu and Pahadiya communities-67 out of 103 Tharu households (ie 65.05 percent) and 38 out of 89 Pahadiya households (i.e. 42.7 percent) had children with CSOM.

CSOM was predominantly seen in male children in both communities (76 percent were male children in Pahadiya community and 56% in Tharu community)

It was seen from the study that URTI was strongly related to CSOM. 48 percent of Pahadiya children with CSOM and 56 percent of Tharu children suffered from 6 or more episodes of common cold in a year. 80 percent of Tharu children and 40 percent of Pahadiya children with CSOM enjoyed swimming. 96 percent of Pahadiya mothers and 80 percent of Tharu mothers put oil or other home remedies in their children's ears.

64 percent of Pahadiya children and 60 percent of Tharu children suffered from some degree of hearing impairment associated with CSOM.

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CHAPTER-I: INTRODUCTION

1.1 BACKGROUND OF THE STUDY

Nepal is the small country with the area of 1,47,181 square KM and the population of 2,32,14,681 (CBS, 2001). This is one of the least developed countries where 90 percent of population lives in rural areas and only 39.6 percent of the people are literate (CBS, 1991). While the developed countries are more concentrated with the diseases of the modern world (Cancer, Cardio-Vascular Diseases etc), Nepal is still fighting with the infectious diseases. This is mainly due to the existing illiteracy, poor socio-economic status, magico-religious beliefs and physical and mental tolerance for the disease among the people.

CSOM is highly common among the children of Nepalese population. This is the major condition-giving rise to hearing impairment and disability. Very few people know that CHOM can take away their lives if not treated in time.

By simply increasing the people's knowledge about the preventive aspects of CSOM, we will be reducing a great number of morbidity, disability and mortality arising from this ear condition. Poor attitudes towards ENT problems is another very important factor contributing to morbidity, disability and mortality, so bringing changes in the people's attitude can bring change in the trends of the same.

The commonest cause of deafness in Nepal as per hospital records is COSM. A report of the sample survey of disabled persons in Nepal in 1981 has revealed that hearing impairment is the number 1 physical disability in Nepal.' According to Bir Hospital, ENT Department, in 1970, 72 per cent of all patients suffering from ear diseases that attended the ENT OPD were suffering from hearing impairment that represented 41 per cent of all ENT patients.

From Baisakh 2043 (2986 AD) to Chaitra 30, 2047 (1990 AD), a total of 611 pediatrics ENT cases were operated in TUTH. Out of those cases, 56.5 per cent were ear infections, 23.8 per cent were throat, 4 per cent were of nose and 5.5 were of the head and neck.

A report published by the ENT Department of TUTH for the period of mid 1990 to mid 1991, shows that, among 18,845 ENT patients, the number with the ear infection was the highest, 44.37 per cent. Nose disease comprised 27 per cent, throat disease 2.02 per cent and of all the ENT cases 14.4 per cent were CSOM.

The first District Ear Survey of Nepal in 1990-1991 was conducted jointly by the ENT Department of TUTH-BRINOS, England and the Department of Community Medicine, IOM. The surveyed districts were Salyan, Mugu, Banke, Jhapa, Panchthar and Sankhuwasabha. The survey revealed that there was high prevalence of diseases among the people, approximately 17 per cent. However, 35 per cent of the cases were preventable deafness. Two third of the affected were school going children and deafness was due to otitis media. Of these, CSOM-AA was 10.9 per cent, CSOM-TT 7.2 per cent and acute otitis media 0.38 per cent.

Matin MA and others (1997) studied 112 patients of CSOM in the department of otolaryngology, Sir Salimullah Medical College, Dhaka, Bangladesh, their reports revealed that 89.3 per cent cases presented with different CSOM complications and 10.7 per cent with no complications. They identified poor socio-economic condition and lack of hospital facilities as the causative factors of CSOM.

Bafaqeeh S.A. and others (1994) examined and screened for hearing loss among 6,421 Saudi children in the King Abdul Aziz University Hospital of Saudi Arabia. Their study revealed that hearing impairment prevailed in 494 children. Out of these, 326 were due to CSOM and 108 due to sensory-neural hearing loss (SNHL)

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'Unity in diversity' can best explain Nepal. It has different geographical regions, Himalayas, Mountains and Plains and various numbers of ethnic groups residing in these areas. Disease is a condition of multi-factorial causation.

Geographical variation as well as ethnic variation contributes to the varying frequency of disease. CSOM is also a similar condition in which there are different contributing factors, the major being the geography, ethnicity and the socio-cultural practices. Different communities have different socio-cultural practices contributing in the causation of CSOM. Identifying these practices will be of immense value in the prevention of CSOM and deafness on the whole.

Tharu community is an indigenous population residing in the Doons and the Plains of Nepal for years with the typicality of socio-cultural practices. Later on different ethnic groups migrated from hills to these areas, but, their presence has merely affected the socio-cultural practices of the Tharu community, so, the infection associated with or contributed by these practices occur in different frequencies in these communities. CSOM is one of these infections, where comparative study will be of immense significance in the prevention of the same.

CSOM is the infection of the middle ear cleft in which there is persistent ear discharge for more than two weeks. The commonest cause of CSOM is bacterial infection. There are two types of CSOM, Attico-Antral and Tubo-Tympanic. Attico-Antral being more grave. CSOM is an infections, which can be prevented easily, but unless treated in time, its complications give rise to morbidity lasting for whole life or can even be fatal if the complication like brain abscess ensues.

The traditional practice of putting mustard oil in the ear and practice of blowing nose forcefully are two important causes of recurrent discharge from the ear. In fact, the most common cause for infection is the regurgitation of milk and

nasopharyngeal secretion through the Eustachian tube into the middle ear. CSOM usually starts in infancy or early childhood because URTI is more common in this age group.

Recurrent infections occur by the entry of water into the middle ear through the existing perforation during bathing or swimming in the ponds and rivers. Some people clean their ears with sticks, hairpin and feathers-such types of practices may introduce infection into the ear.

CSOM is very common in our country mainly due to the ignorance, poverty and inadequate health facilities. Prevention is better than cure. Increasing the awareness about the infection among the people can prevent CSOM. With proper and timely management it can be cured and the complications prevented.

1.2 STATEMENT OF THE PROBLEM

Deafness is one of the serious health problems in Nepal. It is one of the major causes of disability. It is estimated that 16.6% of the population suffer from some degree of deafness and 35% of all the deafness is preventable (1991 National Survey by BRINOS and TUTH).

CSOM is a worldwide problem especially in the developing countries. The growing number of hearing impairment due to CSOM, which has been considered to be the number one preventable ear infection by WHO is still a serious problem in developing countries like Nepal, where most of the people live in villages and remote areas.

CSOM is highly prevalent among the school going children. It is a major ear condition with different contributing factors, if dealt seriously, can be well prevented. So, I was tempted to choose this topic as a subject of my study.

1.3 PURPOSE AND RELEVANCE OF THE STUDY

The growing number of hearing impairment due to CSOM, which has been considered to be the number one preventable ear disease by WHO, is still a serious problem in Nepal. It has different contributing factors associated with different socio-cultural practices, identification of which is of utmost importance for the preventive measures of it.

1.4 OBJECTIVES

1.4.1 General Objective

- 1) To identify the knowledge and care practices of mothers regarding CSOM

1.4.2 Specific Objectives

- 1) To assess the knowledge of Tharu and Pahadiya mothers regarding CSOM.
- 2) To identify the care practices of mothers regarding CSOM.
- 3) To identify its prevalence according to socio-economic conditions.

1.5 OPERATIONAL DEFINITIONS OF TERMS

- 1) **CSOM:** - Persisting ear discharge from one or both ears for 2 or more weeks.
- 2) **Women:** - Mothers of children with unilateral or bilateral ear discharges within the last one-year.
- 3) **Children:** - School going children (5-14 years of age) with unilateral or bilateral ear discharges within last one year.
- 4) **Knowledge:** - Anything expressed by the respondents regarding concerned topic.

- 5) **Practice:** - Activity contributing to the causation of CSOM.
- 6) **Literate:** - Who can read and write only
- 7) **Illiterate:** - Who cannot read and write.
- 8) **Poor:** - Income not sufficient to sustain throughout the year.
- 9) **Mediocre:** - Income just sufficient to sustain throughout the year.
- 10) **Well off:** - Those who save 10,000 or more per year.
- 11) **Nuclear Family:** - Refer to a unit consisting of spouses and their dependent children.
- 12) **Joint Family:** - Refer to a family system of spouses and their dependent children.
- 13) **Extended Family:** - Refers to a family system in which several generations live in one household.
- 14) **Home Remedies:** - Ear-drops prepared at home local resources.

1.6 VARIABLES

1.6.1 Independent Variables

- Age
- Sex
- Socio-cultural practices
- Socio-economic status
- Literacy
- Health beliefs and practices

1.6.2 Dependent Variables

- CSOM
- Hearing impairment

1.7 Hypotheses

- a) CSOM is seen in those children with the habit of pricking ears and blowing nose forcefully.

- b) CSOM is more common in those children with recurrent URTI.
- c) There is high incidence of CSOM in children who have the habit of swimming.
- d) Malpositioning while feeding leads to higher incidence of CSOM.
- e) There is higher incidence of CSOM in low socioeconomic status groups.
- f) CSOM is more common in Tharu children than Pahadiyas.
- g) Children of illiterate parents have higher incidence of CSOM.
- h) Most of the children with CSOM have had put oil or other liquids in their ears by their mothers.

CHAPTER-II: LITERATURE REVIEW

2.1 REVIEW OF SELECTED LITURURE

Literature review is the backbone of the study to be conducted. Its importance in the field of research cannot be undermined. So, review and scrutinization of different studies carried out at different places in different period of time and their findings is a must for a useful and comprehensive study.

Different books, articles and publications were reviewed, Internet browsed and teachers consulted regarding the subject matter and the studies of CSOM.

CSOM is the infection of the middle ear cleft in which there is persisting ear discharge for more than 2 weeks. The commonest cause of CSOM is bacterial infection. CSOM occurs when proper and timely management is not done. There are two types of CSOM, Attico-antral and Tubotympanic. Attico-antral being more grave. CSOM is a disease which can be prevented easily but if not treated in time, its complications give rise to morbidity lasting for the whole life or can even be fatal if the complications like brain abscess ensues.

CSOM is more common in children because they are more vulnerable to infection due to lower immunity. The Eustachian tube morphology in children, which is, shorter, wider and more horizontal than in adults, also makes them more prone to CSOM. The middle ear cleft in children contains more myxoid tissue, which is more susceptible to infection. Upper respiratory tract infection is more common in children, which is an established predisposing factor for the causation of CSOM.

CSOM is a very common disease. It is the commonest disease entity-giving rise to hearing impairment and disability. Many studies and surveys have been carried

out to identify the prevalence, contributing factors, outcome and other aspects of CSOM throughout the world.

CSOM is said to be more common in the developing countries like Nepal and is especially common in children.

In one study carried out in TUTH, among the 1549 cases admitted in the ENT ward in the FY 057-058, 330 of them, which is 21.3% of the total were of chronic suppurative otitis media cases. Among these 330 cases of CSOM, 93 of them, that is 28.13%, were children below 14 years. Here also, the number of male children having CSOM was much larger than the female children. 65.6% were male children and the remaining were female.

In a national survey carried out in 6 districts of Nepal in 1991 by TUTH and BRINOS, it was found that deafness was one of the serious health problems and the major causes of disability. 16.6% of the population suffered from some degree of deafness and 35% of all the deafness being preventable (commonest being CSOM). It was particularly common in younger age group. So, it was recommended that easiest way to prevent a significant proportion of hearing impairment was by focusing on school children.

In another study published in Journal of IOM, 1993 by RCMA, RPS and KBS, Ear Problems were found to be very common but neglected in most parts of the country. Their recommendation was to train the generalist to combat the common ear problems like CSOM.

In a medical report published by the royal medical camp Surkhet in 1988, the total number of ENT cases were 30,66 (9%) out of 33,985 cases and the commonest cause for hearing impairment being CSOM.

In one study carried out by R.K. Gupta et al in Allahabad district, India, and published in Indian journal of Preventive and social medicine 1985, June, of the total ENT cases of 531,205 (55.72%) were CSOM. Males were affected more than the females and children affected much more than the adults. Lower socio-economic groups had higher prevalence rate and CSOM was found to be the commonest cause of deafness.

In another study carried out by P. Fireman in 1997 Feb., the causes of otitis media was found to be multi-factorial, but, 25-40% of upper respiratory tract infection was found to be associated with otitis media.

In a report published in Indian Journal of Pediatrics 1995 Nov.-Dec. by A.K. Verma et al, Community medicine department, AIIMS, of 613 children evaluated in Haryana, 15.3% were CSOM cases contributing 71.6% of hearing impairment. URTI co-related significantly.

In another study carried out in Tanzania and published in International Journal of Paed otorhino-laryngology 1996 Sep, it was found that the prevalence of CSOM was 9.44% in rural school children, whereas 1.3% in Urban school children.

In a study carried out by Baskota, D.K., B.K. Sinha, R. prasad, R.C.M Aamatya, H. Bhattarai and R.P. Guragain to find out the ossicular status in total of 251 cases of CSOM-AA who had undergone mastoid exploration at the ENT Department of TUTH during 5 year period and published in JNMA 1997, showed that males were affected more than the females, right ear was affected more than the left, probably due to the fact that, most people are right handed and thus have the habit of pricking right ear. Maximum affected group was 11-20 years of age.

In another study carried out in 100 complicated cases of CSOM, and published in 'JR-Soc-Health, 1997, June, by Matir, M.A., A.H. Khan, F.A Haroon, Department

of Otolaryngology, Sir Salimulaha Medical College, Dhaka, Bangladesh, revealed that factors associated with late presentation of the cases included poor economic status and lack of adequate hospital facilities.

In a research publication of Ghosh L.M., Dubey S.P., Department of Otolaryngology, Calcutta National Medical College, India, 1991, it's stated that incidence of CSOM as compared to non-suppurative otitis media is high due to lack of awareness, low socio-economic status and increased susceptibility of URTL.

Bafaqueeh, S.A., S.M. Zakzouk, H. Almuhaimeed and A. Essa carried out a study in 6,421 Saudi children, Department of Otolaryngology, King Abdul Ajj University Hospital, Saudi Arabia and published it in J-Lanjngol-otol, 1994, April. Their study revealed that hearing impairment prevailed in 494 children of which 326 were due to CSOM and 168 due to SNHL.

According to Stephen Bleman, children living in developing countries are at high risk of otitis media or CSOM than those in developed countries, that is mainly due to the fact that most children in developing countries are malnourished and thus have low resistance to infections. Over-crowding, large family size, poor personal hygiene and lack of adequate health facilities are other factors involved in the causation of CSOM in children of the developing countries.

According to Luckman and Sorensen-Medical and Surgical Nursing, 3rd edition, Otitis Media most commonly occurs in infants and children due to the favorable structure of the Eustachian tube and CSOM is usually preceded by neglected and recurrent AOM.

According to a paper published by Prasad, R. and RCM Amatya in JNMA, Jan-Mar. 1986, recurrent infections prevent even small perforation from healing, this

can be due to infection from outside, like-oil and other liquids, ear pricking habits or from within, like URTT, blowing nose forcibly, milk regurgitation etc.

According to John Groves, CSOM is more common in infancy and childhood. Lack of proper attention and re-infection either from nasopharynx (esp. in adenoids or cleft palate) or through the perforation, allow active infection to persist or recur.

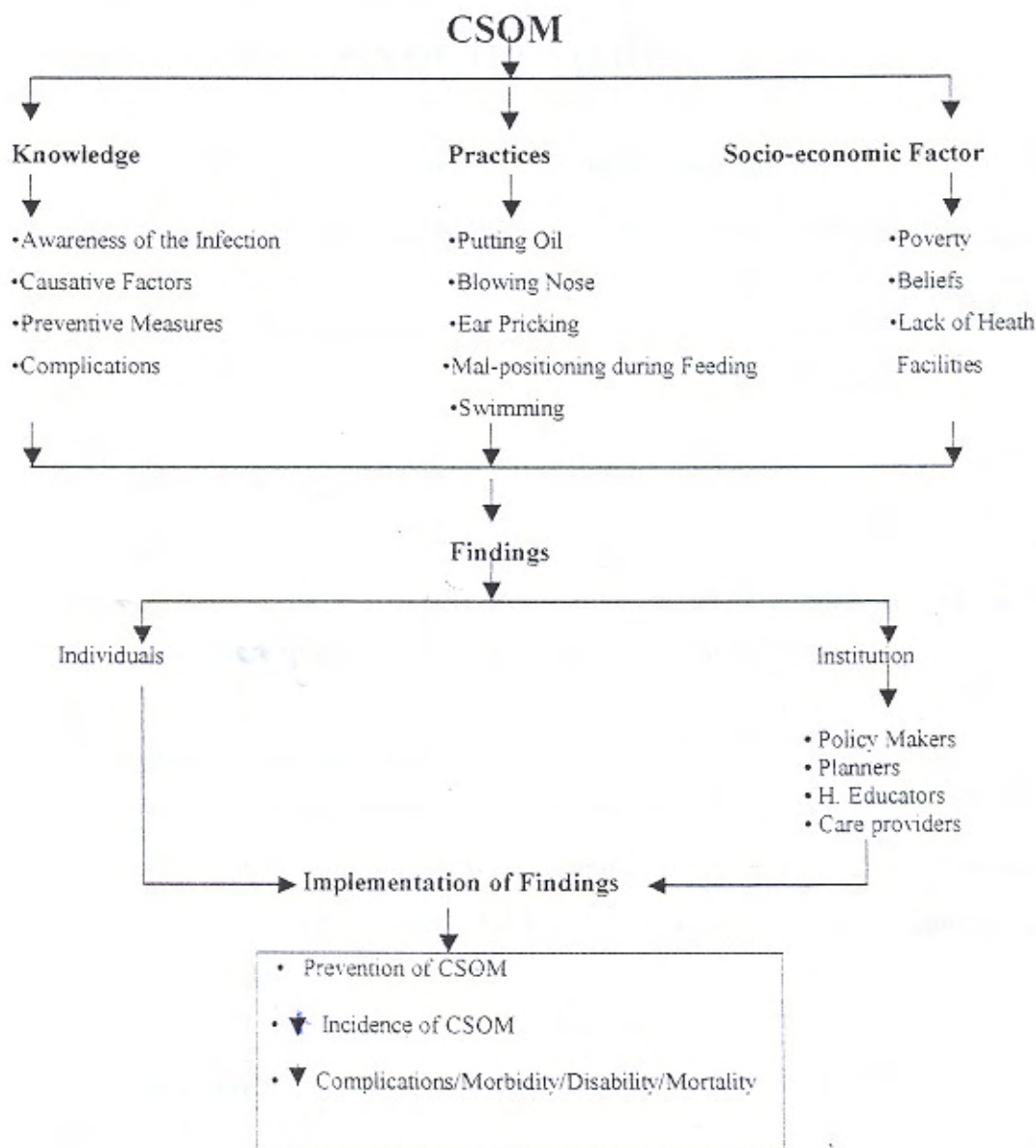
In a study carried out by Deka, R.C. and Published in Indian journal of Otology Dec, 1998, it is found that CSOM causes central perforation of Tympanic Membrane, usually bilateral and that CSOM is more common in rural children mainly because of poor nutrition and improper and inadequate health care attention to them. Initial viral infection is complicated by bacterial infection and untreated or inadequately treated URTT leads to the extension of infection to the middle ear cavity via eustachian tube causing otitis media.

Prasad K., R.C.M , Amatya, R.P.S, Guragain published a review of 48 cases in JNMA, who under-went Tympanoplasty along with modified radical mastoidectomy as one stage procedure in TUTH, from Falgun 2041 to Aswin 2043, all of whose indications for the surgery were CSOM-AA with cholesteatoma with hearing loss.

According to Prasad L.N. in Ear Nose and Throat problems in Nepalese children, the child in Nepal, NMA-IYC Dec 1979, CSOM was the commonest problem in Nepalese children. Traditional practices like putting oil in the ears and blowing nose forcibly are two major factors contributing to the persistence of ear discharge as well as the non-healing of the perforation in the Tympanic membrane. And that CSOM was more common in bottle-fed children than the Breast-fed. The affected ear of the child depended upon the mother's side on which he or she is laid and breast-fed.

According to a report published by Karin S.A on "CSOM its socio-economic and organizational pattern", in Bangladesh Armed Forces Medical Journal, Dec, 1993, there was no religious preponderance, and the incidences were associated with URTT like enlarged adenoids, chronic tonsillitis, chronic nasopharyngitis and chronic sinusitis.

2.2 CONCEPTUAL FRAMEWORK



A conceptual framework formulates the thinking process, so that, other may read and know the frame of reference basic to research problems. Thus, a conceptual framework related with CSOM was developed.

CHAPTER-III: RESEARCH METHODOLOGY

3.1 METHODOLOGY OF THE STUDY

Selection of the research methodology is most important step in research as it gives overall picture about the structure and strategy directed towards this investigation. This chapter includes design, population, study area, sample selection, sample size, instrumentation, data collection technique and plan for data analysis.

3.1.1 Research Design

A small-scale descriptive study of explorative nature attempted to find out the knowledge and care practices of mothers regarding CSOM.

3.1.2 Population Of The Study

A comparative study done on knowledge and care practices of CSOM, between mother of school going children (5-14 years of age) of Tharu community and Pahadiya community.

3.1.3 Study Area

This study was done in Kumarvarti VDC, ward no 4 and 5, in Nawalparasi district. Kumarvarti VDC consists of both Tharus and migrants from the hills.

3.1.4 Sample Size

Sample size was 50 in number, 50% of which were Tharu children and the remaining half from the Pahadiya.

3.1.5 Sample Selection

Children with unilateral or bilateral ear discharge with-in the last one year were taken. The sampling of the population was done on the basis of simple randomized sampling technique.

3.1.6 Data Collecting Instrument

A close-ended questionnaire form was developed by the investigator herself and used for data.Collection as a guideline. The questions of data collection instrument were divided into 4 small categories, Viz, 1) socio-demographic information, 2) CSOM related information, 3) knowledge and 4) care practice of mothers regarding CSOM.

3.1.7 Pilot Study

Pilot study was done before the collection of data.It was done at non study area, only 5 mothers 10% were interviewed and tools were changed as needed.

3.1.8 Data Collection Technique

Interview with semi-structured questionnaires were employed for data collection.

3.1.9 Analysis And Interpretation Of Data

The collected data were compiled and tabulated in master chart manually. Then the data were analyzed by different statistical techniques i.e. -numbering percentage etc. The interpretation of the study was done comparatively on the basis of analyzed data. Necessary recommendations were made. Detail findings of the study will be presented in next chapter.

3.2 VALIDITY AND RELIABILITY

Validity

- The eligible mothers were included in the study.
- Initial test and cross checking was done in 10 percent of the total sample to maintain reliability and modifications were made as necessary.
- Consultation was made with subject experts and guide.
- The other concerned persons were requested to read the questionnaires and give the feedback.

Reliability

- Translation into local language and testing of and retesting was done to find out the consistency of the response.

3.3 ETHICAL CONSIDERATION

During the study period all ethical considerations were maintained and precaution was taking to provide safety of right of all participants of the study.

- Written permission was taken from campus and local body of community area like VDC.
- Study population was selected without any biasness.

- The purpose of data collection was explained prior to interview to the participant.
- Before gathering data, verbal consent was taken from respondents.
- Confidentiality and privacy of the respondents was maintained.

3.4 DELIMITATION OF THE STUDY

- This small scale of study can not be generalized.
- This study covers only 50 children with CSOM and their mothers of Kumarvarti VDC ward No.4 and 5.
- Due to time factor this study could not cover large number of sample size.
- The tool used in this study was only questionnaire.

CHAPTER-IV: DATA ANALYSIS AND PRESENTATION

This chapter includes the socio-demographic and economic background of the respondents. The knowledge and practice regarding CSOM have also presented in this chapter.

4.1 SOCIO-DEMOGRAPHIC RELATED INFORMATION

Table 1: Sex wise Distribution of CSOM Children

S.N.	Pahadiya			Tharu		
	Sex	Frequency	Percent	Sex	Frequency	Percent
1	Male	19	76	Male	14	56
2	Female	6	24	Female	11	44
3	Total	25	100	Total	25	100

Source: Field Survey 2002

The Table No 1 shows that out of 25 Pahadiya children suffering from CSOM, 19 (76 per cent) were male children and the remaining 6 (24 per cent) were female. Similarly,in Tharus, 14 (56 per cent) were males and 11(44 per cent) were females.

These findings are consistent with the findings of the studies carried out in other settings. This might be due to variation in physiological characters of male and female children. Male children tend to play out a lot, go out for swimming and are naughtier by nature than female children

Figure 1
Immunization Status of the Children



100%

It had been observed that both Tharus and Pahadiyas children were 100 per cent immunized

Table 2: Distribution of the Respondents By Type of Family

S.N.	Pahadia			Tharu		
	Type of Family	Frequency	Percent	Type of Family	Frequency	Percent
1	Nuclear	13	52	Nuclear	4	16
2	Joint	11	44	Joint	14	56
3	Extended	1	4	Extended	7	28
4	Total	25	100	Total	25	100

Source: Field Survey 2002

The Table No 2 shows that type of family in Pahadiya and Tharu communities, majority of Pahadiya respondents were from nuclear family (52 per cent) where as 44 per cent from joint family and 4 per cent from extended family. Like wise, majority of the respondent in Tharus (56 per cent) live in a joint family, 28 in the extended family and only 16 per cent in nuclear.

Table 3: Respondent's Level of Education

S.N.	Pahadia			Tharu		
	Level of Education	Frequency	Percent	Level of Education	Frequency	Percent
1	Illiterate	1	4	Illiterate	8	32
2	Literate	3	12	Literate	10	40
3	Primary	13	52	Primary	4	16
4	Secondary	0	0	Secondary	3	12
5	Higher	8	32	Higher	0	0
6	Total	25	100	Total	25	100

Source: Field Survey 2002

Level of education especially mother's, determines the health of their children significantly.

The above table shows that more mothers of Tharu children were illiterate (32 per cent) as compare to the mothers of the Pahadiya children (only 4 per cent). Similarly father of Pahadiya children are seen to be better educated than those of the Tharu children.

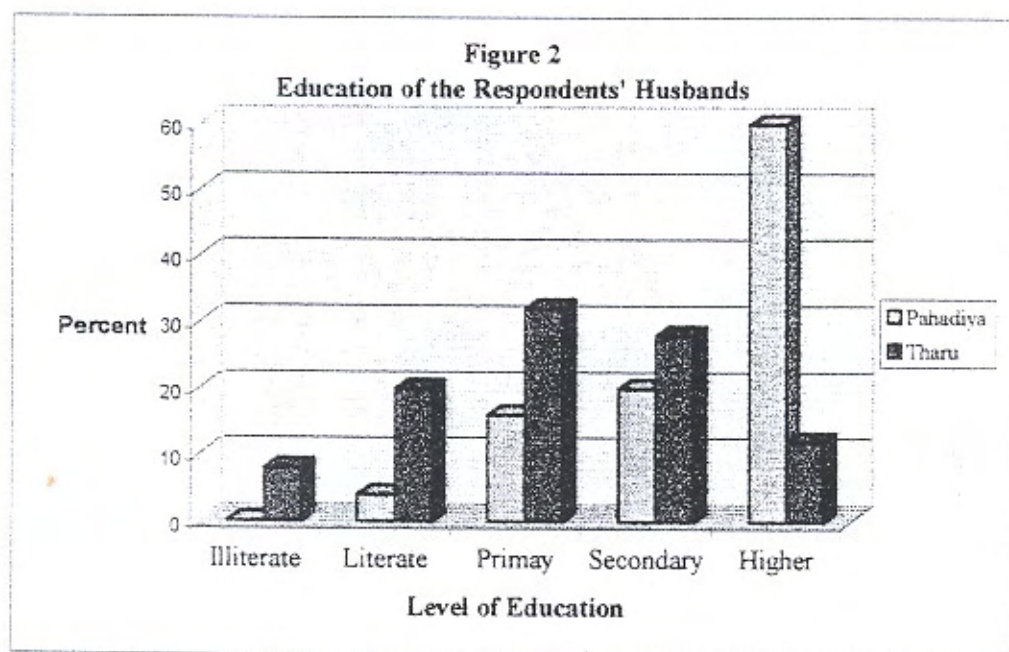


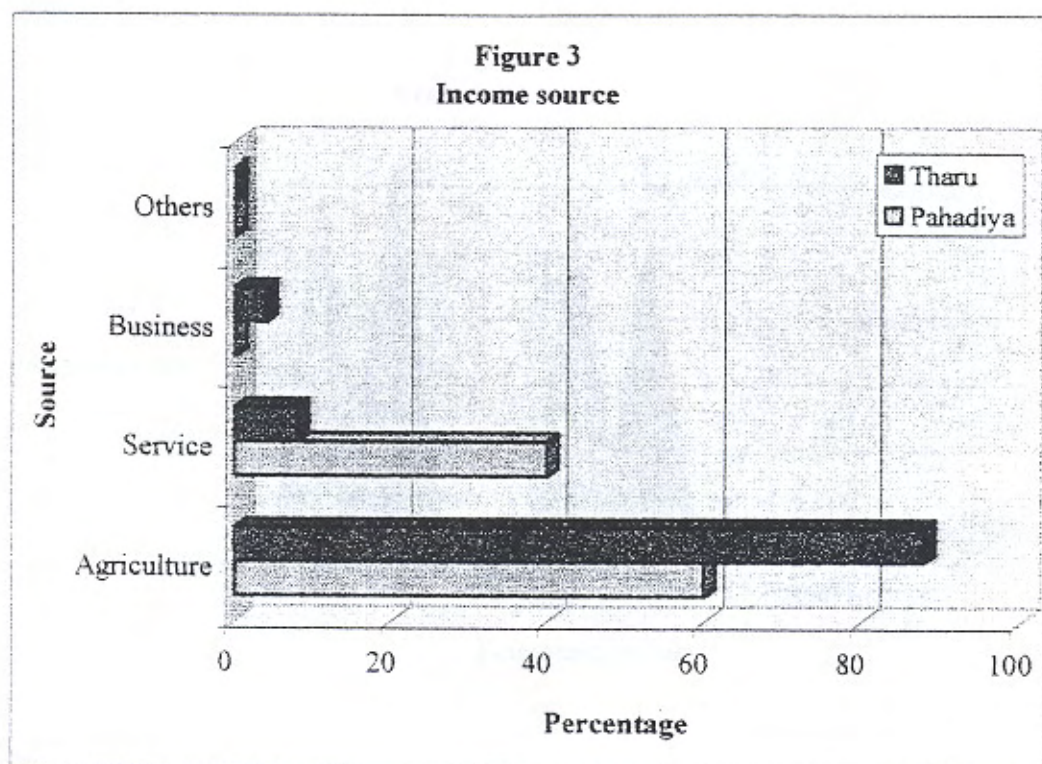
Table 4: Respondents By Occupation

SN	Pahadiya			Tharu		
	Occupation	Frequency	Percent	Occupation	Frequency	Percent
1	Agriculture	3	12	Agriculture	6	24
2	House wife	22	88	House wife	19	76
3	Service	0	0	Service	0	0
4	Business	0	0	Business	0	0
5	Others	0	0	Others	0	0
6	Total	25	100	Total	25	100

Source: Field Survey 2002

Like most of the Nepalese women, the majority of women in both Pahadiya and Tharu communities, as shown in the table above, 88 per cent were housewives in Pahadiyas and 76 per cent in Tharus. Remaining were involved in agriculture work out side the home.

This shows that in most cases, most of the time the mothers are with their children in both the communities



The main source of income of both the communities as shown by the given figure, was agriculture, i.e., 60 per cent in Pahadiyas and 88 per cent in Tharus. Though, majority of Pahadiya fathers were service holders, not all of their major source of income seemed to be the service, those who were service holders were also involved in agriculture.

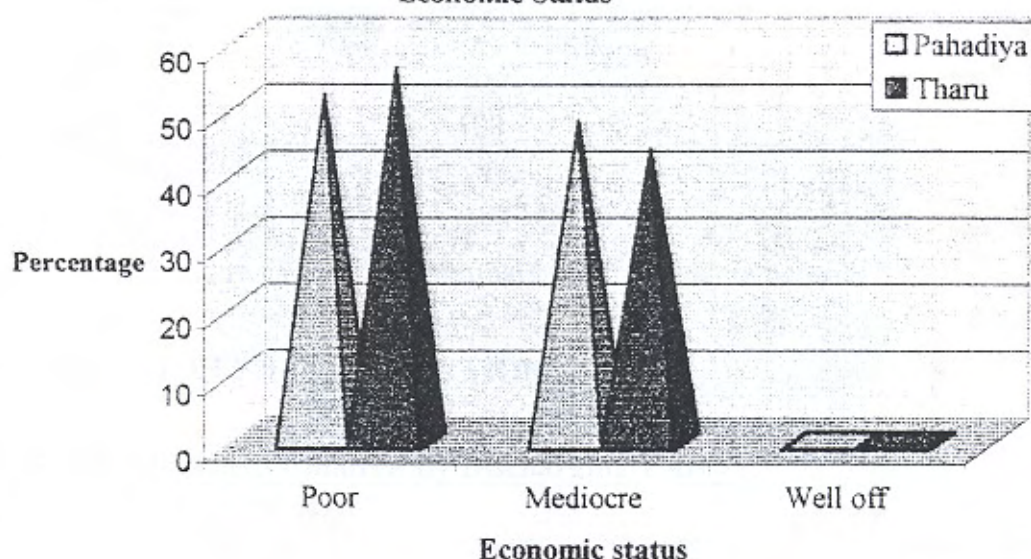
Table 5: Adequacy of Annual Income in Respondents

S.N.	Pahadia			Tharu		
1	Adequate	12	48	Adequate	11	44
2	Inadequate	15	52	Inadequate	14	56
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Adequacy of income has direct impact on health of the people. The above Table shows that the source of income, in majority of cases, in both communities, was not enough to sustain themselves throughout the year.

Figure 4
Economic Status



Majority of the respondents in both the communities were from poor families. In the above figure, 52 per cent of the respondents in Pahadiyas were poor and similarly 56 per cent of Tharus were so, no respondent from either community was from well off (saving Rs. 10,000 or more/ year) family.

Table 6: Fuel Used By the Respondents for Cooking

S.N.	Pahadia			Tharu		
	Method	Frequency	Percent	Method	Frequency	Percent
1	Wood	19	76	Wood	23	92
2	Gas	6	24	Gas	2	8
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Majority of households as shown in the above table, used wood as a fuel in both pahadiya as well as Tharu communities. More tharus (92 per cent) used wood to cook food than the Pahadiyas (76 per cent).

Table 7: Type of Hearth (Chulo) Used By the Respondents

SN	Pahadia			Tharu		
	Type of Hearth	Frequency	Percent	Type of Hearth	Frequency	Percent
1	Simple	19	76	Simple	23	92
2	Smokeless	6	24	Smokeless	2	8
3	Total	25	100	Total	25	100

Source: Field Survey 2002

It has been observed that, only 8 per cent Tharus and 24 per cent Pahadiyas used smokeless hearth and remaining used ordinary ones, which are harmful.

4.2 CSOM RELATED INFORMATION

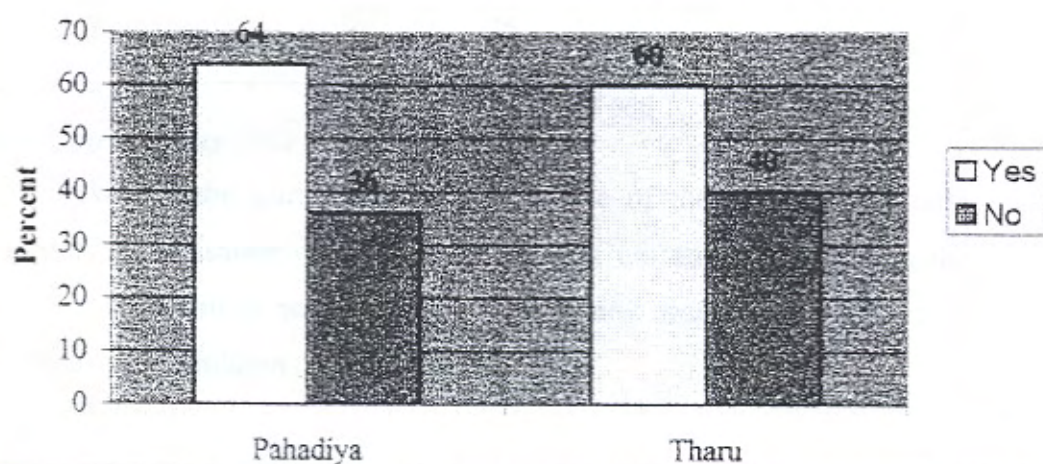
Table 8: Distribution of Children By Discharging EAR

S.N	Pahadia			Tharu		
	Discharging Ear	Frequency	Percent	Discharging Ear	Frequency	Percent
1	Right	12	48	Right	7	28
2	Left	6	24	Left	10	40
3	Both	7	28	Both	8	32
4	Total	25	100	Total	25	100

Source: Field Survey 2002

Above table No 9 shows that majority of children in both the communities have unilateral ear discharge, 72 per cent in Padhiya children and 68 per cent in Tharus

Figure 5
Children With Hearing Impairment



In majority of cases, CSOM was related to some degree of hearing impairment in both the communities. As shown in the Figure No 5, 64 per cent of Pahadiya children and 60 per cent of Tharu children were suffering from some degree of hearing impairment

Table 9: Common Cold Episodes/Year in Children

SN	Pahadia			Tharu		
	Common Cold	Frequency	Percent	Common Cold	Frequency	Percent
1	<3 Episodes/Year	3	12	<3 Episodes/Year	3	12
2	3-6 Episodes/Year	10	40	3-6 Episodes/Year	8	32
3	>6 Episodes/Year	12	48	>6 Episodes/Year	14	56
4	Total	25	100	Total	25	100

Source: Field Survey 2002

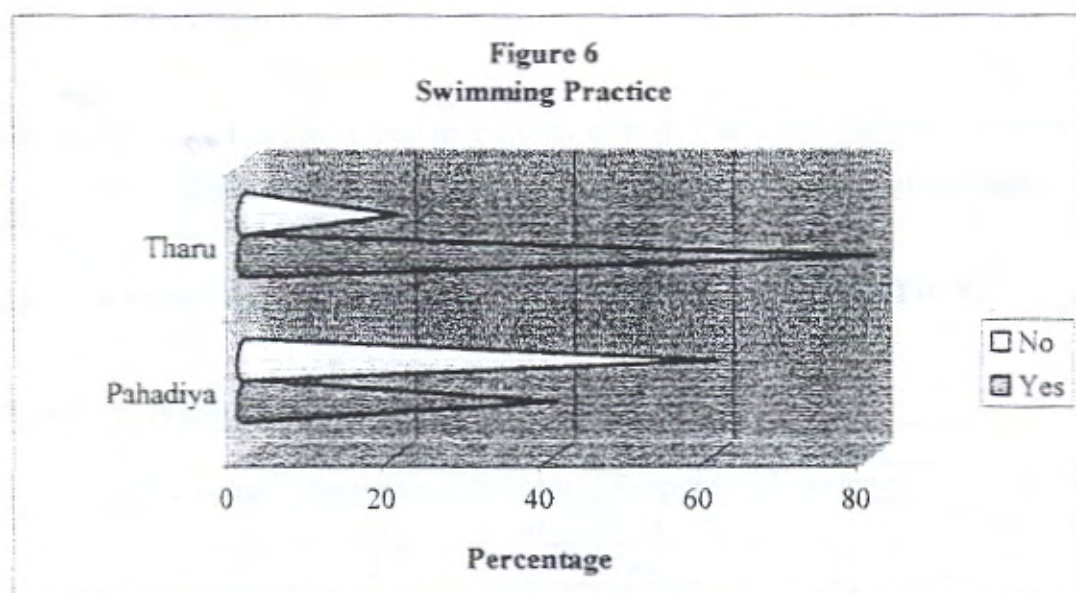
It has been shown by other studies that OM is strongly related to URIT. The above Table shows that both Tharu and Pahadiya community children suffered from several episodes of common cold in a year. 48 per cent of Pahadiya children suffered 6 or more episodes of common cold in a year and the number was even larger in Tharu children (56 per cent).

Table 10: Nose Blowing Habit in Children

S.N.	Pahadiya			Tharu		
	Nose Blowing Habit	Frequency	Percent	Nose Blowing Habit	Frequency	Percent
1	Yes	19	76	Yes	18	72
2	No	6	24	No	7	28
3	Total	25	100	Total	25	100

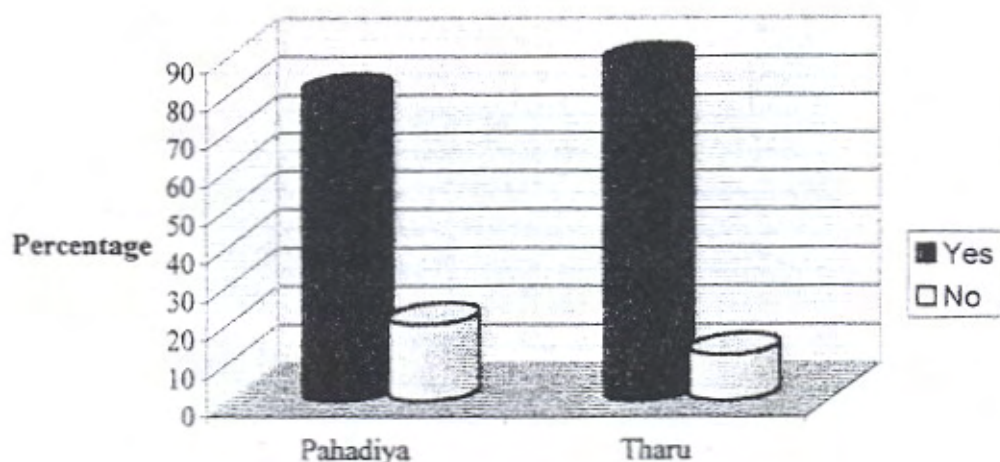
Source: Field Survey 2002

Nose blowing habit during runny nose is one of the established predisposing factors in the causation of CSOM. Majority of children, as shown in the above Table had the habit of nose blowing during runny nose in both Pahadiya (76 per cent) and Tharu children (72 per cent).



Swimming in the ponds and streams predisposes CSOM. It has been seen in Tharu children that, majority of them were fond of swimming (in the ponds and streams). The above table shows that, 80 per cent of Tharu children enjoyed swimming and the percentage in Pahadiya children was much lower (40 per cent) than those of Tharus.

Figure 7
Ear Picking Habit



Ear pricking habit has been seen in majority of both Tharu and Pahadiya children, 88 percent in Tharus and 80 per cent in Pahadiyas, as shown in the given figure.

4.3 KNOWLEDGE ABOUT CSOM RELATED INFORMATION

Table 11: Whether CSOM is Considered a Disease or Not

S.N.	Pahadiya			Tharu		
	Response	Frequency	Percent	Response	Frequency	Percent
1	Yes	20	80	Yes	11	44
2	No	5	20	No	14	56
3	Total	25	100	Total	25	100

Source: Field Survey 2002

It has been observed that, majority of Tharu mothers (56 per cent) did not consider CSOM as a disease where as 80 per cent of Pahadiya mothers considered it to be a disease.

Table 12: Knowledge of the Causation of CSOM

S.N.	Causes of CSOM	Pahadiya		Tharu	
		Frequency	Percent	Frequency	Percent
1	Breast Milk Over the Ear	11	44	6	24
2	Water	7	28	11	44
3	Organism	2	8	-	-
4	Oil	1	4	-	-
5	Weakness	1	4	-	-
6	<i>Kukhat Parera</i>	2	8	-	-
7	<i>Dhan ko Geda Parera</i>	1	4	-	-
8	Ear Pricking Habit	-	-	3	12
9	Don't Know	-	-	4	16
10	Dirt	-	-	1	4
11	Total	25	100	25	100

Source: Field Survey 2002

The above table is related to the mother's knowledge on the causation of CSOM. Majority of Pahadiya mothers(44 per cent) considered spilling of milk over the child's ear to be the cause of CSOM where as, majority of Tharu mothers (44 per cent) considered water in the ear for causation of the same. Only 8 per cent of Pahadiya mothers and none of the Tharu mothers considered organism as the cause of CSOM.

Table 13: Respondents' Knowledge Regarding Prevention of CSOM

S.N.	Pahadiya			Tharu		
	Preventable	Frequency	Percent	Preventable	Frequency	Percent
1	Yes	16	64	Yes	15	60
2	No	9	36	No	10	40
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Though, majority of mothers in both the communities expressed that, CSOM was preventable quite a significant number in both the communities, 36 per cent in Pahadiyas and 40 per cent in Tharus, as shown in the above table still thought that it couldn't be prevented.

Table 14: Respondents' Knowledge about Need for Treatment of CSOM

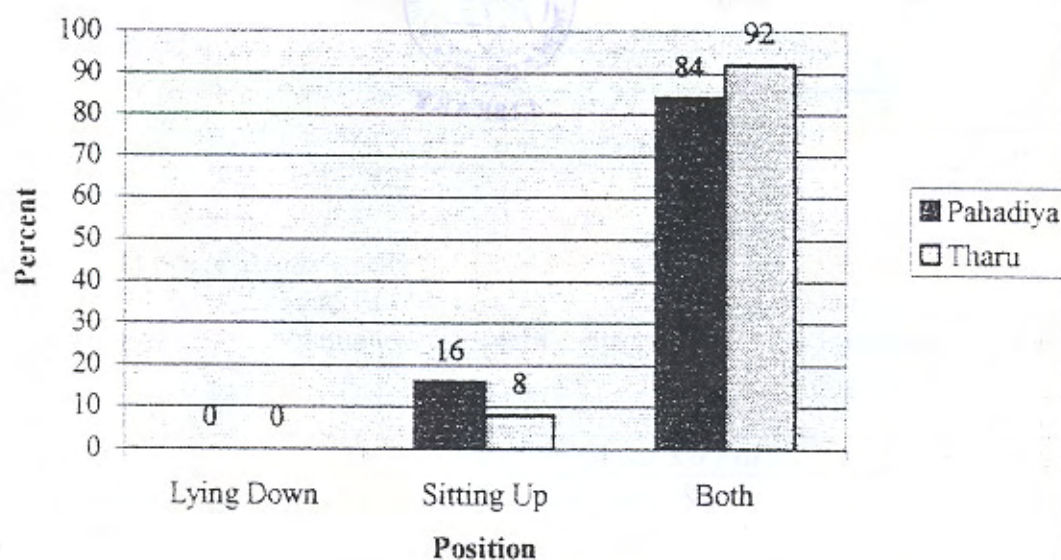
S.N.	Pahadiya			Tharu		
	Need For Treatment	Frequency	Percent	Need For Treatment	Frequency	Percent
1	Yes	20	80	Yes	16	
2	No	5	20	No	9	36
3	Total	25	100	Total	25	100

Source: Field Survey 2002

According to the field survey, 36 per cent of Tharu mothers thought that CSOM needed no treatment, the number was little lower (20 per cent) in Pahadiya mothers.

4.4 PRACTICE (OF CSOM) RELATED INFORMATION

Figure 8
Position of Breast Feeding



In both communities, as shown in the figure above, the mothers who breastfeed sitting up alone were very less, 16 per cent in Pahadiyas and 8 per cent in Tharus.

Majority of them in both communities fed in both lying down and sitting up positions and felt there's no difference whatsoever position they employed.

Table 15: Oil Putting Practice

S.N.	Pahadiya			Tharu		
	Oil Putting Practice	Frequency	Percent	Oil Putting Practice	Frequency	Percent
1	Yes	24	96	Yes	20	80
2	No	1	4	No	5	20
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Almost all Pahadiya (96 per cent) mothers considered putting oil in the ears to be good and practised so. The number practicing it was little lesser (80 per cent) in Tharu mothers.

Table 16: Use of Drops as Home Remedies

S.N.	Pahadiya			Tharu		
	Drop Putting Practice	Frequency	Percent	Drop Putting Practice	Frequency	Percent
1	Yes	10	40	Yes	7	28
2	No	15	60	No	18	72
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Table 17: Types of Drops Used

S.N.	Pahadiya			Tharu		
	Drops	Frequency	Percent	Drops	Frequency	Percent
1	<i>Tulasi</i>	6	60	<i>Gholtapre</i>	2	29
2	<i>Gholtapre</i>	1	10	<i>Pipal Ko Pat</i>	2	29
3	<i>Seudi Ko Pat</i>	2	20	<i>Gaida Ko Pisab</i>	1	14
4	<i>Ajambari Ko Pat</i>	1	10	<i>Gai Ko Pisab</i>	1	14
5				<i>Bichhi</i>	1	14
6	Total	10	100		7	100

Source: Field Survey 2002

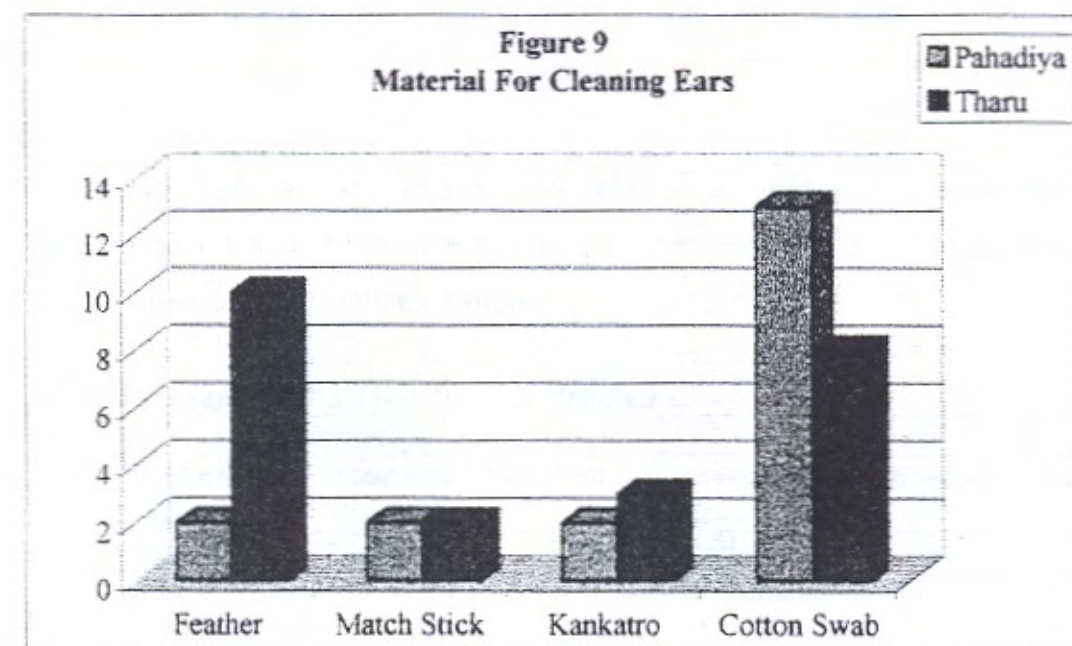
It has been seen that, 60 per cent of Pahadiya mothers and 72 per cent of Tharu mothers put different drops in their children's ears. Of these, 60 per cent of Pahadiya mothers tend to put 'Tusli Patta'. Tharu mothers had the practice of putting 'Ghol Tapre' and 'Peepal Pat'. Some even put *Gaida Ko Pisab* and *Gai Ko Pisab*, as shown in the tables above.

Table 18: Ear Cleaning Habits

S.N.	Pahadiya			Tharu		
	Ear Cleaning Habit	Frequency	Percent	Ear Cleaning Habit	Frequency	Percent
1	Yes	19	76	Yes	23	92
2	No	6	24	No	2	8
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Majority of mothers in both the communities cleaned their children's ears. It has been observed that, 76 per cent of Pahadiya mothers and 92 per cent of the Tharu mothers practiced so.



Majority of Pahadiya mothers (13) tend to do so with the cotton swab and majority of Tharu mothers (10) tend to do with feathers.

Table 19: Slapping Habits

S.N.	Pahadia			Tharu		
	Slapping Habit	Frequency	Percent	Slapping Habit	Frequency	Percent
1	Yes	14	56	Yes	12	48
2	No	11	44	No	13	52
3	Total	25	100	Total	25	100

Source: Field Survey 2002

The above Table shows that the Majority of Pahadiya mothers (54 per cent) slapped their children on their cheeks, the number of Tharu mothers doing so was slightly less (48 per cent).

Table 20: Use of Cotton Balls While Bathing

S.N.	Pahadiya			Tharu		
	Cotton Ball	Frequency	Percent	Cotton Ball	Frequency	Percent
1	Yes	2	8	Yes	1	4
2	No	23	92	No	24	96
3	Total	25	100	Total	25	100

Source: Field Survey 2002

Almost all Tharu mothers (96 per cent) failed to put cotton balls while bathing their children, similar proportion of Pahadiya mothers (92 per cent) did not put cotton balls while bathing their children.

Table 21: Consultation Time for Ear Problems

S.N.	Pahadiya			Tharu		
	Consultation Time	Frequency	Percent	Consultation Time	Frequency	Percent
1	Immediately After Earache	8	32	Immediately After Earache	6	24
2	After Ear Discharge	14	56	After Ear Discharge	18	72
3	After Hearing Impairment	3	12	After Hearing Impairment	1	4
4	Total	25	100	Total	25	100

Consultation period matters a lot in the causation, progression and complications of CSOM. The earlier the children are consulted, the better will be the results, but, very less number of mothers, 32 per cent in Pahadiya and 24 per cent in Tharus, went for consultation immediately after earache. As shown in the table above, most went for medical advice only when their children had ear discharge such trend is seen in 56 per cent of Pahadiya mothers and 72 per cent of the Tharu mothers.

CHAPTER-V: FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 MAIN FINDINGS OF THE STUDY

- a) Total percentage of households with CSOM children in Tharu community (67 out of 103) 65.05 percent.
- b) Total Percentage of Households with CSOM children in Pahadiya community was (38 out of 89) 42.7 percent.
- c) CSOM was Predominantly seen in Male children in both Pahadiya as well as Tharu communities. In Pahadiyas 76 percent were Male children and in Tharus 56 percent were male children.
- d) Majority of the Respondents in both the communities were housewives 88 percent in Pahadiys and 76 percent in Tharus.
- e) Sixty percent of the respondents' husband in Tharu community was involved in agriculture where as in Pahadiyas 48 percent were involved in agriculture and remaining 52 percent were service holders.
- f) Majority (52 percent) of the Respondents in Pahadiya community lived in a nuclear family where as most respondents of the Tharu community lived in a joint or extended family (84 percent).
- g) There were literate Respondents among Pahadiyas (96 percent) than the Tharus (68 percent).
- h) Level of education among the husbands of the Pahadiya Respondents also was better than the Tharus. (96 percent of Pahadiya husbands have had at least Primary education where as 72 percent of the Tharus have had the same.
- i) The main source of the income in the both communities was agriculture (88 percent in Tharus and 60 percent in Pahadiyas).

- j) Majority of the household's income in both the communities was inadequate to sustain throughout the year (52 percent in Pahadiyas and 56 percent in Tharus).
- k) The findings of the study show that 52 percent Pahadiyas and 56 percent Tharus were poor. Literature showed that CSOM is closely related to poor economic status.
- l) In Pahadiyas, 28 percent had separated kitchen and 48 percent in Tharus.
- m) In Pahadiyas, majority of the respondents (76 percent) used wood as a fuel for cooking and heating purpose; only 24 percent had smokeless hearth.
- n) In Tharus 92 percent used wood as a fuel for cooking and heating purpose and only 8 percent had smokeless hearth.
- o) Regarding hearing impairment majority of the children were suffering from some degree of hearing impairment in both Pahadiyas and Tharus (64 percent in Pahadiyas and 60 percent in Tharus).
- p) In Pahadiyas 48 percent children with CSOM suffered from common cold 16 episodes/year, similarly 56 percent of the same was seen in Tharus.
- q) Majority of the children in both the communities had nose-blowing habits during runny nose (76 percent in Pahadiyas and 72 percent in Tharus).
- r) Eighty percent of Tharu children enjoyed swimming where as only 10 percent did so in Pahadiya.
- s) Majority of the children in both the communities had ear Pricking habit, 88 percent in Tharus and 80 percent in Pahadiyas.
- t) Thirty six percent Tharu mothers think that CSOM need no treatment. The no. is little lower (20 percent) in Pahadiya mothers.
- u) All most all 96 percent Pahadiya mother consider putting oil in the ears. The number practicing it is little lesser 80 percent in Tharus mothers.
- v) Ninety-six percent Tharu mother and 92 percent Pahadiya mothers fail to put cotton balls while bathing their children
- w) Very less no of mothers 32 percent in Pahadiyas and 24 percent in Tharus go for consultation immediately after earache.

5.2 SUMMARY OF THE FINDINGS

This, small scale prescriptive study of knowledge and care practices of mothers regarding CSOM in Tharu and Pahadiya communities of Kumarvarti VDC, Nawalparasi, was carried out in the month of Jestha, 2059. The sample selection of 25 mothers Tharu children and 25 of Pahadiya children was done by randomized sampling technique. Interviewing the mothers of the children with CSOM filled close-ended questionnaire forms, the information obtained were tabulated and analyzed according to the hypothesis and the set objectives. Almost all the findings came to be consistent with the set hypothesis.

CSOM is a common disease entity in both Tharu and Pahadiya children, however, incidence was higher in Tharu community where people are comparatively poorer and more ignorant and the majority of children being found of swimming. Male children were affected more than the females. Low socio-economic status and illiteracy both affected largely in the causation and progression of the disease. Improper Breast feeding position, forceful nose blowing habits, ear pricking habits, swimming habits, putting oil and other liquids in the ear all affected significantly in the causation of CSOM. Recurrent URTI, as suggested by other literatures also, showed significant relationship with CSOM in the children of the study area.

5.3 Recommendations

5.3.1 For Future Studies

- a) A large-scale study similar to this can be replicated from different parts of the country.
- b) Knowledge and practice of mothers in ear-care at home can be studied at large, which would be of great help in the prevention of CSOM and hearing impairment on the whole.

- c) Different interventional studies and comparative studies regarding CSOM should be carried out to find out more effective ways of prevention at different levels (primary secondary or tertiary).

5.3.2. Recommendations to Health Planning Authorities

- a) Health Planning Authorities should plan and organize Health Education programs on Ear Hygiene, preventive aspects and treatment of CSOM, so that, CSOM can be prevented at different levels, successfully.
- b) Different Audio-visual programs on COSM should be broadcast over Radio and Television to increase public awareness.
- c) Publication and distribution of different Health Education media e.g. pamphlets, posters, brochures etc, on CSOM, should be done throughout the country.
- d) There should be provisions for ENT Health Services throughout the kingdom including remote parts, if not, at least, regular Ear comps should be organized.
- e) Regular training to Teachers and other community leaders on Ear problems should be carried out, so that, they can communicate to students and the public on the whole, which in turn, will help to reduce the ear-related problems, such as CSOM, in the communities.
- f) Utilization of the studies done in different communities, may it be a small-scale study on contributing fact0rs of CSOM should be done and interventional programs organized.

5.4 Conclusions

This, small scale descriptive study of mothers' knowledge and care practices regarding CSOM in Tharu and Pahadiya communities of Nawalparasai district was done in the month of Jestha , 2059. This study compares the knowledge and care practices of Tharu and Pahadiya mothers regarding CSOM, which contribute in the casuation, as well as complications of it in children.

For the purpose of the comparative study, total sample of 50 was taken, selecting 25 from Pahadiya children and the other 25 from Tharu children, by randomized sampling technique. Close-ended structured questionnaires were developed, tested and filled up interviewing the mothers of the selected CSOM children.

The collected data were analysed and it was found that CSOM was common in both Tharu and Pahadiya children-this being more prevalent in the Tharus.

Poor socio-economic status and illiteracy had a significant role in the causation of CSOM.

Lack of knowledge in both Tharu and Pahadiya mothers contributed significantly in the casuation of CSOM as well as progression to different complications. This was worse with Tharu mothers where majority of them (56 percent) did not consider CSOM as a disease and in those who consider it to be a disease, also , 36 percent felt that needed no treatment.

Care practices of mothers, like, inappropriate feeding positions, forceful blowing of nose during runny nose, slapping the children on the cheeks, putting oil and other home remedies in the ear and improper ear cleaning practices, all contributed in the casuation and progression of CSOM in both the communities.

5.5 Findings Compared with Literature

In a study carried out in TUTH in 057-058, significant number of ENT patient admitted were CSOM cases (21.3 percent), of which, 28.13 percent were children below 14 years and males (65.6 percent) were affected more then the females (34.4 percent) .

This study carried out in Nawalparasi also gave the similar results that CSOM was common and males were affected more than the females.

National Survey done by TUTH and BRINOS in 1991 reflected that around 35 percent of deafness was due to CSOM and similarly this study done in Nawalparasi district further strengthened the fact by revealing around 60 percent deafness of varying degree in children with CSOM.

Like other studies, such as that done in Sir Salimullah Medical College, Dhaka , this study also projected the fact that poor socio-economic status and the ignorance among the parents contributed significantly in the causation and complications of CSOM.

As compared with the papers published, such as by Prasad, R. and RCM Amatya in JNMA Jan-Mar, 1986, Putting oil and other liquids, infection from outside like ear pricking habits, blowing nose forcibly, milk regurgitation, all contributed in the persistence of infection in the middle ear cavity.

As with the many studies done elsewhere this study also supported the fact that recurrent URTI contributed a lot in the causation and complications of CSOM.

This way, most findings of this study are consistent with the findings obtained by reviewing the literature of different research publications.

5.6 Acceptance and Rejection of Hypothesis

- a) CSOM is seen in these children with the habit of pricking ears and blowing nose forcefully, so, the hypothesis is accepted, as the results are consistent with the hypothesis.

- b) The hypothesis that CSOM is more common in those children with the history of recurrent URTI is also accepted as the findings suggested the same.
- c) There is high incidence of CSOM in the children who have the habit of swimming –this hypothesis is also accepted as the study gave the same results.
- d) The hypothesis that malpositioning while feeding leads to higher incidence of CSOM is fully accepted as the findings showed the same thing.
- e) My study also supported the hypothesis that there is higher incidence of CSOM in low socio-economic status group. So, the hypothesis in this case is also fully accepted.
- f) The hypothesis that CSOM is more common in “Tharu” Children than “Pahadiya” is also accepted fully, as my findings matched the set hypothesis.
- g) The hypothesis that children of illiterate parents have the higher incidence of CSOM, is also fully supported by the findings, so, the hypothesis is accepted.
- h) It's seen from the study that most of the children with CSOM have had oil or other liquids put in their ears, so, the hypothesis is fully accepted in this case also.

5.7 Problems Faced by the Investigator

- a) Lack of previous experience made it difficult in topic selection and searching of appropriate and relevant literature.
- b) Inadequate time – as the study had to be done within a short time frame.
- c) Financial constraints – costly Stationeries, Internet access, and computer work.
- d) Lack of adequate Theoretical preparation prior to the research work.
- e) Communication problems with Tharu people.

5.8 Strength and Limitation of the Study

Strength

- a) The study includes two different communities-Tharu and Pahadiya, so that comparison could be made.
- b) Knowledge and care practices of Mothers from Tharu and Pahadiya communities could be studied well and they can be utilized help for interventional programs.

Limitations

- a) Small sample size-only mothers of 50 children with CSOM were included.
- b) Study was carried out within a short time frame.

5.9 Plan for Dissemination

- a) The Report will be submitted to the Advisor
- b) To the Nursing Campus Library, Maharajgunj
- c) To Nepal Health Research Council, Ramsahapath

त्रिभुवन विश्वविद्यालय
चिकित्साशास्त्र अध्ययन संस्थान नर्सिङ्ग क्याम्पस महाराजगञ्ज
स्नातक तह : २०५९

अनुसन्धान अन्तरवार्ता फारम:

- निर्देशन: १) तलका प्रश्नहरु कान पाकेको वच्चाको आमालाई सोधिने छ ।
२) प्रश्न सोध्नु अगाडि व्यक्तिगत स्वीकृति लिइने छ ।
३) प्राप्त जानकारी अनुसन्धानको लागि मात्र प्रयोग गरिनेछ र यसलाई गोप्य राखिने छ ।

अ) सामाजिक एवं आर्थिक विवरण:

- १) मिति:
- २) वच्चाको नाम: उमेर: लिङ्ग:
- ३) खोपको विवरण: डी.पी.टी. ☐☐☐ बी.सी.जी. ☐
पोलियो ☐☐☐ दादुरा ☐
- ४) घरमुलीको नाम:
- ५) आमाको नाम:
- ६) गा.वि.स. : ७) वडा नं.: ८) जाति:
- ९) परिवारको प्रकार: क) एकात्मक ☐ ख) संयुक्त ☐ ग) वृहत् ☐
- १०) शिक्षा:
- १०.१) बाबुको शैक्षिक योग्यता:
क) निरक्षर ☐ ख) साक्षर ☐ ग) प्राथमिक शिक्षा (१-५ कक्षा) ☐
घ) माध्यमिक शिक्षा (६-१० कक्षा) ☐ घ) उच्च शिक्षा (एस.एल.सी.+) ☐
- १०.२) आमाको शैक्षिक योग्यता:
क) निरक्षर ☐ ख) साक्षर ☐ ग) प्राथमिक शिक्षा (१-५ कक्षा) ☐
घ) माध्यमिक शिक्षा (६-१० कक्षा) ☐ घ) उच्च शिक्षा (एस.एल.सी.+) ☐
- ११) पेशागत विवरण:
- ११.१) बाबुको पेशा:
क) कृषि ☐ ख) श्रमिक ☐ ग) नोकरी ☐ घ) व्यापार ☐
ड) अन्य (उल्लेख गर्नु):
- ११.२) आमाको पेशा:
क) गृहिणी ☐ ख) कृषि ☐ ग) नोकरी ☐ घ) व्यापार ☐
ड) अन्य (उल्लेख गर्नु):

- १२) तपाईंको परिवारको मुख्य आम्दानीको स्रोत के हो ?
 क) कृषि ☐ ख) व्यापार ☐ ग) नोकरी ☐ घ) अन्य:
- १३) के त्पा आम्दानीले तपाईंलाई वर्षभरि नै पुग्छ ?
 क) पुग्छ ☐ ख) पुग्दैन ☐
- १४) यदि पुग्दैन भने कति समयको लागि पुग्छ ?
 क) ३ महिना ☐ ख) ६ महिना ☐ ग) नौ महिना ☐

१५) वातावरणीय स्वास्थ्य:

- १५.१) तपाईंको घरमा कति वटा कोठाहरु छन् ? ☐
- १५.२) एउटा कोठामा कति जना व्यक्ति वस्तुहुन्छ ? ☐
- १५.३) भान्सा कोठा छुट्टै छ ?
 क) छ ☐ ख) छैन ☐
- १५.४) खाना बनाउदा के इन्धन प्रयोग गर्नुहुन्छ ?
 क) दाउरा ☐ ख) मडितेल ☐ ग) ग्यास ☐ घ) अन्य:
- १५.५) दाउरामा पकाउनुहुन्छ भने कस्तो प्रकारको चुलो छ ?
 क) सामान्य ☐ ख) धुँवारहित ☐

आ) कान पाक्ने रोग सम्बन्धी प्रश्नावलीहरु:

- १६) के परिवारमा अन्य कसैलाई कान पाक्ने रोग छ ?
 क) छ ☐ ख) छैन ☐
- १७) के कान पाक्नेको वच्चाले कान कम सुन्छ ?
 क) सुन्छ ☐ ख) सुन्दैन ☐
- १८) कुन कानवाट पिप वग्दछ ?
 क) दायाँ ☐ ख) बायाँ ☐ ग) दुवै ☐
- १९) कान पाक्नेको वच्चालाई वर्षमा कति पटक रुघाखोकी लाग्ने गर्छ ?
 क) ३ पटक भन्दा कम ☐ ख) ३-६ पटक ☐
 ग) ६ पटक भन्दा बढी ☐ घ) थाहा छैन ☐
- २०) रुघा लाग्दा वच्चाले सिँ-सिँ गरेर सिँगान फाल्छ ?
 क) फाल्छ ☐ ख) फाल्दैन ☐
- २१) के वच्चा खोलामा पौडी खेल जान्छ ?
 क) जान्छ ☐ ख) जान्दैन ☐
- २२) के वच्चाको कान कोट्याउने वानी छ ?
 क) छ ☐ ख) छैन ☐

इ) रोगको बारेमा आमाको ज्ञान सम्बन्धी प्रश्नावलीहरु:

- २३) के कान पाक्ने समस्यालाई रोग ठान्नुहुन्छ ?
 क) ठान्छु ☐ ख) ठान्दिन ☐
- २४) तपाईंको विचारमा कान पाक्नुको कारण के होला ?
 क) आमाको दूध कानमा पर्नाले ☐ ख) पानी कानमा पर्नाले ☐
 ग) किटाणुवाट ☐ घ) अन्य (उल्लेख गर्नु):

- २५) के यो रोगको रोकथाम सम्भव छ ?
 क) छ ☐ ख) छैन ☐ ग) थाहा छैन ☐
- २६) के यो रोगको लागि औषधोपचार आवश्यक छ ?
 क) छ ☐ ख) छैन ☐ ग) थाहा छैन ☐
- २७) यदि आवश्यक छ भने उपचारको लागि कहाँ लानु पर्ला ?
 क) धामी-भाँकी ☐ ख) स्वास्थ्य कार्यकर्ता ☐
 ग) जान्ने ☐ घ) अन्य

ई) कान पाक्ने रोग सम्बन्धी व्यवहारको प्रश्नावलीहरु:

- २८) तपाईंले वच्चालाई कति समयसम्म स्तनपान गराउनु भयो ?
 क) ६ महिनासम्म ☐ ख) १ वर्षसम्म ☐
 ग) १-२ वर्ष सम्म ☐ घ) २ वर्षभन्दा बढी ☐
- २९) वच्चालाई स्तनपान कसरी गराउनु हुन्थ्यो ?
 क) सुतेर ☐ ख) वसेर ☐
 ग) कहिले सुतेर कहिले वसेर ☐ घ) अन्य:.....
- ३०) के वच्चाको कानमा तेल राख्नुहुन्छ ?
 क) राख्छु ☐ ख) राख्दिन ☐
- ३१) के वच्चाको कानमा जडिवुटीको रस राख्नुहुन्छ ?
 क) राख्छु ☐ ख) राख्दिन ☐
- ३२) यदि राख्नु हुन्छ भने के राख्नुहुन्छ ?
 क) तुलसीको पात थिचेर ☐ ख) कागतीको रस ☐
 ग) घोलटाप्रे ☐ घ) अन्य:.....
- ३३) के तपाईंले वच्चाको कान सफा गर्नुहुन्छ ?
 क) गर्छु ☐ ख) गर्दिन ☐
- ३४) यदि गर्नुहुन्छ भने के ले गर्नुहुन्छ ?
 क) प्वाखले ☐ ख) सलाइको काँटीले ☐
 ग) कनकत्रोले ☐ घ) कपासले ☐
- ३५) के वच्चाले विराएमा जोडले गालामा थप्पड लाउने गर्नुहुन्छ ?
 क) लगाउँछु ☐ ख) लगाउँदिन ☐
- ३६) के वच्चालाई रुघा लागेको वेलामा जोडले सिँ-सिँ गर्न लगाउनु हुन्छ ?
 क) लगाउँछु ☐ ख) लगाउँदिन ☐
- ३७) के वच्चालाई नुहाउनुभन्दा अगाडि कानमा कपास राखिदिने गर्नुहुन्छ ?
 क) गर्छु ☐ ग) गर्दिन ☐
- ३८) वच्चालाई कहिले स्वास्थ्य संस्थामा देखाउन लानुहुन्छ ?
 क) कान दुख्ने वित्तिकै ☐ ख) पिप वग्न थालेपछि ☐
 ग) कान कम सुन्न थालेपछि ☐ घ) अन्य:

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1. The following form will be filled by interviewing the mothers of CSOM children.
2. Informed consent will be taken prior to this.
3. Full confidentiality will be maintained.

A) SOCIO-ECONOMIC CHARACTERISTICS

- 1) Date:
- 2) Name of the child:
a) Age b) Sex
- 3) Immunization Status:
a) B.C.G. ☐ b) D.P.T. ☐☐☐
c) Polio ☐☐☐ d) Measles ☐
- 4) Name of the householder:
- 5) Name of the mother:
- 6) Village:
- 7) Ward No.:
- 8) Ethnicity:
- 9) Type of family: a) Nuclear ☐ b) Joint ☐ c) Extended☐
- 10) Educational status:

10.1) Mother's educational status
a) Illiterate ☐ b) Literate ☐
c) Primary level (1-5 class) ☐ d) Secondary level (6-10 class) ☐
e) Higher (S.L.C. and +)

10.2) Father's educational status
a) Illiterate ☐ b) Literate ☐

- c) Primary level (1-5 class) ☐ d) Secondary level (6-10 class) ☐
 e) Higher (S.L.C.+) ☐

11) Occupational status:

11.1) Mother's occupation:

- a) House-wife ☐ b) Agriculture ☐ c) Service ☐
 d) Business ☐ e) Daily wage earner ☐

11.2) Father's occupation

- a) Agriculture ☐ b) Labour ☐ c) Daily wage earner ☐
 d) Service ☐ e) Business ☐

12) What is the main source of income of your family?

- a) Agriculture ☐ b) Business ☐ c) Service ☐ d) Others ☐

13) Is that income adequate for your family throughout the year?

- a) Yes ☐ b) No ☐

14) If no, how long is it adequate for?

- a) 3 months ☐ b) 6 months ☐ c) 9 months ☐

15) Environmental health:

15.1) How many rooms do you have in your house?

15.2) How many persons live in a room?

15.3) Do you have a separate kitchen?

- a) Yes ☐ b) No ☐

15.4) What do you use to cook food?

- a) wood ☐ b) kerosene ☐ c) gas ☐ d) others ☐

15.5) What type of *Chulo* do you have?

- a) Ordinary ☐ b) smokeless ☐

B) CSOM RELATED QUESTIONNAIRE

16) Do other family members have suffered from CSOM?

- a) Yes ☐ b) No ☐

17) Does the child have hearing impairment?

- a) Yes ☐ b) No ☐

18) Which is the discharging ear?

- a) Right ☐ b) Left ☐ c) Both ☐

19) How often does he have cough and cold?

- a) < 3 episodes/year ☐ b) 3-6 episodes/year ☐
 c) > 6 episodes/year ☐ d) others: ☐

20) Does he blow nose when he has common cold?

- a) Yes ☐ b) No ☐
- 21) Does he go for swimming?
a) Yes ☐ b) No ☐
- 22) Does he have ear pricking habit?
a) Yes ☐ b) No ☐

C) QUESTIONS RELATED TO THE RESPONDENT'S KNOWLEDGE:

- 23) Do you consider CSOM as a disease?
a) Yes ☐ b) No ☐
- 24) What do you think is the cause of CSOM?
a) Breast milk over the ear ☐ b) Water into the ear ☐
c) Micro-organism ☐ d) Others ☐
- 25) Is it preventable?
a) Yes ☐ b) No ☐
- 26) Does it need to be treated?
a) Yes ☐ b) No ☐
- 27) If Yes, where will you take the child for treatment?
a) Health personnel ☐ b) Dhami-Jhankri ☐
c) Jhar-phuke ☐ d) Others: ☐

D) QUESTIONS RELATED TO MOTHER'S PRACTICE:

- 28) For how long did you breast feed the child?
a) < 6 months ☐ b) 6-12 months ☐ c) 1-2 years ☐ d) 2-3 years ☐
- 29) How did you breast feed the child?
a) Lying down ☐ b) Sitting up ☐ c) Both a & b ☐ d) Others ☐
- 30) Do you put oil in the child's ear?
a) Yes ☐ b) No ☐
- 31) Do you put any drops prepared from herbs?
a) Yes ☐ b) No ☐
- 32) If Yes, what do you put?
a) Tulsi ☐ b) Gholtapre ☐ c) Lemon juice ☐ d) Others ☐
- 33) Do you clean the child's ear?
a) Yes ☐ b) No ☐
- 34) If Yes, with what?
a) Feather ☐ b) Match stick ☐ c) Kankatro ☐
d) Cotton ☐ e) Others ☐
- 35) Do you have the habit of slapping the child on the cheek?

- a) Yes ☐ b) No ☐
- 36) Do you ask the child to blow his nose when he has runny nose?
a) Yes ☐ b) No ☐
- 37) Do you put cotton balls in the child's ear before taking bath?
a) Yes ☐ b) No ☐
- 38) When do you go for consultation?
a) Immediately after earache ☐ b) After ear discharge ☐
c) After hearing impairment ☐

Thank You!

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