REPORT ON

COMMUNITY HEALTH DIAGNOSIS

BARPAK SULIKOT RURAL MUNICIPALITY-04

GORKHA, NEPAL

SUBMITTED BY

GROUP- C

14TH BATCH STUDENT OF BPH, 6TH SEMESTER

SUBMITTED TO

DEPARTMENT OF PUBLIC HEALTH

SCHOOL OF HEALTH AND ALLIED SCIENCES

FACULTY OF HEALTH SCIENCES

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This is to certify that the 14th batch "Group-C" students from sixth semester, Bachelor of Public Health (BPH), School of Health and Allied Sciences, Pokhara has Successfully completed the CHD entitled "Community Health Diagnosis of Barpak Sulikot-04, Gorkha". This CHD report is prepared for the partial fulfilment of the requirement for the Bachelor of Public Health (BPH) degree. This report has been accepted and approved.

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ACKNOWLEDGEMENT

The successful completion of this Community Health Diagnosis (CHD) report would not have been possible without the invaluable support, guidance, and cooperation of numerous individuals and organizations. We, the members of Group B, 14th Batch of Bachelor of Public Health (BPH), 6th Semester, express our deepest gratitude to all who contributed to this endeavor.

We are profoundly thankful to Pokhara University, School of Health and Allied Sciences, for providing us with this opportunity to integrate theoretical knowledge with practical community-based learning. Our sincere appreciation goes to Asst. Prof. Rajesh Kumar Yadav, our CHD Supervisor, for his unwavering mentorship, critical insights, and continuous encouragement throughout this journey. We are also grateful to Asso.Prof. Tulsi Ram Bhandari, Director of SHAS and Asst.Prof. Sapna Bhandari, BPH Coordinator, for their administrative support and academic guidance. We are also grateful to Asso.Prof. Bimala Bhatta, Former Director of SHAS and Asst.Prof. Bishwas Aacharya, Former BPH Coordinator, for their administrative support and academic guidance.

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We extend our heartfelt thanks to the local authorities of Barpark Sulikot -04, Saurpani, Gorkha, particularly the Ward Chairperson Mr. Bhimbahadur Gurung and office bearers, for granting us permission to conduct this study and for their generous cooperation. Our deep appreciation goes to the Health Post In-charge Mr.Pashupati Sharma and staff for sharing their valuable time, expertise, and facilitating our data collection process.

Special gratitude is owed to the Female Community Health Volunteers (FCHV) .We also acknowledge the contributions of school teachers,

We are profoundly indebted to the community members of Sulikot-04 for their warm hospitality, active participation, and willingness to share their valuable time and personal experiences. Without their trust and cooperation, this comprehensive assessment would not have been possible.

EXECUTIVE SUMMARY

Community health diagnosis refers to the identification and quantification of health problems in a community in terms of mortality and morbidity rates and ratios and the identification of their correlates for the purpose of defining those individuals or groups at risk or those in need of health care. The major focus of community health diagnosis is on the identification of health problems and different determinants that affect the health of community people. The objective of CHD is to assess the current health status of the people of Barpark Sulikot Rural Municipality-04, Gorkha and identify their health needs with an appropriate intervention with the cost-effective and locally available resources.

A community-based cross-sectional descriptive study was conducted by using a convenient sampling method among 500 households of Barpark Sulikot Rural Municipality-04, Gorkha. Face-to-face interview with each respondent was conducted to collect primary data using a semi structured questionnaire, anthropometric measurement tools. FGD and KII guideline were used to collect qualitative data. Data were entered in Epi-Data 4.7 and analyzed by using SPSS version 27.

The average household size was 4.06 with a nearly equal sex ratio (98.05 males per 100 females). Most families were nuclear (66%) and the literacy rate was 68%, with 17.9% educated up to the secondary level. Agriculture (64.4%) was the main source of income, followed by foreign employment (10.6%), and the majority (94.8%) earned Rs. 20,000–50,000 monthly. About 93% of families were non-migrant and 92.8% had ancestral residence. Only 1% of individuals had a disability. Tobacco and alcohol use were reported by 16.5% and 13.9%, respectively. 36% lacked birth registration and 40% were underweight. Deaths were reported in 3% of households, with 71% registered.

Regarding health knowledge, Tuberculosis (TB): 69% had heard of TB only 34% knew its key symptom (blood in sputum) and 59% were unaware of its transmission. 58% believed TB is curable and 44% identified hospitals as treatment sites. Awareness of DOTS was very low (5%). Diarrhoea: 35% reported diarrhoea in the past 6 month 58% used ORS for management though 51% lacked proper preparation knowledge. Only 14% recognized dehydration symptoms, and 65% identified avoiding stale food as

prevention.Dengue: 73% had heard of it: 92% linked it to mosquito bites and 50% cited mosquito nets as prevention.

Hypertension (HTN): 84% had heard of HTN, but 43% didn't know its causes and 71% were unaware of its complications. Gastritis: 92% were aware main causes cited were fatty meals (55%) and untimely diets (43%). 81% recognized avoidance of oily/spicy food as prevention.Diabetes: 73% had heard of diabetes: 60% blamed high sugar intake but 73% were unaware of complications. 63% suggested sugar reduction as prevention. Asthma: 76% were aware: 42% attributed it to smoking and 60% identified breathing difficulty as a symptom. 44% were unaware of prevention.Uterine Prolapse: 55% were aware: 62% linked it to heavy lifting, while 54% cited avoiding heavy loads as prevention. Mental Health: 51% were aware: major causes identified were stress (80%) and substance abuse (9%). Only 5% had affected family members, and 88% believed it is curable.

Among women surveyed, 65.8% married before 20 and most had first pregnancies between 20–30 years. ANC check-ups were widely practiced most had 4–8 or more visits, primarily at government health facilities, and all took iron tablets. 89% of deliveries occurred in institutions. PNC coverage was moderate 56% received PNC check-ups, and 85% received Vitamin A. All mothers fed colostrum milk to new-borns. Among respondents of reproductive age, 55% were using family planning, mainly sterilization (43%), Depo (30%), and condoms (16%). 30% experienced side effects, including headache, fatigue, and weight loss. The main reason for non-use was not necessary (74%).

Among the participants 57% understood the concept of balanced diet. 81% described it correctly as a mix of grains, fruits/vegetables, and animal sources, regarding sarbottam lito 59% knew its preparation: 77% did it correctly, about infant feeding 81% said colostrum is essential, 59% fed within one hour of birth. Regarding dietary diversity Within 24 hours, 99% ate rice, 72% green vegetables, and 60% cereals: fruit and egg intake were least common. Vegetable consumption: 58% ate daily: fruit consumption averaged 2–4 times weekly. Homemade meals were dominant (88%), with 40% reporting junk food intake. Nearly almost everyone used tap water (98%): 90% were satisfied with its purity, though only 60% purified it. Among those who purified, filtration (61%) and boiling (53%) were most common. Jerry cans (68%) were main storage containers. Most households used firewood (86%) for cooking, followed by gas

stoves (49%). Waste segregation was done by 82%, though 96% practiced burning waste, indicating limited proper disposal systems.

All the children were immunized, where 81 % adolescent girls were vaccinated with HPV vaccine. Most houses were Ardha-Kachhi (77%), with 69% having adequate rooms and 85% separate kitchens. Proper ventilation was present in 65%, and toilet coverage was 98%. Cattle sheds were present in 85% of homes, often within 25 feet. Clear Surrounding was reported by 70%.

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LIST OF ABBREVIATIONS

CHD	Community Health Diagnosis
BHS	Bachelor of Public Health
BP	Blood Pressure
BHS	Basic Health Service
FCHV	Female Community Health Volunteer
HIV	Human Immunodeficiency Virus
HTN	Hypertension
MS Office	Microsoft Office
MS Word	Microsoft Word
PMC	Pokhara Metropolitan City
ANM	Axillary Nursing Midwife
PU	Pokhara University
SHAS	School of Health and Allied Sciences
BHCC	Basic Health Care Centre
TB	Tuberculosis
CD	Communicable Disease
NCD	Non-Communicable disease
MOT	Mode of Transmission
GoN	Government of Nepal
PLA	Participatory Learning Appraisal
FGD	Focus Group Discussion
KII	Key Information Interview
PRA	Participatory Rural Appraisal
DOTS	Directly Observed Treatment Short Course
MHP	Micro Health Project
SPSS	Statistical Package for Social Sciences

CHAPTER I: INTRODUCTION

1.1 Background of CHD

CHD comes under Public Health Application strand, helps to acquire basic and practical skills of various theoretical disciplines of sixth semester as mentioned in course objectives.

CHD refers to the identification and quantification of the health problems in a community in terms of mortality and morbidity rates. Generally, it is a comprehensive assessment of the health status of the community in relation to its social, cultural, physical, psychological and environmental conditions. Its main purpose is to reveal the existing health problems in the community, setting priorities and applying appropriate intervention measures to solve that problem, which is based on the information from the study and observations of the community members.

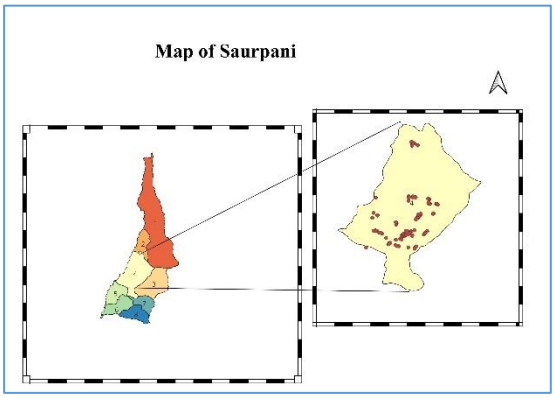
With this program, it is possible to get an initial picture of a community and its health problems within short period of time. The process of CHD involves initial exploration and interaction with the community, planning the study, pre-testing the methods, executing the data collection and analysing the findings. The focus of CHD is on identification of the health problems of the community, identifications of the basic health needs, prioritization of the problems for community health action and applying the appropriate intervention measure to solve those problems. The final task is to feed these conclusions back to the community and health workers so as to initiate the process of interpretation for the planning. The aim of community health diagnosis is to: identify of basic health needs, identify health problems and different determinants that affect the health of community people and assist the community to promote their health by modifying the knowledge, attitude, and practice regarding their health with their own active participation.

Community diagnosis is a fundamental philosophy of Public Health, emphasizing problem-based and self-directed learning as well as community orientation. For BPH students, it is a crucial aspect of their education. Recognizing this, Group-C of the 14th batch of BPH students from Pokhara University were assigned to Barpark Sulikot-04, Gorkha.

1.2 Background of study area

Geographical location

The study area of CHD was Barkpark Sulikot-04 , Gorkha. Ward no. 4 is joined with ward no. 1 and 2 in the north, ward no. 6 and 7 in the south, ward no. 3 in east and ward no. 5 in west. The area of ward no. 4 is 200.6 square km.



Resource information

Ward no. 4, Saurpani is rich in natural resources. The main natural resources are: forests and agricultural land. These resources are very useful for the overall socio-economic development of this ward.

Demographic Information

The population of ward no. 4 is 5133 (Barpak Sulikot-04, Gorkha) . Males and females are nearly equal and the majority of the proportion is the productive age group.

Socio-economic Information

Agriculture is the main occupation followed by people. The majority of people were Janajati followed by Brahmin/Chhetri and Dalit. Hinduism is major religion followed by people.

Institutional Information

This ward is well facilitated with basic infrastructure. It has different institutions such as School, Mother's Group, Schools, Health post, Police Station, Tol Development Committee and governmental organization.

1.3 Rationale of study

The study fulfils the requirement for the field practice to acquire basic and practical skills of various theoretical disciplines of sixth semester as mentioned in our course objectives. Our course helps to develop practical and applied skills to assess health

problems and assessing these problems in scientific way for theory subject delivered during the semester.

1.4 Objective

1.4.1 General Objective

To assess the current health status of the people of Barpark, Sulikot Rural Municipality ward no. 4, Gorkha and identify the health problems of the community, prioritize that health problem and conduct MHP utilizing effective locally available resources.

1.4.2 Specific Objectives

- To identify the socio-demographic structure of the community.
- To explore the knowledge and practices of community people regarding NCDs and CDs.
- To assess the status of communicable disease and non-communicable disease among the community people.
- To assess the knowledge and practice regarding nutrition and food consumption among the community people.
- To access the nutritional status of children under 5 years old and adults.
- To identify the practice regarding safe water and basic sanitation.
- To assess the maternal and child health status in community.
- To assess the knowledge and practice of family planning method in reproductive aged married couple.
- To identify the status of immunization among children under 2 years old and adolescent girls.
- To prioritize the identified health problems and assess the health needs.
- To conduct the school health program.
- To conduct the micro health project utilizing cost effective locally available resources.
- To present overall finding of community health diagnosis to the community people.

1.5 Operational Definition

Average household size: It is the ratio of the total population to total households: (AHS=Total population/Total household)

Sex ratio: Sex ratio is defined as the ratio of males per 100 females: (SR= (No. of male/No. of female) * 100

Productive population: People aged between 15-64 years who were physically and economically active.

Literacy rate: Number of people who are able to write and study divided by the total population. People aged 5 or more years are included for calculating the literacy rate.

Informal Education: Those people who are able to read or write but has not any formal qualification.

Health services Accessibility: Households have health facilities within the walking distance of half an hour (30 minutes).

Teenage pregnancy: Women who were pregnant before the age of 20 years.

ANC protocol: Number of pregnant women who attended 8 ANC as protocol (12,16, 20, 28, 32, 34, 36 and 38 week of pregnancy) at a health facility.

Institutional Delivery: Number of deliveries conducted at health facilities (public or private) by trained health workers.

Exclusive breastfeeding: Lactating women should give only their milk to a newborn child for at least 6 months.

Immunization Target group: children below 1 year. For JE and MRnd 12- 23 months' children as per national protocol.

Reproductive Aged Group (RAG): People aged between 15-49 years who are active and capable of reproduction.

Distance between the source of water and toilet: It should be at least 15 meters (

Correct method of Sarbottam litto : 2 part cereals and 1 part pulses

Distance between house and shed: It should be at least 25 feet.

CHAPTER II: METHODOLOGY

2.1 Study Area

The study area of CHD was Barpak-Sulikot-04, Gorkha, Gandaki Province.

2.2 Study Design

The study design of CHD was cross-sectional descriptive type. The study design of Community Health Diagnosis was cross-sectional descriptive. CHD is snapshot study of overall health status of community. In which measurement of exposure and outcome are made at same time.

2.3 Study Duration

The study period was from 2082/02/28 to 2082/02/27 (30 days).

2.4 Sampling Technique

The sampling technique used for CHD was convenient sampling due to lack of proper sampling frame in which we select those sample who were convinced and willing to participate in our study.

2.5 Sample size

The sample size for CHD was 500.

2.6 Unit of Study

Unit of our study was household.

2.7 Selection Criteria

2.7.1 Inclusion criteria:

- Permanent resident of Barpak Sulikot-04, Gorkha aged above ≥18 years, and willing to participate in the study.
- For family planning related information participants of 15-49 years of married couple were included,
- For maternal and child health related information pregnant women, mothers of under 5 year children and
- For anthropometric measurement children of 6–59 month age children were included.

2.7.2 Exclusion criteria:

- Those people who were not the permanent resident of Barpak Sulikot-04, Gorkha,
- Participants who were not able to respond and
- Age less than 18 years old.

2.8 Source of Data

The source of data was primary which were collected first hand by using semi-structured questionnaire, observation check list, FGD guideline and KII forms.

2.9 Type of data

The type of data for CHD was quantitative and qualitative. Quantitative data were collected by using semi-structured questionnaire while qualitative data were collected through a Focus Group Discussion (FGD) and Key Informants Interview (KII).

2.10 Data Collection Tools and Techniques

Table 1: Data collection tool and technique

Data type	Tool	Participants/Application	Technique
Quantitative	Semi-structured questionnaire	People aged between 18-70 years	Face-to-face interview
	Shakir's tape	U5 children	MUAC measurement
	Weighing machine and Stadiometer	Adults	Height, weight measurement
	Observation checklist	Observing the household and surrounding	Observation
Qualitative	Social map, seasonal calendar, organizational chart, daily time schedule.	Community members	PRA/PLA Technique
	FGD guideline	Concerned stakeholders	Group discussion
	KII guideline	Concerned stakeholders	Interview

2.11 Data Analysis and Management

Data were entered in Epi-Data 4.7 software and Statistical Package for Social Science (SPSS) version 28 was used for data management and data analysis. Descriptive statistics (frequency, mean and multiple responses) were computed. The findings were presented in diagrammatic (pie-chart, bar-diagram) and tabular form.

2.12 Validity and Reliability

To ensure validity, we consulted with the CHD coordinator and subject experts and extensive literature review. To ensure reliability, we pretested the questionnaire in Khudi and made necessary modifications based on the supervisor's feedback.

2.13 Ethical Consideration

The study was approved by the School of Health and Allied Sciences, Pokhara University, and approval was also taken from the ward office of Barpak Sulikot-04, Gorkha. Written informed consent was taken from each participant. Participants were informed of their right to withdraw from the study at any time without reason. Data obtained from the study participants will not be used for any other purpose than for partial fulfillment of the BPH program. Privacy and Confidentiality was maintained.

2.14 Logistics of CHD

Table 2: Logistic of CHD

S.N.	Logistics	Uses
1	Weighing machine	For measuring body weight
2	Shakhir's tape	For measuring MUAC of U5 children
3	Stadiometer	For measuring the height of people
4	BP set	For measuring blood pressure
5	Chart papers, newsprint paper Markers, sign pen, scale, and other stationery items	For preparing chart papers, presentations
6	First aid kit	For using during the emergency and general health problems

CHAPTER III: RAPPORT BUILDING AND SOCIAL MAPPING

3.1 Rapport Building and Orientation

Rapport Building is the process of establishing a friendly, trusting relationship essential for enhancing communication and cooperation between stakeholders.

In this field practice, significant effort was dedicated to cultivating strong, positive connections with all concerned parties. Developing these meaningful bonds, characterized by mutual understanding, trust, and communication ease, is fundamental to community health diagnosis. This process served as the essential foundation for every task undertaken. By intentionally establishing and nurturing these relationships, we were able to build trust with community members, which was critical for facilitating the ethical collection of necessary data and ensuring the effective implementation of community-based programs.

3.2 Process of Rapport Building

3.2.1 Activities of Rapport Building

- Provided appropriate self-introductions during key interactions, including transect walks, community assemblies, and home visits.
- Clearly articulated the project's purposes and objectives using understandable language.
- Shared relevant personal information to foster deeper, more meaningful connections extending beyond the field work requirements.
- Described planned activities and distinctly highlighted the anticipated benefits these activities would bring to the community.
- Demonstrated active interest in community discussions and provided assurance of support as needed.
- Sustained engagement through formal and informal meetings, phone calls, and discussions.

3.3 Social Mapping

Social map is a visual representation of a social network which involves drawing the map of the concerned community with essential resources, along with the full participation of community members. It is very crucial part of our residential field practice since, initially, we are totally unaware about the study area. It is a platform during which we get to know the study area in deeper ways.

3.4 Process of Social Mapping

i. Invitation to Key Informants/Local People

During our social mapping, we invited the key informants of our study area such as the ward president, ward members, BHCC staff, school principals, FCHVs, mother group, and more others.

ii. Local Resources Collection:

We collected different local resources to prepare the map of Barpak Sulikot-04, Gorkha. We gathered stones, pebbles, coal, leaves, stems, grass, sticks etc. We also used the soil from the fields to create various important structures such as health clinics, schools, temples, entrance, chautaras and painted with the help of abir and kesari to color them.

iii. Mapping:

Firstly, we shared the purpose and importance of social mapping to the community people. Then to facilitate the community members, we gathered and dispatched the materials to be used for mapping. The community people initiated the drawing by tracing the boundary and indicating the north pole. They discussed and located all the resources and structures in their community such as road, direction, ward office, health clinics, radio station, forest, temples, church, schools, chautara, FCHVs house and so on. After the mapping was completed, we copied the map into a chart paper using pencils, markers, sign pens etc and thanked each participant for their participation in this process.

Date: 2082/ 02/30

Venue: Outside of School (Shree Himalaya Secondary School)

CHAPTER IV: FINDINGS AND RESULT

4.1 Socio-demographic Information

4.1.1 Demographic information

Out of 500 households our study revealed that the average household size was about 4.062, with a total population of 2031. Males and females were nearly equal, which makes the sex ratio (M/Fe*100) 98.05. Among total households, more than half (66%) were nuclear families. Around one fifth (17.9%) of the people had secondary level education. The overall literacy rate was 68%.

Table 3: Socio demographic status

Socio-demographic Information	Frequency	Percentage (%)
Gender (n=2031)		
Male	1005	49.5
Female	1026	50.5
Education level (n=2031)		
Illiterate	600	29.5
Informal	178	8.8
Basic education	716	35.3
Secondary	363	17.9
Bachelor	67	3.3
Master or higher	19	0.9
Marital Status (n=2031)		
Married	1150	56.6
Unmarried	573	28.2
Widow	90	4.4
Widower	32	1.6
Divorced	12	0.6
Religion (n=500)		
Hinduism	333	66.6
Buddhism	135	27
Christianity	29	5.8
Muslim	3	0.6
Ethnicity (n=500)		
Dalit	103	20.6

Janajati	276	55.2
Muslim	2	0.4
Brahmin/Chhetri	118	23.6
Madhesi	1	0.2
Family Type (n=500)		
Nuclear	330	66.0
Joint	169	33.8
Extended	1	0.2

4.1.2 Socio-economic Information

Among the total 500 households, 64.4% household major source of income was Agriculture followed by 10.6% foreign employment. Majority of household 94.8%, had monthly income twenty to fifty thousand.

Table 4: Socio economic status

Socio-economic Information	Frequency	Percentage (%)
Major Source of Income (n=500)		
Agriculture	322	64.4
Foreign employment	53	10.6
Business	39	7.8
Daily wages	21	4.2
Services	34	6.8
Pension	16	3.2
Private sector/ INGO's	9	1.8
Others	6	1.2
Monthly Family Income (n=500)		
<20000	8	1.6
20000-50000	474	94.8
>50000	18	3.6

4.1.3 Population Pyramid

The population pyramid as shown in figure above indicates the total population is 2031, with 1005 males and 1026 females. The largest age group is 20-24 years and the smallest is 0-4 years.

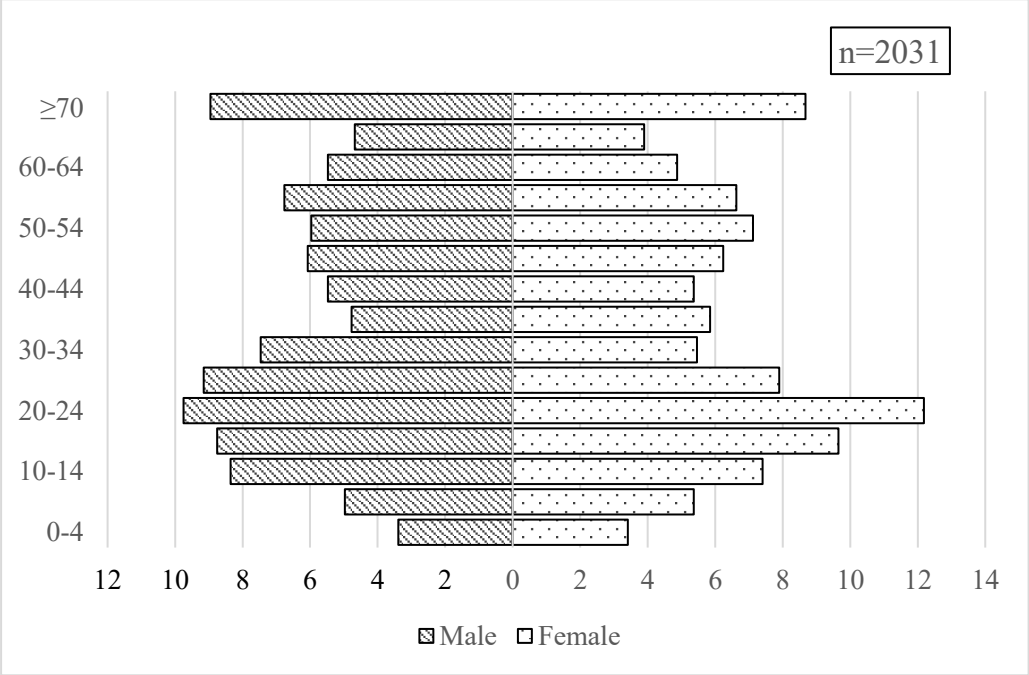


Figure 1:Population Pyramid

4.1.4 Disability among the family members

Among 2031 members, very few (1%) had disability where as others (99%) were with no disability as shown in figure.

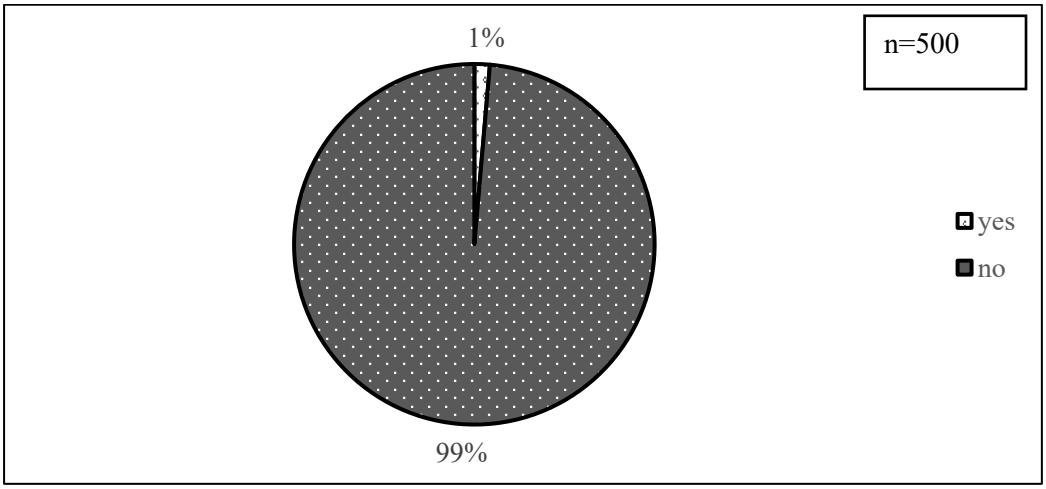


Figure 2 Disability among family members

4.1.5 Tobacco Consumption

Among 2031 population, 16.5 % were currently consuming tobacco whereas 81.4% never consumed tobacco as shown in figure.

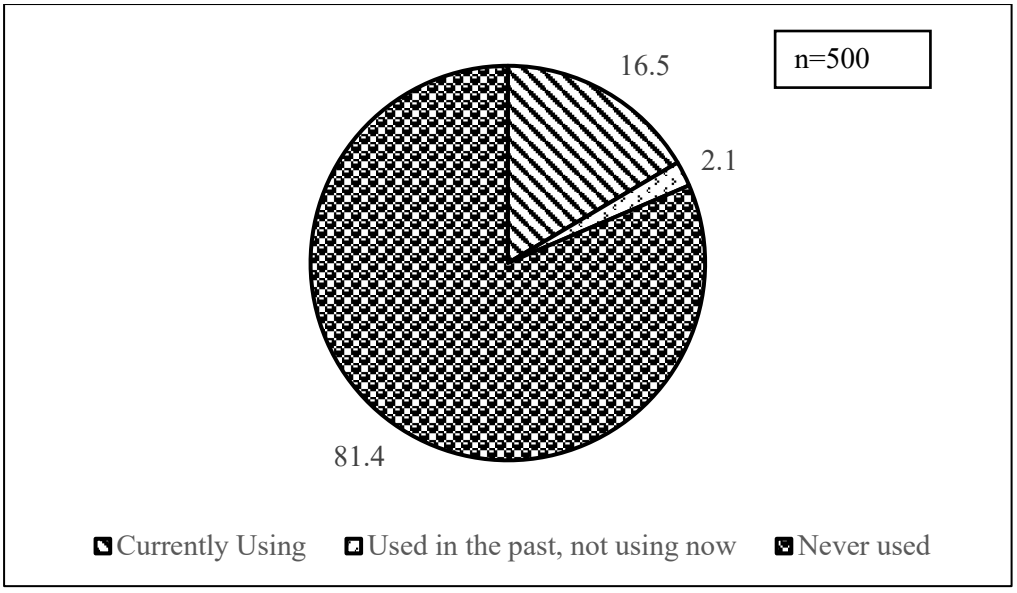


Figure 3:Tobacco Consumption

4.1.6 Alcohol Consumption

Among 2031 population,13.9 % were currently drinking alcohol,2.9% drank in past whereas 83.3 % never drank alcohol as shown in figure.

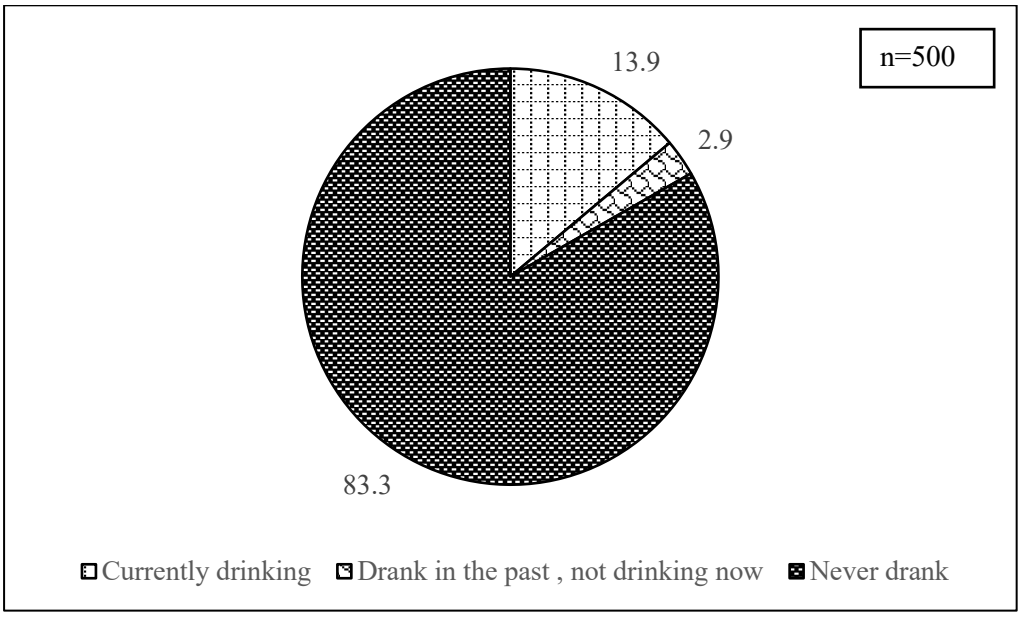


Figure 4:Alcohol Consumption

4.1.7 Birth Related information

4.1.7.1 Birth within 1 year in the family

Out of 500 households 3 % had new-born in their family as shown in figure.

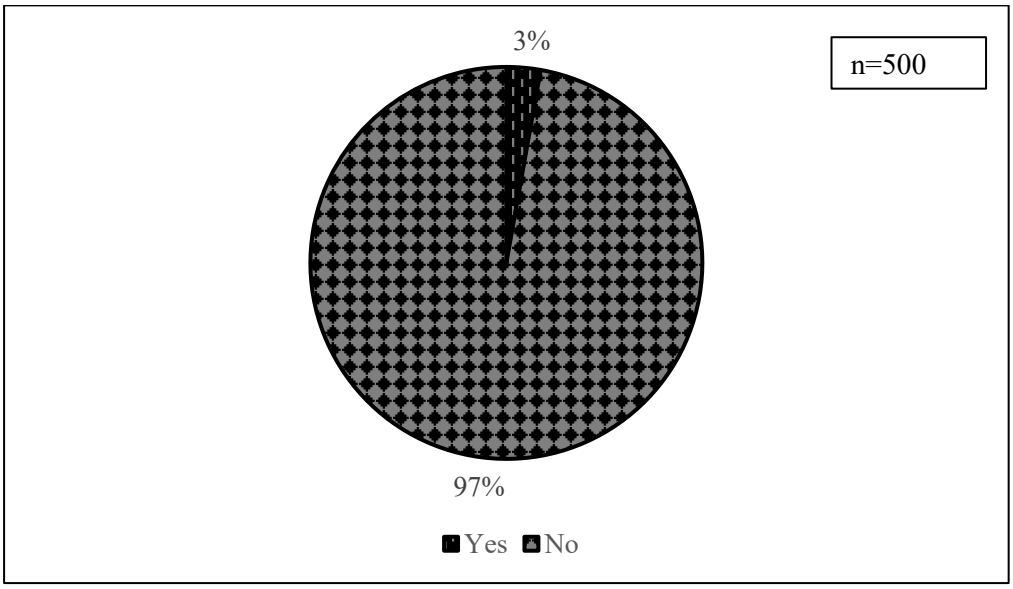


Figure 5 Birth within one year

4.1.7.2 Birth Registration

Out of 14 new-born children, 5 children had no birth registration.

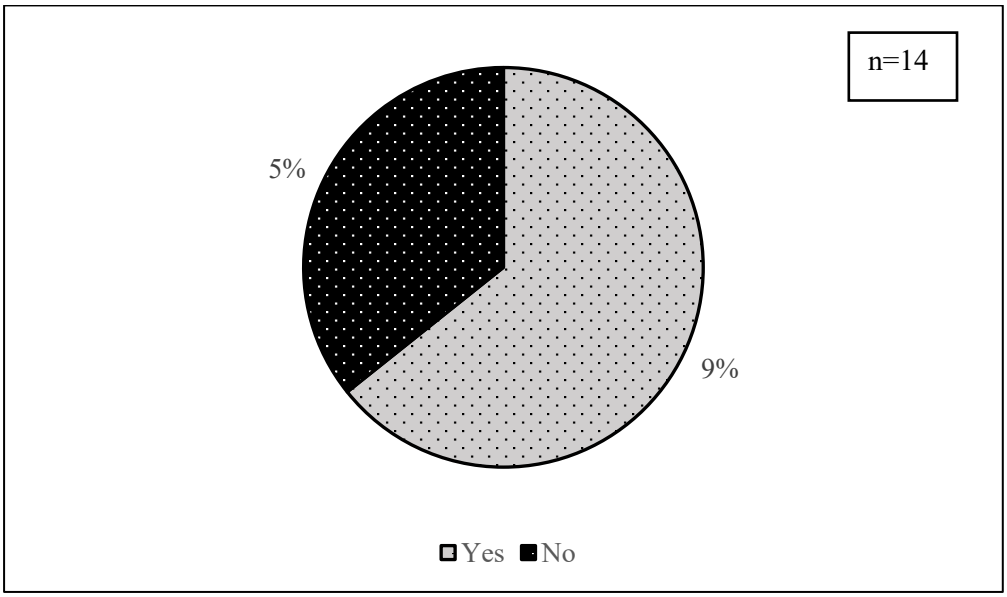


Figure 6 Birth Registration

4.1.7.3 Information related to Birth

Among 10 children under one year of age, 4 children were underweight (< 2.5 kg).

Table 5: Information related to birth

Birth related information (n=10)	Frequency(n)	Percentage (%)
Gender		
Male	4	40
Female	6	60
Birth status		
live	10	100
dead	-	-
Age of mother while giving birth		
20 years or less	2	20
21-29 years	7	70
30 years or more	1	10
Weight of infants		
Less than 2.5 kg	4	40
2.5 kg or more	6	60

4.1.8 Death Related Information

4.1.8.1 Death within one year

Out of 500 households, only 3% reported the death of a family member within the past year as illustrated in figure.

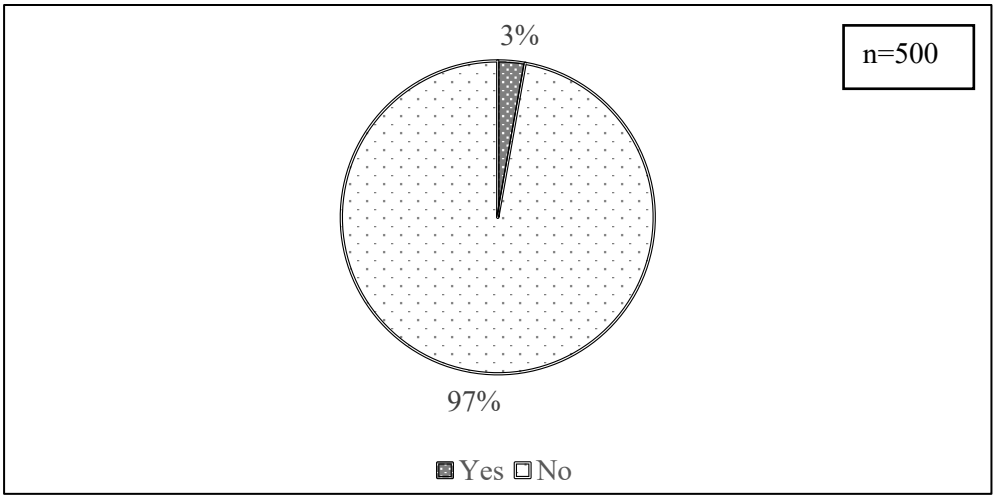


Figure 7 Death within one year

4.1.8.2 Death Registration

Among 14 households informed about death of family member within one year, 10 respondent said they had done the death registration of death family member and 4 said they had not done as it is illustrated in above figure

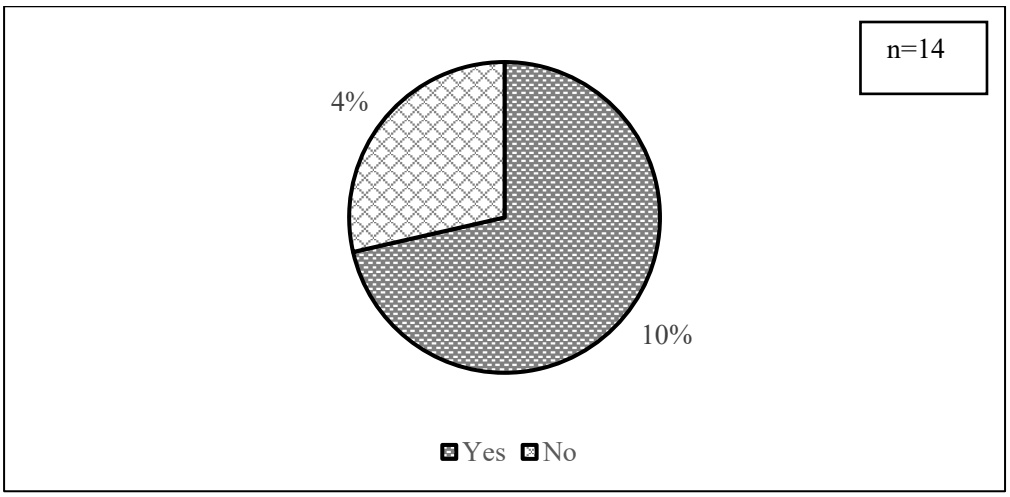


Figure 8 Death Registration

4.1.8.3 Information related to death

Table 6: Information related to death

Death related Information	Frequency(n)	Percentage (%)
Sex (n = 7)		
Male	3	43
Female	4	57
Age at death (n=7)		
<18 years	0	0
18-59 years	1	14
60 years or more	6	86
Reasons of Death. (n=7)		
NCD	4	57.14
Accidents	3	42.85
Visit of Hospital for treatment (n=7)		
Yes	3	43
No	4	57

4.1.9 Information Related to Migration

4.1.9.1 Duration of Residence

Among 500 households, 92.8% were habituated from ancestral and only 0.8% people were living from less than 5 years. Duration of residence information is illustrated in a the figure.

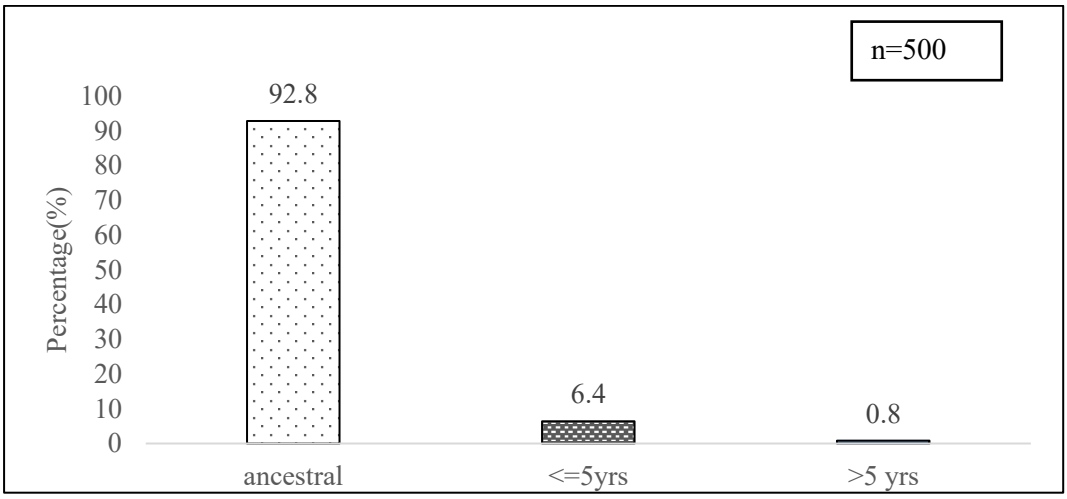


Figure 9 Duration of residence

4.1.9.2 Migration of family members

Among the 500 households ,7% of the family had their family members migrated and 93% of the family hadn't their family members migrated as shown in the illustrated figure.

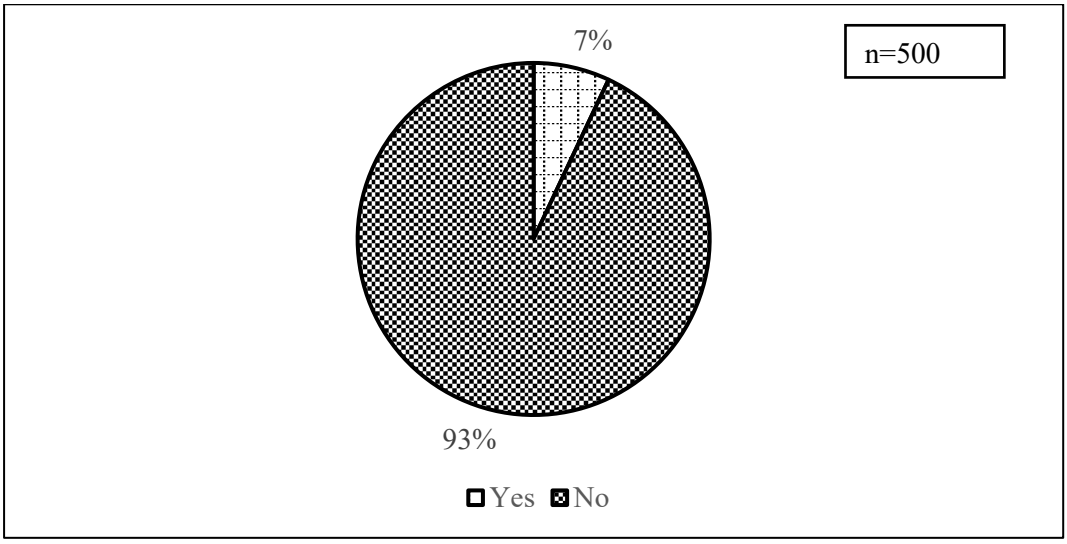


Figure 10 Migration of family members

4.1.9.3 No. of family members migrated

Among the total 33 migrated members, 9.1 % migrated from the one family whereas 12.1 % migrated from the 10 families as shown in the table above.

Table 7: No of migrated family member

No of family members migrated(n=33)	Frequency	Percentage(%)
1	3	9.1
2	5	15.2
3	4	12.1
4	9	27.3
5	5	15.2
6	1	3.0
7	1	3.0
8	1	3.0
10	4	12.1

4.1.10 Family members suffering from disease in past one year

Among the 500 households, 33% of family had suffered from disease whereas 67% of family hadn't suffered from disease as shown in the above figure.

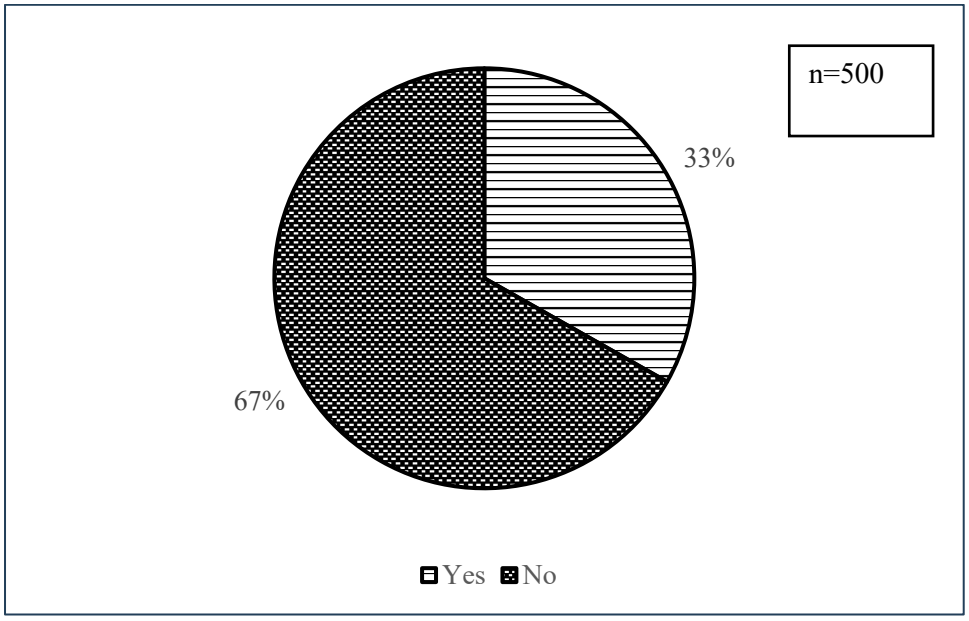


Figure 11 Family members suffering from disease in past 1 year

4.1.10.1 Information related to diseased population

In one year 153 people suffered from diseases as shown in table .

Table 8: Information related to diseased population

Diseased related information	Frequency(n)	Percentage (%)
Sex (n=153)		
Male	52	34
Female	101	66
Age (n=124)		
20 years or less	11	7
21-59 years	80	52
60 years or more	62	41
Type of disease		
NCDs/Accidents	127	83
CDs	26	17
Place of treatment		
Home	18	12
Government Hospital	76	50
Private hospital	44	29
Health Post	15	9
Current Disease Status		
Fit	88	58
Unfit	65	42

4.2 Disease and Epidemiology

4.2.1 Awareness of Tuberculosis

Among total 500 respondents, 69% had heard about TB and rest 31% had not heard about it as shown in figure.

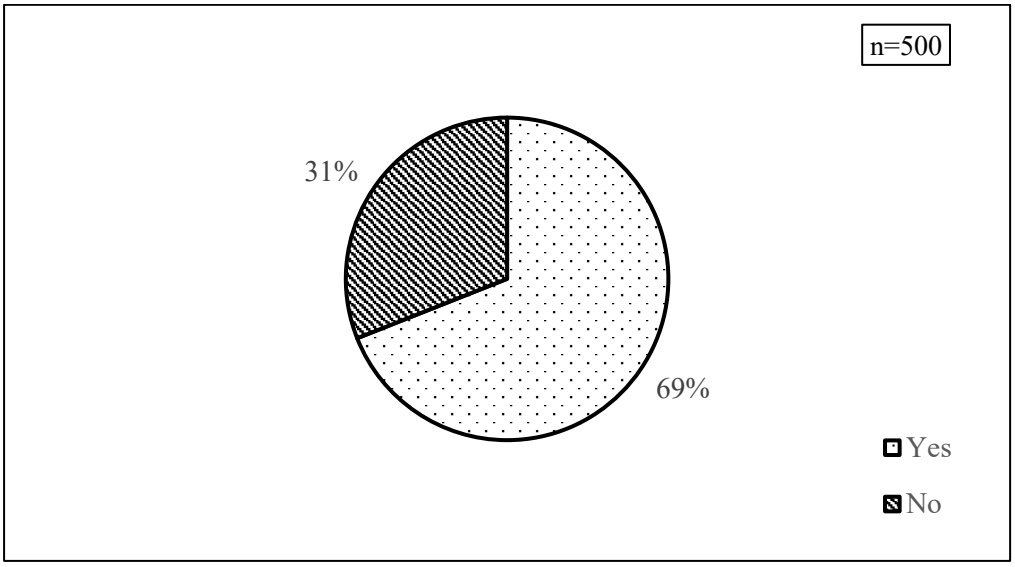


Figure 12 Awareness of tuberculosis

4.2.1.1 Knowledge on Symptoms of TB

Among total 345 respondents who had heard about TB,34% responded blood in sputum ,27% told persistent cough for more than weeks, fever (22%),chest pain (18%),weight loss (9%), loss of appetite (4%) and night sweats by 1% as a symptom of TB. Moreover, a significant portion of the respondents,44% indicated they were unknown about any symptoms,suggesting a major knowlede gap.

Table 9: Knowledge on symptoms of TB

Responses (n=345)	Frequency (n)	Percentage(%)
Blood in sputum	118	34
Persistent cough for more than 2 weeks	92	27
Fever	76	22
Chest pain	63	18
Weight loss	31	9
Loss of appetite	15	4
Night sweats	5	1
Don’t know	151	44

4.2.1.2 Mode of transmission of Tuberculosis

Among total 345 respondents who had heard about TB, most commonly known method of transmission was through the air while talking with patient(20%) followed by 18% responding when the patient sneezes,16% told wearing clothes used by the patient, 10% responded eating food contaminated by patient.Notably ,59% of respondents stated they were unknown about how TB transmits.

Table 10: Mode of transmission of TB

Responses (n=345)	Frequency (n)	Percentage(%)
Through the air while talking with patient	63	20
When the patient sneezes	57	18
Wearing clothes used by the patient	51	16
Eating food contaminated by patient	33	10
Don't know	190	59

4.2.1.3 Knowledge on cure of TB with course medication

Among total 345 respondents who had heard about TB, 58% responded TB is curable with full course medication, 11% responded TB cannot be cured while 21% were unknown as shown in figure.

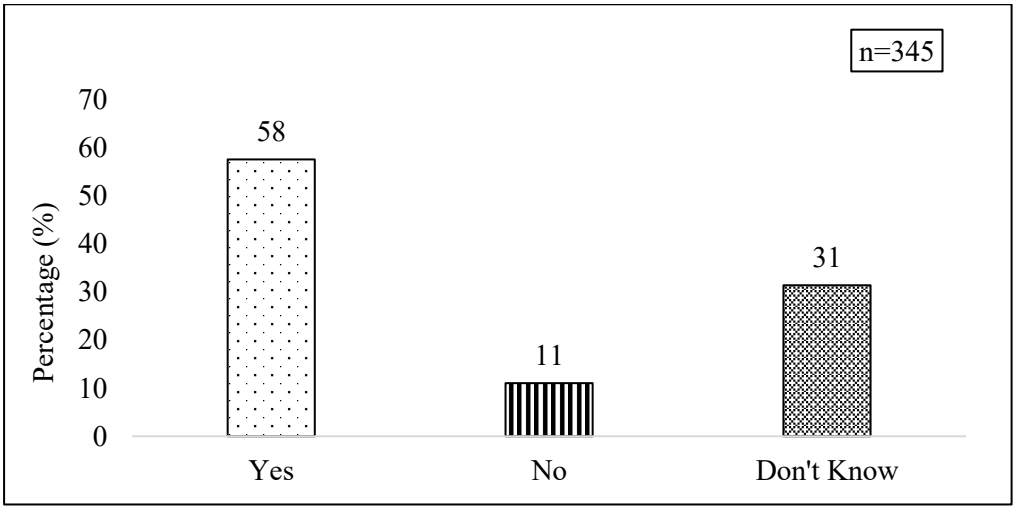


Figure 13 Knowledge on cure of TB with course medication

4.2.1.4 Place for treatment of TB

Among total 345 respondents who had heard about TB, majority (44%) identified hospitals as the place for treatment of TB,followed by Health posts(24%),PHC,traditional healers, pharmacy were each mentioned by only 1% of respondents while 46% indicated they were unknown where to seek TB treatment

Table 11: Place for treatment of TB

Responses(n=345)	Frequency(n)	Percentage(%)
Hospitals	150	44
Health posts	81	24
Primary Healthcare Center	5	1
Traditional Healers	2	1
Pharmacy	4	1
Don't know	158	46

4.2.1.5 Knowledge on preventive measures of TB

Among total 345 respondents who had heard about TB, 20% recognized patient covering nose and mouth while coughing and sneezing ,followed by taking precautions while coming closer to the patient(13%),staying in well-ventilated rooms by 10%, consuming Balanced Diets by 9%, taking complete medicines (8%), B.C.G Vaccination (3%) as preventive measures of TB whereas a substantial majority of respondents,59%, were unknown.

Table 12: Knowledge on preventive measure of TB

Responses(n=345)	Frequency(n)	Percentage(%)
Patient covering nose and mouth while coughing and sneezing	69	20
Taking precautions while coming closer to the patient	44	13
Staying in well-ventilated rooms	33	10
Consuming Balanced Diets	30	9
Taking complete medicines	29	8
B.C.G Vaccination	12	3
Don't Know	203	59

4.2.1.6 Heard about DOTS

Among 345 respondents, only 5% had heard about DOTS which indicates significant lack of awareness as shown in figure .

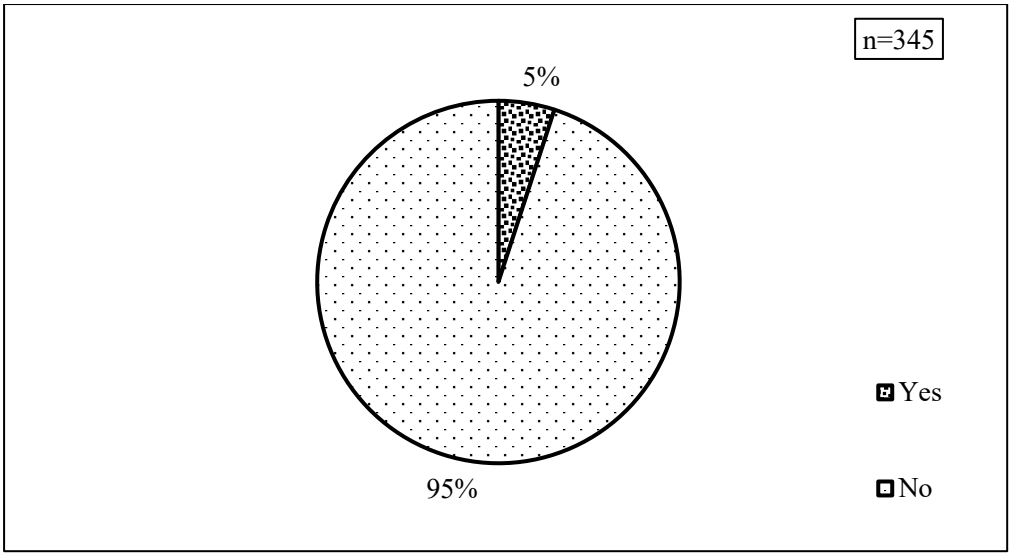


Figure 14 Heard about DOTS

4.2.2 Prevalence of Diarrhoea in Family in past 6 months

Among total 500 respondents, 35% indicated that a family member had experienced diarrhoea in the past 6 months, while 65% reported no such cases as shown in figure .

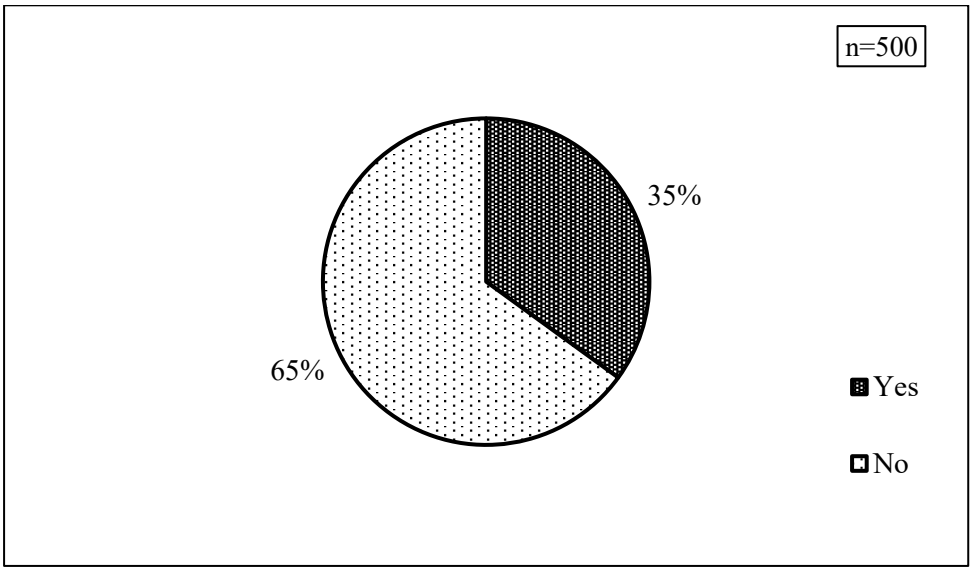


Figure 15 Prevalence of diarrhoea in family in past 6 months

4.2.2.1 Management of Diarrhoea

Among 177 respondents with prevalence of Diarrhoea in family in past 6 months, the most common management method was taking ORS used by 58% of individuals, followed by medication (37%), eating liquid or soupy foods (18%), 10% responded visiting hospitals and 8% told other methods such as staying hydrated, avoiding oily and spicy foods and personal hygiene.

Table 13: Management of diarrhoea

Respondent (n=177)	Frequency(n)	Percentage(%)
Taking ORS	102	58
Medication	65	37
Eating liquid or soupy foods	32	18
Visiting Hospitals	17	10
Others	14	8

4.2.2.2 Correct method of ORS preparation

Among 177 respondents,49% knew the correct method of preparing ORS but a slightly higher proportion (51%) lack proper knowledge as shown in figure .

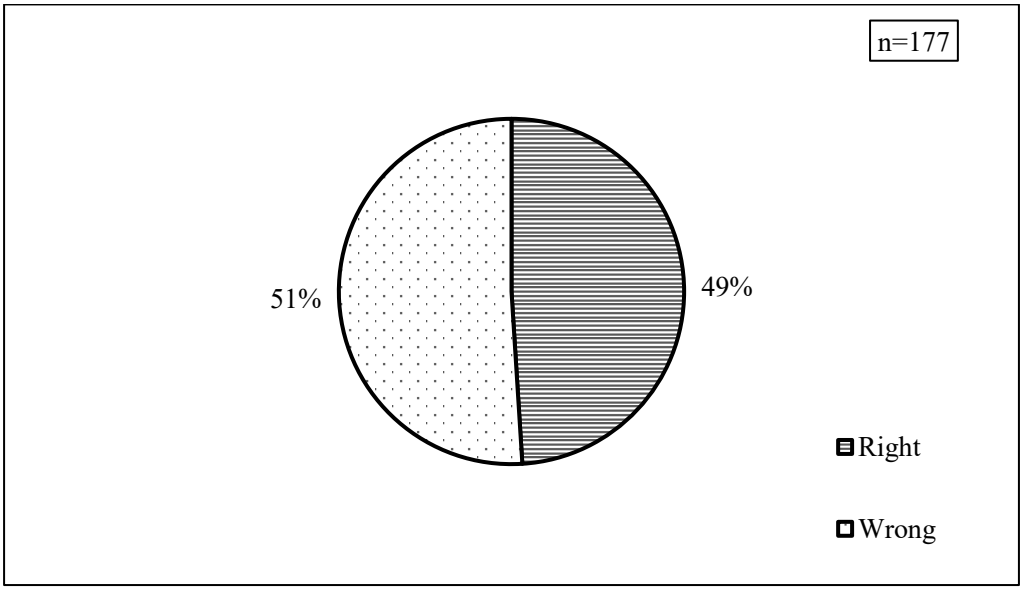


Figure 16 Correct method of ORS preparation

4.2.2.3 Causes of Diarrhea

Among 500 respondents, the most commonly perceived cause of Diarrhoea was eating leftover foods, followed by dirty surroundings (31%) and drinking polluted water (27%), a smaller proportion attributed it to maintaining personal hygiene (5%) and 1% told other reasons such as over eating, eating too much oily and spicy foods while 28% were unknown about causes of Diarrhoea.

Table 14: Causes of diarrhoea

Respondent (n=500)	Frequency(n)	Percentage(%)
Eating Leftover foods	269	54
Dirty surroundings	153	31
Drinking polluted water	132	27
Not maintaining personal hygiene	24	5
Don't Know	139	28
Others	6	1

4.2.2.4 Signs and Symptoms of Dehydration

Among total 361 respondents, only a small minority identified the signs, with 14% reporting weakness,13% reporting a dry mouth and tongue,8% reporting cold hands and feet and 2% responded torn skin while stretching while a concerning large.

Table 15: Sign and symptoms of dehydration

Respondent (n=361)	Frequency(n)	Percentage(%)
Weakness	53	14
Dry mouth and tongue	51	13
Cold hands and feet	31	8
Skin torn while stretching	7	2
Don't know	289	76

4.2.2.5 Prevention of Diarrhoea

Among total 361 respondents, a significant majority of respondents 65% identified avoiding stale, rotten or spoiled foods as a way to prevent Diarrhoea, followed by safe drinking water by 37%, proper sanitation around home by 17%, maintaining personal

hygiene by 13% and 15% of respondents mentioned other methods like handwashing and food hygiene

Table 16: Preventive measure of diarrhoea

Respondent (n=361)	Frequency (n)	Percentage (%)
Avoiding stale, rotten or spoiled foods	320	65
Safe drinking water	183	37
Proper sanitation around home	82	17
Maintaining personal hygiene	62	13
Others	72	15

4.2.3 Awareness of Dengue

Among total 500 respondents, 73% had heard about Dengue as shown in figure .

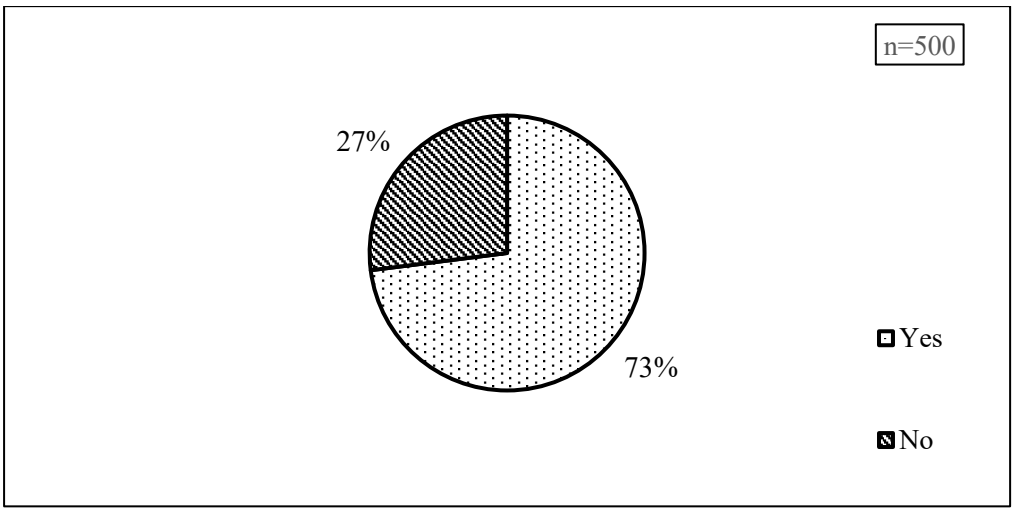


Table 17: Awareness of dengue

4.2.3.1 Knowledge about Causative Factor of Dengue

Among total 364 respondents who had heard about Dengue, an overwhelming majority of 92% identified mosquito bite as the cause,other less common answers included not using mosquito nets, consumption of contaminated water, blood transfusion through infected person and unsafe sexual contact while 8% were unknown about the cause of Dengue.

Table 18: Knowledge about causative factor of dengue

Respondent (n=364)	Frequency(n)	Percentage(%)
Mosquito bite	335	92
Not using mosquito nets	9	3
Consumption of contaminated water	7	2
Blood transfusion through infected person	2	1
Unsafe sexual contact	2	1
Don't know	29	8

4.2.3.2 Symptoms of Dengue

Among total 364 respondents who had heard about Dengue, most widely known symptom of Dengue was fever identified by 61% of respondents, followed by nausea and vomiting 19%, bone and joint pain 17%. Less common symptoms like bleeding from the gums and pain in the back part of the eye were recognized by 2% each while a significant portion 32% were unknown about Dengue symptoms.

Table 19: Symptoms of dengue

Respondent (n=364)	Frequency(n)	Percentage(%)
Fever	223	61
Nausea and vomiting	70	19
Bone and joint pain	62	17
Bleeding from the gums	7	2
Pain in back part of the eye	6	2
Don't know	116	32
Others	4	1

4.2.3.3 Prevention of Dengue

Among total 364 respondents who had heard about Dengue, the most recognized preventive measure was using mosquito nets identified by 50% of respondents, followed by 40% responding wearing long sleeve clothes and 23% responding avoiding water stagnation while 24% were unknown about Dengue preventive measures.

Table 20: Prevention of dengue

Responses(n=364)	Frequency(n)	Percentage(%)
Using mosquito nets	184	50
Wearing long sleeve clothes	147	40
Avoiding water stagnation	83	23
Cleaning water storage vessel once in a week	16	4
Don't Know	88	24

4.2.4 Heard about HTN

Among total 500 participants, 84% had heard about HTN and rest 16% didn't heard about it as shown in figure.

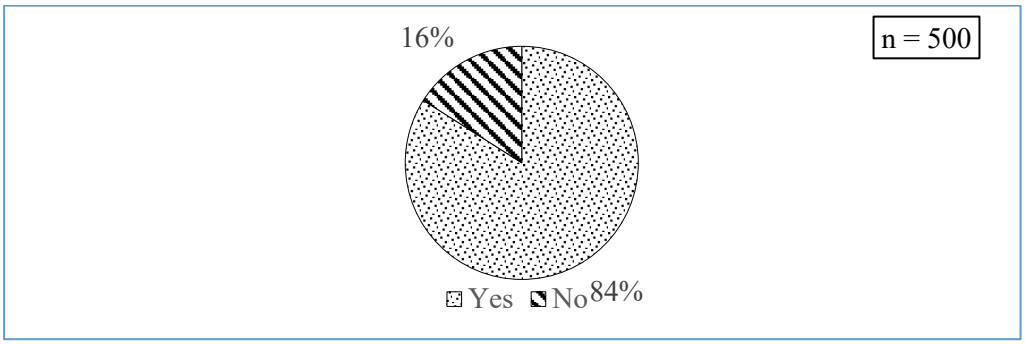


Figure 17 Heard about HTN

4.2.4.1 Knowledge on causes of high blood pressure (multiple response question)

Among total 420 households, 36% respondents had answered high intake of salt, and the causes of the high blood pressure as shown in figure.

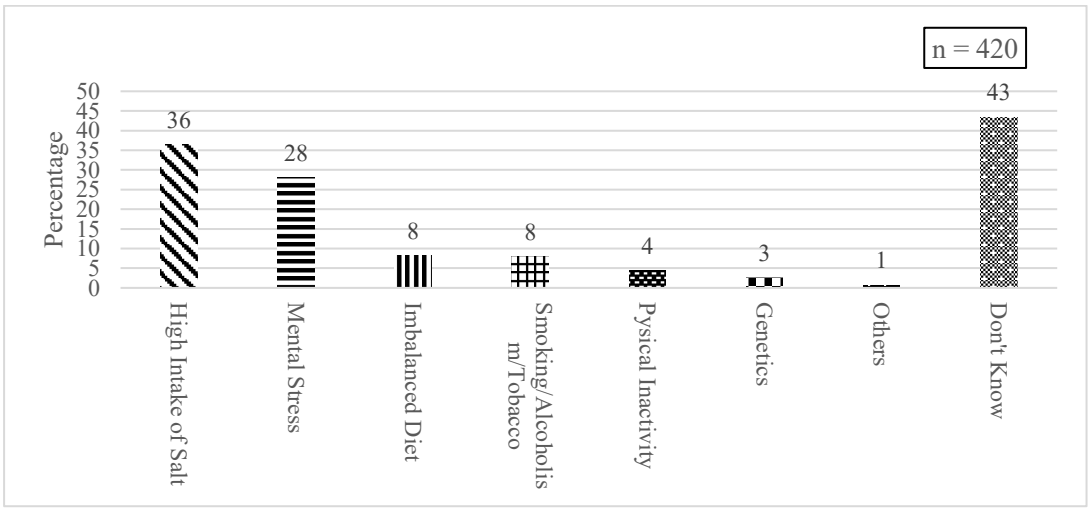


Figure 18 Knowledge on causes of high blood pressure

4.2.4.2 Knowledge on prevention and control of HTN (multiple response question)

Among total 420 households, 40% respondents had answered low intake of salt , 24% reduce stress , 6% physical activity and 47% responded they don't know the preventive measures of high blood pressure as shown in figure.

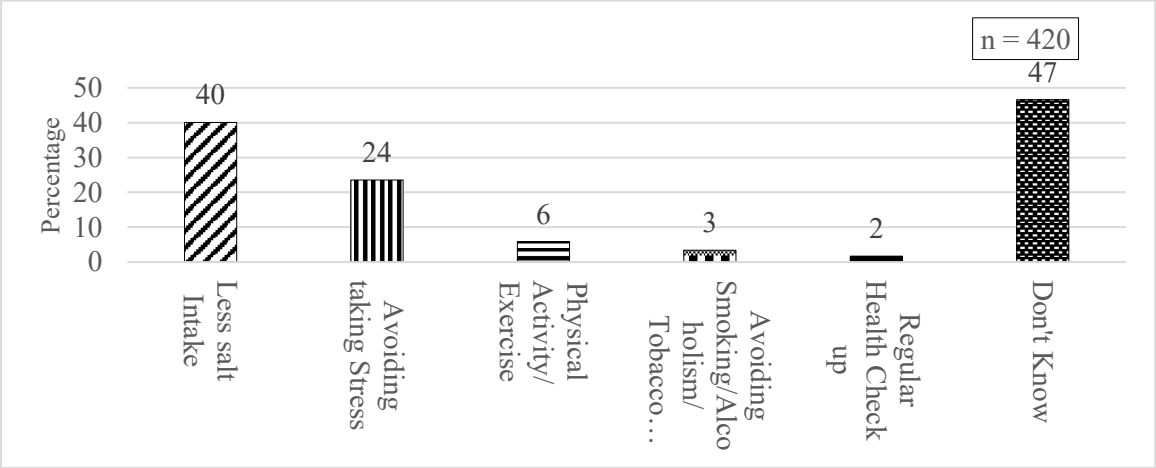


Figure 19 Knowledge on prevention and control of HTN

4.2.4.3 Knowledge on complications of high pressure (multiple response question)

Among total 420 households, 71% respondent don't know the complication of HTN followed by 17% heart attack, 6 % kidney problem and 6% death as shown in figure.

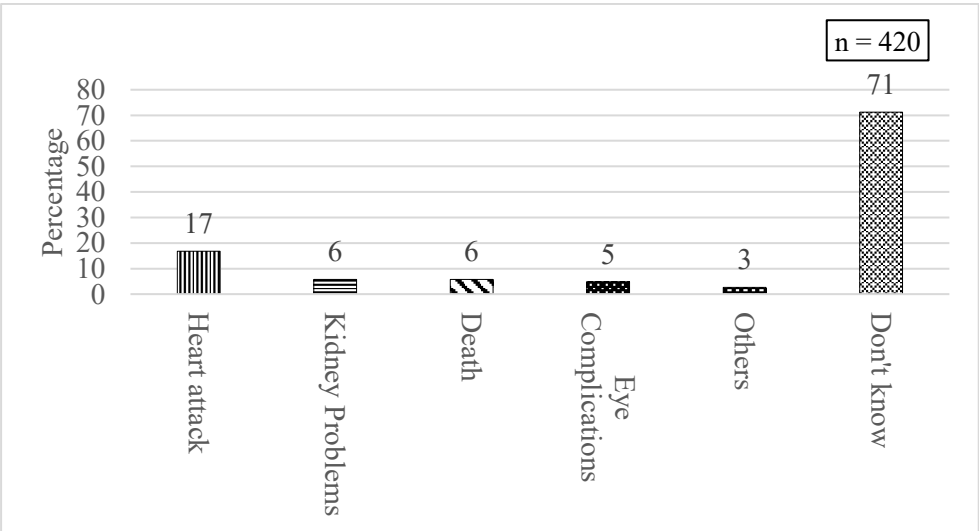


Figure 20 Knowledge on complications of high pressure

4.2.4.4 Status of Hypertensive cases

Among total 500 respondents, 50% respondent suffered from pre-hypertension followed by 30% cases of Normal Blood Pressure, 17% had Stage-I Hypertension and 3% had Stage-II Hypertension as shown in figure.

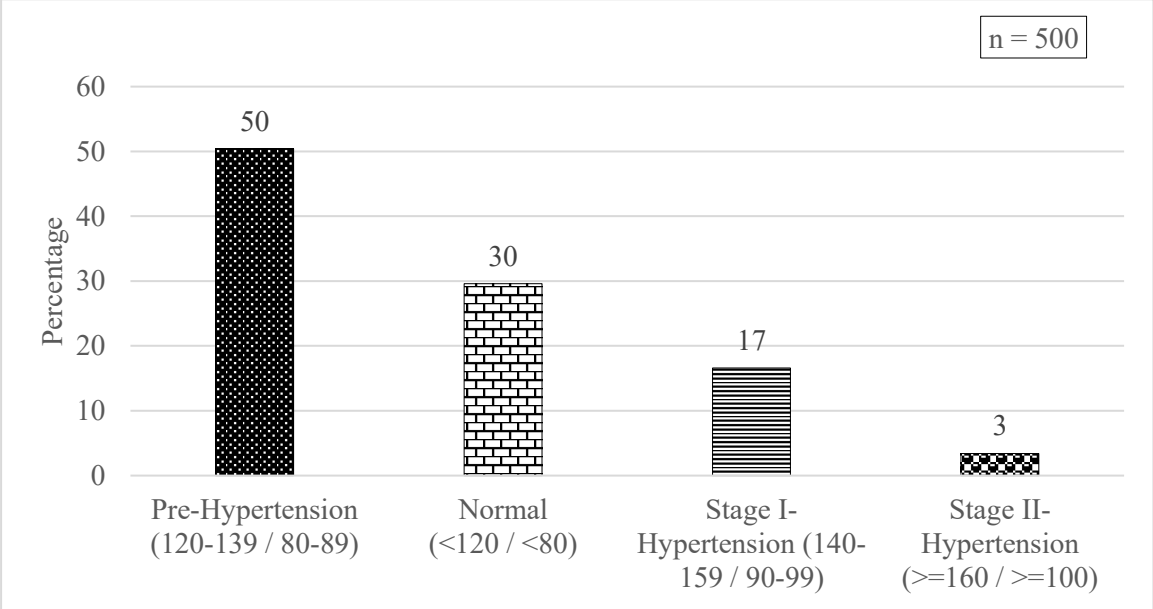


Figure 21 Status of Hypertensive cases

4.2.5 Heard about Gastritis

Among total 500 respondents, 92% had heard about the gastritis and 8% had not heard about it as shown in figure.

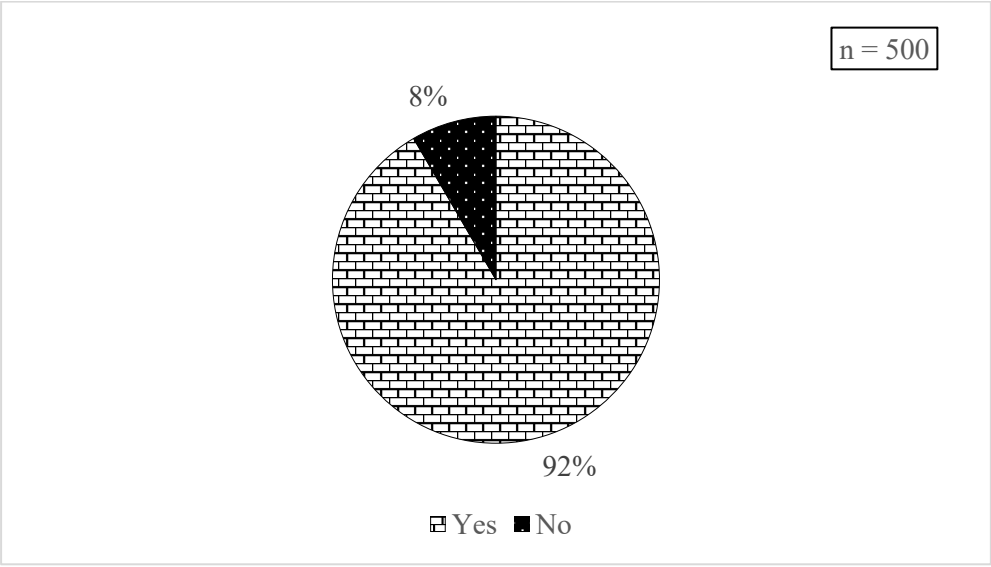


Figure 22 Heard about gastritis

4.2.5.1 Perception on causes of gastritis (*multi response question)

Among the total responses, 55% responded fatty meal, 43% responded with untimely diet, 19% told fasting was the cause of gastritis and 17% responded they didn't know the cause as shown in figure.

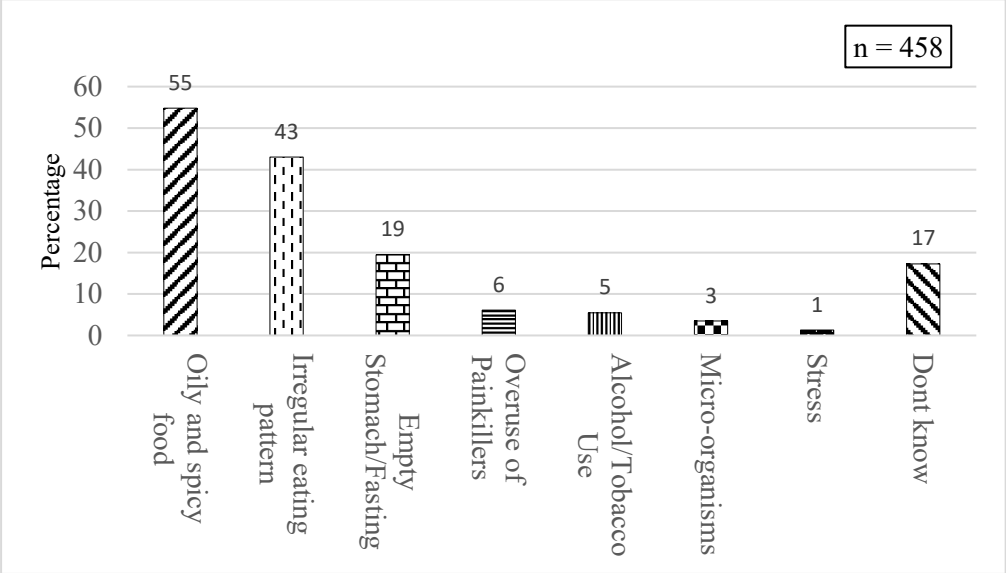


Figure 23 Perception on causes of gastritis

4.2.5.2 Knowledge on symptoms of Gastritis (*Multi-response Question)

Among the total responses, 37% responded Stomach-ache was the symptom of Gastritis, 29% responded with heart-ache, 26% told burping, 25% responded with loss of appetite and 7% said they didn't know any symptoms as shown in figure.

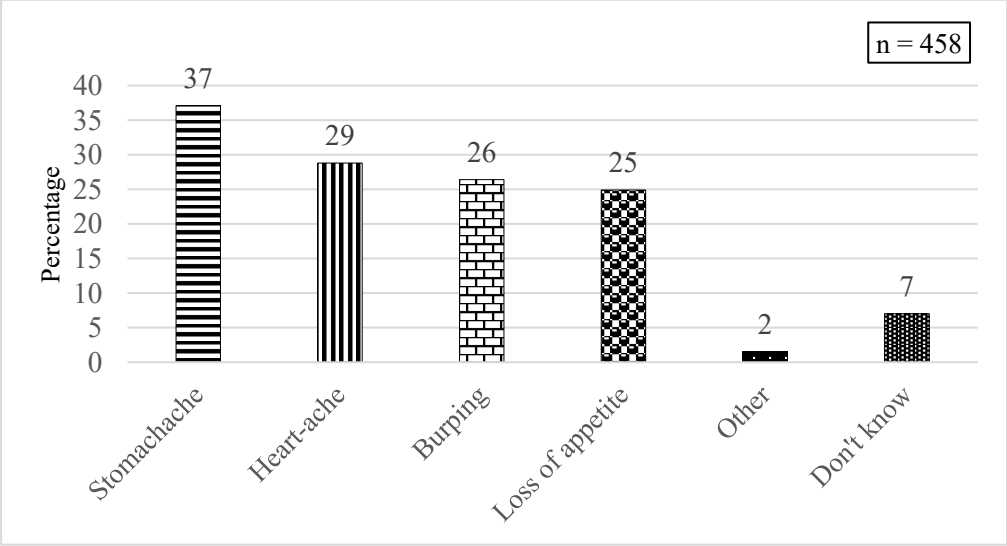


Figure 24 Knowledge on symptoms of gastritis

4.2.5.3 Knowledge on preventive measures of gastritis (*multi response question)

Among the total respondents, 81% said that gastritis can be prevented through avoiding oily and spicy meal, 16% said by maintaining a balanced diet, 14% said by avoiding deep-fried food and 8% said that they don't know about preventive measures as shown in figure.

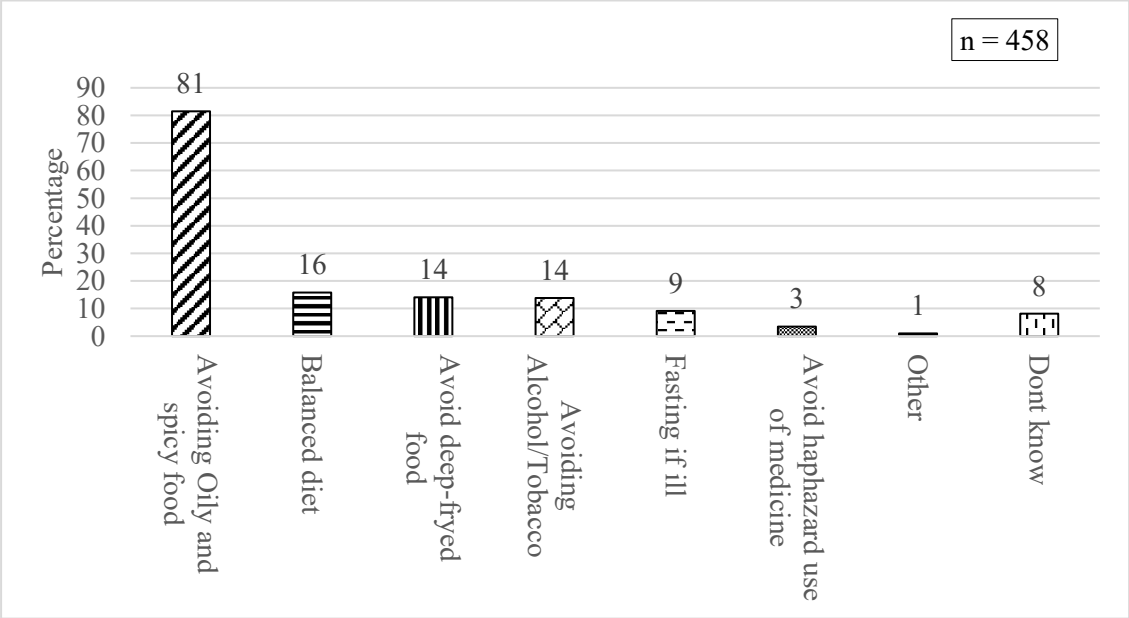


Figure 25 Knowledge on preventive measures of gastritis

4.2.6 Heard about diabetes

Among 500 participants, 73% had heard about diabetes and 27% hadn't heard about it as shown in figure.

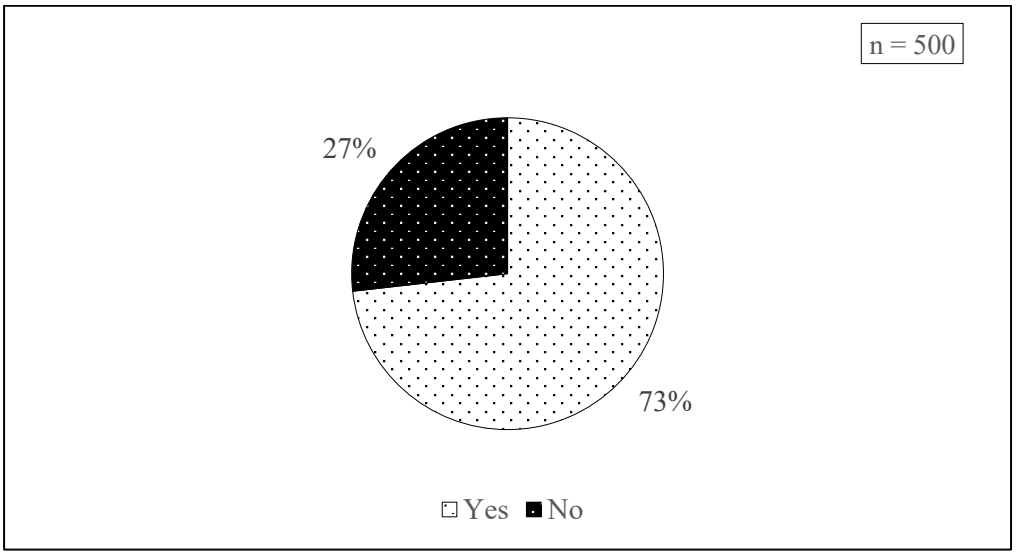


Figure 26 Heard about diabetes

4.2.6.1 Perception on causes of diabetes (*multi response question)

Among total 366 households, 60% respondents answered high intake of sugar followed by 17% who answered growing age and 30% said they didn't know any causes as shown in figure .

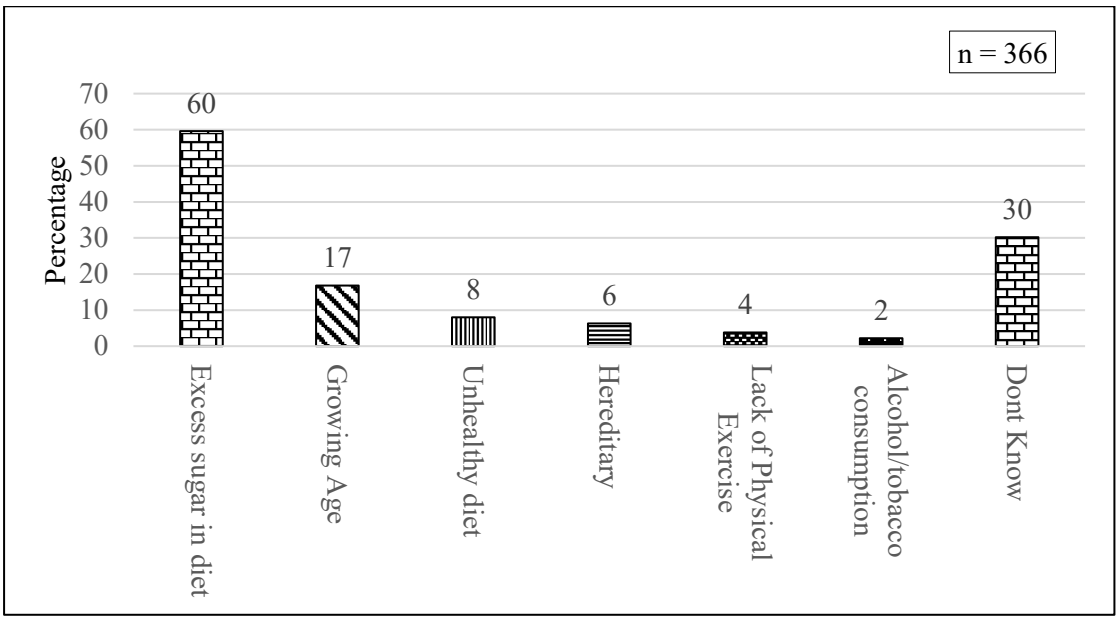


Figure 27 Perception on causes of diabetes

4.2.6.2 Perception on health complications of diabetes (*multi response question)

Among 366 respondents, 12% answered diabetes caused eye problem or even vision loss, 7% answered kidney problem, 7% answered premature death and 73% said they didn't know any health complications due to diabetes as shown in figure.

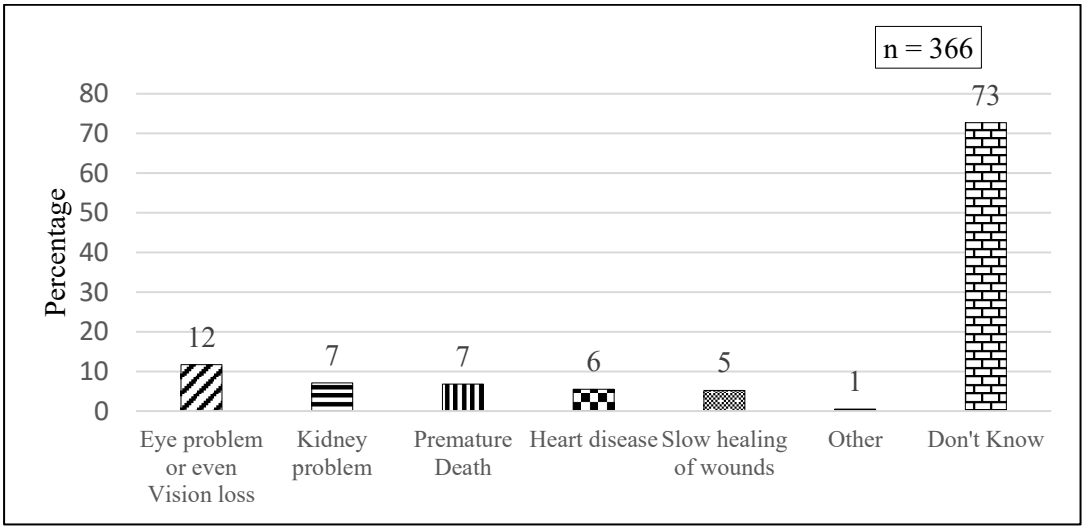


Figure 28 Perception on health complications of diabetes

4.2.6.3 Perception on preventive measures of diabetes (*multi response question)

Among total 366 households, 63% said that diabetes can be prevented through less intake of sugar while people who were mentioning regular physical exercises, consumption of fruits and avoiding alcohol/tobacco consumption were 12%, 36% said they don't know the preventive measures of DM as shown in figure.

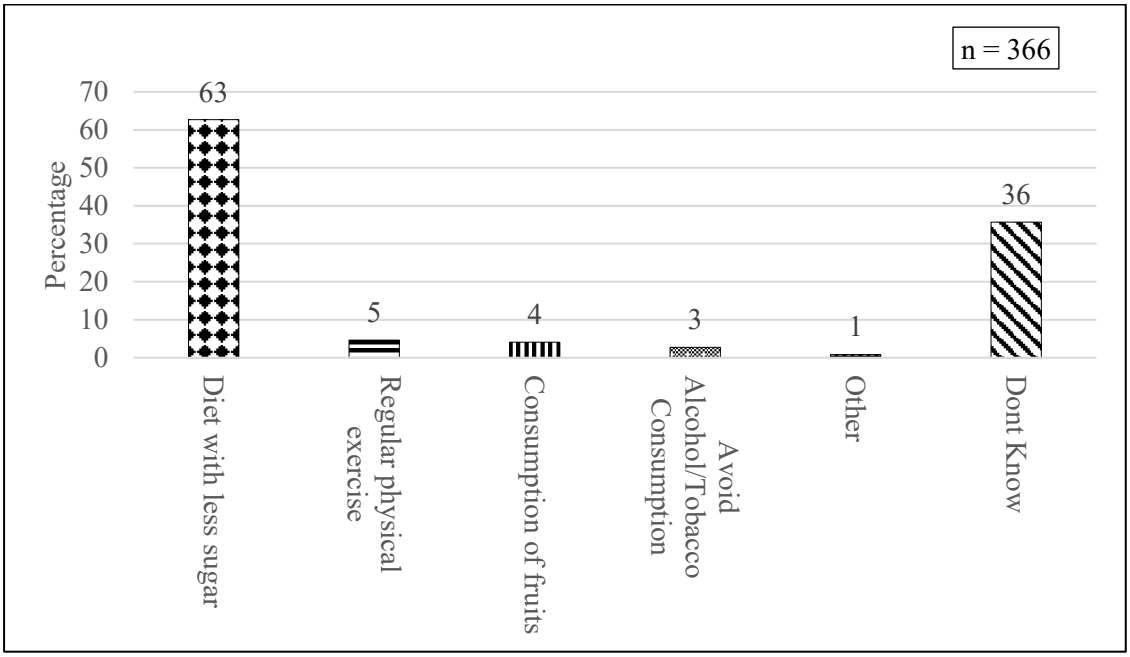


Figure 29 Perception on preventive measures of diabetes

4.2.7 Heard about COPD

Among 500 respondent, 76% had heard about COPD and 24% hadn't heard about it as shown in figure.

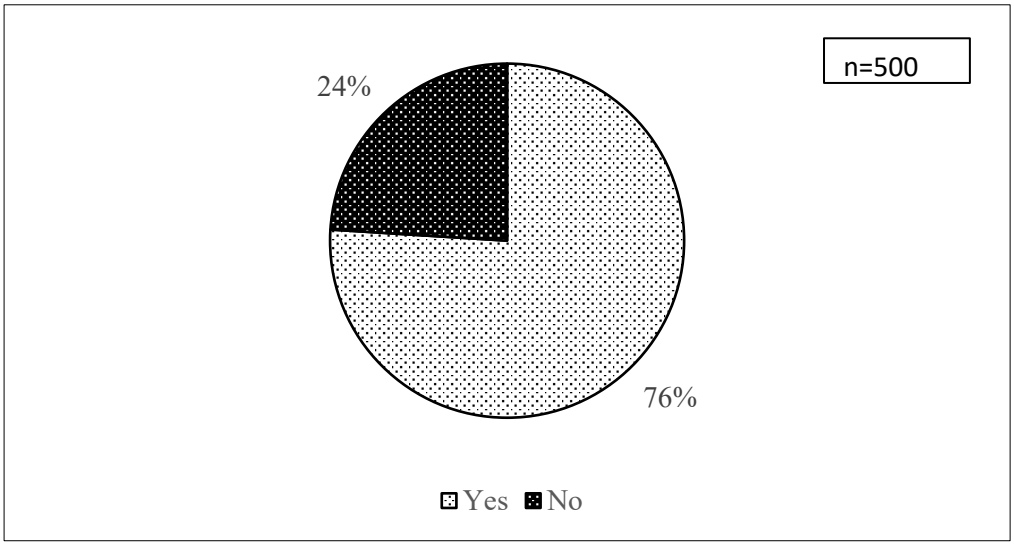


Figure 30 Heard about COPD

4.2.7.1 Perception on causes of COPD

Among 380 respondents who had heard about the COPD 42% had answered that COPD is caused due to smoking, 9% answered cooking in firewood ,5%answered hereditary and 6% answered others such as unhealthy diet, cold, alcohol, oily and spicy food as causes of asthma as shown in figure.

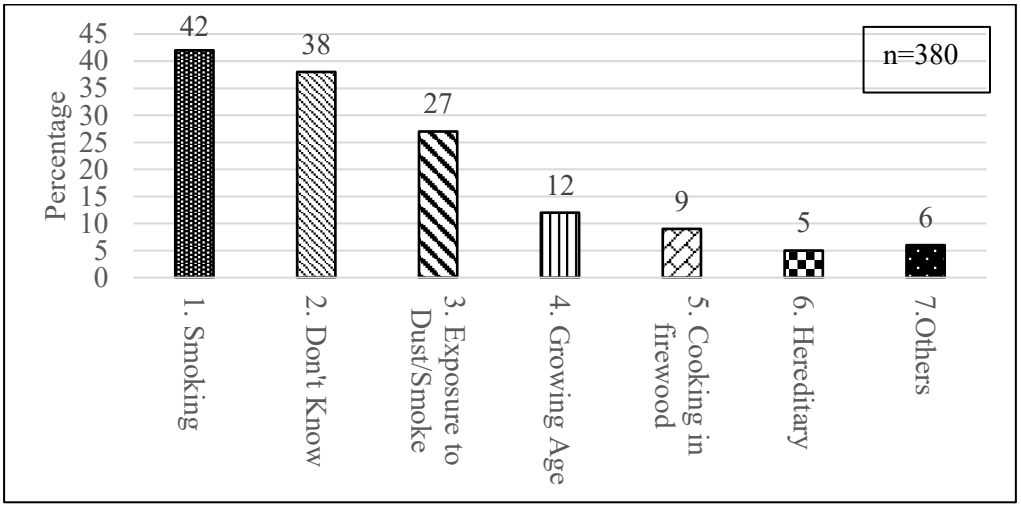


Figure 31 Perception on causes of asthma

4.2.7.2 Perception on symptoms of COPD (*multi response question)

Among 380 respondents, 60% said that COPD can have symptom of difficulty in breathing,35% answered don't know, 3% answered continuously coughing while 1% answered others such as lethargy and cancer as shown in figure.

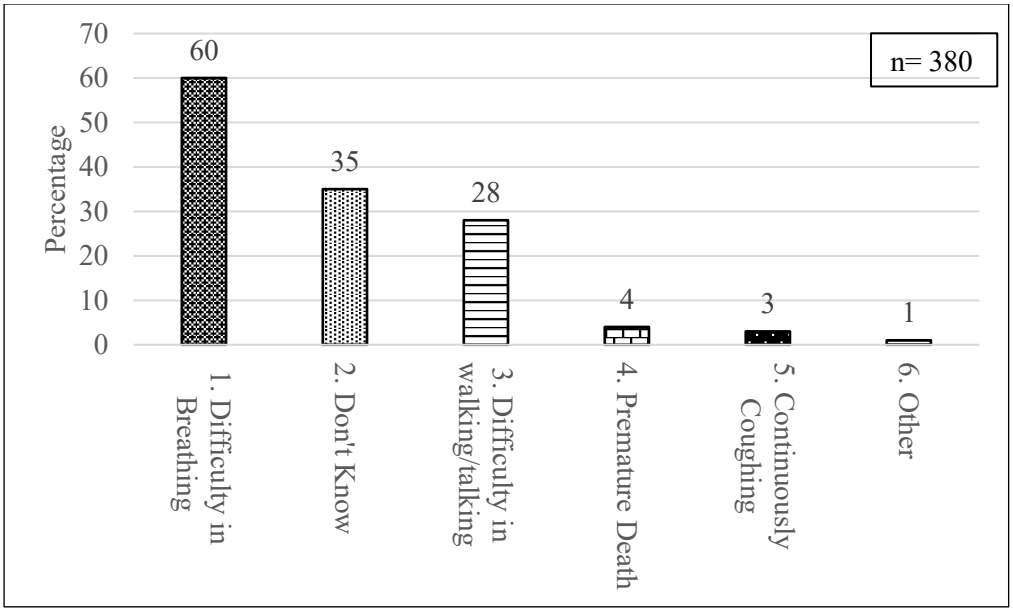


Figure 32 Perception on symptoms of asthma

4.2.7.3 Perception on preventive measures of COPD (*multi response question)

Among 380 respondents, 44% said that they don't know how asthma can be prevented 39% said asthma can be prevented by avoiding contact with smoke, 18% said by using smokeless stove, 15% said by avoiding smoking, 6% said having healthy diet and 6% said consume medicine prescribed by physicians as shown in figure.

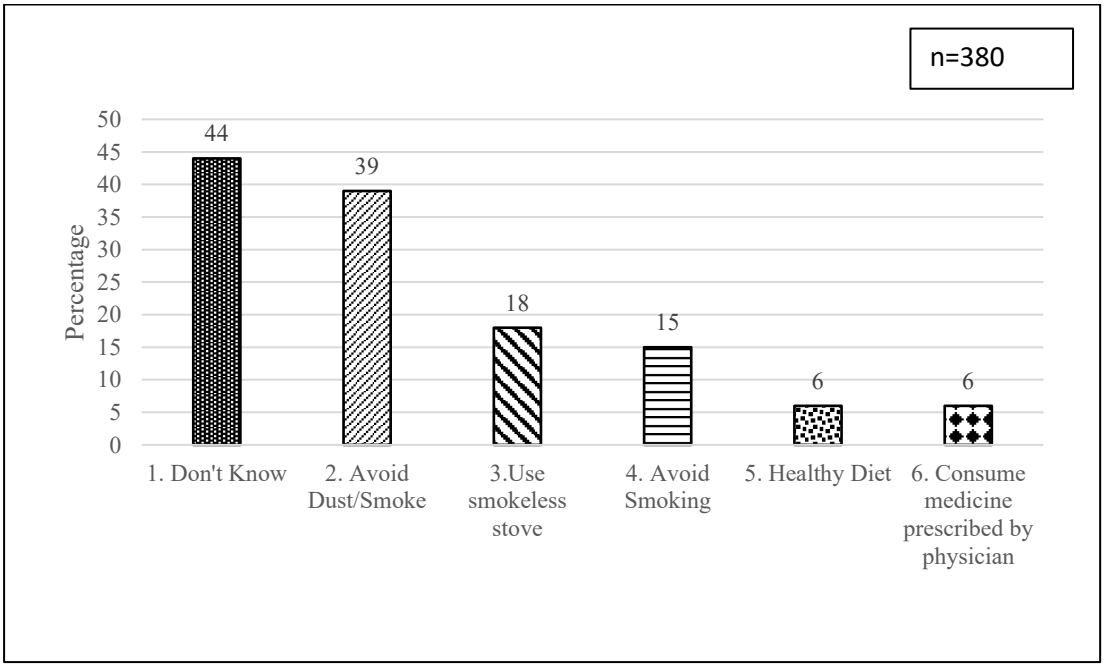


Figure 33 Perception on preventive measures of asthma

4.2.8 Heard about uterine prolapse

Among 500 respondents,55% had heard about uterine prolapse and 45% hadn't heard about it as shown in figure.

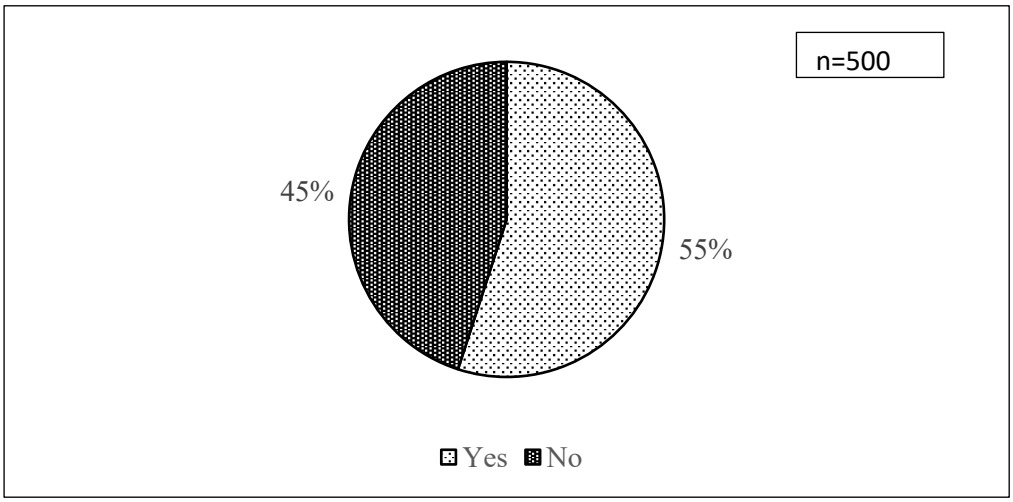


Figure 34 Heard about uterine prolapse

4.2.8.1 Perception on causes of uterine prolapse (*multi response question)

Among 274 respondents who knew about the uterine prolapse, 62% answered heavy weight lifting followed by 29% responded don't know, 18% large number of childbirths,3% due to obesity,2% due to old age and 1% others such as small aged pregnancy and abortion as shown in figure.

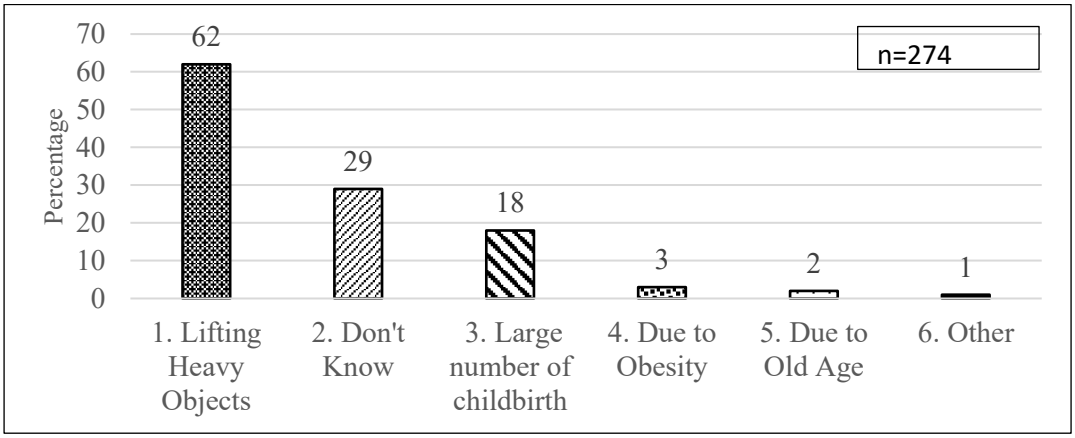


Figure 35 Perception on causes of uterine prolapse

4.2.8.2 Perception on preventive measure of uterine prolapse (*multi response question

Among 274 respondents, 54% said avoiding carrying heavy load , 32% said don't know ,23% said that uterine prolapse can be prevented by not having excessive child birth and 3% said that by maintain healthy weight and 1% were others such as awareness, and no child marriage as shown in figure.

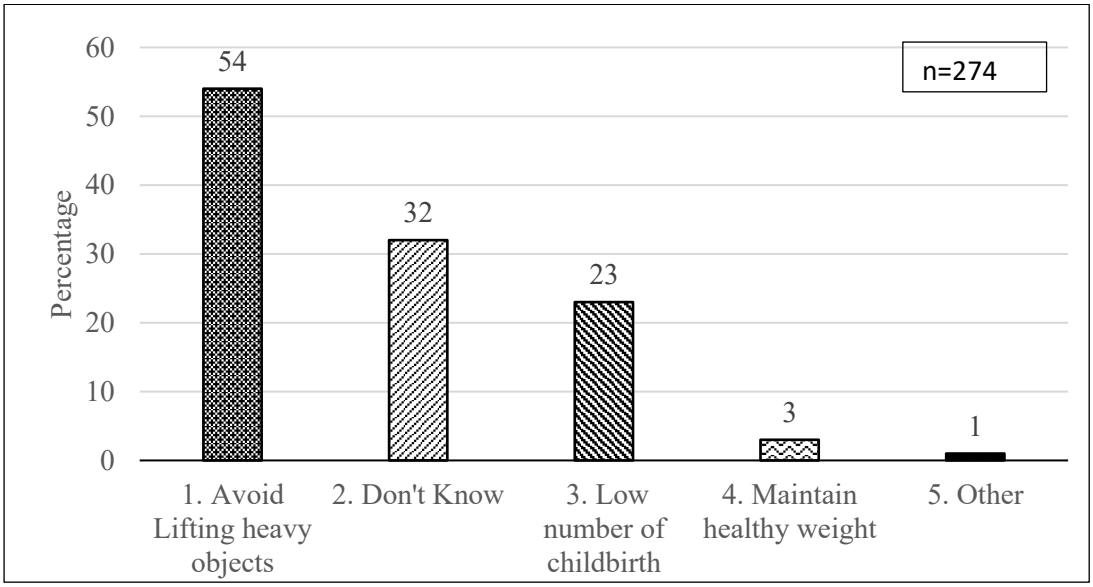


Figure 36 Perception on preventive measures of uterine prolapse

4.2.9 Heard about mental disease

Among 500 respondents, 51% had heard about mental disease and 45% hadn't heard about it as shown in figure.

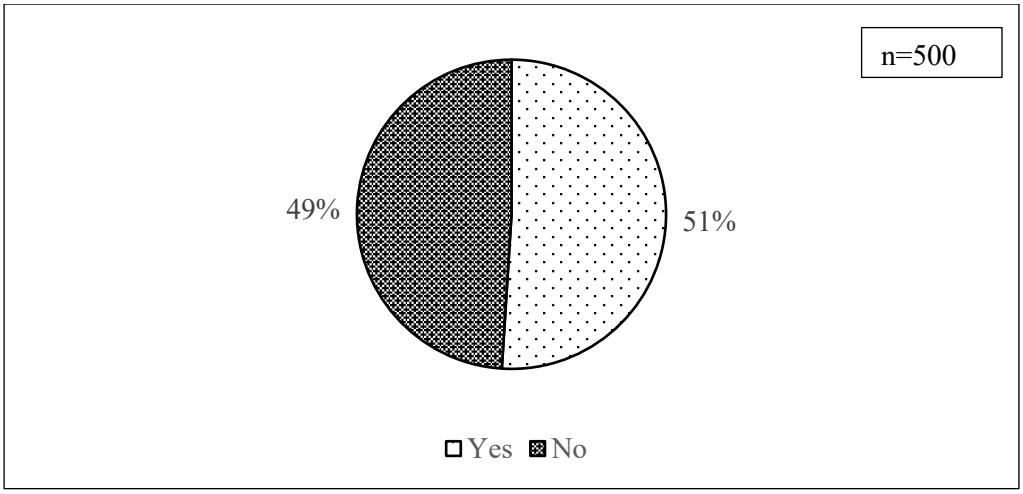


Figure 37 Heard about mental health

4.2.9.1 Source for knowledge on mental disease

Among 257 respondents 63% said from neighbour/friend,20% said from social media, 17% said from radio/tv, 14% said from health worker, 5% said from FCHV, 2% said from newspaper as shown in figure.

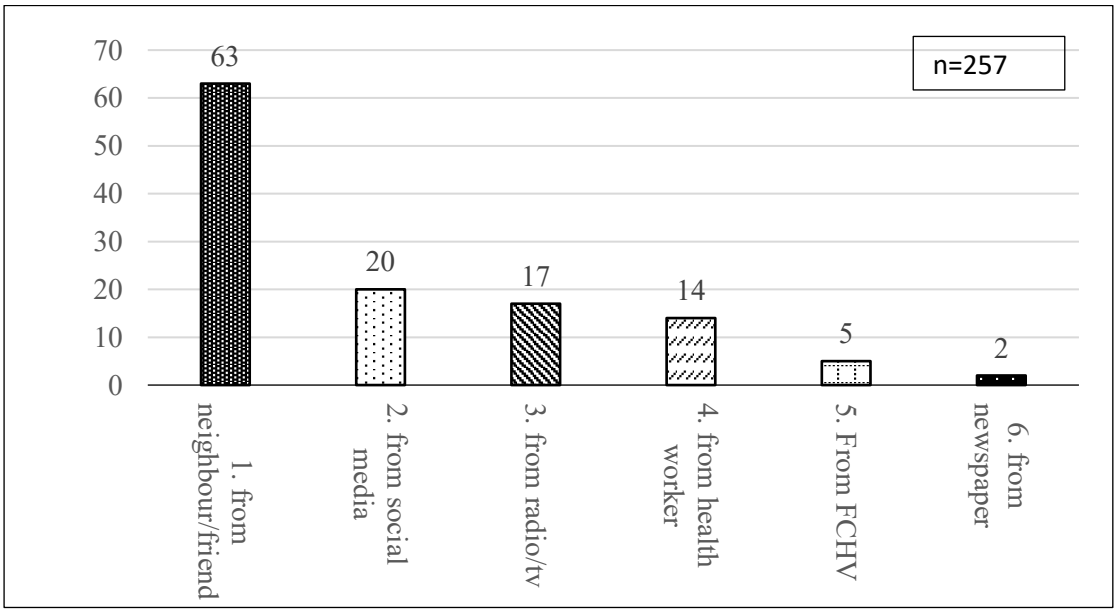


Figure 38 Source for knowledge on mental disease

4.2.9.2 Knowledge about causes of mental disease (*multi response question)

Among 257 respondents 80% said the cause of mental disease is due to stress, 18% said don't know, 9% said by substance abuse while 3% said it is heredity as shown in figure.

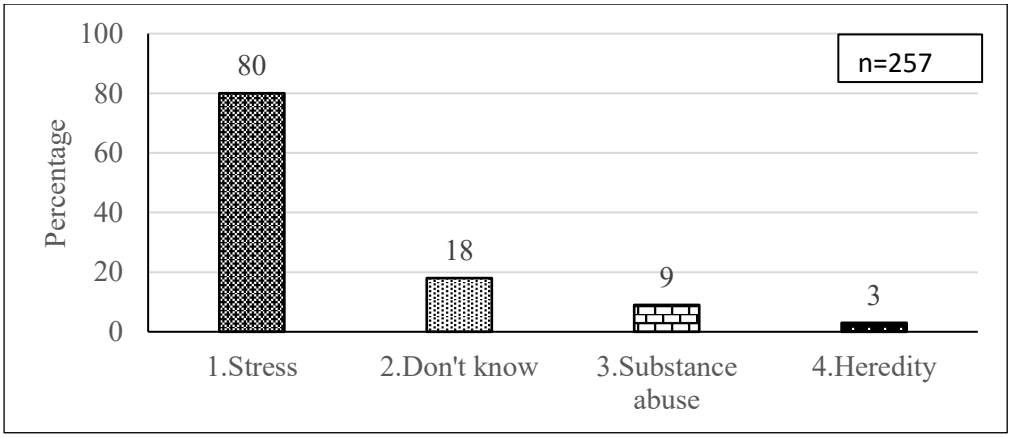


Figure 39 knowledge about causes of mental disease

4.2.9.3 Knowledge about symptoms of mental disease (*multi response question)

Among 257 respondents ,44% said that the symptoms of mental disease is mood swing, 32% said don't know, 27% said mental instability,14% said extreme fear, 7% said change in food habits and sleeping patterns and 1% others such as depression, confusion as shown in figure.

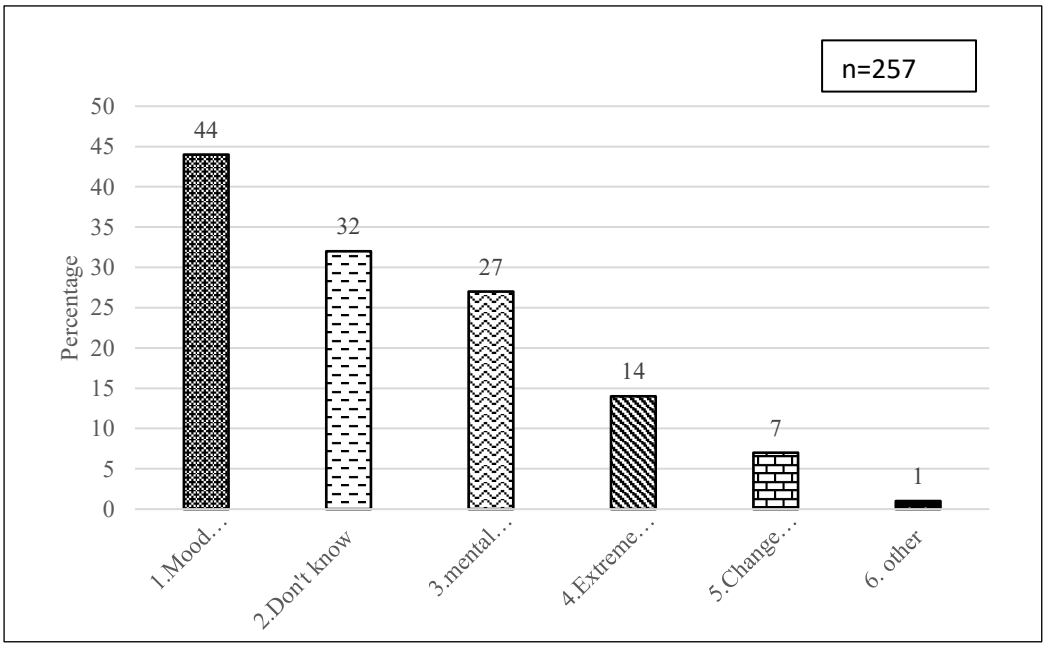


Figure 40 Knowledge about symptoms of mental disease

4.2.9.4 Any family member suffering with mental disease

Among 257 respondents, 5% had family member suffering with mental disease while 95% had no member suffering with mental disease as shown in figure.

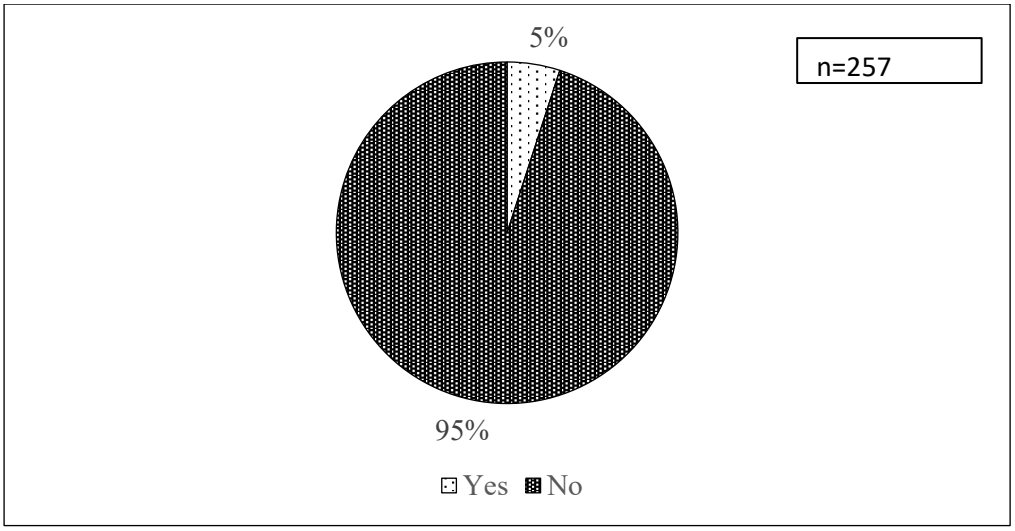


Figure 41 Any family member suffering with mental disease

4.2.9.5 Information related to mental issue

7 people suffered from mental issues as shown in table.

Table 21: Information related to mental issue

Diseased related information	Frequency(n)	Percentage (%)
Type of Disease		
Dementia	2	28
Schizophrenia	2	28
Depression	2	28
Anxiety Disorder	1	16
Age		
0-59	4	57
≥60	3	43
Gender (n=7)		
Male	4	57
Female	3	43
Substance Consumption		
Smoking		
Yes	3	43
No	4	57

Alochol Consumption		
Yes	1	14
No	6	86

4.2.9.6 Knowledge about prevention of mental disease (*multi response question)

Among 257 respondents ,63% said that the prevention of mental disease is hospital visit, 25% said don't know,10% said witch doctor,9% said stress free while 4% said taking good care of the person as shown in figure.

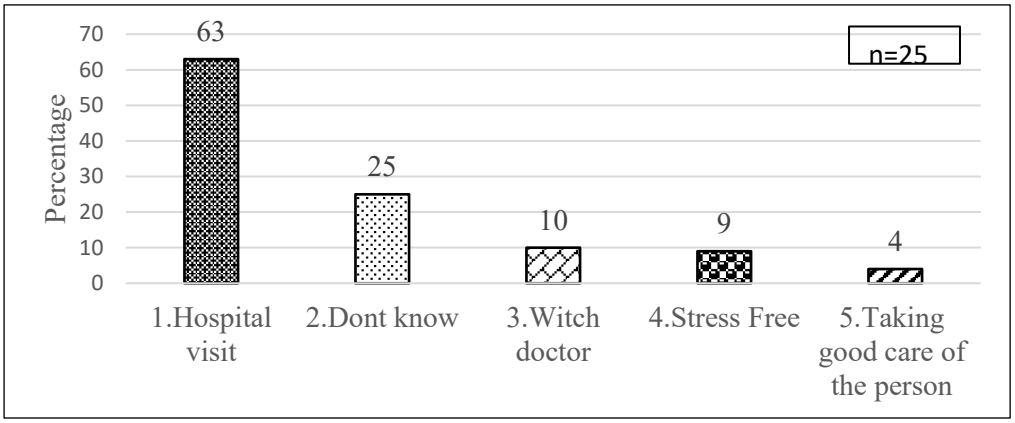


Figure 42 Knowledge about prevention of mental disease

4.2.9.7 Can mental disease be cured

Among 257 respondents 88% said mental disease can be cured while 12% said it can't be cured as shown in figure.

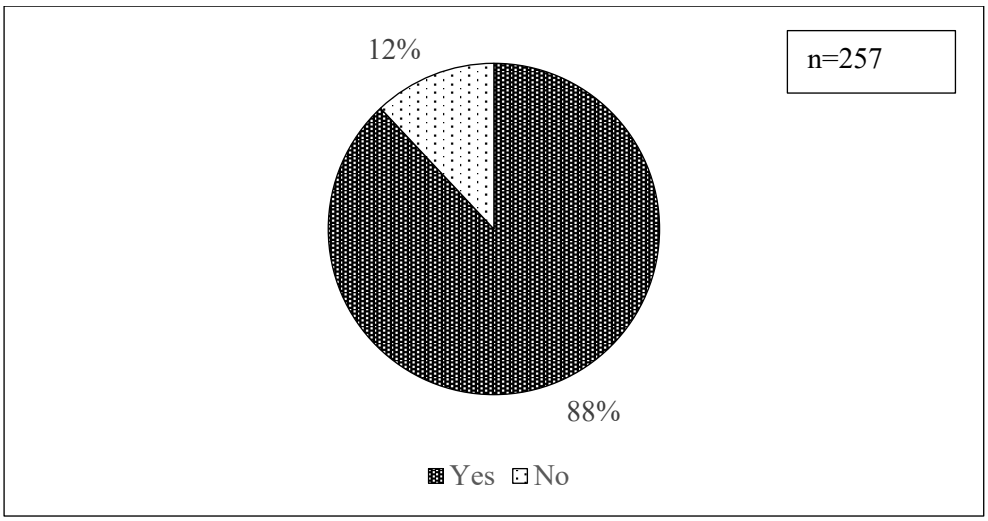


Figure 43 Can mental disease be cured

4.3 Food and Nutrition Consumption

4.3.1 Know about balanced diet

Among 500 respondents, 57% knew about balanced diet while 43% were unknown about balanced diet as shown in figure.

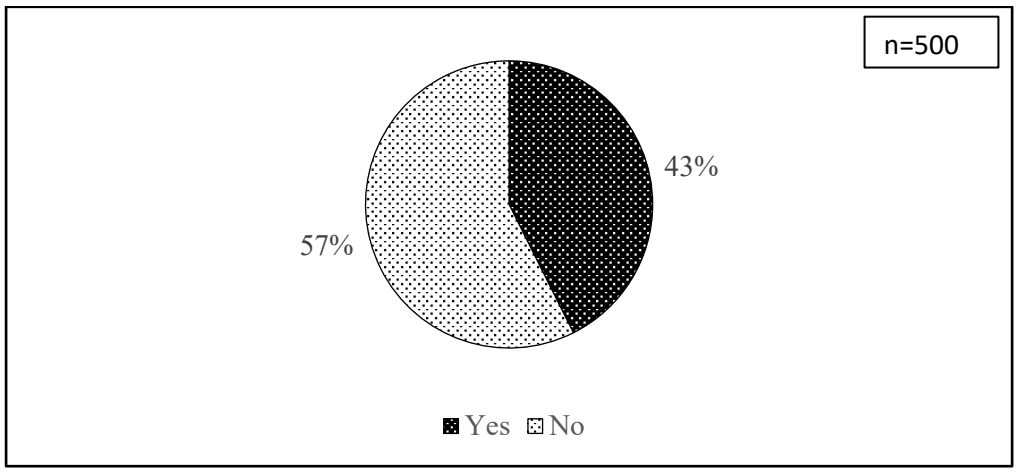


Figure 44 Know about balanced diet

4.3.2 Knowledge about Balanced diet

Among 302 respondents, 81% responded mix type of food items (Grains, cereals, fruits/vegetables and animal source) ,16% responded rice, lentils and vegetables, and 3% responded with unknown as shown in figure.

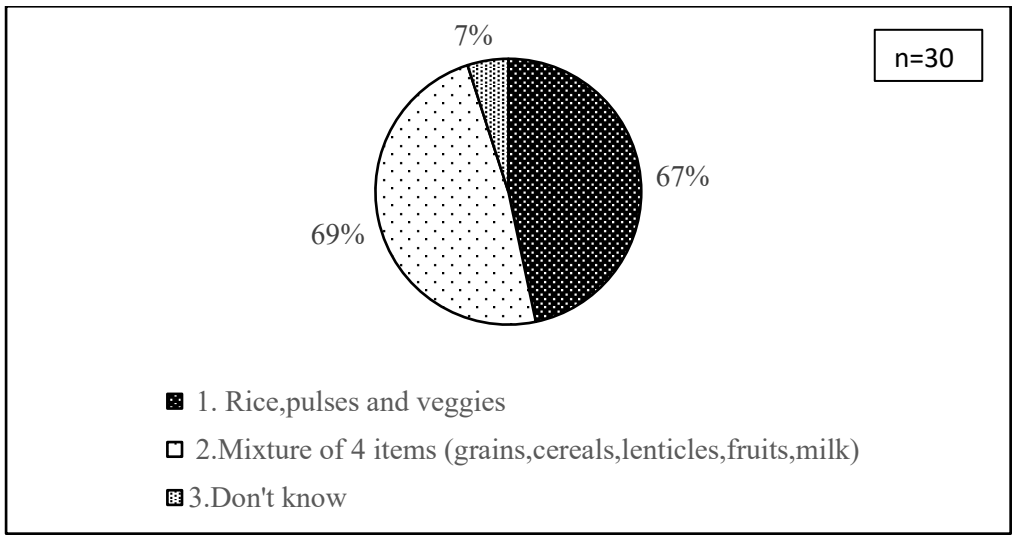


Figure 45 Knowledge about balanced diet

4.3.3 Knowledge about the preparation of Sarbottam litto

Among 500 respondents, 59% respondents knew how to prepare Sarbottam litto and 41% were unknown as shown in figure.

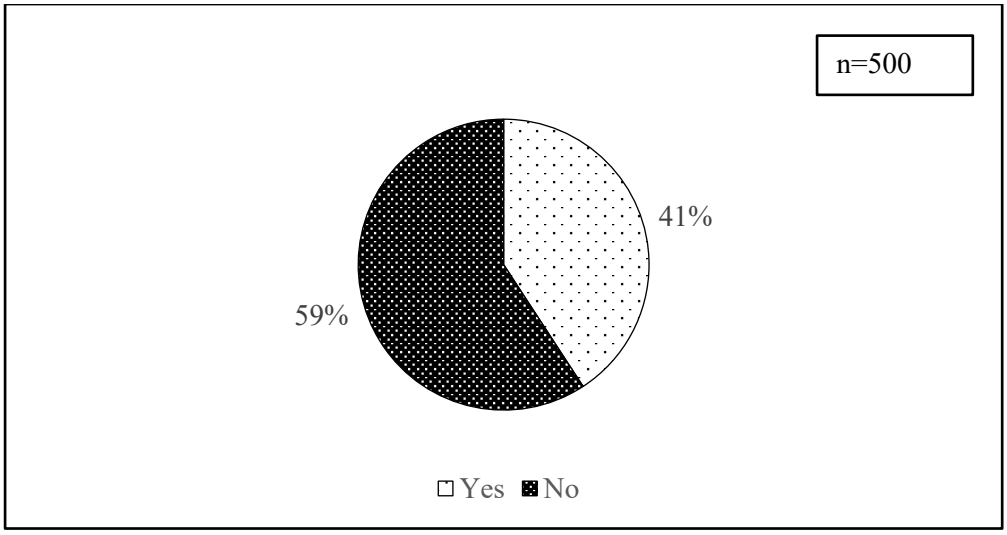


Figure 46 Knowledge about the preparation of Sarbottam litto

4.3.4 Method of preparing Sarbottam litto

Among 205 respondents who had knowledge about the preparation Sarbottam litto, 77% knew the right method of preparing Sarbottam litto while 23% did not as shown in figure.

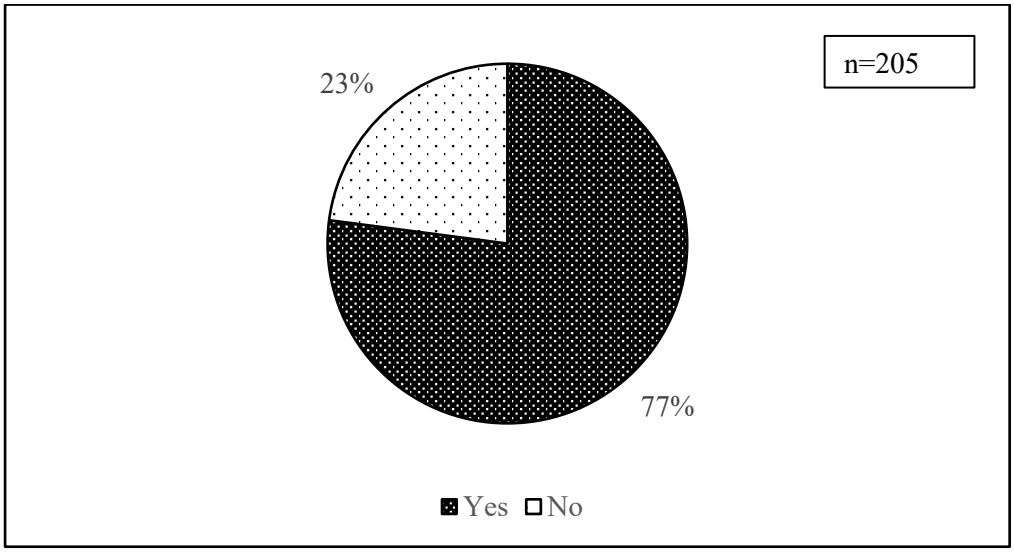


Figure 47 Method of preparing Sarbottam litto

4.3.5 Perception on Feeding of colostrum milk

Among 500 respondents, 81% responded colostrum milk is essential to fed after child birth,14% responded is not essential while 5% respondent weren't aware of it as shown in figure.

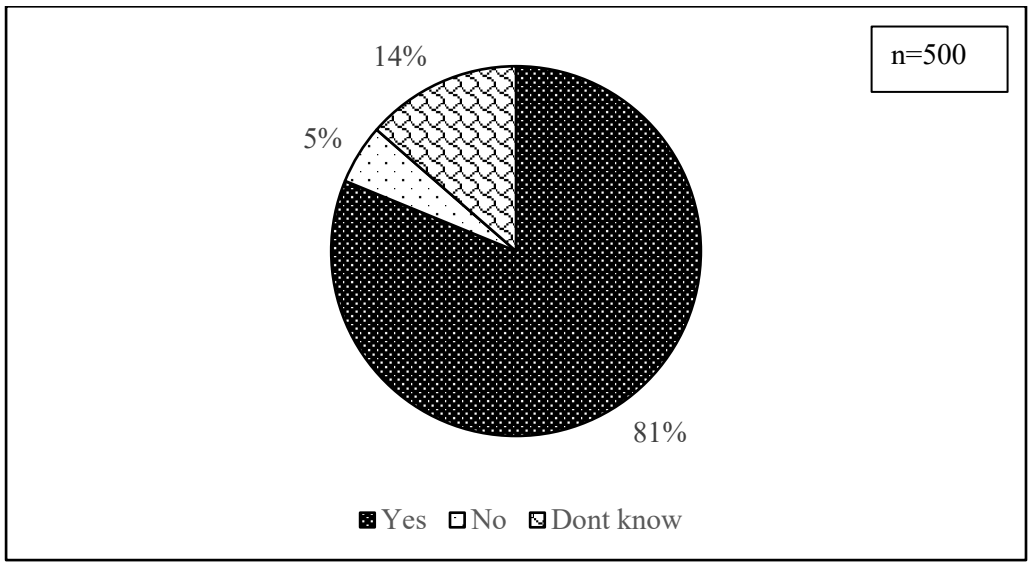


Figure 48 Perception on feeding of colostrum milk

4.3.6 Knowledge on Breast feeding immediately after child birth

Among 500 respondents, 59% responded within 1 hour of child birth while 8% didn't know and 33% responded after 1 hour.

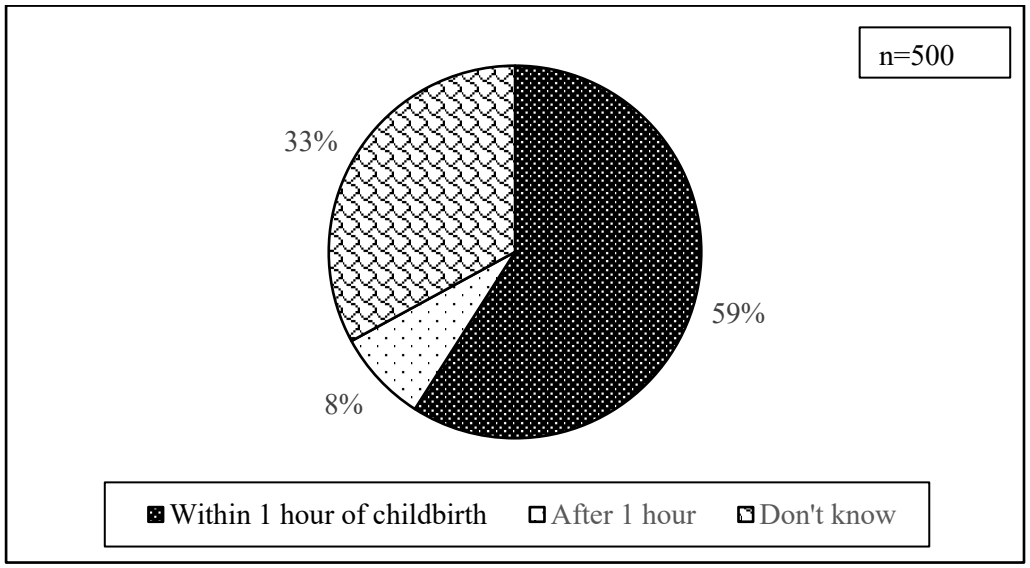


Figure 49 Time for feeding mother's milk

4.3.7 Knowledge on exclusive breastfeeding

Table 22: Knowledge on exclusive breastfeeding

Exclusive breastfeeding	Frequency	Percentage
Less than 6 months	25	5
6 months	419	84
More than 6 months	56	11

4.3.8 Food they had within 24 hours (*multiple choice question)

Among 500 respondents, 99% had rice, 72% had green leafy vegetables, 60% had cereals, followed by 42% ,21%,15%,13%,10% who had dairy product, fish/meat, junk foods, fruits, and eggs respectively within 24 hours as shown in figure.

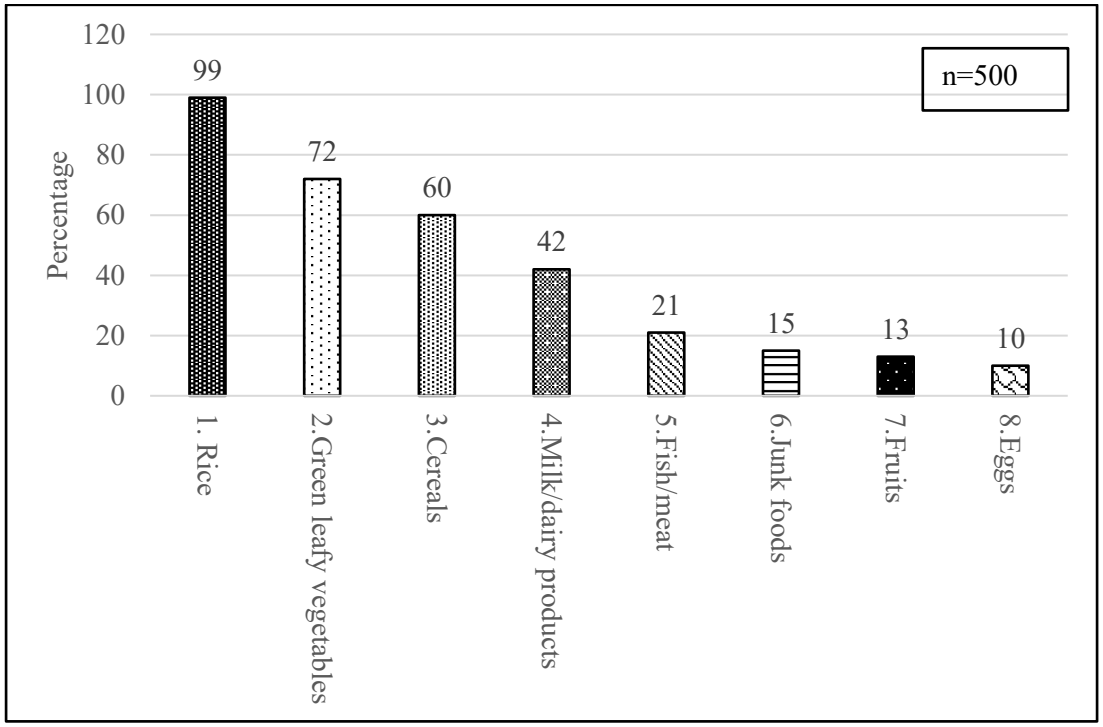


Figure 50 Food they had within 24 hours

4.3.9 Vegetables consumption within a week

Among 500 participants, 8% had consumed vegetable every 1-3 days, followed by 34% and 58% who had consumed vegetables 4-6 days and every day in a week respectively.

Table 23: Vegetable consumption within a week

No of days (n=500)	Frequency	Percentage
1-3 days	40	8
4-6 days	169	34
7 days	291	58

4.3.10 Fruit consumption within week

Among 376 participants, 23% had consumed fruits thrice a week followed by 19% and 17% who had consumed fruits four and two times a week respectively.

Table 24: Fruits consumption within a week

No of days (n=376)	Frequency	Percentage
0 days	75	15
1-3 days	351	70
4-6 days	60	12
7 days	14	3

4.3.11 Food items in lunch (*multiple choice question)

Among 638 respondents, 88% responded they had homemade lunch, 40% had junk food as shown in figure.

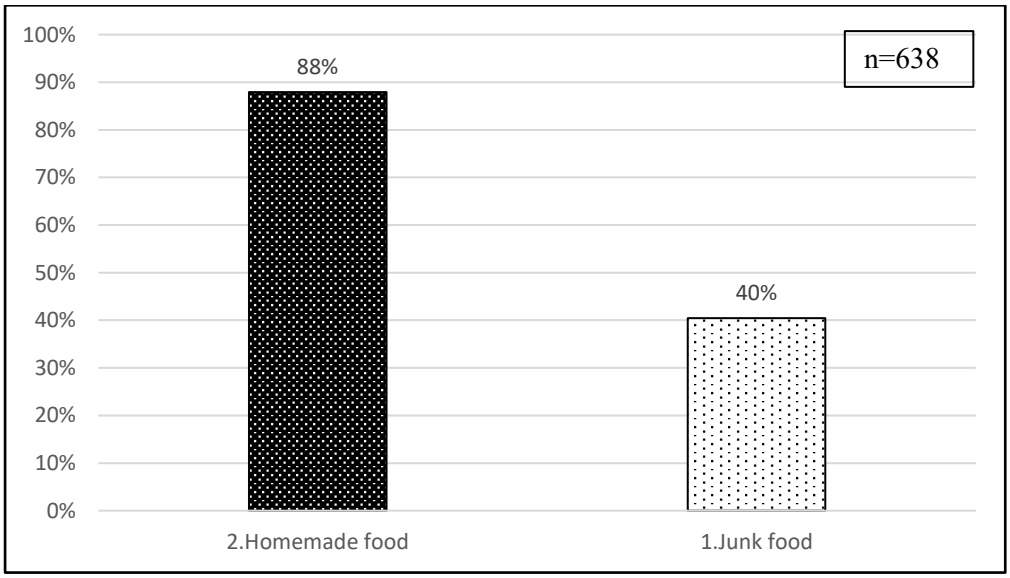


Figure 51 Food items in lunch

4.3.12 Months enough from production for consumption

Among 500 respondents 51% had 3-6 months enough from production for consumption, 27% had 6 months while 22% less than 3 months as shown in figure.

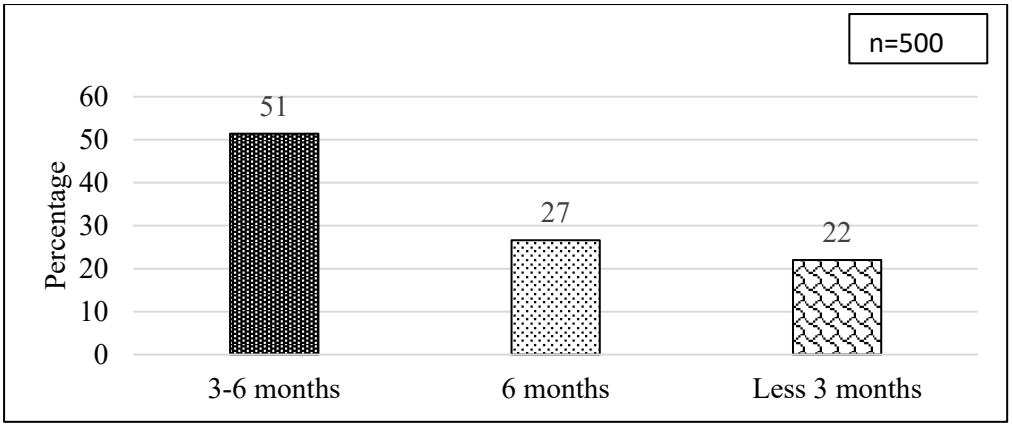


Figure 52 Months enough from production for consumption

4.3.13 Income enough for consumption

Among 500 respondents, 38% had income enough for consumption for more than 6 months, 32% had income enough for 3-6 months while 30% had income enough for less than 3 months as shown in figure.

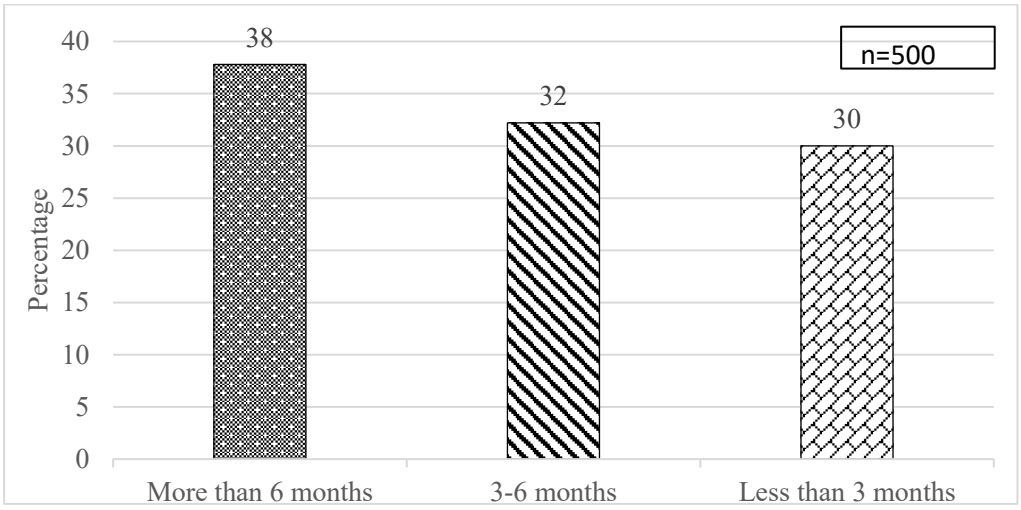


Figure 53 *Income enough for consumption*

4.3.14 Nutritional Status of under 5 years old children

Among the 36 children, 1 of them was stunted and 4 were wasted, 61 % were male female and 39 % were male. After measuring the upper arm circumference by MUAC tape (Shakir tape) 100 % were normal as shown in table.

Table 25: Nutrition status under 5 years

Children (6-59 months) n=36	Frequency	Percentage
Gender		
Male	22	
Female	14	
MUAC		
Severely malnutrition< 11.5 cm	-	-
Moderately malnutrition (11.5-12.5cm)	-	-
Normal more than 12.5cm	36	100

4.3.15 Nutritional status of adults

Among total 500 adults, 44% were male and 56 % were female. After assessing their weight and height, 2.2 % were underweight, 73.4% had healthy weight, 23.4% were overweight and remaining 1% were obese. It is illustrated in table.

Table 26: Nutrition status of adult

Adult (n=500)	Frequency (n)	Percentage (%)
Gender		
Male	222	44
Female	278	56
BMI		
Under weight (<18.5)	11	2.2
Normal weight (18.5-24.9)	367	73.4
Overweight (25-29.9)	117	23.4
Obesity (≥30)	5	1

4.4 Safe Water and Basic Sanitation

4.4.1 Source of drinking water

Among 500 participants, 98% responded tap water, 1% responded Stone spout as the source of drinking water as shown in figure.

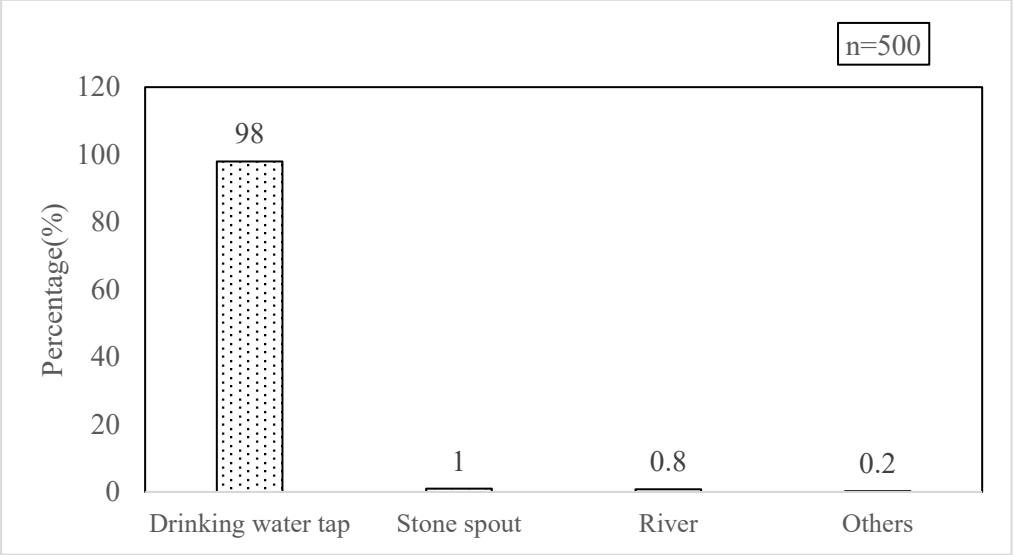


Figure 54 Source of drinking water

4.4.2 Satisfaction with purity of water

Among 500 participants, 90% were satisfied with purity of water while 10% were not satisfied as shown in figure.

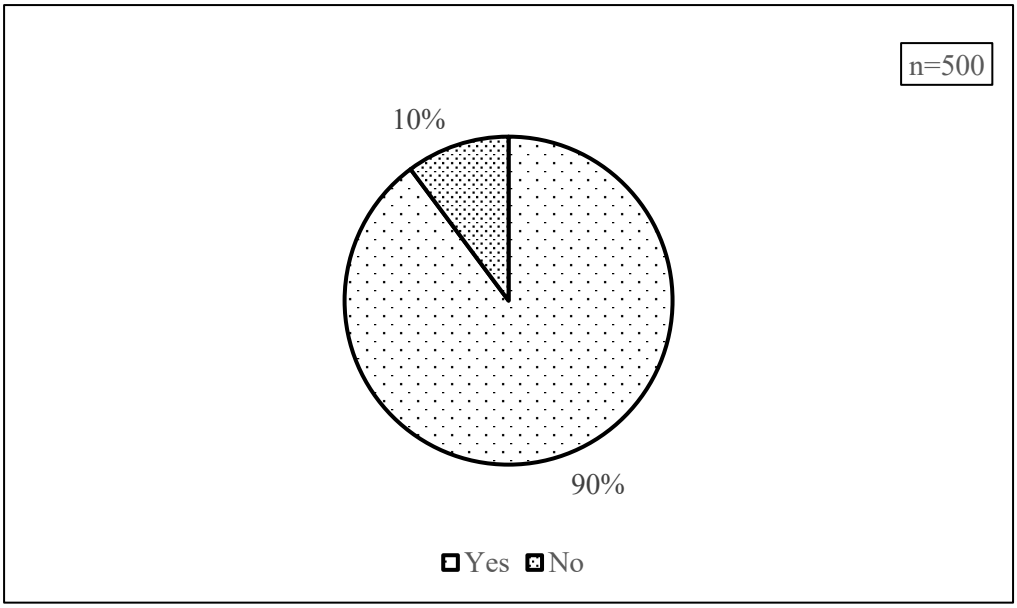


Figure 55 Satisfaction with purity of water

4.4.3 Practice of water purification

Among 500 participants, 60% responded they purify water while 46% responded they didn't as shown in figure.

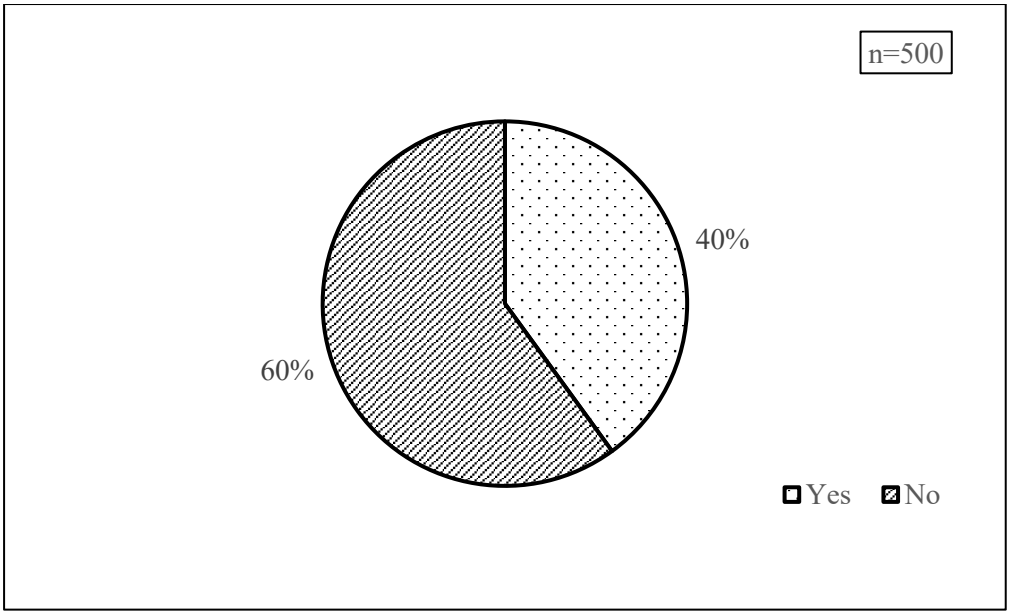


Figure 56 Practice of water purification

4.4.3.1 Methods used for water purification (multiple choice question)

Among 234 participants who purified water, 61% responded they used filtration method, 53% responded as boiling method, 3% responded as purification through sun exposure and 1% responded as using purification tablets as shown in figure.

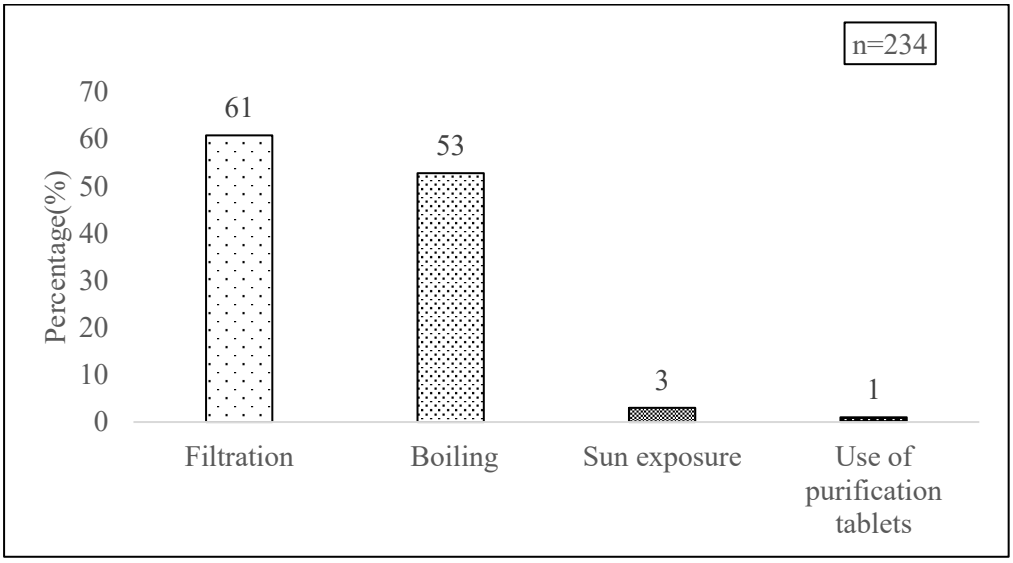


Figure 57 Methods used for water purification

4.4.4 Commonly used pot to store drinking water (multiple choice question)

Among 500 participants, 68% stored drinking water in jerry cans, 42% in plastic containers followed by 8% in copper containers and 2% in clay pots as shown in figure.

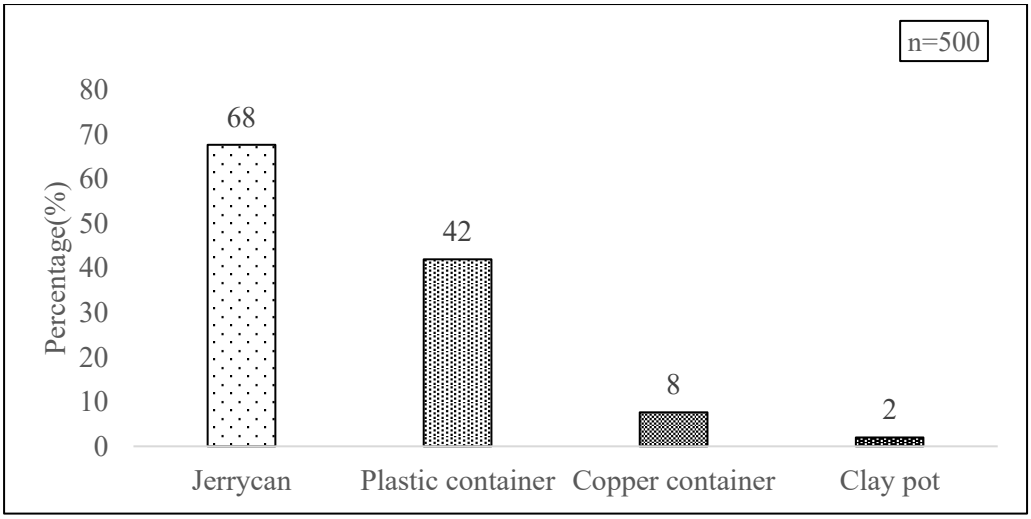


Figure 58 commonly used pot to store drinking water.

4.4.5 Commonly used fuel to cook

Among 500 participants, 86% responded as firewood as fuel used to cook, 49% responded gas stove, 5% responded electric stove, 2% responded improved stove and 1% used Bio gas as fuel to cook food as shown in figure.

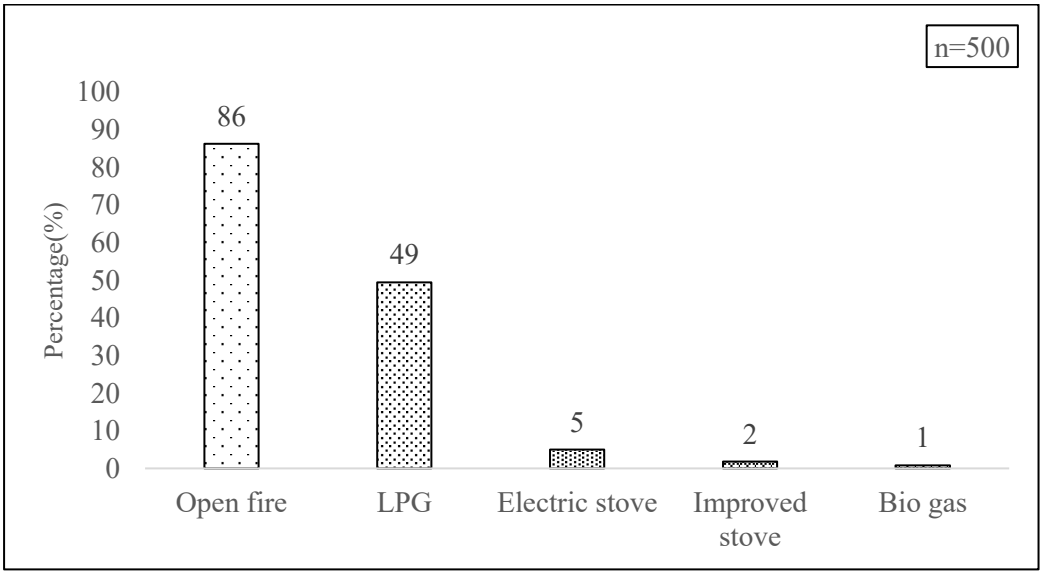


Figure 59 Commonly used fuel to cook

4.4.6 Practice of waste separation

Among 500 participants, 82% separated their waste while 18% didn't as shown in figure.

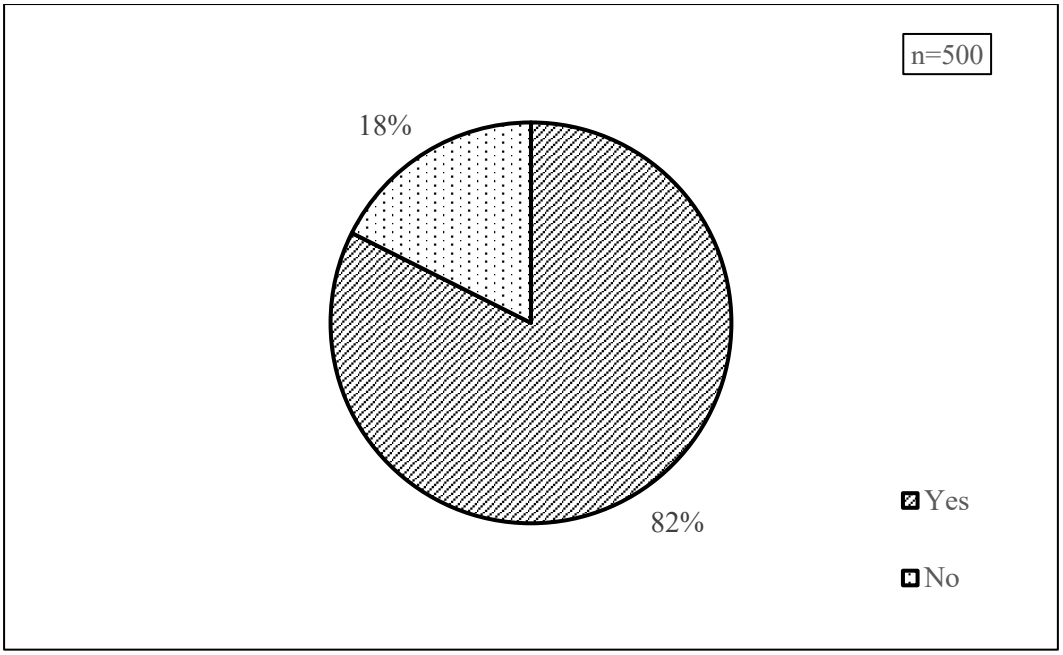


Figure 60 Practice of waste separation.

4.4.6.1 Commonly used practice for management of degradable waste

Among 412 participants, 51% responded they practice draining their waste into ditch, 36% responded by using waste as natural fertilizer and 13% responded as serving to cattle as shown in figure.

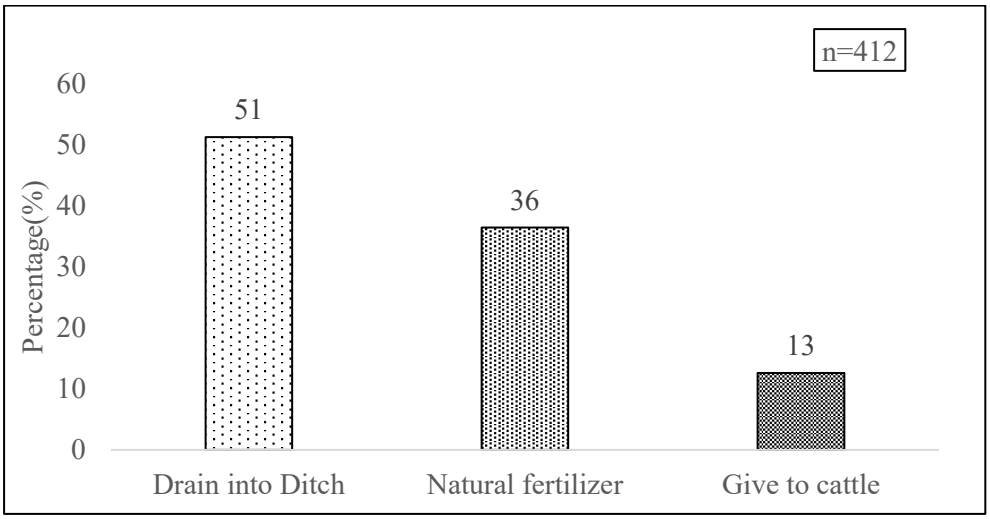


Figure 61 Commonly used practice for management of degradable waste

4.4.6.2 Management of non-degradable waste

Among 412 participants, 96% responded they practice burning method, 2% responded as using municipal van, 1% responded as by burying and 1% responded by throwing in river and water sources as shown in figure .

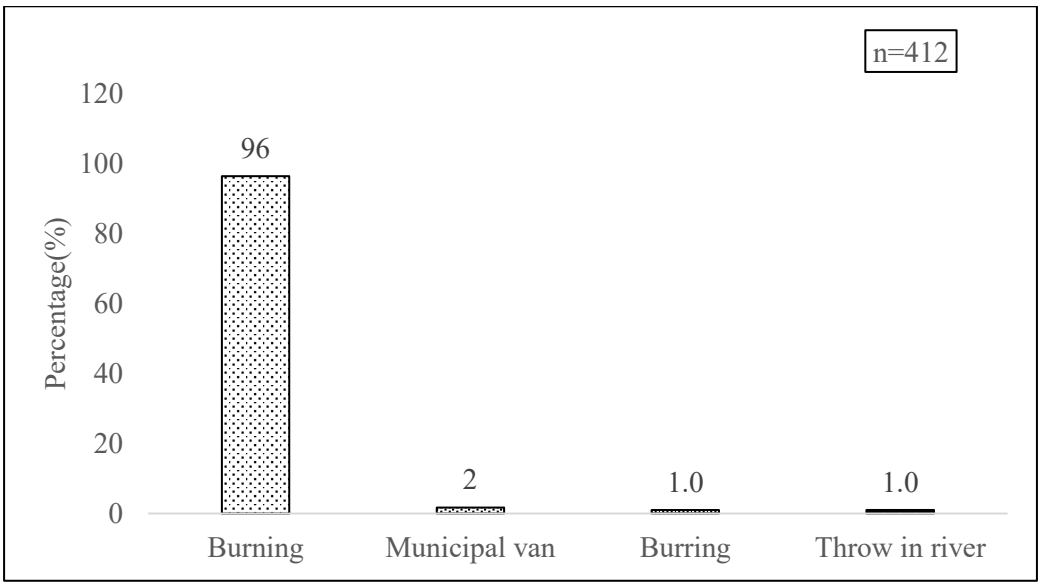


Figure 62 Management of non-degradable waste

4.5 Maternal and Child Health

4.5.1 Pregnancy related information

Among the total participants (n=38) most of the participants i.e. 65.8% got married in <20 years age. Similarly 40% women had said we have to visit 8 or more times for ANC cheackup follwed by 40% < 4 times. Likewise, among 45 children 35 were alive,2 died, 4 were the case of abortion and 4 were the first pregnancy.

Moreover, among 38 respondents, most of the people had done ANC check-up 8 or more times. Similarly, 65.8% respondents responded that they had done ANC check-up to know the condition of the foetus.

Table 27 Information related to pregnancy

Information related to pregnancy	Frequency(n)	Percentage (%)
Age at marriage (n=38)		
<20	25	65.8
20-30	13	34.2
Age at first pregnancy(n=38)		

<20	11	28.9
20-30	27	71.1
Number of children		
Live birth	35	77.8
Still birth	2	4.5
Abortion	4	8.9
1st pregnancy	4	8.9
Frequency of health checkup during pregnancy		
<4 times	15	40
4-7times	8	20
>8 times	15	40
Reason for health check-up during pregnancy (n=38)		
For T.D immunization	8	21.1
To consume iron pills	13	34.2
To consume folic acid tablets	11	28.9
To know condition of foetus	25	65.8
To know condition during pregnancy	6	15.8
Others	1	2.6

4.5.2 Last Pregnancy related information

Among the total participants (n=34) ,32 participants had gone for ANC visits, and 2 had not. 30 participants had visited a government health facility while 2 had gone to private health clinics for checkup during last pregnancy. 2 participants had <4 checkup, 7 had 4 checkup, 16 had 4-8 checkup and 7 had >8 check-up during their last pregnancy. All respondent had consumed iron tablets during their last pregnancy.4 deliveries were conducted at home, 26 at government health institution and 4 at private health institution. Regarding the financial initiatives 4 participants received <Rs3000, 4 received exactly Rs3000 and 26 received >Rs3000.

Table 28: Last pregnancy related information

Information related to ANC	**Frequency (n)**	**Percentage (%)**
Check-up during last pregnancy (n=34)		
Yes	32	94
No	2	6
Place of check-up during pregnancy (n=32)		

Government health facility	30	94
Private clinics / pharmacy	2	6
Frequency of check-up during last pregnancy(n=32)		
<4times	2	6.3
4 times	7	21.9
4-8 times	16	50
>8 times	7	21.9
Consumption of iron tablet during last pregnancy (n=32)		
Yes	32	100
No	-	-
Place of delivery during last pregnancy		
Home	4	12
Government health institution	26	76
Private health institution	4	12
Amount of incentives		
<3000	4	12
3000	4	12
>3000	26	76

4.5.3 PNC related information

Among the participant,19 had gone for PNC check-ups and 13 had not. 15 participants had attended <3 visits PNC visits and 4 had attended 3 visits for PNC. 7 participants received PNC service from health worker, 1 from home clinic, 9 from health post and 2 from hospital. The majority of PNC visits promotions were conducted through FCHVs. Additionally, 29 participants had consumed vitamin A capsule while 5 had not.

Table 29: PNC related information

Information related to PNC	**Frequency (n)**	**Percentage (%)**
Post –natal visit		
Yes	19	59
No	13	41
Frequency of PNC visit (n=19)		
<3 times	15	78.9
3 times	4	21.1

Place of PNC visit (n=19)		
Through health worker at home	7	36.8
Nearby home clinic	1	5.3
Health post	9	47.4
Hospital	2	10.5
Promotion of PNC visit (n=19)		
Through health worker	5	26.3
Mother-in-law	1	5.3
Friends	1	5.3
FCHV	9	47.4
Self	3	15.8
Consumption of vit. A capsule (n=19)		
Yes	14	73.68
No	5	26.31

4.5.4 Feeding to children before breastfeeding

Among the 34 participants, 15% had other things before breast-feeding to their children and among them all had fed Lactogen.

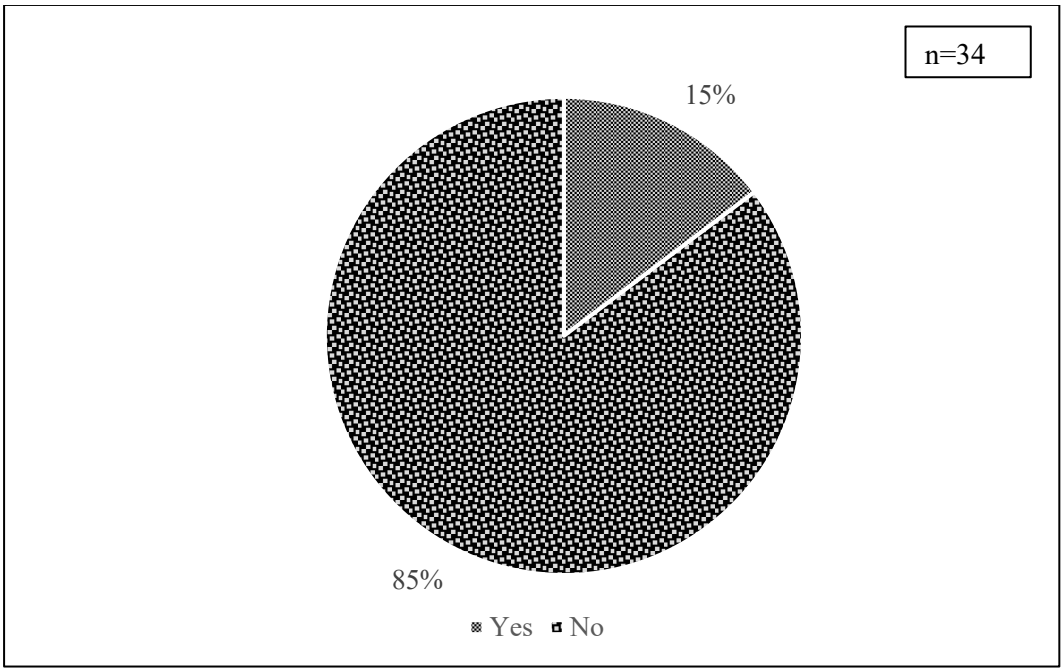


Figure 63 Feeding to Children before breastfeeding

4.5.5 Colostrum milk fed to Child

Similarly, 85% of participants among that of 34, had fed colostrum milk, and among 15% of those who had not fed colostrum milk, all of them responded that milk did not come as the reason for not feeding colostrum milk.

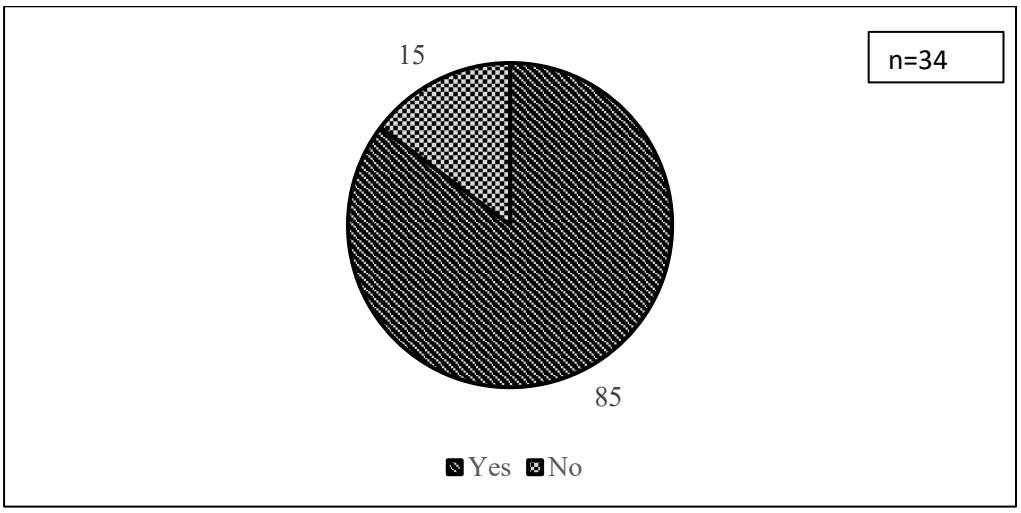


Figure 64 Colostrum milk fed to child

4.5.6 ARI in past one year

Among 46 respondents, 9% had told that their children have been suffered from ARI and 91% told that their children have not suffered from ARI as shown in figure .

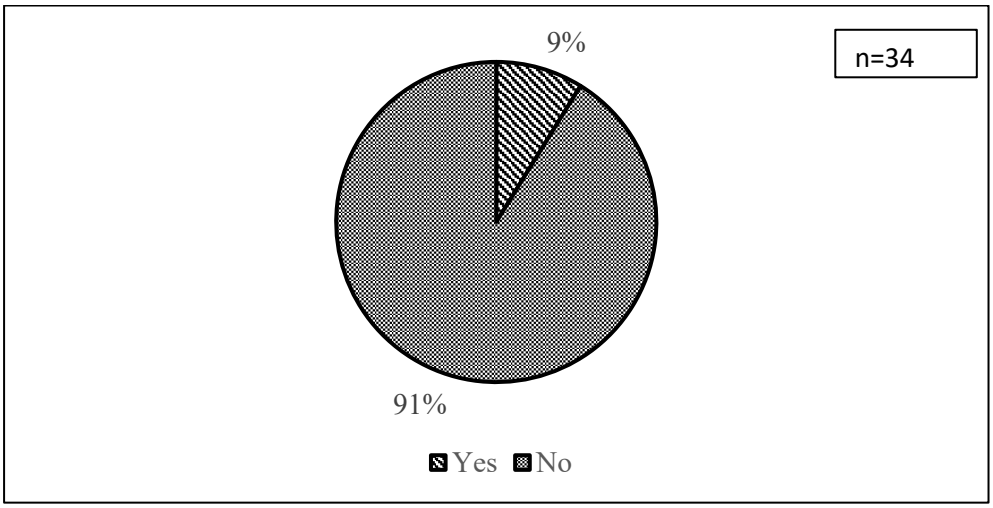


Figure 65 ARI in past One year

4.6 Family Planning

4.6.1 Heard About family planning

Among the 246 respondents of reproductive age (15-49), 51% answered yes, while 29% answered no and 20% they do not want to answer about family planning as shown in figure .

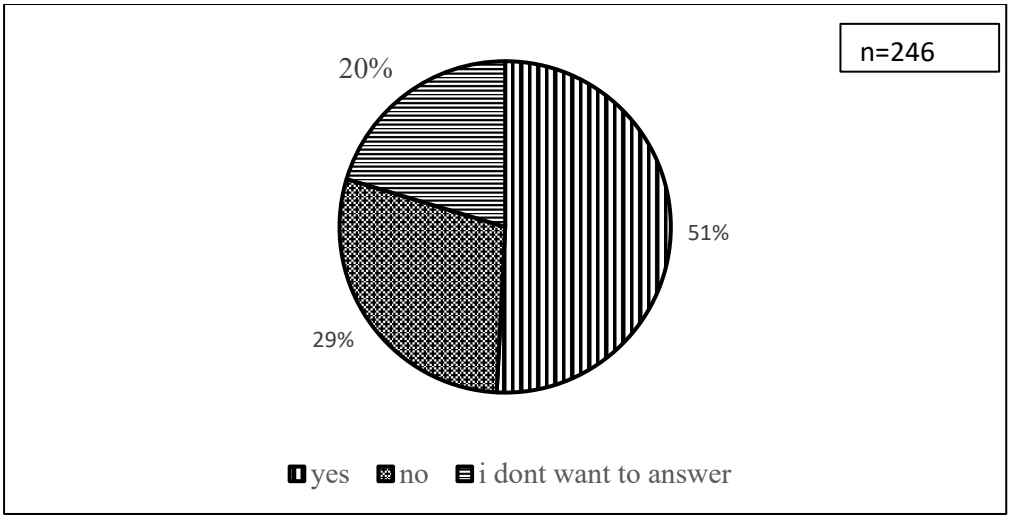


Figure 66 Heard about family planning

4.6.2 Currently Family Planning Using

Among the total respondents,55 % were currently using family planning ,34% were not and 10% didn't want to give answer as illustrated in figure .

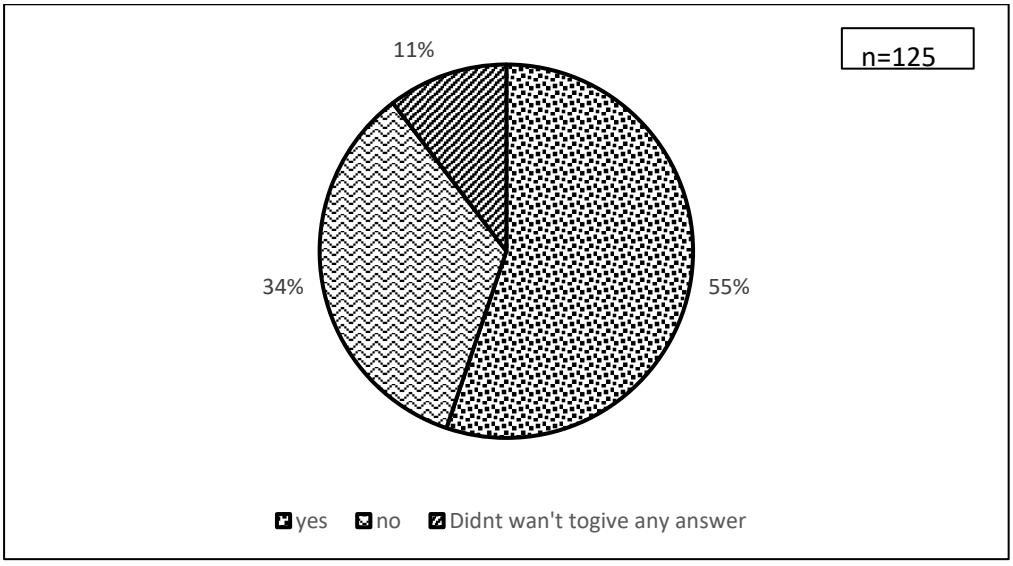


Figure 67 Currently family planning using

4.6.3 Types of family planning currently used

Table show that among the 69 participants currently using family planning, 30 had undergone sterilization, 11 were using condoms, 4 were using pills, 21 were using Depo, 2 were using implants, and 1 were using an IUD

Table 30: Types of family planning currently used

Methods of family planning(n=69)	Frequency (n)	Percentage (%)
Female sterilization	9	30
Male sterilization	21	70
Condom	11	28.2
Pills	4	10.3
Depo	21	53.8
Norplant	2	5.1
IUCD	1	2.6

4.6.4 Suffered from side effect of Family Planning

Out of total respondent 30% get side effect from any type of family planning contraceptives using while 70% were not as shown in figure.

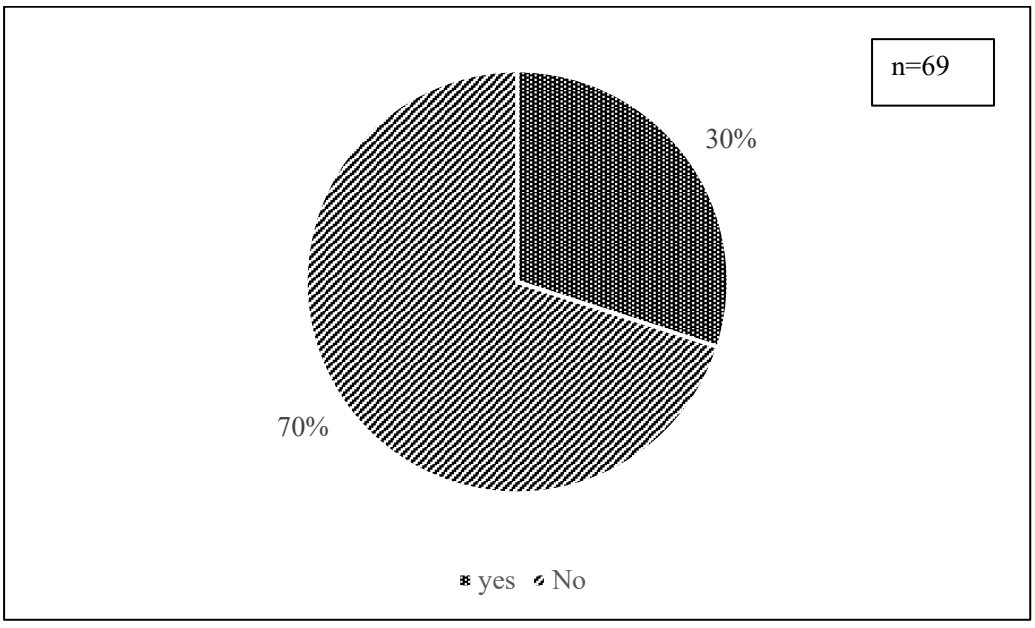


Figure 68 Suffered from side effect of family planning

4.6.5 Side effect of Family planning

In a study sample of 69 individuals, 21 reported experiencing side effects from contraceptive use, 33% were suffered from headache, 33% were suffered from weight loss, 33% were suffered from loss of energy as shown in figure .

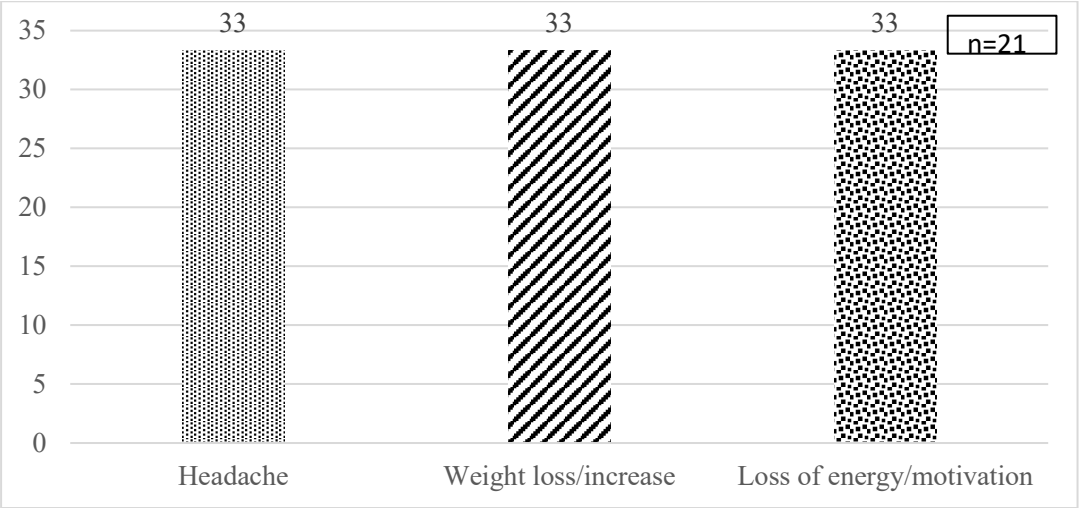


Figure 69 Side effect of family planning

4.6.6 Reasons for not using family planning

Out of total respondent, the most common reason was “not necessary” (74%), followed by partner reason (9%) Indicating that the partner's perspective influenced the decision, “birth planning” (7%), ‘didn’t know’ (5%) and “others” (5%) as shown in figure.

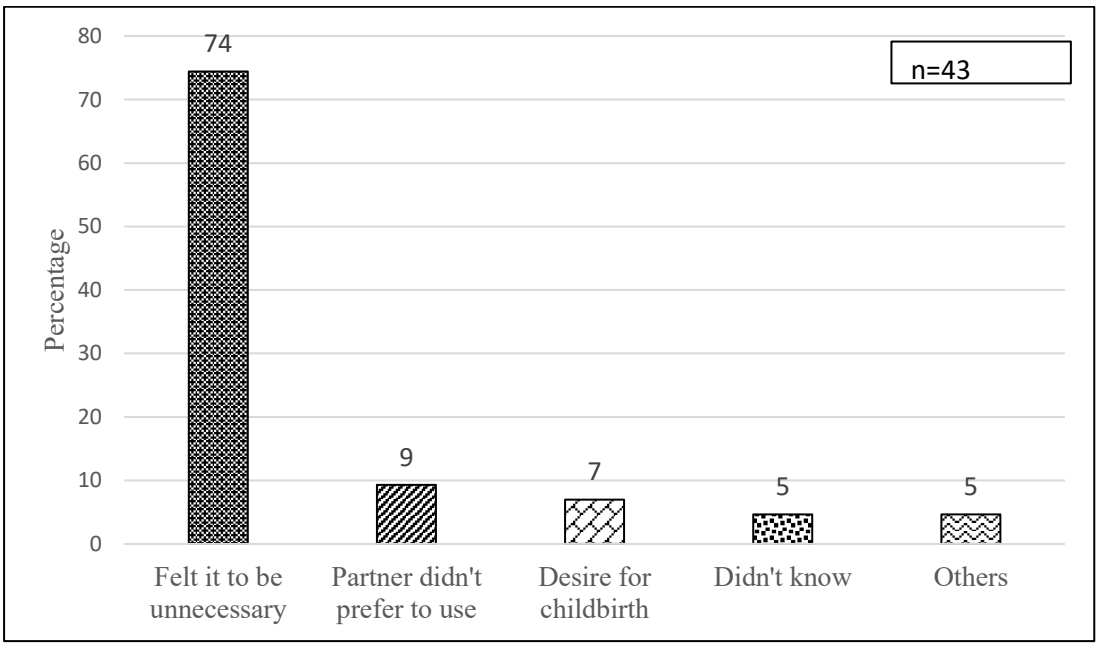


Figure 70 Reasons for not using family planning

4.7 Immunization Against Major Infectious Diseases

4.7.1 Immunization status

All of the respondents (25) have had done immunization of their child.

4.7.2 Immunization card

Among 25 respondent mothers of under two-year child, 96% have had immunization card and remaining 4% of them had not made the card as shown in figure.

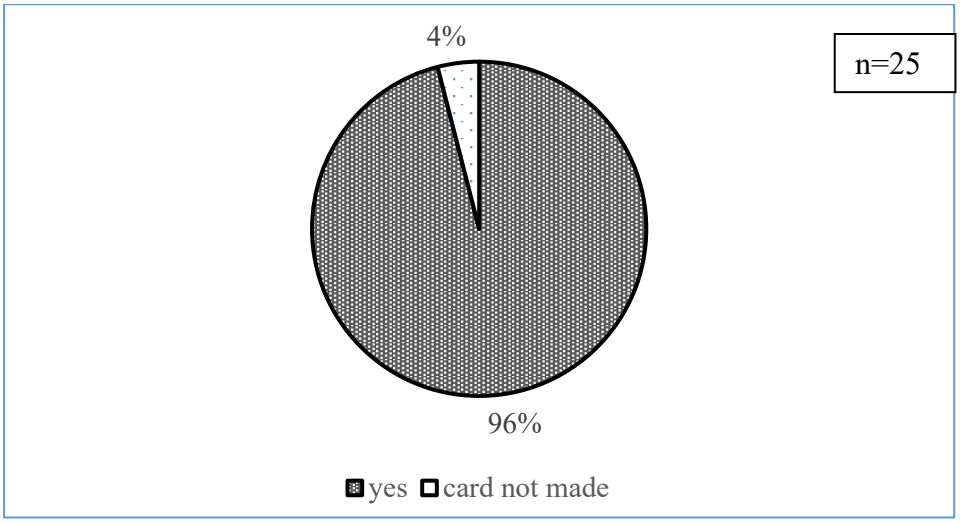


Figure 71 Immunization Card

4.7.3 Vaccination coverage of under 2 years' children

Among 25 respondent mothers of under two-year child who had immunization card (child health card), All under two years' child were vaccinated according to their age as shown in table

Table 31 Vaccination coverage of under 2 years children

Vaccines	Immunized frequency	Percentage	Not Applicable frequency	Percentage
BCG	25	100	0	0
Pentavalent 1st dose	24	96	1	4
Pentavalent 2nd dose	24	96	1	4
Pentavalent 3rd dose	23	92	2	8
OPV 1st dose	24	96	1	4
OPV 2nd dose	24	96	1	4
OPV 3rd dose	23	92	2	8
PCV 1st dose	24	96	1	4
PCV 2nd dose	24	96	1	4

PCV 3rd dose	21	84	4	16
IPV 1st dose	23	92	2	8
IPV 2nd dose	21	84	4	16
MR 1st dose	21	84	4	16
MR 2nd dose	21	84	4	16
JE	21	84	4	16
Rota virus 1st dose	24	96	1	4
Rota virus 2nd dose	24	96	1	4
Typhoid	21	84	4	16

4.7.4 Immunization of 10–15-year adolescent girls

Table 31: Immunization coverage o 10-15 years adolescent girls

Immunization of 10–15-year adolescent girl by HPV vaccination	**Frequency**	**Percentage**
Yes	85	81
No	20	19
Reason of not taking vaccination n= (20)		
Studied under 5 class while vaccination from class six	13	65
Don't know	7	35

4.8 Observation Checklist

4.8.1 Type of house

Among the total households, 77% had Ardha kachhi house, 9% had RCC/Pakki house and 15% had mud/kacchi house as shown in figure.

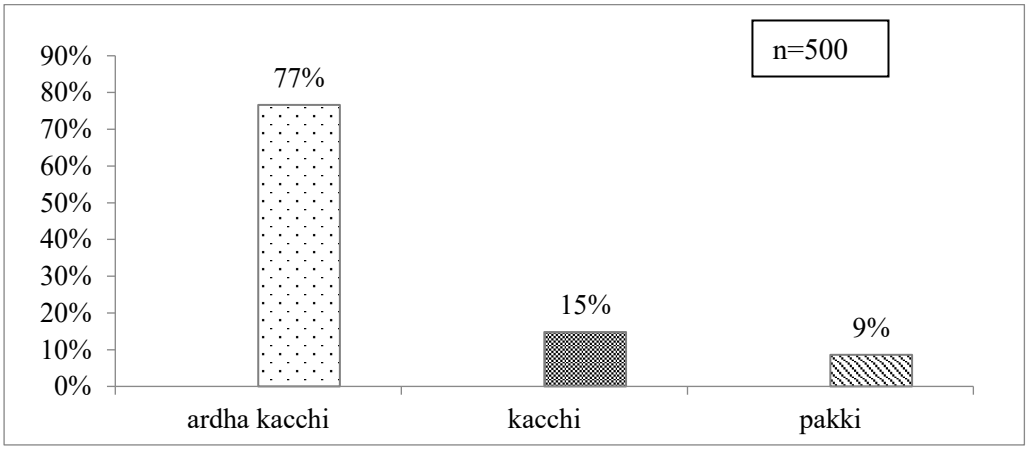


Figure 72 Types of houses

4.8.2 Sufficient lightening in the house

Among the total households, 69% had proper room in the house where as 31% had not as shown in figure.

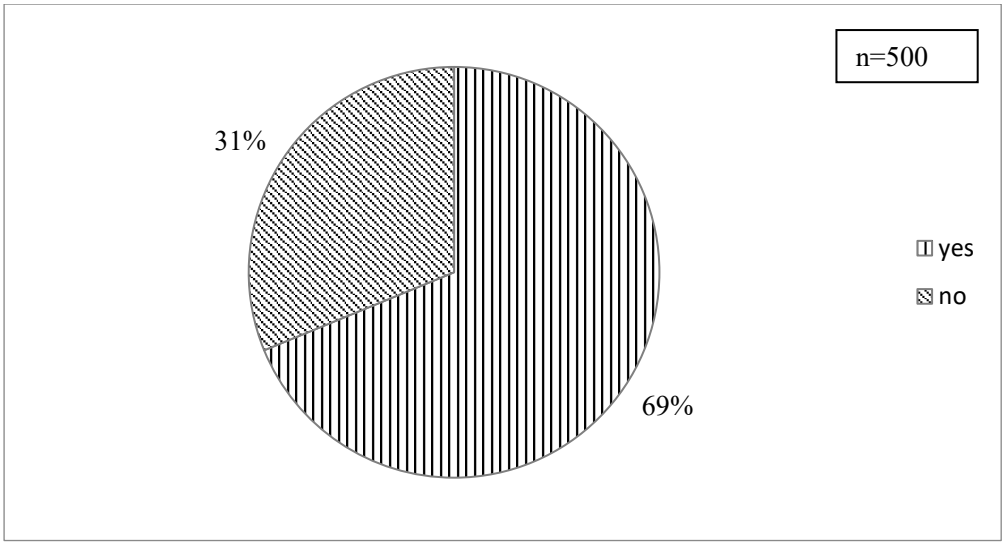


Figure 73 Sufficient lightening in the house

4.8.3 Separation of kitchen and sleeping room

Among total 500 households, 85% household had separate kitchen and sleeping room while 15% household had attached kitchen and sleeping room as shown in figure.

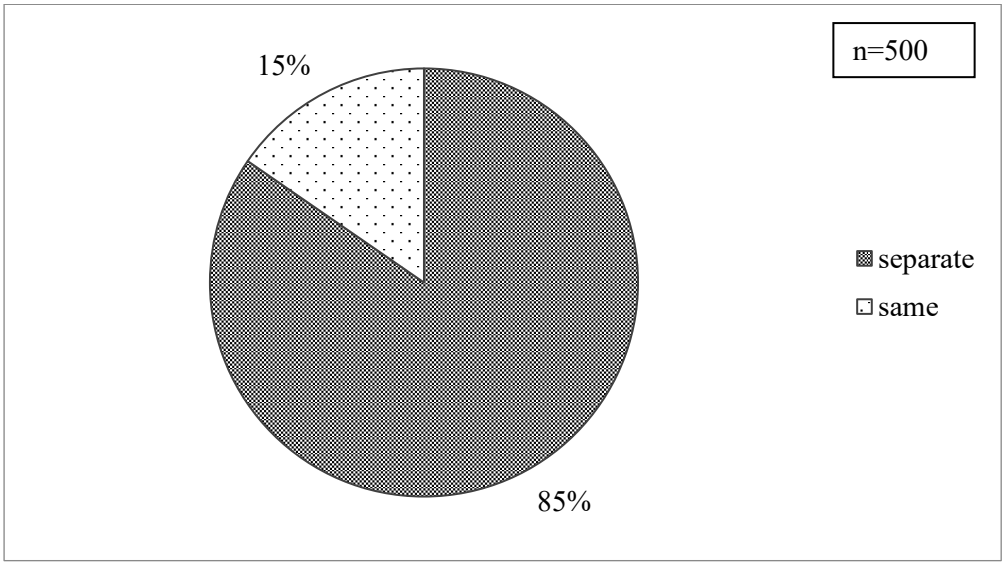


Figure 74 separate kitchen and sleeping room

4.8.4 Ventilation in room

Among total 500 households, 65% household had proper ventilation in each room of the house while 35% household had not proper ventilation as shown in figure.

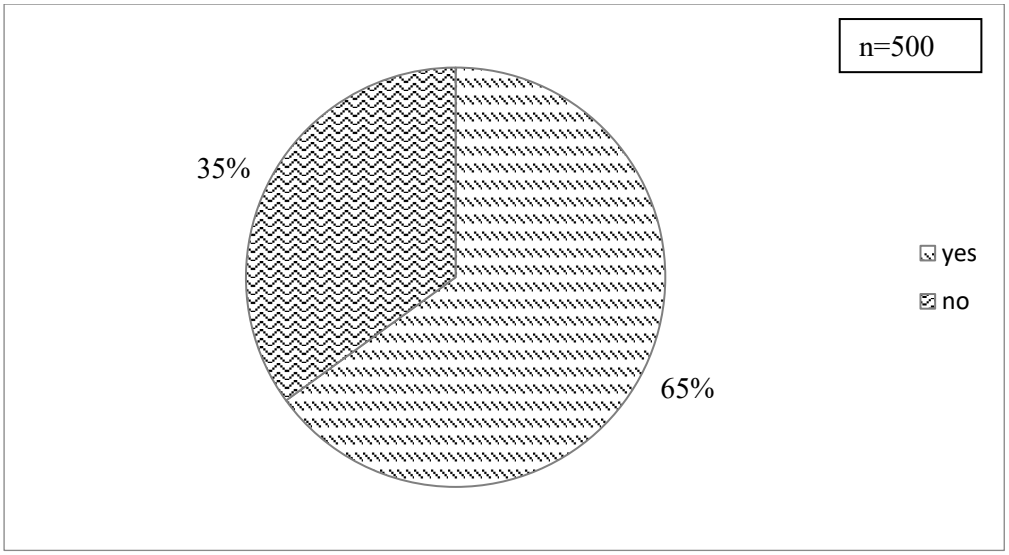


Figure 75 Ventilation in room

4.8.5 Availability of toilet in the house

Among total 500 households, 98% household had toilet in house while 2% household had not as shown in figure.

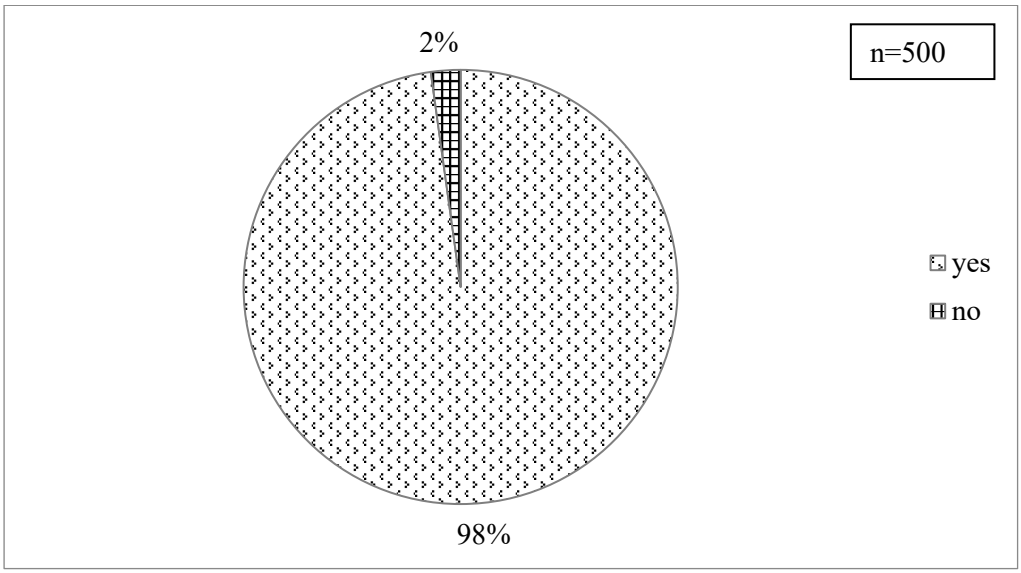


Figure 76 availability of toilet in the house

4.8.6 Distance between source of water and toilet

Among total 500 households, 14% household had distance of source of drinking water and toilet is less than or equal to15 meter and 86% household had the distance of source of drinking water and toilet is more than 15 meters as shown in figure.

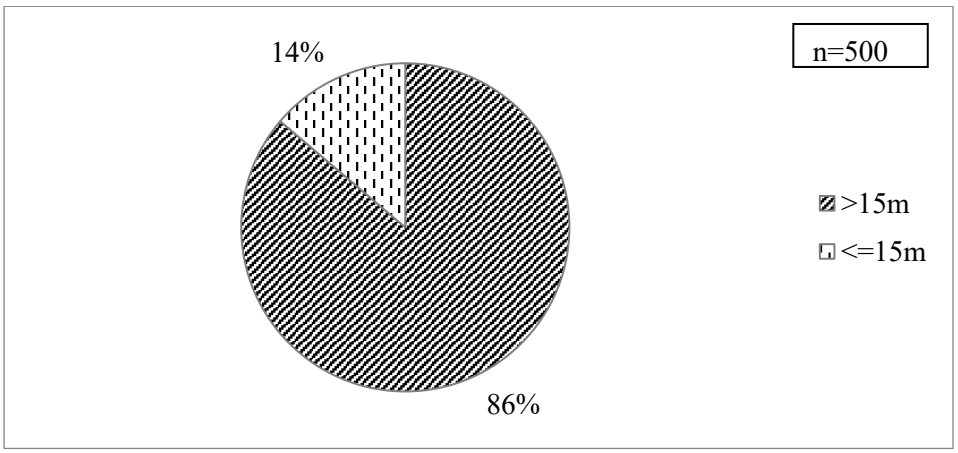


Figure 77 Distance between source of water and toilet

4.8.7 Household having cattle shed

Among total 500 households, 85% household had cattle shed in the house and 15% household had not in their house as shown in figure.

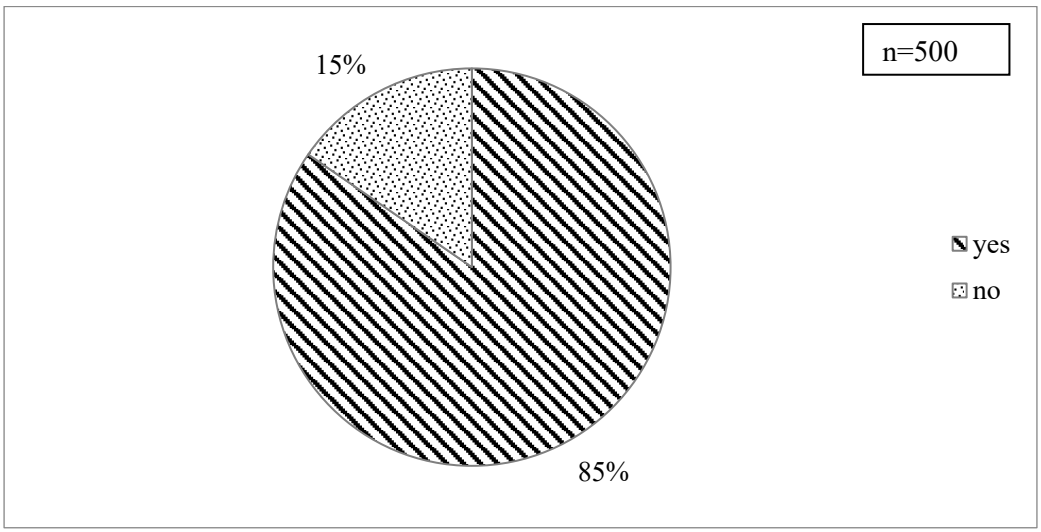


Figure 78 Household having cattleshed

4.8.8 Distance between house and shed

Among the total 500 household who had shed, 42% household had shed in the distance of less than or equal to 25 feet, 28% household had shed in the distance of more than 25 feet and 15% household's shed are attached with house as shown in figure.

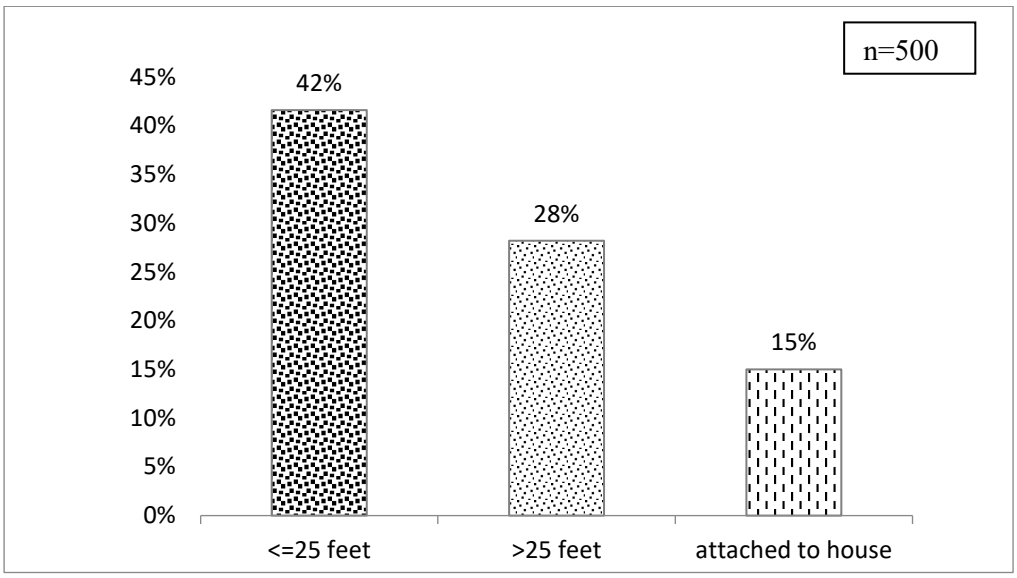


Figure 79 Distance between house and shed

4.8.9 Surrounding environmental status

Among total 500 households 70% household had clean surrounding and 30% had dirty as shown in figure.

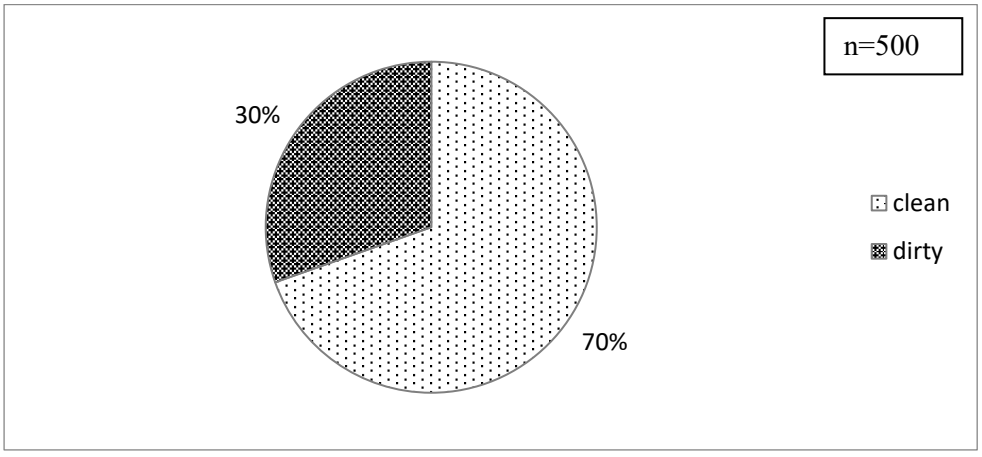


Figure 80 Surrounding environmental status

4.8.10 Time to reach nearest health post

Among total 500 households 70% household can reach nearest health post in less than 30 minute and 30% takes more than 30 min as shown in figure.

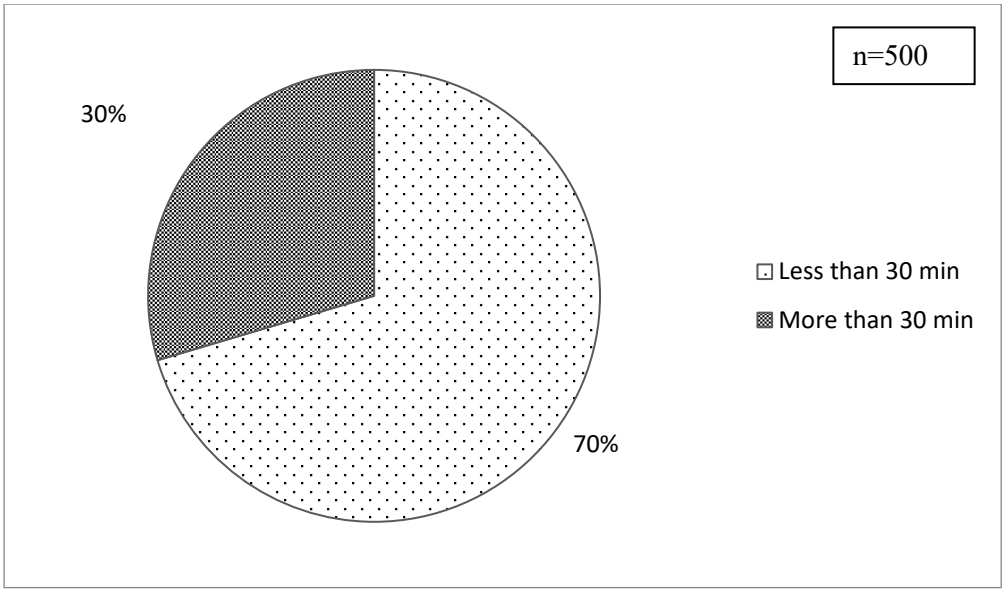


Figure 81 Time to reach nearest health post

CHAPTER V: FOCUS GROUP DISCUSSION AND KEY INFORMANT INTERVIEW

5.1 Focus Group Discussion (FGD)

Relationship Between Junk Food Consumption and Mental Health Among School Students

5.1.1 Introduction

The growing popularity of junk food among school students in Nepal has become a significant concern for both educators and health professionals. Easy availability of packaged snacks such as noodles, chips, and biscuits has influenced students' eating habits, often replacing traditional homemade Discussion (FGD) was conducted among school teachers in Gorkha District. This report summarizes the key findings, challenges, and recommendations derived from that discussion.

5.1.2 Methodology

A qualitative Focus Group Discussion was conducted in one community school of Gorkha District. Discussion mainly focuses on identifying Relationship Between Junk Food Consumption and Mental Health Among School Students. The participant was arranged in face-to-face C-shaped sitting aggrievement. They were informed about the venue, time, Date and FGD objective as per the workplan.

- **Participants:** 12 teachers (both male and female).
- **Facilitators:** Students from Pokhara University.
- **Study Area:** One Community School, Gorkha District,
- **Method:** Semi-structured discussion guided by nine main questions.
- **Duration:** 30 min.
- **Data Handling:** The conversation was recorded, transcribed, translated into English, and thematically analyzed.

5.1.3 Findings (Thematic Analysis)

Theme 1: Students' Mental Health Status

Most teachers agreed that students are not severely mentally disturbed. however, many seem less attentive and their reasoning ability appears weaker. Some teachers observed that students are less active in class and show reduced motivation for learning.

Theme 2: Impact of Junk Food on Mental Health

Participants reported that regular consumption of junk foods especially long-stored packaged noodles and snacks affects both the digestive system and mental alertness. Teachers observed that such students become dull, less energetic, and comparatively weaker in studies.

Theme 3: Effect on Learning and Classroom Activities

Several teachers stated that junk food consumption has led to reduced concentration and thinking capacity among students. The discussion revealed a common perception that junk food contributes to academic underperformance.

Theme 4: Efforts to Control Junk Food Consumption

Schools have taken several initiatives to discourage junk food, such as:

- Encouraging students to bring homemade snacks like roasted corn and soybeans.
- Discouraging or punishing students who bring junk food.
- Collaborating with local government bodies promoting nutrition-friendly programs.
  Day meal program for upto class 6 students.

Theme 5: School Programs for Mental Health Promotion

Schools conduct regular counseling sessions, particularly for adolescent girls. Different teachers are assigned to provide counseling on specific topics. In addition, municipalities and health posts organize annual awareness and counseling programs related to mental health.

Theme 6: Awareness Among Parents and Students

Teachers noted that many parents, especially from lower and middle-income families, lack knowledge about the negative impacts of junk food. Children think avoiding junk food is only necessary at school, not at home. Many parents do not attend awareness programs and often serve junk food as a regular meal.

"When I asked the students during the program or while teaching whether they know why they should not eat junk food, they said, 'Yes, we know,' and when I asked why they should not eat it, they replied, 'Because the head sir will beat us.'This is the kind of mentality they have." (Speaker No: 4)

Theme 7: Challenges Faced by Teachers

Teachers highlighted several challenges:

- Proximity of markets selling junk food near schools.
- Limited control beyond school hours.
- Lack of parental cooperation and awareness.
- Economic factors many families consider junk food as cheap and convenient. Controlling such habits thus remains difficult without community-level intervention.

Theme 9: Suggestions from Participants

- Focus awareness programs on low-income groups.
- Include grades 7–12 students in the mid-day meal program.
- Strengthen collaboration among schools, local government, and parents.
- Encourage monitoring and regulation of food vendors near schools.

5.1.4 Conclusion

The study concludes that junk food consumption negatively influences students' mental alertness, reasoning ability, and learning outcomes. Teachers play a crucial role in promoting healthy habits, but effective control requires community and government collaboration.

5.1.5 Recommendations:

1. Launch regular awareness and counselling programs for students, parents, and teachers.
2. Implement school meal programs up to grade 12 to reduce reliance on junk food.
3. Enforce junk food restrictions within and around school areas.
4. Encourage shops near schools to sell healthy, locally prepared food.
5. Strengthen the partnership among schools, municipalities, and health sectors for sustained awareness campaigns.

5.2 Key Informant Interview

5.2.1 Introduction

This qualitative study explores the roles, experiences, challenges, and community perceptions of Female Community Health Volunteers (FCHVs) in Barpak Sulikot Rural Municipality, Ward No. 4 of Gorkha District.The Key Informant Interviews (KIIs) were

conducted with selected FCHVs of varying experience levels (ranging from 1 year to over 10 years of service).The purpose was to gain in-depth insights into their contributions to community health, particularly in maternal and child health, health promotion, disease prevention, and coordination with local health systems.

5.2.2 Methodology

- Study design: Qualitative descriptive study
- Data collection method: Key Informant Interviews (KIIs)
- Participants: Four FCHVs (Pampha Sodari, Sita Gurung, Sabitri Neupane, and Menu Gurung)
- Setting: Barpak Sulikot Rural Municipality, Ward No. 4, Gorkha District
- Data analysis: Thematic analysis based on inductive coding from translated transcripts. Major themes and subthemes were derived through close reading and pattern identification.

5.2.3 Key Findings and Thematic Analysis

Theme 1: Roles and Responsibilities of FCHVs

Across all interviews, FCHVs described playing multifaceted roles in promoting community health:

- Maternal and Child Health: FCHVs conducted home visits to monitor pregnant women, encouraged antenatal checkups, distributed iron and calcium tablets, facilitated safe deliveries, and promoted postnatal care.
- Health Education: They organized mothers' group meetings to spread awareness about nutrition, sanitation, seasonal diseases, and vaccination.
- Basic Treatment and Referral: FCHVs provided basic first aid, distributed ORS, paracetamol, and referred serious cases to health facilities.
- Disease Prevention: They participated actively in health campaigns and public health awareness, especially during outbreaks.
- Behavior Change Communication: Volunteers emphasized hygiene practices such as handwashing and toilet use, contributing to visible community improvements.

"We go door-to-door to spread awareness… conduct mothers' meetings and teach about nutrition and hygiene." (FCHV ward-04)

Theme 2: Community Perception and Trust

Community acceptance and trust toward FCHVs were consistently positive.

- FCHVs reported being respected and appreciated for their services.
- Community members often sought advice from them, especially regarding child illness and maternal care.
- Their interventions led to improved health-seeking behavior and reduced reliance on traditional healers.

"People value us and come for advice. If it's serious, I refer them to the health post." (FCHV ward-04)

Theme 3: Challenges Faced by FCHVs

While the FCHVs expressed dedication, they highlighted several challenges:

- Geographical barriers: Difficult terrain and long distances to health posts made work physically demanding.
- Limited incentives: Lack of regular allowances and delayed provision of refreshments during meetings reduced motivation.
- Community misconceptions: Some people accused FCHVs of "working for money" despite their voluntary nature.
- Logistical constraints: Insufficient medicines and resources at local health posts limited service delivery.

"People say we get paid for doing this work, but we do it voluntarily." (FCHV ward-04)

Theme 4: Family and Social Support

All participants mentioned strong family support, especially from husbands and in-laws. Such encouragement allowed them to participate actively in meetings and community mobilization activities. However, a few noted social gossip or misunderstanding from neighbours, which they learned to ignore.

"My husband and in-laws support me. They understand my work." (FCHV ward-04)

Theme 5: Impact on Maternal and Child Health

All FCHVs agreed that their work had significantly improved maternal and child health outcomes:

- Decrease in home deliveries and neonatal deaths.

- Increased antenatal and postnatal care utilization.
- Improved hygiene and nutrition practices.
- Decline in preventable diseases such as pneumonia and diarrhea.

"Earlier many infants died at home, now most deliveries happen at health posts." *(FCHV ward-04)*

Theme 6: Coordination and Support from Health System

The findings show varying levels of coordination between FCHVs and health institutions:

- Positive relationships with health post staff and ward officials were reported.
- However, several participants called for better coordination and training opportunities from higher authorities.
- FCHVs expressed a desire for more frequent interaction, monitoring, and collaboration with municipal and provincial health teams.

"If staff came and talked to villagers, it would be more effective." *(FCHV ward-04)*

Theme 7: Expectations and Suggestions for Improvement

FCHVs provided practical suggestions for enhancing their work effectiveness:

- Regular training and capacity-building programs.
- Provision of adequate supplies and incentives.
- Establishment of nearby health facilities for easier access.
- Government investment in equipment such as X-rays and adequate medicines at local health posts.
- Conducting more community awareness programs and health campaigns.

"the government should provide X-ray and operation facilities in local health posts." *(FCHV ward-04).*

5.2.4 Conclusion

FCHVs in Gorkha's Barpak Sulikot ward have made remarkable contributions to improving maternal and child health, community hygiene, and disease prevention. They are trusted health promoters and first points of contact for rural families. However, to maintain and expand these impacts, systematic support, training, and recognition from all government levels are essential.

5.2.5 Recommendations

1. Strengthen training and refresher programs for FCHVs focusing on maternal, child, and communicable diseases.
2. Ensure regular supply of essential medicines and materials at the local level.
3. Introduce performance-based incentives or recognition schemes.
4. Enhance coordination among FCHVs, health facilities, and local government.
5. Expand community health awareness campaigns through mothers' groups and schools.
6. Upgrade local health infrastructure (e.g., X-ray, laboratory, maternity services).

CHAPTER VI: SCHOOL HEALTH PROGRAM

6.1 Introduction

The School Health Program is an important part of community health activities. According to modern concepts, school health programs are an economical and powerful means of raising community health and are most important in the future generations. It can be a strong base in promoting physical and mental health in students, promoting healthy habits, detecting diseases early and treatment and in overall community wellbeing.

School Health Program was conducted based on the felt need of the community people which was identified from the data collection and analysis. Hence, based on these data, we decided to conduct SHP on the topic: Dignified Menstruation and Anti-Tobacco. We had communicated with the head principal of the Shree Himalaya Secondary School and got approval to conduct our School Health Program at the Audio-Visual room of Shree Himalaya Secondary School.

6.2 Objectives

6.2.1 General objective

To promote healthy, hygienic and stigma-free menstrual practices among students as well as to develop awareness about the harms of tobacco and encourage a tobacco-free lifestyle.

6.2.2 Specific objectives

- To change the knowledge and behaviour of adolescents related to menstruation.
- To change the knowledge and behaviour of adolescents related to tobacco consumption.
- To reduce substance abuse among adolescents.
- To encourage safe practices during menstruation.
- To provide information about the consequences of tobacco consumption.
- To provide information regarding symptoms during pre-menstruation and during menstruation.
- To inform about the prevention and control of tobacco consumption and other health problems resulting from tobacco abuse.
- To inform about the proper way of using Sanitary pads.

6.3 Program detail:

Date:2082-3-10		
Time:2PM - 4PM		
Venue: Shree Himalaya Secondary School, Barpak R.M – 4, Saurpani		
Target students: →Class – 7,8 (Dignified Menstruation to both boys and girls) →Class – 9,10 (Anti-tobacco lesson to both boys and girls)		
S.N.	**Activity**	**Description**
1.	Determination of date and venue	We talked with the principal of the school and fixed the date and venue.
2.	Preparation of chart papers and slideshows	We searched the content and prepared the chart papers and PowerPoint slides.

6.3.1 Method and media:

Table 32: SHP method and media

Topic	Method	Media	Facilitator
Introduction to Dignified Menstruation	Mini-lecture	Slides	Rasik Jamarkattel
Menstrual Cycle	Mini-lecture, Group discussion	Slides	Suchita Subedi
Symptoms before menstruation and during menstruation Health complications of menstruation	Mini-lecture	Slides	Janak Gautam
Control of health issues during menstruation Hygiene tips for Menstruation and things to remember during menstruation	Mini-lecture	Slides	Sayelu Adhikari
Proper way of using Sanitary Pads	Demonstration	Sanitary Pad	Dibya Mainali

Topic	Method	Media	Facilitator
Introduction to tobacco and related substances	Mini-lecture	Slides	Sujita Subedi
Economic, Social and health related complications due to tobacco consumption	Mini-lecture	Slides	Ritika Baskota
Vape, its types and effects Hookah, its types and effects	Mini-lecture	Slides	Resham Karki
Effect of Nicotine on Respiratory Tract Trend of Initiation of Tobacco Consumption Types of smokers on the basis of Proximity	Mini-lecture	Slides	Sachin Koirala
Myths and facts regarding Menstruation How to be prevented from tobacco consumption Control of Tobacco abuse and helpline information Environmental Impacts of Tobacco consumption	Mini-lecture	Slides	Savyata Neupane

Evaluation of SHP

Before conducting the session of SHP, we asked question to the students regarding: Dignified Menstruation and Tobacco Consumption to know their knowledge upon them. We taught the students how to properly use Sanitary Pads.

After completion of the SHP session, we asked question to the students and they were able to:

- Know about the menstrual cycle and symptoms before and during menstruation.
- Ways to control health issues and maintain hygiene during menstruation.
- Understand about the consequences of tobacco consumption

- Prevention and Control of Tobacco Consumption.
- Proper way of wearing Sanitary Pads.

In this way, the SHP was conducted in the topic: Dignified Menstruation, Menstrual Cycle, symptoms before and during menstruation, Prevention and control of issues faced during menstruation, Anti-tobacco: Introduction and types, Consequences of Tobacco Consumption, effect of nicotine respiratory tract, age of Tobacco initiators, types of smokers, prevention and control of tobacco consumption and appropriate way of wearing sanitary pads. The students attended the session with curiosity and great attention. The school principal appreciated our session. Photos and videos were taken during and after the session with the students.

CHAPTER VII: MICRO HEALTH PROJECT

7.1.1 Introduction:

Micro Health Project is a small form of a short-term project designed to develop health skills and autonomy on the priority basis of real needs among the community people through maximum utilization of the local resources and techniques. It was just one of the way to demonstrate the method of solving community health problems. To carry out MHP, a health needs assessment should be done at first which was done by discussing the felt and observed needs and deciding the real needs on the priority order.

The process of health need assessment and its prioritization was performed in our first community presentation. As per the obtained result on prioritized real health needs, MHP was implemented on the **23rd of Ashad 2082** at saurpani ward no 4, sulikot, Gorkha with the active participation of community people.

Micro Health Project is conducted after the completion of the following steps:

I. Need Identification

II. Need Prioritization

I. Need Identification

Based on our findings, local people's interests and expectations, the need for Gorkha, Barpark Sulikot rural municipality ward number 04 Saurpani was identified. It was a very crucial part as the whole intervention part is based on it

A. Observed Needs

Observed needs were identified by analyzing the collected data through an interview and observation checklist. The observed needs were:

1. Hypertension
2. Diabetes mellitus
3. Gastritis
4. Tuberculosis
5. Diarrhoea
6. Uterine prolapse
7. Institutional Delivery

8. Health education Awareness
9. Non degradable waste management
10. Safe drinking water
11. Food and Nutrition
12. Facilitated hospital
13. Access to health care

B. Felt Needs

Felt needs were identified from key informants' interviews with Health Post in charge, FCHV, ward president, School teacher informal interaction with the social worker, health workers, FGD, and community people during the first community presentation. The felt needs were:

1. Hypertension
2. Diabetes mellitus
3. Gastritis
4. COPD
5. Safe drinking Water
6. Institutional Delivery
7. Health education and Awareness
8. Facilitated hospital
9. Access to health care

C. Real Needs

Real needs were identified from the joint understanding of prioritized felt needs and observed needs through community participation: while MHP was conducted based on real needs. The real needs identified were:

1. Hypertension
2. Diabetes mellitus
3. Gastritis
4. Safe drinking water
5. Health education and Awareness
6. Facilitated hospital
7. Access to health care

II. Community Interest Identification

Prioritization of actionable programs for intervention was done by prioritization tool need prioritization by Multi-Voting technique to select major health problems in the coordination of FCHVs, health workers, teachers, Local leaders, and community members. In response to them, it was constructed and identified the health problems to run the micro health project and provide appropriate health intervention. The Multi-Voting technique was done as the following:

Table 33: MHP Multi-Voting

Health Indicators	Round 1 vote	Round 2 vote	Round 3 vote
Hypertension	𝍸 I	𝍸 III	𝍸 𝍸 IIII
Diabetes mellitus	III	-	-
Gastritis	𝍸 III	𝍸 𝍸 II	𝍸 𝍸 𝍸 I
Safe drinking water	IIII	IIII	-
Facilitated Hospital	II	-	-
Access to health care	III	-	-
Health education and Awareness	IIII	𝍸 I	-

A multi-voting process was conducted to prioritize the identified health issues, which included Hypertension, Diabetes mellitus, Gastritis, Safe drinking water, Health education and Awareness, Facilitated hospital and Access to health care.

In the first round of voting Diabetes mellitus, facilitated hospital, access to health care were excluded due to lower preference. In the second-round Safe drinking water, Health education and awareness followed by the exclusion of hypertension in third round.

Finally, the Gastritis received the highest number of vote and was selected as the Micro Health Project (MHP) for intervention based on the multi-voting results.

7.1.2 Objective of MHP

1. To aware community about Non -communicable Disease .
2. To aware community people about risk factor, symptoms, preventive measures and complication of Gastritis through role playing.

7.1.3 Planning of MHP:

To implement the MHP effectively, careful planning was essential. After identifying and prioritizing health issues, we planned the MHP. We first set objectives that could be achieved with community participation and available local resources. We then selected an appropriate health education method (role play) to conduct the MHP.

We gathered information on Gastritis causes and risk factors, which were to be shared during the program. We consulted with the ward president, health in-charge, and local leaders to ensure the project's feasibility and effectiveness, incorporating their feedback and support. Additionally, we coordinated with community members, the school principal, and other stakeholders to determine a suitable time and venue for the MHP. This is how we organized the plan.

7.1.4 Role play Planning

We selected role play as an appropriate method to make community people realize their health needs. The topic for role play was Gastritis. The time, situation and characters to be played for each member involved in role play was determined. Then, necessary resources materials were arranged and venue was set up. The team members who were involved in role play acted based on real life situation and narrated the story and message in simple manner. Additionally, colourful posters and charts were used to support the messages so it could be clearly understood by community people. At the end of role play, the effectiveness of program was evaluated by interacting with audience and seeking their feedback.

7.1.5 Implementation of MHP:

With the support and participation of community people along with relevant stakeholders, we conducted MHP at the ward no 04 Saurpani. We did presentation to make the community members aware about the causes, risk factors, complication and preventive action of Gastritis.

We performed role play as our planned script that is basis on real life scenario of Gastric patient who fought with the Gastric with tailored message of risk factors, symptoms, complication of Gastric preventive measures and how we can health behavior, health diet, and regular exercise can reduce risk of Gastritis.

Table 34: Role play method and media

Topic: causes, risk factors and preventive measures of Gastritis			
Date: 2082/03/23			
Venue: Sulikot, Ward no 04 Saurpani			
Topic	**Method**	**Media**	**Facilitator**
Introduction and present condition of Gastritis	Mini-lecture	Poster and charts	Resham karki
Risk factors associated with Gastritis	Mini-lecture	Poster and charts	Suchita subedi
Complication of Gastritis	Mini-lecture	Poster and charts	Divya mainali
Preventive measures of Gastritis	Mini-lecture	Poster and charts	Janak Gautam

Topic: Role play on risk factor, symptoms,preventive measures and complication of diabetes		
Date: 2082/03/23		
Venue: Sulikot, Ward no 04 Saurpani		
Role	**Significance of role**	**Role played by**
Story Narrator	To provide background of story	Shailu Adhikari
Diabetes patient	To shows complication of Gastritis Preventive measures, risk factors of Gastric.	Rasik Jamarkattel
Patients' wife	To encourage patient in healthy behavior	Savyata Neupane
Patients' children	To show health impacts due to junk food in children	Ritika Baskota Janak Gautam
Doctor	To diagnose Gastric, to promote healthy behavior,	Sachin koirala
FCHV	To share knowledge about Gastritis	Sujita Subedi
Neighbor	To help patient	Dibya Mainali,

7.1.6 Evaluation and Sustainability of MHP:

During the MHP, the community members showed great attention and gained lots of information and knowledge on causes, symptoms, complication and preventive measures of Gastritis. At the end of the role-playing session we evaluated the effectiveness of the MHP discussion and interaction with participants and took feedback from participants.

We had formulated a committee in the chairmanship of FCHV for the sustainability of the MHP and we handed over the responsibility to them to regularly conduct awareness program on Gastric as well as other different NCDs. Similarly, this kind of MHP can be replicated in similar setting. Training and educating community people and mobilizing community level health workers in order to educate and aware community people is key for sustainability of this kind of MHP.

CHAPTER VIII: COMMUNITY PRESENTATION

Community presentation is a systematic process of sharing and presenting the findings of the Community Health Diagnosis (CHD) along with the general introduction, objectives, and activities carried out in the community. It involves the use of available local resources and active participation of stakeholders and community members. The presentation is conducted in a simple , polite, and easily understandable language to ensure effective communication and community involvement.

8.1 First Community Assembly

The first community assembly was organized to introduce our team and explain the purpose of the Community Health Diagnosis (CHD). We shared our objectives, reasons for being there, and the activities we planned to do. The meeting also helped us build good relationships with community members, local leaders, and stakeholders, and encouraged their participation and support in the CHD process.

Objectives

1. To introduce ourselves to the community people and inform them about the purpose of community health diagnosis.
2. To conduct social mapping to understand the physical layout and social structure of community and also to identify available community resources and facilities such as schools, health posts, and water sources etc.
3. .To build rapport with community members, stakeholders, and local leaders.

Date of program: 2082/02/30

Venue: Shree Himalaya Secondary School, Barpak Sulikot-04, Gorkha

8.2 Second Community Assembly

8.2.1 Introduction

After the completion of data collection, entry and analysis we found out the key findings on various topics. The entire noticeable, distinct and problematic findings of our survey conducted on households were presented on the day. The major findings reflected the overall health status of the community.

8.2.2 Objectives:

1. To disseminate all the findings of our survey to community people, stakeholders and local leaders.
2. To identify and prioritize the health needs of the community based on discussion with the community members.
3. To identify the possible local resources available in the community for the MHP.

8.2.3 Details of programs

We presented our key findings in forms of pie-chart and bar-diagram and tables in simpler form so that it was easily understandable by community people. The program was organized under the chairmanship of Ritika Baskota and the chief guest , FCHVs, school teachers and community peoples participated in the program.

Date of the program: 2082/03/18

Venue: Health Post, Barpak Sulikot-04, Gorkha

S.N.	Activity	Responsible person	Remarks
1.	Program host	Janak Gautam	
2.	Welcome speech	Shailu Adhikari	
3.	Introduction and objectives of CHD	Savyata Neupane	
4.	Socio-demography finding presentation	Dibya Mainali	
5.	Disease and Epidemiology finding presentation	Resham Karki and Rasik Jammarkatel	
6.	Food supply and nutrition finding presentation	Rasik Jammarkatel	
7.	Safe water and basic sanitation finding presentation	Suchita Subedi	
8.	Maternal and child health finding	Sujita Subedi	

	presentation		
9.	Family Planning and Immunization finding presentation	Sachin Koirala	
10.	Health problem and needs of the community and observation checklist finding presentation	Ritika Baskota	
11.	Speech	Sarita Bisukya	
12.	Conclusion and vote of thanks	Ritika Baskota	

8.3 Final Community Assembly

8.3.1 Introduction

The final community presentation, held at the end of the CHD fieldwork, serves to summarize and share the activities, findings, and experiences of the one-month stay. It is an important program for disseminating results, reflecting on achievements, and engaging with community stakeholders.

8.3.2 Objectives

1. To present the final findings of the CHD and outcomes of the MHP
2. To summarize the entire CHD process reflecting the key achievements,
3. To provide specific recommendations to the concerned stakeholders for addressing the health problems,
4. To ensure active participation and feedback from community members and local stakeholders,

5. To acknowledge and appreciate the continuous support and cooperation of community members, stakeholders, leaders and institutions during the CHD fieldwork.

8.3.3 Details of the program

Date of Program: 2082/03/26

Venue: Outside of Ward Office, Barpak Sulikot-04, Gorkha

After completion of all the activities of CHD as per the work plan, we planned for the third and final community assembly. We prepared the content for the presentation on the chart paper and newsprint. We present the mobility chart , seasonal chart, daily routine of the community members. We pre-informed all the stakeholders and community members for the assembly. The program was conducted under the chairmanship of Ms. Ritika Baskota (Group leader) and Mr. Sunem Gurung (ward member) was the chief guest for the program. Ward members, FCHVs, local leaders were present on the program.

S.N.	Description	Responsible member
1	Program host	Resham Karki
2	Welcome speech	Janak Gautam
3	Introduction and objectives of CHD	Shailu Adhikari
4	Major findings presentation	Savyata Neupane and Suchita Subedi
5	FGD/KII related presentation	Janak Gautam
6	SHP related presentation	Rasik Jamarkattel
7	MHP related presentation	Sujita Subedi
8	PRA tools	Dibya Mainali and Sachin Koirala
9	Conclusion, recommendation and report submission	All member
10	Speech	Sunem Gurung
11.	Conclusion and vote of thanks	Ritika Baskota

CHAPTER IX: DISCUSSION

Our study reveals several key findings when compare to national data. The average household size in our study is 4.06 which is slightly lower than the national average of 4.37 reported in the 2021 Census. Similarly, the sex ratio in our sample is 98.05 slightly surpassing the national figure of 95.59 this could be due to the smaller sample size. The literacy rate (68%) which is lower than the national rate of 76.2% according to Census 2021. Agriculture remained (64.4%) which is similar to population engaged in Farming compared to the national average of 66% as per World bank from 2022.

Health behaviors show stark differences as well, with only 16.5% of population using tobacco, sightly lower than 28.9% reported in the Nepal STEPS Survey 2019. Similarly, 13.9% of people consume alcohol, which is slightly lower compared to the national figure of 23.9%. In terms of maternal health, 93.8% had at least four antenatal care (ANC) visits, which is higher to 81% reported in NDHS 2022. Institutional delivery is notably high in our study, with 86% of women giving in health facilities, compared to the national average of 79%. 59% Under 5 children mother had received Postnatal Care (PNC) services.

Additionally, 85.3% of postpartum mothers took Vitamin A supplements, higher than the national figure of 76.3%. Immunization coverage is excellent, with 100% of children fully immunized according to the NIP schedule, exceeding the national average of 91.2%. Family planning usage among reproductive-age individuals is 55% which is higher compared to modern contraceptive prevalence rate (mCPR) of 27 % for Gandaki Province.

Regarding the infrastructure, 98% of household used tap water as their main source of drinking water, moderately higher than the 87.2% reported in Sulikot rural municipality 2021 Census, and 60% practiced water purification, primarily through boiling and filtration which is significantly higher than the national rate of 25%. Nearly all houses had toilets (98%), reflecting successful sanitation initiatives which is slightly above the 95.5% recorded in the 2021 Census. However, improper waste management burning (96%) or dumping—poses an environmental health concern.

CHAPTER X: LEARNING EXPERIENCE

The one-month residential Community Health Diagnosis (CHD) program serves as a vital bridge between theoretical public health education and practical application in real-world settings. Upon completion of the program, we gain valuable knowledge and skills in personal, professional, and academic domains.

Academic and Professional Development

The CHD program enhances our abilities to design and implement public health initiatives. Key skills acquired include setting objectives, developing tools, and finalizing methodologies. We learn to make informed decisions, negotiate with community members, and establish rapport with key stakeholders. The program provides foundational insights into successful community-level program execution, including social mapping and stakeholder engagement.

During the CHD, we develop practical skills in data collection, including gathering information from community members and preparing data entry sheets in EpiData. we also learn data management and analysis using SPSS. Through interaction with community members, we acquire techniques for creating institutional diagrams, seasonal calendars, daily routines, and community timelines. The program also equips us with qualitative research skills, such as conducting Focus Group Discussions (FGDs) and Key Informant Interviews (KIIs). These methods help identify the community's real needs, enabling us to prioritize and address those issues. Moreover, we learn to conduct School Health Programs (SHPs) to educate and raise awareness among school-aged children and adolescents. The CHD emphasizes the implementation of community-based health interventions that are both time-efficient and cost-effective.

Personal Development

CHD fosters personal growth, particularly in teamwork and collaboration. We learn the importance of working effectively in groups to achieve common goals within set timelines. The experience of living in a rural community offers valuable insights into the local lifestyle, behaviours, and challenges faced by residents. Throughout the program, we refine their communication, coordination, and problem-solving skills. we learn to provide support to those in need, navigate difficult situations with empathy, and maintain politeness and professionalism in all interactions.

CHAPTER XI: CONCLUSION AND RECOMMENDATION

11.1 Conclusion

The community health diagnosis conducted at Barpak Sulikot-04, Gorkha, revealed that the overall health status of the community is moderately satisfactory, yet with several areas needing improvement. The socio-demographic data showed that more than half of the families were nuclear in type, and almost two-thirds of the population depended primarily on agriculture as their main source of income.

In terms of disease awareness, more than half of the respondents had heard about common diseases such as tuberculosis, dengue, hypertension, gastritis, and diabetes, while less than half had knowledge about uterine prolapse and mental health, reflecting major gaps in awareness of certain conditions. Similarly, more than half of the respondents lacked proper knowledge about the prevention and management of communicable diseases such as diarrhoea and tuberculosis.

Regarding nutrition, more than half of the households were aware of balanced diets and the preparation of Sarbottam Lito, and almost all practiced breastfeeding and colostrum feeding. However, less than half of the families had sufficient food or income for more than six months of consumption, which highlights food security issues in the community.

In environmental health, almost all households used tap water as their drinking source, but less than two-thirds practiced water purification. More than four-fifths separated household waste, yet most relied on burning as the primary method of non-degradable waste disposal.

In maternal and child health, more than half of pregnant women had adequate ANC visits and institutional delivery, and almost all received iron supplementation. However, less than half had complete postnatal care as per the protocol. The immunization coverage of children and adolescent girls was almost universal, showing positive health service utilization.

In family planning, more than half of the respondents had heard about family planning and were using some form of contraceptive method, with Depo and sterilization being most common. However, less than half had comprehensive knowledge of possible side effects and proper use.

Overall, more than half of the households had satisfactory housing, lighting, and toilet facilities, but less than half had properly ventilated rooms or separate kitchens.

In conclusion, while the community demonstrates moderate awareness and practices regarding major health determinants, less than half of the population possesses adequate knowledge on several specific health topics. There is a clear need for continued community-based health education focusing on disease prevention, maternal and child health, nutrition, sanitation, and environmental hygiene. Strengthening health literacy and promoting behavioral changes through local health institutions and FCHVs would significantly enhance the overall health status of Barpak Sulikot-04.

11.2 Recommendations

Based on the findings and conclusions of the Community Health Diagnosis conducted at Barpak Sulikot-04, Gorkha, the following recommendations are proposed to improve the community's overall health status:

11.2.1 To Ward Office

1. Facilitate regular collaboration among health posts, schools, and community groups for awareness campaigns on sanitation, nutrition and disease prevention.
2. Include health education and safe drinking water projects in local development plans.
3. Strictly regulate and monitor open burning of household waste through local by-laws and awareness program to reduce air pollution and health problems.

11.2.2 To Health Post

1. Conduct periodic outreach health education sessions on communicable and non-communicable disease (like tuberculosis, gastritis, hypertension and diabetes).
2. Integrate mental health education in outreach programs.
3. Address major NCDs like HTN and diabetes through periodic health screening programs.

4. Provision of Laboratory Services in Health Post

11.2.3 To local people

1. Maintain a balanced diet and engage in regular physical activities.
2. Implement the practice of boiling water for drinking

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ANNEXURE

Annex 1: Questionnaires

पोखरा विश्वविद्यालय

स्वास्थ्य विज्ञान संकाय

स्कुल अफ हेल्थ एण्ड एलाइड साईन्सेज

जनस्वास्थ्य कार्यक्रम

२०८२

नमस्कार, हामी **स्कुल अफ हेल्थ एण्ड एलाईड साईन्सेज, पोखरा विश्वविद्यालय**, पोखरा लेखनाथमा स्नातक तहमा अध्ययनरत (वि.पि.एच. छैठौं सेमेस्टर) जनस्वास्थ्य कार्यक्रमका विद्यार्थी हौं । यस कार्यक्रमको पाठ्यक्रम अनुसार यँहाको समुदायमा सामुदायिक स्वास्थ्य निरुपण (Community Health Diagnosis) गर्नका लागी हामी आएका छौं । यो सर्वेक्षणको उद्देश्य यस क्षेत्रका जनसमुदायमा रहेका विभिन्न स्वास्थ्य समस्याहरु तथा तिनको निदान सम्बन्धी ज्ञान, अवधारणा र व्यवहार कस्तो छ, जनसांख्यीक विवरण, स्वास्थ्य समस्या समाधानका लागी स्थानिय स्तरमा उपलब्ध सोत साधन के कस्ता छन् भन्ने बारे जानकारी संकलन गर्नु रहेको छ । यो जानकारीले हाम्रो अध्ययनलाई सहज बनाई सहयोग गर्नेछ र यसले यस नगरपालिका/गाउँपालिकाको स्वास्थ्य स्थिति उजागर गर्न, स्वास्थ्य सुधार साथै सरोकार पक्षलाई समेत जानकारी गराउन मद्दत गर्न सक्नेछ ।

तपाईंलाई यस सर्वेक्षणको लागि सहभागीको रुपमा छानेका छौं । म/हामी तपाईंलाई यस सर्वेक्षणका केही प्रश्नहरु गर्ने छु/छौं । स सर्वेक्षणका केही प्रश्नहरु नितान्त व्यक्तिगत पनि हुन सक्छन् तर तपाईंले दिनु भएको सबै जानकारीहरु महत्वपूर्ण हुनेछन् र सो जानकारीहरु एकदमै गोप्य राखिनेछ साथै तपाईंले दिनुभएको सुचना तथा तथ्याङ्को यस सर्वेक्षणका लागी मात्र प्रयोग गरिनेछ । यो सर्वेक्षणका यँहाको सहभागिता स्वैच्छिक हुनेछ । यदि तपाईंलाई कुनै वा सबै प्रश्न व्यक्तिगत वा संवेदनशील लागेमा उत्त प्रश्नको जवाफ नदिन पनि सक्नु हुनेछ । यस अध्ययनको समयावधि बढीमा ४५ मिनेटको हुनेछ । म/हामी यो आशा गर्दछु / छौं कि तपाई यस सर्वेक्षणमा सहभागी हुनु हुनेछ ।

के तपाई यस सर्वेक्षणमा सहभागी हुन इच्छुक हुनुहुन्छ ?

छु .....१ अन्तरवार्ता शुरु गर्ने

इच्छुक छैन .....२ अन्तरवार्ता यही टुंग्याउने, धन्यवाद दिने

फारम नं :

अन्तरवार्ता मिति : २०८२...../.....

उत्तरदाताको नाम. .....

ठेगाना : .....

हस्ताक्षर.....

सम्पर्क नं. .....

SECTION A: SOCIO-DEMOGRAPHIC INFORMATION

भाग १: सामाजिक तथा जनसांख्याकिय विवरण

A1.जनसांख्याकिय विवरण :

क्र.सं.	घरमुलिसँगको नाता	S1.लिङ्ग	S2.उमेर	S3.शिक्षा	S4. वैवाहिक स्थिति	S5.पेशा	S6.अपाङ्गता	S7.लुर्तिजन्य पदार्थ सेवन	S8. मध्यपान
१	घरमुली आफै								
२									
३									
४									
५									
६									
७									
८									
९									
१०									
११									
१२									

A2.पुरुष संख्या:..... **A3.**महिला संख्या:..... **A4.**जम्मा परिवार सदस्य संख्या:..... **A5.**बालिग जनसंख्या (<१५ र >६०) वर्ष.....)

नोट:
१. परिवार सदस्यहरु १२ जना भन्दा बढि भएमा अतिरिक्त सिट प्रयोग गर्नुहोस ।
२. उत्तरदाताालाई गोलो घेरा लगाउनुहोला ।
३. टेबल भर्दा तलको कोडहरु प्रयोग गर्नुहोला ।

लिङ्ग : १. पुरुष २. महिला ३. अन्य (खुलाउनुहोस्).....
वैवाहिक स्थिति : १. विवाहित २. अविवाहित ३. विधवा ४. विधुर ५ छुट्टै
शैक्षिक स्तर: १. निरक्षर २. अनौपचारिक ३. साधारणुत ४. माध्यमिक ५. स्नातक
६. स्नाकोत्तर वा सो भन्दा माथि ७. अनुपयुक्त (५ वर्ष भन्दा मुनि)
पेशा: १. कृषि २. सरकारी सेवा ३. व्यापार (सबै खालको) ४. दैनिक ज्याला/मजदुरी
५. पेन्सन र सम्बन्धित ६. निजि संस्थासंस्था/गैरसरकारी ७. वैदेशिक रोजगार
८.विद्यार्थी ९.गृहणी १०.बेरोजगारी ११. अन्य (खुलाउने) .....

लुर्तिजन्य पदार्थ सेवन
१ गर्ने गरेको
२. पहिले गरेको, नहिले नगरेको
३. कहिल्यै नगरेको

मध्यपान
१ गर्ने गरेको
२. पहिले गरेको, नहिले नगरेको
३. कहिल्यै नगरेको

A6. परिवारको प्रकार: १. एकल २. संयुक्त ३. मुहत

A7. परिवारको आम्दानीको मुख्य स्रोत:
१. कृषि २. सेवा (स्वदेश) ३. व्यापार (सबै खालको) ४. दैनिक ज्याला/मजदुरी
५. पेन्सन र सम्बन्धित ६. निजि संस्थासंस्था/गैरसरकारी ७. वैदेशिक रोजगार ८. अन्य (खुलाउनु) .....

A8. परिवारको मासिक आम्दानी (रुपैयाँमा): ने. रु .....

A9. पारिवारिक धर्म: १. हिन्दू २. बौद्ध ३. इसाई ४. इस्लाम ५. अन्य (खुलाउने) .....

A10. जात:
१. दलित २. जनजाती ३.मुस्लिम ४. मधेसी ५ ब्राम्हण/क्षेत्री ६.अन्य (खुलाउने) .....

क) जन्म विवरण:

A11. विगत एक वर्षमा तपाईको परिवारमा कुनै बच्चाको जन्म भएको छ कि छैन? १. छ २. छैन *(यदि छैन भने प्र.नं A14 मा जानुं।)*

A12. यदि छ भने,

क्र.सं.	लिङ्ग	जन्मदाको अवस्था		बच्चा जन्माउँदा आमाको उमेर	सुत्केरी भएको स्थान		बच्चा जन्मदाको तौल
		जीवित	मृत		स्वास्थ्य संस्था	घर	

A13. के तपाईले बच्चाको जन्म दर्ता गराउनु भएको छ कि छैन ? १. छ २. छैन

ख) मृत्युको विवरण

A14. विगत एक वर्षभित्र तपाईको परिवारमा कसैको मृत्यु भएको छ कि छैन ?
१. छ २. छैन *(यदि छैन भने प्र.नं A17 मा जानुं)*

A15. यदि छ भने,

क्र.सं.	उमेर	लिङ्ग	मृत्युको कारण	उपचारको लागी स्वास्थ्यसंस्था गए नगएको

A16. के तपाईले मृत्युदर्ता गराउनु भएको छ कि छैन ? १. छ २. छैन

ग) बसाईसराई सम्बन्धि विवरण

A17.	तपाईहरु यस ठाउँमा कहिले देखि बसोबास गर्दै आउनु भएको छ ? .....
A18.	तपाईको परिवारको कोहि सदस्य जस्तै बसाई सर्नु (स्थायी) भएको छ कि छैन? (५ वर्ष वा सो भन्दा बढी) १. छ २. छैन *(यदि छैन भने प्र.नं A20 मा जानुं)*
A19.	यदि छ भने कति सदस्य बाहिरी बसाई सराई गर्नु भएको छ ? .....जना (संख्या)

घ) बिरामीको विवरण :

A20. विगत १ वर्षमा तपाई अथवा तपाईको परिवारका जन्य कोही सदस्य बिरामी हुनु भएको थियो कि थिएन ?
१. थियो २. थिएन *(यदि छैन भने प्र.नं B1 मा जानुं)*

A21. यदि थियो भने विवरण दिनुहोस्

क्र.सं.	लिङ्ग	उमेर	रोगको विवरण	उपचार गरेको ठाँउ	हाल रोगको स्थिती

SECTION B: Disease and Epidemiology
भाग २: रोग तथा महामारी सम्बन्धी

	क्षयरोग
B1.	**तपाईले क्षयरोगको बारेमा सुन्नुभएको छ ?** १.छ २.छैन (*यदि छैन भने B2 मा जाने*)
B1.a	**तपाईको विचारमा,क्षयरोगका लक्षणहरु के के हुनसक्छन् ?(बहुउत्तर)** १.ज्वरो आउने २.खकारमा रगत देखिनु ३. छाती दुख्नु ४. दुई हप्ता भन्दा बढी समयसम्म लगातार खोकी लाग्नु ५. खाना नरुच्नु ६. दुब्लाउँदै जानु वा तौल घट्दै जानु ७. राति पसिना आउने ८.थाहा छैन ९. अन्य (खुलाउने)...........
B1.b	**तपाईको विचारमा,क्षयरोग कसरी सर्छ ?(बहुउत्तर)** १.थाहा छैन २.रोगीले खोक्दा ३.रोगीले प्रयोग गरेका कपडा लगाउँदा ४.रोगीले हाच्छिउँ गर्दा ५.रोगीसंग कुरा गर्दा हावाका माध्यमबाट ६. रोगीसँग बस्दा ७. रोगीको जुठो खाँदा ८.थाहा छैन ९.अन्य (खुलाउने)...........
B1.c	**तपाईको विचारमा, क्षयरोगको औषधि पुरा अवधिसम्म खायो भने निको हुन्छ कि हुदैन ?** १. हुन्छ २. हुदैन ३.थाहा छैन
B1.d	**तपाईको विचारमा, क्षयरोगको उपचार कहाँ–कहाँ गरिन्छ ?(बहुउत्तर)** १. थाहा छैन २. अस्पताल ३. प्रा.स्वा.के ४. स्वास्थ्य चौकी ५. धामी/झाक्री ६. घरमै परंपरागत उपचार ७. औषधी बिक्रि गर्ने ठाउँमा (फार्मेसी) ८.अन्य(खुलाउने)...........
B1.e	**तपाईको विचारमा, क्षयरोगबाट बच्ने उपायहरु के के हुन ? (बहुउत्तर)** १. बि.सि.जी. खोप लगाउने २. हावाको प्रवाह हुने कोठामा बस्ने ३. बिरामीले खोक्दा वा हाच्छिउँ गर्दा नाक र मुख छोप्ने ४. सन्तुलित आहार खाने ५. क्षयरोगीको सम्पर्कमा आउँदा सावधानी अपनाउने ६. पुर्ण रुपमा औषधि सेवन गर्ने ७. थाहा छैन ८.अन्य (खुलाउने)...........
B1.f	**तपाईले प्रत्यक्ष निगरानीमा गर्ने उपचार डट्स (DOTS)को बारेमा सुन्नु भएको छ?** १. छ २. छैन
	झाडापखाला
B2.	**बिगत ६ महिना भित्रमा, तपाईको परिवारमा कसैलाई झाडापखाला लागेको थियो ?)** १. थियो २. थिएन (*यदि थिएन भने B2.c मा जाने*)
B2.a	**झाडापखाला लागेको बेला कसरी व्यवस्थापन गर्नुभएको थियो ? (बहुउत्तर)** १ जीवनजल बनाएर खाने २ झोलिलो खानेकुरा खाने ३.अस्पताल जाने ४.औषधि सेवन गर्ने ५.अन्य (खुलाउने).....................
B2.b	**यदि जीवनजल बनाउनु परेमा , जिवनजल बनाउने सहि बिधी के हो ?** १. सहि उत्तर २. गलत उत्तर
B2.c	**तपाईको विचारमा झाडापखाला के कारणले लाग्ने गर्छ ?(बहुउत्तर)** १. घर/ वातावरण फोहोर राख्नाले २. बासी सडेगलेको खाना खानाले ३. व्यक्तिगत स्वच्छता नअपनाउनाले ४. दुषित पानी पिउनाले ५.थाहा छैन (*यदि छैन भने B2.e मा जाने*) ६.अन्य (खुलाउने)...........
B2.d	**झाडापखाला लागेको बेलामा जलबियोजनका (Dehydration) लक्षण/चिन्हहरु के के हुन ? (बहुउत्तर)** १. हात खुट्टाचिसो हुनु २. शिथिल हुनु ३. जिब्रो सुख्खा हुनु ४. छाला तान्दाउँदा बिस्तारै फर्किने ५. थाहा छैन ६. अन्य (खुलाउने).........
B2.e	**झाडापखाला बाट बच्न के गर्नुपर्छ ? (बहुउत्तर)** १ बासि सडेगलेको खाना नखाने २ दुशित पानी नपिउने ३. व्यक्तिगत स्वच्छता अपनाउने ४.घर/वातावरण सफा राख्ने ५.अन्य...............

	डेङ्गु
B3	**तपाईले डेङ्गु रोगको बारेमा सुन्नु भएको छ कि छैन ?** १. छ २. छैन *(यदि छैन भने* ***B4*** *मा जाने)*
B3.a	**यदि छ भने, यो रोग कसरी लाग्छ ? (बहुउत्तर)** १. लामखुट्टेको टोकाईबाट २. दुषित पानी पिउनाले ३. सङ्क्रमित व्यक्तिबाट रगत लिनाले ४. असुरक्षित यौन सम्पर्क ५. झुलको प्रयोग नगर्नाले ६. थाहा छैन ७.अन्य (खुलाउने).....
B3.b	**तपाईको विचारमा डेङ्गु लागेको व्यक्तिलाइ कस्ता लक्षणहरु देखा पर्छन् ? (बहुउत्तर)** १. ज्वरो आउनु २. वाकवाकि लाग्नु ३. हाडजोर्नी दुख्नु ४. गिजाबाट रगत बग्नु ५. आँखाको पछिल्लो भाग दुख्नु ६. थाहा छैन ७. अन्य (खुलाउने).....
B3.c	**के-कस्ता उपाय अपनाउदा डेङ्गु रोगबाट बच्न सकिन्छ ? (बहुउत्तर)** १. लामो बाउला भएको लुगा लगाउने २. पानी जम्ने नदिने ३. झुलको प्रयोग गरेर सुत्ने ४. पानी संञ्चय हुने भाँडाहरु हरेक हप्ता सफा गर्ने ५. थाहा छैन ६. अन्य (खुलाउने).....
	मुटु रोग
B4.	**तपाईले उच्च रक्तचापको बारेमा सुन्नु भएको छ कि छैन ?** १. छ २. छैन *(यदि छैन भने* ***B4d*** *मा जाने)*
B4.a	**तपाईको विचारमा उच्च रक्तचाप गराउने कारक तत्वहरु के के हुन् ?(बहुउत्तर)** १. नुन धेरै खानाले २.मानसिक तनाव ३. शारिरीक अभ्यास नगर्नाले ४.अस्वस्थकर खानापिन ५. मुल्पान/सायपान/सुर्ती/गुट्खा सेवनगर्नाले ६. वंशाणुगत ७. थाहा छैन ८. अन्य (खुलाउने) .....
B4.b	**तपाईको विचारमा उच्च रक्तचापको रोकथाम तथा नियन्त्रण कसरी गर्न सकिन्छ ?(बहुउत्तर)** १.नुनथोरै खाने २.मानसिक तनाव नलिने ३.शारिरीक अभ्यास गर्ने ४. मुल्पान/सायपान/सुर्ती/गुट्खा सेवन नगर्ने ५.नियमित स्वास्थ्य जाँच गर्ने ६. थाहा छैन ७. अन्य (खुलाउने) .....
B4.c	**उच्च रक्तचाप भएपछि हुनसक्ने स्वास्थ्य सम्बन्धी जटिलताहरु के के हुन् ?(बहुउत्तर)** १. मृगौलाको समस्या २. आँखामा गम्भिर समस्या आउने ३.हृदयघात ४. मृत्यु ५.थाहा छैन ६. अन्य (खुलाउने) .....
B4.d	**रक्तचाप मापन (Respondents) .....mm of hg (Optional)**
	ग्यास्ट्राइटिस
B5.	**तपाईले ग्यास्ट्राइटिसको बारेमा सुन्नुभएको छ कि छैन?** १. छ २. छैन *(यदि छैन भने* ***B6*** *मा जाने)*
B5.a	**ग्यास्ट्राइटिस भएमा कस्ता लक्षण देखापर्दछन ?। (बहुउत्तर)** १. मुटु दुख्ने र पोल्ने २. खान मन नलाग्नु ३. मुखमा चुकिलो (अमिलो) पानी आउनु ४. डकार आउने ५. पेट दुख्ने ६. थाहाछैन ७. अन्य (खुलाउने) .....
B5.b	**यदि सुन्नुभएको छ, भने के कारकतत्वहरु हुन्छ ?(बहुउत्तर)** १. समयमा खाना नखानाले २. जीवाणुले ३. चिल्लो, पिरो, मसलाधार खाना खानाले ४. धुम्रपान गर्ने औषधि धेरै खानाले ५. मद्यपान र मुल्पानले ६. मानसिक तनाव ७. खालीपेट वा ब्रत बस्नाले ८. थाहा छैन (B6 मा जाने) ९. अन्य (खुलाउने) .....
B5.c	**ग्यास्ट्राइटिस बाट कसरी बच्न सकिन्छ ?(बहुउत्तर)** १. चिल्लो, पिरो, मसलाधारखाना नखाने २. मद्यपान र मुल्पान नगर्ने ३. स्वास्थ्य ठिक छैन भने ब्रत नबस्ने ४. अथाहानी औषधि नखाने ५. सन्तुलित भोजन खाने ६. तारेको खाने कुरा नखाने ७.थाहाछैन ८. अन्य (खुलाउने) .....

	मधुमेह
B6.	**मधुमेह को बारेमा सुन्नु भएको छ कि छैन ?** १. छ २. छैन (यदि छैन भने **B7** मा जाने)
B6.a	**मधुमेह रोग लाग्नुको कारकतत्वहरु के हो ? (बहुउत्तर)** १.उमेर बढ्दै जानाले २. वंशाणुगत ३. अस्वस्थकर खानापिन ४. धुम्रपान/मादापान ५. गुलियो बढी खानाले ६. शारीरिक अभ्यास नगर्नाले ७. थाहा छैन ८.अन्य (खुलाउने) .....
B6.b	**मधुमेह भए पछि हुने स्वास्थ सम्बन्धि जटिलताहरु के के हुन?(बहुउत्तर)** १. आँखामा गम्भीर समस्या उत्पन्न वा दृष्टि गुम्न सक्ने २. मृगौलाको समस्या ३. मुटुरोग ४. अल्पायुमा मृत्यु ५.घाउ निको हुन समय लाग्ने ६. थाहा छैन ७.अन्य (खुलाउने) .....
B6.c	**मधुमेह रोगको रोकथाम तथा नियन्त्रणका उपायहरु के के हुन?(बहुउत्तर)** १. सीठाई वा गुलियो कम गर्ने २. फलफुल खाने ३.नियमित शारीरिक अभ्यास गर्ने ४. मद्यपान र धुम्रपान नगर्ने ५.थाहा छैन ६.अन्य (खुलाउने) .....
	दम
B7.	**तपाईले दमको बारेमा सुन्नुभएको छ ?** *(यदि छैन भने **B8** मा जाने)* १. छ २. छैन
B7.a	**तपाईको विचारमा दम के कारणले लाग्छ ?(बहुउत्तर)** १. धुम्रपान २.वंशाणु ३. धेरै धुवाधुलो ४. उमेर बढ्दै जनाले हुने रोग ५. नागोमा खाना पकाउनाले ६. थाहा छैन ७. अन्य(खुलाउने) .....
B7.b	**दम भएपछी हुने स्वास्थ्य सम्बन्धि जटिलताहरु के-के हुन् ?(बहुउत्तर)** १. स्वास फोर्नगाह्रो हुने २. छिट्टै, बोल्न गाह्रो हुने ३. अल्पायुमा मृत्यु हुने ४. लगातार खोकीलाग्ने ५. थाहा छैन ६. अन्य (खुलाउने) .....
B7.c	**दम रोगको रोकथाम तथा नियन्त्रणका उपायहरु के के हुन?(बहुउत्तर)** १. धेरै धुवाधुलोमा नजाने २. धुवा रहित चुलोको प्रयोग गर्ने ३. खानामा ध्यान दिने ४. धुम्रपान नगर्ने ५. चिकित्सकको सल्लाह बमोजिम औषधि सेवन गर्ने ६. थाहा छैन ७. अन्य (खुलाउने) .....
	प्रजनन् स्वास्थ्य
B8.	**तपाईलाई बाङ्ग खस्ने (पाठेघर खस्ने) समस्याको बारेमा थाहा छ कि छैन?** *(यदि छैन भने, **B9** मा जाने)* १. छ २. छैन
B8.a	**यदिथाहा छ भने , के कारणले हुन्छ जस्तो लाग्छ ?(बहुउत्तर)** १.धेरै बच्चा जन्माउनाले २. गाह्रो भारी बोक्नाले ३. मोटोपनले गर्दा ४. वृद्ध अवस्थामा ५. थाहा छैन ६. अन्य (खुलाउने) .....
B8.b	**बाङ्ग खस्ने समस्याको रोकथाम गर्ने उपायहरु के-के होला ?(बहुउत्तर)** १. धेरै बच्चा नजन्माउने २. गाह्रो भारी नबोक्ने ३.मोटोपन नियन्त्रण गर्ने ४. थाहा छैन ५. अन्य (खुलाउने) .....
	मानसिक स्वास्थ्य सम्बन्धि प्रश्नहरु
B.9	**तपाईले मानसिक स्वास्थ्य बारेमा सुन्नु भएको छ ?** १ छ २. छैन (यदी छैन भने प्र.न. **C1** मा जाने)
B9.a	**यदी छ भने, कहाँबाट सुन्नुभयो ? (बहुउत्तर)** १. रेडियो/टि.भी २. साथी/छिमेकी ३. स्वास्थ्यकर्मी ४. स.स्वा.स्वं.से. ५. सामाजिक संजाल ६. पत्रपत्रिका . ७.अन्य.....(खुलाउनुहोस्)
B9.b	**के कारणले यो मानसिक स्वास्थ्य समस्या हुन्छ ?(बहुउत्तर)** १ पिर/चिन्ता २. लागु पदार्थ सेवन ३ वंशानुगात ४ थाहा छैन ५ अन्य..... (खुलाउनुहोस्)
B9.c	**मानसिक स्वास्थ्य समस्या हुदाँ के के लक्षणहरु देखापर्दछन ? (बहुउत्तर)** १ स्वभाव/सुड चिडियरता २ अत्याधिक डर लाग्नु ३ खानपिन र सुत्ने बानीमा परिवर्तन ४ मानसिक असन्तुलन ५ थाहा छैन ६ अन्य..... (खुलाउनुहोस्)
B9.d	**तपाईको परिवारमा कसैलाई मानसिक समस्या छ ?** १ छ २ छैन (*यदि छैन भने **B9f** मा जाने)*

B9.e	**यदि छ भने, व्यक्तिगत विवरण**

क्र.स	रोगको प्रकार	उमेर	लिङ्ग	खानपानको अवस्था	
				मुखपान	सहपान

B9.f	**मानसिक स्वास्थ्य समस्या उपचार कसरी गरिन्छ ? (बहुउत्तर)** १ डाक्टर कहाँ जचाउन जानुपर्छ २ झाँक्री/धामी कहाँ जाने ३ केही नगर्ने ४ राम्रोसंग स्याहार गर्ने ५ तनाव नलिने ६ थाहा छैन ७. अन्य.....
B9.g	**मानसिक स्वास्थ्य समस्या निको हुन्छ ?** १ हुन्छ २ हुँदैन

SECTION C: FOOD AND NUTRITION CONSUMPTION
भाग ३: पोषण तथा खानेकुराको उपभोग

पोषण सम्बन्धि ज्ञान र जानकारी

C1.	**तपाईलाई सन्तुलित भोजनको बारेमा थाहा छ कि छैन ?** *(यदि छैन भने प्र.नं C3 मा जानुं)* १. छ २. छैन्
C2.	**यदि छ भने, सन्तुलित भोजन भन्नाले के बुझिन्छ ?** १. दाल, भात र तरकारी २. मिश्रित चार प्रकारका खाना समावेस भएको (अन्न, गेडागुडी, सागसब्जी,फलफुल दुध/दही र साझासासु/अण्डा) ३.थाहा छैन ४.अन्य (खुलाउने).....
C3.	**के तपाईलाई सर्वोत्तम पीठो बनाउने तरिका थाहा छ ?** *(यदि छैन भने प्र.नं C5 मा जानुं)* १. छ २. छैन
C4.	**यदि छ भने, सर्वोत्तम पीठो बनाउने तरिका बताउनुहोस् ।** १. ठिक २. बेठिक *(१ भाग गेडागुडि र २ भाग अन्न छुट्टाछुट्टै भुट्ने, पिस्ने र राम्रोसँग मिलाउने)*
C5.	**तपाईको विचारमा बच्चालाई बिगौती दुध खुवाउनु पर्छ या पर्दैन ?** १. पर्छ २. पर्दैन ३. थाहा छैन
C6.	**बच्चा जन्मेको कति समय भित्र नवजात शिशुलाई आमाको दुध खुवाउनु पर्छ ?** १. बच्चा जन्मेको १ घण्टा भित्र २. १ घण्टा पछि ३. थाहा छैन ४. अन्य (लेख्नुहोस्).....
C7.	**बच्चा जन्मेको कति समयसम्म बच्चालाई आमाको दुध मात्रै खुवाउनु पर्छ ?** ..... (महिना)
	पोषण सम्बन्धि अभ्यासहरु
C8.	**गत २४ घण्टामा तपाईले के-के खानेकुराहरु खानुभयो ? (बहुउत्तर)** १. अन्न २. गेडागुडिहरु ३. दुध तथा दुध पदार्थहरु ४. साझा, सासु ५. अण्डा ६. फलफुल ७. हरियो सागपात ८. पशु खाना र प्रशोधित खानाहरु ९. अन्य.....
C9.	**एक हप्ता भित्र तपाई कति दिन हरियो तरकारी खानुभयो?** ..... दिन
C10.	**एक हप्ता भित्र तपाई कति दिन फलफुल खानुभयो?** ..... दिन

C11.	तपाईले खाजामा प्राय के के खानुहुन्छ ? (बहुउत्तर) १ बजारको पशु खना (चाउचाउ / प्रसोधित खान) २ घरमा बनेको खाजा ३.अन्य(खुलाउने).....
C12.	तपाइको उत्पादनले कति समय खान पुग्दछ ? ..... महिना
C13.	तपाइको आम्दानीले कति समय खान पुग्दछ ? ..... महिना

एन्थ्रोपोमेट्रिक मापन

C14. ६ देखि ५९ महिनासम्मका बच्चा भएका घरधुरिका लागी

घरधुरि नं.	नाम	उमेर	लिङ्ग	तौल (किलोग्राम)	उचाई (से.मि)	MUAC (से.मि)

C15. वयस्क व्यक्तिका लागी(*Take anthropometric measurement of Respondent only*)

घरधुरि नं.	उमेर	लिङ्ग	तौल (किलोग्राम)	उचाई (से.मि)	BMI (kg/m^2)

SECTION D: SAFE WATER AND BASIC SANITATION
भाग ४: सुरक्षित खानेपानी र आधारभूत सरसफाई

D1.	तपाईले पिउनको लागि प्रयोग गर्ने पानीको श्रोत के हो ? १. हुंगेधारो/पँधेरो २. खोला ३.हैण्ड पम्प ४. इनार ५. खानेपानिको धारो ६. अन्य (खुलाउने).....
D2.	तपाई स्रोतबाट प्राप्त हुने पानीको शुद्धतामा सन्तुष्ट हुनुहुन्छ कि हुनुहुन्न? १. छु २. छैन
D3.	तपाईले पिउने पानी शुद्धिकरण गर्नु हुन्छ कि हुदैन ? *(यदि छैन भने प्र.नं. **D4** मा जानुं)* १. गर्छु २. गर्दिन
D3.a	यदि गर्नुहुन्छ भने, तपाईले पानी शुद्धिकरण गर्नु पर्दा कसरी गर्नु हुन्छ ? (बहुउत्तर) १. उमालेर २. सौर्यिक डालेर ३. छानेर ४. घाममा राखेर ५. अन्य (खुलाउने).....
D4.	तपाईले घरमा पिउने पानी के मा भण्डार गर्नु हुन्छ ? (बहुउत्तर) १. माटाको भैटो २. प्लास्टिकको भाडा ३. तामाको भाडो ४. गाग्री ५. अन्य (खुलाउने).....
D5.	खाना प्राय जसो के मा पकाउनु हुन्छ ? १. दाउरा २. गोबरग्यास ३.सुधारिएको चुलो ३. बिजुली चुलो ४. सिलिण्डर ग्यास ५. अन्य (खुलाउने).....
D6.	तपाईले घरबाट निस्किएको कुहिने र नकुहिने फोहोरहरु छुट्टयाउने गर्नुभएको छ ? *(यदि छैन भने प्र.नं. **E1** मा जानुं)* १. छ २. छैन
D6.a	कुहिने फोहोरलाई कसरी व्यवस्थापन गर्नुहुन्छ ? १. खाल्डोमा गाड्ने २. मल बनाउने ३. गाइवस्तुलाइ दिने ४. अन्य(खुलाउने).....
D6.b	नकुहिने फोहोरलाई कसरी व्यवस्थापन गर्नुहुन्छ ? १. जलाएर २. फोहोर फाल्ने गाडीमा हाल्ने ३.खाल्डोमा पुर्ने ४. खोलामा फाल्ने ५. अन्य (खुलाउने.....

SECTION E: MATERNAL AND CHILD HEALTH
भाग ५: मातृशिशु स्वास्थ्य
(पाँच वर्ष मुनिको बच्चाको आमालाई वा गर्भवती महिलालाई मात्र सोध्ने)

E1.	**विवाह गर्दा तपाईको उमेर कति थियो ?** ..... **वर्ष**
E2.	**पहिलो पटक गर्भवति हुँदा तपाई कति वर्षको हुनुहुन्थ्यो ?**..... **वर्ष**
E3.	**तपाईले हालसम्म कति जोटा बच्चा जन्माउनु भयो ? (संख्यामा लेख्ने)** १.जीवित..... २.मृत..... ३.गर्भपतन..... ४. पहिलो गर्भधारण
E4.	**तपाईको विचारमा गर्भवति अवस्थामा महिलाले कतिपटक गर्भ जाँच गराउनुपर्छ।** ?..... **पटक**
E5.	**तपाईको विचारमा गर्भवति अवस्थामा महिलाले जाँच गराउनुपर्ने कारण के हुन ? (बहुउत्तर)** १. टि.डी. खोप लगाउन २. आइरन चक्की लिन ३. फोलिक एसिड लिन ४. बच्चाको अवस्था थाहा पाउन ५. गर्भवस्था जोखिमपुर्ण भए/नभएको थाहा पाउन ६.अन्य(खुलाउने).....
	५ वर्ष मुनिको आमा लाई मात्र सोध्ने (यदि हाल पहिलो गर्भवती भए F1 मा जाने)
E6.	**तपाईले पछिल्लो पटक गर्भवति हुँदा स्वास्थ्य जाँच गराउनुभएको थियो कि थिएन ?** १. थिए २.थिएन (गराएको थिएन भने E8 मा जाने)
E6.a	**तपाईले पछिल्लो गर्भवति जाँच कहाँ गराउनु भएको थियो ?** १.सरकारी स्वास्थ्य संस्था २. निजि क्लिनिक/औषधि पसल ३. अन्य(खुलाउने).....
E6.b	**तपाईले पछिल्लो पटक गर्भवति हुदाँ कति पटक (ANC) जाँच गराउनुभएको थियो ?** १. ४ पटक भन्दा कम २. ४ पटक ३. ४ देखि ८ पटक ४. ८ पटक भन्दा बढी
E6.c	**पछिल्लो पटक गर्भवति हुदाँ आइरन चक्की खानुभयो कि भएन ?** १. खाए २. खाइन
E6.d	**पछिल्लो बच्चा कहाँ जन्माउनु भएको थियो ?** १. घर (*E7 मा जाने)* २. सरकारी स्वास्थ्य संस्था ३ प्रईभेट स्वास्थ्य संस्था (*E7 मा जाने)*
E6.e	**यदी सरकारी स्वास्थ्य संस्थामा बच्चा जन्माउनुभएको हो भने सरकारले दिने यातायात खर्च पाउनुभयो ?** १ पाएं (रु.....) २ पाईन
E7.	**सुत्केरी भइसकेपछि तपाईले सुत्केरी जाँच (PNC) गराउनु भयो ?** १. गराए २. गराईन (नगराएको भए E8 मा जाने)
E7.a	**तपाईको विचारमा कतिपटक सुत्केरी जाँच गराउनुपर्छ।** ?..... **पटक**
E7.b	**यदि गराउनु भएको भए, सुत्केरी जाँच कहाँ गराउनु भयो ?** १. स्वास्थ्यकर्मी द्वारा घरमै २. गाउँ घर क्लिनिक ३. स्वास्थ्य चौकी/ प्रा.स्वा.के ४.अस्पताल ५. क्लिनिक/औषधि पसल ६. अन्य(खुलाउने).....
E7.c	**सुत्केरीपछि स्वास्थ्य जाँच गराउनका लागि तपाईलाई कसले प्रेरित गरेको थियो ?** १.श्रीमान् २. सासुनाना ३. देवरानी/जेठानी ४. साथी ५. महिला स्वास्थ्य स्वयंसेविका ६. स्वयम ७. अन्य(खुलाउने).....
E8.	**सुत्केरी भएपछि तपाईले भिटामिन ए क्याप्सुल खानुभयो कि भएन ?** १. खाए २. खाइन

	बाल स्वास्थ्य
E9.	**बच्चा जन्मेपछि नासाको दुध खुवाउनु भन्दा अगाडी केही खुवाउनुभएको थियो ?** १. थियो २. थिएन, (यदी थिएन भने **E10** मा जाने)
E9.a	**यदि थियो भने के खुवाएको थियो** १. मह २. अन्य नासाको दुध ३. ल्याक्टोजेन ४. गौंत ५. अन्य (खु.) .....
E10.	**तपाई आफ्नो बच्चालाई बिगौती दुध खुवाउनुभएको थियो ?** (*यदी थिए भने **E11** मा जाने*) १. थिए २. थिएन
E10.a	**यदि नखुवाउनु भएको भए, नखुवाउनुको कारण ?** १. थाहा नभएर २. आवश्यक नठानेर ३. धर्म/संस्कृति/परम्परा अनुसार खुवाउन मिलदैन ४. दुध नआएर ५. अन्य (खु.) .....
E11.	**बिगत एक वर्षमा तपाईको बच्चालाई श्वासप्रश्वासको समस्या देखिएको थियो ?** १. थियो २. थिएन (If थिएन section F1)
E11.a	**बच्चालाई श्वासप्रश्वासको समस्या देखिएको बेलामा उपचारको लागि कहाँ जानुहुन्छ ?** १. घरेलु उपचार २. स्वास्थ्य संस्था ३. वैद्य (परम्परागत) ४. झाक्री/भाँक्रि/पण्डित/पुरोहित ५. अन्य (खुलाउनुहोस्) .....
	SECTION F: FAMILY PLANNING **भाग ६: परिवार नियोजन** *प्रजननु उमेरका (१५ देखि ४९ वर्ष) वैवाहिक दम्पतीहरु*
F1.	**के तपाईले परिवार नियोजनको बारेमा सुन्नुभएको छ ?** १. छ २. छैन ३. उत्तर दिन नचाहेको (सुनेको छैन वा उत्तर दिन नचाहेको हो भने, **G1** मा जाने ।)
F2.	**तपाई वा तपाईको श्रीमान वा श्रीमतीले हाल परिवार नियोजनका कुनै साधनको प्रयोग गर्नुभएको छ ?** १ छ २. छैन (**F6** मा जाने) ३. उत्तर दिन नमानेको वा नचाहेको (**G1** मा जाने)
F3.	**प्रयोग गरेको साधनको नाम सोध्नुहोस र सोही अनुसार उल्लेख गर्नुहोस ।** **१. स्थायी (बंध्याकरण) :** १. पुरुष बंध्याकरण २. महिला बंध्याकरण **२. अस्थायीसाधन :** १. फण्डम २. पिल्स ३. डिपो ४. नरप्लाट ५. आई.यू.डी
F4.	**तपाईले प्रयोग गरेको साधनले गर्दा स्वास्थ्य समस्याहरु देखिएका थियो ?** १ थिए २. थिएनन् (**G1** मा जाने)
F5.	**यदि छन् भने के कस्ता स्वास्थ्य समस्याहरु थिए ?** (यदि समस्या छैन भने **G1** मा जाने) १. टाउको दुख्ने २. तौल बढ्ने वा घट्ने ३. एलर्जी ४. थकान महसुस ५. अन्य (खु.).....
F6.	**परिवार नियोजनको साधन प्रयोग नगरेको भए, किन प्रयोग नगर्नुभएको ?** १. थाहा नभएर २. आवश्यक नठानेर ३. पार्टनरको कारणले ४ स्वस्थ संस्था टाढा भएकाले ५. अन्य प्राकृतिक तारिका अपनाएकाले ६ बच्चा जन्माउने इच्छा ७. अन्य (खु.).....
F7.	**तपाई वा तपाईको श्रीमान/श्रीमतीको चाहना हुदा हुदै पनि तपाईहरूले परिवार नियोजनका साधन प्रयोग गर्न नसकेको अवस्था हो ?** १. हो २. होइन (**G1** मा जाने)
F7.a	**यदि तपाईहरूले परिवार नियोजनका साधन प्रयोग गर्न नसकेको अवस्था हो भने कारण के हो ?** १.टाढा भएर २. स्वास्थ्य समस्या ३. सेवा उपलब्ध ४. अन्य (खु.).....

SECTION G: IMMUNIZATION AGAINST MAJOR INFECTIOUS DISEASES
भाग ७: संक्रामक रोगहरु विरुद्ध खोप

खोप (२ वर्ष भन्दा कम उमेरका बच्चाका लागि मात्र)

G1. के तपाईले जाफ्नो बच्चालाई खोप लगाउनु भएको छ ?
१. छ २. छैन (यदि छैन भने G4 मा जाने)

G2. खोप लगाउनु भएको छ भने के तपाई संग खोप कार्ड छ ?
१. छ (कार्ड हेर्ने) २. छैन भने-हराएको ३. कार्ड बनाएकै छैन

G3. बच्चाको कार्ड हेरी निम्नलिखित सूचनाहरू भर्नुहोस् ,यदि खोप कार्ड छैन भने बच्चालाई कुन कुन खोप लगाएको छ जानकारी सोध्नुहोस् । (*खोप लगाएको खोप कार्ड हेरी खोपको लगाएको विवरण भर्नुहोस् ।)*

कोड	खोप	लगाएको (१) / नलगाएको (२)			लगाउन नमिल्ने अवस्था (३)	कैफीयत
		1st पटक	2nd पटक	3rd पटक		
B	बि.सि.जि					
P	पेन्टाभ्यालेण्ट					
O	ओ.पी.भी					
PCV	पि.सि.भि					
IPV	एफ.आइ.पि.भि/ IPV					
MR	दादुरा रूवेला					
JE	जे. ई.					
RV	रोटा भाइरस					
TY	टाईफाइड					

G4. के तपाई जाफ्नो १० देखि १५ वर्षको किशोरी बच्चालाई HPV खोप लगाउनु भएको छ ? (यदि छ भने H1 मा जाने)
१. छ २ छैन

G5 *यदि छैन भने के कारणले लगाउनु भएन?* ....

SECTION-H HEALTH PROBLEMS AND NEEDS OF THE COMMUNITY
भाग ८: सामुदायका स्वास्थ्य समस्याहरु र आवश्यकताहरु

H1. तपाईको विचारमा यस समुदायका मुख्य तिन स्वास्थ्य समस्याहरु के के हुन् ?
१. ..... २. ..... ३. .....

H2. यस समुदायका स्वास्थ्य समस्या समाधान गर्नका तिन मोटा उपायहरु के के हुन ?
१. ..... २. ..... ३. .....

H3. तपाइलाइ नजिकको स्वास्थ्य चौकी पुग्न कती समय लाग्दछ ?
१.३० मिनेट भन्दा कम २ ३० मिनेट भन्दा बढी

SECTION I: OBSERVATION CHECK LIST भाग १: अवलोकन फारम				
O1.	घरको प्रकार :	१. कच्ची	२. नर्मकच्ची	३. पक्की
O2.	घर भित्र उज्यालो :	१. छ	२. छैन	
O3.	भान्सा कोठा र सुत्ने कोठा :	१. सँगै छ	२. छुट्टाछुट्टै	
O4.	कोठाहरुमा भेन्टीलेसन :	१. छ	२. छैन	
O5.	घरमा चर्पीको व्यवस्था :	१. छ	२. छैन	
O6	पानीको स्रोत (मुहान/इनार/धारा) र चर्पीको बिचको दुरी कती छ ?	१. ≤१५ मिटर	२. >१५ मिटर	
O7.	घरमा गोठ वा खोर :	१. छ	२. छैन	
O8.	यदी छ भने, घर र गोठ/खोर बिचको दुरी कति छ ?	१. घरसँगै जोडीएको	२. ≤२५ फिट	३. >२५ फिट
O9.	घर वरिपरिको वातावरण (फोहोरको व्यवस्थापन) :	१. सफा	२. फोहोर	

अन्तरवार्ता दिएर सहयोग गर्नु भएकोमा तपाईलाई धेरै धेरै धन्यवाद ।

कुनै प्रश्न छुटेको छ कि ? एकपल्ट रुजु गर्नुहोस् ।

रुजु गर्नेको नाम: ..... सहि:.....

रुजु गरेको मिति: २०८२/...../.....

C11.	तपाईले खाजामा प्राय के के खानुहुन्छ ? (बहुउत्तर) १ बजारको पत्रु खना (चाउचाउ / प्रसोधित खान) २ घरमा बनेको खाजा ३.अन्य(खुलाउने).....
C12.	तपाइको उत्पादनले कति समय खान पुग्दछ ? ..... महिना
C13.	तपाइको आम्दानीले कति समय खान पुग्दछ ? ..... महिना

एन्थ्रोपोमेट्रिक मापन

C14. ६ देखि ५९ महिनासम्मका बच्चा भएका घरमुरिका लागी

घरमुरि नं.	नाम	उमेर	लिङ्ग	तौल (किलोग्राम)	उचाई (से.मि)	MUAC (से.मि)

C15. वयस्क व्यक्तिका लागी(*Take anthropometric measurement of Respondent only)*

घरमुरि नं.	उमेर	लिङ्ग	तौल (किलोग्राम)	उचाई (से.मि)	BMI (kg/m^2)

SECTION D: SAFE WATER AND BASIC SANITATION
भाग ४: सुरक्षित खानेपानी र आधारभूत सरसफाई

D1.	तपाईले पिउनको लागि प्रयोग गर्ने पानीको श्रोत के हो ? १. ढुंगेधारो/पँधेरो २. खोला ३.हैण्ड पम्प ४. इनार ५. खानेपानिको धारो ६. अन्य (खुलाउने).....
D2.	तपाई स्रोतबाट प्राप्त हुने पानीको शुद्धतामा सन्तुष्ट हुनुहुन्छ कि हुनुहुन्न? १. छु २. छैन
D3.	तपाईले पिउने पानी शुद्धिकरण गर्नु हुन्छ कि हुदैन ? *(यदि छैन भने प्र.नं. D4 मा जानुं)* १. गर्छु २. गर्दिन
D3.a	यदि गर्नुहुन्छ भने, तपाईले पानी शुद्धिकरण गर्नु पर्दा कसरी गर्नु हुन्छ ? (बहुउत्तर) १. उमालेर २. सौर्यमि हालेर ३. छानेर ४. घाममा राखेर ५. अन्य (खुलाउने).....
D4.	तपाईले घरमा पिउने पानी के मा भण्डार गर्नु हुन्छ ? (बहुउत्तर) १. माटाको भैटो २. प्लास्टिकको भाडा ३. तामाको भाडो ४. गाग्री ५. अन्य (खुलाउने).....
D5.	खाना प्राय जसो के मा पकाउनु हुन्छ ? १. दाउरा २. गोबरग्यास ३.सुधारिएको चुलो ४. बिजुली चुलो ५. सिलिण्डर ग्यास ६. अन्य (खुलाउने).....
D6.	तपाईले घरबाट निस्किएको फोहोरहरु छुट्टयाउने गर्नुभएको छ ? *(यदि छैन भने प्र.नं. E1 मा जानुं)* १. छ २. छैन
D6.a	फोहोरलाई कसरी व्यवस्थापन गर्नुहुन्छ ? १. खाल्डोमा गाड्ने २. मल बनाउने ३. गाइवस्तुलाइ दिने ४. अन्य(खुलाउने).....
D6.b	नफोहोरलाई कसरी व्यवस्थापन गर्नुहुन्छ ? १. जलाएर २. फोहोर फाल्ने गाडीमा हाल्ने ३.खाल्डोमा पुर्ने ४. खोलामा फाल्ने ५. अन्य (खुलाउने.....

Annex 2: Workplan

S.N.	Activities	Jun 2025																												Jul-25								
		3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	1	2	3	4	5	6	7	8	9
1	CHD orientation Workshop (Tool development, Rapport building, Social mapping, Epidata, SPSS, and EXCEL Training, Pretesting)																																					
2	Preparation for CHD field Practices (Required logistics arrangement, tool finalization and printing																																					
3	Departure from college to community																																					
4	Site Visit (Transect Walk), Rapport building																																					
5	Preparation of First Community Assembly																																					
6	First Community Assembly (Objective Sharing, Social mapping)																																					
7	Data Collection																																					
8	Data Entry and Analysis																																					
9	Preparation for Second Community Assembly																																					
10	Second Community Assembly																																					
11	Need Prioritization, Planning and development of implementation, monitoring and evaluation plan for MHP																																					
12	Conduction , Monitoring, and Evalution of MHP																																					

13	Preparation for Final Community Assembly																																					
14	Final Community Assembly																																					
15	Preparation for departure from Community to College																																					
16	Departure from Community to College																																					

Annex 3: Request letter from college to ward

Pokhara University
Faculty of Health Sciences
SCHOOL OF HEALTH AND ALLIED SCIENCES
Pokhara, Kaski

Ref. No.: 966610E910C2 मिति: २०८२।०२।२०

श्रीमान् प्रमुख ज्यू
बारपाक सुलिकोट गाउँपालिका,
गाउँपालिकाको कार्यालय
गोरखा।

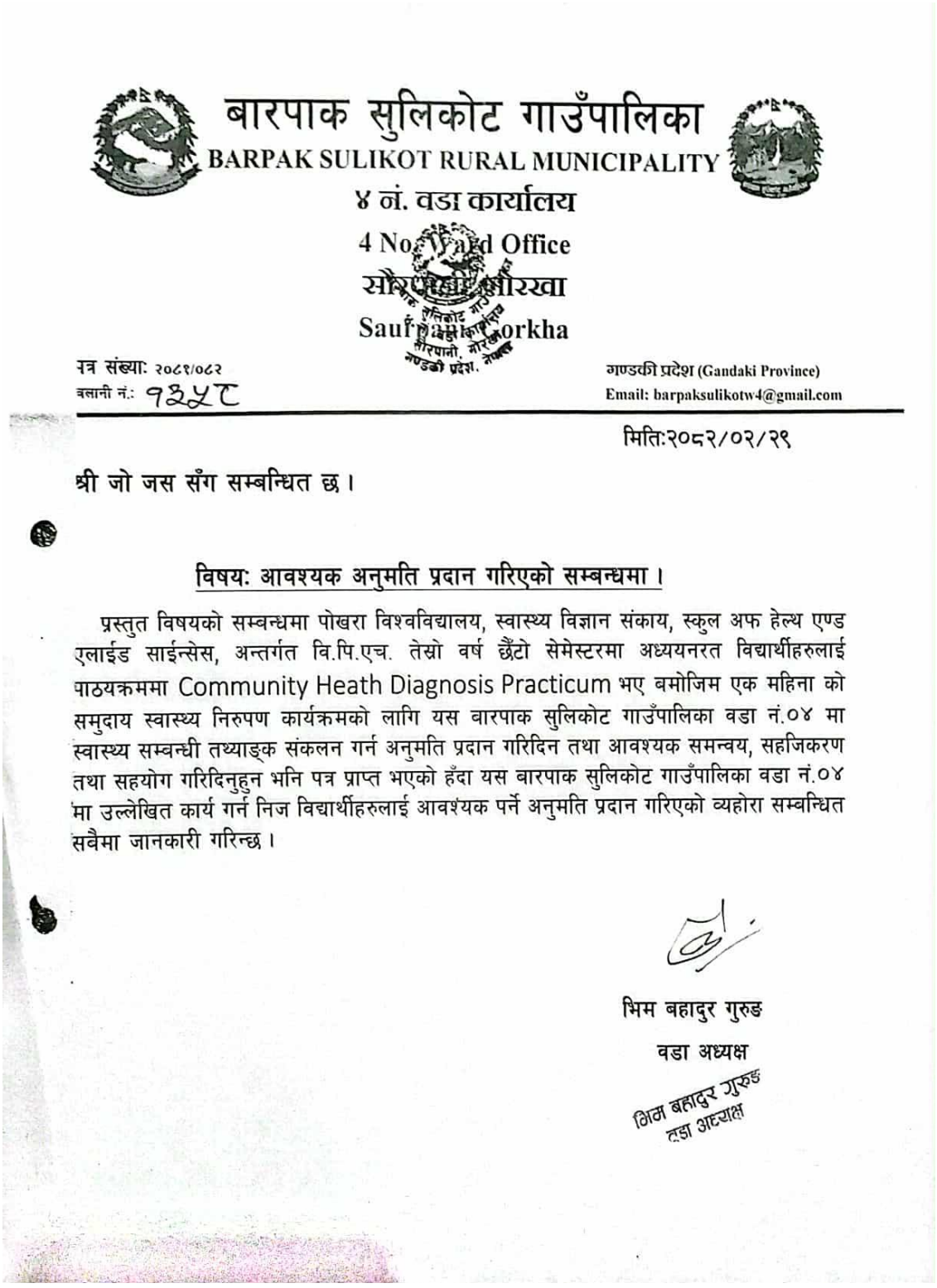
विषय: आवश्यक सहयोग गराईदिने सम्वन्धमा।

उपरोक्त सम्वन्धमा यस पोखरा विश्वविद्यालय, स्वास्थ्य विज्ञान संकाय, स्कूल अफ हेल्थ एण्ड एलाईड साईन्सेस, अन्तर्गत वि.पि.एच. तेस्रो वर्ष छैँटो सेमेस्टरमा अध्ययनरत विद्यार्थीहरुलाई पाठयक्रममा Community Health Diagnosis Practicum भए वमोजिम मा एक महिना (३० दिन) को समुदाय स्वास्थ्य निरुपण कार्यक्रमको लागी बारपाक सुलिकोट गाउँपालिकाको विभिन्न ४ वटा वडामा स्वास्थ्य सम्बन्धी तथ्याङ्क संकलन गर्न आउने लागेको हुदाँ कार्यक्रम सफलतापूर्वक सम्पन्न गर्न आवश्यक समन्वय, सहजिकरण तथा सहयोग गरिदिनुहुन अनुरोध गर्दछु।

निवेदक
राजेश कुमार यादव
उप- प्राध्यापक
वि.पि.एच. कार्यक्रम
फिल्ड संयोजक

P.O. Box 427, Pokhara-30, (Khudi, Dhungepatan), Kaski, Nepal | Tel: +977-61-504036, 504037
E-mail: info@pushas.edu.np, director@pushas.edu.np | Website: www.pushas.edu.np

Annex 4: CHD completion/Appreciation letter from ward



बारपाक सुलिकोट गाउँपालिका
BARPAK SULIKOT RURAL MUNICIPALITY
४ नं. वडा कार्यालय
4 No. Ward Office
सौराघरा, गोरखा
Sauraghara, Gorkha

पत्र संख्या: २०८१/०८२
चलानी नं.: १३५८

गण्डकी प्रदेश (Gandaki Province)
Email: barpaksulikotw4@gmail.com

मितिः२०८२/०२/२९

श्री जो जस सँग सम्बन्धित छ ।

विषयः आवश्यक अनुमति प्रदान गरिएको सम्बन्धमा ।

प्रस्तुत विषयको सम्बन्धमा पोखरा विश्वविद्यालय, स्वास्थ्य विज्ञान संकाय, स्कुल अफ हेल्थ एण्ड एलाईड साईन्सेस, अन्तर्गत वि.पि.एच. तेस्रो वर्ष छैंटो सेमेस्टरमा अध्ययनरत विद्यार्थीहरुलाई पाठयक्रममा Community Heath Diagnosis Practicum भए बमोजिम एक महिना को समुदाय स्वास्थ्य निरुपण कार्यक्रमको लागि यस बारपाक सुलिकोट गाउँपालिका वडा नं.०४ मा स्वास्थ्य सम्बन्धी तथ्याङ्क संकलन गर्न अनुमति प्रदान गरिदिन तथा आवश्यक समन्वय, सहजिकरण तथा सहयोग गरिदिनुहुन भनि पत्र प्राप्त भएको हँदा यस बारपाक सुलिकोट गाउँपालिका वडा नं.०४ मा उल्लेखित कार्य गर्न निज विद्यार्थीहरुलाई आवश्यक पर्ने अनुमति प्रदान गरिएको व्यहोरा सम्बन्धित सबैमा जानकारी गरिन्छ ।

भिम बहादुर गुरुङ
वडा अध्यक्ष

भिम बहादुर गुरुङ
वडा अध्यक्ष

Annex 5: Minuting

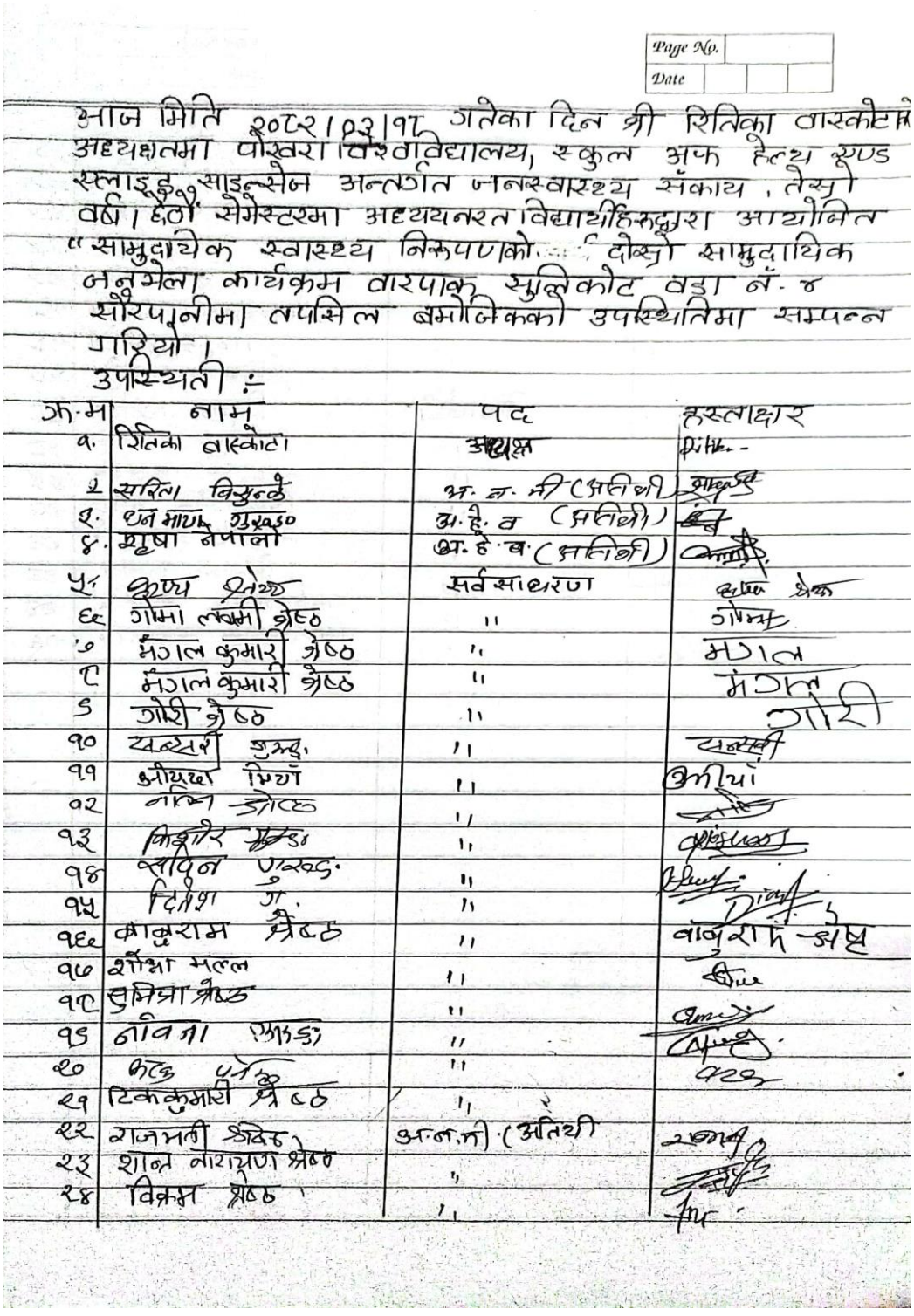
1.Social Mapping and First Community Assembly

आज यही मिति २०८२-०२-२० गतेका दिन जनस्वास्थ्य संकाय तेस्रो वर्ष अध्ययनरत Group-C ले आयोजना गरेको Social Mapping र प्रथम सामुदायिक जनभेला कार्यक्रम शितिका बास्कोटाको अध्यक्षतामा तपसिलको उपस्थितीमा सुसम्पन्न गरिएको छ ।

उपस्थिती :-

क्र.म	नाम	पद	हस्ताक्षर
१.	शितिका बास्कोटा	Leader	Ritiba
२.	रसिक जमरकट्टेल	Vice-leader	[illegible]
३.	दुर्गा बहादुर थापा	शिक्षक	[illegible]
४.	ठाकुर प्रसाद पन्थ	प्र.अ. श्री हिमालय मा.वि.	[illegible]
५.	मिलन ढकाल	कर्मचारी वडा	[illegible]
६.	हरिराम ढकाल	शिक्षक	[illegible]
७.	पशुपति दुगाना	ज.स्वा.नि.	[illegible]
८.	सत्यदेवी ढकाल		[illegible]
९.	हरि प्र. पन्थ	शिक्षक	[illegible]
१०	मंगल प्र. पन्थ	शिक्षक	[illegible]
११.	प्रशान्त लघु [illegible]	सर्वसाधारण	[illegible]
१२.	शान्त नारायण श्रेष्ठ	"	[illegible]
१३.	सुमिता उपरकोटी	वडा नं.८ वडा सदस्य	[illegible]
१४	राज बहादुर गुरुङ	"	[illegible]
१५.	भिम बहादुर सुनुवार	" सर्वसाधारण	[illegible]
१६.	इन्द्रामायाँ बोहोरा	"	इन्द्रा
१७.	गंगा बहादुर परियार	"	गंगा
१८	नरबहादुर परियार	"	नर ब.
१९	रमेश कोइराला	शिक्षक	[illegible]
२०	विपन गुरुङ	"	Bipan
२१.	गोकुल ढकाल	वि. कर्मचारी	[illegible]
२२.	दुर्गा ब. थापा	स.प्र.अ.	[illegible]
२३	सर्मिला घिमिरे	शिक्षक	[illegible]
२४.	बिन्दु पाण्डे	"	[illegible]
२५.	ईश्वरी सेढाइ (पतेरु)	"	[illegible]
२६.	चन्द्रावती वगाले	"	[illegible]
२७.	सलिना श्रेष्ठ	"	[illegible]
२८	गायत्री ढकाल	शिक्षक	[illegible]
२९	अर्जुन नेपाली	शिक्षक	[illegible]
३०	राजु बुन्याल	सर्वसाधारण	राजु
३१	जनक गौतम	विद्यार्थी	[illegible]
३२	सुजिता सुवेदी	"	[illegible]
३३	सुचिता सुवेदी	"	[illegible]
३४	शैलु अधिकारी	"	[illegible]
३५	रेशम कार्की	"	Reshamkarki
३६	सचिन कोइराला	"	Sachin
३७	सभ्यता न्यौपाने	"	[illegible]
३८	प्रिया मैनाली	"	[illegible]

2.Second Community Assembly



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Date

आज मिति २०८२।०३।१८ गतेका दिन श्री रितिका बास्कोटा अध्यक्षतमा पोखरा विश्वविद्यालय, स्कुल अफ हेल्थ एण्ड स्लाइड साइन्सेज अन्तर्गत जनस्वास्थ्य संकाय, तेस्रो वर्ष। दोश्रो सेमेस्टरमा अध्ययनरत विद्यार्थीहरुद्वारा आयोजित "सामुदायिक स्वास्थ्य निरूपण को दोस्रो सामुदायिक अनुभव कार्यक्रम वारपाक सुलिकोट वडा नं. ४ सोरपानीमा तपसिल बमोजिमको उपस्थितिमा सम्पन्न गरियो।

उपस्थिती :

क्र.म	नाम	पद	हस्ताक्षर
१.	रितिका बास्कोटा	अध्यक्ष	Ritika
२	सरिता विश्वकर्मा	अ. ज. मी (अतिथी)	
३.	धन माया गुरुङ०	अ. हे. ब (अतिथी)	
४.	शुषा नेपाली	अ. हे. ब (अतिथी)	
५.	कृष्ण प्रेम्ज	सर्वसाधारण	
६	गोमा लक्ष्मी श्रेष्ठ	"	
७	मंगल कुमारी श्रेष्ठ	"	
८	मंगल कुमारी श्रेष्ठ	"	
९	जोशी श्रेष्ठ	"	
१०	[illegible]	"	
११	[illegible]	"	
१२	[illegible]	"	
१३	[illegible]	"	
१४	[illegible]	"	
१५	[illegible]	"	
१६	[illegible]	"	
१७	[illegible]	"	
१८	[illegible]	"	
१९	[illegible]	"	
२०	[illegible]	"	
२१	[illegible]	"	
२२	राजमती [illegible]	अ.न.मी (अतिथी	
२३	शान्त नारायण श्रेष्ठ	"	
२४	विक्रम श्रेष्ठ	"	

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२५.	जनक गौतम	विद्यार्थी	
२६.	ज्योती गिरी	"	
२७.	वासुना श्रेष्ठ	"	
२८.	दिप्ती श्रेष्ठ	"	
२९.	प्रसी श्रेष्ठ	"	
३०.	सुजना सरुमगर	"	
३१	बिन्दु सुनार	"	
३२	डिम व. पनेरु	"	
३३	सुचिता सुवेदी	विद्यार्थी	
३४	सुजिता सुवेदी	"	
३५	सचिन कोइराला	"	
३६.	शैलु अधिकारी	"	
३७.	दिव्या मैनाली	"	
३८.	रेशम कार्की	"	
३९.	रशिक जमरकट्टेल	"	
४०.	सभ्यता बन्याँपाने	"	

3.Micro Health Project

Page No.
Date

आज यस मिति २०८२।०३।२३ गतेका दिन श्री रितिका बास्कोटा को अध्यक्षतामा पोखरा विश्वविद्यालय, स्कूल अफ हेल्थ एण्ड एलाइड साइन्सेज अन्तर्गत जनस्वास्थ्य संकाय तेस्रो वर्ष/ छैठौं सेमेस्टरमा अध्ययनरत विद्यार्थीद्वारा आयोजित "सामुदायिक स्वास्थ्य निरूपणको सूक्ष्म स्वास्थ्य परियोजना" बारपाक सुलिकोट वडा नं. ४ सौरपानी, श्री हिमालय मा.वि. मा तपसिल बमोजिमको उपस्थितिमा सम्पन्न गरियो।

उपस्थिती

क्र.म	नाम	पद	हस्ताक्षर
१	रितिका बास्कोटा	अध्यक्ष	Ritika
२	टिका कुमारी ढकाल	सि.अ.-नि.मा.वि.(प्र.अ.)	[illegible]
३	सुरेन्द्र गुरुङ	वडा सदस्य (वि. अतिथि)	[illegible]
४	कुदिवल विक	सर्वसाधारण	[illegible]
५	अम्बिका पकाल	"	[illegible]
६	अस्मिता परियार	"	Asmita
७	सन्तली गुरुङ	"	सन्तली
८	चन्द्रप्रसाद घलान	"	[illegible]
९	मानप्रसाद बाहिरा	"	Man
१०	मोती मायाँ	"	मोती
११	ईला मायाँ बोहरा	"	ईला
१२	कृष्ण बराम	"	
१३	सुमन क्षेत्री	"	[illegible]
१४	विन्दु सुनार	"	Bin
१५	पुनम परियार	"	पुनम
१६	ज्योती गिरी	"	Jyoti
१७	पम्फा सोडारी	"	BS
१८	शान्त नारायण सिंह	"	[illegible]
१९	प्रेम नारायण सिंह	"	[illegible]
२०	नन्दलाल सिंह	"	
२१	शेखर क्षात्र	"	[illegible]
२२	सेते नेपाली	"	[illegible]
२३	जमुना श्रेष्ठ	"	[illegible]
२४	फिल्ली श्रेष्ठ	"	[illegible]
२५	दासी श्रेष्ठ	"	[illegible]

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२८	मंगल कुमार श्रेष्ठ	"	
२७	गौमा कुमारी ठाकुर	"	
२८	गौरी श्रेष्ठ	"	
२९	मधु श्रेष्ठ	"	
३०	रचना श्रेष्ठ	"	
३१	विनिशा श्रेष्ठ	"	
३२	दिव्या श्रेष्ठ	"	
३३	[illegible]	लाक अपरेटर वडा	
३४	लाना वज्राचार्य	सर्वसाधारण	
३५	[illegible]	"	
३६	[illegible]	"	
३७	[illegible]	"	
३८	सुजना [illegible]	"	
३९	[illegible]	"	
४०	[illegible]	"	
४१	[illegible]	"	
४२	[illegible]	"	
४३	[illegible]	"	
४४	नम्रता श्रेष्ठ	"	
४५	[illegible]	"	
४६	[illegible]	सर्वसाधारण	
४७	तिका [illegible]	"	
४८	ममता [illegible]	सर्वसाधारण	
४९	जनक गौतम	विद्यार्थी	
५०	सुनिता सुवेदी	"	
५१.	सुचिता सुवेदी	"	
५२.	सचिन कोइराला	"	
५३	रेशम लामा	"	
५४	सम्यता न्यौपाने	"	
५५	रोशन जमरकट्टेल	"	
५६	शैलु अधिकारी	"	
५७	दिव्या मैनाली	"	

4. Third Community Assembly

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Date

आज यस मिति २०८२/०२/२९ गतेका दिन श्री रितिका बास्कोटा-को अध्यक्षतमा पोखरा विश्वविद्यालय, स्कुल अफ हेल्थ एण्ड एलाइड साइन्सेज अन्तर्गत जनस्वास्थ्य संकाय तेस्रो वर्ष छैठौं सेमेस्टरमा अध्ययनरत विद्यार्थीद्वारा आयोजित "सामुदायिक स्वास्थ्य निरूपणको तेस्रो (अन्तिम) सामुदायिक जनभेला कार्यक्रम बारपाक सुलिकोट वडा नं. ४ स्यौरपानी वडा कार्यालयमा तपसिल बमोजिमको उपस्थितिमा सम्पन्न गरियो।

उपस्थिती

क्र.सं	नाम	पद	हस्ताक्षर
१.	रितिका बास्कोटा	अध्यक्ष	Ritika
२.	यमुना भट्ट	वडा कर्मचारी (सो.प)	[illegible]
३.	[illegible]	सा.क.अ वडा कार्यालय	[illegible]
४.	सुजन गुरुङ	प्रमुख अतिथि	[illegible]
५.	कुसुम भट्ट	पशु प्राविधिक	[illegible]
६.	हरि प्रसाद चमलगाईं	सर्वसाधारण	हरी प्रसाद
७.	भिमकुमार गुरुङ	"	[illegible]
८.	बिन्दु सुनार	"	Bind
९.	सोम माया तामाङ	"	सोम माया
१०.	जानुका ढकाल	"	जानुका
११.	नविना पुडासैनी	"	[illegible]
१२.	ओपदा मियाँ	"	ओपियाँ
१३.	सुनसरी गुरुङ	"	सुनसरी
१४.	मैया श्रेष्ठ	"	मैया
१५.	प्रान्सी श्रेष्ठ	"	प्रान्सी
१६.	शान्त नारायण श्रेष्ठ	"	[illegible]
१७.	सोमालक्ष्मी श्रेष्ठ	"	सोमालक्ष्मी
१८.	मंगल कुमारी श्रेष्ठ	"	मंगल कुमारी
१९.	कृष्ण कुमारी श्रेष्ठ	"	कृष्ण कुमारी
२०.	गोरी श्रेष्ठ	"	गोरी श्रेष्ठ
२१.	[illegible]	"	[illegible]
२२.	[illegible]	"	

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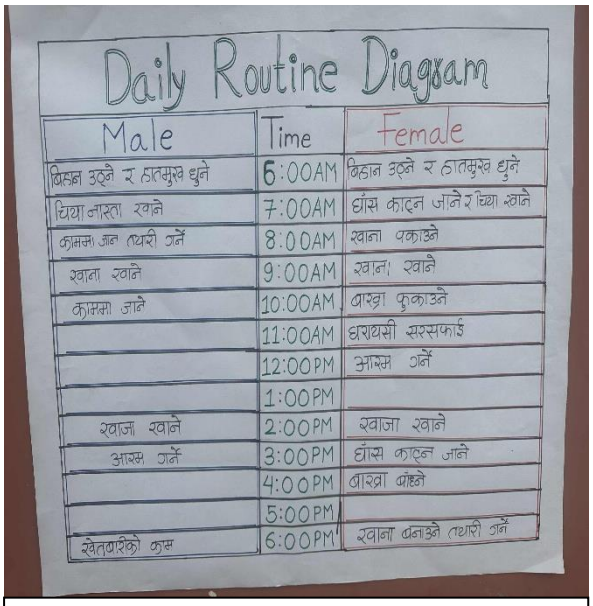
२३.	श्याम ब. गुरुङ	सर्वसाधारण	[illegible]
२४.	पिराज गुरुङ	"	[illegible]
२५.	नर कुमारी	"	
२६.	माया सयल		
२७.	भूषा नेपाली	सौरपानी स्वा. चौकी अ. हे. व.	[illegible]
२८.	धन माया गुरुङ	सौरपानी स्वा. चौ. अ. हे. व	[illegible]
२९.	मधु लामिछाने		[illegible]
३०.	पम्फा सोडारी	महिला स्वास्थ्य स्वयं सेविका	PS
३१.	पबिता गुरुङ	सर्वसाधारण	[illegible]
३२.	लामीनी बराली	"	लामिना
३३.	चन्द्र प्रसाद न्यौपाने	"	चन्द्रप्र
३४.	ठाकुर प्रसाद ढकाल	"	ठाकुर
३५.	मनमाया ढकाल		
३६.	मोहन ढकाल (जि.स.स)	जि.स.स ९८४६०४०४०६	[illegible]
३७.	नवराज तामाङ लामा	सर्वसाधारण	[illegible]
३८.	जनक गौतम	"	[illegible]
३९.	सुजिता सुवेदी	"	Suja
४०.	सचिन कोइराला	"	[illegible]
४१.	रेशम कार्की	"	[illegible]
४२.	समृता न्यौपाने	"	[illegible]
४३.	रशिक अमरकट्टेल	"	[illegible]
४४.	शैलु अधिकारी	"	Shum
४५.	दिव्या मैनालि	"	dibya
४६.	ममता गुरुङ	"	[illegible]
४७.	तिलक्ष्मी श्रेष्ठ	"	[illegible]
४८.	मधु श्रेष्ठ	"	[illegible]
४९.	गौरी सुवेदी	"	गौरी
५०.	दिव्या श्रेष्ठ	"	[illegible]

Annex 6: PRA/PLA tools

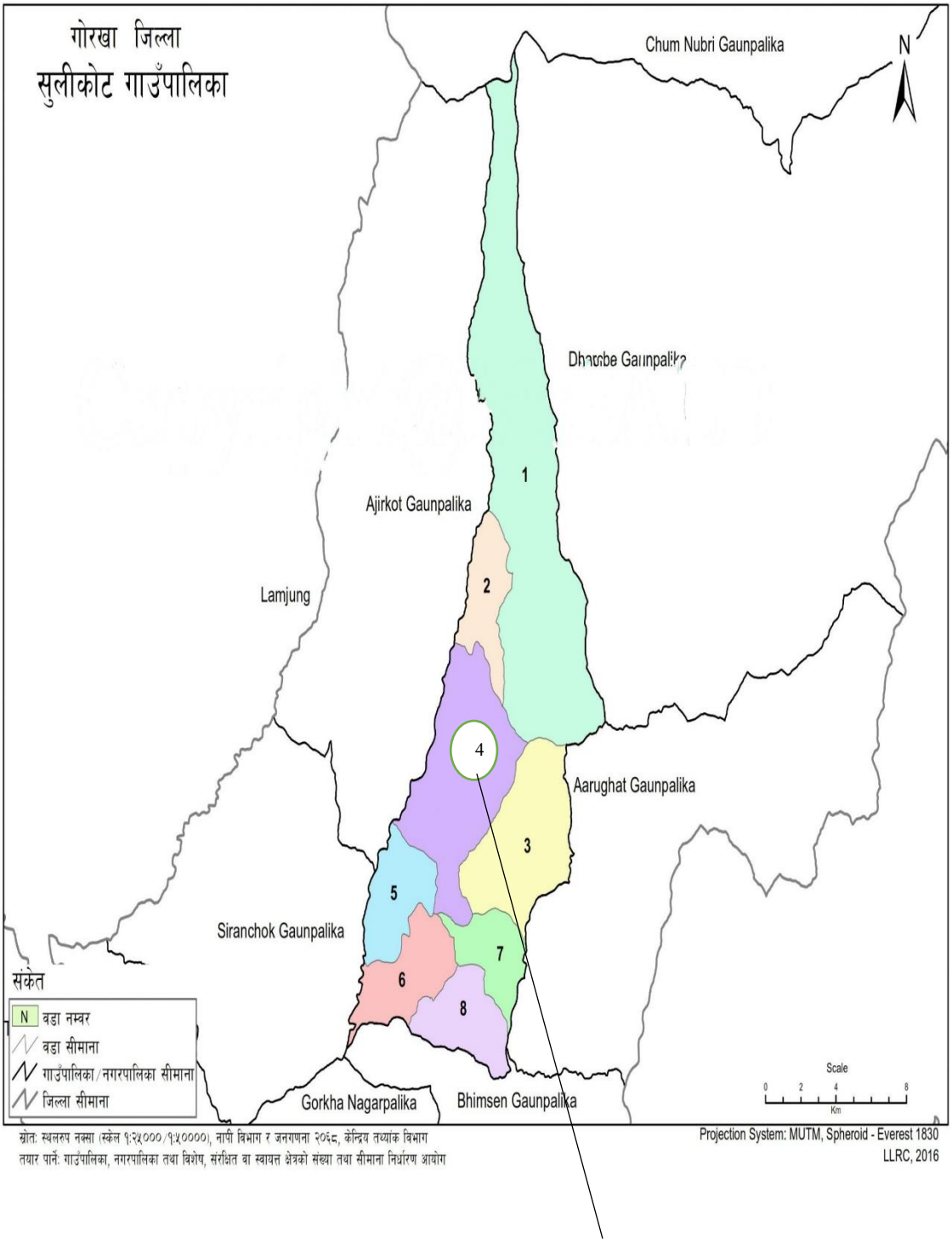


Daily routine Calendar

Mobilty map

Seasonal Callender

Map of Barpak Sulikot-04,Gorkha



Barpak Sulikot-04, Gorkha

Annex 7: Photographs

Image 1: Social Mapping and First Community assembly

Image 2: Data Collection

Image 3: School Health Program

Image 4: Focal Group Discussion

Image 5: KII

Image 6: Second Community Assembly and need priotization

Image 7: MHP

Image 8: Final Community Assembly