COMMUNITY HEALTH DIAGONOSIS REPORT

Lahorepauwa VDC of Rasuwa District

Nepal

2064

SUBMITTED TO PUBLIC HEALTH DEPARTMENT

ASIAN COLLEGE FOR ADVANCE STUDIES

SATDOBATO, LALITPUR

SUBMITTED BY

BPH 2nd Year, 2nd Batch

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Prologue

Assimilation, adjustment, adaptation and learning in real life situation within the new community are not only wonderful but also challenging work. For the fulfillment of requirement of BPH curriculum, we had such programme.

Our objective was to identify the health problem and the determinants of health in the community. It was necessary to have concern with sociological, demographic, psychological, political and behavioral aspects and to learn the association with health and disease.

There are so many health problems in the community to solve those problem there could be successful implementation of health awareness and intervention programme. So, identification and prioritization of the problem is necessary so that, programme can be done according to their need.

In the 21st century, only the theoretical knowledge is not enough without the practical knowledge. So, this community diagnosis was opportunities for us to implement our theoretical knowledge, practically in real life situation, though there were many problems we had successfully finished our programme.

All the finding of our study is included in this report. This report also includes efforts and learning experiences of study team that we had.

Acknowledgement

Community diagnoses programme itself a bit difficult programme to conduct and it is more difficult in learning phase. Though we were in learning phase and was our first experience, we conducted this programme easily and smoothly as our plan. Our programme was more successful than we expect. Behind this success there lies the full cooperation of respondents, support of community leaders, FCHVS, teachers, affection of the community people, guidance and feedback from the faculty members of public health. Our programme wouldn't have been successful without such cooperation, support, guidance and affect.

First and foremost, our study team heartily indebted to the community people of Lahorepauwa VDC, for their encouragement, support and warm love for us. Our sincere gratitude goes to health post in charge, AHW, ANM, VHW and peon of the Lahorepauwa health post. Our team would like to give especial thank to Mr. Rabindra Thakuri, AHW of Lahorepauwa health post who help us for managing our accommodation, providing the logistics and cooperation in each and every function of the programme.

Team member are also thankful to FCHVs and TBAs for gathering of community people in our health education and community presentation programme.

We are very thankful to Mr. Chhatkuli, Head Master of Nava Vijaya Mahendra Mdhyamic Vidyalaya. Mr. Mahananda Timsina, Head Master of Narayansthan Primary School. Mr. Chhatra Bahadur khadka, Head Master of Shree Nilkantha Higher Secondary School. Mr. Shambhu Prasad Adhikari, Head Master of Shree Shivalaya Proposed Lower Secondary School, Mr. Krishna Pd. Sharma, Incharge of Ayurved Ausadhalaya, Lahorepauwa. Mr. Bashu Dev Neupane, President of Sumarga Premi Yuba Club, Yuba Prasad Neupane, President of Kavre Khola Madhyabarti Community Forest, Mr. Nilakankha Acharya, President of Nepal Redcross Society sub- branch Lahorepauwa. Ms. Sharada Devi Acharya, Secretary of Jana Jagriti Mahila Samuh, Mr. Balakrishna Ghimire, President of Shree Kalika Bahu-uddesiya Sahakari Sanstha Lahorepauwa 3, and Mr. Gamvirman Loo of ward no.7

We are also very thankful to Mr. Sudarsan Sedhain, secretary of Lahorepauwa VDC for providing secondary data, VDC hall and the overall information of the VDC.

We would like to give especial thanks to Head of Department, Mrs. Shova Khanal, Mr. Khadga Bahadur Shrestha, Field coordinator and Dr. Khem Bahadur Karki whose support and guidance was for us from the very beginning to the last of the report writing similarly we are also thankful Mr. Bhawani Neupane, Mr. Diwas Gartaula and Mrs. Neeti Sedhai, Lecturers of public health department. We are also thankful to Mr. Kamal Fuyal and Mr. Rajendra Gupta who had facilitated the PRA training, which was very beneficial for practical as well as theoretical knowledge.

At last but not least, surely there are so many personalities who should recognized for their contribution from their position, we would like to say thanks and request for forgiveness for them not being cited.

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CBR	Crude Birth Rate
CD	Community Diagnosis
CDR	Crude Death Rate
DHO	District Health Office
DOTS	Directly Observed Treatment Short course
DPT	Diphtheria, Pertusis, Tetanus
EPI	Expanded Programme on Immunization
FCHV	Female Community Health Volunteer
FP	Family Planning
GFR	General Fertility Rate
GM	Growth Monitoring
HIV	Human Immuno Deficiency Virus
IMCI	Integrated Management of Childhood illness
IMR	Infant Mortality Rate
KAP	Knowledge, Attitude and Practice
MCH	Maternal and Child Health
MHP	Micro Health Project
MUAC	Mid Upper Arm Circumference
ORC	out Reach Clinic
ORS	Oral Dehydration Solution
PEM	Protein Energy Malnutrition
PHC	Primary Health Care
PNC	Post Natal Care
SDK	Safe Delivery Kit
STI	Sexually Transmitted Infections
TB	Tuberculosis
TBA	Traditional Birth Attendance
TTBA	Trained Traditional Birth Attendance
TFR	Total Fertility Rate

TT	Tetanus Toxoid
U-5MR	Under 5 Mortality Rate
VDC	Village Development Committee
WHO	World Health Organization
HI	Health Institution
Tab.	Tablet
STI	Sexually Transmitted Infection
MWRA	Married Women of Reproductive Age
SPSS	Statistical Package for Social Science
ARI	Acute Respiratory Infection
PUO	Pyrexia of unknown Origin
COPD	Chronic Obstructive Disease

SUMMARY

This community diagnosis, field study survey mainly for learning purpose so that how we can conduct any programme in future. The primary purpose of this diagnosis was to identify the real health status and for getting the detailed information about demographic situation, socio-economic status, environmental status, health seeking behavior, MHP, family planning and child health situation.

This report of community diagnosis is submitted to the public health department. This report is the output of community diagnosis field study conducted in Lahorepauwa VDC of Rasuwa district by an effort of team students of BPH 2nd year of Asian college for advance studies, Satdobato Lalitpur within one month.

The objective of the program was to learn from community people to be with them in the process of acquiring knowledge and skills to identify the health related problems and their causes, and the resources available in the community. The aim was also to know about the community in real sense practically.

This report includes the findings and their analysis from household surveys, PRA and information obtained from secondary data. From the record of health post among the 900 households we selected 180 households using the simple random sampling method. According to our study, total population of our sample was 1188 among them Male were 567 (48%) and female were 621 (53%). The male female ratio was 91:100

The average family size was 6.6. The total dependency ratio of the VDC was 60%. The Crude Birth Rate (CBR) was 23.5 per thousand, Crude Death Rate (CDR) was 5.8 per thousand, U-5 Mortality was 10 per thousand. Infant and maternal mortality were not found. Morbidity was found 4%. This may be due to small sample size.

The main occupation of people of the VDC was student (37%). The main source of income of people was agriculture (64%). Only 47% of the population had enough food for the whole year. The main crops cultivated were paddy, millet and maize respectively. Literacy rate was 65%. Tobacco consumption habit was fond 20% and the alcohol drinking habit was 18%. Drinking habit was most common in Tamang ethnicity.

Most of the household (91%) used to bring the drinking water from tap/ pipe. 80% of the household used to cover drinking water.

Only 58% of household had safe disposal of solid waste. 53% of household used to dispose waste water on Kitchen garden. 77% of household used to defecate in toilet. 74% of household used soap water to wash hand after defecation, among the people who used to wash hand after defecation. 88% of household used to daily brushing among them only 16% used to brush twice a day. 98% of household had heard about Diarrhea. 96% had heard about oral rehydrated solution (Jeevanjal), among them only 60% were known the right method of ORS preparation. 88% had heard about ARI/ Pneumonia. 83% had heard about Tuberculosis among them only 29% were known about the correct mode of transmission of TB. 93% respondeents hadn't heard about DOTS. 77% had heard about STI and HIV/AIDS, among them 78% were known that it is transmitted through

sexual contact. 70% of household members used to contact at health institution when gets ill.

Majority (96%) of respondent had got married before the age of 21 yrs. 54% had given birth before the age of 20 yrs. 82% of the respondent had heard about antenatal check up (ANC), among them only 54% had done it. Among those who had done ANC, 60% had done it for four or more times. Only 67% of total respondents had taken TT vaccine and 52% had taken Iron tablet during pregnancy. 31% respondent used to smoke and drink during pregnancy. Only 19% deliveries were at health institution. 64% of respondents had done cord cutting of their child with new and not used blade, among the deliveries out of health institution. Only 33% had done post-natal check up (PNC). Less than half (46%) of the mothers had taken rest during the post-partum period. Half (49%) of post partum mother had received vitamin "A" capsule. Only 13% of household members had problem of uterine prolapse in the family but problem was as hidden health problem. 90% children were feeded colostrum. 43% households used to give supplementary food for their children below than 6 months of age. 81% respondents had heard about super flour, among them only 51% were known about the correct method of its preparation. Almost all (98%) of under 5 children were vaccinated with BCG, 94% were vaccinated with DPT/ HepB and Polio III and 87% with measles. Among them some were on process. 77% of household had used salt having Iodine greater than15 PPM. Less than half (40%) children of under-5 had normal nutritional status.

CPR was found 33.6%. Among the family planning method users, vasectomy (56%) was found higher. Depo-Provera was found the most popular method of temporary family planning (52%). 51% of family planning users had got the suggestion for its use from health workers (including FCHVs). Adoption of FP for the purpose of child spacing was found very low. 94% of households were kachhi, among them only 12% had good ventilation. Only 49% of latrines were sanitary.

1. Introduction

The diagnosis of disease in an individual patient is a fundamental idea in medicine, based on sign and symptoms and making of inferences from them. When this applied to a community it is known as community diagnosis.

“Community diagnosis is a comprehensive assessment of the health status of an entire community in relation to its social, physical and biological environment. The purpose of the community diagnosis is to define existing problem, determine available resource and set priorities for planning, implementation, and evaluating health services, by and for the community.

Community diagnosis field in the BPH 2nd year is one of the major part of BPH curriculum, which is the most important tool for community based learning. This study has 2 major aspects;

1. Implementation of theoretical knowledge in real life situation to learn the factors or determinants that influence the health of the community.

2. To raise the health awareness to change or modify KAP towards positive health through their active participation.

The community diagnosis is based on collection and interpretation of the relevant data such as

- Age and sex distribution of a population
- Vital statistical rates such as the birth rate and death rate
- The incidence and prevalence of the important disease of the area.

Rasuwa district, a part of Bagmati zone is Tourist area with 1,512 square km area. It is a Himalayan region with Langtang Himal and Ganesh Himal and also with high altitude lakes including Gosaikunda, Parvatikunda, Bhairavkunda, and Dudhkunda. Dunche is the district headquarter. It is also known as the land of Tamang; about 80% of people from this region are from this casts.

Lahorepauwa is one model VDC of Rasuwa district. This is the entry VDC of this district through the roadway. Though this District is Himalayan region, this VDC lies in the lower belt so, climate is similar to the hilly region. 1, 2, 3, 9 ward are located at the lower belt of this VDC, where people are more educated and aware than the other wards of upper belt. Upper belt is dominated by Tamang ethnicity where as lower belt is dominated by Chhetris and Brahmins.

This community diagnosis was started from 1st to 30th Falgun 2064. This CD mainly focuses on the identification and quantification of the basic health needs and health problems of the community.

By quantification of health problems, we lay down priorities in disease control and prevention. Secondly, quantification of morbidity and mortality can serve as a bench mark for the evaluation of health services at a later

date. Thirdly the quantification of health problem can be a source of new knowledge about disease distribution, causation and prevention.

We prepared this report by collecting all the problems and findings from data collection. This report also includes the small scale program called as Micro Health Project, which was conducted with the community. At last this report includes recommendation limitation, learning reflection.

2. OBJECTIVE OF COMMUNITY DIAGNOSIS

General objective:-

To identify the health status, factors associated with them and to assist the community people to solve those problems.

Specific objectives:-

1. To describe the Health, demographic and socio-economic status of the community.
2. To identify KAP regarding the common health problems.
3. To identify the health care seeking behaviors of community people.
4. To find out the nutritional status of under 5 children.
5. To identify the KAP regarding MCH, FP and immunization.
6. To describe the personal hygiene and environmental sanitation status of the community.
7. To identify the hidden health problem of the community and explore the available local resources.
8. To identify the real needs, to prioritize them and to plan, implement and evaluate the MHP.

3. METHODOLOGY:-

Study area: - Lahorepauwa VDC, of Rasuwa district

Study population: - Total population/ households of Lahorepauwa VDC

Study Design: - Descriptive cross-sectional study (It is a simple form of an observational study based on a single examination of a cross section of population at one point in time and result can be projected to the total population.)

Unit of analysis: - Household

Sampling frame: - Total 900 households of Lahorepauwa VDC were recognized primarily by the name of head of the family. (Total no. of households and their head was taken from the health post record, provided by FCHVs recently. We couldn't get this information from VDC office due to the past conflict.)

Sample size: - 20% of the total households for data collection (180 households).

Sampling technique: - Simple random sampling; lottery method. Name of all household head was written on pieces of paper and were folded, then were kept on a bag. Then those pieces were selected randomly.

4. TECHNIQUES OF DATA COLLECTION

a) Interview: -

It was taken with the sampled household head and child bearing Married woman of reproductive age, priority was given to the mothers of under 5 children. If nobody was there in sampled house or absence of child bearing MWRA, then we had skipped that house and choosed nearest household.

Data regarding demographic characteristics, socio-economic status, environmental sanitation and personal hygiene, KAP on common diseases, health care seeking behaviors and vital events (morbidity, mortality and fertility) were taken with the household head. Data regarding maternal and child health and family planning were taken with child bearing MWRA.

b) Observation:-

Data regarding housing standard, environmental sanitation and quantity of iodine in salt was collected by this technique. Observation checklist was used for this purpose.

c) Anthropometric measurement:-

Data regarding height weight and mid upper arm circumference (MUAC) to find out nutritional status of under 5 children was collected from this technique.

d) Participatory rural appraisal:-

Social mapping, felt need identification and prioritization were done by this technique.

e) Record review:-

Secondary data was collected from VDC office and health post by this technique.

5. DATA COLLECTION TOOLS:-

a) Interview schedule: - This tool was used for interview.

b) Observation checklist: - This tool was used for observation.

c) Anthropometric measurement tool: -

Shakir tape: - for taking MUAC.

Measuring tape: - for taking height.

Saltar baby weighing: - for taking weight

d) Iodine test kit: - For finding the quantity of iodine in salt.

6. DATA PROCESSING AND ANALYSIS:-

a) Collection of data: - Data were collected from the sampled household.

b) Editing of data: - Collected data were edited daily by the study team.

c) Entry on the dummy table: - To analyze the data in the community edited data were entered on the dummy table.

d) Tabulation, data analysis: - After finishing the entry on the dummy table data were tabulated and analyzed in the community field.

e) Data entry analysis on SPSS: - After returning back from the field all data were entered into the SPSS and were analyzed by SPSS.

F) Anthropometric measurement:-Analysis of the data from anthropometric measurement was done by using standard table according to WHO guidelines.

7. VALIDITY AND RELIABILITY:-

a) Interview classes, inputs from teachers before going to the field.

b) Pre-testing of interview schedule and observation checklist.

c) Pre-setting of instruments, which were used for anthropometric measurement.

d) Cross checking of the weighing instruments and measuring tape was done.

e) Supervision and guidance from faculties.

f) To reduce selection bias the study followed the sample frame strictly.

g) Discussion over questionnaire before data collection and daily discussion on the procedure was followed during data collection.

h) Daily self checking and cross checking of the schedule (range checking, consistency checking and completeness checking).

8. LIMITATIONS OF THE STUDY:-

a) Selection of next household of sampling frame due to absence of members of sample house.

b) Inability to meet mothers of under-5 children in some household and under-5 children also due to unfavorable topography and time selected for community diagnosis.

c) Some of the respondents were not the household head; it may lead to biased answers regarding to KAP on diseases and service utilization,

mainly female respondent may not have much knowledge regarding those, as compared to male.

d) Biased answers for first consultation during illness were likely to arise as the members of the study group were introduced as students of health science.

9. ETHICAL CONSIDERATION

a) Permission for the study was taken from DHO, VDC office and HP.

b) Purpose and objectives of study were explained and verbal consent was taken from each respondent.

c) Assurance of confidentiality of the information.

d) Dignity of individuals was highly considered.

e) Freedom was given to the respondents to skip any question during interview process or, deny the continuation of the interview.

f) Low profile was maintained so as not to let them keep high expectations.

VDC PROFILE

VDC: - Lahorepauwa

District: - Rasuwa

Boundary: - Dhaibung VDC in **East** which is separated by Baghedado. Dadagaun VDC and some part of Nuwakot district in the **West** which is separated by Trisuli River. Ramche VDC in **North** which is separated by Chahare Khola. Nuwakot district in **South** which is separated by Falakhu khola.

Total households: - 900

Total population: - 5132 Male-2546 Female-2586

Major Ethnic groups: - Brahmin: - 40%

Tamang: - 30%

Chhetri: - 8%

Newar: - 5%

Magar, gurung: - 6%

Dalit (Kami, Damai):- 5.5%

Others (Tharu, Sherpa, unknown):-5.5%

Most of the people were Hindu followed by Buddhist.

MAJOR FINDINGS

DEMOGRAPHIC INDICATORS:-

Particular	National	V.D.C.
Total No. of households	4253220	900
No. of sample households	-	180
Population of sample	-	1188
Male population	11563921	567
Female population	11587502	621
Average family size	-	6.6
Sex ratio	-	91:100
Total dependency ratio	-	60%
Child dependency ratio	-	53%
Elderly dependency ratio	-	7%
Crude birth rate	29.2/1000	23.5/1000
Crude death rate	8.5/ 1000	58.9/1000
Under 5 mortality rate	61/ 1000	10/1000
Contraceptive prevalence rate (CPR)	48%	33.6%
Median age of population	20.1yrs	22 yrs
Total literacy rate	54.1%	65%
Male literacy rate	65.5%	54%
Female literacy rate	42.8%	46%

DEMOGRAPHY

Introduction.

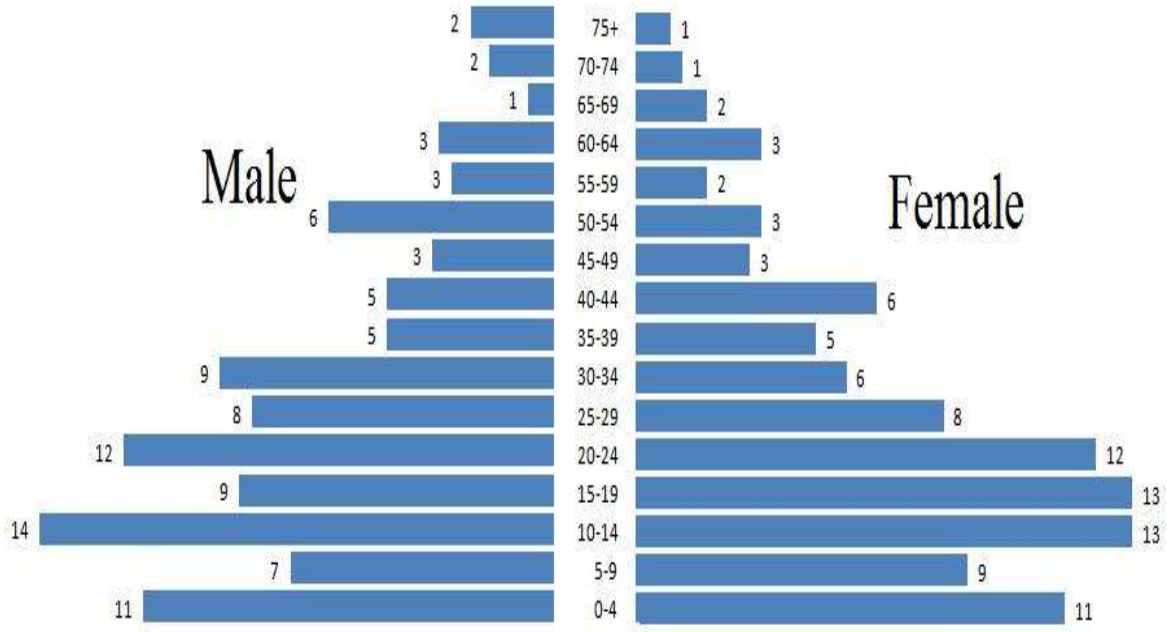
Composition and distribution of the population, population size, dynamic characteristics like: - fertility, mortality, marriage, migration and social mobility are studied scientifically under demography. Community health diagnosis is concerned with various demographic indicator of a community because health status of the community is interlinked with their demographic characteristics.

Population size and composition (%)

According to secondary data obtained from VDC office the total population was 5132. According to health post record total house hold were 900.

We had selected 180 households that were 20%, by simple random sampling method and it comprised around 23% of the total population that is 1188.

Figure 1: Population pyramid



Analysis of population pyramid

- Population pyramid of Lahorepauwa VDC shows that the population of age group and 5-9 less than that of age group 10-14 and 15-19. This may be due to decreasing fertility as a result of effectiveness of family planning methods.
- Population of age group 10-14 and 15-19 is higher in comparison to other age group which may be due to higher fertility rate during 10-19 yrs back.
- Population of age group of 75 and above yrs is higher which may be due to open ended age interval.
- Male population in 75 and above yrs higher than that of female. This shows that male is expected to live more than female.
- The population pyramid resembles to some extend to the pyramid of developing countries.

Family size:-

From sampled household of 180, comprising 1188 population, found that each family has family size of 6.6. This means each family has around 7 no. of family.

Dependency rate:-

Study found that child dependency rate was 53% and elderly dependency ratio 7%. Hence total dependency ratio was 60%. It means two economically active populations support about one economically inactive population.

Crude Birth Rate:-

Crude birth rate is the total no. of live birth per 1000 mid year population. Birth rate is indicator of population increase. Crude Birth Rate was found to be 23.5 per 1000.

Mortality:-

Mortality measures the death of people, which is the indicator of population decrease. Crude Death Rate was found to be 58.9 per 1000.

Morbidity:

Top 4 diseases prevalent within 15 days were; fever/ Typhoid, ARI, Diarrhea and Asthma respectively.

According to the Health Post record of FY 2063/ 064 the top 10 disease were:- ARI, PUO, diarrheal diseases, skin diseases, falls/ injury/ fracture, gastritis, COPD, ear problem, eye problem, and intestinal worms respectively.

Morbidity rate:

It was found to be 40 per 1000 population for last 15 days.

Type of Family

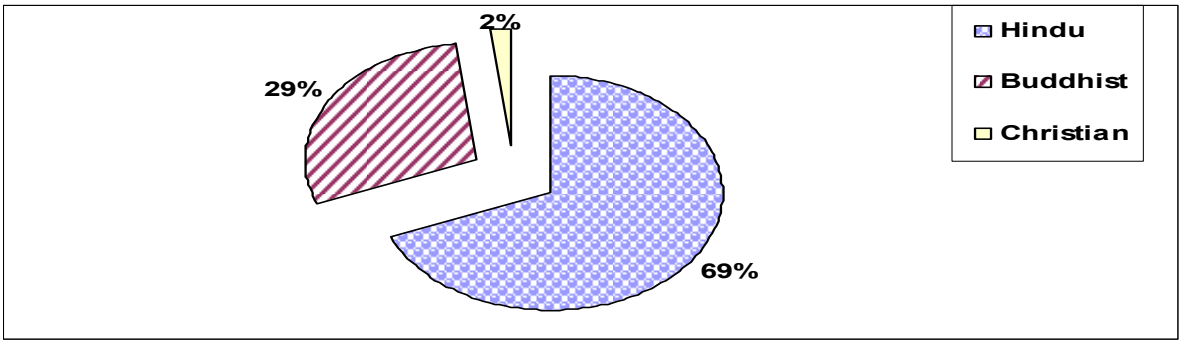
It was found that 49% families were joint, 48% were single, and 3% were extended.

Socio-economic status:

Socio economic status reflexes the health status of people by influencing various demographic processes. Health is directly influenced by socio economic status of community people.

Religion

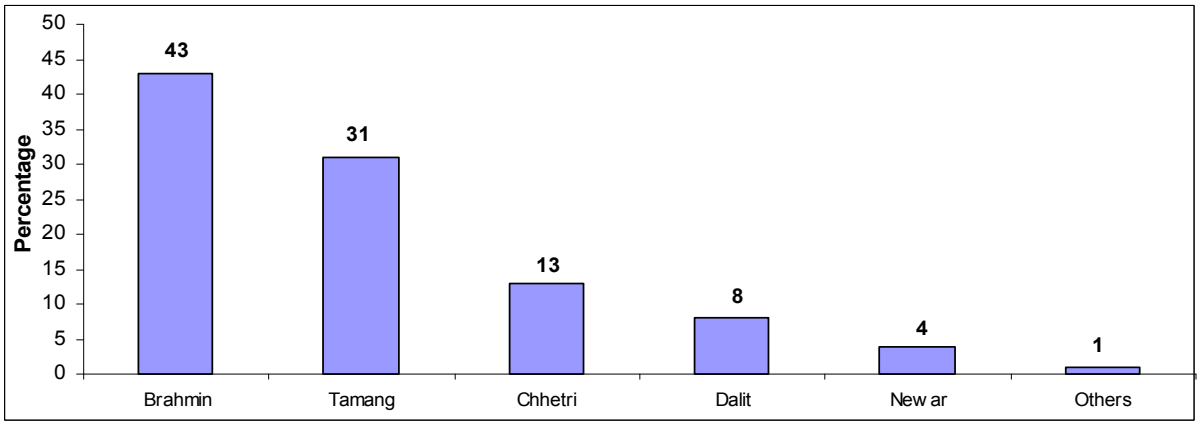
Figure 2: Religion [n=180]



More than half (69%) of the total household were Hindus following by Buddhists and Christian.

Ethnicity

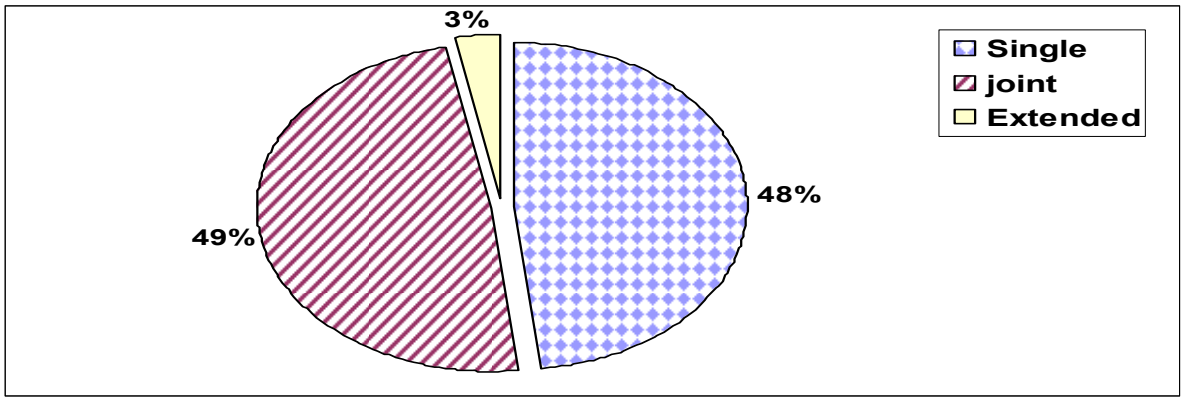
Figure 3: Ethnicity [n=180]



Most (43%) of the total household were Brahmins, 31% were Tamang and 8% were Dalit.

Family type

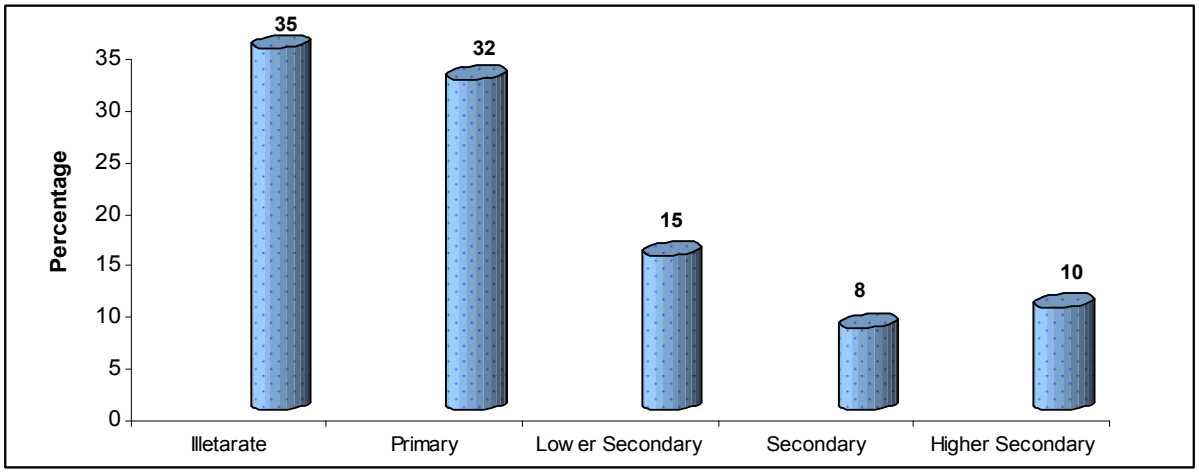
Figure 4: Family type [n=180]



Nearly half (49%) of the total household were joint, only 3% were extended.

Educational status

Figure 5: Educational status [n=1188]



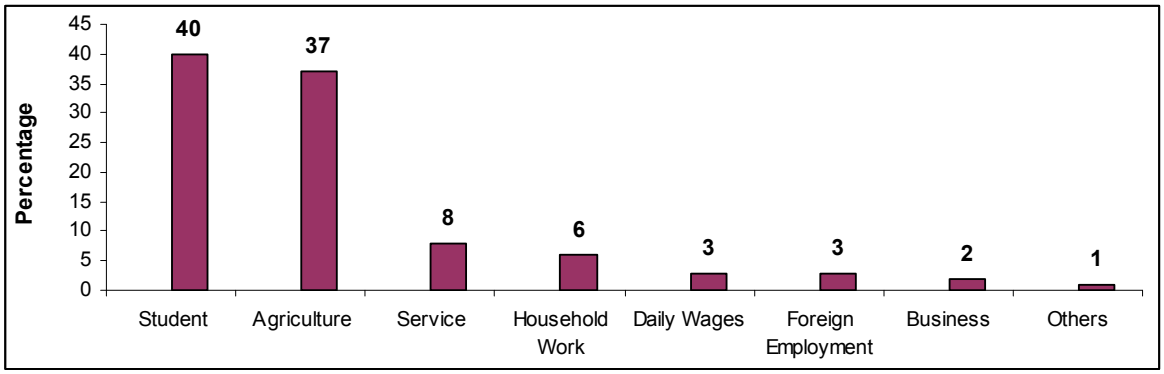
Among total population majority of people were literate (65%) and rest of them (35%) were illiterate. 32% of people were educated up to primary level. 15% were educated up to lower secondary level, 8% were educated up to secondary level and 10% were educated higher than secondary level.

- Educational status was seen higher in Brahmins.
- Male literacy rate was 54% and female literacy rate was 46%.
- Among the total illiterate, Tamang were 40% and Dalits were 7%.

- Among those who had higher education only 10% of them were Tamang and Dalits were just 1%.
- Among Tamang ethnicity, 70% of were illiterate and among Dalits only 50% were literate.

Occupation (Above than 5 years old)

Figure 6: Occupation

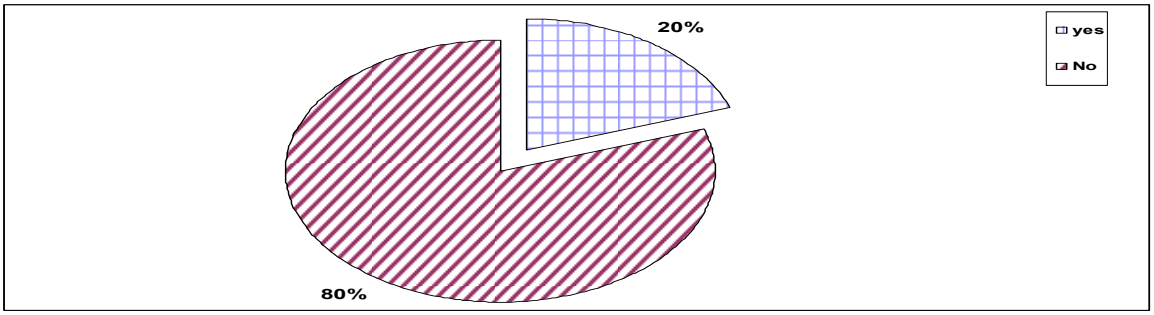


Among the total population 40% were student, 37% had the occupation of agriculture and then other occupation were service, household work and so on as shown in figure.

Tobacco Consumption Habit

Tobacco chewing and smoking has negative effects on health and is associated with increased risk of lung and heart diseases.

Figure 7: Tobacco consumption habit [n=1188]

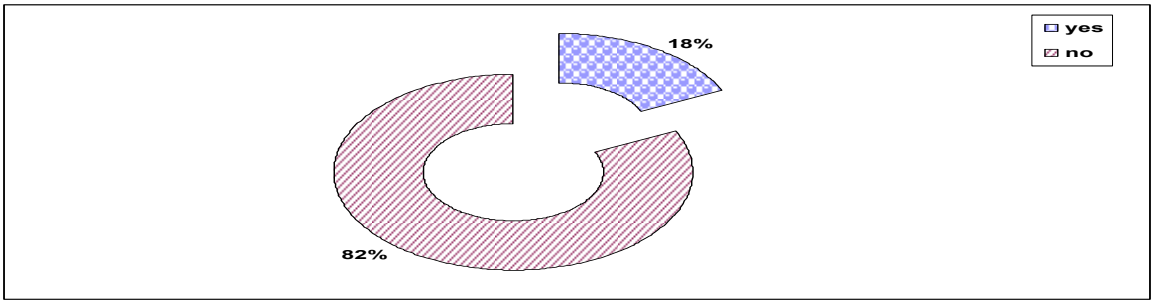


Among total population 20% consumes tobacco. Among total tobacco consumers, 37% were female. Among total consumers, 30% were from Tamang and 7% were from Dalit.

Alcohol consumption

Alcohol consumption has not only bad effect on health. It has social effects also. It also creates the economic burden to the family.

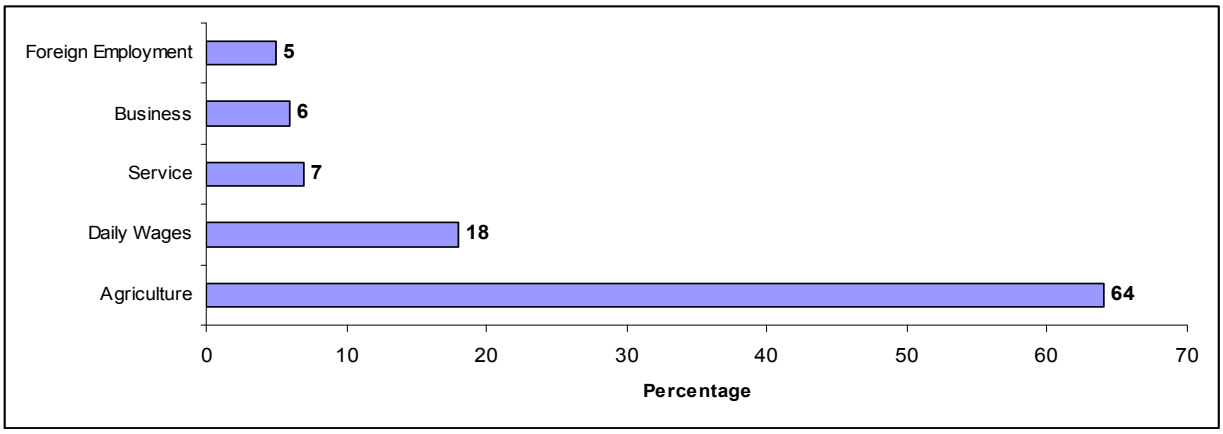
Figure 8: Alcohol consumption [n=1185]



Among the total population18% had drinking habit, among them 41% were female, and most from Tamang.

2.1 Source of income

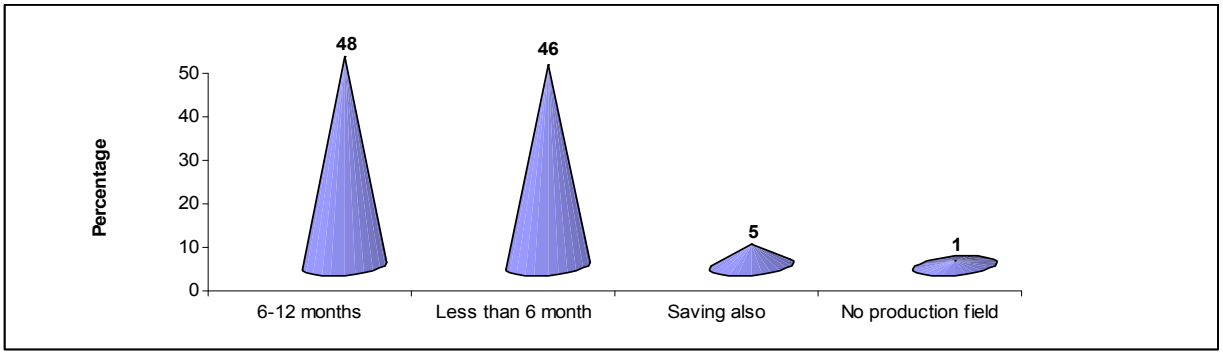
Figure 9: Source of income [n=180]



Main source of income of household was Agriculture (64%) and then daily wages, service, business and foreign employment respectively.

2.2 Longevity of productivity

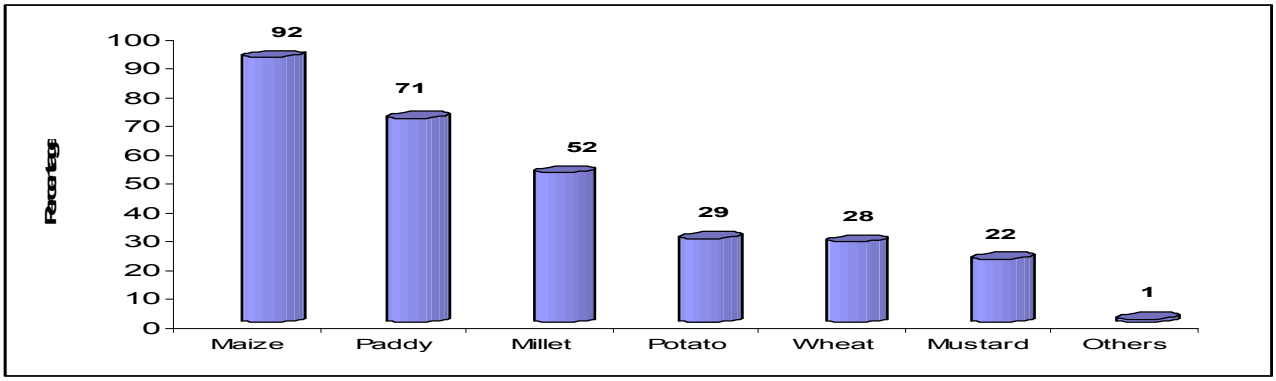
Figure 10: Longevity of productivity [n=180]



As shown in above figure, about half (46%) of total household's production was not adequate for whole year.

2.3 Cultivating main crops

Figure 11: Cultivating main crops [n=180]



The main cultivating crop was maize, 92% of household cultivated maize, similarly 71% cultivated paddy, and 52% cultivated millet, Potato, wheat and mustard were cultivated by 29%, 28 % and 22% respectively.

ENVIRONMENTAL SANITATION

Due to the poor environmental sanitation diseases related to the environment are existing as a public health problem in Nepal. ARI, diarrhea, major cause of U-5 mortality are due to poor environmental sanitation. Similarly other respiratory problems and vector borne diseases are also increasing and re-emerging.

3.1 Source of drinking water

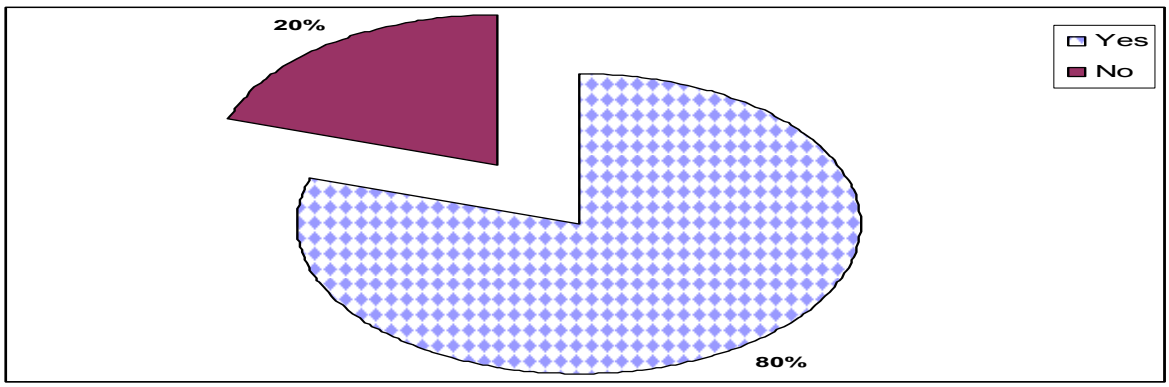
Table 1: Source of drinking water [n=180]

Sources	Percent
Well	5
Tap/pipe	91
River	3
Tank	1
Total	**100**

Almost all the household (91%) had used tap/ pipe as a main source of drinking water.

3.2 Habit of covering drinking water pot

Figure 2: Habit of covering drinking water pot [n=180]



Majority of the household (80%) used to cover the drinking water.

3.3 Method of water purification

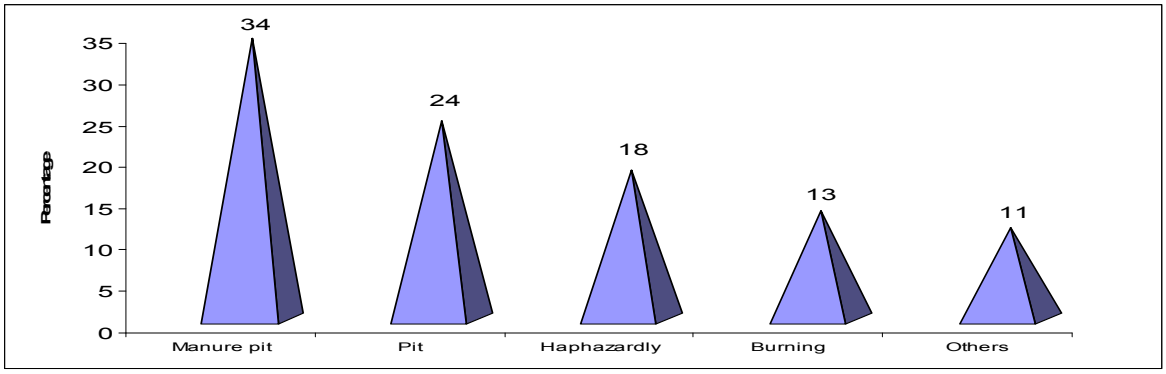
Table 3: Method of water purification [n=101]

Method	Percent
Boiling	24
Filtering	9
Chemical	3
Don not do	63
Others	1
Total	**100**

Among household, who knows about the water purification, only 37% used to purify the drinking water. The most common method was boiling (24%) followed by filtering 9% and chemical 3%.

3.4 Solid waste disposal site

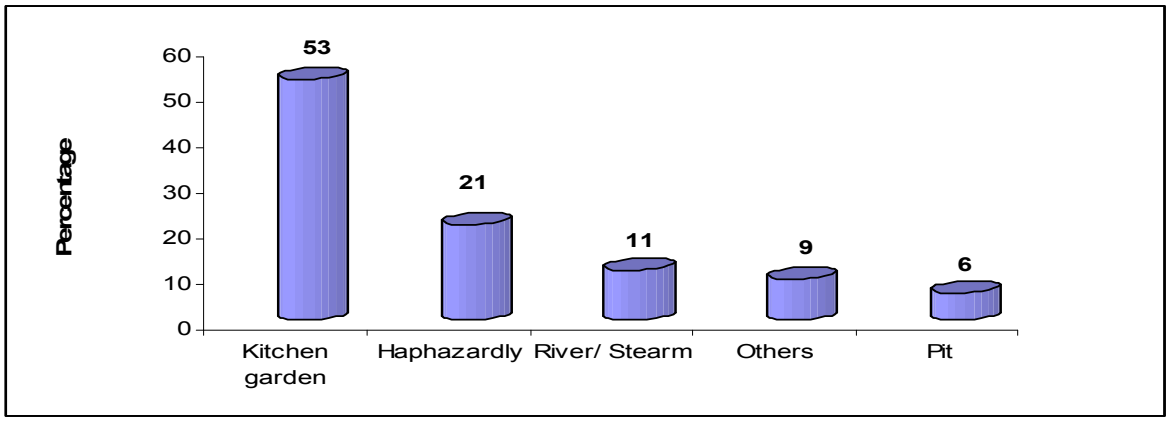
Figure 4: Solid waste disposal site [n=180]



About one third (34%) of total household used to dispose their solid waste in manure pit and 18% disposed haphazardly.

3.5 Liquid waste disposal site

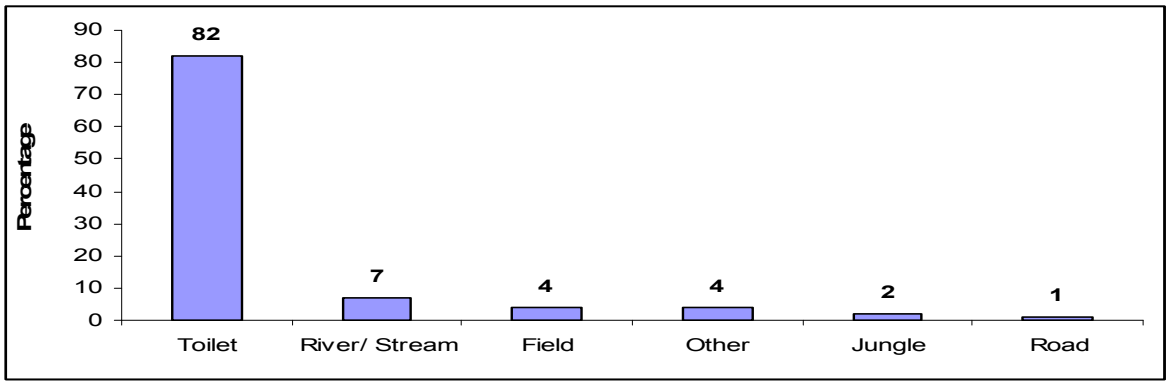
Figure 11: Liquid waste disposal site [n=180]



More than half of household (53%) used to dispose their liquid waste in kitchen garden and 21% disposed haphazardly.

3.6 Excreta disposal site

Figure 12: Excreta disposal site [n=180]



More than two third (82%) of total respondents used to defecate in toilet and other used to openly. Among Tamang ethnicity more than half (56%) used to defecate openly.

3.7 Toilet in house

Table 5: Toilet in house [n=180]

Toilet	Percent
Yes	77
No	23
Total	**100**

Among total respondent, more than two third (77%) of total household had have toilet in their house, Among Tamang ethnicity more than half (56%) household had not have toilet. All Dalit had have toilet in their house.

3.8 Practice of hand-washing after defecation

Table 6: Practice of hand-washing after defecation [n=180]

Hand washing practice	Percent
Yes	98
No	2
Total	**100**

Among total respondents, 2% had not use to wash their hand after defecation and all of them were open defecator, from the Tamang community.

3.9 Hand-washing material

Table 7: Hand-washing material [n=177]

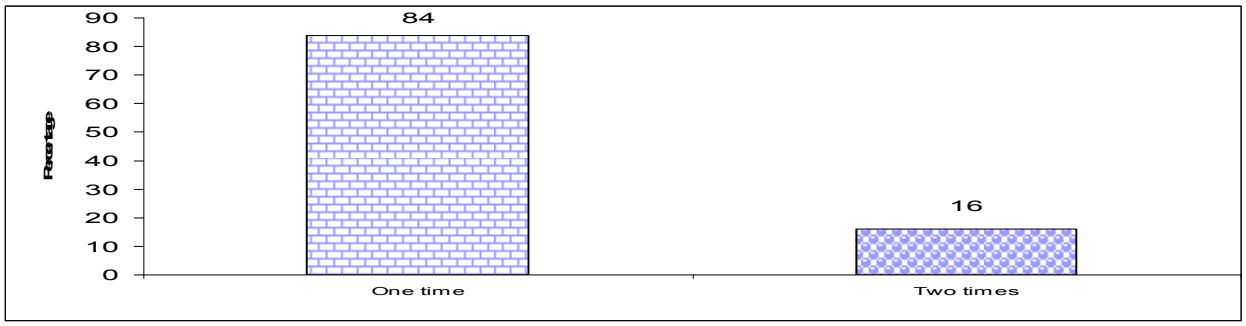
Hand-washing material	Percent
Water	11
Soap water	74
Ash water	11
Mud water	4
Total	**100**

Among total respondent who used to wash their hand after defecation, 74% of them had used soap water and 11% water only.

3.10 Frequency of daily tooth brushing

For the good oral hygiene we should brush our teeth after major meals that means at least two times a day.

Table 8: Frequency of daily tooth brushing [n=159]



Among the 84% of total respondent, who used to brush daily, only 16% of them used to brush twice a day.

3.11 Tooth brushing material

Table 9: Tooth brushing material [n=159]

Material	Percent
Coal	3
Herbs/bamboos	1
Brush/toothpaste	95
others	1
Total	**100**

Almost all (95%) of them had used tooth paste and brush as a brushing material.

3.12 Type of chulo

Table 10: Type of chulo [n=180]

Type	Percent
Wooden chulo	92
Gas chulo	7
Others	1
Total	**100**

Almost all (92%) of total household had used wooden chulo for cooking purpose and 7% used bio-gas or cooking gas.

4. DISEASES

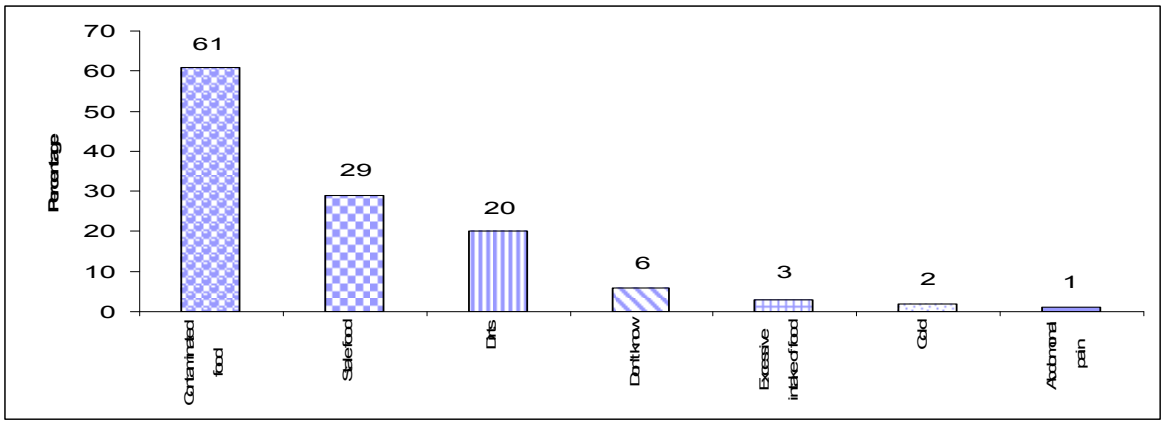
Diarrhea

Passing of loose stool three or more than three times in 24 hours is called diarrhea. It is one of the major public health problems in Nepal.

Dehydration caused by severe diarrhea is major cause of mortality among young children, although it can be easily treated with oral rehydrated solution. Exposure to diarrhea causing agents is frequently related to the use o contaminated water and to unhygienic practices in food preparation and disposal of excreta.

4.1 Cause of Diarrhea

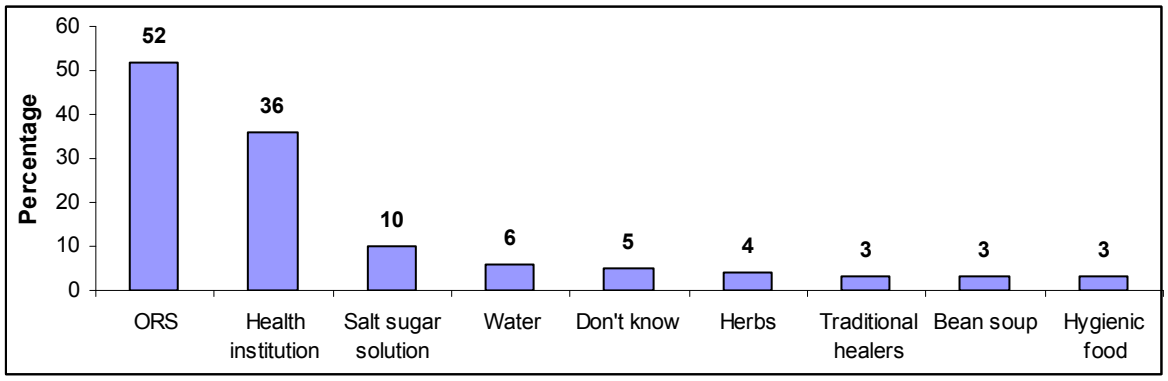
Figure 13: Cause of Diarrhea [n=176]



Among 98% of total respondent, who had heard about diarrhea, 61% were known that it is due to contaminated food and water, 30% due to stale food and 20% due to dirt. Multiple answers were collected.

4.2 Treatment of Diarrhea

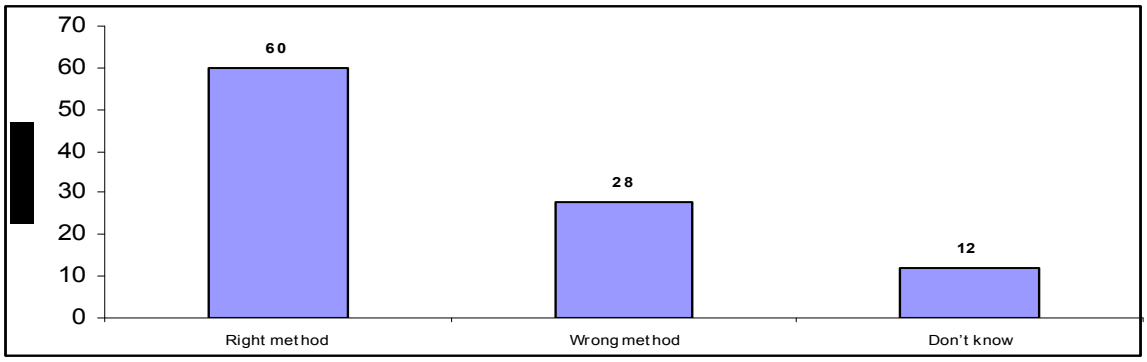
Figure 14: Treatment of Diarrhea [n=176]



Among total respondent, who had heard about diarrhea, only 52% of them had used ORS to treat diarrhea, 36% of them used to go to HI and 3% used to go to the traditional healers.

4.3 Method of Preparing Jeevanjal

Figure 15: Method of Preparing Jeevanjal [n=180]



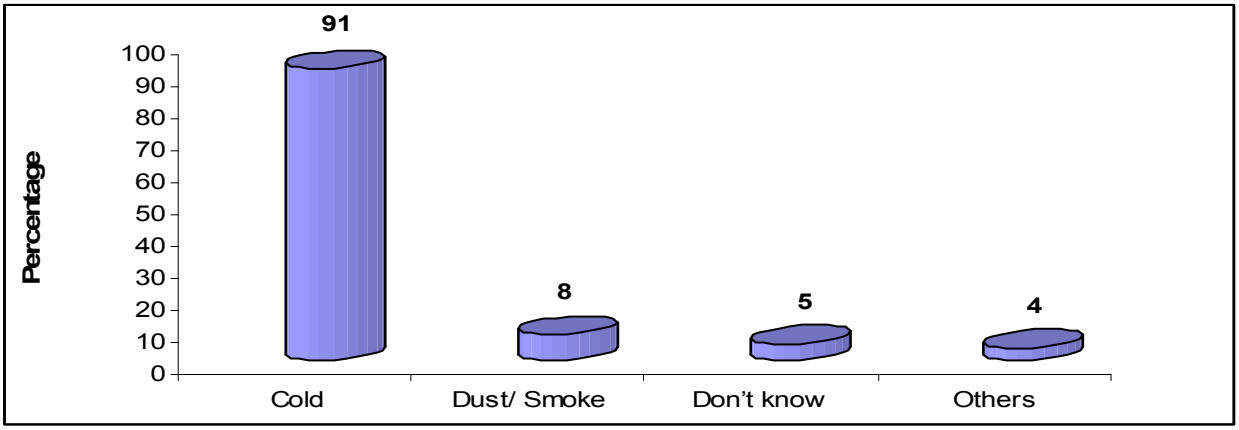
Among the 98% of total respondent, who had heard about Jeevanjal only 60% were known about right metod of preparing it and 12% were unknown.

ARI / Pneumonia

Any infection in the respiratory tract is known as ARI, Pneumonia is the inflammation of the lung tissue. ARI/ Pneumonia is major cause of child mortality. The predisposing factors for ARI/ pneumonia are dust and smoke.

4.4 Cause of Pneumonia

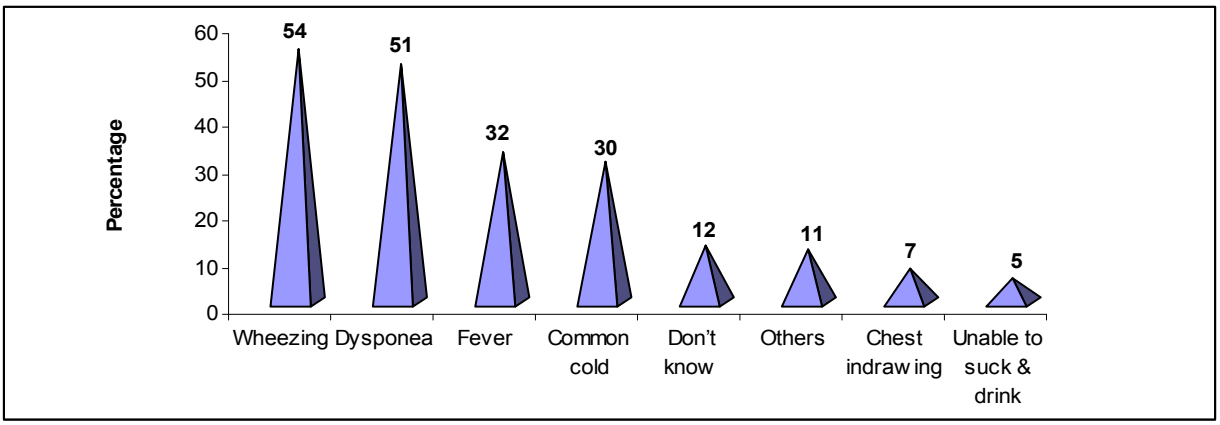
Figure 16: Cause of Pneumonia [n=159]



Among the 91% of total respondent, who had heard about ARI/ Pneumonia 91% said that it is due to cold and only 8% were known that it is due to dust/ smoke. Multiple answers had come from the respondent.

4.5 Symptom of Pneumonia

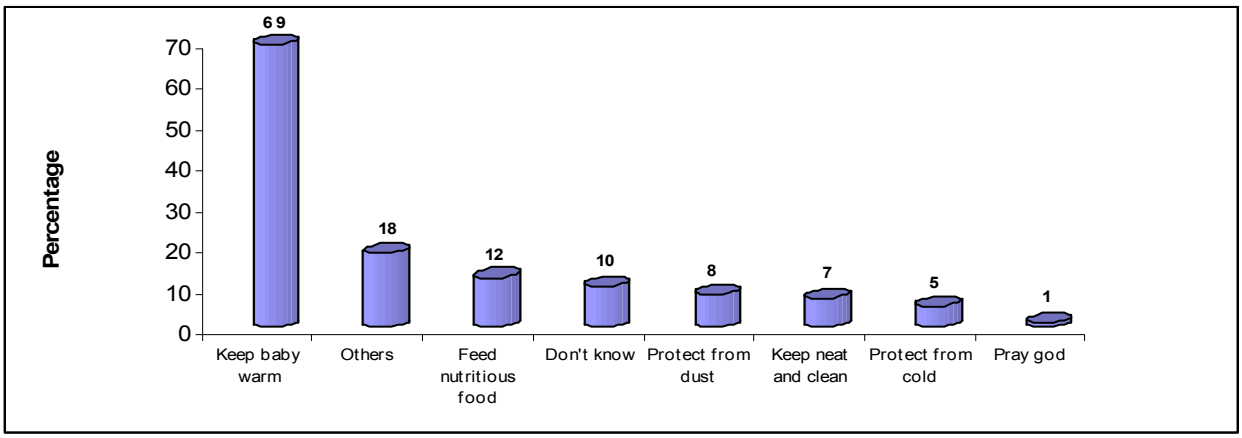
Figure 17: Symptom of Pneumonia [n=159]



The respondents who had heard about ARI/ pneumonia, multiple answers were given about the symptom of diarrhea. 54% of them said wheezing, 51% dysponea, and 12% were unknown about the symptoms.

4.6 Prevention of Pneumonia

Figure 18: Prevention of Pneumonia [n=159]



Multiple answers were given about the prevention of ARI/ Pneumonia. 69% had said protect the baby from cold, only 8% said protect from dust/ smoke and 10% were unknown about it.

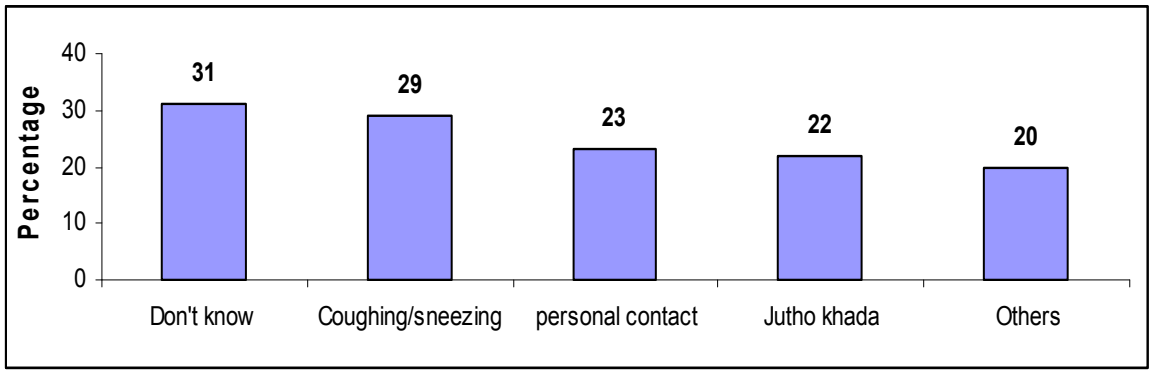
Tuberculosis (TB)

Tuberculosis falls under top ten cause of global mortality in human. It causes more death so it is more threatened disease. Every year 44,000 people develop active tuberculosis of whom 20,000 have infectious disease and annual death is 8000 -11000.

TB is the infectious disease caused by bacteria, Mycobacterium tuberculosis. It is transmitted one person to another through the droplet, mainly during coughing and sneezing.

4.7 Transmission of TB

Figure 19: Transmission of TB [n=147]



Among the 82% of total respondent, who had heard about TB, only about one third (29%) were known about the correct method (coughing and sneezing) of its transmission and 31% of them were unknown about it.

4.8 Case of TB

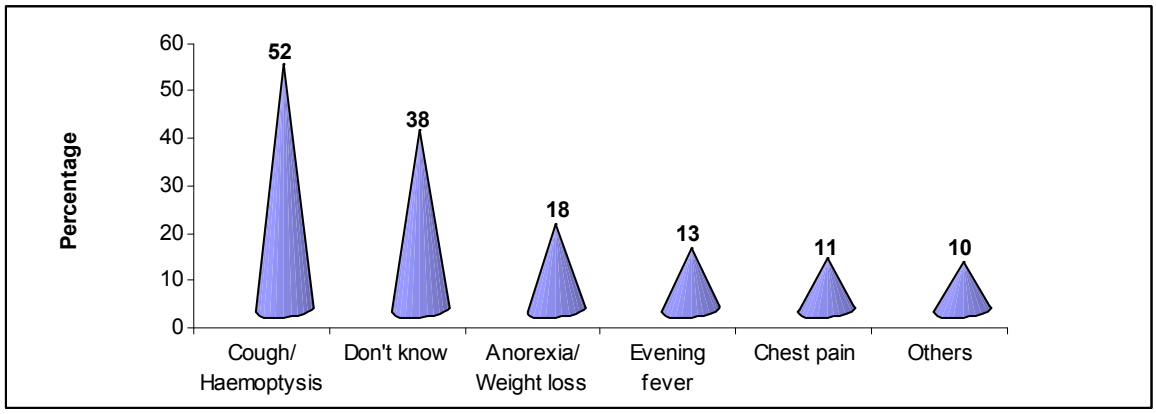
Table 11: Case of TB [n=147]

Case	Percent
Yes	8
No	92
Total	**100**

Only 8% of total respondent, who had heard about TB, had have TB case in past and present as far as they remember.

4.9 Symptoms of TB

Figure 20: Symptoms of TB [n=147]



Among respondent, who had heard about TB had given the multiple answers about the symptoms, 52% had heard cough/ haemoptysis, 18% loss of appetite and 38% were unknown about it.

DOTS:

DOTS is the very effective treatment system of TB, according to this system patients take medicine under the supervision of health worker.

4.10 Knowledge about DOTS

Table 12: Knowledge about DOTS [n=12]

Knowledge	Percent
Correct answer	58
Incorrect answer	42
Total	**100**

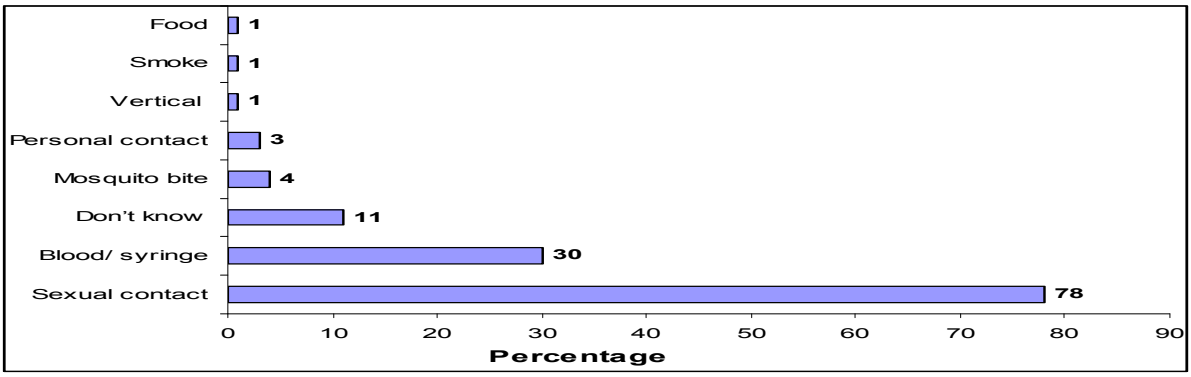
Among 7% of total respondent, who had heard about DOTS, about half (58%) of them had knowledge about it.

STI and HIV/ AIDS

AIDS was first recognized internationally in 1981 and it is growing rapidly throughout the world. HIV/ AIDS pandemic is one of the most serious health concerns in the world today due to the lack of curative treatment or vaccine. Sexual intercourse, intravenous injection, blood transfusion and from infected mother to fetus (vertical transmission) is the main route of transmission of HIV. It can not be transmitted through food, water, insect vectors or causal contact.

4.11 Transmission of STI and HIV/ AIDS

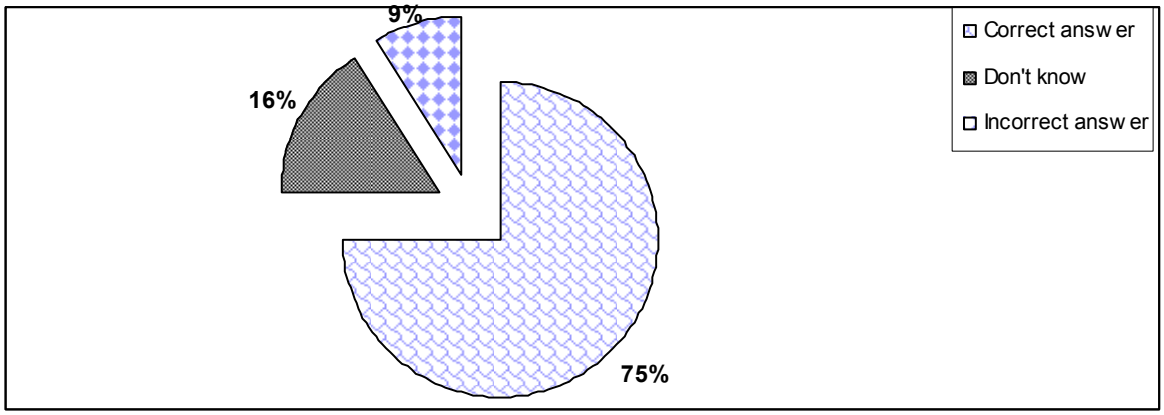
Figure 21: Transmission of STI and HIV/ AIDS [n=139]



From the 77% of total respondent, who had heard about STI and HIV/ AIDS, multiple answers were taken about the cause of disease, 78% and 30% of them said that it was transmitted through the sexual contact and blood/ syringes respectively and 11% were unknown about it.

4.12 Prevention of STI and HIV/AIDS

Figure 22: Prevention of STI and HIV/AIDS [n=139]



The respondents, who had said that STI and HIV/ AIDS could be prevented by avoiding the unsafe sex, was taken as the correct answer. More than two third (75%) of the respondent who had heard about STI and HIV/ AIDS were known about its prevention and 16% of them had no any idea.

4.13 Behavior difference before and after HIV infection

Table 13: Behavior difference before and after HIV infection [n=139]

Behavior	Percent
Yes	55
No	31
Don't know	14
Total	**100**

More than half (55%) of respondent had said that there is behavioral difference to the person before and after the STI and HIV/ AIDS infection.

4.14 Cause of Leprosy

Table 14: Cause of Leprosy [n=104]

Cause	Percent
Purbajanmako pap	3
Germs	11
Don't know	70
Others	16
Total	**100**

Among the 58% of the total respondent who had heard about Leprosy, 70% of them were unknown about the cause of this disease. Only 11% were known that it is due to the Germs.

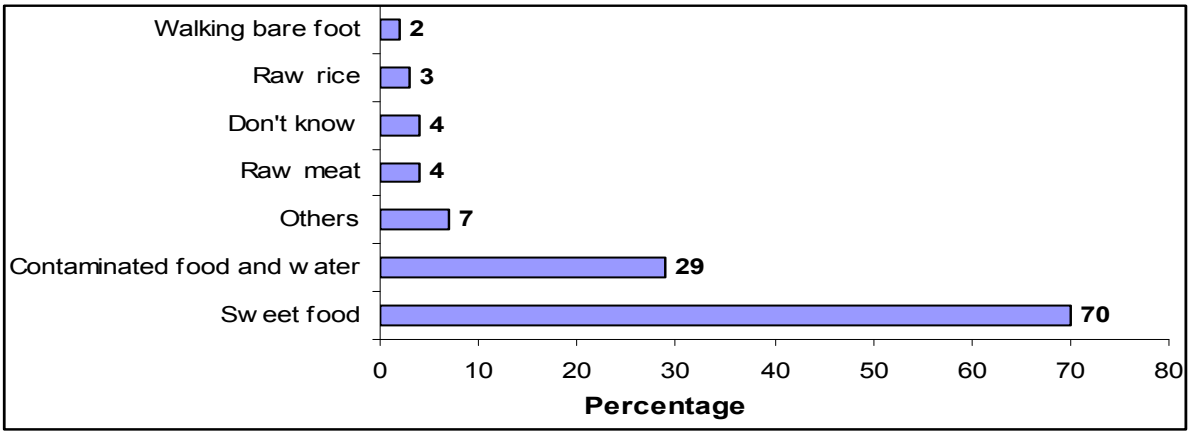
Worm Infestation

Due to the poor environmental and hygienic condition, worm infestation still exists as public health problem in Nepal.

It is transmitted through the food and drink, contaminated with the larva of the worm. Some worms (tape worms) are transmitted through the contaminated raw or undercooked meat. Hook worm is transmitted through the bare foot by penetrating the soft skin.

4.15 Cause of worm infestation

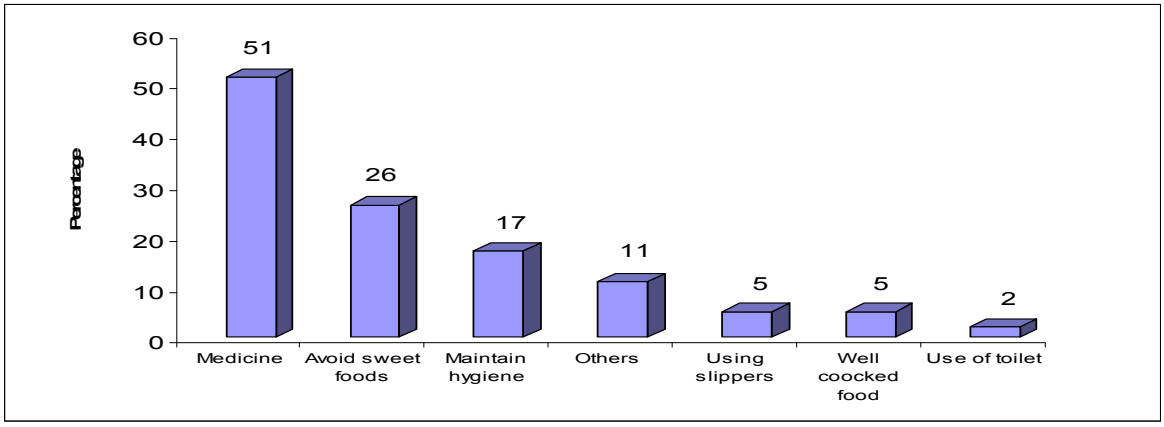
Figure 23: Cause of worm infestation [n=168]



Form the 93% of the total respondent, who had heard about Worm Infestation, multiple answers were taken about the cause of worm infestation, among them 70% had said it is due to the intake of sweet food and only 2% said due to walking with bare foot.

4.16 Prevention of Worm Infestation

Figure 24: Prevention of Worm Infestation [n=168]



Multiple answers were taken about the prevention of worm infection, 51% of the total respondent, who had heard about worm infestation were known that worm infestation can be prevented by taking medicine.

Diabetes

It is the one of the non-communicable diseases which is existing as public health problem. Such non communicable diseases are creating the double burden to the country along with communicable diseases.

4.18 Prevalence of Diabetes

Table 15: Prevalence of Diabetes [n=137]

Prevalence	Percent
Yes	5
No	94
Don't Know	1
Total	**100**

Among the 76% of total respondent who had heard about Diabetes, only 5% had diabetic patient at their home at study time.

4.19 Prevalence of Hypertension

Table 16: Prevalence of Hypertension [n=131]

Prevalence	Percent
Yes	21
No	79
Total	**100**

Among 73% of total respondent, who had heard about hypertension 21% had have hypertensive patient at their home at the study time.

4.20 Prevalence of Cancer

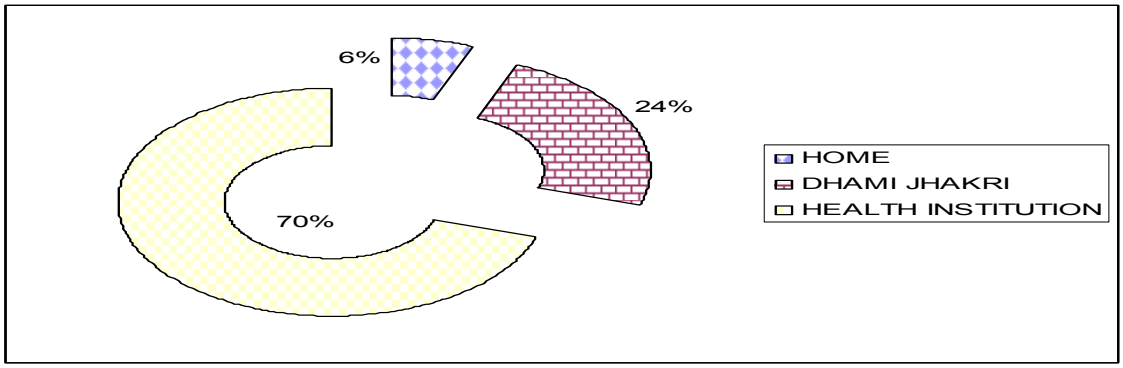
Table 17: Prevalence of Cancer [n=146]

Prevalence	Percent
Yes	0
No	100
Total	**100**

Among the 81% of respondent who had heard about Cancer, there was no case at the study time.

5.1 Place of contact after getting ill

Figure 25: Place of contact after getting ill [n=180]



According to the above figure, 70% of total respondents' family members used to go to HI when they get ill. 24% had contacted trditional healers firstly when they get ill. 60% of them, who were used to go to traditional healers were Tamang. It was seen that Tamang community firstly contact their LAMA (traditional healer) when they get ill.

5.2 Morbidity within 15 days

Table 18: Morbidity within 15 days [n=49]

Morbidity	Percent
Yes	27
No	73
Total	**100**

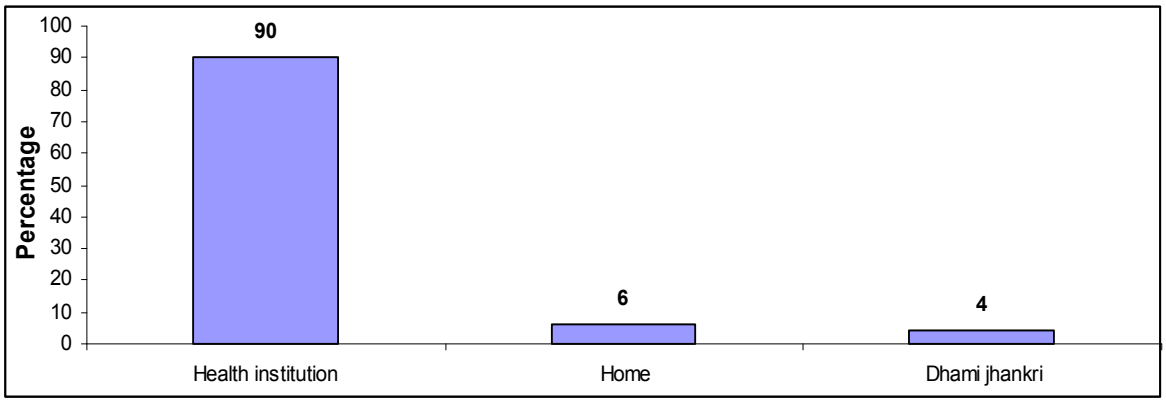
As shown in above table, in 27% of the total household, there were sick person within two weeks.

5.3a Health problems with in 15 days

Among the family members who were sick, 56% of them were suffered from fever/ typhoid, 26% were suffered from ARI and 2% were from measles as said by the respondents.

5.3b Place of treatment

Figure 19: Place of treatment [n=49]



Among the sick people, 90% had taken treatment from the HI similarly, 4% had taken from traditional healers.

5.3c Treatment Method

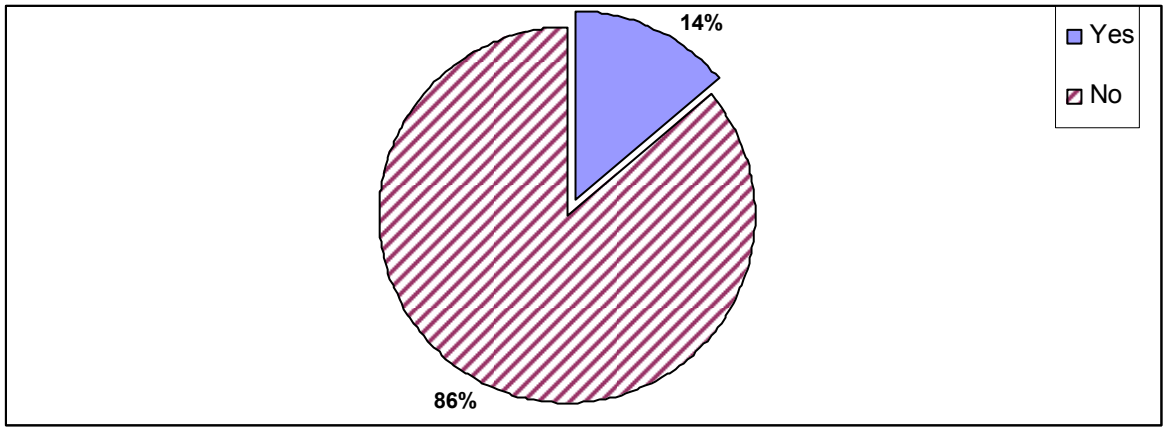
Table 20: Treatment Method [n=49]

Method	**%**
Taking medicine	86
Jharfuk	4
Home treatment	2
ORS	4
Warm fluid	4
Total	**100**

According to above table, 86% of the sick member had taken medicine. And 4% had done Jharfuk (traditional method), among them 50% were the Tamang. All Dalits who were sick had taken medicine.

5.4 Birth within 1 year

Figure 21: Birth within 1 year [n=180]



According to above Figure, there was birth only in 14% of total household.

5.5a Live Birth

Table 22: Live Birth [n=26]

Live Birth	%
Son	39
Daughter	61
Total	**100**

Among the total birth 61% were female baby, there was no still birth**.**

5.6 Mortality within 1 year

Table 23: Mortality within 1 year [n=7]

Mortality	%
Yes	4
No	96
Total	**100**

Among the total household, there was mortality only in 4%.

5.7a Cause of Death

Table 24: Cause of Death [n=7]

Cause	%
High blood pressure	13
Accident	29
Due to old age	29
Asthma	29
Total	**100**

The leading causes of death were Asthma, accident, old age and hypertension respectively.

MATERNAL AND CHILD HEALTH

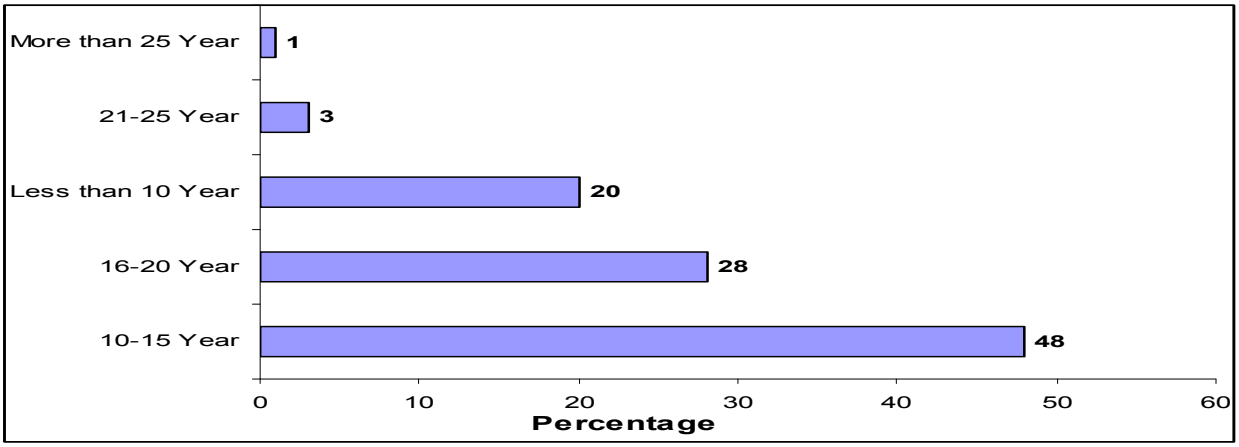
The term maternal and child health refers to the promotive, preventive, curative and rehabilitative health care for mothers and children. It includes the sub-area of maternal hearth, child health, family planning, school health, handicapped children adolescence health, and health aspects of care of children in special settings such as day care.

In Nepal 281 mothers are dying in 1,00,000 live birth and 33 neonatal deaths per 1,000 live births.

7.1 Age at Marriage

The onset of child bearing at an early age has major adverse effect on the health of both mother and child. It also lengthens the reproductive period, thereby increasing the level of fertility.

Figure 26: Age at Marriage [n=180]

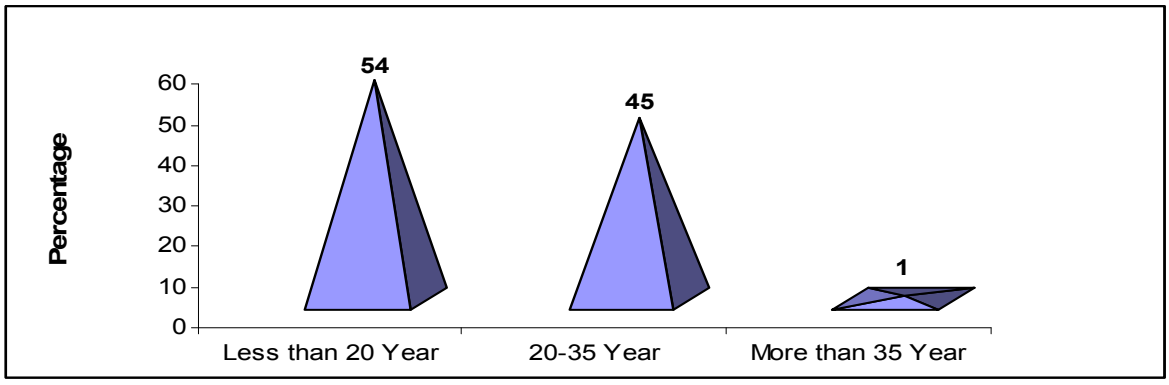


According to the above figure, about half (48%) of total respondent had got marriage with in 10-15 years of age, only 5% had got after 21 years.

7.2 Age of first delivery

All reproductive organs of female become fully developed only after 20 so; age at first delivery should be at least 20 for well being of woman and baby.

Figure 27: Age of first delivery [n=180]



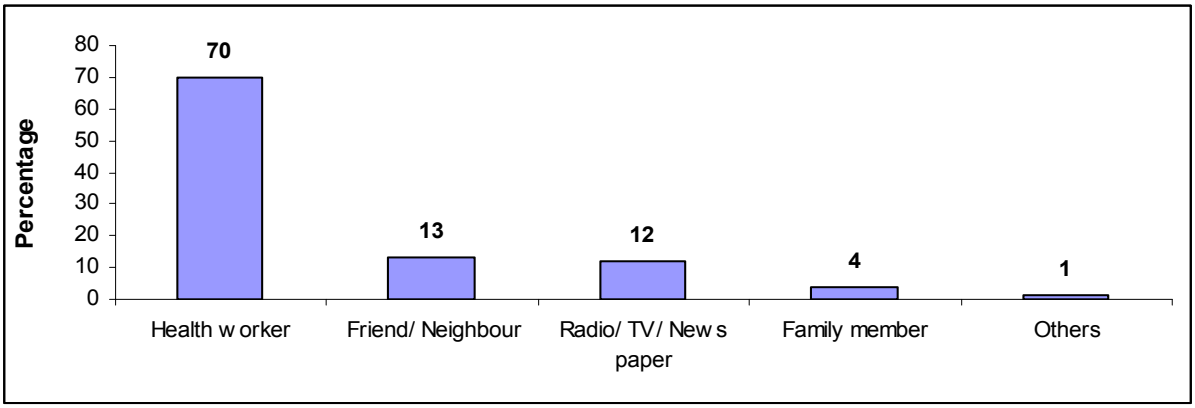
Only 45% of respondents were 20 and more than 20 years at their first delivery.

Antenatal Care

It is the care of the women during pregnancy, the primary aim of ANC is to achieve at the end of a pregnancy healthy mother and a healthy baby.

7.3 Source of information about ANC

Figure 28: Source of information about ANC [n=147]



Among the 82% of total respondent; who had heard about ANC, 70% of them had heard from the health worker (mostly from FCHVs) and 12% had heard from radio/ TV/ newspaper as shown in figure.

7.4 ANC visit in last pregnancy

Table 25: ANC visit in last pregnancy [n=180]

visit	**%**
Done	54
Not done	46
Total	**100**

According to above figure, about half (54%) of the mother had done ANC. It was seen that elderly respondent had not done ANC visit.

7.5 Frequency of ANC visit in last pregnancy

The mother should attend the antenatal clinic at least 4 times during her pregnancy. It should be done at any time when any problem arises.

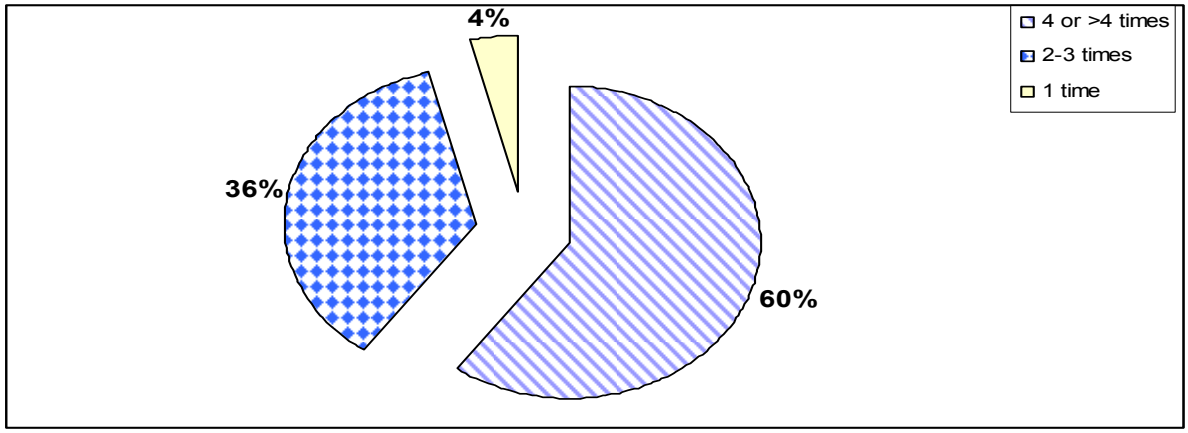
1st visit- as soon as the pregnancy is known/ suspected

2nd visit- within 5-7 months of pregnancy

3rd visit- at 9 month

4th visit- at the week of expected date of delivery.

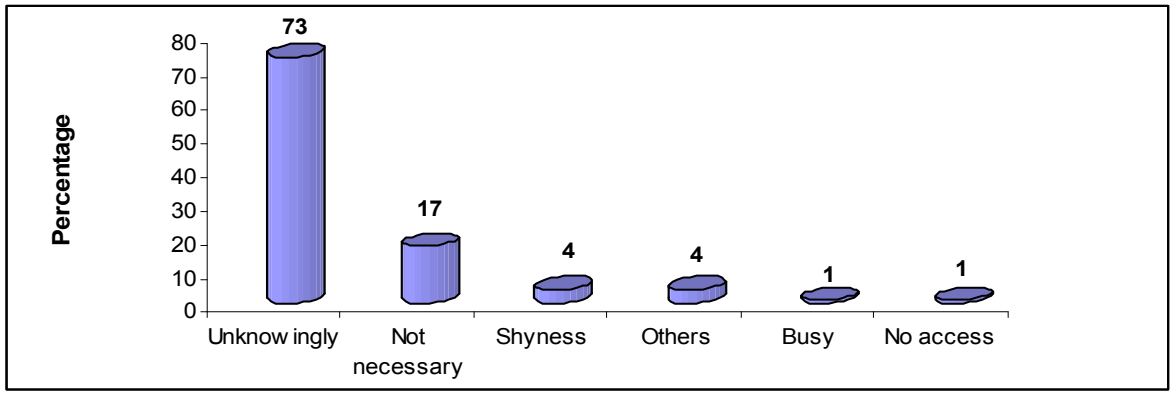
Figure 31: Frequency of ANC visit on last pregnancy [n=98]



More than half (60%) of respondendents who had done ANC, had done it four or more than four times. This may be due to that those who were attended the ANC clinic were fully counseled. Among those who had done four or more than four times 18% were Tamang and 9% were Dalit. Within Tamang ethnicity 44%, within Dalit ethnicity 80% and within the Brahmin ethnicity 79% of resondents had done ANC four or more than four times.

7.6 Reason for not ANC visit

Figure 29: Reason for not ANC Visit [n=82]

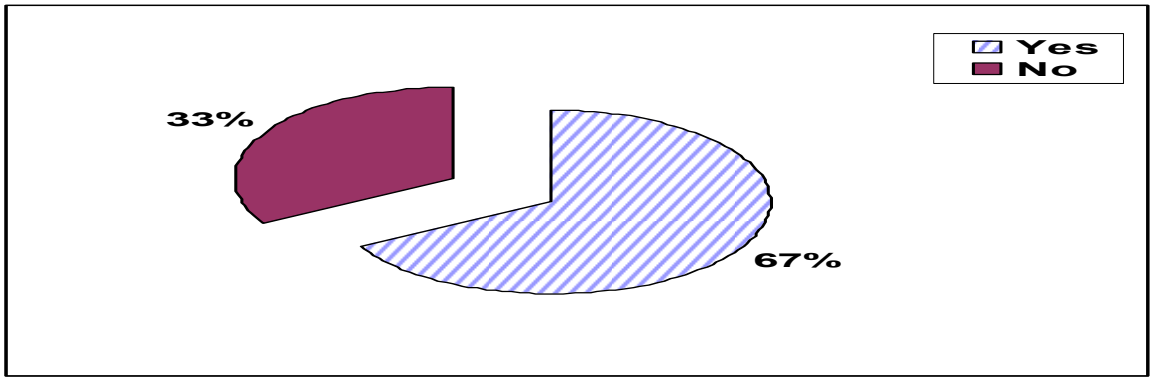


Among those who had not done ANC, 73% of them had not done it due to the lack of awarness and 4% due to shyness.

7.7 TT injection taken

Two injections of TT should take by a pregnant mother during her pregnancy to prevent maternal and neonatal tetanus. First dose in second trimester and another dose after 1 month but it should be taken within 9 month.

Figure 30: TT injection taken [n=180]



According to above figure, 67% of total respondent had taken TT injection. It is higher than the ANC visit; it may be due to its availability at ward level. According to the HP record of FY 2063/ 064 only 57% had taken it two times. This may be due to that respondent might had taken only once and, ward no.1, 2, 3, 9 used to go to Trisuli Hospital for ANC.

7.8 Reason for not TT immunized

Table 26: Reason for not TT immunized [n=60]

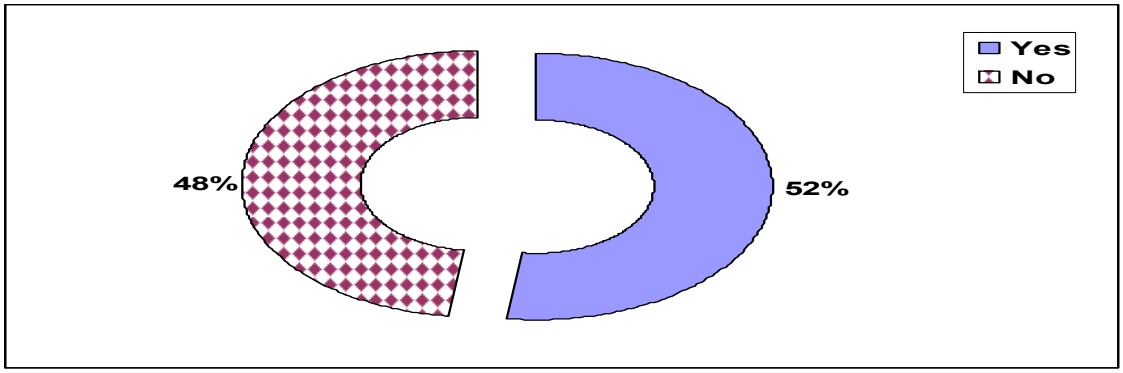
Reason	**%**
Unknowingly	83%
Not necessary	10%
Not access	2%
Farness	3%
Other	2%
Total	**100**

Among those who had not taken ANC, more than two third (83%) of them had not taken due to lack of awareness.

7.9 Iron tablet taken

Iron tablet is also necessary during pregnancy to prevent anemia. It should be taken from beginning of 4 months of pregnancy to 6 weeks after delivery.

Figure 31: Iron tablet taken [n=180]



According to above figure 52% of total respondent had taken iron tab. this is higher than ANC visit and may be due to supply of iron tab. by FCHVs at their household.

7.10 Reason for not taking Iron Tab during last pregnancy

Table 27: Reason for not taking Iron Tab during last pregnancy [n=86]

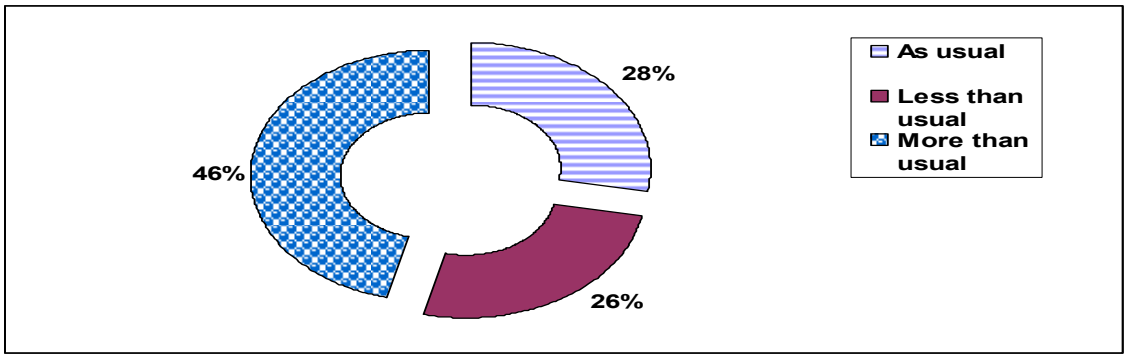
Total	**%**
Unknowingly	85
Boring	6
Others	9
Total	**100**

Among those respondents who had not taken ANC 85% of them had not taken it due to lack of awareness.

7.11 Frequency of taking food during pregnancy

Pregnant mother need extra nutritious food for herself and growing fetus. Her weight should be increased by at least 10kg during her pregnancy.

Figure 32: Frequency of taking food during pregnancy [n=180]



According to the above figure, 46% of total respondents were known that, they should take extra frequency of food during pregnancy.

7.12 Food prohibition during last pregnancy

There are still some negative food taboos relating to the pregnancy. There are no especial foods to be prohibited during pregnancy.

Table 28: Food prohibition during last pregnancy [n=180]

Food prohibition	**%**
Yes	1
No	99
Total	**100**

Only 1% of total respondent had prohibited the food and that was chilli.

7.13 Deworming in last pregnancy

Deworming is also necessary in pregnancy to prevent anemia and hook worm infestation.

Table 29: Deworming in last pregnancy [n=180]

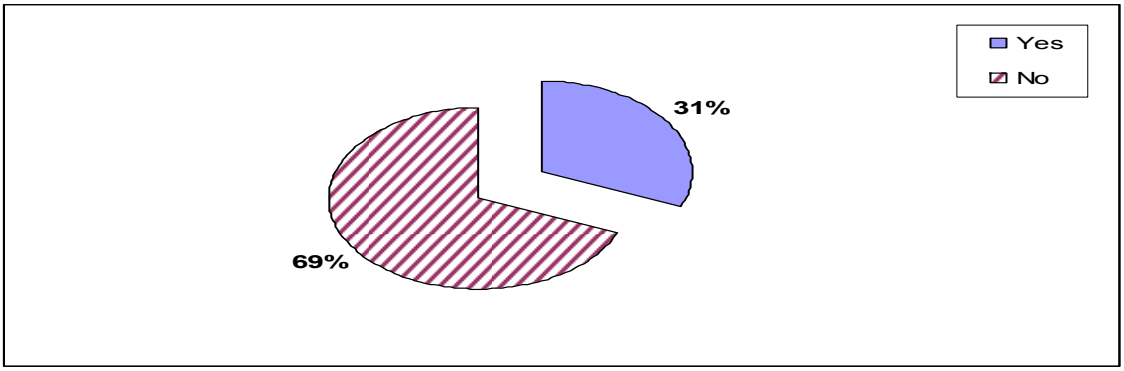
Deworming	**%**
Yes	36
No	64
Total	**100**

According to above table, 36% of total respondents were not dewormed. This is seen lower than ANC visit and may be due to that policy of Deworming pregnant women has come in recent years.

7.14 Smoking and drinking habit during pregnancy

Smoking and drinking habits during pregnancy had so many bad effects for mother and fetus also. It is associated with low birth weight.

Figure 33: Smoking and drinking habit during pregnancy [n=180]



According to above figure 31% of total respondents used to smoke and drink alcohol during pregnancy. Among them 46% were from Tamang ethnicity and 6% were from Dalit ethnicity.

7.15 Complication during last pregnancy

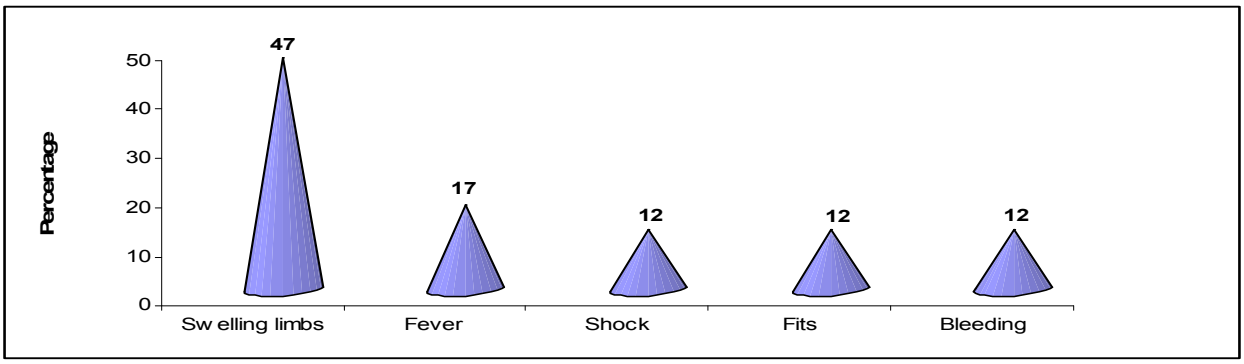
Figure 34: Complication during last pregnancy [n=180]

Complication	**%**
Yes	9
No	91
Total	**100**

ANC visit practice seems too satisfactory as compare to National may be due to that only 9% of total respondent had complication during their last pregnancy.

7.16 Type of complication during last pregnancy

Figure 35: Type of complication during last pregnancy [n=17]

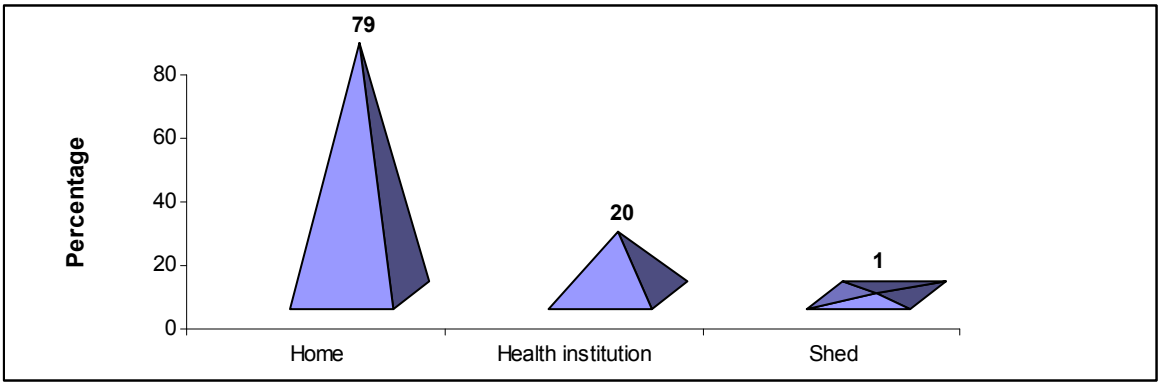


Among the respondendent who had complication, 47% had sweeling limbs, 17% had fever and 12% had shock, fits and bleeding.

7.17 Birth place of last pregnancy

Delivery should be in health institution in presence of trained health worker. The chance of maternal and infant mortality is high in deliveries which are not taken in HIs.

Figure 36: Birth place of last pregnancy [n=180]

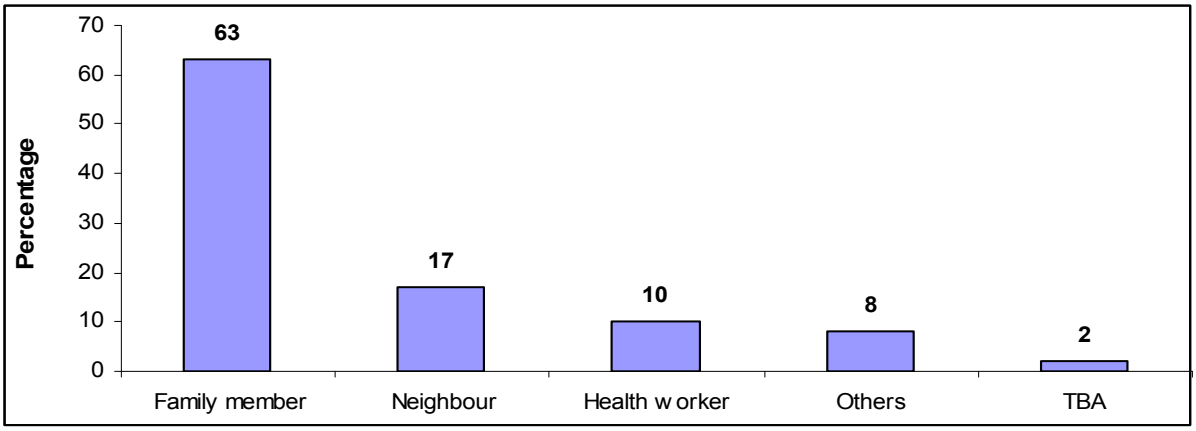


More than two third (79%) of total respondend's deliveries were at home and 20% were in health institution. It is similar to the national figure. Within Tamang ethnicity 93%, within Dalit 63% and within Brahmin 72% deliveries were at home.

7.18 Delivery assisting person in last delivery

Obstetric care from the trained person during delivery is recognized for the reduction of maternal and neonatal mortality (Children delivered at home are usually more likely to be delivered without assistance from a health professional, where as children delivered at a health facility are more likely to be delivered by a trained health professional)

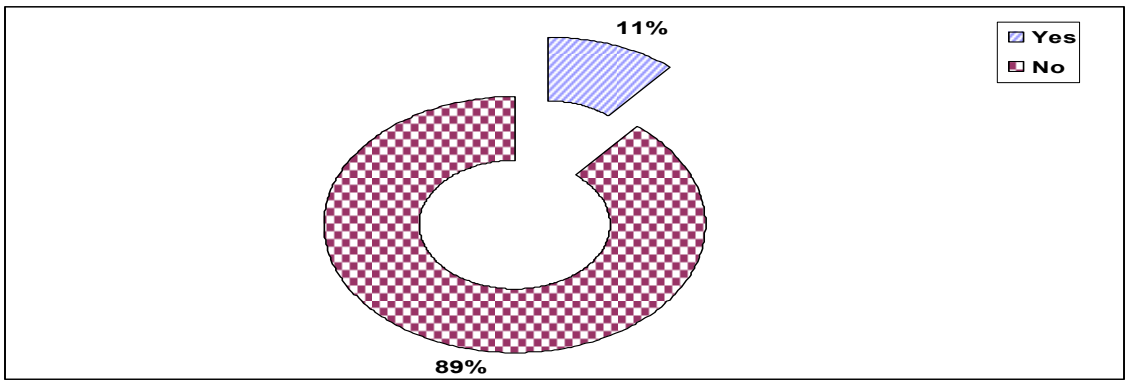
Figure 37: Delivery assisting person in last delivery [n=145]



Study found that, among the deliveries which were at home 63% were assisted by family members, and only 10% were assisted by health worker.

7.19 Complication during last Delivery

Figure 38: Complication during last Delivery [n=145]



Among the deliverires which were at home, only 11% of them had complication.

7.20 Type of complication

In Nepal 47% of maternal mortality are due to post partum hemorrhage following by prolong labor 16%.

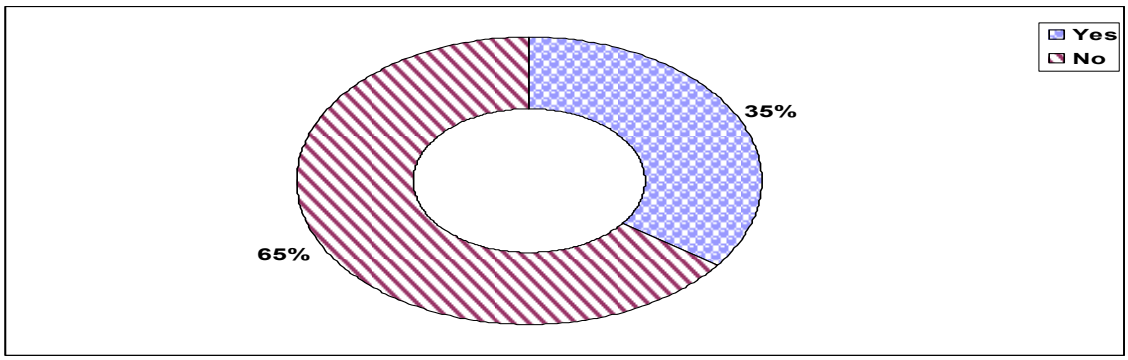
Table 30: Type of complication [n=16]

Type	**%**
Heavy bleeding	50
Retained placenta	12
Prolong labor	13
Shock	6
Others	19
Total	**100**

Among the respondent who had complication during delivery, 50% of them had heavy bleeding (post partum hemorrhage).

7.21 Use of delivery kit in last delivery

Figure 39: Use of delivery kit in last delivery [n=145]

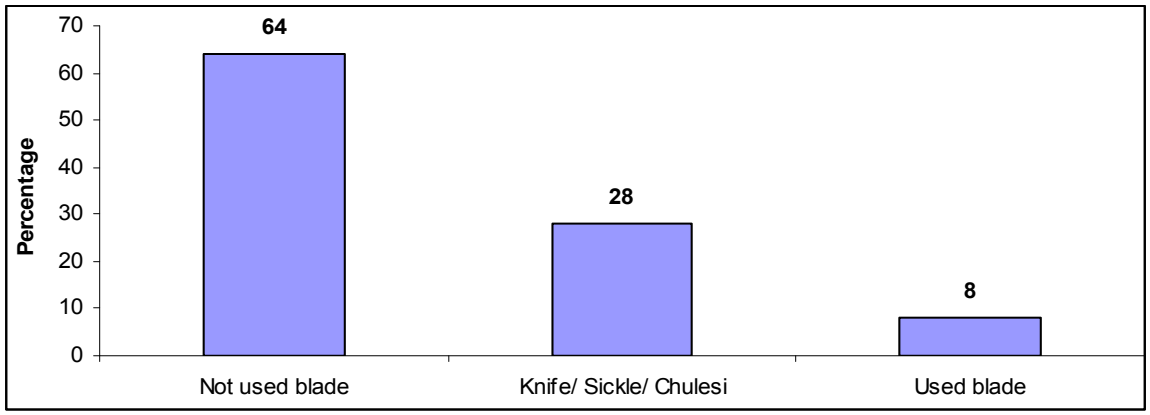


Among 72% of respondents who had heard about delivery kit, only 35% of them had used it.

7.22 Cord Cutting Material in Last Delivery

Cord cutting practice is associated with the neonatal tetanus. So, to prevent neonatal tetanus cord should cut by safe and sterilized instrument. New and not used blade with seal can be taken as safe.

Figure 40: Cord Cutting Material in Last Delivery [n=145]



Study found that, among the resondents whose delivery was at home, 64% had used not used blade to cut cord. It was seen that the elderly respondents had used unsafe instrument.

Among the respondents who had used knife/ sickle/ chulesi to cut cord, 69% of them were Tamang, 24% were Brahmin and 3% were Dalit. Within Tamang ethnicity 52% and within Dalit 20% had used knife/ sickle/ chulesi.

7.23 Vitamin “A” capsule taken during last postnatal period.

Vitamin “A” capsule is given to the mother within 6 weeks of delivery. It is given to prevent maternal night blindness.

Table 31: Vitamin “A” capsule taken during last postnatal period [n=180]

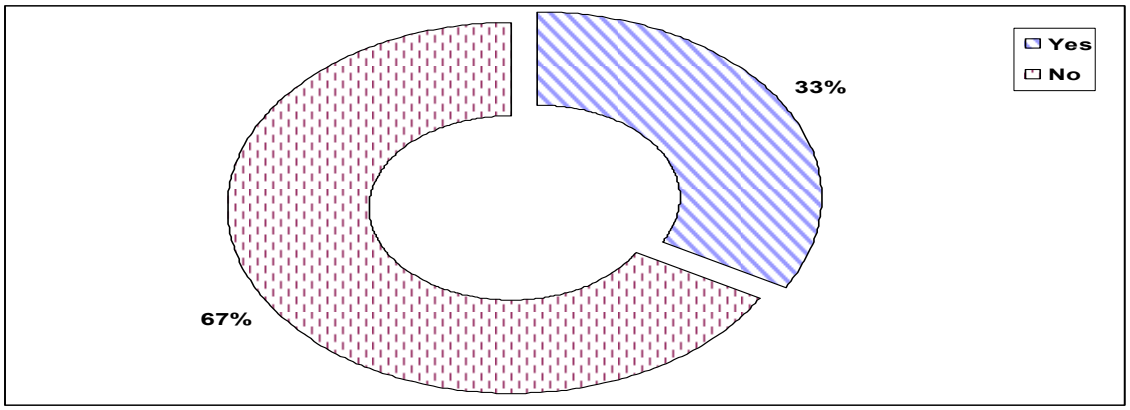
Taken	**%**
Yes	49
No	51
Total	**100**

Though 20% of deliveries were at HI, about half (49%) of total respondents had taken Vitamin “A” capsule. This may be due to supply of Vitamin A by FCHVs and may be taken in immunization clinics.

7.24 PNC visit done last postnatal period

Care of the mother (and the new born) after delivery is known as postnatal care. It should be done to prevent IMR and MMR.

Figure 41: PNC visit done last postnatal Period [n=180]



Study found that among the total respondent, 67% had not done PNC visit. Amog them most (47%) were Chhetris, Tamang 33% and Dalits 6%. Within Tamang ethnicity 37%, within Dalit 38% and within Chhetris 47% had done it.

7.25 Frequency of PNC visit during last postnatal period

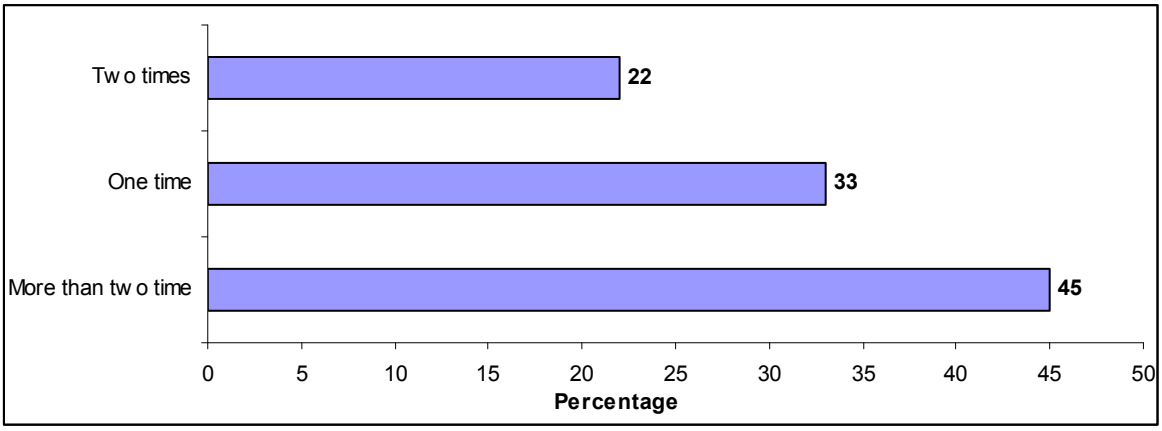
PNC visit should be done at least 3 times and if necessary should be more than this.

1st - Within 24 hours of delivery

2nd - Within 7 days of delivery

3rd - within 7 weeks of delivery

Figure 42: Frequency of PNC visit during last postnatal period [n=60]



Among the respondents who had done PNC visit, 45% of them had done more than two times. Within the ethnic groups, 27% of Tamang respondents, 67% of Dalit respondents, and 60% of Brahmin respondents had done PNC visit for more than two times.

7.26 Duration of rest during last postnatal period

After delivery, mother should take rest for at least six weeks. This period helps in the restoration of mother to optimum health.

Table 32: Duration of rest during last postnatal period [n=180]

Duration	**%**
Less than 6 weeks	54
6 weeks	9
More than 6 weeks	37
Total	**100**

Study found that only 9% of total respondents had taken rest for six weeks, 37% more than six weeks after delivery and 54% were taken rest for less than 6 weeks.

7.27 Problem of Uterine Prolapse

In Uterine prolapse, the uterus has moved from its normal position. This is mainly due to repeated pregnancies, early pregnancy; prolong labour and lack of rest during post natal period. Uterine prolapse is considered as a major cause of maternal morbidity among women in Nepal.

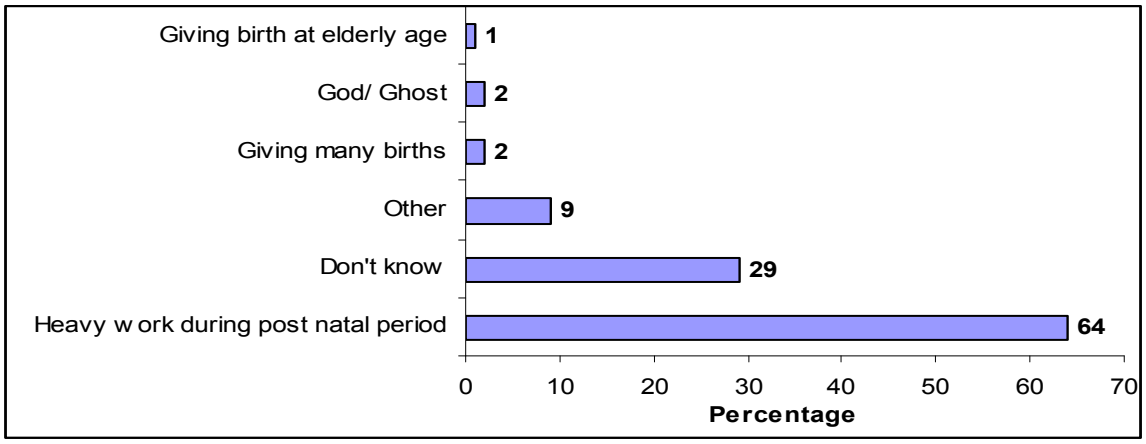
Table 33: Problem of Uterine Prolapsed [n=180]

Problem	**%**
Yes	13
No	87
Total	**100**

According to the above table, only 13% of total household member had this problem. Though here figure is small, but in felt health problem it has appeared as second. Rest during post partum period is poor and age at first delivery is high in below 20 years group. So this problem is existing as hidden health problem.

7.28 Cause of uterine prolapse

Figure 43: Cause of uterine prolapse [n=180]



According to above figure, 64% of total respondent had said that uterine prolapse is due to heavy work during post partum period, 29% were unknown about its cause and 2% said due to god/ ghost.

7.29 Practices during uterine prolapse

Figure 44: Practices during Uterine prolapse [n=180]

Practice	**%**
Treatment in Health Institution	42
Taking advice with sisters	2
Hide	1
Consult with Traditional Healers	2
Don't know	43
Others	10
Total	**100**

Study found that, 42% of total respondent said to take treatment from Health Intitution, 43% were unknown about what to do, and 2% said to consult with traditional healers.

7.30 Knowledge about colostrum feeding

The milk which comes at first after delivery is called colostrum. Colostrum is considered as first immunization of child and is also very nutritious for new born. It is also rich in anti infective factors which protects baby against respiratory infections and diarrheal diseases.

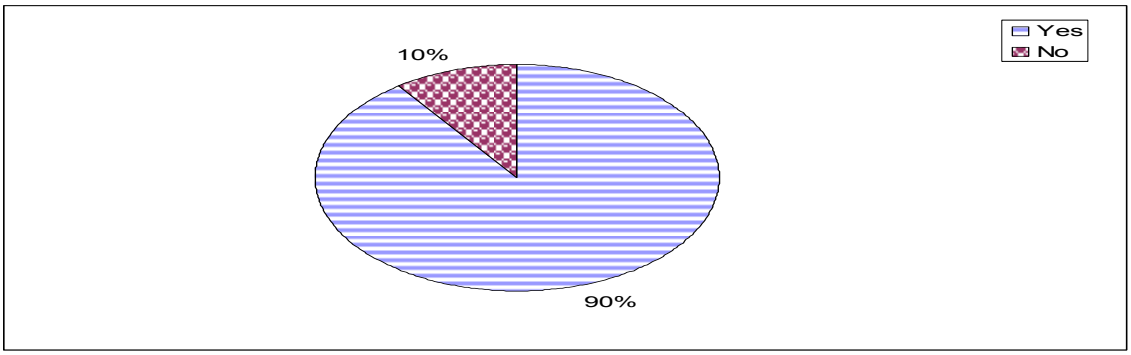
Table 34: Knowledge about colostrum feeding [n=180]

Knowledge	%
Yes	94
No	4
Don't know	2
Total	**100**

According to above table, 94% of the total respondents were known that it should be feed to their children.

7.31 Practice of Colostrum Feeding

Figure 45: Practice of Colostrum Feeding [n=180]



Study shows that 90% of total respondent had fed colostrum to their children. Among those who had not fed 57% were from Tamang. All Dalit had fed.

7.32 Reason for not feeding colostrum

Table 35: Reason for not feeding colostrum [n=18]

Reason	%
Not necessary	6
Fear of bad effect	67
Unknowingly	5
Others	22
Total	**100**

Among those who had not fed colostrum, 67% of them had not fed due to the fear of bad effect.

7.33 Knowledge about exclusive breast feeding

Breast milk is the optimal source of nutrients for infants. Exclusive breast feeding is recommended during the first six months of child's life.

Table 36: Knowledge about exclusive breast feeding [n=180]

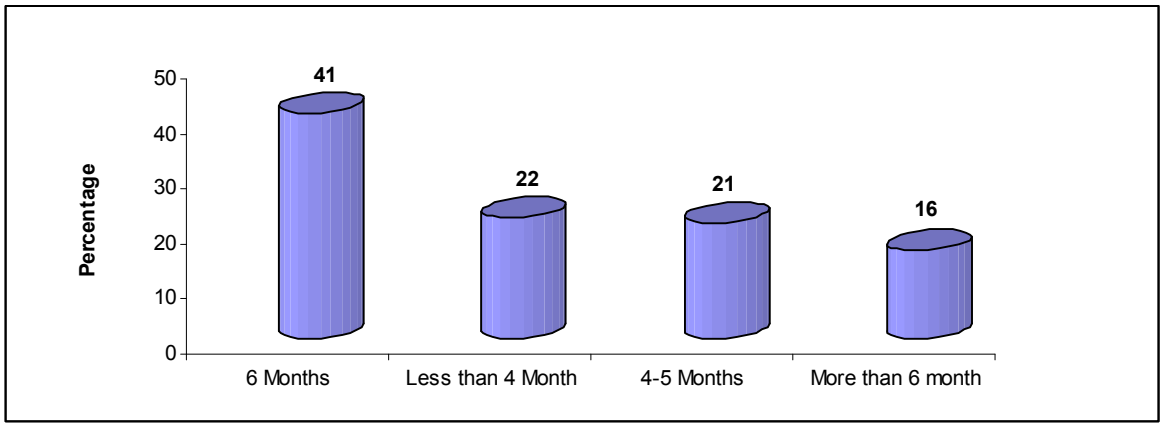
Knowledge	%
Less than 6 month	23
6 month	52
More than 6 month	25
Total	**100**

Only about half (52%) of respondents were known that exclusive breast feeding should be done for six month.

7.34 Practices about Supplementary Food

After reaching the age of six months, a child requires supplementary food in addition to breast milk since breast milk alone is not sufficient to meet a child's nutritional requirements.

Figure 46: Practice about supplementary Food [n=180]

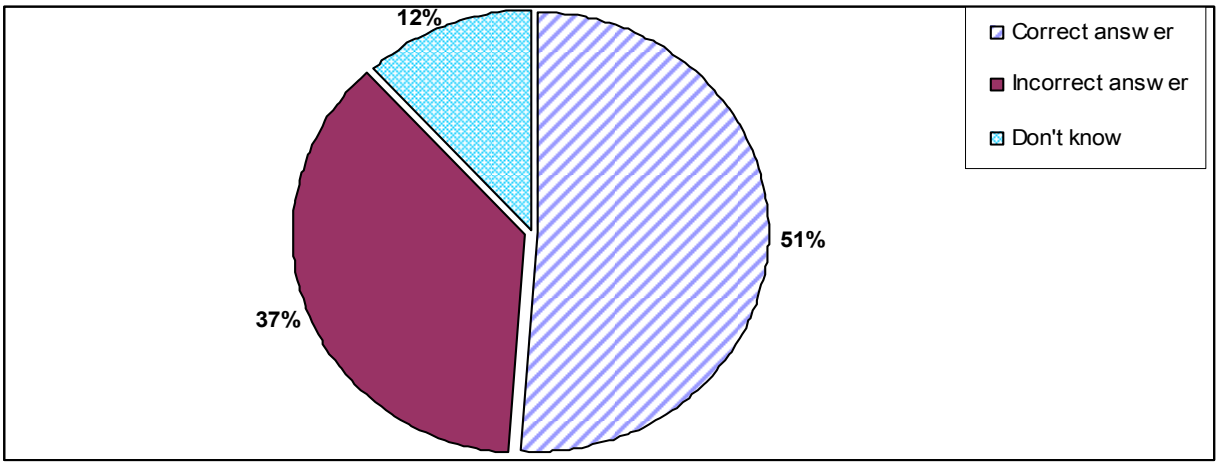


According to above figure, 41% of total respondents had started to give supplimentary food for their children at six month of age and 22% had started below 4 month of age. Among those who had started below four month of age about half (45%) were Brahmins followed by Tamang 27%.

7.35 Method of preparation of super flour

Super flour is taken as the best supplementary food for the children; it is best food for them to prevent from malnutrition.

Figure 47: Method of preparation of super flour [n=145]



Among 81% of total respondents, who had heard about super flour, only 51% of them were known about the correct method of its preparation. Among those who were known about correct method 53% were Brahmins, 14% were Tamang and 10% were Dalit.

7.36 Heard about Child Immunization

Universal immunization of children against the six vaccine preventable diseases - TB, diphtheria, whooping cough, polio and measles is crucial to reducing infant and child mortality.

Table 37: Heard about Child Immunization [n=180]

Heard	**%**
Yes	99
No	1
Total	**100**

Almost all respondents were known about child immunization**.**

7.37 Practice of Immunization

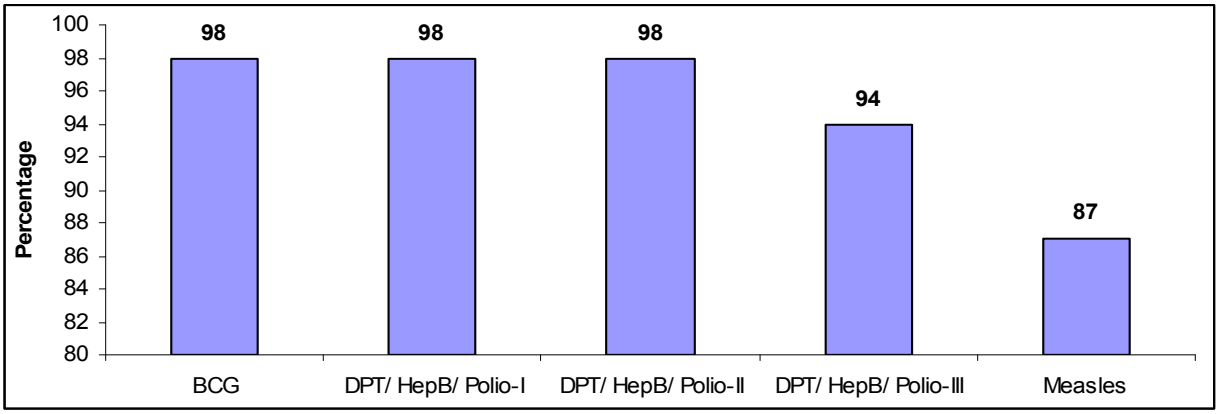
Table 38: Practice of Immunization [n=180]

Practice	**%**
Yes	89
No	11
Total	**100**

According to above table, 89% of total respondent had immunized their children. Within the practice of immunization, 43% Tamang, 50% Brahmin respondents had not immunized their children. It was seen that elderly respondents had not immunized their children.

7.38 Coverage of immunization

Figure 48: Coverage of immunization



Among the total under 5 children, 98% were immunized with BCG, 94% were immunized with DPT, Polio, and Hep-B –III. Similarly, 87% were immunized with Measles, among them some were on process.

7.39 Practice of Growth Monitoring (Less than 3 years Children)

Growth monitoring helps to know whether or not a child has been properly nourished. As it is very difficult for mothers to notice if their children are nourished or malnourished they are expected to bring their children to health institution for examination of child's growth.

Table 39: Practice of Growth Monitoring [n=180]

Practice	**%**
Yes	37
No	63
Total	**100**

Among the total respondents, only 38% had monitored their child's growth. But most of them had done it in Immunization clinics at the time of immunization, but practice for its own purpose was found very low.

7.40 Heard about Malnutrition

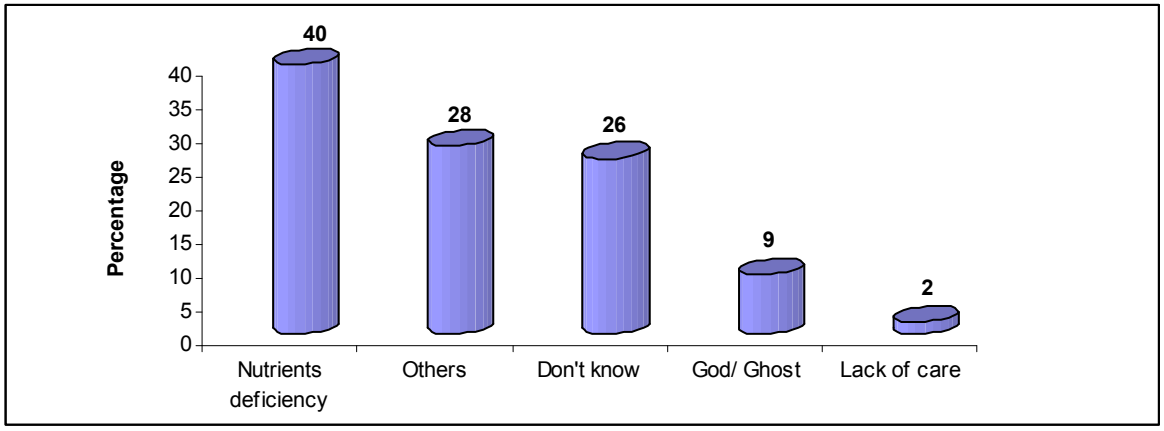
Table 40: Heard about Malnutrition [n=180]

Heard	%
Yes	62
No	38
Total	**100**

Study shows that 62% of total respondents had heard about malnutrition.

7.41 Cause of Malnutrition

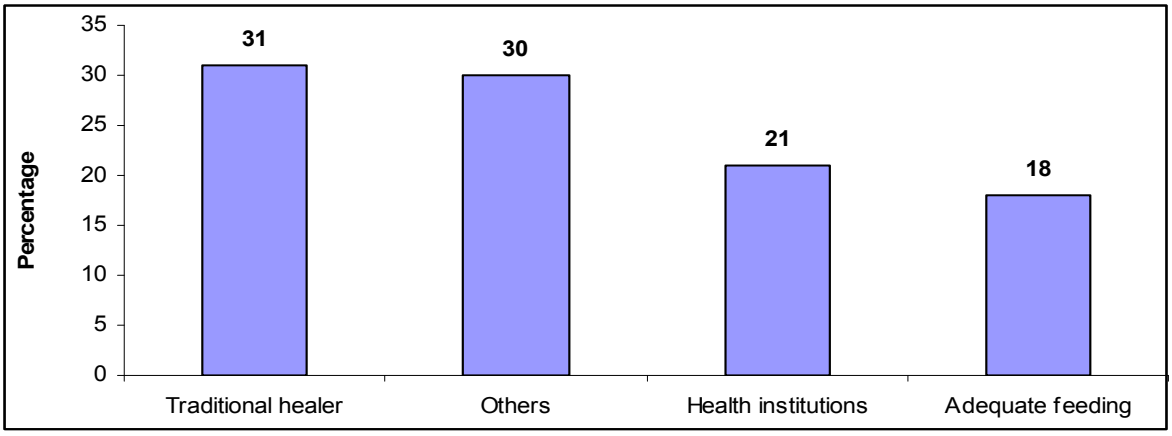
Figure 49: Cause of Malnutrition [n=112]



According to above figure, less than half (40%) respondents were known that malnutrition is due to nutritional deficiency, 26% were unknown about it, and 9% were believed that it is due to god/ ghost.

7.42 Treatment of Malnutrition

Figure 50: Treatment of Malnutrition [n=112]



As shown in figure, among the total respondent 31% used to take their children to traditional healers, 21% to the health institution for the treatement of malnutrition. Within Tamang ethnicity 40%, within Dalit

17% and within Brahmins 29% used to visit traditionl healers for this purpose.

7.43 Heard about Family Planning

Family planning refers to practices that help individuals or, couples to attain certain objectives;

- To avoid unwanted pregnancy

- To bring about wanted birth

- To regulate the intervals between pregnancies

- To control the time at which birth occurs in relation to the mother

- To determine the number of children within family

Family planning has a great role to reduce the maternal and child mortality.

Table 41: Heard about Family Planning [n=180]

Heard	**%**
Yes	93
No	7
Total	**100**

Among the total respondent 7% were unknown about family planning.

7.44 Adoption of family planning method

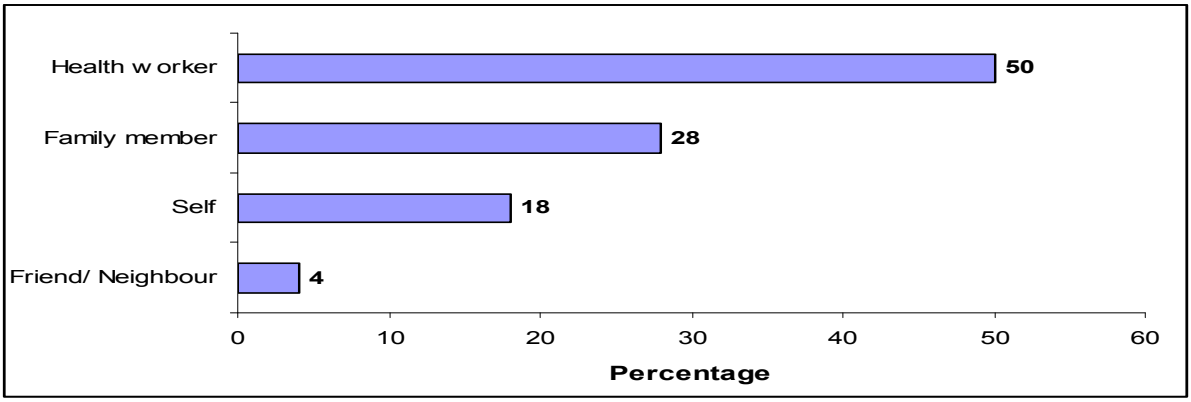
Table 42: Adoption of family planning method [n=95]

Adoption	**%**
Yes	57
No	43
Total	**100**

Among the users Brahmins were the most. Within Brahmins 57% couple had adopted it, within Tamang 37%, and within Dalit 63% had adopted it.

7.45 Advice for the adoption of family planning Method

Figure 51: Advice for the adoption of family planning Method



Most of the couples had got advice from the health workers; among the health worker FCHVs were the most.

7.46a Use of Permanent Method of Family Planning

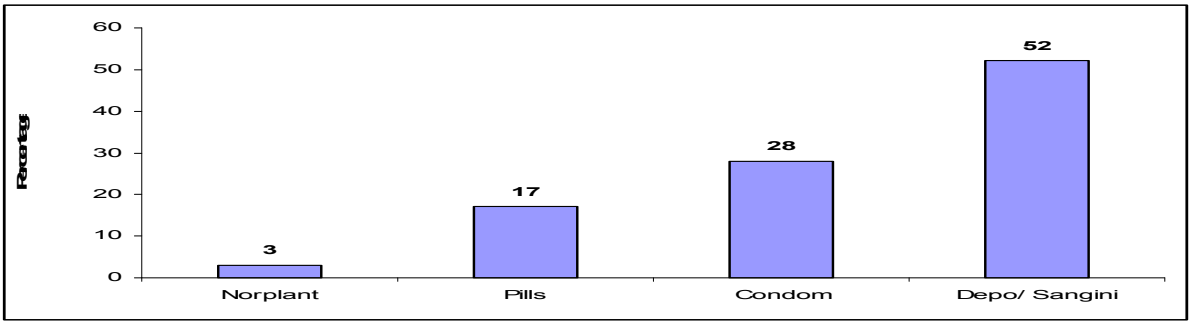
Table 42: Permanent Method

Method	**%**
Vasectomy	80
Minilap	20
Total	**100**

Among the Vasectomy users, Chhetris (75%) were the most within the ethnicity and within Tamang 57%. Similarly, Minilap was high among Tamang within the ethnicity (43%) and nobody was from the Dalit.

7.47b Use of Temporary method of Family Planning

Figure 52: Use of temporary method of family planning



Among the Temporary methods users, Brahmins 41% were the most, Tamang were 23% and Dalit were 18%.

7.48 Knowledge about Child Spacing

Table 43: Knowledge about Child Spacing

Knowledge	**%**
One year	0
Two years	5
More than 2 years	

	95
Total	**100**

Almost all (95%) of the total respondent were known that space between two children should be more than two years.

Observation

1. Type of house

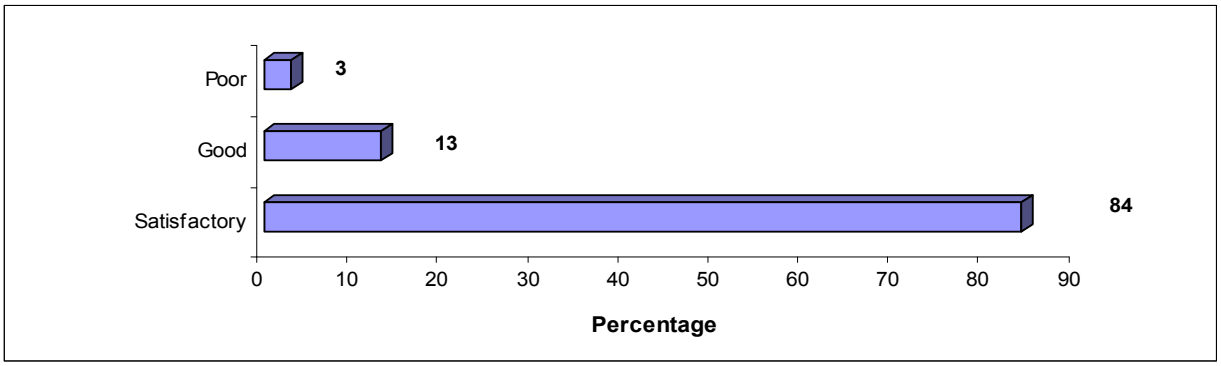
Table 44: Type of house

Type	**%**
Pakka	6
Kachha	96
Total	**100**

Almost all houses (94%) were kachha.

2. Ventilation

Figure 45: Ventilation



Only 12% of total household has satisfactory ventilation, but good was only in 12%.

3. Chula

Table 46: Chula

Chula	**%**
Improved/ smokeless	16
Simple/ with smoke	84
Total	**100**

More than two third (84%) of total household had simple Chula or, Chula with smoke.

4. Chimney

Table 47: Chimney

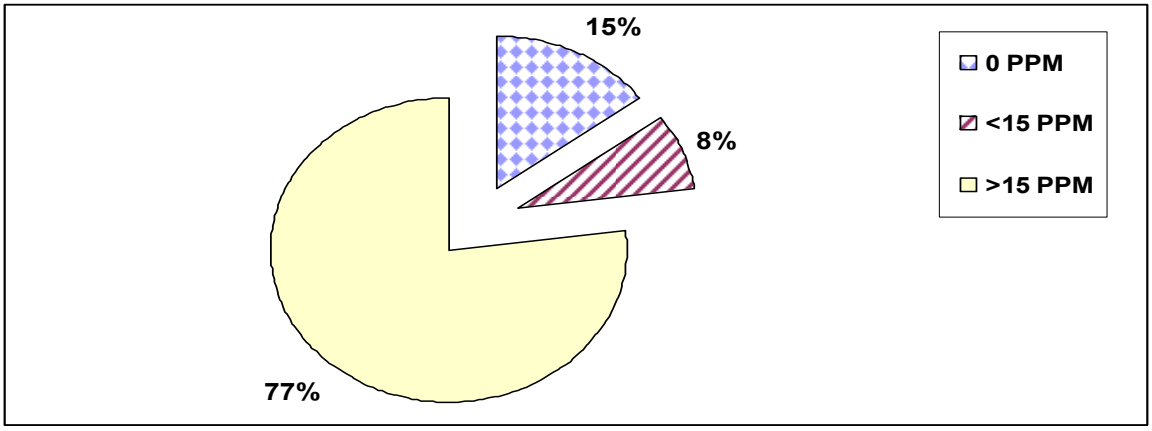
Chimney	**%**
Yes	13
No	87
Total	**100**

Only 13% of household had chimney in their Chula.

5. Quantity of Iodine in eating Salt

Iodine is the micro nutrient which is essential for our health. In the edible salt Iodine should be at least 15 PPM.

Figure 53: Quantity of Iodine in eating Salt



Within Tamang 29%, within Newar 20% and within Brahmins 15% had use to consume salt having 0 PPM Iodine. All Dalits used to take salt with sufficient quantity of Iodine.

6. Waste water disposal Site

Table 48: Waste water disposal site

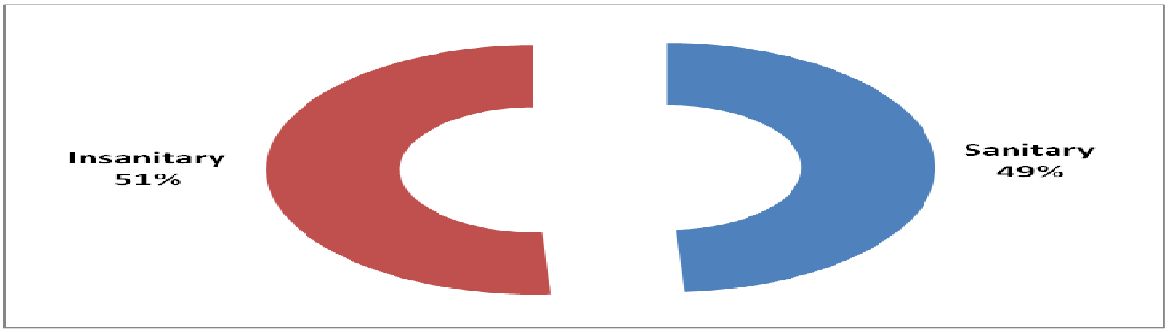
Site	**%**
Kitchen garden	48
Haphazardly	42
Pit	7
Manure pit	2
Toilet	1

Total	**100**

42% of the total household used to throw their waste water haphazardly.

7. Type of Toilet

Figure 54: Type of Toilet



Only About half (49%) of the total toilet were insanitary.

8. Distance between Toilet and House

Table 49: Distance between Toilet and House

Distance	**%**
Joint	15
Near	78
Far	7
Total	**100**

More than two third (78%) of the household were near with the toilet.

9. Use of Toilet

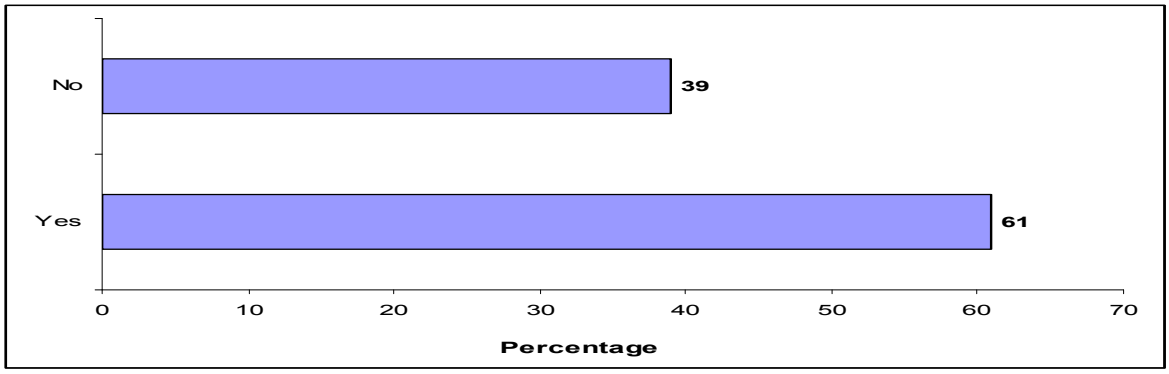
Table 50: Use of Toilet

Use	**%**
Yes	95
No	5
Total	**100**

Among the toilets 5% were not in use, this problem was mostly in ward no.8 and was mainly due to the lack of adequate water.

10. Source of Water in Toilet

Figure 51: Source of Water in Toilet



About one third (39%) of toilet had no source of water with in them.

11. Distance between House and Shade

Table 52: Distance between House and Shade

Distance	**%**
Joint	45
Near	44
Far	11
Total	**100**

Nearly half (45%) of total household had jointed shade.

12. Availability of kitchen garden

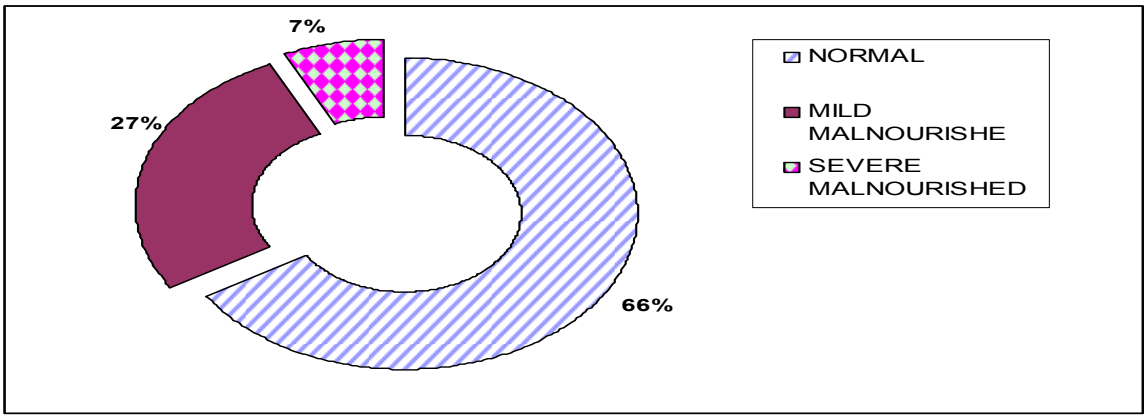
Table 53: Availability of Kitchen garden

Availability	**%**
Yes	88
No	12
Total	**100**

Most of the household (88%) had kitchen garden.

13. Nutritional Status of U-5 Children

Figure 55: Nutritional Status of U-5 Children



According to the water low's classification (weight for age) 27% of total weighted children were normal, 27% were mild malnourished and 7% were severely malnourished.

NEED IDENTIFICATION AND PRIORITIZATION:-

Community problems are those which the community feels or need to be solved. Where the problem there is solution so, we can apply possible solution to combat the problem.

Identification of the problem and taking it as a specific categorization can be considered as research task.

FELT NEED

Felt need are those health and developmental needs, the people in a community feel to be what they need in order to improve their health and socio economic status. Felt needs are those problems, to which community people gain greatest importance.

To find out the felt need of the community people PRA method was used. Community leaders, teachers, FCHVs, represent of mother group, leaders of women group, social workers etc. were participated. Pair wise ranking tool was used for this purpose.

Process:-

First of all their needs which they feel were collected, then each items of need were compared pair by pair; participants were asked which is preferred of the two. Participants were requested to raise their hands to show their preference in only one of the two items. According to the scores following needs were identified and prioritized.

1. Irrigation
2. Drinking water
3. Awareness
4. Road/transportation
5. Employment

FELT HEALTH PROBLEMS:-

1. Health awareness
2. Uterine Prolapsed
3. ARI
4. Typhoid
5. Skin disease

OBSERVED NEEDS:-

Observed needs are those health and/or, developmental needs in order to state a community health or, health related problem. Such needs are seen by outside experts.

By analyzing the data of household survey, secondary data of SHP, observation of every household and during transect walk, following needs were observed.

1. KAP on major diseases.
2. KAP on sarbottam pitho and jeevanjal.
3. KAP on safe motherhood.
4. Safe drinking water.
5. Environmental sanitation.
6. Improved smokeless chulo.
7. Proper ventilation.
8. Growth monitoring.
9. Camp for uterine prolapsed.
10. Irrigation.

REAL NEEDS:-

Real needs are those which are jointly developed from the felt needs and observed needs.

A real need usually tries to get at the root cause of health or development problem for which solution can be found and carried out.

Following were the prioritized real need:-

1. KAP on safe motherhood
2. Growth monitoring.
3. KAP on major communicable diseases.
4. Safe drinking water.

5. Camp for uterine prolapsed.
6. Improved smokeless chulo.
7. Environmental sanitation.
8. Proper ventilation.
9. Irrigation.

COMMUNITY PRESENTATION

Community presentation is the vital aspect of community health diagnosis. Overall two community presentations were conducted after completion of our programme. First community presentation was conducted for the people of lower belt of VDC and second was for the people of upper belt.

FIRST COMMUNITY PRESENTATION:-

Date**:** - 2064-11-25

Time**:** 8:00 -9:00 a.m.

Venue**: -** VDC hall; ward no 2

Participants:-

- About 60 people were attended from the 1, 2, 3 and 9 ward of VDC.
- School teachers, political leaders, social workers, farmer, VDC members, intellectuals, FCHVS, leaders of mothers group, leaders of women's groups, representatives of local NGOS an business man.
- Incharge Ayurved Asusadhalaya, Lahorepauwa, representative of VDC.

SECOND COMMUNITY PRESENTATION:-

Date**: -** 2064-11-26

Time: **-** 8:30-9:30 a.m.

Venue: **-** Health post, Lahorepauwa; ward no.4

Participants:-

- About 50 people were attended from the 4,5,6,7 and 8 ward of VDC.
- Political leaders ,school headmaster and teacher, former VDC members, social workers, FCHVS, leaders of mothers group, represent of local club, business man, traditional healers.
- Health post in charge and other staffs of health post.

Objective of presentation:-

a) To explain different demographic and health related findings to the community people.

b) To present the felt, observed and real needs.

c) To explain about sustainability of MHP programme in future days.

d) To get the comments and feedbacks from participants about study.

Presented subject matters:-

1. Introduction and back ground of programme.

2. Geographic social resource map.

3. Demographic profile.

4. Socio-economic and socio-cultural status.

5. Environmental health.

6. Personal hygiene.

7. KAP on common communicable disease; Diarrhea, ARI, TB, STI and HIV/AIDS, worm infestation.

7. Health care seeking behavior including MCH and FP.

As the desire of the community people we had conducted the programme informally. After finishing the presentation, discussion, question and answer about the findings were done. At last of comment and feedback was taken from one of the participant voluntarily about field study.

NEED PRIORITIZATION:-

Prioritization means using a systematic method of assigning greater or, importance to various diseases, problems, interventions age and sex group, ethnic group etc.

By considering the following criteria, we had determined the real need from the discussion.

Criteria for prioritization of MHP:-

1. Magnitude of problem.
2. Administrative feasibility.
3. Available technology.
4. Acceptability for the community.
5. Sustainability.
6. Cost effectiveness.
7. Man power availability.
8. Infrastructure.
9. Local resources.
10. Time feasibility.
11. Effectiveness of programme.
12. Output.

Prioritized programme for MHP:-

1. School health programme.
2. Health education.
3. Growth monitoring.
4. Health education exhibition
5. Toilet construction at ward no.8

MHP (Micro Health Project)

Micro health project is a small scale time bounded health project with limited resources. The aim of this MHP is not micro level. It is designated to change the, health related knowledge, attitude and behaviors towards the better health of the community people on the basis of their real need through the maximum utilization of locally available resources and technology. Discussing with the community people we had decided the following programmes.

1. School health programme.
2. Health education program.
3. Growth monitoring programme.
4. Toilet construction at ward no. 8.
5. Health education exhibition.

Goal

- To raise the health awareness of the community people by providing education on different prioritized problems.

1. SCHOOL HEALTH PROGRAMME

School health is an important branch of community health. School health service is an economical and powerful means of improving health so, we decided to conduct school health programme.

Objective

I. The promotion of positive health

ii. The prevention of diseases.

iii. Early diagnosis and treatment of disease.

iv. Awaking health consciousness in children.

In the school health service we had conducted medical examination, deworming and health education programme.

a) Medical Examination:-

Since ward no. 8 is backwarded in Lahorepauwa VDC, hygiene and sanitation condition was very poor so we decided to conduct medical examination at Narayansthan Primary school, ward no. 8.

b) Deworming Programme:-

More than to third (66%) of household of ward no. 8, used to defecate openly on their field. We know that wherever the open defecation, there must be intestinal worm infestation problem so; we decided to deworm all students above- 5 year. For under 5 children, biannual deworming programme is running by MOH, DOHS.

c) Health Education:-

It is the most important element of the school health programme. Children take back to their parents the health instructions they receive in schools, and even more important, when they becomes adults they apply this knowledge to their families so, we decided to conduct this programme. In our developing country, where ill health is a major problem" Every school child is a health worker"

2. HEALTH EDUCATION PROGRAMME

According to the world health organization,"health education is the process which enables individual and group of individual to realize their health needs and match them to necessary healthy behaviors for attainment of positive health. Health education like general education is concerned with the change in knowledge, attitude and behavior of the people. In its most useful form it is

Concentrated on the development of such practices as are believed to attain the best possible state of well being."

Health education is necessary but education alone is insufficient to achieve optimum health.

Goal:-

To make realistic improvement in the basic quality of life.

Objective:-

a) To promote the proper use of health services available to them.

b) To arouse interest, provide new knowledge, improve skills and change attitudes in making rational decisions to solve their own problems.

c) To give the education on major communicable diseases, safe motherhood and environmental sanitation.

d) To educate the community for preparation of ORS (Jeevanjal) and sarbottam pitho (super flour)

e) To encourage the use of delivery kit.

f) To encourage the community to keep the surrounding clean.

g) To raise awareness about institutional delivery.

3. GROWTH MONITORING PROGRAMME

It is a low cost technology available for reducing child malnutrition. All under 5 year children should be weighed periodically (under 1 year children twice a month and 1-5 year every thrice a month) and their growth charts maintained. These charts help to identify children at risk of malnutrition early.

Rational:-

1) Poor nutrition is recognized as one of the main reasons for the high infant and child mortality in Nepal.

2) Study team found that only 37% had done periodic growth monitoring.

4) According to the HP record GM is only 32%

Goal:-

To improve the nutritional status of under 5 children

Objective:-

- To find out the nutritional status of the children.

- To make parents aware about their children's nutritional status.

4. TOILET CONSTRUCTION:-

Improper excreta disposal causes contamination of food and propagation of files which leads to many diseases for e.g.: typhoid and Para typhoid fever, dysenteries, diarrhea, cholera, and worm infestation. These diseases are not only burden to the community in term of morbidity and mortality, but a basic deterrent to social and economic progress. Human excreta are not only the source of infection; it is an important cause of environmental pollution. Sanitary latrine provides barrier and segregates the faeces so, that the disease agent can't reach the new host.

Objective:-

To encourage the community people for safe excreta disposal.

Rational:-

Only 56% of Tamang household used to go to toilet.

5. HEALTH EDUCATION EXHIBITION

Exhibition is the systematic and meaningful display of educational materials with an intention to educate large number of people at a particular place.

Rational:-

1. At the local mela large no of people gather so, programme becomes more effective.

2. Provides better learning through varieties of experiences like hearing, seeing, touching for large number of people at a time.

Objective:-

a. To give the knowledge about major diseases including MCH and FP.

b. To make people aware about their health problems.

c. To change people's practice towards positive health.

WORK PLAN

SN	DATE	PROGRAMME /ACTIVITIES	TIME	RESOURCE PERSON	TARGET GROUP	METHOD /MEDIA	VENUE
1	16/11/2064	**I**.School health education on safe motherhood and major communicable disease.	10:00 to 12:00 noon	Study team.	Students of class 8, 9 and 10.	Brain discussion, poster, pamphlets and board.	Shree Nilkantha higher secondary school, ward no. 1
		ii.Growth monitoring	12:00 to 3:00 pm.	Study team.	Under 5 children.	Baby weighing machine.	PHC/ ORC Gumbudada, ward no. 8
		iii.Deworming and general health check up.	10:00 to 12:00 noon	Study team	School students.		Narayanstha n primary school, ward no.8

		iv. Health education on environmental sanitation.	4:00 to 5:00pm.	Study team.	School management committee, leaders and females.	Poster and pamphlets.	Narayanstha n, primary school, ward no.8
2	17/11/2064	**i.**School health education on reproductive health.	10:00 to 11:00a.m.	Study team	School students of 5	Poster, pamphlets and blackboard.	Shree Shivalaya proposed lowery secondary school, ward no. 2
		ii. Growth monitoring	11:00 am to 3:00 pm.	Study team	Under 5 children	Using baby weighing machine.	On PHC/ORC, Majhgaun, ward no. 2
		iii. Health education	4:00 to 5:00 pm.	Study team.	Pregnant women who comes on ANC check up in PHC/ORC	flipchart	PHC/ORC, Majhgaun, ward no. 2
3	18/11/2064	Health education on safe motherhood	4:00 to 5:00 pm.	Study team.	Mother's group of ward no. 5, 6and 7 (Tamang,Dalit and Brahmin)	Group discussion, flip chart, poster and pamphlets.	Health post building.
4	19/11/2064	School health education	11:00 am. to 1:00 pm.	Study team.	Students of 7, 8, 9 and 10	Brain storming, lecture, poster, pamphlet and blackboard.	Nava Vijay Mahendra Madhyamic Vidhyalaya, ward no. 6.
5	20/11/2064	Toilet construction	10:00 am. to 4:00 pm.	Study team.	Community people of ward no. 8		Pakhrin Tole, ward no.8
6	21/11/2064	Health education on uterine prolase, nutrition, preparation of sarbottam pitho and ORS	12:00 pm to 1:30 pm.	Study team.	Mother's group of 2,3 and 9 ward(Brahmin, chhetry and dalit)	Discussion, demonstration and pamphlets.	VDC hall .
7	22/11/2064	Health education on environmental sanitation	8:00 to 9:00 am.	Study team.	Leaders, social workers of ward no. 5,	Brain storming, discussion poster,	Health post

					6 and 7.	pamphlets.	
8	23/11/2064	Health education by exhibition	4:00 to 6:00 pm.	Study team.	Community people of ward no. 5, 6, 7 and 8.	Poster, pamphlet and meta cards	Shiva mandir,at local shiva ratri mela, ward no. 4

IMPLEMENTATION OF MHP

For the implementation of MHP, we had collected required materials like posters and pamphlets from district public health office, Lalitpur, National education, information and communication centre, Teku kathmandu, family planning office pulchok, Maternity hospital Thapathali Kathmandu and health post Lahorepauwa, Rasuwa.

Other equipments like shakir tape, measuring tape, weighing machine, stethescope, Blood pressure, thermometer, tongue depresser, Albendazole tab. and other necessary equipments were provided by college and health post, Lahorepauwa.

1. HEALTH EDUCATION PROGRAMME

Participants were gathered with the help of teachers, students, FCHVs and local leaders.

Demonstration was done among the mothers about Jeevanjal (ORS) preparation. Likewise, group discussion and mini lecture was done on the topics about safe motherhood, waste and excreta disposal, method of preparation of super flour, major communicable diseases and nutrition.

Topic related stories were told to make the subject matter interest and effective education before entering the subject matter. Similarly, during the session jokes were told and sometimes games were also played according to the interest of the participants to refresh and to draw their attention. We all students were involved in health education programme in different places. After the discussion in our group different topics were divided among us.

2. GROWTH MONITORING CAMPAIGN

For the sustainability of the programme we had conducted the growth monitoring campaign on 2 PHC/ORC; Gumbadada ward no. 8 and Majhgaun, ward no. 2

After weighing children, growth monitoring card of each individual child was filled up and their nutritional status was told with their parents. All parents were informed about road to health chart, importance of GM and

date of next visit for GM. Nutrition register of HP was also filed up side by side.

3. TOILET CONSTUCTION:-

From the school management committee, local leaders and members of mother group of ward no.8, one committee named "Environmental Sanitation Committee" was formed. Members of that committee were selected voluntarily as follows;

I. President:- Birbal Tamang (Thing)
II. Member:- Nema Syangmo Pakhrin
III. Member:- Tul Wangju Syangwa
IV. Member:- Chhiring Kemo Pakhrin
V. Member:- Dawa Sonam Syanwa
VI. Member:- Junge Pakhrin
VII. Member:- Raju Syangwa
VIII. Member:- Newa Lakpa Syangwa

Advisors: - Ram Bahadur Shreshtha

Bikram Lopchan

Equal participation of female and male and mostly young people was involved in committee.

Committee has decided to construct at least one toilet in 15 days and conduct cleanliness campaign once a month. They determined that within 1 to 2 years open defecation at that ward will be completely stopped. They also decided that toilet construction would be on the whole members' house firstly, then after that on the others.

According to committee's decision model toilet was constructed at the presidents' home on our technical guidance. We all students were actively involved with community people for carrying materials. On that day they decided to construct another toilet at Nema Syangmo Pakhrin's home after one week.

4. HEALTH EDUCATION EXHIBITION

For the sustainability; this programme was done with the co-ordination of health post, at Karmidada, Shiva mandir of ward no. 4, on the occasion of Shiva Ratri mela. Printed Visuals and some written information, on the basis of real need for e.g. preparation of jeevanjal, super flour, cause of worm infestation, uterine prolapse etc. were displayed. Different attractive posters and pamplets about various information eg; adolescence health, major communicable diseases (ARI, diarrhea, STI and HIV/AIDS), safe motherhood family planning and nutrition were kept on the exhibition according to the need of target group.

To prevent unwanted pregnancy STI, and HIV/AIDS during the celebration condom box with adequate condom was also kept there.

Though the exhibition was self explanatory we students were act as interpreter to help the audience in their need to explain the message exhibited.

5. SCHOOL HEATH SERVICES

A. School Health Education:-

Annual examination of the student's was coming very soon so, we were divided into 2 sub groups for this purpose.

Two friends conducted this programme at Shree Shivalaya Proposed Lower Secondary School; ward no 2, on the request of head master.

We conducted this programme very successfully by using different methods and Medias as mentioned in the action plan. We had made our programme interactive by two way communication.

B. **Medical Examination:-**

Two friends of our group were Health Assistant, conducted this programme successfully and effectively.

During the examination every student was asked about their problem. Adequate time was given to identify their problem, to counsel and to educate them and their parents about problem.

Problem, cause, prevention, treatment and mode of transmission (in case of communicable disease) of their problem were told to students, their parents and teachers. Those students for whom medication was necessary they were referred to health post. During medical examination of 142 students we founded the following health problem as follows.

CLASS	**HEALTH PROBLEM/NO. OF STUDENTS**						
	ARI	DENTAL CARRIES	EAR PROBLEM	NUTRITIONAL DEFICIENCIES	SKIN PROBLEM	HERNIA	ABDOMINAL PAIN
SHISHU	2	2	2	3	2	1	0
1	5	3	0	2	0	0	0
2	7	5	0	2	1	0	0
3	3	3	1	2	3	0	0
4	11	5		17	2	0	3
5	3	5	0	9	0	0	4

Among the nutritional problem more students were suffered from vitamin deficiency. On our opinion this may be due to worm infestation or, low dietary intake.

We didn't have laboratory facility and the students were of under five classes so, they couldn't told their problem clearly and exactly that is why, we were not able to diagnoses worm infestation.

C. Dewormning programme:-

Under 5 years, 119 students were dewormed. This programme was done together with medical examination. Two school teachers were involved especially for this purpose.

EVALUATION OF MHP

1. School Health Education and Health Education Programme:-

For the health education evaluation, question and answer method was used before the summary of session. Most of the participants had answered satisfactorily.

Students were very interested to our education, they had paid great attention. They had asked many questions especially regarding the reproductive health and HIV/AIDS. Some of students asked their personal reproductive health related problem even after finishing the session.

School teachers were also very thankful for us and were very impressed from our health education method and media. Health teacher of one school said, '' Hamile padhauda sabae lajle tauko nihurauthe, question raise gardainathe, tapaiharu le yasari sikauda sarai ramro vayo, every year yasari nae aauda kati ramro hunthyo."

Students had told the information about safe motherhood to their parents after returning back from school. Mothers shared information during the health education of mothers group that they had heard from their children.

Mothers showed great concern regarding home delivery as different complications. Some of the participant had demonstrated the preparation of jeevanjal in correct way. Most of the mothers had answered the correct method of preparation of super flour. After the education on environmental sanitation; we found improvement in some household. Five pits were digen for waste disposal.

2. Medical Examination:-

Students and their parents were informed one day before the programme so; most of parents were present during the programme and were asking about their children. Parents and teachers were thankful, some parents told us "Feri feri Pani Yesto karyakram lyaunu hola."

3. Growth Monitering:-

Parents had paid full attention to hear the importance of GM. They had curiously asked about the road to health chart, and were reconfirming the time of next visit.

4. Toilet Construction:-

Family were using the model toilet, was also covered with the lid when not in use. Bucket of water was also there inside the toilet. Another toilet was also constructed in another committee member.

5. Health education Exhibition:-

Male and female of different age groups were looking and reading at the different visual aids. Audience was seeking help to know more information and to be clear. Some people were seeking permission to take away Pamphlets. Most of the women were seeing towards the cause of uterine prolapse.

Sustainability of programme

1. Environmental sanitation committee was formed in ward no. 8. They had planned to construct one toilet on every two weeks.
2. Study team had talked with incharge and other staffs of health post for the promotion GM. They were committed to give time for GM in every PHC/ ORC.

3. We had discussed with FCHVs and president of different mother's group for the continuation of health education programme in their monthly meeting. They were committed to discuss about health matter in presence of FCHV in every month.

4. Headmaster of Narayansthan Primary School, Gumbudada was committed to take under five years students of shishu class for GM on the right time.

5. Health post Incharge and other staffs were committed to conduct health education exhibition in Shiva Ratri Mela at Shiva Mandir every year.

CONCLUSION

Total population of the VCD was 1188 and total number of households was 900 as the record of HP. Average family size was 6.6. The highest population was in 10 -14 age group. Sex ratio was 91 Males for 100 females. Median age of population was 22 yrs. Total dependency ratio was 60%. Crude Birth Rate and Crude Death date was found to be 23.5 per thousand 5.8 per thousand respectively. The morbidity rate was 40 per 1000. Under 5 mortality rate was found 10 per thousand.

The main occupation of household was Student (37%) and the major source of income was agriculture (64%). Literacy rate was 65%, with male

literacy 54% and female literacy 46%. The prevalence of Tobacco and Alcohol consumption was 20% and 18% respectively.

Majority of people (70%) used to go to health institution to take treatement.

Among the 98% of respondent 61% knew that Diarrhea is caused by contaminated food. 52% of household used to drink ORS to treat diarrhea. Among 96% respondent, 60% knows the correct method of ORS preparation.

Among 88% of respondent only 8% knew that ARI/ Pneumonia is due to dust and smoke. Only 8% said protect from dust and smoke to prevent from ARI/ Pneumonia.

Among 82% of respondent only 29% had known the right mode of transmission of TB. Only 7% had heard about the DOTS. Only 7% of household had TB patients in present and past.

The most well known mode of transmission of STI and HIV/ AIDS was sexual contact. Among the 77% of respondent, 75% were known about the right method of prevention of STI and HIV/ AIDS.

Among the 93% of respondent, 29% and 4% respondent knew that worm infestation is due to contaminated food/ water and eating raw meat respectively. Half of respondent (51%) said to take medicine for its prevention.

Among 76% of household, 5% household had Diabetic patient and among 73% of household, 21% household had hypertensive patient at the study time.

Majority of household (91%) used tap/ pipe as a major source of drinking water. 80% of household cover the drinking water. Among 56% of household, 24% used to drink boiled water.

77% of household use toilet for defecation. On observation 76% of house hold had latrine among them only 49% were sanitary. About one third (34%) of household dispose biodegradable wastes in manure pit. About half (53%) of household utilize their households liquid wastes in kitchen garden but in observation only 48% were found doing this. Almost all (98%) respondent wash their hand after defecation, among them 74% washed with soap water. Among 88% of the respondent, only 16% brushed twice a day. Among 92% of firewood Chula, only 16% had smokeless/ improved.

Nearly half of respondent (48%) had got married between the ages 16-20 years. More than half of respondent (54%) had given birth below than 20 years of age. Among the 82% of respondent, only 54% had done it, among

those who had, 60% had done four or more than four times. 67% of respondent had taken TT injection during pregnancy. Only 52% of respondent had taken Iron tab. during pregnancy. Only 46% of respondent had knowledge of taking extra frequency of food during pregnancy. 31% of respondent had consumed tobacco and alcohol even in pregnancy._Only 9% of respondent had complication during pregnancy. Only 19% deliveries were taken in health institution. Among 72% of respondent only 35% had used it during delivery. Among the deliveries which were not taken in HI, 64% were used not used sterilized blade and rest were used knife, sickle and used blade for cord cutting. Only about half (49%) of post partum mother had received vitamin ''A'' capsule. Only 67% of the respondent had done PNC among them 45% had done it more than twice._Only 13% of household had problem of uterine prolapse in the family but problem is hidden health problem there. 90% of respondent had fed clostrum to their children. 43% of respondent had given supplementary food to their children below than 6 month of age. Among the 81% of respondent, only 51% had knowledge about right method of preparing it._88% of respondent had immunized their children. 77% of household used to take iodized salt having more than 15 ppm iodine and 15% household had 0 ppm iodine. Among the 62% of respondent, only 40% knows that malnutrition is due to lack of nutritious food and among them 31% used to take their child to the traditional healers for its treatment.

Among the 93% of total respondent, one third (34%) of total eligible couples were found adopting FP. Among them 69% were adopting permanent method. Among the temporary method Depo was the most popular method. Adoption of family planning was seen low for the purpose of child spacing. CPR was found to 33.6%.

LEARNING REFLECTIONS

1. We learned to adapt in real field situation.
2. Rapport building is the most important task to work in the community.
3. It was difficult for male study team to take data from the household where females were respondents, especially regarding the STI and HIV/ AIDS and FP/ MCH.
4. Application of theory into practice requires different kinds of modifications in it.
5. Co-ordination is important to identify and to mobilize resources and to plan and implement the program.

6. If team spirit is in all the member of study group, there is no any difficulty to work in group.
7. PRA method is very effective method for social mapping and data collection on some specific topic.
8. If we change ourselves according to the community; community loves as their family member.
9. Rapport building before starting the programme has greater value than that of during programme.
10. Developing competencies to conduct different formal and informal program (meetings, awareness programme) requires confidence and exposure.
11. Convincing power is necessary to bring desired change in community.

RECOMMENDATION

To the Health Post

1) This study shows that GM of under three years children is only 37% and health post record also shows that it needs to strengthen.

2) Awareness is crucial to change the health behavior, which is necessary for long lasting improvement of health status of people. So, it is necessary to strengthen health awareness programme.

3) Due to the lack of 24 hours delivery service and regular unavailability of ANM staff, institutional delivery is not increasing so, it is necessary to manage it properly.

4) Regular drug supply is necessary to improve the health care seeking behavior of the targeted people.

To the VDC

1) Priority need to be given for the for health related programmes, especially for backwarded community. Like toilet construction, smokeless chulo etc.

2) Involvement of community based organization and local NGOS for health awareness programme.

3) Allocation of some budget for health camp, to management uterine prolapse.

4) Water source protection and safe drinking water supply needs to be encouraged.

To the College

1) Questionnaire which was prepared by students should be refined by faculties prior to going community.

2) Questionnaire pre-testing should be done at proper place with adequate times.

3) Formal letter for different organizations of community should be provided.

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FORMULA USED

$$\text{Sex Ratio} = \frac{\text{Total male population}}{\text{Total female population}} \times 100$$

$$\text{Total Dependency Ratio} = \frac{\text{Total population of under 15yrs}}{} \times 100$$

$$\frac{\text{and above 64 yrs}}{\text{Total population 15-64 yrs}}$$

$$\text{Child Dependency Ratio} = \frac{\text{Total population of under 15yrs}}{\text{Total population 15-64 yrs}} \times 100$$

$$\text{Total Dependency Ratio} = \frac{\text{Total population of above 64 yrs}}{\text{Total population 15-64 yrs}} \times 100$$

$$\text{Crude Death Rate} = \frac{\text{Total no. of death in one year}}{\text{Total mid year population}} \times 1000$$

$$\text{Crude Birth Rate} = \frac{\text{Total live birth in one year}}{\text{Total mid year population}} \times 1000$$

$$\text{Average Family Size} = \frac{\text{Total population of observed data}}{\text{Total no. of household in the observed data}} \times 1000$$

Annex-1: Interview Schedule

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@=@ tkfO{sf] v]tjf/Lsf] pTkfbgn] tkfO{sf] kl/jf/nfO{ slt ;do;Dd vfg k'U5 <

s_ ^ dlxgf eGbf sd v_ ^ b]vL !@ dlxgf;DDf u_ art ug{ klg k'Ug] 3_ v]taf/L 5}g

@=# tkfO{sf] v]tjf/Ldf pTkfbg x'g] d'Vo aflnx¿ s] s] x'g\<==========,==========,==========

#= jftfj/0fLo ;/;kmfO{

vfg]kfgL

#=! tkfO{sf] 3/df vfg]kfgL k|foh;f] sxf“jf6 Nofpg' x'G5 <

s_ s'jf ÷kw]/f] v_ wf/f ÷kfO{k u_ vf]nf 3_ em/gf ª_ kf]v/L r_ 6\ofª\sL 5_ cGo==========

#=@ tkfO{nfO{ vfg]kfgL Nofpg ;fdfGotof slt ;do nfU5 <

s_ !% ldg]6 eGbf sd v_ !%—#) ldg]6 u_ cfwf 306fb]vL ! 306f 3_ !306feGbf a9L

#=# tkfO{n]÷tkfO{sf] kl/jf/n] vfg]kfgL 5f]k]/ /fVg' x'G5<

s_ /fV5' v_ /flVbg

#=$ tkfO{nfO{ vfg]kfgL ;'4Ls/0fjf/] yfxf 5< -5}g eg,] **k|Zg g+ #=^ df hfg**] _

s_ 5 v_ 5}g

#=% obL] 5 eg], tkfO{sf] kl/jf/df vfg]kfgL s;/L ;'4Ls/0f ug'{ x'G5 <

s_ pdfn]/ v_ lkmN6/ u/]/ u_ cf}ifwL xfn]/ 3_ wfddf ttfP/ ª_ ub}g}F

r_cGo

==========

#=^ obL ug'{ x'Gg eg], lsg gug'{ ePsf] <

s_ yfxf geP/ v_ cfjZos g7fg]/ u_ kfgLsf] :jfb lju|G5 eg]/ 3_ emGem6 nfu]/

ª_ cGo

==========

kmf]xf]/ Joj:yfkg

#=& tkfO{sf] 3/jf6 lg:sg] kmf]xf]/ sxf“ kmfNg] ug'{ x'G5 <

s_ vfN8f]df v_ dnvfbdf u_ hyfefjL 3_ hnfpg]

ª_ cGo

==========

#=* tkfO{sf] 3/jf6 lg:s]sf] kmf]xf]/ kfgL sxf“ kmfNg' x'G5 <

s_ s/];faf/Ldf v_ vf]nf÷vf]N;fdf u_ vfN8f]df 3_ hyfefjL ª_ cGo

==========

#=(tkfO{sf] 3/kl/jf/ lb;f lk;fa ug{ sxfF hfg'x'G5 <

s_ v]tjf/Ldf v_ rkL{df u_ vf]nfdf÷vf]N;fdf 3_ af6f]df ª_ hª\un

r_ cGo

==========

=

#=!) tkfO{sf] 3/df rkL{ 5< -5 eg] k|Zg g+ #=!@ df hfg] _

s_ 5 v_ 5}g

#=!! obL 5}g eg], lsg gagfpFg' ePsf] xf]nf <

s_ yfxf geP/ v_ cfjZos geP/ u_ cfly{s sf/0f 3_ emGem6 dfg]/

ª_ cGo

==========

==========

====

#=!@ lb;f lk;fa ul/;s]kl5 xft w'g] ug'{ x'G5 < -5}g eg] **k|Zg g+ #=!$ df hfg**] _

s_ w'G5' v_ w'Gg

#=!# 5 eg], s] n] w'g'x'G5 <

s_ kfgL v_ ;fa'g kfgL u_ v/fgL kfgL
3_ df6f] kfgL ª_ cGo

==========

==========

#=!$ tkfO{sf] 3/kl/jf/df vfgf vfg' cuf8L xft w'g'x'5 <

s_ w'G5f}+ v_ w'b}gf} u_ slxn]sfFxL

#=!% tkfO{sf] 3/kl/jf/df b}lgs bft dfem\g] ug'{ x'G5 < -5}g eg], **k|Zg g+ #=!* df hfg]** _

s_ dfem\5' v_ dfem\lbg

#=!^ dfem\5' eg], slt k6s dfem\g' x'G5 <

s_ ! k6s v_ @ k6s u_ @ eGbf a9L

#=!& s] n] dfem\g] ug'{ x'G5 <

s_ c+uf/ v_ btLjg÷af+; u_ g'g 3_ a|; ÷d~hg ª_ cGo

==========

==========

#=!* tkfO{sf] 3/df vfgf ksfpg s:tf] k|sf/sf] r'nf] k|of]u ug'{x'G5 <

s_ bfp/] r'nf] v_ Uof+; r'nf] u_ :6f]e

r_cGo

==========

==========
====

$= /f]ux?

emf8fkvfnf

$=! tkfO{n] emf8fkvfnfsf] af/]df ;'GGf' ePsf] 5< -5}g eg] **k|Zg g+ $=$ df hfg**] _

s_ 5 v_ 5}g

$=@ -5 eg] _ emf8fkvfnf s;/L nfU5<

==========
==========

$=# tkfO{ emf8fkvfnfsf] pkrf/ s;/L ug'{ x'G5 <

==========
==========

$=$ tkfO{n] lhjghnsf] jf/]df ;'Gg' ePsf] 5< -5}g eg,] **k|Zg g+ $=^ df hfg]**_

s_ 5 v_ 5}g

$=% 5 eg], lhjghn s;/L tof/ ul/G5 <

s_ ;xL tl/sf v_ unt tl/sf u_ yfxf 5}g

-;kmf efF8f], ^ lrof lunf;÷! ln= ;kmf kfgL, ! k'/Lof, @$ 306f leq k|of]u_

Zjf;k|Zjf; ÷lgdf]lgof

$=^ tkfO{n] Zjf;k|Zjf; /f]u÷lgdf]lgof jf/] ;'Gg' ePsf] 5< -5}g eg] **k|Zg g+ $=!) Hffg**]_

s_ 5 v_ 5}g

$=& 5 eg], Zjf;k|Zjf; /f]u ÷lgdf]lgof s] sf/0fn] nfU5<

s_ lr;f]n] v_ w'nf] ÷w'"jf u_ e'tk|]t ÷b]jL b]jtf
3_ yfxf 5}g ª_ cGo

==========
==========

$=* lgdf]lgof x'Fbf s] s:tf nIf0fx? b]lvG5g\ <

s_ Hj/f] cfpg] v_ ;f; km]g{ ufx|F]f x'g] u_ 3\of/—3\of/ x'g] 3_ ?3fvf]sL nfUg]

ª_ vfgf÷lkpg g;Sg] r_ yfxf 5}g 5_cGo
==========

$=(Zjf; k||Zjf; /f]u ÷lgdf]lgofaf6 aRg s] ug{ ;lsG5<

s_ jRrfnfO{ Gofgf] kf/]/ /fVg] v_ kf]l;nf] vfgf v'jfpg] u_ ;kmf ;'U3/ /fVg]

3_ b]jL b]jtf efSg] ª_ w'nf] w'“jfaf6 arfpgr_ yfxf 5}g

5_ cGo==========
==========

<u>Ifo/f]u</u>

$=!) tkfO{n] Ifo/f]u÷l6=la=sf] af/] ;'Gg' ePsf] 5 < -5}Gf eg], **k|Zg g+ $=!$ df hfg**]_

s_ 5 v_ 5}Gf

$=!! 5 eg], Ifo/f]u÷l6=la= Ps JolQmaf6 csf]{ JolQmdf s;/L ;5{ <

s_ vf]Sbf ÷xflR5pF ubf{ v_ x]nd]n ubf{ ÷;/;fdfgsf] k|of]u ubf{ u_ h'7f] vf“bf

3_b]jL b]jtfsf] >fkn] ª_ yfxf 5}g r_cGo
==========
===

$=!@ tkfO{sf] kl/jf/df s;}nfO{ Ifo/f]u÷l6=la= nfu]sf] lyof]<

s_ lyof] v_ lyPg

$=!# Ifo/f]u÷l6=la= nfUbf s:tf s:tf nIf0fx? b]lvG5g\ <

s_ vfg dg gnfUg]÷tf}n 36\g] v_ vf]sL nfUg] ÷vsf/df /ut b]lvg]
u_ 5ftL b'Vg] 3_ j]n'sLkv Hj/f] cfpg] ª_ yfxf 5}g r_ cGo==========

$=!$ tkfOn] 86\;sf] af/]df ;'Gg' ePsf] 5 < -5}g eg] **k|Zg g+ $=!^ df hfg**]_

s_ 5 v_ 5}g

$=!% 5 eg], 86\; eg]sf] s] xf]nf<

s_ ;xL pQ/ v_ unt pQ/

<u>of}g/f]u tyf Pr=cfO=le÷P8\;</u>

$=!^ tkfO{n] of}g/f]u tyf Pr=cfO=le÷P8\;sf] jf/]df ;'Gg' ePsf] 5 < -5}Gf eg] k**|Zg g+ $=@@ df hfg**]_

s_ 5 v_ 5}g

$=!& 5 eg] tkfO{sf] ljrf/df of] /f]u s;/L nfU5 <

==========

$=!* Pr=cfO{= le=÷P8\; pkrf/ u/] lgsf] x'G5 <

s_ x'G5 v_ x'b}g u_ yfxf 5}g

$=!(of}g /f]u tyf Pr=cfO{= le=÷ P8\; af6 aRg s] ug'{ k5{ <

s_ ;lx hjfkm v_ unt hjfkm u_ yfxf 5}g

$=@) of}g /f]u tyf Pr=cfO{=le=÷P8\; ;+s|ldt x'g' cl3 / kl15 u/Lg] Jojxf/df s]lx km/s 5 <

s_ 5 v_ 5}g u_ yfxf 5}g -5}g ÷yfxf 5}g eg], **k|Zg g+=$=@@ df hfg]**_

$=@! 5 eg], s] km/s 5 xf]nf==========

<u>s'i7/f]u</u>

$=@@ tkfO{n] s'i7/f]usf] af/]df ;'Gg' ePsf] 5 < -5}g eg], **k|Zg g+=$=@%df hfg]**_

s_ 5 v_ 5}g

$=@# 5 eg], of] /f]u s;/L nfU5 <

s_ b]jLb]jtfsf] >fk v_ k"j{hGdsf] kfk u_ ls6f0f'n] ubf{ 3_ yfxf 5}g ª_

cGo==========

$=@$ tkfO{sf] kl/jf/df s;}nfO{ s'i7/f]u nfu]sf] lyof] ls <

s_ lyof] v_ lyPg u_ yfxf5}g

h'sf

$=@% tkfO{n] k]6df kg]{ h'sfsf] af/]df ;'Gg' ePsf] 5 < -5}g eg], **k|Zg g+=$=@* df hfg**]_

s_ 5 v_ 5}g

$=@^ 5 eg], k]6df h'sf s;/L k5{ xf]nf <

s_ kmf]xf]/ kfgL÷vfg]s'/f v_ u'lnof] vfP/ Uf_ sfFrf] rfdn vfP/

3_ sfFrf] df;' vfP/ ª_ vfln v'§f lx+8]/

r_ yfxf 5}g

5_ cGo=======

$=@& h'sf kg{af6 aRg s] ug'{ x'G5 <

s_ cf}iflw vfg] v_ rlk{df lb;f ug]{ Uf_ /fd|/L ksfP/ vfg]]

3_ ;/;kmfO{df Wofg lbg] ª_ rKkn nufP/ lx8\g] r_ cGo

==========

Dfw'd]x

$=@* tkfO{n] dw'd]x -lrgL /f]u_ sf] af/]df ;'Gg' ePsf] 5 <

s_ 5 v_ 5}g

$=@(tkfO{sf] kl/jf/df s;}nfO{ lrgL /f]u nfu]sf] 5 <

s_ 5 v_ 5}g u_ yfxf 5}g

pRr /Qmrfk÷An8 k|];/

$=#) tkfO{n] pRr /Qmrfk -k|];/_ sf] af/]df ;'Gg' ePsf] 5 <

s_ 5 v_ 5}g

$=#! tkfO{sf] kl/jf/df s;}nfO{ pRr /Qmrfk -k|];/_ ePsf] 5 <

s_ 5 v_ 5}g u_ yfxf5}g

SofG;/

$=#@ tkfO{n] SofG;/ /f]usf] af/]df ;'Gg' ePsf] 5 <

s_ 5 v_ 5}g

$=## tkfO{sf] kl/jf/df s;}nfO{ SofG;/ /f]u nfu]sf] 5 <

s_ 5 v_ 5}g u_ yfxf5}g

%= dxTjk"0f{ 36gfx? M hGd, d[To" / la/fdL ;DjlGw ljj/0f

%=! tkfO{sf] 3/kl/jf/ la/fdL ePkl5 d'Votof sxfF hfg' x'G5 <

s_ 3/}df v_ wfdLeFmfs|L

u_ :jf:Yo ;+:yf 3_

cGo==========

%=@ tkfO{sf] kl/jf/df lat]sf] @ xKtfleq s'g} ;b:o la/fdL x'g' ePsf] 5 <

s_ 5 v_ 5}g

%=# 5 eg],

s||= ;=	Gffd	pd]/	s] ePsf] lyof] <	sfxFf pkrf/ ug'{ eof]	s;/L pkrf/ ug'{ eof]
!					
@					
#					

%=$ ut ! jif{ leq tkfO{sf] kl/jf/df s'g} ;Gtfg hlGdPsf] 5 <

s_ 5 v_ 5}g

%=% 5 eg],

S| m= ;+=	lhljt hGd		v]/ uPsf]	
	5f]/f	5f]/L	hGdb}	hGd]kl5
!				

@				
#				

%=^ tkfO{sf] kl/jf/df uPsf] ! jif{df s'g} ;b:osf] zf]s k/]sf] lyof] <

s_ lyof] v_ lyPg

%=& lyof] eg],

s||= ;=	Gffd	pd]/	ln+u	s] ePsf] lyof] <
!				
@				

^= cfjZostf

^=! tkfO{sf] ljrf/df of] ufpFsf] d'Vo ;d:ofx? s] s] x'g<

s_ v_ u_ 3_

^=@ tkfO{sf] ljrf/df o; ;d'bfosf] d'Vo :jf:Yo ;d:ofx? s] s] x'g\ <

s_ v_ u_

3_

^=# tkfO{sf oL ;d:ofx? s;n] ;dfwfg ug'{k5{ eGg] nfU5 **<**

s_ ;/sf/n] v_ u}/;/sf/L ;+:yf u_ ;d'bfo cfk}mn] 3_ yfxf 5}g

ª_ cGo

==========

==========

==========

&=Dfft[lzz' :jf:Yo

cGt/jftf{ lbg]sf] gfd==========
3/d'nL;Fusf] gftf==========

&=! lajfx xF'bf tkfO{sf] pd]/ slt lyof] <

s_ !)-!% jif{ v_ !^-@) jif{ u_ @!-@% jif{
3_ @% jif{ eGbf dfly

&=@ klxnf] aRrf hGdbf tkfO{ slt jif{sf] x'g'x'GYof] <

s_ @) jif{eGbf sd v_ @)-#% jif{ u_ #% jif{ eGbf dfly

&=# k'j{ ue{jtL hfFrsf] af/]df ;'Gg'ePsf] 5 <

s_ 5 v_ 5}g

&=$ 5 eg], sxfFaf6 ;'Gg'eof] <

s_ /]l8of], l6=le=, klqsf v_ ;fly, l5d]sL u_ :jf:Yo sfo{stf{ 3_ 3/kl/jf/ r_ cGo==========

&=% kl5Nnf] k6s ue{jtL x'Fbf ue{hfFr u/fpg' eof] ls ePg <

s_ u/fP+ v_ u/fO{g

&=^ u/fPsf] eP, slt k6s u/fpg' eof] <

s_ ! k6s v_ @-# k6s u_ $ jf ;f] eGbf a9L

&=& Gfu/fPsf] eP, lsg u/fpg' ePg <

s_ yfxf geP/ v_ cfjZos g7fg]/ u_ gEofP/

3_ :jf:Yo ;+:yf 6f9f eP/ ª_ nfh nfu]/ r_ cGo==========

&=* ue{jtL cj:yfdf l6=l6= sf] vf]k nufpg' eof] <

s_ nufP+ v_ nufO{g

&=(gnufPsf] eP, lsg nufpg' ePg <

s_ yfxf geP/ v_ 8/ nfu]/ u_ cfjZos g7fg]/

3_ :jf:Yo ;+:yf 6f9feP/ª_ cGo==========

&=!) tkfO{n] ue{jtL cj:yfdf cfO/g rSsL vfg'eof] <

s_ vfPF v_ vfO{g

&=!! gvfPsf] eP, lsg vfg'ePg <

s_ yfxf geP/ v_ gkfP/ u_ emGem6 nfu]/

3_ aRrf hGdfpg ufx|f] x'G5 eg]/ ª_ cGo==========

&=!@ ue{jtL cj:yfdf ;flas adf]lhd jf Tof] eGbf al9 vfgf vfg' k5{ <-dfqf ;f]Wg]_

s_ ;flas adf]lhd v_ ;flas eGbf sd u_ ;flas eGbf al9

&=!# tkfO{n] ue{jtL cj:yfdf s'g} vfgf afg'{ eof] <

s_ af/] v_ af/Lg

&=!$ Aff/]sf] eP

	Aff/]sf] vfgf	sf/0f
!		
@		
#		

&=!% tkfO{n] ue{jtL cj:yfdf h'sfsf] cf}ifwL vfg 'ePsf] lyof] <

s_ vfP+ v_ vfO{g

&=!^ ue{jtL cj:yfdf w'd|kfg / dWokfg ug'{ ePsf] lyof] <

s_ lyP+ v_ lyOg

&=!& uef{j:yfdf tkfO{nfO{ s]lx ;d:of cfPsf] lyof] <

-s_ lyof] -v_ lyPg

&=!* cfPsf] lyof] eg], s:tf] ;d:of cfPsf] lyof] <

s_ xft v'§f ;'lGgg] v_ d"5f{ kg]{ u_ sDk cfpg]

3_/ut aUg] ª_ Hj/f] cfpg]

&=!(tkfO{sf] kl5Nnf] aRrfsf] hGd sxfF ePsf] lyof] <-:jf:Yo ;+:yfdf ePsf] eP **k|Zg g+==&=@^ df hfg**]_

s_ 3/df v_ :jf:Yo ;+:yfdf u_ uf]7df 3_
cGo==========

&=@) tkfO{nfO{ aRrf hGdfpg s;n] ;xof]u u/]sf] lyof] <

s_ :jf:YosdL{ v_ 3/kl/jf/ u_ ;'8]gL 3_
l5d]sL ª_ cGo

&=@! ;'Ts]/L cj:yfdf s]lx ;d:of cfPsf] lyof] <

s_ lyof] v_ lyPg

&=@@ lyof] eg], s:tf] ;d:of cfPsf] lyof] <

s_ al9 /Qm>fj v_ ;fngfn c8\sg] u_ Hj/f]
cfpg]

3_ nfdf] Aoyf ª_ a]xf]; x'g]
r_ cGo

&=@# tkfO{n] ;'Ts]/L ;fdu|Lsf] af/]df ;'Gg'ePsf] 5 <

s_ 5 v_ 5}g

&=@$ 5 eg], aRrf hGdfpbf k|of]u ug'{ ePsf] lyof] <

s_ lyP+ v_ lyOg

&=@% aRrfsf] gfn sf6\g s] k|of]u ug'[{ ePsf] lyof] <

s_ rf]of v_ rSs', xFl;of, r'n];L

u_ k|of]u u/]sf] klQ -An]8_ 3_ k|of]u gu/]sf]
klQ -An]8_

&=@^ ;'Ts]/L ePkl5 le6fldg P SofK;'n vfg' eof] <

s_ vfP+ v_ vfO{g

&=@& ;'Ts]/L ePsf] 5 xKtfleq :jf:Yo hfFr u/fpg' eof]<

s_ u/fP+ v_ u/fO{g

&=@* u/fPsf] eP, sltk6s u/fpg' eof] <

s_ ! k6s v_ @ k6s u_@ k6s eGbf a9L

&=@(tkfO{ ;'Ts]/L ePsf] slt ;do kl5 ;fljs adf]lhd sfd ug{ yfNg'eof] <

s_ 5 xKtf eGbf sd v_ 5 xKtf u_ 5 xKtf eGbf a9L

&=#) tkfO{sf] kl/jf/df s;}nfO{ cfË v:g] ;d:of 5 <

s_ 5 v_ 5}g

&=#! tkfO{sf] ljrf/df cfË v:g] ;d:of s] sf/0fn] x'G5 <

s_ w]/} aRrf hGdfP/ v ;'Ts]/L cj:yfdf ux|f} sfd u/]/

Uf_ pd]/ 9Ns]kl5 aRrf hGdfP/ 3_ e't, k|]t, b]jLb]jtfsf] sf/0f

ª_ yfxf 5}g r_ cGo==========

&=#@ cfË v:g] ;d:of x'Fbf s] ug]{ ul/G5 <

s_ :jf:Yo ;+:yfdf pkrf/ ug]{ v_ lbbLalxgL ;+u ;/;Nnfx lng]

u_ s]lx ulb{g,n'sfP/ /fV5' 3_ wfdLeFmflqmsf]df b]vfpF5'

ª_ yfxf 5}g r_ cGo==========

afn :jf:Yo

&=## aRrfnfO{ cfdfsf] lauf}tL b'w v'jfpg' x'G5 ls x'b}g <

s_ x'G5 v_ x'b}g u_ yfxf 5}g

&=#$ x'G5 eg], tkfO{n] ckm\gf] aRrfnfO v'jfpg' eof] <

s_ v'jfPF v_v'jfO{g

&=#% gv'jfPsf] eP, lsg v'jfpg' ePg <

s_ cfjZos g7fg]/ v_ b'w gcfP/

u_ v/fa u5{ eg]/ 3_ yfxf geP/

ª_ cGo==========

==========
====

&=#^ aRrfnfO{ cfdfsf] b'w dfq slt ;do;Dd v'jfpg' k5{ <

s_ ^ dlxgf eGbf sd v_ ^ dlxgf u_ ^ dlxgf eGbf dfly 3_ yfxf 5}g

&=#& tkfO{sf] aRrfnfO{ cfkmgf] b'wsf] ;fy;fy} cGo vfg]s'/f slxn] b]lv v'jfpg ;'? ug'{eof] <

s_ $ dlxgf eGbf d'lg v_ $ b]lv % dlxgf u_ ^ dlxgf 3_ ^ dlxgf eGbf dfly

&=#* tkfO{n] ;af]{Qd lk7f]sf] af/]df ;'Gg'ePsf] 5 <

s_ 5 v_ 5}g

&=#(5 eg], s;/L tof/ ul/G5 <

s_ ;lx tl/sf v_ unt tl/sf u_yfxf 5}g

-@ efu km/s km/s u]8fu'8L, @ efu cGg, cnu cnu e'6\g], lkWg] / ld;fpg]_

vf]kM

&=$) tkfO{n] aRrfnfO{ nufpg] vf]ksf] af/]df ;'Gg'ePsf] 5 <

s_ 5 v_ 5}g

&=$! tkfO{n] cfkm\gf] aRrfnfO{ vf]k nufpg' eof] <

s_ nufP+ v_ nufO{g

&=$@ nufPsf] eP -sf8{ x]/]/ jf ;f]w]/ eg]{_

s| =; +	Gffd	pd]/ ÷ln Ë	BC G	Polio			DPT/HB			Measles
				1st	2nd	3rd	1st	2nd	3rd	
!										
@										
#										

&=$# # jif{ d'lgsf] aRrfnfO{ a]nfa]nfdf :jf:y ;+:yfdf hf]Vg nUg] ug'{ePsf] 5÷lyof] <]

s_ 5 v_ 5}g

&=$$ tkfO{n] s'kf]if0f -?Gr] /f]u_ af/]df ;'Gg'ePsf] 5 <-5}g eg] **k|Zg g+= ^=$& df hfg**]_

s_ 5 v_ 5}g

&=$% 5 eg], s'kf]if0f s] sf/0fn] x'G5 <

s_ kf}li6s tTjsf] sldn] v_ e't k|]t, b]jtf nfu]/

u_ :ofxf/ ;';f/sf] sldn] 3_
cGo==========

&=$^ s'kf]if0f -?Gr]_ nfu]kl5 aRrfnfO{ s;/L lgsf] kfg{] ug{'x'G5 <

s_ :jf:Yo ;+:yf nu]/ v_ wfld emFfls|nfO{ b]vfP/

u_ k|z:t vfg]s'/f lbP/ 3_
cGo==========

<u>kl/jf/ lgof]hg</u>

&=$& tkfO{n] kl/jf/ lgof]hgsf] af/]df ;'Gg'ePsf] 5 <-**5}g eg] ;dfKt ug**]{_

s_ 5 v_ 5}g

&=$* tkfO{n] kl/jf/ lgof]hgsf] ;fwg k|of]u ug'{ ePsf] 5 <-5}g eg] **k|Zg g+= ^=%! df hfg**]_

s_ 5 v_ 5}g

&=$(tkfO{nfO{ kl/jf/ lgof]hgsf] ;fwg k|of]u ug]{ eg]/ s:fn] ;Nnfx lbof] <

s_ :jf:Yo sfo{stf{ v_ 3/kl/jf/ u_ ;fyL, l5d]sL
3_ cfkm}

&=%) tkfO{n] kl/jf/ lgof]hgsf] s'g ;fwg k|of]u ug'{ePsf] 5 <

s_ <u>:yfO{</u> v_ <u>c:yfO{</u>

!=k'?if aGWofs/0f != l8kf],;+lugL ;'OF{
$=g/KnfG6

@= ldlgNofk -Nofk|f]:sf]lk_ @=lkN;

%=sk/ l6

#=s08d

&=%! 5}g eg] lsg k|of]u gug'{ ePsf] xf]nf <

s_ nfh nfu]/ v_ 3/ kl/jf/sf] sf/0fn] u_ emGem6 nfu]/

3_ v/fa c;/ u5{ eg]/ ª_ ;+:s[lt, l/lt l/jfhn] r_ pknAw geP/ 5_

cGo==========

&=%@ tkfO{sf] ljrf/df Pp6f aRrf hGdfPkl5 csf]{ aRrf slt jif{kl5 hGdfpg' /fd|f] x'G5 <

s_ ! jif{ v_ @ jif{ u_ @ jif{ eGbf dfly

==========

cGt/jftf{ lng]sf] Gffd

cjnf]sg kmf/fd

!= 3/sf] k|sf/

s_ sRrf v_ kSsf

@= 3/sf] 5fgf]

s_ v/÷k/fnsf] v_ ss{6kftf u_ 9nfg 3_ 9'ª\uf/6fon ª_ cGo

#= xfjfsf] cfjft hfjt s:tf] 5 <

s_ /fd|f] v_ l7s} u_ g/fd|f]

$= r'nf]

s=;'wf/LPsf] -w'jFf gcfpg]_ v= w'jfF cfpg], ;fwf/0f

%= lrlDg

s_ 5 v_ 5}g

^ Iodine test

s_ 0 PPM v_ lessthan 15 PPM u_ more than 15 PPM

&=3/af6 lg:sg] kmf]xf]/ kfgLsf] Aoj:yfkg

==========

*= rkL{sf] agfj6

s_ ;]g]6/L v_ Og;]g]6/L

(= 3/b]vL rkL{sf] b'/L

s_ hf]l8Psf] v_ glhs u_ 6f9f

!)= rkL{sf] k|of]u

s_ 5 v_ 5}g

!!= KffgLsf] ;|f]t

s_ 5 v_ 5}g

!@= 3/b]vL uf]7sf] b'/L

s_ hf]l8Psf] v_ glhs u_ 6f9f

!#= s/];faf/L

s_ 5 v_ 5}g

!# PGy|f]kf]d]l6«s cfFsf8f **-^ b]lv ^) dlxgf**_

S| m= ;+=	Gffd	prfO (cm)	Tff} n - k.g _	MUAC			W/ A	W / H	H /A	Remarks
				x	k	/f				
!										
@										
#										

Work plan schedule

Activities	**1**	**2**	**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**
Departure from college																														
Rapport building and secondary data collection																														
Social Mapping																														
Data Collection																														
Data Analysis																														
Need prioritization and Planning of MHP																														
MHP Implementation																														
Exhibition																														
Preparation for Final Community Presentation																														
Final Community Presentation																														
Report Writing																														
Evaluation of MHP																														
Departure from Community																														

FORMULA USED

$$\text{Sex Ratio} = \frac{\text{Total male population}}{\text{Total female population}} \times 100$$

$$\text{Total Dependency Ratio} = \frac{\text{Total population of under 15yrs and above 64 yrs}}{\text{Total population 15-64 yrs}} \times 100$$

$$\text{Child Dependency Ratio} = \frac{\text{Total population of under 15yrs}}{\text{Total population 15-64 yrs}} \times 100$$

$$\text{Total Dependency Ratio} = \frac{\text{Total population of above 64 yrs}}{\text{Total population 15-64 yrs}} \times 100$$

$$\text{Crude Death Rate} = \frac{\text{Total no. of death in one year}}{\text{Total mid year population}} \times 1000$$

$$\text{Crude Birth Rate} = \frac{\text{Total live birth in one year}}{\text{Total mid year population}} \times 1000$$

$$\text{Average Family Size} = \frac{\text{Total population of observed data}}{\text{Total no. of household in the observed data}} \times 1000$$

Rapport building

Discussion with FCHVs about CD

Social mapping

Data collection

Need prioritization by PRA

School health education

Medical examination of school students

De-worming program

Growth monitoring

Group discussion on safe motherhood

Counseling for pregnant women

Health education exhibition programme

Discussion on environmental sanitation

Environmental sanitation committee

Toilet Construction

Preparation for community presentation

Community presentation

Community presentation