A Report on

Community Health Diagnosis Of Alapot VDC, Kathmandu

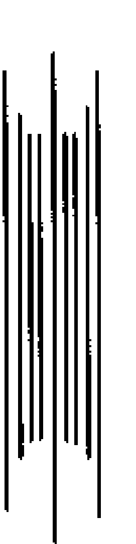
Group "A"

Explored by

2nd batch

Bachelor in Public health

Students



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Faculty of public health

Nepal Institute of Health Sciences

Tusal Boudha, Ktm, Nepal

April 15 to May 16, 2005

Approval Sheet

Purbanchal University
Nepal Institute of health sciences (NIHS)
Boudha-6, Tusal, Ktm

This is to certified that

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Ms MEERA TANDAN	**Ms REKHA BHATTARAI**
Ms SWEETY BHIDHYA	**Ms SYARON BASNET**
Mr BIRATSHARMA	**Mr JANAK THAPA (GROUP LEADER)**

The students of BPH of this institute has completed the community residential field programme (Community health diagnosis) as requirement of Bachelor of Public Health Programme and submitted A report on CHD

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External Examiner
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Supervisor
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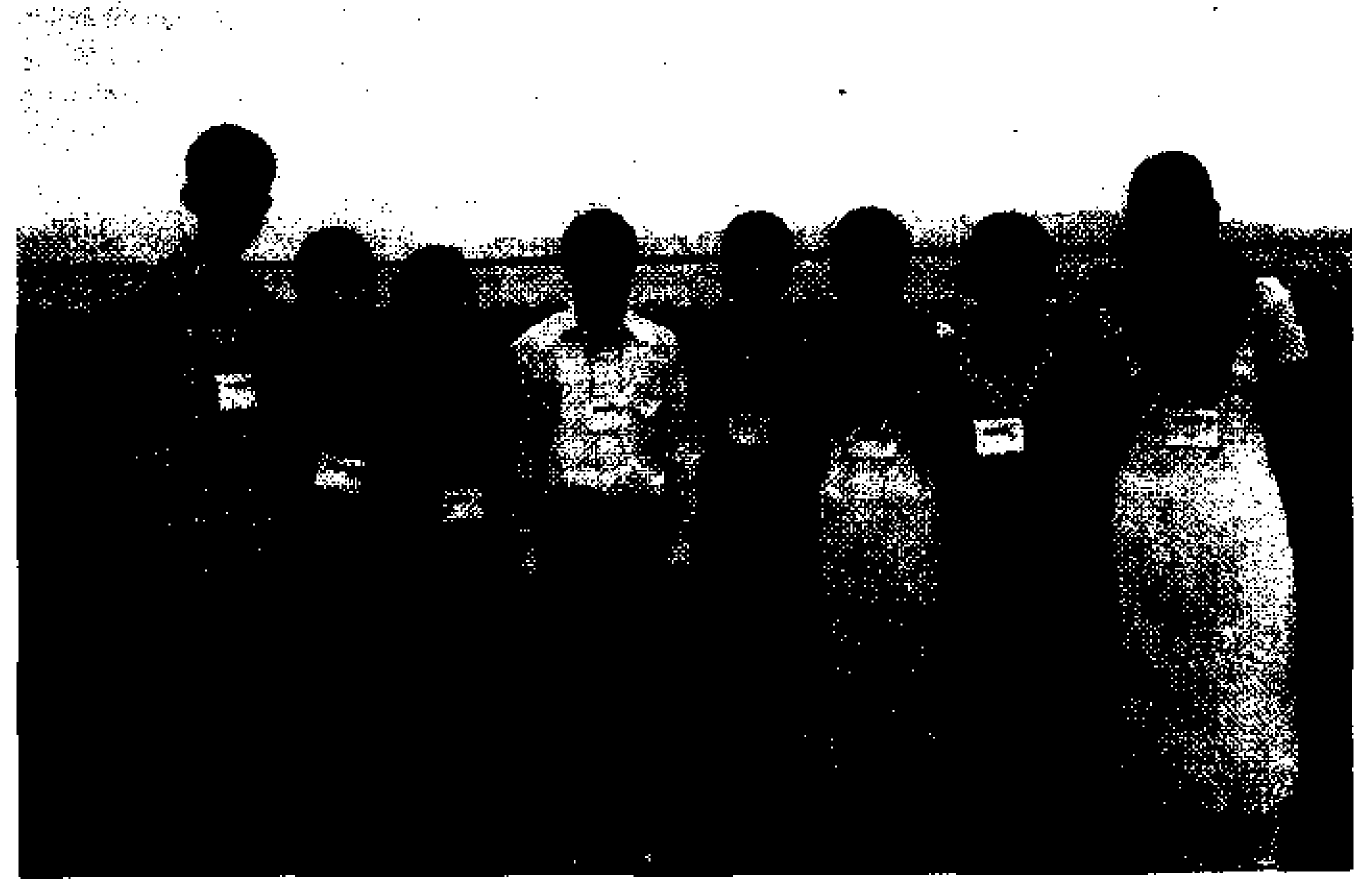

LEFT TO RIGHT: BIRAT SHARMA, SWEETY BAIDHYA, REKHA BHATTARAI, JANAK THAPA, MEERA TANDAN, BIMALA K.C., DIPIKA DAS, SYARON BASNET

Acknowledgement

It's much easier to point out the problem than it is to say just how it should be solved.

Writing acknowledgments has become fashionable in Reports and books. It ought to be boycotted, if its purpose is merely an attempt to return the support, cooperation, and generosity of others though a few nicely written words, some adjectives. To us, writing these acknowledgments was as difficult as writing the report itself. This is not only because we found no words in the dictionary which could do justice to the support and cooperation extended to us by the allapotians, friends and teachers, but because this report is, as an emergent property, an outcome of many individuals and institutions at right moment, in the right way, in the right order and in the right place.

For genuinely sharing their experience and insight with the study team, we would like to express our sincere gratitude with deep appreciation to all the respondents, institutions, key informants for their invaluable guidance, support, cooperation, contribution and participation for making this community diagnosis Programme a success.

For their cooperation during field study, we extend special thanks to Nepal institute of health sciences for providing its full support during our one-month stay in Alapot VDC. We are undoubtfully to our college management and administration for their constructive feedback and encouragement during the period of our study. Without their support and encouragement we would have remain idle to accomplish the study.

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Our convivial thanks goes out to VDC family with special references of Mr.Ramsharan phuyal, Mr. Shudarsan Phuyal, Mr. Rameshwor Phuyal, Mr. Bishnu

EXECUTIVE SUMMARY

To summarize, the alapot V.D.C with total area of 1.61 sq km is located at an altitude of 1300- 1350 ft at sea level maintaining a roadway distance of 17 km from Kathmandu this report is being prepared.

The report focuses on objectives of identifying, understanding and applying of possible solution to the existing health problem related to the topics like demographic, socio –economic, cultural, educational sectors, maternal and child health, environmental health of Alapot V.D.C.and implementation of MHP based on real need of the V.D.C.

The participatory approach and cross sectional/descriptive design including both qualitative (PRA tools) as well as quantitative (questionnaire, checklist) methods are used. The report is based upon the analysis of primary and secondary data. During our one-month field visit we observed a no. of area is to be improved, although most of the demographic indicators are found satisfactory.

In Alapot, joint family is usually the prime arena of production i.e; 57.01%. The diversity of ethnic groups holds important implications for the approaches, methods and concerns of the development. Hinduism, most power ideological force in Nepal is found to be 98.04%.

Median age of marriage for male is 20 years while for female is 19 yrs. Agriculture is the dominant occupation (60.49%), but still 57.1% of the household have to depend in to number of options to run the household 12 months a year.

The median age of pregnancy of women of Alapot is 21yrs. 91.2% of women has ANC visit during pregnancy. 48.25 percentage of women gave birth to their baby at home of which the use of sutkeri samagri is 20%. Colostrums feeding by 97.35% of mother mean that infants are less prone to high risk of health illness.

Immunization coverage resembles to national level which is found BCG 92.60% DPT and POLIO- I 95.34%, II- 91.67%, & III- 93.51% and MEASLES 86.11% coverage.

Nutritional status of children is found very painful, of which 56.89%are healthy child. 12.07% are found malnourished, and 31.04% are in the danger line of to be malnourished

Among the number of problems experienced by women, the problem on uterus prolapsed is 30.3% among which 15%is still untreated.

93.17% of household depends on tap water and 73.66% of household don't apply any purification method. The need for improvement in the construction of toilet and its proper use is recognized, since 25.85% of household is devoid of toilet yet. There has been no individual effort to promote proper disposal of wastes.

Thus, a number of efforts are to be made to help to create an increasingly favorable climate for the development of both child and mother.Hygiene condition which is very poor and consequently hazardous to health is to be improved.Concarted efforts is to be given to promote the construction of toilet.

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CHAPTER 1
INTRODUCTION

1.1 Background
Community diagnosis "An Introduction"

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 community diagnosis is to define existing problems, determine available resources and set priorities for planning, implementing and evaluating health actions by and for the community.

In community health diagnosis the amount of data is much greater and requires more lengthy analysis and usually mechanical processing. The data includes demographic data such as population figures by age and sex, vital rates and survey data. This survey data should cover health matters, use of services and their effectiveness, sociological and cultural information and ecological or environmental data. This gives a view of community health problems and their real needs.

Statistics and epidemiology are the major disciplines involved in planning and analysis of this survey. Specific diagnosis is required in community health diagnosis. Assessment of nutritional status is important. Information on social and cultural factors and physical disability is essential. The environment and its contribution to the picture of health and diseases must be studied .The KAP of the people in the community must be known and the distribution of these within the community must also be determined.

A community usually has a long history and will have attempted to find solutions to some of its health problems .It is necessary to determine the community's perceptions of its problems and what has been done and how successful these measures have proved to be. A community diagnosis not only defines problems and its correlates but also analyses previous measures to alleviate them and purposes new ones that are more appropriate. In this respect, community diagnosis also encompasses evaluation of services (and not necessarily only health services but also other services such as education, occupation, socio-cultural patterns etc.)

1.2 Importance of community diagnosis

- There is always limited resources therefore common disease, preventable diseases and CD should find out disease of greatest concern to the community.
- To eplore the hidden health problem and resources too.
- To aware people about their real health problem.

1.3 Objectives of community Health diagnosis:

General objectives:

✓ To identify, understand and apply possible solution to the existing health problem of Alapot V.D.C.

Specific objectives:

- ✓ To find out demographic, socio-economic, cultural, educational, and gender status of the community.
- ✓ To identify knowledge, attitude, and practice in terms of health, disease and health service utilization pattern in the community.
- ✓ To asses the nutritional status of under 5childern by anthropometric measurement.
- ✓ To study breast feeding practice among mothers.
- ✓ To identify hidden health problems of the community.
- ✓ To determine health care practices of FCHVS.
- ✓ To priorities real health problems on the basis of felt and observed need by community participation.
- ✓ To plan, implement and evaluate micro health project in the community effectively.

1.4 Methodology

The study was carried out in Alapot VDC and has been made to assess the health status of the selected VDC. We adopted the participatory approach and the design was cross sectional/descriptive including both qualitative as well as quantitative methods.As guided we prepared the methodological quantitative tools(questionnaire,checklist) and analytical qualitative tools(PRA tools)to conduct the field study. For this purpose, study team adhered to the following methods to ensure effective outputs from the study.

1.5 Literature review

Reviewing the literature is the important part of any research study.The literature review brings clarity and focus to rsearcher's research problem, improves the methodology and broadens the knowledge for answering research questions.Thus the literature reviewing as the integral part of our survey study.

The relevant document were collected from the center level for review analysis .The most relevant literature, publications and IEC materials were collected, consulted and reviewed analytically to suit the study objectives from DoHs and its various divisions. Review analysis began with study team's visit to documentation centers such as Election commission and various project offices of health related organizations and by obtaining list of literature (reports, documents, brochures and other information, communication and educational materials).The elaborate list of literature was briefly studied and documented suitably. Both desk and field review of the recent literature were considered over and again.

1.6 Site selection and HH selection:

The study has been conducted in the VDC with rural setting community, which aims to explore the health status of the VDC for the detailed study. For the purpose of household selection, the list of the households in the selected VDC was obtained from the election commission office and was cross checked with the one provided by the VDC office of Alapot.

1.7 Sampling:

Systematic simple random sampling technique was used for both households and FCHV's.

Total population of VDC	= 3251(Source, VDC office)
Total household	= 427 (Source, Election commission office)
Total Sample population	=1282(Male: 650, Female: 632)
Total Sample Household (50.3% of total HH)	= 214
Total FCHV's	= 18
Sample (50% of total FCHV's)	= 9

Total U5 population =339
Sample U5 population =116
Sample mother's population =114
Total missing = 9

1.8 Tools & techinique of data collection

Both Qualitative and quantitative data were collected utlizing all availables tools and technique.Questionnaire were used as the main tool for the study.A set of questionnaire was formulated to collect the quantitative informations from the respondents of sampled households.The PRA tools were facilitated to collect qualitative information through perticipation.

Table-1 TOOLS AND TECHNIQUES OF DATA COLLECTION

Data	TOOLS	RESPONDENT	TECHNIQUES
Quantitative	Questionnaire House hold interview questionnaire	Household head or person >20 years who can respond	Structured interview
	< 5 yrs child bearing mother interview questionnaire	< 5 child bearing mother	Structured interview
	Questionnaire for FCHVs	FCHVs	Structured interview
	Questionnaire for leaders	Leaders	Structured interview
	Questionnaire for traditional healers	Traditional healers	Structured interview
	Observation: Observation checklist	Observe household environmental sanitation	Observation
	Anthropometry : anthropometric measurement for <5 children	< 5 years children	measurement
Qualitative	Mapping tool ➢ Transect walk ➢ Social and resource map ➢ Mobility map	Club member, adolescents teachers, leaders and local people	Discussion and participation
	Diagramming tools ➢ DRD ➢ Seasonal calender ➢ ID ➢ Cause and effect diagram	Students, Mothers, Leaders and club members	Discussion and participation
	Discussion and interview ➢ FGD ➢ Timeline	Mothers and elder members of community	Interaction and unstructured interview

1.9 Field implementation:

Starting on 2nd baisakh, CHD was initiated in Alapot V.D.C. Prior to CHD, our instrument was pre tested at Kapan V.D.C which is similar to Alapot V.D.C in most of the aspects as socio-economic structure, population structure, geographical structure. Conceptual clarity on different aspects of community was provided by our teachers' .PRA intensive classes were launched. Intensive orientation classes were conducted for 3 days prior to field. We followed ward and questioned the people. The peak harvesting time emerged as one of the challenges to us as meeting the head of the family was difficult in most of the cases. After 17 days of data collection, data analysis was done. 1st community presentation, which was held on 20th of baisakh in the presence of informal and formal leaders followed data analysis. With the advice and suggestion born on 1st community presentation we planned our MHP as in accordance with the real needs of the community. The final community presentation was carried out with the community people on 31st baisakh. Finally we departed from Alapot on 1st of jestha.

1.10 Data analysis & presentation procedure:

Simple descriptive statistic was followed for data analysis. microsoft word , microsoft excel, microsoft office visio,SPSS, were also used for Tabulation, graphic presentation .And other audio visual aids were used for the presentation of analytical examination.

1.11 Budget & time schudule:

Besides the budget provided by the campus, individual contribution by the group member was made. The time for the total CHD process started from 2nd of baisakh to 2nd of jestha.

1.12 Logistics and management:

- Lodging and fooding: Before reaching the VDC. We have rented 2 rooms in a cemented house with the help of our seniors in ward no.5.For communication our neighbor helped us and also we utilized local telephones. We managed food in a local hotel in ward no.4, requiring10min walk from our house.
- IEC materials: All the IEC materials were brought out from the DoHs and other project offices as the future requirements for MHP and extra-activities.
- Stationeries: All the required stationeries were provided from the NIHS authority which include pencils, sharpners, pens, markers, papers, graphs, masking tape, chart paper, brown paper, staples, scale, colours, tools etc.
- Utensils: The College itself provided Stoves, gallon, kitchen utencils and buckets with the returning authority from the group.
- Medical and anthropometric instruments: BP set; first aid box and all the anthropometric tools were provided by the campus with returning authority from the group.
- Transport facilities: College was flexible enough to provide transportation facilities to the residence point while departing and arriving.

1.13 Validity and Reliability of tools:

- Classes on various aspect of community diagnosis were delivered. PRA classes were conducted to facilitate the students.
- The questionnaire was pretested prior to CHD to avoid confusion and to determine the practicability of the tools in the field at Kapan VDC, Kathmandu and thus the readjustment of the questionnaire were done as per requirements.
- The study tools were revised and finalized and the basis of result obtained from pre-test and a comment made by the supervisor was taken into consideration.
- Intensive orientation classes were facilitated before going to the field.

- Standardization of test instruments like Salter weighing scale, weighing machine and shaker's tape was carried out after the completion of data collection.
- Simple and understanding language was used as far as possible to get response from the respondents.
- Probing of questions was done so as to get the fact information.
- Literature reviewing was done over and again so as to avoid confusion in the group

1.14 Ethical considerations

- Official letter was submitted to Alapot VDC's office and Alapot Illaka health post, written by NIHS thus verbal approval was taken to proceed the diagnosis.
- Teachers and Supervisor met with the concerned authority of the VDC.
- Before fixing date for any programme suggestion and permission were always obtained from the concerned authority so as to avoid disturbance in work and increase the participations.
- Verbal permission was always obtained from the respondents before interview.
- Confidentiality was maintained by avoiding the names of the respondents.
- The responses were utilized only for the study purpose thus maintaining the privacy.
- Right of respondent (To know our objective, freedom to respond and reject etc.) and our limitation (Do no harm, do not judge and offend, never misuse the result etc.)was always taken into consideration.
- MHP was conducted as per the need of local people.

1.15 Pretesting

Pretesting was done prior to the CHD in the field at Kapan vdc,kathmandu with the help of concern subject teacher and expert.

1.16 Biases reduction

- Sample was choosen such that it was inclusive of sample from every wards to reduce biases.
- All the instruments were cheked throughly and care was taken to read measurement while measuring height, weight, and MUAC.
- Probing was also done to reduce biases and errors while touching sensetive issues.
- While implementing PRA tools we focused on the marginalised person lies below the line poverty line.

1.17 Limitation and delimitation of the study

Though the survey was carefully designed and planned to get the most reliable data, some delimitation as well as limitation may arise during the course of survey that are listed below:

- Recall bias
- This study is based on sample data collected from Alapot VDC.Thus; this finding may not be generalized for other groups of people and other part of country.
- Due to peak harvesting seasons, our respondents could not provide us enough time and participation.
- Due to limitation of time we have considered only limited demographic and socio-economic variables.
- Some variables, which are considered as independent variables may be dependent on other factors.
- Due to small sample size, the findings may not be relevant.

1.18 Operational definitation

HEALTH

State of being well and free from illness.

KNOWLEDGE

General awareness or possession on information, facts, ideas, truths or principles.

ATTITUDE

Personal view on something or an opinion or general felling about something

BEHAVIOUR

Manners, way of behaving

ILLITERATE

Unable to read and write,

LITERATE

Able to read and write,

RAPPORT

Communication or relationship especially when useful and harmonious

PRIORTIZATION

Systematic method, giving greater or lesser importance to various disease or problems,

DEMOGRAPHIC

the study of human population, including their information about age, sex, family size, growth, density, distribution as well as statistics regarding birth, marriage etc

MORBIDITY

Presence of illness or diseases or patterns of disease etc

MORTALITY

The state of being certain to die eventually

AT RISK

Chance of something going wrong, the danger that injury, damage or loss will occur

RESOURCES

In sense of building infrastructure, materials, money, etc

RESPONDENTS

Somebody who response to something

COMMUNITY

People living within the organization

NUCLEAR FAMILY

A social unit that consists of a mother, a father, and their children living together and sharing a same "chulo".

JOINT FAMILY

The family as a unit embracing parents and children together with grandparents living together and sharing the common 'chulo'.

UTERUS PROLAPSE

The displacement of uterus from its original position.

HEALTH STATUS

Condition of health and well being of an individual or community

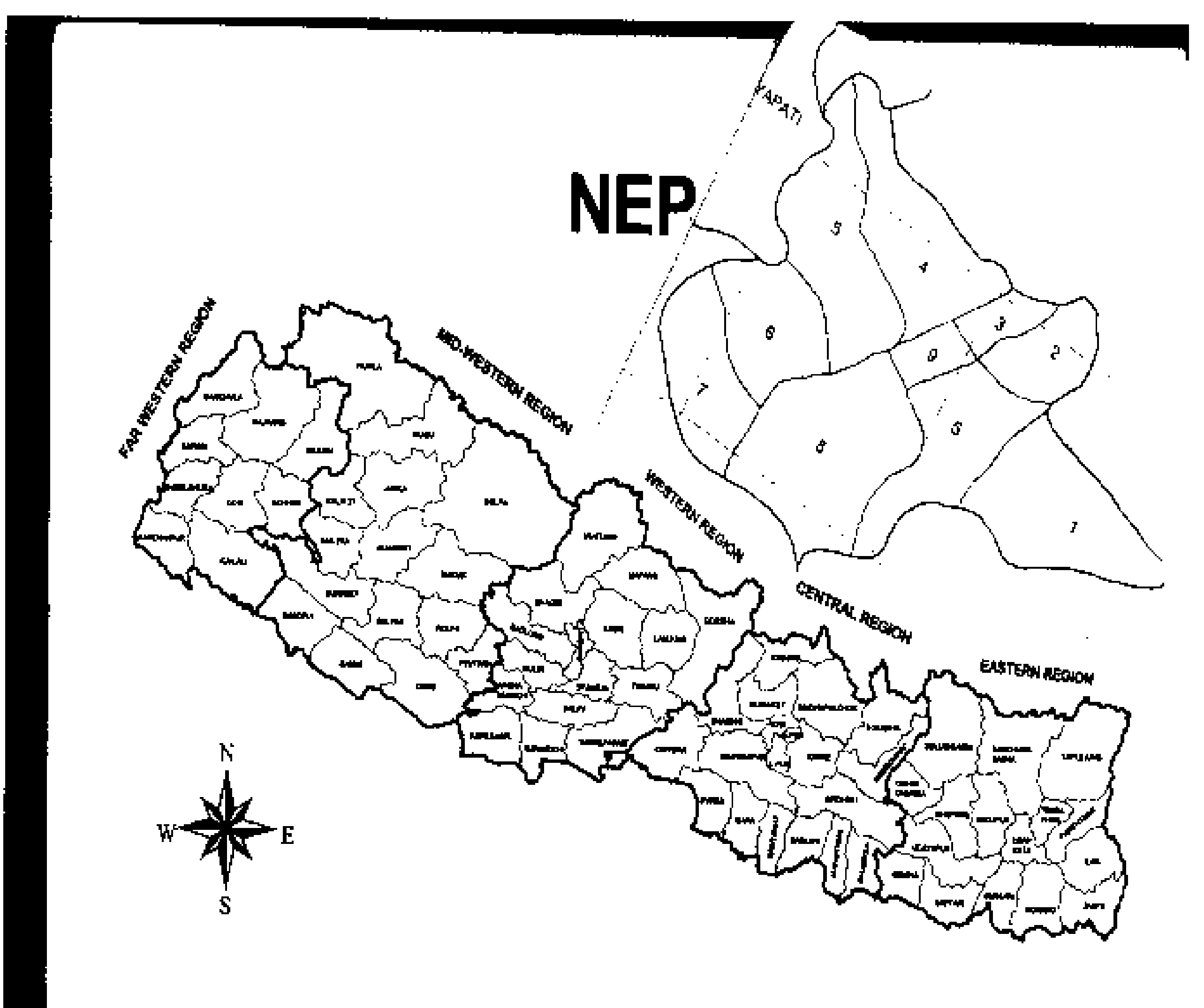
MALNUTRITION

Deficiency of nitritient food

CHAPTER 2
VDC INTRODUCTION

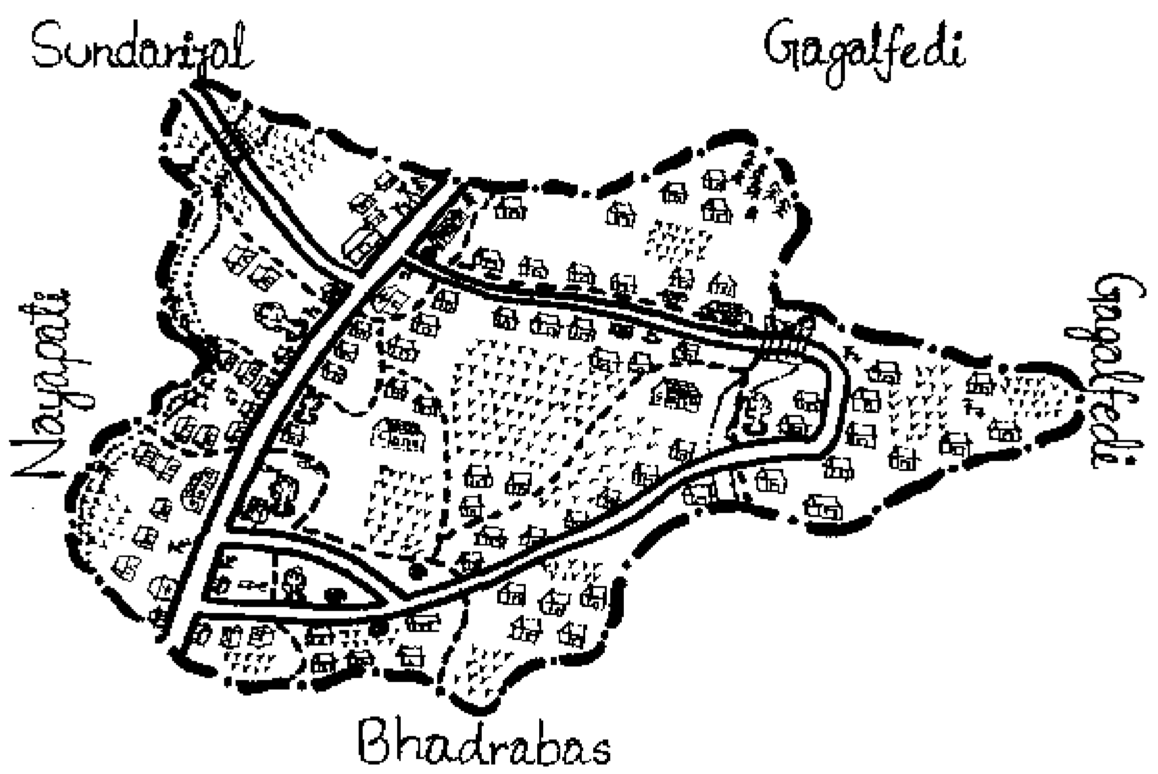
2.1 VDC profile

2.1.1Geographical map



1.2 Social map

ALAPOT VDC-MAP



INDEX

Item	Symbol
Road	
River	
VDC boundry	
Ward boundry	
VDC Office	
Health Post	
School	
Private house	

Item	Symbol
Well	
Tap stand	
Temple	
Club	
Bus-stop	
Chautari	
Tree	
Paddy	

2.2 Overview of Alapot VDC

2.2.1 Location:

Alapot VDC lies 17 km north east from Katmandu and requires about 1 hrs drive by bus from district headquarter –Kathmandu. A black topped road joins upto Danchi with the capital and towards runs a paved road to Alapot.

2.2.2 Political boundary:

Regarding the VDC's boundaries it is a spectacular village far away from the city pollution with Bagmati river in the west along with villages Nayapati and Sundarijal in northern side Gagalfedi in east and Bhadrabas in south.Gagalfedi surrounds the VDC in semicircular pattern .Alapot consists of 9 wards, among which ward 1 is a bite far and remote, ward 7 and 8 are poor in environmental sanitation and personnel hygiene. Ward no.2 is larger in area and consist of largest no. of household in the VDC. Ward no. 9 is the smallest with small no. of household.

Alapot VDC consist of 427 household (according to voter list provided by the election commission office kantipath ktm, 060)

2.2.3 Topography:

Alapot is situated between 80 °25'40"and 25°25'20" latitude and 27°28'to 27°45'6"longitudes, the shape tend to trapezoid. Alapot is situated at 1300-1350 ft from sea level with an area of 1.61 sq km (0.4% of the area of Katmandu district). The village expands from north to south in terms of area.

2.2.4 Socioeconomic and cultural factors:

Peoples with different ethnic races and tribes resides here majority of them being Bhramin , Chettri and Newar .The typical feature of this village is that the settlements are clustered around caste and social standing .Hindusim is the major religion

2.2.5 Language

Nepali is widely spoken language Newari within their families and community .Typical Nagarkoties, Newaris resides in Ward no. 7 and 8.

2.2.6 Husbandry

Most of the Household have some animals and chickens.

2.2.7 Major crops and beverages

Major population grows paddy and wheat as a staple food supported by potato, maize, barley, and millet for survival and sustenance .Unity between the diverse life style, cooperation, hospitality, and respect is the special feature of this VDC which is shown by the "mela practice" being carried out during harvesting period.

2.2.8 Mobility

Internal mobility in brick industries in search of employment, reflects poverty and suffering which is highly observed among the Nagarkoties of Ward no. 7 and 8.

2.2.9 Communication and information

In this vdc regarding communication, telephone services are available every time. There is a post office too for delivering messages. Daily newspapers are found easily over there so that we can get any type information that is happening in any corner of the world. Besides this, a local magazine called 'Boyaka Uthkhanan ' is being published by Bhagwan yuva club monthly.

2.2.10 Electricity

Electricity is accessible to every 9 ward. In the evening vdc was seen so romantic with glowing of bulbs at different houses.

2.2.11 Water and Sanitation

At alapot vdc water supply is being done by local kageswori water supply.It supplies water 2 hrs in morning and evening. Rather people of alapot are using various sources of water like well (deep and shallow), public pipes and dhara.

Major proportion of population does not utilize any purification patterns.

There is no provision of refuse, garbage collection, and proper disposal (solid and liquid).Farmers use river water for irrigation purpose.

2.2.12 Local Institutions:

The Institutions as been observed in the VDC are:

A) Educational institution

1. Shri Balbikash secondary school – ward no.4
2. Shri Natheshwori primary school -ward no. 7
3. Shri Nepal Balsangathan Sishu Kaksha Prathamik Vidyalaya-ward no. 2
4. Bayoka Community English School-ward no. 5
5. Kageshwori Vidya Mandir High School-ward no.3

B) Financial

1. Namuna Sahakari Sanstha Ltd.-ward no. 4
2. Sahayogi Bachat Tathna Rin Sahakari Sanstha Ltd.-ward no.7

C) Clubs and groups

1. Bhagwan club
2. Shree Natheshwori Yuva club

D) Health institution

1. Alapot Illaka health post

Alapot illaka health post supervises 4 sub health post of VDC's namely Nayapati, Sundarijal, Baluwa and Gokarna. Near about 40-55 patients were seemed to have utilized the service of helath post per day.

E) Library

Shree kageswari pustakhalaya
Shree Namuna pustakalaya

2.3 Orientation "An introduction programme"

An introduction program was conducted on 2062-01-02. The first day of our community diagnosis program we had dissimilated the invitation before hand and the program started at 1:30pm on VDC office. Mr. Ram saran phuyal, secretary of Alapot was the chairman of our program. HP in-charge Mr. Manik Ratna Shakya was our guest of honor and FCHV Mrs. Bimala thapa was our chief guest. Our team leader Mr. Janak Thapa forwarded briefing of our formal program. Introduction of each individual present at program hall was taken serially and we maintained the register of each participant. Total --- participants took active participantion in our program. Our remaining group members also introduced themselves where as our team leader explained the objectives of our community diagnosis.

Mr. Madan bahadur khadka, an active leader of alapot VDC presented some of his ideas and facts about the VDC geographic ethnicity, institutions, cultural heritage etc being an ex- president of VDC, he was able to provide a clear vision of the VDC. Mr. Manik ratna shakya incharge of Alapot health post gave us the clear information of the health status of alapot VDC, he gave our senior student a vote of thanks for providing report to the VDC and also explained the importance of such report in comparison and bilateral activities that can be performed in collaboration . All the leaders, teachers, health workers were very much positive in our arrival and they agreed to provide us with their full support and help. Lastly in order to finish the program chairperson Ram Saran Phuyal assured to help us in our one-month stay. He was very much positive on our arrival and he forwarded that this kind of visit should be done again and again but the chairman also comment on the fact that the VDC is in rush hour for cutting and harvesting of crops that strike us most for data collection. The chairman asked us to go every possible field and not to skip any houses thus with all the suggestion and promises to help, we successfully ended our orientation program.

CHAPTER- 3
FIELD FINDINGS

3.1 Demographic characteristics:

Demography, the inter-disciplinary study of human populations. Demography deals with social characteristics of the population and their development through time. Demographic data may include

(1) analysis of the population on the basis of age, parentage, physical condition, ethnicity, occupation, and civil position, giving the size and density of each composite division; (2) changes in the population as a result of birth, marriage, and death; (3) statistics on migrations, their effects, and their relation to economic conditions; (4) statistics of crime, illegitimacy, and suicide; (5) levels of education; and (6) economic and social statistics, especially those relating to insurance.

3.1.1 Demographic Indicators

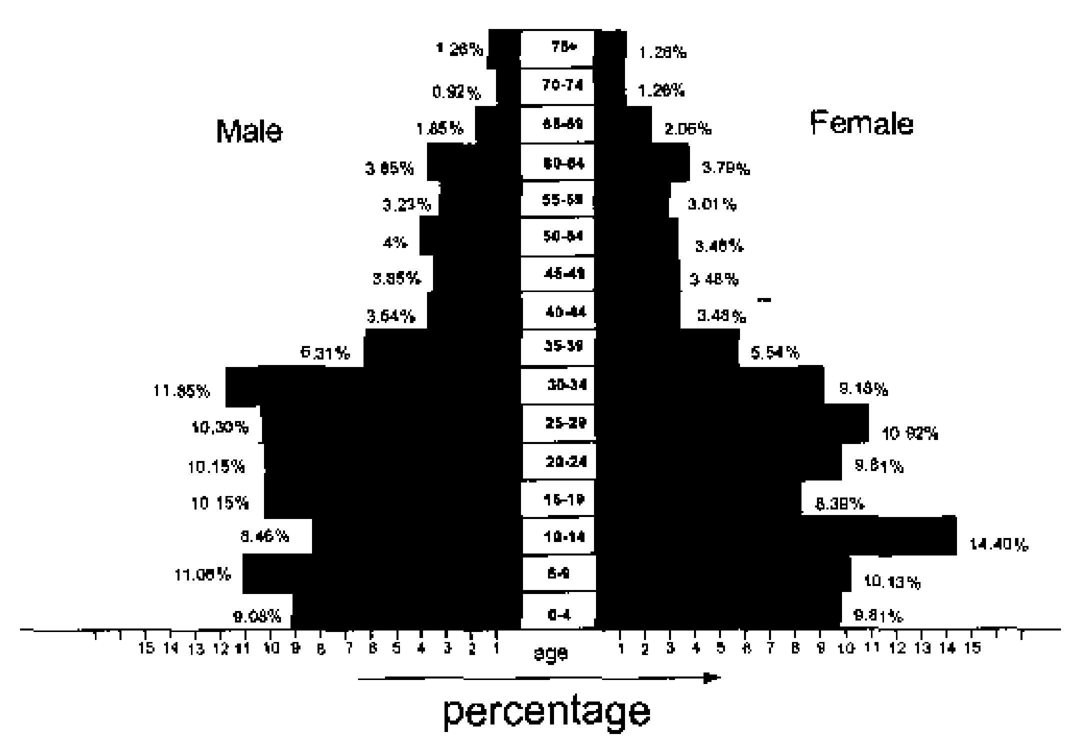
Table-2 Demographic Indicator

S.N	Demographic Indicators	Variables	Figures 1		Figure 2
			Total	Sample (field survey,April2005)	National (2002/2003,CBS)
1	Population size and composition	Population Male Female Sex ratio	3251	1282 650 632 103:100	2,31,51,423 1,15,63,921 1,15,87,502 99:80
2	Dependency Ratio	Child and Elderly		55.77%	42.78%
3	Total literacy rate	Population Male Female		75.15% 87.76% 61.93%	54.1% 65.5% 42.8%
4	Median age of marriage	Male Female		21yr 19yr	22.90yr 19.50yr
5	Fertility	CBR GFR GRR CPR		25.83/1000pop 105/1000 15-49 yr women 0.047 81%	 37.59%
6	Mortality	CDR		8.92/1000 population	
7	Out migration rate			81.12/1000 population	

3.1.2Population Pyramid

In developing countries, population structure is generally described as a pyramid, reflecting the demographer's traditional depiction of populations according to age group, with men on one side of a central axis and women on the other. The shape of the pyramid is determined by both birth and death rates. When both are high, the pyramid has a wide base and tapers off steadily with increasing age. As health improves and fertility falls, the older age groups grow larger than the younger age groups, and the pyramid becomes more of a column.

Figure 1



Analysis of Population Pyramid

- The pyramid is of expansive type similar to the pyramid of the country with broad base and tapering apex.
- Due to the lower CDR and higher CPR the base of the pyramid i.e. 0-4 age group s lower.
- The female population is higher in 10-14 age group, might be because of the son preference.
- The male population is higher in 39-34 age group, which indicates the presence of higher working group in the society.

The population of age group 15-19 years the female is less than the male population, which might be due to early marriage

3.1.3 Dependency ratio

At sixteen, I was stupid, confused, insecure, and indecisive. At twenty-five, I was wise, self-confident, prepossessing, and assertive. At forty-five I am stupid, confused, insecure, and indecisive. Who would have supposed that maturity is only a short break in adolescence?

Dependency ratio can be defined as the relative proportion of total population above 6yrof age and children below 15 yrs of age to the production of productive age group(15-64yrs) .Since the population <15 and >65 are dependent on the productive age group, they are called dependent or of unproductive nature.

Table-3 Average Dependency ratio

Dependency ratio	Alapot Average	National Average
Total (Population <15+population>65 years)	55.77%	42.78%

The average dependency ratio was found to be 55.77% comprising child and elderly which is higher than the national figure (42.78%).

3.1.4 Disability rate

In allapot, VDC disability related to illness or injury is 82.9 per 1000. None of them was found by birth.Among which, according to our sample 10 of them were male and 7 were female which show higher disability rate among males.

3.1.5 Sex ratio

Sexratio resembles the ratio of male is to female in a given population. It is generally expressed as the number of males for every 100 females.

In alapot VDC, the sex ratio is 103:100 i.e;103 males per 100 females.

3.1.6 Family size

Family size is one of the factors affecting the distribution of the food, education, health service and the basic requirements to sustain in a family. Smaller is the size greater will be the distribution.

Table-4 Family size

Total sample HH	No. Of sample male	No. Of sample female	Total sample population	Average family size
214	650	632	1282	5.9

The family size of the selected households in the surveyed VDC is shown in table 1.1.The result of the survey revealed that the average family size of sampled household in the Alapot is 5.9 person a family, which is higher than the national average of 5.40 **(CBS National Report, 2001)**

3.2 VITAL STATISTICS

3.2.1 Migration:

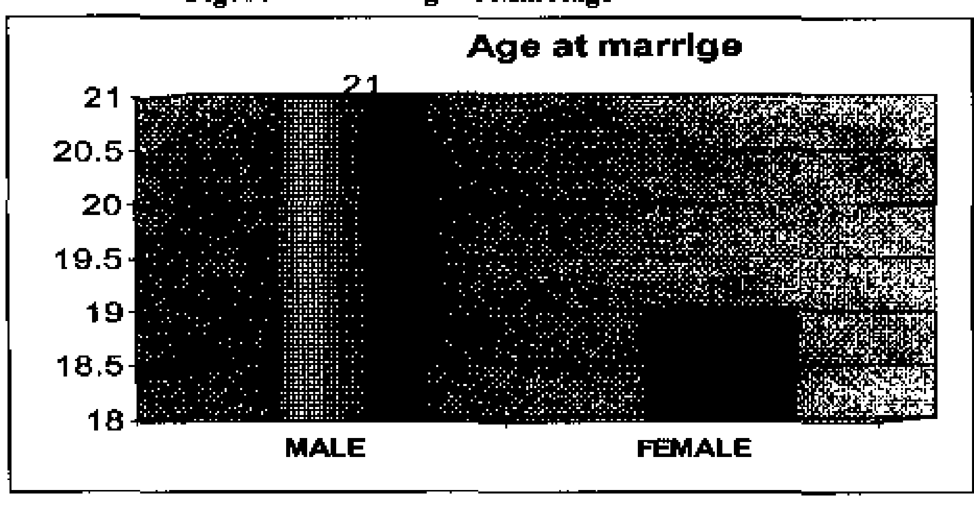
When addressed about migrant population during last 6 months we assessed that 23.42% of family members were found away from the VDC. From our findings, we revealed that educational experience, for the fulfillment of new needs and desires, desire for improving the status appeared to contribute to inclination of migrants. Migration for seasonal work during dry season is common among (ward no. 7 and 8) nagarkoties. Therefore, when the work in the fields is over the family migrate to find work as porters. For these families, the brick factories offer a last chance of obtaining some earning. . Since the whole family members are migrating, it not only visualizes the low opportunities for employment around the VDC but also disturbing the students' education.

3.2.2 Median age at Marriage

Being seventy is not a sin.

The mean age at marriage is highly associated with the increase in the expectation of life at birth (kadi, A.S:1987).Because pregnancies occurring at early motherhood when women is immature and r survival of both mother and child is at risk. The onset of age at marriage in Nepal is increasing but the motion is very slow. According to civil court the minimum age at marriage is set 18 and 21 for female and male respectively.

Figure 2 Median age at Marriage



The median age at marriage was found to be 21 in male and 19 in female.

Age at marriage

Marriage is the primary indicator of women's chances of becoming pregnant. During the past few decades age of first marriage has steadily increased, 19 years of age was explored as the median age of marriage of women in Alapot VDC. Traditional practices and religious beliefs influencing parents to arrange really marriage for their daughters were sought as one of the regions for early age of marriag

3.2.3 Morbidity pattern

When asked about sickness occurrence during last 3 months, our data from sampled HH population revealed that majority (62.44%) of family members had had sickness. Among the sick population the distribution of diseases was found fever/cough 42.52%, hedache 9.19%, stomachache 8.62%, asthama 6.91 joint 6.32%and others like diabetes, hyper tension, toothache gastritis etc. is found26.44%. The comparision between the top five diseases found by our findings and health post are sorted below;

Table-5 Morbidity pattern

S.N	Our findings	Health post
1.	Fever/cough	ARI/Pneumonia
2.	Headache	Skin disease
3.	Stomach ache	Diroheal disease
4.	Asthma	Pyrexia uknown origin
5.	Joint pain	Mouth complains

3.2.4 Mortality pattern

3.2.4.1 Crude death rate (CDR)

CDR is widely use indicator to measure mortality rate. In allapot VDC in sample population CDR is found to be 29 deaths ie; 8.92% which is near to national figure 9.92 per thousand.

3.2.4.2 Infant mortality rate (IMR)

Infant mortality is found nill in Alapot VDC in sample population. It is the no of infant deathb under one year per 1000 live birth in given birth.This shows positive result as compared to national figure(IMR 64.4per 1000)

3.2.4.3 Under five mortality rate

U-5 mortality is found nill in Alapot VDC in sample population. It is the no. of childrens death under five year per 1000 live birth in given birth.This shows positive result.

3.3 SOCIO-ECONOMIC AND RELIGIOUS CONDITIONS

3.3.1 Type of family

Father, Mother, and Me Sister and Auntie say
All the people like us are we and every one else is they.

While household boundaries are constantly, fluctuating and the meanings and relationships they encompass are undergoing continuous change. The family is still a crucial institution for both individual survival and social continuity. The family member itself determines the existence of the family and number of member determines the family type. The larger the number the greater would be the share thus happy and prosperous life can be maintained in the nuclear family. But in the cordial principles of joint family systems are the ideals of solidarity among the members with more security and belongingness.

Table-6 Type of family

VDC	Sample			Type of family				Missing	
Alapot	Total			Nuclear		Joint		Total	
	HH	Missing	Total	HH	%	HH	%	HH	%
	205	9	214	83	38.79	122	57.01	9	4.20

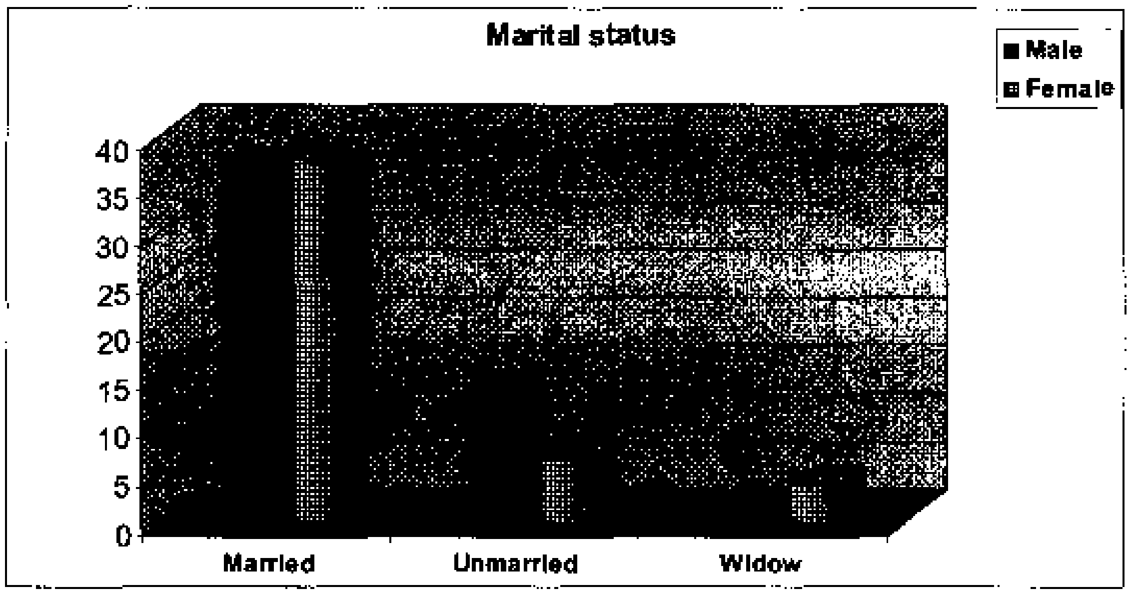
The family type data presented in table 1.2 indicates that about 38.79%of the households in the alapot VDC live in nuclear family and 57.01 in joint family.

3.3.2 Distribution of study population by marital status

Marriage is a relation between the persons of two heterogeneous sexes based on the legal process according to social and religious customs. Marriage plays a very important role in a society. It determines the status of the person along with his/her responsibility.

The analysis of the data from the sampled population indicates that the percentage of married population in females (37.55%) is higher than in males (36.73%) whereas the unmarried male population is higher (13.20%) than the females. The percentage of widow female is higher (4.01%) than the males (1.84%).

Figure 3 Marital status



3.3.3 Religion

The result of the survey revealed that (98.04%) majority of sampled population was Hindus, which is infact higher than national average (80.62%, source CBS Report 2002/2003). While 1.96% were Buddhist which is smaller than national average (10.74%, source CBS Report 2002/2003

3.3.4 Ethinic/Castewise distribution

Man makes holy what he believes as he makes beautiful what he loves.

Nepal is multilingual, multi-religion, multi ethnic country. Caste distribution is a parameter, which helps to determine the social cohesion and the organizational basis in the community. The ethnic composition of the population varies significantly among the caste groups, which includes the distribution as follows:

Table-7 Ethinic/Castewise distribution

S.N	Ethnic group	National figure (%)	Alapot figure(%)
1.	Chettri	15.80	33.66
2.	Newar	----	32.68
3.	Bhramin	12.74	16.59
4.	Kami	---	14.63
5.	Tamang	5.64	2.44

The population of ethnic groups has shown that the considerable variations in demographic and socio-economic characteristics.)

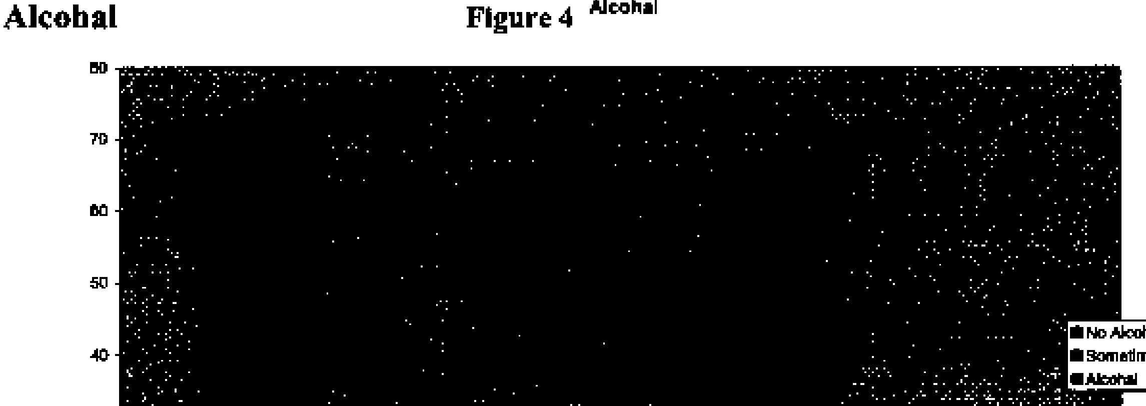
3.3.5Alcoholism and smoking

First you take a drink, then the drink takes a drink, then the drink takes you.

To address the alcohol activities around the selected VDC, we asked the sampled population about their practice Our data reveal the fact that 72.11% of male and 64.34% of female do not take alcohol followed by 10.95% of male and 18.20% female taking alcohol sometimes along with 16.94% of male and 17.40% female taking alcohol on daily basis.

Alcohal

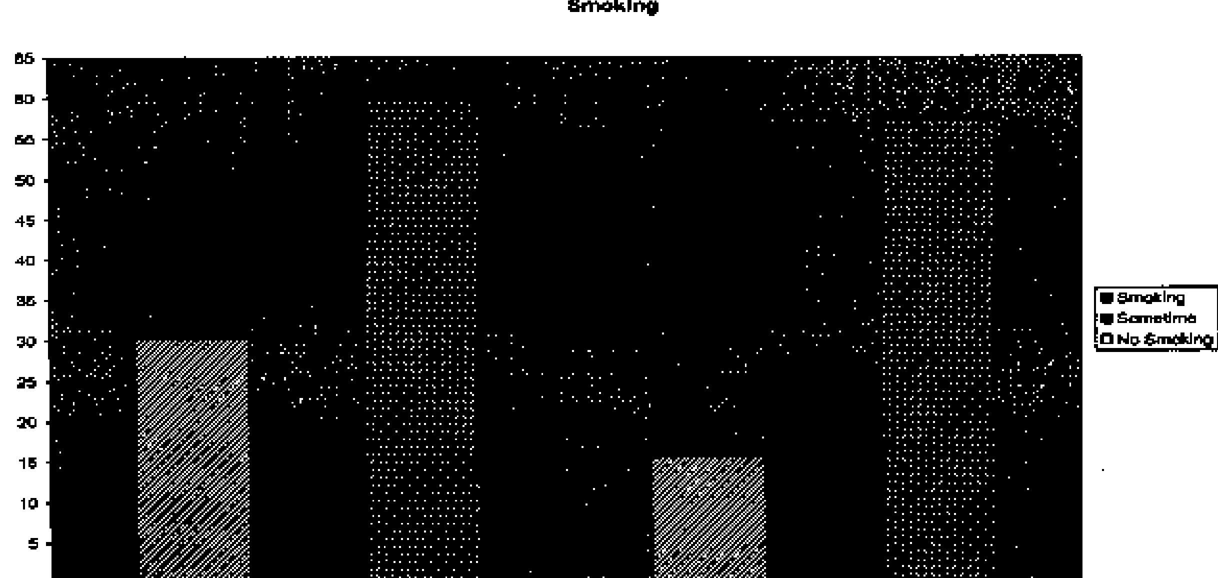
Figure 4



Smoking

Figure-5 Smoking

Smoking kills, and if you're killed, you've lost a very important part of your life.



3.3.6 Education status

The educational process has no end beyond itself; it is its own end.

The extent of women's access to information and education vary across the country, but over all they tend to be more limited than for men, the trend is always in descending order. New ideas spread through radios, schools, health posts, extension services, and tourism are often less accessible to rural women, who might be illiterate, less familiar with the language, and less confident in interacting with strangers.

Table-8 Education status

Status	Male%	Female%
Illiterate	10.7	31.18
Literate	6.72	10.72
Nursery to UKG	16.55	26.55
Primary level	5	6.62
Lower secondary	14.83	5.06
Secondary level	29.3	12.86
Higher secondary	8.10	4.67
Higher education	8.8	2.34

From the data collected out of the sampled household, it appeared that the access to education is higher at secondary level (29.3%) in male and at nursery to UKG level (26.55%) in female. The access to higher education is poorer (2.34%) in female than in male (8.8%). The low literacy level (31.18%) reveals the fact that the access to education is least in female.

Table-9

Education	National average (%)	Alapot average (%)
Male	65.5	87.76
Female	42.5	61.93
Total	54.1	75.15

(Source CBS national report, 2002/2003)

The total literacy rate was found to be 75.15%, which is higher than the national average. The low level of female literacy rate (61.93%) than male (87.76) has had a negative impact on their access to knowledge in Alapot VDC.

3.3.7 Occupation

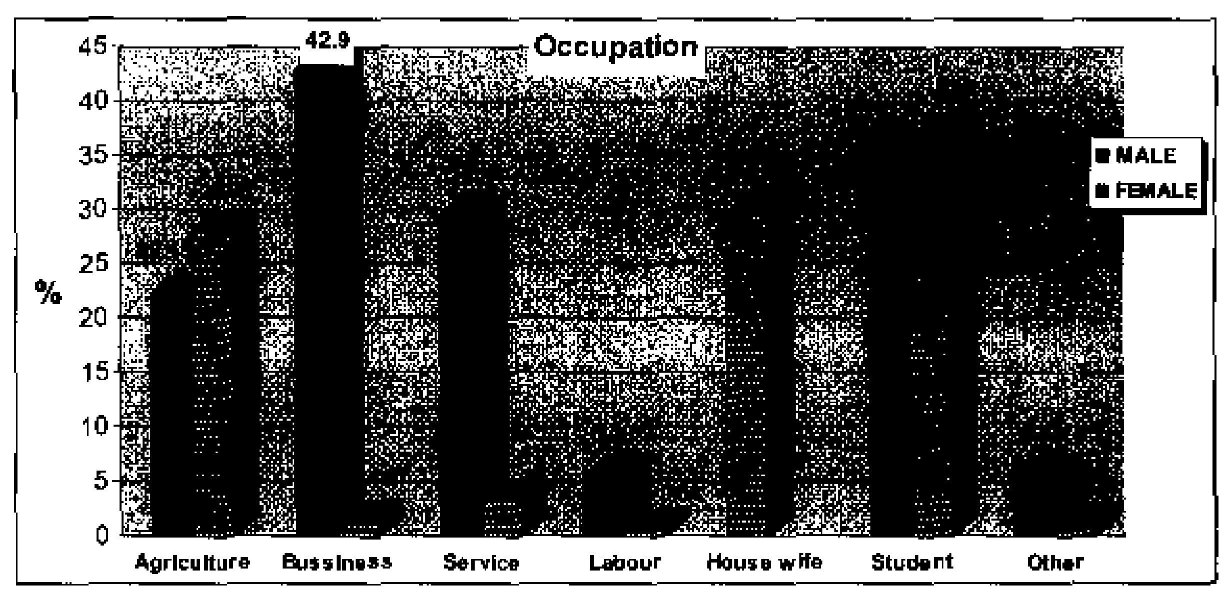
The occupation governs every aspects of human need thus maintaining certain quality of life and providing family with income, security, education, health, food and all the basic as well as additional need of the family.

Table -10 occupation

Occupation	National Figure	Alapot Figure	
		Male	Female
Agriculture	66.43%	22.13%	27.95%
Non-Agriculture	33.47%	77.87%	72.05%

Throughout the country the family farm is the most significant source of subsistence and income (66.43%, CBS Report 2002/2003)

Figure 6 occupation



3.3.8 Source of income/ food availability

Throughout the VDC agriculture was found as most significant source of subsistence and income i.e 60.49%.Agriculture sector was followed by 25.86% service along with 12.19% business and 1.46% wage labour. Out of 60.49% , 70.96% people have food sufficient for whole year. But rest accepts other occupation.

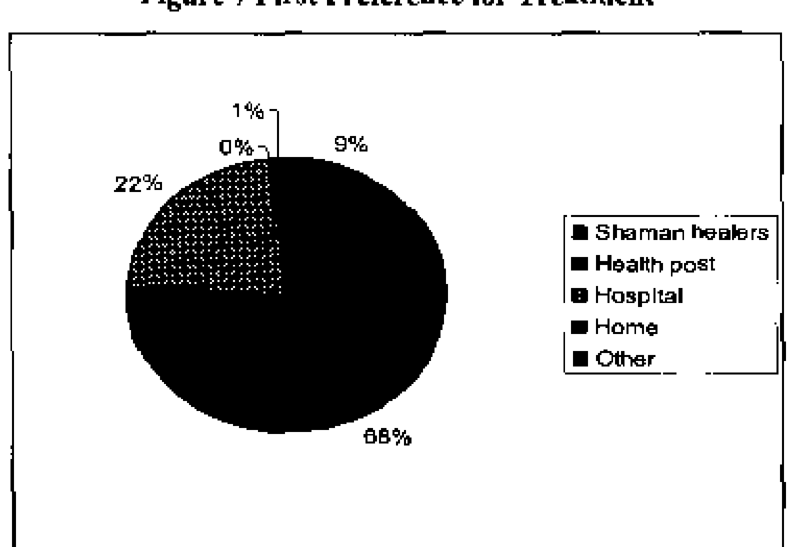
People of some ward of the VDC go for seasonal temporary migration in brick factories for 6 months and also have to borrow loan for around 6 months.

3.4 HEALTH CARE FACILITY UTILISATION

3.4.1 First Preference for Treatment

Around Alapot (66.83%)majority of our respondent primarily contact health post for their treatment, a part from health post people also visit hospitals, shaman healers, home and other places in about 21.95%, 9.27%, 0.49% and 1.46% respectively as their first preference for treatment.

Figure 7 First Preference for Treatment



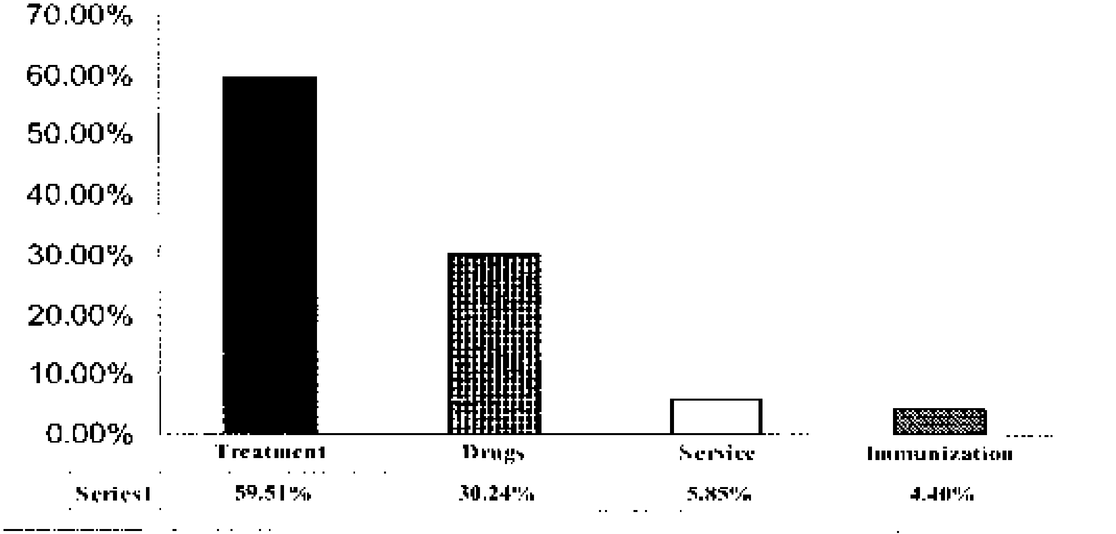
3.4.2Duration for reaching health post

As being the small village, health post is accessible to all the people of the VDC. The suitable position of the health post in the VDC is an advantage to all the people from all the wards for accessibility.

3.4.3 Facility provided by health post

Many type of facility has given by health post , health intervention should be focused on the maximum use of health post facility in the Alapot VDC.Majority of our respondent primarily contact health post for treatment 59.51%,drugs 30.24%, Immunization 4.40% & Service 5.85% respectively as their first preference for treatment.

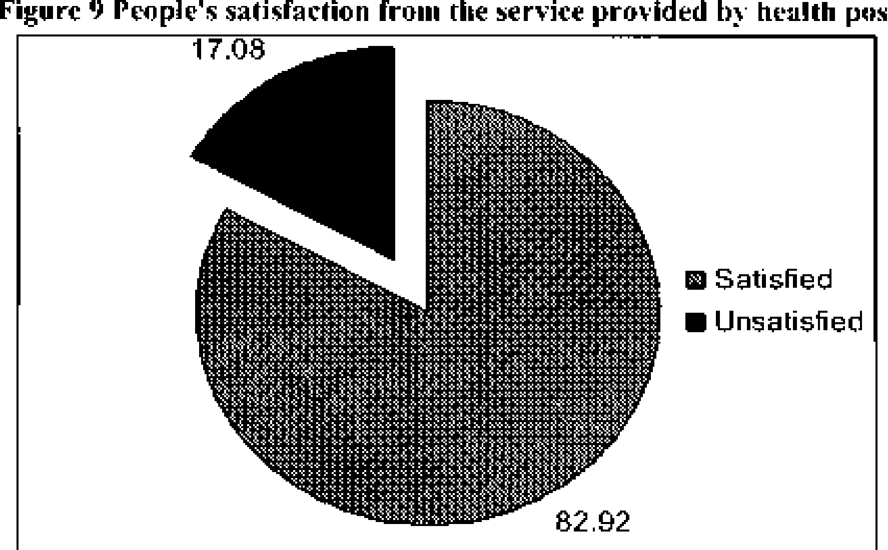
Figure 8 First Preference for Treatment



3.4.4 People's satisfaction from the service provided by health post

When asked about the satisfaction of service, (82.92%) majority of people where satisfied with the service provided by the health post Where as about 17.08%of people where unsatisfied with the service.

Figure 9 People's satisfaction from the service provided by health post



3.4.5 Reasons for unsatisfaction

Don't let ask for moon! When star is there.

Among 17.08% of unsatisfied people majority of them were unsatisfied due to poor quality service. About 31%where because of high price and about 29%where unsatisfied due to ill treatment of health workers in health post.

Figure 10 Reason for unsatisfaction

Reason for unsatisfaction

Due to illtreatment 29%

Poor quality 40%

High price 31%

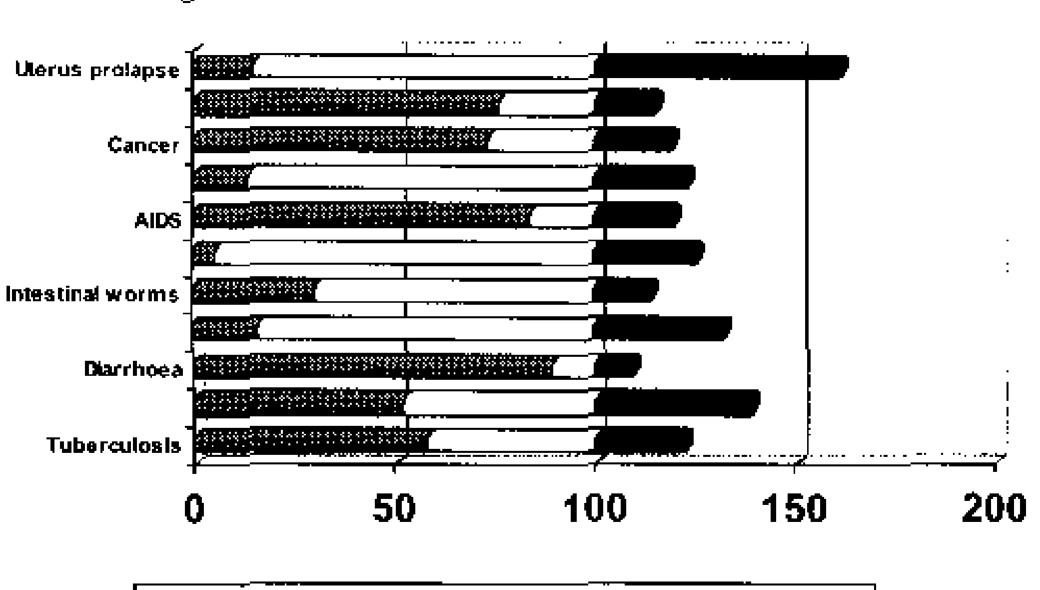
3.5 KNOWLEDGE, ATTITUDE AND PRACTICE

Handsome is that handsome does.

3.5.1 KAP on communicable and non communicable disease

To assess the knowledge prevalence about diseases transmission, we asked the respondents from the sampled households about whether they had heard about the disease. Among the know responden, we also assess the prevalance of negative attitude on the people

Figure 11 KAP on communicable & non-communicable disease



Among the known percentage of sampled population we tried to assess both –ve as well as +ve attitude towards 9 communicable and three non-communicable diseases.

We explore that highest percentage (89.37%) of our respondent had +ve attitude about diarrhea followed by AIDS (83.83%) then asthama/pnemonia i.e. 76.14%. Also the least percentage (5.81%) had +ve attitude towards polio followed by uterus prolapse (15.22%) then measles i.e. 21.95%.

We explore that the highest percentage (94.19%) of our respondents had -ve attitude towards polio (reasons such as polio is non communicable, due to lack of food was most prevalent as negative attitude) followed by measles (86.25%, reasons such as measles is non communicable, due to mothers health were common) then leprosy with 83.69%. Also the least percentage (10.63%) had -ve attitude towards diarrhea followed by 16.17% AIDS along with 23.86% asthma/pneumonia

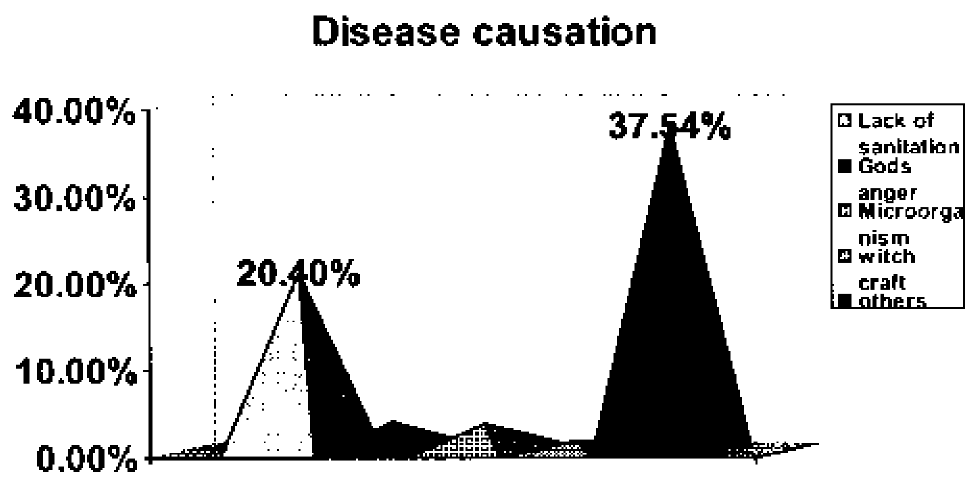
We explore that the highest percentage (60%%) of our respondents from the sampled households were unknown about uterus prolapse followed by skin diseases (38.05%) then leprosy i.e. 31.22%. Also the least percentage (8.29%) were unknown about diarrhea followed by 13.17% intestinal worms along with 14.15% Asthma/pneumonia.

3.5.2 Knowledge on Causation of diseases

The prevention of disease today is one of the most important factors in the line of human endeavor.

Human Disease, in medicine, any harmful change that interferes with the normal appearance, structure, or function of the body or any of its parts. Since time immemorial, disease has played a role in the history of societies. It has affected and been affected by economic conditions, wars, and natural disasters. Diseases have diverse causes, which can be classified into two broad groups: infectious and noninfectious. Infectious diseases can spread from one person to another and are caused by microscopic organisms that invade the body. Non infectious diseases are not communicated from person to person and do not have, or are not known to involve, infectious agents

Figure 12 disease causation

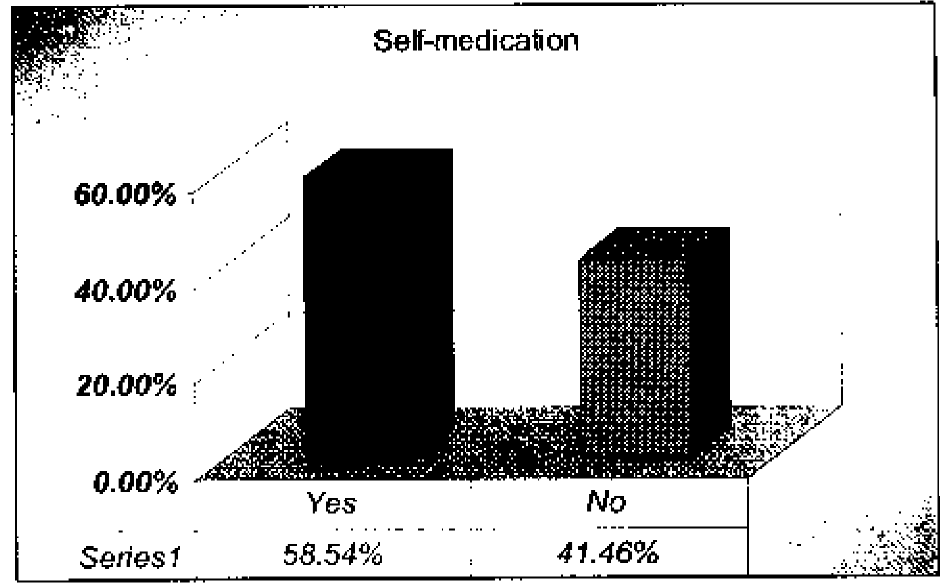


When asked about the causation of diseases the majority of the sampled households population responded that lack of sanitation was the major (59.12%) factor for diseases causation followed by others (37.56%) with reasons such as due to smoking, workload, anger, impure blood etc. Also some percentage of people reveal that micro-organism (2.93%). god's anger (3.14%). and witchcraft (0.98)as some more reasons for diseases causation.

3.5.3 Self medication:

To assess the knowledge and practice regarding self medication, we address the respondent about whether they brought medicine without prescription then majority (58.54%) of our sampled household population said yes while 41.46% said no.

Figure 13 self-medication



Knowledge attitude and practice approach is an effective traditional approach to consider people's conduct of behaviour. The measurable action verbs (indicators) are used to study KAP and to set objectives. It has generally been described that behavior is the consequence of decision-making and the decision is preceded by knowledge and attitude. KAP has direct influence on our health as well thus assessment of KAP was the important aspect of the diagnosis study.

3.6 MATERNAL HEALTH

Maternal health

Nepal has one of the biggest maternal mortality ratios (MMR) in Asia. The govern estimates the MMR to be 559/100,000 live births. Women are susceptible to many major life-threatening diseases. Besides these complications in pregnancy, complications in childbirth are the most visible threat. Even under the best of conditions, pregnancy brings a risk. Lack of knowledge ,education and decision making power,lack of control over her own fertility-all lead to these high maternal mortality rates.Most maternal deaths result from poor health which begins before birth,grows worse through adolescence and becomes critical at the time of childbirth.Thus,exploring the situation of maternal health is of significant importance. the target population for the questionnaire developed for mother where mother's bearing children of age below five years.

3.6.1 Mean Age at first pregnancy

Pregnancy is usually understood as a special and vulnerable state. According to one survey, the highest rate of fetal loss occurs among 15 to 19 years old followed by women giving birth over the age of 45.Thus age of pregnancy below 18 years and above 45 years is considered high-risk pregnancy. The result from the analysis of data from the sampled households address that the mean age at first pregnancy was 21 which is quite in good health both for mother and child.

3.6.2 Consumption of food during pregnancy

For the nine months following conception, the mother's body is the environment. which supports the growth of life. Its nourishment is affected by what she eats and how she works as well as by the environment, which supports the growth of life. Its nourishment is affected by what she eats and works as well as by the environment that surrounds her. Thus the health of the child is directly linked to the mother's health. During pregnant condition usual food is not sufficient for the women and thus an additional food is required for the growth of the child. Our finding indicates that 45.6% had taken additional food while 54.4%hadnot. Thus that data divulge that practices for additional amount of food than the normal diets to be improved.

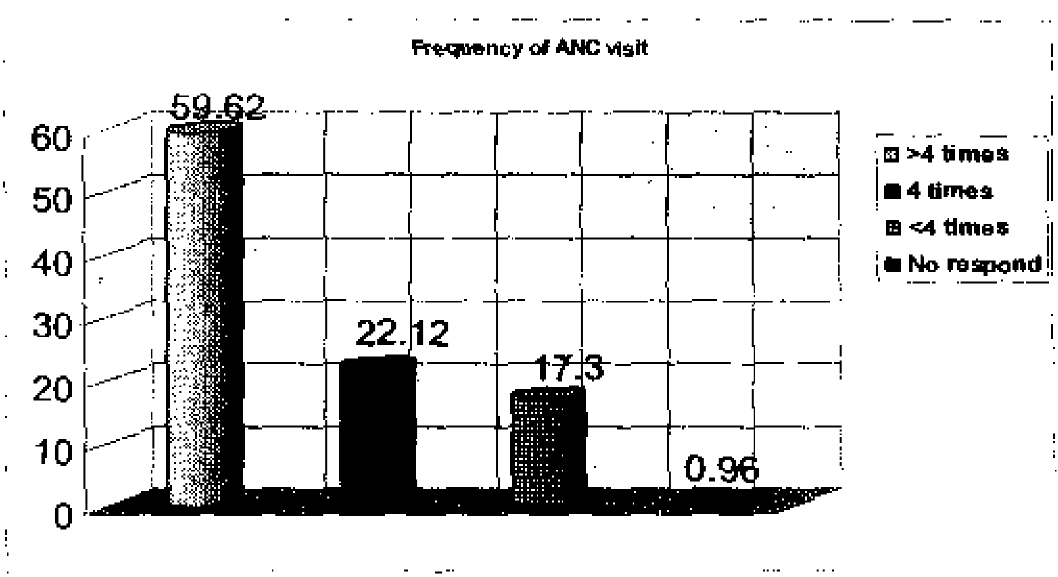
While asking additional food is needed during pregnancy 72.8% showed positive attiduc whereas 27.2%didnot know about the use of such foods.Most of them who had taken additional foods emphasized on taking of pulses, meat, fruits, and green leafy vegetables during pregnancy.

3.6.3 ANC-checkup

The aim of antenatal care of the mother is to achieve at the end of a pregnancy a healthy mother and a healthy baby.

This revealed the conclusion that mothers are aware of the fact that ANC is important and this data is satisfactory as compared to the national figure.

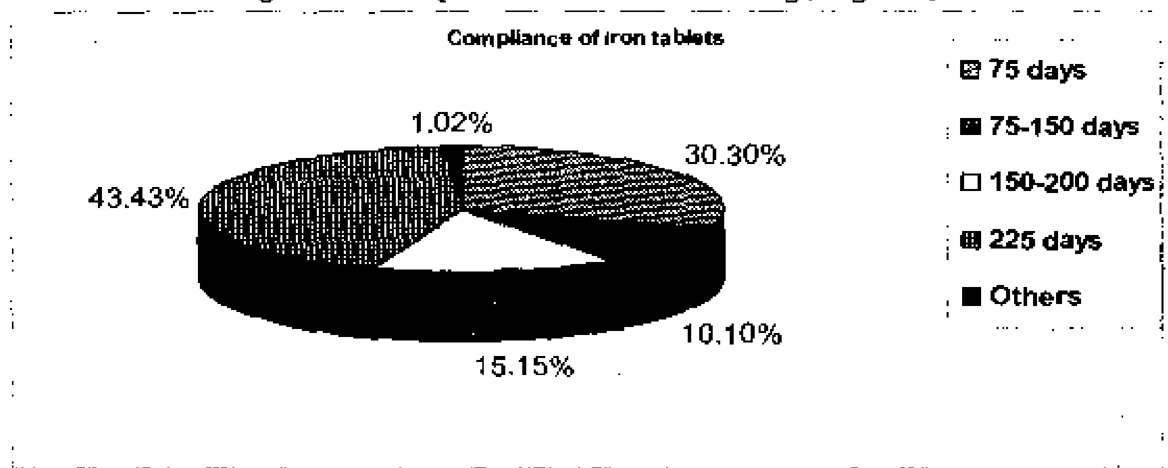
Figure 16 Frequency for ANC –visit



3.6.6 Compliance of iron tablet during pregnancy

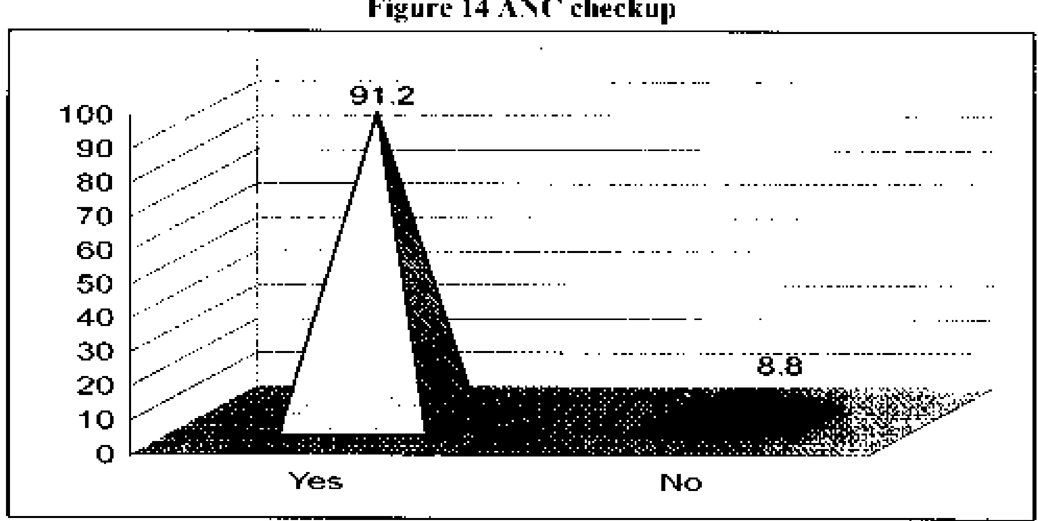
Iron is of great important in human nutrient. During pregnancy the iron requirement increases drastically but low iron intake and worm infestation is leading mothers towards anaemic condition .75% of the pregnant mother were found to be anaemic (Source,NMSS data 1998AD).The government distributes iron tablet after 3 month of pregnancy up to 45 days of delivery. But the compliance of 225 days of iron tablet intake is poorer in the country.

Figure -17 Compliance of iron tablet during pregnancy



In Alapot VDC, our study revealed that about 86.8% of the women had consumed iron tablets during pregnancy. Among them, 30.3% of them had taken iron tablets for up to 75 days, 10.10% of them had taken for 75- 150 days, 15.15% of them had taken for about 150-200 days, about 43.43% of them had taken complete dose of iron tablets, whereas rest (1.02%) of them had forgotten about the consumption of iron tablets.

Figure 14 ANC checkup

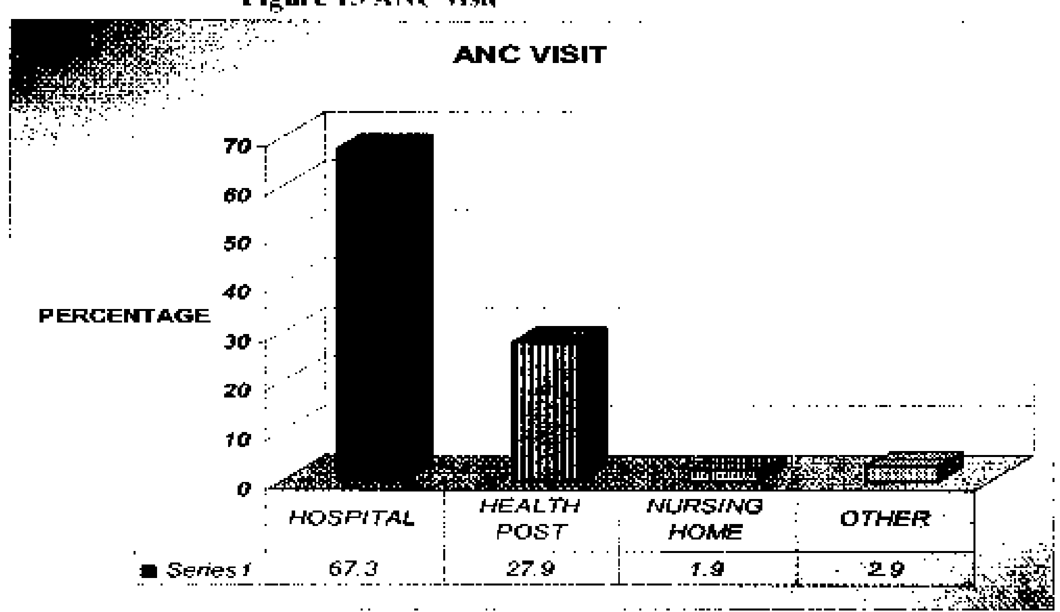


The result of the survey revealed the fact that (91.2%) majority of pregnant women go for ANC check up while about 8.8% do not go for the checkup. The reasons for not receiving ANC visit were lack of knowledge on ANC visit and lack of time as well. Some also mentioned inaccessible health facilities as a major reasons.

3.6.4 Places for ANC-checkup

About 67.3% of the mother respondent had preferred hospitals for ANC checkup, while 1.9% were depended on nursing homes for the checkup. Health post is chosen by only 27.9%of the mother respondent, while rest 2.9% go for clinic as their finest option for the checkup.

Figure 15 ANC visit



3.6.5 Frequency for ANC –visit

At least 4 times ANC visit is recommended by WHO

1st - On confirmation; 2nd - 5-7 months of pregnancy

3rd - Beginning of 9 months of pregnancy; 4th - Last week of pregnancy

Continuity of ANC service is one of the indicaters to access the quality of ANC service.Among the ANC visiters (91.2%) in Alapot VDC, 59.62% of the mothers had ANC check up for more than 4 times. 22.12% of the mothers had ANC check up upto 4 times, 17.3% of the mothers had ANC check up for less than 4 times, whereas rest (0.96%) of the mothers were not sure about the frequency of the ANC visit.

3.6.7 Reasons for not taking complete dose of iron tablets

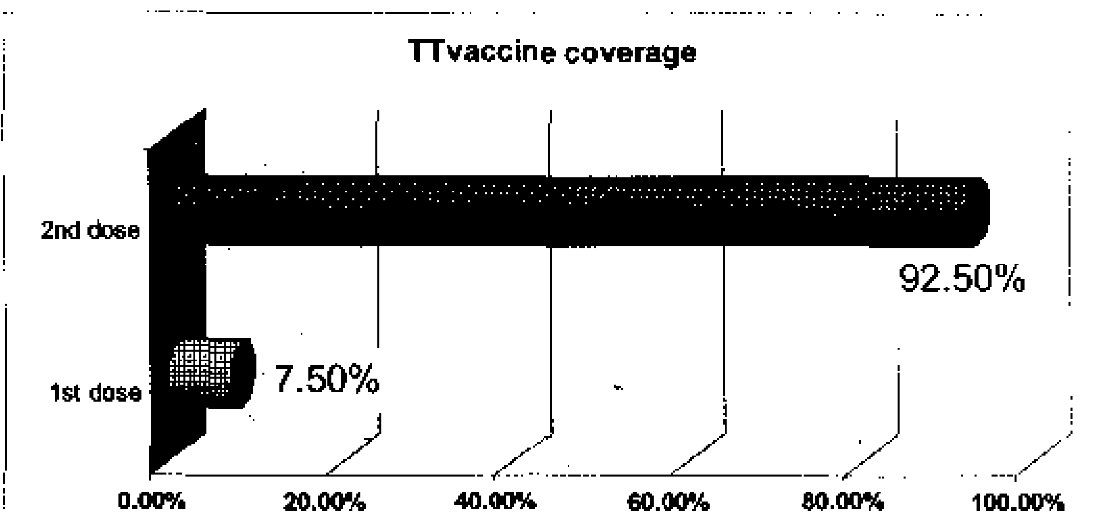
Among the mother respondents who didn't take complete dose of iron tablets,26.7% of them had said that they were not informed, 46.7% of them said that they had no time to take it,6.65 of them said that they had forgotten to take it whereas rest(20%) of them said that they had no desire to take it.

3.6.8 TT injection coverage during pregnancy

A female of 15-45 years is elligible for TT vaccine.vaccine protects the pregnant women and baby from tetanus if taken during pregnancy.

We found that 92.9% of women have been immunised during pregnancy. From those who were immunised, TT vaccine coverage for different doses are;

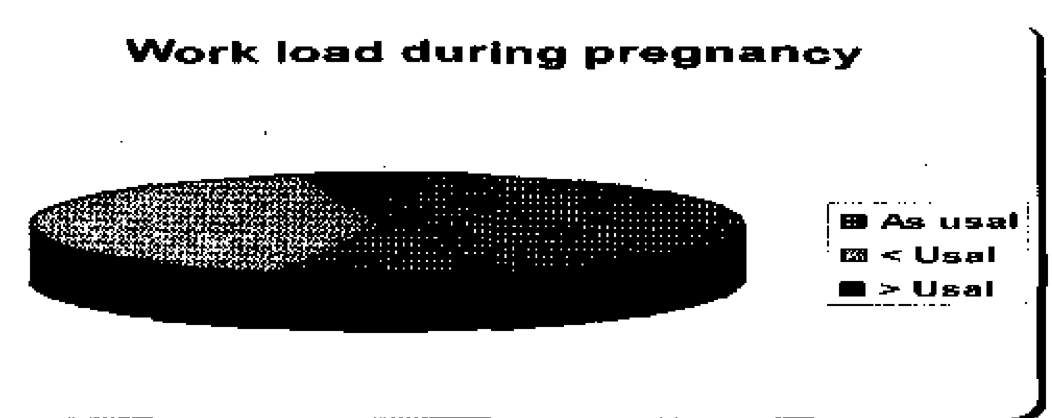
Figure 18 TT injection coverage during pregnancy



3.6.9. Workload during pregnanc

Workload during pregnancy is another major subject to be addressed both in national and community level so as to sensitize the community people so as to achieve healthy baby at the end of the pregnancy. Workload during pregnancy also results in a no. of complications thus endangering the life of both mother and child. Abortion, miscarriages and prolong labour are some of the devastating results.

Figure 19

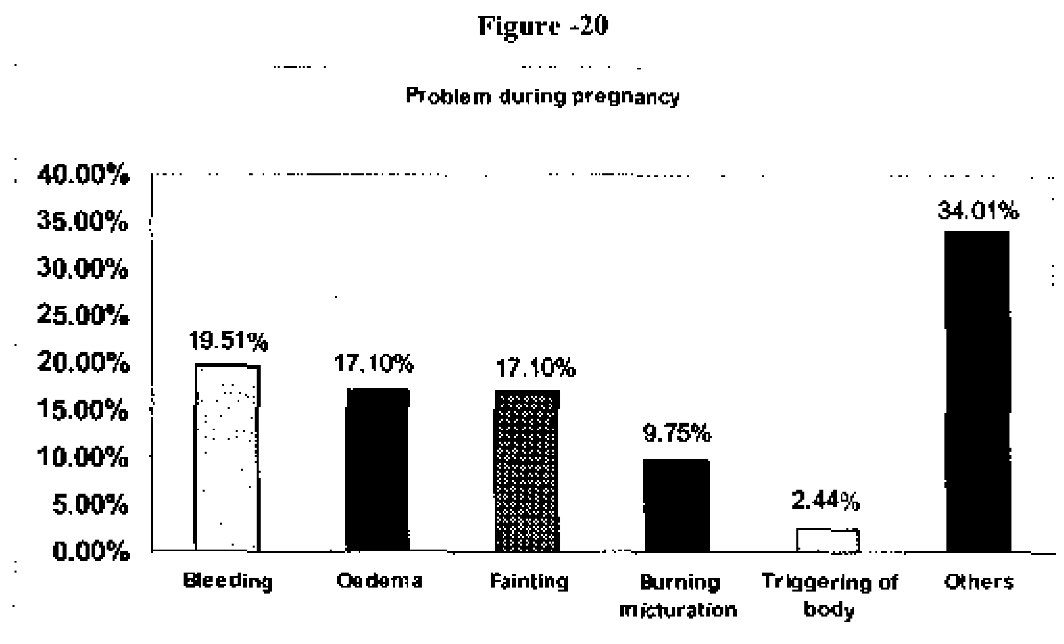


The data from the sampled household indicates that 54.38% of pregnant women work as usual, 4.38% work harder than usual whereas 41.24% work less than usual during pregnancy.

3.6.10 Problem during pregnancy

Complications during pregnancy are the risk factors for maternal and infant mortality .However these complication may be the consequences of early marriage and child bearing age. The result of the survey revealed the fact that 35.9% of women faced the problem during pregnancy while the rest did not. Out of 35.9% bleeding, oedema of legs, fainting, triggering of body, burning micturation etc were some of the major problem faced.

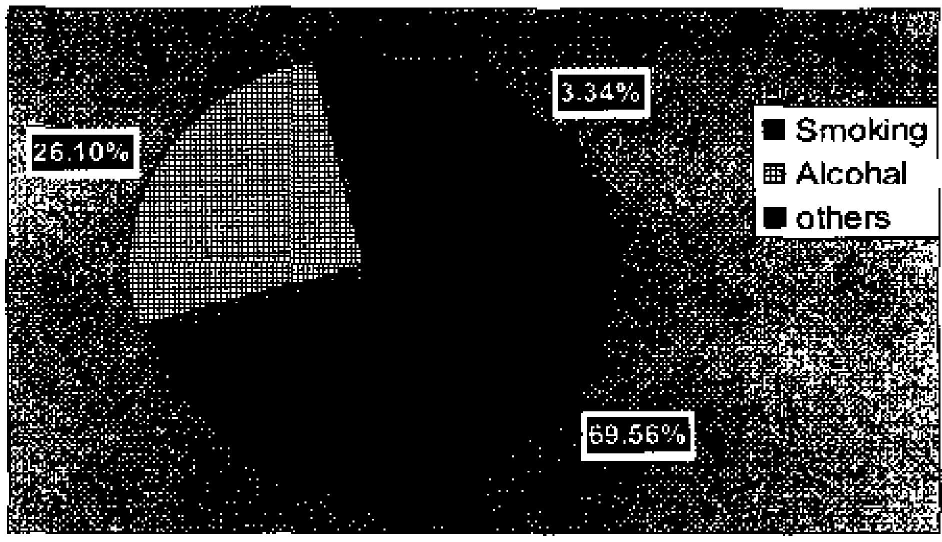
Figure -20



3.6.11 Smoking/alcoholism during pregnancy

Humans consume a wide variety of addictive substances. These causes substantially increased risk of mortality from lung cancer. upper aero digestive cancer, and several other cases. As a result, in population where smoking has been common for many decades, tobacco use accounts for a considerable proportion of mortality and smoking attributable deaths. While cigarette smoking causes the majority of the adverse health effects. Chewing is also hazardous causing oral cancer. While alcohol consumption has health and social consequences via intoxication, dependence, hitual, compulsive throughout the life. Women who smoke during pregnancy may adversely affect the growth of the fetus and the health of the newborn infant and that children of mothers who smoke tend to lag in development.Drinking by mothers during pregnancy is also associated with poor heart and lung function at birth, as well as tremors and irritability. prenatal exposure to alcohol can lower the I.Q level of the child .

Figure 21

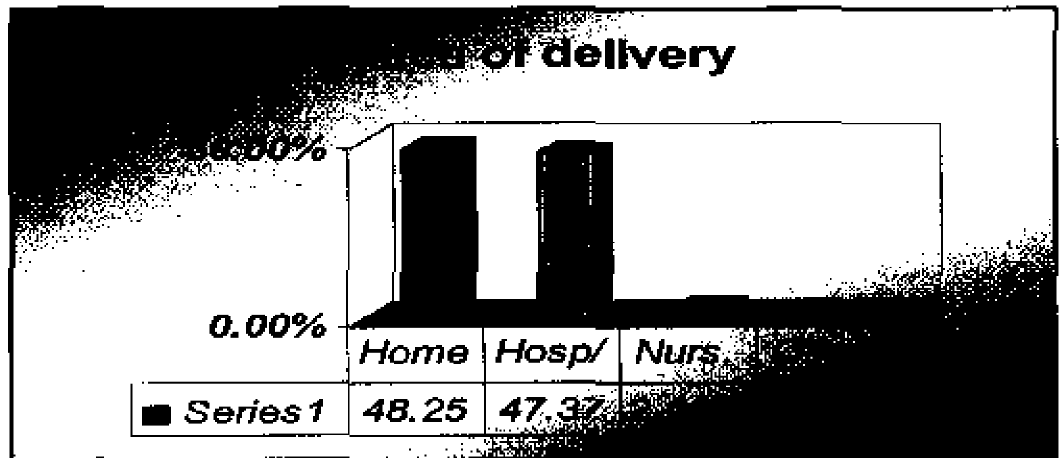


In Alapot VDC, among the women who had both smoking and alcohol during pregnancy (20.17%), 69.56% of them had done smoking, 26.15% of them had taken alcohol whereas rest (4.34%) of them had taken others like jand.

3.6.12. Place of delivery

In Alapot VDC, it seems that about 48.25% of the deliveries were conducted at home, 47.37% of the deliveries were conducted at health post/hospital, likewise about 2.63% of the deliveries were conducted at nursing homes and rest (1.75%) of the deliveries were conducted at other places like on the way to hospital, field etc.

Figure 22



3.6.13. Assistance during delivery

Depanding upon the circumstances of birth and various ethnic values surrounding the delivery,the knowledge and proficiency of the person assisting during the delivery may be crucial to the survival of both mother and child .

Figure -23

Assistance during delivery

By health prosonal 70.91%
By to no one 7.27%
By TBAs 7.27%
By the family member 5.45%

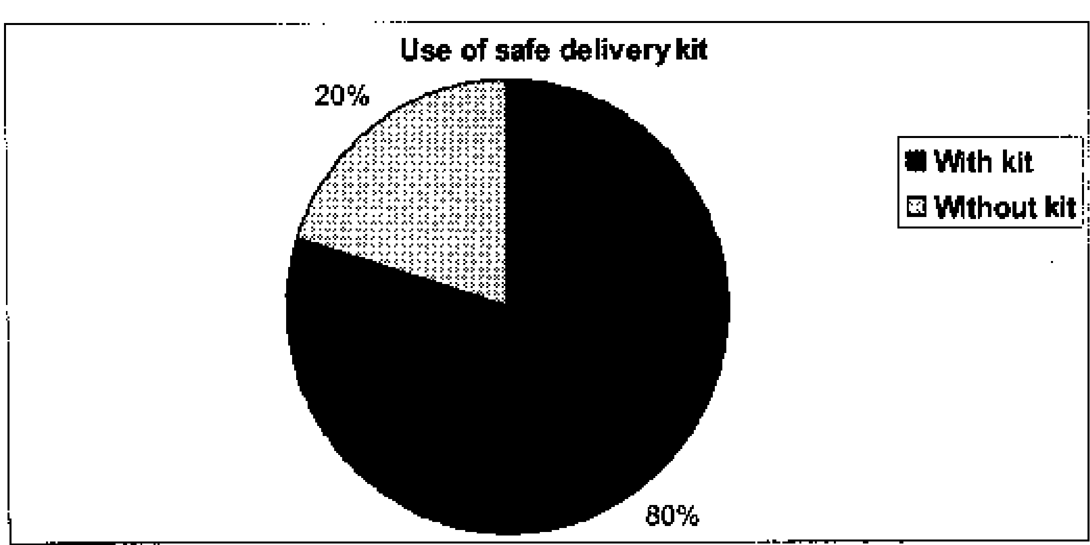
The data from the sampled household states the fact that around Alapot VDC majoritiy (70.91%)of the delivery was conducted by the family members while 7.27% of the birth were assisted by the TBA's ,elderly women. 5.45%were supported by the health personnel and rest 16.37% were assisted by no one .

3.6.14. Use of Safe Delivery kit

Out of 48.25% of the deliveries conducted at home,20% of the deliveries were conducted with safe delivery kit whereas rest(80%) of the deliveries were conducted without kit. 92.72% used new blade for cutting the cord and 5.45% used non sterile blade 1.83% used knife . Hence the practice of using sterilized instrument for cutting the cord was observed higher in Alapot VDC.

Most of them i.e. 56.37% used nothing on cord cut.similarly, 40%of them used oil and turmeric whereas only 3.63% applied medicine on it .Turmeric is proved to be antiseptic by ayurveda. Hence we can say this method of application of turmeric is a good practice

Figure -24



3.6.15. Problem of miscarriage

Figure- 25

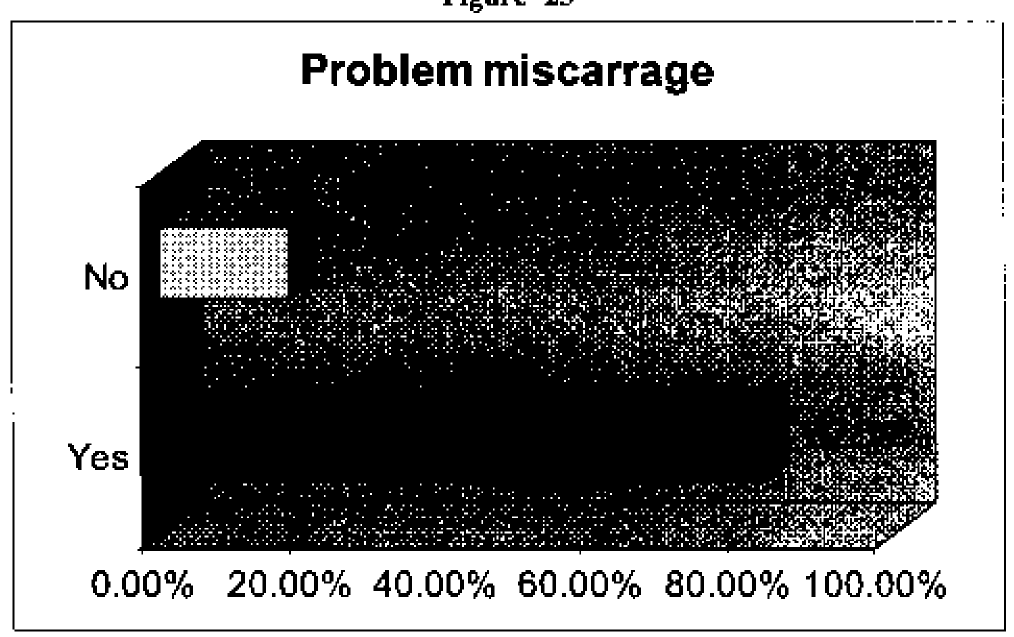


Figure-26 Have you had the problem of miscarriage

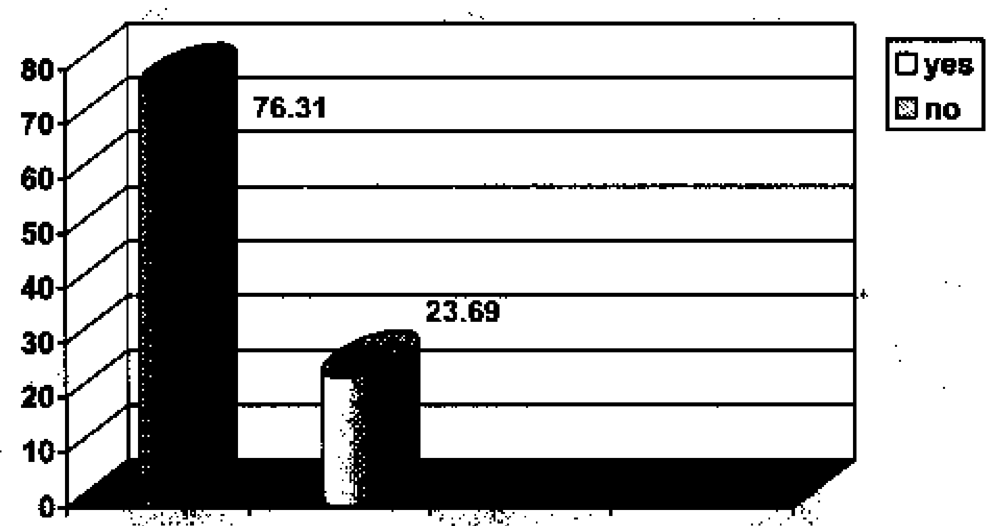
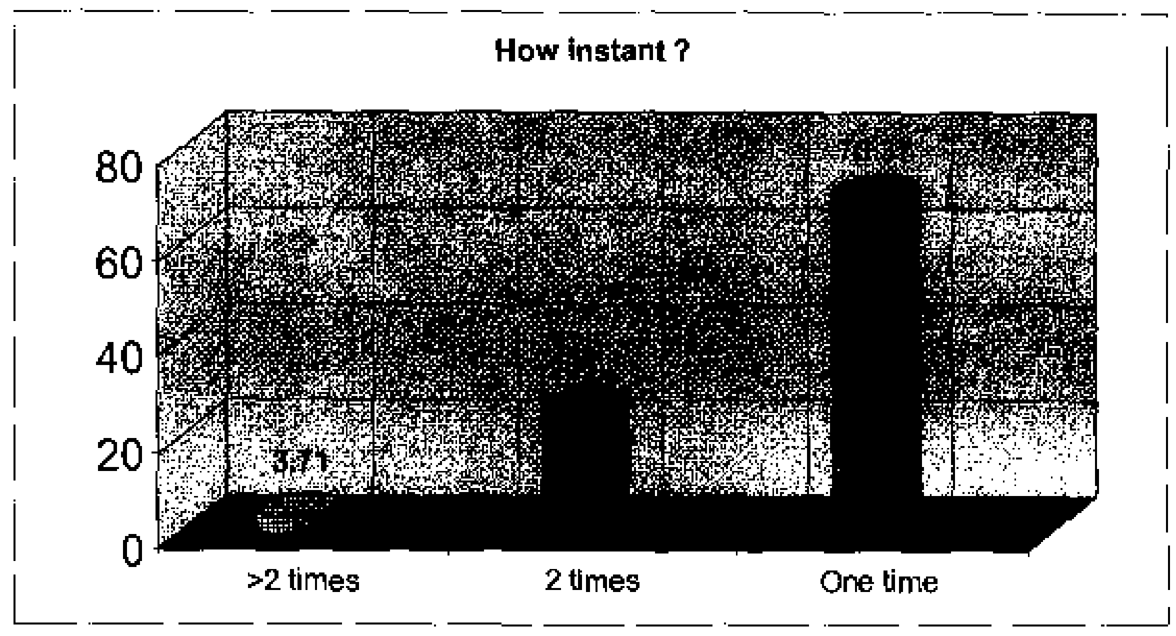


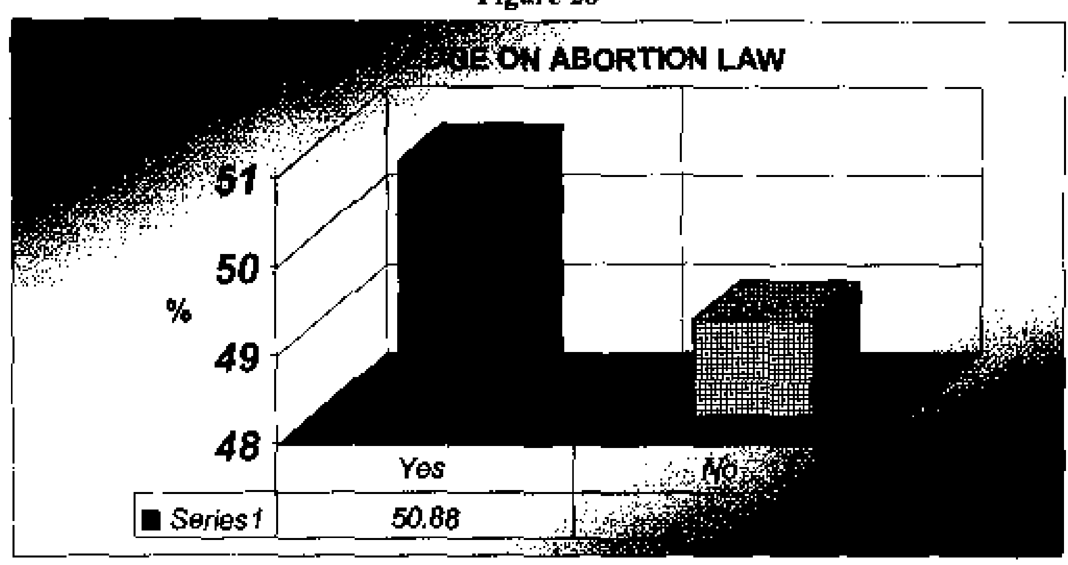
Figure -27 how instant?



3.6.16 Knowledge on abortion law

The extent of women's access to information and education vary across the country and in overall they tend to be more limited than for men. New ideas spread through radios, schools which are often less accessible to rural women and hence they are less informed about the abortion law

Figure 28



While exploring the knowledge on abortion law,among the respondents who had heard about the law(50.88%), 17.24% of them had correct information,62.07% of them had wrong information while rest of them(20.69%) of them didn't respond.

3.6.17. Uterus prolapse

Uterus prolapse is the result of prolonged labor, unsafe delivery, lack of nutritious diet usually during pregnancy, high work load during pregnancy, frequent delivery, chronic cough, early sexual contact soon after delivery etc. Uterus prolapse is nowadays being a major problem throughout

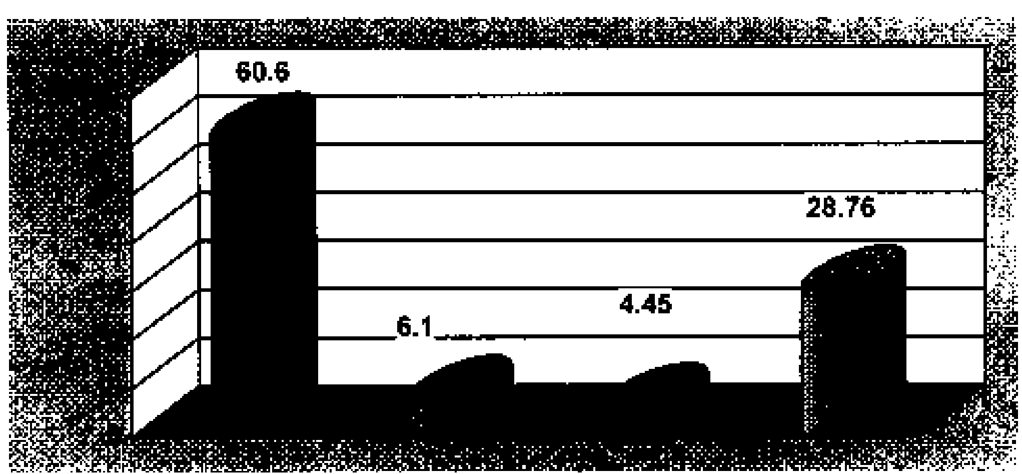
the country. But it is not being reported and its occurrence remains hidden as women are less informed and introversion is still widespread. From our study, it was revealed that 30.3% of women had theproblem of uterus prolapse. However to point out the problem we had to do a lot of probing and it seems that this data may not be sufficient to point out the problem of uterus prolapse in Alapot VDC.

Table 11 UterusProlapse

PROBLEM	YES	NO
Uterus prolapse	30.3%	69.7%

Since the problem of uterus prolapse was prevalent in higher percentage in the selected VDC we access the knowledge, attitude and the practice of uterus prolapse with the women.57.89% of the responded had heard about the problem where as around 42.11% had not .To access the attitude, we asked about the reasons of uterus prolapse. Majority (60.6%) of the respondent address that heavy workload as the leading cause followed by others (28.76%) with reasons such as weakness unhygienic conditions, early sexual contact soon after pregnancy etc. Also some percentages of respondents indicate frequent child-birth (6.1%) and prolong labor (4.54%) as some more reasons of the problem.

Figure -29 Uterus prolapse



To access the practice we asked 30.3% 0f the respondent who had the problem whether they had gone for treatment. Majority of the respondent (85%) had gone for treatment where as (15%) had not.
Practice assessment:

Table-12 Uterus prolapse

Had Problem	Had gone for treatment	Had not gone for treatment
30.3%	85%	15%

3.7 CHILD HEALTH

3.7.1 Breast feeding

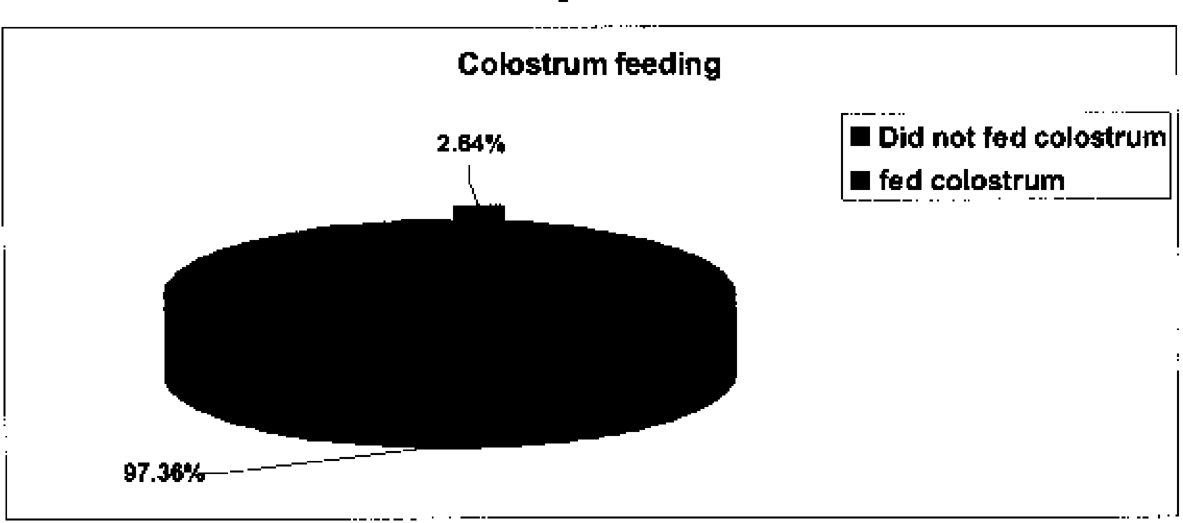
Mother's milk is best milk for baby.

Breast -feeding is assumed to be a normal practice in Nepal. In many communities, young babies are given breast milk as a natural food without being aware of its importance. However, due to the urbanization process and availability of breast milk substitutes, young babies, especially in urban communities, are frequently fed breast milk substitutes. The decreasing trend of breast- feeding has unknowingly increased infants' morbidity and mortality in the country. The adverse effect of the decrease in breast-feeding is not limited to infants' morbidity and mortality, but affects their growth and development as well.

3.7.2 Colostrum feeding

In most communities, mothers begin feeding their infants almost immediately. But in some parts of the country, feeding does not begin for few days, after the colostrum has been discarded. Such practices mean that some new infants are deprived of the immunological qualities of colostrums, and mothers may experience a slower flow due to the late start of suckling.

Figure -30



From our study, we found that colostrum feeding was satisfactory in Alapot VDC as 97.36% of the respondents had fed colostrum to their babies. Rest who had not fed to their baby said it may harm to their baby , one third of them said they dont have the culture of feeding colostrum and one third said baby could not digest it.

Knowledge on colostrum feeding

While assesing the knowledge on benefits of feeding colostrum to our respondent we had found following results shown in table below;

Table-13 Knowledge on colostrum feeding

1	Prevent child from disease	28.83%
2	Child become strong	47.75%
3	Don't know	9.01%
4	Others	14.41%
	Total	100%

Others include colostrum contain vitamins, protein, and after feeding colostrum child sleeps more and so on.

3.7.3 Substance fed immediately after birth

Generally, in Nepal before feeding breast milk a baby is fed with ghee, chini (sugar) honey, water, cow's milk etc.Such practice was also seen in alapot VDC of which 5.71%, 80%, 14.29% fed honey, water, and ghee/chini respectively.

3.7.4 Frequency of breast-feeding

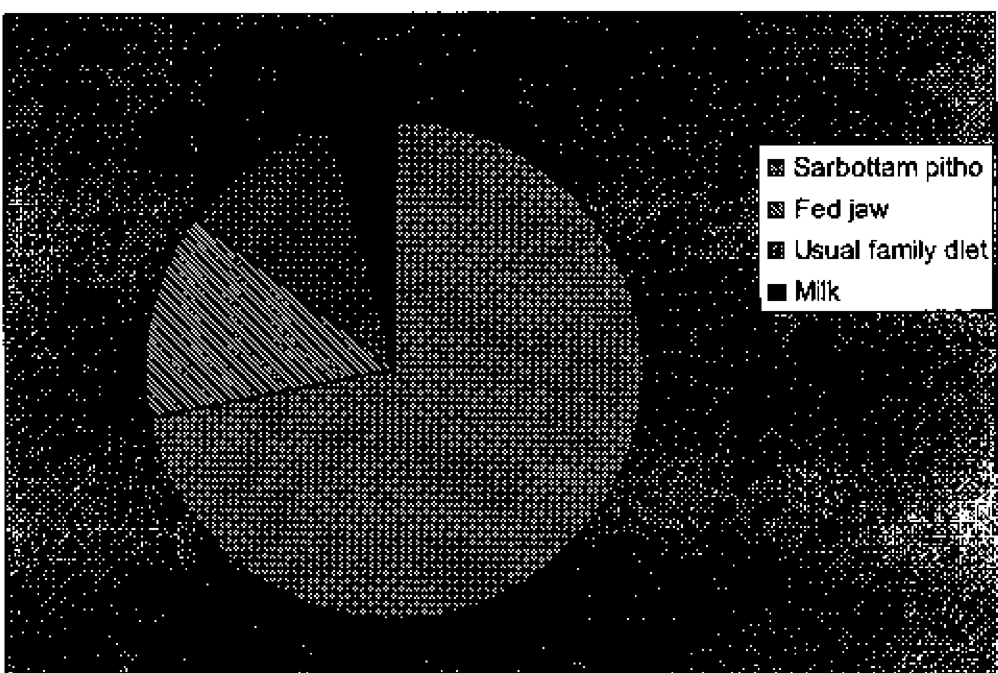
Frequency of breast-feeding practice highly influences the health status of the child. In Alapot VDC.it was found that the mothers generally feed their infants when they demand, but heavy work load sometimes interferes with the frequency of feeding. About 46.49% of the mothers were found breast feeding to their child more than 8 times a day, 32.45% of the mothers were found 6-8 times whereas 21.06%of them were found less than 6 times a day.

While considering frequency of breast-feeding, the time devoted by women to fetch water, household works, field works were appeared to be significant in Alapot VDC.

3.7.5 Weaning practice

Five to six months from birth is an appropriate age to introduce supplementary foods along with breast milk to a baby. After the age of 6 month, in most of the cases mother's milk in not adequate in terms of both quantity and quality to meet the additional requirements of the baby. The introduction of supplementary at too early age (before 4 month) increases the risk of diarrhea and other illness and the practice is not beneficial to mother as well. Energy dense food needs to be given frequently to meet the calorie requirements of the child .It appeared to us that 4.6 is the average-weaning month of a child in Alapot VDC from our sampled households.

Figure -31 Types of weaning food introduced



In Alapot VDC, 72% of the women were found feeding sarbottam pitho to their children,13.16% of them were found feeding jawlo, 10.54% were found feeding usual family food whereas rest(4.35%) were found feeding animal milk to their child as the supplementary food.

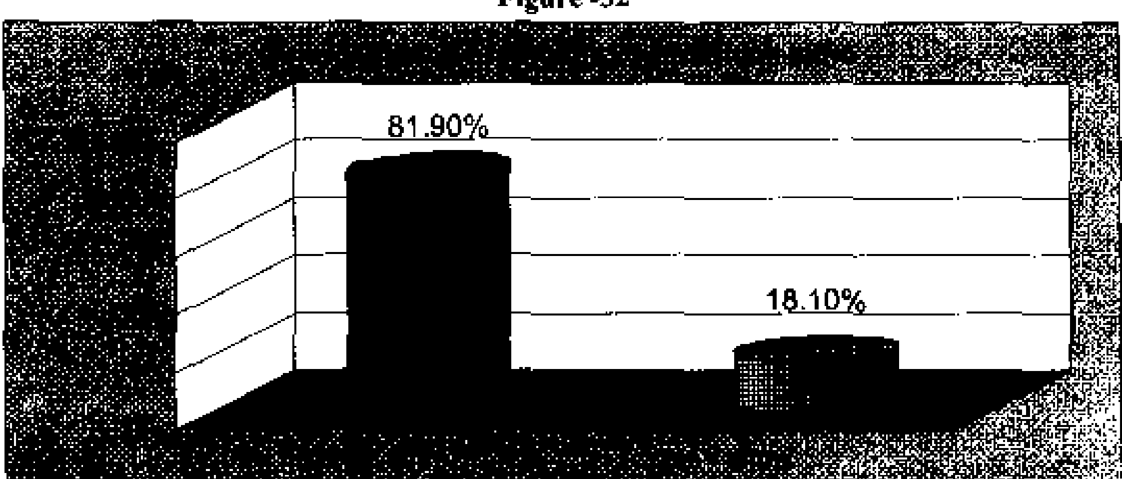
3.7.6 Knowledge on preparation of sarbottam pitho

Sarbottam pitho (super flour) is the most nutritious supplementary food. It makes the child healthy, strong and mentally alert. As supplementary food, it is given to baby after 6 month of birth along with breast milk. It is better to feed child sarbottam pitho along with the mix diet i.e. adding green leaves in sarbottam litho. Mashed fruits can also be fed along with it

Among the 87.72% of the mother respondents who had heard about sarbottam pitho, 18.1% of them knew how to prepare it correctly whereas rest (81.9%) didn't know how to prepare it correctly. The guidelines we used to screen the correctness of procedure was

- 2 parts of pulse (usually Soya beans but large pulse which are difficult to cook by roasting are not suitable to use)
- 2 parts of different cereal grain (usually maize, wheat...) these varieties are roasted separately and are grinned, then mixed and kept in a air tight vessel.

Figure -32



This shows that most of the mothers had knowledge about sarbottam pitho but had wrong practice on it

3.7.7 KAP on Malnutrition

Malnutrition, dietary condition caused by a deficiency or excess of one or more essential nutrients in the diet. Malnutrition is characterized by a wide array of health problems, including extreme weight loss, stunted growth, weakened resistance to infection, and impairment of intellect. Severe cases of malnutrition can lead to death.

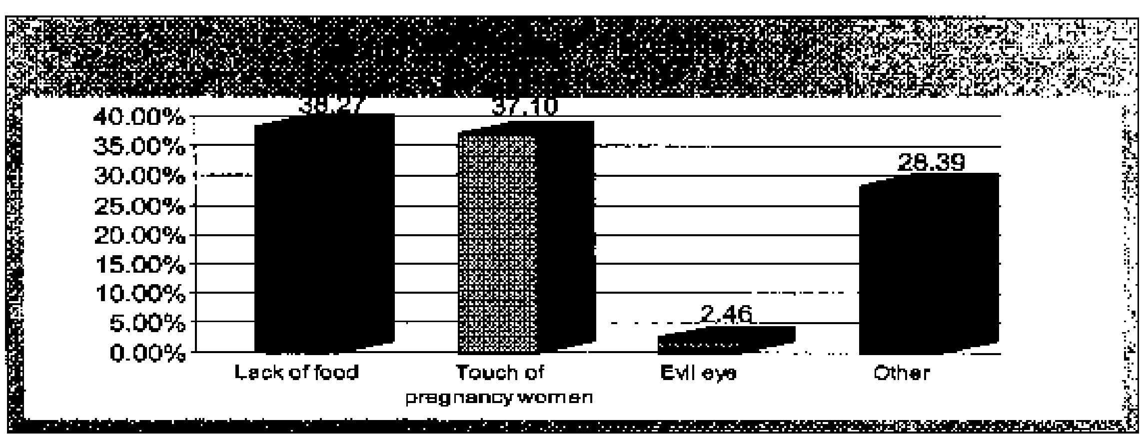
Children suffer from the effects of starvation more quickly than adults do. According to the United Nations Children's Fund (UNICEF), malnutrition contributes to the deaths of more than 6 million children under age five each year. Typically, starving children develop a condition called protein-energy malnutrition (PEM). The two most common forms of PEM, marasmus and kwashiorkor, occur in all developing countries and are life-threatening conditions. Marasmus occurs when a child is weaned earlier than normal and receives foods low in nutrients. The child may also suffer repeated infections, such as gastroenteritis, due to poor hygiene. A child with marasmus is very underweight, with no body fat and wasted muscles. Kwashiorkor occurs when a child is weaned later than normal and receives starchy foods low in protein. In this disease, the child's abnormally low body weight is often masked by water retention, which makes the face moon-shaped and the belly swollen.Malnutrition is being a major problem in developing countries including Nepal.

Table -14 Knowledge on Malnutrition

Condition	Yes	No
Malnutrition	71.1%	28.9%

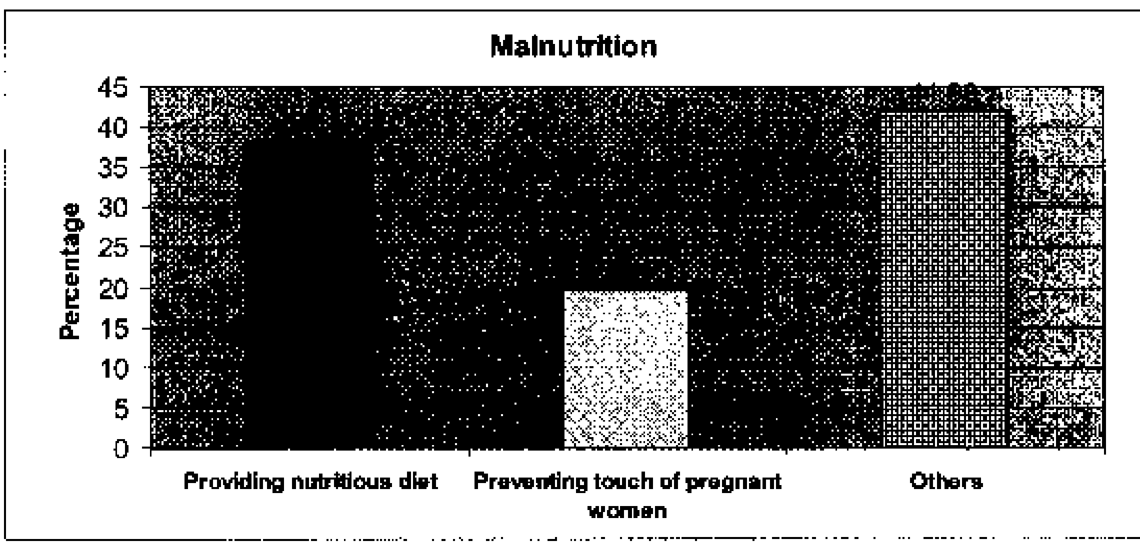
To access the knowledge on malnutrition, we asked mothers whether they had heard about the malnutrition, then majority (71.1%) of women address they had heard while 28.9% had not.

Figure 33



To access the attitude of mothers towards malnutrition, we asked them multiple answer questions about the causation, where majority of them reveal that lack of food (38.27%)being a cause followed by 37.1% addressing the touch of pregnant women being the cause of malnutrition. Also 28.39% reveal others with etc.2.46percentage address evil's eyes to be the cause.The reasons such as lack of vitamin,

Figure 34



To access the practice regarding malnutrition, we address the preventive aspects, where majority (38.27%) of the respondent reveal that providing nutritious diet to the baby can be adapted as the preventive measure also some percentage (19.75%) said preventing the touch of pregnant women can be adapted as well.41.98% of the respondent address others with the reasons such as worshiping, vitamin supplementation, visiting health post, maintaining hygiene can prevent the problem as well.

3.7.8 Nutritional status of U5 children

i) MUAC measurement

Mid Upper arm circumference is generally used method of nutritional status assessment which is carried out in the children of 1-5 years.For this purpose a tape called Shakir's tape is used with the help of which upper arm measured is taken.The tape consists of measurement and three colours-red,yellow and green.

Red-<12.5=Malnutrition
Yellow-12.5-13.5=Moderate
Green->13.5=Normal

In alapot VDC 12% of children were found malnourished while 31% were at risk of malnutrition.

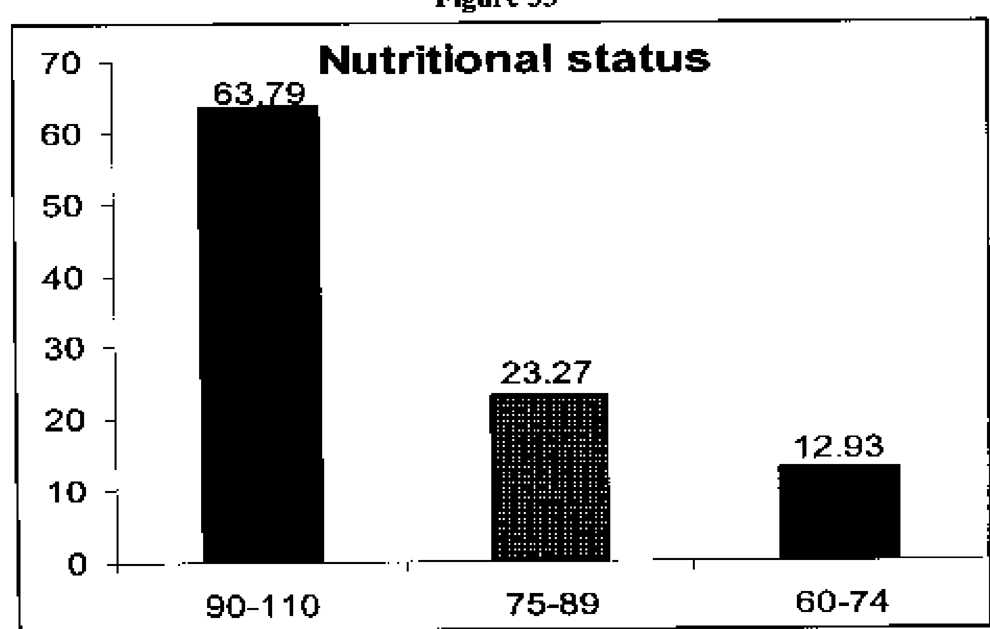
ii)Gomez classification

Gomez classification is based on weight retardation .It locates the child on the basis of his/her weight in comparision with weight of a normal child of same age.

$$\text{Wt. for age (\%)} = \frac{\text{Wt. of the child}}{\text{Wt. of a normal child of same age}} * 100$$

Between 90-110%=normal nutritional status.
Between 75-89%=first-degree mild malnutrition.
Between 60-74%=Second-degree moderate malnutrition.
Under 60% = Third degree severe malnutrition.

Figure 35



According to Gomez classification 63.79%of 0-5 years children were found at normal nutritional status where as 23.27%of them were found to be at first degree mild malnutrition.Similarly 12.93% of them were at second degree moderate malnutrition.At the same time a very good message for alapot vdc,there were none children at third degree severe malnutrition.

3.7.9 Vitamin -A

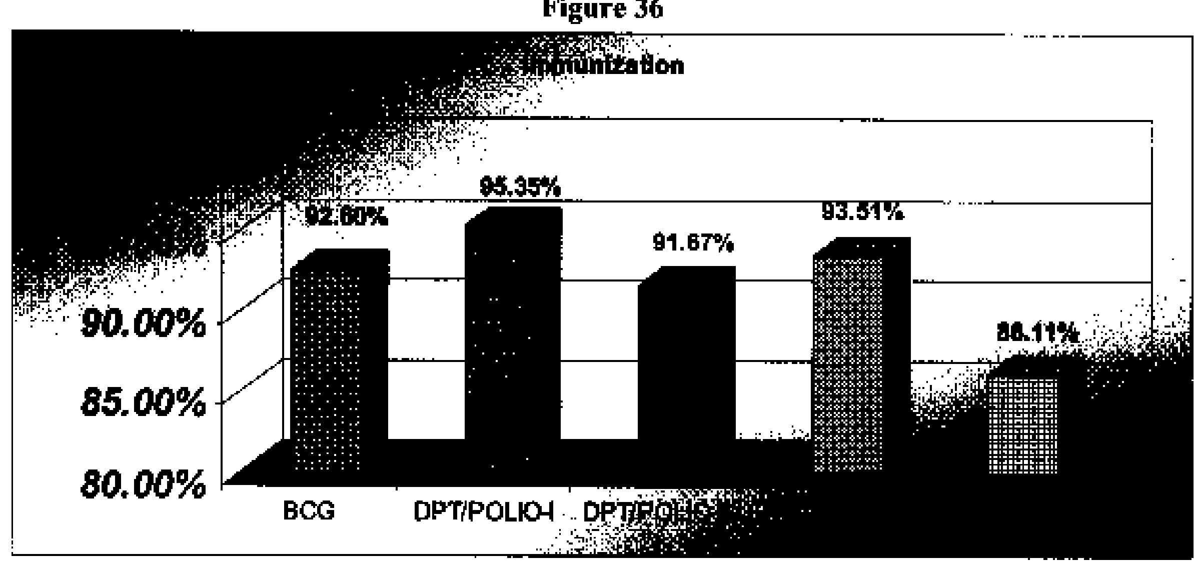
His majesty's Government/Ministry of health initiated the National Vitamin A deficiency (NVAP) to reduce Vit A deficiency (VAD).The objectives of the programme are to reduce child mortality and prevent Xeropthalmia through supplementation of children 6-60 months old with high dose vitamin A capsules .

The average coverage of National vitamin A programme is about 97.4%.There is a remarkabale 100% coverage of vitamin A by National programme in Alapot VDC.

3.7.10 Immunization

The measure objective of immunization is to virtually eliminate vaccine preventable diseases. The global eradication of smallpox, of-course, has been the crowning glory of immunization. All children under the age of 5 years should be immunized. Immunization should preferably be completed within the first year of life and that levels of immunization are sustained so that new generation is protected.

Figure 36



Intensification of immunization program has contributed to significant immunization coverage. The immunization coverage in Alapot VDC is considerable.

3.7.11 Oral rehydration solution prepration

Diarrhoeal disease is one of the top most (3rd) public health problem detoriating the health of under 5 children and one of the main objective of NCDD of HMG is to reduce mortality due to diarrhoea and dehydration and one of the best method used for controlling diarrhoeal disease and dehydration is ORS.

In Nepal, training for the ORS preparation has been given to FCHV's, Traditional healers, mother's group.In Alapot VDC 99% of respondent had heard about ORS of which 100% said that ORS is used in diarrhoea and 92.04% explained correct way of preparing ORS.

Figure 37

JEEVAN JAL PREPARATION

3.8 Family Planning

An expert committee (1971) of the WHO defined family planning as a way of thinking and living that is adopted voluntarily upon the basis of knowledge, attitudes and responsible decisions by individuals and couples, in order to promote the health and welfare of the family group and thus contribute effectively to the social development of a country."

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

1. To avoid unwanted births.
2. To bring about wanted births.
3. To regulate the intervals between pregnancies.
4. To control the time at which births occur in relation to the ages of the parent
5. To determinate the number of children in the family.

The family planning implies not only reduce the childbirth but also fulfill the objectives. Our main objective of the study was to find out the KAP of family planning in Alapot VDC.

3.8.1 Knowledge about the family planning

In Allapot VDC, among 179 respondents, 97.20% have heard about family planning and remaining 2.79% have not heard about family planning.

Table-15 Knowledge about the family planning

Heard about Family Planning	% of eligible couples
Yes	97.20%
No	2.80%

3.8.2 Utilization of family planning methods

In the VDC among the 97.20% respondents who had heard about family planning, 83.33% have used the family planning methods while the rest i.e. 16.67% have not used any type of family planning device.

In Allapot VDC, we find people using both permanent and temporary methods of family planning. Among the temporary contraceptives method users, Depo is most common which is 32.43% similarly among the permanent method users we find vasectomy most common which is 20.69%.

Figure 38

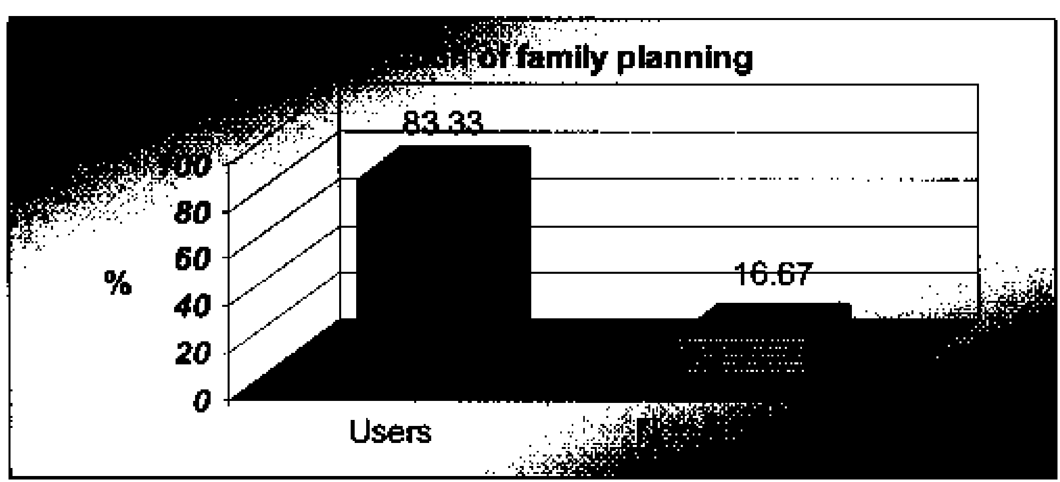


Table-16 Family planning device used

FP Devices	Number	Percentage
Oral Pills	8	5.52%
Depo	47	32.43%
Norplant	1	0.68%
Copper T	6	4.14%
Condom	7	4.83%
Vasectomy	30	20.69%
Laparoscopy	3	2.06%
Minilap	40	27.59%
Others	3	2.06%

According to NDHS (Nepal Demographic and Health Survey), CPR (Contraceptive Prevalence Rate) of Nepal is 39% and the CPR of Allapot VDC is more than 80%. This shows that most people of the community are aware about the Family planning.

3.8.3 Birth Spacing

As repeated pregnancies increases the risk of maternal mortality and morbidity, so there should be the proper birth spacing between two children i.e. of 3-5 years. 67.03% of the respondents say that the space between two children should be 3-5 years and next to it 16.76% say that the space should be more than five years. Similarly 12.29% and 3.91% of the respondents say that the space should be 2 years and less than 2 years respectively.

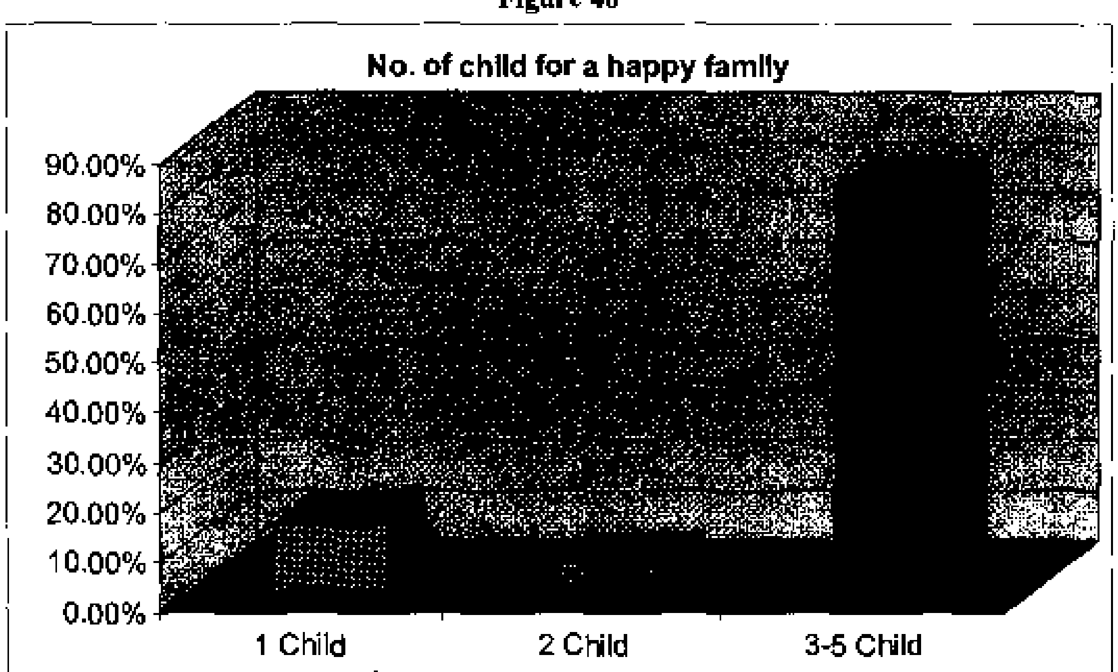
Figure 39

>2 Year
2 Year
2-5 Year
<5 Year

3.8.4 Number of Child for a happy family

When asked about the number of child for a happy family to the community people, 81% of the respondents say two children. 13.40% say that one child is sufficient for a happy family and rest of them desires more than two.

Figure 40



3.9 Environmental Health

"The study of disease is the study of man and his environment"

In order to create and maintain ecological condition that will promote health and prevent disease, environment health is to be addressed. The impact of environmental factors on human health particularly on the health of people is now well established. In this context it is impossible to improve the health of people without including the human population.One of the essential primary health care element is safe drinking water and environment sanitation.The lack of water supply and environment sanitation is the primary reason for why disease is transmitted.Much of the ill health is due to poor environment sanitation that is unsafe water,unhygienic disposal of human excreta and refuse,poor housing.Improvement of environment sanitation is therefore crucial for the prevention of disease and promotion of health of individuals and communities.

Water constitutes a key element in environment and is of critical significance for human health. Disease derived from contaminated water is responsible for a large proportion of deaths among infants and children.

Thus from public health stand point of view sources of water, time, purification of water, procedures for the purification of water and storage of drinking water is to be considered.

3.9.1 Types of house

In Alapot V.D.C, the type of house was categorized by making three criteria's. In the first criteria, we included the houses that had walls with brick, cement, or joined by clay. In second criteria, houses having walls made up of completely raw brick and clay were included. And in the third houses made up of up wood clay are included.

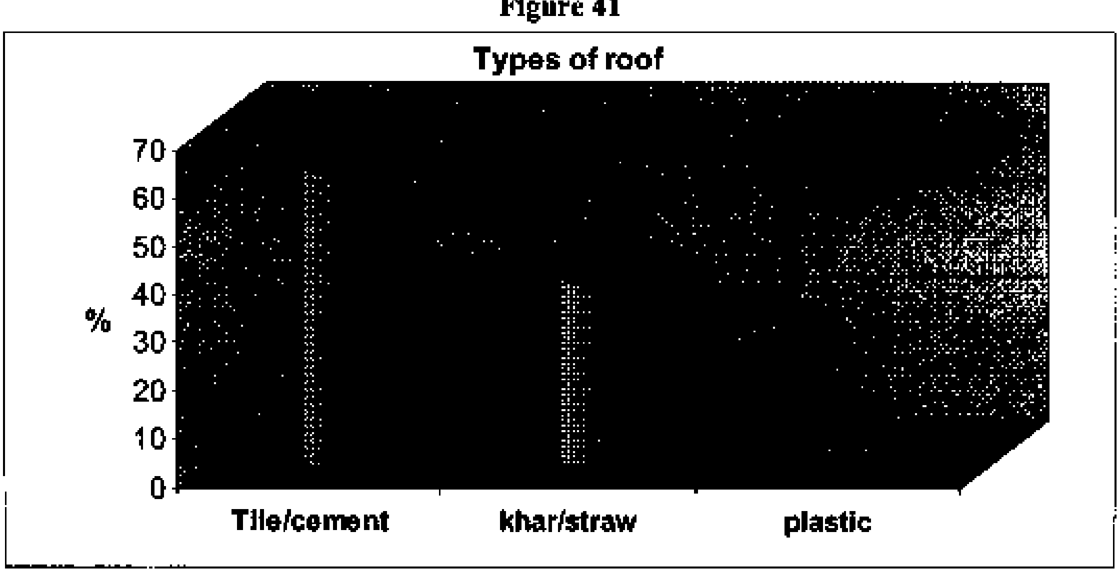
3.9.2 Housing condition

Housing in the modern concept includes not only the physical structure providing shelter,but also the immediate surroundings and the related community service and facilities.The site,set back,floor,walls,roof,rooms,light all determine the housing standard.However in rural areas the approved standards may be lower than in the towns.

3.9.3 Roof

Most of the houses have roof made up of tile, cement, tin. About 60.98% of houses were found having roof made up of tile, tine, cemented roof. While 38.54%of houses have a roof with straw/khar and 0.48%of houses have a roof with plastics.

Figure 41



3.9.4 Ventilation

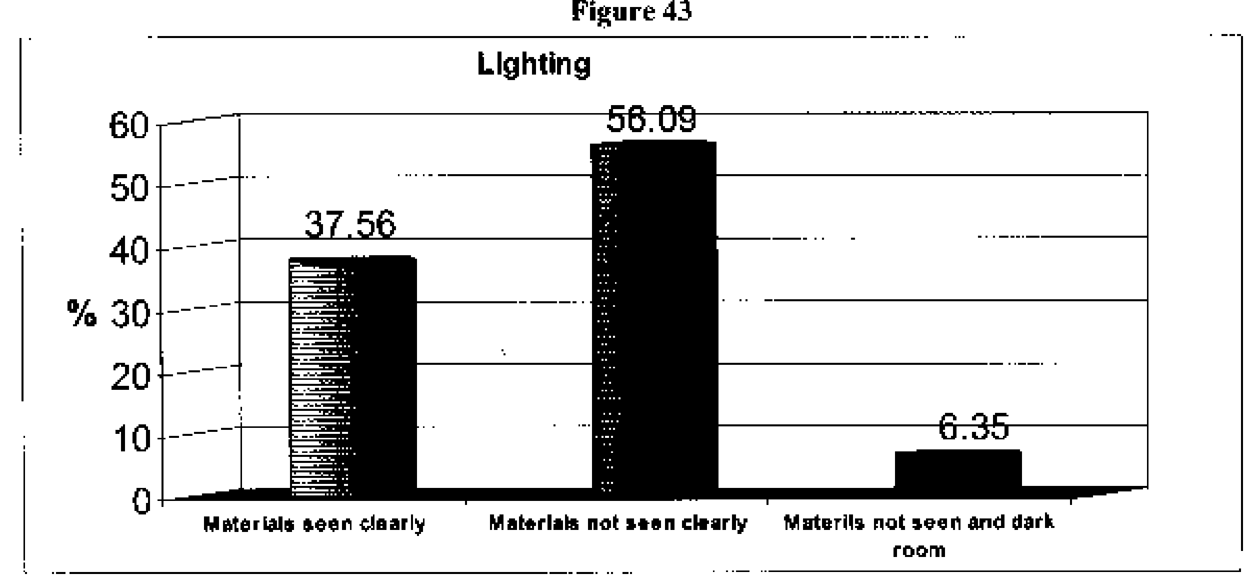
While taking into consideration no. of windows per house, it was revealed that 58.04% of the household has 2 or more than 2 windows. While 32.20% of the household possesses only one window. Besides these, 9.76%of the household does not have any window.

Figure 42

3.9.5 Lightening

From our findings, we revealed that 37.56% of household have good lightening 56.09% houses have inadequate lighting and 6.35% houses have very poor lighting.

Figure 43



3.9.6 Types of kitchen

We found that 19.03%houses had smokeless chulo with a separate kitchen, 52.68%had separate kitchen but there was presence of smoke and rest 28.29%used the same room as kitchen and for living in which there was the presence of smoke

Figure 44

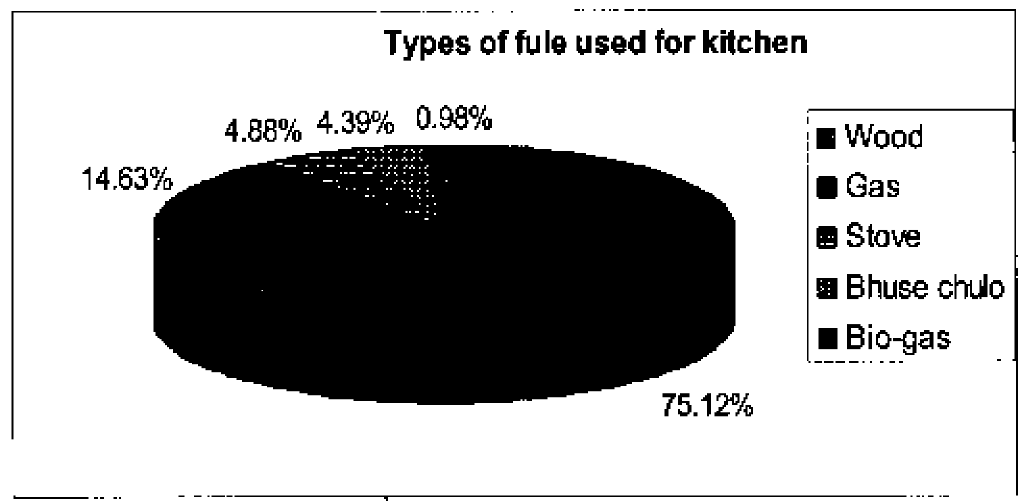
Types of kitchen

Type	%
Smoke+separate	19.03
Smokeless+separate	52.68
Smoke+combined	28.29

3.9.7 Types of fuel used in kitchen

Exposure of traditional society of Alapot to outside is the key factor which has modified social life style of the residents of Alapot V.D.C.But still it was found that 75.12%of the household depend on the wood for cooking purpose.14.63%uses gas for cooking purpose.4.88% of household use stove for cooking purpose, 4.39% depend on bhuse chulo and rest 0.98% use bio-gas. Thus variety of fuel has been observed in Alapot V.D.C for cooking purpose.

Figure 45



3.9.8 Sources of water

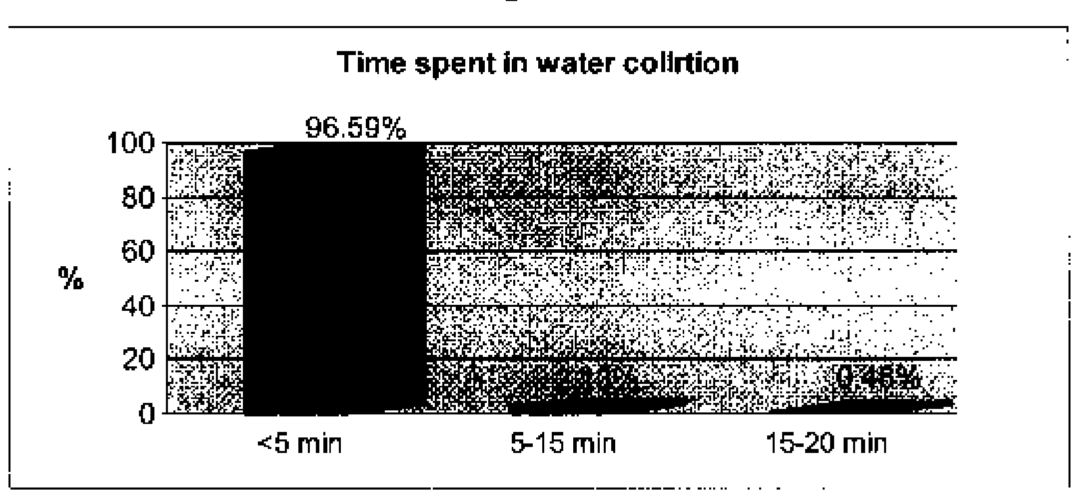
In Alapot V.D.C, most of the residents are dependent on tap water I;e 93.17% of the residents use tap water.Next to tap is well,on which 4.88% of the of the residents depend upon .while Kuwa is also used as water sources by 1.95%of the residents in some parts of V.D.C

Figure 46

3.9.9Time spent in water collection

While considering time frame in water collection, it is found that 96.59% of the residents has easy access to water I;e they consume only upto 5 min in water collecion.While 2.13%of the household take 5-15 min in the collection of water and rest of the household I;e 0.48% take 15-20 min in the collection of water.

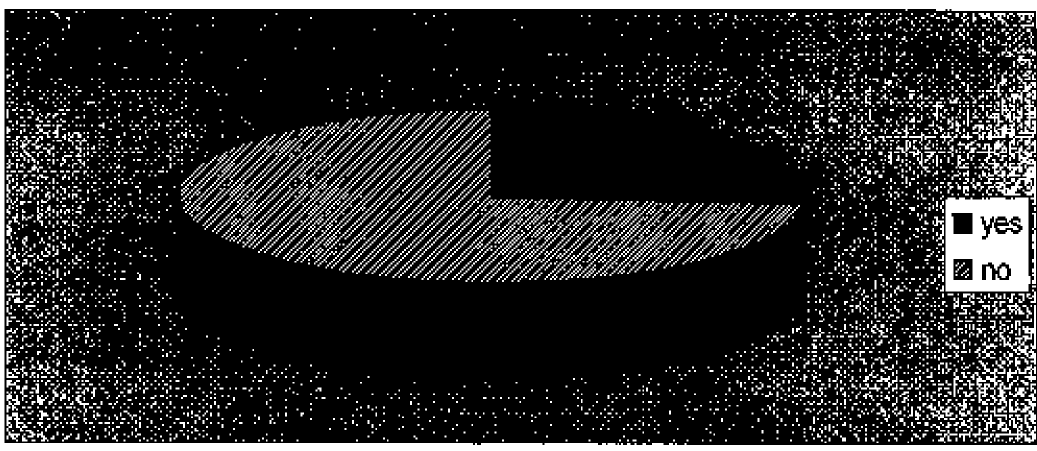
Figure 47



3.9.10 Water purification before drinking

There can be no state of positive health and well-being without safe water. Regarding purification of water, 73.66% of household directly drink water without any purification. Only 26.34% of household purify water before drinking. According to them, the water supplied is safe enough to drink, since lab test is performed twice a year.

Figure 48



3.9.11 Purification method

Out of 26.34%of household, which apply the purification method 55.55% of the population, said that they purify water by filtration through clothes. Boiling process is preferred by 35.19%of household whereas 7.41% use sedimentation method while rest that is 1.85%occasionally boil water in case of sick people in the household.

Figure 49

Purification method

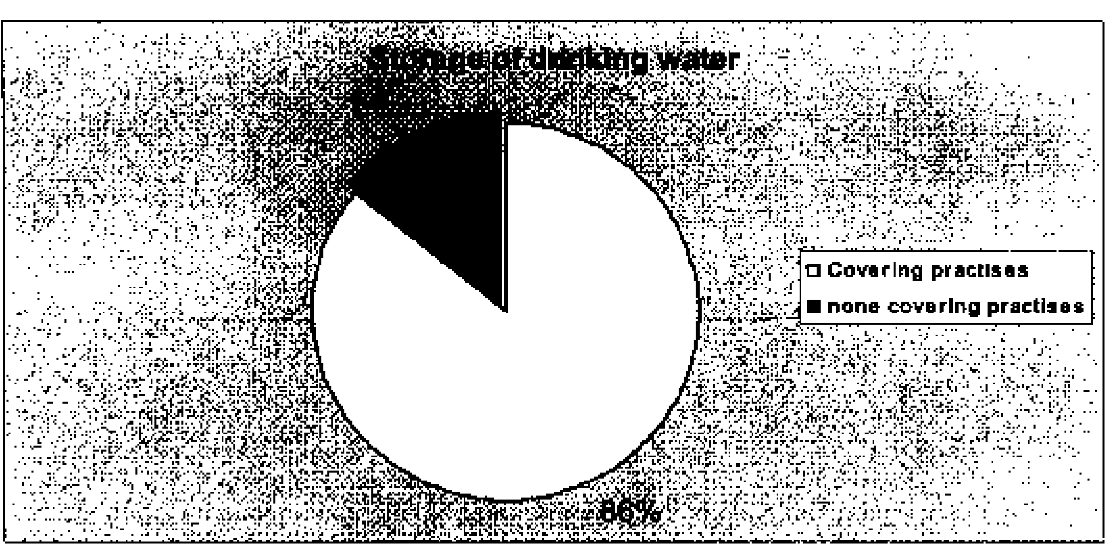
60
50
40
30
20
10
0

boiling filtration sedimentation others

3.9.12 Storage of drinking water

In order to make water free from pathogens and contamination, proper storage of drinking water is of great significance. In AlapotV.D.C 85.85%of household are found having the practice of covering the container of drinking water and rest of the household do not prefer the practice of covering the container.

Figure 50



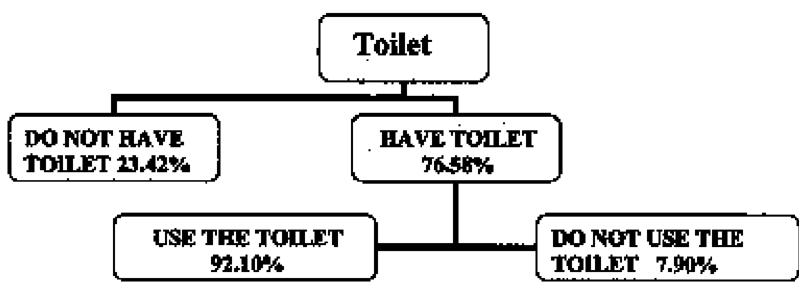
3.9.13 Types of toilet

Human excreta are a source of infection. It is an important cause of environmental pollution. Every society has the responsibility for it's safe removal and disposal so that it doesn't constitutes a threat to public health. Proper disposal of human excreta therefore is the fundamental environmental health service.Thus out of three categories developed to observe the toilet we found that 48.29% use sanitary toilet including water seal and pit latrine, whereas 28.29 % use unsanitary latrine including trench borehole and other simple types.It was explored that 23.42%of the house did not have any kind of latrine.

Figure 51

3.9.14 Use of Toilet

Use of toilet to some extent is responsible for the status of man health and well being. While exploring about the presence of toilet in Alapot VDC 76.58% of the household were found having toilet and rest who didnot have toilet reasoned that they donot have land or money.Among those who have toilet, 92.10% prefer to use it. While 7.90% do not prefer to use the toilet because of lack of water, lack of practice, feel uncomfortable etc.



3.9.15 Personal hygiene:

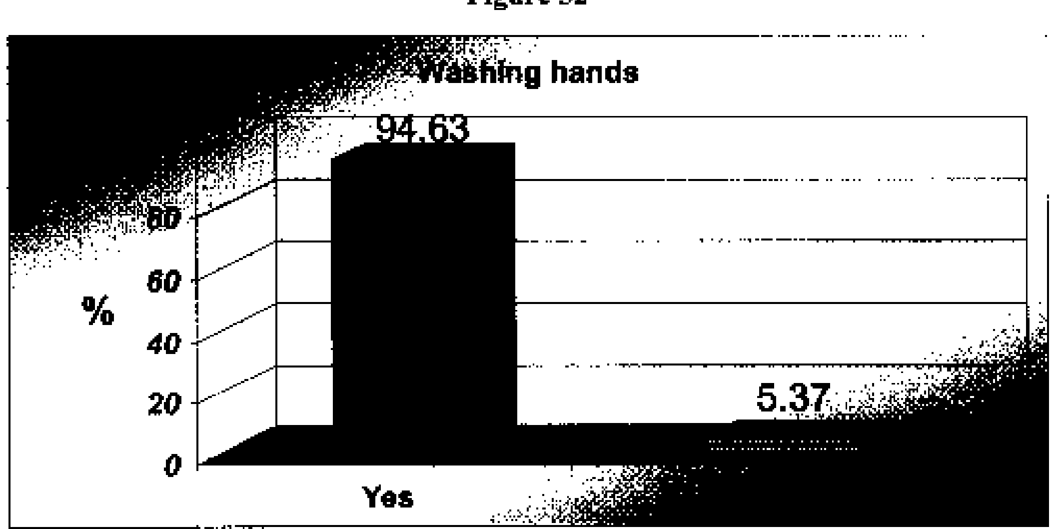
Personal and household hygiene behaviors are important aspects of care. Hygiene behavior directly affects the cleanliness of the environment. It determines the quality of infectious agents people ingest through contaminated food and water or by placing contaminated objects in their mouth. Poor house hold hygiene practices contribute to the high incidence of disease like diarrhoel diseases.

In alapot VDC,people were found aware about their personal health. For this purpose 60.97%, 70.24%,89.27%,76.10% of alapotians use to cut their nails,brush their teeth,take bath, wash clothes respectively . Similarly 6.47%did extra activities like shaving, combing,cleaning home to be more hygienc.

Washing hand

Majority of people i.e. 94.63% wash their hand before eating. Among them about 51.o3% wash their hand by water only whereas 45.36 prefer soapwater, 2.58%prefer ashes and remaining 1.03% prefer mud for washing hands.

Figure 52



3.9.16 Kitchen garden

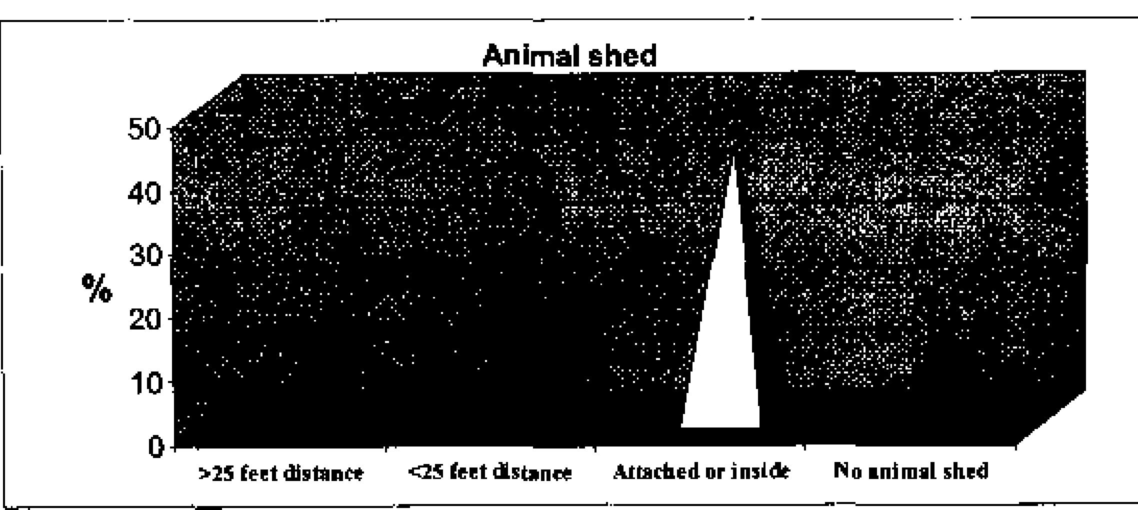
Kitchen garden is one of the way through which access to food is gained by house hold. The notion of food security is applied to various levels but increasing attention is paid to the household level since it is through the social unit of the house hold that most of the people gain access to food. In Alapot V.D.C., most of the houses, i.e. 89.76% have kitchen garden and remaining 10.24% houses do not have kitchen garden.

Figure 53

3.9.17 Animal shed

As per the approved standard of rural housing cattle's shed should be at least 25 feet away from dwelling houses. In Alapot V.D.C., almost 43.42%of the houses kept their cattle inside the house or attached to house .Only 13.17%of the houses had their cattle shed 25 feet away from the house periphery. Rest of the houses i.e. 28.29% in theV.D.C. Meet the second criteria or they have animal shed inside 25 feet of the house periphery .Rest of the houses do not have shed.

Figure 54

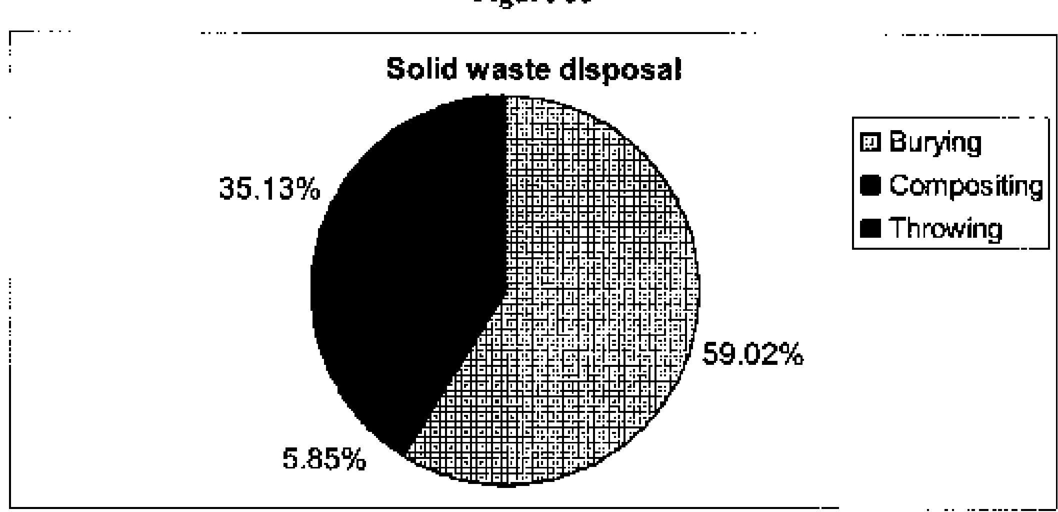


3.9.18 Solid waste management

There is the correlation between improper disposal of solid waste and incidence of vector borne diseases. Therefore, civilized society needs to establish efficient system for its periodic collection, removal, and final disposal without risk to health.

Around 59.02%of household bury their solid waste in the pit far from their houses, composting is done in 5.85%of household and 35.13%of house hold throw solid waste haphazardly.

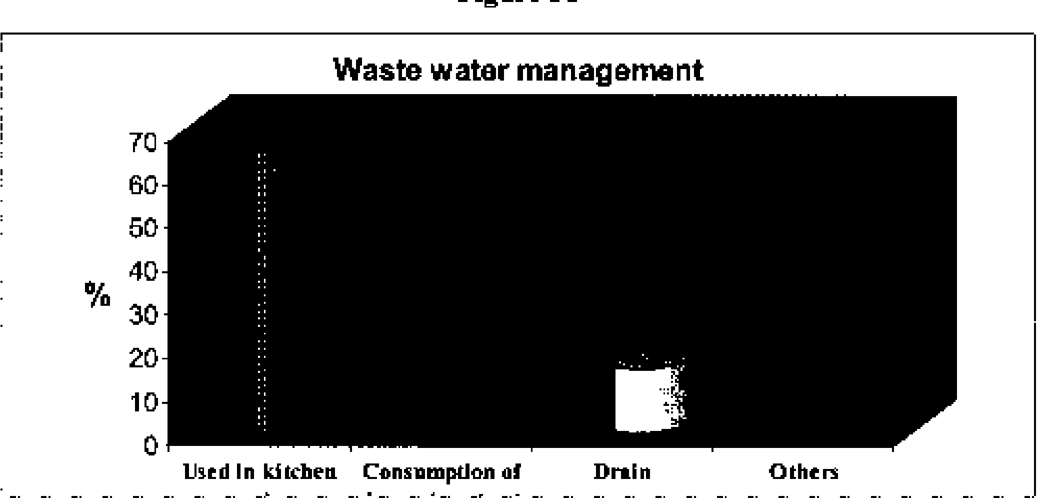
Figure 55



3.9.19 Liquid waste management

64.39% of house hold were observed utilizing waste water in kitchen garden where as 14.63% of household were find having the practice of passing the water in drainage and 6.83%use waste water for the consumption of domestic animal while rest of 14.63%utilises waste water in different purposes.

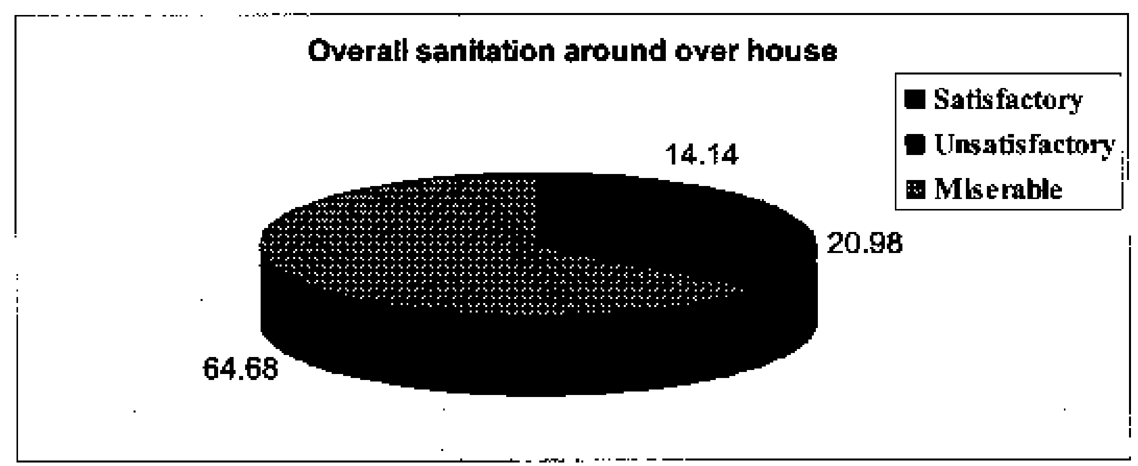
Figure 56



3.9.20 Overall sanitation around house

Only 14.14% houses and their surroundings are clean and free from flies and have well managed solid waste disposal systems in our study overall sanitation of houses are observed in 64.88%of the houses and in 20.98%of houses condition are miserable.

Figure 57



CHAPTER 4
PROBLEM PRIORITIZATION

4.1 Program Schedule;

Inauguration of the program was done by our group leaders, who made the program formal. Mr. Ramsaran Phuyal was headed as special guest and Mr. Ramhari sharma, principal of Balbikash Higher Secondary School, and Mr. Narayan Bahadur Khadka were made chief guest and Mr. Krishna Paudel from NIHS was the guest of the program.

We presented our findings as follows;

1. Demographic data; Sex composition, educational status, occupational status.
2. Knowledge, Attitude and Practice on diseases.
3. Maternal child health; ANC checkup, place of delivery, Colostrums feeding, miscarriage, breast feeding, Sarbottam pitho
4. Nutritional status; Anthropometric measurement of <5, Nutrition of child.

4.2 First community presentation

Our first community presentation was held on 20th of Baishak after 14 of data collection PRA tool utilization and analysis. The program was organized at V.D.C. office and the invitation was dissimilated before hand. The program started at 7:15 am. Many authorized people, social workers, teachers, FCHVs, students, local leaders including community members were present including the superviser Mr. Krishna Paudel, Mr. Prem Panta and Mr. Pralad Bhattarai from NIHS. With no. of participants, we forwarded the program.

Objectives of the presentation;

1. To inform the community people about the observed need and accordingly explore the felt need from community people itself.
2. To inform the community people about the observed need and accordingly explore the felt need from community people itself.
3. To prioritize the real need by comparing the observed need with the felt need of the community.
4. To create maximum participation in the planning, implementation and evaluation of MHP.
5. To fulfill their Quest for health.

At the last of the session we disscused with community people about the felt need and observed need and found real need of the community.

a. Felt Needs

Felt needs are those health and/or development needs. The people in a community perceive (understand and feel) to be what they need in order to improve their health and/or socio-economic status. Felt needs is identified as being of greatest importance to them.

b. Observed Needs-

Observed needs are the needs that are seen by outsiders or experts and they can usually be measured in some ways. Observed need are those health need which can be scientifically shown to be needs in order to solve a community health or health related problem and so to improve health status.

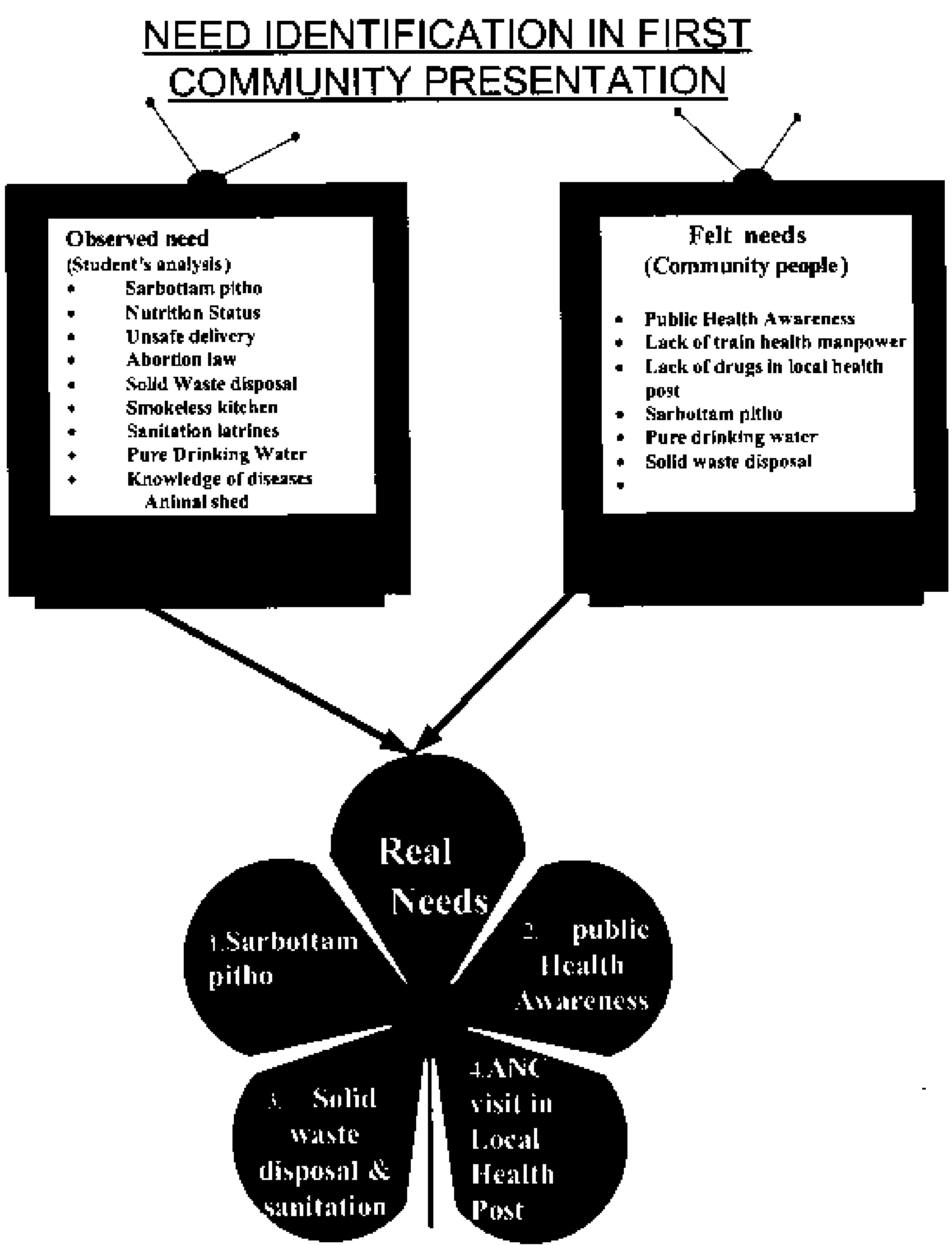
Using different tools and techniques, findings revealed that there were various problems in Alapot, some of the observed needs that have been identified are described below;

C.Real Needs

Real need are those needs which results from a jointly developed understanding of priority needs of the local people(felt need) and priority needs as defined by us(observed needs). A real need usually tries to get at the root cause of a health or development problem for which a solution can be found and carried out.

Identification of felt needs was done through interview with finding leaders, FCHV, Health post staff and through interaction with community members. Leaders in Allapot VDC think that there should be provision of trained health workers in the health post and availability of adequate medicine in health post. Some of the needs that have been felt by the community are as follows:

4.3 Need identificationin community



This showed that the awareness level is low in the people, and even though they are aware. They did not take knowledge into practice. Another problem that has been felt by the community was purification of drinking water. They also emphasized in the nutritional requirements for mother and baby as an important sector for improvement.

4.4 Problem prioritization

Prioritization means using systematic methods of assigning greater or importance to various disease, problem, needs, interventions, age /sex group etc.

By considering the following criteria, we determined the real needs.For the need priortization we requested some of community leaders, FCHVs, community people and start another session.

PRIORITZING REAL NEEDS

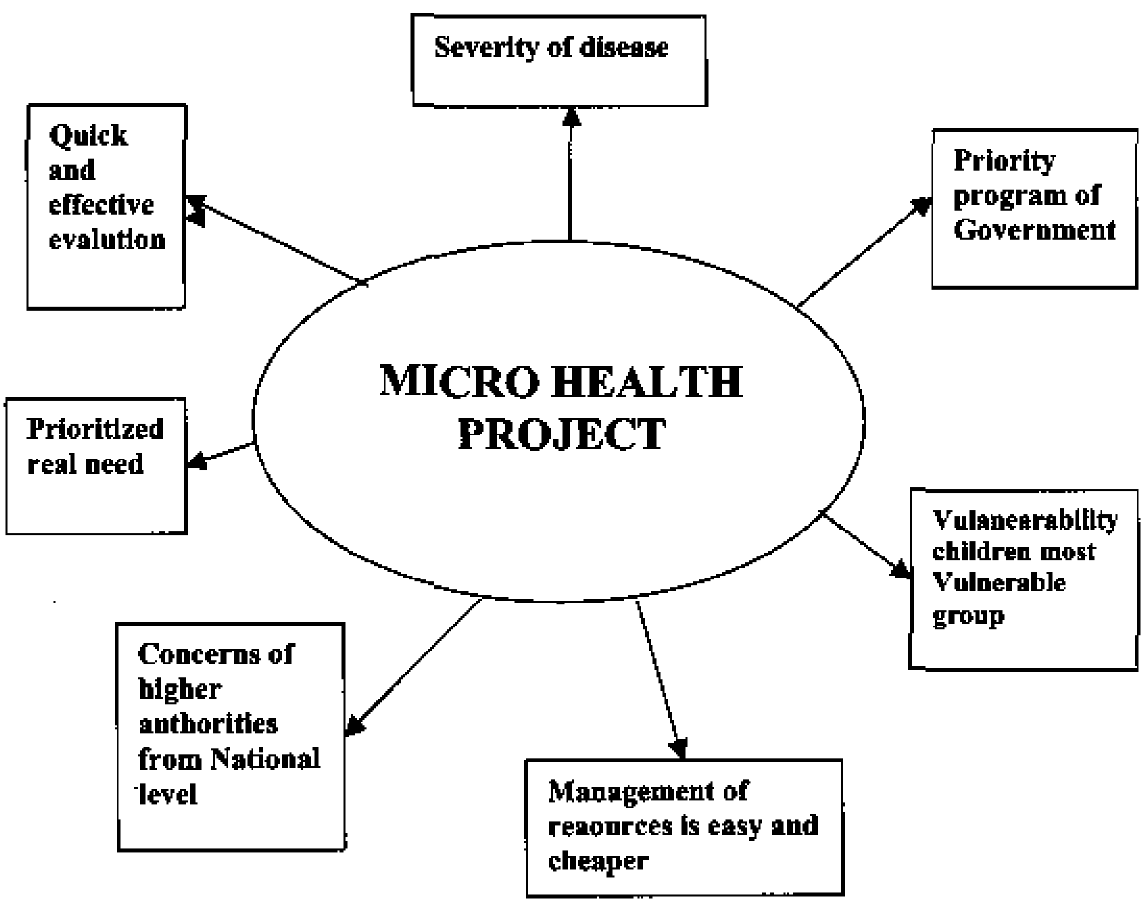
List of real needs	Severity			Resourses			Participation			National health priority			Effectiveness			Evaluation			Total
	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	0	1	2	
sarbattom pitho			2			2		1				2			2			2	11
solid waste management		1			1			1		0				1				2	6
public awareness			2		1			1				2		1			1		8
ANC visit		1			1			1				2		1		0			6
Sanitary toilet			2			2	0			0			0				1		5
Water purtification	0				1		0				1		0			0			2
Iron tablet compilance			2		1		0					2	0			0			5

RESULTS

1. **SARBOTTAM PITHO=11**
2. **PUBLIC AWARENESS=8**
3. **SOLID WASTE MANAGEMENT=6**
4. **ANC VISIT=6**
5. **SANITARY TOILET=5**
6. **IRON TABLET COMPILANCE=5**
7. **WATER PURIFICATION=2**

CHAPTER 5
MICRO HEALTH PROJECT

5.1 WHY MICRO HEALTH PROJECT ON SARBOTTAM PITHO?



5.2 INTRODUCTION

MICRO HEALTH PROJECT

Micro health project is small-scale health project conducted for the achievement of goal in health sector. It is designed to develop health related skills and self -reliance on the priority basis of real needsamong community people through the maximum utilisization of locally available cheap resources and techniques with full community participation.Actually MHP is just one of the ways to solve community health problems in short period of time. However, the project was micro, but aims of such program cannot be micro aims.

After presenting our findingsin front of the community peoplein first community presentation,a meeting was organised involving community people ,leaders, health workers,FCHVs, school teachers, key persons and,youths. For this program invitition was sent to healt workers, formal and informal leaders through letters and also was invited verballyby visitingtheir home.On the same day real health problem were prioritised accordingly on the basis of felt needs and observed needs .after that we decided to conduct micro health project on SARBOTTAM PITHO.

5.3 THE ABOVE FIGURES SHOWS A BRIEF OUT LOOKS OF RATIONALES —— WHY WE CONDUCTED MHP ON SARBOTTAM PITHO?

@ Our study shows12.07percentage and 31.04%children malnourished and in danger line respectively.
@ The figure 12.07% and 31.4% indicates increasement in of malnourished child (<12.5c.m) two times and the children in danger line (12.5-13.5c.m) MUAC measurement three times greater in comparision to the last year (2061) conducted by students of NIHS first batch.
@Children under 5-years of the age are the main victims of malnutrition.so nutrition programme is not only the priority programme of Allapot vdc but also one of the priority programme of goverment of our country to reduce under 5 mortality and morbity rate.
@ Childeren are also more vulnearable to diferent type of diseases like nutritional anaemia, diarroheal diseases etc.
@ It is easy relevant and cheaper to manage locally available resources.
@ About 81% of mothers practicing wrong method for the prepration of sarbottam pitho.
@ Sarbatom pitho is the first real need, which is, the outcome based upon observed and felt need
@ Sarbottm pitho is one of the best solutions for the improvement of nutritional deficiency as it contains proteins and carbohydrates which needs to have high calorie for a child to be healthy.
@ comparing with other programmes, we thought that it could be effective and fruitfull within our framework of time.
@ It is easy for us to evaluate.
@ This programme help us to change KAP of mothers in order to reduce malnutrition found among children.

5.4 TARGETED TO MOTHERS BEARING CHILD <5 YEARS ----WHY?

*Literacy rate of female in vdc is found lower in comparision to male population.And most of the mothers are found illiterate in our study.
*Although 96.38% of mothers says that they know about the prepration of sarbottam pitho,but we found about 81%feeding their children with wrong practices.

5.5 MHP WAS CONDUCTED IN HEALTH POST ---WHY?

_The day when we were conducting MHP was Thursday i.e immunisation day of allapot vdc.so it is easier for us to gather mothers.
_Health post is situated in ward no.4 i.e at centre for which people can reach their within 20 minutes from every wards.
_For our easiness and interest shown by Health post we conducted MHP bilaterally with Health post.

5.6 GOAL

The main goal of MHP is to conduct a sarbottam pitho demonstration programme is to make mothers able to prepare sarbattom pitho/litho in fixed proportion.

5.7 TARGET GROUP

Mothers bearing child under five years of age.

5.8 OBJECTIVES

1. To explain mothers about the importance of sarbatom pitho.
2. To make mothers able to fix the proportion of pulses and cereals in proper way without any confusion.
3. To make mothers perfect in cooking sarbatom litho.
4. To explain mother how and when to feed sarbatom pitho to their child.
5. To help mothers change KAP regarding nutrition.

5.9 MATERIAL USED

-Posters

-Local resources like jatho, utensils, pulses, cereals.

5.10 METHOD USED

-Demonastration

5.11 IMPELEMENTATION OF MHP

Firstly we gatherd and prepared the required materials then we conducted different activities.

The activities are described below sequentially.

EPISODE_I

At the prilimenary stage, we conducted health education on the consequencesof nutritional deficiency.

What is balance diet?

What amount of nutrient do children need to be a healthy?

Health education on:

-Micro and macronutrients

-Sources of body building, energy giving, and security providing foods

-Malnutrition

-sign and symptoms of malnutrition along with Intervention measures.

Along with this comparision between *SAGH* bahadur & *BHAT* bahadur wsa also done to make programme effective by showing poster.

EPISODE-II

Presentation on findings data related to nutrition was done so that they can realize themselves that malnutrition is their own childrens problem.

EPISODE-III

Health education on:

-Importance of sarbottam pitho.

-Presence of nutrient in sarbottam pitho was also given.

EPISODE-IV

DEMONASTRATION

Step-i

Prepration

Mothers were demonastrated about the mixing of pulses and cereals in fixed proportion.After that they were demonasterated about grindingof mixture followed by roast.

Step-ii

Storage

After sarbottam pitho became ready they were demonastrate on how and where to store it properly.

Step-iii

Cooking

Demonastration on how to cook food was done.

Step-iv

At the end of the session we fed prepared sarbottam lito to every children present with their mothers.

At last, mothers were taught about when and how many times to feed litho within twenty. four hours.

5.12 EVALUATION

Evaluation means examining a programme or projectin order to determine whether it has accomplished its goals and objectives.

So after the impementation of every programmeit need evaluation for the measurement of its effectiveness. In the same waywe had also did it.

Total 64 mothers were demonastrated.

Here, we evaluated our programme by asseing positive change in knowledge and practice. A corrosponding level ofchange in knowledge and practice will signify positive impact of the programme.

Therefore, for evaluation we did following things:

At first,

We asked: - would you please say how you prepare sarbottam pitho?

A) If correct

Asked:-wuold you please demonastrate it?

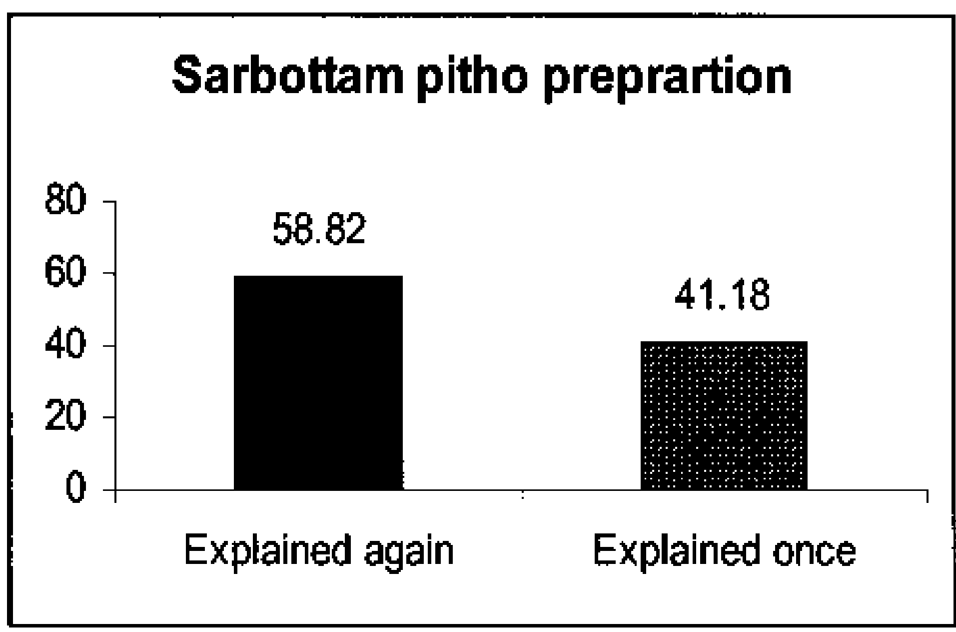
a.1) If correct

We proceed further.

b) If incorrect

We re demonastrate and make them able tom prepare and cook sarbottam pitho.

From above we found following results.



The above chart indicates that 58.82% of mothers need re demonastration.But 42.18%didnot need any re demonastration.At last we made them 100% able to prepare sarbottam pitho/lito.

5.13 SUSTAINABILITY

For the sustainability of the programme distributation of guidelines on sarbottam pitho prepration to FCHVs and mothers was done. In addition to this Health post and vdc also assured us that they will visit door to door to intervane malnourished children bilaterally.

5.14 SUPPORTING PROGRAM FOR MHP

In order to make MHP sucessfulas well as to create awareness and positive change in KAPon nutritionand sarbottam on the same day we invited to student from different school located in Aliapot vdc.

-Balbikash secondary school
-Kageswari vidhya mandir secondary school
- Byoka community English school

5.14.1 OBJECTIVES

- To teach students importance of nutrition to be a healthy man.
- To develop positive KAP in school students about nutrition and sarbottam pitho and through them to their parents.
- To make students aware of nutritional deficiency disease its sign and symptoms,its health hazards,etc.
- To make student able to prepare sarbottam pitho and through them to their parents.

5.14.2 IMPELEMENTATION

1. Health education on;
   - Balance diet
   -Sources of nutrient food items.
   -Malnutrition
   -sign and symptoms of malnutrition
   -Importance of sarbottam pitho
2. Demonastration
   Prepration
   Storage
   Cooking, of sarbottam pitho.

5.14.3 EVALUATION

The programme was evaluated by asking a question to the students.The result was found satisfactory.

CHAPTER 6
EXTRA HEALTH ACTIVITIES

6.1 DEMONASTRATION ON ORS (special programme)

Besides MHP we conducted a special programme on oral rehydration solution prepration.

6.1.1 RATIONALE

1. Although 100%said that ORS is used in diarrohea.And 82.3%said about correct method of prepration.so to test the practiceof preprationof ORS this program was conducted.
2. Diarohea is one of the top diseases causing infant mortality high in National figures.

6.1.2 GOAL

To attain 100%perfect in preparing ORS.

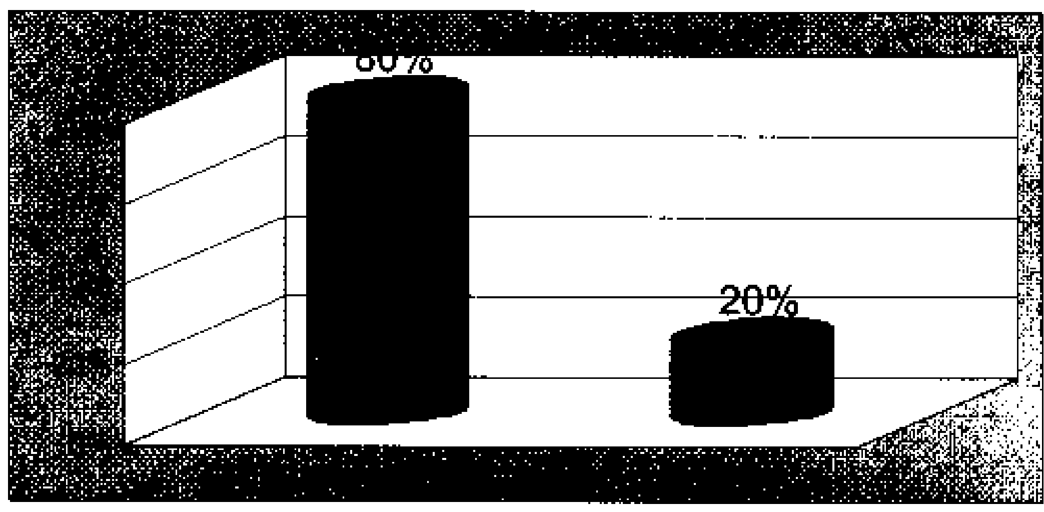
6.1.3 OBJECTIVES

To asses the practice of ORS prepration

6.1.4 IMPELEMENTATION/EVALUATION

At first ORS corner was selected and people visiting ORS corner were asked for the preprationof ORS

From this we found,



This indicates that only 20%of people need repracting of ORs prepration but rest did it perfectly one at a time.

6.2 PLAN OF ACTION

6.2.1 PLAN OF ACTION FOR EXTRA ACTIVITIES-I

Date	Activities	Target group	Place	Evaluation
062-1-6	Observation in vitamin A stall	Community people	All the wards	
062-1-12	Class conducted at Balbikash school about Communicable diseases, AIDS, Community health and abortion	Students of grade 7,8 and 9	Balbikash school	Oral assessment
062-1-13	Participation in Rally	Students	Balbikash School oc Students of Balbikash, Byoka and Kageswori school	
062-1-22	Elocution competition organized at Balbikash school	Students	local leaders home	
062-1-25	Digging compost pit. -	Community people		Observation after 2-3 days

6.2.2 PLAN OF ACTION FOR EXTRA ACTIVITIES -II

Date	Activities	Target groups	Place	Evaluation
062-1-21	School Health Program conducted at Natheswori school about personal hygiene, Nutrition and Diarrhea.	Students of grade 2, 3, 4 & 5	Natheswori school	Oral assessment
	SHP conducted at Kageswori school about Abortion.	Students of grade 9 &10	Kageswori school	Written assessment
062-1-22	SHP at Natheswori school about vitamin A& eye injury.	Students of grade 3, 4 & 5.	Natheswori school	Oral assessment
	SHP conducted at Byoka school about Rabies	Students of grade 7 & 8 students	Byoka school	Oral assessment
	SHP conducted at Kageswori school about uterus prolepses	Students of grade 9 & 10	Kageswori school	Oral assessment
	SHP conducted at Balbikash school about breast feeding, Viral fever, conjunctivitis & tetanus.	Students of grade 9	Balbikash school	Oral assessment
062-1-23	SHP conducted at Byoka school about Adolescent health, menstruation & Abortion.	Students of grade 7 & 8	Byoka school	Oral assessment
062-1-25	Digging compost pit.	Community people	Local leader's home	Observation after 2-3 days
062-1-26	Door to Door health campaign	Ward no. 1 people	Ganesh Mandir	
062-1-27	SHP conducted at Bal Sishu Sadhan about Vitamin A & personal hygiene	Students of grade 3, 4, &5	Bal Sishu Sadhan School	Oral assessment
062-1-29	Health exhibition	All groups especially mothers of <5age & Adolescents	Health post office	
062-1-6	Observation in vitamin A stall		All the wards	
062-1-12	Class conducted at Balbikash school about Communicable diseases, AIDS, Community health and abortion	Students of grade 8, 9, &10	Balbikash school	Oral assessment
062-1-13	Participation in Rally			
062-1-22	Oratory competition organized at Balbikash school	Students of Balbikash, Byoka and Kageswori school	Balbikash School	

6.3 ACTIVITIES DONE AS PER THE REQUESTS

1. OBSERVATION ON VITAMIN- A STALL

As per the request of healthand our interest in knowingdetails about vit A distributation programme we visited different vitAstallin every wards.At the same time we got an opportunityto know about the doses of vitA capsule along with deworming tablet.

2. SCHOOL HEALTH PROGRAMME

After we got request letter taking classes to class 8,9&10 from Balbikash secondary school.we conducted SHP on topcs Community Health and Abortion in class10, HIV -AIDS in class 9 and Tuberculosis in class 8. FOr the evaluation of program oral assesment and home assignment were given to students.

3. PARTICIPATION IN RALLY

We had also got an opportunity to participate in rallywith slogan बाल बालिकालाई स्कूलमा भर्ना गरौं ।

We got such an opportunity fromKageswari vidhya mandir.The rally was started from Gagalfedhi and was ended at Balbikash secondary school in allapot vdc.

6.4 EXTRA HEALTH ACTIVITIES DONE ACCORDING TO THEIR REAL NEED AND MANAGEABILITY OF RESOURCES.

1. ELOCUTION PROGRAME

Inter school eloculation programme was conducted on the topic "PEOPLE'S HEALTH IN PEOPLE'S HANDS" at balbikash secondary school.In this programme 14 students were participating. They were emphasising health is a fundamental human rights, if wealth is lost nothing is lost,' if education lost something is lost, if health is lost every thing is lost.'

The winners of this programme are listed below;

First

Sulochana shrestha------- Byoka Community English school

Second

Arun khadka----------- Kageswari vidhya mandir secondary school

Third

Joyati Thapa -------- Kageswari vidhya mandir secondary school

Fourth

Shrawan kumar khadka------Balbikash secondary school

At the end of this session prize were also distributed to winners by Ram Hari sharma the Chairman of the programme.

2. SCHOOL HEALTH PROGRAMME

Objectives

-To develop positive KAP in school students about communicable disease, non communicable diseaseand maintaining personel hygieneand through them to their parents.

-To educate student about existing health related laws in Nepal.

Impelementation

School health programme was conducted in various school located in allapot vdc. During our SHP we dealt wit different topics. They are:

Balbikash secondary school

Community health, abortion law, HIV-AIDS, Tuberculosis, personnel hygiene, Breast -feeding viral fever, conjunctivities, tetanus etc.

Kageswari vidhya mandir secondary school

Abortion laws and uterus prolapse

Natheswori School

Personnel hygiene, nutrition, and diarrhoea, vit-A, eye injury.

Bayoka community English school

Rabies, adolescent health, mensuration and abortion laws.

BAL sishu sadhan

Vit-A and personnel hygiene.

3. DIGINING PITS

As we found 59.02% are using open pits and 35.13% are throwing wastes every where around house. We decided to teach people about making compost manure from the garbsge that comes from our daily activities. This programme was carriedd in ward no. 4 near health post VHWs house with participation of about 30 people.

4. HEALTH EXHIBITION

Including these, we did different healthn exhibition programme;

i) SODIS

ii) A sample of sanitary home

iii) Differnt posters and phamphalates were displayed and distrubuted.

In addition to this exhibition, a special health promotional programme was also conducted by us. For this, we had emphasised Antenatal visit done duing pregnancy. TO make this programee effective and interesting we had made a slogan" USE OF HEALTH SERTVICES, PROVIDED BY NEAR LOCAL HEALTH POST." Since we found 91.2 % are using ANC service from different places like hospital, nursing home, maternity hospital etc but the main motto of this programme is to increase the no. of ANc visit in local health post rather than in any other places. During this time, mothers were promoted on breast-feeding too.

5. DOOR TO DOOR PUBLIC AWARENESS HEALTH CAMPAIGN

In ward no. 1 at first we visited people in every door, defined them our objectives. After that we gathered people at Ganesh mandir and gave them health education on folowing topics:

i. Use of sanitary toilets

Ii.Personnel hygiene

-use of soap /ash water before eating and after toilet, field work

- nail cutting, batthing, washing, brushing

iii. Proper disposal of wastes

iv. Communicable disease

- TB, polio, measles, skin disease, pneumonia, asthama, diarrohea, worm infestation,

v. Exclusive breast -feeding

vi. Immunisation

vii.ANC& PNC

CHAPTER 7
VIEWS AND PERCEPTION

7.1 Views of Community Leaders

Identify Community health problems we interviewed local leaders. Both formal and informal leaders Health post incharge were asked open- ended questions, to explore the existing problems, the present health situation, and recommendation required for the better improvement of the health situation of the health problems of the community. Five major health problems that were identified by the leaders were alcoholism, smocking lack of hospital, lack of education, lack of trained health workers.

Poverty, poor personal behavior practice, lack of education in women, mental retardation were some of the socio-economic problems identified by the leaders. When the leaders were asked about the factors for the causation of the lack of development activities, most of them answered that it is the transportation, which is lacking. Similarly, due to lack of market for the agricultural products is regarded as another hidden area for the development of the community.

For the improvement of the health service

Service and improvement model was provided by the leaders so as to solve community health problems

- ✓ Public awareness
- ✓ Immunization
- ✓ Vit-A campaign
- ✓ Dots leprosy clinic
- ✓ Safe motherhood programe
- ✓ In order to

Service accomplished by the village development office

- ✓ 24 hrs primary treatment
- ✓ Public awareness campaign
- ✓ School health program
- ✓ Outreach clinic
- ✓ Immunization and vita campaign
- ✓ Health post building construction

Improvement\search

- ✓ Mobilization of fchv;sfor the increment of the public awareness program
- ✓ Conversion of the healthpost in to PHC center
- ✓ Health manpower production

Service and Improvement Model Provided by Local Leaders AND HEALTH POST INCHARGE

Service accomplished by health post

- *24hrs primary treatment*
- *Public awareness*
- *Immunization*
- *Vit-A campaign*
- *DOTS/leprosy clinic*
- *Safe motherhood proggramme*

By village Development Office

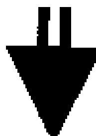
- Public awareness campaign
- School health programme
- Outreach Clinic

For FCHV's

- Immunization and VIT-A camping
- Health Post BUILding construction.

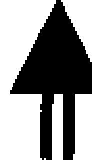
- **Mobilisation of FCHV's for the increment of public awareness programme**
- **Conversion of Health post in to PHC**
- **Health man power production**

Improvement search



Responsible

- **Health workers**
- **Community People**
- **Community Leaders**
- **Government**



- **Increment of literacy level**
- **education and self-dependent programme For backward People of community**
- **Reduce drug addiction**
- **Clean and Safe drinking water services**

Improvement Search

Responsible people

- ✓ Health workers
- ✓ Community people
- ✓ Community leaders
- ✓ Government

Improvement\search

- ✓ Increment of literacy level
- ✓ Education and self dependent programfor backward community
- ✓ Ban on drug addiction
- ✓ Service on clean and safe drinking water

When asked about perception on the traditional healers, leaders were found to be very good as they had vision on motivating the traditional healers in to volunteers that could bridge the gap between health facility and the community, as per them, the relation of SHPwith the vdc was fine.

7.2 Views and perception of FCHV's

Trained local active woman in the form of FCHV is one of the key members for creating community awareness on public health issues. FCHV is the key person for affective community exploration. Thus exploring the activities of FCHV and their perception on public health issues is of significant importance. Nine FCHV each from nine wards was interviewed so as to know their perception and practice of FCHV regarding different health related matters.

All the FCHVs we interviewed were very much satisfied from there Service. Almost half of the FCHVs conduct the mother group meeting twelve times a year but some also said that mothers are to convinced to gather in the meeting.when asked about the discussion topics on the mother meeting they mentioned subjects such as communicable disease, nutrition, environment, immunization, family planning and better counseling on the health related issues. FCHV's also told that H.P calls for meeting 2-4 times year and they mostly discuss on different communicable disease like diarrhea, TB and ARI. Beside discussing on different diseases environment, nutrition immunization, family planning and issues relating to pregnancy and lactating women such as consumption of iron tablets, and visit are some of the major topic of discussion .SHP also emphasize fchv's for the maintenance of proper register.

FCHV's are also providing extra services beside their regular work such as during

- ✓ Vit-A campaign and deworming
- ✓ Vaccination program
- ✓ Family planning
- ✓ Outreach clinic and health education

Around 65% of the fchv's have not conducted home delivery only 35% have conducted deliveries but they have not received training, it is there practice and experience which is working. When asked about the top 10-disease condition, following were their response

1. Fever
2. Diarrhea
3. Influenza
4. Pregnancy related problem(mainly uterus prolapsed)

5. TB
6. Asthma
7. Pneumonia
8. Malnutrition
9. Headache
10. Measles

When asked about the disease requiring the immediate notification, most of them were correct and some didn't know about the disease. Polio pneumonia, diarrhea measles were some of the correct answer. Most of the fchv's agreed that the environmental sanitation and safe drinking water is required to minimise the problem to reach the optimum level of health. Also proper medication and treatment, raising awarness should be highlighted as well.

According to fchv's, solving problem of the community is the responsibility of both the community people and the health post. They also take self-responsibility for solving the problems

7.3 Views and perception of shaman healers

Some of the shaman healers were interviewed so as to know their views and perception regarding health practices. We came to know that they are engaging oneself in this field for 45 –46 years and are providing direct and indirect health services. When asked about the no of patients, we came to know that they are providing health services to 44-45 patients per month in the V.D.C

Shaman healers are providing health services during stomach pain, backache, Diarrhea , fever , TB ,and headache.they are not only using traditional practices in curing the patient but are also suggesting them to go to health post and are also found using ayurvedic medicine .all the shaman healers who were interviewed have not received any health training

CHAPTER 8
PARTICIPATORY RURAL APPRAISAL FACILITATION

8.1 PRA FACILITATION AROUND ALAPOT V.D.C

PRA/PLA is an approach used in identifying needs, planning, monitoring or evaluating projects & programs. PRA symbolizes the concept of participation, which represents "the people", it combines an ever growing tool kit for learning about and engaging with communities. It enables local people to share their perception and identify, prioritize & appraise issues from their knowledge of the local conditions. Utilization of the local resources such as sticks stones grasses, woods tree leaves and soils etc. are emphasized based on availability and accessibility.

8.2. Objectives for carrying out PRA/PLA in Alapot

- To express, view & share information regarding the strength of the community as well as share the areas of improvement for sustainability.
- To explore the available and hidden resourses existing in the community.
- To out line the historical background of the community.
- To triangulate various findings and outcomes.

The PRA tools that were exposed and utilized for collecting the qualitative information in Alapot VDC were;

1. Transect walk
2. Social and resource map
3. Timeline
4. Mobility map
5. Daily routine diagram
6. Seasonal calendar
7. Institutional diagram
8. Cause and effect diagram
9. Focus group discussion

8.2.1 Transect walk/social map

Transect walk is a systematic walk being carried out with local people of community observing ,asking , listening , looking , identifying the strength resources that could be natural , human , social , economic or material , opportunities and areas of improvement in the overall community. The findings are clearly indicated in the form of social map with the help of same people.

PROCESS:

On the second day (2062-2-3) of our one-month community diagnosis we walked around the village along with adolescent group, local peoples, teacher, club members etc. In order to get more information about ht community and for obtaining deeper understanding about the area. From that walk, we had clearer picture about Alapot VDC including good things, area of improvement etc.

8.2.2 Social map

Social map is used to understand the stratification of the communities both in term of resources and their area and distribution

We were able to collect the information regarding the existing social object in the community such as ' road, tap, well, household, schools, local clubs, forests, pond, institution, temples etc,

8.2.3 Time line

It is one of the PRA tool which help us to find the histry of major events in a community with approximates dates and discussion of which changes here occurred. This tool helps us to find out history of the community which is usually taken with elderly people of the community.

For this purpose , two old person (one male, one female) were considered and there views and commands were listed

TIME LINE

DATE	EVENTS
2013 B.S	• Establishment of Bal Bikash secondary school.
2036 B.S	• Establishment of kageswari pustakalaya.
2037 B.S	• Separation of Allapot and Bhadrabans politically. • Establishment of Paropakar Primary Health Care.
2040 B.S	• Special programme on water supply and water distribution. • 35-37 public water tap supply.
2042 B.S	• Electricity facility.
2043 B.S	• Establishment of Health post.
2049 B.S	• Road construction.
2052 B.S	• V.D.C building construction. • Telephone service started. • Old age incentives started.

8.2.4 Mobility map

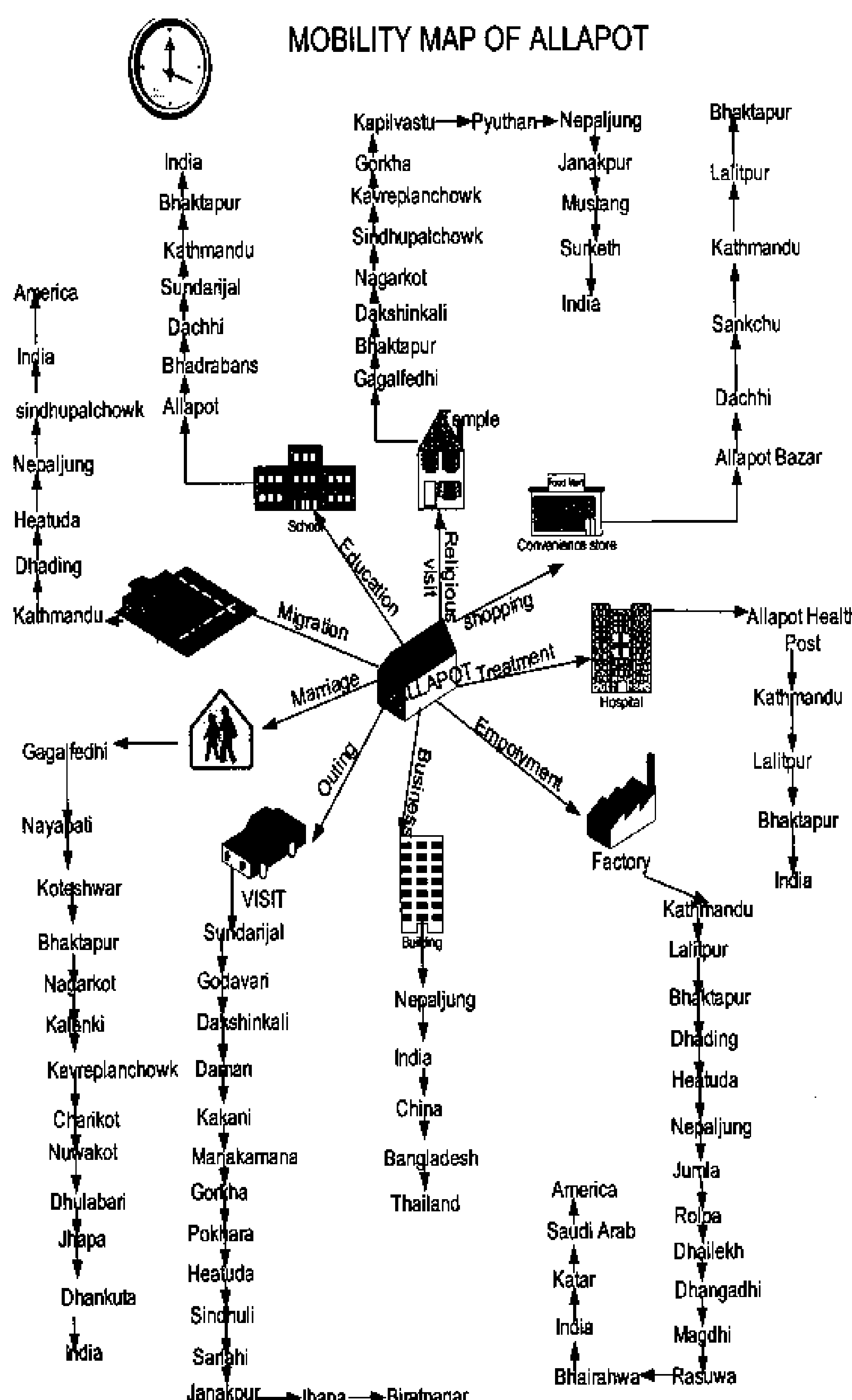
Mobility map is one of the PRA tools, which helps us to get an understanding about the peoples movement in different places with different objects and for different reasons.

In our survey, consult local active social workers and obtained information about people's mobility and different objectives for;

Education
Treatment
Business
Migration
Pilgrimage/ religious trip
Employment
Marriage
Marketing
Tour

From that mobility map, we draw a conclusion that most of the people of this VDC go near by this VDC for different purposes that may be for education, employment, marketing, treatment etc. But some go abroad for employment and business purposes.

The mobility map of alapot VDC is shown below;


MOBILITY MAP OF ALLAPOT
India
Bhaktapur
Kathmandu
Sundarijal
Dachhi
Bhadrabans
Allapot
Kapilvastu
Pyuthan
Nepaljung
Gorkha
Kavreplanchowk
Sindhupalchowk
Nagarkot
Dakshinkali
Bhaktapur
Gagalfedhi
Janakpur
Mustang
Surketh
India
Bhaktapur
Lalitpur
Kathmandu
Sankchu
Dachhi
Allapot Bazar
America
India
sindhupalchowk
Nepaljung
Heatuda
Dhading
Kathmandu
Temple
School
Convenience store
Education
Religious visit
shopping
Migration
Marriage
ALLAPOT
Treatment
Hospital
Allapot Health Post
Kathmandu
Lalitpur
Bhaktapur
India
Outing
Business
Employment
Factory
Gagalfedhi
Nayabati
Koteshwar
Bhaktapur
Nagarkot
Kalenki
Kavreplanchowk
Charikot
Nuwakot
Dhulabari
Jhapa
Dhankuta
India
VISIT
Sundarijal
Godavari
Dakshinkali
Daman
Kakani
Manakamana
Gorkha
Pokhara
Heatuda
Sindhuli
Sarlahi
Janakpur
Jhapa
Biratnagar
Building
Nepaljung
India
China
Bangladesh
Thailand
Kathmandu
Lalitpur
Bhaktapur
Dhading
Heatuda
Nepaljung
Jumla
Rolpa
Dhailekh
Dhangadhi
Magdhi
Rasuwa
Bhairahwa
India
Katar
Saudi Arab
America

8.2.5 Daily routine diagram

Daily routine diagram is used to identify the workload of men and women in the community as well as compare the workload between men and women in the community.

Class nine and ten of a private school Kageshowari vidaya mandir was selected. Then we divided them into two groups sex wise. After that objective of the study was explained to the participants and daily routine of boys and girls were taken separately. The information that we collected from them is as follows in diagram.

Sports
Entertainment
Study
Rest
Household work

DAILY ROUTINE DIAGRAM

WORK DESCRIPTION	BOYS	GIRLS
Personal hygiene	15minutes	45 minutes
Houes hold work	45 minutes	2 hours 20 minutes
sports	70 minutes	20 minutes
Study time	7hours 30 minutes	7 hours 30 minutes
Rest	8 hours 15 minutes	8 hours
Entertainment	20 minutes	30 minutes

8.2.6 Seasonal Calendar

It is a PRA tool which helps to explore seasonal trends and opportunities by diagramming croping patterns, festivals, seasonal disease, fruits, vegetables, climate etc, month by month throughout the year.

At first, we gathered the local members (Women) of Bhagwan Youth club and explained our objectives to the participant. Then twelve different months were drawn and the participants were encouraged to show different activity and its month wise involvement. The information that we collected is as follows.

मौसमी पात्रो

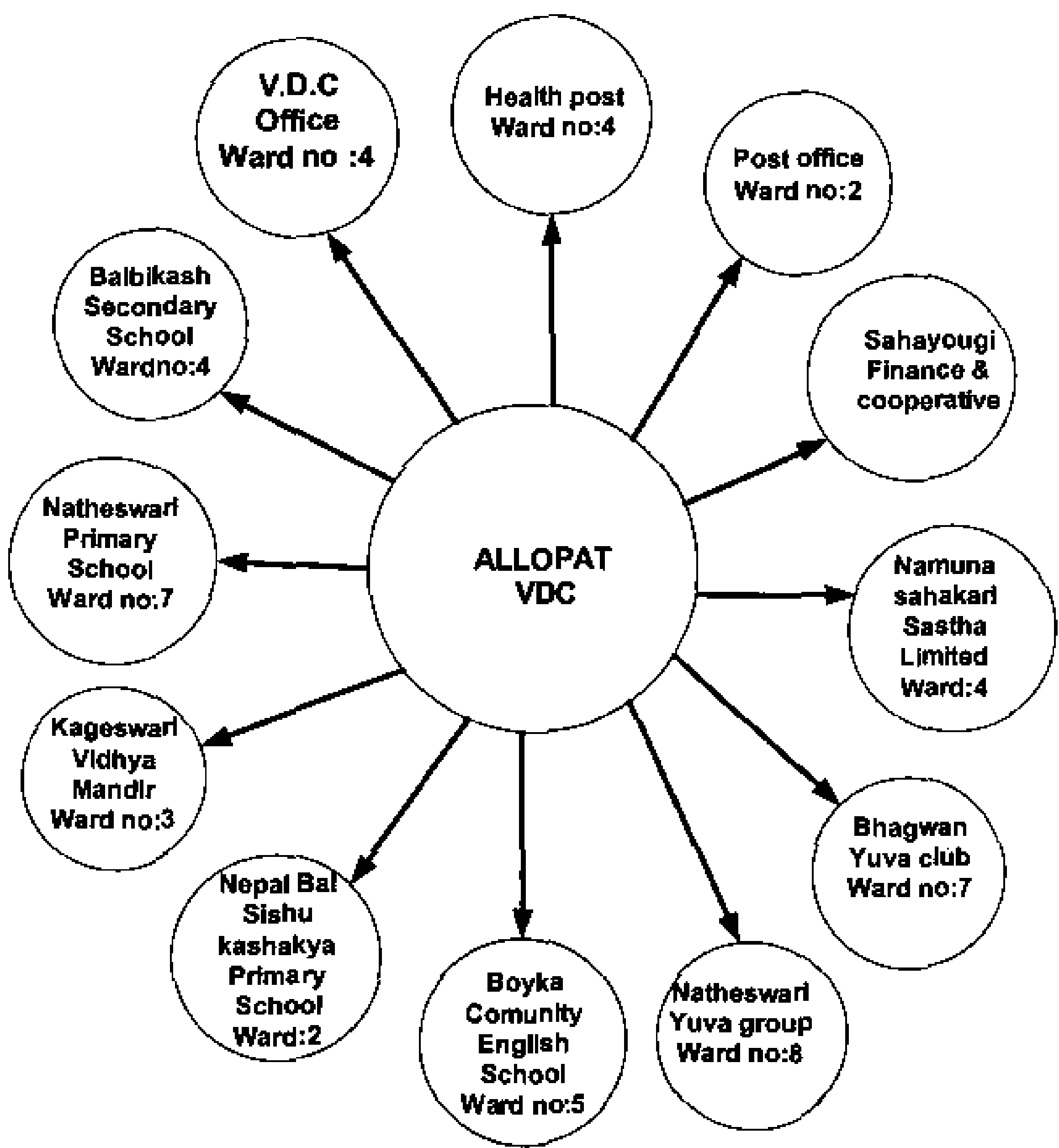
विवरण	वैशाख	जेष्ठ	असार	श्रावण	भदौ	असोज	कार्तिक	मंसिर	पुस	माघ	फाल्गुन	चैत्र
बालीहरु	मकै, भटमास	धान	धान, कोदो, मकै	कोदो	....	....	.....	गहुँ, जौं, फापर	....	..	मकै	..
तरकारी	काउली, बन्दा, घिउसिमी, गोलभेडा, फर्सि, बोडी	घिउसिमी, साग, कर्कलो, स्कुस, गाजर, खुर्सानी	फर्सि गाजर	परवल, फर्सी, स्कुस	फर्सी लौका	भिन्डी, मूला, आलु, साग, गोल भेडा	कर्कलो, भटमास	मूला, गाण्टे मूला	धनियाँ चम्सुर पालुङ्गो गांजर, सोप	धनियाँ चम्सुर पालुङ्गो गांजर, सोप	लसुन, ज, पी लभेडा ोको ग	बकुल्ला कांक्रा सीमी करेला घिरौला
फल(फूल	अंगुर स्याउ काफल केरा मेवा ऐंसेलु	आलुचा ऑप	ऑप लिची	अमला लप्सी	आरु मकडा नास पाती	अम्बा	सुन्तला हलुवा बेद बदाम	केरा	उखु	अंगुर बयर	मौसम	मेवा
रोगहरु	ऑखा पाक्ने, झाडा बान्ता, ज्वरो	ऑखा पाक्ने	निमो निया ज्वरो	दाँत दुख्ने, कान पाक्ने	झाडा बान्ता	ज्वरो रुघा खोकी	ज्वरो	दम	दम खोकी	दम खोकी	झाडा बान्ता	झाडा बान्ता
मौसम	गर्मी	गर्मी	ठीक मौसम	ठीक मौसम	अलिअली जाडो	जाडो	जाडो	जाडो	अति जाडो	अति जाडो	बिहान र बेलुका जाडो दिउँसो गर्मी	गर्मी
चाडपर्वहरु	गणेश भैरव जात्रा, आमाको मुख हेर्ने	सिठी (दिउली) भोज		साउने संक्रान्ती, जनै पूर्णिमा, लाखे जात्रा नाग पन्चमी	कागेश्वरी जात्रा तिज बुबाको मुख हेर्ने औंसी, ऋषि पन्चमी	दशैं	तिहार	ठुलो एका दशी	योमरी पूर्णिमा	माघे संक्रान्ती	फागु पूर्णिमा	चैते दशैं

8.2.7 Institutional diagram

It help us to find out the existing institutions in the community that works for the community, it helps us not only in indicating the institutions working for the community but also about the services provided by them and the relationship among institutions.

For institutional diagram we ask the community people to indicate the institutions within the community and we collected following information from institutional diagram;

INSTITUTIONAL DIAGRAM OF ALLAPOT VDC



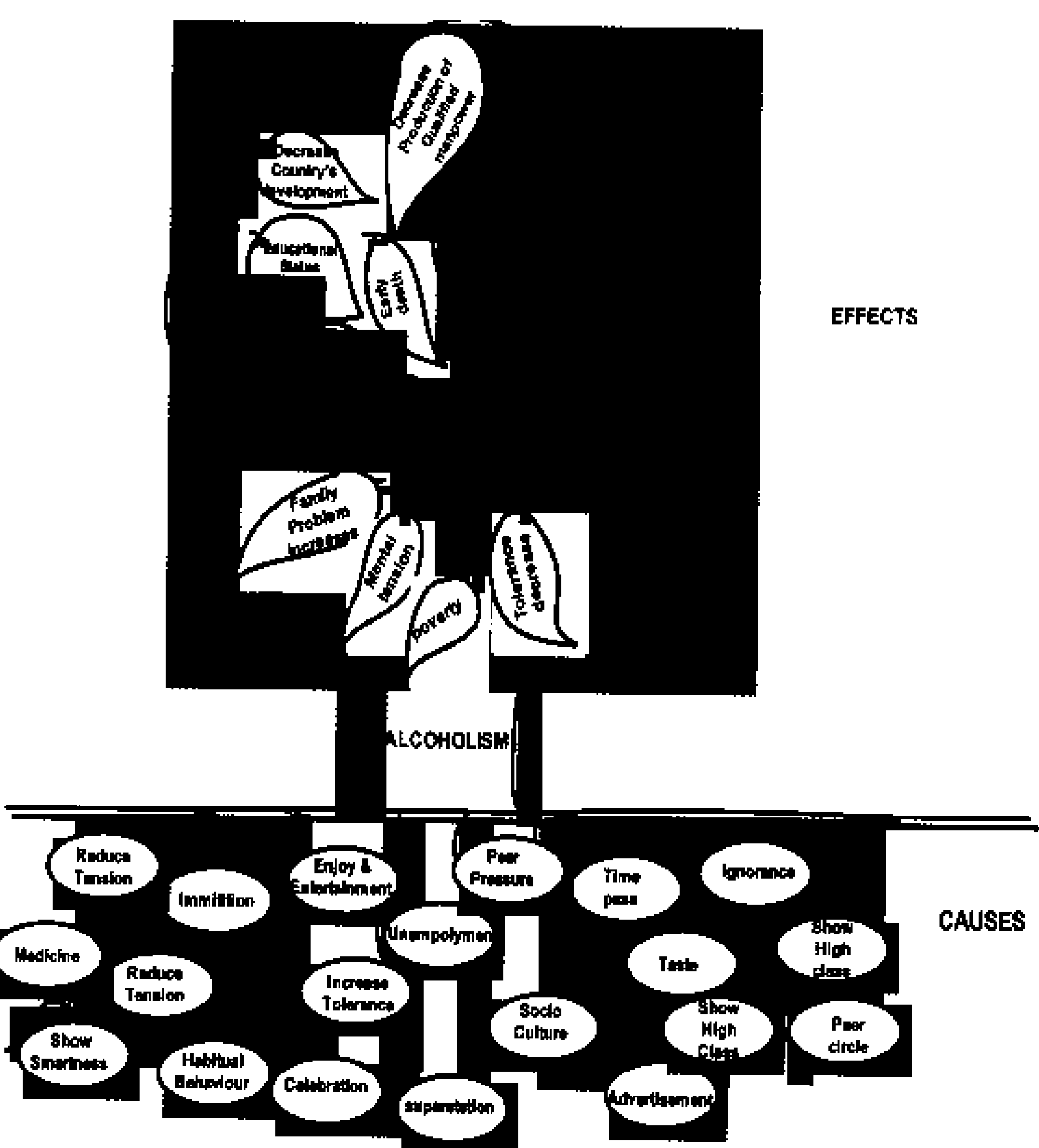
8.2.8 Cause and effects diagram:

Cause and effect is an effective PRA/PLA tools, which enables to find out the causes of any problem discussed and helps to analyze the effects with local community. In this process the real cause and its effect is identified as the community. In this process the real cause and its effect is identified as the community people start the discussions. By cause and effect, diagram facilitator or outsider obtains great opportunity to learn the realities from the local community people. Similarly, the community people also get chance to realize about causes and the effects of the problem.

In Alapot VDC, we performed our cause and effect diagram on alcoholism with the community people at the yard of Bhagwan Yuba club. As the cause of alcoholism was asked, a varying ranges of answers came. Most of them said they just drink to enjoy and get entertainment where some said they use to drink to enjoy and get entertainment where some said they use to drink it for time pass. About one fifth were influenced by advertisement and few of them were trying to show smart. About one-third thought it shows high class and few were pressured by pear circle. Due to ignorance more than half were drinking where two third of them were trying to test its taste. Almost all thought it relief from tiredness and most of them were escaping from their tension. Sociocultural effect was also found there where traditional factor was based.

At the same time very less of them were using it as medicine but some of them said without it they do not enjoy life as their tolerance has been increased.

After getting such answer as the root cause of alcoholism at Alapot VDC, we asked they gave various answers. After drinking, it being mental conversion that helps to loose the memory then person gets relaxed. Social relations may break which decreases the social status. Accidents may occur. Family problem and unnecessary quarrels may arise. Feeling of insecurity comes. Person becomes physically weak and mentally tension. Educational status deteriorates decrease of the production of qualified workers and hence the development of the country goes downwards. Heavy economic loss occurs. Burden of disease increase. People sink in poverty. Finally early death occurs.



8.2.9 Focus group discussion

Focus group discussion is an especial discussion performed on a topic with homogeneous group or the similar interest group. Major discussion is focused on the topic among the members whose effective number is said to be 6 to 12. It may difficult to handle more than 12 people in one discussion. Similarly, participation of less than 6 cannot create many more ideas. 2 or 3 facilitators who raise the issue host discussion. Let participants to participate actively and help to draw the lessons and make conclusion.

Before conducting FGD, we interacted with the members of Bhagwan youth club which in the eniating the active youth club in Alapot VDC . Then we selected the topic on their collaboration which was happened to be" uterus prolapse" then we select the female member of the community to participate in FGD and finally the program was successfully conducted on 2062-1-17 Saturday at 11:00 am at health post meeting hall.

The program was forwarded as per our objectives under major facilitation of our female members. We created an immersive environment as per the need of topic as the topic "Uterus prolapse" itself is prodominant and privacy seeking topic. Hence we successfully conducted our program with superb out come.

Focus Group Discussion

Questions	Correct	Incorrect	Don't know
1. Which group of women is at the risk of uterus prolapse?	Lack of nutritious food. Lifting heavy things right after delivery. Recurrent delivery. Having sexual contacts just after delivery	Adolescents do not have the problem. Heavy bleeding during menstrual period. Only women of 30 to 35 years. Only from poor family	Women having many children. Smoking cigarette and having cough. Tying waist tightly by long cloth (patuka) Being pregnant at young age. Any one i.e. fat, slim, of terai or of Himalayas, young or old.
2. Why uterus prolapse occurs in females?	Lack of balanced diet Having sexual contact just after delivery. Lack of appropriate postnatal care. Due to prolonged labor. Hiding the problem of RT	Tying waist during stomach pain do not effect at all. Cough or stomach pain, which exerts pressure on stomach on stomach don't effect.	Cough exerts pressure at muscles.
3. What problem may exist due to Uterus prolapse?	Bleeding, White fluid discharge. Lower abdominal pain. Difficult to work and walk.	Hated by everyone if told.	May invite multiple marriage and infections. Difficult to defecate and urinate. Difficult during coitus. Difficult during menstruation.
4. How to prevent Uterus prolapse?	Feeding nutritious food. Not lifting heavy thing right after delivery. Not having sexual contact right after delivery Not having sexual contact at young age	Increasing awareness about Uterus prolapse and decrease poverty Utilization of local Health services	Use of ring pessary Lifting heavy things in correct manner FP and birth spacing Taking post natal rest

CHAPTER 9
A SAMPLE OF CASE STUDY

Communicable disease of Alapot (TUBERCULOSIS)

1). INTRODUCTION

This case study has been prepared under the direct contact of the patient.He was born in 29th Falgun 2003BS in the middle family of this vdc.He is literate .When he was young, joined in Nepal army. unfortunately he resigned from job due to different reasons.At this time he became frustrate so he started smoking as chain smoker and used to spend Rs100 per day at that time . In the many bends of life he started business and he came in contact with many persons in his life. so, we can say that these may be the causes of suffering from the TB. Our main aim is to find out causes and route of suffering from the TB.

2). OBJECTIVES

The main aim of this case study is:

1) To find out the causes of TB transmission on him.
2) To find out the ways of treatment provided by the local health instition
3) To know , reasons of drug resistance on him.

3). Methodology

Our study design is cross-sectional study .it includes qualitative methods.

Sample size - only one case
Tools - questionnaire
Technique - semi structure interview
Respondent -TB case patient

4). CASE HISTORY

Talking about TB cases developed in him, he said that in 2045 BS he felt a bit week and went hospital but at that time disease was not diagnosed.In 2052 he visited Kathmandu model hospital, at that time he was diagonased with TB and Diabetes.And then he moved to National Tuberculosis center, Bhaktapur and he was given DOTS treatment.According to him the disease was taransmitted to him from direct contact with his friends in his own village. At first he was treated under CAT-I but he didnot feel comfortable so, he was entered in CAT-II under DOTS treatment.He felt some relief at initial stage but the treatment was found failure.

He was born in 29th falgun 2003 on alapot; Kathmandu.He had also taken BCG vaccination at the time when he was child. He was from medium sized farmer's family with adequate lodging and fooding. He had takenlower secondary education. On those days he used to smoke not by inspiration of family or any friends but by himself. During his days he joined army and resigned after 6 years due to his own reasons. According to him in his family allare healthy but we found that his family use fire wood for cooking purposes. Talking about his visit, he had visited Badrinath, Kedarnath, Birjung and Hetauda.

Today also he is the patient of TB although he had taken medicine. It was found drug resistance towards him. Now he is in contact of JENETOP for further treatment of TB with DOTS plus strategy at kalimati, Kathmandu.

5). DISCUSSION

All the Anti -tubercular medicine are available in the DOTS centers and sub-centers and distributed to the TB cases free of cost as per the policy of NTP ,However ,these medicines are not yet accessible to the remote area of our country. The problem we found is that someTB patients ,who developed into MDRTB were not investigated & monitoring properly during their DOTS course .So we emphasized all the CAT-2 patients should be taken care more than others casesof TB. For examples medicines that they are taking should be done sensitivity test so that the problem of developing MDRTB can be avoided or reduced at one level.

Alapot health post was also following the same rule and pattern of NTP like in all the other DOTS centers and sub-centers. As it was a sub-center there was not provision for sputum test and drug sensitivity test facilities .So there was only medicines that they are providing regularly to the TB patients.

Besides all this findings, at the same time we have find this patient with Diabetes case.He is taking insulin along with DOTS.Probably , insulin is also one of the factors for developing drug resistance on him.

6). RECOMMENDATION

To the patient

- Take medicines regularly under DOTs plus.
- Undergo general health check-up regularly.
- Be more conscious of own health maintaining personal hygiene.

To the health institution

- To conduct DOTS regularly.
- To try to find out the cases of treatment failure.
- It is suitable and good to put patients under DOTS only after doing drug sensitivity test for each and every patient
- If the provision for sputum test is available at each and every DOTS sub-center and center, it would help to find out the hidden cases of TB.

7). CONCLUSION

From this study, we conclude that he is developing TBcases because of, not beingconscious in his ownhealth although he knows that his villager is TB patients. In addition, he used to smoke, using fire wood for cooking purposes too we can also conclude that using DOTS regularly is not working to him Perhaps, there may be interrelationship between Diabetes and Tuberculosis. At last we can say that drugs of Tuberculosis willnot work properly and developresistance if there is coinfection.

CHAPTER 10
TERMINAL RELATIONSHIP

10.1 Final community presentation

The final community presentation was organized on 31st of Baishak, with about 190 participants, we preceded our formal program in Balbikash School, and the invitations were dissimilated the day before. The program commence at 8:00 am, the students from Balbikash helped us mange the sitting arrangements and Bagwan yuva were appreciative enough to provide us with the require miking and pal.It was noticeable that all people from different sector participated for making our program interactive. Mr. Ramsaran phuyal was announced the chair followed by

Dr. Ritu prasad gartoula, chief guest and Mr. Rameshwor phuyal along with other guests had presented their ideas and views. Our main agenda during the presentation was the overview of the whole CHD.We presented all our findings along with the MHP we conducted. The final presentation was the platform for all the members and the leaders of the community to share their problems and the solutions. They were very keen about the problems and some of the future solutions were sought out.

Mr. Madan Bdr. Khadka, the active leader of the community address that some emergency service should be provided to the community by the Stupa community hospital for sustainable relationship. If possible, some volunteers to the health post would be beneficial if provided. He also recommends that our report should minimize the statistical errors. Mr.Jagat Nepali inform the community about the services under health post. He emphasized people to visit the health post for ANC checkup. He recommended NIHS to not only send the BPH students but also students from other health faculty should be send for the field programme. He request NIHS for the some contribution in FCHV's akshaya kosh, which is established in Alapot VDC. Mr. Ramsaran phuyal, the secretary of Alapot VDC. recommend NIHS for the extention of the CHD program on suitable month.He also recommend the study team for providing the report as soon as possible.

For the continuity and sustainability of the CHD program NIHS made various commitments to the community.Mr. Ritu pd. Gartoulla admit the administrative weakness made by college last year.For the estabilishment of institutional relationship, he committed to send students from other faculty and to provide the emergency service as soon as possible. He himself donated some amount of money in the asksay kosh for FCHV's and also praised the launch of such kosh which is never being heard before and is set as an example for others. He recommend the community to establish a commitment team consisting of health post, NIHS and VDC for the further sustainability of relationship.

10.2 College presentation

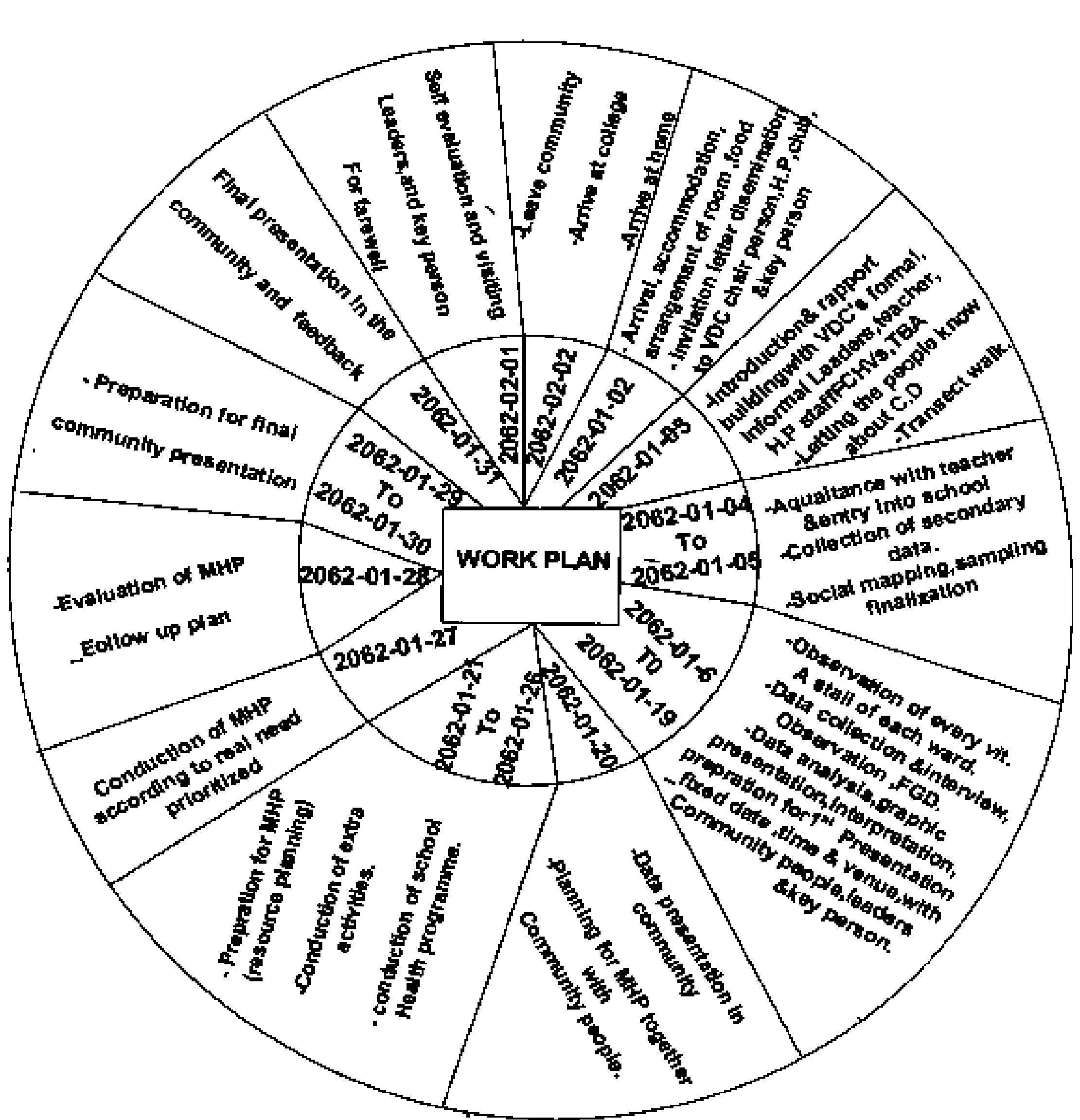
The college presentation was held on 10th of jestha, we presented all our major findings and recommendation to the college authority with the aid of OHP.We also presented charts, graphs and the photo gallery in the Alapot stall. The discussion that we made in the presence of teachers and friends were beneficial in corrections and suggestions for report writing. Driven by the objectives and conclusions reached from the review analysis and field study of selected VDC, we recommend college for the extension of the CHD program in the suitable time of the VDC.

10.3 SWOT analysis (strength, weakness, opportunities and threats)

Swot analysis of the selected VDC is being on handed as the summary table of the community health diagnosis program.

Strength	Weakness
➢ People were very cooperative and hardworking. ➢ Silkworm farming is practiced but requires more promotion. ➢ Diverse land ➢ Coverage of immunization ➢ Commitment of health post and people. ➢ Active leaders and adolescents	➢ Absence of adequate transportation. ➢ Absence of higher secondary schools for further study. ➢ Purification of water is not practiced. ➢ Usage of toilet is insignificant. ➢ Lack of timely refresher training. ➢ Networking with FCHV's for regular reporting is insignificant.
Opportunity	**Threats**
➢ Presence of club such as Bhagwan yuva club, Nathsowri yuva samuha ➢ Presence of secondary schools by government and private sectors.	➢ Practice of attached cowshed, Chimneyless houses. ➢ No. Of bars are increasing day by day. ➢ Problem of uterus prolapse is high ➢ The percentages of healthy children are decreasing day by day.

10.4 work plan



CHAPTER 11

11.1 Recommendations: An wake- up call to the global community

On the basis of review and field findings, it is concluded that addressing the time factor is the most. Following are the list of recommendation we suggest, regardless we want to emphasize that our suggestions are only a proposal or a framework for discussion, debate and future action. They are not meant to dictate what should be. Rather, our intention is to report what we have learned about areas of improvement while working in field.

- Focus should be given to reduce the alcoholism activities around alapot
- Uterus prolapse rate was very high thus major treatment proggrame should be launched along with preventive aspects to reduce the rate
- Our finding suggests that the rate of healthy children is poor thus incentives should be taken as soon as possible so as to increase the rate.
- Emphasis should be given on raising female age at marriage. Therefore, there must be some legal and social attempts to raise the age at marriage.
- Government should give incentives and more facilities for family planning with maximum two children as welfare grant. Micro credit activities and income generating opportunities must be created to increase the income level of women, which has the direct effect on fertility.
- The picture that is taking shape from our survey reveals an intriguing –and alarming insight that people are living dangerously-whether they are aware or not the attached animal shed, drinking water with no purification, chimneyless houses, less use of toilet and the dependency on junk food are some of the risk to their health that is quantifying day by day. Thus we strongly recommend people to lower these risk and raise the healthful living and our recommendations be a wake –up call to all the global community.

Recommendations: Energizing the Future

- We strongly recommend that the proper organization and correction of the tools like Questionnaire, Weighing machine should ascertained before distribution.
- Due to the peak harvesting season, it was very difficult for us to find the respondents thus it would be better if CHD program is postpond.
- Enough Literature are to be provided so that reviewing is possible
- Selection of the site (virgin rural community) should be done considering all the possible difficulties, thus minimizing the problems for the study team.
- Doing usually varies from saying, thus it would be better if not much expectation were given to community if saying is just a saying.

11.2 Conclusions

Based on the objectives we had set for the community diagnosis and field study findings, it is concluded that addressing the possible solutions for the existing health problem is the most. Following are the major health problem based on our findings.

- Uterus prolapse rate was found in high percentage, i.e. about 30.3% of women had had the problem of uterus prolapse. Major concerns and concentrating efforts are required so as to minimize the risk factors causing the problem.

- ➢ The picture that is taking shape form our findings addresses that the percentage of people drinking water with no purification, the practice of attached cowshed and the chimneyless houses are some roots of alarming problems in future.
- ➢ The percentage of healthy children is declining yearly, thus incentives are to be provided as soon as possible.
- ➢ The KAP existing in people is unsatisfactory, thus special attention in addressing KAP so as to minimize the health problem and enable the capacity building incentives is the most.
- ➢ The major issues to be addressed are equity, empowerment, participation and sustainability of the programs. Enhancing the effectiveness of the incentives is essential, seasonal migration was common thus empowerment opportunity would be beneficial. Equity to the needy who had had the problem is the most, also sustainability and the participation are required for cooperation and existance of the programs.

11.3 LESSON LEARNED FROM COMMUNITY

ABOUT SOCIAL SUPPORT

- The support of society is an important factor in makingchoices of action.
- Certain practices recommended for improving health may be contararyto existing customs.eg, use of sutkeri samagari in homedeleveries. ANC visit near health post.use of pits forproper disposalof solid wastes.
- Maternal and child health, nutrition and family planning programme have learned that they must adress groups in community that have the power to influence the people.
- Designing educational programmes for each influential group requires careful study of
  -the beliefs and practices that exists
  -why they exist?
  -how strong &deep rooted they are?
  -how they are prepatuated?
- Improvement in educational status, greater efforts in health education and exposure of traditional societies to outside were some of the key influential factors that have modified social control.
- Programmes such as immunization and contraceptives has been made possible becauseof acceptance in which different social groups accept recommended health practices.

ABOUT SYSTEM SUPPORT

- System support is needed in the form of both assistance and services in order to make health practices possible and easier.
- In addition to health post, a no. of local clubs can provide assistance and services.Thus making it easier for people to make a healthy choice.
- Building alliance through meeting of concerned people, establishing joint committes, publishing and distributing Newsletters, organising joint programmes and field activities, sharing experiences and providing information.
- Direct attention is given to local community leaders, religious leaders and family members who have an important role in making decisions and in supporting behaviour patterns inducive to health.

Appendix-A List of documents reviewed

Reference

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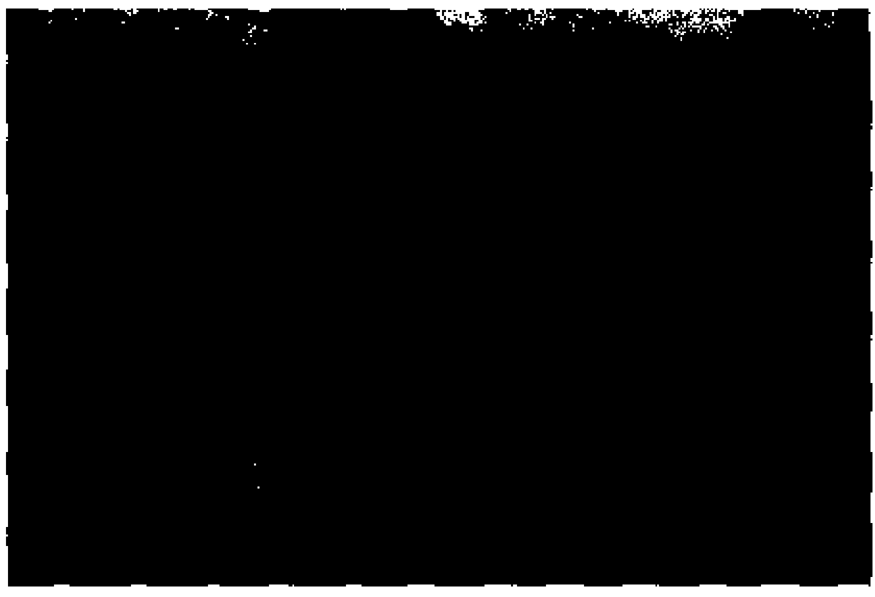
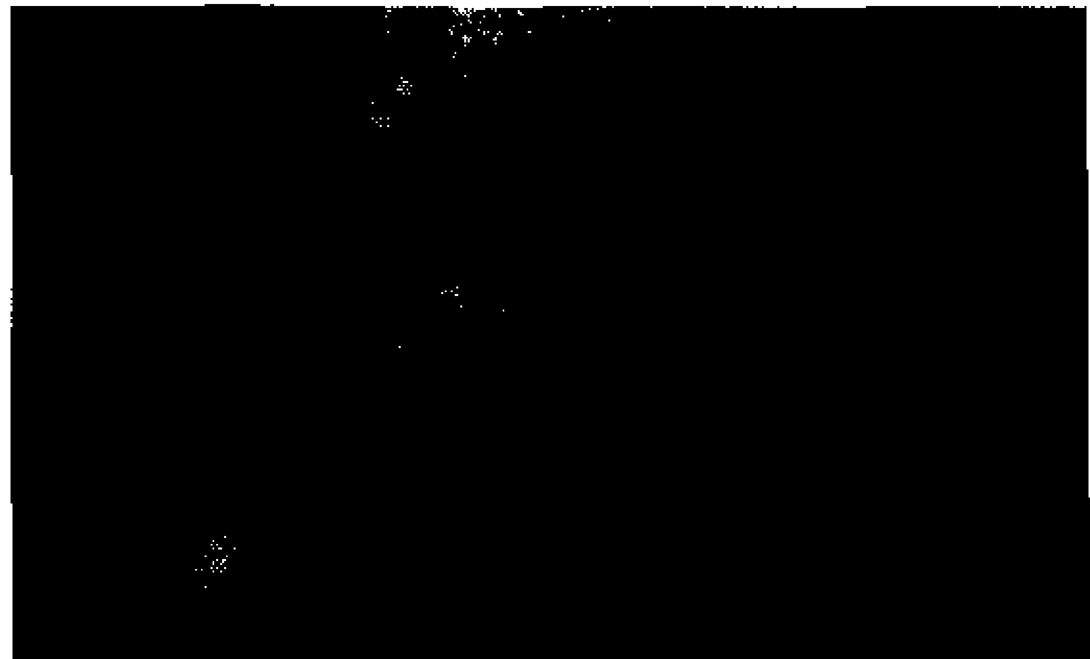
Appendix-B Emotions corner

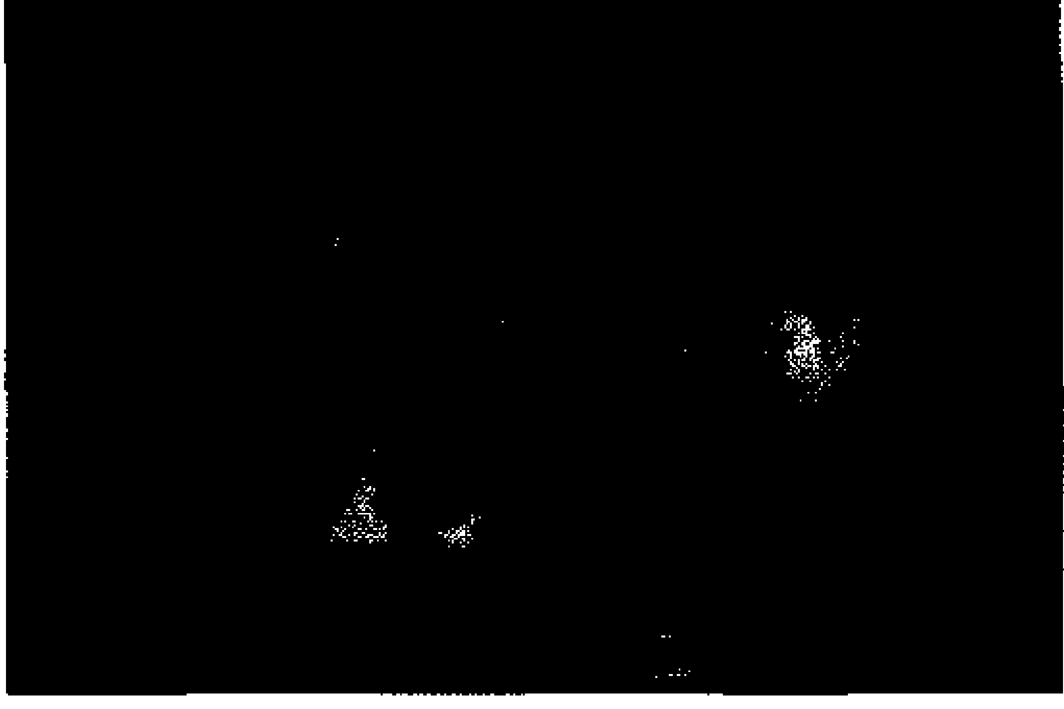
Data collection on community-Day 5th (2062/01/06) 1



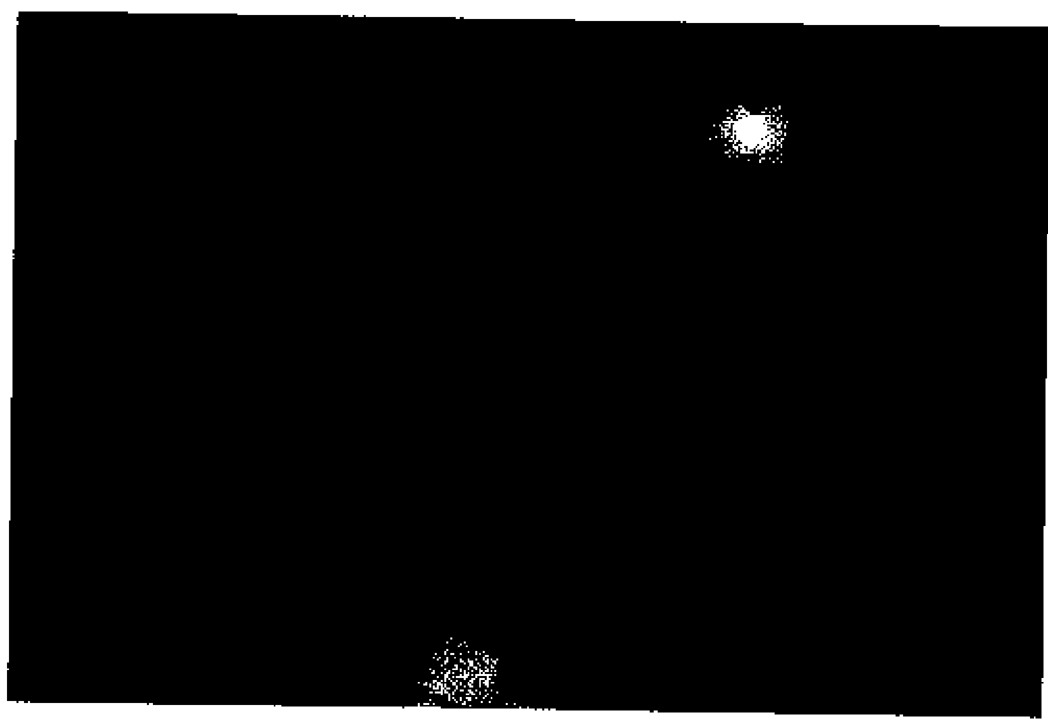
Data collection on community-Day17th (2062/01/18) 2



Preparation of seasonal calender-2062/01/17 3

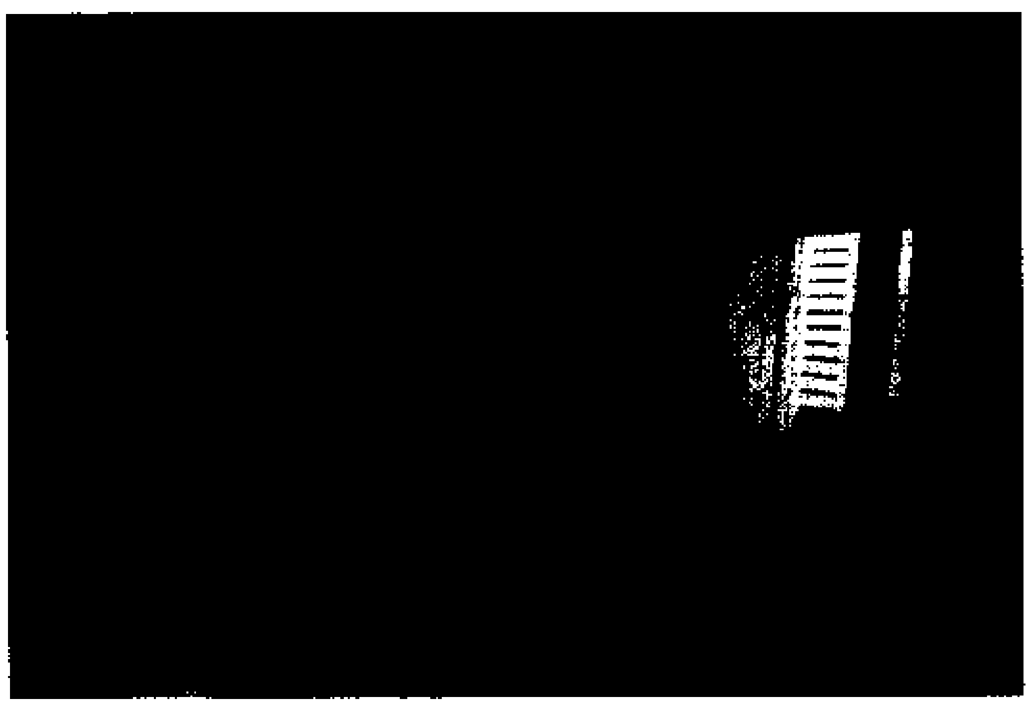


Focus group discussion-2062/01/18 4



First community presentation-2062/01/20 5

Photo session after first coomunity presentation-2062/01/20 6



Conduction of school health program-2062/01/22 7

Conduction of school health program -2062/01/24 8

Micro health project-2062/01/27 9

Prof. Dr. Ritu prasad Gartoulla,Mr. K.P. poudel,Mr Bhola chettri & Alapot student group 10
Final community presentation (2062/01/31)

11 Micro health project-2062/01/27 12

Health education programe -2062/01/28 13

Participation on rally-2062/01/13 14

Oratory competation-2062/01/22 15

Oratory competation-2062/01/22 16

17

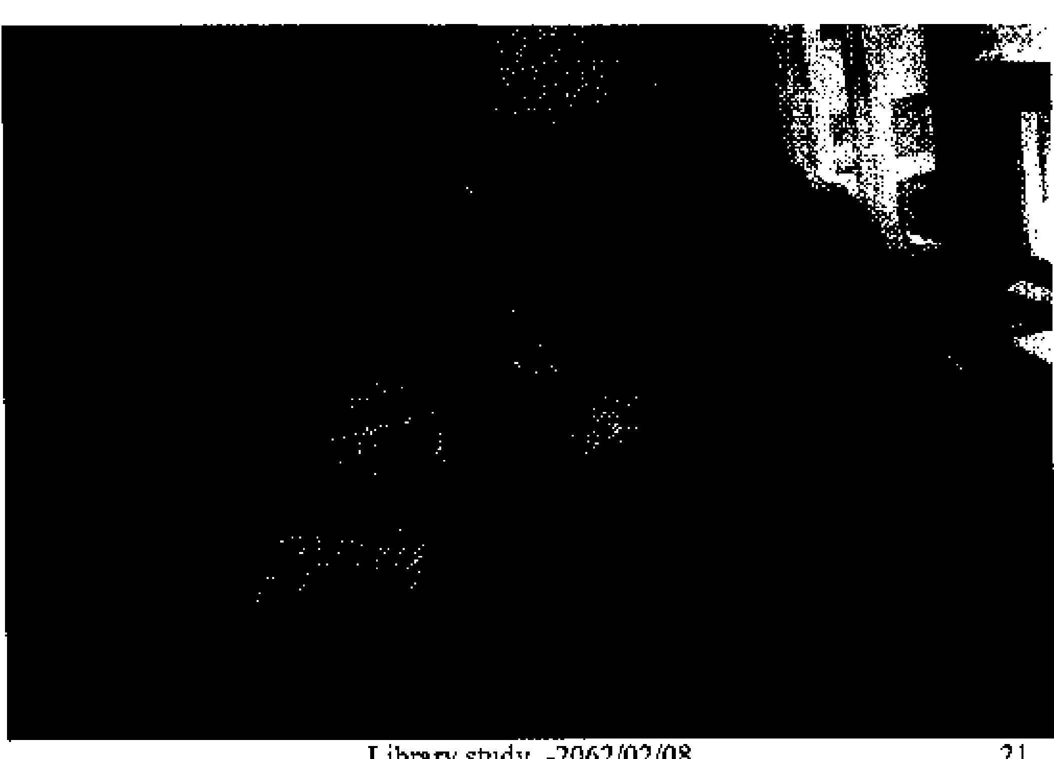
Public participating on digging pit-2062/01/25

18

Final community presentation-2062/01/31

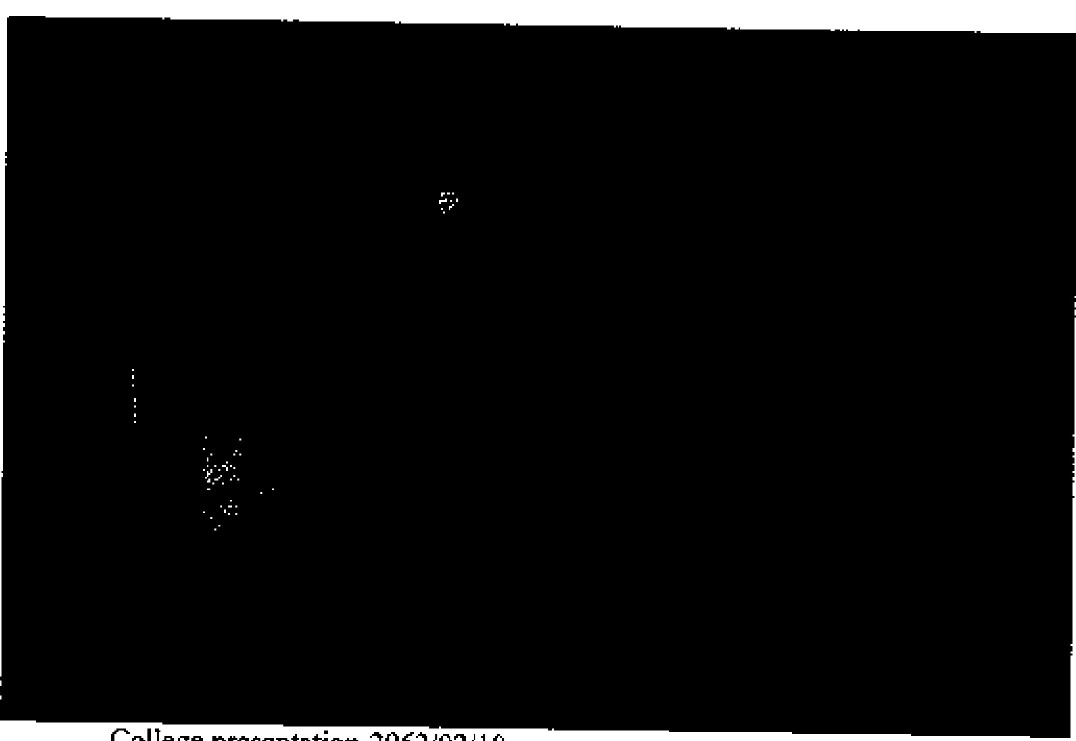
Final community presentation-2062/01/31 19

Farewell programe by the members of Kageswori Vidhya Mandir-2062/01/02 20



Library study -2062/02/08 21

College presentation-2062/02/10 22



College presentation-2062/02/10 23

Appendix-C HH questionnaire and checklist

फाराम नं:-१

पूर्वाञ्चल विश्वविद्यालय
नेपाल स्वास्थ्य विज्ञान अध्ययन संस्थान
बौद्ध, काठमाडौं ।
समुदाय स्वास्थ्य निरुपण
घरमुलिलाई सोध्ने प्रश्नावली
२०६२
बि.पि.एच. द्वितिय बर्ष
(आलापोट समूह)

कोड नं :-
अन्तर्वार्ता मिति :-

अन्तर्वार्ता लिनेको नाम :-

सुचित मञ्जुरी

नमस्कार,

हामी स्वास्थ्य सम्बन्धी कामले आएका हौं । हामी समुदायिक स्वास्थ्य निरुपण गर्नको निम्ति तपाईहरुको स्वास्थ्य स्थितीबारे जानकारी लिन आएका छौं । तपाई यस अन्तर्वार्तामा सहभागी हुनुहुनेछ भन्ने विश्वास गर्छौं । हामी तपाई र तपाईको परिवारको स्वास्थ्य स्थिती बारे प्रश्न सोध्ने छौं । तपाईले दिएको जानकारीहरुबाट हामीले बनाएको प्रतिवेदनले तपाईको गा.बि.स.मा स्वास्थ्य सम्बन्धी योजनाहरु तर्जुमा गर्न मद्दत पुग्नेछ । तपाईले दिनु भएको सम्पुर्ण जानकारीहरु अति गोप्य राखिने छन् ।
यस अन्तर्वार्तामा सहभागी हुने वा नहुने तपाईको स्वेच्छाको कुरा हो । तपाईले यस प्रश्नावलीमा भएको कुनै वा सम्पूर्ण प्रश्नहरुको उत्तर नदिन पनि सक्नु हुन्छ तर हामीलाई आशा छ तपाई अन्तर्वार्तामा सहभागी हुनुहुनेछ किनकी तपाईका बिचारहरु महत्वपूर्ण छन् ।
के तपाई अन्तर्वार्ता सम्बन्धी कुनै कुरा सोध्न चाहनु हुन्छ ?
के हामी अब अन्तर्वार्ता शुरु गरौं ?

उत्तरदाताको मञ्जुरी: छ ☐ छैन ☐

१०० परिचय

जिल्ला :- काठमाण्डौ
गा.बि.स. :- आलापोट
गाउं/टोल :-
वडा.नं. :-
प्रश्न सोध्याको समय :-
घर नं :-
घरमुलिको नाम :-
धर्म :-
उत्तरदाताको नाम :-
जात :-

२०० जनसंख्या सम्बन्धी विवरण :-

परिवारको किसिम एकल ☐ संयुक्त ☐

क.स.	सदस्यहरुको नाम	उमेर	लिङ्ग	घरमुलि संगको सम्बन्ध	वैवाहिक स्थिती	बिवाह हुंदाको उमेर	पेशा	शैक्षिक स्थिती	व्यक्तिगत बानी	
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८										
९										

नोट :- क्रम संख्यामा
आवश्यक संकेत
घरमुलि =Y
बच्चाको आमा =X

लिङ्ग
पुरुष = M
महिला = F

आवश्यक संकेत :-

वैवाहिक स्थीति	पेशा	शैक्षिक स्थीति	धुम्रपान स्थीति	मद्यपान स्थीति
U=अविवाहित	A= कृषि	I= निरक्षर	Y= धुम्रपान गर्ने गरेका	O= मद्यपान नगरेको
M=विवाहित	B=व्यापार/व्यवसायी	L= साक्षर PP= Nursery to UKG	O= धुम्रपान कहिले काही गर्ने गरेका	1= मद्यपान कहिले काही गर्ने गरेका
D=सम्बन्ध विच्छेद	S= जागीरे	P=प्राथमिक तह (१-५ कक्षा)	N= धुम्रपान नगर्ने गरेको	2= मद्यपान दिनहुँ गर्ने गरेको
W=विधवा/विधुर	L= कामदार	L.S=नि.मा. (६-८ कक्षा)		
	H= गृहणी	S=मा. (९-१० कक्षा)		
	St= विद्यार्थी	H.S=उच्च मा. (११-१२ कक्षा)		
	O= अन्य	H.E=उच्च शिक्षा (१२ भन्दा माथि)		

३०० बसाई सराई

३०१ तपाई हाल बसिरहनु भएको गाँउमा लगातार बस्न लाग्नु भएको कति बर्ष भयो ?
क) ६ महिना भन्दा बढी ख) ६ महिना भन्दा कम
ग) जन्मै देखि हाल सम्म घ) अन्य ....

३०२ अहिले तपाईको परिवारको कुनै सदस्य गाँउ भन्दा बाहिर बसोबास गर्नु हुन्छ ?
क) गर्नुहुन्छ (प्रश्न नं. ३०२.१ मा जाने) ख) गर्नुहुन्न (प्रश्न नं.४०१ मा जाने)

३०२.१ कति जना
....

४०० आर्थिक सामाजिक क्षेत्र

४०१ तपाईको परिवारको आम्दानीको मुख्य स्रोत के हो ?
क) कृषि ख) नोकरी
ग) व्यापार/व्यावसाय घ) अन्य (खुलाउने)

४०२ तपाईको आम्दानीबाट १२ महिना घर खर्च चल्छ ?
क) चल्छ (प्रश्न नम्बर ५०१ मा जाने) ख) चल्दैन (प्रश्न नम्बर ४०२.१ मा जाने)

४०२.१ अन्य बिकल्पहरु के के हुन ?

५०० रोग

५०१ बिगत १२ महिनामा तपाइको परिवारबाट कोहि बिरामी हुन भएको थियो ?
क) थियो (प्रश्न नम्बर ५०१.१ मा जाने) ख) थिएन (प्रश्न नम्बर ५०२ मा जाने)

५०१.१

क.स.	बिरामीको नाम	लिङ्ग	उमेर	रोग/लक्षणहरु	उपचार किसिम

क.स.	उक्त बिरामीलाई उपचार गर्न कहाँ लग्नु भएको थियो ?

५०२ तपाईको घरमा कोही शारीरिक असक्त व्यक्तिहरु हुनुहुन्छ ?
क) हुनुहुन्छ (प्रश्न नम्बर ५०२.१ मा जाने) ख) हुनुहुन्न (प्रश्न नम्बर ५०३ मा जाने)

५०२.१

क.स	नाम	उमेर	लिङ्ग	के भएको छ ?	जन्मजात	जन्म पश्चात

५०३. तपाई बिरामी हुंदा प्रथम पटक कहां जानुहुन्छ ?
क) धामीझांक्री ख) स्वास्थ्य चौकी
ग) अस्पताल घ) अन्य (खुलाउने)
ङ) घरमा

५०४ तपाईको घरबाट स्वास्थ्य चौकि पुग्न कति समय लाग्छ ?
क) ३० मिनेट ख) ३० मिनेट भन्दा बढी
ग) ३० मिनेट भन्दा कम घ) अन्य (खुलाउने)

५०५. स्वास्थ्य चौकीले तपाईलाई के फाईदा पु-याएको छ ?

....

५०६. तपाई स्वास्थ्य चौकीको सेवा प्रति सन्तुष्ट हुनुहुन्छ ?
क) छु ख) छैन

५०७ यदि छैन भने किन ?
क) स्वास्थ्य कर्मीको व्यवहार राम्रो नभएर ख) सेवा राम्रो नभएर
ग) महङ्गो भएकोले घ) टाढा भएकोले

६०० स्वास्थ्य स्थिती (ज्ञान ,धारणा र व्यवहार)

६०१ बिरामी हुँदा आफै औषधी किनेर खानु हुन्छ ?
क) खान्छु (प्रश्न नम्बर ६०२ मा जाने) ख) खादिन

६०२ तपाईको बिचारमा रोग के कारणले लाग्छ ?
क) सरसफाईको कमिले ख) किटाणुको कारणले
ग) देउता रिसाएर घ) बोक्सी लागेर
ङ) अन्य

६०३. रोगहरुबारे अन्य जानकारी
आवश्यक संकेत थाहा छ √ थाहा छैन ×

सरुवा रोगहरु	थाहा छ/छैन	यदि छ भने कसरी सर्छ
क्षयरोग		
छाला सम्बन्धी		
झाडाबान्ता		
कुष्ठरोग		
पेटमा लाग्ने जुका		
पोलियो		
दादुरा		
एड्स		

नसर्ने रोगहरु	थाहा छ/छैन	रोगलाग्ने कारणहरु
क्यान्सर		
स्वास प्रश्वासका रोगहरु /दम/निमोनिया		
आङ खस्ने रोग		

६०४. विगत १ वर्षमा तपाईको घरमा कसैको मृत्यु भएको थियो ?
क) थियो (प्रश्न नम्बर ६०४.१ मा जाने) ख) थिएन (प्रश्न नम्बर ७०१ मा जाने)

६०४, १ यदि थियो भने

क.स.	उमेर	लिङ्ग	मृत्युको कारण	उपचारको लागी स्वास्थ्य संस्था लानु भयो / भएन	कैफियत

७०० वातावरणीय स्वास्थ्य

क) पानी

७०१ पिउने पानी प्रायः कहाँबाट ल्याउनु हुन्छ ?
क) धारा ख) कुवा
ग) इनार घ) खोला
ङ) ढुङ्गेधारा च) अन्य........................

७०२ पानी लिन जान कति समय लाग्छ ?
क) ५ मि. भन्दा कम ख) ५-१५ मि
ग) १५ देखि २० मि. घ) २० मि. भन्दा बढी

७०३ तपाईले पीउने पानीलाई शुद्धिकरण गर्नु हुन्छ ?
क) गर्छु (प्रश्न नं. ७०४ मा जाने) ख) गर्दिन (प्रश्न नं. ७०५ मा जाने)

७०४ तपाईहरुले पानी पिउँदा कुन तरिका प्रयोग गरेर पिउने गर्नु हुन्छ ?
क) उमालेर ख) छानेर
ग) थिग्राएर घ) औषधि राखेर
ङ) अन्य..........................

७०५. तपाई घरमा पानी कसरी राख्नु हुन्छ ?
क) छोपेर ख) नछोपेर

ख) चर्पी

७०६ तपाईको घरमा चर्पी छ ?
क) छ (प्रश्न नं. ७०६.१ मा जाने) ख) छैन (प्रश्न नं. ७०६.३ मा जाने)

७०६.१ के तपाई चर्पीको प्रयोग गर्नु हुन्छ ?
क) गर्छु (प्रश्न नं.७०६.२ मा जाने) ख) गर्दिन (प्रश्न नं.७०६.३ मा जाने)

७०६.२ चर्पीको प्रयोगले के के फाईदा हुन्छ ? (बहुउत्तर)
क) सफा सुग्घर हुन्छ ख) आफुलाई सजिलो हुन्छ
ग) झिंगा लामखुट्टे कम हुन्छ घ) रोग लाग्दैन
ङ) घरको इज्जत बढ्छ च) थाहा छैन
छ) अन्य ....

७०६.३ चर्पीको प्रयोग किन गर्नु हुन्न ?
क) पानी नभएर ख) निसासियर
ग) बानी नभएर घ) अफ्ठ्यारो भएर
ङ) अन्य ....
७०६.४ प्राय: जसो कहाँ जाने गर्नु हुन्छ ?
क) खेतबारीमा ख) बाँसको झ्याङमा
ग) खोलाको छेउमा घ) खुला मैदानमा
ङ) अन्य ....

७०६.५ चर्पी प्रयोग नगर्दा के के हुन सक्छ ?

ग) घरव्यवस्था बारे
७०७.१ तपाईंको घरमा कतिवटा कोठा छन ?

७०७.२ तपाईं खाना पकाउन कस्तो चुलोको प्रयोग गर्नुहुन्छ
क) ग्याँस चुलो ख) स्टोभ
ग) भुसे चुलो घ) गोबर ग्याँस
ङ) कोइला च) दाउरा

घ) करेसा बारी
७०८. के तपाईंको घरमा करेसा बारी योग्य जमिन छ ?
क) छ (प्रश्न नं.७०८.१ मा जाने) ख) छैन((प्रश्न नं.७०९ मा जाने)
७०८.१ तपाईंले करेसाबारीबाट उब्जेको सागसब्जी के गर्नुहुन्छ ?
क) पकाएर खान्छौं ख) बजारमा लगेर बेच्छौं
ग) दुवै घ) अन्य (...................)
ङ) व्यक्तिगत सरसफाई

७०९. व्यक्तिगत सरसफाईका लागी तपाईंले के के गर्नुहुन्छ ? (बहुउत्तर)
क) नङ काट्ने ख) दांत माज्ने
ग) नुहाउने घ) लुगा धुने
ङ) अन्य (.................)
७०९.१. तपाई खाना खानु अघि हात धुनु हुन्छ ?
क) धुन्छु (प्रश्न नम्बर ७०९.१.१ मा जाने) ख) धुन्न (प्रश्न नं.७१९.२ मा जाने)
७०९.१.१ हात धुन के प्रयोग गर्नु हुन्छ ?
क) साबुन ख) माटो ग) खरानी
घ) सादा पानी ङ) अन्य (....................................)
७०९.२. तपाई दिसा गरिसकेपछि हात केले धुनु हुन्छ ?
क) साबुन ख) माटो ग) खरानी
घ) सादा पानी ङ) अन्य (....................................)

च) फोहोर मैला विसर्जन

७१०. तपाईंको घर वरपर जम्मा हुने फोहोर कहां फाल्नु हुन्छ ?
क) जहांपायो त्यहिं ख) खाल्टो खनेर पुर्ने
ग) जलाउने घ) अन्य (.........................)

७१०.१ जथाभावी फोहोर फाल्नाले के हुन्छ ?
क) रोग लाग्छ ख) झिंगा लाग्छ
ग) फोहोर हुन्छ घ) गन्हाउंछ
ङ) अन्य (...)

७१०.२ तपाईंको घरबाट निस्केको फोहोर पानी के गर्नु हुन्छ ?
क) करेसा बारीमा हाल्ने ख) खाडलमा हाल्ने
ग) गाईवस्तुलाई खुवाउने घ) अन्य (........................)

फाराम नं. २

८०० मातृ शिशु स्वास्थ्य तथा परिवार नियोजन (५ बर्ष मुनिको बच्चा भएको आमालाई सोध्ने)

cfdfsf] gfd M
pd] / M

८०१ तपाईको बिवाह हुँदा कति बर्षको हुनुहुन्थो ?

क) बर्ष

८०२ पहिलो पटक गर्भवती हुँदा तपाईको उमेर कति बर्षको थियो ?

क) बर्ष

८०३ तपाईको हाल जिवित कति जना छोरा छोरी छन?

क) छोरा

ख) छोरी

ग) जम्मा

८०४ महिलाहरुमा कहिलेकाँही गर्भ महिना पुरा नभई खेर जाने गर्दछ तपाईलाई यस बारे थाहा छ ?

क) छ (प्रश्न नं. ८०४.१ मा जाने)
ख) छैन (प्रश्न नं. ८०४.२ मा जाने)

८०४.१ के तपाईलाई पनि यस्तो समस्या परेको थियो ?

क) थियो (प्रश्न नं.८०४.१.१ मा जाने)
ख) थिएन (प्रश्न नं. ८०४.२ मा जाने)

८०४.१.१ कति पटक

क) १ पटक   ख) २ पटक
ग) दुई पटक भन्दा बढी

८०४.२ हाम्रो देशमा गर्भ पतन सम्बन्धी नियम कानून बारे तपाईले सुन्नु भएको छ ?

क) छ (प्रश्न नं. ८०४.२.१ मा जाने)
ख) छैन (प्रश्न नं. ८०५ मा जाने)

८०४.२.१ यसबारे तपाईलाई के जानकारी छ ?

क) ठिक   ख) बेठिक

√ १२ हप्ता भन्दा कम गर्भावस्था भएको
√ बलत्कार तथा हाडनाताबाट गर्भ रहेमा
√ आमाको स्वास्थ्यलाई हानी पुऱ्याउने खाल्को गर्भ रहेमा
√ पेट भित्र रहेको बच्चा अंगभंग भएमा

८०४.२.२ यस नियम बारे तपाईको के धारणा छ ?

....

८०५. तपाई पछिल्लो पटक गर्भावस्था भएको बेलामा गर्भवती अवस्था जाँच गराउनु भएको थियो ?

क) थियो (प्रश्न नं.८०५.१ मा जाने)
ख) थिएन(प्रश्न नं. ८०५.३ मा जाने)

८०५.१ गर्भवती भएको अवस्थामा तपाईको स्वास्थ्य परीक्षण कहाँ गर्नु भयो ?

क) अस्पतालमा   ख) नर्सिङ होम
ग) हेल्थ पोष्ट   घ) धामी झाक्री
ङ) अन्य (खुलाउने)

८०५.२ कति पटक जानु भएको थियो ?
क) ४ पटक भन्दा बढी	ख) ४ पटक भन्दा कम
ग) ४ पटक	घ) अन्य (..............................)

८०५.३ सेवा किन नलिनु भएको ?
क) थाहा नपाएर	ख) समय नभएर
ग) स्वास्थ्य संस्था टाढा भएर	घ) लाज लागेर
ङ) घरकाले नपठाएर	च) अन्य (..............................)

८०५.४ तपाईलाई गर्भावस्थामा केहि समस्या भएको थियो ?
क) थियो (प्रश्न नं.८०५.४.१ मा जाने)
ख) थिएन (प्रश्न नं. ८०६ मा जाने)

८०५.४.१ कस्तो समस्या भएको थियो ?
क) रगत बग्ने	ख) खुट्टा सुन्निने
ग) जीउ झमझम गर्ने	घ) पिसाब पोल्ने
ङ) रिंगाँटा लाग्ने	च) अन्य (खुसाउने)

८०६. गर्भावस्थामा तपाईले पाखुरामा लगाईने टि.टि सुई लिनु भएको थियो?
क) थियो (प्रश्न नं.८०६.१ मा जाने)
ख) थिएन (प्रश्न नं.८०७ मा जाने)

८०६.१ कति पटक लगाउनु भयो ?
क) .... पटक	ख) थाहा छैन

८०७. गर्भावस्थामा के तपाईले आईरन चक्कि खानु भएको थियो ? (चक्कि देखाएर सोध्ने)
क) थियो (प्रश्न नं. ८०७.१ मा जाने)
ख) थिएन (प्रश्न नं.८०७.२ मा जाने)

८०७.१ कति दिन सम्म खानु भएको थियो ?
क) ....दिन	ख थाहा छैन

८०७.२ किन खानु भएन ?
क) थाहा नभएर	ख) समय नभएर
ग) खान बिर्सेर	ग) खान मन नलागेर
ङ) अन्य (..................)

८०८. गर्भवती भएको बेलामा साबिक भन्दा फरक खाना खानु भएको थियो ?
क) थियो (प्रश्न नं. ८०८.१ मा जाने)	ख) थिएन (प्रश्न नम्बर ८०९ मा जाने)

८०८.१ के के फरक खानु भएको थियो ?
....

८०९. हरियो साग सब्जी कतिको खाने गर्नु हुन्थ्यो ?
क) सधै	ख) जब उपलब्ध हुन्छ
ग) प्रायः जसो	घ) कहिले पनि नखाने
ङ) अन्य..

८१०. तपाईको विचारमा साबिकको भन्दा बढी खाना खानु जरुरी छ।
क) छ (प्रश्न नं. ८१०.१ मा जाने)
ख) छैन (प्रश्न नं. ८११ मा जाने)

८१०.१ कस्तो खाना बढी खानु जरुरी छ ?
क) माछा मासु	ख) सागसब्जी
ग) दुध/घ्यू	घ) फलफुल
ङ)अण्डा	च) सबै

८११. तपाई गर्भावस्थामा धुम्रपान/मद्यपान गर्नु हुन्थ्यो ?
क) गर्छु (प्रश्न नं. ८११.१ मा जाने)
ख) गर्दिन (प्रश्न नं. ८१२ मा जाने)

८११.१ के गर्नु हुन्थ्यो
क) चुरोट ख) रक्सी
ग) खैनी/सुर्ती घ) अन्य.........

८१२. तपाईले गर्भावस्थामा सधैको जस्तो काम गर्नु भएको थियो ?
क) साबिकको जस्तो ख) साबिकको भन्दा बढी
ग) साबिकको भन्दा कम घ) अन्य.............

८१३. तपाईको पछिल्लो बच्चा कहाँ जन्मेको थियो ?
क) घरमा (प्रश्न नं.८१३.१ मा जाने) ख) हेल्थपोष्ट/अस्पताल
ग) नर्सिङ होम घ) अन्य.........................
नोट :- यदि घरमा होइन भने प्रश्न न. ८१४ मा जाने

८१३.१ कसले सहयोग गरेको थियो ?
क) स्वास्थ्य कर्मी ख) सुडेनी
ग) परिवारको सदस्य घ) अन्य....................

८१३.२ के तपाईले सुत्केरी सामाग्रीको प्रयोग गर्नु भएको थियो ?
क) थियो (प्रश्न नं. ८१४ मा जाने)
ख) थिएन (प्रश्न नं. ८१३.२.१ मा जाने)

८१३.२.१ नाल के ले काट्नु भएको थियो ?
क) नयाँ ब्लेड ख) पुरानो ब्लेड
ग) चक्कु घ) कैंची
ङ) अन्य ....

८१३.२.२ नाल काटेको ठाउँमा के लगाउनु भएको थियो ?
क) बेसार र तेल ख) औषधी
ग) माटो घ) अन्य.....................

स्तनपान सम्बन्धी प्रश्नहरु

८१४. बच्चा जन्मेपछि आमाको स्तनबाट निस्कने पहेलो (बिगौती) दुध बच्चालाई खुवाउनु भएको थियो ?
क) थियो (प्रश्न नं. ८१४.१ मा जाने)
ख) थिएन (प्रश्न नं. ८१४.२ मा जाने)

८१४.१ बिगौती दुध खुवाउनाले के फाईदा हुन्छ ?
क) बच्चालाई रोग लाग्दैन ख) बच्चा बलियो हुन्छ
ग) थाहा छैन घ) अन्य........................

८१४.२ किन नखुवाएको ?
क) चलन नभएर ख) थाहा नभएर
ग) हानी हुन्छ भनेर घ) बच्चाले पचाउन सक्दैन भनेर
ङ) फोहर हुन्छ भनेर घ) अन्य...................

८१४.३ बच्चालाई स्तनपान गराउनु अघि अरु केहि खानेकुरा खुवाउनु भएको थियो ?
क) थियो (प्रश्न नं. ८१४.३.१ मा जाने) ख) थिएन (प्रश्न नम्बर ८१५ मा जाने)

८१४.३.१ यदि खुवाउनु भएको थियो भने के खुवाउनु भएको थियो ?
क) मह ख) पानी ग) घिउ, चिनी
घ) अन्य (.........................)

८१५. बच्चालाई दिनमा कति पटक दुध खुवाउनु हुन्छ ?
क) ६ भन्दा कम   ख) ६-८ पटक सम्म
ग) ८ पटक भन्दा बढी   घ) अन्य..................

८१६. तपाईलाई थाहा छ बच्चालाई कति महिना सम्म दुध खुवाउनु पर्छ ?
क) ०-६ महिना   ख) ०-१२ महिना
ग) ०-२४ महिना   घ) अन्य..................

८१७. कति महिनाको उमेर देखि बच्चालाई ठोस खानेकुरा खुवाउनु भयो ?
क)   ख) थाहा छैन (प्रश्न नं. ८१८ मा जाने)

महिना	वर्ष

८१७.१ ठोस खानेकुरा के के खुवाउनु भयो ?थाह
क) लिटो   ख) घरमा पकाएको खाना
ग) जाउलो   घ) अन्य

८१८. सर्वोत्तम पिठोबारेमा सुन्नु भएको छ ?
क) छ (प्रश्न नं. ८१८.१ मा जाने)
ख) छैन (प्रश्न नं. ८२० मा जाने)

८१८.१ सर्वोत्तम पिठो बच्चालाई खुवाउनु हुन्छ ?
क) खुवाउछु (प्रश्न नं. ८१८.१.१ मा जाने)   ख) खुवाउदिन (प्रश्न नं. ८१९ मा जाने)

८१८.१.१ सर्वोत्तम पिठो कहाँबाट ल्याउनु हुन्छ ?
क) आफै घरमा बनाउछु   ख) किनेर ल्याउछु
ग) अन्य

८१९. सर्वोत्तम पिठो बनाउन आउँछ ?
क) आउँछ (प्रश्न नं. ८१९.१ मा जाने)
ख) आउँदैन (प्रश्न नं. ८२० मा जाने)

८१९.१. कसरी बनाउनु हुन्छ ?
क) ठिक   ख) गलत

(दुई भाग एकै किसीमको गेडागुडी, दुईभाग फरक फरक किसिमको अन्न छुट्टाछुट्टै भुट्ने, छुट्टाछुट्टै पिसेर मिसाउने)

८१९.२. बच्चालाई दिनमा कति पटक खाना खुवाउनु हुन्छ ?
क) तीन पटक   ख) तीन पटक भन्दा बढी
ग) जति पटक भोकाउछ /रुन्छ   घ) अन्य (..........................)

८२०. तपाईलाई बच्चामा हुने कुपोषण/रुन्चे/सुकेनासको बारेमा थाहा छ ?
क) छ (प्रश्न नं. ८२०.१ मा जाने)
ख) छैन (प्रश्न नं. ८२१ मा जाने)

८२०.१ कुपोषण हुंदा के हुन्छ ? (बहुउत्तर)
क) दुब्लाउँदै जान्छ   ख) बढी रुन्छ   ग) खान मन गर्दैन
घ) अन्य (..)

८२०.२ तपाईको विचारमा कुपोषण के कारणले हुन्छ ? (बहुउत्तर)
क) खानको कमीले   ख) आखाँ लागेर
ग) गर्भवती महिलाले छोएर   घ) देवी देउताको करणले
ङ) अन्य

८२०.३ कुपोषणको रोकथाम कसरी गर्न सकिन्छ ?
क) पौष्टिक आहार खुवाएर   ख) देवीदेवताको पूजा गरेर
ग) बच्चालाई गर्भवती महिलालाई छुन नदिएर   घ) अन्य (..................)

८२१. के तपाईले आफ्नो बालबालिकालाई भिटामिन ए. क्यापसुल खुवाउनु भयो ?
क) खुवाउछु (प्रश्न नं.८२२ मा जाने) ख) खुवाउँदिन (प्रश्न नं. ८२१.१ मा जाने)

८२१.१ किन ?

८२२ महिलाहरुको आङ खस्ने (पाठेघर) समस्याको बारेमा तपाईलाई थाहाँ छ ?
क) छ (प्रश्न नं. ८२२.१ मा जाने)
ख) छैन (प्रश्न नं. ८२३ मा जाने)

८२२.१ के के हुन्छ ?

८२२.२ यो के कारणले हुन्छ ?
क) लामो समय बेथा लागेर
ख) गाह्रो काम गरेर
ग) छिटो छिटो बच्चा पाएर
घ) अन्य (...)

८२२.३ के तपाईलाई यस्तो समस्या परेको थियो/छ ?
क) छ/थियो (प्रश्न नं. ८२२.३.१ मा जाने) ख) छैन/थिएन (प्रश्न नं. ८२३ मा जाने)

८२२.३.१ तपाईले उपचार गराउनु भयो ?
क) गराए ख) गराइन

खोप सम्बन्धी प्रश्न

८२३. के तपाईको बच्चालाई लगाउने खोप बारे थाहा छ ?
क) छ (प्रश्न नं. ८२३.१ मा जाने)
ख) छैन (प्रश्न नं. ८२४ मा जाने)

८२३.१ तपाईको बच्चालाई खोप लगाउनु भएको छ ?
क) छ (प्रश्न नं. ८२३.१.१ मा जाने र कार्ड हेर्ने)
ख) छैन (प्रश्न नं. ८२४ मा जाने)

८२३.१.१.

क.स.	नाम	उमेर	लिङ्ग	बि.सि.जी	डि.पि.टि.			पोलियो			थप पोलियो थोपा	दादुरा	हेप्पा.बि.
					प्र.	दो.	ते	प्र.	दो.	ते			

नोट :-
( ) कार्डबाट भरिएको
( ) मौखिकबाट भरिएको

जिवनजल सम्बन्धी प्रश्नहरु

८२४. जीवनजलको बारेमा सुन्नु भएको छ ?
क) छ (प्रश्न नं. ८२४.१ मा जाने)
ख) छैन (प्रश्न नं. ९०० मा जाने)

८२४.१ के तपाईलाई थाहा छ यो के भएमा प्रयोग गरिन्छ ?
क) ठिक ख) बेठिक
नोट : झाडापखाला भनेमा ठीक हुनेछ

८२४.२ जीवनजल कसरी बनाउने हो नि ?

क) सहि ख) गलत

- १. लिटर/२ माना/६ चिया गिलासको सफा खाने पानी १ प्याकेट जिवनजल मिसाउने
- त्यसलाई घोलेर एउटा भाडोमा छोपेर राख्ने ।
- २४ घण्टा भित्र जति पल्ट पातलो दिसा हुन्छ, त्यति पल्ट बिरामीलाई खुवाउने ।
- २४ घण्टा भित्र बनाइएको झोल सकिएन भने उक्त झोल प्रयोगमा नल्याउने ।

५ वर्ष भन्दा मुनीका बच्चाको पोषण स्थिति :

क्र.स.	नाम	उमेर	लिङ्ग	तौल	उचाई	MUAC	कैफियत
१							
२							
३							
४							
५							

९००. परिवार नियोजन सम्बन्धी प्रश्नहरु (विवाहित महिलालाई साध्ने)

उत्तरदाताको नाम
उमेर
लिङ्ग

९०१ तपाईलाई परिवार नियोजनको बारेमा थाहा छ ?
- क) छ (प्रश्न नं. ९०१.१ मा जाने)
- ख) छैन (प्रश्न नं. ९०४ मा जाने)

९०१.१ तपाईले परिवार नियोजनको साधनको प्रयोग गर्नु भएको छ ?
- क) छ (प्रश्न नं. ९०१.१ मा जाने)
- ख) छैन (प्रश्न नं. ९०३ मा जाने)

९०१.१.१ के प्रयोग गर्नु भएको छ ?

अ) अस्थाई	आ. स्थायी
क) खाने चक्की	क) भ्यासेक्टोमी
ख) डिपो	ख) ल्याप्रोस्कोपी
ग) नरप्लाट	ग) मिनिल्याप
घ) कपर्टी	घ) अन्य (.....................)
ङ) कण्डम	
च) अन्य (.........................)	

९०२ तपाईको विचारमा परिवार नियोजन किन जरुरी छ ?(बहुउत्तर)
- क) नियोजित परीवार हुन्छ ।
- ख) कम पारीवारीक समस्या आइपर्छ ।
- ग) जनसंख्या घट्छ ।
- घ) भगवान रिसाउनु हुन्छ ।
- ङ) अन्य (...............................)

९०३ तपाईको विचारमा २ वटा बच्चा बिचको जन्मान्तर समय कति हुनु पर्छ ?
- क) दुई बर्ष भन्दा कम
- ख) दुई बर्ष
- ग) दुई देखि पाँच बर्ष
- घ) पाँच बर्ष भन्दा माथी

९०४ सुखद् दाम्पत्य जीवनको लागी कति जना बालबच्चा उपयुक्त हुन्छ ?
क) १ जना ख) २ जना ग) ३,४ जना घ) अन्य (..................)

(अन्तर्वार्ता सकिएको समय ....)

हवसत् धन्यवाद

Appendix-D Guideline questionnaire for Leaders, FCHV's, Health post incharge, and shaman healers

फाराम नं.-३

समुदायका नेताहरुलाई सोध्ने प्रश्नहरु

नाम :

उमेर : लिङ्ग :

नेताको प्रकार :

मिति :

अन्तर्वार्ता लिने व्यक्ति :

१. तपाईंको समुदायको मुख्य समस्या के के छन् ?

२. तपाईंको समुदायमा के के स्वास्थ्य सम्बन्धी समस्याहरु छन् ?

३. तपाईंको बिचारमा स्वास्थ्य खराब हुने प्रमुख कारणहरु के के हुन सक्छन् ?

४. समुदायमा के कस्तो स्वास्थ्यको सुविधा उपलब्ध छ ?

५. के गरेमा समुदायको मानिसहरुको हालको स्वास्थ्यको स्थिती राम्रो पार्न सकिन्छ ?

६. तपाईंले स्वास्थ्य सम्बन्धी कुनै तालिम लिनु भएको छ ?

७. धामी झाँक्री, झार-फुके बारेमा तपाईंको राय के छ ?

८. यस गा.बि.स.को स्वास्थ्य स्थिती सुधार्नको निम्ति तपाईंको बिचारमा कस्को बढी जिम्मेवारी हुन्छ?

९. गा.बि.स.बाट यस वर्ष भित्र गरिने स्वास्थ्य सम्बन्धी सहयोगी कार्यक्रमहरु के -के छन ?

१०. तपाई स्वास्थ्य सहयोग समितिको सदस्य हुनुहुन्छ ?
 यदि हुनुहुन्छ भने,

१०.१ कति समयको फरकमा स्वास्थ्य सहयोग समितिको बैठकमा भाग लिन सम्बन्धित स्वास्थ्य संस्था जानुहुन्छ ?

११. गा.बि.स. र स्वास्थ्य संस्थाको कस्तो सम्बन्ध छ ?

फाराम नम्बर ४.

महिला स्वास्थ्य स्वयं सेविकालाई सोध्ने प्रश्न

नाम : वाड नं.: उमेर : पेशा :

स्वयं सेविका भएको अवधि :

१) तपाई यस पेशामा लागेको कती वर्ष भयो ?

२) तपाई आफ्नो यस पेशाप्रति सन्तुष्ट हुनुहुन्छ ?

३) तपाईले आमा समूहको बैठक बर्षमा कति पटक गर्नुहुन्छ ?

४) आमा समूहको बैठकमा तपाई प्राय कस्तो विषयमा छलफल र सल्लाह दिनुहुन्छ ?

५) तपाईलाई स्वास्थ्य चौकीले बर्षमा कति पटक तालिमको लागि बोलाउंछ ?

६) तपाईलाई स्वास्थ्य चौकीले के कस्ता विषयमा छलफल गराउंछ ?

७) तत्कालै स्वास्थ्य चौकीमा खबर गर्नु पर्ने रोगहरुको सम्बन्धमा तपाईलाई जानकारी छ ?
यदि छ भने के के हुन् ?

८) तपाईले कुन कुन समयमा थप स्वास्थ्य सम्बन्धी कार्यक्रममा सहयोग गर्नुहुन्छ ?

९) के तपाईले सेवाको दौरानमा घरमा सुत्केरी गराउनु भएको छ ?

१०) तपाईको वडामा कस्ता किसिमका स्वास्थ्य समस्या छन् ?

११) तपाईको विचारमा स्वास्थ्य समस्यालाई कम गर्न के गर्नु पर्ला ?

यो कसको जिम्मेवारी हो नि ?

फारम नं. ५

स्वास्थ्य चौकी प्रमुखलाई सोध्ने प्रश्नावली

परिचय

नाम :- उमेर :-

लिङ्ग :-

प्रश्न कर्ताको नाम :-

१. तपाईं यस स्वास्थ्य चौकीमा कार्यरत रहनु भएको कति समय भयो ?

२.तपाइको विचारमा यस समुदायको मुख्य समस्याहरु के के हुन् ?

३. तपाइको विचारमा यस समुदायको स्वास्थ्य सम्बन्धी समस्याहरु के के हुन् ?

४. स्वास्थ्य प्रति यस गाँउवासीहरुको धारणा कस्तो छ ?

५. स्वास्थ्य संस्था र गा.वि.स. बिचको सम्बन्ध कस्तो छ ?

६. विद्यालयमा स्वास्थ्य कार्यक्रम पनि चलाईराख्नु भएको छ ? के कस्ता कार्यक्रमहरु चलाउनु भएको छ ?

७. रोगहरुको रोकथाम तथा स्वास्थ्य प्रवर्धनका लागि के कस्ता कार्यक्रमहरु संचालन भई रहेका छन् ?

८. महिनामा कति पटक गाउँघर घुम्नु हुन्छ ?

९. स्वास्थ्य चौकीमा के कस्ता सुविधाहरु उपलब्ध छन् ?

१०. के गाँउका सबै मानिसहरुले यस स्वास्थ्य चौकीबाट सेवा पाईरहेका छन् ?

११. तपाईको कार्यकालमा भएका उल्लेखनिय उपलब्धिहरु के के हुन् ?

१२. सुधारका अन्य क्षेत्रहरु के के छन् ?

१३. अन्तमा केही .... ? धन्यवाद

फारम नं. ६

धामी झाँकीलाई सोध्ने प्रश्नावली

<u>परिचय</u>

नाम :- **उमेर :-**

लिङ्ग :-

१. तपाई यस कार्यमा कहिले देखि लाग्नु भएको हो ?

२. तपाईकोमा महिनामा सरदर कति बिरामीहरु आउँछन् ?

३. तपाईकाहां प्रायजसो कस्तो खालको बिरामी आउने गर्दछन् ?

४. तपाईको विचारमा यस गाँउको मुख्य मुख्य स्वास्थ्य समस्याहरु के के हुन ?
५. तपाईको बिचारमा यी माथिका समस्याहरु कम गर्न के गर्नु पर्ला ?
६. तपाईले स्वास्थ्य सम्बन्धी कुनै तालिम लिनु भएको छ ?
७. यदि छ भने तालिम पछि उपचार प्रविधिमा के परिवर्तन ल्याउनु भयो ?
८. तपाईले झाडापखालाको बिरामीलाई कसरी उपचार गर्नुभएको छ ?
९. तपाई आफ्नो कार्य प्रति सन्तुष्ट हुनुहुन्छ ?
१०. अन्तमा केहि ....

Appendix-E Guideline questionnaire for case study

QUESTIONNAIRE FOR CASE STUDY

Name.....................

Age/Sex..............

Education.........................

District.....................

VDC ...... Ward no..............

1)When and where did you born?

2) Have you taken BCG vacination?

3) Would you tell me about your family background?

4) Do you have any smoking habbit?

5)Whar occupation you used to do in your life?

6)When did you resign from job?

7)Was there any disease in your family?

8) Were any other family members also getting TB ?

9) what type of fuel do you use for cooking purpose?

10)How many placed have you visited?

11) when and how did you know that you are suffering from TB?

12)On your view , what is the reason for developing TB on you?

13) When did you visited hospital ?

14) Have you taken medicine regularly?

15) How do you feel now adays?

16)Are you suffering from any other disease?

Thanks

Appendix-F List of respondents

NAME OF RESPONDENT

WARD NO:1

S.N	Name of the respondent	Mother's Name
1	Kali Khadka	Januka Khadka
2	Balkrisna Khadka	Arati Khadka
3	Shiva B. Khadka	Maiya Khadka
4	Jayaram Khadka	Kabita Khadka
5	Indira Khadka	
6	Manahari Khadka	
7	Dasharath Khadka	
8	Ramsaran Khadka	Parbati Khadka
9	Musauri Khadka	
10	Sadhuram Khadka	
11	Sushila Khadka	Sushila Khadka
12	Sita Khadka	
13	Keshab Khadka	
14	Manju Khadka	Manju Khadka
15	Ram B. Khadka	
16	Ram Krishna Khadka	Nanu Khadka
17	Rajan Khadka	Ambika Khadka
18	Shyam K. Khadka	Jayanti Khadka
19	Maniram Khadka	Tara Khadka
20	Kedar Tamang	
21	Indra Tamang	
22	Chandra Taman	
23	Jayaram Tamang	Sangita Tamang
24	Depak Nepali	Pampha Nepali
25	GoreNepali	
26	Dhan B. Nepali	
27	Shanti Phuyal	
28	Parshuram Phuyal	Apsara Phuyal

WARD NO: 2

S.N.	Nameof the respondent	Mother's Name
29.	Gauri Phuyal	
30.	Ranadip Phuyal	
31.	Khadadevi Phuyal	Nirmal Phuyal
32.	Khem Prasad Phuyal	Sanu Phuyal
33.	Kumar Aasdhikari	Sunita Aaadhikari
34.	Rjendra Phuyal	
35.	Mandira Phuyal	
36.	Jayaram Phuyal	Santa Phuyal
37.	Mitthu Phuyal	Nirmala Phuyal
38.	Bainkuntha Phuyal	
39.	Kaurab Prasad Phuyal	Gita Phuyal
40.	Apsara Phuyal	Apsara Phuyal
41.	Yamuna Phuyal	
42.	Ramnath Phuyal	
43.	Gopikrishna Phuyal	Ambika Phuyal
44.	Ambika phuyal	Ambika Phuyal
45.	Dhruba Prasad Phuyal	
46.	Sanumaiya Phuyal	
47.	Bimal Dhimal	
48.	Jayaram Phuyal	Sabitri Phuyal
49.	Govind Dulal	
50.	Gauri Dhimal	
51.	Ram Bhadur Nepali	
52.	Bhibisaran Dahal	Ambika Dahal
53.	Indira Dhakal	
54.	Ganga Dhakal	
55.	Krishna Dahal	Goma Dahal
56.	Laxmi Dahal	
57.	Sanu Phuyal	
58.	Radhakrishna Phuyal	Radhika Phuyal
59.	Santa Prasad Phuyal	
60.	Parmeshwor Phuyal	
61.	Guru Prasad Phuyal	Parvati Phuyal
62.	Biswanath Phuyal	Shova Phuyal
63.	Shova Phuyal	
64.	Radhakrisna Phuyal	Kamala Phuyal
65.		

WARD NO.3

S.N	Name of the respondent	Mother's name
66	Krishna. Thapa	Sudha Thapa
67	Saradha Thapa	
68	Sita Thapa	
69	Krishna B. Thapa	Sabita Thapa
70	Achala Thapa	Archana Thapa
71	Nanimaiya Thapa	Nanimaiya Thapa
72	Harikrishna Thapa	
73	Ganga Thapa	
74	Mana K. Thapa	
75	Rajan Thapa	Makhamali Thapa
76	Keshab B. Basnet	Laxmi Basnet
77	Rama Basnet	
78	Baburam Basnet	Gauri Basnet
79	Babita Basnet	Babita Basnet
80	Krishnahari Basnet	Basan Basnet
81	Januka Basnet	
82	Sabita Basnet	Sabita Basnet
83	Shova Basnet	Shova Basnet
84	Pramila Basnet	
85	Krishna B. Shrestha	

WARD NO. 4

S.N	Nameof respondent	Mother's Name
86	Sabita Sinkhada	Sabita Sinkhada
87	Ichharam Khadka	Goma Khadka
88	Tara Khadka	Tara Khadka
89	Sarada Khadka	Nirmal Khadka
90	Uddab Khadka	Bina Khadka
91	Arjun bdr Karki	
92	Shyam Thapa	Shova Thapa
93	Amita Thapa	Amita Thapa
94	Champa Phuyal	Champa Phuyal
95	Atmaram Karki	
96	Susila Rawat	Susila Rawat
97	Pabitra Karki	
98	Ganga Karki	Ganga Karki
99	Tilak Bdr Karki	
100	Sanimaiya Thapa	Sarada Thapa
101	Kumar Bdr Khadka	
102	Saraswati Khadka	
103	Ganga bhakati	Reshama Bhakati
104	Bhim Bbr Khadka	Muna Khadka
105	Kanchi Khadka	Sundari Khadaka
106	Radha Bista	
107	Radhika Bista	
108	Ramhari Nepali	

WARD NO 5

S. N	Name of the respondent	Mother's name
109	Krishna Gopal Khadka	Pabitra Khadka
110	Kanchi Shrestha	Kanchi Shrestha
111	Pabitra Shrestha	Pabitra shrestha
112	Manamaya Shrestha	Lokmaya Shrestha
113	Ratnamaya shrestha	Ratnamaya Shrestha
114	Krishnadevi shrestha	
115	Krishnamaya Shrestha	
116	Gyanmaya Shrestha	
117	Pushpa Shrestha	
118	Nirmala Basnet	Nirmala Basnet
119	Bishnumaya Shrestha	Bishnumaya Shrestha
120	Laxmi Shrestha	Urmila Shrestha
121	Sabitri Shrestha	
122	Basu Basnet	
123	Salina Karki	Salina karki
124	Kumar Basnet	
125	Nirmala Basnet	
126	Purnamaya Kami	Purna maya kami
127	Sanu Basnet	Renuka Basnet
128	Narayan Shrestha	Dhanamaya Shrestha
129	Gauri Karki	
130	Narayan Bdr khadka	Rita khadka
131	Ram lohar khadka	
132	Tara lohar	Maya sunar
133	Rajaram karki	
134	Maya sunar	Santoki sunar
135	Badri basnet	
136	Santoki sunar	

WARD NO.6

S.no	Name of the respondent	Mother's name
137	Ram Shrestha	Goma Shrestha
138	Bimala Ghimire	Bimala Ghimire
139	Nabaraj Shrestha	Santamaya Shrestha
140	Ranjana Shrestha	
141	Rajan Shrestha	Bhagbati Shrestha
142	Ishwari Shrestha	Ishwari Shrestha
143	Ramkeshari Shrestha	
144	Bishnu Shrestha	
145	Ishwari Shrestha	Apsara Shrestha
146	Rameswori Shrestha	
147	Neuchhe Shrestha	Rameswari Shrestha
148	Ganga Shrestha	
149	Srijana Shrestha	Srijana Shrestha
150	Chandradevi Shrestha	Chandradevi Shrestha
151	Sabita Nagarkoti	
152	Sumitra Nagarkoti	Sumitra Nagarkoti
153	Sanukancha Shrestha	Sabitri Shrestha
154	Makhanlal Shrestha	Shova Shrestha

WARD NO.7

S. No	Name of the respondent	Mother's name
155	Buddhimaya Nagarkoti	
156	Krishnadevi Nagarkoti	Krishnadevi Nagarkoti
157	Torimaya Nagarkoti	Asmita Nagarkoti
158	Thangkuti Nagarkoti	
159	Dil B. Nagarkoti	Mina Nagarkoti
160	Fanku Nagarkoti	
161	Gita Nagarkoti	Bimala Nagarkoti
162	Janakmaya Shrestha	Sushma Shrestha
163	Krishna K. Nagarkoti	Rampyari Nagarkoti
164	Dilmaya Nagarkoti	Dilmaya Nagarkoti
165	Pradip Nagarkoti	Kamala Nagarkoti
166	Sunmaya Nagarkoti	Sunmaya Nagarkoti
167	Krishnalal Nagarkoti	
168	Sete Nagarkoti	Sumitra Nagarkoti
169	Gumbe Nagarkoti	Gita Nagarkoti
170	Nanu Nagarkoti	
171	Irman Taman	
172	Bijesh Shrestha	Sarala Shrestha

Ward no. 8

S.No	Name of the respondent	Mother's Name
173	Maila Nagarkoti	Astha Nagarkoti
174	Sanumaiya Nagarkoti	
175	Bhunte Nagarkoti	
176	Kamala Putuwar	Kamala Putuwar
177	Gunmaya Nagarkoti	
178	Aita B. Nagarkoti	
179	Sete Nagarkoti	Sangita Nagarkoti
180	Babukaji Nagarkoti	Dhan K. Nagarkoti
181	Satimaya Nagarkoti	Roji Nagarkoti
182	Ratnamaya Shrestha	Narayan Shrestha
183	Santamaya Shrestha	Bindu Shrestha
184	Sitaram Shrestha	Saraswati Shrestha
185	Bhagwan Shrestha	
186	Rajendra K. Shrestha	
187	Paban Shrestha	

Ward no. 9

S.N	Name of respondent	Mother's name
188	Mittthu Dhimal	Gita Dhim
189	Parbati Dhiamal	
190	Bina Dhimal	
191	Srita Dhimal	
192	Ambika Dhimal	
193	Kunti Dhimal	
194	Tankanath Dhimal	
195	Srikrishna Dhimal	Sarita D
196	Kedarnath Dhimal	Saraswati
197	Janardan Dhimal	
198	Kedar P. Dhimal	
199	Jandevi Dhimal	
200	Sumitra Dhimal	Sumitra Dh
201	Khirkumari Dhimal	Sushila Dh
202	Ramkrishna Dhimal	Kalpana Dh
203	Ambika Dhimal	
204	Min kui. Ghorasaini	Menuka Gh
205	Goma Phuyal	

Appendix-F List of FCHV's

Name of the FCHVs

S.N.	Name of FCHVs	Ward no.
1.	Manahari Khadka	1
2.	Nirmala Khadka	1
3.	Sushila Phuyal	2
4.	Yamuna Phuyal	2
5.	Bimala Thapa	3
6.	Sahansila Basnet	3
7.	Radha Bista	4
8.	Sharadha Karki	4
9.	Sanu Basnet	5
10.	Ramkeshari Shrestha	6
11.	Gyanu Nagarkoti	7
12.	Chakhali Nagarkoti	7
13.	Renu Nagarkoti	8
14.	Dilmaya Nagarkoti	8
15.	Ram maya Nagarkoti	8
16.	Sanumaiya Dhimal	9
17.	Sushila Phuyal	9

Appendix-H Letter of invitations and appreciations