

PN-AR-P-153

SAVE THE CHILDREN
NEPAL FIELD OFFICE
CHILD SURVIVAL 8
BASELINE SURVEY REPORTS

Ilakas 1, 12 and 13
Far Eastern Nuwakot District
Bagmati Zone
Central Development Region

Agency for International Development

Grant # FAO-0500-A-00-2034-00

February 1993

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Note: This document contains two separate baseline survey reports.

The first represents the knowledges and practices of mothers with children under 24 months.

The second is the knowledge, attitudes and practices on sexually transmitted diseases and AIDS.

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CONTENTS

	page
ACKNOWLEDGEMENTS	1
ACRONYMS & GLOSSARY	ii
EXECUTIVE SUMMARY	iii
I. INTRODUCTION	1
A. Background information	1
B. Objective of the survey	2
C. Schedule of activities	2
II. METHODOLOGY	4
A. The questionnaire	4
B. Determination of sample size	4
C. Selection of sample	5
D. Training of supervisors and interviewers	6
E. Conducting the survey	6
F. Method for data analysis	7
G. Costs	8
H. Feedback	8
III. RESULTS	9
IV. DISCUSSION AND RECOMMENDATIONS	17
V. LESSONS LEARNED	24
BIBLIOGRAPHY	25
APPENDICES	26
A. Map of Nuwakot District	26
B. Questionnaire in English	27
C. Questionnaire in Nepali	41
D. List of Survey Team Members	60
E. Supervisors' and Interviewers' Training Agenda & Schedule	61
F. Sample Selection Table with Population Estimate	64
G. Tibetan Calendar Year	67
H. Table of Teams' Assigned Clusters	68
I. Brief Profile of the Project Area	69
J. Summary of Findings	75

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We are also grateful to Ravindra Thapa, Project Coordinator of CS VIII project, for helping the team during all phases of the survey from planning to the writing of this report. The trust put forward by Keith D. Leslie, Country Director, and Bharat Devkota, Program Director, to us to carry out the survey is well appreciated. The capable guidance and encouragement provided by Chanda Rai, Public Health Coordinator, to all the team members deserves our personal gratitude. Our thanks are also due to Narmaya Limbu who helped to design the questionnaire and Navin Pyakuryal in adding a professional edge to our Supervisors' and Interviewers' training.

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ACRONYMS & GLOSSARY

ALC	-	Adult Literacy Class
ANM	-	Auxiliary Nurse-Midwife
ARI	-	Acute Respiratory Infection
CBS	-	Central Bureau of Statistics, HMG Nepal
CDD	-	Control of Diarrheal Diseases
CHL	-	Community Health Leaders
CHV	-	Community Health Volunteer (1/ward)
CS	-	Child Survival
CSSP	-	Child Survival Support Program
Cumu. District	-	Cumulative Administrative division under a zone (There are 75 districts, 14 zones, and regions in Nepal).
DPHO	-	District Public Health Office(r)
EPI	-	Expanded Program on Immunization
GM/P	-	Growth Monitoring/Promotion
GO	-	Government organization
HH	-	Household
HMG/N	-	His Majesty's Government of Nepal
HP	-	Health Post
IEC	-	Information, Education and Communicatio
Ilaka	-	Administrative division at sub-district level (9 ilakas in a district).
JJ	-	Jeevan Jal
K&P	-	Knowledge and Practices
MCH	-	Maternal Child Health
MOH	-	Ministry of Health
NCP	-	<i>Noon Chini Panni</i> , sugar-salt ORS
NFE	-	Non-Formal Education
NFO	-	Nepal Field Office (SC's country office
ORS/T	-	Oral Rehydration Solution/Therapy
PVO	-	Private Volunteer Organization
SC/US	-	Save the Children Federation USA (Save the Children/US)
TBA	-	Traditional Birth Attendant
TT	-	Tetanus Toxoid
VDC	-	Village Development Committee (formally known as Panchayat), administrative division under an ilaka (6-9 VDCs in an ilaka)
VHW	-	Village Health Worker (1/VDC)
Ward	-	Administrative division under the VDC (9 wards in a VDC).
Zone	-	Administrative division of the country (14 zones/5 regions in Nepal).

EXECUTIVE SUMMARY

A baseline survey was conducted in 14 Village Development Committees (VDCs) of Ilakas #1, #12 and #13 of far-eastern Nuwakot District, Central Development Region of Nepal (see Appendix - A). The objective of the survey was to estimate a baseline on the health knowledge and practices (K&P) of mothers with children under two years old of the region.

The survey was successful in compiling benchmark information needed for the Child Survival (CS) VIII project. The project is being implemented by Save the Children USA (SC/US) in close coordination with His Majesty's Government of Nepal, Ministry of Health, District Public Health Office of Nuwakot. SC/US is a private voluntary organization with headquarters in Westport, Connecticut, and country head office in Maharajgunj, Kathmandu.

The CS VIII project is receiving US \$385,231 in A.I.D. funding from the Bureau for Food and Humanitarian Assistance/Office of Private and Voluntary Cooperation (FHA/PVC) to implement child survival activities from October 1, 1992, to September 30, 1995. The total budget will be US \$513,482 over three years with the A.I.D. funding matched by US \$128,274 from SC/US. The combined budget is allocated to be US \$187,639 for Year 1, \$168,954 for Year 2 and \$156,889 for Year 3.

The project will primarily focus on the empowerment and mobilization of women's groups in order to strengthen child survival activities to reduce infant, child and maternal mortality and morbidity in the region. It is planned to be achieved through integrated initiatives such as EPI, diarrheal disease management, maternal health, AIDS prevention, ARI and vitamin A programs with increased emphasis on a broad range of non-formal education activities, especially literacy and early childhood education and nutrition.

The survey questionnaire was based on the CS III final survey's and CS VII baseline survey's questionnaires. It was designed following a standardized format required by A.I.D. for its Child Survival projects. The questionnaire was further refined through a pretest conducted in a Nuwakot Tamang community. The survey team received training in 30 cluster sample surveys facilitated by experienced SC/US staff members. The entire survey was completed within a three week period.

Major survey findings include a 3.3% literacy rate among interviewed mothers. There are no ongoing growth monitoring and promotion programs in the area and 94.3% mothers do not have a GM/P card for their child. Over one third of the children under two years had experienced diarrhea in the past two weeks. Almost all mothers showed lack of proper knowledge for treatment of diarrhea and use of ORS was found to be extremely low. Complete immunization coverage of 12-23 month old children (taken from EPI cards) is 2.4%. No history of antenatal checkup visits of mothers during pregnancy were recorded. The adaptation of family planning materials and methods among the mothers were found to be very negligible.

I . INTRODUCTION

A. Background Information:

Save the Children USA/Nepal Field Office initiated a CS VIII project in Ilakas #1, #12 and #13 of Nuwakot District, Nepal, effective October 1992. The 14 VDCs of these ilakas include:

Ilaka #1:

- | | | |
|-------------|------------|----------|
| 1. Mahakali | 2. Sikre | 3. Likhu |
| 4. Chhap | 5. Talakhu | |

Ilaka #12:

- | | | |
|----------------|----------------|---------------|
| 1. Ralukadevi | 2. Sundaradevi | 3. Sikharbesi |
| 4. Samundratar | 5. Balkumari | |

Ilaka #13:

- | | | |
|----------------|--------------|--------------|
| 1. Ghyangphedi | 2. Gaukharka | 3. Rauthbesi |
| 4. Beteni | | |

These VDCs have a total of 38,098 population with 18,934 (49.7%) females and 19,164 (50.3%) males. Approximately 3,810 are children under two years and 5,334 are children under five years of age. There are 7,696 women between the ages of 15 and 44 years.

SC/US will replicate lessons learned from over ten years of community development experience in Nepal to create a sustained increased demand for child survival services in the region. The project will focus on sustainability through the strengthening of women's groups and the integration of child survival initiatives (EPI, Diarrheal Disease Management, Maternal Health, AIDS Prevention, ARI, and Vitamin A) with a broad range of non-formal education activities, especially Literacy and Early Childhood Education and Nutrition. Child survival messages will be taught through Basic and Advanced Literacy Classes, Child Care Cooperatives, Parenting Classes (for both fathers and mothers), Mothers' Groups (initiated previously by the Ministry of Health), and Women's Savings Groups for production credit (established from the Advanced Literacy Classes). Child survival messages will also be taught in a Child to Child Program. The service delivery systems of the DPHO will be strengthened through intensive training for DPHO and health clinic staff, local health volunteers (CHVs and TBAs) and community leaders. Support will be extended to mobile health clinic camps that provide regular childhood and maternal immunization services.

The goal of the project is to bring sustained reduction in infant, child and maternal mortality and morbidity in the region by empowering families to address their health, educational and developmental needs and by creating an increased demand for improved government health services.

To accomplish the above goal within the October 1, 1992 to September 30, 1995, time frame, SC/US received US \$385,231 from A.I.D. which was matched by US \$128,274 from SC/US. The total budget of US \$513,482 is allocated over a three year period with the yearly amounts totaling \$187,639, \$168,954 and \$156,889 respectively.

B. Objective of the Survey:

A population based sample survey is a very popular method of obtaining rates and measuring situation and changes pertaining to health related matters. It is a very important component of the health information system. Restricting the sample to mothers of children less than 24 months of age not only helps to establish or ascertain the child survival situation of the area but can later rapidly measure the project's achievements and accomplishments in terms of its maternal and child health care interventions.

With this rationale, the following objectives of the survey were established:

- o To do a rapid appraisal of the area to obtain information on health, education and economy in order to better plan CS VIII activities in the region.
- o To establish benchmark information about various aspects of health, education and economy to help easily conduct future impact evaluation of the project.
- o To study the level of knowledge and practices (K&P) of the mothers (15 - 45 age) of children under two years on the following aspects of health:
 - breast-feeding, weaning, growth and primary health care;
 - maternal health care;
 - diarrheal diseases and ORS;
 - childhood and maternal immunization;
 - ARI and childhood diseases;
 - sanitation and hygiene; and
 - birth spacing and family planning.
- o To assess the immunization coverage rates of BCG, DPT, Measles, Polio and TT.
- o To learn the prevailing practices and level of awareness among mothers regarding income generating activities, natural resource conservation, and nutritional vegetables and horticulture cultivation.

C. Schedule of Activities:

- | | |
|----------|--|
| Oct `92 | SC/US staff prepares for the survey, which includes: gathering population-based data for the selection of 30 random cluster sites, selecting supervisors and interviewers, determining costs and logistics of both training for and conduction of the survey together with designing the questionnaire and pretesting the questionnaire. |
| Nov 1-15 | Finalization of questionnaire, time frame, logistics and sample selection. |

Nov 16 Travel to the field.

Nov 17 Meeting with district officials at Trishuli Bazaar.

Nov 18-22 Training of supervisors and interviewers, and field practice of survey.

Nov 23-30 Field survey of 14 VDCs of the targeted program area.

Dec 1-5 Hand tabulation of survey results and dissemination of preliminary findings to SC/US Nuwakot staff.

Dec 6 Travel to Kathmandu.

Dec 7-31 Dissemination of survey findings by SC/US Nuwakot staff to district and VDCs' officials.

Dec 7-31 Report writing and data analysis.

Jan 8 Draft report completed.

February '93 Final copy of the report printed and distributed.

II . METHODOLOGY

A. The Questionnaire:

The questionnaire, which contains 70 questions, was designed to collect information from mothers of children under 24 months of age. The questions were based on a standardized survey format which A.I.D. requires of all PVO CS projects. SC/US NFO further refined the standardized survey questionnaire customizing in accordance with its CS VIII project interventions and the project area.

The questionnaire contains the following focused topics:

<u>Questions #</u>	<u>Focused Topics</u>
1 - 9	Identity of mother and child, family background, mother's literacy, most serious child health problems, breast-feeding and weaning practices.
10 - 14	Child's attendance at growth monitoring sessions, distribution of vitamin A supplements and night-blindness cases.
15 - 31	Diarrheal disease and management of the child with diarrhea.
32 - 34	Hygiene and sanitation.
35 - 40	Immunization status of the child.
41 - 48	Prenatal care and family planning.
49 - 53	ARI disease and management of the child with ARI.
54 - 55	Horticulture and kitchen gardening practices.
56 - 57	Resource conservation practices.
58 - 61	Income generating activities.
62 - 70	Child rearing practices.

Please see Appendices B & C for the English and Nepali versions of the questionnaire that was used in the survey. The questionnaire was based on the CS III final survey's and CS VII baseline survey's questionnaires.

B. Determination of Sample Size:

Sample sizes were calculated with the following formula:

$$n = z^2 (pq) / d^2$$

where n = sample size; z = statistical certainty chosen; p = estimated prevalence/coverage/level to be investigated; q = 1-p; and d = precision desired.

The value of p was defined by the coverage rate that requires the largest sample size (p = .5). The value d depends on the precision, or margin of error, desired (in this case d = .10).

The statistical certainty chosen was 95% ($z = 1.96$). Given the above values, the needed sample size (n) determined is:

$$\begin{aligned}n &= (1.96 \times 1.96) (.5 \times .5) / (.1 \times .1) \\n &= (3.84) (.25) / .01 \\n &= 96\end{aligned}$$

It takes much time to randomly select an identified individual from the survey population and then perform this selection 96 times to identify a sample of $n = 96$. Time can be saved by doing a 30-cluster sample survey in which several individuals within each cluster are selected to reach the required sample size. However, in order to compensate for the bias which enters the survey from interviewing persons in clusters rather than as randomly selected individuals, experience has shown that a minimum sample of 210 (7 per cluster) should be used given the values of p , d and z above (Henderson, et.al., 1982).

The estimate of confidence limits for the survey results were calculated using the following formula:

$$95\% \text{ confidence limit} = p \pm z (\text{square root of } \{ pq / n \})$$

where: p = proportion in population found from survey; z = statistical certainty chosen (if 95% certainty chose, that $z = 1.96$); $q = 1 - p$; and n = sample size.

EXAMPLE: If the proportion of children in the survey who were completely and correctly immunized is 37% and $n = 297$:

$$95\% \text{ confidence limit} = .37 \pm 1.96 (\text{square root of } \{ .37 \times .63 / 297 \})$$

$$(z = 1.96)$$

$$1.96 = .37 \pm .03 (34\% \text{ to } 40\%)$$

In other words, we are 95% sure that the actual proportion of children in the survey area who are completely and correctly immunized is between 34% and 40%.

C. Selection of Sample:

The sample consisted of 210 women with children 0-23 months of age of the entire 14 VDCs of the project area. Seven households were selected in each of 30 selected wards (for cluster sites, see Appendix - F) following the process described in a manual titled The EPI Coverage Survey published by WHO, Geneva, Oct. 1988.

Before the survey teams reached the designated wards, the clusters were further subdivided into villages. Villages are traditional units for which population-based data are not available. One village was randomly selected as the community within each ward to be surveyed. The initial household surveyed in the village, as well as the direction to go from the initial household, was also randomly selected.

D. Training of Supervisors and Interviewers:

The SC/US survey team had pre-selected 12 supervisors from its Nuwakot field office staff. A total of 33 interviewers were hired from the local area including two that were brought from Kathmandu. Interviewer qualifications included SLC pass (high school equivalent) with fluency in both written and spoken Nepali language. The majority of interviewers selected were females because of the nature of the survey.

The training of supervisors and interviewers took place in a five day session (see Appendix - E). The training was facilitated by Mr. Ravindra Thapa, CS VIII Project Coordinator. The training was actively participated in by all the 12 supervisors and by the survey coordinators who took turns conducting trainings within given topics of the training.

The designing of the training was facilitated by Mr. Navin Pyakuryal, Health Research and Training Coordinator, who was actively involved in the first two days of the training. Mrs. Chanda Rai, Public Health Coordinator; Mr. Udaya Chandra Manandhar, Education Program Officer; and Mrs. Sashi Rijal, Productivity Program Officer; were also present during the first two days of the training sessions. They helped the team clarify various technical concepts and survey objectives and methodology. Mrs. Narmaya Limbu, Deputy Public Health Coordinator, went through all the training sessions including the field practice to help the team comprehend the questionnaire and assist with other survey issues.

Day one of the training was dedicated to training the supervisors. The session primarily emphasized sample size calculation and the 30 cluster sample site selection, along with survey objectives and methodology.

From day two onwards, the training included both supervisors and interviewers. Day two was dedicated to introductions, survey objectives and methodology. Day three included a session on interview technique with demonstrations of good and bad interview techniques. Day four and five were dedicated to questionnaire discussion, field practice, logistics distribution and field deployment.

E. Conducting the survey:

The household interviews were conducted over eight days, from November 23 to 30. The 30 cluster sites were distributed equally among 14 VDCs of Ilakas #1, #12 and #13, its area stretched from the southern high hills bordering Kathmandu District to the far northern isolated foothills of Himalayan mountains having approximate elevation starting from 4,000 or 5,000 feet to a maximum of 13,000 feet. In most cases, more than 4 days of the field survey were spent traveling with overnight stays because of this rugged terrain accessible only by difficult walk and trek.

Interviewers and supervisors were grouped at a 2:1 ratio in most cases, and for more difficult and remote areas it was arranged at 3:1 just for accompanying and security reasons (see Appendix - D). The teams were deployed for good on November 23 to return only after the completion of the survey in their assigned cluster's area. The supervisors were given total responsibility for the survey and interviewers including the authority to hire and fire interviewers as deemed necessary. The supervisor of each team was responsible for the selection of the starting household and the direction in each cluster. Supervisors could observe less than 50% of the interviews conducted each day by each interviewer. However, the supervisors checked whether the completed questionnaires were properly filled out before leaving the survey area so that a mother could be visited again in case of missing or incomplete response.

The Survey Coordinator checked every completed questionnaire of each team after they returned from their assigned cluster to ensure that all the information and recorded responses were intact and complete. In some cases, a supervisor and interviewers had to return to their area to obtain information missing from questionnaires. In order to ensure the confidentiality of individual mothers' responses, the Survey Coordinator safely compiled and filed the questionnaires keeping away as much as possible from SC/US staff, team members and local people.

F. Method for data analysis:

The Survey Coordinator designed the tabulation forms when all the team members were away doing the field survey. The compiled tabulation forms were distributed to all the groups of supervisors and interviewers on hand tabulation day. Each participant involved in hand tabulation was given responsibility to compile at least 3 to 4 forms depending on the nature of the information to be tabulated. A group totalling 45 people consisting of supervisors and interviewers were involved in this work. Some supervisors also helped the coordinator supervise the flow of tabulation work.

The tabulation work began on December 1 and lasted until December 5. The first two days went to giving a short training on tabulation technique and to the hand tabulation of the collected data. The tabulation training was conducted by the Survey Coordinator. The next three days were spent verifying the consistency of the data. During the last three days, some of the tabulations had to be retabulated to further verify the validity of previously outputted results that appeared doubtful. Only supervisors and the coordinator were involved in these last three days. After the first two days of hand tabulation, all the interviewers were dismissed as having completed their contract.

G. Costs:

<u>Line item</u>	<u>Description</u>	<u>US Dollars</u>
1	Per diem:	
	- Interviewers (33 x 12 days)	1,218.63
	- SC/US Supervisors (12 x 7 days)	87.09
	- SC/US Coordinator (1 x 21 days)	53.61
	- SC/US Deputy PH Coordinator (1 x 9 days)	29.80
	- SC/US Training Coordinator (1 x 10 days)	28.52
	- SC/US Program Officers (2 x 5 days)	26.80
	- SC/US Drivers (2 x 2 days)	23.35
	- SC/US PH Coordinator (1 x 5 days)	13.40
2	Questionnaire preparation and printing	269.22
3	Interviewers selection	30.00
4	Supplies	141.84
5	Printing of report -- 30 copies (estimated)	201.16
6	Miscellaneous (porters, lodging, etc.)	101.00
<hr/>		
	T O T A L:	2,224.42

Not included are the salaries paid by SC/US to its regular staff members involved in the survey.

H. Feedback:

A summary of the findings of the CS VIII baseline survey were presented to the Ministry of Health, District Public Health Officials, VDCs' members, health posts' staff, school teachers and other local concerned NGOs' staff members. The summary of findings highlighted important findings from each category of the questionnaire (see Appendix - J). The brief profile of the project area attached as an addendum also was used during the feedback and presentation session (see Appendix - I). The SC/US Public Health Coordinator and Deputy Public Health Coordinator shared findings with Kathmandu based MOH and District officials together with other interested parties at their occasionally held informal meetings. Nuwakot SC/US staff shared the findings with local VDCs' members at their monthly meetings and with other groups at meetings that were held to discuss the development plan and strategies. Feedback received from them have greatly helped to prepare the detailed implementation plan (DIP).

A copy of this report will be made available to them promptly after its completion.

III. RESULTS

MOTHER'S AGE:

Range: 15-45 years
Mean: 28.3 years
Median: 27 years

CHILD'S AGE:

The children's ages were rounded down to the nearest whole number of months (e.g., 27 days = 0 months).

<u>Child's Age in Months</u>	<u>Freq.</u>	<u>Percent</u>	<u>Cumu.</u>
0	15	7.1%	7.1%
1	2	1.0%	8.1%
2	21	10.0%	18.1%
3	18	8.6%	26.7%
4	14	6.7%	33.3%
5	6	2.9%	36.2%
6	5	2.4%	38.6%
7	16	7.6%	46.2%
8	12	5.7%	51.9%
9	7	3.3%	55.2%
10	6	2.9%	58.1%
11	6	2.9%	61.0%
12	7	3.3%	64.3%
13	6	2.9%	67.1%
14	6	2.9%	70.0%
15	7	3.3%	73.3%
16	7	3.3%	76.7%
17	6	2.9%	79.5%
18	5	2.4%	81.9%
19	9	4.3%	86.2%
20	9	4.3%	90.5%
21	6	2.9%	93.3%
22	8	3.8%	97.1%
23	6	2.9%	100.0%
TOTAL:	210	100.0%	
Sum	=	2,057.00	
Mean	=	9.80	
Standard deviation	=	7.11	

MOTHER'S EDUCATION:

96.2% of mothers did not go to school and do not read.

96.7% report being illiterate (includes those who received some schooling).

Only 8 of 210 mothers went to school.

1 mother learned to read outside of school.

MOST SERIOUS CHILD HEALTH PROBLEM IN THE COMMUNITIES:

36.7% of mothers thought that diarrhea was the most serious child health problem in the community.

28.1% of mothers thought it was fever.

24.8% of mothers thought it was cough.

8.6% of mothers thought there were other problems.

1.9% of mothers thought it was skin diseases.

LACTATION AND NUTRITION:

95.7% of mothers reported breast-feeding their under 2 year old child now.

Only 6 of the 9 mothers not now breast-feeding reported bottle-feeding their under 2 year old child.

49.5% of mothers reported mixing additional fat (ghee) into their child's solid food.

39.1% (82 out of 210) correctly responded that solid foods should be started between 4-6 months.

23.8% of mothers thought solid foods should be added earlier than 4 months.

35.7% of mothers thought solid foods should be added later than 6 months of age.

FOOD SUFFICIENCY:

Of the 210 households interviewed, 47.1% reported that their harvest lasts more than 9 months, 28.1% reported that it is sufficient for less than 6 months, and the remaining 24.8% reported it lasts between 6 and 9 months.

GROWTH MONITORING:

94.3% of mothers do not have a growth monitoring (GM) card for their under 2 year old child.

5 of the 210 mothers reported having lost the growth monitoring card of their child.

None of the children with a GM card (7 of 210) had been weighed in the past 3 months.

None of the children with a GM card had received a vitamin A capsule.

Only 8 of the 210 mothers reported having observed some kind of night-blindness problem in their children.

DIARRHEAL DISEASES:

92 (43.8%) out of 210 mothers reported that their child had diarrhea during the two weeks before the survey.

Feeding practices during diarrhea:

Breast-feeding: Percentages are based on 92 mothers reporting her child had an episode of diarrhea.

Only 6.5% of mothers reported breast-feeding **MORE** than usual during diarrhea.

81.5% of mothers reported breast-feeding the **SAME** as usual during diarrhea.

8.7% of mothers reported breast-feeding **LESS** than usual during diarrhea.

Fluids: Only 4.4% of mothers reported giving **MORE** fluids than usual during diarrhea.

35.9% of mothers reported giving fluids **SAME** as usual.

15.2% of mothers reported giving **LESS** fluids than usual.

13.0% of mothers reported **STOPPING** fluids completely during diarrhea.

The remainder of mothers (31.5%) reported they were exclusively breast-feeding.

Solid Foods: Only 1.1% of mothers reported giving **MORE** solid foods during diarrhea.

37.0% of mothers reported giving the **SAME** solid foods as usual.

16.3% of mothers reported giving **LESS** solid foods than usual.

14.1% of mothers **STOPPED** solid foods completely.

The remainder of mothers (31.5%) reported they were exclusively breast-feeding.

Oral Rehydration Therapy (ORT) Given:

42.9% of mothers (of 92 reporting diarrhea) reported not giving any treatment when their children had diarrhea.

Only 5.1% of mothers reported treating their children with diarrhea medicine.

Only 4.1% of mothers reported giving other fluids during diarrhea.

30.6% of mothers reported treating their child's diarrhea with traditional healers and methods.

17.3% of mothers (of the 92 reporting diarrhea) reported giving ORT during diarrhea (12.2% Jeevan Jal and 5.1% sugar-salt solution).

9 of the 12 mothers who reported treating her child with Jeevan Jal reported obtaining the Jeevan Jal from either Health Post or Hospital, 2 reported purchasing from local shop and 1 reported obtaining from Women's Group.

6 of the 12 mothers who reported treating her child with Jeevan Jal knew the correct amount of water to be mixed to prepare the solution.

7 of the 12 mothers who reported treating her child with Jeevan Jal reported having consulted with Hospital, Health Post or Village Health Worker.

What actions should be taken by mother for child's diarrhea:

16.0% of 210 mothers reported having no idea what actions should be taken at the time of their child's diarrhea.

8.2% of mothers reported that they should go to the hospital or health post for advice or treatment during child's diarrhea.

26.2% of mothers reported that they should treat their children with ORT during diarrhea (18.0% Jeevan Jal and 8.2% sugar-salt solution).

43.9% of mothers reported treating their child's diarrhea with traditional healers and methods.

The remaining of 5.7% mothers gave multiple answers.

Recovery from diarrhea:

Only 47.2% of mothers know appropriate feeding practices after diarrhea, i.e., smaller, more frequent feeding, more high energy foods, and more food than usual.

13.4% of mothers reported that they DO NOT KNOW what they should do when their child is recovering from diarrhea.

39.4% of mothers reported using other methods, chiefly following traditional ways of treatment.

32.9% of mothers (of 210) reported NOT HAVING HEARD of Jeevan Jal.

68.2% of mothers (of 129) who reported having heard of Jeevan Jal, excluding those who had used the product while their child had diarrhea, DID NOT know the correct amount of water to add to prepare the solution.

HYGIENE AND SANITATION:

Of the 210 households interviewed, only 49 households were found to have pit-latrines.

55.9% of 161 households without a pit-latrine remarked that it was not necessary or needed, 11.8% responded that they do not have the skills to construct one, 4.4% responded that they had not thought to construct one so far and the remaining gave multiple responses.

176 of the 210 mothers reported washing their hands AFTER eating, 195 BEFORE eating, 135 after touching filth and 92 after defecating. Most mothers gave multiple answers.

Of the 210 mothers, 57 (20.8%) reported that they DO NOT KNOW what causes diarrhea, 42 reported careless wastes disposal, 30 reported contaminated water, 25 reported dirty hand, 16 reported careless defecation, and 8 women reported various superstitious beliefs regarding causes of diarrhea. Most mothers gave multiple answers.

IMMUNIZATION:

46.7% of 210 mothers reported that their children have received immunization.

When asked about the appropriate age of measles immunization, 22.4% answered correctly (9 months), 15.7% answered incorrectly, and 61.9% of mothers could not give an answer.

Maternal Tetanus Toxoid (TT) Immunization:

10.5% of mothers report TT will protect either mother or child.

79.5% of mothers do not know why TT should be given.

39.6% of mothers knew that at least 2 doses of TT are needed to protect the mother and child.

18.6% of mothers do not know the number of TT doses needed to provide protection.

Child Immunization:

19.5% of mothers could show an EPI card for their child.

15.2% reported losing EPI card.

65.2% reported never having had an EPI card.

SUMMARY OF IMMUNIZATION COVERAGE:

0-3 Months:

7.1% with card
5.4% BCG coverage

4-11 Months:

26.4% with card
26.4% BCG coverage
4.2% DPT-3 coverage
4.2% Polio-3 coverage

DPT Dropout = 15.8%
Polio Dropout = 15.8%

12-23 Months:

23.2% with card
2.4% DPT-3 coverage
2.4% Polio-3 coverage
21.9% BCG coverage
11.0% Measles coverage

DPT Dropout = 12.5%
Polio Dropout = 12.5%

Complete coverage (12-23 months) = 2.4%

MATERNAL HEALTH:

NONE of the mothers could show a maternal health card, 9 out of 210 reported losing her card.

201 (95.7%) mothers reported never having had a maternal health card.

Maternal TT:

7.1% of 210 mothers had received two or more doses of TT.

6.2% of mothers had received one dose of TT.

It should be noted that TT dose information was obtained from mothers' TT and her child's EPI or GM card, whichever had the most complete information.

Family Planning:

20 (9.5%) mothers reported being pregnant at the time of the interview.

Of 190 mothers who were not pregnant, 18 desire a pregnancy within the next 2 years.

Of the 172 mothers who did not want or did not know if they wanted to be pregnant, only 14 women (8.1%) are using family planning methods.

Of the 14 women using family planning methods, 11 reported adopting temporary methods and 3 reported permanent ones.

ACUTE RESPIRATORY INFECTION (ARI):

92 (43.8%) out of 210 mothers reported their child had cough and difficulty breathing during the last 15 days before the survey.

89 (96.7%) out of 92 mothers reporting ARI observed rapid and difficulty breathing in their child.

51 (55.4%) out of 92 mothers reporting ARI reported seeking treatment for their child.

Of the 51 mothers who reported seeking treatment for their ARI child, 12.9% reported referring to trained health workers, hospital, health post or doctor; 5.9% reported referring to medical shop; 29.7% traditional or faith healer; 12.9% relatives and friends; and others gave multiple responses.

Of the 51 mothers who reported seeking treatment, 14.0% DID NOT have any knowledge of ARI's symptoms; 23.7% reported it is fever; 21.2% thought it is cough; 18.2% thought rapid and difficult in breathing; 8% loss of appetite; 6.6% abdominal respiration; and the remaining gave multiple answers.

HORTICULTURE & KITCHEN GARDENING:

89 (42.4%) out of 210 sample households reported having planted fruit trees in their gardens. The major fruit trees that were grown by these households include banana, guava, grapefruit, orange, mango, peaches, pears and other citrus, like lemon and lime.

47.1% of 121 households without fruit trees remarked that because of inadequate landholdings they have not grown any fruit trees; 33.1% remarked on the unavailability of saplings; and the others gave multiple answers.

Of 210 mothers, 194 (92.4%) of them were found to be growing winter vegetables. The winter vegetables included broad-leaf mustards, pumpkins, onions, garlic, shallot or *chhyapee*, and cauliflower.

RESOURCE CONSERVATION:

120 (57.1%) out of 210 sample households reported having planted fodder trees on their farmland.

205 (97.6%) out of 210 sample households reported NOT having smokeless stoves.

Of the 205 households without smokeless stove, 46.8% responded not having heard of the stove, 14.1% reported that they did not find it necessary to construct, 29.3% reported not having the skills to construct, and 9.9% gave multiple responses.

CHILD REARING:

Of the 210 mothers when asked where do you leave your child when you have to go for outdoor activities, 42.9% reported at home, 40.5% reported keeping them in a cradle at home, 13.3% reported taking them along, and the remaining gave multiple responses.

Of the 210 mothers when asked who looks after your child during morning and evening spare time, 41.4% reported by themselves, 28.6% reported grandparents, 24.8% reported by their siblings, and the remaining gave multiple responses.

127 (60.5%) of 210 mothers thought children's sports is important for their child's growth.

Of the 127 mothers who reported children's sports is important, 71.7% thought it is important for the physical development and 7.9% thought it is important for child's mental growth.

28.1% of 210 mothers were not found to provide any play materials to their children.

Note: Please refer to summary of findings attached to this report as an addendum to get a quick view of the findings together with other miscellaneous analyses which might be of interest.

IV. DISCUSSION & RECOMMENDATIONS

A. NUTRITION & VITAMIN A:

Although breast-feeding is found to be widely practiced in the project area, the mothers' knowledge and practices regarding supplemental foods are found to be very inadequate. In order to increase awareness and the use of nutritious foods, focus should be shifted towards educating mothers about using locally available produce in preparing appropriate foods for children and pregnant mothers. The education and training also needs to emphasize feeding time intervals, hygiene and sanitation factors involved in preparing foods and feeding practice, food quality and quantity required for age specific mothers and children for easy digestion.

Objectives:

- a) 70% of mothers will know to give supplementary foods to their 4-6 months old child.
- b) 40% of children under 5 years will receive vitamin A supplementation every 6 months.

Strategies:

- a) Conduct a focus group survey to find ways and means of promoting the use of locally available nutritional foods.
- b) Conduct regular trainings to mothers' groups on the use and preparation of weaning foods and appropriate foods for pregnant mothers.
- c) Nutrition education will be provided to mothers' groups, women's groups, NFE participants and mothers coming to MCH clinics. Vitamin A rich foods will be emphasized in these nutritional messages.
- d) Street dramas will be organized occasionally in the various project areas to promote good nutrition.
- e) Develop a plan for growth promotion interventions in coordination with DPHO and Health Posts including development of IEC methods and materials.
- f) Support DPHO in establishing vitamin A supplementation program.
- g) Conduct technical trainings to DPHO/HP staff, CHVs, TBAs, and community participants in prevention and treatment of vitamin A deficiency including the promotion of kitchen gardens.

B. DIARRHEA:

Outbreaks of diarrhea and dysentery are common throughout such remote areas of the country every year, especially during the monsoon season. The survey findings reveal that 35.7% of mothers think that diarrhea is the most serious child health problem in their community, and that 43.8% of the respondents' children had diarrhea during the last 15 days before the survey.

The knowledge and practices of mothers regarding diarrhea and treatment are inadequate, i.e., 42.9% of mothers reported seeking no treatment for their child's diarrhea and 30.6% reported having relied on traditional methods. For this reason, the project will focus on educating families about prevention and rehydration therapy for diarrhea and dehydration. These interventions will be planned and implemented in collaboration with the DPHO.

Objectives:

- a) 50% of families with children under 2 years will know how to prepare and administer Jeevan Jal (ORS) correctly.
- b) 25% of children under 2 years with diarrhea in past 2 weeks will be treated with Jeevan Jal.

Strategies:

- a) Conduct focus group survey on the knowledge and use of Jeevan Jal.
- b) Collaborate with the DPHO to conduct a needs assessment of diarrheal disease management at community and health post levels.
- c) Coordinate with the DPHO to develop a plan for CDD interventions at community and health post (HP) levels.
- d) Discuss with the DPHO and HP staff about the availability of Jeevan Jal at HP and community levels.
- e) Develop a plan for a community-based CDD health education program. Messages developed through CS III program will be used in the project area.
- f) Correct use and preparation of Jeevan Jal demonstrations will be held during MCH clinics, NFE classes and during various group meetings including mothers' groups and women's groups' meetings. Although Jeevan Jal will be much more emphasized, the cereal-based rice water or porridge with salt will be equally encouraged as initial home fluid.
- g) Train VHWS, CHVs, TBAs, NFE Supervisors and Mothers' Group members on the communication of health messages, specifically the correct preparation and use of Jeevan Jal.
- h) Review, field test and revise as needed the diarrheal disease management curriculum for literacy classes utilized by SC/US in Gorkha District. Implement the curriculum.

- i) Review, field test, revise as needed and utilize the CDD health education materials developed by other agencies.
- j) Introduce Diarrheal Disease Management messages in the School Health Program.
- k) Review CHVs' and VHWs' reports and records to monitor CDD activities and coordinate with DPHO on surveillance of diarrheal disease.

C. EPI:

Complete immunization coverage of 12-23 month old children for BCG, polio, DPT and measles is 2.4%. This finding was not unexpected, as immunization records provided the basis for coverage calculations. Only 7.1% of women provided records indicating having had two or more doses of TT. Given these low coverage rates, EPI interventions will focus on strengthening delivery of EPI services and educating and motivating mothers for immunization.

Objectives:

- a) 40% of children 12-23 months will be completely immunized with BCG, polio, DPT and measles.
- b) 25% of women 15-45 years will receive 2 doses of TT.

Strategies:

- a) Conduct a needs assessment of EPI service delivery.
- b) Develop plan for strengthening EPI service delivery in close coordination with DPHO.
- c) Coordinate with DPHO and other agencies in mobilizing logistics, manpower and management support for the program.
- d) Provide health post staff refresher training in cold chain maintenance, sterilization, immunization and supervision techniques, and management of the EPI camps.
- c) Train VHWs, CHVs, TBAs, Mothers' Group members and NFE supervisors to educate and motivate mothers for immunization services. The message will primarily emphasize the importance of timely and complete immunization.
- d) Improve immunization coverage through Early Childhood Education (ECE) intervention, school health program, NFE and parenting classes, EPI camps and Home-based Child Care Centers.
- e) TT messages will be disseminated through school health program, women's groups, MCH clinics and NFE classes.

D. ARI:

When the mothers were asked if they observed any sign of respiratory problems such as cough and difficulty in breathing in their child during the last 15 days before the survey, the findings revealed 43.8% of mothers reporting yes. 24.8% of mothers believe that cough is the most serious child health problem in their communities. As such, an appropriate plan for ARI intervention will be developed in close coordination with DPHO and local health posts.

Objectives:

- a) 25% of families with children under 2 years will be competent at early detection of ARI.
- b) 25% of mothers with children under 2 years will refer to health posts for treatment of their child's ARI.

Strategies:

- a) Coordinate with DPHO to establish appropriate referral services through development of treatment protocol and supply system for antibiotics.
- b) Provide technical training to DPHO/HP staff on diagnosis and treatment of ARI cases.
- c) Focus group study will be conducted to develop specific ARI education messages. Promotional materials and methods will be developed according to the findings and established communication strategy.
- d) Early detection of ARI messages will be disseminated through school health program, women's groups, MCH clinics and NFE classes.

E. MATERNAL HEALTH:

Maternal health and family planning services are not commonly utilized by women. Further study is needed to identify the attitudes affecting utilization. With further information, it is anticipated that this intervention will focus on strengthening service delivery and educating and motivating women to utilize the services.

Objectives:

- a) 40% of mothers will know the three clean birth principles.
- b) 15% of eligible couples will be using temporary or permanent methods of contraception.

Strategies:

- a) Conduct focus group survey on attitudes regarding maternal health care and family planning and child spacing together with sexual behavior.

- b) Collaborate with DPHO to provide maternal health and family planning refresher training to health post staff.
- c) Train health post staff, VHWS, CHVs, TBAs, Mothers' Group members, NFE supervisors and facilitators and SC/US staff on child spacing, safe delivery practices, family planning and early childhood education.
- d) Support MCH mobile clinics in providing improved antenatal services and iron/folate supplement.
- e) Promote safe delivery practices by distributing Safe Birth Kits to Women's Groups, Mothers' Groups, CHVs and TBAs.
- f) Discuss with DPHO about the distribution of family planning devices and availability of manpower for family planning services.
- g) Coordinate with DPHO for permanent family planning service delivery and motivate eligible couples for the services.
- h) Develop plan for TBA training and supervision.

F. LITERACY:

The low literacy rate of 3.3% among interviewed mothers, female literacy rate of 6.6%, and 17.1% total literacy rate in the area demands increased opportunity for literacy training programs in the area. A literacy program in the area will support the plan to include literacy training as a child survival intervention.

Objectives:

- a) Female literacy rate will be increased to 30% of the 15-45 year female population.

Strategies:

- a) Conduct basic, advanced and out-of-school children literacy classes utilizing the standard government curriculum with active recruitment of female students.
- b) Review, field test, and revise as needed the literacy materials developed by SC/US and other agencies to use in the literacy classes.
- c) Collaborate with District Education Office (DEO) to increase women's literacy and with Women's Development Division to promote leadership skills and MCH/CS protective behaviors.
- d) Conduct non-formal education classes for CHVs, TBAs, and other women.
- e) Emphasize the EPI, ORT, MCH (including AIDS), and nutrition messages in the NFE curriculum.

- f) Involve women's groups from advanced classes in savings and revolving fund programs for the promotion of small enterprise development programs and income generating activities.

G. WOMEN'S DEVELOPMENT:

The low percentage (13.8%) of women reporting participation in income generation activities stimulated interest in adding Women's Development intervention to the project. The project will support formation of many Women's Groups, Pressure Groups, Saving Groups and Credit Groups in each Ilaka of the project area to carry out some economic development activities.

Strategies:

- a) Provide Mothers' Group and other groups members a training on maternal and child care, nutrition, and leadership and management skills.
- b) Coordinate with local women's development NGOs and GOs such as Nari Bikas Kendra to initiate women development activities.
- c) Assist Women's Group members in studying the feasibility of marketing locally made or available materials.
- d) Coordinate with local banks to obtain loans for Women's Group members to initiate small enterprises.

H. STD/AIDS:

The Nuwakot District has boosted growing concern and awareness at the national level as the region beginning to report some cases of AIDS. The trafficking of women to brothels in the big cities of India and Nepal is an increasingly common trend of the District from the past, that has propelled it to be most unpopular in the country. The CS VIII project area is not an exception in this regard. The continual resettlement of returning prostitutes, with STD and HIV virus, in the area has created this situation. Men engaged in migratory wage labor also adds to aggravate the situation. With a view to address the problem of the project area, SC/US has sought a WHO grant to incorporate the STDs and AIDS program in its CS VIII project. The one year grant program is designed to conduct many STD camps in the area that will help increase awareness of people about AIDS and prevention of STDs. The beneficiary population of the program is targeted to high-risk groups such as returning prostitutes and reproductive age group, especially non-condom users of the entire CS VIII project area. In this respect, SC/US conducted a K&P baseline survey during this survey, sampling 210 males and 210 females between 15-45 years old of the project area.

I. EARLY CHILDHOOD EDUCATION (ECE):

Due to very little or non-existent stimulation provided by parents for their child's growth and development, as revealed by the survey, the CS VIII project will launch an experimental Early Childhood Education (ECE) program linked with EPI and nutrition. In close collaboration with the District Education Office (DEO) the program will examine the possibilities and feasibility of establishing home-based child care cooperatives directed to provide sustainable day care for children, organizing parenting classes for fathers and mothers groups, and a child-to-child program. All members of these groups will receive training on EPI, MCH, breast-feeding, use of weaning and supplementary foods, and growth monitoring.

Objective:

- a) 20% of families will be trained in healthy and stimulating child care practices.

J. MID-TERM EVALUATION:

A mid-term evaluation will be conducted by the SC/US team after one and a half years of project time period, following a 30 cluster sample method.

Objective:

- a) To assess change in K&P and provide baseline information on indicators not included in the baseline survey.
- b) To create rigorous and appropriate benchmark information to supplement this survey data so as to effectively measure the project's impact through the final evaluation.

Strategies:

- a) Conduct a survey using a questionnaire strictly following A.I.D. CS projects' standard format.
- b) Establish a mutual agreement between all the parties concerned, including SC/US staff, regarding findings that can determine a basis from where a comparison can be made in the future of the project's impact through final evaluation.

CONCLUSION:

To carry out these activities effectively, monitoring, supervision and follow-up components of the project will be emphasized and will be given increased importance. To this effect, various record keeping tools at different levels will be designed to establish a workable health information system. This will be achieved by adopting the forms and procedure developed by MOH and by strengthening its utilization. Also, IEC activities will be put at priority to disseminate knowledge and information regarding appropriate maternal and child care and family practices together with promotion of various other development activities.

V. LESSONS LEARNED

The following important lessons can be drawn from this baseline survey:

- o The scope of the survey along with a tentative questionnaire should be prepared well ahead of time. This will allow feedback to be obtained from concerned personnel of the donor agency; SC/US home, country and field offices' senior staff; and some research professionals. This will considerably help to shape and enhance the survey.
- o About 150 extra final questionnaires should be printed along with those that are to be directly used in the survey. While printing the questionnaire, consideration should be given to factors such as number of interviewers and supervisors that will use how many copies of the questionnaire during the training session and field practice time, and how many extra copies are needed to be given to the survey team before they go away to the field. It is no problem to print more, but is a big problem if the questionnaires run out during the survey time.
- o Interviewers should be hired totally from the local area since interviewers brought from Kathmandu and other places will add to extra costs and unnecessary hassles. The few interviewers brought in from outside may enjoy more benefits than their locally hired counterparts, creating a conflicting situation among interviewers. If interviewers need to be hired locally, then hire entirely local people; otherwise bring all the interviewers from outside. The interviewers no matter what should be treated equally.
- o Limit the magnitude of information to be acquired through sample size survey restricting to a specific targeted group, such as mothers of children less than 24 months. The survey can be used to generalize about the specific group of people for the whole area, but can not be used to generalize about the entire population. To obtain the literacy rate, economic status or demographic information of the entire population through this type of survey may not suit the purpose because the data will be considerably skewed. For example, demographic data may project a higher population figure because our targeted household will always be couples with children; the survey will skip households having only couples, young or old, not having any babies, as well as the separated or divorced.

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Questionnaire in English

S.No: _____

Save the Children USA
 Child Survival Baseline Survey
 Questionnaire

All questions are to be addressed to a mother (women 15-45 years old) with a child under two years old (less than 24 months).

Interview Date: _____
 Reschedule Interview Date: _____

Interviewer Name: _____
 Name of Supervisor: _____

1. Name and age of the mother

Name _____ Age (completed years) _____

2. Name and age of the youngest child under two years old

Name _____ Age (completed months) _____

Village Name _____ Ward # _____

VDC _____

Mother's Education

3. What was the highest educational level you attained?

- a. None, does not read []
 b. Went to primary school but cannot read []
 c. Went to primary school and can read []
 d. Went to secondary/high school []
 e. No schooling but knows how to read []

5. What is the most common or most frequent disease your children have?

- a. Diarrhea
- b. Fever
- c. Cough
- d. Skin Infections
- e. Other

6. Are you breast-feeding (name of the child)?

- a. Yes
- b. No

7. Do you bottle-feed (name of the child)?

- a. Yes
- b. No

8. Do you supplement your child's (name of the child) foods with additional ghee (fat/butter)?

- a. Yes
- b. No

9. When should a mother start feeding solid and semi-solid foods to a child regardless of milk?

- a. Start adding earlier than 4 months
- b. Start adding between 4 and 6 months
- c. Start adding 6 months or later
- d. Don't know

Child's Growth and Development

10. Do you have a growth monitoring card for your child (name of the child)?

- a. Yes -- check the card
- b. Lost -- go to Q. #14
- c. No -- go to Q. #14

11. Check the child's growth monitoring card to see if the child was weighed during the last three months.

- a. Yes
- b. No

12. Check the child's growth monitoring card to see if the child was given Vitamin A in the past.

- a. Yes
- b. No -- go to Q. #14

13. If the child was given Vitamin A record the date when the vitamin was given.

Dose	Day	Month	Year
Ist			
IIInd			
IIIrd			
IVth			

14. Have you observed any of your children having visual problems during night or in the darkness?

- a. Yes
- b. No

Diarrheal Diseases

15. Has (name of the child) had diarrhea during the last 15 days?

- a. Yes
- b. No -- go to Q. #25

16. During (name of the child's) diarrhea did you breast-feed (read the choices to the mother)?

- a. More than usual?
- b. Same as usual?
- c. Less than usual?
- d. Stopped completely?
- e. Discontinued long back?

17. During (name of the child's) diarrhea did you provide (name of the child) with fluids other than breast milk (read the choices to the mother)?

- a. More than usual?
- b. Same as usual?
- c. Less than usual?
- d. Stopped completely?
- e. Exclusively breast-feeding?

18. During (name of the child's) diarrhea did you provide (name of child) solid or semi-solid foods (read the choices to the mother)?

- a. More than usual?
- b. Same as usual?
- c. Less than usual?
- d. Stopped completely?
- e. Exclusively breast-feeding?

19. When (name of the child) had diarrhea, what treatments, if any, did you use? (multiple answers possible)

- a. Nothing
- b. Jeevan Jal
- c. Sugar-salt solution
- d. Other fluids
- e. A medicine
- f. Other

If no response to Jeevan Jal, go to Q. #25

20. If answer is Jeevan Jal, from where did you get it? (multiple answers possible)

- a. Shopkeeper
- b. Health post
- c. Clinic
- d. Hospital
- e. Women's group
- f. Other, specify

21. How much water do you mix with one packet of Jeevan Jal?

- a. 6 tea glasses of water
- b. 2 *manas*
- c. 1 liter
- d. Don't know
- e. Other, specify

22. When (name of the child) had diarrhea, did you seek advice or treatment for the diarrhea?

- a. Yes
- b. No

-- go to Q. #25

23. From whom did you seek advice or treatment for the diarrhea of (name of the child)? (multiple answers possible)

- a. Hospital
- b. Health center/clinic/post
- c. Private clinic/doctor
- d. Pharmacy
- e. Village health worker
- f. Traditional birth attendant
- g. Relatives and friends
- h. Traditional/Faith healer
- i. Other, specify

24. What signs or symptoms would cause you to seek advice or treatment for (name of the child's) diarrhea? (multiple answers possible)
- a. Don't know
 - b. Vomiting
 - c. Fever
 - d. Dry mouth, sunken eyes and decreased urine output
 - e. Diarrhea of prolonged duration
 - f. Blood in stool
 - g. Loss of appetite
 - h. Weakness or tiredness
 - i. Other, specify _____
25. What important actions you should take if (name of the child) has diarrhea? (multiple answers possible)
- a. Don't know
 - b. Contact salesperson Name _____
 - c. Take the child to health post/hospital
 - d. Give more to drink than usual
 - e. Give smaller but more frequent feeding
 - f. Give Jeevan Jal
 - g. Give sugar-salt solution
 - h. Withhold fluids
 - i. Withhold foods
 - j. Other, specify _____
26. What important actions should a mother take when a child is recovering from diarrhea? (multiple answers possible)
- a. Don't know
 - b. Give smaller but more frequent feeds
 - c. Give more food than usual
 - d. Give food with high calorie content
 - e. Other, specify _____
27. Have you ever heard of Jeevan Jal?
- Mark "YES" if Jeevan Jal is mentioned in Q. #19 and skip to Q. #32.
 - Mark "YES" if Jeevan Jal is mentioned in Q. #25 and skip to Q. #31.
- a. Yes
 - b. No -- go to Q. #32
28. What is it used for?
- a. To prevent dehydration
 - b. For diarrhea cases
 - c. Don't know
 - d. Other, specify _____

29. Have you ever used Jeevan Jal?
 a. Yes []
 b. No [] -- go to Q. #31
30. How much water did you mix with one packet of Jeevan Jal?
 a. 6 tea glasses of water []
 b. 2 *manas* []
 c. 1 liter []
 d. Other, specify [] _____
31. How much water do you have to mix with one packet of Jeevan Jal?
 a. 6 tea glasses of water []
 b. 2 *manas* []
 c. 1 liter []
 d. Other, specify [] _____
 e. Don't know []

Hygiene and Sanitation

32. Do you have a pit-latrine in your house?
 a. Yes []
 b. No []
- If no, why not?
- a. Not necessary/needed []
 b. No skill to construct []
 c. Not thought to construct so far []
 d. Other, specify [] _____
 e. Don't know []
33. When do you wash your hands? (multiple answers possible)
- a. After toilet []
 b. Before meal []
 c. After meal []
 d. After touching any filth []
 e. Before cooking []
 f. Other, specify [] _____
34. What do you think are the causes of diarrhea and dysentery?
 (multiple answers possible)
- a. Contaminated water []
 b. Dirty hands []
 c. Careless defecation []
 d. Superstition beliefs []
 e. Careless waste disposal []
 f. Don't know []
 g. Other, specify [] _____

EPI

35. Have you immunized (name of the child)?
- a. Yes []
 b. No []
 c. Don't know []
36. At what age should a child be immunized against measles?
- a. Months in figure []
 b. Don't know []
37. Why should a mother be given tetanus toxoid shot during pregnancy?
- a. Protect both mother and child from tetanus []
 b. Protect mother from tetanus []
 c. Protect child from tetanus []
 d. Don't know [] -- go to Q. #39
 e. Other, specify [] _____
38. How many tetanus toxoid shots should a mother be administered during the time of pregnancy to protect a newborn baby from tetanus?
- a. One []
 b. Two []
 c. More than two []
 d. None []
 e. Don't know []
39. Do you have an immunization card for the child (name of the child)?
- a. Yes [] -- check the card
 b. Lost [] -- go to Q. #41
 c. No [] -- go to Q. #41
40. Check the immunization card and record the vaccinations given to the child (name of the child).

Vaccination	Dose:		
	Ist	IIInd	IIIrd
DPT			
Polio			
BCG			
Measles			

Maternal Health & Family Planning

41. Do you have your antenatal examination health card?

- a. Yes -- check the card
- b. Lost -- go to Q. #43
- c. Don't have -- go to Q. #43

42. Check the antenatal health card and record the number of times the mother has gone to obtain antenatal service.

- a. Once
- b. Twice or more
- c. None

43. Do you have your TT immunization card?

- a. Yes -- check the card
- b. Lost -- go to Q. #45
- c. Don't have -- go to Q. #45

44. Check the TT immunization card and record the number of shots given to the mother.

- a. One
- b. Two or more
- c. None

45. Are you currently pregnant?

- a. Yes -- go to Q. #49
- b. No

46. Do you have a desire to have a baby within the next two years?

- a. Yes -- go to Q. #49
- b. No
- c. Don't know

47. Are you adopting any family planning method to protect yourself from being pregnant?

- a. Yes
- b. No -- go to Q. #49

48. What family planning method are you or your husband currently using?

- a. Sterilized -- male/female
- b. Dipo
- c. Pills
- d. Condoms
- e. Other, specify _____

ARI

49. Did you observe any respiratory problem such as cough and difficulty breathing in your child (name of the child) during the last 15 days?
- a. Yes []
b. No [] -- go to Q. #53
50. Did your child (name of the child) breathe rapidly and heavily when he was having an ARI problem?
- a. Yes []
b. No []
c. Don't know []
51. Did you obtain any medical treatment for your child (name of the child) when he was having an ARI problem?
- a. Yes []
b. No []
52. Where did you refer for a medical advice or service for your child (name of the child) when he was having a problem of ARI? (multiple answers possible)
- a. Hospital []
b. Health post/center []
c. Private doctor/clinic []
d. Pharmacy []
e. Village health worker []
f. Traditional/Faith Healer []
g. Traditional birth attendants []
h. Relatives and friends []
i. Other, specify [] _____
53. What signs or symptoms in your child (name of the child) would cause you to seek advice or treatment for ARI? (multiple answers possible)
- a. Don't know []
b. Rapid and difficult breathing []
c. Abdominal respiration []
d. Loss of appetite []
e. Fever []
f. Cough []
g. Other, specify [] _____

Horticulture & Kitchen Gardening

54. Have you planted any fruit trees?
- a. Yes []
b. No []

If yes, what types?

- a. _____
- b. _____
- c. _____
- d. _____

If no, why not?

- a. Not necessary/needed []
- b. Busy, no time []
- c. No good land to plant []
- d. No saplings []
- e. Other, specify [] _____

55. Do you do winter vegetables farming?

- a. Yes []
- b. No []

If yes, what types?

- a. Broad-leaf mustard/Pumpkin
- b. Onion/Garlic
- c. Shallot
- d. Cauliflower

If no, why not?

- a. Not necessary/needed []
- b. Busy, no time []
- c. No good land to plant []
- d. No knowledge of vegetables []
- e. No seedlings []
- f. Other, specify [] _____

Resource Conservation

56. Have you planted any fodder trees?

- a. Yes []
- b. No []

If no, why not?

- a. Not necessary/needed []
- b. No good land to plant []
- c. Forest is near for fodder []
- d. No seedlings []
- e. Other, specify [] _____

57. Do you have a smokeless stove in your house?

- a. Yes: []
- b. No []

If no, why not?

- a. No knowledge about the stove []
- b. Not necessary/needed []
- c. No skill to construct []
- d. Not thought of so far []
- e. Difficult for cooking []
- f. Slow in cooking []
- g. Other, specify [] _____

Income Generating Activities

58. How long does your cultivation last in a year?

- a. Less than 3 months []
- b. Between 3 to 6 months []
- c. Between 6 to 9 months []
- d. Greater than 9 months []
- e. Other, specify [] _____

59. Do you have a desire to do some income generating activities to increase your income?

- a. Yes []
- b. No []

If yes, what types of work do you want to do?

- a. _____
- b. _____
- c. _____
- d. _____
- e. _____
- f. _____

60. Please mention a special skill your family members have for the following income generating activities:

S. No.	Skills in or in Making	* F	* M	Regularities	Place Acquired	Applying Y/N
01	Basket (Doko)					
02	Basket (Tokri)					
03	Rope (Namlo)					
04	Mat (Gundari)					
05	Case (Dhaaki)					
06	Ropes					
07	Clothes					
08	Tray (Naglo)					
09	Sweaters					

10	Carpets					
11	Blankets					
12	Dress (Tailor)					
13	Beekeeping					
14	Paper					
15	Carpentry					
16	Masonry					
17	Pottery					
18	Occupational					
19	Faith Healers					
20	Fishing-Nets					
21	Priest/Guru					
22	Other					

Note: If no response, skip to Q. #62

61. Where do you usually market your products?

- a. Village []
- b. Bazaar []
- c. Kathmandu []
- d. Self use []
- e. Other, specify [] _____

Child Rearing

62. Where do you leave your child when you have to go for farming and other outdoor activity?

- a. Home []
- b. Neighbors' House []
- c. Take them along []
- d. Keep them in a cradle at home []
- e. Other, specify [] _____

63. Who looks after your children during morning and evening?

- a. Self []
- b. Siblings []
- c. Father []
- d. Grandparents []
- e. Other, specify [] _____

64. What do you hope your child will be?

- a. _____
- b. _____
- c. _____

65. What do you do to make your child what you have hoped them to be?

- a. _____
- b. _____
- c. _____

66. How many times do you feed your children?

- a. Only during morning and evening []
- b. 3 times []
- c. 4 times []
- d. Frequently []
- e. Don't know []

67. Please mention types of food you feed your children when they are at the following age?

<u>< 6 months</u>	<u>6 - 12 months</u>	<u>1 - 2 years</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

If no response of *Sarrbottam Pitho* please ask. Do you know about the *Pitho*?

- a. Yes []
- b. No []

68. Do you think child sports is important?

- a. Yes []
- b. No []

If yes, why?

- a. For child's physical growth []
- b. For child's mental growth []
- c. Other, specify [] _____

69. What types of toys have you prepared or provided to your children?

- a. Dolls []
- b. Mud/Stone/Wooden toys []
- c. Ball []
- d. Other, specify [] _____
- e. Don't know []

70. Please mention number of hours do you spend with your children?

Number of hours []

संकेत नम्बर

सेभ द चिल्ड्रेन (यू. एस.)
बाल बचाउ आधारभूत स्वास्थ्य सर्वेक्षण

प्रश्नावली

दुई बर्ष भन्दा कम उमेरको (०-२३ महिना) नानी भएको (१५-४५ बर्षको) आमालाई सोधिने प्रश्नहरू ।

अन्तरवार्ता मिति	दोस्रो अन्तरवार्ता मिति
अन्तरवार्ता लिने व्यक्तिको नाम :	
सुपरिवेक्षकको नाम :	

१. आमाको नाम र उमेर

नाम : उमेर (वर्षमा) :

२. दुई बर्ष मुनिका बालकको नाम र उमेर

नाम :

गते महिना बर्ष

जन्म मिति :/...../..... उमेर (महिनामा) _____

गाउँको नाम : वार्ड नं.:

गाउँ विकास समिति :

आमाको शिक्षा/पेशा

३. तपाईंले कति सम्म पढनु भएको छ ?

१. पढेको छैन / पढन आउँदैन
२. प्राथमिक कक्षा पढेको तर पढन आउँदैन
३. प्राथमिक कक्षा पढेको पढन आउँछ
४. माध्यमिक / निम्न माध्यमिक
५. स्कूलमा पढेको छैन तर पढन आउँछ

<input type="checkbox"/>
<input type="checkbox"/>
<input checked="" type="checkbox"/>
<input type="checkbox"/>
<input type="checkbox"/>

५०

५. तपाईंको बिचारगा बालबालिकाहरूलाई सबै भन्दा बढी कुन किसिमको रोग लाग्छ ?
- क. दिशा पखाला
- ख. ज्यरो
- ग. खोकी
- घ. छालाको रोग
- ङ. अन्य _____
६. तपाईंले (बच्चाको नाम) लाई अझै आफ्नो दूध ख्वाउँदै हुनु हुन्छ ?
१. छ
२. छैन
७. तपाईंले (बच्चाको नाम) लाई सिसि (बोटल) बाट दूध ख्वाउनु हुन्छ ?
१. छ
२. छैन
८. तपाईंले (बच्चाको नाम) को खानासंग घिउ अथवा चिल्लो चिज मिसाउनु हुन्छ ?
१. छ
२. छैन
९. बच्चालाई आमाको दूध बाहेक ठोस खानेकुरा (अन्न) कहिलेबाट शुरु गर्नु पर्दछ ?
१. चार महिना अघिदेखि ठोस खाना दिन थाल्ने
२. चार देखि छ महिना भित्र ठोस खाना दिन थाल्ने
३. छ महिना वा त्यो भन्दा पछि ठोस खाना दिन थाल्ने
४. पाहा छैन

बृद्धि विकास

१०. तपाईंले (बच्चाको नाम) को बृद्धि स्वास्थ्य कार्ड छ ?
१. छ कार्ड हेर्नु पर्छ
२. हरायो प्रश्न नं. १४ सोध्नुहोस्
३. छैन प्रश्न नं. १४ सोध्नुहोस्

११. बच्चाको नाम भएको स्वास्थ्य कार्ड हेरी पत्ता लगाउने, गएको तीन महिना भित्रमा तौल लिएको छ छैन ?			
१. छै	<input type="checkbox"/>		
२. छैन	<input type="checkbox"/>		
१२. बच्चाको बृद्धि कार्डमा हेरी भिटामिन 'ए' दिएको, नदिएको हेर्नुस् ।			
१. छै	<input type="checkbox"/>		
२. छैन	<input type="checkbox"/>	प्रश्न नं. १४ सोध्नुहोस् ।	
१३. यदि छ भने भिटामिन 'ए' दिएको मिति स्वास्थ्य कार्डबाट लेख्नुस् ।			
मात्रा	गते	महिना	वर्ष
प्रथम			
द्वितीय			
तृतीय			
चौथो			

१४. तपाईंको बच्चाहरूले साँझ परेपछि यताउता हिडंडुल गर्दा आँखा राम्ररी नदेख्ने वा रात परेपछि देख्दैन भन्ने यरेको छ ?

छ छैन

भाडा पखाला

१५. तपाईंको (बच्चाको नाम) लाई आज भन्दा १५ दिन भित्र पखाला लागेको थियो ?

१. थियो

२. थिएन प्रश्न नं. २५ जानुहोस्

१६. तपाईंले (बच्चाको नाम) लाई पखाला लाग्दा आफ्नो दूध (अन्तरवार्ता लिनेले तल लेखेको सबै पढ्नुहोस्)

क. सधैं भन्दा बढी खुवाउनु भयो कि ?

ख. सधैं जति नै खुवाउनु भयो कि ?

ग. सधैं भन्दा कम खुवाउनु भयो कि ?

घ. खुवाउन पुरै बन्द गर्नु भयो कि ?

ङ. पहिले नै छुटाई सकेको थियो

१७. तपाईंले (बच्चाको नाम) लाई पखाला लागेको बेला उसलाई आफ्नो दुध बाहेरु अरु केही भोल खानेकरा (अन्तरवार्ता लिनेले सबै पढनुहोस्)

- क. सधै भन्दा बढी खुवाउनु भयो कि ?
- ख. सधै जति नै खुवाउनु भयो कि ?
- ग. सधै भन्दा कम खुवाउनु भयो कि ?
- घ. खुवाउन पुरै बन्द गर्नु भयो कि ?
- ङ. अहिले आफ्नो दुध मात्र खुवाइरहनु भएको छ ?

१८. तपाईंले (बच्चाको नाम) लाई पखाला लागेको बेला अरु खानेकरा (अन्तरवार्ता लिनेले सबै पढनुहोस्)

- क. सधै भन्दा बढी खुवाउनु भयो कि ?
- ख. सधै जति नै खुवाउनु भयो कि ?
- ग. सधै भन्दा कम खुवाउनु भयो कि ?
- घ. खुवाउन पुरै बन्द गर्नु भयो कि ?
- ङ. अहिले आफ्नो दुध मात्र खुवाइरहनु भएको छ ?

१९. तपाईंको (बच्चाको नाम) लाई पखाला लाग्दा तपाईंले कुनै उपचार गर्नु भयो ?
(एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेखनुहोस्)

- क. केही गरेको छैन
- ख. जीवन जल
- ग. नून चिनी पानी
- घ. अन्य भोल (उल्लेख गर्नुस्) _____
- ङ. पखाला रोक्ने औषधीहरू _____
- च. अन्य (उल्लेख गर्नुहोस्) _____

यदि, जीवन जल उत्तर आएन भने, प्रश्न नं. २५ मा जानुहोस् ।

२०. यदि उत्तर जीवन जल हो भने, तपाईंले कहाँबाट पाउनु भयो ?
(एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेखनुहोस्)

- क. पसलबाट
- ख. स्वास्थ्य चौकीबाट
- ग. क्लिनिकबाट
- घ. अस्पतालबाट

- ड. महिला समूहबाट
- च. अन्य (उल्लेख गर्नुहोस्) _____

२१. तपाईंले एक पुरिया जीवन जलमा कति पानी मिसाउनु भयो ?

- क. ६ चिया गिलास पानी
- ख. २ माना
- ग. १ लिटर
- घ. याहा छैन
- ड. अन्य (उल्लेख गर्नुहोस्) _____

२२. तपाईंले (बच्चाको नाम) लाई पखाला लाग्दा कुनै सल्लाह लिने काम गर्नु भयो ?

- क. लिए / गराए
- ख. लिइन / गराइन प्रश्न नं. २५ मा जानुहोस् ।

२३. तपाईंले (बच्चाको नाम) लाई पखाला लाग्दा कसबाट सल्लाह लिने काम भयो ?
(एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेख्नुहोस्)

- क. अस्पताल
- ख. हेल्थ पोष्ट / स्वास्थ्य चौकी
- ग. प्राइभेट डाक्टर
- घ. मऔषधी पसल
- ड. ग्रामीण स्वास्थ्य कार्यकर्ता
- च. परम्परागत सुडेनी
- छ. नातेदार / साथी
- ज. धामी भक्ती
- झ. अन्य (उल्लेख गर्नुहोस्) _____

२४. तपाईंको (बच्चाको नाम) लाई पखाला लाग्दा कस्तो कस्तो लक्षण देखा पर्दा तपाईं उपचार खोज्नु हुन्छ ? (एक भन्दा बढी उत्तरको संभावना भए सबै जवाफ लेख्नुहोस्)

- क. याहा छैन
- ख. बान्ता भएमा
- ग. ज्वरो आएमा
- घ. मख सवन. आँखा र डन. पिसाव कम भएमा

- ड. धेरै दिनसम्म पखाला लागि रहेमा
- च. दिसामा रगत देखा परेमा
- छ. खाना नरुचेमा
- ज. कमजोर अथवा थकित देखिएमा
- झ. अन्य उल्लेख गर्नुहोस्

२५. तपाईंको (बच्चाको नाम) लाई पखाला लाग्ने भने तपाईंले के के गर्नु हुन्छ ?
(एक भन्दा बढी उत्तरको संभावना छ सबै जवाफ लेख्नुहोस्)

- क. थाहा छैन
- ख. बिक्री कार्यकर्ता कहाँ संपर्क राख्छु नाम : _____
- ग. स्वास्थ्य चौकी / अस्पताल लान्छु
- घ. बच्चालाई सधैंको भन्दा बढी पिउन दिन्छु
- ड. बच्चालाई थोरै खानेकुरा घरीघरी दिन्छु
- च. जीवनजल पिउनु दिन्छु
- छ. नून, चिनी, पानी दिन्छु
- ज. भोल कुरा दिन्न
- झ. खानेकुरा दिन्न
- ञ. अन्य (उल्लेख गर्नुहोस्)

२६. तपाईंले (बच्चाको नाम) लाई पखाला कम हुँदै गएको बेलामा कुन किसिमबाट खान दिनु हुन्छ ? (सबै उत्तर लेख्नुहोस्)

- क. थाहा छैन
- ख. बच्चालाई थोरै खाना धेरै पटक खुवाउनु पर्दछ
- ग. सधैंको भन्दा बढी खाना खुवाउनु पर्दछ
- घ. बढी शक्ति दिने खानेकुरा खुवाउनु पर्दछ
- ड. अन्य (उल्लेख गर्नुहोस्)

२७. के तपाईंले जीवन जलबारे सुन्नु भएको छ ?

प्रश्न १९ मा जीवन जलको उत्तर आयो भने प्रश्न नं. ३२ मा जानुहोस् ।

प्रश्न २५ मा मात्र जीवन जलको उत्तर आयो भने प्रश्न ३१ सोध्नुहोस्)

- क. छु प्रश्न नं. २८ मा जानुहोस् ।
- ख. छैन प्रश्न नं. ३२ मा जानुहोस् ।

२८. यो के को लागि प्रयोग गरिन्छ ?

- क. जलवियोजन रोदनको लागि
- ख. पखाला लागेको बेला
- ग. थाहा छैन
- घ. अन्य (उल्लेख गर्नुहोस्)

२९. के तपाईंले कहिल्यै जीवन जल प्रयोग गर्नु भएको छ ?

- क. छ
- ख. छैन

प्रश्न नं. ३१ मा जानुहोस् ।

३०. एक पुरिया जीवन जलमा तपाईंले कति पानी मिसाउनु भयो ?

- क. ६ चिया गिलास पानी
- ख. २ माना
- ग. १ लिटर
- घ. अन्य (उल्लेख गर्नुहोस्)

३१. एक पुरिया जीवन जलमा कति पानी मिसाउनु पर्छ ?

- क. ६ चिया गिलास पानी
- ख. २ माना
- ग. १ लिटर पानी
- घ. अन्य (उल्लेख गर्नुहोस्)
- ङ. थाहा छैन

वातावरण सरसफाई

३२. के तपाईंको घरमा चर्पी बनाउनु भएको छ ?

१. छ २. छैन

यदि छैन भने किन ?

- क. आवश्यकता नै छैन
- ख. चर्पी बनाउन जानेकोनै छैन
- ग. चर्पी बनाउने बारे सोचेकोनै छैन
- घ. अन्य (उल्लेख गर्नुहोस्)
- ङ. थाहा छैन

३३. तपाईंले कहिले कहिले हात धुनु हुन्छ ?

(सवै उत्तरहरु लेख्नुहोस्)

- क. दिशा गरि सकेपछि
- ख. खाना खानु अगी
- ग. खाना खाई सकेपछि
- घ. फोहरकुरा छोएपछि
- ङ. खाना पकाउनु अघि
- च. अन्य (खुलाउने) _____

३४. तपाईंको विचारमा भ्राडा पखाला हुनुको कारण के हो ?

(सवै उत्तरहरु लेख्नुहोस्)

- क. फोहर पानी
- ख. फोहर हात
- ग. जथाभावि दिशा गरेमा
- घ. रूढीवादी अन्धविश्वास
- ङ. फोहर मैला
- च. थाहा छैन
- छ. अन्य उल्लेख गर्नुहोस् _____

खोप

३५. तपाईंको (बच्चाको नाम) लाई खोपाउनु भएको छ ?

- क. छ
- ख. छैन
- ग. थाहा छैन

३६. बच्चा कति उमेरको हुँदा दादुराको खोप दिनु पर्दछ ?

- क. महिनामा लेख्नुहोस्
- ख. थाहा छैन

३६. गर्भवती आमालाई (पेट बोकेको बेला) धनुषटंकारको सुई किन दिनु पर्दछ ?

- क. आमा र शिशुलाई धनुषटंकार रोगबाट बचाउन
- ख. आमालाई धनुषटंकार रोगबाट जोगाउन
- ग. बच्चालाई धनुषटंकार रोगबाट बचाउन

घ. थाहा छैन

प्रश्न नं. ३९ जानुहोस् ।

ड. अन्य

३८. गर्भवती आमाले नवजात शिशुलाई धनुपट्टाकार रोगबाट जोगाउन कतिवटा धनुपट्टाकार रोग विरुद्धको सूई लिनु पर्दछ ?

क. एक

ख. दुई

ग. दुई भन्दा बढी

घ. लगाउनु पर्दैन

ङ. थाहा छैन

३९. तपाईंसँग बच्चाको खोप काडं छ ?

१. छ

काडं हेर्नु पर्छ

२. हरायो

प्रश्न नं. ४१ सोध्ने

३. छैन

प्रश्न नं. ४१ सोध्ने

४०. खोप काडं हेरी काडंबाट खोप दिएको मिति सबै सार्नुहोस् ।

खोप	मात्रा		
	पहिलो	दोस्रो	तेस्रो
डि. पी. टी.			
पोलियो			
बि. सी. जी.			
दादुरा			

आमाको स्वास्थ्य

४१. तपाईंसंग गर्भवती हुँदा जचाउँदाको कार्ड छ ?

- | | | | |
|----|------------|--------------------------|----------------------|
| १. | छ | <input type="checkbox"/> | कार्ड हेर्नु पर्छ |
| २. | थियो हरायो | <input type="checkbox"/> | प्रश्न नं. ४३ सोध्ने |
| ३. | छैन | <input type="checkbox"/> | प्रश्न नं. ४३ सोध्ने |

४२. प्रश्न कर्ताले कार्ड हेरी कति पटक आमाले पूर्व प्रसूति सेवा लिन गएकी छिन् लेख्ने ।

- | | | | |
|----|----------------------|--------------------------|--|
| १. | एक | <input type="checkbox"/> | |
| २. | दुई वा दुई भन्दा बढि | <input type="checkbox"/> | |
| ३. | छैन | <input type="checkbox"/> | |

४३. तपाईंसंग टि. टि. खोप कार्ड छ ?

- | | | | |
|----|------------|--------------------------|----------------------|
| १. | छ | <input type="checkbox"/> | कार्ड हेर्नु पर्छ |
| २. | थियो हरायो | <input type="checkbox"/> | प्रश्न नं. ४५ सोध्ने |
| ३. | छैन | <input type="checkbox"/> | प्रश्न नं. ४५ सोध्ने |

४४. प्रश्न कर्ताले खोप कार्डहरु र बच्चाको स्वास्थ्य कार्ड हेरी कति पटक टि. टि. खोप लगाएको छ तल लेख्नुस् ।

- | | | | |
|----|----------------------|--------------------------|--|
| १. | एक | <input type="checkbox"/> | |
| २. | दुई वा दुई भन्दा बढि | <input type="checkbox"/> | |
| ३. | छैन | <input type="checkbox"/> | |

४५. के तपाईं हाल गर्भवती हुनु हुन्छ ?

- | | | | |
|----|-----|--------------------------|--------------------|
| १. | छ | <input type="checkbox"/> | प्रश्न ४९ सोध्नुस् |
| २. | छैन | <input type="checkbox"/> | |

४६. के तपाईं आउँदो दुई वर्ष भित्र अर्को बच्चा जन्माउनु चाहनु हुन्छ ?

- | | | | |
|----|----------|--------------------------|-------------------|
| १. | चाहन्छु | <input type="checkbox"/> | प्रश्न ४९सोध्नुस् |
| २. | चाहन्न | <input type="checkbox"/> | |
| ३. | थाहा छैन | <input type="checkbox"/> | |

४७. के तपाईले हाल गर्भवती नहुनलाई कुनै परिवार नियोजनको साधन अपनाउनु भएको छ ?

१. छ

२. छैन

प्रश्न ४९ सोधनुस्

४८. गर्भ रोक्नलाई तपाई वा तपाईको श्रीमानले परिवार नियोजनको कुन साधन अपनाउनु भएको छ ?

१. स्थाई बन्ध्याकरण

पुरुष / महिला

२. तीन महिने सूई (डिपो)

३. खाने चक्की (पिल्स)

४. कन्डम (ढाल)

५. अन्य (नाम उल्लेख गर्नुस्)

श्वास प्रश्वास सम्बन्धि रोग

४९. तपाईको (बच्चाको नाम) लाई १५ दिन यता खोकी वा सास फेर्न गाह्रो हुने किसिमको समस्या परेको थियो ?

थियो

थिएन

नोट : थिएन उत्तर आएमा प्रश्न नं. ५३ सोधने ।

५०. (बच्चाको नाम लिएर) विरामी हुँदा गाह्रो गरी छिटो छिटो सास फेरेको थियो ?

थियो

थिएन

थाहा छैन

५१. तपाईको (बच्चाको नाम) लाई श्वास प्रश्वास सम्बन्धि रोग लाग्दा तपाईले कुनै उपचार गर्नु भयो ?

गरे

गरिन

५२. तपाईले (बच्चाको नाम) लाई खोकि लाग्दा वा सास फेर्न गाह्रो हुँदा कसबाट सल्लाह लिने वा उपचार गर्ने गर्नु भयो ? (एक भन्दा बढि उत्तरको सम्भावना भए सबै जवाफ लेख्नुहोस्)

क. अस्पताल

ख. हेल्थ पोष्ट / स्वास्थ्य चौकी

ग. प्राइभेट डाक्टर / क्लिनिक

- घ. औषधी पसल
- ङ. ग्रामीण स्वास्थ्य कार्यकर्ता
- च. धामी / भौकी
- छ. सुडेनी
- ज. नातेदार वा साथी
- झ. अन्य

५३. तपाईंको (बच्चाको नाम) लाई खोकि वा श्वास प्रश्वास रोग लागेको बखतमा कस्तो लक्षण देखा पर्दा तपाईं उपचारको लागि जानु हुन्छ ? (एक भन्दा बढि उत्तरको संभावना छ सबै उल्लेख गर्नुहोस्)

- क. थाहा छैन
- ख. गान्धो संग छिटो छिटो सास फेरेमा
- ग. कोखा हानेमा
- घ. खाना नखाएमा
- ङ. ज्वरो आएमा
- च. खोकी लागेमा
- छ. अन्य (तोडनुहोस्)

फलफूल तथा करेसावारी

५४. तपाईंले फलफूल रोप्नु भएको छ ?

छ छैन

(क) यदि रोप्नु भएको भए कुन कुन ?

क.

ख.

ग.

घ.

(ख) नरोप्नु भएको भए किन ?

- क. आवश्यकता नै छैन
- ख. फुर्सद छैन

- ग. लगाउने राम्रो जमिन छैन
- घ. विरुवा छैन
- ङ. अन्य (उल्लेख गर्नुहोस्)

५५. तपाईं हिउँदे तरकारी खेती गर्नु हुन्छ ?

गर्छु गर्दिन

(क) रोप्नु हुन्न भने किन ?

- क. आवश्यकता नै छैन
- ख. फुर्सद छैन
- ग. लगाउने राम्रो जमिन छैन
- घ. लगाउने तरिका बारे ज्ञान छैन
- ङ. बीउ छैन
- च. अन्य

श्रोत संरक्षण

५६. तपाईंले डाँले घाँस (रुख घाँस) रोप्नु भएको छ ?

छ छैन

यदि छैन भने किन ?

- क. आवश्यक छैन
- ख. ठाउँ छैन
- ग. घाँस जंगलबाट ल्याउँछु
- घ. विरुवा छैन
- ङ. अन्य उल्लेख गर्नुहोस्

५७. के तपाईंको घरमा धुवाँ रहित चूलो बनाउनु भएको छ ?

छ छैन

यदि छैन भने किन ?

- | | | |
|----|-----------------------------------|--------------------------------|
| क. | चूलो बारे थाहा छैन | <input type="checkbox"/> |
| ख. | आवश्यकता नै छैन | <input type="checkbox"/> |
| ग. | बनाउन जानेको छैन | <input type="checkbox"/> |
| घ. | घुर्वाँ रहित चूलो बारे सोचेको छैन | <input type="checkbox"/> |
| ङ. | असजिलो हुन्छ | <input type="checkbox"/> |
| च. | ढिलो पान्छ | <input type="checkbox"/> |
| छ. | अन्य (उल्लेख गर्नुहोस्) | <input type="checkbox"/> _____ |

आय उपार्जन

५८. आफ्नै खेतीबाट कति महिना खान पुग्दछ ?

- | | | |
|----|-------------------------|--------------------------------|
| क. | ३ महिना मुनि | <input type="checkbox"/> |
| ख. | ३-६ महिना | <input type="checkbox"/> |
| ग. | ६-९ महिना | <input type="checkbox"/> |
| घ. | ६ देखि माथि | <input type="checkbox"/> |
| ङ. | अन्य (उल्लेख गर्नुहोस्) | <input type="checkbox"/> _____ |

५९. तपाईंलाई आम्दानी बढाउने इच्छा छ ?

छ छैन

यदि छ भने कस्तो काम गरेमा आम्दानी बढ्ला ?

- क.
ख.
ग.
घ.
ङ.
च.

६०. तपाईं अथवा तपाईंको परिवारका सदस्यहरूले निम्न लिखित खेती बाहेक अन्य आर्थिक व्यवसाय सम्बन्धि विशेष सीपहरू तथा कामहरू जानेका भए कृपया वताई दिनु हुन्छ कि ?

क्र.सं.	सीप तथा कामहरू	काम जान्नेवो संख्या		नियमित	मौसम अनुसार	कच्चा पदार्थ प्राप्त गर्ने ठाउँ	सीप सिकेको ठाउँ	सिकेको सीप व्यवहारमा	
		पुरुष	महिला					छ	छैन
०१	डोको								
०२	टोकरी								
०३	नाम्लो / दाम्लो								
०४	गुन्डी								
०५	ठक्की								
०६	डोरी बाट्ने								
०७	कपडा बुन्ने								
०८	नाइलो								
०९	स्वेटर बुन्ने								
१०	गलैचा बुन्ने								
११	कम्मल बनाउने								
१२	कपडा सिउने								
१३	मौरी पाल्ने								
१४	कागज बनाउने								
१५	सीकर्मीको काम								
१६	डकर्मीको काम								
१७	माटोको षाडा बनाउने								
१८	जातीगत काम								
१९	धामी / फाँकी								
२०	जाल बुन्ने								
२१	पुरोहित								
२२	अन्य								

(यदि सीप व्यवहारमा उतारेको छ भने मात्र प्रश्न नं. ७१ सोध्ने)

६१. तपाईं आफुले बनाएको चीज कहाँ लगेर बेच्नु हुन्छ ?

- क. गाउँ घरमा
- ख. बजारमा
- ग. काठमाडौंमा
- घ. आफ्नो प्रयोगको लागि मात्र
- ङ. अन्य

बाल बच्चाको हेरचाह सम्बन्धि

६२. तपाईं काममा जाँदा वा बाहिर खेतमा जाँदा बच्चा कहाँ राखेर जानु हुन्छ ?

- | | | |
|----|-----------------------|--------------------------------|
| क. | आफ्नो घरमा | <input type="checkbox"/> |
| ख. | छिमेकीको घरमा | <input type="checkbox"/> |
| ग. | आफु संगै | <input type="checkbox"/> |
| घ. | कोक्रोमा (भोलुङ्गोमा) | <input type="checkbox"/> |
| ङ. | अन्य उल्लेख गर्नुहोस् | <input type="checkbox"/> _____ |

६३. बिहान बेलुका तपाईंको छोरा छोरीको हेर बिचार कस्ले गर्छ ?

- | | | |
|----|---------------------------------------|--------------------------------|
| क. | आफैले | <input type="checkbox"/> |
| ख. | जेठी छोरी वा छोराको | <input type="checkbox"/> |
| ग. | बाबुले | <input type="checkbox"/> |
| घ. | हजुर आमाले / हजुर बुबाले (बाजे / बजे) | <input type="checkbox"/> |
| ङ. | अन्य उल्लेख गर्नुहोस् | <input type="checkbox"/> _____ |

६४. तपाईं आफ्नो बच्चा कस्तो होस् भन्ने आशा गर्नु हुन्छ ? (उल्लेख गर्नुहोस्)

- क.
ख.
ग.

६५. आफ्नो बच्चा आफुले सोचेको जस्तो बनाउनको लागि तपाईं के के गर्नु हुन्छ ? (उल्लेख गर्नुहोस्)

- क.
ख.
ग.

६६. तपाईं आफ्नो बच्चालाई दिनको कति चोटी खुवाउनु हुन्छ ?

- | | | |
|----|------------------------|--------------------------|
| क. | बिहान बेलुकी मात्र | <input type="checkbox"/> |
| ख. | ३ पटक | <input type="checkbox"/> |
| ग. | ४ पटक | <input type="checkbox"/> |
| घ. | जति चोटी पायो उति चोटी | <input type="checkbox"/> |
| ङ. | थाहा छैन | <input type="checkbox"/> |

६७. तपाईंका केटाकेटीहरूलाई के के खाने कुरा खुवाउने गर्नु हुन्छ ?

जन्मे देखि ६ महिना सम्म	६-१ वर्ष सम्म	१-३ बर्ष सम्म
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

नोट : (क) प्रश्नकर्ताले उत्तरदातालाई सही र बढी खाने कुराको नाम उल्लेख गर्न उत्सुक गराउने ।

(ख) भिटामिन "ए" पाइने खानेकुराहरूको नाम नआएमा प्रश्नकर्ता आफैले सोध्ने जस्तै -

क. हरियो साग सब्जी - रायो, चम्सुर, पालुङ्गो, लट्टे, मेथीको साग इत्यादी

ख. पहेलो फलफुल - फर्सी, मेवा, गाजर, आँप, हलुवावेद इत्यादी

ग. माछा, मासु, फुल, कलेजो

घ. दुध, नौनी, ध्यू

(ग) यदि सर्वोत्तम पिठो बारे उत्तर नआएमा मात्र सोध्ने ।

के तपाईंलाई सर्वोत्तम पिठोको लिटो भनेको थाहा छ ?

छ छैन

६८. तपाईंको विचारमा बच्चाहरू बढ्न हुर्कनको लागि खेलकूदको महत्व छ वा छैन ?

छ छैन

यदि छ भने किन ?

क. शारिरीक विकासको लागि (बलियो बनाउन)

ख. बौद्धिक विकास (बुद्धिमान बनाउन)

ग. अन्य (उल्लेख गर्नुहोस्) _____

६९. बच्चालाई खेलनको लागि तपाईं कुन कुन सामग्रीहरू तयार गर्नु भएको छ ?

- | | | | |
|----|-------------------------|--------------------------|-------|
| क. | पुतली | <input type="checkbox"/> | |
| ख. | माटो / ढुङ्गा / काठ | <input type="checkbox"/> | |
| ग. | भकुण्डो | <input type="checkbox"/> | |
| घ. | अन्य (उल्लेख गर्नुहोस्) | <input type="checkbox"/> | _____ |
| ङ. | थाहा छैन | <input type="checkbox"/> | |

७०. तपाईं आफ्नो बच्चासंग कुन कुन बेला वस्तु हुन्छ ? (घण्टामा भर्नुहोस्)

LIST OF SURVEY TEAM MEMBERSInterviewers:

1. Basundhara Tamang
2. Bhawani Quikel
3. Bina Thapa
4. Bishwo Nath Mainali
5. Deelip Kumar Lama
6. Gayatri Khatiwoda
7. Gita Thapa
8. Gyanu Gurung
9. Hari Kumar Shrestha
10. Hira Devi Shrestha
11. Ishowari Nepal
12. Ishowari Pandey
13. Jaylaxmi Mainali
14. Kamala Thapa
15. Laluka Pandey
16. Madhu Kala Thapa
17. Narayani Shrestha
18. Nirmala Shrestha
19. Parbati Shrestha
20. Radhika Poudyal
21. Raghu Dhital
22. Raju Tamang
23. Renuka Basnet
24. Saradha Lamichhane
25. Sarasowti Dhital
26. Sarasowti Thapa
27. Sarita Quikel
28. Shanta Thapa
29. Sharmila Upreti
30. Sita Thapa
31. Tara Devi Gurung
32. Vijaya Moktan
33. Yasodha Pandey

Supervisors:

1. Bed Bahadur Lama
2. Bhim Kumari Pun
3. Durga Regmi
4. Jamuna Lama
5. Jay Shrestha
6. Krishna Gurung
7. Meera Kana
8. Netra Prashad Bhatta
9. Rajendra Lama
10. Ranjana Khanal
11. Sharmila Shrestha
12. Tulshi Gurung

Coordinators:

1. Raghu Thapalia
2. Ravindra Thapa

Training Coordinators:

1. Navin Pyakuryal
2. Ravindra Thapa

Administration Support:

1. Neena Gauchan

Tabulation Forms Designer:

1. Raghu Thapalia

Questionnaire Designer:

1. Narmaya Limbu

Office Support:

1. Maya Gole

**SUPERVISORS' AND INTERVIEWERS'
TRAINING AGENDA & SCHEDULE**

DAY 1, Wednesday, November 18, 1992

Target Group: Supervisors
Focus : Survey Objective & Methodology

<u>Time</u>	<u>Activity</u>
09:00 am - 09:30 am	Welcome and introduction
09:30 am - 10:00 am	Survey purpose & objective
10:00 am - 10:30 am	Presentation of time frame of survey activities -- field survey, analysis of data and feedback to community
10:30 am - 11:15 am	Review sampling method and sample size
11:15 am - 12:00 am	Review starting point method
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 01:30 pm	Review tabulation of data
01:30 pm - 02:00 pm	Review how to code/mark questions and consistency of language
02:00 pm - 02:30 pm	Mother and child's age and date of birth calculation
02:30 pm - 03:00 pm	Review Supervisors and Enumerators' job responsibility
03:00 pm - 05:45 pm	Review purpose of each question & discussion
05:45 pm - 06:00 pm	Day 2 training plan and closing

DAY 2, Thursday, November 19, 1992:

Target Group: Supervisors and Interviewers
Focus : Introduction, Survey Objective & Methodology

<u>Time</u>	<u>Activity</u>
09:00 am - 10:00 am	Welcome followed by group introduction
10:00 am - 10:30 am	Brief background information on Save the Children USA and CS VIII project

10:30 am - 11:00 am	Survey purpose & objective
11:00 am - 11:30 am	Presentation of time frame of survey activities -- field survey, analysis of data and feedback to community
11:30 am - 12:00 am	Interviewers' obligation to the agency and their responsibility
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 01:45 pm	Review sampling method and sample size
01:45 pm - 3:00 pm	Review starting point method
03:00 pm - 04:45 pm	Questions and answers
04:45 pm - 05:00 pm	Day 3 training plan and closing

DAY 3, Wednesday, November 20, 1992:

Target Group: Supervisors and Interviewers
 Focus : Interview Technique

<u>Time</u>	<u>Activity</u>
09:00 am - 10:00 am	Review how to code/mark questions and consistency of language
10:00 am - 11:30 am	Mother and child's age and date of birth calculation
11:30 am - 12:00 am	Review tabulation of data
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 01:30 pm	Role play, a bad interview technique
01:30 pm - 02:00 pm	Discussion of a bad interview
02:00 pm - 02:30 pm	Role play, a good interview technique
02:30 pm - 03:00 pm	Discussion of a good interview
03:00 pm - 04:15 pm	Practice interview on small group
04:15 pm - 04:45 pm	Discussion of small group practice
04:45 pm - 05:00 pm	Day 4 training plan and closing

DAY 4, Thursday, November 21, 1992:

Target Group: Supervisors and Interviewers
Focus : Questionnaire discussion and field practice

<u>Time</u>	<u>Activity</u>
09:00 am - 11:30 am	Questionnaire presentation and discussion
11:30 am - 12:00 am	Group arrangements for field practice
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 04:00 pm	Each team of supervisor and interviewers completes 3 household's interview
04:00 pm - 04:45 pm	Discussion of field test experien
04:45 pm - 05:00 pm	Day 5 training plan and closing

DAY 5, Friday, November 22, 1992:

Target Group: Supervisors and Interviewers
Focus : Closing and deployment

<u>Time</u>	<u>Activity</u>
09:00 am - 10:30 am	Feedback on completed field practice questionnaires
10:30 am - 11:00 am	Discussion of technical knowledge of health related matter and materials
11:00 am - 12:00 am	Final discussion about questionnaire, how to code mark responses, date of birth calculation and other related matter
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 02:00 pm	Group arrangements for field surv
02:00 pm - 02:30 pm	Interaction between group members
02:30 pm - 04:30 pm	Distribution of logistics, cash & agreement letters
04:30 pm - 05:00 pm	Reminding of supervisors and interviewer job responsibilities
05:00 pm - 05:30 pm	Farewell and best wishes to the entire group

Sample Selection Table with Population Estimate

VDC	Ilaka #	Ward #	Households	Estimated Population	Est. Pop. %	Cumulative Population	Cum. Pop. %	Cluster Numbers	Cluster Number	R.N.
kamari	12	8	46	234	0.6%	16,328	44.6%	14	16,124	
		9	24	122	0.3%	16,450	44.9%			
		1	54	277	0.8%	16,727	45.6%			
		2	56	287	0.8%	17,014	46.4%			
		3	41	210	0.6%	17,224	47.0%			
		4	16	82	0.2%	17,306	47.2%			
		5	48	246	0.7%	17,552	47.9%	15		
		6	52	267	0.7%	17,819	48.6%			
		7	50	257	0.7%	18,076	49.3%			
		8	36	185	0.5%	18,261	49.6%			
ip	1	9	64	328	0.9%	18,589	50.7%	10	18,568	
		1	36	185	0.5%	18,774	51.2%			
		2	44	226	0.6%	19,000	51.8%			
		3	40	206	0.6%	19,206	52.4%			
		4	46	236	0.6%	19,442	53.1%			
		5	40	206	0.6%	19,648	53.6%			
		6	44	226	0.6%	19,874	54.2%	17		
		7	33	170	0.5%	20,044	54.7%			
		8	24	123	0.3%	20,167	55.0%			
		9	50	257	0.7%	20,424	55.7%			
besi	13	1	131	669	1.8%	21,093	57.6%	18	21,012	
		2	38	194	0.5%	21,287	58.1%			
		3	57	291	0.8%	21,578	58.9%			
		4	55	281	0.8%	21,859	59.7%			
		5	40	204	0.6%	22,063	60.2%			
		6	89	455	1.2%	22,518	61.4%	19		
		7	57	291	0.8%	22,809	62.2%			
		8	34	174	0.5%	22,983	62.7%			
		9	58	296	0.8%	23,279	63.5%			
		arbesi	12	1	63	308	0.8%	23,587		64.4%
2	54			264	0.7%	23,851	65.1%			
3	60			293	0.8%	24,144	65.9%			
4	60			293	0.8%	24,437	66.7%			
5	47			230	0.6%	24,667	67.3%			
6	92			450	1.2%	25,117	68.5%	21		
7	53			259	0.7%	25,376	69.2%			
8	62			303	0.8%	25,679	70.1%			
9	72			352	1.0%	26,031	71.0%			
ghedi	13			1	26	138	0.4%	26,169	71.4%	22
		2	65	344	0.9%	26,513	72.4%			
		3	46	243	0.7%	26,756	73.0%			
		4	49	259	0.7%	27,015	73.7%			
		5	83	439	1.2%	27,454	74.9%	23		
		6	61	323	0.9%	27,777	75.6%			
		7	68	360	1.0%	28,137	76.6%			
		8	67	354	1.0%	28,491	77.7%	24		
		9	35	185	0.5%	28,676	78.3%			
		Avg. HHs Size: 5.16	13	1	69	356	1.0%	29,032	79.2%	25
2	41			212	0.6%	29,244	79.6%			
3	77			397	1.1%	29,641	80.9%			
4	45			232	0.6%	29,873	81.5%			
5	60			310	0.8%	30,183	82.4%			

Sample Selection Table with Population Estimate

VDC	Ilaka #	Ward #	Households	Estimated Population	Est. Pop. %	Cumulative Population	Cum. Pop. %	Cluster Numbers	Cluster Number	R.N.		
kadevi	12	1	85	438	1.2%	438	1.2%	1	238	1	238	
		2	125	644	1.8%	1,082	3.0%			2	1,460	
		3	91	469	1.3%	1,551	4.2%	2	1,460	3	2,862	
		4	90	464	1.3%	2,015	5.5%			4	3,904	
		5	54	278	0.8%	2,293	6.3%			5	5,126	
		6	83	427	1.2%	2,720	7.4%	3	2,662	6	6,348	
		7	117	603	1.6%	3,323	9.1%			7	7,570	
		8	54	278	0.8%	3,601	9.8%			8	8,762	
		9	105	541	1.5%	4,142	11.3%	4	3,904	9	10,014	
10	65	335	0.9%	4,477	12.2%		10	11,236				
khu	1	1	81	418	1.1%	4,895	13.4%			11	12,458	
		2	50	258	0.7%	5,153	14.1%	5	5,126	12	13,680	
		3	52	268	0.7%	5,421	14.8%			13	14,902	
		4	68	341	0.9%	5,762	15.7%			14	16,124	
		5	80	413	1.1%	6,175	16.9%			15	17,346	
		6	70	361	1.0%	6,536	17.8%	6	6,348	16	18,568	
		7	58	299	0.8%	6,835	18.7%			17	19,790	
		8	60	310	0.8%	7,145	19.5%			18	21,012	
		9	42	213	0.6%	7,358	20.1%			19	22,234	
radevi	12	1	41	208	0.6%	7,566	20.6%	7	7,570	20	23,456	
		2	34	173	0.5%	7,739	21.1%			21	24,678	
		3	51	259	0.7%	7,998	21.8%			22	25,900	
		4	45	229	0.6%	8,227	22.5%			23	27,122	
		5	52	264	0.7%	8,491	23.2%			24	28,344	
		6	37	188	0.5%	8,679	23.7%			25	29,566	
		7	34	173	0.5%	8,852	24.2%	8	8,792	26	30,788	
		8	35	178	0.5%	9,030	24.6%			27	32,010	
		9	90	460	1.3%	9,490	25.9%			28	33,232	
u	1	1	48	245	0.7%	9,735	26.6%			29	34,454	
		2	44	225	0.6%	9,960	27.2%			30	35,676	
		3	52	266	0.7%	10,226	27.9%	9	10,014			
		4	33	169	0.5%	10,395	28.4%					
		5	61	312	0.9%	10,707	29.2%					
		6	72	368	1.0%	11,075	30.2%					
		7	70	358	1.0%	11,433	31.2%	10	11,236			
		8	57	291	0.8%	11,724	32.0%					
		9	32	173	0.5%	11,897	32.5%					
al1	1	1	57	309	0.8%	12,206	33.3%					
		2	96	520	1.4%	12,726	34.7%	11	12,458			
		3	59	320	0.9%	13,046	35.6%					
		4	137	743	2.0%	13,789	37.6%	12		13,680		
		5	33	179	0.5%	13,968	38.1%					
		6	40	217	0.6%	14,185	38.7%					
		7	60	325	0.9%	14,510	39.6%					
		8	41	222	0.6%	14,732	40.2%					
		9	35	178	0.5%	14,910	40.7%	13	14,902			
10	38	193	0.5%	15,103	41.2%							
11	25	127	0.3%	15,230	41.6%							
dratar	12	1	32	163	0.4%	15,393	42.0%					
		2	50	254	0.7%	15,647	42.7%					
		3	37	188	0.5%	15,835	43.2%					
		4	51	259	0.7%	16,094	43.9%					

65

Sample Selection Table with Population Estimate

VDC	Ilaka #	Ward #	Households	Estimated Population	Est. Pop. %	Cumulative Population	Cum. Pop. %	Cluster Numbers	Cluster Number	R.N.
		6	37	191	0.5%	30,374	82.9%			
		7	105	542	1.5%	30,916	84.4%	26	30,788	
		8	70	361	1.0%	31,277	85.4%			
		9	108	557	1.5%	31,834	86.9%			
		1	63	343	0.9%	32,177	87.8%	27	32,010	
	Avg. Hhs Size:	2	32	174	0.5%	32,351	88.3%			
	5.44	3	50	272	0.7%	32,623	89.0%			
		4	35	190	0.5%	32,813	89.5%			
		5	39	212	0.6%	33,025	90.1%			
		6	27	147	0.4%	33,172	90.5%			
		7	46	261	0.7%	33,433	91.2%	28	33,232	
		8	46	250	0.7%	33,683	91.9%			
		9	21	114	0.3%	33,797	92.2%			
marka		1	32	186	0.5%	33,983	92.7%			
	Avg. Hhs Size:	2	44	256	0.7%	34,239	93.4%			
	5.81	3	39	227	0.6%	34,466	94.1%	29	34,454	
		4	56	325	0.9%	34,791	94.9%			
		5	37	215	0.6%	35,006	95.5%			
		6	65	378	1.0%	35,384	96.6%			
		7	101	587	1.6%	35,971	98.2%	30	35,676	
		8	57	331	0.9%	36,302	99.1%			
		9	59	343	0.9%	36,645	100.0%			
			7,036	36,645	100.0%					
	ge:		55.8	290.8						
	eviation:		22.9	119.8						
	um:		16	82						
	um:		137	743						
	ency:		126							
	ge Population per VDC:		2,618							
	ge Population per Ilaka:		12,215							

Random Number (R.N.) = 0238 (from currency note, copy attached)
 Sampling Interval (S.I.) = 1,222 (Total Population/30 Clusters -- 36645/30)

Tibetan Calendar YearLo/Bargha Talika:

	<u>Tamang/Sherpa/Gurung</u>	<u>Nepali</u>	<u>B.S.</u>	<u>English</u>	<u>A.D.</u>
1.	Yamya/Chhiba/Chhiba	Musha	2040 2041	Mouse	1984
2.	May/Lang/Lang	Gahee	2041 2042	Cow/Ox	1985
3.	Chayan/Taa/Taa	Bagh	2042 2043	Tiger	1986
4.	Tabar/Ye/Hyoa	Biralo	2043 2044	Cat	1987
5.	Mue/Duku/Mugh	Aakash	2045 2045	Sky/Dragon	1988
6.	Sarpo/Bruel/Bruel	Sarpo	2045 2046	Snake	1989
7.	Ghoda/Tabu/Ta	Ghoda	2046 2047	Horse	1990
8.	Que/Luk/Lhuk	Bheda	2047 2048	Sheep	1991
9.	Makar/Prey/Pra	Bandar	2048 2049	Monkey	1992
10.	Yamya/Chaya/Chya	Chara	2049 2050	Bird	1993
11.	Naghi/Khi/Khi	Kukur	2050 2051	Dog	1994
12.	Toha/Ka/Faa	Badel	2051 2052	Boar	1995

Note:

- The calendar goes in cyclic order and a lo/bargha repeats only after 12 years.
- By asking a person's lo/bargha and looking at his/her physical appearance one can judge his/her age.
- The months go according to Nepalese calendar (Baishak ... Chaitra). However, rural people usually remember their month (date of birth) by the local cropping cycle and festivity.
- The great Tibetan festival called Lohashar marks the beginning of the new year. It falls approximately during January 15 or Magh 1 for Tamangs, but for Gurungs, Thakalis and Tibetians it falls around mid-February or Phalgun 15.
- January 15, 1992 to January 14, 1993 Year of Monkey (Tamang and Sherpa). Similarly, 2048 Magh 1 to 2049 Poush 30 as for Nepalese calendar.

Table of Teams' Assigned Clusters

<u>S.No.</u>	<u>Supervisors</u>	<u>Interviewers</u>	<u>YDCs</u>	<u>I#</u>	<u>W#</u>	<u>C#</u>	<u>*</u>	
1.	Krishna Bahadur Gurung	Gita Thapa	Mahakali	1	3	1		
		Renuka Basnet	- do -	1	5	2		
		Kamala Thapa	Leekhu	1	4	3		
2.	Bed Bahadur Lama	Tara Devi Gurung	Leekhu	1	8	4		
		Gyanu Gurung	Chhap	1	6	5		
3.	Netra Prasad Bhatta	Ishowari Nepal	Talakhu	1	3	6		
		Radhika Poudyal	- do -	1	7	7		
4.	Tulshi Gurung	Madhu Kala Thapa	Sikre	1	1	8		
		Bina Thapa	- do -	1	7	9		
5.	Meera Rana	Hira Devi Shrestha	Ralukadevi	12	1	10		
		Laluka Pandey	- do -	12	6	11		
		Hari Kumar Shrestha	- do -	12	9	12		
6.	Bhim Kumari Pun	Bhawani Quikel	Ralukadevi	12	3	13		
		Jaylaxmi Mainali	Sundaradevi	12	2	14		
		Yasodha Pandey	- do -	12	8	15		
		Bishwo Nath Mainali						
7.	Jamuna Devi Lama	Sita Thapa	Shikharbesi	12	1	16		
		Shanta Thapa	- do -	12	6	17		
		Raghu Dhital	- do -	12	9	18		
8.	Sharmila Shrestha	Sarasowti Dhital	Samundratar	12	1	19		
		Gayatri Khatiwoda	- do -	12	8	20		
			Balkumari	12	5	21		
9.	Ranjana Khanal	Sharmila Upreti	- do -	12	9	22		
		Sarasowti Thapa	Beteni	13	3	23		
		Deelip Lama						
10.	Rajendra Lama	Parbati Shrestha	Ghyangphedi	13	5	24		
		Narayani Shrestha	- do -	13	8	25		
		Raju Tamang						
11.	Durga Regmi	Nirmala Shrestha	Gaukharka	13	3	26		
		Sarita Quikel	Rauthbesi	13	6	27		
		Vijaya Moktan						
12.	Jay Shrestha	Ishowari Pandey	Gaukharka	13	7	28		
		Saradha Lamichhane	Rauthbesi	13	1	29		
		Basundhara Tamang	Beteni	13	7	30		

* I# = Ilaka Number, W# = Ward Number and C# = Cluster Number

**Brief Profile of the Project Area
Raghu Thapalia, December 1992**

Please note that the information presented here was collected mostly from secondary sources and observations made during the survey period. Some information is included from the survey findings.

1. Location & Geography:

Near and so very close yet so far from the capital city of Kathmandu lies Save the Children's working area of Child Survival VIII project. Inaccessible by vehicle, just across a mighty hill covered with dense subtemperate forest inhabited by wild animals, north of Kathmandu, begins the boundary area of CS VIII project that extends even further towards northern isolated foothills of Himalayan mountains. The area with countless beautiful rivers, magnificent waterfalls, patches of high altitude lakes and breathtaking majestic hills and mountains encompasses far-eastern Ilakas #1, #12 and #13 of Nuwakot District, Bagmati Zone, Central Development Region of Nepal.

Ilakas #1, #12 and #13 are bordered by Sindhupalchok District to the east, Rasuwa District to the north and Kathmandu District to the south. Ilakas #2, #10 and #11 of Nuwakot District border the western part of the project area. The 14 VDCs of these three ilakas include:

Household distribution by VDCs

Ilakas/VDCs	Households	%	Cumu.	%
Ilaka #1:				
1. Mahakali VDC	555	23.3%	555	7.9%
2. Leekhu VDC	527	22.1%	1,082	15.4%
3. Talakhu VDC	582	24.4%	1,664	23.6%
4. Sikre VDC	361	15.2%	2,025	28.8%
5. Chhap VDC	357	15.0%	2,382	33.9%
Sub-total:	2,382	100.0%		33.9%
Ilaka #12:				
1. Ralukadevi VDC	804	32.3%	3,186	45.3%
2. Sundaradevi VDC	371	14.9%	3,557	50.6%
3. Shikharbesi VDC	563	22.6%	4,120	58.6%
4. Samundratar VDC	338	13.6%	4,458	63.4%
5. Balkumari VDC	417	16.7%	4,875	69.3%
Sub-total:	2,493	100.0%		35.4%
Ilaka #13:				
1. Ghyangphedi VDC	500	23.1%	5,375	76.4%
2. Gaukharka VDC	490	22.7%	5,865	83.4%
3. Rauthbesi VDC	559	25.9%	6,424	91.3%
4. Beteni VDC	612	28.3%	7,036	100.0%
Sub-total:	2,161	100.0%		30.7%
Total Households	7,036	100.0%		

Source: HMG/N, National Election Commission, 1991 voter's list

The three project ilakas of CS VIII project are each famous for its own distinctive river. Ilaka #1 has Leekhu Khola (river), Ilaka #12 has Chandramati Khola and Ilaka #13 has Suryamati Khola. These rivers collect all the water of the region and shoot off perpetually and tirelessly down hill, striking rocky surfaces. These rivers initially head southward, but shortly thereafter divert towards the west where they rush down like a young bull to join in force to make the Taadi Khola. Collecting every river and stream of the eastern part of the district, Taadi calmly moves to meet the gigantic Trishuli river at Devighat. Devighat is a very sacred place for the majority of Hindu people of the district where many rites and rituals are performed. Also, in this place many dead ones are cremated and their ashes are washed into the holy water. This is the place where Late King Prithivi Narayan Shah (A.D. 1723 - 1775 or B.S. 1779 - 1831), who united the Kingdom of Nepal, was cremated, too. Hence, the place also holds historical importance.

This gives the topographical view of the CS VIII project area picturing how it is blocked towards the north by the great Himalayas, east by the bordering hills of Sindhupalchok District and south by the mighty hills of Kathmandu valley, forcing its marginal plains land towards the west into a somewhat rectangular shape. Access to the outside world to a difficult terrain of the CS VIII ilakas are open through this narrow valley cut by the Taadi Khola that ultimately gets together with the Trishuli river. Trishuli is the river that drains all the water and a negligible amount of wastes of the Nuwakot District. Major transportation and travelling of the three ilakas are done on a network of trails that join one main trail that leads westward through the bank of the three aforementioned rivers and Taadi Khola to the Trishuli Bazaar that is situated on the bank of the Trishuli river.

The nearest roadhead of the project area is located at Gangate, eight kilometers closer than Trishuli Bazaar from Kathmandu. A dirt road is currently being opened up to Dhikure from Gangate where SC/US's storeroom for the three ilaka offices is established. Dhikure is located about four hours, approximately 80 km, drive from Kathmandu. During dry season, the dirt road even reaches Aaprak which is two hours' walking distance far from Dhikure and only three hours walking distance close to SC/US's hub or central office located at Samundratar village; Ward #1, Samundratar VDC, Ilaka #12. Samundratar village is situated at a peninsula made by the union of Suryamati Khola that comes from the upper northern side and Chandramati Khola that runs down from the east. The Samundratar central office is established here to look after Ilaka #1 and #13 CS VIII's development activities administered by its respective offices including that of Ilaka #12. The Ilaka #1 office is planned to be established at Chhap VDC and Ilaka #13 office at Gaukharka VDC. The exact location of these offices is still to be decided, but by the end of January 1993, these offices will have been moved and housed at a fixed spot near or around the VDCs, central to its ilakas.

The elevation of these ilakas ranges from 1,000 meters (3,300 feet) to a maximum of 4,000 meters (13,200 feet). The temperature of the area is mainly controlled by the elevation. The northern parts of Ilaka #12 and #13 is somewhat colder than

southern Ilaka #1 as it is on quite a higher altitude. Hence, the temperature gradually decreases from north to the south. The mean temperature of the area remains 10°C with variance of ±15°C. The low river basins area attains higher temperature and remains pleasantly cool during winter. In the winter, northern parts of Ilaka #12 and #13 get sporadic snowfalls.

Due to the constant denudation of existing forest and as the underlying strata of the land plentifully contain shale and micaceous quartzite, there is much evidence of soil erosion and landslides in the project area. In some places, landslides make travelling from one place to another very difficult. The absence of or poor and worn down suspension bridges over some rivers and streams makes the matter even worse.

2. Demography:

As according to unpublished data obtained from the CBS 1991 census survey, the three ilakas consist of a total of 38,098 population with 18,934 (49.7%) females and 19,164 (50.3%) males. Hence, the sex ratio of the project area comes to 989 females per 1,000 males.

Population distribution by VDC and sex

Ilakas/VDCs	Female	%	Male	%	Total	%
Ilaka #1:						
1. Mahakali VDC	1,713	49.8%	1,729	50.2%	3,442	26.9%
2. Leekhu VDC	1,300	51.0%	1,249	49.0%	2,549	19.9%
3. Talakhu VDC	1,570	50.7%	1,525	49.3%	3,095	24.7%
4. Sikre VDC	996	52.1%	914	47.9%	1,910	14.9%
5. Chhap VDC	921	50.7%	894	49.3%	1,815	14.2%
Sub-total:	6,500	50.7%	6,311	49.3%	12,811	33.6%
Ilaka #12:						
1. Ralukadevi VDC	2,120	50.3%	2,098	49.7%	4,218	31.7%
2. Sundaradevi VDC	1,032	48.5%	1,097	51.5%	2,129	16.0%
3. Shikharbesi VDC	1,471	48.0%	1,595	52.0%	3,066	23.0%
4. Samundratar VDC	935	50.5%	915	49.5%	1,850	13.9%
5. Balkumari VDC	1,008	49.2%	1,041	50.8%	2,049	15.4%
Sub-total:	6,566	49.3%	6,746	50.7%	13,312	34.9%
Ilaka #13:						
1. Ghyangphedi VDC	1,194	46.2%	1,390	53.8%	2,584	21.6%
2. Gaukharka VDC	1,480	50.4%	1,459	49.6%	2,939	24.5%
3. Rauthbesi VDC	1,480	48.4%	1,577	51.6%	3,057	25.5%
4. Beteni VDC	1,714	50.5%	1,681	49.5%	3,395	28.4%
Sub-total:	5,868	49.0%	6,107	51.0%	11,975	31.4%
TOTAL:	18,934	49.7%	19,164	50.3%	38,098	100.0%

Source: HMG/N, CBS, 1991 census survey

Since the ilakas have a total of 38,098 population and 7,036 households, the average family size of the area comes to 5.4 people per household.

Ralukadev VDC of Ilaka #12, with a population of 2,120, is the largest VDC of the project area. Looking at the size of the VDC on a map, it appears to be one of the smallest VDCs in terms of land area. Therefore, the VDC can be assumed to have the highest population density in comparison to the other VDCs of the area.

3. Ethnography:

The CS VII project area is predominantly inhabited by Tibeto-Burman speaking Tamang and highlander Sherpa people. The other minority Tibeto-Burman people that dwell in the area include Gurung, Newar and Magar. The Indo-Aryan groups of high caste Brahmin, Chhetri and the scheduled caste people such as Damai, Kami and Sarki also form a large share of the population of the project area.

Household distribution by ilakas & ethnic groups

Ethnic Group	Ilaka #1		Ilaka #12		Ilaka #13		Total	
	HHS	%	HHS	%	HHS	%	HHS	%
1. Tamang	1,164	48.9%	1,230	49.3%	1,753	81.1%	4,147	58.9%
2. Chhetri	526	22.1%	635	25.5%	127	5.9%	1,288	18.3%
3. Brahmin	168	7.1%	309	12.4%	30	1.4%	507	7.2%
4. Scheduled	113	4.7%	160	6.4%	78	3.6%	351	5.0%
5. Newar	117	4.9%	131	5.3%	4	0.2%	252	3.6%
6. Gurung	212	8.9%	14	0.6%	24	1.1%	250	3.6%
7. Sherpa	4	0.2%	5	0.2%	139	6.4%	148	2.1%
8. Magar	76	3.2%	2	0.1%	3	0.1%	81	1.2%
9. Muslim	2	0.1%	7	0.3%	3	0.1%	12	0.2%
Total HHS:	2,382	100%	2,493	100%	2,161	100%	7,036	100.0%

Source: HMG/N, National Election Commission, 1991 voter's list

The Chhetri, Brahmin, Newar, Muslim and scheduled caste people are mostly concentrated in the river basin plain and fertile area and are better off than others. Generally the Tamang, Gurung and Magar people inhabit mid-hills while the Sherpas occupy northern foothill area of Himalayas.

In the region, the Indo-Aryan groups of Brahmin, Chhetri and scheduled caste Kami, Damai and Sarki, as well as Newars, strictly follow the Hindu religion. It is widely believed that in the distant past, the Tamang, Sherpa, Gurung and Magar people of Mongoloid origin migrated from Tibet with their Buddhist religion to settle in the northern mid-hills of Nepal. As they started mingling with southern Indo-Aryan Hindu people for the necessity of economy and trade, their traditions and religion began to deteriorate. Though these people in the region, excluding Sherpas, equally observe the major rites and rituals of both Buddhism and Hinduism, the majority of them nowadays consider themselves to be Hindus. The only Buddhist religion yet to be impaired by the influence of the Hindu majority of the country remains that of the Sherpa people. Protected by isolation, the Sherpa people still retain their traditional religion, cultures and beliefs.

4. Education:

As according to the survey data, the literacy rate of the project area is extremely low. Only 17.1% of the ilakas total population are literate. The Demographic Sample Survey 1986-87 First Report indicates 34.8% percent of national literacy rate (UNICEF, 1992).

The survey data indicates that women's education status of the area is considerably lower than males while it lists 6.6% female literacy rate and 28.8% male literacy rate. As estimated by HMG/N, Ministry of Education, the national literacy figures are 18% for females and 54% for males.

It is been heard during the survey that there is a very high school dropout rate in the region. In some remote primary schools, only two or three students attend school regularly. Further, it is learnt that due to budget and manpower constraints, a few ALCs organized by the government around the region became total failure.

5. Economy:

To date the national development work has not delivered its promise to alleviate poverty in the region like in most part of the country. Still, much of the population falls below absolute poverty line in the region. In the case of Tamangs and Sherpas, the matter is even worse.

A few centuries back, the Tamang people of the region were believed to be taken by force to become a bondage-laborers (slaves) by then ruler Kings and their men. The men were usually put to work to assist the army as their attendants while the women were turned into mistresses for royalty. The practice escalated to an all time high during the time of Rana rule of late 18 century A.D., as we came to hear during the survey. The social horror that they went through at that time is still evident in some remote Tamang communities of the region. Some elites of the area give us this impression as they told us the people living in some of these communities still run away to hide themselves, afraid of being taken from their family forever, if they see a stranger coming towards their community or else act at least very indifferent to them.

The consequences of this unjust act of past rulers have brought them some social disorder and disharmony that is gradually beginning to come into a light at the national level. One of the most shameful outcomes is the great numbers of young girls and women of the area now found to be indulging in body-trade in the cities of Nepal and India. The Thulo Gaon, or big village as the people of the area usually call the great port of Bombay in India, houses many Tamang prostitutes of the region. The brothels give them substandard living facilities with some or no money to entertain daily many ships' crews and tourists from around the world. Besides Tamangs, other ethnic groups of the area such as Newar, Brahmin and Chhetri are also beginning to lineup for such affairs. In some households and communities, this practice is beginning to become socially accepted for the

mere reason of economic benefit. If this is not put to an end, the practice will soon be turned into a widely accepted social norm of the area. Perhaps the most damaging factor will be the things that these returnee prostitutes will bring back with them into the community, like bad influences and the HIV virus that causes AIDs.

The apparently growing cases of AIDs in the area is not only to be blamed upon these returning prostitutes, but also upon the men who are engaged in migratory wage labor. Forced by social upheaval, poverty, illiteracy, steady growth of population and scarce resources, many Tamang and Sherpa men often are found working in the cities of Nepal and India as a menial laborers. When they return to their community, with little hard-earned wealth, they might also carry the HIV virus with them.

A few Sherpas and the Newar people in the area are found doing petty businesses. Some of them have opened small shops in their home that retail small quantities of daily necessities. The highlander Sherpas also occasionally found to engage in barter trade with Brahmin and Chhetri of lower river basin areas on a seasonal basis. The chief trade items of the Sherpa of the region are negligible amounts of high altitude potatoes and wild alpine herbs that are usually bartered with rice. All the rest of the people of the region are found to depend entirely upon subsistence farming and nominal livestock rearing for their livelihood.

Since some households have occupied the fertile land of lower river basin area, they are relatively well off compared to other ethnic groups of the area. Among them are chiefly the Brahmin and Chhetri. These households often produce little more surplus than what they usually consume in a year. Such groups of households have comparatively higher education and standard of living than others in the region. Based on the measurement of production and consumption factor, an economic standard of a rural household can be truly assessed and can be grouped into three broad categories, namely adequate lot, poor, and the poorest of the poor (POP).

Production vs. consumption pattern of sample households

Consumption	Households	%
Adequate lot:		
>= 9 months	99	47.1%
Poor:		
>= 6 to < 9 months	52	24.8%
Poor of the poorest:		
<= 6 months	59	28.1%
TOTAL:	210	100.0%

These figures will help us estimate the percentage of households or population of the project area falling into these categories in order to assess their economic status.

Summary of FindingsSecondary Source:

1. Households:	Ilaka # 1	-	2,382	33.9%
	Ilaka # 12	-	2,493	35.4%
	Ilaka # 13	-	2,161	30.7%
	Total	-	7,036	100.0%
2. Population:	Female	-	19,164	50.3%
	Male	-	18,934	49.7%
	Ilaka # 1	-	12,811	33.6%
	Ilaka # 12	-	13,312	34.9%
	Ilaka # 13	-	11,975	31.4%
	Total	-	38,098	100.0%
3. Family size per household		-		5.4
4. Ethnic group:	Tamang	-		58.9%
	Chhetri, Brahmin, and scheduled caste groups	-		30.5%
	Newar, Gurung, Sherpa and Magar	-		10.5%

Primary Source (survey):

5. Average family size per household as according to sample households	Ilaka # 1	-		5.8
	Ilaka # 12	-		7.1
	Ilaka # 13	-		6.4
6. Literacy rate:	Female	-		6.6%
	Male	-		28.0%
	Total	-		17.1%
	Interviewed mothers	-		3.9%
7. Mothers currently breast-feeding		-		95.7%
Bottle-feeding mothers		-		2.9%
Mothers supplement child's food with fat-		-		49.5%
Mothers having growth monitoring cards		-		3.3%
8. Diarrheal disease within last 15 days		-		43.8%
Mothers completely stopped breast-feeding while child had diarrhea		-		0%
Mothers completely stopped fluid based foods while child had diarrhea		-		13.0%
Mothers completely stopped solid foods while child had diarrhea		-		14.1%
Did nothing when child had diarrhea		-		42.9%
Gave Jeevan Jal and Sugar-salt solutions while child had diarrhea		-		17.3%
Mothers who correctly prepared Jeevan Jal while child had diarrhea		-		50.0%

Don't have any idea to take any action if child has diarrhea	-	16.0%
Don't have any idea of feeding practice if child has diarrhea	-	13.4%
Mother has no knowledge of Jeevan Jal	-	32.9%
Mothers who either has not heard of the Jeevan Jal or even having heard does not know how to correctly mix it-		77.6%
9. Sample Households having pit-latrine		23.3%
Mothers having no idea of causes of diarrhea and dysentery	-	20.8%
10. Mothers that said their child is immunized	-	46.7%
Mothers who have no idea at what age child should be immunized against measles	-	61.9%
Mothers who have no knowledge why TT shots are given to them	-	79.5%
Mothers having child's immunization card	-	19.5%
Vaccination coverage rate: DPT	-	2.4%
Polio	-	2.4%
BCG	-	18.6%
Measles	-	4.8%
Complete coverage (0 - 23 mo.)	-	1.4%
Complete coverage (12 - 23 mo.)	-	2.4%
11. Mothers having antenatal examination card	-	0%
Mothers having TT card	-	5.2%
TT coverage rate	-	7.1%
Mothers currently pregnant	-	9.5%
Mothers who are not currently pregnant but have a desire to have a baby within next two years	-	9.5%
Mothers who do not want to be pregnant but are not adopting any family planning method currently	-	91.9%
12. Mothers who have observed ARI problem in their child during last 15 days	-	43.8%
Within this case who has rapid and difficulty in breathing	-	96.7%
Within this case who did not seek any treatment for child	-	44.6%
13. Sample households having fruit trees	-	42.4%
Mothers who are doing winter vegetables farming	-	92.4%
14. Sample households having fodder trees	-	57.1%
Sample households having smokeless stove-		2.4%

SAVE THE CHILDREN
NEPAL FIELD OFFICE
CHILD SURVIVAL 8
KAP SURVEY REPORT
Sexually Transmitted Diseases/AIDS

Ilakas 1, 12 and 13
Nuwakot District

Agency for International Development

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Table of Contents

I.	Introduction	
A.	Backgroud	1
B.	Objective of the Baseline Survey	2
C.	Outline of Survey Areaa	3
II.	Methodology	
A.	Sampling	3
B.	Recruitment and Training of Supervisors and Interviewers	5
C.	Data Collection	5
D.	Questionnaire	6
III.	Analysis of Demography and Social Characteristics	
A.	Characteristics of Survey Population	6
B.	Characteristics of Respondents	13
IV.	Survey Findings	
A.	Sexually Transmitted Disease	17
B.	Aquired Immuno Deficiency Syndrome	21
C.	Condom - Safe Sex	28

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Raghu Thapalia, the survey coordinator, worked with patience and endurance. His technical expertise in editing of questionnaires and supervision of interviews was instrumental to the study. We are also grateful to Ravindra Thapa, CS VIII Project Coordinator, for arranging all necessary support for this survey effort and his own work during the planning phase and training of survey field team.

We are most obliged to the Country Director, Keith Leslie, and Program Director, Bharat Devkota, for entrusting us this assignment. We are thankful to District Public Health Office and health post staff for their full cooperation. We are also grateful to both WHO/GPA and USAID for their generous support. We are also thankful to Francis Wang for undertaking the painstaking job of editing the report. Thanks also goes to the secretarial staff, Urmila Kashyap and Anjali S. Manandhar of the Program Department, for making it possible to produce this report in a proper format.

**SURVEY ON KNOWLEDGE, ATTITUDE AND PRACTICE
REGARDING STDs/AIDS IN NUWAKOT**

Executive Summary:

Save the Children US conducted a 30-cluster sample survey of knowledge, attitudes and practice of STDs/AIDS (Sexually Transmitted Disease/Acquired Immune Deficiency Syndrome) and safe sex practices in Nuwakot, a middle hill district of Nepal, in November-December, 1992. 210 males and 210 females aged 15-45 years were interviewed. Most respondents were married (82%) and illiterate (76%). The majority of the inhabitants in the survey area are Tamang people (62%). Due to illiteracy and poverty, many Tamang girls have been taken to India where they have been subjected to prostitution.

General awareness of STDs is very low (15%); for females it is 7% and for Tamangs overall it is 8%. Education level has a clear effect on awareness: only 4% of illiterates are aware of STDs, while 69% of people with 6-10 class level of education are aware of STDs. Only 9% of all respondents know about the prevention of STDs and 13% have knowledge of signs and symptoms of STDs.

More respondents know about AIDS (24%) than STDs: for females it is 13% and for Tamang people 15%. AIDS awareness increases considerably with education. Only 9% of illiterates know of it, while this proportion reaches 80% for those with a 6-10 class level of education. Those who are aware have heard about AIDS mainly from the radio (59%). The reach of other communication media seems limited: 17% from posters and 14% from health workers.

Knowledge regarding AIDS transmission was highly correct. Among those aware of AIDS, 94% think sex is the prime route of transmission. However, some have the misconceptions that handshakes (14%), sharing clothes (20%), and mosquito bites (14%) can cause this disease.

42% have some knowledge about the prevention of AIDS by avoiding sex with an infected person and avoiding use of unsterile skin-piercing instruments. When questioned regarding the use of condoms (safe sex), 46% knew what condoms are, but only 4% of married respondents had used condoms during the previous month. Awareness of condoms is low among females (27%) and Tamangs (31%). Regarding the purpose of condom use, 53% stated pregnancy prevention and 12% stated AIDS/STD prevention.

These findings clearly indicate a need to launch a well-coordinated literacy and AIDS/STD prevention campaign focussed on women and people from disadvantaged castes, like the Tamang.

I. Introduction

A. Background:

The Save the Children US (SC/US) Nepal Field Office initiated a Child Survival VIII (CS VIII) project (funded by USAID) and AIDS Education and Prevention project (funded by WHO) in Ilakas 1, 12, and 13 of Nuwakot District of Central Nepal in October, 1992. The target population of 38,098 includes 6,096 children under five years, and 7,620 women between 15 and 45 years of age. SC/US planned to implement the AIDS Education and Prevention Project in Nuwakot district of Central Nepal because of the problems of women trafficking and prostitution there. The project has been planned to combine the multi-sectoral expertise of SC/US, Shrijana Bikash Kendra and the Nepal National Social Welfare Association (NNSWA) to support Nepal's National AIDS Prevention Project.

The key interventions of the project include identifications of the at-risk population, training of NGO and HMG staff on STD and AIDS education, training of AIDS educators and peer counsellors, transmitting AIDS knowledge, education and awareness; and treating sexually transmitted diseases.

The objectives of the AIDS Education and Prevention Project are:

To train Shrijana Bikash Kendra, NNSWA and government health post and district education office staff on how to provide AIDS education, counselling, referral and support services to villagers;

To educate 50% of the population over fourteen years of age in targeted communities about AIDS, how it is contracted, how to prevent STDs and HIV infection and how to care for people who have AIDS;

To raise awareness among 50% of the targeted population about how to recognize, obtain treatment, and protect against STDs;

To establish peer counsellors in the targeted high-risk communities who will educate community members about AIDS and encourage women at risk of entering prostitution to consider other professions;

To accomplish the above objectives by the end of the project. SC/US has received US \$34,500 from WHO GPA program matched by a US \$513,482 CS VIII budget. The WHO project will end in one year and CS VIII project will continue for over three years in the Nuwakot project area.

81

B. Objective of the Baseline Survey:

The data has been collected from a sample survey which can be used for project design, management and evaluation purposes. The objective of the STD/AIDS baseline survey is to provide project staff with baseline information about the following issues:

- The demographic and social characteristics of the population in the project area;
- The level of knowledge of people about STD/AIDS infections and prevention measures;
- People's perceptions and attitudes towards HIV positive/AIDS patients; and,
- The actual practices of men and women for the prevention of STDs and HIV/AIDS infections.

C. Outline of Survey Areas:

Save the Children US recently started its program in Ilakas 1, 12 and 13 of Nuwakot district. These three Ilakas cover 14 VDCs out of the 62 VDCs of Nuwakot district. Geographically, Nuwakot lies in the Central Region of Nepal. The total area of Nuwakot is 1121 sq.km. and that of the three Ilakas 253 sq.km. This district is surrounded by Kathmandu district to the south, Sindhupalchowk district to the east, Rasuwa district to the north and Dhading district to the west. The project area, although so near to the capital city, Kathmandu, is virtually inaccessible by any modern means of transportation and communication. Trekking is the best way to visit. The altitude of these three ilakas range from about 1000 metres to 4000 meters.

The tables below illustrate the number of households and the population in the project area. The three ilakas consist of a total of 38,098 population with a sex ratio of 101. Ilaka 12 is the most populated with 13,312 inhabitants (35%). Among the VDCs, Relukadevi VDC has the largest population of 4,218 (11%) and Chhap has the smallest with 1,815 (5%).

Table # 1 : Population and Household by VDC.

Ilaka/VDC	# of * house- holds	P O P U L A T I O N **			Sex Ratio
		Male	Female	Total	
<u>Ilaka # 1</u>					
1. Mahakali VDC	555	1,729	1,713	3,442	101
2. Likhu VDC	527	1,249	1,300	2,549	96
3. Talakhu VDC	582	1,525	1,570	3,095	97
4. Sikre VDC	361	914	996	1,910	92
5. Chhap VDC	357	894	921	1,815	97
Sub-Total	2,382	6,311	6,500	12,811	97
<u>Ilaka # 12</u>					
1. Ralukadevi VDC	804	2,098	2,120	4,218	99
2. Sundaradevi VDC	371	1,097	1,032	2,129	106
3. Sikharbesi VDC	563	1,595	1,471	3,066	108
4. Samundratar VDC	338	915	935	1,850	98
5. Balkumari VDC	417	1,041	1,008	1,008	103
Sub-Total	2,493	6,746	6,566	13,312	103
<u>Ilaka # 13</u>					
1. Ghyangphedi VDC	500	1,390	1,194	2,584	116
2. Gaunkharka VDC	490	1,459	1,480	2,939	99
3. Rautbesi VDC	559	1,577	1,480	3,057	106
4. Betini VDC	612	1,681	1,714	3,395	98
Sub-Total	2,161	6,107	5,868	11,975	104
Total	7,036	19,164	18,934	38,098	101

Source: * HMG/N, National Election Commission, 1991 voter's list
 ** CBS, 1991 Census Survey.

II. Methodology

A. Sampling:

This survey has followed the WHO recommended 30 cluster survey technique, which allows a small number of targeted population to be sampled while providing data that is statistically valid.

For the calculation of sample size, the following formula was used in this survey:

$$n = Z_a^2 \times pq/d^2$$

where n = sample size
 Z_a = level of confidence
 p = expected level of prevalence
 q = 1-p
 d = margin of error

For this survey, the desired level of certainty (α) was 95%, from the statistical table which gives a 1.96 level of confidence (Z_a). Allowable margin of error was taken as 0.1 which would give a level of precision +/- 10%. As the level of STD/AIDS awareness or knowledge was not known, p was assumed to be 0.5 which requires the largest sample size.

$$\text{Hence, } n = 1.96^2 \times 0.5^2 / 0.1^2 = 3.84 \times 0.25 / 0.01 = 96$$

The maximum sample size is 96. However, as cluster survey technique is employed here, sample size was increased to 210 in order to balance the effect of bias due to not randomly selecting individuals from the whole population. To obtain separate valid results for males and females, 210 people from each of these two groups were interviewed, which gave a total sample of 420.

i) Selection of Clusters:

30 clusters were selected on the basis of "probability proportionate to size" as mentioned in "Households Survey Manual: Diarrhoeal Case Management, Morbidity and Mortality" (Diarrhoeal Disease Control Program, WHO, Geneva, 1989). For this survey, wards of Ilakas 1, 12 and 13 were taken as clusters. A list of all the wards with population was prepared and population was cumulated. Sampling interval was calculated by dividing the total population by the number of required clusters (i.e. 30 in our case). The first cluster was selected with the help of a random number. The second cluster was selected by adding sampling interval to the random number and subsequent clusters were chosen in the same manner. This technique of cluster selection ensures the sample to be probability proportionate to size.

ii) Selection of Household:

Within the cluster also, one community was randomly selected for the survey. For selecting the households, the survey team first went to the center of the village and chose a direction by spinning a bottle on the ground. All the households in that direction were listed and one household was randomly selected with the help of a currency note. For the subsequent interviews the next closest household was selected until 7 males and 7 females had been interviewed.

As the respondents for the survey were to be sexually active males and females (i.e., 15 to 45 year olds), only those households with such members available for interviews, were selected. In total, 373 households were covered in the survey. This figure is less than 420 because in 47 cases, both males and females were interviewed from the same household.

B. Recruitment and training of supervisors and interviewers:

As this survey was being conducted simultaneously with the "Baseline Health Survey" of the mentioned areas of Nuwakot district, the same Field Supervisors and interviewers were assigned both survey tasks. All the Field Supervisors were taken from among the SC/US field staff. The positions of the interviewers were advertised locally with a minimum qualification of SLC pass. After careful screening, 30 interviewers were hired. 12 Supervisors led the team for a ratio of about 1:3. The majority of members of this data collection team was female.

A week long intensive training was provided to both the Field Supervisors and to the interviewers. In the training, the main emphasis was on the practice sessions which included classroom role plays as well as practice in the real life situation. Topics covered were study objectives, household/respondent selection, questionnaire and interview technique. The training schedule is attached in Appendix 1 at the end of this report.

C. Data collection:

The survey was accomplished in one week's time between November 23 and November 30, 1992, simultaneously with the baseline community health survey. The same survey teams collected data for both studies. In most of the cases, interviews were conducted by female interviewers, and only in some of the instances were male interviewers used. On average, one interview took 30 minutes.

85

D. Questionnaire:

The questionnaire for this survey was designed with the help of standard questions as suggested for KAP (Knowledge Attitude and Practice) Surveys in HAPA Grants Projects. However, for the local context, some of the questions were deleted and other new questions were added.

In order to obtain information about population characteristics on key variables like age, sex, education, ethnicity, and marital status, a family roster was designed. This roster also helped to identify potential respondents for detailed interviews regarding knowledge, attitudes and practice.

The main questionnaire was divided into three parts: STDs, AIDS, and Condoms. For STDs questions were focussed on awareness, knowledge of signs and symptoms, and knowledge about preventions. For AIDS, in addition to these, other questions regarding source of information, knowledge about types of treatment and modes of transmission, and attitudes towards infected people were also included. Questions about condom were designed to obtain data regarding awareness, knowledge of source of supply and use of condoms.

Most of the questions were structured, but some questions could not be closed because all the possible options were not known and so were left open-ended. The questions were pre-tested and modified as needed.

III. Analysis of Demographic and Social Characteristics:

A. Characteristics of Survey Population:

The total number of households surveyed was 373, which comprises 5.30% of the total households in the SC/US project area (Ilakas 1, 12 and 13 of Nuwakot district). Demography and social characteristics of all the household members were collected during the survey. The total population of surveyed households was 2,372, or 6.23% of the population in the project area. The number of households and the population covered in each ilaka have been presented in Table 3 below:

Table # 2: Households (HH) and Population of Ilakas Surveyed

Ilaka#	# of selected clusters	Total # of HHs	# of HHs covered by the survey	% of HH covered by the survey	Total # Population	Total # of Population covered by the survey	% of Population covered by the survey
1	9	2,382	115	4.83	12,811	751	5.86
12	13	2,493	160	6.42	13,312	1,013	7.61
13	8	2,161	98	4.53	11,975	608	5.08
Total	30	7,036	373	5.30	38,098	2,372	6.23

The most people and the highest proportion of households were surveyed in Ilaka 12 (6.42%) whereas other ilakas were almost similar in terms of coverage. This discrepancy of coverage has arisen due to differences in the number of clusters selected from the ilakas and not due to defects in household selection.

The people surveyed were family members who share a common kitchen, irrespective of whether or not they were in the house at the time of the interview. It is the de jure population which is larger than the resident population of the sample households.

i) Population Distribution and Age/Sex Composition:

Table 3: Population distribution by age and sex

Age Groups	Male		Female		Total		Sex Ratio
	No.	%	No.	%	No.	%	M/F x 100
0-4	192	16.11	239	20.25	431	18.17	80.34
5-9	164	13.76	166	14.07	330	13.91	98.79
10-14	148	12.42	130	11.02	278	11.72	113.85
15-19	102	8.55	103	8.73	205	8.64	99.03
20-24	102	8.55	105	8.90	207	8.73	97.14
25-29	103	8.64	102	8.64	205	8.64	100.98
30-34	88	7.38	77	6.52	165	6.96	114.28
35-39	75	6.29	59	5.00	134	5.65	127.12
40-44	70	5.87	62	5.25	132	5.56	112.90
45-49	25	2.10	24	2.03	49	2.07	104.17
50-54	37	3.10	24	2.03	61	2.57	154.17
55-59	22	1.85	23	1.95	45	1.90	95.65
60-64	33	2.77	31	2.63	64	2.70	106.45
65-69	13	1.09	14	1.19	27	1.14	92.86
70-74	12	1.01	13	1.10	25	1.05	92.31
75-79	4	0.34	6	0.51	10	0.42	66.67
80+	2	0.17	2	0.17	4	0.17	100.00
Total	1192	100	1180	100	2372	100	101.02

Source:

Table 3 shows the distribution of the population surveyed by five year age groups and sex. Children under five years correspond to 18% of the total population and 43% are children under fourteen. The productive age population (15 to 64 years) constitutes 52.42%, and the aged population (65+ years) is 2.78%. Thus the aged dependency ratio is quite low (5.30), whereas the child dependency ratio is remarkably high (82.03) which is a typical characteristic of traditional societies with both high fertility and high mortality rates. The total dependency rate is 87.33%.

During childhood, the sex ratio is more skewed towards females (80.34). However for those of reproductive age, the sex ratio is more skewed in favor of males. This indicates a high rate of maternal mortality. As age advances, the sex ratio again favors females. The overall sex ratio of the survey population is 101 males per 100 females.

Although fertility was not directly measured, an idea of it can be obtained from the child-woman ratio. This ratio is 0.85, which means there are 85.0 children below 5 years of age for every 100 women of reproductive age (15 to 44 years). This ratio is a little high, in comparison to that of Nepal overall, which is 0.76.

The proportion of women in the reproductive age group (15 to 44 years) is 21%, which is very near the estimate for all of Nepal in 1990. However, the proportion of children below 5 years of age is higher for the survey population (18%) than that of all Nepal (16%).

ii) Ethnicity and Religion:

Table 4: Household Distribution by Ethnicity.

Ethnicity/ Caste Groups	No.	%	Cumulative %
Tamang	232	62.20	62.20
Chhetri	52	13.94	76.14
Gurung	36	9.65	85.75
Brahmin	29	7.77	93.56
Scheduled Castes (Damai/Kami)	14	3.76	97.32
Other Castes	10	2.68	100.00
Total	373	100.00	

According to Table 4, the project area (ilakas 1, 12, 13 of Nuwakot) is largely inhabited by Tamang people. Tamang households constitute 62.20% of the whole. The second most numerous are Chhetri, who number 13.94%. The dominant Brahmin caste households make up only 7.77%. The more deprived scheduled castes Damai and Kami constitute 3.76%.

Table 5: Household Distribution by Religion.

Religion	No. of Households	% of Households
Buddhist	246	65.95
Hindu	127	34.05
Total	373	100.00

As most of the Tamang people are Buddhist, this religion is followed by an equally high proportion of households (65.95%). All the remaining households belong to the Hindu religion. This suggests that the survey results are substantially influenced by the beliefs and attitudes of the Tamang ethnic group.

31

iii) Population Outside:

Table 6: Population Inside and Outside.

	Male		Female		Total	
	No.	%	No.	%	No.	%
Outside	105	8.81	39	3.31	144	6.07
Inside	1087	91.19	1141	96.69	2228	93.93
Total	1192	100.0	1180	100.0	2372	100.0

As seen in Table 6, out of the total survey population, only 6.07% were outside of the home on the day of the interview. The proportion of females outside is even lower (3.31%). This figure may be understated due to the deliberate or undeliberate under-reporting of females outside. As in other retrospective surveys, the respondent may have forgotten to report family members absent for a long duration. Under-enumeration may also arise if the respondents are ashamed or afraid of disclosing the long absence of a female family member.

Table 7: Population Outside Home and Purpose by Sex.

Purpose/Place	Male		Female		Total	
	No.	%	No.	%	No.	%
Study in Nepal	14	13.33	4	10.26	18	12.50
Work in Nepal	54	51.43	17	43.59	71	49.31
Study in India	x	-	x	-	x	-
Work in India	13	12.38	8	20.51	21	14.58
Missing/Lost	3	2.86	x	-	3	2.08
In Nepal for just a few days (Travelers/visit to relatives)	17	16.19	6	15.38	23	15.97
Others (Children accompanying their parents)	4	3.81	4	10.26	8	5.56
Total	105	100	39	100	144	100

As presented in Table 7 regarding the purpose of being outside, nearly half (49.31%) have gone to work in places within Nepal. For females, the second most popular reason is that they have gone to work in India (20.51%). For males, it is that they have gone travelling or visiting relatives within Nepal (16.19%).

for females to be outside (10.26%), although it is slightly more common for males (13.33%). The percentages here for male and female denote different levels of numbers in absolute terms.

iv) Marital Status:

Table 8: Marital Status of Above-14 Population by Age and Sex (in percentage).

Age Group	Male				Female			
	Unmarried	Currently Married	Widowed	Divorced/ Separated	Unmarried	Currently Married	Widowed	Divorced/ Separated
15-19	65.29	14.71	-	-	66.99	33.01	-	-
20-24	36.27	63.73	-	-	10.48	89.52	-	-
25-29	11.65	97.35	-	0.97	7.54	92.16	-	-
30-34	7.95	92.05	-	-	3.90	93.51	1.30	1.30
35-39	6.67	90.67	1.33	1.33	-	96.61	3.39	-
40-44	-	98.57	-	1.43	1.61	90.32	6.45	1.61
45-49	-	92.00	8.00	-	-	91.67	8.33	-
50-54	-	89.19	10.81	-	-	83.33	16.67	-
55-59	-	86.36	13.64	-	-	86.96	13.04	-
60-64	-	72.73	27.27	-	-	70.97	22.58	6.45
65+	-	80.65	19.35	-	-	37.14	62.86	-
Total	21.51	74.42	3.63	0.44	14.26	78.14	6.98	0.62
n	148	512	25	92	92	504	45	4

Table 8 shows the marital status of the men and women above 14 year by five year age groupings. Although it is sometimes customary to present this data for the above 10 year population, here it is calculated only for above 14 years because there was no one married before that age.

The proportion of married males in the 15 to 19 year age group is 14.7%, whereas for females it is almost double (33%). The largest group of currently married is the 40 to 44 year age group for males (98.64%), and for females it is five years earlier, the 35 to 39 year age group (96.6%). The proportion of currently married gradually decreases after this age for both sexes. In the last age group, 65+ years, the proportion of widowed (62.9%) is far greater than the proportion of widower (19.4%), which indicates a higher mortality rate for elderly males.

The overall proportion of currently married is 74.4% for males and 78.14% for females. Among males, 78% are in the ever-married category and 22% are yet to marry. Among females, this ever-married rate is even higher, 86%, and only 14% are unmarried. This high proportion of marriage is consistent with the universal marriage pattern in most of the countries in Asia.

v) Educational Status:

Table 9: Educational Status of Population Above 4 Years of Age by Sex.

Educational Status	Male		Female		Total	
	No.	%	No.	%	No.	%
Illiterate only	573	57.30	838	89.05	1411	72.69
1-3 grade	115	11.50	30	3.19	145	7.47
Total Illiterates	688	68.80	868	92.24	1556	80.16
Literate only	92	9.20	28	2.98	120	6.18
4-5 grade	84	3.40	23	2.44	107	5.51
6-9 grade	100	10.00	20	2.13	120	6.18
SLC and above	36	3.60	2	0.21	38	1.96
Total Literates	312	31.20	73	7.76	385	19.84
All Total	1000	100.0	941	100.0	1941	100.0

As seen in Table 9, the literacy rate of the survey population is only 19.8%. For males it is 31.2% and for females only 7.8%. This rate is quite low in comparison to the literacy rate of Nepal, which is 40%. (male 55% female

25%). However, this low rate might have been derived due to the strict definition of literacy by SC/US. Only those who can fully read and write or those who have passed grade 4 and above were regarded as literate. Those with schooling below grade 4 were regarded as illiterate. Remarkably, 72.7% of the population has had no exposure to any form of education, neither formal nor informal.

Regarding school education, 7.5% have acquired primary education, 5.5% lower secondary education (4-5 grade), and 6.2% secondary education (6-9 grade). Only a meager 0.2% have secured higher education (SLC and above). The level of female education is even lower. Only 3.2% have received primary education and only 2.2% have received secondary education.

B. Characteristics of Respondents:

Altogether, 210 males and 210 females were interviewed in detail regarding STD/AIDS knowledge and attitudes. From Ilaka 1 there were 126 respondents, from Ilaka 12 there were 182 respondents, and from Ilaka 13 there were 112 respondents.

i) Age and Sex Composition:

Table 10: Age/Sex distribution of respondents.

Age Group	Male		Female		Total	
	No.	%	No.	%	No.	%
15-19	37	17.62	30	14.29	67	15.95
20-24	38	18.10	53	25.24	91	21.67
25-29	33	15.71	47	22.38	80	19.05
30-34	36	17.14	37	17.62	73	17.38
35-39	34	16.19	21	10.00	55	13.10
40-45	32	15.24	22	10.48	54	12.86
Total	210	100.00	210	100.00	420	100.00

Males and females between the ages of 15 to 45 only were selected to be the respondents for this survey. As seen in Table 10, among male respondents, all the age groups are almost equally represented with the 20 to 24 years age group being slightly more represented (18.10%). However, among females, the distribution is uneven. It reaches its peak in the 20 to 24 years age group (25.24%) and becomes lowest for the 30 to 34 years age group (10%). For both sexes also, the 20 to 24 years age group is the most represented

(21.7%). The mean age of male respondents is 29 years and that of female respondents is 27.5 years. For both sexes the mean age is 28.25 years.

ii) Marital Status:

Table 11: Distribution of Respondents by Age and Marital Status (in percentage).

Age Group	Male					Female				
	Unmarried	Married	Widowed	Divorced/ Separated	Total	Unmarried	Married	Widowed	Divorced/ Separated	Total
15-19	81.08	18.92	-	-	100.0	63.33	36.67	-	-	100.0
20-24	34.21	65.79	-	-	100.0	5.66	94.34	-	-	100.0
25-29	9.09	90.91	-	-	100.0	4.26	95.74	-	-	100.0
30-34	2.78	87.22	-	-	100.0	2.70	94.59	-	2.70	100.0
35-39	2.94	94.12	2.94	-	100.0	-	100.00	-	-	100.0
40-45	-	100.00	-	-	100.0	-	100.00	-	-	100.0
Total	22.86	76.67	0.48	-	100.0	11.90	87.62	-	0.48	100.0
n	48	161	1	-	210	25	164	-	1	210

Table 11 presents the marital status of respondents. 77% of males and 88% of female respondents are currently married. Among males, the proportion married is highest in the 30 to 34 years age group (97%) and among females it is highest in 25 to 29 years age group (96%). By age 34, all the females are married and after age 39 all the males are married. At younger ages, more unmarried people have been represented as respondents. The proportion of unmarrieds for younger ages is higher for respondents than for the survey population. On the whole, people widowed/separated/divorced are the least represented as respondents. It shows a tendency, especially among females, for only those currently married to be available for interviews on intimate issues like STD and AIDS.

iii) Educational Status:

Table 12: Distribution of Respondents by Educational Level.

Educational Level	Male		Female		Total	
	No.	%	No.	%	No.	%
Illiterate only	108	(51.43)	191	(90.95)	299	71.19
1-3 grade	16	(7.62)	4	(1.90)	20	4.76
Total Illiterates	124	59.05	195	92.86	319	75.95
Literate only	26	12.38	3	1.43	29	6.90
4-5 grade	16	7.62	7	3.33	23	5.48
6-9 grade	31	14.76	5	2.38	36	8.57
SLC and above	13	6.19	-	-	13	3.10
Total Literates	86	40.95	15	7.14	101	24.05
All Total	210	100	210	100	420	100

On average, respondents have more education than the survey population. However this is largely due to the male respondents. Among female the respondents are consistently at a lower level in almost all categories of educational status than the survey population. 41% of male respondents are literate, while only 7% of females fall in this category. While 6% of males have received higher education (SLC and above), no female has more than a 9th grade education. Overall, the literacy rate is 24% and more than 17% of respondents have received education above grade 3. The educational status of respondents has been given in Table 12.

95

iv) Ethnic Characteristics:

Table 13: Distribution of Respondents by Ethnicity.

Ethnicity/ Group	Male		Female		Total	
	No.	%	No.	%	No.	%
Tamang	135	64.29	126	60.00	261	62.14
Chhetri	28	13.33	24	11.43	52	12.38
Gurung	18	8.57	24	11.43	42	10.00
Brahmin	18	8.57	18	8.57	36	8.57
Scheduled Caste Damai/Kami	7	3.33	11	5.24	18	4.29
Other Castes Sherpa/Newar/Magar	4	1.90	7	3.33	11	2.62
Total	210	100.00	210	100.00	420	100.00

Table 13 illustrates the ethnic distribution of the respondents. The most represented ethnic group of the survey area is Tamang (62%). The subsequent positions are held by the Chhetri (12%), Gurung (10%), Brahmin (9%), scheduled castes (4%) and other castes (3%). In case of both Tamang and Chhetri, there are more male respondents than female. In the case of the Brahmin, both sexes are equally represented, and for other ethnic groups, the females out-number the males.

IV. SURVEY FINDINGS:

A. Sexually Transmitted Disease:

Systematic surveillance of sexually transmitted diseases (STDs) has not yet been completed in Nepal. In 1991, 556 Badi prostitutes were tested for HIV. They all tested negative. Seventy percent of them, however, tested positive for other STDs. This high rate of STD infection almost ensures that it will just be a matter of time before HIV also follows. Therefore, STD surveillance and development of a prevention strategy are urgently needed. In this survey information regarding knowledge on STD were collected to have a better insight on the problem.

i) Awareness Level:

In order to assess the level of awareness in the population regarding sexually transmitted diseases, a direct question was asked "whether they know about STD". The proportion of people aware is quite low as seen in Table 14.

Table 14: Ilakawise Distribution of Respondents According to Awareness of STD.

Ilaka	Awareness	Male		Female		Total	
		No.	%	No.	%	No.	%
1	Yes	15	23.81	2	3.17	17	13.49
	No	48	76.19	61	96.83	109	86.51
	Total	63	100.00	63	100.00	126	100.00
2	Yes	17	18.68	8	8.79	25	13.74
	No	74	81.32	83	91.21	157	86.26
	Total	91	100.00	91	100.00	182	100.00
3	Yes	15	26.79	5	8.93	20	17.86
	No	41	73.21	51	91.07	92	82.14
	Total	56	100.00	56	100.00	112	100.00
All 3 Ilakas	Yes	47	22.38	15	7.14	62	14.76
	No	163	77.62	195	92.86	358	85.24
	Total	210	100.00	210	100.00	420	100.00

Only 22% of males and 7% of females are aware of STDs. Table 15 shows that the level of awareness is highest in Ilaka 13 (17.86%) for both sexes. For females, awareness of STDs is lowest in Ilaka 1, with only 3.2% aware. For males, Ilaka 12 has the lowest awareness level at 18.7%. In all the Ilaka, the awareness level of males is greater than that of females. In total, less than 15% are aware of STDs.

Table 15: Distribution of Respondents with Awareness about STDs by Educational Attainment.

Educational level	Male		Female		Total	
	No.	%	No.	%	No.	%
Illiterate	5	4.63	7	3.66	12	4.01
Literate only	7	26.92	2	66.67	9	31.03
1-3 grade	3	18.75	-	0.00	3	15.00
4-5 grade	4	25.00	2	28.57	6	26.09
6-10 grade	21	67.74	4	80.00	25	69.44
SLC and above	7	53.85	-	-	7	53.85
Total	47	22.38	15	7.14	62	14.76

Table 15 presents STD awareness according to educational level. Among the illiterate, only 4% are aware of STDs. Awareness is highest in the 6-9 grade category (69%). Merely literate females are more advanced in terms of STD awareness (67%) than their male counterparts (27%). However, no female with 1-3 grade education is aware of STDs. This data indicates that people with 1-3 grade education are poor in overall knowledge than the people who can read and write well. However, from the table, it is clear that literacy and education can be important determinants for knowledge of STDs.

Table 16: Distribution of Respondents with Awareness of STDs by Ethnicity.

Ethnicity	Male		Female		Total	
	No.	%	No.	%	No.	%
Tamang	15	11.11	7	5.56	22	8.43
Chhetri	13	46.43	3	12.50	16	30.77
Gurung	6	33.33	-	0.00	6	14.29
Brahmin	10	55.56	3	16.67	13	36.11
Scheduled Castes	1	14.29	-	0.00	1	5.56
Damai/Kami						
Other Castes (Sherpa, Newar, Magar)	2	50.00	2	28.57	4	36.36
Total	47	22.48	15	7.14	62	14.76

Awareness was also cross-tabulated according to ethnicity; the results are illustrated in Table 16. Awareness level is highest among the other caste groups comprised of Sherpa, Newar and Magar (36.36%). The Brahmins also on the same level (36.11%). The Tamang people are least knowledgeable in terms of STD awareness (8% and 6%, respectively). The male-female gap regarding this

knowledge is very wide for all the ethnic groups. This difference is more pronounced in the case of upper caste people, who on the average have a higher awareness of STDs. 46% of Chhetri and 56% of Brahmin males know about STDs, however, this proportion is only 13% and 17% respectively for their female counterparts.

ii) Knowledge on Signs and Symptoms of STD:

Table 17: Distribution of Respondents According to Their Knowledge on Sign/Symptoms of STDs.

Symptoms	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Weight Loss/Weakness	19	40.43	8	53.33	17	27.42
2. Syphilis	9	19.15	1	6.66	10	16.13
3. Ulcer in Private Part	14	29.79	2	13.33	16	25.81
4. Red Spots	3	6.38	2	13.33	5	8.06
5. Itching	13	27.66	1	6.67	14	22.58
6. Discharge/Pus	8	17.02	1	6.67	9	14.52
7. Vaginal/Penise Warts	3	6.38	-	-	3	4.84
8. Urine troubles	3	6.38	-	-	3	4.84
9. Pain in lower abdomen/ vagina during intercourse	2	4.26	-	-	2	3.23
10. Others	9	19.15	1	6.67	10	16.13
11. Do not know	4	8.51	4	26.67	8	12.90
Total %	More than 100% due to multiple answers.					

The respondents who were aware of STDs were asked additional questions about the signs and symptoms of STDs. Their responses have been depicted in Table 17. About 13% could not give any answer, this non-response rate was higher in the case of females (27%) than males. The most common response identified weight loss and weakness (27%) as symptoms of STDs. This answer is highest both in the case of males (40%) and females (53%). Ulcers in private parts (26%) is the second most common answer. Itching was also pointed out by a high proportion (23%) of respondents. On average, male respondents could identify more types of symptoms (10) than females (7). Most of the symptoms identified by respondents were correct, hence it can be concluded that the respondents aware of STDs are knowledgeable regarding symptoms.

iii) Knowledge on Prevention of STD:

Table 18: Distribution of Respondents According to Knowledge of Prevention of STDs.

Knowledge	Male		Female		Total	
	No.	%	No.	%	No.	%
Yes	31	65.96	7	46.67	38	61.29
No	16	34.04	8	53.33	24	38.71
Total	47	100	15	100	62	100

Table 18 shows that only 61% of respondents who are aware about STDs, also know about its prevention. This knowledge level is lower for females (47%) and higher for males (66%). If calculated out of the total 420 respondents, only 9% know about prevention. This proportion is very low for females (3%) and not much higher for males (15%).

Table 19: Distribution of Respondents by Knowledge on Ways to Prevent STDs.

Ways to Prevent	Male		Female		Total	
	No.	%	No.	%	No.	%
1. No contact with infected person (Stay/eat)	3	9.68	4	57.13	7	18.42
2. No sex with infected person	7	22.58	1	14.29	8	21.05
3. No sex with many partners	3	9.68	3	42.86	6	15.79
4. Abstain from sex	6	19.35	-	-	6	15.79
5. Use condom	7	22.58	-	-	7	18.42
6. Clean sex organs before/after intercourse	4	12.90	-	-	4	10.53
7. Medical advice (Hospital/Doctor/Blood test)	12	38.71	1	14.29	13	34.21
8. Others (Herbs, Boil syringe, Safe blood)	5	16.13	-	-	5	13.16
9. Do not know	1	3.23	-	-	1	2.63
Total % more than % due to multiple answers.						

The respondents who answered yes on knowledge regarding prevention were asked an open-ended question on ways to prevent STDs. Their responses are recorded in Table 19. Most respondents could not differentiate between cure and prevention and suggested hospital, doctor, treatment/advice, or blood test

as ways to prevent STDs. Females were more strict in their answers. A high proportion (57%) suggested no contact with infected person. Males are more correct when they responded no sex with infected person (23%) and use of condoms (23%) as ways of prevention.

B. Acquired Immuno Deficiency Syndrome:

Nepal's first AIDS case was detected in 1988. Since that time, the HIV infection has spread steadily and quickly through Nepal. The total number of Nepalese infected is hard to estimate since surveillance has yet to be conducted, but it is estimated that there are as many as 20,000 HIV positive Nepalese.

Because of the presence of women trafficking and prostitution, Nuwakot district in the Central Region of Nepal is one of the most severely hit by this problem. Therefore, awareness about AIDS prevention is vital in that area.

i) Awareness Level:

Table 20: Ilakawise Distribution of Respondents According to Awareness of AIDS.

Ilaka	Awareness	Male		Female		Total	
		No.	%	No.	%	No.	%
1	Yes	19	30.16	6	9.52	25	19.84
	No	44	69.84	57	90.48	101	80.16
	Total	63	100.00	63	100.00	126	100.00
12	Yes	32	35.16	10	10.99	42	23.08
	No	59	64.84	81	89.01	140	76.92
	Total	91	100.00	91	100.00	182	100.00
13	Yes	21	37.50	12	21.43	33	29.46
	No	35	62.50	44	78.57	79	70.54
	Total	56	100.00	56	100.00	112	100.00
All 3 Ilakas	Yes	72	34.29	28	13.33	100	23.81
	No	138	65.71	182	86.67	320	76.19
	Total	210	100.00	210	100.00	420	100.00

All the respondents (15 to 45 year old males and females) were asked whether they are aware of AIDS. Table 20 presents the ilaka-wise distribution of respondents aware of AIDS. 23% of respondents in the survey area were aware of AIDS. The awareness level for males is 34% and for females it is only 13%. It is surprising to note that people are more aware of the relatively new disease AIDS than the age-old STDs.

The low reported awareness of STDs may be more apparent than real. In the interview, the Nepali term "Yon Samparka" was used, which means sexual contact. This word might have been unfamiliar to the respondents in local terms. In many cases they were probed using local terms, yet the response could not be as high as their spontaneous answer would have been. However, in the case of AIDS, people need no Nepali translation to understand.

Among the 3 ilakas, Ilaka 13 has the highest awareness level both in the case of males (38%) and females (21%). This level is lowest in Ilaka 1, where only 30% of the males and 10% of the females are aware of AIDS.

Table 21: Distribution of Respondents with Awareness of AIDS According to Educational Attainment.

Educational level	Male		Female		Total	
	No.	%	No.	%	No.	% of
Illiterate	14	12.96	15	7.85	29	9.70
Literate only	10	38.46	2	66.67	12	41.38
1-3 grade	5	31.25	2	50.00	7	35.00
4-5 grade	8	50.00	5	71.43	13	56.52
6-10 grade	25	80.65	4	80.00	29	80.56
SLC and above	10	76.92	-	-	10	76.92
Total	72	34.29	28	13.33	100	23.81

Table 21 attempts to show a relationship between education and AIDS awareness. Among the illiterate males, 13% are aware of this disease, whereas this is lower in the case of females, only 8%. However, more merely literate females know than males; 67% of females in this category know about AIDS, whereas only 38% of their male counterparts are aware of it. The level of awareness is consistently increasing with the level of education, except in case of 1-3 grade education where it is lower than the literate only category. There is no female who has passed SLC, however among males, 6-10 graders know slightly better than those with more than SLC education.

Table 22: Distribution of Respondents with Awareness of AIDS According to Ethnicity.

Ethnicity/Caste Groups	Male		Female		Total	
	No.	%	No.	%	No.	%
Tamang	27	20.00	13	10.32	40	15.33
Chhetri	20	71.43	6	25.00	26	50.00
Gurung	7	38.89	1	4.17	8	19.05
Brahmin	15	83.33	5	27.78	20	55.56
Scheduled Caste (Damai/Kami)	1	14.29	-	0.00	1	5.56
Other Castes (Sherpa, Newar, Magar)	2	50.00	3	42.86	4	45.45
Total	72	34.29	28	13.33	100	23.81

As ethnicity itself is a major background variable affecting knowledge, awareness has been analyzed in terms of ethnic groups and castes in the survey area (see Table 22). Brahmins have the highest awareness (56%), closely followed by Chhetri (50%) and other caste groups (45%). Among the scheduled caste people, only 6% know this disease, and among the major ethnic group, the Tamang, only 15% know it. The gender gap is high here also for all ethnic groups. While 83% of Brahmin males know about it, only 28% of Brahmin females do. In case of other caste groups this gap much is smaller.

ii) Source of Information:

Table 23: Distribution of Respondents Aware of AIDS According to Sources of Information.

Sources	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Radio	43	59.72	16	57.14	59	59.00
2. Poster	15	20.83	2	7.14	17	17.00
3. Health Worker	12	16.67	2	7.14	14	14.00
4. Drama	3	4.17	2	7.14	5	5.00
5. Neighbors/Friends	5	6.94	8	28.57	13	13.00
6. Others (Magazine/T.V./Video)	13	18.06	5	17.86	18	18.00
Total % more than 100% due to multiple answers.						

To all respondents who answered yes on awareness of AIDS, specific close-ended questions were asked regarding the source of their information. From Table 23, it is clear that radio is the prime source of information. Nearly 60% of males and 57% of

females got their information from the radio. Poster holds the second position with 21% of males and 7% of females. Neighbors and friends are a very important source of information for females (29%), whereas for males this contribution is quite low (7%). Other communication media like TV/video and magazines have an 18% share in case of both males and females. It is very interesting and encouraging to note the high contribution of modern communication media like radio, poster and TV/video in disseminating AIDS messages, however the reach of the media is limited due to low ownership ratio and high illiteracy. Hence, until the ownership rate is known, too much emphasis should not be given to electronic media.

iii) **Knowledge on Causes of Transmission:**

The respondents who are aware of AIDS were asked additional questions regarding their knowledge of causes of AIDS transmission.

Table 24: Distribution of Respondents Aware of AIDS According to Causes of Transmission.

Causes of Transmission	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Hand shakes	12	16.67	2	7.14	14	14.00
2. Sharing clothes/towels	13	18.06	7	25.00	20	20.00
3. Mosquito bite	12	16.67	2	7.14	14	14.00
4. Sexual intercourse	70	97.22	24	85.71	94	94.00
5. Witchcraft/Sorcery	5	6.94	-	-	5	5.00
6. Sharing syringe/needle	2	2.78	-	-	2	2.00
7. Do not know	2	2.78	-	-	2	2.00
Total % more than 100 due to multiple answers.						

The results are presented in Table 25. Most of these respondents have correct knowledge, 97% of males and 86% of females indicated out sex as the cause of transmission. Among males, 17% think AIDS is transmitted by handshake, 18% sharing clothes and 17% mosquito bite. Among females, 7% think handshake, 25% think sharing clothes, and 7% think mosquito bite are modes of transmission.

iv) **Attitudes towards AIDS-Infected Person:**

All males and females who know about AIDS were administered questions regarding their attitude towards AIDS-infected people. This information is very useful for detecting misconceptions related to this disease among the people as well as for knowing community perceptions regarding the AIDS patient's rehabilitation, which may be necessary in future.

104

Table 25: Distribution of Respondents Aware of AIDS According to Their Attitude.

Behaviors	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Visit home of AIDS infected person	44	61.11	7	25.00	53	53.00
2. Eat together with AIDS infected person	27	51.39	7	25.00	44	44.00
3. Live in the same house with AIDS infected person	44	55.56	6	21.43	46	46.00
Total % more than 100, due to multiple answers						

Table 25 presents the responses regarding this issue. 53% of respondents are ready to visit the home of the AIDS-infected person, 44% to eat together and 46% to live together with the infected person. Men are more liberal than women in their attitudes. 61% of male respondents are ready, to visit the home of an infected person, while only 25% of females are. Regarding eating together, 51% of males and 25% of females expressed their willingness. Only 21% of females are willing to stay in the same house with an AIDS-infected person. However, this proportion is more than double for males (56%).

v. Knowledge on Treatment:

As it is important for an AIDS program to the raise level of knowledge about treatment for a sizable population, this survey also focused on that issue. Three types of information were collected in this regard: the proportion of people who think they know about the treatment, their knowledge on types of treatment, and their knowledge about sources of treatment and advice.

Table 26: Distribution of Respondents According to Knowledge of Treatment for AIDS.

Knowledge	Male		Female		Total	
	No.	%	No.	%	No.	%
Yes	7	9.72	7	25.00	14	14.00
No	65	90.28	21	75.00	86	86.00
Total	72	100	28	100	100	100

Table 26 depicts the simple results regarding 'yes' or 'no' answers having to do with knowledge of treatment. Only 14% of respondents who are aware of AIDS also know about its treatment. It is surprising that the knowledge of females (25%) surpasses that of males (10%). However, in terms of absolute numbers, they are equal (7), so it should not be concluded that females know better than males. Moreover, these proportions are calculated out of aware respondents; if calculated out of total respondents, it is a meagre 3.3% for both groups.

As the question regarding knowledge of treatment types was unstructured, the responses were later coded into categories. The responses are presented in Table 27. 43% prescribed medical help or advice and 14% suggested a blood test. Another 14% mistook precaution like no contact or no sex as treatment. 7% (only one female respondent) take AIDS lightly and responds that washing with hot water may cure AIDS. Only two males 14% are perfectly correct, when they respond that no treatment is available for AIDS.

Table 27: Distribution of Respondents with Knowledge on AIDS Treatment According to Types of Treatment.

Treatment type	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Seek Medical help/ advice	2	28.57	4	57.14	6	42.86
2. Blood test	2	28.57	-	-	2	14.29
3. Wash with hot water	-	-	1	14.29	1	7.14
4. Others (No contact/no sex with AIDS patient)	2	28.57	2	28.57	2	14.29
5. No treatment	2	28.57	-	-	2	14.29
Total % more than 100 due to multiple answers.						

All the respondents with AIDS awareness were asked where people can go for treatment and advice. Table 28 attempts to present their answers. 40% pointed to the nearby hospital as a place of treatment, another 5% pointed to Kathmandu hospital. 33% of the respondents thought of the health post. 10% also put forth Health Worker/CHV for AIDS treatment/advice. 3% (all males) gave no source of treatment, as they thought no treatment possible for this fatal disease. The proportion who did not know any place of treatment was 15%. Male respondents were more knowledgeable than females. Males gave seven categories of answers while females could give only three categories. Nevertheless, all the respondents cited only modern types of health facilities (Hospital, Health Post, Doctor, etc.) and no one mentioned traditional types like faith healers, God men/temple, etc.

Table 28: Distribution of Respondents According to Knowledge About Sources of AIDS Treatment/Advice.

Source	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Hospital	26	36.11	14	50.00	40	40.00
2. Hospital in Kathmandu	4	5.56	1	3.57	5	5.00
3. Health Post	25	34.72	8	28.57	33	33.00
4. Doctor	4	5.56	-	-	4	4.00
5. Health Workers/CHV	10	13.89	-	-	10	10.00
6. Other (Village elders/ AIDS Project/Medical shop	7	9.72	-	-	7	7.00
7. No treatment available	3	4.17	-	-	3	3.00
8. Do not know	7	9.72	8	28.57	15	15.00
Total	More than 100 due to multiple answers.					

vi) Knowledge on Prevention:

All respondents who know about AIDS were asked about ways of AIDS prevention. Their responses were later categorized into seven broad answers.

Table 29: Distribution of Respondents According to Ways for the Prevention of AIDS.

Ways for Prevention	Male		Female		Total	
	No.	%	No.	%	No.	%
1. No contact with infected person (eat/stay together/sharing clothes)	8	11.11	12	42.86	20	20.00
2. No sex with infected person	31	43.06	7	25.00	38	38.00
3. No sex with many partners	18	25.00	2	7.14	20	20.00
4. Do not share blade/syringe instruments with infected person	11	15.28	1	3.57	12	12.00
5. Abstain from sex	5	6.94	-	-	5	5.00
6. Do not accept unscreened blood	5	6.94	3	10.71	8	8.00
7. Others (Medical, blood test, bath, clean, etc.) No prostitution	1	1.39	5	17.86	6	6.00
8. Do not know	5	6.94	7	25.00	12	12.00
Total %	more than 100 due to multiple answers.					

From Table 29 it is clear that a sizeable proportion has a fairly good idea about prevention techniques. 38% suggested no sex at all. All together, these three sex-related ways total 63% of respondents. 20% were in favour of no contact with infected person as a safety measure. Eight percent suggested to accept only screened blood and 6% had other ways like clean/medicine or blood test. Males were more in favour of sex precautions (43%, 25% and 7%), while females thought total disassociation with AIDS patient more effective. In total, 7% of males and 25% of females could not give any answer regarding prevention technique.

C. Condom - Safe Sex:

Several intervention measures have been implemented in the world to prevent STDs and AIDS through sexual transmission including health education, condom promotion, and counseling.

Condom promotion for prevention of HIV transmission among sex users, migrant laborers, and the general population has not received much emphasis in Nepal as of yet. Condoms have been promoted only for their contraceptive benefits. Therefore, increasing and emphasizing condom use for HIV prevention is needed.

i) Awareness level:

Information about the number of people who know about condoms is highly important for designing programs to check the spread of AIDS and other STDs. A question regarding knowledge of condoms was also incorporated into this survey.

Table 30: Ilakawise Distribution of Respondents According to Awareness of Condoms.

Ilaka	Awareness	Male		Female		Total	
		No.	%	No.	%	No.	%
1	Yes	47	74.60	22	34.92	69	54.76
	No	16	25.40	41	65.08	57	45.24
	Total	63	100.00	63	100.00	126	100.00
2	Yes	61	67.03	22	24.18	83	45.60
	No	30	32.97	69	75.82	99	54.40
	Total	91	100.00	91	100.00	182	100.00
3	Yes	28	50.00	13	23.21	41	36.61
	No	28	50.00	43	76.73	71	63.39
	Total	56	100.00	56	100.00	112	100.00
All 3 Ilakas	Yes	136	64.76	57	27.14	193	45.95
	No	74	35.24	153	72.86	227	54.05
	Total	210	100.00	210	100.00	420	100.00

In Table 30, the data of respondents answering yes or no to the knowledge question has been presented for all three Ilakas of Nuwakot district. On average, 46% of people know about condoms. Among males, the awareness level is 65% and among female it is only 27%.

The average awareness level for both sex is highest in Ilaka 1 (55%), as well as separately for males (75%) and females (35%). In Ilaka 13, it is lowest, where only 50% of males and 23% of females, and 37% overall, are aware of this device.

Table 31: Distribution of Respondents with Awareness on Condom According to Educational Attainment.

Educational level	Male		Female		Total	
	No.	%	No.	%	No.	%
Illiterate	51	47.22	46	24.08	97	32.44
Literate only	26	100.00	1	33.33	27	93.10
1-3 grade	9	56.25	2	50.00	11	55.00
4-5 grade	13	81.25	5	71.43	18	78.26
6-10 grade	24	77.42	3	60.00	27	75.00
SLC and above	13	100.00	-	-	13	100.00
Total	136	64.76	57	27.14	193	45.95

Table 31 presents the relationship between educational level and awareness of condoms.

Among the illiterates, the proportion aware is only 32% but for merely literates it is very high, 93%. For respondents with school education, of all levels, knowledge is lower than for merely literate.

Here the effects of education is not clear because of other confounding variables like age and marital status. Most of the merely literate people are of older age and therefore married, hence they know more about contraceptive devices than do school going children. However, among the respondents with SLC and above education, awareness level is 100%, because they are also adults and married. Hence, this complex relationships between education and awareness about condoms needs further analysis by controlling other background variables like age and marital status.

Table 32: Distribution of Respondents with Awareness of Condoms According to Ethnicity.

Ethnicity/Caste Group	Male		Female		Total	
	No.	%	No.	%	No.	%
Tamang	68	50.37	13	10.32	81	31.03
Chhetri	27	96.43	15	62.50	42	80.77
Gurung	13	72.22	12	50.00	25	59.52
Brahmin	18	100.00	9	50.00	27	75.00
Scheduled Caste Damai/Kami	6	85.71	6	54.55	12	66.67
Other Castes (Sherpa, Newar, Magar)	4	100.00	2	28.57	6	54.55
Total	136	64.76	57	27.14	193	45.95

Awareness level of condoms for different ethnic/caste groups is illustrated in Table 32. The Tamang people have the lowest awareness level (31%). Chhetris have the highest: 81%. After that, 75% of Brahmins know about it. In all caste groups, females have a far lower level of awareness about condom than men. Among Tamangs, 50% of males know about condoms but only 10% of females do. Similarly, among Chhetri males, 96% are aware, but only 63% of the women are.

ii) **Knowledge on source of supply:**

Knowledge about source of supply is an important variable, determining the perceived accessibility of family planning services. It also reflects the depth of knowledge on any particular contraceptive method. The majority of respondents who are aware of condom know about its source of supply also, only 4% report not knowing. The most common answer regarding condom distribution outlets is hospital or health post. The second most common answer is local shop (36%). It is quite disappointing to note that health workers and volunteers who are supposed to make condoms available at the door step of the villagers are recognised as a source of supply by a meager 8%. A higher proportion of male respondents (52%) consider hospital/health post as a condom distribution outlet than do females (44%). However, more females (40%) than males (35%) recognise local shops as a source of supply. Some of the males (7%) and the females (4%) think only shops in Kathmandu can supply the condoms and they report not knowing any local condom sales center. The knowledge about sources of supply is presented in Table 33.

Table 33: Distribution of Respondents Aware of Condom According to Source of Supply.

Sources	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Hospital/Health Post	71	52.21	25	43.86	96	49.74
2. Health Worker/ Volunteer	15	11.03	1	1.75	16	8.29
3. Local Shop	47	34.56	23	40.35	70	36.27
4. Shop Kathmandu	9	6.62	2	3.51	11	5.70
5. Other (F.P. Clinics/ Medical Shop	7	5.15	1	1.75	8	4.15
6. Do not know	1	0.74	7	12.28	8	4.15
Total % more than 100 due to multiple answers.						

iii) **Purpose of Condom Use:**

Table 34: Distribution of Respondents According to Purpose of Condom Use.

Purpose	Male		Female		Total	
	No.	%	No.	%	No.	%
1. Prevent child birth	68	50.00	34	59.65	102	52.85
2. Space birth	38	27.94	17	29.83	55	28.50
3. Family planning	29	21.32	2	3.51	30	15.54
4. Prevent STDs/AIDS	22	16.18	1	1.75	23	11.92
5. Others	-	7.35	2	3.51	12	6.22
6. Do not know	-	-	2	3.51	2	1.04
Total % more than 100 due to multiple answers.						

From Table 34, it is quite clear that people know about condoms as a fertility regulating device but not as a safe sex measure. A high proportion, 60%, take it as a method to prevent birth, 29% to space births, and 16% simply for family planning. Among all the respondents, only 12% consider the purpose of condom use to prevent STDs or AIDS. When analysed according to sex, few females (2%) consider condom as a STDs/AIDS prevention device, while for males this proportion is slightly higher (16%). However, in all three categories of fertility regulation, the proportion of females is higher than that of males. Some respondents have answered with other purposes of condom use. Among these, males pointed out more sex related purposes like to "sleep with the menstruating wife or the unmarried girls." Only 1% of all the respondents aware of condom could not suggest any purpose of using the device; these in the 'do not know' category were all women.

iv) Condom Users:

In order to know the strength of condoms as a potential measure of safe sex in the survey area, a question was asked regarding its use within the past one month period. As the sample size was not very large and the expected proportion of condom users was very low, the question was asked for a duration of ever use rather than one point of time, current use. This question was asked only of currently married respondents and only to those who know about this method. Among all in the effective marital union only a low percentage, 4%, have used condoms within the past one month period. Among males, the proportion is a little higher, 6% and among females it is only 3%. However there is clear indication of underestimation of condom use in this data. If carefully analysed, the pattern of contraception use can be expected to be evenly distributed among couples, irrespective of the respondents' sex. Maybe females were more reluctant to report condom use than the males. This data on condom use is presented in Table 35.

112

Table 35: Distribution of Married Respondents According to Condom Use in Last One Month.

Condom use	Male		Female		Total	
	No.	%	No.	%	No.	%
Yes	9	5.59	5	2.72	14	4.06
No	96	59.63	47	25.54	143	41.45
Unaware of condom	56	34.78	132	71.74	188	54.49
Total married	161	100.00	184	100.00	345	100.00

सेभ द चिल्ड्रेन (यू. एस.)

यौन रोग तथा एडस् बारे ज्ञान र धारणा सर्वेक्षण

प्रश्नावली

(प्रजनन उमेर १५-४५ वर्ष भित्रका महिला तथा पुरुषका लागि)

अन्तरबार्ता मिति	दोस्रो अन्तरबार्ता मिति
अन्तरबार्ता लिने व्यक्तिको नाम :	
सुपरिवेक्षकको नाम :	

गाउँको नाम : बार्ड नं.:

गाउँ विकास समिति :

घरमुलिको नाम : बोलाउने नाम :

(प्रजनन उमेरका महिला तथा पुरुष मध्ये हाल घरमा भएका एक जना महिला तथा एक जना पुरुष छनौट गरी अन्तरवार्ता लिने)

१. नाम :

२. उमेर (बर्षमा) :

३. यौन सम्पर्कबाट सन्त रोगहरू बारे तपाईंलाई थाहा छ ?

छ छैन प्रश्न नं. ७ सोधनुस् ।

४. यौन सम्पर्कबाट सन्त रोगहरूका के के लक्षण हुन्छन् ? उल्लेख गर्नुहोस्।

क.

ख.

ग.

घ.

५. यौन सम्पर्कबाट सन्त रोगहरूबाट बच्नको लागि कुनै उपाय बारे थाहा छ ?

छ छैन प्रश्न नं. ७ सोधनुस् ।

६. यौन सम्पर्कबाट सन्त रोगहरूबाट बच्नको लागि के के उपाय अपनाउन सकिन्छ ? उल्लेख गर्नुहोस् ।

क.

ख.

ग.

७. तपाईंलाई एड्स रोग भनेको थाहा छ ?

छ छैन प्रश्न नं. १५ सोधनुस् ।

८. एड्स रोग बारे कहाँबाट थाहा पाउनु भयो ?

रेडियो

पोष्टर

स्वास्थ्य कार्यकर्ता.

नाटक

छर-छिमेक

अन्य उल्लेख गर्ने _____

९. निम्न लिखित मध्ये कुन कुन कारणबाट एड्स सर्न सक्छ ?

- क. हात मिलाउँदा
- ख. रोगीले प्रयोग गरेको रूमाल वा लुगा प्रयोग गर्दा
- ग. लामखुट्टेको टोकाईले गर्दा
- घ. एड्स लागेको मानिससंग यौन सम्पर्क राख्न
- ङ. जादु / दुना / बोक्सी लाग्दा

१०. तपाईंको आफन्त वा छिमेकीलाई एड्स लागेको थाहा पाउनु भएमा तपाईं निम्न लिखित के के कार्य गर्न तैयार हुनु हुन्छ ?

क. उसको घरमा आउने / जाने गर्नु हुन्छ ?

गर्छु गर्दिन

ख. संगै बसी खाना खानु हुन्छ ?

खान्छु खाँदिन

ग. संगै एउटै घरमा बस्नु हुन्छ ?

बस्छु बस्दिन

११. एड्स रोगको उपचारबारे तपाईंलाई केही जानकारी छ ?

छ छैन प्रश्न १३ सोध्नुस्

१२. यदि छ भने ती के के हुन ? (सबै उत्तरहरू उल्लेख गर्नुोस)

क.

ख.

ग.

१३. एड्स रोगबाट बच्नको लागि के के गर्न सकिन्छ ? (सबै उत्तरहरू उल्लेख गर्नुोस) ?

क.

ख.

१४. तपाईंको छिमेकमा कसैलाई एड्स रोग लागेमा वा लागेको रंका लागेमा उपचार वा सल्लाहको लागि कहाँ जाने गर्दछन् ? (सबै उत्तरहरू उल्लेख गर्नुोस) ?

क.

ख.

ग.

१५. तपाईंलाई ढाल भनेको थाहा छ ? छ छैन (अन्तरवार्ता टुक्रयाउने)

१६. छ भने यो के को लागि प्रयोग गन्छ ?

क.

ख.

ग.

१७. यो ठाउँमा कसैलाई ढाल चाहियो भने कहाँ प्राप्त हुन्छ होला ?

अस्पताल/स्वास्थ्य चौकी

स्वास्थ्य कार्यकर्ता/स्वयं सेविका

पसल

अन्य (उल्लेख गर्ने)

(विवाहित महिला वा पुरुषलाई मात्र सोध्ने)

१८. तपाईंले/तपाईंको श्रीमानले गरेको एक महिनामा ढाल प्रयोग गर्नु भएको छ ?

छ

छैन

APPENDIX C

Questionnaire (English Translation)

S.No. _____

Knowledge and Attitude Survey on STD and AIDS Questionnaire

(For Female and Male of Reproductive Age 15-45)

Interview Date _____	Second Interview Date _____
Interviewer's Name _____	
Supervisor's Name _____	

Name of the Village: _____ Ward no.: _____

Name of Village Development Committee: _____

Name of the Household Head: _____ Pet Name: _____

(Interview one male and one female among the members of reproductive age group).

1. Name: _____

2. Age (in years): _____

3. Do you know about STD?

Yes []

No []

Ask question No. 7

4. Mention the sign and symptoms of STDs:

- a)
- b)
- c)
- d)

5. Do you know about any method to prevent STDs?

Yes []

No []

Ask question No. 7

120

15. Do you know about condom?

Yes [] No [] Close the interview

16. If yes what is it used for?

- a)
- b)
- c)

17. Where would someone obtain condom here?

Hospital/Health Post [] Health Worker/Volunteer []

Shop [] Other (please specify) _____

18. (Ask only to married respondents)

Have you/your husband used condom in the last one month?

Yes [] No []

12

FAMILY ROSTER

S.N.	(A) NAME	(B) AGE	(C) MARITAL STATUS	(D) SEX	(E) LITERACY		(F) COMPLETED CLASS	(G) Now Staying at Home or not	(H) If not Why and Where	Remarks
					Literate	Illiterate				

Note:

1. For children under five years, write only name, age & sex, leave other columns blank.
2. Circle the serial number of female & male of reproductive age (15-45).

Code for H Column:

1. For study within Nepal
2. For work within Nepal
3. For study in India
4. For work in India
5. Missing/lost
6. Gone for only few days
7. Other (specify)

**SUPERVISORS AND INTERVIEWER'S
TRAINING AGENDA & SCHEDULE**

DAY 1, Wednesday, November 18, 1992

Target Group: Supervisors
Focus : Survey Objective & Methodology

<u>Time</u>	<u>Activity</u>
09:00 am - 09:30 am	Welcome and introduction
09:30 am - 10:00 am	Survey purpose & objective
10:00 am - 10:30 am	Presentation of time frame of survey activities -- field survey, analysis of data and feedback to community
10:30 am - 11:15 am	Review sampling method and sample size
11:15 am - 12:00 am	Review starting point method
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 01:30 pm	Review tabulation of data
01:30 pm - 02:00 pm	Review how to code/mark questions and consistency of language
02:00 pm - 02:30 pm	Mother and child's age and date of birth calculation
02:30 pm - 03:00 pm	Review Supervisors and Enumerators' job responsibility
03:00 pm - 05:45 pm	Review purpose of each question & discussion
05:45 pm - 06:00 pm	Day 2 training plan and closing

DAY 2, Thursday, November 19, 1992

Target Group: Supervisors and Interviewers
Focus : Introduction, Survey Objective & Methodology

<u>Time</u>	<u>Activity</u>
09:00 am - 10:00 am	Welcome followed by group introduction
10:00 am - 10:30 am	Brief background information on Save the Children USA and CS VIII project

10:30 am - 11:00 am	Survey purpose & objective
11:00 am - 11:30 am	Presentation of time frame of survey activities -- field survey, analysis of data and feedback to community
11:30 am - 12:00 am	Interviewers' obligation to the agency and their responsibility
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 01:45 pm	Review sampling method and sample size
01:45 pm - 3:00 pm	Review starting point method
03:00 pm - 04:45 pm	Questions and answers
04:45 pm - 05:00 pm	Day 3 training plan and closing

DAY 3, Wednesday, November 20, 1992:

Target Group: Supervisors and Interviewers
Focus : Interview Technique

<u>Time</u>	<u>Activity</u>
09:00 am - 10:00 am	Review how to code/mark questions and consistency of language
10:00 am - 11:30 am	Mother and child's age and date of birth calculation
11:30 am - 12:00 am	Review tabulation of data
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 01:30 pm	Role play, a bad interview technique
01:30 pm - 02:00 pm	Discussion of a bad interview
02:00 pm - 02:30 pm	Role play, a good interview technique
02:30 pm - 03:00 pm	Discussion of a good interview
03:00 pm - 04:15 pm	Practice interview on small groups
04:15 pm - 04:45 pm	Discussion of small group practice
04:45 pm - 05:00 pm	Day 4 training plan and closing

DAY 4, Thursday, November 21, 1992:

Target Group: Supervisors and Interviewers
Focus : Questionnaire discussion and filed practice

<u>Time</u>	<u>Activity</u>
09:00 am - 11:30 am	Questionnaire presentation and discussion
11:30 am - 12:00 am	Group arrangements for the field practice
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 04:00 pm	Each team of supervisor and interviewers completes 3 household's interview
04:00 pm - 04:45 pm	Discussion field test experience
04:45 pm - 05:00 pm	Day 5 training plan and closing

DAY 5, Friday, November 22, 1992:

Target Group: Supervisors and Interviewers
Focus : Closing and deployment

<u>Time</u>	<u>Activity</u>
09:00 am - 10:30 am	Feedback on field practice: completed questionnaires
10:30 am - 11:00 am	Discussion on technical knowledge of health related matter and materials
11:00 am - 12:00 am	Final discussion on questionnaire, how to code mark responses, date of birth calculation and other related matter
12:00 am - 01:00 pm	----- LUNCH BREAK -----
01:00 pm - 02:00 pm	Group arrangements for field survey
02:00 pm - 02:30 pm	Interaction between group members
02:30 pm - 04:30 pm	Distribution of logistics, cash and agreement letters
04:30 pm - 05:00 pm	Reminding of supervisors and interviewer job responsibilities
05:00 pm - 05:30 pm	Farewell and best wishes to the entire group

APPENDIX E

Interviewers:

1. Basundhara Tamang
2. Bhawani Quikel
3. Bina Thapa
4. Bishwo Nath Mainali
5. Dilip Kumar Lama
6. Gayatri Khatiwoda
7. Gita Thapa
8. Gyanu Gurung
9. Hari Kumar Shrestha
10. Hira Devi Shrestha
11. Ishowari Nepal
12. Ishowari Pandey
13. Jaylaxmi Mainali
14. Kamala Thapa
15. Laluka Pandey
16. Madhu Kala Thapa
17. Narayani Shrestha
18. Nirmala Shrestha
19. Parbati Shrestha
20. Radhika Poudyal
21. Raghu Dhital
22. Raju Tamang
23. Renuka Basnet
24. Saradha Lamichhane
25. Saraswoti Dhital
26. Saraswoti Thapa
27. Sarita Quikel
28. Shanta Thapa
29. Sharmila Upreti
30. Sita Thapa
31. Tara Devi Gurung
32. Vijaya Moktan
33. Yasoda Pandey

Supervisors:

1. Bed Bahadur Lama
2. Bhim Kumari Pun
3. Durga Regmi
4. Jumuna Lama
5. Jay Shrestha
6. Krishna Gurung
7. Meera Rana
8. Netra Prasad Bhatta
9. Rajendra Lama
10. Ranjana Khanal
11. Sharmila Shrestha
12. Tulshi Gurung

Coordinators:

1. Raghu Thapalia
2. Ravindra Thapa

Training Coordinators

1. Navin Pyakuryal
2. Ravindra Thapa

Administration Support:

1. Neena Gauchan

Tabulation Forms Designer:

1. Raghu Thapalia

Questionnaire Designer:

1. Chanda Rai
2. Navin Pyakuryal

Office Support:

1. Maya Gole

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