



HEALTH AND NUTRITION PROFILE OF CHILDREN UNDER FIVE YEARS, AND LACTATING AND PREGNANT MOTHERS, 2080

TILATHI KOILADI RURAL MUNICIPALITY, SAPTARI



Submitted To:

Tilathi Koiladi Rural Municipality, Saptari, Madhesh Province, Nepal

Prepared and Submitted By:

Health Nutrition Education and Agriculture Research Development Nepal

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**HEALTH AND NUTRITION PROFILE OF CHILDREN
UNDER FIVE YEARS, AND LACTATING AND
PREGNANT MOTHERS OF TILATHI KOILADI
RURAL MUNICIPALITY, SAPTARI**

Baseline Survey Report

Submitted To:

Tilathi Koiladi Rural Municipality, Saptari, Madhesh Province, Nepal

Report Submitted By:

Health Nutrition Education and Agriculture Research Development
Nepal

ABBREVIATIONS

ANC	Antenatal Care
BMI	Body Mass Index
COVID-19	Corona Virus Disease 2019
FCHV	Female Community Health Volunteers
FGD	Focus Group Discussions
HEARD Nepal	Health Nutrition Education and Agriculture Research Development Nepal
IUCD	Intrauterine Contraceptive Device
KII	Key Informant interview
MUAC	Mid Upper Arm Circumference
ORS	Oral Rehydration Solution
PHCC	Primary Health Care Center
PNC	Postnatal Care
RM	Rural Municipality
SD	Standard Deviation
TD	Tetanus Diphtheria Vaccine
UNICEF	United Nations International Children's Emergency Fund
VDC	Village Development Committee
WASH	Water Sanitation and Hygiene

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CHAPTER I

INTRODUCTION

Background

Tilathi Koiladi is a rural municipality located in Saptari District of Madhesh Province. established on 2073 Falgun 27, following the government's announcement of new local levels. This rural municipality is composed of eight wards and includes several villages: Tilathi, Launia, Bavangamakatti, Sakarpura, Koiladi, Ko. Madhepura, and Ko. Barsain. These villages were previously governed as Village Development Committees (VDCs) but have since been amalgamated into the current rural municipality structure. The area spans 32.91 square kilometers and has a population of 32,389, making it a significant administrative and demographic unit in the region.

Despite its establishment and importance in the region, Tilathi Koiladi faces a notable gap in comprehensive data regarding the health and nutritional status of its residents especially, women and children. To date, no detailed surveys or studies have been conducted by the local government to assess these critical aspects of public health. This lack of specific information presents a challenge for the formulation of effective strategies and policies aimed at improving the health and wellbeing of the community. Recognizing the critical gap in data, there is an urgent need for a comprehensive survey to be conducted. This survey is envisioned to provide in-depth insights into the health and nutritional status of the mothers and children under five years age of Tilathi Koiladi. The primary goal is to gather relevant data that can be utilized to develop and implement strategies specifically tailored to meet the unique needs of this rural municipality.

Aim and Objectives of the Study

The aim of the study is to obtain baseline information on the health and nutritional status of children under five years of age in Tilathi Koiladi. This health and nutrition survey aims not only to fill the current information void but also to serve as a benchmark for future research and policy-making. To achieve this, the study has several specific objectives:

- To assess the current health and nutritional status of children under five years old in Tilathi Koiladi

- To identify key areas of concern and specific health and nutrition challenges faced by children in this age group.
- To develop targeted strategies and interventions based on the findings of the survey.
- To provide a useful reference for other organizations and agencies conducting similar research.
- To contribute to the broader knowledge base in the field of health and nutrition, especially concerning children under five.

By achieving these objectives, the survey will play a crucial role in promoting better health and nutrition within Tilathi Koiladi and potentially in other similar rural settings. The outcomes of this survey are expected to guide local authorities, health professionals, and policymakers in making informed decisions to enhance the overall well-being of the community.

CHAPTER II

METHODOLOGY

We've conducted health and nutrition survey in the real field in Ward No. 1 to 8 of Tilathi Koiladi Rural Municipality. Our outreach extends to the entirety of the community, with a specific focus on marginalized groups. The intended coverage includes 414 households. Additionally, Key Informant Interviews (KII) were carried out involving the Mayor, Chief Administrative Officer (CAO), and Health Coordinator (HC). Furthermore, targeted programs on Water, Sanitation, and Hygiene (WASH) were implemented, alongside conducting focused Group Discussions.

Study Design

A cross-sectional study design with mixed methods was used in the study.

Survey Area

Tilathi Koiladi Rural Municipality of Saptari District was the study area. Each ward within the municipality was included in the study.

Sampling Technique

Simple random sampling was used to select the sample for quantitative data while purposive sampling technique was used for the collection of qualitative insights.

Sample Size

According to the Tilathi Koiladi Rural Municipality Office the total population of children under five years of age was 3240 and the sample size was calculated based on this population using Slovin's Formula.

Slovin's formula: $n = N / (1 + Ne^2)$

n = Required sample size,

N = Total population i.e. 3240

e = marginal error (5% will be taken for this survey)

Calculated sample size = $356.044 \approx 357$

Adding 10% non response to the calculated sample size: $357 + 35.7 = 392.7 \approx 393$

Based on this calculation total sample size was considered 400 while the final sample size taken was 414.

The ward wise sample size allocation is shown in the table below:

Table 1: Ward wise sample allocation

Ward no.	Under 5 children's population	Sample taken
1	352	42
2	363	56
3	481	64
4	457	63
5	564	71
6	208	24
7	450	48
8	365	46
Total	3240	414

Inclusion and Exclusion Criteria

Inclusion criteria: Mother/father of children aged 0-59 months who were willing to participate in the study and gave consent to conduct the interview.

Exclusion Criteria: Mothers and children who were ill, having communicable diseases and who didn't give consent to participate in the study.

Household Selection

Initially, the sample in each ward was segmented into four distinct sub-samples. The process of selecting these samples from the population began by pinpointing the tentative central point of each ward. Once this midpoint was assumed, a pen was rotated to determine the direction for sample selection. The direction in which the pen pointed data collected was initiated choosing the initial sample from that direction.

The first household to be chosen was one that randomly had children under the age of 5 years and met our selection criteria. Following this, similar households were selected along the same direction. Subsequently, this technique was repeated in the remaining three directions to select additional samples, ensuring a diverse and representative selection from the ward.

Methods and Materials

Survey tools

The following tools were used for the study:

- Household questionnaire
- KII guidelines
- FGD guidelines

The survey employed various tools to gather comprehensive data. The household questionnaire served as the primary instrument, encompassing questions on demographics, ICYF, MIYCN, safe motherhood, family planning, as well as aspects of water, sanitation, health, COVID-19, and Agriculture. Additionally, distinct KII guidelines were tailored for the Mayor, Health Co-coordinator, and Ward Chairperson, aiming to glean insights into governmental perspectives on health and nutrition practices. Further, an FGD questionnaire specifically targeted the mother's group, delving into the practices prevalent among mothers in the surveyed area. By collecting responses from both KII and FGD sessions, the study aimed to corroborate and validate findings obtained through household surveys, enriching the depth and reliability of the gathered information.

Survey instruments

Stadiometer: The stadiometer is an essential tool used in surveys to measure an individual's height accurately which consists of a vertical ruler attached to a stable base, allowing for precise measurements. By using a stadiometer, researchers gathered data on height, which is crucial for various assessments, such as nutritional status, growth monitoring, and determining appropriate interventions.



Figure 1: Measuring height using stadiometer

Weighing Scale: A weighing scale is a key survey instrument used to measure an individual's weight accurately. These scales are designed with precision sensors to ensure precise measurements. By utilizing weighing scales during surveys, researchers obtained the weight of the children, which is essential for evaluating nutritional status, monitoring growth, and assessing overall health.



Figure 1: Measuring the Weight of the Child using a Weighing scale

MUAC Tape (Mid-Upper Arm Circumference): Standard MUAC tape by UNICEF tape is a standard tool recommended by UNICEF for assessing nutritional status, particularly in children and adults. It is a simple, non-invasive measurement that involves wrapping the tape around the midpoint of the upper arm. The MUAC tape provides an estimate of muscle and fat stores, allowing researchers to identify individuals at risk of malnutrition and determine appropriate interventions. This cost-effective instrument is widely used in surveys to collect valuable data on nutritional status quickly and efficiently.



Figure 2: Measuring Mid Upper Arm Circumference using MUAC Tape

Training and orientation of the study

Training and field testing involved a one day orientation attended by local level leaders, government officers, and stakeholders focused on Child and Maternal Health and Nutrition. During the orientation, valuable insights and knowledge regarding child and maternal nutrition and health were shared. The involvement of local leaders and stakeholders demonstrated a collaborative approach towards addressing child and maternal health concerns in the community. The enumerators and field supervisors were trained by HEARD Nepal, to effectively carry out the study. This training equipped the enumerators with the necessary skills and expertise to conduct the study successfully, ensuring accurate data collection for the research project.

Data collection and analysis

Quantitative data were collected using KOBO toolbox while qualitative data were taken through KII/FGD using hard copy form, and documents. The interview and discussions were be recorded and noted, transcribed and analyzed. Importantly, consent from the participants and respondents was obtained before the commencement and recording of the interview and discussions. Data from the KOBO was exported to MS Excel for further analysis.

Activities Conducted

- Anthropometric measurement of the under five children (Age, Height/Length, Weight, and MUAC)
- FGD with mother's group.
- Counseling the interviewee about safe motherhood, child health and its necessity.
- Provided general knowledge on nutrition education, exclusive breastfeeding and social security scheme.
- WASH activities.
- Key life events of food demonstration and counseling to mother's group about nutritious food and healthy feeding practice.

CHAPTER III

RESULTS AND FINDINGS

Sociodemographic information of the respondent

The dataset in Table 2 encompassing 414 respondents, sheds light on the demographic landscape of married individuals. Predominantly female, comprising 98.79% of the sample, the respondents exhibit a wide age range from 18 to 60 years, with an average age of 24.88 and a standard deviation of 4.83. Families, averaging 7.17 members, vary widely in size, spanning from 3 to 25 individuals. Interestingly, a significant portion of these households, 66.18%, have one child under the age of five, while 30.92% have two such children. Education levels among respondents vary, with a substantial portion having basic education (39.61%) or being illiterate (33.33%). Maritally, all respondents are reported as married. Ethnically, the dataset showcases a diverse mix, with Janjati (34.78%) and Madheshi (32.85%) being the prominent groups. Occupationally, the overwhelming majority of respondents are homemakers (96.38%), while a minority engage in non-governmental service, business, government service, or waged work.

Table 2: Sociodemographic information of the respondent

Variables	Frequency	Percentage
Sex of the respondent (n=414)		
Female	409	98.79%
Male	5	1.21%
Age of the respondent (n=414)		
Minimum	18	
Maximum	60	
Mean $\pm$ SD	24.88 $\pm$ 4.83	
Family size of the respondent (n=414)		
Minimum	3.00	
Maximum	25.00	
Mean $\pm$ SD	7.17 $\pm$ 2.87	
Under five children in the family (n=414)		
One	274	66.18%
Two	128	30.92%

Three	12	2.90%
Education level of the respondent (n=414)		
Informal education	42	10.14%
Basic level	164	39.61%
Secondary level	64	15.46%
Illiterate	138	33.33%
Bachelor level	6	1.45%
Marital Status of the respondent (n=414)		
Married	414	100.00%
Ethnicity of the respondent (n=414)		
Janajati	144	34.78%
Dalit	114	27.54%
Brahmin/Chhetri	12	2.90%
Madhesi	136	32.85%
Muslim	8	1.93%
Occupation of the respondent (n=414)		
Non-governmental service	2	0.48%
Homemaker	399	96.38%
Waged work	1	0.24%
Business	7	1.69%
Government service	5	1.21%

Child health and nutrition status

Sex of the child

Among the 414 children surveyed, 39.61% are male (164 children), while 60.39% are female (250 children).

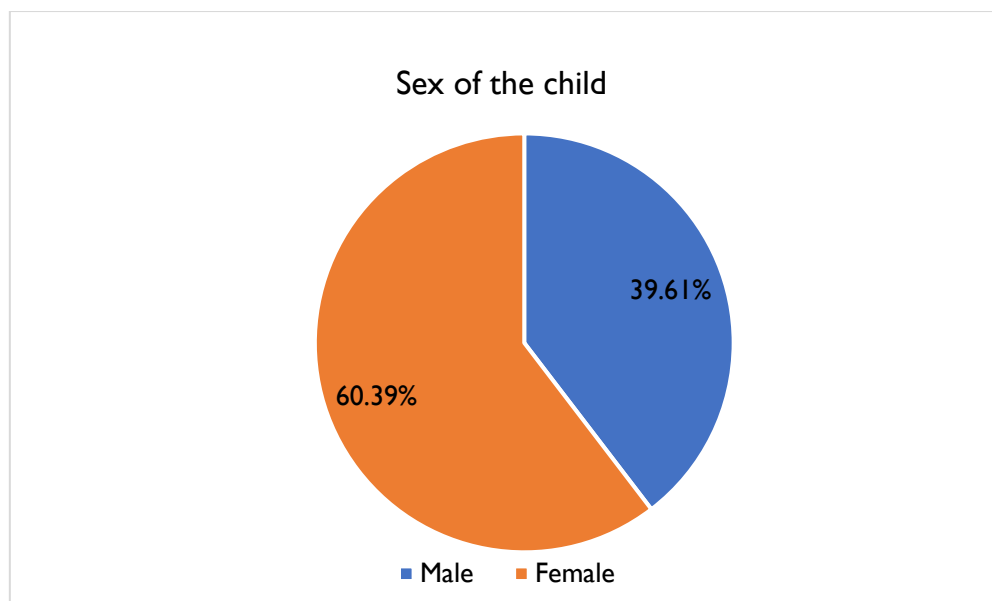


Figure 4: Sex of the child

Age of the children

The age categories for the children were divided into three segments: 0-6 months, 7-24 months, and 25-59 months. Within these categories, there were 14.73% children (61) aged 0-6 months, 178 children aged 7-24 months i.e. 43%, and 175 children (42.27%) aged 25-59 months.

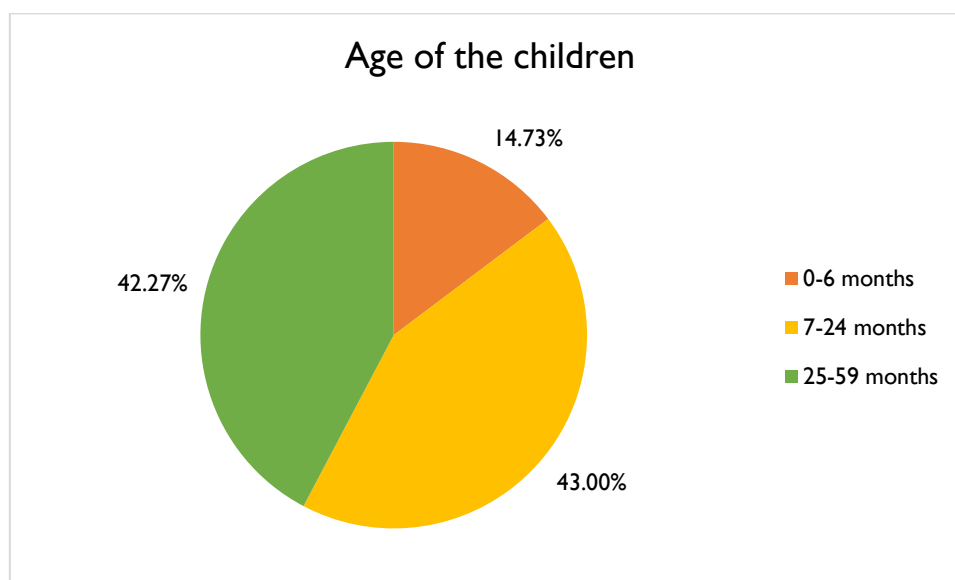


Figure 5: Age group distribution of the child

MUAC and Body Mass Index (BMI) of children

The children's Mid-Upper Arm Circumference (MUAC) measurements were segmented into three distinct categories indicating their nutritional status. Among the surveyed children, 5.56% (23 children) fell into the category of severely malnourished, denoted by a MUAC measurement of <11.5 . A larger proportion, constituting 14.73% (61 children), were classified as moderately malnourished, displaying MUAC measurements within the range of 11.5-12.5. The vast majority, encompassing 79.71% (330 children), exhibited MUAC measurements exceeding 12.5, signaling a normal nutritional status.

When assessing the anthropometric measurements of the surveyed children i.e. weight and height/length, distinct categories emerged. In this survey, Z-score system expressing the anthropometrical value as a number of standard deviations (i.e. Z-score below or above the reference mean or median value) was used as the main tool to assess the nutritional status of children. Z-score were calculated for weight for height (wasting), height for age (stunting) and weight for age (Under nutrition) using the cut-offs based on WHO/NCHS reference curves:

Severe malnutrition	$\leq 3SD$
Moderate malnutrition	$\leq 2SD$
Normal	$\geq 2SD$
Obese/overweight	$\geq 3SD$

Approximately 12.80% (53 children) were classified as experiencing severe malnutrition, while 9.18% (38 children) were identified with moderate malnutrition. The largest segment, encompassing 62.56% (259 children), fell within the category of normal nutritional status. Notably, a smaller percentage, 6.76% (28 children), were identified as obese or overweight. Additionally, a fraction, constituting 8.70% (36 children), did not have their nutritional status specified due to difficulties in taking anthropometric measurements.

Table 3: MUAC and BMI of the children

MUAC of the child (n=414)

<11.5 (severely malnourished)	5.56%	23
11.5-12.5 (moderately malnourished)	14.73%	61
>12.5 (Normal)	79.71%	330

Nutritional status of the children (n=414)

Severe malnutrition	12.80%	53
Moderate malnutrition	9.18%	38
Normal	62.56%	259
Obese/overweight	6.76%	28
Not available	8.70%	36

Growth monitoring, vitamin A and albendazole supplementation and immunization status of the children

Regarding the regular growth monitoring of the children, the majority, accounting for 78.01% (323 children), received consistent monitoring. This practice plays a pivotal role in assessing a child's developmental progress and overall health. Moreover, concerning the administration of Vitamin A and Albendazole supplementation to the last child, a substantial proportion, constituting 79.95% (331 children), received this supplementation, which is crucial in preventing deficiencies and certain parasitic infections.

In terms of immunization coverage, a significant portion, i.e. 97.83% (405 children), were reported as fully immunized. This signifies adherence to crucial vaccination schedules, ensuring protection against various diseases. However, there remains a minority of 2.17% (9 children) who have not received complete immunization, potentially leaving them susceptible to preventable illnesses.

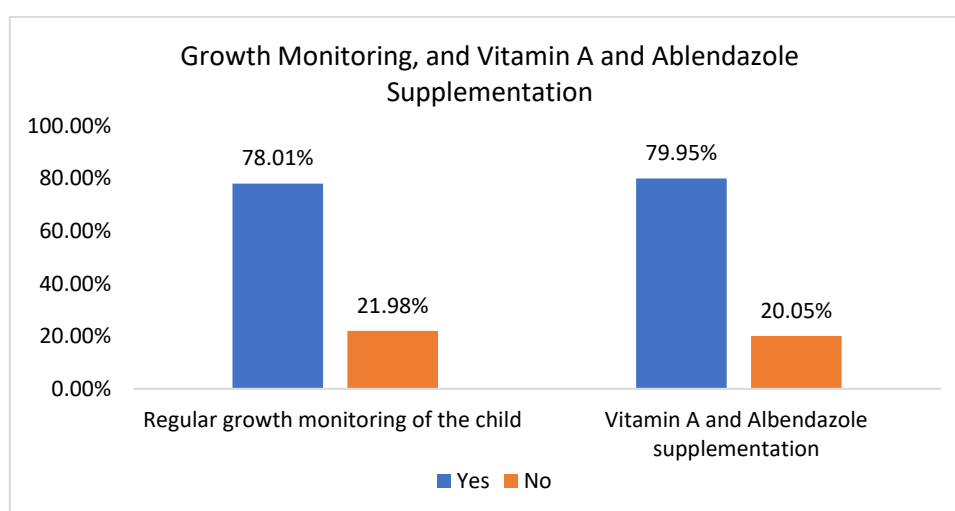


Figure 6: Growth monitoring, vitamin A and albendazole supplementation and immunization status of the children

Nutritional allowances

Among all the respondents, 46.62% (193 out of 414) reported receiving a nutritional allowance for their child. The expenditure of this allowance varies: the majority, 88.08% (170), allocate it towards purchasing foodstuffs, highlighting a direct investment in the child's immediate nutritional needs. A smaller portion, 6.74% (13), use the allowance for the education of their children, indicating an investment in their long-term development. Health-related expenditures also feature, with 9.33% (18) spending the allowance on health insurance, and 15.54% (30) allocating it for medical treatment, underscoring the role of the allowance in addressing healthcare needs. Additionally, a minimal 3.11% (6 out of 193) choose to save the allowance, suggesting a focus on future financial security or unforeseen needs.

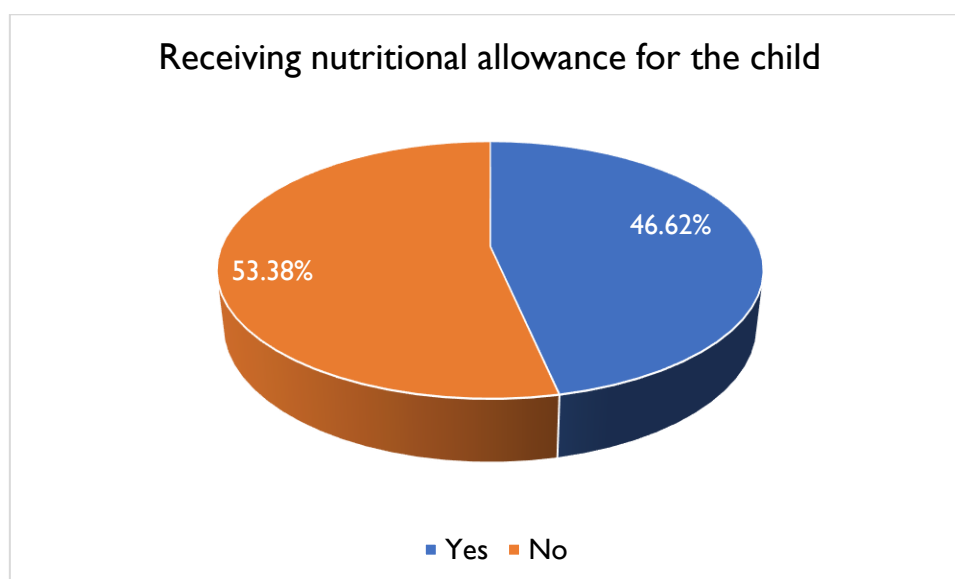


Figure 7: Receiving of nutritional allowance for the child

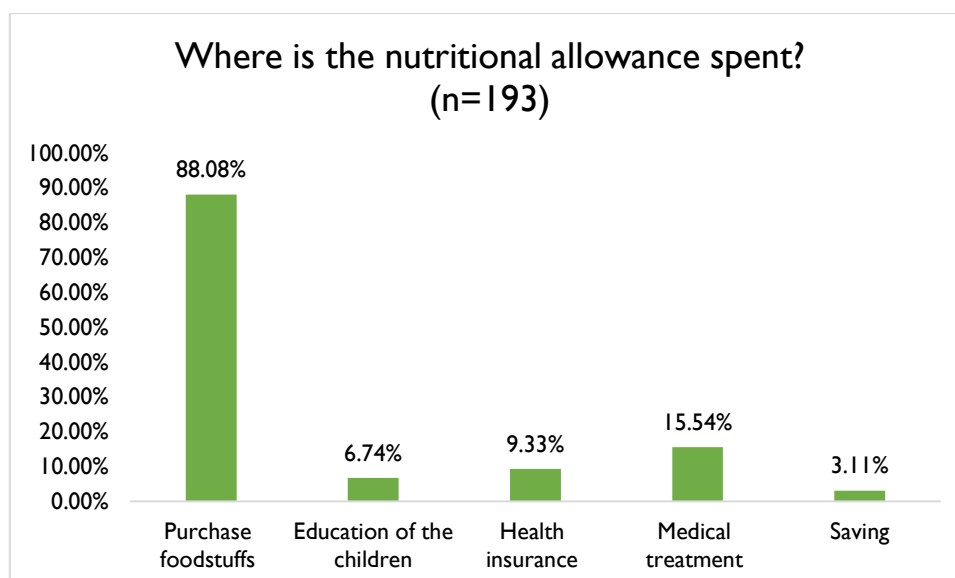


Figure 8: Area of nutritional allowance spend

Remedies for children in case of diarrhea

The data reflects the various remedies used during instances of diarrhea in the children, with the question allowing for multiple responses. The most popular remedy, as indicated by 75.60% (313 out of 414) of the respondents, is Oral Rehydration Solution (ORS), commonly known as Jeevanjal. This high percentage underscores the widespread reliance on ORS for managing dehydration caused by diarrhea. Zinc tablets, another effective treatment for diarrhea, were used by a significantly smaller proportion of respondents, at 5.56% (23 out of 414). An alternative category of 'Use other types of medicine' was chosen by 7.97% (33 out of 414) of the respondents, indicating a preference for various other medicinal approaches to tackle diarrhea. Additionally, a small percentage, 2.17% (9 out of 414), opted for remedies classified under 'Others', which could include a range of different treatments not specified in the main categories.

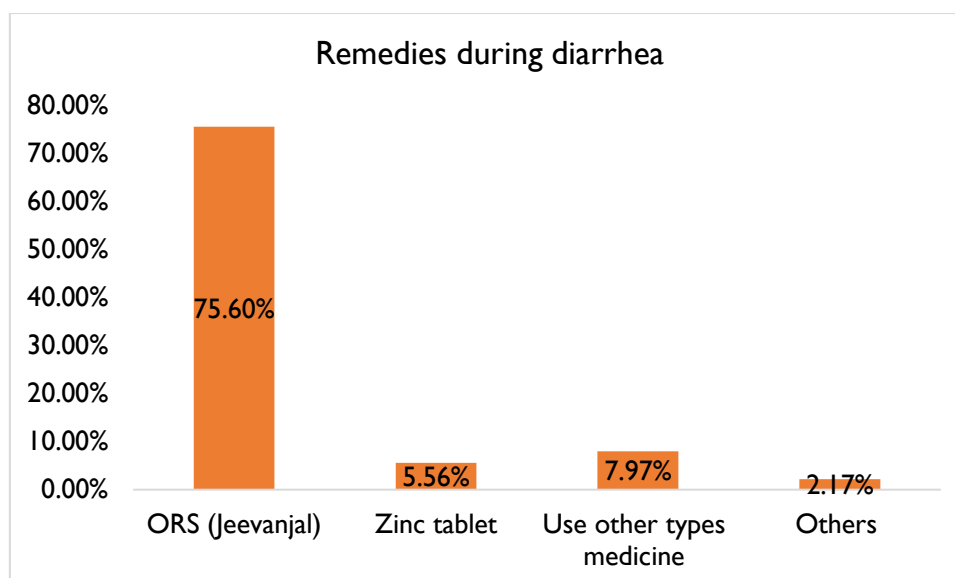


Figure 9: Remedies for child during diarrhea

Child feeding practices

The table below provides a comprehensive overview of infant feeding practices. A significant majority of respondents, 91.30% (378 out of 414), reported of feeding colostrum milk to their infants, highlighting a strong adherence to this recommended practice. In terms of exclusive breastfeeding, the predominant trend was breastfeeding up to six months, as practiced by 83.57% (346 out of 414) of respondents. Only a small fraction breastfed for three months or less and four to five months, each category representing 2.17% (9 out of 414). For infants not exclusively breastfed, alternative foods included Lito/biscuits/Horlicks (22.22%), rice (33.33%), and bottled milk (55.56%).

Regarding the initiation of complementary feeding, a vast majority, 86.23% (357 out of 414), started after six months, aligning with standard health recommendations. Only a small number began complementary feeding at earlier stages, including after four or five months, or as soon as birth. However, 10.14% (42 out of 414) had not started yet since their child is less than six months old. More than half of the respondents, 54.59% (226 out of 414), fed Balvita to their child, a form of supplemental nutrition.

The frequency of child feeding varied, with the highest percentage, 32.37% (134 out of 414), feeding their child three times per day, followed by two times and four times per day. The quantity of food per feeding also varied, with the most common amounts being 1 cup and less than 1 cup. General meal items were the most common mix in

the child's food, as reported by 85.02% (352 out of 414) of respondents. Likewise, mothers were the primary caregivers in terms of feeding, with 95.17% (394 out of 414) taking up this responsibility. Handwashing before and after feeding was widely practiced, with 94.93% (393 out of 414).

Table no. 4: Child feeding practices

Fed colostrum milk		
Yes	91.30%	378
No	8.70%	36
Exclusive breastfeeding		
Upto three months or less	2.17%	9
Four to five months	2.17%	9
Upto six months	83.57%	346
More than six months	0.48%	2
NA (child less than six months)	11.59%	48
If not breast-milk, what fed up to 6 months?		
Lito/biscuits/horlicks	22.22%	4
Rice	33.33%	6
Bottle milk	55.56%	10
After how many months the complementary feeding started		
After four months	1.21%	5
After five months	1.93%	8
After six months	86.23%	357
As soon as birth	0.48%	2
Not started yet	10.14%	42
Fed Balvita to child		
Yes	54.59%	226
No	45.41%	188
Per day frequency of child feeding		
Two times	22.71%	94
Three times	32.37%	134
Four times	21.50%	89
More than four times	13.29%	55

Not started yet	10.14%	42
How much feed the child at once		
Less than one cup	16.43%	68
1 cup	21.01%	87
2 cups	18.36%	76
3 cups	17.63%	73
4 cups	13.29%	55
5 cups or more	3.14%	13
Not started yet	10.14%	42
What is mixed in the food of child		
General meal items	85.02%	352
Cerlax/lito/cowmilk	4.83%	20
Not started yet	10.14%	42
Who feeds the child?		
Self	1.21%	5
Mother	95.17%	394
Brother/sister	0.24%	1
Father	0.24%	1
Grandparents	3.14%	13
Handwashing before and after feeding the child		
Yes	94.93%	393
No	5.07%	21

Type of salt used in home

Almost all households, totaling 99.52%, utilize iodized salt, while merely 0.48% opt for non-iodized salt, showcasing widespread adherence to iodine supplementation guidelines for better public health.

Table 5: Types of salt used in home

Type of salt used in home		
Iodized salt	99.52%	412
Non iodized salt	0.48%	2

Awareness regarding health and issues of children and newborn

About 62.32% of respondents are knowledgeable about newborn eye and ear infections, while 37.68% lack awareness in this regard. Similarly, 67.63% of respondents are informed about the mental and intellectual development of children, while 32.37% are not familiar with these aspects of child growth and cognition.

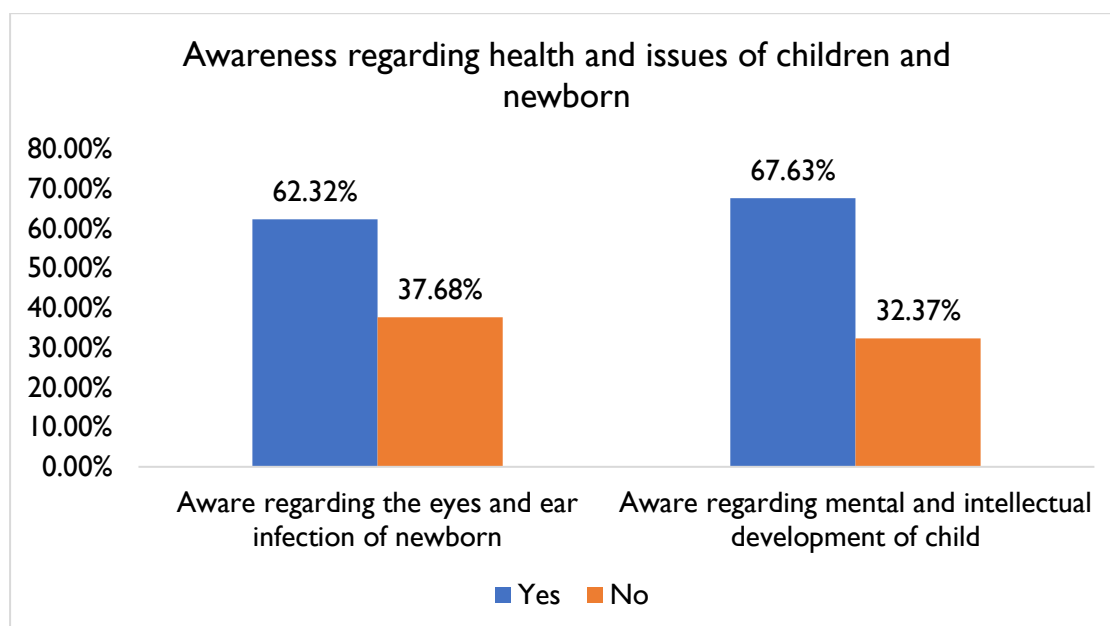


Figure 10: Awareness regarding health and issues of children and newborn

Safe Motherhood and Family Planning

ANC services

The data revealed that 97.83% of the pregnant mothers (405 out of 414) reported receiving Antenatal Care (ANC) services, indicating a high level of engagement with healthcare during pregnancy. Among those who attended ANC, the most common frequency was less than 4 times, as reported by 46.91% (190 out of 405), followed by 4 times by 32.35% (131 out of 405). A smaller percentage received ANC 4-8 times (14.32%, 58 out of 405) and 8 times (6.42%, 26 out of 405), demonstrating varied levels of healthcare access and utilization among the respondents.

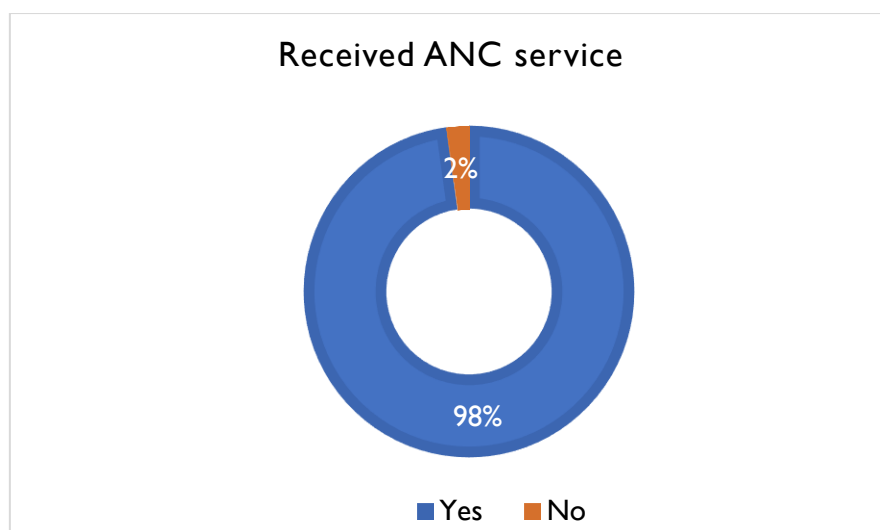


Figure 11: ANC checkup status

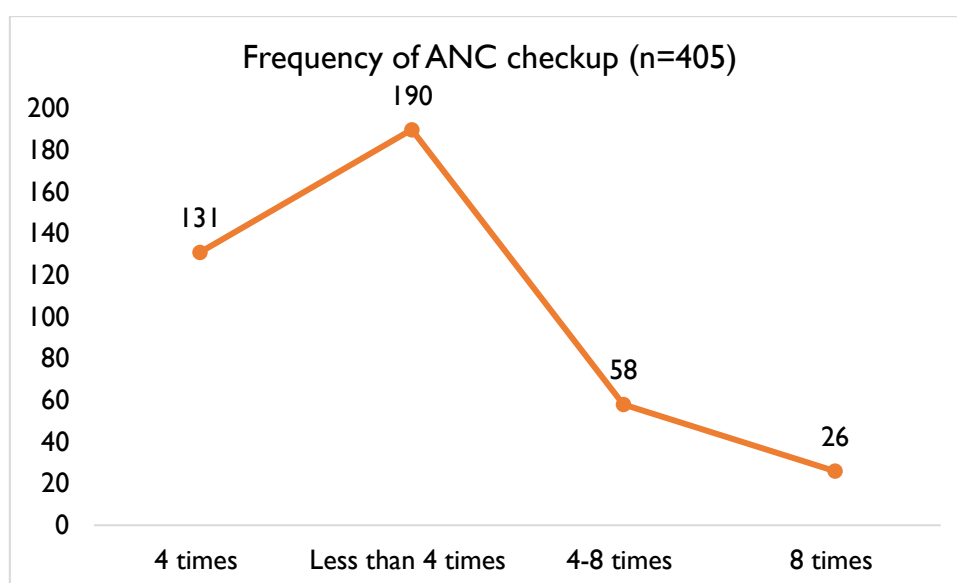


Figure 12: Frequency of ANC Checkup

TD vaccine, iron tablets and folic acid during pregnancy

The data shows a high uptake of Tetanus Diphtheria (TD) vaccinations among the respondents, with 98.55% (408 out of 414) receiving the vaccine, and only 1.45% (6 out of 414) not receiving it. Regarding iron supplementation during pregnancy, 97.83% (405 out of 414) of the respondents took 180 iron tablets, indicating strong adherence to recommended prenatal care practices. However, post-delivery iron tablet consumption dropped, with 66.43% (275 out of 414) taking them and 33.57% (139 out of 414) not taking them.

Folic acid tablet consumption presented a different trend, with a significant 75.36% (312 out of 414) of respondents not taking them at all. Among those who did, 19.08% (79 out of 414) started after three months of pregnancy, 3.62% (15 out of 414) began three months before pregnancy, and only 1.93% (8 out of 414) started after getting pregnant.

Table 6: TD vaccine, iron tablets and folic acid during pregnancy

Received TD vaccine

Yes	408	98.55%
No	6	1.45%

180 iron tablets during pregnancy

Taken	405	97.83%
Not taken	9	2.17%

Iron tablets after the delivery (upto 45 days)

Taken	275	66.43%
Not taken	139	33.57%

Folic acid tablet consumption

Didn't take	312	75.36%
After getting pregnant	8	1.93%
After three months of pregnancy	79	19.08%
Three months before pregnancy	15	3.62%

Place of delivery of last-child

The data reflects the place where the last child of respondents was delivered. The majority, constituting 65.22% (270 out of 414), gave birth in governmental hospitals. A smaller yet noteworthy percentage, 15.46% (64 out of 414), opted for home births. Private hospitals accounted for 14.25% (59 out of 414) of deliveries, while only a minor portion occurred at health posts (4.35%, 18 out of 414) or primary health care centers (0.72%, 3 out of 414).

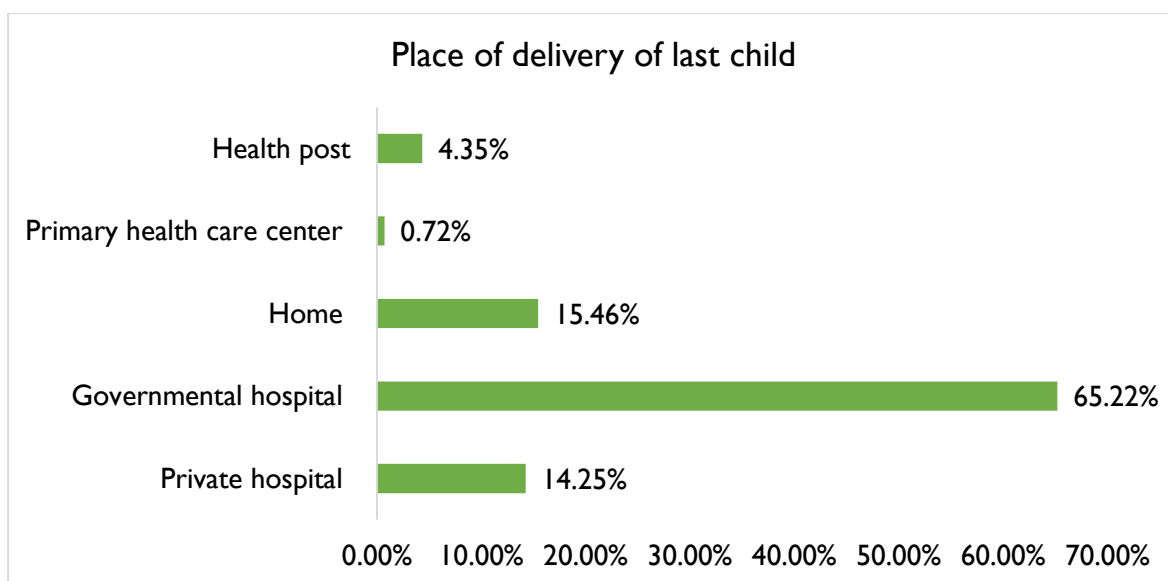


Figure 13: Place of delivery of last child

For the 64 respondents who had home deliveries, the data regarding the cutting of the umbilical cord reveals that a vast majority, 96.88%, used a regular blade, while only 3.13% used a knife. As for the person assisting in cutting the umbilical cord, over half (54.69%) were aided by their mother or mother-in-law. Female Community Health Volunteers (FCHV) or other trained personnel were involved in 28.13% of the cases, indicating a significant presence of skilled assistance during home births. Other family members were involved in 9.38% of the instances, while neighbors helped in 7.81% of the cases.

Table 7: Cutting of umbilical cord

How was the umbilical cord of child was cut (n=64)

Knife	2	3.13%
Regular blade	62	96.88%

Who helped in cutting the umbilical cord (n=64)

Mother/mother-in-law	35	54.69%
FHCV or other trained personnel	18	28.13%
Other family members	6	9.38%
Neighbors	5	7.81%

Travel allowance in case of institutional delivery

Among the 350 respondents who had institutional deliveries, a substantial majority, 81.14% (284 out of 350), received a travel allowance. However, 18.86% (66 out of 350) did not receive this allowance, suggesting that there are still gaps in the implementation of this support system.

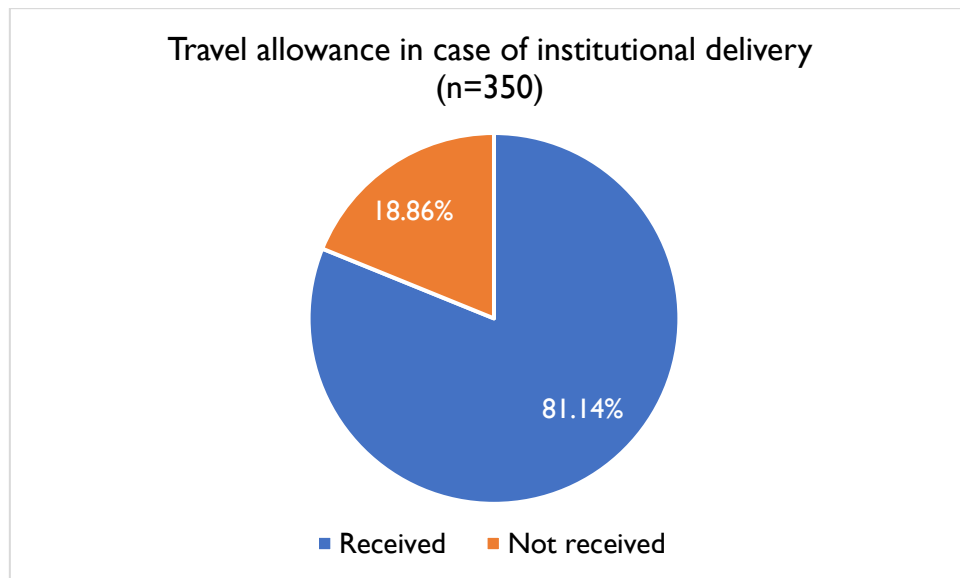


Figure 14: Travel allowance in case of institutional delivery

PNC check up

The data on Postnatal Care (PNC) check-ups shows varied attendance among the respondents. A significant 52.66% (218 out of 414) did not attend any PNC check-up. This highlights a considerable gap in postnatal healthcare engagement. On the other hand, 29.71% (123 out of 414) attended a PNC check-up within 24 hours of childbirth, indicating a proactive approach by a substantial number of new mothers. Attendance on the 3rd day of childbirth was observed in 14.01% (58 out of 414) of the cases, while a much smaller percentage attended on the 14th day (2.90%, 12 out of 414) and the 42nd day (1.93%, 8 out of 414). The data suggests that immediate postnatal care is more commonly sought, with a significant drop in follow-up as the post-delivery period extends.

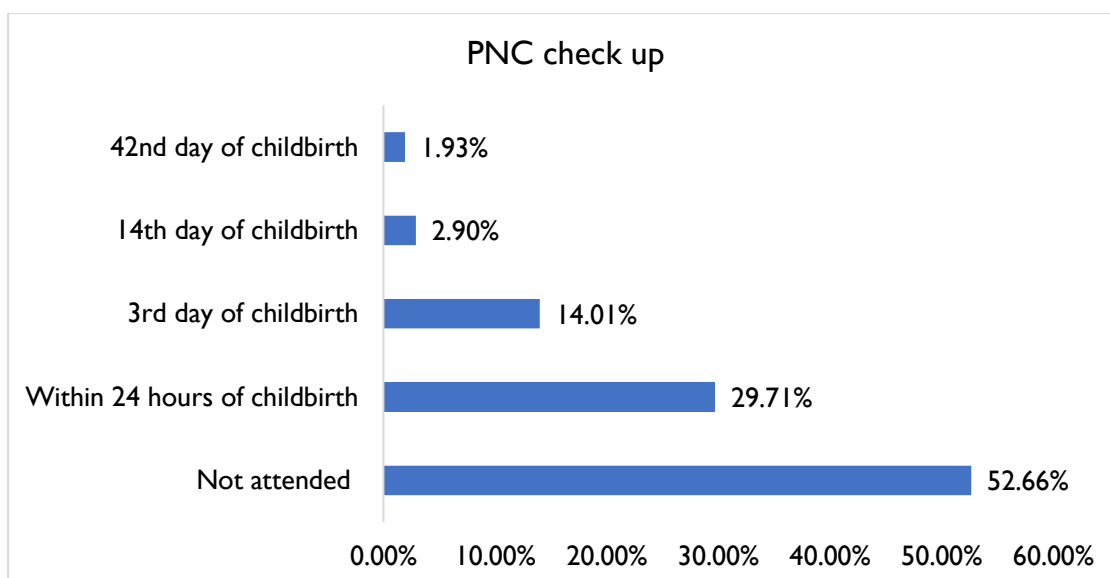


Figure 14: ANC checkup status

Weight of child at birth

A majority, comprising 57.73% (239 out of 414), had a birth weight exceeding 2.5 kg. Additionally, 29.47% (122 out of 414) had a birth weight of precisely 2.5 kg. A smaller proportion, 9.66% (40 out of 414), were born with a weight below 2.5 kg, indicating a lower birth weight category. However, 3.14% (13 out of 414) of respondents did not have information about their child's birth weight.

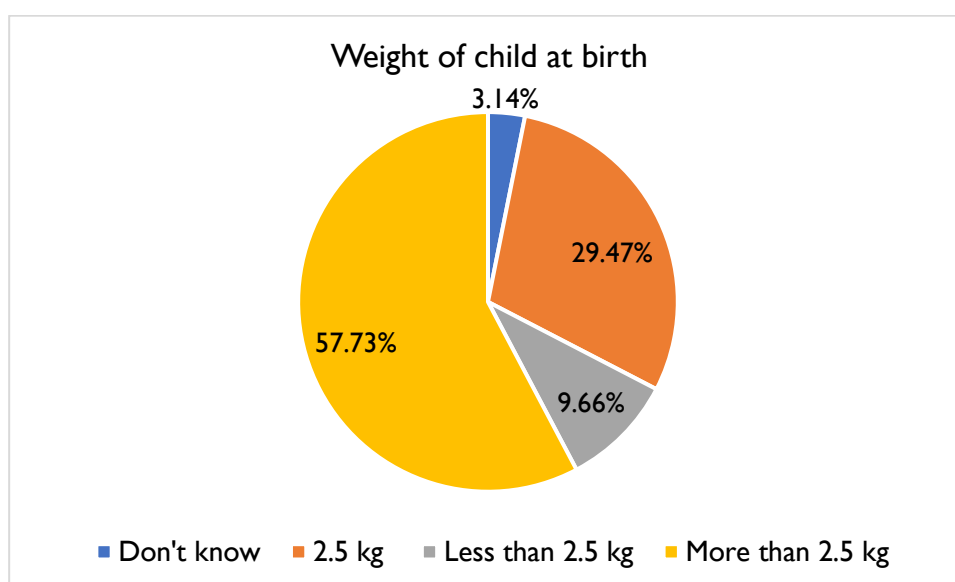


Figure 15: Weight of child at birth

Birth registration of the child

The data reveals that 78.02% (323 out of 414) of the children had their births registered. However, a notable 21.98% (91 out of 414) did not undergo birth registration. Among those who did not register their child's birth, the reasons varied: 16.48% (15 out of 91) were unaware of the need for registration, indicating a gap in information dissemination. A significant 35.16% (32 out of 91) couldn't register due to not having citizenship, and 20.88% (19 out of 91) faced issues due to the absence of a marriage certificate. The absence of the child's father, noted by 10.99% (10 out of 91), and being too busy, reported by 7.69% (7 out of 91), were other reasons. Meanwhile, 8.79% (8 out of 91) mentioned that the process was ongoing.

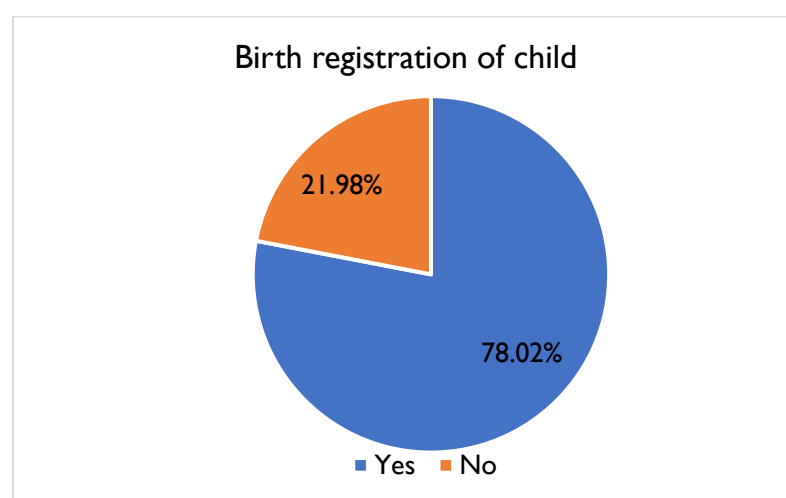


Figure 16: Birth registration of child

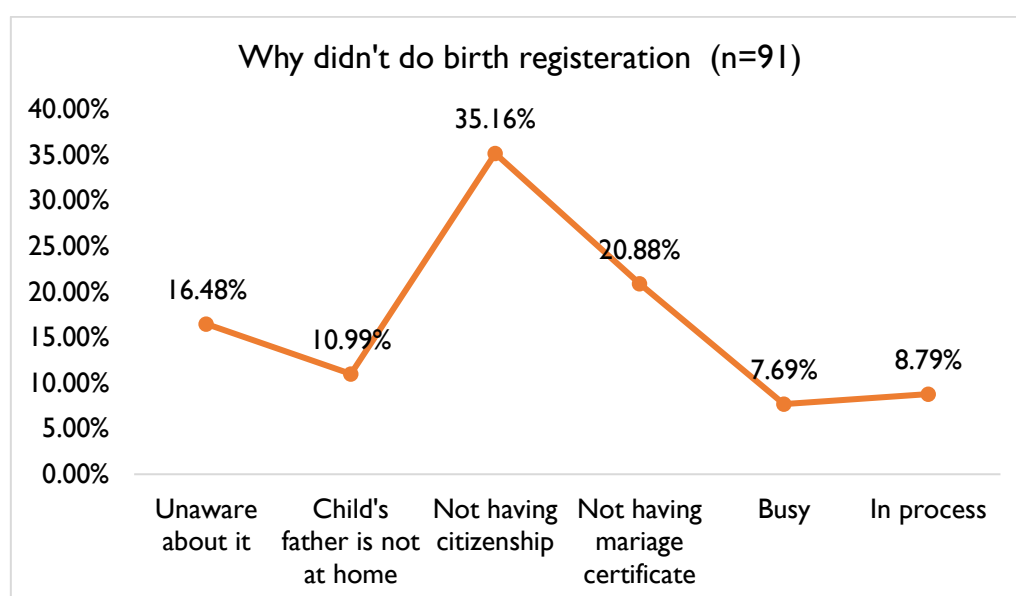


Figure 15: Reason for not doing birth registration of child

Family planning and contraceptive devices

The data reflects the awareness and use of family planning methods among the respondents. Out of 414 respondents, 69.08% (286 individuals) have heard about family planning methods. Among those who were aware of family planning methods (286 respondents), 37.76% (108 individuals) were currently using a family planning device. In contrast, a larger group of 62.24% (178 individuals) were not using any such device at the time of the survey. This disparity suggests various factors like personal choice, health concerns, or lack of access might influence the utilization of family planning methods.

Regarding the types of family planning devices in use (among 108 users), the most common was the Depo injection, used by 37.04% (40 individuals). This was closely followed by oral contraceptive pills, chosen by 35.19% (38 individuals). Condoms were being used by 12.04% (13 individuals), while implants and permanent methods were each opted for by 7.41% (8 individuals). Only 0.93% (1 individual) reported using an Intrauterine Contraceptive Device (IUCD).

Table 8: Family planning and contraceptive devices

Heard about methods of family planning

Yes	286	69.08%
No	128	30.92%

Currently using any type of family planning device (n=286)

Yes	108	37.76%
No	178	62.24%

Which device of family planning is currently used (n=108)

Implant	8	7.41%
IUCD	1	0.93%
Condom	13	12.04%
Depo	40	37.04%
Pills	38	35.19%
Permanent method	8	7.41%

Birth spacing between the last two child

Among the respondents who had two or more children (229 respondents), the distribution of spacing periods varies. The most common spacing was between two to three years, accounting for 31.44% (72 out of 229), followed closely by three to four years, constituting 25.33% (58 out of 229). Other significant periods included one year (13.54%, 31 out of 229) and five years or more (13.97%, 32 out of 229). Spacing between four to five years accounted for 10.92% (25 out of 229), while the smallest segments were one to two years (4.80%, 11 out of 229).

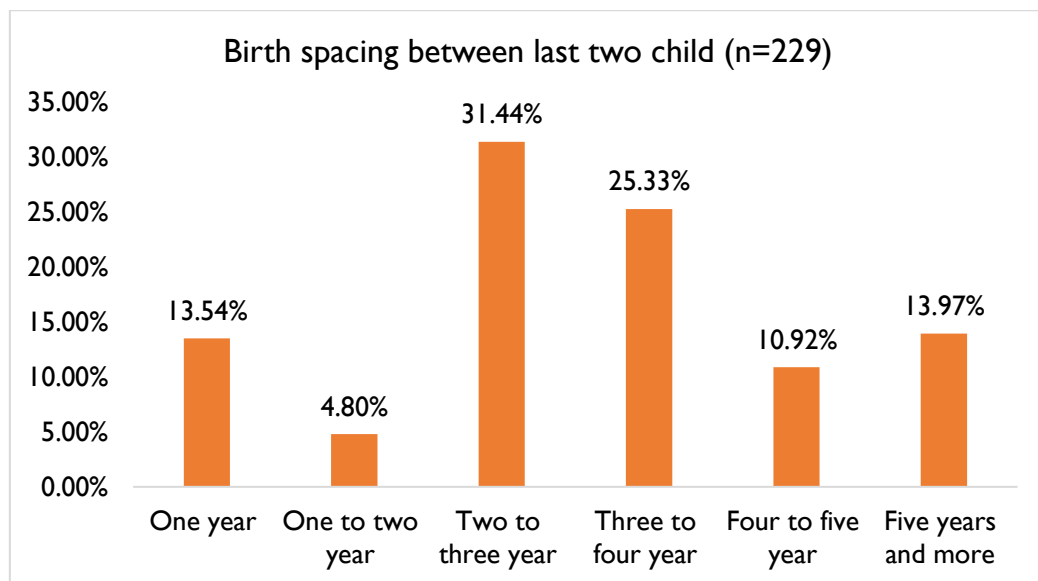


Figure 16: Birth spacing between last two child

Pregnancy indicators

Among the study participants, only a small percentage, 2.90% (12 out of 414), reported experiencing an abortion or miscarriage. The reasons for these incidents varied: 41.67% (5 out of 12) did not know the cause, 25% (3 out of 12) attributed it to health issues, and 33.33% (4 out of 12) to workload. Additionally, 3.14% (13 out of 414) reported a stillbirth, and the same percentage (3.14%, 13 out of 414) experienced the death of an under-five child in the last five years. In cases where a child died, only 7.69% (1 out of 13) of the mothers admitted to smoking or drinking during the pregnancy of the deceased child. In general, smoking or drinking during pregnancy was rare among the respondents, with only 0.72% (3 out of 414) engaging in such habits. Anaemia in the last five years was reported by 16.43% (68 out of 414) of the

participants, while a majority, 78.02% (323 out of 414), did not experience anaemia, and 5.56% (23 out of 414) were unknown about it.

Table 9: Pregnancy indicators

Abortion or miscarriage

Yes	12	2.90%
No	402	97.10%

Reason of abortion/miscarriage (n=12)

Don't know	5	41.67%
Due to health issues	3	25.00%
Workload	4	33.33%

Still birth

Yes	13	3.14%
No	401	96.86%

Death of underfive child in last 5 years

Yes	13	3.14%
No	401	96.86%

Smoking/drinking during pregnancy of that died child? (n=12)

Yes	1	7.69%
No	12	92.31%

Smoking/drinking during pregnancy

Yes	3	0.72%
No	411	99.28%

Anaemia during the last five years

Yes	68	16.43%
No	323	78.02%
Don't know	23	5.56%

Eating frequency during pregnancy and childbirth

The data in the table below presents the frequency of food intake during pregnancy and childbirth among the respondents. During pregnancy, the majority reported consuming food three times a day, accounting for 50.72% (210 out of 414) of the respondents, followed by those eating twice a day, representing 39.13% (162 out of

414). A smaller portion reported consuming food four times a day (8.94%, 37 out of 414) or more than four times (1.21%, 5 out of 414).

During childbirth, a similar pattern emerged, with half of the respondents consuming food twice a day (50.97%, 211 out of 414) and a significant proportion eating three times a day (42.75%, 177 out of 414). Fewer individuals reported eating four times a day (5.80%, 24 out of 414) or more than four times a day (0.48%, 2 out of 414) during childbirth.

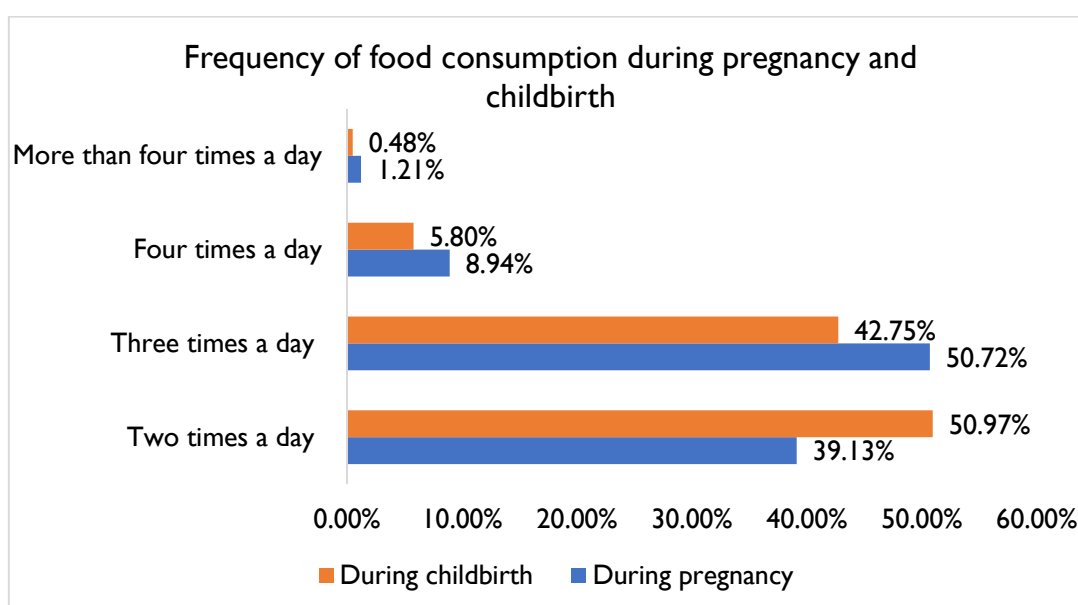


Figure 17: Frequency of food consumption during pregnancy and childbirth

Water Sanitation and Hygiene

Source of drinking water

The dataset illustrated that the primary source of drinking water was handpump, comprising 96.62% (400 out of 414). A smaller percentage, 2.17% (9 out of 414), used jars as their primary water source, while an additional 1.21% (5 out of 414) reported other sources. In terms of proximity to sanitation facilities, 29.95% (124 out of 414) of the water sources are located less than 10 meters from a toilet. A majority, 62.32% (258 out of 414), are situated 10 to 30 meters away, and 7.73% (32 out of 414) are more than 20 meters distant.

Water purity testing has been conducted by 24.88% (103 out of 414) of the respondents. Of those tests, 91.26% (94 out of 103) checked for iron content, and 5.83% (6 out of 103) tested for arsenic. For water purification at home, 35.99% (149

out of 414) of the respondents take measures to purify their water. Among them, 32.89% (49 out of 149) boil their water, and 69.80% (104 out of 149) use filters.

Table 10: Drinking water related information

Main source of drinking water

Handpump	400	96.62%
Jar	9	2.17%
Other	5	1.21%

How many meters far is the source of drinking water from toilet?

Less than 10 meters	124	29.95%
10 to 30 meters	258	62.32%
More than 20 meters	32	7.73%

Water purity test of drinking water done

Yes	103	24.88%
No	311	75.12%

What was tested in the water test (n=103)

Iron	94	91.26%
Arsenic	6	5.83%

Purification of water at home

Yes	149	35.99%
No	265	64.01%

Method of water purification (n=149)

Boiling	49	32.89%
Filter	104	69.80%

Toilet and sanitation

Out of the total respondents, 84.30% (349 out of 414) have toilets in their homes, while 15.70% (65 out of 414) do not. Among those without a toilet in their house, the majority, 60.00% (39 out of 65), use open places for defecation. A smaller portion, 35.38% (23 out of 65), go to riversides, and only 4.62% (3 out of 65) use the facilities at a neighbor's or relative's house.

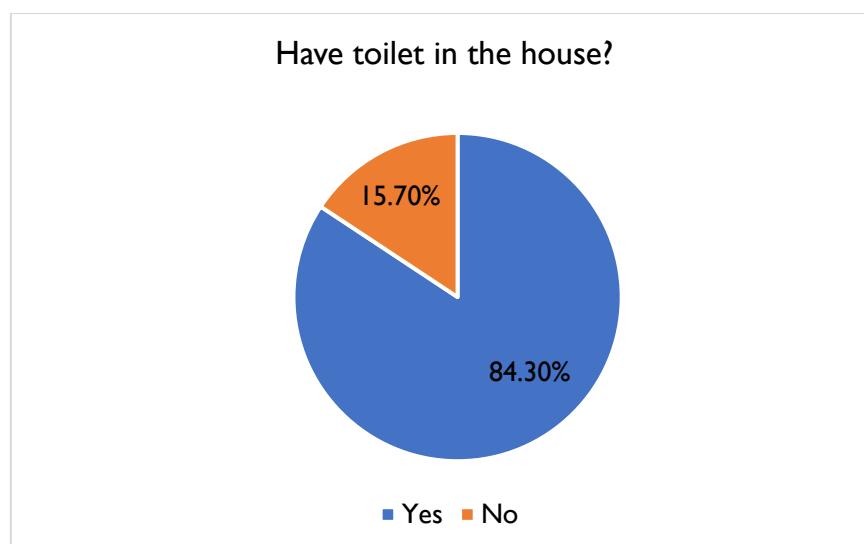


Figure 18: Presence of toilet in the house

Regarding hygiene practices, a majority of 87.20% (361 out of 414) of the respondents use slippers while going to the toilet, which is a good practice for preventing the spread of germs and maintaining personal hygiene. However, 12.80% (53 out of 414) do not use slippers, indicating a potential area for improvement in personal hygiene practices.

Table 11: Hygiene practices in relation to toilet

**If there is no toilet in the house, where does the respondent's family go?
(n=65)**

Open place	39	60.00%
Neighbor's/relatives' house	3	4.62%
Riverside	23	35.38%

Using slippers while going toilet

Yes	361	87.20%
No	53	12.80%

Household waste management

The data depicts diverse methods employed by households for waste management, allowing for multiple responses. Burning emerged as a prevalent practice, with approximately half of the respondents, constituting 50.48% (209 out of 414), resorting to this method. Similarly, dumping waste was a common approach, reported by 47.10% (195 out of 414) of the participants. A smaller yet notable proportion, about 14.25%

(59 out of 414), utilized cowsheds for waste disposal, likely for organic waste treatment. However, a concerning finding was that 18.12% (75 out of 414) haphazardly disposed of waste or threw it into rivers, posing environmental and health hazards.

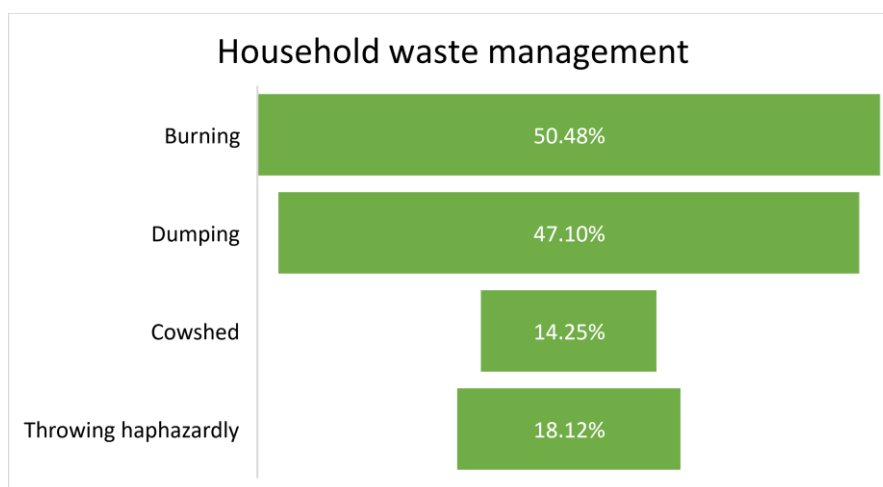


Figure 19: Household waste management

Kitchen garden and crop production sufficiency

Around half of the households surveyed, accounting for 49.03% (203 out of 414), reported having a kitchen garden within their homes. Similarly, the data suggests that crop production from these households might not entirely meet their needs throughout the year, with 54.35% (225 out of 414) indicating that their household crop production falls short of fulfilling their requirements for the entire year.

Table 12: Kitchen garden and crop production sufficiency

Kitchen garden in the home

Yes	203	49.03%
No	211	50.97%

Does the household crop production fulfill the need till a year?

Yes	189	45.65%
No	225	54.35%

Health Status of the Family

Chronic disease in the family

Among the surveyed households, 25.12% (104 out of 414) reported having at least one member with a chronic disease. For those households with chronic illnesses, the most prevalent condition was high blood pressure, affecting 63.46% (66 out of 104) of the families. Diabetes was reported by 16.35% (17 out of 104) of the households, while a smaller percentage cited asthma (4.81%, 5 out of 104), thyroid issues (2.88%, 3 out of 104), and cancer (0.96%, 1 out of 104) as chronic diseases within their families.

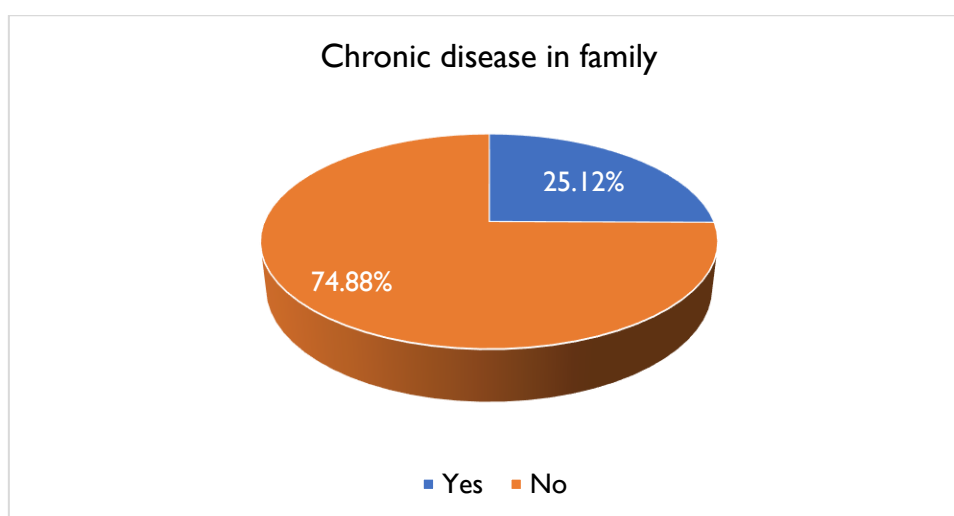


Figure 20: Chronic disease in family

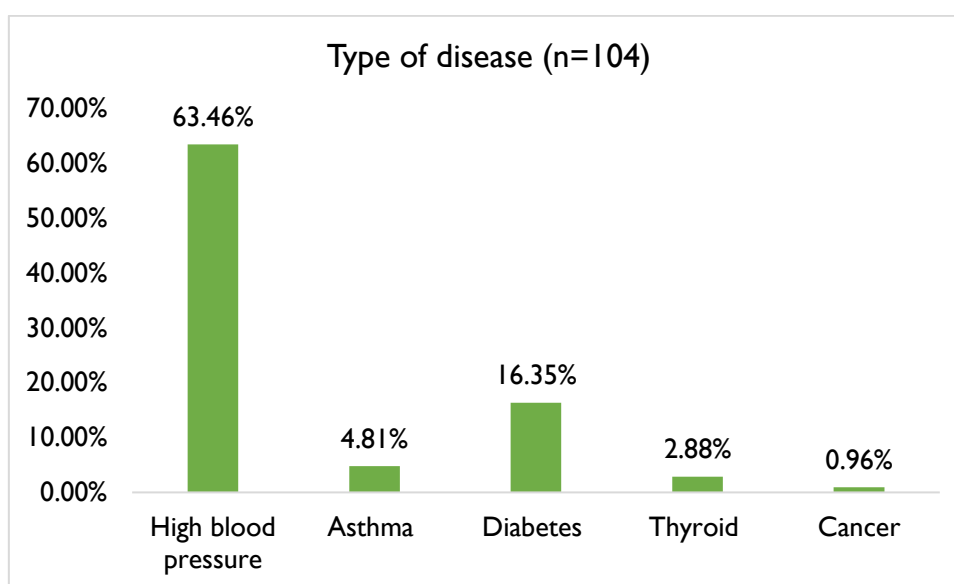


Figure 21: Type of chronic disease in family

TB infection in the family

In the surveyed group, 3.62% of families (15 out of 414) reported having a member with tuberculosis (TB). Among those families with a TB infection, the majority identified the grandparent of the child as the infected individual, accounting for 60% (9 out of 15) of the cases. Parents of the child were the next most common group affected, representing 26.67% (4 out of 15) of the TB cases. Siblings of the child comprised the smallest group, with 13.33% (2 out of 15) being affected.

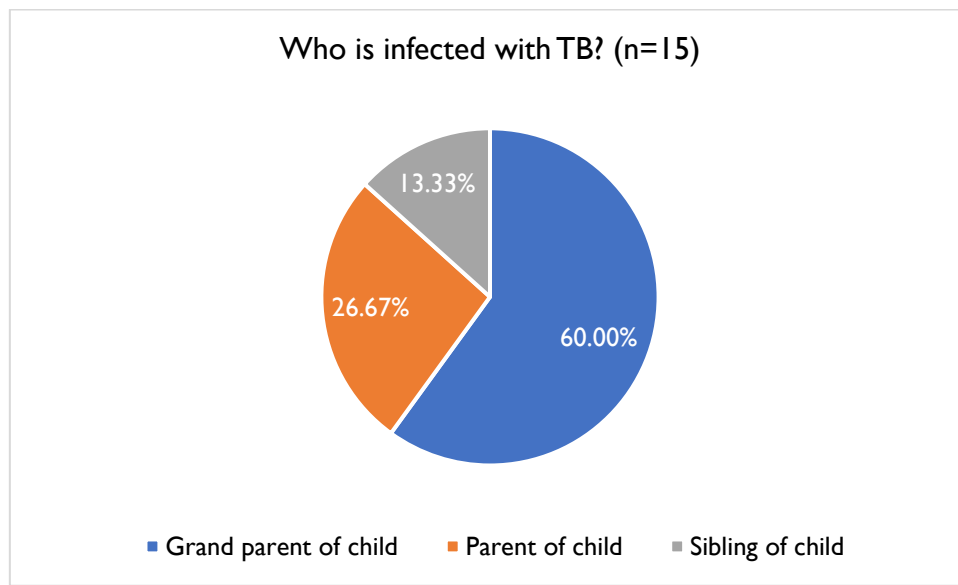


Figure 21: TB infection in the family

Disability

Among the surveyed households, 7.49% (31 out of 414) reported having a disabled individual within their home. Of the families with a disabled member, physical disability was the most prevalent, affecting 52.17% (12 out of 23) of the individuals. Hearing or speaking impairments were reported by 26.09% (6 out of 23), while eyesight disabilities accounted for 13.04% (3 out of 23). Additionally, 8.70% (2 out of 23) mentioned having a family member with mental retardation.

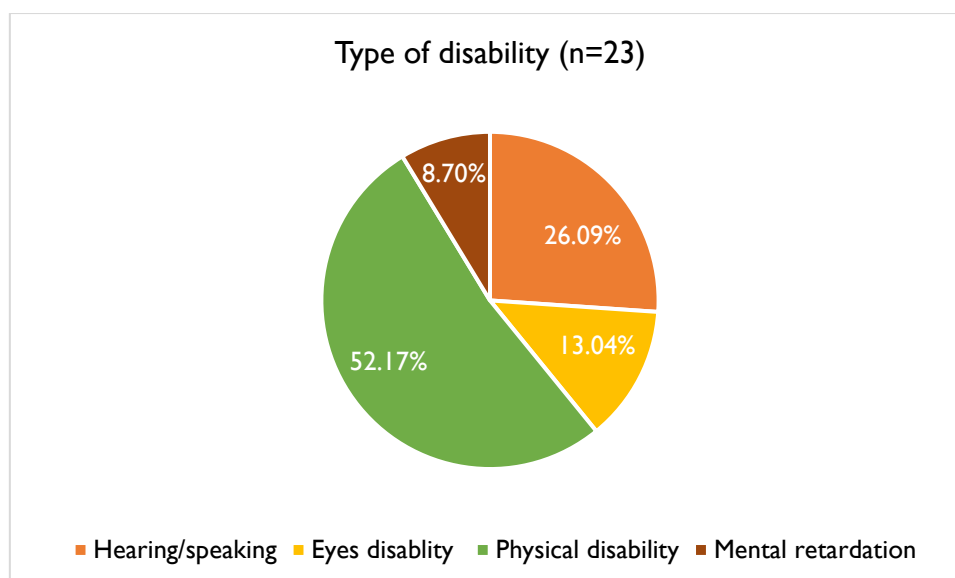


Figure 23: Type of disability

Treatment and health insurance

In the surveyed group, 39.86% (165 out of 414) of households reported that their income was sufficient to cover treatment expenses, while the majority, 60.14% (249 out of 414), indicated that their income was not enough. Regarding healthcare-seeking behavior, when faced with health issues, 50.72% (210 out of 414) of respondents would initially go to a hospital, while 43.96% (182 out of 414) would opt for a health post or primary health care center (PHCC). A smaller percentage, 5.31% (22 out of 414), preferred private clinics.

In terms of health insurance, only 13.04% (54 out of 414) of families had health insurance, with a large majority of 86.96% (360 out of 414) not having any. The reasons for not enrolling in health insurance varied: 63.89% (230 out of 360) were unaware of the service, 25.28% (91 out of 360) cited financial constraints, 2.22% (8 out of 360) lacked citizenship, 5.83% (21 out of 360) did not feel the necessity, and 2.78% (10 out of 360) perceived the service quality as inadequate. These findings reveal significant gaps in health insurance coverage and awareness, as well as financial barriers to healthcare access.

Table 13: Treatment and health insurance related information

Is household income sufficient for treatment expenses?

Yes	165	39.86%
-----	-----	--------

No	249	60.14%
In case of health issues, the initial place to seek treatment		
Hospital	210	50.72%
Health post/PHCC	182	43.96%
Private clinic	22	5.31%
Health insurance of the respondent's family		
Yes	54	13.04%
No	360	86.96%
Why haven't enrolled in the health insurance? (n=360)		
Unaware of the service	230	63.89%
Financial problem	91	25.28%
No citizenship	8	2.22%
Didn't feel necessary	21	5.83%
Felt that service is not good	10	2.78%

COVID-19

From the surveyed households, 4.35% (18 out of 414) reported having someone infected with COVID-19 within their family, while the majority, 95.65% (396 out of 414), did not. Concerning employment, 6.52% (27 out of 414) mentioned that someone in their family lost their job during the COVID-19 pandemic, while 93.48% (387 out of 414) reported no job loss.

In terms of protective measures, 43.72% (181 out of 414) of respondents reported using masks in crowded places, while 56.28% (233 out of 414) did not. Regarding vaccination, 71.50% (296 out of 414) stated being fully vaccinated against COVID-19, while 28.50% (118 out of 414) had not completed their vaccination regimen.

Table 14: COVID-19 related information

Was anyone infected with COVID-19 in the family?

Yes	18	4.35%
No	396	95.65%

Did anyone from the family loss the job during COVID-19 pandemic?

Yes	27	6.52%
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No	387	93.48%
Does the respondent use mask in the crowd?		
Yes	181	43.72%
No	233	56.28%
Fully vaccinated against COVID		
Yes	296	71.50%
No	118	28.50%

CHAPTER IV

QUALITATIVE FINDINGS OF THE STUDY

Findings from Focus Group Discussions

Two focus group discussions were conducted in the ward 2 and 6 of the rural municipality. Study methodology included a qualitative data collection approach, focus group discussion which was conducted among the mother's group to gain their insights on child health practices including mother's behaviors. The findings demonstrated how personal, structural and societal /cultural factors influence meaning of food and dietary practices.

In Tilathi Koiladi rural municipality, various significant nutritional challenges have been identified. A lack of mother's group meetings has been observed, along with varying dietary practices. Nutritional disparity is seen as a significant challenge in this area. It has been noted that poverty and a lack of awareness are major contributors to malnutrition in the community. Reports indicate that unsatisfactory treatment by health care providers at health centers often leads community members to return empty-handed. It has been stated that health workers frequently inform them rudely about the unavailability of nutritious foods for children, causing disappointment when these foods are not available at subsequent visits. Consequently, negative perceptions towards health care providers and their services have developed among the people.

Furthermore, a lack of adequate knowledge about Antenatal Care (ANC) and Postnatal Care (PNC) visits among mothers has been observed. It was found that some mothers cease taking iron tablets immediately after childbirth and are generally uninformed about the importance of folic acid. Additionally, many mothers, lacking citizenship and marriage certificates, are unable to secure nutritional allowances for their children. A preference for institutional over home delivery has been noted. However, there is a lack of proper infant and young child feeding practices among mothers. Only sporadically do Female Community Health Volunteers (FCHVs) conduct the Mid-Upper Arm Circumference (MUAC) test for children in the ward.

It has also been found that most mothers participating in Focus Group Discussions (FGDs) were unaware of health insurance and tended to visit private hospitals when family members fell ill. These mothers reported using untreated tube well water and

a lack of toilets in their homes, often resorting to using relatives' toilets or practicing open defecation. Additionally, issues with Water, Sanitation and Hygiene (WASH) are prevalent in marginalized communities.

A lack of education on safe motherhood in rural areas and awareness of nutrition's role in life have been identified as barriers in accessing maternal healthcare services. The absence of birth registration, often due to mothers lacking citizenship certificates, has been observed. Despite institutional deliveries, many mothers reported not receiving any incentives from hospitals. Furthermore, a lack of awareness about balanced diets and healthy eating practices exacerbates the situation. Overcoming these challenges necessitates comprehensive efforts from health workers, including improving agricultural practices, strengthening community-level healthcare systems, and implementing educational programs to raise awareness about proper nutrition and its long-term benefits.

By the end of the FGDs, participants gained awareness about malnutrition and understood the importance of dietary and feeding practices for children, as well as the significance of nutritional practices in daily life.

Findings from Key Informant Interviews

From the comprehensive Key Informant Interviews (KIs) conducted with varied stakeholders in Tilathi Koiladi Rural Municipality, a multifaceted understanding of the health and nutrition landscape emerged. The consensus among stakeholders underscores the prevailing issue of malnutrition within the community. Ward chairpersons and health coordinator highlighted this concern, attributing it largely to a lack of education and awareness. Instances of malnourished children were observed, prompting immediate intervention through referral to health facilities, reflecting a reactive approach rather than a dedicated budgetary allocation for malnutrition. However, the community's consumption of locally grown food and ongoing nutrition programs in schools showed promising impacts.

The stakeholders collectively emphasized the need for robust nutrition education and poverty eradication strategies to combat malnutrition effectively. Acknowledgment of the Multi-Sectoral Nutrition Plan (MSNP) and its importance in fostering awareness programs, especially in safe motherhood services, was a recurring theme. Challenges

such as limited access to quality healthcare, low awareness, and socioeconomic factors were recognized as impediments. Collaborative efforts between government agencies, NGOs, and national health institutes were stressed upon to strengthen awareness and monitor the efficacy of interventions.

Furthermore, discussions centered on the municipality's commitment to raising awareness, collaborating with different local organizations, and implementing initiatives aimed at improving health and nutrition of under five children and mothers. Efforts included incentivizing institutional deliveries, conducting health camps, and distributing essential supplements. The significance of poverty alleviation, nutritional support for children, and the critical role of water, sanitation, and hygiene (WASH) practices in maintaining good health were recurrent focal points.

Overall, the KIs underscored a unified acknowledgment of malnutrition's presence, emphasizing the imperative for education, awareness programs, and collaborative efforts among stakeholders to effectively address the health and nutrition challenges within Tilathi Koiladi Rural Municipality.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

The survey was conducted in Wards 1 to 8 of Tilathi Koiladi Rural Municipality among of 414 households, prioritizing both the general and marginalized communities. The survey encompassed anthropometric measurements including age, height/length, weight, and MUAC, alongside focused Group Discussions (FGD) with mother's group and Key Informant Interview with the concerned stakeholders. The engagements involved counseling sessions addressing safe motherhood, child health, and their associated benefits. Efforts were made to impart knowledge on nutrition education, exclusive breastfeeding, and social security schemes. Additionally, impactful Water, Sanitation, and Hygiene (WASH) activities were implemented. These combined initiatives aimed to holistically address and enhance health, nutrition, and well-being within the Tilathi Koiladi rural municipality.

Voices received from community

- Mothers' complaint was towards negligence of health worker of health post.
- Mothers were not able to get nutrition incentives and they reported the inequality of nutrition incentive distribution.
- They also complaint that the nutrition food like Bal-Bhita aren't distributed in the community.
- Health workers don't mention the growth monitoring status in the immunization card.
- Health workers are not informed about which medicine we get freely in government health institutions.
- Community people said that we are facing the problem of safe drinking water.
- FCHVs in the community do not provide sufficient information about health insurance and social security scheme.
- Community people were unaware about the health insurance and social security scheme.
- They also had complaint about they didn't get medicine or either folic acid for a pregnant mother on time.

Lesson learnt

- Mothers tend to adhere to traditional and cultural child feeding practices.
- There is a clear need for awareness programs focusing on dietary practices for pregnant women and children.
- Awareness programs to aware the people on the benefits of folic acid supplementation are necessary.
- It's important to motivate mothers to continue taking iron tablets not only during pregnancy but also post-delivery.
- The local government should provide comprehensive training and capacity building for all health workers, including Female Community Health Volunteers (FCHVs).
- Community members need to be proactive in regularly monitoring growth and health check-ups.
- Raising awareness in the community about the importance of citizenship, marriage registration, and birth registration is crucial.
- Most community members share similar practices in child-rearing and care.
- There is a notable lack of health education in the community, especially regarding health insurance and family planning.
- FCHVs need to be more active in educating health to the mother groups about feeding practices, including the use of Balvita for babies.
- Health workers have been primarily measuring MUAC in children, often neglecting height and weight measurements, which has been a concern expressed by community mothers.

Issues & Challenges

- A significant gap in awareness about government services, including a lack of understanding about Antenatal Care (ANC), Postnatal Care (PNC), family planning, and health insurance, uses of Folic Acid.
- Poor hygiene practices among Dalit women and their children, coupled with unsafe birthing practices like using blades for umbilical cord cutting at home.

- Inadequate health facilities and services provided by health workers in Tilathi Koiladi rural municipality, leading to dissatisfaction among mothers and challenges in accessing necessary healthcare.
- Significant environmental sanitation issues, including a lack of toilets and problems with open defecation.
- Barriers in accessing government services due to the absence of birth registration, marriage registration and citizenship, affecting health insurance coverage and social security scheme.
- Poor distribution and accessibility of Balvita and other nutritional supplements, contributing to malnutrition among children.

Recommendations

- Launch awareness programs in marginalized communities to educate them about health and nutrition activities, emphasizing the importance of nutrition for child growth along with different food demonstration programs and nutritional awareness campaigns targeting locally available foods, vegetables, fruits and crop produced.
- The local government should implement programs across all communities, focusing on the significance of child nutrition for healthy development.
- Enhance public awareness regarding water sanitation and hygiene maintenance to promote better health practices. Moreover, WASH activities can be integrated with immunization program for better results.
- Concerned agencies should be tasked with providing thorough and clear information to each community member, ensuring understanding and accessibility.
- Implementation of routine growth monitoring and promotion of infants and young children to regularly trace the nutritional and health status of the children
- The Health Insurance Board should work in close collaboration and coordination with the District Public Health Office to streamline services and enhance efficiency.
- Strengthen and integrate health systems to provide more comprehensive and cohesive healthcare services.

- Increase the level of supervision and monitoring in the field by the local government (Palika), and focus on capacity building for health workers.
- Ensure that Primary Health Care (PHC) and Outreach Clinics (ORC) are accessible to all health consumers, making healthcare more reachable and effective.
- Provide training to health workers at the community level, aimed at educating mothers about various government-provided services and health practices.
- Train Female Community Health Volunteers (FCHVs) in accurate height measurement and in-depth understanding of health insurance, to improve their effectiveness in community health education and support.
- Formation of mothers' group in the community in facilitation of FCHV and local health workers for the effective implementation and achievement of better results from child health and nutrition improvement initiatives.

ANNEX

Photo Gallery









Questionnaire of the study

स्वास्थ्य र पोषण सर्भेको लागि प्रश्नाबलिहरु

छनोट भएका घरका सदस्यलाई सोधिने प्रश्नहरु मंजुरिनामा सहित:

नमस्कार मेरो नाम.....हो । म हर्ड नेपाल संस्थाको प्रतिनिधित्व गर्दै यहाँ आएको छु । म तिलाठी कोइलाडी गाउँपालिकाको सहयोग र सहकार्यमा संचालित पालिकाको पोषण प्रोफाइल निर्माण गर्ने कार्यक्रमको लागि तथ्यांक संकलन गर्नको लागि आएको छु । पक्कै पनि यहाको भरपुर सहयोग हुनेछ भन्ने आसा व्यक्त गरेको छु र केहि समय लिएर केहि प्रश्नहरु गर्ने छु। यस सर्भेको मुख्य उद्देश्य भनेको घरमुली अथवा बिशेषतः बच्चाको आमा संग स्वास्थ्य र पोषण संग सम्बन्धित विविध जानकारी हरु प्राप्त गर्ने, पालिकाको पोषणको प्रोफाइल तयार गर्ने र स्थानीय सरकारलाई उक्त क्रममा देखिएका समस्याहरु समाधान गर्नको लागि बार्षिक नीति तथा कार्यक्रममा समाबिस्ट गर्ने रहेको छ । प्रश्न सोध्ने क्रममा तपाईंलाई गाह्रो अपटेरो हुने खालको कुनै पनि प्रश्नहरु गरिने छैन र तपाईंले दिनु भएको सूचना तथा जानाकारिहरु अति नै गोप्य रहनेछन । तपाईंलाई उत्तर दिन मन नलागेका प्रश्नहरुको उत्तर नदिन सक्नुहुन्छ र अन्तरबार्ता बिचैमा छोड्न पनि सक्नु हुनेछ ।

यस अन्तरबार्ताको लागि करिब ३०-४० मिनेटको समय लाग्ने छ । प्रश्नहरु नितान्त बिषय बस्तुसंग सम्बन्धित रहेका छन्, यहाँ तपालाई कुनै पनि व्यक्तिगत प्रश्नहरु गरिनेछैन र मानहानी हुने खालका कुनै सबाल जबाफ गरिनेछैन । के तपाईं अन्तरबार्ता अगाडी बढाउँन सहमत हुनुहुन्छ ?

यदि यस सर्बेक्षणको बारेमा केहि जानकारी लिनु परेमा राकेश कुमार यादव (९८५५०२८१३७) लाई सम्पर्क गर्न सक्नुहुनेछ ।

सहमत छु (Agree)

सहमत छैन (Disagree).....(अन्तरबार्ता अगाडी नबढाउने) (Stop the process)

सहमत भएमा: (If Agreed):

सर्वेक्षण सम्बन्धि जानकारी: (Information about Survey)		
विवरण (information list)		जबाफहरु (Answer)
१	उत्तरदाताको नाम (Name of respondent):	
२	सम्पर्क न(सम्भव भएमा मात्र) . Contact No:	
३	पालिकावार्ड/ (Palika/ward):	
४	अन्तरबार्ता पुरा भएको मिति (Interview completed date):	
५	अन्तरबार्ताकर्ताको नाम (Name of Interviewer):	
६	अन्तरबार्ताको समय	

जनसांख्यिक विवरण: (Demographic Information)			
१	लिङ्ग (Gender)	महिला (Female) पुरुष (Male) तेस्रो लिङ्गी (Third gender)	१ २ ३
२	पुरा भएको उमेर (Age)	बर्षमा (years).....	
३	तपाईंको घरमा कति जना हुनुहुन्छ ? (No. of family members)		
४	५ बर्ष भन्दा मुनिको कति जना हुनुहुन्छ ? (under 5 years)		
	यदि भएमा, बच्चाको नाम र उमेर उल्लेख गर्ने (Name and Age of child) in months)		

५	तपाईंले पुरा गर्नु भएको माथिल्लो तहको शिक्षा कति हो? (Level of Education)	लेखपढ गर्न नजान्ने (Illiterate)	१
		अनौपचारिक (Informal)	२
		आधारभूत (Basic)	३
		माध्यमिक तह (Secondary level)	४
		स्नातक तह (Bachelor)	५
		स्नातकोत्तर तह (Masters)	६
		स्नातकोत्तर भन्दा माथि (Above masters)	७
		उत्तर दिन नचाहेको (Not interested)	९९
६	तपाईंको जात कुन हो?	दलित (Dalit)	१
		जनजाति (Janjati)	२
		मधेशी (Madhesi)	३
		मुस्लिम Muslim	४
		ब्राह्मण/क्षेत्री (Brahmin/Chhetri)	५
		अन्य(other)	६
		उत्तर दिन नचाहेको (Not interested to answer)	९९
७	तपाइको बैबाहिक स्थिति के हो ?	अबिबाहित (Unmarried)	१
		बिबाहित (Married)	२
		सम्बन्ध बिच्छेद (Divorced)	३

		उत्तर दिन नचाहेको (Not interested to answer)	९९
८	कुन पेशामा संलग्न हुनहुन्छ ?	सरकारी (Governmental)	१
		गैर सरकारी (Non-governmental)	२
		बिद्यार्थी (Student)	३
		व्यवसाय (Business)	४
		घरायसी काम (House work)	५
		अबकास प्राप्त (Retired)	६
		बेरोजगार (Unemployed)	
		ज्यालादारी (wages)	६
		कृषि (Agriculture)	७
		उत्तर दिन नचाहेको (Not interested to answer)	९९

पोषण - बाल पोषण र मातृ पोषण

१. बाल पोषण

A. IYCF (infant and young child feeding practices)

बच्चाको स्वास्थ्य सेवा- (कान्छो बच्चा छान्नुहोस् र प्रश्नहरू सोध्नुहोस्।)			
१.	बच्चाको रेकर्ड लिने – - Ask Growth monitoring card (If have) - Take the record for Growth Monitoring	बच्चाको नाम:-	
		जन्म मिति (DOB):-.....	
		उचाई/ लम्बाई (Length/Height):.....	
		तौल (Weight):.....	

		MUAC.....	
२	बच्चाको नियमित वृद्धि अनुगमन गर्नु भएको छ? Are you regularly monitoring your child growth (at least a time per month till 2 years)	छ Yes छैन No	१ २
३	के तपाईंले कान्छो बच्चालाई भिटामिन ए र जुकाको औषधि खुवाउनुभयो? Did you give Vitamin A and Albendazole?	खुवाएको Yes नखुवाएको No	१ २
४	के तपाईंले आफ्नो बच्चालाई उमेर अनुसार लगाउनु पर्ने सम्पूर्ण खोप लगाउनु भयो ? कार्ड हेर्ने Did you fully immunize your children? See card	लगाइएको / Yes नलगाएको / No	१ २
५	के तपाईंले बच्चाको पोषण भत्ता प्राप्त गर्दै हुनुहुन्छ ? Are you receiving child nutritional allowance?	छ Yes छैन No	१ २
६	यदि पोषण भत्ता प्राप्त गर्दै हुनुहुन्छ भने के मा खर्च गर्नुहुन्छ	खाने कुरा किन्न बालबालिकाको शिक्षा स्वास्थ्य बिमा औषधि उपचार को लागि अन्य.....	१ २ ३ ४ ५
७	बच्चालाई पखाला लागेको बेलामा के खुवाउनु हुन्छ? What do you feed children during diarrhea?	जीवनजल Jeevanjal जिंक चक्की Zinc अन्य other (Specify).....	१ २ ३
८	के तपाईंले बच्चालाई जन्मने बितिककै आमाको बिगौती दुध खुवाउनु भयो ?/Did you feed colostrum to this child? • If yes, move to question number 8 • If no, ask this question	खुवाए (Yes) खुवाइन (No)	१ २
९	बच्चालाई कति महिना सम्म आफ्नो दुध मात्र खुवाउनु भयो?/ खुवाउनु हुन्छ ?	१ महिना सम्म (1 months) २ महिना सम्म (2 months) ३ महिना सम्म (3 months)	१ २

	How long did you nourish your child with your breast milk? If less than 6 months, move to another question otherwise move to question 10)	४ महिना सम्म (4 months) ५ महिना सम्म (5 months) ६ महिना सम्म (6 months) अन्य.....	३ ४ ५ ६ ९९
१०	६ महिनासम्म आमाको दुध मात्र नखुवाउनुभएको भय के के खुवाउनुभयो ? If not breast-milk, what did you feed up to 6 months?	लिटो भात बोटलको दूध अन्य.....	१ २ ३ ९९
११	कति महिना सम्म बच्चालाई आमाको दुध खुवाउनु भयो ? How long did you nourish a breast milk to your child?	६-९ महिना सम्म (6-9 month) ९-१२ महिना सम्म (9-12 month) १२-१८ महिना सम्म (12 -18 month) १८-२४ महिना सम्म (18 -24 month) २४ महिना भन्दा माथि (More than 24 months)	१ २ ३ ४ ५
१२	कति महिना पछि बच्चालाई ठोस आहारा खुवाउन सुरु गर्नुभयो? After how many months did you start the complementary feeding?	जन्मदा देखिने (as soon as birth) ५ महिना पछि (after 5 months) ६ महिना पछि (after 6 months) अन्य (other) 	१ २ ३ ४
१३	बच्चा लाई बालभिटा खुवाउनु भयो ? Did you feed the Bal-Bhita to your child?	Yes छ No छैन	१ २
१४	बच्चालाई दिनको कतिपटक खाना खुवाउनु हुन्छ? In what frequency did you feed your child per day?	२ पटक (2 times) ३ पटक (3 times) ४ पटक (4 times) ४ पटक भन्दा बढी	१ २ ३ ४

१५	बच्चालाई एक पटकमा कति खुवाउनुहुन्छ	६-९ महिना कप ९-१२ महिना कप १२-२४ महिना कप अन्य.....	१ २ ३ ४
१६	बच्चाको खानामा केके कुरा मिसाउनु हुन्छ ? Specify the food diversity you feed?	सामान्य घरको खाना (simple what other eat at home) अन्य (other)..... (खुलाउने)	१ २
१७	खाना धेरै जस्तो कसले खुवाउनु हुन्छ ? Who feed your child usually?	आमा (Mother) बाबा (Father) हजुरबाहजुरआमा/ (Grandpa/ma) दाजुदिदि/ (Brother/sister) Others.....	१ २ ३ ४ ५
१८	खुवाउनु आघि र खुवाइसकेपछी के साबुन पानी ले राम्रो संग हात धुनुहुन्छ? Do you wash your hand with soap and clean water before and after feeding your child?	धुन्छु Yes धुधिन No	१ २
१९	तपाईंको घरमा कस्तो नुन प्रयोग हुन्छ? Which salt do you use?	आयोडिन Iodine ढीके Dhike	१ २
२०	५ बर्ष मुनिकाका बालबालिकाहरु लाई जन्मिने बितिकै देखा पर्ने आखा र कानको समस्याका बारेमा थाहा छ ? Do you know about eye and ear problems that appear at birth in children under 5 years old?	छ yes छैन No	१ २
२१	के तपाईं आफ्नो बच्चाको बौद्धिक र मानसिक विकासको बारेमा सचेत हुनुहुन्छ ?	छ yes छैन No	१ २

	Are you aware of your child's intellectual and mental development?		
--	--	--	--

२. सुरक्षित मातृत्व र परिवार योजना

सुरक्षित मातृत्व र परिवार योजना - (कान्छो बच्चा छान्नुहोस् र प्रश्रहरू सोध्नुहोस्)			
१	के तपाईंले पुर्ब प्रशुती सेवा प्राप्त गर्नुभयो ? Did you receive ANC services?	छ छैन	१ २
२	तपाइले पुर्ब प्रशुती जांच कति पटक गराउनु भयो? How many times did you visit HF for ANC checkup?	४ भन्दा कम (less than 4) ४ पटक 4 times (4 times) ४-८ पटक सम्म 4-8 times ८ पटक 8 times जांच नगरेको Not checked	१ २ ३ ४ ५
४	पुरा मात्रामा TD खोप लगाउनु भयो ? (कार्ड हेर्ने) Did you immunize with TD vaccine?	लगाएको Yes नलगाएको No	१ २
५	के तपाइले गर्भावस्थामा ३ महिना देखि ९ महिना) (सम्म १८० आइरन चक्की खानु भयो ? Did you take 180 iron tablets during pregnancy (3 to 9 months)?	खाएको Yes नखाएको No	१ २
६	के तपाइले बच्चा जन्मिसके पछि पनि ४५ दिन सम्म नियमित iron चक्की खानु भयो ? Did you take iron tablets after delivery of your child?	खाएको Yes नखाएको No	१ २
७	तपाइले कहिले देखि folic acid खाना थाल्नु भयो? When did you start to take Folic acid tablet?	बच्चाको योजना गर्न भन्दा ३ महिना अघि देखि (3 months before planning the child) बच्चा बसे पछि (after getting pregnant) बच्चा बसेको ३ महिना पछि (3 months after getting pregnant) खादै खाईन (did not take any)	१ २ ३ ४

८	कान्छो बच्चा कहाँ जन्माउनु भयो ? Where did you delivered your child?	अस्पतालनिजी- (Hospital-private) अस्पतालसरकार- (Hospital-Government) प्राथमिक स्वास्थ्य केन्द्र (PHC) हेअल्थ पोस्ट (health post) घरमा Home	१ २ ३ ४ ५
९	घरमा delivery भएको खण्डमा, If the baby was delivered at home ● How did you cut umbilical cord? नाभी के ले काट्नु भयो ? ● कसले सहयोग गर्यो ? Who supported? काटेपछि के लगाउनु भयो? (What did you use to cut the umbilical cord? And what did you use after cutting it?	Answer..... a. Delivery kit (सुतकेरि सामाग्री) b. Knife(चक्कु) c. Regular blade (ब्लेड) d. Others (specify) Answer..... Answer.....	१ २ ३ ४
१०	स्वास्थ्य संस्थामा जन्म भएको खण्डमा, के तपाइले स्वास्थ्य संस्थाबाट पाउनु पर्ने यातायात खर्च र प्रोत्साहन समयमै पाउनु भयो ? If the child was delivered in the hospital, did you get any incentives?	पाए Yes पाइन No	१ २
११	उत्तर प्रसुति जाच कति पटक गराउनु भयो ?How many times did you go for PNC checkup?	बच्चा जन्मेको २४ घण्टा भित्र ३ दिनमा (3 times) १४ दिनमा (14 times) ४२ दिनमा (42 times) जांच नगरेको Not checked	१ २ ३ ४ ५
१२	बच्चा जन्मदा तौल कति थियो ? What is your child birth weight?	२ ५.kg भन्दा कम less than 2.5 kg २ ५.kg 2.5 kg २ ५.kg भन्दा बढी more than 2.5 kg	१ २ ३ ४

		थाहा छैन	
१३	प्रशुती जटिलताका कारण ५ वर्ष भित्र तपाइको परिवारमा कसैको निधन भएको छ? कारण के थियो? Is there any death due to pregnancy complication within this 5 year? What was the reason behind it?	छ Yes छैन No Reason:	१ २
१४	बच्चाको जन्म दर्ता गराउनुभयो ? Have you done birth registration? नगरेको खण्डमा, किन ? If not why?	गरेको yes नगरेको No Answer.....	१ २
१५	परिवार योजनाको साधनका बारेमा सुन्नु भएको छ ? Have you heard about Family Planning?	सुनेको Yes नसुनेको No	१ २
१६	के तपाइले तपाइको श्रीमानले कुनै परिवार योजनाका/साधन अपनाउनु भएको छ? Are you using any kind of family planning method?	छ Yes छैन No	१ २
१७	यदि छ भने, कुन साधन If yes, which device/contraception?	कण्डम Condom पिल्स Pills डिपो Dipo Implant IUCD स्थायी बिधि Permanent) अन्य (खुलाउने) if any	१ २ ३ ४ ५ ६
१८	तपाइको दुई बच्चा हरु बिच कति जन्मान्तर छ ?	Answer.....	
१९	के तपाइँ र तपाइको श्रीमानले कुनै परिवार योजनाका साधन को इच्छा गरेको तर लगाउन नपाएको अवस्था छ ? यदि छ भने किन? Do you have unmet need in FP? What was the reason?	छ Yes छैन No Reason:	१ २
२१	के तपाईलाई गर्भपतन भएको थियो? अथवा कुनै कारणले गर्भ खेर गएको छ? कारण के थियो? Did you have abortion? What was the reason behind it?	छ Yes छैन No Reason:	१ २
२२	के तपाईले मृत बच्चालाई जन्म दिनु भएको छ ?	छ Yes	१

	Do you have still birth?	छैन No	२
२३	बिगत ५ वर्ष भित्र, कुनै ५ वर्ष भित्रको बच्चाको मृत्यु भएको छ ? Is there any under 5 year's mortality case within this 5 year?	छ Yes छैन No	१ २
२४	के तपाईंले त्यो बच्चाको गर्भावस्थामा रक्सी पिउनुभयो वा धुम्रपान गर्नुभयो? Did you take alcohol or smoke during pregnancy?	छ Yes छैन No	१ २
२५	प्रशुती अवस्थामा धुम्रपान, मध्यपान गर्नु भयो? Did you drink/smoke during natal stage?	गरे Yes गरिन No	१ २
२६	गत ५ वर्ष भित्रमा के तपाईंलाई रक्त अल्पता भएको थियो? Are you suffering from Anemia within this 5 year period?	थियो Yes थिएन No थाहाँ छैन Don't Know	१ २ ३
२७	तपाईं गर्भवती हुदा दिनको कतिपटक खाना खानु हुन्थ्यो ? What was the frequency of your meal intake during pregnancy?	२ पटक 2 times ३ पटक 3 times ४ पटक 4 times ४ भन्दा बढी	१ २ ३ ४
२८	तपाईं सुत्केरी हुदा तपाईंले दिनको कतिपटक खाना खानु हुन्थ्यो? What was the frequency of your meal intake after delivery?	२ पटक 2 times ३ पटक 3 times ४ पटक 4 times ४ भन्दा बढी	१ २ ३ ४

३. पानी, सरसफाई र सरसफाई (हात धुने), स्वास्थ्य र कोभिड, कृषि

पानी, सरसफाई र सरसफाई (धुने)			
१	तपाईंको घरको खानेपानी को श्रोत के हो? What is the source of drinking water in your home?	कल)hand pump) जार)Jar) धारा Tap अन्य other	१ २ ३ ४
२	तपाईंको घरमा चर्पी / सौचालय छ ?	छ Yes छैन No	१ २

३	यदि सौचालय छैन भने कहाँ जानुहुन्छ ?	खुल्ला ठाउँ (open place) छिमेकि आफन्तको / सौचालयमा (neighborhood/ relatives toilet) नदि खोला (River side) अन्य (other)	१ २ ३
४	तपाईं सौचालय जादा चप्पल को प्रयोग गर्नु हुन्छ कि गर्नुहुन्न ?	गर्छु yes गर्दिन No	१ २
५	खाने पानी को श्रोत सौचालय बाट सरदार कति मि को दुरीमा छ .? How many meters far is the source of drinking water from toilet?	.मि.....	
	तपाइले आफ्नो घरको पानीको सुध्दता जाच गर्नु भएको छ ?	छ Yes छैन No	१ २
	यदि छ भने कुन जाच गर्नु भएको छ ?	PA vail test आर्सेनिक Arsenic आइरन Iron अन्य.....	१ २ ३ ४
६	तपाईं के पानी सुद्धिकरण गर्नु हुन्छ ? Do you purify water in your home?	छ Yes छैन No	१ २
५	गर्ने गरेको भए, कुन बिधि बाट गर्नुहुन्छ? If yes, what is the method?	उमालेर Boiling सोडिस गरेर SODIS फिल्टर Filter क्लोरीनको प्रयोग Chlorination	१ २ ३ ४
६	तपाईं कुन कुन अवस्थामा हात धुनु हुन्छ ? At what time do you wash your hand?	Answer.....	

७	तपाईं घर जस्य फोहोर कसरि ब्यबस्थापन गर्नु हुन्छ ? How did you manage household waste?	खाल्डोमा पुर्ने Dumping मलखादमा हाल्ने Cowshed जलाउने Burn अन्य others.....	१ २ ३ ४
कृषि			
१	के तपाईंको घरमा करेसाबारी छ? Do you have a kitchen garden?	छ Yes छैन No	१ २
२	भएमा, कुन कुन चिज उत्पादन गर्नु हुन्छ? What do you cultivate there?	Answer.....	
३	के तपाईंको घरमा उत्पादन हुने खानाले तपाईंहरूलाई बर्ष भरि खाना पुग्छ ? Do the foods produced in your house fulfill the need till a year?	पुग्छ Yes पुग्दैन No	१ २
स्वास्थ्य र कोभिड			
१	तपाईंको घरमा दिर्घ रोग लागेको कोहि हुनुहुन्छ ? Is there any one with NCD case in your home?	छ Yes छैन No	१ २
२	दिर्घ रोगि भए, कस्तो खालको रोगि हुनुहुन्छ? के घरको आम्दानि ले उपचार गर्न पुग्छ? If yes, what type of disease? Are you capable to expense from your pocket?	 पुग्छ Yes पुग्दैन No	१ २
३	के तपाईंको घरमा कसैलाई क्षयरोग भएको थियो वा छ? Is there anyone who suffered from Tuberculosis In your house or is it?	छ yes छैन No	१ २
४	यदि थियो भने कसलाई थियो? If yes, who had it?		

५	तपाइको घरमा अपांगता भएको व्यक्ति हुनुहुन्छ ? Do you have a disabled person in your home?	छ yes छैन No	१ २
६	यदि छ, भने कस्तो प्रकारको अपांगता छ? If yes, what kind of disability?		
७	के घरको आम्दानि ले उपचार गर्न पुग्छ? If yes, what type of disease? Are you capable to expense from your pocket?	 पुग्छ Yes पुग्दैन No	१ २
८	तपाईं वा तपाइको परिवारमा बिरामी परेमा सर्वप्रथम कहाँ जानुहुन्छ ? Where do you firstly go if you/family member feel ill?	स्वास्थ्य चौकी के .स्वा .प्रा/ HP/PHC अस्पताल Hospital धामी झाँक्री Indigenous healer अन्य Other	१ २ ३ ११
९	के तपाईंले वा परिवारका सदस्यले स्वास्थ्य बिमा गर्नु भएको छ ? Have you done Health Insurance?	छ Yes छैन No	१ २
१०	यदि बिमा गर्नु छैन भने किन गर्नु भएन ?		
११	के COVID-१९ को बेला तपाईंको घरमा कोहि संक्रमित हुनु भयो? Is anyone infected by COVID-19 in your home?	भयो Yes भएन No	१ २
१२	भएको भए, कस्ता कस्ता लक्षणहरु देखिएका थिय? Can you tell me the symptoms?	Answer.....	
१३	के COVID-१९ ले गर्दा तपाइको घरमा कसैले जागिर गुमाउनु पर्यो, ब्यापार ब्यबसाय सदाको लागि बन्द गर्नु पर्यो?	पर्यो Yes परेन No	१ २

	Did anyone loss their job or has to close business because of COVID-19?		
१४	के तपाईं भिड भाडमा जादा माक्सको प्रयोग गर्नु हुन्छ ? Do you use mask now a days?	गर्छु Yes गर्दिन No	१ २
१५	COVID- बाट बच्न 19के गर्नु पर्ला? What do you think are the possible ways to be protected from Corona?	Answer.....	
१६	के तपाइले पुरा मात्रामा कोरोना बिरुद्ध को भ्याक्सिन लगाउनु भयो? Are you vaccinated with full dose of Corona Vaccine?	Yes No	See Card

हजुरको सहभागिता र समयको लागि धन्यवाद!



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