

**Health Literacy and Risk Perception towards COVID-19 among the Raji
and Majhi People of Surkhet**

A Thesis

Submitted to the Department of Health and Population Education
in the partial fulfillment for Master of Education in Health Education.

By

Bhupendra Pandey

Tirbhuvan University

Faculty of Education

Central Department of Education

Department of Health and Population Education

Kirtipur, Kathmandu

Dec., 2021

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Dec., 2021

Submission Date (AD): October 3, 2021

Viva Date (AD): Dec 28, 2021

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Dedication

To,

My grandmother, my respected supervisor and all teachers.

Declaration

I hereby, declare that to the best my knowledge, this thesis is my original work. No part of it was earlier submitted for the candidate of master degree to any university, college or educational institutions.

Date: December 27, 2021

.....

Bhupendra Pandey



त्रिभुवन विश्वविद्यालय
शिक्षाशास्त्र संकाय

स्वास्थ्य तथा जनसङ्ख्या शिक्षा विभाग

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Health & Population Education Department

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Recommendation Letter

This thesis, to certify that **Mr. Bhupendra Pandey** student of Health and Population Education Department has completed this thesis entitled **Health Literacy and Risk Perceptions towards COVID-19 among the Rajhi and Majhi People of Surkhet** in fulfillments for partial requirements of Master Degree in Health Education, under my guidance and supervision.

.....

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Date: 27 Dec, 2021



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Approval Sheet

This thesis entitled **Health Literacy and Risk Perceptions towards COVID-19 among the Rajhi and Majhi People of Surkhet** submitted by **Mr. Bhupendra Pandey** in Partial Fulfillment for Master of Education in Health education has been approved.

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Acknowledgements

First of all, I would like to thank my supervisor Asst. Prof. Shanti Prasad Khanal who helps me for select the research title “**A Study of Health Literacy and Risk Perceptions towards Covid-19 among the Rajhi and Majhi People of Surkhet.**” prepare thesis proposal and necessary in the course of my study. And he has helped to solve a variety of problems encountered during the study. Similarly, my thanks and appreciation also goes to the head of department Asst. prof. Pitambar Acharya for conducting an orientation program and also instructing about thesis writing. Similarly, I am grateful to respected sir Asst. Prof. Yadu Ram Upreti. He gave me valuable time and helped me to create data entry and table from SPSS. . Like that I am grateful to Asst. Prof Mr. Bhagawan Aryal who given me wonderful advice during proposal writing. Similarly, I am grateful to reverend guru the director of Research Center for education Innovation and Development (CERID) Prof. Dr. Surendra Giri. And I am grateful to Dr. Kamal Raj Devkota (CERID). I will always be indebted to him for his found support during this study period. Similarly, I am grateful to my internal Supervisor, Asst. Prof. Bishnu G.C, for his technical guidance and support during study.

I would like to express my sincere gratitude to the External Supervisor for his constructive comments, feedback and suggestions. And my heartily gratitude goes to Mr. Dharmaraj Neupane by helping to English language correction of my thesis. I would like to thank Jeeten Maharjan for his help in the other task like computer and editing. Finally, I am equally thankful to all my colleagues. Who helped me to do my Thesis writing process and making report writing as well as.

Bhupendra Pandey
December, 2021

Abstract

The main objectives of this study are as follow; to explore the level of health literacy among the Raji and Majhi people. To examine the situation of risk perception and protective behavior of respondents regarding COVID-19. To determine association between health literacy levels, risk perception and protective behavior of the respondents.

This study was based on sequential explanatory research design. The data collection tools of this study are interview schedule, likert scale and in-depth interview. . In the first phase of study I had got quantitative data and interpreted and analyzed it. And in the second phase I had got qualitative data and interpreted and analyzed it.

There are more respondents in this community who have studied at the basic levels (28.9%) while agriculture (60.20%) is main occupation here. Total of the people in this community is Hindu. The numbers of people returning from abroad or India after the COVID pandemic are also significant. Corona is an infectious disease, there are 89% of people who believe that I can die from this disease and that people with low immunity and children can infected with this diseases. Turmeric, Timur, Gurjo, Kurila, Jamuna, Garlic, fish shop were found to be used. Some people from the Raji community were found tying/using “BUTI” on the throat to escape from Corona virus. According to them, it is believed that the “Tantric”/ vaidic power in “BUTI” save from COVID. Knowledge transfer from the younger generation to elder generation, about washing hand with soap and water, maintaining physical/Social distance, going to hospital while sick , and use of Ayurveda , “Tantric” knowledge, using ashes for hand washing and use herbs like “Ritha” was passed on from the older generation to the new generation. Radio, teacher and social activist were found to be the main source of information on health education. Some Raji people agree that they don’t affect from COVOD.

The health literacy of these communities is not strong. Due to which, risk perception and protecting behavior has also become weak. To increase the health literacy of those communities, local government needs to run health literacy related programs.

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Abbreviations

Asst	:	Assistance
CDC	:	Centers for Diseases control and Prevention
CDOHP	:	Central Department of Health and Population
CERID	:	Center for Education Innovation and Development
COVID-19	:	Corona Virus Diseases 2019
DOH	:	Department of Health
EU	:	European Union
FPP	:	Family Planning Program
HBM	:	Health Belief Model
HLS-EU	:	The European Health Literacy Survey Scale
IDI	:	In-depth Interview
MCH	:	Maternal and Child Health
MERS	:	Middle East Respiratory Syndrome
MOH	:	Ministry of Health
NDHS	:	Nepal Health Demographic Survey
NHP	:	National Health Policy
Prof	:	Professor
S-TOFHAL	:	Short-Test of functional health literacy
SARS	:	Severe Acute Respiratory Syndrome
TU	:	Tirbhuvan University
WHO	:	World Health Organization

Chapter I: Introduction

Background of Study

Health literacy refers to the degree to which an individual has the capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions. This is also the definition that was included in Healthy People 2010 and 2020 (CDC, 2020). Health literacy impels the achievement of a level of knowledge, personal skills and confidence to take action to improve personal and community health by changing personal lifestyles and living conditions (WHO, 2013). It also personal access and understand and using the information for making decision (DHO of Tasmanian, 2018). Aforementioned definitions indicate that health literacy as an ability and skill of the person to the knowing of health service and education. In today's fast-paced world, knowledge societies are facing health challenges with different opinions; more challenges for individuals through appropriate environment and health service, health care facility and to ability of manage their family and personal health trip. Not well prepared or provided by 'modern' societies actively market unhealthy and unhygienic health life style, health care system and health service make more difficult navigate the themes, and the education system also often provides people with sufficient skill to access, understand evaluated and to improve information. They fails to provide their health behavior and health care system (WHO, 2013). Along with these changes has come the recognition that sophisticated literacy skills are increasingly needed to function in society and that low literacy may have an effect on health and health care. They present a brief history of literacy in the United States, followed by a discussion of the origins and conceptualization of health literacy. (RTI International, 2010,(p. 12-21).

Health literacy shows the examination process in the 'development of evidence to support these policies from intervention to improve health literacy among community populations (Nutbean, Brownyn& Kumar, 2018). Health literacy helps to develop the ability of human to incise the health level (Dunn& Hazard, 2019). It's related to the healthy skill and practice of the people. Health literacy level is different accordance to educational level (Khanal, 2019). Literacy related to the skill, ability and process of developing and taking of health service (Teary & Joshep, 2018).

Protective behavior are the various measure used by individuals or group to prevent any diseases and the various behaviors adapted to stay away from diseases and health problems (Facione & et.al, 2007). Protective behavior is the behavior of the human body to protect against health problems and diseases that can be caused by their behavior and environmental factors (Ying-chih Chung & et. al., 2015).

Risk perception refers to people's subjective judgments about the likelihood of negative occurrences such as injury, illness, disease, and death. Risk perception is important in health and risk communication because it determines which hazards people care about and how they deal with them (Arezes & Miguls, 2008). Recognizing the probable causes or condition of any health problem or disease is the process or knowledge that can be used to control those causes (Adebola A.& et.al,2007).

Nepal is developing country development also related to the health in this process health literacy will be play the good role in the developing process of law and ethic of public and community health policy.

Surkhet District is the province capital of Karnali province. Surkhet is the one of the ten districts of Karnali located about 600 kilometres west of the national capital Kathmandu. The district's area is 2,488.64 square kilometers which is longest in Nepal. It had 288,527 population in 2001 and 350,804 in 2011 which male comprised 169,461 and female 181,381. It is the district headquarters of surkhet and commercial hub of the Karnali state of the new federal republic. It's had five municipalit (Birendanagar, Bheriganga, Lekhbashi, Gurovakot and Panchupari) and (Chaukene, Baharatal, Chinchad, Shimta) four rural municipality (Panchupari Chinari,2074).

Statement of the Problem

Nepal is a country, where is the health education, health service, health related planning are expending (Uprati, 2071). Various health related programs are being conducted to increase the awareness of Covid-19. Literacy rate seems to have increased (Education Information, 2072). Nepal's current literacy rate is 65.9% of which 57.5% are women and 75.1% are men, while the average age of Nepal's is 69(Census, 2018). Various studies showed, the health literacy of an educated person look good (Don, Bryn, Gill & Kumar,2018). Around half population has inadequate

health literacy (HLS-EU,2012), large number of people are affected by low health literacy(WHO,2019). About half percent girl students of college girls of Surkhet has inadequate health literacy (Khanal,2019).

The Raji and Majhi cast is one of the castes living in Nepal, The main occupation of this community is fishing. They are include on Endangered Janajati group (Rai, 2013).The Raji caste has been living mainly in Kailali, Kanchanpur, Surkhet , Banke, Bardia and Dang District of Mid-western and Far-western regions(Saurav,2073). The Rajhi cast considered to be the tribal of Dang Deukhuri These include Pandali,Naukule and Purbeya three surnames(Bista,1972). Total population of Raji and Majhi 83,727 (CBS, 2068)

Raji are mostly uneducated. They have own medical practices, few Raji children's are getting formal education (Bista, 1972). The research study help to find out, about their health practice, education level about health service, risk perception towards COVID-19. According to the European Union health literacy refers to the, “

Conceptual model of health literacy of the European Health Literacy Survey
Source: adapted (from: Sørensen K et al.) Societal and environmental determinants Situational determinants Personal determinants Access understand appraise apply health information knowledge competence motivation health care disease prevention participation health promotion empowerment health costs health service use health behavior health outcomes equity sustainability individual level population level. (WHO, 2013)

Health behavior is an action to maintain, attain, or regain good health and to prevent illness. Some common health behaviors are exercising regularly, eating a balanced diet, and obtaining necessary inoculations. Health behaviors are influenced by the social, cultural and physical environments in which we live and work (M, 2021) this is how risk perception, health protecting behavior can be understood to address the problems of this study. The state of health literacy can be seen in this behavior. In hear risk perception show the, Risk perceptions are beliefs about potential harm or the possibility of a loss. It is a subjective judgment that people make about the characteristics and severity of a risk (R. Ferrer & K. Klein ,2015) Risk perceptions are a prerequisite for protective action. Both scientists and practitioners need to

understand the multifaceted nature of health risk perception and risk communication (Sachmalzele, B. Renner. B & T. Schupp, 2017)

Health protecting behaviors refers to It is a precautionary measure for a person, society to avoid any diseases or health problems (Laura, 2018) Health protective behaviors are actions linked to decreasing risk factors, reducing negative health outcomes, and facilitating a healthy lifestyle. Health protective behaviors can be at the individual, familial, or community level, which all work together to eliminate risk factors that impair health (W .Ping and et, all, 2018).

When we study about above statement its show the without good health service and health education people can't get the health literacy. For improving the health literacy most need to provide good health system for people.

Adequate health literacy and risk of COVID-19 perceived by people are very important for protective action and behavior, but risk perceptions are often biased due to different social cultural contexts and different level understanding, In Nepal, there is lack of sufficient evidences to explain existing perceptions and protective behavior of public at risk. The situation of access level of health literacy of Raji and Majhi people of Surkhet and their risk Perception regards covid-19. So, the topic entitled health literacy and risk perception of Raji and Majhi people of surkhrt is purposed.

Rational of the Study

Health literacy is an important aspect for individuals and the public (WHO, 2014). Health literacy helps in creating a better health condition by changing the knowledge, perception and skill of the person related to health. The prevalence of health literacy teaches people to make maximum use of the health service available around them (Conner, Mentwell & Schulz, 2013).

The European has implemented a short test of health literacy (S-TOFHAL) program to improve the health status of European countries. The program has been implemented in the first phase in Germany, Italian (Conner, Mentwell & Schulz, 2013). Science 2028, health education has been included in the curriculum in Nepal. On the same basis, the Government of Nepal has been expending health program in various schemes which have brought health care and education to the people (Adhakari, 2075).

What is the status of health literacy of Raji and Majhi peoples in the situation where various types of health programs are being conducted? It is justified to study their perceptions and protective behavior. The study helps to the students, teachers and stake holder to develop healthy behavior and utilize available health care services in their community. The study helps students and teachers to access, understand, appraise, and apply health care, health promotion and disease prevention in their life. The community is the place where people developed health related knowledge and skills which promote their health. Hence, health literacy, protecting behavior and risk protecting behavior are very important concept which should be developed and practiced in communities.

This study found out the present condition of health literacy, risk perception and protecting behavior among the Raji and Majhi people which can be useful for further changes and improvements. The findings of the research is useful to the communities people, policy makers and related stakeholders who are concerned for improving to develop and practice health literacy, risk perception and protecting behavior in Raji and Majhi communities as subject of Health Education.

Objectives of the Study

The Specific objectives of this study are:

1. To measure the social status of the people.
2. To explore the level of health literacy among the of Rajhi and Majhi people
3. To examine the situation of risk perception and protective behavior of respondents regarding COVID19
4. To determine association between health literacy levels, risk perception and protective behavior of the respondents.

Research Questions

This study was having interview schedule and liker scale for quantitative and in-depth interview for qualitative research method. The research question under the

1. How do Raji and Majhi people learn and practice health literacy of COVID 19 in daily life?
2. What type of health related knowledge and practice are transfer one generation to next generation?
3. How do they apply health protecting behavior during COVID 19?
4. What are the risk perception behaviors of Raji and Majhi people?

Delimitations of the Study

On this research I had decide those delimitation

1. This research was done in the Rajhi and Majhi people of western part of surkhet district.
2. Only Rajhi and Majhi people above 16 years was taken as a population of this study is population of this study.
3. This study has covered only ward no. 5, 9, 10, and 11 of Panchupari Municipality.

Research Hypothesis

1. There is no different between level of risk perception and health literacy level.
2. There is no relation between health literacy level and protecting behavior of the people

Definition of the Key Terms

Access: The ability of health education, health service according to the health literacy.

COVID19: A rapid pandemic diseases. An acute respiratory tract infection. In humans caused by corona virus. It's found on 2019 December from woung China.

Endangered: A very sparsely populated caste in Nepal that is slowly declining.

Health: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Health literacy: The incise knowledge about health care, health education, health skill and practice.

Health Practice: The delay doing behavior for getting good health.

Information: The process getting knowledge about COVID 19, through the health literacy.

Sources: The way of getting knowledge and health service.

Protecting behavior: The behavior to avoid any disease and accident

Majhi: A cast. IT is marginalized cast of Nepal. Occupation of Maji is fishing

Rajhi: A cast. It's marginalized cast of Nepal. Main occupation of Raji is fishing.

Chapter II: Review of Related Literature

Theoretical Literature Review

Literacy refers to the ability to read and write competence or knowledge in a specified area (university, oxford langague , 2018),who knows or can read and write letter and script is called literate (Academy, Nepal, 2015) viewing at the above statement, literate means that one can read or write written letters, scripts. In this way, when the definition of literacy is linked to the general field of health, it can be understood that the written knowledge about health can be read and put in to practice. Health literacy refers to the relation between literacy skill and health behavior (Nutbeam, 2008) Not well prepared or provided by ‘modern’ societies actively market unhealthy and unhygienic health life style, health care system and health service make more difficult navigate the themes, and the education system also often provides people with sufficient skill to access, understand evaluated and to improve information. Fails to provide their heath behavior and heath care system (WHO, 2013).

Corona virus disease (COVID-19) is an infectious disease caused by a newly discovered corona virus (WHO, 2020) Most of the people infected from COVID-19. Experience mild to moderate respiratory illness and recover without requiring special treatment. Aging people and those who with underlying medical problems like cardiovascular disease, diabetes, chronic respiratory disease, and cancer are more likely to develop serious illness (WHO, 2020) Corona viruses is a large family of respiratory viruses, known to cause illness ranging from the common cold to more severe illnesses such as Middle East Respiratory Syndrome (MERS) and Severe Acute Respiratory Syndrome (SARS) (CDC, 2020).

The current outbreak has been caused by a strain of corona virus that had not previously detected anywhere in the world before the outbreak was reported in Wuhan, China in December 2019 (SSRC, 2020). Seen in this way, the COVID-19 is a pandemic disease seen from the corona virus infection. It has special effect on the human respiratory system. The behavior adopt to avoid this COVID-19 is called risk-perception behavior. Risk perceptions are beliefs about potential harm or the

possibility of a loss. It is a subjective judgment that people make about the characteristics and severity of a risk (Hove, 2017).

Theory and models of health literacy and protective behaviors. There are many type of health model in the world. Each model has its own characteristic. Many models have come in to vogue for study and development of health education, some of which can be presented here for example; health behavior are Social Cognitive Theory, The Trans theoretical Model/Stages of Change, the Health Belief Model, and the Theory of Planned Behavior. The most-often mentioned theoretical model that has not been fully applied in research and practice is the Social Ecological Model.

The Trans theory model posits that health behavior change involves progress through six stages of change: pre contemplation, contemplation, preparation, action, maintenance, and termination. The TTM is not a theory but a model; different behavioral theories and constructs can be applied to various stages of the model where they may be most effective. The TTM posits that individuals move through six stages of change: precontemplation, contemplation, preparation, action, maintenance, and termination (JO Prochaska, 1997 sept 1). Like as Social Ecological Model also famous model of health behaviors change model. This model has its own component these are like: Describes an ecological model for injury prevention that highlights the complex interplay between individuals, groups, community, and the social factors that shape relationships. The Socio-Ecological Model takes into consideration the individual and their affiliations to people, organizations, and their community at large to be effective. There are five stages to this model – Individual, Interpersonal, Organizational, Community, and Public Policy (SD Golden, 2015 march 15)

When I will go to the research about this topic I will most know about health proactive behavior, Health protective behaviors are actions linked to decreasing risk factors, reducing negative health outcomes, and facilitating a healthy lifestyle. Health protective behaviors can be at the individual, familial, or community level, which all work together to eliminate risk factors that impair health (Guten, : 04/04/2014 08:29). Individual factors incorporate having constructive perceptions about one's character; such as a positive self-image, good self-control, and proficient social skills. Upholding a positive self-image can reduce mental health issues and encourage

confidence in one's capabilities. Exercising self-control lowers the risk of substance abuse and various addictions, resulting in better health and wellbeing (Umberson, 09/02/2012) like that there is different level and function of health literacy Functional health literacy: which are the basic skills of reading, writing and numeracy necessary to function effectively in a health context.

Interactive health literacy: which refers to more advanced cognitive literacy skills that with social skills, can be used to actively participate in everyday situations, extract information and derive meaning from different forms of communication, and apply this to changing circumstances. Critical health literacy: is the ability to critically analyses information and use this to exert greater control over life events and situations (Nutbeam.D. 2020).

Policy of health literacy, risk perception and protecting behavior. In the context of Nepal, If Nepal does not adopt a special policy related to health literacy, it will not be able to important various programs through health promotion (Abha Shrestha, October 25, 2018) Health literacy is on the rise as health programs are being run in the general public through Malaria, Kalazar control program, leprosy control program (MOH, 2018) communicable diseases control program, Maternal and child health (MCH), family planning program(FP), through health education course (health, 2018)The present low level of health status is attributable to lack of political commitment, inappropriate strategies and weakness in implementation of preventive, promotion and curative health program up to the grass roots level during the past 30 years. Because of those weaknesses even now the crude death rate is 16 per thousand, crude birth rate is 41 per thousand, child mortality rate is 107 per thousand, maternal mortality rate is 8.5 per thousand and mortality rate of children below 5 years is 197 per thousand (NDHS,2011). These facts and figures have identified Nepal as an underdeveloped and backward nation (National Health Policy, 2048). Planned development of health sector from 2013, the process of preparing and implementing plans began. 2032 BS the first 15 year long term health plan in 2054B.S and second 20 year long term health plan was implemented. Nepal's health policies and programs are inspired by public health concept, with lees-then-intensive programs such as wiper eradication, family planning and maternal and child welfare regular vitamin feeding, and health facilities and hospital providing only medical services. Oriented towards as integrated health system in the 1930-1940Ads rural health workers, and child health

workers and now the world's leading women's health volunteer program, begin. Meanwhile, a community-oriented institute of medical studies was established in Nepal. Started however, access to health care for the general public during period and the people to guarantee their right to health, was basically limited to the facilities of the affluent class (NHP, 2076) Similarly, National health policy 2076 has some goal and mission such as Mission in accordance with the spirit and letter of the new constitution (2072BS), to ensure the fundamental right of citizens to stay healthy by making maximum use of the available resource and through strategic cooperation among the health care providers, service recipients and stakeholder (NHP, 2076).

In addition to the study of the various models presented above, I am using the health belief model for study which is as follows. The health belief model (HBM) is a social psychological health behavior change model developed to explain and predict health-related behaviors, particularly in regard to the uptake of health services. A stimulus, or cue to action, must also be present in order to trigger the health-promoting behavior.

Theoretical Review of the Study

The Health Belief Model (HBM), one of the more widely researched models, originates in the 1950s as a way to understand health-seeking behaviors (Rosenstock, 1974). According to this model, a person's action to change his or her behavior (or lack of action) results from the person's evaluation of several constructs. First, a person decides if he or she is susceptible (perceived susceptible) to a disease or condition, and weighs this against the severity of the disease or condition (perceived severity). A person also weighs the benefits of action to change (perceived benefits) versus the barriers to change (perceived barriers), and this analysis is the strongest predictive factor for behavior change (Janz, Champion, & Strecher, 2002). If a person believes that the benefits outweigh the barriers, then he or she is more likely to take action to change. Cues to action, such as instructions or reminders, can also be used to facilitate change. Self-efficacy, a person's belief that he or she can engage in a behavior (Bandura, 1986), was added as a factor in behavior maintenance.

Health Belief Model (HBM) can be a good model for predicting the behaviors associated with smoking among smokers and non-smokers. Several researchers have suggested HBM application in their educational programs for smoking preventive behaviors (Renuka & Pushpanjali, 2014). Health literacy has a potential effect on the

construct of HBM and it can be used as a moderator in the HBM instead of the knowledge variable (Glashen, Stood, Ferraro & Rohrer, 2015).

One aspect of social capital, interpersonal trust and its relationship to national and community rates of illness and death suggests that in neighborhoods where social trust is high, negative health behaviors (such as smoking and alcohol abuse) might be discouraged through community pressure (Kawachi & Berkman, 1998). Residents in high trust neighborhoods may also share more resources, be willing to help one another and offer one another more emotional support. Community participation to set their agenda for health will be the right start for the 21st century ideal of health for all.

Health literacy with social capital, negotiation tenets, education precepts and sound scientific communication strategies can advance social norms that encompass appropriate health promotion activities/ policies, personal responsible government roles and services, and finally, baseline health knowledge and skills (Ratzan, 2001). This early use of the term shows there is a link between health literacy and health education. Failures in health education are related to poor health literacy, but the health literacy issue is not just inherent in the education system.

Health literacy problems have grown as the health system has become more complex: diagnostic and treatment options have skyrocketed and people are asked to assume more responsibility for self-care. Health literacy can be described as both a goal and an outcome, becoming the currency and capital needed to develop and sustain health (Nutbeam, 2000). Education, health care system, culture, home and community and works relate health literacy and it improves health outcomes and lowers cost of services (Institute of medicine, 2003).

Health literacy is linked to literacy and incorporates people's knowledge, motivation and competencies to assess, understand, appraise and apply health information in order to make judgments and take decisions in everyday life related to healthcare, disease prevention and health promotion to ensure quality of life (Sorensen et al., 2012).

Empirical Literature Review

The fundamental of all research is study. Only by studying the materials of old research can a new subject be studied. The process of studying in this way is empirical literature review (Khanal,2074). I have studied the following reference materials required for this study and related to this study.

In order to conduct any study, it is necessary to revise the published material on the subject related to that field of study. By re-examining the literature review in this way the worldwide perception, condition, principle related to subject can be understood. How the subject or area has been studied, what study method have been used, what kind of fact have been discovered. It is also important to do an empirical review as it looks at how to solve the problem and helps to strengthen my study; I have read the following literature for my study in which I have presented as follow.

Hopkins (1995) also summarizes the essential components to promote health literacy through school health program such as the use of integrated theory-demonstration-practice-feedback program and development programs to ensure skill development, the use of considerable practice in simulated conditions to ensure fluid control of new skills, the employment of regular on-site coaching to facilitate critical transfer of teaching skills, and the preparation of teachers who can provide one with the necessary coaching.

WHO (1996a) states that lack of time and adequate resources are also observed as barriers to enhance health literacy because of the changes in school's work, time consuming task and resources intensive programs for the pre- and post-service education and training offered to the teachers. They argued for government leadership and resources that needs to mobilize towards school health program, particularly from the education sector.

WHO (2013) European Union (EU) apply survey method for finding health literacy level by using EU-HL scale, the finding of this study: There is low Level of health literacy on age group of 15-25 years on Europe. EU health literacy scale is effective scale for finding health literacy. The Keywords of this study; Consumer health, information Decision making, Health literacy, Health management and

planning, Health policy Social determinants. For the study the Researcher use mixed method for knowing the health literacy level

Graça S. & et al (2016) was summarized the this type of finding ,There is lack of health literacy rate on European community. The problematic health literacy rate on European country on the age group <25 years (50-90%). For the study they use of mixed method of Research and using tools are: interview schedule with EU-HL scale. This study has this type of keywords: health literacy levels; disease prevention; healthcare; health promotion; university population. for the finding health literacy level they use EU-HI scale it's like follow: HLS-EU skill.- inadequate: 0 to 25 pts (up to 50%) - problematic: >25 to 33 points (50% to 66%) - sufficient: >33 to 42 points (66% - 84%) - excellent: > 42 to 50 points (above 84%) (Graça S. & et al 2016)

Kicksbuch (2000) Addressing the health, and education divide on the journal of: Health promotion international. Oxford University Press. In this article using research method is sequential explanatory method on the based on mixed method. Tool of data collection is question answer method. According to the article the finding is health is key of public issue. Education level plays the good role for achieving health literacy. Level of literacy is way of achieving the goal of health literacy on people. The research article has this type of keyword health indicator, education, health literacy: literacy. The main them was this study, prior understands of individual capacity - reading fluency, numeracy, existing knowledge. Tailored information, communication, and education.

Parker & et. Al. (1994) many people don't know about health literacy, there is different between literacy and health literacy. Women have low health literacy score then men. Ever well- educated people have poor health literacy practice. For finding the above statement researcher use the Sequential explanatory method on the basis of mixed method with survey method. Key word is this study; literacy, health literacy. In this study there was five hundred respondents was participant.

A part from the empirical review presented above other literature studies are scheduled and placed in the appendix.

Conceptual Framework

On the basis of objectives and theory, the conceptual framework of the study is presented in following schematic diagram.

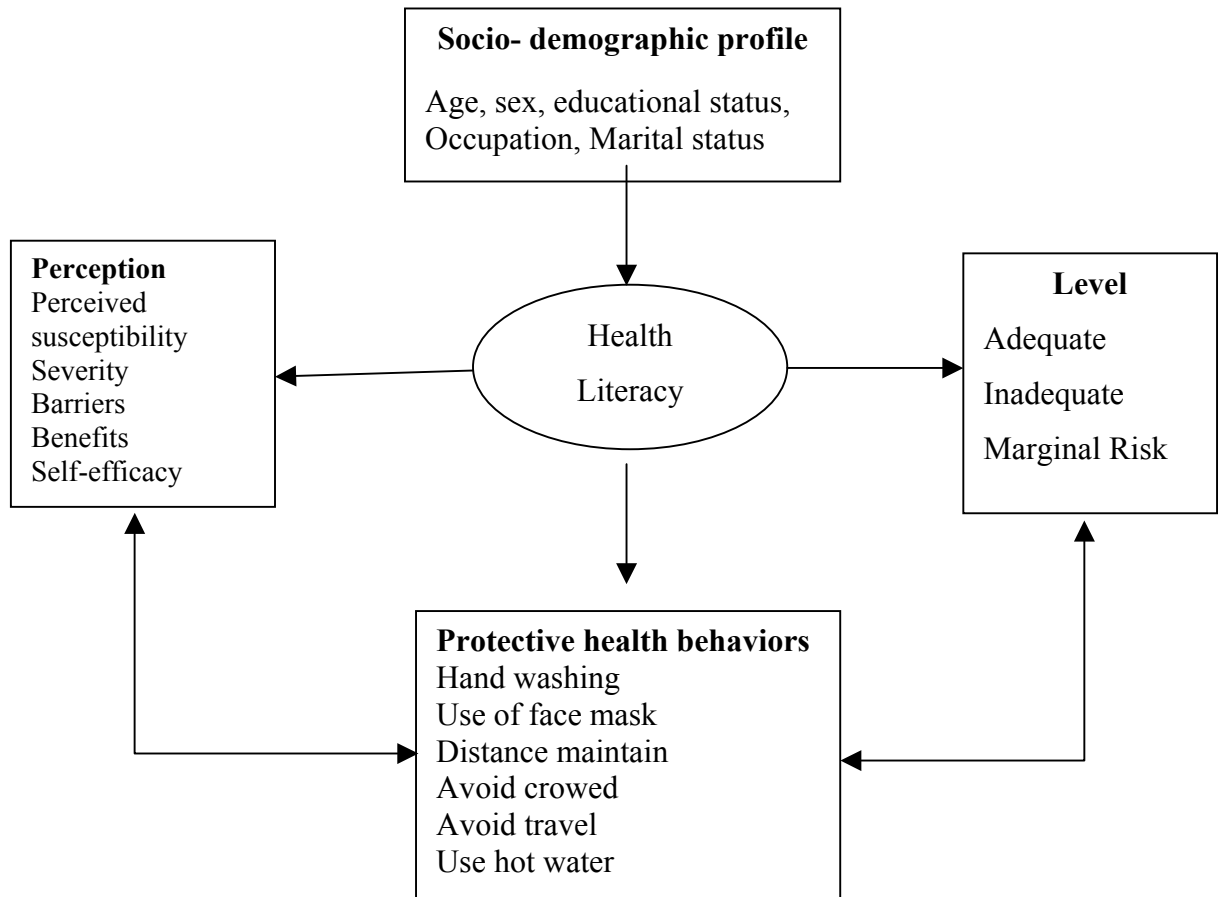


Figure 1

The conceptual framework of the study.

The above conceptual framework has shown the relationship between independent variables and dependent variables as well as research variable. Similarly, It has represented the co-relation between research variable, respondents and research method as well as the research study report and its progress. Here, this framework indicate that which variable are dependent, which are independent and null variable.

Implication of the Review for Study

The various literatures studied are used in different areas of my study. Finding the research gap from the literature I have studied and the empirical review will make it easier for me to study in my field of study. The conceptual framework describes HBM; my study was based on health belief model (HBM). By the using of the six components of the HBM model, I was looked the risk perception behaviors, health protective behavior of Raji and Majhi people. Similarly, EU-HL scale studied its use for looked at the health literacy scale of the Raji and Majhi people. EU-HL scale will be fully followed. I used the various type of literature studied to build my perception of health literacy, risk perception and protecting behavior. I was used it to understand the study methods used during the study.

Chapter III: Methods and Procedures

This chapter deals with the research methodology and methods. This chapter discusses on research design, philosophical considerations. Brief... Moreover, method section in this chapter also defines the study area, population, sampling procedure, study tools, piloting, reliability and validity, data collection procedures. Ethical considerations and .chapter summary are presented at the end of this chapter.

Research Design

For the research, there are three type of research method they are: Qualitative, Quantitative and mix method Research (Khanal.2074). All these methods have their own characteristics. Among the various methods with this feature, the mixed method is used here. The mixed method research design is a procedure for collecting, analyzing and mixing both qualitative and quantitative method in a single or single series of study (Louis, 2007). I had adopted mixed method as both quantitative and qualitative feature are found in the same study and be more effective. For this research I was adopted the sequential explanatory research design under the mix method approach.

During this study, in the first phase, I was taken quantitative data from those Raji and Majh people and analyze it. In the second phase, I was collected qualitative data and interpret analyze the data from analysis. Thus, I have used interview schedule and likert scale for collect quantitative data and I have used the in-depth interview method to collect the qualitative data.

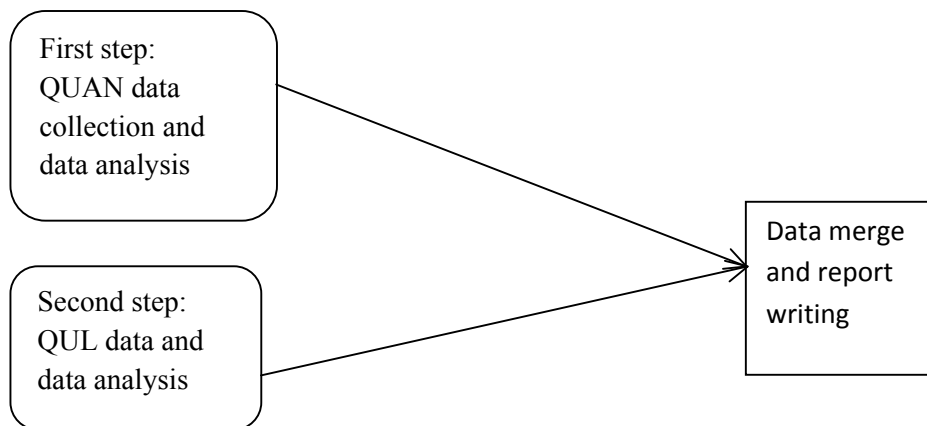


Figure 2

Sequential explanatory research design of the study.

Study area and Source of Data

The study area of this study is located in Surkhet district of Karnali province, which is in Panchapuri municipality, 53 KM west of Birendranagar, and the district headquarters of Surkhet. With a total area of 329.9KM², the municipality has total of 11 wards. The total population is 32231 and 98/KM² density (Details of local Level bodies-2018). The municipality was established on March 10, 2017 by merging Saab's Babiyachaur, Salkot, Chhapre, Bidhyapur and Tatapani VCDs (Panchupari Chinari-2075)

The field of study is decided according to the condition and purpose of any subject. Due to the search for marginalized Raji and majhi communities in this subject, the Raji and Majhi communities in Surket district were assigned as atudy area.

This study area was assigned to the marginalized people Rajhi and Majhi of Panchupari Municipality of Surkhet district; ward nom 5, 9, 10, 11 of the area is the study area of this study area. With a total population of 646 Raji has a population of 437 and Majhi has a population of 209. The study looks at the socio-demographic status of the people, health literacy level, risk perception level and protecting behavior among them.

Population and Sample

For this study, I have included people in the age group of 16 years and above people from the Raji and Majhi communities of panchupari municipality as a study population.

According to the data of Panchupari municipality (2078) Details of endangered caste of Panchupari Municipality) out of a total of 538 respondents of Raji and Majhi, 384 respondents were including for this study. Where, 83 people from ward nom.5, 66 people from ward nom.9, and 278 people from 209 ward no.11. From them expect ward no. 11 all are Raji respondents.

For which sample size was determined using by Raosoft calculator. Samples were determined from a computer with the help of software of Raosoft calculator by

online. <http://www.raosoft.com/samplesize.html>. Among the people of aged 16 (423) and above, 90% (384) were taken as a respondents in this study.

Table 1

Sample size of the study (Source: Panchupari ek chanari, 2074)

SN	Ward nom	Cast	Total population	Under 16 year	+ 16 year	Sample size
1	5	Raji	83	28	55	47
2	9	Raji	76	19	57	48
3	10	Raji	278	111	167	158
4	11	Majhi	209	65	144	131
Total			646	223	423	384

Sampling Technique. In this study the populations are above the 16 years Male and female of Rajhi and Majhi people. I used convenience sampling method for quantitative and qualitative data. I chose the 8 people (4 Male and 4 Female) from Majhi 2male and 2 female and from Rajhi 2 male and 2 female respondent from Rajhi and Majhi community for qualitative data. And then I was get interview from them and analyzed it. The sample size is presented in following table no. 1.

Research Tools

For the research tool I was used, Health literacy scale developed by HLS-EU47 was applied to finding the level of health literacy. For the qualitative data collection I used In-depth interview. Interview schedule, The Interview schedule based on socio economic condition of respondents, Risk perception behavior and protective health behavior, had applied to examine the quantitative data of protective behavior regarding COVID-19 and liker scale had applied to measure the risk perception of the respondents towards COVID-19.HLS- EU-47 health literacy scale; the EU-HL scale for knowing the health literacy level and there was 16 question related to demographic profile, like that , for risk perception Related question 32 likert scale (Perceived severity-5, perceived susceptibility-6, perceived barrier-5, perceived benefit-4, perceived self-efficiency-6, cause to action-4). Like that 15 interview schedule question on the basis of protecting behavior related

I was converted the health literacy scale on three levels (adequate, marginalized and inadequate) and the high and low level of protecting behavior and risk perception level. I used the questioner of the HLS-EU-Q47 to assess the comprehensive health literacy on health care, diseases prevention and health

promotion. The instrument consists of the 47 items of questioner focusing on four type of Health Literacy (HL) level those are, risk perception level, perceived severity, perceived susceptibility, perceived barriers, perceived benefits, perceived self-efficiency and case to action scope reflecting perceived ease or difficulty in an individual's ability to access health information in three ways, (1) understand it, (2) appraise it and (3) apply it. More specifically, the sixteen items includes perceived skills for understanding health information to seek consultation and health information on disease prevention, early detection, health care, health warnings, and advice given by society, family and friends in relation to understand the relevance on, how to seek second opinion, and how to apply advice given by care providers.

Reliability and validity of research tool. In this study the populations are above the 18 years Male and female of Rajhi and Majhi people. When I finalized the total population of target group, sample size is determined. Then I was get pilot data by Census for quantitative and qualitative data and the purposive of qualitative data. I chose the 8 people (4Male and 4 Female) from Majhi 2male and 2 female and from Rajhi 2 male and 2 female respondent from Rajhi and Majhi community .And then I was get interview from them and analyzed it. The interview schedule was analyzed by the SPSS software.

Data was entered, cleaned and analyzed for Cronbach's alpha coefficient using SPSS software. Reliability coefficient of each section of the instrument was tested separately because each section was designed to measure access, understand, appraise and apply on health domain health care, disease prevention and health promotion. The reliability coefficient of instrument became 0.81. After some modification of the questionnaire incorporating researcher's field experience and input of the supervisor and experts, the researcher again went to field to collect data from similar type of Raji community of Pokhighanda ward.10 in study.

Data Collection Procedure

First of all, before reaching the study area, rapport local people. I'm from also hare by the study area. And getting permission from the office, I met with people's representative or stakeholder of the study area and understood the material condition of the area.

After finding out about it there, I went to the person's house to meet the number determined from the sample size and to get an interview for quantitative data. Thus, after reaching home then I took quantitative data from 348 people and analyzed it. After the analyzing quantitative data I got the qualitative data from the four respondents. Of which two were from Raji and two from Majhi community.

Ethical Consideration

I consciously followed various activities to maintain ethical issues like, I had not I mention the basic ethical norms of research like confidential, no biased, no intellectual theft. From, the start to report writing of the research work. At first, I took approval letter from Department of Health and Population, University campus, faculty of education, Tribhuvan University, Kirtipur , Kathmandu.

Method of Data Analysis

After data collection, I encoded my data in SPSS software. For the Response view on the health literacy includes very easy, easy, difficult, very difficult and I don't know. Firstly, it were coded with order 1, 2, 3, 4 and 5 and entered in SPSS. Like that for the respondent view on the protecting behavior include very agree, agree, I don't know, disagree, and very disagree, it were coded with order 1, 2, 3, 4 and 5 and entered in SPSS. Similarly, for the respondent view of protecting behavior include yes, no or No effective, effective, I don't know and very effective then it were coded with order 1 and 2 or 1,2,3,4,5. Then, when I coded in SPSS like this than analyzed from SPSS and built the data table.

The data thus, converted from the method of percentile to, health literacy very easy, easy, difficult, very difficult and I don't know level to inadequate, adequate, marginal then it were coded with order 1,2 and 3. In which adequate is very easy and easy, Marginalize is, I don't know and inadequate is very difficult and difficulty. Like that for the risk perception level I did same as health literacy, very agree, agree, I don't know, disagree and very disagree are convert on low, medium and high then it were coded with order 1,2 and 3. In which very easy and easy to high. Difficult, very difficult to low and I don't know to medium. Like that, for protecting behavior, create individual tables through the frequency of SPSS. Also I have converted high and low level to see the level of protecting behavior.

With the help of SPSS, I added the total score of easy of each of the components (access, understand, appraise, and apply) of health care, disease prevention, and health promotion for health literacy for this study. For example, there are four questions under access to health information on health care domain. I added the score secured by a respondent. One could get highest four scores and lowest zero scores in this particular case. But there are five questions under understanding on disease prevention, so one could get highest five scores and lowest zero scores in this case. After that, I divided three levels with the help of arbitrary scale. I divided three levels of categorical scale of competencies to access, understand, appraise, and apply to health information on health care, disease prevention and health promotion. For example, as there are four questions under access of health care and one could secure four highest score and zero lowest score. The difference of highest score and lowest score was divided by three. I got 1.33, and then I designed inadequate category as 0 to 1.33, limited category as from 1.34 to 2.67 and sufficient category as from 2.68 to 4.00. Likewise, other similar category in other components of health care, disease prevention and health promotion, risk perception level, protecting behavior level and association of them was made. Quantitative data were analyzed using univariate, bivariate (Chi square analysis) and cross table using SPSS.

For qualitative data analysis, Firstly I transcribe the qualitative information into Nepali language. After that I made a code. Then, the data was placed and merged into the relevant heading such as situation of health literacy. The relevant title according to the nature of the data and the report was prepared.

Chapter IV: Results and Discussion

Results

This chapter presents the result and finding of analysis and interpretation of statistics. In this Section contains an on-site study of 384 respondent of the Raji and Majhi community of Panchupari Municipality, Surkhet District. This chapter is based on mainly following 4 sections; the socio-demographic profile, health literacy level, situation of risk perception, protecting behavior and association of them of respondent.

At last here, the meaning of missing of this study is those type of respondents who ignore to provide information about the questioner.

Socio- economic Status

The researcher has taken the general demographic details of the respondent. Based on the details, the respondent has been including in their study. The first socio-demographic description shows a table of respondent's sex, family type, marital status, religion, cast, language, number of family member returning from abroad and number of people infected by COVID-19. The second table shows the age, educational status and major sources of income of the respondent. I have presented socio-demographic details of respondents. On the basis of socio-demographic data, the personal, family, social, economic, educational, health status of the respondents in the study area can be ascertained. It is easy to find out the personal and social behavior of the people living in the area. The above mentioned details give the knowledge of the development service facilities available in the area while the thinking, working capacity of the people determines the personal and social development. The socio-demographic status of the respondents is as follows.

Table 2
Socio-demographic profile of Respondents

SN	Domain	Categories	Number	Percentage	Messing
1.	Sex	Male	207	53.9%	
		Female	177	46.1%	
2.	Marital Status	Married	313	81.5%	
		Unmarried	71	18.5%	
3.	Type of family	Joint	289	75.7%	
		Single	95	24.3%	
4.	Religion	Hindu	384	99.97%	1 (0.3%)
		Other	-	-	
5.	Cast	Raji	253	65.9%	
		Majhi	131	34.1%	
6.	Language	Raji	145	37.8%	
		Nepali	239	62.2%	
7.	Family return from foreign	Yes	142	37%	
		No	242	63%	
8.	Family member infected by COVID-19	Yes	4	1.1%	1 (0.3%)
		No	380	98.9%	

According to given table, table above, the number of male (53.9%) in this study majority. Men who do not work outside due to COVID can be seen staying at home. Similarly, the number of married people is 81.5% and the number of unmarried people is 18.5%. Thus, the practice of early marriage is still prevalent in these two communities. Many people in these communities live in joint families. Due to which, even if the financial burden falls on the person who earns the income of the family, the security of the family, the knowledge and culture of the family is passed down through the generations.

However, the people of those dual communities are 99.97% Hindus. Also, 37.8% of the people in this community speak Raji language. Thus, the influences of Nepali language on Raji language seem to be increasing. Seen in this way, there are

more young people among the speakers of Raji language than adolescence. If Raji language is not passed down, the danger of extinction of Raji language may increase.

The number of people returning home from abroad or India during COVID is 37% in this community. This shows that family members are still forced to go abroad for employment. This community has also not been spared from COVID infection where 1.1% of COVID infected people were found. After the COVID Infection was seen in the community, the people of community seem to have increased their vigilance.

Table no: 2 B

Age group, educational status and source of income

9.	Age Group	< 30 Y	99	25.8%	384
		31-40 Y	111	28.9%	(100%)
		41-50 Y	106	27.6%	
		51-60 Y	63	16.41%	
		+60Y	5	1.3%	
10.	Educational Status	Illiterate	77	20.1%	384
		Literate	112	29.2%	(100%)
		Basic level	111	28.9%	
		Secondary level	57	14.8%	
		Higher education	27	7%	
11.	Source of Income	Agriculture	231	60.21%	384
		Labor	70	18.2%	(100%)
		House wife	39	10.2%	
		Governmental job	5	1.31%	
		Student	38	9.91	

Looking at the above statistics, the most active population in these communities is 28.9% in 31-40 years and 27% in 41-50 years. Thus, the active population in this community is higher. This means that many members of community can earn a living and participate in social work.

Looking at the educational at the educational situation, most of the people in this community have studied at basic level 28.9%, while only 7% have studied higher education. Also 20.1% is illiterate. Hence, this shows that many people in this community do not have access to education and dropout from basic level. In addition, the government's literacy campaign (adult education) has not been effective in this community.

The major source of income of the community is agriculture 60.2%. The lowest source of income is governmental jobs at 1.3%. Although agriculture seems to be the main source of income, most of people in this community go to India seasonally to earn a living. Thus those who work in India don't like to call their main source of income as foreign employment or wages and they call main source of income is agriculture. According to them, they stay home during the farming season and spend the unseasonal farming time in India. That is the way their main source of income is agriculture. However, the source of income of those communities from governmental post and job is less. Looking at this way, it can be said that those communities is deprived of governmental post and job due to lack of education and opportunity.

Health Literacy Situation

Health literacy in the general sense means that a person has knowledge about health and health care facilities, knowledge of people towards the health education and health service available in the community towards community e community. In this way I have sought to know the knowledge and information of the people of health education and health service available.

I have looked at the health literacy level of the people in the community contained in EU-HL47 question item. In which I have found the level of health literacy related to health care, diseases prevention and health promotion. I have found three level of health literacy inadequate, marginal and adequate in these three domains of EU-HL47 question item. The health literacy level of respondents is as follows.

Table 3

Health literacy situation of responds

Aspects	Category	Level						Missing
		Inadequate		Marginal		Adequate		
		No	%	No	%	No	%	
Health care (16 Items)	Access	150	39.1%	202	52.6%	31	8.1%	1 (0.3%)
	Understand	151	39.2%	201	52.4%	31	8.1%	1 (0.3%)
	Appraisal	189	49.2%	112	29.2%	82	21.4	1 (0.3%)
	Apply	141	36.7%	175	45.6%	67	17.4%	1 (0.3%)
Disease prevention (15 items)	Access	141	36.7%	203	52.9%	39	10.2%	1 (0.3%)
	Understand	139	36.3%	129	33.6%	115	29.9%	1 (0.3%)
	Appraisal	139	36.3%	187	48.7%	57	14.8%	1 (0.3%)
	Apply	140	36.5%	149	38.8%	94	24.6%	1 (0.3%)
Health promotion (16 Items)	Access	193	50.3%	89	23.9%	101	26.3%	1 (0.3%)
	Understand	162	42.2%	129	33.6%	92	24%	1 (0.3%)
	Appraisal	201	52.25	98	25.5%	84	21.9%	1 (0.3%)
	Apply	161	41.9%	127	33.1%	95	24.7%	1 (0.3%)

Looking at the table the above, the highest marginalized level is seen in health care. Which health care access are 52.6%, marginalized and 8.1% adequate. Health care understand 52.4% marginalized and adequate 8.1%. On health care appraisal

49.2% inadequate and 21.45% adequate. And health care apply 52.2% marginalized and 10.4% adequate. Seen in this way, most are inadequate and marginalized level found in health care. The numbers of people who know about health care seem to be low. As a result, in this community health care behavior is weak.

Similarly, Diseases prevention access level 45.6%, marginalized and 17.7% adequate. Diseases prevention understand level 36.3%% inadequate and adequate 29.9%. Like that, diseases prevention appraisal level 48.7%, marginalized, adequate and 14.8% adequate. And diseases prevention applies level 38.8% marginalized and 24.6% adequate. Seen in this way, most are inadequate and marginalized level found in diseases prevention. The numbers of people who have knowledge diseases prevention seem to be pathetic.

Also Health promotion level have majority of inadequate and marginalized. Health promotion has 50.3% and 52.255 inadequate in access and appraisal levels and 26%, 245 adequate levels. Like that, understand and apply levels, the order is 42.25 & 41.9% inadequate and 245 & 24.7% adequate.

Seen in this light, all levels of health promotion adequate level look better than all level of health care and diseases prevention expect health care appraisal level, diseases prevention understand and apply level. At the adequate level, understand level 29.9% of diseases prevention look better than other. This means that the understanding of the prevention of diseases is corrective in the community.

Hennas' the health literacy level of the people in the area is weak. As a result their health is affected and it is difficult to decide what to do in case of health problems. There is no information about the health services and their health behavior is not stable as they are deprived of the health service. Due to which their health cannot be promoted.

Situation of Health Education and Literacy Learning and Transfer.

Literacy in the general sense means to read, to write and to solve some daily life mathematical problems. However, in generally the field of health, it is possible to understand whether there is knowledge about health, information about health how to avoid diseases and pandemic. Health literacy in the simple sense means that a person has knowledge about health and health care facilities, knowledge of people towards the health education and health service available in the community towards communities' community.

Here, I have explored what kind of knowledge about health is in these communities and what kind of knowledge has been passed down from one generation to next generation. *“Information about use of herbs and Ayurveda to prevent diseases is provided from the old generation to the new generation.”* (IDI, 40 year Raji male). Like that, *“The knowledge of using ashes, RITHA, leaves of JAMUNA for using hand washing has also passed out from the old generation to the new generation”* (IDI, 39 years, Majhi female).

Seen in this way, the knowledge passed down from the old generation to the new generation is about the use skill of Ayurveda and herbs. However, the older generation has learned health skills from the younger generation. These are as follow. *“Skill and education such as washing hands with soap and water, bathing regularly, maintaining social and physical distance, going to a health post for treatment when sick, and using allopathic medicines are taught the younger generation to old generation”* (IDI, 35 year Maji female and 38 years Rajhi Male).

Similarly, *“The new generation teaches the older generation the health practices that need to be adopted nowadays, the method of occupational safety, and modernizes the knowledge and health skill learned from the older generation”* (IDI, 49 year Majhi Male).

“In order to minimize the problems that may arise in case of emergency, that new generation has made home remedies effective and used them as first aid. (IDI, 36 year Raji Female).”

Seen in this way, the new generation seems to have modernized the knowledge, skill and practice which learned from old generation. As a result learning about health knowledge, skill and practice seems to be scientific as well as effective.

Thus, in the process of transmitting health education and skill, it has been found that understanding in the Raji community is difficulty due to language. *“People are over the age of 40 years who speak Raji language do not easily understand the health related knowledge written and spoken in Nepali language. It is difficult to explain clearly what the knowledge given in Nepali language to the Raji speakers and sometimes it seems to be misinterpreted”*. (IDI, 39 and 49 year Majhi female and male).

In the Raji community, it's difficult for people to get and understanding health education due to language problems. When I asked Raji language speaker to read the pamphlet on the topic of *“preventive measure of COVID-19”* to understand the effect of language, they read pamphlet made it difficult for them understand the language. Then they tried to guess what was being said biased on the picture in the pamphlet. This problem has been seen in those who speak the Raji language for over 40 years.

In this way, different types of health behaviors have been passed down from one generation to next generation. As a result their health practice seems to be improving. Despite this, modern health education skill have not been effective due to lack of education and language problems, disinterest of person and low availability of health related knowledge.

Situation of health literacy level between Raji and Majhi. The state of health literacy can be used to find out about the health related knowledge and behavior of the people in the different area. Seen in this way, the health literature of each community and caste is different. In this study, I have sought the association of health literature and cast of Raji and Majhi communities. This is thus presented in the table below.

Table 4

Situation between health literacy level and Raji and Majhi .

SN	Construct	Category	Cast		Total	X ²	P value
			Raji	Majhi			
1	Health Care Access	Inadequate	103	47	150	5.33	.070
		Marginal	124	78	202	5.31	.060
		Adequate	25	6	31	0.003	.953
		Missing: 1			383		
2	Health Care appraisal	Inadequate	117	72	150	2.594	.273
		Marginal	124	78	202	2.604	.272
		Adequate	25	6	31	0.003	.958
		Missing: 1			383		
3	Health Care Understand	Inadequate	103	47	150	5.332	.610
		Marginal	122	80	202	5.612	.060
		Adequate	23	9	31	0.004	.960
		Missing : 1			383		
4	Health Care Apply	Inadequate	82	59	141	4.300	.077
		Marginal	121	54	175	5.334	.899
		Adequate	49	18	67	0.609	.1222
		Missing: 1			383		
5	Diseases Prevention Access	Inadequate	90	51	141	0.385	.825
		Marginal	136	67	203	0.384	.826
		Adequate	26	13	39	0.281	.596
		Missing: 1			383		
6	Diseases Prevention appraisal	Inadequate	99	41	140	3.594	.174
		Marginal	90	59	149	3.604	.175
		Adequate	63	31	94	0.003	.425
		Missing: 1			383		
7	Health Care Understand	Inadequate	86	53	139	1.537	.464
		Marginal	87	42	129	1.528	.466
		Adequate	63	31	94	0.638	.244
		Missing : 1			383		

8	Diseases Prevention Apply	Inadequate	85	54	139	2.504	.286
		Marginal	130	57	139	2.500	.286
		Adequate	37	20	57	0.880	.384
		Missing: 1			383		
9	Health Promotion Access	Inadequate	134	59	194	2.981	.225
		Marginal	58	31	89	2.954	.228
		Adequate	60	41	101	2.956	.086
		Missing: 1			383		
10	Health promotion appraisal	Inadequate	127	74	201	1.995	.369
		Marginal	70	28	98	2.029	.363
		Adequate	55	29	84	0.441	.507
		Missing: 1			383		
11	Health promotion Understand	Inadequate	99	63	162	3.338	.188
		Marginal	92	37	129	1.528	.466
		Adequate	61	31	92	1.638	.244
		Missing : 1			383		
12	Health promotion Apply	Inadequate	106	55	161	1.639	.441
		Marginal	88	39	127	1.633	.442
		Adequate	37	95	95	0.379	.538
		Missing: 1			383		

Table 4 shows, the association of health literacy level of the community Raji and Majh caste. It is based on three areas of health literacy and four domains in each area. The three areas of health literacy are health care, diseases prevention and health promotion, while access, appraisal, understand and apply have four domains. Here the health literacy level is divided into three levels of inadequate, marginal and adequate.

That health literacy's level on the basis of Raji and Majhi cast and domain of health literacy level is in three categories they have the number on low level of protecting behavior. Here, looking the above table ((on the level of health care the categories of health care appraisal, there are 117 Rajis and 72 Majhis in inadequate level, 77 Rajis and 35 Majhis in marginal level and at adequate level 58 Rajis and 24 Majhis.) (On the level of health care the categories of health care understand, there are 103 Rajis and 47 Majhis in inadequate level, 124 Rajis and 78 Majhis in marginal

level and at adequate level 25 Rajis and 6 Majhis.) (On the level of health care the categories of health care apply, there are 82 Rajis and 59 Majhis in inadequate level, 121 Rajis and 54 Majhis in marginal level and at adequate level 49 Rajis and 18 Majhis.) In this way, the level of Raji communities can be seen as weaker than that of the group. On the level of health care the categories of health care appraisal, there are 117 Rajis and 72 Majhis in inadequate level, 77 Rajis and 35 Majhis in marginal level and at adequate level 58 Rajis and 24 Majhis.) (On the level of health care the categories of health care understand, there are 103 Rajis and 47 Majhis in inadequate level, 124 Rajis and 78 Majhis in marginal level and at adequate level 25 Rajis and 6 Majhis.) (On the level of health care the categories of health care apply, there are 82 Rajis and 59 Majhis in inadequate level, 121 Rajis and 54 Majhis in marginal level and at adequate level 49 Rajis and 18 Majhis.)) In this way, the level of Raji communities can be seen as weaker than that of the group.

On the level of diseases prevention the categories of health care appraisal, there are 90 Rajis and 51 Majhis in inadequate level, 136 Rajis and 67 Majhis in marginal level and at adequate level 26 Rajis and 13 Majhis.) (On the level of diseases prevention the categories of diseases prevention understand, there are 86 Rajis and 53 Majhis in inadequate level, 87 Rajis and 42 Majhis in marginal level and at adequate level 79 Rajis and 36 Majhis.) (On the level of diseases prevention categories of diseases prevention apply, there are 85 Rajis and 54 Majhis in inadequate level, 130 Rajis and 57 Majhis in marginal level and at adequate level 37 Rajis and 20 Majhis.) In this way, the level of Raji communities can be seen as weaker than that of the group. on the level of diseases prevention the categories of diseases prevention appraisal, there are 99 Rajis and 41 Majhis in inadequate level, 90 Rajis and 59 Majhis in marginal level and at adequate level 63 Rajis and 31 Majhis.) (On the level of diseases prevention the categories of diseases prevention understand, there are 103 Rajis and 47 Majhis in inadequate level, 124 Rajis and 78 Majhis in marginal level and at adequate level 25 Rajis and 6 Majhis.) (On the level of diseases prevention the categories of diseases prevention apply, there are 85 Rajis and 54 Majhis in inadequate level, 130 Rajis and 57 Majhis in marginal level and at adequate level 37 Rajis and 20 Majhis. In this way, the level of Raji communities can be seen as weaker than that of the group.

On the level of health promotion the categories of health promotion appraisal, there are 134 Rajis and 51 Majhis in inadequate level, 58 Rajis and 31 Majhis in marginal level and at adequate level 60 Rajis and 41 Majhis.) (On the level of the categories of health promotions understand, there are 99 Rajis and 63 Majhis in inadequate level, 70 Rajis and 28 Majhis in marginal level and at adequate level 55 Rajis and 29 Majhis.) (On the level of health promotion categories health promotions apply, there are 106 Rajis and 55 Majhis in inadequate level, 88 Rajis and 39 Majhis in marginal level and at adequate level 58 Rajis and 37 Majhis.) In this way, the level of Raji communities can be seen as weaker than that of the group. 57 Majhis in marginal level and at adequate level 37 Rajis and 20 Majhis. In this way, the level of Raji communities can be seen as weaker than that of the group.

At last, based on the available health care, diseases prevention and health promotion information; the protective behavior of those communities' people is week. It is important to increase protective behavior along with the health status of the people in the community by imparting knowledge about health care.

Level of Risk Perception of COVID-19

Risk perception is to form own opinion about the risk of any object, situation or event. Information and opinion obtained about the COVOD-19 during the pandemic of COVID and the personal perception formed towards the corona are seen hear at risk perception. To see risk perception, I have looks at six components (Perceived severity, perceived susceptibility, perceived barriers, perceived benefits, perceived self-efficiency, and case to action) under the HBM model. Also, three levels have been built to see the risk perception. They are high, medium, low. The level of risk perception level is as follows.

Table 5

Level of Risk Perception of the people of Raji and Majhi.

SN	Categories	Level						Missing
		Low		Medium		High		
		No	%	No	%	No	%	
1	Perceived Susceptibility	172	48%	114	29.7%	98	25.5%	
2	Perceived Severity	155	40.4%	115	29.9%	114	29.7%	
3	Perceived Barrier	133	34.6%	230	59.9%	21	5.5%	
4	Perceived Benefits	155	40.4%	212	55.25	17	4.4%	
5	Perceived Self-efficacy	177	46.1%	112	29.2%	95	24.7%	
6	Cues to Action	218	56.8%	94	24.8%	71	18.5%	1(0.3%)

Looking at the table, Perceived Susceptibility has the highest risk perception level at low level 40.4% and lowest level in high level 29.9%. In this way, the respondent does not think that they will die from COVID; it does not seem to be only those who have low immunity system. According to the respondents with, medium and high perception, those who return from abroad and those who are infected are more likely to be infected.

Similarly, at the level of perceived severity, the majority of respondent have 48% low level, while the number is high 25.5%. in this way, the respondents does not think that he will die from COVID, it does not seem to be only those who have low immunity power. And otter felt the COVID dangerous and they take precautionary measure.

Like that, perceived barrier has a high score of 59.9% in the medium level and 5.5% at the lowest low level at the risk perception level. Looking at this way, there are more people in this communities who can't wash their hand regularly, can't use sanitizer, can't use mask. As a result, they seem to have a higher risk of diseases.

Lack of knowledge, lack of finances and inability to use the material also seem to be the information towards the mentioned things.

AL those, perceived benefit and perceived self-efficiency have the highest number at low level of risk perception 40.41% & 46.1% while the lowest number is seen at low level of risk perception 4.5% & 24.7%.

Similarly, knowledge gained through the media, health workers and those who do not seek information about the diseases with relative are at lowest level in the case to action of risk perception. Thus the highest number of case to action is at 56.8% low level and 24.7% at high level of risk perception.

Hennas' the people of community seem to have low levels perceived barriers and perceived benefits levels in risk perception levels and need to improve and others level of risk perception are general is satisfactory. Looking at it this way, the low level seem to be higher in the risk perception level. As a result, people in the community are at risk of diseases. Lacks of education, lack of information, lack of financial situation are some of the reason for low level of risk perception.

Situation of Risk Perception between Raji and Majhi People

If the behavior adopted by a person to avoid any health problem is protective behavior, it is the act of getting information about the risk of the diseases and becoming aware of the disease and health problems is risk perception (Wise.T, Zbozinek, & Michelini, 2020). Each community has developed different concept and behaviors to avoid diseases and health problems. This varies from community to community. In this study area, I have explored the assumption of risk perception level of Raji and Majhi caste which ia as follows.

Table 6

Situation between Risk Perception and Raji and Majhi people

SN	Construct	Category	Cast				Total	X ²	P value
			Raji		Majhi				
			No.	%	No.	%			
1	Perceived Susceptibility	Low	121	65.60	51	34.40	172	6.876	.032
		Medium	64	64.60	50	37.39	149	6.743	.034
		High	80	70.11	34	29.89	114	0.313	.576
						384			
2	Perceived Severity	Low	101	70.34	54	39.65	155	1.159	.468
		Medium	72	47.20	43	33.80	115	1.532	.465
		High	80	69.38	34	30.67	114	0.606	.436
						384			
3	Perceived Barrier	Low	88	64.16	45	33.13	133	0.157	.925
		Medium	152	66.88	78	33.91	230	0.154	.926
		High	13	61.21	8	38.09	21	0.533	.817
						384			
4	Perceived Benefits	Low	106	68.38	49	31.61	155	1.058	.583
		Medium	135	63.67	77	36.32	212	1.063	.588
		High	12	70.58	5	29.41	17	0.034	.558
						384			
5	Perceived self- efficiency	Low	122	68.98	55	31.02	177	1.460	.482
		Medium	72	64.28	40	35.71	112	1.404	.482
		High	59	62.10	36	37.8	95	1.404	.236
						384			
6	Case to Action	Low	147	67.43	71	32.56	218	4.672	.097
		Medium	66	70.21	28	29.78	94	4.672	.097
		High	39	54.92	32	45	71	2.424	.119
						383			

Table no. 6 shows at the relationship between risk perception behavior associations on the basis of cast. Here is a look at the situation of the people of Raji and Majhi communities in the sex aspects of risk perception. Hear, the risk perception level of perceived severity is seen in the low Raji community. The adopting high level

of risk perception behavior is seen in the Raji community. Where Raji is low level 65.16% and Majhi on low level and Raji is on high level of risk perception behavior 70.11% and Majhi is 29.8%. At this level, even the weakest protective behaviors at this level seem to in Raji and the high level number is seen in Raji community. The Majhi people seen have middle level of risk perception of the community. (P value $0.468 < 0.05$)

Similarly, at the low level of the perceived susceptibility level the Raji is 68.38% while the Majhi is 31.61% at the high level of risk perception Raji has 61.21% and Majhi has 38.09%. In this way, the Majhi looks better than the low level Raji's Risk perception, but the high level of risk perception Raji's look better than Majhi. (P value: $0.32 < 0.05$)

Like that, perceived barrier at low level of the Raji is 64.16% while the Majhi is 33.13% and at the high level of risk perception Raji has 61.21% and Majhi has 38.09%. In this way, the Majhi risk perception level looks better than the level Raji's Risk perception level. There are 66.8% Raji and 33.9% Majhi's had medium level of risk perception level. Overall, the risk perception levels of Majhi look good. (P value: $0.925 > 0.05$)

Perceived benefits at low level of the Raji are 68.3% while the Majhi is 31.60% and at the high level of risk perception Raji has 70.58% and Majhi has 29.4%. In this way, the Majhi risk perception level looks better than the level Raji's Risk perception level. Looking at the benefits of risk perception level in this way, the overall good risk perception level is seen in Majhi community. (P value $0.589 > 0.05$)

Perceived self-efficiency at low level of risk perception of the Raji is 68.98% while the Majhi is 31.70% and at the high level of risk perception Raji has 62.10% and Majhi has 37.08%. In this way, the Majhi self-efficiency risk perception level looks better than the level Raji's Risk perception level. There are 64.28% Raji and 35.70% Majhi's had medium level of self-efficiency risk perception level. Overall, the risk perception levels of Majhi look good. (P value: $0.482 < 0.05$)

On the case to action risk perception level at low level of the Raji is 67.43% while the Majhi is 32.56% and at the high level of risk perception Raji has 54.92% and Majhi has 45%. In this way, the Majhi case to action risk perception level looks better than the level Raji's Risk perception level. There are 70.21% Raji and 29.78%

Majhi's had medium level of case to action risk perception level. Overall, the case to action risk perception levels of both cast look good. (P value: $0.097 > 0.05$)

Hennas' even if the high level of risk perception looks good on the Raji cast, the risk perception level is good depending on the low and medium level Majhi' risk perception level good. In this way, the impact of available health care and knowledge seem to be felt in the communities.

Protective Behavior

In general, protective behavior is the precautionary measures taken to avoid any untoward incident. Here, a study has been done on the behaviors adopted by the people of the community to keep themselves healthy and to prevent from diseases and the spread of COVID-19 pandemic. I have followed the guidelines set by WHO to see protective behavior in this study. The major behaviors of protective behavior are explained below.

Hand washing behavior. Hand washing is a process that has been going on for centuries. We have been reading and hearing that hands should be washed before and after eating, after going to the toilet, after touching garbage, even show, the WHO has suggested speeding up hand washing to avoid the disease after the COVID-19 pandemic. The hand washing protecting behavior is as follows

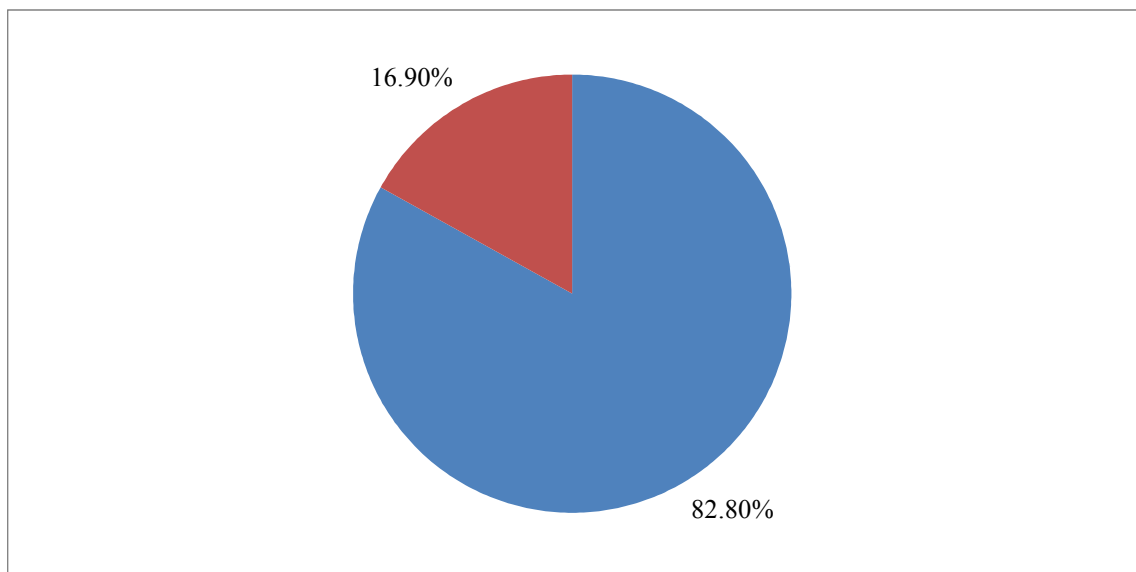


Figure 1

Hand washing behavior

Looking at the table above, the number of hand washes is 82.8% higher than non-hand washes. This means that many people in the community wash their hands regularly to avoid COVID. Due to which the outbreak of corona is reduce. In addition, 16.9% of those who do not wash their hands in this way do not have the facility to wash their hands. The overall table shown above can be viewed as a separate statistic of Raji and Majhi. This is present in the table below.

Table 7

Hand Washing Behavior according to Raji and Majhi

SN	Aspect	Cast			
		Raji		Majhi	
		Nom.	%	Nom.	%
1	Yes	208	82.60	109	83.20
2	No	43	16.99	22	16.79
3	Messing	1(0.39%)			
	Total	252	100%	131	100%

Thus, 82.60% of the people in of the Raji community wash their hand and 16.98% do not wash hand. Similarly, 83.30% Maji People wash their hands and 16.79% do not wash. In this way, even if the hand washing behavior of the community looks good, it seems necessary to increase the hand washing behavior of both communities.

On the basis of in-depth interview (IDI), Some Raji and Majhi people use leaves of Jamuna, Ritha, Tinpane Rakshi and ashes for hand washing (IDI, 35 years Raji Adult Male).

Behavior of using mask. Mask is small piece of cloth or paper made to cover the nose and mouth of the main part of face which is covered with a mask. Mask is used to prevent nasal congestion. Saliva should not be spit out. Also COVID caused by drop let infection. So that WHO recommends wearing a mask to avoid it. The use of mask in this studied community is shown below.

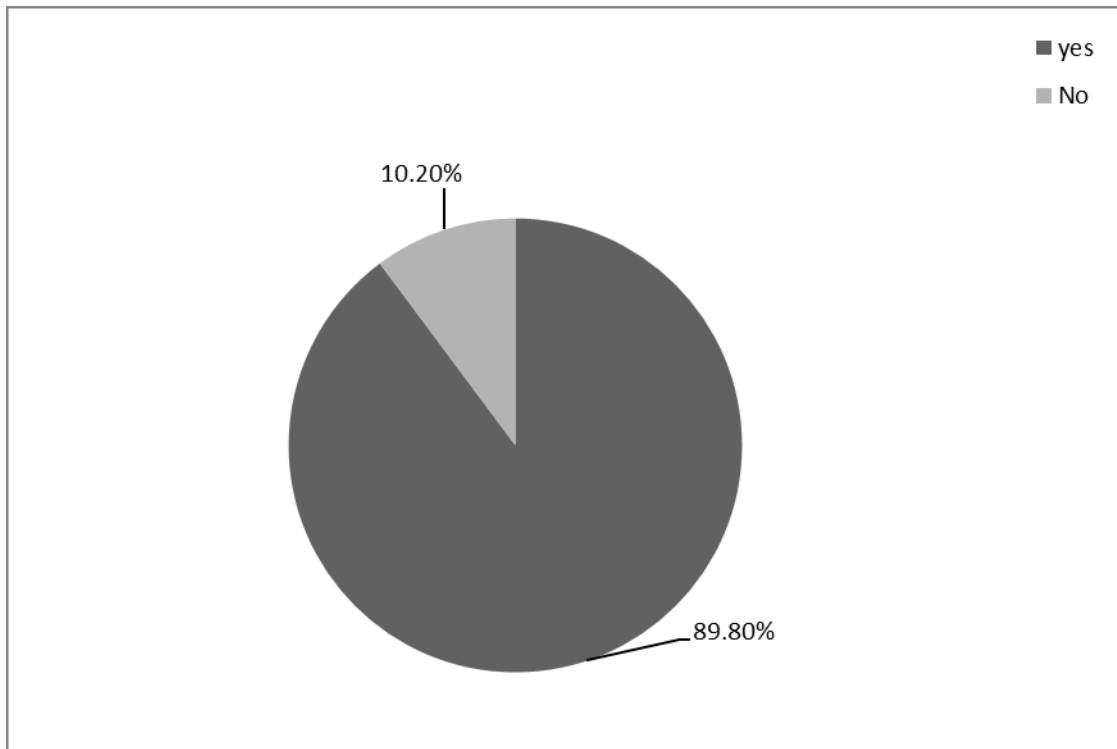


Figure 2

Behavior of Using Mask

Thus the number of people using mask appears to be 89.80%. 10.2% of those who don't use mask seem to be unable to use mask because it is ineffective, uncomfortable to use, not available in the market, cannot porches. In this way, even though the number of people using mask is large, it seems necessary to motivate everyone to use mask.

The overall table shown above can be viewed as a separate statistic of Raji and Majhi. This is present in the table below.

Table 8:

Mask using Behavior according to Raji and Majhi

SN	Aspect	Cast			
		Raji		Majhi	
		Nom.	%	Nom.	%
1	Yes	229	90.51	116	88.58
2	No	24	9.48	15	11.45
	Total	253	100%	131	100%

Thus, 90.51% of Raji use masks and 9.48% did not use mask. While 88.58 of Majhi use Masks and 11.45% do not use. Seen this way, Raji people were use masks more than the Majhi. It's important to teach more about the use mask.

On the basis of IDI, Raji and Majhi women used Hanky, Duppata as a mask, while they are going too crowded. They use it's as a mask for covering mouth and face.

Behavior of using sanitizer. Sanitizer refers to a substance that can be used to clean any item. Sanitizer is used to disinfect the health area. WHO is advised to sanitize after touching any object to avoid COVID. The use of sanitizer in the area studied is presented below.

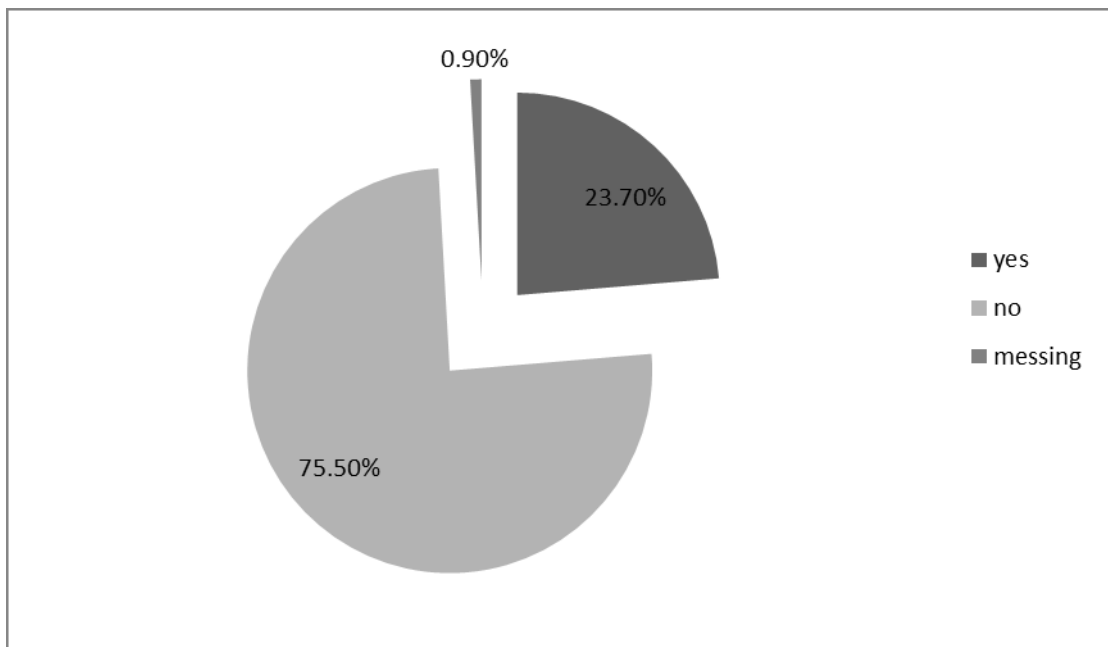


Figure 3

Behavior of using sanitizer

As shown in the picture above, the use of sanitizer is less in these communities. The number of people who do not use sanitizer is 75.5%. The reasons for not using sanitizer are lack knowledge about it, not being available in market, not being able to purchase. Even in 23.7% of those who use sanitizer is found to be low while the number of occasional user is found to be high. The overall table shown above can be viewed as a separate statistic of Raji and Majhi. This is present in the table below.

Table 9

Behavior of using Sanitizer according to Raji and Majhi

SN	Aspect	Cast			
		Raji		Majhi	
		Nom.	%	Nom.	%
1	Yes	58	24.89	33	25.19
2	No	192	82.40	98	74.80
3	Messing		2 (0.79)		
Total		253	100%	131	100%

Thus, only 24.89% of the Raji people and 25.19% the Majhi community used sanitizer. Lack of knowledge about sanitizer, and lack of availability were found to be the main reason for not using mask.

Behavior maintain social / physical distance. Social distance in the general sense means to cover a certain distance without touching any infected person or person who may be infected. It is act of protecting oneself by keeping away from fomites and other materials used by the patient to prevent the spread of the diseases from a person with the diseases or symptom to another person. In order to avoid these diseases, I have explored the behavior of adopting social distance in this society. This is thus present below.

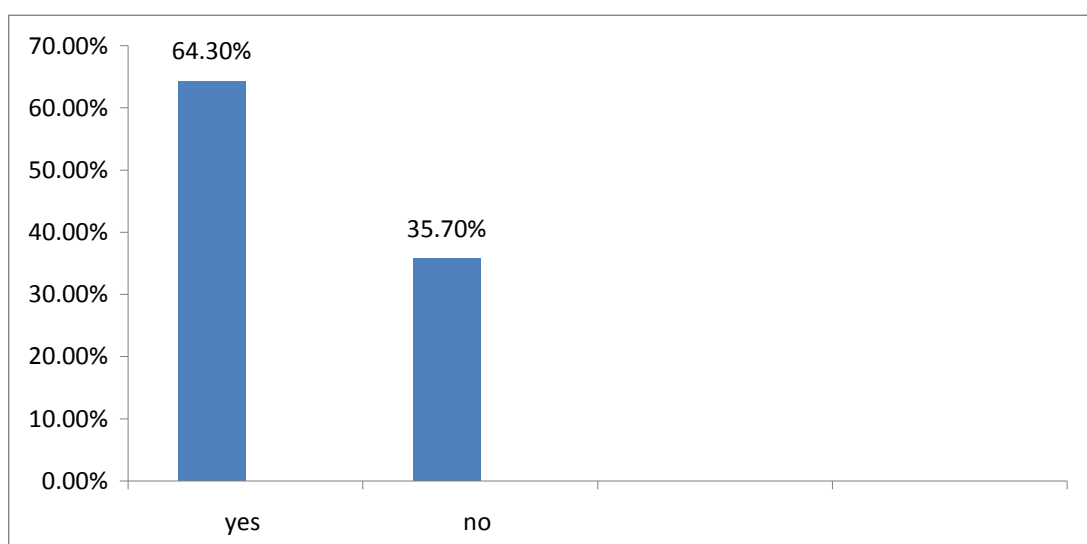


Figure 4

Behavior of following social and physical distance *of respondents*

Looking at the picture above, 64.30% of people in community adopt/ following social distance. In this way, some of those who adopt social distance forget that they forget to follow social distance. 37.7% do not adopt social distance. Thus reasons for not adopting such social distance are lack of education and information relate social distance, Lack of place for adopting social distance in the working place, non-maintenance of social distance by other people etc. The overall table shown above can be viewed as a separate statistic of Raji and Majhi. This is present in the table below.

Table 10

Behavior of following Social or Physical according to Raji and Majhi

SN	Aspect	Cast			
		Raji		Majhi	
		Nom.	%	Nom.	%
1	Yes	106	41.25	87	66.41
2	No	93	36.75	44	33.58
	Total	253	100%	131	100%

Thus, 41.25% of Raji's follow the social? Physical distance 36.75% did not. While 66.41% of Majhi use social distance/ Physical distance and 33.58% do not use social and physical distance. Seen this way, Raji people were followed social distance more than the Majhi. It's important to teach more about the use social and physical distance.

Hennas' although the number of those who adopt social distance is high, the number those who do not adopt it is so significant, so it is necessary to give information about social distance.

Behavior of going crowded. Crowding usually means a large presence of people. The places that are so crowded around the village are especially the markets and shop, some festival, fairs, Meal, work place, temple etc. People in the communities tend to go to such crowded place whether they like it or not. This is as follow.

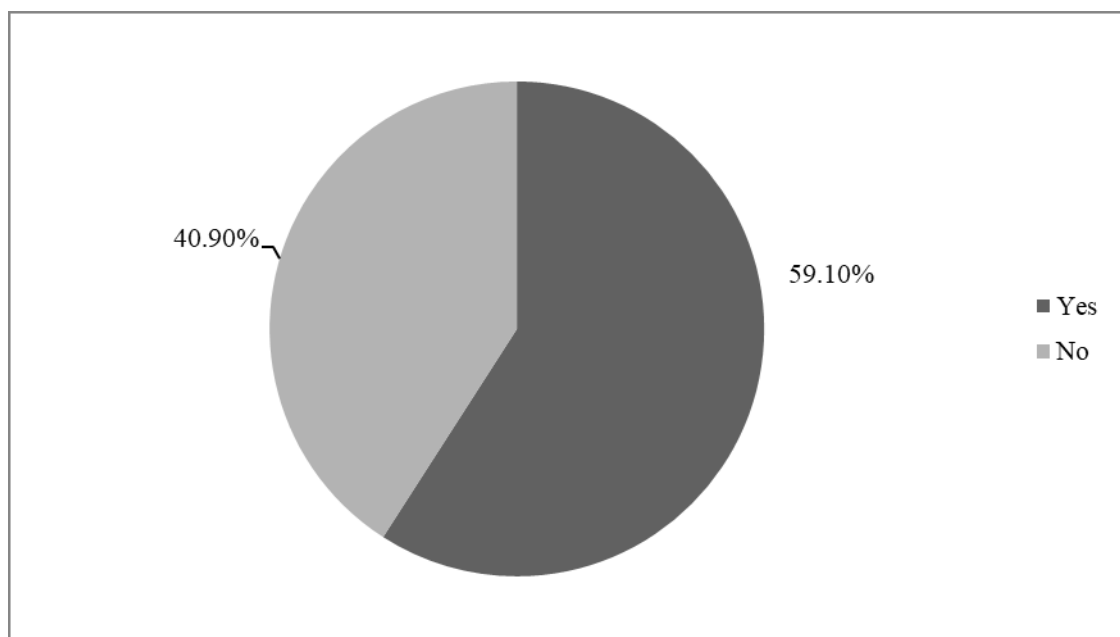


Figure 5

Behavior of Going to Crowded

Looking at the picture above, in which “Yes” show going to the crud while “No” show not going to crud. In this way, the number of people going to the crud is 59.10%. Like that the community is not aware of the fact that the diseases are transmitted by overcrowding. Thus, those who go to the crud seem to be more men. They were found living in a tea shop, in terrace and in a group. However, 40.90% of the people do not go the crud expect for the necessary work.

After all, people in this community do not seem to be aware of the diseases and problems that are transmitted by crud. They need to be education about this. The overall table shown above can be viewed as a separate statistic of Raji and Majhi. This is present in the table below.

Table 11

Behavior of Going to Crowded Place of Raji and Majhi People

SN	Aspect	Cast			
		Raji		Majhi	
		Nom.	%	Nom.	%
1	Yes	149	58.89	78	59.54
2	No	104	36.11	53	40.45
3	Messing				
	Total	253	100%	131	100%

Studying the table above, it is seen that more Majhi people 59.54% went to crowded then to the Raji people. 36.11% of the Raji people was seen went to crowded. In this way, Majhi people appear to be more at risk of COVID, while appear weaker protective behavior.

Behavior of having healthy food. Food is power and basis of living. Eating nutritious food on a regular basis provides immunity to the body. This can prevent various diseases. What is the status of nutritious food in the studied community to keep the body healthy and prevent various diseases? Do they eat nutritious food to avoid COVID? I have tried to know this. This is as follow.

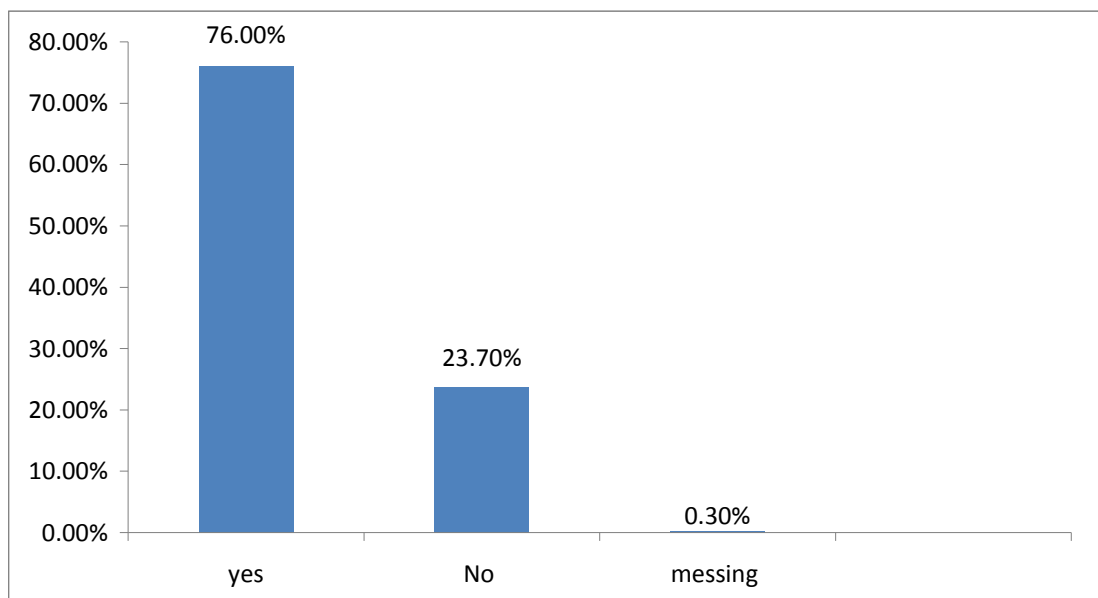


Figure 6

Behavior of having healthy food

According to the picture above the number of people eating nutritious food is 76%. The nutritious food eaten in this way includes milk, curd, fish meat green vegetable nuts and fruits according to the season. Like that the number those who do not eat nutritious food are 23.70%. The reasons for not eating nutritious food are weak economic condition, low production of food, lack of awareness about nutritious food.

After all, even though the number of having nutritious food in this community is high, but may people think that nutritious food is the food available in the market. Therefore, it is important to provide information about nutritious food available at home in the community.

Behavior of covering face while cough and sneeze. Coughing or sneezing causes saliva to come out of the nose and mouth. In this way, the saliva released quickly increase the drop let infection. It is important to cover the nose and mouth when coughing and sizing to reduce the infection caused by saliva. Also COVID is diseases transmitted by droplet infection. I have tried to find out whether the people of these communities cover their noses and mouths when they cough or sneeze during the pandemic of COVID-19. This is as follow.

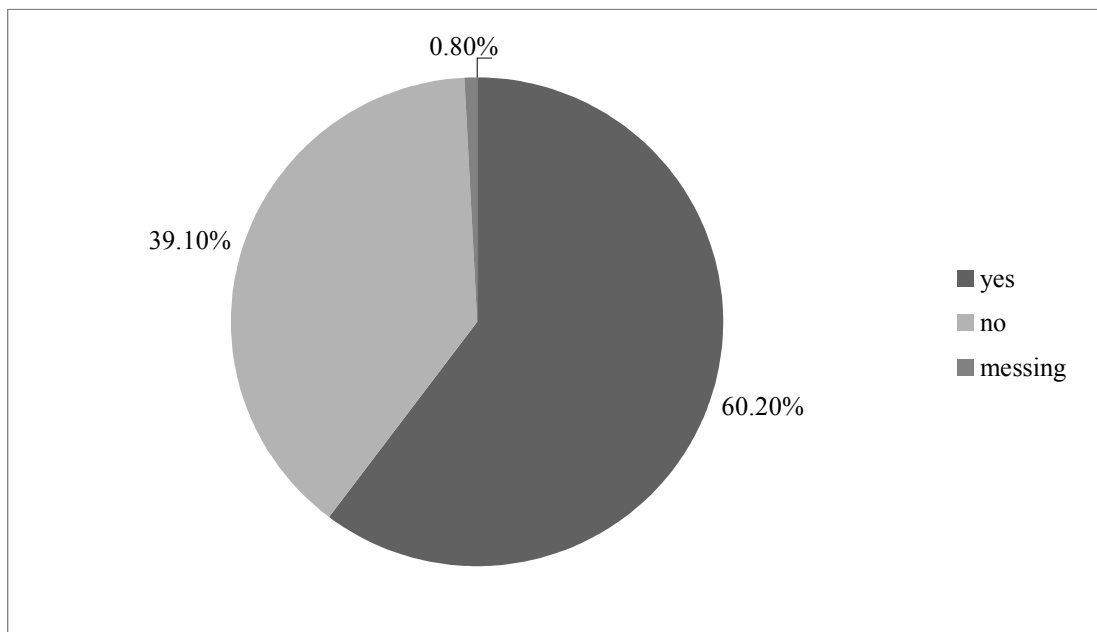


Figure 7

Behavior of Majhi and Rajhi people regarding covering nose and mouth while cough and sneeze

Looking the given above table, It is seen that most of the respondents have been covering their noses and mouths while coughing and sneeze. There are many respondents who use their hands the most to cover their nose and mouth while coughing and sneeze. And there are fewer respondents who use cloth of hanky for cover their noses while coughing and sneeze.

Similarly, the number of people who do not cover their nose and mouth while coughing and sneezing is 39.10%. Looking at the reasons for not covering their nose and mouth are , forgetting to cover the nose and mouth, not knowing why to cover nose and mouth while coughing and sneezing, knowing that the nose should cover the mouth but not adopting it in practice.

Finally, in these communities, there is information about the need to cover one's nose and mouth while coughing and sneeze. But there seems to be a lack of information on how and what to cover. It is important to give knowledge about that.

Adopting behavior for protecting from COVID-19: The government and various organizations have suggested preventive measure to avoid disease and current pandemic COVID-19. Many communities have adopted these preventive measures. The preventive measure recommendations in this way have been adopted by the people of these communities. Hearer researcher looking what traditional and local preventive measure practices have been adopted other than those prescribed by the government. Here are the traditional safety measures adopted at the local level to avoid COVID. Hear I have taken information about the preventive measure prescribed by the government and the people who taken security measures at local level. This is thus presented below.

Table 12

Behavior of adopting behavior for protecting from COVID-19

Level	Frequency	Percent	
Valid	Following governmental preventive measure. (WHO)	204	53.1
	Using local level preventive measure	180	46.9
Total	384	100.0	

Looking at the table above, the number of people adopting the governmental recommended preventive measure is 53.1% high. And the number of locally available preventive measure is 46.9%. In this way, those who follow the government's advice they do, regularly wash their hands with soap and water, use mask, use sanitizers, maintain social and physical distance and avoid social cruds, eating healthy food etc. However, those who take preventive measure at the local level follow the preventive rules suggested by the government as well as other practices which are as follows.

They use a variety of herbs to avoid corona virus, such as drinking hot water, drinking turmeric Gurgo water. Having leaf broth of Guava, lemon, mango, fish broth, Kurilo root, Amala powder, mixed with milk or yogurt, take a bath with Neem leaf, eat Ghotapre leaf, put basil (Tulshi) leaf in water and drink it.(IDI, 49 year Majhi male and 36 years female)

However, some people in the Raji community believe that they will never infect by COVID. They believe that the immunity power of their body can fight against the corona virus. Some Rajhi people were wearing a kind of amulet (Tantric buti) to prevent corona infection in in their body. They believe that the power of Tantric buti does not affect corona virus.

Level of Adopting Protective Behaviors. Protecting behavior means any safety measures taken to avoid health problem. It's protects people from getting sick and also helps them to stay away from potentially contagious things. I have seen the level of protective behavior adopted by the people of those communities to avoid the COVID-19 pandemic. This is thus shown in the table.

Table 13:

Level of adopting proactive behavior by Raji and Majhi people

Level	Frequency	Percent
Low	262	68.2
Valid High	121	31.5
Missing	1	0.9
Total	384	100.0

Looking at the table above, 68.2% of people have low health protective behavior. In this way there is a lack of knowledge, education, practice and health care facility in communities. Due to which their protective behavior seem weak.

Similarly, 31.5% of people in these communities have a high protective behavior level. In this way, even though the condition of protecting behaviors seems to be increase. As the number of people with low protective behavior is high in these communities, those who adopt high protective behaviors are also more risk to get the diseases.

Situation of Protecting Behavior between Raji and Majhi People

In those communities studied, people seem to adopt a variety of health protection measure. Even so, if they adopt different type of health safety behavior, their health protecting behavior looks weak. The level of health protective behavior of the people of the two different Raji and Majhi cast is explored. This is thus explained below with table.

Table 14

Situation of Protecting Behavior between Raji and Majhi People

SN	Aspect	Category	Cast		Total	X ²	P value
			Raji	Majhi			
1	Health protecting behavior	Low	177(70.09%)	85(64.88%)	262	0.055	.052
		High	75 (29.16%)	46 (35.11%)	121	0.053	.058
					384		

Based on the above table, the protective behavior level many people in the Raji community seem to be low. The low protective behavior level of Raji community is higher than that of the Majhi community. Of which 70.90% belong to Raji community and 64.88% belong to Majhi community. In this way, according to the protective behavior of the community, the Raji community does not have strong protective behavior. (P value: $0.052 < 0.05$)

Similarly, the Majhi community is more likely to adopt high protective behavior. Of which 35.11% are Majhi and 29.16% are Raji. In this way, the high protective behavior of the people of Majhi community is more than that of Raji community. The reason for this is that many people in the Majhi community are literate and have access to health care. The protective behavior of the Raji and Majhi community does not seem to be same. (P value: $0.58 < 0.05$)

Finally, although the numbers of the Majhi community and the Rajhi community are different, the protective behavior they adopt varies according to the cast. The protective behavior of the people in the community with good literacy rate is also seen to be good.

Association between Health Literacy and Protective Behavior

Health literacy and protecting behavior and interrelated, even if they are different subjects. It can be understood that protecting behavior is also good if the health related knowledge, skill is good. Whether this knowledge is used daily life or not, I have studied the health behavior in the community on the basis of health literacy. The association between health literacy and protecting behavior is presented below.

Association between health care and protective behavior. The health care within the health literacy refers to the behavior of the people in the community regarding their health care; while the protective behavior refers to the kind of behavior they have adopted to avoid the diseases. The association of health care and protecting behavior is present below.

Table 15

Association between health care and protective behavior of Respondent

Domains	Categories	Protective health behavior				Total	X ²	P value
		Low		High				
		Nom	%	Nom	%			
Access	Inadequate	114	76	36	24	150	7.756	0.021
	Marginalized	22	70.89	8	29.1	31		
	Adequate	126	62.37	76	37.64	202		
	Messing:1(0.3)					383		
Understand	Inadequate	114	75.4	36	23.6	151	7.756	.021
	Marginalized	126	62.37	76	37.6	202		
	Adequate	22	70.36	8	29.1	31		
	Messing; 1 (0.3)					384		
Appraisal	Inadequate	136	71.95	53	28.5	189	7.	.046
	Marginalized	79	71.7	32	28.5	111		
	Adequate	47	57.31	35	42.6	82		
	Messing:2 (0.6)					382		
Apply	Inadequate	99	86.82	42	12.4	141	2.985	0.225
	Marginalized	123	83.87	51	17.31	147		
	Adequate	40	58.82	28	41.17	68		
	Messing:1(0.3)					383		

Table 15 shows that health literacy's domain of health care is categories the have the number on low level of protecting behavior inadequate is 76% at low level and 24% at high level. Like that marginalized level has a low level of 62.37% and high level of 29.1%. Also the adequate level has a low of 62.37% and a high of 37.64%). Level of health literacy inadequate, marginalized, adequate have majority of low level of protective behavior. Both level protective behaviors have been found to be synonymous with health. Here, is the protective behavior based on the availability of health care information of health literacy. (P value= 0.021<0.05)

Health care understanding level refers to where a person can understand the information received about health care. By looking at the health care information available at this level, understand the protective behavior the number practitioner in seems to be low. Of which, 75.3% inadequate is at low level and 23.6% is at high level. This makes the clear that the less health information available in community and the less people understand and practice. Of the 70.36% understand the health information and only 39.1% apply it as protective behavior. If the knowledge information received cannot be understood, Protective behavior cannot be adopted on the basis of that information. So that Association between health care understand and protective behavior appears. (P value= 0.020< 0.05)

If understand and follow the information available about health care, the people can adopt a protective behavior towards diseases. The number of people who understand and follow the information is less in this community Here 76.9% has low level on inadequate level and 28.55 has high level. Similarly, low level adequate level has 57.3% and high level 42.6%. As can see, there is little in the way of applying health knowledge to protective behavior. (P= 0.046<0.05)

The positive knowledge learned should be applied in practice. This helps to develops personal behavior. Here's a look at some of the health care information which people have learned and apply for protective behavior. Here's (inadequate level have 86.2% and high 12.4% as well as low 58.82% and high 41.17% at adequate level). In this way, it can be seen that those who have knowledge have adopted many behavior. (P=0.025<0.05)

At last, based on the available health care information; the protective behavior of those communities' people is weak. It is important to increase protective behavior along with the health status of the people in the community by imparting knowledge about health care.

Association between disease prevention and protective behavior. Diseases prevention is the practice of obtaining information about the transmission of any diseases and preventing the spread of the disease. What are the behaviors adopted by people in the community to prevent the disease after learning about the information of diseases and its impact. What are the protective behavior adopt in relation to disease control based on health literacy, as well as I have explore the association between health literacy diseases prevention and protective behavior. This is as follow.

Table 16

Association of Disease Prevention and Protective behavior of Respondent

Domain	Categories	Protective Behavior				Total	X ²	P value
		Low		High				
		Nom.	%	Nom.	%			
Access	Inadequate	113	75.3	37	24.66	150	7.764	0.021
	Marginalized	124	61.3	78	39.7			
	Adequate	22	73.3	8	26.6			
	Messing:1							
Understand	Inadequate	114	76	37	24	150	7.756	0.080
	Marginalized	126	62.06	76	37.64			
	Adequate	22	73.3	8	26.6			
	Messing: 2							
Appraisal	Inadequate	136	71.95	53	28.64	189	6.175	0.046
	Marginalized	79	71.17	32	28.81			
	Adequate	47	57.31	35	43.2			
	Messing:2							
Apply	Inadequate	99	70.21	42	29.82	141	2.985	0.225
	Marginalized	124	70.45	52	29.45			
	Adequate	40	59.70	27	40.30			
						384		

Table 16 shows that health literacy's domain of information about diseases prevention is categories the have the number on low level of diseases prevention (inadequate is 65.83%at low level and 34.16%at high level. Like that marginalized level has a low level of 72.44% and high level of 27.55%. Also the adequate level has a low of 68.68% and a high of 31.94%). How easy or uncomfortable to it is to get information about health promotion. What are the places to get information about health promotion? The key is whether the person in the community has access to the information. Accesses to information on diseases prevention also play a role in building protective behavior. Looking at it here, the protective behavior of those who do not have access to information about diseases prevention they have weak protective behavior. Here, is the protective behavior based on the availability of information of diseases prevention of health literacy. Here (P value= 0.021<0.05)

Health care understanding level refers to where a person can understand the information received about health care. By looking at the health care information available at this level, understand the protective behavior the number practitioner in seems to be low. Of which, 75.3% inadequate is at low level and 23.6% is at high level. This makes the clear that the less health information available in community and the less people understand and practice. Of the 70.36% understand the health information and only 39.1%apply it as protective behavior. If the knowledge information received cannot be understood, Protective behavior cannot be adopted on the basis of that information. So that Association between health care understand and protective behavior appears. (P value= 0.020< 0.05)

If people will understand and follow the information about diseases prevention, the people can adopt a protective behavior towards diseases. The number of people who understand and follow the information is less in this community Here 76% has low level on inadequate level and 24% has high level. Like that, low level in adequate level has 62.6% and high level is 37.64%. In this way, if the knowledge gained about disease control is weakened, then the protective behavior will also be weakened. However, even if the information available regarding disease control is understood, if it is not put into practice, the protective behavior becomes weak. (P= 0.080>0.05).

How the people of these communities has followed the information and knowledge on diseases prevention. How does the information and knowledge of diseases prevention thus adopted relate to protective behavior? That is what is being explored here,

Here's (inadequate level have 71.95% and high 28.04% as well as low 57.31% and high 43.2% at adequate level). In this way, protecting behavior is weakened by following the knowledge gained without understanding. Many people in these communities have not been able to follow up because of the do not understand the information related to diseases prevention. In this way, if the information is not well understood, they are not able to put into practice and their protective behavior is weakened. ($P=0.046<0.05$)

Once you understand the information available about disease control, that information and knowledge should be put in to practice. Many people in this community cannot follow the information in their daily lives. Here's, in the level of diseases prevention of apply level of health literacy there is (Inadequate' low level of protecting behavior have 70.21% and 29.82 in high level. Moderate level have on low level 70.45%and 29.45 in high level. Like that, adequate level has in low level 59.70% and 40.30 in high level) mostly in low level. In this way, they have not been able to follow the available knowledge about disease control due to lack of understand. Protective behavior seems weak when knowledge of disease prevention cannot be applied in daily life. ($P=0.225<0.05$)

Ultimately, the lack of access to the necessary knowledge related to disease prevention, the inability to understand the available knowledge, the inability to follow the understood knowledge and apply it in daily life makes the protective behavior of the people in these communities look weak. The protecting behaviors of the communities' man are formed on the basis of knowledge about diseases prevention.

Association between Health Promotion and protecting Behavior. Health promotion is the practice of upgrade health related knowledge, skill and information about the healthy behavior and preventing the spread of the disease. What are the behaviors adopted by people in the community to prevent the disease after learning

about the information of diseases and its impact. The association between health promotion and protecting behavior as follow.

Table 17

Association between Health Promotion and protecting Behavior of Respondents

Domain	Categories	Protecting Behavior				Total	X2	P Value
		Low		High				
		Nom.	%	Nom.	%			
Access	Inadequate	104	73.75	37	26.24	141	3.721	0.158
	Marginalized	135	66.83	67	33.16			
	Adequate	23	58.97	16	41.02			
	Messing:2 (0.3)							
Understand	Inadequate	86	61.87	53	38.12	139	5.405	0.067
	Marginalized	96	75	32	25			
	Adequate	80	69.59	35	30.43			
	Messing:2							
Appraisal	Inadequate	93	66.90	47	33.81	139	0.707	0.702
	Marginalized	103	69.12	46	30.87			
	Adequate	67	71.27	27	28.72			
	Messing: 2 (0.6)							
Apply	Inadequate	106	65.83	55	34.16	161	1.464	0.484
	Marginalized	92	72.44	35	27.55			
	Adequate	64	68.68	30	31.94			
	Messing: 2 (0.6)							

Table 17 shows that health literacy's domain of information about health promotion is categories the have the number on low level of protecting behavior ((inadequate is 73.75%at low level and 26.24%at high level. Like that marginalized level has a low level of 66.83% and high level of 33.16%. Also the adequate level has a low of 58.97% and a high of 41.31%). In this way, people in these communities have access to information on health promotion. Due the lack of information, the health literacy and protective behavior of the peoples in this community seem to be weak. Here (P value= 0.021<0.05)

How do people in the community understand health promotion related information available from any source? Health promotion understanding level refers to where a person can understand the information received about health promotion. Thus, based on the understanding of the health literacy of the people in the community, their protective behavior has been studied. Here, 61.87% inadequate is at low level and 38.12% is at high level and adequate level has 69.56 % not understanding information as a low level and understand the health information and only 30.43% apply it as protective behavior. If the information and knowledge related to health promotion is not understood. Protective behavior cannot be adopted on the basis of that knowledge. In this way if the understanding of knowledge is good the proactive behavior seen in high level. If the understanding level is weak, the protective behavior is weak. (P value= 0.067> 0.05)

If people will understand and follow the information about health promotion, the people can adopt a protective behavior towards diseases and health related behavior. The number of people's who understand and follow the information related to health promotion are less in those communities. Here, 66.90% has low level on inadequate level and 33.81% has high level. Like that, low level in adequate level has 71.27% and high level is 28.72%. In this way, it seems that the people in the communities follow the knowledge and information about health promotion. (P= 0.072>0.05).

People in those communities do not seem to be able to apply the knowledge they have learned about health promotion in their daily life. Looking at the above statistics, applying health promotion in the community is as follow. Here's (inadequate level have 65.83% and high 34.16% as well as low 68.68% and high 31.94% at adequate level). In this way, The people's of those communities do not seem to be able to put into practice the knowledge and information they have gained about health promotion, the reason behind no being able to use it in this way is that they are not able to understand the information received. (P= 0.484<0.05)

Intimately, the protective behavior of people in the communities is determined by access to knowledge and information related to the health promotion, understanding of information following and using information.

Major Results

Socio-demographic findings

1. The majority of males in this study are 207 (53.9%) and females are 177 (46.1%).
2. Most of the respondents including in this study are married. Of those 313(81.5%) are married and 71(18.5%) unmarried.
3. Most of people in this community live in 289 (75.9%) joint families. While 95 (24.3%) live in single family.
4. In this communities, the number of people of returning from India/ abroad during the COVID-19 period is 142 (37.8%) while number of people who covid-19 infected is 4 (1.1%).
5. The highest population in this study is 111(28.9%) from 31-40 years and the lowest is 5 (1.3%) in 60+m years.
6. Looking at the educational status of this study area, the number of literate is very high with 112 (29.2%) and the lowest number of higher education students is 27 (7%).
7. Agriculture is the occupation of most of the people in these communities with 231 (60.21%) and 5 (1.31%) governmental jobs.

Health Literacy Level of Respondents

1. The literacy level of perceived susceptibility level of the health literacy is 22.5 at high level and 48% at low level.
2. The literacy level of perceived severity of health literacy is 29.7% at high and 40.4% at low level.
3. The perceived barrier of health literacy is at 34.6 high, 59.9% moderate, and 5.5 high levels.
4. The literacy level of perceived benefits of health literacy level is 40.4% at low 55.25% at moderate and 4.4% at high level.

5. The literacy level of perceived self-efficiency of health literacy level is % at low 55.25% at moderate and 4.4% at high level.
6. The literacy level of perceived benefits of health literacy level is 56.8% at low 24.8% at moderate and 4.4% at high level.

Level of Protective Behavior

1. 82.2% say they wash their hands regularly and 16.9% do not wash.
2. 89.80 use mask while 10.2% do not use mask.
3. 63.3% of people in those communities maintain social and physical distance.
4. 59.10% of the people in these communities go to the crowd while 40.90% do not. Thus, the number of male in the crud is higher.
5. There are many people76.26% that eat healthy food to avoid COVID.
6. The number who does not eat nutritious food is 23.70%. Poverty and low food production are the main reasons for not eating nutritious food.
7. In those communities, the people covering their mouth and nose while coughing and sneeze is 62.2% high.
8. In those communities, the number of people who do not cover their nose and mouth while coughing and sneeze is 39.29%. The main reason for not covering the nose and mouth is to cover the nose and mouth without knowing it, knowingly but not following the practice.
9. Only 53.1% follow governmental-recommendation preventive measure to avoid COVID, while 46.9% follow additional local protective behavior
10. Among the locally adopted protective behaviors are the uses of Ayurveda medicine, the use of herbs, while some people from the Raji community were Tantric amulets (Buti).

Association between Health Literacy and Protective Behavior

Association between health care and protective behavior

1. The inadequate level of protective behavior of health literacy's access of health information is 39.1%, marginal 52.6% and adequate 81%.
2. The adequate level of protective behavior of health literacy's understand of health information is 8.14%, marginal 52.4% and adequate 39.25%.
3. The marginalized level of protective behavior of health literacy's appraisal of health information is 29.2%, inadequate 49.2 % and adequate 21.4%.
4. The marginalized level of protective behavior of health literacy's appraisal of health information is 29.2%, inadequate 49.2 % and adequate 21.4%.

Association between Diseases Prevention and protective behavior

1. The inadequate level of protective behavior of health literacy's access of health information is 36%, marginal 52.3% and adequate 24%.
2. The adequate level of protective behavior of health literacy's understand of health information is 29.9%, marginal 53.6% and adequate 36.3%.
3. The marginalized level of protective behavior of health literacy's appraisal of health information is 48.7%, inadequate 36.3 % and adequate 14.8%.
4. The marginalized level of protective behavior of health literacy's appraisal of health information is 38.8%, inadequate 36.5 % and adequate 24.6%.

Association between Health promotion and protecting behavior

1. The marginalized level of protective behavior of health literacy's access of health information is 29.9%, inadequate 50.3 % and adequate 26.3%.
2. The adequate level of protective behavior of health literacy's understand of health information is 24%, marginal 33.6% and adequate 42.2%.
3. The marginalized level of protective behavior of health literacy's appraisal of health information is 25.5%, inadequate 52.25 % and adequate 21.9%.
4. The marginalized level of protective behavior of health literacy's appraisal of health information is 41.9%, inadequate 33 % and adequate 24.7%.

Discussion

Discussion is an integral part of thesis writing. Discussion is the process of combining the finding of own researches with two or more the two research articles. When writing a discussion such as this, I have to study the literature that is in line with the subject of my study. The related discussions are billow.

Socio-Demographic Status. A study by Jummon, Knott & Marshal (2009), "A cross-sectional study of pandemic influenza health literacy and the effect of public health camping" is done at Australia. According to this study 48% are female respondents. Most of the respondents have tertiary (55.9%) level of educational status. 65% respondents are live in single family and 63.2% respondents are on relationship status.

Study by Kuang, Asrif, Das & Bichhleri(2020), Awareness, risk perception and stress during the COVOID-19 pandemic in communities of Tamil Nadu India. Is find the, the study is done by phone survey. Female respondents are 46%, 27.75% having higher education and 18.65% are not getting formal education. Many Respondents are live on joint family.

Like that my study have, majority of respondents are males 207 (53.9%) a. Most of the respondents including in this study are married 313(81.5%). Most of people in this community live in 289 (75.9%) joint families. In this communities, the number of people of returning from India/ abroad during the COVID-19 period is 142 (37.8%) while number of people who covid-19 infected is 4 (1.1%). The highest population in this study is 111(28.9%) from 31-40 years. Educational status of Raji and Majhi people, the number of literate 112 (29.2%).

Looking at the above study, the educational situation in India and Australia looks good. In Raji, Majhi and Tamil Nadu studies, male participation is more. This is because of the patriarchal society. It is also believed that women should not talk to unknown people and outside. Looking at it this way, health literacy rate also looks good in a community with good educational status.

Health literacy of Respondents. Study by Abel & Qeen (2020), entitled on “critical health literacy and the COVID-19 at the university of Bern, Switzerland, Health literacy raises awareness about a person’s health by increasing their perception of health. Like that, males have higher health literacy rate than females, with males accounting for 65.9%. Under the health literacy of health care has the highest respondent are on understanding 65%, at diseases prevention has the highest respondents has on access 71%. Like that on at health promotion the highest respondents has on apply 53.1%.

A study by Barta &et.al (2021), the study done in Mumbai, India the respondents of those study are dental student. 65% respondents have general knowledge about health literacy. 56% respondents are using governmental health service properly. 92% of respondents seek information about COVID from social media and the internet.

Similarly, according to a study conducted in the Raji and Majhi communities, the number of respondents who do not know about health literacy is high. Like that, on the part of health literacy on, Under the health literacy of health care has the highest respondent are on understanding 52%, at diseases prevention has the highest respondents has on access 52.9%. Like that on at health promotion the highest respondents has on apply 33.1%.

Looking at the above study, the health literacy rate of Switzerland and India seems to be better than that of the Raji and Majhi communities. Switzerland's health literacy rate is higher than that of the Raji Majhi peoples, and the country's health literacy rate is better due to better health facilities. Social media and the internet seem to be used in India to get information about health and diseases, but Raji and Majhi people still have to rely on radio and teacher. The reason for this is the lack of effective development of communication facilities.

Level of Risk perception and Protective Behavior. 72% respondents are use mask and sanitizer. 67.9% respondents following social distance. 93% people follow the government's rules and regulation which related to pandemic. More people take healthy food and regular exercise for prevention from COVID (Able&Queen) 25% respondents are applying Ayurveda and local traditional hurb. Some people use clay for use clay and ashes for hand wash. 12% of the respondents were afraid of starvation. 67% respondents are covering their while cough. 23.3% people can't take nutritious food.

Like that on Raji and Majhi people, 82.2% say they wash their hands regularly. 89.80 use mask 10.2%. 63.3% of people in those communities maintain social and physical distance.59.10% of the people in these communities go to the crowd. Thus, the number of male in the crud is higher. There are many people76.26% that eat healthy food to avoid COVID. 23.70%. Respondents can't have nutrition food due to Poverty and low food production Among the locally adopted protective behaviors are the uses of Ayurveda medicine, the use of herbs, while some people from the Raji community were Tantric amulets (Buti).

Chapter V: Conclusions and Implications

Conclusions

This chapter, which concludes the sequence of the study, directs to cover the main points that have been made and missed in this study. All studies begin with a specific subject area and purpose. This study has also been conducted with a definite objective in the Raji and Majhi community. Studies have been done on health literacy, risk perception and protecting behavior of the people in the study area. Every place's health education, health related behavior is affected by the geographical location, political situation, customs and culture language etc. of that place. Those communities are not immune from that fact. In those communities the main reason the low health literacy rate of these communities is the lack of public access to health education and health service. In the absence of access to the health care and health education, it is natural for health literacy to be low. Not being able to understand and follow the health information available from the media and other sources. The major problem of the community is the inability to put it in to practice even if followed.

Thus, if health education and literacy are weakened, people in the community will not be able to adopt protective behaviors to avoid disease. As a result, their health condition becomes weak. Its effects seen everyone in the community.

In order to increase health literacy, health education should be provided at the local level in a way that suits the region. It is important to provide access to health education and services to all people in the community.

Recommendations

I have prepared this study after researching, analyzing and interpreting all the data related to this study. Here, the effect of the study is presented these results can be contribute to the respective field of policy makers, local governance, NGO, school teachers student and future researcher. I have put the recommendation under the following subtitles:

Recommendations for policy maker

1. It is important to keep social, economic, cultural and demographic details of Raji and Majhi people or communities.

2. It is seems necessary to improve the educational status of Raji and Majhi people.
3. It is important to conduct programs to provide information about health and health services to the people of Raji and Majhi communities.
4. It is necessary to promote and modernize the traditional health treatment methods in the Raji and Majhi people or communities.
5. It is necessary to teach health literacy and health promotion measure to the people of Raji and Majhi communities.

Recommendations for future study

1. The demographics of the people of Raji and Majhi Communities can be studied.
2. To study the socio-economic and cultural condition of Raji and Majhi communities.
3. One can study the traditional health treatment method in Raji and Majhi people and communities.
4. The concept and behaviors related to health can be studied among the young and old generation in the Raji and Majhi people or communities.

Recommendations to Raji and Majhi people

1. It is important to keep a record of the people and culture of own community.
2. It is important to learn about modern method of education and health and apply them to people in the community.
3. It is important to preserve the traditional treatment method in own communities.

Implications of Study

Implications to Policy Makers. The results of this study can be relevant reference to policy makers because as they have provided fresh information about

overall picture on health status of Raji and Majhi people Panchupari municipality. The results of this study can be relevant reference to Raji and Majhi people because they have provided fresh information about health literacy, protecting behavior and risk perception of Raji and Majhi people. The local government, province government and central government have put many efforts to provide literacy but they had not promote health of people Raji and Majhi people due to which community health program and activities has been adopted. Health literacy, health protecting behavior and risk perceptions buffers cost expenses on treatment procedure and available health facilities service for people with non-communicable disease, occupational hazards, chronic diseases people with disability on sight, physical disability and people living with HIV/AIDS.

Therefore, the policy makers raise issues on short and long term impact of health literacy in policy discussion and can develop and implement health friendly policies and program to Raji and Majhi people and local general population, infected and affected population of infected and non-infected disease and disability.

Implications to Raji and Majhi Community and People. In this study, the protecting behavior, Risk perception level and level of health literacy on health care, disease prevention and health promotion on basis the components of access, understanding, appraisal and apply is observed different and inadequate, adequate, Marginalize to find out their health behavior to healthy activities. Hence appropriate awareness activities, use of available health facilities, to modernized ancient treatment procedure and adopt the allopathic and community based health measure for Raji and Majhi people for positive health behavior.

The incorporation of awareness activities for Raji and Majhi in learning activities through their authorized institutions is implicated. Particularly, capability enhancement for teachers and students in their daily activities regarding health is helpful to change and to adopt health behavior on health literacy (health care, disease prevention and health promotion) risk perception and protecting behavior. Ultimately, it helps to upgrade health behavior and health status of community as well.

Implications to Future Researchers. This research will be an academic reference to future researchers on health literacy on health care, disease prevention, and health promotion towards access, understanding, appraisal and application to

health information among students and teachers in Panchupari metropolitan surkhet district.

Firstly, this study was only conducted in Raji and Majhi community. Hence future researcher can study about health literacy and risk perception and protecting behavior of Raji and Majhi community and out of Raji and Majhi community as well. This thesis study has focused only on Risk perception, Protecting behavior and (health care, disease prevention and health promotion) based on health literacy. Future researchers can study health literacy on other infectious/ chronic diseases such as TB, COPD, and communicable diseases like diarrhea, Road traffic accident(RTI), and them immunity system and traditional treatment procedure of among Raji and Majhi. Similarly, it has set avenues for future researcher to carry out local people on health literacy incorporating, to accept protecting behavior and risk perception behavior among Raji and Majhi of people of other level

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Appendix- I: Interview schedule

त्रिभुवन विश्वविद्यालय
शिक्षाशास्त्र संकाय
स्वास्थ्य तथा जनसंख्या केन्द्रीय विभाग
कीर्तिपुर, काठमाडौं ।

स्नातकोत्तर तह चौथो सेमेष्टर अन्तर्गतका Thesis writing (M.Ed. 544) को पाठ्यभार पूरा गर्नका लागि
*Health Literacy and Risk Perception Towards Covid-19 Among the Rajhi and Majhi
People of Surkhet* विषयका Title का लागि तयार पारिएको अन्तर्वार्ता तालिका

खण्ड-एक

नाम : लिङ्ग: उमेर:.....
वैवाहिक स्थिति : ठेगाना: न. पा. / गा. पा. वडा
परिवारको संख्या : म () पु. () अन्य ()
परिवारको किसिम :
धर्म: जात:
भाषा:
१३. शैक्षिक अवस्था:

निरक्षर	साक्षर/साधारण लेखपद	प्रा.वि. तह	माध्यमिक तह	उच्च शिक्षा

१४. प्रमुख आय स्रोत:

निर्वाहमुखी कृषि	नगदेवाली/माछा मार्ने	व्यापार	मजदुरी	वैदेशिक रोजगारी	मौसमी काम	अन्य		
						गृहिणी	सरकारी जागिर	विद्यार्थी

१५. अधिल्लो एक महिनामा तपाईंको घरमा कुनै मान्छे बिदेश भारत कोरोना संक्रमण स्थानबाट आउनु भएको छ ?
(क) छ () (ख) छैन ()
१६. तपाईंको परिवारको कुनै व्यक्तिलाई कोरोना संक्रमण भएको छ ?
(क) छ () (ख) छैन ()

खण्ड ख : Risk Perception Related Question

HBM Related Question

२०१

क्र.सं.	जोखिम नभएको अनुभूति (Receive Involvementary)	धेरै असहमत	असहमत	थाहा छैन	सहमत	धेरै सहमत
१	अरुलाई भन्दा मलाई कोरोना लाग्ने सम्भावना कम छ ।					
२	म जस्तो व्यक्तिलाई कोरोना लाग्दैन ।					
३	मेरो शरीरले कोरोना भाइरसको संक्रमणसँग लड्न सक्छ ।					
४	मैले दैनिक जीवनमा गर्ने व्यवहारले कोरोना रोग लगाउने वा साने सम्भावना एकदम कम छ ।					
५	गाउँको हावापानीमा हुर्किएका बसेकालाई कोरोना लाग्दैन ।					

२०२

क्र.सं.	महशुस गरिएको रोग ग्रहणशीलता (Perceived Severity)	धेरै असहमत	असहमत	थाहा छैन	सहमत	धेरै सहमत
१	यदि म संक्रमित भए भने यो रोगबाट मर्न पनि सक्छु ।					
२	कोरोना गम्भिर र खतरनाक रोग हो ।					
३	वृद्ध, कम प्रतिरक्षा र पहिल्यै देखि रोग भएका व्यक्तिहरुमा मात्र यो रोग देखिन्छ ।					
४	युवाहरु र स्वास्थ्य मानिसहरुमा यसको संक्रमण भए पनि बिरामी हुने सम्भावना कम हुन्छ ।					
५	यदि म कोरोना भाइरसबाट संक्रमित भए भने उपचार बिना निको हुन सक्छु ।					
६	घरेलु उपचार विधिबाट कोरोना उपचार गर्न सक्छु ।					

२०३

क्र.सं.	महशुस गरिएको रोग ग्रहणशीलता (Perceived susceptibility)	धेरै असहमत	असहमत	थाहा छैन	सहमत	धेरै सहमत
१	म कोरोनाबाट संक्रमित हुन सक्छु ।					
२	मेरो परिवारका सदस्यहरु कोरोना भाइरसबाट संक्रमण हुन सक्छन् ।					
३	रोगको जोखिम विदेश वा भारतबाट फर्किनेहरुर उनीहरुको सम्पर्कमा जानेलाई बढी छ ।					
४	कोरोना संक्रमित मान्छेसँग भेटे भने म पनि संक्रमित हुन्छु ।					
५	भिडभाड भएको ठाउँमा कोरोना भाइरस सजिलै सर्छ ।					
६	संक्रमित व्यक्तिले प्रयोग गरेका सामान र छोएको वस्तुबाट पनि कोरोना सर्छ ।					

क्र.सं.	महशुस गरिएका बाधाह (Perceived Barriers)	धेरै असहमत	असहमत	थाहा छैन	सहमत	धेरै सहमत
१	हात धुने सुविधाको अभावको कारणले नियमित रूपमा हात धुन सकिदैन					
२	म नियमित रूपमा सेनिटाइजर प्रयोग गर्न सकिदैन					
३	म नियमित रूपमा माक्स प्रयोग गर्न सकिदैन					
४	मेरो परिवारका सबै सदस्यले माक्स सेनिटाइजर किन्न सक्दैन ।					
५	हात मुख धुन, भौतिक दुरी कायम गर्न बिसिन्छु ।					

२०५

क्र.सं.	महशुस गरिएका फाइदा (Perceived benefits)	धेरै असहमत	असहमत	थाहा छैन	सहमत	धेरै सहमत
१	साबुन पानीले हात धुँदा सेनिटाइजर प्रयोग गर्दा कोरोनाबाट बच्न सकिन्छ ।					
२	हात धुँदा, माक्स लगाउँदा मैले कोरोनाबाट सुरक्षित महशुस गरेको छु ।					
३	सामाजिक दुरीले संक्रमणबाट बचाउँछ ।					
४	सामाजिक दुरी कायम गर्दा म कोरोनाबाट सुरक्षित महशुस गर्छु ।					

२०६

क्र.सं.	महशुस गरिएको सक्षमता(Perceived self-efficiency)	धेरै असहमत	असहमत	थाहा छैन	सहमत	धेरै सहमत
१	कोरोनाबाट जोगिन स्वास्थ्यकर आहार खान्छु ।					
२	म बारम्बार हात धुन सक्छु ।					
३	सरकारले लागू गरेको सुरक्षाको उपायहरू अपनाउन सक्छु ।					
४	आवश्यक नभएसम्म घर बाहिर जाने छैन ।					
५	बजार र भिडभाडमा जाँदा माक्स प्रयोग गर्नेछु ।					
६	कार्यस्थलमा सामाजिक दुरी कायम गर्नेछु ।					

खण्ड ग

Protective Behavior Related

३०१. तपाईंलाई धेरै पटक हात धुने बानीले कोरोना रोग लाग्नबाट जोगिन कतिप्रभावकारी हुन्छ/जस्तो लाग्छ ?
- (क) थाहा छैन (ख) कुनै पनि प्रभावकारी छैन
- (ग) मध्यम प्रभावकारी (घ) धेरै प्रभावकारी
३०२. तपाईंलाई अनुहारमा माक्स लगाउनाले कोरोना रोगलाई रोक्नका लागि कतिको प्रभावकारी हुन्छ/भन्ने लाग्छ ?
- (क) थाहा छैन (ख) कुनै पनि प्रभावकारी छैन
- (ग) मध्यम प्रभावकारी (घ) धेरै प्रभावकारी

३०३. सामाजिक दुरी वा भौतिक दुरी कायम गर्दा कोरोना रोगको रोकथाम कतिको प्रभावकारी हुन्छ जस्तो लाग्छ ?
 (क) थाहा छैन (ख) कुनै पनि प्रभावकारी छैन (ग) मध्यम प्रभावकारी (घ) धेरै प्रभावकारी
३०४. के तपाईं दिन दिनै साबुन पानीले हात धुनुहुन्छ ?
 (क) हो (ख) होइन
३०५. यदि हात धुनु हुन्छ भने कति पटक हात धुनु हुन्छ ?
 (क) २ (ख) ३ (ग) ४ (घ) ५ पटक भन्दा बढी
३०६. तपाईं माक्सको प्रयोग कतिको गर्नुहुन्छ ?
 (क) सधैं (ख) प्रायजसो (ग) एकदम कम (घ) कहिले पनि नगर्ने
३०७. यदि माक्स प्रयोग गर्नु हुन्छ भने कति कति बेला गर्नुहुन्छ ?
 (क) भिडभाडमा जाँदा (ख) घर बाहिर जाँदा (ग) काम गर्ने ठाउँ जाँदा (घ) नयाँ मान्छे सँग भेट्दा
३०८. तपाईं खोकदा हाच्छु गर्दा कतिको नाक मुख छोप्नु हुन्छ ?
 (क) सधैं (ख) प्रायजसो (ग) एकदम कम (घ) कहिले पनि नगर्ने
३०९. तपाईंलाई सेनिटाइजर भनेको थाहा छ ?
 (क) छ (ख) छैन
३१०. यदि थाहा छ भने सेनिटाइजरको प्रयोग कतिको गर्नुहुन्छ ?
 (क) सधैं (ख) प्रायजसो (ग) एकदम कम (घ) कहिले पनि नगर्ने
३११. तपाईं सार्वजनिक स्थल वा कार्य क्षेत्रमा भौतिक दुरी कायम गर्नुहुन्छ ?
 (क) छ (ख) छैन
३१२. यदि गर्नुहुन्छ भने, भौतिक दुरी कतिको कायम गर्नुहुन्छ ?
 (क) सधैं (ख) प्रायजसो (ग) एकदम कम (घ) कहिले पनि नगर्ने
३१३. अहिले तपाईंले कोरोनाबाट बच्न कस्ता व्यवहार अपनाइनु भएको छ ?
 (क) नियमित हात धुने (ख) भौतिक दुरी कायम गर्ने
 (ग) पोषिलो खाने कुरा खाने (घ) जडीबुटीको प्रयोग गर्ने
३१४. तपाईं कोरोनाबाट बच्न सन्तुलित आहार खाने गर्नु भएको छ ?
 (क) सधैं (ख) प्रायजसो (ग) एकदम कम (घ) कहिले पनि नगर्ने
३१५. यदि छ भने सन्तुलित आहार कति खाने गर्नु भएको छ ?
 (क) सधैं (ख) प्रायजसो (ग) एकदम कम (घ) कहिले पनि नगर्ने

खण्ड घ

Health Literacy Scale

Indicator सूचक	Process विधि	Statement विवरण
Health Care स्वास्थ्य सेवा	Access पहुँच	१. आफूलाई आवश्यक पर्ने रोगको लक्षणबारे जानकारी प्राप्त गर्न कति सजिलो र गाह्रो छ ?
		२. आफूलाई आवश्यक पर्ने रोगको उपचार विधि बारेमा जानकारी प्राप्त गर्न कति सजिलो र गाह्रो छ ?
		३. आपतकालीन अवस्थामा के गर्ने भनी जानकारी प्राप्त गर्न कति सजिलो र गाह्रो छ ?
		४. तपाईं आफू विरामी पर्दा चिकित्सकको सल्लाह लिन कहाँ जाने भनेर जान्न कति सजिलो र गाह्रो छ ?
	Understand बुझ्नु	५. चिकित्सकले तपाईंलाई भनेको कुरा बुझ्नु कति सजिलो र गाह्रो छ ?
		६. औषधिसँगै आउने औषधि बारेको पर्चा पढेर बुझ्नु कति सजिलो/गाह्रो छ ?
		७. आपतकालीन अवस्थामा तपाईंले के गर्ने भनी बुझ्नु कति सजिलो र गाह्रो छ ?
		८. चिकित्सक वा औषधि पसलेले तपाईंलाई औषधि खाने तरिका बुझाउँदा तपाईंले बुझ्नु कति सजिलो र गाह्रो छ ?
		९. क्षयरोगको उपचार समयावधि बुझ्नु कति सजिलो र गाह्रो छ ?
	Appraise मूल्यांकन	१०. चिकित्सकले तपाईंको स्वस्थप्रति गरेको निर्णय ठिक छ वा छैन भनी मूल्यांकन गर्न तपाईंलाई कति सजिलो र गाह्रो छ ?
		११. विभिन्न उपचार विधिको वैकल्पिक (आयुर्वेदिक, होमोप्याथी, आधुनिक चिकित्सा पद्धतिको फाइदा वा नोक्सानबारे तपाईंले मूल्यांकन गर्न कति सजिलो र गाह्रो छ ?
		१२. पहिलो चिकित्सकको निर्णयमा संका लागि अर्को चिकित्सकसँग परामर्श लिन पछि कि भनी मूल्यांकन गर्न तपाईंलाई कति सजिलो र गाह्रो छ ?
		१३. संचार माध्यमबाट रोग बारेको जानकारीको विश्वसनीयताको मूल्यांकन गर्न तपाईंलाई कति सजिलो र गाह्रो छ ?
	Apply प्रयोग	१४. चिकित्सकले दिएको सल्लाह अनुसार रोगको उपचार गर्न कति सजिलो र गाह्रो छ ?
		१५. औषधि खाने निर्देशन पालन गर्न तपाईंलाई कति सजिलो र गाह्रो छ ?
		१६. आपतकालीन अवस्थामा एम्बुलेन्सलाई बोलाउन कति सजिलो र गाह्रो छ ?
		१७. चिकित्सक वा औषधि पसलेको निर्देशन तपाईंले पालन गर्न कति सजिलो र गाह्रो छ ?
Disease Prevention रोग रोकथाम	Access पहुँच	१८. अस्वस्थ बानीहरु जस्तै चरोट पिउने, कम शारीरिक गतिविधि गर्ने र बढी रक्सी पिउनेलाई नियन्त्रण गर्ने विधिबारे जानकारी पाउन तपाईंलाई कति सजिलो र गाह्रो छ ?
		१९. मानसिक तनाव वा उदासीनता जस्तो मानसिक समस्याबाट बच्न जानकारी पाउन कति सजिलो र गाह्रो छ ?
		२०. खोप र रोग हुन अघिको स्वास्थ्यजाँच बारेमा तपाईंलाई जानकारी प्राप्त गर्न कति सजिलो र गाह्रो छ ?
		२१. शरीरको बढी वचन, उच्च रक्तचाप वा उच्च कोलेस्ट्रॉल (चिल्लो पदार्थ) जस्तो स्वस्थको नकारात्मक परिस्थितिबाट बच्न वा व्यवस्थापन गर्नेबारे जानकारी पाउन तपाईंलाई कति सजिलो र गाह्रो छ ?
	बुझ्नु	२२. धूम्रपान, कम शारीरिक गतिविधि, बढी रक्सी पिउने बानी विरुद्धको स्वस्थ चेतावनीबारे बुझ्नु तपाईंलाई कति सजिलो र गाह्रो छ ?
		२३. खोपको आवश्यकताको महत्व बुझ्नु तपाईंलाई कति सजिलो र गाह्रो छ ?
		२४. विरामी हुनु अघि नै स्वस्थको परीक्षण गर्नु पछि भनी महत्व बुझ्नु तपाईंलाई कति सजिलो र गाह्रो छ ?
		२५. हेपेटाइटिस विरुद्ध खोपको महत्व बुझ्नु कति सजिलो र गाह्रो छ ?
		२६. पोलिओ विरुद्ध खोपको महत्व बुझ्नु तपाईंलाई कति सजिलो र गाह्रो छ ?

	Appraise मूल्यांकन	२७. धूम्रपान, कम शारीरिक गतिविधि, बढी रक्सी पिउने बानी विरुद्धको चेतावनीको विश्वसनीयताबारे मूल्यांकन गर्न तपाइलाई कति सजिलो र गाह्रो छ ?	
		२८. चिकित्सकद्वारा परीक्षण गर्न कहिले जानु पर्छ भनी मूल्यांकन गर्न तपाइलाई कति सजिलो र गाह्रो छ ?	
		२९. कुन अवस्थामा कुन खोप लगाउनु पर्छ भनी तपाईले मूल्यांकन गर्न तपाइलाई कति सजिलो र गाह्रो छ ?	
		३०. कुन अवस्थामा कुन चाहिँ स्वस्थ परीक्षण गर्नुपर्छ भनी मूल्यांकन गर्न तपाईलाई कति सजिलो र गाह्रो छ ?	
		३१. स्वस्थ जोखिमसम्बन्धी संचारको विश्वसनीयताको मूल्यांकन गर्न तपाईलाई कति सजिलो र गाह्रो छ ?	
	Apply प्रयोग	३२. रेबिज खोप कुन अवस्थामा लिनुपर्छ भनी निर्णय गर्न तपाईलाई कति सजिलो र गाह्रो छ ?	
		३३. संचार माध्यमले दिएको जानकारी अनुसार रोगबाट बच्नुको लागि निर्णय गर्न कति सजिलो र गाह्रो छ ?	
		३४. शिक्षकहरुको जानकारी र सिकाइको आधारमा रोगबाट बच्नुको लागि निर्णय गर्न कति सजिलो र गाह्रो छ ?	
	Health Promotion स्वास्थ्य संवर्धन	Access पहुँच	३५. स्वस्थ क्रियाकलाप जस्तै व्यायाम, स्वस्थ भोजन र पौष्टिक आहारसम्बन्धी जानकारी पाउन तपाईलाई कति सजिलो र गाह्रो छ ?
			३६. मानसिक स्वस्थको लागि विभिन्न क्रियाकलापबारेमा जानकारी पाउन तपाईलाई कति सजिलो र गाह्रो छ ?
३७. तपाईको छिमेक स्वस्थ मैत्री कसरी बनाउने भनी जानकारी पाउन तपाइलाई कति सजिलो र गाह्रो छ ?			
३८. कार्य स्थल वा अध्ययन स्थलले स्वस्थको संवर्द्धन गर्न के के उपाय अपनाउनु पर्छ भनी जानकारी पाउन तपाईलाई कति सजिलो र गाह्रो छ ?			
Understand बुझ्नु		३९. खानेकुराको खोलमा दिएको जानकारी बुझ्न तपाइलाई कति सजिलो र गाह्रो छ ?	
		४०. संचार माध्यममा स्वस्थ कसरी हुन सक्छ भन्ने स्वस्थ कार्यक्रम वा जानकारी बुझ्न तपाईलाई कति सजिलो र गाह्रो छ ?	
		४१. मानसिक स्वस्थलाई अभिवृद्धि गर्न गर्नुपर्ने क्रियाकलापबारेको जानकारी बुझ्न तपाईलाई कति सजिलो र गाह्रो छ ?	
		४२. सामाजिक स्वस्थ सुरक्षा कार्यक्रमको महत्व बुझ्नको लागि तपाईलाई कति सजिलो र गाह्रो छ ?	
		४३. जंक फूड र गुलियो पेयपदार्थ पिउन नहुनेबारे बुझ्न तपाईलाई कति सजिलो र गाह्रो छ ?	
Appraise मूल्यांकन		४४. आवासको अवस्था (वायुसंचार, स्वच्छता) ले स्वस्थ रहन मद्दत पुग्छ भनी मूल्यांकन गर्न तपाईलाई कति सजिलो/गाह्रो छ ?	
		४५. प्रत्येक दिनको कुन क्रियाकलाप (खानेपानी, सुत्ने अवधि, पानी पिउने) ले स्वस्थसँग सम्बन्धित छ भनी मूल्यांकन गर्न तपाइलाई कति सजिलो र गाह्रो छ ?	
		४६. कस्तो विद्यालयको वातावरणले स्वस्थलाई नकारात्मक वा सकारात्मक असर पार्छ ?	
		४७. स्वस्थ सुधार सम्बन्धित गर्न निर्णय गर्न तपाइलाई कति सजिलो र गाह्रो छ ?	
Apply प्रयोग		४८. समुदायमा स्वस्थ क्रियाकलापमा भाग लिन तपाईलाई कति सजिलो र गाह्रो छ ?	

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भुपेन्द्र पाण्डे

धन्यवाद

Appendix-II
Empirical Literature Matrix Review

I have studied various literatures for the empirical Review. Yes, I have submitted it hear as it could not be included in the Empirical review. Which I have thus present below.

S.N	Author name and Publish year	Article title and Journal book name	Data collecting tool/scale	Finding	Key point and	Research design	Remarks
1.	WHO (2013)	Health literacy <i>Solid fact of health literacy</i>	Survey for Finding health literacy level by using EU-HL scale	1. There is low Level of health literacy on age group of 15-25 years 2. EU health literacy scale is effective scale for finding H.L.	Keywords; Consumer health information Decision making Health literacy Health management and planning Health policy Social determinants of health Mixed Method	Mixed method for knowing the health literacy level	Book
2	Graça S. Carvalho 1 , Maria Cristina	EUROPEAN HEALTH LITERACY SCALE (HLS-EU-BR) APPLIED IN A BRAZILIAN HIGHER EDUCATION POPULATION OF RIO GRANDE DO	Use of Mixed method of Research	1. There is lack of health literacy rate on European	Keywords: Health literacy levels; Disease	Mixed Method	HLS-EU skill.- Inadequate: 0 to 25 pts (up to 50%) -

	Pansera Araújo 2 , Eva T. O. Boff 2 , Rosa Branca Tracana 3 & Luís Saboga-Nunes 4 1 CIEC, Institute of Education, Uni (2016)	SUL (RS)	Tool s: interview schedule With EU- HL scale	community. 2. The problematic health literacy rate on European age group <25 years (50-90%)	prevention; Healthcare; Health promotion; university population. 2. Qualitative method		Problematic: >25 to 33 points (50% to 66%) - Sufficient: >33 to 42 points (66% - 84%) - Excellent: > 42 to 50 points (above 84%)
3	Shelley D. Golden, PhD1 , Kenneth R. McLeroy, PhD2 , Lawrence W. Green, DrPH3 , Jo Anne L. Earp, ScD1 , and Lisa D. Lieberman, PhD, CHES4	1.Upending the Social Ecological Model to Guide Health Promotion Efforts Toward Policy and Environmental Change Journal: Health Education & Behavior 2015, Vol. 42(1S) 8S–14S © 2015 Society for Public Health Education Reprints and permissions: sagepub.com/journalsPermissions.nav DOI: 10.1177/1090198115575098	Question answer method	1. Building Partnerships for Policy and Environmental Change 2. Promote More Equitable Distributions of Social and Economic Resources	Keywords environmental change, public policy, social ecological model, structural interventions 2. sequential explanatory method	Ground theory of Qualitative Research design	Health behavior model is famous health behavior change model

	(2015)						
4	Nancy D. Berkman , Terry C. Davis & Lauren McCormack (Sept 10,2015)	Title; Health Literacy: What Is It? Journal of Health Communication ISSN: 1081-0730 (Print) 1087-0415 (Online) Journal homepage: https://www.tandfonline.com/loi/uhcm20	Interview schedule And Survey	The terms “literacy” and “health literacy” have been defined, refined, and measured in a variety of ways over the years, responding to changing demands in an increasingly complex society	Is Health Literacy an Individual or a Broader Construct?	Experimental Research method Quantitative method	..
5	Ilona s. kicksbuch (2000)	Journal: Health promotion international. Oxford university press Title: Health literacy; Addressing the health and education divide	Question Answer Method	Health is key of public issue. 2. Education level play the good role for achieving health literacy. 3. Literacy level way of achieving the goal of health literacy	Key word; health indicator, education, health literacy : literacy	Sequential explanatory method on the based on mixed method	1. Prior understanding of individual capacity - reading fluency, numeracy, existing knowledge 2. Tailored information, communication, education

6	Don Nutbeam* (25 Oct 2008)	<p>Title: The evolving concept of health literacy?</p> <p>Journal: Social Science & Medicine journal homepage: www.elsevier.com/locate/socscimed</p>	Interview schedule	<p>will need to include assessment of a person's ability to gain access to age and context specific information from a variety of different sources, discriminate between sources of information, understand and personalise health information that has been obtained, appropriately apply relevant health information for personal benefit. Assessing interactive and</p>	<p>Keywords: Health literacy Health education Patient education Risk</p>	Sequential explanatory method on the based on mixed method	<p>1. Developed knowledge and capability 2. 4. Skills in social organization and advocacy</p>
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				critical literacy will require additional assessment of oral literacy and social skills such as those involved in negotiation and advocacy.			
7	K. Park 201523 rd edition	A text book of Preventive and social medicine		Health belief model is best model for behavior change			Text book
9	Ruth M. Parker, MID, David W. Baker, MD, MPH, Mark V. Williams, MD, Joanne R. Nurss, PhD (1994)	Journal: Journal of general internal Title; The Test of Functional Health Literacy in Adults: A New Instrument for Measuring Patients' Literacy Skills	Survey Method	Many people don't know about health literacy, there is different between literacy and health literacy	Key point: literacy, health literacy	Sequential explanatory method on the based on mixed method	...