Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal

A Dissertation

Submitted to the Central Department of Rural Development

Tribhuvan University, Kritipur, Nepal

For the Partial Fulfillment of the Requirements of the Degree of

Master of Philosophy in

Rural Development

By

Bidhyan Tamang

MPhil/PhD Third Semester

Roll No: 2030295

TU Registration Number: 7-2-152-2009

Central Department of Rural Development

Tribhuvan University, Kritipur, Nepal

September 2024

Declaration

I, Bidhyan Tamang, a student of Master of Philosophy in Rural Development at the Central Department of Rural Development, Faculty of Humanities and Social Science, Tribhuvan University, Nepal declare that my study titled "Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal" has been recommended by my supervisor for evaluation and acceptance. This document has not been submitted, published, or printed elsewhere in Nepal or abroad. Additionally, I will not use this dissertation for obtaining any degree other than the one stated above. I also confirm my readiness for the presentation and evaluation of the dissertation at the earliest convenience. I fully understand that if my statement is found to be incorrect at any stage, including after the award of the degree, the University has the right to revoke my MPhil degree.

……..

Bidhyan Tamang

Date: 2081/05/17 B.S.

(2024/09/02 A.D)

Recommendation Letter

This dissertation entitled “Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal” is submitted by Mr. Bidhyan Tamang for the partial fulfillment of the requirements for the degree of Master of Philosophy in Rural Development under my supervision. I am fully satisfied with his work and would like to recommend it for evaluation and acceptance.

…….

Dr. Suman Kharel

Supervisor

Date: 2081/05/24 B.S.

(2024/09/09 A.D.)

Approval Letter

This study submitted by Mr. Bidhyan Tamang entitled "Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal", has been accepted and approved as partial fulfilment of the requirement for Master of Philosophy in Rural Development by the research committee comprising of:

Associate Prof. Bishnu Bahadur Khatri ……..
Head of Department Date:
Central Department of Rural Development
Tribhuvan University, Kritipur, Nepal

Dr. Suman Kharel ……..
Supervisor, Associate Professor Date:
Central Department of Rural Development

Dr. Bhim Raj Suwal ……..
Internal Evaluator Date:
Tribhuvan University, Kritipur, Nepal

Prof. Dr.Keshab Prasad Adhikari ……..
External Examiner Date:
Tribhuvan University, Kritipur, Nepal

2081/06/04 B.S.
(2024/09/24 A.D.)

To, Head of the Department Date: 2024/09/09

Central Department of Rural Development

Tribhuvan University, Kritipur

Subject: Self-Declaration

Dear Sir/ Ma'am

I hereby affirm that there exists no disparity in the substance of the physical print and digital version of the document specified below, which has been submitted to this establishment for the purpose of undergoing a plagiarism examination. If any dissimilarity is disclosed between the physical print and digital version, I am prepared to accept any consequences as per the established regulations.

Details:

Author Name: Mr. Bidhyan Tamang

Document Title: Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal

Academic Level: Master of Philosophy (MPhil)

Document Type: Dissertation

Submitted to: Central Department of Rural Development

Mobile No: 9851168255

Email: bidhyan.tu2078@gmail.com

Signature:

Plagiarism Test Report

Acknowledgement

In the completion of this dissertation titled "Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal," I am deeply grateful to the many individuals and institutions that have supported me throughout this journey. Their guidance, encouragement, and invaluable contributions have been instrumental in shaping my research and enriching my understanding of this vital topic.

First and foremost, I extend my sincere appreciation to Associate Professor Bishnu Bahadur Khatri, Head of the Central Department of Rural Development at Tribhuvan University, for his invaluable guidance and support throughout this study. His insights and encouragement have significantly shaped my academic journey.

I am deeply grateful to Dr. Suman Kharel, my supervisor and Associate Professor at the Central Department of Rural Development. His expertise, constructive feedback, and unwavering support have been instrumental in refining my research. Thank you for believing in my work and for pushing me to excel.

I would also like to thank Dr. Bhim Raj Suwal, my internal evaluator, for his critical evaluation and valuable suggestions that enhanced the quality of this study. His thorough review and insights were greatly appreciated.

My gratitude extends to Professor Dr. Keshab Prasad Adhikari, the external examiner, for taking the time to evaluate my work and for providing constructive feedback. His perspectives have enriched my understanding of the subject matter.

Thanks to all the respondents of the Konjyosom Rural Municipality who generously contributed their time, insights, and invaluable perspectives to this study period. Without their willingness to share their knowledge and experiences, this study would not have been possible. Their openness and cooperation significantly enriched the depth and quality of my findings.

On a personal note, I am especially thankful to my wife, Dr. Neetu Lama, whose continued support and positivity have been my anchor. Her encouragement has been a constant source of motivation. I also wish to express my heartfelt appreciation to my parents and close relatives for their love, understanding, and unwavering belief in me. Thank you, my friends Bibek Kanta Neupane and Chandra Parajuli for being an integral part of this journey and for contributing to the recognition of this study.

Mr. Bidhyan Tamang

September 2024

Abstract

This study examines the accessibility and availability of healthcare facilities in Konjyosom Rural Municipality, Lalitpur, Nepal, from a rural development perspective. The objectives are to explore the current healthcare landscape, identify challenges and barriers to access, and propose potential solutions. The study employs a mixed-method approach, including household surveys, key informant interviews (KIIs), and focus group discussions (FGDs), with a survey of 326 households predominantly using quantitative methods. Study findings highlight on the challenges faced by residents in accessing health care services such as child mortality, asthma, and diabetes are highlighted. The study identifies barriers, including geographical, social, and infrastructure challenges. The rural settlements of Konjyosom RM, primarily agricultural and largely populated by the Tamang community, are seeing positive steps in healthcare with the construction of a 15-bed hospital. Key infrastructure developments such as road connectivity, medical equipment, ambulance services, and strategic planning for seasonal challenges are underway to improve access to healthcare. Awareness campaigns and enhancing health literacy are crucial, as low levels of hygiene awareness and poor public transport hinder healthcare access. Media usage varies among residents, suggesting tailored health information dissemination. Community feedback highlights the need for better medical supplies, more health professionals, and improved transport infrastructure. Telemedicine offers promising solutions for remote areas. Administrative reforms and federal funding are essential

to overcome policy delays and enhance healthcare facilities. Comprehensive strategies addressing identified barriers are necessary for sustainable rural healthcare improvements.

Key words: accessibility, availability, healthcare, community.

Table of Contents

List of Tables

List of Figures

List of Photographs

List of Acronyms / Abbreviations

B.S.	Bikram Sambat
CDRD	Central Department of Rural Development
FGDs	Focused Group Discussions
GoN	Government of Nepal
HHs	Households
HSSP	Health Sector Strategic Plan
KII	Key Informant Interviews
LGs	Local Governments
LPG	Liquefied Petroleum Gas
M.Phil.	Master of Philosophy
N	Number (sample number)
NGOs	Non-Governmental Organizations
Nos.	Number
NPHC	Nepal Population and Health Census
NPHC	Nepal Population and Housing Census
NPR	Nepali Rupees
NSO	National Statistical Office
p.	Page

Qual	Qualitative
QUAN	Quantitative
RM	Rural Municipality
RM	Rural Municipality
S.N.	Serial Number
SDG	Sustainable Development Goal
SPSS	Statistical Package for the Social Science
TU	Tribhuvan University
WHO	World Health Organization
Yrs.	Years
$	Dollar

Chapter I

Introduction

Background of the Study

Health is a multidisciplinary field which combines public health, medicine, social sciences, and policy to discourse health concerns that transcend national boundaries. Because of the growing interconnection of our world as a result of globalization, it is critical to take an organized and collaborative method to global health. The health determinants, which include social, economic, and environmental factors, have a major impact on population health results. There are health discrepancies within and between countries, underlining the need for a more justifiable distribution of healthcare resources and access to quality healthcare. Global health is critical for addressing contemporary health concerns such as pandemics, emerging infectious illnesses, and non-communicable diseases. To support health equity and enhance global health results, a comprehensive and combined method is necessary (Beaglehole & Bonita, 2010).

Healthcare access in emerging nations remains a main problem in achieving global health equity. Insufficient infrastructure, a restricted healthcare workforce, and inadequate funding are among the major impediments to healthcare accessibility. The problem of communicable and no communicable diseases in developing nations is exacerbating the healthcare problem. The importance of global cooperation, enlarged funds, and policy improvements is improving access to healthcare in emerging nations. The implication of observing healthcare accessibility as an international concern that demands joint effort from all stakeholders. The creativeness to recover healthcare accessibility in emerging countries in order to ensure equitable access to healthcare for all (Chowdhury & Ravi, 2022).

Nepal's health sector is in its initial phases of development. There are other features to consider, including insufficient healthcare infrastructure, a deficiency of healthcare experts, and insufficient transportation infrastructure. These fundamentals are serious to increasing the equity of access to healthcare facilities in Nepal. It is dynamic to investigate the availability and accessibility of public health services in Nepal's numerous regions. To address Nepal's health concerns, such as refining access to healthcare facilities, improving care superiority, and addressing social and environmental elements of health. Achieving these objectives are demanding association among all owners as well as a obligation to health equity (Cao et al, 2021).

The significance of ethical attentions in global health, mainly in concern to issues of integrity and human rights. The implication of partnership and assistance among stakeholders in beginning global health concerns, as well as governments, non-governmental groups, and the corporate area. The significance of a concerted, moral, and long-term approach to universal health, as well as plans for policymakers and specialists. It is an outstanding source for anyone concerned in global health and the difficulties that the global community has in allocating with these concerns (Claborn, 2018).

Nepal's healthcare structure is a mixture of private and public governments. Primary care centers and hospitals are accomplished by the government, while secondary and tertiary care is providing by viable establishments. Health-care structures challenge issues such as underfunding, a scarcity of medical workers, and a lack of access to precaution in rural parts. The Nepalese administration has been struggling to increase the healthcare system by creating health a nationwide priority and growing funding. However, there is still a gap in access to facilities and care, predominantly for rural persons. Additionally, cultural opinions and

behaviors guidance health-seeking behavior and health-care transfer. Traditional healers have a dynamic part in healthcare, mostly in rural areas. We also need to address non-communicable illnesses and mental health syndromes, which are becoming more prominent in Nepal. General, Nepal's healthcare coordination is refining, but concerns remain that must be addressed in order to complete worldwide access to excellence treatment (Rai et al. 2001).

Nepal's healthcare structure threatens tests from deficiency of resources and infrastructure, limited access to healthcare in rural zones, and a deficiency of healthcare professionals. During the COVID-19 pandemic, these complications were degraded by limited testing capacity, inadequate personal defending apparatus for healthcare workers, and a deficiency of hospital beds. The Nepalese government's response to the epidemic has been criticized for being behind and inadequate, including a lack of effective communication with health employees. However, efforts to improve the health system are being made, including the establishing of isolation and treatment conveniences, increased testing volume, and vaccination campaigns (Neupane et al., 2021).

Healthcare accessibility indications to the suitable use of individual health services to accomplish the best health results. In the proposed study, Access to healthcare services includes the following main steps:

a) Access to the healthcare system
b) Locating a place where healthcare services are provided
c) Finding a provider that the patient can trust and communicate with.

Shortage of health insurance coverage is one of the major barriers to healthcare access, and the inadequate distribution of reporting contributes to inequalities in health. Insufficient health insurance coverage may prime individuals to delay or sacrifice needed care, and medical

debt is common among together assured and uninsured individuals. People with lower earnings are often uninsured, and minority groups account for over half of the uninsured population. Facilitating access is concerned with serving people to command suitable healthcare resources in order to reserve or recover their health. Therefore, it might be essential to explore/identify the reasons such as fundamental and cultural. In this perspective, the proposed study on accessibility and availability of healthcare facilities in Konjyosom Rural Municipality of Lalitpur is contextual and reasonable.

Statement of the Problem

Nepal, a landlocked country with challenging topography, faces significant barriers in providing equitable access to healthcare services across its diverse population. The accessibility and availability of healthcare facilities are critical determinants of health outcomes, particularly in rural and remote areas where infrastructure and services are often inadequate. According to WHO, accessibility refers to the ease with which people can reach health services, while availability pertains to the presence of sufficient services to meet the needs of the population (WHO, 2020). In Nepal, both of these factors are influenced by a myriad of challenges, including geographical barriers, socio-economic disparities, and limited healthcare infrastructure.

The health system in Nepal is characterized by a stark urban-rural divide. While urban centers have relatively better access to healthcare facilities, rural areas, especially in the mountainous and hilly regions, suffer from a severe shortage of healthcare services (Lee et al., 2023). The limited availability of health facilities in these regions means that residents often have to travel long distances to access basic healthcare, a situation exacerbated by poor road conditions and a lack of transportation (Cao et al.,2021). This lack of accessibility directly

impacts health outcomes, as many individuals' delays or forgo medical treatment due to the difficulties in reaching healthcare facilities (Clemente et al.,2022).

Furthermore, the availability of healthcare services in Nepal is often hampered by a shortage of skilled healthcare workers. Despite government efforts to improve healthcare delivery, there remains a significant disparity in the distribution of healthcare professionals between urban and rural areas (Adhikari, Mishra, & Schwarz, 2022). This disparity is particularly pronounced in specialized care, where rural residents may have to travel to urban centers to receive necessary treatments, further straining their already limited resources (Bhatia et al., 2022). Additionally, the availability of essential medicines and medical equipment in rural health facilities is often inconsistent, leading to suboptimal care and, in some cases, preventable deaths (Yenet, Nibret, & Tegegne, 2023).

Another critical issue related to the availability of healthcare services in Nepal is the impact of socio-economic factors. The cost of healthcare, both direct and indirect, remains a significant barrier for many Nepalese, particularly those in lower socio-economic strata (Mishra et al., 2019). The inability to afford healthcare services forces many individuals to rely on alternative or traditional medicine, which may not always be effective (Baral et al., 2020). Moreover, marginalized groups, including women, ethnic minorities, and those living in poverty, often face additional barriers in accessing healthcare services, further exacerbating health inequities (Acharya et al., 2017). The order of Health Centers is affected by a number of factors, including their size and the number of functions they provide (Stafford, 2008). Furthermore, this study aims to highlight the specific challenges faced by vulnerable and marginalized groups in the rural community.

The ongoing decentralization of the health system in Nepal, intended to bring services closer to the people, has shown mixed results. While some local governments have made progress in improving healthcare access, others have struggled due to a lack of resources and capacity (Pandey et al., 2021). This inconsistency in the implementation of health policies has led to varying levels of healthcare accessibility and availability across different regions, contributing to persistent health disparities.

Given these challenges, this research topic was chosen to explore the critical issues surrounding the accessibility and availability of healthcare facilities in Konjyosom RM, Nepal. The rural nature of Konjyosom poses geographical and infrastructural barriers that can impede access to healthcare. Limited road connectivity, inadequate transportation options, and the remote location of many households contribute to difficulties in reaching healthcare facilities. Additionally, the scarcity of healthcare infrastructure, including clinics, hospitals, and trained medical personnel, exacerbates the problem. The study employed a mixed-methods approach, combining quantitative surveys to assess the extent of healthcare accessibility and availability with qualitative interviews to explore the experiences and perceptions of healthcare providers and users. The study attempts to answer the following questions:

1. What is the accessibility to and availability of health care facilities in the study area?
2. How the challenges or barriers that affect the accessibility and availability of healthcare facilities?
3. What are the potential solutions to improve healthcare accessibility and availability in the Study area?

Objectives of the Study

This study mainly focuses accessibility and availability of healthcare facilities in Konjyosom Rural Municipality. The specific objectives of the study are following:

1) To explore the accessibility situation and available healthcare facilities in the study area.
2) To identify the challenges or barriers that affect the accessibility and availability of healthcare facilities.
3) To identify potential solutions that can enhance the accessibility and availability of healthcare services in the study area.

Significance of the Study

Health services are a fundamental right of every individual and a vital factor in promoting health and well-being. However, many people living in rural areas like Konjyosom often encounter significant barriers in accessing medical services due to various factors such as distance, cost, and availability. The goal of this research is to examine the existing state of health facilities in Konjyosom Municipality and to identify problems and potential for enhancing access to health care. This study also investigates potential strategies for improving the availability and accessibility of healthcare facilities within communities.

The significance of this study lies in its potential to provide practical insights and recommendations for healthcare providers in Konjyosom and other rural parts of Nepal. By identifying areas for improvement, the findings can help devise initiatives to increase the availability and accessibility of health services. This research also provides valuable insight into the requirements and expectations of the community, helping healthcare providers develop services tailored to their needs. Moreover, the study's findings can inform policymakers and

stakeholders about the current challenges and opportunities in rural healthcare delivery. This can lead to the development of targeted policies and programs aimed at reducing disparities in healthcare access and improving overall health outcomes in rural areas. Ultimately, this research contributes to the broader goal of achieving equitable healthcare for all, aligning with national and global health priorities such as Universal Health Coverage (UHC) and the Sustainable Development Goals (SDGs).

Additionally, this study holds significant value for researchers and academia. It contributes to the existing body of knowledge on rural healthcare accessibility and availability, providing a foundation for future research. Academics can use the findings to explore further the complex dynamics of healthcare delivery in rural settings and develop innovative solutions to address these challenges. The study also offers a comprehensive framework that can be adapted and applied to similar contexts in other regions, fostering a deeper understanding of rural health issues globally.

Delimitation of the Study

The delimitation of this study is important to ensure that the research stays within its defined boundaries and achieves its objectives. The geographical area of the study is Konjyosom Rural Municipality, a rural area located in the Lalitpur district of Nepal. The study focused on healthcare facilities in this region, such as hospitals, health centers, and clinics. The study focused on accessibility and availability of healthcare services in Konjyosom Rural Municipality. This study focused at the elements that affect the availability of healthcare services, such as staffing, equipment, and medication. Primary data were gathered for the through household surveys, key informant interviews, and site observations.

Organization of the Study

The research follows Tribhuvan University's dissertation formatting and organization manual. The first chapter consist of an introduction to the study area, a statement of the problem, the aims of the investigation, the importance of the study, and the study's limitations. Similarly, the second chapter was a Literature Review, with an emphasis on theoretical and conceptual reviews, as well as empirical reviews, relevant to the study topic. The following Chapter covered the research methods in detail. Similarly, chapter four, five and six investigated the sociographical condition of the study area and discussed research problems separately with thematic and descriptive headings. The final chapter addressed the summary and conclusions.

Chapter II

Reviews of the Literature

Concept and Definition

Ancient civilizations such as Egypt, Greece, and Rome used community health performs such as isolation and sanitation to avoid the extent of disease. The role of religious organizations in the campaign of public health and the development of recent medicine throughout the regeneration. From the 19th century to 20th century, global health developing significantly. The establishing of global health organizations, such as the International Health Council and the World Health Organization, has played a significant part in the cooperation against infectious diseases (Basch, 1991).

The World Health Organization (WHO) was established in 1948 as a specific agency of the United Nations with an instruction to encourage health for all. Since its beginning, WHO has played an important part in global health, from removing smallpox to responding to epidemics such as Ebola and COVID-19 WHO has also shape global health policies and creativities, such as the Alma-Ata Declaration on Major Health Care, which promoters' healthcare as a essential human right. Societies have tackled several challenges over the years, containing budget limitations, political burden, and claims of inadequacy. However, it has sustained to adapt and develop to happen the altering demands of universal health. Looking ahead, WHO requirement meets ongoing experiments, having increasing health discriminations and the emergence of new pandemics, while maintaining its mission to promote health for all (Cueto et.al., 2019).

Nepal has made important improvement in enlightening health indicators in current years, including lower parental and child mortality rates and developed access to health

facilities. However, challenges continue, counting lack of acceptable healthcare substructure and resources, inadequate healthcare capital, and a deficiency of skilled healthcare workers. Numerous creativities that have been applied in Nepal to address these tests include the Government Health Facility aimed at growing access to quality health facilities through growing health amenities and enrolling and training health employees. Contains sector plans. The implication of public-private corporations and the role of expertise in refining healthcare in Nepal. The need for constant investment in the healthcare arrangement of Nepal, particularly in rural zones, to confirm that all Nepalese people have admittance to quality healthcare services. The COVID-19 epidemic has highlighted the significance of a tough and resilient health structure and advance energies are needed to reinforce Nepal's health system (Marasini, 2020). The key terminologies are well-defined as follows;

Accessibility: Accessibility refers to the ease with which individuals can reach and utilize health care services. It encompasses various dimensions such as geographical, financial, and cultural factors that influence the ability of people to obtain necessary health care services (PHCPI, 2020). Healthcare accessibility involves an individual's ability to obtain essential health services, including prevention, diagnosis, treatment, and management of diseases and other health conditions. Access to healthcare means having timely use of personal health services to achieve the best health outcomes, comprising four components: coverage, services, timeliness, and workforce.

In rural communities, primary healthcare is essential, with primary care providers treating a wide range of medical issues. Primary care practices serve as the patient's first point of entry into the healthcare system and the continuing focal point for all needed healthcare

services. These services promote health promotion, disease prevention, health maintenance, institutional delivery, and maternal and child health services (Chowdhury & Ravi, 2022).

Access is a complex concept, understood as a means to achieving greater efficiency and better-quality services. Despite the complex processes involved, universal health coverage (UHC) plays a vital role in accessing healthcare services for all. The sustainable development goals (SDGs) do not consider the UHC target as an end itself but as a political choice to strengthen countries' ever-changing complex systems towards sustainable health development. Accessibility refers to the spatial and people aspects of healthcare services and is subject to the adequacy of available healthcare resources and their fair distribution. Thus, the accessibility of healthcare resources and services can be measured using either a place-based or people-based approach (Woldemichael et al., 2019).

Availability: Availability pertains to the presence of health care services and resources in a given area. It includes the presence of health care facilities, medical personnel, and necessary equipment to provide adequate health care services (PHCPI, 2020).

Access to care involves several dimensions: affordability, availability, accessibility, accommodation, and acceptability. Affordability is determined by how the provider's charges relate to the client's ability and willingness to pay for services. Availability measures the extent to which the provider has the requisite resources, such as personnel and technology, to meet the needs of the client. Accessibility refers to geographic accessibility, determined by how easily the client can physically reach the provider's location. Accommodation reflects the extent to which the provider's operation is organized in ways that meet the constraints and preferences of the client, including hours of operation, telephone communications, and the ability to receive care without prior appointments. Acceptability captures the extent to which the client is

comfortable with the more immutable characteristics of the provider, and vice versa, including age, sex, social class, and ethnicity of both the provider and the client, as well as the diagnosis and type of coverage of the client (McLaughlin & Wyszewianski, 2002).

Primary Health Care (PHC): Primary Health Care is a holistic approach to health and well-being centered on the needs and preferences of individuals, families, and communities. It includes a broad range of services such as prevention, wellness, and treatment of common illnesses and conditions (World Health Organization, 2018).

Quality of Care: Quality of care refers to the degree to which health services for individuals and populations increase the likelihood of desired health outcomes. It is based on evidence-based professional knowledge and is critical for ensuring effective and safe health care (OECD, 2021).

Theoretical Review

Health care behaviors, for example the Andersen Behavioral Model, which recommends that healthcare use is influenced by tendency, probability, and need aspects, and the Health Belief Model, which suggests that healthcare use is partial Numerous models have been advanced to appreciate the by a person's observation of liability to disease and the severity of probable health difficulties. Numerous model techniques exist and variations are produced created on them. One of the maximum extensively used is the "Health Belief Model". Sheeran & Abraham (1996) group the variety of performs measured by the health belief model into three comprehensive parts.

According to the Health Belief Model (HBM), supposed obstacles and apparent profits play a vital role in defining an specific’s health-seeking behavior (Rosenstock, 1974). In rural parts like Konjyosom, geographical obstacles such as distance and deficiency of transportation

can meaningfully hinder access to health care facilities. Financial limitations, including the cost of facilities and deficiency of insurance, additional exacerbate these challenges. Cultural aspects, such as traditional philosophies and performs, may also influence individuals' willingness to pursue current medical care.

Protective health practices, debilitated work implements and access to amenities. In this style of screening, a single recognition allocates the link among socialization and presentation. One of the highest exact models is a adjustment of tuberculosis viewing charges by Hochbaum (1958), who initiate that the hypothesis that patients may be asymptomatic is connected with showing rates. The Health Belief Model applications on two issues: "Hazard monitoring" and "performance evaluation" (Sheeran & Abraham, 1996). Sensitivity of warning is formed on apparent liability and foreseen severity of desolation. Social gratefulness contains opinions about the advantages of the certain performance, and even its boundaries. In addition, it involved a ``call to be active" and a overall ``inspiration for health" The health belief model has been respondent of educating people as disruptive financial superiors, and its application to significant contemporary health concerns such as sexual behavior proposals no knowledge (Sheeran & Abraham, 1996). These models, which test to appraise health performance over a variation of means, make two expectations fundamental to conventional health increase. Health is disposed by performance it is based on Health Behavior Model. Behavior is adjustable (Conner and Norman, 1996). An inadequacy of these models is that approximately everyone's views individuals as normal managers, technically noticing available confirmation and forming determinations for achievement from it or have a sign of how people mark decisions. Fazio (1990) recommends a parting from the present "deliberative processing model" in the form of a "charitable processing model" that receipts into account more of the changeability of a specific

decision-making procedure. Though, the fundamental difficult remains that these models mark the significance of individuals and cognitive practices. This loses the sense that we are all rooted in social situations that affect how we process information and respond in much more complex ways.

The Access to Healthcare model is a idea targeted at refining access to healthcare facilities for underserved or inadequate access to healthcare for persons and societies. While this model has developed over time, its fundamental principle is that healthcare is a major human right and that all publics, unrelatedly of socioeconomic condition should have access to excellence health facilities based on the trust that the history of healthcare admittance models can be outlined back to the public rights movement of the 1960s. The movement has focused inequalities in healthcare access and results among numerous indigenous and socioeconomic groups. This model increased momentum in his 1990s, when the Clinton government proposed healthcare reorganization and has ultimately passed the Reasonable Care Act in 2010. The access to healthcare model contains a variety of policies and creativities to progress access to healthcare facilities. Growing insurance coverage, giving supports to low-income individuals, growing capital for public health centers and wellbeing-net hospitals, and encouraging inhibition and wellness agendas. The model also focused the significance of addressing social elements of health such as poverty, education and housing. These can have a important effect on an individual's health. Models of access to healthcare remain to be an significant framework for policy creators, healthcare workers, and labor supporters to progress access and justice in healthcare. While great advances have remained in current ages, additional wants to be completed to confirm that everyone has access to the healthcare facilities they need to accomplish optimum health and well-being (Andersen & Newman, 2005).

The HBM recommends that supposed severity and professed susceptibility to health topics can encourage persons to pursue available health facilities (Rosenstock, 1974). In Konjyosom, the inadequate availability of health care services and medical workers poses a major challenge. The shortage of important medical apparatus and supplies additional boundaries the capability to deliver broad health care facilities.

The healthcare application and behavior model purpose to recognize how individuals pursue, access and use healthcare facilities. Use behavior models commend that healthcare application is biased by numerous parts, with predisposing, agreeing, and important aspects. Tendency encloses demographic, community, and ethnic worries that effect a person's enthusiasm to pursue medical care. Enablers spread to capitals such as insurance coverage, transportation, and obtainability of medical facilities that enable individuals to access healthcare. Necessity influences discuss to an individual's professed for medical precaution, such as: Illness or Injury. Understanding healthcare consumption strategies is serious to emerging effective healthcare rules and involvements. Health care workers can use this information to progress the accessibility and superiority of care and inspire individuals to seek appropriate and suitable medical precaution. In addition, policy creators can use this evidence to identify disparities in healthcare consumption and work to decrease them. Overall, the use behavior model delivers a framework for understanding how persons seek and use healthcare facilities and is an strength to progress access to excellence healthcare facilities for all (Andersen, 2005).

The major challenges in accessing and utilizing health care facilities in Konjyosom contain geographic barriers, financial restrictions, and cultural issues. The HBM focused that apparent obstruction, such as distance and cost, can prevent individuals from seeking health

care (Rosenstock, 1974). Furthermore, the absence of awareness and education about available health facilities and the welfares of modern medical attention can donate to low consumption rates. The limited availability of health care services and medical personnel additional combinations these challenges, creating its challenging for residents to accept timely and satisfactory care.

Empirical Review

Accessibility to maternal and teenager health facilities for women with disabilities in countryside Nepal. Research has establish that women with disabilities appearance a range of obstacles in accessing maternal health facilities, including physical, financial and social obstacles. These obstacles were additional protected by limited evidence and knowledge of available facilities. As a result, there is an vital need for added comprehensive maternal health facilities that discourse the essentials of females with disabilities in rural Nepal. This needs that healthcare workers, policy creators and groups work organized to create an environment that cares admission to and use of maternal health facilities (Devkota et al., 2018)

Physical elements such as distance and transport were the core obstacles to access to healthcare for the Tarai. Approaches towards healthcare also play a vital matters, with several citizens favoring traditional healers and home medications to modern medical services. Refining transportation structure and raising awareness of the significance of modern healthcare supports progress access to healthcare in the area (Henry et al., 2019)

Refining accessibility to rural fitness services not only expands the health of residents, but also pays to financial and social growth. Governments must participate in rural health structure development, encourage health employees to work in rural zones, and inspire community-based health courses. They also inspire private groups and individuals to work with

administrations to increase health facilities in rural zones. Rural growth can be accomplished by refining accessibility to health services (Ajala et al., 2005)

Health amenities and facilities for countryside residents and the threats to people face in retrieving these facilities. However, availability remained a important issue due to insufficient transportation, deficiency of awareness and insufficient medical structure. Deliver improved transport, increase consciousness through health training agendas, support health infrastructure to progress convenience and deliver quality health facilities to rural populations (Elakoti, 2021).

Assess existing healthcare structure and classify tests residents face in accessing healthcare facilities. There is a major deficiency of medical services in the district, with small concentration of workers and insufficient infrastructure. As a consequence, access to health facilities is insufficient for huge sections of the population, mainly those existing in rural areas. There are numerous plans to expand access and convenience of healthcare, including creation original health services, refining existing services, and growing the number of healthcare workers within the district (Askari, 2021).

Policy Review

The Public Health Service Act, 2075 (2018) spaces a huge significance on fairness and inclusivity, and marks to confirm that public health facilities are accessible and reasonable to all participants of society, with shelved and neglected groups. It also includes provisions for the protection of abandoned populations, such as females, child, and people living with inabilities. The act inaugurates a controlling outline for the authorization and certification of health organizations, as well as the certifying and registering of health specialists. It also holds requirements for the instruction of medical schooling, research, and morals.

Nepal's National Health Policy 2019 highlights the requirement for a multi-sectorial method to healthcare and inspires assistance among diverse areas and investors to accomplish its objectives. It also highlights the development of a strong healthcare method that can deliver quality healthcare facilities to entirely peoples of Nepal. The policy emphases on providing available, affordable and reasonable healthcare facilities to all citizens of Nepal, mainly those existing in remote and underserved parts. The policy also purposes to expand the health position of the population by selecting protective and promotional health facilities.

The Nepal Health Service Act, 2053 purposes to promotion a rational and glowing structure for the appointment, transfer, promotion, and termination of health facility persons in Nepal, with the dynamic objective of filtering the superiority of healthcare facilities distributed to the Nepalese people.

The Nepal Health Service Delivery Standards, reorganized in 2076 (2019/2020), deliver a inclusive outline to confirm the transfer of quality health facilities through the country. The standard protections a extensive choice of parts such as structure, human resources, equipment and materials, managing and distribution of facilities. The standard highlights the importance of patient-centered precaution and inspires workers to arrange patient wants and favorites. They also encourage the use of evidence-based practices and continuous monitoring and evaluation of services to ensure quality and effectiveness.

The National Health Education, Information and Communication Policy of Nepal, reorganized in 2074 (2017/2018) purposes to progress health knowledge and health performance of the Nepalese persons over education, information and communication policies. This strategy identifies that health education, information and communication are vital factors in stimulating healthy performance and stopping infection. This policy highlights the

significance of community involvement and contribution in health education, information and communication creativities. This inspire the use of numerous channels and platforms, with mass media, community media and community-based methods, to convey precise and appropriate health information to a miscellaneous audience.

The Health Sector Strategic Plan (HSSP) (2015-2020) targets to increase access to necessary health facilities, particularly for the underserved and those staying in remote place. This also arrange the protection and control of communicable and non-communicable infections and the raise of healthy lifestyles. About human means, the plan purposes to address the deficiency of health workforces and progress the delivery of health labors countrywide. It also focus the significance of refining the services and abilities of health workforces to deliver quality precaution. Regarding healthcare funding, the plan purposes to growth management investment in healthcare and encourage economic safety for all people. They also inspire public-private partnerships and other advanced capital instruments to activate assets for health.

Summary of the Literature Review

The literature review delivers a comprehensive outline of historical, theoretical, empirical, and policy features associated to healthcare accessibility, mainly in the context of Konjyosom Rural Municipality, Lalitpur, Nepal. Start with a conceptual review, the narrative hints the progress of public health performs from ancient evolutions to modern age, highlighting the part of international health groups like the World Health Organization (WHO). Theoretic standpoints, with the Health Belief Model and the Access to Healthcare model, focused on reasons manipulating healthcare performances and the essential right to healthcare. The empirical review grants revisions underlining obstacles to healthcare access in rural Nepal, emphasizing physical, monetary, and social hindrances. Lastly, the policy review summaries

main healthcare strategies and acts in Nepal, emphasizing fairness, multi-sectoral association, and quality facility transfer. The literature together forms a foundation for accepting the difficulties of healthcare availability in Konjyosom Rural Municipality and sets the phase for the investigation purposes, containing discovering the current healthcare landscape, recognizing obstacles, and proposing results.

Research Gaps

While the literature review provides a comprehensive understanding of healthcare accessibility in various contexts, including rural Nepal, there is a notable research gap specific to Konjyosom RM, Lalitpur. Existing studies have touched upon broader challenges, such as physical, economic, and social barriers, but there is a lack of detailed exploration into the factors influencing healthcare access in this particular region. The literature lacks a different examination of the local dynamics, cultural influences, and community-specific challenges that might significantly impact healthcare utilization in Konjyosom. Additionally, there is limited attention to recent developments, interventions, and their effectiveness in addressing the identified barriers. Therefore, the research gap lies in the need for a focused investigation that explores into the complexities of healthcare accessibility in Konjyosom RM, offering understandings that can inform targeted and context-specific interventions.

Despite the efforts of the government and various NGOs, medical facilities in Konjyosom are limited. There are few primary health centers or health posts scattered throughout the community, making it difficult for people in remote areas to access health services. The accessibility and availability survey helps to identify gaps in the health system and provide valuable insights on how to improve the quality of healthcare services. The research helps to develop effective strategies to improve community health systems and

provides guidance on how resources can be distributed to meet the healthcare needs of populations.

Conceptual Framework

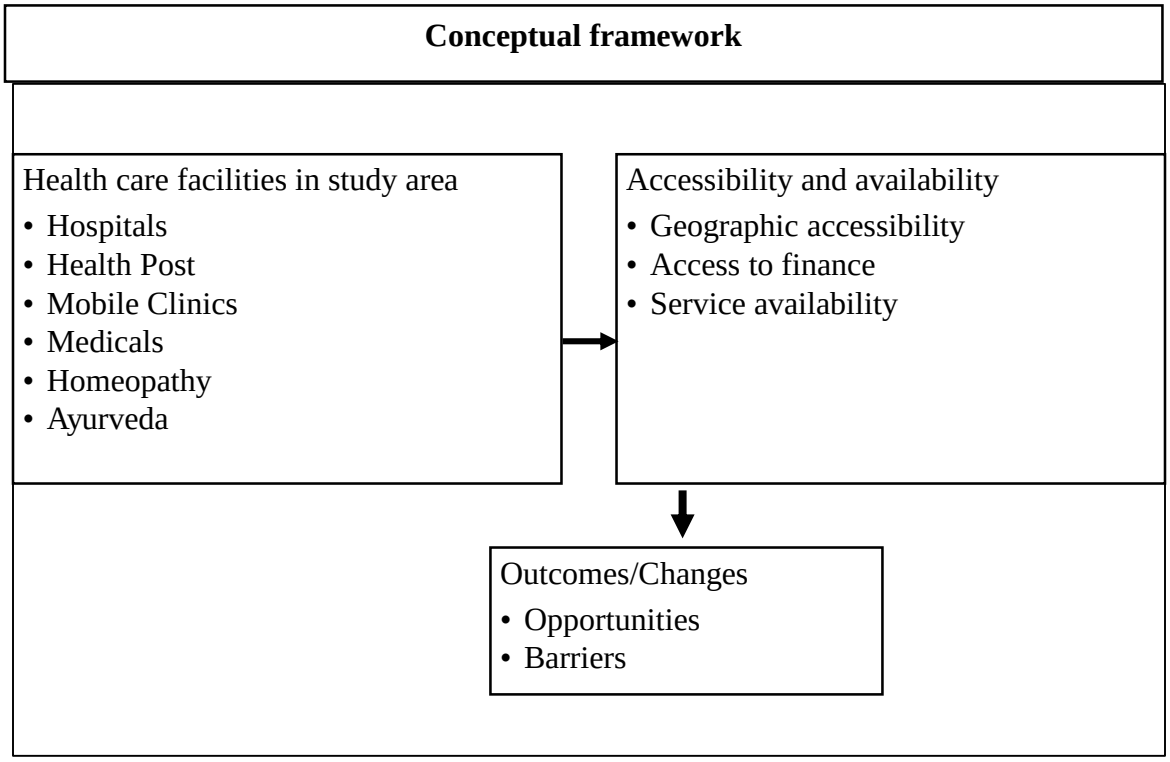
The socio-economic disparity between rural and urban populations is widening, resulting in disparities in service delivery between rural and urban areas. Therefore, it is necessary to examine the current public health system, the gaps in health resource needs in the rural dwellings. A conceptual framework for studying the accessibility and availability of healthcare which considered the geographical, economic, cultural, and environmental and health services as a key factor. Rural populations are repeatedly more helpless to health problems due to a lack of access to clean water, proper sanitation, and adequate nutrition.

Research on the accessibility and availability of healthcare facilities in Konjyosom Rural Municipality can help identify the gaps in the healthcare system and provide valuable insights into how to improve the quality of healthcare services. In this context, the following conceptual framework has been prepared.

The conceptual framework for assessing the accessibility and availability of healthcare facilities in Konjyosom Rural Municipality, Lalitpur, is based on the Health Belief Model (HBM). This framework encompasses key elements such as geographic accessibility, types of health services available, access to finance, and service availability. It also considers the barriers that inhibit access to healthcare, including socio-cultural norms, financial constraints, and a lack of skilled healthcare providers. The model identifies opportunities like health education, policy interventions, and funding programs to enhance healthcare access.

Figure 1

A Conceptual Framework for Accessibility and Availability of Healthcare Facilities



Chapter III

Research Methodology

This chapter provides a detailed overview of the research methodology used in this study. Making informed methodological choices is essential to uphold the research's integrity and validity. The chapter describes the philosophical framework, research approach, study design, data collection methods, and analytical techniques employed to address the research questions and objectives. By presenting this methodology comprehensively, the chapter aims to offer a clear picture of the systematic process followed for data collection, analysis, and interpretation, ensuring the robustness and credibility of the study's results.

Philosophical Standpoint

The philosophical approach guiding this study is pragmatic, which is flexible and not confined to any single philosophical system or reality. Pragmatism is well-suited for mixed-methods research as it allows researchers to draw on both quantitative and qualitative assumptions (Creswell, 2016). According to Creswell, pragmatism supports an adaptable approach to inquiry, endorsing methods that are deemed most suitable for investigating the research questions rather than adhering to rigid methodologies. In this study, the pragmatic perspective necessitates a mixed-methods approach to thoroughly examine the accessibility and availability of healthcare facilities in Konjyosom Rural Municipality, Lalitpur, Nepal. Specifically, quantitative methods are used to explore the current state of healthcare access and identify barriers and challenges, while qualitative methods such as interviews and focus group discussions are employed to uncover potential solutions and gather subjective experiences. This pragmatic stance acknowledges the complexity of the research topic and underscores the

importance of using a flexible and comprehensive methodological approach to effectively address the study's objectives.

Research Design

The research design for this study was mixed. The study, focusing on assessing the accessibility and availability of healthcare facilities in Konjyosom Rural Municipality, Lalitpur, Nepal, used a mixed approach. This approach combined quantitative and qualitative research methods to provide a comprehensive understanding of the healthcare landscape in the selected area. Quantitative data were collected through surveys and statistically analyzed to quantify the extent of accessibility and availability issues. On the other hand, qualitative data were collected through interviews and focus group discussions with local people, healthcare providers, and stakeholders to gain insight into the factors that affected the primary factors affecting the accessibility and availability of healthcare services. This combined approach allowed for a more comprehensive examination of the research problem, thereby improving the certainty and depth of research results.

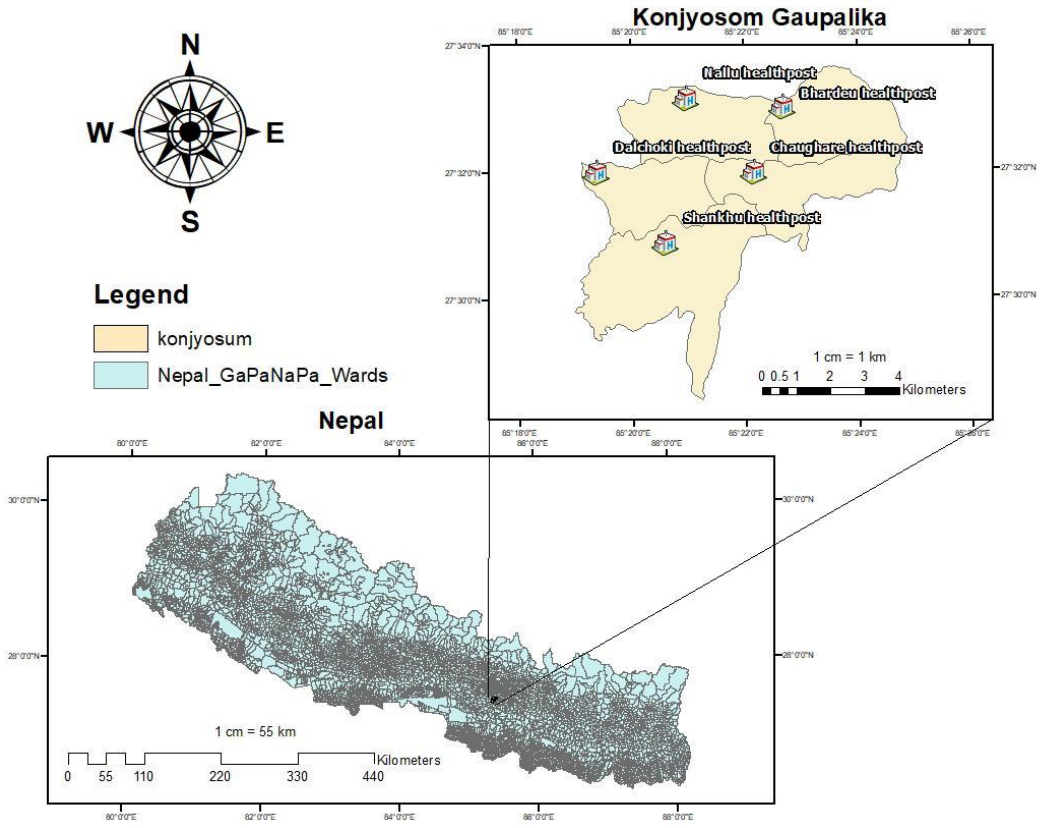
Rational of Study Area Selection

Study area of this research is Konjyosom Rural Municipality of Lalitpur. Konjyosom Rural Municipality is a Rural Municipality in Lalitpur District in Bagmati Province of Nepal that became established in 2017 by merging the previous Village development committees Shankhu, Dalchoki, Chaughare, Nallu and Bhardev. The middle of this rural municipality is placed at Chaughare. The fundamental ethnic organization of this rural municipality are Tamang. The name Konjyosom itself manner Gautama Buddha in Tamang language. In keeping with 2021 Nepal census, Konjyosom has a population of 8989. The reason for choosing Konjyosom Rural Municipality in Lalitpur, Nepal as the study area for this research

dissertation lies in its importance as a representative rural area facing challenges related to regarding the accessibility and availability of health facilities. This particular site selection was motivated by the need to address the severe health care disparities prevalent in remote rural areas, where vulnerable populations often face severe challenges in accessing and accessing essential health services. Focusing on the Konjyosom RM, the aim to obtain information that can inform policy interventions and health resource allocation strategies, thereby contributing to improved access and provide care in similarly underserved rural areas, both in Nepal and around the world.

Figure 2

Location Map of Konjyosom Rural Municipality, Lalitpur



Nature and Source of Data

The nature of the data for this study was qualitative and quantitative. They were gathered from both primary and secondary sources. The primary data were gathered through visual observation, scheduled interview surveys, and group discussions. Secondary data were collected through official documents, newspapers, journals, documentaries, annotated bibliographies, and books.

Universe, Sampling Procedure and Sample Size

The universe/population of this study was the residents of Konjyosom Rural Municipality. The sample design of the research study was also mixed, i.e., purposive sampling for qualitative tools and simple random sampling for the quantitative. According to this purposive sampling design, respondents were selected based on the objective of the study. In the case of the quantitative (survey) method, there was simple random sampling. Both the qualitative and quantitative data were collected using the appropriate techniques and tools.

As per the National Population and Housing Census, 2021 data; there were altogether 2142 households located in Konjyosom RM. By applying this formula;

$$\text{Sample size} = \frac{\frac{z^2 \times p\,(1-p)}{e^2}}{1 + \left(\frac{z^2 \times p\,(1-p)}{e^2 N}\right)}$$

In the given scenario:

The z-score, denoted as "z", is equal to 1.96 at a 95 percent confidence level.

The margin of error, denoted as "e", is 5 percent.

The population size, denoted as "N", is 2142.

The estimated population proportion, denoted as "p̂", is 0.5, representing 50percent.

By utilizing the aforementioned formula and substituting the provided values, the resultant calculated sample size is **326**.

Data Collection Methods Techniques and Tools

During the field visit, the database of households from every ward of the respective rural municipality was obtained. For this proposed study, the primary data collection tools and the sampling design based on specific research objectives were summarized in Table 1 and discussed in detail in the following sections.

During study, the research design employed was mixed, combining both quantitative (QUAN) and qualitative (Qual) approaches. This approach aimed to capture both subjective and objective realities, perceptions, experiences, and practices related to the accessibility and availability of healthcare in Konjyosom Rural Area, Lalitpur, Nepal. The scientific tools used for qualitative data collection included Observation/Field Notes, conducted during field visit. Two Focus Group Discussions (FGDs) were conducted, each with eight participants. One took place in the Palika office, and the other was held at Shankhu Health post. Additionally, Key Informant Interviews (KIIs) were conducted with a total of ten participants. For quantitative data, a household survey was conducted, involving 326 households in the selected area. The households for the survey were purposively selected, and if any person in the chosen household was not available, survey team moved on to the next immediate household. Surveyors' team made sure to consider households proportionately from each ward. The survey took place between June and July of 2023, and researcher pre-tested the questionnaire and checklist before heading out to the field.

Table 1

Summary of Methodological Approach Adopted for the Study

The approach and design	**Rationality and operationalization**	
Research design: Mixed (QUAN-Qual)	Subjective and objective realities, perceptions, experiences and practices.	
Scientific tools to be employed		
Qualitative	Observation/Field Notes	1
	FGDs	2
	KIIs	10
Quantitative	Household survey	326

Qualitative tools

The following qualitative tools, along with an open-ended questionnaire, were employed to collect primary data.

1) **Key Informants Interviews-KIIs**

Key social leaders, health professionals, and local elected representatives were included in the Key Informant Interview (KII) sessions due to their critical roles within the community. Their positions enable them to offer comprehensive insights into the challenges and needs of local health facilities. A total of ten KIIs were conducted to ensure a diverse range of viewpoints, thereby achieving a robust understanding of the local context.

2) Focus Group Discussions (FGDs)

In this study, the aim was to conduct focused group discussions (FGDs) based on a specified checklist to obtain greater depth, detail, and interactive information on different health-related aspects of people residing in the study area. The researcher prepared agreed-upon tools and a checklist to carry out focus group discussions with the selected/identified respondents. The individuals selected for the FGDs were specifically chosen due to their representation of households with direct experience of severe health problems. This unique positioning allowed them to provide firsthand insights into the challenges and benefits associated with the available health facilities in the local area. A total of two FGDs were conducted in public places involving eight number of local people in each group.

3) Field observations and notes

The observations made during the field visits, focus group discussion, and key informant interview promptly noted in the field notes.

Quantitative tools

The researcher took sample size of at least 10 percent of total households in the study area i.e., 326 households. Rural families in need of health services were purposively chosen as the sample for the household survey. The survey was administered using a standard, structured, and closed-ended questionnaire designed to align with the research objectives.

Data Analysis Plan and Procedure

The findings were interpreted based on different techniques of data collection. Computers and other tools of data analysis were used to process the data in an academic manner. Other processes like editing, coding, processing, and tabulation were also followed for the analysis of data using statistical tools from the Statistical Package for the Social

Sciences (SPSS) or Microsoft EXCEL, and relevant data were presented with the help of Tables, charts, and graphs. The qualitative data were analyzed by transcribing and coding the thematic words/issues.

Reliability and Validity

In the research dissertation on "Accessibility and Availability of Healthcare Facilities in Konjyosom Rural Urban Area, Lalitpur, Nepal," concepts of reliability and validity ratio were crucial to ensuring robustness in the mixed approach. Reliability, referring to the consistency and stability of data collected through quantitative and qualitative methods over time and from different observers, was achieved by using structured surveys and interviews, maintaining a standardized set of questions, and implementing rigorous data collection procedures to minimize measurement error. Validity, concerned with the accuracy and appropriateness of the methods used to assess the accessibility and availability of healthcare in Konjyosom, was enhanced by collating data from various sources, including local health records, government reports, and community stories, to verify results and ensure a comprehensive understanding of the healthcare context. By ensuring both reliability and validity, the research aimed to provide a robust and reliable analysis of the accessibility and availability of healthcare in rural urban areas.

Methods of Data Analysis and Interpretation

In this study on “Accessibility and Availability of Healthcare Facilities in Konjyosom Rural Area, Lalitpur, Nepal”, a mixed methods approach was used to investigate comprehensively the multifaceted nature of access to health care in the region. The research uses both quantitative and qualitative data collection methods to gain a comprehensive understanding of the problem.

Quantitative data, collected through surveys and questionnaires, are analyzed using statistical tools such as SPSS and Excel to quantify and measure key indicators related to availability and accessibility access to health care services. On the other hand, qualitative data collected through interviews and focus group discussions provides valuable insights and stories from local people, healthcare providers and stakeholders. The integration of these two types of data allows for a richer interpretation of the results, allowing a more comprehensive assessment of the health care situation in the Konjyosom Rural Municipality.

Ethical Consideration

Ethical considerations played a crucial role in the social science research (Kumar, 2005). In adherence to research principles, ethical clearance was obtained from the prestigious university and offices. The research process ensured respect for the reasonable expectation of privacy, dignity, and freedom for all people directly or indirectly involved. Specifically, the following ethical strategies were empirically followed: informed consent; principles of child protection, gender-responsive behavior, and 'Do No Harm'; use of respectful language and building good personal rapport with politeness and trust; following personal dignity and mutual respect; avoiding plagiarism; respecting the culture of the research participants; ensuring confidentiality (secrecy and anonymity) of the data; and adopting COVID-19 safety protocols.

Novelty and Contribution of the Study in Disciplinary Areas

The research on the "Accessibility and Availability of Health Care Facilities in Konjyosom Rural Municipality, Lalitpur, Nepal" makes a significant contribution to the field of healthcare accessibility in rural areas, particularly in the context of Nepal. This study is novel in its focus on a specific rural municipality, shedding light on the unique challenges and opportunities faced by this region. It seeks to bridge the gap in existing literature by providing a

comprehensive assessment of healthcare facility accessibility and availability in a specific geographic area, enabling policymakers, healthcare providers, and researchers to gain valuable insights into the dynamics of healthcare provision in rural Nepal. Furthermore, by conducting an in-depth analysis of the factors influencing accessibility and availability, this research aims to offer practical recommendations for improving healthcare infrastructure and delivery in similar rural settings, ultimately contributing to the enhancement of healthcare outcomes and the overall well-being of rural populations in Nepal and beyond.to the field of healthcare accessibility in rural areas, particularly in the context of Nepal.

Chapter IV

Accessibility and Availability of Healthcare Facilities

Socio-economic Characteristics of the Study area

Under this sub-chapter, an examination of various aspects has been conducted, encompassing the geographic location of the study area, demographic structure, occupations, literacy status, household amenities, including health, hygiene, and sanitation practices, as well as trends in energy consumption, among other factors. Essentially, this subchapter serves to illuminate the socio-economic landscape of the particular study area.

Geographical Setting

Konjyosom Rural Municipality (RM) is one of the local levels out of 753 LGs in Nepal. It is located in the Lalitpur district of Bagmati Province. It covers a diverse geographical area that includes hills, valleys, and plains. The RM is named by the Tamang people and the name Konjyosom itself means Gautam Buddha in Tamang Language. The region is known for its scenic beauty, with lush green landscapes and panoramic views of the surrounding hills and mountains. Agriculture is the backbone of the local economy, with residents engaged in farming activities such as rice, maize, millet, and vegetable cultivation. The RM is also home to a culturally diverse population, with various ethnic groups residing in the area. Physical infrastructure, education, and healthcare services are some of the key priorities for Konjyosom RM, as it aims to improve the living standards and overall well-being of its residents. The total population of Konjyosom is 8989 and 2145 families are residing in an area of 44.18 km^2.

Settlement Pattern

The settlement patterns in Konjyosom RM of Lalitpur district are characterized by a combination of dispersed and clustered settlements. The RM consists of several villages and

toles (small neighborhood) scattered across its diverse geographical terrain. Even though administratively the study area is divided into five wards, various clusters of the houses in the RM can be grouped into sub settlements. In the hilly areas, settlements tend to be dispersed, with houses and farms spread out across the slopes. This pattern reflects the agricultural nature of the region, where families cultivate their own land and rely on subsistence farming. In the valleys and plains, on the other hand, settlements are often clustered closer together, forming small villages or market centers. The settlement patterns are influenced by factors such as access to water sources, agricultural land, basic services and transportation routes.

Overall, the settlement patterns in Konjyosom RM reflect the harmonious integration of human settlements with the natural environment, while also promoting social cohesion and economic activities within the local community. Majority of households are generally made of Mud bonded bricks/ stone and Cement bonded bricks/ stone in outer wall. Mostly the roof of houses is made of Galvanized sheet and Reinforced Cement Concrete. Likewise, the foundation of houses is Mud bonded bricks/stone, Cement bonded bricks/ stone and Reinforced Cement Concrete with pillars.

Households by Type of Foundation of Housing Unit

The total households of all wards combined is 2142, with the 1434 households indicating the number of structures built using mud-bonded bricks/stone, 594 using cement-bonded bricks/stone, 57 using Galvanized sheet and 36 using wooden pillars. The Table 2 provides information about the households and types of foundations in the Konjyosom RM in Lalitpur district.

Table 2

Households by Type of Foundation of Housing Unit

Ward	Total	Mud bonded bricks/ stone	Cement bonded bricks/ stone	Reinforced Cement Concrete with pillars	Wooden pillars	Other
	2142	1434	594	57	36	21
1	436	155	260	7	3	11
2	434	357	47	19	10	1
3	281	245	34	1	1	0
4	508	308	170	22	6	2
5	483	369	83	8	16	7

Source: NPHC, 2021.

Households by Material Used for Outer Walls of Housing Unit

Out of a total of 2142 households, 1534 have outer walls made of mud-bonded bricks/stone, 540 have cement-bonded bricks/stone, 7 have wood/planks, 3 have unbaked bricks, and 58 have galvanized sheets. Table 3 provides information about the type of materials used for the outer walls of households in different wards of Konjyosom RM.

Table 3

Households by Material Used for Outer Walls of Housing Unit

All Wards	**Total**	**Mud bonded bricks/ stone**	**Cement bonded bricks/ stone**	**Wood / planks**	**Bamboo**	**Unbaked bricks**	**Galvanized sheet**
	2142	1534	540	7	0	3	58
1	436	268	153	0	0	0	15
2	434	359	65	3	0	0	7
3	281	243	35	0	0	0	3
4	508	308	191	0	0	1	8
5	483	356	96	4	0	2	25

Source: NPHC, 2021.

Demography of Konjyosom RM

The age and gender structure of a population is a significant demographic factor that influences migration patterns. The significance of age and gender structure extends beyond demographic analysis and also impacts various aspects of a country's socio-economic and developmental planning. The distribution of males and females within a community influences social and economic relationships. This has a direct connection with social roles, cultural patterns, labor force participation, and the occupational makeup of a community (Subedi 1993).

According to census record (2021), it has 8989 population and 2145 households. The population of male and female is 48.9 percent and 51.07 percent respectively. Of the total

population age group (15-19) has highest population (929) of person in the Konjyosom RM. The later age group, i.e. (20-24) has second higher population (863). Likewise, the age group (25-29) and (10-14) are the third and fourth higher groups having 835 and 826 populations respectively. The age group (95 over) covers only 2 people of the total population.

Table 4

Age and Sex Wise Population Composition

Age group in years	**Population**		
	Total	**Male**	**Female**
Total	**8989**	**4398**	**4591**
00-04 Yrs.	614	321	293
05-09 Yrs.	739	370	369
10-14 Yrs.	826	410	416
15-19 Yrs.	929	467	462
20-24 Yrs.	863	443	420
25-29 Yrs.	835	382	453
30-34 Yrs.	638	306	332
35-39 Yrs.	642	306	336
40-44 Yrs.	630	309	321
45-49 Yrs.	500	222	278
50-54 Yrs.	477	235	242
55-59 Yrs.	355	174	181
60-64 Yrs.	327	165	162

Age group in years	Population		
	Total	Male	Female
65-69 Yrs.	262	137	125
70-74 Yrs.	161	69	92
75-79 Yrs.	110	51	59
80-84 Yrs.	43	17	26
85-89 Yrs.	26	9	17
90-94 Yrs.	10	5	5
95+ Yrs.	2	0	2

Source: NPHC, 2021.

Number of Households, Population by Sex, Average Household Size and Sex Ratio

The population distribution according to the ward wise gender and household is given in the Table. As observed from the average household size is 4.20. The sex ratio is the ratio of total males to females which found to be 95.80. According to the census data 2021 there are 2145 households and 8989 total populations where there are 4591 females and 4398 males in this study area.

Table 5

Number of Households, Population by Sex, Average Household Size and Sex Ratio

Wards	Number of households	Population			Average household size	Sex ratio
		Total	Male	Female		

Total	2142	8989	4398	4591	4.20	95.80
1	436	1942	946	996	4.45	94.98
2	434	1801	882	919	4.15	95.97
3	281	1075	530	545	3.83	97.25
4	508	2134	1071	1063	4.20	100.75
5	483	2037	969	1068	4.22	90.73

Source: NPHC, 2021

A query was made regarding the age of the respondents and categorized into different age groups. Ages above 18 were considered when administering the structured questionnaire to respondents in the sampled households. The majority of respondents fell within the range of 35 to 60, indicating a higher level of active participation from individuals in the productive age group during the survey.

Table 6

Age Group of the Respondents

Age group	Number	Percent
18-24 years	13	3.99
25-34 years	42	12.88
35-44 years	113	34.66
45-59 years	131	40.18
60 and above	27	8.28
Total	**326**	**100.00**

Source: Field Survey, 2023.

The primary focus of the research was to investigate the accessibility and availability of healthcare facilities in Konjyosom RM. In conducting household surveys and Focused Group Discussion (FGD), the researcher sought to gather relevant information from women's groups, considering that women in households are often the primary recipients of health-related challenges. However, the local context presented a different scenario. In many instances, women were preoccupied with household chores, rendering them unavailable to respond to survey questions. This was attributed to their perceived shyness and a prevailing social perception that male members are responsible for dealing with outsiders and managing overall external activities.

Notably, despite the researcher being a local resident, a majority of respondents were male. This skewed gender distribution, with only 17.18 percent of respondents being female, can be attributed to societal norms and constructions that influence the roles and responsibilities assigned to different genders.

Table 7

Gender of Respondents

Gender of respondents	Number	Percent
Male	270	82.82
Female	56	17.18
Total	**326**	**100.00**

Source: Field Survey, 2023.

In the survey, respondents were queried about their marital status, revealing that the majority (92.64 percent) were married. A small percentage, specifically 0.92 percent,

reported being unmarried, while 0.61 percent indicated they were divorced or separated. Additionally, 5.83 percent identified as widows or widowers.

This distribution suggests that the majority of respondents were mature and responsible individuals, likely possessing a comprehensive understanding of local development activities. This demographic also demonstrated an ability to respond to questions regarding the accessibility and availability of healthcare facilities in Konjyosom RM.

Table 8

Marital Status of Respondents (Household Survey)

Marital status	**Number**	**Percent**
Unmarried	3	0.92
Married	302	92.64
Widow/Widower	19	5.83
Divorced/separated	2	0.61
Total	**326**	**100.00**

Source: Field Survey, 2023.

The notion that “small is beautiful” resonates, and the survey aimed to explore the family size of the sampled households. The findings revealed that the majority (87.42 percent) of households consisted of 1 to 4 members, while 12.58 percent had more than 4 members in their family. This suggests that a significant portion of families in the area adheres to a nuclear family structure, with fewer opting for a joint family arrangement.

The average family size indicates a positive correlation with aspects such as health education, family planning, and social awareness, aligning with the slogan "two children are

the gift of God." This observation underscores the influence of these factors in shaping family dynamics in the study area.

Table 9

Family Size Group

Size	Number	Percent
1-4 member	285	87.42
More than 4 members	41	12.58
Total	**326**	**100.00**

Source: Field Survey, 2023.

Caste/Ethnic composition

The ethnic composition of Konjyosom RM is diverse, encompassing various caste and ethnic groups. Caste rules have historically played a significant role in shaping cultural values, occupations, marriage practices, food habits, and other social behaviors within the community.

According to the *Census report of 2021*, the Tamang ethnic group constitutes the highest proportion of the total population, accounting for 79.8percent. Following closely, the Brahmin caste makes up the second-largest group with 10.8 percent of the population. The third and fourth highest proportions are attributed to the Chhetri ethnic group at 2.4percent and the Magar ethnic group at 2.1percent respectively. It is notable that Tamang and Brahmin communities are more abundant in the study area, while Ghale and Pariyar communities have the least representation in terms of percentage residing in Konjyosom RM. This diverse ethnic composition highlights the cultural richness, social dynamics and challenges within the community.

In the survey, it was found that 23.31 percent of respondents belonged to either Brahman or Chhetri families, categorized as upper-class castes. The majority of respondents, however, were from the Janajati group, a trend consistent with the national census database for the particular study area. Interestingly, 3.37 percent of respondents belonged to the socially disadvantaged group, known as the Dalit community, and were included for survey purposes.

This ethnic composition highlights the heterogeneous nature of society, even though the Tamang community predominates in Konjyosom RM. It underscores the diversity within the region, with representation from various ethnic and social groups.

Table 10

Distribution of Surveyed Households by Caste/Ethnicity

Ethnicity	**Number**	**Percent**
Brahman/Chhetri	76	23.31
Janajati	239	73.31
Dalit	11	3.37
Total	**326**	**100.00**

Source: Field Survey, 2023.

Literacy status

Knowing how well people can read and write is really important. In this area, a lot of people can read and write, which is better than the average for the whole country. Figuring out how educated people are in Konjyosom RM area helps us understand how much schooling the local folks have. This analysis is instrumental in gauging the impact of literacy on employment opportunities and financial prosperity. When more people can read and write, they usually have better chances of finding good jobs and making more money, especially in rural areas. Being

able to read and write is important for everything in people's lives, including how they are seen in society.

Table 11

Ward wise Literacy status of Konjyosom Rural Municipality

Wards	Sex	Population aged 5 years & above	Population who			Not stated	Literacy Rate
			Can read & write	Can read only	Can't read & write		
	Total	8375	6192	3	2180	0	73.93
	Male	4077	3340	2	735	0	81.92
	Female	4298	2852	1	1445	0	66.36
1							
	Total	1820	1538	0	282	0	84.51
	Male	895	792	0	103	0	88.49
	Female	925	746	0	179	0	80.65
2							
	Total	1681	1261	3	417	0	75.01
	Male	820	684	2	134	0	83.41
	Female	861	577	1	283	0	67.02
3							
	Total	1009	701	0	308	0	69.47
	Male	491	386	0	105	0	78.62

Wards	Sex	Population aged 5 years & above	Population who			Not stated	Literacy Rate
			Can read & write	Can read only	Can't read & write		
	Female	518	315	0	203	0	60.81
4							
	Total	1971	1404	0	567	0	71.23
	Male	983	796	0	187	0	80.98
	Female	988	608	0	380	0	61.54
5							
	Total	1894	1288	0	606	0	68.00
	Male	888	682	0	206	0	76.80
	Female	1006	606	0	400	0	60.24

Source: NPHC, 2021.

The Table 11 above highlights a breakdown of the population aged 5 years and above in each ward of Konjyosom RM, based on their literacy rates and ability to read and write. In all wards shared, out of 8375 people, 6192 individuals can read and write, while 3 can only read, and 2180 cannot read or write. The overall literacy rate is 73.93 percent. Among the 4298 female population, 2852 can read and write, yielding a literacy rate of 66.36percent. The literacy rates and abilities to read and write vary across the different wards, with Ward 1 having the highest literacy rate of 84.51percent and Ward 5 having the lowest rate of 68.00 percent.

In the Nepalese context, a distinct disparity exists in literacy rates between males and females, a trend that is also reflected among the surveyed households. Table 12, illustrates the literacy status of respondents, outlines the educational distribution based on the respondents' gender.

Remarkably, a higher percentage of males exhibit various levels of educational attainment compared to their female counterparts. For instance, the completion of higher grades, such as Class 5, Class 8, Class 10, and beyond, is more prevalent among males. On the other hand, a significant proportion of females are represented in the categories of non-formal education and never having attended school. This data highlights the existing gender-based educational gap, with a need for targeted efforts to address and promote equitable educational opportunities for both genders in Konjyosom RM.

Table 12

Literacy Status of Respondents

Education Level	Sex of respondents				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Started school, but not completed grade 1	0	0.00	3	0.92	3	0.92
Class 1 completed	3	0.92	0	0.00	3	0.92
Class 2 completed	6	1.84	1	0.31	7	2.15
Class 3 completed	22	6.75	2	0.61	24	7.36
Class 4 completed	4	1.23	1	0.31	5	1.53
Class 5 completed	42	12.88	9	2.76	51	15.64
Class 6 completed	11	3.37	1	0.31	12	3.68

Education Level	Sex of respondents				Total	
	Male		Female			
	Number	Percent	Number	Percent	Number	Percent
Class 7 completed	1	0.31	2	0.61	3	0.92
Class 8 completed	38	11.66	4	1.23	42	12.88
Class 9 completed	1	0.31	1	0.31	2	0.61
Class 10 completed	21	6.44	4	1.23	25	7.67
Class 11 completed	1	0.31	0	0.00	1	0.31
Class 12 completed	11	3.37	3	0.92	14	4.29
Bachelors completed	15	4.60	1	0.31	16	4.91
Master and above	1	0.31	1	0.31	2	0.61
Non-formal education	17	5.21	11	3.37	28	8.59
Never attended school	76	23.31	12	3.68	88	26.99
Total	**270**	**82.82**	**56**	**17.18**	**326**	**100.00**

Source: Field Survey, 2023.

In the general trend, individuals from the upper-class Brahman and Chhetri communities exhibit higher levels of education compared to those from other castes. Historically, there existed a division of labor or occupation structure based on education levels. The study site location proximity to the Kathmandu Valley contributes to a higher literacy rate, particularly among the Janajati group. Interestingly, the percentage of individuals from the Dalit community who have never attended school appears higher compared to upper-class families.

Table 13, illustrates the literacy levels of respondents across different castes, provides a detailed breakdown. It reveals that individuals from the upper-class Brahman and Chhetri

communities have a more significant representation in higher education levels, such as completion of Class 8 and beyond. This nuanced analysis provides insights into the educational dynamics within the various caste groups in the study area.

Table 13

Literacy Level of Respondents According to their Ethnicity

Caste / **Education**	**Upper class (Brahman/Chhetri)**		**Dalit**		**Janajati**		**Total**	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Started school, but not completed grade 1	0	0.00	0	0.00	4	1.67	4	1.23
Class 1 completed	0	0.00	0	0.00	3	1.26	3	0.92
Class 2 completed	3	3.95	0	0.00	4	1.67	7	2.15
Class 3 completed	5	6.58	2	18.18	16	6.69	23	7.06
Class 4 completed	0	0.00	0	0.00	6	2.51	6	1.84

Caste / Education	Upper class (Brahman/Chhetri)		Dalit		Janajati		Total	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Class 5 completed	13	17.11	1	9.09	31	12.97	45	13.80
Class 6 completed	1	1.32	0	0.00	8	3.35	9	2.76
Class 7 completed	0	0.00	0	0.00	3	1.26	3	0.92
Class 8 completed	14	18.42	0	0.00	26	10.88	40	12.27
Class 9 completed	0	0.00	0	0.00	2	0.84	2	0.61
Class 10 completed	7	9.21	0	0.00	17	7.11	24	7.36
Class 11 completed	0	0.00	0	0.00	1	0.42	1	0.31
Class 12 completed	4	5.26	0	0.00	11	4.60	15	4.60
Bachelors completed	6	7.89	0	0.00	8	3.35	14	4.29

Caste / Education	Upper class (Brahman/Chhetri)		Dalit		Janajati		Total	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Master and above	0	0.00	0	0.00	1	0.42	1	0.31
Non-formal education	6	7.89	1	9.09	23	9.62	30	9.20
Never attended school	17	22.37	7	63.64	75	31.38	99	30.37
Total	**76**	100.00	**11**	**100.00**	**239**	**100.00**	**326**	**100.00**

Source: Field Survey, 2023.

Table 14 depicts the number of children who died categorized by the age group of mothers and their literacy or educational attainment. In the specified different age groups, a total of 119 children were reported as deceased. Among mothers who were illiterate or could not read and write, a total of 59 children died, with varying numbers in different age groups. Mothers with literacy skills had a total of 60 children reported as deceased, with distribution across different educational levels. The Table 14 provides a detailed breakdown, including early childhood education, primary education, lower secondary, upper secondary, and higher education levels. Additionally, it accounts for cases where the educational level is not stated or where mothers never attended school.

Table 14 *Number of children died born by age group of mothers*

Literacy/ Educational attainment	Total children died	Number of children died born by age group of mothers						
		15 - 19	20 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49
Total	**119**	**0**	**1**	**13**	**10**	**23**	**30**	**42**
Illiterate	59	0	1	4	3	15	17	19
Can't read and write	59	0	1	4	3	15	17	19
Literate	60	0	0	9	7	8	13	23
Early childhood education (0)	2	0	0	0	0	1	0	1
Primary (1-5)	39	0	0	5	4	5	8	17
Lower secondary (6-8)	11	0	0	3	3	0	2	3
Upper Secondary (9-10)	4	0	0	0	0	1	3	0
Intermediate & equiv.	1	0	0	1	0	0	0	0
No level	3	0	0	0	0	1	0	2

Source: NPHC, 2021.

Occupational structure

Occupation depends on people life styles and their expenditure in their day-to-day life. The occupational structure of Konjyosom RM in Lalitpur district comprises a diverse range of occupations. Agriculture plays a significant role in the economy of Konjyosom RM. Farmers engage in cultivating crops such as rice, maize, millet, wheat, and various vegeTables. They are also be involved in horticulture, growing fruits and cash crops. Livestock farming, including cattle, poultry, and goat rearing, is another important aspect of the occupational

structure in rural areas. Apart from agriculture, small-scale businesses and trade activities contribute to the local economy. These include small shops, grocery stores, tea shops, and local markets where residents purchase essential items and daily needs. The composition and distribution of occupations is influenced by factors such as geographical location, availability of resources, market demand, and individual preferences.

In Konjyosom RM, the occupational structure varies across different wards. Agriculture is the predominant occupation, having the highest number of individuals engaged in agricultural activities (3469), followed by Elementary Workers (688) and Craft related trade workers (255). Professional work is limited (150). Overall, the occupational structure in Konjyosom RM is characterized by a significant reliance on agriculture, a substantial student population, a mix of job holders.

Table 15

Occupational Structure in Konjyosom RM

Sex and occupation	**All ages**	**Age group**											
		10-14 Yrs	15 - 19 Yrs	20-24 Yrs	25 - 29 Yrs	30-34 Yrs	35-39 Yrs	40-44 Yrs	45-49 Yrs	50-54 Yrs	55-59 Yrs	60-64 Yrs	65 Yrs >
Total	**5207**	**143**	**260**	**566**	**722**	**593**	**592**	**576**	**456**	**429**	**299**	**243**	**328**
Armed forces	19	0	0	2	2	5	4	6	0	0	0	0	0
Managers	114	0	1	9	16	18	17	20	12	6	5	6	4
Professionals	150	0	2	14	31	31	23	22	12	10	3	1	1
Technicians and associate professional	55	0	3	15	13	8	6	1	1	4	1	2	1

Office assistance	48	0	4	7	14	7	6	2	6	1	1	0	0
Service & sale workers	228	0	3	27	34	39	30	31	19	13	15	6	11
Skilled agri., forestry & fishery workers	3469	9	103	315	475	386	409	413	347	344	242	198	228
Craft and related trades workers	255	0	4	38	42	31	42	34	22	24	10	4	4
Plant & machine operators & assemblers	176	0	7	35	40	28	25	20	12	7	1	1	0
Elementary workers	688	134	133	102	54	40	30	26	25	20	21	24	79
Occupation not stated	5	0	0	2	1	0	0	1	0	0	0	1	0

Source: NPHC, 2021.

In addition to examining the occupational structure within Konjyosom RM, the study delved into identifying the primary occupations of the surveyed families. Table 14 outlines the major sources of income, with some households providing multiple responses. Notably,

agriculture and livestock emerge as the predominant sources of income, constituting 65.31 percent of the surveyed households. Other significant contributors include business (8.57 percent), service-related activities (6.53 percent), and daily wage labor (6.94 percent). Remittances also play a substantial role, accounting for 7.76 percent of the surveyed households' income. This comprehensive analysis reveals the diverse economic activities within the region, offering valuable information for understanding the socio-economic landscape of Konjyosom RM. It can be observed that foreign employment is on an upward trend in the local context.

Table 16

Main Occupation of Surveyed Households

Major sources of income	**Number**	**Percent**
Agriculture/Livestock	320	65.31
Horticulture	14	2.86
Business	42	8.57
Trade	5	1.02
Service	32	6.53
Daily wage/Labour	34	6.94
Pension	4	0.82
Remittance	38	7.76
Occupational job	1	0.20
Tourism related	0	0.00

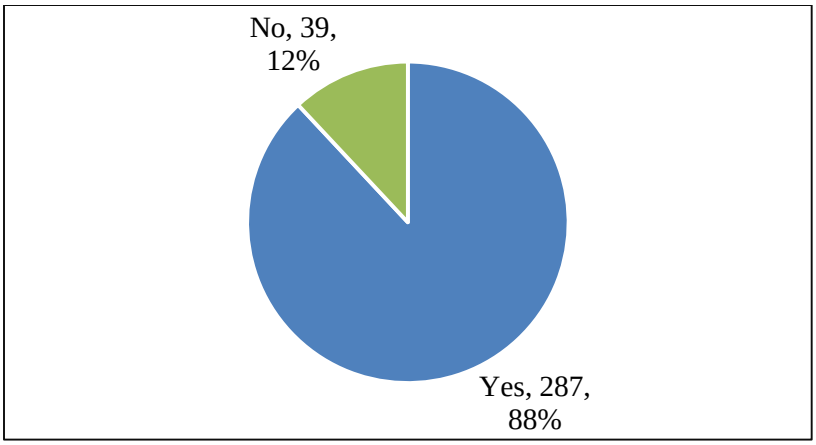
Source: Field Survey, 2023.

Food sufficiency status

The adequacy of food within a household is crucial for maintaining family health and overall living standards. Given that the majority of surveyed households are involved in the agriculture sector, it is reasonable to infer that the food sufficiency status among local inhabitants is relatively favorable. Out of the total 326 surveyed households, 287 respondents asserted that they have sufficient food throughout the year through self-production. However, 39 respondents indicated experiencing a deficit in food sufficiency, relying on external sources to meet their nutritional needs. This insight into the food sufficiency dynamics within the community emphasizes the importance of local agricultural practices in sustaining the well-being of households.

Figure 3

Food Sufficiency Status of Surveyed Households



Source: Field Survey, 2023.

A follow-up inquiry was posed to respondents experiencing year-round food insufficiency. In common practice, those with insufficient agricultural production are often marginalized individuals without land for cultivation. These individuals must rely on the produce of others or explore various sources of income to secure their food supply.

Table 17 delineates the arrangements made by households facing chronic food scarcity over a 12-month period. The data reveals that a fraction of respondents' alternative to seeking loans (2 households, 0.61percent), while others depend on support from relatives or gifts (1 household, 0.31percent). Additionally, a portion options to borrowing (3 households, 0.92percent), and a notable number engage in wage labor within their village, either living at home (17 households, 5.21percent) or not (16 households, 4.91percent). In total, these strategies collectively represent the diverse measures undertaken by 39 households, constituting 11.96percent of the surveyed population, to address their prolonged struggle with food insecurity.

Table 17

Arrangement for Households Do Not Have Enough to eat for 12 Months

Household food security	**Number**	**Percent**
By seeking loan	2	0.61
Asking/received from relatives/gifts etc	1	0.31
By borrowing	3	0.92
Wage labor in the village (living at home)	17	5.21
Wage labor (not living at home)	16	4.91
Total	**39**	**11.96**

Source: Field Survey, 2023.

Economically active population in Konjyosom RM

The presented Table 18 portrays a comprehensive overview of the population distribution across various wards, categorized by gender and economic activity status, among individuals aged 10 years and above. The data has been meticulously segmented into several

key classifications, including "Economically Active," "Not Economically Active," "Economic Activity Not Stated," "Usually Active," "Not Usually Active," "Employed," and "Unemployed." This tabular representation enables an in-depth exploration of the socio-economic dynamics within the study area.

The Table 18 encompasses a total of five wards, with each ward further subdivided by gender (male and female). The demographic distribution is detailed across the following economic activity classifications: "Economically Active," "Not Economically Active," "Economic Activity Not Stated," "Usually Active," "Not Usually Active," "Employed," and "Unemployed." It is evident that the total population aged 10 years and above within the study area is 7636. Out of this total population, 4303 individuals are classified as Economically Active, 192 as Not Economically Active, and 896 as having Economic Activity Not Stated. Additionally, the data reveals that 2243 individuals are Usually Active in economic endeavors, while 2 individuals are Not Usually Active. Moreover, the population engaged in employment comprises 2243 individuals, whereas 896 individuals are unemployed.

Table 18

Economically Active Population in Konjyosom RM

Wards	Sex	Total Population 10 Yrs. and above	Economic Activity Performed				
			Economically Active			Not Economically Active	Economic Activity Not Stated
			Usually, Active		Not Usually Active		
			Employed	Unemployed			
	Total	7636	4303	192	896	2243	2
	Male	3707	2257	83	382	983	2
	Female	3929	2046	109	514	1260	0
1							

Wards	Sex	Total Population 10 Yrs. and above	Economic Activity Performed				
			Economically Active			Not Economically Active	Economic Activity Not Stated
			Usually, Active		Not Usually Active		
			Employed	Unemployed			
	Total	1645	1105	4	128	408	0
	Male	814	560	3	67	184	0
	Female	831	545	1	61	224	0
2							
	Total	1551	862	16	269	402	2
	Male	751	442	7	110	190	2
	Female	800	420	9	159	212	0
3							
	Total	935	611	12	65	247	0
	Male	454	302	7	31	114	0
	Female	481	309	5	34	133	0
4							
	Total	1802	886	137	210	569	0
	Male	895	502	49	94	250	0
	Female	907	384	88	116	319	0
5							
	Total	1703	839	23	224	617	0
	Male	793	451	17	80	245	0
	Female	910	388	6	144	372	0

Source: NPHC, 2021.

Living standards are greatly influenced by household income because it controls both spending and a range of activities. Recognizing the inherent difficulty in gathering correct data, particularly in rural settings where people are frequently unwilling to share financial details, the study set out to determine the annual income of the surveyed families. The complicated relationship between social standing and income levels creates a psychological barrier to disclosure.

It is noteworthy that the income estimates are mostly based on perceptions of respondents and lack accurate information. The Table explains the distribution of household incomes per annum, showcasing a range from 75,000 to 1,50,000 NPR with 1 household (0.31percent), 1,50,000 to 3,00,000 NPR with 21 households (6.44 percent), 3,00,001 to 1,50,000 NPR with 28 households (8.59 percent), and more than 5,00,000 NPR with 276 households (84.66 percent). These findings, derived during the field survey, provide understandings into the economic landscape of the surveyed population.

Table 19

Household Income Per Annum

Tentative annual Income NPR	**Number**	**Percent**
75,000-1,50,000	1	0.31
1,50,000-3,00,000	21	6.44
3,00,001-1,50,000	28	8.59
More than 5,00,000	276	84.66
Total	**326**	**100.00**

Source: Field Survey, 2023.

As mentioned earlier, 7.76 percent of the surveyed households were identified as being primarily reliant on remittances. Out of the total 326 households, 54 are recipients of remittances from various countries. Enhanced remittance inflows have the potential to contribute significantly to improved livelihoods, particularly in terms of access to better health facilities. A higher income level enables more frequent hospital visits for regular checkups and treatments, thereby positively impacting overall healthcare. The acknowledgment of this financial support from remittances highlights the broader implications for the well-being and healthcare options of the surveyed population.

Table 20

Surveyed Households Receiving Remittances in the Past 12 Months

Remittance	**Number**	**Percent**
Yes	54	16.56
No	272	83.44
Total	**326**	**100.00**

Source: Field Survey, 2023.

Main Source of drinking Water

Out of a total of 2142 households, 2024 HHs used Tap/piped water (within premises), 104 used Tap/piped water (outside premises) 6 HHs used the water from the covered well, 2 HHs used uncovered well, 5 HHs spout water and 1 HH used other source of drinking water. Majority of the HHs used Tap/piped water (within premises). Table 4 provides information about the Main source of drinking water used by households in different wards of Konjyosom RM.

Table 21

Sources of Drinking Water

All Wards	**Total**	**Tap/piped water (within premises)**	**Tap/piped water (outside premises)**	**Tube well/ hand pump**	**Covered well/Kuwa**	**Uncovered well/Kuwa**	**Spout water**	**Others**
	2142	2024	104	0	6	2	5	1
1	436	350	80	0	2	0	4	0
2	434	433	1	0	0	0	0	0
3	281	274	4	0	3	0	0	0
4	508	494	13	0	0	1	0	0
5	483	473	6	0	1	1	1	1

Source: NPHC, 2021.

In addition to gathering data on the RM level, the household survey also aimed to identify sources of drinking water. The results reveal that a significant majority, comprising 99.39 percent of households, relies on piped water for their drinking needs. A small fraction, constituting 0.61 percent of respondents, reported using spout water for drinking purposes. The choice of water source is pivotal, as the quality of water consumed directly influences family health and susceptibility to related diseases. This underlines the critical importance of understanding and ensuring access to safe and clean drinking water for the overall well-being of the local people.

Table 22

Main Source of Drinking Water for Surveyed Households

Source of water	**Number**	**Percent**

Tape/pipe	324	99.39
Spout water	2	0.61
Total	**326**	**100.00**

Source: Field Survey, 2023.

Type of Cooking Fuel

The analysis of the Table reveals significant variations in energy source preferences across different wards. Ward 1, with a total of 436 households, predominantly relies on wood/firewood (368 households) and LPG (66 households) for energy. A minimal utilization of other sources, such as biogas and kerosene, is observed, highlighting the limited diversity in energy choices within this ward. In Ward 2, with 434 households, a stark contrast is evident, as a majority (390 households) opt for LPG as the primary energy source, reflecting a shift towards cleaner and more convenient energy options. Electricity consumption is negligible in this ward, signaling potential disparities in infrastructure. Ward 3, characterized by 281 households, displays a prevalence of wood/firewood (228 households) usage, with a minimal presence of other energy sources. This pattern indicates a reliance on traditional energy sources, possibly influenced by socio-economic factors. Ward 4, housing 508 households, showcases a distinctive reliance on wood/firewood (268 households) and LPG (239 households). The presence of electricity as a minor energy source might suggest an ongoing transition towards modern energy solutions. Ward 5, accommodating 483 households, exhibits a balanced utilization of energy sources. The biogas usage is observable in 4 households, indicating a nascent adoption of sustainable alternatives.

Table 23

Use of Cooking Fuels at Household Level

All Wards	Total Household	Wood/ firewood	LPG	Electricity	Biogas	Others
	2142	1614	521	2	4	1
1	436	368	66	1	0	1
2	434	390	44	0	0	0
3	281	228	53	0	0	0
4	508	268	239	1	0	0
5	483	360	119	0	4	0

Source: NPHC, 2021.

In the course of the household survey, a substantial proportion (54.29 percent) of households were found to be utilizing LPG gas for cooking purposes, while only 0.92 percent rely on biogas systems as their primary cooking fuel source. Despite the GoN efforts, as outlined in the Biomass Energy Strategy 2017, and various plans and programs to promote clean cooking technologies with at least tier 3 classification to all households by 2030, a significant 44.79 percent of rural families in the adjoining villages of the Kathmandu valley continue to predominantly use fuelwood. This reliance poses a challenge, especially considering the alarming issue of indoor air pollution, identified as one of the most significant health risks in Nepal. Smoke deriving from traditional Cookstoves using firewood contributes to chronic and acute health effects, leading to severe consequences such as child pneumonia, lung cancer, chronic obstructive pulmonary diseases, and heart diseases.

The SDG Status and Roadmap: 2016-2030 report by the National Planning Commission emphasizes the importance of SDG 7, which focuses on universal access to affordable, reliable, sustainable, and modern energy. Prioritizing the promotion of Cookstoves from tier 3 to tier 5 is crucial for achieving SDG targets and reducing health issues related to indoor air pollution in local rural contexts. Both the GoN and its development partners should give priority to these efforts for the overall well-being of the population.

Table 24

Primary Cooking Fuel at the Surveyed Households

Fuel Type	**Number**	**Percent**
Fuelwood	146	44.79
LPG Gas	177	54.29
Biogas	3	0.92
Total	**326**	**100.00**

Source: Field Survey, 2023.

Women emerge as the primary victims of indoor air pollution in the kitchen, given their role as the primary cooks in households. This exposure is not only confined to women; it extends to children who are directly associated with their mothers, rendering them susceptible to the possibility of suffering from diseases linked to indoor air pollution. The placement of the kitchen within households also plays a significant role in mitigating health problems associated with indoor air pollution.

Table 25 provides insight into the distribution of kitchen locations in surveyed households. Of the total 326 households, 51.84 percent have kitchens located inside the house but lack a separate kitchen room, while 41.41 percent have kitchens situated inside the house but with a

designated separate space. A smaller percentage, 6.75 percent, have kitchens located in a completely separate house. Understanding these dynamics is crucial for implementing strategies that not only address indoor air pollution but also consider the well-being of the primary cooks, particularly women, and their children within the household context.

Table 25

Placement of the Kitchen in surveyed households

Kitchen location	**Number**	**Percent**
Inside the house but not having a separate kitchen room	169	51.84
Inside the house but with a separate kitchen	135	41.41
In a separate house	22	6.75
Total	**326**	**100.00**

Source: Field Survey, 2023.

Main Source of lighting

The analysis of the data reveals absorbing patterns in household main source of lighting. Ward 1 demonstrates a notable reliance on electricity, with 430 out of 436 households utilizing this source. Solar power usage is relatively minor across all wards, but it is noticeable in Wards 2, 4, and 5, with 3 to 6 households adopting this renewable option.

Kerosene usage appears insignificant across all wards, indicating a shift away from this less sustainable energy source. Ward 4 stands out with four households still utilizing kerosene. Biogas, an emerging alternative, is employed by a limited number of households in Ward 4 (3 households). Ward 5 exclusively relies on electricity and solar power, with no utilization of kerosene, biogas, or other alternatives.

The "other" category, encompassing miscellaneous energy sources, is minimal across the dataset, with only three households falling within this category. This underscores the dominance of the primary energy sources, particularly electricity, within the context of household energy consumption.

Table 26

Main Source of Lighting

Wards	Total Household	Electricity	Solar	Others
Total	2142	2121	18	3
1	436	430	6	0
2	434	431	3	0
3	281	279	2	0
4	508	501	4	3
5	483	480	3	0

Source: NPHC, 2021.

During the survey, it was observed that almost all households use national grid electricity. However, a few households opt for solar home systems (SHS) as an alternative source of lighting. In addition to providing lighting, the available electricity is utilized for mobile charging, television watching, internet use, and other relevant activities.

Type of Toilets Used

Across all wards, a total of 139 households have access to flush toilets connected to public sewerage, whereas 1700 households use flush toilets with septic tanks. Pit toilets are used by 287 households, public toilets serve 4 households, and 12 households lack any toilet facility. In Ward 1, out of 436 households, 6 have flush toilets connected to public sewerage, 421 use

flush toilets with septic tanks, 4 use pit toilets, 2 use public toilets, and 3 households lack toilet facilities. Ward 2 exhibits a higher proportion of households with access to flush toilets connected to public sewerage (51 out of 434), while Ward 3 presents a unique scenario with 92 households utilizing pit toilets, reflecting disparities in sanitation facilities. Ward 4 demonstrates a distribution skewed towards flush toilets with septic tanks (312 households), followed by 184 households using pit toilets. Ward 5 displays a balanced distribution across flush toilets with septic tanks (406 households) and pit toilets (7 households).

Table 27

Type of Toilets Used

Wards	Total Household	Flush toilet (public sewerage)	Flush toilet (septic tank)	Pit toilet	Public toilet	Without toilet facility
Total	2142	139	1700	287	4	12
1	436	6	421	4	2	3
2	434	51	383	0	0	0
3	281	8	178	92	0	3
4	508	9	312	184	0	3
5	483	65	406	7	2	3

Source: NPHC, 2021.

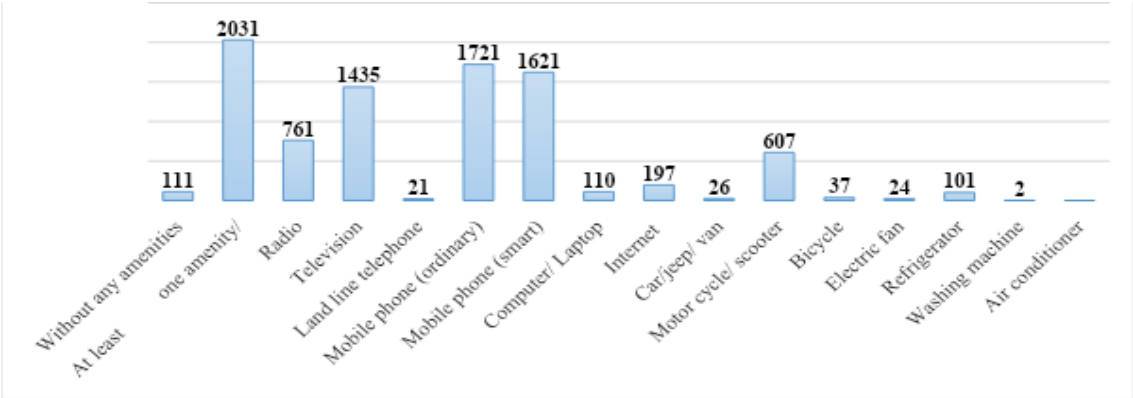
Type of household amenities/assets

Out of 2142 households in Konjyosom RM, 2031 HHs have at least one household amenities in their house. Likewise, 1435 HHs have television, 1721 have mobile phone (ordinary) and 1621 have smart phone. 607 HHs have motorcycle and 197 HHs have internet

facility. Out of total household 2142 only 2 households have washing-machine and no any household have air conditioner. In total there is no any facility in 111 household of Konjyosom RM.

Figure 4

Types of Household Amenities/Assets



Source: NPHC, 2021.

During the survey, respondents were queried about household amenities and assets, highlighted on the prevailing practices in the rural vicinity. The results, as presented in Table 28, depicted the widespread use of electricity or solar power, with a substantial 99.08 percent of households having access to this essential resource. Mobile phones, a ubiquitous element in modern communication, are notably prevalent, with 95.71 percent of households possessing them. The high number of motorbikes among respondents' families serves as an interesting indicator for well-established road connections in rural areas, contributing to enhanced mobility. Beyond the basics, the data also reflect the adoption of modern technologies, such as televisions (76.38 percent), tape recorders (19.94 percent), computers (6.44 percent), and internet facilities (15.34 percent). While cars and refrigerators show lower ownership rates at 7.98 percent and 4.60 percent, respectively, the prevalence of these assets indicates a gradual

integration of modern conveniences in rural households. Furthermore, the possession of cycles and other vehicles, including trucks and buses, is evident, signifying a diverse range of transportation options within the surveyed population. Overall, the survey provides valuable insights into the distribution and adoption of various amenities and assets in the rural context.

Table 28

Number of households by Amenities/Assets Used

Household Assets	Number	Percent
Electricity/Solar	323	99.08
Television	249	76.38
Tape Recorder	65	19.94
Telephone	5	1.53
Mobile	312	95.71
Refrigerator	15	4.60
Computer	21	6.44
Internet Facility	50	15.34
Car	26	7.98
Motor Cycle	153	46.93
Cycle	25	7.67
Other Vehicles (Truck, Bus)	14	4.29

Source: Field Survey, 2023.

Religion of surveyed households

According to the National Population Census, Hinduism remains the predominant religion in the country, encompassing 81.19 percent of the total population, which translates to 23.67

million out of 29.16 million people. Although there has been a slight decrease of 0.11 percent in the Hindu population compared to 2011, it still constitutes the majority. Buddhism, on the other hand, has seen a decrease of approximately 0.79 percent, with 2.393 million people, or 8.21 percent of the population, adhering to the faith. In the surveyed area, as mentioned earlier, the majority of households (61.96 percent) belong to the Tamang Janajati and follow Buddhism. A smaller percentage, 3.68 percent, identifies as Christian, while 34.36 percent adhere to Hinduism as their primary religion. These findings provide a comprehensive overview of the religious landscape, reflecting changes in religious demographics over time.

Table 29

Religion of Surveyed Households

Religion	**Number**	**Percent**
Hindu	112	34.36
Buddhist	202	61.96
Christian	12	3.68
Total	**326**	**100.00**

Source: Field Survey, 2023.

Types of disability at Konjyosom RM

Table 30 presents data on the types of disabilities within the Konjyosom RM, categorized by age groups. The total population surveyed is 8,989, with various types of disabilities identified, including physical disabilities, low vision, blindness, deafness, hard of hearing, deaf-blindness, speech impairment, psycho-social disability, intellectual disability, hemophilia, autism, and multiple disabilities. The Table also shows the population without disabilities and

those where disability status was not stated. The data provides valuable insights into the prevalence of different disabilities across age groups within the study area.

Table 30

Type of Disability in Konjyosom RM

Age group in Yrs.	Total Population	Type of disability										Population without disability
		Physical	Low vision	Blind	Deaf	Hard of hearing	Speech impairment	Psycho-social disability	Intellectual disability	Autism	Multiple disability	
Total	8989	103	22	9	19	10	9	6	3	2	23	8783
00 - 04 Yr	614	2	0	3	0	0	0	0	0	0	0	609
05 - 09 Yr	739	3	0	2	2	1	0	0	1	0	0	730
10 - 14 Yr	826	1	2	0	0	0	1	0	0	0	1	821
15 - 19 Yr	929	3	0	1	0	0	1	2	0	0	2	920
20 - 24 Yr	863	5	2	0	0	1	1	0	1	0	2	851
25 - 29 Yr	835	6	0	1	2	1	1	1	0	0	0	823
30 - 34 Yr	638	6	0	0	0	2	1	0	0	0	0	629
35 - 39 Yr	642	8	0	0	0	3	0	0	0	1	1	629
40 - 44 Yr	630	10	2	1	0	0	0	1	0	0	0	616
45 - 49 Yr	500	9	3	0	2	0	2	0	0	0	2	482
50 - 54 Yr	477	14	2	0	3	1	0	0	0	1	1	455
55 - 59 Yr	355	17	0	0	2	0	0	0	0	0	0	336
60 - 64 Yr	327	5	5	0	1	0	2	0	0	0	2	312
65 - 69 Yr	262	4	3	0	3	0	0	0	1	0	4	247
70 - 74 Yr	161	5	2	1	0	1	0	1	0	0	4	147
75+ Yr	191	5	1	0	4	0	0	1	0	0	4	176

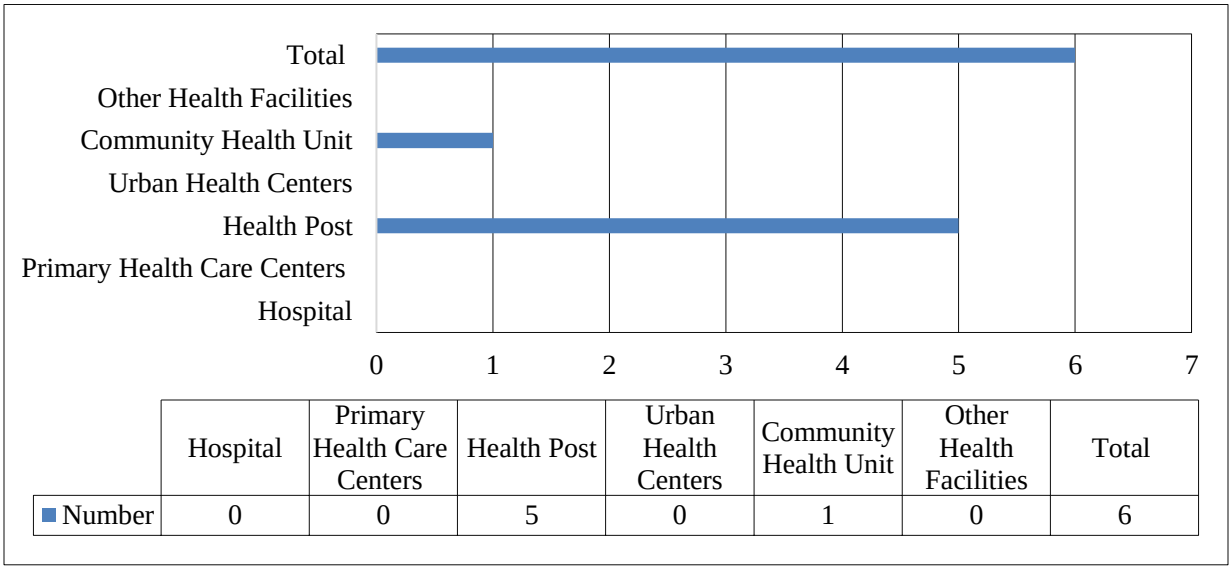
Source: NPHC, 2021.

Overview of Healthcare Facilities in Konjyosom Rural Municipality

There are five health posts in each ward of Konjyosom Rural Municipality. Moreover, there is a health service unit within the RM office. In addition to this, there is one community-level health unit that also serves the rural population. This sub-chapter highlights the overall healthcare facilities and their access and availability at the local level.

Figure 5

Number of Health Facilities in Konjyosom Rural Municipality



	Hospital	Primary Health Care Centers	Health Post	Urban Health Centers	Community Health Unit	Other Health Facilities	Total
Number	0	0	5	0	1	0	6

Source: Field Survey, 2023.

Health conditions of the respondents

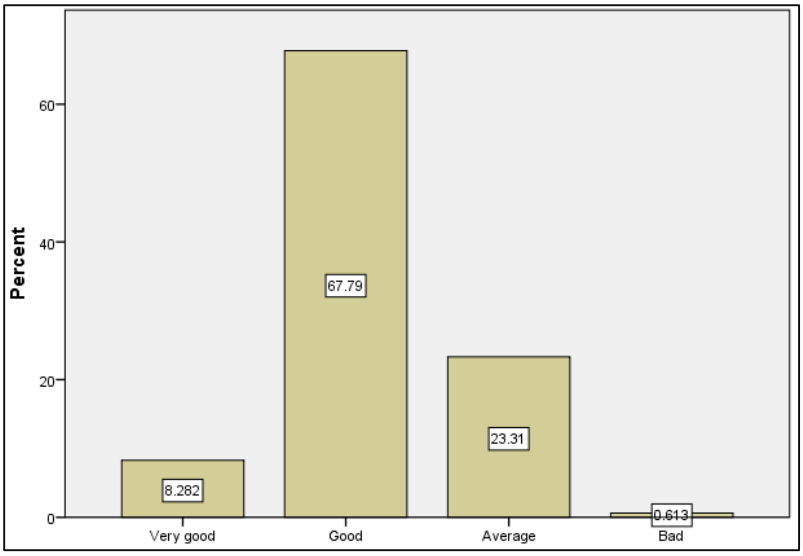
Before probing into health-related inquiries, the researcher and survey team initiated the questionnaire by addressing the overall health conditions of the respondents. A noteworthy 8.28 percent of respondents asserted that they enjoy excellent health, devoid of any serious health issues, as evidenced by their lack of visits to healthcare facilities up to the date of the field survey. The majority, constitutes 67.79 percent of respondents, expressed their health condition as good. Similarly, 23.31 percent of respondents rated their health as average,

attributing this to occasional struggles with short-term viral infections or other diseases. On the other hand, a minimal 0.61 percent of respondents reported having poor health due to the presence of long-term diseases.

In summary, the overall health conditions of the respondents appear to be quite satisfactory, with a majority reporting good or very good health.

Figure 6

Overall Health Conditions of the Respondents



Source: Field Survey 2023

A follow-up question regarding the health status of their families was asked to the respondents. The majority (87.73 percent) of respondents were found to be confident that there was no recent serious illness in their families, whereas 12.27 percent of respondents expressed concern about their family members having a recent serious illness. The perceptions of their family's health provide valuable information regarding the prevalence of health concerns and the overall well-being of the surveyed population.

Table 31

Recent Serious Illness in Surveyed Families

Illness	Number	Percent
Yes	40	12.27
No	286	87.73
Total	**326**	**100.00**

Source: Field Survey, 2023.

Respondents were asked an additional question concerning child mortality within surveyed households over a 36-month period. Table 32 outlines the responses, revealing that 7.98 percent of surveyed families experienced child mortality, while the majority, accounting for 92.02 percent, did not encounter such unfortunate circumstances. This data highlights on the prevalence of child mortality within the surveyed population, providing valuable insights for understanding and addressing factors contributing to child health and well-being.

Table 32

Child Mortality in Surveyed Families Over 36 Months

Child Mortality	Number	Percent
Yes	26	7.98
No	300	92.02
Total	**326**	**100.00**

Source: Field Survey, 2023.

Health status of surveyed families

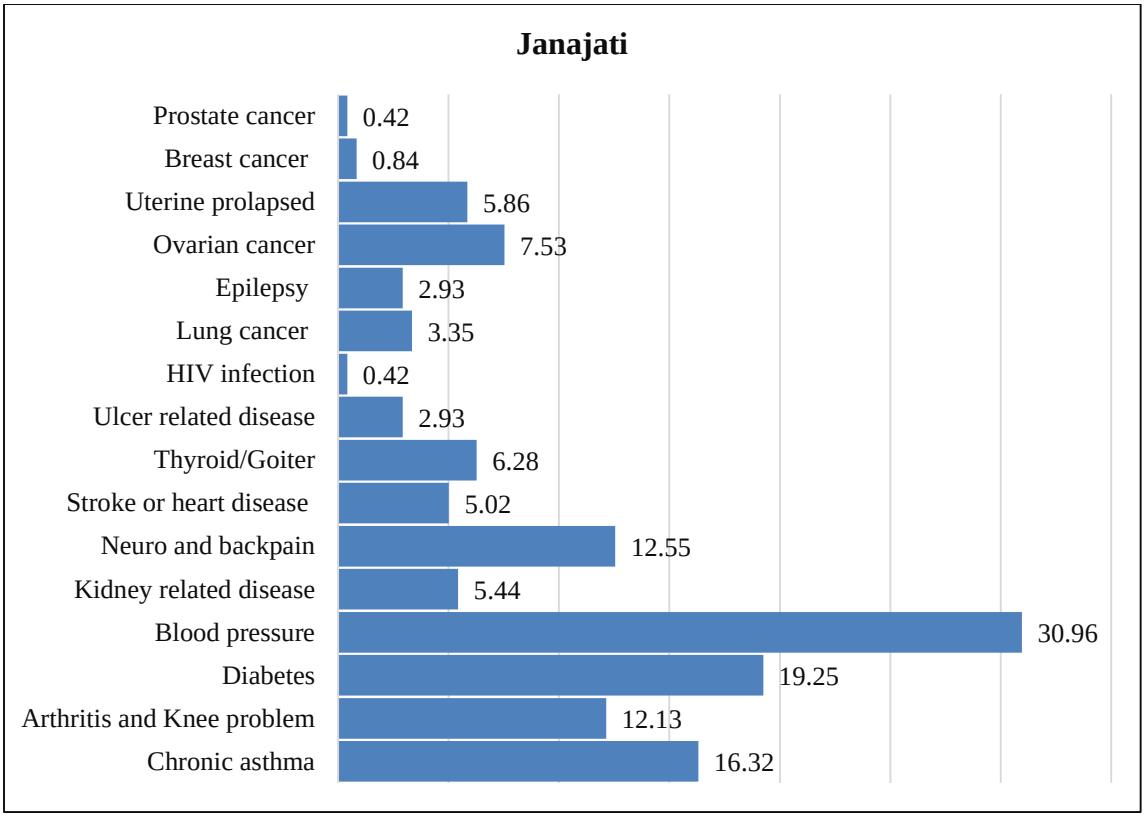
Throughout the survey, the researcher attempted to capture the information on the health challenges faced by family members due to various diseases. Recognizing the diversity in food

habits, living standards, and cultural norms among different castes in rural society, the study took into account these variations. The research probed into the health status of specific communities, including the Janajati group, upper-class families, and socially disadvantaged groups, both as individual entities and within an integrated approach. By adopting this nuanced approach, the study aimed to provide a comprehensive understanding of the health dynamics within the surveyed population, considering the unique factors influencing different segments of the community.

The Figure 7 presents a comprehensive overview of health conditions within the Janajati community i.e., ethic people, with a focus on specific diseases. Chronic asthma is prevalent among 16.32 percent of individuals, followed by arthritis and knee problems affecting 12.13 percent. Diabetes is reported in 19.25 percent of cases, while blood pressure conditions are notably higher at 30.96 percent. Kidney-related diseases are observed in 5.44 percent of individuals, and neuro and back pain affect 12.55 percent. A smaller percentage, 5.02, reports stroke or heart diseases. Thyroid/goiter conditions are seen in 6.28 percent, while ulcer-related diseases are reported in 2.93 percent. HIV infection is minimal at 0.42 percent. Lung cancer is observed in 3.35 percent, and epilepsy affects 2.93 percent. Gynecological conditions include ovarian cancer (7.53 percent), uterine prolapse (5.86 percent), breast cancer (0.84 percent), and prostate cancer (0.42 percent). This detailed breakdown provides valuable insights into the health profile of the Janajati community, highlighting the prevalence of various diseases within the surveyed inhabitants.

Figure 7

Health Status of Janajati Families



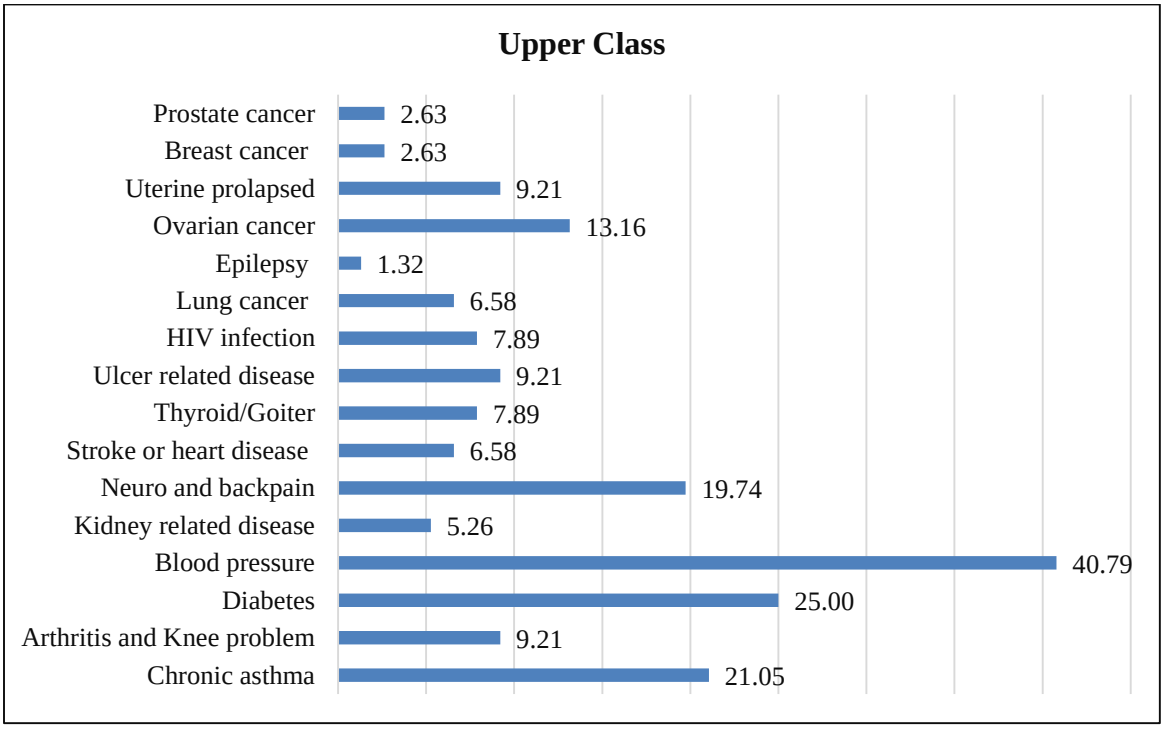
Source: Field Survey, 2023.

The Figure 8 also provides a detailed breakdown of health conditions within the upper-class demographic, offering insights into the prevalence of various diseases. Chronic asthma affects 21.05 percent of individuals, while arthritis and knee problems are reported in 9.21 percent. Diabetes is observed in 25.00 percent, and a significant 40.79 percent report blood pressure conditions. Kidney-related diseases are observed in 5.26 percent, and neuro and back pain affect 19.74 percent. Stroke or heart diseases are reported in 6.58 percent. Thyroid/goiter conditions are seen in 7.89 percent, and ulcer-related diseases affect 9.21 percent. HIV infection is noted in 7.89 percent. Lung cancer is observed in 6.58 percent, and epilepsy affects

1.32 percent. Gynecological conditions include ovarian cancer (13.16 percent) and uterine prolapse (9.21 percent). Breast cancer and prostate cancer are each reported in 2.63 percent of cases. This comprehensive overview elucidates the health profile of the upper-class demographic, showcasing the prevalence of various diseases within the surveyed residents.

Figure 8

Health Status of Upper-class Caste Families

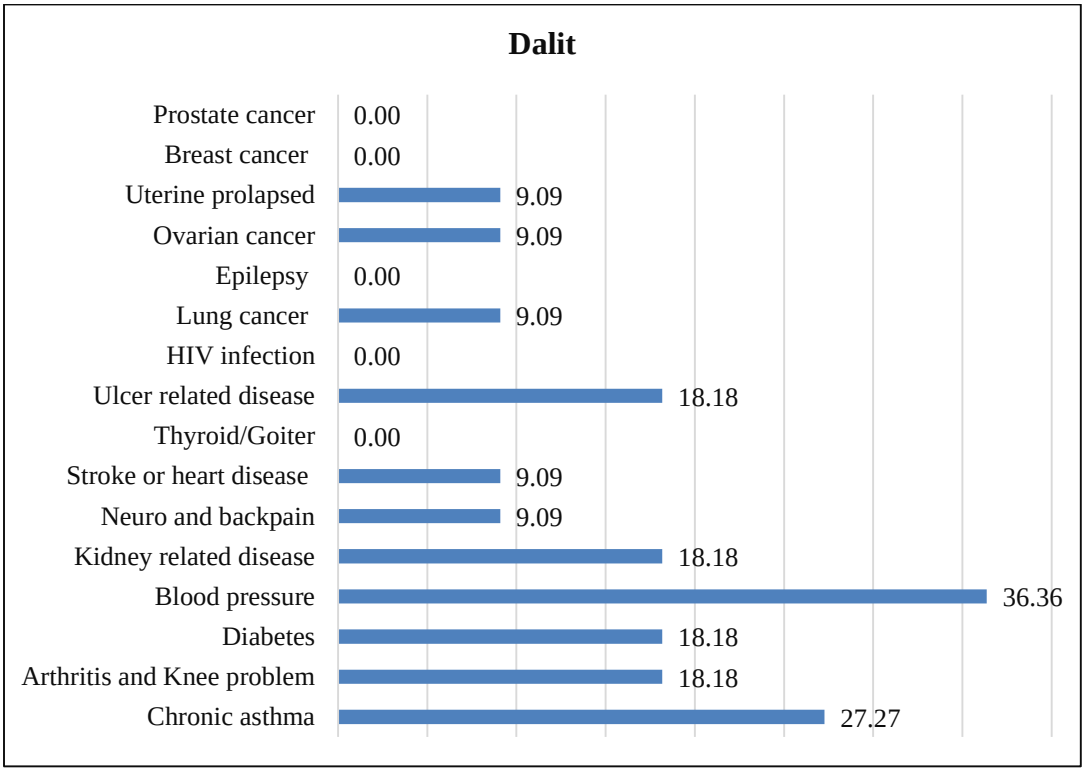


Source: Field Survey, 2023.

Similar to the Janajati and Upper-class caste groups, Figure 8 offers a detailed overview of health conditions within the Dalit community, providing insights into the prevalence of various diseases. Chronic asthma affects 27.27 percent of individuals, while arthritis and knee problems are reported in 18.18 percent. Diabetes and kidney-related diseases are each observed in 18.18 percent, and blood pressure conditions are prevalent in 36.36 percent of cases. Neuro and back pain, stroke, and heart diseases are each reported in 9.09 percent. Ulcer-related

diseases, lung cancer, ovarian cancer, uterine prolapse, and epilepsy are each observed in 18.18 percent. Notably, thyroid/goiter, HIV infection, breast cancer, and prostate cancer are not reported within this demographic. This comprehensive overview provides a valuable understanding of the health profile of the Dalit community among the surveyed households in Konjyosom RM.

Figure 9 *Health Status of Social Disadvantages Caste Families*



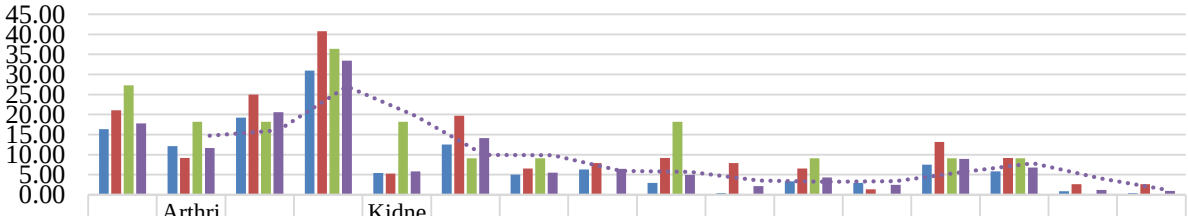
Source: Field Survey, 2023.

The Figure 10 provides a comprehensive comparison of health conditions across different caste groups, namely Janajati, Upper Class, and Dalit, within the surveyed households in Konjyosom Rural Municipality. Chronic asthma is prevalent among 17.79 percent of the total population, with Janajati reporting 16.32 percent, Upper Class at 21.05 percent, and Dalit at 27.27 percent. Arthritis and knee problems affect 11.66 percent overall, with Janajati at 12.13

percent, Upper Class at 9.21 percent, and Dalit at 18.18 percent. Diabetes is reported in 20.55 percent overall, with Janajati at 19.25 percent, Upper Class at 25.00 percent, and Dalit at 18.18 percent. Diabetes with the Upper Caste is slightly higher than other caste group which support for the local folk slogan "*Jaha guliyo tyaha Bahun bhuliyo"*. Blood pressure conditions are prevalent in 33.44 percent overall, with Janajati at 30.96 percent, Upper Class at 40.79 percent, and Dalit at 36.36 percent. The figure below provides a detailed breakdown of various health conditions, offering a valuable understanding of the health profile across different caste groups in the surveyed population.

Figure 10

Sufferings of Family Members from Various Diseases Over Time



	Chronic asthma	Arthritis and Knee problem	Diabetes	Blood pressure	Kidney related disease	Neuro and backpain	Stroke or heart disease	Thyroid/Goiter	Ulcer related disease	HIV infection	Lung cancer	Epilepsy	Ovarian cancer	Uterine prolapsed	Breast cancer	Prostate cancer
Janajati	16.32	12.13	19.25	30.96	5.44	12.55	5.02	6.28	2.93	0.42	3.35	2.93	7.53	5.86	0.84	0.42
Upper Class	21.05	9.21	25.00	40.79	5.26	19.74	6.58	7.89	9.21	7.89	6.58	1.32	13.16	9.21	2.63	2.63
Dalit	27.27	18.18	18.18	36.36	18.18	9.09	9.09	0.00	18.18	0.00	9.09	0.00	9.09	9.09	0.00	0.00
Total	17.79	11.66	20.55	33.44	5.83	14.11	5.52	6.44	4.91	2.15	4.29	2.45	8.90	6.75	1.23	0.92

Source: Field Survey, 2023.

Current Healthcare Practices in Konjyosom RM

During the survey, respondents were queried about their preferred healthcare service facilities, and the majority indicated a preference for nearby health posts. A noteworthy 83.4 percent of respondents reported visiting health posts, emphasizing their significance as a primary healthcare resource in the community. However, 10.4 percent mentioned hospitals as

their most visited facility, reflecting a diverse healthcare landscape. It is interesting to note that 5.8 percent of respondents still opt for traditional healers, including Dhami, Jhakri, and Baidhya, indicating the persistence of traditional healing practices in the study area. The effectiveness of these traditional practitioners was highlighted by participants during the FGD.

Table 33 provides a detailed breakdown of the respondents' preferences in healthcare facilities. It shows that 10.4 percent visited hospitals, 83.4 percent favored health posts, and 5.8 percent sought the services of traditional healers. Additionally, 0.3 percent did not provide a response. These findings underline the varied healthcare choices within the community and the coexistence of traditional healing practices with modern medical facilities. Understanding these preferences is crucial for tailoring healthcare services to the needs and beliefs of the local population.

Table 33

Mostly Visited Healthcare Facility by the Respondents

Mostly Visited	**Number**	**Percent**
Hospitals	34	10.4
Health post	272	83.4
Traditional Healers	19	5.8
No response	1	0.3
Total	**326**	**100.00**

Source: Field Survey, 2023.

The survey included inquiries about the frequency of visits by the respondents or their family members to health clinics or doctors. A substantial majority, accounting for 70.55 percent, reported visiting health clinics or doctors within a one-year time frame. Another 15.95

percent indicated visiting within one to three years. Conversely, 13.50 percent (44 respondents) claimed to have visited health clinics or doctors three years or more ago. The predominant trend suggests that the majority of respondents prioritize regular health checkups, with at least one visit within a year. This indicates heightened awareness among local residents regarding the importance of regular health monitoring and a prevailing trust in modern healthcare facilities and treatments.

Table 34

Last Visit to Health Clinic or Doctor

Time duration	**Number**	**Percent**
Within one year	230	70.55
One to three years	52	15.95
More than three years	44	13.50
Total	**326**	**100.00**

Source: Field Survey, 2023.

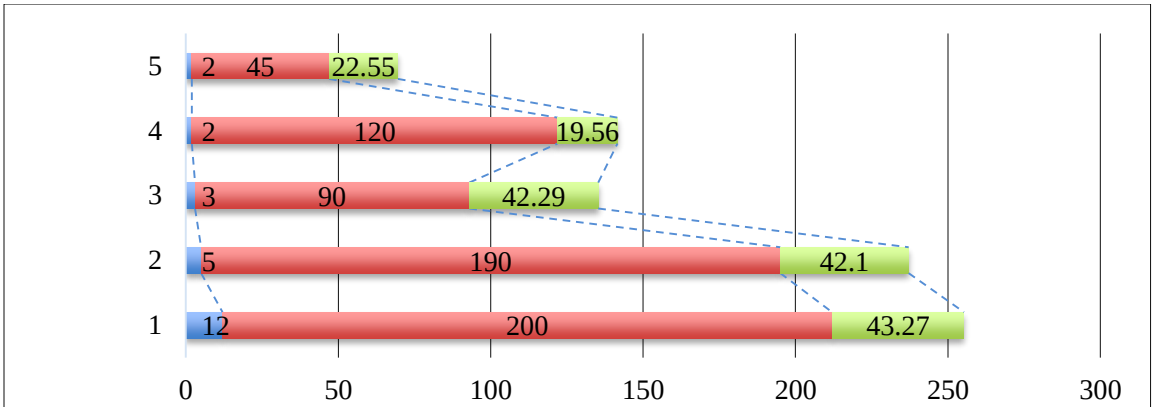
Geographical distribution of healthcare facilities

This study also explores the geographical distribution of healthcare facilities within Konjyosom RM. Understanding the spatial arrangement of healthcare resources is crucial for assessing the accessibility and availability of essential services across different areas within the study area. This study further aimed to provide a comprehensive overview of how healthcare facilities are distributed geographically, focusing on any potential disparities or gaps in access. Analyzing the geographical distribution is instrumental in formulating informed policies and strategies to ensure equitable healthcare provision, ultimately contributing to the overall well-being of the local people in Konjyosom RM.

The distance between settlements and existing healthcare facilities plays a crucial role in assessing the accessibility and availability of services in a rural context. To assess this distance, each respondent was queried about the approximate time required to reach the healthcare facility. The data collected, presented in minutes, reveals the variability across different wards within the rural municipality. In Ward No. 1, the minimum time reported was 12 minutes, with a maximum of 200 minutes and a mean time of 43.27 minutes. Similarly, in Ward No. 2, the minimum time was 5 minutes, maximum was 190 minutes, and the mean time was 42.1 minutes. Wards 3, 4, and 5 also exhibit variations in the minimum, maximum, and mean times required to reach healthcare facilities, providing a comprehensive understanding of the temporal aspects of accessibility in different areas of Konjyosom RM.

Figure 11

Average Distance to Nearest Healthcare Facility from Respondent's House



	1	2	3	4	5
Minimum	12	5	3	2	2
Maximum	200	190	90	120	45
Mean	43.27	42.1	42.29	19.56	22.55

Source: Field Survey, 2023.

Availability of transport facility in the study area

Access to roads plays a key role in ensuring better health facilities during emergencies. The surveyed data emphasizes the presence of seasonal road access, with limited transport options such as public buses and motorbikes. According to information provided by RM representatives, ongoing construction efforts aim to establish motorable roads within the catchment area of Konjyosom RM. However, during field observations and consultations, tangible progress in motorable road construction was not obvious. The quality of road facilities is directly linked to the efficient and timely delivery of health services. The challenges in road access contribute to factors such as high child mortality and other emergency-related deaths, as highlighted by FDG participants during field-level consultations. One of the participants aged 45 said

> In my personal experience, accessing public transportation has been quite a challenge. The availability of public transportation is limited, making it difficult for people in the area to travel conveniently. During the monsoon season, the condition of the roads deteriorates significantly. This not only affects the overall accessibility of public transportation but also poses a significant hurdle for anyone trying to utilize these services. The heavy rains often lead to road closures and difficult driving conditions, further hindering the use of public transportation. Moreover, the occurrence of landslides during the monsoon season creates additional difficulties. These landslides can block roads and pathways, making it nearly impossible to even reach the nearest health post in case of emergencies. The health post, which is an essential service in the area, is unfortunately not easily accessible for everyone. The journey to reach the health post takes a considerable amount of time, around 70 to 80 minutes. This can be particularly challenging for sick patients who require immediate

medical attention. The situation is even more complicated if you don't have a private vehicle like a motorbike at your disposal. One striking aspect of the area's health services is the lack of nearby pharmacies or clinics. Even basic medicines for common ailments like fever, cold, or loose motion are not readily available until one visit the health post. The health post itself has its own set of challenges. Despite the challenges, the health staff at the post have been quite helpful and friendly. Their dedication to providing medical assistance and support to the community is certainly admirable and plays a crucial role in maintaining the overall health and well-being of the local population.

The households' respondents were asked a question, inquiring about their typical mode of transportation to the nearest health care facility. The options provided included walking, bicycling, using a motorcycle, driving a car, or utilizing public transportation. The collected data revealed that a significant majority, 93.87 percent, reported walking as their primary means of transportation. Interestingly, none of the respondents chose bicycling or driving a car. However, 3.68 percent indicated using a motorcycle, and 2.45 percent reported relying on public transportation.

Table 35

Mode of transportation to nearest health care facility

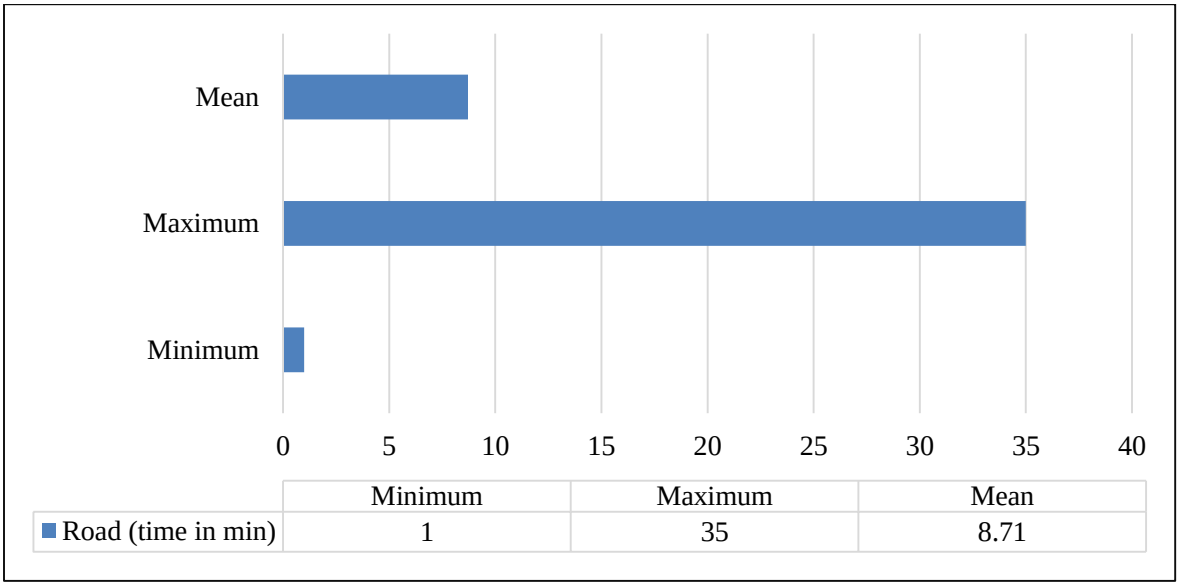
Means of transportation	**Number**	**Percent**
Walk	306	93.87
Bicycle	0	0.00
Motorcycle	12	3.68
Car	0	0.00
Public transportation	8	2.45

Source: Field Survey, 2023.

Similarly, the graph 12 presents information on the nearest road, stipulated the minimum, maximum, and mean travel times in minutes for different areas within the RM. The minimum time required to reach the nearest road is 1 minute, while the maximum is 35 minutes. The mean travel time, representing the average duration to access the nearest road, is 8.71 minutes. This data highlights the variations in travel times within the surveyed area and offers the accessibility of road infrastructure, a crucial factor influencing emergency healthcare services and overall mobility in the community.

Figure 12

Access to Road (Time in Minutes)



Source: Field Survey, 2023.

Availability of other facilities in the study area

In addition to major healthcare facilities, the study examined the availability of various social infrastructures in the study site, a crucial aspect for the overall development of the community. The data presented in Table 36 outlines the status and quantity of different facilities observed during field observations in Konjyosom RM. One ongoing 15-bedded

hospital construction was noted during the field study, indicating a current absence of this major healthcare facility. A single pharmacy was observed, providing pharmaceutical services in the area. Seventeen government-owned community schools were identified, playing a crucial role in the education infrastructure of the region. Only one private school was noted, offering an alternative educational option in the community. No college or university campus was observed during the study period. Five operational post offices were identified, contributing to postal services and communication in the community. A total of 21 milk booths were observed, catering to the dairy needs of the local population.

The study identified 42 grocery shops, serving as essential retail points for residents. No department store was observed during the field study. Eleven small market centers were identified, serving as economic hubs for local commerce and trade. One operational bus station was noted, facilitating transportation within the community. Moreover, a single bank was identified, contributing to financial services for the local people. Similarly, a total of 27 cooperatives were observed, playing a crucial role in community economic activities. No actively operational NGOs were observed during the study. One agriculture extension office was identified, providing support services to the local farming community. Eight agro-processing mills were recorded, contributing to local processing activities. The absence of paved roads was noted, indicating a potential area for infrastructure development. Unpaved seasonal roads were observed and indicated the existing status of transportation infrastructure in the community.

This comprehensive assessment provides a detailed understanding of the diverse social infrastructure within Konjyosom RM, focused on the current status and potential areas for further development of social infrastructures.

Table 36 *Availability of social infrastructure in Konjyosom RM*

Facilities	Status					Total	Remarks
	1	2	3	4	5		
Hospital		Ongoing					
Health Center	1	1	1	1	1	5	
Pharmacy				1			
Community Type School (GoN owned)	4	4	4	3	2	17	
Private School				1		1	
Post Office	1	1	1	1	1	5	
Milk Booth	4	14	6	2	3	21	
Grocery Shop	10	15	12	8	7	42	
Market	2	3	1	2	3	11	
Bus Station	1	1	1				
Bank					1	1	
Cooperatives	8	2	9		6	27	
Agriculture Extension Office		1				1	
Agro-processing mills	3	1	3		1	8	
Paved Road	No	No	No	No	No		
Unpaved Road	Yes	Yes	Yes	Yes	YES		

Source: Field Survey, 2023.

Access to finance of resident of study area

The geographical distribution of health care facilities, as highlighted in the study, illuminates the challenges and opportunities for residents to access essential health services. The varying travel times to health facilities, as well as the ongoing construction of motorable roads, highlight the importance of infrastructure development in ensuring timely access to health care. Moreover, the prevalence of different diseases among distinct caste groups emphasizes the need for targeted and culturally sensitive health interventions. However, the link between health care accessibility and financial access is a crucial aspect that requires attention. While the study identifies the presence of certain financial institutions and cooperatives, the overall linkage between health care accessibility and financial services remains an area for further exploration.

A more in-depth analysis of the economic barriers to health care, the role of insurance or financial support mechanisms, and the impact of existing financial structures on health-seeking behavior could provide valuable insights for policymakers and stakeholders. Ultimately, enhancing both the physical accessibility of health care facilities and ensuring financial inclusivity are integral components of fostering a resilient and healthy community in Konjyosom RM.

In this sub-chapter, the focus is on judicious perceptions of respondents concerning health costs, affordability, and their satisfaction with the current health care facility. The data gathered aimed to highlight the beneficiaries' perspectives on the financial aspects of healthcare, exploring issues related to the cost of services, ease of affordability, and overall satisfaction with the healthcare infrastructure. By probing into these perceptions, the study provides a nuanced understanding of the local experiences and challenges in accessing and

affording healthcare services and contributes valuable insights for potential improvements in the healthcare system in Konjyosom RM.

Health costs and affordability

The health costs and affordability of services provided by health posts in Konjyosom RM present a complex scenario. Despite the standard treatment protocol that mandates the availability of 98 types of medicines free of charge from basic hospitals/primary health centers, and basic health centers/health posts, the practical implementation falls short. Many health posts lack the necessary stock of basic medicines, leading health post officials to refer patients to private clinics or larger hospitals where the required medications might be available. This situation raises concerns about the accessibility and affordability of essential healthcare services for the local people, as they may face additional costs and potential barriers in obtaining necessary medications. Addressing these gaps in the availability of basic medicines is crucial for ensuring that health posts effectively serve their role in providing accessible and affordable healthcare to the community.

During the field survey, respondents were directly questioned about the reasons for visiting the healthcare facility and their corresponding experiences. The multiple responses were noted during the field study. Table 37 provides a comprehensive breakdown of the responses regarding these reasons. A majority of respondents, constituting 61.66 percent, cited proximity as the primary factor influencing their choice of healthcare facility. Additionally, 39.26 percent mentioned selecting a facility known for providing high-quality care, and 38.65 percent considered affordability as a decisive factor.

The familiarity with doctors or nurses working at the facility was a notable factor for 23.31 percent of respondents, and 13.19 percent mentioned that assistance from others facilitated

their access to healthcare. Similarly, the hygiene played a significant role, with 76.07 percent noted that clean restrooms influenced their decision. Other factors contributing to positive experiences included regular attendance of doctors (69.94 percent), respectful treatment of patients (64.11 percent), and reasonable expenses for received treatment (49.39 percent).

Concerns about transparency were evident, with 27.61 percent emphasizing the importance of posted and clearly explained fees ahead of time. A relatively smaller percentage, 21.78 percent, considered a short waiting period as a crucial factor. Unfortunately, a small percentage (2.76 percent) admitted to paying a bribe to receive better treatment and skip the waiting line. Furthermore, 19.33 percent valued the immediate availability of necessary medicines, and 24.85 percent reported being referred to private clinics for further tests. This detailed analysis focused on the multifaceted considerations that influence the choices and experiences of individuals when seeking healthcare in Konjyosom RM.

Table 37

Reasons for Visiting the Healthcare Facility

Reasons	**Number**	**Percent**
It was the closest facility	201	61.66
It is known for high quality care	128	39.26
It is not too expensive	126	38.65
Known doctors or nurses who work in	76	23.31
People helped to access the healthcare facility	43	13.19
The restrooms were clean	248	76.07
Doctor was regular	228	69.94

Reasons	Number	Percent
Patients were treated with respect	209	64.11
Expenses for the received treatment were reasonable	161	49.39
Fees were posted and clearly explained ahead of time	90	27.61
Waiting period is not too long	71	21.78
Paid a bribe in order to get a better treatment	9	2.76
Necessary medicines were readily available	63	19.33
Referred to a private clinic for further tests	81	24.85

Source: Field Survey, 2023.

During the survey, it was found that 86.20percent of respondents choose to visit private clinics or hospitals for their treatment. Subsequently, their satisfaction level with the costs of private healthcare facilities was assessed. Interestingly, a significant majority (49.39percent) expressed high satisfaction with the costs, attributing it to the better services and quality treatment provided. Conversely, a minority (12.88percent) expressed dissatisfaction, mainly due to perceived higher charges from doctors and the overall expensive nature of the services.

Table 38 illustrates the distribution of respondents based on their level of satisfaction with the health costs of private healthcare facilities.

Table 38

Level of Satisfaction with Health Costs of Private Health Facility

Satisfaction	Number	Percent
Very satisfied	161	49.39
Somewhat satisfied	78	23.93

Satisfaction	Number	Percent
Somewhat dissatisfied	33	10.12
Very unsatisfied	9	2.76
Total	**281**	**86.20**

Source: Field Survey, 2023.

Insurance facility of the employer in the study area

The GoN has implemented a social health protection program aimed at ensuring citizens have access to quality healthcare without enduring financial hardship. This program is strategically designed to mitigate the risk of individuals falling into poverty due to healthcare-related expenses resulting from accidents or illnesses. Despite political assurances to decrease out-of-pocket healthcare expenditure through the National Health Insurance Program (NHIP) of Nepal, its implementation faces challenges characterized by low enrolment and high drop-out rates. The effectiveness of such programs often intersects with political economy considerations and the interests of various stakeholders. Nepal has established acts, rules, regulations, and policies to facilitate the implementation of health insurance facilities.

In the course of the FGD and household survey, respondents were queried about their awareness levels regarding health insurance provisions and the existing practices of insurance facilities. The findings revealed that a majority of respondents lacked clarity on health-related insurance and its provisions. However, it was noted that some individuals with employment contracts, particularly job holders, receive health insurance coverage. This disparity in awareness underscores the need for enhanced communication and education regarding health insurance among the general public.

Data on the provision of health insurance by employers are shown in Table 39. Only a small portion (1.84 percent) of the total respondents (78) claimed that their workplaces provide health insurance. The majority (72), or 22.09 percent, said they did not have health insurance through their employers. The data illustrates possible access gaps to such benefits in Konjyosom RM by demonstrating the low incidence of employer-sponsored health insurance throughout the population polled.

Table 39

Employer Provided Health Insurance Coverage

Insurance	**Frequency**	**Percent**
Yes	6	1.84
No	72	22.09
Total	**78**	**23.93**

Source: Field Survey, 2023.

Medical advices received from different sources

Table 40 highlights on the diverse sources from which individuals seek medical advice. The data reveals that 3.99 percent of respondents receive medical advice from pharmacists, indicating a reliance on pharmaceutical guidance. Local healers play a significant role, with 28.53 percent of individuals seeking medical advice from them, showcasing the influence of traditional healthcare practices. Additionally, 13.19 percent turn to the internet for medical advice, reflecting the impact of digital resources on health-related decisions. However, the majority, constituting 52.15 percent, rely on advice from friends, family, and neighbors, emphasizing the importance of interpersonal networks in shaping health-seeking behavior in Konjyosom RM. This exploration into the various sources of medical advice contributes to a

comprehensive understanding of the healthcare services and the diverse channels through which individuals access health-related information and support.

Table 40

Medical Advices Received from Different Sources

Advices received	Number	Percent
Medical advice from Pharmacist	13	3.99
Medical advice from local healer	93	28.53
Medical advice from internet	43	13.19
Medical advice from friends, family and neighbor	170	52.15

Source: Field Survey, 2023.

In Konjyosom RM, there is a noticeable absence of specified financial assistance or aid programs at the local level, particularly beyond regular vaccination programs and awareness campaigns. Despite ongoing efforts in vaccination and awareness initiatives, there seems to be a gap in the provision of targeted financial support to address the diverse healthcare needs of the community. The existing programs primarily focus on preventive measures, leaving a potential area for the development and implementation of comprehensive financial aid strategies that cater to the specific health challenges faced by the residents of Konjyosom RM. This observation emphasizes the importance of tailoring assistance programs to the unique healthcare requirements of the local population for more effective and holistic health support.

Health Service Availability

This subchapter provides the detailed assessment of health service availability within Konjyosom RM, which also provides information on the current state of healthcare infrastructure and services. This section aims to provide an insightful overview of the types,

accessibility, and distribution of health services in the area. The inspection encompasses various aspects, including the types of healthcare professionals, available equipment and facilities, and the range of services offered, offering a nuanced perspective on the healthcare system in Konjyosom RM.

1. Available health professionals in Konjyosom RM

In the majority of the surveyed health posts within Konjyosom RM, the absence of medical doctors is notable, a situation exacerbated by the absence of a hospital in the RM as of the date of the field survey. This aligns with a broader trend in Nepal, where medical professionals often choose to practice in urban centers rather than rural areas.

Table 41 provides an overview of the available health professionals in different wards of Konjyosom RM. Among these, the distribution of health post directors, senior auxiliary health workers, auxiliary health workers, senior auxiliary nurse midwives, auxiliary nurse midwives, female community health volunteers, and office assistants is detailed. The subtotals reveal the distribution across the five wards, reflecting the challenges faced in ensuring a comprehensive health professional presence at the local level.

Table 41

Available Health Professionals in Konjyosom RM

Health Professionals	**Ward Number**					**Total**
	1	**2**	**3**	**4**	**5**	
Health Post Director	1	0	1	0	1	3
Senior Auxiliary Health Worker	2	3	1	1	1	8
Auxiliary Health Worker	0	0	0	3	1	4

Health Professionals	Ward Number					Total
	1	2	3	4	5	
Senior Auxiliary Nurse Midwife	1	1	1	2	2	7
Auxiliary Nurse Midwife	2	1	0	0	1	4
Female Community Health Volunteer	9	9	9	9	9	45
Office Assistant	1	1	1	1	1	5
Sub-total	**16**	**15**	**13**	**16**	**16**	**76**

Source: Field Survey, 2023.

2. Type of medical services provided

In Konjyosom RM, the context of medical services is shaped by a variety of healthcare provisions that aim to address the diverse health needs of the local populace. The healthcare offerings encompass a spectrum of preventive measures, with regular vaccination programs and awareness campaigns playing a crucial role in promoting community health. However, the absence of specified financial assistance or aid programs at the local level raises concerns about potential challenges faced by individuals seeking healthcare, particularly in situations of economic adversity. Particularly, the lack of a hospital in the RM and mostly rely on health posts up to the date of the field survey highlights the reliance on higher-tier healthcare facilities, potentially posing accessibility challenges for residents in rural areas.

The scarcity of medical doctors in health posts, a trend observed in many parts of Nepal, further stresses the urban-rural healthcare divide. Nevertheless, a dedicated cadre of health professionals, including Senior Auxiliary Health Workers, Auxiliary Health Workers, Senior Auxiliary Nurse Midwives, Auxiliary Nurse Midwives, Female Community Health Volunteers, and Office Assistants, plays a crucial role in delivering healthcare services. The distribution of

these professionals across different wards highlights the need for targeted interventions to establish a more equitable and comprehensive healthcare infrastructure in Konjyosom RM.

3. Availability of medical equipment and supplies

In Konjyosom RM, the availability of medical equipment and supplies, including birthing units and X-ray machines, varies across health facilities. All health facilities in the RM offer curative care for children, with approximately 9 out of 10 providing growth monitoring and routine vaccination services. Routine Vitamin A supplementation is uniformly offered in all facilities across wards. Similarly, modern family planning methods are available in facilities, offering male condoms, oral contraceptive pills, or injectable. While the majority of facilities providing family planning services have essential equipment for quality service delivery, only about 1 in 5 have the national family planning guidelines on hand, and a similar proportion have staff who received in-service training related to family planning in the past 24 months.

For facilities offering normal delivery care services, the availability of emergency transport is limited, and most facilities possess all the necessary equipment items for quality care, except for a vacuum extractor and a vacuum aspiration or manual vacuum aspiration kit. In Nepal, all health facilities are equipped to diagnose and/or manage chronic respiratory diseases. The public health system is designed to bolster lower-level facilities by providing logistical, financial, supervisory, and technical support from the center to the periphery. Health posts serve as the initial institutional contact point for basic health services, playing a crucial role in the local healthcare ecosystem.

4. Efficient scheduling and accessing health services

In order to assure prompt and efficient healthcare delivery, Konjyosom RM must have effective scheduling and access to health services. The ability of the local population to

schedule appointments and access health services impacts the overall health outcomes and well-being of the community. Booking appointments efficiently entails maximizing the use of the healthcare resources that are already available, reducing waiting periods, and expediting the appointment procedure for patients who need medical attention.

Access to health services encompasses factors such as the proximity of healthcare facilities, transportation infrastructure, and the overall availability of services. The study focus is on evaluating the mechanisms in place for scheduling appointments, the ease of accessing health services, and identifying potential barriers that may hinder the community's ability to receive timely and appropriate medical care. Understanding these dynamics is crucial for improving healthcare accessibility and enhancing the overall health outcomes in Konjyosom RM.

5. Satisfaction level of customers/patients

A query was posed to respondents, seeking their input on the satisfaction level with the personal care provided to patients in a healthcare facility. Recognizing the pivotal role that personal care and hospitality play in the treatment process, the results are summarized in Table 42. Out of a total of 281 respondents, 54.60percent expressed being “Very satisfied”, while 25.46percent indicated they were “Somewhat satisfied”. A smaller proportion, 5.52percent, reported feeling “Somewhat dissatisfied”, and only 0.61percent claimed to be “Very unsatisfied”. The main reason for dissatisfaction was the rude behavior of medical personnel. They exhibited varying attitudes based on income levels and social status, as reported by local villagers during the field survey. However, the overall findings emphasize the significance of attentive personal care in contributing to a positive patient experience within the healthcare setting.

Table 42

Level of Satisfaction with Personal Care of Patients

Satisfaction	Number	Percent
Very satisfied	178	54.60
Somewhat satisfied	83	25.46
Somewhat dissatisfied	18	5.52
Very unsatisfied	2	0.61
Total	**281**	**86.20**

Source: Field Survey, 2023.

6. Quality of Services of the health care facilities

The health care facilities situated in Konjyosom RM face significant challenges, leading to a decline in their overall quality and the provision of inferior health care. This decline is attributed to a shortage of personnel, inadequate equipment, and a lack of community-level infectious disease prevention and health promotion programs. A broader issue is the uneven distribution of healthcare resources throughout the country, primarily concentrated in major urban centers. This concentration creates disparities in both the quality and accessibility of healthcare services. The FDG participants highlighted the inferior quality of health care services, as well as shortcomings in hygiene, nutrition, and sanitation practices, particularly affecting a substantial portion of the population residing in rural areas. A female participant of 57 said

> Living near a health post has been incredibly convenient as it allows easy access whenever I require medical assistance. The health facilities have significantly improved compared to previous years, which is a relief for the community. One of the most

> remarkable aspects is that health services and medicines are provided free of cost. For someone like me who is facing financial difficulties, the health post is a lifeline. The thought of going to a hospital and bearing the burden of high fees is not feasible for me. The health workers at the health post are not only friendly but also treat me with great care and are always ready to help. In our municipality, each ward has its own health post. This distribution has proven to be immensely beneficial for the people residing in our area. Furthermore, I am pleased to mention that there's new physical infrastructure being developed for the health post, which is a promising sign of continued improvement in the healthcare facilities.

Against this backdrop, the researcher aimed to assess the ratings of medical care quality in public hospitals and the nearest health care facilities. Table 43 provides insights into the perceived medical care quality in both public hospitals and the nearest healthcare facilities. The data, based on responses from 326 individuals, reveals that 9.82 percent rated the medical care as “Excellent”, indicating a commendable standard. The majority, comprising 80.37 percent, expressed satisfaction with a “Good” level of medical care. However, a notable 9.51 percent considered the medical care to be “Poor”, suggesting room for improvement. A minimal 0.31 percent rated the care as “Very bad”. These findings offer a comprehensive overview of the diverse opinions regarding medical care quality, display a range of perspectives within the surveyed population.

Table 43

Medical Care Quality in Public Hospitals and Nearest Healthcare Facilities

Medical care quality	Number	Percent
Excellent	32	9.82
Good	262	80.37
Poor	31	9.51
Very bad	1	0.31
Total	**326**	**100.00**

Source: Field Survey, 2023.

Similarly, the assessment of medical care quality in private hospitals was undertaken, drawing from the perspectives of respondents. The resulting data, presented in Table 44, focus on the satisfaction levels within the private healthcare sector. Particularly, 15.64 percent of respondents deemed the medical care in private hospitals as an excellent, reflecting a commendable standard. A significant majority, accounting for 73.31 percent, expressed satisfaction with a good level of medical care. However, 10.74 percent of respondents identified areas for improvement, rating the care as poor. A minimal 0.31 percent perceived the care as very bad. This dataset provides valuable intuitions into the perceived quality of medical care in private hospitals. It helps to understand the varied opinions within the surveyed population in a more detailed way.

Table 44

Medical Care Quality in Private Hospitals

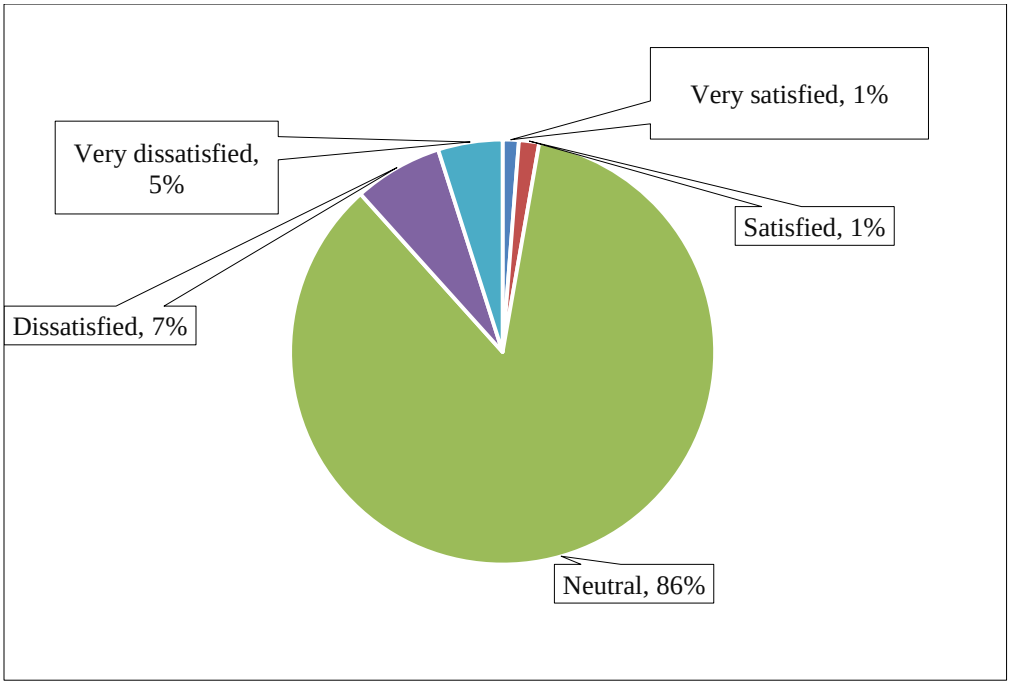
Number	**Number**	**Percent**
Excellent	51	15.64
Good	239	73.31
Poor	35	10.74
Very bad	1	0.31
Total	**326**	**100.00**

Source: Field Survey, 2023.

All 326 respondents were also enquired about their satisfaction with the availability of health care services during weekends and public holidays. The options ranged from “Very satisfied” to “Very dissatisfied”. The data reveals that 4 respondents expressed being very satisfied, while 5 reported being satisfied. A substantial portion, comprising 279 respondents, felt neutral about the availability of health care services during weekends and public holidays. On the other hand, 22 respondents were dissatisfied, and 16 respondents expressed being very dissatisfied. The main reason of dissatisfaction among the surveyed individuals was due to unavailability of health workers and their health care services during weekends and public holidays.

Figure 13

Satisfaction Levels with Weekend and Holiday Health Care Services



Source: Field Survey, 2023.

Chapter V

Challenges and Barriers to Healthcare Accessibility

This chapter explores into the intricate realm of difficulties and barriers to healthcare accessibility. In this study, the researcher attempted to investigate the challenges individuals encounter when seeking access to essential healthcare treatments. The chapter scrutinizes the myriad obstacles that jeopardize the universal right to healthcare, encompassing structural restrictions and socioeconomic challenges. The study imparts a thorough knowledge of the barriers hindering fair healthcare access through an in-depth investigation of these complexities. It is acknowledged that resolving these issues is imperative to establish a more inclusive and accessible healthcare environment.

Access to healthcare encompasses a range of factors, including the availability, accessibility, awareness, accommodation or adequacy, affordability, and acceptability of health services. Limited healthcare facilities, considerable distances to reach health facilities, shortages of medicine, the prevalence of poverty, deficiencies in the number of doctors, dentists, and other health professionals, as well as the level of education and knowledge within the population are all elements that influence access to healthcare.

Geographic Barriers to Healthcare Accessibility

The access to health services in rural areas of Nepal is further restricted by various barriers. The wards within Konjyosom RM are predominantly situated in hilly regions, posing challenges to infrastructure accessibility. As a result, rural residents, already facing limited access to healthcare, encounter additional obstacles. These include geographical challenges such as difficult terrain, significant distances, poor road conditions, and a lack of transportation means. Additionally, the direct and indirect costs associated with attending health services

contribute to the overall limitations faced by the residents. Collectively, these factors compound the difficulties in ensuring accessible healthcare for the rural population in Konjyosom RM.

Table 45 explains the major obstacles that hindering access to healthcare facilities locally. Out of 326 respondents, 23 percent pointed out long travel distances as a significant barrier, indicating the challenges posed by geography. Another notable challenge is the lack of transportation, with 24.5 percent of respondents mentioning its impact on accessibility. Specifically, 45.4 percent of respondents identified the scarcity of healthcare professionals as a critical obstacle, emphasizing the crucial role played by personnel shortages in limiting local healthcare access. The “Others” category made up 7.1 percent, covering various additional challenges not explicitly mentioned. This data highlights the complex nature of barriers to healthcare access at the local level, emphasizing the need for a comprehensive approach to address these challenges and improve overall healthcare accessibility for the surveyed population.

Table 45

Obstacles to Access the Healthcare Facility at Local Level

Obstacles to Assess	**Frequency**	**Percent**
Long travel distance	75	23.0
Lack of transportation	80	24.5
Lack of healthcare professionals	148	45.4
Others	23	7.1
Total	**326**	**100.0**

Source: Field Survey, 2023.

Socioeconomic Barriers to Healthcare Accessibility

The socioeconomic constraints have a significant impact on the use and efficiency of health facilities in Konjyosom RM. This study probes into the complex web of problems caused by resource allocation, social structures, and economic inequalities that together make it difficult to provide healthcare services to the rural population. These socioeconomic factors interact to generate barriers that affect access to healthcare facilities, ranging from financial limitations to a lack of educational possibilities. This study aims to explore the connections between socioeconomic factors and healthcare accessibility in rural Nepal. By examining the complexities within these challenges, the research seeks to provide a nuanced understanding of how socioeconomic determinants impact access to healthcare in the region.

Social traditions and culture

During the FDG, the researcher engaged with local residents to explore the impact of social traditions on healthcare, uncovering both opportunities and barriers. The participants emphasized the multifaceted nature of these traditions. The discussion unearthed that health inequalities are circuitously linked to various socioeconomic factors, spanning age, sex, race, ethnicity, education, income, social status, unemployment, and place of residence. Mostly, many individuals, particularly the youth, perceive themselves as less healthy than their forebears. This perception traces back to a lifestyle shift, with older generations engaging in practices like keeping domestic animals, consuming organic foods cultivated with compost manure, and employing traditional medicinal plants.

The logic follows that these practices contributed to better physical health and longevity. Home remedies and folk healing, aligned with Ayurveda and other traditional systems, were prevalent. Local health traditions, embraced by both individuals and local healers, addressed

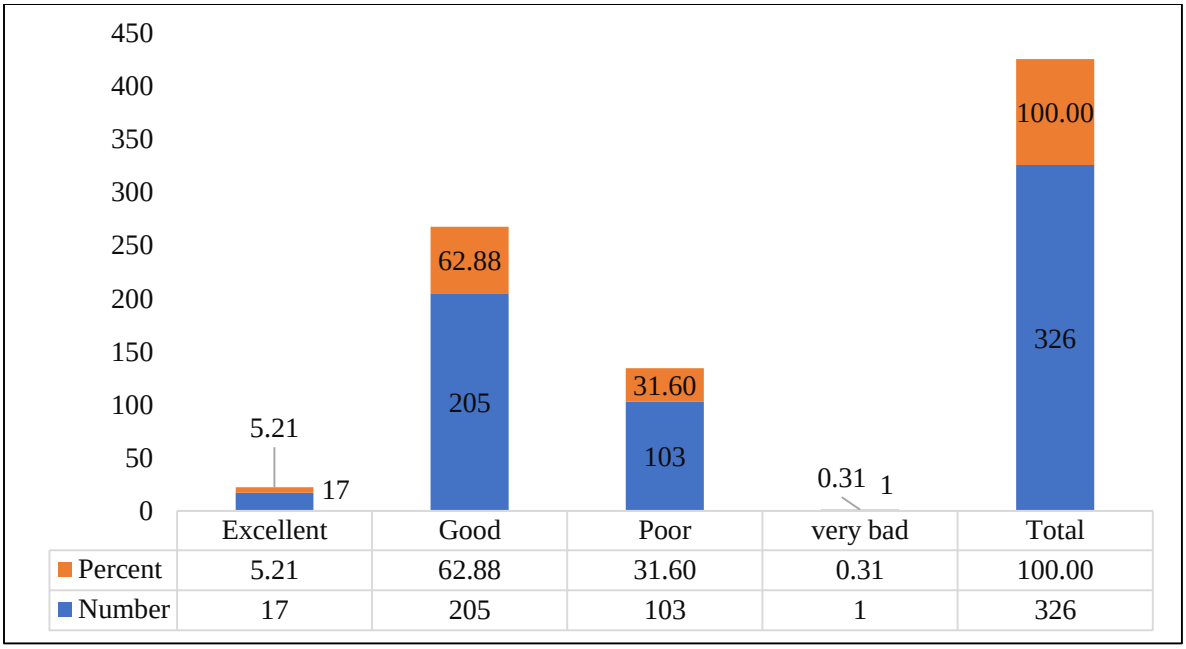
health needs at minimal or no cost, complementing mainstream medicine. The connection between scholarly traditional medicine and local health traditions was historically robust.

In Konjyosom RM, a strong belief persists in local health traditions, encompassing herbal knowledge, home remedies, and folk healing. This belief occasionally leads people to eschew modern healthcare centers in favor of traditional healers, posing challenges for addressing severe illnesses. This complex interplay between social traditions and healthcare choices highlights the importance of understanding and integrating local health practices to enhance healthcare accessibility and effectiveness in the community. Residents in rural areas may harbor reservations about seeking care for various health issues, including mental health, substance use, sexual health, pregnancy, or common chronic illnesses. These concerns often stem from a sense of discomfort or privacy considerations, creating barriers that may impede individuals from accessing necessary healthcare services.

The survey asked local villagers about their satisfaction with local healers, and the results reflected varied opinions. A small percentage, 5.21 percent, indicated excellent satisfaction, suggesting a positive experience. The majority, 62.88 percent, reported good satisfaction, indicating a generally favorable view of local healers. On the other hand, a significant portion, 31.60 percent, expressed poor satisfaction, revealing notable dissatisfaction within the community. Interestingly, only 0.31 percent reported a very bad experience, highlights a rare instance of extreme discontent.

Figure 14

Believe in the Quality of Medical Care Provided by a Local Healer



Source: Field Survey, 2023.

In some ways, the underlying societal traditions might be seen as preventing local residents from using and accepting contemporary healthcare facilities. The deeply rooted attitudes and traditions in the community may cause people to favor conventional medical approaches over cutting-edge ones when it comes to healing. This inclination, which is based on cultural conventions, may prevent people from receiving prompt medical care from trustworthy healthcare professionals.

Financial status of local villagers

The researcher engaged in discussions with local residents during the FGDs to explore the financial status of villagers. As highlighted earlier, rural residents frequently face barriers that hinder their access to essential healthcare services. Healthcare access implies not only the

availability but also the obtainability of services in a timely manner. Unfortunately, rural residents often confront obstacles that limit this access. Even when healthcare services are present in the community, additional factors can impede accessibility.

Traveling to access healthcare places a burden on patients, particularly those with low incomes, no paid time off, physical limitations, acute conditions, or lacking personal transportation. These challenges significantly impact their ability to reach healthcare services, contributing to disparities in healthcare access. Individuals with higher incomes may opt for private hospitals, thereby receiving better healthcare. Conversely, those with lower incomes may grapple with severe illnesses, hampered by their inability to afford quality healthcare services due to financial constraints. This intricate relationship between financial status and healthcare access underscores the importance of addressing economic barriers to ensure equitable and accessible healthcare for all.

Shortage of healthcare workers

The shortage of healthcare workers in rural areas is a universal challenge, impacting both developing and developed countries, although its repercussions are more severe in developing and poorer nations. The majority of rural inhabitants, often comprising the elderly, children, poor, and unemployed individuals, are the most reliant on healthcare services. However, unique challenges specific to rural areas, such as inadequate infrastructure, rudimentary healthcare systems, challenging terrains, and low population densities, collectively deter healthcare workers from choosing rural postings. This results in a substantial disparity in the doctor/patient ratio between urban and rural areas.

A key challenge identified is the scarcity of trained healthcare workers, with each health post having a sanctioned staff of five and primary health center equipped with a larger

complement of staff. The staffing composition at sub-health posts includes a female maternal and child health worker, an auxiliary field worker, and a village health worker.

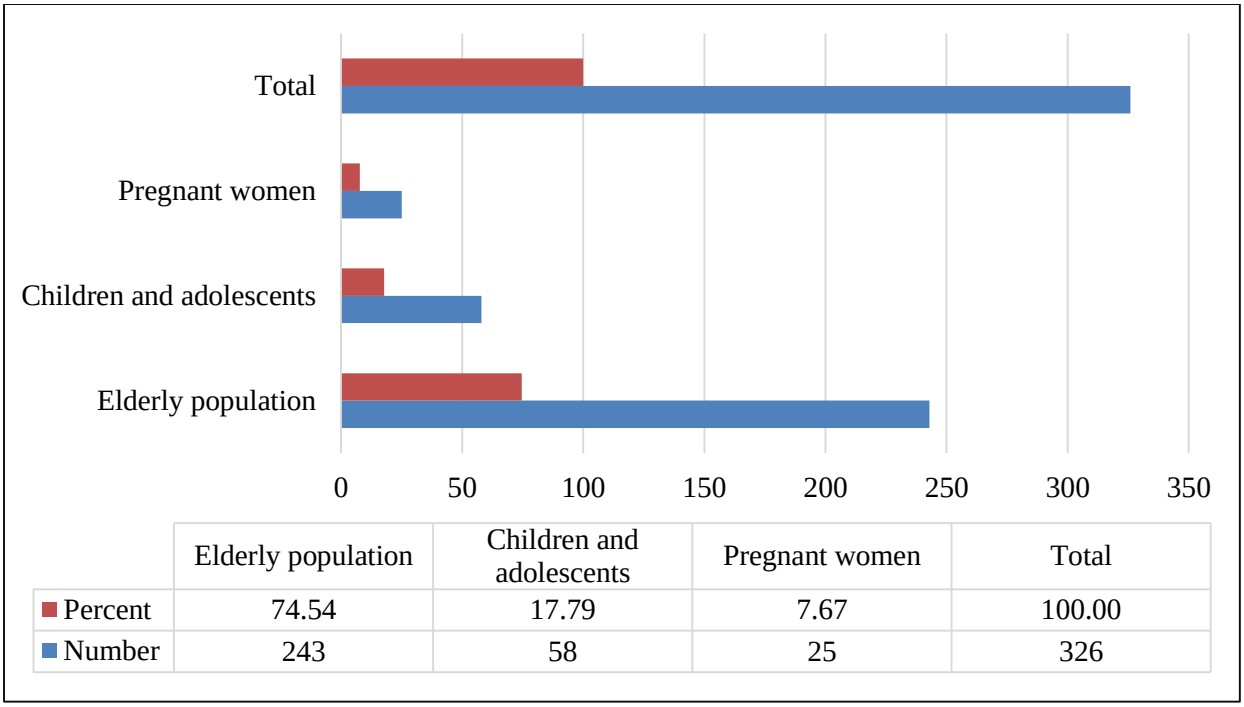
The researcher involved in discussions with local residents during the FDG concerning the presence of skilled health workers. A critical issue identified is the shortage of skilled human resources, significantly affecting healthcare access in rural communities. Having a regular source of care is a key measure of healthcare access, and its attainment is contingent on the availability of an adequate healthcare workforce. Rural areas frequently grapple with challenges related to the recruitment and retention of primary care and other health professionals. According to the villagers' opinion during the consultation, there is an absence of medical doctors and other skilled healthcare personnel.

Challenges in healthcare access among the groups due to the lack of youths

The absence of young individuals within rural families presented a significant challenge to access the health care facilities in rural areas. The youth demographic played a crucial role in contributing to the well-being and functioning of a community. In rural settings, the lack of youths resulted in a diminished workforce, impacting various aspects of community life, including agriculture, local businesses, and social support networks. Additionally, the absence of youths led to challenges in addressing the evolving needs and dynamics of the community, particularly in the context of modernization and changing societal expectations. This demographic gap created hurdles for accessing resources, services, and opportunities, underscoring the need for strategies to attract and retain young individuals in rural areas to ensure the vitality and sustainability of these communities.

Figure 15

Challenges in Healthcare Access Across Age Groups



	Elderly population	Children and adolescents	Pregnant women	Total
Percent	74.54	17.79	7.67	100.00
Number	243	58	25	326

Source: Field Survey, 2023.

Respondents were asked about healthcare access challenges across age groups. The findings revealed that the majority, constituting 74.54 percent (243 individuals), fell within the elderly population. Children and adolescents made up 17.79 percent (58), while only 7.67 percent (25) of pregnant women faced challenges in accessing healthcare facilities. The absence of youths, either due to migration to foreign lands or residing in urban centers for employment, presents a hurdle during difficulties in arranging transportation and other logistical necessities. This situation places local elderly individuals and women's groups at a disadvantage. Consequently, the lack of availability of youths in rural areas directly correlates with difficulties in accessing healthcare facilities for their family members.

Low level of awareness on sanitation and health hygiene

To address the issue and enhance healthcare utilization, awareness campaigns are crucial, and such activities support in informing villagers about the services available at existing healthcare facilities. Interestingly, field observations during the survey revealed a noteworthy lack of seriousness among the majority of people regarding health hygiene and sanitation at the household level. This lack of awareness has led to a decline in confidence among local residents regarding the quality of care available at nearby healthcare facilities. Consequently, health literacy emerges as a potential barrier to accessing healthcare. Health literacy significantly influences a patient's ability to comprehend health information and follow instructions from healthcare providers. In rural communities, where lower educational levels and higher poverty rates are prevalent, low health literacy can lead to reluctance in seeking healthcare. The fear or frustration associated to communicating with healthcare professionals, coupled with challenges in navigating the healthcare system, further complicates access to healthcare services in the studied areas.

Furthermore, to access information on the use of communication means, a direct question was asked to respondents. Various pieces of information related to health problems and their solutions are disseminated through media, including social media networks. Considering this, the access and practices of local people were observed during the study.

Table 46 provides perceptions into newspaper reading habits during the survey week. Among the 326 respondents, only 8.0 percent (26 individuals) reported engaging in newspaper reading during the specified period. In contrast, the majority, accounting for 92.0 percent (300 individuals), indicated that they did not read newspapers during the survey week. This data

highlights a notable disparity in newspaper consumption within the surveyed population, indicating a low prevalence of newspaper reading habits during the specified timeframe.

Table 46

Newspaper Reading Habits During Survey Week

Newspaper	**Number**	**Percent**
Yes	26	8.0
No	300	92.0
Total	**326**	**100.0**

Source: Field Survey 2023

Table 47 illuminated the radio listening habits observed during the survey week. Among the 326 respondents, 24.54percent (80 individuals) reported listening to the radio during the specified period. Conversely, the majority, comprising 75.46percent (246 individuals), did not engage in radio listening during the survey week. This data showcased diverse patterns of radio consumption among the surveyed population, emphasizing a substantial portion of respondents who abstained from radio listening activities during the specified timeframe.

Table 47

Radio Listening Habits Observed During Survey Week

Radio	**Number**	**Percent**
Yes	80	24.54
No	246	75.46
Total	**326**	**100.00**

Source: Field Survey, 2023.

Table 48 provides understandings into the Television and YouTube-watching habits observed during the survey week. Among the 326 respondents, 41.10percent (134 individuals) reported engaging in Television or YouTube watching during the specified period. In contrast, 58.90percent (192 individuals) indicated that they did not watch television or YouTube during the survey week. This data illustrates the regularity of television and YouTube watching within the surveyed population, indicating that a significant portion of respondents received basic healthcare-related information to some extent.

Table 48

Television/YouTube Watching Habits Observed During Survey Week

Television/YouTube	**Number**	**Percent**
Yes	134	41.10
No	192	58.90
Total	**326**	**100.00**

Source: Field Survey, 2023.

The low level of awareness on sanitation and health hygiene is a notable barrier to accessing healthcare facilities. It is crucial to address this obstacle for improved future accessibility. Prioritizing awareness campaigns and educational initiatives can foster a culture of health consciousness in communities, facilitating easier access to healthcare services. Recognizing and actively mitigating this awareness gap contributing to more effective healthcare outreach and better long-term health outcomes.

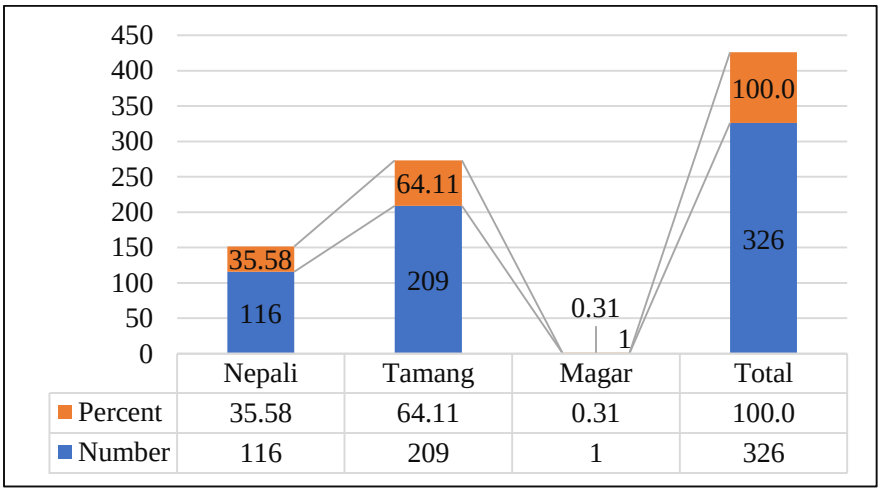
Language barrier

Linguistics categorize the language spoken by the Tamang community within the Tibeto-Burman family. Within this community, individuals communicate using their unique mother

tongue. Among the surveyed households, 64.11 percent indicated that Tamang is their primary language, while a marginal 0.31 percent claimed Magar as their primary language. This linguistic diversity can sometimes pose as a barrier when interacting with health professionals for accessing healthcare facilities. The varied language preferences within the community highlight the importance of considering linguistic diversity in healthcare settings to ensure effective communication and accessibility for all individuals, irrespective of their primary language. Efforts to bridge this language gap can significantly enhance the quality of healthcare services provided to the Tamang community.

Figure 16

Mother Tongue Diversity Among Surveyed Households



Source: Field Survey 2023

Lack of Physical Infrastructure to Healthcare Accessibility

Building upon the discussions in the previous section, Konjyosom RM faces a significant challenge with the absence of a motorable road network, relying instead on seasonal road connections. The ongoing construction of a 15-bedded hospital aims to address some of the healthcare infrastructure gaps. However, the overall state of physical infrastructure

development is not optimal, especially given the proximity of the site to the Kathmandu valley. The deficiency in physical infrastructure poses a hindrance to incorporating modern diagnostic equipment for health-related issues. Consequently, the lack of essential infrastructure, including a motorable black-topped road, stands out as a major barrier to improving the availability and accessibility of healthcare facilities in Konjyosom RM. Addressing these infrastructure deficits is fundamental to ensuring a more robust and effective healthcare system in the area. A female participant of aged 27 said

> I have witnessed the remarkable efforts of local communities to improve health facilities in our area. It's heartening to see how these communities are working tirelessly to ensure better healthcare for everyone. One noteworthy initiative that caught my attention is the construction of a 15-bed hospital. This project, currently in progress, holds the promise of bringing substantial benefits to the residents within the municipality. Once completed, this hospital will play a crucial role in providing medical care to those in need. Furthermore, the dissemination of awareness regarding health insurance has been quite impactful. Broadcasts and informational campaigns have helped spread knowledge about the importance of having health insurance coverage. This effort is contributing to a more informed and prepared community when it comes to their healthcare needs. The emphasis on disease awareness and prevention is another remarkable aspect of our community's health initiatives. Various programs and campaigns are being conducted to educate individuals about different diseases and how to prevent them. These campaigns not only empower people with knowledge but also foster a culture of proactive health management. NGOs and INGOs have also played a significant role in our community's health campaigns. Their support has enabled the implementation of diverse health-related initiatives, ranging

from workshops to health camps. These collaborative efforts have had a positive impact on the overall health awareness and well-being of our community. I have also noticed how students from various health institutions contribute to our community's well-being. These students immerse themselves in understanding the health situation of our village, and they organize awareness programs focused on various diseases. It is truly inspiring to witness the younger generation taking an active role in improving the health outlook of our community.

Table 49 below explored into the seasonal barriers affecting healthcare facilities in Konjyosom RM. Among the 326 respondents, 7.4 percent (24 individuals) identified challenges during the monsoon season, highlighting potential difficulties caused by heavy rainfall and associated issues. Similarly, 6.4 percent (21 individuals) faced obstacles during the winter season, suggesting weather-related impediments. The festive season also posed challenges for 9.8 percent (32 individuals), likely due to increased demands on healthcare services during celebrations.

In contrast, a significant majority, constituting 76.4 percent (249 individuals), reported no specific challenges related to seasons. This data emphasizes that the majority of respondents did not perceive seasonal factors as significant barriers to accessing healthcare facilities. The findings emphasized the need for healthcare planning that accounted for seasonal variations, especially during monsoons and winter, and acknowledged potential increases in demand during festive periods. This analytical intuition could guide strategies to enhance healthcare accessibility, ensuring that the system remained resilient even in the face of seasonal challenges.

Table 49

Seasonal Barriers for Healthcare Facility

Seasonal barriers	Number	Percent
Monsoon season	24	7.4
Winter Season	21	6.4
Festive Season	32	9.8
No specific challenges	249	76.4
Total	**326**	**100.0**

Source: Field Survey, 2023.

Table 50 below provides an overview of transportation challenges faced by the respondents in Konjyosom RM. Among the 326 individuals surveyed, 27.91 percent (91 individuals) identified a lack of frequent public transportation as a significant challenge. This highlights the potential difficulties in accessing healthcare facilities due to the inadequacy of public transportation options.

Furthermore, poor road conditions emerged as a prevalent obstacle, with 35.58 percent (116 individuals) reporting challenges related to the state of the roads. This highlights the impact of infrastructural limitations on transportation, potentially hindering timely access to healthcare. Limited availability of vehicles was another substantial concern, with 36.20 percent (118 individuals) expressing difficulties in accessing transportation when needed. This indicates that the scarcity of available vehicles can pose a significant barrier for individuals seeking healthcare services. Addressing these challenges is crucial for improving the overall accessibility of healthcare facilities in the Konjyosom RM.

Table 50

Types of Transportation Challenges

Transportation challenges	Number	Percent
Lack of public transportation	91	27.91
Poor road conditions	116	35.58
Limited availability of vehicles	118	36.20
Others	1	0.31
Total	**326**	**100.00**

Source: Field Survey, 2023.

Administrative and Policy Challenges to Healthcare Accessibility

Administrative and policy challenges significantly impacted healthcare facilities in the rural areas of Konjyosom RM. The formulation of rural health policies is a complex process involving federal, state, and local levels of government. The overarching vision of "Health for All" for rural populations could only be realized through collaborative efforts, with stakeholders, doctors, nurses, and other healthcare workers working in harmony. Unfortunately, the achievement of this vision was impeded by administrative delays and the absence of favorable policies at the grassroots level, posing obstacles to the accessibility and availability of healthcare facilities within RM.

The concentration of poverty, coupled with low health status and a high burden of disease in rural areas, highlighted the urgency of addressing health challenges specific to these regions. It is crucial to concentrate on dedicated efforts aimed at improving the health of people residing in rural and remote areas. Overcoming administrative hurdles and establishing supportive policies at the grassroots level are essential steps to enhance the overall healthcare

landscape within Konjyosom RM. This necessitates a comprehensive and collaborative approach involving policymakers, healthcare professionals, and community members to ensure that healthcare facilities in rural areas meet the diverse needs of the population.

Opportunities at Local Level to Healthcare Accessibilities

Konjyosom RM, like many other rural municipalities, confronts substantial health challenges, with mothers and their children bearing a disproportionate impact, especially in areas where access to healthcare and resources is limited. Women encounter numerous hurdles in various aspects, including family planning, safe motherhood, childcare, nutrition, and menstrual hygiene practices. The GoN has initiated measures to diminish health disparities and improve accessibility, particularly targeting vulnerable populations in rural areas. Despite the opportunities for healthcare facilities in rural settings are limited, the Female Community Health Volunteers, operating in all wards, play a vital role by providing essential health education and support to local villagers, including mothers and families. Their responsibilities involve registering pregnant and postpartum women, as well as distributing medications and contraceptives within their communities. The relentless efforts of these volunteers have substantially contributed to reducing maternal mortality rates over the years.

Health Education

In the past, there has been a recognized need for increased education on health issues in Nepal, particularly targeting women and girls. The focal points for disseminating health education have been local health posts and Female Community Health Volunteers (FCHV), both playing crucial roles. Remarkably, the landscape of health education in rural areas has expanded beyond traditional channels, incorporating school education and other networks.

During the study, participants in the FGD also emphasized the effectiveness of methods like child-to-child and child-to-parents in spreading public health information. These methods were seen as influential in shaping health-related behaviors within families. The study area grapples with several challenges in achieving universal access to healthcare. Factors such as difficult terrain, cultural diversity, and socioeconomic disparities between the rich and poor, as well as semi urban and rural populations, contribute to these challenges. Remarkably, the rural areas, characterized by high poverty rates and limited access to health facilities, face a heightened risk of various diseases due to both high levels of illiteracy and geographical barriers.

The establishment of small healthcare facilities, such as health posts and units, within the Rural Municipality (RM) has steered in new opportunities for health education. These facilities serve as essential hubs where community members not only receive healthcare services but also gain valuable knowledge about health and wellness. Health posts, being accessible and community-centric, offer a platform for disseminating crucial health information to residents. Similarly, the schools, as educational institutions, play a dual role by integrating health education into their curriculum, thereby reaching a broader audience through students. This convergence of healthcare and education creates a synergistic environment where individuals can access information, resources, and support for promoting healthier lifestyles. The local health infrastructure, comprising these smaller healthcare facilities, becomes a catalyst for fostering a culture of health awareness and empowerment within the community.

Health Camps and awareness

FGD participants were enquired about health camps and social awareness at the local level. According to the information gathered during the field survey, a few health campaigns were

organized through collaboration between the Rural Municipality (RM) office and local health institutions. These short-term medical missions were identified as a means of supplementing human resources for health in underserved areas. The health camps served as a platform to deliver care to patients who might otherwise lack access to primary health services. It is noteworthy that such events are often unregulated, and the perceived quality and health outcomes resulting from these campaigns have rarely been subjected to scrutiny. The information highlights the significance of examining the effectiveness and impact of health camps to ensure their contribution to the overall health and well-being of the local community. A female participant of aged 44 said

> The alteration in living standards is also evident in our daily practices. Instead of relying on traditional firewood for cooking, the use of LPG gas has become widespread. This transition not only reflects modernization but has also significantly reduced the incidence of respiratory issues such as asthma, which were once prevalent due to indoor air pollution. Another remarkable change lies in the sanitation infrastructure. It's heartening to note that every household in our village now boasts a proper toilet facility. This improvement in sanitary management has played a crucial role in mitigating diseases that were once associated with poor hygiene practices. The reduction in health risks is a testament to the positive impact of these advancements. Furthermore, I have observed a heightened awareness of health matters among our fellow villagers. People are now more informed and proactive about maintaining their well-being, engaging in healthier habits and seeking medical advice when needed. This shift towards health consciousness indicates a positive shift in our collective mindset, emphasizing the importance of self-care and a better quality of life.

Health Policy, Plans, Programs

The GoN has undertaken initiatives to develop and expand mobile health and telemedicine services, allowing patients to book appointments online and seek treatment from doctors across the nation. Despite these efforts, the health system in Nepal struggles with significant challenges, including the unequal distribution of healthcare services, poor infrastructure, insufficient supply of essential drugs, poorly regulated private providers, inadequate budget allocation for health, and the retention of human resources in rural areas.

The primary healthcare system had an extensive network, guaranteeing at least one health facility in each ward with FCHVs at the forefront. However, for the GoN's intention to implement health policies, plans, and programs to have a meaningful impact, it was imperative to further strengthen the peripheral health system and ensure equitable distribution of health services. The primary health system needed to be responsive to peoples' needs, and addressing these issues is crucial for improving access to quality health services.

During FGDs, it became evident that more deliberations and debates are needed on how to effectively implement the national health insurance policy, along with other plans and programs, in the local rural context, such as in Konjyosom RM. This observation emphasizes the importance of tailoring health policies to the specific needs and challenges of rural areas, ensuring that implementation strategies are contextually relevant and effective in promoting accessible and responsive healthcare. A local inhabitant female doctor, age of 32 said

> The accessibility to healthcare is made incredibly convenient due to the presence of a health post in each ward. This means that no matter where you live, there's a readily available facility for health care services, eliminating the need for long travel distances. One remarkable aspect of these health posts is the availability of common medicines

without any cost. It has a relief to know that for ailments like fever, common cold, and such, we can easily obtain the necessary medications without worrying about the financial burden. What has stood out to me during my visits to these health posts is the exemplary behavior of the health workers towards the patients. Their kindness, patience, and dedication to providing quality care create an atmosphere of comfort and trust. This plays a significant role in alleviating any apprehensions or fears that patients might have. In terms of physical infrastructure, these health posts have been well-designed and equipped. The buildings are well-maintained, and even the washrooms are clean and hygienic. This attention to detail in the infrastructure enhances the overall experience and contributes to a positive environment for both patients and staff. Moreover, each ward's health post is not just limited to basic healthcare services. They offer a diverse range of services that cater to the various needs of the community. This comprehensive approach ensures that people receive the care they require, addressing both common health issues and more specialized concerns.

Funding opportunities for healthcare facilities

The funding opportunities for healthcare facilities in Konjyosom RM primarily stem from the federal government, serving as a significant source of financing. Additionally, provincial and local government have the potential to make substantial financial contributions to bolster healthcare facilities in rural areas. However, realizing the goal of enhancing the quality of existing primary healthcare services, as outlined in the previous sub-chapters, requires strategic investments. The allocation of funds for training, infrastructure development, and the acquisition of necessary resources is essential to strengthen the healthcare infrastructure, ensuring that it meets the evolving needs of the community. Effective and targeted funding can

serve as a catalyst for sustainable improvements in healthcare delivery, positively impacting the overall health outcomes and well-being of rural people in Konjyosom RM. A female staff of age 34 from local health post said

> I have observed that the staff composition at our local health post is quite diverse. While some personnel are appointed by the government, others seem to secure their positions through political influence, often lacking the necessary professional skills. This dynamic has led to a disparity in the quality of healthcare services provided. Despite having some newly acquired equipment at the health post, the resources remain inadequate. This is particularly concerning because the nearest hospital is located around 25 kilometers away from our village. As a result, many patients, especially those with limited means, are unable to make the journey to the hospital and must rely on the limited facilities at the health post. The health post staff, though well-intentioned, faces limitations in tackling complex medical cases. Such cases require patients to endure a 25-kilometer journey to reach the hospital for proper treatment, adding to the challenges of those already facing health issues. One of the significant barriers to accessing healthcare in our remote village is the poor condition of the roads, which becomes even more pronounced during the monsoon seasons. Patients in these rural areas face additional difficulties in reaching the health post due to these road conditions, further exacerbating their health challenges. On the positive side, the infrastructure of the health post is commendable, offering a stable environment for medical services. Additionally, the wait times for services are relatively short, allowing us to receive the care we need without significant delays.

Chapter VI

Enhancing Healthcare Accessibility: Potential Solutions

In this chapter, the focus shifts towards a meticulous examination of potential solutions geared towards expanding healthcare accessibility in Konjyosom RM. Throughout the preceding chapters, the numerous challenges pursuing the healthcare landscape have been dissected, highlighted the complex challenges faced by the community. This chapter takes a proactive stance, exploring into a retrospective analysis of viable strategies and interventions that could serve as catalysts for positive change. This chapter deals with the potential solutions for the better health care facilities in the study area.

Improved Health Conditions

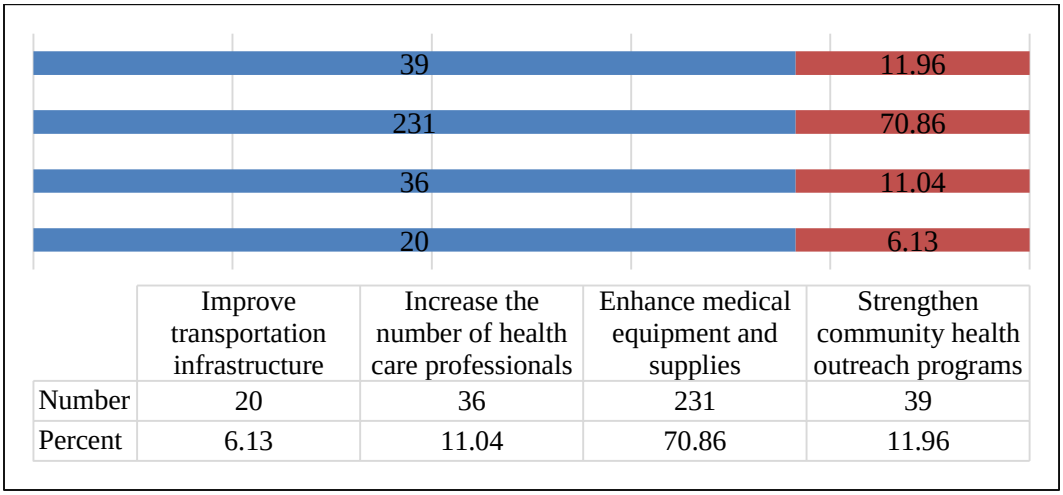
Improving health conditions is essential for the overall well-being of the population, particularly for those facing economic challenges and limited access to healthcare. Strong health systems not only enhance the health status of the entire population but also serve as a protective measure for households against the potentially devastating impact of out-of-pocket healthcare costs. The concentration of poor health among the economically disadvantaged highlights the importance of addressing health disparities, making it a crucial factor for achieving better health accessibility.

During the field study, respondents were asked for suggestions to improve healthcare access. The majority (70.86 percent) emphasized the need to enhance medical equipment and supplies. This was followed by 11.96 percent advocating for the strengthening of community health outreach programs, and 11.04 percent prioritizing the increase in the number of healthcare professionals. Additionally, 6.13 percent of respondents highlighted the need for

improvement in transportation infrastructure. These perceptions reflect the complex nature of challenges in healthcare accessibility and provide a foundation for potential solutions.

Figure 17

Suggestions to Improve Healthcare Access by Local Residents



	Improve transportation infrastructure	Increase the number of health care professionals	Enhance medical equipment and supplies	Strengthen community health outreach programs
Number	20	36	231	39
Percent	6.13	11.04	70.86	11.96

Source: Field Survey, 2023.

Clean Environment

A clean environment stands as a key indicator in the quest to enhance healthcare accessibility, presenting a multi-layered influence on the overall well-being of individuals and communities. The significance of clean, safe, and secure environments cannot be overstated, as they contribute to creating an enabling atmosphere for better health care facilities. The provision of clean air, secure surroundings, and spaces for physical activity establishes prime conditions crucial for the optimal functioning of healthcare services.

In the realm of healthcare, cleanliness is not just a preference; it is an imperative. Healthcare settings, tasked with safeguarding the health of numerous individuals daily, necessitate an environment free from hazards. Cleanliness plays a central role, as it acts as a shield against bacteria and contaminants that may compromise the health of patients

undergoing medical treatment. Whether it is a modest medical center or an extensive hospital, regular cleaning is imperative for maintaining the well-being of patients and preventing the spread of infections within the healthcare setting, as added by FGD participants.

Environmental health indicators emerge as valuable tools in identifying potential risks to human health, offering insights into emerging threats and hazards. These indicators serve a dual purpose by guiding policy actions and resource allocation, helping to target interventions where they are most needed. The pursuit of healthier environments aligns with broader goals of rural health improvement, development, and overall well-being. Moreover, it stands as an indispensable component in the pursuit of Sustainable Development Goals (SDGs), emphasizing the involved connection between environmental health and the aspirations for a healthier, more resilient society. A male participant of age 49 said

> There were high hopes when our local government was established, with the anticipation that it would bring about a transformative change in our village's development. However, I have observed that the efforts put forth by the local government have been insufficient, and the envisioned improvements have not materialized as expected. On a positive note, our local club organizes free health camps, aiming to address some of the health-related concerns within the community. These initiatives, although commendable, only scratch the surface of the larger healthcare challenges we face. A predominant issue contributing to the overall situation is the limited educational opportunities available to our people, stemming from the economic constraints of many families. The lack of proper education has hindered the growth of our community, as people struggle to break the cycle of poverty and ignorance. Another significant concern is the prevalence of superstitions among the villagers. When someone falls ill, it is common for them to seek the assistance of a priest

before considering medical treatment. This belief has, unfortunately, led to tragic consequences at times, with patients not receiving timely medical attention and, in some cases, even losing their lives. The limited education available has also contributed to a mindset that regards education as an unproductive use of time and money. Many individuals in the community believe that pursuing an education is less valuable than directly earning money. This viewpoint has resulted in a lack of emphasis on learning and personal development.

Policy Interventions

Policy intervention is a critical component in the pursuit for enhancing healthcare accessibility, as it involves a strategic framework to address systemic challenges and ensure equitable distribution of resources. The implementation of effective policies plays a crucial role in reforming the landscape of healthcare delivery. In the context of the study area, Konjyosom RM, policy interventions are crucial to overcome existing barriers and promote inclusivity in healthcare services.

One key aspect of policy intervention is the allocation of resources to address infrastructural deficits. By allocating budgets for the development of healthcare infrastructure, three-tier governments can bridge the gaps that hinder accessibility, particularly in rural areas. This includes the establishment of hospitals, medical clinics or labs, and ensuring the availability of essential medical equipment.

Socioeconomic factors often create disparities in healthcare access, and policy interventions can address these root causes. Initiatives that focus on poverty alleviation, education, and employment opportunities contribute to an environment where individuals can

afford and access healthcare services. Policies that prioritize vulnerable populations, such as women, children, and the elderly, can further enhance inclusivity.

As per the insights provided by health workers across the five wards of Konjyosom RM, the health insurance program in Nepal has extended its reach to rural areas. However, despite this expansion, the national coverage, whether for families or individuals, remains remarkably low. The absence of substantial data on health insurance poses a significant challenge to the success of this program at the local level. Several factors contribute to the uncertainty and low enrollment in health insurance programs. Lengthy and complex procedures, tied with poor service quality and dissatisfaction with services, deter individuals from participating. A lack of awareness and understanding of health insurance norms and procedures further compounds the issue. Additionally, concerns about the response of healthcare facilities toward insured individuals during treatment contribute to the overall reluctance.

To address these challenges, information, education, and communication programs focusing on health insurance are imperative. These programs can play a dynamic role in familiarizing potential insures with the details of insurance systems and their processes. Creating awareness and providing clear, concise information can alleviate the concerns and uncertainties that currently hinder enrollment and contribute to high dropout rates.

Policymakers should consider these factors when planning interventions to enhance health insurance enrollment. A comprehensive approach that addresses procedural complexities, improves service quality, and educates the community about the benefits of health insurance is essential for the success and sustainability of such programs at the local level. Furthermore, funding opportunities need to be strategically commissioned into through well-designed policies. Clear guidelines and mechanisms for financial contributions from various levels of

government, as well as private and nonprofit sectors, can ensure a sustained and diversified funding base for healthcare facilities.

Implementing targeted health policies also involves addressing specific health challenges prevalent in the community. This could include programs for maternal and child health, disease prevention, and health education. Tailored policies that consider the unique needs of the population contribute to more effective and responsive healthcare systems. The policy intervention stands as a linchpin in the pursuit of enhancing healthcare accessibility. Strategic policy formulation and implementation are vital to create a healthcare system that is accessible, equitable, and responsive to the diverse needs of the community.

Infrastructure Development

To tackle the issue of healthcare accessibility, attention is turned towards infrastructure development. Particularly, a 15-bed hospital is currently under construction and is anticipated to be completed soon. This initiative aims to address the pressing need for enhanced healthcare facilities. Moreover, the FGD emphasizes the importance of road connectivity, the acquisition of medical equipment, and the establishment of ambulance services in each ward. These developments are integral components of the broader strategy to boost healthcare accessibility. Recognizing the critical role played by well-developed infrastructure, the discussion explores potential solutions to overcome the existing challenges and create a more accessible and robust healthcare system in the study area. A 65 years old male participant said

> I have witnessed a significant improvement in the services and facilities provided at the local health post compared to previous years. There has been a notable upgrade with the installation of new equipment, which has undoubtedly enhanced the quality of care. One of the remarkable changes is the recruitment of new personnel, leading to an increased

number of staff members. This has translated into more efficient and effective services being delivered. What's truly noteworthy is the friendliness and positive attitude exhibited by the staff. Their demeanor creates a comfortable and welcoming environment that puts patients at ease. One of the most noticeable benefits is the reduced waiting time. The services are now provided promptly, without unnecessary delays. Additionally, there is a commendable emphasis on prioritizing the needs of women and children, ensuring they receive the necessary attention and care promptly. A major relief for patients is that most of the facilities and services are offered free of cost. This has alleviated the financial burden that often accompanies healthcare services. It's heartening to know that people can receive the care they need without worrying about the associated expenses. All in all, my experience aligns with Gopal Magar's observations, reflecting a positive transformation in the health post's services and facilities. The strides made in terms of equipment, staffing, efficiency, and affordability have undoubtedly improved the overall healthcare experience for the community.

Community-Based Healthcare Initiatives

Community-based healthcare initiatives stand out as a promising solution to enhance healthcare facilities in the study area. These initiatives are rooted in the principle of empowering local communities to actively participate in their healthcare. The approach involves engaging community members, including local government representatives, creating a shared responsibility for health, and fostering a sense of ownership in healthcare outcomes.

One crucial aspect is the implementation of awareness campaigns or health camps. These campaigns could support educating communities about essential health practices, preventive measures, and available healthcare services. By increasing awareness, such initiatives empower

individuals to make informed decisions about their health and well-being. Health education is another key component of community-based approaches. Educating community members about various health issues, including family planning, safe motherhood, childcare, nutrition, and hygiene practices, contributes to building a healthier and more informed rural population. The dissemination of health-related information becomes a powerful tool in the hands of community members to make proactive choices for their well-being.

Community health workers could play a key role in these initiatives. Such initiatives offer a comprehensive approach to improving healthcare accessibility. By fostering community engagement, increasing awareness, and leveraging the dedication of community health workers, these initiatives have the potential to create a healthcare system that is responsive to the unique needs of the local population. A youth participant of aged 24 from local village said

> Living in the community served by the health post has brought to light several critical challenges related to healthcare accessibility and services. The health post, unfortunately, lacks the necessary provisions for addressing vital diseases, which leaves many of us in a vulnerable position when we face health issues. The majority of the population in this area relies heavily on agriculture as their primary livelihood. With limited income sources and financial constraints, many individuals find themselves unable to afford hospital expenses. As a result, they are compelled to endure their illnesses at home, often suffering silently due to the lack of resources. In times of emergency, the situation becomes even more dire. The only option is to call for an ambulance, but the exorbitant charges associated with this service can create an additional burden on families already struggling to make ends meet. One glaring issue is the distance to the health post. The journey takes around 55 to 60 minutes on foot, which poses significant difficulties for patients, especially those in fragile

health conditions. Moreover, the condition of the roads in our area is far from satisfactory, making transportation a considerable challenge. It is disheartening to note that despite our proximity to the capital city, the inadequate infrastructure further exacerbates our problems. Another critical aspect is the shortage of well-trained health workers at the health post. The dearth of skilled professionals makes it exceedingly difficult to provide the necessary care and treatment to those in need.

Telemedicine and Technology Solutions

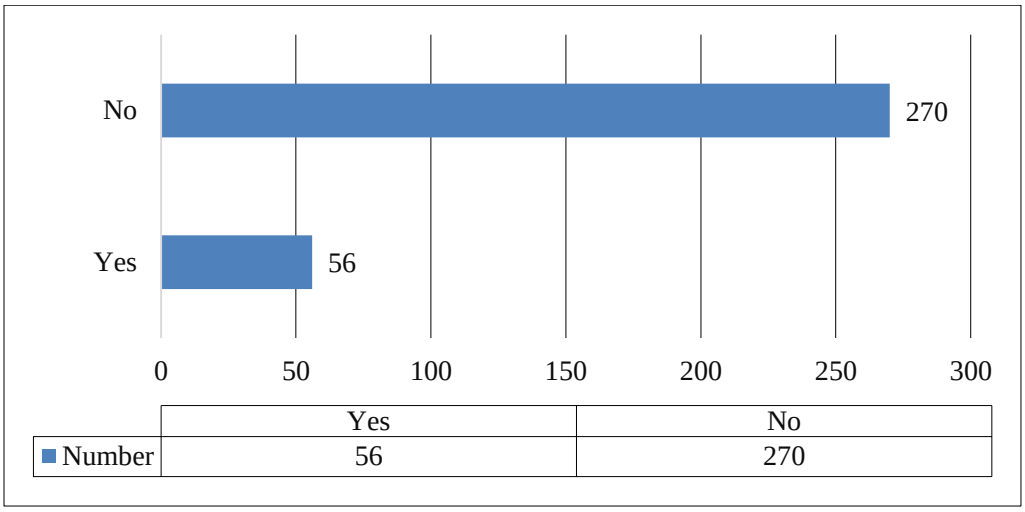
Telemedicine and technology solutions emerge as potential game-changers in enhancing healthcare facilities in the study area. The integration of technology offers innovative approaches to bridge gaps in healthcare accessibility, especially in rural and remote regions. Telemedicine, as a subset of digital healthcare, involves the use of telecommunications technology to provide remote clinical services. It enables healthcare professionals to reach patients in distant locations, breaking down geographical barriers. Through telemedicine, individuals in rural areas can access consultations, diagnoses, and even treatment plans without the need to travel long distances. Furthermore, technology solutions extend beyond telemedicine to include the digitization of health records, the implementation of electronic health systems, and the utilization of mobile health applications. These tools streamline healthcare processes, improve data management, and empower individuals to actively participate in their health management.

In the course of the field study, 326 respondents were queried about their familiarity with telemedicine. The data obtained indicates that 17.2 percent of the surveyed respondents answered affirmatively, signifying that they possess knowledge of telemedicine. On the

contrary, the majority, constitutes 82.8 percent, reported a lack of awareness or familiarity with telemedicine.

Figure 18

Knowledge of Telemedicine Among the Surveyed Respondents



Source: Field Survey, 2023.

The potential benefits of telemedicine and technology solutions include increased access to specialized care, improved efficiency in healthcare delivery, and enhanced communication between healthcare providers and patients. However, challenges such as infrastructure limitations and digital literacy need to be addressed to maximize the impact of these solutions. As per the understandings shared by health workers in Konjyosom RM, telehealth proves to be a valuable asset in rural areas. It enables local doctors to establish connections with specialists, enhancing the overall quality of care provided to patients. Beyond its medical benefits, telehealth emerges as a more cost-effective option, addressing financial concerns faced by individuals. By eliminating the necessity for travel to the doctor for routine checkups, telehealth empowers patients to engage in remote consultations, offering a convenient and accessible healthcare solution.

To sum up, incorporating telemedicine and technology solutions holds promise for transforming healthcare accessibility in the study area. By embracing these digital advancements, healthcare facilities can overcome geographical constraints and provide more efficient, patient-centered care to the local population in Konjyosom RM.

Capacity Building and Training

Capacity building and training are key strategies to address challenges and enhance health care facilities in the study area. These initiatives focus on empowering healthcare professionals and community health workers with the necessary skills, knowledge, and competencies to deliver quality care. One aspect of capacity building involves continuous training programs for healthcare professionals. This ensures that they stay updated with the latest medical advancements, treatment protocols, and healthcare technologies. Ongoing training not only enhances the expertise of healthcare providers but also improves the overall quality of healthcare services.

Community health workers play a vital role in promoting health at the grassroots level. Capacity building programs for these individuals can include training on preventive measures, basic healthcare practices, and community engagement. Equipping them with the right knowledge enables community health workers to serve as effective bridges between healthcare facilities and local communities. Additionally, capacity building efforts can extend to administrative and managerial aspects of healthcare facilities. Training programs for healthcare administrators and managers can enhance their leadership skills, financial management, and strategic planning. This, in turn, contributes to the efficient and effective operation of healthcare facilities.

To sum up, capacity building and training initiatives emerge as integral components in the quest to improve health care accessibility. By investing in the development of healthcare professionals and community health workers, as well as enhancing the managerial capabilities of healthcare administrators, these strategies contribute to a more robust and responsive healthcare system. A female respondent of age 53 said

> The observations made regarding the local government's impact on the health sector and transportation facilities. Despite the establishment of the local government, I did not witness any substantial improvements in these areas. It is disheartening to note that corruption seems to have seeped into the local level, hindering progress in the health sector as well. In theory, there might be road connections to reach the health post, but in reality, these roads do not guarantee accessibility for everyone. Without a private vehicle, accessing the health post becomes an arduous task. It is clear that the transportation infrastructure has not caught up with the needs of the community, especially when it comes to accessing healthcare. Living in a village, I have noticed a lack of even basic medical facilities nearby. The absence of small clinics or pharmacies in close proximity means that obtaining medication for common ailments like fever, cold, and diarrhea is a challenge. This scarcity places a burden on the local health post, which might not be equipped to handle a wide range of medical needs. The health post itself appears to be limited in its capabilities. While it can address minor health problems, it falls short when it comes to more serious medical conditions. When faced with a significant health issue, the only viable option is to travel to a hospital, which might require considerable time and effort. Although there has been some improvement in physical infrastructure compared to the past, these gains have not translated into significant advancements in healthcare and medical

facilities. It is evident that merely focusing on improving physical structures is not enough to bring about meaningful change in the healthcare sector. As someone who has experienced these challenges firsthand, I hope for more comprehensive and effective solutions in the future.

Chapter VII

Summary, Conclusion and Recommendations

Summary of the Findings

The rural settlements of Konjyosom RM are mainly based on agriculture and the majority of the population belongs to the Tamang community. The ongoing construction of a 15-bed hospital is a positive step towards improving medical facilities. Road connectivity, medical equipment, ambulance services and other infrastructure development are important aspects being considered. The study identified specific seasonal challenges, with the monsoon and winter seasons being barriers to access to health care. Awareness campaigns and strategic planning are needed to effectively address these challenges. Lack of public transport, poor road conditions and limited vehicle availability contribute significantly to traffic problems. Addressing these issues is essential to ensure timely access to health facilities. Low levels of awareness about hygiene and sanitation have emerged as an obstacle in accessing healthcare. Health literacy plays an important role in influencing health care-seeking behavior, especially in rural communities.

Media use, including newspapers, radio and television/YouTube, varied depending on the respondents. Understanding media habits is essential to effectively disseminate health care information. Views from community members highlight the need to improve medical equipment and supplies, increase public health awareness programs, and increase the number of medical professionals. Improving transportation infrastructure is also considered important by some people.

Community initiatives, especially those involving community health workers, promise to improve access to health care. Health education programs, awareness campaigns and

community engagement strategies were identified as key elements. Telemedicine is emerging as a viable solution to fill gaps in healthcare access, especially in remote rural areas. The affordability and convenience of telehealth services make them a potentially revolutionary tool.

Improving cleanliness and infrastructure in healthcare facilities was important for infection control and overall healthcare quality. Environmental health indicators played an important role in measuring the impact of these improvements. Administrative delays and lack of supportive policies at the local level hindered access to health care. Policy interventions and administrative reforms were needed to overcome these challenges. The federal government played an important role in funding health care facilities and was likely to receive additional contributions from provincial and local governments. Key findings highlighted the multifaceted nature of healthcare access challenges in Konjyosom RM. The identified barriers, opportunities, and community perspectives provided a comprehensive basis for developing effective strategies and policies to improve access to health care in the study area. The diversity of issues addressed in the dissertation required a comprehensive and collaborative approach to create lasting improvements in rural health care.

In the study area, a thorough survey of 326 households revealed valuable insights into healthcare accessibility, socio-economic characteristics, and health conditions. The predominant use of quantitative methods, accompanied by qualitative methods including key informant interviews and focus group discussions, ensured a comprehensive understanding. The rural setting, characterized by scattered households mainly constructed with mud-bonded bricks/stones, housed a population of 8,989 across 2,145 households. The demographics exhibited a balanced gender ratio, with an average household size of 4.2. The majority of respondents fell within the 35-59 age group, with 92.64% married and mostly belonging to

nuclear families. The Tamang ethnic community prevailed at 73.31%, showing an overall literacy rate of 73.93%.

Socio-economic aspects highlighted agriculture as the predominant occupation (65.31%), with an increasing trend in foreign employment (7.76%). Food sufficiency was reported by 88% of households throughout the year, and a significant majority (84.66%) earned an annual income exceeding 0.5 million. Piped water served as the primary drinking source, while electricity (99.08%) was mainly utilized for lighting. Modern amenities like mobile phones (95.71%) and television (76.38%) were prevalent in that particular predominantly Tamang community.

The healthcare overview indicated the presence of five health posts and one community health unit. A significant majority (87.73%) reported good health, but challenges included child mortality (26), chronic asthma (17.79%), and diabetes (20.55%). Preferences for healthcare utilization showed 83.4% favoring health posts, while 86.20% chose private clinics or hospitals.

Challenges and barriers revolved around geographical factors, social traditions, financial constraints, and limited infrastructure. Language barriers, seasonal road conditions, and a lack of skilled human resources compounded the issues. Opportunities for improvement lay in health education, awareness campaigns, policy interventions, and funding. Potential solutions focused on enhancing medical equipment and supplies, strengthening community health outreach programs, and addressing transport infrastructure. Environmental health indicators, policy interventions, infrastructure development, community-based healthcare initiatives, telemedicine, and capacity building/training emerged as essential strategies for improved healthcare accessibility in Konjyosom RM.

Conclusion

In conclusion, the exploration of health care accessibility and availability in Konjyosom Rural Municipality reveals a complex interplay of challenges and potential solutions. The rural landscape, marked by geographical barriers, infrastructural limitations, and socioeconomic disparities, poses significant hurdles to ensuring universal access to healthcare. The study highlights the multifaceted nature of these challenges, encompassing issues of transportation, infrastructure, health literacy, and policy implementation.

Despite the formidable challenges, there exist promising opportunities and potential solutions. Initiatives such as community-based healthcare, capacity building, technology integration, and policy interventions emerge as key strategies to enhance health care facilities in the study area. Community engagement, empowerment, and awareness play pivotal roles in addressing the unique health needs of the local population.

High rates of infant mortality indicate significant gaps in maternal and child health services, including inadequate prenatal and postnatal care, poor nutrition, and lack of access to essential health services. The prevalence of diabetes suggests a need for better management of chronic diseases, including lifestyle interventions, regular monitoring, and access to medications. Furthermore, the study highlights the importance of collaborative efforts involving government bodies, healthcare professionals, community leaders, and residents to enact sustainable changes. Telemedicine, technology solutions, and innovative approaches to health education stand out as crucial components in transforming healthcare delivery.

In essence, the journey toward improved health care accessibility in Konjyosom RM requires a comprehensive and holistic approach. By addressing the identified challenges with evidence-based strategies and leveraging the available opportunities, it is possible to create a

healthcare system that is not only responsive to the needs of the population but also resilient in the face of rural-specific challenges. As the findings of this dissertation contribute to the broader discourse on rural healthcare, it is hoped that they inform future policies and interventions for better health outcomes in Konjyosom Rural Municipality and similar contexts.

Recommendation

Based on the research findings, several recommendations are proposed to enhance healthcare accessibility in Konjyosom RM. These include fostering community engagement by involving local communities in healthcare initiatives and establishing dialogue platforms. Investing in human resources by recruiting, training, and retaining healthcare professionals is crucial. Infrastructure development, such as completing the 15-bedded hospital and improving road connectivity, is essential. Embracing technology through telemedicine can overcome geographical barriers. Policy reforms at local and national levels are needed to streamline processes and improve service quality. Health literacy programs should educate the community on essential health practices. Environmental health initiatives must ensure clean and secure healthcare facilities. Community-based healthcare initiatives can empower locals in managing their health. Promoting health insurance and establishing a robust monitoring and evaluation framework are also vital for sustainable improvements.

Research for further study

The exploration into the accessibility and availability of health care facilities in Konjyosom RM provides a launching pad for future research endeavors. These opportunities promise not only to deepen our comprehension of healthcare challenges but also to elevate the outcomes of

healthcare provisions in the region. The following potential areas for future studies emerge from the findings of this dissertation:

A comprehensive, longitudinal study to evaluate the enduring impact of implemented interventions and policy changes on healthcare accessibility. This extended research could involve the continuous tracking of health indicators, community health outcomes, and shifts in healthcare-seeking behavior over a substantial period. A focused inquiry into the effectiveness and acceptance of telemedicine solutions within rural settings. This research would delve into the experiences of both healthcare providers and recipients, unveiling barriers and facilitators to the widespread adoption of telehealth services.

In-depth scrutiny of the outcomes arising from community-based health initiatives, with specific emphasis on the role played by community health workers. This research avenue aims to assess the efficacy of health education programs, awareness campaigns, and community engagement strategies. A qualitative exploration aiming to capture the perspectives and satisfaction levels of patients accessing healthcare facilities in Konjyosom RM. Understanding the lived experiences of individuals seeking healthcare can pave the way for informed improvements in service delivery.

Research on the dynamics of health insurance enrollment and the factors influencing the decision-making process of community members. This investigation would explore the perceptions, challenges, and expectations related to health insurance, offering guidance for reforms to enhance participation.

An assessment of the impact of cleanliness and infrastructure improvements on infection rates, patient well-being, and overall healthcare quality. This could encompass both

quantitative measurements and qualitative assessments to provide a comprehensive understanding.

Comparative studies with other rural municipalities or regions facing analogous healthcare challenges. This avenue seeks to analyze the strategies and outcomes of healthcare interventions in comparable settings, contributing to a broader understanding of effective approaches.

An evaluation focusing on the implementation of recommended policies, shedding light on challenges faced, successes achieved, and adaptations made during the process. This research promises insights into the feasibility and effectiveness of policy recommendations.

Exploration of community planning processes to understand how inclusive planning can be seamlessly integrated into healthcare policy development. This avenue aims to uncover participatory approaches and community-driven solutions, enhancing the sustainability of interventions. Investigation into the impact of socioeconomic interventions on healthcare accessibility. This research endeavor would involve studying initiatives aimed at poverty alleviation, educational programs, and community empowerment to gauge their influence on health outcomes.

To sum up, the avenues seek to build upon the foundation established by the present dissertation, offering prospects for continuous improvement in healthcare accessibility and availability in Konjyosom RM and similar rural contexts. Each area delineates unique challenges and opportunities, contributing to the ongoing discourse on rural healthcare improvement.

References

Acharya, B., Basnet, M., Rimal, P., Citrin, D., Hirachan, S., Swar, S., Thapa, P., Pandit, J., Pokharel, R., & Kohrt, B. (2017). Translating mental health diagnostic and symptom terminology to train health workers and engage patients in cross-cultural, non-English speaking populations. *International Journal of Mental Health Systems, 11*(1). https://doi.org/10.1186/s13033-017-0170-2

Adhikari, B., Mishra, S. R., & Schwarz, R. (2022). Transforming Nepal's primary health care delivery system in global health era: Addressing historical and current implementation challenges. *Globalization and Health, 18*(1). https://doi.org/10.1186/s12992-022-00798-5

Andersen, R., & Newman, J. F. (2005). Societal and Individual Determinants of Medical Care Utilization in the United States. *The Milbank Quarterly, 83*(4). https://doi.org/10.1111/j.1468-0009.2005.00428.

Baral, K., Dahal, M., & Pradhan, S. (2020). Knowledge regarding Alzheimer's disease among college students of Kathmandu, Nepal. *International Journal of Alzheimer's Disease, 2020*, 1-6. https://doi.org/10.1155/2020/6173217

Basch, P.F. (1991). A historical perspective on international health. *Infectious disease clinics of North America, 5*(2):183-96. https://pubmed.ncbi.nlm.nih.gov/1869805

Beaglehole, R., Bonita, R. (2010). What is global health? *Global Health Action.3* doi: 10.3402/gha. v3i0.5142.

Becker, M. H., Maiman, L. A., Kirscht, J. P., Haefner, D. P., & Drachman, R. H. (1977). The Health Belief Model and Prediction of Dietary Compliance: A Field Experiment.

Journal of Health and Social Behavior. Journal of Health and Social Behavior, 18 (4), 48–366. https://doi.org/10.2307/2955344

Bhatia, S., Landier, W., Paskett, E. D., Peters, K. B., Merrill, J. K., Phillips, J., & Osarogiagbon, R. U. (2022). Rural–urban disparities in cancer outcomes: Opportunities for future research. *JNCI: Journal of the National Cancer Institute*, *114*(7), 940-952. https://doi.org/10.1093/jnci/djac030

Cao, W., Shakya, P., Karmacharya, B., Xu, D. R., Hao, Y., & Lai, Y. (2021). Equity of geographical access to public health facilities in Nepal. *BMJ Global Health*, *6*(10), e006786. https://doi.org/10.1136/bmjgh-2021-006786

Chowdhury, J. & Ravi, R.P. (2022). Healthcare Accessibility in Developing Countries: A Global Healthcare Challenge. DOI: 10.47363/JCBR/2022(4)152

Chowdhury, J., & Ravi, R. P. (2022). Healthcare accessibility in developing countries: A global healthcare challenge. *Journal of Clinical & Biomedical Research*, 1-5. https://doi.org/10.47363/jcbr/2022(4)152

Claborn, D. (2018). Introductory Chapter: What Is Global Health? *IntechOpen*. doi: 10.5772/intechopen.81978

Coggon, J., & Gola, S. (2013). Global Health and International Community: Ethical, political and regulatory challenges. *Bloomsbury Academic*. http://dx.doi.org/10.5040/9781472544582

Cu, A., Meister, S., Lefebvre, B. & Ridde, V. (2021). Assessing healthcare access using the Levesque's conceptual framework– a scoping review. *International Journal for Equity in Health 20*(116). https://doi.org/10.1186/s12939-021-01416-3

Cueto, M., Brown, T.M. & Fee, E. (2019). The World Health Organization; A history. *Cambridge University Press.* DOI: 10.1017/9781108692878

Durrani,H.(2016).Healthcare and healthcare systems: inspiring progress and future prospects. *Mhealth 2*(2) doi: 10.3978/j.issn.2306-9740.2016.01.03

Fazio, R.H. (2008). Multiple Processes by which Attitudes Guide Behavior: The Mode Model as an Integrative Framework. Advances in Experimental Social Psychology, 23(75-109). https://doi.org/10.1016/S0065-2601(08)60318-4.

Filip, R., Puscaselu, R.G., Norcel, L.A., Dimian, M. & Saage, W. (2022). Global challenges to public healthcare systems during the COVID-19 pandemic: A review of pandemic measures and problems. *Journal of Personalized Medicine,12*(8).https://doi.org/10.3390/jpm12081295

John,C. & Swati, G.(2013). Global Health and International Community. *Bloomsbury Academic.* DOI 10.5040/9781472544582

Le, K.H., La, T.X.P. & Tykkyläinen, M. (2022). Service quality and accessibility of healthcare facilities: digital healthcare potential in Ho Chi Minh City. *BMC Health Research Service 22*,1374. DOI https://doi.org/10.1186/s12913-022-08758-w

Lee, H., Jo, H., Karmacharya, B. M., Sharma, B., Shrestha, P., Satyal, P., & Nam, E. W. (2023). Factors affecting Nepalese rural dwellers' choice of first-contact health facility: A cross-sectional survey. *Journal of Global Health Reports, 7*. https://doi.org/10.29392/001c.75143

Levesque, J.-F., Harris, M. F., & Russell, G. (2013). Patient-centred access to health care: Conceptualising access at the interface of health systems and

populations. *International Journal for Equity in Health, 12*(1), 18. https://doi.org/10.1186/1475-9276-12-18

Marasini, B. (2020). Health System Development in Nepal. *Journal of the Nepal Medical Association, 58*(221), 65–68. https://doi.org/10.31729/jnma.4839

McLaughlin, C. G., & Wyszewianski, L. (2002). Access to care: Remembering old lessons. *Health Services Research, 37*(6), 1441-1443. https://doi.org/10.1111/1475-6773.12171

Mishra, K., Mohapatra, I., & Kumar, A. (2019). A study on the health seeking behavior among caregivers of under-five children in an urban slum of Bhubaneswar, Odisha. *Journal of Family Medicine and Primary Care*, *8*(2), 498. https://doi.org/10.4103/jfmpc.jfmpc_437_18

National Health Policy, 2074 (2019). Ministry of health and population (MoHP), Government of Nepal. https://publichealthupdate.com/national-health-policy-2076nepal

Nepal Health Service Act, 2053(1997). Ministry of health and population (MoHP), Government of Nepal. https://lawcommission.gov.np/en/?cat=612

Neupane, P., Bhandari, D., Tsubokura, M., Shimazu, Y., Zhao, T.& Kono, K.(2021) The Nepalese healthcare system and challenges during COVID-19. *J Glob Health,11.* doi: 10.7189/jogh.11.03030

Norman, P., & Conner, M. (1996). The role of social cognition models in predicting health behaviours: Futuredirections.Open University Press.197-225. https://psycnet.apa.org/record/1996-97268-007

OECD. (2021). *Health at a glance 2021 OECD indicators*. OECD Publishing.

Pandey, Sujita, "Health and Healthcare in Nepal: An Analysis of the Private and Public Sector" (2018). Electronic Theses and Dissertations. 3009.

Pandey, S., Poudel, S., Gaire, A., Poudel, R., Subedi, P., Gurung, J., Sharma, R., & Thapa, J. (2021). Knowledge, attitude and reported practice regarding donning and doffing of personal protective equipment among frontline healthcare workers against COVID-19 in Nepal: A cross-sectional study. *PLOS Global Public Health, 1*(11), e0000066. https://doi.org/10.1371/journal.pgph.0000066

PHCPI. (2020). *Access & Availability*. Primary Health Care Performance Initiative. https://www.improvingphc.org/performance/access-availability

Rai, S., Rai, G., Hirai, K., Abe, A.& Ohno, Y. (2001). The health system in Nepal-An introduction. *Environmental Health and Preventive Medicine, 6*(1). DOI: 10.1007/BF02897302

Rosenstock, I. M. (1974). Historical origins of the Health Belief Model. *Health Education Monographs, 2*(4), 328-335.

Sheeran, P., & Abraham, C. (1996). The health belief model. In M. Conner & P. Norman (Eds.), Predicting health behavior: Research and practice with social cognition models. *Open University Press.* https://psycnet.apa.org/record/1996-97268-002

Stafford, M., Duke-Williams, O., Shelton, N. (2008). Small area inequalities in health: are we underestimating them?*Soc Sci Med.67*(6):891-9. doi: 10.1016/j.socscimed.2008.05.028.

Stafford, I., Dildy, G. A., Clark, S. L., & Belfort, M. A. (2008). Visually estimated and calculated blood loss in vaginal and cesarean delivery. *American Journal of Obstetrics and Gynecology*, *199*(5), 519.e1-519.e7. https://doi.org/10.1016/j.ajog.2008.04.049

The Public Health Service Act, 2075 (2018). Ministry of Law and Justice (MoLJ), Government of Nepal. https://lawcommission.gov.np/en/?cat=630

Universal health coverage partnership annual report 2020: Implementing a primary health care approach towards universal health coverage in the COVID-19 era. (2020). World Health Organization.

Woldemichael, A., Takian, A., Akbari Sari, A., & Olyaeemanesh, A. (2019). Availability and inequality in accessibility of health centre-based primary healthcare in Ethiopia. *PLOS ONE*, *14*(3), e0213896. https://doi.org/10.1371/journal.pone.0213896

World Health Organization. (2018). *Primary health care: Closing the gap*. WHO Press.

Yenet, A., Nibret, G., & Tegegne, B. A. (2023). Challenges to the availability and affordability of essential medicines in African countries: A scoping review. *ClinicoEconomics and Outcomes Research*, *15*, 443-458. https://doi.org/10.2147/ceor.s413546

Annex- Questionnaire, Checklists

Name and Address of the House Owner?

Mother tongue of the home owner?

1. Nepali
2. Maithili
3. Bhojpuri
4. Tharu
5. Other (Specify)

Religion of home owner?

1. Hindu
2. Buddhist
3. Islam
4. Kirat
5. Christian
6. Prakriti
7. won
8. Jain
9. Bahai
10. Sikh
11. Others(specify)

Household Caste/Caste:

1. Khas Arya (Upper Caste)
2. Gahira Dalit Simantakrit Tarai Caste

3. Dalit
4. Simantakrit Janajati
5. Ethnic Groups with Special Privileges (Gurung, Newar, Thakali)
6. Minority Religious Group (Muslim)

What fuel do you mainly usage for cooking?

1. Kerosene/Gasoline
2. Diesel
3. LPG (Liquefied Petroleum Gas)
4. Natural Gas
5. Electricity
6. Manure/Biomass/Briquettes
7. Other (Specify)

What type of washroom your family usage?

1. Flush Toilet (Public Drainage).
2. Flush Toilet (Septic Tank)
3. Basic Pit Toilet
4. No Toilet Facility, Open Fields, Bushes

What are the major sources of income for your family over the last year in aggregate?

1. Agriculture and Animal Husbandry
2. Fruit and Flour farming
3. Trade
4. Industry
5. Employment

6. Daily wage labour
7. Pension
8. Remittance
9. Traditional/ cast base occupation
10. Tourism Related
11. Others

What is the projected twelve-monthly income of your family?

1. Less than NPR 75,000
2. NPR 75,000-NPR 1,50,000
3. NPR 1,50,000-NPR 3,00,000
4. NPR 3,00,000- NPR 5,00,000
5. Above 5,00,000

How much time (in minutes) ensures it take to walk to the nearby health facility/marketplace/road after your household?

nearest health facility/marketplace/road	Minute
1. Health post (Government)	
2.Health post (Private)	
3. Marketplace	
4. Nearest Road	

What is your Home Number??

What is your ward number??

Name of the responded:

What the qualification is of respond person?

Age of the respond person:

This house, where you are presently living, belongs to you or a family persons?

1. Your own
2. Borrowed with somebody else
3. Except your own or rented

How many bedrooms are there in this household? Room number ...../.....

If you have constructed a house, what material has is used for the floor?

(Please circle only one)

1. Bricks
2. Wood
3. Tile/Marble
4. Cement
5. Other (Specify)

What is the main material used in the building of this house? (Choose only one)

1. Carpentered Wooden Structure
2. Brick/Mud/Stone
3. Metal Roofing/Sheets
4. Concrete/Pillars
5. Bamboo/Thatch
6. Mud Plaster
7. Other (Specify)

Where makes your family cook food?

1. Inside the house but not in a separate kitchen room.
2. Inside the house in a separate kitchen room.
3. In a separate house nearby.
4. In an open space near the house.
5. Other (specify)

What is the key basis of drinking water for the members of this family?

(Select only one)

1. Piped water supply
2. Hand pump/well pump
3. Covered well/kuwa
4. Uncovered well/kuwa
5. Surface water (river, stream, pond, lake, canal)
6. Spring water
7. Other (specify)

Which of the following services/items does your family have?

If the answer is "Yes," then how much cash has been expected in total?

From within the country:

From outside the country:

If the answer is "No" for any one, write 00, and if the answer is "Don't know," write 888,888,888.

What were the key three sources of income for your family in last year?

What is the projected yearly income of your family?

1. Less than NPR 75,000
2. NPR 75,000 - 1,50,000
3. NPR 1,50,000 - 3,00,000
4. NPR 3,00,000 - 5,00,000
5. More than NPR 5,00,000

How many months ensures this income tolerate your family for food?

In the last month, was any member of this family very sick?

1. Yes
2. No

In the past three years, have any child in this house aged below 3 years died?

1. Yes
2. No

In the last week , in which key parts have you been mainly involved in work?

How many hours do you work on normal per day?

How much do you make per hour, around?

What is the working atmosphere like?

1. Good (Clean, proper sanitation facilities, canteen available, availability of drinking water)
2. Fair (Clean, proper sanitation facilities, canteen available, availability of drinking water to some extent)
3. Not good

How frequently do you use caring materials correlated to health at the workplace to stop disease?

1. Used frequently
2. Used occasionally
3. Not used at all

Has the employer providing any health-associated insurance to you?

1. Yes
2. No

Overall, how would you define your health position from yesterday?

(Choose one)

1. Very good
2. Good
3. Fair
4. Poor
5. Very poor

Has any member of you or your family hurt from a chronic illness?

1. Yes
2. No

Has any member of you or your family ever feel a illness that effects pain while urinating and uneasiness in the groin part?

1. Yes
2. No

Have you or any member of your family ever been identified with diabetes?

1. Yes
2. No

Have you or any member of your family ever been identified with a sickness associated to high blood pressure?

1. Yes
2. No

Have you or any member of your family ever been identified with prostate cancer?

1. Yes
2. No

Have you or any member of your family ever been identified with epilepsy?

1. Yes
2. No

Have you or any member of your family ever been identified with addiction or substance abuse?

1. Yes
2. No

Have you or any member of your family ever been identified with neurological or heart diseases?

1. Yes
2. No

Have you or any member of your family ever been identified with thyroid/goiter-related diseases?

1. Yes
2. No

Have you or any member of your family ever been identified with ulcer-related diseases?

1. Yes
2. No

Have you or any member of your family ever been identified with Hepatitis B-related illnesses?

1. Yes
2. No

Have you or any member of your family ever been identified with skin-related diseases?

1. Yes
2. No

Has any male member of your family ever been identified with prostate cancer?

1. Yes
2. No

Have you or any member of your family ever been identified with breast cancer?

1. Yes
2. No

Have you or any member of your family ever been identified with cervical cancer?

1. Yes
2. No

Have you or any member of your family faced any genital-correlated difficulties?

1. Yes
2. No

How would you define your mental health position above the few days?

(Varying degrees of positive to negative)

1. Very Good
2. Good
3. Fair
4. Poor
5. Very Poor
96. Don't know
97. No response

Apart from the revealed sicknesses, have you currently suffered from illnesses like fever, seasonal flu, jaundice, typhoid, conjunctivitis, or other eye-related difficulties?

1. Yes
2. No
96. Don't know
97. No response

How earlier period did you or your family member go to a health institute or doctor for your own or their treatment?

1. Within a year1
2. Within one to three years
3. Not been yet (going within 28 days)
96. Don't know (going within 28 days)
97. No response (going within 28 days)

Was the last time you went to a health organization situated within this similar municipality?

1. Yes
2. No

96. Don't know

97. No response

What type of health organization did you previous visit for your individual treatment or treatment of family memberships?

1. Public health institution
2. Private doctor or health facility
3. Health facility operated by NGO/INGO

96. Don't know

97. No response

Did you visit a health institution or doctor due to any of the following reasons?

Did you visit the health institution or doctor because it was the closest one to you?

1. Yes
2. No

96. Don't know

97. No answer

Did you visit the health institution or doctor because they are renowned for providing quality treatment?

3. Yes
4. No

96. Don't know

97. No answer

Did you visit the health institution or doctor because the cost was not too high?

5. Yes

6. No

96. Don't know

97. No answer

Did you visit the health institution or doctor because you personally knew the doctors and nurses working there?

7. Yes

8. No

96. Don't know

97. No answer

Did you visit the health institution or doctor to support individuals contributing to healthcare at that institution?

9. Yes

10. No

96. Don't know

97. No answer

Regarding the doctor and health institution you visited, please indicate whether the following statements are true or not true.

1. True

2. Not True

96. Don't know

97. No response

Restrooms were clean.

3. True

4. Not True

96. Don't know

97. No response

A doctor was present.

5. True

6. Not True

96. Don't know

97. No response

Patients were treated with good manners.

7. True

8. Not True

96. Don't know

97. No response

HD24_4. The cost of treatment was reasonable.

9. True

10. Not True

96. Don't know

97. No response

HD24_5. Timely information was given about treatment costs.

11. True

12. Not True

96. Don't know

97. No response

HD24_6. It didn't take much time to receive treatment after registration.

13. True

14. Not True

96. Don't know

97. No response

HD24_7. I had to bribe to get proper treatment.

15. True

16. Not True

96. Don't know

97. No response

HD24_8. I had to use influence to get proper treatment.

17. True

18. Not True

96. Don't know

97. No response

HD24_9. Medicines essential were certainly accessible in the pharmacy.

19. True

20. Not True

96. Don't know

97. No response

HD24_10. I was referred to a private health center for additional examinations and treatment.

21. True

22. Not True

96. Don't know

97. No response

HD25. Among the following, how happy were you with each side associated to the doctor and health institute you visited?

1. Very Satisfied
2. Somewhat Satisfied
3. Somewhat Dissatisfied
4. Very Dissatisfied

96. Don't know

97. No response

HD25_1. The cost of cure at the doctor and health institute you visited.

1. Very Satisfied
2. Somewhat Satisfied
3. Somewhat Dissatisfied
4. Very Dissatisfied

96. Don't know

97. No response

HD25_2. The individual consideration delivered for patient care at the doctor and health institution you visited.

1. Very Satisfied
2. Somewhat Satisfied
3. Somewhat Dissatisfied

4. Very Dissatisfied

96. Don't know

97. No response

HD25_3. The medical facilities delivered by the doctor and health institute you go to.

1. Very Satisfied
2. Somewhat Satisfied
3. Somewhat Dissatisfied
4. Very Dissatisfied

96. Don't know

97. No response

HD25_4. The facilities and infrastructure of the room/building where the doctor and health institution were located.

1. Very Satisfied
2. Somewhat Satisfied
3. Somewhat Dissatisfied
4. Very Dissatisfied

96. Don't know

97. No response

HD26. Did the following objects deliver help to you or your family?

1. Yes
2. No

96. Don't know

97. No response

HD26_1. Relatives and close friends

1. Yes
2. No

96. Don't know

97. No response

HD26_2. Neighbors

1. Yes
2. No

96. Don't know

97. No response

HD26_3. Caste/ethnic group members

1. Yes
2. No

96. Don't know

97. No response

HD26_4. Local religious community

1. Yes
2. No

96. Don't know

97. No response

HD26_5. Religious donation

1. Yes
2. No

96. Don't know

97. No response

HD26_6. Non-religious donation

1. Yes
2. No

96. Don't know

97. No response

HD26_7. Other civic community groups

1. Yes
2. No

96. Don't know

97. No response

HD26_8. Other professional groups

1. Yes
2. No

96. Don't know

97. No response

HD26_9. Wealthy local family leaders

1. Yes
2. No

96. Don't know

97. No response

HD26_10. Municipal council members

1. Yes
2. No

96. Don't know

97. No response

HD26_11. Local government

1. Yes
2. No

96. Don't know

97. No response

HD26_12. Other groups

1. Yes
2. No

96. Don't know

97. No response

HD27. Did you obtain any support for accessing this health management and for the related expenses?

1. Received
2. Not received

96. Don't know

97. No response received

HD28. Within a year, from the following, wherever did you take medical counsel?

1. Yes
2. No

96. Don't know

97. No response

HD218_1. Pharmacist

1. Yes
2. No

96. Don't know

97. No response

HD218_2. Local medical practitioner

1. Yes
2. No

96. Don't know

97. No response

HD218_3. Internet

1. Yes
2. No

96. Don't know

97. No response

HD218_4. Friends, family, and neighbors

1. Yes
2. No

96. Don't know

97. No response

HD29. In the perspective of cure, how would you rate the superiority of care?

1. Very good
2. Good
3. Not good
4. Very bad

96. Don't know

97. No response

HD29_1. The nearby public hospital to you

1. Very good
2. Good
3. Not good
4. Very bad

96. Don't know

97. No response

HD29_2. The nearby private hospital to you

1. Very good
2. Good
3. Not good
4. Very bad

96. Don't know

97. No response

HD29_3. Private Doctor or health services

1. Very good
2. Good

3. Not good
4. Very bad

96. Don't know

97. No response

HD29_4. The nearby public health services to you

1. Very good
2. Good
3. Not good
4. Very bad

96. Don't know

97. No response

HD29_5. The nearest pharmacy to you

1. Very good
2. Good
3. Not good
4. Very bad

96. Don't know

97. No response

HD29_6. Local Doctor

1. Very good
2. Good
3. Not good
4. Very bad

96. Don't know

97. No response

HD30. When going for treatment to the nearby community health post, can you meet the doctor and get observed at the following times?

HD30_1. 8:30 AM in the morning

1. Yes
2. No

96. Don't know

97. No response

HD30_2. 12:00 PM at noon

1. Yes
2. No

96. Don't know

97. No response

HD30_3. 4:30 PM in the evening

1. Yes
2. No

96. Don't know

97. No response

HD31. Do you or anybody staying with you have an unmet essential for any of the following health facilities, which you or your family members have not been able to obtain?

HD31_1. Medical care (including facilities like vaccinations, taking vitamins, etc.)

1. Yes

2. No

96. Don't know

97. No response

HD31_2. Dental care

1. Yes

2. No

96. Don't know

97. No response

HD31_3. Ear-related issues (hearing problems)

1. Yes

2. No

96. Don't know

97. No response

HD31_4. Mental health

1. Yes

2. No

96. Don't know

97. No response

HD31_5. Family planning

1. Yes

2. No

96. Don't know

97. No response

HD31_6. Telemedicine

1. Yes
2. No

96. Don't know

97. No response

HD32. Have you joined in health insurance?

Note: Health insurance take all your medical expenditures either completely or partly through government or private means.

1. Yes
2. No (Go to 34)

96. Don't know (Go to 34)

97. No response (Go to 34)

HD33. What kind of health insurance do you take?

1. Government
2. Private health coverage

96. Don't know

97. No response

HD34. If you haven't got insurance, what are the core causes?

1. Financial
2. Lack of information
3. Inaccessibility
4. Health concerns

96. Don't know

97. No response

(HD 35) How do you frequently travel to the nearby health care services?

1. Walk
2. Bicycle
3. Motorcycle
4. Car
5. Public transportation

(HD 36) Which health care ability do you visit maximum regularly?

1. Hospital
2. Health post
3. Traditional Healers

(HD 37) How happy are you with the value of health care facilities delivered by the nearest health care center?

1. Very satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very dissatisfied

(HD 38) Are there any particular obstacles while accessing health care facilities?

1. Long travel distance
2. Lack of transportation
3. Lack of healthcare specialists
4. High costs

5. Language barriers
6. Other

(HD 39) Are there any specific times or seasons when accessing health care facilities becomes more difficulties?

1. Monsoon season
2. Winter season
3. Festive seasons
4. No specific challenges

(HD 40) Have you ever used telemedicine or remote health care facilities?

1. Yes
2. No
3. Not aware of such facilities

(HD 41) In what way would you rate the affordability of health care facilities in Konjyosom Rural Municipality?

1. Affordable
2. Moderately affordable
3. Expensive
4. Not sure

(HD 42) Have you faced any financial problems in accessing health care facilities?

1. Yes
2. No

(HD 43) Are there any public health workers or volunteers who deliver health care facilities in your region?

1. Yes
2. No
3. Not aware

(HD 44) How happy are you with the accessibility of medical specialists at the health care services?

6. Very satisfied
7. Satisfied
8. Neutral
9. Dissatisfied
10. Very dissatisfied

(HD 45) Have you ever had to visit several health care services to take sufficient medical attention?

1. Yes
2. No
3. Not applicable

(HD 46) How regularly do you visit health care services for preventive care, such as check-ups?

1. Regularly
2. Occasionally
3. Rarely
4. Never

(HD 47) Do you trust that the local administration is actively working to expand the accessibility and availability of health care facilities?

1. Yes
2. No
3. Not sure

(HD 48) Are there any particular health care facilities that you trust should be selected or expanded in the rural municipality?

1. Primary care services
2. Maternal and child health care
3. Specialized diagnostic services
4. Mental health care services

(HD 49) Have you ever tackled discrimination while looking for health precaution?

1. Yes
2. No

(HD 50) Do you have any recommendations on how to increase the accessibility and availability of health care services in Konjyosom Rural Municipality?

1. Improve transportation infrastructure
2. Increase the number of health care professionals
3. Enhance medical equipment and supplies
4. Strengthen community health outreach programs

(HD 51) How would you rate the total infrastructure and condition of the health care services in Konjyosom Rural Municipality?

1. Excellent
2. Good
3. Fair

4. Poor

(HD 52) Are there any transportation obstacles to access to health care facilities?

1. Lack of public transportation
2. Poor road conditions
3. Limited availability of vehicles
4. Others (please specify)

(HD 53) Are there any precise age groups or demographics that face additional challenges in accessing health care facilities?

1. Elderly population
2. Children and adolescents
3. Pregnant women
4. Others

(HD 54) Are there any cultural or traditional health care practices that coexist with modern health care facilities in the rural municipality?

1. Yes
2. No

(HD 55) Have you ever faced any challenges in accessing health care services during natural disasters or emergencies?

1. Yes
2. No

(HD 56) Are you aware of any health education programs or initiatives that have been conducted in the rural municipality?

1. Yes

2. No

(HD 57) How often do you face challenges in obtaining appointments or scheduling visits to health care facilities?

1. Frequently
2. Sometimes
3. Rarely
4. Never

(HD 58) Are you aware of any initiatives or programs that focus on the prevention and control of communicable diseases in the rural municipality?

1. Yes
2. No

(HD 59) How satisfied are you with the availability of health care services during weekends and public holidays?

1. Very satisfied
2. Satisfied
3. Neutral
4. Dissatisfied
5. Very dissatisfied

(HD 60) Do you feel that nearby is adequate community awareness about the significance of regular fitness check-ups in the rural municipality?

1. Yes
2. No

SA01. How frequently does the community authority accumulate waste in your community municipality?

1. Daily
2. More than once a week
3. Once a week
4. 2 to 3 times a month
5. Once a month
6. Less than once a month
7. Never in practical terms

96. Don't know

97. No response

SA03. Which bases of water do you usage for drinking in your neighborhood? (Multiple responses)

SA03/1. Bottled mineral water

1. Yes
0. No

SA03/2. Tap water at home

1. Yes
0. No

SA03/3. Public tap water

1. Yes
0. No

SA03/4. Open well water

1. Yes
0. No

SA03/5. Piped water supply

1. Yes
0. No

SA03/6. River or lake water

1. Yes
0. No

SA03/7. Rainwater

1. Yes
0. No

SA03/8. Don't know

1. Yes
0. No

SA03/9. No response

1. Yes
0. No

SA04. Within the last week, did you experience...

SA04_1. Inadequate nutrition to eat?

1. Yes
2. No
96. Don't know

97. No response

SA04_3. Inadequate consumption of water?

1. Yes
2. No

96. Don't know

97. No response

SA04_4. Sudden disturbance in water source?

1. Yes
2. No

96. Don't know

97. No response

Checklist and Focused Group Discussion Guideline

1. What are the maximum common health concerns faced by the public in Konjyosom Rural Municipality?
2. How far are the nearby healthcare services from your residence, and how do you usually travel around?
3. What types of healthcare facilities are accessible in your community, and how often do you use them?
4. What are the central financial challenges you appearance when accessing healthcare facilities?
5. How rewarded are you with the superiority of care providing at the healthcare services you visit?
6. What are the social issues that affect your choice to seek healthcare services?
7. What progresses would you identical to see in the healthcare facilities providing in your community?
8. How do you observe the character of traditional remedy?
9. What kinds of health schooling programs are accessible, and how real do you find them?
10. What chances do you consider could develop access to healthcare in your community?

Photographs

Photo 1

Researcher with Respondent During the Household Survey

Photo 2

15-bedded Hospital Under Construction at Konjyosom Rm

Photo 3

A Local Person Interviewed During the Field Survey

Photo 4

The Elderly Grandfather Happily Responded to the Survey Questions