Health Sector Transition and Recovery Programme

468 FCHVs (234 in each district) trained on detecting mental health cases in the community and their referral to health facilities

Transcultural Psychosocial Organisation

April 2016

TPO Nepal
PEACE OF MIND

NHSSP

UKaid
from the British people

Disclaimer: The document has been funded by UKaid from the UK government's Department for International Development (DFID); however the views expressed in this report do not necessarily reflect the UK government's official policies.

Cover photo courtesy of DFID Nepal.

TABLE OF CONTENTS

LIST OF ACRONYMS

CIDT	Community Informant Detection Tool
DFID	Department for International Development (UK Aid)
DHO	district health office
DoHS	Department of Health Services
DPHO	district public health office
FCHV	female community health volunteer
GoN	Government of Nepal
mhGAP HIG	Mental Health Gap Action Program Humanitarian Intervention Guide
MHPSS	mental health and psychosocial support
MoH	Ministry of Health
NGO	non-government organisation
NHSP-2	Second Nepal Health Sector Programme (2010–2015)
NHSSP	Nepal Health Sector Support Programme
NPR	Nepalese rupees
PHCC	primary health care centre
PRIME	Programme for Improving Mental Health Care
PTSD	post-traumatic stress disorder
SHP	sub health post
TPO	Transcultural Psychosocial Organization
VDC	village development committee

1 BACKGROUND AND OBJECTIVES

1.1 Health Care Delivery System in Nepal

In Nepal, central and regional hospitals constitute the tertiary level and zonal and district hospitals the secondary level of the health care system. Primary health care is delivered through primary health care centres (PHCCs), health posts and sub-health posts (SHPs) at electoral constituency and village development committee (VDC) levels. Community participation is ensured at all levels of health care through female community health volunteers (FCHVs). SHPs are the first institutional contact point for basic health services. Altogether, there are 3,129 SHPs in the country,[1] which provide essential health care and monitor the activities of FCHVs and other community level health care activities. The next level up in the health care system is health posts that offer the same package of essential health care services with the additional service of birthing centres, as well as the responsibility of monitoring SHPs' activities. There are currently 676 health posts in the country. Next in the hierarchy are primary health care centres (PHCCs), which are higher level health care institutions established in each electoral area as the first point of referral. The major responsibilities of PHCCs are general medical care including mental health services, family planning, maternal and child health, basic laboratory testing and providing essential health care services. PHCCs monitor the activities of health posts and SHPs. District hospitals are the highest level district health institutions. District public health offices (DPHOs) and district health offices (DHOs) are responsible for coordinating health care activities in districts.

1.2 Female Community Health Volunteers

To ensure community participation in health care the Government of Nepal (GoN) initiated the FCHV Programme in 1988 in 27 districts and expanded it to all 75 districts by 1995. The goal is to support health through community involvement in public health activities. FCHVs also provide advice and basic health care for the empowerment of women. They increase access to safer motherhood; newborn care; immunization; good nutrition; combatting communicable and epidemic diseases, acute respiratory diseases and diarrheal diseases; environmental sanitation; health education and support other national programmes.

1.3 Post-earthquake Mental Health Needs

The earthquakes of April and May 2015 exacerbated many people's pre-existing mental health conditions and created new mental health problems in earthquake-affected communities. A needs assessment carried out after the earthquakes by the Transcultural Psychosocial Organization Nepal (TPO Nepal) found several mental health and psychosocial problems in the communities studied including behavioural problems (e.g., increased anger and aggression); cognitive symptoms (e.g., lack of concentration); sleep problems (e.g., sleeping difficulties); and somatically expressed psychological problems (e.g., lack of sensation in limbs).

However, the resources available to provide mental health services in Nepal are limited. It was therefore seen that building the capacity of primary health care workers in earthquake-affected districts could be an appropriate way of providing basic mental health and psychosocial support to affected communities. In general, people with mental health problems go to their nearest

[1] Note that the government is upgrading all SHPs to health posts

health post or PHCC for help and follow the guidance given by health workers. Therefore, in the aftermath of the earthquakes, TPO saw the need to train primary health care workers and FCHVs to provide mental health services and establish a referral mechanism from the local community level.

1.4 Involvement of FCHVs in Mental Health Care

FCHVs have been involved in delivering mental health services in TPO Nepal's programmes in Pyuthan and Chitwan districts over the last three years. FCHVs were trained on detecting and referring people with mental health problems and providing home-based care for people with severe mental health problems. These activities were very effective especially for encouraging people to seek mental health services and for reducing the stigma associated with mental health problems.

Under HSTRP, TPO is implementing a project supported by NHSSP to increase access to mental health care in the two earthquake affected districts of Ramechhap and Dolakha. Considering the important contributions of FCHVs in mental health care in its previous programmes, TPO proposed training FCHVs for this purpose.

The overall objective of this FCHV training programme was to facilitate the detection of mental health problems in local communities in order to increase the help-seeking behaviour of people with mental health problems.

The specific objectives were to:

- sensitize FCHVs on the mental health and psychosocial issues of people affected by earthquakes;
- prepare a pool of self-motivated volunteers to bridge the gap between mental health services and communities' needs;
- build the capacity of FCHVs to identify and refer people from local communities with mental health and psychosocial problems; and
- increase local community participation in mental health and psychosocial support responses in post-earthquake settings.

2 Methodology

2.1 Development and Validation of CIDT

The Community Informant Detection Tool (CIDT) was developed as a part of PRIME (Programme for Improving Mental Health Care) (www.prime.uct.ac.za) to promote the help seeking of people with mental health problems (Jordans et al. 2015). The CIDT consists of vignettes and associated pictures to facilitate the recognition of mental health problems by lay people. The case vignette of each disorder was made using common symptoms from the World Health Organization's (WHO's) Mental Health Gap Action Program (mhGAP) and a prior ethno-psychological research in Nepal (Kohrt and Harper, 2008). In addition to each case vignette and subsequent pictures, there are three structured questions about the level of match between the vignettes and people who potentially have mental health problems and needs for support. The response to the first question is marked on the Likert Scale of 1- no match, 2- moderate match, 3- good match and 4- very good match, and the other two questions are answered yes or no. For each likely case, if there is some degree of match with the vignette, it leads to an additional two questions about need for support and functioning impairment. A person with a moderate to very good match response to the first question and positive response to any of the two additional questions is identified as someone at risk of having mental health problems and is advised to seek help at a nearby health facility.

The CIDT was also validated to assess how accurate the CIDT procedure is in identifying people with priority mental disorders. About 64% of the people that the community informants (FCHVs) identified as probable cases using the CIDT were actually positive cases based on clinical interviews, and 93% of people that community informants were confident were probable non-cases, were indeed found negative (Jordans et al. 2015)

2.2 Contextualization of the CIDT in a Post-earthquakes Setting

The CIDT was contextualized by TPO to better suit the post-earthquake scenario by changing the background of the pictures. The new background was of destroyed houses and people living in temporary tents as was the case in the aftermath of the April and May 2015 earthquakes. Also, other CIDTs on suicide and post-traumatic stress disorder (PTSD) were developed especially for the post disaster setting. The same methodology and process (which was followed by PRIME) was followed while developing the new CIDTs. Psychiatrists, psychologists and psychosocial counsellors who were working in the post-earthquake scenario were involved in developing the vignettes for the suicide and PTSD CIDTs.

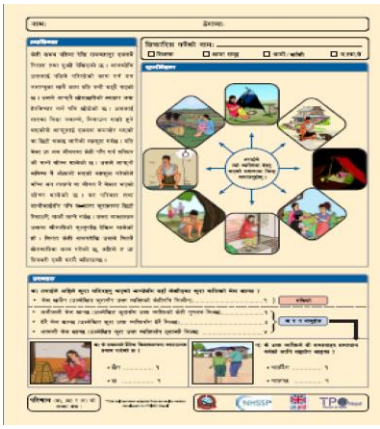

Figure 1: CIDT

2.3 Preparation of Training and Training Materials

The training materials used in the FCHV training was based on the training materials developed in the PRIME project. These materials were contextualized by incorporating post-earthquake related issues and scenarios. The lessons learned by counsellors working in the post-earthquake setting were also incorporated in the training content and materials. The most common mental health reaction of the general

population after disasters such as earthquakes, including increased physical (somatic) symptoms, fear and stress, were included in the training content. There are individual variations in coping after disasters depending upon individuals' psychology, the social context and the level of family support. These points were also incorporated in the training material. Other aspects like myths about the cause of mental health problems and the use of stigmatizing words to people with mental health problems were added. Apart from this, the idea that these problems can be treated with appropriate medications and psychosocial support was also added to the training content. All the content was developed in simple Nepali language.

The trainings of FCHVs were conducted in their respective VDCs. Due to the lack of electricity in many VDCs, newsprints, whiteboards and markers were used in the training programmes. The FCHV participants were also provided with notebooks and pens to note down key points during the training sessions.

2.4 Selection of FCHVs

The training programme aimed to train 234 FCHVs in each of Dolakha and Ramechhap districts. The fact that there were 1,256 FCHVs in Dolakha and 752 in Ramechhap meant that all VDCs could not be covered by the training programme. Meetings of the DHO team (the district health officer, mental health focal person), NHSSP's district coordinator and the TPO Nepal team (project manager, district coordinator and clinical supervisor decided that VDCs that were heavily affected by the earthquakes would be targeted and their FCHVs trained.

Many VDCs have more than 9 FCHVs (i.e. more than one per ward) and so it was decided to include all FCHVs from the chosen VDCs in the first day of the training (i.e. mental health orientation) in Dolakha. Only 9 FCHVs (one from each ward) were included on the second day of the training, the CIDT training. The selection of one FCHV from each ward was done by the FCHVs themselves based on ability to read and write, leadership qualities and availability of time for doing FCHV tasks. In Dolakha 572 FCHVs from 29 VDCs received one day of training and 268 of them received the full two days training including on CIDT (see Annex 2). In Ramechhap, district all FCHVs from the selected VDCs were trained for two full days (as suggested by the DHO team). In total 297 FCHVs from 24 VDCs were trained in Ramechhap (see Annex 3).

2.5 Training Content and Duration

The training was conducted over two days. The duration of each day was six and half hours with a break in between. The first day was dedicated to the introduction to psychosocial problems, brief discussion of the symptoms of depression, psychosis, PTSD, suicide, epilepsy and alcohol use disorder, and stigma associated with mental health problems. On the second day details of the CIDT were discussed, which included procedure for use, the referral of cases and limitations of the tool. The role and responsibilities of FCHVs in this program and case confidentiality for mental health problems were also discussed on day 2. The detailed content of the training is given in Annex 1. A sample page of the CIDT and the referral form is given in Annexes 4 and 5.

2.6 Techniques and Methods Used

The trainings were facilitated by the project's psychosocial counsellors and community psychosocial workers (CPSWs). TPO Nepal counsellors from other districts were also mobilized for the training. The quality of the trainings was ensured by the clinical supervisors from each district

monitoring the training sessions. The in-charges of the respective health facilities were also present for some time during the events and also monitored the conduct of the training.

Clinical supervisor facilitates training (Dolakha)

Several methods were used to deliver the training content. PowerPoint presentations and mini-lectures were given to provide information about mental health problems, their causes and impacts. Group work and discussions were used for making participants aware about stigma associated with mental health problems, myths and misconception about their cause, and treatment in the community. Brainstorming session were conducted on the topic of stigma where participants were asked to think of ways to reduce stigma in their communities. Participants were also asked to describe cases present in their communities and ways of linking them to health facilities.

Psychosocial counsellor facilitating training (Ramechhap)

The trainers also shared case stories on how to help the FCHVs understand the symptoms of mental health problems and how patients often improve after proper referral to health facilities. Trainers focused on role plays for teaching the skills to use the CIDT and referral slip. In the role plays the trainers acted the role of a client where participants had to fill up a CIDT and referral form on the client. The role plays emphasized rapport building with clients and good communication skills. The plays were repeated until they had a satisfactory level of performance as judged by facilitators.

2.7 Implementation of the CIDT

After the training, each FCHV was provided with the CIDT tools on depression, psychosis, epilepsy, suicide, alcohol use disorder and PTSD) and the referral slips. The FCHVs were advised to focus on identifying people with priority disorders (e.g. depression, psychosis etc.) by using the skills and tools they had learned. They will also identify probable cases through day-to-day interactions and observations of community members and from information from family members, relatives and friends. They were advised that if they come across clients who seem to have a mental health issue, they should fill in the CIDT form. For clients needing referring to a health facility, FCHVs were told to provide a referral slip to the client or their family member with the name and address of the client, and place of referral. FCHVs were also told to provide information to family members about the problem, its treatment process and advise them to encourage the client to go for treatment. Completed CIDTs are kept with FCHVs and the client is referred with a referral slip that is later collected at the health facility. During this process, the FCHV should not use any stigmatizing words and should encourage family members and other community members to also avoid such words.

3 ASSESSING TRAINING OUTCOMES

The main outcome of the training is reflected in the number of cases referred to local health facilities after the training period. This can be tracked in two ways:

- By checking the outpatient (OPD) register in the health facilities. One column is for source of referral, including from FCHVs.
- By looking at the number of CIDT forms filled up. These forms will be kept by FCHVs and are collected by CPSW workers during their monthly meetings.

In addition to the application of CIDT and referral of clients to health facilities, FCHVs should also be involved in building community awareness and in sensitizing people on mental health issues through discussions in different meetings. They will also be involved in informal discussions at mothers' groups and small local gatherings. In these discussions the FCHVs should try and make local people aware of available mental health services and encourage relatives of patients to seek support. These discussions are conducted in FCHVs' own wards. Feedback from these discussions will be collected by the CPSWs during monthly supervision meetings.

Considering the basic level of education of most FCHVs, TPO didn't use any form of pre and post-test questionnaire or other evaluation forms. However, several techniques such as verbal questioning on their understanding, assessments of role plays, questions about changes in their attitudes were used to assess comprehension of the training content.

4 SUPERVISION OF TRAINED FCHVS

The post training follow-up mentoring and supervision of FCHVs is being done by the CPSWs of the concerned VDCs once a month by meeting with the trained FCHVs. At these meetings, CPSWs collect all completed CIDT forms from FCHVs and provide new CIDT forms as per the need, discuss the challenges and difficulties FCHVs have faced during the administration of CIDTs, and the challenges of encouraging people with mental health problems to seek services. In addition, other day-to-day challenges faced by FCHVs, such as queries from community members about mental health issues, myths and misconceptions about mental health problems and their treatment are also discussed. In addition, the supervision meetings also include imparting additional skills to FCHVs including problem solving, communication, and simple relaxation exercises. FCHVs that experience major problems during raising awareness and sensitization in their communities, are visited by the project's psychosocial counsellors to solve those problems. FCHVs receive NPR 400 for transportation costs to attend the monthly meetings.

5 PLANS VERSUS ACHIEVEMENTS

As shown in Table 1 all payment deliverable 7 activities have been achieved. The development of training materials and reading materials for the FCHVs was completed with appropriate contextualization. The main people involved in the development and content adoption of the CIDT were TPO's psychologists, psychiatrists and NHSSP's consultant psychiatrist. The decision on which VDCs to target was made by the DHOs in consultation with TPO Nepal and NHSSP's district coordinator consultant psychiatrist.

The project trained more FCHVs than proposed in the project proposal. In total 565 FCHVs (297 in Ramechhap and 268 in Dolakha) successfully received two days' training on CIDT. TPO Nepal believes that the flow of mental illness cases to the health facilities will increase when FCHVs initiate using the CIDT to detect local people with mental health problems. Alongside these training courses other project activities are sensitizing local communities about mental health problems and available services, which will facilitate the work of FCHVs by making local people more aware about mental health issues.

Table 1: Plan versus achievements

Planned	Achieved
1. Develop training material and reading materials	Done
2. Consult with Nepali mental health experts to contextualize CIDT story and pictures	Done
3. Select FCHVs for training	Done
4. Train 468 FCHVs on identification of mental health cases and the referral of cases to health facilities.	Done — trained 565 FCHVs

REFERENCES

IASC (2007). Guidelines for Mental Health and Psychosocial Support in Emergency Settings, Geneva: Inter-Agency Standing Committee.

IASC (2015). Nepal Earthquakes 2015: Desk Review of Existing Information with Relevance to Mental Health and Psychosocial Support. Kathmandu: Inter-Agency Standing Committee (IASC) Reference Group for Mental Health and Psychosocial Support in Emergency Settings.

Jordans, M. J., Kohrt, B. A., Luitel, N. P., Komproe, I. H. and Lund, C. (2015). Accuracy of proactive case finding for mental disorders by community informants in Nepal. The British Journal of Psychiatry, 207(6), 501-506.

Kohrt, B. A., and Harper, I. (2008). Navigating diagnoses: Understanding mind–body relations, mental health, and stigma in Nepal. Culture, Medicine, and Psychiatry, 32(4), 462-491.

Luitel, N. P., Jordans, M. J., Adhikari, A., Upadhaya, N., Hanlon, C., Lund, C., and Komproe, I. H. (2015). Mental health care in Nepal: Current situation and challenges for development of a district mental health care plan. Conflict and Health, 9(1), 1.

WHO (2008). mhGAP. Mental Health Gap Action Programme: Scaling up care for mental, neurological and substance use disorders. Geneva: World Health Organization.

WHO (2010). mhGAP intervention guide. Geneva: World Health Organization.

WHO (2015). mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: World Health Organization.

ANNEX 1: Content of FCHV CIDT training

Day 1	
Content	**Facilitator**
Introduction about the project and TPO Nepal	Counsellor and CPSWs
Introduction about psychosocial problems and mental health, causes and symptoms Brief information about disorders (symptoms, causes, how to treat) • Depression psychosis • PTSD • Epilepsy • Suicide • Alcohol Use Disorder	Counsellor and CPSWs
Stigma • Assessment on stigma in mental health in local communities • Words used to address patients with mental health problems • Encouragement on how to reduce negative perceptions , beliefs and way of addressing patients with mental health problems in communities • Types of stigma • Causes of stigma • Ways to reduce stigma in communities	Counsellor and CPSWs
Names of available medicine and details of psychosocial service available and means of referring cases to higher level facilities	Counsellor and CPSWs

Day 2	
Content	**Facilitator**
CIDT Introduction about CIDT Objectives of CIDT Steps of using CIDT Role play in groups (how to fill up CIDT, how to present with the client, how to speak to clients)	Counsellor and CPSWs
Referring cases Information about referral slips Role plays Simple information about should be done in the presence of client including active listening, presenting in polite way, confidentiality, respectful behaviour, encouraging them for treatment How to provide psycho education Things to avoid including forceful referral to health post , negative words, negative behaviour. **Wrap-up** Role and responsibilities of FCHVs (refer, encourage the family to go health facility) Documentation of CIDT form, monthly meetings and supervision.	Counsellor and CPSWs

ANNEX 2: Number of FCHVs Trained in Dolakha by VDC

	VDC	Number FCHVs trained (first day)	Number FCHVs trained both days
1	Sunkhani	34	9
2	Sundrawati	22	9
3	Phasku	30	9
4	Jiri	35	12
5	Katakuti	23	9
6	Boch	21	9
7	Suspakshemawoti	24	9
8	Magapauwa	18	9
9	Charikot PHCC	9	9
10	Mati	9	9
11	Mali	13	9
12	Dolakha	9	9
13	Alampu	13	9
14	Babre	22	9
15	Suri	21	9
16	Gaurishanker	8	8
17	Laduk	27	9
18	Khare	14	9
19	Bhusapheda	15	8
20	Makaibari	9	9
21	Virkot	19	9
22	Lamidanda	30	9
23	Malu	21	9
24	Lapilang	32	9
25	Chankhu	10	10
26	Marbu	13	13
27	Jafe	21	9
28	Sahare	22	9
29	Bhedpu	29	10
Total	**29 VDC**	**573**	**268**

ANNEX 3: Number of FCHVs trained in Ramechhap by VDC

	VDC	Number of FCHVs trained
1	Saipu	9
2	Bijulikot	15
3	Sanghutar	10
4	Deurali	14
5	Priti	14
6	Doramba	10
7	Those	9
8	Khandapani	13
9	Lokhanpur	12
10	Okhreni	9
11	Sukajor	13
12	Tokarpur	14
13	Kubukasthali	11
14	Bamti	12
15	Khimti	13
16	Bhirpani	14
17	Gaagal	11
18	Majhuwa	10
19	Tilpung	13
20	Sunarpani	9
21	Bhaluwajor	11
22	Puranagaun	11
23	Kathaajor	16
24	Matadum	9
Total	**24 VDC**	**297**

ANNEX 4: Sample Earthquake CIDT tool (Nepali)

नाम: ठेगाना:

आघातजन्य घटना पश्चात देखिने तनावपूर्ण अवस्था

भान्छामा काम गरिरहेकी गीताले एकाएकी भुईचालो आएको थाहा पाएकी थिइन् । चिच्याउँदै, कराउँदै बाहिर निस्कन नपाउँदै उनले आफ्नो घरको छानो भत्किएको देखिन् । भुईचालो गएको एक महिना बितिसक्दा पनि गीता आजभोलि धेरैपटि भुईचालो आयो कि भनेर अत्तालिँदै भाग्छिन् । कोठा भित्र जान नसाहनेकाले धेरैजसो उनको परिवार चालमै बसिरहेका छन् । उनी भत्किएको घर धेरैपटि पनि जान मान्दिनन् ।

उनलाई आजभोलि भुईचालो गएर घरहरू भत्किएको भत्काएको चासोभार आइरहन्छ । निन्द्रामा पनि धेरै जस्तो नराम्रो सपना देखेर अत्तालिने गर्छिन् । अरूसग कुराकानी गर्न उनलाई मन लाग्दैन र भुईचालो सम्बन्धि कुरा गरेमा उनी झर्किएर त्यहाँबाट निस्कन्छिन् ।

आजभोलि उनले कुने कुरामा ध्यान केन्द्रित गर्न सक्दिनन् र उनको मनमा सधै उत्साह छैन । उनलाई आफ्नो भविष्य सधै होला भन्ने पनि लाग्दैन । अनि अनि चिढी चिढने गीताले आजकल धेरै चिढी चिडन थालेकी छिन् ।

सिफारिस गर्नेको नाम: _____

☐ शिक्षक ☐ आमा समूह ☐ धामी / झाँक्री ☐ म.स्वा.से

सुपरीवेक्षण

प्रश्नहरू

क) तपाईंले अहिले कुरा गरिरहनु भएको मान्छेसँग यहाँ लेखिएका कुरा कतिको मेल खान्छ ?

- मेल खाँदैन (उल्लेखित कुरासँग उक्त व्यक्तिको केहीपनि मिल्दैन) ..... १ } सकियो
- अलि अलि मेल खान्छ (उल्लेखित कुरासँग उक्त व्यक्तिको केही गुणहरु मिल्छ) २
- धेरै मेल खान्छ (उल्लेखित कुरा उक्त व्यक्तिसँग धेरै मिल्छ) ३
- अत्यन्तै मेल खान्छ (उल्लेखित कुरा उक्त व्यक्तिसँग ठ्याक्कै मिल्छ) ४

} ख र ग जानुहोस

ख) के समस्याले दैनिक क्रियाकलापमा नकारात्मक प्रभाव पारेको छ ?

- छैन १
- छ २

ग) के उक्त व्यक्तिले यी समस्याहरु समाधान गर्नको लागि सहयोग चाहन्छ ?

- चाहँदैन १
- चाहन्छ २

परिणाम (क), (ख) र (ग) को जम्मा अंक :

"This tool has been adapted from an earlier version developed for PHSME, Nepal"

NHSSP UKaid TPO Nepal

ANNEX 5: CIDT referral form (Nepali)

CIDT सिफारीस पूर्जी

निर्देशन:

यदि CIDT फर्म को प्रश्न क मा दुई भन्दा बढी, प्रश्न ख र ग मध्ये कुनै एकमा २ नम्बर आयो भने यो सिफारिस पुर्जी भर्नु पर्ने हुन्छ । यो पुर्जी सम्बन्धित व्यक्ति, अथवा उसको हेरचाहकर्ता/ परिवारका सदस्यलाई स्वास्थ्य संस्थामा जान प्रोत्साहन गर्दै दिनु पर्दछ । स्वास्थ्य संस्थामा जादाँ यो पुर्जी स्वास्थ्यकर्मीलाई दिनुपर्दछ ।

मिति :		
व्यक्तिको नाम :		
ठेगाना र सम्पर्क नम्बर :		
समुदायीक कार्यकर्ताको नाम :		
समुदायीक कार्यकर्ताको प्रकार (१, २, ३, ४ मध्ये कुनै एकमा गोलो लगाउनुहोस्)	१. महिला स्वास्थ्य स्वयम सेविका २. आमा समुह ३. धामि झाँकि ४. अन्य.....	१ २ ३ ४
सिफारिस गरिएको स्वास्थ्य संस्था		
पहिचान गरिएको समस्या (समस्या पहिचान भए पछि १, २, ३, ४, ५, ६ मध्ये कुनै एकमा गोलो लगाउनुहोस्)	१. राम बहादुर (DEP) २. प्रकाश (PSY) ३. रिता (EPI) ४. कृष्ण (Suicide) ५. राजन (AUD) ६ सीता (PTSD)	
यस बाहेक केही भएमा यहाँ लेख्नुहोस ।	....	