

**REPORT ON HEALTHY LIFESTYLE
CAMPAIGN (HLC)
INITIATED BY DEPARTMENT OF HEALTH,
CTA
FOR TIBETAN COMMUNITIES IN INDIA**

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FOREWORD



། འཕྲོད་བསྟེན་ལས་ཁུངས། DEPARTMENT OF HEALTH

Foreword

The Department of Health (DoHe), Central Tibetan Administration (CTA) would like to present the first-ever pre-post-assessment report on the Healthy Lifestyle Campaign (HLC) in the Tibetan community in India. A healthy lifestyle is a foundation for the overall wellbeing of an individual and can specifically protect people from non-communicable diseases (NCDs) including cardiovascular diseases, cancers, respiratory diseases and diabetes. These are increasing globally, especially in developing countries like India. The WHO reports that 77% of all NCD deaths are in low-and-middle-income countries. Likewise, the Tibetan refugees from all walks of life and settings, from schools, monasteries and institutions, share the similar concern of increasing reports of NCDs. Diabetes and hypertension are the top diseases captured in the Health Information System (HIS), the OPD/IPD data collected from all the branch facilities under the DoHe. Behavioural risk factors for NCDs include tobacco use, harmful use of alcohol, physical inactivity and unhealthy diets.

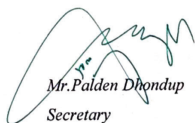
To address these risk factors, The Health Education section has developed a Social and Behaviour Change Communication (SBCC) strategy for a HLC and strived to improve the quality of communication campaigns from the earlier practices of Information Education Communication (IEC). The HLC aims to enhance communicative strategies by focusing on some small doable actions that people can take to improve their diets and increase their physical activity and address some barriers to those behaviours. For instance, using the SBCC framework, people are encouraged to reduce the use of excessive salt, sugar, and fats and have been provided with recipes that show them how to substitute or reduce these unhealthy additives. The campaign was planned to launch in November 2019, which unfortunately coincided with the advent of the COVID-19 pandemic, which became a priority for the DoHe. Nonetheless, under this campaign, the department used social media platforms and conducted more than 30 different activities (as attached in the annexure) to promote a healthy lifestyle.



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DEPARTMENT OF HEALTH

I would like to thank the United States Agency for International Development (USAID) for funding this program and giving opportunities for us to build a healthy community. Also, I wanted to congratulate the Health Education Section for bringing this report, a baseline for future Healthy Lifestyle Campaign.

I believe that each of us can bring positive change in our lives by committing to small doable actions that have a lasting impact on our health. Let us make a New Year's resolution to start small to build a healthier life.



Mr. Palden Dhondup
Secretary

Department of Health
Central Tibetan Administration
Dharamsala

ACKNOWLEDGEMENTS

The fruition of this report is not possible without the endearing support of Ms Susan Shulman, SBCC consultant. Since the beginning of this program in 2019, she has guided us and generously supported us from an initial idea and plan to a concrete program.

We would also like to thank Dr Tenzin Namgha for the technical support and all the research assistants, Tsewang Wangmo, Thupten Lobsang, and Tenzin Tseyang, for aiding us in holding the focus groups (FGs) and in-depth interviews (IDIs) with the target groups, and finally being able to produce this report with recommendations for future SBCC program.

We wanted to express our gratitude to all the Tibetan Voluntary Health Association (TVHA) staff in each settlement for tirelessly serving the health and welfare needs of our community. Their support and hard work encourage us to put more effort into formulating targeted and focused health programs such as the Healthy Lifestyle Campaign.

We express our appreciation and gratitude to Ms. Tenzin Wangmo for beautifully designing the layout for this report.

Finally, we are eternally grateful to USAID for funding this program.

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EXECUTIVE SUMMARY

Supported by USAID via The Tibet Fund (TTF), the CTA's Department of Health (DoHe) has implemented a Social and Behaviour Change Communication (SBCC) initiative to encourage a "Healthy Lifestyles" (HLS) among the Tibetan community in India, Nepal and globally. This is in response to changes to traditional dietary and physical exercise practices that are putting the population at risk for non-communicable diseases (NCDs) which are on the rise. In 2019 the DoHe developed an SBCC strategy (Annex 1) to focus on a few key behaviors related to diet and exercise. Shortly thereafter, covid19 arrived and forced most of the activities on line. The DoHe created and disseminated a number of videos promoting key behaviors, mostly via social media and TV, detailed in Annex 2.

In August 2021, the DoHe hired a consultant to help assess the effectiveness of HLS SBCC activities and to help the DoHe learn and adapt their strategy for the future. The assessment methodology used two methodologies, a largely on-line pre-and post-KAP survey conducted in December 2019 and again in August 2021. Qualitative research also took place in Bylakuppe, Mundgod, Ladakh and Dharamsala and included in-depth interviews (IDIs) and focus group discussions (FGDs) with various target groups and influencers (FGDs with youth, female home makers, monks and nuns and IDIs with Settlement Heads, PTA Representatives, Monastic instituted meal procurers, and doctors.)

While interpretation of the findings from the pre-post-KAP surveys is limited by the fact that the surveys were not representative and that the samples characteristics varied due to some differences in how it was drawn, results show some general trends about diet and exercise and the behavioral determinants that are driving or inhibiting behavior. The post-KAP survey also reveals some information about exposure to the HLS campaign videos

and preferred media channels and platforms. Some interesting findings include:

- The average self-rating of health on a scale of 1-10 improved from 7.1 to 7.5. Nearly all age groups in the post-KAP reported higher scores compared to the same age group in the pre-KAP survey, with the gap widening after age 55. This likely reflects the difference in characteristics of the sample.
- Post-KAP respondents were less likely than pre-KAP respondents to consider the following practices part of a “healthy diet”: a reduction in drinking water (went from 86% to 70%), increased consumption of vegetables (from 85% to 72%) or fruits (78% to 69%), or reduction in meat (53% to 37%), salt (49% to 42%), and butter and oil (62% to 52%).
- A question about the average number of servings consumed on a “typical” day of 10 food groups, (not intended to provide accurate consumption information at the individual level, but rather population trends over time) showed the highest number of servings/days consumed was for vegetables (not counting potatoes) (1.929), pulses (1.879) and fruits (1.829) compared to white meat (1.126) and red meat (0.913).
- In the Pre survey, consumption of unhealthy foods, included: sweetened beverages (average of 0.961 servings/day), fried foods (average of 0.909 servings/day), and fast foods (average of 0.778 servings/day.) The post-KAP found that consumption decreased of these unhealthy foods to (0.696, 0.749 and 0.517 respectively), perhaps due to effects of covid 19 movement restrictions.
- The percent of the samples actively trying to change their diet fell between pre-KAP and post-KAP especially for “eat more vegetables” (from 75% to 52%), “drink more water” (from 74% to 59%), “eat more fruit” (69% to 52%), “eat less red meat” (from 49% to only 37%) and “eat less salt” (36% to 25%).
- A number of behavioral determinants related to knowledge, taste preferences, perceptions of availability, affordability, outcome

expectations for change, self-efficacy and skill, emotions, social norms and intention to change, were assessed using 5-point Linkert scale questions. For both studies the statements with the strongest agreement were related to outcome expectation (“Eating healthier can reduce the need for medicine or medical procedures”) and emotions (“Eating healthy makes me feel happy.”) The biggest change to behavioral determinant questions was a 15% decrease in the score for “I can easily afford healthy food” between the Pre and Post KAP surveys. Again, this may reflect covid19 related inflation and unemployment.

- Comparing data from the Pre and Post KAP on regular exercise reveals a decrease in the percentage of respondents reporting daily exercise, especially daily runs/jogs (from 26% to 12%), walks/kora (from 57% to 26%), yoga (from 20% to 11%) and group sports (from 9% to 3%). However, 17% of the post-KAP sample reported doing "other physical exercise at home", a category not included in the pre-KAP. This may indicate a shift to at home exercising due to covid 19 restrictions.
- In the post-KAP, the most commonly seen content related to “healthy lifestyle”, from any source, was pertaining to “healthy eating”, “yoga/namaskar” and Zumba”. The most common platforms for viewing content related to these topics were YouTube and Facebook.
- When asked about exposure to DoHe-produced or promoted videos, the most widely viewed video was “Zumba with vlogger Derab Woser” and “Yoga postures for hypertension” (both viewed by 47% of the sample.). The least watched videos were the Kunky & Rewa episodes (22%); however, these were also the highest rated videos (rated 3.93/5).
- The preferred platform or channels for receiving more DoHe disseminated content was YouTube (52%), Facebook (36%) and TV (32%).
- Among the most important qualitative findings were mother’s concerns about junk food and energy drinks growing popularity

among their children in schools. Also, the conflict they have in terms of providing pocket money to their children which they know will end up buying junk food. This leads to a sense of constant guilt and a feeling of helplessness. Settlement heads and PTA members echoed concerns over the proliferation of junk food and the difficulty in controlling it.

- Youth reported a lot of unhealthy eating and are spending more time at home on their phones and devices. Affordability and convenience were two factors they said influence their choice of food, along with taste, laziness and habit.
- Monks and Nuns are generally well fed from the monastic institution, but consume a lot of unhealthy junk food in their rooms (specifically Maggie noodles) or when outside the monastery. A primary barrier for them is lack of time for both exercise and healthier eating.
- The recommendation section includes a number of specific strategies and interventions that should be considered to promote HLS among each distinct target group based on findings from the research.

BACKGROUND

With support from USAID via The Tibet Fund (TTF), the CTA's Department of Health (DoHe) implements a Social and Behaviour Change Communication (SBCC) initiative to promote preventive health-seeking behaviour among the Tibetan community in India, Nepal and globally. In 2019, a series of strategic planning workshops took place to review health areas to be targeted with SBCC and define key themes, messages and activities. Prevention of non-communicable diseases (NCDs) including diabetes, hypertension, obesity, precursors to stroke, heart disease, cancers and dementia, that are responsible for an increasing burden of disease and death among the Tibetan community were prioritized. Prevention of NCDs is complex, and involves the consistent practice of multiple healthy behaviours that the DoHe collectively calls adopting a "Healthy Lifestyle (HLS)." This includes reduction of high-risk behaviours such as smoking and alcohol consumption as well as adopting healthy habits such as regular consumption of a healthy diet and exercise. After some initial qualitative research and a workshop in late 2019, the DoHe decided to focus its initial HLS SBC campaign on the following behaviours:

Improved Diet	Increased exercise
Increase the amount of vegetables and pulses in one's diet.	Undertake 2.5 hours/week (20 min/day) of activity that causes shortness of breath/light sweat (yoga, Zumba, sports, dance, walking/kora, etc..)
Reduce consumption of red meat.	Establish a healthy routine of physical activity.
Reduce consumption of fat, sugar and salt.	
Reduce weight	

A summary SBC strategy was drafted (see Annex 1) that included plans to develop materials and guidelines for interpersonal and group activities, and TV and social media (SM) campaigns.

In early 2020, as Covid-19 spread and threw the world into chaos, the DoHe diverted its attention to preventing its spread and eventually vaccinating the population. Beyond the morbidity and mortality caused by Covid-19 itself, the DoHe tried to address another sequel such as poverty and poor nutrition caused by loss of livelihoods and economic disruptions, mental illness due to isolation and uncertainty, and disruptions of normal health care providers due to fear of attending health services. The DoHe's HLS strategy was initially put on hold, but ensuring that the population was eating a well-balanced healthy diet and maintaining some physical exercise during the crisis was increasingly seen as critical to peoples' physical and mental health. The crisis also pushed more people online and on social media to better access information, offering the DoHe an opportunity to reach more people via these communication channels while other interpersonal channels were restricted due to social distancing needs.

Between November 2019 – July 2021, the DoHe created and disseminated various videos or other content (see list in Annex 2) on Tibet TV and/or SM platforms aimed at promoting healthy diets and regular exercise among different segments of the population.

The DoHe seeks to assess the impact of these activities and learn lessons to inform its 2021-2022 plans.

THE OBJECTIVE OF THE ASSESSMENT

- Summarize results of the HLS SBC campaign so far,
- Report on any changes to HLS behaviours and behavioural determinants and exposure to SBC content as detected by the pre- and post-campaign KAP Survey.
- Summarize opinions from various key informants about how the campaign is being received by target groups, and what can be improved in the future to improve targeting, content, messaging, communication channel selection and our overall process.
- Make recommendations for changes to improve the reach and impact of future HLS SBC campaigns and activities.

METHODOLOGY OF THE ASSESSMENT

The assessment included two distinct studies:

Quantitative KAP Surveys

In December 2019, the DoHe conducted an online KAP Survey of 416 respondents aged 18-74 to get more information about people's current diet and exercise habits and what information and activities they were interested to receive or likely to participate in. The sample was selected purposely, through the promotion of the online survey on social media and through administering the survey manually at monasteries and nunneries to ensure this less online sub-population was adequately covered. The DoHe conducted the same survey in August 2021, adding some additional questions about exposure to specific HLS content over the last year. While neither sample is representative, we expect the results of these two surveys will provide a sense of how the HLS campaign has been received, especially among users of

social media, and help inform plans for the campaign's next phase, including helping us answer the following questions:

- How has self-perception of health changed among our samples?
- How have self-reported diet and exercise habits changed?
- How has knowledge, attitudes and other behavioural determinants changed?
- In light of the recent KAP results, what behavioural determinants should be targeted in future campaigns?
- What lessons can be drawn from the data about the program's targeting, content/messaging, or communication activities/platform selection to inform future activities?

Qualitative Research

To supplement the analysis of the quantitative surveys and get a 360-degree picture of what's going on, information was also elicited from various sources with a deeper knowledge of our target groups or those involved in the implementation of the project. The DoHe conducted a qualitative study involving In-Depth Interviews (IDIs) and Focus Groups (FGs) with key informants to improve our understanding of how the past campaign was received by audiences and to inform plans. Informants include:

- Settlement officers/settlement secretary (in-depth interview)
- Monastery & Nunnery Food procurement In-charge (in-depth interview)
- Monks and Nuns (Focus groups)
- Youth Association leaders (in-depth interview)
- Home-makers (focus groups)
- Younger youth (focus group)
- Older youth (focus group)
- Parent-Teacher Association (in-depth interview)
- Tibetan doctors (in-depth interview)

While carrying out the research, key informants were segregated into influencers and target groups. Influencer refers to those who influence the

behaviour of target groups. They are settlement head, monastery/nunnery meal procurer, Parent Teacher Association (PTA), youth association leader and Tibetan doctors. Target groups are those who have been targeted by DoHe for their behaviour change. They are younger youth (18-24), older youth (25-34), monks, nuns and homemakers. In-depth interviews were conducted for influencers and focus group discussions for target groups. DoHe attempted to understand how these influencers and target groups perceive the HLS SBC campaign, and what effect, if any, the campaign content had. Also, it is important to understand their opinions about how the DoHe can adapt and improve SBC activities in the future, including answering the following questions:

- **Who?** Are we targeting the right populations? Who else should we be targeting? Why?
- **Barriers?** What do they think are the greatest barriers for our target groups to change their diet and exercise behaviour?
- **What?** Are we providing the right information or guidance? What additional information or content would be useful or impactful?
- **How?** Is our content resonating with audiences? Is it motivational and persuasive in terms of language or imagery? How can we improve the way we communicate so that our messages lead to more behaviour change?
- **Where/when?** Are we using the right communication platforms? What additional channels can we use (COVID-19 appropriate)? Are there existing channels or opportunities that informants know of that we can use to reach the target group with information and activities?

To understand the qualitative aspects, a systematic sampling design was followed to draw the maximum information from the key informants.

Sampling design

For the current qualitative study, four major Tibetan settlements with the highest population were included: Bylakuppe, Mundgod, Ladakh and Dharamsala. Three research assistants namely Tsewang Wangmo (Mundgod), Thupten Lobsang (Bylakuppe) and Tenzin Tseyang (Ladakh) were trained

online and deployed for conducting a total of 23 in-depth interviews and 15 focus group discussions. Dharamsala data was collected by all three research assistants. However, due to time and resource constraints, focus group discussions in Dharamsala could not be carried out. The DoHe felt that participation in the quantitative online survey was higher among residents of Dharamsala and so given resource constraints, it was more important to supplement that information with qualitative insights from other parts of the country. The data collection was completed in one month i.e., September 2021. With the help of respective settlement officers and camp leaders, participants representing target groups including homemakers, monks, nuns, younger youth and older youth were selected to participate in focus group discussions. Additionally, key influencers, including monastery and nunnery meal procurers, doctors, PTA and youth association leaders, were interviewed with the help of the Tibetan primary health centre under the Department of Health for locating the informants in the settlements. The following table shows sampling distribution among various settlements.

Settlements	Bylakuppe	Mundgod	Ladakh	Dharamshala	Total
<i>In-depth-interview</i>					
Settlement Leader	1	1	1		3
Monastery Administrator in charge of meal planning/food procurement	1	1	1	1	4
Nunnery Administrator in charge of meal planning/food procurement	1	1	1	1	4
Parents Teacher Association (The decision-maker of food items)	1	1	1	1	4

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Tibetan Doctors	1	1	1	1	4
Youth Association Head	1	1	1	1	4
TOTAL	6	6	6	5	23
<i>15 Focus Group discussion (4 people in a group)</i>					
Homemaker (consist of main cook in the households)	1	1	1		3
Younger youth (18-24)	1	1	1		3
Older youth (25-34)	1	1	1		3
Monks	1	1	1		3
Nuns	1	1	1		3
TOTAL	5	5	5		15

RESULTS

Quantitative Findings

Sample Demographics Profiles

The following are the demographic profiles of the pre-and post- KAP survey. As mentioned in the previous section, the sample varies due to sampling bias. In the Pre-KAP survey, the DoHe was specifically interested in learning about the KAPS of monks and nuns, thought to be a vulnerable group and so approximately 200 questionnaires were translated into Tibetan, distributed to monastic institutions and manually filled in by monks/nuns . During the process, the same questionnaire was also made available online, via the DoHe and CTA's social media landing pages on the website (Tibetanhealth.org), DoHe's Facebook, through official email, staff and their references in order to reach the general population. However, the post-KAP survey excluded questionnaire distribution among monks/nuns due to the covid situation and used only social media platform similar to pre-KAP survey method.

Table 1: Gender of the respondents

Gender	Pre-Survey		Post-Survey	
	N	%	N	%
Female	215	52%	174	62%
Male	194	47%	106	38%
Gender Neutral	1	0%	1	0%
Total	410	100%	281	100%

Table 1 shows that males and females share almost equal participation in the pre-KAP survey. However, in the Post KAP survey, it was found that 62% of females participated in the survey and only 38% were male. This may indicate that women were more interested in HLS topics and therefore more likely to voluntarily respond to the on-line post-survey combined with the lack of the intentionally sampled monks in the post-survey.

Table 2: Age of the Respondents

Age	Pre-Survey		Post-Survey	
	N	%	N	%
18-24	70	17	20	7%
25-34	163	40	130	47%
35-44	110	27	76	27%
45-54	42	10%	37	13%
55-64	16	4%	13	5%
65-74	3	1%	2	1%
Total	404	100%	278	100%

The majority of the respondents in both Pre and Post KAP surveys belong to the age category of 18-44 with 84% and 81% respectively.

The geographic distribution of both Pre- and Post-survey showed that majority of the sample comes from the Dharamsala region with 60% and 32% respectively. This was due to oversampling during the Pre-survey of monks/nuns in Dharamsala and both surveys being heavily promoted to civil servants from the Central Administration, Dharamsala. See a detailed analysis of the residency of respondents from both samples in annex-3.

Table 3: Education of the Respondents

Education	Pre-Survey		Post-Survey	
	N	%	N	%
Did not complete school	28	7%	3	1%
Up to grade 9	68	18%	7	3%

Between grades 10-12	66	18%	33	12%
Completed Bachelors	120	32%	103	38%
Completed Masters	81	21%	106	39%
Completed certificate/diploma	14	4%	21	8%
Total	377	100%	273	100%

Table 3 reveals a large difference in the educational backgrounds of the two samples which should be considered when interpreting results. 53% of pre-KAP respondents reported having higher education (bachelors or masters), while 77% of the post-KAP survey reported having higher educations. Again, this may be due to the second sample being drawn exclusively from social media users willing to voluntarily participate and excluding the manually drawn monks/nuns.

Table 4: Profession of the Respondents

Profession	Pre-Survey		Post-Survey	
	N	%	N	%
Monk/Nun	196	48%	9	3%
Office Worker/ Professional	79	19%	131	47%
Civil Servant	38	9%	71	26%
Health Professional	12	3%	19	7%
Student	44	11%	16	6%
Trader/ Businessman	11	3%	8	3%
Home Maker	4	1%	6	2%
Teacher	6	1%	6	2%
Self Employed	3	1%	5	2%
Farmer	0	0%	2	1%
Shopkeeper	6	1%	2	1%
Retired	5	1%	2	1%

Unemployed	2	0%	0	0%
Other	6	1%	1	0%
	412	100%	278	100%

Table 4 confirms this difference, showing that 48% of the pre-KAP survey identified themselves as monks/nuns, compared to only 3% of the post-KAP survey. While Working Professionals (Men-Tsee-Khang (TMAI, LTWA, NGOs, private professionals), civil servants, and students made up only 19%, 9% and 11% respectively in the pre-KAP versus 47%, 26% and 6% of the post-KAP survey. It is also interesting to note that 7% of the post-KAP survey sample identified themselves as health professionals compared to only 3% of the pre-KAP survey.

Self-Reported Health Status

The survey asked respondents to rate their general physical health over the last year on a scale of 1 to 10.

Table 5. Self-reported health status of Pre-and Post-survey

Pre-Survey Average		Post-Survey Average	
Average of Health Rating		Average of Health Rating	
7.1688		7.51648	

Pre-Survey Average Rating by Age		Post-Survey Average Rating by Age	
Average of HealthRating		Average of Health Rating	
18 to 24	7.088	18 to 24	7.05
25 to 34	7.449	25 to 34	7.605
35 to 44	7.19	35 to 44	7.533
45 to 54	7.108	45 to 54	7.378
55 to 64	6.308	55 to 64	7.9
65 to 74	3.667	65 to 74	6.5
(blank)	5.125	(blank)	
Grand Total	7.168831169	Grand Total	7.516483516

The average health score has improved from 7.1 to 7.5. It was also observed that nearly all age groups in the post-KAP reported higher health status scores compared to the same age group in the pre-KAP survey, with the gap increasing especially after age 55. This may reflect the higher educational and professional status of the post-KAP sample, indicators of higher socio-economic status, which is typically associated with increased access to higher quality health care and better health status.

Furthermore, Table 6 shows the diseases or illnesses that respondents report being diagnosed with or treated for over the last year. The list intentionally included various related to unhealthy lifestyles or poor diet including gastritis, constipation, high blood pressure, high cholesterol, obesity, diabetes/pre-diabetes, heart disease, stroke and cancer.

Table 6. Self-reported diseases that the respondent was diagnosed with or treated for over the last year

Diseases	Pre-test		Post-test	
	N	%	N	%
Nothing/no diagnosis	181	48%	113	31%
Gastritis	37	10%	45	12%
Covid*		0%	40	11%
Other	32	8%	25	7%
Constipation	30	8%	24	7%
UTI*	2	1%	19	5%
H Pylori*	1	0%	17	5%
High BP	16	4%	15	4%
Depression/Stress*		0%	12	3%
High Cholesterol	19	5%	11	3%
Hepatitis*	4	1%	11	3%
Obesity	12	3%	9	2%
Arthritis*	1	0%	8	2%
Diabetes	8	2%	6	2%
Pre-diabetes	15	4%	5	1%
TB	14	4%	4	1%
Heart Disease	6	2%	2	1%

Stroke	1	0%	1	0%
Epilepsy*		0%	1	0%
Cancer	0	0%		0%
Total # of Diseases/ Illnesses	379		368	
Total Sample (N)	417		282	

** Indicates that these illnesses/diseases were not listed as possible answers in the Pre-Survey, but may have been reported under "other" or not reported.*

Overall, the pre-KAP survey sample reported less diseases/illnesses than the post-KAP survey sample. Eleven percent of the post-KAP survey reported being diagnosed with covid 19, not included in the pre-KAP survey.

Beliefs about a “healthy diet”

Respondents were asked what they consider to be a “healthy diet” to better understand their beliefs and understanding about the term, shown in Table 7 and Figure 1 below.

Table 7. Belief of healthy diet

Beliefs about Healthy Diets	Pre-Survey		Post-Survey	
	N	%	N	%
Drink More Water	356	86%	197	70%
Eat More Veggies	354	85%	204	72%
Eat More Fruits	325	78%	194	69%
Reduce Butter & Oil	259	62%	147	52%
Reduce Sugar	242	58%	165	59%
Eat Less Red Meat	220	53%	105	37%
Reduce Alcohol	208	50%	128	45%
Reduce Salt	203	49%	118	42%
Eat More Grains	185	44%	133	47%
Reduce Overall Food	143	34%	124	44%
Drink Mencha Tea	135	32%	55	20%
Other	31	7%	21	7%
Total Sample (N)	416		282	

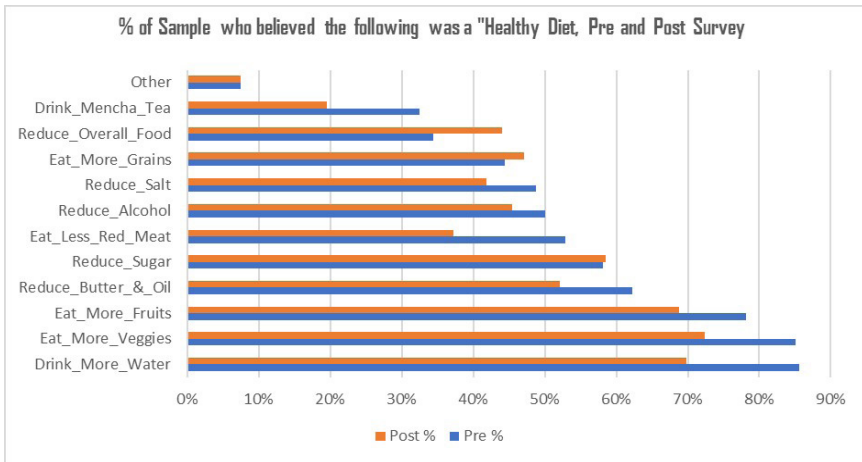


Figure 1. Belief of Healthy Diet

From figure 1, it is clear that the belief in a healthy diet has changed over time. Astonishingly, belief towards healthy diet has reduced in post-KAP survey. post-KAP respondents were less likely than pre-KAP respondents to consider the following practices part of a “healthy diet”: a reduction in drinking water (went from 86% to 70%), increased consumption of vegetables (from 85% to 72%) or fruits (78% to 69%), or reduction in meat (53% to 37%), salt (49% to 42%), butter and oil (62% to 52%.) This change can perhaps be attributed to differences in the characteristics of the sample or due to covid situation.

Typical food consumption pattern

While the DoHe was unable to conduct a “gold standard” food consumption survey, such as a 24-hour recall or 7-day food consumption study, as part of this research, the pre-and post-KAP surveys asked respondents to estimate the number of servings they ate on a “typical” day of 10 categories of food, both healthy and unhealthy. Responses are not intended to be an accurate reflection of actual consumption on an individual level, but can be helpful to track trends over time on a population level.

Table 8. Pre and Post Survey Daily Portion of Food Consumed

PRE-SURVEY					
Food Categories	None/ rarely consumed	1 serving	2-3 servings	4-5 servings	>5 servings
Vegetables	3%	43%	43%	10%	1%
Red meat	45%	34%	16%	3%	1%
White meat	39%	35%	22%	3%	1%
Pulses	7%	52%	31%	8%	2%
Unprocessed grains	22%	45%	26%	4%	3%
Fruits	16%	48%	24%	10%	2%
Sweetened beverages	47%	33%	16%	4%	1%
Sweetened milk tea	13%	40%	37%	9%	1%
Fried foods	45%	34%	16%	3%	0%
Fast food	51%	35%	11%	2%	1%
POST-SURVEY					
Food Categories	None/ rarely consumed	1 serving	2-3 servings	4-5 servings	>5 servings
Vegetables	6%	38%	49%	10%	2%
Red meat	40%	44%	13%	2%	1%
White meat	31%	45%	21%	3%	0%
Pulses	6%	46%	39%	7%	2%
Unprocessed grains	28%	41%	22%	7%	2%
Fruits	11%	44%	35%	8%	2%
Sweetened beverages	58%	26%	14%	2%	0%
Sweetened milk tea	20%	39%	32%	6%	3%
Fried foods	54%	32%	12%	3%	0%
Fast food	63%	28%	8%	1%	0%

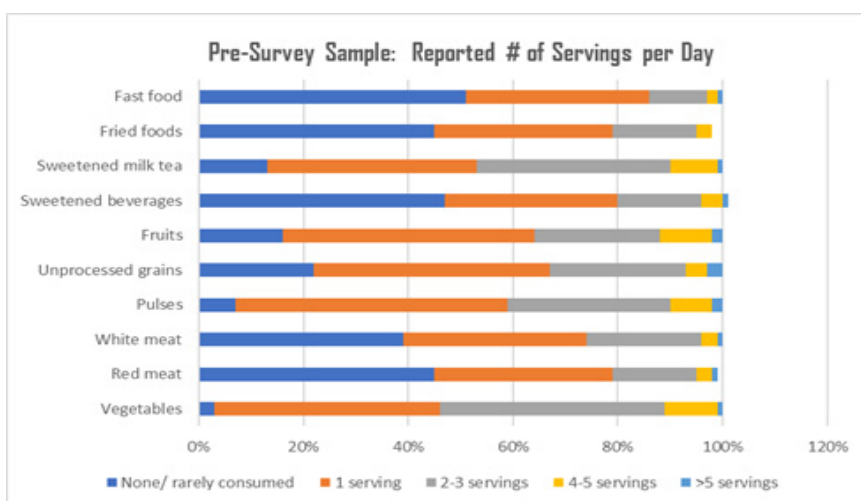


Figure 2 Daily Portion of Food during Pre-Survey

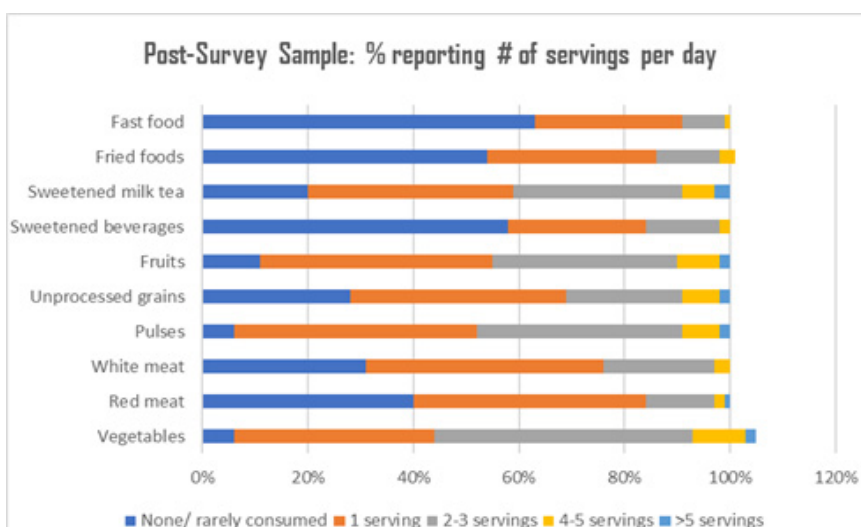


Figure 3 Daily portion of food during post-survey

From table 7 and figures 2 and 3, it is clear that respondents from both pre- and post-survey lie on the left side of the table consuming rarely or 1 serving of healthy foods like vegetables, fruits, white meat, pulses and unprocessed grains. In both the surveys, a third to a quarter of the sample

are consuming harmful sweetened beverages like Coke, Pepsi, Mountain dew etc on daily basis and sometimes 2-3 servings. Likewise, about a third of the samples eat fast food daily, which may impede health in the long run.

Based on these responses from the pre- and post-KAP surveys, we calculated an average number of servings per “typical” day for these foods shown in Table 9, including a column showing changes between the two surveys. The greatest changes in these average number of servings was reduction in reported consumption of fast food, sweetened beverages and fried foods between the two surveys. While we’d like to attribute this to our SBC activities, it is more likely to reflect reporting biases among the more educated, professional post-KAP sample or perhaps changes in food consumption habits related to covid (i.e., lower availability of fast food or fried foods)

Table 9. Change in average reported number of servings on a “typical day”

Average Reported number of servings on a "typical day"	Pre-Survey	Post-Survey	Change	% Change
Vegetables (not including potatoes)	1.9881	1.9294	-0.059	-3%
Sweetened milk tea or butter tea	1.7907	1.6418	-0.149	-8%
Pulses (including tofu/soya, dal, chickpea and beans)	1.7273	1.8792	0.152	9%
Fruits	1.6496	1.8294	0.180	11%
Tsampa or other whole unprocessed grains such as whole wheat, brown rice, etc.	1.4450	1.3944	-0.051	-3%
White meat (including chicken & fish)	1.0977	1.1269	0.029	3%
Red meat (including mutton, beef, buff & pork)	0.9762	0.9126	-0.064	-7%
Sweetened beverages (including Pepsi cola, sweet juice)	0.9618	0.6958	-0.266	-28%
Fried foods (including shapta, pakora, samosa, etc.)	0.9095	0.7491	-0.160	-18%
Fast food/Junk food (iei.e., Mcdonald'sMcDonald's, KFC, Dominos, etc.)	0.7778	0.5170	-0.261	-34%

The intension of changing diet

Respondents were asked if currently, they were actively trying to change their diet and in what way. Results shown in Table 10

Table 10. Currently trying to change diet

In what way?	Pre-Survey	Post-Survey
Eat Less Meat	49%	37%
Eat More Grains	35%	32%
Eat More Veggies	75%	52%
Eat More Fruits	69%	52%
Eat Less Butter & Oil	50%	41%
Eat Less Sugar	51%	50%
Drink Less Alcohol	31%	24%
Eat Less Salt	36%	25%
Drink Mencha Tea	27%	11%
Drink More Water	74%	59%
Consume Less Food	31%	34%
Other	5%	5%

% Reporting that they were actively trying to change their diet,
Pre and Post surveys

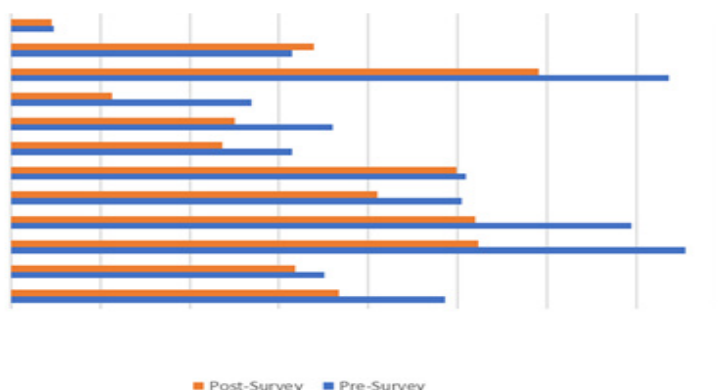


Figure 4 Change in the current diet

The result show that, with the exception of consuming less food overall, a lower percentage of respondents were trying to change their diet in the post-

KAP survey compared to the pre-KAP survey. In the pre-survey a majority of the sample reported that they were trying to eat more vegetables or drink more water, eat less sugar or drink sugar sweetened beverages or consume less butter or oil. For the Post survey, the percent actively trying to change their diet fell especially for eating more vegetables (from 75% to 52%), drink more water (from 74% to 59%), eat more fruit (69% to 52%), eat less red meat (from 49% to only 37%) and eat less salt (36% to 25%.) Some of this may reflect the differences between the 2 samples, especially in terms of the numbers of monks/nuns' participation.

Attitude and Behavioral Determinants

Behavioral determinants are the attitudes and beliefs that can drive or inhibit people’s behavior. These include knowledge, taste preferences, perceptions of availability, affordability, outcome expectations for change, self-efficacy and skill, emotions, social norms and intention to change, for promoting a healthy diet, community workers or agencies must work towards understanding these barriers or facilitators and frame their SBC messages accordingly . The surveys included some statements that express varied behavioral determinants related to healthy diets, asking respondents to rate their agreement with the statements on a scale of 1 to 5, with 1 being “strongly disagree” and 5 being “strongly agree”.

Table 11. Pre-survey attitude scores

Pre-Survey	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Average	N
Healthy diets can reduce the need for medicine (Outcome expectation)	4%	2%	4%	39%	51%	4.312	346
Eating healthy makes me feel happy (emotions)	2%	3%	9%	48%	39%	4.20	352

Fruits & veggies are Available near me	6%	8%	14%	47%	26%	3.799	344
I'm currently planning to change my diet (intention)	5%	7%	20%	43%	26%	3.792	317
I'm confident that I can cook a healthy and tasty meal (Self-efficacy)	4%	9%	20%	43%	24%	3.736	295
I avoid junk food/fast food (Intention)	6%	15%	26%	36%	17%	3.438	322
Primarily reducing meat for religious reasons (Norms)	15%	18%	22%	30%	14%	3.093	333
I can easily afford healthy food (affordability)	23%	35%	21%	17%	5%	2.451	286
I am Unsatisfied by a meal without meat (feeling)*	38%	25%	16%	15%	6%	2.27	274
I don't know any vegetarian recipes (knowledge)*	38%	36%	12%	9%	5%	2.050	278
Vegetarian food has no flavour (taste)*	42%	35%	12%	8%	3%	1.967	269

* For these statements, weak agreement reflects more positive attitudes.

Table 12. Post survey attitude scores

Post-Survey	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Average	N
Healthy diets can reduce the need for medicine (Outcome)	6%	2%	5%	36%	51%	4.228	267
Eating healthy makes me feel happy (emotions)	2%	2%	12%	43%	42%	4.206	267
I'm confident that I can cook a healthy and tasty meal (Self-efficacy)	2%	6%	20%	49%	24%	3.871	263
Fruits & veggies are Available near me	4%	8%	15%	49%	24%	3.797	271
I'm currently planning to change my diet (intention)	3%	7%	23%	49%	17%	3.700	263
I avoid junk food/fast food (Intention)	4%	12%	29%	38%	18%	3.530	266
Primarily reducing meat for religious reasons (Norms)	17%	25%	32%	19%	7%	2.753	267
Unsatisfied by a meal without meat (feeling)*	36%	33%	19%	9%	4%	2.128	266
I can easily afford healthy food (affordability)*	31%	43%	15%	9%	2%	2.089	269
Vegetarian food has no flavour (taste)*	41%	41%	12%	5%	2%	1.875	264

I don't know any vegetarian recipes (knowledge)	45%	39%	9%	5%	2%	1.815	265
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For both studies the statements with the strongest agreement were related to outcome expectation ("Eating healthier can reduce the need for medicine or medical procedures") and emotions ("Eating healthy makes me feel happy") which stayed mostly consistent over two surveys. Program managers might consider how to incorporate these attitudes into future motivational messaging and campaigns.

Table 13. Shows how the average agreement score changed between the two surveys and the percentage change. This can help us infer changes over time.

Agreement with statements (1 strong disagreement, 5 strong agreement)	Pre-Survey Average	Post-Survey Average	Change in average from pre to post	% Change
I can easily afford healthy food (affordability)	2.451	2.089	-0.362	-15%
Primarily reducing meat for religious reasons (Norms)	3.093	2.753	-0.340	-11%
I don't know any vegetarian recipes (knowledge)*	2.050	1.815	-0.235	-11%
Unsatisfied by a meal with outwithout meat (feeling)*	2.27	2.128	-0.138	-6%

I'm currently planning to change my diet (intention)	3.792	3.700	-0.092	-2%
Vegetarian food has no flavor (taste)*	1.967	1.875	-0.092	-5%
Healthy diets can reduce need for medicine (Outcome)	4.312	4.228	-0.084	-2%
Fruits & veggies are Available near me	3.799	3.797	-0.002	0%
Eating healthy makes me feel happy (emotions)	4.20	4.206	0.004	0%
I avoid junk food/fast food (Intention)	3.438	3.530	0.092	3%
I'm confident that I can cook a healthy and tasty meal (Self-efficacy)	3.736	3.871	0.135	4%

Affordability

The biggest change was for affordability of buying healthy food, which decreased by 15% (0.362). This was likely due to covid shock and inflation and the loss of livelihoods that followed.

Norms/religious reason for not eating meat

Considering that the pre-KAP survey contained a large proportion of monks/nuns not included in the post-KAP survey, it was not surprising to find an 11% decrease in agreement with the statement that “Primarily reducing meat for religious reasons” between the two surveys. Respondents from the post-KAP survey disagreed slightly with the statement, meaning religious

beliefs may not be a strongly compelling rationale for them to reduce meat consumption.

Knowledge of recipes

The average agreement score for the statement “I don't know any vegetarian recipes” also fell by 11% indicating more disagreement or that knowledge of vegetarian recipes increased. While we'd like to believe it is due to our efforts to promote healthy vegetarian recipes on social media, it is more likely due to covid preventing people from eating outside and forcing them to learn new recipes from YouTube. During focus group discussions, a few homemakers mentioned a growing trend of learning cooking skills from YouTube during the lockdown.

Dissatisfaction with a vegetarian meal

The dissatisfaction with vegetarian meals statement score dropped by 6% in the post-KAP survey, possibly indicating that people have learned more satisfying vegetarian recipes during lockdown.

Intension to change

Agreement with the intention to change statement was slightly lower in the post-survey. This is in line with answers presented in Table 10 about respondents actively trying to change their dietary habits which also decreased between the two surveys. This trend may be due to stress of covid as people don't have the mental or emotional bandwidth to also change their diets.

Taste: Vegetarian diets have no flavour

There was a 5% decrease in the agreement score for the statement “Vegetarian food has no flavor.” The post score of 1.875 means that most people disagree with that statement. The focus group discussions, especially among youngsters, revealed the importance of taste (and affordability) rather than healthiness when it comes to diet. So it is notable to mention that respondents don't agree that vegetarian diets have no flavor and that attitudes around vegetarianism seem to be “improving” even though the post sample had so many fewer monks/nuns.

Outcome expectations

The benefit of healthy diets is strongly perceived as reducing medical expenses/ need for medicine. This score was among the highest in agreement for both surveys but fell slightly from pre to post. Programmers should consider emphasizing this belief in future SBC campaigns and messaging.

Emotions: healthy food makes people happy

This also scored among the highest in agreement for both pre & post. This could be an opportunity for future Healthy lifestyle campaign messaging around the emotional benefits of “feeding your family real, unprocessed and healthy foods, make everyone happy”.

Current behaviour to avoid junk food

The agreement to avoid junk food increased slightly (by 3%) in the post-survey. This may be due to covid situation where people were more into home cooking.

Self-efficacy/Confidence to cook

There was a 4% increase in the agreement score related to self-efficacy/ confidence in ability to cook a healthy tasty meal between the two surveys. This could be due to respondents spending more time at home cooking during covid restrictions and the many instructional recipes and videos available on line, including those produced by the DoHe.

Involvement in Exercises

Exercises is one of the important indicators of healthy lifestyle. The following table shows both pre-and post-survey data on exercises.

Table 14. Pre-Survey Report of Regular Exercises

Pre-Survey Report of regular exercise	I do not regularly do this	1-3 times/ month	1-2/ week	3-4 times/ week	5-6 times/ week	Daily	N that answered question	N for survey	% That answered
Run or jog	37%	9%	10%	9%	8%	26%	172	416	41%
Walk/Kora	12%	7%	10%	9%	4%	57%	255	416	61%

Gorshe/ Dance/ Zumba	66%	18%	8%	6%	1%	1%	145	416	35%
Yoga	54%	15%	4%	7%	2%	20%	183	416	44%
Go to gym/ lift weights	83%	4%	3%	5%	3%	3%	153	416	37%
Bicycle	86%	7%	1%	4%	1%	1%	142	416	34%
Play sports like basketball or football	59%	16%	7%	4%	5%	9%	150	416	36%
Physical labour/ work	50%	16%	5%	11%	5%	12%	147	416	35%
Other							28	416	7%
Average	56%					16%			

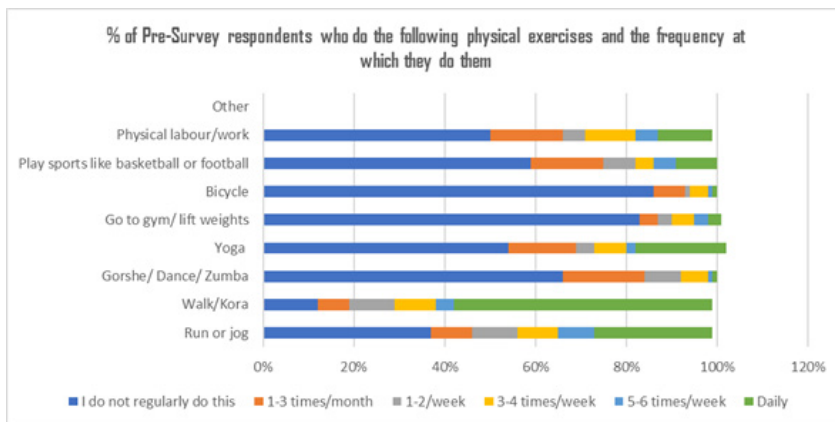


Figure 5 Respondents following Physical Exercises

The fact that not all respondents answered this question makes it somewhat difficult to interpret the data. The percentages represent the frequency of doing the exercise only among those who answered the specific exercise question. The N values for each exercise varies. The most common physical exercise reported was Walking/Kora, with most respondents (61%) answering the question and of those, 57% said they walked daily. Only 12% said they did not regularly do this.

The next most frequent activity was running/jogging. Of the 172 respondents who answered the question, 26% reported running/jogging daily, 8% said 5-6 times per week and 9% said 3-4 times per week. Only 37% said they do not regularly do this.

Yoga was also somewhat popular. Of the 180 respondents that answered the question, 20% reported doing it daily, while 54% said they did not regularly do it.

Some exercises mentioned seem to be more popular as an occasional activity, 1-3 times per month. Those include Gorshay /dance/Zumba (18% among those that answered), group sports like football or basketball (16% among those that answered) or physical labor (16% among those that answered). The activities that were done least frequently were bicycling (86% reported not regularly doing this) and going to gym/ lifting weights (83% not regularly doing this.)

Table 15. Post-Survey Report of Regular Exercise

Post-Survey Report of regular exercise	I do not regularly do this	1-3 times/month	1-2/ week	3-4 times/ week	5-6 times/ week	Daily	N that answered question	N for survey	% That answered
Run or jog	38%	11%	18%	14%	7%	12%	282	208	74%
Walk/Kora	16%	10%	21%	17%	10%	26%	282	216	77%
Gorshay/ Dance/ Zumba	65%	17%	8%	6%	2%	2%	282	207	73%
Yoga	63%	7%	12%	3%	3%	11%	282	205	73%
Go to gym/ lift weights	87%	5%	2%	1%	3%	1%	282	204	72%
Bicycle	83%	10%	2%	2%	1%	1%	282	201	71%
Play sports like basketball or football	69%	10%	8%	5%	4%	3%	282	203	72%
Physical labour/ work	51%	12%	13%	6%	6%	12%	282	208	74%

Other physical exercise at home*	31%	14%	22%	11%	6%	17%	282	212	75%
Other							282	9	3%
Average	56%					9%			

**Not asked on Pre-Survey*

Table 16. Comparison of Pre and Post Surveys, Type and Frequency of Physical Exercise

Pre & Post Surveys Report of regular exercise	Pre-test			Post-test		
	I do not regularly do this	1-3 times/ month	Daily	I do not regularly do this	1-3 times/ month	Daily
Run or jog	37%	9%	26%	38%	11%	12%
Walk/Kora	12%	7%	57%	16%	10%	26%
Gorshay/ Dance/ Zumba	66%	18%	1%	65%	17%	2%
Yoga	54%	15%	20%	63%	7%	11%
Go to gym/ lift weights	83%	4%	3%	87%	5%	1%
Bicycle	86%	7%	1%	83%	10%	1%
Play sports like basketball or football	59%	16%	9%	69%	10%	3%
Physical labour/ work	50%	16%	12%	51%	12%	12%

Other physical exercise at home*	31%	14%	17%
Other			

**Not asked on Pre-Survey*

Looking at a comparison of responses between the pre and post-test (keeping in mind the differences in sampling and response rate) there are some trends apparent, notably what appears like a decrease in the percentage of respondents reporting daily exercise, especially daily runs/jogs (from 26% to 12%), walks/kora (from 57% to 26%), yoga (from 20% to 11%) and group sports (from 9% to 3%). It's noteworthy to mention that the post-KAP survey included a new answer ("other physical exercise at home") to which 17% of respondents said they did daily. So, the results may indicate a shift in exercise practice from outside the home to inside the home, potentially due to concerns over covid 19. The average proportion of respondents that reported that they did ANY of the activities daily was 16% in the pre-survey and 9% in the post-survey. While the average percentage of respondents that said they did not do any of the activities regularly remained the same (56%).

Exposure to various health messaging on media and platform (post-Survey)

Table 17 shows the percentage of the post-KAP survey who reported seeing any content and on the following topics, whether produced by DoHe or not and on which media channel or platform they saw it.

Table 17. Exposure to various health messaging on different media and platforms

Exposure to programming related to:	Youtube	FB	Insta	TV	Health CTA FB	WhatsApp	Tibet. net	Did not see
Healthy Diets	62%	33%	26%	24%	22%	20%	10%	11%
Yoga/ Suryanamaskar	53%	22%	20%	13%	15%	11%	3%	20%
Zumba	44%	15%	11%	15%	16%	6%	2%	25%

Diabetes	30%	13%	7%	11%	18%	6%	5%	35%
Getting enough sleep	47%	23%	15%	10%	14%	6%	3%	24%
Breastfeeding	26%	13%	8%	11%	19%	4%	3%	38%
Hypertension	32%	15%	7%	9%	13%	8%	3%	39%
Kunkyi & Rewa episodes	10%	4%	2%	7%	4%	2%	2%	63%

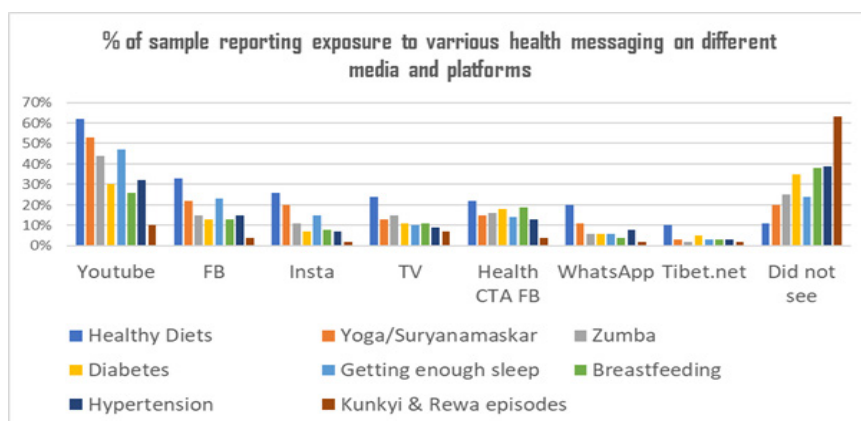


Figure 6 Exposure to various health messaging on different media and platforms

The three most frequently reported topics to have been seen were on “Healthy Eating”, “Yoga/Surya namaskar” and Zumba. The least seen topics were Hypertension, breastfeeding, and the Kunkyi and Rewa episodes. The most popular platform for viewing all this content was YouTube, followed by Facebook. The least popular platform for viewing any of this content was Tibet.net followed by WhatsApp.

Another question on the survey asked respondents if they specifically saw videos produced by the DoHe and if so, to rate those videos on a scale of 1-5 (1=lowest, 5= highest.) Table 18 shows the percentage of respondents reporting that they saw the videos and the average scores given by those who saw it. It is important to note that the survey was promoted and largely drawn from DOH's (CTA) social media channels, the same channels as the videos were disseminated through the Department of Information and International Relation's Tibet TV Facebook and YouTube channel.

Table 18. Exposure to various DoHe produced content

Table 15: Videos disseminated by DOHe	% That saw it	Average Score	N
Suryanamaskara video on World Yoga day	44%	3.74	195
Kunkyi & Rewa episodes	22%	3.93	182
Zumba videos by Instructor Migmar	44%	3.55	195
Video on colorful rotis	36%	3.60	193
Extra vegetables fried rice video	38%	3.63	191
Importance of Nutritionist on diet that help to sleep	44%	3.87	187
Yoga postures for hypertension	47%	3.90	185
Breastfeeding video contest	35%	3.77	188
Animated video on healthy plate	35%	3.66	184
Zumba with vlogger Derab Woser	47%	3.48	191
Healthy vegetarian cooking contest on World diabetes day	42%	3.65	184
Importance of healthy eating messages by Tibetan parents	45%	3.73	185

The most widely viewed video was “Zumba with vlogger Derab Woser” and “Yoga postures for hypertension” (both viewed by 47% of the sample.). The least watched videos were the Kunkyi & Rewa episodes (22%); however, these were also the highest rated videos (rated 3.93/5).

Another question asked respondents which social media channel they’d prefer to receive more HLS content on. Results are presented in Table 19. Fifty two percent of the sample preferred YouTube, followed by Facebook (36%) and then TV (32%) and Instagram (28%).

Table 19. Preferred Social Media Platform

Table 16 Preferred social media platform for dissemination of videos about diet and exercise		%
YouTube		52%
FB		36%
TV		32%
Instagram		28%
WhatsApp		24%
Other		3%
WeChat		1%
N		282

LIMITATIONS OF THE KAP SURVEY

- Due to resource constraints, both KAP surveys were conducted online, except for some deliberate oversampling of monks/nuns for the pre-KAP survey that was not possible for the post-KAP survey due to covid. As such, neither survey is representative of the Tibetan population across India.
- A large proportion of study respondents were from the Dharamsala region. See Annex 3 for the results of the question “where do you reside?”

QUALITATIVE RESEARCH FINDINGS

The qualitative data was analysed using content analysis. Based on pre-determined themes, data were collected using in-depth interviews from key influencers (settlement head, youth association head, Tibetan doctors, monastery/nunnery head, Parent-Teacher Association) and focus group discussions from the target group (homemaker, youth and monks/nuns). Information relating to their current dietary pattern, physical exercises, their perception of healthy and unhealthy food, barriers and facilitators in following a healthy lifestyle were retrieved. This was felt necessary to supplement the quantitative findings to understand the current behaviour and changes in behaviour determinants that have occurred or not. The following table shows all the details of the target group’s current behaviour determinants.

Mothers/Home Makers

FGDs were conducted with mothers/homemakers during which questions were asked about their own diet and exercise and that of their children. Information from IDIs with settlement heads, doctors and PTA representatives supplemented the insights gained from mothers, especially regarding the diet and exercise behavior among school-aged children and adolescents.

Table 20. Major themes discussed in focus group discussions related to adult women

Current Behaviors: Diet	Consuming dal, green vegetables, salads, pulses, fiber, eggs, curd after the meal, whole grains like oats & whole wheat, and refined oil, red meat, salt, rice and white sugar. Fast food consumption: Laphing, potato chips.
Current Behaviors: Exercise	Morning walks, yoga, prostration and stretching, Tibetan circle dance (Gorshay), Zumba.
Current Barriers: Healthy Diet (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Family pressure: Elders not being supportive of eating a healthy diet. Availability: Lack of certain spice ingredients does not allow to cook for homemakers. Lack of knowledge about healthy cooking. Lack of time due to work pressure hinders cooking at home. Laziness and inactive.
Current Barriers: Exercise (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Lack of awareness on various forms of exercise and its benefits. Lack of support from elders who disapprove of outdoor exercises like evening walks. Lack of time. Peer pressure and stigma.
Opportunities for DOHeDoHe to intervene: Healthy Diet:	Introduction of healthy food recipes and sharing knowledge on growing vegetables at home.
Opportunities for DOHeDoHe to intervene: Healthy Exercise:	Creating an avenue for yoga, Zumba, dance competition and other exercises in the camps will lead to more participation as there is an increase in awareness on exercise.
Exposure to past campaigns	Heard about but not seen much by adult women.
Preferred channels and platforms	YouTube, Facebook, WhatsApp. Nyamdel channel (Ladakh settlement)
Possible partnerships	Settlement leaders Tibetan women association

Adult women’s diet and exercises differ from each settlement that was considered for this study. It was found that adult women in Bylakuppe were leading a healthier lifestyle, i.e. consuming a more balanced diet and engaging in regular exercises. They are aware of organic food and consume less meat and white rice to stay healthy. Junk foods like potato chips, Laphing and chilly potato were consumed more by Mundgod and Ladakh. At the same time, it is interesting to find that homemakers in Ladakh are attempting to consume less fast food by substituting Tsampa to suppress their hunger pangs. With regard to exercises, adult women are facing social and family pressure for going to gym or walking which it was found to be harder for daughter-in-law. Yoga and Zumba are most preferred form of exercises among adult women and unanimously requested for regular classes within camp for daily participation.

Children and Adolescents

Children and adolescents were not interviewed as part of this study, but mothers were asked about the habits of their children during FGDs. Information pertaining to the HLS of children and adolescents was also obtained from IDIs with PTA representatives, doctors and settlement heads.

Table 21. Themes discussed related to children and adolescents

Current Behaviors: Eating	Children and teenagers frequently consume a high amount of junk food containing sodium, saturated fats, spices and sugar.
Current Behaviors: Exercise	School activities, basketball, football, breathing exercises, yoga, skipping, cycling.
Current Barriers: Healthy Diet (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Parents couldn't deny their children's strong demand for junk food. Children crave a strong flavorful taste of junk food instead of healthy food.
Current Barriers: Exercise (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Due to online classes, children are spending too much time with mobile and playing video games. Parents couldn't take time out from their classes for outdoor activities, especially in Bylakuppe and Mundgod.

Opportunities to intervene: Healthy Diet:	Children learn best through demonstration therefore expertise like doctors and dieticians visit schools to teach healthy eating. Children enjoy watching videos so simple and attractive video tutorials will help children to learn about healthy eating.
Opportunities to intervene: Healthy Exercise:	Contacting physical education teacher in schools for list of activities being conducted for children during physical training period and keeping track on half yearly or monthly basis.

Research among mothers clearly indicate a strong concern about their children's consumption habits, namely consumption of a high amount of junk food. Some parents do have a guilty conscious about providing unhealthy snacks to their children. Nevertheless, they give in to their child's tantrums. Simultaneously, they are anxious and ashamed of their child's weight and whether others will doubt their parenting skills. Daily, parents do provide soft drinks and artificially sweetened beverages to their children. A few of the parents have shown concern about their children's consumption of the sweetened energy drink, Red Bull. The COVID-19 pandemic has universally affected children's development starting with their education. Children spend more time with mobile phones than with friends amid their school curriculum through online teaching; they hardly spend time playing outdoor games. This will harm children's health. Such issues need to be addressed from now on.

Youth

FGDs were conducted with two age groups of youth, those aged 18-24 and those aged 25-34 to investigate whether diet and exercise habits were similar. Information about the HLS habits of youth was also obtained from interviews with youth association heads, doctors and settlement heads.

Table 22. Major themes discussed in focus group discussions related to youth

Current Behaviors: Eating	Junk food consumption in high amount.
Current Behaviors: Exercise	basketball, football, walking, yoga, Zumba, gym
Current Barriers: Healthy Diet (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Habits: conditioned to eat junk food since childhood. Availability: difficult to control junk food despite a frequent attempt from school heads. Peer pressure: Mukbhang, an eating show that is popular on social media for attracting viewers and it became a trend among youngsters to gain more followers. Lack of knowledge: Youngsters are not aware of diet and nutrition intake. Many of them did not know the ingredients used for fast food and its harmful effects of it. Beliefs: The youngsters view a healthy diet as reducing the amount of food intake but not reducing junk food intake.
Current Barriers: Exercise (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Laziness, peer pressure, the social stigma attached with going for outdoor exercises. Lack of safety measures for women.
Opportunities for DOHeDoHe to intervene Healthy Diet:	Demonstration of cooking, awareness campaign via short videos in social media.
Opportunities for DOHeDoHe to intervene: Healthy Exercise: what facilitating factors (same categories as above)	More tournaments in the settlements
Exposure to past campaigns	a bit exposure to social media contents on a healthy lifestyle by DoHeDoHe

Recommended Channels	Instagram, YouTube
Specific Programs/Organizations	Tibetan National Sports Association (TNSA), Private donors

The youth of today are the leaders of tomorrow; they are the foundation for a healthy community and a society. Special attention needs to be placed on the welfare of the youth and their behaviours which influence the way they lead their lifestyle. Therefore, it is imperative to examine the lifestyle pattern of youth in particular. The DoHe has narrowed down a healthy lifestyle into two main aspects that are healthy eating and exercise. This study highlights that youth are consuming high amounts of junk food. These junk foods contain very low nutritional values and contain high amounts of sodium, saturated fats, and sugar. The increase in market consumerism has led to the rising number of accessible and affordable fast-food chains in the settlements. Samosa, potato chips, ice cream, aloo papad, masala puri, panipuri, burger, pizza, Coke, Pepsi, Mountain Dew are the common unhealthy foods that young people indulge in. Young parents need to be educated on healthy eating because they give junk food as an incentive for their children to behave properly. Such practices need to be eliminated. Cell phones are the major culprit for the sedentary lifestyle of youth by reducing physical movement. This issue needs to be addressed.

Monks/Nuns

To understand diet and exercise habits and beliefs among monks and nuns, researchers conducted FGDs with both groups (separately) and IDIs with monastic institution meal procurers. They also asked questions about these target groups during IDIs with doctors and settlement heads.

Table 23. Major themes discussed in focus group discussions related to monks and nuns

Current Behaviors: eating	Vegetarian food, meat consumption, junk food, aerated drinks, Puri, bread, egg and Tsampa, Rajma, lentils and beans. Tingmo, curd and fruit pudding, Thukpa, fried rice, rice, dal, vegetables, soft drinks, junk food, instant noodles like aggie, Chinese food items. Energy drink (monster). Idli, vada, hogo, Laphing, Panipuri, idli, Coconut water, ice creams, chips, chappati, vegetable, whole-wheat atta, wheat flour, green peas, maize, mushrooms, butter tea, Cauliflower, Rajma, milk, thukpa. Cold drinks.
Current Behaviors: Exercise	Football, sweeping, cleaning and cooking at their own will, walking, breathing exercise, yoga, prostration, Stretching nerves, jogging, and meditation.
Current Barriers: procurement of healthier food (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Availability: fresh vegetables are difficult to get. Monsoon: difficult for transport food as it is in high quantities (300kgs one day prior) and high wastage of vegetables. Accessibility: Quality food is needed. Lack of information: younger monk needs to be educated on healthy food than senior monks. Habits: aerated drink consumption. Lack of knowledge: side effects of sugary drinks. Habits: Most of the monks are from Tibet and they are conditioned from childhood to consume meat as a primary source of nutrition.
Current Barriers: Exercise (knowledge, beliefs, access, affordability, social norms, social support, skills, habits & routines, emotions, intentions)	Time management: difficult to manage time before the pandemic, nuns have to be active from 5 am to 11.30 pm and have no time for exercise. Only during lunch and break time.

Opportunities for DOHeDoHe to intervene Healthy Diet:	According to them, a healthy lifestyle program is a must in a monastery as they belief “health is wealth” “even though you are educated and intelligent, without health, it is like a rotten egg” Awareness program on balance diet and importance of hygiene. The monastery head plays a vital role in enhancing the dietary intake of the monks. Therefore, the monastery head should be educated more to have maximum impact on HLC. Suggested cooking videos using vegetables for homemakers as they find difficulties in cooking vegetarian food items when they visit their houses for prayers.
Opportunities for DOHeDoHe to intervene: Healthy Exercise:	For monks, lectures once or twice a year on the benefits of physical exercises. For nuns, they would be interested to watch only if the videos are short and meant for a specific cause like sinus, back pain, knee pain etc.
Exposure to past campaigns	Has some knowledge of DOH HLC and watched some videos on cooking and hand wash?
Recommended Channels	Tibet Tv, FB, YouTube, WhatsApp
Specific Programs/Organizations	Tsojhe hospital, NGOs, Sponsor from Taiwan/NGO/Tibetan Cancer Society

Monks and nuns have the same barriers for exercises, namely not having time for physical activities. Both groups are served healthy food from their monastery and nunnery kitchens but consume junk food in their rooms or outside the institutions, such as chicken kababs, Gobi Manchurian, and aerated drinks in high quantity. Maintaining the health of monks is imperative

as they are the holders of Buddhist lineage. COVID-19 has harmed monks in particular. As per the record by Tso Jhe (2021), three monks in their early 30s died by COVID-19. Tibetan doctors who practice in the monastery reported that monks suffer from diseases such as high blood pressure, gastric, hepatitis, and obesity. This is a serious concern and is directly linked to a lifestyle they follow. Therefore, healthy eating, physical exercises and a healthy mind are a prerequisite. Although the monasteries and nunneries provide healthy food, monks tend to cook unhealthy food like Maggi, red meat in their respective rooms which have kitchen facilities. Thus, there is not much control over their eating habit. Therefore, a proper workshop or guidance is needed for all monks and nuns to follow healthy dietary practices.

RECOMMENDATIONS

Based on the findings from both the quantitative and qualitative studies, the researchers offer the following recommendations for the different target groups:

Recommendations for adult women/home makers

Adult women play a significant role in influencing the health and diet practices of their immediate family because they typically prepare the daily meals in the household life.

1. Promotion of organic farming in settlements

In collaboration with the Department of Home, the DoHe can organize groups of women to work on vegetable plantations. Each woman can work on a particular vegetable and can exchange it with local markets. This will sustain the practices of organic farming and create a source of income.

2. Recipes and Cooking Tutorials

Adult women have shown a willingness to watch videos on healthy food recipes if the content is in English and Tibetan. Health educators can demonstrate healthy cooking and address other issues concerning water quality and hygiene in the settlements.

3. Women empowerment, social norms and social support

One of the barriers that adult women still endure in their community is the fear of being judged by society if they partake in outdoor activities. For such activities, forming groups can create social support for others to take part in it. Likewise, they can form social groups to create activities concerning mental health, cooking, and physical activity and the DoHe can fund these groups to hire trainers and experts to work with them. Infrequent discussion among their peer groups, the women have quoted that "healthy eating, exercise, and healthy mind is collectively defined as a healthy lifestyle"

4. Workshops and programs in the camp

The factors that hinder adult women from participating in workshops and lectures organized by DoHe on a healthy lifestyle are time

constraints and logistics. Therefore, if such activities can be held in camps rather than community halls, it could attract more participation. All the camps have a separate structure for gatherings, meetings, and prayers which can be used for future activities organized by the DoHe.

As a result of trauma faced by the parent's generation, many parents continuously feed their children without the knowledge of nutrition simply because they are anxious about their child being hungry or malnourished. This has resulted in the current rise of childhood obesity.

Recommendations for children and adolescents

1. Parents should be educated on healthy eating and exercises

Parents are playing an essential role in the upbringing of their children. They have a great influence and are a role model for their children. They need to be educated on the impact and benefits that arise from healthy eating and how to balance wanted to please (spoil?) their children with ensuring they are instilling healthy lifelong habits.

2. Need diet and healthy food videos

Children enjoy animated videos or series like ChotaBheem, a well-known Indian animated series on the Pogo channel that every child in each household talks about. To promote healthy eating among children, such programs will surely convey messages about eating green vegetables, fruits, nuts, and the consequences of indulging in unhealthy eating.

3. Aerated drinks should be banned in school

All artificially sweetened drinks should be banned from being sold and consumed inside schools. In schools, there are separate committees consisting of the school director, headmaster, and discipline teacher to look after the regulations of junk food within the school vicinity. In school canteens, aerated drinks, spicy food, and expensive things are not allowed to be sold. If such regulations are monitored in all the school systems, it will bring a positive change and allow for healthier options to be consumed in school. The DoHe can facilitate activities to implement the guidelines on controlling junk food within and outside the schools.

4. Awareness of side effects of soft drinks and beverages

Immediate awareness of the harmful effects of soft drinks, especially Red Bull, is required for children. It has become a trend among their peer to consume aerated drinks in high amount. Hiring nutritionists and dieticians to educate students on the long-term impacts of these beverages by engaging them in interactive activities such as skit play, storytelling, and group presentations.

5. Ingredients while preparing food

A representative of a nunnery reported that the DoHe's HLC cooking videos were helpful for the nunnery to know healthy ingredients and to control the quantities of each ingredient for cooking. They followed the videos and made changes in their kitchen menu accordingly. This can be further developed by DoHe to improve collaboration with school heads and Parent Teacher Associations (PTA.) The DoHe can provide suggestions for healthy menus based on regional differences. (Example can be the guidelines provided by Dr BIANCA- MARI in following a diet chart menu). PTA/meal procurer/cook should be given the responsibility of providing healthy food in schools and involving them in future activities. The DoHe can reach the school principal in concern about using yeast in Tibetan steam bun (Tingmo). These practices may cause ulcers among youth and should be banned at the earliest.

Recommendations for Youth

1. Awareness of soft drinks and side effects of junk food

Youth should be advocating for healthy food, raising issues on junk food, and promoting awareness among them as well as in society. The DoHe can form youth groups and support them with organizing activities to implement within their settlements. In addition, video messages from popular social influencers, celebrities, or athletes would appeal to the youth. These influencers should be selected based on their routine after thorough research.

2. Need of public talk by Nutritionist (preferably Tibetan) twice a year

This will help youth with choosing the right kind of food. Many youths as young as 20 or 22 years old consume protein powder and other products (company products which cost ranging from Rs. 3500- Rs 6000) for bodybuilding. There is no proper guidance on nutrition and often go by their peer advice. This may have a detrimental effect on their health.

3. Mental health education

This was recommended by youth and the DoHe can organize virtual workshops twice a year. A healthy lifestyle starts from the mind and keeping the mind healthy leads to a healthy body.

4. Zumba and yoga program needed in the settlement

The assigned officer should visit each camp in the settlement and select volunteers who can lead the Zumba and yoga activities. The DoHe can disseminate various activities and messages via the volunteers to reach the target groups.

5. **More tournaments in the settlements**

It was reported that youth tend to follow a healthy diet and exercises only during the period of tournaments which is held once a year. They refrain from having alcohol, cigarettes, and aerated drinks for a few months. Therefore, it is important to form a club that will allow youth to change their behaviour and retain their health eventually becoming a habit. The DoHe can approach the Tibetan National Sports Associations (TNSA) for funding as they are willingly contacting youth association heads in the settlement for encouraging physical movement of the youth. If there are difficulties in hiring new officers due to budget constraints, the alternative can be those excess volunteers in the primary hospitals under the DoHe, which are present in almost all the settlements. They can be given responsibility for all proposed future activities under the direction of the DoHe.

Monks/Nuns Recommendations

1. **Menu guidelines and training of cooks for monastery/nunnery**

Monks suggested having a professional cook in the monastery that knows how to eat healthy food and is health-conscious. A nutritionist can develop menu guides and a training curriculum for cooks to use in preparing meals.

2. **Need more health programs from Tibet TV in Tibetan**

As many monks and nuns only speak Tibetan, short videos and clips can be made on healthy eating in the Tibetan language and disseminated through Tibet TV.

3. **Tibetan doctor intervention**

The DoHe can collaborate with Men-Tsee-Khang to provide education on healthy lifestyles. Tibetan doctors serve as a guiding light for most monks and nuns. This will be an effective strategy to change the behaviour of monks and nuns. This can be achieved by conducting more research on this population's behaviour and planning face-to-face activities or workshops.

4. **Awareness of junk food and aerated drinks**

The amount of aerated drink consumption is high in monasteries in part because expired or old drinks are sold in monasteries shops by local businessman for making profit. There is an urgent need for an awareness program on junk food and aerated drinks through videos and demonstrations through offline mode.

5. **Awareness of menstrual hygiene**

Nuns suggested having a workshop on how to maintain pad hygiene. They feel that many nuns or girls are not aware of it. This can be done through interactive demonstrations rather than lectures or

merely broadcast on social media. An in-person demonstration is effective and it is more pragmatic.

6. Nuns requested to have a medical checkup once a year

Which will help them diagnose the diseases at an early stage. Major diseases are stomach ulcers, blood pressure, diabetes, and hepatitis, which can be prevented by regular checkups. The DoHe can collaborate with organizations like the Tibetan Cancer Society to facilitate or follow them with their ongoing activities for improving the health of the community.

7. Mental health interventions

Although monasteries and nunneries have their curriculum on taming the mind and meditation, this study showed that many monks need mental health education programs. There have been cases of suicide and rising anxiety among monks during this pandemic. The DoHe can approach mental health experts and host a program at least once a year which will help tremendously for those in need.

CONCLUSION

The Healthy lifestyle Campaign assessment by quantitative and qualitative approach revealed some successes and a lot of areas for on-going action. This comprehensive study addresses all the objectives of the study summarizing the results of the HLS SBC campaign, reporting some changes to HLS behaviours and behavioural determinants and exposure to SBC content as detected by the pre-and post-campaign KAP Survey. It also used in-depth interviews and FGDs to obtain opinions from various key informants about how the campaign is being received by target groups, and what can be improved in the future to improve targeting, content, messaging, communication channel selection and the overall process. These have been incorporated in the list of recommendations to improve future HLS SBC campaigns and activities.

ANNEX 1: HEALTHY LIFESTYLE

SUMMARY SBC STRATEGY

	HEALTHY LIFESTYLE - FOR YOUR FAMILY	
	Diet	Exercise
Who is our Target Audience?	Adult age >40	
What is their Psychographics?	Family responsibility, not so open-minded, status-seeking, looks are important, Mopa-believers. The Greatest hope is healthy, peaceful life. Values family and spirituality.	
Where do they get their information?	TV, we chat, Facebook, friends, YouTube, Religious (including mopa) & political leaders	
Major Behavioral Determinants	Lack of knowledge of recipes seems too hard to eat healthy, fatalist about death, belief that fatness isn't unhealthy (considered graceful "sijitsapo", lack of confidence and skill that they can cook tasty healthy meals. People also like the taste of meat, fat, sugar, salt and think healthy food lacks flavour.	Lack of knowledge on specifics (duration & intensity of exercise) to be beneficial, difficult to fit into a schedule, exercise sometimes seen as "showing off", lack of habit, lack of classes, equipment or infrastructure.
What do we want them to KNOW about the problem or solution?	NCDs are rapidly growing problem among Tibetans, having to take medicine every day is hard and expensive, but HTN/Type 2 diabetes can be prevented and managed with diet and exercise. Decreasing meat and increasing vegetable and whole grains in the diet is quick, easy & tasty. Increasing physical movement can also be easy and fun and really help improve your health. Here are some specific recipes and exercise suggestions....	

How do we want them to FEEL about the problem or solution?	Loved and needed by their family. You can live a healthy and happy and long life with your family if you just make some minor changes to your diet and exercise.	
What do we want them to DO about prevention/treatment? (Small Doable Actions)	Increase the amount of vegetables and pulses in your diet. Reduce red meat. Reduce your weight. Reduce fat, sugar and salt.	Advise Exercise: 2.5 hours/week (only 20 min/day) of activity that causes shortness of breath/light sweat (yoga, Zumba, sports, dance, walking/kora, etc., Establish a healthy routine of physical activity.
Which channels will we use to communicate?	Launch event, Healthy recipes (cards & videos), Diabetes Day Event, Other events (cooking contests, White Wednesday Potlucks, etc.), TV Talk Show, regular 30 min healthy cooking show on TibetTV, all promoted by SM and posters & CCOCC nurses, lamas and partnership w/TMAI.	Launch event, Videos of Yoga, Zumba, Gorshe, chair aerobics, etc. aired every morning on TibetTV, special walk/run events, group Kora, other local events TBD, TV Talk Show, all promoted by SM and posters, CCOCC nurses, Settlement leaders, lamas, and partnership with TMAI.
What materials will we produce?	Recipe cards (and eventually book), 30 min cooking videos for TibetTV and YouTube library, 10 sec. recipe videos for SM, event guidance emails for settlement leaders and CCOCC nurse curriculum.	30 min Yoga, Zumba, Gorshe and chair aerobics class videos (for TibetTV and YouTube library.) Guidance to settlement leaders and CCOCC nurse curriculum on how to organize classes and events.
Who is responsible inside DOHe for these activities?	Yangtso & Samten	

Who will implement the activity	Facility nurses and CHW. Samten for SM promotion and some materials development.	Settlement Leaders to assign person responsible for classes. Samten for SM promotion.
Who will help? (partners)	Tibet TV, film-maker consultant (?) Settlement Officers & Executive Secretaries, TMAI, NGOs, Religious Lamas	

ANNEX 2: THE ACTIVITY IS DONE UNDER HEALTHY LIFESTYLE CAMPAIGN

S.No.	Topic	Activity	Timing	Medium
1	To promote & advocate vegetarian diet to control diabetes	Organized Healthy Vegetarian Cooking Contest on World Diabetes Day	14 Nov 2019	Tibet TV FB
2	Introducing new healthy recipe for diabetic person	Cooking Demonstration of the first winner	November 2019	Tibet TV FB
3	Support breastfeeding for healthy babies	Organized video contest on World Breastfeeding Week (16 participants)	1-7 Aug 2020	Tibet TV FB
4	Breastfeeding video contest 1st Winner's video	Observed World Breastfeeding Week		Tibet TV FB
5	Breastfeeding video contest 2nd Winner's video	Observed World Breastfeeding Week		Tibet TV FB
6	Breastfeeding video contest 3rd Winner's video	Observed World Breastfeeding Week		Tibet TV FB

7	Animated video dubbed in Tibetan on 'What is diabetes?'. The focal message is early detection and treatment will keep diabetes at bay.	Observed World Diabetes Day	14 Nov 2020	DoHe YouTube
8	Nutritionist Kelsang stressed on harmful effects of junk food and parents' important role in building healthy eating habit at home.	Observed National Children's Day	14 Nov 2020	Tibet TV FB
9	The video containing collective messages and experiences shared by Tibetan parents from different parts of the World on their children's healthy eating practices at home.	Observed National Children's Day	14 Nov 2020	Tibet TV FB
10	The circular consisting of illustration, guidelines and videos on how to create a healthy plate.	HLC content developed specific to healthy eating for monks & nuns	4 Feb 2021	Email
11	Animated video dubbed in Tibetan on 'Why sleep is important?'	Observed World Sleep Day	19 March 2021	DoHe YouTube

12	'How sleep schedule improves your productivity?'	Observed World Sleep Day	19 March 2021	DoHe YouTube
13	TMAI Dr's perspective on importance of sleep	Observed World Sleep Day	19 March 2021	Tibet TV FB
14	Nutritionist guide to best food to enhance your quality of your sleep	Observed World Sleep Day	19 March 2021	Tibet.net FB
15	Video containing Health Minister's speech on Tibetan Health status based on data collected in HIS (Health Information System) and different survey conducted by different program which was followed by two different healthy recipe videos.	Observed World Health Day	7 April 2021	Tibet TV FB
16	Zumba Demonstration with Vlogger Dherab Woesser	Observed World Health Day	7 April 2021	Tibet TV FB
17	Live conference with tulku Lama Lobsang on Lu Jong (breathing exercise)	Observed World Health Day	7 April 2021	Tibet TV FB
18	Dr. Jigme Kalsang's Video on World Hypertension	Observed World Hypertension Day	17 May 2021	Tibet TV FB

19	Nutritionist Tsering Wangmo's video on World Hypertension Day	Indoor Zumba Dance Workout for all (8.39m)	21 May 2021	Tibet TV FB & YouTube
20	Yoga Fitness trainer Tseyang's video on World Hypertension Day	Zumba Dance Intermediate (14.43m)	23 May 2021	Tibet TV FB & YouTube
21	Zumba video in Tibetan instruction by Zumba Trainer Migmar. The trainer is known for his energetic personality to influence others to take part in Zumba.	Zumba Dance Basic		Tibet TV FB & YouTube
22	Trailer of Tibet Theatre movie Kunkyi&Rewa based on different messages relevant to HLC.	Tibet Theatre movie production (Kunkyi&Rewa)	20 May 2021	Tibet TV FB & YouTube
23	Parents as a role model for their children to build healthy habits from childhood	Episode 1 (length- 8.13 m)	25 May 2021	Tibet TV FB & YouTube
24	Too much screen time will have a harmful effect on child's development	Episode 2 (5.59 m)	26 May 2021	Tibet TV FB & YouTube

25	Harmful effects of junk food leading to depression and eventually social relationship and academic performance	Episode 3 (5.59m)	2 June 2021	Tibet TV FB & YouTube
26	Vegetables and fruits help to prevent lifestyle diseases	Episode 4 (11.38m)	2 June 2021	Tibet TV FB & YouTube
27	Regular habit of exercise will promote both mental and physical wellbeing	Episode 5 (10.19 m)	2 June 2021	Tibet TV FB & YouTube
28	Video showing simple steps to begin Suryanamaskara by instructor Yoga Zamling	Observed International Yoga Day	21 June 2021	Tibet TV
29	Extra Vegetable Fried Rice Recipe to encourage more vegetable ingredients	HLC Food recipe videos	7-Jul-21	DoHe YouTube Channel
30	How to prepare high protein plant-based food for vegetarian		22-Jul-21	DoHe YouTube Channel
31	Simple Salad for Better Skin!		29-Jul-21	DoHe YouTube Channel

ANNEX 3: PLACE OF RESIDENCY FOR PRE AND POST KAP SURVEY SAMPLES

Pre-Survey Residence		Post-Survey Residence	
	Count of Residence		Count of Residence
Bandhara	1	Australia	1
Bengaluru	6	Bengaluru	3
Bhutan	1	Bengaluru	1
Bir	4	Bhutan	2
Bylakuppe	4	Bir	15
Bylakuppe	1	Bylakuppe	2
Bylakuppe	2	Bylakuppe	8
Chandigarh	4	Clement Town	6
Clement Town	2	Dalhousie	2
Dalhousie	2	Darjeeling	4
Darjeeling	3	Dekyiling	9
Dekyiling	6	Delhi	15
Delhi	12	Dharamshala	88
Dharamshala	249	Dolanji	3

Dolanji	3	Dubai	1
Gangtok	7	Hunsur	7
Gujarat	1	Kalimpong	1
Hunsur	2	Kamrao	1
Kamrao	1	Kheracamp	1
Kollegal	10	Kollegal	5
Kullu	1	Kullu	1
Ladakh	22	Ladakh	14
Lhakhanwala	2	Lhakhanwala	2
Mainpat	6	Mainpat	4
Mandi	3	Mandi	3
Mundgod	5	Miao	2
Mysore	6	Mundgod	19
Nepal	4	Nepal	11
Odisha	10	Odisha	4
Other (please specify)	4	Paris	1
Paonta Sahib	1	Raipur	1
Puruwala	10	Ravangla	2
Ravangla	2	Satuan	1
Satuan	1	Shillong	1
Shillong	2	Shimla	3

Shillong	1	Sonada	2
Shimla	1	Swiss	1
Tenzingang	2	Tashijong	3
Tezu	7	Tenzingang	2
US	1	Tezu	2
(blank)		Tsojhe	13
Grand Total	412	Tuting	3
		US	5
		Varanasi	1
		(blank)	
		Grand Total	276

