

Report on

Transmission Assessment Survey (TAS 3) in 3 Districts (Ilam, Panchthar and Tehrathum) of Nepal



Government of Nepal
Ministry of Health and Food Safety
Vector Borne Disease Research and Training Centre (VBDRTC)

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EXECUTIVE SUMMARY

Background: Lymphatic filariasis (LF) is a mosquito-borne parasitic disease targeted for elimination as a public health problem. Transmission Assessment Survey 3 (TAS 3) was conducted in Ilam, Panchthar, and Tehrathum districts to determine whether LF transmission has remained below the critical threshold after previous successful TAS rounds. The survey was implemented by the Vector Borne Disease Research and Training Centre (VBDRTC) in coordination with EDCD, WHO, and district and local-level stakeholders. **Methods:** A school-based cross-sectional survey was conducted following WHO TAS guidance. Two Evaluation Units were used for the survey: EU1 included Ilam and Panchthar districts, while EU2 included Tehrathum district. Grade 1 and Grade 2 students were selected as the survey population because the districts had more than 75% net school enrolment. Schools were selected using the WHO Survey Sample Builder (SSB) based on updated school lists. A total of 240 schools were surveyed, including 116 schools in EU1 and 124 schools in EU2. Data were collected using two forms. Form 1, the school check-in form, was completed directly in KoboToolbox on mobile devices and captured school-level information such as school identification, GPS location, enrollment, attendance, consent, and reasons for absence. Form 2 captured individual sociodemographic and diagnostic information. It was first completed on paper during fieldwork and later entered into KoboToolbox. Blood samples were collected through finger prick and tested using Filariasis Test Strips (FTS) provided by WHO/EDCD. Test results were read exactly at 10 minutes and interpreted using the TAS testing algorithm. Data were cleaned and verified in Excel, analyzed using STATA version 16, and GPS data were mapped using QGIS. **Results:** Among 3,277 eligible Grade 1 and Grade 2 children, 3,001 (91.6%) were present and tested, achieving 100% testing coverage among eligible children present. After excluding one inconclusive result, 3,000 valid test results were available for TAS interpretation. Overall, 13 children tested positive for lymphatic filariasis (LF) antigen, resulting in an overall prevalence of 0.43% (13/3,000; 95% CI: 0.23%–0.74%). All positive cases were detected in EU1, where the prevalence was 0.82% (13/1,587; 95% CI: 0.44%–1.40%), while no positive cases were detected in EU2. The prevalence of LF antigenemia was similar across age groups and sexes. Among children aged 6–7 years, the prevalence was 0.43% (8/1,857; 95% CI: 0.19%–0.85%), compared with 0.44% (5/1,143; 95% CI: 0.14%–1.02%) among children outside the 6–7-year age group. By sex, the prevalence was 0.41% (6/1,454; 95% CI: 0.15%–0.90%) among females and 0.45% (7/1,546; 95% CI: 0.18%–0.93%) among males. Within EU1, the

prevalence was 0.77% (95% CI: 0.33%–1.50%) among children aged 6–7 years and 0.92% (95% CI: 0.30%–2.14%) among children outside the target age group. Similarly, prevalence was 0.78% (95% CI: 0.29%–1.68%) among females and 0.86% (95% CI: 0.35%–1.76%) among males, indicating no substantial differences by age or sex. Based on WHO TAS decision rules, EU1 did not pass TAS 3, as 13 positive cases exceeded the critical cutoff value of 6, whereas EU2 passed TAS 3, with no positive cases, remaining below the critical cutoff value of 4. Geospatial analysis identified 13 positive cases across six schools, with 11 cases in Ilam and two in Panchthar. The largest cluster (7 cases) was detected at Heritage National Academy, Ilam Municipality Ward 9, indicating persistent focal transmission in this area. Household residence duration among the 13 positive cases ranged from 2 to 30 years, with a mean of 12 years. Nine positive children (69.2%) belonged to households that had lived in the current locality for more than five years. **Conclusion** The TAS 3 survey was successfully implemented and achieved adequate sample sizes in both Evaluation Units. The findings demonstrate different epidemiological situations between the two Evaluation Units. EU1 did not pass TAS 3 because the number of positive cases exceeded the critical cutoff, indicating possible persistent, recurrent, or reintroduced transmission. EU2 passed TAS 3, suggesting that transmission remains below the critical threshold in Tehrathum district. Programmatic decisions should therefore be made separately for each Evaluation Unit rather than on the basis of the combined positivity rate. **Recommendations**: For EU1, two alternative programmatic options may be considered: establishing a sub-Evaluation Unit covering Ilam Municipality and the adjoining border area between Ilam Municipality and Sandakpur Rural Municipality, where positive cases were concentrated, followed by one round of IDA using Ivermectin, Diethylcarbamazine, and Albendazole and an IDA Impact Survey; or implementing one round of IDA throughout the existing EU1, comprising Ilam and Panchthar districts, followed by an IDA Impact Survey across the entire Evaluation Unit. Before either option is selected or implemented, the national lymphatic filariasis elimination programme should consult WHO and the relevant Regional Programme Review Group to review the TAS 3 findings, geographic clustering of positive cases, investigation results, proposed intervention boundaries, IDA strategy, survey design and timing, and criteria for subsequent reassessment. Detailed microplanning, high directly observed treatment coverage, community mobilization, independent monitoring, adverse-event preparedness, and complete documentation should be ensured. For EU2, active and passive post-MDA surveillance should continue to detect possible recrudescence or reintroduction of

transmission, while epidemiological, programmatic, surveillance, treatment, and historical MDA information from Tehrathum should be compiled for national elimination dossier readiness. Morbidity management and disability prevention services should also be maintained and properly documented. All 13 antigen-positive children received treatment, and eligible household members were provided with anti-filarial medicines; therefore, continued follow-up, surveillance, documentation, and coordination with local, national, and international partners will be essential for addressing the findings in EU1 and supporting Nepal's progress toward validation of lymphatic filariasis elimination as a public health problem.

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ABBREVIATIONS

Ag	Antigen
CEHRD	Center for Education and Human Resource Development
CI	Confidence Interval
EDCD	Epidemiology and Disease Control Division
EMIS	Education Management Information System
EU	Evaluation Unit
FTS	Filariasis Test Strip
GIS	Geographic Information System
GPELF	Global Programme to Eliminate Lymphatic Filariasis
GPS	Global Positioning System
ICT	Immunochromatographic Test
IDA	Ivermectin, Diethylcarbamazine, and Albendazole
LF	Lymphatic Filariasis
MDA	Mass Drug Administration
MMDP	Morbidity Management and Disability Prevention
NSE	Net School Enrolment
NPABSON	National Private and Boarding Schools' Association Nepal
PABSON	Private and Boarding Schools' Organization Nepal
QGIS	Quantum Geographic Information System
RPRG	Regional Programme Review Group
RM	Rural Municipality
SSB	Survey Sample Builder
SOP	Standard Operating Procedure
STH	Soil-Transmitted Helminths
TAS	Transmission Assessment Survey
TAS 1	First Transmission Assessment Survey
TAS 2	Second Transmission Assessment Survey
TAS 3	Third Transmission Assessment Survey
VBDRTC	Vector Borne Disease Research and Training Centre
WHO	World Health Organization
WHA	World Health Assembly

CHAPTER 1: INTRODUCTION

1.1 Background

Lymphatic filariasis (LF) is a parasitic mosquito-borne endemic disease spread in 72 countries worldwide.¹ Globally, an estimated 36 million people are living with clinically significant manifestations of LF.² Approximately 17 million individuals experience LF-related lymphoedema (elephantiasis), characterized by swelling of the limbs, breasts, or genitalia, while nearly 19 million men are affected by urogenital disease, predominantly hydrocoele. These chronic conditions substantially impair physical functioning, social participation, and quality of life, while also limiting occupational productivity. Although LF is rarely fatal, its long-term debilitating effects make it one of the leading causes of permanent disability worldwide.³

In 1997, The World Health Assembly adopted Resolution WHA 50.29, which called on Member States to initiate steps to eliminate lymphatic filariasis as a public health problem. In response to this call, WHO launched the Global Programme to Eliminate Lymphatic Filariasis (GPELF) in 2000 which has two components: 1. Mass Drug Administration (MDA) to interrupt the transmission and 2. Morbidity Management and Disability Prevention (MMDP) to alleviate suffering. Nepal is also signatory body to eliminate Lymphatic Filariasis (GPELF) by 2030.

Lymphatic filariasis (LF) is targeted for global elimination by 2030 through treatment of entire at-risk population with repeated annual MDA.⁴ This target was revised as many countries were behind the initial target of elimination in 2020. Essential for program success is defining and confirming the appropriate endpoint for MDA when transmission is presumed to have reached a level low enough that it cannot be sustained even in the absence of drug intervention. WHO recommends a transmission assessment survey (TAS) to determine if MDA can be stopped within an LF evaluation unit (EU) after at least five effective rounds of annual treatment.

Lymphatic filariasis (LF) remains a significant public health concern in Nepal. The country is intensifying efforts to eliminate LF as a public health problem by 2030. Of the 64 districts

¹ World Health Organization. Global programme to eliminate lymphatic filariasis: progress report, 2023. In: Weekly Epidemiological Record. 2024; 99(40):565–576 (<https://iris.who.int/handle/10665/379120>).

² Ramaiah KD, Ottesen EA. Progress and impact of 13 years of the global programme to eliminate lymphatic filariasis on reducing the burden of filarial disease. PLoS Negl Trop Dis. 2014;8(11):e3319 (<https://doi.org/10.1371/journal.pntd.0003319>)

³ World Health Organization. The World Health Report 1995: bridging the gaps. World Health Forum. 1995;16(4):377–85 (<https://iris.who.int/handle/10665/45087>)

⁴ NTD Modelling Consortium Lymphatic Filariasis Group. The roadmap towards elimination of lymphatic filariasis by 2030: insights from quantitative and mathematical modelling. Gates Open Res. 2019 Sep 13;3:1538. doi: 10.12688/gatesopenres.13065.1. PMID: 31728440; PMCID: PMC6833911.

historically endemic for LF, 57 have successfully interrupted transmission and have discontinued mass drug administration (MDA)⁵ after meeting the World Health Organization (WHO) criterion of a microfilaria prevalence below 1%.

According to WHO guidance, to measure the impact of an LF elimination program, it is necessary to conduct a series of two post-MDA surveillance surveys after TAS 1 to evaluate whether recrudescence has occurred. Each survey should be conducted approximately 2–3 years following the previous survey. Transmission assessment surveys (TAS 3) should be conducted two to three years after the transmission assessment survey (TAS 2) in districts where mass drug administration has been stopped. Once districts have passed TAS 3, they will undergo other forms of active and passive surveillance along with Morbidity mapping and disability prevention activities, get ready for dossier development and stay eligible for elimination from that district. The target population of a TAS is children aged 6-7 years or grade 1 and 2 students if net primary school rate is more than 75 percent. The rationale is that children in this age-group should have lived most (or all) of their lives during MDA in the area being surveyed. If adequate drug coverage was achieved, the infection rate in the population should have decreased with little potential transmission, so that young children are probably protected from infection. Therefore, any positive results in young children are likely to indicate recent transmission.

As of April 2023, 3 districts (Ilam, Panchthar and Tehrathum) were eligible for TAS 3 because these districts were successful in TAS 2 conducted in March 2023. The team decided the district is equivalent to one evaluation unit (EU) for Ilam and Panchthar (EU 1), Terhathum district is categorized in to one EUs (EU-2) based on WHO guidance of forming Evaluation unit (Districts having features like similar geographic region, adjoining districts, similar socioeconomic characteristics and similar epidemiological features like baseline prevalence and MDA coverage can be combined to make an Evaluation unit).

The TAS 3 was a school-based cluster survey following established WHO guidance and implemented by Nepal's Vector Borne Disease Research and Training Centre (VBDRTC). VBDRTC obtained updated lists of schools from Ministry of Education, Science and Technology; Center for Education and Human Resource Development and ran the WHO Survey Sample Builder

⁵ World Health Organization. MDA campaign launched in four districts to eliminate Lymphatic Filariasis [Internet]. Kathmandu: World Health Organization, Regional Office for South-East Asia; 2026 Jan 23 [cited 2026 Jul 18]. Available from: <https://www.who.int/nepal/news/detail/23-01-2026-mds-campaign-launched-in-four-districts-to-eliminate-lymphatic-filariasis>

tool (TAS +STH SSB) in close coordination with Nepal's Epidemiology and Disease Control Division (EDCD), and WHO to select schools to be surveyed. WHO/EDCD provided the filariasis test strips (FTS)-Diagnostic tool, and positive control to be used for this survey. Data was entered into a mobile device (kobotoolbox) and hard copies have been kept for records. Students of grade 1 & 2 were the target population for sample collection. A total of 3001 samples were taken from 2 EUs. Comparing antigen-positive cases to the critical cut-offs is more important than comparing differences among the base line, pre-TAS, TAS 1 and TAS 2 evaluation. If the TAS 3 or other post MDA evaluation results are greater than the critical cut-off point, this suggests that there could be ongoing transmission of LF in the EU and the national program should consult the WHO Regional Programme Review Group for advice.

1.2 Objective of the TAS 3 Survey

The objective of this survey was to determine whether the number of positive children in a school-based survey is below the critical infection threshold ("critical cut off") under which transmission is likely no longer sustainable. If the number of positive children in TAS 3 is less than or equal to the survey's critical cut off, the EU continues with post-MDA surveillance. If the number of positive individuals from TAS 3 is greater than the critical cut off point, this determines that there has been either a re-introduction or recurrence of LF in that EU. The national program should consult the WHO Regional Programme Review Group (RPRG) for advice.

CHAPTER 2: METHODOLOGY

2.1 Survey Area and Survey Population

This survey was conducted in schools of three districts (Ilam, Panchthar and Tehrathum) of Nepal. For this TAS 3 survey, the Evaluation Units were determined during the survey design stage in coordination with EDCD, VBDRTC, WHO, and partners. The Evaluation Unit was defined as the geographic area for which the TAS result would be interpreted and programmatic decisions would be made. The grouping of districts into Evaluation Units considered programme history, epidemiological context, school-based sampling requirements, and operational feasibility. In this survey, two Evaluation Units were used. EU1 included Ilam and Panchthar districts, while EU2 included Tehrathum district. Separate sample sizes, selected schools, critical cutoffs, and TAS interpretations were applied for each Evaluation Unit. Therefore, the TAS 3 result was interpreted separately for EU1 and EU2 rather than using the combined result across all districts. Students of grade 1 & 2 (proxy of 6 & 7 years) were the survey population for sample collection.

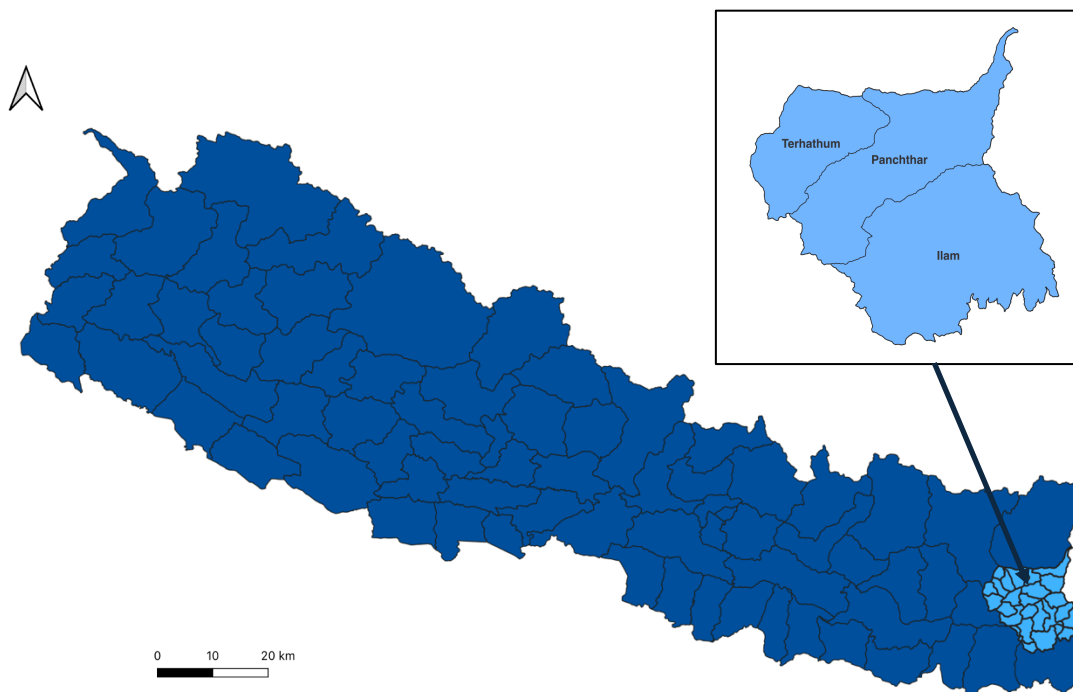


Figure 1: Districts for TAS-III survey

2.2 Survey Design

A cross-sectional survey methodology was applied to determine the prevalence of lymphatic filariasis (LF) antigenemia. Primary-level school students from Grade 1 and Grade 2 were selected as the sample population because the selected districts had more than 75% net school enrolment (NSE). This TAS 3 survey was a school-based survey conducted in accordance with established WHO guidance. The Vector Borne Disease Research and Training Center (VBDRTC) collected an updated list of schools from the Ministry of Education and Sports, Center for Education and Human Resource Development (CEHRD), and WHO. Schools were selected using the WHO Survey Sample Builder (SSB) tool. Filariasis Test Strips (FTS), provided by WHO/EDCD, were used as the diagnostic tool for the survey. Collected data were recorded using two forms. Form 1, the school check-in form, was completed directly in KoboToolbox on mobile devices during school visits. Form 2, which included individual sociodemographic and diagnostic details, was first completed on paper during fieldwork and later entered into KoboToolbox for data management and analysis. The targeted sample size for this survey was at least 2,916 children across two Evaluation Units from selected schools in three districts. The survey algorithm is provided in Annex 1. TAS design depends upon factors such as the net primary school enrolment rate in each EU, number of grade 1 & 2 students in given evaluation unit, number of schools, non-response rate, vector type and parasite species as mentioned in Annex 1 to determine the sample size, number of schools, critical cut off value, sampling interval and fraction. Microsoft Excel computer tool entitled *WHO* Survey Sample Builder (SSB) was used to determine sample size and number of schools.

2.3 TAS 3 Eligibility

According to WHO TAS guidance, it was necessary to conduct transmission assessment surveys (TAS 3), 2 years after the successful completion of TAS 2. Ilam, Panthar and Tehrathum districts were now eligible for TAS 3 as these districts succeeded the TAS 2 in 2023. TAS 1, TAS 2 & Re Pre TAS results of TAS 3 districts and MDA coverage results of these districts are mentioned in Table 1 and Table 2 respectively.

Table 1: TAS 2, TAS 1 and Pre TAS/ Re Pre -TAS Results of TAS 3 districts:

District / EU	Current population	Pre-/Re-pre-TAS Ag (%)	TAS 1 positive / cutoff	TAS 2 positive / cutoff	TAS 3 eligibility
Tehrathum EU2	88,731	1.33 / 0.98 2016	0 / 16 2017	0 / 18 2023	ELIGIBLE
Ilam EU1	279,534	1.32 / 0.33 2018	0 / 18 2019	0 / 18 2023	ELIGIBLE
Panchthar EU1	172,400	0.32 / 0.32 2018	0 / 18 2019	0 / 18 2023	ELIGIBLE

Source: Lymphatic Filariasis Elimination Program Annual Report 2017/18 and unpublished internal records of the National Lymphatic Filariasis Elimination Programme, Epidemiology and Disease Control Division, Ministry of Health and Population, Nepal.
Department of Health Service. Annual Health Report 2079/80. Kathmandu: Ministry of Health and Population, Government of Nepal."

Table 2: MDA Coverage/Baseline Survey Results of TAS 3 districts:

District profile			MDA coverage by year (%)							
District	EU	Baseline (ICT)	2012	2013	2014	2015	2016	2017	2018	2019
Tehrathum EU2		1.06	48.99	60.85	65.29	65.88	66.27	69.88	—	—
Ilam EU1		0.80	61.25	69.82	70.77	78.01	78.10	79.83	79.64	60.77
Panchthar EU1		0.30	59.11	65.73	66.59	69.61	70.59	72.74	64.84	66.51

Reported coverage lower higher

Tehrathum **69.88%** highest reported coverage • 2017

Ilam **79.83%** highest reported coverage • 2017

Panchthar **72.74%** highest reported coverage • 2017

Source: Lymphatic Filariasis Elimination Program Annual Report 2017/18 and unpublished internal records of the National Lymphatic Filariasis Elimination Programme, Epidemiology and Disease Control Division, Ministry of Health and Population, Nepal.
Department of Health Services. Annual Health Report 2076/77. Kathmandu, Nepal: Ministry of Health and Population, Government of Nepal

2.4 Sampling Technique and Sample Size

TAS methodology was based on the methodology recommended by World Health Organization (WHO).⁶ Districts were identified based on their eligibility to conduct TAS-3. As per WHO TAS guidance, school students were selected for the survey population because national statistics

⁶ Monitoring and epidemiological assessment of mass drug administration in the global programme to eliminate lymphatic filariasis: a manual for national elimination programmes, second edition. Geneva: World Health Organization; 2025. Licence: CC BY-NC-SA 3.0 IGO.

accounts more than 75% of the school enrollment rate. All the schools under the EUs were listed in geographical order and used WHO Survey Sample Builder (SSB) software to determine the sample school and students sample size. SSB provided the random numbers. Random numbers were matched with the list of the geographically ordered schools and matched schools were selected for the survey. All students from grades one and two were selected for the survey. WHO SSB Excel tool was used to select schools and sample students. The following criteria were used:

- The threshold level is $< 1\%$ antigen-positive in Anopheles/Culex/Mansonia areas.
- At least a 75% chance of passing if the true prevalence of antigenaemia in Bancroftian areas is half the target level: 0.5% in Anopheles/Culex/Mansonia areas.
- No more than about 5% chance of passing (incorrectly) if the true prevalence of antigenaemia in Bancroftian areas is $\geq 1\%$ in Anopheles/Culex/Mansonia areas.

Sample size was calculated by using WHO TAS + STH SSB for survey evaluation units, EU wise sample size distribution and critical cut off level is given in Table 3.

Table 3: Sample school and sample size

SN	Evaluation Units	Total Schools	Total Students	Sample Size	Critical Cut Off	# of Selected Schools	Sampling Interval
1	EU 1: Ilam and Panchthar	931	15602	1548	6	109	Test all Children
2	EU 2: Tehrathum	248	3518	1368	4	114	Test all Children

**Sample size was calculated assuming 15% absentee rate. 10 extra schools were selected for the EU if any shortfalls.*

2.5 School Selection

The list of schools, including all primary schools regardless of type, such as government, private, Madrasa, and Gumba schools, along with the number of Grade 1 and Grade 2 students, were collected by VBDRCT from the Ministry of Education and Sports and the Center for Education and Human Resource Development (CEHRD) prior to the development of the survey protocol. The school lists were arranged in geographical order for each Evaluation Unit. The list of schools to be visited was then generated using the WHO TAS + STH Survey Sample Builder (SSB) as mentioned in Annex 8. In addition to the originally selected schools, extra schools were selected

for each Evaluation Unit to address possible sample shortfalls. During implementation, all Grade 1 and Grade 2 students in the selected schools were tested in Ilam and Panchthar (EU1) and Tehrathum (EU2). If the required sample size was not achieved after visiting all originally selected schools, the field team proceeded to the first additional school. If the sample size was still not met, the team continued to the next additional school, and so on, until the required sample size was achieved. All Grade 1 and Grade 2 students present in the final selected school were tested, even if the required sample size was reached before testing all students in that school. In this survey, 7 additional schools were selected and visited in EU1, and 10 additional schools were selected and visited in EU2 to meet the required sample size.

2.6 Training to Enumerators

Vector Borne Disease Research and Training center recruited 6 qualified and experienced enumerators (32 Counselors and 33 lab personnel) to conduct this TAS 3 survey in 2 districts. VBDRTC organized two days Enumerator's Training on TAS-3 in two batch at VBDRTC training hall in Hetauda. The training was organized on 23rd and 24th June 2026 in close coordination with EDCD, WHO and other concerned stakeholders. Survey field supervisor/counsellor and lab personnel including survey team participated in this training. VBDRTC research team along with EDCD technical team facilitated the training.

The WHO training guidelines materials were utilized in the training. The training sessions covered introduction and context of LF and Nepal LFE program, TAS survey approach and TAS protocol, recording and reporting of data in mobile/paper, approach of organizing school level coordination meeting, mobile application Kobotoolbox utilization for data collection. Role play of field situation led by VBDRTC survey team and supported by other stakeholders was also part of training. Training also covered research ethics, rapport building and overcoming embarrassment. The knowledge of participants was assessed before and after the training using a standard WHO TAS training questionnaire customized for Nepal. The mean pre-test score was 17.15 out of 24, equivalent to 71.44%. The mean post-test score increased to 21.97 out of 24, equivalent to 91.54%. This showed an improvement of 4.82 points in the mean score and an increase of 20.10 percentage points.

2.7 District Level Coordination and Planning Meeting

VBDRTC organized district-level coordination and planning meetings in all three survey districts in close coordination with the respective District Health Offices prior to the initiation of the scheduled survey. The objective of the meetings was to inform key stakeholders about the objectives, importance, methodology, selected schools, and implementation plan of the TAS 3 survey, and to seek their support for smooth field implementation. The meetings were facilitated by trained VBDRTC supervisors, LF focal persons of the respective Health Offices, and district health managers. Due to time constraints, the meetings were focused on key implementation stakeholders, including District Health Office representatives, municipality/rural municipality health section chiefs, and education section chiefs from the local levels where selected schools were located. Other participants in the district-level coordination and planning meetings included journalists, security personnel from the Nepal Army, Armed Police Force, and Nepal Police, representatives of private school associations such as PABSON and NPABSON, district health supervisors, representatives from the District Education Development and Coordination Unit, District Coordination Committee, and the Chief District Officer or representative from the District Administration Office.

During the meetings, the list of selected schools was shared and discussed with the concerned municipal representatives. Field movement plans and route mapping were prepared in coordination with the health and education section chiefs to ensure timely access to the selected schools. Their support was also requested for communication with school authorities, coordination of school-level activities, and facilitation of sample collection. District-level coordination and planning meetings were organized on 26 June 2026 in Ilam, Panchthar, and Tehrathum districts. The participation of district-level and municipal-level stakeholders helped strengthen local coordination and supported the effective implementation of the TAS 3 survey at the school level.

2.8 School level Coordination meeting

VBDRTC's trained enumerators visited the selected schools in the concerned municipalities and rural municipalities. Upon arrival, the enumerators first coordinated with the principal or head teacher of each selected school using the support letters received from the district and municipal authorities. A brief meeting was then organized with the school management committee, head teacher, and school teachers. During the meeting, the enumerators explained the data collection procedures, overall importance, and methodology of the TAS 3 survey. They also described how

the survey would contribute to the elimination of lymphatic filariasis and clarified the roles and responsibilities of school authorities for the smooth implementation of the survey. Meeting minutes were prepared and served as written consent from the school authority to conduct the survey in the school. After receiving consent, all Grade 1 and Grade 2 students who were present on the survey day were gathered in a suitable room. The students were briefly oriented about the survey and the procedures to be followed. All survey activities were then carried out with the support of the school teachers.

2.9 Specimen Collection and Testing

The counselor organized the school-level meeting and obtained consent from the school management to conduct the survey in the selected school. Blood samples were collected from survey respondents according to the blood collection protocol provided in Annex 2. Field activities were conducted from **27 June to 5 July 2026**. The Filariasis Test Strip (FTS) procedure was applied to detect LF antigenemia among the survey population. Blood was collected directly into a small **75- μ L blood collection pipette** after pricking the left ring finger. After the blood sample was drawn, it was transferred to the sample application pad using the pipette, and the test result was assessed exactly after **10 minutes**. The FTS kits used for this survey were provided by **WHO/EDCD**. Each FTS was labeled with a unique ID so that the test result could be linked with the information collected from the respondent. The unique ID consisted of the Evaluation Unit number, the selected school code, and the sequential number of the tested student. School codes were assigned based on the Evaluation Unit and district. For example, **EU1-Ilam school codes started from 101, EU1-Panchthar school codes started from 201, and EU2-Tehrathum school codes started from 301**. The student test number was then added sequentially. For example, the sample code **1-102-7** indicates that the student was the seventh child tested from selected school number 102 in Evaluation Unit 1. Test results were coded as follows: 0 = negative, indicated by the presence of the control line only, and 1 = positive, indicated by the presence of both the test and control lines. Positive tests were retested for confirmation before final recording. The TAS testing algorithm was followed to determine the final test result and treatment requirement. Children with a negative antigen test were recorded as negative and did not require further testing or treatment. Children with a positive antigen test were recorded as positive and were recommended for treatment. If the first test result was invalid, a second test was performed. When

the second test was positive, the final result was recorded as positive and treatment was recommended. When the second test was negative, the final result was recorded as negative and no treatment was required. If both the first and second tests were invalid, or if the first test was invalid and the second test was refused or not done, the result was classified as inconclusive and excluded from the final sample. Children who refused testing were recorded as refused and were not counted in the sample. Individuals with inconclusive or indeterminate results were removed from the overall sample and did not count toward the designated TAS sample size. Treatment recommendations were provided for positive cases, and the local health system was responsible for treatment and follow-up of positive individuals and their families as needed. [Annex 6]

2.10 Data Collection and management

Data were collected using KoboToolbox on mobile devices. Two separate forms were used for data collection: Form 1: School Check-in Form and Form 2: Sociodemographic and Diagnostic Information Form. Form 1 was completed during the school visit and captured school-level information, including school identification, Evaluation Unit, district, municipality, GPS location, enrollment, attendance, consent, and reasons for absence. Form 2 captured individual-level information for each participating child, including sociodemographic details and diagnostic test results. During field implementation, Form 2 was first completed on paper at the school level. After completion of fieldwork, the

paper-based records were entered into KoboToolbox for digital data management and analysis. This approach allowed school-level and child-level data to be collected separately and later linked using the Evaluation Unit, School Code, and Sample Code. The data monitoring team from

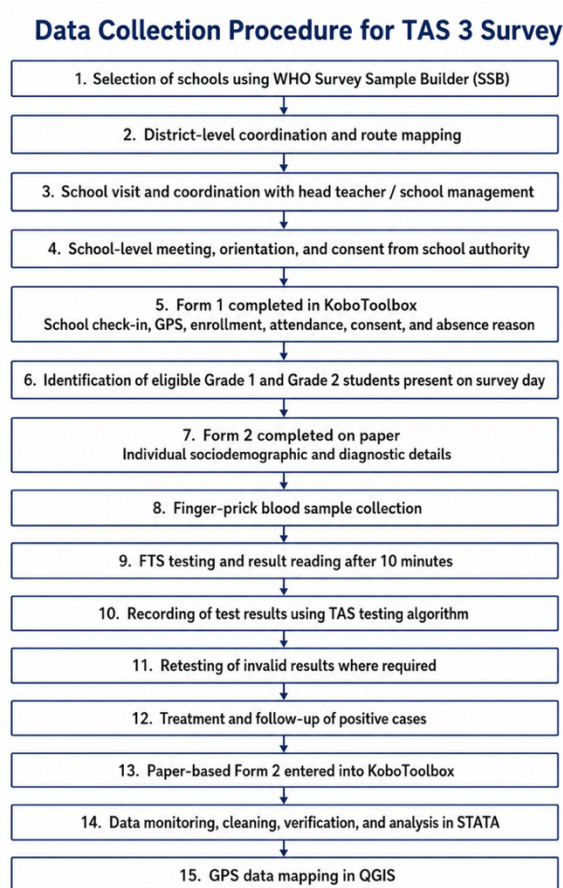


Figure 2. Flow of data collection, testing, data entry and analysis for the TAS 3 survey

VBDRTC regularly monitored the data uploaded to the KoboToolbox server. If any errors or inconsistencies were identified, the team contacted the respective district supervisor and provided feedback for correction and updates to the data collection team. The supervisors then coordinated with enumerators to review and correct the data as needed. After data collection, the summary data were cleaned and reviewed in Excel. The datasets were finalized after cross-verification, and consistency was checked against the paper-based forms during the data cleaning process. The cleaned data were then exported to STATA version 16 for further analysis, and result tables were generated for inclusion in the final report. GPS data were used for mapping in QGIS.

2.11 Ethical Consideration

Assessment of risk to participants

This survey was a part of routine programmatic activity and offers very minimal risk of harm to the participants. The pricking needle for blood draw was minimal of risk, but may result in anxiety and discomfort, and rarely, infection or bleeding in some individuals. Participants stand to benefit from this survey, as anyone testing positive was referred to the nearest health facility for follow-up treatment. In addition, the list was provided to Health Office District/ Health Service Office in the district/ municipalities for further follow up treatment.

Approval from school meeting

Informed consent form (Annex 4) was developed in Nepali language by VBDRTC before executing field works. Then, the counselor visited selected schools prior to sample collection. He/ She organized school meeting and was responsible to get informed consent from school authorities and available guardians in the meeting via minute of the meeting.

Consent from children

The verbal consent was taken from selected children. The children who did not agree to withdraw blood and/or not willing to participate were not recruited in the survey.

2.12 Monitoring and Supervision

Monitoring and supervision were conducted by the VBDRTC survey team according to the survey protocol. Monitoring was also undertaken by the concerned District Health Office, LF focal persons, district managers, and health and education section chiefs from the respective rural and urban municipalities. VBDRTC team members visited selected survey schools to monitor field activities. During supervision, the team reviewed the overall survey process, observed the field

survey team, completed the WHO-adapted TAS supervision checklist, and provided on-the-spot feedback. Frequent telephone communication was maintained with district supervisors and field teams to monitor survey progress and ensure the quality of data collection. District managers and program focal persons also supervised the field activities. They verified the reading of test results, quality control procedures, waste management, counselling, follow-up of positive cases, local coordination, field activity management, and data verification.

2.13 Informing the Authorities about the Survey Completion

Before leaving the respective survey areas, the survey team informed the District Health Office and local authorities, including municipality and rural municipality representatives, about the completion of survey activities. The district supervisors shared a brief summary of the survey activities conducted and discussed the treatment and follow-up plan for positive cases with the local health facility. After completion of the survey, the field team informed the respective authorities about the number of children tested, the number of positive children, and the details of positive cases for treatment and follow-up. Formal letters were also requested from the districts and schools as evidence of survey completion. During the survey, all field teams were provided with LF MDA drugs under the IDA regimen, along with the required logistics. Therefore, all positive children were treated on the spot with supports from local health facility personnel and municipality officials.

CHAPTER 3: RESULTS

3.1 Overview of Survey Implementation

The TAS 3 survey was conducted in 240 selected schools across two Evaluation Units. Data were collected using two Kobo forms: Form 1 for school-level check-in, enrollment, attendance, consent, GPS location, and absenteeism information; and Form 2 for child-level sociodemographic and diagnostic test results. A total of 3,001 children from Grade 1 and Grade 2 were tested during the survey. The survey followed the TAS protocol, which uses school-based cluster sampling and final TAS interpretation by Evaluation Unit.

Sample adequacy indicator

The sample adequacy indicator shows whether the number of valid children tested met the planned WHO Survey Sample Builder sample size. Both Evaluation Units achieved more than 100% of their planned sample size. EU1 achieved 1,587 valid samples against a planned sample size of 1,548, representing 102.52% achievement. EU2 achieved 1,413 valid samples against a planned sample size of 1,368, representing 103.29% achievement.

Table 1: Planned versus achieved valid sample size by Evaluation Unit

Evaluation Unit	Planned Sample Size	Valid Sample Achieved	Achievement
EU1	1,548	1,587	102.52%
EU2	1,368	1,413	103.29%

3.2 School Coverage

A total of 240 schools were surveyed across the two Evaluation Units. Of these, 116 schools were located in EU1, which included Ilam and Panchthar districts, while 124 schools were located in EU2, Tehrathum district. The QGIS map shows that surveyed schools were geographically distributed across the selected municipalities and rural municipalities within the three districts, indicating broad spatial coverage of the TAS 3 survey area.

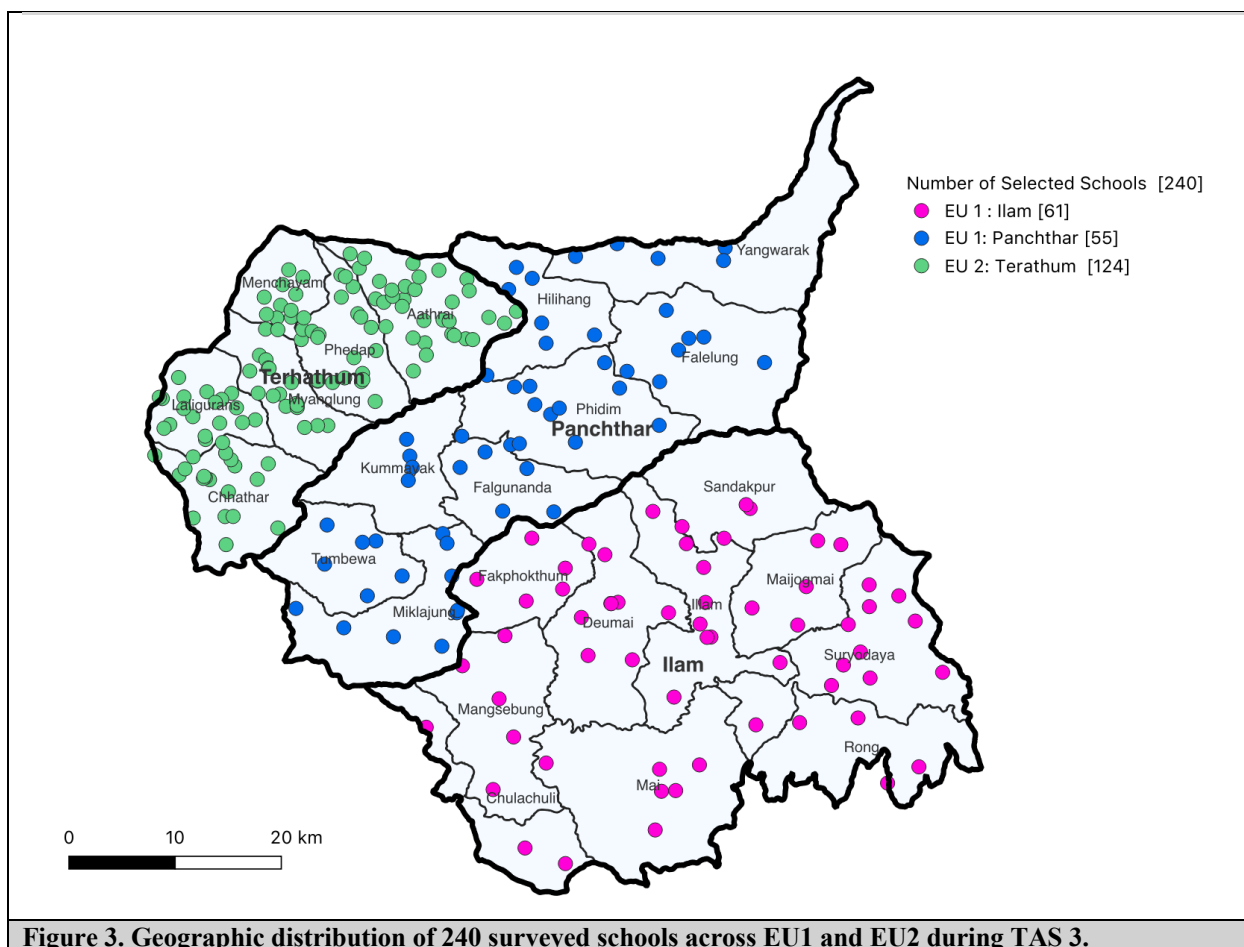


Figure 3. Geographic distribution of 240 surveyed schools across EU1 and EU2 during TAS 3.

3.3 Enrollment and Attendance Status

A total of 3,679 students were expected based on the EMIS/provided school list across the surveyed schools. During field verification, 3,277 eligible children were recorded as admitted in Grade 1 and Grade 2. Of these, 3,001 children were present on the day of the survey, while 276 children were absent, resulting in an overall attendance rate of 91.58%. In EU1, which included Ilam and Panchthar districts, 1,880 students were expected from the EMIS/provided school list. During the school-level check-in, 1,726 eligible children were recorded as admitted, of whom 1,588 were present and 138 were absent. The attendance rate in EU1 was 92.00%. In EU2, which included Tehrathum district, 1,799 students were expected from the EMIS/provided school list. A total of 1,551 eligible children were recorded as admitted, of whom 1,413 were present and 138 were absent. The attendance rate in EU2 was 91.10%. Overall, attendance was high in both Evaluation Units, with more than 91% of eligible admitted children present during the survey. The

attendance and enrollment information was collected through the school-level check-in process, which is part of the TAS school enrollment and consent procedure.

Table 2: School Enrollment and Attendance Summary

Evaluation Unit	District(s) Included	Expected Students	Total Eligible Admitted	Total Eligible Present	Total Eligible Absent	Attendance Rate
EU1	Ilam and Panchthar	1,880	1,726	1,588	138	92.0%
EU2	Tehrathum	1,799	1,551	1,413	138	91.1%
Total		3,679	3,277	3,001	276	91.5%

Formula: Attendance Rate = Total Eligible Present / Total Eligible Admitted × 100

3.4 Reasons for Absence

A total of 114 schools reported the major reason for student absence during the survey. Among these schools, 34 schools (29.82%) reported migration as the major reason for absence, while 80 schools (70.18%) reported reasons not related to migration.

Table 3: Major Reasons for Absence Reported by Schools

Major Reason for Absence	Number of Schools	Percent
Due to migration	34	29.8%
Other than migration	80	70.1%
Total schools reporting absence reason	114	100.0%

3.5 Testing Coverage

Testing coverage among eligible present children was 100.00% in both Evaluation Units. In EU1, all 1,588 eligible children present during the survey were tested, and in EU2, all 1,413 eligible children present were tested. Overall, 3,001 children were present and tested across the surveyed schools, indicating complete implementation of testing among available eligible children.

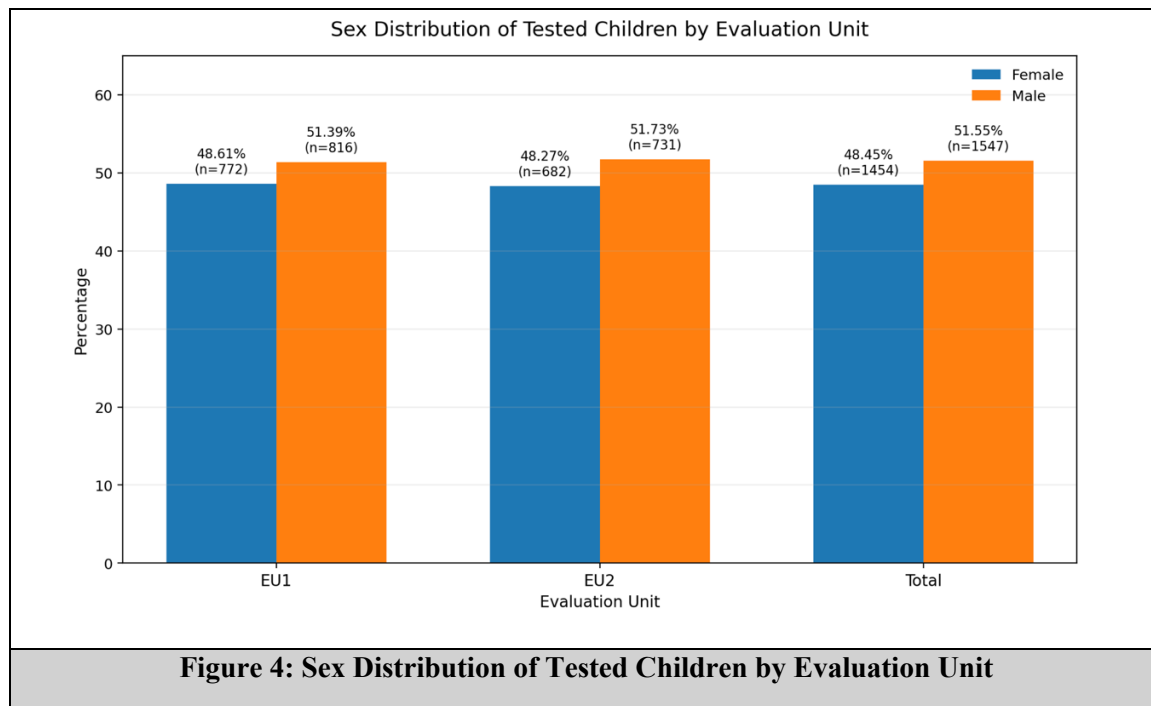
Table 4: Testing Coverage Among Eligible Present Children

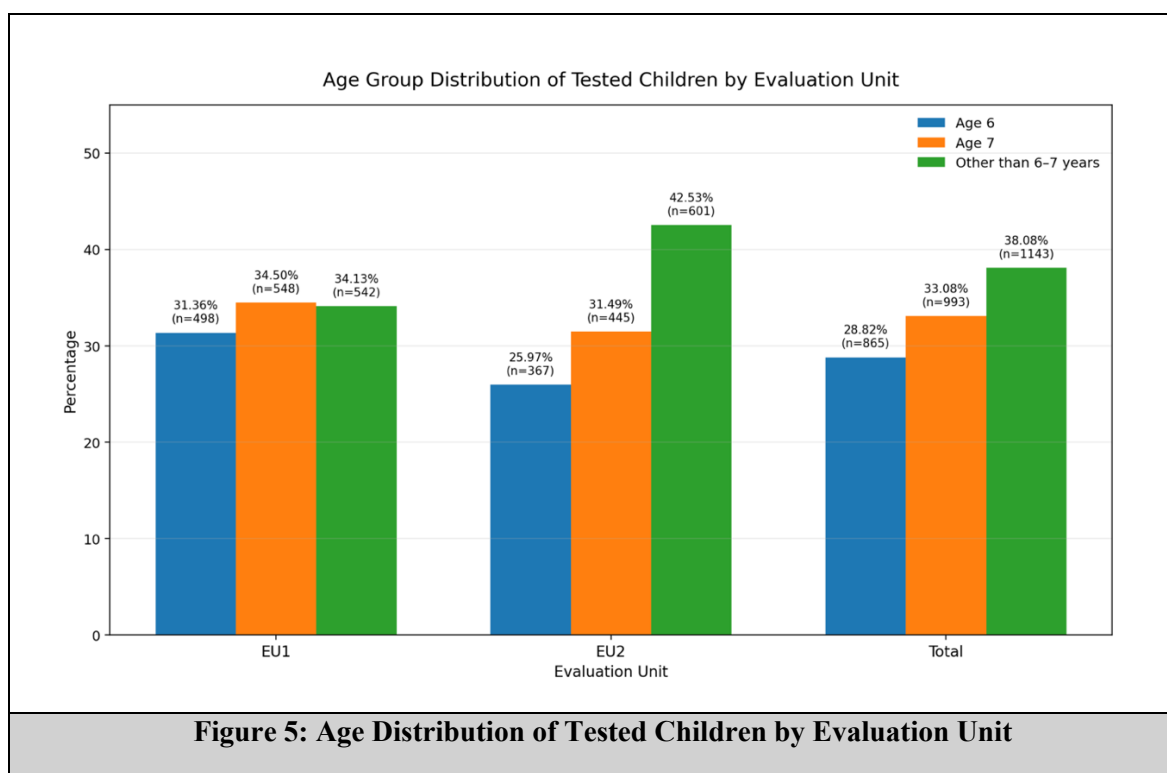
Evaluation Unit	Eligible Children Present	Children Tested	Testing Coverage
EU1	1588	1,588	100%
EU2	1413	1,413	100%

Formula: Testing coverage = Children tested / Eligible children present × 100

3.6. Demographic Characteristics of Tested Children by Evaluation Unit

The sex distribution was relatively balanced across both Evaluation Units. Overall, 1,454 children (48.45%) were female and 1,547 children (51.55%) were male. In EU1, females represented 48.61% and males represented 51.39% of tested children. Similarly, in EU2, females represented 48.27% and males represented 51.73%. By age group, 865 children (28.82%) were aged 6 years, 993 children (33.08%) were aged 7 years, and 1,143 children (38.08%) were outside the 6–7 years age group. EU2 had a higher proportion of children outside the 6–7 years age group (42.53%) compared with EU1 (34.13%). Overall, the demographic profile shows that the survey included a balanced distribution of male and female children. Although the TAS target age group is generally 6–7 years, the survey was conducted among Grade 1 and Grade 2 students, which can include some children outside the 6–7 years age range.





3.7 Final Diagnostic Results

A total of 3,001 children were tested across the two Evaluation Units. Among them, 2,987 children tested negative, 13 children tested positive, and 1 child had an inconclusive final result. In EU1, which included Ilam and Panchthar districts, 1,588 children were tested. Of these, 1,574 children were negative, 13 children were positive, and 1 child had an inconclusive result. All positive cases detected during the survey were from EU1. In EU2, Tehrathum district, 1,413 children were tested. All children tested in EU2 had negative final results, and no positive or inconclusive cases were recorded. Overall, the findings show that LF antigen-positive cases were detected only in EU1, while EU2 recorded zero positive cases. The one inconclusive result was excluded from the valid sample denominator for TAS interpretation, consistent with the TAS testing algorithm.

Table 5: Final TAS Results by Evaluation Unit

Evaluation Unit	Inconclusive	Negative	Positive	Total Tested
EU1	1	1,574	13	1,588

EU2	0	1,413	0	1,413
Total	1	2,987	13	3,001

3.7 Valid Sample and Positivity Rate

The valid sample includes only children with final positive or negative results. The one inconclusive result was excluded from the valid sample denominator. Across both Evaluation Units, a total of 3,001 children were tested. After excluding 1 inconclusive result, the total valid sample was 3,000 children. Among the valid results, 13 children tested positive, giving an overall positivity rate of 0.43%. In EU1, 1,588 children were tested. After excluding 1 inconclusive result, the valid sample was 1,587 children. A total of 13 positive cases were detected in EU1, resulting in a positivity rate of 0.82%. In EU2, 1,413 children were tested and all had valid final results. No positive cases were detected, resulting in a positivity rate of 0.00%.

Table 6: Valid Sample and Positivity Rate

Evaluation Unit	Total Tested	Inconclusive	Valid Sample	Positive	Positivity Rate
EU1	1,588	1	1,587	13	0.82%
EU2	1,413	0	1,413	0	0.00%
Total	3,001	1	3,000	13	0.43%

Formula: Valid sample = Positive + Negative

Positivity rate = Positive / Valid sample $\times$ 100

3.8 TAS 3 Interpretation by Critical Cutoff

Result was interpreted separately for each Evaluation Unit using the assigned critical cutoff. The decision is based on whether the number of positive cases is below or above the critical cutoff, not only on the percentage positivity. In EU1, the valid sample was 1,587 children, and 13 positive cases were detected. The critical cutoff for EU1 was 6. Since the number of positive cases was greater than the critical cutoff, EU1 did not pass TAS 3. In EU2, the valid sample was 1,413 children, and no positive cases were detected. The critical cutoff for EU2 was 4. Since the number of positive cases was below the critical cutoff, EU2 passed TAS 3. Although the overall positivity rate across both Evaluation Units was 0.43%, the TAS 3 decision must be made at the Evaluation Unit level. Therefore, EU1 requires further programmatic review and follow-up action, while EU2

meets the criteria for passing TAS 3. The TAS protocol also specifies EU-wise sample sizes and critical cutoffs for interpretation.

Table 7: TAS 3 Decision by Evaluation Unit

Evaluation Unit	Valid Sample	Positive Cases	Critical Cutoff	TAS 3 Result
EU1	1,587	13	6	Did not pass TAS 3
EU2	1,413	0	4	Passed TAS 3

EU1

Valid Sample
1,587

Positive Cases
13

Critical Cutoff
6

Positivity Rate*
0.82%

DID NOT PASS TAS 3
Positive cases (13) are above the critical cutoff (6).

EU2

Valid Sample
1,413

Positive Cases
0

Critical Cutoff
4

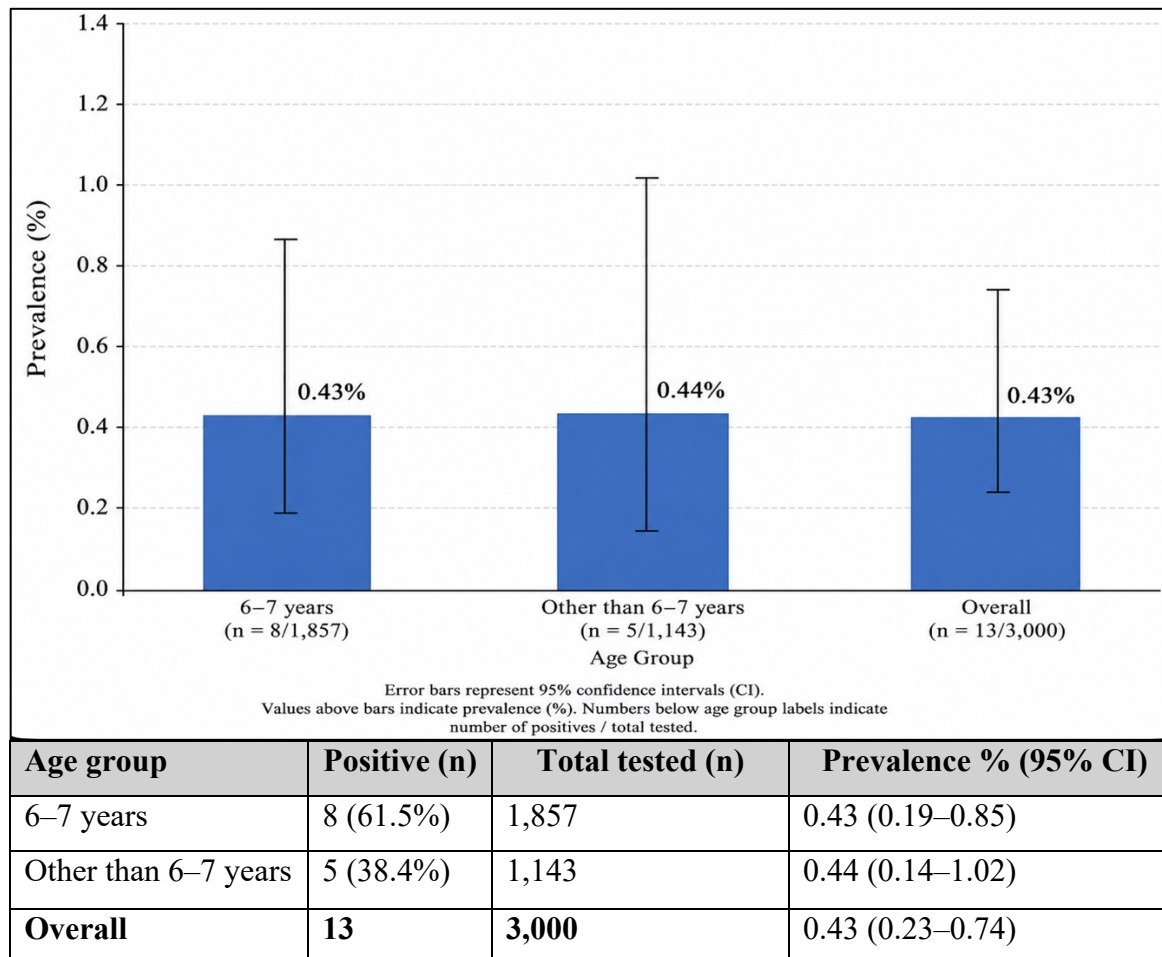
Positivity Rate*
0.00%

PASSED TAS 3
Positive cases (0) are below the critical cutoff (4).

3.9. Prevalence of LF Antigenemia by Age Group

The overall prevalence of lymphatic filariasis (LF) antigenemia among the 3,000 children tested was **0.43%** (13/3,000; **95% CI: 0.23%–0.74%**). Among children aged **6–7 years**, who represent the target population for the WHO TAS, **8 of 1,857** children tested positive, giving a prevalence of **0.43%** (**95% CI: 0.19%–0.85%**). Among children **outside the 6–7-year age group**, **5 of 1,143** children tested positive, corresponding to a prevalence of **0.44%** (**95% CI: 0.14%–1.02%**). The prevalence of LF antigenemia was therefore similar between the WHO TAS target age group and children outside the target age group.

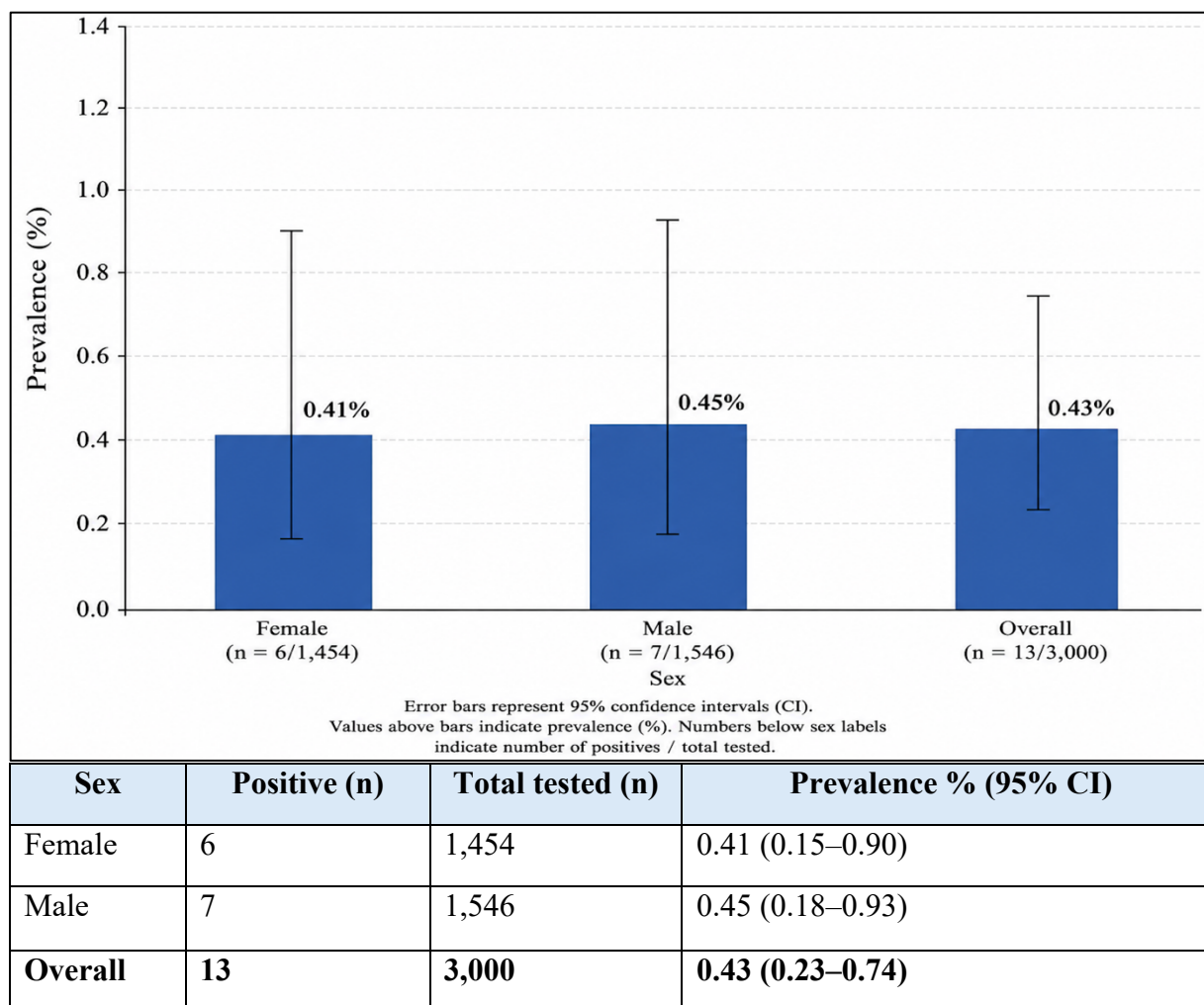
Figure 6. Prevalence of LF Antigenemia by Age Group



3.10. Prevalence of LF Antigenemia by Sex

The overall prevalence of lymphatic filariasis (LF) antigenemia was similar between female and male children. Among **1,454 female children**, 6 tested positive, giving a prevalence of **0.41% (95% CI: 0.15%–0.90%)**. Among **1,546 male children**, 7 tested positive, corresponding to a prevalence of **0.45% (95% CI: 0.18%–0.93%)**.

Figure 7. Prevalence of LF Antigenemia by Sex



3.8 Prevalence of LF Antigenemia by Age Group and Sex in EU1

All 13 LF antigen-positive children identified during the survey were detected in EU1. Therefore, age- and sex-specific prevalence was assessed within EU1 to describe the distribution of LF antigenemia in the Evaluation Unit that did not pass TAS 3. The one inconclusive result was from a 6-year-old male child and was excluded from the relevant age- and sex-specific denominators. Among children aged 6–7 years, 8 of 1,045 children with valid results tested positive, corresponding to a prevalence of 0.77% (95% CI: 0.33%–1.50%). Among children outside the 6–7-year age group, 5 of 542 children tested positive, corresponding to a prevalence of 0.92% (95% CI: 0.30%–2.14%). By sex, 6 of 772 female children tested positive, giving a prevalence of 0.78% (95% CI: 0.29%–1.68%). Among male children, 7 of 815 children with valid results tested positive, corresponding to a prevalence of 0.86% (95% CI: 0.35%–1.76%). The observed

prevalence was slightly higher among children outside the 6–7-year age group and among male children, although the confidence intervals overlapped substantially.

Table 7: Prevalence of LF Antigenemia by Age and Sex Group in EU1

Age group	Total tested	Inconclusive	Valid sample	Positive	Prevalence % (95% CI)
6–7 years	1,046	1	1,045	8	0.77 (0.33–1.50)
Other than 6–7 years	542	0	542	5	0.92 (0.30–2.14)
Sex					
Female	772	0	772	6	0.78 (0.29–1.68)
Male	816	1	815	7	0.86 (0.35–1.76)
Total EU1	1,588	1	1,587	13	0.82 (0.44–1.40)

3.11. Geographic concentration of positive cases

A total of 13 positive cases were identified across six schools, all located in EU1. Among these, 11 cases were from Ilam district and 2 cases were from Panchthar district. The highest number of positive cases was recorded in Heritage National Academy, Ilam Municipality Ward 9, with 7 positive cases, followed by Mount Merry English School, Ilam Municipality Ward 5, with 2 positive cases. The remaining four schools each reported one positive case.

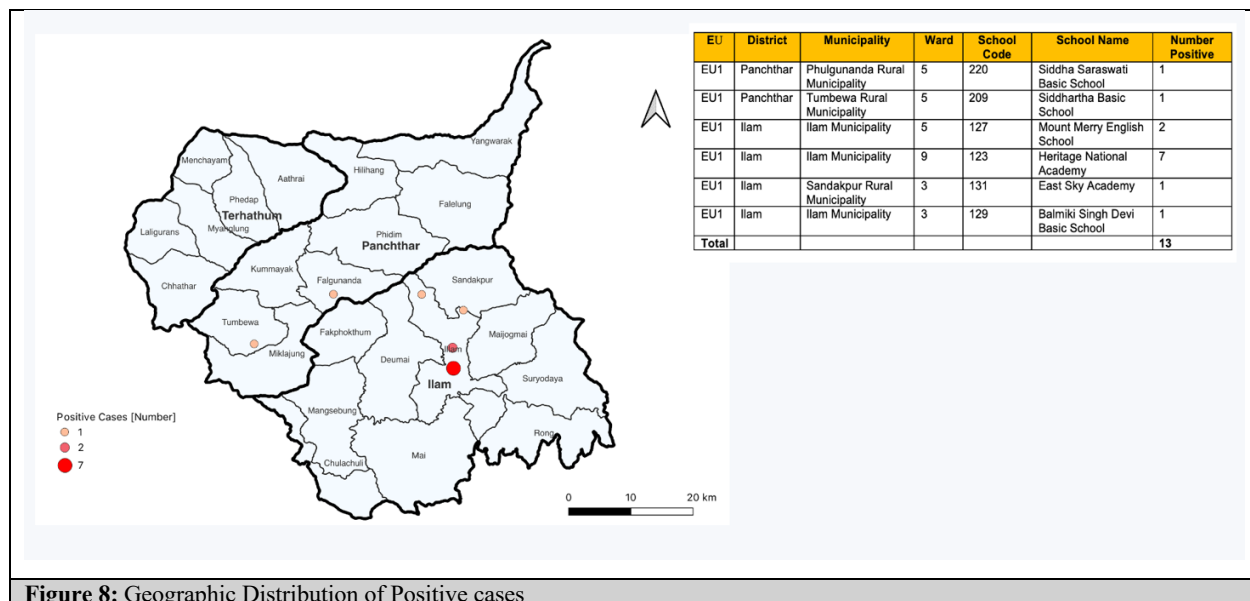


Figure 8: Geographic Distribution of Positive cases

3.12 Duration of Household Residence Among LF Antigen-Positive Cases

Information on household duration of residence was available for all 13 LF antigen-positive children. The duration for which the children's households had resided in their current locality ranged from **1 to 35 years**, with a **mean of 13.7 years** and a **median of 10 years**. Four positive children (30.8%) belonged to households that had lived in the current locality for five years or less, three (23.1%) belonged to households with 6–10 years of residence, three (23.1%) to households with 11–20 years of residence, and three (23.1%) to households that had resided in the locality for more than 20 years. **Overall**, 9 of the 13 positive children (69.2%) belonged to households that had lived in the current locality for more than five years, indicating that most positive cases were identified among families with relatively long-term residence in the survey area. However, household duration of residence alone does not establish where infection was acquired.

Table 8: Duration of Household Residence Among LF Antigen-Positive Cases

Duration of household residence	Positive cases, n	Percent
5 years or less	4	30.8%
6–10 years	3	23.1%
11–20 years	3	23.1%
More than 20 years	3	23.1%

Line listing of Positive cases

EU	District	Municipality	Ward No.	Age	Sex	Grade	Years in this residence
EU1	Panchthar	Phalgunanda Rural Municipality	5	3	Female	Class 1	13
EU1	Panchthar	Tumbewa Rural Municipality	5	4	Female	Class 1	35
EU1	Ilam	Ilam Municipality	3	6	Male	Class 1	6
EU1	Ilam	Ilam Municipality	9	7	Female	Class 2	10
EU1	Ilam	Ilam Municipality	9	7	Male	Class 1	4
EU1	Ilam	Ilam Municipality	9	7	Male	Class 1	4
EU1	Ilam	Ilam Municipality	9	7	Male	Class 1	4
EU1	Ilam	Ilam Municipality	9	7	Male	Class 1	1

EU1	Ilam	Sandakpur Rural Municipality	3	7	Female	Class 1	30
EU1	Ilam	Ilam Municipality	9	7	Female	Class 1	30
EU1	Ilam	Ilam Municipality	5	8	Male	Class 2	15
EU1	Ilam	Ilam Municipality	5	8	Male	Class 2	10
EU1	Ilam	Ilam Municipality	9	9	Female	Class 2	16

3.13 Inconclusive and Invalid Results

A total of **9 children** had invalid results in the first test, representing a first-test invalid rate of **0.30%** overall. The invalid rate was **0.31% in EU1** and **0.28% in EU2**. Among the 9 children with invalid first-test results, **8 were retested and had negative second-test results**. One child in **EU1** refused the second test after an invalid first test; therefore, the final result was classified as **inconclusive** and excluded from the valid TAS sample denominator. No invalid second-test results were recorded.

Table 9. Invalid Test and Retesting Outcomes by Evaluation Unit

Evaluation Unit	Total Tested	Invalid First Test	First-test Invalid Rate	Second Test Negative	Second Test Refused	Invalid Second Test	Final Inconclusive
EU1	1,588	5	0.31%	4	1	0	1
EU2	1,413	4	0.28%	4	0	0	0
Total	3,001	9	0.30%	8	1	0	1

Formula: First-test invalid rate = Invalid first tests / Total tested × 100

3.14 Reasons for Invalid Test Results

Among the 9 invalid first-test results, 4 (44.44%) were due to human error, specifically insufficient blood volume due to issues other than the pipette. Another 4 invalid results (44.44%) were due to test issues, specifically sample migration problems. One invalid result (11.11%) was due to an operational challenge involving a broken white sample pad, where the test was attempted but could not be read.

Table 10: Reasons for Invalid First Test Results

Reason Category	Specific Reason	n	%
Human Error	Insufficient blood volume due to issues other than the pipette	4	44.44%
Test Issues	Sample migration issues	4	44.44%
Operational Challenges	White sample pad broken; test attempted but could not be read	1	11.11%
Total		9	100.00%

3.15 Treatment and Household Follow-up of Positive Cases

All 13 LF antigen-positive children received treatment following confirmation of their positive test results. Eligible family members of the positive children also received anti-filarial medicines through the local health system. Thus, treatment coverage among identified positive cases was 100%. Treatment and household follow-up were conducted in coordination with the respective local health facilities and municipal health sections. Telephone follow-up was also conducted with the children's parents or guardians to confirm that the children and eligible household members had received the recommended treatment.

CHAPTER 4: CONCLUSION AND RECOMMENDATIONS

4.1 Conclusion

The TAS 3 survey was successfully completed in 240 schools across two Evaluation Units comprising Ilam, Panchthar, and Tehrathum districts. A total of 3,001 Grade 1 and Grade 2 students were tested. Both Evaluation Units achieved more than 100% of their planned sample sizes, and all eligible children present on the survey day were tested. These findings demonstrate adequate sample coverage and successful implementation of the survey in accordance with the planned TAS methodology. The TAS 3 results differed between the two Evaluation Units. In EU1, comprising Ilam and Panchthar districts, 13 antigen-positive cases were detected among 1,587 children with valid test results. The number of positive cases exceeded the critical cutoff of 6; therefore, EU1 did not pass TAS 3. In EU2, comprising Tehrathum district, no antigen-positive cases were detected among 1,413 children tested. As the number of positive cases was below the critical cutoff of 4, EU2 passed TAS 3. The programmatic decision was made separately for each Evaluation Unit, as required by the TAS protocol, rather than on the basis of the combined positivity rate of 0.43%. All 13 positive cases were identified in EU1, including 11 cases in Ilam district and two cases in Panchthar district. The cases were concentrated in six schools, with the highest concentration reported in selected schools of Ilam Municipality. This geographic clustering indicates the possibility of persistent, recurrent, or reintroduced LF transmission in specific localities of EU1 and requires further epidemiological and programmatic assessment. EU2 successfully passed TAS 3 and may proceed toward readiness for inclusion in the national lymphatic filariasis elimination dossier. However, passing TAS 3 does not by itself complete the elimination process. EU2 should continue active and passive surveillance, morbidity mapping, morbidity management and disability prevention activities, and documentation of programme achievements to demonstrate that the interruption of transmission has been sustained. These activities will provide the necessary evidence for dossier development and national validation of LF elimination as a public health problem. All antigen-positive children identified during the survey received anti-filarial treatment, and eligible members of their households were also treated through the local health system. Continued follow-up of the positive children, their families, schools, and communities will be important to reduce the risk of ongoing transmission and to guide further programme action in EU1.

4.2 Recommendations

Recommendations for EU1: Ilam and Panchthar

EU1 did not pass TAS 3, with 13 antigen-positive children detected against a critical cutoff of 6. The geographic distribution of positive cases, including clustering in Ilam Municipality, suggests possible persistent, recurrent, or reintroduced transmission within parts of the Evaluation Unit. Therefore, further epidemiological investigation and programme review are required before determining the geographic scope of additional interventions.

The National Lymphatic Filariasis Elimination Programme should formally review the TAS 3 findings in consultation with WHO and the relevant Regional Programme Review Group or other appropriate WHO technical review mechanism. The review should consider the distribution and clustering of positive cases, previous MDA performance and treatment coverage, population movement and migration, household and community investigations, historical transmission patterns, and other relevant epidemiological and programme information. Based on this review, one of the following programmatic approaches may be considered.

Recommendation 1: Risk-Based Subdivision of EU1 Before Further MDA

Where epidemiological investigation demonstrates substantial heterogeneity in transmission risk within EU1, the original Evaluation Unit may be divided into epidemiologically meaningful sub-Evaluation Units in consultation with WHO. The geographic boundaries of any proposed sub-EUs should be determined using the positive-case line list, residential locations of positive children, locations of affected schools, household investigation findings, previous MDA coverage, migration and travel histories, historical transmission information, and other locally relevant risk factors. Particular attention should be given to Ilam Municipality and adjoining areas, including the border area between Ilam Municipality and Sandakpur Rural Municipality, where positive cases were concentrated during TAS 3.

A follow-up TAS or other survey recommended by WHO may be considered in appropriately defined lower-risk sub-EUs to determine whether areas with no or few positive cases in the original

TAS 3 require further MDA. Areas or sub-EUs identified as having continuing transmission risk should receive the additional MDA response recommended following WHO technical review.

Where additional IDA is recommended, two effective rounds of mass drug administration using Ivermectin, Diethylcarbamazine, and Albendazole should be implemented among eligible populations, with appropriate intervals between rounds and with emphasis on achieving high epidemiological and directly observed treatment coverage. Following completion of the recommended IDA rounds, an Epidemiological Monitoring Survey (EMS) should be conducted according to WHO guidance and the agreed programme timeline. If the EMS meets the required threshold, the area should subsequently proceed to the appropriate Transmission Assessment Survey or IDA Impact Survey, as recommended by WHO, before a decision is made regarding cessation of MDA and progression to post-MDA surveillance.

Recommendation 2: Additional IDA Across the Existing EU1 Followed by Reassessment

Alternatively, following epidemiological investigation and WHO technical review, two effective rounds of IDA may be implemented throughout the existing EU1, comprising Ilam and Panchthar districts. This approach would address the possibility that transmission extends beyond the currently identified geographic clusters and would avoid prematurely excluding areas where undetected transmission may still be occurring. The IDA rounds should aim to achieve high epidemiological and directly observed treatment coverage among all eligible populations. Particular attention should be given to communities with antigen-positive children, border and mobile populations, migrants, populations previously missed during MDA, communities with a history of low treatment coverage, and other groups considered to be at increased risk of infection or non-participation.

Following completion of the recommended IDA rounds, an Epidemiological Monitoring Survey should be conducted in accordance with WHO guidance. If the EMS meets the required threshold, the programme should proceed to an appropriate TAS or IDA Impact Survey before making a decision on cessation of MDA. After the additional MDA rounds, the programme may also consider dividing the existing EU1 into smaller Evaluation Units for subsequent assessment where epidemiological evidence demonstrates meaningful differences in transmission risk. The

geographic boundaries, sampling design, timing, diagnostic methods, critical thresholds, and interpretation of subsequent surveys should be agreed in consultation with WHO and relevant technical partners.

Technical Review and Programme Decision-Making

Before implementing either approach, the National Lymphatic Filariasis Elimination Programme should formally consult WHO and the relevant Regional Programme Review Group or appropriate technical review mechanism. The consultation should review:

- the TAS 3 findings and geographic distribution of antigen-positive cases;
- findings from household, community, migration, and epidemiological investigations;
- historical MDA coverage and treatment-compliance information;
- evidence of possible persistent, recurrent, or reintroduced transmission;
- the epidemiological justification and proposed boundaries for any sub-Evaluation Units;
- the relative merits of focal and EU-wide intervention approaches;
- the geographic scope and number of additional IDA rounds;
- strategies for achieving and independently monitoring high treatment coverage;
- the timing, design, and interpretation of the subsequent EMS and TAS or IDA Impact Survey; and
- criteria for returning to post-MDA surveillance and progressing toward national elimination dossier readiness.

Detailed microplanning should accompany any additional MDA. This should include community engagement and social mobilization, directly observed treatment, identification and follow-up of populations previously missed by MDA, independent monitoring of treatment coverage, appropriate management of adverse events, adequate drug and logistics management, and complete documentation of programme implementation.

Conduct Further Epidemiological and Qualitative Investigation in EU1

Further epidemiological investigation should be conducted around the positive children, their households, schools, and communities to better understand the possible source and extent of

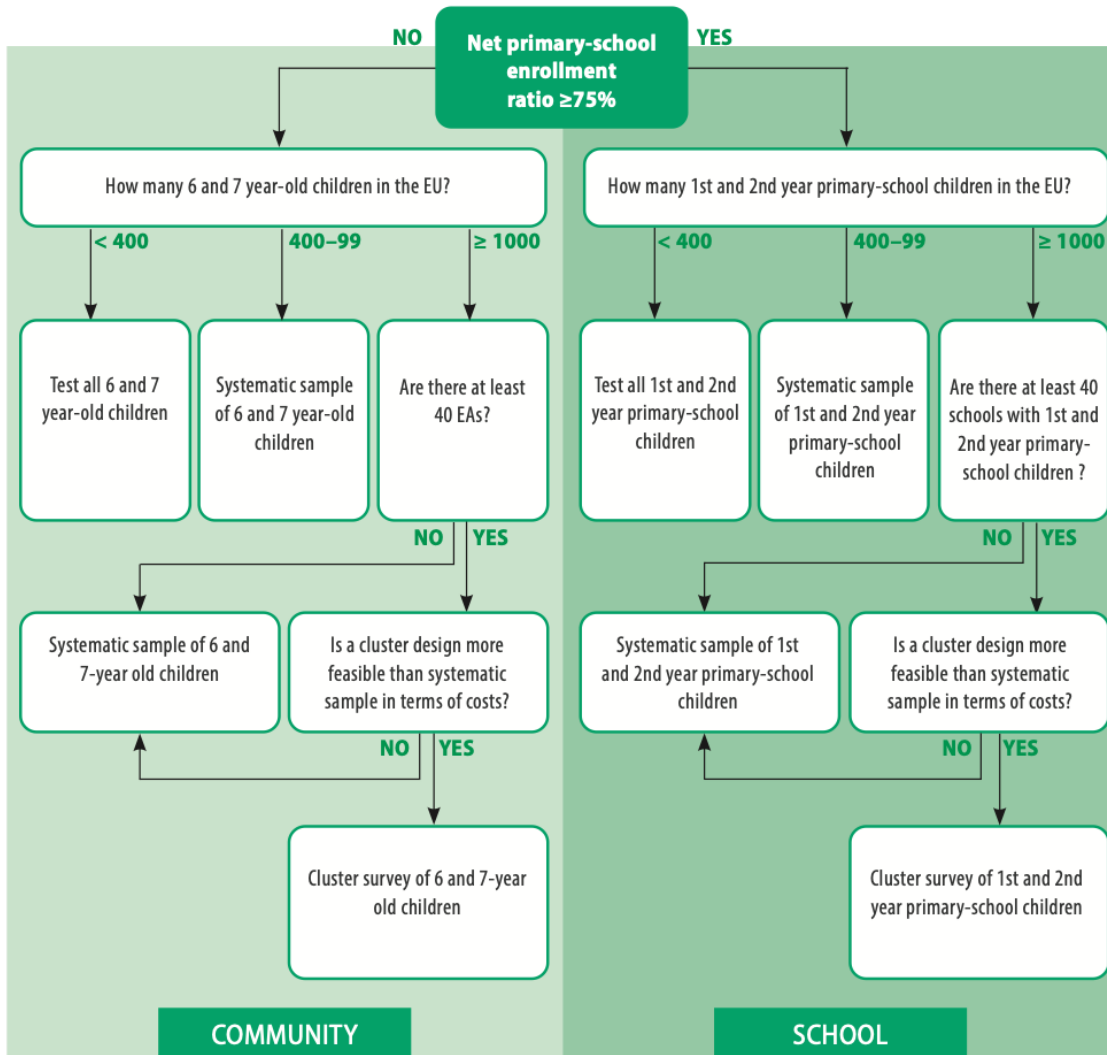
ongoing transmission. Investigations should include residence and migration history, previous residence in other LF-endemic areas, travel patterns, participation in previous MDA rounds, household treatment history, and other potential epidemiological risk factors. Qualitative research may also be undertaken in affected areas of Ilam and Panchthar to understand social, behavioural, cultural, and operational factors that may have contributed to continued or reintroduced transmission. In-depth interviews, key-informant interviews, and focus-group discussions may be conducted with parents and guardians of positive children, community members, migrants and mobile populations, health workers, teachers, local leaders, female community health volunteers, and programme implementers. The qualitative assessment should explore knowledge and perceptions of lymphatic filariasis, participation in previous MDA rounds, reasons for non-participation or refusal, migration and travel patterns, access to treatment, treatment adherence, trust in the programme, perceived adverse events, and barriers to achieving effective treatment coverage. Findings should be used to strengthen community engagement, communication strategies, IDA microplanning, treatment delivery, surveillance, and subsequent programme assessments. All antigen-positive children and their eligible household members should continue to receive appropriate follow-up through the local health system. Treatment, follow-up investigations, and subsequent outcomes should be fully documented.

Recommendations for EU2: Tehrathum

EU2 passed TAS 3, with no antigen-positive children detected among 1,413 children with valid test results. The district should therefore continue post-MDA surveillance to ensure that interruption of transmission is sustained and to detect any possible recrudescence or reintroduction of lymphatic filariasis. Active and passive surveillance should be maintained through appropriate health-system and programme mechanisms. Epidemiological, programmatic, surveillance, treatment, historical MDA, TAS, and other relevant information from Tehrathum should be compiled, reviewed, and maintained as part of the evidence required for Nepal's national lymphatic filariasis elimination dossier. Health facilities should continue identifying, referring, and managing persons affected by lymphoedema, elephantiasis, hydrocoele, and other chronic manifestations of lymphatic filariasis. The availability, accessibility, and quality of morbidity management and disability prevention services should be maintained and appropriately documented. Continued coordination among the National Lymphatic Filariasis Elimination Programme, provincial and

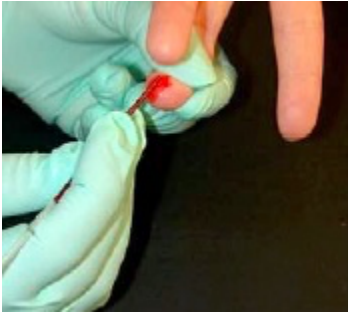
local health authorities, health facilities, communities, WHO, and other technical partners will be important to sustain surveillance, maintain morbidity management services, document programme achievements, and support Nepal's progression toward validation of elimination of lymphatic filariasis as a public health problem.

Annex 1: Algorithm for choice of TAS survey design in *Culex* areas



Ag, antigen; EMS, epidemiological monitoring survey; IIS, IDA impact survey; MDA, mass drug administration; Mf, microfilariae; TAS, transmission assessment survey.

Annex 2. Blood collection protocol



1. Clean the finger to be pricked with an alcohol swab.
2. Allow the finger to dry.
3. Prick the internal side of the finger using a sterile lancet
4. Discard the lancet into a sharps container.
5. Collect 75 microliter (up to marked line) blood into a pipette provided in the test kits using capillary action.
6. Follow all universal precautionary measures as per SOP while collecting and handling blood and participants.

Annex 3. FTS protocol

The Alere™ Filariasis Test Strip is a rapid diagnostic tool used for the qualitative detection of *Wuchereria Bancrofti* antigen in human blood samples collected by finger prick. Although the test is relatively simple to use, adequate training is necessary to reduce inter-observer variability and to reduce the misreading of strips.

Basic guidelines

1. Kits should be stored at 2-37°C. Test strips should **NOT** be frozen. The Alere™ Filariasis Test Strip kit is stable until the expiration date marked on its outer packaging when stored as specified. Kits should **NOT** be used past the expiration date.
2. Before beginning field surveys, two strips from each lot of kits should be tested using a positive control that can be obtained from the Filariasis Research Reagent Repository Center (www.filariasiscenter.org). DO NOT use strips that are negative when tested with the control.
3. When transporting strips for use in the field, a cool box is not required. However, care should be taken not to expose strips to extreme heat for prolonged periods of time.
4. Strips must be read using bright unfiltered light. Faint lines can be difficult to see when lighting is not adequate. This is especially important when reading strips at night.

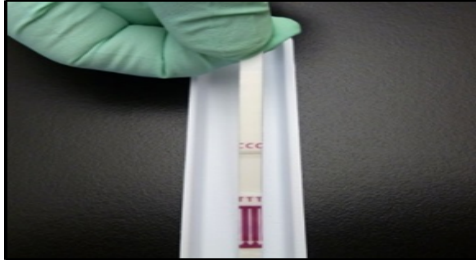
Sample collection

1. Allow all kit components to equilibrate to ambient temperature (15-37°C) before testing.



Remove contents from the foil pouch just prior to use. Provided materials include one test strip, plastic work tray and fixed volume (75µL) micropipette.

2. Strips should be handled carefully and held only at the end without the arrows. DO NOT apply pressure to the sample pad at the bottom of the strip.



Strips should be labeled with appropriate patient identifiers. Strips can be labeled directly (preferred) (A). Alternatively, the work tray can be labeled (B).

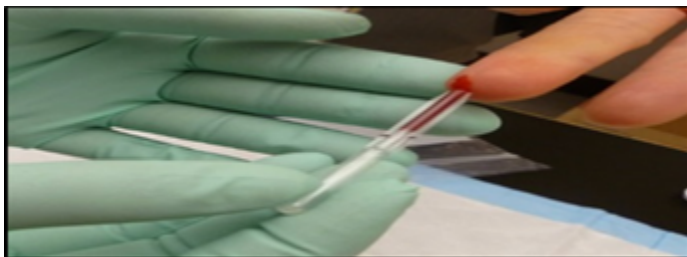


The strip should be placed in the work tray before the sample is added.

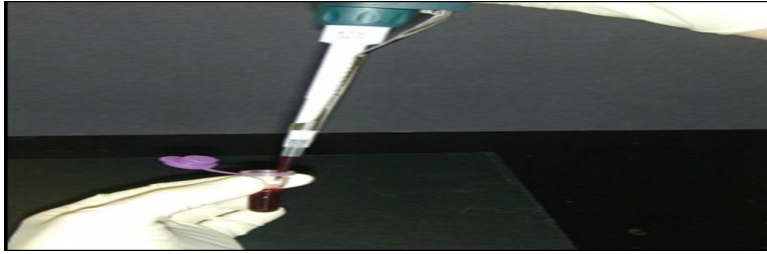


NOTE: It is advisable to secure the strip to the work tray with a sticker -type patient identifier label or tape.

3. Collect 75 μ L of fingerstick blood by holding the supplied micropipette slightly above the horizontal plane.

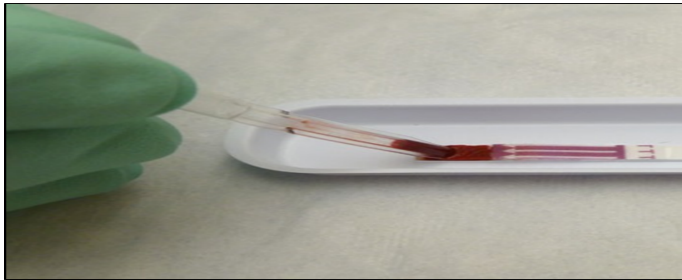


DO NOT squeeze the bulb end of the micropipette when collecting the sample. Alternatively, measure 75 μ L of anti-coagulated blood from a micro-centrifuge tube using a calibrated micropipette



DO NOT add blood directly from the finger to the strip

1. Slowly add the blood sample to the lower half of the sample pad by gently squeezing the bulb.



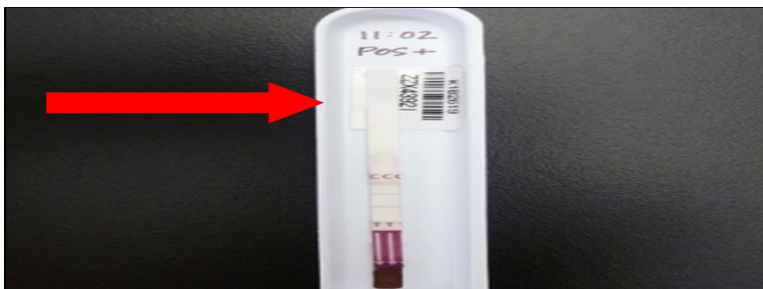
Set a timer for 10 minutes.



NOTE: It is helpful to record the reading time on the work tray.

4. Read test results 10 minutes after the sample has been added.

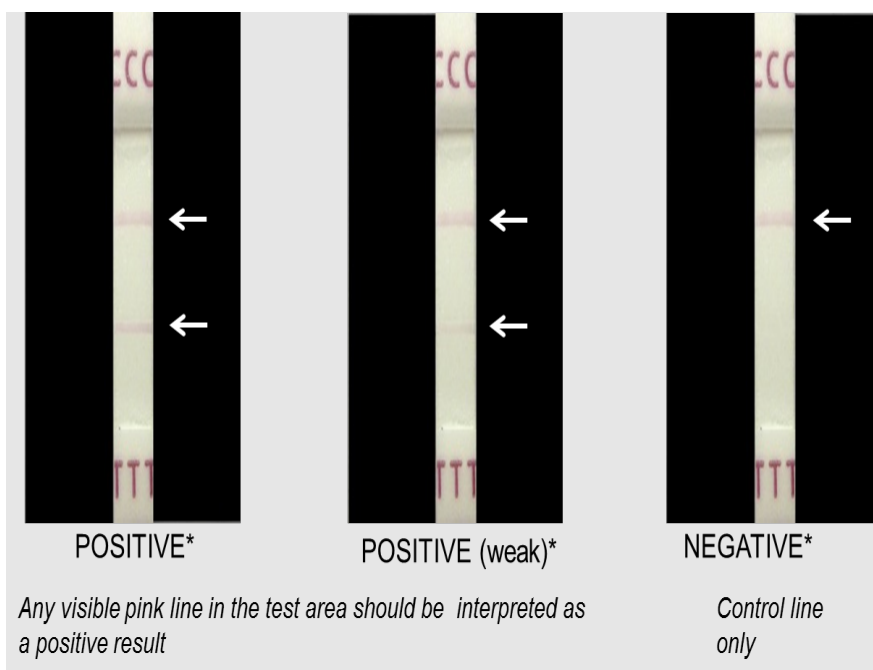
NOTE: Record the appropriate result on the strip (preferred) or work tray



DO NOT read tests if the sample has not migrated ALL the way up the strip.

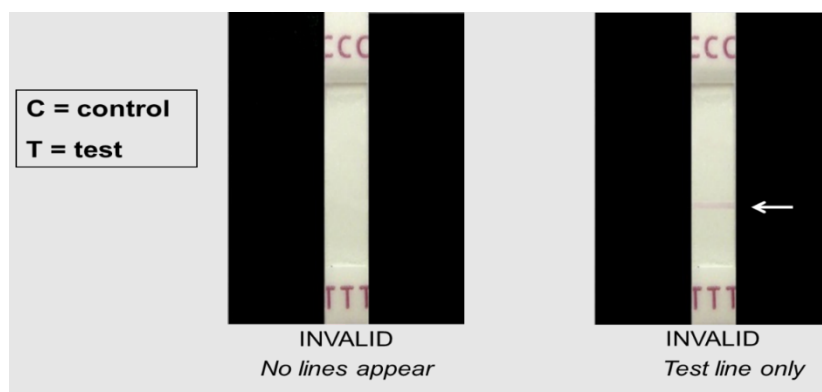


5. FTS interpretation I



Scoring of test strips is useful but optional. Negative, 0; test line weaker than control line, 1; test line equal to control line, 2; test line stronger than control line, 3. An electronic version of this bench aid can be found at: <http://www.ntdsupport.org/resources>

FTS Interpretation II



Annex 5: TAS Survey Form 1 and 2

Transmission Assessment Survey (TAS 3) in 3 Districts

Form 1 and 2



Ministry of Health and Food Safety
Vector Borne Disease Research and Training Centre

Transmission Assessment Survey

FORM 1: SCHOOL CHECK-IN FORM

A. Survey Information

Variable	Information
Date of Survey (DD/MM/YYYY)	_____
Recorder ID	_____
EU Code	_____
EU Name	_____
District	_____
Municipality (Palika)	_____

B. School Information

Variable	Information
School Code	_____
School Name	_____
School Address (Palika/Ward/Location)	_____
School Phone Number (if available)	_____
Name of Head Teacher/Focal Person	_____
Contact Number of Head Teacher/Focal Person	_____

C. GPS Location of School

GPS Information	Value
Latitude	_____
Longitude	_____
Altitude (m)	_____
Accuracy (m)	_____

School Enrollment and Consent		
1. Total eligible children <i>For school, this is the total # enrolled in class 1 and 2.</i>	2. Total eligible children present <i>For school, this is the total # students in class 1 and 2 who are present during the survey.</i>	3. Total absent students
_____	_____	_____

Reasons for Absent 1) Due to Migration 2) Not due to migration



Ministry of Health and Food Safety
Vector Borne Disease Research and Training Centre

Transmission Assessment Survey

Form 2 (Sociodemographic and Diagnostic Information)

Date of Survey (DD/MM/YYYY):				Lot No. of FTS used and Expiry date (Box):				Recorder ID:			
Evaluation Unit:				Name of selected school:				School Code:			
Name of District:				Address of school (Palika/ward/location):							
Total sample taken:				Total invalids (Count each invalid):							
Total valid Sample (Positives + Negatives only):				Total inconclusive (count results with discordant and inconclusive):							
Test Results: P=Positive, N=Negative, I=Invalid, R=Refused, ND=No further testing needed,											
Final Results: P=Positive, N=Negative, D=Discordant, In=Inconclusive, R=Refused											
Reasons for Invalids:											
Reason for invalid (test issues) A = no control line B = broken/ partial control line C = sample absorption issues D = sample migration issues E = blood not clearing F = insufficient blood volume due to pipette issues G = other (add to comments)				Reason for invalid (human error) H = insufficient blood volume (due to issues other than the pipette) I = adding sample to wrong place on test J = improper use of capillary tube K = adding blood drops without waiting for last one to absorb L = improper use of buffer (BR) M = other (add to comments)				Reason for invalid (operational challenges) N = multiple tests in one packet O = missing desiccant P = missing buffer Q = missing micropipette R = test broken and not used (add specifics in comments) S = other (add to comments)			

Sample Code (EU-School code-Sample) "EU1-106-1"	Name	Home Address [Palika/Ward]	Age	Sex	Grade	First Test result	Reason for invalids	Second Test result (If needed)	Reason for invalids	Record FINAL RESULT	If Positive		
											Name of Guardian	Years in this residence	Contact Number

Annex 6. Rapid Test Results

TAS Testing Algorithm for Results and Treatment

#	Test 1 Result	Test 2 Result	Final Result	Treatment Needed
1	Negative Ag test	No further testing needed	Negative	No
2	Positive Ag test	No further testing needed	Positive	Yes
3	Invalid	Positive	Positive	Yes
4	Invalid	Negative	Negative	No
5	Invalid	Invalid	Inconclusive (Exclude from sample)	No
6	Invalid	Refused/Not done	Inconclusive (Exclude from sample)	No
7	Refused	Not done	Refused (Do not count as sample)	No

Note: Individuals with Inconclusive (Indeterminate) results are removed from the overall sample and do not count towards the designated sample. The survey team provides treatment recommendations, and the local health system will treat the individuals and their families as needed.

Annex 7. Completion Letter [Ilam, Panchthar and Terhathum]



कोशी प्रदेश सरकार
स्वास्थ्य मन्त्रालय
स्वास्थ्य निर्देशनालय
स्वास्थ्य कार्यालय इलाम
इलाम, नेपाल



प.सं. :- ०८२/८३

च.नं. :- ५००

मिति :- वि.सं. २०८३/०३/२२

ने.सं. :- ११४६ तछलागा, ६ सोमवार

विषय: TAS-III सम्मपन्न भएको सम्बन्धमा ।

श्री कीटजन्य रोग अनुसन्धान तथा तालिम केन्द्र, हेटौँडा, मकवानपुर

प्रस्तुत विषयमा तहाँ कार्यालयबाट हात्तिपाइले रोग निवारण कार्यक्रम अन्तर्गत तेस्रो चरणको Transmission Assessment Survey-III (TAS-III) को लागि खटिई आउनुभएको २७ जना Enumerator हरूले इलाम जिल्लाका ६१ वटा विद्यालयहरूमा कक्षा १ र २ मा अध्ययनरत जम्मा १०३२ जना विद्यार्थीहरूको रक्त नमूना संकलन गरी Filaria Test Strip (FTS) को प्रयोग गरी हात्तिपाइले रोगको परजीवी भए/नभएको परिक्षण गर्ने कार्य मिति २०८३/०३/१२ देखि २०८३/०३/२० सम्म संचालन भई सम्पन्न भएको व्यहोरा प्रमाणित गरिन्छ ।

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(आदित्य शाक्य)

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श्री स्वास्थ्य निर्देशनालय, धनकुटा ।

"कोशीको गौरव हिमालको शान, पर्यटन वर्षमा सबैलाई सम्मान"

फोन नं: ०२७-५२३०३६, ईमेल: dphoilam@gmail.com, वेबसाइट: dhoilam.gov.np



कोशी प्रदेश सरकार
स्वास्थ्य मन्त्रालय
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स्वास्थ्य कार्यालय पाँचथर
फिदिम, नेपाल



प.सं. :- ०८२/८३

च.नं. :- २५६

मिति :- वि.सं. २०८३/०३/२५

ने.सं. :- ११४६ तछलागा, ९ बिहिवार

विषय: TAS-III सम्पन्न भएको सम्बन्धमा ।

श्री किटजन्य रोग अनुसन्धान तथा तालिम केन्द्र , मकवानपुर
, मकवानपुर

प्रस्तुत विषयमा तहाँ कार्यालयबाट हात्तिपाइले रोग निवारण कार्यक्रम अन्तरगत तेस्रो चरणको **Transmission Assessment Survey-III (TAS-III)** को लागि खटिई आउनुभएको २७ जना **Enumerator** हरूले पाँचथर जिल्लाका ५५ वटा विद्यालयहरूमा कक्षा १ र २ मा अध्ययनरत जम्मा ५५८ जना विद्यार्थीहरूको रक्त नमूना संकलन गरी **Filaria Test Strip (FTS)** को प्रयोग गरी हात्तिपाइले रोगको परजीवी भए/नभएको परिक्षण गर्ने कार्य मिति २०८३/०३/१२ देखि २०८३/०३/२० सम्म संचालन भई सम्पन्न भएको व्यहोरा प्रमाणित गरिन्छ ।

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कार्यालय प्रमुख



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स्वास्थ्य कार्यालय तेह्रथुम
म्याङ्लुङ्ग, तेह्रथुम



प.सं. :- ०८२/८३

च.नं. :- ३६२

मिति :- वि.सं. २०८३/०३/२२

ने.स. :- ११४६ तछलागा, ६ सोमबार

विषय: TAS-III सम्मपन्न भएको सम्बन्धमा ।

श्री किटजन्य रोग नियन्त्रण अनुसन्धान तथा तालीम केन्द्र, हेटौडा-१, मकवानपुर प्रस्तुत विषयमा तहाँ कार्यालयबाट हात्तिपाइले रोग निवारण कार्यक्रम अन्तर्गत तेस्रो चरणको **Transmission Assessment Survey-III (TAS-III)** को लागि खटिई आउनुभएको २७ जना **Enumerator** हरूले तेह्रथुम जिल्लाका १२५ वटा विद्यालयहरूमा कक्षा १ र २ मा अध्ययनरत जम्मा १४१३ जना विद्यार्थीहरूको रक्त नमूना **Filaria Test Strip (FTS)**को प्रयोगले संकलन गरी हात्तिपाइले रोगको परजीवी भए/नभएको परिक्षण गर्ने कार्य मिति २०८३/०३/१२ देखि २०८३/०३/२० सम्म संचालन भई सम्पन्न भएको व्यहोरा प्रमाणित गरिन्छ ।

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Annex 8: List of selected school by WHO-SSB

EU1: Panchthar Ilam

S.N	Province	District	Local Level	Ward	Sample Code	School Name	School Code	School Type	G1 Girls	G1 Boys	G1 Total	G2 Girls	G2 Boys	G2 Total
1	Koshi	Ilam	Chulachuli R.M.	1	3	Sagar Basic School	030060013	Public	4	1	5	0	0	0
2	Koshi	Ilam	Chulachuli R.M.	3	11	Suryodaya Basic School	030060010	Public	7	1	8	1	3	4
3	Koshi	Ilam	Chulachuli R.M.	6	20	Devismrity Basic School	030380010	Public	1	1	2	0	0	0
4	Koshi	Ilam	Mangsebung R.M.	4	28	Bidhyasirjanatmak Secondary School	030020004	Public	7	2	9	3	1	4
5	Koshi	Ilam	Mangsebung R.M.	5	37	Phalgunanda Secondary B.S.	030020019	Private	9	3	12	6	6	12
6	Koshi	Ilam	Mangsebung R.M.	3	45	Jiwanjyoti Secondary School	030090002	Public	4	6	10	5	2	7
7	Koshi	Ilam	Mangsebung R.M.	2	54	Janata Kalyan Basic School	030090003	Public	1	1	2	6	1	7
8	Koshi	Ilam	Mangsebung R.M.	1	63	Mandika Basic School	030120007	Public	3	7	10	7	6	13
9	Koshi	Ilam	Phakphokthum R.M.	4	71	Jala Kanya Basic School	030350006	Public	1	4	5	2	1	3
10	Koshi	Ilam	Phakphokthum R.M.	3	80	Shree Malika Devi Basic School	030010002	Public	0	0	0	0	0	0

11	Koshi	Ilam	Phakphokthum R.M.	1	88	Sange Chyomdande Chyoling Gumba	030330010	Religious	3	1	4	0	0	0
12	Koshi	Ilam	Phakphokthum R.M.	6	97	Banasthali Boarding School	030100013	Private	18	16	34	10	18	28
13	Koshi	Ilam	Phakphokthum R.M.	7	105	Guru Udaya Basic School	030100012	Public	0	6	6	2	3	5
14	Koshi	Ilam	Deumai Municipality	1	169	Janata Basic School	030040004	Public	1	3	4	2	0	2
15	Koshi	Ilam	Deumai Municipality	2	159	Saraswati Basic School	030280009	Public	1	2	3	1	1	2
16	Koshi	Ilam	Deumai Municipality	4	153	Ilam Morning Glory School	030280015	Private	11	9	20	11	12	23
17	Koshi	Ilam	Deumai Municipality	5	115	Bhagawati Secondary School	030080003	Public	3	1	4	2	4	6
18	Koshi	Ilam	Deumai Municipality	9	124	Gajurmukhi Basic School	030180009	Public	9	2	11	5	1	6
19	Koshi	Ilam	Deumai Municipality	7	132	Gorkhe Pra V	030450006	Public	2	1	3	1	0	1
20	Koshi	Ilam	Deumai Municipality	3	146	Suryodaya Shiksha Sadan	030280011	Private	9	22	31	15	13	28
21	Koshi	Ilam	Deumai Municipality	6	142	Evanjelina English Boarding School	030420011	Private	4	6	10	3	2	5
22	Koshi	Ilam	Ilam Municipality	11	205	Simle Basic School	030460001	Public	3	1	4	2	4	6
23	Koshi	Ilam	Ilam Municipality	9	209	Heritage National Academy	030150027	Private	29	17	46	27	32	59

24	Koshi	Ilam	Ilam Municipality	10	217	Narayan Basic School	030130003	Public	2	1	3	4	6	10
25	Koshi	Ilam	Ilam Municipality	7	226	Adarsha Secondary School	030150001	Public	3	1	4	4	3	7
26	Koshi	Ilam	Ilam Municipality	6	190	Dripa Devi Basic School	030150017	Public	2	4	6	0	3	3
27	Koshi	Ilam	Ilam Municipality	5	186	Mount Merry English School	030030013	Private	4	18	22	7	12	19
28	Koshi	Ilam	Ilam Municipality	4	238	Ilam Sagarmatha English School	030270008	Private	1	2	3	4	7	11
29	Koshi	Ilam	Ilam Municipality	3	242	Balmiki Singh Devi Basic School	030360003	Public	1	2	3	3	6	9
30	Koshi	Ilam	Sandakpur R.M.	1	250	Chandrodaya Adhar V	030270007	Public	5	2	7	3	5	8
31	Koshi	Ilam	Sandakpur R.M.	3	259	East Sky Academy	030480010	Private	4	11	15	7	8	15
32	Koshi	Ilam	Sandakpur R.M.	4	268	Prabodh Ma V	030240008	Public	3	0	3	3	2	5
33	Koshi	Ilam	Sandakpur R.M.	5	276	Rastriya Basic School	030160004	Public	1	1	2	0	1	1
34	Koshi	Ilam	Maijogmai R.M.	2	285	Jyoti Adharbhut Bidyalaya	030190008	Public	2	1	3	0	3	3
35	Koshi	Ilam	Maijogmai R.M.	6	293	Shree Mahadev Basic School	030190007	Public	0	2	2	0	1	1
36	Koshi	Ilam	Maijogmai R.M.	5	302	Shree Oriental Academy	030470011	Private	5	0	5	0	5	5
37	Koshi	Ilam	Maijogmai R.M.	3	310	Bidhyodaya Basic School	030290008	Public	2	3	5	3	1	4

38	Koshi	Ilam	Maijogmai R.M.	1	319	Ilam Shuvakanya English School	030300009	Private	6	11	17	11	10	21
39	Koshi	Ilam	Suryodaya Municipality	1	327	Himalaya Secondary School	030140003	Public	1	3	4	6	1	7
40	Koshi	Ilam	Suryodaya Municipality	2	336	Rose Valley Academy	030320008	Private	5	4	9	0	9	9
41	Koshi	Ilam	Suryodaya Municipality	3	374	Shanta Basic School	030320003	Public	7	4	11	0	0	0
42	Koshi	Ilam	Suryodaya Municipality	4	345	Mahendra Basic School	030440003	Public	3	3	6	2	3	5
43	Koshi	Ilam	Suryodaya Municipality	5	353	Samalbung Secondary School	030400002	Public	1	3	4	2	3	5
44	Koshi	Ilam	Suryodaya Municipality	7	362	Krishnashram Secondary School	030200008	Public	7	10	17	3	7	10
45	Koshi	Ilam	Suryodaya Municipality	9	379	Budanilkantha Basic School	030340002	Public	7	5	12	0	0	0
46	Koshi	Ilam	Suryodaya Municipality	10	387	Adarsha Basic School	030340008	Public	0	0	0	1	1	2
47	Koshi	Ilam	Suryodaya Municipality	10	396	Sunrise English Secondary School	030340017	Private	11	18	29	33	35	68
48	Koshi	Ilam	Suryodaya Municipality	12	404	Ganeshwori Secondary School	030310002	Public	6	3	9	2	2	4
49	Koshi	Ilam	Suryodaya Municipality	14	413	Balkalyan Basic School	030220012	Public	4	2	6	3	2	5
50	Koshi	Ilam	Rong R.M.	6	503	Lamitar Basic School	030170005	Public	2	3	5	1	2	3
51	Koshi	Ilam	Rong R.M.	5	498	Narayan Basic School	030110004	Public	4	3	7	1	2	3

52	Koshi	Ilam	Rong R.M.	3	490	Shanti Niketan Secondary School	030210001	Public	6	3	9	5	4	9
53	Koshi	Ilam	Rong R.M.	2	479	Shantipur Secondary School	030430002	Public	5	1	6	0	0	0
54	Koshi	Ilam	Mai Municipality	5	469	Laxmi Bidya Bhawan Basic School	030070011	Public	2	3	5	3	1	4
55	Koshi	Ilam	Mai Municipality	4	460	Nepal Academy	030070028	Private	14	19	33	13	9	22
56	Koshi	Ilam	Mai Municipality	2	457	Shishusewa Secondary School	030070006	Public	6	4	10	3	7	10
57	Koshi	Ilam	Mai Municipality	7	440	Bhakta Karki Smriti Shiksha Sadan	030250019	Private	24	15	39	10	10	20
58	Koshi	Ilam	Mai Municipality	6	438	Singhadevi Basic School	030250011	Public	2	1	3	2	1	3
59	Koshi	Ilam	Mai Municipality	3	428	Saraswati Secondary School	030070010	Public	1	3	4	1	4	5
60	Koshi	Panchthar	Miklajung R.M.	1	507	Bal Namuna Pra V	020340015	Public	2	3	5	1	2	3
61	Koshi	Panchthar	Miklajung R.M.	1	515	Sirijanga Basic School	020340009	Public	2	1	3	0	2	2
62	Koshi	Panchthar	Miklajung R.M.	2	524	Yuwabarsa Secondary School	020340002	Public	6	4	10	4	1	5
63	Koshi	Panchthar	Miklajung R.M.	3	532	Sayapatri Basic School	020030007	Public	1	3	4	0	0	0
64	Koshi	Panchthar	Miklajung R.M.	4	541	Nava Jyoti Boarding School	020310010	Private	11	18	29	12	13	25

65	Koshi	Panchthar	Miklajung R.M.	5	549	Pancha Kanya Basic School	020140006	Public	2	5	7	1	4	5
66	Koshi	Panchthar	Miklajung R.M.	7	558	Saraswati Basic School	020150005	Public	2	1	3	0	2	2
67	Koshi	Panchthar	Miklajung R.M.	8	566	Shaktika Basic School	020090003	Public	0	0	0	2	0	2
68	Koshi	Panchthar	Tumbewa R.M.	5	575	Siddhartha Basic School	020130005	Public	3	2	5	2	3	5
69	Koshi	Panchthar	Tumbewa R.M.	4	584	Buddheshwari Ma Vi	020240002	Public	2	1	3	5	0	5
70	Koshi	Panchthar	Tumbewa R.M.	3	592	Laxmi Bal Sewa Basic School	020010007	Public	1	1	2	2	2	4
71	Koshi	Panchthar	Tumbewa R.M.	2	601	Phikuwa Khola Basic School	020190006	Public	2	1	3	1	4	5
72	Koshi	Panchthar	Tumbewa R.M.	1	609	Singha Bahini Basic School	020010004	Public	1	1	2	4	0	4
73	Koshi	Panchthar	Kummayak R.M.	1	618	Amrit Basic School	020410004	Public	5	2	7	2	1	3
74	Koshi	Panchthar	Kummayak R.M.	1	626	Subjani Basic School	020410007	Public	5	4	9	1	2	3
75	Koshi	Panchthar	Kummayak R.M.	3	635	Chandrodaya Basic School	020320015	Public	1	1	2	3	2	5
76	Koshi	Panchthar	Kummayak R.M.	4	643	Shree Singhabahini Basic School	020320004	Public	3	3	6	0	1	1
77	Koshi	Panchthar	Phalgunanda R.M.	6	652	Panchakanya Basic School	020020005	Public	5	5	10	5	2	7

78	Koshi	Panchthar	Phalgunanda R.M.	7	660	Shanti Chhetra Basic School	020230005	Public	2	3	5	1	1	2
79	Koshi	Panchthar	Phalgunanda R.M.	5	669	Siddha Saraswati Basic School	020280005	Public	2	1	3	1	0	1
80	Koshi	Panchthar	Phalgunanda R.M.	4	677	Tinchule Basic School	020060007	Public	6	2	8	1	2	3
81	Koshi	Panchthar	Phalgunanda R.M.	2	686	Jana Kalyan Basic School	020110004	Public	4	2	6	1	0	1
82	Koshi	Panchthar	Phidim Municipality	9	695	Shree Phemesuwa Basic School	020170003	Public	3	3	6	3	3	6
83	Koshi	Panchthar	Phidim Municipality	3	703	Jana Kalyan Ma V	020290003	Public	6	6	12	5	3	8
84	Koshi	Panchthar	Phidim Municipality	8	712	Shree Buddha Basic School	020330007	Public	2	0	2	2	1	3
85	Koshi	Panchthar	Phidim Municipality	13	720	Mahadev Basic School Phidim	020160006	Public	3	2	5	3	1	4
86	Koshi	Panchthar	Phidim Municipality	12	729	Shree Nangeen English Boarding School	020220014	Private	23	27	50	14	13	27
87	Koshi	Panchthar	Phidim Municipality	7	737	Shree Ranitar Ma. Vi.	020330001	Public	1	1	2	4	2	6
88	Koshi	Panchthar	Phidim Municipality	1	746	Shree Pipalbote Basic School	020290013	Public	1	3	4	2	2	4
89	Koshi	Panchthar	Phidim Municipality	2	754	Shree Suryodaya Adharbhuta Vidyalaya	020290010	Public	5	10	15	6	4	10
90	Koshi	Panchthar	Phidim Municipality	5	763	Shree Singha Devi Basic School	020070006	Public	5	5	10	2	3	5

91	Koshi	Panchthar	Phidim Municipality	4	771	Sukhabodh Secondary School	020290002	Public	20	22	42	8	8	16
92	Koshi	Panchthar	Phidim Municipality	10	780	Millennium English Boarding School	020290027	Private	1	11	12	3	3	6
93	Koshi	Panchthar	Hilihang R.M.	7	789	Kanchanjangha Himsringkhala Basic School	020050007	Public	4	8	12	3	2	5
94	Koshi	Panchthar	Hilihang R.M.	7	797	Mechi Basic School	020260006	Public	2	4	6	1	1	2
95	Koshi	Panchthar	Hilihang R.M.	6	806	Shree Siddhakali Secondary School	020050003	Public	6	6	12	7	4	11
96	Koshi	Panchthar	Hilihang R.M.	5	814	Nilgiri Secondary School	020370001	Public	7	7	14	3	8	11
97	Koshi	Panchthar	Hilihang R.M.	4	823	Singha Devi Basic School	020260009	Public	2	2	4	0	2	2
98	Koshi	Panchthar	Hilihang R.M.	1	831	Amarpur Secondary School	020040001	Public	5	3	8	3	4	7
99	Koshi	Panchthar	Yangwarak R.M.	6	840	Sikshya Niketan Basic School	020210007	Public	3	1	4	3	1	4
100	Koshi	Panchthar	Yangwarak R.M.	4	848	Janata Basic School	020390009	Public	4	1	5	1	2	3
101	Koshi	Panchthar	Yangwarak R.M.	3	857	Gyanjyoti English Boarding School	020250009	Private	8	6	14	8	7	15
102	Koshi	Panchthar	Yangwarak R.M.	2	865	Jasoda Basic School	020120006	Public	2	1	3	2	0	2
103	Koshi	Panchthar	Yangwarak R.M.	1	874	Pabitra Basic School	020080005	Public	3	1	4	1	1	2

104	Koshi	Panchthar	Phalelung R.M.	3	882	Phalalung EBS	020200011	Private	2	7	9	2	3	5
105	Koshi	Panchthar	Phalelung R.M.	4	891	Shree Phalelung Basic School	020300006	Public	1	0	1	0	1	1
106	Koshi	Panchthar	Phalelung R.M.	5	900	Siddha Aa Bi Lungmadin	020300008	Public	1	4	5	1	3	4
107	Koshi	Panchthar	Phalelung R.M.	7	908	Chintapu Pra V	020350006	Public	2	3	5	1	2	3
108	Koshi	Panchthar	Phalelung R.M.	8	917	Gyanjyoti Adharbhut Bidyalaya	020400004	Public	7	5	12	2	3	5
109	Koshi	Panchthar	Phalelung R.M.	2	925	Jaringe Pra V	020100006	Public	2	0	2	3	1	4

Extra Schools – Ilam Panchthar

A.SN	G. Order	Province	District	Local Level	Ward	School Name	School Code	School Type	G. Total
1	232	Koshi Province	Ilam	Ilam Municipality	4	Devkota Basic School	030270006	Public	20
2	511	Koshi Province	Panchthar	Miklajung Rural Municipality	1	Haibung Basic School	020340010	Public	5
3	605	Koshi Province	Panchthar	Tumbewa Rural Municipality	1	Janata Basic School	020010006	Public	2
4	884	Koshi Province	Panchthar	Phalelung Rural Municipality	3	Shree Kanchan Shiksha Niketan	020290013	Private	7
5	698	Koshi Province	Panchthar	Phidim Municipality	6	Shree Bhagawati Secondary School	020360001	Public	11
6	791	Koshi Province	Panchthar	Hilihang Rural Municipality	7	Shree Mahadev Basic School	020050009	Public	7
7	140	Koshi Province	Ilam	Deumai Municipality	5	Kalika Devi Basic School	030080002	Public	9

EU2: Tehrathum

S.N	Province	District	Local Level	Ward	Sample Code	School Name	School Code	School Type	G1 Girls	G1 Boys	G1 Total	G2 Girls	G2 Boys	G2 Total
1	Koshi	Tehrathum	Laligurans Municipality	4	2	Jana Jagaran Pra V	080200004	Public	1	2	3	0	3	3
2	Koshi	Tehrathum	Laligurans Municipality	4	4	Sarbajanik Secondary School	080200001	Public	3	2	5	2	3	5
3	Koshi	Tehrathum	Laligurans Municipality	3	6	Mahakali Aa V	080030004	Public	2	1	3	1	2	3
4	Koshi	Tehrathum	Laligurans Municipality	2	9	Basanta Secondary School	080030007	Public	3	4	7	2	7	9
5	Koshi	Tehrathum	Laligurans Municipality	2	11	Kalika Pra V	080030006	Public	3	1	4	3	1	4
6	Koshi	Tehrathum	Laligurans Municipality	2	13	Mount Makalu English Boarding School	080030011	Private	19	11	30	12	9	21
7	Koshi	Tehrathum	Laligurans Municipality	1	15	Prabhat Basic	080030009	Public	0	1	1	2	1	3
8	Koshi	Tehrathum	Laligurans Municipality	7	17	Ganesh Basic School	080300005	Public	2	4	6	3	4	7
9	Koshi	Tehrathum	Laligurans Municipality	7	19	Krishna Secondary School	080300009	Public	2	4	6	2	3	5

10	Koshi	Tehrathum	Laligurans Municipality	9	22	Janata Pra V	080280005	Public	1	1	2	2	0	2
11	Koshi	Tehrathum	Laligurans Municipality	9	24	Prajatantra Basic School	080280002	Public	1	1	2	0	1	1
12	Koshi	Tehrathum	Laligurans Municipality	8	26	Gauri Shankar Basic School	080280004	Public	3	2	5	1	3	4
13	Koshi	Tehrathum	Laligurans Municipality	8	28	Ratna Secondary School	080280008	Public	5	5	10	3	3	6
14	Koshi	Tehrathum	Laligurans Municipality	6	30	Kali Chokmalung Basic School	080300001	Public	2	1	3	3	0	3
15	Koshi	Tehrathum	Laligurans Municipality	5	32	Deep English Boarding School	080030013	Private	2	3	5	8	2	10
16	Koshi	Tehrathum	Laligurans Municipality	5	35	Kalika Secondary School	080060001	Public	2	4	6	1	4	5
17	Koshi	Tehrathum	Chhathar R.M.	1	37	Bhagawati Basic School	080020001	Public	2	3	5	3	4	7
18	Koshi	Tehrathum	Chhathar R.M.	1	39	Ratna Devi Basic School	080020004	Public	0	2	2	2	1	3
19	Koshi	Tehrathum	Chhathar R.M.	1	41	Shree Saraswati Secondary School	080020006	Public	8	5	13	1	3	4
20	Koshi	Tehrathum	Chhathar R.M.	2	43	Chhattar English Boarding School	080090008	Private	10	12	22	4	5	9
21	Koshi	Tehrathum	Chhathar R.M.	2	45	Janajyoti Basic School	080090005	Public	7	4	11	6	4	10

22	Koshi	Tehrathum	Chhathar R.M.	2	48	Shree Saraswati Secondary School	080090001	Public	14	20	34	7	6	13
23	Koshi	Tehrathum	Chhathar R.M.	3	50	BP Basic School	080180003	Public	0	1	1	0	0	0
24	Koshi	Tehrathum	Chhathar R.M.	3	52	Public Basic School	080180004	Public	1	5	6	2	1	3
25	Koshi	Tehrathum	Chhathar R.M.	3	54	Saraswati Basic School	080180005	Public	1	2	3	4	0	4
26	Koshi	Tehrathum	Chhathar R.M.	3	56	Sungava English Boarding School	080180008	Private	7	7	14	2	7	9
27	Koshi	Tehrathum	Chhathar R.M.	4	59	Jal Kanya Basic School	080190002	Public	0	1	1	2	0	2
28	Koshi	Tehrathum	Chhathar R.M.	4	61	Seti Sila Basic School	080190001	Public	0	6	6	1	2	3
29	Koshi	Tehrathum	Chhathar R.M.	4	63	Siddheshwar Basic School	080190005	Public	3	1	4	0	0	0
30	Koshi	Tehrathum	Chhathar R.M.	5	65	Bharati Basic School	080160001	Public	3	3	6	2	2	4
31	Koshi	Tehrathum	Chhathar R.M.	5	67	Nishan Basic School	080160006	Public	2	4	6	0	2	2
32	Koshi	Tehrathum	Chhathar R.M.	5	69	Shree Sharada Basic School	080160008	Public	2	7	9	2	6	8
33	Koshi	Tehrathum	Chhathar R.M.	6	72	Janajyoti Basic School	080290003	Public	3	5	8	4	3	7
34	Koshi	Tehrathum	Chhathar R.M.	6	74	Saraswati Basic School	080290006	Public	2	2	4	2	0	2
35	Koshi	Tehrathum	Chhathar R.M.	6	76	Singha Bahini Basic School	080290005	Public	2	2	4	2	2	4

36	Koshi	Tehrathum	Chhathar R.M.	6	78	Light Academy EBS	080160009	Private	6	12	18	5	17	22
37	Koshi	Tehrathum	Myanglung Municipality	2	80	Gyanodaya Pre School	080010007	Private	5	2	7	0	0	0
38	Koshi	Tehrathum	Myanglung Municipality	2	82	Singhabahini Secondary School	080150004	Public	42	46	88	10	8	18
39	Koshi	Tehrathum	Myanglung Municipality	1	85	Pancha Kanya Basic School	080150002	Public	5	3	8	1	3	4
40	Koshi	Tehrathum	Myanglung Municipality	1	87	Tehrathum Academy	080150013	Private	14	13	27	11	22	33
41	Koshi	Tehrathum	Myanglung Municipality	10	89	Sarada Basic School Myanglung-10	080310004	Public	0	0	0	0	0	0
42	Koshi	Tehrathum	Myanglung Municipality	10	91	Tri Kanya Basic School	080310002	Public	1	4	5	3	1	4
43	Koshi	Tehrathum	Myanglung Municipality	9	93	Narayan Secondary School	080230001	Public	6	1	7	2	3	5
44	Koshi	Tehrathum	Myanglung Municipality	3	96	Tehrathum Basic School	080150005	Public	6	8	14	6	4	10
45	Koshi	Tehrathum	Myanglung Municipality	4	98	Janata Basic School	080210004	Public	1	3	4	2	2	4
46	Koshi	Tehrathum	Myanglung Municipality	4	100	Sharada Basic School Myanglung-4	080210002	Public	0	0	0	0	0	0
47	Koshi	Tehrathum	Myanglung Municipality	5	102	Munaratna Basic School	080120004	Public	7	0	7	3	1	4

48	Koshi	Tehrathum	Myanglung Municipality	6	104	Evergreen Secondary Boarding School	080120008	Private	7	14	21	9	11	20
49	Koshi	Tehrathum	Myanglung Municipality	6	106	Ideal Academy English School	080120009	Private	7	6	13	7	12	19
50	Koshi	Tehrathum	Myanglung Municipality	7	109	Chaite Basic School	080010001	Public	5	2	7	2	3	5
51	Koshi	Tehrathum	Myanglung Municipality	7	111	Singhakali Basic School	080010005	Public	1	5	6	1	9	10
52	Koshi	Tehrathum	Myanglung Municipality	8	113	Kobek Pra V	080010003	Public	3	5	8	4	3	7
53	Koshi	Tehrathum	Menchhayayem R.M.	6	115	Lalit Chandra Basic School	080140001	Public	1	2	3	1	1	2
54	Koshi	Tehrathum	Menchhayayem R.M.	6	117	Pancha Kanya Basic School	080140003	Public	4	2	6	2	1	3
55	Koshi	Tehrathum	Menchhayayem R.M.	5	119	Basistha Basic School	080140002	Public	1	1	2	2	2	4
56	Koshi	Tehrathum	Menchhayayem R.M.	5	122	Jante Basic School	080140004	Public	4	5	9	5	5	10
57	Koshi	Tehrathum	Menchhayayem R.M.	5	124	Ratna Basic School	080140009	Public	1	1	2	1	1	2
58	Koshi	Tehrathum	Menchhayayem R.M.	4	126	Shree Srijung Secondary School	080260001	Public	5	14	19	11	7	18
59	Koshi	Tehrathum	Menchhayayem R.M.	3	128	Shree Kalika Basic School	080260002	Public	3	3	6	3	3	6
60	Koshi	Tehrathum	Menchhayayem R.M.	2	130	Jalkankya Basic School	080220004	Public	3	2	5	4	3	7

61	Koshi	Tehrathum	Menchhayayem R.M.	1	133	Jana Kalyan Basic School	080220006	Public	1	1	2	0	1	1
62	Koshi	Tehrathum	Menchhayayem R.M.	1	135	Singhadevi Basic School	080220003	Public	2	1	3	0	2	2
63	Koshi	Tehrathum	Phedap R.M.	5	137	Ishibu Secondary School	080070001	Public	2	3	5	2	5	7
64	Koshi	Tehrathum	Phedap R.M.	5	139	Jaleswor Basic School	080070006	Public	5	0	5	1	1	2
65	Koshi	Tehrathum	Phedap R.M.	5	141	Kalika Basic School	080070004	Public	2	0	2	0	2	2
66	Koshi	Tehrathum	Phedap R.M.	5	143	Singha Bahini Basic School	080070007	Public	1	1	2	1	1	2
67	Koshi	Tehrathum	Phedap R.M.	3	146	Gram Sudhar Secondary School	080110008	Public	3	8	11	5	0	5
68	Koshi	Tehrathum	Phedap R.M.	3	148	Jal Kanya Basic School	080110006	Public	4	2	6	1	1	2
69	Koshi	Tehrathum	Phedap R.M.	3	150	New Sunshine English Boarding School	080110009	Private	9	10	19	10	3	13
70	Koshi	Tehrathum	Phedap R.M.	3	152	Shankar Secondary School	080110005	Public	2	5	7	2	1	3
71	Koshi	Tehrathum	Phedap R.M.	2	154	Jal Kanya Basic School	080170003	Public	3	3	6	3	3	6
72	Koshi	Tehrathum	Phedap R.M.	2	156	Janata Basic School	080170007	Public	7	4	11	4	2	6

73	Koshi	Tehrathum	Phedap R.M.	2	159	Pathibhara Basic School	080170002	Public	6	3	9	3	1	4
74	Koshi	Tehrathum	Phedap R.M.	2	161	Siddhakali Secondary School	080170011	Public	2	4	6	4	5	9
75	Koshi	Tehrathum	Phedap R.M.	2	163	Singha Devi Basic School	080170005	Public	6	2	8	3	3	6
76	Koshi	Tehrathum	Phedap R.M.	4	165	Hyatrung Jharana English Boarding School	080240010	Private	2	3	5	2	3	5
77	Koshi	Tehrathum	Phedap R.M.	4	167	Jalapa Devi Basic School	080240002	Public	0	1	1	2	0	2
78	Koshi	Tehrathum	Phedap R.M.	4	169	Netrajyoti Basic School	080240008	Public	2	2	4	1	2	3
79	Koshi	Tehrathum	Phedap R.M.	4	172	Singh Devi Basic School	080240005	Public	1	1	2	0	1	1
80	Koshi	Tehrathum	Phedap R.M.	1	174	Balmakar Secondary School	080270003	Public	2	4	6	2	2	4
81	Koshi	Tehrathum	Phedap R.M.	1	176	Janajyoti Secondary School	080270001	Public	3	4	7	2	4	6
82	Koshi	Tehrathum	Phedap R.M.	1	178	Kalika Basic School	080270009	Public	0	0	0	3	2	5
83	Koshi	Tehrathum	Phedap R.M.	1	180	Pathibhara English Boarding School	080270012	Private	5	6	11	5	5	10
84	Koshi	Tehrathum	Aathrai R.M.	1	183	Arubote Bal Bikash Kendra	080250012	Public	0	0	0	0	0	0

85	Koshi	Tehrathum	Aathrai R.M.	1	185	Ganesh Basic School, Sakranti Bazar	080250003	Public	3	0	3	2	0	2
86	Koshi	Tehrathum	Aathrai R.M.	1	187	Lisibung Basic School	080250006	Public	2	2	4	3	0	3
87	Koshi	Tehrathum	Aathrai R.M.	1	189	Mulpani Basic School	080250001	Public	1	1	2	2	1	3
88	Koshi	Tehrathum	Aathrai R.M.	1	191	Panchakanya Basic School	080250011	Public	3	1	4	1	3	4
89	Koshi	Tehrathum	Aathrai R.M.	1	193	Ram Sanskrit Secondary School	080250008	Public	11	15	26	1	5	6
90	Koshi	Tehrathum	Aathrai R.M.	2	196	Athrai EBS	080050009	Private	2	5	7	5	13	18
91	Koshi	Tehrathum	Aathrai R.M.	2	198	Janata Basic School, Khamlalung	080130009	Public	2	2	4	3	1	4
92	Koshi	Tehrathum	Aathrai R.M.	2	200	Kalika Basic School, Khamlalung	080130002	Public	3	5	8	5	3	8
93	Koshi	Tehrathum	Aathrai R.M.	2	202	Nawajyoti Basic School, Khamlalung	080130007	Public	3	1	4	1	1	2
94	Koshi	Tehrathum	Aathrai R.M.	2	204	Panchakanya Bal Bikash Kendra	080130011	Public	0	0	0	0	0	0
95	Koshi	Tehrathum	Aathrai R.M.	2	206	Sharada Secondary School	080050001	Public	6	4	10	4	7	11

96	Koshi	Tehrathum	Aathrai R.M.	3	209	Hangyakma Basic School, Hwaku	080100007	Public	2	1	3	3	2	5
97	Koshi	Tehrathum	Aathrai R.M.	3	211	Jalshing Basic School, Hwaku	080100003	Public	2	1	3	0	2	2
98	Koshi	Tehrathum	Aathrai R.M.	3	213	Mahadev Basic School, Hwaku	080100008	Public	1	3	4	3	3	6
99	Koshi	Tehrathum	Aathrai R.M.	3	215	Saraswati Basic School	080100002	Public	3	1	4	4	1	5
100	Koshi	Tehrathum	Aathrai R.M.	3	217	Shree Laxmi Basic School	080100004	Public	2	1	3	5	4	9
101	Koshi	Tehrathum	Aathrai R.M.	4	220	Buddha Basic School	080130010	Public	2	2	4	3	1	4
102	Koshi	Tehrathum	Aathrai R.M.	4	222	Janata Basic School	080080004	Public	1	1	2	1	3	4
103	Koshi	Tehrathum	Aathrai R.M.	4	224	Pranami Secondary School, IWA	080080001	Public	4	2	6	6	6	12
104	Koshi	Tehrathum	Aathrai R.M.	4	226	Shiva Basic School, IWA	080080006	Public	1	0	1	1	3	4
105	Koshi	Tehrathum	Aathrai R.M.	5	228	Nageshwori Basic School, Chhate	080040006	Public	1	2	3	2	1	3
106	Koshi	Tehrathum	Aathrai R.M.	5	230	Naule Basic School, Chhate	080040007	Public	4	1	5	4	3	7
107	Koshi	Tehrathum	Aathrai R.M.	5	233	Saraswati Basic School, Hoda	080040002	Public	4	1	5	3	2	5

108	Koshi	Tehrathum	Aathrai R.M.	6	235	Suryodaya Basic School, Chuhandada	080050005	Public	4	7	11	4	1	5
109	Koshi	Tehrathum	Aathrai R.M.	6	237	Bhagawati Basic School, Chuhandada	080050003	Public	0	1	1	3	2	5
110	Koshi	Tehrathum	Aathrai R.M.	6	239	Kalika Basic School, Chuhandada	080050007	Public	1	3	4	1	2	3
111	Koshi	Tehrathum	Aathrai R.M.	6	241	Saraswati Basic School, Thoklung	080320009	Public	0	1	1	1	1	2
112	Koshi	Tehrathum	Aathrai R.M.	7	243	Bhagawati Secondary School, Thoklung	080320007	Public	3	4	7	1	3	4
113	Koshi	Tehrathum	Aathrai R.M.	7	246	Namjang Basic School	080320003	Public	5	4	9	3	2	5
114	Koshi	Tehrathum	Aathrai R.M.	7	248	Adharbhut Janasmriti Basic School, Thoklung	080320004	Public	2	3	5	1	0	1

Extra Schools – Tehrathum

S.N.	Random No.	Province	Local-Level Code	District	Local Level	Ward	School Name	School Code	School Type	Grade 1–2 Total
1	131	Koshi Province	4	Tehrathum	Menchhayayem Rural Municipality	2	Janapriya Secondary School, Pauthak	080220001	Public	20

2	7	Koshi Province	1	Tehrathum	Laligurans Municipality	3	Shree Man Smarak Shiksha Niketan Ma.Vi.	080030008	Public	21
3	31	Koshi Province	1	Tehrathum	Laligurans Municipality	6	Singhadevi Secondary School	080300010	Public	34
4	155	Koshi Province	5	Tehrathum	Phedap Rural Municipality	2	Janakalyan English Boarding School	080170012	Private	69
5	81	Koshi Province	3	Tehrathum	Myanglung Municipality	2	Ram Thala Basic School	080150011	Public	11
6	57	Koshi Province	2	Tehrathum	Chhathar Rural Municipality	4	Adarsha Basic School, Chhathar-4, Tehrathum	080190007	Public	4
7	205	Koshi Province	6	Tehrathum	Aathrai Rural Municipality	2	Shamthang Basic School, Khamlalung	080130003	Public	7
8	107	Koshi Province	3	Tehrathum	Myanglung Municipality	6	Saraswati Adharbhut School	080120007	Public	70
9	181	Koshi Province	5	Tehrathum	Phedap Rural Municipality	1	Singhabahini Basic School	080270004	Public	16
10	231	Koshi Province	6	Tehrathum	Aathrai Rural Municipality	5	Okharbote Basic School	080040008	Public	11

Annex 9: List of Contributors of the Transmission Assessment Survey -3 [Ilam, Panchthar and Terathum] Report

Name	Position	Organization
Dr Bhim Prasad Sapkota	Director	Vector Borne Disease Research and Training Center
Bihari Sharan Kuikel	Entomologist	Vector Borne Disease Research and Training Center
Ram Balak Ray	Lab Technician	Vector Borne Disease Research and Training Center
Dipak Kumar Shah	Junior Entomologist	Vector Borne Disease Research and Training Center
Radha Subedi	Junior Entomologist	Vector Borne Disease Research and Training Center
Ram Kumar Iteni	Lab Technician	Vector Borne Disease Research and Training Center
Dr Pratibha Parajuli	Microbiologist	Vector Borne Disease Research and Training Center
Lok Raj Bhatt	Public Health Officer	Vector Borne Disease Research and Training Center
Lisasha Poudel	Public Health Officer	Vector Borne Disease Research and Training Center
Hari Joshi	Public Health Officer	Vector Borne Disease Research and Training Center
Jiwan Chauhan	Public Health Officer	Vector Borne Disease Research and Training Center
Aarju Bhatta	Nursing Officer	Vector Borne Disease Research and Training Center
Ram Kumar Mahato	Public Health Officer	Epidemiology and Disease Control Division, Department of Health Services
Rabindra Khaniya	Program Coordinator	World Health Organization
Satya Raj Poudel	Data Management Officer	FAIRMED Foundation

Administrative Support

Name	Position	Organization
Dr. Gokarna Dahal	Section Chief	NTD/VBD Epidemiology and Disease Control Division, Department of Health Services
Pramod Mainali	Account Officer	Vector Borne Disease Research and Training Center
Bhim Bahadur Thapa	Nayab Subba	Vector Borne Disease Research and Training Center
Kuber Parajuli	Computer Operator	Vector Borne Disease Research and Training Center



Government of Nepal
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