HIMALAYAN PROJECT

BAKANJE HEALTH SURVEY 2008

Bakanje V.D.C., Solukhumbu District, Nepal

Supported by PONA-Foundation

CONTENT :

Introduction by Papa Kurt Lomborg ..... Page 3
Introduction by Survey Team Leader Sonam Doka Sherpa ..... Page 7
Survey Team Namelist ..... Page 10
General Health Survey Bakanje VDC ï Questionaire ..... Page 11
Economic Survey Ward 1&2 Chhirringkharka ï Questionaire ..... Page 15
RESULTS from General Health Survey ..... Page 19
RESULTS from Economic Survey ..... Page 32
Kinja Hospital ..... Page 39
Discussion ..... Page 40
Conclusion ..... Page 41
Nepali Health Staff Acronyms ..... Page 42
Constitution of Chhirringkharka Community Emergency Clinic ..... Page 43
Namelist ..... Page 45

INTRODUCTION

By Papa Kurt Lomborg, Chairman of Himalayan Project

This survey report, which is now in your hands, is the result of a survey performed in autumn 2008 in Bakanje V.D.C. (municipal) in Solukhumbu District in north-eastern part of Nepal. The survey came in existence because Himalayan Project have a wish to support the two very isolated and remote wards, 1 and 2, Patale and Chhirringkharka, of Bakanje VDC with a health facility, and we wanted to know some details on the health situation and the capacity of the area, before we would go into a project in the health sector for the first time in our organizations history.

Himalayan Project is a Danish NGO working for improving the life conditions for the people of Nepal with special emphasis on the population of Upper Solu in Solu-khumbu District. We are doing this through a well-established scholarship programme supporting 136 students from class one up to the higher university levels. We have established a primary school in Chhimbu, ward 8 in Bakanje, and are now running it for the 8th year. We have updated and reconstructed a number of schools in Bakanje, Beni Takshindu and Thamakhani VDCs, most of them schools which were established with the support of late Sir Edmund Hillary around 40 years ago.

To support the works of Himalayan Project the Nepali organization Himalayan Project Nepal (HIPRON) is established in Kathmandu under the management of Namgyal Jangbu Sherpa and administration by Ambika Maharjan. The organization is under the leadership of Rotarian Bishnu Subedi, and with Rotarian Madhur Shrestha as Vicechairman, Secretary Namgyal Jangbu Sherpa, Treasurer Sonam Doka Sherpa, Member Dorjee Lama and scholarship receiver Yangzee Sherpa. One of the key activities of HIPRON is the "Runner Service" where Namgyal Jangbu Sherpa is visiting Upper Solu every 3 months to perform the activities of Himalayan Project and to monitor our projects in the area.

The scholarship work is financed by private donors, who is directly supporting a specified student with Himalayan Project as the administrator. Most school projects is run as Rotary projects from a Danish, German or American Rotary Club with Rotary Club of Kathmandu or Rotary Club of Lalitpur as Host partner, and Himalayan Project as adviser, manager and monitor team. It is Skivehus Rotary Klub and Schwerin Rotary Club (Chhimbu school), Padborg-Kruså Rotary Klub (Sagar-Bakanje, Thamakhani, Mopung and Chhimbu schools), Sydthy Rotary Klub (Loding school), Køge Nord Rotary Klub (Solung school) and Nykøbing Mors Rotary Klub (Sagar-Bakanje school).

In 2008 a new donor entered the scene in Solu, when the Danish-American family owned PONA Foundation decided to support the running of Chhimbu Primary School. And simultaneously PONA decided to support the survey, which has resulted in this report, with 5.000 DKr (65.000 Rs). A member of the board of the foundation, Ulla Laier from Danmark, will visit Solu in the spring of 2009 to create her own impression on the situation in the local area. And it is our wish that this report will help her in understanding the local conditions.

After seeing the results from the examination of the survey in November immediately after the return from the project site, I decided on behalf of Himalayan Project to set in action the construction of "Chhirringkharka Emergency Clinic". This name is an immediate working title and will probably be changed according to the wish of the local

inhabitants and the District Health Office. The project is already funded for the initial stages of itôs construction, by Dental Doctor Benny Frømann (Skive), Veterinary Doctor John Dee and Anne Sofie Urne (Viborg), Venø Menighedsforening, Svend & Anne Grethe Præst (Kjeldbjerg) and many more donors giving their support in our donation box. After returning from Nepal I will through Himalayan Project search more donors for the completion of this project.

Chhirringkharka is a very remote place in Upper Solu. It is situated on the slopes of Konyaklemo Danda in a height of 2500-2600 meter. Probably ever since the Sherpa people came down to Solu from Khumbu and Eastern Tibet some 300 years ago, they have grazed their yaks with the fertile pastures (kharka) of this ridge. Dawa Lama is now an elderly noble man and the descendent in third generation of Ngatar Sherpa of Sagar-Bakanje, who was the head of the first family who started living here permanently all the year. Today 57 households are inhabited by roughly 300 persons. The settlement is divided into three villages with Chhirringkharka in the centre, and the smaller village Lole to the east, with a more scattered habitation and predominantly inhabited by Sherpa, and to the northwest Patale, mainly inhabited by Thami and Sherpa.

The slopes here are situated southwards towards the sun, and so high that the cooling valley winds with foggy climate are far below. On the other hand the surrounding high mountains are to some extend attracting the rain clouds during the monsoon period, so that the slopes are receiving sufficient precipitation. The result is very fertile slopes, where the varieties of plants and their growth are far better that the high altitude should predict. Potatoes and barley dominate the crops, but also wheat is harvested, but the most yielding crop is grass for cows. The people of Chhirringkharka are strong and solid cattle farmers and agricultures, who are famous for their breeding and cross breeding of yak and cow. They produce high quality of butter and cheese products, but as Buddhists they rarely produce meat for food as they, according to their religion, donôt kill living creatures.

The settlement is situated in a really isolated corner of Solu. It is the last settlement uphill. Only high pastures (kharka) and High Himalayas are found that way. To the east the landscape soon changes into steep, rugged mountainside. To the west it goes very steep down to Likhu Khola at 1.700 meter (meaning 8-900 meters steep down and 3-400 meters up again) with connection to the villages of Kyama, Gumdel and Changnyima. To the south several trails lead down to Bakanje Khola (Honde Khola) and all finally leading up to Sagar-Bakanje Village at the same altitude as Chhirringkharka. Of the two most used trails, the eastern trail is not so steep and meets the river at 2.200 meters (meaning 350 meters down and up again ï long, but not so steep). It is considerably longer than the more direct trail, which is steeper and meets the river at 1.900 meters (meaning 6-700 meters relatively steep down and not so steep up). For a tourist it will take 2½-4 hours between Chhirringkharka and Sagar-Bakanje, but for schoolchildren who goes to the school in Sagar-Bakanje (Lower Secondary level) it takes 1½-2 hours each way. For a strong, grown-up person it sometimes takes only 5 quarters. The people of Chhirringkharka are so used to this hardship, that they are among those inhabitants of Solu, who you will find anywhere at any time being ignorant of steepness and length. But on the other hand it is very rare to find other people of Solu, who have ever been in Chhirringkharka, even having relatives there, because the trails are much too hard. When I visited the village on 3. November 2007, they told me that I was the second western visitor after Sir Edmund Hillary 22 years ago, though they

knew that an unknown tourist went trough at nighttime in 1998, and another went through Patale in 2001. I could tell them, that both strangers were me.

To sum up: for healthy and well-fit Chhirringkharka dwellers the hardship of remoteness is not a big issue, but for everyone else it is somewhat of a problem to go to and from the village. But what about the sick persons? For preventive treatments like vaccinations and other minor treatments, there is a Health Post in Sagar-Bakanje with regular service operated by a Health Assistant walking around from place to place. For more serious problems, the nearest hospital is in Phaplu on the other side of Lamjura Pass (3.550 meter), which means some 10-12 hours away ï and that is for healthy and well-fit persons! But for acutely injured persons, severe illness, complicated deliveries etc., the problem is really critical and several persons have died or become disabled because of the remote position of the village. The persons might have had a better outcome if proper facilities had been available locally.

It is not to be expected that a well educated health worker would start to live in this remote place with only 300 inhabitants and a long distance to the next settlement ï not to speak of a person with an even higher medical education. If a local person would take such an education, it is only to expect that he or she would very soon be searching for another working field, where a higher and more stable income could be expected. But if several of the locals could receive a basic training in first aid, wound treatment, common diseases like diarrhea, coughing etc., a lot of acute problems could be solved locally in a proper way. And if those who already have a practical experience, like birth assistants, could have proper and convenient facilities locally, they could give a better help in many situations. It would be an obvious advantage if a sick person could be moved from an unhealthy and smoky hut into a proper clean and fresh room or building, and in this way improve the process of curing, not to talk about the paramount importance of being able to isolate a contagiously infected person from the rest of the family. If such facilities could be created, it would be more likely to get an agreement with the local District Health Office to have a Health Officer to visit the Sub Health Post at regular intervals for more thorough and specific examinations and treatment.

During my visit in November 2007 I got the impression that the wish of having a health facility was very intense. They almost held their breath, staring intensely at me when a few persons explained the problems, and there were a big relief and smiles all over, when I agreed to work on it. When I presented some quite severe problems, there immediately was someone who had an idea of how to solve it, and the rest agreed actively. I had a strong impression that this project is very necessary, and also that the people of Chhirringkharka will make great efforts to make it run in a sustainable way, and on their own means. I asked them to form a committee, which should describe how they would run this place. Two months later I received the constitution paper which is attached here as an appendix. Such a quick, specific and serious answer is most unlikely in Nepal, and tells me how important this problem is to them and which capacity I could expect in our future cooperation.

I proposed that the necessary land for the construction should be donated from local side, and immediately two landowners showed me a sufficient piece of land situated in the middle of the settlement and not too rugged and steep, which they wanted to donate for the purpose. And the villagers themselves proposed that they would level the land and make it ready for construction by volunteer labor as soon as I do send the message of project initiation.

We had a preliminary discussion on how we would imagine the Emergency Clinic to be constructed. A firm wall with a gate with a lockable door shall surround the compound. The health post building shall have two rooms. One examination room with plenty of cupboards, racks, examination table, ñdoctorsò table and chair, patients chair, examination table with the length of a bed, and halogen examination lamps and other equipment. One room for the sick with 2-3 comfortable and easy-to-clean beds and some light chairs. Both rooms shall have wooden covering along walls and roof and skylight plates shall be in the roof. Along the front side there shall be a wide veranda, where both sick and waiting persons can stay sheltered from rain and sun. Attached to the end of the veranda shall be a building with toilet and bathroom. In the garden there shall be grown medical and restorative herbs.

Himalayan Project shall go into the construction phase of the project after the committee have drawn deeds of the land and after the land is levelled. Himalayan Project will support all the constructions on the compound, settle it with necessary interior covering and equipment and fill it up for a start with dressing materials and medicines according to need and the level of education of the personel. When the construction part run by Himalayan Project is completed, the whole project will be handed over to the Committee of Chhirringkharka Emergency Clinic, which shall run the place on their own in a proper and sustainable way. Himalayan Project shall not have any obligation of continual support of the running of the facility.

The ñBakanje Health Survey 2008ò was performed in the period of 17. October to 22. October 2008 under the leadership of Sonam Doka Sherpa who just few weeks before has completed her education as a Staff Nurse with scholarship from Himalayan Project. She was supported both in the survey and in the reporting by her classmate Uteen Sherpa, and in the survey also by Sumitra Tamang who had just admitted in her education for staff nurse also with scholarship from Himalayan Project. The 3 women joined us for the first days of the survey when Namgyal Jangbu and I were in Solu for project monitoring. Unfortunately the project leader Sonam Doka fell ill in the middle of the survey, and she decided to cancel the rest of the survey and to let herself carry by 3 local strong men all the way over Lamjura to Junbesi which village we had reached on our way. In this way she experienced on her own body how the situation is for those inhabitants in Chhirringkharka who become ill. By cancelling the project on this stage the survey still is missing some very interesting parts of Bakanje to be examined. This is especially the villages of Tangnyingma and lower parts of Sagardanda, but also the villages on the way up Lamjura, like Sete, Dakchhu and Goyem. Also the village of Kenja should have been better examined, but nevertheless the most important part of the survey was almost completed in Chhirringkharka and Patale. Also the Health Post in Sagar-Bakanje should have been examined, but this was unfortunately cancelled. But the result, which has come out of the survey, has shown good enough for the decision to construct a health facility in Chhirringkharka. Probably one of the best-documented projects in this part of Nepal. And a namelist of wonderful and dedicated persons, which cannot be surpassed easily.

Thank you to your all for your support towards this very special project to the remotest of the remote Nepal.

Kathmandu 6. November 2008
Papa Kurt Lomborg!

INTRODUCTION by SURVEY LEADER

Sonam Doka Sherpa

In autumn 2008 I got a chance to conduct a health and economic survey in Bakanje VDC through HIPRON. I had heard so much about that place from Papa Kurt so I am quite excited to visit the place. I am originally from the same district, but have no knowledge about my native village. So I am happy to go there and make a survey.

But first I had to conclude my education as a Staff Nurse, so my time was limited in the beginning, But Lucy and Toby Stavely, from UK but temporarily living and working in Kathmandu, did a lot of preparatory work for the Survey. They even went to Solu and visited also Chhirringkharka. I wish to express my deep gratitude towards Lucy and Toby for all her help and support.

On 14. Oct we finally could start our Survey Trek. After one day of bus and three days of walk we finally reached there.

We started making surveys. It was going fine, we found people there are wonderful. More or less it was an adventurous journey, climbing tough hills up and down, sight of distant mountains, more or less like the journey of life.

On 17th Oct we started the 1st phase of survey or General Health Survey. We were planning to conduct this survey in all the 9 wards of Bakanje VDC, surveying approximately 50% of all households in wards 3 to 9 and 100% of household in ward 1-2.

On 20th Oct we started 2nd phase of our survey or Economic survey. It was to be taken in ward 1 & 2 Chhiringkharka. It was a wonderful place; people over there are very cooperative so we found it easier to carry out our task. We forgot all our difficulties that we faced on the way with their warm welcome.

Suddenly on 22nd morning I feel not well and I had slight fever in morning time so I did only few surveys on that day. But in evening time my condition got more worse. I took some Antipyretics but it didn't work and according to the local people's suggestion I also took a local herbal medicine (kurki) that made my condition more worse. I think its because of the wrong amount or wrong medicine.

I couldn't decide what to do? Even in night I start vomiting and couldn't sleep all night. I wanted to visit a health care center in Sagar Bakanje but it was at the distance of about 4 hours walk from the place I was staying, there wasn't any system of transportation and I couldn't walk. But even if I was carried to the place, I will meet a locally trained health worker if I was really lucky because according to the local people it usually remains closed. I felt the real need of a small emergency clinic there at that moment. As soon as the clock strikes to 6am in morning my friends and sister start discussing what to do? Local people suggested consulting a traditional healer and we did so but saw no hope of improvement, then we decided to contact Papa Kurt who left 2days back but we couldn't contact them because of no communication system.

We decide to go back to Katmandu immediately because the fear of death started in my mind just being left over there. But it wasn't easy to get back to Katmandu because of transportation system. We need porters to carry me. Then finally we got three local people who will be helping us.

Then we decided instead of Katmandu to go to Junbesi to join Papa Kurt for probable later transport to Phaplu Hospital. I was carried on the back of porter for 10hrs over the Lamjura pass 3550meter high. It was my first experience to be carried on someone's back in a basket, which I found it very difficult. We climbed up for 7hrs, as we go in higher altitude I feel more sick. After climbing 7hrs up we started climbing down.3hrs continues travel on rocky, stiff down hill made me almost breathless. Finally we reached Junbesi at 8pm and there we meet our group including papa Kurt. I can still feel the sheer joy I felt then, when I saw all of them there.

I went for rest but couldn't sleep because being carried in basket all the way in cold windy weather, made my body very painful. I even got sicker the next day because of the way I got transported there. We try to find a health person in Junbesi but found no one because they were in holiday leave.

I felt an undreamed complexity of human life from the heart as much as from the head. I realize the need of health care services in reality. Then I try to introspect myself, my only need of the moment was someone to diagnose me and provide me with health care but my need was not met. Any way Papa Kurt and Mummy were with me who were taking good care of mine. Finally with one more day of being carried in a basket we reach Phaplu and the next day I fly to Katmandu.

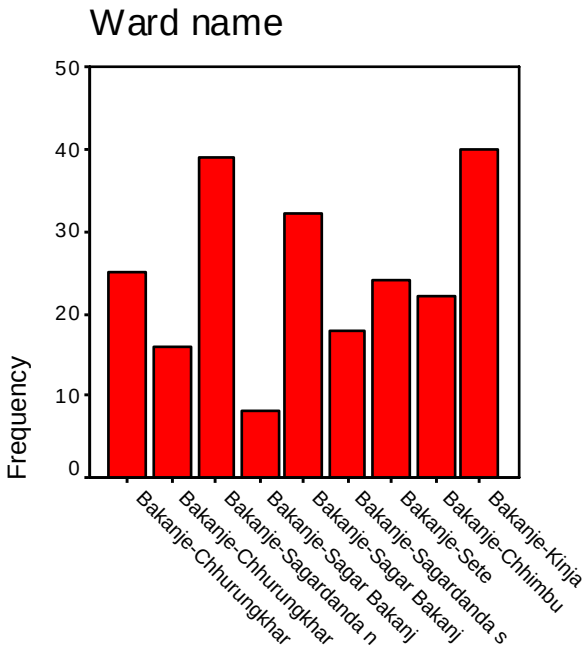
Today I got the reality that there is more in our experience of the real world than can possibly get through the stories and articles. This experience of getting ill in real remote Chhiringkharka is very significant for me, even though it was most hurting experience I ever had. It's significant particularly in the sector of the health. As I look back over the journey lots of question arise in my mind, some of them which always struck in my mind are; How many people over there are left untreated? How long they have been fighting with the fear of death before they get in health center and still how long they should suffer the same fear? Why is life always complex for those who lived there? How can we pull them out that lack of health facilities?

The emergency clinic project from HIPRON should be a lifesaver, the greatest gift they ever had for their life. This should be the first step towards the force of change. I can imagine if this clinic was already there when I am sick. Sleeping in a dark corner of a noisy house cannot provide you physical and mental rest. My illness was not that great illness, even being a health person why should I be so scared for such a simple fever? It may be a question most of you have inside you but I request all of you to imagine once how you will feel like if you are left with a very minor illness in the middle of now here with strangers who don't know how to handle a sick person, what to feed a sick person and no one else knows about medical treatment, obviously at that moment your sickness will be more serious by itself. You will miss your guardians who handle you softly with care, who serve you with the best for your health and with love and tender care your sickness will disappear. I realize that sickness itself is not a big problem but when you are left with unknown people and feel mentally unsecured it can be dangerous. HIPRON is providing support for those in need of health care to ease the pain, to talk about their fear form themselves and their family. I wish change in the society to prevent death occurring from fear of death will be supported.

It was our plan that we should cover all the Bakanje VDC in such a way that Ward 1 and 2 should be close to 100% and rest of the Wards 50%. But due to my illness situation our survey is not completed so here I am giving an overview about how much part of the Bakanje VDC is surveyed and how much is not. For the exact estimation we have to find the general data of the Solukhumbhu District, which we couldn't find within our time limits. Instead we extracted the number of households in Bakanje VDC from our own Upper Solu Survey 2005. But in this survey we took 80-90% of all households so our estimate about surveyed households can't be exact but just approximately:

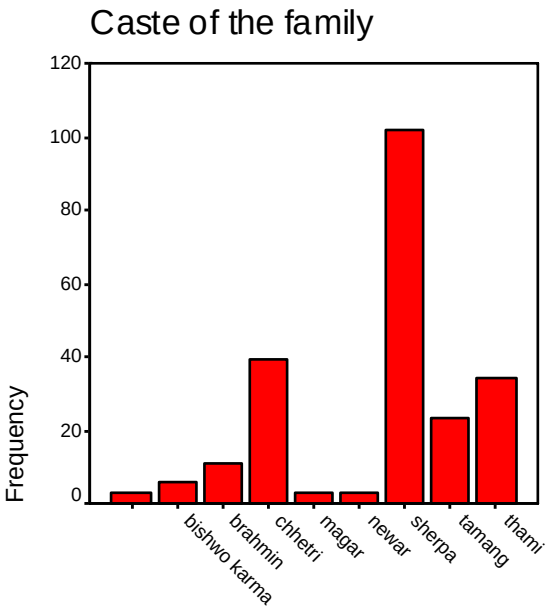
Ward 1: Patale	Surveyed household= 23	Estimated = 92%
Ward 2: Chhiringkharka	Surveyed household= 9	Estimated = 56%
Ward 3: Sagardanda	Surveyed household=7	Estimated = 17%
Ward 4: Sagar-Bakanje	Surveyed household=4	Estimated = 35%
Ward 5: Sagar-Bakanje	Surveyed household=11	Estimated = 34%
Ward 6: Sagardanda	Surveyed household=7	Estimated = 38%
Ward 7: Sete	Surveyed household=7	Estimated = 30%
Ward 8: Chhimbu	Surveyed household=12	Estimated = 54%
Ward 9: Kinja	Surveyed household=4	Estimated = 10%

Surveyed Households in Bakanje VDC from Upper Solu Survey 2005

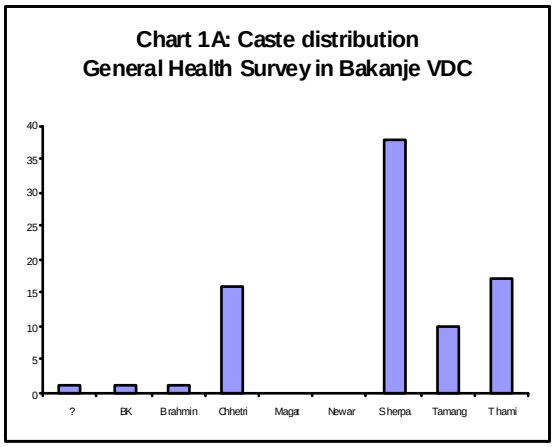


Ward name		House-hold	Percent
1	Chhirringkharka Patale	25	11,2
2	Chhirringkharka Marbu	16	7,1
3	Sagardanda north	39	17,4
4	Sagar Bakanje upper	8	3,6
5	Sagar Bakanje south	32	14,3
6	Sagardanda south	18	8,0
7	Sete	24	10,7
8	Chhimbu	22	9,8
9	Kinja	40	17,9
	Total	224	100,0

Caste Distribution in Bakanje VDC from Upper Solu Survey 2005



Caste of the family	Frequency	Percent
No caste mentioned	3	1,3
bishwo karma	6	2,7
brahmin	11	4,9
chhetri	39	17,4
magar	3	1,3
newar	3	1,3
sherpa	102	45,5
tamang	23	10,3
thami	34	15,2
Total	224	100,0



	Caste of the family									Total
	bi ka	brah min	chhetr i	magar	newar	sherp a	tamang	thami		
1 Chhurungkharka Patale	1	1	0	0	0	13	1	9	0	25
2 Chhurungkharka Marbu	0	0	0	0	0	9	5	2	0	16
3 Sagardanda north	0	0	13	3	0	17	5	0	1	39
4 Sagar Bakanje upper	0	0	0	0	0	8	0	0	0	8
5 Sagar Bakanje south	4	0	0	0	0	26	0	2	0	32
6 Sagardanda south	0	0	17	0	1	0	0	0	0	18
7 Sete	0	0	2	0	0	12	8	2	0	24
8 Chhimbu	0	0	0	0	0	4	3	15	0	22
9 Kinja	1	10	7	0	2	13	1	4	2	40
Total	6	11	39	3	3	102	23	34	3	224

Name List of Survey Group

Sonam Doka Sherpa
Survey Team Leader
Age: 19yrs
Native Address: Taksindu 8: Solukhumbhu
Staff nurse, Completed 3 yearsø PCL nursing course with community health nursing
involved in Upper Solu Survey 2005.
Receiving Scholarship from HIMALAYN PROJECT

Uten Lhamu Sherpa.
Survey team member
Age: 20yrs
Native Address: Namche, Solukhumbhu
Staff nurse, Completed 3 years PCL nursing course with community health nursing.

Sumitra Tamang.
Survey team member
Age: 26yrs
Native Address: Taktok, Solukhumbhu
Auxilary Nurse Midwife
Student staff nurse 1st year
Involved in Upper Solu Survey 2005.
Receiving Scholarship from HIMALAYN PROJECT

Papa Kurt Lomborg
Survey Supervisor
Chairman of HIMALAYAN PROJECT, involved in different developmental work in Upper Solu, providing scholarships for students, and doing reconstruction of schools and much more.

Namgyel Jangbu Sherpa
Survey Facilitator
Managing director of HIPRON, directing and monitoring all the development works carried out through HIMALAYAN PROJECT.

Tika Ram Rai.
Porter Leader.
Office Assistant, HIPRON

Rinji Sherpa
Survey Assistant
Age: 14yrs
Native Address: Taksindu, Solukhumbhu
Student of class 8 at Unique English Higher Secondary School.
Receiving Scholorship from HIMALAYAN PROJECT

BAKANJE HEALTH SURVEY 2008
QUESTONNAIRE

by Himalayan Project, Denmark
Survey leader Sonam Doka Sherpa
sonam_339@hotmail.com / peacesolu@yahoo.com

A health screening in the whole Bakanje VDC

4.A General data

1.Surveyor	
2.Date	
3.Starting time	
4.Completing time	
5.VDC	
6.Ward	
7.Village Name	
8.Place Name	
9.Houseownerôs Name	
10.Houseowners occup	

4.B: Number of Inhabitants of the household

Age group	male	female
1. 0-5		
2. 6-12		
3. 13-19		
4. 20-39		
5. 40-60		
6. 60 +		

4.C: has anyone in your household suffered from TEMPORARY diseases/injuries

	YES	NO	Comment
1. From daily work			
2. From animals			
3. From accidents			
4. Others			

4. D: has anyone in your household suffered from Organic disease?

	YES	NO	Comment
1. Jaundice			
2. Heart diseases Circulatory			
3. Brain or nervous			
4. Diabetes			
5. Others			

4.E: has anyone in your household suffered from :

	YES	NO	Comment
1. Malnutrition related			
2. Allergies			
3. Poisoning			
4. Others			

4.F: Respiratory tract infections for the last 2 year (sinus, nose, throat, lung):

Age group	frequency	Severity (ranking 1-5)
1. 0-5		
2. 6-19		
3. 20-39		
4. 40-59		
5. 60 +		

4.G: Gastric problems for the last 2 year

Age group	frequency	Severity (ranking 1-5)
1. 0-5		
2. 6-19		
3. 20-39		
4. 40-59		
5. 60 +		

4.H: Dental problems:

	Frequency		
1. How many members of the household brush their teeth?			How often?
2. How many members of the household had tooth ache the last 1 year?			What did you do?
3. Do you know what a dentist is and how he can help?	Yes	No	comment

4.I: Traditional Medicine:

	Frequency		
1. How many times did members of household use local herbal medicine during the last 2 years?			comment
2. How many times did members of household use traditional healer during the last 2 years?			comment
3. Which kind of treatment do you believe most, traditional or scientific	**Trad**	**Scien**	comment

4.J: Other Problems for the last 5 year:

	YES	NO	Frequency	Comment
1. Worms				
2. UTI				
3. Genital				
4. Eye				
5. Ears				
5. Fungal Skin				
6. Other skin				
7.				

4.K: Is anyone in your household ever suffered from chronic diseases:

	YES	NO	Comment
1. Major physical disability			
2. Minor physical disability			
3. Mental diseases			
4. Heart and Bp			
5. Lungs			
6. TB			
7. Diabetes			
8. Epilepsy			
9. Cancer			
10. Others			

4.L: Maternal and child health - How many children have been born in this household

	Total	Survived first 10 years
1. Houseowner wife		
2. Houseowner mother		

4.M: Complicated pregnancy

	Yes	No	Comment
1. Houseowner wife			
2. Houseowner mother			

4.N: Complicated delivery:

	Home delivery	Who assisted	complicated
1. Houseowner wife			
2. Houseowner mother			

4.O:What could have been done better:

4.P: Vaccination

	Yes	No	comment
1. Children receive vaccination			
2. Follow programme strictly			

4.Q: Family planning

	Yes	No	comment
1. Know about FP			
2. Use contraceptives ï M			
3. Use contraceptives ï F			
4. Source of information			
5. Does it work for you			

4.R: Has any person in the household died within last years

Years ago	Reason for death	Age
1. 0-3		
2. 3-10		
3. 10+		

4.S: Food economy

	YES %	NO	Comment
1. Producing self			
2. Buying			
3. Exchanging			
4. Payment for work			

4.T: Food cultural aspects in the household

	YES	NO	Comment
1. Some having different items			
2. Any vegetarians			
3. Any religious rules			
4. Any rules for pregnancy/lacta			
5. Any practices for sick child			
6.			

4.U: Surveyors subjective impression:

1: What is your impression about the house in a health perspective

2: What is your impression of the family members in a health perspective

3: What is your impression of the familyôs nutritious situation

BAKANJE HEALTH SURVEY 2008 QUESTONNAIRE

by Himalayan Project, Denmark
Survey leader Sonam Doka Sherpa
sonam_339@hotmail.com / peacesolu@yahoo.com

A supplement to health screening in Bakanje VDC with special reference to Chhirringkharka

Supplementary questions only for Chhirringkharka ward 1&2

5.A: General Data:

1. Surveyor		
2. Date		
3. Tick off (5.M.2)	**Questionaire A**	**Questionaire B**
4. Starting time		
5. Completing time		
6. VDC		
7. Ward		
8. Village Name		
9.Place Name		
10.Houseowenerôs Name		

11. Houseowners occup	

Which facilities should in your opinion be available in Chhirringkharka Clinic:

5.B: STAFF:	**Comment (describe which staff you wish)**
1. Permanent staff	
2. Volunteer staff	
3. Temporary staff	
4. Regular visiting staff	

5.C: FIXTURES	**YES**	**NO**	**Comment**
1.Examination couch			
2. Gynae couch			
3. Delivery couch			
4. Dentistôs chair			
5. Sick bed			**How many?**
6. Laboratory table			
7. Others			

5.D: MEDIC/EQUIP	**YES**	**NO**	**Comment**
1. Delivery			
2. Gynecology			
3. Accidents/injuries			
4. Dental care			
5. Contraception			
6. Most important diseases			
7. All general diseases			
8.			

5.E: Maintenance	**YES**	**NO**	**Comment**
1. Peon on salary			
2. One Volunteer			
3. Shifting volunteers			
4.			

5.F: How many times a year do you think that your household will utilize the service of the clinic which you have just described above:	

5.G: Annual Expenses (except medicines): Give your personal estimate on the costs of a clinic which have all the above mentioned facilities, which you have just mentioned here above (you MUST reply one of them - just give your best bid):	**5.000rs**	
	10.000rs	
	25.000rs	
	50.000rs	
	75.000rs	
	100.000rs	
	100.000+	

5.H: Income sources - How will the villagers be able to support this yearly costs economically (tick off - as many point as you find appropriate):

	YES	NO	Comment				
1. Paying for service			One visit rs	upto	(max) rs	= average	rs
2. Paying for medicines							
3. Yearly fee from all inhabitants							
4. Yearly fee from some inhabitants							
5. Fine for late payment							
6. From relatives living other place							
7. Personal extra donations							
8. From DHO							
9. From NGO							
10.							

5.I: How will you suggest a yearly fee to be paid (tick off - you can tick more than one):

	YES	NO	Comment
1. Per Household			(42 households?)
2. Per inhabitant ï above 16 years			
3. Per inhabitant ï aboce 2 years			
4. Per Household AND inhabitant			
5. Only permanently living here			
6. Also temporarily living here			
7. Shall all pay same fee			
8. Discount for old/child/temporary			
9. Different fee for rich/average/poor			
10.			

5.J: If it is decided that there will ñbe a different fee for rich/average/poor peopleò, how much will YOU suggest that each fee-bearer in Chhirringkharka shall pay in ANNUAL FEE?:

1. HOUSEHOLD FEE: **Respondent guess how many:** (suveyor calculate)					
Rich houses pay	Rs	X rich houses in CK		=	
Average houses pay	Rs	X average houses in CK		=	
Poor houses pay	Rs	X poor houses in CK		=	
1. Total				=	
2. PERSONAL FEE: **Respondent guess how many:** (Surveyor calculate)					
Rich people pay	Rs	X rich people in CK		=	
Average people pay	Rs	X average people in CK		=	
Poor people pay	Rs	X poor people in CK		=	
2. Total				=	
3. Grand total				=	

5.K: If it is decided that there will ñbe a different fee for rich/average/poor peopleò, how much will YOUR own household have to pay in ANNUAL FEE?:

1. How will respondent categorize their own household: Rich/Average/Poor						
	Yes	**No**	**Comment**			
Rich						
Average						
Poor						
2. Then your own Household shall pay in annual fee:					=	
3. PERSONAL FEE: **Respondent guess how many:** (Surveyor calculate)						
Number of people in household full fee		**X personal fee**			=	
People in household with reduced fee		**X reduced fee**			=	
3. Total					=	
4. Grand total					=	

5.L: SURVEYOR: Please do this Calculation:

1. INCOMES:					
Result from 5.F	times	**X result from 5.H.1**	Rs		
X number og households in CK =			hh	=	
The Grand Total from 5.J.3:				=	
Total Income from the villagers:				++ =	
2. EXPENSES:	**Result from 5.G:**			=	
3. BALANCE:	**1. Income minus 2. Expense:**			= +/÷	

5.M:

If Balance 5.K.3 is positive (5.K.1 bigger than 5.K.2)	**The survey is completed.**
If Balance 5.K.3 is +/÷ 5.000 Rs	**Thank you for your support.**
If Balance 5.K.3 is negative (5.K.1 smaller than 5.K.2)	**Continue supplementary survey**

5.N: SUPPLEMENTARY SURVEY (when balance is negative):

1. This deficit of money has to be found from other sources, do you have an idea from where?:		
2. If you can realize that this is not realistic, then you can fill in a new questionnaire, where you can make other results. Do you want to fill in a new questionnaire:	**YES**	**NO**

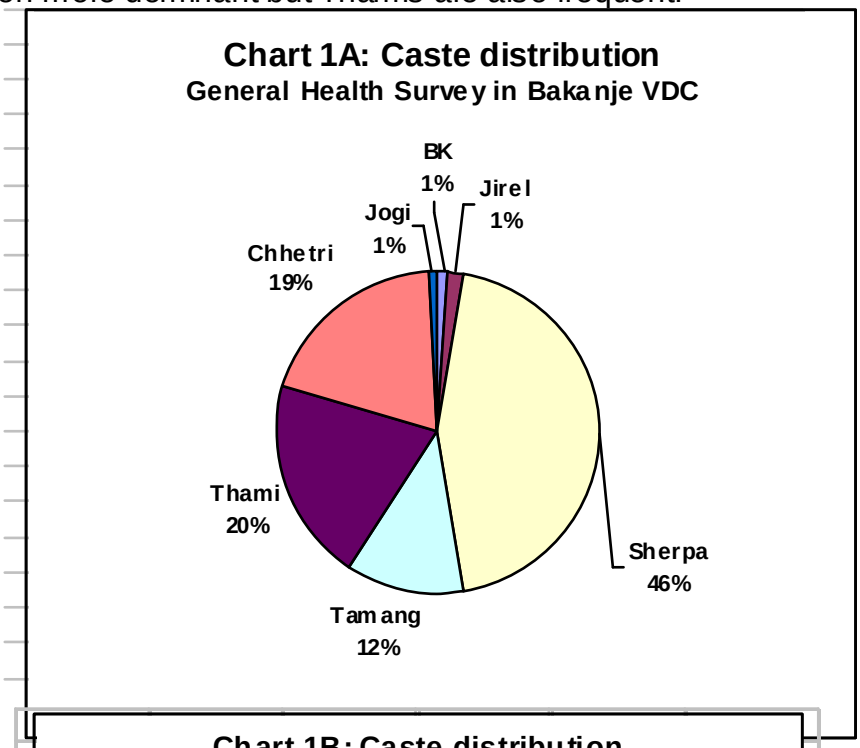
COMMENT:

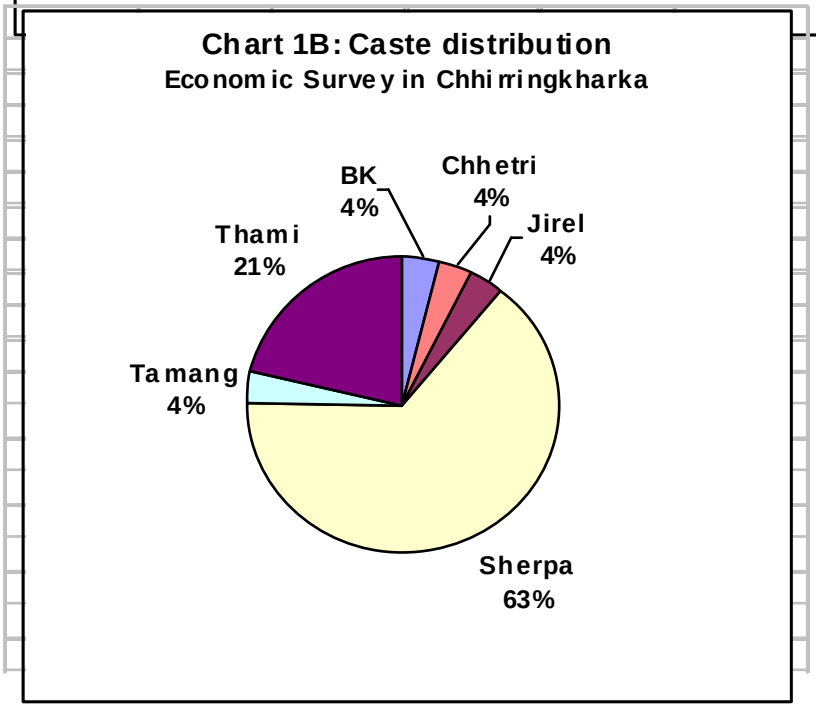
When you fill in a new form then you shall do some changes to make a better result:

- **You can reduce some of the Staff in 5.B to reduce the expenses**
- **You can change the number of visits in 5.F according to the services**
- **You can re-evaluate the expenses in 5.G which match the services you did choose**
- **You can raise the price of a visit in 5.H.I**
- **You can change how many persons shall pay the fee in 5.H and 5.I**
- **You can change the fee for Households and Personal fee in 5.J**

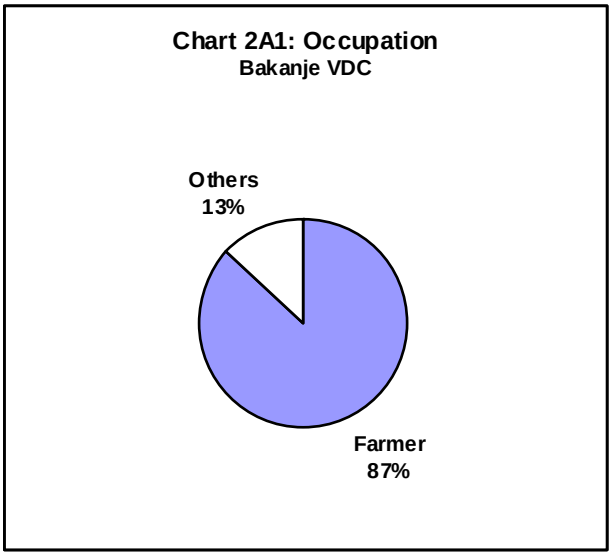
RESULTS from Bakanje Health Survey 2008

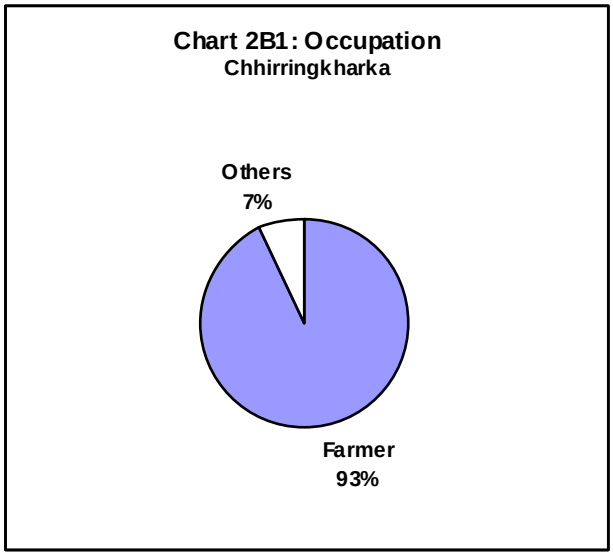
Chart 1: shows that the population of Bakanje VDC is dominated by the Sherpa caste but also the Chhetri Thami and Tamang casts are frequent. In Chhiringkharka the Sherpa are even more dominant but Thamis are also frequent.

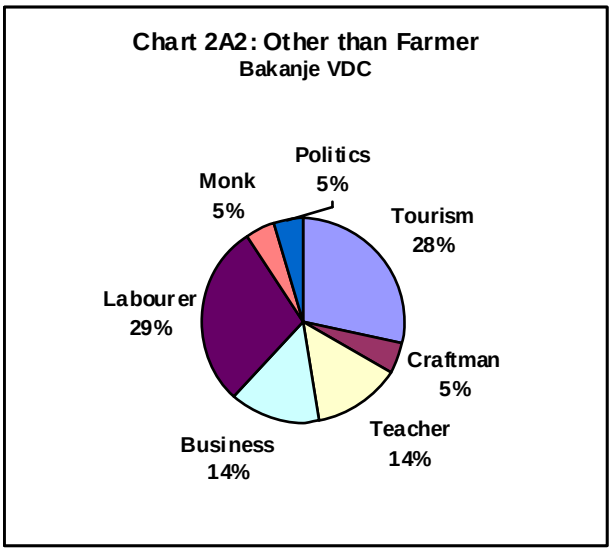




The Charts 2: show that the far predominant occupation of Bakanje VDC is farmer and even this is clearer in Chhiringkharka. The occupation other than farmer shows more variation in rest of Bakanje than in Chhiringkharka**.**
The occupation Farming doesn't show how far the respondent is a farmer who owns his own land or a farm worker who is working for the farmer. The chart only shows the primary occupation as mentioned by the respondents. 11 farmers gave tourism, business, peon, politician and laborer as their second occupation.







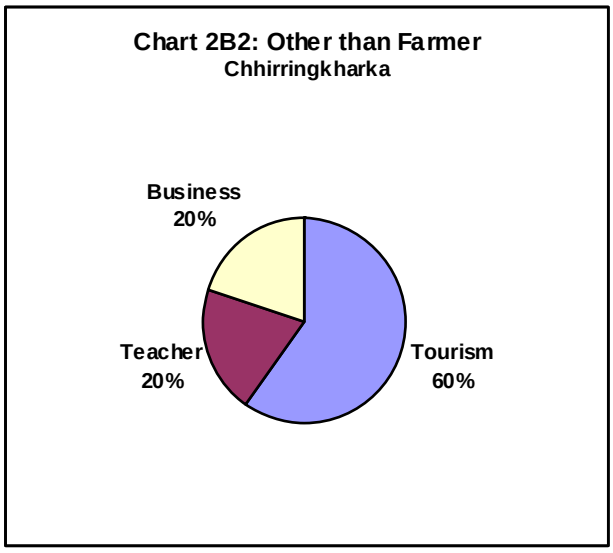


Chart 3: **compares the number of children per family in Chhiringkhraka and rest of the Bakanje VDC through percent of families. Its clear that the families have more children in Chhiringkharka than in rest of the Bakanje VDC.**

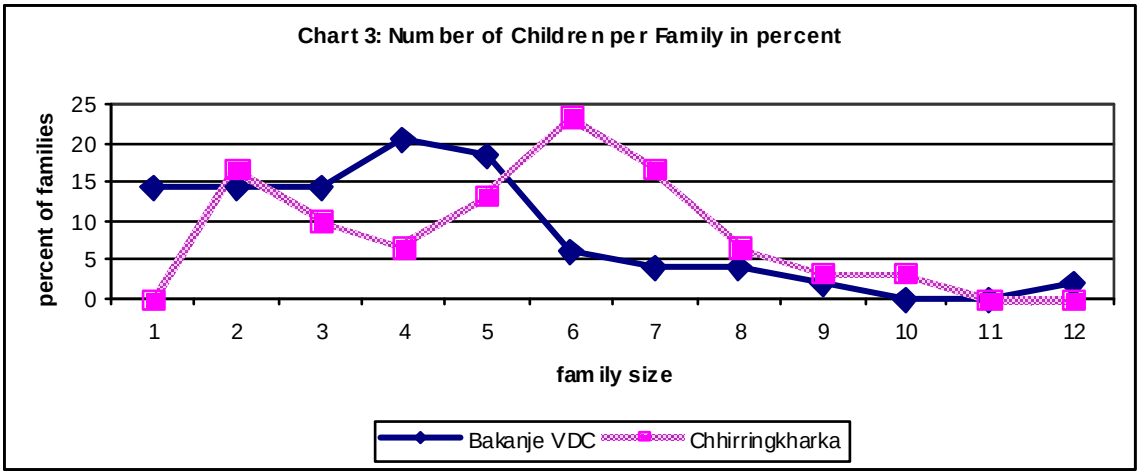


Chart 4 shows how many households have experienced temporary disease and injuries in their day-to-day lives. It shows that most household experienced injuries from their daily work. But also injuries caused by animal and more severe accidents are quite common. Among others is mentioned birth defect, back ache, swollen face and muscle cramp.

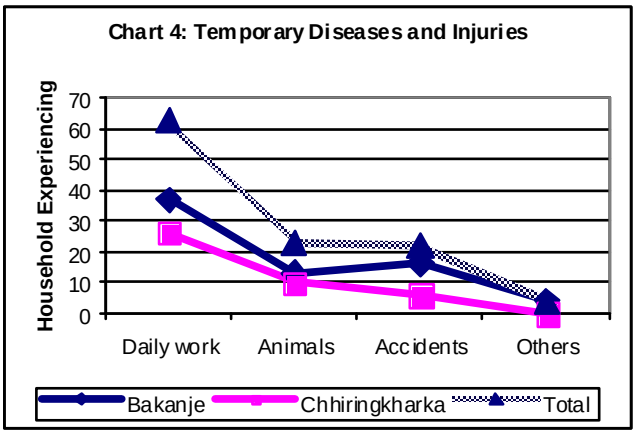
Injuries from the daily work are predominantly cutting injuries as a khukuri is commonly used in daily work. In one case cut injury lead to tetanus, which was survived.

Among the injuries caused by animal we found dog bite very common. In 12 cases of dog bite there are 2 cases of bite from bear.

Among the accidents fracture are common from falling often from trees.

The chart 4B shows that this kind of ailments is more common in the rest of Bakanje VDC than in Chhiringkharka.

During our survey we learned that many people are suffering from temporary fever and diarrhea but it can't be seen from our survey. This is basically because the questionnaires thought that the common respiratory and gastric problems should go for later chapter. Therefore the rare experiences of other temporary diseases can't be regarded as true. Actually almost all respondents gave the positive answer that they have experienced other temporary diseases like fever, cold, cough, diarrhea and gastritis. This fact is regrettable, as an emergency clinic in Chhiringkharka should have quite a lot of work in this field. But anyhow this chart shows that there is a dramatic need of an emergency clinic not only in Chhiringkharka but in the whole of Bakanje VDC.



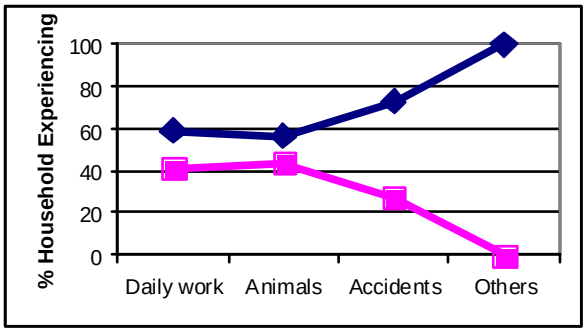
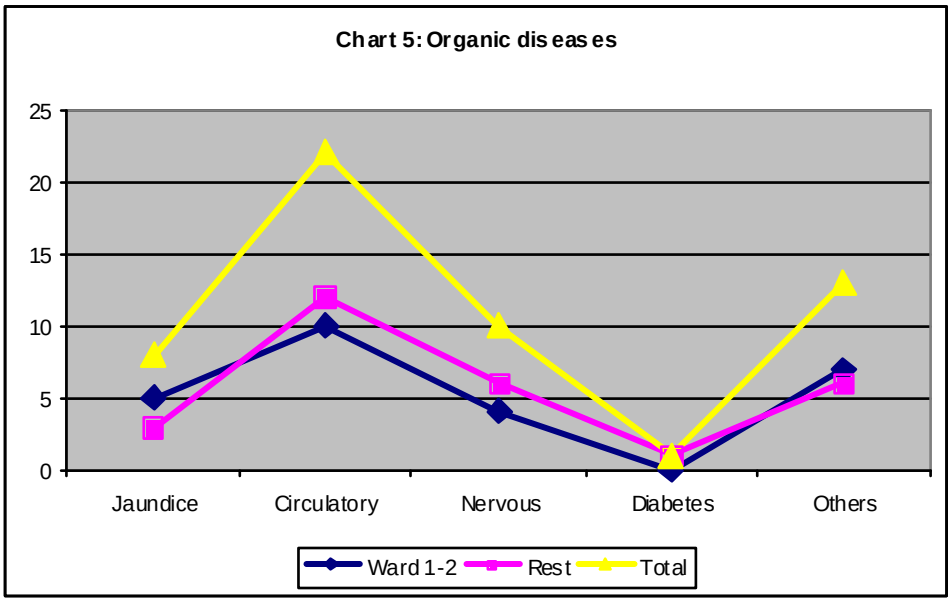


Chart 5: represents the Organic diseases suffered by the people of Chhiringkharka compared with rest of the Bakanje VDC. It seems like most of the households have experienced Heart diseases. Also jaundice and nervous disease seems to be quite common. But unexpectedly Diabetes seems quite rare. Other diseases involve joint pain, backache, abdominal pain, epilepsy, respiratory diseases and common cold.
The lower chart compares the frequency of Organic diseases between Chhiringkharka and the rest of Bakanje.
This chart is not very reliable in the sense that the population is not diagnosed properly and they have no proper idea about their illness but still it shows a tendency. It seems like Diabetes is 100% more common in rest of Bakanje than in Chhiringkharka but this is based only on one case, which is even not properly diagnosed**.**



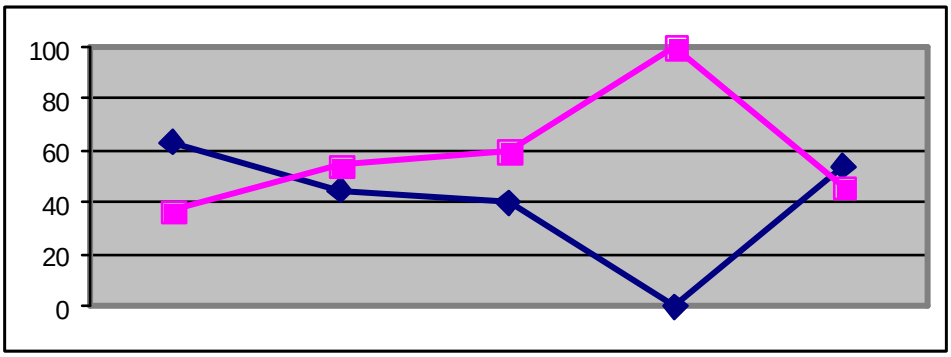


Chart 6: The chart represents health problems related to nutrition. First of all it seems like only few are experiencing malnutrition problem oppositely what we would have expected. But we are surprised to see so many experiencing allergy related problems. The respondents reply mostly with itching, which actually can be an allergy but could also be just an insect bite or not practicing good personal hygiene. Some are also commenting ringworm and boils, which are actually infections. Some mentioned that they have allergy towards fire, cold, heat and sun.
Very few have experienced poisoning. One has experienced poisoning from mushroom and one has experienced being offered tea, which was added poison with purpose.
There doesnôt seem to have other nutrition related problems in the area.
From chart 6B itôs obvious that there is no difference between Chhiringkharka and rest of Bakanje. Only in poisoning there sees to have difference but this result is based on only 3 positive answers.

Many people have no clear understanding about allergies and other dermatological problems and therefore canôt differentiate.

Almost no one have measure their childrenôs growth and development so actually they donôt know whether their child are suffering from malnutrition or not, but the answer here we got is all based on what the respondents can see physically for themselves and their children. But we found that something like 20%of children have symptoms of malnutrition. We also found that many grown-ups have a substantial part of their diet from alcoholic drinks. Probably the many health problems that we found in our questionnaire could be based on malnutrition. So its our impression that malnutrition is much more common than the respondents feel.

Some respondents have experienced the problem only once while others have experienced more than once but as questionnaire was based on yes/no this is not clarify by the chart .

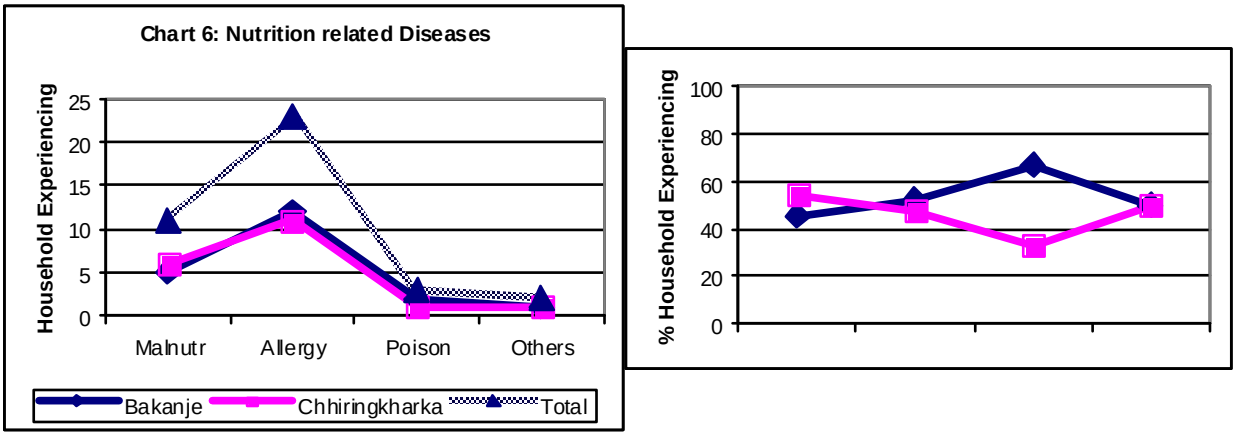


Chart 7 : According to the results of our survey on people experiencing Respiratory tract infection in the last 2 years, we can see that the younger age groups has suffered, and amazingly more the 6 to 19 years then the younger group. Itôs amazing to see that the age group of 60+ has the minimum sufferers from the respiratory tract infection. The common respiratory problems that children of age group 0 to 5 have faced were Pneumonia. Itôs not surprising to see that all age group had mostly suffered from common cold. Sinusitis was also common in the age group of 6 to 19. We asked for the severity of these infections and were surprised to see that most respondents replied with less severity, only two cases are considered severe.

People are considering snotty brat as a normal situation and not as an infection although it is. Many cases of respiratory tract related symptoms could be obscured by irritation from kitchen fire.

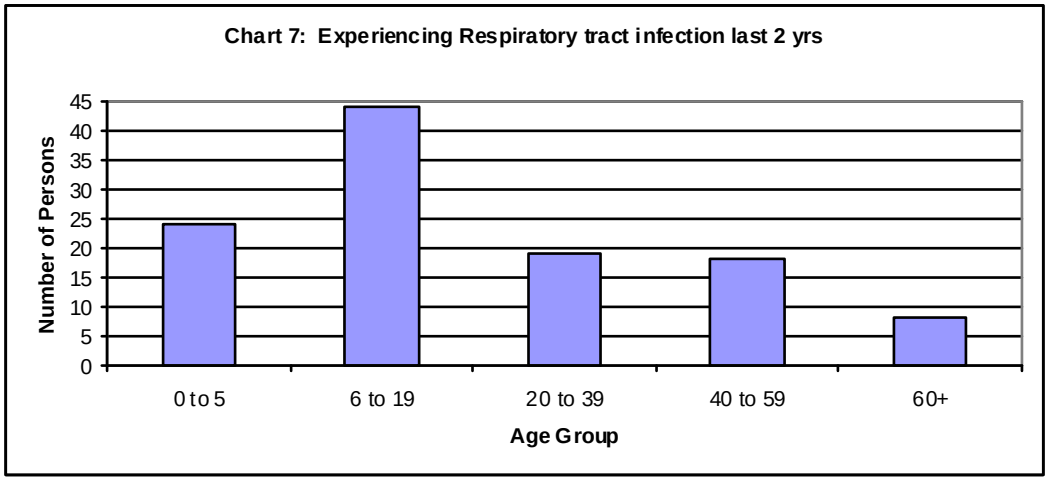


Chart 8: Gastritis as we can see, is very common problem among the people of Bakanje VDC. The chart shows that gastric problems are suffered manly by the working age of 20 to 39 and elder. Itôs also very sad to see that children of age group 0 to 5 also suffers from gastric problems adding additional problem to already existing other disease like Jaundice, Pneumonia, etc.
Itôs our impression that there should be much higher frequency of gastric problem among children. One problem could be that people doesnôt consider diarrhea as a gastric problem but only are referring to acidity and stomach problems. The questioners sometimes gave this awareness but not consequently so this can be the explanation that mainly the elder group experience this problem.

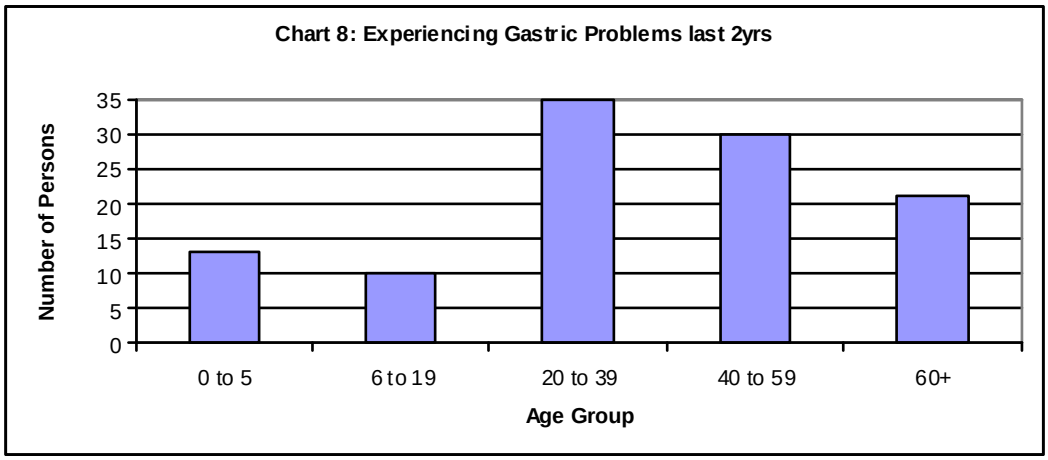


Chart 9: The chart represents other health problems experienced by the persons of the responding households in the last 5 years. Some of them have experienced more than once. Many people seem to have suffered from worms, eyes and ear problem but not so many have suffered from genital diseases.
Most of those suffered from worms are small children, de worming is found to be practiced more or less regularly. Most of the eye problems were blurred vision and watery eyes.
The urinary tract infection and genital problems were expected higher but we found it lowest and this may be unrealistic as the people are shy to let others know about their genital and urinary infections. We think problem like uterine prolapsed must be common there because most of the women have given birth to higher number of children, which is main cause of uterus prolapsed. From other sources we found that fungal skin problem are very common in this area but it is not seen our survey because it may be the same reason that they feel uneasy to talk about this kind of diseases.

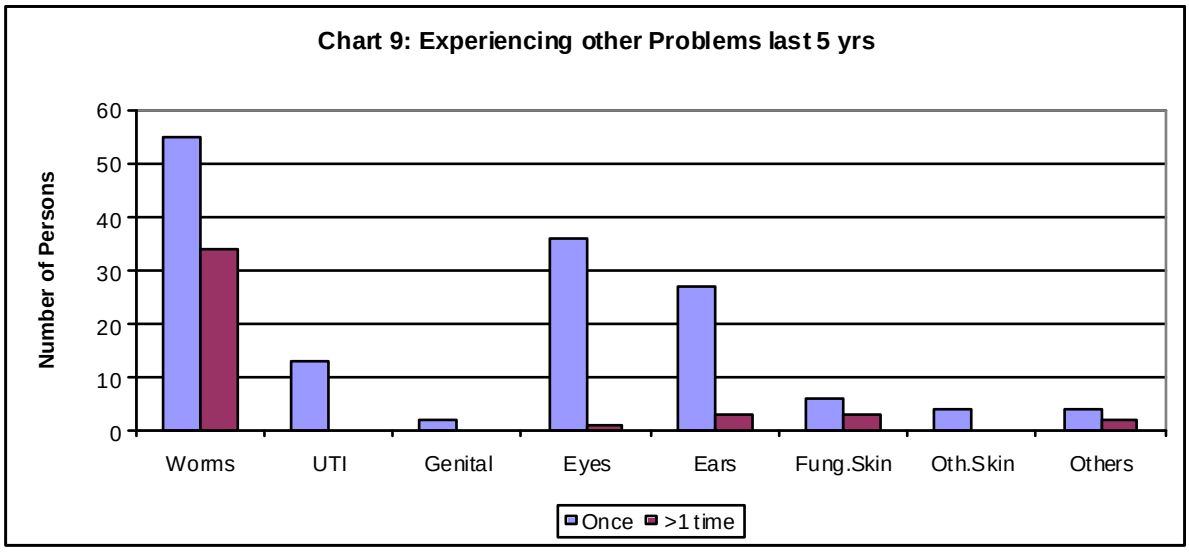


Chart 10: The chart shows the chronic disease and number of people suffering from it. The most suffered chronic disease stands tall and represents itself and thatôs non other than the heart disease/pressure. Itôs also very amazing to find out that none of them have suffered from Cancer, which I feel may be very unrealistic. The people out there may not know about the disease such as Cancer but have surely suffered and died without any diagnosis or specific cause.
We consider this chart not very realistic in terms of appropriate diagnosis because many of the surveyed respondents never had gone through medical diagnosis for their disease. Itôs funny but true that people there diagnose their illness by themselves like in the case of one respondent; his answer to my question ñDo you have high or low blood pressure?òwas ñYes, I think so, because I get angry and irritated very quickly in small petty things.òThis answer was kind of inappropriate, but I consider it as a witty answer!

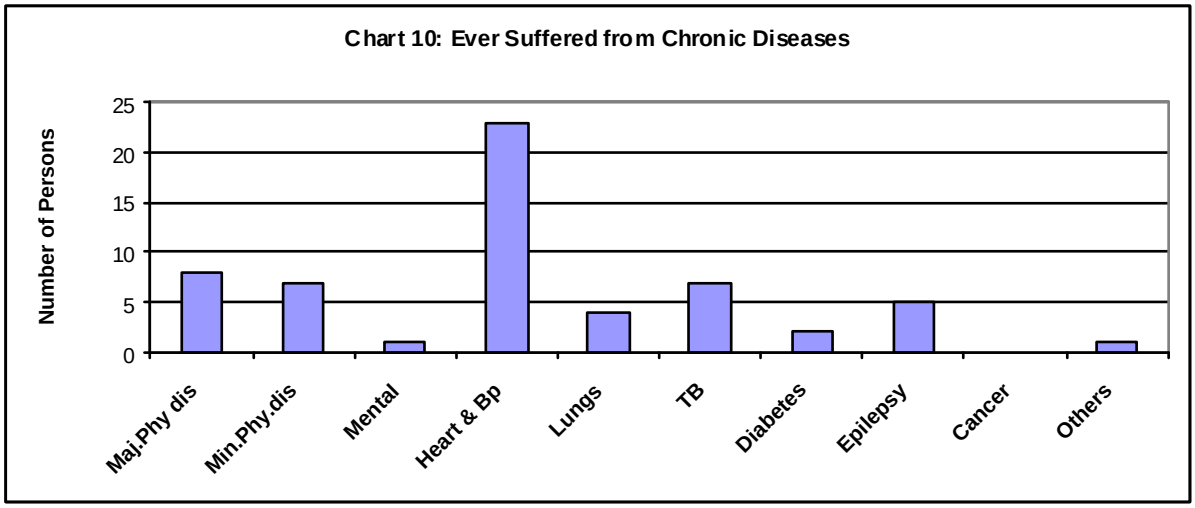


Chart 11 : this chart represents the percentage of people brushing their teeth. Among the entire surveyed household there are 7 houses who have never brushed their teeth. Then among the rest of the houses data represent most of the people brush their teeth once a day. Surprisingly we even found some who practice brushing their teeth twice a day. Among those who practice brushing their teeth only sometimes, they do it when they have to go out for ceremony or some kind of celebration.
Even good dental health is dream which lies far behind their reach, we consider this as a positive result because people are more or less aware about keeping their teeth clean.

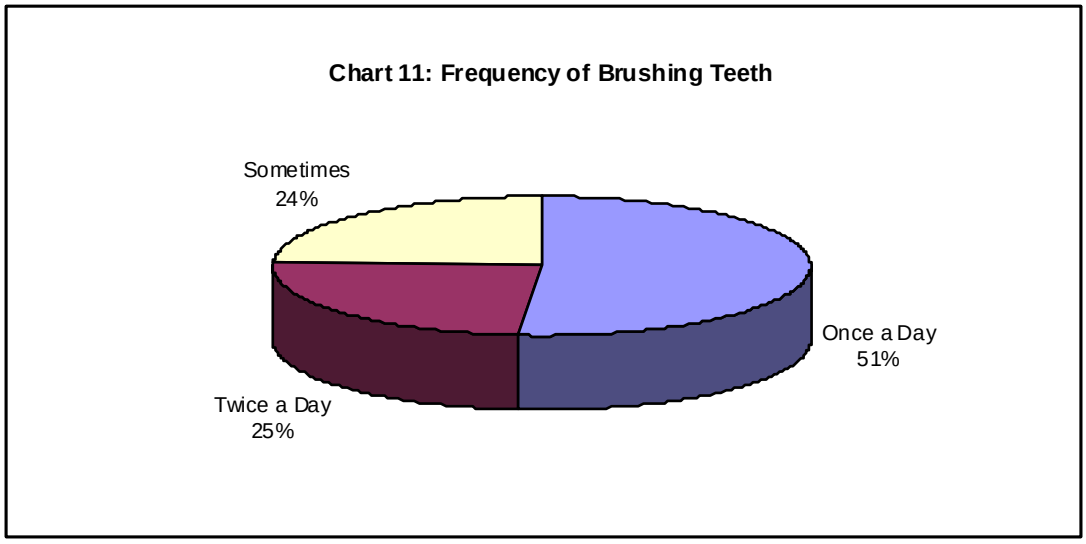


Chart 12: The chart shows how many percent of the people used the traditional methods when they got ill. Among the different traditional methods the most used methods, is the use of the traditional healer (witch doctor) and use of herbal medicines.
It is the reality that the population donôt have access to scientific treatment method. Their only option is to believe in traditional methods. So it is not surprising to know that even though they believe in scientific treatment they practice traditional method. Many diseases will recover automatically by itself and especially among strong natural people like population of Bakanje VDC so in many cases even though they survived by themselves the credit will go for traditional healer.
The herbal medicine as I know, is a very strong medicine but it can be dangerous too if not used in an appropriate manner or right amount. But anyhow the herbal medicines used in a right way can be lifesaver.
But even they are deprived of scientific medicines there is still surplus of people who believe in scientific method than in traditional method.

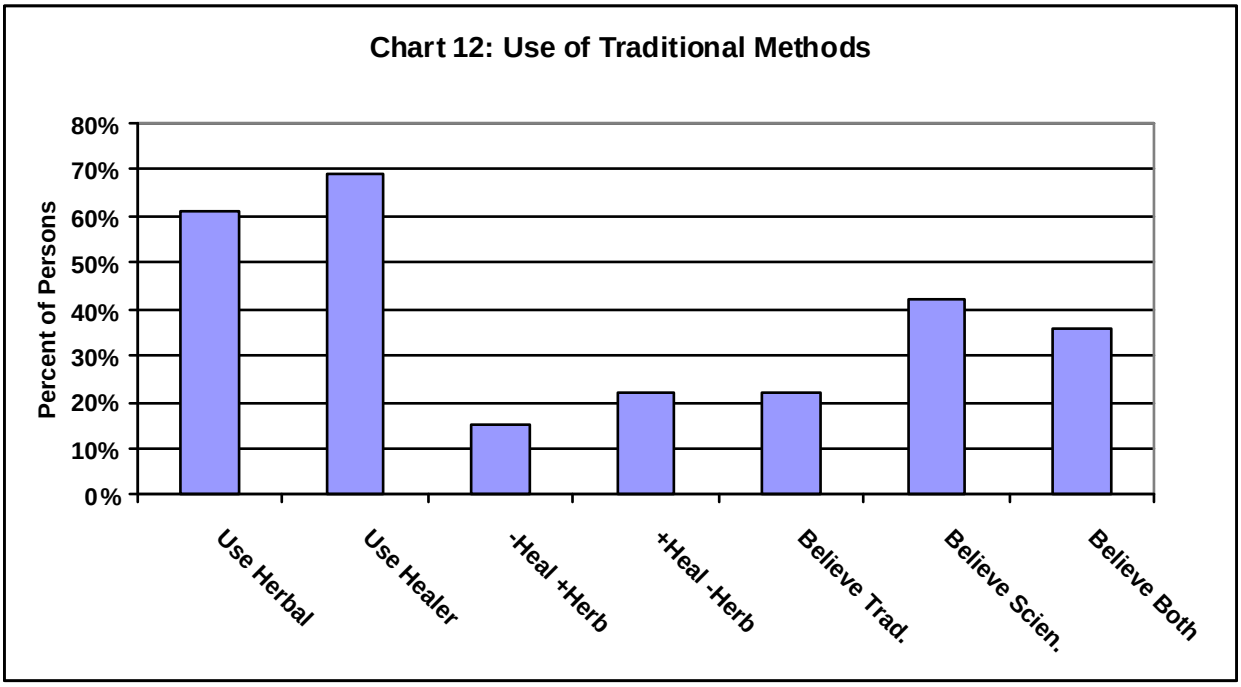


Chart 13: shows the size of the families comparing the current family and grandparentsô family. It could seem like the grandparents family size was smaller than current family size but 25% of the respondents didnôt remember about the grandparents family size so if we magnify the grandparents graph with 25% it will show that the family size are quite similar though the tendency for bigger families in the grandparents generation.
We shall be very careful to conclude anything about it as information about grandparentsô generation was insufficient.

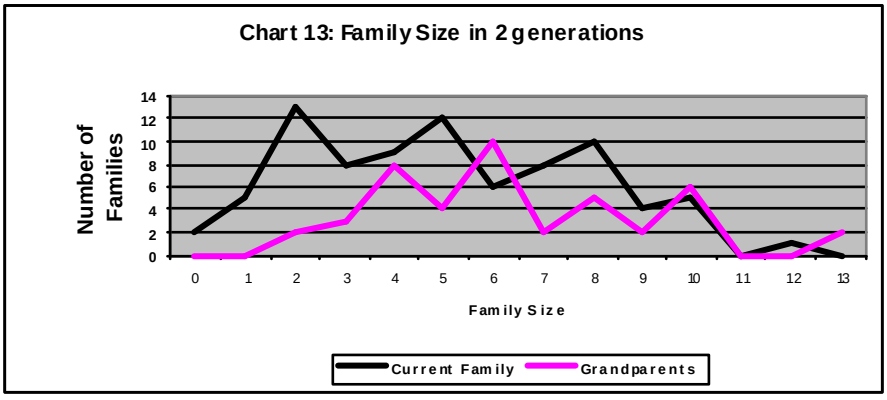


Chart 14: The chart show the number of children born in each family and how many percent of those children who died before the age of 10 years.
It shows that the death rate increases with the family size. The average death rate is 10.4% which is very high.
The death rate can be high, because there is no access to a good health facilities which easily results death for even simple diseases which could have been cured. There could be a connection between having a big family and not being able to control all of it in the hard working everyday life giving proper care and nutrition. The reason can also be if there is high child mortality rate in a family they could keep on producing more children. But we didnôt surveyed the detail reason of this connection.

When we asked about the incidents of death in the family within the last years we found that:

- 15 persons has died within the last 3 years.
  - 6 from 1 family ï 3+3 from 2 families.
  - Reasons:Measles(fever),Cancer,Drowning,Fetal.
- 14 persons has died within the last 3-10 years.
  - from 1 family ï 2+2+2 from 3 families.
  - Reasons:Fetal,Diarrhoes,Fever,Weakness,Burn,Pneumonia,Old age,Sudden death
- 44 persons has died before 10 years ago.
  - 3 from 2 families ï 2 from each of 8 families.
  - Reasons:Fever and Cold,Fetal,Pneumonia,Retention of urine,Cancer,Abdominal pain,Operation,Headache,Diarrhoea,Accident,Malnutrition.
- 14 Died before 1month of age.
- 17 Died between 1 month and 2 years.
- 6 Died between 2 and upto 6 years.
- 11 Died between 6 to 20 years.
- 3 Died between 20 to 40 years.
- Died after 40+ of age.

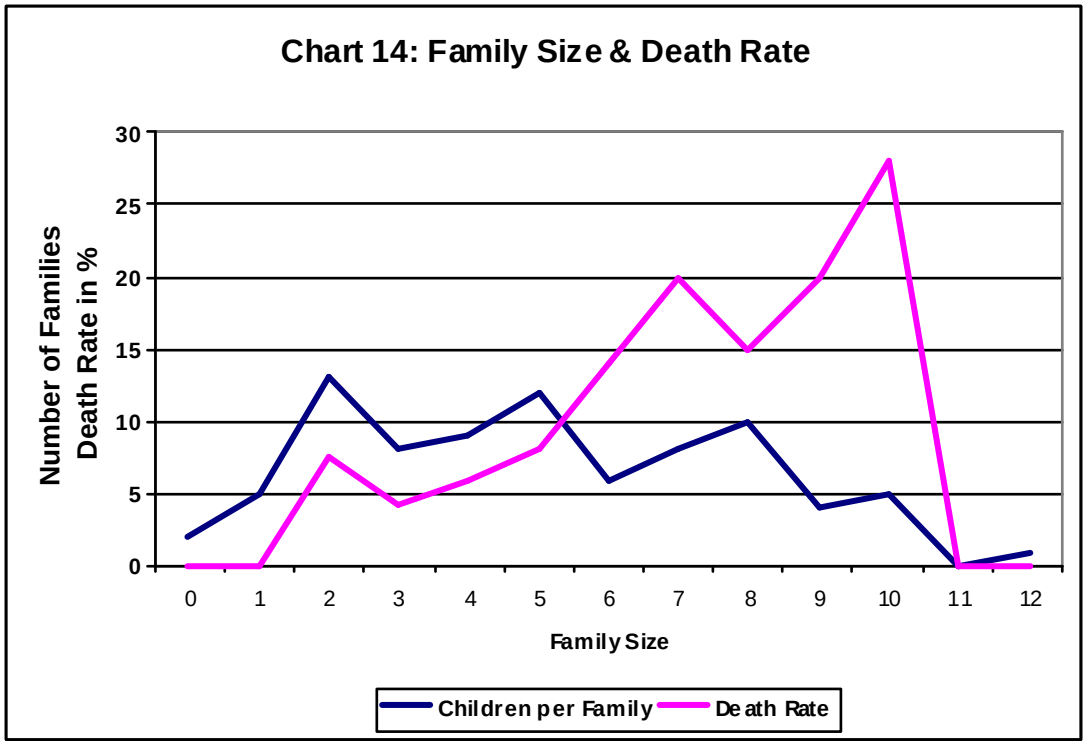


Chart 15: shows that 19% of respondents have experienced complicated pregnancy but it doesn't tell how far they have experienced more than one time. Their comments were mainly swelling of legs and edema but also shortness of breathing, numbness, abdominal pain and loss of appetite.

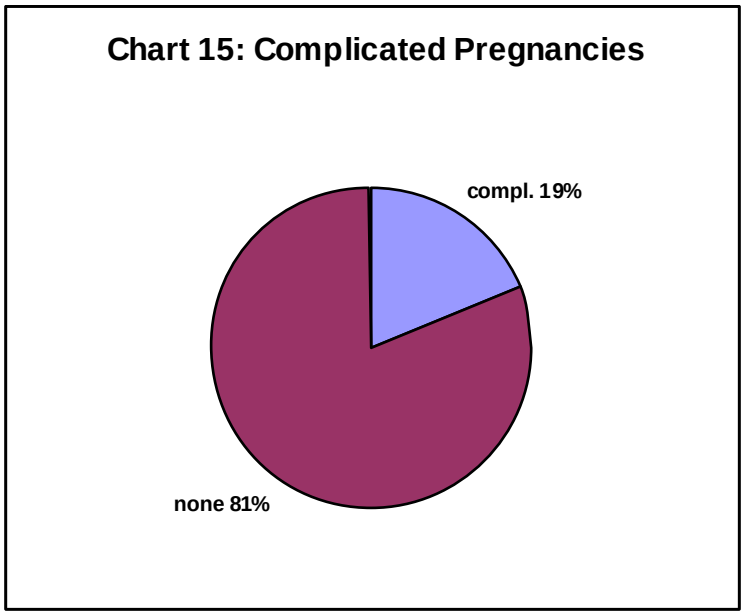


Chart 16: Among the respondents 6% replied that they had experienced complicated delivery. But this represents only 5 complicated deliveries out of 421 deliveries, which is only 1,2% of all deliveries. A comment said prolonged labor. Among those deliveries 413 took place in home, while only 8 took place in a hospital or clinic, but also those were uncomplicated.
It seems like the process of giving birth is quite uncomplicated in this area which might be somehow amazing. The reason might be that they are considering some complication as minor and normal.

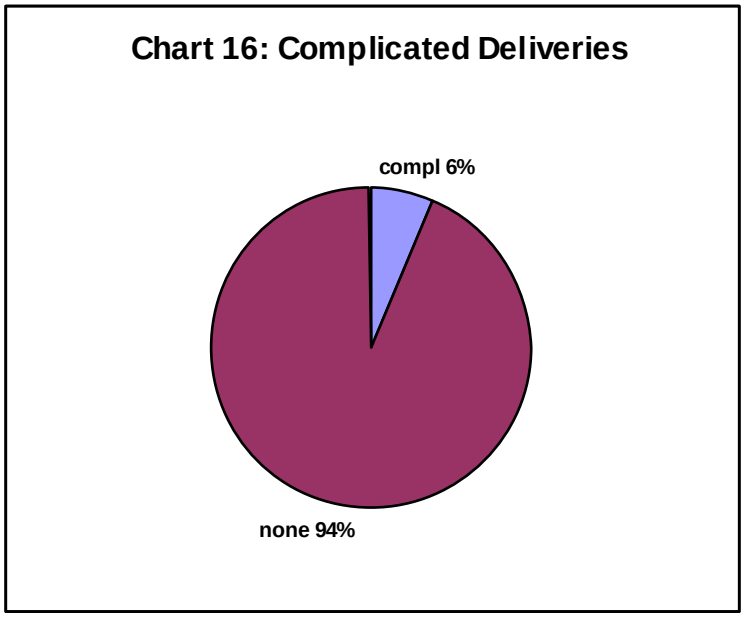


Chart 17: According to our survey, the answers to our question ñwho assisted you during the delivery?ò was answered quite uniform as most of them were assisted by the husbands. Thus, the husband there seems to be really caring and helpful. Itôs weird that these women got helped by their husbands, family members, neighbors who werenôt trained but still then there was very less complication rate. Only those families who can perform perfect pregnancy and delivery will survive so this is actually ñsurvival of the fittestò. Nevertheless the opinion among the people of Chhiringkharka was that if there was a delivery facility in the emergency clinic they would definitely use it probably in all cases. Mostly because it will be more clean and hygienic and probably sooner or later there will be some trained staff there.

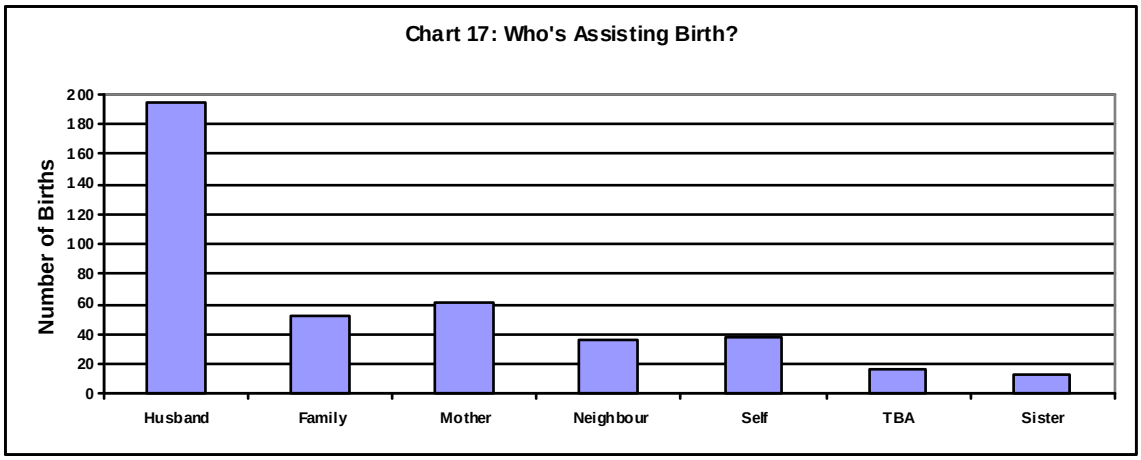


Chart 18: The chart represents the number of the persons using family planning device. The chart shows that the women who are using the family planning methods more than the men. The most used device is found to be Depo-Provera. It is good to know that most people know about the family planning and its methods but very sad that they arenôt putting this into use, especially the men are very selfish as they refuse to use the family planning device even in the request of their wives. Some women also gave up, because they said that none of the device worked for them. They had many side effects. We even found higher failure rate of the device and in our own view its because of lack of knowledge on proper use and follow up. For e.g. if a women in Chhiringkharka had depo provera injection today she should go to take next dose in another 3 months but she forgets to follow up or at that day she finds the clinic (which is in 4 hours walking distance) is closed. Same case with oral pills in many cases they forget to take it regularly and in case of condoms it is same that they have no easy access.

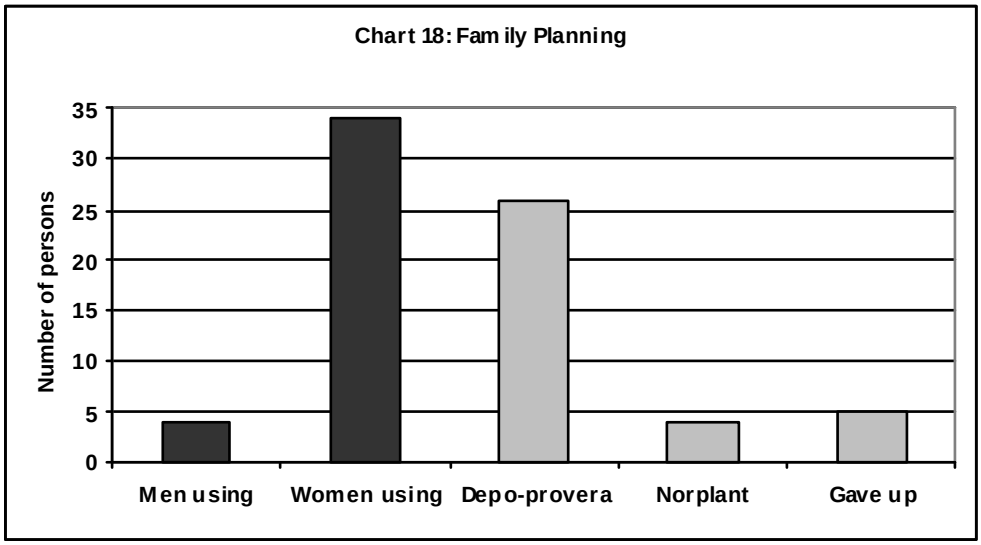


Chart 19: The chart represents from where the household will find their food. The ratio of food income is more by producing and then followed by buying. Very less percent of food income has been by work payment and seems almost nil by exchanging. It also seems that the remote Chhiringkharka is buying less and producing more than rest of the VDC.

It should be expected that higher percentage of food income should come from own production than buying. It should also be expected that those who have no land would receive food as a payment. But the reality show that those who have their own land is producing higher percentage by themselves while those who are not having land is taking money as payment for work and after that is buying their food. It is also little unexpected that so few are exchanging food items between each other.

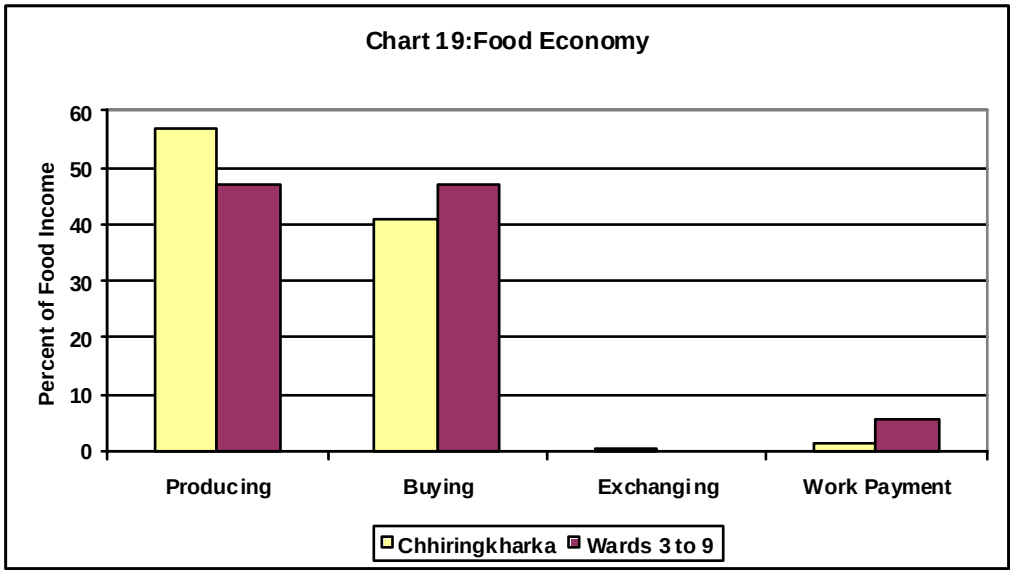


Chart 20: From our questionnaire it is shown that very less people are vegetarians and those who are is vegetarians because of some health problems. There are some religious food taboos, which restrict the people to have certain food patterns. Common restriction of food was found to be pork, buffalo meat and cow meat by the religions of Tamang and Chhetris. Some Sherpas say that they will not eat killed meat. Even the pregnant women have some restrictions and some are even give ñchhangò(local alcohol made out from rice). But most restrictions among pregnant and lactating tell that they are not supposed to take alcohol, smoking, eating meat, dairy products, chilly and even some are rejecting vegetables. The sick child are commonly given some specific diet but avoid eating sour, hot and oily food and raw milk of cows, eggs, salt, lemon, yogurt, pickles, alcohol and potato. Some said that they are giving soup and others as prescribed by health personnel. But in general it seems like people of Bakanje VDC are eating whatever is available for them.

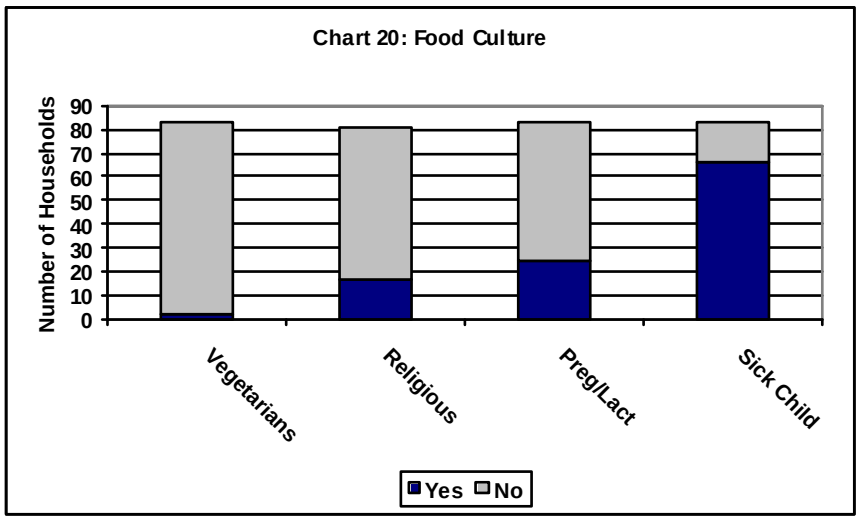
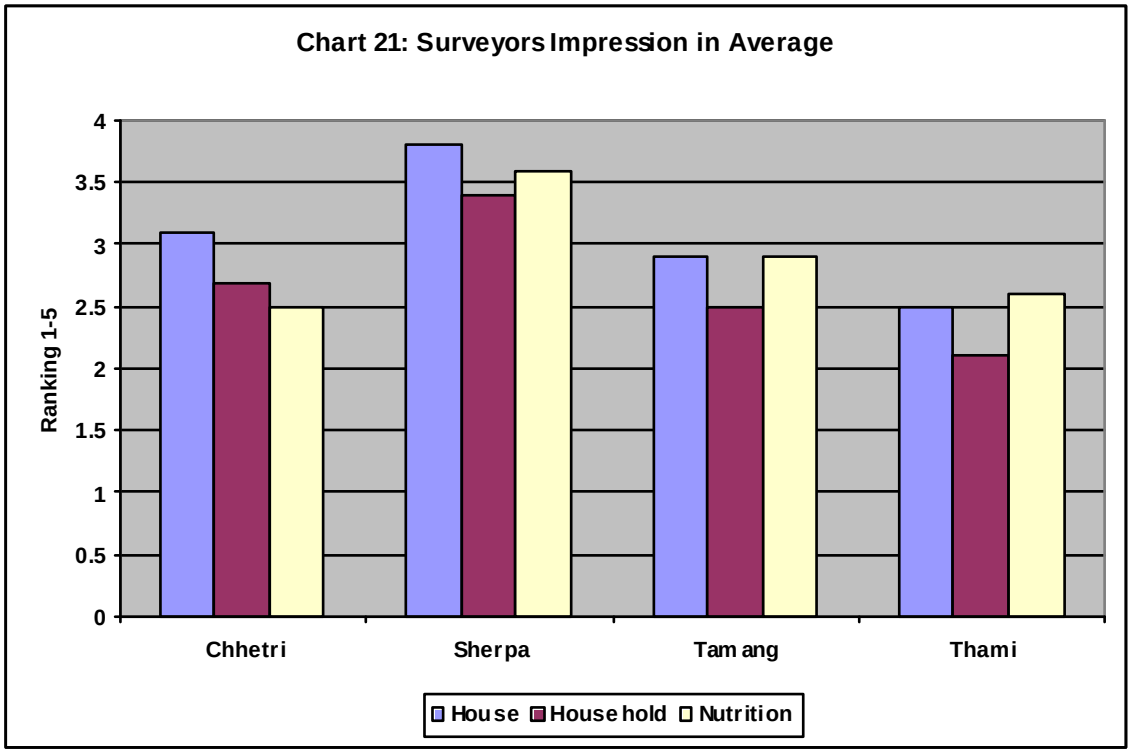


Chart 21: We surveyors made a ranking scale from 1 to 5, and we ranked our personal impression on the home of the family in health perspective, the family as a whole in health perspective and the familyôs nutritious situation.
This chart shows that we gave Sherpaôs the highest rank in all three aspects. Itôs probably because of the socio-economic condition. Almost all of the Sherpa families have better housing with enough ventilation but not hygienic in all cases, their own land and are able to grow nutritious crops (but not practice balanced diet). But while talking about other casts they are comparatively less well to do in economic sector so as a result familyôs nutrition, health and housing are affected.
Itôs our impression that problem directly related with nutrition is higher among Chhetri and Thami compared to Sherpa and Tamang.
This is the surveyors personal impression that we got from meeting one respondent per household and in some cases we even didnôt see the house and other family members because we met the respondents on the field or on the way.



Vaccination: we found that even though there are very less health facilities in the area they are though performing a well controlled vaccination program as far the most of the responding family claimed that they are following the vaccination program very strictly.

- 33 out of 83 surveyed households have children below 19 years of age, which is equal to 88%.
- 70 out of 73 families with children below 19 is following the vaccination program which is 96%.
- 63 out of 70 families giving vaccination is following the program strictly which is 90%.

RESULTS from Chhiringkharka Economic Survey 2008

Chart 22: Shows that among the total surveyed household (27) in Chhiringkharka, wish for a well trained permanent staff in the Emergency Clinic is high. Itôs because the well to do sherpas think that to get quality service and 24 hours service, permanent staff with good health knowledge must be there and they are ready to pay for permanent staff. Also some of the more poor inhabitants wish for high quality staff but they had no idea about the cost and how to cover this. Those who wish for volunteer staff, (which can be local or/and foreigner) want to minimize the cost for staff salary. Few household wish for regular visiting staff from related organization or District Hospital because they thinks that it is not practical and possible to have a permanent staff with very high salary for such a small village with very small number of population.
All of the above answers have their own rationale but still to be more practical a locally trained person with some First Aid and Midwifery related knowledge can be a permanent staff in the proposed emergency clinic, it will help to reduce the cost in one hand and have more trust and effective service in other hand.

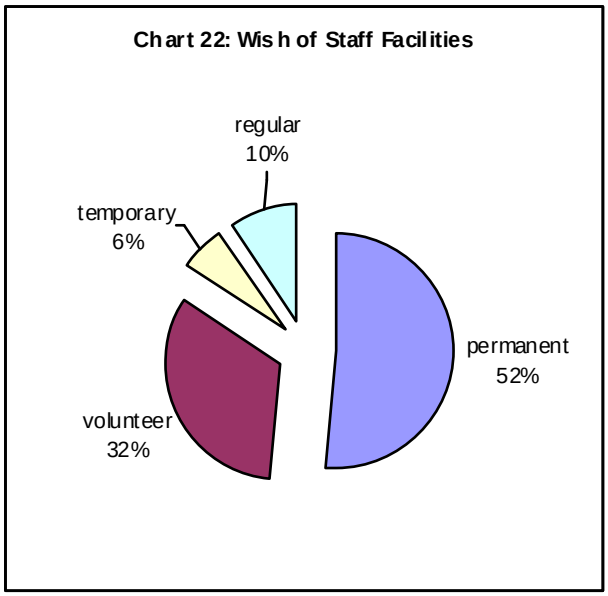


Chart 23: when we were asking about the wish for fixture facilities in the clinic most people just wanted everything. Some less replied about the dentistôs chair and laboratory probably because they have no idea about those facilities. And also less replied about gynecologic couch probably because they will be too shy to use it anyhow. When we asked about other fixtures their wishes were toilet, waiting room and special units like pediatric, eye and other furniture.
While asking this question we faced a problem frequently. The most frequently faced problem was that, most of the respondents have never been to hospital, so they have no idea about the difference between hospital and a simple emergency clinic. They start telling about their wishes which were really high for an emergency clinic. So with the help of surveyors explanation we finally got this result.
Its natural that they want all kind of facilities in the emergency clinic because they have never thought about how can they run the Clinic on their own. They were thinking that HIPRON will always support for everything in the clinic. So during our survey we tried to make them realize that demanding something is very easy but after getting their demand fulfilled they have to carry out it properly which can be very difficult.
There was a family who replied us that òwe will accept whatever is given by Papa Kurt because they thinks that Papa Kurt is going to bring a clinic for them so they just need to accept that.ò

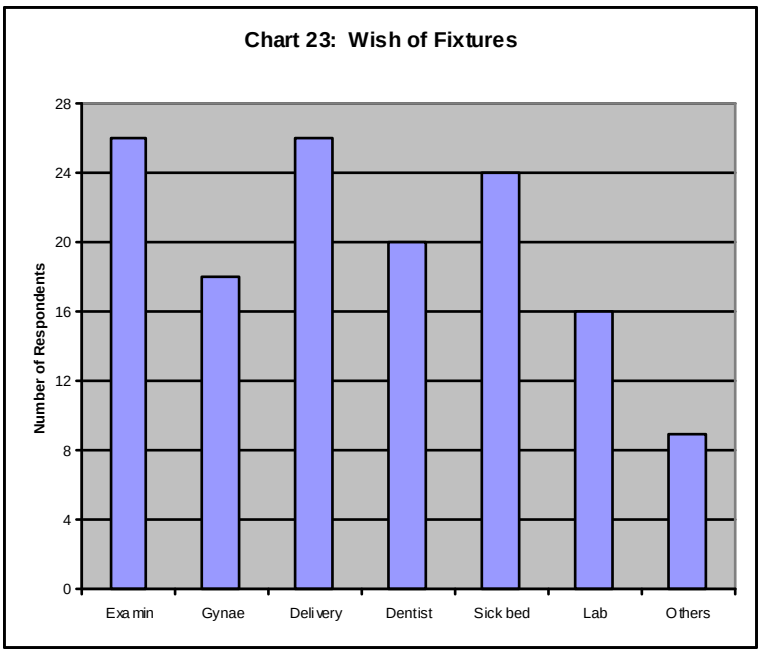


Chart 24: represents that what kind of facilities with medical equipments and medicines our respondents wish to have in the clinic. Wish for the facility of contraceptive counseling, Delivery service, injury management and minor diseases is high. Also gynecological service & dental care service is in demand but a little less probably due to lack of knowledge and shyness. Here other refers to immunization and special facility for child.

We are surprised to see high demand on delivery facility even though they experienced very less complicated pregnancy and delivery. It might be because they think it will be more hygienic and comfortable with special delivery bed. Amazingly even though there we couldnôt find any gynecological problem as shown in chart 12, some want this facility. This is a discrepancy but this seems to prove that there really are gynecological problem which were not revealed in health survey. Injuries are quite common so the wish for facility to treat injury is of course high. According to chart 8 they didnôt seem to know properly about dentist but still they are demanding this facility. It came up during the question of chart8 and we explained them about what dentist is so when coming to this question they knew. And definitely there is a need for extraction of the tooth for toothache. High demand on family planning service represents that they want good counseling so that they can control their family size. We had a problem defining what is most important diseases, so we were asking the question about those diseases which need hospitalization and intensive care. Therefore the wish for those facilities seems unrealistic in the clinic.

It is obvious that they want everything as far as possible. But what matters is what they can demand with themselves for their health. It is another problem that how they will utilize the services without knowing itôs importance. We found that people lack even very minor health awareness including personal hygiene, balance diet and regular health checkups. So itôs necessary that we have to make them feel that they must have health facility, and they should be concern about their health.

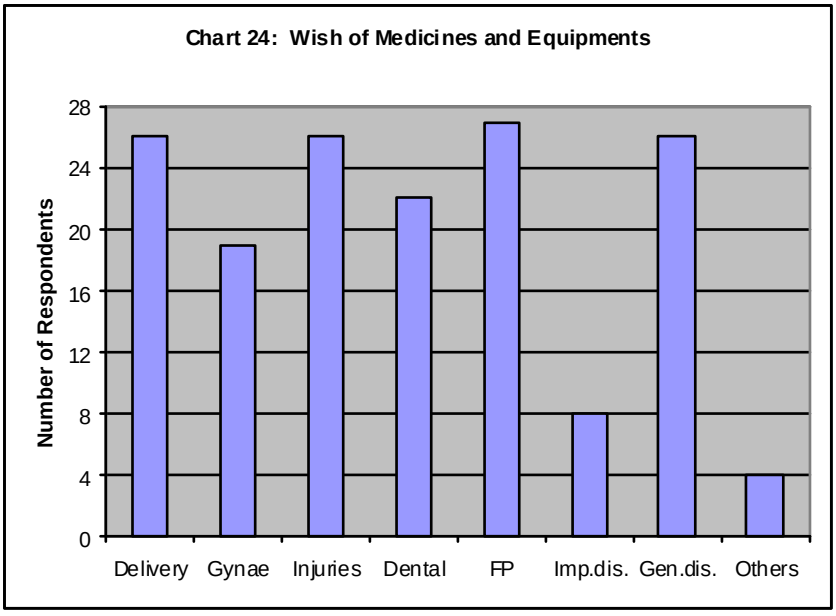


Chart 25: represents that how the villagers can keep up-to-date maintenance of the clinic. Most of the household replied that they wish for a peon on salary, as he/she will be more regular because there will be a demand when salary is given. Few wanted to maintain and repair the Clinic through shifting volunteer among the villagers and fewer thinks that it is good to have one volunteer regularly because they could save the money but the rest claimed that they will not be reliable without salary. One person replied an other idea about management but we didnôt have any comment on this.

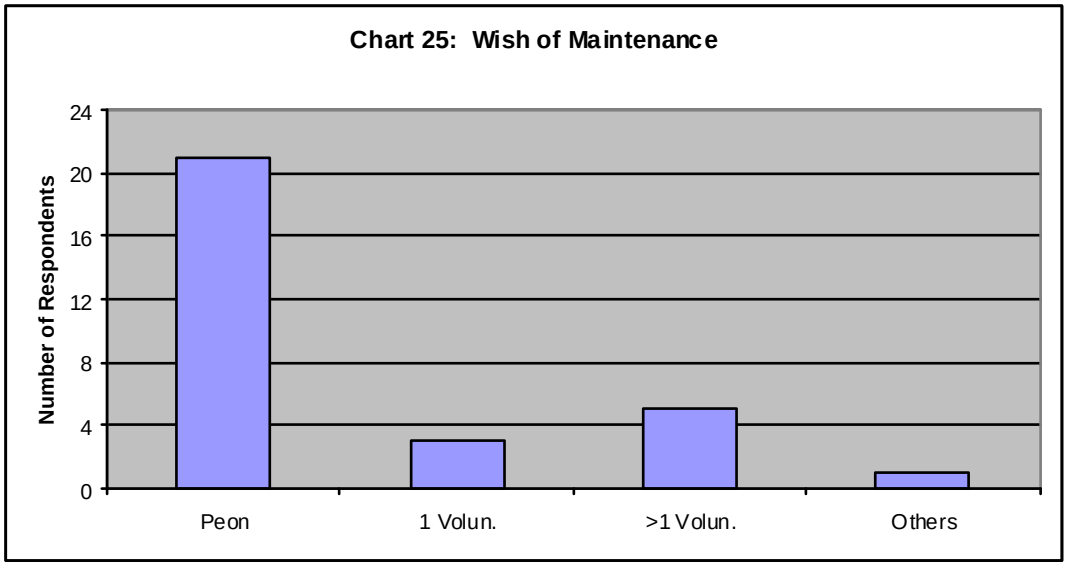


Chart 26: represents what the respondents expects will be the number of visits to the Clinic from their household in a year. We got very different answers because no one in the village have had regular health checkup and most of them just replied us that òwe visit anytime we get sick and we donôt know how many time we get sick in a yearòso this data shows just an random idea of the people. Itôs a real difficult job to estimate how many time one can get sick in a year and also depend on the family size. Bigger the size of the family more will be the visit in clinic as per our imagination. In our calculation on the basis of this data average visits will be 2 in a day. Which we think is quite reqlistic in comaprision to the population size in Chhiringkharka. But of course they should imagine about an expensive permanent staff with mere 2 cases a day.

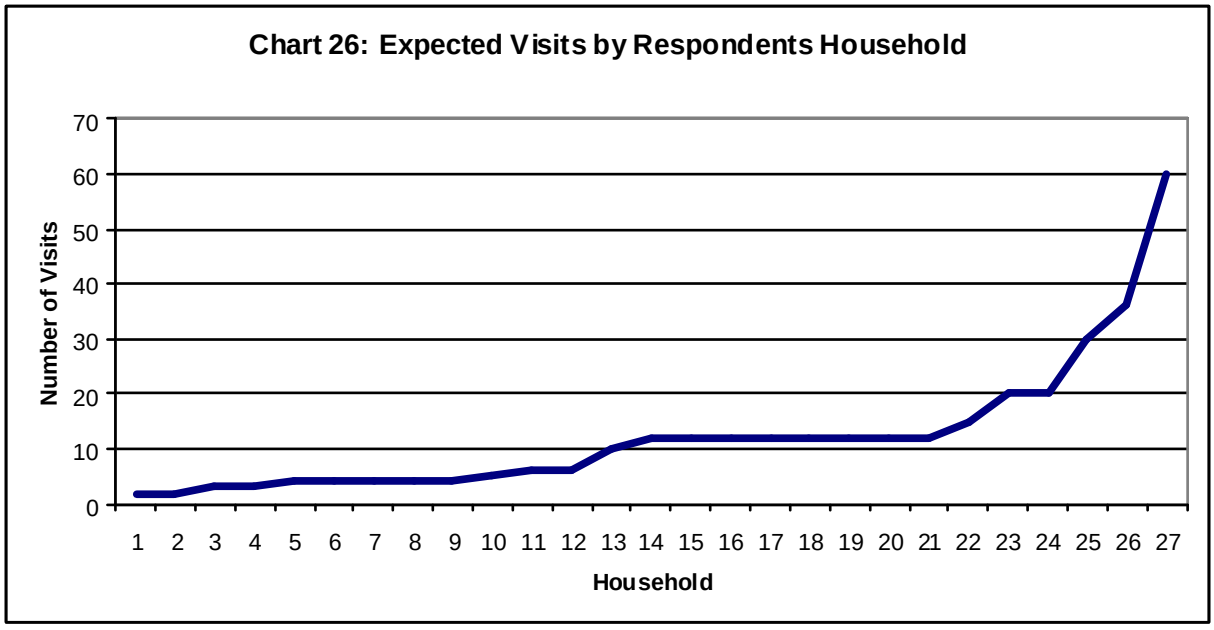


Chart 27: represents what the respondents expects the annual expenses to be to run the Emergency Clinic. All the respondents were not the perfect estimators because they had never thought about this kind of thing before. If this clinic should have any capacity in my personal view it will be quite unrealistic to run such a clinic for less than 100.000 Rs. Even if there should be just a few basic trained personnel like ANM it will probably be more than 200.000 Rs, and if we should meet all the wishes of the respondents it will probably be even more.
So the replies, which we received, represents in our view that some of the people have unrealistic views on the expenses to run a clinic. So this is just what stroked in there mined all of sudden, their best bid. As the average bid is around 100.000 Rs it will still be realistic to run an emergency clinic in this amount as long as they donât put their wishes too high.

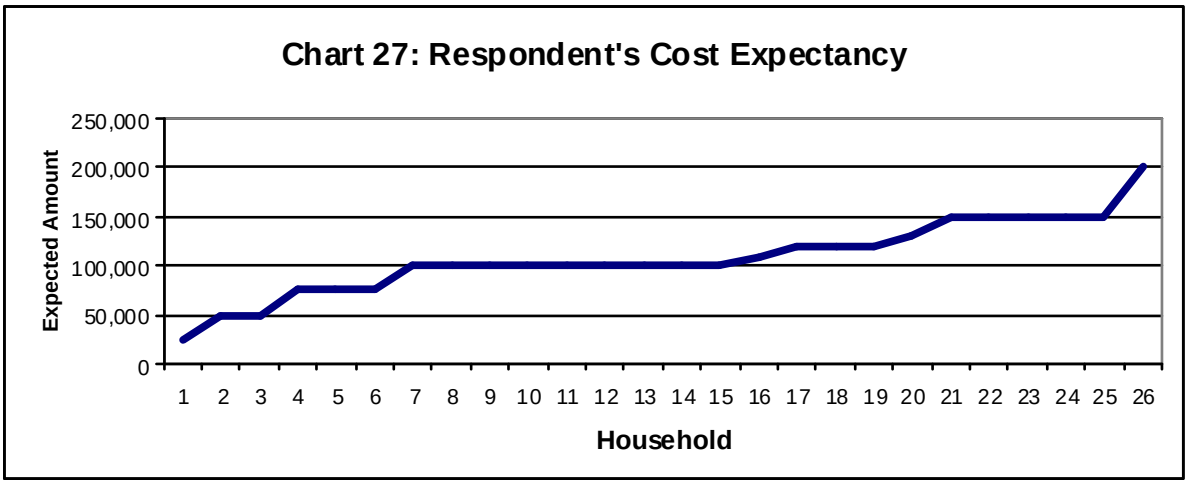


Chart 28: shows the respondents suggestion on sources of income to support the yearly running cost of the clinic. Most of people suggest that the income sources should be NGOs or DHO (district health office). Some also suggest the money to come from relatives and personal donations. Only 60% thinks that the payment for medicine can be a source of income. The 40% doesnât like the idea because DHO is providing free medicines for Health Posts so this should also be implemented here. There is a wide agreement on paying yearly fee from all inhabitants, some didnât reply this because they think that yearly fee should be only paid by those above 16 yrs of age. And even they think fine for late payment can be good source of income. One suggested that for the income they can form their own group and collect funds.

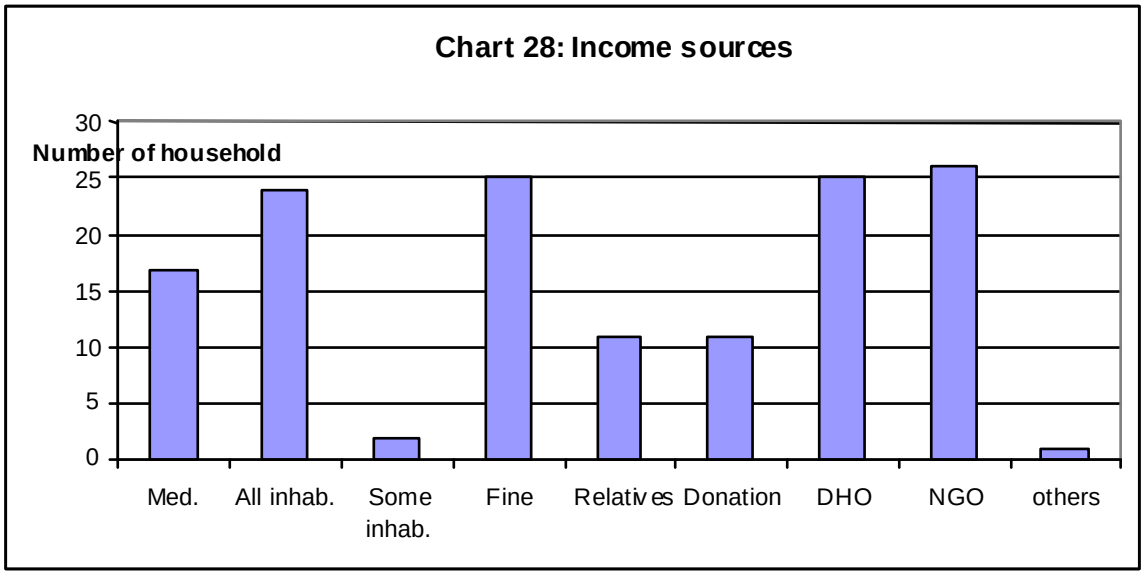


Chart 29: represents how the respondents suggests how the yearly fees of the clinic should be paid. 90% of the respondents want to pay yearly fee per household. 85% suggests that there should also be paid personal fee for persons above 16 years of age. Only 36% recommend this personal fee payment should be above 2yrs of age. 85% also suggest that not only permanently living persons but also temporarily living people should pay yearly fee. 75% is of the opinion that there should be progressive fee, which is different fee for rich, average and poor household.

While collecting this data we asked very simple and clear questions so answers we got are realistic. Its important to observe that there is general agreement that both household fee and personal fee should be paid from both permanent and temporary inhabitants. Its also impressive to see that there is general social commitment to take the economic condition of the family in view by paying progressive fee, although we must admit that there was social imbalance in this reply because more poor than rich are giving a positive respond to this issue.

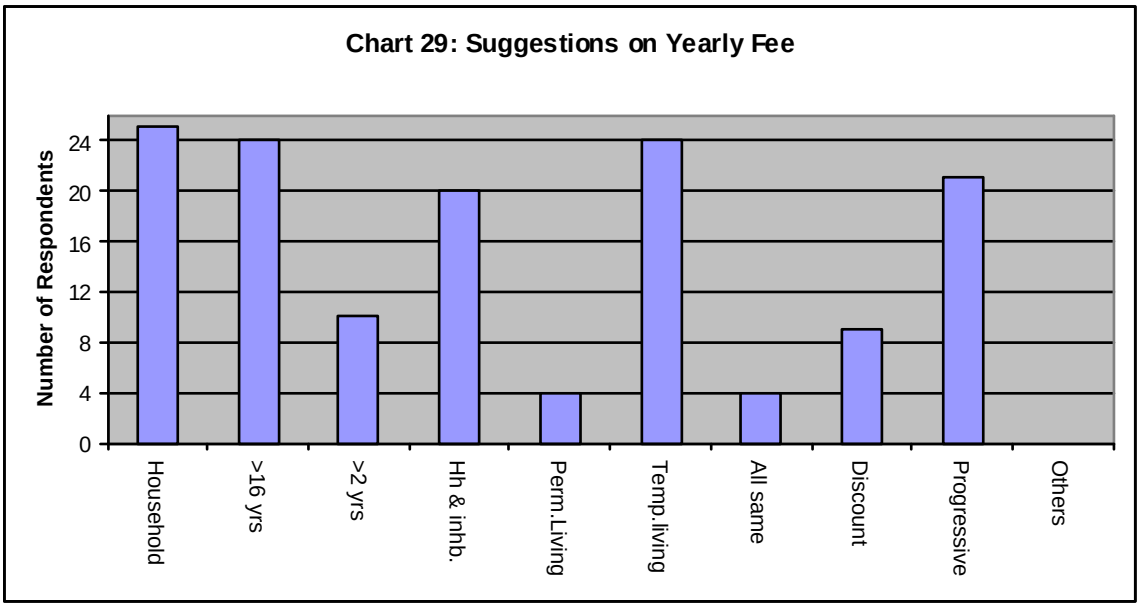


Chart 30: These two charts shows what is the suggestion of the respondents on the household fee and personal fee for rich, average and poor households. As we experienced that the respondents find it a good idea to have to have different fee for rich, average and poor households and persons so the service will be affordable and accessible for all. But it depends on their cooperation and seems they are cooperative. There didn't seem to have any tendency on being selfish on giving this suggestion. But the suggestions seem to be given from a genuine wish to make possible to run the facility and to give their support. But the big variation is rather a difference in knowledge about this kind of economy as they never had been involved in this kind of calculation before. So this answer shows that they really have a good social understanding in Chhiringkharka.

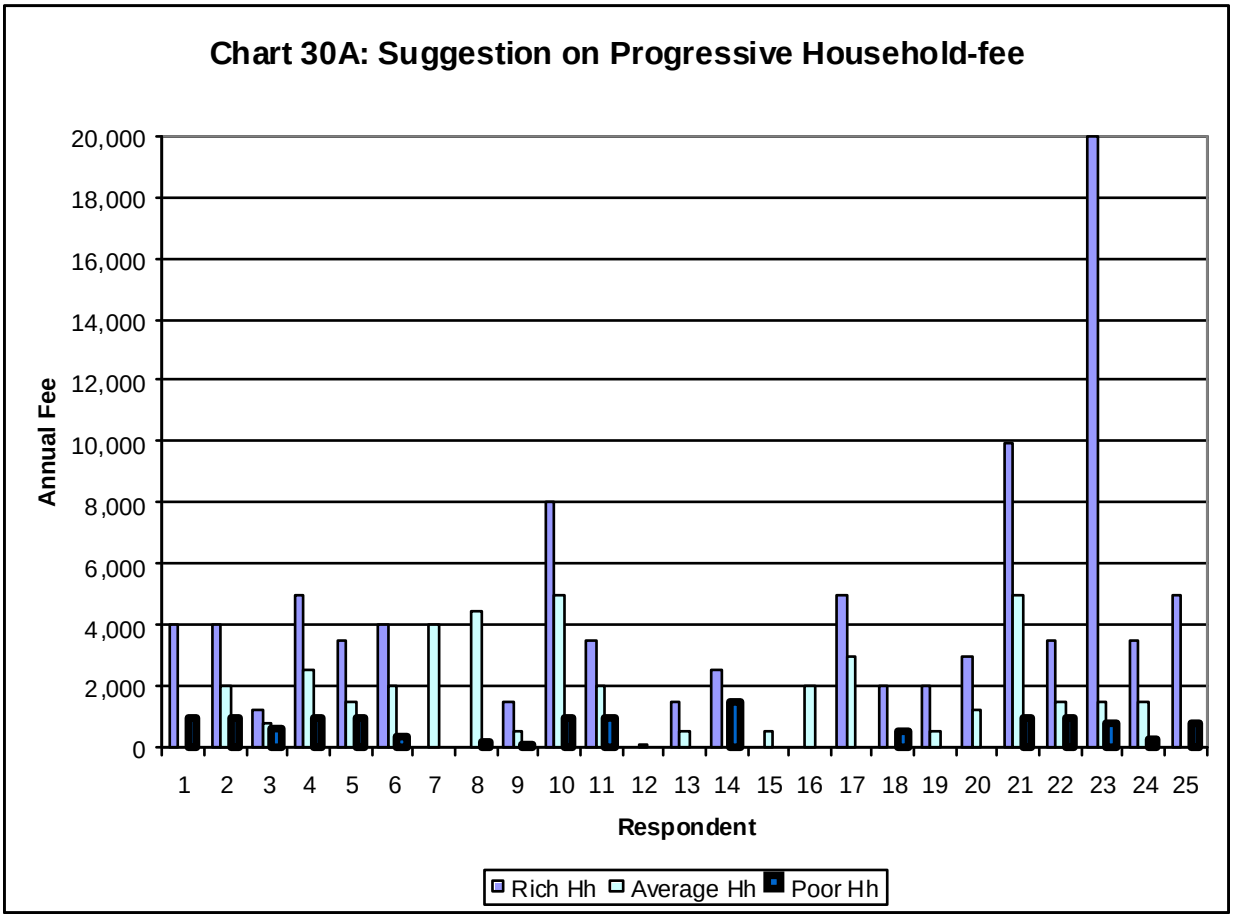


Chart 30A: Suggestion on Progressive Household-fee
Annual Fee
20,000
18,000
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Respondent
Rich Hh
Average Hh
Poor Hh

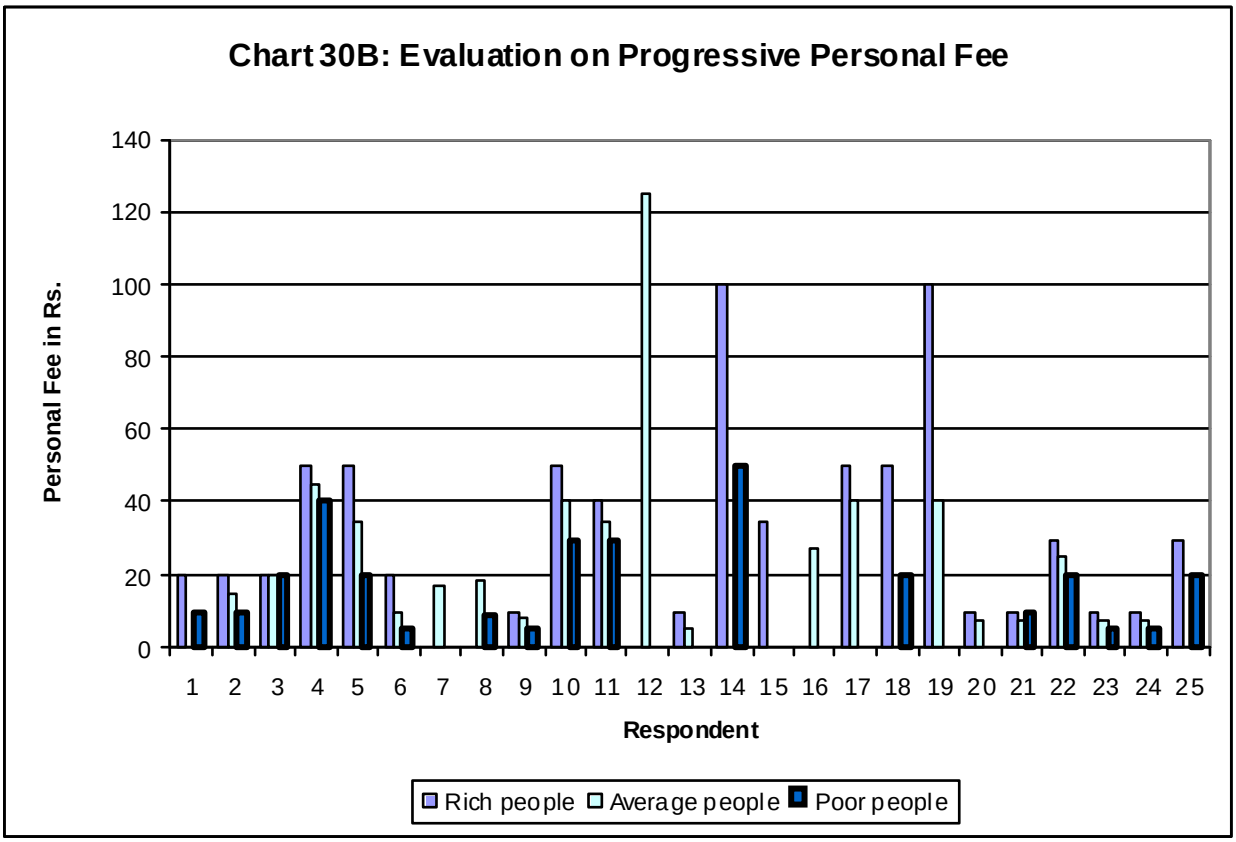
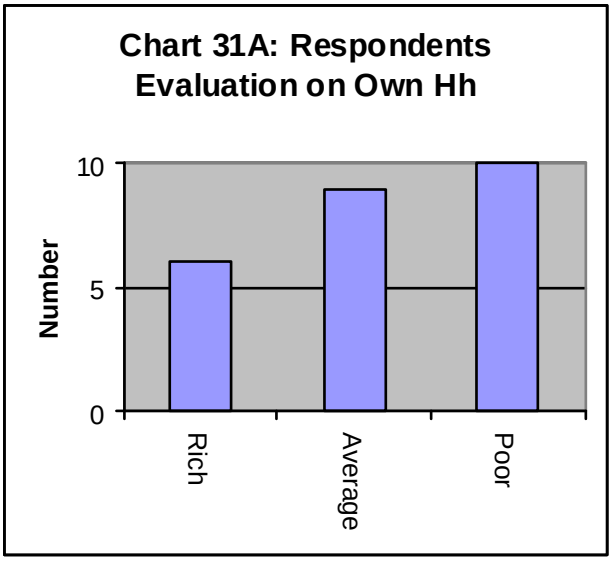


Chart 30B: Evaluation on Progressive Personal Fee
Personal Fee in Rs.
140
120
100
80
60
40
20
0
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25
Respondent
Rich people
Average people
Poor people

Chart 31: represents respondentsø evaluation on their own householdsø economic status, and 42B represents our calculation on the respondents from 5J with their estimates on all the household of the Chiringkharka. It is obvious to see that the general consideration show higher number of average households than poor and rich but when they estimate on their own household the majority of respondents consider poor households to be the most common. But this discrepancy is not that big.



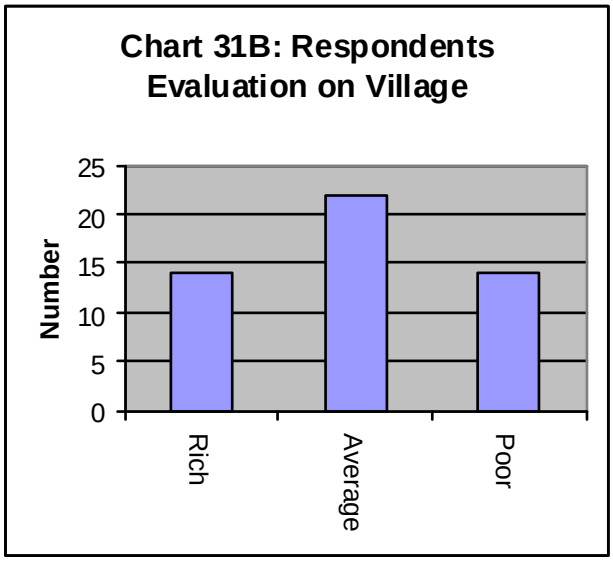
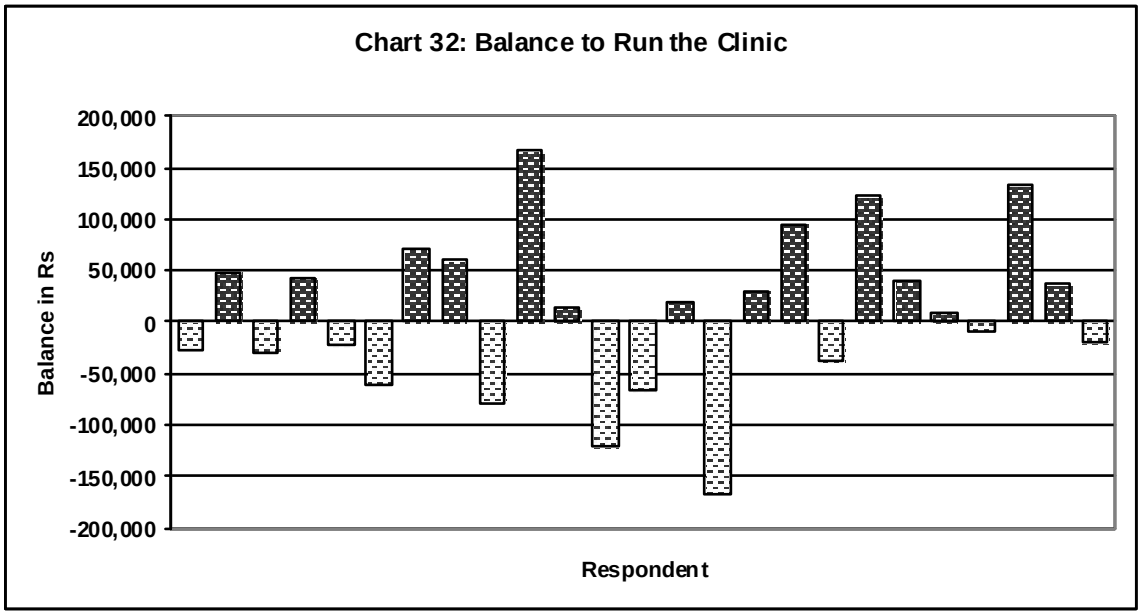


Chart 32: from the information we obtained in question 5F, 5H1, 5J3 and 5G we did a calculation on the most important of the suggested incomes and withdraw the expected annual expense to calculate how far there will be a positive or negative balance in the estimates of the respondents.
Here we can see 50% of respondents are estimating for a positive balance and the rest for a negative. Even though that the respondents have no clear vision of the economy and in this kind of calculation still shows that their estimates are no so bad in general. If we had tried to do this survey one more time after the respondents could have had the time to reconsider the result could easily be much more in the favour of positive balance.
So as a conclusion we can say that respondents support is positive in economic point of view. It makes us to be positive toward the plan to construct an emergency clinic in Chhiringkharka.



Kinja Hospital

In Bakanje VDC among 9 wards Kinja is one of the ward, which got better facilities compared to other wards. There is a hospital in Kinja. It was established in 1995 by Himalayan Health & Environmental Service Solukhumbhu. As we are concerned with the overall Health of Bakanje VDC, we like to see the Kinja Hospital.
We went and observed the hospital, it looks good in the first glance but actually it is very poorly constructed and will not last for many years more. It is big enough to treat the patients of whole VDC. It contains

- Out Patient Department,
- Minor operation theatre
- Delivery room
- Examination room
- Mortuary room
- Doctorôs private room
- Kitchen
- Toilet
- Some medicines and equipments like tray, mattresses, dressing drums, gauze etc are left over here and there.
- All the wooden floor ceiling and pillars are rotten and pillar are supported with some stones (seems construction was very poor).

But shamefully there was no doctor in this hospital and all the rooms were not used properly it seems like they are misused. When we were there we met a peon (18 yrs boy)
According to him he will provide medicines and even injections (depo provera) in absence of doctor (he got no any health related training or education). We realize that this hospital fail to provide health service.
After getting this kind of impression we talked with some of the local people about the condition of hospital. According to the former chairman of hospital, construction part of hospital and staffing is funded by some foreign donor and District Health Office is responsible for the medicine supply. Hospital was functioning well 7years back and slowly the supply of medicines were cut off from District Hospital (they donôt know the reason) then without medicine Doctors could do nothing and they left the hospital.
According to some other villagers, committee is not able to make decisions because they donôt have authority to do so, but they donôt know who is responsible for that. Seems to be a lots of disputes between casts.
So it seems like hospital is running out of existence in between the conflict and confusion of villagers and committee.
But it is a real need to make this hospital work again because it can be a great contribution to the health of people in Bakanje VDC.

DISCUSSION

All of you whoever read this report you may have your own evaluation on this survey but here in this chapter I would like to draw some of my personal criticism on the overall survey we made. As every thing has their own good and bad aspects, this survey has its own strengths and limitations too. While talking about limitation and weak points of the survey I like to start it with the questionnaire we prepared. As it is our first health survey, we lack experience on developing questions so in some cases I found some of our questions were asking about scientific methods, which the population know nothing about. This will not lead to a good result. Some questions like ñhow many time do you think your household will visit the clinicòmade respondent puzzled because they have never had regular health check up and they cant say how many times they will fall sick in the years to come. Some of our questions are asking about the diseases which respondents are shy to answer. In spite of these small limitations I think our questionnaire are blameless to give a perfect result on general health and economic survey as per our need. Questions were simple, easy to understand and precise without needing long explanation; we prepared different and appropriate questions for health and economic survey. Which was easy to answer and easier to ask.

There is some lacking on respondents side also. The most important one is that most of them have never visited health center for their illness so many of them didnôt know what we were asking them about. It made us to report answers of the health problem on unrealistic diagnosis made by them. People donôt know the importance of healthy living so they donôt think health care is one of their needs. These are some very common problem, which we have faced during previous surveys too. But actually this is why we are doing this survey and in this respect even the negative answers can show us something about the awareness of the people. We can say they need health care and health awareness dramatically because we found the need there so it is a best place where a simple emergency clinic means a lot.

Finally surveyors have some limitations on their side, which include lack of experience. Two of us have completed staff nurse education but one has just started but anyhow we are all related to health sector and have at lease some extent of knowledge on health. In some cases surveyors misunderstood the questions and misguided the answers. In other cases people asked us to explain our question and those explanations must have been quite different depending on the surveyors and the situations. I am regretful that due to my health condition where I fell ill in Chhiringkharka we had to conclude the survey before we were supposes to conclude it. Therefore due to this situation our survey is done only in two third of Bakanje VDC. I apologize for the inconvenient.

At last for my personal impression, our main target to get the real reality of the population of Bakanje VDC was more or less affected due to above listed limitations. The result we got from survey were unrealistic in some cases, so this is the fact that we do have some very weak parts too but this result is the best extracted from our overall survey. It is my impression that we are reaching 80% near to the real reality.

The main objective of this survey was to know some details of the general health and economic condition of the people in Bakanje VDC with a view to provide them with an emergency clinic. So I am quite satisfied with the survey and I can say that this was a successful survey and I hope you do too.

CONCLUSION

Nepal remains among the poorest and least developed countries, ranking 142 out of 177 countries. Poverty is severe and widespread in many rural areas with significant disparities between groups and regions. Nepal has some of the poorest reproductive health indicators in the world, and Bakanje VDC is definitely not one of those with higher indicators. The population in Bakanje have large family size, less access to health facilities and education about health.

Our survey says that the population of Bakanje VDC is strong and healthy in broad prospective as they are living under natural condition. But itôs obvious that they have high fertility rate, child mortality rate, many accidents and injuries from their daily work, less awareness about dental health, high frequency of intestinal parasites, very few complicated pregnancies and deliveries. Vaccination programs are followed, most families are using contraceptives, most of their foods are self produced, there are very few cultural restriction on food and finally many people use and believe in traditional medicinal method.

The economic survey in Chhiringkharka did show that they have high expectation of permanent and well educated health staff, fixture equipments, medicines and equipment for treatment. But on the other hand the cost for running the facilities which they expect is not full realistic. The discrepancy between high expectancy on facilities and low cost is something that population of Chhiringkharka has to deal with if they want to run such a health facility in sustainable way. In average, expected visit to the clinic is around 2 visits per day which definitely canôt take much time of permanent staff. They suggested payment of services which result in less than Rs10.000 for income which means that most income has to come from other means. But their idea about accepting a yearly household fee and personal fee and even letting this to be a progressive fee is giving a realistic hope that they can obtain the goal to run an emergency clinic.

Our recommendation for the population of Chhiringkharka is that they shall consider more about the economy. They should consider in which extent they shall seek approval from DHO to have support from central health office. And they shall consider how to have staff in their emergency clinic who can support their need. As a highly educated staff is not probably achievable they shall consider how can they train and educate their own population so at least some of their hopes can be fulfill in economically sustainable way.

But someone has to take a first step toward development. And the people of Chhiringkharka did that when they approach Himalayan Project to support them in starting up a health facility. So finally what I can say on the basis of our this survey is that what they really need is some hands to help them to achieve their goal, some good heart to make them realize their own potentialities and richness of the nature so after some years we can see people with small family size happy and healthy.

Sonam Doka Sherpa
Kathmandu on 26th nov 2008.

ANNEXES:

Nepalese Health Staff Acronyms, Titles & Descriptions

FCHV - Female Community Health Volunteer - Grassroots government health volunteers based in their respective wards (9 wards make one village (Village Development Committee VDC). FCHVs are selected by the mothers group of their ward. They are the responsible person to deliver health messages to the mothers group once a month and they also distribute pills, condoms, polio drops, oral rehydration salts and vitamin A. Government provides training to update their knowledge on basic health messages.

TBA - Traditional Birth Attendant - During the post partum period TBAs give care to the mother and baby, such as oil massage to mother and baby, bathing the baby, and washing the clothes of mother and baby. Family members give the TBAs some money and clothes for performing this job. In the past TBAs have been widely trained in maternal care but the indicator improvement rates were not high, due to a range of reasons surrounding their position in society.

VHW - Village Health Worker - VHWs are the lowest level of government employee in the health system. They are mobile. Their main job is to give immunizations to under-five children in the villages. They distribute pills, condoms, and refer clients for other methods of Family Planning. They also provide some health education in the village.Together with MCHWs they also conduct outreach clinic in their villages. They supervise FCHVs and help them to perform their job as per the needs.

AHW - Auxiliary Health Worker - AHWs are trained for one year after secondary school. They are the Sub-Health Post In-charge. They are responsible for MCHWs, VHWs and Peons in the Sub-Health Post. Main job is to examine patients at the Sub-Health Post and refer them to further help if needed. Reports to the Health Post In-charge.

HA - Health Assistant ï Has are based in the health posts. They are the Health Post In-charge. They hold a Certificate in General Medicine (3 years training). They perform curative and prevention roles and are the recognized prescribe at the health post level.They are responsible to supervise the Health Post staff and to supervise Sub-Health Posts in their area. HAs report to the District Public Health Officer (DPHO) at district level.

MCHW - Maternal & Child Health Worker ï MCHWs are mainly local woman of the VDC. She is based in the Sub-Health Post to provide maternal and child health services. She is trained for three months after the 8th or 10th grade of schooling. She conducts antenatal clinics, provides TT immunization, nutrition education, conducts normal deliveries, recognizes danger signs and refers the woman for appropriate care. She also counsels couples regarding Family Planning (Pills, Condom, Depo).

ANM - Auxiliary Nurse Midwife ï ANMs are based at Health Posts to conduct maternal and child heath care services. She is trained for 18 months after the 10th grade of school. Like an MCHW, her main job is to conduct antenatal clinics, provide TT immunization, nutrition education, conduct normal deliveries, recognize danger signs and refer the woman for appropriate care. She also conducts post natal clinics to provide immunization services for children. She counsels couples and provides Family Planning services (Pills, Condom, Depo, IUD, Norplant). She is also responsible to supervise MCHW.

Constitution of the Chhiring Kharka Community Emergency Clinic
17th November, 2008

1 Name and Logo of Organization

1.1 The Name of This Organization will be ñChhiring Kharka Sub Health Postò(CSHP)

1.2 The Logo will be in circular having symbol of health post in middle, name and Est. date in around.

2 Objectives And Policies

2.1 To provide the local people of first aid treatment

2.2 To make health facility accessible to the local people

2.3 To make local people aware of the common diseases

2.4 To give an education of the sanitation and food to the local people

2.5 To make general people conscious about increasing of pollution in the village and it affect to the human health

2.6 To avoid the conservative thinking of the local people about the health treatment

2.7 To make national health program available in Chhiring Kharka

3 Service coverage area

All the village of Bakanje VDC ward no 1 & 2 (Patale Village, Chhiring Kharka Village, Lole Village)

4 Methodology

4.1 The youths of the village who live in village permanently will be given basic health training.

4.2 They shall be performing a health duty in the ñCSHPò in turn wise as a health worker

4.3 They will be given the refresh course training in time to time

4.4 At least one health worker shall in any time be ready to give the service for the patient

5 Management committee

5.1 Management committee of CSHP shall be formed to run the sub-health post proper way. Committee will be formed in following way:

5.2 Member of each household from Bakanje VDC, ward 1& 2 will be the general member of CSHP and General member shall elect the 9 member comprise ñCSHPò Management Committee by majority.

5.3 Following will be the management committee:

- Chairman 1
- Vice-Chairman 1
- Secretary 1
- Treasure 1
- Members 5

5.4 The tenure of the above of Committee will be for 2years.

5.5 Sub committee can be formed if necessary

6. Committee Meeting

6.1. The Committee Meeting shall be held once every two months and it can be any time if needed.

6.2. The time of next meeting will be as per decision of previous meeting.

6.3. The Sub committee meeting will be directed by Board committee as per requirement.

6.4. The place for sub-committee meeting will decided by Board Committee.

6.5. The Committeeôs decision will made by Majority.

7. General Assembly

7.1. General Assembly shall be held in once a year.

7.2. The member of General Assembly will be 1 member of each house of Bakanji VDC-ward1& 2 .

8 Responsibilities & Authorities of Committee

8 Duties, Responsibilities &Authorities of chairman

- Chairman will Directed the meeting.
- Commanding & Leading the Committee.
- Caring the all assets of Committee. (Movable & Non-movable)
- Give final decision in the committee.

- Bank account operation.
- Sub-committee formation.
- To monitoring & coordinating the activities of Board & sub-committee&put in action.

9 Duties &Responsibilities of Vice-chairman

- In absence of chairman, Vice-chairman should handle whole duties.
- Vice-chairman could have all authorities of chairman while on duty.

10 Duties & Responsibilities of secretary

- To call members in meeting in direction of chairman.
- To minute the decision & Generalized it.
- To put decision in action
- To manage office & official work in proper way.

11 Duties & Responsibilities of treasurer

- Keep clear Account of income & expenditure
- Always be active to generate source of income.
- Let to do Auditing of income & expenditure socially.
- Plan to generate necessary income for the next year.
- To present the clear statement of account of income & expenditure in annual meeting.

12 Duties & Responsibilities of General Member

- To put own responsibilities report in meeting
- To follow the decision and direction given by the Managing committee
- To give suggestion to the Managing committee and put comment on its action
- To follow the duties & responsibilities commanded by Chairman and Committee.

13 Income of CSHP

- Membership fee
- Amount received from Ticket & Medicine
- Donation of any Firm or Person with their own wish.
- Donation or any kind of help by Government.
- Donation, Help or Liabilities by International Organizations or Person.

14 Bank Account Operation

14.1 The Chhiring Kharka Sub Health Post will open its own saving account in Branch of Rastriya Banajya Bank in Sallery.

14.2 The collected amount in organization shall be saved in its bank account and operate the account with combine signatures of among of three and Treasurerôs signature is compulsory. In Bank there will

- One Fixed Account
- One Current Account.

15 Proper Management & Running of Account

15.1 There will be two kind of account

I) Petty Cash Account
II) Foundation Account

Petty cash money will be saved in current bank account and foundation money will be saved under fixed bank account

15.2 Each member of the CSHP shall pay Rs.50 per month which will be saved in petty Cash Account.

15.3 Amount receives from Ticket & Medicine shall be collected in Foundation Account.

15.4 VDC & District health office will be requested for the workers salary & medicine

15.5 Some youth of the village shall take Health training recently and shall serve to the patient as a volunteer but some incentive shall be provided through petty cash.

15.6 Petty cash will expense for the medical expenditure and workers salary until VDC or District health office support CSHP.

NAMELIST

1.Ad-hog Committee of Chhiringkharka First aid Care post

1.	Sarki Sherpa	Chairman
2.	Pemba Rinji	Vice ï Chairman
3.	Nima Chhewang	Secretary
4.	Pasang gyalzen Sherpa	Treasurer
5.	Tenji Doma Sherpa	Member
6.	Suk Bir Thami	Member
7.	Mingma Chhiri Sherpa	Member
8.	Phuti Lama	Member
9.	Tenji Sherpa	Member
10.	Diku Sherpa	Member
11.	Dolma Sherpa	Member

2.Interested candidate for basic health training program

	Name	Age	Sex	Status	Qualification
1.	Diku Sherpa	43	Female	Married	-
2.	Chhemi Sherpa	19	Female	Unmarried	10 class passed
3.	Kandu Lama	18	Female	Unmarried	7 class passed
4.	Nima Yangji Sherpa	21	Female	Unmarried	5 class passed
5.	Dolma Sherpa	43	Female	Married	S.L.C passed
6.	Samde Sherpa	33	Male	Married	
7.	Kanchhi Thami	35	Female	Married	
8.	Tenji Sherpa	unknown		unknown	

3.Volunteers of the up coming Chhiringkharka health camp

1. Tenji Doma
2. Ang Doma Sherpa
3. Fur Diki Sherpa

4.Project responsible:

Chhirring Kharka Health Committee
Chairman Ngima Chhewang Sherpa, Chhirring Kharka, Bakanje Ward 2, Solu-khumbu
00977-9741 147869

Himalayan Project Nepal (HIPRON)
Manager Namgyal Jangbu Sherpa, Neel Saraswati Marga, Lazimpat-2, G.P.O.Box 8974 E.P.C.168, Kathmandu, Nepal
00977- 1-6914163 / 00977-9841344690
hipron@wlink.com.np

Himalayan Project Danmark
Chairman Kurt Lomborg, Kjeldbjergvej 34, DK-7800 Skive, 0045 97 54 53 08
klomborg@post11.tele.dk

Doctor Per Steinoe, Kielgastvej 36, DK-7800 Skive, 0045 97 56 40 05
apst@ringamt.dk

Thorbjørn Ydegaard, Fjordvej 4, DK-6200 Aabenraa
tyd@ucsyd.dk

5.Name list of Donors

PONA Foundation, Ulla Laier, Elmosevej 40, DK-8330 Beder
ulla_laier@msn.com

Dental Doctor Benny Frømann Nielsen, Skovbakken 29, DK-7800 Skive
dentist@nielsen.mail.dk

Veterinary Doctor John Dee and Anne Sophie Urne, Livøvej 7, DK-8800 Viborg
jcd@centerdyreklinik.dk

Venø Menighedsforening, Venø, DK-7600 Struer

6.Survey Team

Sonam Doka Sherpa, G.P.O.Box 8974 E.P.C.168, Kathmandu, Nepal
00977-9841476553
sonam_339@hotmail.com

Uteen Sherpa, 00977-9803261849
allstars_teen@hotmail.com

Sumitra Tamang
Sumitra_nurse@hotmail.com

7. Supporter

Lucy and Toby Stavely
enquiries@firstspark.org
www.firstspark.org