

OVERVIEW: WHO WE HELPED

In early 2013, we endeavoured to survey villagers in Humla who had accessed health care via one of the recent ISIS-sponsored health camps carried out in upper Humla 2010-2012. Interviews were conducted by Catherine Sanders, ISIS Research Associate, with the assistance of Wangduk Lama, research assistant. Data were entered by Catherine, and the RM&E team in Montana, USA, and were analyzed by Catherine and Kimber. This report summarizes our findings (please see also the report 'Knowlegde, Attitudes and Practice; Humla Nepal Projects 2013). We surveyed 90% of the households in Kholshi and 77% of the households in Yalbang. People attended at least one of the ISIS camps from 68 of the 91 (74%) households surveyed in Kholshi and Yalbang (75% of surveyed households attended in Kholshi, and 74% of Yalbang households). Of those combined, 27 households (40%) had members that attended more than one camp. 108 health complaints were addressed at the camps. 33 households attended in Kholshi, 36 in Chauganphaya, 18 in Yalbang, and 3 in other locales.

With responses for 64 of the 91 camp-attending households in the sample, all but 2 attendees perceived that they had been treated by a doctor. 84% received medicine at the camp. 44% of attendees said their camp experience improved their health, while 40% perceived no difference, and 15% experienced only a slight or ephemeral improvement in overall health. 89% said they followed the doctor's instructions about the medicine, and only 5% admitted to sharing their medicine with others.

The adult male-female attendance ratio was 40/60 for the sample. This ratio may be slightly biased toward females because it was difficult to talk to any men from Yalbang due to travel schedules, and people often answered only about the illnesses with which they had first-hand experience. In Kholshi, where we interviewed males and females proportionally, 56% of attendees were women. Men have better access to distant and better health care because of culturally-sanctioned mobility, offering another reason why more women might avail themselves of nearby camp healthcare instead of other services. In Kholshi, 58% of women camp attendees made use of treatment services in their own and a neighbouring village as opposed to 44% of male attendees (the latter who, correspondingly, had slightly higher percentages of distant health service usage).

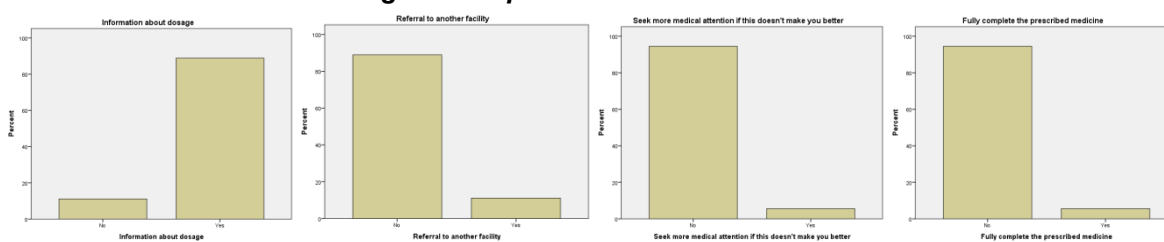
| Symptom experienced at Camp: | Frequency (households) | Valid Percent | Cumulative Percent |
|---|---------------------------|---------------|--------------------|
| (No camp attendance) | 23 | 25.8 | 25.8 |
| 1. Gastrointestinal illness | 20 | 22 | 34.8 |
| 2. Respiratory illness | 13 | 12 | 42.7 |
| 3. Chronic illness/pain (ragan/back pain/cancer) | 16 | 15 | 57.3 |
| 4. Female issues (pregnancy/bleeding/uterus) | 11 | 10 | 68.5 |
| 5. Eye infections/vision disabilities | 18 | 17 | 83.1 |
| 6. Injury/accident; minor skin/ear infection; headache | 19 | 18 | 93.3 |

| | | | |
|---|-----|-------|-------|
| 7. Other infectious disease (measles/DPT/flu/TB) | 4 | 4 | 95.5 |
| 8. Dental complications | 1 | 1 | 96.6 |
| 9. Epileptic fits | 1 | 1 | 97.8 |
| 10. Disability (deaf/blind/lame/stutter) | 2 | 2 | 98.9 |
| 11. Other (general check-uo) | 3 | 3 | 100.0 |
| Total | 106 | 100.0 | |

For the 66 camp-attending households for which we have data, 9 households attended the camps preventatively, often in addition to addressing a specific symptom or for an antenatal check-up. Interestingly, only 1 out of the 9 was a Kholi household.

Friends and radio adverts equally alerted people to the presence/timing of the camps.

What information did doctors give their patients?



Buddhist villagers were more likely to say that camp doctors had provided them with dosage information, while Hindu villagers said the doctors referred them to other facilities significantly more than Buddhist villagers.

Why didn't some villagers go to the camps?

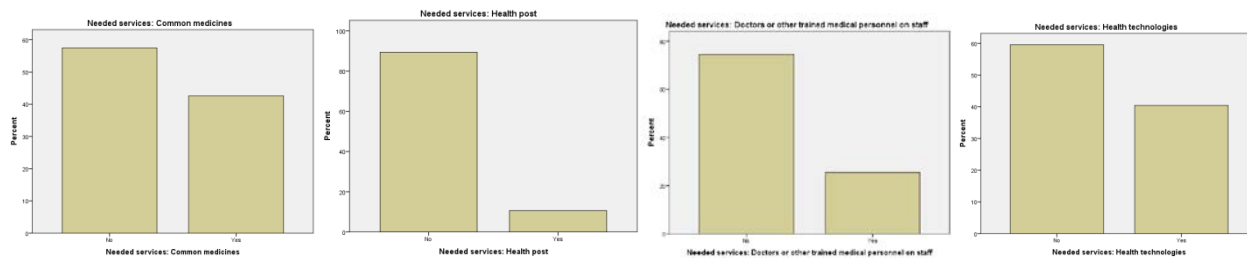
People did not go to the camp if they were not ill, if they had heard negative things about the efficacy of the camps, if they hadn't heard about the camps, or sadly, if they were too old or ill to get there.

FUTURE CHALLENGES

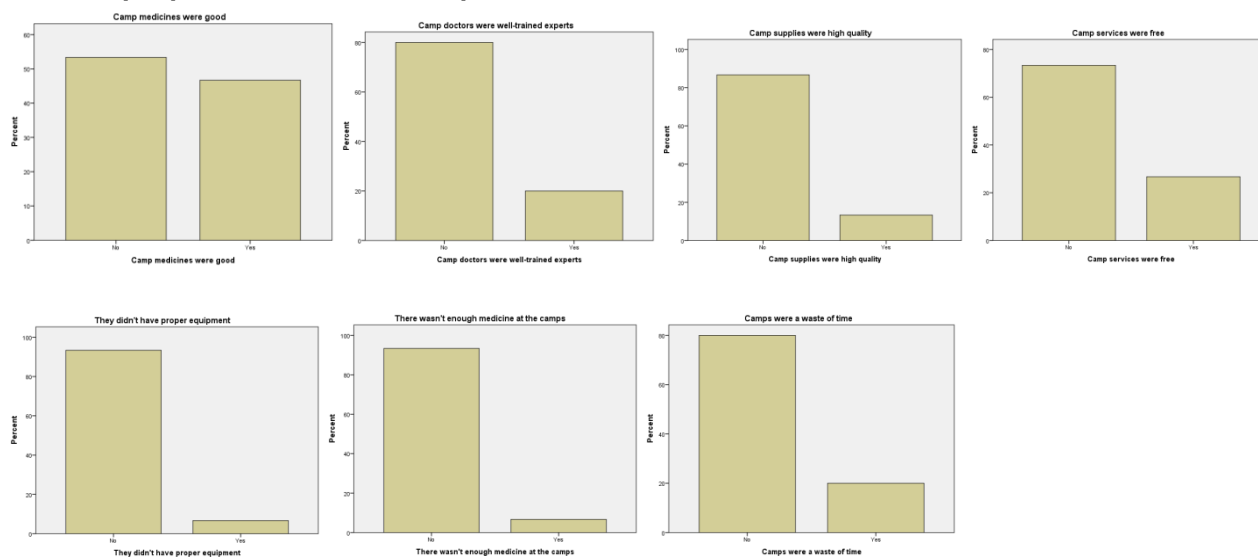
Our camps occur once a year, but many villagers wanted a more consistent medical presence in the villages. On average, villagers wanted the camps to occur every 2 weeks throughout the year. 62% of respondents agreed that the longer camp was preferable to the "more doctors" approach, affording the doctors more time to see patients and follow-up with them, as opposed to a "one-shot" deal in which the doctors may feel harried and lack continuity with villagers because of the schedule. 6% said they wanted more doctors *and* a longer camp experience. Many villagers felt that the doctors seemed rushed and they lacked due attention to their ailments.

In response to questions about other health services needed in the villages, 57% of respondents listed medicine as a priority. 51% said the villages needed year-round doctors. 12% listed various medical technologies.

Services needed at camps:



What did people hear about the camps?

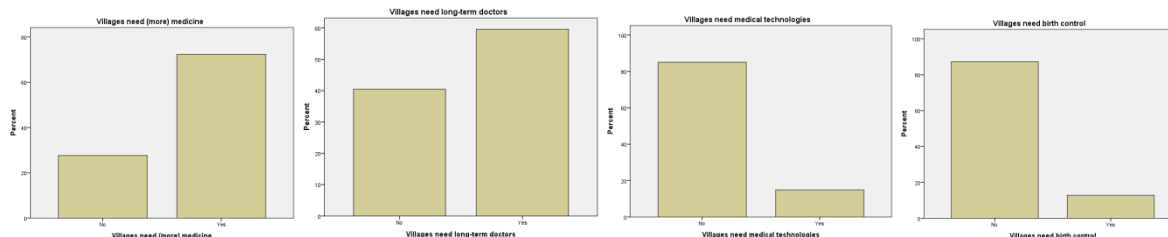


BASELINE HEALTH ISSUES

In our interviews, people reported that they eat on average 3 meals a day, and one of these 'meals' may be only a snack (*nasta*). They go to sleep hungry about once a week. In winter, they eat white rice almost once a day. When rice is more readily available, nearly 2 of their 3 meals consist of white rice. These reports reflect the low total caloric intake of this infamously food insecure area, as well as the poor nutritional quality of their diet (white rice is increasingly common in Humli diets and is considered by local people and nutritionists alike to be a low quality food – high prestige, in Humla, but not a food that gives people a lot of energy). White rice, especially unfortified, is a notoriously poor food. The quality of the rice distributed in Humla should be checked (thiamine and iron fortification are critical).

The wait period before seeking a first treatment was off the charts, at a mean of between 377-877 days, signalling some pretty serious gaps in health service access.

What medical services are needed in the villages?



Only Hindu villagers mentioned the need for birth control.

VILLAGE DIFFERENCES

Kholsi had higher fertility, with nearly 5 vs. nearly 4 births per woman, but not significantly ($p=.12$).

In Yalbang, all residents went to Yalbang camps, whereas 36 Kholsi villagers went to Chauganphaya camp (the previous year) vs. the 33 who attended Kholsi camp (also, 2 went to Lama Kholsi and 1 to Kermi).

Yalbang residents ate statistically significantly more times in a day than Kholsi villagers (3.3 vs 3). When people have white rice, Kholsi residents eat it significantly more times in a day than Yalbang residents (2 vs 1.6).

Kholsi villagers experienced different illnesses than Yalbang villagers for which they sought camp treatment ($p=.000$).

- Kholsi villagers sought treatment for more gastrointestinal, respiratory, chronic pain, and infectious diseases than Yalbang villagers, and Yalbang villagers sought treatment for more eye infections/vision problems ($p<.01$)

Yalbang's camp attendees were disproportionately female, while Kholsi's were equally divided between genders (see caveat above).

Treatments prior to the camp experience: Yalbang villagers travelled significantly farther to arrive at prior treatment locations. But Yalbang residents usually only did 1 previous treatment, while Kholsi residents partook of 2-3 (usually, trips to a local pharmacy or health post) before resorting to the camps.

Yalbang villagers tended to identify highly technological/expert services they needed, while Kholsi villagers listed more basic services like doctors (GPs) and common medicines.

Kholsi villagers tended to request that the camps come more often (29 vs 17x/year on average) than Yalbang villagers, but not significantly (high standard deviations $p=.56$). This might reflect a difference in how much time Dr. Kelsang spends in Yalbang, and the presence of the health post in Yalbang.

While the general opinion was that the camps should be longer with fewer doctors as opposed to shorter with more doctors, Kholsi villagers were more ambivalent about which camp model they preferred (2/3 wanted longer), whereas Yalbang villagers exclusively opted for the longer camp as opposed to more doctors.

QUALITATIVE RESPONSES

Villagers are concerned about the quality of the services due to long lines and time limitations. They also comment that the camp is not a long-term solution and does not allow for follow-up service or primary health care. Hindu and Buddhist villagers alike frequently cited these problems with the health camps, not just villages without access to health posts. However, this may mean that the health camp functions to serve critical needs before the health infrastructure can be brought up to speed. While many villagers appreciated the health camps (if that is all there is), there was a popular sense of their unsustainability, and, on the other hand, the need for a doctor who resides in the village and can follow up, check healthy as well as sick people, and help prevent as well as cure illnesses of all kinds. People of Dharapori, Chauganphaya, and Kholsi were the most negative about the camps and health situation, since they do not have ready access to a health post, but all villagers expressed a need for better healthcare. This is a critique, we believe, of health development in Humla more generally, and testament to the difficulties of accessing services.

We believe our efforts in terms of the camps, the health posts, and preventative care are addressing a variety of critical needs in the community. Humlis will further benefit from a long-term solution to their basic

health problems, through our continued investment in the hygiene, sanitation, and clean drinking water infrastructure. For future camps, we believe that the type of camp needs to be carefully chosen in concert with local medical personnel and the District Health Officer, with a preference for primary health care and perhaps eye camps. Our recommendation is that all camps should be followed by a dedicated follow-up camp, preferably within two months and with the same medical personnel.

APPENDIX 1: DESCRIPTIVE DATA

Descriptive Statistics: Scale Variables

| | N | Minimum | Maximum | Mean | Std. Deviation |
|---|----|---------|---------|---------|----------------|
| Age of male or female household head | 45 | 1 | 63 | 30.91 | 17.69 |
| Years married | 65 | 0 | 50 | 15.93 | 10.62 |
| Number of previous marriages or concurrent partners | 54 | 0 | 5 | 1.26 | .71 |
| Number of total births | 63 | 0 | 14 | 4.59 | 2.69 |
| Number of surviving children | 63 | 0 | 8 | 3.38 | 1.76 |
| Number of meals per day | 69 | 1.5 | 5.0 | 3.12 | .57 |
| In a week, how many days do they sleep hungry? | 58 | .0 | 7.0 | 1.34 | 1.67 |
| In a day, how often do they eat rice? (now/winter) | 76 | .0 | 4.0 | .74 | .96 |
| In a day, how often do they eat rice? (if they have on hand) | 40 | .00 | 4.00 | 1.88 | .97 |
| Was a camp check-up preventative? | 66 | .00 | 1.00 | .14 | .35 |
| 1 st camp illness: How many days did they wait before the first treatment? | 43 | 0 | 2190 | 491.00 | 700.26 |
| Average age of camp patient | 46 | 1 | 73 | 31.83 | 18.56 |
| Were they seen by a doctor?* | 64 | 0 | 1 | .98 | .13 |
| Did they receive medicine?* | 67 | 0 | 1 | .84 | .37 |
| Did they get better?* | 64 | 0 | 2 | .78 | .72 |
| 2 nd camp illness: How many days did they wait before the first treatment? | 12 | 5.00 | 1825.00 | 1096.42 | 791.46 |
| Were they seen by a doctor?* | 21 | 0 | 1 | .95 | .22 |
| Did they receive medicine?* | 19 | 0 | 1 | .89 | .32 |
| Did they get better?* | 20 | 0 | 2 | .65 | .67 |

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|--|----|----|-------|------|-------|
| In a year, how many times should there be a mobile medical camp? | 58 | .0 | 365.0 | 26.5 | 69.36 |
| Did they follow the instructions?* | 57 | 0 | 1 | .96 | .19 |
| Did they share the medicine with anyone else?* | 57 | 0 | 1 | .04 | .19 |

*For yes/no questions, 0 indicates a negative and 1 indicates a positive response

Descriptive Statistics: categorical variables

| Variable | Response | Frequency | Valid percent |
|-------------------------------|-----------------------|-----------|---------------|
| Patient's village | Kholsi | 68 | 41.7 |
| | Yalbang | 23 | 14.1 |
| | Total | 163 | 100.0 |
| Marital Status | Single, never married | 1 | 1.4 |
| | Monogamous | 70 | 98.6 |
| | Total | 71 | 100 |
| 1 st Camp attended | Kholsi | 18 | 28.57 |
| | Chauganphaya | 26 | 41.27 |
| | Kermi | 1 | 1.6 |
| | Yalbang | 18 | 28.57 |
| | Total | 63 | 100.0 |
| 2 nd Camp attended | Kholsi | 15 | 55.6 |
| | Lama Kholsi | 2 | 7.4 |
| | Chauganphaya | 10 | 37.0 |
| | Total | 27 | 100.0 |
| Camp illnesses | (see table above) | | |
| Treatment | Spiritual | 5 | 4.4 |
| | Pharmacy | 4 | 3.5 |
| | Clinic | 19 | 16.8 |
| | Camp | 65 | 57.5 |
| | Chinese medicine | 1 | .89 |
| | Hospital | 19 | 16.8 |
| Total | | 113 | 100.0 |

| | | | |
|--|--|-----|-------|
| Location of treatment | Kangalgaon | 7 | 5.26 |
| | Kholsi | 27 | 20.3 |
| | Chauganphaya | 29 | 21.8 |
| | Yalbang | 20 | 15.04 |
| | Syada | 12 | 9.02 |
| | Simikot | 30 | 22.56 |
| | Hilsa/Taklakot | 1 | .75 |
| | Nepalganj | 3 | 2.26 |
| | Kathmandu | 4 | 3.01 |
| | Total | 133 | |
| Gender of 1 st patient | Male | 11 | 42.3 |
| | Female | 13 | 50.0 |
| | Both | 2 | 7.7 |
| | Total | 26 | 100.0 |
| Gender of 2 nd patient | Male | 6 | 66.7 |
| | Female | 1 | 11.1 |
| | Both | 2 | 22.2 |
| | Total | 9 | 100.0 |
| Gender of 3 rd patient | Male | 1 | 33.3 |
| | Female | 2 | 66.7 |
| | Total | 3 | 100.0 |
| Camp services needed | Common medicines | 20 | 35.71 |
| | Permanent health post | 5 | 8.93 |
| | Permanent, expert medical personnel | 12 | 21.43 |
| | Health technologies | 19 | 33.93 |
| | Total | 56 | 100.0 |
| Source of camp info | Friends | 23 | 38.3 |
| | Radio | 23 | 38.3 |
| | Direct observation | 6 | 10.0 |
| | ISIS staff | 8 | 13.3 |
| | Total | 60 | 100.0 |
| What did people say about the camp? | Good medicine | 7 | 33.33 |

| | | | |
|--|------------------------------|-----------|--------------|
| | High quality camp supplies | 2 | 9.52 |
| | Expert doctors | 3 | 14.29 |
| | Free services | 4 | 19.05 |
| | Improper equipment | 1 | 4.76 |
| | Insufficient medicine | 1 | 4.76 |
| | Time waste | 3 | 14.29 |
| | Total | 21 | 100.0 |
| What did doctors instruct them? | Dosage/ how to take medicine | 51 | |
| | Referral | 6 | |
| | Follow up | 3 | |
| | Side effects | 0 | |
| Preferred camp model | Neither | 6 | 9.4 |
| | More doctors | 13 | 20.3 |
| | Longer camp | 39 | 60.9 |
| | Both | 6 | 9.4 |
| | Total | 64 | 100.0 |
| Medical services needed in the village | Medicine | 34 | |
| | Doctors | 28 | |
| | Technologies | 7 | |
| | Birth control | 6 | |

Average wait period prior to 1st treatment of camp illness*

| Quartiles | Frequency | Valid Percent |
|--------------------|-----------|---------------|
| 1-7 days | 11 | 25.6 |
| 1 week - 5 months | 11 | 25.6 |
| 6 months - 3 years | 13 | 30.2 |
| More than 3 years | 8 | 18.6 |
| Total | 43 | 100.0 |

*Differences in wait periods for varying genders and age groups were not statistically significant