

MARTINA STEGER

## Masterarbeit

zur Erlangung des akademischen Grades  
eines Master of Arts  
der Studienrichtung Global Studies  
an der Karl-Franzens-Universität Graz

Begutachter: O.Univ.-Prof. Dr.phil. Friedrich  
Zimmermann

Institut: Geographie und Raumforschung

Graz, November 2013

[Text eingeben]

*To the people of Pawai and Bakhachol.*

[Text eingeben]

## Preface

This paper is my master thesis for the conclusion of my master's degree program Global Studies at the Karl Franzens University of Graz. I really appreciate many people who helped me with the project. I firstly thank my supervisor O.Univ.-Prof. Dr.phil. Friedrich Zimmermann, who supported the whole project from its beginnings and shared his knowledge and experience with me. He gave me many useful instructions and many practical tips on scientific communication and how to implement a research project. I am also in gratitude for the support of Elisabeth Mackner, project coordinator at EcoHimal. She gave me a lot of trust and flexibility and without her, this project would never have come into existence. I would also like to thank Sangita Shakya and Narayan Dhakal from EcoHimal in Nepal. My gratitude goes as well to Birat Upreti, who accompanied me during the whole field trip and translated everything with great patience and empathy.

I also want to thank my family who supported me not only in a financial way, but also morally. They have always encouraged my free thinking and accompanied me through all the highs and lows on my way. In addition, I want to thank my friends in both Innsbruck and Bischofshofen, who motivated me in the way they can do best – just by being who they are.

[Text eingeben]

## Abstract

Poverty is not primary a socio-economic issue and must rather be seen as a multidimensional phenomenon, comprising health as one major issue. In Nepal, one of the poorest countries in Southern Asia, health plays an essential role, as access to health care is limited. This master thesis deals with the impacts of a participatory rural health development program implemented by the Austrian-Nepalese organization EcoHimal in the middle hills of Eastern Nepal. A qualitative research, based on the problem-oriented method of interviewing, has been applied for evaluation. This allowed a direct interpretation of the data generated through interviews and participating observation in the field. The analysis of data, backed by participating observations, indicated that the program was successful in consideration of the program objectives. However, the results suggested, that there is still scope for improvement, for example in terms of waste management. Furthermore my results openend a prospect on future chances and recommendations for similar programs in the field of rural development, involving cultural, political, institutional and local aspects.

Key words: Nepal, health care, rural development, evaluation

[Text eingeben]

## Content

Preface.....	2
Abstract.....	3
List of Acronyms.....	0
1. Introduction .....	1
2. Connecting the dots between a rural health development program and geography .....	5
2.1 Health and geography – some fundamental concepts.....	6
2.1.1 Defining “health” and “disease”.....	6
2.1.2 Defining geographical concepts.....	8
2.2 Health and Empowerment –conceptual explorations.....	9
2.2.1 The empowerment process model.....	9
2.2.2 Giving a sense of the landscape – definitions on empowerment.....	11
2.2.3 Empowerment – a healthy way to improve health?.....	13
3. The United Nations Millennium Development Goals.....	15
3.1 Importance of health in the millennium declaration .....	16
4. Nepal at a glance .....	21
4.1 Country Profile.....	21
4.1.1 Location.....	22
4.1.2 Population .....	24
4.1.3 The caste system .....	24
4.2 Health care in Nepal .....	25
4.2.1 Health policy and planning .....	25
4.2.2 Health status .....	29
4.2.3 Decentralization of health care services .....	30
4.3 Nepal’s progress in achieving the millennium development goals.....	31
4.4 Quantifying inequality – the Gini index.....	33
5. Program evaluation and methodology .....	34
5.1 Approaching the grassroots – the EcoHimal program document.....	34
5.1.1 Setting the scene – the target region.....	36

[Text eingeben]

5.2 Setting the scene for evaluation .....	37
5.3 Methodology .....	39
5.3.1 To do the talking – a qualitative research method.....	39
5.3.2 The problem-oriented interview .....	39
5.3.3 Guidelines for interviews .....	40
6. Results, performance & lessons learned .....	43
6.1 General aspects.....	43
6.2 Data evaluation.....	46
6.3 Mission accomplished? .....	57
6.4 Recommendations .....	61
References.....	64
Appendix A.....	70
Transcript of interviews .....	70
Figure 1: The empowerment process model.....	10
Figure 2: Distribution of causes of deaths in children under five in 2010.....	18
Figure 3: Births attended by skilled personnel. ....	20
Figure 4: Prevalence of HIV, TBC and Malaria in Nepal and worldwide.....	21
Figure 5: Highlands, Samdo, Gorkha district, 4460m above sea level .....	24
Figure 6: Pawai VDC, Solukhumbu district, 1800m above sea level.....	234
Figure 7: Distinct features of the Tenth Plan (PRSP .....	289
Figure 8: Key data on health care in Nepal .....	31
Figure 9: Nepal’s MDGs` progress status at a glance .....	33
Figure 10: District map of Nepal. ....	37
Figure 11: Assessment of interview.....	46

## List of Acronyms

CDC	Community development committee
CMA	Community medical assistant
DDC	District development committee
EHCS	Essential health care services
EHF	Emergency health fund
GHP	General health plan
HIV	Human immunodeficiency virus
ICIMOD	International centre for integrated mountain development
M & E	Monitoring and evaluation
MDGs	Millennium development goals
MOHP	Ministry of health and population
NHSP	Nepal health sector program implementation plan
NGO	Nongovernmental organization
RBMP	Roll back malaria program
RHDP	Rural health development program
PRSP	Poverty reduction strategy paper
PZI	Problemzentriertes Interview
SHP	Subhealth post
SLTHP	Second long-term health plan
TBC	Tuberculosis
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
VDC	Village development committee
WHO	World Health Organization

[Text eingeben]

*In a thousand ages of the Gods  
I could not tell thee of the glories of the Himalaya  
(Puranas)*

## 1. Introduction

### *The background and objective of the study*

This master thesis is a study on a rural health development program in the eastern hills of Nepal, including a theoretical approach to geographies and health. People belonging to the lower castes and ethnic minorities are more stricken by poverty than other population groups. This suggests an unfair distribution of resources among the various population groups of Nepal. Inequality has always been a breeding ground for social and political conflicts. The connection between political stability and poverty is omnipresent throughout the history of Nepal, and the country tends to be kind of an illustration of connecting the two (Rajbhandari, 2005). Before Nepal opened its borders to the world in the early 1950's, it was considered a "mysterious and forbidden" kingdom, shielded from the rest of the world by its scorching lowlands and frosty altitudes. Later in time, the foreign perception of the Himalayan state tended to be a peaceful and tolerant *Shangri-La*, a paradise for mountaineers and enthusiasts of cultural and religious treasures. In the late 1990's, the fairy tale romance came to an abrupt end when a Maoist guerilla war started (Donner, 2007). Since then the political situation has remained unstable. In May 1991, the first democratic elections were held and for the first time in years, the Nepalese population had the chance to opt between different parties. Soon after the elections, the newly established political elite was seen as corrupt as their predecessors. The people resorted to violence as an expression for their disaffection for the government can be seen as a symbol for the fail of a democratic system. The root causes for such disaffection and hence violent outbursts can be reduced to a lack of something, which is commonly known as the term *development* (Donner, 2007).

In Nepal, development has a long history. Development is not only since the various efforts of foreign aid organizations an omnipresent term. From 1962 until

[Text eingeben]

1990 Nepal was ruled by a system known *panchayat*, a variant of a party-less guided democracy. Initiated by king Mahendra the *panchayat* was geared towards an overall development of the country, regardless of ethnicity and caste affiliations. Under the pretext of nationalism and patriotism, political parties or any connatural organizations were forbidden. The fruits of development including increasing educational institutions, however, were refused to the general public and limited to the higher-castes, who have always been linked with a high literacy rate and academic privileges (Gellner, 2007).

In modern, developed societies, the ideal concept of development is commonly based on merit and accessible to everyone, regardless of any discriminatory criteria. Even though this ideal concept does not always agree with reality, the concept of inequality is not as present as in less developed countries like Nepal, where chances are not equal to everybody. Thus, it seems quite reasonable, that it is the socio-economic class system of Nepal, which causes an unequal distribution of wealth and income. Those affiliated to higher castes and ethnic groups are wealthier compared to their fellow citizens and hold prestigious positions, with a high level of political influence. Jobs with a high income are concentrated only within certain population groups, which intensifies the social stratification even more. All these aspects have led to an increasing gap between Nepal's different castes and ethnic groups, in terms of income, wealth distribution and as a consequence – health (Rajbhandari, 2005).

This is the point where I would like to revert to the actual topic of this thesis: evaluating a rural health development program in the eastern hills of Nepal. The topic of this thesis was not created by chance. It all started in 2012, when I was completing an internship at the Austrian office of EcoHimal in Salzburg. EcoHimal is an international nongovernmental organization heavily experienced in the field of rural development and operating from two offices, one in Salzburg and one in Kathmandu. During this internship, I had the chance to get in touch with rural development programs, each of them aiming at the same goal: improving the life of disadvantaged people –those who are left behind when it comes to the distribution of resources and wealth. A few months later, the vision of writing about one of EcoHimal's programs became concrete. A field trip to the program regions Pawai and Bakhachol VDCs in the districts of Solukhumbu and Khotang then resulted in a variety of data, used for evaluating the rural health development program implemented by EcoHimal in 2009.

[Text eingeben]

Bridging from inequality to health is not as farfetched as it might seem at first glance. A lot of the literature on health examines how health differs on a socio-economic level. The focus of many studies is on inequalities of health status and accessibility, or determining health by income and social status. Some researchers (e.g. Kwan, 2004, Wagle, 2010) agree that there is a correlation between health status and socioeconomic position. Income is thus often used as a basic indicator for measuring well-being, or health status. Pradhan (Pradhan et al; 2001), however, goes beyond the income related dimension of inequality and study how health varies across of other dimensions like geographic location – another key word important for this paper The geographic location of the program area of the rural health development program examined in this paper is of special interest is characterized by its extreme isolation. The communities of Pawai and Bakhachol VDC are situated in the Middle Hills of Nepal at an altitude of 945m to 2700m, scattered, isolated, and not accessible with motor operated vehicles. A heavy annual monsoon season limits the accessibility even more, as from June to September landslides are recurrent hazards, which may block trails for days or even weeks and cut off the villages from the outside world and, as a consequence, from health care accessibility.

Summing it up, the population of Pawai and Bakhachol faces all of the barriers, which can negatively affect the health status: low income, affiliation to low/middle castes, lack of education and political power and geographic isolation/lack of infrastructure. Like other developing countries around the world, Nepal is affected by a heavy divide between urban and rural areas, with the latter one clearly disadvantaged. How do the major international organizations react to these contrasts? In the year 2000 the United Nations established the Millennium Development Goals, eight measurable targets for reducing poverty and improving health and development in developing - or how the UN names it - industrializing countries. Three out of these eight goals are directly and explicitly found within the health sector: reduce child mortality, improve maternal health and reduce incidence of HIV/AIDS, malaria and other diseases (Gatrell & Elliott, 2009). Policy plans and strategy papers published by the World Health Organization define the necessity to reduce the differences in health status between countries and between socioeconomic groups within its population (WHO, 2007, WHO Country Office Nepal, 2012). This begs the fundamental questions what makes help efficient and sustainable. By evaluating the rural health care program in Pawai and Bakhachol, I tried to get one-step closer to the answer to this question.

[Text eingeben]

Sen (1979), a well-known economist and philosopher argues that poverty is inadequately captured by income or expenditure. He further states that poverty is the deprivation of basic capabilities, and a functional failure, and not only a low-income status (Sen, 1979). Bearing this in mind, I strongly agree that measuring the deprivation of capabilities, or simply poverty, indicators like health and literacy rate are more direct measures than just the level of income. No wonder, that also the Article 25 (1) of the Universal Declaration of Human Rights (United Nations, 1948) adopted by the UN's General Assembly in 1948 considers that poverty is not only an socioeconomic issue: *"Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."* Evaluating a program, which tries to bring people one-step closer to these rights, motivated me to choose this master thesis topic.

[Text eingeben]

## 2. Connecting the dots between a rural health development program and geography

Despite inventions of biomedical interventions like vaccines, inoculations and prevention programs, the world today is still affected by epidemic infections. Many illnesses comprise both enormous social loss and emerging social stigmas and prejudices. This leads to some questions like the question of inequality and accessibility of health care services as well as the question of social difference and how “health” and “illness” are defined (Del Casino, 2009). So when is social geography not about health? The daily strenuous efforts, which many people go through, are intimately connected with the question of “good” and “bad” health (Moss & Dyck, 2002). These patterns of healthiness are interconnected with a variety of socio-spatial developments, which conciliate or even regulate the accessibility of health care services. These developments, however, do include not only physical health but also mental and emotional health as well (Del Casino, 2009). As Kwan (2004) states, geographies of health are too much complex to be fully expounded by only one single perspective or only one single group of explanatory factors (i.e. individual attributes, environmental features, social relations, institutional processes and cultural systems). A process moving away from the separatistic thinking of analytical medical geography and social and cultural health geography would be helpful for enhancing our understanding of health in general. By implementing a rural health development program in the eastern hills of Nepal, an organization (in this case EcoHimal) strongly intervenes in the area of social geography and geographies of health. As particularly expressed in the program title, the program is strongly defined by its unique geographic location. Implementing a health care program in the rural areas of eastern Nepal requires a different approach than implementing such a program in an area characterized by excellent infrastructure and health care service accessibility. However, the requirements towards a health care program in rural areas are not only limited to geographic boundaries. A holistic approach considering a variety of explanatory factors like stated above (Kwan, 2004) is key component for a successful program.

The following section tries to address some approaches regarding social geographies and geographies of health relevant for the rural health development program under review.

[Text eingeben]

## 2.1 Health and geography – some fundamental concepts

This chapter deals with some concepts needed for a basic understanding of “health” and “geography”. After examining them separately, an attempt to reveal the connection between them is given.

### 2.1.1 Defining “health” and “disease”

Stressing the need for detailing meaningful definitions of health conditions is vital for any health related research. In the Bulletin of the World Health Organization Nay Awofeso, Professor at the School of Public Health and Community Medicine in Sydney, argues as following: *“Although concern with health and disease have been a major pre-occupation of humans since antiquity, the use of the word ‘health’ to describe human ‘well being’ is relatively recent”* (Awofeso, 2013). The word “health” originates from the old English word “hoelth”, which meant a state of being sound, and was generally used to deduce a soundness of the body (Dolfman, 1973). An often-cited definition of health is the one couched by the WHO more than 50 years ago: *“...a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity.”* (WHO, 1948). The WHO definition of health is criticised very often for being utopian, unrealistic and lacking flexibility. Moreover, involving the word “complete” makes it virtually impossible that any human being would be healthy for a decent period of time (Awofeso, 2013). Since the WHO definition of health came into force in 1948 demographic changes in population and in the nature of diseases emerged. In 1948, the main threats to health were acute diseases and terminal chronic diseases. Along with demographic changes, these disease patterns changed as well. Measuring public health by nutrition, hygiene and sanitation status and by more powerful healthcare interventions are recent accomplishments (British Medical Journal, 2011). For decades, the percentage of the population suffering from chronic diseases is increasing worldwide and aging with the burden of chronic illness has become standard. This and the fact that chronic diseases account for most of the expenditures of the healthcare system<sup>1</sup> make the WHO definition

---

<sup>1</sup> According to the Wirtschaftskammer Österreich, the treatments of chronic illnesses account for the major part of health expenditures in Austria. 25% of assured people cause 80% of health expenditures (Wirtschaftskammer Österreich, 2010).

[Text eingeben]

counterproductive as it declares people with chronic diseases and disabilities definitively ill (British Medical Journal, 2011).

Another crucial point is the measurement of the definition. Even if the WHO has developed several ways of classification of diseases and aspects of health, disability, functioning and quality of life, the definition of health remains impracticable because “complete” is not measurable. Although there have been various efforts for reformulating the definition of health like the *Ottawa Charter for Health Promotion* in 1986, which underlines social and personal resources as well as physical capacity, there have not been any changes in the definition yet (British Medical Journal, 2011). Nevertheless, the insufficiency of the current definition gains importance for health policies as the definition of health determines the outcome measures for prevention and healthcare programs (British Medical Journal, 2011). Apart from the WHO definition of health, there are various other generally accepted definitions. Bircher (2005) defines health as “...a *dynamic state of well-being characterized by a physical and mental potential, which satisfies the demands of life commensurate with age, culture, and personal responsibility*”. Bircher’s definition has consideration for changing health needs, especially in relation to age, culture and personal responsibility.

As an absence of health seems to be easier to conceive than the presence of health, it is more likely to investigate disease and illness. Like Gatrell and Elliott (2009) argue, it is generally more common to measure disease rather than illness, since a number of people affected by a particular disease can be observed whereas illness is a more subjective experience. The study of population or within a group of population is called *epidemiology*; under a geographical aspect, epidemiology is the study of how disease is distributed in geographical space. However, spatial verification is not only about the distribution of disease, but also about the approach to treatment. According to Gatrell and Elliott (2009), the traditional western model is a very sequence-specific one, which usually starts with a visit to a general health professional engaged in primary health care. Depending on the diagnosis, the patient might be referred to another, more specialized health professional, usually changing to stationary treatment (secondary sector) or even to the tertiary sector, which would be a complex surgery. In recent years however, a more holistic approach to medicine has reached the western world. Complementary (also alternative/traditional) medicine has become more popular and geographers start to examine how the usage of this complementary medical

[Text eingeben]

approach differs spatially. In Nepal, as well as in other non-western countries, traditional medicine is the norm. I experienced that people, especially in rural areas firstly address a local traditional healer before making use of primary health care. The holistic approach to health strongly promotes a connection between body and mind/soul and emphasizes on a balance between lifestyle and diet, use of herbal medicine and meditation (Gatrell & Elliott, 2009).

### 2.1.2 Defining geographical concepts

There might be places, which are either good or bad for health – and this is where health bridges to geography. By shortly investigating some geographical concepts in this paper, *location* is considered as a key word. Gatrell and Elliott (2009, p. 8) define location as a “*...fixed point or geographic area on the earth’s surface, somewhere that can be pinpointed by using a pair of locational coordinates.*” In terms of health or disease, the meaning of location certainly depends on what we are looking at – the world as a whole or at a specific spatially limited region. Places, which are disadvantaged in regards of accessibility to primary health care and health promoting resources, in general (as it is the case in the rural areas of Nepal) are not associated with a high health status. Gatrell and Elliott argue that there might be a huge discrepancy between one place, low in resources and its resource-rich neighbour, resulting in negative consequences for the first one. Affinity to places for them might be separation for those (Gatrell & Elliott, 2009). Cornwell (1984, p. 53) states that “*where there is belonging, there is also not belonging and where there is inclusion, there is also exclusion.*”

[Text eingeben]

## 2.2 Health and Empowerment –conceptual explorations

The rural health development program implemented by EcoHimal in Pawai and Bakhachol VDC has been strongly focused on empowerment by the means of participation. Empowerment of women, both on individual and collective basis, is a key issue of the program. For many years, empowerment has been regarded as a key concept in disciplines like critical and community psychology, multicultural and feminist counselling and the field of improving human lives. Social, political and material resources as well as inequalities in the environment are pointed out (Zimmerman, 2000). Empowerment conveys as a sense of personal control, which has been linked significantly to an improved health status (Bennett Cattaneo & Chapman, 2010). In addition to that, it provides a method for eliminating imbalances of power in the society (Freire, 2000). Bennett Cattaneo and Chapman (2010) argue that even though the term “empowerment” is frequently used and continuously gaining popularity, the construct is not well defined. A lack of precise definitions has made it receptive to a variety of applications, which as a consequence then exacerbated the lack of a precise definition. Bennett Cattaneo and Chapman (2010) further criticized that an attempt to measure empowerment and to employ the concept in the field of program development and evaluation showed that current understandings are difficult to apply.

### 2.2.1 The empowerment process model

Generally spoken the process of empowerment is about gaining power (Masterson & Owen, 2006). The term power itself has been investigated in many fields of academic research. From a scientific point of view, power is embedded in social interactions. These interactions are not limited to conflicts about dominance; they also involve a wide array of ways in which people exercise influence over others. Thus, an increase in power is an increase in one’s influence on social relations at any level of human interaction, from bilateral interactions to the interactions between an individual and a system (Bennett Cattaneo & Chapman, 2010). Based on this understanding of power Bennett Cattaneo and Chapman (2010, p. 647) define empowerment as an “...*iterative process in which a person who lacks power sets a personally meaningful goal oriented toward increasing power, takes action toward that goal, and observes and reflects on the impact of this action, drawing on his or her evolving self-efficacy, knowledge, and competence related to the*

[Text eingeben]

goal. Social context influences all six process components and the links among them.”

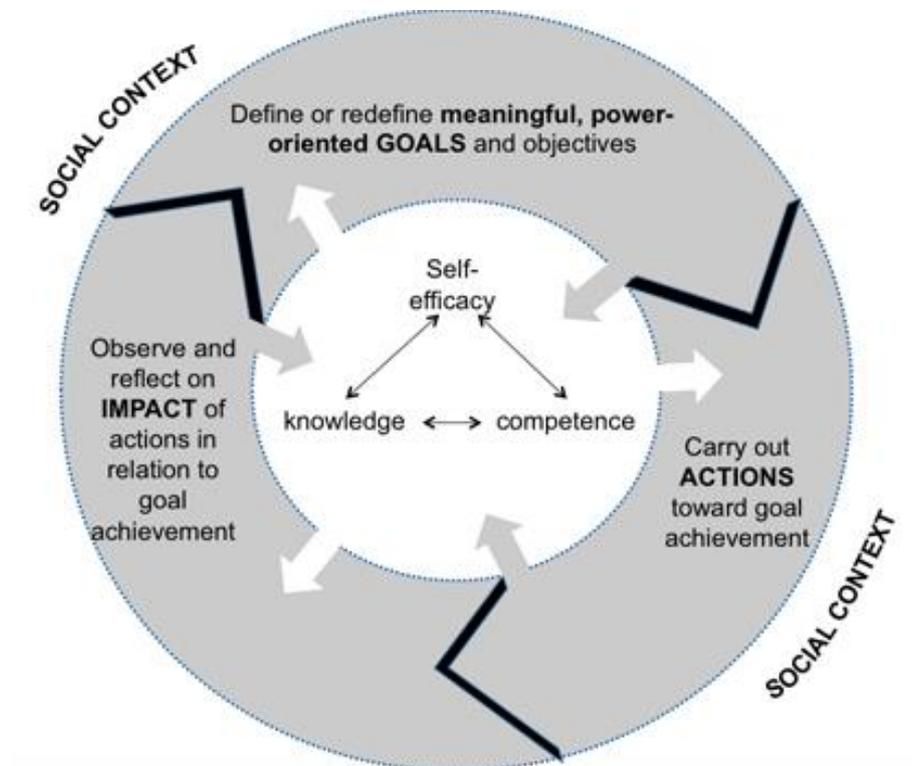


Figure 1: The empowerment process model. Source: Bennett Cattaneo & Chapman, 2010

As shown in figure 1, the process of empowerment is not a linear one, whereby repeating various process cycles is a common thing in regards to specific goals and connected objectives. Reevaluation is encouraged as experiences encourages reflection. According to Bennett Cattaneo and Chapman (2010) the process of empowerment is successful if a person gains personally meaningful power through his or her own efforts.

The empowerment process model delimits itself from other popular concepts (i.e. self-determination) in two ways. Primary, a subcategory of personally meaningful and power oriented goals is defined. Second, the empowerment process model focuses on changing a person’s social behaviour and subsequently the social influence, rather than just focusing on the individual mental change. To sum it up, the process model tries to create a change in human behaviour at multiple levels. According to Bennett Cattaneo and Chapman (2010) the social context in the empowerment process is of high importance, as the process of empowerment

[Text eingeben]

usually takes place in a social context, where power is not distributed equally and where social structures contribute to the continuity of power of some over others. The two authors (Bennett Cattaneo & Chapman, 2010) describe “...*this context influences the entire process but becomes most starkly apparent in the impact component. It is this component that most clearly extends the empowerment process out of the intrapsychic realm, moving the model beyond people’s feelings about their abilities to include the ways in which social context constrains or facilitates their efforts*”.

### 2.2.2 Giving a sense of the landscape – definitions on empowerment

There are some authors who have had a profound influence on the development of the empowerment concept. The most notable is probably Julian Rappaport (1995, 1987), an US-American author who is strongly associated with the concept of empowerment and developed the concept theoretically. He, together with other authors, highlighted the decisive connection of the individual and the community level. He discussed a phenomenon, which is also important in regards of this paper: the failure of social programs to provide social solution and the notorious side effect of such programs – the generation of powerlessness among the people in need of the program. Rappaport claims that the roots cause of failure is ignorance - ignorance of local capacities regarding knowledge and resources as part of amending interference.

The following section provides some commonly used definitions of empowerment:

#### *Empowerment is mastery*

Rappaport (1987, p. 122) defines empowerment as “...*a mechanism by which people, organizations, and communities gain mastery over their affairs*”. This definition includes the three different categories of individual people, organizations and communities. Rappaport (1995) explicitly recognizes that all of them have their own story and that there is a reciprocal influence process between these stories, with a very powerful impact on human behaviour. Especially those people who lack power, either by social, political or economic means are affected by narratives in their community, their neighbourhood or their cultural background, either negative (narrow) ones, created by others or all of them mentioned above. Individuals who pursue change either on an individual or on a collective basis feel restricted if there is a lack of collective support and subsequently a new collective narrative. Such

[Text eingeben]

narratives can be related with certain consequences involving social support and role identification (Rappaport, 1995).

#### *Empowerment is participation*

Participation in a group is considered as an ideal (but not exclusive) method of promoting individual empowerment. What seems contradictory at first is quite logical. Individuals receive support in many different ways (emotional, social, financial, educational,...) as part of the change process and acquire new skills for future public action (Rappaport, 1995). It was also Rappaport who later approved the empowerment definition by the Cornell University Empowerment Group (1989, p. 2), which argued that empowerment is defined as “...an intentional ongoing process, centred in the local community, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources.” As the rural health development program under review is excessively linked with the participatory empowerment approach, this paper is mainly focusing on this one.

#### *Empowerment is counselling*

McWhirter (1991, p. 622) defines empowerment as “..the process by which people, organizations or groups who are powerless (a) become aware of the power dynamics at work in their life context, (b) develop the skills and capacity for gaining some reasonable control over their lives, (c) exercise this control without infringing upon the rights of others and (d) support the empowerment of others in the community.” Mc Whirter’s definition of empowerment strongly appeals to the well-being of communities. She clearly distinguishes between two different situations of empowerment. Firstly, the *situation of empowerment*, where the empowerment process is already common practice and conditions a to d are fulfilled. Secondly, the author describes an *empowering situation*, where not all four but one or more conditions are fulfilled or even under construction.

#### *Empowerment is achievement*

Mechanic (1991, p. 641) defined empowerment as “...a process in which individuals learn to see a closer correspondence between their goals and a sense of how to achieve them, and a relationship between their efforts and life outcomes”. This definition again clarifies that empowerment and hence the achievement of goals differ on an individual basis – based on whatever is personally meaningful to

[Text eingeben]

a person. Contrary to the empowerment process model, described in chapter 2.2.1, this definition on empowerment can be interpreted as an entirely intrapsychic one, where actual changes in power are not particularly enforced.

### 2.2.3 Empowerment – a healthy way to improve health?

#### *Focus on participatory empowerment approaches*

The participation of local communities is a crucial point in reducing, or at least not enhancing the dependency on professional health workers. The uneven path of empowerment through participation leads across culturally sensitive programs, fostering capacity and sustainability of the change process, involving community members in the program development, guaranteeing effectiveness and efficiency and promoting health in a substantive way (WHO Regional Office for Europe's Health Evidence Network, 2006).

A major factor for the success of a program is the participation of local opinion leaders (i.e. chiefs of committees, head farmers, teachers, traditional healer, and religious role models). Together with health workers, social and political institutions, they are key facilitators to participation. According to a report published by the WHO (WHO Regional Office for Europe's Health Evidence Network, 2006) an alleged low value of individuals and/or a weak leadership constitute a threat to participation on a psychological basis. The majority of threats however, are of cultural and structural nature. These cultural barriers of empowerment involve unequal balance of power, which affects marginalized groups of the population like women, children and disabled. Structural barriers are notorious and especially relevant in the case of this paper, as the program under review is located in Nepal, an exceptionally state in many ways. Structural barriers include authoritarian regimes, high social disparity, a low level of participation on behalf of the government through a long lapse of time, ethnic stratification and a lack of management, organization and acquiring resources (WHO Regional Office for Europe's Health Evidence Network, 2006).

#### *Four elements of empowerment – adapted to the health sector*

In today's world, there are thousands of successful stories, where individuals, at community levels, the government or the private sector, initiated empowerment. According to the World Bank (2002), these successful efforts of empowerment through participation share four main elements:

[Text eingeben]

- Access to information on public health issues
- Inclusion and participation
- Accountability
- Local organizational capacity

Additionally the World Bank (2002) remarks that timely information about programs or government strategies are an essential precondition for promoting change, people in need of the program may not take action because institutional mechanisms do not exist or because the efforts by an individual may be too high. Due to this lack of institutional mechanisms, local organizations may still be disconnected from local governments and the private sector and be deprived of access to information. The WHO (2006, p. 9) adds *“...a significant strategy to counter exclusion and promote empowering participation is community control of project funding. In minority communities, in particular, empowerment interventions should support minority leadership, recognize potential for cross-cultural conflict, and build on existing strengths.”*

According to Israel et al. (1994) there is some epidemiological, sociological and psychological evidence of the connection between empowerment and health, providing justification for a community empowerment approach to health. The authors state that there are studies, which prove that a lack of empowerment can directly be linked to a poor status of both mental and physical health, social exclusion, increased morbidity and mortality and a lack of access to primary health care. The WHO (2006) argues that there is only a small number of published documents about the hypothesis that community participation shows an improvement in the health status of the population or the accessibility of health care services. The outcome of empowering strategies in consideration of different population groups to achieve both empowerment and health results, includes patients and health care consumers; and those groups especially at risk for social exclusion and disempowerment, i.e., women, children and disabled people.

[Text eingeben]

### 3. The United Nations Millennium Development Goals

Following the Millennium Summit of the United Nations in 2000, all 193 UN member states and at least 23 international organizations made a promise to free people from extreme poverty and multiple deprivations. This pledge turned into the eight Millennium Development Goals. Based on the United Nations Millennium Declaration following goals should be achieved by the year 2015 (United Nations Development Programme, 2013):

1. Eradicating extreme poverty and hunger
2. Achieving universal primary education
3. Promoting gender equality and empowering women
4. Reducing child mortality rates
5. Improving maternal health
6. Combating HIV/Aids, malaria and other diseases
7. Ensuring environmental stability
8. Developing a global partnership for development

A road map published by the UN Secretary General includes the actual eight Millennium Development Goals, subdivided in 21 quantifiable and time bound targets, which are measured by 60 indicators. These indicators pursue a comprehensive field of research; from the proportion of fish stocks within safe biological limits to the official development assistance received in landlocked developing countries as a proportion of their gross national incomes (Leo & Bartheimer, 2010).

Similar to many other poor countries, like Burkina Faso and Ghana, Nepal's achievements regarding the Millennium Development Goals are quite remarkable (Leo & Bartheimer, 2010). In 2010, the United Nations Development Programme, along with the government of Nepal, put out the *Millennium Development Goals Needs Assessment Report for Nepal*, a joint initiative to estimate the resources required and identify gaps for achieving the country's MDG targets within 2011 and 2015. According to this report, most of the MDG targets can be met by the year 2015, given that the government is able to mobilize resources and create institutional and policy capacity required. While some goals have already been achieved, others still have need for improvement. This includes goals, which are related to:

[Text eingeben]

- employment
  - survival rate to grade five
  - equal access for boys and girls to tertiary level education and equal rate of literate women and men aged 15-24 years
  - percentage of births attended by a skilled obstetrician and general access to reproductive health
  - environmental issues
- (United Nations Development Programme, 2013)

### 3.1 Importance of health in the millennium declaration

Three out of eight Millennium Development Goals are directly and explicitly found within the health sector:

#### *MDG 4: Reducing child mortality rates*

Target: Reduction of two-thirds of the under-five mortality rate

Indicators: Under-five mortality rate<sup>2</sup>, infant mortality rate<sup>3</sup>, proportion of 1-year old children immunised against measles (United Nations Development Program and Government of Nepal, 2006)

As the health situation of Nepalese children is very poor, improving child health is a major concern for the country's government (United Nations Development Program and Government of Nepal, 2006). However, there has been a continuous decline in infant and under-five mortality in Nepal over the last several decades (Thapa, 2008). Due to an intensification of child survival interventions like vitamin A distribution, pneumonia treatment and immunization<sup>4</sup>, the mortality rate among children under the age of five has been tremendously diminished in the last years from 141 in 1990 to 50 in 2010 (Unicef, 2010). Irrespective this significant progress in child survival interventions, pneumonia and prematurity are still the two most important causes leading to death in the group of children under the age of five.

---

<sup>2</sup> Under-five mortality rate: Probability of dying between birth and exactly five years of age expressed per 1,000 live births (Unicef, 2010).

<sup>3</sup> Infant mortality rate: Probability of dying between birth and exactly one year of age expressed per 1,000 live births (Unicef, 2010)

<sup>4</sup> Immunization: Vaccines for polio, diphtheria, pertussis, tetanus, measles, hepatitis B (United Nations Development Program and Government of Nepal, 2006, p. 33)

[Text eingeben]

Neonatal death itself accounts for more than 60 percent of infant mortality (United Nations Development Program and Government of Nepal, 2006).

Figure 2 illustrates the distribution of causes of deaths in children under five. In 2010, prematurity caused 32 percent of deaths, pneumonia 16 percent. HIV/Aids, malaria and measles however, are no object in terms of child and infant mortality.

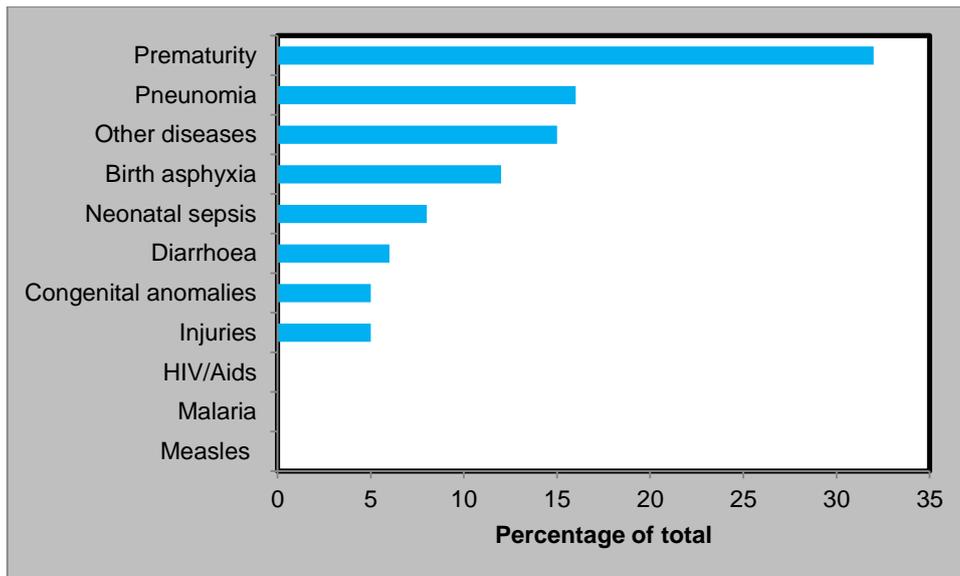


Figure 2: Distribution of causes of deaths in children under five in 2010. Source: Nepal Health Profile, WHO 2012

#### MDG 5: Improving maternal health

Target: Reduction of maternal mortality rate by three quarters

Indicators: Maternal mortality ratio, proportion of births attended by skilled health personnel (United Nations Development Program and Government of Nepal, 2006). Pursuant to the *Millennium Development Goals Needs Assessment for Nepal* (2006) Nepal's maternal mortality ratio is among the highest maternal mortality rates in the world. UNICEF (2010) sets the reported maternal mortality rate in the years 2006 - 2010 by 280<sup>5</sup>. Furuta and Salway (2006) argue that the main reason for this comparably high rate is a low use of maternal health care. Despite some serious efforts on national level, like trainings of auxiliary midwives and an expanded clinic network also in rural areas, only one out of five births are

---

<sup>5</sup> Annual number of women dying from pregnancy-related causes per 100,000 live births (Unicef, 2010).

[Text eingeben]

attended by a skilled birth health personnel. Especially worth mentioning is the disparity between rural (and urban areas, regarding the rate of births attended by skilled health personnel, which is illustrated in figure two. Figure 2 also shows that it is the poor population stratum, which is affected most by these inequalities in health care utilisation. According to the World Health Organization (2012), a lack of health services for pregnant women, the prevalence and practice of giving birth at home and the lack of skilled birth attendants are among the main reasons for the high maternal mortality in Nepal.

Generally, the World Health Organization (2012) states three delays causing the country's high maternal mortality rate: delay in seeking care, delay in reaching care and delay in receiving care. Discerning that the major part of Nepalese women does not have access to maternal health care services due to social, economic and political reasons, Nepal defined safe motherhood, which is the key to reducing maternal mortality, as one of eight components of the essential health care package (confer chapter 3.2.1).

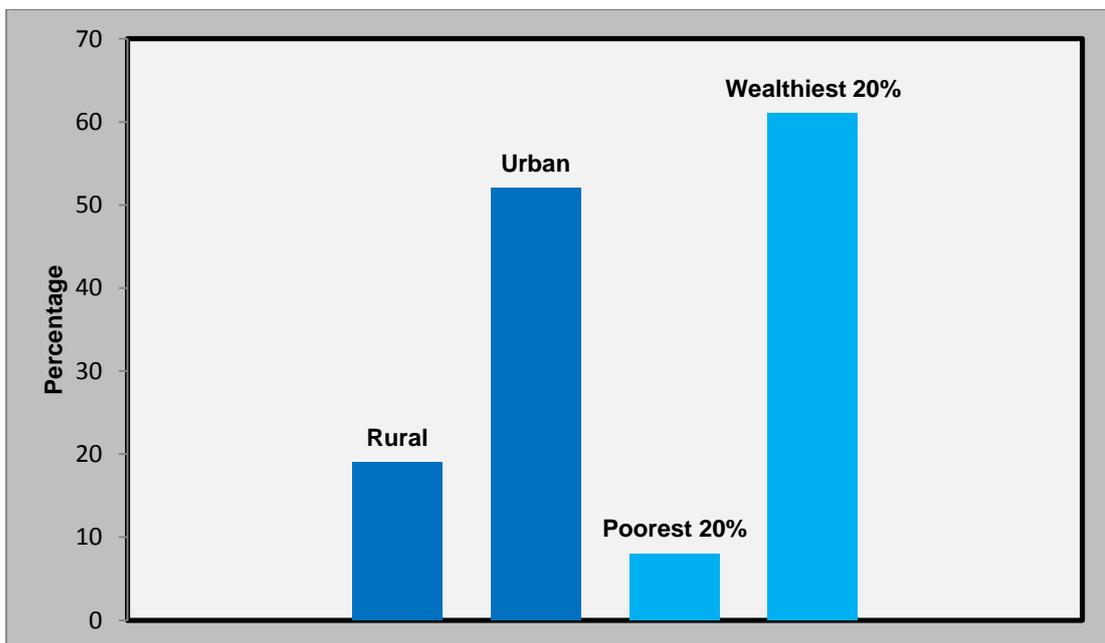


Figure 3: Births attended by skilled personnel. Source: Nepal Health Profile 2012

*MDG 6: Combating HIV/Aids, malaria and other diseases*

Target: Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases

[Text eingeben]

Indicators: Prevalence and death rates associated with malaria, proportion of population in malaria risk areas using effective malaria prevention and treatment measures, prevalence and death rates associated with tuberculosis, proportion of tuberculosis cases detected and cured under directly observed treatment short-course (United Nations Development Program and Government of Nepal, 2006). The sixth Millennium Development Goal states the battle against three major diseases, which, if unattended, are likely to extend to an epidemic level. These three diseases are tuberculosis, HIV/Aids and vector-borne diseases such as malaria. (United Nations Development Program and Government of Nepal, 2006). As tuberculosis prevention is part of the immunisation program among children, this disease has not been addressed severally. In consideration of communicable vector-borne diseases, malaria accounts for more than 95 percent of all cases occurring throughout the country. As a consequence malaria control is among the top five public health priority programs in the country's Tenth Plan (confer chapter 3.2.1). Diminishing the malaria prevalence rate in Nepal largely remains time-bound and program/project based. In the years 2001-2005, the so-called Roll Back Malaria Program (RBMP) was implemented as a pilot program, however, only in three districts, and not in all 12 districts at high risk. Considerably problematic are also communicable water-borne diseases like diarrhoea and several other infectious diseases in all three ecological regions of the country and affecting the overall health status (United Nations Development Program and Government of Nepal, 2006, pp. 36, 37).

Figure 4 illustrates the prevalence of the three major diseases mentioned in the last preceding paragraph, HIV, tuberculosis and malaria:

	Country	Global average
Prevalence of HIV (per 100.000 adults aged 15 to 49) <sup>6</sup>	<b>4</b>	<b>8</b>
Prevalence of tuberculosis (per 100.000 population)	<b>238</b>	<b>178</b>

---

<sup>6</sup> Data refers to 2009

[Text eingeben]

Number of reported cases of Malaria in total	<b>3894</b>	<b>219 M.</b>
---	-------------	---------------

Figure 4: Prevalence of HIV, TBC and Malaria in Nepal and worldwide. Source: WHO 2012

[Text eingeben]

## 4. Nepal at a glance

Prominent for its astonishing mountain scenery and well presented in documentaries about alpinist heroics and tragedies, the country of Nepal has still preserved its mystical appearance, which attracts millions of travellers each year. Nevertheless, Nepal is among the poorest countries in the world. Poverty, social disparities, evanescence of natural resources and a corrupt government, unable to deal with these issues, have resulted in political turmoil's.

The following section gives some general country information on Nepal and bridges to Nepal's achievement regarding the Millennium Development Goals and health care in Nepal.

### 4.1 Country Profile

Until 1951 Nepal, the world's only Hindu monarchy was ruled by a hereditary prime ministership. The then Nepali monarch ended the century old system and introduced a governmental cabinet system. After years of political instability including a ban of political parties by King Mahendra in 1960, reforms in 1990 established a multiparty democracy within the framework of a constitutional monarchy. The centrist Nepali Congress party won the legislative elections held in 1991, with the Communist party as the leading opposition party. In 1994, after the Nepali Congress-ruled government lost a parliamentary vote, the Communists became the largest party and formed a minority government. A political turmoil initiated by Maoist extremists broke out in 1996. The ensuing 10-year civil war between extremists and government forces resulted in the dissolution of the cabinet and parliament and assumption of absolute power by the king. Following years of instability with mass protest and peace negotiations, the newly established Constituent Assembly declared Nepal a federal democratic republic and abolished the monarchy in 2008. The country's first president was elected. In 2011, Baburam Bhattarai of the Communist Party became prime minister. As the Constituent Assembly failed to draft a constitution within the deadline, the prime minister dissolved the CA. After months of negotiations, Khil Raj Regmi was sworn in as Chairman of the Interim Council of Ministers for Elections to lead an interim government and charged with holding Constituent Assembly elections by December 2013.

[Text eingeben]

#### 4.1.1 Location

The Kingdom of Nepal, located at the southern disposition of the Himalaya, comprises an area of 47,181 sq. km. The country is located between the latitudes of 26° 22' and 30° 27' N, and longitudes of 80° 40' and 88° 12' E. The average length of the country is 885 km from east to west; the width varies from 145 km to 241km, with a mean of 193 km north to south. 64 percent of Nepal's national territory is situated above 1000m altitude, more than 28 percent even higher than 3000m altitude. The altitude within the country varies from 67m above sea level at Kechana Kalan Jhapa in the south-eastern Terai, to Mount Sagarmatha (Nepali name for Mount Everest) at 8,848m, the highest point in the world. Due to its mountain ranges, valleys, lowlands and plateaus Nepal disposes a variety of regionally isolated unities with differing climatic and hydrological characteristics (Donner, 1990).

Generally, the country can be divided in three major zones:

- Terai, the Lowland
- The Middle Mountains with the Shivaliks or Churia Ridge (up to 1500m) and the Mahabharat Range (2000-3000m)
- The highland with the Himalaya Range (up to 8848m)

Together with a variety of predominant geographic landforms like the Hindu Kush, the huge Tibetan Plateau, Pamir Knot and the Karakorum, the Himalaya embraces the world's largest accumulation of high mountain ranges and plateaus and provides the basis for the monsoon system. The lowlands are recharged by some of the world's greatest rivers and the occasional exuberant monsoon precipitation support more than a quarter of humankind (Ives, 2004, p. 26). The Himalayan range merely disposes of a total snow and ice cover of 35,110 sq. km. Especially in the Hindu Kush-Himalaya mountain range, adaption, mitigation and flexibility have always been characteristic for the local population. Throughout the years, the Himalayan population has maintained a rich cultural identity with their own traditions (ICIMOD, 2007).

[Text eingeben]



**Figure 5: Highlands, Samdo, Gorkha district, 4460m above sea level**

The Middle Mountains of Nepal (in the following referred to as the Middle Hills) command the highest population density in the country, in spite of a recently high out-migration to the Terai. The Terai belt (67-300m) is a flat stretch of fertile agricultural land in southern Nepal, which forms part of the alluvial Gangetic plain (ICIMOD, 2007).



**Figure 6: Pawai VDC, Solukhumbu district, 1800m above sea level**

The Middle Hills merge subtly with the Himalaya and are bounded on the south by the Mahabharat Range with maximum heights up to 3000m and do not carry permanent ice and snow (Ives, 2004). Landlocked and dominated by its mountainous landscape Nepal contains eight of world's ten highest mountains,

[Text eingeben]

including Mount Everest and Kanchenjunga - the world's tallest and third tallest - on the border with China (including Tibet Autonomous Region) and India respectively. Together with Sri Lanka, the Maldives, Bangladesh, Bhutan and Pakistan Nepal forms the Indian Subcontinent (Schmidt, 2013).

#### 4.1.2 Population

Situated in Southern Asia, on the southern slopes of the Himalayan Range, the Kingdom of Nepal is ethnically diverse. This diversity can be ascribed to three major migration waves from India, Tibet and Central Asia. The Newar, residing in the Kathmandu Valley and aboriginal Tharu in the southern parts of the Terai are among the earliest inhabitants. The ancestors of the Brahman and Chhetri caste groups came from India, while other ethnic groups trace their origins to Central Asia and Tibet, including the Gurung and Magar in the west, Rai and Limbu in the east, and Sherpa and Bhotia in the north. People in the Terai region bear great physical and cultural resemblance with the Indo-Aryan people of northern India. People of Indo-Aryan and Mongoloid origin live in the Middle Hill Region. Kathmandu Valley, made up of the Kathmandu District, Lalitpur District and Bhaktapur District in the mid hill region, constitutes a small fraction of the nation's area but is the most densely populated, with a population of 1.5 million and an annual growth rate of more than 7%. Nepal's 2001 census enumerated a total population of 26.6 million and 103 distinct caste/ethnic groups including unidentified. While the caste system can be traced back to the Hindu religion, the ethnic system is rooted in historical mutual seclusion and the occasional state intervention (ICIMOD, 2007).

#### 4.1.3 The caste system

An inherent part of Nepalese society is the presence of the Hindu caste system, modelled after the ancient Brahman system of India. For Nepalese people castes are an essential way of identifying themselves. It affects their family life, food, dress, occupations and culture. Also in these days, the caste system can be seen as an instrument for social stratification (Shrestha, 2002).

The establishment of the caste system was a decisive factor for the feudalistic economic structure of Nepal. Members of the higher-caste started to usurp lowland areas - these areas were easier to access, more cultivatable and more profitable -

[Text eingeben]

including land properties of existing tribal people. They introduced the system of individual ownership. In series, migrants from the north were incorporated into the Hindu caste system, holding the positions of power and authority. Tibetan migrants did not practice private ownership; their system was based on communal ownership. Based on Hindi dispositions, the caste system is immediately applied among Nepal's Indo-Nepali population group, the main adherents of Hinduism (Shrestha, 2002).

## 4.2 Health care in Nepal

Some of the major challenges regarding health and development in Nepal are its unique location within three ecological zones (high mountains, middle hills, lowland), its cultural and ethnic diversity, political instability including decade long conflict and violence and the country's slow economic growth with high rates of unemployment and poverty. Despite many challenges, the country has made some progress in overall socio-economic development. In recent years, Nepal has made improvements in the health status; especially in terms of life expectancy, total fertility rate, child immunisation and access to basic health care services. Still the country is hit hard by infectious diseases along with emerging epidemics and an upward trend of lifestyle related non-communicable diseases (WHO, 2007).

### 4.2.1 Health policy and planning

The Government of Nepal has drafted a comprehensive framework of Health Policies. These policies are elucidated in the National Health Policy 1991 document, which aims at extending the primary health care system to the rural population on an equitable basis.

The main components of the framework are as following (WHO, 2007):

- *National Health Policy 1991*

When the National Health Policy was adopted in 1991, its major objective was to improve health conditions of the Nepalese population. The primary health care system should be optimized, especially in rural areas, providing people with the advantages of modern medicine and trained health care providers.

The National Health Policy addresses the following areas:

[Text eingeben]

- Preventive health services
  - Promotive health services
  - Curative health services
  - Basic primary health services
  - Ayurvedic and other traditional health services
  - Organization and management
  - Community participation in health services
  - Human resources for health development
  - Resource mobilisation in health services
  - Private, nongovernmental health services and inter-sectorial coordination
  - Decentralisation and regionalisation
  - Blood transfusion services
  - Drug supply
  - Health research
- 
- *Second Long Term Health Plan 1997-2017*

Developed by the Ministry of Health the SLTHP aims at providing a guiding framework to build successive periodic and annual health plans that improve the health status of the population; to develop strategies, programs and action plans reflecting the countries health priorities. The SLTHP focuses on improving the health status of women and children, the rural population, the poor, underprivileged and marginalised. Actions implemented by the SLTHP should be affordable and consistent with available resources and coordination among public, private and development partners should be established. The Second Long Term Health Plan's vision is a national healthcare system, which guarantees equal access and quality services in both rural and urban areas. The SLTHP should procure sustainability, community participation, decentralisation and gender sensitivity, effective and efficient management as well as private and nongovernmental participation. The plan points up the urge for revising resources from high-cost, low-impact interventions to low-cost high-impact essential health care services (EHCS)<sup>7</sup> or simply to increase efficiency and effectiveness.

---

<sup>7</sup> The EHCS is a package of 20 elements, which are priority public health measures and essential clinical and curative services for the appropriate treatment of common diseases (WHO, 2007, p. 8).

[Text eingeben]

- *Nepal Health Sector Program Implementation Plan (NHSP-IP) 2004-2009*  
Emphasizing the same objectives as the Tenth Plan, the NHSP-IP has three program outputs and eight sector outputs, which are: prioritised EHCS decentralised health management, private and NGO sector development, sector management, financing and resource allocation and management of physical assets. One of the eight outputs of identified under the NHSP-IP is the area of sector management.

The concerned strategies identified under the sector management output are:

- strengthen joint Ministry of Health and population/donor annual planning, programming budgeting and monitoring cycle.
  - strengthen ongoing MoHP/donor programmatic collaboration
  - strengthen sector management at the central level
  - strengthen regional and district management
  - capacity building at central and district levels
  - assess institutional and organizational arrangements systematically
  - redefine roles and responsibilities through the health system.
- 
- *The Tenth Plan (Poverty Reduction Strategy Paper) 2002-2007*  
These two policies have been adapted to improve social and economic services in rural areas and a comprehensive inclusion of the poor and disadvantaged groups. By developing the Health Sector Strategy - an agenda for reform - in 2004, the PRSP has been implemented. The agenda focuses on achieving the Millennium Development Goals with the outcome of an improved health status for the poor and marginalised among the Nepalese population and to contribute to poverty reduction in general.

The following figure shows the distinctive features of the Tenth Plan, compared to the Nepal Health Sector Implementation Program:

[Text eingeben]

- The Tenth Plan is Nepal's Poverty Reduction Strategy Paper.
- The Plan appreciates the role of local bodies, community organizations and NGOs in development and reflects the government's commitment to decentralisation and functional development.
- The Plan applies modern planning tools and the Logical Framework Approach to define institutional tasks and responsibilities
- The plan clearly defines priorities which are P1, P2 and P3 projects and clear cut allocation commitments
- The plan emphasises extensive M & E provisions, involving an annual poverty monitoring commitment and process monitoring.

**Figure 7: Distinct features of the Tenth Plan (PRSP). Source: WHO**

- *Three Year Interim Plan*

The Three Year plan has been introduced for bridging the gap between the Tenth and Eleventh five-year plans. Apart from pursuing the intentions of the Tenth Plan, the most important features of this plan are to initiate new programs not included in the EHCS package as well as to antagonize current weaknesses of Nepal's health system. Initiatives involve prevention and control of dengue, avian influenza and introduction of new vaccine (i.e. measles, mumps and rubella vaccine). Invoking the right to health, the Three Year Interim Plan also wants to maximize efforts for achieving the Millennium Development Goals. As Nepal is one of the 189 countries committed to the MDGs, a pledge is renewed in its current Three Year Plan (2010 -2013).

In spite of these clearly formulated policies and strategies, the implementation has not been fully satisfactory. One of the major health sector challenges in Nepal is how to accomplish the process of translating policies into practices at all levels of the health care systems in a sustainable and efficient way (WHO Country Office Nepal, 2012).

According to the World Health Organization (2012), it is positive to register that the health systems management at national level is willing to face new issues and challenges in policy making and planning:

[Text eingeben]

*“Persisting disparities in people’s health status and access to services: rising cost of health services and emergence of new diseases and cross border transmission are some of those. The achievement of the millennium development goals is itself a great challenge that demands efficient management and effective coordination. Further there are cross cutting issues such as globalization of trade, environmental degradation etc. will have impact on health services. All this creates new challenges for policy makers and planners. It is therefore imperative to upgrade managerial skills, competencies and other leadership qualities.”* (WHO Country Office Nepal, 2012).

#### 4.2.2 Health status

According to a study published in the Environmental Health and Preventive Medicine Journal in 2001 (Rai & Rai, 2001) about two-thirds of the health problems in Nepal are infectious diseases. Epidemics are characterised by a high morbidity and mortality rate, they occur frequently, though there are also occasional outbreaks of infectious diseases of unidentified aetiology.

Like in 1956, when the first General Health Plan was introduced, the Nepalese health system is still focusing on primary health care. Since then a comprehensive health care system has been developed. Arranged like a nationwide network, the most basic unit is a subhealth post or health post in each Village Development Committee (VDC) area. In 1956 and in the following years, however, the expansion of the health system has not been aligned with an expansion in domestic resources and in addition to that, an efficient distribution of resources available did not happen. Resources for preventive and promotive medicine are insufficiently available and non-infectious diseases like cardiovascular diseases and cancer are increasing (Rai & Rai, 2001).

Figure 8 illustrates some key data regarding health care in Nepal (figures in parenthesis are the figures for Austria):

[Text eingeben]

Gross national income per capita in \$	<b>1,210</b> (39,790)
Life expectancy at birth m/f (years)	<b>65/69</b> (78/83)
Probability of dying under five (per 1000 live births)	<b>48</b> (4)
Probability of dying between 15 and 60 m/f (per 1000 population)	<b>234/159</b> (102/50)
Total expenditure on health per capita in \$ 2010	<b>66</b> (4,388)
Total expenditure on health as % of GDP 2010	<b>5.5</b> (11.0)

**Figure 8: Key data on health care in Nepal (Figures are for 2009 unless indicated). Source: Global Health Observatory**

In comparison with Austria, the low standard of health care services in Nepal gets even more obvious. Especially noticeable is the probability of dying under five, which is more than ten times higher in Nepal than in Austria.

In general, Nepal's health sector has to face some major challenges. One of the most challenging is the persistent disparity in health care between the rich and the poor, urban and rural areas and the different ethnic groups. According to the WHO (2007, pp. 11, 12) the challenge is *"...how to design cost-effective interventions and reach the target groups who are still unreached because of socio-economic barriers and difficult geographical terrain"*.

#### 4.2.3 Decentralization of health care services

In line with the comprehensive decentralisation framework of the Nepalese government, in 2003 the Ministry of Health and Population (MoHP) initiated community management of health care services. Following actions have been designed (WHO, 2007):

- Management of sub-health posts by local committees
- Verification of attendance of staff at subhealth posts by the VDCs before issuing pay cheques to them
- Arrangement of compulsory public notice in the sub-health posts regarding the range of services, fees, and opening hours to be verified by VDCs and DHO.

[Text eingeben]

In total more than 1400 health care facilities including subhealth posts and primary health care centres were handed over to local committees in the years 2004 and 2005 (WHO, 2007).

### 4.3 Nepal's progress in achieving the millennium development goals

Indicators	Earliest	Latest	2015
Percentage of Poor (National Poverty line)	42 <sup>1</sup>	25.4 <sup>3</sup>	21
Underweight children under five years of age	57 <sup>1</sup>	31 <sup>4</sup>	29
Net Enrolment Rate in primary education	64 <sup>1</sup>	93.7 <sup>3</sup>	100
Ratio of girls and boys in primary education	0.56 <sup>1</sup>	0.99 <sup>4</sup>	100
Under-5 mortality rate (per 1,000 live births)	141 <sup>1</sup>	48 <sup>4</sup>	45
Infant mortality rate (per 1,000 live births)	97 <sup>1</sup>	39 <sup>4</sup>	41
Maternal mortality ratio (per 100,000 live births)	850 <sup>1</sup>	229 <sup>3</sup>	213
Skilled birth attendance (%)	7.4 <sup>2</sup>	28.8 <sup>3</sup>	60
Forest cover (% land area)	33.7 <sup>1</sup>	25.4 <sup>3</sup>	-
Safe drinking water (% population)	76 <sup>1</sup>	89 <sup>3</sup>	-
Basic sanitation (% population)	10 <sup>1</sup>	31 <sup>3</sup>	-

Figure 9: Nepal's MDGs` progress status at a glance, <sup>1</sup>=1990, <sup>2</sup>=1991, <sup>3</sup>=2010, <sup>4</sup>=2011. Source: [www.socialwatch.org](http://www.socialwatch.org)

According to the Socialwatch (2013), a network comprised by national coalitions of civil society organizations, the country's ongoing poverty originates in unequal balance of power over both economic and political resources. In spite of a considerable progress in the last few years, there are blatant gaps. Nepal's development trend is characterized by an increase in food insecurity and hunger, unemployment, gender-based discrimination and violence, disparities between the

[Text eingeben]

rich and the poor, heavy dependence on foreign aid agencies, political instability and corruption.

It is a fact that the progress, which has been made in poverty reduction in the last few years, eventuates from a high rate of remittance. Almost 60 percent of Nepali households receive remittances from outside the country (United Nations Resident and Humanitarian Coordinator's Office, 2011). Little progress has been made regarding a decrease in neonatal mortality, nevertheless the number of children being underweight is still high and a notoriously high number of people, especially children still die from diarrheal diseases. The last is because 69 percent of the population still lacks the facility of improved sanitation. In regards of gender equality Nepal has still a long to walk. It is common practice that women still suffer from economic, social and cultural discrimination or even gender based violence. The progress achieved in Nepal in ending gender discrimination and empowering women has been measured only in terms of improvements in primary and secondary education, and reduction in maternal mortality rates (Gautam & Prerna, 2013).

[Text eingeben]

#### 4.4 Quantifying inequality – the Gini index

Even if Nepal sets the pace regarding the Millennium Development Goals, there is one important point, which still needs to be addressed: the equal distribution of wealth.

The Gini index is an index, which “*measures the extent to which the distribution of income or consumption expenditure among individuals or households within an economy deviates from a perfectly equal distribution.*” (The World Bank, 2013, p. 1). Also known as Gini coefficient this index was developed in 1912 by Conrado Gini, an Italian sociologist. The index is calculated by a Lorenz curve, which outlines the cumulative percentages of total income received, compared with the cumulative number of recipients, starting with the poorest. The index is measured by the area between a country's Lorenz curve and the 45 degree helping line and by the triangular area under the helping line. The closer a country's Lorenz curve is to the 45 degree helping line, the lower its Gini index and the more equal its income distribution. A Gini index of zero represents perfect equality, while an index of 100 stand for perfect inequality (CIA, 2013). According to a World Bank report (The World Bank, 2013) Nepal (32,8) is at a global rank of 128, with Lesotho (63,2) at first place and Sweden (23.0) at last. Even though Nepal is in a better position than many other developing countries (especially sub-Saharan development countries), published statistics state that the level of economic inequality has been raising in the last three decades (Wagle, 2010). According to figures from 2010 26,5 percent of the income share is held by the 10 percent of the Nepalese population (The World Bank, 2013).

The inglorious trend of rising inequality in Nepal can partially be traced back to the Nepalese caste system (see chapter 4.1.3). The cultural discrimination against people from lower castes and ethnic minorities is an omnipresent phenomenon in Nepal. There are also discussions that this discriminating culture contributed to the success of the Communist Party of Nepal, dominating the national political affairs and alter the political landscape of this traditionally ethnically diverse country (Wagle, 2010).

[Text eingeben]

## 5. Program evaluation and methodology

The previous chapters offered a systematic theoretical approach to the field of research and shall provide a foundation for the qualitative research covered in the following chapters.

### 5.1 Approaching the grassroots – the EcoHimal program document

The grassroot document for this paper is the program document drafted by EcoHimal in 2009. The program success will be monitored based on the program objectives and expected results outlined in the program document.

The following section provides some general information given in the program document (EcoHimal, 2009):

- *Program duration:* 1<sup>st</sup> January 2010 – 31<sup>st</sup> December 2012
- *Program title:* Participatory rural health development program to improve the health situation of the rural population in the middle hills of eastern Nepal
- *Main objective:* Improved health status of the most vulnerable groups (in Nepal): rural population, poor and marginalized population, underprivileged, women and children
- *Program objectives and expected results:*
  1. Local people are empowered to positively change their health seeking behavior and make demands regarding priority health needs.
    - Awareness and knowledge on health and hygiene of local population increased
    - Participatory development models – based on traditional and new forms – are effective.
  2. Local basic health service delivery systems are accessible, and efficiently and effectively respond to demands for priority health needs.
    - Economic base of local population improved
    - Capacity of local health service providers - traditional as well as modern - improved.

[Text eingeben]

- Quality health and hygiene infrastructure (including water supply and sanitation systems and equipment of sub-health posts) at VDC level is effective.
3. Strengthen existing and develop new participatory development models concerning community cooperation.
- Participatory development models based on the integration of traditional and modern methods have been elaborated, analyzed, discussed, shared and disseminated.
  - Program management established and efficiently implemented.

According to the NGO-Framework Program – Program Document published by EcoHimal (2009) the main focus of the Framework Program is a change processes being supported.

The change processes of the program summarized:

- Using participatory approaches –group formation through reflection, analysis, and action.
- Integrating traditional and new practices in community cooperation and health.
- Helping people perceive the benefits of the proposed changes in health and hygiene behaviour.
- Fostering ownership and involvement of key stakeholders by training individuals and teams.
- Critical examination of the experiences with development of local people including their understanding of reasons for success or failure.
- Development of strategies and processes.
- Ensuring an effective communication strategy within and outside the program.
- Analyse, document and share the experiences and new practices gained at the program level with other development actors and potential implementers for broadening and institutionalising new effective models.

[Text eingeben]

### 5.1.1 Setting the scene – the target region

The target areas of the program are two Village Development Committees (VDCs) in Solukhumbu and Khotang district of eastern Nepal: Pawai and Bakhachol VDC. Both Pawai and Bakhachol VDC are situated in the Middle Hills of Nepal at an altitude of 945 m to 2700m.

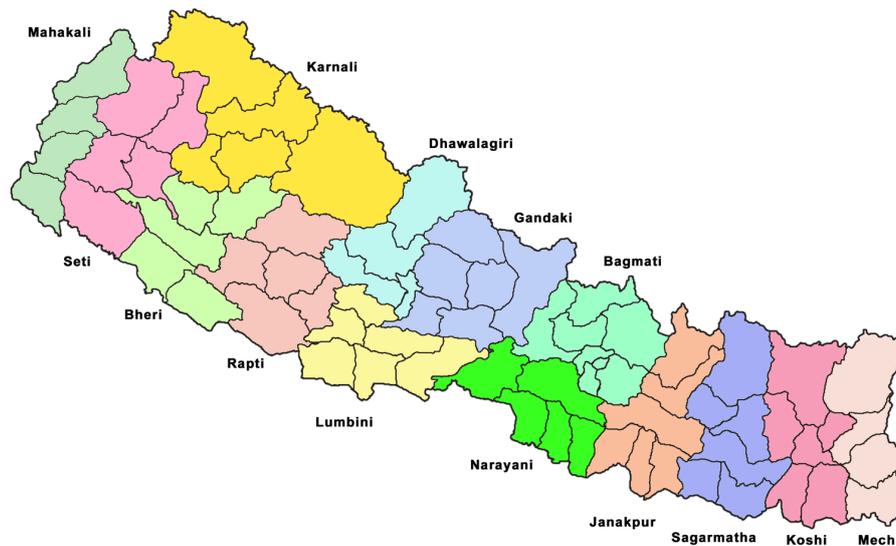


Figure 10: District map of Nepal. Source: rootsweb

Figure 10 indicates the administrative division of Nepal. Solukhumbu and Khotang district are located in the Sagarmatha zone in the eastern part of the country. Nepal is divided into 14 zones and 75 districts, grouped into five development regions. The population of Pawai and Bakhachol VDC belongs to the poorest and most vulnerable population group of Nepal with very limited access to health care services and poor infrastructure. As recently as a few decades ago, the local farmers depended entirely on subsistence farming. Especially noteworthy is the topographical diversity and the district specific north-south divide. In the northernmost area of Solukhumbu district, at the base of Mt. Everest, the Sagarmatha National Park is located. The constant increase of tourism together with the Sagarmatha National Park Buffer Zone programs have contributed to a growing affluence with good quality education, health care services and higher life expectancy. However, this development has not extended to the village communities of southern Solukhumbu and northern Khotang. The communities of

[Text eingeben]

Pawai and Bakhachol VDC are scattered and isolated, far away from roads and motor-operated vehicles. During the heavy annual monsoon from June to September, landslides are recurrent hazards, which may block trails for days or even weeks and cut off the villages from the outside world. The two targeted VDCs are inhabited by a number of diverse ethnic groups: The Tibeto-Burmese Rai community constitutes the largest ethnic group; the following language-groups form the local minorities: Indo-Nepalese Chhetris and Occupational Hindu Castes: Kami, Brahmin, and Damai and the Tibeto-Burmese Sherpa, Tamang, Magar, Newar, Dole, Gharti, Bhujel and Gurung (EcoHimal, 2009).

Pawai Village Development Committee (VDC), situated in the Solukhumbu District, is located on terraced slopes, separated by Hunku and Inku river and comprises 549 households with a total population of 2853. Bakhachol VDC is located in the north of Khotang District with a similar landscape as Pawai VDC, separated by three rivers: Hume, Rakha and Liding. It comprises 674 households with a total population of 3750 (EcoHimal, 2009).

## 5.2 Setting the scene for evaluation

For the sake of data acquisition, I spent two months in the country. During a field visit to Pawai and Bakhachol VDC local opinions about the program have been examined. I was travelling independently and unconstrained by EcoHimal staff. As the vast majority of people in the program area does not have sufficient command of the English language, a translator for Nepali-English accompanied me. However, even with a translator I was at some points stretched to language barriers, as some Nepalis do not speak Nepali as their native language (i.e. Sherpa people).

For research, the tool of interviewing was chosen. The interviews have been conducted as guideline based interviews, giving the interviewee the chance to narrate about whatever seems to be important. The conversational gambit is characterized by information about the purpose of the interview, the fact, that every data is treated as confidential and the hint that the interview is recorded. The aim is to gain an insight in the interviewee's relevant structures and experiences. Not thematized topics can be interpreted as non important, even though the interviewer might follow up on it later, if relevant. Predetermination by the interviewer has to

[Text eingeben]

be avoided as far as possible. For asserting the narrative flow, the interviewer repeats phrases already said and nods approvingly (Lamnek, 2005).

The style of communication or merely the interview behaviour can be described as soft. Soft in this case means that the interviewer tries to establish a relationship of trust, by demonstrating sympathy towards the interviewee (not the answers) (Fuchs et al; 1978).

The sampling of interview partners was selected by random choice - by approaching people directly at their homes, on the track or in the fields. Additionally Ms Sangita Shakya, project coordinator at the EcoHimal office in Kathmandu and proven expert on public health, gave some recommendations about possible interview partners. The interest has been directed towards typical cases. Ms Sangita Shakya was also a great support in regards of the guideline for interviews. The first draft I did was discarded by her immediately, arguing that the questions were too complicated for the people living in Pawai and Bakhachol VDC. Ms Shakya recommend keeping questions as simple as possible, without getting to much detailed. In fact, the inhabitants of Pawai and Bakhachol are mostly poor educated and hence simple questions facilitate the interview situation. Overall, 28 interviews were recorded; out of this 22 interviews were transcribed for this paper (Appendix B). The remaining six interviews were not suitable due to problems in regards of recording and replay or because they did not contain relevant information. Some interviews were conducted with several people at a time, which is the case in interview number three (Khorda women's group), 12 (Lakpa Tamang and male villagers) and 17 (health personnel of the subhealth post in Bakhachol VDC). I seeked for a balanced proportion of female and male interview partners, which results in 12 interviews given by men and ten by women.

[Text eingeben]

## 5.3 Methodology

The basis for empirical research is methodology. The following chapters deal with the methodology applied for this paper's research topic.

### 5.3.1 To do the talking – a qualitative research method

As an empirical method, interviewing represents a systematic, methodical and reflected process, which considers external factors of influence as well. In regards of empirical social research, interviewing is the most commonly used way of assessment (Klammer, 2005). The interview itself is quasi dominated by the perspective of the interviewer. The qualitative research in general is interested in the perspective of the subject, or merely in the interpretation of the interviewee (Diekmann, 2010). Diekmann (2010) states that there are three requirements on data assessment:

1. Relatedness to the subject
2. Openness in regards of questions, answers and methodologies
3. Data assessment takes place in a daily situation

Even if the value of qualitative research has not been denied by the quantitative social research, the applicability of qualitative methods is mostly limited to explorative studies. Explorative studies conduce the development of typologies, systems of categorization and the formation of hypotheses. Qualitative research methods are seen as an independent, alternative method for the assessment and interpretation of data (Diekmann, 2010).

### 5.3.2 The problem-oriented interview

For this study, the problem-oriented method of interviewing has been applied. Together with a variety of other forms of interviewing, the problem-oriented method of interviewing falls within the category of guideline-based interviews. Developed by German psychologist Andreas Witzel the problem-oriented interview (problemzentriertes Interview PZI) is a theory generating method, which tries to remove the alleged contradiction between theory-orientation and frankness. Witzel (2000) strongly encourages a subjective presentation of the problem. In addition to that, narrations are complemented by dialogues, which resulted from creative and

[Text eingeben]

guideline-based inquiries (Witzel, 2000). As distinguished from the narrative interview, the interviewer plays an active role during the problem-oriented interview. The interviewer refers to an interview guideline and is allowed to pose questions during the narrative phase. The chronological order of the guideline-based questions should be adjusted accordingly to the situation. Hence, the problem-oriented interview is more structured than the narrative interview (Diekmann, 2010).

*Tools of the problem-oriented interview:*

Witzel (2000) defines four tools that facilitate and support the conduction of problem-oriented interviews:

- *Short questionnaire:* By a short questionnaire, social data (age, occupation, family status etc.) can be collected. These questions shall be inquired before the actual interview, as they might give useful hints for following inquiries.
- *Recording:* In contrast to a written report, a recording, usually accepted by the interview partners, enables an authentic and precise capture of the communication process. Hence, the interviewer can focus on the interview situation including nonverbal communication and situative circumstances.
- *Interview guideline:* A guideline for interviews allows an open conversation, oriented towards a prepared order of questions, which are relevant for the research project. During the interview the interviewer takes up an active part and tries to encourage interview partners to spontaneous reactions
- *Transcript of recordings:* Immediately after the interview, transcripts are rendered. They include a short information about the interview partner, comments on the previously mentioned nonverbal communication and situative circumstances. Additionally spontaneous thematic conspicuities and ideas of interpretation can be noted, which may later be helpful for evaluation.

The transcriptions of the interviews can be found in Annex A.

### 5.3.3 Guidelines for interviews

As an empirical method, interviewing represents a systematic, methodical and reflected process, which considers external factors of influence as well. In regards of empirical social research, interviewing is the most commonly used way of assessment (Klammer, 2005). A guideline for interviews allows an open

[Text eingeben]

conversation, oriented towards a prepared order of questions, which are relevant for the research project. During the interview, the interviewer takes up an active part and tries to encourage interview partners to spontaneous reactions (Klammer, 2005).

In addition to the guideline for interviews, a short questionnaire is developed. This is useful as social demographic data can be collected in a quick and simple way.

**Questionnaire**

1. Resident of:            Pawai VDC  
                                   Bakhachol VDC

2. Sex:                        Female  
                                   Male

For this paper, all interviews will be recorded and later transcribed. As the interviewer is not familiar with the local language, a translator will attend the interview and translate into English. As translating is inherently an interpretative action, a loss of details, peculiarities of the original language, like local turns of expression is likely to occur. Interviews in the original language tend to be more authentic and objective; in this case, however, it is not possible for the interviewer to ask questions in the local language (Kruse et. al, 2012).

*Setting and principles of the interview:*

- Interviewer introduces herself, shortly explains the reason for the interview
- Underlining confidentiality and anonymity
- Frankness
- Flexibility in dealing with interview partners (order of questions is not invariably and can change during the course of interviews)
- Full attention is paid to the interview partner (eye contact, no page turning, obvious interest)
- Allowing pauses of reflection/recreation (interview partners add some information spontaneously)
- No pressure or enforcement on interview partner
- Respecting borders given on behalf of the interview partner

[Text eingeben]

- Participants are considered as “experts” and treated with respect
- Statements are not judged and/or commented by the interviewer

*After the interview:*

- Giving thanks to the interview partner and inform about further actions
- Compilation of an interview-protocol (including place and length of the interview, impressions, atmosphere and eventual unclear points)

[Text eingeben]

## 6. Results, performance & lessons learned

The long and adventurous journey to the extremely remote villages of Pawai and Bakhachol has not been taken without a reason. The recorded interviews but also the hear-to-heart talking, discussions during meals and tea accompanied conversations with the inhabitants of Pawai and Bakhachol aimed at giving an insight in their daily lives and examine the impacts of a rural health development program, implemented by EcoHimal. Even though the method of interviewing is a decent way of qualitative research, the informal conversations like mentioned above are essentially completing the data acquisition, of which more later.

This paper accomplishes two tasks:

- Evaluating the impacts of the rural health development program implemented by EcoHimal in the eastern hills of Nepal
- and in further consequence making recommendations for future programs

### 6.1 General aspects

Basically, the program aims at poverty reduction with an integrated approach on water, health and sanitation, rural development and income generation, capacity building and participatory development. For more than twenty years, EcoHimal is implementing rural development and health care programs in the Himalaya region. Health care is also a major challenge for the Nepali government but in spite of policies and strategies, the implementation has not been fully satisfactory.

#### *Case study: Impressions of Pawai and Bakhachol VDC*

While walking the way from Nele Bazar to Pawai, it becomes obvious why this region has been selected as programme area. Both Pawai and Bakhachol are located extremely remote, hours away from a road and offside the Great Himalayan Trail or any other trekking routes.

Khorda, the first station of the field-visit, is characterised by a big river just a few meters down of the village and its steep terraced fields, where mainly rice and corn are growing. The ward appears comparatively clean and the plaited dustbins seem to be used, as most of them are full. There are tabs almost everywhere and even if not for every single household, they are nearby, making sure that water is

[Text eingeben]

available just within a few minutes walking. Our host, Mr Lamichhane is very active in the community life, as animal health worker and as a member of the health management committee. So is his wife, who takes us to the monthly held women's group meeting, where current issues are discussed and the monthly membership fee is collected. Khorda's population in general seems to be very encouraged in community activities and still holds regular meetings, "punishing" everybody who is not attending with a fine of five Rs. Later on this trip it becomes clear that Khorda is kind of a prototype-ward, also because it is the first ward you reach when coming from Nele Bazar. The impressions and experiences made in Khorda are quite the same like in the other wards.

During the field-visit, it can be seen that improved cooking stoves are used on a daily basis, for preparing all meals and there are just a view households, which kept their ordinary stoves as well. Experiencing dinner with both ICS and ordinary open-fire stoves makes the difference obvious: whereas the production of smoke is marginal with the ICS, it is almost impossible to sit in the kitchen while cooking on open-fire and constantly there has to be put more wood on the fire.

Kitchen hygiene and hygiene in general seem to be quite good; there is soap provided on the side of many tabs, ash nevertheless is rarely seen. According to the local people, the percentage of people washing hands with soap after going to the toilet was zero before the programme, increasing up to 50 percent afterwards. Toilets are in a comparatively good condition and running water for cleaning is provided. Children and the population of Pawai in general make a clean and neat impression, which could be traced back to the fact, that some toilets include a fresh, cold "shower" as well.

In Bijharkaka, ward 9 of Pawai VDC, and notoriously known for its special geographical location far away from any water sources, the RHDP probably had its biggest impact. According to the local population, there have been 13 other organisations trying to bring water to this ward and none of them succeeded. People in this ward are particularly thankful; for them bringing water to the village is simply the biggest advantage of the programme.

A visit in Pawai's ward 6 includes a visit to the subhealth post, a clean and modern building in the middle of the village. The staff is nice and helpful, wearing extraordinary clean clothes. The medicine cabinets are well stocked and organised

[Text eingeben]

and the stock is document in detail. The walls are decorated with info sheets on maternal health, personal hygiene and first aid.

Leaving Pawai VDC behind and heading on to Deurali, a ward of Bakhachol VDC, the situation is similar to Pawai with one difference: all toilets are locked. Keys are handed out after questioning, but in Deurali in general toilets look like they are not as frequently used as they should. Of all of the places visited during this trip, Deurali is probably the one where least progress has been made. In Jakribash, the next ward on the way, the situation changes. Toilets, taps and water are in excellent condition, men as well as women can be seen washing themselves extensively, using soap. The population of Jakribash stands out from all other wards of Bakhachol by its great ambition. Everybody is involved in the construction of the community building, which makes a very good impression, even if not finished yet.

At every place visited during the fieldtrip, many houses are provided with a kitchen garden. Well arranged and surrounded by a fence, cauliflower, spinach, onions, garlic, chillies, tomatoes, leek, potatoes and herbs like mint and coriander are growing. The daily served Dal Bhat is accompanied by homegrown vegetables and herbs. Another thing of which the local population is very proud of is their animals. Buffalos, chicken and goats seem to be in good condition, they are well fed and provided with a shelter. Milk is either directly used or processed to curd, cream or cheese. As in Pawai, the SHP of Bakhachol makes a good impression, even though medicine provided in the cabinets seems to be a little less. The staff is dressed neatly and clean and documents everything very detailed. On the wall, there is a poster, which documents who claimed the Emergency Health Fund, for what reason and so on. However, the roof of one of the rooms is in bad condition, leaking and in need of renovation.

In my opinion there is one thing that needs to be addressed a little bit more: waste management. Even though there are dustbins provided everywhere and most of them seem to be used, there is hardly awareness of waste management. People still drop their waste wherever they are. As everywhere in Nepal this is the standard and certainly a big challenge to change, nevertheless it would be worth to try. In general, the programme seems to be a great success and the feedback of the local population mainly positive. EcoHimal has an unblemished reputation and has the trust of the people.

[Text eingeben]

## 6.2 Data evaluation

The analysis of the interviews is accomplished after Mayring (2003), orienting towards the method of the summarizing content analysis. According to Mayring, the summarization is one possible method of interpretation. The first step of interpretation is done by paraphrasing. Not or little content-related parts of the interview are sort out, the remaining parts are brought to a consistent level. The second step of interpretation is generalization. Paraphrases are generalized to a level of abstraction. It is vital that the content of the paraphrases is retained in the generalization. Theoretical presuppositions can be helpful. As partly congruent paraphrases evolve by doing paraphrasing and generalization a “primary reduction” can be made. Here again. Theoretical presuppositions can be helpful. The new categories can now be interpreted and compared (Mayring, 2003). The following figure shows the process from paraphrase to reduction:

Interview	Line number	Paraphrase	Generalization	Reduction
1	23/24	There were no good doctors here and there are no educated people.	There is a lack of doctors and a lack of education	<p>Before the EcoHimal program people were lacking if medical services and education. Changes since the program:</p> <ul style="list-style-type: none"> <li>• drinking water facilities improved</li> <li>• toilets improved</li> <li>• hygiene improved</li> <li>• health situation of the children improved</li> </ul> <p>There is still improvement possible.</p>
	31	Since EcoHimal has been here there have been quite some changes	The EcoHimal program brought some changes.	
	43	There are much more drinking water facilities than before.	The supply of drinking water facilities improved.	
	51/51	There were no toilets, there was no concept of using a toilet but now people have a toilet	The supply of toilets improved.	
	53/54	50 percent of the people now wash their hands after toilet but still 50 percent do not	The hygiene situation improved; there is still something to do.	
	60/61	The children are healthier than before, they don't get diarrhoea and cold that easily and we do not have to take them to the hospital as frequently.	The health situation of the children improved, illnesses diminished.	
2	13-15	Since EcoHimal has been here, women	Women are more confident and	Changes since the program:

[Text eingeben]

		have more self-confidence, they can stand for themselves - not to an extreme extent, but yes, they are much more confident now.	stand for themselves.	<ul style="list-style-type: none"> <li>• women are more empowered</li> <li>• drinking water facilities improved</li> <li>• time saving</li> <li>• people use ICSS (usage of timber is less, decrease in eye disease)</li> </ul> <p>Expansion of the program in desired</p>
	16/17	There are much more facilities of drinking water, improved cooking stoves and much more women empowerment.	Drinking water facilities improved, people dispose of ICSS and women are more empowered	
	39/40	Before I had to go 15 minutes one way to fetch the water but now, it is available directly at the house.	Water is available directly at the house, so she saves 15 minutes for one way.	
	46/47	Since the construction of improved stoves, the smoke is less, before we had problems with eyes because of smoke but now it is much better.	The construction of ICSS led to a decrease in eye disease	
	51	I save 50 percent of firewood because of improved cooking stoves.	Usage of timber is less	
	56-58	We want the program here for more years, because we all think that even more improvement could be achieved here.	An extension of the program is desired, people think that there could be more improvement.	
<b>3</b>	32	We really like the concept of the meeting, we all like it so we will continue	Concept of holding meetings is appreciated	Meetings are still held because: <ul style="list-style-type: none"> <li>• concept is appreciated</li> <li>• people can benefit from the fund</li> <li>• fund contributes to women empowered</li> </ul> <p>More trainings and programs are desired.</p>
	32/33	When people get sick, the fund is very useful and we can get them to hospital.	People in need benefit from the women's fund	
	33/34	We feel more empowered now; we can take the money for ourselves.	The fund contributes to women empowerment.	
	44-47	We wish some more programs and trainings like sewing would be held. Since EcoHimal we can stand for ourselves and we really feel more empowered.	More programs and trainings are desired. Empowerment increased since the program	

[Text eingeben]

4	12-14	I received trainings about farming as well as growing vegetables. I do have the knowledge, I do have the skills but because of hardship of this very remote area I am not able to do it as good as I could.	He is well trained but it is hard to work in this area.	He has the knowledge and the skills, external factors have a negative impact.
	18/19	The problem is that I have to get my seeds from a place far away and the quality of the seeds fluctuates every year	Seed quality is very unstable, which is a problem.	
5	49/50	EcoHimal provided toilets in the village and also in the school. They did nice work. They improved the stoves as well, they did good work.	EcoHimal did good work in the village, including the school. They provided toilets and ICSSs.	Changes in school life since the program: <ul style="list-style-type: none"> <li>• improved toilets</li> <li>• improved ICSSs</li> <li>• improved hygiene</li> <li>• medicine is provided</li> </ul>
	60/61	In the household, I use ash to wash my hands, but in school we usually use soap and we teach them how to use it.	Hands are washed after toilet and hygiene is trained in school.	
6	17/18	Since the training it is easier for me, I can generate some additional income.	Because of training, some additional income can be generated.	The training has been the most important impact of the program, it contributes to income generation..
	41	I have benefited most from this training, but also from the toilets.	The training was most beneficial, but also the toilets.	Besides this the improved toilets and the improved water supply are very appreciated.
	47/48	I do not have to say "either this or that" anymore. I can choose and if there is a lot of income, I can spend it on food. It is much easier for me.	She is not limited to only one expense. Life is easier now.	More trainings are desired.
	75/76	Yes, I like the improved water supply and I hope to get an advanced sewing training, so we all wish they had stayed for longer.	Water supply has been improved, advanced sewing training desired.	
7	38	Before we had to stand in the queue at the water source for over 40 minutes.	A lot of time used to be spend on fetching water.	Water supply improved a lot and lead to
	40/41	Before there was lots of hardship, but now it is like heaven. Today only three	The water supply for the households improved enormously.	<ul style="list-style-type: none"> <li>• time savings</li> <li>• better hygiene</li> </ul>

[Text eingeben]

		households have to share one tab.		<ul style="list-style-type: none"> <li>improved health situation</li> </ul>
	45/49	Before we had to go to the only source, there was not enough water for all of us. One and a half hour away. We had to wake up at 3am to fetch water.	A lot of time used to be spend on fetching water.	
	55	We are more hygienic now and we fall less sick	Hygiene improved and illness decreased.	
<b>8</b>	38-41	I like the concept of the Emergency Health Fund very much. We collect the money for the EHF and anyone, who is in need of money because of health problems, can take the money as a loan. It is used quite often.	The EHF is used frequently by people in need.	<p>The EHF is used frequently. Due to kitchen gardens and agricultural trainings, malnutrition diminished extremely. Health status improved due to</p> <ul style="list-style-type: none"> <li>improved toilets</li> <li>improved water supply</li> <li>improved hygiene</li> </ul>
	48-50	We have benefited a lot from the kitchen garden...now everybody has a kitchen garden. They also gave trainings about agriculture.	Since the program people dispose of kitchen gardens. Some got trainings about agriculture.	
	55-59	Malnutrition in general does not exist anymore as well as a lack of vitamins. It changed a lot. We don't have diseases like those that we had before, also because of the water facilities and the toilets. We now use soap for washing hands and everybody uses the toilet.	Malnutrition diminished extremely. Toilets, improved water supply and improved hygiene lead to better health status.	
<b>9</b>	45/46	It did not work for us; there is always one in the group who is unsatisfied. We do not want to get involved in any other program.	The program did not work and there is no interest in any other program.	Program failed.
<b>10</b>	32/33	Before EcoHimal was here the program was unimaginable, we were not aware of any health concern.	Before the program there was no awareness regarding health.	Before the program there was no awareness regarding health.

[Text eingeben]

	34-36	Even after EcoHimal left we are continuing with the EHF. Overall, 14 people have benefited from it.	The EHF still exists and has been successfully used.	<p>Changes:</p> <ul style="list-style-type: none"> <li>• Womb falling diminished and awareness has been raised.</li> <li>• Hygiene improved</li> <li>• Traditional healing is still practiced, bt medical treatment also accepted</li> <li>• EHF concept is successful</li> </ul> <p>Recommendations:</p> <ul style="list-style-type: none"> <li>• Give clear announcement and avoid misunderstandings about loans etc.</li> <li>• Decision making should happen autonomously</li> </ul>	
	64/65	Before EcoHimal came here the situation was unimaginable, we did not know anything about the problems regarding health.	Before the program there was no awareness regarding health.		
	66-68	Women had big problems with this falling of the womb. Since the EcoHimal program, many women had an operation and now they are aware of those things.	Falling of the womb has been a problem. Situation improved because of program and awareness has been raised.		
	69/70	After they build these toilets and dustbins, people are more hygienic.	Due to toilets and dustbins, hygiene improved.		
	77-79	We still practice traditional healing methods like before. Now we have the concept that we have to go to the health post and take medicine as well.	Traditional healing is still practiced but medical treatment is also accepted.		
	87-89	After EcoHimal there was maybe 60 or 70 percent change but if the program had stayed here for two or three years more there were maybe 90 percent change.	There has been a lots of change since the program. There is still room for more change.		
	101/102	Things were not really clear and some people understood it wrong that they will get paid for building toilets. So they were a little bit dissatisfied.	Misunderstandings about money lead to dissatisfaction among some people.		
	122/123	I would like to decide things among ourselves instead of calling out too many meetings.	Decision making should happen autonomously.		
11	12/13	The drinking water is better now, the toilets are better now, lots of things changed to a better way.	Drinking water facilities and toilets improved.		<p>Changes since the program:</p> <ul style="list-style-type: none"> <li>• toilets improved</li> </ul>

[Text eingeben]

	28/29	The quality of the water is the same it's only the supply that changed.	There is no change in the quality of the water but the supply improved.	<ul style="list-style-type: none"> <li>• hygiene improved</li> <li>• drinking water facilities improved</li> <li>• less smoke in the rooms</li> <li>• dustbins are used</li> </ul>
	40/41	Especially regarding hygiene there have been huge improvements, everybody uses the toilet now. I also have a metallic ICS, so there is less smoke.	Hygiene improved due to toilets. ICS lead to diminished smoke emission.	
	46	We have dustbins and collect the rubbish now.	Rubbish is collected in dustbins now.	
<b>12</b>	14/15	EcoHimal initiated this Health Management Committee and encouraged us. Before there have not been any committees	New committees have been established by EcoHimal.	<p>New committees have been established, women participation increased.</p> <p>Children have been trained on sanitation and hygiene and labour donation program is highly accepted</p> <p>Overall, there are only positive impacts.</p>
	19-21	In this committee, there are 33% women. Before there were no women at all involved in decision making. But EcoHimal raised their awareness that women have to participate equally.	EcoHimal succeeded in raising awareness among women to participate equally.	
	29-31	The ten-minute donation actually is a great labour donation program. Every man in the ward donated ten minutes of workforce per day, but we were not happy with only ten minutes, so people donated more	Labour donation program was appreciated, people even spent more time.	
	94	We don't find any negative impacts only positive ones	There are no negative impacts, only positive ones.	
	102/103	There have been trainings for the kids regarding sanitation and hygiene.	Children have been trained on sanitation and hygiene.	
<b>13</b>	11/12	Everything is good; all their projects are good. The best ones are the toilets and the improved stoves.	All projects are good, toilets and ICSs are the major improvements.	<p>There would not be a progress without EcoHimal.</p> <p>Impacts of the program:</p>
	22/23	I did have a kitchen garden before as well but there was not	Now there are more vegetables growing in the	

[Text eingeben]

		much growing. EcoHimal showed us how to grow cauliflower, cabbage and much more.	kitchen garden than before.	<ul style="list-style-type: none"> <li>• More vegetables are growing</li> <li>• Communal work is done through the labour donation program</li> <li>• Toilets and ICSS are major improvements</li> </ul>
	35/36	We use the labour donation program in the village for cleaning roads, making paths, dustbins and so on..	The labour donation program is used for communal work.	
	55	I think there could not have been any progress if EcoHimal did not stay here.	Without EcoHimal, progress would not have been possible.	
<b>14</b>	17-22	I prefer the labour donation program to the concepts of wages. Because in this way, I feel more involved in the construction.	The labour donation program contributes to a feeling of involvement.	Impacts of the program: <ul style="list-style-type: none"> <li>• Improved water supply</li> <li>• Improved health and hygiene</li> <li>• Labour donation program leads to involvement</li> </ul>
	27/28	Before they did this, there was not enough water for the entire community. Now, we are fine.	Improved water supply	Women benefit most.
	64/65	Especially for women it is much better now, they save lots of time in fetching water and water	Especially women benefit from the program, they save time when fetching water.	
	96-98	Everybody washes his/her hands after toilet. We don't get sick as much often as before. Before the program, this place was very dirty but now we even use dustbins.	Health status and hygiene improved.	
<b>15</b>	12-15	When EcoHimal came here there was no possibility for veterinary treatment at all, no provision for animal health care. Under the program they had this thing about animal health and they wanted to do something here and there were many people interested in this thing.	Before the program there was no veterinary treatment, animal health has been promoted by the program.	Impacts of the program: <ul style="list-style-type: none"> <li>• Improved sanitation and hygiene</li> <li>• Improved animal health</li> <li>• Environment changed in a positive way.</li> <li>• Involvement was distributed equal.</li> </ul>
	65-69	The environment changed a lot. Mainly because of the improved cooking	Environmental changes have been made due to ICSS and toilets.	Physical structures are still missing.

[Text eingeben]

		<p>stoves and the toilets. We don't have smoke and need less firewood so we don't have to cut as many trees as before. People use toilets and are aware of sanitation and animal insurance. So environmentally, the program affected us a lot.</p>	<p>Sanitation and hygiene improved.</p>	
	71-74	<p>We have seen lots of changes here. There might be some missing regarding physical structures like bridges and roads but that's not important because we now have fresh vegetables and sanitation.</p>	<p>Many changes have been made since the program, even though there is still a lack of physical structures.</p>	
	96/97	<p>I am very happy with the program and I think everybody has been involved, there was nobody left behind.</p>	<p>People were involved equally in the program. The program is good.</p>	
<b>16</b>	30-34	<p>We are very satisfied with the program here. Many committees have been established, the community health committee, the women's group, the animal health committee, the child health club. We are satisfied with the work. What we are most happy about is that our VDC has been declared open defecation free area.</p>	<p>People are satisfied with the program. Many committees have been established and people are happy about the fact that the VDC has been declared open defecation free area.</p>	<p>Committees have been established and women's participation increases because of empowerment. Biggest success: declaring the VDC an open defecation free area.</p>
	103/104	<p>You can find many women in the committees but it could be more. It increased mainly because of EcoHimal's empowerment.</p>	<p>Due to empowerment by EcoHimal, women's participation in the committees increased.</p>	

[Text eingeben]

	112-115	Unlike Pawai, this is a big VDC with many wards and Bakhachol has been declared second open defecation free zone in the whole district. So I think that this was the biggest success of the program.	Declaring the VDC an open defecation free area has been the biggest success.	
<b>17</b>	21-24	We are three people here working in the SHP but EcoHimal did not have any trainings related to health here. They gave primary health care training to the volunteers but I already had some.	EcoHimal did not give any trainings related to health, except some primary health care trainings for volunteers.	The rate of patients and illnesses decreased because awareness has been raised. Volunteers have been educated in primary health care.
	41-43	The rate of patients decreased, there are less illnesses. It decreased to the half. Before this place was very dirty. People through all the rubbish just on the street and we did not have toilets.	The rate of patients diminished by half, there are less illnesses. Before the program, the VDC had a problem with hygiene.	
	76-80	The EHF is really needed. Many people would die without this.	The Emergency Health Fund is important.	
	100	The awareness of health definitely increased.	The awareness regarding health increased.	
<b>18</b>	11-15	When EcoHimal was here I benefited a lot. I am very happy that they came in this village.	The EcoHimal program has been very beneficial.	The program has been very beneficial, especially sanitation and hygiene as well as the women's committee.
	46-47	We benefited from the toilet, drinking water, soap, dustbins, women's committee.	Toilets, drinking water facilities, sanitation, hygiene, and the women's committee are beneficial.	
<b>19</b>	83/84	There is a committee of disabled people in the VDC and we have a fund. EcoHimal donated 10.000 Rs. to this fund.	EcoHimal established a committee of disabled people and donated 10.000 Rs. to the fund.	Because of sewing training, the economic situation improved. Disabled people organize themselves in a committee.

[Text eingeben]

	119/120	Before this sewing training, I had to go to other houses as well and offer my help. However, I only get a 100Rs. for that. This is not enough.	Before the training, the economic situation was poor.	
	124/125	In the past two years, I could not do the sewing for some time, but in the past two years, I earned about 25.000 Rs. out of this activity.	Because of training, an income of 25.000 Rs has been generated.	
<b>20</b>	15-18	EcoHimal took five people from each VDC for a CMA training. I was one of the chosen ones.	Five people from each VDC had the chance to attend a CMA training by EcoHimal.	Because of program she is able to attend a CMA training. This and the program in general have a positive impact on the society. There is still room left for improving medical supply.
	48-49	I am very happy with the program. I am able to do my work now and people have less problems, I can treat them and even give them medicine.	Because of program she is able to work and successfully treat people and their illnesses.	
	66/67	I like the program, every project has a positive impact on the society and even after the program is over, the positive impacts are still there.	The program has positive impacts on the society, which sustain even after the end of the program.	
	77-79	Now that EcoHimal gave 13 types of medicine more it is much better. There would be still missing one or two more but it is definitely better.	Medical supply improved, but there is still some more medicine needed.	
<b>21</b>	53-55	They have declared Pawai an open defecation free area. Before there were no toilets but the major attraction is the drinking water, which they have provided there.	Pawai has been declared an open defecation free zone. Improved water supply is the major attraction.	
	60-62	I think there is a need for programs like this also in other villages.	In other villages as well programs like this are needed.	
	77-79	We have been doing work in these villages but the work EcoHimal is doing, I mean the quality of work, we could not have done this on our	The district level would not have been able to reach the same quality of work without EcoHimal.	

[Text eingeben]

		own and achieve the same quality.		
<b>22</b>	17-19	One problem is to access the population for health care.	Access to health care is a major problem.	<p>The accessibility and availability of subhealth posts is a major problem. Both maternal and child mortality declined in the last years but are still high. Nutrition is still a challenge.</p> <p>Close cooperation between organizations and the government is vital from the beginning of a program. Cooperation leads to sustainability and support by the government.</p> <p>Almost seven percent of the national budget is spend on health each year –planned to be upscaled.</p>
	20-21	The problem is that in the Solukhumbu many health post places are very far. It takes hours to drive.	The distances to subhealth posts in the Solukhumbu region are very large.	
	27-30	Two problems especially in Nepal: number of health posts is not enough, in the mountain region they have a problem. The other problem is maternal health.	The number of subhealth posts is not enough, especially in mountain regions. The other major problems is maternal health.	
	31-33	Actually the decline of maternal mortality is dramatic over the years. The decline in child mortality as well. Although it declined very fast it is still high.	Both maternal and child mortality declined in the last years but are still high.	
	34	Nutrition is another challenge for us. Particularly the maternal and child nutrition.	Nutrition in general but especially maternal and child nutrition are a challenge.	
	52	If these organizations work in close cooperation with the government it's good.	Close cooperation with the government is good.	
	56-59	If they work together with the government it will sustain and there will be support from the government as well.	If there is cooperation, the program will be sustainable and supported by the government.	
	57-59	I think that so far the role of the organizations is good and supporting. In some areas they need help, and they help there is very good.	In general international organizations do good work.	
	64-65	A program needs to be designed in consultation with the stakeholders from the government side, so the real gap will be addressed.	Cooperation with the government is important from the beginning of the program.	
	82-83	In nutrition we are behind. Otherwise, in maternal and child	Maternal and child health improved,	

[Text eingeben]

		health we are doing well.	nutrition is still a challenge.	
	94	Almost seven percent of the national budget is spend on health each year. We are trying for ten percent now.	Almost seven percent of the national budget is spend on health each year. This should be scaled up to ten percent.	

Figure 11: assessment of interviews

### 6.3 Mission accomplished?

The evaluation of the RHDP is based on the program objectives and expected results outlined in the program document drafted by EcoHimal in 2009:

*Objective 1:* Local people are empowered to positively change their health seeking behavior and make demands regarding priority health needs.

- Awareness and knowledge on health and hygiene of local population increased
- Participatory development models – based on traditional and new forms – are effective.

There is no other program activity as successful as improving the supply of water and constructing toilet.

Having a look at the rightmost column of figure 11, the following statements were mentioned conspicuously often:

- drinking water facilities improved
- toilets improved
- hygiene improved

These three statements have been topic in every interview and have often been rated as the most important impact of the program. Even if none of these statements contains the word “health”, their impact on health is undoubtable. In consequence of the improved water supply, people changed their health seeking behavior. Soap or its cheaper alternative ash are provided at every tap, proudly used by women, men and children. Education on hygiene already starts in school. Sarita Lamichhane (interview 5) explains: *“In the household I use ash to wash my hands, but in school we usually use soap and we teach them how to use it. Since the children are very small - it is a primary school - the children tend to make a mess but still we tell them.”*

[Text eingeben]

Since almost every household has a kitchen the traditional *Dal Bhat*, a plate consisting of rice and lentils eaten at least twice a day is accompanied by nutritious vegetable, herbs and spices. Debika Basned, teacher in Pawai VDC explains: *“Malnutrition in general does not exist anymore as well as a lack of vitamins. It changed a lot.”* EcoHimal has provided seeds and agricultural trainings about various farming techniques and organic farming without artificial fertilizer have been given.

Once an enormous health issue affecting women, the uterine prolapse or colloquially falling of the womb is now a decreasing phenomenon. Awareness raising activities transferred the former intimate and private issue to a socially acceptable health issue. Even though subhealth posts and medical treatment play an important role, traditional healing methods are still practiced. Tara Kumar Rai (interview 10), chairperson of the health management committee in Pawai VDC states: *“We still practice traditional healing methods like before. We have it for years and we still have it. But now we have the concept that we have to go to the health post and take medicine as well.”*

*Mission accomplished:* According to the information given in the interviews and my personal perception while visiting the target region, objective 1 is accomplished. However I have the feeling that the integration of traditional healers into the health care services, including the cooperation with subhealth posts and doctors can still be improved. Traditional healers might perceive modern ways of health care as a threat to their age-old business and their reputation. It is vital that both approaches are appreciated on the same level and traditional healers are willing to refer patients to the SHP, when needed.

*Objective 2:* Local basic health service delivery systems are accessible, and efficiently and effectively respond to demands for priority health needs.

- Economic base of local population improved
- Capacity of local health service providers - traditional as well as modern - improved.
- Quality health and hygiene infrastructure (including water supply and sanitation systems and equipment of sub-health posts) at VDC level is effective.

[Text eingeben]

According to several interview partners (i.e. interview one and seven), the situation regarding health and hygiene was more than precarious before the program. It took people hours to go and fetch water and water scarcity was omnipresent. In *Bhijakaka*, a high-situated ward of Pawai VDC progress is most recognisable. Bushba Basned, chairperson of the CDC argued that there have been 12 or 13 other organizations before EcoHimal trying to bring water up to the ward. He also says that the unsuccessful tries of the other organizations gave rise to doubts that EcoHimal would be successful.

Another accomplishment of the program are the toilets, which have been constructed by the villagers themselves under the slogan “one house one toilet”. By now, both Pawai and Bakhachol have been declared open-defecation free zone.

All these accomplishments lead to a common outcome: the improvement of health. Danbar Kumari Sunuaar (interview 17), health post personnel in Bakhachol VDC confirms that the general health situation improved “*Yes, the rate of patients decreased, there are less illnesses. It decreased to the half I would say. Before this place was very dirty. People through all the rubbish just on the street and we did not have toilets.*” Women and children, a target group of EcoHimal’s program, benefits as well from improved cooking stoves. Many families deliberately decided for ICSs as smoke emissions are less and women and children, who spent most of the time in the kitchen, are not exposed to excessive smoke.

The accessibility of health care services goes hand in hand with people’s income. Health care is never for free and medical treatment often expensive. Many of my interview partners received trainings, in agriculture, animal health, sewing or medical assistance. All of them share the fact that their trainings had a positive impact on their financial situation. Alternatively, they were able to generate additional income. This income however can be spend on whatever is needed, including health care. Devita Koirale (interview 6), a disabled women from Pawai VDC who received a sewing training argues: “*Before the training, it was very difficult for me. I am disabled and this is a very remote area. Since the training it is easier for me, I can generate some additional income. When EcoHimal came to this place, they saw me and asked me if I want to attend this training and I said yes*”.

[Text eingeben]

*Mission accomplished:* According to the information given in the interviews and my personal perception while visiting the target region, objective 2 is accomplished. Capacity building was successful, in every perspective but still there is some space left. The supply still lags behind the demand. Although each VDC has as SHP the distances from the wards are still long. The water supply, however, improved in an extraordinary way and quality is appreciated not only on VDC level. Maniram Nepal (interview 21), a district authority employee states: *"We have been doing work in these villages but the work EcoHimal is doing, I mean the quality of work, we could not have done this on our own and achieve the same quality"*.

*Objective 3:* Strengthen existing and develop new participatory development models concerning community cooperation.

- Participatory development models based on the integration of traditional and modern methods have been elaborated, analyzed, discussed, shared and disseminated.
- Program management established and efficiently implemented.

Community cooperation in both Pawai and Bakhachol is expressed mainly in form of various committees and groups like the health management committee, the women's group, the committee of disabled people, CDC-committees, the child club, the school management committee and many more. Like shown in figure 11, the general attitude towards meetings is a positive one. People argue that the concept of holding meetings is successful and the participation of women in the committees is almost equal to men's participation (interview 3). A special feature of committees and groups is their fund. Committee members or the villagers themselves collect money for the fund. The renowned fund is probably the emergency health fund (interview 8, 10). Danbar Kumari Sunuaar (interview 17), health post personnel in Bakhachol VDC claims that 18 people have benefited from the emergency health fund since the concept was introduced by EcoHimal. Still there are some critics, like Luv Kumar Rai (interview 9): *"This committee also existed before. Before EcoHimal, there was Care Nepal here and they introduced the system of collecting two Rs from every committee member. But the fund was misused, so I am afraid now. In addition, there is this saying in Nepali: "if you are afraid once, you are afraid always". So now I am not convinced, if it is sustainable. We cannot satisfy everybody."* And more: *"It did not work for us; there is always one in the group who is unsatisfied. We do not want to get involved in any other*

[Text eingeben]

*program.*” Luv Kumar Rai was the only person during this field trip who decidedly speaks against the concept of holding meetings. He refers to former misuse and does not think that the committee will sustain. An aspect, which was also frequently mentioned, was the empowerment of women. Both men and women argued that the program was more beneficial for women. This can be traced back to following reasons:

- Most program interventions (kitchen garden, improved cooking stoves, tap water at each house) are household-related and therefore affecting the women
- Empowerment strategies and the establishment of women groups lead to an increased participation of women in the community life.
- Focus of health care and prevention trainings is on typical female disease like uterine prolapses

Mission accomplished: Committees are a good thing – provided that meetings are held on a regular basis and women participate equally. The latter one seems to be fulfilled and even if not a 100 percent equally the participation of women definitely increased. This can be traced back to empowerment activities focusing on women. At a meeting of the Khorda women’s group in Pawai VDC the following statement has been recorded: *“If someone is getting sick or does need any help, we can use this money from the fund and we also take interest. Sometimes women want to start a small business and they can then lend some money and pay it back with interest rate. Before EcoHimal was here, we did not know much about these things but they came here and taught us, hold your meetings, collect money and you will later benefit from this.”* The concept of committees and hence the concept of collecting for funds had a positive impact not only on a social level, but also on a financial level.

## 6.4 Recommendations

As already shining through in chapter 6.3 the program has reached its goals and objectives and has been, at least from my point of view, very successful. What has been confirmed after the analysis of data, including the content analysis of the interview and participatory perceptions, was already visible during the weeks I spent in the program region. EcoHimal has an excellent reputation and joins the trust of the local population. What distinguishes EcoHimal’s programs from those of other organizations is certainly their strong local network. In my opinion, EcoHimal’s staff both on the organizational level at the Kathmandu based office

[Text eingeben]

and directly in the villages contributes a lot to the excellent reputation and trust of the organization. Staff members often have their origins in nearby villages and share the same ethnic group as the local population. During interviews and unrecorded, personal talks, I often got to hear that the reason for an unsuccessful program is mainly because of a lack of commitment from the organizations. For example, in Bijharkaka, a ward of Pawai VDC there have been 13 (!) organizations before EcoHimal, trying to get water access for the ward. According to the local population, none of these organizations stayed at the region for more than a few days and mainly foreigners came. Consequently, the people did not feel involved and were suspicious about the program from the beginning. The attribute of a “participatory” rural health development program is in so far warrantable, as empowerment is strongly supported by EcoHimal throughout the program. To share and give information and knowledge is the essential essence of a program like this. There might be the greatest trainings, committees and meetings, they are useless and not demanded, if the advantages are not convincingly transmitted. My recommendation for future programs is to focus even more on women and disabled people. In a patriarchal society, where physical integrity and strength is essential for accomplishing all work load and hence for survival as we find it in Nepal, women and disabled people are still at the lower level of community. Additionally women tend to respond better on the program, as their level of benefit is higher. The committee or group where I experienced most commitment was certainly the women’s group. The meetings are not just obligatory appointments in the women’s daily life, they are happenings, where husbands and other paterfamilias are not allowed to participate.

In the very rare case of a negative feedback, the root cause for this was often found in a lack of involvement. Regardless of whether this has been a personal charge or an omission from side of EcoHimal, informational events and informal communication can be preventional.

Summing it up, following recommendations can be given for future programs:

- Focusing even more on women and disabled people. Empowerment through knowledge, education and voice
- Improved integration of traditional healers into the health care services, including the cooperation with subhealth posts and doctors. Combining traditional healing methods with conventional medicine. Creating a common level of appreciation.

[Text eingeben]

- Giving detailed information about every step of the program, financing, chances and duties to the local population. Communication and involvement is the be-all and end-all!
- Draw clear lines defining which are the objectives of the program and which are not part of it.
- Gain and sustain! Regular visits after the program duration ensuring that all measures sustain and for promoting a communal spirit.

All in all the attribute “successful” is warrantable for this rural health development program. By retaining their professionalism and following a few extra tasks, future programs can be even more successful.

[Text eingeben]

## References

- Anderson, M. (1996). *Development and Social Diversity*. Retrieved July 4, 2013, from Development in practice: [www.developmentinpractice.org/sites/developmentinpractice.org/files/DiP%20Reader%20SocDiv%20text.pdf#page=86](http://www.developmentinpractice.org/sites/developmentinpractice.org/files/DiP%20Reader%20SocDiv%20text.pdf#page=86)
- Awofeso, N. (2013). *Bulletin of the World Health Organization*. Retrieved February 28, 2013, from [http://www.who.int/bulletin/bulletin\\_board/83/ustun11051/en/index.html](http://www.who.int/bulletin/bulletin_board/83/ustun11051/en/index.html)
- Bennett Cattaneo, L., & Chapman, A. R. (2010, October). The Process of Empowerment: A Model for Use in Research and Practice. *American Psychologist*, Vol. 65, No. 7, pp. 646-659.
- Bircher, J. (2005). Towards a Dynamic Definition of Health and Disease. *Medicine, Health Care and Philosophy*, 335-341.
- British Medical Journal. (2011, July 26). *BMJ*. Retrieved February 28, 2013, from <http://www.bmj.com/content/343/bmj.d4163>
- Browe, B. (1996, 08). *Geography and Landscape in the Solukhumbu Landscape, Nepal*. Retrieved 01 25, 2013, from International Mountain Society : <http://www.jstor.org/stable/3673947>
- CIA. (2013, November 5). *CIA - The world factbook*. Retrieved from <https://www.cia.gov/library/publications/the-world-factbook/rankorder/2172rank.html>
- Cornell Empowerment Group. (1989). Empowerment and family support. *Networking Bulletin*, 1 (2), pp. 1-23.
- Cornwell, J. (1984). *Hard-earned Lives: Accounts of Health and Illness from East London*. London: Travistock Publications.
- Del Casino, V. J. (2009). *Social Geography*. Singapore: Utopia Press Pte Ltd.
- Diekmann, A. (2010). *Empirische Sozialforschung. Grundlagen, Methoden, Anwendungen*. Reinbek bei Hamburg: Rowohlt Taschenbuchverlag.
- Dolfman, M. (1973). The concept of health: an historic and analytic examination. American School Health Association.

[Text eingeben]

Donner, W. (1990). *Nepal, im Schatten des Himalaya. Beck'sche Reihe Aktuelle Länderkunden*. München: Beck.

Donner, W. (2007). *Nepalkunde. Menschen, Kulturen und Staat zwischen Monsunwald und Bergwüste*. Bergisch Gladbach & Kathmandu: Lähure Kitàb.

EcoHimal. (2009). *NGO Frameworkprogramme - Programme Document*. Salzburg.

Freire, P. (2000). *Pedagogy for the oppressed*. New York (NY): Continuum.

Fuchs, W., & R. Klima, R. L. (1978). *Lexikon zur Soziologie*. Opladen: Westdeutscher Verlag.

Furuta, M., & Salway, S. (2006, March). Women's Position Within the Household as a Determinant of Maternal Health Care Use in Nepal. *International Family Planning Perspectives*, pp. 17-24.

Gatrell, A., & Elliott, S. (2009). *Geographies of health. An introduction*. Chichester: Wiley-Blackwell.

Gautam, P., & Prerna, B. (2013). *The long road to achieve the MDGs*. Montevideo: Socialwatch. Retrieved from Si.

Gellner, D. (2007). Nepal: towards a democratic republic. Caste, Ethnicity and Inequality in Nepal. *Economic and Political Weekly*, 1823-1827.

Hiermansperger, P., & Greindl, S. (2013, September 26). Durchführung qualitativer Interviews und Auswertung. Retrieved from [http://wdl.wzw.tum.de/forschung/publikationen/download/Qualitative\\_Interviews\\_und\\_Auswertung.pdf](http://wdl.wzw.tum.de/forschung/publikationen/download/Qualitative_Interviews_und_Auswertung.pdf)

ICIMOD. (2007). *ICIMOD - International Centre for Integrated Mountain Development*. Retrieved 01 24, 2013, from <http://books.icimod.org/demo/uploads/ftp/Nepal%20Biodiversity%20Resource%20Book.pdf>

ICIMOD, Ministry of Environment, Science and Technology, Government of Nepal . (2007). *ICIMOD International Centre for Integrated Mountain Development*. Retrieved February 25, 2013, from

[Text eingeben]

<http://books.icimod.org/uploads/ftp/Nepal%20Biodiversity%20Resource%20Book.pdf>Bujhu

Israel, B. A., Checkoway, B., Schulz, A., & Zimmermann, M. (1994). Health Education and Community Empowerment: Conceptualizing and Measuring Perceptions of Individual, Organizational, and Community Control. *Health Education Quarterly*, Vol. 21 (2), pp. 149-170.

Ives, J. D. (2004). *Himalayan Perceptions. Environmental change and the well-being of mountain peoples*. New York: Routledge.

Klammer, B. (2005). *Empirische Sozialforschung: Eine Einführung für Kommunikationswissenschaftler und Journalisten*. Konstanz: UVK Verlagsgesellschaft.

Klammer, B. (2005). *Empirische Sozialforschung: Eine Einführung für Kommunikationswissenschaftler und Journalisten*. Konstanz: UVK Verlagsgesellschaft.

Kruse, J., Bethmann, S., & Niermann, D. (2012). *Qualitative Interviewforschung in und mit fremden Sprachen. Eine Einführung in Theorie und Praxis*. Weinheim & Basel: Beltz Juventa.

Kwan, M.-P. (2004). Beyond difference: From canonical geography to hybrid geographies. *Annals of the Association of American Geographers* 94 (4):, pp. 756-63.

Lamnek, S. (2005). *Qualitative Sozialforschung*. Weinheim: Beltz.

Leo, B., & Bartheimer, J. (2010, August). Who Are The MDG Trailblazers? A New MDG Progress Index. Washington DC, United States: Center for Global Development.

Markus, H., & Nurius, P. (1986). Possible selves. *American Psychologist* 15, pp. 954-969.

Masterson, S., & Owen, S. (2006). Mental health service user's social and individual empowerment: Using theories of power to elucidate far reaching strategies. *Journal of Mental Health*, Vol. 15, pp. 19-34.

Mayring, P. (2002). *Einführung in die qualitative Sozialforschung*. Weinheim: Beltz.

[Text eingeben]

- Mayring, P. (2003). *Qualitative Inhaltsanalyse. Grundlagen und Techniken*. Weinheim: Beltz.
- McWhirter, E. (1991). Empowerment in counselling. *Journal of Counselling and Development*, 69, pp. 222-227.
- Mechanic, D. (1991). Adolescents at risk: New directions. *Journal of Adolescent Health*, 12, pp. 638-643.
- Moss, P., & Dyck, I. (2002). *Women, Body, Illness: Space and Identity in the Everyday Lives of Women with Chronic Illness*. Lanham: Rowman and Littlefield.
- Parr, H., & Butler, R. (1999). *Mind and Body Spaces: Geographies of Illness, Impairment and Disability*. London: Routledge.
- Pradhan, M., & D. E. Sahn, S. D. (2001). *Decomposing World Health Inequality*. Amsterdam: Tinbergen Institute.
- Rai, S. K., & Rai, G. (2001, April). The Health System in Nepal - An Introduction. *Environmental Health and Preventive Medicine*, pp. 1-8.
- Rai, S., Rai, G., & Hirai, K. (2006). The Health System in Nepal - an Introduction. *Environmental Health and Preventive Medicine*, 1-8.
- Rajbhandari, S. N. (2005, March). Inequality of Income and Wealth Distribution in Nepal. Lugano: Faculty of Economics, University of Lugano, Switzerland.
- Rappaport, J. (1987). Terms of empowerment/exemplars of prevention: Toward a theory for community psychology. *American Journal of Community Psychology* 15, pp. 121-148.
- Rappaport, J. (1995). Empowerment meets narrative: Listening to stories and creating settings. *American Journal of Community Psychology* 23 (5), pp. 795-807.
- Schlehe, J. (2002). Formen qualitativer ethnographischer Interviews. In J. Schlehe, & B. (. In: Beer, *Methoden und Techniken der Feldforschung* (p. 79). Berlin: Gebrüder Mann Verlag.
- Schmidt, P. (2013). *Nepal-Information.de*. Retrieved 02 20, 2013, from <http://www.nepal-information.de/>

[Text eingeben]

Sen, A. (1979). Personal utilities and public judgment: Or what's wrong with welfare economics? *Economic Journal* 89 (355), pp. 537-558.

Shrestha, N. R. (2002). *Nepal and Bangladesh. A Global Studies Handbook*. . Santa Barbara: ABC - Clio.

Thapa, S. (2008). Declining Trends of Infant, Child and Under-five Mortality in Nepal. *Journal of Tropical Pediatrics, Volume 54, Issue 4*, pp. 265-268.

The World Bank. (2013, November 5). *The World Bank. Working for a world free of poverty*. Retrieved from <http://data.worldbank.org/indicator/SI.POV.GINI>

Unicef. (2010). *Unicef*. Retrieved March 8, 2013, from [http://www.unicef.org/infobycountry/nepal\\_nepal\\_statistics.html](http://www.unicef.org/infobycountry/nepal_nepal_statistics.html)

Unicef. (n.d.). *UNICEF*. Retrieved November 12, 2013, from [http://www.unicef.org/infobycountry/nepal\\_nepal\\_statistics.html](http://www.unicef.org/infobycountry/nepal_nepal_statistics.html)

United Nations. (1948). *Universal Declaration of Human Rights*. Retrieved November 17, 2013, from UN Website: <http://www.un.org/en/documents/udhr/index.shtml#a25>

United Nations Development Program and Government of Nepal. (2006). *Millennium Development Goals Needs Assessment for Nepal*. Kathmandu: UNDP (United Nations Development Programme) Government of Nepal, Nepal Planning Commission.

United Nations Development Programme. (2013). *United Nations Development Programme*. Retrieved March 7, 2013, from <http://www.undp.org/content/undp/en/home/mdgoverview.html>

United Nations Resident and Humanitarian Coordinator's Office. (2011). *Nepal Peace and Development Strategy 2010-2015: A contribution to development planning from Nepal's international development partners*. Kathmandu: United Nations Resident and Humanitarian Coordinator's Office.

Üstün, B., & Jakob, R. (2005). Calling a spade a spade: meaningful definitions of health conditions. *Bulletin of the World Health Organization*.

[Text eingeben]

- Wagle, U. R. (2010). Economic inequality in Nepal: Patterns and changes during the late 1990s and early 2000s. *Journal of International Development*, Vol.22, pp. 573-590.
- WHO. (1948). *Preamble to the Constitution of the World Health Organization*. New York: WHO (World Health Organization).
- WHO. (2007, January). *WHO Nepal*. Retrieved March 6, 2013, from [http://www.who.int/countryfocus/cooperation\\_strategy/ccs\\_npl\\_en.pdf](http://www.who.int/countryfocus/cooperation_strategy/ccs_npl_en.pdf)
- WHO. (2007, November). *WHO Nepal*. Retrieved March 3, 2013, from [http://www.nep.searo.who.int/LinkFiles/Health\\_Information\\_HSC.pdf](http://www.nep.searo.who.int/LinkFiles/Health_Information_HSC.pdf)
- WHO Country Office Nepal. (2012, May). *WHO Country Office Nepal*. Retrieved March 17, 2013, from <http://www.nep.searo.who.int/EN/Section4/Section41.htm>
- WHO Regional Office for Europe's Health Evidence Network. (2006). *What is the evidence on effectiveness of empowerment to improve health?* Copenhagen: WHO Europe.
- Wirtschaftskammer Österreich . (2010, August 25). *Portal der Wirtschaftskammer Österreich* . Retrieved February 28, 2013, from [http://portal.wko.at/wk/format\\_detail.wk?AnglID=1&StlID=567986&DstlID=8713](http://portal.wko.at/wk/format_detail.wk?AnglID=1&StlID=567986&DstlID=8713)
- Witzel, A. (2000). Das problemzentrierte Interview. *Forum Qualitative Social Research*, Vol.1, No.1.
- World Bank. (2002). *Empowerment and poverty reduction: A Sourcebook*. Washington.
- Zimmerman, M. A. (2000). Empowerment theory: Psychological, organizational and community levels of analysis. In J. Rappaport, & E. Seidman, *Handbook of community psychology* (pp. 44-63). New York (NY): Kluwer Academic Plenum.

# 1 Appendix A

## 2 Transcript of interviews

3

4 1. Bhalakaji Lamichhane

5 Pawai VDC

6 Sex: male

7 Age: 35

8 Occupation: farmer

9 Family status: married, four children

10



11 *As you are a member of the Health Management Committee, what are your major*  
12 *tasks?*

13

14 What type of sicknesses are there, which type of people are coming there, what  
15 are their injuries, I monitor them. I suggest if the management is working properly  
16 in the health post, how they work, what is their work and how they help the sick  
17 people and also to give advice, like you have to do this or that.

18

19 *According to you, what is the major health problem here or what used to be the*  
20 *major problems?*

21

22 There were no good doctors here at first and the next is that there are no educated  
23 people. The people are not literate and the manpower of doctors from the city area  
24 - those who are skilled - they are not willing to come here and stay at the health  
25 post for giving services. This is the main problem.

26

27 *Do you see any changes since the program implementation by EcoHimal,*  
28 *regarding health or generally in daily life?*

29

30 Since EcoHimal has been here there have been quite some changes. Some skilled  
31 doctors were here. Now there is still one professional but he is not able to give that  
32 much efficiency towards health. Maybe we would require more personnel.

33

34 *So during the implementation time of the program there has been more personnel*  
35 *but now it diminished?*

[Text eingeben]

36 No, it has been quite the same but it is not enough.

37

38 *Regarding drinking water, how was the situation before the programme, how is it*  
39 *now and how does it affect daily life?*

40

41 There are much more drinking water facilities than before. Before there used to be  
42 one tap for two or three houses and now there is one for every house. We had to  
43 register the source of water, but that has not been completed yet. The facilities are  
44 much better than before.

45

46 *Do you think that the habits of the population regarding sanitation and hygiene*  
47 *changed?*

48

49 The situation before was unimaginable. There were no toilets, there was no  
50 concept of using a toilet but now people have a toilet. Still the change is not quite  
51 effective because it is working slowly. 50 percent of the people now wash their  
52 hands after toilet but still 50 percent do not. Some do not even take water to the  
53 toilet. It is 50/50.

54

55 *Do you or your family see some improvement regarding health since the program?*

56

57 There has been many changes; we have gained knowledge about hygiene and  
58 things like that. The children are healthier than before, they don't get diarrhea and  
59 cold that easily and we do not have to take them to the hospital as frequently.

60

61 *Thank you for the interview*

1

1 2. Januka Lamichhane  
2 Pawai VDC  
3 Sex: female  
4 Age: 25  
5 Occupation: farmer  
6 Family status: married, two children  
7



8 *Do you think there have been some changes since the EcoHimal program has*  
9 *been implemented and if yes what are these changes?*

10

11 This is a very remote place so the women were left behind. They could not even  
12 stand up and tell their mind, they did not have the confidence but since EcoHimal  
13 has been here, women have more self-confidence, they can stand for themselves  
14 - not to an extreme extent, but yes they are much more confident now. Since  
15 EcoHimal has been here, there are much more facilities of drinking water, improved  
16 cooking stoves and much more women empowerment. There is also this Women's  
17 Committee.

18

19 *Are you a member of this committee?*

20

21 Yes, I am. The women are generally more self-aligned now than before. You could  
22 not even imagine how it was before. But now we can identify ourselves and say, I  
23 can do this on my own.

24

25 *Do you also dispose of things like an improved cooking stove, crops, and livestock,*  
26 *provided by EcoHimal?*

27

28 I have an improved cooking stove and EcoHimal also told me that they will give me  
29 some goats. I did not get them so far but I will get them soon.

30

31 *Do you also benefit from water and sanitation improvement?*

32

33 Before there were drinking water facilities, we had to go very far.

34

35 *Can you estimate how much time do you save due to improved drinking water*  
36 *facilities?*

37

[Text eingeben]

38 Before I had to go 15 minutes one way to fetch the water but now it is available  
39 directly at the house.

40

41 *As you mentioned before you have an improved cooking stove. What are the major  
42 differences compared to the old one?*

43

44 We are farmers, we cannot keep lots of hygiene here, we live in a remote place.  
45 But since the construction of improved stoves the smoke is less, before we had  
46 problems with eyes because of smoke but now it is much better.

47

48 *What about timber? Do you need less timber than before?*

49

50 I save 50 percent of firewood because of improved cooking stoves.

51

52 *What would you wish for the future? What might be missing in the EcoHimal  
53 program for you? Are there any problems left?*

54

55 We all wish that the program were still here for one or two years more. We want  
56 the program here for more years, because we all think that even more improvement  
57 could be achieved here. So all people think that we could develop much easier, if  
58 they were here for one or two years more.

59

60 *Thank you for the interview.*

1 3. Meeting of the Women's group  
2 Khorda, Pawai VDC  
3 Approximately 20 participants.



4  
5  
6  
7  
8  
9 *What are the major tasks of Women's group in Khorda?*

10

11 We discuss about how to keep the village clean, what could other organization do  
12 here and about the well-being of people or anything what can be done here. We  
13 cannot collect lots of money, this is a remote place, but we are getting there.

14

15 *Is there a leader of the committee?*

16

17 We usually hold the meeting on the 10th of each month, but this time we shifted it  
18 to this day, so you can also attend. Normally we are about 30 women, today only  
19 about 20 because we could not inform everybody early enough.

20

21 *What do you buy with the money?*

22

23 If someone is getting sick or does need any help, we can use this money from the  
24 fund and we also take interest. Sometimes women want to start a small business  
25 and they can then lend some money and pay it back with interest rate. Before  
26 EcoHimal was here, we did not know much about these things but they came here  
27 and taught us, hold your meetings, collect money and you will later benefit from  
28 this.

29

30 *So do you continue with the meetings even after the end of the program?*

31

32 We really like the concept of the meeting, we all like it so we will continue. When  
33 people get sick, the fund is very useful and we can get them to hospital. We feel  
34 more empowered now, we can take the money for ourselves.

35

36 *So you don't have to ask the men on what to spend the money?*

37

[Text eingeben]

38 No, we don't have to ask. We want to thank EcoHimal for teaching us and for  
39 empower us. We wish some other organizations will come here in the future as  
40 well and do some good work.

41

42 *Is there something you are missing out of the program, what would that be?*

43

44 EcoHimal gave us 5000Rs as a startup. We wish some more programs and  
45 trainings like sewing would be held. Pawai VDC is the most remote place of the  
46 Solukhumbu district, we wish some more programs would be implemented. Since  
47 EcoHimal we can stand for ourselves and we really feel more empowered.

48

49 *How was the reaction from the males to this change?*

50

51 They mostly like it, there are just one or two who's male ego feels offended.

52

53 *Thank you for the interview.*

1 4. Jagat Bahadu Rai  
2 Pawai VDC  
3 Sex: male  
4 Age: 54  
5 Occupation: farmer  
6 Family status: married, six children



7  
8  
9 I have been told that you received some trainings from EcoHimal. Could you tell  
10 me some more about it?

11

12 Yes, I received trainings about farming as well as growing vegetables. I do have  
13 the knowledge, I do have the skills but because of hardship of this very remote  
14 area I am not able to do it as good as I could.

15

16 *After the .training, which changes have been there for you?*

17

18 I learned a lot. But the problem is that I have to get my seeds from a place far away  
19 and the quality of the seeds fluctuates every year. But the people only want to buy  
20 the good seeds.

21

22 *What are the types of vegetables you grow most in the garden?*

23

24 Spinach, tomatoes, eggplant, cauliflower.

25

26 *What was the impact on your daily life of the EcoHimal program?*

27

28 I learned about various farming techniques and organic farming without artificial  
29 fertilizer.

30

31 *What was your motivation for attending the training?*

32

33 I thought I could benefit from it. If there was a market place nearby, not only in  
34 Nele, Salleri and Mukli, I could benefit even more. I have to take my products very  
35 far to sell them. The people who live here, they ask for vegetables without paying  
36 and I give it to them out of courtesy. Here, there is no need for market, because  
37 only local people live here and most of them have their own garden.

[Text eingeben]

38 *Thank you for the interview.*

1 5. Sarita Lamichhane  
2 Pawai VDC  
3 Sex: female  
4 Age: 25  
5 Occupation: teacher  
6 Family status: married, one child



7

8

9 *You are a teacher at the local school is that right?*

10

11 Yes.

12

13 *How many children are attending this school?*

14

15 About 50.

16

17 *How many teachers are there?*

18

19 Five.

20

21 *How many of them women and how many men?*

22

23 Three women and two men.

24

25 *What do you teach?*

26

27 I teach maths.

28

29 *Where have you been educated as a math teacher?*

30

31 I studied in Sotang, in secondary school up to class five. After that, I did my school  
32 teaching certificate in Solu.

33

34 *Do the children here like to go to school?*

35

36 Yes, they love it.

37

[Text eingeben]

38 *How many days of school are they attending?*

39

40 Six days a week, Saturday is holiday.

41 Saturday we clean the school and wash school uniforms.

42

43 *How much time does the school way take?*

44

45 15 to 20 minutes maybe.

46

47 *Did you hear about EcoHimal's program?*

48

49 Yes, EcoHimal provided toilets in the village and also in the school. They did nice  
50 work. They improved the stoves as well, they did good work. We would benefit  
51 more, if we had one more toilet in school. We have asked for it and maybe they  
52 will give it to us. For 55 people one toilet is not enough.

53

54 *Do you and the other people in school use ash or soap after going to the toilet?*

55

56 Yes, we use soap.

57

58 *Do the children in school also learn how to wash hands and how to use the toilet?*

59

60 In the household I use ash to wash my hands, but in school we usually use soap  
61 and we teach them how to use it. Since the children are very small - it is a primary  
62 school - the children tend to make a mess but still we tell them. It is only about four  
63 months, since I am teaching here. The school exists for 20 years now. One of the  
64 former students is now doing her master's degree.

65

66 *Do parents have to pay for this school?*

67

68 The education is free; the clothes have to be bought by themselves.

69

70 *Who pays your loan?*

71

72 My salary is 3500Rs; I get paid by the district.

73

74 *What about the Child Club? What can you tell me about it?*

[Text eingeben]

75

76 Each student in school collects five Rs individually. The teachers collect it and  
77 invest it somewhere. Students gain interest out of this and this interest is invested  
78 again. The students decide on their own, what they want to do with the money.  
79 Teachers are kind of guardians for helping the children, if they cannot decide what  
80 to do with their money.

81

82 *Is the child club existing since EcoHimal's program or did it start before?*

83

84 Since EcoHimal was here.

85

86 *Which other impacts on school life have been since the program?*

87

88 EcoHimal also provided medicine for the school. One of the children is the leader  
89 of the Child Club, he keeps the medicine in a store and whoever needs some will  
90 benefit from the medicine.

91

92 *Who elects the leader?*

93

94 The children hold a meeting where the leader is elected. Usually one of the older  
95 children is elected. The teachers hold a hand on it, but children decide on their  
96 own. If one of the children misses class, he or she has to pay five Rs penalty. Now  
97 students are even keener on going to school.

98

99 *What happens with the money?*

100

101 This money is also given to the Child Club.

102

103 *Does it happen often that somebody is missing class?*

104

105 No, not anymore.

106

107 Thank you for the interview.

1 6. Devita Koirale  
2 Pawai VDC  
3 Sex: female  
4 Age: 30  
5 Occupation: seamstress  
6 Family status: married, two children



7  
8

9 *Can you please tell me something about the sewing training?*

10

11 EcoHimal gave me once a three-months training and some time before a two  
12 months training.

13

14 *What did you do before the training? How did you generate income?*

15

16 Before the training, it was very difficult for me. I am disabled and this is a very  
17 remote area. Since the training it is easier for me, I can generate some additional  
18 income. When EcoHimal came to this place, they saw me and asked me if I want  
19 to attend this training and I said yes.

20

21 *Are you able to life out of this income?*

22

23 The training has helped a lot, it is my main occupation and as well the only one. I  
24 am not able to do farming because I am disabled so this is my only way of income  
25 generation.

26

27 *Do you also sell the clothes or is it only for family and yourself?*

28

29 I sew almost everything, whatever people want. But not fashionable things, only  
30 the simple things and of course I sell them and use some on my own.

31

32 *In general, how is the life as a disabled person in the community?*

33

34 The people take it in a good way, but for me it is a problem. It is now for almost  
35 four years. I was outside for fetching grass and fell from a tree. I was sent to  
36 Kathmandu for treatment. And I also did some physiotherapy there.

37

[Text eingeben]

38 *Apart from the sewing training, do you benefit from other things provided by*  
39 *EcoHimal?*

40

41 I have benefited most from this training, but also from the toilets. Now there is one  
42 toilet for every household. What I am most happy about is the scholarship, which  
43 was given to my child. They are educating her now.

44

45 *Do you have more income since the training and on what do you like to spend it?*

46

47 I do not have to say "either this or that" anymore. I can choose and if there is a lot  
48 of income, I can spend it on food. It is much easier for me.

49

50 *Are you the only person who attended a sewing training in this VDC?*

51

52 Five people from Pawai and five people from Bakhachol. They were willing to give  
53 training to more people but the people did not want to go.

54

55 *Do you have an explanation why some people would not want to attend the*  
56 *training?*

57

58 Some people have children, some have to take care of the household, and some  
59 have to go to fetch grass. They could not leave the household.

60

61 *How is the situation on your case?*

62

63 One of my girls she is going to school in Kathmandu and my husband married  
64 someone else after my accident. The house where I am staying at is my parents'  
65 house.

66

67 *Where did the training take place?*

68

69 The first training took place near my house. I requested this because I am disabled  
70 and I cannot travel far. The next training took place in Mukli, which is about two or  
71 three hours of walking away for normal people but someone had to carry me so it  
72 took almost one day.

73

74 *Are there other trainings or projects of the program you got use of?*

[Text eingeben]

75 Yes, I like the improved water supply and I hope to get an advanced sewing  
76 training, so we all wish they had stayed for longer. The instructor told me that for  
77 the basic course, I need nine months training and I could take some advanced  
78 course for fashion design so I can get more income out of it.

79

80 *Thank you for the interview.*

1 7. Bushba Basned  
2 Pawai VDC  
3 Sex: male  
4 Age: 60  
5 Occupation: farmer  
6 chairperson of CDC ward eight  
7 Family status: married, four children



8  
9  
10 *You are the chairperson of CDC of ward 8, is that right?*

11  
12 Yes.

13  
14 *What are your major tasks in this position?*

15  
16 The tasks are as EcoHimal has told me. I hold meetings, we collect the mustihidaan  
17 (a palmful of grains or greens are collected for the Emergency Health Fund), each  
18 month I collect money from the members for the fund and I look after the meeting.

19  
20 *Is it true that there have been nine other organizations trying to bring water to*  
21 *Bhijakaka?*

22  
23 Before EcoHimal there were 12 or 13 organizations here. When EcoHimal came  
24 and said to him, ok we will bring water, I said you cannot bring water here; the  
25 water will not climb up here. But the person from EcoHimal just said "you will be  
26 quiet, you just listen to us, we will bring water up here you don't have to worry." I  
27 was still skeptic how they will do it. But they did it and now we are all amazed and  
28 we benefit really now.

29  
30 *According to you, what is the reason why the other organizations did not succeed?*

31  
32 They did not study the place properly, what the problem with the water is all about  
33 and about the water source. Mr. Mo from EcoHimal convinced me and they really  
34 made it.

35  
36 *How was the situation before?*

37

[Text eingeben]

38 Before we had to stand in the queue at the water source for over 40 minutes. We  
39 left our utensils there and came later in the evening to fetch water, because there  
40 were so many people at one place. Before there was lots of hardship, but now it is  
41 like heaven. Today only three households have to share one tab.

42

43 *So there was water before but only very scarce?*

44

45 Before we had to go to the only source, there was not enough water for all of us.

46

47 *How far was the source away?*

48

49 One and a half hour. We had to wake up at 3am to fetch water.

50

51 *Did the quality of the water also change? Is there a decrease in cases of diarrhea  
52 as well?*

53

54 Now we can wash ourselves at any time, the children can wash, we can wash the  
55 clothes, we are more hygienic now and we fall less sick.

56

57 *Did you or other members of the community ever consider moving away from this  
58 place due to water insecurity?*

59

60 Yes, I did consider it and some people already moved away.

61

62 *Thank you for the interview*

1 8. Debika Basned  
2 Pawai VDC  
3 Sex: female  
4 Age: 23  
5 Occupation: student and teacher  
6 Family status: unmarried



7

8

9 *Do you know about the program implemented by EcoHimal three years ago?*

10

11 Yes, I do know.

12

13 *What can you tell me about it?*

14

15 I know about a health project, the water and sanitation project, the toilets, the  
16 emergency fund and some trainings.

17

18 *How have you been involved?*

19

20 I have taken a teachers training as well as a School Management Committee  
21 training. I was one of the members of the Health Management Committee as well.

22

23 *Would you have been able to attend such trainings outside of EcoHimal's  
24 program?*

25

26 No, I could not have taken trainings because there were no trainings like these  
27 before.

28

29 *You mentioned you were a member of the Health Management Committee. Does  
30 the Committee still exist or was it cancelled after the end of the program?*

31

32 The HMC from before has changed a little bit because the man in charge had been  
33 transferred, since than it is difficult. I think we would need some more persons on  
34 charge like technicians and health personnel.

35

36 *Can you tell me something about the Health Emergency Fund?*

37

[Text eingeben]

38 I like this concept very much. We collect money by going from house to house and  
39 by the musthidaan<sup>8</sup>. We collect the money for the Emergency Health Fund and  
40 anyone, who is in need of money because of health problems can take the money  
41 as a loan. And it is used quite often. For example one man - he was attacked by a  
42 bear - he took some loan from the fund and got some treatment. When people  
43 have enough money, they return the loan to the fund. This is still going on, we  
44 regularly do it.

45

46 *Which other changes have been made since the program?*

47

48 We have benefited a lot from the kitchen garden. EcoHimal provided us with the  
49 seeds and now everybody has a kitchen garden. They also gave trainings about  
50 agriculture and they appointed some people and said "you are responsible for  
51 livestock", "you are responsible for herbs".

52

53 *Did your way of nutrition change because of kitchen garden?*

54

55 Yes, malnutrition in general does not exist anymore as well as a lack of vitamins.  
56 It changed a lot.

57 We don't have diseases like those that we had before, also because of the water  
58 facilities and the toilets. We now use soap for washing hands and everybody uses  
59 the toilet.

60

61 *Thank you for the interview.*

---

<sup>8</sup> A palmful of grains or vegetables collected and sold at the market. The revenue goes directly to the Emergency Health Fund.

1 9. Luv Kumar Rai  
2 Pawai VDC  
3 Sex: male  
4 Age: 35  
5 Occupation: farmer  
6 chairperson of CDC ward four  
7 Family status: married, three children



8  
9

10 *What are your tasks as a CDC Chairperson?*

11

12 The main responsibility is to discuss which things are necessary to do for the  
13 community, but maybe this council will not exist in the future.

14

15 *So there are no more meetings held in the future?*

16

17 No, it does not continue.

18

19 *Are these meetings held since EcoHimal was here or also before?*

20

21 This committee also existed before. Before EcoHimal there was Care Nepal here  
22 and they introduced the system of collecting two Rs from every committee member.  
23 But the fund was misused, so I am afraid now. And there is this saying in Nepali:  
24 "if you are afraid once, you are afraid always". So now I am not convinced, if it is  
25 sustainable. We cannot satisfy everybody.

26

27 *The misuse happened at that time when Care Nepal was here?*

28

29 Yes.

30

31 *Did EcoHimal know about this and if yes did they try to avoid things like this misuse  
32 happen again?*

33

34 When EcoHimal came up with this approach of funds and meetings again we said  
35 it did not work for us the last time. But they said "you have to do something about  
36 this, it is your choice but in the end it will pay off". But we are still skeptical about  
37 it. The Women's Committee for example, they are disbanding the committee

[Text eingeben]

38 because they do not plan to distribute the money among themselves and not going  
39 to hold further meetings. Again they say, once there is a misuse there will always  
40 be misuse.

41

42 *How exactly did that misuse happen?*

43

44 It was in the meeting, among the members, they said ok, let's distribute the money  
45 for ourselves. It did not work for us; there is always one in the group who is  
46 unsatisfied. We do not want to get involved in any other program.

47

48 *Thank you for the interview.*

1 10. Tara Kumar Rai  
2 Pawai VDC  
3 Sex: male  
4 Age: 35  
5 Occupation: teacher  
6 chairperson of the HMC  
7 Family status: married, four children



8  
9 *Mr. Rai can you tell me something about your work at the Health Management*  
10 *Committee?*

11

12 As a chairperson, I am responsible for holding the meetings, gathering people  
13 together discuss problems in the health sector and findings solutions.

14

15 *What are typical problems in the VDC.?*

16

17 There is one person from every ward and they inform us about the health problems  
18 in their ward. The representatives of each ward nominate people of their ward who  
19 are in need for the emergency health fund. So they can take some money out of  
20 this and giving it back within three months without interest.

21

22 *Which problems do occur mainly?*

23

24 The primary focus is on emergency cases, like broken legs. These are things we  
25 cannot fix here, we have to send them to Kathmandu. We also have provision for  
26 people with heart diseases, we do not have these cases yes but we would be able  
27 to support them with 4000Rs.

28

29 *Is the Emergency Health Fund active since EcoHimal was here and what is the*  
30 *reason why you still continue this concept?*

31

32 Before EcoHimal was here the program was unimaginable, we were not aware of  
33 any health concern. They introduced the Musthidaan, they made us collecting  
34 money from every household during the Dihar festival and lots of new things. Even  
35 after EcoHimal left we are continuing with these things. Overall, 14 people have  
36 benefited from it.

37

[Text eingeben]

38 *Can you tell me something about the emergency medicine at the Subhealth Post?*  
39 *Did EcoHimal supplied it? And is it covering the demand?*

40

41 We bought the medicine ourselves from the Emergency Health Fund. We charge  
42 ten percent extra for the transportation and the wages of the carrier. We label the  
43 prices and say, ok we sell this medicine for this price. We sell it at the subhealth  
44 post. The medicine in this place is a little bit cheaper than the medicine in other  
45 places. There is a problem because the main person in the subhealth post, the  
46 person who is prescribing the medicine is not here now. But there is the possibility  
47 that another person will come here soon.

48

49 *Why is the person not here?*

50

51 The previous one has been transferred to another place. There are many places,  
52 but people are left behind. The government does not do anything. There is a lack  
53 of manpower, they have not been able to send to people to all the health posts.

54

55 *Is the medicine you provide in the subhealth post affordable for everybody?*

56

57 Apart from the medicine we provide the government has provided 22 types of  
58 medicine, free of course. I don't think there is such a case that someone cannot  
59 afford the medicine. Even if there is a case they can just take the medicine without  
60 paying or can pay later.

61

62 *Which impacts regarding health have been made since the EcoHimal program?*

63

64 Before EcoHimal came here the situation was unimaginable, we did not know  
65 anything about those things, about the problems regarding health. For example  
66 women had big problems with this falling of the womb, it was a big topic, but a very  
67 private one too. But since the EcoHimal program many women had an operation  
68 and now they are aware of those things. They have treated it. Also men take it  
69 positive know. Before it was very private and everybody was shy about it. Also after  
70 they build these toilets and dustbins people are more hygienic. And now we have  
71 this strong concept that we have to take medicines. Before it was like if you have  
72 a headache we had to eat some leaves or smoke some things, we had this  
73 traditional thing. But now we have this concept of medicine if we have a cold or a  
74 headache for example.

[Text eingeben]

75 *So you do not have to depend on traditional healing methods anymore?*

76

77 No, we still practice traditional healing methods like before. We have it for years  
78 and we still have it. But now we have the concept that we have to go to the health  
79 post and take medicine as well.

80

81 *You mentioned awareness raising before. How exactly did that happen? How did  
82 you get informed and in which ways was awareness raised?*

83

84 Before EcoHimal was here there were one or two toilets maybe and we did not  
85 know if we should use toilet or not. EcoHimal came here with the vision that every  
86 household should have a toilet and soap or ash for clean the hands afterwards.  
87 We are better now. After EcoHimal there was maybe 60 or 70 percent change but  
88 if the program had stayed here for two or three years more there were maybe 90  
89 percent change.

90

91 *Can you think of any negative impacts of the program?*

92

93 When EcoHimal came here we had many quarrels among the people. They said  
94 "why should we build that?" and due to EcoHimal's strong vision and some leading  
95 people in the community we convinced them that we need these toilets. When  
96 EcoHimal started the work here they did not say "you have to do this and you have  
97 to do this". Instead they said it at the end of the work. But it would be good to make  
98 it clear from the beginning. There is this one case when they sent a technician here  
99 and he said to us "ok you will gather the sand and the stones and we will bring the  
100 rest for the toilets". Then he left and when he brought the material for the roof. But  
101 things were not really clear and some people understood it wrong that they will get  
102 paid for it. So they were a little bit unsatisfied. But the program was not about  
103 getting paid, it was about labour donation. They were a little bit misguided.

104

105 *Misguided by whom?*

106 There were two people from EcoHimal and they lost their job in the end. They  
107 misguided the people. They had a meeting later with EcoHimal and EcoHimal ask  
108 them "why did you tell the people wrong things?" They misguided the people so  
109 they could not go back to the villages.

110

111 *In general, are the people satisfied with the labour donation program?*

[Text eingeben]

112 EcoHimal brought the materials with the vehicle up to Shotang and then they said  
113 “you have to collect manpower for bringing the material the remaining way up to  
114 the village”. It would have been nice if they had brought the material a little bit  
115 further up. But it was not possible. They people were a little bit unsatisfied but this  
116 is a weakness here. I personally think that it is a good thing.

117

118 *What do you think in general about the representation of EcoHimal in this area?*

119

120 EcoHimal called out a lot of meetings during this program but I think we live a bit  
121 far away, we had to walk one or two hours to attend the meeting. We have usual  
122 work as well. I would like to decide things among ourselves instead of calling out  
123 too many meetings.

124

125 *On the other side you want to be involved in decision making?*

126

127 Yes, but we can arrange the small things among ourselves.

128

129 *Do you think the willingness of holding meetings depends on the community?*

130

131 I think it is a good thing to hold regular meetings of each committee because now  
132 that EcoHimal is gone. When other organizations came before they also wanted  
133 us to hold regular meetings but after they were gone, we dispended it. EcoHimal  
134 started again with the meetings and now we are still holding them. It’s a good habit  
135 for us, we are saving money. If we are not able to meet every month, we hold it  
136 every three months now, but the money we collect is the same.

137

138 *Thank you for the interview*

1 11. Janak Bahadur Tamang  
2 Bakhachol VDC  
3 Sex: male  
4 Age: 46  
5 Occupation: farmer, hotel owner  
6 Family status: married, three children



7  
8  
9 *Can you tell me something about your life in Bakhachol since the EcoHimal*  
10 *program has been implemented?*

11  
12 The drinking water is better now, the toilets are better now, lots of things changed  
13 to a better way.

14  
15 *The jet of water in this ward here seems very thin, is there enough water for all of*  
16 *the people in this ward?*

17  
18 This is the driest season; there is sometimes a lack of water. But during monsoon  
19 season we have enough.

20  
21 *What would be a solution to solve this problem?*

22  
23 We are happy with the situation; there is no need for change something.

24  
25 *What about water quality? Has there been any changes?*

26  
27 We drink water from the same source for 46 years know. When EcoHimal came  
28 here they renovated the still existing old source, so the quality of the water is the  
29 same it's only the supply that changed.

30  
31 *Before EcoHimal came here, did the villagers ever tried to renovate the source on*  
32 *their own?*

33  
34 Many years ago the district committee tried to do something about the water, but  
35 they did not have the knowledge. EcoHimal then came and built a 12-liter reserve  
36 tank, they constructed a new system and new pipes.

37

[Text eingeben]

38 *Which other changes have been made since the EcoHimal program?*

39

40 Especially regarding hygiene that have been huge improvements, everybody uses  
41 the toilet know. I also have a metallic ICS, so there is less smoke.

42

43 *Why do you use metallic stoves instead of clay ones here?*

44

45 Because of the altitude. In winter after cooking you can close the lid and it's nice  
46 and warm. We have dustbins and collect the rubbish now.

47

48 *What do you do with the collected rubbish then?*

49

50 We either burry it or burn it.

51

52 *Is this how EcoHimal explained it to you?*

53

54 They told us that burying and burning is a possibility, but not very good in case of  
55 plastic waste. They suggested that we should take the plastic to the city and sell it  
56 there. But this is hardly feasible.

57

58 *Do you feel that the population of this ward was involved in the program and in the  
59 decision making from the beginning?*

60

61 Everyone was involved and if there were some people in the village who did not  
62 want to participate, we just convinced them. Because the program effects  
63 everybody in the village.

64

65 *Thank you for the interview.*

1 12. Lakpa Tamang  
2 Bakhachol VDC  
3 Sex: male  
4 Age: 46  
5 Occupation: teacher  
6 chairperson of the HMC  
7 Family status: married, five children



8  
9  
10 *As you are a Member of the Health Management Committee, can you tell me*  
11 *something about your activities there?*

12  
13 In this committee we gather among ourselves. We decide together what to do, what  
14 improvements can be done. EcoHimal initiated this committee and encouraged us.  
15 Before them there have not been any committees.

16  
17 *Who forms this committee, of which people is it composed of?*

18  
19 In this committee there are 33% women. Before there were no women at all  
20 involved in decision making. But EcoHimal raised their awareness that women  
21 have to participate equally. But there is a special committee for women as well, so  
22 they hold their own meetings there.

23  
24 *Can you tell me something about the community building, which we saw on the*  
25 *way down here?*

26  
27 It was our vision to have a community health center in this ward and EcoHimal  
28 provided some help, they gave us the roof and some more equipment we needed.  
29 The ten-minute donation actually is a great labour donation program. Every man  
30 in the ward donated ten minutes of workforce per day, but we were not happy with  
31 only ten minutes, so people donated more.

32  
33 *What is this community building used for?*

34  
35 There is a community health center going on there.

36  
37 *Like a subhealth post?*

[Text eingeben]

38 Yes it is planned to be like a subhealth post. We have the vision of constructing an  
39 important health facility. We did not manage it until now but if we get enough help  
40 we might get there soon. As we live in this very remote area we have the vision to  
41 have health facilities. If we get enough help, we can do it.

42

43 *How far is the next subhealth post away?*

44

45 One hour.

46

47 *Do you get any support by the government?*

48

49 No, not at all. In this area we do not get support from the government or from the  
50 district development committee. We do it among ourselves. People in this ward  
51 donated more than just 10 minutes of the labour donation program of their time.  
52 The people who live here collected among themselves. Also people who migrated  
53 from this area to the USA or UK or the Gulf countries send us money. All in all we  
54 collected 80 or 90 thousand Rs. And as I said before we have the vision of a  
55 subhealth post for many people. As this ward is in the buffer zone between  
56 Solukhumbu and Khotang district we don't want to build it only for the Bakhachol  
57 area. So we can give help to many people, some from the Solu area some from  
58 the Khotang area. Because we used to have many health problems there. When  
59 people had to buy Cetamol they did not know if they can get it.

60

61 *Seems like you have a very strong community feeling in this ward. Where does  
62 this come from? Is it since EcoHimal implemented the program or has it always  
63 been like this?*

64

65 There is an actual story behind the idea of constructing this community building.  
66 There is this guy in our village who is a porter guide. One day he was  
67 accompanying a group of doctors who came from Germany. On their way to a trek  
68 in the north this guy saw a health post in one of the villages they passed. So he  
69 asked the doctors, ok what can we do if we also want to have a health post like  
70 this and they planned a health post down here in this village. Next time when  
71 Elisabeth (Mackner, project coordinator EcoHimal) came here, the German doctors  
72 get in touch with her. Elisabeth and all of EcoHimal helped us with the planning,  
73 the cost estimation the material and so on. The roof, which is the major cost was  
74 donated by EcoHimal as well as the furniture. Now we are collecting more money.

[Text eingeben]

75 There is a small Tamang community in Kathmandu and we explained them our  
76 problem. As we are all Tamang we help each other and depending on their ability  
77 everybody donated like 1000 rupees for the community building. Now we came a  
78 lot farer but there are still lots of things to do like painting the ceiling and there are  
79 lots of empty rooms.

80

81 *Who are the decision makers regarding the community building here? Is it the*  
82 *health management committee?*

83

84 First we initiated the name "Himalayan Community Center" then "Himalayan  
85 Community Health Management Center". Both names were not allowed by the  
86 government."Himalayan Health Facility Center" is now registered. And there is this  
87 foundation in Kathmandu who provided this technician called PMA, (?) and this  
88 person was trained and paid by EcoHimal. Dr. Fegerl who is also associated with  
89 EcoHimal helped us in the design phase of the construction.

90

91 *Can you tell me about some impacts either positive or negative of the EcoHimal*  
92 *program?*

93

94 We don't find any negative impacts only positive ones. First we had the vision of  
95 building a small building with only three rooms. I went to Kathmandu to the  
96 EcoHimal office to meet Mr. Narayan Dakhal but he recommended us "now that  
97 you start building you should get a big one and use it as a hospital as well".

98

99 *Mr. Lakpa Tamang as you are a teacher as well can you tell me about the impacts*  
100 *of the EcoHimal program on school?*

101

102 As in many other schools we also have a child club here. There have been trainings  
103 for the kids regarding sanitation and hygiene. In general meetings of all groups like  
104 child club, women's group and so on are still held on a regular basis.

105

106 *Do you feel that EcoHimal is still interested in community life, even after the*  
107 *program ended?*

108

109 Yes, they have implemented a program about seed production and they gave us  
110 seeds for growing maize. It's a five-year program.

111

[Text eingeben]

112 *Is it difficult to grow vegetables in this altitude?*

113

114 In this area we have quite good conditions for growing vegetables.

115

116 *Does the cultivation of vegetables contribute as well to income generation?*

117

118 Yes. We get most of the seeds from the Terai region, then produce more seeds  
119 and then sell it again. The whole community benefits from this.

120

121 *To come back to the government and the district development committee, do you  
122 feel left outside or is this just the normal case?*

123

124 We have been to the government office before and informed them about our plans  
125 to build a community building like this and ask for help. They said they have similar  
126 plans in a place nearby and said they will come to our place when they finish the  
127 first one. But they never came. It is our government and we want them to help us  
128 but they never do. You might now as well about the political situation in Nepal.

129

130 *Do you think this is due to a lack of financial resources or due to a lack of  
131 motivation?*

132

133 There are many factors but they main problem is the lack of education. This is a  
134 very remote area in the buffer zone of Khotang and Solukhumbu district. We cannot  
135 have a leader due to a lack of education. We cannot address the government.  
136 There are many problems.

137

138 *Did EcoHimal address the issue of empowerment and education?*

139

140 They told us to go to the district development committee and express our wishes,  
141 which did not work either.

142

143 *Thank you for the interview.*

144

145 Following people were additionally contributing to the interview:

146

147 Mr. Phul Bahadur Tamang

148 Mr. Nanda Kumar Tamang

[Text eingeben]

149 Mr. Phurtimean Tamang

150 Mr. Phul Bahadur Tamang

1 13. Mitra Kumari  
2 Bakhachol VDC  
3 Sex: female  
4 Age: 46  
5 Occupation: farmer  
6 Family status: married, four children



7  
8  
9 *What changed for you personally during and after the change program?*

10

11 Everything is good, all their projects are good. The best ones are the toilets and  
12 the improved stoves. We also have one out of clay but we would like to have a  
13 metallic one. First we did not know about the metallic ones and then we found out.  
14 We missed in I don't know why, we had to show our citizen card for metallic stoves  
15 and now even after the program has ended we are still trying to claim for a metallic  
16 one.

17

18 *What about the kitchen garden? Do you have it since the EcoHimal program and*  
19 *if yes how did you manage cooking before. What did you and your family mainly*  
20 *eat?*

21

22 I did have a kitchen garden before as well but there was not much growing.  
23 EcoHimal showed us how to grow cauliflower, cabbage and much more.

24

25 *Did they also distribute some seeds?*

26

27 Yes, they did.

28

29 Was it distributed for free?

30

31 Yes.

32

33 *Did you also take part in the labour donation program?*

34

35 Yes, we still do. We use it in the village for cleaning roads, making paths, dustbins  
36 and so on. Everybody donates two hours a week. EcoHimal told us about this  
37 program.

[Text eingeben]

38 *What about the emergency health fund?*

39

40 Yes, we have this fund. The women committee they have their own health fund as  
41 well, as a lot of people already benefited from this concept, we all pay into the fund.

42

43 *Is the fund by the women's committee used only for the women?*

44

45 The fund collected by the women is not like an emergency health fund. They use  
46 it for women in need.

47

48 *Are you a member of the women's group?*

49

50 Yes.

51

52 *Do you think the program would be as successful if the staff did not stay here in  
53 this area for such a long time, but manage everything from Kathmandu?*

54

55 I think there could not have been any progress if they did not stay here. For  
56 example, the district development committee sometimes try to send us goods but  
57 when they asked later if the goods had already reached us we have to deny; they  
58 might vanish on the way here.

59

60 *Do you feel informed about the program and involved as well?*

61

62 Everyone was involved and even if there were people who did not want - we just  
63 forced them to (laughing). There were no people left behind, not even the old and  
64 disabled ones.

65

66 *Did you attend any trainings by EcoHimal?*

67

68 There were training about cattle farming and making small benches, but I was not  
69 able to attend them.

70

71 *How are the trainings organized?*

72

73 EcoHimal said, ok we can offer you these trainings and then people decided  
74 among themselves which training they wanted to attend. It were mostly the literate

[Text eingeben]

75 people who attended the trainings.

76

77 *Thank you for the interview.*

1 14. Tulasi Ram Ghimirk  
2 Bakhachol VDC  
3 Sex: male  
4 Age: 57  
5 Occupation: farmer  
6 Family status: married, four children

7

8

9 *Do you know about the EcoHimal program?*

10

11 Yes, I do. I liked it. They provided us with toilets, drinking water, cattle and many  
12 more.

13

14 *Have you heard about the labour donation program and if yes did you also donate  
15 your work in order to construct toilets?*

16

17 Yes, I am familiar with this and I also donated some of my work. I prefer the labour  
18 donation program to the concepts of wages.

19

20 *Why do you think so?*

21

22 Because in this way, I feel more involved in the construction.

23

24 *How was the situation before the program?*

25

26 Previously we had water here, but not for a long time. EcoHimal renovated the  
27 existing water supply system. Before they did this, there was not enough water for  
28 the entire community. Now, we are fine.

29

30 *Do you have an Improved Cooking Stove?*

31

32 No, I don't.

33

34 *Why?*

35

36 In this ward there are not many people who have ICS. In this area we have a lot of  
37 timber, huge branches and for the ICS you need small ones.

[Text eingeben]

38 *You could cut it down, right?*

39

40 In these days, I did not have time.

41

42 *Do you have a kitchen garden?*

43

44 No, not really. In this area it is difficult to grow vegetables because of the bad  
45 weather.

46

47 *Where do you get your vegetables from?*

48

49 We have to buy it at nearby markets.

50

51 *So is there anything which grows in this area?*

52

53 We usually have radish, beans, potatoes and spinach.

54

55 *What about the toilets? On the way to the village there are some toilets but they  
56 are locked. Why?*

57

58 Everyone uses it, but we lock it because there are lots of people from outside who  
59 are passing this ward. So we lock it and give the key to people who need it.

60

61 *Do you think that the EcoHimal program is generally more beneficial to men or  
62 women?*

63

64 Especially for women it is much better now, they save lots of time in fetching timber  
65 and water.

66

67 *What other activities are going on in this ward? Are there any committees?*

68

69 Yes, we have a CDC. We have meetings on every 11th of the month in the school  
70 over there.

71

72 *Do you still continue the meeting after EcoHimal has left?*

73

74 Yes, we still hold them regularly and I don't think they will decrease in the future.

[Text eingeben]

75 *Does the committee consist of both men and women?*

76

77 It's 50/50? Participation is from both side.

78

79 *What do you think about the government of your country? Do you feel any support*  
80 *from this side?*

81

82 The government itself does not provide any direct help. But whenever an  
83 organization like EcoHimal comes we have a helping hand.

84

85 *Is there anything that did not work out for you in the EcoHimal program?*

86

87 No, we did not have any problems?

88

89 *Is EcoHimal the first organization, which came to this area?*

90

91 There were no organization here before.

92

93 *Overall, did your habits regarding sanitation and hygiene change since the*  
94 *program?*

95

96 Yes, definitely. Everybody washes his/her hands after toilet. We don't get sick as  
97 much often as before. Before the program this place was very dirty but now we  
98 even use dust bins.

99

100 *Is there anything, which you would have desired from the program?*

101

102 When EcoHimal came here they held regular meetings within the village  
103 community and asked everybody if they want tap water. Some people, maybe out  
104 of a lack of wisdom did not ask for tap water and later they were complaining.

105

106 *Did you feel enough informed about the program before EcoHima came here?*

107

108 Yes, everybody was very involved and it was the people's own fault if they did not  
109 know about the activities going on.

110

111 *Thank you for the interview.*

1 15. Birka Sing Sunuaar  
2 Bakhachol VDC  
3 Sex: male  
4 Age: 27  
5 Occupation: animal health worker  
6 shop owner  
7 Family status: married, no children



8  
9  
10 *Can you tell me about your animal health worker training?*

11

12 When Ecohimal came here there was no possibility for veterinary treatment at all,  
13 no provision for animal health care. Under the program they had this thing about  
14 animal health and they wanted to do something here and there were many people  
15 interested in this thing. In case of election who will be the leader and who gets the  
16 training I was elected. I had to chance to go to Pokhara for 35 days and get the  
17 animal health worker training. I did the training there, had to pass a test and then  
18 get the permission to work as animal health worker. Since then I have been doing  
19 my duties over here. There have not been any problems regarding animal health  
20 in this area. The work is still in progress here but we do not have any problems  
21 here.

22

23 *In case of somebody is in need of medical treatment for their animals do they have*  
24 *to pay for it?*

25

26 They have to pay for it.

27

28 *Where do you get the medicine from?*

29

30 I have to buy the medicine from the district head quarter in Kathmandu.

31

32 *What kind of animal diseases occur here in general?*

33

34 Regarding chicken we have problems with diarrhea and bloody urination and  
35 sometimes cholera.

36

37 *So your workload is comparatively little as animals are mostly healthy here?*

[Text eingeben]

38 There are problems arising here and sometimes I even have to go to other villages  
39 in the surrounding areas. Sometimes I can solve the problem on phone and  
40 sometimes I have to visit the places.

41

42 *Are you the only animal health worker in Bakhachol?*

43

44 Now there is a man in Bakhachol not as good as me but I am primarily the only  
45 one and all medicine is found here.

46

47 *Do you think it is ok not to get paid for the training but get the chance of education?*

48

49 I am happy with it.

50

51 *Do you plan to educate other people and share your knowledge about animal  
52 health work?*

53

54 We have the plan to treat this topic in school as well but it is not like there are  
55 people coming to me and asking me for education. But if somebody asks I am  
56 willing to tell them everything about animal health of course.

57

58 *Was it your idea to treat this topic in school or is it planned by EcoHimal?*

59

60 It was my idea.

61

62 *Can you tell me about other impacts of the EcoHimal program here in this ward  
63 and for you specifically?*

64

65 The best thing I can think of is the change of the environment. The environment  
66 changed a lot. Mainly because of the improved cooking stoves and the toilets. We  
67 don't have smoke and need less firewood so we don't have to cut as many trees  
68 as before. People use toilets and are aware of sanitation and animal insurance. So  
69 environmentally the program affected us a lot.

70 When EcoHimal came to this area they promised us a lot of changes but we  
71 thought ok, maybe not all of them are really happening. But we have seen lots of  
72 changes here. There might be some missing regarding physical structures like  
73 bridges and roads but that's not important because we now have fresh vegetables  
74 and sanitation.

[Text eingeben]

75 *Is it possible for the community to build infrastructure in their own?*

76

77 We need some infrastructure like bridges and roads and community buildings. We  
78 have lots of different communities here and they all want their own building. We  
79 ourselves are not able to build it on our own as it is very cost intense. We asked  
80 EcoHimal if they could help us out with things like roofs because roofs are the most  
81 expensive ones. There have been talks about it but in never happened. We also  
82 asked for a transmitter for mobile phone connection. Those things were all in our  
83 agenda.

84

85 *Which agenda?*

86

87 People here have a list, a kind of agenda with things we need in our village.

88

89 *What is on this list?*

90

91 Bridges, the transmitter for mobile phone connection, a community building, a  
92 mill...things like that.

93

94 *Do you feel involved in the program?*

95

96 I am very happy with the program and I think everybody has been involved, there  
97 was nobody left behind.

98

99 *You mentioned the missing infrastructure before and that in Lokhim (a neighbor  
100 village) they had an infrastructure program. If you could decide what would you  
101 have preferred, a health program like it is now or an infrastructure program.*

102

103 In Lokhim there are two programs going on simultaneously - the infrastructure and  
104 the health program. But people in Lokhim work very hard and work together so it  
105 is possible.

106

107 *Do you think this is also because Lokhim is a smaller village.*

108

109 The area is maybe smaller but people are very active. If we go to Khorda or  
110 something via Lokhim we see the bridges there and we would like to have similar  
111 ones.

[Text eingeben]

112 *Do you think that tourism will reach Bakhachol also one day?*

113

114 We have great water here, and fresh air and there are lots of people who are  
115 connected with tourism here as porters. But in the village itself there are no tourists  
116 at all.

117

118 *Thank you for the interview.*

1 16. Bhaktu Kumar Rai  
2 Bakhachol VDC  
3 Sex: male  
4 Age: 47  
5 Occupation: farmer  
6 chairperson of Community  
7 Committee, Chairperson of School  
8 Welfare Committee  
9 Family status: married, three children



10

11

12 *You are the chairperson of the community committee is that right?*

13

14 Yes, I am.

15

16 *What are your main tasks?*

17

18 As a chairperson of the community committee my major tasks are to look after the  
19 program which EcoHimal implemented. I have to look after toilets, water tanks and  
20 things like this but I also listen to the people, what problems they have and what  
21 they say to the program...seeing in the future that these programs are working well.

22

23 *In this community committee are there only people from this ward or from the whole*  
24 *VDC?*

25

26 All of the ten wards are represented.

27

28 *Are you satisfied with the program?*

29

30 We are very satisfied with the program here. Many committees have been  
31 established, the community health committee, the women's group, the animal  
32 health committee, the child health club. We are satisfied with the work. What we  
33 are most happy about is that our VDC has been declared open defecation free  
34 area.

35

36 *Who has declared this?*

37

[Text eingeben]

38 EcoHimal.

39

40 *Are the committee meetings still held?*

41

42 Yes, all of them.

43

44 *What can you tell me about the school management committee?*

45

46 In the school management committee we talk about organization of the school but  
47 we cannot do many things because there are no funds. Beside this we to the  
48 musthidaan we collect vegetables for the emergency health fund. We give loan to  
49 people without interest and to all the people in need in this VDC.

50

51 *Has the school management committee been established during the EcoHimal  
52 program?*

53

54 It existed before.

55

56 *Do you think that EcoHimal used the existing structures in the VDC or did they  
57 establish new committees?*

58

59 They established new ones.

60

61 *Do you think this is good?*

62

63 Only the school committee existed, so all other committees had to be created from  
64 the beginning.

65

66 *Is every child in this CDC able to attend primary school?*

67

68 Not everyone can attend school.

69

70 *Is there a school fee?*

71

72 School is free but you have to buy school uniform and so on, so not everybody can  
73 attend school.

74

[Text eingeben]

75 *Has EcoHimal also been involved in school and education or was this not part of*  
76 *the program?*

77

78 EcoHimal had a program for one and a half year, they could not have it longer,  
79 where they build toilets and tap water for the school. And they had this program  
80 where every child was given a baby chicken, this chicken is worth 1000Rs. When  
81 the chicken is old enough they can sell it and give the 1000Rs. back. They rest of  
82 the earnings out of selling eggs as well they can keep for themselves. The whole  
83 thing was managed by the school management committee

84

85 *Did EcoHimal ever give some recommendations on what the new generated*  
86 *income should be spend on?*

87

88 They talked about this with the child club. It's the child club who decides.

89

90 *Is every child in this CDC in the child club?*

91

92 No only children who attend school can participate as all activities are happening  
93 in the school.

94

95 *Why are you personally involved in the school management committee?*

96

97 I was involved in the school committee from the beginning, also when we got the  
98 land for the school building so I am very familiar with this committee.

99

100 *What about women's participation in all committees? Do you think this is equal to*  
101 *men's participation?*

102

103 You can find many women in the committees but it could be more. It increased  
104 mainly because of EcoHimal's empowerment.

105

106 *Do you think that the males are ok with females in the committees?.*

107

108 Yes, they have to. In some committees there are more women than men.

109

110 *Is there anything else you would like to mention?*

111

[Text eingeben]

112 Unlike Pawai, this is a big VDC with many wards and Bakhachol has been declared  
113 second open defecation free zone in the whole district, Nuntala was the first. There  
114 were some other organizations there, but they don't have toilets as good as ours.  
115 So I think that this was the biggest success of the program.

116

117 *Thank you for the interview.*

1 17. Danbar Kumari Sunuaar  
2 Bakhachol VDC  
3 Sex: female  
4 Age: 49  
5 Occupation: health personnel  
6 Family status: married, three children



7

8 *We are sitting here in the subhealth post. What can you tell me about this building?*

9

10 Except for the table and this chair everything was donated by EcoHimal.

11

12 *You work here as health personnel is that right?*

13

14 Yes, I am working here. My husband is the chairperson of the health management  
15 committee. The doctor is currently at a meeting in a neighboring village but  
16 normally he is here.

17

18 *What are your tasks here in the SHP?*

19

20 Before EcoHimal came here I had many trainings regarding health, including a  
21 health assistant training six month training. We are three people here working in  
22 the SHP but EcoHimal did not have any trainings related to health here. They gave  
23 primary health care training to the volunteers but I already had some. About 13  
24 people have been trained.

25

26 *Do you get paid for your work here?*

27

28 The district pays my salary.

29

30 *What are the main problems why people come to the SHP?*

31

32 In this season it is mainly because of cough and cold but also because of diarrheal  
33 diseases and pregnancies.

34

35 *Do you think that there is enough capacity to meet these needs?*

36

37 We would still need some more personnel here.

[Text eingeben]

38 *Do you see any differences in the occurrence of diseases since EcoHimal*  
39 *implemented the program?*

40

41 Yes, the rate of patients decreased, there are less illnesses. It decreased to the  
42 half I would say. Before this place was very dirty. People through all the rubbish  
43 just on the street and we did not have toilets.

44

45 *Do you think the decrease in diseases can also be traced back to the kitchen*  
46 *gardens as people tend to eat more vegetables?*

47

48 I cannot say because we did not have many cases of malnutrition here.

49

50 (switching to the volunteer, name unknown)

51

52 *So you attended the primary health care training offered by EcoHimal?*

53

54 I did a three-day training here in this CDC.

55

56 *What did you learn in this training?*

57

58 Normal things about primary health care and hygiene.

59

60 (Addressing both women)

61

62 *Can you tell me about the Emergency Health Fund?*

63

64 This is a concept, which we use very frequently. In the other room we have a piece  
65 of paper on the wall where all emergencies are recorded. All in all maybe 18 people  
66 benefited from this.

67

68 (Looking at the paper)

69

70 *So this is the record of one year?*

71

72 Yes, there are the past cases and also the new ones.

73

74 *Is everybody able to pay the loan back?*

[Text eingeben]

75 Yes. This is the list of people who already paid and these are the one who are still  
76 missing. So the health fund is really needed.

77

78 *How would the situation be without the emergency health fund?*

79

80 Many people would die without this.

81

82 *You also have a health statistic here, can you tell me about this?*

83

84 It is mainly for pregnant women, they get registered here and we try to give them  
85 solutions for their problem.

86

87 *So you offer ANC- and PNC-care here in this SHP?*

88

89 Here there is no tradition like coming to the SHP for delivery, we come to the  
90 women's houses. We don't have the habit to come to the SHP for delivering a  
91 baby.

92

93 *According to you, is there an increase in the demand of checkups during and after  
94 pregnancy?*

95

96 Yes, women are very aware of this now, also regarding vaccination.

97

98 *Do you charge this to EcoHimal?*

99

100 The awareness of health definitely increased.

101

102 *Are there more men or women coming to the SHP?*

103

104 Most of them are women.

105

106 *Can you say how many babies are born every year in this CDC?*

107

108 In general the number has been decreasing because of contraceptives but I would  
109 say that in the whole VDC there are about 20 to 25 babies born each year.

110

111 *What about child mortality and mother's mortality, did this also decrease?*

[Text eingeben]

112 We do not have problems of child mortality during birth here. I am working here for  
113 ten years now but I never saw any case. I have been grown old here.

114

115 *Do people tend to see the traditional healer first before they come to the SHP.*

116

117 Yes, this is the traditional approach. They only come if the traditional healer can  
118 not help.

119

120 *Where do you get the medicine from, how is it distributed and who pays for it?*

121

122 We get the 23 medicines, which are one the list from the district level.

123

124 *Do you think that these 23 medicines are sufficient for a good treatment?*

125

126 No the 23 medicines are not enough. EcoHimal started to buy more from the  
127 emergency health fund and they started a little increase in the price of just half a  
128 ruppe for these additional medicines and then people could buy it. The other  
129 medicine is for free.

130

131 *Is there any equipment, which is highly needed for this SHP?*

132

133 The main problem is the roof in the other room you saw. This one is new but the  
134 other one is old and the problem is that it leaks. We talked about this with EcoHimal  
135 but nothing happened yet. And we could also need a staff building. Also some  
136 additional medicine would be nice, even if EcoHimal brought us 13 additional  
137 medicine.

138

139 *How many patients come here every day in search for treatment?*

140

141 I would say in average 20 to 25 people.

142

143 *Thank you for the interview.*

1 18. Bhakta Kumari Puri  
2 Bakhachol VDC  
3 Sex: female  
4 Age: 31  
5 Occupation: farmer, hotel owner, shop keeper  
6 Family status: married, four children



7  
8

9 *What can you tell me about the EcoHimal program?*

10

11 When EcoHimal was here I benefited a lot. Before I was living for rent but now I  
12 can afford a house. During the program when the EcoHimal staff was here I they  
13 used to have lunch and little snacks at my house, about 100 people a day. They  
14 liked me and knew about my hardship. I am very happy that they came in this  
15 village. He (pointing at a little boy) was still in my stomach then. I have two oven,  
16 one I can use for boiling water the other for cooking. I have four children.

17

18 *Is there less smoke since you have an ICS?*

19

20 Yes, a lot less. You can even take this shield of and clean it. I clean it every 15  
21 days.

22

23 *Why did you decide for a metallic stove?*

24

25 I explicitly asked for a metallic one. I am a hotel owner you know, I have a lot of  
26 cooking to do. Everyone who wanted a metallic stove had to pay 5000Rs. and I  
27 paid an extra of 500Rs. to the man who constructed it here. I did not want to have  
28 the clay one.

29

30 *Do you have a lot of guests in your house?*

31

32 When EcoHimal was here, there were even more than 110 people here having  
33 lunch. I was very poor back then but then my business started. Narayan Dhakal he  
34 gave me 10.000 Rs. He was very nice and knew about my situation, I was pregnant  
35 and all that. I am very thankful. When they returned, we cut a goat for them. Before  
36 EcoHimal was here I was very shy and I was not able to express myself and speak  
37 for myself. Even after they were here I was still the same but slowly I started to

[Text eingeben]

38 open and was able to talk for myself.

39

40 *Are you a member of the Women's Group?*

41

42 Yes, I am.

43

44 *In which other way did you benefit from the program?*

45

46 Toilet, drinking water, soap, dustbins, women's committee. I wish they stayed here.

47 There were talks about extending the program for a year but it was not possible. If

48 all the people could have acted as one like in Lokhim it could have been extended.

49

50 *Thank you for the interview.*

1 19. Dhana Maya Khatri  
2 Bakhachol VDC  
3 Sex: female  
4 Age: 30  
5 Occupation: seamstress, farmer  
6 Family status: married, no children



7  
8  
9 *Is it true that you get a sewing training by EcoHimal?*

10

11 Yes, it's true.

12

13 *Where did the training take place?*

14

15 First training was in Hulu, second training was in Mukli because I am not really able  
16 to walk.

17

18 *Did you have the training with Debika, a disabled women from Hulu?*

19

20 Yes, Debika was also there. The two of us disabled and three non-disabled.

21

22 *Who trained you?*

23

24 Bika Tamang, a woman from Khotang. The first training was given by her the  
25 second by a women from Ilang.

26

27 *How did you benefit from the training?*

28

29 I have taken the basic course, which is over six months, and there is still one month  
30 left.

31

32 *Will you take the one left in the future?*

33

34 I am not sure about that.

35

36 *Why are you unsure?*

37

[Text eingeben]

38 The training ended now. I thought it was an advanced training but it was a basic  
39 training.

40

41 *Did EcoHimal tell you that it was an advanced training?*

42

43 I thought so but then I heard that I have to attend six months of basic training before  
44 going to the advanced class. And I would like to do a fashion design training.

45

46 *What are your plans for the future?*

47

48 I have interest in fashion design. I can make some simple stuff now. I show you.

49

50 (she shows several pieces of clothes)

51

52 *Beautiful, looks very nice.*

53

54 Our clothes here are designed very simple but in other areas, they have more  
55 embroideries and stuff and I would like to learn this.

56

57 *Do you sell the clothes to people in your village or do you mainly sew for your own  
58 use?*

59

60 People come here with their clothes and I take measurements, sew for them, give  
61 it back and they pay me.

62

63 *Are you able to live from this income?*

64

65 For me alone it is enough.

66

67 *How much do you earn with one piece of clothes?*

68

69 About 200RS.

70

71 *And how many hours do you usually spend for one piece?*

72

73 If I only do this work I can make two clothes in one day but I have other duties as  
74 well so it depends.

[Text eingeben]

75 *Is the sewing machine given by EcoHimal?*

76

77 No, I paid 4000Rs. for it. But they gave me this one (pointing at another machine).

78 I also asked Narayan Dakhal for another machine so I could sew also thicker  
79 clothes for winter but we have to see.

80

81 *In which other way did you benefit from the program?*

82

83 There is a committee of disabled people in the VDC and we also have a fund.

84 EcoHimal donated 10.000 Rs. for this fund. The money is in the bank.

85

86 *What is this disabled committee about?*

87

88 In the committee there are six or seven people, other disabled women as well. But  
89 they are not aware, they don't attend the meeting regularly. I have initiated that we  
90 start this fund and I went to the bank, accompanied by somebody else to bring the  
91 money to the bank.

92

93 *What do you use the fund for?*

94

95 Many people in this place do not care about their disabled family members and  
96 they say "what will you do with this money, you cannot do anything, it's only few  
97 money. You should divide it among the committee members". Whatever they want  
98 to me to, but I will not divide the money EcoHimal gave to us. I insist on keeping  
99 the money in a bank account. But disabled people do not have a strong voice and  
100 nobody is willing to support us.

101

102 *Do you think that EcoHimal missed it to raise awareness among the disabled  
103 people?*

104

105 The power is in the people, they just have to attend the meetings. Some people do  
106 feel left out because they are disabled, they are shy and don't want to participate.

107

108 *Do you also work in the field?*

109

110 Yes, I do.

111

[Text eingeben]

112 *Are you in need of medical support because of your disability?*

113

114 If I want an x-ray, I have to go to Dikthel but I cannot even wear a shoe with this  
115 leg. I have other duties as well.

116

117 *How would your life be without the sewing training?*

118

119 Before this sewing training, I had to go to other houses as well and offer my help.  
120 But I only get a 100Rs. for that. This is not enough.

121

122 *Would you say that your life conditions improved because of training?*

123

124 In the past two years I could not do the sewing for some time, but in the past two  
125 years I earned about 25000 Rs. out of this activity. If I could take an advanced  
126 sewing training for six months, I could also train other people and get more income  
127 out of this.

128

129 *So you would like to train other people?*

130

131 Yes, I would like to.

132

133 *Do you think that there are some people in this VDC who would be willing to learn  
134 how to sew?*

135

136 In this VDC not but I could go to other villages.

137

138 *Thank you for the interview.*

1 20. Goma Devi Khatri  
2 Bakhachol VDC  
3 Sex: female  
4 Age: 20  
5 Occupation: CMA-student  
6 Family status: unmarried, no children



7  
8  
9 *Your are a community medical assistant is that right?*

10

11 Yes, that's right.

12

13 *Can you tell me some more about your education?*

14

15 EcoHimal took five people from each VDC for a CMA training. The five people of  
16 each VDC have been elected by the CDC as well as from the village development  
17 committee. We had to pass some entrance exams, both written and oral and I was  
18 one of the chosen ones.

19

20 *Have you already completed the training?*

21

22 It is already over. The training lasted for 15 months.

23

24 *Where took the training place?*

25

26 In Dhankuta.

27

28 *So you stayed in Dhankuta for 15 months?*

29

30 From the two VDCs of Pawai and Bakhachol we went to Dhankuta and we spent  
31 there 13 months and two months in Dikthel.

32

33 *Was the accommodation provided by EcoHimal?*

34

35 Yes, everything was provided by EcoHimal.

36

37 *Where do mainly work now?*

[Text eingeben]

38 At the time when the program was still running I was working in the EcoHimal office  
39 house but then they moved to Waku and Deusa. Now I stay home for studying for  
40 the public service examination to work for the government.

41

42 *Would you like to work in a public hospital in the future?*

43

44 Yes.

45

46 *Are you in general happy with the program?*

47

48 I am very happy with the program. I am able to do my work now and people have  
49 less problems, I can treat them and even give them medicine.

50

51 *Could you also imagine staying in the village and work in the SHP?*

52

53 Yes, I can imagine but I have to pass my public service examination first.

54

55 *What specifically did you learn during your CMA education?*

56

57 Minor treatment like treating wounds, medical treatment and primary health care.

58

59 *Is the CMA work the kind of work you wanted to do?*

60

61 I have always been interested in the field of health and when EcoHimal came to  
62 the village, I was really happy. I want to specialize as a health technician.

63

64 *What other changes have been made since the program?*

65

66 I like the program, every project has a positive impact on the society and even after  
67 the program is over, the positive impacts are still there.

68

69 *Do you plan to educate other people, especially in your VDC in the field of health.*

70

71 Yes, I really want to do this and sometimes I already do when people come over  
72 and ask me questions.

73

74 *What do you think about the medicines given by the government, are covering the*

[Text eingeben]

75 *needs of the patients?*

76

77 The 12 types of medicine given by the government are definitely not enough. Now  
78 that EcoHimal gave 13 types of medicine more it is much better. There would be  
79 still missing one or two more but it is definitely better.

80

81 Thank you for the interview.

1 21. Maniram Nepal  
2 Salleri  
3 Sex: male  
4 Age: unknown  
5 Occupation: District Authority employee  
6 Family status: unknown



7  
8  
9 *Do you know about the program of Ecohimal in Pawai and Bakhachol?*

10

11 Pawai yes, Bakhachol is in another district, Khotang. I have heard about a health  
12 program and a sewing program there. But not much.

13

14 *What are your mayor tasks in your position?*

15

16 My main tasks are to explore and find local resources, which can be found in this  
17 area.

18

19 *Which local resources are there?*

20

21 Local resources like handmade Nepali paper and some handmade clothes called  
22 tata and some candies made from ginger, potato chips, pine leaves and bamboo.  
23 You can make handcraft goods out of this leaves. We go to the people and tell  
24 them "you could do these things" and we show them how to do this.

25

26 *Have you visited also Pawai VDC once?*

27

28 In Pawai we found these very underprivileged people who are very left out of  
29 society and we tried to reach them. We trained them in making copper pots and  
30 cooper tools for agricultural use.

31

32 *Do you consider Pawai VDC as one of the most rural areas in this district?*

33

34 Yes, this place is very remote. They don't have any infrastructure there. But they  
35 are very rich in resources. For example, there are these natural herbs available.  
36 Can you remember when we saw those leaves, and I told you beware of these  
37 leaves? They produce some sort of powder out of these leaves and export it for

[Text eingeben]

38 making medicine. They can't make it here, they don't know how to implement it.  
39 But they are rich in those resources.

40

41 *Are these resources used?*

42

43 We got use of alu, it is a kind of hemp and we export it. They make clothes out of  
44 it.

45

46 *How does the local population benefits out of these resources?*

47

48 It just had started now.

49

50 *Do you think EcoHimal made a good decision when choosing Pawai VDC as  
51 program area?*

52

53 Yes, I think it was a good decision. They have declared Pawai an open defecation  
54 free area. Before there were no toilets but the major attraction is the drinking water  
55 which they have provided there.

56

57 *Do you think there is some more need of programs like the one EcoHimal  
58 implemented in Pawai and Bakhachol?*

59

60 I think there is a need for programs like this also in other villages. The area  
61 EcoHimal selected now for their new program, Waku and Deusa VDC are the best  
62 places for implementing the program.

63

64 *Is there any cooperation between the district level and EcoHimal?*

65

66 EcoHimal got an award for their work among all organizations working in this  
67 district. And yes there is some cooperation.

68

69 *In which way do you exactly cooperate?*

70

71 We have a good cooperation. Together we select the program area - areas in need  
72 where there is a lack of drinking water or food.

73

74 *Do you think the district authorities would be capable of promoting rural*

[Text eingeben]

75 *development without organizations like EcoHimal?*

76

77 We have been doing work in these villages but the work EcoHimal is doing, I mean  
78 the quality of work, we could not have done this on our own and achieve the same  
79 quality.

80

81 *Due to a lack of financial resources?*

82

83 There are 34 VDCs in this district and according to the fund which the government  
84 gives us we cannot use it properly, we cannot allocate enough manpower, we  
85 cannot cover all VDCs.

86

87 *Do you think there is a lack of interest by the government regarding rural  
88 development?*

89

90 There is a lack of leadership from the people in the villages and they don't hold  
91 proper elections. Until now they do not have the leadership and the voices to  
92 express their opinions. It is because of ongoing elections. People are not able to  
93 choose their leaders.

94

95 *Do you see some change in the future, after the elections?*

96

97 Yes, I see a bright future for this district. We have the Mount Everest, which attracts  
98 a lot of international tourists as well as domestic tourists. And we have a high  
99 royalty. These royalties go directly to the government. We asked for these royalties  
100 and said "they should go directly to us". There have been talks about it. If this  
101 happens, there will be some great progress.

102

103 *Do you think that tourism will play a key role in the future?*

104

105 In addition to the Great Himalayan Trail we are implementing a new trail which  
106 extends from the Lower Solukhumbu region. People only know about the Higher  
107 Solukhumbu where all the high mountains are. Now this trail starts in the Lower  
108 Solukhumbu region reaching up to the Higher Solukhumbu region.

109

110 *What is the name of the new trail?*

111

[Text eingeben]

112 Sub-Great Himalayan Trail. It's already on the map. There have already been  
113 trainings to find out what can be done for tourists in these trails. There is an  
114 organization from the Netherlands, which is funding this trail. So the future is bright  
115 here.

116

117 *Do you think that drinking water facilities and sanitation are preconditions for*  
118 *places like Pawai for benefiting from tourism?*

119

120 Pawai is also on this trail and there have been trainings there to the people- hotel  
121 management trainings. How can you earn money instantly, how to build hotels  
122 there. So there have been free trainings to the people there.

123

124 *When did that happen?*

125

126 Recently. In the last two months.

127

128 *Did the people welcome this initiative?*

129

130 Yes.

131

132 *From an environmental point of view, are there also programs needed in this*  
133 *district?*

134

135 The first thing is rural transportation; we just recently opened some new tracks.  
136 People are aware of the open defecation free area, every village is implementing  
137 this now. We have some problems regarding drinking water and sanitation and we  
138 have not been able to use the drinking water resources properly. These are the  
139 main problems.

140

141 *Thank you for the interview.*

1 22. Anonymous  
2 Ministry of Health and Population  
3 Kathmandu  
4 Sex: male  
5 Age: Unknown  
6 Occupation: employee MOHP, Department of Policy, Planning and International  
7 Cooperation

8

9 *Three weeks ago I was in the Solukhumbu region for examining the rural health*  
10 *development program by EcoHimal. Are you familiar with EcoHimal?*

11

12 Yes, a little bit. But I don't know much about it. But you could ask me more specific  
13 if you want.

14

15 *Well, according to you what are the major problems regarding health in Nepal?*

16

17 One problem is to access the population for health care. But each problem has sub  
18 problems as well. For example financing. There is a financial, cultural and  
19 geographical lacking. Because many people cannot afford to get health services  
20 available. Geographical as well. You might have noticed in the Solukhumbu that  
21 many health post places are very far. It takes hours to drive. In need of emergency  
22 that cannot be used. Another thing is the cultural thing. There are some people  
23 who might not use the doctor. Even if they are sick they don't know whether to use  
24 or not. This is a cultural barrier. This is one of the main challenges. And second  
25 one is the system. Our system is a fragile one. The health system changed  
26 especially in 1991. Because there was much in population, much change in  
27 development, much change in disease. But in financing not much changed. Two  
28 problems especially in Nepal: number of health posts is not enough, very small  
29 number. Even those health posts are not fulfilled. Particularly in the mountain  
30 region they have a problem. There might be other problems but these are the major  
31 ones. Other problem is maternal health. It took a lot. Actually the decline of  
32 maternal mortality is dramatic over the years. The decline in child mortality as well.  
33 There is a very fast decline in the past few years. But how to suspend that decline?  
34 Although it declined very fast it is still high. Nutrition is another challenge for us.  
35 Particularly the maternal and child nutrition. So our focus will be on various stages  
36 of nutrition because it is very alarming.

37

[Text eingeben]

38 *Does the government promote breast-feeding?*

39

40 Yes, the government promotes breast-feeding. Luckily breast-feeding is very much  
41 practiced in Nepal, the government just has to maintain this level. Because it's  
42 traditional. The mothers do this till they cook. Particularly in rural areas women will  
43 breast-feed for a longer period. Ten months or longer, no problem. But in urban  
44 areas now there is the tendency that breast-feeding is replaced by other milk, like  
45 milk powder. So basically we have to focus on urban areas. But luckily the majority  
46 of women in rural areas does breast-feeding. But still the percentage of babies who  
47 get breast-fed has slightly declined. Because of the urban areas.

48

49 *What do you think of the work of international organizations regarding health?*

50 *Would the Nepali health sector be able to survive without these organizations?*

51

52 If these organizations work in close cooperation with the government it's good.  
53 Sometimes we found that the organizations did not go to the government. If they  
54 are trying to work for themselves this is not going to sustain. And the government  
55 will not take the responsibility. Maybe they will be supported for one, two, or three  
56 or maximum five years. If they work together with the government it will sustain  
57 and there will be support from the government as well. I think that so far the role of  
58 the organizations is good and supporting. In some areas they need help, and they  
59 help there is very good.

60

61 *According to you, what characteristics need to be fulfilled by a program to be*  
62 *sustainable?*

63

64 A program needs to be designed in consultation with the stakeholders from the  
65 government side, so the real gap will be addressed. Number two those programs  
66 are not for a long period, so if there is not much financial support from the  
67 government the government will incorporate those programs in the government  
68 system. If it has been initiated with the consultation of the government. Then it will  
69 not have much problems. But if the government is not incorporated it will not know.  
70 Even the local population will not know what is going on.

71

72 *So the program has to be in line with governmental regulations?*

73

74 Not only regulations. We are designing health policies. Now we are designing the

[Text eingeben]

75 second national health sector program 2010 to 2015. Not only the ministry of health  
76 and population. Also other ministries, international organizations and the medical  
77 college have been represented.

78

79 *So the current health plan is 2010 to 2015 is that right? So far, is the development*  
80 *going in the right direction?*

81

82 So far, yes. We are very much on track except for one, which is nutrition. In nutrition  
83 we are behind. Otherwise, in maternal and child health we are doing well.

84

85 *Do you also do funding for nongovernmental organizations?*

86

87 We have our one system. We don't do direct funding but we have certain  
88 cooperation with NGOs. So in that case there have been many examples where  
89 we did funding. For example for mental health. #00:10:00-0#

90

91 *We talked about financing before. Do you have an idea of how much of the*  
92 *annual budget is spent on health per year?*

93

94 Almost seven percent of the national budget. We are trying for ten percent now.

95

96 *Do you think that the new government will bring some changes regarding this after*  
97 *the election?*

98

99 Hopefully.

100

101 *Thank you for the interview*

