

Introduction

On the 6th of December 2008, after a period of preparation, the Medical Checks for Children (MCC) team met in Kathmandu to travel together for the fourth time to the Sauraha region, which MCC has called "Chitwan".

The MCC Chitwan 2008, mission which was headed by Karlien Bongers, in daily life working as a general surgeon in the Netherlands, checked and treated 1162 children.

The team members with a medical background were, Eva Bouwsma, trainee gynaecology, Luc Coffeng, epidemiologist in training, Carlien Erlings, trainee general physician and Jan Keppel Hesselink, MD and professor in pharmacology.

The non-medical team members were Elsa Geilman, retired teacher and coach living in Greece, Marian de Kok, physiotherapist, Femmie Meenhorst, radiological assistant, Rens Wintjes, medical technician, Joke van de Zwaan, medical secretary, and Marjolein van Zanten, law student.

The Sauraha region, in which on estimation 33.000 people live, is situated in the Rapti Valley in the south of Nepal nearby the Royal Chitwan National Park. The park is to the south of the Thulo Rapti river, the people live to the north of the river. Annually, the river gives a lot of problems during the monsoon.

The region used to be primeval forest where Tharu people lived. Fifty years ago it was transformed into agricultural land. Nowadays most of the Tharu people are living in poverty. Around 40 % can not read and write properly. In the region are three public schools (in Maalpur, Bauchali and Gothauli) with grade 1 to 10. Quality of education is low with lack of proper class rooms and a deficit of teachers. Around 90 % of the children go to school and the drop out rate is high because they are needed "at home". Only 70 % of the children finish primary education.

Infrastructure is mainly formed by sand roads. The nearest hospital is situated in Bharatpur, 16 kilometres away. The hospital has 140 beds, 17.000 admissions a year and 6000 deliveries. It has a children ward with 35 beds, supervised by four dedicated paediatricians. Because of a lack of (qualified) nurses there are no high/medium care units for children. Around 150 children a day are seen in the outdoor clinics.

In Bachhauli, a condensation of houses in the Sauraha region is a medical post in which a doctor from the hospital of Bharatpur has some working hours. Daily health care is delivered by Raj Kharel, who followed an education as "para-medicus" and has his medical shop in Sauraha itself.

Because of the man power problem in Nepal there are no real options for improving the (local) health care system. The overall hygienic situation is poor with small houses, lack of lavatory systems and safe water supplies.

Because of the world wide economic recession and after a long period of political instability in Nepal, 2008 was a hard year for the Nepali people with increasing oil prices and lack of electricity.

The free of costs medical checks in Chitwan were organised in close cooperation with the local NGO named Sapana Village Development Centre (SVDC). SVDC has a small development project called Sapana Village (www.sapanavillage.com) which is supported by the Dutch development organizations NCDO (Nationale Commissie voor Internationale Samenwerking en Duurzame Ontwikkeling) and FEMI (www.femi.org).

Aim of the Sapana Village, which is Nepali for "Dream village", is to support the local Tharu community and preserve their culture heritage. Education and Culture awareness are the main issues. This target is reached through local programs. The lodge is aimed to support the financial cost and manage the organization here for.

With the help of Prakash Bhatta (www.treks2nepal.com) MCC bought local medication from Padam Prasad Gautam, a pharmaceutical wholesaler in Kathmandu.

The people of the Sapana Village Development Centre provided transport, food, and local human resources in translators and volunteers (a team of in total 20 members) in order to facilitate the medical checks.

Special thanks go to Dhurba Giri, President of SCDC and Bishnu Puri, Secretary of SVDC for their fantastic organisation and coordination during the whole week.

We are grateful to all parents, care takers and community people for bringing the children and helping to conduct the program.

We are happy to got the opportunity to work with and to learn from all volunteers, translators, SCDC team members and other supporting members who have helped directly or indirectly despite their own work duties.

Special thanks go to the people of Kumrose who borrowed us their tables and chairs for a whole day.

Again we enjoyed working together with the people of the Ozone Youth Club in Hardi who gave us their home and the opportunity to learn more about the Tharu way of living.

We also like to thank Celia Sluijter (www.celia.nl) a Dutch designer, for her support during this week of checks.

A special thanks goes to Joke vd Zwaan who donated the money to buy toothbrushes, paste and soap for all children.

But most of all, we thank the children who came to the checks for their inspiring presence.

Medical Checks for Children on location:

The medical checks of the 1162 children were performed in seven days at the following four locations:

Chitrasari		Hardi		Kumrose		Sapana Village	
Bhagtini Bagaicha	5	Bagmara	120	Kumrose	293	Badrani	2
Chitrasari	168	Debauli	10			Ketaketigar	12
Gothauli	41	Hardi	41			Malpur	58
Jothula	1	Narkatiya	59			Padampur	3
Manhara	29					Sapana	197
Taar	60					Sauraha	4
Taardi	10					Siswar	46
Total**	314		230		293		321

* Children from any one village were not necessarily checked at one specific camp location. Therefore, data are pooled per place of stay.
 ** Of three children, place of stay was unknown.

Table 1: Place of stay of checked children per geographical area.*

All villages (see Table 1) are poor rural areas although some of the inhabitants are in a wealthier position because of income from the tourist industry or money made outside Nepal. We checked only the poorest children from these places.

In Hardi and its surrounding villages live mainly Tharu people.

We visited Kumrose, a village out in the jungle, is built on governmental property and the people are so poor they can't even effort buying tea and sugar. They ate everything the land and the jungle gives for free. There is no running water and hardly any real toilet. Luckily there is a streaming river nearby. We visited Kumrose for the second time. Last year, a lot of children were afraid seeing our white faces while the people are not used to European people visiting their village. This year they recognized us and were more willing to come to the checks.

Most of the medical cases which received our attention were anaemia, growth abnormalities, skin problems and worm infections. On each location the children stood in line for medical care. They were given a numbered form and were admitted to the first station where their name, age and MCC number were written on the form by a local helper. This paper was than given to the child who kept it until his or her treatment had been completed.

After their weight and height had been taken, oxygenation of the blood was measured and blood was checked for haemoglobin. A complete physical examination was done by one of the doctors who subscribed treatment when needed. Afterwards the child was sent to the last station where the clinical forms were kept after medication was dispensed and information was given with the help of a local worker.

The data of the children were put in a special computer program.

At the end of the MCC carrousel, every child got a toothbrush, paste and soap.

Every evening an analysis of the charts and diagnosis was made.

As with most medical missions, we made efforts to include local volunteers (medical workers, teachers, students etc.) in the care of the children. We greatly respected their vast knowledge and experience. Without their help MCC could not work so effectively.

Diagnosis and categories of ailments:

During the week, MCC checked 1162 children.

Due to the high risk of under five years of age mortality and morbidity, the focus of MCC is checking young children. Of all checked children, 91 % of the children had the age of twelve years or younger and one fourth of the children had the age of five or younger.

Age category	Total (%)	Chitrasari	Hardi	Kumrose	Sapana
< 1 year	40 (3.4)	5 (1.6)	8 (3.5)	20 (6.8)	7 (2.2)
1 – 5 years	253 (22)	63 (20)	45 (20)	81 (28)	63 (20)
5 – 12 years	765 (66)	215 (68)	154 (67)	170 (58)	225 (70)
≥ 12 years	104 (9)	32 (10)	22 (10)	22 (7.5)	28 (8.7)
Boy	609 (52)	178 (57)	107 (47)	153 (52)	170 (53)
Girl	553 (48)	137 (44)	122 (53)	140 (48)	152 (47)
Total	1159*	315	229	293	322

* Of three children, age was unknown.

Table 2: Age and gender distribution of checked children, total and per area. Figures represent absolute numbers with percentage of children in the area between brackets.

Except of the 561 (45%) children with anaemia, 101 children had another major diagnosis (see table 3). Most of the ailments, except the dental problems, could be treated on the spot. We referred 19 children (1.6% of 1162) to a medical specialist for further diagnoses and/or treatment.

Major diagnoses	Active worm inf.	Scabies	Lice	Pneum.	TBC	Path. Murmur	Psych. retard.	Painful caries
Chitrasari	34 (11)	1 (0.3)	1 (0.3)	12 (3.8)	-	5 (1.6)	1 (0.3)	16 (5.1)
Hardi	18 (7.9)	-	5 (2.2)	7 (3.1)	-	1 (0.4)	-	20 (8.7)
Kumrose	20(6.8)	1 (0.3)	13 (4.4)	8 (2.7)	1	2 (0.7)	2 (0.7)	11 (3.8)
Sapana	29 (9.0)	1 (0.3)	17 (5.5)	6 (1.9)	1	5 (1.6)	-	43 (13)
Total	101 (8.7)	3 (0.3)	36 (3.1)	33 (2.8)	2 (0.2)	13 (1.1)	3 (0.3)	90 (7.7)

Table 4: Disease prevalence among al 1159. children, total and per area. Figures represent absolute numbers with percentages of children between brackets.

1: Anaemia (516 , 45 %)

Anaemia is the most prevalent micronutrient disorder. In Nepal no national policy has been implemented to provide iron supplements to pregnant women or young children. While iron deficiency is frequently the primary factor contributing to anaemia, it is important to recognise that the control of anaemia requires a multi faceted approach which, through integrative interventions, addresses the various factors that play a significant role in producing anaemia in a given community. In addition to iron deficiency, infectious diseases such as worm infections, other chronic infections, particularly HIV-AIDS and tuberculosis, malaria, as well as other nutritional deficiencies, are especially important.

As in other populations, we found a larger percentage of anaemia in children one to five years of age.

We treated the children with anaemia (and their mothers if they were breast fed) with supplements for three months.

The twelve children with a haemoglobin levels less than 5.0 mmol/l were referred to the hospital for further diagnostic procedures.

Age category	Total (%)		Chitrasari	Hardi	Kumrose	Sapana
< 1 year	28 (70)		22 (67)	4 (80)	7 (70)	3 (75)
1 - 5 years	116 (46)		33 (52)	21 (48)	39 (48)	23 (38)
5 - 12 years	341 (45)		96 (45)	79 (52)	76 (45)	89 (40)
≥ 12 years	31 (30)		12 (38)	8 (36)	5 (23)	6 (21)
Hb ≤ 5.0 mol/l	12 (1.0)		-	-	5 (1.8)	2 (0.6)
Total	516 (45)		143 (46)	112 (50)	127 (45)	121 (38)

Table 4: Anaemia prevalence among children from who successful blood samples were obtained, total and per age category and area. Figures represent absolute numbers with percentage of children in age category between brackets. In the analysis above, haemoglobin levels at or below the CDC criteria were considered to represent anaemia (same procedure as winter 2007).

In comparison with the anaemic children we saw in 2007, an improvement can be seen. Of course we can only speculate about the origin of the improvement. Possibly it was only a selection bias because we saw in 2008 more children than 2007 so maybe we saw in 2007 the more needy ones.

2: Worm treatment (967 profylactic and 109 therapeutic (5 days) treatments were given)

Due to the relationship between helminth, *Ascaris lumbricoides*, *T. trichiura* and anaemia the children were simultaneously treated with Albendazol. In the last years a de-worming program was established in Nepal where there is a high prevalence of *A. Lumbric*, helminth, Hookworm and *T. Trichiura* in school-aged children.

We treated children who were not in the de-worming program on the spot with Albendazol and left medication for repeating the treatment after six months.

A active worm infection was suspected in 101 (8.7%) children. They were treated with anti-worm tablets for 5 days. Of course we left medication to repeat the prophylactic treatment after six months

Health education on the spot and at the school in Chitrasari, was aimed at increasing awareness of worm transmission, the disabilities caused by intestinal helminth and the importance of the de-worming program every half year.

Simple ways of improving personal hygiene and sanitation through hand washing, nail trimming, wearing of shoes and use of a latrine and clear water supplies were encouraged.

Although all members of a population can be infected by worms, those who are at most risk and would benefit most from preventive interventions are the pre-school (2-5 years), school age children, adolescent girls and women of childbearing age.

3: Growth abnormality and malnutrition:

Percentages of stunting indicating moderate to severe growth retardation is correlated with living conditions, showing higher prevalence in poor rural versus richer urban children in middle class schoolchildren.

At present, Nepal has the highest levels of malnutrition in South-East Asia. A study conducted in 2006 by the Ministry of Health and Population shows that 49 percent of children under the age of five are stunted, reflecting chronic malnutrition. A recent report of the World Bank shows that one percent decrease in adult height due to childhood stunting correlates with 1.4 percent loss of productivity. The report shows furthermore the fact that stunting in general is associated with as much as eleven points decrease in Intelligence Quotient (IQ).

According to UNCCA the two major causes of malnutrition are poor feeding practices and inadequate childcare. Adequate food intake and education programs addressing nutritious food need to be provided nationwide.

Malnutrition is thought to account for one third of all deaths of children under five years of age (UN Millennium Developmental Goals). Therefore, we assessed growth abnormalities, measuring and weighing all children in a standardized fashion, using the following criteria:

- Underweight = weight for age at or under the third percentile of the reference population (WHO growth curves), only children up to 10 years old. This is an indicator of malnutrition or weight loss because of disease.
- Wasting = weight for height at or under the third percentile of the reference population (WHO growth curves), only children up to 120 cm in height. This is an indicator of acute malnutrition.
- Stunting = height for age at or under the third percentile of the reference population, (WHO growth curves) only children up to 19 years of age. This is an indicator of chronic malnutrition.

It has to be noted that reference data were only available for certain heights, weights and ages (as specified above), leading to the following general prevalences of growth abnormalities: underweight: 24% (274/933), wasting: 6.4% (72/656), stunting: 28% (320/1157).

Data on stunting were complete as opposed to underweight and wasting data. However, estimation of age is sometimes troublesome without official documents stating date of birth and children or even parents not knowing children's age, making the stunting data less reliable than wasting data.

During the medical check-ups, we gave all children's guardians hygiene and nutritional advice, with emphasis on hand-washing, vitamin C and vegetable intake, so that their children may grow healthy and strong. For babies, we advised exclusive breastfeeding up to six months.

4: Pneumonia (33; 2.8%)

The 33 children with a severe acute respiratory infection (ARI) were treated with appropriate antimicrobials and home treatment advice.

"Pneumonia", "sannipat", "fast/difficult breathing", "chest indrawing" and "inability to suck milk" are the key words used by care-takers indicating a (severe) ARI.

One case of TBC had already been diagnosed (Sapana) and was being treated by hospital specialist. Another case (Kumrose) was suspected of having TBC because of coughing and intermittent fever since 6 months. She was referred to the hospital.

For a doctor normally working in Europe it is amazing how few children have asthma in Nepal. This year we saw no children with symptoms of bronchiolitis.

The principles of the Integrated Management of Childhood Illness (IMCI, see www.who.int/child-adolescent-health/integr.htm) for recognition and treatment of a pneumonia were transferred to the local workers, teachers and care takers.

5: Suspected pathological Cardiac Murmurs (13; 1.1%)

The MCC carousel includes a cardiac examination. We suspected 13 children of having a pathological heart murmur, mainly due to a septal defect.

In Nepal the prevalence among school age children in Kathmandu of rheumatic heart disease is 1.2/1000 and 1.3/1000 for congenital heart disease. Mitral regurgitation and atrial septal defects being the most common heart problems (Indian Heart J 2003;55:615-618).

For this condition no treatment is available although a good dental situation is essential for a healthy life. The children and their care takers with the suspected pathological heart murmurs were stressed on teeth brushing procedures. Besides this, they were told and got a written explanation to give their child antibiotics when going to a dentist for a teeth extraction.

6: Stomach ache and other gastrointestinal complaints (die typische buikpijn-niet-drinken-weinig plassen kinderen zijn niet als zodanig gecodeerd in de database, dit is allemaal mondeling geregeld. Heb wel overzichtje van alle GI klachten voor je: 1 giardia, 3 dysenterie, 12 diarree zonder uitdroging, 1 fecale incontinentie)

During our health checks we encounter a rising percentage of (older) schoolchildren with complaints of stomach pain. In the absence of weight loss, bloating or fever these pains could be stress induced. Pressure on adolescents to succeed academically is well known in Nepal, along side with problems at home. Data on milk products sensitivity, gastritis or peptic ulcers are currently lacking, as well as the prevalence of Helicobacter pylori bacteria. One study done in Nepal reported an overall higher rate of infection with H. pylori in an urban population compared with a rural population (25.8 % versus 10.2 %) (Eur J Gastroenterology 1998;10:47-49).

7: Ear-Nose-Throat (ENT) (4 OMA, 4OME, 35 O.externa, 5 tympanic perforation, 2 adenotonsillitis, 1 lymfadenitis colli, 3 corpora aliena, 1 hearing impairment, 1 candida, 1 cholesteatoma (out of 1162))

The prevalence of acute ear infections was comparable with the prevalence in the Netherlands. Chronic or recurrent ear infections are a common condition encountered by the ENT surgeons in Nepal. Effective initiatives for better hygiene and nutrition will play a part in diminishing chronic ear infections and their complications. Treatment of middle ear infections with antibiotics have a big impact in preventing deafness as well.

8: Skin diseases (Lice not included)

Diagnosis	Frequency	%	Diagnosis	Frequency	%
Wounds n.o.s.	22	1,9	Acne	2	0,2
Eczema n.o.s.	11	0,9	Impetigo	9	0,8
Seb. eczema	7	0,6	Chicken pox	1	0,1
Dermatomycosis	11	0,9	Alopecia areata	3	0,3
Herpes simplex	2		Generalised lesions (DD: staph.dermatitis or leishmaniasis)	1	0,1

Among the skin diseases the following disorders are the most common in children in Nepal: pyoderma, tinea capitis, scabies, viral skin disorders (mainly moluscum contagiosum) pedicosis capitis, dermatitis and reactions due to insect bites.

A peak of prevalence for pyoderma was observed among 5-9 year olds, with a progressive constant decrease over three years of age.

Pyoderma, scabies and tinea capitis are more common in overcrowded households and orphanages.mps. The role of traumatic sores as a predisposing factor for pyoderma was also common. Especially legs and less commonly ears (because of septic ear piercing in girls) were common of posttraumatic pyoderma. The children were treated with Fusidic crème and/or macrolides for pyoderma.

Antifungal cream (eventually in combination with hydrocortison) was given for fungal infections and hydrocortison crème was given for different forms of dermatitis. We did not treat the children with tinea capitis with griseofulvine as there were limited supplies and the great majority heals spontaneously when in puberty.

Scabies is an infective skin disease caused by a mite (*Sarcoptes scabiei*) and is transmitted in situations of poor hygiene and prolonged physical contact (15 min) with an infected person or contaminated bed sheets or clothing. The female mite burrows just beneath the upper skin layer, producing 0.2 - 0.6 cm long lines on the skin, primarily between and on the fingers, palms, wrists, around nipples (women) and genital areas (men). In severe cases, the mite spreads even to the skin of the belly and sometimes the back. Itching and sometimes secondary infection of scratch lesions are the main symptoms. Chronic severe scabies infection may lead to dark (hyperpigmented) spots on the skin.

9: Eye problems (4 refractory problem, 5 strabismus, 4 kerato-conjunctivitis, 1 blind eye after trauma (old), 3 blefaritis (2 combined with hordeolum), 1 congenital cataract, 1 pterygium). Especially in the group of children above five years of age a rather common complaint was dry and/or painful eyes. Xerophthalmia can be attributed to Vitamin A deficiency. Vitamin A deficiency effect growth, the differentiation of epithelial tissues and immune competence. The most dramatic impact, however is on the eye and includes night blindness, xerosis of the conjunctiva and cornea and ultimately corneal ulceration and necrosis of the cornea. Vitamin A deficiency occurs when body stores are exhausted and supply fails to meet the body's requirements, either because there is a dietary insufficiency, requirements are increased, or intestinal absorption, transport and metabolism are impaired as a result of conditions such as diarrhoea. The most important step in preventing Vitamin A deficiency is insuring that children's diets include adequate amounts of carotene containing cereals, tubers, vegetables and fruits.

10: Urinary tract infections (N=2)

We performed urine screening test in the children with fever and in almost all children with underweight and stunting to exclude a kidney disease. Some protein will appear in the urine if the level of protein in blood becomes high (infections) even when the kidney is functioning properly. Antibiotics, severe emotional stress and strenuous exercise can interfere with the test.

Dip-sticks were not performed routinely. (Nauwelijks dipsticks gedocumenteerd! Geen idee hoeveel er gedaan zijn) . Additionally, the diagnosis enuresis nocturna was established in two cases (advice: peeing alarm clock). Further, we saw one case of phymosis and a case of urinary incontinence (e.c.i., normal dipstick).

11: Dental (painful caries: 90, 7.7%)

This Medical Check for Children mission to Nepal did not include a dentist.

The number of cases mentioned probably even underestimate the prevalence of dental disease in the children we checked with severe toothaches and caries. We stressed the care takers of the children with painful caries to take their child to a dentist.

We had the impression that the more wealthier the people were, the more painful caries we saw. Maybe this is due to the more buying of sweets and cookies when there is more money available.

After the check volunteers gave out toothbrushes and toothpaste and educate the people.

Education health workers, caretakers and other local helpers

One of the important tasks of MCC is to encourage the continuation of education of the caretakers and older children. During our week we had teaching sessions on common diagnoses of frequent illnesses and medication. We especially focused on anaemia and malnutrition, on balanced diet, infection, parasites and failure to thrive. Our information mainly consisted of knowledge and practical advice about nutritious food and vitamin supplements, as well as hygienic and health promotion issues.

Future medical needs

- On all the locations visited, there is a strong need for comprehensive and systematic health promotion and preventive measures. Special emphasis needs to be put on personal hygiene, dental care, good eating habits and nutritious food.
- It is important to stress, over and over again, the importance of regular (half yearly) de-worming off all children up to fourteen year of age.
- There is a need to find a method for keeping relevant information with the child (like the need of antibiotics before dental extraction in children with a cardiac septal defect).
- Maybe in the future, a dental camp can be planned shortly after the check of Medical Checks for children. In this way MCC can select the children with the most urgent dental problems.

Last words

This trip has been again one of the wonderful experience in my live and in the lives of the team members.

Over the last four years I have participated in medical missions at different places in Asia and Africa. Witnessing the evolution of the programs and the development of local expertise is exciting.

It is stimulating to work with team members from different background, exchanging ideas and to learn from each other.

I enjoy learning from the local cultures and experiencing the beauty of people at the different destinations. I am inspired by the efforts of our hosts facing the vast medical demands with limited supplies.

Both medical and non-medical volunteer work is fantastic and I am proud to work with such kind and generous individuals.

A special personal thanks go to Inès von Rosenstiel for her contribution to this report and to Luc Coffeng who did a huge amount of work in analysing the computer data.

I hope to return to Nepal next year to see the smiling faces of the children and work together again with all the people who put their time and energy in creating a better world for all of us.

I am looking forward to return to the children of Chitwan in 2009.

Karlien Bongers, MD, General Surgeon, mission leader MCC mission Chitwan 2008
Amsterdam, 25 February 2009

Medical Report Chitwan - Nepal 2008 Medical Checks For Children

Appendix A: Overview of purchased medication				Inventory at start of mission					Inventory at end of mission		
Medication	Content per unit	Unit		Bought in KTM	Import from NL	Local stash from last year	Bought during mission	Total	Total left over	Expiry date	Total used
Polif iron sirup	15 ml	bottle		0	0	150	0	150	0		150
Haemogen capsules	10 caps	strip		0	0	60	5500	5560	320	March 2010	5240
Hemak caps	10 caps	strip		2000	0	4600	0	6600	0		6600
Viron caps	10 caps	strip			0	0	1500	1500	0		1500
Haematin sirup	150 ml	bottle		360	0	0	0	360	213	Jan 2010	147
Omnivit capsules	10 caps	strip		35000	0	0	0	35000	7750	Nov 2010	27250
Lomoplex vit susp	15 ml	bottle		600	0	0	0	600	166	Oct 2010	434
Fortiplex vit caps	10 caps	strip		0	0	144	0	144	0		144
Albendazole antiworm	25 tabs	box		1300	0	0	0	1300	0		1300
Albendazole antiworm	50 tabs	box		0	0	0	1500	1500	200		1300
Ivermectin	4 tabs	box		0	20	0	0	20	18		2
Gammabenzeen antiscabies	20 gr	tube		21	0	3	0	24	19		5
Amoxicilline susp	60 ml	bottle		30	0	7	36	73	9		64
Amoxicilline caps 500	10 caps	strip		200	0	10	0	210	120	May 2010	90
Amoxicilline caps 250	10 caps	strip		300	0	10	600	910	620	Aug 2010	290
Cotrimoxazol 480		caps		60	0	0	0	60	16	2011	44
Flagyl 200		tabs		56	0	0	0	56	40	May 2010	16
Clarithromycine granulaat	60 ml	bottle		0	0	5	0	5	5	Dec 2008	0
Clarithromycine 250 tab	4 tabs	strip		0	40	0	0	40	32		8
Azithromycine susp	15 ml	bottle		30	0	0	0	30	19		11
Eye/ear drops chloramphenicol	5 ml	flacon		0	0	10	0	10	10		0
Eye/ear drops ciprofloxacin	5 ml	flacon		0	0	10	0	10	0		10

Medical Report Chitwan - Nepal 2008 Medical Checks For Children

Eye/ear drops neomycine	5	ml	flacon	28	0	0	0	28	0	28
Hydrocortison cr	15	gr	tube	25	0	12	0	37	24	13
Fusidine cr	10	gr	tube	40	0	0	0	40	25	15
Daktarin gel	20	gr	tube	30	0	0	0	30	10	20
Dactacort cr + genta	10	gr	tube	15	0	4	0	19	1	18
Iodine lotion			bottle	20	0	0	0	20	11	9
Bactroban cr			tube	0	0	33	0	33	30	3
Paracetamol	10	tabs	strip	0	0	0	200	200	178	22
Zovirax				0	0	0	0	?	7	?

Medicatie	Samenstelling
Polif iron sirup	per 1 ml: 50 mg elemental iron
Haemogen capsules	300 mg ferrous fumarate; 75 mg ascorbic acid; 1 mg folic acid; 15 mg elemental zinc; 1 mg manganese sulphate; 0.2 mg copper sulphate; 15 mcg cyanocobalamin
Hemak caps	300 mg ferrous fumarate; 0.75 mg folic acid; 75 mg ascorbic acid; 7.5 mcg cyanocobalamin
Viron caps	200 mg ferrous fumarate; 1.5 mg folic acid; 7.5 mcg cyanocobalamin; 15 mg zinc sulphate
Haematin sirup	per 5 ml: 60 mg elemental iron;
Omnivit capsules	5.0 mg thiamine; 5.0 mg riboflavine; 1.5 mg pyridoxine; 45 mg niacinamide; 75 mg ascorbic acid; 5.0 mcg cyanocobalamin; 1.0 mg folic acid; 15.0 IU Vit E; 5000 IU Vit A
Lomoplex vit susp	per 1 ml: 8330 IU Vit A; 667 IU Vit D3; 1.67 mg thiamine; 1.67 mg riboflavine; 1.67 mg pyridoxine; 5 mg D-panthenol; 16.7 mg nicotinamide; 80 mg ascorbic acid (vit C)
Fortiplex vit caps	5000 IU Vit A; 75 mg Vit C; 500 IU Vit D3; 15 IU Vit E; 4.5 mg Vit B1; 5.0 mg Vit B2; 2.0 mg Vit B6; 45 mg nicotinamide; 6.0 mcg cyanocobalamin (Vit B12); 11 mg calcium pantothenate; 1 mg folic acid.
Albendazole antiworm	400 mg
Ivermectin	6 mg
Gammabenzeen antiscabies	1% gammabenzeen
Amoxicilline susp	per 5 ml: 125 mg
Amoxicilline caps 500	500 mg
Amoxicilline caps 250	250 mg
Cotrimoxazol 480	360 + 120 mg
Flagyl 200	200 mg

Clarithromycine granulaat	per 1 ml: 50 mg
Clarithromycine 250 tab	Clarithromycine 250 mg
Azithromycine susp	per 1 ml: 40 mg
Eye/ear drops chloramphenicol	Chloramphenicol 0.5%; chlorbutol 0.5% (preservative)
Eye/ear drops ciprofloxacin	Ciprofloxacin 0.3%; Benzalkonium 0.02%
Eye/ear drops neomycine	Betamethason 0.1%; neomycine 0.5%; benzalkonium 0.02%
Hydrocortison cr	Hydrocortison 1%
Fusidine cr	Fusidine 20 mg/gr
Daktarin gel	Miconazol 2%
Dactacort cr + genta	Gentamycine 0.1%; betamethason 0.05%; miconazol 2.0%
Bactroban cr	Mupirocine
Paracetamol	500 mg