**The Britain Nepal Medical Trust**



Translating HumanRights into HealthRealities in Nepal:

Exploring Rights-Based Approach to Health in the Eastern Development Region

Rights-Based Programme Evaluation

2007

submitted to:

**Inter-Church Organisation for Development Co-operation**

**(ICCO)**

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# Acronyms

|  |  |
| --- | --- |
|  |  |
| AHW | Auxiliary Health Worker |
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ANC | Ante Natal Care |
| ANM | Auxiliary Nurse Midwife |
| ARI | Acute Respiratory Infection |
| BNMT | The Britain Nepal Medical Trust |
| CBO | Community Based Organisation |
| CEO | Chief Executive Officer |
| C-to-C | Child to Child |
| DAG | Disadvantaged Group |
| DDC | District Development Committee |
| DHO | District Health Office |
| DPHO | District Public Health Office |
| EDR | Eastern Development Region |
| FCHV | Female Community Health Volunteer |
| HA | Health Assistant |
| HC | Health Committee |
| HI | Health Institute |
| HIP | Health Improvement Programme |
| HIV | Human Immune Deficiency Virus |
| HP | Health Post |
| ICCO | Inter-Church Organisation for Development Cooperation |
| M&E | Monitoring and Evaluation |
| MCHW | Maternal and Child Health Worker |
| NGO | Non-Governmental Organisation |
| NTP | National Tuberculosis Programme |
| PHAAP | Participatory Health Analysis and Action Process |
| PHC | Primary Health Centre |
| PLA | Participatory Learning and Action |
| RB | Rights-Based |
| RBA | Rights-Based Approach |
| S/AHW | Senior/Auxiliary Health Worker |
| SHP | Sub-Health Post |
| SN | Staff Nurse |
| ST | Street Theatre |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| VDC | Village Development Committee |
| VHW | Village Health Worker |

# Executive Summary

**Rights-based Approach to Health: The BNMT Experience**

**Background**

In 2005, The Britain Nepal Medical Trust (BNMT) received a grant from the Inter-Church Organization for Development Coordination (ICCO) to develop a programme entitled *“Translating human rights into health realities in Nepal: exploring rights-based approach to health in the eastern development region”*. The programme was very well designed in the traditional development format describing specific programme objectives and targets. The implementation of the programme was creative, multi-focal and based on deeply internalized participatory designs and methods.

The BNMT staff is a highly trained, loyal group of health professionals steeped in the ethic of community control/participation, prevention of infectious and other diseases and the importance of coordination with government and other non-governmental organizations (NGOs) to achieve programme goals.

Four districts in the Eastern Development Region (EGR) were selected for the programme - Morang, Dhankuta, Khotang and Sankhuwasabha. Morang is a plains district and the other three are hill districts. In effect, the practical start of the programme was in September 2005. Despite conflict and blockades, programme has been implemented earnestly in 2006 and 2007.

During November – December 2007, an evaluation team conducted interviews and observations of programme activities in Kathmandu, Morang and Dhankuta. This report describes that experience with recommendations for the next eighteen months - the expected length of the bridge grant to be submitted to ICCO.

Two major recommendations from the evaluation include streamlining the monitoring and evaluation system to focus on a minimum set of indicators that reflect the desired rights-based outcome and focusing on an advocacy network that will build recognition for innovative BNMT programmes, broaden their understanding of how rights-based (RB) programs succeed elsewhere and within Nepal, encourage all rights-based groups by bringing them together in a supportive advocacy network throughout the country.

The BNMT rights-based approach (RBA) to the health information programme is a solid, innovative, energetic, well-resourced, well-staffed initiative. First steps have been made to “force” the energy and resources to the “corners” - to the women, children and disadvantaged groups. Now, this work can be streamlined and intensified not only in its advocacy efforts but to communicate with more women, more children and disadvantaged groups so that what was a ‘corner’ now flows easily into the mainstream of community – receiving and giving.

# 1. PART I: RIGHTS-BASED PROGRAMME EVALUATION METHODS

### 1.1 General Overview of Evaluation Method

**Process Adopted for the Evaluation Exercise**

An experienced, external, international health consultant (Dr. VMR Turner) was engaged to conduct the evaluation with a team from BNMT. The team from BNMT included Ram Bahadur Rana, Ph.D, Resource Mobilisation Coordinator from the Kathmandu office; Ram Dev Chaudhary, Programme Manager from Regional Office, Biratnagar; Chura Mani Ghimire, District Programme Coordinator (Sankhuwasabha); and, other BNMT staff joined the team as needed for the field visits. Prior to arriving in Kathmandu, Drs. Rana and Turner discussed the plan for the evaluation by telephone and e-mail and a guideline was developed (Annexes A, B and C). Once in country, evaluation activities and interviews were scheduled (Annex D). Due to the length of this document and graphics, the Annexes are presented as a separate document. The Terms of Reference and Dr. Turner’s CV are in a separate file called *“Evaluation Attachments”.*

The field work in Nepal was undertaken from 26 November to 5 December 2007. A series of discussions with District Programme Coordinators, Programme Officers and Finance Assistants from the project districts in BNMT were held in the Kathmandu BNMT office. The team jointly prepared the field itinerary and included visits to Morang and Dhankuta districts and included as Annex C.

Interaction with RBA groups:

* Participatory Health Analysis and Action Process for both spouses – PHAAP
* Participatory Learning and Action (PLA) by women – PLA
* Child-to-Child among school children - C-to-C
* Street Theatre among youths – ST
* DAG youth mobilization
* Health Committee members
* Health Institutions in-charge and staff



In addition, the consultant met with and interviewed District Health Offices' team in respective districts and visited partner non-governmental organisations (NGOs) and interacted with their team members. Separate interviews were held with BNMT Chief Executive Officer (CEO), Dr. Anil Subedi and Programme Director, Asha Lal Tamang in Biratnagar. While the consultant was in Kathmandu she also attended BNMT’s 40th Anniversary celebration and interacted with guests and observed the programme to get firsthand knowledge on BNMT’s approach to government officials.

Prior to submission to ICCO, the evaluation report was submitted to staff and board members for their comments and feedback. Their suggestions are included in this final version.

Interviews and visits were conducted in Kathmandu, Biratnagar and the districts of Morang and Dhankuta. Measures of change are difficult to agree upon, collect and understand. For this evaluation exercise, we had hoped to review facility utilisation data from the districts/clusters where the RB programme had been implemented and if possible compare that to clusters without RBA influence (but still in range of available health services) or to other districts, within the same timeframe. Unfortunately, we were unable to get facility utilisation data -- at that time. It was hoped that the team prior to my arrival might be able to secure data from government facilities or their own tracking system to analyse whether, in fact, women children and disadvantaged groups (DAGs) are using these facilities in increased numbers. For the team, this work led to a keen sense of how a monitoring and evaluation data collection system needs to perform and what elements are important when you want to describe and evaluate the programme. We now examples of this data generated into tables and figures by Dr. Rana and the BNMT staff and presented and discussed in Part II.

The evaluation planned to canvas a diversified group of individuals and more than accomplished this except for interviews with officials in Kathmandu due to difficulties encountered on the day of the appointments (the day of consultant departure from Nepal). Interviews and discussions were positive, free flowing and wide ranging yet focused on discovering perceptions and observations witnessed since the beginning of the RB Programme since “change” is a major focus of evaluation methods in the literature of the rights-based community. We asked –

* What changes have you noted over the last two years (or since you had been working on the RB Programme)?
* Do rights-holders claim rights?
* Can the rights be verbalised by rights-holders and duty-bearers?
* Was there a change in the uptake of services?
* Are there records documenting a change in health facility use by women, children and DAGs?
* What went well? What did not go so well?

It was emphasized that while this was an evaluation, it was also a time for data review, creative thinking and planning for the future.

While our attempts to collect utilisation data proved unprofitable at the time, it led to a great deal of discussion on what data is being collected and, importantly, is this type of data collection system for a rights-based programme. This prompted Dr. Rana to begin to grapple with the data collection system as one of his first BNMT tasks.

Another area of discussion surrounding relevant data collection is the reasoning and system behind “Annex 1”. Annex 1 has appeared in each annual report for 2005 and 2006. It is a highly complex data collection tool matching numbers to objectives in complicated “*sumif*” functions. Mind you, it is a work of genius but can it be used to facilitate an understanding of the ways in which the programme is translating human rights to health realities or is in an artifact from the needs-based, process indicator, development programmes of the past? One function “Annex 1” performs is to link the financial expenditure to programme activity since all the line items are coded. However, the same problem exists: it is so deeply detailed, a great deal of time would be needed to discuss the relationship, decide on where to collapse and where to expand categories and print out some reports. This may be a current activity but I did not see reports generated in this way. Programme evaluation is only as good as the monitoring system and only as good as the reports generated by that system and yet, the question of whether the system has made the transition from needs-based to a rights-based focus – still needs to be answered.

### 1.2 Travel and Interview Schedule

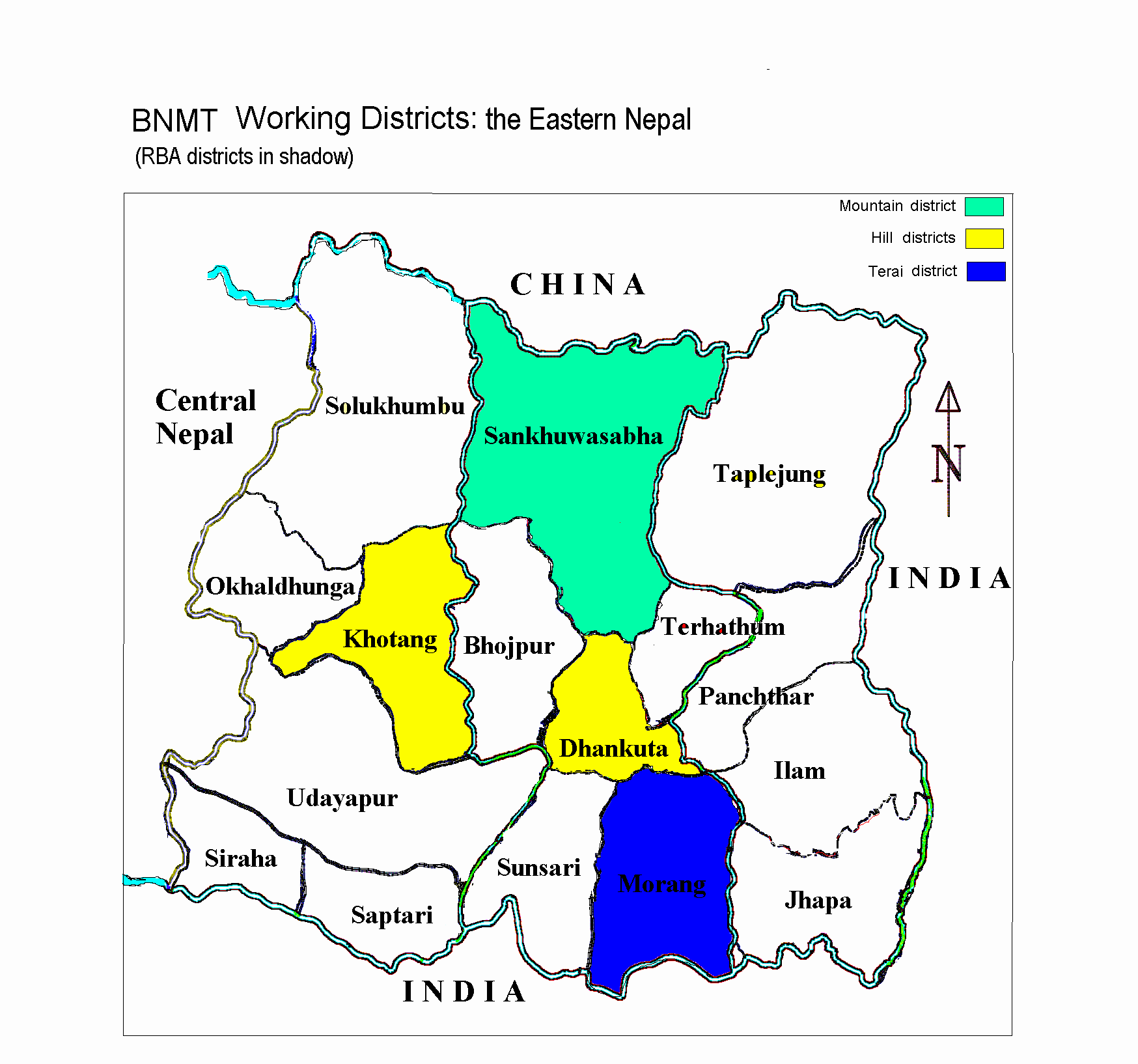
The team travelled from 30 November to 4 December to the districts of Morang and Dhankuta. Detailed information on the itinerary is presented in Annex D.

### 1.3 Project Area

The project was implemented in 4 of 16 districts in the Eastern Development Region - one mountain district (Sankhuwasabha), two hill districts (Dhankuta and Khotang) and one *terai*/plains district (Morang). The project activities are carried out in 55 disadvantaged clusters as shown in Table 1 and Map 1:

#### Table 1 Project districts and clusters

|  |  |
| --- | --- |
| **Districts** | **Number of Clusters** |
| 1. Sankhuwasabha | 14 |
| 2. Dhankuta | 14 |
| 3. Khotang | 10 |
| 4. Morang | 17 |
|  | **55** |



**Project Districts in Eastern Development Region of Nepal**

**(map first presented in RB proposal to ICCO)**

### 1.4 Interviews

Details of group interviews held in Kathmandu with BNMT staff and partners are presented in Annex E. The discussions were held in English in Kathmandu and Nepali elsewhere. Either Dr. Rana, Ram Dev or Chura Mani Ghimire translated for Dr. Turner.

### 1.5 BNMT Rights-Based Programme Monitoring and Data Collection

Part II is dedicated to presenting information and tables generated from the Outcome Monitoring Checklist. It is expected that Dr. Rana will then streamline the data collection system as has been recommended in Part III. These tables and the discussion they create will be invaluable in developing upcoming programme plans.

# 2. PART II: OUTCOME MONITORING CHECKLIST – DATA TABLES

## 2.1 Performance Evaluation: Targets versus Achievements

Under performance evaluation, the team considered three major components, namely programme achievements, i.e. target versus achievements for activities/events; number of target groups directly participating in the programme; and, financial compliance (budget versus expenditure) while implementing programme in the field.

### 2.1.1 Major Project Activities or Events: Target versus Achievement

The evaluation team analysed the achievements against the number of targets set for RBA activities or events in the proposal. The output has been presented below (Table 2) for each project year.

##### Table 2 Targets and achievements for major project activities

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Major RBA Activities** | **2005** | | **2006** | | **2007** | |
| **Target** | **Achieved** | **Target** | **Achieved** | **Target** | **Achieved** |
| 1. Carry out planning and preparatory exercises | 9 | 2 | 4 | 7 | 4 | 14 |
| 2. Implement participatory learning and action (PLA) by health workers | 8 | 4 | 4 | 7 | 4 | 5 |
| 3. Implement participatory learning and action (PLA) by health committees | 807 | 552 | 811 | 741 | 807 | 654 |
| 4. Implement participatory health analysis and action process (PHAAP) with both spouses | 11 | 0 | 17 | 114 | 5 | 145 |
| 5. Implement theatre for development by local NGOs/CBOs | 0 | 2 | 6 | 125 | 5 | 111 |
| 6. Implement participatory learning and action (PLA) by women | 11 | 16 | 6 | 111 | 5 | 151 |
| 7. Mobilise disadvantaged DAG youths | 11 | 17 | 17 | 123 | 5 | 149 |
| 8. Implement Child-to-Child activities by children aged between 10-15 years | 73 | 1845 | 67 | 182 | 66 | 189 |
| 9. Implement activities for advocacy at all levels, i.e. village, district, region, national and international | 49 | 72 | 48 | 42 | 49 | 284 |

All RBA activities can be broadly classified into ‘supply-side’ and ‘demand-side’ activities. Supply-side activities for ‘duty-bearers’ include strengthening their capacity to provide quality health services to ‘rights-holders’ without discrimination. RBA activities such as planning and preparatory exercises, PLA by health workers, and PLA by Health Committees have been identified as capacity building events for service providers. Similarly, PHAAP exercises with both spouses, ST for development, PLA by women, C-to-C activities, mobilisation of DAG youth groups are all classified as RBA activities that empower ‘rights-holders’ to exercise their rights to health. Finally, RB policy advocacy efforts were conducted at village, national and international levels.

Overall, the RBA project has far exceeded the targets set out in the proposal. It is especially true for empowerment related activities for rights-holders. Once the DAG members were oriented about the programme; completed training on how to analyse their situation (problems, opportunities, resources); developed an action plan and implemented the activities set in the plan -- group work continued on a regular basis. This has been documented by outcome monitoring which validated that all 55 DAG clusters have developed and implemented their action plans. Interaction with different groups in the field during evaluation exercise also suggested that the group members have internalised this process, value the service and have been able to negotiate with health service providers due to a better understanding of their health rights. On the other hand, the capacity building activities for duty-bearers, especially the frontline health workers: Female Community Health Volunteers (FCHVs) and Maternal and Child Health Workers (MCHWs), and Health Committee members, still needs more attention from the project. The evaluation team felt that duty-bearers need basic health equipments and infrastructure renovation support to provide quality health services to its constituencies.

### 2.1.2 Project Target Groups: Number of Participants

In the RBA proposal, there is no specific mention of number of target groups to be reached though it stated that project working area comprised of 55 disadvantaged clusters in four districts. However, the proposal highlighted that its focus is DAGs especially the women, children, dalits and members of minority groups, among others. The Table 3 presents the number of target groups, disaggregated by gender, who directly participated in RBA activities.

##### Table 3 Target groups reached by the RBA project 2005-2007

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SN** | **Target Beneficiaries** | **2005** | **2006** | **2007** | **Total** | **% of Total** |
| 1 | Female | 52,832 | 24,673 | 12,479 | 89,984 | 62 |
| 2 | Male | 15,765 | 29,344 | 10,165 | 55,274 | 38 |
| 3 | **Total** | 68,597 | 54,017 | 22,644 | 145,258 | 100 |

From Table 3, it is apparent that a total of 145,258 members participated in different RBA activities (PHAAP for both spouses, PLA by women, C-to-C, DAG youth groups, Street Theatre for development, PLA by Health Committees, PLA by Health Workers) during the project period. Of the total figure, 62% were female participants and remaining 38% were male members.

### 2.1.3 Financial Aspects of the Project: Programme Budget versus Expenditure

The evaluation team analysed the programme budget and expenditure for major line items (Table 4). Overall, there was a programme budget of 163,357 Euros, which represents about 33% of the total project budget over three years period. The expenditure for the programme was 148,426 Euros, which represents 91% of the programme budget.

##### Table 4 Programme budget and expenditure for major project activities

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Major RBA Activities** | **2005** | | **2006** | | **2007** | |
| **Budget** | **Expense** | **Budget** | **Expense** | **Budget** | **Expense** |
| 1. Carry out planning and preparatory exercises | 59925 | 123226 | 2208 | 2907 | 22400 | 12408 |
| 2. Implement participatory learning and action (PLA) by health workers | 29750 | 21291 | 172499 | 175938 | 108916 | 56193 |
| 3. Implement participatory learning and action (PLA) by health committees | 100640 | 70531 | 829005 | 851966 | 305659 | 217622 |
| 4. carry out specific training needs of health workers and health committees | 1862945 | 1293770 | 2709362 | 3654348 | 1789886 | 1333981 |
| 5. Implement participatory health analysis and action process (PHAAP) with both spouses | 73015 | 26550 | 722074 | 878389 | 299000 | 247196 |
| 6. Implement theatre for development by local NGOs/CBOs | 116535 | 128057 | 368423 | 285055 | 172930 | 93158 |
| 7. Implement participatory learning and action (PLA) by women | 61880 | 66168 | 335667 | 301606 | 196304 | 188266 |
| 8. Mobilise disadvantaged DAG youths | 25670 | 11045 | 332739 | 305893 | 195734 | 171469 |
| 9. Implement Child-to-Child activities by children aged between 10-15 years | 46070 | 26763 | 474189 | 424278 | 212623 | 170654 |
| 10. Implement additional activities on community awareness and behaviour change | 1548785 | 1280027 | 282821 | 286218 | 137600 | 8530 |
| 11. Implement activities for advocacy at all levels, i.e. village, district, region, national and international | 97155 | 94675 | 42738 | 40885 | 779906 | 228353 |
| 12. Carry out additional activities on advocacy and networking | 172635 | 123732 | 0 | 0 | 14400 | 157218 |
| **Total** | **4195005** | **3265834** | **6271726** | **7207428** | **4235358** | **2885049** |
| **Total in Euros (€1 = Rs 90)** | **46611** | **36287** | **69686** | **80083** | **47060** | **32056** |

The majority of project activities were accomplished in year 2006 and this is reflected in the expenditure as well with 15% over spending than the budgeted figure. For other two years, the spending has been less than the budgeted figures.

## 2.2 Performance Evaluation: Outcome Monitoring

There was no formal baseline survey (*ex ante* evaluation) so a formal *ex post* evaluation was of limited use for making ‘before’ and ‘after’ comparison of changes in ‘key indicators to quality health services’ due to programme interventions. Thus, the evaluation team adopted a less formal evaluation approach. Having said that, BNMT had conducted an extensive survey of more than 8000 households in the eastern development region (EDR) in 2003, and for practical reasons the figures derived from the survey findings have been used as baseline figures (in a few cases), against which the progress indicators have been set, for this project. Besides, BNMT has been collecting data from the fields on regular basis (two times a year) using Outcome Monitoring Forms/Checklist. Therefore, the evaluation team analysed the monitoring datasets: first set (early 2006) and fourth set (mid 2007), to compare the shifts in major indicators between the years as well as against the baseline figures because of programme interventions. It is important to acknowledge that the fourth round of dataset represents progress till the middle of 2007. The final/fifth round of outcome monitoring data collection is complete and data are being entered onto computer. The final project report will comprise findings from the final dataset.

Table 5 is a summary fact sheet comparing what was promised in the proposal and what has been achieved up to mid-2007. This is followed by some of the results to illustrate the points the evaluation team discovered through interaction and direct observation in the field.

##### Table 5 Summary of indicators for measuring project outcomes

|  |  |  |  |
| --- | --- | --- | --- |
| **Project purpose** | **Indicators for measuring project outcomes** | **Baseline (2003/05)** | **Mid-2007** |
| Disadvantaged communities empowered to demand quality health services from capable and responsive service providers in a supportive policy environment | 1. By the end of 2007, at least 90% Local Health Committees will be functioning effectively:   * Regular meeting of health committee * Implementation of action plan | 29% (2006) | 100%; in all 55 clusters committees meet regularly; action plan implemented |
| 2. By the end of 2007, 55 Health Institutions of the project area will have a system of adequate and timely supply of essential drugs and medical supplies resulting in dispensing of more than 90% prescribed items from the health institutions | 67% (2003) | 89%; target is likely to be achieved by end 2007 |
| 3. By the end of 2007, disadvantaged groups’ awareness on health rights will be increased by 50% from the baseline with awareness on health rights and demanding services from service providers | 0% | 67% -2006 and 78% - 2007; DAGs had no idea about their health rights in 2003 |
| 4. By the end of 2007, disadvantaged groups’ awareness on health issues (e.g. HIV/AIDS, Tuberculosis, Malaria, Kala-azar) will be increased by 50% from the baseline with awareness on health rights and demanding services from service providers | 14% (2006) | TB – 71%; HIV/STI – 37%; Kala-azar – 31%; Malaria – 38% |
| 5. By the end of 2007, disadvantaged households increasingly seek and obtain essential health care will be increased by 25% from baseline data | 207,532 (2003) | By mid 2007 the number is 217,926; so meets target |

In the following sub-sections, we present the project outcomes and the achievements made during the project in sequential order.

### 2.2.1 Health Committees: Action Plan, Implementation and Coordination

Health Committees (HCs) provide a pivotal link between government health service providers ‘duty-bearers’ and general public ‘rights-holders’ for the utilisation of health services. Indicator for measuring project outcome one, i.e. **“by the end of 2007, at least 90% Local Health Committees will be functioning effectively: Regular meeting of health committee and Implementation of action plan”.** Many of the program activities focused on revitalising HCs, e.g., action plan preparation, implementation. More than the expected results have been achieved (Figure 1). By mid 2007, in all the 55 clusters, HCs have prepared action plan and implemented the plans with varying levels of success. For instance, reforming HCs to include more DAG members has been accomplished in all the HCs. Many HCs have been successful in demanding more quality services for its members and in many instances HCs have requested for extra community level health provisions through Village Clinics. There is an increasing trend that government health services are targeting their programmes to DAGs. In 2006, there were only five health institutions (9%) that monitored their services reached DAGs but this number increased to 13 (24%) in 2007. Similarly, RBA has been able to influence other NGOs and CBOs in the project area to develop DAG specific programmes. In 2006, only 22 (40%) clusters reported to have targeted programmes but this has increased to 37 (67%) clusters by mid 2007, which clearly indicates that HCs have been able to make their voices heard among other development partners in the project area. However, influencing other local government agencies such as District Development Committees (DDCs) and Village Development Committees (VDCs) to develop plans and programmes for DAGs is a major challenge. We all know that it is a long term process and will take a while to influence and change government system. Nevertheless, in some clusters HCs have been able to bring on board DDCs and VDCs to commit themselves to developing DAG focused programmes. There were four (7%) clusters where DDCs/VDCs developed DAG specific programmes and this number has doubled to eight (15%) in 2007 suggesting that given time, government agencies may develop DAG focused programmes.



##### Figure 1 Different Initiatives undertaken by Health Committees 2006 - 2007

### Health Committees: Inclusion of DAGs in the Committees

In general, the composition of HCs does not reflect the demographic composition of the population. Hence, making HCs more socially inclusive of DAGs especially women, dalits and ethnic minorities has been a priority of RBA programme. In line with this objective, HCs have been reformulated and revitalized in the project clusters.

##### Table 6 Status of composition of Health Committees in project clusters

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SN** | **Types of Health Committee Members** | **2006** | **2007** | **% Change** |
| 1 | Male members | 296 | 369 | 25 |
| *2* | *Female members* | *178* | *184* | *3* |
| 3 | Dalit male members | 17 | 37 | 118 |
| *4* | *Dalit female members* | *44* | *39* | *-11* |
| 5 | Janjati male members | 83 | 178 | 115 |
| *6* | *Janjati female members* | *59* | *94* | *59* |

The data from 2006 and 2007 indicate that significant progress has been made in changing the composition of HCs to make them more socially inclusive with more members from DAG communities being included in the committees (Table 6). For instance, the number of dalit males in the committees has more than doubled in the given period, however, over the same period; there is a slight decrease in number of dalit females in the committees. This could be a matter of concern – are dalit females being replaced with dalit males in the process? On the other hand, representation from minority groups (janjatis) has jumped with janjati males more than doubling in membership. An impressive jump was also noticed for janjati female membership in the committees with about 60% increase over the years. In terms of gender balance, the male members account for 67% representation in the committees, whereas female representation is 33%, which is the minimum limit set by the government in any government-formed committees. There seems to be room for improvement concerning gender balance though significant progress has been made to reflect inclusion of disadvantaged communities.

### 2.2.3 Health Committees and Other Institutions Response

In the RBA programme, it is envisaged that Health Committees (HCs) will perform a pivotal role serving as a bridge between ‘duty bearers’ and ‘rights holders’. It is expected that while performing its role, the HCs will increasingly be able to bring on board government institutions such as DDCs and VDCs to provide quality health services to DAGs. The data from Outcome Monitoring Forms indicate that 15 HCs were able to convince VDCs to allocate funds for health institutions (HIs) in DAG clusters. The support from VDC was in three areas: direct financial support; fund for drugs purchase; and, materials support. The monetary support was about €2,778 (Rs 250,000) in 2006. In 2007, one HC (Dhankuta district) was able to convince the DDC to chip in money for health institutions (HI) in the DAG cluster, though there is no change in overall number of HCs being able to generate additional resources for DAG clusters. An additional sum of € 2,500 (Rs 225,000) was generated from DDC and VDCs for the HIs in DAG clusters. These funding arrangements may not reflect the long term commitment from these local government agencies. Thus, there is a need for policy influence at DDC and VDC levels to encourage regular contributions to HIs/HCs on an annual basis.

Strengthening HCs capacity to generate additional funding for the HIs in DAG clusters has to be the thrust of the RBA programme in future. Having a regular source of funding from DDCs and VDCs will enable the HCs to plan a relief package to DAG members so that the members can access quality health services.

### 2.2.4 Availability of Essential Drugs at Heath Institutions

For the service providers or duty-bearers to function at their best, the availability of essential drugs in their health institutions is a pre-requisite. Therefore, this has been taken as one of the indicators for measuring project outcomes **“by the end of 2007, 55 Health Institutions of the project area will have a system of adequate and timely supply of essential drugs and medical supplies resulting in dispensing of more than 90% prescribed items from the health institutions”**. Accordingly, the project has been regularly collecting the relevant information from project sites. In the Table 7, we present the findings on the availability of essential drugs across clusters.

The baseline figure of 2003 indicates that 67% of the Health Institutions (HIs) in the project areas had essential drugs available to them for dispensing. The figure has gone up to 89% in the year 2006 and the HIs have been able to maintain the gains made so far. By the end of 2007, the project target of 90% is likely to be achieved in the project area. However, with the recent government policy change, of supplying all health services free including drugs at Health Post and Sub-Health Post levels, might have some unforeseen consequences on the result, which we need to closely monitor over time.

##### Table 7 Availability of essential drugs across clusters in 2006-07

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SN** | **Essential Drugs** | **2006** | **2007** | **% Change** |
| 1 | Amoxicillin | 50 | 45 | -10 |
| 2 | Benzylbenzoate | 48 | 51 | 6 |
| 3 | Cotrimoxazole | 55 | 55 | 0 |
| 4 | Eye/Ear Drops | 50 | 53 | 6 |
| 5 | Iron/Folic Acid | 51 | 52 | 2 |
| 6 | Mebendazole/Albendazole | 55 | 51 | -7 |
| 7 | Oral Rehydration Salt | 47 | 51 | 9 |
| 8 | Paracetamol | 55 | 52 | -6 |
| 9 | Ringer Lactate | 26 | 31 | 19 |
| 10 | Tincture Iodine | 52 | 48 | -8 |

### 2.2.5 Disadvantaged Groups: Awareness on Health Rights

In order to monitor DAG members’ level of awareness of their health rights, random interviews are conducted for two DAG members and two for non-DAG members, while they visit health institutions for accessing health services[[1]](#footnote-1). There are two specific questions: **‘did the health worker listen to you and respond to your (the DAG member) problems adequately?** and **‘did the health worker show any discriminating behaviour to you (the DAG member) for treatment?’** that elicit respondent’s awareness level on health rights. Since DAG members are oriented on health rights, they are able to observe the behaviour of health professionals and develop their opinion while their cases are being dealt with. It was proposed that **“by the end of 2007, disadvantaged groups’ awareness on health rights will be increased by 50% from the baseline with awareness on health rights and demanding services from service providers”.** In 2003, community members had no clear concept about health rights and health professionals were also not oriented on their roles and responsibilities while discharging their duties. Therefore, comparison between baseline and now may not be relevant but what is relevant is to see how things have changed over time, i.e. between 2006 and 2007 (Table 8).

Table 8 indicates that rights-holders’ level of satisfaction, irrespective of their category, have increased significantly, from 67% to 78% for DAGs and 71% to 86% for non-DAGs, over the observation periods. Similarly, the number of individuals reporting a discriminatory behaviour by health worker has reduced considerably in both groups. In 2006, 18% of the respondents in both groups report discriminatory behaviour; however, the percentages have gone down to 4% and 7% for DAGs and Non-DAGs respectively. The figures clearly indicate that substantial progress has been made in the provision of quality health services by the duty-bearers. High percentages of customer satisfaction also indicate that increasing number of rights-holders know and expect quality time and services from health professionals.

##### Table 8 Community members' satisfaction with the quality of services from Health Institutions

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Member Category** | **Satisfaction with Health Institutions' Service Quality** | **Clusters** | **2006** | **2007** |
| DAGs | 1. Satisfied with health worker's response to your problem | 110  (100%) | 74  (67%) | 86  (78%) |
| 2. Noticed discriminatory behaviour from health workers | 110  (100%) | 20  (18%) | 4  (4%) |
| Non-DAGs | 1. Satisfied with health worker's response to your problem | 110  (100%) | 78  (71%) | 94  (86%) |
| 2. Noticed discriminatory behaviour from health workers | 110  (100%) | 20  (18%) | 8  (7%) |

### 2.2.6 Disadvantaged Groups: Awareness on Health Issues

In this sub-section, we analysed the level of knowledge of DAG members and non-DAG members on different health issues. It is proposed in the project document that **“by the end of 2007, disadvantaged groups’ awareness on health issues (e.g. HIV/AIDS, Tuberculosis, Malaria, Kala-azar) will be increased by 50% from the baseline with awareness on health rights and demanding services from service providers”.** The lowest figure of 14% (2006) was taken as baseline figure for comparison purpose. The Outcome Monitoring Checklist has data on several other health issues such as pneumonia, diarrhoea, pregnancy and drug use, but they have not been presented here. Table 9 presents comparative data (2006 and 2007) on respondents’ knowledge[[2]](#footnote-2) on tuberculosis, HIV/STI, malaria and kala-azar.

##### Table 9 Knowledge of respondents on different health issues

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **SN** | **Knowledge on Health Issues** | **Respondents** | **2006** | | **2007** | |
| **DAG** | **Non-DAG** | **DAG** | **Non-DAG** |
| 1 | Tuberculosis | 110 | 64 (58%) | 77 (70%) | 78 (71%) | 97 (88%) |
| 2 | HIV/STI | 110 | 21 (19%) | 32 (29%) | 41 (37%) | 52 (47%) |
| 3 | Kala-azar | 110 | 15 (14%) | 17 (16%) | 34 (31%) | 38 (35%) |
| 4 | Malaria | 110 | 21 (19%) | 23 (21%) | 42 (38%) | 51 (46%) |

It is apparent from Table 9 that respondents’ knowledge on different health issues has increased significantly over the years. BNMT has been working on tuberculosis (TB) for a long time in the region, hence the level of knowledge and understanding about its symptoms and preventive measures are quite clear to a vast majority of people. On the other hand, one has to acknowledge the fact that the level of knowledge gap between DAG and non-DAG members on different health issues is self evident. Owing to RBA programme in DAG clusters and other programmes (mass media awareness campaign) run by government line agencies and other health institutions, the knowledge of respondents has increased for all the major health issues such as HIV/STI, Kala-azar and Malaria.

### 2.2.7 Disadvantaged Groups: Seeking and Obtaining Health Care Services

One of the important outcome indicators is looking at behaviour change among DAG members towards health care services. It is logical to expect that with increased knowledge and understanding on different health issues and health rights by the DAGs, they may be more inclined to seek and obtain health care services. Thus, in proposal it was envisaged that **“by the end of 2007, disadvantaged households increasingly seek and obtain essential health care will be increased by 25% from baseline data (n= 207,532; 2003)”.** The cumulative figure for 2005, 2006 and up to mid 2007 indicate that the number of individuals seeking and obtaining essential health care services reached 217,926. By the end of 2007, the figure exceeded 270,000, i.e. an increase of about 30% over the baseline figure.

## 2.3 Additional Indications of Progress

In this sub-section, we present findings reflecting success of the RBA programme in providing access to quality health services.

* + 1. Availability of Health Professionals in Health Institutions

To provide quality health services at HIs, lack of trained human resources at the point of service has been identified as one of the major constraints. Therefore, the RBA programme focused on two aspects: creating enabling working environments for higher level trained staff, e.g. doctors, to serve in remote areas, and empowering DAGs to negotiate with government officials to depute trained health professionals to DAG communities.

##### Table 10 Availability of health professionals at health institutions in project area

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **SN** | **Health Professionals** | **2006 (no)** | **2007 (no)** | **Direction of change** |
| 1 | Doctor | 1 | 5 | 🡩 |
| 2 | Health Assistant (HA)/Senior Auxiliary Health Worker (SAHW) | 22 | 23 | 🡩 |
| 3 | Staff Nurse (SN) | 7 | 5 | 🡫 |
| 4 | Auxiliary Health Worker (AHW) | 51 | 51 | *status quo* |
| 5 | Auxiliary Nurse Midwife (ANM) | 34 | 27 | 🡫 |
| 6 | Village Health Worker (VHW) | 35 | 32 | 🡫 |
| 7 | Maternal and Child Health Worker (MCHW) | 18 | 24 | 🡩 |

There are two hospitals, five primary health centres, 19 health posts and 29 sub-health posts spread across 55 clusters. Positions of doctors and staff nurse are confined to hospitals and PHCs, whereas VHW and MCHW are frontline health professionals mainly stationed in Health Posts and Sub-Health Posts. HAs, SAHWs and AHWs are mainly responsible at PHCs and HPs levels. Overall, there is no change in staff numbers between two observation periods (Table 10), but there is remarkable increase in number of doctors in hospital and PHCs. There is also significant increase in number of MCHWs in HIs but decrease in number of SNs and ANMs. A case below shows how one of the Health Committees was able to negotiate with District Public Health Office (DPHO), Morang to get staff in their PHC.

Box 1. Success story: Health Committee negotiates staff for PHC, Bahuni

***Case of Bahuni Primary Health Centre (PHC) in Morang District***

When the RBA programme initiated in the Bahuni cluster, the Primary Health Centre (PHC) in the area had no doctor, staff nurse or qualified laboratory assistant. Most of the government sanctioned positions in the PHC were vacant. However, the situation improved drastically after the Health Committee (HC) members received an orientation and training on RBA. HC members prepared action plan and they started implementing them. One of the activities in the action plan included demand for qualified human resources at the PHC. For this action, HC members assigned Gopal Bajgain, member of HC, Bahuni to negotiate and follow up with District Public Health Office (DPHO), Morang and Regional Office, Dhankuta for post fulfilment. Because of successful negotiations, PHC now has a doctor, health assistant, staff nurse, two auxiliary health worker, three auxiliary nurse midwifes, and laboratory assistant including other non-technical staff. The PHC now has all the government sanctioned positions fulfilled. This case story indicates that rights-based programming has been highly successful in generating awareness and interest at local level, and local groups have been highly motivated with their success.

### Tuberculosis (TB) Case Finding Rate

National Tuberculosis Programme (NTP) has set a target of case finding rate of 70% with treatment success rate of 85% to ensure that TB no longer remains a public health issue in Nepal by 2050. TB smear positive cases finding rate for the DAG clusters for 2006 was 62%, which is below the government’s target. However, the case finding rate increased to 70% in 2007 just meeting the government commitment (Figure 2). The main contributing factor has been discovering smear positive cases among female members (DAGs) – this outcome is in line with the focus of RBA programme on DAG members. There has been remarkable coverage amongst female with no change in number of male members being reached by the programme.



##### Figure 2 Number of smear positive cases for TB in project clusters

### Infectious Disease: Management of Pneumonia Cases

Among many infectious diseases, the RBA project is concentrating on Acute Respiratory Infection (ARI) among children (<5 years) with special focus to treatment of pneumonia cases. The figures from 2006 show that there were 3974 reported cases of ARI in the project clusters and of those 53% were DAG members (Figure 3). In 2007, the number of ARI cases rose to 4055, an increase of 2% over the 2006 figure. Similarly, the number of ARI cases amongst DAGs increased to 2258, an increase of 7% over the 2006 figure. However, the overall number of children treated with antibiotics has decreased by 23% and for DAG children the decrease is about 9% over the same period. Although the antibiotics (Cotrimoxazole) was available throughout the 55 clusters, the heath professionals did not prescribe the drug because they were better able to diagnose the problem and prescribe other alternative means to cure the ailment. This also indicates that the rational use of drugs has increased and so is the ability of health care service providers to diagnose the problem and prescribe remedial action. This is reflected by higher levels of satisfaction towards their services expressed by the rights-holders.



##### Figure 3 Number of ARI cases and pneumonia treated with antibiotics

### Reproductive Health and Safer Motherhood

Reducing the child and maternal mortality rate in Nepal is a priority for achieving the Millennium Development Goals 4 and 5 (MDGs). Regular ante natal care (ANC) check-up by pregnant women is recognised as an important factor contributing to safer motherhood. Thus, the RBA message has been to have at least four ANC check-up(s) during pregnancy. The data on ANC check-up(s) for two different years (2006 and 2007) is presented in Figure 4.

There is a modest increase of about 2% in the number of pregnant women presenting for ANC Check-up(s) each year. It is interesting to see how the percentages have changed, for better, for the number of check-ups. The data for 2006 indicate that only 32% of those who went for the first ANC check-up, turned up for second ANC check-up and the percentage further deceases to 24% for third ANC check-up and ultimately goes up (46%) for the fourth. The analysis of 2007 data indicate that more women went for second (65%) and third (53%) ANC check-ups, with relatively modest increase (55%) for fourth ANC check-up. It is encouraging to note the behaviour change of not only the pregnant women but also of their spouses and mother-in-laws, who play important role in well being of ‘would be’ mother and child. Without an active support and cooperation of family members, pregnant women in rural areas would find it very difficult to come to health institutions for regular ANC check-up.



##### Figure 4 Pregnant women and ANC check-ups for 2006 and 2007

### Health Financing Scheme

For universal realisation of health rights by the DAGs, the RBA efforts need to go beyond provision of free health care services and essential drugs at health institutions. There are many instances when DAG members do not access health services due to travel distance to health institutions, time and financial resources they have to forego when visiting health institutions. Therefore, there is a strong justification to have health financing scheme in place to support DAG members. Efforts were made in all the health institutions through health committees to have a revolving fund for this purpose. In fact, a majority of HCs have revolving funds at their disposal. The amount ranges from Rs 9,024 to Rs 230,778 and, at the discretion of HC members, can be utilised for subsidising health care services for DAG members. The revolving fund is replenished by donations from different sources including DDCs and VDCs among others. It is important to increase the funding base so that more and more DAG members have access to health care services.

# 3. PART III: CONCLUSIONS AND RECOMMENDATIONS

## Summary and Conclusions

It is the consensus of the team and the external evaluator that the RBA Programme has achieved and exceeded many of its objectives and has missed the mark on some. Dr. Turner was impressed that team members were quite aware what was working well, for example, the programme entitled “Participatory health analysis and action process (PHAAP) with both spouses of disadvantaged households” and what still needs attention - advocacy at all levels and thorough, routine networking for advocacy.

A guideline for the evaluation was developed and while not followed rigorously, Dr. Rana noted that we had covered the “territory” outlined in the document. The following is a brief review of the major categories identified in the guideline and the experience of the evaluators:

Partnership

At the beginning of the programme, Ministry officials were said to be sceptical of this approach but by the time of this evaluation, district officials were full of praise and requests for the programme to be expanded to other areas. Perhaps this request was due to the fact that they receive much more timely and accurate information from these clusters or that the RBA programme had, in fact, made “converts”. Nonetheless, the fact that BNMT has an office at the DPHO, Biratnagar and the relationship is positive and active is a very good sign.

BNMT works through many local partners and appears to have solid, collegial relationships with them. Partner organizations vary in levels of sophistication and immersion in the rights-based approach. One excellent aspect of these relationships is that with most of these local district partners, BNMT is **not** their only source of financial support and this needs to be commended, supported and developed.

Education

While some work needs to be done on the content of information passed along*,* the importance of working with many groups per cluster is highlighted by the way information appears to be transmitted through communities. In the schools, through the Child to Child clubs we heard evidence of children bringing home important health information to their parents and in Morang during the meeting of the Participatory Learning and Action (PLA by Women), on World Aids Day, when asked what she would do with the pamphlets that were just handed to her about HIV, a member said she would take them home for her children to read to her. There is a lot to be said for this kind of reinforcement of programme components and goals.

Management

BNMT is a very well organized and resourced NGO and it shows in their work plans and reports. This being said, perhaps some thought needs to be given to ways to craft management systems that supports an RB programme, specifically, and not a needs-based programme and see where differences emerge.

The System

During the evaluation it was noted that the government may change policy and decide to provide free drugs to everyone. In this case, the RB program would have to be very diligent and reinforce its monitoring/surveillance system to discover positive and negative impacts of this change. Since supplies may be limited, it was thought that the disadvantaged might not fare well if more of the population were given access. This is an opportunity for the BNMT RB Programme to streamline its M&E system and become a more responsive, efficient system able to rapidly recognise emerging situations.

Training

The evaluation was not long enough to conduct a detailed evaluation of the training component. However, this was identified as a major area for further reflection and adjustment in the next eighteen months since there appears to be a gap in training for health providers.

Research

The team was not aware of any research being undertaken that was relevant to rights-based programming in health. However, some thought should be given to what types of research might enhance the results of the RB Approach or the HIP strategies.

Quality

This is a difficult aspect to uncover through observation and interviews over a ten day period. In discussions with group members about the quality of health services, the perception of quality improvement is noted. The BNMT Outcome Monitoring Checklist collects data on this question and Table 8 provides insight and appears to support this perception. However, over the next 18 months the team will revisit how to capture data to describe improvements in quality of care.

Rationalization (of Ministry personnel)

A major finding or, rather, a concern for the evaluation team is the constant transfer of health centre staff and the effect on the RB programme. Health providers in most instances had no training in the rights-based approach and the team saw this as a major area of concern that needs to be addressed. Training at the district level for all health providers might be considered.

Policy/Advocacy

This is an aspect of the programme where the BNMT staff state they have not met the objective and wish to address designing ways to enhance their discussions and relationships with policy makers who influence acceptance and support for the rights-based approach.

## Recommendations

**Specific Suggestions for the Next 18 Months**

Clearly, the BNMT RB Programme has taken a major step in defining how a rights-based approach can provide a community with ways to claim their health rights. Over the next eighteen (18) months, it will be worthwhile to reconsider:

**Rights-based Outcome Indicators:** It is still not clear if we have exacting rights-based outcome indicators that reflect the influence of a BNMT rights-based programme. To that end, one or more indicators need to be discussed and tested. In every BNMT RBA programme group, members of the group are required to negotiate their claims. If this could be captured, then it might be a better indicator of programme influence (see PowerPoint file called “Measuring Change 4” and included in a file called “Evaluation Attachments”). The following four (4) indicators may be worth discussing and testing over the next 18 months:

* Number of SUCCESSFUL interactions negotiated
* Percent of Action Plan Completed (currently this data is collected)
* Increase in group membership (could be number of new groups depending on programme design)
* Increase in savings/credit, fund raising, reserve, etc. (see section on health financing schemes in Part II)

Most successful, global initiatives strive for a few well-accepted and tested indicators of programme success – a minimum set. This saves time and money and allows comparisons with similar programmes.

**Programme Monitoring**: While a great deal of useful data is collected, getting this into timely and useful programme information is a challenge. One of the recommendations for both the 2005 and 2006 annual report (Annex F) emphasized that the M&E system needs to be streamlined. In addition, some thought to the development of a log frame (or a log-frame-like planning tool) specifically for rights-based programming, in health, might be researched and developed. Finally, during the evaluation it was realized that if the government acted and made all drugs free for everyone, the RB programme needs to set-up a surveillance system through the existing Outcome Monitoring System to rapidly assess if the new policy effected women, children and DAGS negatively, i.e., fewer drugs would now be available to the disadvantaged since more of the population had access. The next 18 months is the right time to take a hard look at the M&E system and find out why – although recommended each year – the system is still cumbersome.

**Advocacy:** BNMT would benefit from a more formalized relationship with national and international rights-based groups and have a great deal to offer in these relationships. In addition, BNMT might serve as support for other ICCO organizations beginning to embark on the implementation of rights-based health programming. The ways this can unfold and be developed might be tested over the next 18 months.

**Training for Health Providers:** The training for health committees and community members seems to be more established than training for health providers. Since repeated transfers are an issue, training at the district level might be considered.

**Communication – Dalit Villagers** *(Optional)*:Accessing the three hill communities is very challenging, time consuming and energy inefficient for BNMT, partners and government officials. Consideration might be given to testing if -- once a Dalit group is trained and aware of their rights and how they might claim these rights - a novel communication approach might be tested. Cell service worked in the BNMT village we visited (although a way to recharge the phone was not checked out). One method of communication to claim rights would be cell phone conversations (three-way if at all possible for an interaction between BNMT partner – PLA member – government official or NGO officer). In addition, the PLA group could charge for use of the cell phone and build their reserves. There are well documented small business models of village cell phone rental, i.e., Bangladesh.

**Sustaining Gains**: BNMT has a successful RB/HIP programme and has evidence to prove it. Like highly-controlled intervention research, however, a strategy that was developed in research mode (or a pilot programme as in this case) may not be as successful as time goes on and in less-controlled, minimally-resources situations. BNMT would do well to take the time to identify realistic programme goals since they appear to have over-achieved in most target categories and may not be able to sustain this level of success and thus, appear to be under-achieving when in fact finding the correct level for what is truly possible is the issue. BNMT efforts to assist partners to become financially independent and to encourage government involvement are two areas that may sustain success overtime.

In summary, it is hoped that this evaluation along with financial and organizational information about BNMT will provide a picture of a dynamic forty-year old organization leading the way in exploration of human rights and the right to health. Issues identified as in need of repair, consideration or change are well within the capabilities of the staff. This initiative is heading in the right direction and deserves further support and a higher profile in the international health rights advocacy network.

1. BNMT field based staff conduct interviews while they visit Health Institutions to collect relevant data for the Outcome Monitoring Checklist. The interviews form the second part of the Outcome Monitoring Checklist. [↑](#footnote-ref-1)
2. Respondents’ knowledge on different health issues is judged based on their ability to describe at least one symptom and one prevention method correctly during the interview process. [↑](#footnote-ref-2)