Religion and Health Project Evaluation

Data Analysis and Final Report

Anims at the Kuenga Rabten Anim Dratshang

Dratshang Lhentshog
Health Division
UNICEF

(Prepared by: Marion Young - July 1999)

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Menchey Rimdu
Medicine and Puja

Some years ago a young Bhutanese boy fell sick. He couldn't walk, he couldn't feel anything in his hands and feet and he didn't want to eat anything.

His mother called the health worker who came from the BHU four hours away to see the boy. The health worker left some medicine for the boy to take but every time he was given the medicine it made him vomit.

His mother called the local religious practitioner who told the boy's mother that an evil spirit lived in the tree outside the house. They must cut down the tree and plant another tree in its place. Only then would the boy be able to take the medicine.

This was done – the tree was cut down, another tree was planted and the boy was able to take the medicine. Happily for the whole family, the boy recovered.

The boy is now a monk and has recently attended Religion and Health Project training.

He and his family believe that both puja and medicine work together.

A personal story told by a monk in Bhutan
June 1999

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Introduction

The Religion and Health Project was initiated in 1992 forming a partnership between the Central Monastic Body, Dratsang Lhentsog and Health Division with financial support from UNICEF. The project has two basic components:

a) Training of religious communities in basic health information in order for them to become good role models and effective health promoters
b) Improvement of water sanitation and kitchen facilities of monastic institutions.

In preparation for the joint RGoB and UNICEF mid-term review of the current country programme (1997-2001), an evaluation of the Religion and Health Project was undertaken from April to July 1999.

Development of an evaluation protocol was contracted to Ms Caroline Marrs who presented the evaluation tools and methodology at a pre-evaluation workshop attended by all project stakeholders in May 1999.

Data collection, analysis and report preparation was contracted to Ms Marion Young. A translator, Sonam Dhendup, accompanied Ms Marion Young throughout the field work data collection phase. Piloting of the evaluation tools was conducted jointly with the Ms Marrs and Ms Young. The draft report was presented to the stakeholder group in July 1999, before finalisation and submission to UNICEF, Bhutan.

Throughout the fieldwork every assistance was offered to the evaluation team from the Dratsang and health services at each site visited. This alone was enough to convince anyone of the high value placed on the Religion and Health Project. UNICEF staff assisted with office preparation and support. Dratsang Lhentsog enabled the work to proceed smoothly by accompanying the evaluation team during the pilot and first field visits to assist with technicalities of translation and protocol; Dratsang Lhentsog also ensured that all permits were obtained and officials informed in advance of the evaluation teams' visit to each site.

The evaluation work was both interesting and enlightening. I trust the Evaluation Report and Evaluation Analysis offers some clear insights into the progress of the Religion and Health Project to date and some useful guidelines for the future drawn from the wealth of experience of those who participated so willingly in the evaluation.

Tashi Delek

RHP Project Objectives

UNICEF's Master Plan of Operations for 1997-2002 identifies the following general and specific objectives for the Religion and Health Project (RHP):

General Objective:

To improve the quality of life of the Bhutanese people by harmonising religious faith and practices with information on modern health care, particularly for child survival.

Specific Objectives:

1) To promote health and nutrition education to parents through informed monks and community-based religious practitioners.

2) To increase the knowledge and skills of community-level practitioners to provide adequate advice on modern health and child care.

3) To increase capacity and strengthen motivation of the monks and monastic teachers in incorporating modern health-care in their teachings and life-style.

4) To improve physical facilities at the monasteries, enabling the monks to practice improved sanitation and hygiene, and promoting personal hygiene practices.

5) To broaden the curriculum of the monastic education system to include preventive and promotive health information.

At the RHP Review Meeting of December 1st, 1998, the point was made that Specific Objectives 4) and 5) might be better considered as strategies rather than as objectives. Instead, it was agreed that these two objectives would be termed "Immediate Objectives" and that the project's objectives be reformulated along the following lines:

Long-Term Objective:

To improve the health of the people in general and women and children in particular to attain the goal of "Health for All by year 2000".

Immediate Objectives:

1) To improve physical facilities at monasteries enabling monks to practice improved sanitation and personal hygiene.

2) To increase the knowledge and skills of the community-based religious persons to provide adequate advice on health and child-care.

3) To broaden the curriculum of the monastic education system to include health and hygiene information.

These are the objectives that have been retained for the present evaluation.

RHP Evaluation Objectives

Following the terms of reference supplied by UNICEF, the general objectives of the present evaluation are to:

1. Evaluate how well the project's strategies have helped to achieve the programme's overall goals;
2. Develop future strategies by identifying areas of the project which could be improved, particularly in the areas of monitoring, training and project management; and
3. Develop a guideline for future activities in the areas of monitoring, evaluation, training, project management and partner coordination.

Evaluation Report and Evaluation Analysis

The report will be presented in two sections:

Evaluation Report, and
Evaluation Analysis

The Evaluation Analysis is a complete documentation of all responses to open and closed format questions for all the tools used. It could be considered as an Appendix for people to refer to if they require some further detail not presented in the evaluation report.

The Evaluation Report draws information from the Evaluation Analysis for each tool to provide INDICATORS and CONCLUSIONS to each KEY QUESTION.

Evaluation Objective 1 is covered in Key Questions and Main Conclusions
Evaluation Objective 2 and Evaluation Objective 3 are covered in Future Strategies and Guidelines for Future Activities

Background to the RHP Project

In 1989, the Health Division and the Dratshang Lhentshog conducted a National Workshop on Health and Religion. This workshop represented the formal recognition of the health promotion potential of the religious leaders in the country and led to the development of a government project, "Health and Religion", supported by UNICEF.

Project activities started in 1990. Activities implemented since the inception of the project include:

Training:	1,100 religious practitioners in over 13 dzongkhags trained in basic health knowledge and practice, with decentralisation of training to the gewog-level instituted since 1995;
Water/Sanitation:	Water supply and sanitation facilities upgraded in 15 monastic institutions;
Curriculum Development:	Dzongkha versions of Facts for Life and Health is in Our Hands have been made available to religious institutions.

In order to put the project in perspective, some background information on the religious communities in Bhutan is briefly presented.

There are approximately 3,000 Buddhist monasteries in Bhutan, of which:

- 20 *Rabdeys* (with anywhere from 100 to 300 monks);
- 19 Monastic schools;
- 13 *Shedras* (Buddhist Colleges);
- 15 *Drubdras* (Meditation Centres);
- several Nunneries; and
- numerous *Lhakhangs* (smaller monasteries) and *Gomdeys* (temples).

A *Rabdey* is the most senior institution in each dzongkhag. Each *Rabdey* is headed by a *Neten* (Abbot) and run by four senior *Lopens*, four *Choetrim Zhis* (religious administrators), four junior *Lopens* and a *Dungchen* (Secretary).

There are thousands of Buddhist religious personnel in the country, of which:

- 3,500 state supported monks;
- 4,000 more receiving education/training in state-supported institutions;
- 3,000 on private patronage (including most nuns); and
- about 15,000 *gomchen* (lay monks).

In addition to these Buddhist practitioners, there exist numerous other religious practitioners, including some from pre-Buddhist and Hindu traditions, such as: *tsips*, *pawos*, *pamos*, *pandits* and *jakris*.

CORRECTIONS

- Training: 2,378 religious practitioners in 19 Dzongkhags trained in basic health knowledge and practice, with decentralization of training to the geog-level instituted since 1995;

- Water/Sanitation: Water supply and sanitation facilities upgraded in 35 monastic institutions;

- Punakha Rabdey to be read as Pung-Thim Dratshang

Financial input into the Religion and Health Project for 1992 to 1998

Activities	1992	1993	1994	1995	1996	1997	1998	Total
Study tour for key people in Dratshang		21,000.00						**$ 21,000.00**
Training of two project staff in Management		3,650.00		3,700.00				**$ 7,350.00**
Consultant to support the R&H project				2,000.00	5,116.00	350.00	6,257.00	**$ 13,723.00**
Supply of reference book Health is in our Hands		2,163.00	7,029.00					**$ 9,192.00**
Project establishment support		1,270.00	4,035.00	1,269.00	5,481.00	50.00		**$ 12,105.00**
Training workshop for monks and community								
based religious persons	1,934.00	16,138.00	17,616.00	9,084.00	28,773.00	3,203.94	8,904.54	**$ 85,653.48**
Monitoring					1,200.00			**$ 1,200.00**
Consultation workshop for Dratshang Dungchen,								
District Engineers, DMOs and DHSOs			3,330.00					**$ 3,330.00**
Training of Trainers for Dungchens and Health								
Workers			562.00					**$ 562.00**
Water and Sanitation and kitchen improvement	8,910.00	18,149.00	44,012.00	42,322.00	3,380.00	48,195.00	28,470.00	**$ 193,438.00**
Total:	**$10,844.00**	**$62,370.00**	**$76,584.00**	**$58,375.00**	**$43,950.00**	**$ 51,798.94**	**$ 43,631.54**	**$ 347,553.48**

Evaluation Methodology

Evaluation Tools

The evaluation tools and methodology, presented in a separate package, were designed by Ms Caroline Marrs and piloted by Ms Marrs and the Evaluator prior to the start of the fieldwork.

It had been the intention of UNICEF Bhutan Office to employ a local Bhutanese evaluator in keeping with the original concept paper proposal published by Dr Jigmi Singay (Dec.1990). Unfortunately the recruitment of a national evaluator was not possible. Consequently Ms Marion Young was contracted to take on the field work, analysis and report presentation.

As the fieldwork required local language proficiency Sonam Dhendup, a class 12 student, was selected as translator to accompany the evaluator throughout the fieldwork. The evaluator and translator attended a pre-evaluation presentation of the Evaluation Tools given by Ms Marrs. RHP staff briefed the translator on specific health and hygiene terminology used in the evaluation tools, for example difficulties of translating *dehydration* and *malnutrition* into Dzongkha.

The evaluation tools were designed within the following structure:

- Nine tools were developed to represent the range of stakeholders:

Tool 1	Water/Sanitation Observation Checklist	[open/closed]
Tool 2	Health Knowledge Test	[closed]
Tool 3	Institution-based Religious Community Questionnaire	[open/closed]
Tool 4	Institution-based Religious Community in-depth Interview	[open]
Tool 5	Health Workers Questionnaire	[open/closed]
Tool 6	Community Questionnaire	[open/closed]
Tool 7	Community-based Religious Practitioners Questionnaire	[open/closed]
Tool 8	Community-based Religious Practitioners in-depth Interview	[open]
Tool 9	Brief Interview with DHSO	[open]

- Four packages were produced to represent the range of RHP inputs:

Package 1: Evaluation Tools for Institution-based Intervention Sites (Hardware and Software)
To assess effects in monastic institutions where the RHP has intervened both in water/sanitation upgrades (hardware) and training (software).

Package 2: Evaluation Tools for Institution-based Intervention Sites (Hardware-only)
To assess effects in monastic institutions where the RHP has intervened solely in water/sanitation upgrades (hardware).

Package 3: Evaluation Tools for Control Sites (No Project Intervention)
To assess the health practices and roles of monastic institutions where there has been no RHP intervention to date.

Package 4: Evaluation Tools for Gewog-based Intervention Sites (Software-only)

- The country was divided into four geographical zones. Sites were selected to represent each zone:

Zone 1:	Chukha, Samtse, Haa, Paro and Thimphu.
Zone 2:	Gasa, Wangdue Phodrang, Punakha, Dagana, Tsirang.
Zone 3:	Trongsa, Bumthang, Lhuntse, Sarpang, Zhemgang.
Zone 4:	Mongar, Trashiyangtse, Trashigang, Pemagatshel, Samdrup Jongkhar.

The evaluator felt that there were some limitations to the evaluation design and planned use of the evaluation tools, caused in part by having to contract the design consultant, an external evaluator and a translator. The limitations of the tools and methodology are discussed further in the following two sections, evaluation process and evaluation limitations.

Evaluation Process

Pilot: At the pre-evaluation workshop it was agree that the evaluation tools be piloted. For this purpose the methodology design consultant, the evaluator, the translator and Lopen Tashi Geley from Dratsang Lhentsog RHP Office visited two sites, Dalida Shedra and Thinleygang BHU over a two-day period. All the tools were trialed and feedback was received from participants as well as from the evaluation team. This exercise was invaluable for the modification of some questions and also for the translator and the RHP gelong to discuss the fine-tuning of the interview technique.

Workplan: Also at the pre-evaluation workshop the committee agreed on the minimum revised workplan to be used for fieldwork. The selected workplan covered 10 sites distributed evenly across zones and packages. The workplan had to be substantially modified at the outset of the field work phase because:

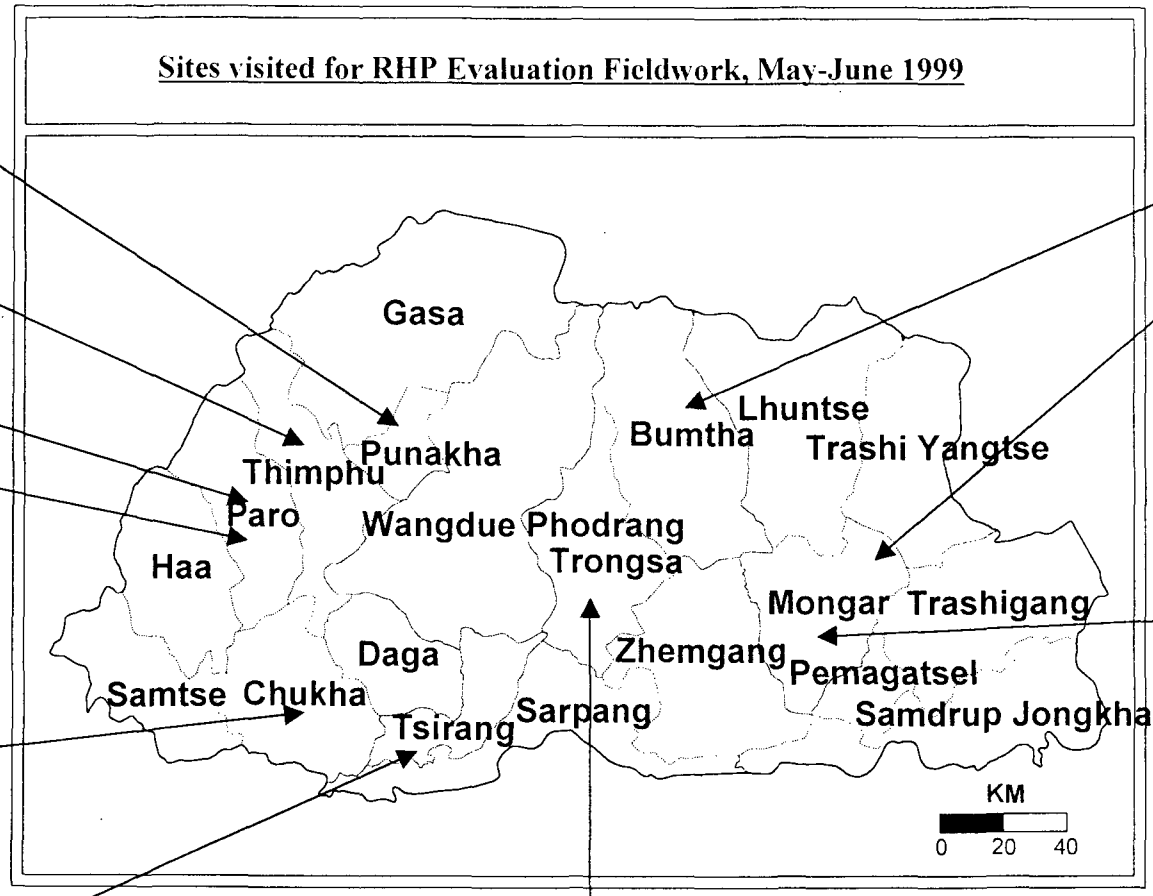
(i) not enough time had been allowed for travel to two sites with a minimum one day walk;
(ii) the required permits to visit two districts were not approved by the Home Ministry for security reasons.

Six out of 10 sites and 2 out of 5 districts in the original plan had to be revised one day before the scheduled start of the fieldwork. The issue of permits to visit restricted locations may not have arisen had the evaluator been a national person.

The revised original field workplan with which the evaluation team started the fieldwork included 11 sites covering all four zones and all four packages. The Original Field WorkPlan [p.15] allowed two days at each site in addition to travelling time. Once the evaluator and translator started using the evaluation tools in situ, it became clear that:

(i) two days was more than sufficient time to complete the full package of interviews at each site;
(ii) a fifth package requirement was identified for sites in which there had been only a software input and no hardware – this was categorised as Package 1a and the tools designed for use with Package 1 were used; and
(iii) Package 1a and 3 and Zones 2,3 and 4 were less well represented.

A further revision to the field workplan was proposed to UNICEF, Dratsang Lhentsog and Health Division by the evaluator and was approved. This added 9 sites to the original 11 sites giving a total of 20 sites across 8 districts with a better distribution of zone and package coverage. The final revised field workplan and details of sites visited by zone and package used is presented on pages 16 and 17.



Punakha Rabdey

Thimphu Tango Shedra

Paro Rabdey

Paro Keela Gompa

Chuka Chapcha Community

Chuka Rabdey

Tsirang Rabdey

Tsirang Tsokhana Community

Tsirang Shemjong Community

Tsirang Chanauti Community

Tongsa Rabdey

Tongsa Kunga Rabten Nunnery

Tongsa Langtel Community

Tongsa Nyimshong Community

Bumthang Rabdey

Bumthang

Kurjey Lhakang

Mongar Dremetsi Shedra

Mongar Ngatshang Shedra

Mongar Kadam Gompa

Mongar Rabdey

Original RHP Evaluation Field Workplan - May / June 1999
Marion Young - Evaluator & Sonam Dhendup - Translator

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	May 24	25 Thimphu – Tango	26 Thimphu – Tango	27 Paro - Rabdey	28 Paro - Rabdey	29 Paro - Keela Gompa
30 Paro - Keela Gompa	31 Chuka – Rabdey	June 1 Chuka – Rabdey	2 Silver Jubilee – Free	3 Silver Jubilee - Free	4 Chuka - Chapcha Community	5 Chuka - Chapcha Community
6 Free - Analysis	7 Thimphu to Tongsa	8 Tongsa Rabdey	9 Tongsa Rabdey	10 Tongsa to Nyimshong	11 Nyimshong Community	12 Nyimshong Community
13 Nyimshong to Tongsa	14 Free – Analysis	15 Tongsa to Mongar	16 Mongar – Rabdey	17 Mongar - Rabdey	18 Mongar - Ngatshang Shedra	19 Mongar - Ngatshang Shedra
20 Free - Analysis	21 Mongar to Tongsa	22 Tongsa to Tsirang	23 Tsirang – Rabdey	24 Tsirang - Rabdey	25 Tsirang - Community	26 Tsirang - Community
27 Tsirang to Thimphu	28 Free – Analysis	29 Free – Analysis	30	31		

Final revised RHP Evaluation Field Workplan - May / June 1999
Marion Young - Evaluator & Sonam Dhendup - Translator

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
	May 24	FW 25 Thimphu – Tango	FW 26 Thimphu – Tango	FW 27 Paro - Rabdey	FW 28 Paro - Rabdey	FW 29 Paro - Keela Gompa
30 Paro - Keela Gompa	31 Chuka – Rabdey	June 1 Chuka – Rabdey	2 Silver Jubilee - Free	3 Silver Jubilee - Free	4 Chuka - Chapcha Community	5 Free - Analysis
6 Free - Analysis	7 Thimphu to Tongsa	8 Tongsa Rabdey / Kunga Rabten Nunnery	9 Tashicholing Gomdey – Langtel	10 Tongsa to Nyimshong -Nyimshong Comm.	11 Nyimshong to Tongsa Tongsa Rabdey	12 Tongsa to Damphu
13 Tsirang - Rabdey	14 Tsirang – Tsokhana Community	15 Tsirang – Shemjong Community	16 Tsirang – Chanauti Community Damphu to Thimphu	17 Halt Thimphu	18 Thimphu to Bumthang	19 Bumthang to Mongar
20 Mongar - Rabdey	21 Mongar – Kadam Gompa	22 Mongar - Ngatshang Shedra	23 Mongar – Dremetsi Lhakang	24 Mongar - Bumthang	25 Bumthang Rabdey / Kurjey Lhakang Bumthang - Thimphu	26 Halt Thimphu Analysis
27 Punakha Rabdey Punakha - Thimphu	28 Analysis	29 Analysis	30 Analysis	1		

RHP Evaluation May/June 1999
Field Work Sites

	Package 1 Inst. – HW + SW	Package 1a. Inst. – SW only	Package 2 Inst. - HW only	Package 3 Inst. - none	Package 4 Community – SW only	Total in each zone
Zone 1		Chuka Rabdey	Thimphu – Tango Shedra Paro - Keela Gompa	Paro - Rabdey	Chuka - Chapcha Community	5 sites
Zone 2	Tsirang – Rabdey			*Punakha - Rabdey*	Tsirang – Tsokhana Community *Tsirang – Shemjong Community* *Tsirang – Chanauti Community*	5 sites
Zone 3	Tongsa – Rabdey *Tongsa - Kunga Rabten Nunnery* *Bumthang – Kurjey Lhakang*	*Bumthang - Rabdey*			Tongsa - Nyimshong Community *Tongsa – Langtel, Tashicholing Gomdey*	6 sites
Zone 4	Mongar – Rabdey *Mongar – Dremetsi Shedra* *Mongar – Kadam Gompa*		Mongar – Ngatshang Shedra			4 sites
	7 Institutions	2 Institutions	3 Institutions	2 Institutions	6 Communities	20 sites

Note: Nine additional sites given in *italic*

Logistics: The RHP Office of Dratsang Lhentsog ensured that all necessary permits and letters of introduction were available as required by the evaluation team which was a great help in the smooth running of the field work programme. Dratsangs, health services and dzongkhag administrators were all informed in advance of our visit to each location.

The evaluation team was able to fulfil the revised field workplan due to the assistance given by the district Dratsang and health staff. At each location the sample group to be interviewed were called according to our requirements. In some locations we visited people in the village and in other places the villagers were called to us or were visiting the BHU or Gompa. At each site, the following minimum sample of people were interviewed:

Tool 1	observation and information from the senior person interviewed
Tool 2	two religious practitioners, trained or untrained
Tool 3 or 7	two religious practitioners, trained or untrained
Tool 4 or 8	the senior representative of the religious institution or community of religious practitioners
Tool 5	the health worker for the community
Tool 6	two community people
Tool 9	the DHSO

Sample: In some locations an additional person was available for interview and, if they fitted the criteria, we took the opportunity to include them in the sample. Throughout the field work the evaluator kept track of the emerging sample, considering the balance of trained and untrained religious practitioners interviewed and the balance of male/female community people by age and by town or remote. The final sample range is fairly representative of all the variables being considered. Some variables are given below:

Sample Range by Tool Used

	Trained	Untrained	Male Age range	Female Age range	Total
Tool 2	18	22	36 17-74 yrs	4 21-42 yrs	40
Tool 3	12	18	36 17-55 yrs	4 21-42 yrs	30
Tool 4	8	6	15 29-78 yrs	1 42 yrs	14
Tool 5					26
Tool 6			26 25-78 yrs	17 20-70 yrs	43
Tool 7	9	5	14 32-74 yrs	0	14
Tool 8	5	1	6 35-74 yrs	0	6
Tool 9			7	0	7

The full details of the sample range by package and tool used is given in the Sample Range section of the Evaluation Analysis document.

A total of 180 separate interviews were conducted with 137 different people. The full list of people interviewed at each site is given in the Sample Range section of the Evaluation Analysis document.

The sample range included some people who represented more than one category from religious practitioner health and community groupings. For example:

	Religion	community	health
RHP and VHW trained Gomchen	✓	✓	✓✓
RHP trained female village elder		✓	✓
VVHW Pandit, not RHP trained	✓	✓	✓✗
Gelongs as RHP facilitators	✓		✓
HA's as RHP facilitators			✓
VHW gelong, not RHP trained.	✓		✓✗

Some of the village health workers were interviewed as community people and sometimes as the health representative for their community, where there was no BHU facility. In several cases the VHW who are religious practitioners were interviewed as health workers and some others were interviewed as religious practitioners. The choice was based on covering the full sample range for each site.

Questions: Throughout the fieldwork the tools had to be used with some flexibility since some of the questions produced very similar answers as they were originally worded, or caused some confusion when translated into Dzongkha. For example:

6.3 If you do practice good health and hygiene habits (including going or not to the BHU), why do you?
6.4 Do you think having good health and hygiene habits is important? If so, why? If not, why not?

Questions 6.3 and 6.4 were reworded during the fieldwork to focus on what made people change their H+H habits (qu.6.3) and why H+H habits are important compared to how things were before good H+H were practised (qu.6.4).

Question	Usual response
6.8 Who do you turn to for advice when someone in your family is ill?	Medical advice and puja
HAVE YOU RECEIVED HEALTH ADVICE FROM A MONK LATELY?	NO (in which case qu.6.11 is not asked) Re-worded as
6.11 On what occasion did you receive health or hygiene advice from a monk (e.g. puja for illness, childbirth, death, or other occasion)?	"Have you or anyone you know had a sickness in the family?" "What was the problem?" "What did you do?" "What did the religious practitioner do / advise?"

Data Analysis: Some data analysis had been started during the fieldwork as a UNICEF laptop computer was provided , which was invaluable.

Data from all the interview papers has been tabulated and transcribed and is presented in the Evaluation Analysis document as raw data. The raw data was then used to identify indicators for each of the 19 Key Questions originally drawn up by UNICEF. The INDICATORS and CONCLUSIONS for each KEY QUESTION are presented. The MAIN CONCLUSIONS are then drawn from the Key Question Analysis.

Evaluation Limitations

Several limitations were identified in the evaluation methodology document. They are:

Unfortunately, evaluation results will not be able to say with any degree of certainty whether the RHP has had any impact on the Long-term Objective, namely improved mother-and-child health, primarily because:

- No baseline date on the pre-project mother-and-child health situation in specific project intervention sites was collected.

- No research was done to establish the influence, if any, and the degree of influence of monks and other religious practitioners on mother-and-child health, as opposed to myriad other possible influences such as the availability of health care, health information campaigns, general education levels, and so on.

For example, the evaluation may well find that water and sanitation facilities are maintained and used, that monks are cleaner and healthier, and that they impart health messages whenever possible. Though one can make the valid assumption that these achievements result in a net benefit for monks and even their communities, one cannot conclude that, specifically, mother-and-child health has improved nor that improvements are due to RHP specifically.

C.Marrs, May 1999

Other limitations require comment, arising from the field work and evaluation analysis process.

Evaluation team - constraints: The need to employ two external consultants with contracts that were not able to overlap was an unavoidable circumstance. This places limitations on the evaluation because the evaluator was not able to share the perspective or insights of the design consultant. The rationale for some of the methodology may have become lost or changed from the original intention. Likewise questions may have similarly lost some of the original design purpose, as may the process of analysis. This is acknowledged but was unavoidable.

Translator: It was unfortunate that a Bhutanese national could not be recruited as evaluator and that it was therefore necessary to recruit a translator to accompany the evaluator. There are several limitations:

- the obvious information loss when questions cannot be asked and answered direct
- the inexperience and immaturity of the translator (though he worked diligently, had a pleasant interview manner and was an able translator)
- the possible bias in the interpretation of responses (the translator asked and told the answer to the questions time and again – did he pick out the common repetitions or the individual nuances in answers given?)

It is not possible to know what was lost or biased by having to work through a translator.

Two interesting occurrences relate to the issue of translating. One community person who was interviewed was visiting the town from a quite remote village. The interview took place in a tea shop in the bazaar with the community person, the evaluator, the translator and a gelong from the Rabdey. The interview was conducted in four different languages with only two of any of the four people gathered being able to speak directly with each other:

community person ↔ gelong ↔ translator ↔ evaluator

The second incident involved the use of a temporary translator in one location. A health worker was asked to stand in as translator for some of the interviews as the official translator was unable to attend. He knew the people being interviewed, through his work contact. He also had good communication skills and knew the subject of H+H well. With this small sample of interviewees the responses were so similar to the translations of the original translator that the evaluator believes this did not bias the results. It did serve to clarify that the original translator was achieving satisfactory and valid results.

Interviews: On several occasions during the interviews it was not possible to interview people individually without an audience of some sort. This was due to the places in which the interviews were conducted:

MCH clinic	roadside	Prayer hall	school classroom	BHU
a nunnery prayer room and private quarters			Dzong during a Tsechu	hospital
village houses (in one of which there was an annual puja in progress)			Gompa during a puja	shop front

The only interviews in which it was possible to insist on being left alone were the Health Knowledge Tests. Generally the interviews did not seem to be affected by one or two curious observers. Several times the Lam attended during interviews with gelongs, which clearly made them nervous. However it did not seem acceptable to ask the Lam to leave.

Tools: The evaluator felt at times that the evaluation tools, while being very comprehensive and well prepared, were a little too over-complicated and sophisticated for the task in hand. The evaluator has followed the guidelines for the evaluation methodology entirely. However at times there was some confusion created by having:

- 19 key questions
- impact analysis categories A and B
- 9 tools to account for different stakeholder groups
- 4 (later 5) packages containing different combinations of the 9 tools with variations in some of the questions for each different package.

The evaluation package prepared by the consultant has also been used for this analysis. The same comments hold for the complexity and sophistication of the evaluation package.

This limitation relates back to the limitation raised earlier, of the design and evaluation being undertaken by two consultants with little exchange of insight into the design thinking.

The results of the evaluation objectives are valid. Triangulation verified the consistency between the views of religious practitioners, community people and health workers. Comparisons between trained and untrained religious practitioners were also possible for some of the evaluation. All the impacts are shown to be positive and the evaluator has therefore introduced a conditionality to each key question, which describes the most significant condition, which enables the impact to be positive.

Sample: Paro was selected as a control site since there has been no hardware or software input (or very little!). Another control group which, in hindsight, would have been more representative would have been a community where there has been no input (religious community with no RHP training/no easy access to health services) since the community people are the ultimate beneficiaries of the inputs. No remote communities with no inputs were visited.

Other H+H inputs: Concern was expressed by the Stakeholder Committee (10th May 1999) that sites in which there had been UNFPA interventions would distort the findings for the RHP evaluation. The UNFPA training is similar to that of RHP. Of the sites visited for the RHP evaluation Punakha and Tsirang are the only districts to have received both RHP and UNFPA inputs. Stakeholders agreed that RHP evaluation sites could coincide with UNFPA sites, since the evaluation results of sites with UNFPA intervention would in a sense confirm (or not) the validity of RHP strategies.

The evaluator observed that there have been a number of H+H inputs over recent years. Some beneficiaries are very clear as to the source of the input, others are quite unclear as to the funder.

Baseline indicators of religious practitioners' health knowledge: As there is no baseline measure of the level of knowledge the religious practitioners had before RHP training it is only speculative to say that the level of knowledge of untrained religious practitioners as measured by the Health Knowledge Test will give some indication of the pre-RHP training levels of knowledge among religious practitioners. Other factors will include:

- the religious practitioner's level of basic education
- their exposure to other sources of health information, and
- their access to other training, for example some religious practitioners are also trained as VHW.

Note: Terminology used throughout the Evaluation Report and Evaluation Analysis:

1. **RHP** is used to abbreviate reference to the **Religion and Health Project**.
2. The term **religious practitioner** has been used as an inclusive term referring to **monks and community-based religious practitioners** collectively. When reference is made to a specific category for example Gomchen or gelong, this term is used explicitly.
3. **FFL** and **HOH** is used to abbreviate the titles of the two main health publications used in the RHP workshops, **Facts for Life** and **Health in our Hands**.
4. **H+H** is used to abbreviate reference to **health and hygiene.**
5. **SW** and **HW** are used to abbreviate **Software** (ie. RHP training) and **Hardware** (ie. water and sanitation facilities)

Key Questions

Stemming from the above evaluation objectives, a number of Key Questions were developed. For analysis purposes, these key questions will be grouped according to whether they correspond to finding out about:

A-Behavioural Changes in Religious Communities, or
B-Effective Performance of Religious Communities as health promoters.

The Key Questions are as follows:

a) Role of religious communities in promoting health:

a1) Is the health promotion role of the religious community (ordained monks) and/or community-based religious practitioners understood by themselves (and by the community and by health workers)?
a2) How successful have the religious community and/or community-based religious practitioners been in their role as health promoters (views of religious communities themselves, community members and health workers to be asked)?
a3) Do the religious community and/or community-based religious practitioners feel that they can contribute more in promoting health? If yes, what more and how?
a4) Do community-based religious practitioners (such as *tsips, pawos, pamos, gomchens, jakris*) view the role being promoted by the RHP as a threat to their livelihood? (above cited people are usually approached in times of ill health to perform rituals/pujas and get paid in cash or kind for their services).

b) Behavioural changes in the religious community:

b1) Are there changes in the health seeking and hygiene practices of the religious community and/or community-based religious practitioners after RHP training workshops?
b2) How have the improved water/sanitation facilities been used and maintained?
b3) Have the religious community's attitudes towards sanitation and hygiene changed with the introduction of improved water/sanitation facilities?
b4) Do the religious community and/or community-based religious practitioners provide advice on health care when approached for religious services in the event of family illness?

c) Behavioural changes in the community:

c1) Do community members receive health advice from the religious community and/or community-based religious practitioners when approached for religious services in the event of family illness?
c2) Has the religious community and/or the community-based religious practitioners influenced the health seeking and hygiene practices of the community?
c3) Are there any added advantages of the religious community and/or community-based religious practitioners promoting health?
c4) Are there changes in the health seeking and hygiene practices of the religious community and/or community-based religious practitioners after RHP training workshops?

d) Health workers' views:

d1) Rate the effectiveness of the religious community and community-based religious practitioners as promoters of health messages.
d2) Do health workers view the religious community and community-based religious practitioners as competitors or complementary?
d3) Has there been an increased number of patients from the community referred by the religious community and/or community-based religious practitioners following RHP workshops?

e) Effectiveness of training workshops:

e1) What knowledge has been retained by religious persons who attended RHP training workshops?
e2) What is the knowledge of religious persons who have not been trained?
e3) What additional areas of health would the religious community and/or community-based religious practitioners like to learn about in the training workshop to enhance their role as health promoters?
e4) How can training workshops be further improved?

Note: **Format of Key Question Analysis**

Each Key Question is now considered against the evaluation findings.

Information relating to each Key Question is presented as INDICATORS and CONCLUSIONS.

For each Key Question the views of the religious practitioners, community people and health workers are considered, as appropriate.

For each INDICATOR, the TOOL REFERENCE is given. Analysis of each Tool is presented in the Evaluation Analysis document.

The impact of the Religious and Health Project is given for each Key Question using the two analysis categories given in the evaluation design:

Analysis A: Positive Behavioural Changes in Religious Communities
Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities

For each statement of impact, a statement of condition is given ie. the main condition which has to be met in order to achieve a positive impact. The MAIN CONCLUSIONS and the RECOMMENDATIONS are a summary of the Key Question conclusions, given at the end of the section.

Key Question a1. - *Role of religious communities in promoting health*

Is the health promotion role of the religious community (ordained monks) and/or community-based religious practitioners understood by themselves (and by the community and by health workers)?

View of Religious Practitioners
Indicators:

- 39 out of 40 religious practitioners interviewed said that they provide H+H advice in their community

[Tool 3.11/Tool 7/5 YN - closed]

- Comments from the religious practitioners indicated a reasonable level of H+H knowledge and awareness of H+H issues

[Tool 3/Tool 7 site profiles - open]

- The religious practitioners made the following comments:
  - ⇒ Health advice can be given when making home visits for puja
  - ⇒ The young monks are taught to tell their parents H+H messages
  - ⇒ The double message from the religious community and the health workers leads to improved standards of health
  - ⇒ People will mostly follow the advice of the religious person even if the advice has been given by the health worker
  - ⇒ If called for a puja and there is a sick person they advise the person to go to the hospital
  - ⇒ When giving messages and teachings in the community the monks should be clean to set a good example
  - ⇒ Once a month the trained anim is sent to remote communities to give H+H messages
  - ⇒ Before RHP we didn't have the knowledge and so we might be in conflict with the health workers if the astrology said not to do something. Now it's the same advice
  - ⇒ If there is some misunderstanding with the community people the gelong tries to clarify. For example people thought that medicine was poison; now with training even his doubt is clarified
  - ⇒ If Lam asks people to construct a latrine or call the health worker or take the patient to hospital they will do it
  - ⇒ The training of the monk body in H+H has influenced to the grass roots level not otherwise reached

[Tool 3/Tool 7 site profiles – open]
[Tool 4/Tool 8 - open]

View of Community People
Indicators:

- 32 out of 40 community people said they appreciate the religious practitioners' contribution to health matters in the community. The 8 remaining responses were non-committal and were from sites where there have been minimal or no RHP training programmes

[Tool 6.13 - closed]

- The community people made the following comments:
  - ⇒ If the monks have health knowledge they go to the villages and they can be the bridge between the village and the medical people
  - ⇒ Some people only consult the religious practitioner, so they (the religious practitioner) can identify whether the person should seek medical advice
- Other comments suggest the role of the religious practitioner as health promoter is not fully understood by some community people:

⇒ First they go to the Jakri who will tell if they should go to the BHU or the hospital. If it is a fever the Jakri will do a little puja and then immediately send to the hospital. If it is psychological he will do puja for 2-3 days.
⇒ Monks will not have medical knowledge and cannot force people to go to the clinic

[Tool 6.8/9 - open]

View of Health Workers
Indicators:

- 20 out of 22 health workers considered that health and hygiene habits had been influenced by the health promotion activities of the monks

[Tool 5.14 - closed]

- The health workers made the following comments:
  ⇒ The role is only to advise people to go for medication
  ⇒ 60-70% are advising to do puja and come for medication. Before they came for medication too late
  ⇒ We call the gomchens the health motivators – they are the first to see the sick person
  ⇒ What the monks say is taken up by the community – their one word to our three
  ⇒ More remote places are not much improved. They need the RHP training
  ⇒ Local healers need training especially

[Tool 5.8 - open]

Conclusions

a1: The role of the religious community and religious practitioners as health promoters is understood by themselves, by community people and by health workers.

The religious community indicated that they have been giving H+H messages but that referral to the BHU or hospital is a new role since RHP. Some health workers indicated that there is a change in this respect amongst both gelongs and religious practitioners in the community but that there is still a delay in referral in some cases. There are two possible reasons for the difference in perspective. First, many of the religious community stated positively that they do both puja and refer for medical advice but the evaluation did not pursue whether there is still some delay while the puja actually takes place. Some religious practitioners mentioned categorically that they do a very short mantra and refer quickly if the case is urgent. Secondly, many religious practitioners qualified the referral for medical advice by stating that referral would always be the case if the person had a disease but that a spiritual sickness would require puja, then medical advice. The evaluation did not manage to clarify how the religious practitioner might distinguish which sickness required medical advice more urgently. The comment from several HA's suggested that a fever might trigger referral advice whereas ARI for example is still not taken seriously enough.

The response from the community indicates their complete trust in the word of the religious practitioners and that they will advise correctly to the community on health matters. This highlights the importance of the role of the religious practitioners in the community and therefore the importance of training such as the RHP workshops to improve their knowledge and understanding of health issues.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question a1 = POSITIVE IMPACT
Conditional: RHP training is a key to grass roots health promotion

Key Question a2. - *Role of religious communities in promoting health*

How successful have the religious community and/or community-based religious practitioners been in their role as health promoters (views of religious communities themselves, community members and health workers to be asked)?

View of Religious Practitioners

Indicators:

- Health knowledge test scores range from 70% to 100% with an overall average of 87%. There was very little difference between the scores of trained and untrained religious practitioners (See e1/e2 for further analysis of test scores)

[Tool 2 - test]

- 39 out of 40 religious practitioners stated that they are providing H+H advice to their community, 13 of whom were not doing this prior to RHP and a further 17 did not receive training
- 7 of the 21 religious practitioners who attended RHP training were practising good H+H habits prior to the training, in their view.
- 39 out of 40 religious practitioners feel confident in providing health advice
- 39 out of 40 religious practitioners enjoy giving health advice
- None of the religious practitioners saw providing health advice as a burden
- All the religious practitioners saw providing health advice as benefiting the community

[Tool 3.9-16/Tool 7.3-10 - open]

- The religious practitioners gave the following indicators of the success of RHP:
  - ⇒ Increased level of knowledge and understanding of H+H
  - ⇒ Change of living standards
  - ⇒ Cleaner living environments
  - ⇒ More people seek advice from the health workers
  - ⇒ People are not so sick

> **If you keep on giving the same message at last the villagers follow the advice. Then they realise the benefits for themselves and they will continue the good habits. Then it is successful**
>
> **Comments from a religious practitioner**

[Tool 3 - open]

View of Community People

Indicators:

- 31 out of 40 community people think that the religious practitioners have been successful as health promoters. The remaining 9 people didn't know (8) or had no contact with religious practitioners (1)

[Tool 6.14 - closed]

- The community people made the following comments:
  - ⇒ The monks are very effective at giving medical advice. If the health worker advises to go for medical treatment the villagers will make excuses not to go.
  - ⇒ A child was sick with diarrhoea. The Pandit told him to give boiled water and fresh food. The VHW said to keep the surroundings clean and keep utensils and linen clean. The child got better without having to go to the hospital.
  - ⇒ Before the RHP some villagers would go for medical advice as well as puja but sometimes a person would die if only puja was performed

[Tool 6 - open]

View of Health Workers
Indicators:

- 20 out of 23 health workers considered the role of the religious practitioner as health promoter to be successful. Those who responded that the role has not been successful either stated there is more still to do or that RHP is not the only reason for success in communicating health messages.

[Tool 5.17 - closed]

- The health workers made the following comments:
  - ⇒ 60-70 % of religious practitioners are advising people to do puja and come for medication. Before, they came for medication too late.
  - ⇒ Regular follow up is needed. The religious practitioners are capable and if you follow up they will continue. If you leave it they will too.

> **RHP is not yet successful.**
> **Still only a few are trained and they only have a small knowledge.**
> **They don't worry about diarrhoea.**
> **They only worry about the high fever cases.**
> **There are still a lot of health messages to teach.**
> **Comments from a health worker**

[Tool 5 - open]

Conclusions

a2: The religious community and/or community-based religious practitioners have been successful in their role as health promoters – view of the religious community, community people and health workers

The religious practitioners' level of knowledge contributes to their success as health promoters. Their response to the role is very positive. Those who have been involved are enthusiastic and those who have not yet participated expressed an interest to do so should the opportunity arise.

The religious practitioners are advising on a range of H+H issues, in some cases following up and supporting the initiatives of the headman or health worker, for example with latrine construction, and in other cases giving messages on cleanliness, early referral and STD/AIDS, etc.

Though the messages indicating success are very positive other points were raised. The religious practitioners are not all capable or interested in communicating health messages, they are not all trained, and not all the religious practitioners from monastic institutions work regularly in the community. These points are further considered in the strategies for future training.

The assessment of "successful" is very subjective and is based on perspective and experience. The perception of success may vary between religious practitioners, community people and health workers. Whatever the interpretation the consensus indicates success, but there is more that can be achieved.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question a2 = POSITIVE IMPACT
Conditional: RHP is one of a number of H+H inputs. More can still be done through RHP.

Key Question a3. - *Role of religious communities in promoting health*

Do the religious community and/or community-based religious practitioners feel that they can contribute more in promoting health? If yes, what more and how?

View of Religious Practitioners
Indicators:

- Yes ..... what more? Some comments:
  - ⇒ More messages on sanitation and hygiene
  - ⇒ Continue the same messages encouraging people to take medicine as well as puja
  - ⇒ If there is more training we can do more – new information or refresher
  - ⇒ We could take on the VHW role
  - ⇒ If the manual was in Nepali we could read it

- No ..... why not? Some comments:
  - ⇒ With no facilities the role can only be this much
  - ⇒ Medical advice should be given direct by the HA
  - ⇒ Some topics are forbidden in Buddhist teachings and it is difficult for monks to speak out eg. STD/AIDS, pregnancy and family planning
  - ⇒ May not be able to fulfil more
  - ⇒ Gomchens have their own farm work to do, so it is difficult to see how they could do more
  - ⇒ Some can but would not want to or have a different way of thinking
  - ⇒ Jakri should not do the VHW type of role

[Tool 4.9/8.7 - open]

View of Community People
Indicators:

- 28 out of 40 community people feel that religious practitioners can contribute more in promoting health. 12 said they don't know.

[Tool 6.15 - closed]

- Yes ..... what more? Some comments:
  - ⇒ More facilities for the religious practitioners
  - ⇒ Give medicines
  - ⇒ More training = more knowledge to pass on, especially early referral
  - ⇒ Train at the gewog level especially the powas and pams – they don't like to leave the village
  - ⇒ Make the role more official
- Yes ..... what more for general health promotion?:
  - ⇒ Train labour officers; more trained VHW's; more books

[Tool 6.16 - open]

View of Health Workers
Indicators:

- 23 out of 23 health workers feel that religious practitioners can contribute more in promoting health

[Tool 5.19 - closed]

- Yes ..... what more? Further comments:
  - ⇒ Monks should be aware of the health worker role and then, if well informed, they can support us and impart some knowledge

⇒ There have been improvements but more is needed – and time too. It is not satisfactory yet. Need to stress more on keeping animals separate. Communities are not happy to do this. Also need budget to do this.

[Tool.5 - open]

Conclusions

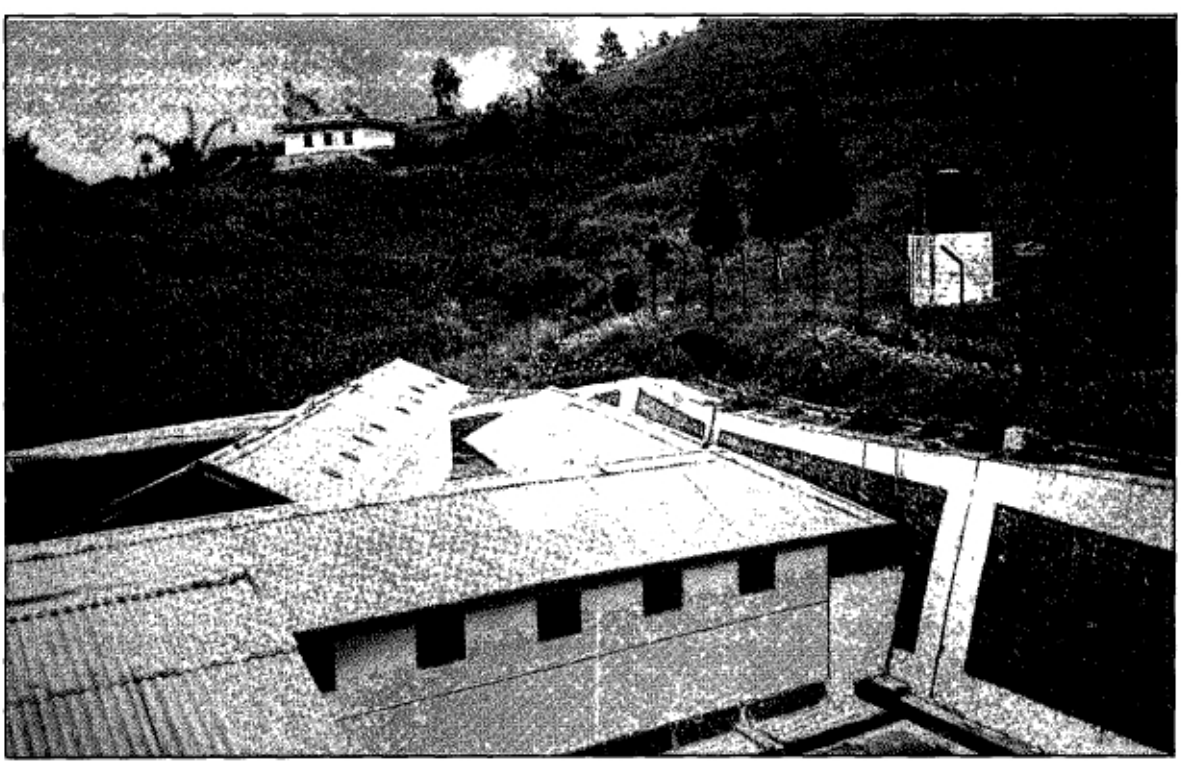
a3: The religious practitioners, the community people and the health workers generally feel that the religious community can contribute more in promoting health

The religious practitioners have different views on the extent of their role and commitment to it. The general view was that what can be done "on the way" is sufficient. Some were more enthusiastic but many responses suggested that this and the continuing motivation is dependant on some incentive, for example further training and materials such as FFL and HOH, maybe even some recognition and follow up is sufficient.

The community are keen to see more improvements but identify less directly with RHP unless they have had some direct link with the project, for example several headmen and village women interviewed had participated in the gewog level RHP.

The health workers are perhaps in the best position to give more constructive and focussed guidance on this question in future. This will be raised again in the Future Strategies.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question a3 = POSITIVE IMPACT
Conditional: Interest and ability varies between individual religious practitioners.



Bath house at Tsirang Rabdey

Key Question a4. - *Role of religious communities in promoting health*

Do community-based religious practitioners (such as *tsips, pawos, pamos, gomchens, jakris*) view the role being promoted by the RHP as a threat to their livelihood? (above cited people are usually approached in times of ill health to perform rituals/pujas and get paid in cash or kind for their services).

View of Community-based Religious Practitioners
Indicators:

- All 6 community based religious practitioners responded that the role being promoted by the RHP is not a threat to their livelihood. 5 out of 6 had attended RHP training.

[Tool 8.9 - closed]

- The community-based religious practitioners made the following comments:
  - ⇒ First the normal religious practices are followed. Then if there is no improvement the person seeks medical advice.
  - ⇒ Learning is a benefit to yourself
  - ⇒ If no client is coming they feel comfortable
  - ⇒ It is not a threat because it is not going against the religion. It's just giving health advice
  - ⇒ We can do both (medical advice and puja) side by side

[Tool 8.9 - open]

Conclusions

a4: Community-based religious practitioners (such as *tsips, pawos, pamos, gomchens, jakris*) do not view the role being promoted by the RHP as a threat to their livelihood

The sample interviewed is small and may not be representative of the general view or of the view held in more remote communities. As a limitation of the evaluation it is noted that the sample did not include any religious practitioners from the more remote communities where for example access to BHU facilities are difficult and RHP training has not been received. Whether the religious practitioners interviewed had thought of this as a threat prior to the RHP training is not established but their view is unanimously positive now. Whether the religious practitioners have another main source of income (cash or kind) other than income from their religious works is again not established from this evaluation. A religious practitioner with little other source of income may be more threatened and this may well apply to those in the more remote locations.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question a4 = POSITIVE IMPACT
Conditional: none

It only takes 2-3 days to make a pit latrine
If you fall sick how many days of work will you lose?
Comment from a Pandit

Key Question b1. Behavioural changes in the religious community

Are there changes in the health seeking and hygiene practices of the religious community and/or community-based religious practitioners after RHP training workshops?

View of the Religious Community

Indicators:

- All 21 religious practitioners who had participated in RHP training adopted some new H+H practices after the workshop.
- Of the 21 RHP trained religious practitioners 8 were giving health messages prior to RHP and one is not in contact with the community.
- 12 out of 21 religious practitioners changed their practice of giving H+H advice to the community as a result of the RHP training

[Tool 3.11/7.5-6 - closed]

- Of the 15 sites visited with hardware facilities the following was observed:

	adequate condition	not adequate condition
Water Supply (tap stands)	12 of which 4 UNICEF funded	3 of which 0 UNICEF funded
Water Tank	11 of which 0 UNICEF funded	4 of which 0 UNICEF funded
Water Heater	none	None
Bath House	5 of which 3 UNICEF funded	2 of which 1 UNICEF funded
Latrine	6 of which 3 UNICEF funded	9 of which 6 UNICEF funded
Septic Tank	8 of which 2 UNICEF funded	1 of which 0 UNICEF funded
Drainage	9 of which 0 UNICEF funded	3 of which 0 UNICEF funded
Electricity	12 of which 0 UNICEF funded	0 of which 0 UNICEF funded
Kitchen Improvement	6 of which 3 UNICEF funded	3 of which 0 UNICEF funded
Bumthang Stove	3 of which 2 UNICEF funded	1 of which 0 UNICEF funded
Garbage Disposal	9 of which 0 UNICEF funded	2 of which 0 UNICEF funded
Dustbin	8 of which 0 UNICEF funded	2 of which 0 UNICEF funded

⇒ See site reports for further details

⇒ To summarise, the essential facilities for good H+H practice (water supply, latrine and kitchen improvement) were all to some extent inadequate, in some cases the condition of UNICEF funded facilities were found to be inadequate (See Evaluation Analysis Tool 1 Site Profiles for further details)

[Tool 1.2 - closed]

- The religious practitioners made the following comments:

⇒ Before in the Dzong you used to see dirty hands, feet and clothes. Now you don't see this

⇒ Previously the monks had to go far to get water so it wasn't easy to keep clean
⇒ After the training most people made proper drainage and kept their houses clean
⇒ H+H has improved even from before RHP due to the influence of health staff from the BHU and the VHW

[Tool 4.2/8.2 - open]

Conclusions

b1: There are changes in the health seeking and hygiene practices of the religious community and/or community-based religious practitioners after RHP training workshops

The changes in H+H practises of the religious community are demonstrated in their awareness of the H+H issues and in some cases observation of monks cleaning teeth or washing latrines, etc. The changes are, at least in part, a result of the RHP workshops. H+H messages have been communicated through a variety of channels including BBS broadcasts, Kuensel articles, active District officials and headmen, government circulars and RHP workshops supported by water and sanitation facilities.

There are some constraints to good H+H practice which are outside the control of the religious practitioners. For example in some cases the water and sanitation facilities are not adequate for the population or have not been upgraded, in some places the water supply is not adequate or the seasonal variations do not always provide for a nutritious diet. The religious practitioners demonstrate their awareness of H+H by stating these factors as constraints and the attitude now is that they would like to have the means to practice good H+H habits.

Analysis A: Positive Behavioural Changes in Religious Communities
Key question b1 = POSITIVE IMPACT
Conditional: H+H practices are changing where facilities are functioning

Key Question b2. - *Behavioural changes in the religious community*
How have the improved water/sanitation facilities been used and maintained?

View of the Religious Community
Indicators:

- Of the 15 sites visited with hardware facilities the following was observed:

	Cleanliness adequate	Cleanliness not adequate
General	15	0
Latrine	11 of which 6 UNICEF funded	4 of which 3 UNICEF funded
Bath House	6 of which 3 UNICEF funded	0
Kitchen Hygiene	12 of which 3 UNICEF funded	3 of which 0 UNICEF funded
Waste disposal sites	15 of which 0 UNICEF funded	0

- To summarise, the essential facilities for good H+H practice (latrine, bath house and kitchen improvement) were generally kept adequately clean. In three cases the condition of UNICEF funded latrine facilities were found to be inadequate due to over population and uncertainty or inaction when the facility becomes full. (See Evaluation Analysis Tool 1 Site Profiles for further details)

[Tool 1.5] - closed

- 25 out of 28 monks help to keep the water supply clean and maintained
- 21 out of 26 monks help to keep the water tank clean and maintained – 2 do not have this facility
- 6 out of 8 monks help to keep the bath house clean and maintained – 20 do not have this facility
- 26 out of 28 monks help to keep the latrine clean and maintained – 2 have shared Dzong facility
- 17 out of 28 monks help to keep the garbage disposal clean and maintained – 11 have shared Dzong facility
- 17 out of 28 monks help to keep the dustbin clean and maintained – 11 have shared Dzong facility

[Tool 1.3 - closed]

- Issues relating to <u>use</u> of water and sanitation facilities– comments
  - ⇒ The water source and latrine (used also by the public) are outside the Dzong. The doors of the Dzong are locked at night so the gelongs cannot go out
  - ⇒ The number of gelongs using the facility ranges from 100 during the summer months to 1000 for a major puja
  - ⇒ There is always a rush for the taps before morning prayers – not enough taps and not enough time
  - ⇒ The latrines are not pleasant to use
- Issues relating to <u>maintenance</u> of water and sanitation facilities – comments
  - ⇒ If training, tools and budget were available the Dratsang could maintain the facilities
  - ⇒ One gelong was trained in plumbing and has some basic tools
  - ⇒ The water tank is open at the top and they have had dead rats and live frogs inside the tank

⇒ Unclear who should maintain, the Dratsang or the Dzongkhag Administration
⇒ The water source is fenced. The monks inspect the tank regularly and clean if necessary
⇒ The Dzong sweeper empties the dustbins

- Examples of use and maintenance problems:
  ⇒ Water pipe damaged from a landslide
  ⇒ The water source is dry from November to March
  ⇒ The latrine waste freezes in winter causing a blockage in the pipe
  ⇒ Some village people dirty the water by walking and grazing animals near the source

[Tool 1 profiles/Tool 4.4 – open]

First has to come the safe water supply.
Then only the H+H messages can be practised
Comment from a health worker

Conclusions

b2: Use and maintenance of the improved water/sanitation facilities

Information was gathered on all water and sanitation facilities, whether funded by UNICEF or another source (see note below).

The general standard of cleanliness was adequate but observation suggested that the evaluator's visit may have prompted some cleaning up of the facilities. The most common response to cleaning and maintenance of facilities is that minor problems will be fixed by the monks or anims but for major problems a skilled person will be called from the Dzong. Those religious institutions that share the Dzong with the administrative offices also share the Dzong sweeper and plumber for cleaning and maintenance of facilities. Some monks and anims have been trained in basic maintenance and have been provided with tools. Several institutions have been given a fixed deposit by UNICEF. The Dratsang has deposited an equal amount and the interest on the account provides a fund for maintenance of water and sanitation facilities.

Note: At some sites there was some uncertainty in being able to identify which facilities had been provided with UNICEF funding. In several cases this was due to a change of personnel since the installation of facilities, but more generally it seemed that the funding had been channelled through the Dzongkhag Administration or Public Works Division and the source of the funding was unknown. Also it was the case at some sites that there had been several sources of funding including UNICEF, RGoB and private donations. Who actually paid for the pipe, tank or tap was unknown. What was known was whether the facility was functioning and associated problems, of which there were some problems to be heard at almost every location.

Analysis A: Positive Behavioural Changes in Religious Communities
Key question b2 = POSITIVE IMPACT
Conditional: Facilities maintained where skills, tools and funding are available.

Key Question b3. - *Behavioural changes in the religious community*

Have the religious community's attitudes towards sanitation and hygiene changed with the introduction of improved water/sanitation facilities?

View of the Religious Community

Indicators:

- All 28 gelongs interviewed said that water and sanitation facilities make them feel better
- 27 out of 28 gelongs interviewed said either that improved water and sanitation facilities have changed their attitude to H+H or that their attitude would change if improvements were made to their water and sanitation facilities

[Tool 3.5-6 – closed]

- The religious practitioners made the following comments:
  - ⇒ If there is a reliable water source then they can practice good H+H habits. This is what they would like to be able to do.
  - ⇒ The preference would be to use the latrine rather than open defecation but due to few latrines they sometimes have to use the jungle or the fields
  - ⇒ If there were improved facilities then their attitude would change. They would feel better if there was water inside the Dzong
  - ⇒ They know it is good to have good H+H habits but the facilities are not functioning well
  - ⇒ The monks are enjoying the easier access to water – they have to wash from early morning when there is a puja and they no longer have to go down to the water source
  - ⇒ With improved facilities there would be 100% change in attitude. The facilities have to come first. For example, even to make a garden we need the water first

[Tool 3 site profiles/Tool 4.5 – open]

Conclusions

b3: Changes in the religious community's attitudes towards sanitation and hygiene with the introduction of improved water/sanitation facilities

Monks are appreciative of improved facilities including the provision of safe water, latrines and water supply for body and clothes washing. Those who do not yet have improved facilities look forward to future improvements which will change their attitude to what is presently arduous (eg. collecting water), difficult (for example washing in the 15 minutes between rising and morning prayers) or unpleasant (eg. using over-used latrine facilities).

There is little reference made to the impact of improved kitchen facilities and garbage disposal. Those who have Bumthang stoves appreciate the convenience. Many institutions use a system whereby rice is cooked for all gelongs and monks have gas stoves in their rooms to prepare curry and to boil water. Institutions in which there are younger monks generally cook collectively for all the residents. At puja and Tsechu times kitchen facilities are particularly stretched. In a number of locations collective cooking is still done on traditional open fires with associated problems of soot deposit, and in several cases there is no open ceiling for the smoke to escape. The issue of garbage disposal is discussed further in c4.

Analysis A: Positive Behavioural Changes in Religious Communities
Key question b3 = POSITIVE IMPACT
Conditional: Attitudes change when facilities are improved and are functioning

Key Question b4. - *Behavioural changes in the religious community*

Do the religious community and/or community-based religious practitioners provide advice on health care when approached for religious services in the event of family illness?

View of Religious Practitioners

Indicators:

- 39 out of 40 religious practitioners provide advice to the community. The interview question does not investigate what advice is given in the event of a family illness

[Tool 3.11/7.5 - closed]

- The following comments illustrate the kinds of advice given by religious practitioners:
  - ⇒ There is a dual system of puja and medicine. Puja is the traditional system based on wisdom (sherub); medicine is the method (thub). We say to the village people the two should not be separated
  - ⇒ The lhabsang puja is conducted regularly in the hospital to clear illusions
  - ⇒ The main messages being given to the villagers are:
    - Cleanliness – if you don't stay clean this will cause problems
    - Pregnancy – if you are pregnant then you should go for a check up
    - Immunisation – children should be immunised against diseases or they will suffer
    - STD/AIDS – can be transmitted through sexual contact and blood, eg. re-used needles
  - ⇒ Previously we used to give some basic H+H information during pujas. Since RHP training we have more knowledge and can give more and better advice
  - ⇒ When we go for puja and we see uncleanness we give advice
  - ⇒ Before RHP we only gave the traditional advice
  - ⇒ Some follow the advice, others don't. Those who have listened to the advice have benefited
  - ⇒ If called for a puja for a sick person we first see if it is caused by disease. If so we advise to go to the BHU. Before we didn't give this advice. If the disease is not curable by a puja then we send the patient to the BHU

[Tool 3/Tool 7 site profiles - open]

Conclusions

b4: Advice on health care is provided by the religious community and/or community-based religious practitioners when approached for religious services in the event of family illness

The responses given by the religious practitioners indicates that the H+H messages are being communicated to the community during pujas and family illness. It is also clear that the messages are those that the RHP seeks to convey through the religious practitioners and is a change of practice for the religious practitioners as a result of RHP training.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities

Key question b4 = POSITIVE IMPACT

Conditional: The evaluation responses re-emphasise the need for training of religious practitioners in early referral and signs and symptoms of serious illnesses.

Key Question c1. - *Behavioural changes in the community*

Do community members receive health advice from the religious community and/or community-based religious practitioners when approached for religious services in the event of family illness?

View of Community People

Indicators:

- The community people described what advice they have received when there has been a sickness in the family:
  - ⇒ A relative was sick and the monks at the puja advised him to seek medical advice. It was only from the medical advice that he discovered it was typhoid.
  - ⇒ The religious practitioners tell the village people to do puja and then go to the hospital. Before when there was no easy access to medical help, when there was no BHU, they would do puja and if it didn't work the person might lose their life. It would take more than one day to reach the BHU. Now it's a 2 hour walk
  - ⇒ If the sickness is serious then we go for medical advice. If the illness is caused by the spirits then we would go to the Gomchen for a puja which will cure the person
  - ⇒ If a sickness is not curable we call the Tsip for astrology
  - ⇒ Puja is for suffering from spiritual problems. Medication does not help for spiritual problems
  - ⇒ Monks will not have the medical knowledge and cannot force people to go to the clinic
  - ⇒ Some people perform puja rather than go for medical treatment – even if the advice is to go for medical treatment some villagers will have many excuses
  - ⇒ Religious practitioners give H+H advice during annual puja, collecting alms, reading astrology, Tsechu and when people die
  - ⇒ There are some diseases where puja is better and other diseases where medication is better. Problems like diarrhoea, stomach ache and body ache the Gomchen will advise to do the puja and also go to the BHU

[Tool 6.8-9/6.11]

Conclusions

<u>c1: Health advice received by community members from the religious community and/or community-based religious practitioners when approached for religious services in the event of family illness</u>

Improved H+H habits are dependent on improved facilities. So too, for some communities and religious practitioners, the choice between medical and religious practices in times of sickness depends on access to facilities. Access to medical facilities is improving rapidly but some people are more reluctant to change their traditional ways quickly. The encouragement of the religious practitioners, in these cases especially, gives strength to the messages from the health workers.

As in any small community everyone will know of events surrounding a sickness, especially if a visit to the hospital or BHU is required. The outcome of the visit will also be known and can influence belief greatly. It would seem that the credibility of medical advice is still not as widely and happily accepted by some as the traditional advice of the religious practitioner. In this dual system it is important that the religious practitioners, with the greater and

unthreatened credibility, are knowledgeable in health and hygiene since people place so much trust in them.

Note: It was observed in the interviews that people seemed reluctant to relate personal family experiences of sickness but would more happily tell of the fortunes or misfortunes of others. Some examples are transcribed in the RHP Evaluation Analysis: Tool 6.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question c1 = POSITIVE IMPACT
Conditional: The evaluation responses re-emphasise the need for training of religious practitioners in early referral and signs and symptoms of serious illnesses.

Monks and Community members using the water facilities at Drametse

Key Question c2. - *Behavioural changes in the community*

Has the religious community and/or the community-based religious practitioners influenced the health seeking and hygiene practices of the community?

View of Community People
Indicators:

- 32 out of 40 community people said they appreciate the religious practitioners' contribution to health matters in the community. The 8 remaining responses were non-committal and were from sites where there has been minimal or no RHP training

[Tool 6.13 - closed]

- All 40 community people interviewed said that they use latrine (no open defecation), wash hands before meals and after the latrine and bath regularly. 37 out of 40 community people said that they put waste in a pit or dustbin

[Tool 6.2 - closed]

- Many comments suggested that there are a variety of influences on community H+H practices:
  - ⇒ H+H messages learned from school, from health workers, from seeing others with good H+H habits
  - ⇒ The Dzongkhag has advised to keep the surroundings clean
  - ⇒ The Government provided kidu for animal shelters
  - ⇒ H+H messages were given in the army
  - ⇒ BBS news and health announcements have explained the problems
  - ⇒ H+H messages and pictures of a model village in National Day exhibition
  - ⇒ As Tsokpa, when I go from house to house I give health messages
  - ⇒ H+H advice received from monks and religious practitioners

[Tool 6.3 – open]

View of Health Workers
Indicators:

- 20 out of 22 health workers considered that health and hygiene habits had been influenced by the health promotion activities of the monks

[Tool 5.14 - closed]

- Comments from health workers reveal some further perspective in the influence or not of the religious practitioners' health promotion role on the community people:
  - ⇒ **Sometimes people still wait too long before coming to hospital. It is not only the remote and uneducated, it happens with town and educated people too. The belief is so strong**
  - ⇒ Health personnel have been giving these messages for many years but religious practitioners have only recently been introduced to this. It is a result of everyone's contribution. If the health worker is the only person giving the health messages it will not work. If the Gomchen is trained, he is trusted by the people and the people will listen, even though the message may have been given 100 times by the health worker
  - ⇒ RHP has brought changes in personal and environmental hygiene

[Tool 5.8/Tool 5 site profiles – open]

Conclusions

<u>c2: Influence of the religious community and/or the community-based religious practitioners on the health seeking and hygiene practices of the community</u>

No one is denying that there has been an influence on the H+H habits of the community people. The message is clear, that the changes and improvements are a result of everyone's effort. Neither is anyone denying that the role of the religious practitioners is one that has a

particular influence on communities because of the trust and respect accorded to religious practitioners in Bhutan.

Though the community response to questions on their H+H practice indicated that good practice is the norm this is the most likely response since it would be difficult for anyone to admit to bad habits. It is fairly certain that awareness has been raised, if habits not completely changed. If this is the case then reminders and reinforcement of the main messages will eventually turn awareness into practice and habit.

Note: Qu 6.3 was re-worded – If you do practise good H+H habits were did you learn these habits?

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question c2 = POSITIVE IMPACT
Conditional: Changes have to become habit, eg. waste pit use, then the influence is complete.

Sunday, a day for washing and bathing for monks at the Dechenphodrang Monastic School

Key Question c3. - *Behavioural changes in the community*

Are there any added advantages of the religious community and/or community-based religious practitioners promoting health?

View of Community People
Indicators:

- The community people made the following comments:
  - ⇒ Some can accept and understand advice from monks while others will accept from the health workers. Some will only have contact with one or the other – so this way all get the health messages
  - ⇒ Much improved health in the village after RHP.
    - 5-6 children used to die each year from diarrhoea, now there are none
    - Vasectomy and family planning advice was done
    - STD/AIDS messages given
- Suggestions which give even more added advantage:
  - ⇒ Those religious practitioners who have not been trained may continue to conduct the puja and delay the medical treatment. It would help if those people were trained
  - ⇒ If the health worker could visit the more remote places where the religious practitioners still find it difficult this would be of more benefit
  - ⇒ The powa cannot really communicate. An able communicator is the one who should be trained
- Problems embedded in tradition yet to be overcome:
  - ⇒ Village people see sometimes that even with an injection or operation you do not get better – you may die - and they are scared
  - ⇒ The powa misleads and the people have to do as they are told. Some people have died because they haven't gone for medical treatment

[Tool 6.10 – open]

Conclusions

c3: Added advantages of the religious community and/or community-based religious practitioners promoting health

The main advantage is the channel for communication that the religious practitioners have with the local community as an alternative and direct means of promoting health messages. Most people interviewed could identify no problems in the role of religious practitioners as health promoters. To the community people the benefits can already be seen in better living conditions and less sickness.

The issue was raised of targeting of those who can bring more benefit the local communities. This includes those religious practitioners in more remote locations where change is more gradual or perhaps more resisted, or where access to health services is more difficult; and to identify participants for training who are most able as communicators. It has also been suggested elsewhere that those who are interested and influential should be selected for training. This will be raised again in the Future Strategies.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question c3 = POSITIVE IMPACT
Conditional: Greatest advantage if training is targeted to give the greatest impact.

Key Question c4. - *Behavioural changes in the community*

Are there changes in the health seeking and hygiene practices of the religious community and/or community-based religious practitioners after RHP training workshops?

View of Community People

Indicators:

- 38 out of 40 community people feel that religious practitioners have good H+H habits; 3 people couldn't comment on the H+H practice of religious practitioners
- 37 out of 40 feel that those good habits include use of latrine (no open defecation), hand washing before meals and after latrine, cleaner personal appearance and waste put in pits and bins; 3 people couldn't comment on the H+H practice of religious practitioners

[Tool 6.5-6 - closed]

- The community people made the following comments:
  - ⇒ The health workers taught the religious practitioners which has led to improvements in H+H habits
  - ⇒ The Gomchens know from reading the books (FFL and HOH) and from the RHP training. Then others can see from the example of those who are trained

[Tool 6.7 – open]

View of Health Workers

Indicators:

- All 25 health workers have fairly regular contact with religious practitioners
- All 25 health workers have noticed changes in the H+H practices of the religious practitioners

[Tool 5.1-2/5.5 - closed]

- All 25 health workers have noticed improvements in religious practitioners' use of latrine (no open defecation), hand washing before meals and after latrine, and cleaner kitchens.
- 23 out of 25 health workers have noticed improvements in religious practitioners' putting waste in pits or bins. 2 health workers have noticed no improvement in religious practitioners' putting waste in pits or bins
- 9 health workers feel there is an improvement in vaccination of monks. 16 health workers considered this not to be relevant either because they are vaccinated when they are small, before becoming monks or because the religious institution takes older, adult monks [See note below]
- 24 out of 25 health workers have noticed an increase in the number of religious practitioners seeking medical advice from health workers
- 22 out of 24 health workers feel that there is improved knowledge of STD/AIDS by religious practitioners. 2 health workers feel there is no improvement in the knowledge of STD/AIDS by religious practitioners and one health worker couldn't say yes or no. [See separate section Key Issue - STD/AIDS]

[Tool 5.4/5.6 – closed]

- The health workers made the following comments:
  - ⇒ After RHP anims came to the BHU for treatment and they brush their teeth. The anims and the Lama give the advice to seek medical treatment when called for puja
  - ⇒ RHP will improve the sanitation and personal hygiene of the monks and they are the main contact with the community who will listen to them. It is equally benefiting the community
  - ⇒ RHP water taps and latrines have brought improvements
  - ⇒ RHP has introduced new knowledge and practice in use and construction of latrines, knowledge of STD/AIDS and early referral to hospital

⇒ Those Jakri who have been trained give better H+H messages
⇒ Great change in seeking treatment in times of emergency even with the sick in the Dratsang. They used to do puja and bring gelongs late for medical advice

[Tool 5.7 – open]

Conclusions

c4: Changes in the health seeking and hygiene practices of the religious community and/or community-based religious practitioners after RHP training workshops

Community people see changes in the H+H practices of religious practitioners as coming from other sources apart from RHP including advice from Je Khenpo and Dasho Dzongdas, from sector meetings in the Dzongkhag, from the health workers, from the Lam and the Rimpoche, and from the Buddhist teachings of the virtues of happiness [Tool 6.7].

Health workers see improvements in: hand washing (now routine), waste disposal (before they used to throw down the slope), health (scabies used to be a problem – now it is completely cut down), personal hygiene (they maintain the bedding), vaccinations (now almost all are covered). The health workers also mentioned that routine visits or ORC are now provided to religious institutions. The problem of providing health advice to those in meditation seems to have been solved by training gelongs as VHW in some institutions.

Of all the H+H habits listed, waste disposal is the only one in which several health workers feel there has been no improvement and, as was noted in Key Question b3, is one habit to which religious practitioners make no reference in their wide ranging comments. This may be because there is still a lack of awareness of this as a serious H+H problem. However evidence in the environment throughout Bhutan suggests that this has yet to become a habit generally. Comments on use of waste pits: "We have been encouraging this but still they are not doing this. Some use it, most still don't - 40% use the waste pit".

Note: All the community based religious practitioners indicated that vaccinations are given. 2 religious institutions with younger anims and monks indicated that vaccinations are given. If this is considered a critical issue it is suggested that a more focussed survey be undertaken. One problem with the findings in this evaluation are that the persons questioned may not have been the person who would know this information.

Analysis A: Positive Behavioural Changes in Religious Communities
Key question c4 = POSITIVE IMPACT
Conditional: Changes becoming habit.

Key Question d1. - *Health workers' views*

Rate the effectiveness of the religious community and community-based religious practitioners as promoters of health messages.

View of Health Workers

Indicators:

- The results of the Health Knowledge Test indicate a good level of health knowledge for both RHP trained and untrained religious practitioners

[Tool 2 – test]

- 11 out of 23 health workers rated religious practitioners' health knowledge as FAIR
- 12 out of 23 health workers rated religious practitioners' health knowledge as GOOD
- 8 out of 23 health workers rated religious practitioners' as FAIR communicators
- 14 out of 23 health workers rated religious practitioners' as GOOD communicators
- 1 out of 23 health workers rated religious practitioners' as VERY GOOD communicators

[5.11-12 - closed]

- The health workers made the following comments:
  - ⇒ People have special trust in the monks; with HA they will make excuses that they are too busy
  - ⇒ Villagers believe what the monks say
  - ⇒ Some Gomchens are very good at giving health messages
  - ⇒ It achieves the goal of health services by reaching the community directly – the messages must be simple
  - ⇒ There is a big role the religious practitioners can play if they have the knowledge and use it in the right way
  - ⇒ We can reach the maximum population with help from the religious community – indirectly or directly they and the community will benefit
  - ⇒ The religious practitioners make the health workers job easier
  - ⇒ For the person giving the messages they have to give the correct messages not the wrong messages

[Tool 5.9 - open]

Conclusions

<u>d1: Effectiveness of the religious community and community-based religious practitioners as promoters of health messages</u>

The health workers consider religious practitioners to be effective promoters of health messages. Of those religious practitioners who are actively promoting health and have been trained the health workers considered their health knowledge and communication skills to be fair or good.

The reasons given for the effectiveness of the religious practitioners as health promoters are:

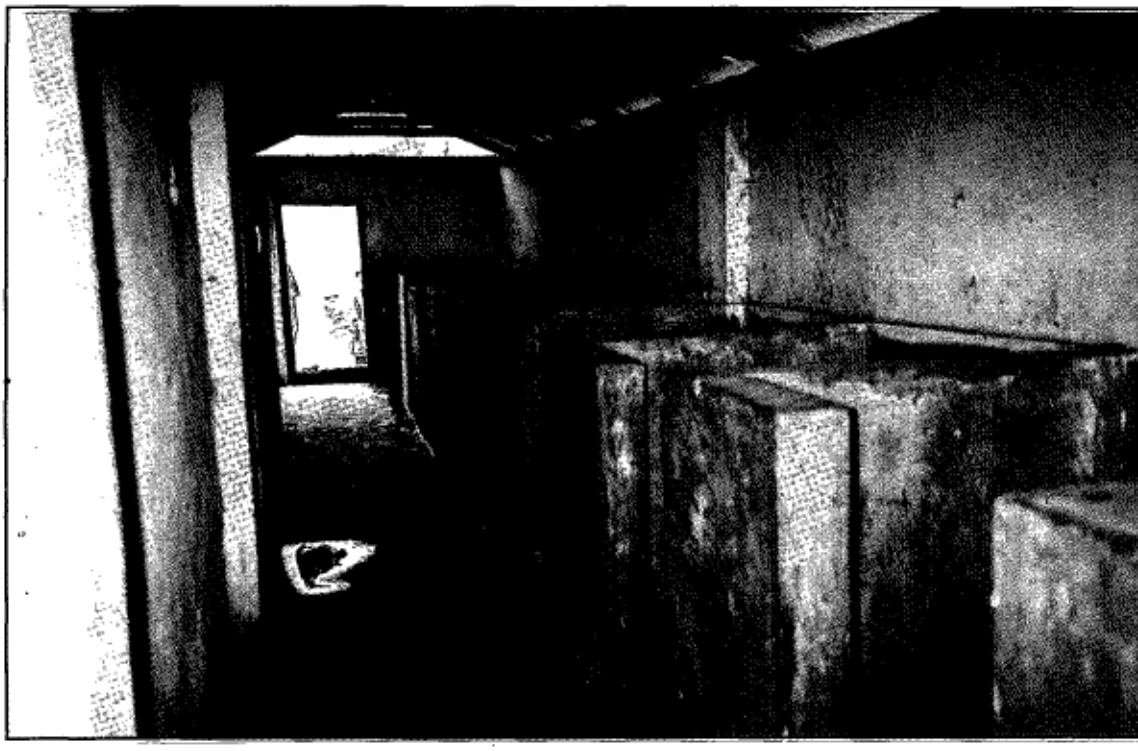
Trust from the community
Communication skills
Simple messages
Health knowledge
Direct contact with the community

Some health workers expressed a concern that the role might be taken too far by some religious practitioners and wrong messages given. The health workers suggested that the safeguards against this happening are

a) to give regular refresher courses since the religious practitioners might forget the messages
b) use some selection criteria for participation in workshops for example the trust from the community and the interest of the religious practitioner in the training, and
c) clarify the extent of the role with the religious practitioners.

These points will be raised again in Future Strategies.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question d1 = POSITIVE IMPACT
Conditional: Effectiveness is dependant on religious practitioners' knowledge and communication skills, interest and enthusiasm.



Toilet for monks at Tsirang Rabdey

Key Question d2. - *Health workers' views*

Do health workers view the religious community and community-based religious practitioners as competitors or complementary?

View of Health Workers

Indicators:

- 23 out of 23 health workers appreciate the contribution of religious practitioners to health matters in their community

[Tool 5.18 – closed]

- The health workers made the following comments:
  - ⇒ There used to be a barrier between the religious community and the health workers. Now the religious people are advising people to come to the BHU. The RHP workshop has changed the attitude. We cannot say don't do puja
  - ⇒ It is a result of the involvement of the two sectors – religion and health. The community always goes to the religious practitioner first. We see big improvements now they are communicating H+H messages
  - ⇒ When the BHU was newly established some villagers were not happy, especially with vasectomy. Lam and the Gup attended a community meeting to discuss the problems
  - ⇒ The VHW, the Gup and the Gomchen have taught the villagers to improve H+H in the community

[Tool 5.7 – open]

Conclusions

<u>d2: Health workers view the religious community and community-based religious practitioners as complementary</u>

Health workers are working in partnership with the religious practitioners to convey health messages to the community people. VHWs and staff at BHU's who are working in the community are generally working very directly with the religious practitioners, especially in cases where the health workers have also participated in or facilitated RHP workshops. Both health workers and religious practitioners are key people within their community. In some cases a Gomchen, monk, Tsip, Jakri, Gup or Tsokpa was also RHP trained, VHW trained or both and in several cases the VHW was also RHP trained.

The majority of the Health Assistants interviewed showed a high level of commitment to RHP linked to their level of involvement in the project, which was commendable. The evaluator observed that religious practitioners (including monks, anims, Jakri, Gomchen, Powa, Pandit and Tsip) and health workers (including VHWs, BHWs, ANMs, HAs and DHSO) in some districts were particularly active and a strong relationship had been established between the religious community and the health staff

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question d2 = POSITIVE IMPACT
Conditional: none

Key Question d3. - *Health workers' views*

Has there been an increased number of patients from the community referred by the religious community and/or community-based religious practitioners following RHP workshops?

View of Health Workers

Indicators:

- 19 out of 23 health workers indicated that there has been an increase in the number of patients, of whom 18 considered this to be in part a result of the religious practitioners' role as health promoters. The four health workers who have seen a decrease in the number of patients explained that this is due to easier access to another facility eg. a new BHU construction.

[Tool 5.15-16 - closed]

Conclusions

d3: An increased number of patients from the community are referred by the religious community and/or community-based religious practitioners following RHP workshops

As has been seen in earlier comments there is an increase in the number of community people seeking health advice and this could in part be attributed to the impact of the RHP training. It could also be attributed to the other factors that have persuaded people to seek medical advice:

Accessibility to BHU or hospital
Impact of education and development generally
Community awareness of importance of H+H
H+H messages communicated from various sources including health workers and religious practitioners

Key Question a1 considered the issue of early referral, which could be further investigated.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question d3 = POSITIVE IMPACT
Conditional: Early referral is the key factor

Key Question e1 / e2. - *Effectiveness of training workshops*

What knowledge has been retained by religious persons who attended RHP training workshops?

What is the knowledge of religious persons who have not been trained?

Indicators:

- The most popular and least popular topics in the health knowledge test

	Trained religious practitioners	Untrained religious practitioners
Most popular topic	Prevention of Diarrhoeal Diseases	Personal Hygiene and Sanitation
Least popular topic	Immunisation	Immunisation

- Personal Hygiene and Sanitation **topic** produced the **highest scores** for both trained and untrained religious practitioners
- Immunisation **topic** produced the **lowest scores** for both trained and untrained religious practitioners
- The **questions** which produced the **best scores** are:
  2.16 What is the best source of food and drink for a baby in its first few months of life?
  2.21 What does immunisation do for children? *Re-worded question led to answer*
  2.1 What is diarrhoea? *Re-worded question led to answer*
  2.8 What are the main food preparation practices that prevent illnesses? *General – many answers*
- The **questions** which produced the **worst scores** are:
  2.25 Pregnant women should go to the hospital or BHU for immunisation against one disease especially. Which disease? *Only one correct answer possible*
  2.17 What are the advantages of breastmilk over formula or cow's milk? *One reason give – two required*
  2.2 Why is diarrhoea of such concern? *Specific reason not given*
- **Don't know responses**:
  Trained religious practitioners did not know the answer to 4% of the questions asked
  Untrained religious practitioners did not know the answer to 8% of the questions asked
- **Wrong answers**:
  Trained religious practitioners gave the wrong answer to 3% of the questions asked
  Untrained religious practitioners gave the wrong answer to 4% of the questions asked
- **Partly correct answers**:
  Trained religious practitioners gave partly correct answers to 22% of the questions asked
  Untrained religious practitioners gave partly correct answers to 27% of the questions asked
- **Correct answers**:
  Trained religious practitioners gave the correct answer to 71% of the questions asked
  Untrained religious practitioners gave the correct answer to 61% of the questions asked
- **Untrained scores** ranged between **62% to 100%** with an **overall average score of 84%**
  Trained scores ranged between **75% to 98%** with an **overall average score of 89%**

[Tool 2 – test]

The **alternative responses** given to questions in the Health Knowledge Test are analysed in the RHP Evaluation Analysis [Tool 2 Alternative Responses]. For example, responses given for causes of diarrhoea included:

- playing in cold water
- sitting on wet ground
- keeping the children cold

The tally for each answer is also given, showing the most frequent and least frequent responses for each answer. For example, again in response to the question on the causes of diarrhoea only one person mentioned infection as a cause of diarrhoea, whereas 22 people responded that dirty food is the cause of diarrhoea and 14 people responded that the reason is dirty hands or dirty water.

[Tool 2 alternative responses]

Conclusions

c1: Knowledge retained by religious persons who attended RHP training workshops
c2: Knowledge of religious persons who have not been trained

The test results between trained and untrained religious practitioners are quite closely matched. More untrained religious practitioners said they did not know the answer and more trained religious practitioners gave the correct answer. The range of scores is wider for untrained than for trained religious practitioners.

Since there is no measure of the level of knowledge the religious practitioners had before training we might assume that the untrained religious practitioners give some indication of the pre-RHP training levels of knowledge among religious practitioners. We can only then conclude that either

a) a lot of knowledge was acquired in the RHP training and some is now lost (*therefore there is a need for refresher courses*) - but still the trained religious practitioners have more knowledge than those who are untrained, or
b) little new knowledge was gained in the RHP training

The general consensus is likely to be in favour of (a), which therefore supports the case for refresher training, if this hypothesis is accepted.

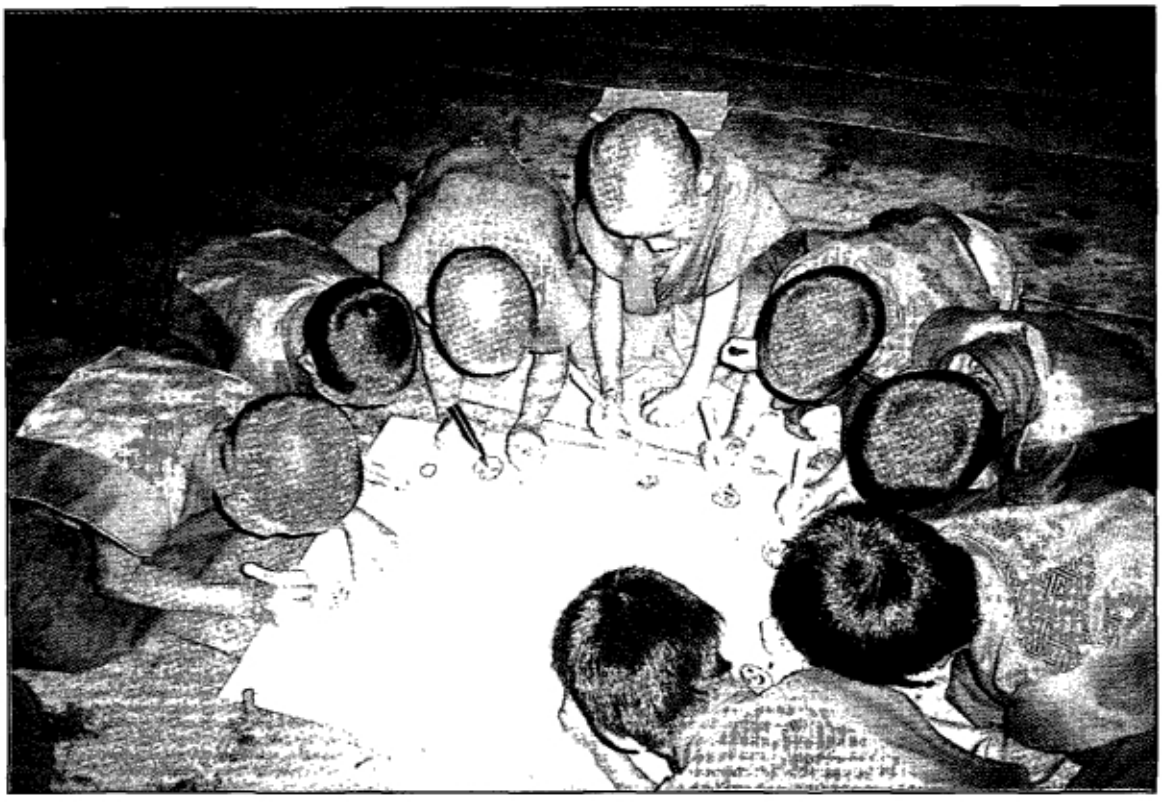
The untrained religious practitioners showed a reasonable level of health knowledge. Some of the health knowledge questions related to general H+H practice, such as qu.2.7 *When is it most important to wash the hands?*. Other questions required actual health knowledge, such as qu.2.10 *What is a water-borne disease that could be prevented with better hygiene/clean water?*. Some religious practitioners who have not received RHP training have either been trained as VHW or have been informed of some of the health messages through others in their community who have been RHP trained. It is pleasing to note that the general level of health knowledge is quite reasonable but training would improve this still further and, perhaps more importantly, would give the religious practitioners more confidence in their level of health knowledge

The analysis of the Health Knowledge Test responses and the Health Knowledge Test itself may be useful for monitoring and evaluation in the future. It should be noted that some questions needed to be re-worded for clearer understanding. This will be raised again in Future Strategies.

Note: questions had different weighting according to whether there was one and only one correct answer or whether there were several possible answers; whether one answer gave a correct score or whether at least two answers had to be given; and whether the questions were general knowledge or technical health knowledge. This would account for some variation in scores between questions but was not taken into account in the design of the scoring system.

Analysis A: Positive Behavioural Changes in Religious Communities
Key question e1/ e2 = POSITIVE IMPACT
Conditional: Provision of training courses, reference books and refresher training

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question e1 / e2 = POSITIVE IMPACT
Conditional: Selection of participants for training who are interested to participate and have contact with the community people.



Little Monks at a Participatory Rapid Appraisal (PRA) session at Dechenphodrang Monastic School

Key Question e3. - *Effectiveness of training workshops*

What additional areas of health would the religious community and/or community-based religious practitioners like to learn about in the training workshop to enhance their role as health promoters?

View of Religious Practitioners
Indicators:

- The religious practitioners made the following comments:
  - ⇒ Training in giving the same 9 medicines given by the VHW
  - ⇒ No new topics – what has been received is good
  - ⇒ First Aid teaching would be helpful
  - ⇒ Refresher of what was taught last year and has been forgotten
  - ⇒ How is malaria and typhoid caused and how should we treat diarrhoea?

[Tool 4.12/8.11 - open]

> **Helping to find a way around the astrology chart when something conflicts with going for medical advice. For example, if the person is not to go East and the BHU is East. Finding a way around this is important.**
>
> **Comment from a Gomchen**

View of Health Workers
Indicators:

- **Topics** which the health workers feel are **understood by the religious practitioners and the community people**:
  - ♦ Personal health education
  - ♦ Family planning – 100 % take up in some areas
- **Topics** which the health workers feel are **not understood by the religious practitioners and community people** and which should be included in RHP workshops:

> Tragically a 2 year old child died the night we arrived at one location. The sickness was pneumonia but the parents didn't know the fatal symptoms of ARI. The child had been sick for nine days before being brought to the BHU. The Health Assistant worked through the night for 12 hours to try to save the child but could do nothing in the end.
>
> ***Early referral would have saved the child's life.***

  - ♦ Diagnosis of signs and symptoms of illnesses for timely referral eg. ARI
  - ♦ Family planning
  - ♦ Personal hygiene
  - ♦ Environmental sanitation and safe water
  - ♦ Basic medicines
  - ♦ Complications of Diarrhoea
  - ♦ Training for mothers
  - ♦ Nutrition
  - ♦ First Aid
- The health workers made the following additional comments:

⇒ Early referral:– still some people delay when there is no-one to advise or because of their belief
⇒ There is still a problem of single mothers who are too shy to come for anti natal check up. The village leaders are following up
⇒ The religious practitioners still need health and personal hygiene education
⇒ Teach the simplest things
  - Keeping the surroundings clean
  - Make a paved path
  - Latrine construction
  - Personal hygiene

[Tool 5.7 – open]

Conclusions

e3: Additional areas of health the religious community and/or community-based religious practitioners would like to learn about in the training workshop to enhance their role as health promoters

The religious practitioners are satisfied with the RHP training topics covered previously and the consensus view is to leave the choice of topics to the professionals, the health workers, for future training programmes. Some suggestions have been proposed by the health workers as given above. This is further considered in Future Strategies.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question e3 = POSITIVE IMPACT
Conditional: Review training needs for each training depending on participant and community H+H needs, based on advice from health workers.

> Several religious practitioners simply said "Let the health workers identify what is needed, whatever they think is most necessary".

Key Question e4. - *Effectiveness of training workshops*
How can training workshops be further improved?

View of Religious Practitioners
Indicators:

- The religious practitioners made the following comments:
  - ⇒ Monks as workshop facilitators
  - ⇒ Train influential and educated religious practitioners who can run a workshop in their village
  - ⇒ By seeing we learn 70% so the messages will be learned quickly with videos and photos. Some people don't understand the lecture method

[Tool 4.13/Tool 8/12 – open]

View of Health Workers
Indicators:

- The health workers made the following comments:
  - ⇒ Religious practitioners need more follow up and guidance
  - ⇒ Train people in their own community
  - ⇒ Some people forget - some are not trained - some have retired. A regular programme of workshops is needed
  - ⇒ Workshops once a year with religious practitioners as facilitators
  - ⇒ Some villages are less clean. Call those people specifically
  - ⇒ If workshops are given for two villages with people attending from some households this would be helpful
  - ⇒ Video is easier for people to understand than lecture – everyone will come!

One Jakri commented: Train some younger people. I have been trained twice and I am 74 years old.

[Tool 5 Site Profiles - open]

Conclusions

e4: How training workshops can be further improved

A number of suggestions have been put forward by religious practitioners and health workers which support many of the findings in the earlier analysis. Consideration needs to be given to participants, content, location, facilitators, methodology, logistics including planning, monitoring and follow up. Needs analysis may be useful to clarify which improvements should be made.

The consensus definitely supports the continuation of the RHP training programme but there is scope for review.

Analysis B: Effective Performance of Religious Communities as Health Promoters in their Communities
Key question e4 = POSITIVE IMPACT
Conditional: Review the RHP training programme model

People are interested because there is good food and you can gain more knowledge
Comment from a gelong

Key Issue - *Effectiveness of Project Management*

How can RHP project management be further improved?

View of the Religious Practitioners

Indicators:

- The following suggestions were put forward by the religious practitioners:
  - ⇒ Annual gathering of Dungchens and focal points to discuss and share ideas otherwise the objectives will be abandoned
  - ⇒ Focal points could assist with the workshops in other Dzongkhags. This would give encouragement and they would prepare carefully. There would be opportunity for greater sharing of ideas
  - ⇒ Translation of Guidelines into Dzongkha would be useful
  - ⇒ Better planning eg. coordination of dates for workshops and advanced information for budgeting and accounts
  - ⇒ More monks should have the opportunity to attend workshops in the future
  - ⇒ More funding for more workshops
  - ⇒ Workshops should be held in locations which are easy to access for the participants
  - ⇒ Dratsang Lhentsog should call a meeting of all the religious practitioners and people from the shedras who have influence. Then they could discuss ideas for the future of RHP

[Tool 4.14 – open]

View of the DHSO's

Indicators:

- The following suggestions were put forward by the DHSO's:
  - ⇒ At Dzongkhag level there should be a focal person. Train some monks with close monitoring from Thimphu and they can take responsibility to conduct workshops on a regular basis
  - ⇒ Training of tsips needs to be intensified. Better to go into the field for training, for example covering two blocks. If we go to the religious practitioners we do not miss them. Here (in the Dzongkhag HQ) only a few will come.
  - ⇒ Coordination should have been decentralised otherwise there are problems of executing the workshops on time, waiting for the approval for everyone to be ready.
  - ⇒ Decentralise and hand over to trained trainers with support from Dratsang Lhentsog + books and videos
  - ⇒ Monitoring can be done at village level if you sit with the community and hear their problems
  - ⇒ Proper guidelines need to be developed
  - ⇒ If the funding is given we can mobilise down to the village level
  - ⇒ There should be timely and regular follow up from the centre.

[Tool 9 – open]

Conclusions

<u>How RHP project management can be further improved</u>

The main criticisms of management of the RHP programme are those of which the project management is well aware: *No monitoring and evaluation*
No refresher courses
Not decentralised

The religious practitioners and DHSO, while taking the opportunity to provide constructive critical comment on the RHP project also acknowledge the achievements. One DHSO states that RHP is not going as well as it should and refers to the above points of criticism. However this is not negative since it is not suggesting that RHP is moving in the wrong direction or achieving nothing. Rather the comments from all the respondents refer to the need to continue the project, that more can be achieved, and that in the light of experience it is perhaps time to review and improve some aspects of the project.

It is the task of the project management to now review the situation and address these particular weaknesses. The ideas that have arisen from the evaluation are drawn together in Future Strategies and Guidelines for Future Activities which the project management should seek to action.

Management Analysis
Key Issue = POSITIVE IMPACT
Conditional: Review the management of the RHP project:- re-define roles and responsibilities of all stakeholders to village level

> **RHP is achieving the purpose of educating the religious practitioners and sensitising them. Unsure whether the message is getting to the villagers**
>
> **Comments from a DHSO**

Key Issue – *STD/AIDS*

Issues relating to STD/AIDS knowledge among religious practitioners

The evaluator singled out STD/AIDS as, of all the H+H topics, it emerged as being the most sensitive for the religious community to discuss. The Health Division advises not to single out this topic. However the sensitivity of the subject with institution-based religious practitioners and the support given by Je Khenpo to this issue suggests that it should be acknowledged as part of the evaluation process.

The question (3.8.4, 7.2.4 and 5.6.3 to religious practitioners and health workers) was re-worded from the original "What do you do to stay healthy – STD/AIDS prevention" which drew the response that this is not an issue for celibate religious practitioners. The re-worded question "What knowledge of STD/AIDS do you have?" drew more useful responses as given below.

View of Religious Practitioners

Indicators:

- The religious practitioners were asked whether they had knowledge of STD/AIDS:

Knowledge of STD/AIDS	RHP trained	Untrained	Total
Yes	16 (42%)	13 (34%)	29 (76%)
No	4 (11%)	5 (13%)	9 (24%)
2 – commented not applicable to religious practitioners			

[Tool 3.8.4/Tool 7.2.4 – closed]

- Further comments:
  - It is a family problem. Monks won't get it
  - Many of the monks are so small it is not relevant to them
  - Since monks don't marry they don't have to take action
  - HIV can be transmitted from shaving heads
  - Have heard of AIDS and know there is no treatment for AIDS but that you have to use condoms
  - I know the problems of STD/AIDS and say to people "A person might look clean but you can't tell if they have STD/AIDS. You shouldn't make easy relationships" Some people don't want to know
  - Not an approved topic for the anims

[Tool 3 Site Profiles – open]

View of Health Workers

Indicators:

- 22 out of 24 health workers feel that there is improved knowledge of STD/AIDS by religious practitioners. 2 health workers feel there is no improvement in the knowledge of STD/AIDS by religious practitioners and one health worker couldn't say yes or no.

[Tool 5.6 – closed]

- Further comments:
  - You shouldn't feel shy about discussing the topic. People should know about it and know the dangers

- After the promotion of STD/AIDS issues even the monks know this now if they have attended training workshops
- Messages have been communicated through BBS. The monks are not supposed to listen to the radio
- The monks have a little knowledge and they are asking about prevention
- STD/AIDS was not included in the RHP training but the Gomchens need to be educated on this topic

[Tool 5 – open]

Conclusions

Issues relating to STD/AIDS knowledge among religious practitioners

There is little difference in knowledge of STD/AIDS between the RHP trained and the untrained religious practitioners which suggests that this message is being communicated through other channels, but one quarter of those interviewed had no knowledge of STD/AIDS according to their response.

Is this a topic which needs to be approached in a different way for the religious practitioners, particularly for the anims?
Should representatives from the religious community and Health Division review the issue?

STD/AIDS
Key Issue = POSITIVE IMPACT
Conditional: The sensitivity of the subject needs to be considered in future training programmes and further consideration given to overcoming the taboo.

Main Conclusions

> **Health workers had always seen the problem from their perspective.**
> **A new scenario is there even in the far flung places.**
> **Also the practice in the religious community has improved.**
> **Comments from a DHSO**

To summarise, the **main conclusions** from the Religion and Health Project Evaluation are:

Behavioural Changes in Health and Hygiene Practise (religious community and wider community):

1. Religious practitioners have improved their health and hygiene practices.

2. Religious practitioners have been effective in communicating basic health and hygiene messages to the community people.

3. Community people have improved their health and hygiene practices.

Religious Practitioners as Health Promoters:

4. Religious practitioners and community people practice both medicine and puja at times of sickness in the family. The common practice varies according to the sickness:

   - Serious illnesses are referred to the BHU or hospital immediately
   - For less serious illnesses a puja is conducted and then the person is taken for medical advice if there is no improvement.
   - Spiritual problems are treated by puja.
   - Some religious beliefs still present an obstacle between puja and medical treatment. For example, the direction a person should take.

   It is not possible to establish from the evaluation what would constitute a serious illness. The evaluation was not designed to find out any more detail about what would constitute a serious illness, a less serious illness or a spiritual problem but this topic could be further explored.

5. Religious practitioners and health workers believe there is more that can be done in mobilising the religious practitioners as promoters of good health and hygiene habits in the community.

   - More training and mobilisation of religious practitioners.
   - More responsibilities for those who are willing, eg. the VHW role.
   - More of the same messages already being given.

Provision and Maintenance of Water and Sanitation Facilities:

6. RHP improved water and sanitation facilities contribute to improved health and hygiene practices for religious practitioners and community people.

   - H+H awareness and training without improved facilities is frustrating.

- The standard of facilities at religious institutions is generally less than satisfactory. Either there have been few improvements or those improvements that have been made are not functioning as they should.
- The ratio of population to facilities is not adequate.
- The rush to use the limited facilities at certain times of the day eg. before morning prayers, is not practical given the limited facilities. It is often the younger monks who are unable to access the facilities and who may consequently receive punishment.

7. Water and sanitation facilities are properly maintained in most sites visited, where this is within the means of the religious practitioners or Dzongkhag maintenance people.

- Some religious practitioners are trained in maintenance and they have some basic tools. Some religious institutions have a deposit fund, the interest from which is used to pay for on-going maintenance costs.
- At some sites the facility is not functioning and the religious practitioners do not know what action to take.
- The latrine and water supply facilities give the most maintenance problems.

8. Water and sanitation facilities are kept clean in most sites visited:

- The younger monks tend to be the worst offenders with latrine facilities, which suggests additional input targeted at the younger age group would be beneficial, eg. children's books. Punishment is not necessarily helpful but is sometimes used.

9. The H+H habit least well practised by the religious community and community people, is waste disposal. There has been an improvement in construction of waste pits but these are not always used.

Effectiveness of RHP Training:

10. RHP training workshops and the associated books Facts for Life and Health in our Hands have been very effective in raising the awareness and level of knowledge of religious practitioners to key H+H messages:

- The training programme should continue.
  - There are many religious practitioners who have not yet been trained.
  - Those who have been trained require refresher courses.
- Future training programmes must include a component on maintenance of water and sanitation facilities
- Future training programmes should target key people as participants. For example:
  - those from the most needy communities
  - those who are interested and enthusiastic
  - those who are influential within the community
  - those who are least educated.
- Other training strategies could be considered, for example:
  - greater decentralisation
  - use more religious practitioners as facilitators
  - include community people as participants as well as religious practitioners
  - training of trainers.
- Guidelines should be produced for workshop facilitators.
- The health publications should be distributed in Nepali in some districts.

Monitoring and Evaluation:

11. Monitoring and evaluation of RHP has been seriously neglected to date.

- M&E has been included in RHP documentation since the Concept Paper in 1990
- Reports on workshops are submitted to RHP. How are these used?
- M&E can be undertaken at central, district and village level
- A M&E strategy and plan of action needs to be developed and implemented

STD/Aids as an issue for the Religion and Health Project:

12. There is some knowledge of STD/AIDS within the religious community but for many it remains a sensitive subject or is considered not to be relevant to religious practitioners.

- STD/Aids is likely to be a less sensitive issue for community based religious practitioners.
- STD/Aids should not be singled out as separate issue, but ways to include the topic in H+H training for religious practitioners needs to be reviewed.

Effectiveness of Project Management:

13. Project management is satisfactory but there are some aspects of management that could be reviewed:

- Decentralisation of roles and responsibilities of all stakeholders to village level.
  - management at district level
  - monitoring at village level and
  - regular follow up from the centre
- Monitoring and evaluation needs to be reviewed and followed up

14. The partnership between Dratsang Lhentsog and Health Services, with funding assistance from UNICEF, is working well in conveying health and hygiene messages for the benefit and well being of the citizens of Bhutan.

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The Religion and Health Project has contributed to improvements in health and hygiene practices throughout communities in Bhutan. By communicating health and hygiene messages to community people when the religious practitioners visit people in their homes, they have influenced the health and hygiene habits of community people in Bhutan. There are still some health and hygiene messages that are not understood by the religious practitioners or community people and which need to continue to be stressed. There are still some religious institutions and village communities where more can be done to provide access to safe water and improved sanitation facilities.

Other agents of health promotion have also contributed to the overall achievements and it is not possible to state exactly which achievements are directly attributable to RHP or to any other agent of change in the health sector. More important than trying to make such distinctions, is to acknowledge that different agents have different points of access and different comparative advantages.
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

Comparative Advantage of Religious Practitioners as Health Promoters:

- The religious practitioners have a unique means by which to access people in all corners of the country.
- The religious practitioners are trusted and highly respected by community people.
- The religious practitioners are usually the first people to be called to a house when there is a family sickness.
- The Religion and Health training programme has increased the knowledge and awareness of religious practitioners to some key aspects of health and hygiene practice.

Recommendations

Arising from the main conclusions is the following list of recommendations:

Recommendation 1: Religious practitioners are the key to grass roots health and hygiene promotion and they should be encouraged to continue this role.

Recommendation 2: Not enough is known about what has been done and what is still needed through the Religion and Health Project.

- Data should be collated to show who has received software and hardware inputs and the present condition of hardware inputs.
- Needs Analysis should then identify which locations have not received software or hardware inputs, to identify priority areas

Recommendation 3: All hardware inputs should be accompanied by software inputs. The software inputs should include training in hardware maintenance.

Recommendation 4: The Religion and Health Project is only one of a number of inputs, which has brought about improvements in H+H practice. The hardware and software inputs from all agents needs to be monitored and coordinated, for more effective coverage and communication of health and hygiene messages.

Recommendation 5: A review of the Religion and Health Project Monitoring and Evaluation strategies should be undertaken, and a Monitoring and Evaluation plan of action should be shared with all stakeholders.

Recommendation 6: There is still a need to convey the importance of early referral, especially with cases such as ARI. Religious practitioners and community people need to be taught the basic signs and symptoms and to refer early rather than delay, if in any doubt. Where the sickness is more serious the religious practitioners and the community people must know that medicine has to come first, before puja.

Recommendation 7: Further information should be sought on reasons for late referral including obstacles for the religious practitioner and ways around these obstacles; and community people's perceptions of serious and less serious sickness and spiritual problems.

Future Strategies and Activities: Suggestions for Project Improvement

RHP Evaluation Objective 2: Develop **future strategies** by identifying areas of the project which could be improved, particularly in the areas of project management, monitoring and training.

RHP Evaluation Objective 3. Develop **a guideline for future activities** in the areas of project management and partner coordination, monitoring and evaluation, and training.

Strategy 1: Project Management and Partnership
Post-Evaluation Review of the RHP Project by Stakeholders

a) **Project Objectives** - The RHP Project management team, in the light of the evaluation, should review the Project Objectives. The same or revised Project Objectives can then be used as a reference point for all subsequent strategic considerations by the management team.

b) **Roles and Responsibilities** - The roles and responsibilities of the various stakeholders from central level, district level and village level should be reviewed:

- to ensure effective participation and decision making
- to enable further decentralisation and delegation of responsibility if appropriate, and
- to build and utilise capacities at the local level.

c) **Decentralisation** – RHP evaluation responses indicated a demand for greater decentralisation of the coordination and management of the Religion and Health Project. Relating to roles and responsibilities (1b. above), a strategy for decentralisation of some aspects of the project needs to be considered.

d) **Priority Target Groups** – The future software and hardware inputs need to target priority groups. Criterion for identification of target groups needs to be clarified.

e) **Plan of Action** – The RHP management team need to decide who is to take action and when the activities are to be implemented or actioned.

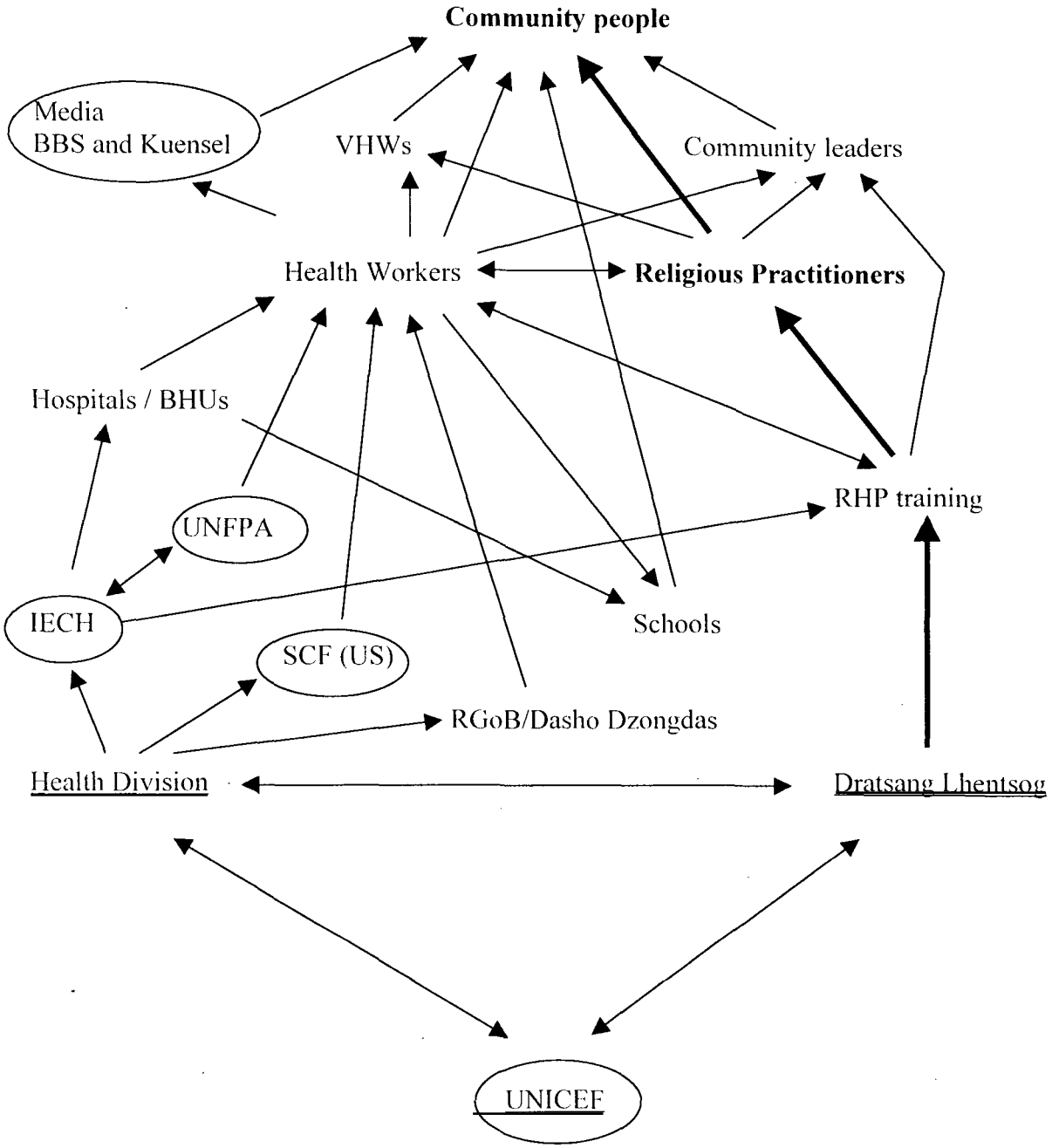
f) **Networking between Communicators of H+H messages** – The RHP management team should consider strategies to facilitate a network between the various agents communicating H+H messages to the community for more effective and consistent coverage. A mapping of the interconnections between the various participants communicating health messages to community people is given below.

Project Management and Partnership: Post-Evaluation Review of the RHP Project by Stakeholders

Activity 1: Review Project Objectives

i. Review the RHP Project Objectives and decide whether to amend or revise the Project Objectives for the next project period.

ii. Ensure that the Project Objectives, whether the same or revised, are used as the reference point which underpins all further decisions.



Interconnections between the various participants communicating health messages to the community people

The RHP evaluation shows that health messages are being communicated to the community people and there have been significant improvements in health and hygiene practices generally. The evaluation indicates that some of this change is a result of the RHP project but that there are other agents of change.

The above diagram illustrates some of the inputs and the interconnections. It shows RHP as having a direct and unique channel of input to the community and it also shows the key role which Health Division and the health workers play in the whole scenario.

Activity 2: Review Roles and Responsibilities

i. Use a Stakeholder Participation Matrix and Strengths, Weaknesses, Opportunities and Constraints Analysis (SWOC) to identify:

- The present roles and responsibilities of each stakeholder group from central, district and village level
- The strengths and weaknesses of the present structure at central, district and village level, and the opportunities and constraints which exist at each level.

ii. Use a second Stakeholder Participation Matrix to define a new structure of roles and responsibilities for each stakeholder group.

*Examples (1) a **Stakeholder Participation Matrix** and (2) a **SWOC Analysis Framework** are given at the end of this report.*

iii. Ensure that new roles and responsibilities and clarified and agreed with those to whom they apply. Link this activity to Activity 5ii. Decentralisation

Activity 3: Define Priority Target Groups

i. The RHP management team should define the target groups for future software and hardware inputs by considering:

- The Project Objectives (Activity 1)
- Baseline Data of inputs and comparison of all potential recipients of software and hardware (Activity 12)
- A Needs Analysis of community health and hygiene issues

ii. Link this activity to Activity 4. Plan of Action and 5ii. Decentralisation.

Activity 4: Draw up a Plan of Action

i. The RHP management team should draw up a long term plan to cover the period from this evaluation to the next proposed evaluation (see Activity 11) including targets for software and hardware inputs, and key stages in the strategic planning process.

A summary table of Activities and Action - who/when (Example 3) is given at the end of this report.

ii. The implementers of software and hardware programmes should draw up a long term plan, coordinating their inputs to ensure that software and hardware inputs coincide.

Activity 5: Review opportunities for greater Decentralisation

i. Introduce and coordinate an Annual Meeting of stakeholders and focal points.

ii. The initial meeting should be convened to address the most significant outcomes of this evaluation and subsequent review of the RHP, including discussion of:

- Roles and Responsibilities of each stakeholder group from central, district and village level (from Activity 2).

- Priority Target Groups and associated Needs Analysis (from Activity 3)
- Decentralisation opportunities and implications

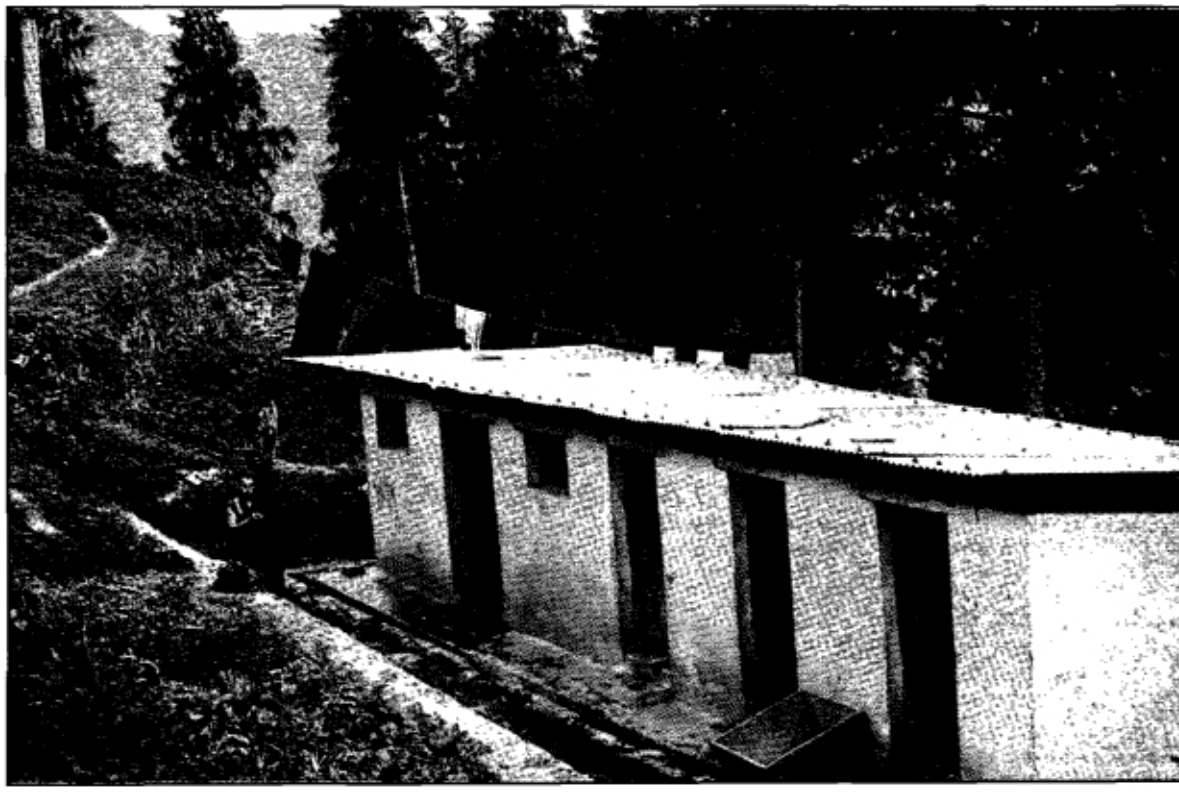
Activity 6: Facilitate a Network between Communicators of H+H Messages

i. Identify the various agencies involved in communicating H+H messages to the community.

ii. Facilitate a forum for networking between the agencies to exchange ideas and to ensure consistency and effective coverage.

iii. Identify the comparative advantages of different agents. The comparative advantages of the religious practitioners as health promoters is given on p.62 of this report.

iv. Use the comparative advantages to consider appropriate focuses for each agency.



Recently constructed teachers toilet at Dechenphodrand Monastic School

Strategy 2. Monitoring and Evaluation
Introduce a Monitoring and Evaluation Process

a) **Baseline data** is required which describes the software and hardware that has already been provided by UNICEF (see Summary Table of UNICEF Software and Hardware Inputs for each Site, p.69)

b) Additional data is also required on software and hardware inputs from other agents to identify areas of duplication and neglect

c) **Tools** are required for on-going monitoring of software and hardware project inputs

d) **Workshop reports** need to be presented in a standardised format. Clarify the purpose of the reporting process. Can the Workshop Reports in the correct format be used for on-going monitoring purposes, as in 1c above?

e) Follow a cycle of: Plan → Implement → Monitor → Review → Plan →→→→

f) **Roles and Responsibilities** for all parts of the Monitoring and Evaluation process need to be agreed, involving stakeholders from central to village level.

g) A second **project evaluation** will be required, dependant on project timeframes. Clear objectives should be defined against which to measure impact or achievement. Do the objectives need to be reviewed or do the existing objectives still hold as the focus or the project?

Monitoring and Evaluation: Introduce a Monitoring and Evaluation Process

Activity 7: Baseline Data Collection

i. Collate all available information as site profiles in a standardised format, or as a database

ii. Conduct a simple survey for specific data not already available

Activity 8: Tools for on-going monitoring of Software and Hardware

i. Design some tools for on-going monitoring by first considering the following questions:

Who requires the information?

- UNICEF
- Dratsang Lhentsog
- Health Division
- Others

For what purpose is the information required / How will the information be used?

- Future funding
- Future training programmes
- Success of past training programmes (impact)
- Future hardware inputs
- Maintenance support for hardware inputs

- Other

Who can provide the information?

- Central level - Dratsang Lhentsog / Health Division / UNICEF
- District level - Dratsangs / Health workers
- Village level - community-based practitioners / VHWs /community people

What information is required?

ii. Design a simple process of data collection, which is easy to analyse and which gives the specific information required.

iii. Decide who is responsible for data collection, analysis and feedback.

Activity 9: Use of Workshop Reports

i. Review the purpose of workshop reports.

- Who is the information for?
- How is the information used?
- Is the information received, the information which is required?

ii. Design a simple workshop reporting format and introduce into future workshop programmes

iv. Decide who should receive the completed workshop reports, and how the information is to be disseminated or collated. Is some of the data relevant for on-going monitoring (linked to Activity 8.ii above)?

*An Example (4) of a **Monitoring Framework for RHP Workshops** is given at the end of this report.*

Activity 10: Roles and Responsibilities for Monitoring & Evaluation

i. Use a Stakeholder Participation Matrix (*see Example 1 at the end of this report*) to allocate roles responsibilities for all aspects of the process of monitoring and evaluation. The matrix should be modified to focus only on M&E roles and responsibilities.

ii. Complete one participation matrix to represent the current roles and responsibilities and then complete as second matrix to show the new roles and responsibilities, delegating out to the district and village levels as appropriate.

Activity 11: Planning for Evaluation

i. Review the present project objectives and agree within the management team on whether the present objectives will need to be modified as objectives to be measured in the next evaluation (from Activity 1).

ii. Build the next scheduled evaluation into the project framework (see Activity 4)

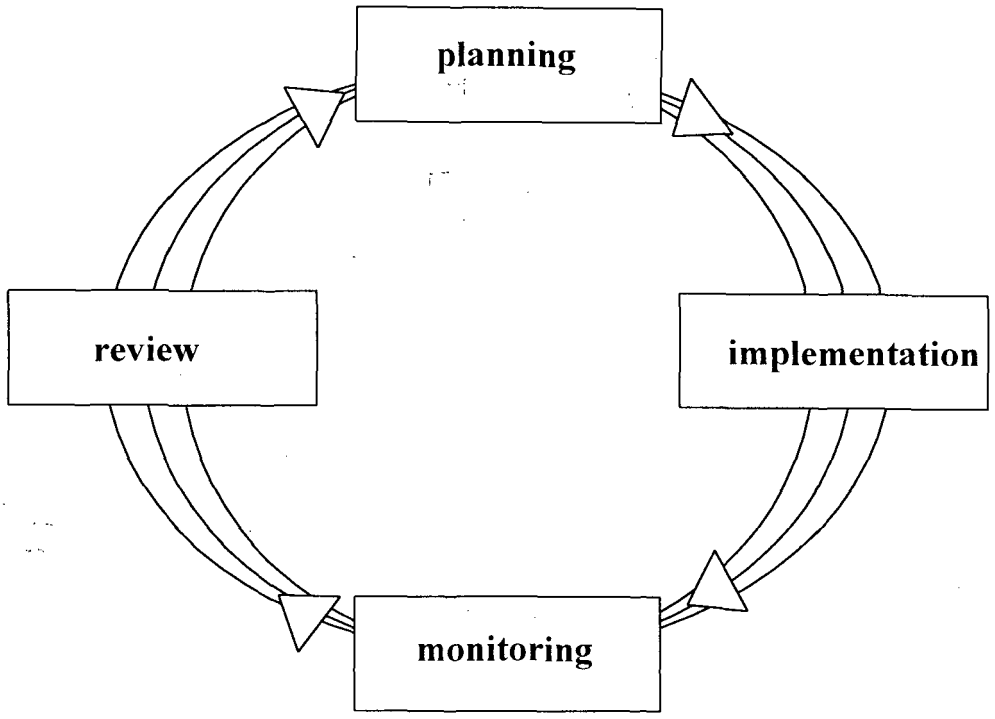
Summary Table of UNICEF Software and Hardware Inputs for each Site

			Software received - UNICEF			Hardware received - UNICEF						
			Institution	Gewog based	Mixed	Latrine	Septic tank	Water tap	kitchen	Bath house	stove	Waste pit
Pk.1	Site 1.1	Tongsa – Rabdey Users: 30 in summer, 330 in winter	1997	-	1990	✓	-	-	-	✓	✓	-
	Site 1.2	Mongar – Rabdey	1995	-	1993	-	✓	✓	✓	✓	✓	-
	Site 1.3	Tsirang – Rabdey	1996	-	1995	✓	-	-	-	✓	-	-
	Site 1.4	Kunga Rabten Nunnery	1997	-	-	✓	-	✓	-	-	-	-
	Site 1.6	Mongar – Kadam Gompa	-	-	1990[1]	✓	-	-	-	-	-	-
	Site 1.7	Mongar – Dremetsi Shedra	-	1993	-	✓	-	-	-	-	-	-
	Site 1.8	Bumthang – Kurjey Lhakang Users: 30 in winter, 330 in summer	- as Tongsa Rabdey -			✓	✓	-	✓	-	-	-
Pk.1a	Site 1.5	Chuka – Rabdey	1995	-	1993							
	Site 1.9	Bumthang Rabdey	-	-	1998							
Pk.2	Site 2.1	Thimphu – Tango Shedra	-	-	-	✓	-	-	-	-	-	-
	Site 2.2	Paro - Keela Gompa	-	-	-	✓	-	✓	✓	✓	✓	-
	Site 2.3	Mongar - Ngatshang Shedra	-	1996[2]	-	✓	-	✓	-	-	-	-
Pk.3	Site 3.1	Paro – Rabdey										
	Site 3.3	Punakha Rabdey										
Pk.4	Site 4.1	Chuka - Chapcha Community	-	1996	-							
	Site 4.2	Tongsa – Nyimshong Community	-	1997	-							
	Site 4.3	Tsirang – Tsokhana Community	-	-	1995							
	Site 4.	Tongsa - Langtel Community	-	1997	-							
	Site 4.5	Tsirang – Shemjong Community	-	-	1995							
	Site 4.6	Tsirang –Chanauti Community	-	-	1995							

The above table is a collation of the information from the RHP evaluation site visits.

[1] Only Lam attended training

[2] Monks stay at the Shedra for four years. Those who participated in the gewog training have left. Some new students have received training from Mongar Rabdey



Software Issues:

- In some sites monks have received training but the trained monks have moved on
- At one site visited the trained monks interviewed had received their training at their previous institution
- The proportion of monks trained in each site varies eg. only the Lam has received training in one site whereas according to the record 90 out of 120 monks were trained in Mongar Rabdey
- In the Shedras monks have received training but they are engaged in studies and have little direct contact with the local community for pujas, etc.

Hardware Issues:

- Some sites have received hardware, which for various reasons is no longer functioning
- Some sites have received hardware from several sources including UNICEF and are not sure who funded what, for example in the case where the Lam Neten is newly appointed to the Rabdey or where the funding was channelled through the Dzongkhag.
- Several institutions, which are clearly in need of improved hardware facilities, are on hold because of major renovations or planned move to another location.
- One site had poor water facilities due to the expansion of other institutions such as schools and BHU services, and the growth of the local population.
- In Tongsa and Bumthang the monks move between two sites from winter to summer and the number of users of the facilities changes from 30 to 330 for each site.
- In Punakha the number of resident monks can range between 100 in summer to 1000 for a major puja.

Strategy 3. Training

Review the Present Training Programmes and Modify as necessary

i. **Baseline data** is required, as in Strategy 2a and 2b. above, which describes the software that has already been provided by UNICEF. At present this information is largely in the institutional memory of 2-3 people. Data should be collated covering participants, facilitators, content, location and date

ii. A full list of all potential participants is also required, by religious institution and religious community, to be able to **identify future priorities and target groups**.

iii. A **Needs Analysis** is required to identify the needs of participants and the needs of the community. This will vary from workshop to workshop, and from district to district.

iv. **Plan each workshop** taking into consideration:

- **Who will facilitate**: suggestions arising from evaluation:- the facilitators could be trained trainers, monks facilitating within the Dzongkhag and between Dzongkhags, the health workers with influential people to monitor and supervise, or focal persons from both religion and health sectors.
- **What topics should be covered**: suggestions arising from the evaluation are given in Key Question e3. The messages should be simple and refresher courses should be given. The religious practitioners' role as health promoter should be clarified in the training.
- **Who will participate**: Selection criteria need to be defined. Suggestions arising from the evaluation:-
  - Train *educated and influential religious practitioners*. They can then run a workshop in their village and can then reach everyone. Local people will not listen to an outsider.
  - Train the *religious practitioners who are capable and interested* in communicating health messages and those who work regularly in the community.
  - Train those *religious practitioners who have not been trained* and who may continue to conduct the puja and delay the medical treatment.
  - Train those *religious practitioners in more remote locations* where change is more gradual or perhaps more resisted, or where access to health services is more difficult
  - Use some *selection criteria for participation* in workshops for example the *trust from the community* and the *interest of the religious practitioner* in the training
  - HA wanted to *train atsara and gomchen before Tsechu* but there was no budget
- **Who will coordinate and manage the training**: the evaluation responses suggest coordination between health workers and Dratsang, taken down to the village level to include the VHW and gup, tsokpa or chimi. A regular programme of workshops and Guidelines for Facilitators are requested.

Training: Review the Present Training Programmes and Modify as necessary

Activity 12: Identification of target groups and priorities

i. Compare the baseline data of training already conducted against the full range of potential participants. Identify, from this comparison, areas of weakness in the coverage of RHP training to date.

ii. The management team should decide on the priority target groups as the focus for future RHP training (linked to Activity 3).

Is the priority target group:

- Religious practitioners at community level?
- Institution-based religious communities?
- Mixed religious practitioners and influential community members?
- More remote and isolated locations?
- Refresher course for those already trained or training for those as yet untrained?

Activity 13: Needs Analysis

i. A Needs Analysis for each training workshop should be undertaken at two levels:

- A simple Needs Analysis by the local health workers to assess the H+H needs of the community, which can then be used to identify the key topics for the workshop.
- A Needs Analysis of the participants to assess their level of knowledge and main areas of weakness in the H+H topics. This can be done by the facilitators at the beginning of the workshop, through discussion. The facilitators will need to be able to incorporate this assessment into the workshop. They may have to modify the training programme at the last moment.

ii. A survey of attendance at MCH clinics could be conducted to identify the H+H practices of mothers and children. Information could be gathered by health workers on:

- changing views – mothers to grandparents view
- difference between rural and urban practices and views
- perceptions and understanding of health issues
- concerns and problems concerning health issues

Activity 14: Workshop Planning

i. Plan in advance to give sufficient time to:

- Identify training needs (Activity 13) and select the topics based on the needs analysis
- Prepare the facilitators
- Select the participants based on clear criterion
- Organise the logistics and budget at Dzongkhag or village level

ii. Ensure, by the end of the workshop, that participants understand the difference between serious illnesses and less serious illnesses and can detect the signs and symptoms of

more serious illness. Also that they advise on medical treatment first and then puja in the case of serious illnesses.

iii. With advice from Health Division, decide how the topic of STD/AIDS should be presented for religious practitioners.

iv. Use a variety of methodologies including participatory activities and visual resources

v. Plan the monitoring component of the training (linked to Activity 9iv.)

vi. A modification of the Health Knowledge Test could be used to assess the health knowledge of participants before and after the training. The test has to be given orally so could be given to a small, random sample of participants. Care should be taken not to make this threatening or off-putting to the participants since it will be an unfamiliar exercise to those who are uneducated.

vii. Prepare Guidelines for Training Courses

<u>Activity 15</u>: Review RHP Training - Alternative Models

i. The management team should consider the following Models for RHP Training proposed by religious practitioners and health workers during the evaluation. Several different training models could be piloted and monitored over a 2-3 year period. For example:

- Target a gewog which has not had input yet; conduct a baseline sample survey of peoples' beliefs and practices, access to water and sanitation facilities, common problems, etc. Compare with a follow up study after 1yr and 2 yrs
- Train monks and community based religious practitioners as facilitators. The introduce a programme of village based training using monks as facilitators
- Train monks and community-based religious practitioners as VHW.
- Training only religious practitioners or training religious practitioners and community people – the two options require a different training focus. Do they both align with the RHP Project Objectives (Activity 1)

ii. Plan future training programmes based on the outcome of Activity 12 and 13, tailoring the participants, topics and coordination of the workshops accordingly.

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The strategies and activities described in this section are drawn from suggestions put forward by religious practitioners and health workers in response to the evaluation questions.

The Religion and Health Project management team can pick from these suggestions the strategies and activities which are most workable or are considered most appropriate for the future direction of the project.

The over-riding impression from the evaluation was the enthusiasm and interest shown in the project. If the management team can find ways to harness and utilise this energy then the next phase of the project should continue the achievements and success of the project so far.
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Summary of Future Strategies and Guideline of Activities

Future Strategies		Guideline of Activities	
Project Management and Partnership			
Strategy 1:	Post-Evaluation Review of the RHP Project by Stakeholders	Activity 1:	Review Project Objectives
		Activity 2:	Review Roles and Responsibilities
		Activity 3:	Define Priority Target Groups
		Activity 4:	Draw up a Plan of Action
		Activity 5:	Review opportunities for greater Decentralisation
		Activity 6:	Facilitate a Network between communicators of H+H Messages
Monitoring and Evaluation			
Strategy 2.	Introduce a Monitoring and Evaluation Process	Activity 7:	Baseline Data Collection
		Activity 8:	Tools for on-going monitoring of Software and Hardware
		Activity 9:	Use of Workshop Reports
		Activity 10:	Roles and Responsibilities for Monitoring & Evaluation
		Activity 11:	Planning for Evaluation
Training			
Strategy 3.	Review the present Training Programmes and modify where necessary	Activity 12:	Identification of target groups and priorities
		Activity 13:	Needs Analysis
		Activity 14:	Workshop Planning
		Activity 15:	Review RHP Training - Alternative Models
Example 1:	Stakeholder Participation Analysis Matrix - Who does what?		
Example 2:	SWOC Analysis (Strengths, Weaknesses, Opportunities, Constraints)		
Example 3:	Activities and Action – who/when		
Example 4:	Monitoring Framework for RHP Workshops		

Example 1: Stakeholder Participation Analysis Matrix - Who does what?

Complete one matrix to show the present areas of participation and, through discussion of the results, plan a new matrix of participation to reflect revised roles and responsibilities for the future.

Examples of aspects of the project in which different stakeholders may participate – modify as appropriate.	Dratsang Lhentsog	IECH	UNICEF	RHP management committee	Dungchens	Gelongs	Community-based religious practitioners	DHSO	Health Assistants	Village Health Workers	Village leaders	Villagers	External consultant
Project Planning													
Management – central level													
Management – district level													
Management – village level													
Coordination – central level													
Coordination – district level													
Coordination – village level													
Focal Point													
SW planning													
Selection of participants													
Selection of location													
Workshop implementation													
HW planning													
HW maintenance													
SW Monitoring													
HW Monitoring													
Beneficiaries – Target groups													
Project Evaluation													✓
Budget			✓										

Example 2: SWOC Analysis (Strengths, Weaknesses, Opportunities, Constraints)

To follow up the Participation Matrix analysis a SWOC analysis could be completed to identify: *What works? Why? What doesn't work? Why?*

Consider (a) strengths, weaknesses, opportunities and constraints at three levels:
i. Central level SWOC
ii. District level SWOC
iii. Village level SWOC
(b) for the key roles eg. management, coordination, planning, facilitating, maintenance

	Central level	District level	Village level
Strengths Management Coordination Planning Facilitating training Maintenance			
Weaknesses Management Coordination Planning Facilitating training Maintenance			
Opportunities Management Coordination Planning Facilitating training Maintenance			
Constraints Management Coordination Planning Facilitating training Maintenance			

Example 3: Activities and Action – who/when

Future Strategies and Activities: Suggestions for Project Improvement

STRATEGIES/ACTIVITIES	BY WHOM/WHEN
Strategy 1: Post-Evaluation Review of the RHP Project by Stakeholders Activity 1: Review Project Objectives Activity 2: Review Roles and Responsibilities Activity 3: Define Priority Target Groups Activity 4: Draw up a Plan of Action Activity 5: Review opportunities for greater Decentralisation Activity 6: Facilitate a Network between communicators of H+H Messages	
Strategy 2. Introduce a Monitoring and Evaluation Process Activity 7: Baseline Data Collection Activity 8: Tools for on-going monitoring of Software and Hardware Activity 9: Use of Workshop Reports Activity 10: Roles and Responsibilities for Monitoring & Evaluation Activity 11: Planning for Evaluation	
Training Strategy 3. Review the present Training Programmes and modify where necessary Activity 12: Identification of target groups and priorities Activity 13: Needs Analysis Activity 14: Workshop Planning Activity 15: Review RHP Training - Alternative Models	
Example 1: Stakeholder Participation Analysis Matrix - Who does what? Example 2: SWOC Analysis (Strengths, Weaknesses, Opportunities, Constraints) Example 3: Activities and Action – who/when Example 4: Monitoring Framework for RHP Workshops	

Example 4: Monitoring Framework for RHP Workshops

Before any reporting back format is used the following questions should be clarified:
Who is it for?
Who completes it?
How will the information be used?
What information do we need to know? Eg.

- Knowledge before / after RHP
- How knowledge is received / used
- Impact on communities

Facilitators could use a simple format to report back on workshops:

Location:	
Date:	
Number of participants: List of participants:	
List of key facilitators:	
Key topics covered:	
Budget:	
Participants' feedback:	
Notes- comments:	

Glossary

Anim	Nun
ANM	Auxiliary Nurse Midwife
ARI	Acute Respiratory Infection
Atsara	Bhutanese clown
BHU	Basic Health Unit
BHW	Basic Health Worker
Chaupory	Village elder (Nepali term)
Chimi	People's Representative in the National Assembly
Choep	Religious practitioner in the village
Dasho Dzongda	Head of the District
DHSO	District Health Supervisor Officer
DMO	District Medical Officer
Dratsang Lhentsog	Council for Religious Affairs
Drubdra	Meditation centre
Dungchen	Secretary
Dzong	Fortress – residence of the Dratsang and District Administration
Dzongkha	Bhutan's national language
Dzongner	One who takes care of the Dzong
FFL	Facts for Life (UNICEF publication)
Gelong	Monk
Gewog	Block
Gomchen	Community person who practices religion
Gomdey	Institute for training of Gomchen
Gompa	Buddhist temple
Gup	Village headman
HA	Health Assistant
HOH	Health in our Hands (UNICEF publication)
IECH	Information, Education, Communication for Health
Jakri	Hindu community religious practitioner
Je Khenpo	Head of the monastic body in Bhutan
Kidu	Consideration – gift
Kudung	One who looks after discipline in the Dzong
Kueney	One who takes care of the Lhakang (monastery)
Kuensel	Bhutan's national weekly newspaper
Lam Neten	Head Abbot of Rabdey
Lhabsang puja	Purification puja
Lopen Gengop	Assistant prayer leader
Mangup	Village Committee Head
MCH	Mother and Child Health clinic
Menchey Rimdu	Medicinal treatment and puja performed side by side in sickness
Merchen	One who takes care of the dead body of Lamas
ORC	Out Reach Clinic
Pam	Female oracle in Buddhist community
Pandit/Purit	Scholar of Hindu religion
Powa	Male oracle in Buddhist community
Rabdey	District head institution of the monk body
RGoB	Royal Government of Bhutan

RHP	Religion and Health Project
Rimpoche	Reincarnate Lama
RWSS	Rural Water Supply and Sanitation
Sang	Herbs for burning
Shedra	Monastic senior college
Sherub	Wisdom
Thub	Method
Tsechu	Festival (mask dance) on 10th day of 10th month of Bhutanese calendar
Tsedup	Blessing for long life
Tsip	Astrologer
Tsokpa	Village leader
Umzey	One who leads the puja
UNFPA	United Nations Population Fund
VHW	Village Health Worker

Mochi tabna doenchi thoen	a Bhutanese saying which is spoken by the oracle - a prediction for future well being will always have some spiritual basis that will require some action to be taken.