Fifty Years of Improving Peoples Health in Nepal

The Britain-Nepal Medical Trust
1967-2017

Gillian Holdsworth

Prof. S. Subedi

Patrons and Trustees

Royal Patron
HRH The Prince of Wales KG, KT, GCB

Patrons
Sir Christian Bonington CBE, DSc(Hon)
Dr Robert Fryatt
MB, BS, MD, MPH, DTMH, MRCP, FFPHM
Prof Sir Andrew Haines
MB, BS, MD, FRCGP, FFPHM, FRCP, FMedSc
Lady Hughes-Hallet
Lady Pike
Dr J.O.B. Rosedale
Col J.N.B. Stuart

Trustees
Dr G. Holdsworth – Co-Chair
Prof S. Subedi – Co-Chair
Dr R. Dhital
Mr J.W. Mecaskey
Dr J. Payne

Company Secretary/Administrator
Mrs A.G. Peck

Cover photo:
Children in Humla, 1987

Chairs' Foreword

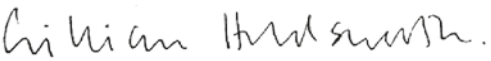
This year the Britain Nepal Medical Trust celebrates 50 years – a significant milestone for any organisation. It provides us with an opportunity to celebrate the legacy of that small team of doctors and nurses who set out for Nepal with the ambition of 'doing something of value in a part of the world where their medical skills were more urgently required than UK'.

In this report we reflect on the achievements of BNMT as well as changes in Nepal in the past 50 years. We describe programme developments over the years, and how the Trust always focused on the poor – its role in tuberculosis control, essential drugs supply and community drug schemes, community health and development, training, the rights-based approach, and research, advocacy and partnership. We also outline how BNMT developed innovative models and approaches which were later adopted and embedded in health policy – in Nepal and elsewhere.

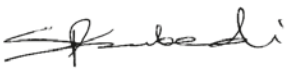
The report describes the transition of the original medical model to a public health organisation which right from the start reflected the philosophy 'that we must not start projects which would not or could not be continued when the team is no longer there'. And then, the slow but steady handover to Nepalese: the transfer of the TB programme to the National Tuberculosis Programme, the oversight and management of the Trust by a team of Nepalese staff in Kathmandu and the establishment of BNMT Nepal – a local NGO established in 2012 with its own governance structure, which works in partnership with BNMT UK.

Finally, we consider what it was about BNMT that enabled this tremendous success story and give an update on the past year's activities.

Once again – thank you all for your continued support: none of this would ever have happened without you all. And a big thank you to Claudia McConnell who reviewed the BNMT archives and wrote the 50-year review for us.



Gillian Holdsworth



Prof. S. Subedi OBE, QC
Joint Co-chairsof BNMT UK


Drs John and Penny Cunningham shortly after their marriage in 1966 and before they left the comfort and amenities of the western world to rough it in beautiful, but basic Nepal.

Drs John and Penny Cunningham, the founders of BNMT

50 Years of Improving People's Health in Nepal

by Claudia McConnell

1: Introduction

In 1967 two young British doctors, eager to use their skills where they were needed most, started planning a medical expedition to Nepal. It is unlikely that anyone involved then could have imagined that the organisation would still be working to improve the health and wellbeing of the Nepalese in 2017. Over five decades the relationship between Nepal and the Britain-Nepal Medical Trust (BNMT) has grown and deepened, in the teeth of political upheaval and natural disaster, as well as the Trust's own ups and downs in funding and, occasionally, direction. Today, BNMT Nepal provides support, partnership and interventions in 40 districts across all the regions of the country.

In this 50th anniversary report we celebrate BNMT's achievements, reflect on changes in the last 50 years, review programme developments, and highlight the people who have contributed to the Trust's work over the years. We consider how BNMT has persevered, the impact it has had and the successful creation of a new Nepalese-run NGO called Birat Nepal Medical Trust (BNMT Nepal), with which it now works in partnership.

Biratnagar Hospital in 1970

BNMT at Biratnagar Zonal Hospital

BNMT helped to:

- re-equip the outpatient room
- establish the pathology laboratory
- introduce record systems
- improve practice in and around operating theatres
- build a nurses' home and children's ward
- provide drugs and equipment.

By the end of the first five years the Trust had built a new out-patient department (with funding from Misereor), established a physiotherapy department, and trained many nurses. The team also established child health clinics in the *terai*.

2: 1967–1977: The early years

The idea for the medical expedition to Nepal came from John and Penny Cunningham, newly qualified doctors with a desire to do something 'bold and imaginative' before settling down to a regular job in the UK. They chose Nepal as the country, second only to Nigeria, with the lowest doctor/patient ratio in the world (then 200 doctors for 10 million people), and because of Britain's relationship with the Gurkhas and Sherpas. After a short exchange of letters in 1966 with the Ministry of Health in Kathmandu (which can be summarised as 'Can we come and help?' 'Yes please') and a visit to Kathmandu in 1967, the idea became a reality.

Making it happen would require resources, primarily equipment, drugs and land rovers, and obtaining these took a marathon effort: more than 10,000 letters were written in two years. The Britain Nepal Medical Expedition finally set out overland in 1968.

The rationale for the overland trip was cost: £600 for three vehicles and 11 people compared to £2,000 by air. This focus on making the most of resources was a feature of BNMT from the start. But what they lacked in money they more than made up in ambition. The first annual report states that 'we hope that our results will be of value, not only to the people here but also to world health in general.'

Much has been written about the arrival and early days of this group of doctors and nurses, both in John Cunningham's 1975 account *Kingdom in the Sky* and in BNMT annual reports. Suffice to say that they were supported and welcomed by

the British Embassy and set about the task of establishing a base in the Kosi Zone in eastern Nepal, in the *terai* (lowlands). It was not what they had dreamed of. In John's words 'Hastily-studied maps showed Biratnagar to be about as far away from our prospective zone as possible; and we were deeply disappointed that we were not going to the hills'. He would be pleased to know that much of BNMT's subsequent work was in the hills, in recent years reaching as far as Acham and Baitadi districts in the Far Western Region.

By July 1968 the whole team was in Biratnagar, setting up home and work in a sea of mud as the monsoon struck. In that respect, little has changed. A news item in *The Himalayan Times* of 19 August 2017 reads: 'Biratnagar Airport has resumed its services partly from today, more than a week after it was inundated by flood water. The runway including the check-in counters were all covered by mud and sand due to inundation caused by incessant rainfall last week.'

In its first year the team in Biratnagar did valuable work in the Zonal hospital (see box). John Ward carried out surgery for goitre, cleft palate, burns and many other conditions, initially in the *terai* but also in the small hospital in Dhankuta.

In the second year some Trust members ventured further afield. One of the team, Barney Rosedale, had just completed a year working in Nigeria and had a Diploma in Tropical Medicine. His experience, knowledge and skills proved invaluable. He understood that when resources are limited and need is great, the organisation must focus on priorities, especially those identified by communities themselves.

Trips into the hills helped the team to identify new priorities beyond the confines of the hospital: the scourge of TB and the chronic shortage of medicines for the hill population. The work that developed – providing TB medicines through district-based clinics, mass BCG vaccinations, and selling medicines to shopkeepers in the hills – was based on observed need. The decisions were pragmatic and opportunist rather than based on a sense of mission or prescribed objectives. This has remained a feature of BNMT for most of its 50 years.

The optimism and pioneer spirit of these early years was dampened somewhat towards the end of the first decade. In 1975 Noel Leigh Taylor, Penny Cunningham's father, died after seven years as Chairman of the Trustees. He had been instrumental in supporting, funding and connecting the team in Nepal to influential people such as Sir John Hunt, Charles Wylie, and others. These were

The BCG vaccination programme: BNMT nurse Jan Patterson with a young patient, 1970

A father and child; in the 1960s Nepal had the second-lowest doctor-patient ratio in the world

Barney Rosedale

One of the founders of BNMT, Barney Rosedale worked for the Trust in Nepal for four years (1968–1972), as its Leader for the final year. He then served as a Trustee for 20 years (1975–1995). He qualified as a doctor at St Thomas' Hospital, London, in 1964. After completing Diplomas in Child Health and Tropical Medicine and Health at Liverpool in 1966, he worked as a paediatric registrar in Ibadan, Nigeria, for a year during the Biafran War. At a New Year's Eve party just before his departure for Nigeria, he and John Cunningham discussed plans for the Nepal expedition, and Barney agreed to join it on his return. By 1968, after a month in the UK, Barney was driving to Nepal with the initial team in his own Land Rover.

On returning to the UK in 1972, he completed obstetric training in Taunton, and began work as a GP in Marlborough in 1974. During his 20 years as a Trustee he made several visits to the Trust, and continued to climb and trek in Nepal until very recently.

Don Patterson (BNMT Director 1977-79) and MB (Cook) in Biratnagar

people who loved Nepal because of their army and climbing connections and they did much to help publicise and support the Trust's work over many years. At the same time, the team in Nepal were at a low ebb – the annual report for 1976 states that 'we have drifted through the year with no positive aims in front of us and we have been pulled up short by realistic criticism which we found hard to accept'.

The criticism referred to was a 1975 report for Oxfam by Bill Acworth, saying that BNMT was the worst Oxfam-funded project he had ever seen and recommending immediate closure. This impression, justified or not, came mainly from seeing bored and frustrated expatriate doctors unable to practise as clinicians because there was insufficient work in the clinics. In response to this criticism the team in Nepal shifted focus to public health. They established a regional TB programme working for and with the government and quickly recruited staff with an interest in public health work. Many of these went on to work in and influence international public health after their start in BNMT. Within a few years, the Trust was being praised for its approach and programmes (see Sir John Crofton's comments below, for example).

By 1976 the millionth BCG vaccination had been given, TB clinics were operating in several districts in the Eastern hills, and 31 Hill Drug Scheme shops had been established. Apart from the medical facilities on the East-West Highway set up and run by BNMT doctors, the Trust's geographical scope remained in the Eastern Region.

Suresh Lama

Suresh Lama, the son of a Gurkha, was born and grew up in Dharan. He first worked with BNMT in the 1977-81 BCG campaign. Suresh joined BNMT again in 1987 as part of a BNMT work experience programme for young Nepalese. He was employed as a Health Post Visitor in the Phidim clinic and later moved to Taplejung, where his wife's family came from, and was appointed to run the Taplejung Clinic. After BNMT's TB clinics were handed over to the Ministry of Health in 2002, Suresh teamed up with a colleague, Bir Bahadur Gurung, and established Mechi St Mary's Boarding School. Today this school provides education from nursery to class 10 for over 450 pupils in Taplejung, of which around 60 are full-time boarders. The school has won numerous awards at national and district level and is renowned for achieving 100 per cent School Leaving Certificate pass rates.

3: 1977–1987: Development and stability

During this decade BNMT continued to expand its programmes and its understanding of the development challenges facing Nepal. The 10th annual report summarises these as:

- poor communications over difficult terrain
- poor education facilities
- rapidly expanding population
- inflexible caste/class structure
- inadequate water supply and sanitation
- environment predisposing to infectious diseases
- food shortages and malnutrition
- little family planning
- inadequate trained manpower
- slow socio-economic growth.

Out of this understanding, and building on the work already under way in its network of TB clinics and the BCG campaigns, BNMT recognised that it could contribute to the government's health agenda by training Village Health Workers (VHWs) who were seen as 'the base of the pyramid of the health service structure'. Functioning health posts were few and far between, so VHWs were often the only contact that impoverished Nepalese had with any kind of public health advice or support.

BNMT started training VHWs in 1978 in Mamling and Akhibhuin wards in Sankhuwasabha district. Based on this experience, BNMT was invited to help develop and implement a government pilot programme training Community Health Leaders (CHLs). These were selected by local people and, despite BNMT's

best efforts, only one of the first 18 volunteers was a woman. The key to this programme was that each CHL was well known to the community and was responsible for a smaller geographical area than the VHW. They provided simple preventive and curative health care and were supervised by the VHWs.

The BNMT team in 1983 Left to right: Johnny Payne, Caroline Payne, Gillian Corble, Frank Guthrie with daughter Maya, Mari Sullivan, Sarah Newell Price, Vince Costello, Andy Schmidt, Phil Groman, Steve LeClerq, Claudia McConnell, Andrew Cassels

The TB work continued through TB clinics and laboratories that BNMT established in six hill districts (Dhankuta, Sankhuwasabha, Bhojpur, Panchtar, Taplejung and Terathum). These were attached to district hospitals and staffed by trained Nepalese, supervised by expatriate doctors.
The Nepalese staff were trained and skilled in delivering all the components of a TB control programme: accurate diagnosis through physical examination and microscopy, treatment with first-line drugs, and providing hostel accommodation for patients who had travelled too far to return home during their initial treatment. Cure rates were almost certainly boosted by the unique addition of the defaulter chaser role (see box).

Defaulter chasers

In the 1970s the TB treatment course was long – as much as 18 months of daily medication. As treatment progressed, there was a high risk of patients not completing the full course – partly because they felt well again, and partly because many experienced side effects from the medication. This created a risk of drug resistance developing. Aware of this risk, BNMT introduced the post of defaulter chaser. If a patient failed to turn up for their next month's supply of medication, the defaulter chaser would go to their house and bring the patient back to the clinic for more health education and their next month's treatment.

Sir John Crofton visited Nepal twice, in 1978 and 1980, as the World Health Organisation (WHO) consultant on TB and saw BNMT's TB control work at first hand. He said:

> *I believe that the BNMT has been the most highly effective, and most continuously effective, foreign aid programme I have seen in any third world country... they have regarded themselves as part of the Nepalese government service and integrated with it... as one problem comes in sight of solution they move on to another.*

Sir John remained a much-valued supporter of BNMT, frequently attending and contributing to Trustee meetings, and was a patron of BNMT from 1983 until his death in 2009.

BNMT also supplied all the hospitals and health institutions in the Eastern Region with TB medicines. This depended on the stamina and loyalty of BNMT's porters, who would carry the drugs into the districts, most of which had no roads. And it provided an opportunity to train additional health staff when the drugs were received.

Some Nepalese doctors were posted outside Kathmandu in those days, but many found the life hard and wanted to return to their families. Thus the expatriate doctors were often the only doctors in the hill districts. They visited isolated health

Building works on the East-West Highway across Nepal 1968

Dr Murdoch Laing with health post staff in Kulung, Bhojpur, 1986

workers in the government health posts to give support and training on all aspects of preventative and curative medicine. Although their main role was to supervise the TB and leprosy clinics and hostels, the doctors were regularly called on to help with emergency surgery, difficult births, and to repair damage caused by snakes and bears.

The BCG programme was often headed by American ex-Peace Corps volunteers because of their superior Nepalese language skills and familiarity with the country. The service itself was delivered by 30 trained Nepalese vaccinators. They vaccinated as many as 130,000 children aged under 15 each year and usually achieved above 80 per cent coverage – well above the level recommended by the WHO. In 1981 six of the BCG team vaccinators were seconded to a Nepalese government team (funded by British Aid) to carry out a mass campaign of iodised oil injections to combat goitre and cretinism, conditions commonly found in the most northerly districts of the country. In 1982 the BCG programme was handed over to the government.

Monitoring child health: a BNMT-trained community health volunteer in action, Sankhuwasabha 1980

The Hill Drug Schemes were evolving all the time in response to identified problems and new needs. The aim was to ensure a year-round supply of basic essential drugs for people attending hospitals and health posts in the hills. By the mid-1970s the initial scheme – drugs sold to local shopkeepers based near a hospital or health post – had been supplemented by a new scheme in Bhojpur. Here, a local health committee was formed and charged with raising small amounts of money from each patient to contribute to the total cost of drugs for that health post or hospital. BNMT was already considering different forms of financing and with this work, as with so much it has done, was ahead of the curve. The global campaign for access to essential medicines did not start until 1999.

This decade marked a turning point for BNMT: the Trust worked with local people and communities, and with government. It was also a rare time of relative stability in the country. The government was stable, the monarchy revered, the partyless *panchayat* system established. Meanwhile BNMT was benefitting from the loyalty and commitment of its Nepalese staff, many of whom had worked for the organisation for more than 10 years, and all of whom were experienced, well trained and trusted by local people and government officials. The work, whether in TB, drugs or community health programmes, was being refined and adapted as needed. The expatriates were aware of the changes and developments in global and international health – for example, the 1978 Alma Ata declaration on Primary Health Care for All – and often brought that knowledge to BNMT before building and developing their careers in international public health.

Andrew Cassels

Andrew Cassels worked for BNMT from 1977 to 1983, latterly as Director, and was a Trustee from 1983 to 1991. He graduated in medicine from St John's College, Cambridge, in 1975, and in public health from the London School of Hygiene and Tropical Medicine in 1984. After a long assignment in India in the 1980s, he was appointed to the staff of the Liverpool School of Tropical Medicine. There he established a new post-graduate course on the management of primary health care, and developed a research programme focusing on donor policies in the health sector; decentralisation and the role of local government; and health care planning and management. Between 1992 and 1998, he worked as a senior adviser to a wide range of governments in developing and transitional countries, as well as to several multilateral and bilateral development agencies. He has published widely on issues related to health sector reform and pioneered new approaches to development assistance in health, including sector-wide approaches. In 1998 he joined the WHO, where he worked as Director of Strategy in the office of the Director-General.

BNMT staff in charge of TB clinics, 1987, left to right: Indra Bdr Basnet, Ilam; Kirtiman Gurung - Diktel; Shiv Narayan Chaudhary - Biratnagar; Bhagwan Shrestha - Bhojpur; Yam Bdr Gurung - Drug scheme; KashiRam Chaudhary - Paanchter; PR Acharya - Tehratum; Harka Bdr Gurung - Khadbari; Pramod Shrestha - Dhankuta; BB Gurung - Taplejung

4: 1987–1997: Transition and turmoil

An evaluation carried out for ICCO in 1991 identified positive aspects of BNMT's work, and suggested that the Trust could do more to share its learning through research, training and actively contributing to the development of health policy in Nepal.

While BNMT maintained all its original programmes – TB, drugs, and community health – it had recognised the important role it could play in training others and by 1990 the training unit was developing. It went on to train hundreds of health workers across the region.

During this decade BNMT pioneered new approaches to TB treatment in Nepal. The success of the Directly Observed Treatment (DOTs) pilot programme in Dhankuta laid the groundwork for a national scheme that extended DOTs throughout the country. The decade also saw the move from delivering TB services in eastern Nepal to helping to develop an effective national TB control programme. Case finding, clinics and hostels were handed over to the government, and BNMT took on the role of training staff.

In 1994 the TB programme was evaluated by the WHO as part of its review of the National TB Programme. The report stated:

> *the BNMT TB programme is a glaring success. It shows that an 85% cure rate is a realistic target for the NTP... reasons for success include excellent logistic support and drug supply, staff stability, motivation, status and solidarity, intense and supportive supervision, regular training and workshops, use of DOTs, priority given to patients' needs, and effective defaulter retrieval system...*

Sakuntala Singh

After training as an auxiliary nurse midwife in Nepalgunj in 1978, Sakuntala Singh worked in government service for four years, and then trained as a staff nurse in Patan, completing the course in 1985. In 1988–91 she undertook a Bachelor's degree in nursing at Maharagunj. She joined BNMT as the Hill TB programme manager in 1992, later becoming the TB programme manager for both the Hill and Terai TB programmes. In 1997–8 Sakuntala moved to Liverpool to study for a Master's in international public health, before returning to work with BNMT in Nepal as the TB programme coordinator. In 2002 she joined the International Trachoma Initiative and project-managed the Nepal Trachoma Programme in collaboration with Nepal Netra Jyoti Sangh for four years. In 2006 Sakuntala moved to the UK with her family, where she continues to work as a nurse and nurse manager.

The BNMT team in 1989, left to right: Suzanne Knapp, Elout Vos, Bob Fryatt, Jamie Ervin, Jackie Howell, Chris Vickery, Tony Bondurante, Jean Marion Aitken, John Chalker, Pru Chalker, Ellen Kristvik, Gillian Holdsworth in front with the dog

Jean Marion Aitken

After working in BNMT's Community Health Programme from 1987 to 1989, Jean Marion Aitken served as a Trustee from 1990 to 2000. She worked for Liverpool School of Tropical Medicine, Keele University Centre for Health Planning and Management, and as a freelance consultant in the 1990s, then joined the Department for International Development (DfID) in 2000. She worked for DfID as a Health Adviser in Malawi, Cambodia, and Kenya, and as Head of the South Asia Research Hub in Delhi from 2012 until 2016. She is now DFID's Senior Health Adviser in Malawi.

Mahesh Sharma

BNMT's first Nepalese director (1994-1998), Mahesh Sharma is now Chair of the Birat Nepal Medical Trust board. With more than 20 years of experience in programme development and management in health, HIV and AIDS, TB, and community development, he has worked with the Government of Nepal, Save the Children (UK), BNMT, the United Nations Development Programme in Nepal, and has taken up HIV/AIDS-related assignments in Bangladesh, India, Vietnam, and the UNAIDS regional support team in Bangkok.

The 1994 annual report also notes that less than 6 per cent of patients died under BNMT treatment, compared to nearer 50 per cent treated elsewhere in the country.

The Community Health Development Programme (CHDP) was transformed during this decade into a large and innovative programme with many separate but linked components. In addition to the original CHL project, the programme included adult non-formal education, street theatre, school and community development, and TB education work with traditional healers. Despite the obvious value and successes of the programme, the 1991 evaluators noted that the staff felt inferior and less important than those in the curative and clinic-based roles.

In 1996 the CHDP strategy was revised, in response to a review the previous year. Instead of continuing with geographical expansion, the team realised that more effort was required to truly build the capacity of established community groups to deliver lasting results without intensive support. Women's groups were developed following a successful programme of literacy classes, and these groups in turn were supported to develop activities based on their own priorities: sanitation campaigns, the construction of school buildings, kitchen gardens, microfinance projects and buying a stretcher to transport sick people to the health post.

Development period	Type of programme	Characteristics
Community oriented (1969-1980)	Hill Drug Scheme (HDS) - At private retailers	Cost price +10% handling charge + 12.5% mark up - Managed by retailer
Community based (1980-1996)	Hill Drug Scheme (HDS) - At private retailers	Cost price +10% handling charge + 15% mark up - Managed by retailer
	Cost Sharing Drug Scheme (CSDS) - At hospitals and health posts	- Flat fee: per prescription or per drug, NRs 1-8 - Cost shared by patient, HMG & BNMT - Managed by BNMT & health institution
Community organised (1996-2003)	Hill Drug Scheme (HDS) - At private retailers	Cost price +10% handling charge + 15% mark up - Managed by retailer
	Cost Sharing Drug Scheme (CSDS) - At hospitals, health centres and health posts	- Unit item fee: for smallest unit of drug, initially about 40% of cost price at HPs/PHCs & 50% of cost price at hospitals/PHCs - Cost shared by patient, VDC, HMG & BNMT - Managed by LHSC & health institution
	Community Hill Drug Scheme (CHDS) - At hospitals and health posts	- Unit item fee: per smallest unit of drug, about cost price - Cost shared by patients, HMG and VDC - Managed by LHSC & health institution

The TB clinic in Bhojpur, 1987

The Drug Scheme Programme continued to evolve. By 1996 its goals included the original Hill Drug Scheme and the Cost Sharing Drug Schemes in operation since 1969 and 1980 respectively (see box).

The Drug Scheme Programme

The goals of the Drug Scheme Programme, as stated in the 1996 annual report were:

- To improve the availability of essential drugs (where needs are not being met)
- To develop and support drug supply systems that are sustainable at the local, district and regional levels
- To promote rational prescribing and consumer use of essential drugs.

The programme team carried out a comprehensive evaluation in 1996, based on focus group discussions and interviews with 2,000 patients, 70 retailers and more than 100 health workers in over 30 shops and 50 health centres in eight districts. The main findings were that the schemes improved the availability of drugs; fees charged in health institutions did not prevent people from obtaining drugs but higher shop prices did; charging per item was better for rational prescribing than charging per prescription; and although both schemes had sustainable aspects, neither was completely sustainable.

Mahesh Sharma was the first Nepalese Director of BNMT, appointed in 1993 and in post for four years. Towards the end of this decade Nepalese staff were beginning to run BNMT programmes, and the CHDP in particular was clearly a potential Nepalese NGO in its own right.

The three programmes were all running well and benefitting from specialist advice from the Board of Trustees (for example Dr Ian Campbell on TB, Philippa Saunders on drug schemes, Jean-Marion Aitken on CHDP), but there were concerns that these programmes were going their own separate ways and that the Trust's work was becoming less integrated.

Dr Kathy Holloway

Dr Kathy Holloway worked for BNMT from 1991 to 1998, first as a field doctor in Bhojpur and Khotang, and then as Drug Scheme Coordinator. She managed all BNMT drug supplies to government health facilities and village drug shops in eight hill districts of the Eastern Region. In 1999 she joined the WHO, where she led a programme of international training and research on promoting rational use of medicines. She also led the WHO programme on containing antimicrobial resistance. From 2010 to 2016, she was WHO's Regional Advisor on Medicines in South-East Asia, advising governments on all aspects of medicines management. Much of her work for WHO relied on drug management skills first learnt with BNMT. In 2017, having retired from WHO, she joined the Institute of Development Studies at Sussex University.

A women's literacy class in Sankhuwasabha, 1987

Patients at BNMT's TB hostel in Taplejung 1987

By 1997, after 30 years in Nepal, BNMT could have finished its work. The government was more than capable of running the TB control programme; other NGOs were establishing drug schemes based on BNMT's pioneering models; and community health programmes were developing and expanding across the country. Sustainability and Nepalisation remained part of BNMT's frequent deliberations on future direction throughout these years.

Nepal itself was heading for another and far more serious period of turmoil. The People's Movement of 1989-90 – which saw riots on the streets and mass arrests – restored the parliamentary system of government and constitutional monarchy. Then in 1996 Maoists launched a 'people's war' against the government. The result was a decade of brutal armed conflict, during which more than 13,000 people died, up to 5,000 disappeared, and over 100,000 were displaced.

5: 1997–2007: Painful and hopeful[1]

This was probably one of the most difficult periods for BNMT, with a toxic combination of political upheaval, civil war, the massacre of Nepal's royal family, and funding shortages for the Trust.

Nepal and its people were seriously affected by the Maoist insurgency, although it is clear that BNMT fared better than many other organisations. Despite gun battles in the main towns in Sankhuwasabha (Chainpur and Khadbari) and the danger of working in the midst of an armed conflict, BNMT was able to continue much of its work because of its long track record of delivery and because communities trusted it.

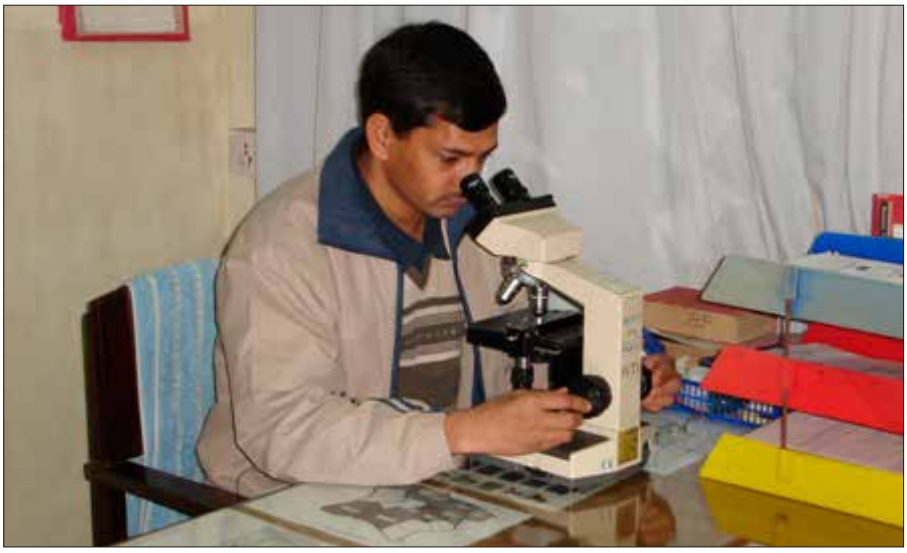
Today, the factors behind the Maoist-led insurgency are better known. Back then however, the Maoists' campaign puzzled scholars and civil society. The People's Revolution demanding more equality and rights began when Nepal had restored

1 Title of 2002/3 annual report

A post office destroyed by a Maoist bomb, Jumla, 2007

Bob Fryatt

From 1988 to 1991 Bob Fryatt worked for BNMT as a field doctor, covering Khotang and Bhojpur Districts and sharing the work with his partner Siobhan Crowley. He then returned to the NHS to complete his post-graduate public health training in London. He went on to work in public health and social policy in low, middle and high-income countries and for non-governmental, government, and multilateral organisations – including DfID, WHO, USAID and the governments of Australia and South Africa – in Asia, Africa and Europe. He specialises in public health strategy, institutional development, health systems, governance, health economics, and service delivery reforms. He is currently Director of the USAID Health Financing and Governance Project. Bob's Medical Doctorate focused on the economic evaluation of TB programmes in Nepal.



BNMT provides training and quality assurance for TB microscopy; Biratnagar 2010

democracy and was moving towards becoming a rights-based society. In addition to the impact of armed conflict on people and state institutions, the Maoists' ideology affected ways of working, especially for organisations like BNMT that had charged for some services, such as the drug schemes. After parliamentary elections in 2008 and the election of the United Communist Party of Nepal, charging for services was suddenly no longer acceptable: the regime advocated free services for all citizens, even if that meant no services. The Maoist ideology also influenced the future direction of BNMT by insisting that international NGOs must work through local partners, rather than delivering services directly. Hence the Trust's move away from operational delivery to handover of services, and a clear commitment to working with and through partners.

By 2001 the partners of the CHDP included regional and district health offices, district, village and local health committees, UNDP, and other national and local NGOs such as Save the Children. BNMT moved away from direct implementation to training and support for local NGOs, whose staff were included in all the planning, monitoring and evaluation of activities.

A wide-ranging health needs survey was carried out in 2003 to help determine future priorities and strategy, and out of this the Health Improvement Programme (HIP) was born. This refocused the work around four key themes (see box) and reinforced BNMT's role in training, research, institutional development and capacity building of local organisations and people. The HIP was designed to:

> *... improve the health services available to communities, in particular to the most marginalised groups: women, excluded castes, ethnic minorities and the poor. It seeks to build their capacity to identify and address common health problems, and demand health services that respond to their needs.*
>
> (BNMT Annual Report 2004/5)

In remote hill villages, TB patients rely on porters for transport Gorkha, 2007

Binod Chapagain

Binod Chapagain worked for BNMT from 1996 to 2000 as CHDP Programme Manager in Sankhuwasabha. He and his team developed participatory processes that empowered local women to address common health problems such as diarrhoea and respiratory tract infection, which were the major causes of death of women and children in rural Nepal. After his years with BNMT he built on his 'addiction to the participatory health development approach that I learnt from BNMT'. He developed the Participatory Organisational Capacity Analysis Process (POCAP), which enables NGOs to use participatory methods to develop and monitor their institutional capacity building plans. POCAP has been used by more than 500 NGOs in Nepal. The tool is also used in natural resources management, particularly to monitor benefits from forest resources to local women and marginalised people. He is currently Senior Programme Officer at the Center for People and Forests at Kasetsart University, Bangkok.

Health Improvement Programme

The components of the Health Improvement Programme were:

- Quality care for and prevention of infectious diseases (malaria, kala-azar, acute respiratory disease and diarrhoea)
- Reproductive health and safe motherhood
- Quality care for and prevention of TB/HIV/AIDs (including harm reduction) and STIs
- A sustainable supply of essential drugs.

Ripchet village in the Tsum valley, western Nepal 2015

The handover of all BNMT-run TB clinics, started in 1999, was completed in 2002, with all TB and Leprosy control services integrated into the government's infrastructure in all eight hill districts. Throughout this process the programme continued to achieve the WHO target of an 85 per cent treatment success rate.

BNMT's new support role now focused on:

- Training health professionals
- Supporting health workers
- Logistical support for supplies of drugs, laboratory chemicals, forms and registers
- Conducting and/or assisting in research for the NTP
- Microscopy quality assurance for the NTP.

BNMT continued to innovate, and pioneered treatment for TB-HIV co-infection, starting with a pilot project in Sunsari District in 2001. This was an essential step in a country still ravaged by TB and its co-dependency with HIV, especially as many young men returned from work in India and further afield, no longer able to work because of their illness.

The first mention of the rights-based approach to health appears in the 2002/03 annual report, which refers to empowering individuals and communities to know and demand their rights to health and health care, and to support partners to help deliver health services. In practice BNMT was also continuing with its familiar programmes, albeit in more of a facilitating role.

Schoolchildren at Salpa Pass, Sankhuwasabha, 2007

The decade ended with an annual report focused on safe motherhood, which traced BNMT's pioneering work in improving maternity services in hospitals in the 1960s, through community health leaders improving take-up of maternal and child health care in the 1970s and 80s, to the implementation of the Safe Motherhood Innovation Project with funding in the early 2000s. The project, funded by the Adventist Development and Relief Agency, went ahead despite continuing disruption caused by the Maoists, especially in Khotang and Ilam.

6: 2007–2017: Upheaval and change

Transhimalaya trek

The Transhimalaya trek Gillian Holdsworth (centre) with her porter, Sonam Sherpa (right) and a passer-by, Annapurna region 2007

In 2007 BNMT's 40th anniversary was celebrated by a Transhimalaya trek led by Dr Gillian Holdsworth with her porter of many years, Sonam Sherpa. She was joined en route by a number of former Trust members, including Dr Kathy Holloway, Bharat Gautam and Dr Siobhan Crowley. The trek started in Simikot, Humla on 2 September and finished on 11 November (71 days later) in Olangchung Gola, Taplejung. It raised £42,000 and was the start of the Great Himalayan Trail.

The 2010/11 annual report sums up Nepal's political landscape at the start of this decade:

> *With the adoption of a power-sharing interim constitution in January 2007, Nepal seemed to be back once again on the road to a democracy, albeit a fragile one. However, the challenges that Nepal faces today have never been greater or more serious and they are likely to become even more complex. Nepal is in political disarray... the change that Nepal has undergone in the recent past has been breathtaking in some respects and alarming in others. The country decided not only to embrace a republican system of government but also a federal one. In this time of political ferment every ethnic, religious, racial and linguistic group became politically conscious and aware of their rights...*

BNMT's own programmes reflected this, with the rights-based approach focusing on helping the most disadvantaged. This terminology was not embraced wholeheartedly by the Trustees in the UK, perhaps because it sounded like development jargon and seemed to take BNMT away from its core business. But in practice BNMT remained focused on its original mission of improving the health of Nepalese people. Tackling TB remained a priority, with new and significant challenges of drug resistance and the impact of HIV and AIDs.

Health education: Mr Hari Bdr Rajbanshi, who lives with HIV, talks to a youth group in Sijuwa 2010

Mrs Dhan Kumari is examined at a health post supported by BNMT in Rajghat, Morang, September 2010

Shobhana Pradhan

Shobhana G. Pradhan was Director of BNMT from 2011 to 2015. She came to the organisation with a Master's degree in Business Administration and had previously worked for F-SKILL, an organisation providing employment and training to young people from disadvantaged and difficult backgrounds. Her experience in steering F-SKILL from an international NGO to a private company was invaluable to BNMT as it explored organisational models for a long-term future. In her time at BNMT, she worked with Gillian Holdsworth to establish the Nepalese NGO Birat Nepal Medical Trust (BNMT Nepal). As one of the founders, Shobhana remains on the Board of Trustees of BNMT Nepal. At present, Shobhana works as the Programme Director for BBC Media Action in Nepal.

What is striking, reading the annual reports of this era, is that the chapter headings have changed from the 40 years of TB, Drugs, and Community to Research, Advocacy, Partnership and so on. And yet the reports for 2009–2012 retain a strong focus on TB – BNMT's core business. The renewed focus on TB was stimulated by the Trust becoming a secondary recipient (implementing partner) of the Global Fund – financing that, apart from a period when Nepal was not a recipient – continues to this day.

Two seismic changes occurred during this period that will have a lasting impact on BNMT.

First, in 2012 BNMT established and registered a Nepal-based organisation called BNMT Health that could work with BNMT as a local partner. It enabled BNMT to apply for funds available only to local NGOs and to ensure the long-term future of BNMT's vision and values in a changing political and development environment. BNMT had always known that it wanted to hand over its work – whether to the government (in the case of the TB programme) or to a local organisation that would be more sustainable than one based in the UK. This organisation was subsequently renamed Birat Nepal Medical Trust (to retain the acronym BNMT) and was formally registered in Nepal on 13 August 2012. To avoid confusion, the two organisations are now referred to as BNMT Nepal and BNMT UK. The relationship between the two is evolving, as the BNMT Nepal website explains (see box).

BNMT Nepal and BNMT UK

BNMT Nepal is governed by a board of Nepalese nationals with diverse experience in health, livelihoods, climate change, and social and community development. The BNMT Nepal board and the BNMT UK Trustees have been mentoring and transferring their knowledge, skill and experiences to the newly-formed BNMT Nepal over the past few years for the benefit of the Nepalese people. BNMT UK continues to offer this oversight and mentoring to BNMT Nepal to ensure that BNMT Nepal can benefit from the partnerships, collaboration and success of BNMT UK and attain the vision of its board.

Second, in April and May 2015, two massive earthquakes struck Nepal, killing thousands, injuring tens of thousands, and depriving millions of people of their homes, schools, health facilities and livelihoods. Many of those worst hit were the most vulnerable: the elderly and very young in the hills, in villages where the entire young male population has gone elsewhere for work, and poor families living in poor quality housing in the worst hit towns. The government, still in disarray and permanently distracted by political infighting, was in no position to provide a timely and adequate response to the devastation.

Female Community Health Volunteers at a training session in Sindhupalchowk, 2016

BNMT Nepal, with a presence across the country and especially in the areas worst affected by the earthquake, was able to quickly mobilise its teams to provide immediate support and relief. Often, it did so alongside the government, and never in competition with it. BNMT Nepal initially provided immediate relief and later much needed mental

health and psychosocial support. It subsequently supported work in communities to provide water, sanitation, hygiene, and rebuild the health sector.

BNMT national level staff at a training session on research methodology, 2012

BNMT Nepal's response to the earthquake exemplifies one of BNMT's lasting legacies: because it is relatively small and local, BNMT Nepal can respond quickly to problems as they arise. This was never more so than in this case, when the bulk of government-to-government aid has yet to be spent and thousands of people still languish in makeshift camps, unable to return to or rebuild their homes. All this was made possible by the continuing generosity of loyal and new supporters who donated nearly £200,000 to the earthquake appeal.

On 17-18 July 2015 BNMT Co-chairs Dr Gillian Holdsworth and Professor Surya Subedi organised a non-stop 100km walk across the South Downs with friends and supporters to raise money for the BNMT Earthquake appeal. The walk started in Appledore in Kent and finished in Lewes, East Sussex and raised £7,000.

Seven Sisters, East Sussex 2015. Left to right: Rosie Blandy, Andy Sparkes, Shona Duncan, Surya Subedi, Paula Willmore, Nicky Willmore, Gillian Holdsworth and Boris, the dog.

The earthquake, catastrophic though it was for so many, was the making of' BNMT Nepal, which has since grown into an organisation with a countrywide presence in 40 districts and a diverse set of funding and implementation partners. Its current projects include:

- working with the Americares Foundation to reconstruct health facilities and strengthen health services in Makwanpur District
- working with BNMT UK, with support from the Big Lottery Fund, to improve community health in five earthquake affected districts (Makwanpur, Sindhupalchowk, Nuwakot, Bhaktapur and Kathmandu)
- working with Save the Children and the Global Fund to implement the national TB Programme from January 2017 in 20 districts across the country: Ilam, Jhapa, Morang, Saptari, Sunsari, Siraha and Udayapur in the Eastern Development Region; and Achham, Baitadi, Banke, Bardiya, Dadeldhura, Dang, Doti, Kailali, Kanchanpur, Pyuthen, Rolpa, Salyan and Surkhet in the Mid and Far Western Development Regions
- working with WHO on the fifth wave of the TB Reach, which explores new ways to find active TB cases
- research collaboration with the Liverpool School of Tropical Medicine and partners on the EU-funded IMPACT TB project, which has intensified TB case-finding in Chitawan, Mahotari, Makwanpur, and Dhanusha.

BNMT UK's role now is to provide support and a small proportion of the overall funding to BNMT Nepal, which raises and receives its own funds directly. The reduced number of UK Trustees (five, including the two Co-chairs Gillian Holdsworth and Surya Subedi) reflects the reduced but important role during this transition.

Phulmaya, a staff member at the Diktel TB clinic, with her child

7: Survival strategies – how has BNMT kept going?

This report started by acknowledging how remarkable it is that BNMT has reached its 50th anniversary. But how and why was it able to do so? Previous staff and Trustees contributed their thoughts on this, and some common factors emerged:

Staying local. For all but the last few years, BNMT's focus stayed in Eastern Nepal, and its base remained in Biratnagar. This enabled the organisation to build relationships and trust with communities and government officials, and meant that it could respond to the needs of a specific area. This approach paid off during the Maoist uprising, when the trust and high regard people had for the organisation enabled it to continue working when others had to withdraw. It also enabled BNMT to keep a low profile, without getting sucked into the time-consuming 'development circus' in Kathmandu. The downside of this is that BNMT has probably had less influence than it might have had on national policy (with the exception of TB work) and remained somewhat invisible to those outside the TB world.

Good relations with government. A guiding principle of BNMT over the years has been to do work that can ultimately be handed over to the government, and to work closely with government officials. It is likely that BNMT's relationship with the MOH protected it from the more political world of the Social Welfare Council and its successors. Relationships with local government officials inevitably varied and depended hugely on personalities. But local officials knew that BNMT could be trusted to deliver and thus help them to improve their own reputation. Maintaining a technical role in support of government, in an era when many NGOs see their role as opposing or criticising government efforts, also helped.

Poverty and community focus. By focusing on TB, drug supply and community health, BNMT was focusing on helping the poor, even if that was not explicit at the outset. Although some evaluations acknowledged that some BNMT

The TB hostel in Phidim, 1987

programmes were unable to reach the poorest (for example some drug schemes and community health approaches), BNMT had greater success than many NGOs in avoiding wholesale capture of its work by the better off. In 2009/10 a special annual report entitled *Stopping TB in Nepal* states that 'TB has persisted as both a cause and a marker of persistent poverty and inequity' and BNMT has always tried to ensure that the benefits of its work reached the poorest. BNMT staff, both Nepalese and expat, were always in the field, gaining an understanding of how people really lived and what they thought about health and disease. BNMT staff were therefore trusted and respected for their knowledge and hands-on experience.

Community health leader trainers take a break, 1987

Flexible and responsive. As a small NGO working in one country, BNMT was able to set strategy locally and avoid the top-down global strategy trap. Approaches dictated from the West are rarely sufficiently tailored or sensitive to an individual country's needs.[2] BNMT has been able to adjust its resources and skills, recruit staff as required, develop training and skills to enhance its programmes, and adapt approaches when necessary to obtain funding. A strategic review carried out in 2001 noted that the 'survival [of the organisation] depends on its ability to move with the times' and this sentiment was repeated in the 2008/9 report.

Low-key approaches and low overheads. From the beginning BNMT always had more ambition than resources to back it up. Trust doctors sold personal clothes and belongings in Biratnagar to pay salaries in the late 1960s, and there were acute money worries in some years. In both its programmes and the lifestyles of all its staff, the watchword was low key and low tech, striving to make the most of limited resources. The expatriates were expected to live on volunteer pay and in simple conditions. Sir John Crofton acknowledged this approach in his letter in 1983: 'in short I know of no organisation which will give a more impressive return for a donor's money in terms of furthering the future welfare of the poor of a

2 An example of this, experienced and implemented by the author, was the Save the Children Fund UK global strategy which prioritised 'advocacy and influencing' over direct implementation. This led to the closure of four busy and highly effective maternal and child health clinics in Nepal in the 1990s – when it was quite clear that the government could not run them and was not interested in 'being influenced' by external organisations.

developing country'. The same could be said of the most recent challenges BNMT and Nepal have faced in the aftermath of the 2015 earthquake. While billions of aid dollars remain pledged and unspent, BNMT has been able to help and support people in their time of need with a fraction of this money.

Accessible treatment: TB patients are examined by doctors at a mobile chest camp, May 2012

Loyal funders. From the start BNMT benefitted from huge loyalty from key funders and supporters. In the early days this took the form of money and other resources. The fourth annual report lists more than 230 companies who supplied products (from Avon Rubber to Wrights Biscuits Ltd) and 60 financial contributors. It is impossible to name them all, but Oxfam, Christian Aid, Misereor and Save the Children all funded BNMT for many years (Oxfam for over 20 years, breaking all its own rules about paying for programmes with expatriates); the Netherlands Leprosy Relief Association (NLRA) gave important support for the TB work; ICCO consistently funded the community focus and rights-based work; the British government (ODA then DfID) intermittently supported ongoing work (including through crucial untied funds); and, latterly the Global Fund has sustained the TB work. Some commentators, both inside and outside the trust, had concerns that BNMT was at times too donor-driven. Others, however, would describe this as strategic repackaging of the Trust's work to suit the whims and fashions of the

Education materials on display Ilam district 2010

funders. Either way, BNMT has managed to sustain its work over 50 years, and has always benefitted from the crucial support and loyalty of individual donors – whether through covenants, legacies, or fundraising activities. This has provided a vital source of unrestricted funds.

Focus on sustainability from the start. In the fifth annual report (1973) the Chair of Trustees writes that the 'basic concept was that we must not start projects which would not or could not be continued when the team is no longer there'. This remained an ambition throughout BNMT's operations and led to the successful handover of the TB programme and the establishment of BNMT Nepal. The approach manifested itself in a number of ways. BNMT always tried to work alongside the government and not in competition with it. The Trust established clinics in keeping with the neighbouring health facilities, rather than grand structures that could not be maintained. It ensured that Nepalese staff were trained to a standard that would secure them government employment. It provided scholarships for clinic staff to attend a year's training at the Central Health Laboratory in Kathmandu, which brought recognition as a government lab assistant, and supported junior staff to pass their School Leaving Certificate or apply for VHW training courses.

Loyal staff. Over the years BNMT has benefitted from the commitment of its Nepalese staff. The recruitment of local people enhanced BNMT's reputation as an organisation providing access to scarce jobs and opportunities in the hills, and helped BNMT to gain trust and build strong relationships in the areas in which it worked. Many staff were with BNMT for more than 30 years, often fulfilling different roles, and some continue to support the Trust to this day.

Accessible education: a youth group puts on a street theatre performance in Rani, June 2012

Ian Baker

Ian Baker worked in Nepal in 1973 and 1974 as one of the team doctors. Despite this relatively short period in post, he went on to serve as a Trustee for 38 years. During this period (1976–2014) he was chair of the Trustees twice and had a vital role in helping to secure funds. He visited the BNMT in Nepal several times to ensure that he was up to date with the work. He was awarded the MBE for his services to BNMT in 2007.

Many expatriates who worked for BNMT maintained their association with the organisation and Nepal with both personal and professional ties: returning to work for BNMT more than once, returning to or staying in Nepal to work for other organisations, or serving as Trustees for many years on their return to the UK.

Long serving Trustees. A statement in the 15th annual report sums up BNMT's approach to its Trustees.

> *It always endeavoured to maintain a Board of Trustees which is small, committed and up to date in its knowledge of the team's work... the fact that half the Trustees are ex-team members from within the last 3 years... ensures a high level of mutual understanding and an ability to adopt a pragmatic approach without blurring of roles.*

As a result, more than half of all the Trustees have been returnees from Nepal (see chart of Trustees (page 30). The duration of some Trustees' service is notable and Ian Baker deserves a special mention (see left). The Trust also benefitted over the years from Trustees with specialist expertise in TB or drug schemes.

UK office support. BNMT in Nepal has always relied on administrative and accounting support from the UK office. Most notable for her long commitment to BNMT is Gay Peck who served as Secretary to the Trustees and provided the vital link with the team in Nepal from 1984 to this year. Tim Crees has provided essential financial advice and support to the Trustees since 1978.

8: What has BNMT achieved?

BNMT has had an impact on the health of people in Nepal, on health service provision and policies, and on the personal and professional lives of the individuals who worked for it.

Dr Kulesh Thapa, BNMT Country Director, at a health camp treating survivors of the 2015 earthquake, Sindhupalchowk

BNMT has almost certainly had an impact on the health of Nepalese in its programme area, although this has always been hard to measure. BNMT did no formal planning or objective-setting in the early years, and a series of evaluations carried out in the first 35 years were rarely able to measure impact in terms of absolute changes in health status. However, BNMT conducted some small research projects on numerous topics, many of which were described in BNMT annual reports or Nepalese or international journals.

It is clear that thousands of people have been cured of TB because of BNMT's work, because the cure rate of 85 per cent was regularly documented. It is clear that many people had successful treatment for their illnesses because of the drug schemes, in areas where drugs would not otherwise have been available. It is clear that many people have improved their knowledge, attitudes and practice about health and health care because of BNMT's community health programmes. It is clear that there are Nepalese health workers and doctors who are more knowledgeable and skilled because of training that BNMT provided. And there is a cadre of Nepalese ex-BNMT staff who gained skills and experience that enabled them to contribute to other organisations or to their own communities.

BNMT has certainly had an impact on government services and programmes. Nepal in the 1960s, and for many years after, had no history or examples of public services that worked. The general population, especially in the hills, had low expectations of what could be provided and were seldom surprised that nothing was. This was also true of many health workers, who had little or no idea of what it was like to work in an environment with drugs, equipment, and the ability to help their patients. BNMT provided a working model of what was possible in TB work and influenced the form and content of TB services and government support for them. In terms of outside influence, it was matched only by the government of Japan and, latterly, the Global Fund.

In community health and access to medicines, BNMT was often ahead of its time and provided innovative models and approaches for others to emulate. Perhaps it could have been more influential. But it certainly recognised and acted on the potential to improve outreach through local health workers and new ways

Chetri men smoking home-grown tobacco, Karnali valley, Humla, 2007

of financing drug supplies that took many years to feature more widely on the national and international agenda.

There is no doubting the impact that BNMT has had on its own staff. Many Nepalese staff went on to work for the government, or other national or international NGOs, or to use their management, organisational and community development skills to improve their own communities.

BNMT had an enormous influence on the expatriates that came to work in Nepal. In the words of one:

> *For us young expats the opportunity to really work 'out in the sticks' and to see at first hand how health services worked (or didn't) and how the community lived was invaluable and has been something I have drawn on repeatedly in my working life since.*

This hands-on experience, and the burgeoning aid scene which offered opportunities for work in international health, resulted in many people going on to positions of influence, but with the enormous advantage of understanding how things work in the real world. Some have featured in this report, and there are others who went on to work for WHO, DfID, SCF, Plan International, the World Bank and many other international organisations.

Good health and a decent income go together: BNMT's role in reconstruction after the armed conflict included support for livestock rearing projects like this one in Godak Ilam district, 2010

Annex 1
A turbulent 50 years in Nepal

When BNMT started work in 1967, Nepal had been an absolute monarchy for16 years. The royal family were revered as gods in a Hindu kingdom, and the people were ruled under an indigenous system of governance, the partyless *panchayat* system. The People's Movement in 1989-90 led to a parliamentary system of government, and a constitutional monarchy. Unfortunately, the aspirations of people calling for greater democracy were not fulfilled and within a few years an ultra-leftist party calling itself the Communist Party of Nepal (Maoist) began a brutal armed rebellion against the state. Initially limited to the Mid and Far Western regions, and inspired by a similar guerrilla movement in Peru, the Shining Path, the Maoist Party called its campaign a 'People's War'. The Maoists began their campaign by strategically targeting government buildings such as police stations and government offices.

The Maoists called for concrete solutions to inequality and poverty and for the abolition of the monarchy. After the government rejected its demands, the Maoist Party formally launched its armed insurgency. During the next decade Nepal witnessed many human rights violations and abuses by both the government security forces and the Maoists. Extra-judicial killings were recorded throughout the country.

At the height of the insurgency, in 2001, the royal family were shot dead by the heir to the throne, who then killed himself. It was the beginning of the end of monarchy in Nepal. The new King Gyanendra (who had been out of the country at the time of the massacre) deployed the Royal Nepal Army against the Maoists, a step that his older brother had pointedly refused to take. This turned the insurgency into a fully-fledged civil war, and the King declared a state of emergency, suspending all political rights and freedoms.

Absolutist and authoritarian rule united the political parties, and eventually strikes and street protests forced the King to surrender his powers to the politicians. A Comprehensive Peace Accord was signed between the Seven Party Alliance and the Maoists, which brought the Maoist Party into the political mainstream.

After years of violence, resulting in the deaths of more than 13,000 people, the disappearance of between 1,000 and 5,000, and the displacement of about 100,000 more, the guns finally fell silent. Thanks to the adoption of a power-sharing Interim Constitution in January 2007, Nepal was back on the road to democracy. The election for the Constituent Assembly took place in April 2008 and the monarchy was abolished a month later.

After more years of political stalemate, the massive earthquake of April 2015 pressured the political parties to draft and pass a constitution, which was promulgated in September 2015. This established Nepal as a federal republic and made the country secular. Unhappy with the constitutional and political developments in Nepal, India imposed an unofficial economic blockade which lasted for four months.

In June and September 2017 the second round of local elections under the new constitution were completed, and there are some signs that democracy seems to be maturing in Nepal.

Annex 2
Signs of progress: Health indicators in Nepal 1967-2015

Despite the political upheavals and natural disasters that Nepal has faced over the past 50 years, its people are living longer, healthier lives. Life expectancy increased by more than 30 years – from 38.1 years in 1966 to 70 years in 2015, growing at an average annual rate of 1.25 per cent. In the same period, the infant mortality rate shrank from 195.9 deaths per thousand live births to 29.4 deaths per thousand live births. However, infant mortality is higher in rural than urban areas, owing to lack of access to hospitals and neonatal clinics.

The number of maternal deaths fell from 4,900 in 1996 to 1,500 in 2015. The fertility rate dropped too, from six births per woman in 1966 to 2.2 in 2015. Nepal's birth rate fell gradually, from 43.3 live births per 1,000 people in 1966 to 20.2 per 1,000 people in 2015.

The incidence of tuberculosis in Nepal fell gradually from 163 cases per 100,000 people in 2007 to 156 cases per 100,000 people in 2015.

	Health indicators	1967	1977	1987	1997	2007	2011	2015
1	Crude birth rate (per 1,000 pop)[1]	43.2	42.3	39.8	34.7	25.6	22.1	20.2
2	Fertility rate (births per woman)	6.0	5.8	5.4	4.5	3.0	2.5	2.2
3	Life expectancy[2] at birth for females	38.9	44.9	52.2	61.1	67.9	69.8	71.5
4	Life expectancy[2] at birth for males	38.5	44.3	51.2	59.1	65.3	67.1	68.6
5	Life expectancy[2] at birth, total population	38.7	44.6	51.07	60.1	66.6	68.4	70.0
6	Infant mortality rate[3]	192.03	152.30	111.59	70.10	42.19	35.01	29.22
7	Maternal deaths[4]				4,700	2,700	2,000	1,500
8	Incidence of TB[5] per 100,000 pop	-	-	-	-	164.0	162.0	156.0

Source: World Data Atlas https://knoema.com/atlas/Nepal/topics/Demographics/Mortality/Infant-mortality-rate accessed on 12.09.2017

Notes

1. The crude birth rate indicates the number of live births occurring during the year, per 1,000 population estimated at midyear.
2. Life expectancy at birth indicates the number of years a newborn infant would live if prevailing patterns of mortality at the time of its birth were to stay the same throughout its life.
3. Infant mortality rate is the number of infants dying before reaching one year of age, per 1,000 live births in a given year.
4. Maternal death is the death of a woman while pregnant or within 42 days of the end of the pregnancy.
5. Incidence of tuberculosis is the estimated number of new pulmonary, smear positive, and extra-pulmonary tuberculosis cases.

BNMT in 2017

BNMT continues to support people in communities all over Nepal, with a particular focus on women, children and the elderly, and marginalised groups. Our main areas of work in 2017 were TB; water, sanitation and hygiene; mental health and psychosocial support; and access to health services in the aftermath of the 2015 earthquake.

Reconstruction

The earthquake damaged or destroyed hundreds of health service buildings in central Nepal. BNMT is helping to rebuild this vital infrastructure.

In 2016/17, the Trust rebuilt and equipped seven damaged health posts in Makwanpur, one of the districts hit hardest by the disaster. All seven are now providing a range of services including obstetrics, family planning, counselling, minor surgery and a basic emergency service.

Tistung health post: a community endeavour

After the earthquake, the villagers of Tistung, Makwanpur, relied on a health service housed in cramped quarters in the local school, working with inadequate equipment. Outpatient care, family planning, and ante- and post-natal care operated from a single room, and many patients left without seeking treatment because of the lack of privacy. The delivery room had no wash basin or IV stand.

BNMT began reconstruction work after consulting the district health authorities and the local community. Local people provided land for the site, working together to level a hillside and helping to raise money. Once the health post was finished, they helped build 200m of road to connect it to the highway.

Achievements

In 2016/17, as a result of BNMT's work:

- 300,000 people have access to purpose-built and properly equipped health posts.

> *The new health post is better in every way. It is spacious and well-equipped. I had no fear that the building might collapse any time. I could walk around easily in the hospital premises before my delivery. There is sufficient lighting, warmth and cleanliness inside the room, unlike the previous one. The toilet is also inside the building, comfortable to use even at night.*

Tistung resident **Sujana Bal**, who had her baby at the new health post in December 2016

The new health post in Tistung, Makwanpur 2017

Mental health and psychosocial support

In2016/17 BNMT trained health workers in 22 villages to identify cases of mental and psychosocial problems and refer people for appropriate treatment. The Trust also provided psychosocial support to earthquake survivors, in particular school students, to help them overcome mental trauma, fear and emotional distress.

A group discussion on signs and symptoms of mental and psychosocial problems Makwanpur 2017

Achievements

In 2016/17, as a result of BNMT's work:

- 15 Mental Health and Psychosocial Support Services (MHPSS) help desks were established in 15 villages to provide general information on MHPSS and basic counselling to local people
- 200 health workers received introductory training on MHPSS
- 608 FCHVs, community leaders, teachers and Health Facility Management Committee members received introductory training on MHPSS
- 1,598 people affected by the earthquake were given counselling
- 1,354 school students had classes on stress management
- 18 people with mental or psychosocial problems were counselled and referred to specialist facilities.

Facing fears

Shrijana Tamang (not her real name), aged 14, was referred for individual counselling by one of her teachers at the Shree Sipa Teebut Gharey Sanskrit High School. Shrijana had fainted several times and was increasingly absent from school, but the local doctor had confirmed that there was no physical cause for her fainting. Counselling provided by BNMT helped her open up, and reveal that the fainting fits had begun after she attended the cremation ritual for a dead relative. Further therapy and exercise techniques helped her relax and boosted her physical and mental strength. She says it has helped her become more positive towards her life. Now, she says, 'No matter what problems occur, I will face it, not fear it.'

Community toilets in Saatbise, Nuwakot 2017

Water, sanitation and hygiene

BNMT educates communities on the importance of safe water, sanitation and hygiene (WASH) for preventing illness, and supports them to practice healthy behaviour.

In 2016/17 BNMT built 20 toilet blocks in 15 villages in five earthquake-affected districts. The toilets are 'gender friendly' – with separate compartments for males and females. Local WASH committees supervised the construction, and will take charge of maintenance. So far, four toilet blocks have been handed over to the local committee.

Health camps

The earthquake damaged roads in the hill districts, making travel to and from remote communities difficult and precarious. BNMT took health professionals and services to some of these communities to address urgent problems, particularly for the most vulnerable: pregnant women, children, the elderly, and people injured in the earthquake.

In 2016/17 BNMT organised health camps in Bhaktapur, Sindhupalchowk and Nuwakot, with a team of specialist doctors to provide paediatric, gynaecological, orthopaedical and general medical services. Medicines were given free of charge to people who needed them, and some patients were referred to health institutions. Tests for TB were also conducted.

British medical student Arun Fryatt examines an earthquake survivor at a health camp Sindhupalchowk 2015

Achievements

In 2016/17, as a result of BNMT's work:

- 20 community toilets were built in five earthquake affected districts
- 284 FCHVs, community leaders and teachers received basic education on water, sanitation and hygiene
- 256 health workers and Health Facility Management Committee members received basic education on water, sanitation and hygiene
- 1,135 school students received basic education on menstrual hygiene management
- 490 people received information on hand-washing with soap and use of toilets.

Achievements

In 2016/17, as a result of BNMT's work:

- 890 people received medical care at health camps conducted in three-earthquake affected districts.

Tuberculosis

BNMT's TB programme is delivered in partnership with government health institutions in eastern, mid-western and far-western Nepal. The programme covers 20 districts. Its main focus is on detecting cases of TB and ensuring that people who have the disease receive treatment. This is done through three TB-related projects run in partnership with other organisations: Impact TB (supported by the European Union); TB Reach (supported by WHO) and the contributing to the National TB Programme (supported by the Global Fund/Save the Children International).

The Global Fund project operates in 20 districts, screening and testing family members of index cases, strengthening the TB-HIV cross-referral system, encouraging private sector care providers to notify TB cases, and raising awareness of TB among schoolchildren and their teachers. BNMT also worked on improving the efficiency of diagnosis by introducing a new courier system for sputum samples: volunteers transport samples collected at treatment centres weekly to the microscopy labs for testing.

The Impact TB and TB Reach projects focus on finding cases of active TB. Under these projects, we have installed six GeneXpert machines in government hospitals. The GeneXpert machine provides a molecular test for TB which is more accurate and quicker than microscopy - enabling early detection and treatment and a reduction in transmission.

Knowledge put to use

Gautam Sunar, 70, had a persistent cough, fever, night sweats and weight loss but thought he could not afford health care. So even though his condition was worsening every day, he did nothing about it.

One day, a student named Sriti Channd-Thakuri visited his house and advised him to check his sputum sample at the Khajura health post. She gave him a pamphlet explaining the signs and symptoms of TB, and a referral slip. Mr Sunar had not realised that the health post was near his home, and that he would not have to pay.

At the health post, he was diagnosed with TB and in the counselling session that followed, it emerged that he had been treated for TB 10 years previously. He was immediately enrolled for the treatment and referred for further testing.

Sriti had learnt about TB at school, from the education programme conducted by BNMT. In addition to learning how to recognise the main signs and symptoms of TB, the students were asked to encourage people with those symptoms to seek treatment.

Achievements

In 2016/17, as a result of BNMT's work:

- 1,341 microscopy centres were linked in a courier system
- 14,569 presumptive cases of TB were identified
- 172 people were diagnosed with TB
- 722 health workers received basic training on TB
- 180 doctors were oriented
- 11,929 school children received basic training about the signs and symptoms of TB
- 176 school health teachers received basic training on the sign and symptoms of TB.

Financial Report

The Financial information presented in this report does not constitute the statutory accounts of the Britain-Nepal Medical Trust. The full accounts for the year ended 31st December, 2016 have been submitted to the Registrar of Companies and the Charity Commissioners. The Independent Examiner's Report on the Trust's accounts to 31st December 2016 is not qualified in any way. A copy of the Reports and Financial Statements may be obtained from the Trust's office c/o Foot Davson Ltd, 12 Church Road, Tunbridge Wells TN1 1LG.

Balance Sheet as at 31 December 2016

	2016		2015	
	£	£	£	£
Fixed assets				
Tangible assets		935		1,169
Current assets				
Debtors	11,730		8,636	
Investments	66,053		113,100	
Cash at bank	246,383		211,282	
	324,166		333,018	
Creditors:				
Amounts falling due within one year	13,703		12,729	
Net current assets		310,463		320,289
Total assets less current liabilities		311,398		321,458
Income funds				
Restricted funds		169,670		158,051
Unrestricted funds		141,728		163,407
		311,398		321,458

The accounts have been prepared in accordance with the Companies Act 2006 and Accounting and Reporting by Charities: Statement of Recommended Practice applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (as amended for accounting periods commencing from 1 January 2016)

Directors' responsibilities:

- The members have not required the company to obtain an audit of its financial statements for the year in question in accordance with section 476;
- The directors acknowledge their responsibilities for complying with the requirements of the Act with respect to accounting records and the preparation of financial statements

These financial statements have been prepared in accordance with the provisions applicable to companies subject to the small companies' regime.

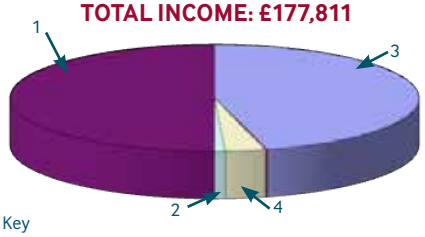
The financial statements were approved by the board of directors and authorised for issue on 14 September 2017 and are sign on its behalf by:

Dr. G M C Holdsworth (Co.Chair)

Dr. J.M.V. Payne (Trustee)

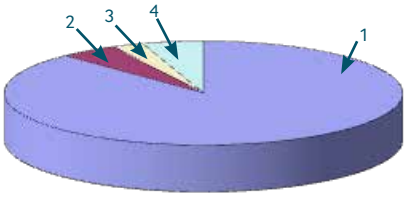
The Britain-Nepal Medical Trust is a company limited by guarantee and registered in England under number 921566
Charity Registration No. 255249

TOTAL INCOME: £177,811



Key
1. Donations and Legacies £163,047
2. Investments £611
3. Other Income £11,200
4. Gains on Investments £2,953

TOTAL EXPENDITURE: £187,871



Key
1. Direct charitable expenditure £148,172
2. Costs of generating income £14,649
3. Support costs £5,629
4. Goverance costs £19,421

Donors 2016/17

It is the generosity of our donors that makes BNMT's work possible. The Trust would particularly like to thank the following, who supported our work this year:

Anne Cadbury
A. Taylor
Ann Walters
B. Powis
Barry & Peggy High Foundation
Big Lottery Fund
C. Virgo
Cambridge Jesus Lane Quakers
D. & H.E.W. Gaunt
Charitable Settlement
J. Hudson
J. Sayers
N.J. Bennett
P. Day
Swire Charitable Trust
The Murray Charitable Trust
The Princes Trust
The Stonewall Park Charitable Trust
Wychwood School
S. Blunt - deceased
R. Hardie - deceased
W. Ritchie – deceased

We would also like to thank the many individual donors, too numerous to mention, many of whom donate every month.

BNMT Directors in Nepal 1968-2017

1968–71 John Cunningham (Leader)

1971–72 Barney Rosedale (Leader)

1972–73 Peter Curzon (Leader)

1973–74 Ian Baker (Leader)

1974–75 Nick Maurice (Leader) and Ken Tomlinson (Medical Director)

1975–76 Paddy Smyth (Leader) and David MacPherson (Field Director)

1976–77 Nigel Padfield (Acting Director) and Don Patterson (Director)

1977–79 Don Patterson (Director)

1979–82 Andrew Cassels (Director)

1982–84 Gillian Corble (Medical Director) and Frank Guthrie (Field Director)

1984–85 Penny Dawson and Jamie Uhrig (joint Medical Directors) and Frank Guthrie (Field Director)

1985–86 Penny Dawson and Jamie Uhrig (joint Medical Directors) and Steven Le Clerq (Field Director)

1986–88 Penny Dawson (Medical Director) and Steve Le Clerq (Field Director)

1988–89 Elout Vos (interim Medical Director)

1988–90 John Chalker (Medical Director) and Tony Bondurant (Field Director)

1990–92 Gillian Blackwood (Director) and Tony Bondurant (Field Director)

1992–93 Cath White (Director)

1993–97 Mahesh Sharma (Director)

1997–99 Marc Long (Director)

1999–2002 Sandra Bernklau (Director)

2002–06 Chanda Devi (Shrestha) Rai (Chief Executive)

2006–08 Anil Subedi (Chief Executive)

2008–11 Sadhana Shrestha and Bhanu B Niraula (joint Country Directors)

2011–15 Shobhana Gurung Pradhan (Country Director)

2015–17 Kulesh Bahadur Thapa (Country Director)

BNMT Trustees 1968-2017

Dates in brackets show years of work in Nepal for BNMT

Noel Leigh Taylor 1968–75

Douglas Robb 1968–75

Donald Teare 1968–75

Charles Wylie 1968–85 and 1994–96

John Cunningham 1973–90 (1968–72)

Norfolk Turner 1973–75

Barney Rosedale 1975-95 (1968–72)

Bill Acworth 1975-76

AG Patterson 1976–79

Ian Baker 1976–2014 (1973–74)

Nick Maurice 1976–2014 (1973–74)

Wallace Fox 1977–91

WF Doyle 1978–82

David Macpherson 1978–82 (1973–74)

Deborah Lehmann 1979–81 (1976–79)

Graham Heafford 1981–93 (1979–1981)

Don Patterson 1981–2013 (1971–72 and 1977–80)

Eric Heineman 1982–93 (1979–81)

Andrew Cassels 1983–91 (1977–83)

Claudia McConnell 1983–94 (1977–83)

Knut Ovreberg 1984–2008

F Gronseth 1984–94

Simon Sinclair 1986–2013 (1980–83)

Janet Darbyshire 1987–96

Nigel Padfield 1989-2006 (1976–77)

Jean Marion Aitken 1990–2000 (1987–89)

Johnny Payne 1990–present (1983–84)

Elout Vos 1990–95 (1987–89)

Ian Campbell 1991–2013

Bob Fryatt 1993–95 (1988–91)

Gillian Holdsworth 1993–present (1986–89)

Philippa Saunders 1995–2003

Ian Harper 2000–03 (1990–93)

Devika Tamang 2000–06

Pauline Wilson 2000–06

Jeff Mecaskey 2001–present (1984–87)

Andrew Freedman 2001–13

Mahesh Sharma 2006–11 (1994–98)

Sakuntala Singh 2006–10 (1992–97 and 1998–2002)

Surya Subedi 2008–present

Wendy Darby 2010-17

Raghav Dhital 2012–present

BNMT NEPAL
PROJECT COVERAGE DISTRICTS

the BRITAIN NEPAL
medical trust
serving the people of nepal since 1968

YEARS

The Britain-Nepal Medical Trust

Vision

Improved health and wellbeing of the Nepalese people.

Mission

To ensure equitable access to quality health care and an enabling environment for socially and economically disadvantaged people.

Programme focus

Health, climate change and environment – contributing to improved health, livelihood and social harmony.

Working principles

Adhere to and appreciate partnership at all levels

Ensure sustainable development

Respect for equity and diversity

Inclusion

Promote transparency and accountability

Working approaches

Human rights based

Partnerships and alliances

Participatory, gender and social inclusion

9 781527 215504 >

50 YEARS THE BRITAIN NEPAL medical trust serving the people of nepal since 1968

LOTTERY FUNDED

Registered Company Address
c/o Foot Davson Ltd • Chartered Accountants
17 Church Road • Tunbridge Wells • Kent TN1 1LG
Tel: +44 (0)7486 910807 **Email:** info@britainnepalmedicaltrust.org.uk
Web: www.britainnepalmedicaltrust.org.uk

Registered Charity No 255249