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① ミニッツ

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③ ＰＣＭ現状分析ワークショップの結果

④ 短期調査団収集資料

⑤ 保健省組織図

⑥ ネパール国内における公立病院および保健医療施設

⑦ ヌワコット郡で行われている地域保健活動

⑧ カブレ郡の小児の健康に関する基礎調査結果（ユニセフ）

⑨ 国別事業実施計画概念図

⑩ ネパール地域小児保健プロジェクト概要（案）

⑪ ネパール保健指標

⑫ ネパールにおけるマオイスト活動の拡大にともなう旅行者への危険勧告地域

① ミニッツ

THE MINUTES OF MEETING
BETWEEN
THE JAPANESE PREPARATORY STUDY TEAM
AND
THE AUTHORITIES CONCERNED OF
HIS MAJESTY'S GOVERNMENT OF NEPAL
ON
THE JAPANESE TECHNICAL COOPERATION
FOR
COMMUNITY CHILD HEALTH PROJECT

The Japanese Preparatory Study Team (hereinafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Hiroyuki Nakano visited the Kingdom of Nepal from April 2 to April 27, 2001 for the purpose of working out the details of the technical cooperation for Community Child Health Project (hereinafter referred to as "the Project").

During its stay in the Kingdom of Nepal, the Team exchanged views and had a series of discussions with the authorities concerned of His Majesty's Government of Nepal.

The Team and the authorities concerned of His Majesty's Government of Nepal discussed the matters referred to in the attached document.

Kathmandu, April 26, 2001

Dr. Hiroyuki Nakano	Dr. B.D. Chataut
Leader	Director General
Japanese Preparatory Study Team	Department of Health Services
Japan International Cooperation Agency	Ministry of Health, HMG
Japan	Nepal

The Attached Document

1. Title of the Project

Community Child Health Project

2. Beneficiaries of the Project

1) Recipient of Japanese Technical Cooperation: Ministry of Health
2) Direct beneficiary of the project: Child Health Division, Department of Health Services, Kanti Children's Hospital, Model District Health Office
3) Ultimate beneficiary: Vulnerable children in the rural area in Nepal

3. Overall Goal of the Project

Health status of under five children is improved in Nepal.

4. Purpose of the Project

Health promotion of under five children, prevention of childhood diseases and effective management of common childhood illnesses in the community.

5. Outputs of the project

1) Knowledge and skills of child health development are enhanced in the community.
2) Implementation of IMCI is broadened in the community.
3) Community activities to address management of childhood malnutrition are broadened.
4) Appropriate referral system for childhood illnesses is established.
5) IMCI training activities of Kanti Children's Hospital are extended to the community.
6) MOH's capacity to plan and implement activities for community participation and empowerment is strengthened.

6. Duration of the Project

The duration of the Project will be 5 years. The exact commencement/termination dates are determined in the Record of Discussions (R/D), which will be signed between the Japanese Implementation Study Team visiting Nepal at the end of this year, and the authorities concerned of His Majesty's Government of Nepal.

7. Administration of the Project

1) Director General, Department of Health Services, Ministry of Health will be responsible for overall management of the Project and coordination among the related divisions.
2) Child Health Division will be responsible for the implementation of the Project.
3) A Joint Coordinating Committee is to be established and will be defined in R/D to ensure better communication among relevant authorities and for smooth implementation of the Project.

8. Inputs from the Government of Japan

The Japanese side will take the following measures, which are four basic components of Japanese project-type technical cooperation, for successful implementation of the Project.

1) Dispatch of Japanese experts in relevant fields for the Project.
2) Provision of training in Japan for Nepalese counterparts designated for the Project.
3) Provision of equipment necessary for the technical cooperation of the Project.
4) Provision of local cost necessary for the smooth implementation of the Project.

9. Responsibilities of His Majesty's Government of Nepal

The responsibilities of the Government of Nepal will be specified later.

10. Notes

1) The short-term experts will be dispatched to the Ministry of Health for 3 months at around July 2001 and will materialize the details of the project design.

2) For the purpose of formulating the concrete implementation plan of the Project-based on mutual consultation, the Japanese side will send an implementation study team to Nepal at around December 2001.

PDM (Draft)

Project Name : Community Child Health Project Duration : February 1, 2002 January 31, 2007 (5 Years)

Project Area : Kavre District, Nepal Target Group : Under five Children in Community Date : April 25th, 2001

Narrative Summary	Objective Verifiable Indicator	Means of Verifiable	Important Assumptions
Super Goal Health Status of under five children is improved in Nepal			
Overall Goal Health Status of under five children is improved in Kavre	-Under five mobility/mortality rates	-DOHS Annual Report	-Outbreak of childhood illnesses does not occur.
Project Purpose Health promotion of under five children, prevention of childhood illness and effective management of Common Childhood Illnesses in the communities are achieved	-Outpatients -Inpatients -Under five death -Under five referrals -Counselling by FCHVs -Confirmed diagnosis -Mothers capable of home treatment	-Outpatient Register -Indoor patient Register -Annual Report, Baseline Survey -OPD/Emergency Register -ARI management sheet (JSI) -Hospital Register -Baseline Survey	-Project benefits are sustained long enough to demonstrate on a project goal.
Outputs 1-Knowledge and skills of child health development are enhanced in the community 2-Implementation of IMCI is broadened in the community 3-Community activities to address management of childhood malnutrition are broadened 4-Appropriate referral system for childhood illnesses is established 5-IMCI training activities of Kanti Children s Hospital are extended to the community 6-MOH s capacity to plan and implement activities for community participation and empowerment is strengthened	-Training materials prepared -Staff trained in IMCI -Workshops and seminars organized -Meetings with FCHV -Training conducted at designated health facilities -Villages with functional community level health services -Changes in the number of childhood malnutrition and micronutrient deficiency -Changes in the number of common childhood illnesses -Established alternative models of community based management of childhood illnesses -Referral U/5 children -Increased understanding in the community -Increased understanding by policy makers	-Project Progress Report -Project Progress Report -Project Progress Report -Project Progress Report -Project Progress Report -Project Progress Report -Results of the baseline and evaluation surveys -Results of the baseline and evaluation surveys -Project Progress Report -Monthly report of health facilities -Project Progress Report	-At minimum, the current level of health staff is maintained at all health facilities. -Retention of health workers at district health facilities is improved after decentralization and improved management. -Full support from Kanti Children s Hospital is given for IMCI training. -Central officials do not resign after the training. -Health management information system is strengthened.

Activities

1-1 Review and revise training module
1-2 Develop the training programs
1-3 Prepare materials for community child health
1-4 Conduct training of trainers for IMCI
1-5 Conduct training for Female Community Health Volunteers
1-6 Advocate health services
1-7 Conduct IEC activities
1-8 Improve program management capacity
2-1 Review existing training materials
2-2 Develop the training programs
2-3 Prepare IMCI materials
2-4 Provide IMCI lectures to the people in the community
2-5 Conduct training of trainers for IMCI
2-6 Visit health post to supervise IMCI
2-7 Evaluate training courses
3-1 Review existing activities
3-2 Develop programs for childhood malnutrition
3-3 Prepare materials for childhood malnutrition
3-4 Conduct training of trainers for childhood malnutrition
3-5 Conduct IEC activities to the people in the community
3-6 Improve program management capacity
3-7 Evaluate activities for childhood malnutrition
4-1 Review existing referral system
4-2 Set up criteria for the referral cases
4-3 Prepare the referral form
4-4 Conduct training for the management of childhood referral
4-5 Establish the referral network of health facilities
4-6 Monitor and evaluate the referral system for childhood illnesses
5-1 Review the existing IMCI training system in Kanti Children s Hospital
5-2 Prepare IMCI training module
5-3 Establish IMCI training system for district health workers
5-4 Enhance training capacity of Kanti Children s Hospital
5-5 Evaluate IMCI training system of Kanti Children s Hospital
5-6 Cooperate with in-country training activities in Kanti Children s Hospital
6-1 Review existing MOH s community activities for child health program
6-2 Provide essential equipment and supplies
6-3 Improve program management capacity
6-4 Strengthen health information system for child health
6-5 Conduct operational research on child health improvement
6-6 Monitor and evaluate activities

Inputs

Japanese Nepalis

1) Personnel
   Long-term experts:
   Chief advisor 1
   Nutritionist 1
   Community nurse 1
   Laboratory technician 1
   Project coordinator 1
   Short-term expert:
   Health planning
   Epidemiologist
   Health management information system
   Pediatricians (nutrition)
   Pediatrician (infectious disease)

2) Project management
   Supporting staff
   Office equipment
   Transport
   Office running cost

3) Operational cost
   Development of training materials
   Workshops/meetings
   Salary for local staff
   Cost for training
   Cost for fuel
   Water/electricity/communication

4) Equipment
   Audio-visual
   IEC materials
   Computer systems
   4WD vehicles
   Bicycles
   Weighing scales

Preconditions

-The project activities are supported by the national health policy.
-Responsibilities and flow of health budget is made clear between central ministries and district offices.
-Maoist activities do not interfere project activities.
-Communities are motivated to participate in the activities.

Baseline Surveys are needed:

Referral system
Number of mothers capable of home treatment

Annex1 Expectations from the workshop

1. To be covered by the workshop

1. To know about the means of child health Services
2. Understand existing child health network at District Level
3. Learn about the initial findings of JICA in the process of build up to this workshop
4. Share the little experience I have in the field of child health especially in Management of CS Projects
5. Analysis of problems of management (Qualitative) from periphery to central children hospital (i.e. Kanti)
6. Analysis of child health problem (Coverage & listing of all the problems in different community & locality)
7. Identify problem in child health in community
8. To list priorities in child health sector in the community for their problem
9. Community problems will be analysed
10. To know about idea of community child health
11. Problems on child health will be analysed at community level
12. Better performance of discussion by a good team
13. Lively participation to find out the effective and fruitful result
14. To get information and ideas for the project planning for child health improvement in Nepal
15. Locate the areas for child health improvement
16. Ideas and information for Project Planning will be collected
17. Problems on Community child health will be analysed
18. I get to know more people who are involved in child health in Nepal

To be covered partly by the workshop

19. Review of previous problems while implementing
20. To understand how to improve child health at community level
21. Identify the means for child health improvement
22. I get to know the vision of child health promotion in Nepal

B. Beyond this workshop

1. Discuss the project framework and design and how to achieve the objectives

Annex 2 Participation Analysis

Participants	*Characteristics*	*Interests*	*Strengths*	*Weakness*	*Suggestions*
• Medical Institutions, TU, IOM, Medical Colleges • Kanti Children Hospital	• Manpower generator • Service provider • Research activities • Advisory capacity • Monitoring agencies • Training & education	• Prevention of Disease • Management of illness (Hospital + outreach) • Hospital & community research • Promotion of health • Upgrading education	• Well established hospital • Sub-speciality Service introduced • Continuous medical education system going on • Act as main referral centre • Qualitative medical manpower • Good co-ordination with other medical institutions • Very strong IMCI training centre	• Instability of manpower • Inadequate resources • Inadequate preventive activities • Lack of social paediatrics units • Limited sub-speciality activities • Lack of research activities	• Upgrading existing service • Maintain stability of manpower • Introduction of preventive and primitive services • Take hospital out to community • Political + social commitment necessary • Regular training of manpower • Introduce research activities
• Village Development Committee/District Development Committee	• Constitutionally Elected bodies for local governance • Local level planners • Local level implementations • Supporters/ Coordinators/ Facilitators • Local level organizers	• Local development activities	• Co-ordinating as chairperson of health activities • Solution of local problems • Quick decision making • Involvement with local problem identification • Mediator between service provider & community • Decentralization in the process	• Politically biased • Diversified interests • Low education among VDC/DDC members • Poor management of available resources • Limited resources • Irregular presence of VDC/DDC members in certain districts and VDCs due to security problems	• Obtain needed firm and unbiased political commitment • Monitor resource mobilization • Obtain support of VDCs/DDCs to the project
• Ministry of Health, DoHS, CHD	• Policy maker • Main employer • Infra-structure developer • Major planner of implementator • Coordinator for international linkage • Main evaluator & supervisor • Possible counterpart organization of the project	• Improvement of child health status of Nepal • Over-all implementation of health activities	• Better health information management & dissemination • Apex of health pyramid • Possess Policy/Plan/Budget/Human Resources	• Frequent transfer of personnel • Centralized authority & decentralized responsibility (mismatch of authority, responsibilities and resources • Poor management • Too politically influenced • Mismanagement of Cadat HRD • Poor commitment	• Try for unbiased decision making • Improve financial & human resources management • Avoid political influence on decision making
• District Health Office 1. District Health Officer 2. District Health Assistants	• Part of MOH/DOHS • District level health offices responsible for health service delivery	• Optimum utilization of resources • Smooth implementation of programs • Timely supervision • Approve & Coordinate program • Implement & Supervise different programs • Provide health service to the people	• Authority • Clarity of structure • Trained human resources • Provision of financial, material resources • Well set programs • Approve & coordination of programs • Implementation & supervision of different programs	• Too much political interferences • Weak support from regional & central level • Poor infrastructure • Over lapping programs • Inadequate management of manpower budget & materials • Weak co-ordination of programs	• Provide adequate infrastructure build-up • Avoid negative political interferences • Strengthen evaluation procedures • Avoid frequent transfers • Provide management training • Strengthen surveillance system
• PHC 1. Medical officer 2. Health Assistant 3. Nursing staff	• Primary Health Care Centres • Electoral constituency	• Provide F.P./MCH program • Provide supervision of local government level health services	• Referral centre • Provision of manpower • Emergency beds delivery	• Inadequate supplies of essential drugs, stationery • Vested interest in PHC site selection • Inadequate physical presence of manpower	• Encourage training • Request adequate manpower • Infrastructure build-up (building, diagnostic facilities)

• HP/SHP 1. AHW 2. VHW 3. ANM 4. MCHW	• 1 HP serves 4-7 VDCs • Each SHP serves 1 VDC • Mobilization of CHVs • PHC outreach clinics	• Provide community health services • Provide health education	• Proximity to community • MCHW from own community • Empowerment for VDC level programs	• Less active S/HP staff • Lack of proper utilization training • Lack of supplies drugs • Inadequate training of MCHW • Poor supervision of MCHWs • Poor working conditions • Poor infrastructure of SHPs	• Implement performance evaluation • Strengthen support committee • Provide adequate & timely supplies • Initiate drugs schemes
• Village 1. FCHV 2. TBAs 3. Tradition al healers	• Community based health workers, volunteers and facilitators	• Mothers group meeting • Health education • CBD (Community based distribution of contraceptive) • Maternity & child care • Health information collection • Health services	• Community based • Referral system • Back bone of health system • Exemplary work in National programs (NID, VITA) • Good facilitators for health service provision	• Low level of education • Lack of support • Job overload	• Obtain their support for community awareness program for service utilization • Provide functional education • Field support during supervision
• District Education Office (DEO)/ Ministry of Education & Sports (MoES)	• Formal organization under ministry of education • Indirectly involved	• Provide health education • Support health activities	• Good communication system • Generally well educated & respected teachers in community • Advocates for health activities • Provide non formal education • Provide distant education	• Lack of health education materials • Lack of practical education (Child health) • Lack of trained manpower (Frequent transfer) • Politically biased	• Roles should be specified • Provide orientation and training • Obtain more support for health activities • Establish DEO-DHO collaboration system
• CBO/Mothers group/Mother/ Family	• Directly involved • Target group	• Take care of children • Improve public health services • Improve mother s health	• Can support health activities • Early detection of children s health problems • Entry point for health activities	• Lack of free time • Often limited low level of education • Lack of resources • Weak organization as CBOs	• Provide orientation & training • Strengthen child health program through mother group • Improve literacy rate (if less than 50%) • Establish functional groups (not only by name)
• JICA	• Bilateral cooperating agency at government level • Directly involved to support the project	• Improve child health services at the community level • Develop skilled human resources • Reduce IMR, U5MR, MMR	• Provide support for health programs in Central Dev. Region • Well established recognized & resourceful • Can provide good technical assistance on child health project • Child health is JICA s priority in the world • Provide volunteers in health services in all five regions	• Centralized authority • Less activity in community heath • Expensive personnel • Hiring Nepali technical staff is difficult • Too infrastructure oriented	• Should involve more in human resource development • Cooperate NGOs • Should involve more Nepali resource persons • Need to give more focus at community level • Increase involvement in difficult terrain & like Mid-Western, Far-Western
• Public Health Laboratory	• Research activities • Training & education	• Promotion of diseases • Community Research	• Good coordination with medical institutions • Referral system • Provision of finance and human resources	• Weak support from MOH • Lack of research activities	• Introduce preventive services • Provide investigation matters • Provide timely investigation • Strengthen surveillance system

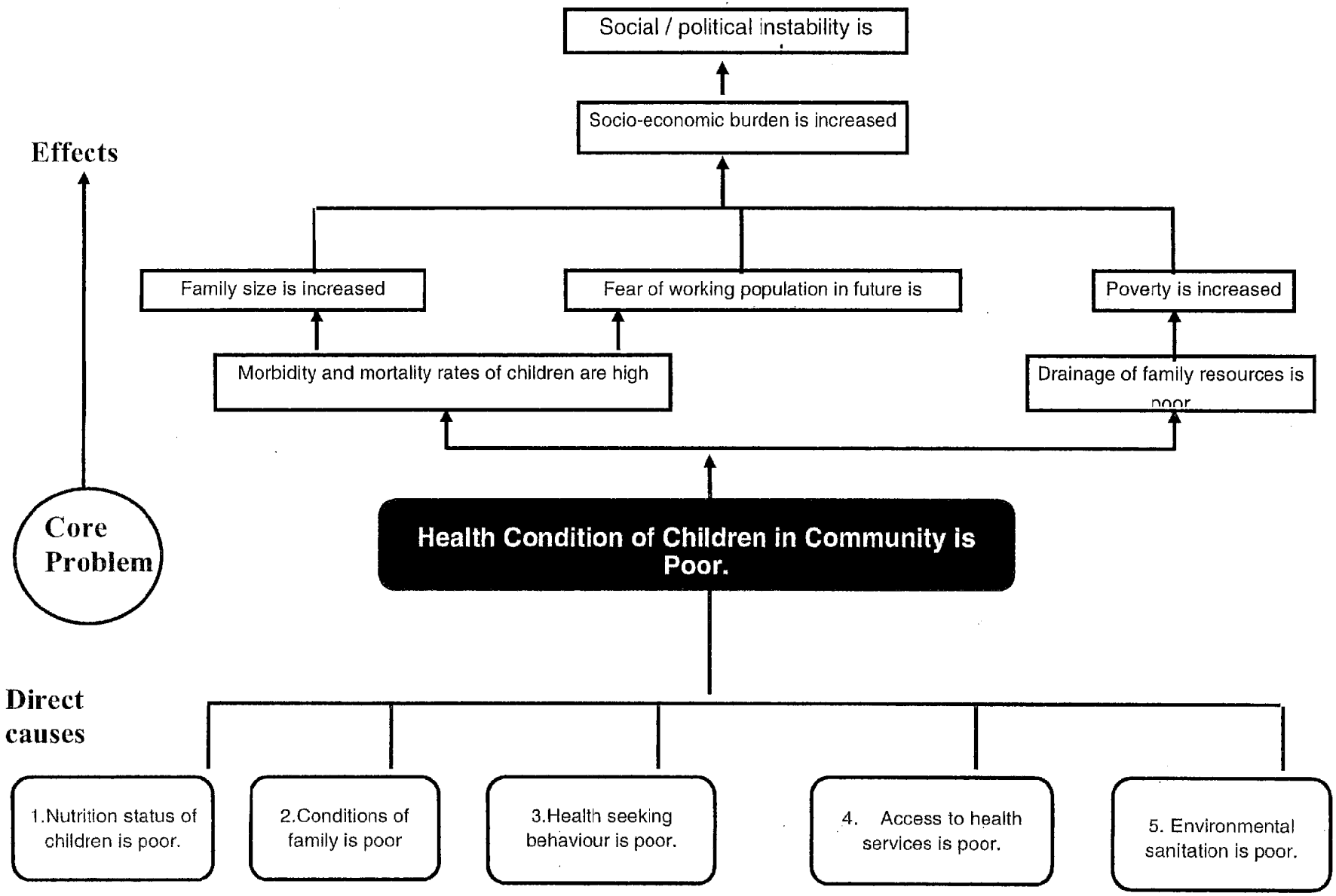
Annex 3 Problem Analysis

Direct causes	*Effect-Cause Relationship*	
• **1. Nutritional status of children is poor**	• Babies are not properly breast fed	• Baby is not breast fed exclusively • Mothers don t get enough time to breast feed • Mothers discard colostrums • Breast feeding is not properly initiated
	• Baby is born below average weight	• Mother is malnourished • Mothers smoking habit • Mother is born herself small • Maternal care is poor during pregnancy • Mothers take alcohol too excess • Women are married in early ages • Mothers are pregnant frequently • Outreach clinic is inadequate
	• Parents are poorly educated	• Educational opportunities are poor • Parents workloads are high • Many children leave school early
	• Weaning practice is poor	• Parents have poor knowledge about food • Food is not adequately available • Traditional habit are hindering good practice
	• Family is poor	• Parents economic condition is poor • Job opportunity is less
	• Child becomes frequently ill	• Unhygienic feeding is given Artificial feeding causes ill effect • Child is not taken care well • Parents are not aware of health • Parents ignore diseases • Environment is not healthy in the community • Personal hygiene is poor
• **2. Conditions of family is poor**	• Agricultural practice is poor	• Working lands are difficult to farm • They are unaware of new technology agriculture • Agriculture training is poor • Farmers have to depend on rain fed cultivation • Market of agricultural products is lacking • There is lack of diversification of crops • Parents are not educated • Land is not economical fragmented
	• Poor economic condition in country	• Industrialization is poor in country • Investors are facing risk of their workers • Political situation is unstable • Infrastructure development is poor • Present condition of law and order is another factor of poverty • Economic progress in remote areas is inadequate
	• Family is large	• People are gender biased • Family needs more manpower • Infant death is high • False belief in family planning progress • Family planning practices are poor

3. Health seeking behaviour is poor	People depend on traditional healer too much	• Presence of health worker is irregular • Faith in modern health services is lacking • Family/society is surrounded by confounding factors
	Advocacy of health services is low	• Demand from consumers is low • Self-motivation of health personnel is low • IEC services is ineffective
	Reliability of health facilities is low	• Number of health facilities is inadequate • Quality of health services is poor • Management of health delivery system is poor
	Socio-economic condition of family is poor	• Family size is large • Economics opportunities is less • Education status of family is low
	Community initiative is insufficient	• Awareness on health benefits is lacking • People depend on external supports too much • Organization of community is inadequate • Local government is inadequate
4. Access to health services is poor	• Location of health institutions is improper	• Plans can not be implemented by health system • Location of health institutions are unnecessarily interfered
	• Health facilities are inadequate	• Health facilities are ill equipped & irregularly supplied • Physical facilities of health institutions are inadequate • Allocation of budget is inadequate in health facilities • Planning for supplies and equipment is not properly done • Maintenance and repair of health facilities are poor
	• Quality of health services is not satisfactory	• Skill and knowledge of health personnel are not satisfactory • Health personnel are inadequate in number • Outreach service is not adequate • Health personnel are not supervised regularly and properly • CBOs/Volunteers are inadequately mobilized • Ineffective training of health personnel • Health personnel are not trained as per local needs • Health personnel are frequently transferred • There is less physical presence of health personal in health institutions • Discrimination against ethnic groups in service delivery
	• Transport facilities are poor	• All health facilities are not linked with all weather roads • Alternative transports are not available in the community • Vehicles are not sufficient in the rural are • Inter-sectored coordination is poor
	• In-effective referral system	• Referral system is not established • Health worker not well motivated • Family not able to use available reference system • Ambulance are not provided in all the health facilities • Communication system is poor at the rural area • Referring card is not properly honoured by all the health facilities

5. Environmental sanitation is poor	• Less sufficient amount of water is available in the community • Sewerage system is not developed in the rural area • Environmental pollution like air, water, noise are increasing in the community • Open disposal of domestic and industrial garbage exists in the community • Community is not aware of sanitation • Health behaviour is poor in the community • Health education is poor in the community • Livestock management is unsatisfactory in the community • No coordination between the DHO and District livestock office to control zoon tic diseases	

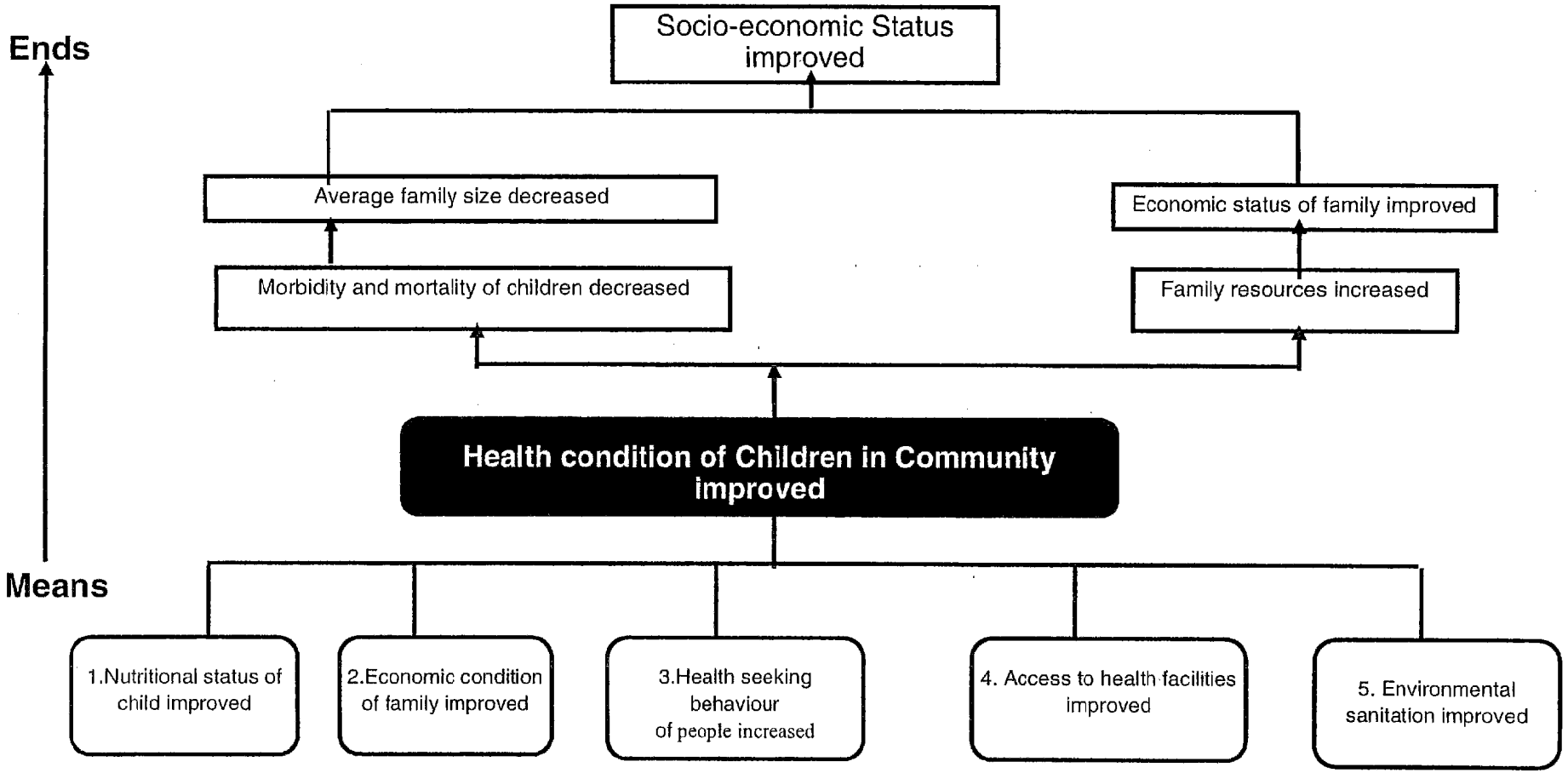
Annex 3(a) Problem Tree



Annex 4 Objective Analysis

Means	Means-End Relationships	
1.Nutritional status of child improved	• Breast feeding practices improved	• Brest feeding practice is promoted • Support provided to the working mother
	• Low birth weight infant decreased	• Antedated and neonate care provided
	• Parents are poorly educated	• School attendance improved • Educational adult education provided
	• Weaning practice improved	• Counselling on feeding practice provided
	• Frequency illness decreased	• Management of childhood illness improved
	• Economical status of family improved	• Income generating activities initiated
2. Economical condition of family is improved	• Parents are better educated	
	• Number of children in family is reduced	• Family planning practices improved acceptance
	• Improve the economic condition of the country	• Improved agricultural method promoted • Alternative income opportunities provided
	• Productivity of land increased	• Better land management systems introduced
3. Health seeking behaviour of people increased	• Dependency of traditional healers reduced	• Regularity of health workers increased • Advantages of modern health services communicated • Family and social support improved
	• Socio-economic condition of family improved	• Family planning programs provided • Economic opportunities increased • Education status of family increased
	• Level of advocacy of health services increased	• Demand from consumers increased • Self motivation of health personnel increased • Effective IEC services provided
	• Community initiation improved	• Awareness on health benefits increased • Local resources mobilized • Community organization improved • Local government made more effective
	• Reliability of health facilities increased	• Adequate number of health facilities provided • Quality of health services improved • Management of health delivery system improved • Accessibility to health facility improved
4. Access to health facilities is improved	• Health facilities properly located	• Health system implemented as planned • Location of health institutions are not unnecessarily interfered
	• Health facilities improved	• Health facilities are equipped sufficiently and regularly • Physical facilities of health institutions are adequately maintained
	• Quality of health services improved	• Skill and knowledge of health personnel are upgraded • Health personnel properly placed • Outreach services improved
	• Transport facilities improved	
	• Referral system effectively activated	• Health workers motivated for their task competition • Family encouraged in using referral system • Appropriate referral system established
5 Environmental sanitation improved	• Sufficient water supplied in the community • Awareness of community towards sanitation increased • Livestock management improved • Required sanitation system developed in rural area • Domestic waste disposed properly managed	

Annex 4(b) Objective Tree



Annex 5　PCMワークショップ日程・参加者リスト

Programme of the JICA Project Planning Workshop
on "Community Child Health"
Samelan Hall, Hotel Shangri-la
April 23~24, 2001

Day One:	**Monday, April 23**
08:30 - 09:00	Registration
	Tea/Coffee break
09:15 - 0925	Informal Opening
	Expectations for the Workshop
10:30 - 10:45	***Tea/Coffee break***
10:45 - 12:30	Participation Analysis
12:30 - 13:30	***Lunch Break***
13:30 - 15:00	Participation Analysis (Group work)
15:00 - 15:30	Presentation Group 1
15:30 - 15:45	***Tea/Coffee Break***
15:45 - 16:50	Presentation Group 2
16:50 - 17:10	Presentation Group 3

Day Two:	**Tuesday, April 24**
08:30 - 09:00	Registration
	Tea/Coffee break
09:15 - 09:40	Theory of Project Planning Method
09:40 - 10:00	Explanation of Problem Analysis
10:00 - 11:30	Problem Analysis (Group work)
11:30 - 11:45	***Tea/Coffee break***
11:45 - 12:30	Problem Analysis
12:30 - 13:50	***Lunch Break***
13:50 - 14:05	Presentation Group 3
14:05-14-25	Presentation Group 2
14:35-15:00	Presentation Group 1
15:00 - 15:20	Explanation of Objective Analysis
15:20-15:45	Objective Analysis
15:45-16:00	***Tea/Coffee break***
16:00-16:45	Objective Analysis (Group Work)
16:45 -17:05	Presentation of workshop outcome; Floor discussion
17:05 - 17:20	Closing Session
17:20- 19:00	Cocktail Reception

Annex 6 **List of Participants in PCM Workshop (Community Child Health)**

S.No.	Name	Designation	Institution
1	Dr. Hiroyuki NAKANO	Mission Leader	St. Mary s Hospital
2	Dr. Ayako TOKUNAGA	Mission Member	Former Project Formulation Advisor
3	Mr. Hiroaki YAMAZAKI	Mission Member	St. Mary s Hospital
4	Mr. Shigeki FURUTA	Asst. Resident Representative	JICA Nepal Office
5	Dr. Sushil Nath PYAKUREL	District Health Officer	Nuwakot District
6	Ms. Til Kumari GURUNG	Health Officer, Nuwakot	Save the Children (USA)
7	Mr. Madhav KHADKA	Senior Programme Officer	JICA Nepal Office
8	Mr. Katsumi ISHII	Project Coordinator	Community TB & Lung Health Project
9	Ms. Piyush PANT	Matron	Kanti Children s Hospital
10	Ms. Suhas SHRESTHA	Asst. Matron	Kanti Children s Hospital
11	Dr. T. P. RAJBHANDARI	Senior Consultant Pathologist	Kanti Children s Hospital
12	Dr. Laxman SHRESTHA	Asst. Professor	Department of Pediatrics, IOM
13	Dr. J. R. DHAKHWA	Consultant Pediatrician	Kanti Children s Hospital
14	Mr. Satish Raj PANDEY	Director, Program Management	ADRA Nepal
15	Mr. Govinda LAMICHHANE	Program Officer	School & Community Health Project
16	Mr. Gyan Bahadur BASNET	Sr. Health Assistant	DHO, Kavre District
17	Dr. G. P. OJHA	Director	Kanti Children s Hospital
18	Dr. Ranendra P. SHRESTHA	Senior Consultant Pediatrician	Kanti Children s Hospital
19	Dr. B. P. PANDIT	Senior Consultant Pediatrician	Kanti Children s Hospital
20	Dr. Masamine JIMBA	JICA Expert	School & Community Health Project
21	Ms. Izumi MURAKAMI	JICA Expert	School & Community Health Project
22	Dr. Lyndon BROWN	Technical Advisor	USAID
23	Dr. Tekendra KARKI	National Operation Officer	WHO
24	Dr. Chhatra AMATYA	Director	Planning Division
25	Ms. Padma MATHEMA	Social Sector Development Economist	National Planning Commission
26	Dr. B. D. Chataut	Director General	Department of Health Services
27	Mr. Ken Hasegawa	Resident Representative	JICA Nepal Office
	Moderator		
	Dr. P. K. ADHIKARY	Moderator	COMAT

Report Submitted To
Japan International Cooperation Agency (JICA)
Kathmandu

Communty Child Health Project (CHP)

Dr. Poorna K. Adhikary
Communication And Management Institute (COMAT)
Maharajgunj, Kathmandu
April 2001

Content

PCM Workshop Report

1. Introduction

Since last several years Nepal-Japan Cooperation has been taking place in the health sector. Japanese Government support was there in strengthening the Kanti Children Hospital (KCH). As a follow up of the earlier venture, a new project in the field of community child health is being initiated to be implemented in a district in the Central Development Region of Nepal. In this context, new roles of Kanti Children Hospital as well as Child Health Division (CHD) of the Department of Health Services of Ministry of Health are also being investigated. In April 2001 a team of experts from Japan visited Nepal on behalf of Japan International Cooperation Agency (JICA), which implements Japanese Government cooperation projects. The team made an appraisal study for the proposed project. A two day participatory workshop with the application of Project Cycle Management (PCM) was carried out during April 23-24, 2001 in Kathmandu. The objectives of the PCM workshop was to carryout the situation analysis which can help identify the project. Specifically the workshop intended to carry out:

- Participation Analysis so as to understand the groups, institutions and power centers, which can be directly, indirectly or potentially related with the proposed Community Child Health Project (CHP).
- Problem Analysis so as to understand the problem situation which calls for the CHP.
- Objective Analysis so as to understand the desirable objective conditions which can help identify potential CHP objectives and activities.

This author was contracted by JICA Nepal to assist as the workshop facilitator with the following Terms of Reference (TOR):

- Working together with the JICA Project Appraisal Team.
- Interview some important personalities of Child Health Division (CHD), Department of Health Services (DHS) and Kanti Children Hospital (KCH).
- Facilitate the two day long PCM-situation analysis workshop in collaboration with Ms.Yukari Ando, JICA Team Member PCM Facilitator.
- Report on the process and products of the PCM workshop.

The workshop anticipated participation of representatives of various actors as stakeholders. For the list of the invitees and that for those who actually participated, please refer to Annex 1. For the Tentative schedule of the workshop, please refer to Annex 2.

2. Workshop Preparation and Process

2.1 Preparation

After a brief discussion with the JICA Team experts this author interviewed Dr. G.P. Ojha, Director of KCH, Dr. S.L. Thapa, Program Manager CDD/ARI Section/CHD, Ms. Sharada Pandey, Chief, Nutrition Section/CHD and Dr. B.D. Chataut, Director-General/DHS. He also worked together with the JICA team in terms of workshop design and organization of the venue.

2.2 Workshop Process

2.2.1 Workshop opening, introduction and expectations

The workshop was informally inaugurated by a few opening remarks by Dr. Hiroyuki Nakano, JICA Appraisal Team Leader. After a brief introduction of all the participants, their expectations from the workshop were listed and analyzed if they could be covered by the workshop. They were grouped into three categories: to be covered fully by the workshop, only to be covered partly and those which are beyond this workshop. For information please refer to Annex 1.

2.2.2 PCM Concept and Participation Analysis

A small presentation was made by this facilitator on the concept of the Project Cycle Management (PCM). Here the concepts of outset situation, the objective situations and the project as a vehicle to transform the undesirable conditions of the outset situation to the desirable ones of the objective situations were discussed. The responsibilities of the different partners of the project as its participants were also discussed. Then the concept of the Participation Analysis was presented in the plenary as a part of the situation analysis. After identification of some important Project Participants in the Buzz Groups and agreed upon them in the plenary discussion, a list of eight Project Participants were identified to analyze further

in terms of their characteristics, interests, strengths and weaknesses. Based upon thus obtained information, they were also expected to make suggestions on how the project participants can be dealt by the project in terms of its planning process as well as implementation. The work was first carried out in three groups and then presented in the plenary for discussion and consensus decision. The task of the Participation Analysis was completed on the first day. For information, please refer to Annex 3.

2.2.3 Problem Analysis

The concept of the Problem Analysis was presented first in the plenary. The problem was defined as a negative/undesirable existing situation but which has a solution. Thus the problem is not conceived in the absence of a solution. The Core Problem of the problem conditions relating to the child health in Nepali community was identified through a process of the Buzz Group work and plenary discussion. The Core Problem thus identified is:

Poor Health Condition of Children in Community

The effects as well as the main causes of such a Core Problem were also identified in the plenary. The main causes are:

- Nutritional Status of Children is Poor
- Conditions of Family is Poor
- Health Seeking Behavior of (people) is Poor
- Poor access to Health Services
- Poor Environmental Sanitation

Three groups were formed to further analyze the causes and their causes of the above main causes of the Core Problem. One of the groups was also asked to complete the effects of the Core Problem. The group work products in the form of a Problem Tree, where the problems at different levels can be understood as cause-effect relationship, were presented in the plenary for discussion and consensus decision. For information on the Problem Analysis, please refer to Annex 4.

2.2.4 Objective Analysis

The concept of the Objective Analysis was presented in the plenary and the method of transforming the problem statement to the objective statement was also explained. Here the objective condition is a desirable future situation, which can be achieved realistically while resolving the problem and which is also sustainable. It was also explained how the objective conditions at different levels can be understood in terms of their means-ends relationship. The same group works which did the problem analysis were asked to do objective analysis by transforming the negative conditions to the positive conditions. The group works were completed, but due to lack of sufficient time, plenary discussion could not take place for Objective Analysis. For information, please refer to Annex 5.

2.3 Product Presentation and Closing

At the end of the two days workshop a session was organized to present the workshop products as mentioned above to higher authorities of JICA, KCH and DHS. Among others, Dr. G.P. Ojha, Director of KCH, Dr. Chattra Amatya, Director of Planning and Foreign Aid Division and Dr. B.D. Chataut, Director-General of DHS and Mr. Ken Hasegawa, Resident Representative of JICA/Nepal were present at this session. After brief presentation of the products and some discussion on them, closing remarks were made by Dr. Ojha, Dr. Nakano, Dr. Chataut and Mr. Hasegawa.

2.4 Finalization of Workshop Products

The JICA team together with this facilitator and Mr. Furuta of JICA/Nepal worked together on April 25th to go through the whole products of the workshop. Some editing as well as some substantial works were done on finalization of the Objective Analysis, which had not been discussed during the workshop due to insufficient time. The Team also added Medical Laboratory in the list of the Project Participants and which was then analyzed like the others.

3. Facilitator s Comments

3.1 Participation

As not everybody arrived in time, this workshop had difficulty to start in time. On both days it started half an hour late making a total loss of one hour of workshop time. This had effects for some time on the motivation of the rest of the participants and overall task completion. Also loss of one hour is significant in a workshop like this. This is one of the reasons why group work products on Objective Analysis could be discussed in the plenary. The complete absence of Child Health Division in the workshop is not understandable, especially when it was and still is expected to be the main counterpart of the Project for its implementation. The explanation provided was that the many of the staff of DHS were engaged elsewhere in another workshop, which happened to take place at the same time.

Although Dr. Chataut, the Director-General of DHS, assured for the Project s proper implementation, one may still question about its ownership, as the main counterpart was totally absent from the PCM workshop. Also absent were the local government representatives from the potential districts for Project implementation. This violets the basic principles of the PCM practice. Many of the other participants invited at the workshop also did not turn up. Other than such absenteeism and late arrival of some participants, the overall interests and participation at the workshop was optimal. There is no place for complain for their motivation and participation. The interests and participation demonstrated by the officials of Kanti Children Hospital has been quite remarkable.

3.2. Products

The products coming out of the two days workshop also seem quite satisfactory, although there are rooms for questioning their total validity due to absence of the main counterpart at the workshop. As mentioned above, the JICA Team together with this facilitator worked to finalize the products on the following day. This kind of work is also not very usual, as it is often expected to complete such tasks at the workshop itself. Other than this, the products are good enough for identification of a community level child health project, which can be implemented by the Department of Health Services in collaboration with Kanti Children Hospital and JICA.

3.3 Follow Up

Based upon the above products of the PCM workshop on situation analysis, JICA Team is expected to prepare a Project Design Matrix (PDM) for internal discussion in Japan between the Japanese Government and JICA. There is plenty of information needed in the situation analysis to prepare the PDM. However, it is suggested to have some advance discussion with the counterparts so that the negative experience made in this workshop with regard to their absence is not repeated again. For a cooperation project to provide enough benefits, it is essential to have ownership by the concerned counterparts and the project participants. For this reason, it would be essential to assure participation of all concerned at the next workshop on development of the Project Design Matrix at the country level as well as preparation of the Plan of Operation to implement the Project. It may be better then to plan the PCM workshop and invite the participants jointly by both JICA and the concerned HMG organization. If needed support of a local PCM advisor could also be obtained to assist the both sides in terms of workshop design, identification of the participants, venue and other logistical works.