付　属　資　料

１．ミニッツ

２．討議議事録（R/D）

1．ミニッツ

The minutes of discussions

Between
The Japanese Management Consultant Team
And The Authorities Concerned of His Majesty's Government of Nepal
On The Japanese Technical Cooperation
For The Community Tuberculosis and Lung Health Project

The Japanese Management Consultant Team (hereafter referred to as "the Team") organized by the Japan International Cooperation Agency (hereafter referred to as "JICA") and headed by Nobukatsu Ishikawa, visited the Kingdom of Nepal for the purpose of working out the details of the Technical Co-operation Program concerning the Community Tuberculosis and Lung Health Project in the Kingdom of Nepal.

During the 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 in respect of desirable measures to be taken by both Governments for the successful implementation of the above-mentioned Project.

As a result of the discussions, the Team and the authorities concerned of His Majesty's Government of Nepal agreed to recommend to their respective Governments the matters referred to in the documents attached hereto.

Kathmandu, 11th February 2002

Dr. Nobukatsu Ishikawa
Leader
Japanese Management Consultant Team
Japan International Cooperation Agency
Japan

Mr. Mahendra Nath Aryal
Secretary
Ministry of Health
His Majesty's Government of Nepal
Nepal

For Joint Coordinating Committee (JCC)
On the Japanese Technical Cooperation for
Community Tuberculosis and Lung Health Project:
September 2000 – September 2005

Monitoring report of the project
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For Joint Coordinating Committee (JCC) on the Japanese Technical Cooperation for Community Tuberculosis and Lung Health Project : September 2000 – September 2005

Monitoring report of the Project

February 11 2002

Summary

Tuberculosis (TB) control activities are going on fairly smoothly mainly for the support of national tuberculosis control program and model area improvement in urban setting. Some delay of the project results especially in laboratory activities needs to be accelerated. Activities for the improvement of acute respiratory infection case management are going on fairly well in Rupandehi. as mainly IMCI (integrated management of childhood illness) training is done and improvement of supervision for ARI cases is under preparation For the adult lung health activities, literature review on COPD (chronic obstructive pulmonary disease) has been done, a survey on COPD is going on. A basic plan for the other activities in adult lung health need to be modified, with main focus on anti-smoking activities.

I. Achievement report

1. Review of the project activities : September 2000 – February 2002

1.1. Achievement of project purpose 1. as of February 2002. : Overall performance of NTP is further strengthened

75 districts will be covered by DOTS by 2003 : Achieved by now.

85% of treatment success rate has been achieved (nationwide) by 2005 : 84.3% (10314 cure and 639 complete among 12992 smear positive new cases) for the 2056/57 <Western calendar 1999/2000> fiscal year cohort including DOTS and non DOTS cases. As for DOTS cases only, 89% cure rate.

85% of TB patients covered by DOTS by 2005. : 74% of new sputum smear positive cases for the 2056/57 fiscal year cohort. For the 2057/58 fiscal year cohort 95% of cases are covered by DOTS.

1.1.1. Achievement of outputs A as of February 2002 : Managerial capacity of the NTP is further strengthened : Indicators by PDM

Major decisions on project implementation are mutually decided by NTP and JICA team in areas covered by the project : to be investigated at the end of the project

All health personnel responsible for implementing NTP at the specific level having the clearly defined descriptions are evaluated upon their performance and provided opportunities in line with their capacity and career developments : to be investigated at the end of the project

Local NGOs, social workers, CBOs, local governments, NATA, HP are found increasingly taking part in such program as world TB day, DOTS workshops. : Some NGOs that are supporting National TB Program attended the DOTS workshops.

Experience made on the basis of implementation of the plan is found incorporated in the successive year's plan documents. : It is done according to the annual report of the department of health services.

Monitoring results of the activities A.

Activities on PDM

A1. Provide training to technical and non-technical staff : Training was done for Microscopy maintain ace and repair for QC assessors (21 trainee), 2 module trainings in Rupandehi (38 trainee) with JICA budget. For some other trainings, project technical staff joined as facilitators.

A2. Participate in international / regional / national conferences : no activities yet done except for those under A3.

A3. Continue the DOTS workshop in each DOTS implementing district : DOTS workshop, DTLA workshop and RTLA workshop are done by NTC. JICA project contributed for the DOTS workshop technically and budgetary in Kathmandu (57/58 3rd), Rupandehi (57/58 3rd), DOTS workshop technically only in Kathmandu (58/59 1st) and DTLA workshop in Central (58/59 1st) and Western (58/59 1st), and RTLA workshop (58/59 1st).

A4. Improve staff performance evaluation system : activities not yet done.

A5. Coordinate for service linkage with INGOs, donors, local governments and the private sector : TBCN meeting is held under NTC together with organizations working for TB.

A6. Carry out IEC program activities : World TB day (2001) was supported. Printing materials such as poster and pocket calendars (2001/2) were made.

A7. Review and update NTP guidelines and formats when necessary : These were done by NTC. Project technical staff contributed for the revision.

A8. Strengthen monitoring and evaluation system : On progress.

A9. Other related activities : Statistics of tuberculosis 2057/58 were compiled and is to be published as the statistical report. This will contribute for the evaluation and analysis of situations in Nepal and also for the feedback to the activities of peripheral DOTS workers.

1.1.2. Achievement of output B : management system for the laboratory and logistics of the NTP is made sustainable

Indicators by PDM

By 2005, achieve 70% case finding with proportion if smear positive patients being over 55%. : In 2000/01, 66% case (based on census population, 69% based on projected population) finding rate with the proportion of smear positive patients being 60% of pulmonary new cases.

By 2005, overall agreement rate is more than 90% with less than 5% false result : achieved.

80% functioning MCs by 2005. : achieved.

At least 80% of the equipment at all levels and at all times are found functional : 80% of microscopes are functioning (221 microscopes are functioning among 292 donated ones minus 16 ones at the stock storage). But other materials need to be surveyed.

By 2003, no instances of stores not having logistic materials in stock are reported at all the stores are achieved. : At the national level no stock out happened. In the more peripheral level, this indicator needs to be evaluated by 2003.

By 2003, drug supply at all the levels within the range of 85%-135% of requirement. : Drugs are distributed following the requirements. But the validity of requirement (stock is correctly recorded or not) needs to be checked.

Monitoring results of the activities related to output B

Activities on PDM

B1. Train HMG lab technicians for QC in all regions : Done by NTC. Technical assistance by JICA short term expert was postponed because of the security reason.

B2. Adopt a mechanism for assessing the performance of QCA : Done by NTC. Technical assistance by JICA short term expert was postponed because of the security reason.

B3.. Conduct regular regional Q.C. workshop for laboratory staff: Done by NTC. Technical assistance by JICA short term expert was postponed because of the security reason.

B4.Provide training on QCA to DTLAs : Done by NTC. Technical assistance by JICA short term expert was postponed because of the security reason.

B5.. Establish reference lab in NTC : No progress due to the lack of adequate counterpart, although some initiative has been taken by the Ministry of Health.

B6. Improve coordination between NTC and LMD : Coordination is basically done (Storekeepers in regional level attends the RTLA workshops).

B7. Improve logistics management systems for drugs, laboratory and related materials within each region : The JICA expert investigated the situations during the supervision visit and recommendations were done. A short term expert on logistics management will come in February.

B8. Adopt a system for equipment maintenance : For the maintenance of microscopes, training was done to 20 participants working for TB microscope laboratories.

1.1.3. Achievement of output C : Models for TB control in Urban and hard-to reach areas are established

Indicators by PDM

Within 2 years 70% of the estimated TB patients in the model area will have a cure rate of 85% through the use of modified DOTS method : To be evaluated later.

90% of TB patients in hilly model area(s) have DOTS services accessible within 2 hr walk : .cannot be evaluated because model area activities in hilly area are not done.

By the end of the project 80% of private practitioners (Drs, AHWs etc) in model areas will have managed (treatment and/or referral) their TB patients using NTP guidelines : Activities for private practitioners are under preparation.

80% of hospitals/nursing homes in urban areas will have DOTS clinics : Activities for private practitioners are under preparation..

The ratio of (no. of DOT sites established/estimated no. of DOT sites suitable for the model area) found progressively increased over several years : increasing

Monitoring results of the activities related to output C : Urban area, Kathmandu

Activities on PDM

C1.. Select areas (urban, hilly, prison etc.) for model demonstration : Kathmandu area is selected for model area and other area will be sought.

C2. Develop appropriate strategies for case finding and treatment : Strategy for the DOTS improvement in Kathmandu urban area has been discussed. Kathmandu municipality department of public health is fully involved in the activities and main focus has been put on late patient tracing and community mobilization.

C3. Train /orient staff in the model areas : Planned in February to March 2002.

C4. Coordinate with NGO and private practitioners : NGOs including NATA Kathmandu are involved in the activities.

C5. Establish /expand DOTS clinics in rural and urban areas : Planned in 2002.

C6. Adopt defaulter tracing system in the community : Volunteers are selected in January / February 2002 and will be trained in February / March 2002.

C7. Monitor the progress of the model areas : Monitoring workshop of volunteers and strengthening of supervision is planned in 2002.

C8. Review explicability of the approaches adopted : will be done in 2003.

Activities discussed at the JCC meeting 2001

1. Visit all general hospitals and selected NGO clinics and explore interests to participate in DOTS as treatment centre or sub-treatment centers : Because we changed the strategy from "to do both DOTS center improvement and DOTS center expansion at the same time" to "first DOTS center activities improvement and next DOTS center expansion", this activity is basically done in the next fiscal year. (activity plan 1 (C))

2. Hold advocacy meeting for political leaders such as Kathmandu Metropolitan mayors, vice mayors and ward leaders. : Vice mayor is invited to the meeting of DOTS improvement in Kathmandu municipality in November 2001. Ward chiefs are invited to the "DOTS committee orientation <re-construction>" meetings in January and February 2002.

3. Hold seminar for chest physicians on standard TB diagnosis and treatment : As in '1', this activity will be done in 2002.

4. Hold meeting for a group of NGOs on the NTP : As in '1', this activity will be done in 2002.

5. Train staff members of general hospitals and selected NGO clinics. : Basically as in '1', this activity will be done in 2002. But some training were done to these members already.

6. Provide basic equipment for DOTS clinic for general hospitals and selected NGO clinics such as cabinets, tables, chairs and water containers as necessary. : As in '1', this activity will be done in 2002.

7. Monitor and supervise general hospitals and selected NGO clinics. :As in '1', this activity will be done in 2002. However, for those who are already providing DOTS, the project joined the supervision activities.

8. Co-fund quarterly workshops for health workers for evaluation and sharing experiences : Done for the first quarter of 2058/59 (July 2001) in Kathmandu and Rupandehi. (not done in the second quarter with limitation of budget)

9. Conduct drug resistance surveys. : Not done because it is done by WHO/NTC/GENETUP. A project expert joined the technical meeting before starting.

Monitoring results of the activities related to output C : Hilly area

Activities on PDM

Due to the security problems, not starting as yet.

1.2. Achievement of project purpose 2. Functional models for improved community lung health are established.

Mortality rate due to ARI will reduce 10% by 2005 in selected areas. : No statistics is available at present. For the purpose of obtaining the result, specific survey will be necessary but with the present system and project plan, it is impossible to know.

HMG's program for the application of the models in other areas : unknown because model is not yet established.

No. of measures adopted by the registered cases in prevention of lung diseases : unknown as yet.

1.2.1. Achievement of output D : Case management of children with ARI is improved in selected districts

Indicators by PDM

All indicators are not available as yet. The project activity will enable the monitoring of these indicators.

Monitoring results of the activities related to output D :

Activities on PDM

D1-3. Conduct district-level planning workshop and DDC -level orientation, training and orientation : IMCI training is done at health facility level. (until February 7, 143 participants for the training and 2 follow up activities of training were done)

D4,5. Ensure timely and adequate provision of drugs for ARI at service delivery points and Involve the Health Management Committee (HMC) and health facilities for sustainable logistics management : CDP (community drug program) will be done by DFID in Rupandehi.

D6. Monitor and evaluate ARI case management at all levels : This will start from February 2002.

Activities discussed at the JCC meeting 2001

1. Participate in training of health staff in Danusha as facilitator. : Participated as a participant. In Danusha, other donors mainly worked and it was not necessary for JICA staff to participate as facilitators.

2. Train health staff of hospitals, health posts, sub-health posts on IMCI at zonal hospital and AMDA maternal and child hospital. : The staffs of all public health facilities were trained for IMCI in Rupandehi.

3. Procure drugs for ARI programme (or IMCI) : Not done because community drug program is done by DFID as D4-5.

4. Supervise and monitor ARI program. : This activity is planned after the completion of IMCI training in Rupandehi. Follow up of training is done in January-March 2002 and supervision and monitoring will start after completion of this "follow up ".

5. Hold quarterly workshop with Nawalparasi Districts : Not done because the activities are now focused in Rupandehi districts.

1.2.2. Case management of adults with respiratory illnesses is improved in selected areas

Case management guidelines of adult respiratory illness has been developed by the joint activities of WHO and lung health experts (adult lung health initiative). And at the meeting in 2000, the project has little role for the development and distribution of case management system. So these activities were not done and these are to be deleted from the PDM.

1.2.3. Communities adopt measures against lung health problems

Considering the too wideness of the area, the project concentrated on COPD and anti-smoking activities.

Indicators by PDM

Increased numbers of lung heath promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives ; not yet starting and cannot be evaluated.

No. of people seeking medical services for respiratory problems increase by ( )% by (2003) : Because we concentrate on anti-smoking activities, this will be better to be omitted.

By the end of the project the sample population in the targeted areas who can state the methods for preventing chronic

cough (COPD) increases by 20% : to be evaluated by the survey.

By the end of the project (5 yr.) smoking rate in the selected (targeted) area decreased by 20%; to be evaluated by the survey.

By the end of the project, 20% of the people in the targeted area adopted alternative cooking method to prevent indoor air pollution ;Because we concentrate on anti-smoking activities, this will be better to be omitted

The no. of people who have started home therapy at the beginning of respiratory infection increase by x % by 2003 ; Because we concentrate on anti-smoking activities, this will be better to be omitted.

Monitoring results of the activities related to output F :

Activities on PDM

F0.: Literature review of COPD was done.

F1-5. : Activities will be focused on anti-smoking and will be done from April 2002.

Activities discussed at the JCC meeting 2001

Prepare and conduct "base-line" survey on sings and symptoms of smoking, indoor air pollution and outdoor air pollution in the same locations investigated in 1970s and other areas. : Because of the security reason, the survey is prepared and now being conducted in Kathmandu valley. However, this activity is delayed and will be completed in May 2002.

2. Input from Japan until now.

2.1. Dispatch of experts

Long-term

Dr. Takashi Yoshiyama (Chief Advisor)	30/8/2001 - 1/3/2002
Mr. Katsumi Ishii (Project Coordinator)	7/10/2000 -6/10/2002
Dr. Jinichi Kato (Medical Expert)	7/5/2001- 6 /5/2002

Short-term

Dr. Katsunnori Osuga (TB Control)	25/11– 4/12/2000
Dr. Akira Shimouchi (Lung Health)	26/11-8/12/2000
Ms. Akiko Fujiki (TB Laboratory)	11-23/12/2000
Dr. Jinichi Kato (Lung Health)	7-24/3/2001
Dr. Nobukatsu Ishikawa (TB Control)	14-24/3/2001
Dr. Nobukatsu Ishikawa (TB Control)	25/4/-1/5/2001
Dr. Takashi Yoshiyama (TB Control :DOTS)	1-12/5/2001
Dr. Akira Shimouchi (Lung Health)	7-19/5/2001
Dr. Akira Shimouchi (Lung Health)	19-28/11/2001
Dr. Hiroyuki Nakano (Lung Health)	19-30/11/2001
Ms. Nakae Noguchi (logistics)	25/2-31/3/2002

2.2.Counterparts training in Japan (at Research institute of tuberculosis = RIT)

Dr. Shrawan Shyam Narayan Choudhary, medical Superintendant, District Health Office, Dang

"National Tuberculosis Programme Management" 8 January 2001- 25 February 2001 at RIT

Mr. Amir Khati, Senior Administrator (Chief), Kathmandu Public Health Office

"Managing Tuberculosis at intermediate -level" 14 May-12 August 2001 at RIT

Dr. Kashi Kant Jha, Senior Consultant Physician (Chest), National TB Centre

"Tuberculosis Control Management" 20 January 2002- 2 February 2002 at RIT

2.3. Equipment supply

JFY"00 (Oct /'00-Mar /'01): ¥15,721,900

Vehicles (3), Computer(1) and others

JFY'01 (Apr/'01-Mar/'02) : ¥ 3,169,004

Computer(2),Stabilizer(1), UPS(1), Mobile Electric Spiro-meter(2), Microscope Lenses(25)

Microscope Parts(6) and others

2.4. Local cost (project budget)

JFY"00 (Oct /'00-Mar /'01) US$55,388.92

JFY'01 (Apr/'01-Mar/'02) US$170,684.32

II. Plan of action for the February 2002-March 2003

1. Overall performance of NTP is further improved

1.1. Plan of action of (A) The managerial capacity of the NTP is further strengthened

Domestic training is basically done within the framework of NTC training plan. JICA will support a part in the model area. International training and conference participation will be done as part of counterpart training and technical exchange programme. IEC program will be done at world TB day meeting.

1.2. Plan of action of (B) : Management system for the laboratory and logistics of the NTP is made sustainable

Laboratory experts will be dispatched for the QC system improvement in 2002. After the appointment of laboratory technologist for the culture and drug susceptibility test, technical assistance for the reference laboratory will be made.

For the logistics management, experts will do the technical advice for the improvement of monitoring system.

1.3. Plan of action of (C) : Models for TB control in urban and hard-to reach areas are established

For the urban area, DOTS improvement in Kathmandu area municipality will be done and private sectors will be invited after the improvement of the existing system. This will be done in this year.

For the hilly area, it will be decided upon the Nepali situations.

For some difficult to reach population, operational research will be done in order to supplement the epidemiological information collected by NTC concerning HIV related TB and drug resistant TB.

1 : Long term survival of the defaulters and failure persons will be monitored at Rupandehi. and if possible for the drug resistant TB found at the drug resistance surveillance in 1999.

2: Following the result of HIV sentinel surveillance and drug resistance surveillance by NTC, necessity for the action against HIV related TB and drug resistant TB will be investigated.

2. Functional models for improved community lung health are established

2.1. Plan of action of (D) Case management of children with ARI is improved in selected districts

2(D)-1 Community based IMCI training will be done in 2002-2003.

2(D)-2 Supervision will be done by project staff together with district health office staff from 2002.

2(D)-3 IMCI room will be set up at Rupandehi PHC.

2(D)-4 Treatment outcome monitoring will be done by FCHV, VHWs for each case.

2(D)-5 Monitoring the ARI control activities at the supervision and reporting will be done.

2(D)-6 Periodical workshop of ARI will be done for the evaluation of the result.

2(D)-7 Doctors and other staff in the core hospital will be trained about IMCI.

2.2. Plan of action of (E) Case management of adults with respiratory illnesses is improved in selected areas

Plan will be decided according to the outputs of PAL Nepal, including the possibility of revision or deletion of this output component.

2.3. Plan of action of (F) Communities adopt measures for anti-smoking

2(F)-1. Complete the "base-line" survey.

2(F)-2. Consciousness assessment with focus group discussion about the need of anit smoking activities.

2(F)-3. Training of staff about communication methods and anti-smoking

2(F)-4. Health education materials will be made

2(F)-5. Conduct targeted health education about smoking (for those who have intentions or those with symptoms)

2(F)-6. Conduct "anti-smoking class" to raise the awareness of the community people.

2(F)-7. Activities against indoor air pollution will be decided after obtaining the result of the survey.

Also if some of the actvities will not be performed properly in the next 1 or 2 years, it will be necessary to discuss in the following areas,

Anti-smoking activities

Model area activity in hilly area

Reference laboratory

3. Input from JICA (plan)

3.1. Dispatch of experts

Long term experts : 3 long-term experts (chief advisor, medical experts, coordinator)

Short-term experts

Experts on Tuberculosis Laboratory

Experts on Tuberculosis Control

Experts on Logistics Management

Experts on Lung Health (ARI)

Experts on Adult Lung Health (Anti-smoking)

3.2. Counter part training in Japan

Tuberculosis Control

Tuberculosis Laboratory

3.3. Equipment supply

3.4. Local Cost

III. Proposal for the modification of PDM

1. Addition of activieits within output C

Activities proposal :

Operational research will be done.

Indicators proposal

1. existence of objective indicators about the magnitude of HIV among TB cases and those about the magnitudes of drug resistant TB among new smear positive cases.

2. Modification of output F

2.1. Purpose modification

Proposed output: Communities adopt measures for anti-smoking

2.2. Activities proposal : same as before but with emphasis on anti-smoking and component F2/F6 will be deleted..

2.3. Indicators.

"2. No. of people seeking medical services for respiratory problems increase by ( )% by (2003), 6. The no. of people who have started home therapy at the beginning of respiratory infection increase by x % by 2003" will be deleted because it is not directly related to COPD and anti-smoking.

IV. Recommendation

1. For tuberculosis control

The Managerial capacity of the NTP is further strengthened as the planned

As a counterpart, posting of laboratory technologist should be materialized for the reference laboratory in National Tuberculosis Center to promote the project plan, as soon as possible..

Model for TB control in urban area is to be further developed in Kathmandu as planned. Other area for model activities needs to be explored. Operational research should be made for the area of HIV and drug resistant tuberculosis control.

2. For non TB lung disease

IMCI program and additional component of ARI case management should be further conducted as planned.

For the component of case management of adults with respiratory illness, plan will be revised or deleted based on the outputs of ongoing PAL Nepal.

For the communities adopt measures against lung health problems, activities will focused on smoking and major activities will be with the counterpart of NHEICC (National health education information and communication centre) in collaboration with other departments and organizations. Based on the COPD survey, the necessity of inclusion of indoor air pollution activities will be discussed.

Abbreviations

AHW : Auxiliary Health Workers
ARI : Acute Respiratory Infection
CBO : Community Based Organization
CDP : Community Drug Program
COPD : Chronic Obstructive Pulmonary Disease
DDC : District Development Committee
DFID : Department for International Development
DOTS : WHO tuberculosis control strategy
DTLA : District Tuberculosis / Leprosy Assistant
FCHV : Female Community Health Volunteer
GENETUP : German Nepal Tuberculosis Project
HIV : Human Immunodeficiency Virus
HMG : His Majesty's Government
HP : Health Post
IEC : Information, Education and Communication
IMCI : Integrated Management of Child Illness
INGO : International Non Governmental Organization
JCC : Joint Coordination Committee
JICA : Japan International Cooperation Agency
LMD : Logistic Management Division
NATA : Nepal Anti Tuberculosis Association
NGO : Non Governmental Organization
NTC : National Tuberculosis Centre
NTP : National Tuberculosis Control Program
PDM : Project Design Matrix
PHC : Primary Health Center
QC : Quality Control
QCA : Quality Control Assessor
RIT : Research Institute of Tuberculosis
RTLA : Regional Tuberculosis / Leprosy Assistant
SHP : Sub Health Post
TB : Tuberculosis
WHO : World Health Organization

Project Design Matrix (PDM) for TB & Lung Health Project

Objectives	Narrative Summary						Assumptions
Overall Goal	Lung health among the people is improved						
Purposes	Overall performance of NTP is further improved			Functional models for improved community lung health are established			• Communities continue to use the services of the NTP • Achievements made in the lung health program are extended beyond the model areas
Outputs	**The managerial capacity of the NTP is further strengthened (A)**	**Management system for the laboratory and logistics of the NTP is made sustainable (B)**	**Models for TB control in urban and hard-to reach areas are established (C)**	**Case management of children with ARI is improved in selected districts (D)**	**Case management of adults with respiratory illnesses is improved in selected areas (E)**	**Communities adopt measures for anti smoking (F)**	• NTP will institutionalize the project achievements • Program support will be continued
Major Activities	A.1 Provide training to technical and non-technical staff A.2 Participate in international/regional/national conferences A.3 Continue the DOTS workshop in each DOTS implemented district A.4 Improve staff performance evaluation system A.5 Coordinate for service linkages with INGOs, donors, local governments and the private sector A.6 Carry out IEC program activities A.7 Review and update NTP guidelines and formats when necessary A.8 Strengthen monitoring & evaluation system	B.1 Train HMG lab technicians for Q.C. in all regions B.2 Adopt a mechanism for assessing the performance of QCA B.3 Conduct regular regional Q.C. workshop for laboratory staff B.4 Provide training on QCA to DTLAs B.5 Establish reference lab in NTC B.6 Improve coordination between NTC and LMD B.7 Improve logistics management systems for drugs, laboratory and related materials within each region B.8 Adopt a system for equipment maintenance	C.1 Select areas (urban, hilly, prison etc.) for model demonstration C.2 Develop appropriate strategies for case finding and treatment C.3 Train/orient staff in the model areas C.4 Coordinate with NGO and private practitioners C.5 Establish /expand DOTS clinics in rural and urban areas C.6 Adopt defaulter tracing system in the community C.7 Monitor the progress of the model areas C.8 Review replicability of the approaches adopted C.9 Operational research will be done	D.1 Conduct district-level planning workshop and DDC -level orientation D.2 Adopt IMCI training package D.3 Conduct training /orientation (for doctors, basic health staff, volunteers, traditional healers, VDC members, etc) D.4 Ensure timely and adequate provision of drugs for ARI at service delivery points D.5 Involve the Health Management Committee (HMC) and health facilities for sustainable logistics management D.6 Monitor and evaluate ARI case management at all levels	E.1 Classify common non-TB respiratory illnesses E.2 Conduct baseline studies E.3 Review existing information both in Nepal and elsewhere E.4 Plan pilot schemes in some selected areas E.5 Prepare operational guidelines including modules, formats and flow charts E.6 Conduct training for the concerned health workers /partners E.7 Implement pilot schemes in selected areas E.8 Coordinate programs with relevant partners E.9 Review replicability of the approaches adopted	F.1 Involve DOTS committees to work for lung health in coordination with other community organizations F.2 Train health staff in interpersonal communication and group work facilitation F.3 Conduct advocacy programs on lung health for the general public F.4 Conduct targeted health education F.5 Adopt participatory methods in lung health programs (e.g. anti-smoking campaign, reduction of indoor and outdoor air pollution)	A-F Vacant posts are filled and frequent transfers do not upset the program C • Private practitioners will increasingly continue to support NTP policy with DOTS • The partners will continue to cooperate as per the agreement C,F • Cooperation for DOTS will continue to be available at local level **Pre-condition:** Agreement between HMG/Nepal and Govt. of Japan is reached in time with specified human and material resources

Original :11 September 2000 ; Revised in 11 February 2002

Project Design Matrix (PDM) for TB and Lung Health Project

Objectives	Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification (MOV)
Overall goal	Lung health among the people is improved	Morbidity and mortality rates due to TB and non-TB lung illnesses are reduced over several years in Nepal	• HMG statistics • TB prevalence survey/impact study reports
Purposes	1. Overall performance of the NTP is further strengthened 2. Functional models for improved community lung health are established	1. • 75 districts covered by DOTS by 2003 • 85% of treatment success rate has been achieved (nationwide) by 2005 • 85% of TB patients covered by DOTS by 2005 2. • By 2005, mortality rate due to ARI decrease by 10% in all selected areas • HMG's program for the application of the models in other areas • No. of measures adopted by the registered cases in prevention of lung diseases	1. • Annual evaluation report of the NTP • Proceedings of national reporting and planning workshop 2. • Register/records of health institutions • MoH documents • Retrospective/prospective survey reports
Outputs	The managerial capacity of the NTP is further strengthened (A)	1. Major decisions on project implementation are mutually decided by NTP and JICA teams in areas covered by the project 2. All health personnel responsible for implementing NTP at the specified level having a clearly defined job descriptions are evaluated upon their performance and provided opportunities in line with their capacity and career development 3. By mid-2005 allocated trained staffs are found working in at least 80% of the technical posts at all levels and at all times 4. Local NGOs, social workers, CBOs, local govt. (VDC, DDC MP), NATA, HP are found increasingly taking part in such programs as world TB day, DOTS workshop 5. Experience made on the basis of implementation of the plan is found incorporated in the successive year's plan documents	1. Minutes of meeting 1. Interviews with NTP staff 2. The plan of operation and organogram 2. Interviews of the health staff 3,5 District DOTS, DTLA and RTLA workshop proceeding 4. Spot check 4. Survey report 4,6 NTP documents
	Management system for laboratory and logistics of NTP is made sustainable (B)	1. By 2005, achieve 70% case finding with proportion of smear positive patients being over 55% 2. By 2005 overall agreement rate is more than 90% with less than 5% false result 3. 80% functioning MCs by 2005 (nationwide) 4. At least 80% of the equipment at all levels and at all times are found functional 5. By 2003, no instances of stores not having logistic materials in stock are reported at all the stores are achieved 6. By 2003, drug supply at all the levels within the range of 85% - 135% of requirement	1. Case finding report of each district presented by DTLA quarterly 2. The report is presented by each QCA quarterly 3. Report is submitted by QCA during the workshop quarterly 4. Spot check, NTP documents 5,6 Monthly report from regional stores to NTP/LMD – QCA presenting status of lab materials (quarterly report) – RMS submitting monthly supply report and stock condition quarterly 5,6 Quarterly reports from district by DTLA, regional reports by RTLA quarterly – QCA presenting status of lab materials (quarterly report) – RMS submitting monthly supply report and stock condition quarterly
	Models for TB control in Urban and hard-to reach areas are established (C)	1. Within 2 years 70% of the estimated TB patients in the model area (but only 60% in hilly areas) will have a cure rate of 85% through the use of modified DOTS method 2. 90% of TB patients in hilly model area(s) have DOTS services accessible within 2 hr walk 3. By the end of the project 80% of private practitioners (Drs, AHWs etc) in model areas will have managed (treatment and/or referral) their TB patients using NTP guidelines 4. 80% of hospitals/nursing homes in urban areas will have DOTS clinics 5. The ratio of (no. of DOT sites established/estimated no. of DOT sites suitable for the model area) found progressively increased over several years 6. Existence of objective indicators about the magnitude of HIV among TB cases and those about the magnitudes of drug resistant TB among new smear positive cases.	1,2 TB register, lab register, treatment card 3,4 Spot visit 3,4 Survey report 3,4 Practitioners record 5. NTP documents

PDM Horizontal logic

Original : 11 September 2000 ; Revised in 11 February 2002

Project Design Matrix (PDM) for TB and Lung Health Project

Objectives	Narrative Summary	Objectively Verifiable Indicators (OVIs)	Means of Verification (MOV)
Overall goal	Lung health among the people is improved	Morbidity and mortality rates due to TB and non-TB lung illnesses reduced over several years in Nepal	• HMG statistics • TB prevalence survey/impact study reports
Purposes	1. Overall performance of NTP is further strengthened 2. Functional models for improved community lung health are established	1. • 75 districts covered by DOTS by 2003 • 85% of treatment success rate has been achieved (nationwide) by 2005 • 85% of TB patients covered by DOTS by 2005 2. • By 2005, mortality rate due to ARI decrease by 10% in all selected areas • HMG's program for the application of the models in other areas • No. of measures adopted by the registered cases in prevention of lung diseases	1. • Annual evaluation report of the NTP • Proceedings of national reporting and planning workshop 2. • Register/records of health institutions • MoH documents
Outputs	Case management of children with ARI is improved in selected districts (D)	1. By 2004 cure rate of pneumonia is more than 85% in the selected district with ARI program 2. By 2004, 80% of registered ARI cases are properly managed (diagnosed, treated, referred) at all levels 3. By 2004, at least 80% of the registered pneumonia (2 months – 5 years) cases have 3rd day follow-up 4. At least 80% of all age groups receive the correct dosage of medicines as per WHO standards	1. FCHV ARI treatment book 1-3 ARI register at health facilities 2. Minutes of ARI supervisors' meeting at the district level 4. Survey on practice of health staff
	Case management of adults with respiratory illnesses is improved in selected areas (E)	1. By the end 2004, guidelines available in concerned health institutions on prevention and case management (identification, classification and basic treatment) 2. Number of subsequent visits by affected people to health institutions after registration 3. Number & frequency of lung heath problem cases identified in the project area 4. Number and duration of second-line treatment cases after failure of first-line treatment 5. Number of health institutions using the prescribing guidelines in the specified areas and providing feedback for their utility and modification 6. Health workers who properly manage "chronic cough (COPD)" increased by 20%	1. Guidelines available in health institutions 2-4 Register at health facilities 5. Spot check (Supervision) 6. Survey reports
	Communities adopted measures for anti smoking (F)	1. Increased numbers of lung heath promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives 2. By the end of the project the sample population in the targeted areas who can state the methods for preventing chronic cough (COPD) increases by 20% 3. By the end of the project (5 yr.) smoking rate in the selected (targeted) area decreased by 20% • (Purchase and utilization of cigarettes • Number of non-smoking zones/villages/parks etc.) 4. By the end of the project, 20% of the people in the targeted area adopted alternative cooking method to prevent indoor air pollution	1. Records of DOT + Committees 2-4 Survey reports + Spot checks

Agenda

Joint Coordination Committee Meeting
JICA/HMG Community Tuberculosis and Lung Health Project

Chairperson : Secretary of Health
Time : 11:00-13:00, February 11, 2002
Venue : Blue Star Hotel

1. Opening remarks — Dr. B.D.Chattaut, Director General, Project Director

2. Self Introduction of Member

3. Project report
   Goal and Purpose — Dr. K.K.Jha, Act.Director, NTC
   Achievement, plan of action and comments from Japanese team
   Dr. K.K Jha, Dr.T.Yoshiyama, Dr.N.Ishikawa
   - Strengthen the managerial capacity of NTP
   - Management system of laboratory and logistics
   - Model area
   - Case management improvement for ARI
   - Case management improvement of adult respiratory illness
   - Communities adopt measures against lung problems

4 Proposal of modification of PDM

5. Discussion

6.Remarks by chairperson

7.Vote of thanks — Dr. H. D.Sah, Director, Child Health Division

8.Closing Remarks by Secretary, Mr.N.H.Aryal

Attached document
1)PDM (original / proposed one for revision)
2) Monitoring of the Project

Member of the Joint Coordination Committee Meeting

No.	Name	Designation	Organization / Company
1	Mr. Mahendra Nath Aryal	Secretary	Ministry of Health
2	Mr. Arjun B.Singh	Under Secretary	PPFA & M Division, MoH
3	Dr. Bubaneswori Datta Chatuat	Director General	Department of Health Services
4	Mr. Durga Khatiwada	Section Officer	National Planning Commission
5	Mr. Sundar Man Shrestha	Under Secretary	Ministry of Finance
6	Dr. Sarala Malla	Director	National Public Health Laboratory
7	Dr. Mahendra Bahadur Bista	Director	Epidemiology Disease Control Division
8	Dr. Hukum Dev Sah	Director	Child Health Division
9	Dr. Yashovardan Pradhan	Director	Logistics Management Division
10	Dr. Kashi Kanta Jha	Act. Director	National Tuberculosis Centre
11	Mr. Binod Bindu Sharma	Sr. Health Education Officer	National Health Education Information & Communication Centre
12	Mr. Eitaro Mitoma	Resident Representative	JICA Nepal Office, Kathmandu
13	Mr. Shigeki Furuta	Asst.Res. Representative	JICA Nepal Office, Kathmandu
14	Dr. Nobukatsu Ishikawa	Leader/ Vice Director	Management Consultation Team, JICA Research Institute of Tuberculosis, Japan
15	Dr. Takenori Yagi	Member	Management Consultation Team, JICA
16	Ms. Kiyoka Takeuchi	Member	Management Consultation Team, JICA
17	Dr. Takashi Yoshiyama	Chief Advisor	JICA/HMG CTLHP
18	Dr. Jinichi Kato	Expert	JICA/HMG CTLHP
19	Mr. Katsumi Ishii	Project Coordinator	JICA/HMG CTLHP
20	Ms. Sunita Bista	Programme Officer	JICA Nepal Office, Kathmandu