付　属　資　料

1. ミニッツ・合同評価報告書
2. PDM1（和訳）
3. 評価グリッド
4. 関連の活動実績
5. 聞き取り調査議事録
6. Project activity mid term report

1. ミニッツ・合同評価報告書

MINUTES OF MEETINGS
BETWEEN THE JAPANESE MID-TERM EVALUATION TEAM AND THE AUTHORITIES CONCERNED OF HIS MAJESTY 'S GOVERNMENT OF NEPAL ON JAPANESE TECHNICAL COOPERATION FOR THE COMMUNITY TUBERCULSIS AND LUNG HEALTH PROJECT

The Japanese Mid-term Evaluation Team (hereinafter referred to as "the Team"), organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Dr. Katsunori OSUGA, has been visiting the Kingdom of Nepal from March 3 to 15, 2003. The purpose of the Team was to monitor the activities and evaluate the progress made so far in the Community Tuberculosis and Lung Health Project (hereinafter referred to as "the Project").

During its stay, both the Team and the authorities concerned of His Majesty's Government (hereinafter referred to as "both sides") had a series of discussions and exchanged views on the Project. Both sides jointly monitored the activities and evaluated the progress based on the Project Design Matrix (hereinafter referred to as "PDM").

As a result of the discussions, both sides agreed upon the matters described in the document attached hereto.

Kathmandu, March 14, 2003

Dr. Katsunori OSUGA
Leader
Mid-term Evaluation Team
Japan International Cooperation Agency
Japan

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

JOINT EVALUATION REPORT
ON JAPANESE TECHNICAL COOPERATION
FOR
THE COMMUNITY TUBERCULOSIS AND LUNG HEALTH PROJECT

Japan International Cooperation Agency, Japan
And
His Majesty's Government of Nepal

March 14, 2003

Joint Evaluation Report
Table of Contents

K.O.

Abbreviations

AHW : Auxiliary Health Workers
AIDS : Acquired Immunodeficiency Syndrome
ARI : Acute Respiratory Infections
ARTI : Annual Risk of Tuberculosis Infection
BNMT : Britain Nepal Medical Trust
CB-IMCI : Community Based Integrated Management of Childhood Illnesses
CBO : Community Based Organization
CDP : Community Drug Program
COPD : Chronic Obstructive Pulmonary Disease
CPs(C/Ps): Counterparts
CTLHP : Community Tuberculosis and Lung Health Project
DDC : District Development Committee
DFID : Department for International Development
DOTS : Directly Observed Treatment, Short course
DPHO : District Public Health Office/r
DTLA : District Tuberculosis / Leprosy Assistant
FCHV : Female Community Health Volunteer
FGD : Focus Group Discussion
FY : Fiscal Year
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 Childhood Illnesses
INGO : International Non-Governmental Organization
IUATLD : International Union Against Tuberculosis and Lung Diseases
JCC : Joint Coordinating Committee
JICA : Japan International Cooperation Agency
LHL : Norwegian Heart and Lung Health Association
LMD : Logistics Management Division
MDR : Multi-Drug Resistance
MOH : Ministry of Health
NATA : Nepal Anti-Tuberculosis Association
NGO : Non-Governmental Organization
NHIECC : National Health Information, Education and Communication Centre
NRL : Netherlands Leprosy Relief

K. O.

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NTC : National Tuberculosis Centre
NTP : National Tuberculosis Control Program
PCM : Project Cycle Management
PDM : Project Design Matrix
PHC : Primary Health Care Center
QC : Quality Control
QCA : Quality Control Assessor
RD(R/D) :Record of Discussions
RIT : Research Institute of Tuberculosis
RTC :Regional Tuberculosis Centre
RTLA : Regional Tuberculosis / Leprosy Assistant
SAARC : South Asian Association for Regional Cooperation
SHP : Sub-Health Post
TAG : Technical Advisory Group
TB : Tuberculosis
TBCN : Tuberculosis Control Network
TBCP : Tuberculosis Control Project, JICA, Phase 1 and 2
TSI : Tentative Schedule of Implementation
URTI : Upper respiratory tract infections
VDC : Village Development Committee
VHW : Village Health Workers
WHO : World Health Organization

K. O.

1. Introduction

1.1 Preface

Japan International Cooperation Agency (JICA) has collaborated with His Majesty's Government of Nepal (HMG/N) in implementing the Community Tuberculosis and Lung Health Project (Hereinafter referred to as "the Project") with two target activities in line with national policies in each area. One is tuberculosis control and the other is control of lung diseases other than TB. The Project was initiated in September 2000 and will be completed by the end of August 2005.

The Project has continued the support to the National Tuberculosis Control Program through the improvement of tuberculosis control in Kathmandu, technical advice to the logistics, and general support to National Tuberculosis Centre. In the field of other lung diseases, activities for the improvement of case management of the acute respiratory infections (ARI), and activities for the promotion of anti-smoking have been carried out. In the field of case management of ARI, the Project has conducted IMCI training, and carried out activities to improve supervision of childhood disease management. Special emphasis was placed on the management of ARI. The IMCI training has contributed to the improvement of the knowledge of health workers. As a result, it has been observed that both case management skills and case finding of ARI cases have improved in Rupandehi District. In the field of promotion of anti-smoking activities, pilot interventions are going on in 3 VDCs. The impact on people's smoking behavior needs to be assessed in the future.

This time, since the first half of the cooperation period has passed, the Japanese Mid-term Evaluation Team dispatched by JICA has been visiting Nepal from March 3 to 15, 2003 for the purpose of evaluating the activities and the achievements of the Project. The evaluation has been jointly undertaken by the Nepalese and the Japanese Evaluation Team, concerned with the Project.

1.2 Objective of the Visit

Objectives of the visit are as below:

(1) To grasp the inputs of the Nepalese and Japanese sides to the Project and assess progress of the plan of the Project.

(2) To carry out a comprehensive evaluation on the progress of the Project from the viewpoints of five criteria (explained later in this document).

(3) To make recommendations for the future perspective of the Project, and to revise the second half of the implementation plan of the Project.

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1.3 Evaluators

(1) The Japanese side

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Ms. Shinobu MAMIYA	Researcher, Global Link Management Inc.
Mr. Shigeki FURUTA	Assistant Resident Representative, JICA Nepal Office
Dr. Takashi YOSHIYAMA	Chief Advisor, JICA CTLHP

(2) The Nepalese side

Mr. Mahendra Nath Aryal	Secretary for Health, Ministry of Health (MOH), Chairman of JCC
Dr. Bhubanesori Datta Chataut	Chief Specialist Policy, Planning & International Coordination Division, MOH
Dr. Benu Bahadur Karki	Chief, PP & International Coordination Division, MOH
Dr. Laxmi Raj Pathak	Ag.Director General, Department of Health Service
Dr. Dirgh Singh Bam	Director, National Tuberculosis Centre
Dr. Mahendra Keshari Chhetri	Director, Logistic Management Division
Dr. Govinda Prasad Ojha	Director, Child Health Division, MOH
Dr. Sarala Malla	Director, National Public Health Laboratory
Dr. Kashi Kant Jha	Senior Consultant Chest Physician
Mr. Ramesh Neupane	Ag. Director, National Health Information, Education and Communication Centre (NHIECC)
Dr. Padam Bahadur Chand	Director, Epidemiology & Disease Control Division, MOH
Mr. Gyanendra Kumar Shrestha	Undersecretary, National Planning Commission
Mr. Lal Shankar Ghimire	Undersecretary, Ministry of Finance

1.4 Methodology of Evaluation

The Evaluation Team conducted surveys in the project site and interviewed the counterpart personnel, collaborating donor agencies, NGO/INGOs, residents and patients in the model areas as well as the Japanese experts involved in the Project. The Team analyzed and evaluated the Project by means of Accomplishment Grid and Evaluation Grid from the viewpoints of evaluation criteria following the Project Cycle Management (PCM) method. Finally, the Team made a set of recommendations.

Accomplishment of the Project in terms of Inputs, Activities and Outputs were assessed in comparison with the R/D, the Project Design Matrix (PDM0) as shown in Annex 1.

1.5 Criteria for Evaluation

Both sides reviewed all activities and achievement, and evaluated the Project based on the following five aspects:

(1) Relevance	Relevance of the Project is reviewed by the validity of the Project Purpose and Overall Goal in connection with the government development policy and needs of tuberculosis patients in Nepal.
(2) Effectiveness	Effectiveness is assessed to what extent the Project has achieved its purpose, clarifying the relationship between the Project purpose and outputs.
(3) Efficiency	Efficiency of the Project implementation is analyzed with emphasis on the relationship between outputs and inputs in terms of timing, quality and quantity.
(4) Impact	Impact of the Project is assessed in terms of positive /negative, and intended/unintended influence caused by the Project.
(5) Sustainability	Sustainability of the Project is assessed in terms of organizational, financial and technical aspects by examining the extent to what the achievements of the Project will be sustained or expanded after the Project is completed.

1.6 Information for Evaluation

In order to evaluate the past performance, the following materials were used:

1) The Record of Discussions (R/D), Tentative Schedule of Implementation (TSI), Technical Cooperation Program, Annual Work Plans, Minutes of Discussions, and other documents agreed to or accepted in the course of implementation of the Project.
2) The Project Design Matrix
3) Input and output data from the Project
4) Result of series of interviews and questionnaires

1.7 Preparation of the PDM for evaluation

As a result of discussions between the Team and the Nepalese authorities concerned, the PDM for evaluation (hereinafter called "PDMe") was created as shown in Annex 2, considering the changed circumstances of the Project and the actual activities carried out.

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2. Achievements and Implementation Process

2.1 Inputs

2.1.1 Japanese Side

a) Experts

i. Long-term experts: A total of four (4) long-term experts have been dispatched. They are the Chief Advisor, Project Coordinator, and the expert on Lung Health.

ii. Short-term experts: A total of eighteen (18) short-term experts have been dispatched. The fields of experts are as follows:
TB Control, Lung Health, TB Laboratory, Epidemiology, Logistics, Tobacco Control.

The list of experts is shown in Annex 3.

b) Provision of machinery and equipment

The machinery and equipment worth approximately 49 million Japanese yen in total have been provided.

The list of equipment is shown in Annex 4.

c) Trainings for Counterparts

The total of six (6) counterparts have been trained under the C/P training scheme in Japan in the fields of Tuberculosis Control, TB Programme Management, and TB Laboratory Management at the Research Institute of Tuberculosis (RIT) in Japan.

The list of these trainings is shown in Annex 5.

d) Others (Local cost support)

For the effective and smooth implementation of the Project, a total amount of 51million Japanese yen has been provided since the project was started. The breakdown by item of expense of each year is shown in Annex 6.

2.1.2 Nepalese Side

a) Identification of counterpart personnel

Twenty-one (21) responsible persons have been identified to implement the Project by the Nepalese side.

The list of counterpart personnel is shown in Annex 7.

b) Office space for experts

The office space for Japanese experts has been provided on the 1st floor of NTC building.

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c) Allocation of budget

The project has been supported by the budget under NTP, Nepal. The breakdown by item of expense of each year is shown in Annex 6.

2.2 Achievement of Activities

Activities consist of the following thirty (30) fields as shown in the PDM. Activities were reviewed at Workshop by discussions among those Nepalese counterparts and Japanese experts who have been involved in the Project. Activities completed and ongoing at the time of evaluation are summarized as follows: The italicized sentences below shows the proposed solutions discussed in the workshop. For the details of discussion results, see Annex 8.

Activities	Results
1.1 Provide training to technical and non-technical staff. Participate in the international /regional, national conferences	Twenty (20) trainees from laboratory were trained by the trainer from Dec. 13-15, 2001 in regard to equipment maintenance. Joining the domestic training at NTC as follows: Doctors on HIV and TB 3 times, Lab technician and statistics officers on surveillance once, storekeepers on combined drug 4 times. In Oct. 2002, 3 CPs joined the global congress on lung health in Montreal. In Nov. 2002, 4 visited Cambodia through technical exchange program.
1.2. Strengthening the monitoring and evaluation system by conducting DOTS workshops, regional, national workshop, and national review (national and international).	DOTS workshops are conducted every 4 months (Mar, Jul, and Nov.) at 75 districts by NTC. Chief Advisor and technical staff joined in those held at Kathmandu, and Rupandehi.
1.3 Improve staff performance evaluation system	The activity has been done by NTC.
1.4 Coordinate for service linkages with INGOs, donors, local governments and the private sector.	Continue TBCN under the chairmanship of NTC director and initiative of Nuffield institute. Recent topics are on HIV/AIDS.
1.5 Carry out IEC program activities.	Every year, IEC program has been done at world TB day.
1.6 Review and update NTP guidelines and formats when necessary	NTP manuals were published in 1990s. They have been revised with the support of the Project. (3 publications – NTP manual, lab manual, modules, volunteer training manual.) For the details of publication and printing, see Annex 9.
2.1 Train HMG lab technicians for QC in all regions	Trainings have been done by NTC.
2.2 Adopt a mechanism for assessing the performance of QC	The system of assessment of QCA is implemented by NTC. Its performance needs improvement. *Human and material resources are needed to strengthen the national QCC.*
2.3 Conduct regular regional QC workshop for laboratory staff	The activity has been done by NTC.
2.4 Provide training on QCA to DTLAs	The activity has been done by NTC. *RTLA were trained and orientation was given to DTLAs and future training has been planned.*

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2.5 Establish reference lab in NTC	The activity is behind the schedule due to the delay of appointment of CP. One short-term expert arranged the equipment / staffing. (Aug. 02) Equipment in FY of 2002 will arrive in July 2003. CP started working in Feb. 2003. *Human and material resources are needed. One medical technologist has been recruited. And there is a need to have a microbiologist or to train the available person.*
2.6 Improve coordination between NTC and LMD/ Improve logistics management systems for drugs, laboratory and related materials within each region.	Short-term experts recommended "the implementation of the regular actual physical verification" at all levels. Improvement was reported by logistics of short-term experts. (Jan. – Mar. 2003) *There was a transportation problem. For proper planning, plan beforehand for seasonal problems.*
2.7 Adopt a system for equipment maintenance	Equipment maintenance training was done and the follow-up of training was done as reported. The status of equipment maintenance is recorded at the achievement. *There is a lack of trained manpower. And no regular maintenance was conducted. Therefore, semi-annually, or annually maintenance services to be developed. And microscope maintenance training is to be given to district staff also.*
3.1 Urban DOTS improvement (strategy, training, coordination, DOTS center, late patient training), KTM	Urban areas in Kathmandu were selected for model demonstration of DOTS improvement. The late patient tracing with mobilization of volunteers through strengthening of DOTS committee was developed. *Late patient tracing system should be strengthened.*
3.2 Hilly DOTS improvement (strategy, training, coordination, DOTS center, late patient training)	Japanese input has been limited due to the security reasons.
3.3 Urban, Coordinate with NGOs and private practitioners, KTM	Private sector orientation is in progress. *It is necessary to further involve factories and industries.*
3.4 DOTS improvement (strategy, training, coordination, DOTS center, late patient training) e.g. Rupandehi	Based on the result of interventions on DOTS committee re-activation / volunteer mobilization, late patient tracer will be introduced in some DOTS areas with higher defaulter rate.
3.5 Coordinate with NGOs and private practitioners, e.g. Rupandehi	Coordination with NGOs/ INGOs, and private practitioners has been progressed smoothly.
3.6 Monitor the progress of the model areas	*Regular supervision should be continued.*
3.7 Framework of the model is developed with adaptabilities to other areas with necessary modification.	*Framework of the model has been nearly completed. It could be replicable in other urban setting once it is finalized.*
3.8 Operational research is conducted. -HIV seroprevalence evaluation. Strengthening case finding among HIV positive persons DOTS plus, initiated by NTC/WHO.	*This is a new activity. Discussions of operational research were done.*

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4.1 Conduct district-level planning workshop and DDC-level orientation	For health facility staff and doctor's level planning meeting and DDC-level orientation was conducted on July 2001. For village health workers, health volunteers level and traditional healers, district level planning meeting and DDC-level orientation were conducted on Nov. 2002.
4.2 Adopt IMCI training package	For health facility staff and doctors, IMCI training was done from Aug. 01 to Jan. 02. For the village health workers, health volunteers and traditional healers, CB-IMCI training is in progress from Dec. 2002.
4.3 Conduct training / orientation (for doctors, basic health staff, volunteers, traditional healers, VDC member, etc.)	*Training materials (sound timers) did not arrive in time. And activities were carried out right after material arrived.*
4.4 Monitor and evaluate ARI case management at all levels	Supervision of ARI case management is done after the training of IMCI. IMCI workshop (IMCI review meeting) was started from Aug. 02. Monitoring ARI case management (Regular monitoring was started with regular monthly supervision. Four-monthly reporting system was introduced from Jul. 2002. National program introduced IMCI register with support of USAID. New follow-up system utilizing ARI follow-up cards will be introduced. *Health Post, PHC in charge level monitoring meeting is conducted regularly. Sub Health Post in charge level monitoring meeting need to be emphasized. There should be opportunity to observe other areas activities.*
6.1 Conduct baseline studies for COPD 6.5 COPD literature review	These activities have been completed. Epidemiology and risk factors of Chronic Obstructive Pulmonary Diseases (COPD) was published with the combined effort of one of Nepalese counterpart and JICA CTLH project in Mar. 2002. COPD survey was conducted from Jan. to Apr. 02 with cooperation of Nepalese professors and her colleagues. Studied 4,000 populations in cross sectional survey. According to this survey results, anti-smoking activity sites were selected.
6.2 Adopt participatory methods in lung health programs, focus group discussion	Activities have been conducted as lung health program, which focuses on mainly tobacco control, in selected community having high smoking rate. Training for volunteers have been conducted in the selected VDC to initiate the focus group discussions (FGD).
6.3 Train health staff in the Interpersonal communication and group work facilitation	In selected three VDCs, health staff was trained, and is in progress to communicate each DOTS volunteers, FCHVs and other groups, and facilitate their group works of FGD and regular review meeting, and summarize their report.
6.4 Conduct advocacy programs on lung health for the general public / conduct targeted health education.	In selected three VDCs, trainings were held for health staff to conduct health education to smokers among patients who visit their health facilities, to lead the smokers to quit smoking. Lung health seminar was held for all health workers and volunteers working in Kathmandu valley in Nov. 2001. Anti-smoking workshop was held to advocate on lung health with other NGOs working for Tobacco control on World No Tobacco Day, in May 2002.

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2.3 Achievement of Outputs

Achievement of outputs are summarized as follows:

Output A: The managerial capacity of the NTP is further strengthened.

Through interviews and questionnaires during the evaluation period, it was revealed that the NTP has been smoothly implemented with the teamwork of all involved in Tuberculosis Control, under the strong leadership of the Director of NTC. The Project has contributed to strengthen managerial capacity of the NTP in collaboration with other donors. It appears that monitoring and supervision has to be strengthened in order to maintain high quality of the NTP.

Output B: Management system for the laboratory and logistics of the NTP is made sustainable.

Establishment of the reference laboratory in NTC has been delayed because the appropriate counterpart was not appointed until February this year. Dispatch of two short-term experts was cancelled due to the security reasons. Trainings of lab technicians for Quality Control, and equipment maintenance was conducted as scheduled. Six indicators set to monitor achievement have already shown positive results as follows:

According to the result of 1st quarter of FY 2059/60, the proportion of registered cases divided by the estimated occurrence of smear positive new cases were 70% and the proportion of smear positive cases among all new TB cases was 58%. (Indicator B-1) According to the 3rd quarter meeting of FY 2058/59 (Mar.~Jul.02), overall agreement rate was 94% with false positivity as 1.9% and false negativity as 1.5%. (B-2) At the survey of Nov. 2002, 82% of microscopy centers functioning among those implemented DOTS centers. (B-3) Among 300 equipment at stock in NTP, 270 (90%) were functioning in Feb. 2002. (B-4) At the national level, no stock out occurred. (B-5) During the 1st quarter of 2059/2060, 23 among 44 districts investigated, PZA[1] was provided within the range of 85%~135% of expected amount calculated from the number of TB cases. (B-6)

Output C: Models for TB control in urban and hard-to reach areas are established.

In Kathmandu, the number of urban DOTS clinic has increased from 19 at the beginning to 29 at present. This was materialized through collaboration with private practitioners,

[1] PZA =Pyrazinamide

NGOs/INGOs, medical colleges, and municipality health services. The approach to involve the private sector has been proven to be effective.

As for DOTS in hard-to-reach areas, such as in hilly areas, sufficient assistance by the Project was unable to be provided due to the security reasons. In Rupandehi, DOTS has been improved through expansion of DOTS sub-centers in Butwal municipality area without delay, although indicators after intervention are not yet available for assessment at the time of this review.

Output D: Case management of children with ARI is improved in selected districts.

Trainings for IMCI and DDC-level orientation, and the district-level planning meeting have been conducted as scheduled. Some training was delayed due to unavailability of equipment in time. To further promote the ARI case management, the regular review meetings and regular supervision were started in 2002. Four indicators set to monitor the achievement have also shown the progress made during the first half of the Project period as follows:

Available data has shown that among those reported pneumonia cases; cure rate of pneumonia is 89%. (D-1) According to the investigation conducted at health facilities in 2002, more than 80% of registered ARI cases were properly managed (D-2), and around 20% of pneumonia cases were followed after two days of treatment. (D-3) Available data also shows that more than 80% of pneumonia cases from 2 months to 5 years of age received correct dosage of antibiotics, which follow WHO standards. (D-4)

Output E: Case management of adults with respiratory illnesses is improved in selected areas.

Out of the planned activities in this Output (E), the baseline survey on the COPD, and the literature review were completed by the Project. The rest of the activities were not carried out, since PAL Nepal project, which has the same objectives as the Output (E), was in progress. Although a responsible medical officer within the MOH was assigned as the C/P for this Output (E), only COPD survey was conducted with this C/P. Considering ongoing PAL Nepal project, limited program management capacity, and time remained for the rest of the Project; it does not appear feasible to accomplish this Output.

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Output F: Communities adopted measures for anti-smoking.

Activities under this Output started recently. Focus group discussions were carried out by DOTS committee members in 3 selected VDC areas. In addition, lung health seminar and anti-smoking workshop were conducted for health volunteers. In order to evaluate the achievement of output, baseline study was conducted a year ago and the achievement of this output will be evaluated by conducting the same study by the end of the Project.

2.4 Implementation Process

Although efforts were made, implementation of the Project was unexpectedly slowed down due to the absence of Chief Advisor during the first year. Social and political situations also influenced the smooth implementation of the Project. The implementation process has been accelerated since the beginning of the second year through regular meetings and joint supervision and other collaborative activities. Japanese experts and Nepalese counterparts have been closely working together at the central level as well as in the field level.

However, it is noticed that the progress has not always been monitored by PDM. One of the reasons is that the design of original PDM did not follow the JICA's format and have not served as an efficient monitoring tool. During the evaluation mission, PDM was reviewed and revised to reflect all the current activities. It is recommended that the Project shall be implemented along the revised PDM in the remaining period of the Project.

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3 Evaluations by Five Criteria

3.1 Relevance

The Project's overall goal and project purpose have consistency with the policy of MOH/HMG. The MOH/HMG, in its overall national health policies and strategies, has set the dominant national objective for the health as to provide the preventive and curative services. Among those health services, the MOH/HMG put the high priority toward the tuberculosis control and child health. As for the tobacco control, a draft of "The National Anti-Tobacco IEC Strategy for Nepal" has now been in the process of preparation and the strategy will be adopted in the future.

The Project is relevant to the need of TB patients, children under five years old and community people. In Nepal, over 60% of total population are infected with TB. Of these, up to 80,000 people have active TB and there are 40,000 new cases of the disease every year.

(In order to respond to the need for controlling the disease, the His Majesty's Government adopted Directly Observed Treatment Short Course (DOTS) strategy in 1996 and DOTS has been implemented in all district successfully by April 2001. It has greatly contributed to preventing thousands of TB deaths a year.) As for the child health, the mortality rate of the children below five years of age in Nepal is 91 per thousand live births in 2001.[2] The Acute Respiratory Infection (ARI) is recognized as one of the major causes of under-5 child deaths in Nepal. Smoking rate in Nepal is considerably high, 73% of men smoke and 29% of women smoke every day[3], and smoking habit causes lung diseases, such as COPD. Therefore, the need to raise awareness for anti-smoking among people is quite high.

Overall Goal and Project Purpose are also consistent with the policy of JICA's assistance to Nepal, which defines the health sector development as one of the key issues to be tackled.

3.2 Effectiveness

Five outputs have directly contributed to the achievement of the Project Purpose. The Project is heading for the right direction. Combined efforts of Japanese and Nepalese sides have contributed to improve the overall performance of NTP and to establish the functional models for improved community lung health. According to the interviews and the questionnaires, it is indicated that the contribution of this project toward the national goal has been highly appreciated.

The following points are recognized as the promoting factors for project advancement. First, the framework of urban TB control with involvement of NGOs/INGOs and private

[2] HMG/N, National Demographic and Health Survey, Preliminary Report, 2001.
[3] Nepal, Demographic and Health Survey, 2001.

sectors have served as the effective approach to combat the disease in urban setting. Second, the community mobilization by empowering the volunteers and community people has also served as the effective means to expand DOTS in the areas with poor accessibility to the health facility. Third, training of community volunteers such as Female Community Health Volunteer (FCHV) under the Project has greatly contributed to improve the capacity building of health care providers over all.

3.3 Efficiency

3.3.1 Japanese Side

a) Dispatch of experts

Long-term experts in the field of Chief Advisor, Lung Health, and Coordinator have been dispatched. Totally eighteen (18) short-term experts were dispatched as almost scheduled. There were some constraints caused by the delay of arrival of the Chief Advisor. However, despite the absence of the Chief Advisor at the beginning, the Project managed to achieve most of the outputs expected during this period. It is assessed that the amount and the expertise of Japanese experts are appropriate. It is indicated by the Nepalese side, that it serves as very effective if the same person will be dispatched in a short-term basis for smooth technical transfer and communication.

b) Provision of equipment and machinery

The quality and quantity of the equipment were appropriate, and very much appreciated by the Nepalese side. Most of equipment is properly utilized for the project implementation. However, the distribution of equipment (sound timers for ARI) was delayed, and this has influenced the progress of some activities.

c) Counterparts Training

It is evaluated that the contents of TB training in Japan are very good for counterpart personnel and it serves to increase their expertise and motivation, and TB training should be continued. It is also indicated by the Nepalese side that the counterparts of ARI activities and Tobacco control should get the opportunity for the trainings in the future.

3.3.2 Nepalese side

a) Office space for experts

Provision of the office space on the 1st floor of NTC that locates on the same floor of those of counterparts has been facilitating the close communication between Japanese experts and Nepalese counterparts.

b) Counterparts

The Nepalese side has assigned twenty-one (21) counterparts to work under the National Tuberculosis Program, ARI activities, and Tobacco Control activities in collaboration with Japanese experts. A part-time medical technologist was recently assigned to the NTC laboratory, as the shortage of manpower in the NTC laboratory was a constraint for the establishment of the reference laboratory. Absence of suitable counterpart for adult lung health has hampered the efficient achievement of the Output (E) "Case management of adults with respiratory illnesses is improved in selected areas."

3.4 Impact

Although the impact of the Project Purpose to the Overall Goal will be assessed at the final evaluation, following positive impact, especially the impact of TB Control Program on the General Health Care Services are observed.

First, TB Control Program has contributed to improve the capacity buildings of health workers over all. Trainings under the TB control program have helped to expand the knowledge and skills for health workers and volunteers. In addition, those health workers have been empowered through the regular review meeting such as DOTS workshop in which they can expose themselves to the new training with other health workers, to share their knowledge and experiences, and to be recognized by senior level of supervisors.

Second, TB Control Program has contributed to empower the community people through the approach of community mobilization. In the hard-to reach areas, the community people have voluntarily contributed the DOTS expansion. Village Health Workers (VHW) and Female Community Health Volunteers (FCHV) have worked to trace the late patients and to bring them back to the DOTS services.

Third, TB Control Program has contributed to involve the private practitioners and NGOs/ INGOs in the public health care services. In Kathmandu, the private practitioners and NGOs/INGOs have been involved in the DOTS expansion either to treat the TB patients under the NTP guideline or to refer them to the appropriate DOTS clinic. The collaboration with private practitioners will be important to improve the cure rate in the urban setting, which holds the great number of mobile population.

3.5 Sustainability

a. Organizational aspect

The Project Purpose is consistent with the development policy of the HMG. The NTC assumes overall responsibility for NTP to sustain the achievement of national goal. With the

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internationally recognized strategy (DOTS), the NTP appears capable for maintaining the TB control activities in Nepal. As for the ARI activities, the HMG has strongly committed to support activities through implementing IMCI throughout the country. Although the new strategy is to be adopted for Tobacco control in the near future, the government's commitment needs to be increased. Without an appropriate program for Tobacco control within MOH, the Output (F) "Communities adopted the measures for anti-smoking" will not be sustained.

b. Financial aspect

Currently, it is not possible to predict whether the financial resources are secured for the future activities after the Project term is finished.

c. Technical aspect

Technical transfer to the Nepalese counterparts has been progressed. The basis for TB control is especially firm with the adoption of DOTS strategy. The Project is currently managed by active participation and communication between Nepalese and Japanese sides, and it is projected that the technology will be further transferred to other Nepalese after the Project term is finished.

4. Recommendations

The current project was developed based on the long-lasting JICA collaborations in the field of TB control. With the construction of the NTC and the RTC, development of human resources through C/P trainings, and technical support through Japanese Experts at central and field levels, the NTP has been substantially strengthened. Although the Project has challenged new areas, such as community lung health other than the TB control, the Team had a strong impression that the collaboration can be decentralized, focusing on priority activities. The Team wishes to make the following recommendations.

4.1 Revision of the PDM

Based on the discussions among the Team and the concerned Nepalese authorities, it was agreed that the revised PDM (PDM1) would be used to monitor the project activities for the remaining period of the Project. (Annex 10)

1) Revision of Indicators

Indicators for Project purpose 2 (P2-1 and P2-2) will be modified for practical purposes.

P2-1

Original : "In 2005, mortality rate due to ARI decreased by 10% in all selected areas."

Modified: "In 2005, the number of severe pneumonia cases among the number of children under 5 years old attending the health facilities in selected areas will decrease."

P2-2 "HMG's program for the application of the models in other areas." , being identified not as an indicator, has been deleted.

Indicators for Outputs will be modified accordingly to reflect the changes in Project plan. For details, see Annex 10.

2) Addition to the Important Assumption

Progress of some activities has been negatively affected because the provision of Japanese short-term experts was cancelled due to the unavoidable security situations in Nepal. Considering the situations, the following Important Assumption will be added.

"Japanese input will not be disturbed due to the unavoidable security situations."

3) Revision of Activities

Activities will be modified accordingly to reflect the changes in Project plan.
For details, see Annex 10.

4.2 Assignment of counterpart for reference laboratory of NTC

To establish the reference laboratory, the present medical technologist should be upgraded, and another appropriate full-time medical technologist should be posted for the reference laboratory.

4.3 Change of counterpart for the Adult Lung Health (Output E)

For the better implementation of the Output (E), the NTP has been designated as the counterpart for this Output. The Project will revise the indicators for the Output (E).

4.4 Commitment to promote the anti-smoking activity (Output F)

To sustain effective anti-smoking activities after the completion of the Project, the government's commitment is crucial. The NHIECC has been identified as the focal point in collaboration with the NTP and the other related organizations, such as the Cancer Relief Society.

4.5 Modification of the Project support by the Chief Advisor

Considering the current status of the NTP and the other programs related to the Project, the long-term Chief Advisor based at the Project site is considered unnecessary. A short-term expert, as the Chief Advisor, will make regular visits to monitor the progress of the Project. During the absence of the Chief Advisor at the Project site, the long-term medical expert for the Project is expected to manage daily implementation of the Project as the Acting Chief Advisor.

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 against lung health problems (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	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, ARI etc.)	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 <u>Pre-condition:</u> Agreement between HMG/Nepal and Govt. of Japan is reached in time with specified human and material resources

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	1,2 TB register, lab register, treatment card 3,4 Spot visit 3,4 Survey report 3,4 Practitioners record 5. NTP documents

Annex 1

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 against lung health problems (F)	1. Increased numbers of lung heath promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives 2. No. of people seeking medical services for respiratory problems increase by ( )% by (2003) 3. 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% 4. 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.) 5. By the end of the project, 20% of the people in the targeted area adopted alternative cooking method to prevent indoor air pollution 6. The no. of people who have started home therapy at the beginning of respiratory infection increase by x % by 2003	1. Records of DOT + Committees 2. Records at health institutions 3-6 Survey reports 4-5 Spot checks

PDM Horizontal logic

11 September, 2000 (revised)

Project Design Matrix for Evaluation (PDMe) - "The Community Tuberculosis and Lung Health Project"

Annex 2

Project Name: The Community Tuberculosis and Lung Health Project

Target Group :

Duration: 2000.9 ~ 2005.8

Project Area:

Date Issued : Feb. 19, 2003

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumption
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	1 The health system reform is smoothly implemented. 2 Big epidemic of HIV does not occur.
Project Purpose			
1. Overall performance of NTP is further improved.	P1-1 75 districts covered by DOTS by 2003	Annual evaluation report of the NTP	1 Communities continue to use the services of the NTP
	P1-2 85% of treatment success rate has been achieved (nationwide) by 2005	Proceedings of national reporting and planning workshop	2 Achievements made in the lung health program are extended beyond the model areas
	P1-3 85% of TB patients covered by DOTS by 2005		
2. Functional models for improved community lung health are established.	P2-1 ~~By 2005, mortality rate due to ARI decrease by 10% in all selected areas~~ -> In 2005, # of sever pneumonia case at the health facilities / # of children under -5 years old will decrease.		
	P2-2 -> To be discussed at the Mid-term Evaluation. HMG's program for the application of the models in other areas		
	P2-3 ~~No. of measures adopted by the registered cases in prevention of lung diseases~~ -> will be evaluated by conducting the survey How community people make the measures against smoking, and how many measures against tobacco smoking adopted by the community, in the targeted area through learning anti-smoking campaign by the end of the		
OUTPUTS			
<OUTPUT for the Project Purpose 1> A 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.	Minutes of meeting Interviews with NTP staff	1 NTP will institutionalize the project achievements
	A-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	The plan of operation and organogram Interviews of the health staff	
	A-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	District DOTS, DTLA ad RTLA workshop proceeding	
	A-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	Spot check, Survey report, NTP documents	
	A-5 Experience made on the basis of implementation of the plan is found incorporated in the successive year's plan documents	District DOTS, DTLA and RTLA workshop proceeding NTP documents	2 Program support will be continued.
B Management system for the laboratory and logistics of the NTP is made sustainable	B-1 By 2005, achieve 70% case finding with proportion of smear positive patients being over 65%	Case finding report of each district presented by DTLA	
	B-2 By 2005 overall agreement rate is more than 90% with less than 5% false result	The report is presented by each QCA quarterly	
	B-3 80% functioning MCs by 2005 (nationwide)	Report is submitted by QCA during the workshop	
	B-4 At least 80% of the equipment at all levels and at all times are found functional	Spot check, NTP documents	—> To be added
	B-5 By 2003, no instances of stores not having logistic materials in stock are reported at all the stores are achieved.	Monthly report from regional stores to NTP/LMD Quarterly reports from district by DTLA, regional reports by RTLA quarterly	3 Social condition in Nepal will not grow worse so as to obstruct the project implementation.
	B-6 By 2003, drug supply at all the levels within the range of 85% - 135% of requirement	Monthly report from regional stores to NTP/LMD	
C 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	TB register, lab register, treatment card	
	C-2 90% of TB patients in hilly model area(s) have DOTS services accessible within 2 hr walk	TB register, lab register, treatment card	
	C-3 To be changed to (combined C3 and C4) -> The number of patients who received TB treatment at non-DOTS treatment center will decrease. ~~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~~	Spot visit, Survey report, Practitioners record	
	C-4 ~~80% of hospitals/nursing homes in urban areas will have DOTS clinics~~	Spot visit, Survery report, Practitioners record	
	C-5 The ratio of (no. of DOT sites established/estimated no. of DOT sites suitable for the model area) found progressively increased over saveral years	NTP documents	
	C-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.		
<OUTPUT for the Project Purpose 2> D 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	FCHV ARI treatment book ARI register at health facilities	
	D-2 By 2004, 80% of registered ARI cases are properly managed (diagnosed, treated, referred) at all levels.	Minutes of ARI supervisors' meeting at the district level ARI register at health facilities	
	D-3 By 2004, at least 80% of the registered pneumonia (2 months - 5 years) cases have 3rd day follow-up		
	D-4 At least 80% of all age groups receive the correct dosage of medicines as per WHO standards	Survey on practice of health staff	
E —> To be elimnated. ~~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)~~	~~Guidelines available in health institutions~~	
	~~E-2 Number of subsequent visits by affected people to health institutions after registration~~	~~Register at health facilities~~	
	~~E-3 Number & frequency of lung health problem cases identification in the project area~~	~~Register at health facilities~~	
	~~E-4 Number and duration of second line treatment cases after failure of first line treatment~~	~~Register at health facilities~~	
	~~E-5 Number of health institutions using the prescribing guidelines in the specified areas and providing feedback for their utility and modification~~	~~Spot check (supervision)~~	
	~~E-6 Health workers who properly manage "chronic cough (COPD)" increased by 20%~~	~~Survey reports~~	
F Communities adopted measures for ant-smoking.	F-1 Increased numbers of lung health promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives	Records of DOTS + Committees	
	F-2 By the end of the project the sample population in the targeted areas who can state the methods for preventing chronic cough (COPD) increased by 20%	Records at health institutions	
	F-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/parts etc.)	Survey reports Spot checks	
	F-4 -> To be elimnated ~~By the end of the project, 20% of the people in the targeted area adopted alternative cooking method to prevent indoor air pollution~~		

Activities	INPUTS		
—> To be discussed at the Workshop 1			
A The managerial capacity of the NTP is further strengthened.	**Nepalese Side**	**Japanese Side**	
A-1 Provide training to technical and non-technical staff / Participate in international/ regional / national conference	1 Counterpart	1 Long-term Experts	Vacant posts are filled and frequent transfers do not upset the program
A-2 Participate in international / regional / national conferences	2 Trainee	Chief-Advisor	
A-3 Continue the DOTS workshop in each DOTS implemented district	3 Facility, Land	Coordinators	Private practitioners will increasingly continue to support NTP policy with DOTS
A-4 Improve staff performance evaluation system		Lung Health / Anti-smoking	
A-5 Coordinate for service linkages with INGOs, donors, local governments and the private sector		2 Short-term Experts	The parterns will continue to cooperate as per the agreement
A-6 Carry out IEC program activities		TB Control	
A-7 Review and update NTP guidelines and formats when necessary		Lung Health	Cooperation for DOTS will continue to be available at local level
A-8 Strengthen monitoring & evaluation system		Anti-smoking	
B Management system for the laboratory and logistics of the NTP is made sustainable.		Logistics Management	**Pre-Conditions**
B-1 Train HMG lab technicians for Q.C. in all regions		Laboratory Technology	* Agreement between HMG/Nepal and Govt. of Japan is reached in time with specified human and material resources
B-2 Adopt a mechanism for assessing the performance of QC.		Information Management	
B-3 Conduct regular regional Q.C. workshop for laboratory staff		3 Equipment	
B-4 Provide training on QCA to DTLAs		4 Training in Japan	
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 Models for TB control in urban and hard-to reach areas are established.			
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 tracting 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 is conducted			
D Case management of children with ARI is improved in selected districts			
D-1 Conduct district-level planning workshop and DDC-leval 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 -> To be elimlated. ~~**Case management of adults with respiratory illnesses is improved in selected areas**~~			
~~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 Communities adopt measures for anti-smoking.			
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 problems (e. g. anti-smoking campaign, reduction of indoor and outdoor air pollution, ARI etc.)			

Annex 3

Dispatch of Experts

Long Term Experts

No.	Name	Designation	period
1	Mr. Katsumi ISHII	Project Coordinator	Oct.07,2000 - Oct.06,2002
2	Dr. Jinich KATO	Lung Health	May 07,2001- May 06,2003
3	Dr. Takashi YOSHIYAMA	Chief Advisor	Aug.30,2001 - Mar.01,2003
4	Mr. Akira NARUSE	Project Coordinator	Sep.19,2002 - Sep.18,2004

Short Term Experts

FY 2000/2001

1	Dr. Katsunori OSUGA	TB Control	Nov.25,2000 - Dec.04,2000
2	Dr. Akira SHIMOUCHI	Lung Health	Nov.27,2000 - Dec.08,2000
3	Ms. Akiko FUJIKI	TB Laboratory	Dec.11,2000 - Dec.23,2000
4	Dr. Jinich KATO	Lung Health	Mar.07,2001 - Mar.24,2001
5	Dr. Nobukatsu ISHIKAWA	TB Control	Mar.14,2001 - Mar.24,2001

FY 2001/2002

1	Dr. Nobukatsu ISHIKAWA	TB Control	Apr.25,2001 - May 01,2001
2	Dr. Takashi YOSHIYAMA	Epidemiology	May 01,2001 - May 12,2001
3	Dr. Akira SHIMOUCHI	Lung Health	May 07,2001 - May 19,2001
4	Dr. Akira SHIMOUCHI	Lung Health	Nov.19,2001 - Nov.30,2001
5	Dr. Hiroyuki NAKANO	Lung Health	Nov.19,2001 - Nov.28,2001
6	Ms. Nakae NOGUCHI	Logistics	Feb.25,2002 - Mar.31,2002

FY 2002/2003

1	Dr. Hiroyuki NAKANO	Lung Health	Jul.10,2002 - Jul.24,2002
2	Mr. Hiroaki YAMAZAKI	TB Laboratory	Aug.10,2002 - Aug.25,2002
3	Dr. Masakazu NAKAMURA	Tobacco control	Aug.17,2002 - Aug.25,2002
4	Dr. Katsunori OSUGA	TB control	Oct.22,2002 - Nov.02,2002
5	Ms. Tomoyo MIYAKE	Logistic	Jan.10,2003 - Mar.10,2003
6	Dr. Hiroyuki NAKANO	Lung Health	Jan.26,2003 - Feb.08,2003
7	Ms. Hiroko MATSUMOTO	TB Laboratory	Apr.06,2003 - Apr.11,2003 (planned)

K.O.

Provision of Equipment (>100 000 Yen)

No.	Date of Arrival	Equipment	Specification	Maker	Price	Used by	Place
Donated equipments							
1	Jun. 2001	4 wheel Drive Vehicle	Landcruiser VX	TOYOTA	¥4,824,100	National TB Center	National TB Center
2	Jun. 2001	4 wheel Drive Vehicle	Landcruiser VX	TOYOTA	¥4,824,100	JICA CTLH Project	National TB Center
3	Jun. 2001	4 wheel Drive Vehicle	Landcruiser VX	TOYOTA	¥4,824,100	JICA CTLH Project	National TB Center
4	Aug. 2002	Motorbike	COOX 125cc	YAMAHA	¥139,000	JICA CTLH Project	JICACTLH Project Rupandehi
Office equipments							
5	Dec. 2002	Timers	UNICEFF			FCHVs	With FCHVs
6	Dec. 2002	Motorbike	BOSS 100 cc	KINETIC	¥130,000	DPHO Office MOH	DPHO、Rupandehi
7	Feb.. 2003	Microscope	50 sets CX-31	OLYMPUS	¥10,296,000	DOTS Clinics	Each clinic
8	Feb.. 2003	Microscope	50 sets CX-31	OLYMPUS	¥10,139,000	DOTS Clinics	Each clinic

Accompanied equipments

1	Dec.27,2000	Laptop Computer	Think Pad A21m	IBM	¥369,000	JICA CTLH Project	Expert's Room (Long-term expert)
2	Aug.01,2001	2 Laptop Computers	Think Pad A22m	IBM	¥259,000 X 2	JICA CTLH Project	Expert's Room (Long term expert)
3	Aug.30,2001	V. Stabilizer	SPR-1K	Matsunaga	¥258,000	JICA CTLH Project	Expert's Room (Long term expert)
4	Aug.30,2001	Software for PC	SPSS10J Base	SPSS	¥140,000	JICA CTLH Project	Expert's Room (Long term expert)
5	Nov.28,2001	2 Spirometers	Chestgraph Jr101	Chest	¥190,000 X 2	JICA CTLH Project	Expert's Room (used at COPD survey)
6	Apr.15,2002	Spirometer	Chestgraph Jr101	Chest	¥182,000	JICA CTLH Project	Expert's Room (used at COPD survey)
7	Aug.14,2002	2 Carbon M. Monitor	Smoker Lyzer	Bedfont Sc.	¥156,000 X 2	JICA CTLH Project	Expert's Room (used by tobacco control expert)

List of counterpart training

No.	Name	Period	Training Course	Institution	Position
1.	Shrawan Kumar CHOUDHARY	Jan.08,2001 - Feb.25,2001	TB Programme Management	RIT	Medical Superintendent, DHO, Dang,, MOH
2	Amir KHATI	May 14,2001 - Aug.12,2001	TB Control	RIT	Senior Administrator, District Public Health Office, Kathmandu, MOH
3	Kashi Kant JHA	Jan.20,2002 - Feb.02,2002	TB Programme Management	RIT	Senior Consultant Physician, NTC, MOH
4	Rajendra Prasad PANT	May 14,2002 - Aug.11,2002	TB Control	RIT	Senior Medical Officer, NTC, MOH
5	Jagat Bahadur KHADKA	Sep.10,2002 - Dec.15,2002	TB Control Management	RIT	Medical Technologist, Regional Public Health Laboratory, Pokhara, MOH
6	Vishnu Prasad POUDYAL	Jan.14,2003 - Mar.02,2003	TB Programme Management	RIT	Senior Medical Officer, Lumbini Zonal Hospital, MOH

Annex 6

Operational Expenses on local activities

1. Local running cost ;

(a) Japanese side (JICA budget) :

Year	2000/2001	2001/2002	2002/2003	2003/2004
Local running cost	¥ 4,850,000	¥ 21,849,000	¥ 24,370,000	¥ 24,060,000

(Applying)

(b) Nepalese side (NTC budget) :

Year	July 2000/ July 2001	July 2001/ July 2002	July 2002/ July2003
Regular budget	Rs. 5,722,000	Rs. 6,836,000	Rs. 6,498,000
Development budget	Rs. 12,760,000	Rs. 29,300,000	Rs. 19,602,000
Total	Rs. 18,482,000	Rs. 36,136,000	Rs. 26,100,000

2. Equipment cost

Year	2000/2001	2001/2002	2002/2003	2003/2004
Donated	¥ 14,472,300	¥ 0	¥ 29,171,000	¥ 3,780,000
Accompanied	¥ 552,120	¥ 4,126,542	¥ 639,476	
Total	¥ 15,024,420	¥ 4,126,542	¥ 29,810,476	¥ 3,780,000

(Applying)

Annex 7

List of Counterparts

JICA/HMG Community TB & Lung Health Project
Duration:Sep.25,2000 - Sep.25,2005

NAME	Designation
***Ministry of Health (MOH) Ramsahapath, Kathmandu.**	
1. Mr. Mahendra Nath Aryal	Secretary for Health
2. Dr. Bhubanesori Datta Chataut	Chief Specialist, PP & International Coordination Division
3. Dr. Benu Bahadur Karki	Chief, PP & International Coordination Division.
***Department of Health Services (DOHS) Teku, Kathmandu.**	
1. Dr. Laxmi Raj Pathak	Ag.Director General, Department of Health Services.
2. Dr. Sun Lal Thapa	Chief, CDD/ ARI, Child Health Division.
3. Dr. Mahendra Keshari Chhetri	Director, Logistic Management Division.
4. Dr. Govinda Prasad Ojha	Director, Child Health Division
5. Dr. Sarala Malla	Director, National Public Health Laboratory
6. Mr. Ramesh Neupane	Ag. Director, National Health Information, Education and Communication Center
***National Tuberculosis Centre (NTC) Thimi, Bhaktapur.)**	
1 .Dr. Dirgh Singh Bam	Director
2. Dr. Kashi Kant Jha	Senior Consultant Chest Physician
3. Dr. Pushpa Malla	Senior Consultant Chest Physician
4. Dr. Sharat Chandra Verma	Senior Consultant Chest Physician
5. Dr. Rajendra Prasad Pant	Senior Medical Officer
6. Mr. Dhurba kumar Khadka	Medical Technologist
7. Mr. Badri Nath Gyawali	Statistical Officer
8. Ms. Jyoti Acharya	Medical Technologist
***Regional Tuberculosis Centre (RTC) Pokhara**	
1. Dr. Mohan kumar Prasai	Ag. Director, RTC. MoH
***Others**	
1. Mr. Amir Khati	District Public Health Officer,Kathmandu District,DOHS,MOH
2. Mr. Biswo Ram Shrestha	District Public Health Officer,Rupandehi District.,DOHS,MOH
3. Dr. Shanta Bahadur Pande	Sr. Researcher, Nuffield Institute for Health/NTP

as of March 2003

Annex 8

Date: March 6, 2003

Accomplishment of Activities

OUTPUT		Activities	Current situation (from "Project activity mid-term report")	Result of Workshop 1 (Review of Activities)			Required Step
				Grade	Reasons for Deviation from the Plan	Measures / Actions we can take	
(A) The managerial capacity of the NTP is further strengthened	1-1	Provide training to technical and non-technical staff, Participate in international/regional / national conferences	-20 trainees from laboratory were trained by the trainer, Mr. Dallakoti (BTS) from Dec. 13-15, 2001 in regard to equipment maintenance -Joining the domestic training at NTC as follows: Doctors on HIV and TB 3 times, Lab technician on statistics officers on surveillance once, storekeepers on combined drug 4 times -In Oct. 2002, 3 CPs joined the global congress on lung health in Montreal. -In Nov. 2002, 4 visited Cambodia thru technical exchange program.	A			
	1-2	Strengthening the monitoring and evaluation system by conducting DOTS workshop , regional, national workshop, and national review. (national and international.)	-DOTS workshops are conducted every 4 months (Mar. Jul., and Nov.) at 75 districts. CA and technical staff joined in those held at Katmandu, and Rupandehi.	A			To be approved by JCC
	1-3	Improve staff performance evaluation system	-The activity has been done by NTC.	A			
	1-4	Coordinate for service linkages with INGOs, donors, local governments and the private sector	-Continue TBCN under the chairmanship of NTC director and initiative of Nuffield institute. Recent topics are on HIV/AIDS	A			
	1-5	Carry out IEC program activities	-Every year, IEC program has been done at world TB day (No specific study was done about the impact of World TB day.)	A			
	1-6	Review and update NTP guidelines and formats when necessary	-NTP manuals were published in 1990s. They have been revised with the support of CTLH. (3 publications - NTP manual, lab manual, modules, volunteer training manual)	A			
	1-7	To be combined with 1-2 ~~Strengthening the monitoring and evaluation system~~					To be approved by JCC
(B) Management system for the laboratory and logistics of the NTP is made sustainable.	2-1	Train HMG lab technicians for QC in all regions	-Trainings have been done by NTC. No ST experts was involved in the QC except for the expected one in Apr. 2003.	A			
	2-2	Adopt a mechanism for assessing the performance of QCA	-Short-term expert was not dispatched due to the security reasons. Will be resumed at national workshop	C	-Resources - Human / material	-Strengthen the national QCC - one person / region	
	2-3	Conduct regular regional QC workshop for laboratory staff	-The activity has been done by NTC.	A			
	2-4	Provide training on QCA to DTLAs	-The activity has been done by NTC, Short-term expert was not dispatched due to the security reasons. Will be resumed at national workshop	B	-Need was not felt till now '-RTLAs - already trained (future they already planned)	-DTLAs - orientation given (Future training already planned)	
	2-5	Establish reference lab in NTC	- The activity is behind the schedule due to the delay of appointment of CP 1 ST expert arranged the equipment / staffing (Aug. 02), Equipment in FY of 02 will arrive Jul. 03. CP started working in Feb 03. 1 ST expert in early 03.	C	-Resources - Human / material '-Technical & logistic supply from JICA	-One medical technologist already recruited Microbiologist needed or train available persons	
	2-6	Improve coordination between NTC and LMD / Improve logistics management systems for drugs, laboratory and related materials within each region	-ST experts recommended " the implementation of the regular actual physical verification " at all levels. -Improvement will be reported by logistics ST experts (Jan. - Mar.2003)	B	-Vehicle problems (transportation)	-Proper planning beforehand for seasonal problems	
	2-7	Adopt a system for equipment maintenance	-Equipment maintenance training was done and the follow-up of training was done as reported. The status of equipment maintenance is recorded at the achievement	B	-Lack of trained manpower. '-No regular maintenance programme	-Six monthly / yearly maintenance service to be developed -Microscope maintenance training to be given to district staff also	

Accomplishment of Activities

Date: March 6, 2003

OUTPUT		Activities	Current situation (from "Project activity mid-term report")	Result of Workshop 1 (Review of Activities)			Required Step
				Grade	Reasons for Deviation from the Plan	Measures / Actions we can take	
(C) Models for TB control in urban and hard-to reach areas are established.	3-1	Urban DOTS improvement (strategy, training, coordination, DOTS center, late patient tracing), KTM	-Urban area - Kathmandu were selected for model demonstration of DOTS improvement -developed the late patient tracing with mobilization of volunteers thru strengthening of DOTS committee.	A		-Late patient training system should be strengthened through encouraging volunteers.	
	3-2	hilly DOTS improvement (strategy, training, coordination, DOTS center, late patient tracing)	-Temporarily the activity has been stopped due to security reasons	*	-Stopped due to security reasons(JICA)	-Stopped due to security reasons(JICA)	To be discussed at JCC
	3-3	Urban, Coordinate with NGO and private practitioners , KTM	-Private sector orientation is on progress.	A	-Need to further involve factories and industries	-Indicator of Output (C4) needs to be realistic	
	3-4	DOTS improvement (strategy, training, coordination, DOTS center, late patient tracing), Rupandehi	-Based on the result of interventions on DOTS committee re-activation / volunteer mobilization, late patient tracer will be introduced in some DOTS areas with higher defaulter load.	*	To be discussed in Rupandehi	To be discussed in Rupandehi	
	3-5	Coordinate with NGO and private practitioners, Rupandehi		*	To be discussed in Rupandehi	To be discussed in Rupandehi	
	3-6	Monitor the progress of the model areas		A / B	-Delay in preparing action plan	-Regular supervision should be continued.	
	3-7	~~Review replicability of the approaches adopted~~ -> To be rephrased Framework of the model is developed with adaptabilities to other areas with necessary modification.		A / B	-Urban DOTS has not been yet implemented yet in all municipalities	-A full proof late patients tracing system needs to be in place before replicability It could be replicable in other urban setting.	To be approved by JCC
	3-8	Operational research is conducted.. - HIV seroprevalence evaluation - Strengthening case finding among HIV positive persons DOTS plus, initiated by NTC/WHO		NA	This is a new activity to start.	-Discussion of Operational Research was done.	To be approved by JCC
(D) Case management of children with ARI is improved in selected districts	4-1	Conduct district-level planning workshop and DDC-level orientation	-For health facility staff and doctor's level, district-level planning meeting and DDC-level orientation was conducted on July 2001. -For village health workers, health volunteers level and traditional healers, district-level planning meeting and DDC-level orientation was conducted on Nov. 2002.	B	-DPHO was busy in regular program	-DPHO managed time according to priority	
	4-2	Adopt IMCI training package	-For health facility staff and doctors, IMCI training was done from Aug. 01 to Jan 02. -For the village health workers, health volunteers and traditional healers, CB-IMCI training is in progress from Dec. 2002.	A	-DPHO is more familiar with the program	-CB-IMCI program is going on	
	4-3	Conduct training / orientation (for doctors, basic health staff, volunteers, traditional healers, VDC members, etc.)		B	-Training material (sound timer) did not arrive on time. -Training is conducted on contract basis	-Activities conducted right after material arrived in the country -District health program familiar trainers should be involved effetively.	
	4-4	~~Adoption of CDP~~ - > To be dropped because the activity has been done by the support from DFID not by JICA		C	-Process of donor partner (DFID) was complex in releasing budget -DPHO was busy in regular / other activities	-Now, it is starting from 16 health facilities	To be approved by JCC
	4-5	Monitor and evaluate ARI case management at all levels	- Supervision of ARI case management is done upon the training of IMCI. - IMCI workshop,(IMCI review meeting) was started from Aug., 2002. -Monitoring ARI case management (Regular monitoring was started with regular monthly supervision, Four-monthly reporting system was introduced form Jul. 2002, National program introduced IMCI register with support of USAID. -New follow-up system utilizing ARI follow-up cards will be introduced.	B	-Ilakawise review meeting is conducted regularly	-SHP wise review meeting need to be emphasized -Opportunity to observe other areas activities	

Accomplishment of Activities

Date: March 6, 2003

OUTPUT		Activities	Current situation (from "Project activity mid-term report")	Result of Workshop 1 (Review of Activities)			Required Step
				Grade	Reasons for Deviation from the Plan	Measures / Actions we can take	
				As activities under OUTPUT(F) have just started, the review of activities was focused on what has been done.			
					What have been done so far.	*What are the plan for the future this year.*	
(F) Communities adopted measures for anti-smoking.	6-3	**Train health staff in interpersonal communication and group work facilitation**	-In selected three VDCs, health staff was trained, and is in progress, to communicate each DOTS volunteers, FCHVs and other groups, and facilitate their group works of FGD and regular review meeting, and summarize their report.	B	-2 phase training to health staff at Chapagao on anti-smoking -1st phase training at Chahagun VDC	-2nd phase workshop At Chanpagaon VDC will be conducted - Within 2 weeks for Health Worker/Volunteers / teachers	
	6-4	**Conduct advocacy programs on lung health for the general public / Conduct targeted health education.**	-In selected three VDCs, trainings were held for health staff to conduct health education to smokers among patients who visit their HF, to lead the smokers to quit smoking. -Lung Health seminar was held for all health workers and volunteers working in KTM valley in Nov. 01. -Anti-smoking workshop was held to advocate on lung health with other NGOs working for Tobacco control on World No Tobacco day, in Mar. 2002.	B	-Lung health seminar conducted for health volunteers -Anti-smoking workshop is conducted	-Organize teaching try on anti-smoking in the selected areas by mobilizing the trained health workers. -Conduct school health teaching on anti-smoking by utilizing trained teachers -Mass teaching on anti-smoking at the community level by mobilizing community volunteers.	
	6-2	**Adopt participatory methods in lung health programs, focus group discussion**	-Activities have been conducted as lung health program, which focuses on mainly tobacco control, in selected community having high smoking rate.	B	-Training for volunteers have been conducted in the selected VDC to initiate the focus group discussion	-Support and mobilize the local volunteers to initiate the focus group discussion on anti-smoking at the selected VDCs. -Mobilize community people as much as possible by utilizing volunteers.	
	6-6	**-> To be dropped** ~~**Develop guidelines against indoor air pollution**~~		NA	-The activity was planned, but found not feasible to complete by the end of the Project.		To be approved by JCC
	6-1	**Conduct baseline studies for COPD**	These activities have been completed. - Epidemiology and risk factors of Chronic Obstructive Pulmonary Diseases (COPD) was published with the effort of Dr. M. R. Pandey and JICA CTLH project in Mar. 2002. - COPD survey was conducted from Jan. to Apr. 02 with cooperation of Prof. B Shrestha and her colleague. Studied 4,000 population in cross sectional survey. According to this survey results, anti-smoking activity sites were selected.		-Activities have been completed.		
	6-5	**COPD literature review**					

"Grade" is defined as follows:

Project activity is :

"A" = proceeded as scheduled

"B" = delayed, but this is not affecting the progress of project implementation.

"C" = very delayed, and this is greatly affecting the progress of implementation.

"NA" = This activity is not applicable.

Annex 9

Publications and Presentations

1. Presentations

1.1. Dr. Pant et al / Presentation at 33rd IUATLD world conference on lung health
Title: Process of Implementation of Urban TB Control Strategy in Kathmandu Municipality, Nepal
Author: Pant R, Yoshiyama T, Bam D.S, Shrestha G
Address: National TB Center, Thimi, Nepal E-mail- jicactlh@mos.com.np

1.2. Dr. Kato et al / Presentation at 33rd IUATLD World Conference on Lung Health
Title: The proportion of Pneumonia among URTI cases at one district in Nepal
Author: Kato J., Banskota H. K., Thapa S. L., Yoshiyama T
Address: C/o JICA Nepal Office, P.O.Box: 450, Kathmandu, Nepal

S. No.	Date	Particulars	Quantity
1	Mar-01	Clinical Manual	1,000 pcs
2	Mar-01	Dairy for Urban for volunteer	500 pcs
3	Mar-01	Annual Report of TB Control Program 2057/58 (2000/01)	1,000 pcs
4	Mar-01	Calendar Pocket 2058 (2001/202)	10,000 pcs
5	Mar-01	Calendar Wall 2058 (2001/202)	5,000 pcs
6	Aug-01	IMCI Training Module (9 set)	150 pcs
7	Dec-01	Flip chart for FCHV (Cloth)	1,000 pcs
8	Dec-01	Reprint Logistics Curriculum (Nepali version)	500 pcs
9	Dec-01	Reprint LogisticsTraining Handout (Nepali version)	500 pcs
10	Mar-02	Epidemiology and Risk Factors of Chronic Obstructive pulmonary diseases (COPD)	1000 pcs
11	Mar-02	Lab Manual (Nepali version)	300 pcs
12	Mar-02	Lab Module (English version)	300 pcs
13	Mar-02	Lab Module (Nepali version)	300 pcs
14	Oct-02	TB fact, figures and concept in English version (English version)	500 pcs
15	Dec-02	Defaulter Tracing Handout for FCHV (Nepali version)	200 pcs
16	Feb-03	Lab Manual (English version)	100 pcs
17	Feb-03	Lab Module (English version)	100 pcs
18	Feb-03	Map for Public Private Partnership for TB control	500 pcs
19	Feb-03	Reprint of Lab Manual (Nepali version)	500 pcs
20	Feb-03	Reprint of Lab Module (Nepali version)	500 pcs
21	Feb-03	Reprint of TB fact, figures and concept	500 pcs
22	Mar-03	Tuberculosis in Nepal (English version)	1,000 pcs
		Under process	
1	Mar-03	Annual Report of TB Control Program 2058/59 (2001/02)	1,000 pcs
2	Mar-03	Anti-Smoking Manual (Nepali version)	300 pcs
3	Mar-03	Calendar Pocket 22060 (2003/204)	10,000 pcs
4	Mar-03	Calendar Wall 2060 (2003/204)	5000 pcs
5	Mar-03	Tuberculosis in Nepal (Nepali version)	10,000 pcs

1

K.O.

Project Design Matrix (PDM1) - "The Community Tuberculosis and Lung Health Project"

Annex 10

Project Name: The Community Tuberculosis and Lung Health Project

Target Group : TB Patients Duration: 2000.9 ~ 2005.8

Project Area: Whole country

Date Issued : Mar. 14, 2003

Narrative Summary	Objectively Verifiable Indicators	Means of Verification	Important Assumption
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	1 The health system reform is smoothly implemented 2 Big epidemic of HIV does not occur.
Project Purpose			
1. Overall performance of NTP is further improved.	P1-1 75 districts covered by DOTS by 2003	Annual evaluation report of the NTP	1 Communities continue to use the services of the NTP
	P1-2 85% of treatment success rate has been achieved (nationwide) by 2005	Proceedings of national reporting and planning workshop	2 Achievements made in the lung health program are extended beyond the model areas
	P1-3 85% of TB patients covered by DOTS by 2005.		
2. Functional models for improved community lung health are established.	P2-1 In 2005, the number of severe pneumonia cases among the number of children under 5 years old attending at the health facilities in selected areas will decrease."	Annual Report of the Department of Health Services	
	P2-2 How community people make the measures against smoking, and how many measures against tobacco smoking adopted by the community, in the targeted area through learning anti-smoking campaign by the end of the Project	Smoking Survey	
OUTPUTS			
<OUTPUTs for the Project Purpose 1>			
A 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.	Minutes of meeting Interviews with NTP staff	1 NTP will institutionalize the project achievements
	A-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	The plan of operation and organogram Interviews of the health staff	2 Program support will be continued
	A-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	District DOTS, DTLA ad RTLA workshop proceeding	
	A-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	Spot check, Survey report, NTP documents	
B Management system for the laborabory and logistics of the NTP is made sustainable	B-1 By 2005, achieve 70% case finding with proportion of smear positive patients being over 55%.	Case finding report of each district presented by DTLA quarterly	
	B-2 By 2005 overall agreement rate is more than 90% with less than 5% false result	The report is presented by each QCA quarterly	
	B-3 80% functioning MCs by 2005 (nationwide)	Report is submitted by QCA during the workshop quarterly	
	B-4 At least 80% of the equipment at all levels and at all times are found functional.	Spot check, NTP documents	
	B-5 By 2003, no instances of stores not having logistic materials in stock are reported at all the stores are achieved.	Monthly report from regional stores to NTP/LMD Quarterly reports from district by DTLA, regional reports by RTLA quarterly	3 Japanese inputs will not be disturbed due to the unavoidable security situation.
	B-6 By 2003, drug supply at all the levels within the range of 85% - 135% of requirement	Monthly report from regional stores to NTP/LMD	
C 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	TB register, lab register, treatment card	
	C-2 90% of TB patients in hilly model area(s) have DOTS services accessible within 2 hr walk	TB register, lab register, treatment card	
	C-3 The number of patients who received TB treatment under non-DOTS will decrease.	Spot visit, Survey report, Practitioners record	
	C-4 The ratio of (no. of DOT sites established/estimated no. of DOT sites suitable for the model area) found progressively increased over several years.	NTP documents	
<OUTPUTs for the Project Purpose 2>			
D 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	FCHV ARI treatment book ARI register at health facilities	
	D-2 By 2004, 80% of registered ARI cases are properly managed (diagnosed, treated, referred) at all levels.	Minutes of ARI supervisors' meeting at the district level ARI register at health facilities	
	D-3 By 2004, at least 80% of the registered pneumonia (2 months - 5 years) cases have 3rd day follow-up		
	D-4 At least 80% of all age groups receive the correct dosage of medicines as per WHO standards	Survey on practice of health staff	
E 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)	Guidelines available in health institutions	
	E-2 Number of subsequent visits by affected people to health institutions after registration	Register at health facilities	
	E-3 Number & frequency of lung health problem cases identification in the project area	Register at health facilities	
	E-4 Number of health institutions using the prescribing guidelines in the specified areas and providing feedback for their utility and modification	Spot check (supervision)	
F Communities adopted measures for ant-smoking.	F-1 Increased numbers of lung health promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives	Records of DOTS + Committees	
	F-2 By the end of the project the sample population in the targeted areas who can state the methods for preventing chronic cough (COPD) increased by 20%	Records at health institutions	
	F-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/parts etc.)	Survey reports Spot checks	

Activities	INPUTS		
	Nepalese Side	Japanese Side	
A The managerial capacity of the NTP is further strengthened.	1 Counterpart	1 Long-term Experts	Vacant posts are filled and frequent transfers do not upset the program
1-1 Provide training to technical and non-technical staff / Participate in international/ regional / national conference		Chief-Advisor	
1-2 Strengtening the monitoring and evaluation system by conducting DOTS workshop, regional, national workshop, and national review (national and international)	2 Trainee	Coordinators	Private practitioners will increasingly continue to support NTP policy with DOTS
1-3 Improve staff performance evaluation system		Lung Health / Anti-smoking	
1-4 Coordinate for service linkages with INGOs, donors, local governments and the private sector	3 Facility, Land	2 Short-term Experts	The parterns will continue to cooperate as per the agreement
1-5 Carry out IEC program activities		TB Control	
1-6 Review and update NTP guidelines and formats when necessary		Lung Health	Cooperation for DOTS will continue to be available at local level
B Management system for the laboratory and logistics of the NTP is made sustainable.		Anti-smoking	
2-1 Train HMG lab technicians for Q.C. in all regions		Logistics Management	**Pre-Conditions**
2-2 Adopt a mechanism for assessing the performance of QC		Laboratory Technology	• Agreement between HMG/Nepal and Govt. of Japan is reached in time with specified human and material resources
2-3 Conduct regular regional Q.C. workshop for laboratory staff		3 Equipment	
2-4 Provide training on QCA to DTLAs		4 Training in Japan	
2-5 Establish reference lab in NTC			
2-6 Improve coordination between NTC and LMD / Improve logistic management systems for drugs, laboratory and related materials within			
2-7 Adopt a system for equipment maintenance			
C Models for TB control in urban and hard-to reach areas are established.			
3-1 Urban DOTS improvement (strategy, training, coordination, DOTS center, late patient tracing), KTM			
3-2 hilly DOTS improvement (strategy, training, coordination, DOTS center, late patient tracing)			
3-3 Urban, Coordinate with NGO and private practitioners, KTM			
3-4 DOTS improvement (strategy, training, coordination, DOTS center, late patient tracing) eg. Rupandehi			
3-5 Coordinate with NGO and private practitioners, eg Rupandehi			
3-6 Monitor the progress of the model areas			
3-7 Framework of the model is developed with adaptabilities for other areas with necessary modification			
3-8 Operational reseach is conducted - HIV seroprevalence evaluation. - Strengthening case finding among HIV positive persons DOTS plus, initiated by NTC/WHO			
D Case management of children with ARI is improved in selected districts			
4-1 Conduct district-level planning workshop and DDC-level orientation			
4-2 Adopt IMCI training package			
4-3 Conduct training/ orientation (for doctors, basic health staff, volunteers, traditional healers, VDC members, etc.)			
4-4 Monitor and evaluate ARI case management at all levels			
E Case management of adults with respiratory illnesses is improved in selected areas			
5-1 Classify common non-TB respiratory illnesses			
5-2 Conduct baseline studies			
5-3 Review existing information both in Nepal and elsewhere			
5-4 Plan pilot schemes in some selected areas			
5-5 Prepare modules, formats and flow charts.			
5-6 Conduct training for the concerned health workers/partners			
5-7 Implement pilot schemes in selected areas			
5-8 Coordinate programs with relevant partners			
F Communities adopt measures for anti-smoking.			
6-1 Adopt participatory methods in lung health problems, focus group discussion			
6-2 Train health staff in interpersonal communication and group work facilitation			
6-3 Conduct advocacy programs on lung health for the general public/ Conduct targeted health education.			