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1. ミニッツ・合同評価報告書（英文）

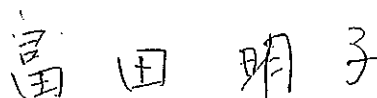
MINUTES OF MEETINGS BETWEEN THE JAPANESE TERMINAL EVALUATION TEAM AND THE AUTHORITIES CONCERNED OF HIS MAJESTY'S GOVERNMENT OF NEPAL ON JAPANESE TECHNICAL COOPERATION FOR THE COMMUNITY TUBERCULOSIS AND LUNG HEALTH PROJECT

The Japanese Terminal Evaluation Team (hereinafter referred to as "the Team"), organized by the Japan International Cooperation Agency (hereinafter referred to as "JICA") and headed by Ms. Akiko TOMITA, visited His Majesty's Government of Nepal from May 9 to 21, 2005. The purpose of the Team was to review and evaluate the whole activities and achievements of the Community Tuberculosis and Lung Health Project (hereinafter referred to as "the Project").

During its stay, both the Team and authorities concerned of His Majesty's Government (hereinafter referred to as "both sides") had a series of discussions and exchanged views on the achievements of the Project. Both sides jointly monitored the activities and evaluated the achievement based on the information and data collected through the evaluation. Both sides compiled the results of the findings in the evaluation report and presented it to the Joint Coordinating Committee on 20th of May 2005 at Kathmandu.

As a result of the discussions, both sides agreed to the matter referred to in the documents attached hereto, and the result of evaluation were compiled in the Joint Evaluation Report with mutual understanding.

Kathmandu, May 20, 2005



Ms. Akiko TOMITA
Team Leader
Terminal Evaluation Team
Japan International Cooperation Agency
Japan



Dr. Nirakar Man Shrestha
Officiating Health Secretary
Ministry of Health and Population
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**

20 May 2005

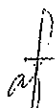


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ABBREVIATIONS

AHW	Auxiliary Health Workers	KAP	Knowledge, Attitude, Practice
AIHD	ASEAN Institute for Health Development	LHL	Norwegian Heart and Lung Health Association
AIDS	Acquired Immunodeficiency Syndrome	LMD	Logistics Management Division
ARI	Acute Respiratory Infections	MCHW	Maternal and Child Health Worker
CAT	Coalition Against Tuberculosis	MDR	Multi-Drug Resistance
CB-IMCI	Community Based Integrated Management of Childhood Illness	MOHP	Ministry of Health and Population
CBO	Community Based Organisation	NATA	Nepal Anti-Tuberculosis Association
CDD	Control of Diarrhoeal Disease	NEPAS	Nepal Paediatric Society
CDP	Community Drug Programme	NCDA	Nepal Chemist/Druggist Association
CHD	Child Health Division	NFHP	Nepal Family Health Programme
CIDA	Canadian International Development Agency	NGO	Non-Governmental Organization
COPD	Chronic Obstructive Pulmonary Disease	NHEICC	National Health Education, Information and Communication Centre
CPs(C/Ps)	Counterparts	NMA	Nepal Medical Association
CTLHP	Community Tuberculosis and Lung Health Project	NORAD	Norwegian Agency for Development
DDC	District Development Committee	NTC	National Tuberculosis Centre
DfID	Department for International Development	NTP	National Tuberculosis Control Program
DOTS	Directly Observed Treatment, Short course	PDM	Project Design Matrix
DHO	District Health Office/r	PHC	Primary Health Care Centre
DHS	Department of Health Service	QC	Quality Control
DPHO	District Public Health Office/r	QCA	Quality Control Assessor
DST	Drug Sensitivity Test	PHC	Primary Healthcare Centre
DTLA	District Tuberculosis/Leprosy Assistant	RD(R/D)	Record of Discussions
EQA	External Quality Assessment	RIT	Research Institute of Tuberculosis
FCHV	Female Community Health Volunteer	RTC	Regional Tuberculosis Centre
FGD	Focus Group Discussion	RTLA	Regional Tuberculosis / Leprosy Assistant
FY	Fiscal Year	SAARC	South Asian Association for Regional Cooperation
GENETUP	German Nepal Tuberculosis Project	SHP	Sub-Health Post
HIV	Human Immunodeficiency Virus	TAG	Technical Advisory Group
HMG	His Majesty's Government of Nepal	TB	Tuberculosis
HP	Health Post	TBCN	Tuberculosis Control Network
IEC	Information, Education and Communication	TSI	Tentative Schedule of Implementation
IMCI	Integrated Management of Childhood Illness	TUTH	Tribhuvan University Teaching Hospital
INGO	International Non-Governmental Organisation	UHC	Urban Health Clinic
IUATLD	International Union Against Tuberculosis and Lung Diseases	USAID	United States Agency for International Development
JCC	Joint Coordinating Committee	VDC	Village Development Committee
JICA	Japan International Cooperation Agency	VHW	Village Health Workers
KMC	Kathmandu Metropolitan City	WHO	World Health Organization

1. INTRODUCTION

1.1 Background and Objective of the Visit

Japan International Cooperation Agency (JICA) has collaborated with His Majesty's Government of Nepal (HMG) in implementing 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 (TB) 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 September 2005.

This time, since the Project is scheduled to terminate in about four months, JICA dispatched the Terminal Evaluation Team to Nepal from May 9 to May 21, 2005 for the purpose of joint terminal evaluation on the Project. The evaluation has been jointly undertaken by the Nepalese Counterparts and the Japanese Evaluation Team, concerned with the Project.

Objectives of the visit are as follows:

- 1) To review the past inputs, activities and outputs in the Project in consultation with the Nepal authorities
- 2) To analyse the progress and achievements based on the Project Design Matrix and five criteria for evaluation; Efficiency, Effectiveness, Impact, Relevance, and Sustainability
- 3) To draw lessons learned from the project, and to give recommendations for the remaining period of the Project and after the end of the Project
- 4) To make agreement on the result of the evaluation, and to prepare the Joint Evaluation Report
- 5) To hold the Joint Coordinating Committee to confirm the results of evaluation through discussions

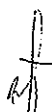
1.2 Evaluators

(1) The Japanese side

Name	Designation	Position, Organisation
1 Ms. Akiko TOMITA	Leader	Director, Group IV (Health II), Human Development Department, JICA
2 Dr. Nobukatsu ISHIKAWA	TB Control	Vice-Director, The Research Institute of Tuberculosis, Japan Anti-Tuberculosis Association
3 Dr. Tadatoshi KURATSUJI	Lung Health	Director-General, National Research Institute for Child Health and Development
4 Ms. Tomoko SHIMADA	Evaluation Planning	Staff, Infectious Disease Control Team, Group IV (Health II), Human Development Department, JICA
5 Ms. Yoko OGAWA	Evaluation Analysis	Researcher, Social Development Dept. Global Link Management, Inc.

2) The Nepalese side

Name	Position, Organisation
Dr. Nirakar Man Shrestha	Officiating Health Secretary, MOHP
Dr. Bishunu Prasad Pandit	Director General, Department of Health Services, MOHP
Dr. Hari Nath Acharya	Chief, PP & International Coordination Division, MOHP
Dr. Keshab Bhakta Shrestha	Director, National Tuberculosis Centre, MOHP
Dr. Yasho Verdan Pradhan	Director, Child Health Division, MOHP
Dr. Mahendra Keshari Chhetri	Director, Logistic Management Division, MOHP
Dr. Sarala Malla	Director, National Public Health Laboratory, MOHP



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Mr. Babu Ram Koirala	Director, National Health Information, Education and Communication Centre, MOHP
Dr. Mahendra Bahadur Bista	Director, Epidemiology & Disease Control Division, MOHP
Mr. Gyanendra Kumar Shrestha	Under Secretary, National Planning Commission
Mr. Deepak Kharel	Under Secretary, Ministry of Finance

1.3 Mission Schedule

Date	Activities	remarks
9/May (Mon)	12:35 Arrival in KTM (TG 319) Meeting with JICA expert Courtesy call to NTC Director	Ms.Ogawa
10/May. (Tue)	Meeting with JICA staff Visiting to NTC, Interview to NTC C/P (Drs Jha, Malla) 13:00~17:00 Workshop 1 at NTC	Ms.Ogawa
11/May. (Wed)	AM Interview (DPHO, MOH, Anamnagar private DOTS clinic & pharmacy) PM NTC Laboratory	Ms.Ogawa (Mr Naruse, Mr Sharan) Ms Ogawa,
12/May. (Thu)	10:15 Interview to NHEICC AM Interview with patient (Teku Hospital) PM Visiting project site of anti-smoking (Chapagaun) & Interview to volunteers (teachers) & health staff	Mr Ogawa (Mr Thapa) WSI & Interviews by Mr Sharan & Ms Yoshida in Rupandehi
13/May. (Fri)	10:00 Interview to Dr. C. Gunneberg (WHO) (Dr. Kuratsuji 12:35 Arrival in KTM TG319) PM Meeting with expert & NTC visit 16:00 Interview to Mr. Tuladhar (Rupandehi ex-DPHO) at NTC	Ms.Ogawa (Dr. Kuratsuji) Ms. Ogawa, Dr. Kuratsuji (Sharan, Dr. Sugiyama)
14/May. (Sat)	10:00 Interview to 2 health workers from Rupandehi PM Analysis of the collected data	Ms.Ogawa, Dr Kuratusji (Mr Sharan)
15/ May. (Sun)	10:00 Interview to Dr. Thapa 12:35 Arrival in KTM(TG319) PM Meeting (Evaluation Team & JICA expert)	Ms.Ogawa, Dr Kuratusji Dr.Ishikawa,Ms.Tomita, Ms.Shimada
16/May. (Mon)	10:00 Courtesy Call to Embassy of Japan 12:00 Courtesy call to NTC 16:00 Ministry of Health (Secretary) 16:30 JICA office	All
17/May. (Tue)	10:00 Visiting Urban DOTS Clinic Baneshwor 11:30 Himalaya H. Centre 13:00 Kanti Hospital 14:30 Teaching Hospital PM Meeting at NTC	All
18/May. (Wed)	09:30~15:00 Workshop 2 (Hotel Everest) 15:15~ Presentation 18:30~ Reception	All
19/May. (Thu)	AM Drafting Joint Evaluation Report (team) PM Final drafting with C/P (DG, NTC Drs) at MOH	All All

Date	Activities	remarks
20/May. (Fri)	10:00 Joint Coordinating Committee 12:00 Lunch Hosted by the team Signing of the Minutes of Meeting 15:00 Reporting to Embassy of Japan. JICA office	All All All
21/May. (Sat)	13:40 Leaving KTM (TG320)	All

1.4 Stakeholders Consulted/Interviewed

The following table shows those stakeholders who were individually consulted and/or interviewed by the Evaluation Team. Lists of participants in the Workshop (10th, 12th and 18th May, 2005) is attached in Annex I.

(1) The Japanese side

1	Dr. Tatsuro Sugiyama	Chief Advisor, CTLH Project
2	Dr. Takashi YOSHIYAMA	Former Chief Advisor
3	Ms. Akiko FUJIKI	Short-term Expert on Laboratory Technology

(2) The Nepalese side

1	Dr. Nirakar Man Shrestha	Officiating Health Secretary, Ministry of Health and Population
2	Dr. Keshab Bhakta Shrestha	Director, National Tuberculosis Centre (NTC)
3	Dr. Dirgh Singh Bam	Former Director, NTC
4	Dr. Kashi Kant Jha	SAARC Director and Senior Consultant Chest Physician, NTC
5	Dr. Puspa Malla	Senior Consultant Chest Physician, NTC
6	Dr. Sun Lal Thapa	Chief, IMCI, Child Health Division, Department of Health Service (DHS)
7	Mr. Babu Ram Koirala	Director, National Health Education, Information and Communication Centre, DHS
8	Dr. Jyoti Raj Shrestha	District Public Health Officer (DPHO), Kathmandu District, DHS
9	Mr. Astha Ratna Tuladhar	Former DPHO, Rupandehi DPHO, DHS
10	Principal, Vice Principal, Teachers and students participated in Anti-Smoking Activities	Emerald English School and Shangri-la International School, Lalitpur District
11	Health Post in Charge, a MCHW and FCHVs who are engaging in community-based IMCI activities	Devdana VDC, Modhubani VDC, Lumbini VDC in Rupandehi District
12	Principal, Vice Principal, Teachers and students engaging in Anti-Smoking Activities	Emerald English School and Shangri-la International School, Lalitpur District
13	Health Post in Charge, a health worker, DOTS Volunteers and an ex-smoker engaging in Anti-Smoking Activities	Chapagaun Teaching Health Post, Lalitpur District
14	Mr. Tamding Dorje Lama	Programme Coordinator, Himalayan Healing Centre
15	Ms. Uma Basnet	Health Post in Charge, Baneswor Urban Clinic
16	DOTS Volunteers, TB Patients undergoing DOTS	Anam Nagar Polyclinic, Teku Hospital, Himalayan Healing Centre, Baneswor Urban Clinic
17	Dr. U. R. Upadhaya	President, NEPAS
18	Dr. R. Shrestha	Acting Director, Kanti Children's Hospital

19	Dr. G. B. Baniya	Chief, Medical Department, TUTH
20	Dr. K. N. Yogi	Assistant Professor of Medicine, TUTH
21	Ms. Sarala Sherchan	Coordinator, DOTS Activities, TUTH

(3) Project Staff

1	Mr. Basant Thapa	Technical Officer, CTLH Project
2	Mr. Ram Sharan Gopali	Programme Officer, CTLH Project

(4) Development Partners

1	Dr. Christian Gunneburg	WHO Medical Officer (Tuberculosis)
2	Mr. Dharmpal Pd. Raman	Program Specialist, Office of Health and Family Planning, USAID
3	Dr. John Quineley	Health & Child Survival Advisor, Office of Health and Family Planning, USAID
4	Mr. Dilip Chandra Poudel	Team Leader, Child Health, NFHP
5	Mr. Bhandari	NFHP

1.5 Methodology of Evaluation

1.5.1 An Overview

In line with the "JICA Project Evaluation Guideline (revised: January 2004)," the Terminal Evaluation of the Technical Cooperation Project: "Community Tuberculosis and Lung Health Project (September 2000~September 2005)" was conducted using the Logical Framework Approach (cf. Table 1-1). The evaluation process is consisting of three steps, namely, i) adopting the logical framework¹ (hereafter referred to as LogFrame) which was revised at the time of Mid-Term Evaluation (March, 2002) as a framework of the Project; ii) confirming and analysing the present status of the Project on its achievement levels, adequacy of implementation process as well as causal relationships between the Project-related interventions and the current situation; and, iii) examining the value of the Project against the five criteria, namely, "relevance", "effectiveness", "efficiency", "impact", and, "sustainability".

Through the above analysis, the evaluation team also committed to specify factors that promoted or inhibited the achievement levels, so that the lessons learnt from the Project could be applied to other similar projects.

¹ Former "JICA Project Evaluation Guideline." as well as the textbook on the PCM Method published by FASID used to use the term Project Design Matrix (PDM) to call Logical Framework (LogFrame).

Table 1-1 : Contents of a Logical Framework (Narrative Summary)

Overall Goal	Broader effects that affect a larger population, sought to be achieved through the achievement of the Project Purpose.
Project Purpose	Direct and positive effects expected to prevail as a consequence of the Project interventions. Intended to benefit the target group and a segment of the society.
Outputs	Physical goods and services that can be produced through conducting the planned activities
Activities	Actions necessary to produce the planned Outputs
Objectively Verifiable Indicators	Criteria to measure the attainment level of the Project Outputs, Project Purpose and Overall Goal
Means of Verification	Sources of information to verify indicators
Important Assumptions	Situations, events, conditions necessary for project success, but beyond the control of the project management
Preconditions	Necessary conditions that must be overcome before a project is initiated
Inputs	Personnel, equipment, and costs required for Project Activities

1.5.2 Criteria for the Evaluation

Definition² of the five evaluation criteria that were used as viewpoints in analysis for the Terminal Evaluation is given in Table 1-2 below.

Table 1-2 : Definition of the Five Evaluation Criteria for the Terminal Evaluation

Five Evaluation Criteria	Definitions as per the JICA Evaluation Guideline
1. Relevance	The question whether the "Overall Goal" and "Project Purpose," as stipulated in the LogFrame, are still in line, at the time of the evaluation, with the needs of the target group, the policy directions of Nepal, as well as the adequacy of selected solutions to the issues concerned, of the strategy that the Project has taken, and of the nature of the Project as an official development assistance.
2. Effectiveness	The question as to what extent the Project has benefited or would benefit the target group or a segment of the society. More specifically, the question as to clarify the causal relationship between the Project Purpose and Outputs.
3. Efficiency	The question on the relationship between the cost and the effects obtained by the Project, whether the Inputs has been effectively utilized. More specifically, the question on the adequacy in terms of its timing, quality and quantity, as well as the degree to which Inputs have been converted into intended Outputs.
4. Impact	The question on what changes, whether positive/negative or anticipated/unanticipated, have been produced as a result of the implementation of the Project.
5. Sustainability	The question on self-reliance of the Project in terms of organizational, financial and technical aspects: whether the benefits of the Project will continue after the discontinuation of external assistance.

² "JICA Project Evaluation Guideline (revised: January 2004)," Office for Evaluation and Post-Project Monitoring, JICA.

Table 1-3 below also shows how different levels of the Narrative Summary in the LogFrame relate to the five evaluation criteria.

Table 1-3 : The Five Evaluation Criteria and the LogFrame

Narrative Summary	Five Evaluation Criteria				
	Relevance	Effectiveness	Efficiency	Impact	Sustainability
Overall Goal					
Project Purpose					
Outputs					
Inputs					

Under this Project, the Plan of the Project has been produced in the PDM format at the beginning of the Project, which was modified into the PDM₁ in March 2002 at the time of the Mid-Term Evaluation. The Terminal Evaluation also utilised the PDM₁ as a framework of the Project in order to formulate the evaluation design (Please see ANNEX II for PDM₁ and PDM₀).

Upon formulation of the evaluation design, evaluation questions were set in order to define "What the evaluation seeks to know," after which the required data, its collection methods and data analysis methods were identified and examined in order to answer those questions. Main evaluation questions for this Terminal Evaluation are as follows:

1. Is the strategy of the Project still coherent with the needs of the target groups, that of Nepalese government and Japanese assistance strategy?
2. To what extent has the Project contributed to the achievement of the objectives of the NTP and services improvement for lung health? What are the challenges still remained to be tackled? What were the factors that inhibited or promoted the achievement of the results?
3. What were the factors that has enforced or lowered productivity and/or efficiency of the Project implementation?
4. What were there unexpected negative/positive effects brought about due to the Project intervention?
5. What were the approaches/methods that were found effective in establishing/enforcing sustainable implementation structure of the NTP and provision of services in lung health?

1.5.3 Evaluation Indicators

In order to respond to the above evaluation questions, the Team first confirmed, through the data gathered by the Project, the level of achievement as per the Objectively Verifiable Indicators given in the PDM₁, other supplementary indicators as well as the data on implementation process that may have contributed the achievement.

1.5.4 Data Collection Methods and Analysis

Both quantitative and qualitative data was gathered and utilized for analysis. Data collection methods used by the Team was as follows:

- Literature/Documentation Review;
- Questionnaires (Counterparts, Japanese Short and Long-term Experts);
- Key Informant/Group Interviews (Counterparts, Japanese Long-term Experts, Health Workers, volunteers, relevant donor agencies);
- Participatory Workshops (Project Stakeholders); and,
- Direct Observation

The analysis and interpretation process was conducted in participatory manner with the stakeholders of the Project, as shown in the Table 1-4. The Workshop 2 was divided into two sessions: session 2-1 is a continuation of evaluation analyses from Workshop 1 with the same participants; and, session 2-2 involves wider stakeholders such as the Ministry of Health and Population and other development partners to obtain their opinions/views on the evaluation results as well as plans ahead.

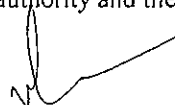
Table 1-4 : Overview of the Terminal Evaluation Workshop

Date	Workshop 1 (In KTM & Rupandehi) 10 th and 12 th May 2005	Workshop 2 (In KTM) 18 th May 2005
Venue	Everest Hotel	Everest Hotel
Purpose	<ol style="list-style-type: none"> 1) Workshop participants to share and confirm gathered data on achievements 2) Workshop participants to examine the extent of outputs and their direct beneficiaries 3) Workshop participants to examine the flow of benefits to the target group 	<p>《2-1》</p> <ol style="list-style-type: none"> 1. Workshop participants to determine the results based on the 5 evaluation criteria 2. Workshop participants to draw recommendations and lessons learned <p>《2-2》</p> <ol style="list-style-type: none"> 3. Wider stakeholders to discuss future plans and comment on recommendations
Participants	Counterparts, MOHP TB/IMCI/IEC-related Officers, Health Workers, Community Volunteers, NGOs, WHO, Japanese Experts, JICA Nepal Office Moderator: Evaluation Team Member & Project Staff	Counterparts, MOHP TB/IMCI/IEC-related Officers, NGOs, WHO, Japanese Experts, JICA Nepal Office Moderator: Evaluation Team Member & Project Staff

The Terminal Evaluation Team compiled a draft Joint Evaluation Report using contents that have been agreed in the workshop as well as the results of the evaluation survey. The draft has been discussed with the focal Nepalese Counterparts and revised for the subsequent presentation in the Joint Coordination Committee, which was held on the 20th of May 2005. Comments were reflected in the final document, which was signed by both the Nepalese authority and the Japanese Evaluation Team.



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2. Achievements and Current Status of the Project

2.1 Inputs

2.1.1 Japanese Side

a) Experts

Long-term Experts: A total of 5 (five) Long-term Experts in three (3) areas of expertise, totalling 133.8 MM, have been allocated. They are the Chief Advisor, the Project Coordinator and experts on Lung Health.

Short-term Experts: A total of fourteen (14) short-term experts in thirty-three (32) visits, totalling 13.7 MM, have been dispatched at the time of the Terminal Evaluation. Average duration per visit was relatively short at 0.4 MM, with frequent visits by the same Experts averaging 2.4 times per person. The fields of expertise included the following five (5) areas: TB control, Epidemiology, Lung Health, Laboratory Technology, and Logistics Management.

The list of experts is shown in ANNEX III.

b) Provision of machinery and equipment

Machinery and equipment worth JPY 43,128,400³ (US\$ 403,069⁴) in total has been provided at the time of the Terminal Evaluation. No additional machinery and equipment is planned for provision by the end of the Project.

The list of equipment is shown in ANNEX IV.

c) Training for Counterparts

A total of eight (8) persons have been trained under the C/P training scheme in the fields of Tuberculosis Control at the Research Institute of Tuberculosis (RIT) in Japan, at Faculty of Tropical Medicine and AIHD of the Mahidol University in Thailand. The focus and duration of each training programme vary, ranging from a two-week TB Programme management to an almost two-year masters course in microbiology. This makes a total of 43 months worth of training in duration, averaging 5.4 months per person. To date, five (5) out of eight trained Counterparts (63%) have transferred to other posts within the public health system.

Additionally, the Project also funded nine (9) Counterparts and three (3) Experts to take active part in the 33rd, 34th and 35th IUATLD conferences on Lung Health as well as in a technical exchange programme with the JICA-funded TB Project in Cambodia in order to gain experience through exchanges with foreign professionals working in the same field. Three (3) out of nine (9) trained Counterparts have been transferred (33%) to other posts but continue to serve for the public health system.

The list of the above training provided is shown in ANNEX V and ANNEX VI.

³ Equipment provision amounting JPY40,324,700 was made that was supplemented by the equipment accompanied by the Expert with the amount of JPY2,803,700.

⁴ Calculation was made with the exchange rate at 1US\$=107JPY

d) Operational Costs

A table/chart of the local operational costs over five years is shown in ANNEX VII.

A total of 96,056,000 JPY (US\$ 897,720) was expended for local operational costs at the time of the Terminal Evaluation from the Japanese side. The amount includes miscellaneous costs for effective and smooth implementation of the Project.

2.1.2 Nepalese Side

a) Appointment of Counterpart and administrative personnel

Total of twenty-three (23) persons with the positions as stipulated in the R/D of September 2000, have been allocated as the counterpart personnel by the Nepalese side. Frequent transfers of the personnel and their overloaded responsibilities often made allocation of sufficient time to the Project difficult.

The list of counterpart personnel is shown in ANNEX VIII.

b) Buildings and facilities

Sufficient space for the implementation of the Project, office space and necessary facilities for the Chief Advisor and Japanese Experts have been provided in the Ministry of Health and Population as well as on the 1st floor of NTC building.

c) Cost-sharing expenses

The Nepalese side financially contributed to the Project's activities through their routine budget allocated for NTP and provided by other development partners.

A table/chart of the NTP budget over five years is shown in ANNEX VII.

2.2 Activities Conducted

Activities consist of the following thirty-two (32) fields as shown in the PDM₁. Activities were reviewed at the Workshop held on 10th and 12th May through discussions among the Nepalese counterparts and Japanese experts who have been involved in the Project. Activities completed and ongoing at the time of evaluation are summarised as follows:

Activities as per PDM ₁	Results
Output A: The managerial capacity of the NTP is further strengthened.	
A-1 Provide training to technical and non-technical staff. Participate in the international /regional, national conferences	<ul style="list-style-type: none">■ The trainer at NTC trained twenty (20) trainees from selected laboratories from 13-15 December 2001 with regard to equipment maintenance.■ NTC staff members received the following in-country training at NTC:<ul style="list-style-type: none">➤ Doctors on HIV and TB (3 times);➤ Lab technician and statistics officers on surveillance (once);and,

Activities as per PDM ₁	Results
	<p>➤ Storekeepers on combined drug (4 times).</p> <ul style="list-style-type: none"> ■ Three (3) counterparts joined the global congress on lung health in Montreal in October 2002. ■ Four (4) counterparts visited Cambodia through technical exchange programme in November 2002. ■ One epidemiologist (2003/04) and one medical technologist (2003~date) at NTC received specialized training in Mahidol University in Thailand. ■ Five (5) laboratory technicians participated in a training programme at GENETUP on DST in September 2004. ■ With auspices of the Nepal Medical Association and its sister academic association, and the Nepal Chemists/Druggists Association in 2003/04, eight hundred (800) doctors and doctors-in-training as well as one hundred and eighty (180) chemists participated in the event. ■ JICA supported the sending of one participant to the 35th Conference of the IUATLD held in Paris in October 2004. ■ Experts and counterparts took part in the Conference of the IUATLD, Eastern Region in Kathmandu in September 2003. ■ The Chief Advisor, Project's Technical Staff and counterparts took part in the SAARC Conference on TB, HIV/AIDS and Lung Disease in 2004. ■ JICA supported the 1st SAARC Conference on Tuberculosis, HIV/AIDS and Lung Disease in Kathmandu in December 2004. ■ The Chief Advisor and counterparts took part in the TB session of the Annual Conference of the Nepal Medical Association in 2005. ■ JICA experts and technical staff participated in the training organized by NTC as lecturers and facilitators. Especially, TB modular training for health workers of Kathmandu District was well supported in 2004.
A-2. Strengthening the monitoring and evaluation system by conducting DOTS workshops, regional, national workshop, and national review (national and international).	<ul style="list-style-type: none"> ■ NTC initiates and conducts DOTS workshops every four (4) months (March, July and November) at district (all 75 districts), regional (5 regions) and national levels. The Chief Advisor and the technical staff joined in those held at Kathmandu (Central Region) and Rupandehi (Western Region). ■ NTC initiate and conducts annual review meetings of the NTP (the 2004 meeting was cancelled due to the security issue.).
A-3 Improve staff performance evaluation system	<ul style="list-style-type: none"> ■ The activity has been conducted as a routine exercise by NTC.

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Activities as per PDM ₁	Results
A-4 Coordinate for service linkages with INGOs, donors, local governments and the private sector.	<ul style="list-style-type: none"> ■ TBCN continued to meet under the chairmanship of NTC director. ■ Since 2004, the Chief Advisor of the Project has initiated to carry on the TBCN, which conducts three (3) meetings per year. Number of NGOs which participate in the TBCN meeting is recently on decline. ■ Programme reviews have been conducted annually by the technical advisor group of the development partners. Due to security concerns, the review could not take place during 2004.
A-5 Carry out IEC program activities.	<ul style="list-style-type: none"> ■ Every year, the Project conducted various IEC programmes including broadcasting in FM radio and posting newspaper articles on the World TB Day. ■ The Project has produced awareness raising materials on TB/DOTS in various forms, including posters, booklets and leaflets. The list of materials is shown in Annex IX.
A-6 Review and update NTP guidelines and formats when necessary	<ul style="list-style-type: none"> ■ Three (3) NTP manuals, which were originally published in 1990s, have been revised and/or translated into Nepali and re-printed with the technical and financial support of the Project. Those include the NTP manual, the laboratory manual and modules, and the volunteer training manual. (see Annex IX)
■ Output B: Management system for the laboratory and logistics of the NTP is made sustainable.	
B-1 Train HMG lab technicians for QC in all regions	<ul style="list-style-type: none"> ■ Training on QC has been initiated and conducted for the trainers of laboratory technicians (11 in 2002/03, 10 in 2003/04) by NTC, where project have provided technical support.
B-2 Adopt a mechanism for assessing the performance of QC	<ul style="list-style-type: none"> ■ The system of assessment of QC has been implemented by NTC, whose performance requires further improvement. ■ The medical technologist who is to spearhead the improvement process is absent from June 2003 to date pursuing further studies in Thailand. Additional post for a medical technologist was created, and agreement was made to second a staff from the National Public Health Laboratory on part-time basis, which could not be fulfilled; despite the fact that C/P training in Japan was provided at RIT. ■ Posting additional human resource, which was recommended to strengthen the national QC at the time of the Mid-Term Evaluation has been fulfilled partially.
B-3 Conduct regular regional QC workshop for laboratory staff	<ul style="list-style-type: none"> ■ Regular regional QC workshops for laboratory staff have been conducted every four months with the initiative of NTC. The Project has supported by giving technical advice.
B-4 Provide training on QCA to DTLAs	<ul style="list-style-type: none"> ■ RTLA were trained and orientation was given to DTLAs. ■ DTLA has been involved with the training of trainers of QC. The activity has been conducted with the initiative of NTC. The Project

Activities as per PDM,	Results
	has provided technical advices.
B-5 Establish reference lab in NTC	<ul style="list-style-type: none"> ■ The activity has been delayed at the initial stage due to the late appointment of a Counterpart. One short-term expert arranged the equipment as well as staffing in August 2002. ■ Equipment in FY of 2002 arrived in December 2003. The assigned Counterpart started working from February 2003. ■ Additional human and material resources recommended as necessary at the time of Mid-Term Evaluation have been assigned to the laboratory since June 2003, including one medical technologist. ■ For setting up the reference laboratory, one Japanese short-term expert arranged the equipments and advised on the drug susceptibility test with the proportion method (February 2004) ■ Five laboratory staff were sent to GENETUP to study DST in September/October 2004.
B-6 Improve coordination between NTC and LMD/ Improve logistics management systems for drugs, laboratory and related materials within each region.	<ul style="list-style-type: none"> ■ Short-term experts recommended "the implementation of the regular actual physical verification" at all levels. Improvement was reported by logistics of short-term experts. (January – March 2003) ■ The problem regarding transportation pointed out at the time of Mid-Term Evaluation has been dealt with through proper planning beforehand to avoid seasonal problems ■ Logistics management for TB drugs and laboratory and related materials has been fully taken up by NTC and properly maintained according to the RTLA Workshop in 2004. The Project has provided technical advice for this activity.
B-7 Adopt a system for equipment maintenance	<ul style="list-style-type: none"> ■ 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. ■ No regular maintenance was conducted. Therefore, a programme for semi-annual, or annual maintenance services is to be developed, and microscope maintenance training is to be given to district staff ■ The lack of trained manpower regarding regular equipment maintenance, pointed out at the Mid-Term Evaluation, was addressed through refresher training for laboratory technicians regarding equipment maintenance, which was conducted by NTC in 2003/04 where seventy-three (73) technicians have participated. ■ The laboratory manager at the regional level has been maintaining the equipment.
■ Output C: Models for TB control in urban and hard-to reach areas are established.	
C-1 Urban DOTS improvement (strategy,	<ul style="list-style-type: none"> ■ The late patient tracing with mobilization of volunteers through strengthening of DOTS committee was developed.

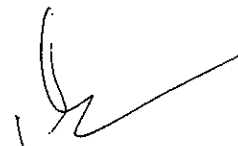
Activities as per PDM ₁	Results
training, coordination, DOTS centre, late patient training) in Kathmandu District	<ul style="list-style-type: none"> ■ The Project has been in contact with the NTC, Central Regional Health Division, Kathmandu District Public Health Office, Kathmandu City Health Department and the Nepal Tuberculosis Association for better Urban DOTS practices. ■ With regards to the late patient tracing, which was to be strengthened, improvement was seen in the Project-level indicators. ■ The number of DOTS centres in Kathmandu urban area has increased from nineteen (19) in 2001 to thirty-four (34) in 2005 with the Project's support in staff/volunteer training and equipment provision. ■ Twenty-seven (27) DOTS centres organized DOTS committees and conducting regular volunteer's meeting. Additionally, two (2) new DOTS centres (Dhumbarahi UHC and BABA Foundation) also started volunteer's activity. In order to share the experiences in each DOTS centre, wider-area review meetings were held in Kathmandu as well (including DOTS centre staff, committee members and volunteers). ■ Volunteers mainly act as late patient tracers, as treatment supervisors for those who cannot come to the clinic (because of weakness and so on), and as advocacy members. Reduction of defaulters was the target of late patient tracing; treatment outcomes are as follows: <ul style="list-style-type: none"> ➤ Treatment success rate: increased to 82% in 2002/03; and ➤ Defaulter rate: decreased to 5 % in 2002/03.
C-2 Hilly DOTS improvement (strategy, training, coordination, DOTS center, late patient training)	<ul style="list-style-type: none"> ■ Rasuwa District in Central Region has been selected as a pilot district. ■ In Rasuwa district, the district hospital at Dhunche used to be the only DOTS treatment centre with nine (9) sub-centres. To improve the poor accessibility to DOTS, two (2) microscopic centres were set up in Jibjibe PHC and Syafrubeshi HP, and DOT was conducted at all eighteen (18) (sub-) health posts, offering two-hour access to residents. The Project supported equipment and training for this expansion, including modular and refresher training for health-post workers, and late patient tracing training for community volunteers. ■ The Project also supported awareness raising activities on the World TB Day in 2004, in collaboration with the District Department of Health. ■ Japanese input to this activity has been more limited than planned, due to security conditions that restricted communication and transportation to the sites.
C-3 Urban, Coordinate with NGOs and private practitioners, KTM	<ul style="list-style-type: none"> ■ TB Orientation was conducted for 800 doctors including medical students and 180 chemists under the auspices of the Nepal Medical Association and its sister academic association, and the Nepal Chemists/Druggists Association in 2003/04. ■ Recommendation was made by the Joint Mid-Term Evaluation to further involve factories and industries, and TB orientations were

Activities as per PDM ₁	Results
	performed by DOTS committee as an advocacy programme.
C-4 DOTS improvement (strategy, training, coordination, DOTS centre, late patient training) e.g. Rupandehi	<ul style="list-style-type: none"> ■ Rupandehi district has two semi-urban areas, Butwal municipality and Bhairahawa municipality. In Butwal one (1) DOTS treatment centre used to work without any sub-treatment centres before launching Urban TB program. As one DOTS clinic at Lumbini Zonal Hospital covering around 110,000 populations, five (5) sub-treatment centres were newly established to collaborate with the Butwal DOTS clinic. Bhairahawa now has two (2) DOTS treatment centres and two (2) sub-centres. ■ The Project supported equipment and training for this expansion, including modular and refresher training for health-post workers. ■ The Project supported the organization of volunteers to strengthen late patient tracing. In 2002/03, treatment success rate has increased to 86% while the drop-out rate decreased to 4%. ■ The Project supported awareness raising activities on the World TB Day in 2003~05, in collaboration with the District Public Health Office.
C-5 Coordinate with NGOs and private practitioners, e.g. Rupandehi	<ul style="list-style-type: none"> ■ Coordination with NGOs/ INGOs, and private practitioners has been progressed smoothly. ■ The eight (8) new DOTS sub-centres (five in Butwal and three in Bhairahawa) are all operated by the private and NGO sector. ■ TB orientation seminar in 2004 was conducted in collaboration with the Nepal Medical Association in Rupandehi.
C-6 Monitor the progress of the model areas	<ul style="list-style-type: none"> ■ At every DOTS centre, regular meeting with health workers and supervision have continued to be carried out, as recommended in the Mid-Term Evaluation Report. ■ Regular (three times/year) monitoring at DOTS Treatment Centre in Kathmandu and Rupandehi has been conducted by DTLA, which is supported by the Project's technical staff.
C-7 Framework of the model is developed with adaptabilities to other areas with necessary modification.	<ul style="list-style-type: none"> ■ The framework for "model" practices has been defined and is being replicated in other urban areas (such as Pokhara) with the initiative of NTP, which entails involvement of private service providers.
C-8 Operational research is conducted. –HIV sero-prevalence evaluation. Strengthening case finding among HIV positive persons DOTS plus, initiated by NTC/WHO	<ul style="list-style-type: none"> ■ As discussed in the mid-term of the Project, operational research on TB/HIV dual infections and multi-drug resistant tuberculosis was conducted in 2001/02. The Project has provided technical support for this research activity. ■ The result of the research is to be reflected to the upcoming pilot project on DOTS Plus starting 2005 with the support of WHO.

Activities as per PDM ₁	Results
Output D: Case management of children with ARI is improved in selected districts.	
D-1 Conduct district-level planning workshop and DDC-level orientation	<ul style="list-style-type: none"> ■ For health facility staff and doctor's, a planning meeting and DDC-level orientation were conducted in July 2001. For VHWs, MCHWs, FCHVs and traditional healers, district level planning meeting and DDC-level orientation were conducted in November 2002.
D-2 Adopt IMCI training package	<ul style="list-style-type: none"> ■ For health facility staff and doctors, IMCI training was done from August 2001 to January 2002 by NEPAS. For the VHWs, MCHWs, FCHVs and traditional healers, CB-IMCI training was done from December 2002 to October 2003. ■ IMCI Training Package has been utilised in the training.
D-3 Conduct training / orientation (for doctors, basic health staff, volunteers, traditional healers, VDC member, etc.)	<ul style="list-style-type: none"> ■ Training materials (sound timers) did not arrive in time. And activities were carried out right after material arrived. ■ Training for 145 health facility staff including doctors was conducted with the technical and financial support by the Project in 2001/02. These activities include one management-level, six (6) district-level and six (6) medical institution level training. Training for 119 VHWs and MCHWs was conducted in 2002/03. ■ Fourteen (14) training workshops and orientation seminars took place during 2002/03 where 1,211 volunteers, 849 VDC members, 255 traditional healers, and, 21,904 mothers have participated.
D-4 Monitor and evaluate ARI case management at all levels	<ul style="list-style-type: none"> ■ Supervision of ARI case management was done after the training of IMCI by focal persons in DPHO and Project staff. Monitoring ARI case management (Regular monitoring) at community level was started with regular monthly supervision by health workers at health facilities. The Project supported the activities by consultation at DPHO. ■ IMCI workshop (IMCI review meeting) started from August 2002, where fifty-three (53) VDCs have taken part. Triannual reporting system was introduced from July 2002. Review meetings have extended to involve volunteers, which have been introduced to fourteen (14) VDCs in 2004. The Project supported technically and financially. ■ Health Post, PHC in charge level monitoring meeting is conducted regularly. Sub Health Post in charge level monitoring meeting was not sufficient. There should be opportunity to observe other areas of activities. ■ National program introduced IMCI register with support of USAID. Introduction of new follow-up system utilizing ARI follow-up cards is planned. The Project technically supported the production of IMCI register.

Activities as per PDM ₁	Results
■ Output E: Case management of adults with respiratory illnesses is improved in selected areas	
E-1 Conduct baseline studies for COPD	<ul style="list-style-type: none"> ■ 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 March 2002. ■ COPD survey was conducted from January to April 2002 with the cooperation of Nepalese professors and their colleagues. ■ The Project studied 4,000 populations in cross sectional survey. According to this survey results, three (3) VDCs were selected as anti-smoking activity sites. ■ WHO-supported PAL-Nepal Project in Nawalparasi District developed categorisation scheme according to which the COPD symptoms could be identified.
E-2 Conduct a literature review on national and international situations regarding adult COPD	<ul style="list-style-type: none"> ■ Epidemiology and risk factor of COPD was jointly published by the Project and NTC in March 2002.
E-3 Plan a pilot project in selected areas	<ul style="list-style-type: none"> ■ WHO has supported setting up the PAL-Nepal pilot project in Nawalparasi District.
E-4 Formulate module, formats and flowcharts for diagnosis and treatment of COPD	<ul style="list-style-type: none"> ■ WHO-PAL modules, formats and flow charts have been utilised in the Pilot Project.
E-5 Conduct training for health workers and other stakeholders	<ul style="list-style-type: none"> ■ WHO-supported PAL-Nepal Pilot Project has conducted training in Nawalparasi District. The CTLH Project has supported sending facilitator to the training and supervisor to follow up this activity.
E-6 Implement pilot activities in selected areas	<ul style="list-style-type: none"> ■ WHO-supported PAL-Nepal Pilot Project was launched in Nawalparasi District.
E-7 Coordinate with related organizations in conducting COPD activities.	<ul style="list-style-type: none"> ■ Project experts participated in the meeting of PAL-Nepal Pilot Project.
■ Output F: Communities adopted measures for anti-smoking.	
F-1 Adopt participatory methods in lung health programs, focus group discussion	<ul style="list-style-type: none"> ■ Activities have been conducted as lung health program, which focuses on mainly tobacco control, in selected three (3) communities having high smoking rates. ■ Training for volunteers has been conducted since 2002 in the selected VDC to initiate the focus group discussions (FGD). ■ Schoolteachers have been involved in educating students regarding anti-smoking and tobacco, through integrating the contents into their

Activities as per PDM ₁	Results
	<p>extra-curricular classes and organising poem/art/marathon competitions with the theme.</p> <ul style="list-style-type: none"> ■ Economic support is regularly provided to conduct school activities regarding anti-smoking from the school budget.
F-2 Train health staff in the Interpersonal communication and group work facilitation	<ul style="list-style-type: none"> ■ In selected three (3) VDCs, health staff was trained. ■ In the three (3) VDCs, DOTS volunteers, FCHVs and school teachers also received skills development training with regard to anti-smoking interventions. ■ The trained stakeholders have facilitated Focus Group Discussions, attended regular review meetings, and summarized their report. During 2003-05, regular monitoring and refresher training have been conducted and been instrumental in maintaining skills among stakeholders.
F-3 Conduct advocacy programs on lung health for the general public / conduct targeted health education.	<ul style="list-style-type: none"> ■ In selected three (3) 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. ■ In the three (3) VDCs, Lung health seminar was held for all health workers and volunteers working in Kathmandu valley in November 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 and 2003. In the 2004 World No Tobacco Day, these three VDCs organised their own communication activities advocating for stopping smoking. ■ Three VDCs also organised activities for the World TB day. ■ Schools and health facilities conducted different anti-smoking activities on their own resources. ■ The Project's technical staff has taken part in the publication process of a trainer's manual along with the "Nepal Stop Smoking Advocacy Campaign Strategy (2004~2008)".




2.3 Review of Implementation Process/Management of the Project

2.3.1 Implementation Process

The absence of the Chief Advisor during the first year unexpectedly slowed down the implementation of the Project, despite efforts made to address this issue by assigning the Project Coordinator as acting Chief Advisor. The implementation process accelerated after 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. Communication/collaboration among various development partners and other NTP stakeholders are considered to be sufficient, with the tradition of the NTP Annual Review meetings and the Project-initiated CAT meeting, where stakeholders engaging in urban DOTS programme in Kathmandu areas discuss and find solutions for more effective and efficient implementation. With regards to the coordination with other development partners supporting CB-IMCI activities, JICA CTLH Project has been taking part in the USAID-led forum where development partners including INGOs/NGOs and government stakeholders meet and share ideas and experiences.

2.3.2 Management of the Project

The Mid-term Evaluation Team noted that the activities were not conducted in accordance with the Project Design Matrix (PDM), nor did they duly refer to the PDM for monitoring, mainly due to the fact that the initial period had been dedicated to operational researches to define the scope and contents of cooperation within the Project to the newly initiated fields such as COPD and anti-smoking. The Mid-term Review Mission reviewed and revised the PDM to reflect all the current activities, and thereby, define the direction of the Project. The last half of the Project has been implemented along the revised PDM.

Despite the fact that this Project has been formulated through participatory planning workshops involving Counterparts, and that the Mid-term Evaluation was also conducted with the participation of the Counterparts, participants of the Terminal Evaluation Workshop exhibited a limited sense of ownership of the Project.

There seems to be a widespread perception among Counterparts from the central to the community who took part in the Project, that "the Project" is equivalent to "the Japanese Experts," rather than Nepali Counterparts teaming up with Japanese Experts to jointly implement the Project.

One thing to note is that the Project management has enjoyed technical and administrative contribution of well skilled and motivated staff of its own⁵. Furthermore, the full-time and part-time technical/programme officers and field workers often played roles as trainers and supervisors to health facilities within the Project to fill in a gap of Counterparts.

⁵ At the time of the Terminal Evaluation, the Project had three (3) full-time local administrative staff, three (3) full-time technical staff as well as six (6) part-time field workers and one (1) part-time administrative staff.

2.4 Achievement of Outputs

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

OVI for Output A:

A-1 Major decisions on project implementation are mutually decided by NTP and JICA teams in areas covered by the project

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

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

A-4 Local NGOs, social workers, CBOs, local government (VDC, DDC municipality), NATA, HP are found increasingly taking part in such programs as world TB day, DOTS workshop

Through undertaking Project activities in good collaboration, participating in international and local training in specialised fields at RIT and other organisations, and through technical and moral supports provided by the Japanese Experts, the managerial capacity of the NTP is further strengthened, and thus Output A is achieved. WHO's supports to human resources, provided in the form of assigning regional TB officers and technical advisory, as well as continuous financial support from NORAD through LHL has also contributed to the achievement of this Output.

NTP is now capable of making decisions on a priority basis, and with coordination with related stakeholders: NTC and JICA have been making mutual decisions over Project's matter; and the status of Project's implementation is also shared and discussed with wider stakeholders in the TBCN meetings (3 times/year) and the Project-initiated Coalition Against Tuberculosis (CAT) meetings.

NTC has also strengthened its ability to involve INGOs/NGOs and Private Sectors into the NTP, through implementation of urban DOTS programme and coordination meetings: In the 2004/05 World TB Day, a collaborative initiatives have taken place by the authority of Kathmandu City, DOTS treatment centre in Rupandehi District, NGOs, Kathmandu Urban Health Clinics, the Nepal Anti-TB Association, and GENETUP, in TB awareness raising activities. As the number of DOTS centres in Kathmandu and Rupandehi increased, so did the participating partners in the World TB Day events (where DOTS committees of all 75 districts have took part).

All health personnel responsible for implementing NTP at the specified level now have clearly defined work descriptions through formulation of individual plans. The Project has supported selected staff working under NTP to be trained in international and national conferences as well as in training courses abroad and in-country. Most of the trained staff has remained in the public health system, some serving as Regional Health Directors and District Health Officers, which in turn strengthened regional implementing structure of the TB Programme. Although the percentage of those currently engaging in TB-related activities among those trained is not clearly recorded at the NTC, one could observe that most of the trained staff working in the public health/medical institutions (excluding laboratory staff) is involved in work relating to TB. Actual allocation of staff vis-à-vis the approved post has improved during the Project.

Future challenges include strengthening programming skills through routine epidemiological monitoring/analysis and operational research activities to initiate response to changing demands of the

patients such as the issues relating to MDR-TB and HIV/TB issues.

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

OVIIs for Output B:

- B-1 By 2005, achieve 70% case finding with proportion of smear positive patients being over 55%
- B-2 By 2005 overall agreement rate is more than 90% with less than 5% false result
- B-3 80% functioning Microscopic Centres by 2005 (nationwide)
- B-4 At least 80% of the equipment at all levels and at all times are found functional
- B-5 By 2003, no instances of stores not having logistic materials in stock are reported at all the stores are achieved
- B-6 By 2003, drug supply at all the levels within the range of 85% - 135% of requirement

Output B is mostly achieved, with the sufficient performance of laboratory network and supply/stock of logistics. Nevertheless, an attempt to establish a reference laboratory at NTC with an acceptable DST capacity remains a challenge for the future. Reviewing the drug supply at regional/district levels would be helpful to capture the status and to suggest further improvement in logistics management. Contribution of WHO in human resources as well as CIDA's support to SAARC TB Centre also supported the management system for the laboratory and logistics of NTP.

Sufficient technical capacity in maintaining the laboratory network was developed in NTC to conduct TOTs to DTLAs in Quality Control, and with improved coordination at different levels as well as improved supervisory system. Staff motivation was also raised through technical exchange with Cambodia and other Project-related activities. Case finding reached the target 70% in 2001/02, which was further increased at 71% in 2003/04. Proportion of smear positive patients among the newly registered cases reached 50% in 2002/03, but decreased slightly in 2003/04 to 49%. The overall agreement rate of smear test results surpassed the target and reached 97% in 2003/04, with false positive rate of 1.5% and false negative rate of 1.0%. At the end of 2004, three-hundred and thirty-one (331) microscopy centres out of the total three-hundred and sixty-four (364)(91%) are providing service: Out of the non-functioning thirty-three (33) microscopy centres, only two were out of service due to malfunctioning microscopes; in the other eighteen (18) centres, microscopes were not managed sufficiently due to the lack of staff.

At the central NTC level, no stock outs of logistic materials were reported. Nevertheless, in the beginning of the 2004/05, the review workshop reported there were some centres in Eastern and Western Regions that had expired ample of streptomycin in stock. One DOTS centre in Kathmandu was also spotted in 2004 to have ample of streptomycin close to the expiry dates in stock. Whether the amount of drugs distributed to the regions/district is matching the amount actually on demand is currently being reviewed at the NTC.

Establishment of culture/research laboratory in NTC has been delayed, as the assignment of an additional medical technologist had not materialised to date. A visit by short-term expert was cancelled due to concerns over security conditions. To fill in this gap, the Project arranged five (5) laboratory staff to be locally trained in GENETUP, an NGO that has an international track record of being a reference laboratory, after which the NTC laboratory introduced the DST proportion method with L-J media. Preliminary record indicates that further technical support will be needed to improve the

quality of the DST. The returning medical technologist who had received MSc.-level training in Thailand under this Project should be assuming the role to establish the capacity to conduct DST at NTC.

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

OVI for Output C:

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 .

C-2 90% of TB patients in hilly model area(s) have DOTS services accessible within 2 hr walk

C-3 The number of patients who received TB treatment under non-DOTS will decrease

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

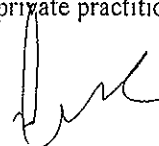
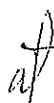
Indicators to measure the achievement level of the Output C show positive sign on the effectiveness of Project's pilot interventions. The cure rate increased from 79% before the intervention to 85% for Kathmandu metropolitan area in 2004/05 1st and 2nd quarter, and the number of DOTS sites also increased during the Project period. Similar outputs are observed in Butwal city in Rupandehi District. The Project has benefited from the experience in an urban DOTS programme implemented by the Nuffield Institute as well.

Number of DOTS centres increased from nineteen (19) to thirty-four (34) in Kathmandu, one (1) to six (6) in Butwal city (Rupandehi), and one (1) to five (5) in Bhairahawa by 2005. This was achieved through collaboration with the Nepal Medical Association, the Nepal Chemists/Druggists Association, private practitioners, NGOs/INGOs, medical colleges, and municipality health services. Quality and quantity of involvement and collaboration among stakeholders has been enhanced through CAT meetings, where the diverse stakeholders gather and collectively troubleshoot problems and discuss better ways to implement urban DOTS programme.

In Kathmandu metropolitan area, the number of newly registered smear positive patients have increased from 799 to 930 cases over the past four years, and treatment success rate improved from 79% to 82%, just short for the target 85%. The programme did managed to minimise the defaulters from 8% to 5%, while 7% was migrated to other areas (T/O cases). In Butwal city, new smear positive cases have increased from 137 to 169, with a significant increase in treatment success rate from 79% to 86% over the three years since starting the urban DOTS activities.

In the pilot district of hilly area, Rasuwa District, it is not adequate to see the effectiveness through the treatment success rate, as the project's interventions have been limited only for half a year from the middle of 2003 due to the security concerns. However, the Project supported the expansion of DOTS (sub-)centres in Rasuwa District from ten (10) to nineteen (19) through staff/volunteer training and equipment provision, and the access to the DOTS centres for villagers have improved to within 2-hour walking distance from villages.

Proportion of TB patients having received non-DOTS regimen requires a survey targeting private practitioners to capture what portion of the TB treatment services do the private practitioners account for. The Project will consider conducting such surveys in June.



An overall effectiveness of the Project's diverse attempts on urban DOTS, that is, to shift the pattern of patient flow by increasing and enhancing referral and diagnosis/treatment points to make sure the increased number of TB-suspected patients obtain DOTS, could be confirmed through a careful review of survey results that is currently being compiled.

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

OVI for Output D:

- D-1 By 2004 cure rate of pneumonia is more than 85% in the selected district with ARI programme
- D-2 By 2004, 80% of registered ARI cases are properly managed (diagnosed, treated, referred) at all levels
- 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

Through Project's financial and technical support to the introduction of the Community-based IMCI (CB-IMCI) in Rupandehi District,⁶ case management of children with ARI is improved in the District. The Project's scrupulous attempt to ensure that all the ARI cases are followed-up with regular guidance to the FCHVs through review meetings has borne fruit, with an 88% case follow-up rate by the FCHVs and a relatively high 87% cure rate. DfID's support to Community Drug Programme (CDP) contributed to enhancing and sustaining the motivation of FCHVs. Sharing of the ideas and experiences with other CB-IMCI partners, such as USAID-funded Nepal Family Health Programme (NFHP) working in other Districts has also been beneficial for this achievement.

Data obtained in review meetings from 9 VDCs and 24 health facilities (out of all 69 VDCs and facilities in Rupandehi) presented in the review meeting indicate that twelve percent (12%) of newly recorded pneumonia cases in the locality were diagnosed at the community level in 2003/04. Among the 996 pneumonia cases (including 172 severe cases) diagnosed at the community, 872 cases (88%) have been followed up, with three (3) deaths and 869 improvements, reaching the cure rate of 87% (869/996). In contrast, follow-up rate of health facility is quite limited at 25% (345 out of 1,397 cases) in 2003/04, while cure rate was 86% in January 2002~June 2004. There were 8,378 ARI cases in 2003/04.

Indicators that demonstrate proper management of ARIs could not be obtained as only the pneumonia cases are subject to follow-ups. Nevertheless, interviews conducted with the 194 community health volunteers revealed that: 85% could properly identify danger signs of pneumonia, 90% the breathing frequency criteria, 90% the proper home care instructions, and all 43 female health volunteers who were entitled to treat the patients could correctly specify the amount of antibiotics to be prescribed. Thus, one could safely infer that more than 80% of the ARI diagnosis, treatment and referral have been managed properly at the community level.

⁶ Data from 24 health facilities in Rupandehi suggests that ARI cases account for 42% (January ~August 2002), 38% (July 2002~June 2003), and 33% (July 2003~June 2004) of all the IMCI cases.

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

OVI for Output E:

- E-1 By the end 2004, guidelines available in concerned health institutions on prevention and case management (identification, classification and basic treatment)
- E-2 Number of subsequent visits by affected people to health institutions after registration
- E-3 Number & frequency of lung health problem cases identified in the project area
- E-4 Number of health institutions using the prescribing guidelines in the specified areas and providing feedback for their utility and modification

Out of the planned activities in this Output (E), only 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 the PAL Nepal project, which has the same objectives as the Output (E), was in progress. Therefore, the Project has been assisting PAL-Nepal in Nawalprasi District when need arises, as per decision of the Mid-Term Evaluation. With this very reason, most of the OVIs set to measure achievement level of Output E became either obsolete or inadequate to measure the performance of this Project. Assistance provided to PAL-Nepal Project included provision of the Project's technical staff as a resource person in the development of COPD management guidelines.

Output F: Communities adopted measures for anti-smoking.

OVI for Output F:

- F-1 Increased numbers of lung health promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives
- 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) increases by 20%
- F-3 By the end of the project (5 yr.) smoking rate in the selected (targeted) area decreased by 20% (or, Purchase and utilization of cigarettes; Number of non-smoking zones/villages/parks etc.)

Activities under the Output F are assessed to be on track in achieving the target, although confirmation of the expected effect on the smoking rate has to wait for the results of the survey that took place in April 2005.

Activities under this Output started during 2002, as the Project required time to come up with its focus on COPD-related interventions through a study. In contrast to the commonly practiced mass campaigns using electronic media, the Project took "face-to-face" approach, in which anti-smoking messages were conveyed from person to person, and directly connects to actions to change the audience's attitudes. At the first stage of interventions, seminars on lung health and awareness raising workshops on hazards of smoking were conducted for health workers, health volunteers and representatives from all the schools in the three selected VDCs with the worst smoking rate. This training equipped the schoolteachers, health workers and volunteers with technical knowledge and skills to transcend anti-smoking messages. This motivated schoolteachers to conduct extra-curricular programmes, health workers to conduct counselling activities on smoking cessation, and volunteers to take part in anti-smoking programmes.

These training activities are being translated into significant outputs: 1) two-hundred fifty (250) focus group discussions were carried out with the initiative of volunteers in three (3) selected VDC areas, where a total of one thousand and two-hundred eighty (1,280) villagers participated; 2) schoolteachers and volunteers carried out anti-smoking activities in the form of rallies and development and dissemination of IEC materials on smoking hazards on the World No Tobacco Day in 2004; a DOTS-like patient registration and follow-up system was introduced at the health facilities; and, 869 COPD patients were registered by the health workers, of which, sixty-five (65) (7% of those registered) patients received counselling and 26 (43%) patients had subsequently been refraining from smoking for more than six (6) months. Proportion of those who quit smoking makes 3% among those registered with COPD. In addition, the areas designated as non-smoking areas increased to forty-five (45) places in these intervened three VDCs, including schools, VDC offices and temples. Changnarayan temple, a UNESCO World Heritage, is part of the designated places, thanks to efforts by Project staff members.

Activities related to Anti-smoking interventions are still at the start-up phase in Nepal⁷. In this regard, the Project's experience in three (3) VDCs is one of the few known to in Nepal. As such, the Project's technical officer, who has been involved in implementing and monitoring the activities, took part in the formulation of the National Anti-tobacco Communication Strategy as well as developing national training manuals for Health Workers, Volunteers and NGOs, where Project's experiences were shared.

In order to capture the achievement of the Output, baseline study was conducted in 2002 on residents' knowledge on the hazards of smoking and prevention method of COPD. A follow-up study had to be postponed to April 2005 due to security concerns. The results should further demonstrate the effects of this Project's interventions.

2.5 Achievement of Project Purpose

Project Purpose 1: Overall performance of the NTP is further strengthened	Project Purpose 2: Functional models for improved community lung health are established
OVI for the Project Purpose 1: P1-1 75 districts covered by DOTS by 2003 P1-2 85% of treatment success rate has been achieved (nationwide) by 2005 P1-3 85% of TB patients covered by DOTS by 2005	OVI for the Project Purpose 2: P2-1 By 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 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

The Project Purpose 1, "Overall performance of the NTP is further strengthened," is achieved. By 2001, all the 75 districts had been covered by DOTS. Cure rate and treatment success rate among the newly registered smear positive TB patients in 2003/04 were 86% and 88%, respectively (NTC, 2005). In 2001/02, 97% (13,669 cases) of the newly registered smear positive TB patients received DOTS,

⁷ National Anti-tobacco Communication Strategy is to be approved by the Ministry and the House before its implementation.

while other 3% received non-DOTS. All the registered TB cases are to be offered DOTS since 2002/03. Measuring actual proportions of TB patients who are covered by DOTS and the rest non-DOTS would require a country-wide survey to capture the number of patients receiving non-DOTS treatment in the private sector: A survey in Kathmandu is planned to take place the following month of this evaluation.

The Project Purpose 2, "Functional models for improved community lung health are established," is mostly achieved. In Rupandehi District, the reported under-five ARI incidence rate decreased from 124 per thousand children in 2000/01 to 104 in 2001/02, but relapsed to 136 in 2002/03. Among these, severe pneumonia cases accounted for 2.2% in 2000/01 and relapsed to 2.5% in 2001/02, but decreased again to 1.3% in 2002/03. A declining trend of under-five severe pneumonia cases per one thousand population is observed in the District, from 2.73/1,000 in 2000/01, 2.60 in 2001/02 to 2.04 in 2002/03 (Ministry of Health and Population, 2001~04). According to the data obtained from 24 out of 69 health facilities in Rupandehi, the number of severe pneumonia cases under 5 decreased from 64 (January - August 2002), 41 (July 2002 - July 2003) to 39 (July 2003 - July 2004). This is more likely to be attributed to Project's interventions, as nearly 90% of the FCHVs had correct memories of severe diseases and pneumonia signs, and more than 87% of pneumonia cases and 76 of severe pneumonia cases were followed up by the FCHVs at the community level, and at about 90% of all age groups are estimated to have received the correct dosage of Cotrimoxazole from FCHVs..

As for the effects in anti-smoking activities in three VDCs, a KAP survey on smoking took place in April 2005 to measure the effects of interventions at school, health facilities and community levels. Unfortunately, the results of this survey were not available for evaluation.

The effectiveness of the models, that is, adopting a DOTS-like concept of rigid patients follow-up system to improve the ARI case management and the Anti-smoking interventions, still requires some analyses of collected data and scrutiny to determine its feasibility for replication.



3. Evaluation by Five Criteria

3.1 Relevance

Relevance of the Project is considered to be very high as Project's strategy addresses the needs of the target group and are coherent with the policy of MOHP/HMG as well as the assistance strategy of JICA.

In Nepal, over 60% of total population are estimated to be 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. As for the child health, the mortality rate of the children under five years of age in Nepal is 91 per thousand live births in 2001.⁸ Moreover, with insurgency affecting lives of the people living in rural areas, a surge of in-migration to urban areas is observed in recent years, making it even more crucial to address an urban DOTS issue. 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 day⁹, and smoking habits are considered to be major factors affecting people's lung health.

The Project's community-focused strategy in dealing with TB, ARI and smoking issues responds to the needs of the population. Under the NTP component, the Project tried expanding and strengthening the services delivery points to the closest possible to the patients in urban and hard-to-reach areas by building functional network with existing service providers, combining those with community mobilisation. The ARI component as well as anti-smoking component try establishing community-focused models through strengthening services delivery at the sub-health posts and community levels and combining it with social mobilisation. This matches the needs of the target group, where socio-economic conditions affect patients' mobility, and stigma attached to the diseases still persist.

Workshop participants feel that the selection of the target group and areas for the TB and ARI components was good but could address larger areas in the future. Selection criteria for anti-smoking interventions may well be more focused to vulnerability of areas and groups considering socio-economic and cultural factors, instead of basing it solely on the proportion of the smokers in a given population.

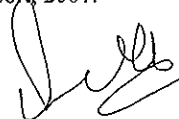
The MOHP/HMG, in its overall national health policies and strategies, has set the dominant national objective for the health as to provide the preventive and curative services. Among those health services, the MOHP/HMG put the high priority toward the tuberculosis control and child health. Worth noting was in the NTP component, intensive advocacy activities has resulted in even increased commitment on DOTS interventions from stakeholders at various levels. As for the tobacco control, "The National Anti-Tobacco communication Strategy for Nepal" has been prepared, awaiting adoption by the Ministry. Additionally, JICA's country programme has its focus on health sector support, especially on areas relating to 1) infectious disease control, and 2) maternal and child health.

3.2 Effectiveness

Effectiveness of the NTP component as well as the ARI component was good, with reduced defaulter and improved treatment success rates, and greatly improved case management of ARI in Project's

⁸ HMG/N, National Demographic and Health Survey, Preliminary Report, 2001.

⁹ Nepal, Demographic and Health Survey, 2001.



intervened areas. Confirming the effectiveness of the model interventions in Kathmandu and Rupandehi to consider expanding the effective interventions to larger areas will be the challenge ahead. Effectiveness of the Anti-smoking interventions was considered to be fair: Knowledge and attitudes/motivation of those involved have significantly increased, but with limited percentage of those who quit smoking at this stage. Except for Output E (COPD service development component) and a model development in hard-to-reach areas under the Output C where Project had to limit its inputs in order to avoid duplication and security risks, all the Outputs have contributed to the achievement of Project Purposes.

Factors that have proved effective in achieving the target include the following. First, the framework of urban TB control with involvement of multi-stakeholders including the KMC, the NGOs/INGOs and private clinics and pharmacies have served as an effective approach to increase accessibility in urban setting for NTP. Second, building capacity at the community level by empowering the volunteers and community people has also served as the effective means to address accessibility and sustainability issue for all the components. In particular, regular review meetings both at community and district levels followed by comprehensive training to equip service providers with much needed specific and technical knowledge and skills, are found to be essential in sustaining commitment, motivation as well as technical competency of service providers, especially that of community health volunteers. Patients now have easier access to treatment and/or diagnostic services not restricted in terms of distance, opening hours and in some instance, language barriers. Local leaders/administration sensitised with the issue are cooperative to the work of health workers and community volunteers.

Factors that limited the effectiveness include the restricted mobility of people due to frequent bandha and security conditions, highly mobile and low socio-economic profile of urban population that made the DOTS follow-up difficult, limited budget of local government to support regular reviews/supervisions of programme, and transfer of focal persons trained and motivated to conduct specific activities, the lack of hand-over plan to institutionalise a new initiative in anti-smoking.

3.3 Efficiency

Overall, efficiency of the Project was at the satisfactory level, with quality, quantity and timing of the provision of most inputs being adequate and thus utilised to achieve Outputs. The expertise of the Japanese experts is considered to be excellent. The management and coordination of activities of the Project, such as TBCN, CAT and IMCI meetings with other development partners and cooperating medical institutions were also effective in avoiding overlaps and promoting collaborative actions.

The Project had to run without a Chief Advisor in the beginning, which slowed down implementation of the Project activities. Assignment of some Counterparts was not timely, which also delayed some activities. Additionally, some inputs such as laboratory equipment for culture were under-utilised due to the transfer and shortage of manpower in the NTC laboratory. A motorcycle meant to be utilised for supervision by District officers was seized by the insurgency group and did not serve the purpose.

Factors that limited efficiency include, frequent transfer of trained staff that restricted continuity of activities at the speed it previously had, frequent bandha and other security situations that limited mobility of people, shortage of personnel that stagnated actions and limited regular supervision to facilities and having several experts to assist in one area.

Factors that promoted efficiency include, improved logistics and diagnosis network system from the

centre to the periphery, much of that can be attributed to a legacy from the first and second phases of the Project, and, already trained manpower during the last phase being placed to different regions that promoted solid implementing structure of the NTP.

3.4 Impact

The workshop participants considered that the improved NTP performance by the Project has contributed to the attainment of the Overall Goal (reduction of morbidity and mortality due to lung health conditions), reserving the conclusion, as it still requires verification through prevalence surveys. As for the lung health component, impact on morbidity and mortality is too early to judge at this moment, as the interventions were short and covered only limited areas. In order to have a significant impact through anti-smoking activities, the workshop participants felt that it requires legal regulations to discourage smoking in addition to community-based interventions.

Furthermore, the Project stakeholders and the Evaluation Team observed the following positive and negative impacts relating to Project's interventions.

First, TB Control Programme has contributed to improve the overall capacity building of health workers. Training conducted under NTP, IMCI programme and anti-smoking programme has equipped health workers and volunteers with the practical and technical knowledge and skills. In addition, those health workers have been empowered through the regular review meetings such as DOTS workshop in order to share their knowledge and experiences, and to be recognized by senior supervisors.

Second, NTP and CB-IMCI programme have contributed to empower the community through advocacy activities. It in turn resulted in VDC's active involvement in health issues and reducing stigma attached to TB. VHWs, FCHV and DOTS volunteers/committees have worked to trace the late patients and to bring them back to the DOTS services. In Rupandehi, orientations were conducted to wider stakeholders, from VDC officials to traditional healers, to support FCHVs activities in the community. Another factor to note, is that giving FCHVs a role of diagnosis and managing patients through provision of a sound timer and Cotrimoxazole increased credibility and recognition of FCHVs in the community, and that in turn motivated FCHVs to perform better.

Third, through the CB-IMCI interventions, a good monitoring tool has been developed which could be utilised for any health-related interventions. Other components such as nutrition education and Control of Diarrhoeal Disease management could be improved through improved ARI case management as well.

Fourth, Project's undertaking in the urban DOTS programme in Kathmandu, has contributed to a development of a framework to involve the public and 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 an appropriate DOTS clinic. The collaboration with private practitioners will be important to improve the case finding rate and cure rate in the urban setting, which holds the great number of population.



3.5 Sustainability

Overall sustainability of the Project is considered to be good, with institutions having established system and technical capacity to maintain current interventions and outputs. Some challenges remain in institutionalising a mechanism that sustains the current level of technical capacity and financial security, and further developing technical capacity to meet the new challenges, such as TB/HIV and MDR-TB.

Factors that limited the level of sustainability include: 1) frequent transfer of well-oriented and trained professionals; 2) continuous in-migration to the city and persisting poverty; 3) drop-out of volunteers observed in some community; and, 4) widespread feelings of reliance on external aid agencies and/or Project personnel among those involved in Project activities, that seemed to be linked to general underestimation of their personal, institutional and technical capacity to sustain the outcomes they have produced.

3.5.1 Organisational/institutional aspect

NTC assumes overall responsibility for NTP to pursue and sustain the achievement of national objectives. With the internationally recognized strategy (DOTS), the NTP is well established to sustain outcomes it has produced. As for the ARI activities, the HMG has strong commitment to expand the CB-IMCI model to all the districts by 2014, and sufficient donor supports could be expected for this successful scheme. Anti-smoking component requires further government's commitment to approve the Anti-Smoking Communication Strategy and to implement its plan. Output (F) "Communities adopted the measures for anti-smoking" may face difficulty to be sustained without institutionalisation of continuous training and regular supervisory mechanism, as that was mostly provided by the Project itself with less involvement of locally established structure.

3.5.2 Technical aspect

Sustainability with regards to technical aspect is high, as NTP currently has an established system and trained personnel to maintain their present DOTS interventions, including a good physical facility, logistic supply network that goes down to sub-health posts and community levels, sufficient network of diagnostic centres, functioning supervisory mechanism and trainers to continue staff orientation and training. Moreover, NTC has built a stable link with various willing partners, such as non-governmental and private services providers as well as the community through volunteers and DOTS committees. CB-IMCI and the anti-smoking initiatives also built a good relationship between service providers and the community.

In order to sustain the current technical level, nevertheless, continuous training for transfer-in staff, as well as review meetings and refresher training are essential.

3.5.3 Financial aspect

Financial resources to run NTP are satisfactory to some extent, with other development partners having contribution, and with the Global Fund application being signed soon. As for CB-IMCI, essential budget could be secured with many development partners showing interests in supporting CB-IMCI activities, such as USAID, UNICEF, CARE and the World Bank. As for Anti-smoking communication programme, the draft National Anti-tobacco communication Campaigning Strategy for Nepal (2004 ~ 2008) is soon to be approved by MOHP. Health Tax Fund has some annual allocation for anti-smoking activities for use by Districts and for



developing Behaviour Change Communication activities¹⁰.

4. Recommendations

4.1 Management of NTP

4.1.1 For continuation of the current activities:

- 1) NTC is to enforce urban and hard-to-reach areas DOTS in the current areas, and to replicate to other areas
- 2) Every staff (NTP, Urban DOTS) is to review and implement what s/he learned from the training/project
- 3) TB orientation to HIV health workers is to be continued by NTC/CTLHP in collaboration with the National Centre for AIDS and STD Control by the end of the project to further build the capacity of HIV care workers in dealing with the TB/HIV issues

4.1.2 For meeting newly emerged demands and challenges:

- 1) NTC is to develop a five-year pilot plan and proposal for TB/HIV for submission to development partners by the end of July 2005
- 2) NTC is to plan and conduct tuberculosis prevalence survey
- 3) MOHP is to expedite the process of increasing NTC staff (doctors and laboratory personnel)

4.2 Laboratory and Logistics

- 1) MOHP/DHS is to allocate additional manpower to NTC, especially in laboratory
- 2) NTC/CTLHP is to coordinate with the LMD for logistics distribution
- 3) MOHP/NTC/CTLHP to provide training for the maintenance of microscope by the end of the Project. In so doing, possibility to collaborate with Biomedical Training Institute at Department of Health Services to be sought
- 4) NTC/CTLHP in collaboration with NPHL to provide training on QC to DTLAs
- 5) NTC/CTLHP is to strengthen NTC laboratory looking into upgrading NTC to a national TB reference laboratory with the capacity of DST. In so doing, MOHP/NTC to consider establishment of a linkage with Supranational Laboratory
- 6) MOHP/NTC/CTLHP is to examine the change in the sampling size for EQA to a new QC system of WHO/IUATLD

4.3 Urban DOTS

- 1) DPHO/NTC is to continue coordination among urban DOTS partners
- 2) MOHP/KMC should explore partners/donors to continue urban TB control programme in Kathmandu
- 3) CTLHP/NTC are to conduct Non-DOTS patient survey with bigger sample and analyse the result

¹⁰ Twenty million (20,000,000) in FY 2003/04 and ten million (10,000,000) rupees in FY 2004/05 was allocated.

- 4) CTLHP to organise a workshops to disseminate the achievements on urban DOTS with concerned stakeholders

4.4 IMCI

- 1) CHD/DPHO/CTLHP to continue review/monitoring meeting at health facility level and community level
- 2) LMD/DPHO to strengthen Community Drug Programme and to expand in remaining VDCs in Rupandehi
- 3) CHD/CTLHP/DPHO to consider offering IMCI training to newly-transferred staffs into Rupandehi District
- 4) CHD/CTLHP/DPHO/RHD to conduct regular supervision
- 5) CHD/DPHO and other partners such as NGOs working in the area to hold regular co-ordination meeting with municipality for training of municipality FCHVs
- 6) DPHO to conduct training on the neonatal management module to trained staff

4.5 Anti-Smoking

- 1) NTC, CTLHP and NHEICC to examine the HMG 10th National Development Plan, the Second Long-term Plan and the Nepal Health Sector Programme - Implementation Plan for further extension of anti-smoking interventions
- 2) CTLHP, NTC and NHEICC to expedite developing varieties of health education activities focusing on behaviour change communication



ATTENDANCE

Workshop on Final Terminal Evaluation of JICA CTLH Project

DATE : - 10 May, 2005

Place: Training Building, NTC, Thimi

S. N.	NAME	Designation	Health Institutions
1	Dr. Kashikant Jha	Sr. Consultant C/ Physician	NTC
2	Dr. Pushpa Malla	Sr. Consultant C/ Physician	NTC
3	Dr. Sundar Shyama Jha	Medical Officer	NTC
4	Mr. Bholu Choudhary	Lab Technician	NTC
5	Mr. Ram Babu Shrestha	Lab Technician	NTC
6	Mr. Bishnu Jaisi	RTLA	NTC
7	Mr. Laxmi Maharjan	Storekeeper	NTC
8	Mr. Sudarshan Adhikari	Asst. Storekeeper	NTC
9	Mr. Krishna Murari Acharya	Medical Technologist	Teku Hospital
10	Dr. Rajendra Pant	Public Health Administrator	CRHD
11	Dr. Jyoti Raj Shrestha	DPHO	DPHO, Kathmandu
12	Ms. Sarala Sherchan	PHI	TUTH
13	Ms. Geeta Acharya	DTLA	DPHO, Kathmandu
14	Ms. Tara Shrama	DTLA	DPHO, Rupandehi District
15	Mr. Ram Krishna Prajapati	HP Incharge	Chapagaon THP, Lalitpur District
16	Mr. Bhagirath Baniya	AHW	Tokha PHC, Kathmandu District
17	Ms. Sharmila Neupane	Teacher	Shangri-la Int'l School, Chapagaon
18	Mr. Deependra Shrestha	Teacher	World Vision Academy, Tokha
19	Mr. Rishikesh Upadhaya	Volunteer	Red Cross, Changunarayan VDC
20	Ms. Sarit Maharjan	Volunteer	Chapagaon VDC
21	Dr. Sunlal Thapa	Chief, IMCI Section	CHD, DoHS
22	Mr. Ram Chandra Khanal	DPHO	DPHO, Rupandehi District
23	Mr. Mukund Raj Gautam	Supervisor, IMCI	DPHO, Rupandehi District
24	Ms Phul Maya Ghale,	FCHV	Devdana VDC (serving at Devdana SHP)
25	Ms Urmila Gupta,	FCHV	Modhubani VDC (serving at Lumbini PHC)
26	Ms. K. Yoshida	Project Formulation Adviser	JICA Nepal Office
27	Mr. K. Umetsu	Asst. Resident Representative	JICA Nepal Office
28	Dr. Tatsuo Sugiyama	Chief Advisor	JICA CTLH Project
29	Mr. Akira Naruse	Coordinator	JICA CTLH Project
30	Ms. Yoko Ogawa	Consultant	JICA-JAPAN
31	Mr. Ram Kumar Shrestha	Liaison Office	JICA CTLH Project
32	Mr. Rabindra D. Joshi	Adm. Officer	JICA CTLH Project
33	Mr. Ram Sharan Gopali	Programme Officer	JICA CTLH Project
34	Mr. Basant Thapa	Technical Officer	JICA CTLH Project
35	Mr. Munal Thikey	Asst. Adm. Officer	JICA CTLH Project
36	Mr. Hari Maharjan	Driver	JICA CTLH Project
37	Mr. Santos KC	Driver	JICA CTLH Project
38	Mr. Radhakrishna	Driver	JICA CTLH Project
39	Mr. R. K. Mahaju	Electrician	NTC
40	Mr. B. Katiwada	Attendant	NTC
41	Ms. Ruri	observer	JOCV
42	Mr. RK Sunari	Attendant	JICA CTLH Project

ATTENDANCE

Workshop on Final Terminal Evaluation of JICA CTLH Project

DATE : - 18 May, 2005

Place: Hotel Everest, Kathmandu

S. N.	NAME	Designation	Health Institutions
1	Dr. Kesab Bhakta Shrestha	Director	NTC
2	Dr. Kashikant Jha	Sr. Consultant C/ Physician	NTC
3	Dr. Pushpa Malla	Sr. Consultant C/ Physician	NTC
4	Dr. Sundar Shyama Jha	Medical Officer	NTC
5	Mr. Sitaram Ghimire	Statistical Officer	NTC
6	Dr. Christian Gunneberg	Medical Officer	WHO/NTP
7	Mr. Bhola Choudhary	Lab Technician	NTC
8	Mr. Ram Babu Shrestha	Lab Technician	NTC
9	Mr. Bishnu Jaisi	RTLA	CRHD
10	Mr. Laxmi Maharjan	Storekeeper	NTC
11	Mr. Sudarshan Adhikari	Asst. Storekeeper	NTC
12	Mr. Krishna Murari Acharya	Medical Technologist	Teku Hospital
13	Dr. Rajendra Pant	Public Health Administrator	CRHD
14	Dr. Jyoti Raj Shrestha	DPHO	DPHO, Kathmandu
15	Dr. Babu Ram Gautam	Chief	PHD/Kathmandu Metropolitan City
16	Dr. Bhawana Shrestha	Chief Medical Officer	GENETUP
17	Ms. Sarala Sherchan	PHI	TUTH
18	Ms. Geeta Acharya	DTLA	DPHO, Kathmandu
19	Ms. Tara Shrama	DTLA	DPHO, Rupandehi District
20	Mr. Ram Chandra Khanal	DPHO	DPHO, Rupandehi District
21	Mr. Mukund Raj Gautam	Supervisor, IMCI	DPHO, Rupandehi District
22	Dr. Sunlal Thapa	Chief, IMCI Section	CHD, DoHS
23	Mr. Babu Ram Koirala	Director	NHEICC, DoHS
24	Mr. Ram Krishna Prajapati	HP Incharge	Chapagaon THP, Lalitpur District
25	Mr. Bhagirath Baniya	AHW	Tokha PHC, Kathmandu District
26	Ms. Sharmila Neupane	Teacher	Shangri-la Int'l School, Chapagaon
27	Mr. Deependra Shrestha	Teacher	World Vision Academy, Tokha
28	Mr. Rishikesh Upadhaya	Volunteer	Red Cross, Changunarayan VDC
29	Ms. Sarit Maharjan	Volunteer	Chapagaon VDC
31	Ms. Akiko Tomita	Leader	Evaluation Mission
30	Dr. Nobukatsu Ishikawa	TB Control	Evaluation Mission
32	Dr. Tadatoshi Kuratsuji	Lung Health	Evaluation Mission
33	Ms. Tomoki Shimada	Evaluation Planning	Evaluation Mission
34	Ms. Yoko Ogawa	Consultant	Evaluation Mission
35	Ms. Akiko Fujiki	Expert	RIT, Japan
36	Mr. Akira Naruse	Coordinator	JICA CTLH Project
37	Mr. K. Umetsu	Asst. Resident Representative	JICA
38	Mr. Ram Kumar Shrestha	Liaison Office	JICA CTLH Project
39	Mr. Rabindra D. Joshi	Adm. Officer	JICA CTLH Project
40	Mr. Ram Sharan Gopali	Programme Officer	JICA CTLH Project
41	Mr. Basant Thapa	Technical Officer	JICA CTLH Project
42	Mr. Munal Thikey	Asst. Adm. Officer	JICA CTLH Project
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45	Mr. Radhakrishna	Driver	JICA CTLH Project
46	Ms. Ruri	observer	JOCV
47	Mr. RK Sunari	Attendant	JICA CTLH Project

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

Project Name: The Community Tuberculosis and Lung Health Project

Project Area: Whole country

Target Group: TB Patients Duration: 2001-2006.8

Date Issued: Mar. 10, 2003

Interventive Summary	Outcome Variable 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 diseases are reduced over several years in Nepal.	HMG clinicians TB prevalence survey/impact study reports	1 The health system reform is smoothly implemented 2 Bg epidemic of HIV does not occur.
Project Purpose 1. Overall performance of HTP is further improved. 2. Functional models for improved community lung health are established.	P1-1 75 districts covered by DOTS by 2003 P1-2 85% of treatment success rate has been achieved (national level) by 2005 P1-3 85% of TB patients covered by DOTS by 2005. 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. 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 training and smoking campaign by the end of the project	Annual evaluation report of the HTP Proceedings of national reporting and planning workshop Annual Report of the Department of Health Services Smoking Survey	1 Communities continue to use the services of the HTP 2 Achievements made in the lung health program are extended beyond the model areas
OUTPUTS A. The managerial capacity of the HTP is further strengthened. B. Management system for the laboratory and logistics of the HTP is made sustainable C. Models for TB control in urban and hard-to-reach areas are established. D. Case management of children with ARI is improved in selected districts E. Case management of adults with respiratory illnesses is improved in selected areas F. Communities adopted measures for anti-smoking.	A-1 Major decisions on project implementation are mutually decided by HTP and JICA teams in areas covered by the project. A-2 All health personnel are possible for implementing HTP at the specified level having a clearly defined job descriptions and are evaluated upon their performance and provided opportunities in line with their capacity and career development. 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 A-4 Local NGOs, social workers, CSOs, local govt., VDC, DDC, NPT, NATA, HP are found increasingly taking part in such programs as: World TB day, DOTS workshop B-1 By 2005, achieve 70% case finding with proportion of smear positive patients being over 55%. B-2 By 2005 overall agreement rate is more than 90% with less than 5% false result B-3 80% functioning IACs by 2005 (national level) B-4 At least 60% of the equipment at all levels and at all times are found functional B-5 By 2005, no instances of stores not having logistic materials in stock are reported at all the stores are achieved B-6 By 2005, drug supply at all the levels within the range of 85% - 125% of requirement C-1 Within 2 years, 15% of the estimated TB patients in the model area (but only 66% in HTP areas) will have a cure rate of 85% through the use of modified DOTS method C-2 90% of TB patients in HTP model area(s) have DOTS services accessible within 2 hr walk C-3 The number of patients who received TB treatment under non-DOTS will decrease. C-4 The ratio of (no. of DOT sites established/estimated no. of DOT sites suitable for the model area) found progressively increased over time/years D-1 By 2004 cure rate of pneumonia is more than 85% in the selected district with ARI program D-2 By 2004, 80% of registered ARI cases are properly managed (diagnosed, treated, referred) at all levels. D-3 By 2004, at least 80% of the registered pneumonia (2 months - 6 years) cases have 3rd day follow-up D-4 At least 65% of all age groups receive the correct dosage of medication as per WHO standards E-1 By the end 2004, guidelines available to concerned health institutions on prevention and case management identification, classification and basic treatment E-2 Members of subsequent visits by affected people to health institutions after registration E-3 Number & frequency of lung health problem cases. Identification in the project area E-4 Number of health institutions using the prescribing guidelines in the specified areas and providing feedback for their site and modification F-1 Increased numbers of lung health promotion program activities (e.g. anti-smoking campaigns) carried out by community initiatives 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 25% 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 rates/obstacles (etc.)	Minutes of meeting Interview with HTP staff The plan of operation and management Interviews of the health staff District DOTS, DTLA and RTLA workshop proceeding Spot check, Survey report, HTP documents Case finding report of each district presented by DTLA quarterly The report is presented by each OCA quarterly Report is submitted by OCA during the workshop quarterly Spot check, HTP documents Monthly report from regional stores to HTP/LHD Quarterly reports from district by DTLA, regional reports by RTLA quarterly Monthly report from regional stores to HTP/LHD TB register, lab register, treatment card TB register, lab register, treatment card Spot visit, Survey report, Practitioner record HTP documents FCHV ARI treatment book ARI register at health facilities Minutes of ARI supervision meeting at the district level ARI register at health facilities Survey on practice of health staff Guidelines available in health institutions Register at health facilities Register at health facilities Spot check (supervision) Records of DOTS + Committees Records at health institutions Survey reports Spot checks	1 HTP will include/achieve the project achievements 2 Program support will be continued. 3 Japanese inputs will not be disturbed due to the unavoidable security situation
Activities A. The managerial capacity of the HTP is further strengthened. 1-1 Provide training to technical and non-technical staff / Participate in international / regional / national conference 1-2 Strengthening the monitoring and evaluation system by conducting DOTS workshop, regional, national workshop, and national review (referral) conference 1-3 Improve staff performance evaluation system 1-4 Coordinate for service linkages with NGOs, donors, local governments and the private sector 1-5 Carry out IEC program activities 1-6 Review and update HTP guidelines and format when necessary B. Management system for the laboratory and logistics of the HTP is made sustainable. 2-1 Train HMG lab technicians for O.C. in all regions 2-2 Adopt a mechanism for assessing the performance of OC 2-3 Conduct regular regional O.C. workshop for laboratory staff 2-4 Provide training on OCA to DTLAs 2-5 Establish reference lab in HTPC 2-6 Improve coordination between HTPC and UNB / Improve logistic management system 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, data point facing), KTM 3-2 HTP DOTS improvement (strategy, training, coordination, DOTS center, data point facing) 3-3 Uiten, Coordinate with NGO and private practitioners, KTM 3-4 DOTS improvement (strategy, training, coordination, DOTS center, data point facing) 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 research is conducted. - HIV seroprevalence evaluation - Strengthening case finding among HIV positive persons DOTS plan, reviewed by HTP/VHO 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 RAG training package 4-3 Conduct training/ orientation (to 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 hospital and elsewhere 5-4 Plan pilot schemes in some selected areas 5-5 Prepare modules, forms and flow charts 5-6 Conduct training for the concerned health workers/partners 5-7 Implement pilot schemes in selected areas 5-8 Conduct 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 techniques 6-3 Conduct advocacy programs on lung health for the general public / Conduct targeted health education	Nepal's Side 1. Contingent 2. Treacher 3. Facility, Land	Japanese Side 1. Long-term Experts Chief-Adviser Coordination Lung Health / Anti-smoking 2. Short-term Experts TB Control Lung Health Anti-smoking Logistics Management Laboratory Technology 3. Equipment 4. Training in Japan	Vacancies and frequent transfers do not upset the program Private practitioners will increasingly continue to support HTP policy with DOTS The patients will continue to cooperate as per the agreement Cooperation for DOTS will continue to be available at local level Pre-Conditions * Agreement between HMG/Japan and Govt. of Japan is reached in time with specified human and material resources

JICA/HMG Community TB & Lung Health Project
Duration: Sep.25,2000 - Sep.24,2005

Long Term Experts

No.	Name	Designation	Period	Duration (months)	Re.
1	Mr.Katsumi ISHII	Project Coordinator	Oct.07,2000 - Oct.06,2002	24.0 Month(s)	
2	Dr.Jinich KATO	Lung Health	May 06,2001- Dec. 15,2003	31.3 Month(s)	
3	Dr.Takashi YOSHIYAMA	Chief Advisor	Aug.30,2001 - Apr.15,2003	19.5 Month(s)	
4	Mr.Akira NARUSE	Project Coordinator	Sep.19,2002 - Sep.24,2005	36.2 Month(s)	
5	Dr.Tatsuo SUGIYAMA	Chief Advisor	Oct.27,2003 - Sep.24,2005	22.9 Month(s)	
LONG TERM EXPERTS TOTAL (in Months)				133.8 Month(s)	
LONG TERM EXPERTS AVERAGE DURATION (in Months)				26.8 Month(s)	

Short Term Experts

No.	Name	Designation	Period	Duration (months)	Re.
FY 2000/2001					
1	Dr.Katsunori OSUGA	TB Control	Nov.25,2000 - Dec.04,2000	0.3 Month(s)	
2	Dr.Akira SHIMOUCHI	Lung Health	Nov.27,2000 - Dec.08,2000	0.4 Month(s)	
3	Ms.Akiko FUJIKI	Lab. Technology	Dec.11,2000 - Dec.23,2000	0.4 Month(s)	
4	Dr.Jinich KATO	Lung Health	Mar.07,2001 - Mar.24,2001	0.6 Month(s)	
5	Dr.Nobukatsu ISHIKAWA	TB Control	Mar.14,2001 - Mar.24,2001	0.3 Month(s)	
FY 2001/2002					
6	Dr.Nobukatsu ISHIKAWA	TB Control	Apr.25,2001 - May 01,2001	0.2 Month(s)	
7	Dr.Takashi YOSHIYAMA	Epidemiology	May 01,2001 - May 12,2001	0.4 Month(s)	
8	Dr.Akira SHIMOUCHI	Lung Health	May 07,2001 - May 19,2001	0.4 Month(s)	
9	Dr.Akira SHIMOUCHI	Lung Health	Nov.19,2001 - Nov.30,2001	0.4 Month(s)	
10	Dr.Hiroyuki NAKANO	Lung Health	Nov.19,2001 - Nov.28,2001	0.3 Month(s)	
11	Ms.Nakae NOGUCHI	TB Control	Feb.25,2002 - Mar.31,2002	1.2 Month(s)	
FY 2002/2003					
12	Dr.Hiroyuki NAKANO	Lung Health	Jul.10,2002 - Jul.24,2002	0.5 Month(s)	
13	Mr. Hiroaki YAMAZAKI	Lab. Technology	Aug.10,2002 - Aug.25,2002	0.5 Month(s)	
14	Dr. Masakazu NAKAMUR	Lung Health	Aug.17,2002 - Aug.25,2002	0.3 Month(s)	
15	Dr.Katsunori OSUGA	TB Control	Oct.22,2002 - Nov.02,2002	0.3 Month(s)	
16	Ms.Tomoyo MIYAKE	Logistic Management	Jan.10,2003 - Mar.10,2003	2. Month(s)	
17	Dr.Hiroyuki NAKANO	Lung Health	Jan.26,2003 - Feb.08,2003	0.4 Month(s)	
18	Ms.Hiroko MATSUMOTO	Lab. Technology	Apr.04,2003 - Apr.11,2003	0.2 Month(s)	

(continued)

JICA/HMG Community TB & Lung Health Project
Duration: Sep.25 2000 - Sep.24 2005

Short Term Experts

No.	Name	Designation	period	Duration (months)	Re.
FY 2003/2004					
19	Dr.Katsunori OSUGA	Chief Advisor	Jun.17,2003 - Jun.27,2003	0.3 Month(s)	
20	Dr.Takashi YOSHIYAMA	TB Control	Sep.17,2003 - Sep.26,2003	0.3 Month(s)	
21	Dr.Tatsuo SUGIYAMA	TB Control	Sep.24,2003 - Oct.03,2003	0.3 Month(s)	
22	Dr.Hiroyuki NAKANO	Lung Health	Oct.16,2003 - Oct.26,2003	0.3 Month(s)	
23	Dr.Katsunori OSUGA	Chief Advisor	Nov.19,2003 - Nov.28,2003	0.3 Month(s)	
24	Ms.yoshiko KUDO	Lab. Technology	Jan.26,2004 - Feb.22,2004	0.9 Month(s)	
FY 2004/2005					
25	Dr.Akira SHIMOUCHI	Lung Health	Jun.17,2003 - Jun.27,2003	0.3 Month(s)	
26	Dr.Jinich KATO	Lung Health	Sep.17,2003 - Sep.26,2003	0.3 Month(s)	
27	Dr.Takashi YOSHIYAMA	TB Control	Sep.24,2003 - Oct.03,2003	0.3 Month(s)	
28	Dr.Katsunori OSUGA	TB Control	Oct.16,2003 - Oct.26,2003	0.3 Month(s)	
FY 2005/2006					
29	Dr.Jinich KATO	Lung Health	Apr.18,2005 - Apr.27,2005	0.3 Month(s)	
30	Dr.Akira SHIMOUCHI	Lung Health	Apr.30,2005 - May.07,2005	0.2 Month(s)	
31	Dr.Takashi YOSHIYAMA	TB Control	Apr.30,2005 - May.08,2005	0.3 Month(s)	
32	Ms.Akiko FUJIKI	Lab. Technology	May.11,2005 - May.19,2005	0.3 Month(s)	
SHORT TERM EXPERTS: TOTAL (in Months)				13.7 Month(s)	
SHORT TERM EXPERTS: TOTAL (in Number)				14 Persons	
SHORT TERM EXPERTS: TOTAL (in Visits)				32 Visits	
SHORT TERM EXPERTS: AVERAGE DURATION per TRIP (in Months)				0.4 Month(s)	
SHORT TERM EXPERTS: AVERAGE TRIPS per EXPERT (in Months)				2.4 Times	
SHORT TERM EXPERTS: NO. of TRIPS per EXPERT (in Months)				1~6 Times	

As of Mar.24,2005

Equipment accompanied with the experts

JICA/HMG Community TB & Lung Health Project
Duration: Sep.25,2000 - Sep.24,2005

* Equipment which is more than 20,000yen

No.	Date of Arrival	Equipment	Specification	Maker	Price	Used by	Place	Re.
1	Dec.27,2000	Laptop Computer	Think Pad A21m	IBM	¥369,000	JICA CTLH Project	Expert's Room	
2	Dec.27,2000	Software for PC	MS-Office 2000	MS	¥66,000	JICA CTLH Project	Expert's Room	
3	Dec.27,2000	Software for PC	MS-Office 2000	MS	¥66,000	JICA CTLH Project	Expert's Room	
4	Aug.01,2001	Laptop Computer	Think Pad A22m	IBM	¥259,000	JICA CTLH Project	Expert's Room	
5	Aug.01,2001	Software for PC	MS-Office 2000	MS	¥64,000	JICA CTLH Project	Expert's Room	
6	Aug.01,2001	Laptop Computer	Think Pad A22m	IBM	¥259,000	JICA CTLH Project	Expert's Room	
7	Aug.30,2001	V.Stabiliser	SPR-1K	Matsunaga	¥258,000	JICA CTLH Project	Expert's Room	
8	Aug.30,2001	UPS for PC	650J-LL	APC	¥38,900	JICA CTLH Project	Expert's Room	
9	Aug.30,2001	ZIP Drive	Omega 250MB	ZIP	¥22,000	JICA CTLH Project	Expert's Room	
10	Aug.30,2001	MO Drive 230MB	TS2343W/WN	Olympus	¥41,000	JICA CTLH Project	Expert's Room	
11	Aug.30,2001	Software for PC	100J Base System	SPSS	¥140,000	JICA CTLH Project	Expert's Room	
12	Nov.28,2001	Spirometer	Chestgraph Jr101	Chest	¥190,000	JICA CTLH Project	Expert's Room	
13	Nov.28,2001	Spirometer	Chestgraph Jr101	Chest	¥190,000	JICA CTLH Project	Expert's Room	
14	Apr.15,2002	Spirometer	Chestgraph Jr101	Chest	¥182,000	JICA CTLH Project	Expert's Room	
15	Aug.14,2002	Carbon M. Monitor	Smoker Lyzer	Bedfont Sc.	¥156,000	JICA CTLH Project	Expert's Room	
16	Aug.14,2002	Carbon M. Monitor	Smoker Lyzer	Bedfont Sc.	¥156,000	JICA CTLH Project	Expert's Room	
17	Nov.11,2003	Laptop Computer	Thinkpad T40	IBM	¥297,000	JICA CTLH Project	Expert's Room	
18	Aug.16,2004	Digital Camera	DSC-P100	SONY	¥49,800	JICA CTLH Project	Expert's Room	
		TOTAL (in Yen)			¥2,803,700	US\$26,202.80		

Note: Exchange rate: 1 US\$ = 107 JPY

List of Equipment

JICA/HMG Community TB & Lung Health Project
Duration: Sep.25,2000 - Sep.24,2005

* Equipment which is more than 100,000yen

No.	Date of Arrival	Equipment	Specification	Maker	Total Price	Used by	Place	Re.
1	Jun. 2001	4 wheel Drive Vehicle	Landcruiser VX	TOYOTA	¥4,824,100	National TB Centre	National TB Centre	
2	Jun. 2001	4 wheel Drive Vehicle	Landcruiser VX	TOYOTA	¥4,824,100	JICA CTLH Project	National TB Centre	
3	Jun. 2001	4 wheel Drive Vehicle	Landcruiser VX	TOYOTA	¥4,824,100	JICA CTLH Project	National TB Centre	
4	Aug. 2002	Motorbike	COOX 125cc	YAMAHA	¥139,000	JICA CTLH Project	JICA CTLHP Rupandehi Office	seized in action
5	Dec. 2002	Motorbike	BOSS 100cc	KINETIC	¥130,000	DPHO Office, MOH	National TB Centre	
6	Feb., 2003	Microscope 50 sets	CX-31	OLYMPUS	¥10,296,000	Laboratory	DOTS Clinics	
7	Feb., 2003	Microscope 50 sets	CX-31	OLYMPUS	¥10,139,000	Laboratory	DOTS Clinics	
8	May 2003	Safety Cabinet	BHC-1300IIA	Air Tech	¥978,300	Laboratory	National TB Centre	
9	May 2003	Water Distillation Apparatus	Bansnet Type	NONAKA	¥273,000	Laboratory	National TB Centre	
10	May 2003	Electronic Balance	AX120	Shimadzu	¥109,000	Laboratory	National TB Centre	
11	May 2003	Ultra-Low Freezer	MDF-U71V	SANYO	¥897,000	Laboratory	National TB Centre	
12	May 2003	Refrigerated Centrifuge	LX-130	TOMY	¥756,000	Laboratory	National TB Centre	
13	May 2003	Ultrasonic Pipette Cleaner	UT-56	SHARP	¥263,000	Laboratory	National TB Centre	
14	Dec. 2003	Incubator	ITD-100	ALP	¥386,100	Laboratory	National TB Centre	
15	Dec. 2003	Digital Video Camera	DSR-PD150P	SONY	¥387,000	Public Relation	National TB Centre	
16	Dec. 2003	LCD Projector	ELP-73	EPSON	¥210,000	Training	National TB Centre	
17	Jan. 2004	Desktop Computer 4 sets	EVD 33C	Compaq	¥551,000	Statistics	National TB Centre	
18	Jan. 2004	Laptop Computer	EVONV 9010	HP Compaq	¥227,000	Doctors'	National TB Centre	
19	Jan. 2004	35mm Camera	F55D	NIKON	¥111,000	Public Relation	National TB Centre	
		TOTAL (in Yen)			¥40,324,700	US\$376,866.36		

Note: Exchange rate: 1 US\$ = 107 JPY

List of Counterpart Trainees

JICA/HMG Community TB & Lung Health Project
Duration: Sep.25,2000 - Sep.24,2005

No	Name	Period	Duration	Training Field	Training Course	Institution	Post at the time of Training	Present Post
1	Shrawan Kumar CHOUDHARY	Jan.08,2001 - Feb.25,2001	1.6 Month(s)	TB Control	TB Programme Management	The Research Institute of TB	Medical Superintendent, District Health Office, Dang, MOH	Regional Director, Mid-western Regional Health Directorate
2	Amir KHATI	May 14,2001 - Aug.12,2001	2.9 Month(s)	TB Control	Managing TB	The Research Institute of TB	Senior Administrator, District Public Health Office, Kathmandu, MOH	Regional Director, Far-western Regional Health Directorate
3	Kashi Kant JHA	Jan.20,2002 - Feb.02,2002	0.4 Month(s)	TB Control	TB Programme Management	The Research Institute of TB	Senior Consultant Physician, National TB Center, MOH	No Transfer
4	Rajendra Prasad PANT	May 14,2002 - Aug.11,2002	2.9 Month(s)	TB Control	Managing TB	The Research Institute of TB	Senior Medical Officer, National TB Center, MOH	Senior Medical Officer, Central Regional Health Directorate
5	Jagat Bahadur KHADKA	Sep.10,2002 - Dec.15,2002	3.2 Month(s)	TB Control	Laboratory Management	The Research Institute of TB	Medical Technologist, Regional Public Health Laboratory, Pokhara, MOH	No Transfer
6	Vishnu Prasad POUDYAL	Jan.14,2003 - Mar.02,2003	1.6 Month(s)	TB Control	Managing TB	The Research Institute of TB	Senior Medical Officer, Lumbini Zonal Hospital, MOH	Medical Officer, Palpa District Public Health Office
7	Badri Nath GYAWALI	Jun.26,2003 - Mar.31,2004	9.1 Month(s)	TB Control	Master of Primary Health Care Management	AIRD, Mahidol University	Statistics/Planning Officer, National TB Center, MOH	Statistical Officer, Central Regional Health Directorate
8	Dhruba Kumar KHADKA	Jun.26,2003 - Mar.31,2005	21.1 Month(s)	TB Control	Master of Science (Microbiology)	Faculty of Tropical Medicine, Mahidol University	Medical Technologist, National TB Center, MOH	No Transfer
TOTAL (in Month)			42.8 Month(s)					
AVERAGE DURATION (in Month)			5.4 Month(s)					

As of Mar.24,2005

International Conference, Exchange Program, Missions*** The Dispatch of C/Ps to the 33rd IUATLD Conference on Lung Health in Montreal, Canada**

(Period: Oct. 04, 2002 - Oct. 13, 2002)

1. Dr. Jinichi Kato	Expert on Lung Health, JICA CTLH Project
2. Dr. Sun Lal THAPA	Chief, CDD/ARI, Child Health Division, MOH
3. Dr. Kashi Kant JHA	Senior Consultant, National TB Center, MOH
4. Mr. Dhurba K. KHADKA	Chief Laboratory Section, National TB Center, MOH

*** Technical Exchange Programme in Cambodia**

(Period: Nov. 24, 2002 - Dec. 01, 2002)

1. Dr. Takashi Yoshiyama	Chief Advisor, JICA CTLH Project
2. Mr. Amir Khati	Chief District Public Health Officer, Kathmandu, MOH
3. Dr. Mohan K. Prasai	Ag. Director, Regional Tuberculosis Center, Pokhara, MOH
4. Mr. Badri N. Gyanwali	Statistical Officer, National TB Center, MOH
5. Dr. Babu Ram Gautam	Chief, Public Health Department, Kathmandu Metropolitan City

*** The Dispatch of C/Ps to the 34th IUATLD Conference on Lung Health in Paris**

(Period: Oct. 29, 2003 - Nov. 02, 2003)

1. Dr. Rajendra Prasad Pant	Medical Officer, National TB Center, MOH
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*** The Dispatch of C/Ps to the 35th IUATLD Conference on Lung Health in Paris**

(Period: Oct. 27, 2004 - Nov. 03, 2004)

1. Dr. Tatsuo Sugiyama	Chief Advisor, JICA CTLH Project
3. Dr. Kashi Kant JHA	Ag. Director, National TB Center, MOH

*** JICA Management Consultation Mission**

(Period: Feb. 04, 2002 - Feb. 13, 2002)

1. Dr. Nobukatsu Ishikawa	Vice Director, Research Institute of TB, JATA
2. Dr. Takenori Yagi	Chief, Division of Thoracic Disease, Chiba-higashi Hospital
3. Ms. Kiyoka Takeuchi	Staff, Medical Cooperation Department, JICA

*** JICA Mid-Term Evaluation Mission**

(Period: Mar. 02, 2003 - Mar. 14, 2003)

1. Dr. Katsunori Osuga	Chief, Manpower Development Division, Dept. of International Cooperation, Research Institute of
2. Dr. Tatsuro Sugiyama	Chief, Dept. of Pathology, Yuri-Kumiai General Hospital
3. Ms. Shinobu Mamiya	Consultant, Global Link Management, Inc.

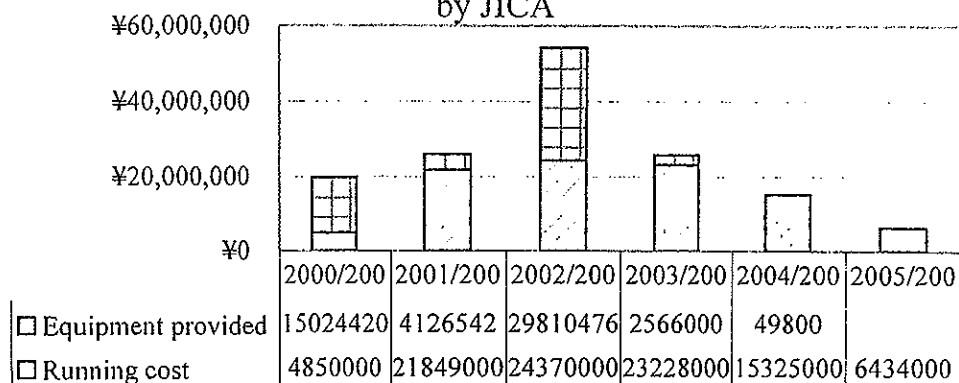
*** JICA Terminal Evaluation Mission**

(Period: May 8, 2005 - May 22, 2005)

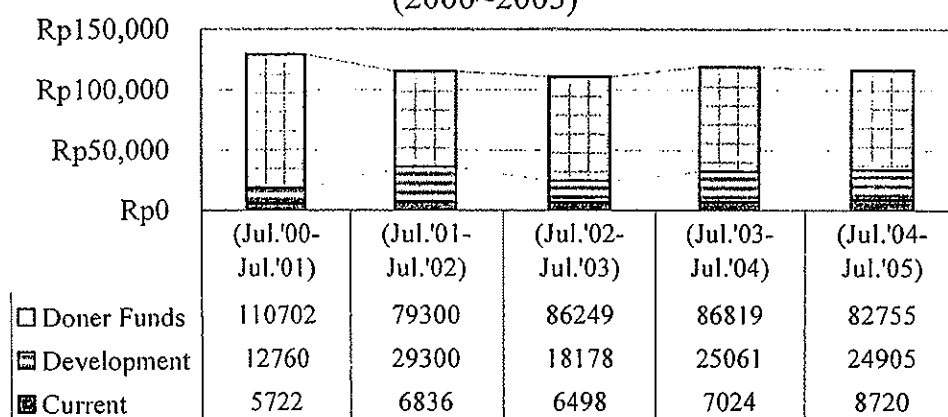
1. Ms. Akiko Tomita	Director, Human Development Department, JICA
2. Dr. Nobukatsu Ishikawa	Vice Director, Research Institute of TB, JATA
3. Dr. Tadatoshi Kuratsuji	Director-General, National Research Institute for Child Health & Development
4. Ms. Tomoko Shimada	Staff, Infectious Disease Control Team, Human Development Dep., JICA
5. Mr. Yoko Ogawa	Consultant, Global Link Management, Inc.



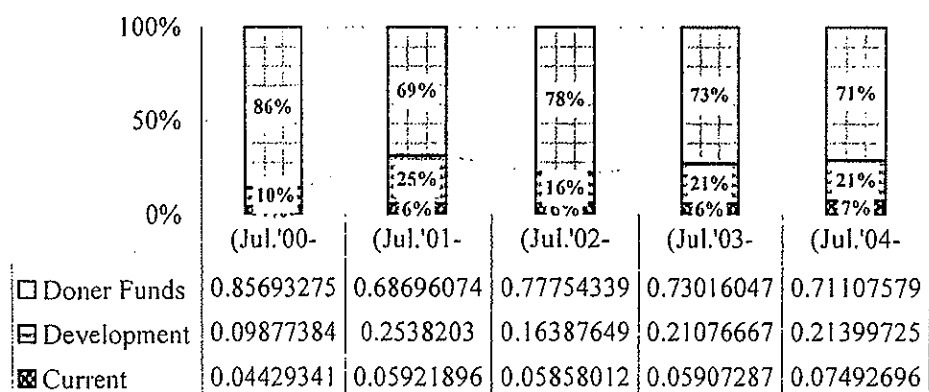

OPERATIONAL COST/EQUIPMENT PROVISION by JICA



ANNUAL NTC/NTP BUDGET by Category (2000~2005)



% SHARE of ANNUAL NTC/NTP BUDGET by Category (2000~2005)



List of Counterparts.

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

NAME	Designation	C/P Training
*Ministry of Health (MoH) Ramsahapath, Kathmandu.		
1. Mr. Lav Kumar Devkota	Secretary	
2. Dr. Nirakar Man Shrestha	Chief Specialist, PP & International Coordination Division.	
3. Dr. Hari Nath Acharya	Chief, PP & International Coordination Division.	
*Department of Health Services (DHS) Teku, Kathmandu.		
1. Dr. Bishunu Prasad Pandit	Director General, Department of Health	
2. Dr. Yasho Verdan Pradhan	Director, Child Health Division	
3. Dr. Sun Lal Thapa	Chief, IMCI, Child Health Division.	02(Conf.)
4. Dr. Mahendra Keshari Chhetri	Director, Logistic Management Division.	
5. Dr. Mahendra Bahadur Bista	Director, Epidemiology & Disease Control	
6. Dr. Sarala Malla	Director, National Public Health Laboratory	
7. Mr. Babu Ram Koirala	Ag. Director, National Health Information, Education and Communication Center	
*National Tuberculosis Centre (NTC) Thimi, Bhaktapur.)		
1 .Dr. Keshab Bhakta Shrestha	Director	
2. Dr. Kashi Kant Jha	SAARC Director, Senior Consultant Chest Physician	1996, 2002 & '02,'04(Conf.)
3. Dr. Puspa Malla	Senior Consultant Chest Physician	1989 & 1993
4. Dr. Sundar Shyam Jha	Medical Officer	
5. Mr. Dhurba kumar Khadka	Medical Technologist	02(Conf.),'03-'05
6. Mr. Sitaram Ghimire	Statistical Officer	
*Central Regional Health Directorate (CRHD) Pulchowk,Lalitpur		
1. Dr.Nand Prasad Sharma	Regional Director, CRHD, MoH	
*Regional Tuberculosis Centre (RTC) Pokhara		
1.Dr.Sarad Chandra Verma	Director, RTC, MoH	1997
2.Dr. Mohan kumar Prasai	Medical Officer	2002(Exch.)
*Others		
1. Dr. Jyoti Raj Shrestha	District Public Health Officer,Kathmandu District,DHS,MoH	
2. Mr. Ram Chandra Khanal	District Public Health Officer,Rupandehi District.,DHS,MoH	
3.Dr.Babu Ram Gautam	Chief, Public Health Department, KTM Metropolitan City	2002(Exch.)

* (Conf.):The IUATLD Conference

*(Exch.):The Technical Exchange



as of Mar.2005



Publication printing in the year of September 2000 to March 2005				
No.	Date	Particulars	Intended Audience	Quantity
2000-2001				
1	2001 March	A Clinical Manual, National Tuberculosis Programme of		1000 pcs
2	2001 March	Calendar Wall 2058 (2001/02)		10000 pcs
3	2001 March	Calendar Pocket 2058 (2001/02)		5000 pcs
2001-2002				
4	2001 August	CB IMCI Training Modules (9 sets)		150 pcs
5	2001 December	Flip chart for FCHV (Cloth)		1000 pcs
6	2001 December	Logistics Curriculum (Nepali Version) reprint		500 pcs
7	2001 December	Logistics Handout (Nepali Version) reprint		500 pcs
8	2002 March	Annual report of TB Control Programme 2057/58 (2000/01)		1000 pcs
9	2002 March	Epidemiology and Risk Factors of Chronic Obstructive Pulmonary Disease (COPD)		1000 pcs
10	2002 March	Report of NTP Laboratory Quality Assurance and Microscopy Network		
11	2002 March	Lab Module (Nepali version) reprint		300 pcs
12	2002 March	Lab Module (English version) reprint		300 pcs
13	2002 March	Lab Manual (Nepali version) reprint		300 pcs
14	2002 March	Lab Manual (Nepali version) reprint		300 pcs
2002-2003				
15	2002 October	TB fact, figures and concept (English version)		500 pcs
16	2002 December	Defaulter Tracing Handout for FCHV (Nepali version)		200 pcs
17	2003 February	Map for Public Private Partnership for TB Control		500 pcs
18	2003 February	Lab Manual (English version) reprint		100 pcs
19	2003 February	Lab Module (English version) reprint		100 pcs
20	2003 February	Revised Lab Manual (Nepali version)		500 pcs
21	2003 February	Revised Lab Module (Nepali version)		500 pcs
22	2003 February	TB fact, figures and concept (English version) reprint		500 pcs
23	2003 February	Tuberculosis in Nepal (English version)		1000 pcs
24	2003 February	Annual report of TB Control Programme 2058/59 (2001/02)		1000 pcs
25	2003 March	Anti Smoking Manual (Nepali version) 3 sets		300 pcs
26	2003 March	Calendar Wall 2060 (2003/04)		5000 pcs
27	2003 March	Calendar Pocket 2060 (2003/04)		10000 pcs
28	2003 March	Diary for Volunteer (Urban TB Control Programme)		500 pcs
2003-2004				
29	2003 June	Defaulter Tracing Handout for FCHV (Nepali version)		1000 pcs
30	2003 September	Project Activity Mid Term Report (September 2000 ~ February 2003)		200 pcs
31	2004 February	Diary for Volunteer (Urban TB Control Programme)		1500 pcs
32	2004 March	Wall Calendar 2061 (2004/05)		15000 pcs
33	2004 March	Pocket Calendar 2061 (2004/05)		15000 pcs
34	2004 March	3 Sheet Wall Calendar 2061 (2004/05)		5000 pcs
35	2004 March	A4 Leaflet for Urban TB Programme		100000 pcs
36	2004 March	Annual Report of TB Control Programme 2059/60		1000 pcs
37	2004 March	Wall TB poster		10000 pcs
2004-2005				
38	2004 May	FCTC convention		300 pcs
39	2004 June	Anti Smoking Leaflet		3000 pcs
40	2004 November	Basis Modular training manual set (Revised)		500 pcs
41	2005 February	Lab Manual (Nepali version) reprint		500 pcs
42	2005 February	Lab Module (Nepal version) reprint		700 pcs
43	2005 March	Defaulter Tracing Handout for FCHV (Nepali version)		5000 pcs
44	2005 March	Logistics Curriculum (Nepali Version) revised		500 pcs
45	2005 March	Logistics Handout (Nepali Version) revised		100 pcs
46	2005 March	Calendar 2062 (2004/05)		15000 pcs
47	2005 March	Pocket calendar 2062 (2004/05)		15000 pcs
48	2005 March	A Clinical Manual, National Tuberculosis Programme of Nepal (Revised)		2000 pcs
49	2005 March	Diary for Volunteer (Urban TB Control Programme)		3000 pcs
50	2005 March	Annual Report of TB Control Programme 2060/61 (2003/04)		1000 pcs
51	2005 March	A4 Leaflet for Urban TB Programme reprint		100000 pcs
52	2005 March	Anti Smoking leaflet revised		5000 pcs

2 . P D M 1 (和 訳)

和訳(案) プロジェクトデザインマトリックス(PDM1)“ネパール国地域の結核と肺の健康プロジェクト”

プロジェクト名:“地域の結核と肺の健康プロジェクト”

プロジェクト対象地域:ネパール王国全土

プロ:

プロジェクトの要約	指標	指標データ入手手段	
上位目標			
住民の肺の健康が改善される	ネパール国において、結核、非結核に関する罹患率、死亡率が数年間の間に減少する。	政府の統計資料 結核の有病率・インバクト調査報告書	1 ヘルスト 2 HIVの患
プロジェクト目標			
1. 国家結核対策プログラム(NTP)の総合的な実施事項が改善される。	P1-1 2003年までに 75郡すべてにDOTSが普及する。 P1-2 2005年までに ネパール国全土で治療率85%を達成する。 P1-3 2005年までに結核患者の85% をDOTSで治療する。	NTPの年次報告書 ワークショップでの国レベルの報告資料	1 コミュニ 2 モデル地
2. 地域の肺の健康の機能的モデルが確立される。	P2-1 2005年までに、対象の医療施設で治療をうけた小児のうち重症肺炎患者の数が減少する。 P2-2 対象地域における、地域住民の喫煙に対する考え方、および喫煙に対する住民活動の実施状況。	保健省の年次報告書 喫煙サーベイ	
成果項目			
<プロジェクト目標1に対する成果項目> A NTPの管理・運営能力が強化される。	A-1 プロジェクト実施に関する主要な決定がNTPとJICAチーム共同で行われる。 A-2 NTPの活動を行っているものの業務内容を明確に記載し、その実施状況を評価し、能力とキャリアの開発の機会を与えること。 A-3 2005年中盤までに訓練をうけたスタッフのうち少なくともその80%のスタッフが訓練で得た技術を活用した業務に携わっている。 A-4 国内NGO、ソーシャルワーカー、CBO、地方政府(VDC, DDC MP)、ネパール結核予防会、ヘルスポスト等から結核予防プログラム(世界結核デー、DOTSワークショップ等)に参加する人数が増加する。	会議議事録、NTPスタッフへのインタビュー 業務計画、組織図 ヘルススタッフへのインタビュー 郡レベルのDOTSワークショップ等での報告 サーベイ結果、NTPの資料	1 NTPが 2 ログラ
B 結核菌検査及び薬品ロジスティックが強化される。	B-1 2005年までに、塗抹陽性患者の発見率70%、および新規発見患者のうちの塗抹陽性割合55%、を達成する。 B-2 2005年までに喀痰検査の一致率90%以上及び、偽陽性/陰性率5%以下、とする。 B-3 2005年までに 検査の行われるセンターのうち80%が結核菌塗抹検査を行っている。(全国レベル) B-4 機材の80%が常に稼動可能な状況にある。 B-5 2003年までに、どの管理倉庫においても資材不足が発生しない。 B-6 2003年までに、薬品需要の85%～135%を実際に配布している。	四半期毎の症例報告書 QCA四半期報告書 四半期QCAの報告(DOTSワークショップでの) NTPの資料 NTP/LMDに対する地域管理倉庫の月間報告書 DTLA、RTLAからの四半期報告 地域の管理倉庫の月間報告書	3 日本側
C 都市部及び僻地における(治療困難な人に対する)結核対策モデルが確立される。	C-1 2年間のうちに、モデル地域での結核患者の70%(僻地地域では60%)がDOTSによる治療によって治療率85%を達成する。 C-2 僻地モデル地域での結核患者の90% が徒歩2時間以内でDOTSサービスを受けることができる。 C-3 DOTS以外で結核治療をうけた患者が減少する。 C-4 DOTSを行う必要のあるセンターの数のうちの、導入されたDOTSセンターの数の割合が年々増加する。	結核登録、ラボ登録、治療簿 結核登録、ラボ登録、治療簿 視察、サーベイ結果、民間ドクターの記録簿 NTPの資料	
<プロジェクト目標2に対する成果項目> D 小児急性呼吸器感染症(ARI)対策が改善される。	D-1 2004年までに、プログラム対象地域の肺炎の治療率が85%以上を達成する。 D-2 2004年までに、登録されたARI症例の80%が適切に治療される。(診断、治療、照会) D-3 2004年までに、登録された(2ヶ月以上～5歳未満の)肺炎患者のうち80%が治療の“3日目”のフォローアップを受ける。 D-4 すべての年齢層において最低80%の患者がWHO基準による投薬を受けることができる。	FCHV のARI治療記録簿 各医療施設のARI疾病登録簿 郡レベルのARISーパーバイザーミーティングの議事録 各医療施設のARI疾病登録簿 FCHV のARI治療記録簿 各医療施設のARI疾病登録簿 ヘルススタッフの実績サーベイ	
E 成人の肺疾患対策が改善される。	E-1 2004年末までに、疾病判定、類別、基本的治療に関する予防とケースマネジメントのガイドラインが利用可能になる。 E-2 登録後に継続して医療施設を来院した患者数 E-3 プロジェクト対象地域での肺疾患関連の症例数とその頻度 E-4 対象地域において、ガイドラインを活用し、フィードバックを行っている医療機関の数	医療機関でのガイドライン活用状況 医療施設の患者登録簿 医療施設の患者登録簿 視察(スーパービジョン)	
F コミュニティによる禁煙対策が導入される。	F-1 コミュニティが中心となって行った肺の健康促進活動(禁煙キャンペーン等)の数 F-2 プロジェクト終了までに、対象地域でCOPD予防に関する方法を知っている人が20%以上増加する。 F-3 プロジェクト終了までに、対象地域での喫煙率が20%以上減少する。(煙草の購入、禁煙ゾーンの数等で把握)	DOTSコミッティーの記録 医療機関の記録 サーベイ結果、視察	

活動項目	投入		
	ネパール側	日本側	
A NTPの管理・運営能力が強化される。 1-1 技術スタッフ、 総務スタッフ(または非技術スタッフ) に対しトレーニングを実施する。/ 国際、国レベル、地域レベルの会議に参加する。 1-2 DOTSワークショップや、地域、国レベルのレビューミーティングを開催して、モニタリング、評価の機能を強化する。 1-3 スタッフの実績評価システムを向上する。 1-4 国際NGO、援助機関、地方政府および民間セクターとの連携を調整する。 1-5 IECに関する活動を実施する。 1-6 NTPのガイドライン見直しを行い、必要であれば改訂する。 B 結核菌検査および薬品ロジスティックが強化される。 2-1 すべての地域のラボ技術者に対しQCのトレーニングを実施する。 2-2 QCの実態を監査する体制を導入する。 2-3 ラボ技術者に対し、QCに関するワークショップを定期的に実施する。 2-4 DTLAに対してQCAIに関するトレーニングを実施する。 2-5 NTC内にReference lab を設置する。 2-6 NTCとLMDとの連携関係を改善する。各地域内での薬品、ラボ関連機材のロジスティックマネージメントを改善する。 2-7 ラボ関連の機材維持管理システムを導入する。 C 都市部および僻地における(治療困難な人に対する)結核対策モデルが確立される。 3-1 都市(カトマンズ市)でのDOTSを改善する。(戦略、トレーニング、連携、DOTSセンター、患者のフォローアップ等) 3-2 山岳部でのDOTSを改善する。(戦略、トレーニング、連携、DOTSセンター、患者のフォローアップ等) 3-3 都市(カトマンズ市)で、NGOと民間セクターの連携をよくなる。 3-4 Rupandehi 地域でのDOTSの改善をする。(戦略、トレーニング、連携、DOTSセンター、患者のフォローアップ) 3-5 Rupandehi 地域で、NGOと民間セクターの連携をよくなる。 3-6 モデル地域でのDOTS進捗をモニターする。 3-7 他地域への汎用性のあるモデルフレーム を開発する。 3-8 オペレーションズリサーチを実施する。(HIV、DOTSプラスに関して) D 小児急性呼吸器感染症(ARI)対策が改善される。 4-1 郡レベルの企画ワークショップ、郡開発委員会オリエンテーションを実施する。 4-2 IMCIのトレーニングパッケージを導入する。 4-3 医師、ヘルススタッフ、ボランティア、心霊治療者、VDCメンバー等を対象として、(IMCIの)トレーニングやオリエンテーションを実施する。 4-4 ARIの症例対処に関してのモニタリング評価を行う。 E 成人の肺疾患対策が改善される。 5-1 非結核の一般の呼吸器疾患を類別する。 5-2 ベースラインデータ調査を実施する。 5-3 ネパール国内、国外の成人肺疾患に関する情報を概観する。 5-4 対象地域での パイロットプロジェクトを企画する。 5-5 モジュール、フォーマット、フローチャートを作成する。 5-6 ヘルスワーカー/関係者に対するトレーニングを実施する。 5-7 対象地域での パイロットプロジェクトを実施する。 5-8 関係機関との調整を行う。 F コミュニティによる禁煙対策が導入される。 6-1 フォーカスグループディスカッション等を通して、肺疾患に関する問題解決の参加型手法を導入する。 6-2 ヘルススタッフに対してコミュニケーションスキル、グループワーク促進のスキルをトレーニングする。 6-3 一般住民 に対しての肺疾患に関する広報活動を実施する。健康教育を実施する。	1 カウンターパートの配置 2 研修の実施 3 施設設備の提供	1 長期専門家 チーフアドバイザー 調整員 肺の健康・禁煙対策分野の専門家 2 短期専門家 結核対策 肺の健康 禁煙対策 ロジスティックマネジメント 検査室 3 機材供与 4 CP研修	欠員の補 異動が速 NTPのIC プロジェ 継続する 地域レベ ネパール 材に関す

3. 評価グリッド

作成日: 2005年4月22日

評価項目	調査項目	必要な情報・データ	情報源	調査方法
実績	上位目標の達成度(見込み)	介入地域およびネパール国全体における結核罹患率、死亡率の推移(1994～2005年)	保健省の統計データ	資料レビュー
	プロジェクト目標達成度(見込み)	DOTSの普及した郡の総数の推移(2000～2005年)	NTCの資料	資料レビュー
	プロジェクト目標1: 国家結核対策プログラム(NTP)の複合的な実施事項が改善される	ネパール全国における結核治癒率の推移(1994～2005年)	NTCの資料	資料レビュー
		結核治癒率(介入地域と非介入地域)の推移(1994～2005年)	NTCの資料	資料レビュー
		ネパール全国におけるDOTS治療を受ける結核患者の割合(介入地域と非介入地域)の推移(1996～2005年)	NTCの資料	資料レビュー
	プロジェクト目標2: 地域の肺の健康の機能的モデルが確立される	プロジェクト介入地域の医療施設で治療を受けた小児のうち重症肺炎患者の割合(2000年以前、以後)	プロジェクト資料 CPs、村落のボランティア	資料レビュー (グループ)インタビュー
		プロジェクト介入地域における地域住民の喫煙に対する考え方、喫煙に対する住民活動の実施状況(2000年以前、以後)	村落のボランティア、郡公衆衛生官	(グループ)インタビュー
	アウトプットの達成度			
	アウトプットA: NTPの管理・運営能力が強化される	プロジェクト実施に関する主要な決定が如何にして行われたか	JCCの議事録、JCCメンバー他	資料レビュー、インタビュー
		NTPの業務内容の明確さ・実施状況のモニタリング・能力開発の実施状況	プロジェクト資料、CPs、専門家	資料レビュー、インタビュー
		結核予防プログラムの活動の参加者の種類と数(2000年以前と以後)	プロジェクト資料、ワークショップ参加者	資料レビュー、インタビュー
		管理・運営能力の変化(2000年以前と以後)	CPs、専門家	アンケート、インタビュー
		同上	他ドナー、WHO	インタビュー
	アウトプットB: 結核菌検査及び薬品ロジスティクスが強化される	全国のラボにおける塗沫陽性患者の発見率及び新規発見患者のうちの塗沫陽性割合の推移(1994～2005年)	NTCの資料	資料レビュー
		喀痰検査の一致率、偽陽性/陰性率の推移(1994～2005年)	NTCの資料	資料レビュー
		結核菌塗沫検査を実施している全国の検査対象センターの割合の推移(1994～2005)	NTCの資料	資料レビュー
		稼動可能な状況にある機材の割合の推移(2000年以前と以後)	NTCの資料、プロジェクト資料	資料レビュー
		資材不足の発生状況の推移(2000年以前と以後)	NTCの資料、プロジェクト資料	資料レビュー
		検査結果の精度管理のレベルの変化(2000年以前と以後)	他ドナー、WHO	インタビュー
	アウトプットC: 都市部及び僻地における結核対策モデルが確立される	モデル地域におけるDOTS治療を受ける結核患者の割合及びその治癒率の推移(2000年以前と以後)	プロジェクト資料、NTCの資料	資料レビュー
		モデル地域における塗沫陽性患者の割合の推移(2000年以前と以後)	プロジェクト資料、NTCの資料	資料レビュー
		僻地モデル地域における結核患者のうち徒歩2時間以内でDOTSサービスへのアクセスがある患者の割合の推移(2000年以前と以後)	プロジェクト資料、NTCの資料	資料レビュー
		同上	CPs、専門家	インタビュー
		モデル地域においてDOTS以外で結核治療を受けた患者の数(2000～2005年)	プロジェクト資料、NTCの資料	資料レビュー
		モデル地域においてDOTS導入の対象センターの中で実際に導入したセンターの割合の推移(2000～2005年)	NTCの資料、プロジェクト資料	資料レビュー
		モデル地区(都市部・僻地)および通常地域におけるDOTS脱落者の割合の推移(2000～2005年)	NTCの資料	資料レビュー
		都市結核対策のリファラル・モデルの汎用性	薬局、私的医療機関、DOTSセンター、患者、ヘルスポスト責任者(ルバンディヒ)、WHO、ドナー・NGO関係者	インタビュー

評価項目	調査項目	必要な情報・データ	情報源	調査方法
実績	アウトプットD:小児急性呼吸器感染症(ARI)対策が改善される	プログラム対象地域と非対象地域における肺炎の治癒率の推移(2000年以前と以後)	プロジェクト資料、NTCの資料	資料レビュー
		ARI対策の改善度合い	CPs、専門家、WHO、医療機関(病院やヘルスポスト)のヘルスワーカー、FCHV	アンケート、(グループ)インタビュー
		同上	ワークショップ参加者	グループインタビュー
		プログラム対象地域と非対象地域における肺炎患者のフォローアップ率の推移(2000年以前と以後)	プロジェクト資料、NTCの資料	資料レビュー
		同上	CPs、専門家	インタビュー
	アウトプットE:成人の肺疾患対策が改善される	成人の肺疾患に関する疾病判定、類別、基本的治療に関する予防とケースマネジメントのガイドラインが利用になった時期と利用者の広がり	プロジェクト資料、医療機関統計	資料レビュー
		プログラム対象地域において患者登録後に継続して医療施設に来院した患者の数と全体に占める割合	プロジェクト資料、医療機関統計	資料レビュー
		プロジェクト対象地域での廃止間関連の症例数とその頻度の推移(2000年以前と以後)	プロジェクト資料、医療機関統計	資料レビュー
		対象地域において、ガイドラインを活用し、フィードバックを行っている医療機関の数	視察(スーパーヴィジョン)記録	資料レビュー
	アウトプットF:コミュニティによる禁煙対策が導入される	対象地域のコミュニティが中心となって実施した肺の健康促進活動の数(2000年以前と以後)	DOTSコミティの記録	資料レビュー
		対象地域でCOPD予防に関する方法を知っている人の割合(2000年以前と以後)	医療機関の記録	資料レビュー
		対象地域での喫煙率の割合(タバコの購入、禁煙ゾーンの数など)(2000年以前と以後)	サーベイ結果	資料レビュー
		対象地域のコミュニティにおける禁煙対策の実施状況	専門家、CPs(NHIECC、NTP)	アンケート、インタビュー
		同上	FCHV	インタビュー
	投入の実績	ネパール側		
		* プロジェクトに必要な人員	プロジェクト資料	資料レビュー
		* プロジェクト実施に必要な経費と資材(研修の実施など)	プロジェクト資料	資料レビュー
		* 施設・設備の提供	プロジェクト資料	資料レビュー
		日本側		
		* 専門家派遣(長期・短期)	プロジェクト資料	資料レビュー
		* 供与機材	プロジェクト資料	資料レビュー
		* CP研修	プロジェクト資料	資料レビュー
		* 現地コスト負担	プロジェクト資料	資料レビュー
		* その他連携への貢献	プロジェクト資料	資料レビュー

評価項目	調査項目	必要な情報・データ	情報源	調査方法
実施プロセス	活動の進捗状況	プロジェクト進捗状況	プロジェクト資料	資料レビュー
		同上	ワークショップ参加者	グループインタビュー
		同上	CPs, 専門家	アンケート、インタビュー
	モニタリングの実施状況	モニタリングの仕組み	合同調整委員会議事録など	資料レビュー
		同上	プロジェクト関係者、TBCNメンバー	アンケート、インタビュー
		PDM、詳細活動の軌道修正内容	CPs, 専門家	資料レビュー、インタビュー
		PDM・モニタリングシステムの活用方法	合同調整委員会議事録など	資料レビュー
		同上	CPs, 専門家	アンケート、インタビュー
		外部条件の変化への対応	合同調整委員・委員会記録	資料レビュー、インタビュー
		同上	CPs, 専門家	アンケート、インタビュー
	専門家とカウンターパートとの関係性	コミュニケーションの状況	CPs, 専門家	アンケート、インタビュー
		共同作業による問題解決方法の見直し状況	CPs, 専門家	アンケート、インタビュー
		カウンターパートの変化(主体性、積極性)	CPs, 専門家	アンケート、インタビュー
	受益者の事業への関わり方	FCHV・患者の巻き込み	CPs, 専門家	アンケート、インタビュー
		同上	WHO	インタビュー
	相手国実施機関のオーナーシップ	JCCの主体性・総括実績	CPs, 専門家、JCC	アンケート、インタビュー
		ARIプログラム、NHIECC、NTCの予算(1999～2004年): 項目別ブレイクダウン含む	NTC資料、保健省資料	資料レビュー
		カウンターパートの適正度	プロジェクト資料、専門家報告書	資料レビュー
1. 妥当性	1.1 上位目標のネパールの開発政策との整合性	ネパールの開発計画における保健医療分野に関する政策	国家開発計画	資料レビュー
		保健医療分野に関する政策の方向性	保健医療分野製作文書	資料レビュー
	1.2 プロジェクト目標の相手側のニーズとの整合性	NTCのニーズとの整合性	プロジェクト資料	資料レビュー
		Health Professionalsのニーズとの整合性	HCスタッフ	グループインタビュー
		DOTS実施状況の変遷と新たな課題	専門家報告書	資料レビュー、インタビュー
		同上	ワークショップ参加者	グループインタビュー
		同上	プロジェクト資料	資料レビュー
	1.3 プロジェクト目標のターゲットグループのニーズとの整合性	ターゲットグループの選定、規模の適正度	CPs, 専門家、保健省担当官、WHO	アンケート、インタビュー
		結核患者のニーズとの整合性	結核患者	グループインタビュー
	1.4 上位目標の日本の開発援助政策との整合性	日本の国別援助方針など	外務省の関係資料	資料レビュー
		JICAの国別事業実施計画など	JICAの関係資料	資料レビュー
2. 有効性(目標達成度)	2.1 プロジェクト目標の達成度合い	結核治癒率・死亡率	プロジェクト資料	資料レビュー
	2.2 プロジェクトの目標とアウトプットの関連	各アウトプット間の関連性・貢献度合い	CPs, 専門家	アンケート、インタビュー
		同上	ワークショップ参加者	グループインタビュー
		同上	プロジェクト資料	資料レビュー
	2.3 外部条件の影響	プロジェクトの進捗を妨げる事例	プロジェクト資料	資料レビュー
		同上	CPs, 専門家	アンケート、インタビュー
終了時評価時点で、被援助国のニーズ、政策との整合性、日本の援助事業としての妥当性はあるか。	プロジェクトの実施により、期待される効果が得られたか？ プロジェクト計画は有効であるか？	プロジェクト以外に結核治癒率・発見率に影響を与えた要因	CPs, 専門家、WHO、ドナー・NGO関係者	アンケート、インタビュー

評価項目	調査項目	必要な情報・データ	情報源	調査方法
3. 効率性 プロジェクトは効率的であるか。(投入された資源量に見合ったアウトプットが達成されているか。)	3.1 日本側投入の適正度	専門家派遣(人数、タイミング、分野)	CPs、専門家	アンケート、インタビュー
		供与機材(種類、機種、数、タイミング)の適正	CPs、専門家	アンケート、インタビュー
		研修員受入(タイミング、人数、研修内容)	CPs、専門家	アンケート、インタビュー
	3.2 ネパール側投入の適正度	CPsの配置(人数、タイミング、分野)	CPs、専門家	アンケート、インタビュー
		プロジェクト運営費	NTC資料、CP、専門家	資料レビュー、インタビュー
		提供された施設設備の適正度	CP、専門家	インタビュー
		同上	ワークショップ参加者	グループインタビュー
	3.3 活用されなかった投入の有無	人材	CPs、専門家	アンケート、インタビュー
		資材・機材	CPs、専門家	アンケート、インタビュー
		業務費	CPs、専門家	アンケート、インタビュー
	3.4 プロジェクト運営管理	プロジェクト運営委員会、合同調整委員会の実施状況	合同調整委員会記録、CP、専門家	資料レビュー、アンケート
		プロジェクト運営管理能力	CPs、専門家	(グループ)インタビュー
		フェーズ1・2プロジェクトのリソース活用度	CPs、専門家	インタビュー
		他国の結核プロジェクトのリソース活用度	CPs、専門家	インタビュー
4. インパクト プロジェクトを実施した結果、どのようなプラス・マイナスの波及効果があったか？	4.1 結核罹患率、死亡率の減少への貢献度	上位目標の達成度合い(結核による死亡率、結核罹患率の減少)	NTC資料	資料レビュー
		プロジェクト以外に死亡率・結核罹患率に影響を与えた要因	CPs、専門家、WHO、ドナー・NGO関係者	アンケート、インタビュー
		同上	ワークショップ参加者	グループインタビュー
	4.2 予想しなかったプラスの影響 ＜想定できうるプラスの影響＞	NTC内、関連機関、特定の社会グループへの波及効果の事例 ＜General Healthcareのプラス効果、医療機関へのAccessibility改善など＞	CPs、専門家 プロジェクト資料	アンケート、インタビュー 資料レビュー、インタビュー
	4.3 予想しなかったマイナスの影響	NTC内、関連機関、特定の社会グループへの波及効果の事例 ＜ドナー間の待遇の違いによる患者・Health Professionalsへの影響、診療・管理業務への興味を超える研修活動への興味など＞	CPs、専門家 プロジェクト資料	アンケート、インタビュー 資料レビュー、インタビュー
	4.4 外部条件による影響	外部条件により変更された活動の有無 同上	CPs、専門家、その他 プロジェクト資料	アンケート、インタビュー 資料レビュー
5. 自立発展性 プロジェクトの効果は今後も持続していくか？(プロジェクトの効果を最大限活かしていくには何が必要か？)	5.1 政策的支援の継続、組織運営能力	ネ王国の方針、結核に対する対応策	プロジェクト資料	資料レビュー
		組織運営能力(自己査定)	CPs	グループインタビュー
		組織運営能力	日本人専門家、WHO、ドナー・NGO関係者	アンケート、インタビュー
	5.2 NTCの運営財源の確保の可能性	予算の確保、財政支援の継続性	NTC	資料レビュー、インタビュー
		施設、機材の保守、維持管理システム	CPs、専門家	アンケート、インタビュー
	5.3 移転した技術の定着と普及の仕組み	CPsの定着度合い	NTC資料、NTCスタッフ	資料レビュー、アンケート
		自己評価結果	CPs	グループインタビュー
		機材維持管理能力	CPs、専門家	アンケート、インタビュー
	5.4 持続的効果の発現要因と阻害要因	プロジェクトで得られた効果が引き続き発現してゆくために必要な要因と、考えうる阻害要因 同上	CPs、専門家、その他 プロジェクト資料 ワークショップ参加者	アンケート、インタビュー 資料レビュー グループインタビュー
		今後のプロジェクトの展開についての構想、助言等	CPs、専門家、その他	アンケート、インタビュー
		同上	プロジェクト資料	資料レビュー
			ワークショップ参加者	グループインタビュー

4. 主要面談者リスト

1. ネパール側

(1) 保健省

1	Dr. Nirakar Man Shrestha	Officiating Health Secretary, Ministry of Health and Population
2	Dr. Sun Lal Thapa	Chief, IMCI, Child Health Division, Department of Health Service (DHS)
3	Mr. Babu Ram Koirala	Director, National Health Education, Information and Communication Centre, DHS
4	Dr. Jyoti Raj Shrestha	District Public Health Officer (DPHO), Kathmandu District, DHS
5	Mr. Astha Ratna Tuladhar	Former DPHO, Rupandehi DPHO, DHS

(2) 国立結核対策センター (NTC)

1	Dr. Keshab Bhakta Shrestha	Director, National Tuberculosis Centre (NTC)
2	Dr. Dirgh Singh Bam	Former Director, NTC
3	Dr. Kashi Kant Jha	SAARC Director and Senior Consultant Chest Physician, NTC
4	Dr. Puspa Malla	Senior Consultant Chest Physician, NTC

(3) その他

1	Health Post in Charge, a health worker, DOTS Volunteers and an ex-smoker engaging in Anti-Smoking Activities	Chapagaun Teaching Health Post, Lalitpur District
2	Mr. Tamding Dorje Lama	Programme Coordinator, Himalayan Healing Centre
3	Ms. Uma Basnet	Health Post in Charge, Baneshwor Urban Clinic
4	DOTS Volunteers, TB Patients undergoing DOTS	Anam Nagar Polyclinic, Teku Hospital, Himalayan Healing Centre, Baneshwor Urban Clinic
5	Dr. U. R. Upadhaya	President, NEPAS (Nepal Pediatric Society)
6	Dr. R. Shrestha	Acting Director, Kanti Children's Hospital
7	Dr. G. B. Baniya	Chief, Medical Department, TUTH

2. 日本側

(1) プロジェクト専門家

1	杉山 達郎	チーフアドバイザー
2	成瀬 章	業務調整員
3	藤木 明子	短期専門家 (結核菌検査)

(2) 在ネパール日本大使館、JICAネパール事務所

1	富田 晃次	在ネパール日本大使館 一等書記官
2	吉浦 伸二	JICAネパール事務所長
3	今井 史夫	JICAネパール事務所 次長
4	梅津 径	JICAネパール事務所 所員
5	吉田 久美子	JICAネパール事務所 企画調査員

4. 関係機関（国際機関、NGO等）

1	Dr. Christian Gunneburg	WHO Medical Officer (Tuberculosis)
2	Mr. Dharmpal Pd. Raman	Program Specialist, Office of Health and Family Planning, USAID
3	Dr. John Quineley	Health & Child Survival Advisor, Office of Health and Family Planning, USAID
4	Mr. Dilip Chandra Poudel	Team Leader, Child Health, NFHP (Nepal Family Health Program)
5	Mr. Bhandari	NFHP (Nepal Family Health Program)

Community Tuberculosis and Lung Health Project

(2000 September – 2005 September)

Tatsuo Sugiyama

Joint Coordinating Committee meeting

Everest Hotel

May 20th 2005

TB Project in Nepal

- Western Region, Public Health Project (1973-1989)
- National TB Control Project (1987-1994)
NTC established in 1989.
- National TB Control Project, phase II (1994-2000)
DOTS started in 1996.
- Community TB & Lung Health Project (2000-2005)
Expand DOTS and introduce technique of DOTS to lung health management.

Community TB & Lung Health Project (2000-2005)

Overall Goal

Lung health among the people is improved.

Project Purposes

- Overall performance of NTP is further improved. (TB part)
- Functional models for improved community lung health are established.
(Non-TB part)

(PP1: Overall performance of NTP is further improved)

Outputs for Project Purpose 1 (TB)

Output 1

- The managerial capacity of the NTP is further strengthened.

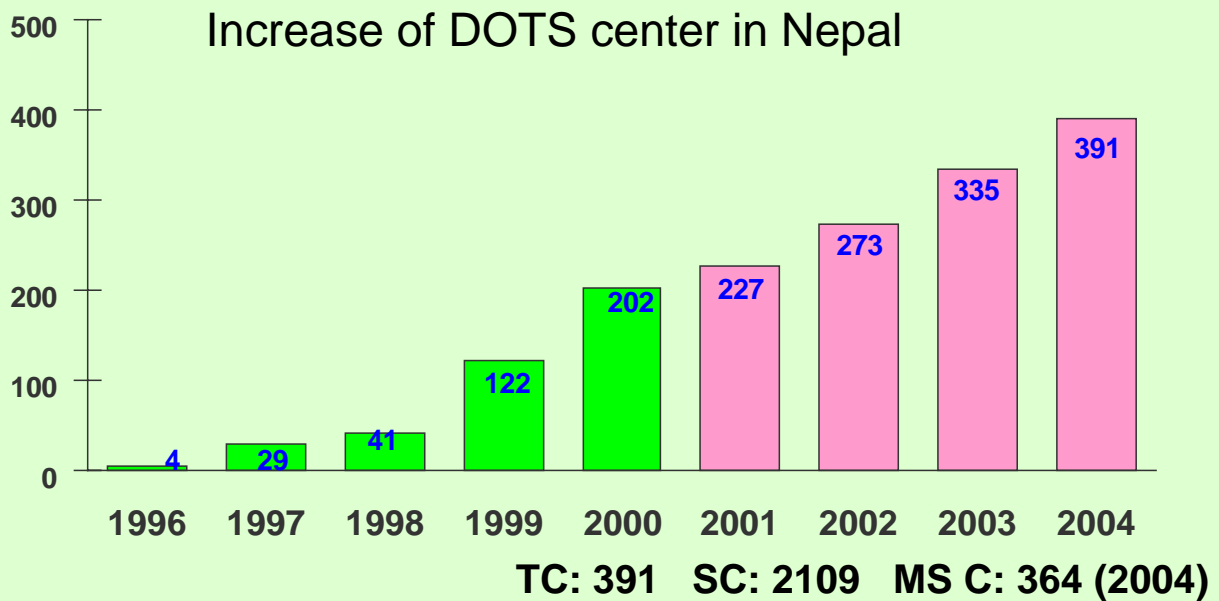
Output 2

- Management system for the laboratory and logistics of the NTP is made sustainable.

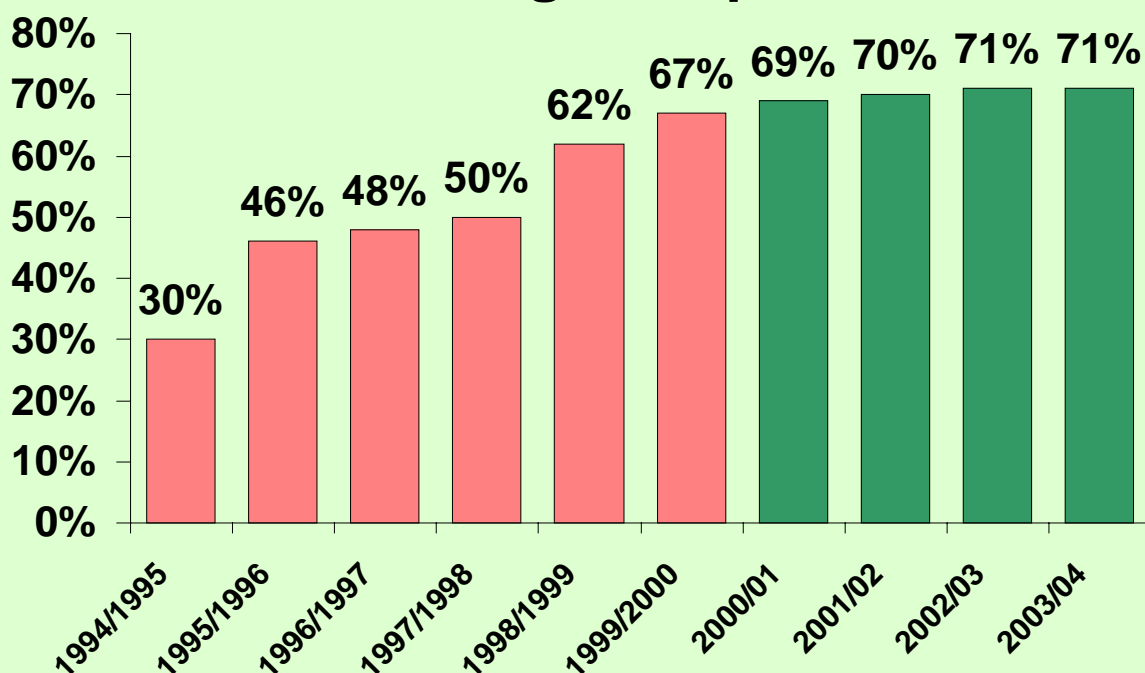
Output 3

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

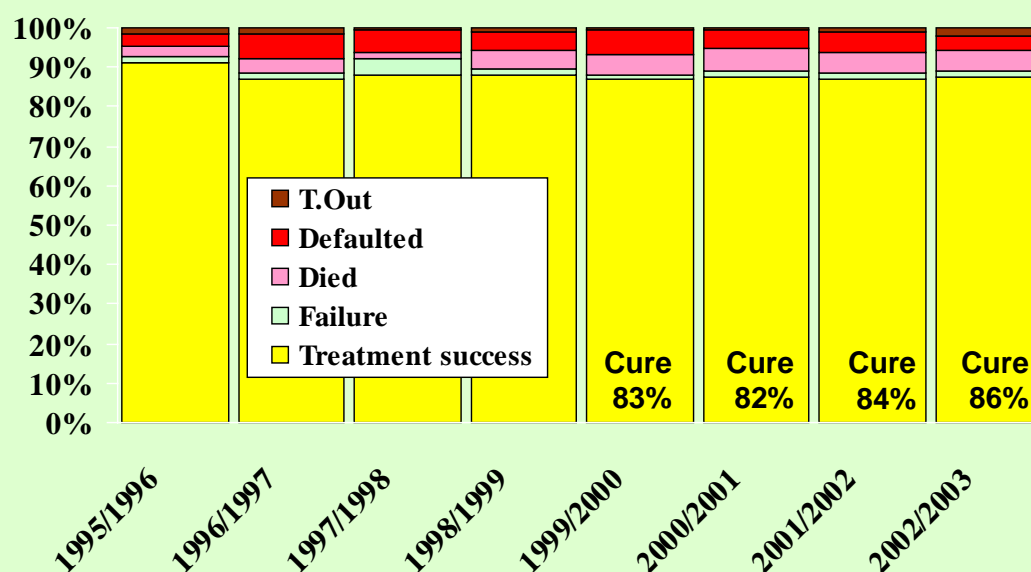
- **All 75 districts have been covered by DOTS since 2001.**



Case finding in Nepal



NS(+) treatment outcome in Nepal



Laboratory

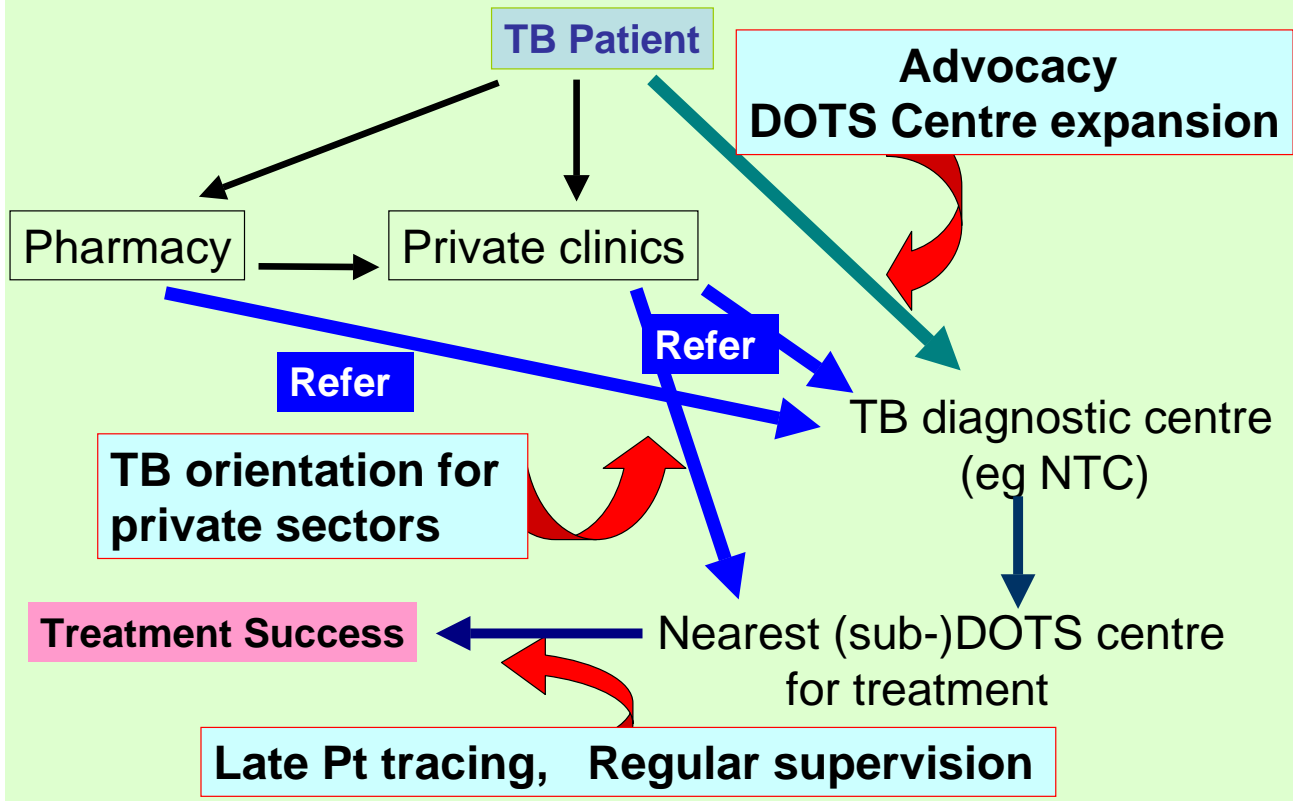
- Out of 364 Microscopic centres 331 were functioning in December 2004, ie. 91% of the total.
- Quality Control of sputum examination showed 97% overall agreement rate in 2003/04.

Logistics

- TB Drug supply at regional level was within the range of 85% - 135% of requirement and stock-out did not take place in 2003/04.

Reinforcement of DOTS in Urban area

TB Output 3



Expansion of DOTS centre

TB Output 3

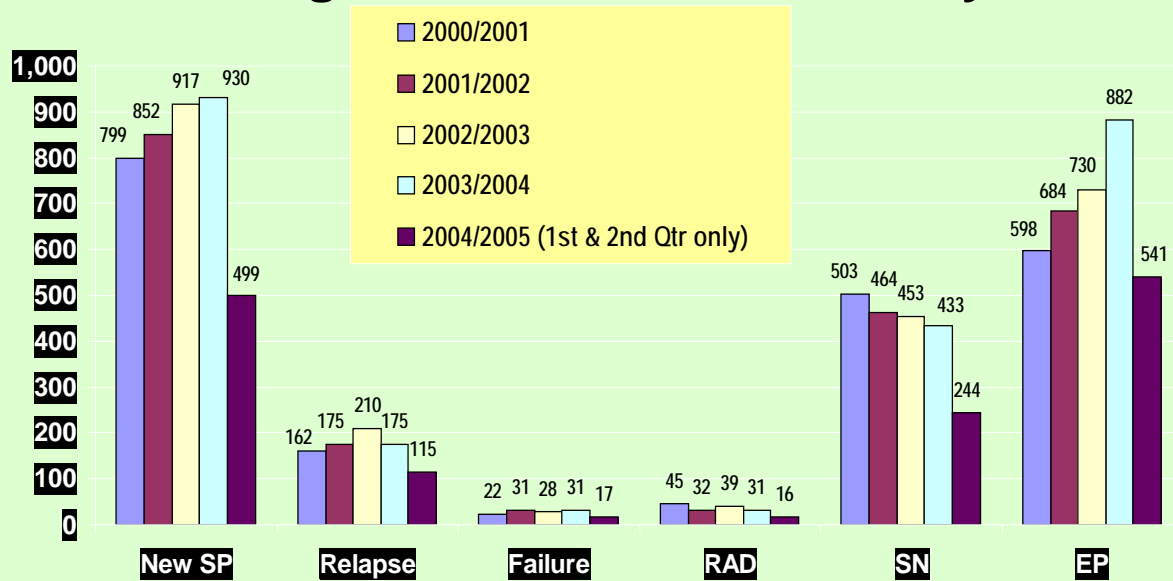
DOTS centres were increased from 19 (2000) to 34 (2005).



34 DOTS centres

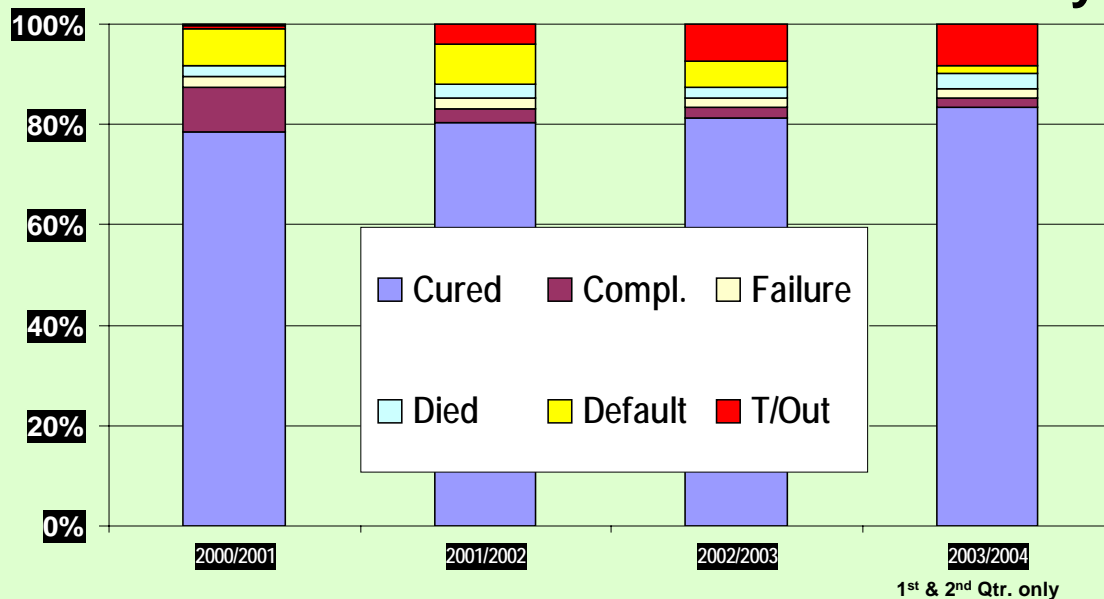
- : Public (7:HMG, 14 KMC)
- 6 : Private
- 7 : I/NGOs

Case Finding of Kathmandu Urban City



New smear(+) cases increased from 799 to 930 in 3 years.
 New sm(+) case rate in all new cases was 41% (2003/04).
 (2004/2005 data includes 1st & 2nd Qtr. Only)

Treatment Outcome of Kathmandu Urban City



Cure rate was improved from 79% to 84% and defaulter rate was able to decrease from 8% to 2%. But transfer-out cases increased to 8%.
 (2003/2004 data includes 1st & 2nd Qtr. Only)

Improvement of accessibility to DOTS centre in Rasuwa (hard-to-reach area)

(2001)

1 treatment centre
9 sub-centres
1 diagnostic centre



(2004)

1 treatment centre
18 sub-centres
3 diagnostic centres

Treatment:

Each VDC has a DOTS (Sub) centre.

Access within 2 hrs

Diagnosis:

3 microscopic centres improved access to TB diagnosis.



(PP2: Functional models for improved community lung health are established)

Outputs for Project Purpose 2 (non-TB)

Output 1

- Case management of children with ARI is improved in selected districts (Rupandehi)

Output 2

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

Output 3

- Communities adopted measures for ant-smoking.

- ARI management is one of the components of IMCI programme so that the Project supported IMCI programme to improve ARI in Rupandehi district since 2001.
- 3rd day follow-up of patient was introduced in the IMCI registration to monitor and achieve treatment outcome.



Training/orientation on IMCI

Description	Achievements
District / PHC / HP / SHP Staff orientation / training	145
VHW / MCHW	119
FCHV basic training	1211
FCHV refresher training	1172
DDC / VDC level orientation	849
Traditional healers orientation	255
Mother's group orientation	21904

*Training was finished by Sept 2003.

Age	Res. rate (/min)	Criteria	Management
<2 months	60	-	Refer to health facilities
2- 60 months (<5 y.o)	60 Indrawn Chest	Severe pneumonia	Refer to health facilities
	50	Pneumonia	Treat with antibiotics

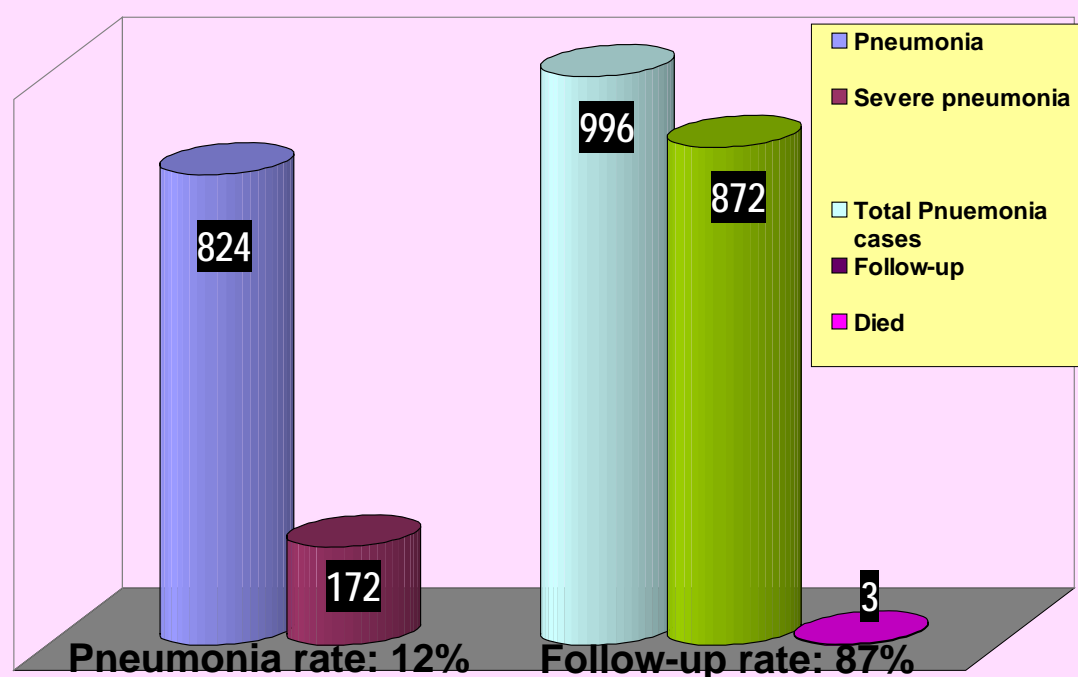


Sound Timer (1min)



Result of community-base IMCI

Out of total registered ARI cases 8,378 (9 VDCs)



Anti-Smoking Activity

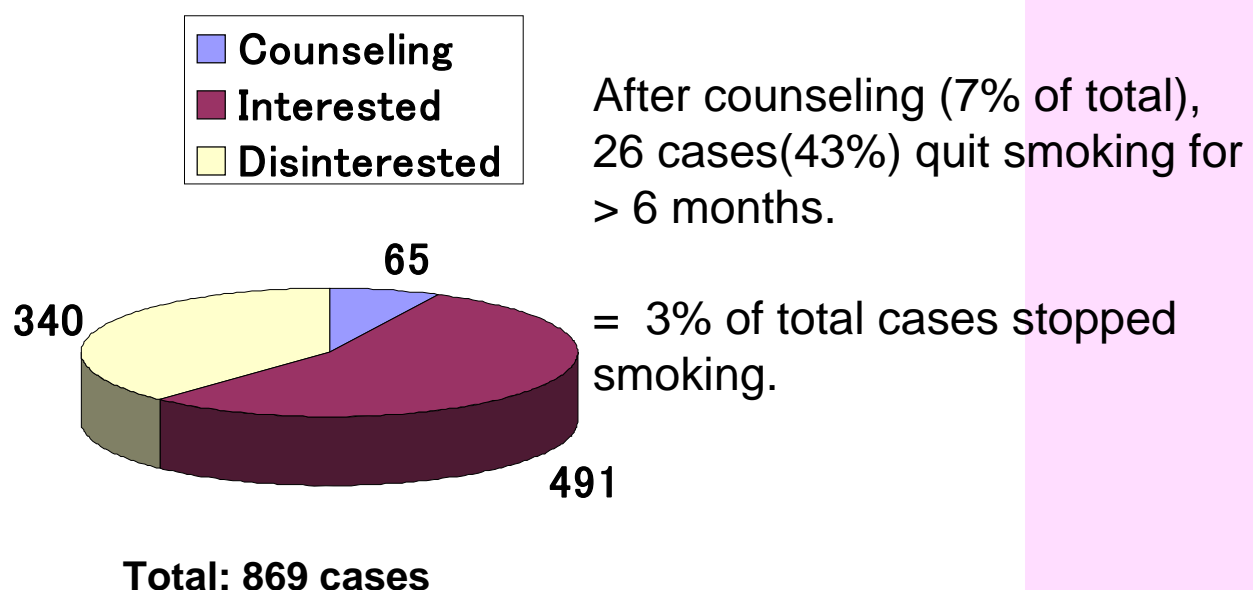
COPD survey was conducted in Kathmandu valley in 2002.

According to the survey result, 3 VDCs were selected for anti-smoking activities.

(Activity)

1. Counseling of smoking cessation for COPD patients
2. School education on anti-smoking
3. Community mobilization by anti-smoking volunteers

Smoking-cessation condition of registered cases (chronic lung diseases) at health facility



Non-Smoking Zones

Non-smoking zones were set at 45 areas (eg. temples, schools) in 3 VDCs.



