CB -IMCI PROGRAMME

An FCHV conducting a Mother's Group Meeting

ANNUAL REPORT
2004

IMCI Section
Child Health Division, Teku

August 2005

ACRONYMS

ARI	-	Acute Respiratory Infection
AHW	-	Auxiliary Health Worker
ANM	-	Auxiliary Nurse Midwife
AusAID	-	Australian Agency for International Development
BPKIHS	-	B. P. Koirala Institute of Health Sciences
C-BAC	-	Community Based ARI & CDD
CB-IMCI	-	Community Based Integrated Management of Childhood Illness
CDD	-	Control of Diarrhoeal Diseases
CDP	-	Community Drug Programme
CHW	-	Community Health Workers (VHW, MCHW & FCHVs)
CMR	-	Child Mortality Rate
CTEVT	-	Council for Technical Education and Vocational Training
DACAW	-	Decentralised Action for Children and Women
DDC	-	District Development Committee
DHS	-	Department of Health Services
DHO	-	District Health Office/Officer
EPI	-	Expanded Programme on Immunisation
EF	-	Endowment Fund
FCHV	-	Female Community Health Volunteer
HA	-	Health Assistant
HMG	-	His Majesty's Government
HMIS	-	Health Management Information System
HP	-	Health Post
IMCI	-	Integrated Management of Childhood Illness
IRHDTC	-	Integrated Rural Health Development Training Center
JICA	-	Japan International Cooperation Agency
MCHW	-	Maternal and Child Health Worker
MIRA	-	Mother and Infant Research Association
MNTE	-	Maternal and Neonatal Tetanus Elimination
MOH	-	Ministry of Health

NEPAS	-	Nepal Paediatric Society
NFHP	-	Nepal Family Health Programme
NHEICC	-	National Health Education Information & Communication Center
NTAG	-	Nepali Technical Assistance Group
PHO	-	Public Health Officer
PHC	-	Primary Health Center
SAHW	-	Senior Auxiliary Health Worker
SHP	-	Sub Health Post
VDC	-	Village Development Committee
VHW	-	Village Health Worker
UNICEF	-	United Nations Children's Fund
USAID	-	United States Agency for International Development
WHO	-	World Health Organisation

Preface

IMCI section/CHD, Ministry of Health, continues to implement its activities in close collaboration with the partners. This is the fourth consecutive Annual Report covering the period of 2004.

This Report, I hope, will be successful in providing the readers all the information about this section's activity from one source, as with the previous reports. I would appreciate for your constructive and innovative comments to improve the subsequent issues.

I would like to thank Rajendra Karki of UNICEF for taking the initiation and Health Section, UNICEF for providing resources for the printing of this report. Besides, I would like to thank Dilip Poudel, Babu Ram Acharya and Ram Bhandari of NFHP, Dr. Tekendra Karki of WHO, Dr. Dhana Raj Aryal of NEPAS and Mr. Krishna Prasad Acharya of NTAG for their valuable contribution to the completion of this report. Several other people, who have in some way or the other contributed to the preparation of the report but have not been mentioned here, also deserve my sincere appreciation.

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CB-IMCI PROGRAMME

1. Introduction

Nepal has a population of 23.15 million and in the last decade the annual population growth rate has been 2.24 % (Census 2001). Nepal has an area of 147,181 Sq. Kms.

Geographically, the country is divided into three regions - Mountain, Hill and Terai accommodating 7, 44 and 49 percent of the population respectively. These regions constitute 35, 42 and 23 percent of the total land area.

There are 5 development regions and 75 administrative districts. Districts are further divided into smaller units, called Village Development Committees (VDC) and Municipality. Currently, there are 3,914 VDCs and 58 Municipalities in the country. Each VDC is composed of 9 wards and Municipalities consists of 9 to 35 wards. Urban population is about 14 % of the total population (Census 2001).

Per capita GDP is estimated in the order of US $240 (preliminary estimate) for 2000/01. About 80 % of the people are dependent on agriculture. Overall literacy is 53.74 percent, 42.49% for female and 65.08 percent for males (Census 2001).

The status of sanitation is very poor; in 2002, only 30 % of households had any kind of safe toilet system. However, 80 % of households did have access to safe drinking water. Only 31.7% of the people are reported to have access to electricity (Nepal Human Development Report 2004).

1.1 Country health situation:

Over the years, there has been gradual improvement in the health status of the people of the country. However, much still remains to be done. Nepal's health situation is characterised by low life

expectancy, high child mortality and high maternal mortality rates. Life expectancy at birth is 60.98 year (Census 2001).
Communicable diseases continue to contribute significantly to the overall burden of disease of the country. Maternal mortality ratio is one of the highest in the world at 539/100,000 live births.

Neonatal mortality (39/1000live births) is one of the highest in the world. In the past years deaths due to diarrhoea and other communicable diseases has gone down, especially in older children, and so the proportion of Neonatal mortality has gradually increased and constitutes about 60% of the IMR. This indicates that unless neonatal mortality is addressed effectively, reduction of IMR or <5 mortality would not be possible.

Only about 12 % of the deliveries are attended to by health workers and overall utilization of health facilities is very low, about 30%. Tuberculosis kills about 5,000-7,000 people each year.

However, since November 2000 no case of polio has been reported. Three rounds of Maternal and Neonatal Tetanus Elimination (MNTE) has been completed in all the districts. In 2004, Measles control programme was initiated and covered the Eastern and Central Region of the country targeting 57% of children between 9 moths to 15 years of age. Hepatitis B immunisation has already been introduced in several districts and will eventually be a part of the routine immunisation programme.

Vitamin A programme has proved to be a successful public health intervention and now covers all the 75 districts of the country with significant impact on the child morbidity and mortality. This works through bi-annual campaigns. In recent years, deworming has been introduced and reaches all the districts along with Vitamin A distribution rounds and has shown promising results.

At the community level, Female Community Health Volunteer (FCHVs) contribute very significantly, among others, to Child Health issues. About 48,500 of these women serve in the nook and cranny of the country as volunteers and are instrumental in the success of programmes such as Vitamin A immunisation

including polio eradication, and for some time in the treatment of cases of pneumonia in children <5 years of age in 24 districts of the country. Besides they also help with a host of other health programmes such as family planning etc.

To cater to the health care needs of the country, at the Government level, there are 84 hospitals, 188 Primary Health Care Centers, 698 Health posts and 3129 Sub health posts. There is at least one health facility (mostly SHPs) serving in a VDC which is manned by an Auxiliary Health Worker (AHW) as the incharge and a VHW and a MCHW. In Nepal, it is estimated that for every 20,000 population, one doctor is available. But among these, most are concentrated in urban areas, particularly in the capital. ..... hospital beds are available throughout the country in the Government health facilities.

Drugs are essential to the running of the Government health facilities, more so in remote areas where there are no alternates. Government allocates Rs. 125,000, Rs 75,000 and Rs. 32,000 for PHC, Health post and Sub-health posts respectively. In many cases this is enough to meet the demand for 3-4 months only. However, in districts where Community Drug Programme (CDP) is implemented, clients pay for the drugs, drugs are available throughout the year. CDP is implemented in 31 districts only, in some only partially. In recent days, CDP has experienced some problem due to insurgency, as it involves charging for the drugs.

1.1.1 Child health situation

Though <5 mortality has gradually declined over the years, findings of the Nepal Demographic Health Survey (NDHS), 2001 has estimated the CMR at 91/1000 live births and IMR at 64.2/1000 live births, which is still far from satisfactory. ARI, particularly pneumonia, and Diarrhoeal diseases continue to be the leading cause of morbidity and mortality in children under 5 years of age. Malnutrition is an associated cause in more than 50 % of child deaths.

Death due to diarrhoea continues to decline every year. In 2060/61 (HMIS), only 194 diarrhoeal deaths were reported. Although case fatality rate has gone down, but still for every 100,000 cases, 20 die (HMIS 2060/61). Neonatal mortality is very high at 39/1000 live births requiring urgent attention. Very recently more attention is being paid to this aspect. In this respect the Government came out with a Neonatal Strategy for the first time in 2004.

Until very recently, about 5,000 children <5 years were estimated to die due to Measles every year. However, with the Measles campaign completed in some parts of the country, the figures for death may be expected to come down. Cases of neonatal tetanus has seen a dramatic decline after the completion of the Maternal and Neonatal Tetanus Elimination campaing (MNTE) in the country in 2003.

2. Programme delivery mechanism

CB-IMCI activities are implemented by the Child Health Division (CHD), MoH in collaboration with USAID/NFHP, WHO, UNICEF, CARE, SCF/US, JICA, PLAN Nepal and AusAid. Child Health Division, responsible for implementing CB-IMCI programme, is one of the 7 Divisions within the Department of Health Services (DHS) of the Ministry of Health. IMCI Section is one of the three sections within the CHD, the other two being Nutrition and EPI.

In implementing IMCI programme, the following groups of people are provided with training or orientation for varying duration:

Training:

a. Health workers (Doctors and paramedics)
b. Basic health workers (VHW and MCHWs)
c. Volunteers (FCHVs)

Orientation:

d. Political and social leaders
e. Others (Drug retailers and traditional healers)
f. Mothers/caretakers

3. Historical perspective

Before the current IMCI programme came in place, it has evolved through several stages. CDD Programme started in late 1982 as part of the global WHO initiative to establish National CDD programmes. Later, in 1987, ARI Programme was launched in Chitwan district, which gradually expanded to cover the entire country. CDD Reactivation Programme was launched in 1993 from the Eastern Region and gradually expanded to cover the rest of the Regions. In 1995, ARI Strengthening Programme was launched as a pilot programme in 4 districts. An evaluation of this programme in 1997 with technical support from WHO, recommended a cautious expansion of the 'Treatment Model'.

CBAC (Community Based ARI/CDD) Programme is operational in 8 districts of the country; the training package included diarrhoea, ARI, nutrition and EPI. All Government health workers as well as the community level health workers (VHWs, MCHWs and the FCHVs) were trained to diagnose and treat cases of pneumonia in children <5 years; however, VHWs/MCHWs and FCHVs referred children less than 2 months with pneumonia. This programme is a predecessor of the IMCI programme.

It has been the policy of the Government to gradually convert the CBAC districts into CB-IMCI districts by training the health workers on IMCI. Therefore, these days CDD, ARI or CBAC programme are no longer implemented; it is only the IMCI programme that is implemented in the new programme districts.

IMCI (Integrated Management of Childhood Illness)

Programme: Integrated Management of Childhood Illness (IMCI) is a WHO/UNICEF global approach to address major childhood

illnesses; diarrhoea, ARI, measles, malnutrition and malaria, which together account for about 70% of the childhood mortality in developing countries.

In IMCI, a child is looked at in a holistic manner saving unnecessary visits to the health facility and reducing unnecessary medication. In Nepal, IMCI was first implemented in Mahottari in 1997. Since then it has gradually expanded.

IMCI consists of three major components:

- Improving the knowledge and skills of health workers
- Improving the health system.
- Improving Family and Community practices about the Child.

4. Activities conducted in 2004

Major activities accomplished during the period are as follows:

4.1 Central Level

Several activities including trainings, meetings and other activities have taken place at the central level which are as follows:

Workshop to revise HF and CHW's IMCI modules and to adapt WHO/SEARO BHW newborn package: WHO and NFHP supported this activity. Staff from UNICEF, NFHP, WHO, IMCI Section, NTAG, SNL (SCF US), MIRA and IRHDTC participated in this 5-day workshop at Dhulikhel and 4 days in CHD, Teku and hotel Blue Star Tripurshwor. It reviewed all the related materials and incorporated the neonatal component into the IMCI package at all levels paving the way for inclusion of the neonatal part for health workers as well as at the community level. All the related job aids were also revised, translated and adapted. In the end, this workshop came out with a prototype of the revised materials.

Orientation on revised IMCI materials incorporating neonatal package: Staff from UNICEF, USAID, WHO, NFHP, CDD/ARI section, FHD, NEPAS, KCH, NTAG, CARE Nepal, IRHDTC, and PLAN Nepal participated in this 1-day orientation on 23 July. The meeting briefed about the proposed neonatal package and put forward for discussion and endorsement. WHO supported this activity.

Focal Person's meeting: The purpose of this meeting is to bring together IMCI focal persons of the CB-IMCI/CBAC programme districts and share experiences among the districts and with the center. This meeting has proved to be a useful exercise over the years. This year it was conducted in Chitwan from 5-9 April, supported by USAID and facilitated by NFHP staff. Because of indefinite blockade in that region, participants had hard time getting to the venue and at one point it was felt that the meeting would probably have to be called off. However, most participants arrived at the meeting venue despite facing extreme difficulties. Director of Child Health Division, Dr. Ojha and Chief of IMCI Section represented MOH. Other stakeholders, UNICEF, Plan and CARE also participated. Thirty five person participated in the meeting. Apart from the facilitators, this included 1 participant each from the 18 participating districts.

Basically, there were two parts to this meeting; first, presentation by the districts followed by discussion; second, field visit. During the presentations, participants explained about the programme, its constraints and the recommendations. During the field visit, participants were taken to health facilities of Nawalparasi district to observe the activities of the health facilities and learn from them.

Central level supervision: CHD Director Dr.Y.V. Pradhan visited Kavre along with Dr. Thapa and Dr. Thapa, Chief of IMCI section visited Dang, Rupandehi and Tanahu from 16-26 November. Although staff of NFHP, UNICEF and WHO were supposed to join the trip to Dang, because of the blockage on the road to Dang, they could not. These visits were useful and received feedback from the facilities regarding skill and practices of the health

workers, organisation of the health facility, drug availability and other problems in IMCI implementation. In each district 2 days were spent.

4.2 District level

a. Training of health workers on IMCI (to convert CBAC into IMCI districts):

In line with the Government's decision of gradually converting the CBAC districts into IMCI districts, training of health workers is continued with support from different partners. This year several partners supported this endeavour. Of the 3 district which conducted the training, Jhapa, has now been converted into an IMCI district.

Jhapa: Training of health workers were conducted with support from SCF(US) and the facilitation was done by IRHDTC, a new partner this year. This district, earlier a CBAC district, is now effectively converted into an IMCI district after the completion of the health worker's training on IMCI.

Morang: Training of health workers is being conducted with support from Plan Nepal; NEPAS was hired to do the job. Prior to the health worker's training, a District planning and orientation meeting was held in Biratnagar, which was participated in by the IMCI programme manager and other stakeholders. Remaining batches of health worker's training will continue into 2005.

Sunsari: Two batches of health worker's training were conducted with support from WHO from 5-25 May; 2 batches remain to be completed. Facilitation was done by BPKIHS facilitators. Altogether 45 health workers received the training. Remaining batches of training of health workers will continue into 2005.

a. Training of health workers on IMCI (in new IMCI districts):

In six districts, health workers were trained on IMCI for 9 days. Three private institutions, NEPAS, BPKIHS and IRHDTC, supported the training in different districts.

Kavre: Health workers training was conducted in 2004 with support from UNICEF. However, participants were brought to Kanti Children's Hospital (KCH) in Kathmandu and was facilitated by NEPAS. This is the first time ever that all the participants from a district were brought to KCH for the IMCI training. This was necessitated by the fact that Kavre did not have the required facilities to conduct the training and that KCH was not far away. Although this increased the cost, it ensured better quality of the training.

Sarlahi: Training of health workers was initiated. Before this a District Planning and orientation meeting was conducted. Ten batches of the training were conducted training 180 health workers including supervisory level staff. This activity was funded by USAID and was jointly facilitated by NFHP and IRHDTC.

Advocacy visits: Sarlahi district was visited in preparation for initiating the IMCI activities. This visit a) provided orientation to the DHO/DPHO staff about the programme and prepared the ground work for the subsequent activities. b) assessed the district/zonal hospital's capacity to provide adequate clinical practice for the participants of the training and c) identified the number of health workers to be trained.

Saptari: This district has 114 VDCs. UNICEF supported this activity and the facilitation was done by BPKIHS. In all, 168 health workers were trained in 8 batches. Similarly, 11 district supervisors were also trained. This was the first time that BPKIHS had done this training outside of their institution premises.

Tanahu: Training of health workers which started in 2003 were completed in early part of 2004. This was done with support from

UNICEF. In 2004, altogether 65 health workers were trained in 3 batches. Similarly, 10 district supervisors were also trained separately for 4 days.

In 3 districts, Doti, Dadeldhura and Bajhang, training of health workers was completed and was funded by CARE Nepal. Participants were brought to Nepalgunj for them to avail of more case practice. It was facilitated by NEPAS facilitators.

b. Follow-up after training:

Follow-up after training is an integral part of the health worker's training of IMCI. This activity should ideally happen 4-6 weeks after the training of health workers. However, this has not happened in some districts either due to lack of funds or for security reasons. This year, follow-up after training was completed in 2 districts.

Tanahu: WHO supported this activity. Altogether 66 health workers were followed up between 5-14 May. The field work was contracted out to NEPAS. CHD staff also participated.

Dhankuta: WHO supported this activity. Altogether 32 health workers were followed up between 6-15 June. The field work was contracted out to IRHDTC. CHD staff also participated.

Jhapa: IRHDTC conducted the follow-up after training. 123 health workers were followed up between June 19-August 21.

c. Training of transferred health workers:

Transfer of trained health workers has been a perennial problem. Especially for those programmes which are not nationwide, transfer of health workers has serious implications. When there are more than 15 people who have been transferred to the district and are not trained on IMCI, a course is felt necessary. Accordingly, in many districts trainings are conducted each year. This year such trainings were conducted in 3 districts where ... health workers

were trained. As more districts implement IMCI, demands for such trainings are increasing each year.

Dhanusha: One batch of training of newly transferred health workers was conducted. This was funded by WHO and was facilitated by NFHP staff.

Dhankuta: One batch of training was conducted for health workers of Dhankuta in November in Biratnagar with support from WHO and was facilitated by NEPAS. Although the target was to train 20 staff, only 14 were available for training.

Mahottari: Two batches of training of newly transferred health workers was conducted. This
was funded by WHO and was facilitated by NFHP staff.

Kanchanpur: One batch of HF level training organized in Nepalgunj for transferred staff of Kanchanpur This activity was supported by CARE and facilitated by NEPAS

Training for transferred VHW/MCHW: VHW/MCHW provide support to the FCHVs. For this reason, training of transferred or

newly recruited VHW/MCHW is very important. This year a total of 100 VHW/MCHWs were trained in 2 districts (Jhapa and Parsa,) with support from SCF and NFHP.

Training of community health workers

Besides paramedics, VHW/MCHW and FCHVs need to be trained at the community. Each year, this is done in new districts or in old districts for dropouts. This year also such trainings were conducted in several districts.

Bankey: Trainings at the community level were conducted. This included the FCHV level 2nd phase training. Financial support was provided by PLAN and technical support by NFHP. Altogether 635 FCHVs participated in this training.

Dang: Community level trainings were initiated in 2004 and except for the IInd Phase training of the FCHVs, all the other activities have been completed. More importantly, in 2004, with the completion of the 5-day training of the FCHVs, this district started the diagnosis, treatment/referral of cases of pneumonia in the community. Selling of Cotrimxazole at the community level by the FCHVs is ongoing in several VDCs of Dang.

Tanahu: This activity was supported by UNICEF and was contracted out to Nepali Technical Assistance Group (NTAG). Activities completed in the period of 2004 included the District Planning and Orientation meeting, the 2-day management training for the health workers (88 trained) and 3 batches of the VHW/MCHW training (58 trained). Remaining trainings will be completed in 2005. Some of these activities were pushed back to 2005, as the district had to be busy with the Measles campaign in that region.

Saptari: As agreed earlier, the community activities on IMCI in Saptari was supported by AusAID and facilitated by NTAG. First of the activity, District Planning and Orientation meeting was participated in by stakeholders including UNICEF, NFHP, USAID, WHO, NTAG and the IMCI programme manager. Other activities

followed later; 2-day management training of the health workers, VHW/MCHW training were completed in 2004. Because of the Measles campaign, remaining training activities were pushed back for 2005.

5. New initiatives:

Introduction of Neonatal health package: Existing IMCI course in Nepal only addressed children from 1 week upto 5 years. It was long felt that neonates should also be part of the IMCI course in order to address the large chunk of the neonatal mortality, which is about 40% of the total Childhood mortality and about 60% of the IMR in the country. A workshop was conducted with support from WHO and involvement of all the stakeholders to incorporate the essential neonatal health care. A draft was prepared during the workshop. This was later developed into a course and has now been incorporated into the IMCI training module for the health worker, VHW/MCHW and also the FCHVs.

Reduction of the duration of the IMCI training: For various reasons, it had long been felt that the IMCI training duration should be shortened without compromising the quality of the training, which will on the one hand reduce the cost and the other hand reduce the duration the health workers have to be out of their duty station. The CB-IMCI partners agreed to the idea and worked at several stages to bring down the training duration to 7 days from 9 days. This revised course has been successfully pre-tested in Sarlahi district. Most importantly, it was possible to reduce the duration even after adding the neonatal part to the course.

Video and interactive CD on IMCI: An interactive video and interactive CD on IMCI has been developed, pretested and finalized ,which is being used in Doti,Dadeldhura, Bajhang and Sarlahi at HF and community level. All the partners in the IMCI group reviewed it. The Child Health Director, Dr. Yashovardhan Pradhan released the CDs, amidst a function during the IMCI working group meeting,. This activity was supported by NFHP

Zinc supplementation in treating diarrhoea in children <5:
Preliminary discussion have taken place in the IMCI working group for the introduction of Zinc supplementation in the treatment of acute watery diarrhoea. MoH has received it positively and necessary action is being taken to develop the policy and logistic management in that direction.

6.0 Supervision and Monitoring

For the success of any programme, supervision and monitoring are very important. For IMCI, it is done through various means.

6.1 District level Review Monitoring meetings

Supervision and monitoring continues to be accorded priority in the programme. Review/monitoring meetings are conducted once a year in programme districts where CB-IMCI is implemented. These meetings are conducted both at Health Facility and the Community level as well. .
Objectives of the meeting are to:

a) review the records and report at these levels to identify the disease pattern and service delivery system on ARI/IMCI, and
b) assess the strengths and weakness of the programme and correct the weaknesses.

District Level Monitoring Meeting
F.Y. 2060/2061 (2003/2004)

S/N	District	District Level			District Level with DDC Membe			
		Dist/HF Staff	NFHP, INGO	Total	Dist/HF Staff	NFHP, INGO	DDC Mem.	To
1	Jhapa	57	7	64	14	4	10	
2	Morang	72	11	83	20	5	16	
3	Sunsari	54	7	61	21	7	6	
4	Siraha	111	20	131	19	4	7	

5	Dhanusha	93	9	102	20	3	13	
6	Mahottari	85	5	90	16	2	8	
7	Rautahat	101	18	119	15	2	8	
8	Bara	105	27	132	17	3	7	
9	Parsa	83	5	88	17	3	4	
10	Chitwan	52	9	61	12	3	8	
11	Makwanpur	60	7	67	19	1	4	
12	Rasuwa	19	3	22	16	2	11	
13	Nawalparasi	80	12	92	9	5	4	
14	Bardiya	37	10	47	15	3	6	
15	Kanchanpur	22	7	29	11	5	13	
16	Bajura	28	4	32	15	4	12	
17	Kailali	46	12	58	18	7	5	
Total		1105	173	1278	274	63	142	4

Kaski district also conducted District level monitoring meeting with the support of UNICEF.

6.1.2 CHW level monitoring meeting: This activity was conducted in NFHP supported 17 core program districts.

The main objectives are:
-To collect their performance record and provide feed back for correction.
- To refersh FCHVS,VHW/MCHW in content areas.
- To supply the necessary materials

CHW Level Monitoring Meeting, Achievement

F.Y. 2060/2061 (2003/2004)

S/No.	Districts	No.Of Batch	VHW/ MCHW	FCHV	VDC Mem.	Total
1	Jhapa	21	83	434	24	541
2	Morang	30	101	567	42	710
3	Sunsari	21	83	438	9	530
4	Siraha	44	178	926	159	1263
5	Rautahat	35	141	855	0	996
6	Bara	48	152	866	0	1018
7	Parsa	33	123	729	102	954
8	Makawanpur	26	59	335	0	394
9	Chitwan	18	62	326	79	467
10	Rasuwa	17	22	140	1	163
11	Mahottari	38	136	676	93	905
12	Dhanusha	50	169	895	0	1064
13	Kanchanpur	40	28	621	37	686
14	Nawalparasi	37	122	667	148	937
15	Bajura	26	36	227	37	300
16	Kailali	51	62	986	137	1185
17	Bardiya	37	50	774	0	824
Total		**572**	**1607**	**10462**	**868**	**12937**

6.2 Monitoring and supervisory visits

MoH staff and staff of other collaborating partners NFHP/USAID, UNICEF and WHO made visits to the programme districts. Government staff from central as well as district level undertook these visits. Field staffs of NFHP regularly visit the districts and report on the progress, problems identified, and the recommendations. They also supply materials such as ORS packets, Blue plastic cups for ORS preparation, Cotrimoxazole paediatric tablets and other materials necessary for the programme.

UNICEF staff, from the centre as well as the Field Offices, made visits to CB-IMCI programme in UNICEF focus (DACAW) districts.

Central level supervision: With support from WHO, Chief of the IMCI section, Dr. Thapa visited Dang, Tanahu, Rupandehi and Kaski districts. Although other partners were supposed to join during the trip, despite the efforts, because of the security situation, others could not join.

7. IEC Activities

IEC activities related to health programmes are carried out through National Health Education Information and Communication Centre (NHEICC), the IEC wing of the Department of Health Services. Major activities carried out on IMCI in 2004 are as follows: Radio jingles, TV spots, Posters, Interpersonal, Flip charts &Video & CD. USAID supports most of these IEC activities.

WHO's, Nepali translation of “Illustrated Guide to Improve Family and Community Practices”, which is a flipchart based on Key Family Practices is being used by CORE, an INGO, in their programme districts. It will be a very useful guidebook to all CHWs (VHW/MCHW/FCHV).

8. Supplies

Major supplies used for CB-IMCI activities are as follows:

a. ***Cotrimoxazole Paediatric Tablet:*** This year, with a change in strategy, the Government fund for buying Cotrim was provided directly to the districts. Districts were to purchase as per the guidelines from the Child Health Division (CHD). However, UNICEF supplied cotrim for the DACAW districts, as always, were procured offshore. For treatment of pneumonia at the community level, it is important that

cotrimoxazole tablets are available all the times for people to avail of the services provided by the FCHVs.

b. ***Timer:*** UNICEF provided 3000 timers to the programme for use in the DACAW districts. CHD received 10,000 timers from NFHP purchased with DfID fund. This was helpful in replacing the broken timers in programme districts. However, there is a need to rethink on the use of Timers as programme is expanded to more districts and the need to replace the broken Timers is ever increasing.

c. ***ORS packets:*** A total of 1.244 million packets were supplied throughout the country by IMCI Section in Fiscal Year 2003/2004 (2060/61). Last year 4.825 million packets were supplied. All the FCHVs of the country are provided ORS packets on a regular basis. This year some problems were observed in ORS supply in some districts of the country.

d. **IEC materials:** IEC materials are supplied to the health workers and volunteers in the programme districts. These include poster, pamphlets, classification cards etc. Mother's cards are supplied to districts for distribution to the caretakers of children visiting the health facilities with children <5 years.

e. **Recording/reporting materials:** Regular supply of recording and reporting formats is important. These are supplied to the districts, as needed, from the centre. A laminated case recording form, CB-IMCIOPD Register,Monthly report forms for VHW/MCHWs and HF and Treatment book, Referral book, classification card, Hometherapy card Treatment card ,IMCI chart booklet is supplied to health facilities which is used to record <5 cases.

f. **ORT Corner materials/Blue plastic cups:** ORT corner sets are supplied to districts to replace the broken ones. In 2002/2003, 260 sets of ORT corner materials were procured by HMG and distributed to the needy health facilities. Blue plastic cups are supplied to the health facilities and particularly the Female Community Health Volunteers

9. Private partnership in IMCI training

This year, partnership has been initiated with one more organisation, Integrated Rural Health Development Training Center (IRHDTC). This has enhanced the programme's capacity to expand faster, should funds be available. And due to competition, cost has come down.

Partnership with private institutions in the field of training activities (health facility level and community level) started 4 years back and continues to grow. More districts are being covered with this partnership. Quality of the training activities has so far been consistent.

9.1 NEPAS (Nepal Paediatric Society)

Partnership with NEPAS started in 2001 and continues to-date. In 2004, NEPAS trained 75 health workers in 3 districts (Doti 58, Dadeldhura - 58 Bajhang 17).

9.2 NTAG (Nepal Technical Assistance Group)

In 2004, NTAG completed various trainings at the community level in Dang, Tanahu and Saptari districts. In Dang, the activities completed include: 2 batches of VHW/MCHW training (7 days), FCHVs training (Phase I) and the traditional healers orientation. In Tanahu, 2-day training for health workers and 3 batches of VHW/MCHW trainings were completed.

9.3 B. P. Koirala Institute of Health and Science (BPKIHS)

BPKIHS is involved in several public health activities in districts of the Eastern Region. Several district hospitals in the Eastern Region serve as field practice sites for its medical students, where some of its staff doctors are also posted.

In 2003, for the first time, BPKIHS entered into a formal contract to conduct the IMCI training in Saptari. This year it conducted 2 batches of health worker's training on IMCI in Sunsari.

9.4 Integrated Rural Health Development Training Center / Nepal (IRHDTC / Nepal)

The institute of Integrated Rural Health Development Training Center/Nepal (IRHDTC / Nepal) is a private organization established in 1998. This institute trains health personnel and conducts community based research and development program in the country.

Since 2004, with financial support from WHO, USAID/NFHP, SCF/US and CARE/Nepal , IRHDTC has completed follow-up after training in Dhankutta and Jhapa, Health Facility Level training in Jhapa and Sarlahi and Community level training (VHW/MCHW) in Jhapa.

.Doti,Dadeldhura and Bajhang . IRHDTC was also involved in the development of IMCI and neonatal training package along with other stakeholders. In 2004, IRHDTC entered into a contract for training health workers in Jhapa and Sarlahi. This will continue in 2005.

IRHDTC, one more institution conducting the IMCI training activities, both at the health facility and the community level, has brought down the cost of the IMCI training through competition.

10. HMIS (Health Management Information System) Report

Under IMCI, major childhood conditions included are Diarrhoea, ARI, measles, malnutrition and malaria. In Nepal, first 3 of the conditions are the major direct cause of mortality in children <5 years of age, while malnutrition is an associated case in many of these deaths. An attempt will be made here to analyse the available

information with regards to diarrhoeal diseases and ARI, two of the leading causes.

As IMCI programme is still not nationwide, a complete reporting of all the indicators under IMCI is not possible. However, many of its major components find place in the HMIS of Ministry of Health. A separate recording and reporting system is in place in the CB-IMCI programme districts to supplement the HMIS information collection system. For this a CB-IMCI/ARI OPD register and individual case reporting form has been developed and is in use.

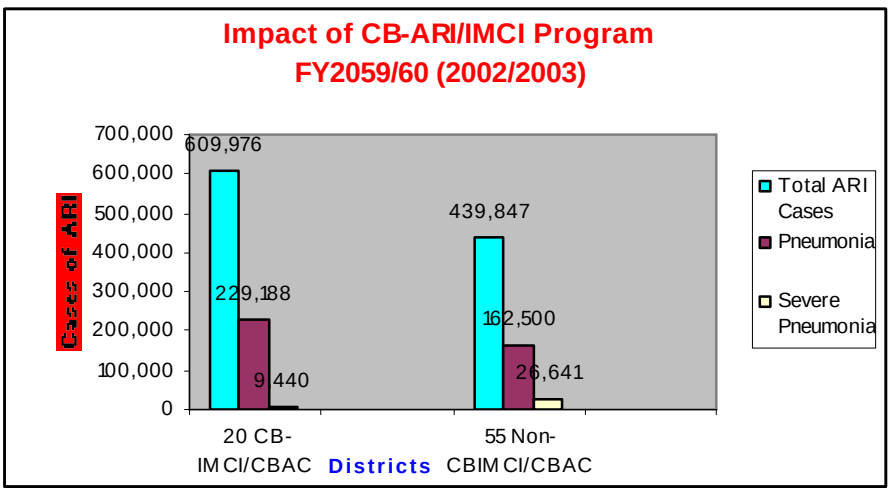
10.1 CDD

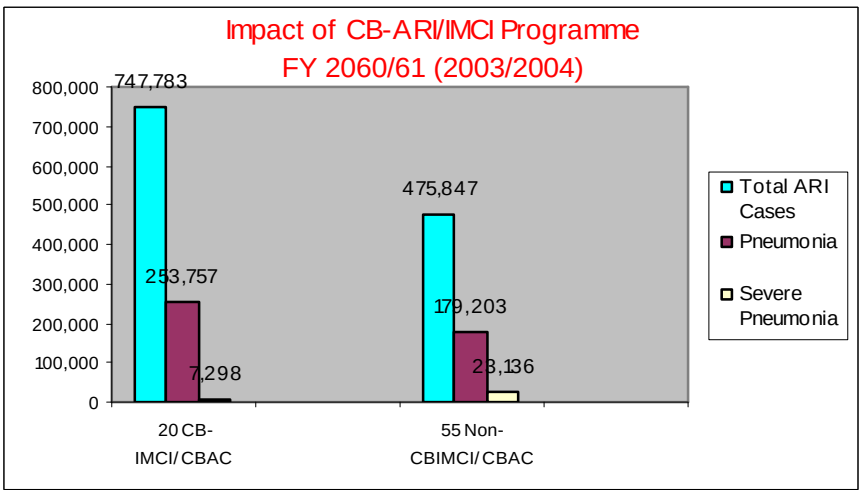
According to the HMIS report for the fiscal year 2003/2004 (July to June), 194 children < 5 years are reported to have died due to diarrhea that year. In 2002/2003 only 148 children were reported to have died. Although the absolute number of deaths has increased, case fatality remains the same at 0.2/1000 cases reporting to the health facilities, same as that for the last year. In fact, case fatality has remained constant for the last three years. There has been an increase in the number of incidence of diarrhea from 200/1000 in 2002/03 to 217/1000 <5 yrs. children, in 2003/04. This report is only from the health facilities and is obviously underreported. Increase in incidence is probably due to better reporting.

Cases of severe dehydration has been going down over the years and stood at 3.21 % of the total cases of diarrhea reported in 2001/2002. This was 3.55 % the previous year and 4.26 % before that. Similarly, cases treated with IV has also been going down and stands at 4 % of the total cases of diarrhea treated in 2001/2002 which was 4.4 % the previous year and 5 %, the year before that. This could be because cases of diarrhea are brought at an early stage, when dehydration has not set in. This is shown by the fact that, of the total cases reporting to the health facilities, 55.43 % had No dehydration this year, whereas the figure was 54.87 % for the previous year and 54.07 % the year before that.

10.2 ARI

It is obvious that with FCHVs managing cases of ARI at the community level in more and more districts, the proportion of cases managed in IMCI programme districts is high. This is evident in the figure given for the fiscal year 2060/61 as represented in the graph below.

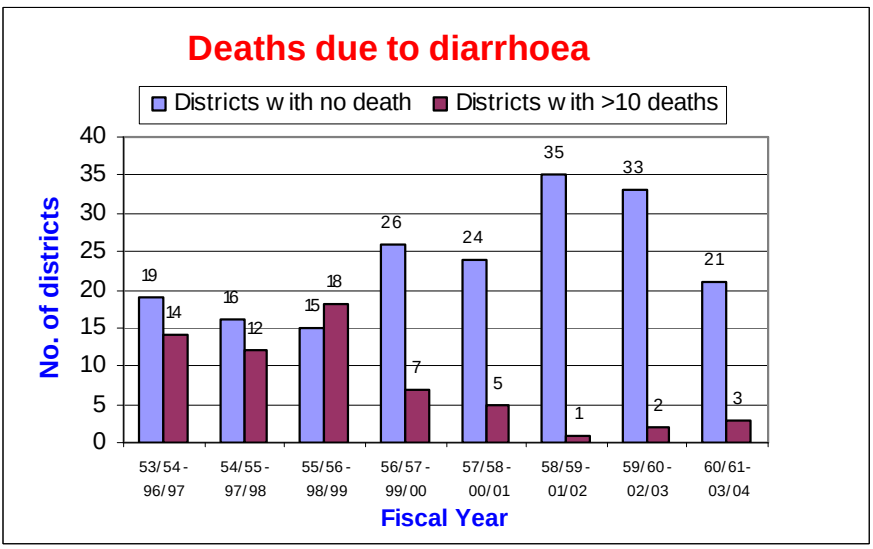


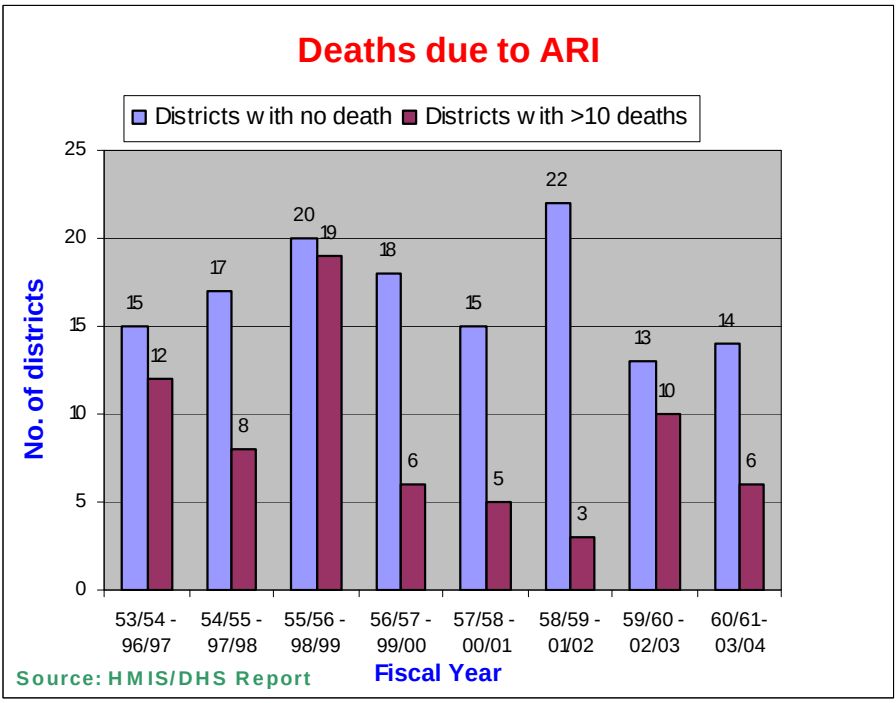


The above bar diagram compares the cases of pneumonia and severe pneumonia managed at the community and at the health facilities in programme versus non programme districts. In programme districts, 37.57 % of the total ARI cases were pneumonia, whereas in non-programme districts this percent was

36.94 %. This shows that percent of pneumonia in both programme and non-programme districts are not significantly different. However, in the programme districts, 1.55 % of the total ARI cases is severe pneumonia whereas in non-programme districts, this percent is 5.6%. This indicates slow progress into severe pneumonia in programme districts. This could be attributed to early diagnosis and treatment of incidences of pneumonia in the community by the FCHVs.

In mature programme districts, severity of cases of pneumonia has gone down over the years obviously indicating a decline in mortality due to pneumonia. A case in point is the performance in Nawalparasi district over the years. Chitwan and Makwanpur also show similar trends over the years.





The above two graphs show that the number of districts reporting zero death due to diarrhea or ARI is constantly on the rise. The findings are more remarkable in case of diarrhea where in Fiscal Year 2001/02, 47 % of the district reported 0 deaths and only 1 district reported more than 10 death. Similarly, for ARI, number of districts reporting 0 deaths is constantly on the rise and for the Fiscal year 2001/02, 29 % of the districts reported 0 death and 3 districts reported more than 10 death in that period. Similarly, districts reporting 10 or more deaths per year due to ARI is constantly on the decline.

As the number of districts with CB-IMCI programme is ever increasing and more cases are seen at the community level the total cases managed has been growing. This was 1,049, 850 in 2002/2003 (2059/60), whereas it went to 1,219,630 in 2003/2004 (2060/61), an increment of over 16%. This can mostly be attributed to improved case finding in the new CB-IMCI districts. In the Fiscal Year 2002/2003 (2059/60) case fatality rate for cases of ARI was 0.3/1000 cases presenting at the health facilities; however for 2003/2004 (2060/61) it has gone down to 0.2/1000 cases.

11. Opportunities

- 47.6 % of the < 5 children of the country in 24 districts have now access to pneumonia treatment through CBAC or CB-IMCI programme.
- Increase in number of private partners has meant more districts being covered and faster. It is now possible to implement the programme in more districts in a year, provided funds are available.
- Considerable reduction in the cost of hiring private institutions for the training of health workers as more organisations have step in.
- Quality of the training at the health facility and the community level, conducted by the private partners, continues to be consistently good.
- Review/monitoring meetings conducted at Community and the district level have helped to identify the weakness and strengths and take corrective measures in time.

12. Challenges

- Worsening security situation has affected expansion of the programme as well as the supervision and monitoring of the existing programme.
- Follow-up of IMCI-trained participants has not been completed in some districts due to the difficult security situation.
- In districts with smaller hospitals and low case load, finding adequate number and type of cases for clinical training is a problem necessitating shifting of venue to adjacent districts. This problem will become more acute, as the programme moves to districts in the hill and the mountain Region. As the programme moves to more remote districts, striking a proper balance between practices of cases by the health workers and keeping the cost low will be a challenge.

- Many donor partners are unwilling to spend money on training of health workers, and rather prefer to put their money at the community level.
- Problem observed in the supply of ORS and Cotrimoxazole tablets after the districts were authorised to procure as part of the process of decentralisation.
- Keeping track of the people trained on IMCI has been difficult.
- In some districts, conducting review and monitoring meetings at the health facility and at the community level has been a problem.
- Sustaining the review and monitoring meetings in the programme districts is a problem, as partners phase out from the districts or do not want to support the monitoring activities for long.

13. Recommendations

- Mechanisms need to be thought for the training of health workers in the remote districts, as it may not be possible to bring all the health workers to a place in the Terai because of the cost considerations as well.
- Alternative mechanisms of follow-up after training should be explored, as the security situation continues to deteriorate.
- Sustainable mechanism for the review and monitoring meetings needs to be explored in the programme districts, as partners phase out from the districts or do not want to support the monitoring activities for long.
- Authorising districts to buy Cotrimoxazole should be reviewed.
- A database should be prepared of the trained health workers so that those who are trained do not get retrained.

Annex – 1

IMCI Activities Completed in 2004

No.	Activity	Venue	Date	No. of Participants	Supporting Agency	Re
1.	Training of Health Workers of Doti on IMCI	Nepalgunj	November – December	58	CARE Nepal	5 B
2.	Training of Health Workers of Dadeldhura on IMCI	Nepalgunj	November – December	58	CARE Nepal	5 B
3.	Training of Health Workers of Bajhang on IMCI	Nepalgunj	November – December	58	CARE Nepal	5 B
4.	District planning and DDC orienatation	Sarlahi	July	27	NFHP	1Ba
5.	HF level CB-IMCI training	Sarlhai	6 Nov- 2feb.05	180	NFHP	10 Bat
6.	District Planning and Orientation meeting on IMCI	Dang	20-21 September	18	UNICEF	Fac by
7.	2-day management training on IMCI	Dang	20 - 26 September	99	UNICEF	6 ba
8.	VHW/MCHW training on IMCI	Dang	26 September – 9 October	64	UNICEF	3 ba
9.	FCHV training (Phase I) on IMCI	Dang	30 October – 4 December	808	UNICEF	39
10.	1-day traditional healer's orientation on IMCI	Dang	7 December	150	UNICEF	8 ba

11.	District Planning and Orientation meeting on IMCI	Tanahu	22-23 September	18	UNICEF	Fac by
12.	2-day management training on IMCI	Tanahu	28 October - 1 November	88	UNICEF	4 ba
13.	VHW/MCHW training on IMCI of Tanahu	Damauli	3– 24 November	58	UNICEF	3 ba
14.	District level Planning and Orientation meeting for Community level IMCI in Saptari	Rajbiraj		25	AusAID	
15.	2-day management training on IMCI in Saptari	Rajbiraj		175	AusAID	bat
16.	VHW/MCHW training on IMCI in Saptari	Rajbiraj		190	AusAID	bat
17.	FCHV training (Phase I) on IMCI in Saptari	Saptari		637	AusAID	....
18.	Health facility level training to health workers of Sunsari district	Sunsari	5-25 May	45	WHO	Fac by BP
19.	'IMCI in Nepal an Update' - a presentation during the 12th Nepalese Congress of Paediatrics	Kathmandu	20 March	150	WHO	
20.	Orientation on revised IMCI modules incorporating Neonatal package	Kathmandu	23 July 2004	18	WHO	
21.	Workshop for revising CHW's IMCI modules and to adapt, translate and incorporate SEARO BHW's newborn package	Dhulikhel	10-14 May 2004	16	WHO	
22.	Printing of health profile of Nepal 2003	Kathmandu	August 2004	500 copies printed	WHO	

23.	Follow-up after training in IMCI in Tanahu	Tanahu	5-14 May	66 health workers followed-up	WHO	Fac by IRH
24.	Follow-up after training in IMCI in Dhankuta district	Dhankuta	6-15 June	32 health workers followed-up	WHO	Fac by NE
25.	Health facility level training for transferred health workers of Dhankuta	Biratnagar	2-11 November	14	WHO	1 ba
26.	Central level Supervision and Monitoring visits	Dang, Rupandehi, Tanahu and Kavre districts	16-26 November		CHD/WHO	

Annex - 2

CBAC/CB-IMCI Districts (By end of 2004)

No.	Region/District	Total Pop. (Census 2001)	No. of VDCs/ Municipality	CBAC	CB-IMCI	CB-IMCI (Up to Health Facility)	CDP Dist.
	Eastern Dev. Reg.	***2,902,156***					
1.	Dhankuta	166479	35/1		*		
2.	Jhapa	691173	49/2		*		
3.	Morang	843548	65/1	*			*
4.	Sunsari	628405	49/3	*			*
5.	Siraha	572551	111/1	*			* GTZ -pt.
6.	Saptari	570282	114/1			*	
	Central Dev.Reg.	***3,982,234***					
7.	Makwanpur	338513	43/1		*		
8.	Chitwan	470713	36/2	*			*
9.	Bara	557093	98/1		*		***Plan - pt.**
10.	Parsa	494888	82/1	*			*
11.	Rautahat	547210	96/1	*			***Plan - pt.**
12.	Dhanusha	686986	101/1		*		
13.	Mahottari	553857	76/1		*		* CARE
14.	Rasuwa	44496	18	*			
15.	Kavrepalanchowk	385672	93/2			*	*
16.	Nuwakot	288,478	61/1		*		***JICA - pt.**
	Western Dev.Reg.	***1,646,193***					
17.	Nawalparasi	562090	74/1		*		*
18.	Tanahu	315641	46/1			*	*

19.	Kaski	381580	43/2		*		*
20.	Rupandehi	702523	69/2		*		***DHSP- pt.**
	Mid-West.Dev.Reg.	***769,560***					
21.	Dang	225201	38/2		*		*
22.	Bardiya	383720	31/1		*		***GTZ - pt.**
23.	Bankey	385840	46/1			*	*
	Far-West. Dev.Reg.	***1,106,218***					
24.	Bajhang	167381	53			*	* CARE
25.	Bajura	108730	27	*			
26.	Dadeldhura	126162	25/1			*	
27.	Doti	20895	53			*	*CARE pt
28.	Kailali	616697	43/1		*		*
29.	Kanchanpur	380791	19/1		*		* CARE
	Total 45% (of 23,151,423)	**10,406,361**	**1171/26**	**8**	**14**	**7**	**7**

CBAC – Community Based ARI/CDD programme. Health workers are not trained either in the 9-day or the 11-day IMCI training However, CHWs (FCHV, VHW, MCHW) are treating cases of pneumonia in the community.

CB-IMCI –Districts where the health workers are trained on 9-day IMCI training course and CHWs (FCHV, VHW, MCHW) ar treating cases of pneumonia in the community.

CB-IMCI (Up to the HF Level) – Districts where the health workers are trained on 9 - day IMCI training course and the CHW (FCHV, VHW, MCHW) are planned to be trained to treat cases of pneumonia in the community in 2003.

pt. - Partial

NEPAL

CBAC/CB-IMCI Districts, 2004