WORLD HEALTH ORGANIZATION ORGANISATION MONDIALE DE LA SANTE

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With the compliments

of the

Director-General

and the Executive Director
Global Programme on AIDS

15 October 1994

Avec les compliments

du

Directeur général

et du Directeur exécutif du
Programme mondial de Lutte contre le SIDA

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AIDS PROGRAMME REVIEW
FACT FINDING LOG SHEET

I. PREVENTION STRATEGIES / INTERVENTIONS

A. PREVENTION OF SEXUAL TRANSMISSION

1. Promotion of Safer Sexual Behavior

Information, Education, and Communication (IEC)
Mass Media / Health Education (general public)

Achievments:

Constraints:

Recommendations:

Specific Target Group Education

Achievements:

Constraints:

Recommendations:

School Education / Out-of-School Education

Achievements:

Constraints:

Recommendations:

Other IEC Programmes

Acheivements:

Constraints:

Recommendations:

Condom Programmes (promotion, distribution, quality assurance, marketing)

Achievements:

Constraints:

Recommendations:

2. Diagnosis and Early Treatment of STD

Promotion of early diagnosis and treatment

Achievements:

Constraints:

Recommendations:

Diagnostic criteria guidelines and clinician training

Achievements:

Constraints:

Recommendations:

B. PREVENTION OF TRANSMISSION THROUGH BLOOD / BLOOD PRODUCTS

1. Promoting reduction in blood/blood product consumption

Achievements:

Constraints:

Recommendations:

2. Promotion of Safe Blood

Achievements:

Constraints:

Recommendations:

3. Interventions to reduce HIV in IDU's/ skin piercing

Achievements:

Constraints:

Recommendations:

4. Promotion of sterile conditions and Universal Precautions

Achievements:

Constraints:

Recommendations:

5. Promotion of Laboratory Services

Achievements:

Constraints:

Recommendations:

C. PREVENTION OF PERINATAL TRANSMISSION

1. Provision of Information to HIV-positive Women

Achievements:

Constraints:

Recommendations:

2. Provision of Health Care to Pregnant Women

Achievements:

Constraints:

Recommendations:

II. REDUCTION OF PERSONAL AND SOCIAL IMPACT OF HIV INFECTION

1. Provision of health care services

Achievments:

Constraints:

Recommendations:

2. Provision of Community Care

Achievements:

Constraints:

Recommendations:

B. REDUCE SOCIAL IMPACT

1. Promotion of action to protect rights of individuals

Achievments:

Constraints:

Recommendations:

2. Provide Social Services

Achievements:

Constraints:

Recommendations:

3. Helping Communities Provide Social Support

Achievements:

Constraints:

Recommendations:

III. REDUCTION OF ECONOMIC IMPACT OF HIV

A. REDUCTION OF IMPACT ON SPECIFIC SECTORS

1. Agriculture

2. Transportation

3. Defense

4. Tourism

5. Others

IV. PROGRAMME MANAGEMENT

A. PROGRAMMRE ORGANIZATION & COORDINATION

1. Planning and Implementation

Achievements:

Constraints:

Recommendations:

2. Intersectoral Coordination

Achievements:

Constraints:

Recommendations:

3. Programme Structure and Functions

Achievements:

Constraints:

Recommendations:

B. PROGRAMME STAFFING, FACILITIES AND ACCOMODATION

Achievements:

Constraints:

Recommendations:

C. TRAINING

1. Central and Peripheral Training Programmes

Achievements:

Constraints:

Recommendations:

2. Training Methods and Methodologies

Achievements:

Constraints:

Recommendations:

3. Production and Distribution of Training Modules, Manuals, other materials and equipment

Achievements:

Constraints:

Recommendations:

4. Integration of HIV/AIDS into medical, paramedical and community health worker training and studies

Achievements:

Constraints:

Recommendations:

D. PROGRAMME LOGISTICS

1. Transportation

Achievements:

Constraints:

Recommendations:

2. Supply Handling / Logistical System

Achievements:

Constraints:

Recommendations:

E. PROGRAMME MONITORING, REPORTING AND EVALUATION

1. Programme Monitoring System

Achievements:

Constraints:

Recommendations:

2. Surveillance and Research

Achievements:

Constraints:

Recommendations

3. Financial Monitoring System

Achievements:

Constraints:

Recommendations:

F. PROGRAMME FINANCE

1. Disbursement / Obligation of Funds

Achievements:

Constraints:

Recommendations:

2. Disbursement by Programme Area

Achievements:

Constraints:

Recommendations:

Draft

Information, Education and Communication for Health in Bhutan

Report of Danida review mission

September, 1993

Contents

Abbreviations

ANM	Assistant Nurse-midwife
BBS	Bhutan Broadcasting Service
BHU	Basic Health Unit
BHW	Basic Health Worker
CDD	Control of Diarrhoeal Disease
COHS	Co-ordinating Officer for Health Services
Danida	Danish International Development Agency
DCC	Development Communication Centre
DHS	Department of Health Services
DHSO	District Health Supervisory Officer
DMO	District Medical Officer
DCC	Development Communication Centre
DTP	Desk Top Publishing
EPI	Expanded Programme on Immunization
GNM	General Nurse Midwife
GYT	Gewog Yargey Tshogchung - block level public representative body
HA	Health Assistant
IECH	Information, Education and Communication for Health
KAP	Knowledge, Attitude and Practice
MCH/FP	Maternal and Child Health/Family Planning
NGO	Non Governmental Organization
NIFH	National Institute of Family Health
NWAB	National Womens Association of Bhutan
PHC	Primary Health Care
RBA	Royal Bhutan Army
RBP	Royal Bhutan Police
RGB	Royal Governmentof Bhutan
RIHS	Royal Institute of Health Science
UNICEF	United Nations Children's Fund
WHO	World Health Organization
VHW	Village Health Worker

Note:

dzongkhag	The administrative unit in Bhutan that is equivalent to a district
gewog	The administrative unit that is equivalent to a block

Executive Summary

This report presents the findings of a review of the IECH programme initiated in 1991 with support from Danida.

Despite the hard work and commitment of the Programme Director, the implementation of the programme has fallen short of the objectives in the original project document. The IECH Bureau has not been staffed to the planned level - there is only one Bhutanese national with a post-graduate training in IEC. With the exception of water/sanitation and AIDS/STD, IECH has not been significantly incorporated into the planning processes for disease control programmes. The planned introduction of improved curricula for IECH into health worker training has not taken place, virtually no communication materials have been developed and there has been little systematic use of the mass media.

The review team was impressed by the considerable enthusiasm for IECH in the dzongkhags (districts) and the energy that was being put into developing workplans and implementing IECH activities. The setting up of a decentralised system for supporting IECH in the districts and providing both funds and equipment represents a major achievement for the programme. However, the educational methods being used tend to be of the traditional didactic kind. There is a need to train field workers to base their educational activities on influences on community health behaviour and in the use of alternative approaches especially participatory learning methods.

The main reason for lack of achievement of planned objectives has been the grossly inadequate staffing level of the IECH Bureau. Although media companies have recently set up in Bhutan to produce educational materials, their activities complement, but do not replace, the need for a strong IECH Bureau. A core group of specialists in health education and IECH is essential to provide the coordination, training, research, behavioural science and evaluation skills necessary to mobilise and provide effective leadership for IECH activities by the government, Dzonkhags, NGOs and other groups in Bhutan.

In consultation with the Programme Director of IECH, the recommendations listed below have been formulated together with a workplan for the period up to the end of 1994. Of special note has been the suggested revision of the structure of the IECH Bureau to create an unit for liaison with the dzongkhags and the designation of a focal person for planning and coordinating IECH activities in the dzongkhags. The staffing requirements of the IECH Bureau have been reduced by delaying the establishment of media production facilities and making use of free-lance and media companies.

If implemented, these practical and workable recommendations would build upon the current decentralization and primary health care policy and lead to a substantial increase in both the quality and quantity of IECH activities in the community. But these objectives will only be achieved if urgent attention is given to resolving the serious staffing problem in the IECH Bureau.

Recommendations of IECH Review Team

1. *Strengthen IECH Bureau and national IECH planning structures*
   1. Recruitment of a minimum of two additional professional/ graduate staff
   2. Form a multi-sectoral Advisory Group.
   3. Revise the structure and internal management system of the IECH Bureau.
   4. Increase awareness of the structure and role of the IECH Bureau among agencies at the national and district level.

2. *Support dzongkhag level IECH activities*
   1. Identify a focal person for planning and coordinating Dzonkhag level IECH activities and provide initial training through a workshop and follow-up activities.
   2. Work intensively in at least three dzongkhags to explore innovatory methods in IECH.

3. *Provide media support for IECH*
   1. Develop use of radio and audio-cassettes.
   2. Develop printed materials to support IECH.
   3. Establish a collection of audio-visual materials, books and newsletters on IECH for reference and loan to field staff.
   4. Establish closer contact with the local media.

4. *Strengthen training in IECH of all field workers.*
   1. Develop pre-service, in-service and continuing education (including distance education) in IECH through a curriculum workshop and follow-up activities.
   2. Develop support materials for training in IECH.

5. *Strengthen IECH activities in schools*
   1. Encourage participation of Department of Health in the IECH advisory group.
   2. Support teacher training and develop educational materials.
   3. Participate in discussions leading up to the next review of the school curriculum.
   4. Set up a school health task force to coordinate school health activities within Departments of Health and Education.

1. Introduction

In 1991 a project proposal was prepared by the Royal Government of Bhutan for a National Programme on Information, Education and Communication for Health (IECH) to take place over a five year period from 1991/92 to 1996/7. This project was accepted for funding by Danida as part of its overall programme for strengthening primary health care in Bhutan. The plan of operation specified activities was broken down into the following components with an initial workplan covering the period 1991/1992:

(1) Strengthening of the PHC system in support of IECH activities.
(2) Organisational structure of IECH in Bhutan.
(3) Operational research
(4) Human resource development.
(5) Development of IECH activities.

This report contains the findings of a review that was carried out in Bhutan over the period 6-17 September, 1993. The review team consisted of a health education specialist Dr John Hubley from Leeds, United Kingdom as team leader; and communication specialist Siok Sian Pek, a Singapore national living in Bhutan. The terms of reference for the review mission are given in Annex 1. The review team worked closely with the Programme Director of the IECH Bureau and would like to thank him for the help and support he and his staff provided during the review mission.

1.1 Review methodology

The methodology of the review involved interviews with key persons involved in IECH at the national and dzongkhag level. These visits took place in Thimphu and in the dzongkhags of Wangdi, Punakha and Trongsa. The programme of visits is given in Annex 2 and list of persons consulted given in Annex 3. In addition the review team consulted a range of documents including monitoring reports, health sector reviews and working documents of the IECH Bureau (see Annex 4 for list of documents consulted).

2. Achievements and shortfalls

A review of the extent of achievements on the IECH activities in the original project document is presented in Annex 5. It is evident that in the first two years of the project that the project has completed many of its planned activities. Notable achievements have been:

- Establishment and equipping the IECH Bureau.
- Procurement of educational materials and audio-visual equipment for the dzongkhags.
- Support for the development of dzongkhag workplans and disbursement of funds to dzongkhags for IECH activities.

Details of expenditure of the IECH project over the two financial years 1991/2 and 1992/3 are given in Annex 6.

However, not withstanding the above achievements and the considerable effort put in by the Programme Director, there have been delays and lack of achievement in many areas. Some of these delays have resulted from changes in health service policy e.g. the abandonment of a zonal structure, a move away from time-consuming committees. Other delays have resulted from weaknesses and problems that were not foreseen in the original project formulation especially the severe shortage of staffing for IEC.

Notable shortfalls in achievement have been:

- Failure to meet the original planned staffing requirements of the IECH Bureau.
- Limited input of the IECH Bureau into national planning of key health programmes.
- Lack of progress in development and implementation of training curricula for IECH.
- Virtually no production of audio-visual materials to support IEC.
- Lack of a coordinating mechanism for IECH activities by different agencies with some exceptions.

These issues and the constraints that underlie the implementation of the IECH programme in Bhutan are described in the next section.

3. Critical issues/Constraints

3.1 The organisational set-up for IECH.

The current staffing of the IECH Bureau consists of the following:

Programme Director
UNV Volunteer (expatriate)
WHO AIDS/STD Short-term Professional (expatriate)
Assistant Professional Officer
Driver
Cook/peon (on loan from the National Inst. Family Health)
Driver (.. .. ..)
Audio-visual assistant (.. ..)

Thus the IECH Bureau is well short of its planned staffing. There are only two Bhutanese professional staff, only one of whom has a post-graduate training in IECH. There are two short-term expatriate staff (without counterparts) and three staff assigned on a temporary basis because of the closure of the National Institute of Family Health).

The IECH Bureau has good accommodation in two adjacent apartments. However, the premises have not yet been adapted to the needs of an IECH Bureau. There is no display area or library. Equipment has been procured including computers and audio-visual equipment but a room for material design has not been set up. The IECH Bureau does not contain a documentation centre of relevant texts or subscribe to any newsletters or journals.

Planning and management of the IECH Bureau is through informal meetings between the Programme Director and individual staff. Team meetings do not take place.

In the initial project document, a National IECH Committee was proposed. This has not been set up - apparently due to a national policy decision to restrict the number of committees. However, coordination groups have been set up on specific topics, the most notable being that for Water and Sanitation.

There are proposals to construct purpose built premises that will house both the Royal Institute of Health Sciences and the IECH Bureau. This will be of considerable benefit

as it will allow for sharing of key resources including a library and audio-visual production/storage facilities. However, it will be at least three years before the premises are constructed.

3.2 Review of the manpower constraints and future needs: ideally and realistically.

The IECH Bureau is grossly understaffed and this is a major limitation on its ability to achieve its objectives. The failure of the Department of Health is due in part to a general shortage of suitably qualified graduate or professional persons. This shortage is aggravated by the need to recruit staff through the RCSC who only recruit part of the pool of available graduate personnel.

However, the staffing problem is also a reflection of the weak profile and perceived low importance of the IECH Bureau in the Department of Health and other IECH agencies. The IECH Bureau is caught in a vicious circle. Low staffing limits activities which in turn reinforces the perception that it is not a dynamic and active organization worthy of support. The IECH should take steps to raise its 'image' and counter the poor understanding of its function by different agencies.

While the original planned staffing level of the IECH Bureau was probably over-ambitious, the review feels that it is crucial to assign at least two or three professional/graduate staff on a permanent basis to the IECH Bureau. It is highly unlikely that the persons recruited will have adequate training in IECH and some form of training will be required. These persons would also act as national counterparts to the expatriate staff.

It will thus be necessary to revise the staffing structure and allocation of duties to make the best use of limited available staff. The IECH Bureau, in consultation with the review team, have trimmed down the original requirements to make the units functional with the minimum number of staff - at least for the next year. This reduction is based on the assumption that the IECH Bureau could make use of technical facilities in the independent media companies including the Development Communication Centre and Bhutan Broadcasting Services as well as the small pool of private consultants and artists (see section 3.3 below).

3.3 Assessment of the capacity for communication development, within and outside the health sector.

Outside the health sector there are four main bodies that can contribute to media development. Three of them are in the process of being reconstituted as independent income-generating companies - the Development Communication Centre, Kuensel Corporation and Bhutan Broadcasting Service. The fourth agency is the Curriculum Development Centre which is part of the Department of Education.

The *Development Communication Centre* (DCC) has facilities for graphic design, desk-top publishing, photography, video production and silk screen printing. It is in the process of transition from a government agency assisting in media development at subsidized rates to an independent company charging full cost. In addition, the DCC can run training courses on development of audio-visual materials. Currently the IECH Bureau has commissioned the DCC to produce a leaflet on condom use.

The *Kuensel Corporation* operates the weekly newspaper *Kuensel* (published in English,

Dzongkha and Nepali) as well as a commercial printing press. This newspaper provides regular coverage of health topics both in news, features and letters sections. While the readership is limited to the literate and educated section of the community, this provides an opportunity to reach decision-makers.

The *Bhutan Broadcasting Service* operates the national radio station which broadcasts on one channel in four languages on short wave and on FM in Thimphu (with plans to extend the FM to other major dzongkhags). It broadcasts regular health programmes and health topics are also covered in its news broadcasts. The BBS has very good facilities for recording and editing radio programmes and a team of trained production staff. It also has facilities for making multiple copies of audio-cassettes.

The *Curriculum Development Centre* of the Department of Education has good facilities for the production of learning materials for use in schools including text books and wall charts. These facilities are for use in the education sector and thus would only be available for IECH activities in schools.

The *Farmer-Extension Communication Support Unit* of the Department of Agriculture was set up in 1992 to serve as a resource for production of communication materials for agricultural extension activities. It has desk-top publishing facilities, off-set printers and a super-VHS video editing suite. It produces a newsletter for extension staff and a range of printed material both for farmers and for school children. In May-July 1993 it organised a survey in four dzongkhags to determine farmer's knowledge about agriculture. This survey also asked about the influence of different communication media and thus also provided useful information for IECH planning. As the main emphasis of the unit is on support of agricultural extension the only area where it might be a useful resource for IECH would be for nutrition education.

The media production facilities of the IECH Bureau are limited. There is a desktop publication facility based on the Apple Mackintosh computer, a lap-top computer, camera and dark-room equipment (which is not set up). There is an audio-visual assistant but no audiovisual technician or artist.

In reviewing the communication for IECH the following points emerge:

- There is no systematic programme of audience research to determine media habits in Bhutan. However, various KAP studies on health topics indicate that radio is the most powerful method for reaching the rural population. Newspapers reach the educated minority and is thus more important for targeting decision-makers.

- With the purchase of audio-visual equipment for the dzongkhags, the IECH Bureau will be under pressure to produce and distribute materials for use on this equipment.

- Good facilities exist within the media companies for the technical aspects of development of communication media. Given the severe staffing constraints discussed in section 3.2 it would be inappropriate for the IECH Bureau to duplicate these technical facilities. However, once it is fully operational with a communications officer, the IECH Bureau may review its need for communication production facilities.

- Although the media companies have good production facilities, they do not have persons trained in health issues or research. The contribution of the IECH Bureau to media production should be on the technical content of media, defining the educational processes that require media support, initial research, pre-testing, evaluation and training of field staff in using media in teaching methods.

- Although there is considerable IECH content in the radio and newspapers, the content and scheduling is largely left to the BBS and Kuensel with little input from the IECH Bureau with the exception of water and sanitation. There is no overall coordinated strategy to the use of mass media for IECH. Such a strategy might inovolve national themes or coordinated campaigns linking the use of mass media with face-to-face communication by field staff in the dzongkhags with accompanying print material to support the programme.

- Both the BBS and Kuensel said that they would welcome a reliable point of contact with the Department of Health that would respond rapidly to their requests for information and interviews, provide technical briefings on key health topics and press releases on their activities. There is an information officer within the Department of Health but this person has many other functions and is not always able to provide the quick response demanded by the media. Thus the media tend to go directly to a small group of doctors that they have contacts with. While this reflects a positive relationship between health workers and the media, there is a clear function for the IECH Bureau in providing a reference point for press relations within the Department of Health, provision of briefings papers on key health topics, sending press releases on their activities and holding press meetings. The IECH Bureau should take a more aggressive role in its media relations and not wait passively until it is contacted.

- A more innovative approach is needed in determining learning material requirements to support IECH. At present there is a strong demand for posters and videos. However there is a need to develop other methods, especially those which will support participatory learning activities that develop critical thinking and empowerment. Such methods might include audio-cassettes, games, exercises such as sorting games, stories and flip-charts. Field staff will need training to use these methods.

3.4 Analysis of the need for curricula development for relevant health cadres.
Human resource development was one of the five components of the original IECH proposal which contained extensive plans for curriculum development for key health cadres. The activities planned included review of the IECH curricula for pre-service and in-service training of key health cadres, the development of a certificate course and the development of learning materials.

Training in IECH is an area where achievement has been disappointing. Only a superficial review of IECH components of training has taken place and the planned certificate course has not materialised. As will be described below, the main approach in IECH by field workers consists of didactic teaching and there is an urgent need to introduce field staff at all levels to a wider range of IECH activities especially the use of nonformal and participatory learning methods.

The Royal Institute of Health Services (RIHS) is the institute responsible for pre-service training of ANMs, HAs and BHWs. The National Institute of Family Health was responsible for in-service training but was closed down in 1990 on a temporary basis (and their library and three technical staff transferred to the IECH Bureau). It is likely that the NIFH will be reopened at some time in the future but plans have not been announced.

Thus the RIHS is the only functioning health training institute in Bhutan at present. Their ability to implement teaching in IECH is limited by their limited staffing. The lecturer in health education resigned his post earlier this year. The Programme Director of the IECH Bureau has been requested to fill the gap but is only able to make a small input. Although staffing is limited, it is worth noting that the RIHS has a good library and collection of audio-visual resources run by a librarian. The RIHS also produces a quarterly newsletter *The Mirror*.

The original proposal identified a need for training of ANMs, Health Assistants, Basic Health Workers, village health workers and this need is still relevant now. A need that is becoming important is for training of the District Health Supervisory Officers (DHSOs). This cadre is taking on an increasingly important role in developing dzongkhag level IECH activities and in the recommendations of this report it is proposed that their role in IECH be formalised by the designation of a 'Dzongkhag Focal Person for IECH'. DHSOs should be a priority group for training.

There is a need to develop in-service training for field staff at the dzongkhag level. The annual assemblies of the three regions provide an opportunity for in-service training and further opportunities are also available in those dzongkhags who are convening annual meetings of health staff. However, a major constraint to training is the travel time often required. In one dzongkhag visited by the mission a total of three days travel was required for the furthermost health staff to come to the district hospital. Thus there is a need to explore the use of distance learning methods e.g. radio/audio-cassettes.

There is an urgent need to develop learning resources to support training activities. The IECH Bureau has procured 500 copies of the WHO handbook *Education for Health* and is beginning to distribute this to the dzongkhags. The IECH Bureau has also procured an audio-visual kit of overhead projector, video, slide projector and whiteboard for each dzongkhag and hospital. In addition it is supplying a radio cassette recorder for heath Basic Health Unit. The challenge is now to develop and distribute relevant slide sets, audio-cassettes, videos etc. and provide training in using these resources. It will be important to complement these electronic media with simpler participatory learning materials e.g. flip charts, games etc

3.5 Review of selected district and block IECH activities with emphasis on planning and management.

In Bhutan the traditional geographical are corresponding to a district is the *dzongkhag*; and the equivalent to the block is called the *gewog*. The review mission was able to visit three dzongkhags in Central Region and also have discussions with the Coordinating Officer for Health Services for Eastern Region.

One of the strengths of the IECH project is the mobilisation of the dzongkhags that has

taken place. The review mission found a considerable level of energy and enthusiasm for IECH at all levels.

The most important innovation in IECH has been the setting of dzongkhag workplans for IECH for funding by Danida through the Department of Health. The IECH Bureau has played a valuable support role in assisting the development of these plans and ensuring that funds are available. Annex 6 provides details of funds provided for funding activities in dzongkhag level workplans as well as purchase of books and audio-visual equipment for the dzongkhags.

The district health system is in a state of change and this has affected the systems for supporting district level activities. Zones were abolished and replaced by regions which has led to modification in the approach outlined in the original IECH proposal. Another area of change is the relationship between the Dongkhag administration and the District Medical Officers. The Coordinating Officers for Health Services in the three regions are emerging as key persons in assisting the development of dzongkhag level IECH plans and administration of IECH budgets.

Thus the concept and machinery of dzongkhag level planning appears quite well established in Bhutan. However, although the quantity of IECH in the dzongkhags has increased substantially as a result of the IECH project, this is not matched by quality. In particular:

- Most of the activities budgeted are for training and IEC within a traditional information-giving framework. There appears little innovation or use of participatory IEC methods directed at developing community involvement and empowerment.

- Activities are planned for a year in advance with little flexibility to respond to issues or concerns of the community that may arise during the year. These activities are not coordinated with national IECH activities e.g. radio broadcasting.

- Funding was arbitrarily set in the original proposal at 5000 Ngultrum per Gewog without reference to variations in needs of the Gewogs. Feedback received from the first two years of the project has indicated that this has restricted activities and this policy should be reconsidered.

- The processes for planning local IEC activities do not make use of the '12 steps in health communication' that were outlined in the original project document and circulated in a booklet by the IECH Bureau. For example the messages are promoted in the IECH include behaviours that are epidemiologically less important e.g. water boiling (only relevant when the water source is actually polluted). There is no systematic process of understanding of influences on behaviour, methods used are often dull and uninteresting.

- There is very little evaluation of IEC based on demonstration of changes in behaviour. The reports produced by the dzongkhags on their IEC activities mainly list activities undertaken, persons attending workshops etc.

Some of the actions needed to deal with the above problems have already been

discussed in sections 3.3 and 3.4 dealing with communication support and curriculum development. An urgent priority is for the IECH Bureau to work with regional and dzongkhag level staff to improve the quality of IECH activities in the dzongkhags, develop a more flexible planning that can respond to changing community priorities and develop simple methods of evaluation of IECH activities that can assist local decision-making. There is a clear task for the IECH Bureau to provide support to dzongkhag level IECH by providing guidelines on key health topics, suggestions for indicators of evaluation, and details of scheduling of radio campaigns on health issues. The IECH Bureau cannot provide this support without an increase in staffing (see discussions on staffing in sections 3.1 and 3.2)

It is important that the activities of the IECH Bureau reflect the needs of the dzongkhags. The Programme Director of the IECH Bureau has been able to maintain good links with the dzongkhags through field visits and attendances at national and regional health conferences. As the activities undertaken by the IECH Bureau increase, it will be necessary to develop more formalised links with the dzongkhags and section 4 will contain recommendations for the appointment of focal persons for IECH at the dzongkhag level as well as the establishment of a Dzongkhag Liaison Unit in the IECH Bureau.

3.6 Review of the integration/coordination of IECH into specific disease control programmes.

A major success for integration of IECH into specific disease programmes has been the Water and Sanitation Steering Committee. The original suggestion for the adoption of water and sanitation as an annual theme came from the IECH Bureau. This committee has been successful in coordinating IECH activities, obtaining media coverage and developing educational materials. Another example of integration of IECH has been the AIDS/STD programme and a WHO Short Term Professional for AIDS/STD education is based in the IECH Unit.

The IECH Bureau has contributed to CDD (Control of Diarrhoeal Disease), ARI (Acute Respiratory Infection), Safe Motherhood, Primary Eye Care and the Baby Friendly Hospital programmes. Apart from these, the involvement of IECH in specific disease control programmes has been disappointing. No coordinating committees similar to that for Water and Sanitation have been set up for other health issues. Also, as described in section 3.1, the low image of the IECH Bureau has meant that it is not automatically invited by different sections of the Department of Health to join in their planning activities.

While the water and sanitation committee has been a success, the proliferation of committees on a range of health topics would not be appropriate. A better approach would be to set up a single IECH advisory group that would coordinate IECH activities on a range of health issues and this is described further in the recommendations in section 4.

3.7 Assessment of the achievements in multi-sectoral collaboration and the scope for strengthening this collaboration.

The most notable example of multi-sectoral collaboration has been the Water and Sanitation Steering Committee described in the previous section. This has brought the IECH Bureau into close contact with the Works and Housing Department. There has been some contact with the IECH Bureau and the National Commission on

Environmental Issues. Apart from this there has been little multi-sectoral collaboration in IECH at the national level.

The most obvious scope for collaboration is between the Departments of Health and Education. The Curriculum Division of the Department of Education has a staff member with post-graduate training in health education wit a strong interest in the development of health education activities. A curriculum has been recently developed for population education with a strong health education content. The strengthening of IECH in schools was part of the original IECH proposal and school-based activities are undertaken by the dental health and eye health sections of the Department of Health. The IECH Bureau been able to have little input on curriculum development in schools and there are no formal coordination mechanisms between the two departments. However, despite the lack of cooperation in the past, there appears to be a genuine interest in the Department of Education to coordinate on IECH activities. The Department of Health will need to become more sensitive to the planning cycle in the Department of Education who develop new curricula and textbooks every five years.

Multi-sectoral collaboration takes place more readily at the dzongkhag and gewog (block) level and this is mainly due to the coordinating role of the dzongkhag administration and the general enthusiasm for IECH that was described in section 3.5 above. Examples of collaboration that the review mission came across in the field visit include health workers visiting schools, village health workers acting as translators for the agricultural extension officers, collaboration between health workers and volunteers of the National Womens Association of Bhutan, school children carrying out community projects on health.

The most suitable mechanism for development of multisectoral collaboration at the national level would be through the establishment of an IECH advisory group with representation from different sectors. The need for such a group was also raised in the previous section and in the recommendations in section 4.

3.8 Assessment of capability for research, monitoring and evaluation of IECH activities. The assessment of capability for research, monitoring and evaluation was not included as part of the original terms of reference but emerged as an important issue during the course of this review.

As described in sections 3.3 on communication development and 3.5 on district/block IECH activities, IECH activities are not based on a systematic programme of research and the subsequent impact are not evaluated.

In the original IECH proposal it was intended to evaluate the impact of the programme through a KAP study at the beginning and look for change in a follow-up study. Problems in research and evaluation have been highlighted by the delays in data collection and analysis of data and the results of this study are still not available. This delay is due in part to the short staffing of the IECH Bureau and the limited research and data-processing capacity in the Department of Health. There is a need to identify sources of help for research and data analysis in other agencies that can be commissioned to undertake studies.

However, with the difficulties in undertaking large scale studies, it would be more appropriate to consider the use of small scale 'rapid appraisal' studies using qualitative methods such as focus group discussion which provide practical guidance for IECH planning.

It would also be appropriate for the IECH Bureau to agree on a set of simple indicators that can be used for evaluation of IEC activities the dzongkhags and which might be incorporated into the health information system that is currently under development.

In the original staffing proposal, the IECH Bureau designated one of their three sections to have responsibility for manpower development and research. Given the severe staffing constraints in the IECH Bureau described in section 3.1 above, it would seem more appropriate to recruit IECH specialists with research skills rather than a full time researcher. The IECH Bureau should seek to make use of local facilities for research and data analysis under supervision of IECH staff. This situation should be reviewed at a future stage when the establishment of a research/evaluation section should be considered.

4. Recommendations

The basic approach in the original proposal for the need to strengthen IECH in Bhutan remain valid. The recommendations that will be presented below are based on the principles that planned IECH activities in Bhutan should be:

- an *integral part* of all activities directed at improvement in health;
- based on a *systematic process* involving community participation, research, field testing, evaluation and sharing of experiences between the dzongkhags;
- *sustainable* in the long-term and should therefore include an element of capacity building - both strengthening of human resources and institutional structures for IECH at national and dzongkhag level;
- *decentralised* with dzongkhag level planning and involvement of the dzongkhags and GYTs;
- *realistic* within the existing constraints of resources - both human resources (especially trained IEC persons), funds, transport;
- based as much as possible on *in-country* training and support - making use of overseas training and external consultants only when necessary;
- *multi-sectoral* with the mobilisation and coordination of all departments and field staff with an involvement in IECH;

The strategy that is proposed in this review for strengthening of IECH falls into five activity areas: Strengthening of the IECH Bureau; Support of dzongkhag level IECH activities; Development of support materials for IECH; Curriculum development and training in IECH - including pre-service, in-service and continuing education; and Strengthening of IECH activities in schools. A workplan/plan of action for the period up to June 1995 is presented in Annex 7.

4.1. *Strengthen IECH Bureau and national IECH planning structures*

All cadres of workers in health services and many other sectors e.g. education, women's affairs and agriculture have a role to play in IECH. Improving the quantity and

quality of IECH by these field staff as well as reaching out directly to the community through the mass media will involve leadership, support and coordination. *This can only be achieved through a strong and effective National IECH Bureau.* Although media companies have recently set up in Bhutan to produce educational materials, they complement - but do not replace - the need for a core group of specialists in health education and IECH with the necessary multi-disciplinary mix of behavioural science, education, communication, epidemiology, research methodology and management.

The following activities are proposed to strengthen the IECH Bureau to enable it to fulfil its function as a coordinating and planning IECH activities and also provide support to dzongkhag level IECH activities.

.1 *Recruit a minimum of two additional professional/ graduate staff* to fill the vacant posts in the IECH Bureau and, if necessary provide training. The IECH Bureau is unable to fulfil its role without additional professional staff. While in the short-term it may be possible to use expatriate contract/volunteer staff, this does not provide the long-term sustainability that is necessary.

.2 *Form a multi-sectoral Advisory Group*. The membership would include persons from Department of Health, Education, Home Affairs, UNICEF, WHO and other relevant bodies including interested donors. It should also include representatives from the dzongkhag level health staff such as the COHSs.The function of this body are described more fully in Annex 8 and will be to:

- Provide a framework for national planning in IECH.
- Coordinate IECH activities and messages.
- Agree on a set of standardised messages/fact-sheets on key health topics for use in IECH activities.
- Provide a mechanism for involvement of different sectors in IECH;
- Act as a forum for exchanging experiences on IECH by participating bodies;
- Provide a mechanism for dzongkhags providing an input into planning national IECH activities.

.3 *Revise the structure and internal management system of the IECH Bureau*. The roles and functions of the IECH Bureau should be revised to take into account the limited staffing available. Furthermore it would seem more appropriate to use the technical facilities for preparing art work, video, radio etc at the Development Communication Centre, BBS or using freelance artists and producers rather than duplicate these facilities at the IECH Bureau. A proposed alternative structure is given in Annex 9.

As the activities of the IECH Bureau expand, a mechanism will be needed to ensure adequate management of activities including systems for supervision, internal communication and involvement of staff in coordinating and planning activities of the IECH Bureau and structure. The basis of this management process should be regular team meetings and staff workplans. Management training should be provided for the Programme Director.

.4 *Increase awareness of the structure and role of the IECH Bureau among agencies at the national and dzongkhag level.* The IECH Bureau should actively

promote a greater understanding of its role and function within the different sections of the Department of Health as well as other agencies. Educational activities that should be carried out should include preparation of a leaflet describing its functions and activities and organizing a suitable display/exhibition for visitors to the IECH Bureau and at other locations e.g. conferences/workshops. In addition the IECH Bureau should liaise closely with the radio and newspaper to ensure coverage of IECH Bureau activities in the local media.

4.2 Support dzongkhag level IECH activities

The importance of the national decentralization policy has been taken into account by the formulation of a revised structure with a Dzongkhag Liaison Unit (see Annex 9 and 4.1.3 above). In addition the following additional steps are proposed for supporting Dzonkhag level IECH.

.1 *Identify a focal person for planning and coordinating dzongkhag level IECH activities and provide training through a workshop follow-up activities.* It is proposed that one person in each dzongkhag should be assigned the responsibility for planning and coordinating IECH activities in consultation with the District Medical Officer and other relevant persons. It is not proposed to appoint new staff for this, but to have IECH as part of an existing health worker's responsibility.

A suggested job description for this focal person's role is provided in Annex 9 and includes: planning, monitoring and evaluating dzongkhag IECH activities, coordinating and training IECH of field staff, supervising the dzongkhag resource collection of audio-visual equipment and learning resources, liaison with national IECH Bureau on IECH activities etc. In many dzongkhags, the District Health Supervisory Officer has been used as the focal point and this practise should be formalised in all the dzongkhags.

The IECH Bureau should provide training for the dzongkhag level focal persons in IECH. This would consist of an annual workshop which will provide a joint function of training and information exchange between dzongkhags. In the first year, this workshop would be for two weeks and in subsequent years for one week. These workshops will be supported by training using a distance learning approach through regular mailings of articles etc. At some point it would be appropriate to consider organizing a study tour to a neighbhouring country to explore IECH approaches. An outline of the initial training workshop for Dzongkhag Focal Persons for IECH is given in Annex 10 and details of the consultancy support required given in Annex 11.

.2 *Work intensively in at least three dzongkhags to explore innovatory methods in IECH.* In addition to providing general support to IECH throughout Bhutan, the IECH Bureau should select a minimum of three dzongkhags as pilot areas for the following activities:

- Exploration of alternative teaching methods e.g. participatory learning methods, games, role plays etc.
- Development of support materials e.g. flip charts, radio programmes.
- Development of monitoring and evaluation tools for IECH.

The experiences in these pilot areas will be shared with other dzongkhags at the Annual Health Conferences and the Regional Health Workshops through the revised training programmes being developed for IECH (see below).

Selection of suitable dzongkhags should depend on proven interest in IECH, willingness to participate in the programme by dzongkhag staff and representativeness of the locality for generalising the methods developed to other dzongkhags in Bhutan. It would also be appropriate to select dzongkhags on a geographical basis e.g. Eastern, Western and Central. The chosen dzongkhags might include at least one of the dzongkhags involved in the "Acceleration and intensification of PHC activities" programme to be supported by Danida.

4.3 *Provide media support for IECH*

The IECH Bureau should take advantage of and not duplicate the technical facilities provided by the media/ communication organisations including Bhutan Broadcasting Service, Development Communication Centre and Kuensel Coorporation.It should also build up closer rapport with the local media so that IECH activities get media coverage.

If the IECH Bureau is to make use of free-lance agents and media companies, the present time-consuming procedures for the Programme Director obtaining authorization for commissioning work should be streamlined.

.1 *Use radio and audio-cassettes*. Radio is the single most important mass media outlet in Bhutan. While mass media on its own is usually insufficient to change behaviour it can provide a suitable climate of knowledge to support the IECH activities of field workers. It is proposed to increase both the quantity and quality of radio for IECH. This will involve developing a planned and systematic strategy for the use of radio taking into account seasonal needs and campaigns and national themes. Research and pre-testing will be built into the production process which will involve ccoperation between IECH Bureau, BBS and dzongkhag level staff.

The procurement by the IECH Bureau of a radio cassette recorder for each Basic Health Unit provides an unique opportunity for use of audio-cassettes for IECH. This will include recordings of radio items originally broadcast as well as cassettes specially prepared for use in IECH e.g. collections of songs, drama etc. Cassettes will be made by the IECH and BBS although dzongkhags may want to record cassettes tailor made for their dzongkhags.

.2 *Develop printed materials to support IECH.* The IECH Bureau should develop printed materials to support IECH activities. Emphasis will be on materials to support participatory learning e.g. flip charts. The first priority will be a set of six flip charts on key health themes to be used by staff at BHUs and village health workers.

The initial design and pre-testing will take place in the dzongkhags with involvement of the IECH Bureau and the artists of the Development Communication Centre together with field workers and the community. The final preparation of camera-ready copy and printing will take place at Thimphu under supervision of DCC and IECH Bureau.

.3 *Establish a collection of audio-visual materials, books and newsletters on IECH for reference and loan to field staff.* A reference collection should be maintained of available audio-visual materials including slide sets, flip-charts wall charts and posters in Bhutan as well as materials produced in other countries. In addition a collection should be maintained of newsletters, books and reports on local IECH activties/surveys in Bhutan. Where appropriate, additional copies should be kept for loan purpose to field staff. Many of these materials are freely available at no charge from international agencies on request. Items should be stored appropriately on shelves, filing cabinets and flat storage shelves with a simple catalogue system under the supervision of the audio-visual technician.

.4 *Establish closer contact with the local media.* The IECH Bureau should play a more active role in keeping the BBS and Kuensel up to date with developments and activities for IECH at the national and dzongkhag level. The Bureau should send out news releases, pertinent reports/ publications,assist the media in planning health programmes and even hold periodic news briefings with reporters and producers on major developments in health in Bhutan. The closer rapport would help to build a more informed and regular media support for IECH.

4.4 *Strengthen training in IECH of all field workers.*

An important priority should be to increase the quantity and quality of IECH activities carried cut by all levels of field workers. There is a need to embark on a comprehensive programme of curriculum development to develop appropriate training strategies for IECH.

.1 *Develop pre-service, in-service and continuing education (including distance education) in IECH through a curriculum develop workshop and follow-up activities.* A curriculum development workshop should be held to review content of IECH training taking into account existing experiences in Bhutan, feedback from the pilot areas and relevant experiences in other countries. From this curriculum development workshop, a strategy will be developed for strengthening of IECH components of training which will: determine the content of IECH training in pre- and in-service training, explore the possible use of distance learning, define needs for training of trainers and the development of support learning materials. An outline of this proposed curriculum development workshop is given in Annex 10 and details of consultancy support for this given in Annex 11.

.2 *Develop support materials for training in IEC.* Support materials are required for training in IECH. This will include materials for direct use in supporting teaching as well as distance learning materials that can be used by field staff at their place of work. The nature of materials produced will depend in part on the recommendations of the curriculum workshop described above but would include:

- Handbook with participatory learning training exercises for IECH.
- Slide sets which might involve modification of existing commercially available slide sets (e.g. from Teaching Aids at Low Cost) as well as entirely new sets.
- A distance learning programme on IECH methods for field staff which is to be broadcast on the radio and also distributed in the form of audio-cassettes.
- Videos on training/teaching methods, planning IECH etc.

4.5 *Strengthen of IECH activities in schools*
Activities supporting school-based IECH will need to be phased in with the curriculum development and textbook production process within the Department of Education.

.1 *Encouragement of participation of Department of Health in the IECH advisory group.* The curriculum development specialist in Health Education should be invited to participate in the proposed IECH advisory group.

.2 *Support teacher training and develop educational materials.* The IECH Bureau should provide support for the training of teachers and development of learning resources for implementing the IECH components of the current curricula in schools.

.3 *Participate in discussions leading up to the next review of the school curriculum.* The IECH bureau should participate in next review of the school curriculum and revision of school textbooks which will take place in about 1996.

.4 *Set up a school health task force to coordinate school health activities within Departments of Health and Education.* The IECH Bureau should convene a task force that will bring together various interest groups to coordinate activities on school health. The composition of this task force could include: relevant staff from Department of Education; persons from the Department of Health involved with screening children for dental health, eye health and de-worming; agencies with interests in school-based environmental and population education. This task force could be constituted as a sub-committee of the IEC Advisory Group described above.

Annex 1

Terms of reference for a review of the IECH component under the health sector support programme in Bhutan

1. Background

The agreement between the government of Bhutan and Denmark on the Health Sector Support Programme (HSSP) was signed in October 1990. Among the major components included in the agreement was the support to Information Education and Communication in Health (IECH) with an allocated budget of DKK 5.9 million.

In May 1991 a team of consultants assisted the Department of Health Services (DHS) in preparing a plan of operation to guide the implementation of the component. The actual implementation was charged to the newly-established IECH Bureau under DHS. The project document proposed a revised budget of 26.1 mill Ng. (approx DKK 6.5 mill.) The revised budget was recommended by the programme review in May 1992 in connection with the preliminary allocation of previously unallocated funds and approved by Danida in September 1992.

The objectives of the component are to increase the level of awareness and knowledge of health issues among the population in Bhutan and to integrate IECH into formal and non-formal health activities and into programmes in other sectors.

The major elements in the project document were institutional development of the capacity to deliver IECH at all level, integration of IECH into all elements of Primary Health Care (PHC) and appropriate human resource development to undertake the planned activities.

The implementation started in July 1991. The review in May 1992 noted that there was a general delay in the implementation and that this was particularly pronounced for the central level activities. Efforts would be made to improve the planning and implementation capacity for he central level staff.

In the annual HSSP progress report for 1992 it is stated that approx. 70% of the planned activities were actually carried out during the year, but it is envisaged an increase in IECH activities during 1993, particularly at the dzongkhag and gewog levels.

A major problem is that the IECH bureau has been understaffed since its inception and that the agreed manpower never has been posted to the Bureau. The communication section in particular has suffered from the shortage as three out of four positions have remained unfilled. The planned posting of a volunteer to strengthen this area has, also not taken place.

The manpower shortage affects most areas covered by the project and it is especially serious in the Bureau, where the achievements during 1993 have been continuously impeded. Although funds are distributed to the dzongkhags and to the gewogs, the Bureau is largely unable to monitory or support these IECH activities at these levels, The number of activities undertaken at the periphery is not totally known.

It has therefore been agreed to undertake a review of this component at this stage with a view towards a replanning which will consider the actual constraints and potentials for IECH during the remaining period of the HSSP.

This review will not focus primarily on the potential impact of IECH since this is considered too early in the programme. It will concentrate on managerial, organisational and institutional development aspects.

2. Objectives

the objectives of the review are:

- a review of the achievements and constraints in implementation of IECH
- a revision of the plan of operation for 1993-1997

3. Output

- a review report covering 1991-1993
- a revised plan of operation for the remaining programme period in the form of a Project Document

4. Scope of work

The review will include, but not necessarily be limited to:

- an analysis of the organisational set-up for IECH
- a review of the manpower constraints and future needs: ideally and realistically
- an assessment of the capacity for communication development, within and outside the health sector
- an analysis of the need for curricula development for relevant health cadres
- a review of selected district and block IECH activities with emphasis on planning and management
- a review of the integration/coordination of IECH into specific disease control programmes
- an assessment of the achievements in multi-sectoral collaboration and the scope for strengthening this collaboration
- development of a revised plan of operation for 1993-1997 in the form of a project document, including a workplan for 1993-4

5. Timing

The review will take place during the period from 6-20 September, 1993

6. Methodology/Reporting

The review team will work with the management of the IECH Bureau throughout its stay in Bhutan, it will visit few districts and blocks, The team will meat with the Development Communication Centre, the Ministry of Communication, BBS, Kuensel, the involved sections in DHS including RIHS, Danida, Thimphu and other relevant institutions and individuals.

The team will work in Bhutan from 6-20 . It will present its major findings and recommendations to DHS and Danida prior to its departure from Bhutan. The team leader will brief the Royal Danish Embassy in Delhi after leaving Bhutan. The draft review report together with the revised plan of operation will be forwarded to Danida, Copenhagen in 6 copies no later than three weeks after comments from RGOB and Danida has been received.

Annex 2

Itinerary

5 September

6 Briefing by Danida Bhutan Office
Meetings with Director General for Health and Joint Director
Visit to IECH Bureau

7 Visits to: Kuensel Corporation
Development Communication Centre
UNICEF

8 Visits to: Bhutan Broadcasting Service
Education Curriculum Division

9 *Note: The team split up during 9-12 Sept: one person went on field visit and the other person (**) had meetings in Thimphu*

Field visit: Thinleygang Basic Health Unit
Wangdi (discussions with district health team)
Meeting with Dr D.K. Singh, School Oral Health Program**

10 Field visit: Phubjika Basic Health Unit
Tongsa - discussions with district health team
Meeting with Dr N.K. Sharma, Mobile Eye Camps, School Eye Clinics**
Discussion with Education Department

11 Field visit: Tongsa Hospital - K/rabten Dispensary
Tsangkha village

12 Field visit: Punakha BHU
return to Thimphu

13 Discussions with IECH Bureau
Discussions with COHS, Eastern Region

14 Discussion with IECH Bureau and preparation of report

15 Meetings with: Joint Secretary of Health
WHO Representative
Visit to Agriculture Department's Farmers Extention Communication Support Unit

16 Discussions with IECH Bureau and preparation of report
Meeting with the Communications Officer at UNICEF

17 Presentation of draft report to Director General of Health Services and Danida representatives from Thimphu and Delhi Offices

18 End of mission: Dr Hubley departs for UK to finalise report.

Annex 3

list of persons consulted

Department of Health

Dasho Sangay Ngedup	Director General for Health
Dr Jigme Singye	Joint Director, Health
Dr N.K. Sharma	Opthalmologist
Dr D.K. Singh	Dental Surgeon
Dr Rinchen Chophel	COHS, Eastern Region

Information, Education and Communication for Health Bureau

Dr Kunzang Jigmi	Programme Director
Dr. N.N. Goswami	United Nations volunteer Tutor (NIFH)
Mr Prem Sing Srida	Assistant Professional Officer.
Ms Else Melgaard	W.H.O Consultant (AIDS/std)

Royal Institute of Health Sciences

Dr Kunzang Jigmi	Acting Principal, RIHS
	Faculty members/ tutors

Education Department

Dasho Thinley Gyamtsho	Director General of Education
Mr Rinzin Pam	Curriculum Division, Education

Danida Bhutan Office

Dr Bjorn Melgaard	DANIDA Representative

Media/Communication Organisations

Mr Kinley Dorji	Editor in chief, Kuensel Corporation
Capt. B. Yeshey Dorji	Director, Development Communication Centre
Mr Sonam Tshong	Executive Director, Bhutan Broadcasting Service
Mr Tashi Dhendup	Programme Co-Ordinator, BBS
Mr Samdrup Rigyal	Farmers Extention Communication Support Unit Agriculture Department

International Organisations

Mr Henk Van Norden	Project Officer, Water Supply and Environmental Sanitation, UNICEF
Dr Kees Goudswaard	Project Officer, Coordinator, Health and Nutrition UNICEF
Mr Taufique Mujeba	Information/Communication Officer, UNICEF
Dr B.A. Kawengian	World Health Organisation, Bhutan Representative

District level personnel

Chakshu Tshering	Senior Health Assistant, Thinleygang BHU
Jewan	Health Assistant, ..
Zangmo	Senior A.N.M. ..
Dawa Tshering	Senior Compounder ..
Dr Leki Wangdi	District Medical Officer, Wangdi District
Mr Tshewanag Phuntso	District Health Supervisory Officer, Wangdi District
Dr Ramesh Pakhrin	District Medical Officer Trongsa
Mr Dorji Thinlay	District Health Supervisory Officer, Trongsa
Mr Wang Chuk	Village Health Worker, Trongsa Dzonkhag
Mrs Sonam Choden	Village Health Worker, Trongsa Dzongkhag
Mrs Rinzin Tsomo	NWAB Volunteer, Tzangkha village
Dr D.K.Nirola	District Medical Officer, Puhnakha District
Mr Palden Lepcha	District Health Supervisory Officer, ...
Mr Tsewang Dorji	Health Assistant, ...

Annex 4

List of documents consulted

Danida (1992) Health sector support programme - project proposal outlines 1992-1997.

Danida (1992) Agreed minutes for health sector support programme first annual review, 18-23 May, 1992.

Department of Health (1992) Institutional development of the royal Institute of Health Sciences Construction of Library, IECH Bureau, Conference Room and Hostel. Department of Health/Ministry of Social Services, Royal Government of Bhutan.

Department of Health Services (1993). Progress report for July 1992 - June 1993 of the National Programme on IECH.

Department of Health Services (1993). Initial drafts of sections of the KAP study study on IECH in Bhutan. IECH Bureau, Bhutan.

Royal Government of Bhutan (1991) National Programme on Information, Education and Communication for Health: Plan of operation (1991/2 -1996/97) and Workplan (1991/2).

Royal Government of Bhutan (1991) Health Sector Review. The Planning Commission and the Department of Health Services, RGOB.

UNICEF (1992) Children and women in Bhutan, 1991 - a situation analysis. UNICEF, Thimpu.

WHO (1991) Report of short term consultant on school health education in Bhutan.

Annex 5

Extent of achievement of planned activities

Activity	Date for completion	Status of activity	Comments
5.3 Organizational structure of IECH 1. *Establishment of IECH Centre* Setting up of office, procurement of equipment, computer, a/v equipment, library and reference materials.	1991/2	Suitable premises rented, equipment procured, WHO health education books purchased, library not yet set up	IECH Bureau does not have a librarian. Book budget for two years used up in purchase of WHO text; need to purchase a/v materials
Administrative bodies *Zonal administration*: procure/supply a/v equipment, conduct meeting and submit half yearly reports to IECH and prepare workplans for 92-93 for IECH Bureau.	1991/2	IECH Director held meetings with Zonal health officers - however discontinued because Zones were discontinued.	Zones disbanded in 1991/2
Dzongkhag administration: procure and supply a/v equipment, conduct meeting and submit half yearly plans to ZHO; prepare workplan for 92-93 for ZHO.	1991/2	Equipment ordered and delivery expected Oct. 1993 (27 sets of: overhead projector/slide projector/whiteboard/public address system for Districts. 70 radio-cassette recorders ordered - one per Basic Health Unit.	Delays were experienced because the orders for equipment had to be routed through the State Trading Corporation Board of Bhutan. The Department of Health Services were allowed to order equipment.
National IECH Committee Formation and meetings	1991/2	Not implemented	Approval not given because of a general policy to reduce the number of committees.
Zonal IECH Committee Formation and meetings	1991/2	Not implemented because of disbandment of zones	
Dzongkhag IECH Committee formation and meeting	1991/2	Not implemented and function transferred to GYT.	Since GYTs were being formed it was felt that this coordination function should be carried out by the GYTs.
Training Institutes RIHS - procure and supply a/v equipment	1991/2	Equipment procured: video projector/screen, still camera/enlarger/film	
5.4 Operational research *KAP study*	1991/92	Data collection completed January 1993, analyzed and report currently being written up.	Data analysis by the Public Health Division took longer than expected because of staffing shortage. Original budget insufficient because of transport costs.

Annex 5 *Extent of achievement of planned objectives/continued*

Training needs assessment	1992/3	Not implemented	Lack of staff
Case studies	1992/3	Not implemented	Lack of staff
5.5 Human Resource Development *Pre-service training* Review/revise curricula for GNM/AN.	1991/2	Not implemented	Plans to reschedule this at a future date to be implemented by a consultant.
Strengthening of support and reference materials.	ongoing	50,000 Ng supplied to RIHS for purchase of materials.	Funds released for first year only at a late stage. Second release has not taken place.
Review/revise curricula for HA/ANM BHW	1991/2	IECH assisted in review of syllabus (1992) but revised syllabus not implemented.	Health education lecturer at RIHS has left post with no replacement. Health education currently not being taught on courses in RIHS. Request was made to IECH to provide training.
Supply of IECH manual to HA/ANM BHW.	1991/2	WHO manual procured but not yet distributed	
In-service training Review/revise curricula for IECH training.	1991/2	Not implemented	Review for VHWs is being delayed until results of proposed survey of VHW performance are available.
Strengthening and support of reference materials - procurement and supply of materials	1991/2	Books have been procured for central resource library.	The IECH Bureau is about to take over NIFH library and resource collection
Training workshops/seminars	ongoing		
Strengthening of refresher courses for VHWs	ongoing	Not carried out by IECH Bureau. Part of Dzongkag activities.	Survey of VHW performance is being planned with IECH Bureau participation. Data collection scheduled for January 1994.
Certificate courses on IECH plan, organise and conduct certificate course	1991/2	Has not been carried out.	Discontinued because of problems associated with promotion and salary increases for persons completing diploma course. Some form of training course without award of a certificate might be considered at some future date.

School Health Education Review/revise training curricula for IECH in schools and teacher training institutes.	92-93	Not been carried out by IECH Bureau although WHO consultant has reviewed this and prepared a plan.	Department of Education was not involved in WHO consultancy and has not accepted recommendations. The Department of Health also felt that it was not feasible at the moment. There is no mechanism for liaison between Department of Education and IECH on health education.
Implement revised curriculum	92-93	Not implemented - see above	Not implemented - see above.
IECH Activities			
1. *National theme* Select theme, plan activities, produce and distribute materials	annual activity	Water/sanitation theme selected and a steering group selected which have undertaken IEC activities.	This Water/sanitation steering group has been effective in mobilizing activities. However, no further themes have been selected or similar steering groups formed for other health topics. There is no multi-sectoral mechanism for selecting themes.
2. *IECH components of specific health programmes*	1991/2	IECH has contributed to CDD, AIDS/STD, ARI, Safe mother hood, primary eye care and baby friendly hospital programme.	The contribution by IECH has been mainly that of supply of a/v equipment and participating in workshops rather than playing an active role in advising on IECH strategy. Notable gap is a lack of involvement of IECH in nutritional activities.
3. *IECH activities in other sector health programmes*	1991/2	Some input into National Environmental Commission environmental issues and also Works & Housing on water activities.	IECH has not been involved in planning activities. Most sectors are not aware of potential for involving IECH. No involvement of IECH with Agriculture.
4. *IECH activities in NWAB*	1991/2	IECH have released funds for training NWAB members in three Dzongkhags	There is no information on nature of IECH activities following this training.
5. *IECH activities of monk body*	1991/2	Funds have been provided to Thimphu Monastery for toilets/education on personal hygiene.	Thimphu will take responsibility for disbursing funds to other monasteries. So far only Thimphu has received funds - delays in receiving accounting for these funds have prevented the release of further funds .

Annex 5 *Extent of achievement of planned objectives/continued*

6. *IECH activities of city corporations (Thimphu and Phuntsholing)* request plan and budget, approve plans, distribute funds, receive reports.	1991/2	Funds have been provided for Thimphu for waste bins, clean-up campaign, tree planting)	IECH Bureau not involved in clean-up campaign. There have been problems in receiving accounts from Thimphu city corporation. Funds are likely to be transferred to Phuntsholing city in 1994.
7.*Zonal IECH activities* Workshop following National Health conference to finalise zonal plans, transfer of funds, implementation of Zonal IECH activities, submit reports, follow up workshop	1991/2	No activities because of disbanding of zones.	
8 *Dzongkhag IECH activities* Workshop following national health conference to finalise 1991-92 IECH Plan, transference of funds, implementation of plans, submissions of reports and accounts.	1991/2	15 of total of 20 Dzongkhags have prepared IECH plans for 1993/4 period.	It was not possible to have two day follow up to annual Health Meeting to work with Dzonghags to prepare plans. There is no set formula for funding proposals (although the IECH Bureau has prepared a reporting/monitoring form).
9. *Gewog IECH activities* Transfer of funds to DHSO, implementation of IECH activities, submission of reports and accounts.	1991/2	Funds have been transferred to Gewogs.	No activities set up for 1993/4 because accounts for existing allocations have not been received.

Annex 6

Details of funds spent by the IECH project**

Activity	1991/2 (Ng.)	Comments
National IECH Review Meeting	37,570	General operating/equipment costs of the IECH Bureau are combined with the costs for 1992/3
National Womens Association of Bhutan	33,000	
Monk Body	75,000	
City Corporation, Thimphu	100,000	
Regional activities		
COHS (Eastern Region)	78,000	
COHS (Western Region)	105,000	
COHS (Central Region)	130,000	
Former zones (now disbanded)		
Zonal Health Office IV	140,000	
Zone I IECH Review	25,000	
Zone II IECH Review	18,000	
Zone III IECH Review	18,000	
Zone IV IECH Review	18,000	
Districts		
Thimphu	35,000	Thumphu at that time was not a district but Gewog
Pemagatshel	85,000	
Bumthang	10,000	
Mongar	10,000	
Lhuntsi	7,000	
Tashigang	20,000	
Riserboo	7,000	
Punakha	52,000	
Paro	10,000	
Sandrup Jonkhar	10,000	
Haa	20,000	
TOTAL	1,023,658.00	

** Table compiled from data provided by Programme Director of IECH Bureau

Annex 6 Details of funds spent on IEC/continued

Activity	1992/3 (Ng.)	Comments
Programme Director, IECH	400,000	Funds also used for KAP study and training of health workers
City Corporation, Thimphu	3,177.35	
City Corporation, P/ling	50,000	
Kuensel Coorporation	9,500	Advertisements
Regional activities		Funds provided for allocation directly to GYTs
COHS (Eastern Region)	227,113	
COHS (Western Region)	155,000	
COHS (Central Region)	75,000	(total for regions 557,113Ng)
Districts		District level IECH activities. Funds provided based on plans submitted from districts.
Pemagatshel	85,000	
Bumthang	7,000	
Mongar	10,000	
Lhuntsi	7,000	
Tashigang	20,000	
Riserboo	7,000	
Wangdi	75,000	
Dagana	30,000	
Punakha	70,000	
Samchi	120,000	
Paro	100,000	
Damphu	21,000	Total for districts: 541,000 Ng
Audio-visual equipment for hospitals	2,530,000	
TOTAL	4,011,713.35	

Annex 7 Revised plan of action/workplan continued

Activities	1993/4								1994/5											
	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
3. Mobilization of media support for IECH																				
3.1 Set up audio-visual/resource library at IECH Bureau			•	•																
3.2 Subscribe to newsletters/publications		•																		
3.3 Produce/modify/duplicate slide/posters/videos	•	•	•	•	•			•	•	•	•	•	•	•	•	•	•			
3.4 Distribute slides/posters/ videos to districts			•				•				•				•				•	
3.5 Distribution of briefing kits to radio/newspaper			•		•		•		•		•		•		•		•		•	
3.6 Development of coordinated IECH radio plan		•				•				•				•				•		
3.7 Implementation of IECH radio plan					•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
3.8 Preparation of set of flip charts on key health topics									•											
4. Strengthen training in IECH for field workers																				
4.1 Curriculum development workshop for IECH training of health workers						•	•													
4.2 Implementation of revised pre-service IEC curricula										•										
4.3 Preparation of plan for in-service training	•												•							
4.4 Implementation of in-service training activities		•	•	•	•	•	•	•	•		•	•	•	•	•	•	•	•	•	•
4.5 Production of learning materials to support training			•																	
4.6 Production of radio/audio-cassette distance learning training package for field workers										•	•									
5. Strengthen IECH activities in schools																				
5.1 Set up school health task force					•															
5.2 Support teacher training activities on health						•														
5.3 Liaise with Education Dept. on proposed IECH curricula for schools																•				

Annex 7

Revised plan of action/workplan

Activities	1993/4								1994/5											
	N	D	J	F	M	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
1. Strengthening IECH Bureau and national IECH planning structures																				
1.1 Form IECH Advisory Group/draw up workplan	•	•																		
1.2 Recruit additional staff	•	•																		
1.3 Select health theme for 1994/5						•	•													
1.4 Review implementation of IECH strategy												•								
1.5 Prepare revised IECH strategy/workplan													•	•						
1.6 Produce leaflet and exhibition on IECH Bureau function		•																		
1.7 IECH exhibition/presentation at annual health workshop						•	•											•	•	
1.8 IECH exhibition/presentation at regional health workshops			•						*(dates for other regional workshops to be filled in)*											
2. Strengthening district level IECH activities																				
2.1 Formalise appointment of DHSOs as focal persons	•																			
2.2 Training workshop for district focal persons				•																
2.3 Review implementation of district workplans for 1993/4									•											
2.4 Receive district workplans for 1994/5									•											
2.5 Implement district support activities										•	•	•	•	•	•	•	•	•	•	•
2.6 Select pilot districts for IECH	•																			
2.7 Implement pilot district IECH activities					•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•

Annex 3

Functions of the IECH Advisory Group

The *functions* of this group will be to:

Act as a forum for exchanging experiences on IECH by participating bodies.

Coordinate activities to ensure that they complement and do not overlap.

Agree on IECH messages based on accurate epidemiological information and the social context of Bhutan.

Plan joint programmes, select themes for national IECH campaigns.

Provide an input into national planning for IECH.

Assist the IECH Bureau in planning its activities.

Identify needs for learning materials to support public education and training of fieldworkers in IECH.

Provide a mechanism for districts providing an input into planning national IECH activities.

The composition of this advisory group will be open to all those agencies, government departments and bodies involved in IECH in Bhutan who are willing to work together. This would include, but would not necessarily be limited to:

- Sections of the Department of Health with an interest in IECH e.g. the IECH Bureau, AIDS/STD Control Programme, Dental Health, Eye Health, CDD etc.
- Representatives from other departments with an interest in IECH e.g. Department of Education, Agriculture
- International agencies and donors with an interest in IECH e.g. UNICEF
- Other agencies/NGOs such as National Womens Association of Bhutan Representatives from the dzongkhags and regions.
- Media companies such as Bhutan Broadcasting Service, Development Communication Corporation.

The IECH Bureau will act as the secretary to the Advisory Group and a Chairperson will be chosen from its membership on an annual basis.

Establishment of the group

The first meeting of the advisory group would take the form of a one day workshop where the participants exchange views on IECH priorities in Bhutan, the terms of reference for the advisory group and set a programme for future activities. It is expected that, in its establishment phase, the advisory group might meet as often as once a month. Later the group would meet less frequently e.g. bi-monthly with much of the activities taking place through ad hoc working groups set up for specific purposes.

Annex 9

Proposed revised structure for IECH Bureau and functions of district IECH focal person

Planning and Administration Unit

1. Be responsible for the management of the IECH Bureau including preparation of plans, staffing, budget, equipment.

2. Liaise with IEC Advisory Group, the Department of Health and other interested groups on assessing national priorities for IECH activities and preparation of the programme for the IECH Bureau.

3. Participate in planning activities of health programmes e.g. AIDS/STDs, CDD etc to provide assistance in the formulation of IECH components.

4. Represent the IECH Bureau at Annual and Regional Health Conferences and other meetings.

5. Provide administrative support e.g. secretarial, transport etc.

Dzonkhag Liaison Unit

1. Make regular visits to Dzonkhags to meet Focal Persons for IECH, District Medical Officers and other key persons to assess needs and provide support.

2. Receive and process annual workplans and funding requests from the Dzonkhags and process them for consideration by the IECH Bureau for funding.

3. Receive reports from the Dzonkhags and draw to the attention of the Programme Manager any issues for consideration.

4. Coordinate with the Training and Curriculum Development Unit on the organization of training activities in the Dzonkhags.

5. Provide general support to the activities of the IECH Bureau as and when required.

Training section and Curriculum Development Unit

1. In consultation with the Programme Director for IECH, The Dzongkhag Liaison Unit, The IECH Advisory Group, and health training institute and other relevant bodies to prepare a programme for IECH training of field workers.

2. Coordinate curriculum development activities for IECH.

3. Liaise with the health training institutes and provide support for their pre-service and in-service training activities for IECH.

4. Liaise with other health programmes including AIDS/STD, CDD, Water Sanitation to assist in IECH components of training activities.

5. Identify needs for learning resources e.g. manuals, audio-visual aids, participatory learning exercises etc. to support training activities. Arrange to purchase required materials or, if necessary, liaise with the Media and Learning Resources Support section to produce learning materials.

6. Provide general support to the activities of the IECH Bureau as and when required.

Media and Leaming Resources Unit

1. Liaise with the Programme Director of IECH, Training, Dzongkhag Liaison Unit, IECH Advisory Group to draw up a schedule for mobilization of mass media and the production of media and learning resources.

2. Manage the resource collection and media production equipment at the IECH Bureau.

3. Coordinate the production of communication/learning materials including: initial concept research, preparation of design briefs/scripts, liaison with media companies, pre-testing and arranging for printing.

4. Liaise with Kuensel and BBS on IECH coverage.

5. Provide general support to the activities of the IECH Bureau as and when required.

District Focal Person for IECH

1. Work with the community and local field staff including District Medical Officer, Dzongkhag Administration, DYTs to determine local priorities for IECH activities, the need for national support and the preparation and implementation of district level IECH plans.

2. Liaise with the District Liaison Section of the IECH Bureau and COHS on the submission of district workplans, requests for national support, receipt of funding, monitoring and evaluation of district IECH activities.

3. Make supervisory visits to the Gewogs to provide support to IECH activities of field staff.

4. Organize training of field staff in IECH in consultation with District Medical officer, Dzongkhag Administration, the Training and Dzongkhag Liaison sections of the IECH Bureau.

5. Act as the main point of contact for the IECH Bureau for distribution of educational materials including audio-visual equipment, learning materials, books, leaflets, newsletters etc.

6. Manage the district resource collection of learning materials and audio-visual equipment and supervise arrangements for their use in the field.

Annex 9 /continued Structure for IEC Bureau in original project document

ORGANOGRAM IEC BUREAU

Annex 10 Suggested outline of workshops

1. *Workshop for training/orientation of District Focal Persons for IECH*
The aim of this workshop is to provide the initial orientation and training for the persons selected to act as the district focal persons.

A secondary aim is to give a core group of trainers experience in using participatory learning methods in field worker training.

The initial training will take place in a workshop lasting two weeks. This will be followed up by a one week workshop on an annual basis which will serve a dual function of providing a forum for introducing new IECH methods as well as obtaining feedback on their activities in the field, problems encountered and needs for support from national level institutions. The Communication Development Centre will be asked to prepare a videotape of the methods used in this workshop which can be a learning resource for future occasions.

Objectives of the workshop
By the end of the workshop participants will:

1. Have shared experiences on some of the barriers - including epidemiological, social, cultural and economic factors - in implementing effective IECH activities in the field and be able to develop strategies for overcoming them.

2. Have had practical experiences of using - and be able to use themselves - a range of participatory learning educational methods including role play, games, learning exercises, s ory telling, songs.

3. Be able to use and undertake simple maintenance of audio-visual equipment supplied to the districts including: the overhead projector, slide projector, video recorder and radio-cassette recorder.

4. Be able to conduct simple research methods and use them for the planning, evaluation and pre-testing of educational materials.

5. Be able to discuss the national IECH strategy including the role of the Bureau, the role of the District IECH Focal Person, procedures for preparation of district level workplans, monitoring and evaluation strategies.

6. Have prepared action plans to cover their own IECH activities in their district over their next year.

Learning methods used in the workshop
The workshop will be participatory in nature and encouraging a sharing of the experiences of the participants. Participants will be exposed to a range of innovative teaching methods with an emphasis on participatory methods which develop problem-solving and empowerment e.g. role play, exercises, games, active discussion. Participants will explore issues in the workshop setting and try out simple educational and research methods in the field. The workshop structure will adopt a problem-solving approach. Groups of participants will be given specific health problems, conduct simple research in the field, develop suitable educational methods and try them out in the field. At the end they will draw conclusions from their experiences and adapt them to their own settings and set the agenda for their future IECH activities.

Resources required
The workshop will require one large and three small rooms for group work. There should be access within one hour's drive to realistic settings where participants can conduct field work. The workshop facilitators will include staff of the IECH Bureau, Development Communication Centre and the Royal Institute of Health Sciences. These will be supplemented by an external consultant with experience of participatory learning, training workshops and IECH.

Annex 10 Suggested outline of workshops/continued

2. *Workshop to undertake curriculum development for health worker training*
The aim of this workshop is to review the IECH components of the pre-service and in-service training of key field workers including Health Assistants, Auxiliary Nurse Midwives and Village Health Workers and to make recommendations for changes in their curriculum.

This will be achieved in a one week workshop followed by a two week period where core trainers and external consultants work together to draft revised curricula.

Workshop participants will be a multi-disciplinary mix of health trainers, staff at the IECH and field workers from the districts with experience in IECH. A core group will be chosen of key health trainers who will be given the responsibility of taking the recommendations of the one week workshop and translating them into a curriculum development strategy including revised curricula, details of teaching methods and requirements for learning materials.

This core group of trainers will have participated in the earlier workshop for training of District IEC Focal Persons and thus received exposure to the participatory learning materials used in that workshop.

Objectives of the workshop
By the end of the one week workshop participants would have:

1. Reviewed current curricula for IECH training of key health workers and assessed their relevance for current health problems and IECH strategies in Bhutan.

2. Explored a range of training methods for IECH and considered their usefulness for the Bhutan situation.

3. Explored the concept of distance learning and considered to what extent this is feasible in the Bhutan situation.

4. Made recommendations for change of curricula and teaching methods for key health workers including discussions on assessment.

5. Considered the constraints to the implementation of the proposed changes and developed a strategy for overcoming these constraints and implementation of their revised curriculum which will include: training of trainers, assessment, development of learning materials, guidelines for supervision of fieldwork and evaluation of curriculum.

Learning methods
The workshop will be participatory in nature and involve sharing of experiences of participants. Some participants will have been involved in the workshop for training of district focal person and will draw upon this experience. Participants will have access to key documents including the current curricula, IECH Strategy documents, key texts on participatory learning and copies of relevant surveys including the forthcoming evaluation study on Village Health Worker performance. The participants will break up into groups with specific tasks e.g. in-service, pre-service training, training of VHWs, ANMs, HAs, BHWs. Where appropriate these groups will make brief field visits to discuss with recently trained fieldworkers their perceptions of the training needs and training received. The video prepared on the methods used in the previous workshop for district focal persons can be used to provide examples of different teaching methods.

Resources required
This workshop should be held away from Thimphu so the participants can discuss issues without distractions. There should be a single large room and smaller rooms for groupwork. A resource collection of manuals on IECH training, copies of current curricula, copies of relevant surveys should be made available. An external consultant will be required.

Annex 11

Terms of reference for consultancy support required

1. *Consultant to support the training of District Focal Persons for IECH*

Objectives of Consultancy
The primary objective of this consultancy is to assist with the running of a two week workshop for initial orientation/training of District IECH Focal Persons.

The secondary objective is to use the experience of this workshop to determine future training needs of district focal persons and recommend ways in which these needs can be met.

Expertise required from consultant
The consultant should have an understanding of the organizational issues involved with the development of IECH in developing countries, preferably Asia, and experience of the use of participatory learning methods and their use for training in IECH.

Duration and terms of reference of consultant
The consultancy should last for four weeks in Bhutan (with one week prior to arrival in Bhutan for preparation and one week afterwards for report writing).

During this period the consultant would undertake the following activities:

1. Procure/prepare materials including handouts for use in the workshop.

2. Work with the IECH Bureau to finalise plans for the workshop including discussion of the participatory learning methods to be used, preparation of timetables, arrangements for field visits etc.

3. Act as a resource person in the operation of the workshop and facilitate sessions where appropriate.

4. Work with the local team to prepare a report of the workshop in the form of a handbook containing the practical guidelines emerging from the recommendations.

5. Critically assess the functioning of the workshop including content, teaching methods and learning by the participants and make recommendations on the organization and content of future in-service workshops and training of trainers.

6. Make recommendations on the support required by the District Focal Persons on their return to the field including the scope/feasibility of distance education and the content of future in-service workshops.

2. *Consultant to support curriculum development workshop*

Objective of consultancy
The objective of this consultancy is to facilitate a curriculum development workshop and work with a core group of trainers to develop a plan for introduction of a revised IECH curriculum into in-service and pre-service training of health workers.

Expertise required of consultant
The consultant should have experience in developing countries, preferably Asia, of training health personnel in IECH and be familiar with the process of curriculum development and the introduction of curriculum change. It may be difficult to find a single person with both extensive IECH experience and health worker training and two consultants may be required (not necessarily for the same length of time).

Duration and terms of reference of consultant

The consultancy shall last for four weeks in Bhutan (with an additional week prior to arrival in Bhutan for preparation and one week afterwards for report writing).

During this period the consultant would undertake the following activities:

1. Procure/prepare materials including handouts for use in the workshop.

2. Work with the IECH Bureau and core group of trainers to finalise plan for workshop including organization of the sessions, need for field work, timetable etc.

3. Act as a resource person to the workshop and facilitate sessions where appropriate.

4. Work with the core group of trainers for two weeks after the workshop to prepare revised curriculum and a strategy for implementation including requirements for training of trainers, learning materials, curriculum evaluation and workplan/budget for implementation.

5. Prepare a brief report critically assessing the workshop and follow-up activities as a process for curriculum development and make recommendations on future needs for external support for curriculum development.

BHUTAN

MEDIUM TERM PLAN REVIEW

1993

A
Joint Review of
Bhutan's Medium Term Plan
for
the Prevention and Control of AIDS
carried out by
The Department of Health Services, Ministry of Health
in collaboration with
the World Health Organization
17 October to 5 November 1993

Thimpu, Kingdom of Bhutan

EXECUTIVE SUMMARY

The Kingdom of Bhutan launched a National AIDS Prevention and Control Programme (NAPCP) with the implementation of a Short-term Plan in 1989, progressing to the formulation and implementation of a three-year Medium Term Plan (MTP-I) covering the period from 1990-93. Internal reviews for the first two years of MTP implementation have been carried-out annually.

In 1989, a National STD/AIDS Advisory Committee was established in the Ministry of Social Services. At present, this committee is chaired by the Joint Secretary of Health, and comprised of representatives from various ministries.

To date only 2 HIV seropositive individuals have been identified through sentinel surveillance activities, however national STD prevalence rates are unusually high (roughly 12% of all syphilis tests are positive) and social mores on sexual behavior are generally liberal, both indicating a definite need to pursue an aggressive STD/AIDS prevention programme.

The implementation of the MTP-I in Bhutan has led to major achievements in creating public awareness on AIDS and HIV infection, establishing a sentinel surveillance system, promoting condoms, screening of blood donations, and the training of health care workers at all levels. Other notable achievements are characterized by the effective decentralization and integration of the STD/AIDS programme to the peripheral levels.

Since the MTP-I terminates at the end of 1993, an external review was conducted from 17 October to 5 November 1993, with the objectives to assess the progress of the AIDS prevention and control programme, and to assist in the formulation of a new Medium Term Plan for AIDS Prevention and Control (MTP-II) for 1994-1996. The review team members were comprised of national and international professionals.

The final review of MTP-I has evaluated the national programme's major achievements and constraints in the areas of (1) programme management, (2) health education, (3) condom procurement and distribution, (4) sexually transmitted diseases services, (5) intravenous drug use, (6) safe blood supply, (7) counselling, (8) clinical care, (9) surveillance, and (10) involvement of non-government organizations.

Abbreviations

ANM	Auxillary Nurse Midwife
BBS	Bhutan Broadcasting Service
BHU	Basic Health Unit
BHW	Basic Health Worker
Danida	Danish International Development Agency
DCC	Development Communication Centre
DHSO	District Health Supervisory Officer
DMO	District Medical Officer
ED	Education Division
EDP	Essential Drugs Programme
EPI	Expanded Programme on Immunization
GNM	General Nurse Midwife
HA	Health Assistant
HCW	Health Care Worker
IECH	Information, Education, and Communication for Health
JDWNRH	Jigme Dorji Wangchuck National Referral Hospital
KABP	Knowledge, Attitudes, Beliefs, and Practices
MCH/FP	Maternal Child Health/ Family Planning
MCP	Malaria Control Programme
MSD	Medical Supply Depot
NAC	National AIDS Committee
NAPCP	National AIDS Prevention and Control Programme
NGO	Non-Governmental Organization
NWAB	National Women's Association of Bhutan
PHC	Primary Health Care
RIHS	Royal Institute of Health Sciences
RPR	Rapid Plasma Reagin (syphilis test)
STP	Short Term Plan
TGH	Timphu General Hospital
TOT	Training of Trainers
VDRL	Venereal Diseases Research Lab (syphilis test)
VHW	Village Health Worker

Note:

dzongkhag	The administrative unit in Bhutan that is equivalent to a district.
gewog	The administrative unit that is equivalent to a block.

Introduction

In 1990 the Royal Government of Bhutan developed its first three-year Medium Term Plan for the Prevention and Control of STD/AIDS and began implementation the same year. As of this review (October 1993), no AIDS cases have been diagnosed and only 2 HIV positive individuals have been identified through the country's national sentinel surveillance programme.

The strategic objectives of the Medium Term Plan were as follows:

a. to prevent HIV transmission;

b. to limit the morbidity and mortality associated with HIV infection;

c. to reduce the social and economic impact of STD/AIDS.

The MTP developed a detailed 3-year workplan specifying the major programme areas listed below:

1. Strategies for Prevention and Control of AIDS including a) prevention of sexual transmission; 2) transmission through blood and blood products; 3) transmission through injections and skin-piercing instruments; 4) perinatal transmission; 5) management of HIV/AIDS cases;

2. Programme Support through a) strengthening epidemiological surveillance; b) strengthening of laboratory facilities; c) strengthening of IEC; d) training of health workers; strengthening of STD control programme; and,

3. Management and Coordination through a) strengthening the NAC; b) defining the role of central and peripheral levels; c) programme monitoring and evaluation; d) developing and following a workplan and budget.

Review Methodology and Terms of Reference

An external review of the MTP was conducted from 17 October to 5 November. The review team consisted of four Bhutanese national (Dr. Chencho Dorjee, Dr. TB Rana, Dr. Kunzang Jigme, Dr. Jigme Singay) and three expatriate professionals (Dr. QM Islam, Dr. Cato Almnes, and Mr. David J. Winters). The review chairperson was Dr. Singay Jigme.

The objectives of the review team were as follows:

I. Analyze the relevance and adequacy of the Bhutan MTP-I.

1. Review thoroughly all elements/components of the MTP-I and analyze its adequacy and relevance as it relates to all HD policies pertinent to HIV/AIDS.

2. Determine the practicality and realism of the MTP-I as to targets, activities, time-frame and funding.

II. Assess the adequacy, effectiveness and efficiency of activities and appropriateness of the structure of the National AIDS Prevention and Control Programme (NAPCP).

1. Review the NAPCP management structure and recommend possible means of strengthening.

2. Determine the adequacy of the NAPCP activities, operation of the HD and its linkages with government and non-government organizations in carrying out the activities outlined in MTP-I.

III. Assess the progress and efficiency of both government and NGO AIDS control activities in Bhutan.

1. Determine the activities implemented based on the timetable in the plan.

2. Determine the level or extent of implementation of IEC, care, counselling, surveillance, testing of blood donors.

IV. Identify the constraints in programme implementation particularly in the following areas and recommend ways to resolve them:

1. Appropriateness of strategies undertaken to meet the long and medium term objectives of the programme.

2. Accomplishment of activities within each strategy.

V. Assess the adequacy of NAPCP management information systems and its plans for the evaluation of programme effectiveness and impact.

1. Evaluate the structure, flow, relationship of NAPCP management information systems.

At the beginning of the review, the team divided into two groups and spent 6-7 days in various districts of western and central Bhutan interviewing a wide range of health officials, health staff, private business persons (hotel staff, store owners, sex workers), and other non-health sector government officials.

The review team members organized their notes according to a strategic outline which delineates key areas such as Prevention of Transmission (including

sexual, blood/blood products, perinatal), Reduction of Social and Economic Impact, and Programme Management (see Annex A).

The review team's findings below highlight the NAPCP's major achievements and constraints as defined by goals and objectives set forth in the first national MTP (MTP-I). The recommendations herein, are intended to guide the development of a strategic plan for the second Medium Term Plan (MTP-II) and its subsequent workplans.

A. PREVENTION OF SEXUAL TRANSMISSION

1. Promotion of Safer Sexual Behavior

Information, Education, and Communication (IEC)
Mass Media / Health Education (general public)

Health education and promotion is considered a vital area in the strategic national policy of primary health care. It is realized by the highest levels of government authority, that health education programming is the single most important strategy to combat the spread of HIV throughout the Kingdom and reduce its social and economic impact.

Achievements:

1. Under the AIDS prevention Short-term Plan, several posters were developed. During the MTP, however, pamphlets on AIDS (in Dzongkha and English), a STD slide presentation, guidelines for STD management and other booklets and posters have been produced.

2. Under the guidance of the IECH, the Kuensel newspaper has run articles on STD/AIDS and the BBS (Bhutan Broadcasting Service) has made announcements and aired special topic presentations on AIDS.

3. Currently under production are a locally produced video, a slide presentation, and guidelines of universal precautions.

4. BHU's have posters present listing the risks associated with HIV infection and posters promoting condom use. Many of these posters have been drawn and developed by local BHU staff.

5. The IECH developed an activities monitoring form for DHSO's to complete quarterly.

Constraints:

1. The IECH is seriously understaffed and can not accommodate the many demands placed upon it for producing quality health education materials and programmes. As well, the NGO and private business sector are, at present, incapable of compensating for the IECH's human resource constraints.

2. IEC materials are literature-focused making them inaccessible for many villagers and labourers.

3. There is a limited supply of non-tested materials coming from the central

office in Thimpu and those being generated at the local level. There is also no one trained at the IECH in Training of Trainer methods and interpersonal (one to one) communications skills (e.g. counselling).

4. Some of the STD/AIDS information advocated through materials at the BHU could be misleading or misinterpreted by attenders.

5. There is no defined structure for delivering health education services. District and BHU level health workers operate with little or no guidance and supervision.

6. The District and BHU level health staff develop health education materials on their own accord. They receive no special funds for their own initiatives.

7. Health education activities for both HCW training and target group consumption are based upon traditional information-giving, didactic methods with little or no participatory involvement.

Recommendations:

A.1.1. The review team strongly supports the recommendations outlined in the recent DANIDA-sponsored review of the IECH (Annex B) which emphasizes the following main points:

a. Strengthen the IECH Bureau through human resource capacity building and restructuring of its internal management system. Until more professional health educators are employed, expanding the necessary STD/AIDS prevention activities suggested in this review will not be possible.

b. Support dzongkhag level IECH activities.
c. Provide media support of IECH Bureau.
d. Strengthen training through IECH.

A.1.2. IEC materials will need to consider the multi-ethnic, multi-linguistic composition of the country and develop materials accordingly, focusing on non-linguistic, imaged-based communications.

A.1.3. An expanded IECH staff should include at least one person trained in interpersonal communications skills and programme development. Sometimes the most effective way of helping someone understand and change high risk behavior is through one-to-one communication.

A.1.4. There is an urgent need to improve the communications networks between district level hospitals and BHU's in order to improve not only access to quality health care, but the development and

distribution of health education and promotion messages, programmes, and materials.

A.1.5. All IEC materials should be research-based (qualitative or quantitative) and targeted along specific demographic parameters.

A.1.6. Under the guidance and supervision of DMO and DHSO's, district level HA 's and BHU HA's should receive special IEC training on AIDS/STD materials development considering their self-reliant, self-sustaining approach to health care delivery.

A.1.7. Increased use of mass media channels such as radio and the national newspaper, Kuensel, should be encouraged. Audience listening patterns, preferences, and availability of radios should be studied. Programme content and distribution times should conform to audience preferences.

A.1.8. The IECH should explore and support when appropriate, the possibilities of supporting folk theatre, drama, and dance to carry the message of STD/AIDS prevention.

2. Specific Target Group Education

Considering the lack of resources (especially human and financial) to implement a wide range of educational activities, the NAPCP realizes the need to focus scarce resources on population groups most vulnerable to STD/AIDS. To date targetted programmes and messages have not received the priority they should.

Achievements:

1. Some research on the KABP of high school students has been conducted.

2. Some target group education has been directed towards such groups as drivers and military.

Constraints:

1. Limited experience with targeting AIDS/sexuality-related IEC materials.

2. Initial awareness efforts have stressed fearful messages.

Recommendations:

A.2.1 The IECH should promote, through BHU staff, VHW's and teachers, the targeting of people "most vulnerable" to HIV infection (e.g. youth, migrant workers, truck drivers) and teach

strategies for developing community-based approaches to reach vulnerable individuals.

A.2.2. Shift focus on awareness raising from using fearful messages to other types of campaigns such as increasing knowledge levels of how HIV is/is not transmitted and/or creating a favourable and supportive environment for people with STD/HIV.

3. School Education / Out-of-School Education

The wide daily use and instruction in English in the Bhutanese education system, will greatly facilitate the introduction of STD/HIV curricula. A large proportion of Bhutanese children, however, do not finish primary education, and these children will need to be accessed with important STD/AIDS prevention messages and programmes.

Achievements:

1. BHU's and district hospitals have school health programmes where they periodically visit local schools (primary, junior, and senior levels) teaching youth about personal hygiene, disease prevention and STD/AIDS.

Constraints:

1. Though VHW's reach out-of-school youth by virtue of their village-based activities, there are no specific plans to target these youth.

2. As yet, there have been no resource booklets and/or education curricula developed for teachers.

Recommendations:

A.3.1. The IECH should collaborate with the Education Division (ED) and encourage them to develop and support peer education activities through extra-curricular events such as Youth Sports, Drama Clubs, Health Clubs, etc.

A.3.2. Since health related subjects have already been included in the school-based curricula, the NAPCP should encourage the ED to develop age-specific and age-appropriate STD/AIDS modules for inclusion at their respective school levels.

A.3.3. With technical assistance from the IECH Training Coordinator, the Education Divison should be encouraged to develop a Train-the-trainer (TOT) programme for district-level focal persons (e.g.

biological science or social science teachers), providing teacher training supported with educational materials.

A.3.4. Parents and/or parent groups' active participation in the development of school-based education curricula should be encouraged and supported.

4. Indigenous Medicine

Indigenous medical professionals are incorporated into the primary health care structure and work side by side with allopathic-trained health care workers. The NAPCP should seek to build upon this collaborative relationship in the future.

Constraints:

1. Though traditional or "indigenous" doctors are an integral part of the Primary Health Care programme, they have not all, to date, been formally targeted for HIV/AIDS training.

2. There is another group of indigenous healers called "traditional village healers" who operate outside of the system of traditional healers mentioned in number (1) above. These village level "healers" are not a part of the traditional medical system, per se, yet may be engaged in practices that pierce the skin through a practice called "sucking."

Recommendation:

A.4.1. Special consideration for the institutionally recognized group of indigenous doctors should manifest in the form of producing educational materials and trainings appropriate for and sensitive to indigenous medical principles.

5. Condom Programmes (promotion, distribution, quality assurance, marketing)

It was with great pleasure that the review team noted the wide distribution and promotion of condoms at all dzongkhag and gewog levels. The general acceptance of condoms as the key to HIV prevention will most certainly prove a vital step in the wide dissemination of HIV throughout the country. Condom distribution has nearly doubled from 1991 to 1993 (See Annex C).

Achievements:

1. When supplies are present, condoms are made freely and readily available at BHU's and at selected merchants in larger towns.

2. Condoms are displayed prominently at the BHU, and people are encouraged to take them from canisters hanging outside on a post.

3. Condoms are also being distributed by VHW's during their routine village outreach activities.

4. Health care workers have a positive attitude about condoms and the role they play in preventing STD/HIV.

5. Condoms represented about 40% of contraceptive methods used by family planning acceptors.

Constraints:

1. There has been no systematic assessment of consumer behavior (patterns/likes/dislikes) on condoms making "points of sale" and advertising slogans arrive from guess work as opposed to a thorough understanding of consumer behavior.

2. Perhaps some of the merchant distributers are inappropriate since youth might feel embarrassed to approach them (e.g. one merchant was the local teacher).

3. Knowledge about the correct application and removal of condoms by health care professionals and other users was sometimes lacking.

Recommendation:

A.5.1. The national AIDS programme should sub-contract a marketing research firm (perhaps regionally based) to examine the nature and extent of condom utilization and consumer behavior especially among youth. The research and/or consultancy would deliver a strategy for increasing the use of condoms and a system for monitoring their distribution and use.

A.5.2. Noting the common presence of the phallus throughout Bhutanese villages as a culturally accepted symbol of power and fertility, it is felt that the NAPCP should produce hard-wood model penises for distribution for condom demonstrations.

6. Diagnosis and Early Treatment of STD

Promotion of early diagnosis and treatment

A high prevalence of STD in Bhutan has been documented, even though surveillance activities and reporting to date have been less than optimal. Strengthening the diagnosis, treatment and prevention of STD, particularly

among women, will remaing a crucial component in the overall success of the NAPCP.

Achievements:

1. STD/AIDS information is being integrated into BHU's general community outreach activities. This might encourage youths to seek medical treatment earlier.

2. Essential STD drugs are in good supply and well maintained.

3. A STD reporting form has been developed (See Annex D).

Constraints:

1. There are no accurate incidence or prevalence data on STD. Reporting is irregular and non-consistent.

2. Lack of positive health seeking behaviours in general, compounded by the easy access (along border districts) to antibiotics for self-medication purposes.

3. Limited knowledge among health care workers about the diagnosis and treatment of STD.

4. Women are often asymptomatic and therefore don't present themselves for gynaecological exams, and ANM's or HA 's usually don't investigate gynaecological questions unless there's a clinical manifestation to observe.

5. Laboratory facilities are ill-equipped (in supplies and person-power) to meet the demand for diagnostic STD tests.

Recommendations:

A.6.1. All health care workers should be trained/retrained to understand and implement the national guidelines already established (Annex E) on STD case management.

A.6.2. There is an urgent need to assess the magnitude of STD problems in the country and improve STD epidemiological surveillance activities; surveillance procedures should follow the guidelines and protocols formulated in a national workshop on STD Surveillance.

A.6.3. Simple STD diagnostic capabilities for STD e.g. syphilis serology and simple microscopic tests to be improved at district level laboratories.

A.6.4. The efficacy and sensitivity of STD drugs need to be ascertained in Bhutan periodically in order to better improve the quality of treatment provided. Capacity building at the central level in conducting operational and clinical research is needed.

A.6.5. Improve the health seeking behavior of people (especially women) with or suspected to have STD, through health promotion campaigns and improved service delivery (e.g., special GYN clinics featuring female clinicians, non-judgemental and more confidential environments).

A.6.6. Look into posibilities in screening pregnant women for syphilis. Reinstitute universal newborn eye prophylaxis for the prevention of ophtalmia neonatorum.

B. PREVENTION OF TRANSMISSION THROUGH BLOOD / BLOOD PRODUCTS

To date most blood and blood products intended for human use are being screened for HIV-1, and in general, sterile procedures and precautions are being followed by health care workers.

1. Promoting reduction in blood/blood product consumption

Achievements:

1. Rational use of blood and blood products is in place.

Recommendation:

B.1.1. Continue promoting the rational use of blood products.

2. Promotion of Safe Blood

Achievements:

1. When rapid test kits are available, which is nearly 100% of the time, all district level hospitals test all blood units for HIV before transfusion.

Constraints:

1. Donors are told that their blood will be tested for HIV, but it's clear that donors either don't know what the HIV test is or they feel that they are not at risk since few people ever come back for their test results.

2. No appropriate pre-test counselling is being conducted for people having their blood tested for HIV, nor do guidelines exits for lab technicians on

protocols and procedures for informing "live donors" of their serostatus, should they test positive.

Recommendations:

B.2.1. HIV test kits should be provided to all hospitals screening blood for human consumption.

B.2.2. Health care personnel conducting blood screening procedures should be provided with a set of guidelines and basic questions for promoting donor self-deferral.

B.2.3. All health care personnel conducting the HIV tests and/or phlebotomists should be properly trained in pre and post test counselling techniques/procedures and receive guidelines for carrying this out.

3. Interventions to reduce HIV in skin piercing practices

Achievements:

1. A series of workshops on Universal Precautions were held at central, regional and district levels where indigenous doctors attended as well as MCP workers and some barbers (See Annex F).

Constraints:

1. Presence of traditional healers who continue a practice called "sucking" whereby incisions are made on the patients' body and then, through negative pressure, blood is extracted from a slit on the skin.

Recommendation:

B.3.1.. BHU VHW's should be encouraged to meet with village level traditional healers who engage in unsterile skin-piercing practices and teach them sterilization and handling precautions.

4. Promotion of sterile conditions and Universal Precautions

Achievements:

1. Health care workers are implementing a one needle, one person policy.

2. All equipment is sterilized (at least by boiling) and most BHU's use a pressure cooker type of sterilizer

Constraints:

1. It has been observed that even though health care staff have been trained in universal precautions, some occupational behaviours such as picking up soiled sharp instruments with bare hands still prevail.

2. Health care professionals are using boiling methods and pressure-cooker sterilizers for purposes other than their intended EPI use.

Recommendation:

B.4.1. All health care staff, including janitorial staff, should receive an expanded training on universal precautions (particularly on the handling of soiled waste items and sharps) based upon the national guidelines already developed (See Annex G).

B.4.2. Health care facilities should make available to all health care workers the necessary paraphernalia in order to ensure universal precautions such as disposable syringes, needles, garments, latex gloves, detergents, disinfectants and water heaters.

B.4.3. Prepare for and carry-out proper disposal of soiled, solid wastes and sharps in an environmentally and occupationally safe manner.

B.4.4. Modifications to the current pressure-cooker sterilizers need to be made in order to accommodate larger barrelled syringes, and/or separate sterilization apparatus need to be supplied.

B.4.5. The Health Division should investigate the utility and feasibility of developing Central Supply Units at district level hospitals which would provide the hospitals' and surrounding BHU's sterile instrument needs. Each Central Supply Unit would be equipped, ideally, with an autoclave.

5. Promotion of Laboratory Services

Currently STD are being clinically evaluated and treated with minimal support through laboratory diagnosis. Blood screening for HIV-1, however, is being carried out through the use of rapid tests; confirmation tests and sentinel surveillance samples are sent to Thimpu for testing.

Achievements:

1. Laboratory technicians have received trainings on gram stain testing,

rapid test procedures for screening blood transfusions, and test kits have been supplied.

Constraints:

1. Though trained to perform gram stains and VDRL testing and some having access to microscopes, not all laboratory technicians have the proper facilities to do so.

2. Many laboratory technicians are still pipetting by mouth.

Recommendations:

B.5.1. Laboratory technicians should be included in HIV/STD workshops so they have a thorough understanding of their role in prevention activities.

B.5.2. There should be a national standardization of laboratory facilities and service capabilities according to health care facility levels (e.g. district hospital and BHU).

B.5.3. Lab technicians should have available the necessary equipment needed in order to ensure adequate occupational protection.

C. PREVENTION OF PERINATAL TRANSMISSION

1. Provision of Health Care to Pregnant Women

Achievements:

1. ANM's have participated in STD/AIDS trainings and are including STD/AIDS information into MCH clinic activities.

Constraints:

1. The level of understanding among ANM's about perinatal transmission and the psychosocial needs inherent with HIV/AIDS, are inadequate to meet future needs of HIV positive women.

Recommendation:

C.1.1. Increase the quantity and quality of STD/HIV trainings for ANM's and HA 's regarding clinical and psychosocial issues. These two health care professional classes should be the focal points for providing first-level HIV/STD/AIDS counselling services.

II. REDUCTION OF PERSONAL AND SOCIAL IMPACT OF HIV INFECTION

A. Provision of health care services

Recommendation:

A.1.1 Increase the amount of time spent on HIV/AIDS issues (especially psychosocial issues and community responses) in all future trainings for all health care workers. Emphasis should be placed upon using participatory methods of instruction.

B. Provision of Community Care

Constraints:

1. On several occasions, people interviewed by the review team mentioned that they think people with HIV/AIDS should be isolated from the community, and in one survey a significant number of respondents hoped for the same (Annex H).

2. Health care professionals have not been trained in counselling techniques in order to provide better quality of care to people with STD/HIV/AIDS.

Recommendations:

B.1.1. Provisions should be made, based upon a Train-the-Trainer (TOT) model, for key district-level HA 's and ANM's to receive intensive counselling training. One or two persons should also go abroad (regionally) to observe, first-hand experience in counselling people with HIV/AIDS. It is also recommended that the TOT for counselling be pilot tested with health care staff at Jigme Dorji Wangchuck National Referal Hospital (JDWNRH).

B.1.2. For MTP-II, the IECH should develop and include health education messages which seek to reduce the stigma associated with HIV/AIDS and promote a more tolerant and positive environment for HIV positive people.

C. REDUCTION OF SOCIAL IMPACT

1. Promotion of action to protect rights of individuals

Achievements:

1. Basic policy guidelines specifically pertaining to HIV/AIDS health and social issues have been developed and are currently in draft form (See Annex I).

Constraints:

1. As of this review, national policies on HIV/AIDS have not been formally instituted, and considering the potentially volatile nature of some negative attitudes regarding people with HIV, as well as some basic misunderstandings, it is imperative that such policies are firmly in place.

Recommendations:

C.1.1. The Health Division should conduct a 2-3 day workshop to review and finalize drafted national policies concerning HIV/AIDS. Multisectoral representatives from the NAC should promote the development of their own sectoral policies in conformation with and approval of the National AIDS Committee.

C.1.2. The draft policy statements already developed should be reexamined for wording and emphasis placed on the basic rights and responsibilities of people with HIV/AIDS and health care workers.

III. REDUCTION OF ECONOMIC IMPACT OF HIV

A. REDUCTION OF IMPACT ON SPECIFIC SECTORS

There are two fundamental relationships concerning the economic impact of AIDS. The first relationship is between economic, social and cultural variables and the spread of HIV or in other words how these factors are influencing the spread of HIV. The other is between HIV and AIDS and how the the economic and social system can cope with the strain of HIV/AIDS.

An effective National AIDS Programme must strengthen national capacity to identify and estimate the economic and social impact of AIDS; to act as a catalyst in the mobilisation of financial and human resources, and to establish operational planning to minimize the economic and social costs within a multisectoral framework.

Constraints:

1. To date, AIDS prevention and control activities have been developed and implemented almost exclusively by the health sector.

2. Other important socio-economic sectors such as Commerce, Industry, Department of Roads, Transportation, Tourism, and Agriculture have not

participated in the national effort to prevent AIDS.

Recommendations:

A.1.1. There is a need for collaboration among concerned ministries in terms of resource allocation and the establishment of institutional structures for effective sector programme development, implementation, and evaluation.

A.1.2. Various transport personnel (especially truck drivers and road workers) should be targeted for specific research-based interventions.

A.1.3. Employers in all sectors should be encouraged to establish effective HIV/AIDS prevention programmes in the workplace.

A.1.4. Criteria for identifying economic vulnerability of both agrarian and household systems should be developed, and followed by the development of programme to reduce the vulnerability of these groups.

IV. PROGRAMME MANAGEMENT

A. PROGRAMME ORGANIZATION & COORDINATION

The National AIDS Prevention and Control Programme has been actively implementing Bhutan's Medium Term Plan since January 1990. The Programme is essentially horizontal in nature conforming to the overall Primary Health Care strategy.

The Review Team has noted that a high degree of activities related to HIV/AIDS prevention and control have been prompted by initiatives from the central level. At the Dzongkhag hospital and BHU levels, it appears that independent planning for HIV/AIDS prevention and control activities has occurred, particularly in 1993. Recent activities undertaken at the local level have been a result of regional planning workshops which have directed district level health officials in such areas as blood safety, community education, and condom promotion.

1. Multi-sectoral Involvement and Commitment at all levels (staff, activities, support, etc.)

The Review has found that the various officers of the Health Division (COHs, DMOs, DHSOs,HAs, ANMs, BHWs) seem to be serving as the primary personnel initiating or undertaking HIV/AIDS prevention and control activities.

2. Government Sector Involvement and Coordination

The AIDS programme manager seems to be the primary catalyst in the coordination of the national STD/AIDS programme activities at both central and peripheral level.

3. Programme Structure and Functions

Until last year Bhutan was divided into 4 zones, but has now been divided into 3 regions, each with a coordinating officer of health. There are 20 districts. In each district the District Medical Officer (DMO) is in charge of the District Hospital and all of its activities. The activities in the Basic Health Unit and Dispensaries are controlled by a District Health Supervisory Officer (DHSO) who is directly responsible to the District Administrator. This structure is about to change whreby the DMO will be responsible for all health activities in the district, and the DHSO will report to the DMO. All health activities are under the Ministry for Health and Education, Division for Health.

Centrally, the Programme is lead by a National Programme Manager who is currently operating on a part-time basis with an assistant who is also part-time and shared with other programmes.

4. Intra-Ministerial Collaboration

Willingness for intra-ministerial collaboration is apparent, though the necessary mechanisms to formalize this collaboration into effective programme planning and implementation are needed.

Constraints:

1. The majority of AIDS prevention and control activities in the country are undertaken through or with prompting from <u>one</u> office (the NAPCP).

2. Limited technical information on STD and AIDS is reaching other Departments and information provided is usually available only to selected individuals.

3. The Ministry of Health and Education, the Health Division has limited human resources to implement the necessary programme activities.

Recommendations:

A.1.1. More efforts need to be made to identify and support basic community groups and/or organizations with whom the NAPCP programme could plan and implement HIV/STD/AIDS programme activities in order to expand the reach of the programme and ensure that all target groups are addressed.

A.1.2. In order to ensure effective programme implementation NACP should ensure that all activities implemented by participating agencies in the STD/AIDS prevention programme are coordinated with and through NAPCP.

A.1.3. The IECH should initiate the publication and dissemination of a regular newsletter-like report of STD/AIDS, to keep people within and outside the Health Ministry informed of the Programme's activities, as well as regional and global developments and news regarding STD/AIDS. This newsletter would also serve to improve the communication between the different districts which now are meeting only once a year.

B. PROGRAMME STAFFING, FACILITIES AND ACCOMMODATION

Constraints:

1. There is a lack of basic AV equipments in all regions.
   The manpower available to the central, district and community levels is severely limited, which consequently hampers expansive programme implementation.

Recommendation:

B.1.1. In order to carry out the necessary STD/AIDS prevention activities for the three year period covered by the MTP-II, a full-time Programme Manager's post should be created.

B.1.2. At least each region should be well equiped with Audio-visual aids to facilitate communications towards illiterate population groups.

C. TRAINING

Several training programmes have occurred for various types and levels of health care personnel throughout the country. Most important has been the inclusion of HIV/AIDS into the VHW training curricula, focusing on STD prevention and condom distribution and promotion.

The review team fully supports the recommendations contained in the recent DANIDA-sponsored IECH review and, again, underscores the need to build the human resources capacity of the IECH. Many of recommendations in this section are based upon and/or tangential to that singular recommendation.

Achievements:

1. Most VHW's in the BHU's have been trained (in some cases more than one training) to talk about STD/AIDS in their village outreach visits. They will spend roughly 30 minutes per outreach visit addressing STD/HIV.

2. Integration of HIV/AIDS into medical, paramedical community health worker training was initiated.

Constraints:

1. Training reference materials are not currently available in adequate quantities or subject matters for the current volume of training envisaged.

2. Continuing education programmes and reorientation training were not existing for Basic Health Staff to develop skills needed for their job.

Recommendations:

C.1.1. Designation within the IECH of a Training Coordinator who would be responsible for developing and designing targeted STD/AIDS training materials and programmes in collaboration with representatives (focal persons) from other sectors (e.g. DOR, Chamber of Commerce, etc.).

C.1.2. Other Ministries and non-health sectors should be encouraged, through regular intersectoral meetings, to develop STD/AIDS prevention training programmes for their employees using the assistance of the IECH Training Coordinator.

C.1.3. Regular on-going "in-service" trainings should be developed for health care professionals (e.g. HAs, ANMs,BHWs, VHWs, etc.) on various aspects of STD/AIDS, depending on the information needs of the health personnel.

C.1.4. The IECH Training Coordinator should provide technical support and assistance to other Departments, Ministries and private sectors, in order to help them identify STD/AIDS-related training needs as well as assist in the development of training programmes and training timetables.

C.1.5. The IECH should increase the quantity and quality of AIDS/STD training programmes directed to health care staff, especially VHW's. Training programmes should seek to include a wider range of HIV related issues, especially psychosocial issues.

C.1.6. The Training Coordinator should emphasize the development of a few Dzongkhag-level core trainers or focal points (HAs), who may be used for future trainings as trainers/ resource persons.

C.1.7. Training materials appropriate for targeted audiences should be developed and distributed to trainers through Training-of-Trainers (TOT) workshops, using trainers mentioned above (5).

C.1.8. The IECH and other individuals/sectors working in AIDS prevention materials development should be provided a 7 day training course, via a consultant, on using computer generated graphics and word-processing programmes.

D. PROGRAMME LOGISTICS

1. Transportation and Vehicles

Transportation in Bhutan is long and difficult upon steep and winding roads, and the public transport system is not very good. Transportation is therefore carried out with different vehicles owned by the programme or by individuals in their private cars.

Constraints:

1. The programme has been provided one vehicle under the STP and one vehicle under the current MTP. The oldest of the vehicles is stationed at a hospital and the newest is used centrally.

Recommendations:

D.1.1. All the three regions should each have a vehicle. As it is now, they have to compete for and/or borrow a vehicle from other programmes. This often leads to postponment of planned activities due to competition with other programme activities.

D.1.2. The vehicles currently assigned to NAPCP are operated according to standard policies and regulations for the Kingdom of Bhutan.

2. Supply handling/Logistical System
Needs assessment and handling

Constraints:

1. Supplies and equipment having been ordered in time, are still often delayed for a long time (e.g. some of the S&E ordered through SEARO in 1992 has yet to be delivered).

2. Delivery of test kits has usually met few constraints except in a few cases.

Recommendation:

D.2.1. A more systematical follow-up on orders placed should be implemented.

3. Receiving, Storage and Dispatch

Achievements:

1. The programme is utilizing the Public Health Laboratory's storing capacity. When dispatched to other locations it is done through a coldchain when necessary.

E. PROGRAMME MONITORING, REPORTING AND EVALUATION

1. Programme Monitoring System

Monitoring on a regular basis of activities is weak. Occasionally some one is visiting the activity under implementation, and therefore a positive confirmation can be obtained that the activity has been carried out. Most of the time an activity report is non-existent. For IEC activities there is a half yearly reporting required.

Constraint:

1. There are no activity reports on a regular basis, and no evaluation of activities carried out.

Recommendations:

E.1.1. An activty monitoring and reporting system should be introduced which requires giving details on activity implementation and which records some progress indicators. Such a report should be mandatory before more funds are released.

2. Sentinel Surveillance and Reporting

According to the MTP-I, the NAPCP has been successful in implementing a system of sentinel surveillance where strict confidentiality has been maintained. However, during the MTP-I, a voluntary system of HIV testing including trained counsellors who could provide appropriate pre and post test counselling was not instituted. Laboratory technicians have been trained in conducting HIV tests, however the review team found that many were unclear about the goals and objectives of HIV sentinel surveillance.

To date only 2 persons have tested positive through the sentinel surveillance system, while cumulatively there have been approximately 24,000 HIV tests conducted since the start of the programme in late

1989. The system, as it is was originally planned for MTP-I, was perhaps too large and ambitious (18 districts) for the level of training and resources made available to the activity. (See Annex J).

Achievements:

1. During the MTP-I, a surveillance system was established, laboratory technicians trained, and test samples received in Thimpu for surveillance testing.

Constraints:

1. Many laboratory technicians were not clear about their role in HIV sentinel surveillance or about guidelines for reporting STD.

2. Many serum samples were not collected on a randomized basis, indicating a strong possibility for selection bias.

3. Sentinel surveillance samples were not collected as anonymous or unlinked.

Recommendations:

E.2.1. The national AIDS prevention programme should re-examine the extent and nature of its sentinel surveillance programme in light of Bhutan's small population, limited human and financial resources, and the pre-existing knowledge of which population groups are most vulnerable for HIV infection. This examination should occur in the forum of a 1-2 day national workshop culminating in national programme for the surveillance of HIV/STD.

E.2.2. Until a departmental consensus is achieved on sentinel surveillance for HIV, the current system should be streamlined whereby no more than 5-7 sentinel sites are operational, clear guidelines on anonymous sample collection are understood by sentinel site technicians, and a consistent number of minimum target sample sizes are collected (e.g. at least 200 from each predefined group and perhaps 300 for "general population" groups such as ANC attenders and blood donors). All sentinel surveillance samples should be unlinked and anonymously collected.

E.2.3. Sentinel surveillance samples should be extracted from blood collected primarily for other purposes (e.g. ANC attenders, blood donors, STD patients, medical exams for military recruits, etc.) In this way, blood can be easily collected anonymously, reducing the chances of selection bias and therefore improving the data's interpretability. Suggested sentinel surveillance groups are ANC attenders, STD patients, blood donors, and military recruits.

E.2.4. It is recommended to discontinue as much as possible "ad-hoc" serosurveys of population subgroups outside of the predefined sentinel surveillance groups.

E.2.5. Data from sentinel surveillance or other surveys should not be aggregated for analysis.

3. Behavioural and Ethnographic Studies.

One national KABP survey was conducted in 1989 and another school-based KABP study was conducted in 1992 (Annex K). Both of these studies have set baseline levels of AIDS awareness and knowledge among those interviewed, however, more studies are needed in order to monitor KABP over time and the impact of health education programmes/messages on the targeted audiences comprising these studies.

Constraints:

1. The IECH is very limited in person-power and does not have the human resource capacity to carry out large-scale, quantitative or qualitative studies necessary for monitoring and evaluation as well as materials development.

Recommendations:

E.3.1. Assuming an increase in the number of staff at the IECH, junior level officers should then be encouraged to seek additional training and/or advanced, graduate level diploma's in quantitative & qualitative assessments in the areas of behavioral epidemiology, sociology and/or anthropology. This increased knowledge will serve to conduct better behavioural studies more quickly.

E.3.2. During the MTP-II, small-scale behavioral studies should be implemented by members of an expanded IECH, at the beginning of the MTP-II for the purposes of programme planning and development, and then again at the end of the MTP period to assess progress and changes.

4. Socio-Economic Studies

No studies on the potential social and economic impact of HIV on Bhutan have been conducted to date. Though AIDS prevention activities have been instituted, most all have been conducted through the impetus of the Health department. Other vital partners (Commerce, Industry, Agriculture, Transportation) have not assessed the impact of the epidemic on their specific sectors.

Recommendation:

E.4.1. The AIDS Programme Manager should encourage and direct the private sector in collaboration with other non-health sectors (e.g. commerce, roads, industry) to conduct social and economic studies examining the impact of HIV on Bhutan in order to develop more specific strategies for reducing the overall social and economic impacts.

5. Evaluation System / Programme Evaluation Indicators

The NAPCP should develop, in collaboration with other partners, clear programme progress and evaluation indicators which could be used to measure/quantify the future impact of the current HIV/AIDS prevention and control activities.

Constraints:

1. District level DMO's and laboratory technicians are unclear about the goals and objectives of sentinel surveillance for HIV infections. Sentinel surveillance activities appear to be implemented somewhat inconsistently.

2. No comprehensive monitoring of the supply flow (e.g. condoms) is being carried out by DHSO's and Central office.

3. Detailed information regarding the district-level activities being undertaken by hospitals and BHU's is not readily available to central office in Thimpu.

4. There appears to be a communication gap between the AIDS Programme and the peripheral staff on procedures, guidelines and recommendations about surveillance.

5. Diagnostic capabilities for STD are often unavailable in district level hospitals and usually non-existent in BHU's.

6. There are difficulties in performing behavioural studies in some population groups due communication constraints (geographic, linguistic) in the country.

Recommendations:

E.5.1. A comprehensive monitoring system to follow-up on orders placed, goods delivered and distributed, and eventual rates of use/consumption (especially for condoms and HIV test kits) should

be developed in order to evaluate the use and future needs of supplies and equipment for the Programme.

E.5.2. Comprehensive Programme monitoring and evaluation Indicators should be developed by the NAC technical working group in collaboration with the other participating parties by June 1994 to enable the Programme to measure/quantify its current and future impact on the HIV/AIDS situation.

6. Financial Monitoring System

Funds disbursed to the National AIDS programme from WHO/GPA is controlled by WR's office

7. Disbursement of Funds from the Programme

Constraints:

1. A clear-cut monitoring system for activities already having received disbursed funds does not exist.

Recommendation:

E.7.1. Although there is little doubt that funds are utilized as planned, a clear mechanism for monitoring funds disbursed by the programme should be developed.

E.7.2. The reporting should be on a monthly basis and should, together with the activity report, be the basis for further disbursement of funds.

8. Funds availability

Constraints:

1. Funds for 1993 activities have not been available for the programme manager until the 3rd quarter although the funds have been avaiable for Bhutan National AIDS Programme in SEARO since 26 March 1993.

2. The situation has been clarified and rectified.

9. Evaluation System / Programme Evaluation Indicators

The NAPCP should develop, in collaboration with other partners, clear programme progress and evaluation indicators which could be used to measure/quantify the future impact of the current HIV/AIDS prevention and control activities.

Constraints:

1. District level DMO's and laboratory technicians are unclear about the goals and objectives of sentinel surveillance for HIV infections. Sentinel surveillance activities appear to be implemented sporadically and inconsistently.

2. No comprehensive monitoring of the supply flow (e.g. condoms) is being carried out by DHSO's and Central office.

3. Detailed information regarding the field-level activities being undertaken by many Governmental and Non-Governmental groups is not readily available to central office in Thimpu.

4. There appears to be a communication gap between the AIDS Programme and the peripheral staff on procedures, guidelines and recommendations about surveillance.

5. Diagnostic capabilities for STD are often unavailable in district level hospitals and usually non-existant in BHU's.

6. There are difficulties in performing behavioural studies in some population groups due communication constraints (geographic, linguistic) in the country.

Recommendations:

E.9.1. A comprehensive monitoring system to follow-up on orders placed, goods delivered and distributed, and eventual rates of use/consumption (especially for condoms and HIV test kits) should be developed in order to evaluate the use and future needs of supplies and equipment for the Programme.

E.9.2. A comprehensive activity monitoring and reporting format, including information on target audiences, financial expenditure, and final results of each activity should be designed by the NAPCP in order to facilitate Programme monitoring and reporting.

E.9.3. Comprehensive programme monitoring and evaluation indicators should be developed by the NAPCP in collaboration with the other participating parties by June 1994 to enable the programme to measure/quantify its current and future impact on the HIV/AIDS situation.

E.9.5. At least two different types of HIV test kit should be supplied to the hospitals to help in diagnosis.

F. PROGRAMME FINANCE

1. Disbursement / Obligation of Funds by Sector

As per the attached annexes.

2. Disbursement by Programme Area / Strategy

As per the attached annexes.

List of Annexes