Nepal Health Sector Support Programme

HEALTH SECTOR TRANSITION AND RECOVERY PROGRAMME

NHSSP 1: Quarterly Reporting Period: August – October 2015

UKaid
from the British people

NHSSP

Health Sector Transition and Recovery Programme

List of Acronyms

AA	anaesthetic assistant
ADRA	Adventist Development and Relief Agency
ANM	auxiliary nurse midwife
ASBA	advanced skilled birth attendant
AWPB	annual work plan and budget
CAPP	consolidated annual procurement plan
CBR	community based rehabilitation
CEONC	comprehensive emergency obstetric and neonatal care
CHD	Child Health Division
C/S	caesarian section
DDC	district development committee
D(P)HO	district (public) health office(r)
DfID	UK Department for International Development
DG	Director General
DHIS-2	District Health Information System-2
DHO	district health office(r)
DoHS	Department of Health Services
DPO	Disabled People Organisation
DRFU	Disability and Rehabilitation Focal Unit
DUDBC	Department of Urban Development and Building Construction
EDP	external development partner
EOC	emergency obstetric care
EPI	Expanded Programme on Immunisation
EWARS	early warning and reporting system
FCHV	female community health volunteer
FHD	Family Health Division
FMIP	Financial Management Improvement Plan
FMR	Financial Monitoring Report
FP	family planning
FY	fiscal year
HEoC	Health Emergency Operation Centre
HFoMC	Health Facility Operation and Management Committee
GBV	gender-based violence
GESI	gender equality and social inclusion
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	Government of Nepal
HF	health facility
HFOMC	health facility operation and management committee
HIIS	Health Infrastructure Information System
HMIS	Health Management Information System
HR	human resources
IRSC	Injury and Rehabilitation Sub Cluster
IP	infection prevention
IUCD	intrauterine contraceptive device
JAR	Joint Annual Review
KFW	Kreditanstalt für Wiederaufbau (German Development Bank)
KOICA	Korean International Cooperation Agency
LMD	Logistics Management Division
M&E	monitoring and evaluation

MoWCSW	Ministry of Women, Children and Social Welfare
MD	Management Division
MNCH	maternal, neonatal and child health
MNH	maternal and newborn health
MoF	Ministry of Finance
MoFALD	Ministry of Federal Affairs and Local Development
MoHP	Ministry of Health and Population
MoU	memorandum of understanding
MS	medical superintendent
MToT	Master Training of Trainers
MWCSW	Ministry of Women, Children and Social Welfare
NDF	National Disabled Fund
NGO	non-governmental organisation
NHSP-2	Second Nepal Health Sector Programme
NHSP-3	Third Nepal Health Sector Programme
NHSS	Nepal Health Sector Strategy
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
OB/GYN	obstetrics/gynaecology
OCMC	one-stop crisis management centre
OPM	Oxford Policy Management
P&O	Prosthetics and Orthotics
PD	Population Division
PFM	public financial management
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Division
PNC	postnatal care
PPICD	Policy, Planning, and International Cooperation Division
QI	quality improvement
QoC	quality of care
RA	rapid assessment
RH	reproductive health
SBA	skilled birth attendant
SM	safe motherhood
SMNSC	Safe Motherhood and Neonatal Steering Committee
SSU	social service unit
TA	technical assistance
TABUCS	Transaction Accounting and Budget Control System
TARF	Technical Assistance Resource Fund
TB	tuberculosis
ToR	terms of reference
ToT	training of trainers
TWG	technical working group
UNFPA	United Nations Family Planning Association
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VDC	village development committee
VP	visiting provider
VSC	voluntary surgical contraception
WDO	Women's Development Office
WHO	World Health Organization

1.0 Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit its first quarterly report for the period August-October 2015 under Ministry of Health and Population's (MoHP's) new DFID funded Health Sector Transition and Recovery Programme (HSTRP).

The 7.8 magnitude earthquake that hit Nepal on the 25th April, and the multiple after-shocks that followed claimed an estimated 10,000 lives, injured more than 23,000, and destroyed over half a million homes. In its aftermath, the Government of Nepal declared fourteen districts as those most severely affected. In July 2015, as part of its multi-sector response to the earthquakes, DFID contracted Options Consultancy Services to provide additional TA support to the HSTRP. These inputs build on DFID's existing support to NHSSP which has been providing Technical Assistance (TA) to MoHP and the Department of Health Services (DoHS) since 2010 to support implementation of the second Nepal Health Sector Programme (NHSP-2, 2010-15).

Under HSTRP, Options has partnered with Oxford Policy Management (OPM) and three non-governmental organisations (Handicap International Nepal (HI Nepal), the Spinal Injury Rehabilitation Centre (SIRC), and the Transcultural Psychosocial Organization (TPO)). This 12 month programme runs until July 2016 and aims to restore essential health care services - including obstetric care - family planning, physical rehabilitation, and psychosocial support across the 14 worst affected districts with a particular focus on three hard hit districts - Ramechhap, Dolakha and Sindupalchowk. NGO partners are also providing services in three further districts - Nuwakot, Kavre, and Rasuwa.

In the aftermath of the earthquakes, MoHP immediately prioritised emergency services, medical evacuations and the supply of essential medicines and goods to the hardest hit areas. Within two weeks these activities gave way to the deployment of specialist teams to conduct detailed post disaster needs assessments (PDNAs) in earthquake affected districts and coordination meetings with external development partners (EDPs) for the restoration of services in the 14 worst affected districts.

Drawing on the PDNAs and more in-depth assessments carried out by NHSSP advisers and partners in focal districts, HSTRP work plans were prepared and agreed with ministry counterparts. A consolidated summary of planned inputs by thematic areas and districts is presented overleaf.

HSTRP proposal development and negotiations between DFID and Options concluded with the signing of a formal contract on 27th July, 2015. However delays followed in securing Cabinet approval such that the memorandum of understanding (MoU) between the Ministry of Finance (MoF) and DFID could only be signed on 2nd September 2015.

Planned Inputs by District

Services	Districts with TA Support Funding					
	Ramechhap	Dolakha	Sind.	Rasuwa	Nuwakot	Kavre
Repair buildings	X	X	X			
Restore MNCH services	X	X	X			
Restore CEONC services	X	X				
Restore FP services (VP; LARC)	X	X	X			
Support e-reporting from HFs	X	X	X			
Strengthening HMIS	X	X	X	X	X	X
Planning support to DHO	X	X	X			
Establish OCMC Units	X	X	X			
Equity monitoring	X	X	X			
Support Establishment of CHUs	X	X	X			
Trauma rehabilitation		X	X	X	X	
Psychosocial services	X	X			X	X
TABUCS	X	X	X	X	X	X
TARF	X	X	X	X	X	X

Following GoN approval, and in order to facilitate final high level consultations and work plan approval, NHSSP presented the HSTRP implementation plan to MoHP's Policy Planning and International Cooperation Division (PPICD) and senior health officials on September 3rd. PPICD's chief subsequently wrote to all DHOs in earthquake affected districts to notify them of the approval and launch of the programme.

Two weeks following HSTRP's launch, Nepal's new federal constitution was passed (on 20th September) and sparked widespread protests by Madhes groups in the southern plains of the terai. A blockade of the Indian border followed which, in turn, created major fuel and gas shortages. At the time of writing the unrest shows few signs of abating and the blockade is now seriously affecting the availability of medicines and limiting the abilities of advisers and partners to travel to support district level activities.

In order to overcome delays in securing Cabinet approval, Options took the decision to pre-finance programme activities at central and district levels, including the hiring of key personnel. It also released funds to ensure the continuation of services following the emergency support phase and helped kick start the activities of two NGO partners. These activities, and those of the expanded TA team are described in more detail in section 2.

A total of 51 output deliverables form the basis of the HSTRP contract with DFID. These outputs align with the DFID log framework and monitoring framework and cover 10 thematic areas as follows:

Essential health care services	Health planning
Family Planning	Gender equality and social inclusion
Infrastructure	Monitoring and evaluation
Procurement and supply chain	Psychosocial support (Appendix 1)
Health financing and public financial management	Physical rehabilitation support (Appendix 2)

2. Detailed Quarterly Updates

2.1 Essential Health Care Services

2.1.1 Support to MoHP and DoHS

In the immediate aftermath of the earthquakes, NHSSP's EHCS team coordinated with MoHP, Unicef, GiZ and USAID to carry out PDNAs in Rasuwa and Ramechhap districts. As a core member of MoHP's reproductive health (RH) sub-cluster committee, advisers helped FHD assess the status of health facilities and maternal and neonatal health (MNH) services in district hospitals and birthing centres in the 14 severely affected districts. This included assessing the functionality of comprehensive emergency obstetric and neonatal care (CEONC) services and making support visits to facilitate prompt service resumption.

Visits were made to Manthali PHCC in Ramechhap where new CEONC services were established and to district hospitals in Nuwakot, Dhading, Sindhuli and Dolakha where service functionality was successfully restored. Key enabling factors included close coordination with supporting partners to provide clinical support to service providers, drugs for C-section services and fuel. In addition, advisers coordinated with FHD, Voluntary Services Overseas (VSO), Medicines Sans Frontier (MSF) Belgium and the National Academy of Health Science (NAMS) to assure the continuity of CEONC services in Ramechhap, Sindupalchok and Dolakha districts. CEONC service providers were recruited on two month contracts in 7 earthquake affected districts and an anaesthesia assistant (AA) was contracted for 4 months for Sindhuli District Hospital. Support to FHD for the monitoring of CEONC functionality in the 14 districts continues.

In a separate initiative FHD began providing free referral support from birthing centres to referral hospitals for women with obstetric complications. This followed recommendations made by the Safe Motherhood and Neonatal Care Sub-Committee (SMNSC). FHD also coordinated with external partners to prepare a 2015/16 service recovery plan.

Advisers also supported Child Health Division (CHD) to map out and supplement human resources, notably for immunisation and childhood illnesses, focusing on staff trained on the integrated management of childhood illness (IMCI). Data collected was used to prepare action plans to restore child health services in earthquake affected districts.

2.1.2 Support at district level: Progress made against HSTRP work plans

In two of NHSSP's three focal districts the DHOs in Dolakha and Ramechhap were supported to prepare a coordinated district transition and recovery plan in consultation with district partners. Two day planning workshops were conducted by the DHOs with resulting plans focusing on access to quality maternal, newborn, child health and family planning services from district hospital level

down to community level. Plans made included infrastructure repair and reconstruction; the procurement of equipment and furniture; increasing human resources; capacity development of staff including training needs assessments for skilled birth attendants (SBAs), medical abortion and family planning; improving referral systems; monitoring and evaluation including e-reporting from facilities and equity monitoring; community level awareness and demand creation activities mainly focusing on strengthening female community health volunteers (FCHVs) and messaging using local radio and other media; and mobile medical and RH services to selected areas.

Following these workshops, the DHOs shared the coordinated plan with partners for their comments and to elicit commitments. The two DHOs are currently in the process of finalizing these plans with the support of NHSSP's district coordinators.

As noted, establishing CEONC services at Manthali PHCC in Ramechhap required coordinated support for the supply of additional human resources, equipment and supplies. In order to ensure these services can be sustained, the re-modelling of buildings and supply of a pre-fabricated structure is required to house an operating theatre (OT), post-operation ward, and in-patient facilities. It should be noted that fuel and transportation shortages are delaying this remodelling and construction work.

Effective district coordination with various line agencies including the district development committee (DDC), municipality and political leaders led to a road being constructed to the PHCC in the reporting quarter. In addition, VSO recruited three doctors (OBGYN, paediatrician, and anaesthetist) and one nurse to support services.

In Dolakha the DHO was supported for the continuation of CEONC services at Charikot PHCC following the departure of MSF Belgium. Coordination with NAMS for additional human resources and use of FHD's CEONC fund allowed the DHO to recruit additional service providers.

Ramechhap and Dolakha were also supported to select strategic birthing centres to be upgraded to comprehensive centres of excellence under the Nepal Health Sector Strategy (2015-20). The two districts identified a total of eleven centres to be upgraded following criteria developed by FHD.

Additional activities in the two districts included

- The provision of salaries for five nursing staff for 2 – 3 months
- An assessment of reproductive health (RH) service availability including HR gaps, the recruitment of an auxiliary nurse midwife (ANM) at district level, conducting a district level annual review and various trainings supported by partners.
- Participation and documentation of district health and nutrition cluster meetings with WHO
- On-site coaching and mentoring of SBAs on core skill enhancement including infection prevention in Jiri hospital (5 staff), Charikot PHCC (4 staff), Manthli PHCC (5 staff) and Ramechhap hospital (4 staff). Of these staff, 7 were selected for development as clinical mentors for SBA/ANMs posted to birthing centres.

The main constraints experienced in carrying out this work were are as follows:

- The new daily subsistence allowance (DSA) guideline from government has hampered SBA and ASBA training. In the past the DSA allowance per trainee for two months was around NPR 21,000; now it is between NPR 85,000–100,000. The National Health Training Centre (NHTC), which is responsible for paying these allowances, has insufficient funds to pay them and has appealed to MoF to revise DSAs for long courses and halted SBA (2 months) and ASBA (3 months) training.
- The current fuel crisis is seriously limiting district visits and impacting the supply of materials/equipment, repairs and re-construction, staff training and on-site visits to health facilities.
- The busy schedule of the DHO in coordinating with various agencies makes scheduling DHO support activities challenging.
- NHSSP TA are having to juggling their time between ongoing NHSSP and HSTRP activities and increased demand for their services from Government and EDPs and partners wanting to inform their forward plans, and other I/NGO partners who are providing support.

2.2 Family Planning

In the post-earthquake period, strong emphasis was placed on district level coordination and planning meetings led by DHOs. In Dolakha and Ramechhap, TA supported the DHOs to prepare one year district health recovery plans, incorporating family planning, with key district players.

At national level the FP adviser met Child Health Division's (CHD's) immunisation focal person to explore the possibilities of using expanded programme of immunisation (EPI) vaccinators as visiting providers for family planning services in Sindhupalchowk district. He also met with the Director and training focal person of Paropakar Maternity and Women's Hospital (PMWH) to initiate clinical family planning training (IUCD, Implant) with support from NHSSP.

Specialised technical support was provided to help USAID-DFID finalise plans and budgets for family planning (FP) services in 5 districts. In addition, technical inputs were provided to design and prepare a submission for a UNFPA/FHD led FP2020 Rapid Response Mechanism (RRM). This aims to respond to emerging and urgent opportunities to expand access to FP services in selected districts.

Capacity enhancement inputs saw the first batch of service providers from Dolakha (4 service providers) complete training on implant insertion and removal. This was carried out at the Chhetrapati Family Welfare Centre (CFWC) training site in Kathmandu.

2.3 Infrastructure and Procurement

The main infrastructure activity undertaken in the quarter was the completion of physical and structural assessments of all the health facilities in the 14 earthquake affected districts. Data was uploaded and the report completed and submitted. A further analysis of data to assess the intensity of structural damage and types of repair required has now begun. Initial findings were presented to MoHP and external health partners, 30 of whom signed MoUs for the reconstruction and rehabilitation of health facilities in all 14 districts at a cost in excess of $30 million.

TA also provided technical, financial and logistical support to MoHP for a workshop on post disaster infrastructure planning and progress made to date with DHOs, regional directors and government officials. Each district made a presentation on damage sustained, progress made and gaps remaining. A second workshop was held to review the progress of EDPs signing MoUs with GoN for rehabilitation and reconstruction work. This included technical review sessions, descriptions of inputs required and facilitating meetings with local vendors able to supply prefabricated and other construction materials.

In order to support re-construction work, standard guidelines on the construction of health facilities were updated to include the use of pre-fabricated materials and all major stakeholders were orientated on their use. Electrical, sanitary, structural and other technical specifications and designs were incorporated within the guidelines. The infrastructure adviser also made recommendations on various technical proposals received to date for the reconstruction, repair and maintenance of damaged buildings in various districts. This helped MoHP prepare MoUs with various agencies.

Extensive technical exchange and coordination with JICA's technical team in order to finalise design outlines for the construction of Bir and Maternity Hospitals also took place. JICA and GoN later signed an agreement for the reconstruction of these hospitals by August 2018. In addition TA supported Management Division/DoHS to refine designs for Mugu District Hospital with KOIKA appointed consultants.

Progress monitoring visits were made to NHSSP's 3 focal districts, Sindhupalchowk, Dolakha and Kavre.

2.4 Health Financing and Public Financial Management

In designing the HSTRP it became evident that the tracking of EHCS service data and expenditure in earthquake affected districts is essential if the overall efficiency of recovery inputs is to be assessed. In this regard, MoHP's Transaction Accounting and Budget Control System (TABUCS) provides a sufficient level of detail and range of financial reports to satisfy this requirement. Accordingly, assuring TABUCS functionality in all earthquake affected districts was a TA priority in the quarter with key activities as follows:

a) Preparing ToR for the collection of financial information using TABUCS at district level;
b) Beginning the process of recruiting 6 financial data entry assistants for a), and
c) Updating the current TABUCS system to generate electronic financial monitoring reports (FMRs) from 31 earthquake affected districts.

In addition to expenditure monitoring, TA worked with MoHP to make additional financial resources available in earthquake affected districts through the new Social Health Insurance scheme. MoHP's Social Health Insurance Board was supported to develop plans to introduce the scheme and roll it out across the districts in question.

Assuring the availability of MNH services in earthquake impacted districts requires that both demand and supply side inputs are fully functional. This includes MoHP's demand side financing scheme – the Aama programme. Accordingly TA supported the development of a questionnaire to assess Aama functionality at facility level and the selection, appointment, training and deployment

of 14 field assistants. In addition ToR for the next Aama programme rapid assessment were finalised and advertisements placed for a third party to carry out this work. The assessment of bid submissions from third parties was subsequently completed.

2.5 Gender Equality and Social Inclusion (GESI)

An early priority activity for the GESI team was a rapid assessment of One Stop Crisis Management Centers (OCMCs) and Social Service Units (SSUs) in earthquake affected districts. OCMCs in Hetauda, Kathmandu, Dhulikhel, Baglung, Dang, Panchthar, Solukhumbu, Bardiya, Tanahu, Doti were contacted to better understand gender issues and vulnerabilities in the aftermath of the quakes and to identify support needed.

Similarly, SSUs in Bharatpur, Pokhara and Kathmandu were contacted and it became evident that SSUs had played a vital role in coordinating free, round-the-clock services in hospitals to earthquake victims. Visits to over a dozen facilities were made which indicated that the hospitals had been able to manage high patient loads, and even extended service availability through outreach camps, thereby improving access to services for those unable or unwilling to travel.

At national level, coordination and support was provided to several MoHP clusters and groups including gender based violence (GBV), mental health/psychosocial and protection in help finalise ToR, agenda, training content, the service directory (which describes services available to survivors such as case management, psychosocial, legal aid, safe houses) and provide details of referral pathways for survivors.

GESI perspectives were also incorporated in MoHP's District Health Sector Recovery and Revitalisation Plan and the longer term Health Sector Recovery Plan. These now include psychological first aid and mental health services and strengthening health system capacity to provide these services.

2.5.1 GESI Focal District Activities

At district level, the scoping of GESI activities (OCMCs, mental health and psychosocial counselling, Social Service Unit (SSU), Community Health Unit (CHU) and Equity Monitoring) and needs in focus districts (Ramechhap, Dolakha, Sindhupalchowk and in Kavre and Nuwakot) was completed. TA also facilitated workshops of district health and nutrition clusters to prepare integrated transition and recovery plans, including GESI activities, in Dolakha and Ramechhap districts. GESI related activities were also incorporated in Sindhupalchowk's DHO district plan supported by other external agencies.

OCMC and community health unit establishment and the strengthening of equity monitoring of health services were included in each of three focal districts' plans. Mental health and psychosocial counselling activities were planned in Ramechhap and Dolakha with NHSSP support and in Sindhupalchowk with the assistance of other agencies.

A scoping visit to Nuwakot for the establishment of an SSU in Trisuli Hospital was also made in the quarter with hospital management committee (HMC) members being oriented by advisers. The HMC subsequently submitted a letter to PPICD formally requesting SSU establishment.

Other district level TA activities related to psychosocial inputs included:

- Meetings with TPO to plan psychosocial support inputs including inputs into their HSTRP proposal
- District level support to TPO to harmonise their inputs with those of other NGOs
- Contracting of a national consultant to quality assurance psychosocial inputs in focal districts.
- Support to TPO for a first batch of training to prescribers in Ramechhap.

2.5.2 One-stop Crisis Management Centres

Sindhupalchowk:

- A one day orientation on GBV and OCMCs for members of the district GBV cluster was organised. This highlighted the requirements of safe homes for GBV survivors. EDPs committed to support establishment of a OCMC in a pre-fabricated building.
- A meeting with the DHO, DPHO, focal persons, WDO, UNFPA and Medicines Du Monde (MDM) and others was held for the establishment of an OCMC in the Chautara hospital. An appropriate site for an OCMC in prefabricated structure was identified. NHSSP will be responsible for the making of prefab structure.

Ramechhap:

- An OCMC will be established in Manthali PHC in a prefabricated structure.

Dolakha:

- An OCMC will be established in Charikot PHC following basic orientation to the DHO and others. A meeting was also held with the women's development office (WDO) and key stakeholders including UNFPA on the establishment of a safe home for GBV survivors.

<u>Other GBV Related Activities</u>

- NHSSP TA also worked with Population Division and UNFPA to roll out GBV clinical protocol training in the 14 worst affected districts. This training was carried out through ADRA with financial support from UNFPA.

- Forensic training for medical officers of OCMCs, SSUs and hospitals (including selected hospitals of disaster affected districts) was planned for September but was postponed until late November due to the political unrest, the blockade and resulting fuel shortages.

2.5.3 Community Health Units (CHUs)

- Following lobbying by TA, PHCRD approved the establishment of CHUs in the three disaster affected districts. The DHOs identified appropriate sites and NHSSP, which has budgeted for 8 CHUs in its three focal districts will provide 3 each in Dolakha and Ramechhap and 2 in Sindhupalchowk.
- In Sindhupalchowk, one of the sites will be in Kharigaun (Saling VDC) where a large number of internally displaced people (IDPs) (450 HH) are located. For this, the DHO will send a request letter to PPICD for a prefab construction to be provided by NHSSP.

2.5.4 Social Service Units

- Preliminary scoping of SSU establishment in Trisuli Hopital (Nuwakot) and Hetauda Hospital (Makawanpur) was completed. Orientation was conducted for key stakeholders and both hospitals decided to establish SSUs with December set as the target date for completion.
- The planned SSU scoping visit to Gorkha Hospital was postponed due to the fuel crisis.

2.5.5 Equity Monitoring

- Equity monitoring guidelines (approach, methodology and tools) were drafted and shared with PHCRD, which translated them into Nepali.

- Plans were made to carry out equity monitoring in the programme's three focal districts and potential local NGOs identified. In Dolakha, an NGO partner was selected with orientation of field monitors planned for late November.

2.5.6 Challenges Faced

- Fuel and transportation shortages have delayed trainings and equity monitoring activities across the board.

- The delivery of mental health and psychosocial services to disaster survivors is proving challenging as a result of prevailing attitudes and the stigma associated with those suffering from mental illness.

- Completion of the first round of skills development training in Ramechhap will take a few more months to complete. Similarly, OCMC and SSU establishment are delayed due to the late arrival of pre-fabricated structures.

2.6 Monitoring and Evaluation

2.6.1 Support HMIS e-reporting from health facilities

NHSSP advisers supported MoHP to conceptualize, develop guidelines for, coordinate and collaborate with development partners, to initiate HMIS e-reporting from health facilities in 14 earthquake affected districts from second quarter of 2015/16. Key factors include ensuring the availability of computers, electricity and internet connectivity, health worker training, operation, maintenance and regular supportive supervision and mentoring support. In this respect, NHSSP committed to provide intensive support for e-reporting in its three focal districts.

These inputs will help health facilities report electronically on a daily, weekly or as required basis, improve the quality of data and promote its use at local levels. This initiative may be seen as a key stage in MoHP's long term plan to move towards paperless 'e-recording and reporting'.

2.6.2 Strengthening of routine information systems, particularly HMIS in 31 affected districts

TA continued to support MoHP in the quarterly monitoring of key HMIS indicators and other routine information systems with a focus on the 31 earthquake affected districts. This is essential to help MoHP monitor outputs and outcomes of the T&R programme.

2.6.3 Support EDCD/DoHS in information management and surveillance in the recovery phase

Immediately following the 25th April earthquake, NHSSP supported MoHP to establish and operationalise a health information center in the Health Emergency Operation Center (HEOC). The symptomic disease surveillance system has now been taken over by the Epidemiology and Disease Control Division (EDCD) at DoHS but advisers are continuing to strengthen information management,

particularly related to the Early Warning and Reporting System (EWARS) which is now able to publish weekly EWARS bulletins.

2.6.4 Support MoHP in documentation of health sector response to the 2015 Earthquake

TA also supported MoHP to formulate and prepare ToR for a review of the effects of the earthquake on Nepal's health sector, the sector's response and lessons learnt. It is anticipated that findings from this review will help improve disaster preparedness and management in the event of another disaster. NHSSP is supporting MoHP to coordinate with partners to take this initiative forward.

2.6.5 Monitoring and Evaluation (M&E) plan for T&R Programme

As noted, NHSSP advisors supported MoHP for the design and implementation of Post Disaster Need Assessments (PDNAs) including in the NHSSP's three focal districts. These assessments helped inform MoHP's post-disaster transition and recovery plan including preparation of a monitoring plan and framework in coordination with partners supporting district level activities.

Accordingly an M&E plan was developed to monitor programme outcomes, outputs, and activities related to NHSSP's support to HSTRP. The plan lays out the indicators, data sources, frequency of data collection, and responsibilities for data collection. These are important to ensure coordinated data flow, data sharing and the supervision of activities.

2.6.6 Service Coverage this Quarter (Shrawan-Ashoj 2072/July-Oct 2015)

The table below shows the number of beneficiaries who utilized the listed services in the first quarter of the last and the running fiscal year (2071/72 and 2072/73), as reported by HMIS on 20 November 2015. HMIS provides annual target populations by selected age groups for each village development committee (VDC) and the health facilities use these target populations to monitor health service utilization in their catchment areas. Facilities are not provided with monthly targets.

The major target groups are:

- Total population
- 0 to 6 months
- 6 to 23 months
- 0 to 59 months
- Female population 15-49 years
- Married female population 15-49 years
- Expected pregnancies
- Expected live births

Health facilities are supposed to report to the district by the 7th day of the next month and districts are supposed to enter the data into the database by the 15th of the month, but a number of health facilities and districts do not comply with this requirement. Some facilities delay in sending the report and some districts delay in entering the data. Furthermore, updating the previous months' data in the database is a common practice as there are no strict provisions to prevent facilities and districts updating data after the specified reporting period has passed. Accordingly, the data

recorded in any given month in the central server may differ from that month's data at the district level when the report is generated in the following date/month.

Efforts to improve data quality by preventing health facilities and districts from updating data after the specified timeframe have not yet succeeded. This is only likely to be achieved when DHIS2 is implemented since this has a strict data validation and approval rule that prohibits modified data entries after the specified time frame has passed. Efforts are being made to implement DHIS2 at health facilities in the 14 earthquake affected districts and in all 75 districts at the district level from this fiscal year.

In the current context, the data recorded in a particular month in the central server may not reflect the actual service coverage data of a particular district/health facility in a particular period. This is mainly the result of under reporting, which may be due to the delay in reporting from health facilities, delays in entering data into the database at the district, or data modification in later months.

As shown in the table below, comparatively health service utilisation of selected services in the first quarter of the running fiscal year (2072/73) was lower than the first quarter of the previous year (2071/72). This does not necessarily mean the service coverage was less than last year but it may be because of under-reporting as described above. Improvements in service coverage for this period are expected to be seen in the next quarter. This type of data quality issue is expected to be resolved in the next few months when DHIS2 is effectively implemented in all 75 districts.

Number of beneficiaries of selected services in the first quarter of last and running fiscal year (2071/72 and 2072/73)

Indicator	FY 2071/72 Shrawan-Ashoj	FY 2072/73 Shrawan-Ashoj
Institutional delivery	93,110	26,600
SBA delivery	88,549	25,023
FP new acceptors	160,054	68,332
Children immunized against measles	130,274-1st dose 3,057- 2nd dose	52,898-1st dose 3,122- 2nd dose
Under five years children treated for diarrhea	772,244	300,699
Under five years children treated for pneumonia	28,7718	11,6033
Under five children who received Vitamin A in the last mass campaign	58,743	3,133
Total OPD cases	585,1741	242,6434

2.6.7 Key challenges

A major challenge faced in M&E is building common understanding among various stakeholders on M&E approaches and indicators, building MoHP ownership of processes and creating a collaborative working environment.

3 Payment Deliverables

The following deliverables were submitted in the reporting period:

PD #	Org'n	Description of PD
HI 1	HI	Work plan finalised and approved
TPO 1	TPO	Work plan finalised and approved
SIRC 1	SIRC	Work plan finalised and approved
TPO 2	TPO	Adaptation and translation of Mental Health Gap Action Plan Humanitarian Intervention Guide (mhGAP HIG) and other manuals for use in Nepal
SIRC 2	SIRC	Carer training programme reviewed and patient self-care manual updated and reprinted
HI 3	HI	14 Social Workers trained on comprehensive assessment of needs of the injured and mobilized in health facilities, step down facilities, OCMCs and during outreach in communities.
1	NHSSP	Detailed plan for repair, maintenance and rebuilding for three focal districts agreed with DHO/MoHP; detailed structural assessments for all 14 districts
2	NHSSP	1st Quarterly Progress Report (this report)
3.1	HI	Quarterly report - HI (annex to this report)
3.2	TPO	Quarterly report TPO (annex to this report)
3.3	SIRC	Quarterly report SIRC (annex to this report)
3.1	NHSSP	Consolidated Annual Procurement Plan (CAPP) prepared and submitted by LMD to MoHP on time (by October 2015) for FY 2015/16

Appendix 1: Quarterly Report: Handicap International

1.0 Introduction

Data gathered from the three main health facilities in Kathmandu treating earthquake victims showed that of the 1,005 patients who received care within 4 weeks of the earthquake, 71% (714) suffered from fractures, 8% (80) from spinal cord injuries and 4% (40) required amputations. Based on additional information from MoHP's Health Emergency Operation Center (HEOC) and sample data from hospitals and international organisations, it is estimated that between 1,500 and 2,000 patients require medium or long term nursing and rehabilitation support.

During the post-earthquake intervention period, health facilities in Kathmandu showed limited capacities to provide post-surgical care due to staff shortages in the areas of trauma management and rehabilitation. In terms of injury management and long term rehabilitation capacity, even specialised rehabilitation services in the Kathmandu Valley proved unable to cope with increased demand due to their low capacities and limited outreach to rural and remote communities in the worst affected districts.

A contributing factor here is the failure to integrate specialised rehabilitation services and community-based services within the rehabilitation health care cycle and this has created major challenges in post-trauma case management at facility level and in ensuring continuity of care at tertiary, district and community levels. Further, safe patient discharge and rehabilitation referral procedures - including for community based follow up services - are insufficiently developed.

Given the lack of capacity of medical teams for follow up, a number of discharged patients have failed to receive rehabilitation support and thereby increased the risks of severe complications, worsening disability and even death. In addition, the absence of an effective network of social support services at various levels to carry out comprehensive needs assessments (functional, emotional, social including basic needs such as shelter) and to support the most vulnerable (disabled, women, children and the elderly) through the rehabilitation process remains a major gap in health sector provisions.

2.0 Achievements against the Approved Plan

HI Nepal, as a service provider for a twelve month project "Rehabilitation Service Support in Earthquake Affected Districts" is implementing ten activities to achieve nine deliverables/milestones. The following progress is reported.

2.1 HI 1: Work plan finalized and approved

This deliverable was achieved through the following activities:

- HI staff assessed specific rehabilitation needs at health facility and community levels in working districts;

- Resources needed to address these needs in consultation and coordination with DHOs, facility staff and NHSSP advisers were identified;
- A costed work-plan describing proposed activities, their sequencing and implementation timeframes was prepared;
- A series of payment deliverables was identified against which contract payments will be made; and,
- The work plan was submitted to Options for subsequent DFID approval

2.2 HI 2: 14 district level trainings on injury management provided to 280 health professionals (including doctors, nurses and rehabilitation professionals).

The following progress was achieved:

- 8 out of 14 planned district level training courses for a total of 227 health professionals were completed in Dolakha, Sindhuli, Rasuwa, Nuwakot, Makwanpur, Dhading, Kavre and Gorakha Districts. The 6 remaining trainings could not be held as district health staff were occupied on the National Campaign for Mumps and Rubella and, during the latter part of the quarter, the fuel crisis prevented travel. These training courses have been rescheduled for December 2015.

- Technical, managerial and financial support was provided to the Disability Rehabilitation Focal Unit (DRFU) for the planning and delivery of district level injury management training including:
    - Formation of a Training Working Group (TWG) and coordination with stakeholders linked with injury/trauma management including hospital staff, health professionals and academics to finalise the curriculum for national and district level training manuals;
    - Preparation of participant selection criteria by the TWG;
    - Development of an integrated training programme with tools to assess participants' knowledge, skills and attitudes;
    - Organisation of a 3-day Master Training of Trainers (MToT) course at national level and 24 master trainers trained, and,
    - Coordination with district level health offices for planning and the selection and invitations to participants.
- 5 senior officials from MoHP (including the Central Regional Health Director, Director of National Health Training Centre, Director of Leprosy Control Division, Representative PHC Revitalisation Division and Section Officer of Curative Division/HEoC observed the trainings for monitoring purposes;
- Staff from DRFU, NHTC, Regional Health Directorate (Central) participated in the training to monitor training quality. Feedback from the participants was very positive in all districts with several participants noting that this was the first time they had received training of this kind which they felt was essential, as they regularly see trauma cases (e.g. victims of road accident victims or those who have fallen from trees while cutting fodder).

2.3 HI 3: 14 social workers trained on comprehensive assessment of needs of the injured and mobilized in health facilities, step down facilities, OCMCs and during outreach in communities.

This activity was completed in the reporting period with 14 social workers recruited and trained, 13 of whom have now been deployed. The training report was submitted in November. This activity involves the following:

- A vacancy announcement was made and 20 out of 835 applications were short-listed. 14 social workers were recruited in accordance with HI Nepal's HR policy. 1 social worked subsequently resigned and a replacement is expected to be in place by mid-December.
- A comprehensive training package for social workers comprising two 3-day modules was developed with the following content:
    - Comprehensive assessment of injury and trauma management - head injury, fracture, spinal cord Injury, burn, poly-trauma, mental health and psychosocial support linked to rehabilitation services; orientation on personalised social support approach;
    - Orientation for conceptual clarity and skills for psychosocial counseling to patients and their care takers;
    - Orientation on assistive devices including wheelchair services;
- An exposure visit was also organised to two rehabilitation centres – the National Disabled Fund (NDF) and Spinal Cord Injury Rehabilitation Centre (SIRC) to allow participants to better understand rehabilitation care and referral pathways for specialised services.

2.4 HI 4: 7 health facilities are equipped with rehabilitation and physiotherapy supplies and have functional PT units continuously providing rehab care to people with injury/ functional limitation

- 6 health facilities were identified and staffed with 7 physiotherapists (2 for the trauma centre at Bir Hospital, Kathmandu) and 13 social workers.
- The initial 7 health facilities included 3 Hospitals in Kathmandu: the trauma centres at Bir Hospital, Patan Hospital and Tribhuwan University Teaching Hospital (TUTH). However later assessments showed that both Patan Hospital and TUTH were not in need of additional human resources. Patan just needed the replacement of some essential equipment, which was supplied. Staff are currently exploring the need for Dhading District Hospital.
- 5/7 health facilities (Rasuwa, Nuwakot, Sindhupalchowk and Kathmandu) have now been equipped with equipment for the 2 remaining health facilities (Charikot and Jiri in Dolakha District) stuck in Kathmandu due to the on-going fuel crisis.
- Staff also carried out a rapid needs assessment to gauge the quality and quantity of rehabilitation and physiotherapy supplies needed in consultation with HI Nepal's rehabilitation and technical coordinator and logistics managers;
- Planned procurement, purchasing and delivery of rehabilitation and physiotherapy supplies to the respective hospitals was carried out;
- Coordination meetings with DHOs, hospital development boards were held to assess the feasibility of setting up physiotherapy units including the availability of space within hospital compounds, or by using tents as appropriate;

- Staff handed-over and installed the therapeutic equipment in hospitals
- 7 physiotherapists were recruited and deployed; two plus three social workers were deployed at the National Trauma Centre, Bir Hospital.
- Orientation and refresher training to physiotherapist was organized on the use and maintenance of equipment;
- Standard Operating Procedures (SOP) covering assessment, follow-up, goal-setting and planning tools were upgraded and orientation on their use provided to project and hospital staff;
- Staff supported physical rehabilitation services from Hospitals ensuring severity-based follow-up through in/out patients departments, community outreach and home visits;
- Staff also continued to facilitate appropriate referrals and follow-up processes in district hospitals and primary health care facilities linking with the network of existing rehabilitation centres and specialised hospitals; and,
- HI Nepal's project coordinator, rehab technical coordinator, head of operations and logistics manage made four technical and managerial supervision and support visits to Rasuwa, Nuwakot, Dolkha and the National Trauma Centre.

2.5 HI 6: Harmonized assessment, referral forms and referral pathways in place

Work on this deliverable began in the reporting period with the following forms being developed with technical support from HI's rehabilitation coordinator and senior physiotherapist:

- Physiotherapy assessment form;
- Social worker assessment form;
- Treatment card;
- Follow-up card and
- Referral card (adapted from the referral card developed by MoHP just after earthquake);

- These tools were tested at service delivery points and feedback incorporated during finalisation;
- A database format for data management was developed by HI Nepal's M&E officer;
- Information was disseminated to project team members on referral pathways for those with injuries and disabilities requiring specialised and tertiary care and rehabilitation;

2.6 HI 7: 1600 patients and care givers (including 600 caregivers) are trained on proper care and sensitised on the benefits of rehabilitation to ensure a proper follow-up and referrals

Activities for this deliverable have begun with a total of 427 beneficiaries (83 of whom are direct earthquake injured) having had an initial assessment for service delivery and 158 care givers sensitised on the benefits of rehabilitation.

2.7 HI 8: 1000 patients with injuries and persons with functional limitations affected by the earthquake re-trained on proper care and sensitised on the benefits of rehabilitation to ensure a the proper follow-up and referrals

Activities for this deliverable have also begun with a total of 427 beneficiaries (83 of whom are direct earthquake injured) having had an initial assessment for service delivery. Of this total 39 are persons with amputations requiring long term physical rehabilitation services.

2.8 HI 9: MoHP Disability and Rehabilitation Focal Unit (DRFU) has taken over work from HI.

The activity has begun as summarized below:

- Right from project inception HI has worked closely with DRFU, and in particular the Sr. Public Health Officer as focal point, to support the coordination and implementation of activities;
- Several group and bilateral meetings were conducted to develop the training manuals, plan and organise MToT courses and develop district training and DRFU strategy development;
- HI Nepal deployed a admin and logistics assistant (from Aug 2015) to provide coordination and management support to DRFU and provided essential office equipment and communication support;
- The costs of MoHP officials monitoring training courses were supported; and,
- To date, 8 district level training events and one MToT in KTM have been held. The DRFU supported event coordination, communications, management and monitoring of district level training.

2.9 Constraints and Challenges

To date the fuel crisis has led to the postponement of 6 district level training course and delays in delivering physiotherapy equipment and assistive devices to 2 health facilities in Dolakha District.

Appendix 2: Quarterly Report – Spinal Injury Rehabilitation Centre (SIRC)

2.1 SIRC 1: Finalised and Approved Workplan

The HSTRP is enabling SIRC to provide free, comprehensive medical and rehabilitation services to people based on individual needs and circumstances. Patients with spinal injuries are best managed in a specialized facility having the capacity to manage injuries and provide appropriate rehabilitation. The services provided will help ensure that the patient can regain maximum levels of functional independence.

In order to work effectively under the programme a detailed workplan has been prepared and submitted for approval. This has been taken into use to plan and direct overall project activities. Further, it has guided SIRC staff in understanding how the project will be implemented and facilitated efforts to keep project activities on track. The timeframe of project activities is seen to be helpful in completing various deliverables on time.

2.2 SIRC 2: Carer training programme reviewed and patient self care manual updated and reprinted

Given the remote, rural settings in which many earthquake victims and other patients live, it is important to recognize the instrumental role played by family members in providing a continuum of care to patients. Critical to their abilities to do this is the development of an understanding on the needs and fears of family members as patients transition back to their communities.

Through SIRC's comprehensive carer training programme, knowledge, skills and confidence in supporting and managing rehabilitation of loved ones will be advanced. Greater awareness of different aspects of the condition will help them understand their role and its impact on the patient. Carer training is also intended to provide opportunities to problem-solve, to reduce stress levels and empower family carers and those they look after. An emphasis on practical knowledge helps carers build core skills in the management of patient health and complication prevention.

During the reporting period, the carers' training program was reviewed as planned and is now being implemented. Feedback from participants has been very positive. The patient self-care manual has been updated and will be printed in early December. Up to November 15 2015, 51 carers had been trained by a multi-disciplinary SIRC team including doctors, nurses, therapists, social workers and psychologists.

2.3 SIRC 3: Individual needs assessment carried out for each person admitted to SIRC-using standardized quality assessment tools including ASIA score and SCIM

Ongoing needs assessments are carried out for each person admitted by SIRC's multi-disciplinary team. Updated records help staff to keep track of patients and provide comprehensive patient records. SIRC's well-developed data collection systems, assessment and outcome measurement tools collect information on the physical, psychological, social and economic status of each patient. An initial individual assessment is completed for each patient and this forms the basis for short,

medium and long term goal planning and the care pathway for each patient with the goal of healthy and integrated living in the community. The assessment and goal setting form the base line against which levels of physical and psychological well-being and socio-economic inclusion can be assessed.

2.4 SIRC 4: National and District Level Trainings to Health and Rehabilitation Professionals in Coordination with HI.

Preparations for hands on practical SCI training for 60 hospital staff including doctors, nurses, counselors and therapists from 5 district hospitals in affected focal districts were completed and training scheduled for November. In addition comprehensive training on "basic principles of neuro-rehabilitation" for 50 nurses at five focal districts, also in November. The courses also aim to support the development of appropriate systems of care for people with SCI in district hospitals and the development of referral pathways from district hospitals to specialized hospitals and rehabilitation centers.

2.5 SIRC 5: Caretakers program for 100 caretakers

This activity aims to train caretakers in batches of 20 to 30 over four days. The training will be provided in November by teams comprising nurses, physiotherapists, peer counselors, social workers, psychologists and occupational therapists. The curriculum covers the following:

- Educating family members and the caregiver on the prevention of SCIs.
- Identifying complications, preventions and management of SCIs.
- Building better relationships between the patient and his/her family.
- Personal care techniques, including proper bathing and lift-and-carry techniques.
- Recognizing early warning signs of health issues and illnesses.
- Meeting the physical and nutritional needs of care recipients.
- Emotional support and wellness issues.
- Maintaining one's health and wellbeing as a caregiver.

2.6 SIRC 6: Follow-up home visit services support for 200 ex-patients of SIRC living in affected districts

In the reporting period, SIRC employed 5 community out-reach workers to cover earthquake affected districts. Each of these community based rehabilitation (CBR) workers received SIRC training for two days. Each trained CBR worker is now responsible for a district and required to follow up on at least 15 patients per month. To date, 42 follow up visits have taken place. The CBR workers are currently in Sindhuli, Nuwakot, Kavre, Gorkha and Ramechhap.

During home visits, the CBR workers provide specialized training and education and are trained to use catheters if required. These visits are complemented by telephonic follow-up, advisory and information service. In addition to continuing with home visits referrals to other services are made. In this regard the SIRC team is working closely with HI to establish a 2 way referral system in each focal district for physiotherapy and social work case management support.

2.7 Constraints and Challenges

Fuel and transportation shortages are constraining most project activities including the follow up of patients and training courses. This has effectively limited follow up visits to those living in the Kathmandu Valley only.

Appendix 3: Quarterly Report - Transcultural Psychosocial Organisation

In the reporting period, several activities for the successful initiation of the project were carried out. Key activities included arrangements for project establishment, adaptation of the mental health Gap Action Programme-Humanitarian Intervention guide, finalization of training curricula, training health workers and conducting coordination meetings with the concerned stakeholders. More detail about these activities is elucidated below:

3.1 Work Plan and Project Establishment

This is one of the key activities conducted in this quarter. As per the government of Nepal's rules and regulations, all NGOs should receive approval from Social Welfare Council in Kathmandu and from District Development Committee and Chief District Office. Similarly, office set up, orientation and project inception in the respective districts are important for effective implantation of the project. Major activities conducted under this milestone are as below:

- Project agreement between TPO Nepal and Options on 4th September 2015
- Project approval from Social Welfare Council, respective District Development Committee (DDC) and Chief District Office (CDO)
- District offices have been set up in both districts
- Staff recruitment (Project manager, project officer, consultant psychiatrist, district coordinator, clinical supervisors)
- Community psychosocial workers have been hired and mobilized in Nuwakot district
- Program Sharing with district level stakeholder have been accomplished

3.2 PD 2: Adaptation of Mental Health Gap Action Program (mhGAP) Humanitarian Intervention Guide (HIG)

mhGAP-HIG is the key intervention guide we will be using in our program; therefore, contextualization of the guidelines into Nepali context is essential. Contextualization includes revision of the symptoms of different disorders as per Nepal context; highlighting how Nepali communities express their mental health problems; existing coping mechanisms and referral center in case of emergency. At the present, mhGAP HIG has been translated and contextualized by a group of Nepali psychiatrists, who had received 5 days training of trainers, and supervisors in early July 2015. Key activities conducted under this milestone includes:

- mhGAP HIG translated in Nepali
- Contextualized mhGAP HIG based on PRIME experiences
- Post-Traumatic Stress Disorder (PTSD) has been added in the PRIME module
- Drugs have been modified on the free drug list
- Local idioms of distress have been

3) Training curriculum, manuals and training materials finalized

As mental health is not included in the existing government training manual of the primary health care workers, we contextualized PRIME training content to use in the emergency. This includes 8-days training curriculum for prescribers (i.e. medical officers, health assistants, community medical assistants) and 3-days curriculum for non-prescribers (e.g. staff nurse, auxiliary nurse mid-wives). In addition to this, we also developed training materials such as powerpoints, and adapted training videos from mhGAP training guidelines. Key activities under this output includes:

- Training content developed and finalized
- Training materials (in powerpoints) have been developed and finalized
- Adapted mhGAP training videos (especially role plays and consultation with patients) in Nepali
- All training manuals and materials have been reviewed and approved by NHSSP's consultant psychiatrist

4) Training of health workers initiated

Capacity building of primary health care (PHC) workers is one of the key project activities; therefore, we initiated training of PHC workers in Ramechhap in this reporting period. This will be continued after Tihar holidays in both Ramechhap and Dolakha districts.

- Training of prescribers in Ramechhap conducted between 2 to 9 November 2015
- Training was initiated with a short formal program where key district level stakeholders including DHO, LDO, CDO etc were invited in the program
- Twenty four health workers including medical doctors from 20 health facilities attended the training
- Training was divided into two parts i.e. 5 days for disorder specific training following mhGAP intervention guide and 3 days for basic psychosocial support
- Training was led by two TPO Nepal's consultant psychiatrists in support with NHSSP consultant psychiatrist
- Pre-post assessment was conducted to evaluate the effectiveness of the training and to assess psychosocial competencies of the trained health workers.

5) Coordination with partner organizations and other concerned stakeholders

Coordination and networking with partner organizations and other concerned stakeholders is one of the important indicators for effective implementation of any program. In addition to this, mental health and psychosocial support (MHPSS) is a cross cutting issue; therefore, coordination with District Health Office (DHO), and organizations working in the emergency is one of the main project activity conducted in this reporting period. Below is a list of activities conducted under this milestone.

- District level orientation among key district stakeholders has been conducted in Dolakha
- District level planning meeting with DHOs have been accomplished in both districts
- Project inception in both districts along with NHSSP

- Regular participation in health and protection cluster meeting
- Meeting with different organization working in the emergency
- Conducted a 3-days training on psychosocial and mental health among HI's field mobilizers

Constraints and Challenges

- Delays in receiving project approval from SWC, and respective DDCs and CDOs
- Difficult to travel to the project districts and initiating project activities due to fuel crisis
- Lack of support from District Health Office Dolakha due to lack of clarity in the project modality (i.e. nature of collaboration between TPO Nepal and NHSSP and between NHSSP and MoHP)
- Delay in initiating training program due to several ongoing training program in both districts

Likely associated risks in the coming quarter include

- If NHSSP or MoHP do not clarify the project modality and key project activities to DHO Dolakha immediately then there will be more delay in initiating training of PHC workers in Dolakha district.
- If the current fuel crisis remains the same, then there will be a huge problem to continue training program and initiate community level activities such as mobilization of community psychosocial workers (CPSWs), initiating community orientation programs, FCHV's training and drug procurement.
- Possible delay to accomplish capacity building activities (i.e. training programs) due to several ongoing training in both districts.