

Health Sector Transition and Recovery Programme

THIRD QUARTERLY REPORT

February – April 2016

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NHSSP

Health Sector Transition and Recovery Programme

This report is submitted in accordance with the Health Sector Transition and Recovery Programme's (HSTRP's) payment delivery (PD) schedule, specifically NHSSP PD 7: 3rd Quarterly Progress Report including:

- HMIS Service Utilisation Reports (with comparison for last year for SBA/institutional delivery, FP new accepters, immunization, total OPD clients, total under-five children treated for diarrhoea and pneumonia and supplemented for vitamin A)
- Review of progress against Consolidated Annual Procurement Plan
- Progress against PDs and plan in case of any deviation.

The submission further meets the quarterly reporting requirements of the HSTRP's three implementing partners: Handicap International (HI 6.1); Transpersonal Psychosocial Organization (TPO 6.2) and the Spinal Injury Rehabilitation Centre (SIRC 6.3).

While HSTRP is funded by the UK government's Department for International Development and implemented through Nepal's Ministry of Health, the views expressed in this report do not necessarily reflect those of the UK or Nepal governments.

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List of Acronyms

AA	anaesthetic assistant
ANC	ante-natal care
ANM	auxiliary nurse midwife
ASBA	advanced skilled birth attendant
AWPB	annual work plan and budget
BC	birthing centre
BME	bio medical engineer
CAPP	consolidated annual procurement plan
CBR	Community Based Rehabilitation
CDO	chief district officer
CEONC	comprehensive emergency obstetric and neonatal care
CHD	Child Health Division
CHU	community health unit
CMC	case management committee
CMS	contract management information system
COFP/C	comprehensive family planning/counseling
CPR	contraceptive prevalence rate
CPSW	community psychosocial worker
C/S	caesarian section
CYP	couple years of protection
DC	direct contract
DCC	district coordination committee
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)
DLI	disbursement linked indicators
DoHS	Department of Health Services
DRFU	Disability and Rehabilitation Focal Unit
DoWC	Department of Women and Children
DSF	demand side financing
DUDBC	Department of Urban Development and Building Construction
EDP	external development partner
EDCD	Epidemiology and Disease Control Division
EHCS	essential health care services
EHR	electronic health records
EOC	emergency obstetric care
EM	equity monitoring
EQ	earthquake
EWARS	early warning and reporting system
FA	financial aid
FCGO	Financial Comptroller General's Office
FCHV	female community health volunteer
FEP	follow up enhancement programme
FHD	Family Health Division

FMIP	Financial Management Improvement Plan
FMR	Financial Monitoring Report
FP	family planning
FY	fiscal year
GBV	gender-based violence
GESI	gender equality and social inclusion
GiZ	Deutsche Gesellschaft für Internationale Zusammenarbeit
GoN	Government of Nepal
H4L	Health for Life
HF	health facility
HFOMC	health facility operation and management committee
HI	Handicap International
HISP	Society for Health Information Systems Programmes
HMIS	Health Management Information System
HP	health post
HPP	health policy and planning
HQIP	hospital quality improvement process
HR	human resources
HSTRP	Health Sector Transition and Recovery Programme
ICB	international competitive bidding
IEC	information and education communications
IMP	implant
IP	infection prevention
IRSC	Injury and Rehabilitation Sub Cluster
IUCD	intra-uterine contraceptive device
JAR	Joint Annual Review
JCM	Joint Consultative Meeting
JFA	Joint Financing Agreement
JICA	Japan International Cooperation Agency
KOICA	Korea International Cooperation Agency
LARC	long acting reversible contraceptive
LMD	Logistics Management Division
MA	medical abortion
MDM	Medicines du Monde
MEC	medical eligibility criteria
mhGAP	mental health gap action programme
MHPCS	mental health and psychosocial counseling services
MNH	maternal and neonatal health
MoH	Ministry of Health
MoWCSW	Ministry of Women, Children and Social Welfare
MPDR	maternal and perinatal death review
MPDSR	maternal and perinatal death surveillance and response
MSI	Marie Stopes International
MToT	master training of trainers
NCB	national competitive bidding
NHFS	Nepal Health Facility Survey
NHRC	Nepal Health Research Council
NHSP-2	Second Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre

NNBC	Nepal National Building Codes
NPC	National Planning Commission
NSI	National Statistical Institute
NSV	non-surgical vasectomy
OAG	Office of the Auditor General
OCMC	one stop crisis management centre
OPD	out patient department
OPM	Oxford Policy Management
OPMCM	Office of the Prime Minister and Council of Ministers
P&O	prosthetics and orthotics
PDNA	post disaster needs assessment
PFM	public financial management
PHAMED	Public Health Administration, Monitoring and Evaluation Division
PHCC	primary health care centre
PHCRD	Primary Health Care Revitalisation Divison
PNC	post-natal care
PPICD	Policy, Planning and International Planning Division
PPMO	Public Procurement Management Office
QI	quality improvement
QIC	quality improvement committee
QoC	quality of care
RA	rapid assessment
RHTC	regional health training centre
SA	social audit
SBA	skilled birth attendant
SIRC	Spinal Injury Rehabilitation Centre
SOP	standard operating procedures
SN	staff nurse
SSU	social service unit
TA	technical assistance
TABUCS	Transaction Accounting and Budget Control System
TPO	Transpersonal Psychosocial Organisation
TARF	Technical Assistance Response Fund
TWG	technical working group
UNICEF	United Nations Children's Fund
UNFPA	United Nations Family Planning Association
UOO	University of Oslo
USAID	United States Agency for International Development
VDC	village development committee
VP	visiting provider
VSC	voluntary surgical contraception
WDO	women's development office
WHO SEARO	World Health Organisation South East Asia Regional Office

1.0 Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit its third quarterly report for the period February to April 2016 under the Nepal Government Ministry of Health's (MoH's) Health Sector Transition and Recovery Programme (HSTRP).

In July 2015, as part of its multi-sector earthquake response, DFID provided GBP 6 million of financial aid (FA) to MoH for the delivery of 'Transition and Recovery of Nepal's Health System in Post-earthquake Situation'. DFID contracted Options Consultancy Services, UK, to provide service delivery support and technical assistance (TA) to the programme at a cost of GBP 4.15 million. The HSTRP builds on DFID's FA and TA support to NHSSP2, since July 2010, to help MoH implement its Nepal Health Sector Programme (NHSP-2, 2010-15) and both programmes (NHSSP2 and HSTRP) ran concurrently from July 2015 to January 2016 and beyond.

In March, the team took part in the NHSSP2 Project Completion Review (PCR) providing detailed presentations and participating in questions and answer sessions, facility and district field visits, and follow up meetings (result achieved A+) and the Family Planning Annual Review (result achieved A).

During this period the team also provided support to a visit from the DFID Internal Audit Department including making a presentation on fiduciary risks and controls in place and demonstrating the Transaction Accounting and Budget Control System (TABUCS) in district facilities in early March.

Also in the same month (15th – 16th March) the HSTRP team supported the MoH in preparations for a two day Joint Annual Review (JAR) with external development partners (EDPs). This involved several key advisers developing the comprehensive main JAR report, helping draft the agenda and developing presentations for senior government counterparts. These covered (i) the overall direction under the new Nepal Health Sector Strategy, including the new NHSS results framework; (ii) post-earthquake reconstruction and recovery and the way forward, and (iii) progress in infrastructure, procurement, public financial management, gender equity and social inclusion; (iv) results achieved and use of evidence, (v) programme implementation progress, challenges and lessons learned. Following the JAR, selected advisers supported MoH finalize the Aide Memoire.

As part of the two programmes running concurrently and a strong push by the team to submit all but one NHSSP2 dissemination payment deliverable before the project end date of the 23rd December 2015 (later extended to 23rd January to allow dissemination) along with other deliverables under the HSTRP, 5 NHSSP2 payment deliverables submitted earlier were approved with minor changes in February and March.

Under this 12 month programme, Options is partnering 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)).

The programme aims to restore essential health care services, including obstetric care, family planning, physical rehabilitation, and psychosocial support in the 14 worst earthquake affected districts with a focus on Ramechhap, Dolakha, and Sindupalchowk districts. HSTRP's three NGO partners are providing further rehabilitation and psychosocial services in Nuwakot, Kavre, and Rasuwa.

Immediately following the earthquakes, MoH prioritised emergency services, medical evacuations and the supply of essential medicines and goods to the hardest hit areas. District level post-disaster needs assessment (PDNAs) were then undertaken as a basis for district and national level planning, supported by external development partners (EDPs), in order to restore health services in the 14 worst affected districts.

A summary of planned HSTRP inputs by thematic areas and districts is given below:

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

HSTRP's implementation plan was approved by MoH on September 2nd 2015. Later that month Nepal's new Federal Constitution, eight years in the making, was approved but protests related to new state boundaries and ethnic representation led to a five month blockade with India. This created shortages of essential supplies and transportation across the country and limited the abilities of staff to travel to districts and of patients to travel to health facilities for treatment. These difficulties eased mid way through the reporting period allowing the pace of programme implementation to increase.

The DFID project log frame for HSTRP gives its intended outcome as:

'The expanded availability of essential health services including rehabilitation and psychosocial services.'

There are three outputs:

1. Restore functionality of health facilities to deliver essential health care services
2. Access to psychosocial and rehabilitation services by people in earthquake affected districts, and
3. Restoration of the health system's capacity to plan, manage and monitor post-earthquake health and wellbeing needs.

The activities of the combined TA team, including implementing partners, cover the following technical areas:

- Essential health care services
- Family planning
- Infrastructure
- Procurement and supply chain
- Health finance/public financial management
- Value for money
- Health policy and planning
- Gender equality and social inclusion
- Monitoring and evaluation
- Psychosocial support
- Physical rehabilitation support

Section 2 (NHSSP) and the appendices (partners) of this report provide progress updates against these thematic areas, as related to MoH and DFID approved workplans and payment deliverables. Other important activities, many continuing from NHSSP phase 2 and having a strong bearing on NHSS 2015-20, and are also described.

In addition to programme support, a technical assistance response fund (TARF) is available to MoH divisions and centres and DHOs. In the reporting period, three applications were received for:

1) Detailed engineering design for Logistic Management Divisions (LMD's) stores in Teku and Pathalaiya
2) A study on C-sections in Nepal from the Department of Health Services (DoHS), and
3) The monitoring of post disaster reconstruction and recovery activities including health infrastructure assessments in 17 additional earthquake affected districts from MoH's Policy, Planning and International Coordination Division (PPICD).

Comments from DFID on these requests to use TARF had not been received at the end of the reporting period.

2. Detailed Quarterly Updates (NHSSP)

2.1 Essential Health Care Services

2.1.1 Support to expand effective comprehensive emergency obstetric and neonatal care (CEONC) services with an emphasis on the 14 earthquake affected districts

Support to FHD to expand and strengthen CEONC services in earthquake affected districts continued by way of (i) on-site visits and assistance in recruiting service providers for selected facilities; (ii) tracking service functionality and human resource (HR) status at facilities, and (iii) informing FHD's director, and thence the Department of Health Services' (DoHS) Director General, of recommended supportive actions.

In the 14 districts, nine (Kathmandu, Lalitpur, Bhaktapur, Kavre, Dolakha, Sindhuli, Okhaldhunga, Nuwakot and Gorkha) continued to successfully provide C-section services. Within these, continuity of CEONC services in Nuwakot district hospital was maintained by recruiting a locum doctor.

Recently resumed CEONC services at Dhading District Hospital had earlier been interrupted by staff transfers but were resumed with the appointment of short-term staff using NHSSP financial support.

In HSTRP focal districts, a new CEONC site was established at Manthali Primary Health Care Centre (PHCC) (Ramechhap) and two C-sections were carried out. In Charikot PHCC (Dolakha), 50 C-sections were carried out following establishment in January. This is the second facility in Dolakha now offering CEONC services (Jiri being the other one).

The planned establishment of CEONC services at Chautara hospital (Sindupalchowk) was delayed due to renovation work on the operating theatre and post-operation rooms. In Rasuwa, FHD decided to start CEONC services in FY 2016/17 only. C-section services are now available in 61 out of 69 'official' CEONC districts, up from 49 districts in early August 2015.

The CEONC mentor continued to support CEONC sites across Nepal primarily through a) ongoing monitoring of functionality and service continuity, b) supporting staff recruitment, c) trouble shooting service bottlenecks, and d) on-site visits and mentoring to improve clinical skills.

In the last programme quarter workshops on the hospital quality improvement process (HQIP), including infection prevention (IP), were held in Jiri Hospital and Charikot PHCC for 89 staff. The HQIP self-assessment tool was introduced, quality improvement committees (QIC) formed and quality improvement (QI) plans prepared.

In this quarter follow up support visits were made which revealed that 11 out of 12 planned IP actions had been implemented at Jiri hospital and 16 out of 18 at Charikot PHCC. However, more remains to be done to improve service quality. As reported last quarter, Charikot PHCC's self assessment showed that four of eight

quality domains scored “red” and only one “green”, while six out of nine CEONC signal functions scored “red” and only three “green”. The self-assessment at Jiri hospital showed similar results.

2.1.2 Support to resume MNH and FP services in three focal districts

Support to strengthen and quality improvement of strategic birthing centres and birthing centres in Ramechhap and Dolakha districts

Mirroring the QI process above, TA supported a three day on-site coaching programme in 26 birthing centres, including 12 strategic birthing centres, in Ramechhap district in February and March. 410 participants (127 health workers and 283 health facility operation and management committee (HFOMC) members) took part. The programme was also carried out in ten birthing centres in Dolakha district.

The coaching programme uses the health facility QI self-assessment and infection prevention approach outlined above including action planning, coaching and mentoring of clinical staff (skilled birth attendants [SBAs] and auxiliary nurse midwives [ANMs]) using the follow up enhancement programme (FEP) tools developed by the National Health Training Centre (NHTC). Local management and health workers then conducted self-assessments at health facilities focusing on MNH service availability, readiness and service provision practice using 13 QoC domains.

59 ANMs/staff nurses (SNs), including 33 SBAs from 26 birthing centres, participated in the programme which focused on delivery care and emergency obstetric care (EOC) complication management. Participants learned how to set up facilities and critical equipment and received various aides including a complications management flow chart and post-natal care (PNC) guidelines.

The first round follow up in Ramechhap district was completed in April 2016, a minimum of one month following the initial assessments. The following changes were recorded:

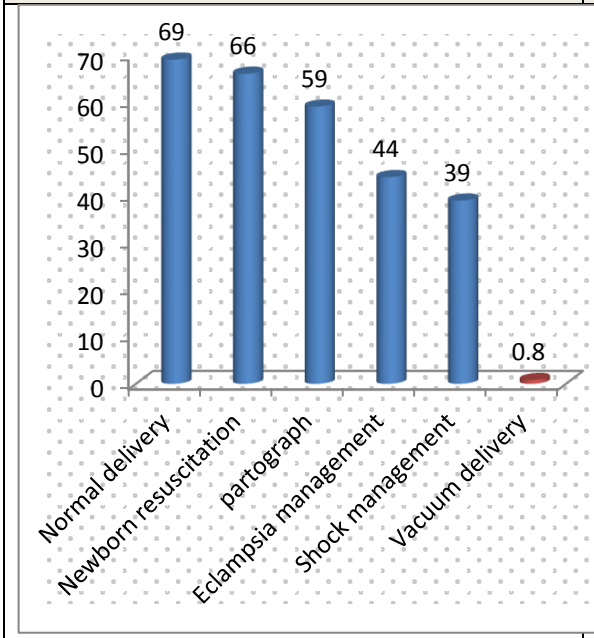
Table: Traffic light scores at baseline and follow up at 26 birthing centres in Ramechhap district

	Traffic Light Scores	Baseline	Follow Up
	Health facility quality assessment (MNH focus) – 338 scores		
1	Green	80	159
2	Amber	123	131
3	Red	135	48
	Infection prevention practices – 26 scores		
1	Green	6	24
2	Amber	10	2
3	Red	10	0

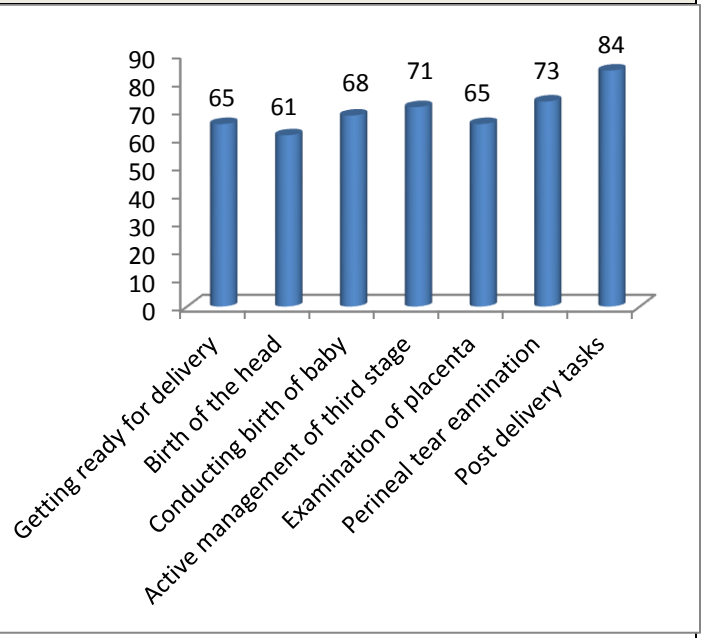
Of the seven signal function indicators related to service availability and readiness, green scores increased from 81 at baseline to 118 at follow up. This suggests that on-site coaching and mentoring has improved the availability and quality of MNH services in these facilities. However, continuous support and supervision is needed if improved practices are to be sustainable in the long term.

Of the eight clinical mentors providing BC/BEONC on-site coaching and mentoring, four were from Ramechhap and two from Dolakha. The following graph shows the baseline knowledge, skills/practices on the management of normal and complicated deliveries of the 33 SBAs from Ramechhap. It is normally expected that each SBA will score more than 80% in each knowledge and skills/practices area.

Percentage knowledge and skills on normal labour and complicated deliveries



Percentage skills and Practices on steps in management of normal labour (second and third stage)



The end line scores from Ramechhap will be reported in the next quarter.

Free referral from birthing centres to CEONC sites

In February, under the leadership of Dolakha's district health office (DHO) and supported by the district ambulance providers association (whose chairman is the chief district officer [CDO]), free referral transportation services for obstetric complications began between Charikot PHCC (birthing centre) and Jiri Hospital or Charikot PHCC (CEONC sites). Eleven out of fifteen referral-in obstetric complications cases in Dolakha benefitted from this service in the reporting period. In Ramechhap, a similar scheme began at the end of April. Both districts advertised the free referral provision on local FM radio.

Staff training for expansion of MNH/FP services at strategic birthing centres

In the reporting period 40 SBAs from birthing centers in Ramechhap (23) and Dolakha (17) received training on medical abortion (MA) service provision. MA certification of service providers and service sites is now being taken forward by NHTC and FHD.

Further, ten ANM/SNs from strategic birthing centres in these two districts began SBA training at Birganj hospital in early April and will complete in early June. The HSTRP Dolakha team also supported one batch of district level MNH update training for ANM/SNs in the quarter.

Support for equipment and supplies

Based on the district level coordinated transition and recovery plans, the programme provided critical equipment needed for improved delivery care at BCs in Dolakha (7) and Ramechhap (11) districts. Similarly, four BCs in Dolakha and 9 non-BCs in Ramechhap received IP equipment and supplies. All strategic birthing centres in the two districts received simple lab test kits (urine protein and urine sugar dip test; pregnancy test).

Support review, planning and budgeting of Family Health Division/Child Health Division (FHD/CHD) and others

The programme's EHCS advisers continued to support FHD to monitor MNH service availability and prepare service status updates. Support for planning and budgeting for fiscal year 2016/17, including needs and performance based budget allocations to districts, was also provided.

At the request of FHD, TA supported district level orientation on maternal and perinatal death surveillance reviews (MPDRS) implementation in Kailali and Banke districts and helped organise MoH's national annual review and several preparation meetings for the Joint Annual Review (JAR)..

2.1.3 Comparative data on service utilization (FY 2014-15 [2071/072] and 2015-16 [2072/073]) in focal districts

		Ramechhap		Dolakha		Sindupalchowk	
SN	Service	2014-15 (2071/72) (8 months)	2015-16 (2072/73) (8 months)	2014-15 (2071/72) (9 months)	2015-16 (2072/73) (9 months)	2014-15 (2071/72) (8 months)	2015-16 (2072/73) (8 months)
1	Total number of ANC 1st visit any time	1939	1895	2269	2269	2568	2463
2	Total number of ANC visit at 4th month	1422	1461	1822	1773	1904	1646
3	Total number of ANC 4th visit as protocol	1075	1052	1380	1299	1220	959
4	Total number of Institutional delivery	884	921	808	1180	743	780
5	Total number of Pills new acceptors	260	208	721	521	561	326
6	Total number of Depo new acceptors	1067	879	2440	2261	2196	1700
7	Total number of IUCD New users	83	149	87	60	182	145

8	Total number of Implant New users	272	1222	279	283	2717	1746
9	Total number of safe abortion service	165	82	155	110	102	114
10	Total number of C-section done at the district	0	1	22	113	0	0
11	Total number of children immunized with measles	1816	1991	2532	2640	3416	2500
12	Total number of U-5 children treated for diarrhoea[2]	8474	1456	2618	2738	14137	13601
13	Total number of U 5 children treated for pneumonia	3866	1843	2336	1932	6062	5131
14	Supplemented for Vit A (6-11 month)	2158	3112	1890	3530	2195	4352
15	Supplemented for Vit A (12-59 month)	15147	22615	12998	26906	16153	32025
16	Total number of OPD cases treated (New OPD Visits)	116951	110308	125876	134944	134316	147825
17	Total number of OPD cases treated (New and Repeated OPD Visits)*	124397	114518	137096	145457	165878	156449

Challenges

- Delays caused by external agencies working at district level failing to meet their commitments in implementing coordinated district plans
- Delays in infrastructure repair and rebuilding which are slowing improvements in service delivery and affecting staff morale
- The frequent transfer of staff and poor matching of skills with posts which are affecting the continuity of service provision e.g. posting an anaesthesia assistant at a PHCC and an SBA trained ANM at a non-BC facility.

2.2 Family Planning (FP)

2.2.1 Long Acting Reversible Contraceptive (LARC) Service Delivery and Onsite Coaching by Visiting Providers

Altogether six visiting providers (VPs) have been deployed in Sindhupalchowk, Ramechhap and Dolakha for LARC service delivery and on-site coaching. From February to April 2016, 583 women received implant insertion and 27 women received IUCD insertion services.

Table 1: Visiting Provider's service (February to April 2016)

SN	Name of District	Number of VPs	Number of Implant insertions	Number of IUCD insertions
1	Ramechhap	2	204	8
2	Dolakha	2	149	17
3	Sindhupalchok	2	230	2
	Total	*6*	*583*	*27*

Furthermore, five SBA trained health workers from Dolakha and two from Sindhupalchowk were coached in intrauterine contraceptive device (IUCD) insertion skills. In addition, VPs coached implant trained health workers in their workplaces. Similarly, trained health workers are also providing LARC service from their respective health facilities.

2.2.2 LARC service delivery by local service providers

Following capacity building and onsite coaching, government service providers initiated LARC services from their health facilities. The following table compares FP new acceptors in 3 focal districts with the previous year (Source HMIS). The number of implant new acceptors has increased in Ramechhap and Dolakha compared to same period in the previous year. IUCD new acceptors increased in Ramechhap but were lower in Dolakha and Sindhupalchowk than in the previous year. One should interpret these findings with caution since the number of reports received during the same period in current fiscal year is much lower than received during the same period in previous year, especially in Sindhupalchowk.

Table 2. Number of LARC new acceptors in 2014-15 (2071/72) and 2015-16 (2072/73) from mid July (Shrawan) to mid March (Falgun)

Districts	Reports received		# New Acceptors IUCD		# New Acceptors Implant		Remarks
	2014-15 (2071/72)	**2015-16** (2072/73)	**2014-15** (2071/72)	**2015-16** (2072/73)	**2014-15** (2071/72)	**2015-16** (2072/73)	
Ramechhap	453	443	83	149	272	1222	
Dolakha	453	437	68	57	216	219	
Sindhupalchowk	674	568	182	144	2,717	1,746*	*Reports from MSI for implant services in Sindhupalchowk included

2.2.3 Rehabilitation, Recovery and Strengthening/Expansion of Family Planning (FP) Services (with a Focus on Long-Acting Reversible Contraception - LARC) in 5 Earthquake Affected Districts.

As a result of the earthquake, wide scale displacement from homes, villages remaining isolated from services and pressure placed on the public health system, the delivery of regular FP services has been constrained resulting in women struggling to receive the FP services they need. Accordingly, FP services need to be strengthened to reach those in hard-to-reach/affected areas and in temporary settlements. Five priority districts have been selected on the basis of 1) FP support need (low contraceptive prevalence rate [CPR] and few health facilities providing 5 FP methods); 2) whether other FP support partners are present in the district and 3) recommendations from FHD's FP focal person. The proposed five districts are: Okhaldhunga, Sindhuli, Nuwakot, Lalitpur and Gorkha. Activities carried out in the 5 districts during this quarter are outlined below.

2.2.4 Capacity Building (Training and Onsite coaching to health workers)

During this quarter, 36 health workers were trained on implants (8-days competency based training from NHTC approved training sites) while 47 SBAs from 39 BCs received coaching/mentoring support on IUCD services by 15 VPs in 5 programme districts (Table 3). Forty six VP days were devoted to on-site coaching by 15 VPs in 5 districts with service providers. In order to coach some SBA providers from BCs having low client loads, VPs invited them to other sites with greater patient numbers. Of the total 47 SBAs coached/mentored on IUCD

insertion skills from 39 BCs, 23 SBAs satisfactorily performed IUCD insertion and were competent to insert IUCDs independently. The remaining 24 SBAs will be provided with further coaching.

LARC services have been started in BCs following coaching/mentoring, and service providers are happy to have their skills enhanced. In addition to IUCD coaching, VPs also coached 24 service providers on implant insertion/removal in 5 districts. Furthermore, VPs coached implant and IUCD trained service providers, from non-birthing centers, whenever necessary. In addition, 2 medical officers were trained on non-surgical vasectomies (NSV), one each from Okhaldhunga and Gorkha.

Table 3: Training and on-site coaching to health workers

Districts	Basic training on Implants (# health workers)	Onsite IUCD coaching (#BCs)	NSV training (# health workers)	Implant coaching (# health workers)
Lalitpur	**4**	**5**	**0**	**8**
Nuwakot	**6**	**4**	**0**	**3**
Okhaldhunga	**6**	**14**	**1**	**6**
Sindhuli	**4**	**7**	**0**	**3**
Gorkha	**16**	**9**	**1**	**4**
Total	**36**	**39**	**2**	**24**

2.2.5 Instruments and IEC materials support

Instruments and equipment along with some information and education communications (IEC) materials, based on needs assessment findings, were handed over to DHO stores in all 5 districts in March 2016. Altogether 200 IUCD insertion/removal sets and 309 implant insertion/removal sets were supplied to districts to ebable them to resume/strengthen implant/IUCD services (Table 4).

Furthermore, a total of 21 autoclaves (single drum electric autoclaves with surgical drums) for 21 BCs were supplied to districts in March 2016. Informed choice posters for Family Planning (n=294) were also supplied to districts. Store receipts from all districts acknowledging the arrival of instruments/equipment have been received. Based on needs assessment findings, each BC having trained service providers but lacking insertion/removal sets will receive 2 IUCD insertion/removal sets and 3 implant insertion/removal sets from the district store. Table 4 shows the instruments and IEC materials supplied to districts to date.

Table 4: Instruments, equipment and IEC materials supplied to districts

District	Number of BC	Number of IUCD sets	Number of Implant sets	Number of Functional Autoclaves supplied	Number of informed choice FP Posters

Lalitpur	18	22	30	1	40
Nuwakot	28	36	60	8	63
Okhaldhunga	37	58	87	5	56
Sindhuli	20	22	36	5	56
Gorkha	40	62	96	2	79
Total	***143***	***200***	***309***	***21***	***294***

2.2.6 LARCs service delivery by VPs

Fifteen VPs have been mobilized in 5 earthquake affected districts having low CPRs. Up to the end of April, 921 implants and 86 IUCD insertions had been provided by VPs which is equivalent to 3,895 CYP (Table 5). Approximately 1,007 people have been reached through VP's service during this quarter.

Table 5: LARC services provided by VPs in 5 programme districts

District	# of VPs deployed	Implant insertion	IUCD insertion	CYP
Lalitpur	**3**	**204**	**2**	
Nuwakot	**3**	**312**	**8**	
Okhaldhunga	**3**	**59**	**35**	
Sindhuli	**3**	**89**	**12**	
Gorkha	**3**	**257**	**29**	
Total	**15**	**921**	**86**	**3,895**

2.2.7 VSC+ Service

Sunaulo Pariwar/MSI Nepal has been contracted to deliver VSC+ services in 5 districts. Up to the end of April, pre-VSC meetings with FCHVs had taken place in 20 sites and 17 VSC+ camps had been run in 3 districts. Fifty minilaps (female sterilization), 22 NSVs, 157 implants and 10 IUCD services had been provided by the end of the reporting period (Table 6). A total of 239 people have been reached through VSC+ service. The detailed plan for VSC+ camps in 5 districts is shown in Annex 2 below.

Table 6: VSC+ camp progress until 30th April

District	SN	Name of Place	Camp Date From	Camp Date To	Performed Cases				Remarks
					TL	NSV	IMP	IUD	
Lalitpur	1	Bungmati	17-Apr-16	17-Apr-16	0	0	9	0	
	2	Manikhel	18-Apr-16	19-Apr-16	0	3	3	0	
	3	Lubhu	21-Apr-16	21-Apr-16	0	1	8	1	
	4	Bhattedanda	23-Apr-16	24-Apr-16	0	1	3	0	
	5	Ashrang	26-Apr-16	26-Apr-16	0	1	12	0	
	6	Thula Durlung	28-Apr-16	28-Apr-16	0	0	25	1	
	Sub-total				**0**	**6**	**60**	**2**	
Gorkha	1	Batase	17-Apr-16	18-Apr-16	0	0	12	0	
	2	Palungtar	20-Apr-16	21-Apr-16	2	1	4	0	
	3	DHO Hospital	23-Apr-16	25-Apr-16	6	3	3	1	
	4	Ashrang	27-Apr-16	28-Apr-16	1	0	8	0	
	Sub-total				**9**	**4**	**27**	**1**	

Sindhuli	1	Sirthouli PHC	11-Apr-16	12-Apr-16	11	0	0	0	
	2	Ranibas HP	14-Apr-16	15-Apr-16	11	3	29	1	
	3	Dudhouli HP	17-Apr-16	18-Apr-16	18	1	4	0	
	4	Gwaltar	20-Apr-16	21-Apr-16	0	0	10	0	
	5	Solphathana	23-Apr-16	24-Apr-16	1	4	9	0	
	6	Kapilakot	26-Apr-16	27-Apr-16	0	3	7	2	
	7	Belghari	29-Apr-16	30-Apr-16	0	1	11	4	
	Sub-Total				**41**	**12**	**70**	**7**	
	Total				**50**	**22**	**157**	**10**	

2.2.8 Challenges

- Stock outs of FP commodities such as implants in district stores and health facilities in some districts
- Insufficient numbers of insertion and removal sets to deliver implant services from HFs
- Frequent transfer of trained human resources
- Poor quality of recording and reporting
- Lack of instrument, IP materials in health facilities to start FP service after training
- Insufficient supervision and monitoring from NHSSP and DHO at health facility level
- Low demand for IUCD services and provider bias
- Low client flows in VSC+ camps due to the work

2.2.9 Recommendations

- Ensure an adequate supply of FP commodities based on demand
- HFs with trained human resources to be supplied with at least 3 Implant sets and 2 IUCD sets
- HR management systems to be made more systematic
- Data quality verification and onsite coaching to be promoted
- Community level awareness programmes to be carried out focusing on LARCs
- Proper planning of VSC+ camps with intensive demand generation activities

2.2.10 Technical Support at Central Level

NHSSP's FP team (FP advisor, M&E officer and FP Technical Officer) provided technical support to several DoHS divisions and centres as follows:

FHD/Service delivery/Enabling environment

- Support to FHD FP focal person for preparation of TRACK20 workshop and training
- Shared HSTRP FP monthly movement plan and tentative program budget with FHD Director
- Reviewed and submitted a revised version of the FP chapter of Management Division's Annual Report for 2014/15 (2071/72)
- FP PowerPoint presentation for Annual Review meeting reviewed, edited and submitted to FHD's Director
- Participated in national annual review meeting at Staff Administrative College, Jawalakhel
- Prepared presentations and participated in the DFID instigated FP (AWPB) Annual Review meeting at FHD with FHD and DFID representatives
- Provided technical support to finalise the FP component of FHD/DoHS' AWPB for 2015/16 (2073/74)
- Participated in a preliminary meeting to finalise on templates and dummy tables for the forthcoming National Demographic Health Survey (NDHS), 2016.

NHTC/Capacity development

- Reviewed the technical comments of the NSV training package

- Facilitated a session on the decision making tool (DMT) flip chart and WHO MEC wheel for regional health training centre (RHTC) trainers as part of the ToT on revised comprehensive family planning/counseling (COFP/C) training package
- Updated the FP knowledge of the COFP/C trainer from RHTC Pathalaiya and provided one set of WHO MEC wheel for training purposes.

LMD/FP commodity:

- Prepared FP commodity and equipment/instrument specifications and cost estimates for FHD which were shared with LMD.
- Facilitated a two days FP commodity and equipment/instrument specifications and costing meeting at FHD

Miscellaneous

- Shared knowledge update literature with FP Sub-Committee members
- Reviewed the FP chapter of the JAR report
- Participated in FP monthly meetings at DFID
- Reviewed and edited the ANM FP Supplementary Pre-service Manual revision at the request of the Council for Technical and Vocational Training (CTEVT) through Health for Live (H4L)/Research Triangle Institute (RTI) and participated in the finalization workshop

2.2.11 Photographs

<table>
<tr>
<td> 
Handover of Instruments in Okhaldhunga DHO store</td>
<td> 
VP coaching a local female service provider on implant insertion, HP, Sindhuli</td>
</tr>
</table>

Pre-VSC meeting at Municipality hall, Bidur, Nuwakot

Joint FHD/NHSSP monitoring visit to Bhattedanda VSC+ camp

2.2.12 Case Study

An SBA Trained Service Provider Who Prefers Evening Shifts For IUCD Coaching

Sita Karki (name changed), is a nurse at Lubhu PHCC Lalitpur. She trained as an SBA 5 years ago and received 8-days interval IUCD training from NHTC. However, she was not sufficiently confident to provide IUCD services. When VP Laxmi Acharya reached the PHCC and carried out her competency assessment using the IUCD QI tool, Sita lacked some key skills on both insertion and withdrawal. When the VP wanted to coach her on the same day, she was reluctant since she did not want her colleagues to know that she lacked IUCD skills, although she was eager to learn. She requested VP Laxmi to come during an evening shift so that she could learn when her colleagues were not around. The VP went to the HF at the requested time and provided coaching on a real client. Now, having received coaching, Sita has inserted 2 IUCDs on her own. She is very happy and thankful to the VP that helped her gain confidence on IUCD services.

Annex 2. NHSSP VSC+ camp Schedule

Camp Date	Lalitpur			Gorkha			Sindhuli			Okhaldhunga			Nuwakot		
	Place/Camp #	**# of days**	**Pre VSC**	**Place/Camp #**	**# of Days**	**Pre-VSC date**	**Place/Camp #**	**# of days**	**Pre VSC date**	**Place/Camp #**	**# of days**	**Pre VSC date**	**Place/Camp #**	**# of days**	**Pre VSC date**
11th April 16							Sirthouli PHCC (1)	Day 1	**5-Apr**						
12th April							Sirthouli PHCC	Day 2							
13th April 16															
14th April							Ranibas HP BC (2)	Day 1	**6-Apr**						
15th April							Ranibas HP BC	Day 2							
16th April 16															
17-Apr-16	Bungmati (1)	Day 1	11-Apr	Batase (1)	Day 1	9-Apr	Dudhouli HP BC (3)	Day 1	7-Apr						
18-Apr-16	Manikhel (2)	Day 1	14-Apr	Batase	Day 2		Dudhouli HP BC	Day 2							
19-Apr-16	Manikhel	Day 2													
20-Apr-16				Palungtar (2)	Day 1	11-Apr	Gwaltar HP BC (4)	Day 1	10-Apr						
21-Apr-16	Lubhu (3)	Day 1	17-Apr	Palungtar	Day 2		Gwaltar HP BC	Day 2							
22-Apr-16															
23-Apr-16	Bhattedanda (4)	Day 1	18-Apr	District Hospital (3)	Day 1	14-Apr	Solphathana HP BC (5)	Day 1	8-Apr						
24-Apr-16	Bhattedanda	Day 2		District Hospital	Day 2		Solphathana HP BC	Day 2							
25-Apr-16				District Hospital	Day 3										
26-Apr-16	Ashrang (5)	Day 1	19-Apr				Kapilakot PHCC (6)	Day 1	19-Apr						
27-Apr-16				Ashrang (4)	Day 1	21-Apr	Kapilakot PHCC	Day 2							
28-Apr-16	Thuladurlung (6)	Day 1	20-Apr	Ashrang	Day 2										
29-Apr-16							Belghari PHCC (7)	Day 1	22-Apr						
30-Apr-16				Sirdibas HP (5)	Day 1	24-Apr	Belghari PHCC	Day 2							
1-May-16	Manikhel (Repeat)	Day 1		Sirdibas HP	Day 2										
2-May-16															
3-May-16	Ashrang (Repeat)	Day 1		Machhakhola HP (6)	Day 1	26-Apr				Fulbaari HP (1)	Day 1	24-Apr			
4-May-16				Machhakhola HP	Day 2					Fulbaari HP	Day 2				
5-May-16															
6-May-16										Gamnangtar HP (2)	Day 1	26-Apr	Raautbesi HP (1)	Day 1	2-May
7-May-16				Thumi (shoti) (7)	Day 1	28-Apr				Gamnangtar HP	Day 2		Raautbesi HP	Day 2	
8-May-16				Thumi (shoti)	Day 2										
9-May-16										Chandeswori HP (3)	Day 1	28-Apr	Samundratar HP (2)	Day 1	3-May
10-May-16				Khanchock (8)	Day 1	2-May				Chandeswori HP	Day 2		Samundratar HP	Day 2	
11-May-16				Khanchock	Day 2										
12-May-16										Palapu HP (4)	Day 1	2-May	Kharaanitar PHCC (3)	Day 1	4-May
13-May-16										Palapu HP	Day 2		Kharaanitar PHCC	Day 2	
14-May-16				Takukot (9)	Day 1	4-May									
15-May-16				Takukot	Day 2					Manebhanjyang HP	Day 1	4-May			
16-May-16										Manebhanjyang HP	Day 2		Chaughadha HP (4)	Day 1	5-May
17-May-16				Barpak (10)	Day 1	6-May									
18-May-16				Barpak	Day 2					Pokhare HP (6)	Day 1	8-May	Ghorasing HP (5)	Day 1	6-May
19-May-16										Pokhare HP	Day 2		Ghorasing HP	Day 2	
20-May-16				Bhachheck (11)	Day 1	8-May									
21-May-16				Bhachheck	Day 2										
22-May-16							Reapeat Site 1(Will be decided based on camp results..Will be known						Sallemaidan HP (6)	Day 1	8-May
23-May-16				Chhipleti (12)	Day 1	10-May							Sallemaidan HP	Day 2	
24-May-16				Chhipleti	Day 2		Reapeat Site 2(Will be decided based on camp results...Will be known								
25-May-16													District Hospital (7) Nuwakot	Day 1	9-May
26-May-16				Thalajung (13)	Day 1	12-May							District Hospital Nuwakot	Day 2	
27-May-16				Thalajung	Day 2					Fulbari HP (repeat)	Day 1	18-May			
28-May-16													Chaugadha HP (repeat)	(1 day	
29-May-16				Paluntar (Repeat)	Day 1								District Hospital (	(2 day	
30-May-16															
31-May-16				District Hospital	Day 1										
Sub Total	6 sites	8 days		13 sites	27 days		7 sites	14 days		6 sites	12 days		7 sites	13 days	
Repeat site/camp	2 (in Manikhel and Ashrag (date not fixed)	2 days		2 (in Pakungtar and District hospital)	2 days		2 sites (not fixed)	2 days		1 (in Filbari(date not fixed) ??	1 day		2 sites (Chaugadha and District Hospital)	3 days	
Previously agreed sites and days	6 sites	10 days		13 sites	29 days		9 sites	19 days		7 sites	13 days		9 sites	16 days	
Previously agreed sites	44 sites and 87 days														
Revised number of sites and days	number of camp sites=39	Total events=39 (first)+9 (repeats)=48			Toatal camp days= 84										

2.3 Infrastructure and Procurement

2.3.1 Infrastructure

In the last reporting period, an in-depth analysis of the status of health infrastructure in the fourteen earthquake affected districts was completed to determine the extent of damage, types of repairs and costs needed for all repairable buildings. The analysis and reports were uploaded to the nhsp.org.np website for use by government, EDPs and others in planning, repair and reconstruction activities.

The analysis has since proved invaluable with MoH and several major EDPs drawing from it to plan reconstruction activities. In particular, the ministry used it as the basis for preparing the infrastructure section of its annual work plan and budget (AWPB) for 2016-7 and Multi-year Post-Disaster Recovery Plan.

The assessment has been commended by MoH and EDPs alike and provided the basis for an article in the German Federal Ministry for Economic Cooperation and Development Development's (BMZ) 'Healthy Developments' magazine. The article entitled "The power of information: Better data smoothes the way for the post-earthquake reconstruction of health facilities in Nepal" describes MoH's needs assessment with technical support provided by BMZ via the Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) and DFID. A key theme is how comprehensive field level information serves as an open-access public resource for reconstruction planning.
(see *http://health.bmz.de/events/In_focus/The_power_of_information/index.html*).

As noted in previous quarterly reports, responsibility on behalf of MoH for helping EDPs prepare infrastructure designs consistent with MoH's approved standards, national building codes and bylaws rests with NHSSP's Infrastructure team. This responsibility includes technical supervision and the on-site monitoring of major works. In this respect, the following activities were undertaken in the quarter:

1. Support to MoH and JICA to finalise architectural drawings for the reconstruction of Bir Hospital and Maternity Hospital in Kathmandu. This included verifying the structural models prepared by JICA in accordance with Nepal National Building Codes (NNBC). JICA and MoH were also supported to prepare a safety focused demolition plan for these buildings and a memorandum of understanding (MoU) was signed between JICA, MoH and hospital representatives for this purpose.
2. Support to GIZ's reconstruction and recovery team to monitor and supervise reconstruction work in health facilities in Dhading and Nuwakot Districts
3. Support to the Japanese Red Cross to monitor and supervise health facility reconstruction work in Sindhupalchowk District
4. Provision of these services to several INGOs and NGOs working at district level
5. Close coordination with USAID, KOICA and KFW for reconstruction and recovery works using permanent and prefabricated structures
6. Review, rectification, finalisation and approval of working drawings for reconstruction work, including consideration of site conditions, as submitted by EDPs prior to starting reconstruction work

- Support to Management Division/DoHS to finalize the structural design of Mugu District Hospital (supported by KOICA). This design has since been reviewed by the Department of Urban Development and Building Construction (DUDBC) to ensure compliance with Nepal NNBC and approved.

2.3.2 Procurement

There has been steady progress in the Logistic Management Division's (LMD's) capacity to manage the procurement of health care goods and services since the start of NHSP-2 in 2010. Major advances include the introduction of consolidated annual procurement plans (CAPPs), a technical specifications bank to improve the quality of items procured and a contract management system (CMS) able to track the progress of goods procurement.

Under HSTRP, the implementation of LMD's CAPP is essential to the supply of essential equipment, drugs and services to earthquake affected districts. To this end, TA helped facilitate a progress review with the key stakeholders (see Appendix 4A for meeting minutes).

The table below provides a summary of the status of CAPP implementation to just beyond the reporting period (23rd May) and covers international competitive bidding (ICB), national competitive bidding (NCB), quality control based services (QCBS). A detailed progress report is included as Appendix 4.

Summary Status of Procurement: 23 May, 2016, CAPP FY 2015/16

Procurement Method	Number in Procurement Plan		Number Started Bidding Processes	Contract Already Signed	Contract in Process of Signing	Remarks
	Number of Package	Number of Contracts				
ICB (Goods)	9	161	148	3	1	90 contracts in final stage of bid evaluation
ICB (Works)	0					
Direct Contract (DC)	0					
NCB (Goods)	17	33	11	6	1	1 contract in final stage of Bids Evaluation
NCB (Works)	1	1	1	0	0	Notice Floated
NCB (Non Consulting Service)	1	6	6	1	0	5 contracts in final stage of Bids Evaluation
QCBS (Consulting Service)	3	3	1	0	0	Expression of interest (EOI) Received

In the reporting period TA continued to support LMD for the preparation of bidding documents, ensuring compliance with tendering procedures and bid evaluation processes. The team's bio medical engineers (BMEs) also helped LMD and several other divisions inspect newly purchased equipment including anesthesia machines, vaccine freezers, operating theatre tables and other items and a new anesthesia machine was installed in Ramechhap Hospital.

Procurement systems were further strengthened through the preparation of ***Technical Specifications for Hospital Equipment to be Procured under ICB*** in the current fiscal year. Specifications and cost estimates were subsequently prepared for Baglung, Parbat and Sukraraj hospitals.

TA also supported LMD to prepare Standard Operating Procedures (SOPs) for the Post-shipment Inspection of Equipment and a Framework Contracting Bidding Document for the Decentralized Multi-year Procurement of Drugs to improve the supply of medicine supplies at local facility level.

To this end senior representatives of LMD and other divisions met to finalise the document on 9th May 2016. The SOPs are now being updated prior to being forwarded to the Public Procurement Management Office (PPMO) for endorsement.

Further capacity building inputs in the quarter included support to three LMD officials to enable them to participate in a Global Procurement Summit in New Delhi from 21 to 22 April 2016.

2.4 Health Financing (HF) and Public Financial Management (PFM)

In the reporting period the HF/PFM team supported MoH planning by helping to cost and prioritise activities in earthquake affected districts. In the absence of clear funding commitments from some EDPs, unchanged from 2015/6 or 'flat' budgets were used in projections. The team also helped MoH prepare a draft of the Joint Financing Arrangement (JFA) with EDPs for NHSS 2015-2020. Once finalised funding predictability for NHSS (2015-20) is expected to improve.

The TA team also helped to prepare disbursement linked indicators (DLIs) for NHSS 2015-20. This included developing metrics to verify progress made and the process to be followed when recruiting a third party to manage assessment processes. The DLI approach is a new funding modality under which the World Bank proposes to disburse its NHSS (2015-20) loan funds.

TA also supported DFID Nepal's internal audit process by accompanying audit team members to Pokhara to assess financial systems at the district treasury controller's office, regional hospital and district public health office. The auditors further observed the transaction accounting and budget control system (TABUCS) in operation in Pokhara.

Technical support was provided to Crown Agents for the design of a rapid assessment of PFM functions in 31 earthquake affected districts. This assessment is needed for DFID to release its remaining funding allocations to government treasury. NHSSP TA will not take part in the assessment itself but will provide logistical and other support as required.

2.4.1 Transaction Accounting and Budget Control System

As noted last quarter, a TABUCS module was developed to help MoH capture monthly expenditure in 31 earthquake affected districts. This can now provide the detail needed to track expenditure on standard activities, line items and cost headings and produce detailed financial reports. In the reporting quarter, the functionality of TABUCS in the 31 districts was verified and monthly expenditure reports against planned budgets were prepared. A TABUCS report capturing expenditure from the 31 districts including an analysis of budgets against expenditure was submitted to DFID.

2.4.2 Financial Monitoring Report (FMR)

A provisional draft of the second Financial Monitoring Report (FMR) was prepared with data drawn from TABUCS and forwarded to DFID for review. A funding analysis shows that DFID's FA contribution of £6 million will be expended by the end of April 2016. It is projected that DFID's final reimbursement of FA can be made in the first week of July 2016.

2.4.3 Clearance of Audit Queries

In the reporting quarter an additional five years of audit backlog data were uploaded into TABUCS thereby allowing MoH, DoHS and other cost centres to view their audit histories. Importantly, MoH's Secretary is now able to view progress in audit clearance at each cost centre across the country. Nine years of audit data are now available in TABUCS (FY 2060/61 to 2068/69 (2003/04 to 2011/12)) although some records remain to be verified.

Also in the reporting period, audits of 320 MoH cost centres (187 GoN and 133 Hospital Development Samitis) for FY 2071/72 (2014/15) were completed by the Office of the Auditor General (OAG). Performance audits of D(P)HOs in Dhanusa, Kaskai, Jumla, Kailai, DHO Palpa, & B. P. Koirala Memorial Cancer Hospital, Chitawan were also completed.

MoH's financial statements for 2014/15 were submitted to the OAG for compilation in its Audited Financial Statements Report.

NHSSP TA also worked with MoH to present TABUCS to the Financial Comptroller General's Office (FCGO) whose Secretary noted the potential to roll out TABUCS to other ministries. A committee was subsequently formed to further assess its suitability.

2.4.4 MoH's Financial Management Improvement Plan (FMIP)

A revised FMIP, with all PFM indicators for NHSS 2015-20, was circulated to EDPs in the reporting period. Additional analysis to identify challenges likely to be faced and a workshop to finalise the FMIP through consensus building are now being planned.

2.4.5 Aama Stock Take Analysis

The Aama stock take analysis report submitted to DFID in the last reporting period was finalized and approved in this quarter. This document captured the status of Aama implementation in the 14 earthquake affected districts. Based on the analysis and various district planning workshops, a detailed Aama earthquake recovery plan was prepared.

Participants at the district workshops included one service provider and one HFOMC member from each Aama implementing facility. A separate planning report was prepared for each district and subsequently merged in the final report. Facilities in Ramechhap, Dolakha and Sindhupalchowk have now begun implementing the proposed changes.

In the reporting period, the demand side financing (DSF) adviser submitted an abstract on the Aama unit cost analysis to a national scientific workshop organized by Nepal Health Research Council (NHRC) who subsequently published the article in its professional journal.

2.4.6 Rapid Assessment (RA) of Aama (ninth round)

Following completion of field level data collection and analysis, NHSSP's DSF adviser supported the contracted third party, the National Statistical Institute (NSI), in report writing. Facilities in ten districts: Dhankuta, Okhaldhunga (eastern region), Sindhupalchowk, Lalitpur, Dhading, Makawanpur (central region), and Gorkha, Lamjung, Baglung and Arghakhanchi (western region) were included in the assessment. Some of these were affected by the 2015 earthquake and had not been covered in previous RA rounds. No Terai districts were included in the sample. The report is due to be finalized in June 2016.

2.5 Gender Equality and Social Inclusion

2.5.1 National level Inputs

At national level, technical support was provided on gender based violence (GBV), referrals and mental health including GBV and one stop crisis centre (OCMC) orientation to police officers attending a ten days training of trainers programme on victim counselling. A coordination meeting was also attended with representatives from the Department of Women and Children (DoWC) and the Women and Children Directorate (Police HQ) and programme partners (TPO, SIRC and HI) on psychological first aid and mental health services for disaster survivors. Strengthening the health system's capacity to provide these services, including creating effective referral pathways and safe home services for survivors, were also discussed.

Further support and coordination inputs were provided for MoH's national review of NHSP-2 and the 2015 Joint Annual Review (JAR) for which the GESI team prepared a report and presentation on progress made by MoH in institutionalizing GESI principles and actions in the health system including at the point of service delivery. A status report on MoH's Governance and Accountability Action Plan (GAAP) was also prepared.

Draft GBV Integrated National Guidelines were prepared with adviser support and submitted for final comments to the mutli-sectoral steering committee chaired by the Ministry of Women, Children and Social Welfare's (MoWCSW's) secretary. Members include representatives from the National Planning Commission (NPC), the Office of the Prime Minister and Council of Ministers (OPMCM), OAG and Police Headquarters.

As a part of draft AWPB preparations for 2016/7, TA supported various ministry divisions and centres incorporate costed GESI activities for the coming year.

2.5.2 Direct District Level Support

Monitoring and support visits with a focus on OCMCs, social service units (SSUs), social audits (SA) and equity monitoring (EM) were made to nine health facilities as follows: Rapti Sub-regional Hospital (Dang), Bheri Zonal Hospital (Nepalgunj), Trisuli District Hospital (Nuwakot), Gorkha District Hospital (Gorkha), Dhaulagiri Zonal Hospital (Baglung), Chautara District Hospital (Sindhupalchowk), Manthali PHC (Ramechhap), Charikot PHC (Dolakha) and Palpa DHO.

During these visits, the implementation of the GESI components of district transition and recovery plans was assessed. In general, these activities – principally OCMCs, mental health and psychosocial counselling, SSUs, Community Health Unit (CHUs) and EM - were progressing well under DHO leadership both in the three focal districts and in Kavre, Gorkha and Nuwakot districts. Collaboration with district stakeholders including the women's development office (WDO), the United Nations Family Planning Association (UNFPA), Medicines du Monde (MDM), JICA and local NGOs was also judged effective.

In the three focal districts, OCMCs and CHUs have been established and equity monitoring of health services is now underway. In Dolakha and Ramechhap, plans were made for mental health and psychosocial counselling activities, though not in Sindhupalchowk where this support is being

provided by several national and international agencies including the Institute of Medicine (IOM), MDM, the Asia Foundation, UNICEF, Israid, Help Age and Care Nepal through NGOs including TPO, Sathi, and Tuki Sang.

Beyond the three focal districts, four SSUs were established in Dhaulagiri Zonal (Baglung), Hetauda (Makwanpur), Rapti Sub-regional (Dang) and Lumbini Zonal (Butawal) Hospitals in the reporting period.

2.5.2.1 OCMCs

In Sindhupalchowk, an OCMC at Chautara Hospital was inaugurated by the CDO followed by TA supported orientation on OCMC guidelines for key stakeholders including district coordination committee (DCC) members. A first meeting of the DCC and case management committee (CMC) followed to nominate an OCMC focal person, hire a staff nurse and prepare an OCMC action plan. Services to GBV survivors have now begun with 3 cases treated to date, but a lack of suitable infrastructure to house the centre is limiting the range of services available.

Similarly in Ramechhap, the CDO inaugurated an OCMC at Manthali PHCC. Orientation on operational guidelines was provided for key stakeholders including DCC members. A CMC was also established, roles and responsibilities clarified and a staff nurse hired. To date, 4 cases have been treated.

In Dolakha, the OCMC has treated 16 GBV cases to date, most of them the result of domestic violence. Multi-sectoral support has been provided including referrals for police support and safe home services.

2.5.2.2 Social Service Units (non-focal districts)

In Gorkha District Hospital, the selection process for the facilitating NGO was completed and a contract signed for SSU support. The unit is expected to become operational in the next quarter. Following SSU establishment in Lumbini Zonal Hospital (Butwal), hospital staff, HFOMC members and other stakeholders were orientated on operational guidelines. 103 clients have so far been served.

In Trishuli Hospital (Nuwakot) formal processes for SSU establishment were completed but the unit has not yet opened due to a lack of suitable premises. Construction of a prefabricated building to host the unit is now underway. In Hetauda Hospital (Makwanpur), the SSU was established, a chief and deputy chief appointed and stakeholder orientation completed. The selection of an NGO to support SSU functioning was also completed.

At Rapti Sub-regional Hospital, a SSU was formally established, orientation completed and a partner NGO selected while in Dhaulagari Zonal Hospital, SSU establishment was completed and services have begun. A visit to Bheri Zonal Hospital's SSU found that the unit was doing exceptionally good work providing quality services in a financially transparent and well documented manner.

2.5.3 Mental Health and Psychosocial Counselling Services (MHPCS)

NHSSP TA provided backstopping support to TPO to help build the capacity of service providers for MHPCS. The planned training of prescribers (141) and non-prescribers (127) on WHO's mental health gap action programme (mhGAP) and the basics of psychosocial support was completed in February. Similarly, the second phase of community psychosocial worker (CPSW) training was completed for 565 female community health volunteers (FCHVs) and 52 CPSWs from Ramechhap and Dolakha districts.

Monthly on-site supervision of prescribers by psychiatrists continued in these two districts with 4 support visits made in Ramechhap and 3 in Dolakha. In addition, mental health and psychosocial support (MHPSS) services were made available at most health facilities and communities in these two districts.

In Nuwakot and Kavre, CPSWs and community counsellors were mobilized with 896 people receiving MHPSS services from health facilities; 329 from community counsellors and 729 from CPSWs. A further 494 people were referred to health facilities by FCHVs and 208 received specialized care from a psychiatrist.

With regard to drug stocks and supplies, dwindling stocks have led DHOs to begin purchase processes. High client flows in some districts have caused a shortage of drugs and led to borrowing from other facilities.

2.5.4 Community Health Units (CHU)

The identification of sites for CHU establishment was completed in the three focal districts. The programme has allocated a budget to establish 9 CHUs (3 each in Dolakha [Singiti, Lapilang and Kharidhunga VDCs]; Ramechhap [Bungdel, Bhirpani and Majuwa VDCs]; and Sindhupalchowk [Salang, Ramche and Karthali VDCs]). Staff recruitment and logistical support was completed in the quarter and staff training has now begun.

2.5.5 Equity Monitoring

Under the programme, equity monitoring is to be carried out in 18 VDCs of each focal district (54 total) with VDCs selected by respective DDCs based on a mapping exercise. In the reporting period, EM was carried out in 17 VDCs in Dolakha, 16 VDCs in Ramechhap and 6 VDCs in Sindhupalchowk.

To increase understanding and develop consensus on the EM process and tools, an intensive 2 days workshop was organized for EM staff, health management information system (HMIS) coordinators, DHOs, Primary Health Care Revitalisation Division (PHCRD) staff and NHSSP programme district coordinators. The workshop focused on VDC and district data collection and analysis. Following this, a one day workshop in Dolakha prepared a data analysis and reporting template. The equity monitors, HMIS and district coordinators along with the DHO and staff participated in the meeting which identified equity gaps through an analysis of district HMIS data.

All equity monitoring activities are on schedule for completion by the end of July including the preparation of action plans and sharing of findings by DHOs with senior stakeholders from government, EDPs and NGOs.

Others Activities:

- A Pulse report was developed on four thematic areas – GESI, SSU, OCMC and Social Auditing.
- A meeting was held with the Palpa DHO and staff on social auditing progress in the district. The DHO stated that following cuts in the social auditing budget it has been difficult to monitor the performance of facilities. The DHO also praised the many positive changes resulting from properly budgeted social auditing including the improved selection of land for new birthing centers, local resource mobilisation from VDCs, improved opening hours of health facilities, regular meetings of HFOMCs, improved financial transparency of agencies working in the district and greater health worker ownership of services provided. The DHO and staff further recommended that the social audit guidelines be revised to become more specific, practical and easier to implement.

2.6 Monitoring and Evaluation

2.6.1 Support HMIS e-reporting from health facilities

During the reporting quarter, the 'Minimum Standards and Implementation Guideline for Initiating e-Reporting from Health Facilities' prepared by MoH's Public Health Administration, Monitoring and Evaluation Division (PHAMED) with support from partners, was endorsed by the ministry. This guideline prescribes the minimum standards to be met at health facility level in order to begin e-reporting and provides guidance to implementers and supporting partners on maintaining uniformity of approach and data quality. This initiative will be rolled out in selected public health facilities in the 14 earthquake affected districts using the District Health Information System 2 (DHIS2) for data entry and reporting purposes. This will help improve the quality and use of data at the point of generation.

NHSSP will support the PHAMED, Management Division and the concerned DHOs/DPHOs in initiating e-reporting from those public health facilities meeting the specified criteria. Given the limited time remaining in the programme, a minimum of five health facilities in the three focal districts will be supported to begin e-reporting in the fourth programme quarter. Other partners working in the 14 districts will support additional qualifying health facilities to implement the initiative.

2.6.2 Electronic Health Records (EHR) at hospitals and PHCCs

Rapid progress has been made around the world in the use of open source software for medical record keeping and reporting. In Bayalpata Hospital (Achham) and Charikot PHCC (Dolakha) 'Bahmni', a user friendly open source electronic medical record (EMR) and hospital data system, has been introduced with the assistance of Possible (previously known as Nyaya Health).

This software combines and enhances other open source products such as 'Open MRS' for electronic medical records and patient management, 'OpenERP' for inventory, billing and financial accounting and OpenELIS for laboratory management.

The 'Bahmni' was readily customized to match the general requirements of Nepal's health system and used to generate monthly HMIS reports at these two facilities. MoH, with support from NHSSP and other development partners, is now seeking to expand this initiative to other public health facilities, initially in the 14 earthquake affected districts, and then later to other districts.

NHSSP's M&E Advisor and PHAMED officials visited the facilities and held discussions with MoH, Possible, WHO and GIZ on further customizing 'Bahmni' to meet more specific health data needs in Nepal.

In the next quarter, NHSSP and GIZ will support MoH to conduct a feasibility study. If found feasible, NHSSP will support MoH to roll out the system to selected PHCCs and hospitals in the three focal districts. GIZ will similarly support the initiative in selected public health facilities in Achham, Nuwakot, Dhading and Rasuwa districts.

2.6.3 Supporting Districts to Improve the Use and Quality of HMIS Data

During this quarter, the HMIS coordinators in Dolakha and Ramechhap districts supported the districts and health facilities to improve the quality and use of HMIS data. A 'dash board' (flex print) was developed showing key HMIS indicators and the monthly performance of programmes in the health facility and district health offices. The indicators were selected in consultation with DHO focal persons and HMIS at the center. A guideline was developed to help health workers update the data shown on the flex and use it during local monthly and quarterly reviews.

2.6.4 Roll out of DHIS2

Advisers continued their efforts to support the HMIS Section roll out the DHIS2 for improved HMIS reporting across the country. As agreed with Management Division, WHO, NHSSP and GIZ, WHO SEARO initiated a process to contract the Society for Health Information Systems Programmes (HISP) India for one year to further develop the DHIS2 system with technical backstopping from the University of Oslo. A key objective is to support the HMIS section establish a formal linkage between Nepal DHIS2 team and the global DHIS2 core team in order to fix technical problems and support overall roll out, institutionalization of DHIS2 and build capacity of the Nepal team.

2.6.5 Support EDCD/DoHS in Information Management and Surveillance

TA continued its support to the Epidemiology and Disease Control Division (EDCD)/DoHS in order to strengthen information management, particularly as related to MoH's Early Warning and Reporting System (EWARS). NHSSP is supporting EDCD with one information management officer who has been instrumental in continuing to publish weekly EWARS bulletins every Sunday.

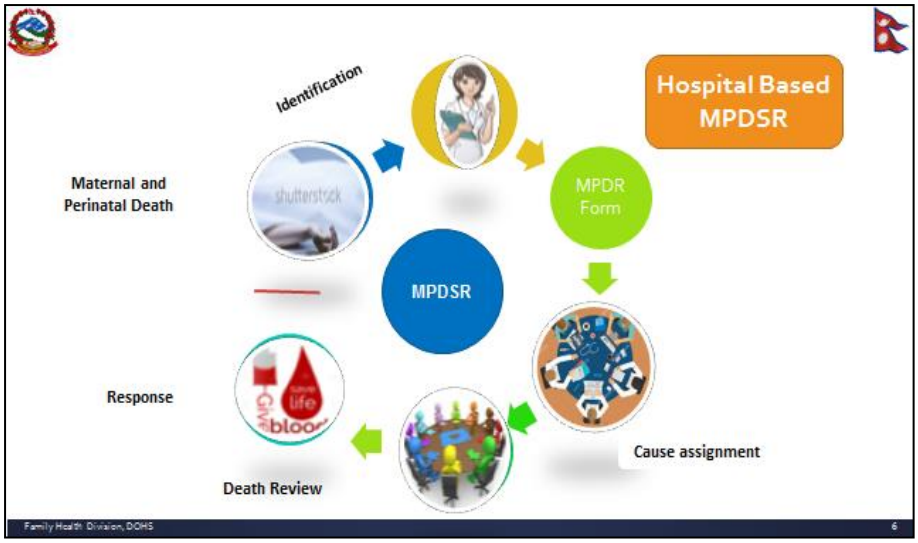
EDCD, with support from NHSSP, GIZ and WHO further customized the DHIS2 to meet the needs of EWARS which is now ready for roll out. Recording tools, reports and dash board were developed and the legacy data for 2014 and 2015 were migrated to the DHIS2 database.

EDCD is planning to share these products (the reports and the dashboards) with the DoHS and ministry officials and launch the DHIS2 officially in the next quarter.

2.6.6 Support FHD in Maternal and Perinatal Death Review (MPDR)

The history of MPDRs in Nepal goes back to the 1990s when the maternal death review process was first introduced at Maternity Hospital in Kathmandu. By 2014 it had been expanded to 44 hospitals. In addition to a hospital based reviews, Nepal carried out maternal mortality and morbidity studies in 1998 and 2008/09 which helped understand the underlying causes of maternal and perinatal deaths and prepare responses likely to prevent avoidable deaths.

The established practice in 2008/09 was to repeat this type of study every 10 years, so now is an opportune time to plan for the next survey in 2018/19. However, given that MoH is already implementing a Maternal and Perinatal Death Surveillance and Response (MPDSR) system, NHSSP TA are advocating to strengthen this surveillance system to meet the objectives of the MPDR rather than implement a new survey. TA are also supporting FHD to standardize and institutionalize the MPDSR in the regular system.



During this quarter, NHSSP supported FHD to develop modular training packages to roll out the MPDSR in five districts - Dhading, Kaski, Kailali, Banke and Solukhumbu. The modular training package includes a trainer's manual, user's manual, powerpoint slides for each session, tools and reference materials for each target group including district stakeholders, hospital staff, DHO/DPHO staff, health post and primary health care centre workers, FCHVs, cause assignment teams; and MPDSR committees at different levels.

The modular training package will soon be shared in the MoH and NHSSP web site.

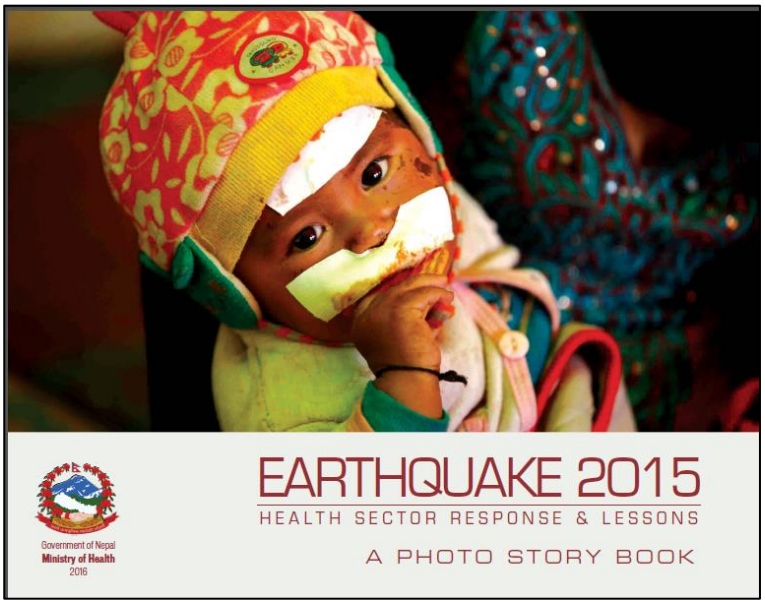
2.6.7 Support MoHP in Documentation of Health Sector Response to the 2015 Earthquake

NHSSP advisors continued their support to MoH to track TA and other partner resources as part of a review of the health sector's response to the earthquake and lessons learnt. Based on the

ToR developed jointly with WHO, GiZ, UNICEF, World Bank and USAID four outputs will be produced:

1) a consolidated comprehensive report reviewing the health sector preparedness, damage to the health sector, response,
2) lessons learnt and recommendation for better preparedness and management of disaster when it occurs;
3) a report with compilation of case studies;
4) a photo story book and a documentary.

NHSSP supported MoH to prepare a Photo Story Book. Though the plan was to disseminate all these four products by 25 April; only the draft version of the Photo Story Book was shared during the Lessons Learnt Conference jointly organized by MoH and WHO on 21 and 22 of April 2016 in Kathmandu.



The draft photo story book includes around 100 photos covering preparedness activities before the earthquake, the damage caused by the earthquake to the health sector, the response of health sector and lessons. The draft photo story book is available at www.nhssp.org.np.

NHSSP is continuously supporting MoH's Curative Services Division to coordinate with partners to complete this initiative as soon as possible. NHSSP is now updating the draft Photo Story Book incorporating suggestions from the conference participants, other stakeholders and reviewers. It is expected that all the four products will be finalized within the next two months.

2.6.8 Monitoring and Evaluation (M&E) Plan for the Transition and Recovery Programme

NHSSP's M&E and Policy Planning Advisers visited Dolakha and Ramechhap districts to support district teams and DHOs develop M&E plans to monitor TRP activities. A framework/template was developed and district teams supported DHOs to complete and review data regularly. This will help districts monitor progress of activities being supported by all development partners and help accelerate progress.

2.6.9 Service Coverage (July 2015 - April 2016)

The tables below shows the number of beneficiaries who utilized the listed services in the eighth month period between July 2015 and April 2016 (HMIS data of 28 May 2016). Comparatively, health service utilization in this period was lower than the corresponding period in the previous year. This does not mean that service coverage was less, rather that under-reporting is

occurring[1]. It is expected that more accurate monthly aggregated 'live' data will be available from the next fiscal year with the roll out of DHIS2.

Indicator	July – Apr 2014/15	July – Apr 2015/16
Number of institutional delivery	2,69,002	2,05,014
Number of SBA delivery	2,65,595	1,97,960
Number of FP new acceptors	5,67,213	4,46,632
Number of children immunized against measles	4,16,975	3,28,844
Number of under five years children treated for diarrhea	11,27,694	8,35,164
Number of under five years children treated for pneumonia	8,40,741	5,60,523
Number of under five children who received Vitamin A in the last mass campaign	2,62,727	1,90,489
Number of OPD new cases	1,64,81,904	1,22,92,544
Source: HMIS		

Availability of basic health services and health facilities' readiness to provide quality services in the 14 earthquake affected districts and at the national level

According to the Nepal Health Facility Survey (NHFS), 2015, carried out just after the earthquake, despite the huge damage caused to the health sector, it responded well and was able to resume basic health services in the 14 worst affected districts. The table below shows that the availability of tracer basic health services in these districts was not very different when compared with national level estimates (NHFS 2015)[2]. Similarly, the availability of basic amenities and key commodities compared well with the national average.

[1] The under-reporting of HMIS data now is primarily due to the current practice of not having a 'data lock' system (i.e., not allowing facilities/districts to enter data into the server after completion of the reporting period'). Thus the data recorded in a particular period in the central server may not reflect the actual service coverage data for that period. The data for a particular period is normally updated/added in the following months as facilities/districts keep on updating the data for the previous months. Some facilities delay reporting and some districts delay entering data into the database. This accounts for differences in reported data when accessed at two different times.

[2] Data collection for the Nepal Health Facility Survey, 2015, took place in two phases: Phase 1 took place from 20 - 25 April 2015 in Sunsari, Jhapa, and Morang districts. Due to the earthquake on 25 April and multiple aftershocks, phase 2 of data collection took place from June 4 – November 5, 2015, when the situation was assessed and determined to be feasible for survey data collection. Data collection in the 14 districts most affected by the earthquake took place in October and November 2015.

Availability of health services

Percentage of health facilities offering basic health services in the 14 earthquake affected districts and at the national level

Indicator	EQ affected 14 districts	National
Child curative care	99.4	99.5
Child growth monitoring	93.9	95.6
Child vaccination	89.6	87
Any temporary modern FP services	98.3	98.6
Antenatal care	99.5	98.1
STI services	78	73.7
Tracer basic client services*	68.0	62.7
Normal delivery	40.6	48.6
HIV treatment (ART)	100	94.9
Malaria diagnosis or treatment	99.4	99.8
TB diagnosis or treatment	91.9	92.8
Blood transfusion	54.9	48.6
Laboratory services	22.5	26.5
HIV testing and counseling	16.8	16.6

Note:

Source: Nepal Health Facility Survey 2015

*Tracer basic client services as per NHSS basic health care package, include outpatient curative care for sick children either at the facility or as outreach, child growth monitoring either at the facility or as outreach, child vaccination services either at the facility or as outreach, and any temporary modern method of family planning, antenatal care, and services for sexually transmitted infections (STIs).

Availability of basic amenities for client services

Percentage of health facilities with indicated amenities considered basic for quality services in the 14 earthquake affected districts and at the national level		
Indicator	EQ affected 14 districts	National
Regular electricity	46.3	49.5
Improved water source	77.6	81
Visual and auditory privacy	70.0	78.6
Client latrine	85.1	81.6
Communication equipment	25	20.2
Computer with internet	14	11.4
Emergency transport	67.7	59.4
Source: Nepal Health Facility Survey 2015		

Availability of key commodities		
Percentage of health facilities with indicated key health commodities in the 14 earthquake affected districts and at the national level		
Indicator	EQ affected 14 districts	National
At least 3 temporary modern FP methods	95.5	93.7
ORS	94.5	92.2
Co-trimoxazole tablets	85.6	91.7
Cotrimoxazole suspension	48.2	48.8
Amoxicillin syrup suspension or dispersible pediatric-dosed tablets	40.4	24.2
Gentamycin injection	44.8	63.6
Iron and folic acid combination tablets	94.5	90.6
Zinc	92.8	95.4
Albendazole	96.1	97.4

Availability of key commodities		
Percentage of health facilities with indicated key health commodities in the 14 earthquake affected districts and at the national level		
Indicator	EQ affected 14 districts	National
Vitamin A	89.9	89.3
Source: Nepal Health Facility Survey 2015		

Key challenges

A major challenge faced in M&E is building a common understanding among stakeholders of M&E initiatives and approaches and harnessing available technical assistance and other resources to have maximum impact on the strengthening of M&E systems.

2.7 Health Policy and Planning

2.7.1 Support MoH to Align Disaster Recovery Plans with AWPB

At ministry level, technical assistance worked to position the disaster recovery programme within MoH's AWPB for 2016/7. Government has allocated NPR 2.5 billion for this purpose. Further, NHSSP's HPP adviser and Infrastructure team supported development of a Post-disaster Recovery Framework document for Policy, Planning and International Cooperation Division (PPICD).

2.7.2 Support to Capture Strategic Priorities (Both Recovery and Preparedness) Emerging from the Earthquake in NHSP-3 and its Implementation Plan (IP)

Finalisation of the implementation plan for NHSS (2015-20) is now underway following the formation of various bodies including a steering committee and task team. NHSSP's HPP adviser sits as a member of the implementation task team. The IP development process has been slowed due to competing PPICD priorities including functional analysis, managing the JAR and AWPB development. This said, it is clear that the strategic priorities identified following the earthquake will feature strongly in the IP.

2.7.3 Support Review Processes Under NHSP-3, Including Organising JARs and JCMs

NHSSP TA played a prominent role in supporting PPICD/MoH to organise the JAR in February, 2016. As in earlier years this included preparing thematic reports, discussion documents and presentations. TA also helped organize a Joint Consultative Meeting (JCM) between MoH and lead EDPs on 12th May 2016 and provided assistance in drafting the JAR's Aide Memoire and the Joint Financing Arrangement for NHSS (2015-20).

2.7.4 Support MoH to Coordinate Planning Processes Through the Development of Guidelines and Planning Frameworks

TA supported PPICD's planning section to develop a budget preparation guideline for AWPB preparation for MoH departments, divisions and centers and helped draft MoH's 14th Three Year Plan for submission to the National Planning Commission (NPC).

2.7.5 Provide Direct Support to Undertake Effective Planning In Line with Guidelines and Frameworks in Three Focal Districts

At district level, NHSSP's district coordinators worked with DHO planning teams to prepare district coordinated health plans together which were subsequently endorsed by their respective DDCs. However in the absence of guidelines to direct local health planning, this support proved to be less streamlined than anticipated.

2.7.6 Support MoH to Effectively Coordinate EDP Inputs to Earthquake Response

This activity has largely focused on infrastructure related inputs and been led by NHSSP's infrastructure team. The HPP adviser has however supported PPICD on the coordination of EDP inputs when requested.

Other Activities

- On September 2015, under the aegis of broader GoN initiative to transition different sectors to federalism, MoH formed a task team comprising government officials and other national experts. The task team is working in coordination with a team from MoGA, entrusted by GoN to conduct functional analyses across various sectors including health. The task team is working on three aspects:
    - Propose functions for the health sector across three tiers of governance, i.e. federal, provincial and local
    - Propose an optimal structure for the health sector to carry out the defined functions effectively and efficiently
    - Propose a plan to transition the health sector to a federal form of governance

The team has prepared a first draft document to be submitted to MOGA and OPMCM. In this process TA has served as a technical task team member and supported PPICD in organizing discussion meetings as required.

As a technical working group member the HPP and M&E advisers supported Curative Division to document lessons from the earthquake response, recovery and reconstruction efforts (see M&E section).

3.0 Payment Deliverables

The following HSTRP deliverables were submitted in the reporting period:

PD	Deliverable	Submitted to DFID
HI 2	14 district level trainings on injury management provided to 280 health professionals (including doctors, nurses and rehabilitation professionals).	Feb.
TPO 3	120 (60 in each district) prescribers are trained on mhGAP HIG.	Mar.
TPO 4	120 non-prescribers (60 in each district) are trained on psychosocial support.	Mar.
TPO 5	52 Community Psychosocial Worker (CPSWs) trained (26 in each district) to carry out mental health prevention and promotion activities in the community.	Submitted on schedule (Feb.). Resubmitted following DFID queries
TPO 6	Procurement and delivery of psychotropic drugs to focal districts	Submitted on schedule (Mar.). Resubmitted following DFID queries
SIRC 3	Individual needs assessment carried out for each person admitted to SIRC – using standardised quality assessment tools including ASIA score and SCIM	Mar.
TPO 7	468 FCHVs (234 in each district) are trained on the detection of mental health cases in the communtiy and their referral to health facilities	Apr.
SIRC 4	National and district level trainings provided to health and rehabilitation professionals in coordination with HI	Feb. (1 month early)
HI 4	7 health facilities are equipped with rehabilitation and physiotherapy supplies and have functional PT units continuously providing rehab care to people with injuries/ functional limitation	Mar. (1 month late)
FP 2	Overall plan for the comprehensive mobile camps and visiting provider completed for all 5 districts	Feb.
FP 3	Procurement and supply of infection prevention, insertion/removal sets completed in 50 BCs out of approximately 121 BCs in 5 districts[1]	Apr.
4	Detailed plan for restoration of Aama programme to at least pre-earthquake situation for three focal districts agreed with DHOs/FHD and assessment completed for all 14 districts.	Apr. (1 month delay agreed with DFID)

5.1	Financial expenditure captured and reported in TABUCS in earthquake districts and trimester Financial Monitoring Report (FMR) prepared with • Line item showing expenditure in 'district integrated health programme' • Comparison of planned budget vs expenditure of 'district integrated health programme' of FY 2015/16	Apr. (1 month delay agreed with DFID)
6	2nd Quarterly Progress Report including • HMIS Service Utilization Reports (with comparison for last year for SBA/institutional delivery, FP new accepters, immunization, total OPD clients, total under-five children treated for diarrhoea and pneumonia and supplemented for vitamin A) • Review of progress against Consolidated Annual Procurement Plan • Progress against PDs and plan in case of any deviation	Feb.
5.1	Quarterly report - HI (annexed into main report)	Feb.
5.2	Quarterly report TPO (annexed into main report)	Feb.
5.3	Quarterly report SIRC (annexed into main report)	Feb.
5.2	Financial expenditure captured and reported in TABUCS in earthquake districts and trimester Financial Monitoring Report (FMR) prepared with • Line item showing expenditure in 'district integrated health programme' • Comparison of planned budget vs expenditure of 'district integrated health programme' of FY 2015/16	Apr.
3.2	Progress against CAPP monitored by the procurement technical working group	Feb. (1 month early)
	PDs due in reporting period but delayed	
SIRC 6	200 former and recently discharged patients of SIRC living in affected districts have received follow-up home visit services support.	Due Apr. (submitted May)

In addition, five remaining NHSSP2 payment deliverables were submitted and approved in the reporting period:

RA 3	Remote area pilot completed with lessons for NHSP3 identified	Feb 2016 (due Nov 15)
20	Strategic survey plan developed as part of the NHSP-3 M+E framework with NHRC ensuring clarity on the survey needs	Feb 2016
M12	NHSSP Handover report	Mar 2016
M11	Dissemination report	Mar 2016
PFM-13	FMR submitted within 45 days	Mar 2016

Appendix 1

Third Quarterly Report

Reporting period: 1 February–30 April 2016

PROJECT: REHABILITATION SUPPORT SERVICES IN EARTHQUAKE-AFFECTED DISTRICTS

(Project Period: 27 July 2015–26 July 2016)

Submitted to:

Options Consultancy Services Limited,

Devon House, 58 St. Katharine's Way, London E1W 1LB

Submitted by:

10 May 2016

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LIST OF ACRONYMS AND ABBREVIATIONS

CBR	community based rehabilitation
DFID	Department for International Development
DHO	district health office
DoHS	Department of Health Services
DPO	disabled people's organization
DRFU	Disability and Rehabilitation Focal Unit
GoN	Government of Nepal
IOM	International Organization for Migration
IMC	International Medical Corps
LCD	Leprosy Control Division
MoH	Ministry of Health
MToT	master training of trainers
NDF	National Disabled Fund
NGO	non-government organisation
NPPAD	National Policy and Plan of Action on Disability
PT	physiotherapy
P&O	prosthetics and orthotics
PHCC	primary health care centre
SIRC	Spinal Injury Rehabilitation Centre
SW	social worker
TPO	Transcultural Psychosocial Organization

Achievements/Deliverables Against Approved Plan

The achievements against the anticipated achievements/milestones/deliverables to be provided by Handicap International (HI) against the approved plan for the current reporting period of 1 February to 30 April 2016 and are as follows:

HI Deliverable 1

Work plan finalized and approved

This deliverable has been achieved, payment deliverables submitted and approved by DFID.

HI Deliverable 2

14 district level trainings on injury management for 280 health professionals (including doctors, nurses and rehabilitation professionals)

This deliverable has been achieved, payment deliverables submitted and approved by DFID.

HI Deliverable 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 deliverable has been achieved; payment deliverables submitted and approved by DFID.

HI Deliverable 4

7 health facilities equipped with rehabilitation and physiotherapy supplies and have functional physiotherapy (PT) units continuously providing rehab care to people with injury/functional limitations

This deliverable has been achieved, payment deliverables submitted and now awaiting approval.

A limited number of pieces of physiotherapy equipment and assistive devices, which were delayed in procurement and delivery to the respective PT units due to the fuel crisis, have now had been delivered to respective PT units in this quarter. ***(Annex 1**: List of PT equipment and assistive devices delivered this quarter)*

HI Deliverable 5

Five district hospitals, one primary health care centre and one national trauma centre engage in the proper discharge of injured patients and proper referral to health and or social/community services

The deadline for this deliverable was amended from April 2016 to July 2016. Five district hospitals (Dhading, Nuwakot, Rasuwa, Sindhupalchowk and Dolakha-Jiri), one primary health care centre (PHCC) in Charikot, Dolakha District and one National Trauma Centre in the Kathmandu Valley have been providing physiotherapy and rehabilitation services with a focus on the proper discharge of injured patients and their proper referral to health and social/community services through Activity 3 (Support 7 hospitals to develop PT/rehab units and deliver services) and Activity 6 (harmonization of assessment, referral forms, trauma care pathways, for spinal cord injury, amputation, and fractures). The progress during this reporting period was as follows:

Physiotherapy assessment forms, social worker assessment forms, discharge forms, and follow up/treatment forms have been further updated and are in use at all seven

physiotherapy/rehabilitation units for the comprehensive needs assessment of the injured, goal setting and rehabilitation intervention and follow-up care in hospitals and communities. These forms have been compiled together as part of the standard operating procedures (SOP) for physiotherapy/rehabilitations units in Nepal's district hospitals. See PD 6 below for more details on these SOPs.

A total of 328 assistive devices (118 mobility aids, 105 braces/splints, 77 therapeutic aids and 28 other assistive devices (bedpans, toilet chairs and anti-bed sore mattresses) have been provided to 315 persons with injuries and functional limitations (82 earthquake affected cases and 233 other cases) as per their comprehensive need assessments. Data analysis shows the earthquake affected clients as needing the most mobility aids (wheelchairs, walkers, crutches and walking sticks) which is expensive combatively to other brace and therapeutic aids. Thus the project was also able to support patients with acute non-earthquake related injures such as back-pains, ankle sprains, arthritis clients with the provision of physiotherapy, assistive devices and therapeutic aids. (Annex 2: database). Donation forms are signed by each beneficiary for inventory management purposes.

A caregivers' orientation checklist has been developed, and 831 caregivers (male: 385, female: 446) have received one-to-one orientations on patient care and required assistance including home exercises. information, education and communication (IEC) materials has been used to support these orientations. (Annex 2: database)

Twenty-three earthquake injured patients, amongst a total of 53 patients, were referred to specialized services:

- 10 to the Spinal Injury Rehabilitation Centre (SIRC) for spinal cord injury treatment and support;
- 11 to the Transcultural Psychosocial Organization (TPO) for psycho-social counselling and mental health services;
- 25 to the National Disabled Fund (NDF) for assistive devices;
- 3 to Hospital and Rehabilitation Center for Disabled Children (HRDC) for orthopaedic cases for children under 18 years; and
- 1 to Prerana Rehabilitation Center, Sarlahi for rehabilitation.

Nine earthquake injured amongst a total of 14 beneficiaries were identified for corrective/ reconstructive surgery. These were complicated surgeries that could neither be done at district hospitals nor through outreach mobile surgery camps. Thus they were referred to the Sushma Koirala Memorial Hospital (SKM), a specialized hospital for corrective and reconstructive surgery in Kathmandu. Among the six cases who underwent surgery three were injured by the earthquakes. This was facilitated through an MoU signed between HI and SKM for the referral of beneficiaries for surgery.

Twenty-nine earthquake injured beneficiaries amongst a total of 100 clients were referred to community services. Among the 100 were:

- 49 persons with disability supported to acquire disability identity cards;
- 2 persons with disability linked to a disabled people's organization for membership at the local level;
- 13 children were supported to be enrolled in school;

- 8 persons were oriented on livelihood options and linked to government and non-government organization at the district level;
- 5 persons with a disability were supported for vocational education and employment opportunities and orientated on getting a disability card; and
- 23 persons were sensitized on the rights of people with disabilities and social protection issues.

*A s*eries of coordination meetings were conducted with like-minded organisations that provide other specialised rehabilitation services, including SIRC, TPO, International Medical Corps (IMC) and NDF and referral guidelines for specialized services were developed *(*Annex 3: Coordination meeting minutes*).*

HI Deliverable

Harmonized assessment, referral forms and referral pathways in place

The deadline of deliverable 6 is July 2016. As reported in the first and second quarterly reports, forms and procedures were developed based on the previous experience of HI on rehabilitation system management, and similar national and international documents.

During this quarter, the forms and procedures used at the PT/rehabilitation units, were revised based on feedback from field staff and district health authorities and were consolidated in a single document. This Standard Operating Procedure (SOP) for Physiotherapy/Rehabilitation Units at Government District Hospitals has now been finalised. The SOP is a comprehensive guiding document that outlines the scope of PT/Rehabilitation Units, modalities of interventions, operational aspects, quality assurance both at the hospital and in communities and referral pathways (See Guideline for Referral Pathway for Physiotherapy/Rehabilitation Unit). Annex 4: Standard Operating Procedures).

These tools include:

- PT assessment form
- Social worker assessment form
- Follow up form
- Referral form
- Caregiver orientation checklist
- Discharge form
- Monthly plan and monthly report form
- Case study format
- Location and contact details organizations
- WHO wheelchair service provision form

Guidelines for referral pathways for physiotherapy/rehabilitation units for specialized services (also an integral part of the SOP) were developed based on current practices in the district level health system and after a series of consultation meetings with all specialized services providers including SIRC, TPO, NDF and IMC. A mapping of existing specialised services with their criteria for services provision was carried out, as well as the identification of focal persons for each service. These guidelines will facilitate referrals to specialised and tertiary

care and further rehabilitation support and follow up. (Annex 6: Guideline for Referral Pathway for Physiotherapy/Rehabilitation Unit).

Discussion is on-going with the Disability and Rehabilitation Focal Unit (DRFU) of the Leprosy Control Division (LCD) for the finalization and handover of both the referral guidelines and the SOP by the Ministry of Health (MoH). These resources are available to develop service specifications and quality control mechanisms for the sector as per the long term plans of DRFU.

A further update has been done of the database of beneficiaries as per feedback received from Dr Santhosh Rath, Option's technical consultant, and data entry and analysis continued to generate the periodic report

HI Deliverable 7

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

The deadline of this deliverable is July 2016, now implemented through Activity 1: Training to health and rehabilitation personnel on injury management, Activity 3: Support 7 hospitals to develop PT/rehab Units and deliver services and Activity 2: Training and mobilization of social workers on case management with following sub-activities:

Progress during this reporting period was as follows:

A total of 2,172 patients (566 earthquake affected), excluding children under 5 years of age and persons with intellectual disabilities, have been provided individual patient education during the treatment of their injuries and the provision of trauma care on the benefits of rehabilitation. Additionally, 226 caregivers of earthquake survivors (F: 101, M 125) amongst a total of 831 caregivers (F: 380, M: 451), have been provided individual orientation on the care of patients, and the benefits of rehabilitation, to ensure proper follow up and referrals through the use of the caregiver checklist. (Annex 2: database).

IEC materials on 12 different topics including amputation care; deep vein thrombosis (DVT) care; wound care; pressure ulcer care; bladder and bowel care; cognitive, emotion and communication care; spasticity and flaccidity; respiratory tract infection care; urinary tract infection care; scar and hypertrophic scar care; itching and infection care; post burn contracture available in Nepali language have been used during orientation sessions ensuring two way communications and the exchange of feedback.

See Annex 5 for a case study on community interventions promoting access to rehabilitation.

HI Deliverable 8

1,000 persons with injuries and persons with functional limitations affected by the earthquake receive rehabilitation support at hospital and continue to receive support in their communities

The deadline of this deliverable is July 2016. The services is being continuously delivered to persons with injuries and with functional limitations affected by the earthquakes through the PT/rehab unit at district hospitals and outreach clinics as well as through Activity 1 (Training to health and rehabilitation personnel on injury management), Activity 3 (Support 7 hospitals to develop

PT/rehab Units and deliver services) and Activity 2 (Training and mobilization of social workers on case management) with the following sub-activities:

A total of 574 persons (F: 331, M: 243) with earthquake-related injuries were amongst a total of 2,216 persons (F: 1,171, M: 1,045) who have been provided rehabilitation support at the seven physiotherapy/rehabilitation units and in their communities (1,739 persons at hospital and 477 persons through 57 community outreach and home visits).

Districts	No. of community outreach events/visits
Dolakha-Charikot	11
Dolakha-Jiri	3
Dhading	3
Kathmandu, Bhaktapur and Lalitpur	12
Nuwakot	14
Rasuwa	5
Sindhupalchowk	9
Total	**57**

A total of 3,732 treatment sessions were given to patients including 1,516 follow up sessions (Annex 2: database).

A total of 328 assistive , including 118 mobility aids, 105 braces/splints, 77 therapeutic aids and 28 other assistive devices have been provided through 7 physiotherapy/rehabilitation units (Annex 2: database)

A total of 92 patients (M: 46, F: 46) including 18 with earthquake injuries, have been discharged from their treatment after having achieved their functional outcomes agreed in their individual rehabilitation plans. Amongst these discharges, people with fracture was the highest both for earthquake and non-earthquake affected beneficiaries. Generally, these discharge cases will not need follow up services (Annex 2: database)

The project was able to reach out to a larger number of clients other than the 1,000 initially targeted clients with earthquake related injuries, as the major portion of the budget was for therapeutic equipment, setting up the PT Unit, human resource costs, and outreach activities to identify earthquake affected clients. Thus with the same investment the project was able to expand services to non-earthquake clients.

HI Deliverable 9

MoH's Disability and Rehabilitation Focal Unit (DRFU) takes over work from HI

The deadline of this deliverable is July 2016. This is an on-going activity, partially achieved through Activity 10 (Management support to DRFU to support to enhance institutional/managerial capacity of the DRFU within MoH to continue to initiate, develop and scale up comprehensive rehabilitation service in Nepal):

DRFU, LCD, realizing the requests from five district hospitals for the continuation of the physiotherapy/rehabilitation services considering the higher need in their districts, acknowledged and appreciated HI for rendering physiotherapy and rehabilitation services in

earthquake affected districts and approached the Curative Service Division, MoH for the continuation of these services

The project continued to provide administrative and logistical assistance support to support the daily activities of DRFU and for coordination and communication between HI and its government counterparts. In addition, HI is in the process of procuring additional office equipment and supplies at the request of DRFU, LCD to strengthen DRFU.

HI contributed to the development of MoH's 10 year Health and Rehabilitation Plan to support the National Policy and Plan of Action on Disability facilitated by the Ministry of Women Children and Social Welfare as part of the operationalization of the Nepal Health Sector Strategy. The project team and other likeminded organisations provided technical inputs to design the tools for the gap analysis methodology and handy tools for gap analysis at the policy level and service delivery levels.

HI contributed to develop an injury database after April 2015 earthquake led by DRFU, LDC through participation in meetings and sharing of the HI database with LCD.

HO continued technical support by developing tools for setting up and running rehabilitation units (SOPs and referral guidelines) in coordination with other rehabilitation providers.

Cross-Cutting Activities For Smooth Operating Environment

Continuous professional development of rehabilitation professionals:

Seven physiotherapists from the project, two physiotherapists from SIRC and one physiotherapist from the Institute of Medicine (IoM) participated in a wheelchair service familiarization training based on World Health Organization basic and intermediate wheelchair service packages from 31 January to 3 February 2016 (Annex 7: Wheelchair service familiarization report).

Awareness raising

HI developed a pamphlet featuring information about the physiotherapy/rehabilitation service available in district hospital in the Nepali language for distributing to stakeholders and people in far off and remote locations

Regular meetings

HI participated in regular meetings with DFID/Options and implementing partners for project progress updates, to raise technical and managerial issues, to strengthen functional coordination among partners and to discuss possible extensions/amendments to deliverable deadlines. The project team also engaged to develop and submit a proposal for project extension**.**

Project monitoring visits

The DFID Options consultant conducted a monitoring visit to project sites in Sindhupalchowk, Nuwakot and Dhading.

HI Nepal's country director, an HI headquarter representative and the project team carried out a monitoring visit in Sindhupalchowk. The country director also conducted monitoring visits to Dolakha-Jiri and Charikot.

HI's senior management team (SMT) members and the project team (country director, head of operations, project coordinator, senior project officer) and the trauma and rehabilitation project officer conducted monitoring visits to the physiotherapy/rehabilitation units in project catchment district hospitals and gave feedback to concerned DHOs and staff for enhancing quality of care (Annex 8: Field visit report*) (**Annex 9:** Project activities photographs)*

Plan For Next Quarter

Project Deliverable Specific

HI 5: Five district hospitals, one primary health care centre and one national trauma centre engage in proper discharge of injured patients and proper referral to health and or social/community services:

Identify patients who need further specialised services — orthopaedic and re-constructive surgeries and referral

Analyse date of three different groups of beneficiaries to better define rehabilitation needs: i) discharged patients and persons in need of short term rehabilitation, ii) persons in need of continued follow-up services and iii) persons requiring long term rehabilitation care.

Calculate the cost of a physiotherapy/rehabilitation unit to support DRFU's planning process.

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

Continue data entry and analysis.

Institutionalise the SOPs by sharing the documents with DFRU and MoH and further working on addressing any DRFU and MoH recommendations.

Implement referral pathways and explore their sustainability.

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:

Continue orientation to patients and care givers on the benefits of rehabilitation to ensure proper follow-up and referrals.

Continue IEC materials dissemination.

HI 8: 1,000 persons with injuries and persons with functional limitations affected by the earthquake have received rehabilitation support at hospital and continue to receive support at hospital and community level:

Continue to explore different strategies and strengthen community outreach for meeting targets.

HI 9: HI Deliverable 9: MoH's Disability and Rehabilitation Focal Unit (DRFU) has taken over work from HI:

Organize a national workshop for district approach demonstration for the Ministry of Health.

Community based rehabilitation manual revision with incorporation of injury management and institutionalisation with the National Health Training centre (NHTC), MoH

Run multidisciplinary training on injury/trauma management and rehabilitation for doctors, nurses and physiotherapists.

Officials from the Curative Service Division, DRFU and HI make monitoring visits to PT units in district hospitals.

Continued advocacy with MoH for continuation of support.

Support activities for achieving project deliverables:

Project team review meeting.

Continue data collection and disaggregation to enhance accuracy and allow better analysis, planning and evaluation of outcomes at HI internal level.

Share of monthly achievements with the district health office in the official format used by DHOs/DPHOs to feed into the Health Management Information System under the coding 9.3, Section 15. Outpatient Morbidity—4 (Including under-5 year old children)

A study is being done on 'The lived experience of injury and rehabilitation after the Nepal Earthquake: A mixed method, cross-sectional study of transitions between health and rehabilitation services'.

Monitoring visits by district health offices, Leprosy Control Division and Curative Service Division, MoH

Participate in regular meetings of DRFU/LCD, to contribute in the development process of the long term disability and rehabilitation plan being prepared by DRFU, Leprosy Control Division.

Coordinate with concerned stakeholders, DPOs and participate in relevant meeting related to injury/trauma and rehabilitation services, special protection and advocacy for disability rights.

Challenge and Constraints and Adjustments

Constraint 1: Physiotherapy/rehabilitation units are functioning under temporary structures in most catchment districts.

Mitigation measure: Dialogue is ongoing with DHOs, hospital management boards, DRFU/LCD and the Curative Service Division, MoH for providing more permanent infrastructure and space.

Constraint 2: The non-availability of funds for supporting discharge and referrals including the purchase of fixators for poor and needy patients from remote and far off locations who have limited access to physiotherapy and rehabilitation services.

Mitigation measures:

- Dialogue on-going with DHOs, hospital management boards, DRFU/LCD and Curative Service Division, MoH for supporting discharge and referrals including fixators purchase.
- A temporary arrangement has been made from funds identified by HI from external sources to support the discharge and referral of poor and needy patients in line with the guidelines for supporting discharge and referral cases.

Constraint 3: High transportation costs at the district level for conducting community outreach in remote and far off VDCs and thus, limited community outreach at district level:

Mitigation measure: Map local vehicle hire vendors in districts and make wise use of vehicles hired for community outreach and reach far off VDCs to provide services to needy people.

Constraint 4: The complete achievement of PD 9 of MoH's Disability and Rehabilitation Focal Unit (DRFU) taking over work from HI within the current project period, ending July 2016.

Mitigation: Despite the acknowledgment of the relevance and quality of support currently provided by HI, the achievement of this complex deliverable is challenging from several points of view. The integration of rehabilitation services into the health system will require comprehensive needs assessment and planning, the further development of DRFU's capacities (technical and managerial) and the engagement of the health sector from a financial point of view, taking into account all the priorities in the reconstruction phase. These system challenges were discussed extensively during the visit by Dr Santosh and propositions made to continue building on the current activities beyond the current project.

Signature: ……

Date:

Name: Sarah Bin,

Designation: Country Director, Handicap International Nepal

Annex 1: List of PT Equipment and Assistive Devices Delivered this Quarter

S.N.	Description of Goods or Services	Quantity	Unit	Unit Price (NPR)	Total Price NPR	PSR reference
	PT Equipment					
1	Corner chair with detachable tray (Small size)	1	no.	8,000.00	8,000.00	NEP/16/009/007
2	Stand in table for children (Small size, height adjustable)	1	no.	35,000.00	35,000.00	
3	Foam role(tumble) (15cm*60cm long)	1	no.	8,000.00	8,000.00	
4	Activity mattress 120*190*10	1	no.	20,000.00	20,000.00	
5	Activity mattress 120*190*5 (Portable)	1	no.	18,000.00	18,000.00	
6	CP chair (Small size)	1	no.	12,000.00	12,000.00	
7	CP chair (Medium size)	1	no.	24,000.00	24,000.00	
8	Stand in frame (Adult size)	1	no.	16,000.00	16,000.00	
9	Stand in frame (Child size)	1	no.	12,000.00	12,000.00	
10	Wall mirror (6*5 feet)	1	no.	12,000.00	12,000.00	
11	Mushroom board (Child size)	1	no.	6,000.00	6,000.00	
12	Smooth exercise board (Top 120 cm * 100 cm, angle adjusted both side)	1	no.	20,000.00	20,000.00	

13	Weight cuffs 250 gm.	2	no.	600.00	1,200.00	
14	Axial shoulder exerciser (With 360 degree scale)	1	no.	6,500.00	6,500.00	
15	Continuous passive unit (Lower extremity)	1	no.	60,000.00	60,000.00	
16	Climbing stool (10"* 12"* 2" High)	1	no.	5,500.00	5,500.00	
17	Climbing stool (16"* 20"* 8 " High)	1	no.	5,500.00	5,500.00	
18	Parallel walking bar (Height adjustable from 76 CM to 100 CM)	1	no.	30,000.00	30,000.00	
19	Cervical & Lumbar traction kit (Sitting, 5 KG)	1	no.	66,000.00	66,000.00	
20	Muscle stimulator (Stimulator, TENS & IFT Combo)	1	no.	38,000.00	38,000.00	
21	Moist heat (4 stream packs)	1	no.	40,000.00	40,000.00	
22	Wall bar (Wooden, 90 CM wide and 250 CM height)	1	no.	30,000.00	30,000.00	
23	Balance board (Wooden)	1	no.	8,000.00	8,000.00	
24	Cycle ergociser (Semi recumbent seat arrangement)	1	no.	25,000.00	25,000.00	
25	Prone crawling board (30cm*90cm*7cm)	1	no.	11,760.00	11,760.00	
26	Measuring tape (Metallic, 3 meter)	1	no.	300.00	300.00	
27	Examination couch (Low, 36"* 12)	1	no.	22,000.00	22,000.00	
28	Wooden foot stool (45 CM deep * 30 CM height)	1	no.	4,800.00	4,800.00	
29	Dumb bells 2 kg, covered with plastic incase	1	no.	1,130.00	1,130.00	

30	Dumb bells 3 kg, covered with plastic incase	1	no.	1,412.50	1,412.50	
31	Weight cuffs 0.5 Kg	2	no.	508.50	1,017.00	
32	Weight cuffs 1 KG	2	no.	649.75	1,299.50	
33	Knee hammer (With the metal stand)	1	no.	107.35	107.35	
34	BP set (Manual, Adult size)	1	no.	2,034.00	2,034.00	
35	BP set (Manual ,Child size)	1	no.	2,147.00	2,147.00	
36	Portable pulse oximeter (Choice Med)	1	no.	3,842.00	3,842.00	
37	Examination couch (High, 72"*24")	1	no.	17,515.00	17,515.00	
38	Weighing machine (Child and adult size)	2	no.	2,175.25	4,350.50	
39	Bed sheet (Large size, Green color)	2	no.	974.62	1,949.24	
40	Macintosh (6*4 feet)	2	no.	282.50	565.00	
41	Portable curtain divider (Metal stand, 3 folds)	1	no.	4,068.00	4,068.00	
42	Pillow (rexine covered, adult size)	2	no.	395.50	791.00	
43	Pillow (rexine covered, adult size)	1	no.	395.50	395.50	
44	Normal Quadriceps exercise table (70 CM * 80 CM * 120CM high)	1	no.	28,137.00	28,137.00	
45	Shoulder pulley set (With Tee Bracket)	1	no.	2,825.00	2,825.00	
46	Wedge (4.30 CM* 60 CM* 70 CM)	1	no.	10,735.00	10,735.00	

47	Goniometer (360 degree)	1	no.	1,017.00	1,017.00	
48	Rangela moulding dough (5 safe moulding dough)	2	no.	500.00	1,000.00	
49	Child friendly room (Back ground Pic and toys)	1	no.	15,000.00	15,000.00	
50	Floor carpet (As per the size of therapy room)	3	room	2,350.00	7,050.00	
51	Towel (Blue color)	2	no.	1,000.00	2,000.00	
52	Wall clock (Battery operated)	1	no.	1,000.00	1,000.00	
53	Water filter (Steel)	1	no.	2,000.00	2,000.00	
54	Heater (Electric)	1	no.	3,000.00	3,000.00	
55	Water Glasses (Metal)	4	no.	200.00	800.00	
56	Body chart (Musculoskeletal system)	1	no.	300.00	300.00	
57	Book (Disabled village children, by David Werner)	1	no.	150.00	150.00	
58	Book (Where there is no doctor by David Werner)	1	no.	400.00	400.00	
59	Furniture (Table, 2 chairs and one bench)	1	no.	8,500.00	8,500.00	
60	Notice board (Wooden)	1	no.	5,000.00	5,000.00	
61	Activity mattress 120*190*5 (Portable)	4	no.	18,000.00	72,000.00	NEP/16/009/014
62	Cervical & Lumbar traction kit (Sitting, 5 KG)	5	no.	66,000.00	330,000.00	
63	Muscle stimulator (Stimulator, TENS & IFT and ultrasound Combo)	5	no.	103,000.00	515,000.00	

64	Moist heat (4 stream packs)	5	no.	40,000.00	200,000.00	
65	Goniometer (360 degree)	2	no.	1,200.00	2,400.00	
66	Measuring tape (Metallic, 3 meter)	5	no.	300.00	1,500.00	
67	Examination couch (Low, 36"* 12)	2	no.	22,000.00	44,000.00	
68	Wooden foot stool (45 CM deep * 30 CM height)	2	no.	4,800.00	9,600.00	
69	Knee hammer (With the metal stand)	3	no.	107.35	322.05	
70	BP set (Manual, Adult size)	5	no.	2,034.00	10,170.00	
71	Stethoscope	2	no.	847.50	1,695.00	
72	Weighing machine (Child and adult size)	4	no.	2,175.25	8,701.00	
73	Bed sheet (Large size, Green color)	6	no.	974.62	5,847.72	
74	Portable curtain divider (Metal stand, 3 folds)	5	no.	4,068.00	20,340.00	
75	Pillow (rexine covered, adult size)	6	no.	395.50	2,373.00	
	Assistive Devices					
1	Arm Sling Small size	21	no.	260	5,460	NEP/16/009/044
2	Arm Sling Medium size	21	no.	260	5,460	
3	Toilet chair Small size	55	no.	2,450	134,750	
4	Toilet chair Large	14	no.	4,900	68,600	

5	Knee Cap Child size	7	no.	320	2,240	
6	Knee Cap Adult size	14	no.	320	4,480	
7	Anklet Small size	14	no.	320	4,480	
8	Anklet Adult size	21	no.	320	6,720	
9	Thermoplastic with foam Upper limb	7	no.	3,200	22,400	
10	Thermoplastic with foam Lower limb	7	no.	3,200	22,400	
11	Chip cushion (460*460*50MM)	35	no.	1,000	35,000	
12	Knight Tailor brace Medium size	7	no.	1,950	13,650	
13	Knee immobilizer Medium size	14	no.	1,065	14,910	
14	Anit -bed sore cushion - Electricity operated	14	no.	3,750	52,500	
15	Anti-DVT stocking (Pairs)	14	no.	2,550	35,700	
		Total amount NPR.			**2,329,796.36**	

Annex 2: Client Database – see separate digital file included with submission

Annex 3: Coordination Meeting Minutes

Coordination meeting minute

Context

Referral and appointment is one of the important service steps in health service delivery. In Nepal rehabilitation services are not still integrated within the health. The service is being delivered by mostly local NGOs through the donor funded and some few government funds. The census done in 2011 claims 1.94 % of the people in Nepal have disability out of which 36% of them have physical disability. In addition to that, the injuries due to the recent earthquake in Nepal have further enhanced the demand for rehabilitation. Within the Leprosy Control Division, Department of Health Services (DoHS) of Ministry of Health (MoH), a Disability Rehabilitation Focal Unit (DRFU) has been formed which is the focal department in health for disability and rehabilitation. A short- term, medium- term and long- term plan for the development of rehabilitation services was made by the MoH as part of the Health Sector Rehabilitation and Reconstruction Plan after an April 25th 2015 Earthquake.

Among actions identified in the medium to long term strategy, the **decentralization of rehabilitation services to the most affected districts** was acknowledged as a priority to ensure continuum of care and address the long term follow up needs for the injured.

The establishment and extension of existing rehabilitation services by the several national and international organizations is part of this strategy. With the limited availability of the multidisciplinary team and unavailability of range of services for different type of physical disability/injury within the same roof, existing facility need to refer the cases to ensure the continuum of the care

Therefore the first and second coordination among the stakeholder was done to better understand the nature of service delivery and then agree and promote the common systematic referral and appointment procedure among the service providers.

Date: 8th April 2016

Participants

Name	Organizations
Mahendra Bikram Shah	HI
Kit Leung	IOM
Dr. Girwan Timilsina	IOM
*Pushpak Newar	HI
Dr. Pawan Sharma	TPO
Dr. Pratikshya Chalise	TPO
Amit Dhungel	IMC
Esha Thapa	SIRC
Sunil Pokhrel	HI
Dipesh Pradhan	SIRC
Ashok Poudel	IMC

Discussions

- Presentation about the nature of service delivery and referral criteria was done by each organization
- Each organization agreed to promote the systemic cross referral mechanism
- Each organization agreed to work jointly to advocate and lobby with government in matter related to quality assurance and sustainability of the rehabilitation services in Nepal

Action points

- To promote the systematic cross referral and appointment system , a common referral guideline that consist of detail referral criteria, services available and contact details of the focal person has to be agreed upon.
- Referral form shared by TPO is simple that is to be circulated among the participants to have the feedback. By the next meeting the form to be finalized.
- Each organization will share the referral criteria and HI will organize all the information of each organization into the single document.
- Cross referral to each organization needs to be documented to generate evidence which can be shared to government later on
- Next coordination meeting will be conducted at IOM country office.

Annex 4:

2016

Standard Operating Procedure for Physiotherapy/ Rehabilitation Unit in District Hospitals of Nepal

Standard Operating Procedure for Physiotherapy/ Rehabilitation Unit in District Hospitals of Nepal

HANDICAP INTERNATIONAL

Table of Contents

List of acronyms

CBM	Christian Blind Mission
CBR	Community Based Rehabilitation
CP	Cerebral Palsy
COPD	Chronic Obstructive Pulmonary Diseases
DFID	Department of International Development
DHO	District Health Office
DPHO	District Public Health Office
DPO	Disable People Organization
FCHV	Female Community Health Volunteer
IEC	Information Education and Communication
IFT	Interferential Therapy
IMC	International Medical Corps
IOM	International Organization for Migration
IPD	In-Patient Department
IRSC	Injury Rehabilitation Sub- cluster
MOHP	Ministry of Health and Population
MSF	Médecins Sans Frontières
MWCSW	Ministry of Women Children and Social Welfare
NCD	Non-Communicable Diseases
OCMC	One Step Crisis Management Center
OPD	Out Patient Department
PT	Physiotherapy, physiotherapists
SCI	Spinal Cord Injury
SOP	Standard Operating Procedure
SW	Social Workers
TB	Tuberculosis
TENS	Transcutaneous Nerve Stimulation
UKIETR	UK International Emergency Trauma Register
UNCRPD	United Nation Convention on the Rights of Persons with Disabilities
UNDP	United Nation Development Program
VDC	Village development Committee
WHO	World Health Organization

1. Background

Nepal is one of the countries with highest risk of devastating earthquake. In 2004, the United Nations Development Program (UNDP), Bureau of Crisis Prevention and Recovery ranked Nepal as the 11th most vulnerable country with respect to seismic hazard out of 200 countries in world.

The Ministry of Health with the support of WHO and the contribution of humanitarian and development actors such as Handicap International have been working in disaster preparedness with a focus on mass casualty management since few years in Kathmandu Valley. Trauma protocol guidelines, training manuals, IEC materials on injury management were jointly developed and health staff (Doctors, Nurses and Physiotherapists) working in the most important referral hospitals were trained.

Following the earthquakes that hit the country in April and May 2015, 8856 people lost their life and 22,309 were injured. Out of the 14 affected districts, only Kathmandu, Bhaktapur, Lalitpur and Kavrepalachok have surgical and rehabilitation facilities. Given the high number of survivors with impairments caused by earthquake-related injuries, an Injury and Rehabilitation Sub-Cluster (IRSC) was established under the Health Cluster to help coordinate the response of Foreign Medical Teams and local organizations. The Leprosy Control Division at the MoH was given the responsibility to lead this group with the support of UKIETR for the first 2 months of the response.

The members of the IRSC were rehabilitation stakeholders (rehabilitation centers, hospitals and professional associations) in Nepal and non-state actors like Handicap International (HI), CBM, IOM, MSF and IMC. Several working groups were established under the IRSC in order to address specific needs identified during the early response such as further trainings on injury management to health staff and community actors, development of guidelines for the management of spinal cord injury and amputation, and last but not least policy development for rehabilitation services to address a pre-existing gap within the health system. A short term, medium term and long term plan for the development of rehabilitation services was fostered by the MOHP as part of the Health Sector Rehabilitation and Reconstruction Plan.

Among actions identified in the medium to long term strategy, the **decentralization of rehabilitation services to the most affected districts** was acknowledged as a priority to ensure continuum of care and address the long term follow up needs for the people with injury/functional limitation and disability.

The establishment of 7 PT/rehabilitation units is part of this strategy and it has been implemented by HI in partnership with the newly established Disability Unit at the MoHP and the support of DFID Option. PT/Rehabilitation units have been set up in Sindupalchok, Dhading, Nuwakot, Rasuwa, Dolakha and Kathmandu.

Location of 7 physiotherapy and social service units

2. Objectives of standard operating procedures for PT/Rehabilitation units at Hospital setting

In Nepal regulation of rehabilitation services and definition of standards of care are still poorly developed. PT/rehabilitation units exist in some tertiary level hospitals and in urban areas only, while the establishment of such units at the district level is very recent and triggered by the increased needs after the earthquake.

The definition of SOP for PT/rehabilitation units in Nepal is an ongoing process and further revisions are expected with the contribution of stakeholders engaged in the development of rehabilitation services, both MoHP and non-state actors. The SOP can be used for the rehabilitation units at the tertiary level hospital care as well, with some modifications.

This document is meant to:

- Support the MoH to establish common procedures and standards of care for the delivery of rehabilitation services at district level;
- Provide comprehensive information to clinical staff, health facility managers and users on how a rehabilitation unit should look like, what kind of services are available and what are the modalities of access; and, .
- Ensure that rehabilitation services are delivered according to quality criteria in health care such as effectiveness, efficiency, patient-centered, equity and accessibility.

The contents of this initial document were developed with reference to:

- Existing SOP in use in physical rehabilitation centers in Nepal, managed by civil society organizations;
- Scope of practice of physiotherapy profession according to the World Confederation of Physical Therapy;
- Quality health care guideline by the WHO;
- Rehabilitation Management System -Handicap International (used in Nepal and elsewhere)
- WHO Community Based Rehabilitation guideline;
- WHO "Guidelines on the provision of manual wheelchairs in less resource settings"
- Nepal government policy on quality assurance in health care service; and,
- Nepal government free health care guideline.

3. Scope of PT/ Rehabilitation Units at Hospital Setting of Nepal

Rehabilitation services at the district health system represent a strategy to decentralize care and improve access to quality rehabilitation in communities. In this sense, rehabilitation units contribute to the **health** component of the **community-based rehabilitation** strategies according to the CBR matrix by World Health Organization. It should be in link as much as possible with available CBR programmes.

The presence of social workers in the unit is meant to facilitate the links with other non-health CBR components, in particular to access disability cards (Women and Children Office in districts), linkage with One Step Crisis Management Center (OCMC) and disable people organizations and other community-based resources.

PT/Rehabilitation services at the district level contribute to the following areas in the health care:

Health promotion: promoting strategies for people with or without impairments on how to achieve or maintain good health. Often, people with impairments and disabilities have little awareness on how to maintain good health. The role of rehabilitation services in health promotion focus on health education, referring to health promotion programmes implemented in the communities and providing specific information on healthy life style by adapted to the specific needs of individuals, with or without impairments (for example for people with diabetes, or people with chronic pain). Some examples: teaching regular exercise or avoiding smoking to prevent respiratory diseases.

Prevention: implementing strategies to avoid further complications when certain conditions are already present. For example, referring children with malnutrition to nutritional rehabilitation centers to prevent developmental delays; adapting homes or providing mobility aids to prevent falls for the elderly; teaching pressure relief techniques to caregivers of bedridden patients to avoid pressure sores; identifying signs of post-traumatic psychological distress and referring to specialized care to avoid worsening of the condition.

Medical care: Physiotherapist work in tandem with doctor, nurses and paramedics on this part of care and are able to identify needs for referral to medical care, especially on orthopedic or plastic surgery as part of the rehabilitation process. Chest physiotherapy is another example of intervention that is complementary to drug therapy in case of respiratory diseases.

Habilitation & Rehabilitation: Assist those who experience loss of function and need to learn or re-learn how to perform activities of daily living to maximize function. This includes early stimulation of children with developmental delays, gait training with prosthesis for amputees, muscle strengthening through exercise after fractures.

Assistive devices: External appliances designed, made, or adapted to assist a person to perform particular task. It includes mobility aids such as wheelchairs, developmental aids, orthoses and prosthesis (see *Assistive Devices services* chapter in this document for more details

4. Clinical conditions eligible for rehabilitation services

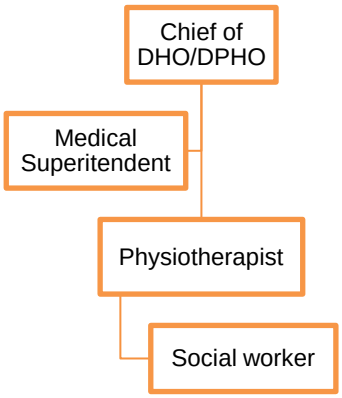
Even if the main focus of intervention is on people with injuries, rehabilitation services have a larger scope and a wider range of people with impairments can benefit from it.

The following table includes all types of impairments and conditions that can be identified and assessed at the district level and benefit from PT/rehabilitation unit either directly delivered at the unit or referred for more specialized care:

Orthopedics	**Neurological**	**Cardio respiratory**	**Other NCDs**
Post trauma/surgery joint stiffness	Multiple sclerosis	COPDs	diabetes (Foot ulcers, pain, limb amputation)
Post trauma/surgery joint pain/swelling	Paralysis due to Poliomyelitis	Dyspnoea	Cardiovascular diseases (hypertension)
Post trauma/surgery muscle weakness	Peripheral nerve injury	Airflow obstruction/mucous retention	Peripheral vascular disease
Stump management following amputation	Hemiplegia	Restrictive lung diseases	
SCI patients-medically and			

surgically stabilised		**Pediatrics** Birth defects: club foot, spinal bifida, Down Syndrome, cleft lip/ palate Developmental delays (including the ones due to malnutrition) and Cerebral palsy **Others** Referral for the specialized services: Wound management, Prosthesis & Orthoses, Corrective & Reconstructive surgeries and specialized rehabilitation services
Burns	Neurological conditions due to Meningitis	
Head trauma – Stabilised	Parkinson's disease	
Torticollis	Muscular dystrophy	
Idiopathic scoliosis	Transverse myelitis	
Ankylosing spondylitis	Multiple sclerosis	
Spondylolisthesis(isthmic type and post- surgical)	Motor neurone diseases	
Spondylitis	Peripheral nerve injury	
Osteoarthritis	Hemiplegia	
Rheumatoid arthritis	Poliomyelitis	
Septic arthritis	Meningitis	
Osteomyelitis	Parkinson's disease	
Ligament and tendon disorders		
Soft tissue injuries		
TB spine after medical or surgical management		

5. Organogram of PT/Rehabilitation unit:



The chief of DHO/DPHO is the focal unit for health services in districts; hence the overall management of the services falls under the management of chief of DHO/DPHO. As the rehabilitation unit is functionally located on the health facility, the **health facility in charge** or **medical superintendent** is the direct manager of all service delivered. Therefore the physiotherapy, rehabilitation and social protection services delivered from the same hospital falls under the management of in-charge or medical superintendent. Leaves and prior approval for the training of physiotherapist and social worker has to be approved by in charge or medical superintendent of the hospital. Similarly, the yearly appraisal of both staff is done by the medical superintendent with the final validation by **chief of DHO/DPHO**.

Each PT/rehabilitation unit is composed of 1 physiotherapist and at least 1 social worker. The major component of services to be delivered is the physical rehabilitation that's why the physical therapist is the in-charge of the PT/rehabilitation unit who are responsible to directly line manages the social workers. The physiotherapist reports to medical superintendent and chief of DHO/DPHO on clinical activities, data collection and general working conditions.

Physiotherapists and social workers are based at the district hospital. However, given the need of supporting **identification** of patients with low mobility and the need of **direct follow up** and home visits for **care-giver education** and **home adaptations,** they may both deliver their services directly in the villages through outreach.

Supervision: At present the national health system does not have a rehabilitation specific human resources strategy and system in place for the management of rehabilitation services, including a supervision system. Therefore, physiotherapists and social workers are supported by International organizations that hold the expertise on the sector. Support is provided on data collection and management, creating patient flow procedures and continuing professional development to ensure the highest standards of care. This is done in accordance to the MoH service regulation and in close collaboration with health facility and in-charge/medical superintendent and chief of DHO/DPHO.

Responsibilities of PTs

- Undertake a comprehensive examination/assessment of the clients or their needs;
- Evaluate the findings from the examination/assessment to make clinical judgments regarding client.
- Make a diagnosis, prognosis and plan

- Formulate the problem list and set goals in partnership with the client and other health care professionals who are involved in the management of the client;
- Provide consultation within their expertise and determine when clients need to be referred to another healthcare professional
- Implement a physical therapy intervention/treatment programme
- Determine the outcomes of any interventions/treatments
- Make referral and appointment, assessment, prescription, product preparation. For specialized devices like Prostheses & Orthoses seek consultation with a Prothetist & orthotist from nearest rehabilitation centre (s)
- Direct line management of social workers and support on their continuing professional development
- Record, evaluate and report the various activities conducted through the physiotherapy/ rehabilitation service unit of the hospital to the chief of District Public Health office in close coordination with District Tuberculosis and Leprosy Officer (DTLO), Statistics Officer and Medical Recorder;
- Represent various sub-clusters directly or indirectly related to rehabilitation under the health clusters in district;
- Participate on the health and rehabilitation related outreach activities organized by district public health office and also conduct the camp in close collaboration with disable people organizations
- Ensure that each of the beneficiaries receives the appropriate follow up based on the severity of the conditions
- Facilitate the referral of beneficiaries to specialized hospitals and rehabilitation centers whenever and wherever appropriate for the client
- Awareness raising and care giver orientation
- Inventory management of physiotherapy and assistive devices
- Mobilize office helper to maintain the safety, hygiene and cleanliness of the department
- Make coordination with all concerned stakeholders to improve access to and utilization of health and rehabilitation of need of the people with injury/functional limitation and disability.

6. Responsibilities of Social Workers

- Identify the injured/earthquake survivors, vulnerable individuals and households at hospital facility, PT/rehabilitation unit of deployed hospital through comprehensive assessment of needs that include physical rehabilitation, reconstructive surgery, various injuries management including spinal injury care services, prosthetics, orthotics, psycho-social and basic needs including nutrition;
- Evaluate socio-economic status of injured, traumatized and priorities the needs of individual client and plan social protection need and facilitate to approach to concerned stakeholders for the provision of essential support;
- Assess the psychosocial support/counseling need of client and their care takers provide psychosocial first aid, psychosocial support/counseling with anticipated quality;
- Support physiotherapist /clinician, hospital administration, patient and care givers for supported discharge plan; and,
- Records and manage all relevant information of patients and provide available data to the concerned patients and to the professionals as appropriate for the patients' welfare.

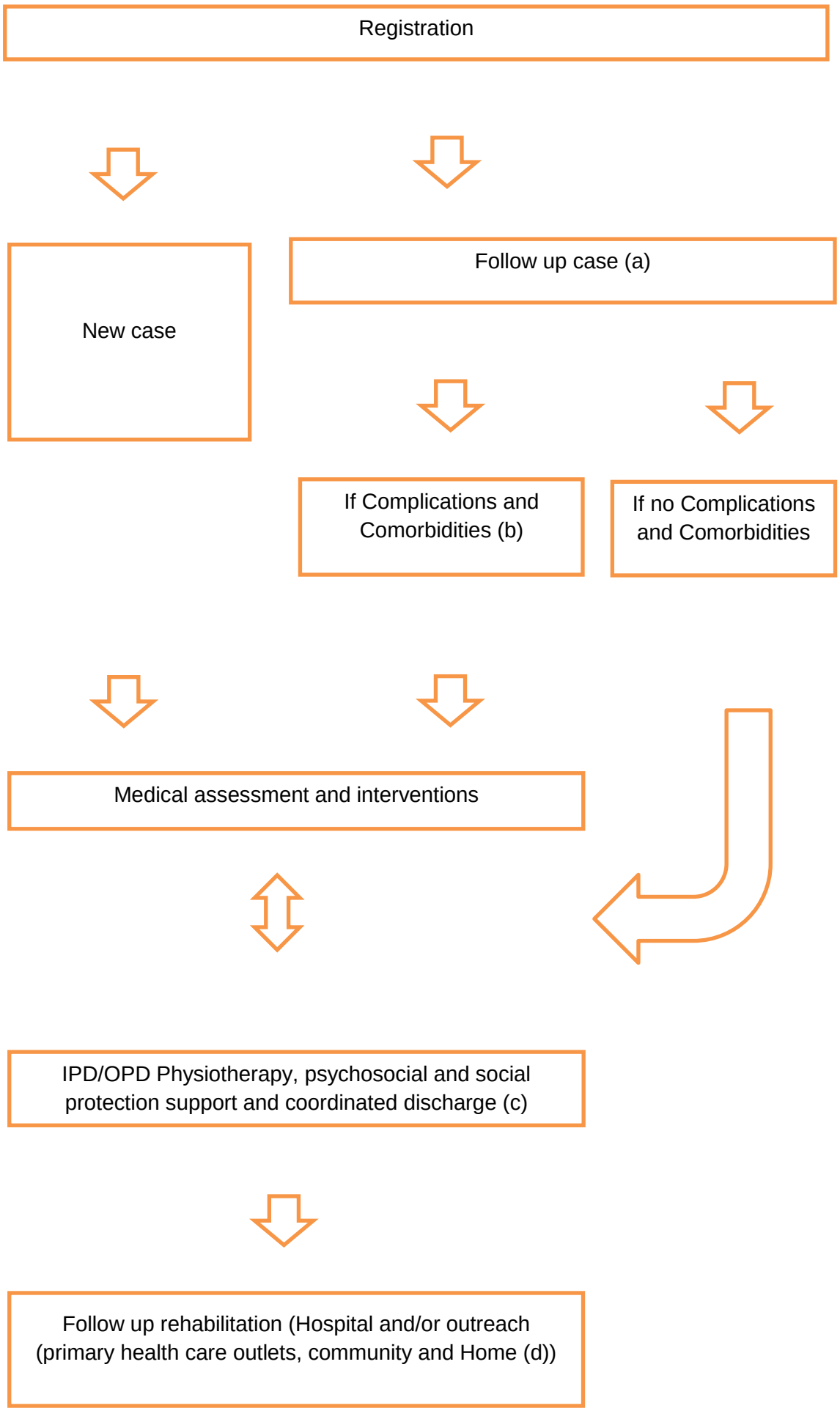
7. Modalities of interventions:

To promote the access of services to maximum population, there should a blended approach of a care that includes hospital based, outreach (primary health care outlets,

community and patient's home based services and referrals to specialized health and rehabilitation services)

- **Hospital-based physiotherapy**: Is delivered to clients who are referred by the health professional, social workers/mobilizer of same or different hospital/organizations.
- **Outreach (primary health care outlets, Community and home visit) based care**: Based on the severity of the impairment services should be delivered on the home of client who has difficulty in reaching the hospital for timely care. Home visit also includes interventions to support client and family members on promoting the physical accessibility. Individual home visit to all clients may not be feasible every time to cover the need, therefore outreach events to cover the unmet need has to be also conducted to deliver the services in or nearby the doorstep of the people.
- **Referral to specialized services**: Health and rehabilitation facility in district level is a bridge between the community and specialized services. The specialized services mean any intervention that is beyond the capacity of district hospital. Therefore there should be the appropriate cross-referral mechanism with the facilities having the specialized services (orthopedic surgery, plastic surgery and orthopedic workshops)

8. Service pathway of client requiring the rehabilitation services in district hospital



a) **Follow up cases***:* It refer to case who receive the service from PT/rehabilitation unit for the follow up or the cases who already received similar service from another hospital or organization. Rehabilitation is a long term process and usually requires several sessions hence it needs a follow up care to ensure continuum of care.

b) **Complications:** see in the table below a list of common complications in people with injuries and trauma. They can be also caused by co-morbidities (for example diabetes), poor mobility and poor hygiene (in wound care & catheterization)

Musculoskeletal	• Joint stiffness • Contracture • Arthralgia/Myalgia • Hemarthosis • Associated physical injury
Neurological	• Spasticity • Reflex sympathetic dystrophy • Autonomic dysreflexia • Bladder and bowel problems
Circulatory	• Peripheral cyanosis • Swelling • Orthostatic hypotension • Hypovolemic shock
Genitourinary	• Urinary tract infection
Systemic	• Systemic infection • Central cyanosis
Skin	• Wound infection • Pressure ulcers

c) **Coordinated discharge:**

It's a joint decision making process for discharge from the hospital. The team in district hospital setting is doctors, physiotherapist, social worker and nurses. During the coordinated discharge, the follow up needs has to be identified jointly and noted down in discharge forms.

d) Rehabilitation in community

Community based care in rehabilitation is very important to ensure identification of new cases especially in remote communities, referral to require services and/or follow up.

Please see also section 9 *Community interventions and outreach* for detailed information

9. Community interventions and outreach

These are programs that provide specific physical rehabilitation services by a team of professionals to people who would otherwise not have access to those services because of financial constraints in covering travelling costs or the remoteness of the region. As general principles, outreach activities by physiotherapists and social workers based in district hospitals are carried out in case of:

- Need of specific interventions that cannot be delivered in the hospitals: mobility limitation of patients and remoteness and financial costs for travelling to the hospital cannot be covered.
- Limited capacity on identification, referral and follow up of individuals in need of rehabilitation by CBR worker or primary health care staff and FCHV.

The outreach activities to be conducted include 4 main types of services:

a) Identification of new clients and assessment of rehabilitation needs

b) Follow up:

- Monitoring of progress and re-assessment if necessary
- Ensure that client is performing home exercises (respect of type and frequency) as prescribed in initial sessions at home or at the hospital.
- Identify further supports needs in term of family member orientation/education on proper caregiving such as positioning, getting dressed, toileting, transfers within and outside the house, support for exercise
- Explore what local resources can be utilized for the rehabilitation
- Accessibility audits and prescribes local measures to reduce the physical barriers
- Support on repair and maintenance of assistive devices if required
- Coordinate with local VDC office; disable people organizations and local community groups to promote participation and access to specific support measures

c) Referral to specialized service centres, if required:

Referrals are to be made following the specific referral guideline made for the PT/Rehabilitation unit in district hospitals.

d) Awareness raising

Awareness raising about rights to health and inclusion of persons with disability & availability of services.

Follow up in the community needs to be prioritized for the following cases:

- People with the complex injuries like spinal cord injury, head injury and multiple traumas who live very far from the district hospital but needs periodic care.
- People who have received the assistive devices, especially wheelchairs, to ensure the proper use of device for safety and to address any accessibility issue
- Children with the disabilities whose therapy and assistive device need varies as the age goes on increasing

e) Methodology to conduct an outreach event

Collect the information of injured survivors from DHO/DPHO or District administration office or district level DPO or collect from all and choose the best one

List down the VDCs with priority number 1, 2, 3, 4 based on the highest to lowest load of survivors

Select one or two VDCs at a time where you have to conduct your outreach. Then decide the nearest health facility for these selected VDCs. If not health facility then school or VDC office can be selected as venue

Propose DHO/DPHO about the plan and request the support to disseminate the message of this outreach to the health facility in charge. Then ensure that health facility in charge is going to disseminate the information to FCHVs who are supposed to disseminate information to each household. This process may take a week time. At the same time forward the similar request to disable people organization who will be disseminating the information to their VDC network

After the green signal from DHO and DPO, write a TOR mentioning the objective of this visit, duration of travel and budget required. Seek an approval from the project.

Conduct the outreach as planned (Travel on your scooter if applicable otherwise propose a budget for vehicle

A quick update of the outreach shall be shared as soon as after the completion and detail of it should appear in monthly report.

- PT must be there in each visit. If not, participating social worker should collect all the information mentioned in their assessment form. Very importantly on the intervention plan there should be information on how long the person will require a care. If not then it has to be clearly stated that s/he do not require further care.
- Still there is not the well-established therapeutic culture in clients to seek rehabilitation services. While disseminating the information about camp it's very vital to spread messages about the services to be offered on the proposed outreach. Very specifically information about the type of impairment and devices to be offered has to be well communicated beforehand. On these outreach, focus on calling all the injured survivors irrespective of severity.
- Involve DHO/DPHO and DPO at least in a quarter as the process of the joint monitoring.
- Involve local health facility staff like nurses and other paramedics so as to maximize the responsiveness.
- Apart from local health facility and disable people organizations, also utilize the VDC network like school teachers and ward citizen forum to disseminate information about outreach

10. Referral

In many instances the available medical and surgical services are not sufficient to deliver the comprehensive treatment. When more specialized care is required, referral is made according to the needs of each patient to the specialized care centers/hospitals (Annex-4) In particular:

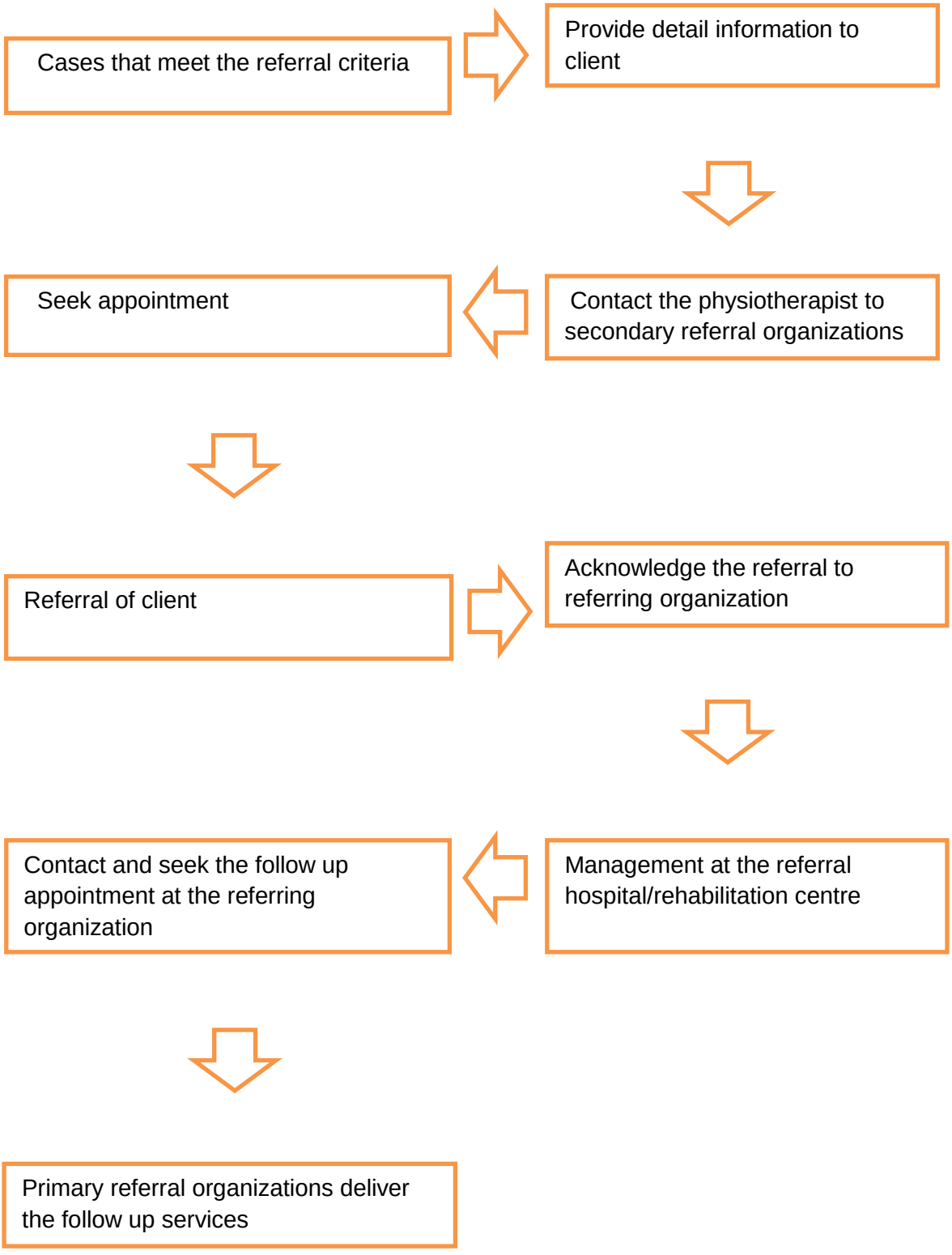
- Specialized hospitals with capacity to conduct corrective and reconstructive surgeries orthopedic surgery and neurosurgery
- Rehabilitation centers with orthopedic workshop for production and fitting of Prosthesis and Orthoses
- Health mobile camps scheduled in the districts and delivered by MoH or NGOs (surgery, rehabilitation & others)
- Specialized rehabilitation centers delivering intensive care for specific health condition such as spinal cord injuries
- Psycho-social support and mental health services

Other referrals might be needed to support clients eligible for social security schemes delivered by the MWCSW or for other specific community-based services within CBR programmes

- Women and Children Office for disability card
- Livelihood programmes, education programmes, and social services

Procedures for referral

The referring organization should follow this procedure while referring cases to district hospitals. The mechanism of the referral is as below,



Section 4 explains the condition to be referred for the PT/rehabilitation unit of the district hospital

a) **Provide detailed information:**

The referring organization provides information about the organizations to be referred which includes the following,

- The location and contact details of the focal person of organization to be referred
- It also includes the mode of transportation from the district. Many clients may require the rough map of the bus station from their native to the hospital to be referred.
- Services available and cost of the services
- Tentative duration of stay and also discuss if one person need to accompany for the caregiving
- Importance of the post-surgical rehabilitation follow up after s/he get discharged from hospital
- Informing clients to take previous medical test report and previous medical/follow up card

b) **Seek appointment**

The organization that is supposed to receive the referral may have already a waiting list. Hence it's very important to have prior appointment of the clients. For this the referrals form (Annex 4) can help decision making since it contains all relevant information on the client: age, clinical history, investigation reports and photos. Referral form and reports can be shared via email, what's app or viber (whatever applicable). This will help the doctors and rehabilitation team of hospital receiving the referral to decide if the intervention is possible at the hospital or not, the possible prognosis and tentative cost of the intervention. Sharing of information also help to check the possibility of refusal after client come to hospital.

c) **Referral of client:**

After providing all the information, facilitate the referral of client to the hospital where the appointment has been taken. A copy of the referral form should be handed over to client who should submit the same to the hospital. The referral form will serve an identity proof of the same client whose appointment was taken previously.

d) **Acknowledge the referral to referring organization**

Once the client is received at the hospital it always advisable to inform the referring hospital. Sometime clients could not track the location of the hospital or due to unexpected reason client fails to reach the hospital. At that scenario both the hospitals need to have a follow up on the status of clients and explore the measures to support.

Note: Refer Annex 9 for the contact details of HI supported PT/Rehabilitation unit and other rehabilitation centers and specialized hospitals

11. Quality assurance of the rehabilitation services at the district level

With reference to WHO quality care guide and Rehabilitation Management System of Handicap International, dimensions for quality and standards of care have been defined as reference for quality assurance process.

The monitoring and review of quality assurance is currently done with the support of HI senior staff in collaboration with DHO/DPHO.

In order to ensure long-term quality control, it is recommended to

- Include the physiotherapist in district level quality assurance committee that already exists. The committee should identify priority areas of quality (see table below) and set indicators.
- At the central level (MoHP) include representatives of the leprosy control division on quality assurance steering committee (already existing).The leprosy control division should be supported by non-state organizations with expertise on technical issues related to rehabilitation services standards and quality assurance.

The following framework is proposed

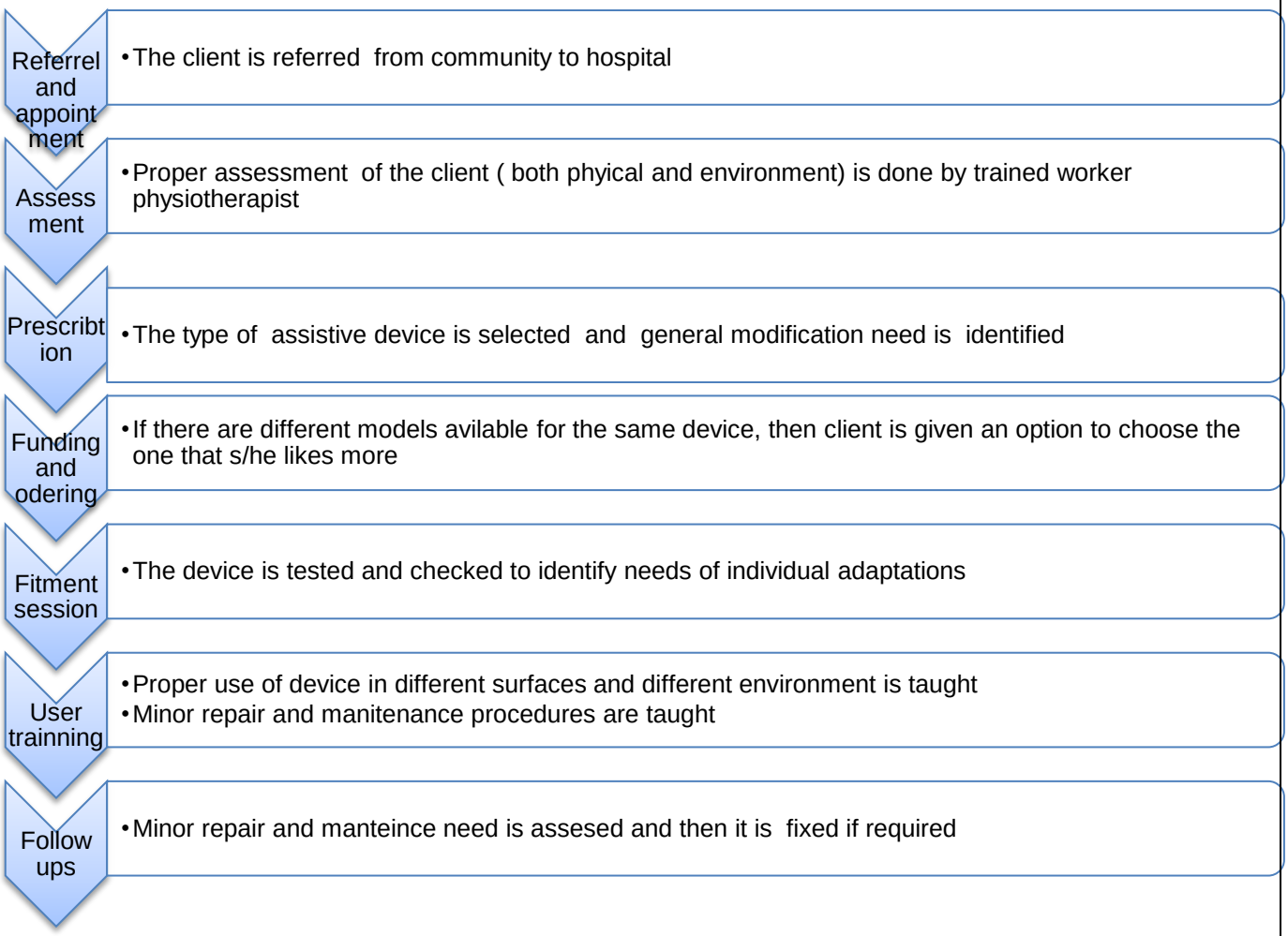
Areas	Description/Standards	Major methods
User focused/patient-centered	• Timely delivery of services(including strategies to reduce waiting times if any) • Appropriate follow up services • Holistic services • Engage client & family members in decision making • Client participate in an active way to the rehabilitation process (decision-making process)	• Reduce waiting time; engage client and family members by the use of IEC materials. • Conduct the severity based follow ups. • Doctors, Nurses, Paramedics and physiotherapist involvement in decision making • Try to use Nepali or local dialect if possible • Delivering rehabilitation care which takes into account the preferences and aspirations of individual service users and the cultures of their communities. • Client centered goal setting

	• Patients receive all information useful for informed choice	• Utilize user feedback to improvise the service delivery procedures • Provide information related rehabilitation services and available social security schemes in an understandable way • Consider client safety, dignity and privacy • Client satisfaction through set questionaries'
Clinical governance	• Suitability qualified staff • Clinical audit • Promote evidence –based practice	• Entry level qualification defined by Nepal Health Professional Council , Continuing professional development in line with Nepal health professional council mandates • Senior PT staff, joint monitoring with district level quality assurance committee • Continuous professional development :Participation and support for trainings and conferences
Evidence based practice	The integration of clinical expertise, patient values, and the best research evidence into the decision making process for client care	• Refer the evidence based database in rehabilitation: Physiopedia, Physiotherapy evidence based database, Journal of physiotherapy- Australian physiotherapy association • Technical guidelines developed by WHO- Provision of manual wheelchairs in less resourced settings
Monitoring & Evaluation	• Periodic measurement and review of indicators set by the unit • Documentation of the impact	• Monthly meeting for planning and review indicator tracking • Case studies, good practices , baseline and end line of the beneficiaries having access to rehabilitation services
Universal precaution of infection and		• Waste management of the PT/Rehabilitation unit • Ensure that all the therapeutic equipment tested before the application

Safety	Delivering health care which minimizes risks and do not harm service users.	• Conduct safe and ready to use check before fitting the assistive device • Conduct proper users training that should include the how to use assistive device correctly and do some minor repairs and maintenance • Teach the proper way of care giving to the family members • Do not place object that has risk to fall from the wall • Explain the exit mechanism to client and family members in case of any emergency

12. Assistive devices services:

The service pathway of all mobility aids and braces available in the facility should comply with the standard of the WHO for the wheelchair services as the process of selecting a device, fitting to individuals and training to use is similar for all mobility aids:



The following assistive devices should be available around the clock at the PT/Rehabilitation unit in districts:

- Auxiliary crutches
- Elbow crutches
- Cane
- Walker
- Toilet chair
- Wheelchairs
- Braces and splint for back and peripheral joints
- Anti-pressure sore mattress

Note:

- These devices should be available in different sizes (small, medium and large) to fit each individual and ages.
- Assistive devices that are durable and that can be adjusted should be preferred for procurement.
- Clients of should be given the opportunity to choose their device among several options if possible

13. Equipment and supplies

The equipment and supplies should cover therapeutic and assistive devices. Please refer annex 6 for the detail list.

14. Documentation:

The following documents shall be used to record the information related to services

Documents	Description
PT and SW Assessment (Annex I & II)	Demography, history, examination, diagnosis, goals , intervention plan
Follow up form (Annex III)	Interventions from the second follow up
Referral form (Annex IV)	To be filled when client is to be referred to other facility
Caregiver orientation checklist (Annex V)	Covers how to avoid the complications and access the available services like health , education, livelihood , social and empowerment
Equipment and supplies (Annex VI)	Therapeutic and assistive device list
Wheelchair assessment, prescription, safe and ready to use , fitting checklist, user training checklist and wheelchair follow up form[3]	To be filled in each service steps of wheelchair
OPD Register (available in DHO store)	Available in DHO store
Monthly plan (Annex VII)	Monthly forecast of the activities to be conducted by physiotherapist and social workers
Monthly report (Annex VIII)	Its detail narrative report of all the activities, achievements, challenges and lesson learns
Location and contact details organizations (Annex IX)	HI support PT/rehabilitation units and specialized service providers
Case study(Annex X)	Consist both the clinical information as well information regarding the change/impact made as the result of interventions
Discharge form (Annex XI)	To be filled once no further hospital based physical rehabilitation follow up is not required for the same impairment

[3] The assessment forms for wheelchair services are available at WHO website. Basic level service- **http://www.who.int/disabilities/technology/wheelchairpackage/en/** and Intermediate training - **http://www.who.int/disabilities/technology/wheelchairpackage/wstpintermediate/en/**

Consent form(Annex XII)	Take it before clicking the individual photographs
Inventory register	Record of incoming and outgoing devices(Therapeutic and assistive devices)
Database (both electronic and hard copy)	Soft copy of all the demographic information, number of assessments and follow up provided. It should also have information on the delivery of assistive devices to the particular clients. The analysis extracted from this data base can be utilized for reporting purpose
Photo documentation	Photos showing the delivery of the interventions and showing the events conducted under the goal ownership both in hospital and community. The captions in photo are so important to explain about the conditions

15. Work time

As this facility runs under the leadership and governance of the District Health Office in District Hospitals, the staff of the PT/Rehabilitation Unit should follow the same timings being practiced in the hospital. The OPD time should coincide with the doctors OPD time to have the effective and timely referral of the clients.

16. Reporting

At district level: The summary of monthly achievements needs should be submitted to the district health office. The format given by DHO/DPHO should be used for this purpose so that the collected information feeds into the **Health Management Information System under the coding 9.3, Section 15. Outpatient Morbidity—4(Including under 5 children)**

Supporting partner agencies (HI at moment) level: Data on interventions are collected in an excel database, together with detailed monthly narrative reports, photos and case studies.

17. ANNEXES

a) ANNEX I: PT Assessment form

PHYSIOTHERAPY ASSESSMENT FORM

Government of Nepal

Ministry of Health and Population

Department of Health Services

National Academy of Medical Sciences

National Trauma Center

Assessment date: …… HI ID number:……Date if injury :

Hospital Registration no.: …… Name of the client: ……

Caregiver of the client: …… Relationship with Client: ……..

Age:…… Gender: ……

Occupation:……..

Date of impairment:

Address:

District: VDC: Ward: Local address/tole:

Contact no.: ……..

Referred Source (from):

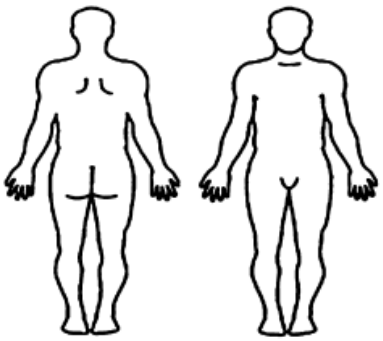
□□□ Social Worker □□□ Emergency unit □ Mobile Camp □ NGOs □ INGOs □ FCHV □ Health Facilities □ Center Walking

Diagnosis: ……..

□Amputation □Burn □Cerebral Palsy □CTEV □Fracture □Head Injury □PPRP □SCI □Stroke

□Other Ortho (hip dislocation, arthrogryposis, rickets, post fracture complications, amelia, osteogenesis imperfecta, osteomyelitis, arthritis, syndactylus/ polyductulus, dwarfism, sprain, low back pain)

□Other Neuro (spina bifida, nerve injuries, epilepsy, meningitis, encephalitis, hydrocephalus, leprosy, VIC, spondylitis, muscular dystrophy, others)



Main Patients Complain:

Subjective

History of Present Condition:

- Surgery

- Investigation/ Findings /

Previous Medical History:

Socio-Economic History:

Pain Assessment:

Objective

On observation:

On palpation:

On examination:

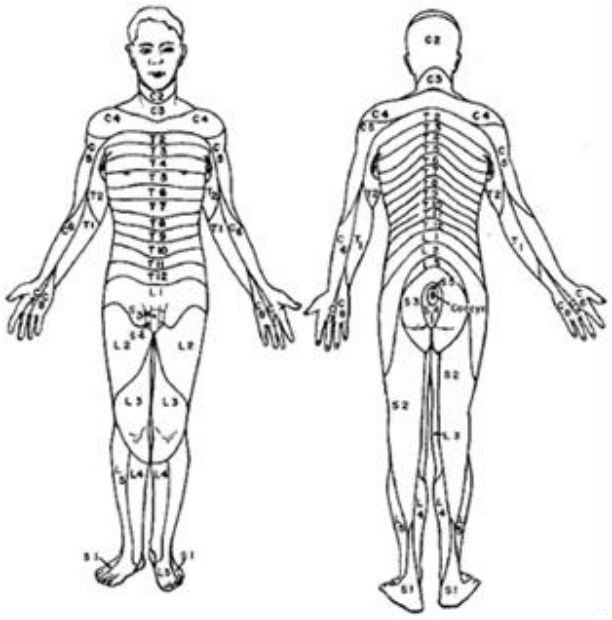
Range of Motion (only mention affected joints)

Manual Muscle Testing

Tone:

Muscle Tightness:

Reflexes:



Sensation:

Special Test:

COMPLICATIONS

Wound infection Location: Severity:	Fracture mal-union Location:	Pressure sore Location: Severity:
Hypertrophic scar Location:	Peripheral nerve injury Nerve root:	Necrosis Location: Severity:
Urinary Tract Infection Yes: No:	Compartment syndrome Location:	DVT Yes: No: Location:
Contracture (Left/ Right)	Muscle Atrophy Left/ Right	Other

Muscle:	Muscle:	

FUNCTIONAL ASSESSMENT

PLEASE NOTE: When scoring the functional outcome, the following numbers are assigned to responses:

0 = No Difficulty**; 1** = Mild Difficulty**; 2** = Moderate Difficulty**; 3** = Severe Difficulty**; 4 =** Extreme Difficulty or Cannot Do

Source of informant: □ Individual □Family member/ Caregiver

ICF classification	Activities	Initial Score	Max Score
Body structure & function	Sitting/Standing for long periods such as 30 minutes		
	Walking a long distance such as a kilometer [or equivalent]		
	Moving around inside house:		
	Moving around outside house:		
Daily life activity	Drinking/eating:		
	Washing your whole body		
	Getting Dressed		
	Toileting		
Participation and inclusion	Taking care of your household responsibilities?		
	Your day-to-day work/school?		
	Joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?		
	Overall Score		

Physical accessibility :(House: entrance, floor/ WASH-toilet , School, Workplace)

SUMMARY OF ASSESSMENT RESULTS

Summary of Assessment (Problem list):

Prescription: Assistive devices/ IEC materials etc.

Goal Setting:

Short-term:

Long-term:

Interventions:

Assistive Devices:- (Delivery)

Prosthesis:

Orthosis:

Mobility aids:

Developmental aids:

Orientation/ Advice provided to family member/ Caregiver: □□**Yes** □□**No**

□□Health education (Amputation; Fracture; Head Injury; SCI; Pressure sore; Burn; Wound care; Deep Vein Thrombosis; Urinary Tract Infection; Respiratory Tract Infection)

□ Transfers training □□Use of mobility device □□Information on rehabilitation process

□ Other services

Follow up plan:

Referral to:

- Speicalized Rehab center (NDF)……..
- Spinal Injury Rehab Center, specify……
- Speicalized hospital Specify:…….
- Other:……

Name of therapist _____

Signature _____

b) ANNEX II: SW Assessment form

SOCIAL WORKER ASSESSMENT FORM

Government of Nepal

Ministry of Health and Population

Department of Health Services

National Academy of Medical Sciences

National Trauma Center

0. DATA MANAGEMENT

0.1 Entered in database? □ Yes

0.2 HI individual ID number ……

1. ASSESSMENT INFORMATION

1.1 Name of the Individual:

1.2 Caregiver's Name:

Ethnicity: □Dalit □Disadv Janajati □Dis adv non dalit Terai cast □Religious Minorities □Relatively adv. Janajatis □Upper cast

1.3 Relation with the Individual:

1.4 Caregiver's education:

□ informal □ primary level □ high school

□ bachelor □ master □Illiterate

□ other specify:

1.5 Head of Household Name:

1.6 Total family members: ……

Total Male……

Total Female……..

1.7 Name of interviewer

1.8 Referred Source (from):

□Social Worker □DAU □Mobile Camp □NGOs □INGOs □FCHV □Health Facilities □NDF □Center Walking

1.9 District of intervention

□ Dolakha □ Sindhupalchowk □ Nuwakot

□ Rasuwa □ Kathmandu, □Bhaktapur □ Lalitpur,

1.10 Date of assessment (Month/Day/Year)

1.11 Type of Area

□ Urban area □ Rural area

1.12 Level of assessment

□ Hospital, specify : □ In-patients department □ Out-patients department

□ Community level, specify : □ Step-down facility □ Camp (shelter)

□ Home Visit □ Fix point □ Other, specify :

Specify ……

(Hospital, step-down facility, village, etc.)

2. IF THIS ASSESSMENT IS DONE BEFORE THE PHYSIOTHERAPY ASSESSMENT

2.1 Phone number: **2.2 Citizenship card number:**

2.3 Earthquake victim ID number if available: **2.4 Age:**

2.5 Date of birth: **2.6 Gender** □ Male □ Female

2.7 Occupation of Individual:

□ Business, □Agriculture, □House wife, □Civil servant, □Student, □Foreign employment, □Others

Address

2.8 Permanent address? Address where you usually live

District : VDC: Ward: Local address/tole :

2.9 Current living address? Address where you currently stay, if displaced

District : VDC: Ward: Local address/tole :

2.10 Are you planning to move? □Yes □No

If yes, What will be your new location?

□ Hospital, specify : □ In-patients department □ Out-patients department

□ Community level, specify □ Step-down facility □ Camp (shelter)

□ to my permanent address □ Other, specify :

2.11 Specify the name (hospital, step-down facility, shelter, etc.):

2.12 If the individual is going <u>back to his/her home</u> or <u>to a new home</u>, specify :

District : VDC: Ward: Local address/tole :

2.13 Status:

□Internally Displaced People □Refugee □Rest population

Personal factors

3.1 Type of impairment: other impairments

□ Moving □ Learning □ hearing speaking

□ Seeing □ Behavior □ Feeling

□ Others

3.2 Education:

□ informal □ primary level □ bachelor □ master □□Illiterate □ other specify:

3.3 Do you have a disability card?

□Yes □No

If Yes, which color:

□Red □Blue □Yellow □White

3.4 If No disabilities Card: referral to ……..

ENVIRONMENT

Are there any barriers in your family?

□ Yes □ No

If Yes, What are the barriers in your family? □Family members not supportive, □unavailable Caregiving, □Single, □Poverty, □Gender discrimination, □Stigma, □Other

What are facilitators among your family, neighbors, friends, other services?

How is your family going to help you? Your friends? (to be link with goal setting later if there are some issues)

Accessibility		
Can you move inside your house?	**Can you move outside your house?**	**Can you reach health services, school?**
□ Yes □ No	□ Yes □ No	□ Yes □ No
If No, why?	If No, why?	If No, why?

PARTICIPATION -Employment

Have you ever been employed?

□ Yes □ No

Other Financial resources? Reference: Land, agricultural product (crops, livestock), business, foreign employment, daily wages, civil services, house rent, loans etc.

Annual Household income? (NPR)

□□Less than 20,000

□□20,000- 50,000

□□50,000- 1,00,000

□□More than 1,00,000

Skills:

□□Vocational skills □□Agriculture

□□Animal husbandry □□Others □□None

Socio-Economic Category: (D being poor)

□A □B □C □D

PARTICIPATION : social

Are you participating in family chores/discussions?	□ Never	□ Sometimes	□ Always
Are you involved in decision making?	□ Never	□ Sometimes	□ Always
Do you have regular interaction with you friends?	□ Never	□ Sometimes	□ Always

Do you participate to religious/cultural events?

□ Never □ Sometimes □ Always

Are you associated to local networks?
□Yes□□□No

PSHYCO-SOCIAL

The next questions are about how you have been feeling during the **last two weeks**

About how often did you feel so afraid that nothing could calm you down – would you say:

□ All of the time □ Most of the time
□ Some of the time □ A little of the time
□ None of the time □ Don't know
□ Refuse to answer

About how often did you feel so uninterested in things that you used to like, that you did not want to do anything at all – would you say:

□ All of the time □ Most of the time
□ Some of the time □ A little of the time
□ None of the time □ Don't know
□ Refuse to answer

About how often did you feel so hopeless that you did not want to carry on living – would you say :

□ All of the time □ Most of the time
□ Some of the time □ A little of the time
□ None of the time □ Don't know
□ Refuse to answer

You may have experienced one or more events that have been intensely upsetting to you, such as the recent events.

During the last two weeks, about how often did you feel so severely upset, that you tried to avoid places, people, conversations or activities that reminded you of such event?

□ All of the time □ Most of the time
□ Some of the time □ A little of the time
□ None of the time □ Don't know
□ Refuse to answer

Injury

GENERAL INFORMATION

4.1 Type of Impairment (Diagnosis):

□**Amputation** □**Burn** □**Cerebral Palsy** □**Club foot** □**Fracture** □**Head Injury** □**Polio**

□**Spinal Cord Injury** □**Stroke** □**Peripheral Nerve Injury**

□**Other Ortho** (hip dislocation, arthrogryposis, rickets, post fracture complications, amelia, osteogenesis imperfecta, osteomyelitis, arthritis, syndactylus/ polyductulus, dwarfism, sprain, low back pain)

□**Other Neuro** (spina bifida, nerve injuries, epilepsy, meningitis, encephalitis, hydrocephalus, leprosy, Volkmann ischemic contracture, spondylitis, muscular dystrophy, others)

4.2 Cause of Impairment:

□**Earthquake** □**Congenital** □**Conflict** □**Accident** (road, work, home, sports, others)

□**Disease** (Diabetics, Cardiovascular, Hemophilia, Others) □**Unknown (CP)**

4.3 What treatment have you had for it? (Including rehab services) health facilities?

4.4 What other problems have you had before?

4.5 Are you taking medicines? □□Yes □ No

4.5 Any investigations?

4.6 Observation

Bedridden Muscle wasting Nutrition

Deformities

4.7 Any signs of complications linked to injury?

Wound infection	Fracture Malunion	Pressure sores
Hypertrophic scar (enlarged)	Peripheral nerve injury (hand/ leg)	Necrosis (dead tissues)
Pain	Fever	Compartment syndrome
Urinary Tract Infection		

4.8 TRANSFERS

Fill in the table below (put a √ in the appropriate box)

	Independent	Minimum Assist	Maximum Assist	Remarks (mention position)
ROLLING TO : Left				
Right				
LYING TO SITTING				
SITTING				
SITTING TO STANDING				
TRANSFERRING Eg BED TO CHAIR				

4.9 Write if they use any aid (Assistive devices) □Yes □ No

If yes, □Prosthesis□ Orthosis□ walker □ stick □ crutches □wheelchair □Others:……

4.10 If they use a device where and when did they obtain it

□HI □Others organization, mention name .....

Received when:……

PLEASE NOTE: When scoring the functional outcome, the following numbers are assigned to responses:

0 =No Difficulty; **1** =Mild Difficulty; **2**= Moderate Difficulty; **3**= Severe Difficulty; **4**= Extreme Difficulty or Cannot Do

Source of informant: □ Individual □Family member/ Caregiver

ICF classification	Activities	Initial Score	Max Score
Body structure & function	Sitting/Standing for long periods such as 30 minutes		
	Walking a long distance such as a kilometer [or equivalent]		
	Moving around inside house:		
	Moving around outside house:		
Daily life activity	Drinking/eating:		
	Washing your whole body		
	Getting Dressed		
	Toileting		
Participation and inclusion	Taking care of your household responsibilities?		
	Your day-to-day work/school?		

	Joining in community activities (for example, festivities, religious or other activities) in the same way as anyone else can?		
	Overall Score		

4.11 PROBLEM LIST

1. Shelter :

2. Nutrition:

3. Livelihood

4. Psycho-social

5. Health and rehabilitation:

6. Others:

4.12 REHABILITATION PLAN AND GOAL SETTING (SMART)

GOAL and timeframe	**INTERVENTIONS:** Information on available services. Referral to other services: health, nutrition, shelter. Mobilization and Assistance with Activities of Daily Living. Education of patients and caregivers on prevention of complications .Monitoring of use of assistive devices. Counseling and follow up plan
GOAL 1	
GOAL 2	

GOAL 3	

4.13 Orientation provided to family member/ Caregiver: □Yes □No

□□Health education (Amputation; Fracture; Head Injury; SCI; Pressure sore; Burn; Wound care; Deep Vein Thrombosis; Urinary Tract Infection; Respiratory Tract Infection)

□ Transfers training □Use of mobility device □□Information on rehabilitation process

□ Other services

4.14 Any further support:

4.15 Referral to:

□Women Children Office □District Admin Office □Rehab Center/NDF □DPOs □Other NGOs □ Transcultural Psychosocial Organization □□Spinal Injury Rehab center □Specialized Hospital □Other

Name of Social Worker: _____Signature: _____

Signature of PT _____

c) ANNEX III: Follow up form

HI Individual ID No.:……..….	
Name of the Client:…… ……	

TREATMENT SHEET						
S.N.	**Date**	**NOTES and INTERVENTIONS**	**IP/OP/HV**	**Goal review/ Status**	**Next Appoint. date**	**Attended by**

Acronyms SOAP: Subjective Objective Assessment Plan; **IN**: in-patient; **OP**: Out-patient

d) ANNEX IV: Referral form

TO BE FILLED BY PHYSIOTHERAPIST

Referred Hospital/Rehabilitation centre: Date of Hospital Appointment:

Referee Details

Date of Referral (dd/mm/yy):

Referral Organization: Telephone number (referral organization):

Assessment done by: Doctor /PT/ OT/ PO/ SW Other *(explain)*

Client Details

Name of Client: Age/Gender: VDC & Ward number:

District: Client Telephone number: Name of Care giver:

Relationship to client:

Does the client have a Disability Card? Yes □ *which colour: Red* □ *Blue* □ *Yellow* □ *White* □ *don't know* □

No□ *why: not ware*

Does the client live in an area where natural disasters occur (such as floods, landslides, wild fires etc.)?

No □ Yes √ □ *what:*

Clinical History

Diagnosis (if known):

History of present condition:

Has any intervention done before for this condition? No □ Yes □ *Where and When:*

Type of intervention and Outcome of intervention

Any complications of previous intervention: No □ Yes □ what:

Does the client have any other known conditions (like epilepsy, diabetes mellitus, hypertension, etc.)?

If yes, has s/he had treatment for the same? No

Description of Clinical Observations:

Which body area/s is involved?

Are there problems with strength of the affected part/s: No □ Yes □ *Explain:*

Are there problems with range of motion of the affected part/s: No □ Yes □ *Explain:*

Does the client have wounds/ulcer or other problems? No□ Yes □ *Explain: around ankle joint*

Other Comments (tone, sensation etc.):

Current Functional Status

➢Does the client use an assistive device: No√ □ Yes □ *what type and since when:*

CRITERIA / **ACTIVITIES**	**Completely Independent** *(please mention if independent with pain and/ or with difficulty and/ or by using unaffected limb)*	**Independent with the use of aids/devices**	**Needs some Assistance from a carer** *(please mention whether mild, moderate or maximal assistance needed)*	**Needs full support**	**Comments**
Mobility					
Walking inside (on flat ground)					
Walking outside (on uneven ground)					
Stair climbing/ descending (or walking on inclined ground)					
Grooming (Brushing teeth, combing)					
Dressing					
Toileting					
Bathing					

Feeding/ Eating					
Other *(please explain)***:**					

➢**Communication:** Speech √□ Sign □

Education and Employment

➢**Has the client been to school?**
Yes □ *what class did the client finish:*

No □ *Due to: Physical Access □ Financial Reasons □ Teased □ School did not allow □ Family did not allow □ other (please explain):*

➢**Is the client currently employed (include housework and raising children):**
Yes □ *Doing what:*

No □ *Why not:*

Was s/he employed in the past? *(Explain)No*

How do you think further intervention (Consultation/Medical care/ Specialized rehabilitation/surgery could help this client

Socio-Economic Status Evaluation ***(please tick relevant items)***

CLASSIFICATION	Class A	Class B	Class C	Class D
House:	□ Has own house on own land □ Either concrete or non-concrete house. □ Garden around the house.		□ Stays in own non-concrete house	□Stays in thatch-roof house (Jhupadi)
Agricultural Fields:	□ Has agriculture field more than	□ Has agricultural	□ Having agricultural	□Having own agricultural

	1.33 hectare (2 bigaha)	field from 0.53 hector (16 kattha) to 1.33 hector (2 bigaha)	field from 0.2 to 0.5 hector (6-15 katthas) □ Work in others fields as share or in lease up to 0.53 to 1 hector (16-30 katthas)	field up to 0.16 hector (5 katthas) □ Work in others field, share or lease up to 0.5 hector (15 katthas)
Profession:	□ Skilled labour, service holder, has a shop or industry, milk or animal seller business	□ They contribute 20-50% of their labour in other person's fields or agricultural labourer either in Nepal or India □ Skilled or unskilled labour	□ Generally 51-99% labour in others' fields or agricultural labourer either in Nepal or India □ Unskilled labour	□Labours for other fields or agricultural labourer either in Nepal or India □Unskilled labour
Means of Transport:	□ Has own tempo, motorbike or tyre cart	□ Has own tyre cart	□ Public	□Public
Gross Cash Income of Family	Number of members in the family : 3 members (2 male 1 female)			
	□ More than NRs 50,000 annual income **OR** □ Annual income from his/her profession or agricultural production is sufficient for annual living expenses or more	□ NRs 25,000 to NRs 49,999 annual income **OR** □ Annual income from his/her profession or agricultural production is sufficient for meeting living expenses for	□ NRs 13,000 to NRs 24,999 annual income **OR** □ Annual income from his/her profession or agricultural production is sufficient for meeting living expenses for	□ Up to NRs 12,999 annual income **OR** □ Annual income from his/her profession or agricultural production is sufficient for meeting living

		at least 9 months	at least 6 months	expenses for less than 6 months

Overall Socio-economic Category: Class A □ Class B □ Class C □ Class D □

Have all aspects of the surgical process been explained to the client and family?

Please go through the following checklist with the client:

Screening at community level

Assessment at hospital level (with possibility of refusal of surgery/medical care due to comorbid condition)

Interventions– options and benefits

Importance of Follow-up at community level

Cost-sharing by patient ___will need transportation support_____

(*Please mention the amount and/or costs being borne by patient)*

Hospital location and contact detail

□ Is there a <u>Photo</u> attached?

□ Have you sent a copy of the referral to the <u>Injury rehabilitation officer</u> at Handicap International and focal person of the referral hospital/Rehabilitation centre?

Handicap International

Narayan Gopal Chowk, Sallaghari,

PO Box 10179, Kathmandu, Nepal

Tel: 01 4378482/ 4374609

Tel/ Fax: 01 4376983

***Please send all above details to a relevant Hospital with a copy to Injury rehabilitation Officer (Email:* spt.rehab@hi-nepal.org)**

e) ANNEX V: Caregiver Orientation Checklist

To be completed with a family member of each patient	Skills to Teach	Skills Taught	Not req.
General information			
Information about the condition and its prognosis	☐	☐	☐
The need for physical and psychological support	☐	☐	☐
Importance of routine care/ follow up	☐	☐	☐
Information about the available services for patients	☐	☐	☐
Information about the referral needs	☐	☐	☐
Information about social security schemes			
Disability card (Why to make, From where, How to use it?)	☐	☐	☐
Available health services	☐	☐	☐
Available educational services	☐	☐	☐
Available livelihood schemes	☐	☐	☐
Membership on local disable people organization	☐	☐	☐
Information on complications linked to impairment			
Joint stiffness	☐	☐	☐
Osteoporosis	☐	☐	☐
Peripheral cyanosis	☐	☐	☐
Swelling	☐	☐	☐
Wound and Systemic infection	☐	☐	☐
Contracture	☐	☐	☐
Deep vein thrombosis	☐	☐	☐
Hemarthosis	☐	☐	☐
Joint / muscle pain: Mechanical , Non mechanical , Phantom limb pain	☐	☐	☐
Pressure ulcers	☐	☐	☐

Exacerbation of underlying diseases such as diabetes or Hypertension	☐	☐	☐
Shock	☐	☐	☐
Spasticity	☐	☐	☐
Bladder and bowel problems	☐	☐	☐
Dyspnea	☐	☐	☐
Associated physical injuries	☐	☐	☐
Orthostatic hypotension	☐	☐	☐
Urinary tract infection	☐	☐	☐
Autonomic dysreflexia	☐	☐	☐
Pneumonia	☐	☐	☐
Other :	☐	☐	☐
Exercises, transfers and ADL			
Explain type, intensity, duration, repetitions of each exercise	☐	☐	☐
Support in performing home exercises	☐	☐	☐
Local exercise materials for the home exercises	☐	☐	☐
Transfers: caregiver's and patient's safety, adaptations	☐	☐	☐
Positioning	☐	☐	☐
ADL: Eating , Brushing, Bathing , Toileting , Writing	☐	☐	☐
If using assistive devices			
Care and proper use of a device	☐	☐	☐
Support on donning and doffing	☐	☐	☐
Minor repair and maintenance	☐	☐	☐
Where to contact if there is irreparable damage	☐	☐	☐
Psychosocial support			
Psychosocial support provided to client	☐	☐	☐
Psychosocial support provided to caregivers	☐	☐	☐

What to do if there is a problem			
Inform HI supported Rehabilitation Centre	☐	☐	☐
Seek appointment from nearby health facility	☐	☐	☐

f) ANNEX VI: Equipment and supplies list for PT/rehabilitation unit

S. N	Items	Specification	Quanti ty
1	Corner chair with detachable tray	Small size	1
2	Stand in table for children	Small size, height adjustable	1
3	Foam role(tumble)	15cm*60cm long	1
4	Activity mattress	120*190*10	1
5	Activity mattress	120*190*5(Portable)	1
6	Gym ball	Adult size	1
7	Gym ball	Child size	1
8	CP chair	Small size	1
9	CP chair	Medium size	1
10	Stand in frame	Adult size	1
11	Stand in frame	Child size	1
12	Wall mirror	6*5 feet	1
13	Mushroom board	Child size	1
14	Smooth exercise board	Top 120 cm * 100 cm, angle adjusted both side	1
15	Dumb bells	2 kg, covered with plastic incase	1
16	Dumb bells	3 kg, covered with plastic incase	1
17	Weight cuffs	250 gm.	2
18	Weight cuffs	0.5 Kg	2
19	Weight cuffs	1 KG	2
20	Moulding dough	5 safe moulding dough	2
21	Child friendly room	Back ground Pic and toys	1
22	Axial shoulder exerciser	With 360 degree scale	1
23	Continuous passive unit	Lower extremity	1

24	Quadriceps exercise table	70 CM * 80 CM * 120CM high	1
25	Climbing stool	10"* 12"* 2" High	1
26	Climbing stool	16"* 20"* 8 " High	1
27	Parallel walking bar	Height adjustable from 76 CM to 100 CM	1
28	Cervical & Lumbar traction kit	Sitting, 5 KG	1
29	Shoulder pulley set	With Tee Bracket	1
30	Muscle , TENS IFT & Stimulator	Stimulator, TENS & IFT Combo	1
31	Moist heat	4 stream packs	1
32	Wedge	4.30 CM* 60 CM* 70 CM	1
33	Wall bar(Wooden)	90 CM wide and 250 CM height	1
34	Balance board	Wooden	1
35	Cycle ergociser	Semi recumbent seat arrangement	1
36	Floor carpet	As per the size of therapy room	1
37	Prone crawling board with wheels	30cm*90cm*7cm	1
38	Therapeutic Ultrasound	Dual head, 3 and 1 MHZ, with aqua sonic gel	1
39	Goniometer	360 degree	1
40	Measuring tape	Metallic, 3 meter	1
41	Knee hammer	With the metal stand	1
42	BP set	Manual, Adult size	1
43	BP set	Manual ,Child size	1
44	Portable pulse oximeter	Choice Med	1
45	Stethoscope	Littman	1
46	Examination couch	High, 72"*24"	1
47	Examination couch	Low, 36"* 12	1

48	Wooden foot stool	45 CM deep * 30 CM height	1
49	Weighing machine	Child and adult size	2
50	Goniometer	360 degree	1
51	Measuring tape	Metallic, 3 meter	1
52	Knee hammer	With the metal stand	1
53	BP set	Manual, Adult size	1
54	BP set	Manual ,Child size	1
55	Stethoscope	Littman	1
56	Examination couch	High, 72"*24"	1
57	Examination couch	Low, 36"* 12	1
58	Wooden foot stool	45 CM deep * 30 CM height	1
59	Weighing machine	Child and adult size	2
60	Goniometer	360 degree	1
61	Measuring tape	Metallic, 3 meter	1
62	Knee hammer	With the metal stand	1
63	Towel	Blue color	2
64	Bed sheet	Large size, Green color	2
65	Macintosh	6*4 feet	1
66	Portable curtain divider	Metal stand, 3 folds	1
67	Curtain	Medium size	3
68	Pillow	Rexine covered, adult size	2
69	Pillow	Rexine covered, adult size	1
70	Wall clock	Battery operated	1
71	Water filter	Steel	1
72	Heater	Electric	1
73	Water Glasses	Metal	4
74	Body chart	Musculoskeletal system	1

75	Book	Disabled village children, by David Werner	1
76	Book	Where there is no doctor by David Werner	1
77	Construction of ramp	As per Accessibility guideline of GON	1
78	Modification of toilet	As per Accessibility guideline of GON	1
79	Modification of therapy room	As per Accessibility guideline of GON	1

g) ANNEX VII: Monthly plan

Days	Physiotherapist	Social Workers-1	Social workers-2
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			

18			
19			
20			
21			
22			
23			
24			
25			
26			
27			
28			
29			
30			

h) ANNEX VIII: Monthly Report

MONTHLY REPORT

Rehab Unit	
Project Title	
Reporting Month	
Report Prepared by	
Report Submitted to	
Report Submitted Date	

1. Compile data of services

Month/Year	Identified and assessed new beneficiaries				Total number of caregivers benefited		Earthquake affected in new identified cases		Follow-up/ Treatment session provided	
	OPD/IPD		Community		F	M	F	M	F	M
	F	M	F	M						

2. No. of days involve in the event, service & others for each staff member

Name of the staff	Total working day at PT/Rehab unit at district	No of days - community visit	No of days for training/WS/ meetings + Travel days	Leave taken for the month (AL,SL,TL, Others)	Off days (Week - end+ Public Holiday)

3. Key priorities for the upcoming Month for each PT/Rehabilitation unit

S.N.	Key priorities
1	
2	
3	
4	
5	
6	
Plan and work activities	
1	

2	
3	
4	
5	
6	

4. Monitoring and Evaluation

5. Any challenges and measures taken by PT/Rehabilitation team

SN	Challenges faced by team	Measures taken by team	Supported Needed
1.			
2.			

7. Significant Change as a result of Project Activity

8. Lessons Learned/ Documentation

Date Identified	Identified By	Subject	Situation	Recommendations & Comments	Follow-Up Needed	Documentation Available

9. Conclusions and Recommendations

10. Conclusions

11. Recommendations

12. Annexes Checklist

Annexes	Frequency	Yes-☑ No- ☒ Not App-	Remarks
1. Reflection of services data in table	Monthly		
2. Monthly Action Plan/Rehab unit team jointly	Monthly		
3. Plan VS Achievement	Monthly		
4. Field Visit (Home visit + community outreach) Report by	Monthly		
5. Stakeholder meeting note (Coordination, Update-sharing,	Monthly		
6. Time Sheet (Individual staff)	Monthly		
7. Training / workshop reports (Person who participated)	Monthly		
8. Case studies (Individual, Organization and Community) / Success stories – with name, age, photos before and after	Monthly		
9. Lesson learnt – reflection of project activities (Success and	Monthly		
10. Project activities photos with brief description	Monthly		
11. Press Cutting, News-articles and publication (if any)	Monthly		
12. Others (outreach report)	Event based		

10.1 Plans VS Achievements

S.N.	Plans	Achievements	Justification

10.2 Project activities photos with brief description

i) ANNEX IX: Location and contact details organizations

Name of HI PTs	Based station	Email
Anu Bhatta	Trisuli hospital , Nuwakot	pssu.nuwakot@hi-nepal.org
Sabita Baniya	District hospital, Sindhupalchowk	pssu.sindhupalchowk@hi-nepal.org
Sudan U. Rimal	National Trauma Centre , Kathmandu	pssu.traumaktm@hi-nepal.org
Diksha Joshi	National Trauma Centre , Kathmandu	pssu.dhading@hi-nepal.org
Om Ishwor Disti	District Hospital, Charikot, Dolakha	pssu.dolakha.c@hi-nepal.org
Bibek Khadka	Jiri Hospital, Dolakha	pssu.dolakha.j@hi-nepal.org
Susmita Shakya	District hospital, Rasuwa	pssu.rasuwa@hi-nepal.org

Specialized hospital and Centers

Organization	Phone numbers
Spinal Injury Rehabilitation Centre, Kavre	**9818239173**
National disabled fund	**014239586**
Hospital for the rehabilitation of disabled children	**011-661666**
Sushma Koirala Memorial Hospital	**014450826**

j) ANNEX X: Case study template

Part one CASE STUDY individual : background information

1. General Information	
Country	
Project	
Reporting team members:	

2. General Information individual PWD:		
Full Name		**Sex: M ( ) F ( )**
Date of birth		**Age in years:**
Father Name		
Mother Name		
Spouse		
Live in town or village?		
Address		
Phone no		
Household livelihood activities		
Number of People in Household		
Primary Income Earner, primary income generating activity		

3. Disability information	
Type of Disability	**Physical Disability ( ) Intellectual Disability ( )** **Mental Illness ( ) Visual Impairment ( )**

	Hearing Impairment ( )
When and how the person acquired disability?	**At birth ( )** **Road accident ( ) Accident at home ( ) Accident at work ( )** **Illness/disease ( ) please describe:** **Unknown ( )** **Other ( ) please describe:**
Age when disability acquired	
<u>General background information</u> • **Family/home life** • **Community situation** • **Socio economic situation etc**	
How does the person's disability affect their everyday life?	
Have they had PRT, traditional healer, medical, surgical, early childhood development activities before?	
What is his/her present feeling	
What does the person see for their future?	

4. Role of PWD in family	
Position of PWD in family **ie mother/ father/ grandparent/ 2nd child of 4 etc**	

Goes to School?	**Yes ( ) No ( )**
What type of School?	**Special school ( )** **Primary: formal ( ) non formal ( )** **High school ( ) vocational training ( ) University ( )** **Other (please describe)**
Employment Status	
Livelihood activities	
Contribution to household (non formal, eg tidying house, caring for siblings)	
Barriers to education/ employment/ livelihood/ contributing to household	
Employment/ education/ livelihood goals	

- ***Please use as many interesting quote directly as possible***

Part two CASE STUDY individual PWD: follow up information.

Please complete over time to monitor change

1. Intervention Plan
Priority/goals defined by person with disability and family

Please use as many interesting quote directly as possible

GOALS: BARRIERS STRENGTHS AND ACTIONS

GOAL ONE:			
Barrier	**Strength**	**Action plan**	**Goal/outcome**

•	•	•	**Achieved ( )** **Part achieved ( )** **Not achieved ( )**
GOAL TWO:			
Barrier	**Strength**	**Action plan**	**Goal/outcome**
			Achieved ( ) **Part achieved ( )** **Not achieved** ( )
GOAL THREE:			
Barrier	**Strength**	**Action plan**	**Goal/outcome**
			Achieved ( ) **Part achieved** ( ) **Not achieved ( )**

Summary of outcomes:

1. **Narrative Intervention Plan – what happened during visit**

First visit:

Name and signature of the persons doing interview:

Position:

Date:

2. **Activities of Daily Living (ADL)**

Initial assessment	Mid-term assessment	Final assessment
Description of a typical day for PWD		
	•	
Description of a typical day for the household		
	•	

PERSONAL/SELF CARE ACTIVITIES

ACTIVITY	Initial assessment	Mid-term assessment	Final assessment
Eating	•	•	
Dressing			
Bathing			
Toileting			

DOMESTIC/HOUSEHOLD ACTIVITIES

ACTIVITY	Initial assessment	Mid-term assessment	Final assessment
Cooking			
Cleaning			

EDUCATIONAL AND LIVELIHOOD ACTIVITIES

ACTIVITY	Initial assessment	Mid-term assessment	Final assessment
Schooling			
Employment			
Contribution to household			

RECREATIONAL/LEISURE AND COMMUNITY ACTIVITIES

ACTIVITY	Initial assessment	Midterm assessment	Final assessment
Leisure (Sports, socializing, community activities etc)	•	•	

3. Environmental Information

DESCRIPTION OF PHYSICAL ENVIRONMENT:

Initial Assessment	Mid-term assessment	Final Assessment
Accessibility at homestead and community level:		

DESCRIPTION OF FAMILY/SOCIAL/CULTURAL ENVIRONMENT:

Initial assessment	Mid-term assessment	Final assessment

Name and signature of the persons doing assessment:

Position: **Date:**

k) ANNEX XI: Discharge form

Government of Nepal

Ministry of Health and Population

Department of Health Services

District Public/ Health Office

……

DISCHARGE FORM

1. DISCHARGE INFORMATION

1.1 Name of the individual **1.2 Date**

Signature

1.3 Level of intervention at discharge

☐ Health facility specify : ☐ In-patients department ☐ Out-patients department

☐ Step-down facility ☐ Home

2. REASON FOR DISCHARGE

☐ End of follow-up (according to the Action plan) ☐ Move to another location: ☐ Unsuccessful / No solution found

☐ Refusal of intervention ☐ Deceased ☐ Other, specify :

3. SERVICES PROVIDED

6.1 Services Provided and number of sessions:

☐ wound care	☐ surgery	☐ laboratory
☐ physical therapy	☐ devices	☐ peer support
☐ Caregiver training/education ☐	☐ Information on services	☐ Referral to specialized services specify:

4. DISCHARGE PLAN

Medical Follow up Rehabilitation Follow up

5. INFORMATION AND SOCIAL ACCOMPANIMENT

Service	Name of the organization for referral / orientation	Referral (R) or Orientation on Services (contact)
□ Step down facility /shelter		
□ Transportation		
□ Mental Health Services		
□ Prosthesis & Orthosis		
□ Orthopedic/reconstructive surgery		
□ Social Security/disability card		
□ Food		
□ Other, specify:		

l) ANNEX XII: Photo consent form

AUTHORISATION FOR THE USE OF STILL AND MOTION PICTURES

I the undersigned ……

residing at ……../VDC … Ward no……

Tel.: ……give Handicap International the right to use, free of charge, the still/motion pictures of mine/my child/children as portrayed in the photographs/movies taken on this day.

Name of the child/children –……

This authorisation concerns the reproduction of this still/motion picture for informative and illustrative purposes for documents produced by the Handicap International: □ Internal training and documentations □ Donor reports □ Posters □ External publications and public relations including for fundraising □ Internet / intranet sites □other .....

This authorisation will be renewed every year by tacit renewal, and remains valid in the event of a change in civil status unless the undersigned expresses, in writing, their wish to cancel the authorisation. Handicap International will then stop the use of these still/motion pictures within one month of reception.

Signed in ……..on …….

Read and approved.

_____

Signature

SECTION TO BE FILLED IN BY THE PHOTOGRAPHER

⇒ Name of photographer:

⇒ Still/motion picture reference: ……..

⇒ Description of still/motion picture:
…….

⇒ Place. .....

Descriptions of the action taking place or any information that may help identify the photographs in which the subject of the photograph features:

……

Annex 5: Case Study: Community interventions promoting access to rehabilitation

Elderly people are at heightened risk of falling and injuries. This is one of the most vulnerable groups prone to injury during disasters as pre-existing comorbidities predispose them to injury and prevents them from reaching safe positions. This was the case with Mr Laxmi Kanta Bhattarai, 84 who sustained an injury on his right thigh and lost a son and grandson in the April 2015 earthquake. He is from a remote village of Sindupalchowk and now lives with his other son. A doctor performed a hip joint replacement surgery for him in a Kathmandu hospital. He was discharged eighteen days after the operation. He received bed-side physiotherapy during his stay at the hospital but this can't be continued after his discharge from the hospital. Since then he has been living in his village dependent on his family members for mobility.

In fact the injury he sustained after an earthquake has changed the clock of his life. He lost his son and grandson which increased the sorrow of losing his wife a few years before the earthquake. In addition, he lost his livelihood means as he was the priest in the village. Just before he was traced in Sindupalchowk in February 2016, he was crawling around, which was very stressful and a harmful means of mobility for his osteoporotic bones. He had not re-learned walking in the hospital or after he returned home from the hospital.

The physiotherapy/rehabilitation unit in Sindupalchowk district hospital started his rehabilitation through physiotherapy services and by providing him with a walker and toilet chair. He is being continuously followed up in his house as regular attendance at the district hospital was not possible for him and his family members as they live far away. Now he can walk in and around his house with the help of a walker. This has increased his mobility but the complex terrain surrounding his house prevents his mobility in his village. His further mobility depends on follow up rehabilitation services.

Mr Laxmi is an example of many such cases who were injured in the earthquakes and have since returned home. Even though physiotherapy services are available at district hospitals, distant settlements and unavailable transport prevents him from reaching the hospital for regular rehabilitation services. For people like Laxmi, rehabilitation should be part of the continuum of care which should be ensured for community people. Hence, community interventions like home visits and outreach activities are very important to improve access to rehabilitation services.

Annex 6:

Standard Operating Procedure for Physiotherapy/ Rehabilitation Unit in District Hospitals of Nepal

Contents

1. List of acronyms

COPD	Chronic Obstructive Pulmonary Diseases
DFID	Department of International Development
DHO	District Health Office
DPHO	District Public Health Office
GlOFS	Glacial Lake outburst floods
HI	Handicap International
ICU	Intensive care unit
IOM	International Organization for Migration
IRU	Injury Rehabilitation Unit
MOH	Ministry of Health
OPD	Out Patient Department
OT	Occupational Therapy/Therapist
PO	Prosthesis & Orthoses/ Prothetist & Orthotist
PT	Physiotherapy/ Physiotherapist
SDCF	Step down care facility
SIRC	Spinal Injury Rehabilitation Centre
SW	Social Worker
VDC	Village Development Committee

2. Introduction

Referral and appointment is one of the important service steps in health service delivery. In Nepal rehabilitation services are not still integrated within the health. The service is being delivered by mostly local NGOs through the donor funded programs. The Census done in 2011 claims 1.94 % of the people in Nepal have disability out of which 36% of them have physical disability. In addition to that, the injuries due to the recent earthquake in Nepal have further enhanced the demand for rehabilitation. Within the Leprosy Control Division, Department of Health Services (DoHS) of Ministry of Health (MoH), a Disability Rehabilitation Focal Unit (DRFU) has been formed which is the focal department in health for disability and rehabilitation. A short- term, medium- term and long- term plan for the development of rehabilitation services was endorsed by the MoH as part of the Health Sector Rehabilitation and Reconstruction Plan after an April 25th 2015 Earthquake.

Among actions identified in the medium to long term strategy, the **decentralization of rehabilitation services to the most affected districts** was acknowledged as a priority to ensure continuum of care and address the long term follow up needs for the injured.

The establishment of seven rehabilitation units is part of this strategy and it has been implemented by Handicap International in (HI) partnership with the newly established DRFU at LCD, with financial support of DFID/Option. PT/Rehabilitation units have been set up in Sindupalchok, Dhading, Nuwakot, Dolakha Rasuwa and Kathmandu. Out of seven health facility, five are district hospitals, one is located in Primary Health Care Center and one is National Trauma Center, Kathmandu. With the limited availability of the multidisciplinary team and needful infrastructure these units need to refer the cases for the further management to tertiary hospital or specialized rehabilitation service centre. Therefore this referral guide is made to support these 7 PT units and specialized hospital and rehabilitation for the effective cross-referral, timely service delivery and proper follow of the clients.

This referral guideline covers both referral in and referral out for health and rehabilitation services for people with injury/trauma, functional limitation and disability.

3. Services available at the district level include the following interventions:

- Physical assessment and treatment plan
- Delivery of therapy: exercise, mobilization, physical modalities and gait training
- Functional training for daily activities to increase autonomy
- Fitting of assistive devices and train to use for aids like crutches, sticks, walkers and wheelchair. Delivery is ensured after proper individual assessment and user trainings

- Identification of needs for specialized rehabilitation services (such as reconstructive surgery, prosthetics and orthotics and other rehabilitation specialized rehabilitation services)

4. Services required but not available now

- Transportation to pick and drop all clients for rehabilitation services
- Allowances for accommodation within district hospital but coordination with the hospital is done to admit the client for the long term rehabilitation

5. Physiotherapy sessions are delivered according to the following modalities:

- **Inpatients:** The length of session is usually 15 to 30 minutes and can be repeated at least 2 times a day, according to the needs (for example, for patients with respiratory conditions). It is done in coordination with the medical and nursing team and it must be reported in the patient file (form available with the team). The session can be delivered either in wards or in the PT OPD, depending on mobility. Follow up is mandate either in the wards or in PT OPD based on the need.
- **Outpatients**: 45 to 60 minutes session, in the physiotherapy room. Follow up of each case is mandatory.
- **Outreach (primary health care outlets, community and home visit)**: Outreach to the patient's house is planned weekly by the physiotherapist and social worker that are based on severity of conditions and limited mobility. This can include first assessment or follow up after discharge from hospital or identifying the need of intensive rehabilitation care in specialized centers.

  Physiotherapy sessions are delivered by professional physiotherapists who received trainings based on international standards as established by the World Confederation of Physical Therapy. Physiotherapist work according to the MoHP schedule and report to the DHO/DPHO.

  Physiotherapist is team leader for each PT/Rehabilitation of the District Hospitals. Apart from physiotherapist, there are two **social workers** with paramedical, ANM and psychosocial background based at each district working under the team leader. Social workers contribute to need assessments including psycho-social needs, provide information on rehabilitation services and facilitate access to available educational, livelihood and social protection opportunities such as disability card released by the Women Children Office.

6. Eligibility criteria for referral: causes of impairment

The focus of newly-set PT/Rehabilitation units at district hospitals is to respond to the needs of the injured by the earthquake and earthquake survivors. However, HI - supported PT/rehabilitation units also welcome case whose cause of impairment is other than earthquake and precisely:

- Post - Earthquake survivors;
- Road traffic accident;
- Domestic accidents;
- Non communicable diseases;
- Previous/other disasters such as conflict, Earthquakes, landslides, floods, Glacial Lake outburst floods(Glofs), fire, drought, avalanches and thunderbolts;
- Work related musculoskeletal and neurological problems; and,
- Congenital physical impairments and developmental delays.

7. Exclusion and Inclusion criteria

Cases needing urgent medical or surgical interventions. These are the inclusion criteria for referrals. These cases can be,

- Severe cardiovascular compromise
- Cases requiring the immediate ICU interventions
- Case requiring the immediate live saving medico-surgical procedures
- Cases needing the specialized surgeries that are beyond the capacity of district hospital
- Cases requiring the complex devices like customized orthotics and prosthesis

8. Common Conditions that can be referred to physiotherapy/Rehabilitation Unit at District Hospital

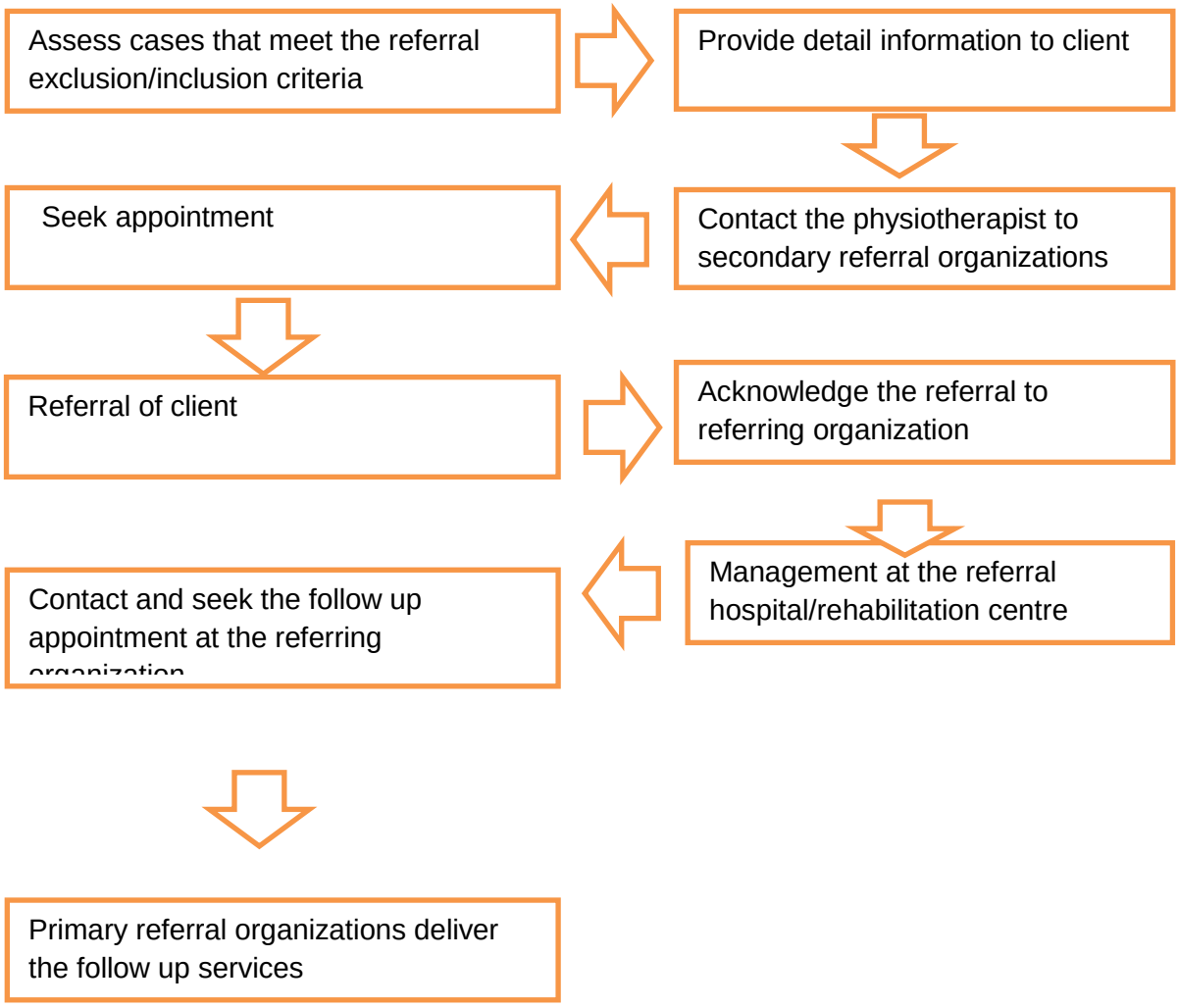
<table>
<tr><th>Orthopedics</th><th>Neurological</th><th>Cardio respiratory</th><th>Other NCDs</th></tr>
<tr><td>Post trauma/surgery joint stiffness</td><td>Multiple sclerosis</td><td>COPDs</td><td>Diabetes (Foot ulcers, pain and limb amputation)</td></tr>
<tr><td>Post trauma/surgery joint pain/swelling</td><td>Paralysis due to Poliomyelitis</td><td>Dyspnoea</td><td>Cardiovascular diseases (hypertension)</td></tr>
<tr><td>Post trauma/surgery muscle weakness</td><td rowspan="2">Peripheral nerve injury</td><td>Airflow obstruction/mucous retention</td><td rowspan="2">Peripheral vascular disease</td></tr>
<tr><td rowspan="2">Stump management following amputation</td><td>Restrictive lung diseases</td></tr>
<tr><td>SCI patients- medically and surgically stabilised</td><td colspan="2" rowspan="2">Pediatrics

Birth defects: club foot, Spina bifida,</td></tr>
<tr><td>Burns</td><td>Neurological conditions due to</td></tr>
</table>

	Meningitis	Down Syndrome, cleft lip/ palate Developmental delays (including the ones due to malnutrition) and Cerebral palsy **Others** Referral for the specialized services: Wound management, Prosthesis & Orthoses, Corrective & Reconstructive surgeries and specialized rehabilitation services
Head trauma – Stabilised	Parkinson's disease	
Torticollis	Muscular dystrophy	
Idiopathic scoliosis	Transverse myelitis	
Ankylosing spondylitis	Multiple sclerosis	
Spondylolisthesis(isthmic type and post- surgical)	Motor neurone diseases	
Spondylitis		
Osteoarthritis		
Rheumatoid arthritis		
Septic arthritis		
Osteomyelitis		
Ligament and tendon disorders		
Soft tissue injuries		
TB spine after medical or surgical management		

9. Procedures for referral

The referring organization should follow this procedure while referring cases to district hospitals. The mechanism of the referral is as below:



a. Provide detailed information:

The referring organization provides information about the organizations to be referred which includes the following,

- The location and contact details of the focal person;
- It also includes the mode of transportation from the district. Many clients may require the rough map of the bus station from their native to the hospital to be referred;
- Services available and cost of the services;
- Tentative duration of stay and also discuss if one person need to accompany for the caregiving;
- Importance of the post-surgical rehabilitation follow up after s/he get discharged from hospital; and,

- Informing clients to take previous medical test report and previous medical/follow up card.

b. Seek appointment

The organization that is supposed to receive the referral may have already a waiting list. Hence it's very important to have prior appointment of the clients. For this, the referrals form can help decision making since it contains all relevant information on the client: demographic details, clinical history, investigation reports and photos. Referral form and reports can be shared via email, what's app or viber (whatever applicable). This will help the doctors and rehabilitation team of hospital receiving the referral to decide if the intervention is possible at the hospital or not, the possible prognosis and tentative cost of the intervention. Sharing of information also help to check the possibility of refusal after client come to hospital.

c. Referral of client:

After providing all the information, facilitate the referral of client to the hospital where the appointment has been taken. A copy of the referral form to be handed over to client who should submit the same to the hospital. The referral form will serve an identity proof of the same client whose appointment was taken previously.

d. Acknowledge the referral to referring organization

Once the client is received at the hospital it always advisable to inform the referring hospital. Sometime clients could not track the location of the hospital or due to unexpected reason client fails to reach the hospital. At that scenario both the hospitals need to have a follow up on the status of clients and explore the measures to support.

10. Referral procedures to HI supported PT/rehabilitation unit for the cases identified by other staff at VDC level

In many instances VDC based staff may not have access to good internet facilities to facilitate the referral process. The procedures are suggested if the electronic communications are not feasible,

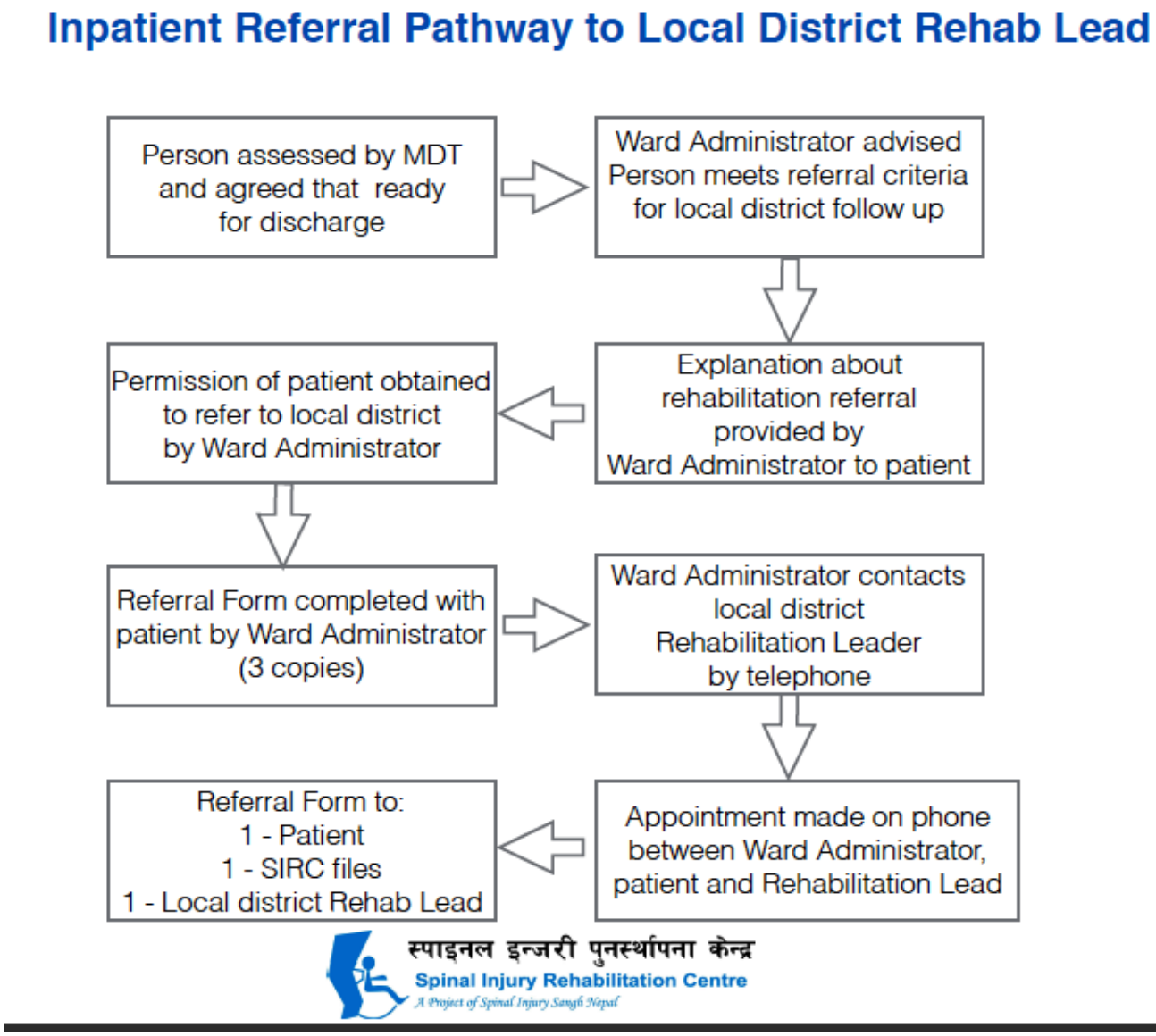
- The staff who identifies the case calls and inform to the HI physiotherapist at the district hospital
- HI physiotherapist plans a visit to community or calls the client/family members for an appointment on the district hospital
- HI Physiotherapist informs the referring staff about the status of the service delivery to that particular client.

11. Location and contact details of Physiotherapist based at District Hospital

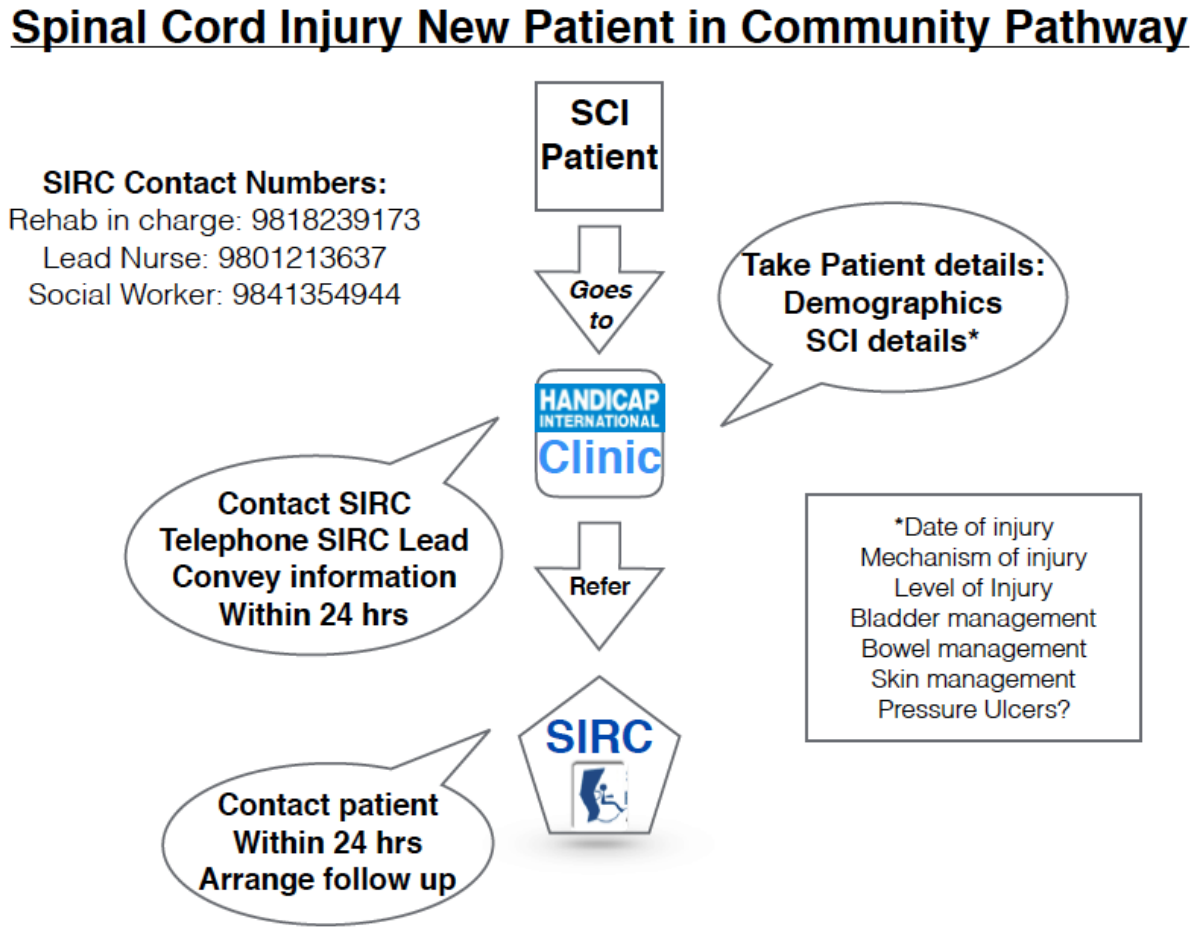
Name	Based station	Email	Telephone
Anu Bhatta	Trishuli hospital , Nuwakot	pssu.nuwakot@hi-nepal.org	9801089747
Sabita Baniya	District hospital, Sindupalchok	pssu.sindhupalchowk@hi-nepal.org	9801089749
Sudan U. Rimal	Trauma Centre , Kathmandu	pssu.traumaktm@hi-nepal.org	9801089745
Dikshya Joshi	Trauma Centre , Kathmandu	pssu.dhading@hi-nepal.org	9851025371
Om Ishwor Disti	District hospital, Charikot, Dolakha	pssu.dolakha.c@hi-nepal.org	9801089748
Bibek Khadka	Jiri Hospital, Dolakha	pssu.dolakha.j@hi-nepal.org	9801089750
Susmita Shakya	District hospital, Rasuwa	pssu.rasuwa@hi-nepal.org	9801089746

12. Referral criteria of spinal injury rehabilitation centre (SIRC)

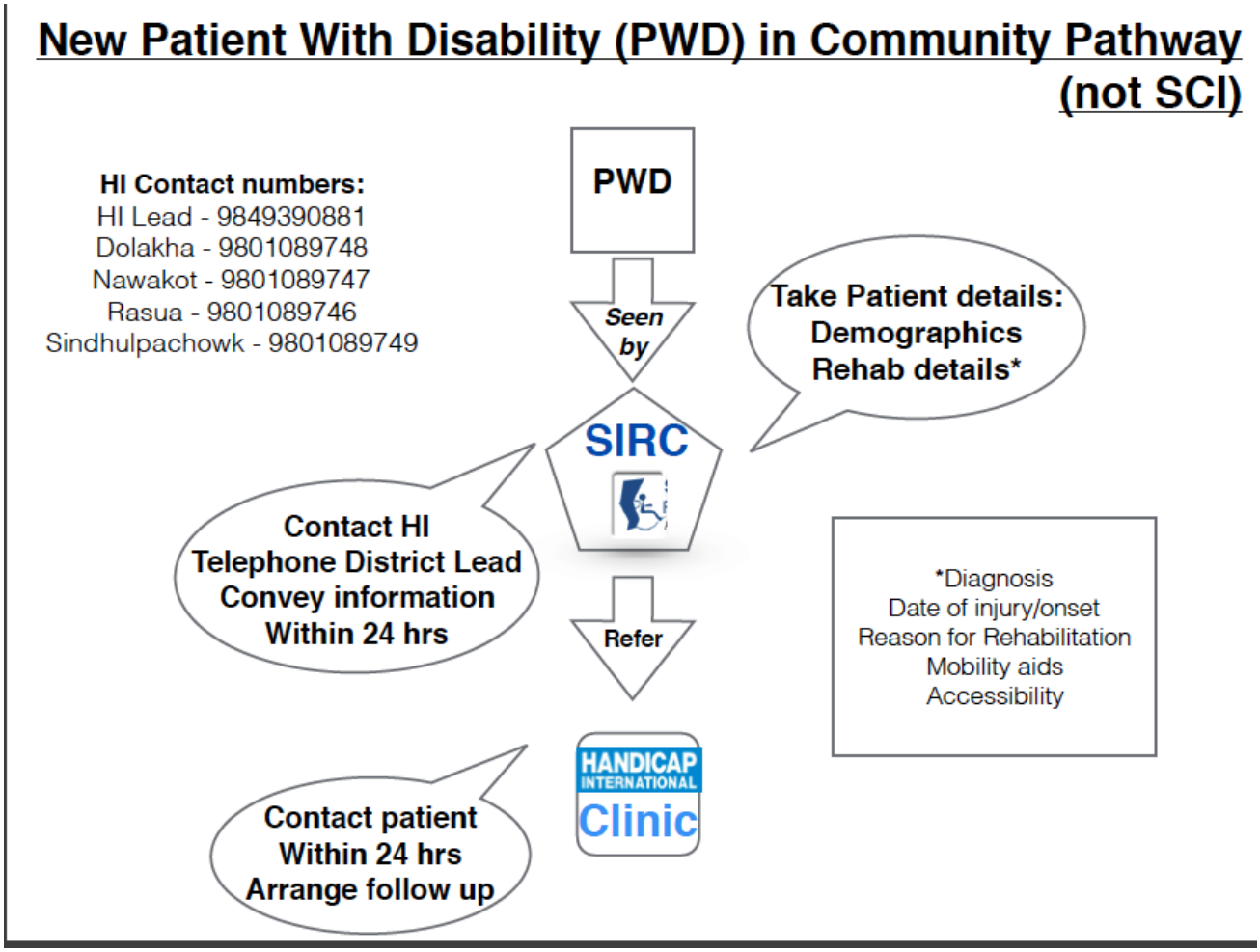
I. Referral to district based PT/Rehabilitation unit from SIRC



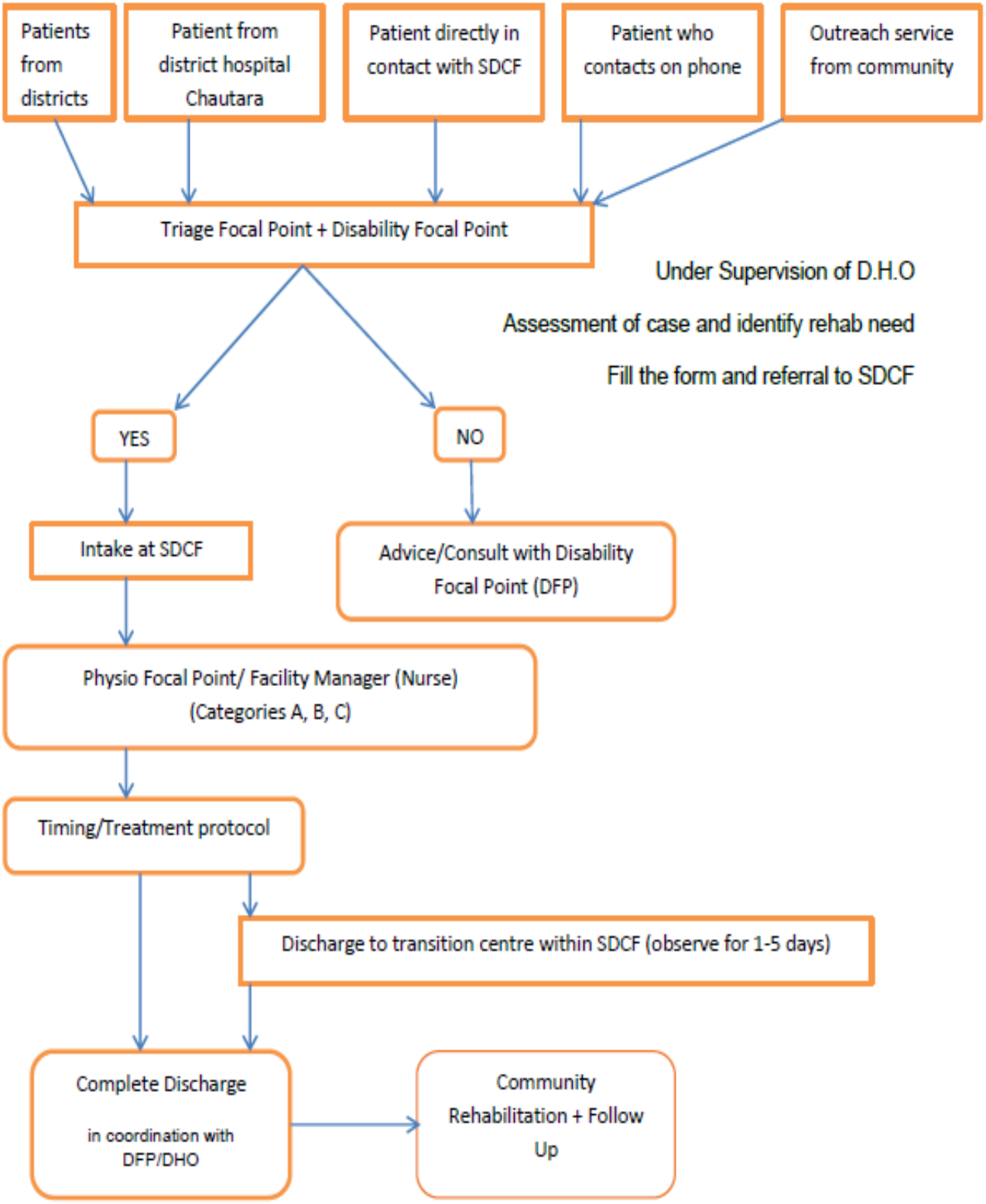
II. Referral of the spinal injury cases by district based PT/ rehabilitation unit to SIRC



III. Referral of other people with disability to PT/rehabilitation unit by SIRC



13. Referral pathway for Injury Rehabilitation Unit (IRU) of International organization for migration



Facility Focal point IOM IRU at Sindhupalchowk: Hotline Number: 980 110 8432

14. Referral Criteria of TPO Nepal

Transcultural Psychosocial Organization Nepal (TPO Nepal) is one of Nepal's leading psychosocial organizations. It was established in 2005 with the aim of promoting psychosocial well-being and mental health of children and families in conflict affected and other vulnerable communities. TPO Nepal is a knowledge-driven, innovative organization working in areas disrupted by violence and poverty. We strive to develop local psychosocial, mental health and conflict resolution capacity and systems that promote community resilience, quality of life and self-reliance through education, research, service delivery and advocacy.

The project funded by NHSSP/OPTION has been proving the services of capacity building and psychosocial support in the aftermath of earthquake under the title "Technical assistance to support transition and recovery of Nepal Health's system in post-earthquake situation" with a main objective of integrating mental health in primary care setting.

District covered under NHSSP/OPTION:

a) Dolakha

b) Ramechhap

c) Kavre

d) Nuwakot

Services available

1) Basic psychosocial support, emotional support, counseling services in all 14 earthquake affected districts.
2) Basic Mental Health Services in the health facilities (training of health workers from all health facilities in prescribing psychotropic medications and basic psycho social support): The services are provided by the government health facilities in Ramechhap, Dolakha, Sindhuli, Gorkha and Dhading.
3) Once a month supervision of health workers by Psychiatrist in Ramechhap, Dolakha, Sindhuli, Gorkha and Dhading where psychiatrists from TPO Nepal see and discuss about the individual cases present in the community.

REASONS FOR REFERRAL:

Any client with psychosocial problems can be referred for our services. Major symptoms that is encountered are

1. Changes in mood / emotion
2. Changes in personality
3. Sleep / Appetite disturbance
4. Behavioral disturbances as in relation to previous behavior
5. Violent / aggressive behavior
6. Suicidal ideations / attempt
7. Irrelevant talk / behavior
8. False firm belief
9. Hearing things others cannot hear / seeing things others cannot see
10. Substance abuse (Alcohol, Cannabis, Opiates etc.)
11. Grief

After the initial management of other disabilities and injuries the patient may have changes in the mood, emotion or behavior or any psycho-social problems and they can be referred for the mental health and psychosocial services to the service providers of TPO Nepal.

Below is the list of focal persons in different districts to be contacted (NHSSP/OPTION)

SN	District	District Coordinator	Phone number
1	Dolakha	Ms. Ganga Rimal	9851192182
2	Ramechhap	Mr. Pandab Prasai	9854040855
3	Kavre	Mr. Rajendra Kafle	9844667959
4	Nuwakot	Mr. Prakash Ghimire	9857051660

Apart from this our services are also present in others earthquake affected districts:

SN	District	Focal Person	Phone number
1	Gorkha	Mr. Bijay Acharya	9851143590
2	Sindhuli	Ms. Janani Magar	9841610658
3	Dhading	Mr. Sunil Khanal	9851153197
4	Sindhupalchowk	Mr. Ram Babu Nepal	9851127479
5	Lalitpur	Ms. Parbati Subedi	9841021433
6	Bhaktapur	Ms. Maiya Laxmi Koju	9841662119
7	Rasuwa	Mr. Punjan Shrestha	9863613501
8	Makwanpur	Ms. Rupa Gurung	9849133363

Annex: 7

Report on Wheelchair service familiarization based on World Health Organization Basic and Intermediate Wheelchair services

31st January to 3rd February 2016

1. Background

Wheelchair service provision is one of the important components of the service delivery for the people with disability. After the publication of the guideline by WHO," ***Provision of manual wheelchair in less resource setting***" 2008, there have been many changes and upgradation on the wheelchair delivery system in less resource setting. Based on this guideline, WHO has launched the wheelchair **basic (http://www.who.int/disabilities/technology/wheelchairpackage/en/), intermediate (http://www.who.int/disabilities/technology/wheelchairpackage/wstpintermediate/en/)** service training packages. These packages specially direct the service providers on executing the thorough conducive physical rehabilitation of the clients requiring or already using the wheelchair.

In 2013 & 2014, Motivation International (an UK based INGO working in wheelchair service provision) conducted the training based on the service training packages developed by WHO. 12 technical staff of 4 rehabilitation centre including staff from Handicap International and Spinal Injury Rehabilitation Centre received the same training. Due to the limited seats available for this training, many physiotherapists could not participate. In 2013 and 2014, with an aim to transfer the skill to the remaining physiotherapist of the partner organizations and to one of the physiotherapy school in Nepal (Kathmandu University), Handicap International (HI) conducted adapted version of the same training.

The wheelchair service training packages were endorsed in 2013 and 2014 and still the training packages are not well incorporated in the training curriculum of physiotherapists in India and Nepal. **The project activity 7 and project deliverable 9 highlights the support to be provided for the continuous professional development of the rehabilitation workforce in particular physiotherapist**. There were many people with spinal cord injuries and complex multiple fractures to whom wheelchairs were delivered after April 25 mega earthquake. A total of 281 wheelchairs were delivered to injured survivors through hospitals and communities by the emergency unit of Handicap International during the response and early recovery phase. These wheelchairs were delivered following the WHO protocols on wheelchair service under the supervision of senior HI technical expert. Considering the follow up need and less practical skills of the newly recruited physiotherapists on the WHO based wheelchair service provision, this training was planned.

Therefore HI Nepal aimed at familiarizing this course to the 7 physiotherapists of the project, "Rehabilitation support services in earthquake affected districts". In addition the same project also supported the participation of physiotherapists of the like-

minded organizations working for the rehabilitations of earthquake survivors and the organizations are:

Organizations	Facility located at	Participants
Spinal Injury Rehabilitation Centre	Rehabilitation centre, Sanga, Kavre	2 Physiotherapist
International Medical Corps	Step down facility in Gorkha hospital	2 Physiotherapists
International Organization of Migration	Step down facility in Sinduplachok	1 Physiotherapist

2. Objectives of the familiarization of wheelchair service training package

- To improve the standard of the wheelchair service delivery provided to people with injury in and around projects sites
- To enhance the knowledge of physiotherapist in the field of appropriate wheelchair service provision as per WHO wheelchair guideline.
- To improve access to quality wheelchairs, adapted to users and their environments, and raise awareness about the risks of using wheelchairs which are not adapted.
- To increase the number of wheelchair users who receive training in the use and maintenance of wheelchairs and how to stay healthy in a wheelchair.
- To develop skills to assess the people with disabilities need.

3. Method and materials/resources considered for training familiarization.

Methods

- Practical demonstration on assembling of commonly used wheelchairs in Nepal (World made 2, World made 4, Emergency wheelchair and Whirlwind roughrider wheelchair) was made.
- Theoretical knowledge (Core knowledge and Service steps) through presentation taken from training package developed by WHO.
- Practical demonstration on users training, transfer techniques, checking pressure sore and preparation of pressure relief cushion.
- Practical demonstration to adhere all 8 steps of wheelchair service delivery with client.

- Sharing of the experience of wheelchair service by the experienced trainers (physiotherapist, prothetist and orthotist of Handicap International) through case study, photos and videos.

Materials/Resources used

For the familiarization of the training materials developed by WHO for basic and intermediate level training was utilized this includes,

- Reference manual for participants
- Power point presentations
- All forms and checklists developed by WHO for wheelchair service.

4. Activities carried out

As suggested by WHO, the training was focused on delivering the both theoretical and practical skills on the eight steps of the wheelchair services delivery that include the following,

- Referral and appointment
- Assessment
- Prescription
- Funding and ordering
- Product preparation
- Fitting
- User training
- Follow up, repairs and maintenance

5. Additional activities

Apart from the content utilized from the WHO training package, HI also shared its lesson learns and challenges of delivering the wheelchair services in Nepal. Similarly, a special session on perspective of the wheelchair service delivery in Nepal was discussed. In this session, the present actions of service providers, decision makers and user groups related to wheelchair service in Nepal were discussed.

6. Training evaluation

Pre and post test questions were designed covering all the aspect of training content. The score of pre and posttest is mentioned here under

Tests	Mean Score
Pretest	4.47
Post test	8.88

The pretest score 4.47 indicates only some knowledge on the wheelchair service provisions whereas the raise on the posttest score to 8.88 relates to significant knowledge gain after the training.

Pre-test score	1.5	3	3.5	4.5	5	5.5	6.5
Frequency	1	4	2	1	3	3	3

The mode value of pretest score is only 3 out of 10. 9 participants out of 17 scored 5 and above and remaining 8 participants scored below than 5. It also signifies only some knowledge on the wheelchair service provision on participants.

Post-test score	5	6	7.5	8	8.5	9	9.5	10
Frequency	1	1	1	2	2	2	2	4

Index

Requires immediate review

Acceptable but development possible

Strong

The mode value of posttest is 10 out of 10. None of the participants underscored (below than 5). Out of the 17 participants, 16 scored above than 5 which indicates the significant understanding of the topics covered.

7. Feedbacks from participants

- The training was new but lots of practical made it interesting, that helped to learn many new things
- Intermediate level of the service is difficult than the basic level hence again a refresher is required.
- Assembly of the wheelchair is a bit difficult hence assembly manual is required to ease the process

8. Conclusion:

As per the feedback from participant this training was conducive, simple and informative. WHO prepared tools and presentations were utilized during the training. Wheelchair service provision is a process; hence it needs to be monitored, evaluated and supported periodically. Participants felt that the intermediate level service is more complex than the basics hence more practice need to be done in daily settings.

Annex 8:

Monitoring Visit Report

March 2016

Project Monitored:	**Health System Strengthening Project (HSSP)**
Background and Purpose:	The DFID-funded project "Rehabilitation support services in earthquake affected districts" intends to meet rehabilitation needs in order to minimize secondary complication and regain function among people with injuries induced by earthquake of 25th April 2015. The project aims at achieving the overall objective of preventing disability through key approaches which include providing post-surgery care, supporting safer discharge and long term rehabilitation and putting in place skills and basic start-up systems for sustaining rehabilitation services.
Visit duration with date	17-22 March, 2016
Visit Location	Dhading, Sindhupalchowk, Jiri and Charikot
Specific objectives and expected outputs:	• To discuss and review the project progress update and plan for upcoming month; • Plan for outreach/community mobilization strategy • Provide on the job mentoring on Physiotherapy Unit (PT); • To provide the technical backup to field staffs on reporting template; and • Follow up action plan and prepare an action plan for upcoming month
Monitored by:	• Projects Coordinator Mahendra Bikram Shah • Project Officer Gyanendra Shrestha • Project Assistant Prajwol Shrestha

A. Observation

1 PT unit set up at Dhading, Sindhupalchowk, Jiri and Charikot

2 Store management at project districts

3 Review of documents-assessment forms, HMIS reporting template

Activities conducted

1	**Meeting with field based staffs at Dhading, Sindhupalchowk, Charikot and Jiri** A meeting was conducted with field based staffs comprising of one physiotherapist and social workers in Project districts. The meeting intended to discuss and review the project progress update and plan for upcoming month for effective delivery of physiotherapy/ Rehab services in project districts. **Dhading** Project Coordinator Mahendra Bikram Shah introduced newly appointed social worker Geeta Bhattarai with the Dhading team. Dhading team welcomed her and congratulated her for new roles and responsibilities and tenure in Dhading PT/rehab unit as a social worker. The team hoped to accelerate and deliver rehab service to people with EQ injured/functional limitations and disability with the joining of new team member Diksha Joshi, physiotherapist based in Dhading Diksha Joshi shared the progress update and challenges of the PT/rehab unit. • In Dhading, a total of 70 clients including 37 male and 33 female have received physiotherapy services till February 2016 and among them 3 clients including 2 males and one female were earthquake victims. • During the press meet conducted by District Health Office, the DHO has informed the media persons about the availability of free PT/rehab service in district hospital. • Good coordination with stakeholders and likeminded organizations to provide PT/rehab service to people with EQ injured/functional limitations. The meeting discussed on strategies to increase community outreach and deliver rehab service to people with EQ injured/functional limitations and disability. The team came up with following strategies to increase community outreach in the days to come. • Locate EQ affected people on the basis of name list provided by police office and NDF community workers • Broadcast information about PT/rehab services to general public through local FMs after consultation with communication officer in HI office • Disseminate message about PT/rehab during Health facility/FCHV and microfinance

	meetings • Discuss with participants of injury/trauma management training regarding the earthquake injured people • Conduct meeting with Disability People Organizations in the district and discuss on the people with disability in the district • Distribute pamphlets to different VDCs in coordination with local stakeholders • Increase outreach visit by following flowchart sent from central office • Visit the VDCs most affected by the April 15 EQ on priority basis **Sindhupalchowk, Jiri and Charikot** Project Coordinator Mahendra Bikram Shah introduced newly appointed social worker Bal Bahadur Bhujel with the Sindhupalchowk team and Pushpa Rai with the Charikot team. He shared objectives of field visit with the district teams. Project Officer Gyanendra Shrestha highlighted on the pivotal role of social workers to identify and locate EQ survivors and people with disability and link them with rehab and social protection services Physiotherapist based in Sindhupalchowk Sabita Baniya shared about progress and update of the PT/ Rehab Service. • The local stakeholders such as DHO, District Hospital, DPOs, IOM, Karuna Foundation are providing necessary support and coordination for smooth running of PT/rehab services. • The organizations (IOM, Karun Foundation and DPOs) have started to refer patients who need physiotherapy service to the PT/ Rehab unit. • The district team has planned to visit highly affected VDCs for identifying the EQ affected clients for their treatment and facilitate social protection issues. Physiotherapist based in Jiri Bibek Khadka shared about progress and update of the PT/ Rehab Service. • District Hospital Jiri provided adequate space for set up of PT/ Rehab service at Jiri, now well setup and functioning of PT/ Rehab service at Jiri • Good coordination with government and non-government organizations working in Jiri. The organizations have started to refer patients who need physiotherapy service to the PT/ Rehab unit. • Focused to intensify community visits to identify new EQ patients who really need physiotherapy and social protection service • Request has been made from local Disability People Organization to HI for providing

	support and facilitate the process of acquiring disability card from WCDO Dolakha Physiotherapist based in Charikot Om Ishwor Disti shared about progress and update of the PT/ Rehab Service. • A total of 183 clients including 88 male and 95 female received physiotherapy services till date and among them 41 clients including 17 males and 24 females were earthquake victims. • Good coordination with the government and non-government organizations working in Charikot. Coordination with Community Service Association of Disabled and Blind to provide advertisement in F.M. about the physiotherapy/ rehab service provided by Handicap International in Charikot • Participation at district sharing and planning meeting organize by NHSSP and shared the project update and upcoming plan • Focused to increase community visits/ outreach for tracking EQ patients and facilitating social security and protection activities During the meeting with staffs, Project Coordinator briefly discussed on role and responsibility of social workers, which included client's assessment and support clients and their care takers for social support for physical rehabilitation and social protection issues. • Reinforced the district teams to increase EQ survivors and emphasised on mapping of social service and social protection provision at local level and make linkage with local stakeholders such as District Development Committee, District Public Health Office, District Women Children Office, District Education Office, District Agriculture Development Office, Disabled People's Organization and local private organizations who are working in the field of health and disability for their livelihood option and education. • Advised to keep proper patient record with compatible to government morbidity record register. Shared draft outreach / community mobilization framework (Attached in Annex I) and agreed follow-up of the outreach framework. Meeting also agreed to display a district map with highlighting the highly EQ affected VDCs which will be supported to plan the outreach visit • Meeting discussed and agreed to develop a district factsheet and collect the information for services mapping of concerned stakeholders that will be supported to develop linkage others development organizations. (The Format of factsheet and mapping are attached in Annex II and III)

2	**Progress Data Sheet (October 2015 – February 2016)**

District/ PT/ Rehab Unit	OPD/IPD			Community			Total new beneficiaries(OPD/IPD + Community)			Care giver benefitted			Eart affe
	F	M	Total	F	M	Total	F	M	Total	F	M	Total	F
Jiri	99	72	171	9	3	12	108	75	183	55	64	119	14
Charikot	95	88	183	15	10	25	110	98	208	46	56	102	24
Sindhupalchowk	110	99	209	4	3	7	114	102	216	32	36	68	33
Dhading	37	33	70	0	0	0	37	33	70	7	10	17	1
Grand Total	**341**	**292**	**633**	**28**	**16**	**44**	**369**	**308**	**677**	**140**	**166**	**306**	**72**

3	**Meeting with stakeholders at project districts** • Act. Chief of District Health Office (Dhading) thanked HI for running PT/rehab service in district hospital and anticipated for long running of PT/rehab services. He committed for providing necessary support from district health office and district hospital. He advised HI team for submission of monthly report to DHO and called for participation in regular meetings to share progress and challenges. • Medical Superintendent (Dhading Hospital), Dr. Rashila Amatya expressed her happiness for running PT/rehab services and told that the EQ injured populations in Dhading are still unaware about the establishment of PT/rehab unit in Dhading hospital. She suggested announcing about the PT/rehab service in Dhading hospital through local media (F.M.). She even told that the hospital is exploring space to shift the PT/rehab unit from the existing location. In response to Dr. Amatya's notion to charge fee from patients for accessing PT/rehab service in district hospital, Project Coordinator requested to hold the idea of charging fee for the time being. She even requested to plan for capacity building activities for the members of Hospital Development Board and Health Facility Operation Management Committee on health management at their local situation. • Focal Person of Primary Health Care Centre Dolakha suggested expanding community level outreach activities to address the vulnerable beneficiaries at hard to reach area. He requested for basic training on injury/trauma management training to health professionals in the district, who were left out during the first training and refresher training for the participants who have attended the training. During the meeting, all district authorities showed their commitment to support PT/ Rehab unit in the respective districts. On behalf of the visit team, Mr Mahendra Bikram Shah thanked hospital management board and District Public Health Officers for providing support for the establishment of PT/ Rehab unit in project districts.

B. Findings and Challenges

SN	Findings/ Challenges	Remarks
1	Lack of community outreach and follow up due to transportation problem	
2	PTs and district health counterparts are worried about the long-term sustainability of PT units	
3	Water logging in tarpaulin used to cover tent during rain fall	

C. Recommendations and Plan of Action

SN	What	When	Who support required
1	Preparation of upcoming plan/ Activities for the month of April 2016	Last week of March 2016	PT
2	Organise sharing and planning workshop with concern line agencies at district level	First week of April 2016	PT/ SW
3	Manage PT room (Service Delivery Room) at Charikot with the close coordination with DPHO, Dolakha	Third week of March 2016	PT/ SW
4	Display District map with located of ranking of highly earthquake affected VDCs in front of PT unit	First week of April 2016	PT/ SW
5	Monthly reporting to DHO all PT/ Rehab unit	First week of April 2016	PT/ SW
6	Mobilization local FM for broadcasting key message of PT/ Rehab Service at Dhading	Third week of March 2016	PT/ SW
7	Support and facilitate to DPO of Jiri for taking Disable card for the Disable People	First week of April 2016	PT/ SW

D. Action Photos

IEC materials at Jiri PT/ Rehab Unit (22/03/2016)

Meeting with District Team at Sindhupalchowk (20/03/2016)

Observed PT/ Rehab unit at Jiri, Dolakha by Monitoring Team

Providing physiotherapy service from PT unit of Sindhupalchowk (20/03/2016)

Annex I

Methodology to track earthquake survivors

Collect the information of injured survivors from DHO or District Administration Office or district level DPO or collect from all and choose the best one

List down the VDCs with priority number 1, 2 , 3 ,4 based on the highest to lowest load of survivors and mapping and finalize the VDC for outreach after finalize the VDC also priority the wards and community

Select one or two VDCs at a time where you have to conduct your outreach. Then decide the nearest health facility for these selected VDCs. If not health facility then school or VDC office can be also selected so as to cover both VDCs at a time

Propose DHO about the plan and request the support to disseminate the message of this outreach to the health facility in charge. Then ensure that health facility in charge is going to disseminate the information to FCHVs who are supposed to disseminate information to each household. This process may take a week time. At the same time forward the similar request to disable people organization who will be disseminating the information to their VDC network

After the green signal from DHO and DPO, write a TOR mentioning the objective of this visit, duration of travel and budget required. Seek an approval from the project.

Conduct the outreach as planned (Travel on your scooter if applicable otherwise propose a budget for vehicle but at this condition you need to see at least 7 or more clients)

A quick update of the camp shall be shared as soon as after the completion and detail of it should appear in monthly report.

Other tips

- PT must be there in each visit. If not, social worker should collect all the information mentioned in their assessment form. Very importantly on the intervention plan there should be information on how long the person will require a care. If not then it has to be clearly stated that s/he do not require further care.
- On these outreach, focus on calling all the injured survivors irrespective of severity. And also cover the people who stay on the way to outreach venue.
- Try to be diplomatic if health worker or DPO people ask incentive in VDC. Stress these things to DHO and DPO at districts level during the preparatory meetings that we are focusing on service with the limited budget we have. Also inform to DHO and DPO that people will get services through this approach which is obvious in addition information collected from this event will help to identify the rehabilitation needs and its required cost for the district which can be presented by DHO and DPO in local and national forums to raise the support to continue the service.
- Invite DHO and DPO on one visit that should not be more than one in a quarter. It will help to enhance the ownership on the process.
- Mobilize of Index EQ patients for screening others EQ survivors patients for their treatment and social protection activities
- Manage logistic arrangement for transportation, medicine and nutrition cost to the needy EQ patients based on the result of assessment verified by staffs and collect all the necessary required documents such as photocopy of patient OPD card, if possible citizenship or disability cards, application of beneficiary

Annex II

Health System Strengthening Project (HSSP)

REHABILITATION SUPPORT SERVICES IN EARTHQUAKE AFFECTED DISTRICTS

District Fact Sheet

District:

Head Quarter:

SN	Particular	Number	Remarks
1	Total Population		
	Male / Female		
2	Total no of VDC		
3	Total no of Municipality		
4	No of Government Hospital		
5	No of Primary Health Care Centre		
6	No of Health Post		
7	No PHC Out Reach Clinic		
8	No of EPI Clinic		
9	Total No of FCHVs		
10	**Human Resource**		
	Medical Officer		
	Nurses (SN, Sr. ANM,ANM)		
	Paramedics (HA, Sr. AHW, AHW)		
	Public Health Offices (PHO, PHI)		
	Physiotherapist		
	Lab Technicians		
	District Supervisors		
11	No of DPOs (Disable People Organization) (Organization who work for disabilities protection and long-term rehabilitation)		

12	Total no of Disable People (M/F)		
13	Total no of Disable Card Holders		
	Committee		
14	Functioning – Hospital Development Board		
15	Functioning –HFOMC (Health Facility Operation and Management Committee)		
16	Functioning -RHCC (Reproductive Health Coordinating Committee)		
17	Functioning – RRT (Rapid Response Team)		
18	Functioning –DDRC (District Disaster Relief Committee)		
19	Functioning - DACC (District Aids Coordination Committee)		
	Social Service		
20	Non-Governmental Organization Affiliated to SWC (I/NGOs)		
21	Name of Organization working in Health and Disability Sector (I/NGOs)		
22	No of Private Hospital		
23	No of Private PT/ Rehab service		
24	Total no School (Primary – Higher Secondary)		
25	Total no of Disable Students (M/ F)		
26	No of Disable Friendly School Building		
27	No of Disable friendly Health Institution Building		
28	OCMC (Y/N)		
29	Total Injured people with injury / Functional limitation During the EQ		
	Network		

30	Network of DPOs (Y/N)		
31	NGO federation (Y/N)		
32	Network of Disable people (Y/N)		
33			

Prepared by:

Date:

Annex III

Health System Strengthening Project (HSSP)

REHABILITATION SUPPORT SERVICES IN EARTHQUAKE AFFECTED DISTRICTS

Mapping of Health and Development Sector Stakeholders

District:

SN	Name of Organization	Contact Person	Contact No.	Email Id	Major Activities	Focused Area (Health, Social Development, Social Protection, Livelihood, Skill based, Agriculture)	Target Beneficiaries	Covered Area / VDCs	Service Charge	Areas of possibility for partnership (Joint effort)	Link with Injury/ functional limitation and Disability
1	District Public Health Office , District Hospital (DPHO)										
2	Women Children Development Office (WCDO)										
3	District Development Committee (DDC)										
4	District Agriculture Development Office (DADO)										
5	Small Cottage Industry Office										
6	District Horticulture Development Office										
7	Municipality										
8	District Education Office (DEO)										

Annex 9:

Photos of project activities

Woman with injury learning to walk

Physiotherapist supervising the user training to the wheelchair users in an outreach event

A physiotherapist teaching a woman with injury to walk

Physiotherapists conducting the home follow of a person injured by earthquake

Physiotherapist supervising the balance training in beneficiary house

Injury rehabilitation officer mentoring the physiotherapist to assemble the wheelchair

Physiotherapists accessing a case in an outreach event organized in Melamchi primary health care centre

Social workers conducting the community follow up of beneficiaries

Appendix 2:

स्पाइनल इन्जरी पुनर्स्थापना केन्द्र

Spinal Injury Rehabilitation Centre

A Project of Spinal Injury Sangh Nepal

Third Quarter Progress Report

(February to April 2016)

May 2016

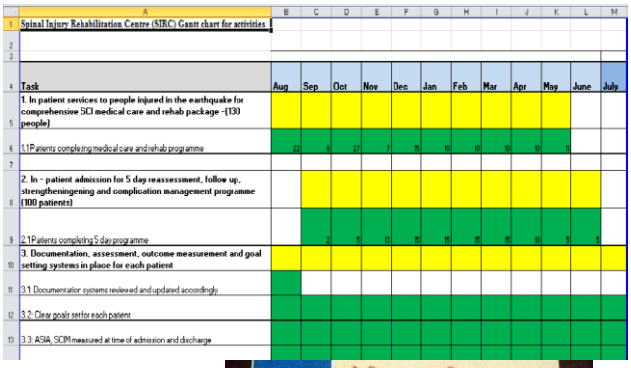
Table of Contents

1. Deliverables completed to end April 2016

SIRC 1: Workplan finalised and approved

Work plan with sequence of activities finalized in Gantt chart (see right).

This work plan helped in keeping project activities on track within the timeframe of the project.

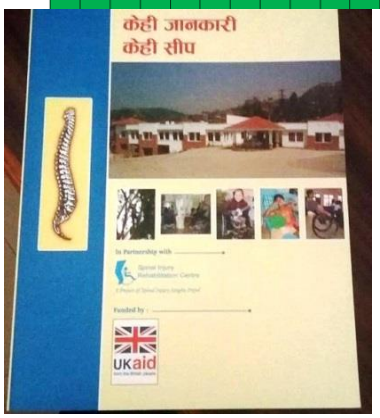


Spinal Injury Rehabilitation Centre (SIRC) Gantt chart for activities												
Task	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July
1. In patient services to people injured in the earthquake for comprehensive SCI medical care and rehab package -(130 people)												
1.1 Patients completing medical care and rehab programme	22	8	27	7	15	10	10	10	10	11		
2. In - patient admission for 5 day reassessment, follow up, strengtheningening and complication management programme (100 patients)												
2.1 Patients completing 5 day programme		2	8	13	18	18	18	18	18	8	8	
3. Documentation, assessment, outcome measurement and goal setting systems in place for each patient												
3.1 Documentation systems reviewed and updated accordingly												
3.2: Clear goals set for each patient												
3.3: ASIA, SCIM measured at time of admission and discharge												

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

The carer training programme was reviewed and a training programme delivered to caretakers of spinal injury patients (see below at SIRC 5). The knowledge and skills of caretakers are expected to have been enhanced by the training programme.

The patient self-care manual was updated, printed and distributed (see cover at right). New images in the manual should be more easily understood by patients.



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

Regular needs assessments were carried out for each person admitted to the Spinal Injury Rehabilitation Centre (SIRC, which is located in Kavre Palanchok district).

At admission each patient is assessed related to bowel, bladder, skin and respiratory functions included plans for rehabilitation. These assessments provide the basis for short, medium and long term goal planning of the patients. See assessment form on the right.

Patient ID …113/2015….. SIRC - MDT Needs Assessment Summary

Mechanism of Injury: EQ **Level of Injury:** T12 wedge compression # **ASIA:** A **Spine:** surgical fixation

SCIM (function) Score: 10 **DASS Score (Depression & Anxiety):** ?

PRECAUTIONS: Bed rest. Log roll, Brace

Assessment and Plan:

XComplex functional impairments: MDT evaluation and treatment to include medical team (doctor, nursing), physiotherapy, occupational therapy, seating/equipment team, nutrition specialist, social work, psychology, peer counseling, vocational rehabilitation, recreational therapy, discharge planning. Refer to ASIA, SCIM, DASS assessment forms.

XNeurogenic bladder:
- XCatheter
- XUrinalysis, C/S (If negative discontinue indwelling catheter and begin CIC/CISC training.)
- □Oxybutynin 2.5mg PO TID
- XCystometry on or after: _____ □Urological ultrasound on or after: _____

XNeurogenic bowel:
- XDaily bowel program to include: Digital stimulation,

XImpaired sensation - Skin:
- XPressure ulcer on admission Yes/No XPU Grade: 2 heel

SIRC 4: National and district level trainings to health and rehabilitation professional in coordination with Handicap International

SIRC and Handicap International collaboratively formed a dedicated training working group to design and deliver national level trainings. As part of this group, two staff from SIRC served as master trainers while four staff were chosen as district level trainers.

SIRC provided all the evidence-based spinal cord injury-related materials to Handicap International for developing a training manual on injury and trauma management.

A senior nursing officer from SIRC was engaged as a district trainer in the training programmes conducted by Handicap International. These programmes covered wider aspects of various injuries and trauma management. The involvement of SIRC's staff with Handicap International was instrumental in raising awareness about how to seal with spinal cord injuries and spinal cord injury patients, and the management and rehabilitation of such injuries.

Two hands-on training programmes were conducted in conjunction with Handicap International. The trainings were conducted in Ramechhap and Lalitpur Districts (see photo of Ramechhap training). These trainings focused on providing practical aspects of spinal cord injury management and the handling of patients with spinal cord injuries. These trainings educate and guide district health workers about spinal cord injuries and their management at the local level.

SIRC 5: Caretakers programme for 100 caretakers

SIRC has successfully trained 107 patient caretakers in the quarter. SIRC has educated them on bowel, bladder and skin-related care of patients. Along with this, they are educated about complications and their prevention and proper management while handling spinal care spinal cord injury patients at home and in communities.

Other important aspects such as disability rights, vocational training, sexual function, psychological support, respiratory management, home advice for the caretaker, pain in spinal cord injury, physical therapy (PT) assistive devices, transfer, accessibility, activities of daily living (ADL) and assistive devices, diet and nutrition were covered in this training. For continuous reinforcement and learning, the manual '*Kehi jankari kehi sip*' (some information and skills) was distributed to all participants.

This training programme should contribute to the improved provision of care of spinal injury patients in family and community environments. Trained caretakers (such as those in the photo) will be better able to provide needed attention to patients and support them emotionally thereby increasing the self-esteem and confidence of patients.

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

Five community outreach workers had completed 290 home visit services support to the end of the reporting period. During these visits, clients are provided with essentials such as catheters, xylocaine jelly, dressing kits, and other medications. Mobile phones have been given to some needy patients to enable telephonic follow-up of cases.

Outreach workers complete a home visit follow-up form for each patient they visit. These forms provide detailed information on the patients' demographic,

economic, health and family situation. In addition, the outreach workers collect and provide follow-up information on and to caretakers training and vocational training participants. This provides SIRC with information about the impact and outcome of its training programmes for caretakers and the vocational training package for vocational trainees. The workers also take photographs of patients during their visits (see right).

To date, home visits service support has been completed for 290 patients. Analysis and reporting has been done of 217 of these home visits. From the analysis, SIRC has come to better know about the condition of patients and their immediate needs. SIRC learns much in this way including the realization of the crucial role community based rehabilitation (CBR) workers play through home visits support services. Several patients have been referred to other like-minded organizations; as a result of which the quality of life of these patients has improved by receiving the right treatment in the right place at the right time. Telephonic follow up is being done to support home visit service support. A detailed report has been already submitted on this deliverable.

2. Deliverables still to be completed

SIRC 7: Referral system established between community and Handicap International district rehabilitation points

A series of meetings was held with like-minded organizations such as Handicap International, the Transcultural Psychosocial Organization (TPO), the Injury and Rehabilitation Unit (IRU), and the International Medical Corps (IMC) to create a common referral form and written referral criteria/guidelines. A common referral form has been finalized and is being used by related organizations. All the referral activities will be recorded on these forms.

This referral system has been initiated and all of the above organizations are committed to continuing the referral activities in the longer term. Regular meetings will be held between referral agencies and SIRC project staff to share experiences on establishing referral systems and improvements to be made. Meeting minutes will serve as evidence and provide information on action plans. A report on the referral system will be submitted.

SIRC 8: 30 female patients will have received comprehensive vocational training package to support the commencement of income generation activities

This activity is related to developing the capacity of patients by providing sewing training. Sewing work is suitable for most spinal injury patients who have limited movement. The patients will learn to sew clothes which will enable them to start their own tailoring businesses. To allow them to commence this business, as soon as they reach their houses/communities after taking part in the training programme, SIRC will provide them with a sewing package including a sewing machine, accessories related to sewing (such as scissors, thread, machine oil, needles, cutting/ironing table, cupboard and an iron) and unstitched pieces of material.

SIRC will follow up on the patients who have received sewing packages to know how their new enterprises are going. This will help SIRC measure the impact and evaluate the outcomes of the sewing training. In addition, any lessons learned by training facilitators will be documented in to improve future vocational training activities for female and male spinal cord injury (SCI) patients that offer viable methods of income generation in their communities.

SIRC 9: 130 people receive in-patient services at SIRC with assessment of functional improvement, psychological acceptance and management of complications

The major objective of activity SIRC 9 is to have evidence based outcomes whereby all the assessments will be recorded in a database and then analysed. This will support SIRC to develop an operationally effective and clinically sound measurement system. This will facilitate a true reflection of the services being provided to patients. This will inform SIRC's multi-disciplinary team about the current position and ways of improving care pathways for patients. The implementation of learning will be an ongoing practice across SIRC's multidisciplinary team. Learning will also be supported and monitored by key SIRC personnel in management and supervisory positions.

A report on in-patient services delivered and outcomes measured is forthcoming.

SIRC 10: 200 ex-patients of SIRC living in earthquake affected districts receive follow up home visit services support

Out of the targeted 400 follow up home visit services support (combined SIRC activities 6 and 10), 290 home visits have been completed. The community based rehabilitation workers are in earthquake affected districts to conduct the remaining home visit follow up services. Similar to the reporting of SIRC 6 above, a final report will be submitted after the analysis of the data received from the home visits. The findings in this report will be useful to create an evidence based model of community based rehabilitation services provided by SIRC.

SIRC 11: Hand-over report of work by SIRC to MoH's Disability and Rehabilitation Focal Unit (DRFU)

A final comprehensive report illustrating the status of the cohort of patients, continuing needs in the field of the rehabilitation sector, referrals made to different organizations, human resource development, along with the lessons learnt and action plans for future based on the learning will be submitted to the Ministry of Health, DRFU and the Nepal Health Sector Support Programme (NHSSP).

3. Added Value Outputs (Activities completed but not listed in deliverables)

10 days training on basic principles of Neuro-rehabilitation to 50 nurses

SIRC ran a 10 day long comprehensive training on neurological rehabilitation for 50 nurses from six earthquake affected districts on. The main objective of the training was to increase skills and competencies of neurological rehabilitation nurses.

This 10 days residential training covered aspects related to neuro-rehab such as stroke, polio, traumatic brain injury, paediatric nursing, and spinal cord injury

complications and management. The training was delivered by a multidisciplinary team including physiotherapy, occupational therapy, social work and nursing experts.

Based on evidence-based practice and information, SIRC delivered the above comprehensive training programme, which was perceived as detailed and informative by trainees. A final report on this training is forthcoming.

Hands on training on spinal cord injury management for 60 health workers

The main objective of the hands on training on spinal cord injury management programme was to develop the capacity of health care professionals who care for spinal cord injury patients. The practical focus of the programme was to give participants an accurate understanding of the techniques used by a multidisciplinary team working with spinal cord injury patients.

SIRC has completed these three day long hands on trainings for 137 health professionals in six earthquake affected districts. SIRC has successfully conducted training in Ramechhap, Dolakha, Rasuwa, Sindhupalchowk, Nuwakot, Kavre and Lalitpur. SIRC also coordinated and held discussions with the Handicap International team on enhancing referrals and supporting patients after discharge.

SIRC's training team achieved a positive shift in the knowledge base of the participating health workers. However, participants said it would be better to deliver the training on –site rather than in an outreach setting. They believed this would increase the knowledge gained and would reinforce the information disseminated through visual learning. A final and compiled report on this training is forthcoming.

Team building training to SIRC staff

A one day team-building training was held for all SIRC staff at Gokarna Forest Resort, Kathmandu on 3 May 2016. Note that some staff (helpers, nurses and canteen support staff) stayed back at SIRC to take care of the in patients. This training was led by Raman Nepali, visionary life coach from the Prabha Raman Foundation.

The major objectives of this training were to:
create a climate of trust among all SIRC staff;
improve the personal relationships and understanding among staff; and
promote the basic principles of team work like team leadership, coordination, communication and conflict management.

The training started with inspiring visual interactive learning along with modern meditation sessions. Later, SIRC personnel were divided into six teams with each team consisting of members from different departments. The initial group activity was discussions relating to

amazing factors and challenges at SIRC along with the solutions to the challenges. Different aspects related to the importance of team work were realized with the help of different games for each team. The training ended with a learning and experience sharing session. All staff were pleased with the training as they realized the beautiful aspect of working in a team and the impact it makes on overall performance.

4. Risks and Risk management for the coming quarter

The completion of outstanding project deliverables may be threatened by known risk factor. The forthcoming monsoon season may hamper the extensive travel that is required by the community based rehabilitation team and the training team during May and June. While all staff involved in project deliverables will continue to follow the detailed work plan as agreed, challenges may be created by heavy rain and possible landslides in target areas. In the light of potential delays caused by this wet season, both community based rehabilitation and training staff members are aiming to expedite the completion of the work in both a timely but conscientious manner.

The preparation and submission of reports is dependent on the completion of project deliverables. Therefore the risk described above could cause delays in writing reports which detail project outputs and outcomes. Ongoing communication between field staff and the project manager will highlight challenges that are being experienced and pinpoint risks to timely reporting and how this might affect the reporting timeline agreed with DFID. A meticulous work plan has been developed for each remaining deliverable and agreed with the staff members responsible for the project outputs. These plans will guide the implementation of activities for the remaining project timeline. Nevertheless, it would be very helpful if an extension could be received for two months for reporting purposes.

5. Collaborative Action with Others

As mentioned in earlier reports, SIRC has been coordinating with the district health offices and district public health offices (DHOs and DPHOs) of earthquake affected districts in order to get approval to conduct various training programmes and follow up home visit services support. With regard to the establishment of referral pathways, regular meetings and coordination are taking place with Handicap International, Transcultural Psychosocial Organization, the International Medical Corps and the Injury Rehabilitation Unit. Similarly, while delivering team building training to the staff of SIRC, continuous coordination took place with Raman Nepali, coach of Prabha Raman Foundation. Mr Raman Nepali will be making a follow up visit at the centre to assess the outcome of the training.

Appendix 3:

HEALTH SECTOR TRANSITION AND RECOVERY PROGRAMME

Quarterly Activities Report

February 2016 to April 2016

May 2016

TRANSCULTURAL PSYCHOSOCIAL ORGANIZATION NEPAL (TPO NEPAL)
QUARTERLY ACTIVITIES REPORT
FEBRUARY 2016 TO APRIL 2016

The key activities conducted in this February to April 2016 reporting period included building the capacity of health workers (prescribers and non-prescribers), community psychosocial workers (CPSWs) and female community health volunteers (FCHVs); mental health and psychosocial support services delivery in health facilities and communities; community sensitization programmes; and the identification and referral of people with mental illness using the Community Informant Detection Tool (CIDT). The details of the activities are presented below:

Training and Capacity building

All the proposed training events for health workers (prescriber and non-prescribers) were accomplished in February. Also, the second phase CPSWs training and FCHVs training on CIDT were also completed in this quarter.

23 prescribers received 8 days training on the mental health Gap Action Program Humanitarian Intervention Guide (mhGAP HIG) and basic psychosocial support in Dolakha.

21 non-prescribers received 5 days training on psychosocial support in Dolakha.

48 CPSWs (24 from Ramechhap, 19 from Dolakha and 5 from Kavre) received 7 days training on psychosocial support.

565 FCHVs (297 from Ramechhap and 268 from Dolakha) received 2 days training on CIDT. 304 FCHVs received one day training on mental health and psychosocial issues in Dolakha

2 clinical supervisors received 4 days training on clinical supervision from an expert psychologist from New Zealand.

Two days training and mentoring provided to of M&E assistants by the M&E officer.

Supervision of Health Workers, CPSWs and FCHVs

As per the project proposal, ten monthly case conferences and on-the-job supervision were conducted by psychiatrists to prescriber health workers. Similarly, the clinical supervisors in both districts (Dolakha and Ramechhap) conducted six case conferences as well as on-the-job supervision of non-prescriber health workers on a monthly basis. The project's community psychosocial workers were supervised by the clinical supervisors, and the FCHVs received one supervision visit by CPSWs in this reporting period. These supervisions were very helpful for enhancing the clinical capacity of the health workers, counselors and CPSWs.

176 prescribers (87 in Dolakha and 89 in Ramechhap) received supervision at 10 monthly case conferences.

24 prescribers (9 in Dolakha and 15 in Ramechhap) received on-the-job supervision from psychiatrists.

68 non-prescribers (25 in Dolakha and 43 in Ramechhap) received supervision at 6 case conferences.

16 non-prescribers (8 in Dolakha and 8 in Ramechhap) received on-the-job supervision from counsellors and clinical supervisors.

237 FCHVs (117 In Dolakha and 120 in Ramechhap) received 1 day's supervision by the CPSWs.

40 CPSWs (20 in Ramechhap and 20 in Dolakha) received 2 group supervisions by counsellors.

12 CPSWs (6 in Kavre and 6 in Nuwakot) received 3 group supervisions by psychosocial counsellors.

Mental Health and psychosocial services delivery in health facilities and communities

From the beginning of this reporting period, mental health and psychosocial support (MHPSS) services were made available in most of the health facilities and in communities of Dolakha and Ramechhap districts. Similarly, CPSWs and community counsellors were mobilized in both Nuwakot and Kavre districts. In this reporting period, more than 880 people received MHPSS services from health facilities, 316 from community counsellors and 729 from CPSWs. In addition to this, 494 people were also referred to health facilities by FCHVs.

880 people (517 from Ramechhap and 363 from Dolakha) with priority disorders (256 depression, 111 psychosis, 167 epilepsy, 81 alcohol use disorder, 56 Post-traumatic stress disorder [PTSD], 96 anxiety disorder, 8 with suicidal ideation, 37 conversion disorder and 68 others) received MHPSS services from health facilities.

316 people (167 in Dolakha, 99 in Ramechhap, 30 in Nuwakot, and 20 in Kavre) received individual counseling services from community counsellors.

729 people (170 in Dolakha, 414 in Ramechhap, 87 in Nuwakot, 58 in Kavre) received basic psychosocial support from CPSWs.

190 people with severe mental illness (93 in Dolakha, 51 in Ramechhap, 46 in Kavre) received specialized care from psychiatrists

494 people (340 from Dolakha and 154 from Ramechhap) were referred to the health facilities by FCHVs for mental health services using CIDT.

141 people with mental health and psychosocial problems (46 from Dolakha, 15 from Ramechhap, 36 from Nuwakot and 44 from Kavre) were linked to other organizations for other services including the Women and Child Welfare Council, the district police office, Maiti Nepal, the women development office, Koshish Nepal and Plan International.

Community Sensitization Programme

Mental health is highly stigmatized in local communities in Nepal. Also very few people are fully aware about mental health and psychosocial problems and the reasons for these problems. Hence, several awareness and orientation programmes were conducted in all four districts to sensitize key community members on mental health issues and related services available in their districts. These programmes were conducted by CPSWs and FCHVs. The key community members included teachers, political leaders, member of mother groups, government officials and local cooperative members. Altogether 3,176 people participated in these programmes. These programmes helped to sensitize communities on mental health issues and increase help seeking behaviour.

3,176 key community members (1,409 in Dolakha, 966 in Ramechhap, 265 in Nuwakot and 536 in Kavre) participated in 72 awareness and orientation programmes.

2000 information, education and communication (IEC) materials on 6 priority disorders were distributed.

72 VDCs (35 in Dolakha, 25 in Ramechhap, 6 in Nuwakot and 6 in Kavre) were covered by the sensitization programme.

Coordination with local and national level stakeholders:

Several coordination meetings were conducted with district and national level stakeholders for effective implementation of the programme. These meetings were helpful to improve quality of services by learning and sharing the best practices and challenges.

Two meetings held with personnel at Dolakha district health office (DHO) to discuss training schedule, supervision modality, drugs procurement and supply, FCHV training and referral modality of patients.

Three meetings held with Ramechhap DHO personnel to discuss drugs procurement and supply, the involvement of the DHO in the supervision of health workers, and the training of FCHVs.

Joint meeting with Handicap International (HI) and Spinal Injury Rehabilitation Center (SIRC) to establish and improve two way referral mechanisms.

A joint meeting with HI, SIRC, International Medical Corps (IMC) and International Organization for Migration (IOM) in Kathmandu to develop and finalize a referral document and referral criteria.

Meeting with DHO Nuwakot to discuss the need for a psychiatric outpatient department (OPD) on a monthly basis at Nuwakot. However, the need for this was not felt as the mental hospital, at Lagankhel in Lalitpur runs a psychiatric OPD on a monthly basis.

Met with Kavre DHO personnel to ensure that project activities were implemented smoothly in the district and the DHO is getting updates regularly

Several meetings (N=21) were conducted with local organizations in all 4 project districts to enhance coordination and establish referral mechanisms for different services available in the districts.

Challenges and Risks

Challenges

The transfer of the trained health workers outside the project districts.

The regular absenteeism of trained health workers in the health facilities due to other training programmes and their involvement in other community activities.

Delay in the distribution of drugs to the health facilities that are remotely located.

Delays in the procurement of additional drugs due to delayed approval from the Ministry of Health.

Fuel shortage in the early months of this quarter hampered the distribution of drugs, field visits and supervision of the programme.

Delayed payment even after the timely submission of the payment deliverables.

Possible risks in the coming quarter

If the transfer of trained health workers continues; then this might have a huge impact on service delivery from the health facilities and also achieving the targets indicated in the original proposal.

Delay in drugs procurement.

Further delays in payment could adversely impact the ongoing project activities.

Appendix 4: CAPP Update – see separate digital file accompanying this report

Appendix 4A: CAPP Monitoring Meeting 8th April

Ministry of Health
Department of Health Services
Logistics Management Division
Meeting on Monitoring of CAPP with NHSSP
Minutes of the Meeting

Venue: Meeting Hall LMD Time: 1130 -1300
Presence: List attached

A joint meeting was held on the 8th April 2016 between DoHS-LMD Procurement Technical Team along with representatives of NHSSP on the following Agenda:

1. Monitoring of the progress of CAPP
2. Dissemination of Specifications with the Users
3. Human Resources for LMD
4. Finalization of Pre-shipment Inspection Document
5. Finalization of Framework agreement Document
6. Participation in Global Procurement Summit
7. Other issues

1. The meeting chaired by Director LMD, Dr Bhim Singh Tinkari .Procurement Unit made the presentation and highlighted the progress and achievement made on CAPP. It was noted that procurement processes of all slices of Vaccine'procurement except that of MR Vaccine has been concluded. The procurement of MR Vaccine (ICB 100) could not be concluded and it has to be re-advertised because bidder's quoted price was 15 per cent higher than the estimated cost. The technical evaluation regarding the procurement of essential drugs (ICB 102) has not been concluded due to unavailability of Pharmacist. The Procurement Unit highlighted reasons behind delay in the procurement of hospital equipment/cold chain equipment. The tender notice has been published in March for procurement of drugs-2 (ICB103).There is a substantial delay in the approval of specifications from the concerned divisions and in estimating the cost as pricing information is not readily available.

   Procurement process of DMPA has not been initiated due to delay in receiving specification from the concerned division. Procurement Unit has just received specifications of Inj. DMPA and is in the process of incorporating specs in bidding documents. It is informed that contract for the procurement of printing materials has been signed and the consignments will be received at the end of the fiscal year.

   Procurement of LLIN (NCB115)has not been initiated because it is not required as informed by the concerned division. Procurement of drugs for EDCD/FHD/CHD (NCB 116) as well as procurement of diagnostic Kit for MD and EDCD (NCB117) is in the process of finalizing bidding documents. It was noted that procurement unit has requested information regarding specifications and cost estimations to the concerned divisions and yet to receive them.

   Revisions have been made in the requirements of Medical consumables for PHCRD and CHD (ICB 120). It was noted that procurement unit has received revisions lately and is in the process of advertise bids accordingly.LOI has been issued for the procurement of bags (NCB122).Detail progress status of CAPP (as of March 31, 2016) is attached.

Government of Nepal
Ministry of Health
Department of Health Services
Tilla, Kathmandu

Action:
Regularize Joint meeting and review CAPP progress

2. It is noted that there is a need to discuss and disseminate Technical Specifications of medical equipments with users to make them user friendly. Dr. Tinkari requested NHSSP support in organizinga two day workshop in May, 2016 to this purpose.

   Action:

   Mr. Sujeet Baskota to coordinate with LMD for the workshop

3. It isnoted that there is a need of a procurement specialist and a pharmacist in LMD. Dr. Tinkari requested NHSSP support in hiring procurement specialist and pharmacist. He also requested for the extension of contract of NHSSP official working in LMD whose terms are expiring in April, 2016.

   Action:
   LMD to collect three CVs (pharmacist) and submit to NHSSP
   NHSSP to extend contract of Bio Medical Engineer, Consultant (IT) till July 25, 2016

4. It is noted that draft documents for hiring of pre-shipment and post- shipment inspection agent and draft SOP for Pre and Post Shipment Inspection has been shared with LMD officials. Dr. Tinkari requested NHSSP support in organizing a two day workshop to discuss and finalize the draft document.

   Action:
   Avanindra to coordinate with LMD for the workshop

5. It is also noted that draft SBD for Framework agreement has been improved considering comments and suggestions made during Nagarkot Workshop. It is advised to deliberate issues and finalize the draft document organizing meetings in LMD Office.

6. Capacity development training for LMD official was discussed. Dr. Tinkari informed about "Global Procurement Summit to held in India from 21-22 April, 2016 and requested NHSSP support to send three participants from LMD in the Summit.

   Action:
   LMD to nominate three participants and inform NHSSP

7. It is agreed that next Joint meeting will be organized in late May/Early June.

8. Finally,Dr. Tinkari thanked the participants of the meeting, with special thanks to the NHSSP for the support.

Meeting Title: CAPP Meeting
Date: 8th April 2016 **Time:** 11:30am
Venue: Logistics Management Division

#	Name	Organisation	Designation	Office No. /Cell	Email	Signature
1	Dr. Bhim Singh Tinkari	DoHS/ LMD	Director			
2	Baburam Lamichhane	"	Under Secretary			
3	Deepak Adhikari	"	PHO	9841408869		
4	Kanak Raj Shrestha	FHD	PO	9841279526	shresthakanakraj@gmail.com	
5	Tilak B. Rai	EDCD	PO	9857019577		
6	Aminda Kumar Shrestha	NHSSP	Proc. Reform Advisor	985104881	[illegible]@gmail.com	
7	Stuart King	— " —	Team Leader		stuart@nhssp.org	
8	Krishna Sharma	TRP-NHSSP	Deputy Team L.	9851085228		
9	SUJIT BANSKOTA	NHSSP	BME	9851155655	sujit@nhssp.org.np	
10	Khagendra Adhikari	NHSSP	consultant	9852681922	adhikarikk@gmail.com	
11	Rana Bahadur Gharti	DoHS/LMD	PHI	9841373375	rbghartiz006@gmail.com	
12	Himlal Gyawali	LMD.	PHI	9841507144	himlalgyawali@yahoo.com	
13	Shankar Prasad Karnad	LMD	Store officer	9845554187	[illegible]@yahoo.com	
14	Hari Pd. Adhikari	LMD	PHI	9851147528	adhikarihari@gmail.com	
15						
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CAPP Update: 31st March

Ministry of Health and Population
Department of Health Services
Procurement Plan for Goods and Services
F/Y 2015-16 -- Status of March 31, 2016

S.N.	Description	PP Status	Expected Approval of Cost Estimate	Estimate in mil.	Proc. Method	No. of Package	Bidding Document: Prepn.	Bidding Document: Approval	No Objection from DP	Invitation for Bidding: Publish Date	Invitation for Bidding: Opening Date	Invitation for Bidding: Evaluation completion	No objection on Evaluation Report	Publication of LOI	Contract signing	Commencement of Contract	Contract completion	Status
1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
1	NHSP-II/DOHS/G/ICB-100/2015-16 Procurement of Vaccines for Child Health Division and Epidemiology and Disease Control Division	P	22-Sep-15	367.36	ICB	7	15-Sep-15	22-Sep-15	NA	25-Sep-15	10-Nov-15	10-Dec-15	NA	22-Dec-15	6-Jan-16	6-Jan-16	5-May-16	LOI Published
1.1	BCG Vaccine 20 Dose- 201,600 Vial			33.000														
1.2	MR Vaccine 10 Dose- 201,600 Vial			128.177														
1.3	Bivalent Polio Vaccine 10 Dose- 215,600 Vial			40.320														
1.4	JE Vaccine 5 Dose- 201,600 Vial			45.500														
1.5	Td Vaccine 10 Dose- 1,71,863			19.660														
1.6	Inj. ASVS- 68,000 (For EDCD)			50.000														
1.7	Inj. ARV - 3,00,000 (For EDCD)			50.700														
		A								11-Dec-15	8-Feb-16	3-Mar-16		6-Mar-16				
2	NHSP-II/DOHS/G/ICB-002/2015-16 Procurement of Drugs-I	P	NA	438.398	ICB	34	18-Sep-15	25-Sep-15	10-Oct-15	13-Oct-15	28-Nov-15	28-Dec-15	12-Jan-16	26-Jan-16	21-Feb-16	21-Feb-16	20-Jan-16	Bids in evaluation process.
2.1	Tab. Cetirizine HCl 10mg - 5,00,000			1.000														
2.2	Susp.Metronidazole 60 ml (200mg/5ml) -500,000			8.500														
2.3	Inj.Metronidazole 100 ml (500mg/100ml) -30,000			0.600														
2.4	Tab. Metronidazole 400 mg - 220,00,000			22.000														
2.5	DT Amoxycillin 125 mg - 1,00,00,000			30.000														
2.6	Cap.Amoxycillin 500 mg- 1,00,00,000			90.000														
2.7	Sus. Amoxycillin125mg/5ml -120,000 (CHD)			2.040														
2.8	DT Amoxycillin 250 mg -123,50,000 (CHD)			43.225														
2.9	Tab.Tinidazole 500 mg -700,000			3.500														
2.1	Eye/Ear Drop Ciprofloxacin 5ml, 0.3% w/v - 36,00,000			28.800														
2.11	Tab.Ciprofloxacin 250mg - 7,50,000			2.250														
2.12	Tab. Ciprofloxacin 500mg -170,00,000			85.000														
2.13	Inj. Ceftriaxone 1gm - 50,000			3.500														
2.14	Tab. Sulfamethoxazole + Trimethoprim 960 mg - 50,00,000			12.500														
2.15	Tab.Sulfamethoxazole + Trimethoprim 480 mg- 20,00,000			4.000														
2.16	Cap.Doxycycline 100mg -300,00,000			30.000														
2.17	Cap Cloxacillin 250 mg - 500,000			2.000														
2.18	Cap Cloxacillin 500 mg - 500,000			3.000														
2.19	Tab. Acyclovir 200mg - 50,000			0.350														
2.2	Tab. Folic acid 5mg - 10,00,000			2.000														

S.N.	Description	PP Status	Expected Approval of Cost Estimate	Estimate in mil.	Proc. Method	No. of Package	Bidding Document Prepa.	Bidding Document Approval	No Objection from DP	Invitation for Bidding Publish Date	Invitation for Bidding Opening Date	Invitation for Bidding Evaluation completion	No objection on Evaluation Report	Publication of LOI	Contract signing	Commencement of Contract	Contract completion	Status
2.21	Inj. Sodium chloride 500 ml- 90,000			4.050														
2.22	Inj Dextrose Solution 5%w/v 500 ml -50,000			2.250														
2.23	Tab. Amlodipine 5mg - 70,00,000			21.000														
2.24	Tab. Chlorpromazine 100 mg - 500,000			1.250														
2.25	Tab. Amitryptiline 10 mg - 500,000			1.250														
2.26	Tab. Amitryptiline 25mg- 500,000			1.325														
2.27	Tab. Metformin 500mg - 1,00,00,000			20.000														
2.28	Tab. Digoxin 0.25 mg - 500,000			1.000														
2.29	Pessary Tab. Clotrimazole 100 mg - 500,000			0.600														
2.3	Inj Diazepam 2ml (5mg/ml) - 150,000			3.000														
2.31	Gention violet 2% 10 ml - 50,00,000			10.000														
2.32	Tab. Carbamazepine200 mg - 20,00,000			4.000														
2.33	Tab. Carbamazepine 400 mg - 500,000			2.000														
2.34	Nasal Drop Oxymetazoline 0.1% 5ml - 36,000			1.400														
		A								19-Jan-16	14-Mar-16							
3	NHSP-3/DOHS/G/ICB-103/2015-16 **Procurement of Drugs-2**			398.091														Notice published on March 3
3.1	Inj Lignocaine 2% without adrenaline -50,000			1.000														
3.2	Tab. Paracetamol 500mg - 50,00,000			1.750														
3.3	Syp. Paracetamol 60ml (125mg/5ml)-5,00,000			7.500														
3.4	Tab Aspirin -75 mg -5,00,000			0.375														
3.5	Tab Aspirin 150mg-3,00,000			0.270														
3.6	Tab Ibuprofen-400 mg -135,00,000			12.825														
3.7	Inj Diclofenac-3ml (25mg/ml) - 90,000			0.630														
3.8	Cap Indomethacin 25mg - 400,000			0.900														
3.9	Cap Indomethacin 50 mg - 300,000			0.900														
3.1	Tab. Chlorpheniramine 4 mg - 4,00,00,000			6.000														
3.11	Inj.Pheniramine 2ml (22.75 mg/ml) - 80,000			0.400														
3.12	Sus.Cetirizine HCl 60ml (5mg/5ml) -300,000			5.100														
3.13	Inj. Gentamycin 2ml vial (40mg/ml)-525,000			2.500														
3.14	Inj. Ciprofloxacin (200mg/100 ml) -30,000			0.600														
3.15	Appl/eap Chloramphenicol 1% - 32,00,000			3.200														
3.16	Cap Chloramphenicol 500mg -200,000			0.400														
3.17	Tab. Azithromycin 250 mg-500,000			5.000														
3.18	Tab Azithromycin 500mg - 500,000			7.000														
3.19	Cap Cloxacillin 125mg -500,000			1.500														
3.2	Cap Cloxacillin 500 mg - 500,000			3.000														
3.21	Neomycin skin ointment 15 gm -500,000			15.000														

S.N.	Description	PP Status	Expected Approval of Cost Estimate	Estimate in mil.	Proc. Method	No. of Package	Bidding Document: Prepn.	Bidding Document: Approval	No Objection from DP	Invitation for Bidding: Publish Date	Invitation for Bidding: Opening Date	Invitation for Bidding: Evaluation completion	No objection on Evaluation Report	Publication of LOI	Contract signing	Commencement of Contract	Contract completion	Status
3.22	Tab Fluconazole 150mg - 50,000	P	2-Oct-15	0.500	ICB	38	25-Sep-15	2-Oct-15	17-Oct-15	20-Oct-15	5-Dec-15	4-Jan-16	19-Jan-16	31-Jan-16	28-Feb-16	28-Feb-16	27-Jun-16	
3.23	Ointment Fluconazole 15 gm - 50,000			2.000														
3.24	Ointment Acyclovir 5 gm - 10,500			0.200														
3.25	Tab Ferrous sulphate 60 mg - 60,00,000			7.200														
3.26	Cap Vitamin B complex - 1,00,00,000			16.000														
3.27	Tab. Atenolol 50 mg - 200,00,000			40.000														
3.28	Calamine lotion 30 ml 15% w/v - 500,000			7.500														
3.29	Gamma benzene hexachloride 100 ml 1% w/v - 500,000			7.500														
3.3	Povidone Iodine 500ml 5%w/v - 270,000			17.550														
3.31	Tab.Aluminium hydroxide + Mag. Hydroxide 250 mg+250 mg - 15,00,00,000			60.000														
3.32	Inj.Ranitidine 2ml (25mg/ml) - 50,000			0.250														
3.33	Tab. Ranitidine 150 mg - 300,00,000			22.500														
3.34	Inj. Atropine (0.6 mg/ml) - 18,000			0.216														
3.35	Inj.Hyoscine butylbromide 1ml (20mg/ml) - 18,000			0.108														
3.36	Tab.Hyoscine butylbromide 10 mg - 450,000			0.450														
3.37	Tab.Hyoscine butylbromide 20mg- 30,00,000			5.520														
3.38	ORS (WHO Formula) -68,00,000			40.800														
3.39	Clove oil 5ml - 150,000			1.500														
3.4	Inj. Metoclopropamide 2ml (5mg/ml) -100,000			0.800														
3.41	Tab. Promethazine Hydrochloride 25 mg- 100,000			0.220														
3.42	Ointment Benzoic acid + Salicylic acid 30 gm (6%+3%) w/w - 300,000			4.800														
3.43	Inj. Dexamethasone 2ml (4mg/ml) - 50,000			0.600														
3.44	Tab. Salbutamol 4mg - 145,00,000			2.175														
3.45	Inj. Pralidoxim sodium 500 mg - 18,000			1.440														
3.46	Tab. Phenobarbitone 60mg- 210,000			0.535														
3.47	Tab. Alprazolam 0.25 mg - 500,000			1.750														
3.48	Inj.Hydrocortisone 100 mg/vial- 50,000			3.000														
3.49	Inj.Adrenaline 1ml,(1:1000) - 100,000			0.900														
3.5	Cream Silver Sulphadiazine 1% w/w -500,000			17.500														
3.51	Cream Clotrimazole 25 gm 1% w/w - 300,000			12.000														
3.52	Tab. Allopurinol 100 mg - 500,000			2.500														
3.53	Tab. Allopurinol 300 mg - 500,000			3.000														
3.54	Cap Tetracycline 500 mg - 300,000			1.500														
3.55	Tab. Levothyroxin 100 mcg - 15,00,000			10.500														
3.56	Inj. Ampicillin 500 mg/2ml - 69,000			1.042														
3.57	Tab. Zinc 20mg -1,73,80,481			17.380														

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							Prepn.	Approval		Publish Date	Opening Date	Evaluation completion						
3.58	Gel CHX 4% 3gm- 662250			39.594														
		R/A								3-Mar-16								
4	**NHSP-II/DGHS/G/ICB-104/2015-16 Procurement of RUTF, Fortified flour, Micronutrient Powder for Child Health Division**			**105.00**														
4.1	Ready to Use Therapeutic Food- 1,085,000 Sachet	P	5-Oct-15	38.00	ICB	3	28-Sep-15	5-Oct-15	NA	8-Oct-15	23-Nov-15	23-Dec-15	NA	4-Jan-16	19-Jan-16	19-Jan-16	18-May-16	
4.2	Fortified Flour- 378,732 Bag (Bags of 3 KG)			58.00														
4.3	Multiple Micronutrient Powder- 4,50,000 Sachet			9.00														
		A																
5	**NHSP-II/DGHS/G/NCB-106/2015-16 Procurement of Syringes For Child Health Divion**			**8.74**														
5.1	2nd Reconstitution Syringe for BCG- 223,972 Pc	P	26-Oct-15	1.10	NCB	4	19-Oct-15	26-Oct-15	NA	29-Oct-15	29-Nov-15	29-Dec-15	NA	10-Jan-16	25-Jan-16	25-Jan-16	24-Apr-16	
5.2	AD Syringe 0.05 ml for BCG Vaccine- 875,770 Pc			4.32														
5.3	5ml Reconstitution Syringe - 414,597 Pcs			3.318														
		R/A																
6	**DGHS/G/ICB-108/2015-16 Procurement of Hospital Equipments For LMD, FHD,MD, [illegible]**			**161.97**														
6.1	X-Ray 300 mA- 10			37														
6.1	x-Ray 100 mA- 10			20														
6.2	Dental X-Ray -25			4														
6.3	ECG Machine-100			20														
6.4	Nebulizer -300			1.5														
6.5	Suction Machine-50			7.5														
6.6	Oxygen Concentrator-58			32.5														
6.7	OT Table-30			15.75														
6.8	OT Light-30	P	22-Oct-15	8	ICB	15	15-Oct-15	22-Oct-15	NA	25-Oct-15	10-Dec-15	9-Jan-16	NA	21-Jan-16	5-Feb-16	5-Feb-16	4-Jun-16	
6.9	Dental Chair- 10 Set (For MD)			3														
6.10	Anaesthesia Machine- 5 (For FHD)			7.5														
6.11	Cautry for MSV-31 (For FHD)			0.62														
6.12	Cryo Machine with Co2 Cylinder-15 (For FHD)			3														
6.13	Portable Ultrasound Machine -5 (For FHD)			6														
6.14	Supply, delivery and installation of ELISA Reader			2														
6.15	Blood Culture System- 4			6														
6.16	ENT Operating Microscope-2			3														
6.17	ENT Treatment Unit-2			1.2														
6.18	Bone Marrow Transfusion Set-1			5														
		R/A																
7	**DGHS/G/ICB-107/2015-16 Procurement of Hospital Instrument and Furniture For LMD, FHD, CBD**			**59.616**														
7.1	Hospital Bed with IV stand-800			14.4														
7.2	Hospital Mattress-1000			12														
7.3	Bed Side Locker-800			8														
7.4	Dental Extraction Set- 80 Set			1														
7.5	MVA Kit -500			1.5														

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7.6	Equipment for 2nd Trimester for 4 Site	P	25-Oct-15	0.416	ICB	15	18-Oct-15	25-Oct-15	NA	28-Oct-15	13-Dec-15	12-Jan-16	NA	24-Jan-16	8-Feb-16	8-Feb-16	7-Jun-16	
7.7	Implant removal kit- 1000			5														
7.8	IUCD insertion and removal kit - 1000			6														
7.9	Mini lap Kit -200 Set			2														
7.10	NSV Kit - 400			2.4														
7.11	Salter Scale- 7,000 Set			5														
7.12	IMNCI Equipment (Detail list as per attached)			0.9														
7.13	ARI Sound Timer-4000 Pcs			2														
		R/A																
8	**DOHS/G/NCB-108/2015-16 Procurement of Printing for MD, LMD, CHD, EDCD**	P	7-Oct-15	**31.8**	NCB	4	30-Sep-15	7-Oct-15	NA	10-Oct-15	10-Nov-15	10-Dec-15	NA	22-Dec-15	7-Jan-16	7-Jan-16	6-Apr-16	Contract Signed
8.1	HMIS Printing- For MD			23														
8.2	Annual Report-2500 - For MD			1														
8.3	LMIS Stock Book-			3.8														
8.4	Agriculture Food Security Printing for CHD			6														
8.5	Printing of Ebola, Swine Flu, Bird Flu prevention material for EDCD			10														
8.6	Zoonotic disease printing For EDCD			12														
		A								10-Dec-15	27-Jan-16	31-Feb-16		22-Feb-16	23-Mar-16			
9	**NHSP-II/DOHS/G/NCB-109/2015-16 Procurement of Cold Chain Equipment For Child Health Division**	P	25-Oct-15	**19.00**	NCB	5	18-Oct-15	25-Oct-15	NA	28-Oct-15	28-Nov-15	28-Dec-15	NA	9-Jan-16	24-Jan-16	24-Jan-16	23-May-16	
9.1	Ice Pack (0.4 Litter) 40,000			2.00														
9.2	Refrigerator - 25 Unit			5.00														
9.3	New Cold Room for Central Store-1			3.00														
9.4	New Cold Room for Regional Store, Hetauda and Dhangadi			4.00														
9.5	Central Cold Room-1			5.00														
		R/A																
10	**NHSP-II/DOHS/G/NCB-110/2015-16 Procurement of Spare Parts for CHD and EDCD**	P	27-Oct-15	**3.52**	NCB	2	20-Oct-15	27-Oct-15	NA	30-Oct-15	30-Nov-15	30-Dec-15	NA	14-Jan-16	29-Jan-16	29-Jan-16	29-Mar-16	
10.1	Spare Parts for Cold Chain For CHD			2.52														
10.2	Supply and Delivery of the spare parts for Insecticide spray pump For EDCD			1														
		R/A																
11	**NHSP-II/DOHS/G/ICB-111/2015-16 Procurement of Inj. DMPA-10,00,000**	P	8-Oct-15	99	ICB	1	1-Oct-15	8-Oct-15	NA	11-Oct-15	26-Nov-15	26-Dec-15	NA	7-Jan-16	4-Feb-16	4-Feb-16	3-Jun-16	
		R/A																
12	**NHSP-II/DOHS/G/ICB-112/2015-16 Procurement of 5-Year Implants - 20,000**	P	31-Oct-15	24.3	ICB	1	24-Oct-15	31-Oct-15	NA	3-Nov-15	19-Dec-15	18-Jan-16	NA	30-Jan-16	14-Feb-16	14-Feb-16	14-May-16	
		R/A																
13	**NHSP-II/DOHS/G/NCB-113/2015-16 Procurement of IUCD**	P	5-Nov-15	2.627	NCB	1	29-Oct-15	5-Nov-15	NA	8-Nov-15	9-Dec-15	24-Dec-15	NA	5-Jan-16	20-Jan-16	20-Jan-16	19-Apr-16	
		R/A																
14	**NHSP-II/DOHS/G/SQ-114/2015-16 Procurement of Motorcycle-5 for Management Division**	P	27-Sep-15	1	SQ	1	20-Sep-15	27-Sep-15	NA	30-Sep-15	16-Oct-15	31-Oct-15	NA	12-Nov-15	19-Nov-15	19-Nov-15	19-Dec-15	
		R/A																
15	**NHSP-II/DOHS/G/NCB-115/2015-16 Procurement of LLIN**	P	9-Oct-15	30	NCB	1	2-Oct-15	9-Oct-15	NA	12-Oct-15	12-Nov-15	12-Dec-15	NA	24-Dec-15	8-Jan-16	8-Jan-16	7-May-16	

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							Prepn.	Approval		Prebids Date	Opening Date	Evaluation completion						
		R/A																
16	**NHSP-II/DOHS/G/NCB-116/2015-16 Procurement of Drugs for EDCD, FHD and CHD**	P	20-Oct-15	117.5	ICB	8	11-Oct-15	18-Oct-15	NA	21-Oct-15	6-Dec-15	5-Jan-16	No	17-Jan-16	1-Feb-16	1-Feb-16	31-May-16	
16.1	Tab. DEC 100mg - 12,50,000 (For EDCD)			12.5														
16.2	Tab. Mebendazole 50 mg (For EDCD)			5														
16.3	Tab. Mesoprostol 200 mcg - 600,000 (For FHD)			6														
16.4	Combi Pack (Misoprostal + MEfepristone)-12500 Pack (For FHD)			4														
16.5	Cap. Vitamin A - 10,000,000 (For CHD)			60														
16.6	Iron Tablet - 100,000,000 (For CHD)			30														
16.8	Tab Albendazole 400 mg- 22,75,000			5														
		R/A																
17	**NHSP-II/DOHS/G/NCB-117/2015-16 Procurement of Diagnostic Kit For Management Division and Epidemiology and Disease Control Division**	P	20-Oct-15	44	NCB	2	13-Oct-15	20-Oct-15	NA	23-Oct-15	23-Nov-15	23-Dec-15	NA	4-Jan-16	19-Jan-16	19-Jan-16	18-May-16	
17.1	Supply and delivery of diagnostic kit for Chikungunya and dengue. (For EDCD)			1														
17.2	Urinay Test Kit (1,00,80,000 Pcs) (For MD)			43														
		R/A																
18	**NHSP-II/DOHS/G/NCB-118/2015-16 Procurement of Insecticides For Malaria and Kala-Azar for Epidemiology and Disease Control Divion**	P	20-Oct-15	30	NCB	1	21-Oct-15	28-Oct-15	NA	31-Oct-15	1-Dec-15	16-Dec-15	NA	31-Dec-15	15-Jan-16	15-Jan-16	14-Apr-16	
		R/A																
19	**NHSP-II/DOHS/G/NCB-119/Supply and delivery of health logistics for malaria control for Epidemiology and Disease Control Division**	P	27-Oct-15	81.719	NCB	1	20-Oct-15	27-Oct-15	NA	30-Oct-15	30-Nov-15	15-Dec-15	NA	27-Dec-15	11-Jan-16	11-Jan-16	10-Apr-16	
		R/A																
20	**NHSP-II/DOHS/G/ICB-120/2015-16 Procurement of Medial Consumables For PHCRD and CHD**	P	30-Oct-15	41.084	ICB	10	23-Oct-15	30-Oct-15	NA	2-Nov-15	18-Dec-15	17-Jan-16	NA	29-Jan-16	15-Feb-16	13-Feb-16	12-Jun-16	
20.1	Absorbant Cotton Roll 400gm - 3600			0.25														
20.2	Bandage Than -3600			0.4														
20.3	Gauze Than - 3600			0.4														
20.4	Surgical Gloves 6.5, 7.0, 7.5 - 400,000			8														
20.5	IV Set- 100,000			2.5														
20.6	IV Canula - 200,000			5														
20.7	Phenol Bottle 500 ml - 50,000			3														
20.8	Disposable Syringe 5ml - 25,00,000			7.5														
20.9	Suture set - 1000			0.14														
20.10	Catgut 1/0, 2/0 - 4000			0.35														
20.11	Adhesive tape 4" - 30,000			4.23														
20.12	Surgical Blade - 400,000			2.8														
20.13	Rubber Catheter - 58,800			2.25														
20.14	Rectified Spirit 500 ml - 1,80,000			4														
20.15	Chlorine powder 200 gm - 1,00,000			3.5														
20.16	Perigoin Suction- 4700 (For CHD)			2.35														
20.17	Delee Suction - 68225 (For CHD)			0.795														
20.18	Thermometer Digital - 9500 (For CHD)			2.849														

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		R/A																	
21	NHSP-II/DOHS/G/NCB-121/Procurement of Essential Logistics for Emergency	P	5-Nov-15	5	NCB	1	29-Oct-15	5-Nov-15	NA	8-Nov-15	9-Dec-15	9-Jan-16	NA	21-Jan-16	5-Feb-16	5-Feb-16	6-Mar-16		
		R/A																	
22	NHSP-II/DOHS/NS/NCB-214/Procurement of Transportation Service	P		30	NCB	6	Continuation of Last FY PP											One slice contracted, Remaining 5 slices Re-tendered	Ghanashyam Dhewani Sewa NPR 2,602,456.68
		A1								15-Sep-15	15-Oct-15	1-Jan-16		14-Jan-16					
		A2								11-Mar-16								Re invited for 5 slices	
23	NHSP-II/DOHS/G/NCB-122/Procurement of Bags	P	29-Sep-15	8.78	NCB	1	22-Sep-15	29-Sep-15	NA	2-Oct-15	2-Nov-15	3-Dec-15	NA	15-Dec-15	30-Dec-15	30-Dec-15	28-Feb-16	Bid Evaluation complete	
		A								9-Dec-15	8-Jan-16	11-Feb-16							
24	NHSP-II/DOHS/G/NCB-123/Procurement of Generator, UPS, Voltage Stabilizer, Inverter for X-Ray Power Back up	P	24-Sep-15	8	NCB	2	17-Sep-15	24-Sep-15	NA	27-Sep-15	28-Oct-15	28-Nov-15	NA	10-Dec-15	25-Dec-15	25-Dec-15	23-Feb-16		
		R/A																	
25	NHSP-II/DOHS/G/NCB-124/Procurement of Printing of BCC Training Material for Nutrition and Food Security*	P	28-Sep-15	6	NCB	1	21-Sep-15	28-Sep-15	NA	1-Oct-15	1-Nov-15	1-Dec-15	NA	13-Dec-15	28-Dec-15	28-Dec-15	26-Feb-16	Contract signed NPR. 5,304,685.80	National Mansarowar Printing Press P. Ltd.
		A								7-Oct-15	6-Nov-15	22-Nov-15		1-Dec-15	21-Dec-15	21-Dec-15			
26	NHSP-II/DOHS/G/NCB-125/Procurement of Printing of Training and Program Guidelines for Filariasis Elimination Program	P		4.4	NCB	1			NA				NA					Contract signed NPR 30,62,239.80	Bidyadhari Printing Press
		A								28-Nov-15	21-Dec-15	31-Dec-15		7-Jan-16	1-Feb-16	1-Feb-16			
27	NHSP-II/DOHS/G/NCB-126/Procurement of Lab Supplies For Epidemiology and Disease Control Division	P		6.9	NCB	1	10-Feb-16	10-Feb-16	NA	13-Feb-16	15-Mar-16	14-Apr-16	NA	26-Apr-16	11-May-16	11-May-16	25-Jun-16	Bids opened	
		A								26-Feb-16	27-Mar-16								

* Brought from NCB-188.4