Nepal Health Sector Support Programme

# HEALTH SECTOR TRANSITION AND RECOVERY PROGRAMME

## NHSSP 6: Quarterly Report

## November 2015 – January 2016

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# Health Sector Transition and Recovery Programme

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**List of Acronyms**

| | |
|---|---|
| AA | anaesthetic assistant |
| ADRA | Adventist Development and Relief Agency |
| ANM | auxiliary nurse midwife |
| ASBA | advanced skilled birth attendant |
| AWPB | annual work plan and budget |
| CA | Constituent Assembly |
| CAPP | consolidated annual procurement plan |
| CBIMCI | community based integrated management of childhood illness |
| CBNCP | community based newborn care package |
| CBR | Community Based Rehabilitation |
| CEONC | comprehensive emergency obstetric and neonatal care |
| CHD | Child Health Division |
| CMS | contract management information system |
| C/S | caesarian section |
| DDC | district development committee |
| D(P)HO | district (public) health office(r) |
| DfID | UK Department for International Development |
| DG | Director General |
| DHIS-2 | District Health Information System-2 |
| DHO | district health office(r) |
| DoHS | Department of Health Services |
| DPO | Disabled People Organisation |
| DRFU | Disability and Rehabilitation Focal Unit |
| DUDBC | Department of Urban Development and Building Construction |
| EAP | Equity and Access Programme |
| EDP | external development partner |
| ENAP | Every Newborn Action Plan |
| EOC | emergency obstetric care |
| EPI | Expanded Programme on Immunisation |
| EWARS | early warning and reporting system |
| FCHV | female community health volunteer |
| FHD | Family Health Division |
| FMIP | Financial Management Improvement Plan |
| FMR | Financial Monitoring Report |
| FP | family planning |
| FY | fiscal year |
| HEoC | Health Emergency Operation Centre |
| HFoMC | Health Facility Operation and Management Committee |
| GBV | gender-based violence |
| GESI | gender equality and social inclusion |
| GiZ | Deutsche Gesellschaft für Internationale Zusammenarbeit |
| GoN | Government of Nepal |
| H4L | Health for Life |
| HF | health facility |
| HFOMC | health facility operation and management committee |

| | |
|---|---|
| HIIS | Health Infrastructure Information System |
| HMIS | Health Management Information System |
| HQIP | hospital quality improvement process |
| HR | human resources |
| HuRIS | Human Resource Information System |
| IRSC | Injury and Rehabilitation Sub Cluster |
| MoWCSW | Ministry of Women, Children and Social Welfare |
| MToT | Master Training of Trainers |
| NDF | National Disabled Fund |
| P&O | Prosthetics and Orthotics |
| PRIME | |

# 1.0 Introduction

The Nepal Health Sector Support Programme (NHSSP) is pleased to submit its second quarterly report for the period November 2015 – January 2016 under the Ministry of Health's Health Sector Transition and Recovery Programme (HSTRP).

In July 2015, as part of its multi-sector response to the earthquakes, DFID contracted Options Consultancy Services to provide TA support to the HSTRP. This initiative builds on DFID's existing support through NHSSP for the provision of Technical Assistance (TA) to MoH and the Department of Health Services (DoHS) since 2010 to support implementation of the second Nepal Health Sector Programme (NHSP-2, 2010-15).

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

Immediately following the earthquakes, MoHP prioritized emergency services, medical evacuations and the supply of essential medicines and goods to the hardest hit areas. Rapid district level post disaster needs assessment (PDNAs) followed ahead of extensive national and district level planning with external development partners 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 MoHP's Policy Planning and International Cooperation Division (PPICD) and senior health officials on September 2nd 2015.

Later that month, on 20th September, Nepal's new federal constitution was approved but protests in the terai belt led to a blockade of the border with India followed by acute shortages of essential goods and fuel throughout the country. The blockade continued to affect the supply of medicines and equipment in the reporting period and restricted the abilities of TA and partner staff to travel to and within districts and for patients needing rehabilitation support to reach health facilities for new and follow up treatment.

The activities of the TA team cover the following thematic areas and are described in section 2 below:

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

# 2. Detailed Quarterly Updates

## 2.1 Essential Health Care Services

### 2.1.1 Support to expand and effective comprehensive emergency obstetric and neonatal care (CEONC) services, emphasis on 14 earth quake affected districts

Support to FHD to expand and strengthen CEONC services in earthquake affected districts continued through (i) on-site visits and assistance in recruiting service providers for selected hospitals; (ii) tracking service functionality and human resources (HR) status at facilities, and (iii) informing the Family Health Division (FHD) director on possible supportive actions.

By the end of the reporting period C-section services were being provided in 57 out of 67 'official' CEONC districts, up from 49 districts in early August 2015. In the 14 severely affected districts, nine (Kathmandu, Lalitpur, Bhaktapur, Kavre, Dolakha, Sindhuli, Okhaldhunga, Nuwakot and Gorkha) have continued to provide C-section services despite the departure of foreign emergency medical teams.

One district (Dhading) has failed to provide CEONC services in the last month but two HSTRP focal districts (Sindupalchok and Ramechhap) are on track to begin CEONC services in the coming months. It should be noted that FHD has yet to commit to starting CEONC services in Rasuwa due to the district's small population and the availability of these services in neighbouring Nuwakot.

As noted, NHSSP support has been focused on the restoration of EHCS services in to 14 EQ affected districts and, in particular, establishing CEONC services in Chautara Hospital (Sinduplachok), Charikot PHCC (Dolakha), and Manthali PHCC (Ramechhap).

CEONC services began at Charikot PHCC in January 2016 following discussions with Naya Health (Possible Health) which has signed an MoU with MoH to provide services at this 15 bedded facility. C-section services are now being provided by staff contracted using CEONC funds and by additional staff from Naya Health. By the end of January, five C-sections had been performed compared with 37 (4.6 per month) performed by Medicines sand Frontier (MSF) between the earthquake in late April 2015 and the end of December 2015.

In Manthali PHCC, renovation to incorporate an operating theatre, post-operation room and indoor services was completed despite delays caused by the fuel crisis. While the majority of equipment needed to run the operating theatre (OT) is available on site, anaesthesia and ultrasound machines are needed. Encouragingly, the district development committee (DDC) recently completed construction of an access road to the facility.

Following discussions with FHD and the district health officer (DHO), NHSSP agreed to support the DHO led recruitment of C-section service providers (a doctor and anaesthetic assistant) for Manthali. Voluntary Services Overseas (VSO) had earlier agreed to provide this support but is now only able to supply service providers in July 2016.

In Chautara, the DHO and hospital management committee are converting an old building to an OT with NHSSP technical and financial support. The DHO has advertised for a doctor and anaesthetic assistant who will be appointed once the physical facility is ready.

In support of CEONC and other service provision, workshops on the hospital quality improvement process (HQIP) were held in Jiri Hospital and Charikot PHCC. 89 staff took part in this training which focused on use of the HQIP self-assessment tool and the formation of quality improvement committees (QIC).

Even while Jiri Hospital is providing uninterrupted CEONC services, its self-assessment showed that the facility is generally poor in providing quality services (two green scores out of eight quality domains) and signal function readiness (two green scores out of nine signal functions). By comparison Charikot PHCC, which began providing C-sections in late January, obtained one green score out of eight quality domains and three green scores out of nine signal functions.

As a part of the quality improvement (QI) process, coaching and mentoring of clinical staff (skilled birth attendants [SBAs]/Auxiliary Nurse Midwives [ANMs]) using tools developed by the Nepal Health Training Centre [NHTC] (the follow up enhancement programme tools) were carried out at Jiri Hospital, Charikot PHCC, Ramechhap Hospital and Manthali PHCC. 18 nursing staff were assessed for knowledge and skills and received coaching on practical skills covering 80% of cases likely to be encountered in maternity care. Eight skilled birth attendants (SBAs – staff nurses [SNs]/Sr. ANMs) were selected as district level clinical mentors for staff providing maternal and neonatal health (MNH) services at birthing centres (BCs)/BEONCs.

In addition to these inputs, an orientation, demonstration and practical skills training programme on infection prevention was held for 159 staff from the four facilities. This covered topics such as equipment processing, housekeeping and waste disposal. Upon follow up, Ramechhap Hospital had completed 13 out of 22 of its planned activities with a further seven ongoing while Manthali Hospital had completed 6 out of 18 activities with an additional two underway.

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

In the reporting period, NHSSP's EHCS team was requested to provide technical support for MNH update/training in the three focal districts. Accordingly three batches of training were run in Ramechhap (total 73 nursing staff) and one in Dolakha (31 nursing staff). The training focused on demonstrations and practical sessions for skills enhancement and improved decision making in clinical settings.

Based on the district coordinated transition and recovery plans (TRPs), each of the three focal district plans to restore birthing centre (BC) services at all health facilities where they were available prior to the

earthquake. Further, 11-12 BCs in each earthquake affected district were selected for upgrading to strategic birthing centres (Str. BCs) where FHD envisions that 24/7 delivery service with complications management (BEONC), five family planning methods, medical abortion services and simple laboratory services (blood sugar, urine protein, pregnancy test) will be available. In the three focal districts, FHD plans to establish 3 new BCs in Ramechhap, 5 in Dolakha and 3 in Sindupalchok.

Based on district plans, an equipment needs assessment was carried out in Ramechhap and Dolakha and the necessary items purchased. District training needs assessments on safe motherhood, family planning and abortion were also conducted and training on medical abortion and family planning began following the signing of a memorandum of understanding (MoU) between NHTC and NHSSP. The types and numbers of training courses were agreed based on requests received from DHOs and a recommendation letter from FHD. To date, 16 SBAs from Ramechhap have completed medical abortion training and will begin services at their health facilities once they receive certification from FHD. In the next quarter on-site coaching and mentoring on clinical skills for SBAs and infection prevention including the QI process will be conducted in the three focal districts.

As a part of NHSSP's support for the implementation of district action plans, TA helped the DHO in Dolakha to develop a guideline on free referrals for all obstetric complications from all BC/BEONCs to Charikot PHCC or Jiri Hospital. Based on the national referral guideline for MNH, this guideline was modified to fit the district context. In particular, the district ambulance management committee led by the chief district officer (CDO) fixed fees for all ambulances travelling from HFs/VDCs and provided ambulance drivers with a service providers' guideline. Under this arrangement, ambulance owners are receiving fuel from the CDO and have begun free referrals from all BCs/BEONCs for obstetric complications. Ramechhap district also initiated discussions with the district ambulance management committee and is currently in the process of finalising an ambulance fee rate (NPR/Km) from all HFs/VDCs. Free referral services will then be provided once CEONC services are available at Manthali PHCC.

### 2.1.3 Evaluation of remote areas MNH pilot (RAMP) in Taplejung district

Beyond HSTRP activities, evaluation of the MNH remote areas' pilot was completed in the reporting period with findings shared with district health stakeholders. The findings and lessons learned were also shared with the Safe Motherhood and New born Care Sub-committee (SMNSC) and MoH officials.

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

TA orientated FHD's new director on NHSSP's support to the sector, including the HSTRP, essential health care services (EHCS) and FP. Advisers also briefed the director on CEONC services and the access of unreached populations to MNH/FP services based on current national policies and plans.

NHSSP continued supporting FHD efforts to monitor CEONC service functionality, finalise its operational guideline, revise the complications management flow chart, and provide feedback to Save the Children on its internal assessment report.

### 2.1.5 Strategic Birthing Centres (Str. BCs) support in Banke District

A final internal assessment of the strategic birthing centre and free referral initiative in Banke district was completed. This found that Str. BCs centres improved levels of community trust and increased the number of deliveries at these sites. The free referral component did not appear to have increased the rate of inappropriate referrals from Str. BCs compared with comparison sites although it is acknowledged that the implementation period was relatively short (May – September 2015). In intervention sites, obstetric referrals increased by 300% (7 to 21 referrals) with the majority of cased deemed appropriate. Appropriate referrals (proxy indicator: complicated/assisted deliveries at hospital among referred cases) increased from 57% to 62%. At comparison sites, obstetric referrals increased by 20% (20 to 24) with no changes seen in appropriate referral (30% to 29%).

Interviews with women five months following the launch of free referrals showed that health workers are a) successfully managing free referrals, b) exhibiting polite and helpful behaviour and c) providing prompt service and good nursing care. These factors appear to have encouraged women to use Str. BCs for maternity care. Travel distance and other natural barriers were the main causes of self-referral both in intervention and control VDCs whereas proximity to home, and incentives to deliver at BCs encouraged women to use them. Use of the official referral slip was rarely practiced in both intervention and comparison VDCs.

Table: Number of institutional deliveries and referrals for obstetric complications six months before and after starting free referrals:

| SN | | Intervention sites | | | Comparison sites | | |
|---|---|---|---|---|---|---|---|
| | | 6 months before | 6 months after | % increase | 6 months before | 6 months after | % increase |
| 1 | Institutional deliveries | 306 | 518 | 69% | 381 | 525 | 38% |
| 2 | Obstetric referrals | 7 | 21 | 300% | 20 | 24 | 20% |
| 3 | % Complicated deliveries among referred cases (proxy appropriate referrals) | 57% | 62% | | 30% | 29% | |

### 2.1.6 Challenges

- Working with various partners to support DHOs in implementing coordinated district plans since delays in partner programmes can impede district progress.
- The continuing fuel crisis is affecting implementation including in-district travel and the ability to make follow up visits
- Delays in infrastructure repair and rebuilding are hampering service delivery improvements and affecting staff morale.

## 2.2 Family Planning (FP)

### 2.2.1 HSTRP focal districts: Ramechhap, Sindhupalchok and Dolakha

**Planning and capacity building**

In the reporting period, the FP team supported:

a) district consultations and preparations for the inclusion of FP in coordinated district plans
b) capacity building of health workers on FP (Long Acting Reversible Contraceptives [LARCs])

48 health workers (16 from each focal district) were trained on implants and an additional four from Dolakha on intra uterine contraceptive devices (IUCDs). The training programmes were conducted at NHTC accredited training institutions (see Annex 1a-d). Following training, the number of Implant service delivery sites increased by 125%, 61% and 66% in Dolakha, Sindhupalchok and Ramechhap, respectively.

Trained service providers in the majority of health facilities in the three districts have now been provided with implant/IUCD insertion and removal sets and the delivery of FP instruments in remaining HFs is in process. The following table shows the number of LARC sites before and after the training. It should be noted that less than half of HFs (44%) currently offer implant services and less than one quarter (22%) provides IUCD services.

**Table-1: LARC service sites during and after the earthquake in 3 focal districts**

| SN | District | Total HFs | Implant services | | IUCD services | | Remarks |
|---|---|---|---|---|---|---|---|
| | | | Immediate after Earthquake | After training* | Immediate after Earthquake | After training** | |
| 1. | Dolakha | 53 | 12 | 27 | 11 | 19 | 4 trained by other agency |
| 2. | Sindhupalchok | 79 | 13 | 21 | 13 | 13 | |
| 3 | Ramechhap | 56 | 21 | 35 | 18 | 18 | |
| | Total | 188 | 46 | 83 | 42 | 50 | |

** not all HWs have initiated the delivery of implant services after training*
*** includes HWs also trained with the support of other agencies*

**Service outputs**

Although it is too early to assess training outcomes, new acceptors of LARCs are evident following the establishment of additional LARC sites in the three focal districts. Further efforts will be made to strengthen LARC service delivery and utilization in the coming months. In addition, 2 out of 6 planned visiting providers (VPs) have been deployed in Sindhupalchok and Ramechhap for LARC service delivery and on-site coaching.

**Challenges**

- Frequent transfer of trained human resources
- Systemic issues such as lack of instruments, IP materials in health facilities to start FP services after training
- Motivation and social responsibility among health service providers is often lacking
- Less supervision and monitoring from NHSSP and the DHO at health facility level.

**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, many villagers in affected areas are unable to access the FP services they need. Further, the pressure placed on the public health system in the aftermath of the earthquake has limited FP service availability more generally.

FP services need to be strengthening if they are to be available in hard-to-reach and earthquake affected areas including those living in temporary settlements. Accordingly, five priority districts were selected for targeted interventions on the basis of 1) FP support need (low contraceptive prevalence rate (CPR), 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 five districts are Okhaldhunga, Sindhuli, Nuwakot, Lalitpur and Gorkha.

The following section summarises the activities carried out in these districts.

A. <u>Initial district consultation</u>

An initial scoping visit was carried out in all 5 districts with representatives from FHD participating in 3 visits. DHOs and district FP focal persons participated and were briefed on the rationale, objectives and activities of the FP strengthening programme. Various programme documents, an introductory letter from PPICD/MoH and a draft FP assessment checklist were shared. Dates were also obtained for a one day district planning meeting in each district.

B. District planning workshop

A district planning workshop was held in each district for all health facility in-charges. G.S. Pokharel (FHD FP focal person) and 2 other staff from FHD participated in Lalitpur. However, representation from FHD was not possible in the other 4 districts although DHOs and district focal persons participated. Active participation from district participants was observed with the FP supervisor, statistical officer, and PHN leading facilitation in most districts. Representation from key non-state district partners was also evident. In each case, participants (DHO team and health facility in-charges) expressed their full commitment to support this new FP intervention throughout their district. Each DHO spoke positively and committed full support to implement the programme.

GS Pokharel, FHD with Lalitpur DHO Kedar Parajuli making remarks during opening session of planning workshop at Lalitpur

Each district considered the planning workshop a rare opportunity to focus on family planning seeing it as, effectively, a district specific FP review and planning workshop. Several districts flagged the importance of such support in the wake of recent government budget cuts in FP activities. The workshop also provided an opportunity to refresh participants on (1) HMIS recording and reporting related to FP, (2) contraceptive updates and (3) quality of care.

**Table 2. District-wise dates of initial consultative meeting and planning workshop**

| District/s | Consultative visit | Date of District Planning Meeting | Remarks |
|---|---|---|---|
| Lalitpur | December 07-08, 2015 | December 20, 2015 | • All FHIs participated |
| Nuwakot | December 21, 2015 | January 04, 2016 | • All FHIs participated |
| Okhaldhunga | December 23, 2015 | January 07, 2016 | • 1 HFI did not participate |
| Sindhuli | December 24, 2015 | January 17, 2016 | • 6 HFI did not participate |
| Gorkha | December 27, 2015 | January 22-23, 2016 | • 2 days in 2 batches, All FHIs participated |

C. Outputs of initial consultative and district planning meetings

The following outputs were achieved at these meetings:

1. Orientation to DHO team and health facility in-charges on the FP transition and recovery program.
2. Needs assessment for training, FP instruments/equipment, condom boxes, information and education communication (IEC) materials.
3. Public commitments from DHOs, health facility in-charges and stakeholders to support the programme.
4. Preparation of visiting provider movement plans.
5. Scheduling of VSC+ camps.

D. Recruitment of staff (district coordinator, technical officer, visiting provider)

Three district coordinators, one FP technical officer and 15 VPs were recruited for the 5 districts. Eight VPs (3 -Lalitpur, 2 - Sindhuli, 1 - Gorkha, 1-Okhaldhunga, 1-Nuwakot) have been deployed. 2 VPs are currently being recruited and 5 are receiving implant training. All newly recruited staff were orientated on administrative and programmatic aspects prior to deployment in districts.

### 2.2.2 Family Planning pilots to reach unserved populations

In 2015, NHSSP in coordination with the respective DHOs implemented 3 different pilot interventions for FP service delivery in 4 districts of Nepal. These pilots were completed in December 2015 with the final reports with lessons learned being submitted to donors. The following section summarises the key achievements and lessons learned.

**EPI/FP integration in Sindhupalchok**

Key Achievements

In total 243 integrated clinics (164 outreach and 79 static clinics) were providing integrated expanded programme of immunization (EPI)/FP services. An analysis of reports shows that out of 6800 mothers who attended group health education, 31 % used FP methods. Although CPR stalled during the intervention period, the percentage of new users of short term methods increased by 1.2% from 7.7% (of married women of reproductive age [MWRA]) to 8.9 % after 6 months of the pilot intervention. Verbatim reports from health workers and managers also indicated that the programme contributed to meeting unmet family planning needs in the district.

Group health education session, outreach EPI clinic, Sipapokhari VDC, Sindhupalchowk

Lessons learned

Effective HR management is the key noting that:

- annual contracting of health workers does not ensure regular service delivery.
- The need to strengthen community participation in health facility management through health facility operation and management committee (HFOMC] strengthening and other accountability mechanisms including social audits
- Regular HFMOC meetings, and HF staff meetings are very important.

Intensive supportive supervision effort is needed to:

- improve service delivery
- motivate health workers
- improve recording/reporting

Scalability and Sustainability

GoN and donor agencies have indicated their willingness to expand the integrated EPI/FP approach as evidenced by the collaboration seen in scaling up by FHD of the EPI/FP approach in 4 districts.

### 2.2.3 Visiting Provider pilot intervention-Ramechhap

**Key achievements**

- After implementing the VP pilot in Ramechhap, the number of HFs providing 5 FP methods increased from 8 to 18.
- The number of HFs with at least one LARC provider increased from 16 to 28 as of December 2015. Visiting providers visited all 31 non-BCs to provide LARCs. Over the 10 months of implementation, VPs provided a total of 1039 Implants and 64 IUCDs.
- The CPR increased by 1% in 2071/72 compared to 2070/71 which may be partly attributed to VP intervention. The number of new acceptors of LARCs increased by 180% in 2071/72 compared with 2070/71.
- Visiting providers coached 16 SBA trained providers on IUCDs who then subsequently provided 71 IUCDs.

Lessons learned

- There is a high demand for LARC (especially implant) services in communities and a corresponding need for an appropriate and continuous service delivery system.
- Increasing the utilisation/uptake of IUCDs requires considerable efforts to counter the myths and misinformation surrounding IUCDs among both providers and clients.
- Increasing the availability of contraceptives choices (i.e. to 5 methods) at service sites will help increase women's preferred method continuation rates.
- Maintaining an adequate supply of contraceptive commodities and preventing stock-outs in HFs is crucial to ensuring client choice and rights for preferred contraceptive methods.

VP providing information on LARCs to women in a non-BC

### 2.2.4 VSC+ intervention in Baitadi and Darchula

**Key achievements**

- From August to December, 12 camps in four sites were organized in Baitadi.
- 106 minilaps, 29 NSVs, 15 Implants and 1 IUCD were provided at comprehensive VSC camps.
- In Darchula, 4 rounds of camps (16 camps total) were organized from September to December 2015 in 4 sites. Altogether, 85 Implants, 41 NSVs, 27 minilaps, 8 Depo and 6 IUCD were provided.

Lessons learned

- The VSC+ implementation experience demonstrated that if comprehensive FP services including VSC services are available off-season, people will be inclined to use them. Previous perceptions of uptake of VSC services only during the winter season can then be dispelled.
- Using school students is an effective way to convey messages on VSC+ camp dates in the communities. The use of local FM radio to air VSC+ camp information has complemented FCHV information dissemination.
- Sufficient time is needed (at least 15 days) to inform community members of VSC+ camp venues and dates.


LARC counseling at Haat HP, Baitadi

- Satisfied users are potential ambassadors of FP programmes and all efforts should be made to provide quality care while preserving the privacy of service users.
- Camp teams need to carry at least 5 complete sets of minilaps, vasectomy kits, implants and IUCDs at planned service sites.

### 2.2.5 Progress against PDs

During this quarter NHSSP FP 10 and HSTRP PDs FP1 and FP2 were submitted. The following table shows progress of FP payment deliverables.

| No | Payment Deliverable | MoV | Due by | Progress |
|---|---|---|---|---|
| FP1 | Verification report of family planning needs and gaps in 5 earthquake affected districts through district consultation and planning meeting | Verification Report (including district planning meetings) | 31 Jan-16 | Submitted and waiting for approval |
| FP2 | Overall plan for conducting comprehensive mobile camps and mobilizing visiting providers completed for all 5 districts | Plan for comprehensive mobile camp and VP movement plan | 31 Jan-16 | Submitted and waiting for approval |
| FP3 | Procurement and supply of infection prevention, insertion/removal sets completed in 50 BCs out of approximately 121 BCs in 5 districts | Store receipt | March -16 | Quotation and purchase order completed; procurement and delivery is in process |
| FP4 | First round of 10 of the 30 comprehensive FP mobile camps conducted in 5 districts | Project report | March -16 | Preliminary discussion with MSI/ Sunaulo Pariwar Nepal (SPN) have been completed. SPN is currently reviewing budget and will proceed to MoU signing and camp conduction. This deliverable may be delayed or only partially completed by 16th March. |
| FP5 | A total of thirty (30) comprehensive FP mobile camps conducted in 5 districts | Project report | Jul-16 | As above |
| FP6 | Training of 40 SBAs and paramedics on LARC (primarily implants) services and 5 doctors for VSC completed | Training report | March-16 | Need assessment completed and participants have been selected. MoU with NHTC has been signed. This deliverable may be delayed or only partially completed by 16th March. |
| FP7 | First round mobilization of integrated coach/mentor for IUCD coaching to SBAs completed in 25 BCs | Project Implementation report | Mar-16 | 8 out of 15 VPs have been deployed. Assessment of health worker's competency in health facilities is ongoing. The initial assessment will be the basis for coaching health workers and quality improvement. |
| FP8 | Trained visiting providers provide first round of LARC service to 100 HFs without BCs | Project report | April-16 | Deployed visiting providers have commenced health facility assessment and Implant/IUCD service where request from health facility has been |

| | | | | |
|---|---|---|---|---|
| | | | | received. This deliverable may be delayed or only partially completed by 16th April. |
| FP9 | Trained visiting providers provided LARC service, in total, to at least 150 HFs without BCs | Project report | Jun-16 | As above |
| FP10 | FP Project completion report, highlighting overall progress and lessons learned | Project report | Jul-16 | |

### 2.2.6 Technical support and representation

#### Technical support

NHSSP's FP Advisor provided technical support to various DoHS divisions and centres including:

FHD/Service delivery/Enabling environment

- Provided technical and program inputs on:
    - finalisation of FHD program implementation guideline: Family Planning chapter
    - the conceptualisation, design and write up of the proposal of rapid response mechanism (RRM), a FP2020 transition and recovery program funded by FP2020 executed through UNFPA and implemented by ADRA Nepal in 4 conflict affected districts - Udaypur, Sunsari, Sarlahi and Rautahat. The VSC+ approach (from Baitadi and Darchula pilot) and VP approach (Ramechhap pilot) was included.
- Facilitated and led to:
    - finalize male condom box specification with FHD and other key stakeholders
    - help FHD to finalize the DMT and MEC wheel need requirement for FY 2072/73 including suggestions for resource mobilization options for printing
    - draft a response letter from FHD to USAID on emergency procurement request for DMPA and condom. FHD response letter signed by FHD director.
- Shared FP WWW- FP actor mapping—template and participated in a meeting organized by Plan Nepal advisors at FHD.

NHTC/Capacity development

- Participated and facilitated in finalizing the COFP/C training package, participated in the TWG meeting of PPIUCD and provided technical inputs in the development of video content for PPIUCD
- Drafted and signed a new MoU with NHTC and NHSSP for FP training
- Started vaccination/VP training in Sindhupalchowk
- Completed implant training in Ramechhap

LMD/FP commodity

- Participated as a technical expert in the family planning commodity expert committee meeting at MoH as requested by FHD and MoH. Provided expert opinion and technical inputs on commodity specifications especially DMPA PQ requirements and helped resolve the long pending issue.
- Re-submitted FP Equipment/Instrument bidder's specification verification (as FP expert) to LMD on request of the LMD director
- Drafted a FP commodity lab testing requirement for bidders for FHD and LMD on request of FHD

Miscellaneous

- Met with the new directors of FHD and NHTC and provided technical and programmatic briefings
- Participated in monthly FP meeting at DFID
- Brought 50 pieces of DMT flip chart and MEC wheels each from FHD/ADRA store for distribution to NHSSP's FP program districts.

### 3.2.5 Participation in ICFP conference

Mr Yuba Raj Paudel, FP M&E officer, NHSSP participated in the 4th International FP conference held in Nusa Dua, Indonesia from 25-28 January 2016. The conference drew approximately 3000 policy makers, researchers and professionals from around the world. Joining a Nepalese delegation led by FHD's FP focal person, Mr Ghanashyam Pokhrel, he presented a poster entitled "Prevalence and correlates of unintended pregnancy in Nepal" in the conference. The major benefits of attending the conference included: an opportunity to network and interact with FP programmers; staying up-to-date on the changing paradigm of FP programmes (from youth bulge to youth led FP programming, renewed focus on urban poor and other high unmet need groups, renewed focus on private sector involvement for universal coverage of FP services, emphasis on advocacy, promotion of mHealth and innovations) and sharing of Nepal's FP status and issues in the global forum.


## 3.3 Infrastructure and Procurement

### 3.3.1 Infrastructure

In the reporting period, TA completed the analysis of data from the detailed assessment of health facilities in Nepal's fourteen earthquake affected districts to determine the extent of damage, types of repairs and costs needed for all repairable buildings. The analysis and reports, including data from each facility, was uploaded to the website (nhsp.org.np) for use by EDPs, government and others in planning, repair and reconstruction activities. These data include spatial dimensions and other information including electricity, access, water, availability and type of land of each facility.

The designs in the standard reconstruction guidelines were revised in response to feedback from the field during monitoring visits. The structural design of steel members for prefab. constructions have now been incorporated in the revised guidelines. A press conference was organised at MoH's request to disseminate progress in the reconstruction and recovery work. This progress is summarised in the table below.

Overall responsibility for verifying the designs submitted to MoH has been assigned to NHSSP's infrastructure team. Accordingly design consultations and recommendations on the suitability of construction materials have been provided to those EDPs signing MoUs with MoH for reconstruction activities. TA has also continued to review technical proposals for reconstruction, repair, and maintenance of fully and partially damaged buildings and recommend changes as required. The infrastructure advisers have also facilitated the signing of MoUs between MoH and external agencies for the repair and maintenance of facilities.

Also during the reporting quarter, supervision and monitoring visits were paid to Sindhupalchowk, Dolakha, Kavre and Manang districts.

Support was provided to Management Division/DoHS to finalize the design of Mugu District Hospital which is being supported by KOIKA and a site visit was made. Further inputs were provided to finalize prefab design components including electrical, sanitary and other details for UNICEF who are ordering prefab materials from China. Consultations were also held with USAID for a preliminary design for Barhabise PHCC.

The need for conflict resolution related to damaged buildings constructed by DUDBC saw advisers step in and mediate between the two concerned parties and successfully resolve the issue. Repair work has now begun in some sites.

Support was also provided to MoH to prepare a reconstruction and repair and maintenance plan for the 14 highly affected districts and 17 medium hit districts. Planning and budgeting was completed and submitted to the National Planning Commission (NPC) which subsequently approved the plan. Similarly planning and budgeting was completed and approved by MoH for NHSSP's three focal districts for reconstruction work based on district level recommendations.

**Achievements**

Signed commitments for the reconstruction of 322 health facilities were obtained from various external agencies worth NPR 3,126,988,077.

The status of reconstruction work as of January 18th 2016 was as follows:

| Progress status | Numbers |
|---|---|
| Handed Over | 13 |
| Completed | 18 |
| Work in finishing stage | 2 |
| Roofing work in progress | 1 |
| Truss work completed; wall panelling in progress | 5 |
| DPC completed | 8 |
| Foundation work in progress | 10 |
| Repair Ongoing | 11 |
| Site mobilisation | 64 |
| Contract awarded | 14 |
| Tendering in process | 102 |
| Detail design in progress | 56 |
| Site amendment | 18 |
| Total | 322 |

**Prefab construction in Barhabise PHCC**

**Regular Work**

Under ongoing NHSSP activities, advisers developed and completed structural, electrical and sanitary designs for two more types of health post suitable for smaller population catchment areas. Progress made by the Department of Urban Development and Building Construction (DUDBC) in regular construction activities was reviewed with Management Division and recommendations to complete delayed projects identified.

### 2.3.2 Procurement

There has been steady progress in the Logistic Management Division's (LMD's) system for managing the procurement of health care goods and services since the beginning of NHSP-2). Highlights include the introduction of consolidated annual procurement plans, a technical specifications bank and contract management System (CMS), and the adoption of more systematic procedures for handling bids and contracts. In addition, many bidders have an improved understanding of procurement processes while many LMD staff are carrying out their jobs more efficiently.

Considerable challenges remain however including the delayed preparation of annual procurement plans, an inadequate number of appropriately skilled personnel, the too frequent transfer away of skilled staff, and concerns over levels of transparency and interference in the procurement process. The status of procurement progress against the consolidated annual procurement plan (CAPP) is as follows:

| Ministry of Health and Population | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Department of Health Services | | | | | | | | | | | | | | | | | |
| Procurement Plan for Goods and Services | | | | | | | | | | | | | | | | | |
| F/Y 2015-16 -- Status of February 24, 2016 | | | | | | | | | | | | | | | | | |
| S.N. | Description | PP Status | Expected Approval of Cost Estimate | Estimate in mil. | Proc. Method | No. of Package | Bidding Document | | No Objection from DP | Invitation for Bidding | | | No objection on Evaluation Report | Publication of LOI | Contrct signing | Commencement of Contract | Contract completion | Status |
| | | | | | | | Prepn. | Approval | | Purlish Date | Opening Date | Evaluation completion | | | | | | |
| 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 Epeidemiology and Disease Control Division** | P | 22-Sep-15 | **367.360** | 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 | **Bids opened on Feb 8, in process of evaluation** |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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- 1,71,063 | | | 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 | | | | | | | |
| 2 | **NHSP-II/DOHS/G/ICB-102/2015-16 Procurement of Drugs-1** | | | **438.390** | | | | | | | | | | | | | | |
| 2.1 | Tab. Cetirizine HCl 10mg - 5,00,000 | | | 1.000 | | | | | | | | | | | | | | |
| 2.2 | Susp.Metronidazole 60 ml (200mg/5ml) - 500,000 | P | NA | 8.500 | ICB | 34 | 18-Sep-15 | 25-Sep-15 | 10-Oct-15 | 13-Oct-15 | 28-Nov-15 | 28-Dec-15 | 12-Jan-16 | 24-Jan-16 | 21-Feb-16 | 21-Feb-16 | 20-Jun-16 | **Notice Pubmished on January 19, Pre-bid meeting held on February 17** |
| 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 Amoxycilin 125 mg - 1,00,00,000 | | | 30.000 | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2.6 | Cap.Amoxycilin 500 mg- 1,00,00,000 | | | 50.000 | | | | | | | | | | | | | | |
| 2.7 | Sus. Amoxycilin125mg/5 ml -120,000 (CHD) | | | 2.040 | | | | | | | | | | | | | | |
| 2.8 | DT Amoxycilin 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 - 16,00,000 | | | 20.800 | | | | | | | | | | | | | | |
| 2.11 | Tab.Ciprofloxacin 250mg - 7,50,000 | | | 2.250 | | | | | | | | | | | | | | |
| 2.12 | Tab. Ciprofloxacin 500mg -170,00,000 | | | 85.000 | | | | | | | | | | | | | | |
| 2.13 | Inj. Ceftrixone 1gm - 50,000 | | | 2.500 | | | | | | | | | | | | | | |
| 2.14 | Tab. Sulfamethoxazole + Trimethoprim 960 mg - 50,00,000 | | | 12.500 | | | | | | | | | | | | | | |
| 2.15 | Tab.Sulfamethoxazol e + Trimethoprim 480 mg- 20,00,000 | | | 4.000 | | | | | | | | | | | | | | |
| 2.16 | Cap.Doxycycline 100mg -100,00,000 | | | 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 | | | | | | | | | | | | | | |

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| 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 - 100,000 | | | 0.600 | | | | | | | | | | | | | | |
| 2.3 | Inj.Diazepam 2ml (5mg/ml) - 150,000 | | | 3.000 | | | | | | | | | | | | | | |
| 2.31 | Gention violet 2% 10 ml - 50,00,000 | | | 50.000 | | | | | | | | | | | | | | |
| 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 | | | | | | | | |

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| 3 | **NHSP-II/DOHS/G/ICB-103/2015-16 Procurement of Drugs-2** | P | 2-Oct-15 | **398.091** | ICB | 58 | 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 | **Document ready for IFB, Notice will be published on Feb. 26** |
| 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)- | | | 2.500 | | | | | | | | | | | | | | |

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| | 525,000 | | | | | | | | | | | | | | | | | |
| 3.14 | Inj. Ciprofloxacin (200mg/100 ml) - 30,000 | | | 0.600 | | | | | | | | | | | | | | |
| 3.15 | Applicap 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 | | | | | | | | | | | | | | |
| 3.22 | Tab Fluconazole 150mg - 50,000 | | | 0.500 | | | | | | | | | | | | | | |
| 3.23 | Ointment .Fluconazole 15 gm - 50,000 | | | 2.000 | | | | | | | | | | | | | | |
| 3.24 | Ointment Acyclovir 5 gm - 10,500 | | | 0.300 | | | | | | | | | | | | | | |
| 3.25 | Tab Ferrous salphate 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 | | | | | | | | | | | | | | |

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| 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 lodine 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. Metoclorpropamide 2ml (5mg/ml) - | | | 0.800 | | | | | | | | | | | | | | |

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| | 100,000 | | | | | | | | | | | | | | | | | |
| 3.41 | Tab. Promethazine Hydrochloride 25 mg- 100,000 | | | 0.328 | | | | | | | | | | | | | | |
| 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- 250,000 | | | 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 | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 3.54 | Cap Tetracyclne 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 | | | 1.043 | | | | | | | | | | | | | | |
| 3.57 | Tab. Zinc 20mg - 1,73,80,401 | | | 17.380 | | | | | | | | | | | | | | |
| 3.58 | Gel CHX 4% 3gm-662250 | | | 10.596 | | | | | | | | | | | | | | |
| | | R / A | | | | | | | | | | | | | | | | |
| 4 | **NHSP-II/DOHS/G/ICB-104/2015-16 Procurement of RUTF, Fortified flour, Micronutrient Powder for Child Health Division** | P | 5-Oct-15 | **105.00** | 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 | **Last years procurement order just arrived so it is in stock and procurement may not be required.** |
| 4.1 | Ready to Use Therapuytic Food-1,085,000 Sachet | | | 38.00 | | | | | | | | | | | | | | |
| 4.2 | Fortified Flour-378,732 Bag (Bags of 3 KG) | | | 58.00 | | | | | | | | | | | | | | |
| 4.3 | Multiple Micronutrient Powder- 4,50,000 Sachet | | | 9.00 | | | | | | | | | | | | | | |
| | | R / A | | | | | | | | | | | | | | | | |

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| 5 | **NHSP-II/DOHS/G/NCB-105/2015-16 Procurement of Syringes For Child Health Divion** | P | 26-Oct-15 | **8.74** | 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 | **Last years procurement order just arrived so it is in stock and procurement may not be required.** |
| 5.1 | 2ml Reconstitution Syringe for BCG-223,572 Pc | | | 1.10 | | | | | | | | | | | | | | |
| 5.2 | AD Syringe 0.05 ml for BCG Vaccine-675,770 Pc | | | 4.32 | | | | | | | | | | | | | | |
| 5.3 | 5ml Reconstitution Syringe - 414,787 Pcs | | | 3.318 | | | | | | | | | | | | | | |
| | | R / A | | | | | | | | | | | | | | | | |
| 6 | **DOHS/G/ICB-106/2015-16 Procurement of Hospital Equipments For LMD, FHD,MD, EDCD** | P | 22-Oct-15 | **161.57** | 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 | **Proper Need identification in progress. Once verified the bidding process will start.** |
| 6.1 | X-Ray 300 mA- 10 | | | 37 | | | | | | | | | | | | | | |
| 6.1 | x-Ray 100 mA- 10 | | | 20 | | | | | | | | | | | | | | |
| 6.2 | Dental X-Ray -20 | | | 4 | | | | | | | | | | | | | | |
| 6.3 | ECG Machine-100 | | | 20 | | | | | | | | | | | | | | |
| 6.4 | Nebulizer -100 | | | 1.5 | | | | | | | | | | | | | | |
| 6.5 | Suction Machine-50 | | | 7.5 | | | | | | | | | | | | | | |
| 6.6 | Oxygen Concentrator-50 | | | 12.5 | | | | | | | | | | | | | | |
| 6.7 | OT Table-30 | | | 15.75 | | | | | | | | | | | | | | |
| 6.8 | OT Light-30 | | | 6 | | | | | | | | | | | | | | |

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| 6.9 | Dental Chair- 10 Set (For MD) | | | 3 | | | | | | | | | | | | | | |
| 6.10 | Anaesthesia Machine- 5 (For FHD) | | | 7.5 | | | | | | | | | | | | | | |
| 6.11 | Cautry for NSV-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 for diagnosis of Dengue and chikunguinea fever. (For EDCD) | | | 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 | **DOHS/G/ICB-107/2015-16 Procurement of Hospital Instrument and Furniture For LMD, FHD, CHD** | P | 25-Oct-15 | **59.616** | ICB | 13 | 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 | **Proper Need identification in progress. Once verified the bidding process will start.** |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | | | | | | | | |
| 7.6 | Equipment for 2nd Trimestor for 4 Site | | | 0.416 | | | | | | | | | | | | | | |
| 7.7 | Implant removal kit-1000 | | | 5 | | | | | | | | | | | | | | |
| 7.8 | IUCD insertion and removal kit - 1000 | | | 5 | | | | | | | | | | | | | | |
| 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 | **Bid Evaluation complete, LOI issued** |
| 8.1 | HMIS Printing- For MD | | | 23 | | | | | | | | | | | | | | |
| 8.2 | Annual Report-2500 - For MD | | | 1 | | | | | | | | | | | | | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 8.3 | LMIS Stock Book- | | | 1.8 | | | | | | | | | | | | | | |
| 8.4 | Agriculture Food Security Printing for CHD | | | 6 | | | | | | | | | | | | | | |
| 8.5 | Printing of Ebola, Swine Flu, Bird Flu prvention material for EDCD | | | 10 | | | | | | | | | | | | | | |
| 8.6 | Zoonotic disease printing For EDCD | | | 12 | | | | | | | | | | | | | | |
| | | A | | | | | | | | 10-Dec-15 | 27-Jan-16 | 11-Feb-16 | | | | | | |
| 9 | **NHSP-II/DOHS/G/NCB-109/2015-16 Procurement of Cold Chain Equipment For Child Health Division** | | | **19.00** | | | | | | | | | | | | | | |
| 9.1 | Ice Pack (0.4 Litter) 40,000 | P | 25-Oct-15 | 2.00 | 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 | **This procurement will be pacakaged with equipment and furniture** |
| 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 | | | | | | | | | | | | | | | | |

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| 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 | **Specification and details not yet received from concerned depertment** |
| 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 | **Specification and details not yet received from concerned depertment** |
| | | R / A | | | | | | | | | | | | | | | | |
| 12 | **NHSP-II/DOHS/G/ICB-112/2015-16 Procurement of 5-Year Implants - 30,000** | 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** | 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 | **Specification and details not yet received from concerned** |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **IUCD** | | | | | | | | | | | | | | | | **depertment** |
| | | 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 | **May not be required as the last years order are coming in** |
| | | 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 | Na | 17-Jan-16 | 1-Feb-16 | 1-Feb-16 | 31-May-16 | **Specification and details not yet received from concerned depertment** |
| 16.1 | Tab. DEC 100mg - 12,50,000 (For EDCD) | | | 12.5 | | | | | | | | | | | | | |
| 16.2 | Tab. Miltefosine 50 mg (For EDCD) | | | 5 | | | | | | | | | | | | | |
| 16.3 | Tab. Misoprostal-200 mcg - 600,000 (For FHD) | | | 6 | | | | | | | | | | | | | |

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| 16.4 | Combi Pack (Misoprostal + Mifeprostone)- 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- 22,25,000 | | | 3 | | | | | | | | | | | | | | |
| | | 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 | **May not be required as the last years order are coming in** |
| 17.1 | Supply and delivery of diagnostic kit for Chikungunya and dengue. (For EDCD) | | | 1 | | | | | | | | | | | | | | |
| 17.2 | Urinay Test Kt (1,00,00,000 Pcs) (For MD) | | | 43 | | | | | | | | | | | | | | |
| | | R / A | | | | | | | | | | | | | | | | |

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| 18 | **NHSP-II/DOHS/G/NCB-118/2015-16 Procurement of Insecticides For Malaria and Kala-Azar for Epidemiology and Disease Control Divion** | P | 28-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 | **Bidding process initiated** |
| | | 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 | **51.719** | 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 | **Specification and details not yet received from concerned depertment** |
| | | R / A | | | | | | | | | | | | | | | | |
| 20 | **NHSP-II/DOHS/G/ICB-120/2015-16 Procurement of Medial Consumables For PHCRD and CHD** | P | 30-Oct-15 | **41.054** | ICB | 18 | 23-Oct-15 | 30-Oct-15 | NA | 2-Nov-15 | 18-Dec-15 | 17-Jan-16 | NA | 29-Jan-16 | 13-Feb-16 | 13-Feb-16 | 12-Jun-16 | **Specification development in progress** |
| 20.1 | Absorbant Cotton Roll 400gm - 3600 | | | 0.25 | | | | | | | | | | | | | | |
| 20.2 | Bandage Than -3600 | | | 0.4 | | | | | | | | | | | | | | |
| 20.3 | Gauze Than - 3600 | | | 0.4 | | | | | | | | | | | | | | |

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| 20.4 | Surgical Gloves 6.5, 7.0, 7.5 - 400,000 | | | 6 | | | | | | | | | | | | | | |
| 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 | | | 0.32 | | | | | | | | | | | | | | |
| 20.11 | Adheshive tape 4" - 30,000 | | | 4.23 | | | | | | | | | | | | | | |
| 20.12 | Surgical Blade - 400,000 | | | 2.8 | | | | | | | | | | | | | | |
| 20.13 | Rubber Catheter - 50,000 | | | 2.25 | | | | | | | | | | | | | | |
| 20.14 | Rectified Spirit 500 ml - 1,00,000 | | | 4 | | | | | | | | | | | | | | |
| 20.15 | Chlorine powder 200 gm - 1,00,000 | | | 3.5 | | | | | | | | | | | | | | |
| 20.16 | Penguine Suction-4700 (For CHD) | | | 2.35 | | | | | | | | | | | | | | |
| 20.17 | Delee Suction - 66225 (For CHD) | | | 0.795 | | | | | | | | | | | | | | |
| 20.18 | Thermometer Digital - 9500 (For CHD) | | | 2.849 | | | | | | | | | | | | | | |
| | | 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 | **Specification and details not yet received from concerned depertment** |

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| | | R / A | | | | | | | | | | | | | | | | |
| 22 | **NHSP-II/DOHS/NS/NCB-214/Procurement of Transportation Service** | P | | **30** | NCB | 6 | Contunuation of Last FY PP | | | | | | | | | | | |
| | | A | | | | | | | | 15-Sep-15 | 15-Oct-15 | 1-Jan-16 | | 14-Jan-16 | | | | |
| 23 | **NHSP-II/DOHS/G/NCB-122/Procurement of Bags** | P | 29-Sep-15 | **3.75** | 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 | |
| | | A | | | | | | | | 9-Dec-15 | 8-Jan-16 | 11-Feb-16 | | | | | | |
| 24 | **NHSP-II/DOHS/G/NCB-123/Procurement of Generator, UPS, Voltage Stabilizer, Invertor for X-Ray Prower Back up** | P | 24-Sep-15 | **5** | 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** |
| | | A | | | | | | | | 7- | 6- | 22- | | 1- | 21- | 21- | | |

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|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Oct-15 | Nov-15 | Nov-15 | | Dec-15 | Dec-15 | 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 | | | | | | | | | | | | **Contract signed** |
| | | A | | | | | | | | 20-Nov-15 | 21-Dec-15 | 31-Dec-15 | | 7-Jan-16 | 1-Feb-16 | 1-Feb-16 | | |
| | **** Brought from NCB-108.4*** | | | | | | | | | | | | | | | | | |

## 3.4 Health Financing and Public Financial Management

In designing the HSTRP the tracking of EHCS service data and related expenditure in earthquake affected districts was seen as is essential if overall efficiency of inputs is to be measured. MoH's Transaction Accounting and Budget Control System (TABUCS) is able to provide the level of detail needed against standard cost headings and generate appropriate financial reports. Accordingly, assuring TABUCS functionality in earthquake affected districts is a programme priority.

In the reporting period five data entry assistants were hired to enter financial data from 31 EQ affected districts and have now been trained and deputed to their work areas. An earth quake TABUCS module has now been designed and integrated in the TABUCS to generate electronic financial monitoring reports (FMRs). A revised FMIP was circulated to EPDs in the reporting period.
In the first six month of FY 2015/16 more than 75% of total expenditure was captured through TABUCS.

Further, NHTC was supported to conduct two TABUCS training courses for 46 finance officers and 186 programme managers and finance officers were trained in financial management at three regional workshops as follows:

| | |
|---|---|
| In Western Region, Pokhara on October 1-5, 2015 | Participants 77 |
| In Centre Region, Kathmandu on October 8-11, 2015 | Participants 54 |
| In Far West Region, Dhangadi on November 27-30, 2015 | Participants 55 |

Monitoring visits by a team led by MoH's joint secretary were made to the DHOs/DPHOs in Regional, Zonal and District Hospitals of Kaski, Parvat, Baglung, Rupandehi, Palpa districts.

**Audit queries record update in TABUCS:** To update the old audit queries up to 8 years (FY 2060/61-2068/69) of audit query records (81 books) were copied from the OAG. These data were then entered in TABUCS and are currently being verified.

An audit of MoH and its entities is now underway by the Office of the Auditor General (OAG) for FY 2014/15 and is scheduled for completion in April 2016. A performance audit (on basic health delivery, free medicine management, health infrastructure, health information and effectiveness evaluation) of health institutions in Dhanusa, Kaski, Palpa, Jumla and Kailai districts and at BP Koirala Memorial Cancer Hospital Chitawan is also underway by OAG.

**Financial Reporting**

Unaudited financial statements for 2014/15 were prepared in December 2015 but due to a change (transfer) in the Financial Comptroller General, the required signatures could not be obtained. This was rectified in January and the statements were submitted to the Word Bank on 22 January, 2016.

MoH has given special instructions to all departments and concerned health entities to maintain financial discipline and follow audit report issues and suggestions. It further instructed all entities to clear outstanding audit queries as a priority within the stipulated timeframe.

**Aama Stock Take**

In the reporting period, design of Aama stock take analysis was completed. This aims to capture the current status of Aama programme implementation in 14 EQ affected districts. A mixed method approach was used in the study and a set of questionnaires was developed and finalized. Data collection assistants were recruited, trained and deployed for the data collection. Despite the ongoing fuel crisis, the team completed data collection and the report is now being finalised.
ToR for the next Aama programme rapid assessment (RA) were finalised and a third party was contracted to implement it.

In the reporting period, the Aama unit cost study was finalided and circulated to all stakeholders. The health financing team in Nepal will write a policy note and help translate findings into policy level recommendations. The discussion on normative costing for maternal and newborn condition could not be conducted because of other FHD commitments. The unit cost study team will hold these discussions in the future and findings will be presented in a separate report which will contribute to reaching clarity and consensus on the next generation of the Aama programme.

## 2.5 Gender Equality and Social Inclusion

### Post-earthquake Response

District level

TA made visits to six hospitals (Western Regional, Bharatpur, Nuwakot, Trisuli (Nuwakot), Gorkha, Chautara (Sindhupalchwok) and two PHCCs (Manthali [Ramechhap] and Charikot [Dolokha]) to assess post disaster needs, in particular, the need for one stop crisis management centres (OCMCs) and social service units (SSUs).

National level

Coordination and support were provided to various national level clusters and groups (including Gender Based Violence (GBV) and Mental Health/Psychosocial and Protection clusters) on training content, the design of a manual for the delivery of psychological first aid and mental health services to survivors suffering distress. A further objective was to help strengthen health system capacity to provide these services and establish effective referral pathways.

### 2.5.1 Focal District Activities

#### Development of integrated district level transition and recovery plans

The incorporation of GESI support structures and activities in HSTRP plans in Ramechhap, Dolakha and Sindhupalchok is a key achievement in the reporting period. These plans now make provision for OCMCs, mental health and psychosocial counselling, SSUs, Community Health Units (CHU) and equity monitoring. In the three focal districts, coordination with the DHO and district-level stakeholders including WDO, UNFPA, UNICEF, Nyaya Health, H4L, MDM, JAICA, TPO, CMC and local NGOs enabled the following:

- OCMCs and CHUs established and strengthened equity monitoring of health services introduced.
- The planning of mental health and psychosocial counselling activities in Ramechhap and Dolakha (note that the Institute of Medicine (IOM), Medicines du Monde (MDM), The Asia Foundation, UNICEF, and others are providing this support in Sindhupalchok).

### 2.5.2 One-stop Crisis Management Centres

Progress made in this area included:

- The revision of OCMC guidelines to address the needs of disaster survivors. These are now with MoH's Secretary for approval.
- The inauguration of an OCMC in Dolakha PHC by the CDO. The case management committee (CMC) held its first meeting, nominated a OCMC focal person, hired a staff nurse and prepared an action plan. Services have now begun.
- Two cases were successfully managed at the OCMC in Charikot PHC.
- The establishment of OCMCs in Ramechhap and Sindhupalchowk is planned for February 2016.

### 2.5.3 Social Service Units

- An SSU scoping visit was made to Gorkha hospital where hospital staff, the hospital management committee (HMC) and other stakeholders were briefed and oriented. The HMC has now formally requested MoH for the establishment of a SSU, formed a SSU management committee begun hiring a facilitating NGO.
- In Nuwakot (Trishuli hospital) processes for SSU establishment were completed but a lack of space for the pre-fab unit means that the unit has not yet been opened.
- In Hetauda hospital orientation was completed and a unit chief and deputy appointed. The SSU began providing services and the selection of a facilitating NGO is now under way.

### 2.5.4 Mental Health and Psychosocial Counselling Services (MNPCS)

In the area of mental health and psychosocial counselling, support was provided to TPO to:

- finalize the training curriculum for non-prescribers, community psychosocial workers (CPSW) and FCHVs and build the capacity of CPSWs
- Initiate mental health services in the ministry's PHC system
- Provide guidance through NHSSP's Mental Health Quality Assurance Consultant on the training of prescribers, non-prescribers, and community psychosocial workers (see appendix 3) and for the supervision of FCHVs
- Meet with staff from Patan Mental and Trishuli hospitals on the management of district referrals requiring advanced care
- Support district level collaboration and cooperation efforts, including with HI and others.

### 2.5.5 Forensic Training

Forensic training for OCMC, SSU and hospital medical officers (including selected hospitals of disaster affected districts) was carried out for 14 participants.

### 2.5.6 Community Health Units

NHSSP advisers helped identify appropriate sites for the establishment of three Community Health Units (CHUs) in each focal district and allocated a budget. Dolakha and Ramechhap hired an area health worker and ANM to temporarily operate the CHU services from the VDC building. An orientation program for these staff will be held prior to their deployment.

### 2.5.7 Equity Monitoring

The magnitude of earthquake destruction, scale of the relief required and prevailing social exclusion practices raise the possibility that recovery efforts may not be delivered equitably and that some populations may not receive the health care they need. For these reasons equity monitoring is essential.

Social auditing provides a useful mechanism for citizen engagement in health service monitoring and the responsiveness of health services to needs. Equity monitoring is intended to complement/supplement social auditing in disaster-affected areas and specifically monitor the level of equity in health service delivery and identify those at risk of being underserved or left out. In the last quarter:

- Equity monitoring was planned in 18 VDCs of each focal district (54 total), each selected following DDC mapping.
- Field testing of the equity monitoring manual was completed. This is now pending approval with the director general.
- The process to identify and select NGOs to implement equity monitoring was finalised.
- In Dolokha, a tripartite agreement between the DHO, NGO and NHSSP was signed to implement equity monitoring and orientation of the NGO (TUKI) and orientation of DHO supervisors was carried out. Monitoring in two VDCs was completed.
- Orientation of NGO and DHO staff in Ramechhap and Sindhupalchowk is planned for February 2016.

### 2.5.8 Beyond the Transition and Recovery Programme

SSU activities

- Orientations for SSU establishment were held in Lumbini Zonal Hospital, Rapti Sub-regional Hospital, Dhaulagiri Zonal Hospital, Hetauda Hospital and Gorkha Hospital.
- Training on communication and psychosocial support was provided to 47 SSU service providers from 8 hospitals. This three days training programme enhanced participants' skills to provide psychosocial support and appropriate referrals.
- An SSU web application was developed to help improve patient recording and was approved by MoH. SSU facilitators were trained in the use of this software and medical superintendents and medical recorders were briefed. The system now generates a wide range of reports including:
    - Patient frequency disaggregated by target group, ethnicity, economic profile, and services provided.
    - Cost of health services and subsidies provided.
    - Investigational and other costs.
    - Analytical report on the basis of targeting criteria and ethnicity.

OCMC activities

- **National GBV Integrated Guidelines**: To improve coordination of the multi-sectoral response to GBV, the Office of the Prime Minister and Counsel of Ministers (OPMCM) decided to develop integrated guidelines for the delivery of integrated services to survivors of GBV. The final draft guidelines are now ready to share with the Steering Committee which is scheduled to meet in February 2016.
- **Gender Based Violence (GBV) Clinical Protocol**: TA supported MoH and UNFPA to roll out GBV clinical protocol training in the 14 worst affected districts. This was done through ADRA with the financial support from UNFPA. The roll out will be gradually introduced (year wise) to service providers at all levels.
- **OCMC to OPMCM action plan**: The OPMCM circulated a memo to all line ministries, including MoH, with a mandate to strengthen and scale-up OCMCs across the country. NHSSP TA prepared the action plan which proposes the establishment of OCMCs in 35 districts within 2017/18 including the roll-out of the GBV clinical protocol in all health facilities and alliance building with multi-sectoral stakeholders for the prevention of GBV.
- **Assessment of GESI Mainstreaming Training**: GESI mainstreaming training aims to develop a common understanding of GESI concepts and enhance knowledge and skills on GESI responsive program planning, implementation, monitoring and evaluation. It further seeks to strengthen the capacity of health facilities to manage S/GBV survivors and provide appropriate medical

services. To date, more than 2000 service providers from 31 districts have been trained and an assessment of this training in 6 districts was completed and submitted to MoH.

### 2.5.9 Challenges Faced

- Fuel and transportation shortages have delayed trainings and equity monitoring.
- OCMC and SSU establishment are delayed due to the late arrival of pre-fabricated structures.

## 2.6 Monitoring and Evaluation

### 2.6.1 Support HMIS e-reporting from health facilities

In the reporting period, MoH's Public Health Administration, Monitoring and Evaluation Division (PHAMED), supported by partners, drafted a 'Minimum Standards and Implementation Guideline for Initiating e-Reporting from Health Facilities'. Once finalized and endorsed the guideline will be rolled out to selected public health facilities in the 14 earthquake affected districts with DHIS2 used as the reporting platform. E-reporting will enable health facilities to report on a daily, weekly or as required basis, improve the quality of data and promote its use at local levels. This initiative may be seen as a key milestone in MoH's plan to adopt paperless 'e-recording and reporting'.

With respect to implementation, participating facilities will be selected in accordance with their degree of readiness including compliance with minimum data standards. Around 250 health facilities will participate in the first round in this fiscal year and be provided with computers, electricity and internet connectivity, health worker training and operation and maintenance support. A joint monitoring plan is currently being developed for regular district level supportive supervision and mentoring. NHSSP advisers are also helping MoH harness sufficient resources from partners to supply facilities in all 14 districts. NHSSP will provide support for e-reporting in its three focal districts.

Importantly in the quarter, e-reporting began from health posts and PHCCs in Kanchanpur district building on the existing electronic immunization recording and reporting system supported by WHO.

### 2.6.2 Supporting districts to improve the use and quality of HMIS data

During the reporting quarter, two HMIS coordinators were appointed for the three focal districts. The coordinators are based at the DHOs in Dolakhar and Ramechhap and have began supporting districts and health facilities to improve the quality and use of HMIS data. A 'dash board' (flex print) has also been developed to display monthly performance against key HMIS indicators for various programmes at health facilities and at the DHO. The coordinators also supported health facilities to make better use of collected data locally, particularly during monthly and quarterly reviews.

### 2.6.1 Capacity Building in DHIS2

Eleven government officials including two senior MoH staff members participated in the DHIS2 Academy organized by University of Oslo (UoO) and HISP India in Goa, India in November 2015.
Dr. G.D. Thakur, Chief of PHAMED and Dr Bhim Acharya, Director of Management Division attended supported by WHO, GiZ, NHSSP, HISP and UoO.

NHSSP is currently assisting MoH in a collaboration with Kathmandu University with a view to strengthening M&E systems through the improved use of ICT. Accordingly, one KU professor and one student were also supported to attend the Academy meeting in India.

Also in the quarter, HISP's founding chairperson and UoO professor, Dr Sundeep Sahay, visited NHSSP with GiZ Nepal officials to explore how UoO can better support the institutionalization of DHIS2 in Nepal. Similarly, Mr Mark from WHO's South East Asia Regional Office met officials at HMIS, PHAMED and various partners to discuss DHIS2, OpenMRS, CRVS and others. Following these discussions UoO, WHO, HISP India and HMIS reached a gentleman's agreement for WHO to provide one focal person to support HMIS and establish a formal linkage between the Nepal team and the global DHIS2 core team in order to address any technical issues and support institutonalisation and roll out through capacity building for few months in the initial stage.

### 2.6.2 Support EDCD/DoHS in information management and surveillance

NHSSP continued its support to EDCD/DoHS to strengthen information management, particularly as related to the Early Warning and Reporting System (EWARS). NHSSP is funding one information management officer who has been instrumental in publishing weekly EWARS bulletins.

The Surveillance, Research and Planning Section chief of EDCD also participated in the DHIS2 Academy in Goa following which EDCD customized DHIS2 to better meet the needs of EWARS. As noted, the recording tools, reports and dash board have been developed and EWARS legacy data for 2014 and 2015 have now been migrated to the DHIS2 database. Once EWARS data from 2012 and 2013 have been migrated, EDCD will share the reports and dashboards with DoHS and ministry officials and officially launch the DHIS2.

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

NHSSP advisors are supporting MoH to harmonize TA and available partner resources to review the health sector's response to the earthquake and identify lessons learned. During this quarter, ToR were developed jointly with partners (WHO, GiZ Nepal, UNICEF, World Bank and USAID) and agreement reached help produce four products: 1) a consolidated comprehensive report reviewing health sector preparedness, damage to the health sector, response, lessons learned and recommendations for improved disaster preparedness and management; 2) a report compiling various case studies; 3) a photo story book; and 4) a documentary. These are expected to be disseminated on or before 25 April 2016.

For effective implementation of this initiative, MoH formed a technical working committee chaired by the chief of HEOC with representation from PHAMED, PPICD, EDCD, NHRC, NHSSP/DFID, WHO, GIZ Nepal, UNICEF, USAID and World Bank.

### 2.6.4 Monitoring and Evaluation (M&E) plan for the HSTRP

An M&E plan was developed to monitor programme outcomes, outputs, and activities related to NHSSP's support to HSTRP. This plan lays out the indicators, data sources, frequency of data collection, and responsibilities for data collection in order to ensure coordinated data flows, data sharing and the supervision of activities.

### 2.6.5 Service Coverage this Quarter (Kartik-Poush 2072/Oct-Jan 2016)

The table below shows the number of beneficiaries who utilized the listed services in the second quarter of the last and current fiscal years (2071/72 and 2072/73), as reported by HMIS in February 2016. Health facilities are supposed to report to the district by the 7th day of the next month and districts are supposed to enter the data into the database by the 15th of the month, but many health facilities and districts do not comply with this requirement. Some facilities delay in sending the report and some districts delay in entering the data. Furthermore, updating the previous months' data in the database is a common practice since there are no strict provisions to prevent facilities and districts updating data after the specified reporting period has passed. Accordingly, the data recorded in any given month in the central server may differ from that month's data at the district level when the report is generated in the following date/month.

Efforts to improve data quality by preventing health facilities and districts from updating data after the specified timeframe have not yet succeeded. This is only likely to be achieved when DHIS2 is implemented since this has a strict data validation and approval rule that prohibits modified data entries after the specified time frame has passed.

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

| Number of beneficiaries of selected services in the second quarter (Kartik-Poush) of last and running fiscal year (2071/72 and 2072/73) at national level | | | | |
|---|---|---|---|---|
| Indicator | FY 2071/72 Kartik-Poush | FY 2072/73 Kartik-Poush [as of 14 Feb 2016] | FY 2072/73 Shrawan-Ashoj [Reported in last quarter: as of 20 Nov 2015] | FY 2072/73 Shrawan-Ashoj [as of 14 Feb 2016] |
| A | b | c | d | e |
| Number of institutional delivery | 82,718 | 40,884 | 26,600 | 63,989 |
| Number of SBA delivery | 82,269 | 38,805 | 25,023 | 61,639 |
| Number of FP new acceptors | 175,670 | 100,400 | 68,332 | 132,359 |
| Number of children immunized against measles | 120,045 | 77,370 | 52,898 | 103,795 |
| Number of under five years children treated for diarrhea | 575,110 | 313,444 | 300,699 | 259,012 |
| Number of under five years children treated for pneumonia | 187,744 | 119,564 | 116,033 | 213,969 |
| Number of under five children who received Vitamin A in the last mass campaign | 2,014,526 | 1474,646 | 3,133 | 13,058 |

| Number of beneficiaries of selected services in the second quarter (Kartik-Poush) of last and running fiscal year (2071/72 and 2072/73) at national level | | | | |
|---|---|---|---|---|
| Indicator | FY 2071/72 Kartik-Poush | FY 2072/73 Kartik-Poush [as of 14 Feb 2016] | FY 2072/73 Shrawan-Ashoj [Reported in last quarter: as of 20 Nov 2015] | FY 2072/73 Shrawan-Ashoj [as of 14 Feb 2016] |
| A | b | c | d | e |
| Number of OPD new cases | 4,374,370 | 2,278,629 | 2,426,434 | 4,589,243 |

**Comparative service data across the same time line in three districts is as follows**

| SN | Service | Sindhupalchok | | Ramechhap | | Dolakha | |
|---|---|---|---|---|---|---|---|
| | | Shrawan to Poush (6 months) | | | | | |
| | | 2071/72 | 2072/73 | 2071/72 | 2072/73 | 2071/72 | 2072/73 |
| 1 | Total number of ANC 1st Visit Any time | 1963 | 1586 | 1492 | 1707 | 1531 | 1504 |
| 2 | Total number of ANC visit 4 months | 1426 | 1067 | 1083 | 1062 | NA | NA |
| 3 | Total number of ANC 4th visit as protocol | 906 | 544 | 841 | 810 | 958 | 806 |
| 4 | Total number of Institutional delivery | 532 | 467 | 701 | 735 | 556 | 715 |
| 5 | Total number of C section done at the district | 1 | 4 | 0 | 0 | 15 | 68 |
| 6 | Total number of IUCD New users | 132 | 136 | 56 | 96 | 56 | 23 |
| 7 | Total number of Implant New users | 1991 | 1180 | 149 | 991 | 155 | 133 |
| 8 | Total number of Safe abortion service | 73 | 90 | 115 | 122 | 92 | 96 |
| 9 | Total number of children immunized with measles | 2642 | 1575 | 1719 | 1361 | 1720 | 1653 |
| 10 | Total number of U 5 children treated for diarrhea | 10382 | 8837 | 1219 | 1094 | 1555 | 1748 |
| 11 | Total number of U 5 children treated for pneumonia | 4660 | 3556 | 1853 | 1467 | 1574 | 1423 |
| 12 | Total number of OPD cases (New OPD Visits) | 105261 | 99279 | | | 85343 | 91349 |
| 13 | Total number of OPD visits | 128195 | 106305 | 96011 | 88402 | 94309 | 97792 |

### 2.6.6 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.

## 3.0 Payment Deliverables

The following deliverables were submitted in the reporting period:

| PD | Deliverable |
|---|---|
| HI 1 | Work plan finalised and approved |
| TPO 1 | Work plan finalised and approved |
| SIRC 1 | Work plan finalised and approved |
| HI 3 | 14 Social Workers trained on comprehensive assessment of needs of the injured and mobilized in health facilities, step down facilities, OCMCs and during outreach in communities. |
| 3.1 | Consolidated Annual Procurement Plan (CAPP) prepared and submitted by LMD to MoHP on time (by October 2015) for FY 2015/16 |
| 2 | 1st Quarterly Progress Report including<br>• 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)<br>• Review of progress against Consolidated Annual Procurement Plan<br>• Progress against PDs and plan in case of any deviation |
| 3.1 | Quarterly report - HI (annexed into main report) |
| 3.2 | Quarterly report TPO (annexed into main report) |
| 3.3 | Quarterly report SIRC (annexed into main report) |
| TPO 2 | Adaptation and translation of Mental Health Gap Action Plan Humanitarian Intervention Guide (mhGAP HIG) and other manuals for use in Nepal as described in TOR |
| 1 | Detailed plan for repair, maintenance and rebuilding for three focal districts agreed with DHO/MoHP and detailed structural assessment completed for all 14 districts |

## Appendix 1: Handicap International

### 1.0 Introduction

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

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

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

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

### Achievements against the Approved Plan

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

### 1.1 HI 1: Work plan finalized and approved

This deliverable has been achieved and payment deliverables submitted to Options and reported on in the first quarterly report.

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

The deadline for the submission of this deliverable was amended from October, 2015, to the 15th January, 2016. This deliverable has now been fully achieved through **Activity 1: Training to Health and Rehabilitation personnel on injury management** by executing various sub- activities as follows:

- Of the 14 targeted district level trainings, eight were accomplished and reported in the first quarterly report. The remaining six district level trainings (with two events for Kathmandu to cover 71 participants) were accomplished during this quarter.
- A total of 412 health professionals (Female: 182 and Male: 230) including medical doctors, nurses, paramedics, rehabilitation professionals, and health care managers of the 14 target districts (Dolakha, Makwanpur Gorakha, Rasuwa, Dhading, Sindhuli, Kavrepalanchowk, Nuwakot, Sindhupalchowk, Okhaldhunga, Bhaktapur, Ramechhap, Lalitpur, and Kathmandu) were trained on injury/trauma management. The major objective of the training was to strengthen the referral system amongst the health and rehabilitation institutions and to prevent secondary complications for injured people.
- The Disability Rehabilitation Focal Unit (DRFU), Leprosy Control Division (LCD), and the Ministry of Health and Population (MoHP) led the coordination and communication for the planning and delivery of the trainings.
- Training monitoring and quality assurance was carried out by senior government officials from the Curative Service Division, MOH, DRFU, LCD, Department of Health Services (DoHS), National Health Training Centre (NHTC), Regional Health Director, the Regional TB/ Leprosy Officer from the Central Regional Health Directorate, and the respective District Health Office (DHO) and District Public Health Office (DPHO) staff.
- Training feedback received from previous training events was incorporated in the latter trainings. Participants expressed that they had not received a training of this kind which they felt was essential, as they have encountered many injury and trauma cases associated with road traffic accidents (RTAs) and falls from trees and cliffs while cutting fodder.
- Immediate outcomes of the training:
    - Improved skills, attitudes, and knowledge of the participants on injury management by 23%, verified through a comparison of participants' pre-test (average score 41%) and post-test (average score 63%) scores.
    - Participant's quote: "We received real exposure on mass injury and trauma cases at the time of the recent earthquake. We managed these cases using the learning acquired from our academic courses. This training has contributed to building our confidence, which will foster quality work in the future" – Dr. Ritesh Thapaliya, Medical Officer, Changunarayan Primary Health Care Centre (PHCC), Bhaktapur.
    - Some of the participants in the Injury Management Training were further deployed as trainers for community level injury management and referral training organised by Anandaban Hospital and the Hospital and Rehabilitation Centre for Disabled Children (HRDC).
    - The health staff at Nuwakot District Hospital expressed that they recently were able to manage a mass casualty incident during a road traffic accident in Rasuwa and

were able to do triage and make quick referrals to hospitals in Kathmandu as a result of the training. See Annex 3: Report on a Bus Accident in Rasuwa.

The reasons for the delay in the completion of this deliverable are as follows:

- District health staff were occupied with the Nepal Government's National Campaign for Mumps and Rubella and so were not available to participate in the trainings.
- The on-going fuel crisis during the second half of the quarter limited the mobility of vehicles and personnel.
- Health staff were engaged in various activities from various agencies, all in a short span of time, in the districts.

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

This deliverable was fully achieved in October 2015 and reported on in the last quarterly report. Currently, social workers are continuously engaged in the following tasks:

- Case management, early detection, follow-up, and referral for medical/ rehabilitation care
- Basic psychosocial support and personalised social support
- Linkages for social protection to the Women and Children Office, DPOs, and DHOs for disability cards
- Linkages for other services to other health, education, and livelihood organisations

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

The deadline of this deliverable was amended to the 15th February, 2016. All seven health facilities (five in the first reporting quarter and two in the second) have established PT/Rehabilitation Units, equipped with rehabilitation and physiotherapy supplies and have been providing rehabilitation care to people with injuries/functional limitations and disability and a wider population with unaddressed physiotherapy needs.

Through the payment deliverable **"support seven hospitals to develop PT/ Rehab Units and deliver services"** various steps of interventions have been executed:

- The sixth PT/ Rehab Unit was set up and equipped in Dolakha District Hospital, Jiri, at the end of October 2015. Social workers and a physiotherapist have been deployed to this unit.
- After a rapid needs assessment carried out on the 8th Dec, 2015, the seventh PT/ Rehab Unit has been set up and equipped in Dhading District Hospital, Dhading Beshi. The unit is located on the first floor of the hospital with modifications carried out to connect it with the ground floor with an accessible ramp and toilet facilities. The unit is staffed by one physiotherapist and two social workers and started delivering the physiotherapy,

assistive devices, and psychosocial services from the 7th February, 2016. The Honourable State Minister for Health Mr. Mo. Mustak Alam visited Dhading District Hospital (7th February, 2016) to observe a health camp being run by the hospital, and opened the Physiotherapy Unit by distributing an assistive device to one of the patients. The Minister was briefed about the project activities being implemented in Dhading and five other earthquake affected districts.

### 1.5 HI 5: Four district hospitals/PHCCs in Nuwakot, Sindhupalchowk, Rasuwa and Dolakha districts engage in the proper discharge of injured patients and proper referral to health and/or social/community services.

The deadline of this deliverable is April 2016. Services have already begun from four District Hospitals/PHCCs in Nuwakot, Sindhupalchowk, Rasuwa, and Dolakha districts through **Activity 3: Support seven hospitals to develop PT/ Rehab Units and deliver services and Activity 6: Harmonisation of assessment, referral forms, trauma care pathways (for spinal cord injury, amputation, and fractures)** by implementing the following sub-activities in the last quarter:

- Assessment forms developed in the first quarter were finalised and orientation provided to the physiotherapists and social workers. These forms were used for assessment and goal setting to support physiotherapy/rehabilitation services as well as for follow up, the provision of assistive devices, and for documenting the patient education given to care givers.
- A total of 90 patients' referrals were made, including 33 to specialised services (Spinal Injury Rehabilitation Centre [SIRC] for spinal cord injuries x 8, Transcultural Psychosocial Organisation (TPO) for psycho-social counselling and mental health services x 5, the National Disabled Fund [NDF] for assistive devices x 18, and two to specialised hospitals).
- The National Trauma Centre, Kathmandu, has referred 53 patients to either existing step-down facilities in Kathmandu (the Nepal Health Care Equipment Development Foundation [NHEDF], Yellow Gumba, and Tara Chaur camp) and district health facilities including PHCC Charikot, District Hospital Jiri, Nuwakot and Rasuwa, Tansen Mission Hospitals, and Rapti sub-regional hospital.

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

The deadline of this deliverable is June 2016. The initial achievement of **Activity 6: Harmonisation of assessment, referral forms, and trauma care pathways (for spinal cord injury, amputation, and fractures)** was reported in the last quarterly report. Progress during this reporting period is as follows:

- The assessment forms including the treatment card, follow-up card, and referral card have been standardised in consultation with the district health authorities and are currently being used by the physiotherapists and social workers to document the beneficiaries' records at each PT unit.
- Referral pathways have been developed by mapping the existing specialised services with their criteria for service provision and the identification of a focal person for referral etc. This is in order to provide specialised and tertiary care and further

rehabilitation support and follow ups. Physiotherapists and social workers are currently being sensitised on referrals to specialised services and linkages to social services through networking and collaboration with local stakeholders.

- A standard database to record beneficiaries has been developed and is currently in use. The format has been shared with Options for feedback.

### 1.7. 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

The deadline of this deliverable is July 2016 and it is an on-going activity. **Activity 1: Training to health and rehabilitation personnel on injury management, Activity 3: Support seven hospitals to develop PT/ Rehab Units and deliver services**, and **Activity 2: Training and mobilisation of social workers on case management with the following sub-activities**:

The following achievements mark progress as of January 2016:

- A total of 1,152 patients and 487 care givers (1,639/ 1600 target) have been provided with a one to one orientation on the benefits of rehabilitation in order to ensure proper care, follow-up, and referrals.
- Physiotherapists have provided orientations to individual patients and their accompanying caregivers on patients' diagnosis, the need for continuous rehabilitation services, and the need for goal setting.
- During the orientation session, specific IEC materials relating to different diagnoses (12 categories), which were available in Nepali languages, were used. Through two way communications, an exchange of feedback was ensured during these sessions.
- The rehabilitation teams in the districts were given the materials necessary to facilitate the patients' and caregivers' education by HI's Technical team following the World Health Organization (WHO) guidelines. A care giver's orientation checklist has also been developed and shared with physiotherapists and social workers.
- Care givers are usually family members, relatives, friends, and neighbours.

For more information, see Annex 1: Care Givers Orientation Checklist.

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

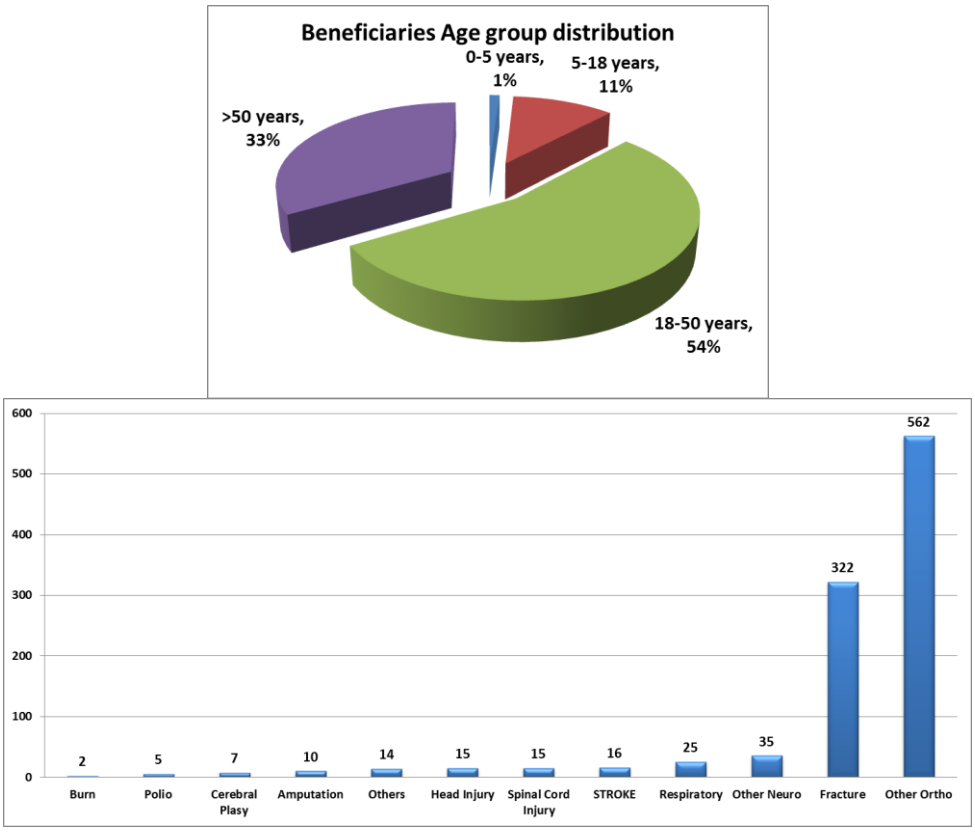
The deadline of this deliverable is July 2016. These services are currently being delivered to persons with injuries and persons with functional limitations affected by the earthquake through the PT/ Rehab Unit at district hospitals as well as outreach through**: Activity 1: Training given to health and rehabilitation personnel on injury management, Activity 3: Support seven hospitals to develop PT/ Rehab Units and deliver services,** and **Activity 2: Training and mobilisation of social workers on case management** with the following sub-activities:

- A total of 1,152 persons (F-49% and M-51%) with injuries and functional limitations were provided with rehabilitation services from six health facilities in five districts as well as the Kathmandu valley covering Kathmandu, Lalitpur, and Bhaktapur. The seventh Physio

Unit at Dhading has just been set up and a total of 45 patients have been seen to date since the 7th February. However, this site is not included in the database yet.

- A total of 2,261 treatment sessions (including 1,036 follow up sessions) were delivered.

For more information, see Annex 3: Case Study from Jiri, Dolakha.




## 1.9 HI 9: MoHP Disability and Rehabilitation Focal Unit (DRFU) has taken 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 for the DRFU** through the continuation of the following sub-activities:

- The management support mentioned in the first quarterly report has been continued into this reporting period.
- The monitoring visits for the district level trainings were jointly conducted with HI, the Curative Health Service Department, Ministry of Health, DRFU, Leprosy Control Division, DoHS, NHTC, and the Regional Health Director of the Central Regional Health Directorate.
- HI has supported the DRFU with their work on Health and Rehabilitation strategies in the National Policy & Plan of Action on Disability (NPPAD) being reviewed under the lead of the Ministry of Women Children and Social Welfare.

### 1.10 Constraints and Challenges

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

### 1.11 Cross Cutting Activities for a smooth operating environment

**Two Quarterly Review meetings** were organized between 8th- 9th November, 2015 and 29th-30th January, 2016. The objectives of these meetings were to review project progress and achievements, discuss managerial, technical, and administrative issues and work out relevant solutions to facilitate the entire project team including at district and central level. These meetings also facilitated the planning of up-coming quarterly activities so that everyone was prepared to execute them.

The major discussion points in the first meeting were:

- Orientation on the different assessment forms and formats
- Logistics and security for the setup of new physiotherapy/rehabilitation units at target health facilities
- Communications, staff mobilisation and technical issues concerning project activities.

The discussion points from the second meeting agenda included:

- Project progress and achievement updates
- Sharing on database analysis and findings
- The M&E system
- Caregiver's checklist finalisation
- The reinforcement of roles and responsibilities for project staff
- How to improve and maintain functional coordination among DHOs, district hospitals, and other stakeholders
- Status review of physiotherapy and assistive devices available in each unit
- Logistic support and communication (telephone/internet)

**Continuous professional development of rehabilitation professionals:**

- Eight physiotherapists (seven from HI and one from the National Trauma Centre) participated in the 14th Asian Spinal Injury Network Conference in Nepal (ASCoN) which enhanced PT skills and knowledge on rehabilitation.
- Twelve physiotherapists (seven project PTs and five government/ other stakeholder's PTs) received gait training for assistive devices and orientation on the WHO Disability Scale.
- PTs participated in familiarisation training based on WHO basic and intermediate wheelchair service packages.

**Regular meetings with DFID/Options and implementing partners** were held for project progress updates, technical and managerial issues, strengthening functional coordination among partners, and possible extension/amendments to deadlines of PDs. Key issues addressed include:

- **Coordination/communication** with Option's partners (SIRC and TPO) for functional coordination, referrals for spinal cord injuries, psychosocial counselling, and joint trainings.
- **Coordination/communication** with other health related agencies working in health sector response and rehabilitation including WHO, Oxfam, Save the Children, Christian Blind Mission (CBM), NDF, the Rural Community Development Centre (RCDC), and the Institute of Medicine (IOM).
- **Coordination and networking** with concerned stakeholders, patients, physiotherapists, and social workers involved in the different camps listed below for the identification of people with disabilities. These patients were then referred to the district PT/ Rehab Unit. The camps included:
    - Fitment camps organised by the NDF
    - General Free Health camps organised by the DHO (Jiri, Rasuwa, Nuwakot, and Sindhupalchowk)
    - Orthopaedic camps organised by the National Orthopaedic Hospital
- **Donor visits.** Project staff participated in a group discussion during the DFID/Options visit to the National Trauma Centres at Bir Hospital, Dolakha District Hospital, Jiri, PHCC Charikot, and the District Hospital of Sindhupalchowk.
- **Field visits,** HI senior staff from HI-HQ and Kathmandu frequently visited the PT/ Rehab Units of project catchment districts.
- The Project Coordinator participated in the **training on the Hospital Emergency and Response Programme** organised by the Asian Disaster Preparedness Centre, Bangkok.

## Implementation Plan for the Upcoming Quarter

**Payment Deliverables**

**HI 5: Four District Hospitals/ PHCCs in Nuwakot, Sindhupalchowk, Rasuwa, and Dolakha districts engage in the proper discharge of injured patients and proper referral to health and/ or social/ community services**. Actions include:

- Provide referral services to the patients who need specialised services
- Identify patients who need further specialised services including orthopaedic and re-constructive surgeries
- Preparation for two surgical camps
- Discharge process documentation

**HI 6: Harmonised assessment, referral forms, and referral pathways in place:**

- Continue data entry and analysis
- Finalise referral pathways and explore sustainability
- Conduct meetings with referral centres to discuss referral criteria, the available provision of services, a focal person at both the centre and the district, and the referral form

**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.**

- Patients and care givers will be continuously trained and sensitised on the benefits of rehabilitation to ensure proper follow-up and referrals.
- IEC materials will be disseminated and essential patient education will be delivered.

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

- People with injuries, disabilities, and functional limitations will continuously receive rehabilitation support at district hospitals and be involved in community outreach activities in the coming quarter.

**HI: 9: MoHP's DRFU has taken over work from HI:**

- The DRFU is a newly established unit under the LCD. HI deployed an Admin and Log assistant to carry out project management, project related communications, and coordination support until the end of the project.
- Officials from the Curative Service Division, DRFU, and HI will participate in monitoring visits to PT units in the district hospitals.

### Challenges, Constraints, and Adjustments

- **The current fuel crisis** has slightly affected the smooth implementation of the project activities, particularly causing:
  - Delays in conducting district level trainings as per the planned schedule
  - Slight delays to the transfer of materials, PT equipment, and assistive devices to the districts
  - Difficulties concerning staff movement for outreach activities
  - Difficulties for patients who want to visit hospitals with limited and irregular transport in the districts

The above was mitigated through the internal contingency plan of HI.

- There is **high demand for the rehabilitation services** in the Kathmandu valley for people with injuries, functional limitations, and disabilities. However, there exists today only limited step-down facilities with limited resources such as no provision for ambulance services, no supported discharge, and a limited number of beds. This is because most of the step down facilities were closed after the earthquake. Rehabilitation is not a one-time service, it requires continuous follow ups and patients need to stay for at least a few days after their accident to make use of rehabilitation services.
- PT units at district hospitals have been facing similar challenges for patients coming from remote areas. The district hospitals do not have accommodation facilities for these patients and some patients are from very poor families requiring support for food and transportation too.

## Annex 1: 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 | ☐ | ☐ | ☐ |
| Dyspnoea | ☐ | ☐ | ☐ |
| 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 | ☐ | ☐ | ☐ |

## Annex 2: Quality Rehabilitation Care at District Level: A Step to Regain Mobility for Injured People

"I feel far better now compared to before" says Ram Bahadur KC, 56, of Jiri in Dolakha district. KC is a retired soldier of middle class economic status. He is the breadwinner for his family of eight. He is engaged in farming to earn a living while his son, who is serving in the Nepalese Army, also partly contributes to family expenses.

Life was stable for KC until the 24th November, 2015, when he sustained an injury during a fall at his farm. It took his family 12 hours to take him to Jiri hospital due to the remoteness of the terrain. The X-ray taken immediately upon his arrival at the hospital revealed a complex pelvic fracture. It was a challenging case for the medical and rehabilitation team at the hospital.

The medical doctor-general practitioner (MDGP), Handicap International (HI) other medical staff decided to immediately manage the case, despite the lack of the traction kit equipment usually applied to keep the bone in alignment to promote the fracture healing. The physiotherapist was able to make a traction kit with locally available materials such as cardboard and ropes to best fit KC's need. Following this, he was instructed to follow that treatment for almost two months.

Facilitating KC to remain lying continuously in the same position for almost two months was challenging for the medical and rehabilitation team because there is a high chance of developing stiffness in other joints Therefore, he was given extra care through the provision of adequate bed exercises and an anti-pressure sore mattress. Through this treatment, the likelihood of developing pressure ulcers was reduced. KC was taught how to stand and walk on different surfaces with the help of assistive devices such as crutches and parallel bars. The physiotherapists also trained him on how he could safely resume farming and other household chores. Gradually, KC started walking independently and carrying out his daily activities comfortably, without any support.

KC believes that the follow-up rehabilitation is crucial for him to further improve. Because of this, he always arrives on time for the follow-up physiotherapy sessions. Now, he has resumed his previous livelihood work of farming and is engaging in household activities again.

KC represents many other Nepali people who sustain a domestic accident, develop complications, and die unfortunately due to the unavailability of timely and comprehensive health care. Thanks are due to the team work at Jiri Hospital including the physiotherapist, who improvised locally available materials to design the device to stabilise KC's fracture, trained him on assistive devices, and delivered physiotherapy care that prevented complications and restored KC's mobility and participation.

## Annex 3: Rasuwa Bus Accident

**"Had there been no PT service, the patients would have suffered from pain and be bound by medicines, deprived of rehabilitation services that would have led to their suffering from other associated complications, and could have caused disability in major numbers even for those who only had minor injuries," Anu Bhatta , HI physiotherapist engaged in accident response activity.**

### 1. CONTEXT

**Handicap International (HI)** is an independent and impartial aid organisation working in situations of poverty, exclusion, conflict, and disaster. HI has been present in more than 60

countries, including Nepal, since 2000. HI works alongside people with disabilities and vulnerable populations, taking action and bearing witness in order to respond to their essential needs, improve their living conditions, and promote respect for their dignity and fundamental rights.

**The Role of HI in Nuwakot**

Nuwakot is one of the 11 most affected districts following the recent earthquake in Nepal. HI was extensively engaged in the rehabilitation response and relief activities after the earthquake. In the current recovery phase, HI, in partnership with the ministry of health, is running a physiotherapy unit within the district hospital in Nuwakot to support the long term rehabilitation of injured survivors. Even though the primary aim is to support the rehabilitation of injured survivors of the earthquake, the physiotherapy unit also supports the rehabilitations of all patients who need it, irrespective of the causes.

At present, the physiotherapy unit functions within the framework of district level health system. The human resources engaged are one physiotherapist and two social workers supported by HI. Social workers are responsible for supporting the inclusion of the beneficiaries by linking them to available opportunities. In addition to this, social workers are also responsible for facilitating collaborations with district level state and non-state actors to ensure the best and coordinated delivery of rehabilitation services.

## 2. INCIDENT REPORT

A tragic road traffic accident took place in Ramche-3, Rasuwa, approximately 20 miles north of Kathmandu, on the 3rd November 2015 (Tuesday) while it was heading towards Rasuwa from the capital along the Pasang Lhamu highway. The passenger bus (Na 3 Kha 5706) skidded 200 meters down the hilly road around 12.30 p.m., carrying over 70 passengers.

The overcrowded bus met with the accident after its front tire was punctured. The puncture is considered to be the accident's specific cause. However, there were other factors that also led to the puncture such as carelessness regarding passenger safety, the fact that many of the passengers did not want to miss out the ongoing festival with their families causing overcrowding, the unavailability of buses due to the scarcity of fuel and, perhaps most importantly, traveling along a very rough graveled road (according to the information provided by the government officials).

Nepalese military troops, police officers, and locals carried out a rescue operation after the accident. Among the total passengers, approximately 51 were counted injured. Out of these passengers, 37 were brought to Trishuli District Hospital, Nuwakot, where three of them were pronounced dead on arrival. Twenty of the injured were referred to a tertiary hospital in Kathmandu. Six were admitted and seven were discharged at a later date. One child lost her life during the course of treatment there. The casualties were in the age group of six months to 63 years old. Most of the injured passengers belonged to the age group of 20 to 30 years old. Thirty of the passengers died on the spot and six more were pronounced dead during the course of treatment, leading to a total death toll of 36.

The rest of the remaining passengers were taken to Dhunche District Hospital, Rasuwa, and several other hospitals in Kathmandu for treatment.

## 3. MECHANISM OF ACTION

Regarding the incident, HI staff were first informed by the hospital supervisor to be prepared to respond and also by a police officer who works inside the premises of the hospital.

As soon as the causalities arrived, the physiotherapist along with other duty health workers organised the appropriate trauma management without creating a chaotic situation. Additional help was also called on from the staff who had a day off on that day. The physical obstacles around the hospital were cleared so as to create adequate space for the patient's examination on the ground. Also, a few mattresses supported by HI were placed around to give as much space as possible so as to run the treatment process in a calm and managed way. The PT unit supported the safe transfer and stabilisation of the survivors then started assessing the need for assistive devices. They also provided psychological First Aid (PFA) to those who needed it. In addition to this, the PT unit provided non-clinical support and helped the doctors and nurses by transferring medicines and dressing materials, connected the wounded persons with their relatives, and gave information about their condition and whereabouts (DVFP).

There was lack of human resources, as the number of patients was increasing every 15 minutes and so the need for medical management was exponentially rising. This caused a somewhat chaotic situation for responders at the beginning. Moreover, limited resources such as stretchers, bandages, lumbar belts, and cryotherapy created another barrier to support the comprehensive management of the patients in their acute stage of the injury.

In addition to the above mentioned complications, a crowd of local people gathered and this created a hindrance during the transport of the patients and affected the movement of the health workers. The Chief District Officer (CDO), Mr. Shivaram Gelal, was present and coordinated and monitored the transportation, situation management, and referral of the patients. A briefing of the support provided by HI was given to the District Health Officer (DHO) of Nuwakot, Mr. Bishowram Shrestha.

## 4. REFLECTIONS

Despite the presence of a medical team, there was a gap in creating well-organised system for managing the response to the accident. Also, some of the critical cases who were brought to Nuwakot could have been saved, had they been taken to the capital on time. This showed a weakness in conducting triage both in the field (accident site) and in the hospital. Through reviewing the severity of the patients' injuries and also due to the limits of the services provided in the district hospital, patients were referred to the tertiary hospitals. Approximately 20 patients were taken to Kathmandu on the same day and the following day one more patient was referred for treatment. That makes a total of 21 patients. Out of the 21 survivors, 20 of then require long term rehabilitation services as the majority of cases were head injuries, and a few had multiple injuries. For these patients to be tracked down for long term rehabilitation, the police authority of Rasuwa can be contacted.

Based on this experience, it is clear that a physiotherapy service is necessary from the moment any incident like this happens rather than after the situation has normalised. There were demands for assistive devices such as braces, bandages, and wheelchairs but there were not enough of them in stock. Due to this, we had to use local resources and modify them to work as well as possible.

Had there been no PT service, the patients would have suffered from pain and be bound by medicines, deprived of rehabilitation services that would have led to suffering from other associated complications, and could have caused disability in major numbers even for those who only had minor injuries.

In situations such as this, especially when a message is received about such accidents, the hospital management and the medical superintendent need to collaborate and plan a well-organised management strategy. There needs to be an incident commander who can direct staff to carry out the necessary procedures. All of the medical team need to be on standby, should be well versed on the rules, and have explained properly and in detail to the team who exactly will be working. The medical recorder needs to write in detail so as to track the patients for future treatment, taking help from the locals and the police officers on duty. The emergency department always needs to be well equipped and the hospital or physiotherapy department has to have assistive devices that are most likely to be used in case of an emergency. Last but not the least, there should be a properly defined care pathway with a division of roles and responsibilities.

## Appendix 2: Spinal Injury Rehabilitation Centre (SIRC)

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

### 2.1 SIRC 1: Finalised and Approved Workplan

The detailed workplan for the programme was prepared in November, approved in December and is now operational. Submission of the work plan occured within four weeks of the initially projected date.

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

The role played by family members in providing a continuum of care for patients, particularly in remote areas, is vital for successful case outcomes. The report on SIRC's comprehensive carers' training programme was submitted in November, within four weeks of the initially projected date, and approved in December. This programme helps carers gain the knowledge, skills and confidence needed to support and manage the rehabilitation of patients under their care.

As planned, feedback from the training was used to update the patient self-care manual.

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

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

Individual needs assessment for each patient have been completed to support individual goal setting. The report of the needs assessment is planned for NHSSP for review in February 2016, one month following the initially projected date.

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

Hands on practical spinal cord injury (SCI) training for 60 hospital staff including doctors, nurses, counselors and therapists from 5 district hospitals was completed in Ramechhap and Lalitpur districts. This initiative was carried out in collaboration with MoH's Disability Unit, HI and other

stakeholder organisations. Similarly, comprehensive training on "basic principles of neuro-rehabilitation" for 50 nurses from five focal districts was completed. The training report was initially submitted in November 2015 and will be resubmitted in February once additional information on collaborative efforts with HI and the resulting efficiencies has been added.

Both courses aim to support the development of systems of care for SCI patients in district hospitals and referral pathways to specialized hospitals and rehabilitation centers. To this end SIRC collaborated with HI to design the national level training programme, syllabus and training manual and materials through a dedicated training working group under MoH's Injury and Rehabilitation Sub-cluster. Four SIRC staff supported district level implementation serving as master trainers following their participation in a master training of trainers (MTOT) course organized by HI. A senior SIRC nursing officer was also engaged as a district trainer under the programmes conducted by HI.

Collaboration with HI and others has resulted in health professionals from several district hospitals being trained in injury management at the local level and in referral procedures and pathways to specialised centres.

### 2.5 SIRC 5: Caretakers program for 100 caretakers

The caretaker programme aims to train caregivers on complications, their prevention and the management of spinal cord injuries while supporting SCI patients at home and in the community. By the end of the reporting period, 73 out of a target of 100 caretakers had been trained. The associated payment deliverable (training report) is on track for submission to NHSSP in May 2016.

Delivery of the training is carried out by a multi-disciplinary training team comprising doctors, nurses, physiotherapists, occupational therapists, psychologists, social workers, speech therapists, nutritionists and wheelchair service technicians. This team provides holistic knowledge on essential care for caretakers for three hours a day over a four day period. The training content includes:

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

The training sessions are interactive and materials used include power point presentations, videos and practical demonstrations. Based on feedback received from the first two batches additional content on diet and nutrition was added for the third batch training. In support of this training, we are providing a training manual "Kehi jankari Kehi sip" to the participants.

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

In the last reporting period, SIRC employed 5 community based rehabilitation (CBR) out-reach workers for Sindhuli, Nuwakot, Kavre, Gorkha and Ramechhap districts. Following training and coordination with the respective DHOs and community workers, the CBR workers are now undertaking home visits carrying essential items such as urinary catheters, dressing kits, and various medications. Each CBR worker is responsible for a district and required to follow up at least 15 patients per month. To date, 75 visits have taken place.

During these visits CBR workers, with consent, complete a home visit follow up form and take photos of each patient. The report includes detailed information on the patient's health and economic condition.

The CBR workers have the knowledge of basic therapy and management of complications such as dressing, clean intermittent catheterization, etc. Consultations with SIRCs MDT teams also take place as required and patients are referred to SIRC as needed. This means that if a patient has a major complication or requires therapy or another health service, they will contact SIRC's social service department or other service providers in the district such as HI rehabilitation points, local district hospitals, or other hospitals in the Kathmandu Valley.

Once the 200 CBR evaluation forms have been analyzed, the effectiveness and needs of CBR workers in delivering outreach support will be known together with related problems such as the frequency of post-discharge complications. This information will help SIRC refine its rehab programme and strengthen the evidence base around CBR effectiveness in Nepal.

## 2.7 Constraints and Challenges

**Fuel and Transportation**: Even though the fuel situation is beginning to ease, there are only a few vehicles operating in the earthquake affected districts of Nuwakot, Dhading, Gorkha and Dolakha. As a result, CBR workers are finding it difficult to access transportation in order to make follow up home visits. Many are therefore walking and, as a result, it is taking a longer to make these visits, so fewer visits can be made in the time available. Until this problem is solved, CBR workers are tending to continue to focus on patients living closer to major population centres.

**Supporting Resettlement Communities**: In order to better access those requiring services, there is a need to work more closely with agencies supporting resettlement activities. Accordingly we are aiming to collaborate with such organisations or work directly with patients and families living in temporary shelters. For those living in temporary shelters, either independently or supported by an agency, we will seek to provide them with physical and psychological support and to identify problems early since their associate risk of complications is higher than those permanently settled.

**Recommendations for NHSS (2015-20):**

1. Support from government for specialized centers such as SIRC in places where government facilities are not available.
2. Expand rehabilitation services to districts through public-private partnership with specialised organizations and local agencies able to set up and manage effective rehab units.
3. Work on policies related to the set up and management of rehabilitation services at different levels in order to efficiently provide and maintain the quality of care for patients.

Planned work stream activities to be taken forward in the coming quarter include:

**SIRC 7: Referral system established between community and HI district rehabilitation points**

- A referral activity/pathway will be created between the local community, other organizations, HI and SIRC to support the reintegration process of people with SCIs returning to the community post discharge. There will be a recording system of referral pathways.
- During follow up activities, any cases identified other than spinal cord injuries will be referred to HI/ other available health services.

**SIRC 8: 30 female/male patients will have received comprehensive vocational training package and seed fund to support the commencement of income generation activity:**

- Train patients to stitch/sew clothes.
- Provide a sewing package which includes sewing machine, accessories related to sewing (scissors, thread, oil, and needles), table, cupboard, iron and clothes to be stitched. It is believed that this will motivate patients to start a business on their own as soon as they go home.
- Document capacity development through the measurement of 'knowledge', 'skill' and 'confidence' (start and end) in the provision of a vocational training program to 30 female /male patients in SIRC in preparation for independence through income generation by providing tailoring/sewing services to the community. Rehabilitation services, specifically the management of SCI conditions.
- Develop ways for SIRC staff/CBR workers to assess the trained patients' capacity to generate income as a result of the training.
- Collect feedback from community customers availing of tailoring/sewing services provided by the SCI patient.
- Document lessons learned for facilitators of training in order to arrive at an optimal service design for vocational training for female and male SCI patients that offer viable methods of income generation in their community.

**SIRC 9:** 130 people will have received in patient services at SIRC with assessment of functional improvements, psychological acceptance, and management of complications.

- Completion of SCI specific outcome measures recorded through ASIA scores and Spinal Cord Injury Measurement (SCIM), alongside other clinically relevant tests that document medial and post-acute interventions used during rehabilitation to support functional improvements, psychological assessments and reductions in complications.
- Sharing of assessment information with the rehabilitation multi-disciplinary team to plan and agree an individualized care pathway for each patient.
- Review of ASIA and SCIM measurements to inform revision of care plans and agree actions within the multi-disciplinary team.
- Recording of all assessments and related actions in the SIRC database at an individual level using patient identifiers.
- Review of patient outcome measures such as prevalence of urinary tract infections and pressure ulcers and provision of evidence based practice to reduce these risks.
- At the end of this activity, a session will be conducted at SIRC to get the learning feedback from staff regarding improvement required in rehab practices and patient responsiveness to treatment.
- Receiving information from the patient on discharge about different services at SIRC and how it can be improved?

- Implementation of learning in ongoing practice across the multidisciplinary team and incorporation in departmental plans and strategic plans. This will be reviewed on quarterly basis.
- Learning supported and monitoring by key SIRC personnel in management and supervisory positions.

**SIRC 10: 200 ex patients of SIRC living in affected districts have received follow up home visit services support.**

- 5 communities out-reach workers (Community Based Rehabilitation - CBR) for the project will be based in 14 affected regions.
- Conduct home visits; provide specialized training and education and provision of essentials such as urinary catheters and consumables.
- Organize referrals and sign-post people with SCI to other relevant services.
- SIRC's home visits will be complemented through a telephonic follow-up, advisory and information service.
- Completion of CBR workers comprehensive evaluation assessment capturing information on the physical, emotional and social wellbeing of ex patients including economic/vocational assessments.
- Document lessons learned for CBR workers in order to arrive at an evidenced based model of CBR services provided by SIRC.

**SIRC 11: Hand over report of work by SIRC to MoHP Disability and Rehabilitation Focal Unit (DRFU)**

- Provide a comprehensive technical report using all Monitoring and Evaluation (M&E) data gathered during the 1 year project to assess outcomes against targets.
- A report covering all the activities carried out including the experiences and achievements will be submitted to MoHP Disability and Rehabilitation Focal Unit (DRFU).
- Assessment of outcomes against targets.
- Proposition of model of implementation based on evidence gathered during the 1 year project.
- Lessons Learned drawn out of M&E evidence from all stakeholders and data types relating to project activities.
- Develop a model of implementation from lessons learned that point to the active ingredients, drivers and facilitators in SCI rehabilitation in post-earthquake Nepal.

## Appendix 3: Transcultural Psychosocial Organisation (TPO)

Transcultural Psychosocial Organisation's (TPO's) key activities in the reporting period included hiring project staff, finalizing the training curriculum for non-prescribers (community psychosocial workers (CPSWs) and female community health volunteers (FCHVs)) and building the capacity of CPSWs. In addition mental health services in the primary health care facilities were begun.

Further details on these activities are provided below.

### 3.1 TPO 1: Work Plan

TPOs work plan was submitted in November and approved in December 2015.

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

The globally recognized mhGAP-HIG is the key intervention guide used on the programme. The guide has been translated into Nepali and contextualised based on experiences with PRIME with a section on post-traumatic stress disorder (PTSD) added. The Nepali version of the mhGAP-HIG and related training materials were submitted in November and approved in December 2015.

### 3.3 TPO 3: 120 (60 in each district) Prescribers Trained on mhGAP

As noted, the capacity building of primary health care (PHC) workers on mhGAP HIG and basic psychosocial support is a central project activity. In the reporting period, three batches of prescriber training were carried out in Ramechhap (73 prescribers) and two in Dolakha (47 prescribers). The HSTRP target of 120 prescribers trained has therefore been met.

Each course ran for 8-days and was conducted by clinical supervisors and psychiatrists. Participants included medical officers, health assistants and community medical assistants. A number of patients suffering with mental health issues were also invited to the training to help participants assess and manage mental health problems. A pre- and post- evaluation of participants' knowledge, attitudes and behavior was conducted in order to assess the impact of, and subsequently improve, training. The training report is due for submission in February.

### 3.4 TPO 4: 120 Non-prescribers (60 in each district) are Trained on Psychosocial Support

Four batches of non-prescribers (e.g. staff nurses and auxiliary nurse mid-wives) training (two in Ramechhap (62 participants) and two in Dolakha (44 participants to date) were carried out on mental health and psychosocial care and support'.

This 3-day curriculum was conducted by a clinical supervisor and psychosocial counselors with several patients suffering from mental health concerns also invited to help participate assess and manage mental health issues.

Pre- and post-learning assessments were conducted to evaluate training effectiveness and the psychosocial competencies of participants. The report on the training of non-prescribers is due for submission in February 2016.

### 3.5 Recruitment and Training of Community Psychosocial Worker (CPSWs)

During the reporting period, 52 community members (26 from Ramechhap; 20 from Dolakha and 6 from Nuwakot) were trained as CPSWs. These workers will be responsible for carrying out community sensitization activities, identifying villagers suffering from mental health issues, providing basic psychosocial support, supervising FCHVs and referring complicated cases to health facilities and/or counselors for further treatment.

Participants were selected from various VDCs in collaboration with local Women and Children Offices (WCO), District Health Offices (DHO) and organisations working in the mental health and psychosocial support services (MHPSS) field in the respective districts. Training was carried out in both Ramechhap and Dolakha by clinical supervisors and psychosocial counselors.

Once trained, the newly trained CPSWs were mobilized in communities and many have now initiated community level activities. Several CPSWs also received 2 days trainer of trainers (ToT) training on the Community Informant Detection Tool (CIDT) and are facilitating CIDT training for FCHVs.

### 3.6 Procurement of Psychotropic Medicines

TPO Nepal is working in collaboration with MoH, LMD and the respective District Health Offices (DHO) for the procurement and supply of drugs to district level health facilities. In this quarter, approval to procure was received from MoH and psychotropic drugs were included in the government's free drugs list. Medicines such as Amitriptyline, Chlorpromazine, Phenobarbitone, and Diazepam were also supplied to district level health facilities.

Since the exact number of patients needing psychotropic medicines was not known from the outset, we procured only a limited quantity of medicines in the first phase. We are now preparing a second round of procurement based on known client flows in health facilities.

The procurement process followed involved DHOs collecting quotations from different suppliers following which bids were compared and one vendor selected. TPO Nepal's district level staff were involved in the entire process including during requesting quotations, awarding of contracts and payments.

In order to ensure the quality of supply, the medicines were checked by TPO Nepal's psychiatrists and payment was only made following a review of drug stocks, review of the original receipts and comparison with market prices.

### 3.7 Supervision of the Health Workers Initiated

Regular supervision and mentoring is important to assure the quality of services provided and build the capacity of health workers to correctly diagnose and manage cases. Accordingly the monthly supervision of prescribers was initiated in the reporting period. Psychiatric case supervision was carried out once in Ramechhap where 34 prescribers participated. Here supervision checklists and implementation modality were developed, monthly case conferences involving all prescribers initiated. Health workers shared their experiences and difficulties in detecting and managing mental health cases and psychiatrists clarified key points, provided additional knowledge and skills training during supervision sessions. 6 cases were discussed during supervision with the psychiatrists providing specialized care for each.

### 3.8 Services Initiated in both Health Facilities and Communities

Following health worker training and the procurement of drugs, mental health and psychosocial services were initiated at both health facility and community level. Below is the list of activities conducted under this milestone.

- Counselors and CPSWs are trained and mobilized in all four districts
- PHC workers initiated service delivery in most health facilities
- 36 cases received counseling services from psychosocial counselors
- 484 people received basic psychosocial service support from CPSWs
- 234 key community people participated in the community orientation program
- 17 people with mental health issues received services from psychiatrists

### 3.9 Coordination with Partner Organizations and other Concerned Stakeholders

Several meetings were held with MoHP, PHCRD, LMD and respective DHOs and other district level stakeholders in the reporting period as follows:

- District level orientation for key district stakeholders in Dolakha and also in Nuwakot
- Discussions with the DHOs of Nuwakot and Kavre on the project modality and role of DHOs and district hospitals for effective project implementation
- Discussions with Dhulikhel hospital team to establish a referral mechanism for specialized mental health cases and with the Mental Hospital Lagankhel about their monthly mobile clinic in Nuwakot and the mechanism used to refer cases for psychiatric care

### 3.10 Constraints, Challenges and Risks

- Continuing difficulties experienced travelling to project districts and initiating project activities as a result of the blockade.
- Recent increases in the daily supplement allowance (DSA) in government system have had a large impact on our programme budget
- The unrealistic expectations of DHOs and health workers i.e. for the training for all health workers and FCHVs in the district. The budget is insufficient for this.
- If the current fuel crisis continues, the regular supervision of health workers and conducting of training programmes will be difficult.
- Any delays in payment will have a large impact on the implementation of project activities
- More human resources are needed than originally planned due to the ongoing crisis and this is also impacting on budget.