Health Sector Transition and Recovery Programme

Final Report with Recommendations for the Disability and Rehabilitation Focal Unit (DRFU)

Handicap International Payment Deliverable 9

September 2016

HANDICAP INTERNATIONAL

NHSSP

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This document addresses the requirements of Handicap International's (HI's) Payment Deliverable 9 under the Health Sector Transition and Recovery Programme (Nepal):

'Submission of report with recommendations on work carried out to Ministry of Health (MoH) Disability and Rehabilitation Focal Unit (DRFU)'.

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List of Acronyms

CBR	Community Based Rehabilitation
DDC	District Development Committee
DFID	Department for International Development
DoHS	Department of Health Services
DHO	District Health Office
DPHO	District Public Health Office
DPO	Disabled People's Organisation
DRFU	Disability and Rehabilitation Focal Unit
DTLO	District TB and Leprosy Officer
FCHV	Female Health Care Volunteers
HEOC	Health Emergency Operation Centre
HFOMC	Health Facility Operation and Management Committee
HI	Handicap International
HMIS	Health Management Information System
HP	Health Post
HSSP	Health System Strengthening Project
IRSC	Injury and Rehabilitation Sub Cluster
LCD	Leprosy Control Division
MoH	Ministry of Health
NHSSP	Nepal Health Sector Support Programme
OCMC	One-stop Crisis Management Centres
PHCC	Primary Health Care Centre
PT	Physiotherapist
SOP	Standard Operating Procedures
SW	Social Worker
VDC	Village Development Committee
WCDO	Women and Children Development Office
WHO	World Health Organization

1. Background

The 7.8 magnitude earthquake that hit Nepal on the 25th April 2015 and the multiple after-shocks that followed claimed more than 9,000 lives, left more than 23,000 people injured, and destroyed over half a million homes[1]. Fourteen districts were identified as those most severely affected. Based on initial information from the Health Emergency Operation Centre (HEOC) and sample data from hospitals and international organisations, it was estimated that between 1,500 and 2,000 people would need on-going nursing and rehabilitation support and will continue to require long-term rehabilitation services.

Given the high number of survivors with earthquake-related injuries, the newly established Disability and Rehabilitation Focal Unit (DRFU) at the Leprosy Control Division (LCD) within the Department of Health Services (DoHS), Ministry of Health (MoH) was given the responsibility to lead the activities of the sector's Injury and Rehabilitation Sub-Cluster (IRSC). This decision was taken to address specific needs identified in the early earthquake response period and to advance policy development to fill gaps in rehabilitation services within Nepal's health system.

Among actions identified in DRFU's medium term plan, the decentralisation of rehabilitation services to the worst-affected districts is seen as a priority to ensure a continuum of care and address the long-term follow-up needs for earthquake injured and affected people. The establishment of seven physiotherapy/ rehabilitation units by Handicap International (HI) was included under the "Rehabilitation Support Service in Earthquake Affected Districts", in coordination with DRFU with financial support from DFID. Accordingly, seven units were set up in Rasuwa, Nuwakot, Dhading, Sindhupalchowk, Dolakha (Charikot and Jiri), and in the Kathmandu valley (Lalitpur, Bhaktapur, and Kathmandu).

Since July 2015 these units, located in the district hospitals, have been providing physiotherapy/ rehabilitation services with a focus on identification, rehabilitation, and follow-up of clients with injuries, functional limitations and disabilities. Key activities included supporting referrals and discharge services, providing assistive devices, orienting caregivers, and referring patients to specialised services including social services.

The project anticipated that by project end, follow-up services for patients requiring long-term rehabilitation, including community-based and specialised services in the Kathmandu valley and districts, will have been strengthened.

[1] The PDNA Report, Planning Commission, Government of Nepal, 2015

2. Achievements vs. Targets for Rehabilitation Service Support

Achievements against payment deliverable targets, assessed using a traffic light scoring system (Green = achieved; Amber = partially achieved; Red = not achieved), are as follows:

SN	Deliverables	Target	Achievement
1	Develop, finalise, and gain approval for a Health Sector Transition and Recovery Programme (HSTRP) work plan	1	1
2	Fourteen district level trainings on injury management provided to 280 health professionals	280	412
3	Fourteen Social Workers (SWs) trained on comprehensive assessments of needs of the injured and mobilised in health facilities, step-down facilities, one stop crisis management centres (OCMCs) and during outreach in communities	14	14
4	Seven health facilities are equipped with rehabilitation and physiotherapy supplies and have functional physiotherapy units continuously providing rehab care to people with injuries/functional limitations	7	7
5	Four hospitals (district hospitals/PHCCs of Nuwakot, Sindupalchowk, Rasuwa, and Dolakha districts) engage in the proper discharge of injured clients and proper referral to health and or social/ community services.	4	7 Units in Nuwakot, Sindupalchowk, Rasuwa, and Dolakha District Hospital, Charikot PHCCs and National Trauma Centre, Kathmandu and Dhading
6	Harmonised assessment, referral forms, and referral pathways in place	1	1
7	One thousand six hundred patients and caregivers (including 600 caregivers) are trained on proper care and sensitised on the benefits of rehabilitation to ensure proper follow up and referral	1000 patients 600 caregivers	4428 patients 1428 caregivers
8	One thousand persons with injuries and persons with functional limitations affected by the earthquake have received rehabilitation support at hospital and continue to receive support at hospital	1,000 persons	1,127 Earthquake injured received rehabilitation support
9	Submission of report with recommendations on work carried out to MoH, Disability and Rehabilitation Focal Unit (DRFU)	1 report	This report

In summary, all payment deliverables were satisfied and, in several cases, exceeded.

3. Other Achievements Related to Health System Strengthening for Managing Injury/ Rehabilitation Linked with Health Sector Emergencies

3.1. Leadership and governance

3.1.1. National level: DRFU/ LCD, DoHS, MoH

At national level, the DRFU/LCD has led overall support for planning, coordination, and monitoring for effective implementation of the project and has coordinated district level trainings on injury/ trauma management and the set-up of the physiotherapy/rehabilitation units to deliver quality rehabilitation services. The DRFU also advocated with various MoH departments to integrate the physiotherapy/rehabilitation units within the government health system in order to address the rehabilitation needs of both earthquake-affected and non-earthquake affected people in target districts into the future.

3.1.2. District level: DHO/DPHO and District Hospital Development Board

At district level, the DHO/DPHO and district hospital development boards played a central role in establishing the seven physiotherapy/rehabilitation units and supporting the delivery of quality services. They also facilitated coordination with district stakeholders (District Development Committees (DDCs), Women and Children Development Offices (WCDOs), Municipality Offices, and local NGOs, etc.) for the integration/delivery of livelihood and social protection services alongside physiotherapy and rehabilitation services. The physiotherapy/rehabilitation units became an important part of the local health system and concerned line agencies were lobbied to support their continuation into the future.

3.1.3. Community level outreach services conducted at PHCCs, HPs, DPOs, and VDCs

At community level, social workers based in district hospitals coordinated with primary health care centres (PHCCs), health posts (HPs), Disabled Peoples Organisations (DPOs), and Village Development Committees (VDCs) for the identification of patients injured in the earthquake and referred them to the physiotherapy/rehabilitation units at district level. They also helped raise awareness among community members of the importance of physiotherapy and rehabilitation services and the social protection needs of people with injuries, functional limitations and disabilities. In addition, physiotherapists and social workers participated in integrated health camps organised by DHOs/DPHOs and provided rehabilitation services to clients from remote areas.

3.2. Service Delivery: Both Hospital and Community Based Physiotherapy

A total of 1,127 persons (F: 670, M: 455) with earthquake related injuries were among a total of 4,617 persons (F: 2,475; M: 2,142) provided with rehabilitation services at the seven physiotherapy/rehabilitation units based at the health facilities and through community outreach visits. The project was able to provide rehabilitation services to a larger number of clients in addition to the 1,000 clients initially proposed with earthquake related injuries. This was because, as the major portion of the budget was for therapeutic equipment, setting-up the PT/rehabilitation units, human resource costs, and outreach activities to identify earthquake affected clients, the project was also able to

address unmet needs of earthquake affected, as opposed to earthquake injured, clients from the same investment.

Gender	Earthquake Injured		Non Earthquake Injured		Total clients	
	Number	Percentage	Number	Percentage	Number	Percentage
Female	670	59.50%	1,805	51.72%	2,475	53.60%
Male	457	40.50%	1,685	48.28%	2,142	46.40%
Total	1,127	100%	3,490	100%	4,617	100%

A total of 746 earthquake-injured clients among a total of 1,597 clients received rehabilitation services at community level through community outreach and home visits and 381 earthquake-injured clients out of a total of 3,020 clients received rehabilitation services at hospital level. 7,195 treatment sessions were conducted for clients including 1,857 sessions in the community and 5,338 sessions at the hospital. Follow-up sessions totalled 2,578 including 260 in the community and 2,318 at health facilities. Data showed higher numbers of earthquake injured persons treated in communities due to local priority being given to identifying them during outreach activities. Their access to hospital based services tended to be limited however due to several barriers including embargo-related transportation difficulties, associated costs and shortages of travel companions. The earthquake injured tended to seek and travel for facility level care only when their conditions had become particularly acute.

Indicators	Community		Hospital		Total
	Number	Percentage	Number	Percentage	
Earthquake Injured clients	746	66.2%	381	33.8%	1127
Rehabilitation service delivered	1597	34.6%	3020	65.4%	4617
Follow up sessions delivered	260	10.1%	2318	89.9%	2578
Treatment sessions conducted	1857	25.8%	5338	74.2%	7195

Further analysis of data shows:

- A total of 4,428 (F: 2,379, M: 2,049) patients (including 1090 earthquake affected) were provided with individual patient education on self-care and the benefits of rehabilitation.
- Of the total clients, 54% were female and 46% were male.
- 1,428 caregivers (F: 644, M: 784), including 443 caregivers of earthquake survivors (F: 205, M: 238), were provided with individual orientation on patient care, the benefits of rehabilitation to ensure proper follow up, and referrals using the patient/caregiver education checklist.
- Of the total clients receiving rehabilitation services (4,617), 167 were discharged, 38 of whom were earthquake injured.

The majority of the remaining clients are still receiving follow-up services but many have stopped coming to the physiotherapy/rehabilitation units and are not included in discharge data. This accounts for the low number of discharges reported above.

The high number of non-earthquake injured patients seen at the units indicates that the units are addressing wider unmet needs for rehabilitation services in districts. However, there are still many

barriers limiting access to rehabilitation services for earthquake affected clients. Poverty is the main barrier to accessing rehabilitation services for 47% of clients followed by unavailability of a caregiver (39 %). The table below provides an overview of these barriers:

Reported Barriers to Accessing Rehabilitation Services	Percentage
Poverty	47%
Unavailability of caregiver	39%
Others	8%
Family not supportive	4%
Stigma	1%
Gender discrimination	1%
Total	**100%**

3.2.1 Quality assurance of rehabilitation services at district level

With reference to the World Health Organization's (WHO's) Quality Care Guide and HI's Rehabilitation Management System, indictors for quality standards have been defined for the quality assurance process. The monitoring and review of quality assurance is currently carried out with the support of HI senior staff in close collaboration with the DRFU/ LCD and the DHO/ DPHO.

In order to ensure long-term quality control the following steps are recommended:

- physiotherapists should be included in existing district level quality assurance committees. These committees should identify priority quality domains (see table below) and set appropriate indicators.
- at the central level (MoH) representatives of the LCD should be included in the existing quality assurance steering committee. The LCD should be supported by non-state organisations with technical expertise related to rehabilitation service standards and quality assurance.

The following framework is proposed:

Area	Description/Standards	Major methods
User focused/ patient-centred	• Timely delivery of services (including strategies to reduce waiting times if any) • Appropriate follow up services • Holistic services • Engage patient and family members in decision making • Client patients actively participate in the rehabilitation process (decision-making process) • Patients receive all useful information in order to make an informed choice	• Reduce waiting times, engage clients and family members through the use of Information and Education Communication (IEC) materials • Conduct severity based follow ups • Doctor, nurse, paramedic and physiotherapist involvement in decision making • Try to use Nepali or the local dialect if possible • Provide rehabilitation care that takes into account the preferences and aspirations of individual service users and the cultures of their communities • Client centred goal setting • Utilise user feedback to improvise service delivery procedures • Provide information related rehabilitation services and available social security schemes in an understandable way • Consider client safety, dignity, and privacy • Client satisfaction through set questionnaires
Clinical governance	• Suitability qualified staff • Clinical audit • Promote evidence - based practice	• Entry level qualifications defined by Nepal Health Professional Council, continuing professional development in line with Nepal health professional council mandates • Senior physiotherapy staff, joint monitoring with district level Quality Assurance Committee • Continuous professional development, participation and support for training and conference attendance
Evidence based practice	• The integration of clinical expertise, patient values, and the best research evidence into the decision making process for client care	• Refer to the evidence based database in rehabilitation: Physiopedia, the Physiotherapy Evidence Based Database, the Journal of Physiotherapy, the Australian Physiotherapy Association • Technical guidelines developed by WHO-provision of manual wheelchairs in less resourced settings
Monitoring & Evaluation	• Periodic measurement and review of indicators set by the unit • Documentation of the impact	• Monthly meeting for planning and review indicator tracking • Case studies, good practices , baseline, and end line of the beneficiaries having access to rehabilitation services

Universal precaution of infection and safety	Delivering health care which minimises risks and does not harm service users	• Waste management of the physiotherapy/ rehabilitation unit • Ensure all therapeutic equipment is tested before being used • Conduct safe and ready to use checks before fitting the assistive device • Conduct proper user training that should include how to use assistive devices correctly and carry out minor repairs and maintenance • Teach the proper way of care-giving to family members • Do not place objects that risk falling from walls • Explain the exit routes and mechanisms to clients and family members in case of an emergency

3.3 Human Resources: Numbers and Types (PTs and SWs) and their Functions

Each physiotherapy/rehabilitation unit is staffed with one physiotherapist and two social workers. The major service provided is the physical rehabilitation. Accordingly, the physiotherapist is in charge of the unit and responsible for line managing the social workers.

The physiotherapist reports to the medical superintendent and DHO on clinical activities, data collection, and general working conditions. He/she also coordinates with the District TB and Leprosy Officer (DTLO) as the focal person for field activities and mobilisation of primary health care workers at PHCCs and HPs.

Physiotherapists and social workers are based at the district hospital. However, they also conduct community/home visits to identify patients with low mobility in need of direct community level follow-up. During home visits, they provide orientation on rehabilitation services, health and rehabilitation education, and home adaptations to clients and care-givers.

Responsibilities of Physiotherapists:

The designated responsibilities of physiotherapists are to:

- Undertake comprehensive examinations/assessments of clients and their needs
- Evaluate findings from examinations/assessments and make clinical judgments on the care required
- Make a diagnosis, set goals, and draw up a session plan together with each client
- Formulate a problem list and set goals in partnership with the client and other health care professionals involved in case management
- Provide consultations within their areas of expertise and determine when clients need to be referred to other healthcare professionals
- Implement a physical therapy intervention/treatment programme
- Determine the outcomes of any interventions/treatments

- Make referrals and appointments, assessments, prescriptions, and product preparations for specialised devices such as prostheses and orthoses; seek consultations with a prosthesis and orthotics specialist from the nearest rehabilitation centre(s)
- Direct line manage social workers and support their continuing professional development
- Record on written forms and computer; evaluate and report on the various activities conducted in the physiotherapy/rehabilitation units to the DHO and concerned district hospitals in close coordination with the DTLO, Statistics Officer, and Medical Recorder
- Represent various sub-clusters directly or indirectly related to rehabilitation in the various health clusters in the district
- Participate in health and rehabilitation related outreach activities organised by the DHO/DPHO including camps in close collaboration with disabled people's organisations (DPOs)
- Ensure that each client receives appropriate follow-up based on the severity of his/her condition
- Facilitate referrals of clients to specialised hospitals and rehabilitation centres as appropriate
- Carry out awareness raising and care giver orientation
- Carry out inventory management of physiotherapy and assistive devices
- Coordinate with all concerned stakeholders to improve access to and utilisation of health and rehabilitation services to meet the needs of those with injuries or functional limitations and disabilities

Responsibilities of Social Workers:

Social workers at physiotherapy/rehabilitation units cover the following:

- Identify injured people/earthquake survivors, vulnerable individuals and households at the hospital facility or physiotherapy/rehabilitation unit of the hospital through comprehensive assessments of needs including physical rehabilitation, reconstructive surgery, management of various injuries including spinal injury care services, prosthetics, orthotics, psycho-social care, and basic needs including nutrition
- Evaluate the socio-economic status of injured and traumatised persons, prioritise their needs, plan social protection provisions and facilitate approaches by concerned stakeholders for essential support
- Assess the psychosocial support/counselling needs of clients and make provisions including care takers being able to provide psychosocial first aid, and psychosocial support/ counselling
- Support physiotherapists/clinicians, hospital administration staff, patients and caregivers in preparing a supported discharge plan
- Record and manage all relevant information pertaining to patients and provide data to the concerned patients and relevant professionals as appropriate in support of patients' welfare.

3.4. Health Financing

The seven physiotherapy/rehabilitation units were functional in the respective earthquake affected districts until the 26th September 2016, with financial support from DFID. From the 26th September onwards, the physiotherapy/rehabilitation unit of the National Trauma Centre (NTC) will be phased out and all commodities handed over to the team of physiotherapists at NTC who were deployed during the project period. From October to December 2016, HI using its own financial resources will continue to support the remaining six units which will later be handed over to the respective DHOs/DPHOs and district hospitals.

In order to set up and run a physiotherapy unit for a year, the budget lines and minimum costs required are as follows:

SN	Description	Amount (NPR)
1	PT unit set up cost including establishment of PT unit*	15,00,000
2	HR (1 SW and 2 PTs)	18,00,000
3	PT and assistive devices (Consumables)	10,00,000
4	PT unit running cost (water, electricity, cleaning and office supplies)	150,000
5	Community/ home visits and outreach	150,000
6	Continuous professional development of health professionals	150,000
	Total	4,750,000

* Instalment cost included.

3.5. Health Information System

Physiotherapy assessment forms, social worker assessment forms, discharge forms, and follow up/ treatment forms were designed, pre-tested, and finalised to facilitate the collection of accurate information on clients and were taken into use at all seven units. These supported comprehensive needs assessments of the injured for goal setting, rehabilitation interventions and follow-up care in health facilities and communities. These forms have been compiled as a part of a set of Standard Operating Procedures (SOP) for Physiotherapy/ Rehabilitations Units in district hospitals.

Guidelines for Referral Pathways for Physiotherapy/Rehabilitation Units for specialised services (also an integral part of the SOP) have been developed based on current practices in the district health system following a series of consultation meetings with specialised service providers including SIRC, TPO, NDF, IOM, and IMC. A mapping of specialised services and criteria for service provision has been carried out including identifying a focal person for each service. These guidelines have helped district teams during referrals to specialised and tertiary care, further rehabilitation support, and follow ups.

The guidelines for referrals and SOPs have now been shared with the DRFU/LCD, MoH, for their finalisation and approval. These resources are now an asset of the LCD that can be used to develop service specifications and quality control mechanisms for the sector as per long term plans of the DRFU/ LCD.

4. Sustainability of Rehabilitation Services in Nepal

Since July 2015, the seven rehabilitation units have been functioning parts of district hospitals of MoH in selected earthquake affected areas. They have provided physiotherapy/rehabilitation services with a focus on identification, rehabilitation, and follow-up of people with injuries, functional limitations, and disabilities. Key activities included supporting referrals and discharge services, providing assistive devices, orienting caregivers, referring to specialised services, and referring to social protection services.

At the central level, NHSSP is working with the DRFU/LCD/MoH, supporting them in planning and coordination among relevant stakeholders and advocating with them to incorporate the continuation of the rehabilitation units by the MoH as part of its health delivery system.

The earthquake disaster and the health sector's response have improved the government's understanding of the usefulness and importance of rehabilitation and served as a catalyst for policy reform. For example, the last version of the Nepal Health Sector Strategy 2015- 2020 notes that the post-earthquake scenario has created additional health needs including rehabilitation services.

Consequently, with the support of the NHSSP, the LCD has proposed a large number of indicators and key interventions for disability prevention and rehabilitation to be included in the implementation plan of the NHSSP.

Furthermore, as "Disability/Rehabilitation" is a cross-cutting issue, NHSSP has supported several other divisions of DoHS (Family Health Division, Child Health Division and the Primary Health Care Revitalisation Division) to include specific indicators and interventions linked to disability/rehabilitation within their work streams.

HI has also facilitated District Hospital Management Boards for the continuation of physiotherapy/ rehabilitation service delivery and arrangements related to infrastructure. Dhading and Jiri Hospital Management Board have already moved forward in these areas.

5. Major Gaps and Actions Taken to Mitigate Them

Gap 1: Low number of physiotherapy units providing child care (12% of total patients) compared with children with disabilities (30 % of all cases) in Nepal shown in the SINTEF report.

Mitigation measures:

- The referral of children can be increased by reaching out to all health workers including female community health volunteer (FCHVs) through training and orientation
- Reinforce the integration of physiotherapy/rehab units in the district health system. Train health workers and FCHVs to detect birth defects, disabled children (incl. development delays and cerebral palsy), and disabled adults (linked to non-communicable diseases and

injuries).

Gap 2: Low number of patients officially discharged and the unknown status of many patients (linked to the difficulty of geographical access)

Mitigation measure:

- Increase outreach activities with the engagement of FCHVs, primary health care outlets (PHCCs, HPs) and DPOs.

Gap 3: Few physiotherapy sessions received by patients related to difficulties of geographical access and transportation.

Mitigation measure:

- Promote step down facilities and train physiotherapists on the Person Centred Approach to care for children and adults with disabilities needing long term rehabilitation care;
- Social protection activities especially cash support for supported discharge and supported referrals
- Promote awareness raising activities
- Mobilise local stakeholders especially mothers groups, youth, clubs and other community based organisations (CBOs).

Gap 4: No specific monitoring and evaluation provisions for unit activities by the DRFU/LCD/MoH (partially due to insufficient human resources in the DRFU/LCD/MoH)

Mitigation measures:

- A monitoring and evaluation process developed and endorsed by the DRFU/LCD/MoH
- Set-up this monitoring and evaluation process in districts (recruitment of additional human resources needed).

Gap 5: Three out of seven units are still operating from tents due to the destruction of the district hospital by the earthquake

Mitigation measure:

- Materialise the outcomes of the current dialogue with the DHO, hospital management board, the DRFU/LCD, the Curative Service Division, and MoH to make provision for new physical infrastructure and space.

Gap 6: Financial sustainability (PTs and SWs salaries and financial services cover) of the units

Mitigation measures:

- Lobbying from the DRFU/LCD to MoH to recruit PTs and SWs and/or create a funding mechanism to cover services through, for example, joint initiatives between government and external development partners and public private partnerships; lobbying from the

DRFU/LCD to MoH/MWCSW other relevant ministries to increase government funding for service delivery (esp. outreach activities, referrals, and long term follow-up); lobbying of MoH, MWCSW and other relevant ministries by DRFU/LCD CSW to add assistive devices to services covered under insurance systems.

Gap 7: Harmonisation and adoption of rehabilitation services in the Health Management Information System (HMIS) is in its initial phase.

Mitigation measure

- HI to work with the DRFU/LCD and HMIS division on a new monitoring format.

6. Major Lessons Learned

The following are the major lessons learned from the project:

- Physiotherapy/rehabilitation services are essential for reducing primary and secondary complications of injuries at the time of mass casualty incidents
- There is a high unmet need for physiotherapy/rehab services at district hospitals: in 11 months, 3490 earthquake affected clients and 1127 clients with earthquake injuries were served
- Joint community outreach with DHOs and other I/NGOs helped to decrease costs and increase the number of follow up visits
- Children are also among the injured (data pool shows approximately 12%), so special attention must be given to reduce this impairment burden in the community
- Social security/social protection (disability card and linkages to social services) also needs to be addressed
- There is a need for cash support for referrals and following discharge in order to help clients reach health facilities and then return home
- Psychosocial support has to be integrated within health and rehabilitation services targeted at people with injuries and disabilities
- Strong referral pathways are to be established and informed to all district teams
- Rehabilitation services need to be available in districts in the long term, but there is presently no provision for physiotherapy/rehab units in the districts
- Several further barriers identified during project implementation were: low awareness on the importance of rehabilitation; poor accessibility including transport shortages; high costs and various logistical challenges. These barriers need to be considered for future projects.

7. Recommendations for the Rehabilitation of Those with Injuries, Functional Limitations, and Disabilities

- Create/fulfil sanctioned posts for physiotherapy, prosthetist and orthoptists, occupational therapists and psychosocial workers in district hospitals

- Systematically follow-up clients who need long term follow-up and surgical support
- Provide supported discharge and supported referrals for ultra-poor patients
- Ensure social protection/security activities
- Provide a budget for construction of physiotherapy/rehabilitation units in earthquake affected districts
- Carry out activities with health posts and FCHVs to increase early detection and referrals.

8. Photos of Project Activities

<table>
<tr><td>  </td><td>  </td></tr>
<tr><td>Social worker supporting a client to use auxilliary crutches, Sindhupalchowk</td><td>Physiotherapist service provision to a client, Jiri</td></tr>
<tr><td>  </td><td> 
</td></tr>
<tr><td>Woman with injury re-learning to walk,</td><td>Physiotherapist supervising a wheelchair user in an outreach</td></tr>
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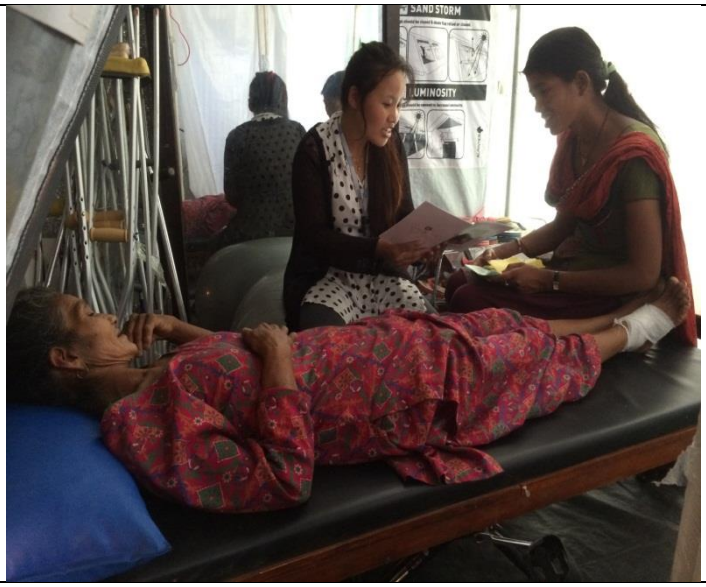
Rasuwa	event, Kathmandu
	
A physiotherapist re-teaching a woman with injury to walk, Nuwakot	Physiotherapists conducting a follow up home visit, Kathmandu
	
Physiotherapist supervising balance training in a client's house, Rasuwa	Injury rehabilitation officer mentoring a physiotherapist to assemble a wheelchair, Kathmandu

	
A woman with a right pelvis fracture exercising in a physiotherapy unit	Physiotherapist session for a woman in Sindhupalchowk
	
Physiotherapists treating a patient in an outreach event in Melamchi PHCC	Social worker conducting community follow up of beneficiaries

	
Physiotherapist facilitating a child to be in four point position to help her crawl	Social worker giving education on wound care to a client and her caregiver