



Evaluation of the Minimum Initial Services Package (MISP) of Reproductive Health Services for Internally Displaced Persons in Kathmandu and Sindhupalchowk Districts, Nepal

**Literature Review
Focus Group Discussions
Key Informant Interviews
Health Facility Assessments**



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The Women's Refugee Commission improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Acronyms & Abbreviations

ADRA	Adventist Development and Relief Agency
ANC	Antenatal care
ANM	Auxiliary nurse midwife
ART	Antiretroviral treatment
ARV	Antiretroviral
ASRH	Adolescent sexual and reproductive health
BEmOC	Basic emergency obstetric care
BEmONC	Basic emergency obstetric and neonatal care
CDK	Clean delivery kit
CDRC	Central Disaster Relief Committee
CEmOC	Comprehensive emergency obstetric care
CEmONC	Comprehensive emergency obstetric and neonatal care
CHW	Community health worker
CMR	Clinical management of rape
CoC	Code of conduct
DHO	District health office
DLM	Distance learning module
DoHS	Department of Health Services
DoWC	Department of Women and Children
DRR	Disaster risk reduction
EC	Emergency contraception
EmOC	Emergency obstetric care
EPP	Emergency preparedness plan
FCHV	Female community health volunteers
FFS	Female-friendly space
FGD	Focus group discussion
FHD	Family Health Division
FPAN	Family Planning Association of Nepal
GBV	Gender-based violence
HEOC	Health emergency operations center
HIV	Human immunodeficiency virus
IAWG	Inter-agency Working Group on Reproductive Health in Crises
IEC	Information, education, and communication
IPPF	International Planned Parenthood Federation

IUD	Intra-uterine device
KI	Key informant
KII	Key informant interview
LGBTI	Lesbian, gay, bisexual, transgender, intersex
MISP	Minimum Initial Services Package
MNH	Maternal and newborn health
MOH	Ministry of Health
MoU	Memorandum of understanding
MOWCSW	Ministry of Women, Children and Social Welfare
NCASC	National Center for AIDS and STD Control
NEOC	National Emergency Operations Center
NRC	Norwegian Red Cross
NGO	Nongovernmental organization
OSCMC	One Stop Crisis Management Center
PEP	Post-exposure prophylaxis
PHCC	Primary health care centers
PLWHIV	People living with human immunodeficiency virus
PMTCT	Prevention of mother-to-child transmission
PPH	Post-partum hemorrhage
RH	Reproductive health
RRT	Rapid response team
SBA	Skilled birth attendant
SEA	Sexual exploitation and abuse
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TOT	Trainer of trainers
UNFPA	United Nations Population Fund
UNFPA	United Nations Population Fund
UNOCHA	United Nations Office for the Coordination of Humanitarian Affairs
VCT	Voluntary counseling and testing
VDC	Village development committee
WHO	World Health Organization

LITERATURE REVIEW

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Current Emergency

Background of current crisis

On April 25, 2015, a 7.8 magnitude earthquake occurred in Nepal's Gorkha District, northwest of Kathmandu.¹ This earthquake was followed by more than 300 aftershocks and a 7.3 magnitude earthquake on May 12, 2015 in Dolakha District, northeast of Kathmandu.^{2, 3} Within the 75 districts of Nepal, 35 districts were affected by the earthquake, with the most destruction occurring in 14 districts.⁴ These districts include Gorkha District in the Western Region of Nepal, as well as Bhaktapur, Dhading, Dolakha, Kathmandu, Kavre, Lalitpur, Makwanpur, Nuwakot Ramechhap, Rasuwa, Sindhuli, Okhaldhunga, and Sindhupalchowk Districts in the Central Region.⁵

Of the 26.6 million individuals living in Nepal, 5.6 million are in need, including an estimated 940,000 children.⁶ As of May 2015, nearly 9,000 people died in the earthquake and over 22,000 others were injured.⁷ At the height of the crisis, some 188,900 people were displaced, with around 600,000 houses destroyed and an additional 290,000 damaged.⁸ According to the United Nations Population Fund (UNFPA), 1.4 million women of reproductive age and 93,000 pregnant women were among those most affected.⁹ Within the first three months of the earthquake, an estimated 10,000 women were expected to give birth each month, with around 1,000 to 1,500 women at risk each month of

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- 1 Sen, Anjali, *Update of IPPF/SAR and SPRINT's Emergency Response From the #NepalEarthquake* (May 2015).
 - 2 Office for the Coordination of Humanitarian Affairs, Nepal: *Earthquake 2015- Situation Report No. 15* (Nepal, May 13 2015).
 - 3 Government of Nepal National Planning Commission, *Post Disaster Needs Assessment Executive Summary* (2015).
 - 4 On-Site Operations Coordination Centre, *Situation Analysis Nepal Earthquake* (May 15 2015).
 - 5 Ibid.
 - 6 See note 2.
 - 7 United Nations Population Fund, *Nepal Earthquake 100 Days into the Humanitarian Response* (August 27, 2015).
 - 8 Ibid.
 - 9 MoHP, "Nepal: Update from the RH Sub-Cluster" PowerPoint, May 11, 2011.

pregnancy-related complications requiring emergency obstetric care.¹⁰ Additionally, within the first three months after the earthquake, using the [Minimum Initial Service Package \(MISP\) calculator](#),¹¹ an estimated 28,000 women required post-rape treatment.¹²

Nepal is a landlocked country with 80 percent of individuals living in rural areas.¹³ Nepal's rugged terrain and inadequate infrastructure are major barriers to individuals seeking food, water and power. Following the earthquake, over 3,000 landslides occurred. At the time of the assessment (May 2015), the monsoon season was projected to begin in early July, and was expected to create further destruction. For women and girls specifically, a further safety concern included protection against trafficking and abuse, as well as a lack of citizenship documents (since some women were not registered or had lost their documents).¹⁴

Nepal background

In Nepal, 24.82 percent of the population live below the poverty line and only 49 percent of households are food secure.¹⁵ The major occupation is agriculture, with 76 percent of households involved in the industry.¹⁶ Remittances are also a major source of income, with 56 percent of households receiving remittances.¹⁷ Of the 92 languages spoken within Nepal, the majority speak Nepali (44.6%). Maithili (11.7%) and Bhojpur (8%) are the other two major languages.¹⁸ Hinduism is the major religion, followed by Buddhism, Islam, Kirat, and Christianity.¹⁹ Caste plays a large part in Nepalese culture, with a 2006 World Bank/DfID Gender and

10 United Nations Population Fund, Nepal Earthquake 100 Days into the Humanitarian Response (August 27, 2015).

11 <http://www.iawg.net/resources/calculator.html>

12 See note 9.

13 Government of Nepal's Ministry of Health and Population: Population Division. Nepal: Demographic and Health Survey, 2011.

14 Press Release, Second Nepal Earthquake increases child trafficking threat, 13 May 2015.

15 See note 13.

16 Ibid.

17 Ibid.

18 Ibid.

19 Ibid.

Social Exclusion Assessment finding caste a more powerful predictor of empowerment and inclusion than gender.²⁰ Overall, a third of Nepal's variation in empowerment and inclusion levels stem from both gender and caste.²¹

Recent projects on reproductive health (prior to the earthquake)

Before the earthquake, the Family Planning Association of Nepal (FPAN) was active in the country, providing 11,000 volunteers and 480 staff members in 300 medical facilities.²² FPAN, the largest women's health and rights organization in Nepal, works closely with the Nepalese government and is a member of various health committees, including the Reproductive Health Coordination Committee of the Department of Health Services. The USAID-funded Nepal Family Health Program II supported the Nepalese Ministry of Health and Population in strengthening services throughout Nepal. JSI Research and Training Institute implements the Nepal Family Health Program II with its partners (EngenderHealth, Jhpiego, Nepali Technical Assistance Group, Nepal Fertility Care Center, Management Support Services, Nepal Red Cross Society, Save the Children, World Education, United Mission to Nepal, BBC World Service Trust, Digital Broadcast Initiative Equal Access Nepal, and FPAN).²³

Health Indicators in Nepal

With the Nepal Family Health Program implementing the National Reproductive Health Strategy's integrated package of health services, there has been great improvement in the health of women and children.²⁴ With one in three births assisted by a skilled provider, the maternal mortality ratio in Nepal has drastically decreased from 539 deaths per 100,000

20 Government of Nepal's Ministry of Health and Population, *Nepal Health Sector Programme-Implementation Plan II (NHSP-IP 2), 2010-2015* (Nepal, April 7 2010).

21 World Bank and Department For International Development, *Unequal Citizens: Gender, Caste and Ethnic Exclusion in Nepal Summary* (Nepal, January 2006).

22 International Planned Parenthood Federation, *IPPF to provide Sexual and Reproductive Health Services to Earthquake Affected People in Nepal* (Nepal, April 27 2015).

23 See note 15.

24 World Health Organization, *Accelerating Universal Access to Reproductive Health* (Nepal, 2011).

live births in 1996 to 281 in 2011.²⁵ There has also been a continuous decrease in neonatal mortality from 59 deaths per 1,000 in 1990 to 22 deaths per 1,000 in 2015.²⁶

Currently, the total fertility rate is 2.6 births per woman, although fertility rates differ greatly throughout the country. According to the 2011 Nepal Demographic and Health Survey (DHS), rural women generally have approximately one more child than urban women.

Age Specific Fertility Rates²⁷

Age Range	Fertility Rate
15-19 Years Old	81 per 1,000 women
20-24 Years Old	187 per 1,000 women
25-29 Years Old	126 per 1,000 women
30-34 Years Old	71 per 1,000 women
35-39 Years Old	36 per 1,000 women
40-44 Years Old	14 per 1,000 women
45-49 Years Old	5 per 1,000 women

Currently, 50 percent of married women aged 15-49 years use some form of contraception, with the government providing 69 percent of contraception to all women.²⁸ Female sterilization is the most prevalent form of contraception, followed by injectables, male sterilization, and traditional methods.²⁹ The unmet need for family planning among currently married women aged 15-49 years is 27 percent and the unmet need for birth spacing is 10 percent.³⁰

Initially considered a country with low human immunodeficiency virus (HIV) prevalence in 1988, HIV has reached epidemic proportions among several concentrated groups. The prevalence of HIV among adults in

25 See note 15.

26 The World Bank,(2015) Neonatal Mortality Rate [Data File].

27 See note 15.

28 Ibid.

29 Ibid.

30 Ibid.

Nepal is 0.3 percent.³¹ The majority of cases are among injection drug users and female sex workers and their clients, as well as men who have sex with men. Since 2004, Nepal has been providing free antiretroviral therapy (ART), a combination of at least three antiretroviral (ARV) drugs; however, patients must pay for transportation and diagnostic tests out of pocket.^{32, 33} ART is now available at 23 sites throughout Nepal, and 23.7 percent of the HIV-positive population uses ARVs.³⁴

Concerning violence against women, 22 percent of women aged 15-49 report experiencing physical violence at least once since age 15, and 12 percent of women aged 15-49 report experiencing sexual violence.³⁵ For pregnant women between 18 and 49 years old, 6 percent report experiencing violence during their pregnancy.³⁶ Within marriage, one in three ever-married women experience sexual, physical or emotional abuse by her spouse.³⁷ Among survivors, two out of three never disclose the violence.³⁸ Age of marriage by 15 years stands at 10.1 percent of girls, and marriage by the age of 18 at 40.7 percent.³⁹

From 1995 to 2011, there was an increase from USD 35 to USD 68 on total health expenditure per capita.⁴⁰ The Nepalese government created the Department of Health Services, which is divided into six divisions: Management, Family Health, Child Health, Primary Health Service Revitalization, Logistic Management, Epidemiology and Diseases, as well as three sections: Leprosy Control, Personal Administration, and Finance

31 UNICEF, *Nepal Country Statistics* (2013).

32 Laxmi Bhatta, et al. "Survival on antiretroviral treatment among adult HIV-infected patients in Nepal: a retrospective cohort study in far-western Region, 2006–2011." *BMC infectious diseases* 13.1 (2013): 604.

33 Wasti SP, Simkhada P, Teijlingen ER. "Antiretroviral treatment programmes in Nepal: problems and barriers." *Kathmandu Univ Med J (KUMJ)* 2009;7:306–14.

34 See note 32.

35 See note 15.

36 Every Premie-SCALE, *Nepal Profile of Preterm and Low Birth Weight Prevention and Care* (2015).

37 See note 15.

38 Ibid.

39 Aleksandra Perczynska, *Child Marriage in Nepal: What About Girls? Girls Not Brides* (August 2013).

40 Nepal Ministry of Health and Population. *Success Factors for Women's and Children's Health* (2015).

Administration.⁴¹ Within the Family Health Division, seven programs focus on RH. The Safe Motherhood and Newborn Health (SMNH) Program works to improve maternal and newborn health and manage RH morbidity.⁴² The Family Planning Program works to expand services to communities to reduce fertility, enhance maternal and neonatal health and child survival through the public and private health service sector.⁴³ The Adolescent and Sexual Reproductive Health Program works to create an environment in public health facilities that is accessible to adolescents.⁴⁴ The Female Community Health Volunteers garner community involvement in public health activities. Primary Health Care Outreach Clinics improve access to rural communities, so communities can receive basic health services, including family planning and safe motherhood.⁴⁵ Finally, the Demography and Reproductive Health Research Program estimates annual targets, and also conducts and monitors research with the Family Health Department.⁴⁶

Enabling Restrictive Laws/Policies/Protocols

The rights of women and reproductive health

Nepal has ratified all major international health and development covenants, treaties, and commitments, which preserves the rights and protection of the Nepalese people. The Nepalese government identifies health as a fundamental right to women in the Interim Constitution of 2007, which specifically addresses RH.⁴⁷

The National Health Sector Program Implementation II (2010-1015) aims to continue previous policies while placing greater attention on gender and social exclusion issues. The previous policies, found in the

41 Government of Nepal's Ministry of Health and Population: *Department of Health Services. Department of Health Services Annual Report* (February, 2015).

42 Ibid.

43 Ibid.

44 Ibid.

45 Ibid.

46 Ibid.

47 *Tracking Cases of Gender-Based Violence in Nepal: Individual, Institutional, Legal and Policy Analyses*, (2013).

Nepal Health Sector Strategy Implementation Plan of 2004 through 2009, focus on the achievement of the health sector's Millennium Development Goals and the improved health outcomes of the poor, as well as those living in rural areas to reduce general poverty.⁴⁸ Emphasis has been placed on the improvement of maternal and child health indicators, such as Nepal's maternal mortality ratio; total fertility rate; neonatal, infant, and under-five mortality rates; contraceptive prevalence rate; and percentage of underweight children.⁴⁹

The National Reproductive Health Strategy integrates RH activities into other sectors, strengthens training and supervision of medical staff, supports a youth-focused curriculum, and fortifies health delivery systems.⁵⁰ This strategy also provides a holistic package of health services at all levels of the health care system, including family planning, safe motherhood, and prevention and management of abortion complications, as well as sexually transmitted diseases (STDs)/HIV.⁵¹ To provide universal access to RH by 2015, Nepal's National Reproductive Health Commodity Security Strategy ensures the supply of contraceptives, condoms, and other essential RH supplies. Woven into the National Health Sector Program Implementation II are guidelines to assist medical facilities in preparing for emergencies. Established activities comprise training all staff within health facilities on applicable protocol during emergency situations, prepositioning appropriate medical resources, creating clear work guidelines, and coordinating communication among health facilities and the Ministry of Health committees throughout Nepal.⁵²

Since the onset of the earthquake, the Nepalese government's National Health Training Center and the Family Health Division have led development of a new adolescent sexual and reproductive health training manual, which includes a trainer's guide, a participant's handbook, and reference

48 Government of Nepal's Ministry of Health and Population. *Nepal Health Sector Programme-Implementation Plan II, (NHSP-IP 2) 2010-2015*, April 7, 2010.

49 See note 15.

50 Bhadari, T. R., and G. Dangal. "Maternal mortality: paradigm shift in Nepal." *Nepal Journal of Obstetrics and Gynaecology* 7.2 (2014): 3-8.

51 World Health Organization, *Accelerating Universal Access to Reproductive Health* (2011).

52 See note 48.

material.⁵³ With technical support from the Adventist Development and Relief Agency and with UNFPA's financial support, the manual will allow for an improvement of the quality of services available to adolescents.⁵⁴

Birth control pills, condoms, and injectables can be found at health posts, sub health posts, and primary health care outreach clinics, while female community health volunteers work within the community to disperse sexual health education, condoms and birth control pills.⁵⁵ Prior to the earthquake, sterilization, intrauterine devices (IUDs), and implants were available at a limited number of primary health care centers and health posts.⁵⁶ Sterilization was also available in some districts or through mobile outreach units.⁵⁷ To address need after the earthquake, micro-planning for family planning was discussed as a tool to inform health officials.⁵⁸ Thereby allowing health officials to develop strategies to address women's access to contraceptive information and supplies.⁵⁹

Looking toward maternal and child health care, the National Safe Motherhood Plan (2002-2017) focuses on using a human rights-based approach to scaling up coverage at all levels of the health care delivery system.⁶⁰ This is done through strengthening maternal health care providers' technical capacity and increasing consumer use of medical services. The 2006 National Policy for Skilled Birth Attendants specifically ensures a sufficient number of new health staff and the retraining of current staff.⁶¹ The policy focuses on improving the midwifery skills of nurses, doctors, and auxiliary nurse midwives throughout the nation. Utilization of skilled birth attendants still varies greatly between rural and urban areas of Nepal. In an attempt to reach rural areas, 52,000

53 UN Population Fund, *Upgrading Adolescent Sexual and Reproductive Health Services in Nepal* (October 25 2015).

54 Ibid.

55 See note 41.

56 Ibid.

57 Ibid.

58 United Nations Population Fund. *Family Planning Vital in Post-Quake Nepal* (September 9 2015).

59 Ibid.

60 World Health Organization. *Success Factors for Women's and Children's Health* (2015).

61 Ibid.

female community health volunteers work to mitigate pregnancy risks by providing maternal health information.⁶² Between 1996 and 2011, the number of skilled birth attendants present at a birth rose from 9 percent to 36 percent.⁶³

In 2009, the Safe Delivery Incentive Program was merged to Aama Suraksha-Karyakram, or Aama Program in an effort to cover costs for women seeking care.⁶⁴ The government provides financial incentives for transportation to the clinic, free delivery, free medical checks, and incentives to women who complete a package of antenatal, delivery, and postnatal care services.⁶⁵ The Community-Based Newborn Care Package, currently under revision, was created in 2009 to promote the use of clean delivery kits (CDKs), cord care, prevention and management of hypothermia, and drying and bathing of newborns.⁶⁶

Regarding the UN process indicators, an estimated 10 percent of obstetric care needs are met in Nepal, and 3 percent of neonates are born by cesarean section.⁶⁷ The number of emergency obstetric and neonatal care facilities increased threefold from 2004 to 2011.⁶⁸ The emergency obstetric case fatality rate from hospital reporting is nearly two percent, while the World Health Organization's standard is less than one percent.⁶⁹ Finally, more than 85 percent of emergency obstetric care facilities are located in urban areas, while 80 percent of individuals live in rural areas.⁷⁰

62 The Global Campaign for the Health Millennium Development Goals 2010, *Putting the Global Strategy for Women's and Children's Health into Action* (2010).

63 B. Choulagai et al., *Barriers to using skilled birth attendants' services in mid-and far-western Nepal: a cross-sectional study*. *BMC international health and human rights*, 13(1), 49 (2013).

64 G. Baral. "An assessment of the safe delivery incentive program at a tertiary level hospital in Nepal." *Journal of Nepal Health Research Council* (2012).

65 Ibid.

66 Y. V. Pradhan et al. "Newborn survival in Nepal: a decade of change and future implications." *Health policy and planning* 27, no. suppl 3 (2012): iii57-iii71.

67 T. R Bhandari and G. Dangal, *Emergency Obstetric Care: Strategy for Reducing Maternal Mortality in Developing Countries* (2014).

68 See note 60.

69 See note 67.

70 Ibid.

Services for survivors of gender-based violence

In 2010, the Gender Empowerment and Coordination Unit was created within the Prime Minister's Office to monitor and collect data on gender-based violence (GBV). The unit works to increase gender sensitivity of service providers (including paramedical staff, psychosocial counselors, and hospital staff), establish a legal aid hotline, and create women's cells in police stations and one-stop crisis centers in district hospitals. Post-exposure prophylaxis (PEP) is available in all ART centers and for prevention of mother-to-child transmission (PMTCT) and at some HIV testing and counseling sites.⁷¹ With a new constitution adopted in 2015, data on the timeline to report rape was not determined.^{72,73,74} Though the previous Muluki Ain, or General Code, stated that "If a suit on the matter of rape is not filed within thirty-five days from the date of the cause of action, the suit shall not be entertained."⁷⁵

An evaluation by the Asia Foundation found the current referral system for legal and medical assistance to be weak and unorganized.⁷⁶ Generally, police officers work as mediators, settling cases through reconciliation and negotiation, with few cases referred to prosecution.⁷⁷ A study by Georgetown University's Community Justice Law Project found doctors, who do not receive appropriate training, generally do not treat survivors of sexual assault without a police report, though many police officers will not file a report without a medical report to corroborate the incident.⁷⁸

71 Government of Nepal's Ministry of Health and Population: National Centre for AIDS and STD Control, National HIV/AIDS Strategy 2011-2016 (Kathmandu, 2011).

72 U.S. Department of State. *Executive Summary: Nepal 2014 Human Rights Report* (31 July 2015).

73 Charles Haviland, Why is Nepal's New Constitution Controversial? BBC News ((19 Sept. 2015).

74 Indian Council of World Affairs. *Issue Brief: Nepal-Salient Features of the New Constitution* (1 October 2015).

75 Muluki Ain (General Code), *supra* note 13, Chapter 14 on Rape, No. 11.

76 Asia Foundation. *Nepal Preliminary Mapping of Gender Based Violence* (Kathmandu, Nepal, July 2010)

77 *Ibid.*

78 Margot Dankner, et al., *Confidentiality and the Legal Process* (The Community Justice Project: Georgetown University Law Center, 2011).

Emergency contraception

Twenty eight percent of women are aware of emergency contraception and any pharmacy registered with the Department of Drug Administration can sell emergency contraception.⁷⁹ Nepal requires women to obtain a doctor's prescription before they are able to purchase emergency contraception, though it is reported that this law is not always enforced by pharmacists. Emergency contraception is generally not available at government hospitals and other health facilities since the public sector does not procure emergency contraception.⁸⁰

Abortion

In 2002, abortion became legal with the enactment of the National Safe Abortion Policy and Procedural Process within the 11th Amendment to Muluki Ain or Country Code.⁸¹ The Nepalese government allows women to terminate their pregnancy within the first 12 weeks; within the first 18 weeks if the pregnancy is the result of rape or incest; at any point a medical practitioner authorizes it if the woman's physical or mental health is at risk; as well as if the fetus is deformed.⁸² Mifepristone is used for medical abortions.⁸³ Currently, only 38 percent of women are aware of abortion services; expanding services throughout the country is a major goal of the government to increase women's use of abortion services, as well as task-shifting abortion care to nurse-midwives. Prior to the earthquake, there were 245 registered medical abortion facilities in the 75 districts of Nepal.⁸⁴

79 See note 13.

80 Sarah Rich, "International Consortium for Emergency Contraception," email to IAWG, May 2015.

81 Savitri Goonesekere. *Harmful Traditional Practices in Three Countries of South Asia: Culture, Human Rights and Violence Against Women* (United Nations Economic and Social Commission for Asia and the Pacific: Social Development Division, 2009).

82 Yagya Karki et al., *Factors Responsible for the Rapid Decline of Fertility in Nepal—An Interpretation: Further analysis of the 2006 Nepal Demographic and Health Survey* (Nepal, 2008).

83 IPAS, *Medical Abortion Training Guide*, (United States of America, 2013).

84 Susheela Singh, et al. "Making abortion services accessible in the wake of legal reforms: A framework and six case studies." Guttmacher Institute. (2012).

STDs and HIV/AIDS

In 1987, the National Center for AIDS and STD Control (NCASC) was established within the Ministry of Health and Population.⁸⁵ The National HIV/AIDS Strategy places prevention and treatment as key strategic goals to reducing HIV transmission, while the National Health Section Implementation Plan works to scale up and integrate HIV into sexual and RH services by 2015.⁸⁶ A review of the country's response to HIV was conducted in 2014 by the government of Nepal and found a "coordination mechanism had been established to integrate reproductive health services with HIV programs."⁸⁷ Their response included the development of HIV curriculum and the National Planning Commission creating specific guidelines for key ministries to address HIV.⁸⁸ The major goals of the NCASC are to attain universal access to HIV prevention and treatment by reducing new HIV infections by 50 percent and reducing HIV-related deaths by 25 percent in 2016.⁸⁹ As of 2006, statistics on the prevalence of STDs were generally amassed within HIV statistics, leading to "scarce and nonspecific" data on STD prevalence.⁹⁰ The Ministry of Health recommends using syndromic diagnoses and treatment of STDs, as laboratories able to test physical samples for STD are limited in Nepal.⁹¹

Blood transfusions

In 1993, a national blood policy and guidelines on blood transfusion services was created to guarantee adequate, safe, and timely supply of

85 Government of Nepal's Ministry of Health and Population: National Centre for AIDS and STD Control. *Country Progress Report on HIV/AIDS Response Nepal* (Kathmandu, March 2014).

86 Ibid.

87 Ibid.

88 Ibid.

89 Ibid.

90 Ministry of Health and Population: National Center for AIDS and STD Control. *National Guidelines on Sexually Transmitted Infection Case Management* (Kathmandu, September 2006).

91 Ministry of Health's Family Health Division, *National Medical Standard for Reproductive Health Volume II: Other Reproductive Health Issues* (August 2003).

blood products.⁹² Revised in 2006 and 2012, the national blood policy mandates all blood donations to be screened for HIV, hepatitis B, hepatitis C, and syphilis.⁹³

Menstruation

Women are generally found to use sanitary pads or cloth during menstruation. In rural areas, sanitary napkins are expensive and not easily accessible, and many women are unaware that they are available.⁹⁴ The Nepal Fertility Care Center has introduced homemade reusable pads to address the needs of women in three districts in central and eastern Nepal.⁹⁵ The government's Sanitation and Hygiene Master Plan of 2011 has placed the responsibility of providing menstrual hygiene products in schools with the Department of Education.⁹⁶ Traditional beliefs hinder a woman's ability to function within the community during menstruation, as items touched by menstruating women are deemed impure.⁹⁷ The practice of "Chhaupadi," isolating women during their menstrual cycle, was outlawed by Nepal's Supreme Court, but the practice is still reported in various regions within Nepal, specifically within the Western regions.⁹⁸

MISP trainings pre-earthquake

In 2010, Adventist Development and Relief Agency (ADRA) facilitated a MISP training of trainers for RH in crisis; participants included members of government ministries, UNFPA, UNICEF, and other international NGOs.⁹⁹ With financial support from ECHO through UNFPA, the training

92 Nepal Department of Health, *Screening Donated Blood for Transfusion-Transmissible Infections in Nepal*, (Nepal National Guidelines, 2013).

93 Ibid.

94 Thérèse Mahon and Maria Fernandes, *Menstrual Hygiene in South Asia: A Neglected Issue for WASH (Wash, Sanitation and Hygiene) Programmes* (Gender and Development, 2010).

95 Kamala Gautam, *A Day in the Life of a Menstruating Woman in Nepal* (Jhor Mahankal. Global Press News Service, 13 June 2014).

96 UNICEF Regional Office for South Asia -Kathmandu, NP & Nepal. National Planning Commission -NP, 1996. NMIS cycle 3: diarrhoea, water and sanitation: key points for discussion and action. , p.9 p.: 5 maps.

97 See note 94.

98 Rose George. "Blood Speaks," *Mosaic: The Science of Life* (March 11 2014).

99 Office for the Coordination of Humanitarian Affairs. *Nepal Monthly Situation Update*

was part of an emergency RH outreach program.¹⁰⁰ As UNHCR's implementing partner, AMDA-Nepal has provided primary health care services to Bhutanese refugees and RH trainings to medical staff since 2001.¹⁰¹ In terms of gender, the National Strategy on Disaster Risk Management (not yet passed into law) places priority on disaster risk reduction (DRR) training to women and other marginalized groups. The Local Disaster Risk management Guideline of 2011 requires one-third female leadership on taskforces.¹⁰²

Current MISP Implementation

MISP and the Health Cluster

To encourage the incorporation of MISP by service providers, a one-page checklist on RH can be found on the Health Emergency Operation Center website. National RH protocols and other technical documents have also been uploaded to the site and a visual breakdown of the support provided by the Health Cluster for specific districts, as of May 15, 2015, can be found here.

MISP response on the national level

The Central Disaster Relief Committee (CDRC) met within two hours of the first earthquake.¹⁰³ The National Emergency Operation Center's report informed the CDRC's recommendations to focus on search and rescue, as well as lifesaving activities.¹⁰⁴ With the funds immediately allocated from the Prime Minister's Disaster Relief Fund, the 11 sectors (protection, food, security, emergency communication, camp management and coordination, shelter, health, education, water and sanitation, logistics and nutrition) were instantly activated.¹⁰⁵

(January 2010).

100 Ibid.

101 Interagency Working Group on Reproductive Health in Crises, Meeting Report (2008).

102 The Economist Intelligence Unit, The South Asia Women's Resilience Index (2014).

103 Government of Nepal, *Nepal Earthquake 2015: Post Disaster Needs Assessment Executive Summary* (2015).

104 Ibid.

105 Ibid.

As of August 2015, 32 partners had participated in the RH sub-cluster meetings, with the Family Health Division and UNFPA co-leading the RH sub-cluster and the Department of Women and Children leading the GBV sub-cluster.¹⁰⁶ Gorkha and Sindhupalchowk districts were the field hub centers.¹⁰⁷ UNFPA and UNICEF distributed tents, equipment, medicines, and supplies to initiate maternal and newborn health (MNH) and RH.¹⁰⁸ Selected districts had also been sent necessary equipment to provide MNH, RH, and child health services (family planning, EmONC, sexual violence, STD, and miscarriage) for up to 90,000 women and children until Mid-July 2015, though 1.5 million were needed.¹⁰⁹

As reported on April 28, 2015, the Department of Foreign Affairs and Trade of the Australian Government and International Planned Parenthood Federation-South Asia region (IPPF-SAR) were providing funding to specifically address SRH needs in Nepal through FPAN.¹¹⁰ FPAN, which is a member of the IPPF Association, is partnered with SPRINT and various stakeholders to work in the affected areas. FPAN coordinates its efforts with the government, as FPAN is a member of the Reproductive Health Coordination Committee of the Department of Health Services and sub-committees chaired by the Family Health Division.¹¹¹ They work to provide individuals with access to health check-ups, safe delivery and care for newborns, post-natal care to pregnant and lactating women, and family planning and reproductive health care.¹¹² With 11,000 volunteers and 480 staff members, FPAN planned to reach out to 18,000 individuals.¹¹³ Furthermore, youth were being used to distribute information about condom use and safe sex practices.¹¹⁴

106 United Nations Population Fund, *Nepal Earthquake 100 Days into the Humanitarian Response* (August 27, 2015).

107 Ibid.

108 Ibid.

109 Ibid.

110 International Planned Parenthood Federation, *Sprint Initiative Reaches Out to the Earthquake-Affected Population of Nepal; Provides Sexual and Reproductive Health (SRH) and Medical Services* (April 28 2015).

111 Ibid.

112 Ibid.

113 Ibid.

114 Ibid.

As of May 5, 2015, Jhpiego is working with GFA, a German consulting group funded by GIZ, in Dhading District and 10 districts in the mid-west and far-west.¹¹⁵ They worked to reestablish systems to provide primary care services, rebuild services, and prepare staff for health facilities.¹¹⁶

Earthquake aftereffects

As of mid-September 2015, there were 11,700 households (58,690 individuals) displaced in 120 sites.¹¹⁷ Over 450 humanitarian agencies have responded to the earthquake, with services provided in 741 village development committees (VDCs) in the most affected districts.¹¹⁸ While 100 percent of damaged health facilities were able to provide services at that time, 765 health facilities were still in need of reconstruction.¹¹⁹

According to the Nepalese Government's Post-Disaster Needs Assessment, with a particularly high number of individuals working overseas, the 14 worst-affected districts have a large absentee population.¹²⁰ Since the earthquake, over 10,000 migrants have returned home to help rebuild their homes, though the largest damage and loss occurred for the socially disadvantaged groups within the most impoverished districts.¹²¹ As women account for the greatest number of individuals working in the agricultural and informal sectors, the aftermath of the earthquake will have a major impact on their ability to generate an income.¹²² As men generally have more access to other forms of income, have a larger asset base, and are not in charge of household duties, men are expected to recover more easily than women.¹²³ Additionally, those in low-status social groups, like Dalits, and individuals in remote regions will also face the greatest challenges in recovery.¹²⁴

115 Chandra Rai, *Nepal Village Hit by Earthquake Receives Medical Supplies* (May 2015).

116 Ibid.

117 United Nations Office for the Coordination of Humanitarian Affairs and Humanitarian Partners, *Nepal Earthquake Response: April to September of 2015* (November 2015).

118 Ibid.

119 Ibid.

120 See note 103.

121 Ibid.

122 Ibid.

123 Ibid.

124 Ibid.

As of May 1, 2015, the Reproductive Health sub-cluster reported that of the 351 health facilities in Nepal providing emergency obstetric maternal and neonatal care previous to the earthquake, 112 were completely damaged and 144 were partially damaged in the 14 most seriously affected districts.

Earthquake aftereffects by zone, district and geographical region

Bagmati Zone

Hill region:

Kathmandu

- Estimated number of people in need: 350,676 (20.1% of the district)
- Number of IDPs: 15,168
- Birthing centers: 1 completely damaged and 8 partially damaged
- Hospital: unlisted
- Primary health care center: 8 partially damaged
- Basic emergency obstetric and neonatal care (BEmONC): unlisted
- Comprehensive emergency obstetric and neonatal care (CEmONC): unlisted
- Paropakar Maternity and Women's Hospital ready for obstetric referrals
- RH response
 - Within IDP camps in Kathmandu, the emergency response team conducted rapid assessments of need¹²⁵
 - UNFPA, through FPAN, provided RH services to women and girls, as of May 10, 2015

Nuwakot

- Estimated number of people in need: 291,191 (100% of the district)
- Number of IDPs: 11,690
- Birthing centers: 10 completely damaged and 14 partially damaged
- Hospital: 1 completely damaged
- Primary health care center: 1 partially damaged
- BEmONC: 3 partially damaged
- CEmONC: 1 partially damaged

125 IAWG Adolescent RH Sub-Working Group Teleconference Meeting Note. 5 May 2015.

- RH response:
 - As of May 10, 2015, GIZ/HSSP working to provide support in the district to resume maternity services in 10 completely damaged birthing centers
 - Installed three tents in birthing centers (Kharanitar, Samundritar, and Rautbess PHCCs)
 - With similar interventions planned for Gerku VDC, and Nuwakot Birthing Centre¹²⁶

Dhading

- Estimated number of people in need: 284,236 (84.6% of the district)
- Number of IDPs: 6,238
- Birthing centers: 32 completely damaged and 15 partially damaged
- Hospital: 1 partially damaged
- Primary health care center: 1 completely damaged and 1 partially damaged
- BEmONC: 1 completely damaged and 1 partially damaged
- CEmONC: 1 partially damaged
- RH response:
 - International Medical Corps providing support for MISP training to district-level health care workers
 - As of May 3, 2015, UNFPA and CARE conducted an RH needs assessment, distributed RH kits and were planning to focus on:
 - » Working with female community health volunteers (FCHVs) to distribute CDKs, create referral networks, and encourage pregnant women to seek care
 - » Distributing SRMH supplies (male condoms, CDK, health facility delivery kits, referral level (hospital) emergency supplies) expected to be procured by UNFPA
 - » Undertaking MISP activities, specifically community mobilization (possibly logistics, specifically for rural delivery)
 - » Supporting health facilities/birthing centers with equipment and support midwives to provide EMOC
 - As of May 10, 2015, UNFPA distributed CDKs
 - As of July 1, 2015, cesarean services were restored by UNFPA,

126 Health Cluster, *Nepal Earthquake Bulletin* (Nepal, 12 May 2015).

under the leadership of the District Health Office. Training of local doctors and nurses was also taking place to expand the network of those who can provide care

Bhaktapur

- Estimated number of people affected: 124,238 (40.8% of the district)
- Number of IDPs: 7,997
- Birthing centers: unlisted
- Hospital: 1 completely damaged and 2 partially damaged
- Primary health care center: 2 partially damaged
- BEmONC: unlisted
- CEmONC: unlisted
- RH response
 - Within IDP camps in Bhaktapur, ERT had conducted rapid assessments of need¹²⁷
 - As of May 9, 2015, IPPF, through SPRINT Initiative and FPAN, had organized mobile RH health camps to provide general health services, as well as crucial sexual and reproductive health services¹²⁸
 - UNFPA, through FPAN, provided RH services to women and girls, as of May 10, 2015

Lalitpur

- Estimated number of people in need: 94,631 (20.2% of the district)
- Number of IDPs: 2,698
- Birthing centers: 5 completely damaged and 8 partially damaged
- Hospital: unlisted
- Primary health care center: 2 partially damaged
- BEmONC: 5 completely damaged and 8 partially damaged
- CEmONC: unlisted
- RH response:
 - As of May 3, 2015, UNFPA and CARE had conducted an RH needs assessment, distributed RH kits, and were planning to

127 See note 125.

128 International Planned Parenthood Federation, *Nepal Earthquake Second Update* (9 May 2015).

focus on:

- » Working with FCHVs to distribute CDKs, creating referral networks, and encouraging pregnant women to seek care
- » Distributing SRMH supplies (male condoms, CDK, health facility delivery kits, referral level (hospital) emergency supplies) expected to be procured by UNFPA
- » Undertaking MISP activities, specifically community mobilization (possibly logistics, specifically for rural delivery)
- » Supporting health facilities/birthing centers with equipment and support midwives to provide EMOC
- o As of May 9, 2015, IPPF, through SPRINT Initiative and FPAN, had organized mobile RH health camps to provide general health services, as well as crucial sexual and reproductive health services
- o As of May 10, 2015, UNFPA had distributed CDKs, specifically in Thulodurlung VDC, and RH services through FPAN

Kavre (Kavrepalanchok)

- Estimated number of people in need: unlisted
- Number of IDPs: 4,188
- Birthing centers: 17 completely damaged and 18 partially damaged
- Hospital: 1 partially damaged
- Primary health care center: 1 completely damaged
- BEmONC: 3 partially damaged
- CEmONC: unlisted
- RH response:
 - o As of May 9, 2015, IPPF, through SPRINT Initiative and FPAN, had organized mobile RH health camps to provide general health services, as well as crucial sexual and reproductive health services¹²⁹
 - o A mobile unit run by ADRA visited the community of Dhunkharka from May 22-24, reaching 590 people¹³⁰
 - o UNFPA, through FPAN, had provided RH services to women and girls, as of May 10, 2015

129 Ibid.

130 United Nations Population Fund, *Mobile Camps Bring Life-Saving Care to Nepal's Quake-Affected* (June 2 2015).

Mountain region:

Sindhupalchowk

- Estimated number of people in need: 287,574 (99.9 % of the district)
- Number of IDPs: 2,189
- Birthing centers: 11 completely damaged and 3 partially damaged
- Hospital: 1 partially damaged
- Primary health care center: 1 completely destroyed and 2 partially damaged
- BEmONC: 1 completely destroyed and 3 partially damaged
- CEmONC: unlisted
- RH response:
 - As of May 10, 2015, UNFPA had distributed CDKs
 - As of May 9, 2015, IPPF, through SPRINT Initiative and FPAN, had organized mobile RH health camps to provide general health services, as well as crucial sexual and reproductive health services¹³¹

Rasuwa

- Estimated number of people affected: 41,848 (96.6% of the district)
- Number of IDPs: 2,925
- Birthing centers: 5 completely destroyed and 3 partially damaged
- Hospital: 1 completely destroyed
- Primary health care center: unlisted
- BEmONC: 1 completely destroyed
- CEmONC: unlisted
- RH response:
 - As of May 10, 2015, UNFPA had distributed CDKs

131 See note 128.

Janakpur Zone

Mountain region:

Dolakha

- Estimated number of people in need: 212,331 (100% of the district)
- Number of IDPs: 2,483
- Birthing centers: unlisted
- Primary health care center: unlisted
- BEmONC: unlisted
- CEmONC: 1 partially damaged

Hill region:

Ramechhap

- Estimated number of people in need: 184,214 (90.9%)
- Number of IDPs: 981
- Birthing centers: 8 completely destroyed and 8 partially damaged
- Hospital: 1 completely destroyed
- Primary health care center: 1 completely destroyed and 2 partially damaged
- BEmONC: unlisted
- CEmONC: unlisted

Inter Terai region:

Sindhuli

- Estimated number of people in need: 145,187 (49.0% of the district)
- Number of IDPs: 3,279
- Birthing centers: 1 completely destroyed and 14 partially damaged
- Hospital: 1 partially damaged
- Primary health care center: 1 completely destroyed and 2 partially damaged
- BEmONC: unlisted
- CEmONC: unlisted

Gandaki Zone

Hill region:

Gorkha

- Estimated number of people in need: 236,719 (87.3% of the district)
- Number of IDPs: 7,045
- Birthing centers: 1 completely destroyed and 2 partially damaged
- Hospital: 2 partially damaged
- Primary health care center: 1 completely destroyed and 2 partially damaged
- BEmONC: 1 completely destroyed and 2 completely destroyed
- CEmONC: 2 completely destroyed
- RH response:
 - o As of May 2015, UNFPA, in coordination with Women and Children Office, had distributed 2,100 dignity kits to key affected areas
 - o As of June 1, 2015, International Medical Corps had supported MISP training for district-level health care workers in VDCs. International Medical Corps had also provided a total of 12 CDKs to local health workers through mobile medical units and 28 to visibly pregnant women
 - o As of May 3, 2015, UNFPA and CARE had conducted needs RH needs assessment, distributed RH kits and focused on:
 - » Working with FCHVs to distribute CDKs, create referral networks, and encourage pregnant women to seek care
 - » Distributing SRMH supplies (male condoms, CDK, health facility delivery kits, referral level (hospital) emergency supplies) expected to be procured by UNFPA
 - » Delivering MISP activities, specifically community mobilization (possibly logistics, specifically for rural delivery)
 - » Supporting health facilities/birthing centers with equipment and support midwives to provide EMOC

Lamjung

- Estimated number of people in need: unlisted
- Number of IDPs: unlisted
- Birthing centers: 3 completely destroyed

- Hospital: 1 completely destroyed and 1 partially damaged
- Primary health care center: 1 partially damaged
- BEmONC: unlisted
- CEmONC: unlisted
- RH response:
 - o As of May 3, 2015, UNFPA and CARE had conducted an RH needs assessment, distributed RH kits, and planned to focus on:
 - » Working with FCHVs to distribute CDK, create referral networks and encourage pregnant women to seek care
 - » Distributing sexual reproductive and maternal health (SRMH) supplies (male condoms, CDK, health facility delivery kits, referral level (hospital) emergency supplies) expected to be procured by UNFPA
 - » Delivering MISP activities, specifically community mobilization (possibly logistics, specifically for rural delivery)
 - » Supporting health facilities/birthing centers with equipment and support midwives to provide EMOC

Naranyani Zone

Inner Terai region:

Makwanpur

- Estimated number of people in need: 156,489 (37.2% of the district)
- Number of IDPs: 601
- Birthing centers: 20 completely destroyed and 8 partially damaged
- Hospital: unlisted
- Primary health care center: 1 partially damaged
- BEmONC: unlisted
- CEmONC: unlisted
 - o As of May 9, 2015, IPPF, through SPRINT Initiative and FPAN, had organized mobile RH health camps to provide general health services, as well as crucial sexual and reproductive health services¹³²

132 Ibid.

Sagarmartha Zone

Hill region:

Okhaldhunga

- Estimated number of people in need: 59,818 (40.4% of the district)
- Number of IDPs: 6,684
- Birthing centers: unlisted
- Hospital: 1 partially damaged
- Primary health care center: unlisted
- BEmONC: unlisted
- CEmONC: unlisted

*Estimated population affected as of May 29, 2015¹³³

**Status of health facilities as of May 19, 2015¹³⁴

***Number of IDPs as of June 2015¹³⁵

Flash appeal for April through July 2015¹³⁶:

- Minimum Initial Service Package for Reproductive Health to 23,625 women, men, and newborns by CARE Nepal (\$175,000)
- Maternal and child health service support to disaster-affected children, pregnant women, and lactating mothers by PLAN (\$436,423)
- Ensuring lifesaving sexual and reproductive health services in earthquake-affected districts by UNFPA (\$6,420,000)
- Equitable emergency lifesaving primary health care services for mothers, newborns, and children by UNICEF (\$15,498,000)

133 Nepal Earthquake Assessment Unit, Nepal Earthquake: Number of People in Need (Nepal, May 25 2015).

134 Government of Nepal's Health Emergency Operation Centre, *Health Sector response: Earthquake 2015-Daily Situation Update Report* (Nepal, May 19 2015).

135 International Organization for Migration, *Displacement Tracking Matrix* (Nepal, June 15 2015).

136 United Nations Office for the Coordination of Humanitarian Affairs, *Nepal Flash Appeal for Response to the Nepal Earthquake* (May 4, 2015).



NEPAL EARTHQUAKE HUMANITARIAN RESPONSE

CONTRIBUTIONS MOBILIZED FOR THE EARTHQUAKE RESPONSE	USD
JAPAN	1,000,000
UNITED KINGDOM (DFID)	777,604
CENTRAL EMERGENCY RESPONSE FUND	753,815
EMERGENCY RELIEF FUND	605,000
GLOBAL PROGRAMME ON REPRODUCTIVE HEALTH COMMODITY SECURITY	500,000
AUSTRALIA (DFAT)	401,606
SWITZERLAND (EMBASSY OF NEPAL)	273,972
GERMANY (GIZ)	113,244
OCHA	100,000
AUSTRALIA (DFAT) REGIONAL FUNDS	56,912
WAKA-WAKA (value of in-kind contribution)	52,000
MATERNAL HEALTH THEMATIC FUND	44,950
FRIENDS OF UNFPA	41,010
UNFPA THAILAND (Country Office)	30,000
WORLD HEALTH ORGANIZATION (value of in-kind contribution)	27,405
UNITED BUDGET RESULTS ACCOUNTABILITY FRAMEWORK (UBRAF)	20,000
FRIENDS OF UN ASIA PACIFIC	10,313
LUMINAID (value of in-kind contribution)	10,055
UNFPA VIETNAM (Country Office)	5,042
GRAND TOTAL	4,822,928

* Amounts reflect contribution received based on the exchange rate applicable at the time of receipt.



NEPAL EARTHQUAKE HUMANITARIAN RESPONSE

ANNEX I. COVERAGE OF EMERGENCY REPRODUCTIVE HEALTH SUPPLIES (as of 19th Aug 2015)

Kits #	Name of RH kits	# of kits distributed	Health facilities	Direct beneficiaries	Beneficiaries
KIT 0	Administration & Training kit	19		0	SRH coordinator and health service providers/workers
KIT 1A	Male Condoms	25.5		10,200	Sexually active men
KIT 2A	Clean delivery - individual	79.5		15,900	Pregnant women
KIT 2B	Clean delivery (for use by birth attendants)	91		455	Birth attendants
KIT 3	Rape treatment	53		3,180	GBV survivors
KIT 4	Oral & injectable contraception	110		41,250	Women of reproductive age
KIT 5	Treatment of STIs	107		29,425	People with STIs
TOTAL BLOCK I		485		100,410	
KIT 6A	Clinical delivery assistance - reusable equipment	95	95	-	Pregnant women with assisted deliveries in health facilities
KIT 6B	Clinical delivery assistance - drug & disposable equipment	95		4,275	Pregnant women with assisted deliveries in health facilities
KIT 7	Intra uterine devices	78		4,680	Women of reproductive age
KIT 8	Management of complications of miscarriage	53		3,180	Women with miscarriage or suffering from complications of abortion
KIT 9	Suture of tears (cervical & vaginal) and vaginal examination	34		1,530	Pregnant women with assisted delivery in health facility
KIT 10	Vacuum extraction delivery	31		279	Pregnant women with assisted delivery in health facility
TOTAL BLOCK II		386		13,944	
KIT11A	Referral level for RH - reusable equipment	7	7	-	Pregnant women and complicated deliveries in health facilities
KIT11B	Referral level for RH - drugs & disposable equipment	7		735	Pregnant women and complicated deliveries in health facilities
KIT 12	Blood transfusion	6		600	Pregnant women and complicated deliveries in health facilities
TOTAL BLOCK III		20		1,335	
GRAND TOTAL		891	102	115,689	



NEPAL EARTHQUAKE HUMANITARIAN RESPONSE

ANNEX II. MONITORING & EVALUATION INDICATORS (as of 19th Aug 2015)

SEXUAL AND REPRODUCTIVE HEALTH	
TEMPORARY FACILITIES	
1 No. of RH camps conducted	93
2 No. of maternity tents set up and operationalized	6
3 No. of transition homes set up for pregnant and postpartum women in targeted affected districts	21
4 No. of pregnant and postpartum women accessing services through transition homes and maternity tents.	49
MOBILE RH CAMP SERVICES	
5 No. of total services provided to affected populations with SRH, GBV, FP, Other (Dignity kit, IEC/Awareness raising, PSC, general health) through mobile RH camps	60,439
<i>Women and girls</i>	49,613
<i>Men and boys</i>	10,826
6 No. of FP service users through mobile RH camps	4,369
<i>Women and girls reached</i>	3,255
<i>Men and boys reached</i>	1,114
7 No. of affected population reached with awareness-raising sessions and IEC materials distributed on SRH and GBV through mobile RH camps	4,830
<i>Women and girls reached</i>	3,645
<i>Men and boys reached</i>	1,185
8 No. of affected population reached with SRH services through mobile RH camps	20,015
<i>Women and girls reached</i>	18,358
<i>Men and boys reached</i>	1,657
9 No. of affected population reached with GBV services through mobile RH camps	1,972
RH KIT DISTRIBUTION	
10 No. of partners, other than IPs and earthquake-affected district health facilities provided with RH kits	891
<i>UNFPA IPs</i>	431
<i>Distribution Status beyond IP: District Health Offices</i>	110
<i>Distribution Status beyond IP: UN, I/NGO, Private, Comm. Hospital, OCMCs</i>	350
CAPACITY BUILDING	
11 No. of health workers oriented on RH kits	105
12 No. of youth facilitators, volunteers trained / mobilized	181
ASRH AWARENESS RAISING (OUTSIDE RH CAMPS)	
13 No. of adolescents (10-24 years) reached through ASRH awareness-raising sessions (outside mobile RH camps)	1,455
RADIO MESSAGING	
14 No. of episodes airing SRH, GBV and ASRH messages in local FM radios	5,110



NEPAL EARTHQUAKE HUMANITARIAN RESPONSE

GENDER BASED VIOLENCE		
FEMALE-FRIENDLY SPACE		
15	No. of FFSs established	14
16	No. of affected women and adolescent girls in targeted districts accessing FFSs	9,022
17	No. of adolescent girls, women, survivors of GBV reached with psychosocial counseling, case management and PFA	8,001
	<i>RH Camp</i>	<i>4,086</i>
	<i>FFS</i>	<i>2,194</i>
	<i>PFA Volunteer, Outreach Workers</i>	<i>1,721</i>
18	No. of GBV cases referred for services (only for GBV survivors that were provided services in FFS by PSC, CM and outreach workers)	68
DIGNITY KIT DISTRIBUTION (inside and outside FFS)		
19	No. of dignity kits distributed to female vulnerable groups	11,268
	<i>FFS</i>	<i>504</i>
	<i>RH Camp</i>	<i>937</i>
	<i>Outside FFS and Outside RH Camp, beyond IP</i>	<i>9,827</i>
RH KIT DISTRIBUTION		
20	No. post-rape treatment kit (RH Kit 3) provided in RH camps and OCMC	47
CAPACITY BUILDING		
21	No. of health service providers trained, oriented to implement GBV response and CMR	130
22	No. of trained PSC, CMs, and PFA volunteers in place for the provision of services	91
	<i>Psychosocial Counselors</i>	<i>12</i>
	<i>Case Managers</i>	<i>14</i>
	<i>PFA Volunteers</i>	<i>65</i>

FOCUS GROUP DISCUSSION FINDINGS

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*Thanks to Research Input and Development Action (RIDA)
for conducting the focus group discussions; and Family
Planning Association of Nepal for coordinating, scheduling,
logistics, and overseeing recruitment of participants.*

Summary of FGD Methods

Purposive sampling was used to select participants for the focus group discussions (FGDs) in Kathmandu and Sindhupalchowk from September 14 to 18, 2015. Thirty-two FGDs were conducted, with no more than 10 youth or adults per group, representing a maximum number of 320 participants. There was a sufficiently large target sample size to achieve saturation of themes within and across the four gender-age strata with two FGDs each: girls aged 18 – 24 years; boys aged 18 – 24 years; women aged 25 – 49 years; and men aged 25 – 49 years. Each gender-age stratum included one pre-test focus group.

Age-Gender Group	Site 1 – Kathmandu		Site 2 – Sindhupalchowk		Total
	No. of FGDs near health facilities	No. of FGDs far from health facilities	No. of FGDs near health facilities	No. of FGDs far from health facilities	No. of FGDs across all sites
Girls aged 18-24 years	2	2	2	2	8
Boys aged 18-24 years	2	2	2	2	8
Women aged 25-49 years	2	2	2	2	8
Men aged 25-49 years	2	2	2	2	8
Total No. of FGDs	8	8	8	8	32

Inclusion criteria:

- Age 18 - 49
- Nepali speaking
- Near facility: Live in walking distance of a health facility that provided reproductive health services after the earthquake
- Far from facility: Not within walking distance of a health facility that provided reproductive health services after the earthquake (>1 hour)

Four teams of research assistants, consisting of one facilitator and two note takers, collected the FGD data. The teams participated in a

three-day training, including one pilot FGD. In Kathmandu, discussions with study participants were conducted in various community centers, such as a Family Planning Association of Nepal (FPAN) clinic, gymnasium, school, and tents located in displaced person camps. In Sindhupalchowk, discussions took place in schools, community shared spaces, private homes, hospital grounds, and female-friendly spaces. On average, FGDs took about 90 minutes and used a standardized guide consisting of structured and unstructured questions to facilitate the discussions. Notes were handwritten during the discussions by the note takers, and were transcribed and translated within one week by the FGD teams.

For the analysis, FGD teams debriefed at the end of each discussion as a group with the supervisor to clarify responses and notes, and to begin the identification of key themes in each discussion and key similarities and differences between discussions. The facilitator included their notes on nonverbal actions during the FGDs to the transcriptions. A codebook was developed to list all codes and their definitions using a deductive coding process based on themes identified a priori. During the coding process, data was continuously reviewed, emerging patterns noted in memos, and relationships between codes and themes further refined. Additionally, important participant quotes were underlined or highlighted to further illustrate examples.

1. Description of Sample

Kathmandu

We interviewed 16 groups of Nepali earthquake-affected persons with an estimated age range of 18 to 49 in Kathmandu District, with eight groups of males and eight groups of females. Eight groups totaling 54 participants were 18-24 years old, and eight groups totaling 59 participants were 25-49 years old. We spoke to a total of 57 women and 56 men, including those who live near and far from health facilities. In Kathmandu District, we conducted FGDs in the following towns and villages: Kapan, Jorpati (Besigaun), Thali (Dachi), Gagalphedi, and Chuchepati. The participants we spoke with were recruited by relief agencies such as FPAN and their community health volunteers. The participants in Thali and Chuchepati had been residing in displaced person camps for the

past five months (post-earthquake). The participants who were not living in camps had lived in the same town pre- and post-earthquake.

Sindhupalchowk

We interviewed 16 groups of Nepali earthquake-affected persons with an estimated age range of 18-49 in Sindhupalchowk District, with eight groups of males and eight groups of females. Eight groups totaling 69 participants were 18-24 years old, and eight groups totaling 67 participants were 25-49 years old. We spoke to a total of 70 women and 66 men, including those who live near and far from health facilities. In Sindhupalchowk District, we conducted FGDs in the following village development committees (VDC): Chautara, Badegau, Melamchi, Dadapakha, and Barabise. The participants we spoke with were recruited by female community health volunteers (FCHVs), with guidance from UNFPA and FPAN. All participants we spoke with were living in the same villages they had been prior to the earthquake.

2. General Situation for Humanitarian Response

General concerns among Nepal's crisis-affected population

Although the primary purpose of the FGDs was to gather information on reproductive health (RH) services, the Nepali participants had a desire to share additional information that was pertinent to them.

Kathmandu

In Kathmandu, general health care was mentioned consistently in several groups including male and female participants. They described a need for having more adequate care at health posts, with longer hours of operation and greater variety of medicines, and in Kapan and Gagalphedi, they expressed concerns about facilities that are too far for them to access care now. One group mentioned the need for psychological counseling services. Among men, most voiced concerns with unemployment issues particularly for the “youth.” Females living in the displacement camps expressed concerns about the safety of accessing toilets and water supply in the evening because they were afraid of “robbers” or “kidnappers.” Participants who lived in displacement camps were concerned about the lack of sanitation and clean water immediately after

the earthquake, and still faced problems with flooding and mosquitoes inside their tents.

Sindhupalchowk

In Sindhupalchowk, the primary concern raised by all focus groups was the need for permanent housing with sufficient space for families, and improved living conditions. Participants talked of having to share temporary shelters, including tents, with many families, and concerns with trying to keep everyone healthy and having sufficient privacy. Other critical needs mentioned included access to clean water and toilets. Six focus groups also mentioned mental health and “fear” stemming from the earthquake and the ongoing need for psychological counseling, especially for children. Focus group participants voiced frustration that health facilities, particularly health posts, carried only paracetamol so could not effectively respond to the health needs of the community.

3. MISP Coordination

Community participation in service delivery

Kathmandu

In Kathmandu, when participants were asked about their participation in the humanitarian response, most of the groups across the sites reported that they actively participated in the humanitarian response. Community participation consisted of volunteering to distribute materials, disseminating information about distributions, or identifying those in most need. In one site, a management committee facilitated the distribution of supplies or relayed the community’s concerns to the response organizations.

Most of the group participants did not report that their communities were contacted directly by relief organizations to inform them of available services. Instead, information about available services was delivered using announcements (via loudspeakers), radio, and television. All participants in one male youth group felt that social media should have been used to share information on the location of services and distributions.

Sindhupalchowk

In Sindhupalchowk, participants spoke of the role that their VDC and

a variety of organizations played in distributing food stuffs, clothes, menstruation pads, packaged nutritional porridge for children (lito), tents, and psychological counseling within a few days or weeks of the earthquake. Inclusion within the service delivery was noted only by men, not women, and was primarily in regard to their involvement in the water and sanitation programs. In two villages, youth were also involved in some nutrition and health campaigns.

Adolescent centers

Kathmandu

The majority of FGD participants did not know of any adolescent programs or centers. In Kapan, the female groups were aware of weekly education sessions on reproductive health for adolescent girls held at the FPAN clinic. Prior to the earthquake, the participants in one site reported that youth groups were held for adolescents on HIV/AIDS and sex trafficking. The majority of groups reported a desire for centers that are for adolescents only because most feel shy accessing reproductive health services from the health post or hospitals.

Sindhupalchowk

No focus groups knew of any adolescent programs or centers except one women's focus group, which mentioned adolescent reproductive health education at school. Similarly to Kathmandu, many participants voiced interest in having an adolescent reproductive health program and the benefits of having such education, given that most members felt shy, particularly men and boys, in accessing sexual health services from the FCHVs or local health posts.

4. Prevent and Manage the Consequences of Sexual Violence

Measures to protect affected populations

Kathmandu

The majority of female and male groups did not voice concerns about fear of physical or sexual violence in their communities, while several participants described cases where intimate partner violence and

sex-selective abortion might occur in their communities.

“It’s not as big an issue. But it is a problem. We haven’t seen such problems here.”

– Thali, male participant

“We do not have any problems from our husband. It is not like before these days, things have changed. Sometimes we fight with our husband....[W]e have not heard about any such issues in the nearby communities either.”

–Gagalphedi, female participant

“We can now see that both husband and wife are job holders. There is competition between them. There are many cases of doing blackmail and rape as well. There are men who threaten their wife for sex or they will leave them.”

– Jorpati, male participants

“Discrimination is there between having a son and daughter. The female fetus is killed and the male fetus is kept.”

– Chuchepati, female participant

The women in both displacement camps (i.e., Thali and Chuchepati) spoke about fear of accessing water or toilets in the evening, robberies, and kidnappings of small children. All groups expressed that there are no safety concerns that would prevent the community from accessing health services.

Sindhupalchowk

Similarly to Kathmandu, nearly all groups said that sexual violence does not occur in their own communities. Those respondents who spoke of violence in their communities mostly referred to violence between a husband and wife that was dealt with in private. In just a few villages, violence was mentioned in the form of touching, verbal sexual harassment, and violence by mothers-in-law. In one village, reports of kidnapping and trafficking were discussed, but participants said they had occurred elsewhere. A few participants voiced safety concerns in their temporary shelters or walking alone, but no one reported personal experiences of

violence or said these fears had come from community incidents. Many participants noted that even if violence did occur, reporting would be rare out of fear of blame and shame against the survivor.

“In my view, there is no such gender violence in our community. We have seen simple fights between husband and wife that we sort out on our own.”

– Barabise, male participant

“Touching and doing bad behavior. When traveling, boys touch. Even teasing but it does not happen in our place. It happens in unknown places. Touching women’s genital parts, showing one’s genital parts. There are few in this village, not much.”

– Barabise, female participant

“We don’t feel secure. It is not like staying in home. What if they come breaking the tents?”

– Dadapakha, female participant

“There is no such insecurity. But we are afraid to walk alone.”

– Badegau, female participant

“What I say is it is also in our villages. But these things don’t come out. If they talk about it with their mothers, then they blame the daughters, that it is you who is like that. So they don’t tell their mothers; if they do so they will get scolded. But I talk with my daughters. And they have grown up so they share every problem.”

- Badegau, female participant

Age at marriage

Kathmandu

Male and female participants consistently reported that women and men are both getting married later because the youth are becoming more educated and prefer to marry after age 20. The majority of groups

reported women and men marry after the age of 20, although there are some young girls that are married by the age of 15 to 18. Most felt that the age of marriage had not changed after the earthquake.

Sindhupalchowk

Male and female respondents reported no change in the age of marriage since the earthquake, but a change from marriages previously occurring at 13-14 to currently taking place at 18-22 years. A few focus groups mentioned that for more rural communities, the age of marriage, although becoming later, was closer to 15-16 years. Five focus groups spoke of the ages of couples having love marriages, and eloping, as a few years younger (15-16) than arranged marriages by parents (18-22).

Clinical care for rape survivors

Kathmandu

When participants were asked about the types of services available in the community for someone who has experienced physical or sexual violence, all groups reported that they are not aware of any services for physical or sexual violence, including psychological care. While all FGD groups reported that there are no clinical services, most felt that services should be available in the community for physical or sexual violence.

Sindhupalchowk

In Sindhupalchowk, awareness of services for physical and sexual violence consisted of knowing that survivors can report violence to the police and/or to women's rights organizations. When asked about the availability of psychological services, most had not heard of programs for survivors but a few mentioned psychological counseling after the earthquake, particularly for children. A few focus groups mentioned the need for psychological counseling and two focus groups mentioned the need for health services for survivors.

Community awareness of services

Kathmandu

Participants described that people who experienced GBV should consult with the police, obtain health treatment, and receive "financial empow-

erment” and psychological services. In some cases of intimate partner violence, the wives would seek help from the mother-in-law before seeking justice from the police. In Gagalphedi, participants shared that their community tries cases where there is violence between a husband and wife. Despite the desire for health services for GBV survivors, the majority of participants were not aware of the benefits of seeking timely health care. For those who thought services should be available, the participants described that the service providers should be respectful and trustworthy, and health facilities for GBV survivors should be open 24 hours a day.

Sindhupalchowk

Many focus groups said they were unsure of what services are available should violence occur. The focus groups that spoke of services for survivors mentioned accessing women’s rights organization (such as Maiti Nepal, Sathi, or Pink) and/or reporting the incident to the police. Three focus groups also mentioned the survivor should seek counseling. Even if violence takes place, it was clear that it is not often reported because of blame on the survivor. As in Kathmandu, the majority of the participants, even those who mentioned health services, were not aware of the benefits of seeking timely medical care for GBV survivors.

“Women remain silent [so] that others would [not] know about it. Otherwise they will be blamed and disgraced, even if they are innocent.”

– Badegau, female participant

5. Reduce HIV Transmission

Availability of condoms

In both Kathmandu and Sindhupalchowk, the majority of participants, regardless of sex or age group, were aware of free and accessible condoms in or near to their communities. Health posts and other government facilities were described as the main locations for accessing free condoms.

“We can get it for free, but if we get it in the clinic we have to pay. The cost depends on the place. We should be able to spend for our health. I don’t think there are people in Kathmandu who can’t buy condoms.”

– Jorpati, male participants

In Kathmandu, some groups felt that condoms that were freely available were not good quality and preferred to purchase them from the pharmacy (cost about Rs 5-15). In Chuchepati displacement camp, none of the groups were aware of how to access free condoms and stated that they are not freely available because agencies were concerned that the community will misuse or sell them.

Knowledge of transmission and prevention of HIV and other STIs

In both districts, the participants had mixed knowledge of how HIV is transmitted or of how they can prevent the transmission of HIV and other sexually transmitted infections (STIs). In Kathmandu, the younger male and female age groups, aged 18 to 24, described that HIV and other STIs can be transmitted through blood, sex trafficking, mother to child, syringe exchange, unsafe sex, and multiple sex partners. In Sindhupalchowk, participants described transmission of HIV through sleeping with multiple partners, unsafe sex, and using unclean blades and syringes. Groups reported learning about HIV and other STIs in school, as well as in books, posters, newspapers, FCHVs, TV, and radio. In Kathmandu, several groups shared that the younger generation is learning about STI transmission and prevention in their classes at school. Among older groups, male participants were more aware of HIV transmission mechanisms and prevention strategies (e.g., testing and condoms) than female participants. Similarly, in Sindhupalchowk, men spoke more than women about HIV transmission, symptoms, and services available.

The majority of groups, in both age groups and both districts, were either unaware of where to access services for HIV and other STIs, or felt that there is too much stigma with accessing available clinical services. In Sindhupalchowk, many groups said there was no one with HIV in their community so they did not know any services. A few groups said if there was someone with HIV, they would seek health services at the health facilities far from the community and they would not speak about it within

the community because of stigma.

“Since the people who have HIV are looked [at] in bad way, so many people hide this illness.”

– Kapan, male participant

“If they get such disease, people are scared what the society will say about them. Uneducated people hide the disease, but educated people treat it.”

– Gagalphedi, male participant

“At first, if they know about it they hide it.”

– Melamchi, female participant

“There might be in this community, but who will share such thing? They do not speak about it.”

- Dadapakha, female participant

“Those who want to know asks in health post. Others hide and wait to die. Everybody says it is bad.”

– Barabise, female participant

“In my opinion, people are afraid to do the test here because other villagers might know about them and so they go to Dhulikhel and Kathmandu to do the test for STI.”

– Badagau, male participant

“We don’t have any health services related to HIV and thus, we go to Dhulikhel hospital for the treatment.”

– Barabise, male participant

“We don’t have treatment for STIs here. For this we can go to Dhulikhel and Kathmandu for the treatment.”

– Melamchi, male participant

6. Prevent Excess Maternal and Newborn Morbidity and Mortality

Availability of emergency obstetric care (EmOC) and newborn care services

Kathmandu

In Kathmandu, all participants, regardless of whether they lived near to or far from a facility, knew where to go to receive maternal and newborn care, particularly after the earthquake. The majority of participants said that women in the community would go to a hospital to deliver and they would not deliver at home. Nearly all groups reported that they would go to a government hospital if they cannot afford to go to a private hospital. While all groups were aware that government hospitals would give Rs1,000 (USD 9.12) as an incentive for facility-based delivery, a few groups reported that there is still a high cost for medicine and overnight stay at the facility. Immediately after the earthquake, only two groups recalled that maternal and newborn services were free of charge in government facilities and at reduced cost in private hospitals. In Chuchepati, both female groups reported that humanitarian organizations came to gather the names of pregnant women and arranged for them to be taken to the hospital for a check-up. The list of hospitals accessed for maternal care by all groups consist of Thapathali Maternity Hospital, Helping Hand, Teaching Hospital of Maharajgunj, Nepal Medical College, WOREC, and Om Hospital.

In response to questions about newborn care services, FGDs reported that sick children are taken to the closest health post, Kanti hospital, a private clinic, or the hospital where the newborn was born. The health posts were reported to provide vaccinations. Two groups reported first seeking care for sick newborns from the traditional healer in their community prior to going to a hospital.

“They mostly go to a traditional healer rather than going to the hospital. Such places are nearby. Only a few go to hospitals.”

– Kapan, male participant

When asked specifically about their perceptions of maternal and newborn services, the groups gave mixed responses. Several groups of male and female participants expressed that the community prefers private health

facilities as opposed to public facilities because of concerns about the quality of care at public facilities, which included the lack of provider knowledge, long wait times, limited staff during holidays and evenings, and far distance to public facilities. Participants also reported financial barriers to accessing maternal care at government facilities, such as increased charges in the evening hours and fear of referral to expensive facilities for advanced care.

Sindhupalchowk

In Sindhupalchowk, all participants regardless of whether they lived near to or far from a facility, knew where to go to receive maternal and newborn care. There were mixed responses on how equipped the nearest health post was as a delivery facility. Nearly all groups said they deliver at the nearest health facility, often a health post, unless they are having complications, in which case they seek services at a district hospital, which can be up to four hours away. With the destruction of the Sindhupalchowk district hospital during the earthquake, comprehensive emergency obstetric care was not perceived to be available in Sindhupalchowk and for any complications patients visited hospitals in Dhulikhel or Kathmandu.

“We go to health post for small problems like stomach pain, but if any complication occurred we have to go to district hospital and we cannot afford it.”

– Melamchi, female participant

Perceptions of higher quality in district hospitals over health posts was reported as a reason to bypass health posts for district health facilities for higher quality reproductive health services. Perceptions of low health worker knowledge, insufficient stock of medicines, and limited working hours were reasons given for going straight to district hospitals for critical care. However, the cost of bypassing the health post and paying for private or district hospital care, and the transport costs to get there, were also a concern.

For women in close proximity to roads, an ambulance is called in emergency cases. For communities farther from road access, patients were carried out on stretchers. However, many communities explained that after the earthquake many roads were blocked so patients had to be carried out on stretchers. Because of damage during the earthquake,

community members spoke of having to skip their closest health facility and take complicated cases directly to neighboring district hospitals where they had faith in the availability of equipment.

“We have problems of road. We have to carry the patient. Sometimes in bed sheet, sometimes on our back. We have to carry till the road where ambulance can come.”

– Chautara, female participant

“After earthquake, the road system was destroyed so the youths of the village helped by carrying patients on stretchers”

- Dadapakha, male participant

“Before the earthquake they had easy access of test and treatment from health post. But now since the equipment is destroyed by the earthquake, they have to go somewhere outside the district.”

– Badegau, male participant

All but one focus group said their nearest health facility was not operating 24/7. This meant that either services were unavailable or community members would have to pay to access services if emergencies happened outside of working hours. Four focus groups mentioned seeking health care services for delivery at private facilities during holidays or outside the hours of 10am-4pm when government health facilities were closed. One participant said they prefer private facilities for better health workers. Accessing care outside of working hours meant added costs to patients, even in government health facilities.

“Private offices have more nice doctors than governmental [facilities], therefore, we take the baby to the private clinics in case of serious problems.”

– Chautara, male participant

Communities spoke often of seeking out advice from the FCHVs, midwives, and skilled birth attendants before making decisions of what health facility to access. Women noted they also seek support from family members, including husbands and mother-in-laws.

Recommendations given by participants for better health care include nutritional food for women, 24/7 access to quality health care (included well-trained staff, appropriate and sufficient medicines and good quality equipment, and closer access to comprehensive services), and access to free ambulances.

Type of delivery

Kathmandu

When asked about preference for delivery method, there was a mixed response from all groups and sites. Half of the groups stated that they preferred natural births, whereas the other half preferred cesarean sections. The majority of groups stated there has been no change in the preference for the delivery method following the earthquake; however, two groups mentioned that immediately after the earthquake women preferred to have a cesarean section because they feared being indoors for the long duration of a natural birth.

Sindhupalchowk

In Sindhupalchowk, women spoke of a preference for natural births. Cesarean sections were only mentioned in case of complications when a natural birth was not possible, and the additional cost of having a cesarean section was mentioned. Although few focus groups discussed whether they give birth at home or at a facility, it was noted a few times that most people were accessing facilities for births.

Breastfeeding newborns

All FGDs in both districts agreed that women generally begin breastfeeding newborns immediately after delivery until about two years of age (up to 3-4 years mentioned in Sindhupalchowk). Several participants across groups mentioned that women might wait two hours to two days after delivery to initiate breastfeeding because there is no milk production. Since the earthquake, nearly all FGDs agreed that there has been no change in the breastfeeding practices in their community. In Sindhupalchowk, awareness raising of breastfeeding was credited to Suuahara, Tuki, FCHVs, radio, TV, and newspapers. In one community, and anecdotally in others, lack of privacy in shared temporary housing after the earthquake affected breastfeeding practices.

Establish a referral system to facilitate transport and communications

Kathmandu

The majority of participants reported that women primarily take an ambulance or taxi when seeking delivery services. For newborns, most reported taking a motorbike, taxi, or bus, whereas an ambulance was taken only when there is an emergency. In all 16 FGDs in Kathmandu, the participants reported that the relatives, friends, and members of the community would provide financial support to help pregnant women reach the facility. One group recommended for ambulances to be free of cost so women could reach facilities more quickly.

Sindhupalchowk

Participants reported knowing about birthing services through FCHVs, newspapers, radio, books, and health posters at the facility. The majority of participants reported that women either take an ambulance or stretcher, carried by family members and youth, to a facility. Many respondents spoke of the costs of transport to the health facility, as an ambulance's costs depend on distance, as well as additional costs if emergencies occur outside of facility working hours. Other more discrete costs noted included food and family members' transport.

“Apart from health post, if we have to take emergency services we have to bear cost of transportation and treatment. We get basic services from this health post; to get emergency services we have to go to other clinic.”

– Dadapakha, male participant

“Ambulance charge according to the distance; if it's far they charge one thousand and if it's near they charge six hundred to eight hundred.”

– Melamchi, female participant

As mentioned in the section on availability, patients often bypass health posts for district facilities if they have complications. This decision is

often made with those supporting them, such as family members and FCHVs. With the destruction of the Sindhupalchowk district hospital during the earthquake, patients went directly to Dhulikhel or Kathmandu, particularly Thapathali hospital, for complicated cases but sometimes even for standard care, because of the perceptions of higher quality care for the birth and follow-up treatment.

“[We seek care after birth at the] hospital. Health post does not have enough facilities.”

– Badegau, female participant

Knowledge of danger signs for maternal and newborn care

Kathmandu

All participants, including males and females, were able to describe basic danger signs that might occur during pregnancy, such as heavy bleeding, excessive stomach pain, and lack of fetal movement. For newborns, there was less awareness of danger signs among male participants. However, female groups were aware of danger signs, including jaundice, inadequate weight gain, respiratory illness, feeling cold or a fever, umbilical infection, and no appetite.

Sindhupalchowk

All focus groups were able to describe basic danger signs that might occur during pregnancy such as heavy bleeding, fever, excessive pain, and lack of fetal movement. However, some participants included itching and watery discharge as danger signs. Participants listed danger signs for newborns, including fever, jaundice, loss of weight, diarrhea, trouble breathing, inability to nurse, and pneumonia, while some also mentioned blisters, cold, wound, and rash as danger signs. Sometimes traditional healers were sought because of the expense of taking children to district hospitals in Kathmandu or Dhulikhel.

“When women have white watery discharge or bleeding, then they go to health post or hospital. But many of them don’t go because older women say that nowadays young

women go to health post even if they have no problem. So women hide their problems and stay in home."

– Chautara, female participant

"When jaundice is seen in babies or when the baby has blisters, either they are taken to health post or some are kept in home. Some are given herbal medicines. There are problems in home. It is very expensive to go to Kathmandu for treatment. Most people don't take their kids for treatment to Kathmandu. They go only when the condition is severe. It is because of financial crisis and many people don't have money."

– Badegau, female participant

7. Plan for Comprehensive RH Services

Barriers to seeking reproductive health services

Kathmandu

Women and men perceived several difficulties to seeking reproductive health services in Kathmandu. For maternal and newborn health services, the main reason expressed by participants across groups was financial costs.

"If we could have free health services, then it would be good. For the poor, it is like 'If we don't take the health service it will be hard on us and if we take it then it will also be hard' as it is expensive."

– Kapan, male participant

As described above, quality of care received at facilities was an important predictor of where participants would go to seek health services. For family planning, STI and GBV health services, participants uniformly voiced negative perceptions by the community or lack of privacy as key barriers to accessing these services. For female participants, several groups frequently reported the lack of female providers as a barrier to accessing family planning services.

“When we go to health posts for injections or for buying pills, when we see a man there we feel really awkward. We feel shy asking them for these services.”

–Thali, female participant

Sindhupalchowk

Focus groups reported multiple barriers to health-seeking behavior for reproductive health services. Barriers mentioned included perceptions of the low quality of care, including low health provider knowledge and limited availability of appropriate equipment or medicines. Shyness, reported by both men and women, in disclosing reproductive health needs, was also mentioned frequently, as was the fear of appearing weak in the eyes of community members or family. As in Kathmandu, financial costs of visits were another big deterrent to seeking health services.

“They are shy to be open about it so they hide it instead.”

- Badegau, female participant

“They are afraid people will know about it and gossip.”

– Chautara, female participant

“Actually women don’t seek help because in villages people don’t take much rest. The mother-in-law and other women tell [them] that they never rested or got any health services when they were pregnant. So the pregnant women here don’t much seek any services. They hide their problems in fear of what people will think.”

– Badagau, female participant

“We don’t have money, how will we go?”

– Dadapakha, female participant

Nearly all male focus groups noted the lack of health services for men, and some mentioned this as a barrier to seeking sexual health services.

“In health facilities, mostly there are female health workers, which makes us uncomfortable to openly talk about our health problems.”

– Badegau, male participant

“Some men feel ashamed to ask condoms in health posts and so they prefer to buy in private medical shops.”

– Badegau, male participant

7. Additional Priorities of the MISP

Ensure contraceptives are available to meet demand

Kathmandu

When asked about what people in the community do to prevent pregnancy, all groups had a great deal of knowledge of both short- and long-term methods of family planning. The primary methods that were reportedly used in the community included Depo-Provera, birth control pills, Norplant, and the copper IUD. All participants expressed a strong desire for family planning, and the majority of groups reported that family planning was easily accessible and free of charge. All male participants were aware of where to access free condoms. Participants reported that knowledge of contraceptives was primarily obtained through the media, mothers' groups, word of mouth, and health facilities.

Across male and female FGDs, the majority of participants did not know about emergency contraception and the few participants who were aware stated that it was too expensive to use (about Rs200-300 (USD 1.80 – 2.70)).

When asked about what a woman would do if she were pregnant and did not want to be, nearly all respondents reported, regardless of sex and age, that the woman could have a safe abortion after the husband and wife had a discussion.

Sindhupalchowk

All focus group participants had a great deal of knowledge of both short- and long-term methods of family planning. All participants knew where

to get family planning methods and that they were free of charge. Most men reported using condoms or having the option to have a vasectomy once they had had the desired number of children. Vasectomies were mentioned as available through outreach campaigns occurring every six months. Information on family planning methods was received through school, health workers, radio, TV, posters, and family members and friends. The contraceptive methods reported included the pill, Depo-Provera, Norplant, condoms, and IUD. No focus groups had heard of emergency contraception. Abortions were rarely acknowledged as taking place, and participants reported that even if abortions occurred, women would not disclose this because of stigma. A few participants talked about community incidents of unsafe abortions and one participant mentioned suicide as a result of the stigma.

“In our community, women use medicine if they do not want to be pregnant. They also do abortion if they know they are pregnant but they do not want to be. In our society, women don’t tell anyone that they are pregnant.”

– Dadapakha, male participant

“In my opinion, women who don’t want to become pregnant do abortion, but in village it is known to everybody, so they do abortion in cities.”

– Badegau, male participant

Syndromic treatment of STIs is available to patients presenting with symptoms

Kathmandu

Participants in Kathmandu had nearly no knowledge of the types of services available to those who may have an STI, or where to access these services.

Sindhupalchowk

Very few participants in Sindhupalchowk mentioned examples of STIs and no participants had knowledge of the types of services available for those who may have an STI. They did recommend seeking services at the health post but, like HIV, said those actually seeking services would probably go farther away from the community for privacy purposes.

Culturally appropriate menstrual protection materials are distributed

Kathmandu

The majority of women in all eight FGDs in Kathmandu said they had not received a single distribution of menstrual materials since the earthquake. However, both displacement camps had received one to two distributions of sanitary pads. Both sites reported that some women did not know how to dispose of the sanitary pads, and recommended that future distributions include instructions for disposal.

Sindhupalchowk

All female focus groups except for one said they had received sanitary pads after the earthquake. Pads were often distributed alongside other sanitary items such as soap and clothes, and other necessary items such as food and tents. Challenges with privacy and having enough sanitary pads or clothes were one of the primary concerns raised by women related to reproductive health after the earthquake.

Draft Recommendations

- Improve women's and children's safety in accessing toilets and water in camps/communities.
- Improve access to safe, permanent shelter with consideration to adequate privacy and security.
- Consider the use of social media in future humanitarian emergencies and plan for its use during the process of disaster risk reduction.
- Expand adolescent-friendly services and safe places in the camps and in future humanitarian emergencies.
- Strengthen GBV referral pathways and conduct awareness campaigns with the GBV Sub-cluster on improving knowledge of GBV characteristics and benefits for immediately seeking health services among communities.
- Ensure access to free condoms in Chuchepati displacement camp.
-

- Improve community knowledge of HIV and STI prevention and treatment mechanisms.
- Use different media to inform the community of where to access free reproductive health services immediately following a humanitarian emergency.
- Improve community knowledge of danger signs for newborns and where to access free newborn services immediately following a humanitarian emergency.
- Improve access to free ambulances to health facilities and stretchers where roads are impassable.
- Reduce costs incurred when emergencies occur outside of health post or Primary Health Care Center (PHCC) working hours, or when complications demand accessing hospitals in other districts.
- Improve access to comprehensive emergency obstetric care (CEmOC) in Sindhupalchowk to reduce additional risks to the patient and baby when seeking care in other districts
- Conduct community awareness campaigns to disseminate information on services available and reduce stigma associated with survivors of violence, women who have had abortions, and persons who have HIV/STIs.

Limitations

There were multiple limitations to this evaluation. The evaluation was conducted nearly six months post-crisis, which resulted in a longer recall period for FGD participants. This recall may bias the findings on the availability and knowledge of humanitarian services immediately after the crisis. Facilitators tried their best to differentiate the responses of participants from the pre-crisis period to immediately after the earthquake using repeated probes for clarification. The information collected during the FGDs may have been biased by the facilitators' lack of probing on issues to generate more in-depth information. There may also be selection bias, given participants for the FGDs were selected based on their residence in a predefined site that may not have been as affected by the earthquake as other sites in Kathmandu or Sindhupalchowk.

KEY INFORMANT INTERVIEWS

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Key Informant Interview Methodology

The purpose of undertaking key informant interviews (KIIs) during a Minimal Initial Service Package (MISP) for reproductive health (RH) evaluation is to understand the extent to which the MISP has been integrated into the humanitarian response and disaster risk and reduction (DRR) efforts.

The current assessment was undertaken following the April 2015 earthquake in Nepal.

Objectives

1. Assess key informants' knowledge of the MISP and additional priorities.
2. Assess key informants' knowledge of current MISP response.
3. Assess agencies' preparedness to implement the MISP.
4. Assess agencies' MISP response.
5. Explore overall availability of and accessibility to MISP services.
6. Determine integration of the MISP into DRR health policies and risk assessment and reduction measures in the host country.
7. Determine key facilitating factors and barriers to MISP implementation in this crisis response.

Summary of KII Methods

Purposive sampling was used to select reproductive health, gender-based violence (GBV) and HIV coordinators, managers, directors, and focal points from the Department of Health Services (DoHS) Family Health Division (FHD), and Disaster Management sections, relevant United Nations agencies, including the UN Population Fund (UNFPA), World Health Organization (WHO), and UNICEF, and international, national, and local nongovernmental organizations (NGOs) working in RH, GBV and HIV in Kathmandu and Sindhupalchowk, Nepal. Key informants (KIs) were identified through the MISP assessment background research, from websites such as the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) and Relief Web mapping who is doing what where in health and RH in Nepal, and with

the tremendous support of the UNFPA and International Planned Parenthood Federation (IPPF)/Family Planning Association of Nepal (FPAN).

A total of 26 KIIs, including 12 RH, 10 GBV, and 4 HIV, using three different (RH; GBV; HIV) semi-structured questionnaires, were conducted from September 13-21, 2015 in Kathmandu and Sindhupalchowk. The general RH and GBV questionnaires were each piloted two times, including with a representative working in the crisis in Nepal. The HIV questionnaire was piloted once. Fourteen KIIs were conducted in Kathmandu and 12 in Sindhupalchowk.

Participants in Kathmandu: 14 KIIs

RH	GBV	HIV
Epidemiology and Disease Control Division/Disaster Management Section/DoHS	Department of Women and Children	National Center for AIDS and STD Control (NCASC)
Family Health Division	UNFPA	
UNFPA	Ministry of Women Children and Social Welfare (MOWCSW)	
WHO	UNICEF	
CARE (international NGO)	WOREC (national NGO)	
FPAN (national NGO)		
UNICEF		
Save the Children (international NGO)		

Participants in Sindhupalchowk: 12 KIIs

RH	GBV	HIV
Medecins Du Monde France	District Child Welfare Board	National Red Cross Society
UNICEF	Saathi (national NGO)	Mlremire (national NGO)
District Health Office (DHO)	Shakti Samuha (national NGO)	Life versus Addiction
UNFPA	UNFPA	
	MANK – Women’s Self-Reliance Center	

Data Analysis

Qualitative data was entered into Microsoft Word and coded and analyzed under the study components: MISP awareness, knowledge, and training; coordination; RH concerns and needs: MISP Response; DRR, including emergency preparedness and key facilitating factors and barriers to response. Quantitative data was entered into Census and Survey Processing System forms developed for the MISP Assessment and then exported for analysis using SPSS v.22.

Limitations

The evaluation was undertaken nearly five months after the earthquake and KIIs may have had recall bias on knowledge about the availability of services over time. In addition, there may have been selection bias, with some agencies active immediately after the earthquake and having resumed a development agenda at the time of the assessment and therefore not available to participate. In addition, the number of HIV KIIs was too low for saturation of information from HIV KIIs, particularly in Kathmandu.

Summary of General RH Key Informant Interviews Findings and Discussion

Awareness and knowledge of the MISP and additional priority activities

Although representatives of the lead agencies for RH were knowledgeable about the MISP objectives and priority activities, the majority of RH KIs were not trained in the MISP despite multiple trainings offered in Nepal. However, even without training, perhaps through awareness raising on the MISP in the RH sub-cluster, many KIs could cite some key priority activities, such as clinical management of rape (CMR) or making free condoms available, but there was a lack of understanding about critical activities, such as ensuring communities are aware of the benefits and location for seeking CMR services, safe blood transfusion services, and enforcing respect for universal precautions. Importantly, there was a lack of understanding about what activities are not part of the MISP, diluting the concept of priority activities or actions. There are also indications that high-level key decision-makers within Nepal would benefit from information about the importance of priority RH services within the larger scope of humanitarian needs. With gaps in knowledge about the MISP among RH staff, they are less likely to collectively convince all stakeholders about the life-saving needs of the priority activities in the MISP or to benefit from working together on shared RH priorities in the early days and weeks of an emergency.

Reproductive health concerns and needs

The majority of KIs had heard of incidents of sexual violence post-earthquake associated with displacement to new living situations, such as the camps. Sexual exploitation and abuse (SEA) was reported to occur, and as a long-standing problem in Nepal given the number of people trafficked, may have been further exacerbated post-earthquake(s), compelling humanitarian actors to ensure that at a minimum, SEA is not associated with the delivery of aid by enforcing a code of conduct (CoC) against SEA. Most KIs said their agency had a CoC; some were required to sign, although most were not. Some KIs had heard of a few incidents of maternal mortality associated with transport obstructions, while twice as many had heard of incidents of newborn mortality, with

some incidents associated with gaps in newborn emergency care, indicating the need to strengthen the routine availability of these services. A couple of KIs had heard of incidents of unplanned pregnancy or unsafe abortion, supporting the importance of ensuring contraceptives are available to meet demand and that standard precautions are enforced at health facilities.

Response

Ensure the health cluster/sector identifies an agency/agencies to lead implementation of the MISIP

Routine coordination to lead implementation of the MISIP was in place through the RH sub-cluster within days post-earthquake in Kathmandu, with the FHD and UNFPA the designated lead agencies. RH coordination originally took place in the health cluster meetings and started meeting as a separate RH sub-cluster approximately two months later in Sindhupalchowk. Overall, KIs reported that key stakeholders were present in the RH sub-cluster meetings, with the notable inclusion of adolescents, but suggestions were made for improvements, such as more participation and leadership from the FHD, district health office (DHO), and the District Women and Children's Office, and with representation from the lesbian, gay, bisexual, transgender and intersex (LGBTI) community, HIV, new local and international NGOs, and the private sector.

Effective leadership and function of the RH sub-cluster resulted in dedicated funding largely sufficient to meet RH emergency needs and sufficient RH commodities and supplies in Kathmandu and Sindhupalchowk. Although there were challenges and lessons identified with the inter-agency RH kits, all RH Kits (1-13) were available for the response, as were RH supplies generally. The RH sub-cluster held a number of meetings to share information about what was planned and procured and utilized a template to organize and map equipment and supply needs. The RH lead agencies participated in the health cluster meetings and maintained ongoing communication and coordination with the health cluster.

RH activities post-crisis were coordinated for MISIP implementation using templates for data and information collection on the 4W's – who was doing what, where and when - and the need for RH kits and other

commodities, use of standardized RH protocols, RH Kit training materials to assist health workers on the job, collection of MISP indicators, and the engagement of affected communities, particularly adolescents and female community health volunteers FCHVs. RH sub-cluster meeting minutes were consistently documented and disseminated to participants and others through global forums. Coordination of the RH sub-cluster was rated good to excellent by RH KIs, with a few suggestions for improvement, such as to improve inter-sectoral participation from GBV and HIV; strengthen orientation to the MISP with one idea put forth to disseminate information about the MISP via email – this could be simply routinely sending and otherwise sharing the MISP cheat sheet; to improve engagement of specific sub-populations, such as LGBTI, in the RH sub-cluster as noted above; and to improve the participation of all RH sub-cluster members on the agenda and during meetings.

The rapid formation of the RH sub-cluster in Kathmandu and its success may be related to pre-disaster coordination mechanisms, where RH is a standing line item on the Health and Nutrition Cluster agenda and the engagement of agencies with expertise in the MISP in emergency settings, such as CARE, which had an established a memorandum of understanding (MoU) with UNFPA and IPPF/FPAN through the SPRINT initiative and Save the Children. In addition, the rapid coordination response may have been influenced by pre-disaster trainings. Clearly, individual leadership, commitment, and hard work of the representatives of the lead agencies in health and RH in the government, relevant united nations (UNFPA, UNICEF, WHO) agencies, and national and international NGOs influenced the response. The more delayed establishment of a separate RH sub-cluster in Sindhupalchowk in the aftermath of such a large crisis is typical and better than in some contexts, where it has taken longer to activate sub-national coordination mechanisms if they are established at all (Kenya 2008; Haiti 2010).

Prevent and manage the consequences of sexual violence

There is limited evidence from RH KIs to show that specific measures were undertaken during the emergency response to address the earthquake-affected population's safe access to health facilities, although one KI from a lead agency in Kathmandu reported that lighting was taken into consideration when RH camps were established and a KI

from Sindhupalchowk said that sex-separated latrines were available in the first eight weeks of the crisis. According to KIs in Kathmandu, the extent protection measures are in place depends on the level of the health facility where higher-level facilities will have protection measures such as sex-separated latrines and guards, while lighting was reportedly largely available. However, KIs in Sindhupalchowk were more likely to report the presence of sex-separated latrines with locks inside and less likely to report lighting or guards.

The overwhelming majority of informants in both districts reported that CMR was available or partially available. For the most part, KIs referenced CMR being partially available based on the limited locations was available in the district or the lack of availability of some services in the Nepal protocol for CMR where CMR was reportedly available. In Kathmandu, KIs said CMR was available at One Stop Crisis Management Centers (OSCMCs) and other public facilities and that there were only OSCMCs in three of the 14 most-affected districts, including Kathmandu but not Sindhupalchowk. In Sindhupalchowk, KIs said CMR was available at the district hospital and the two primary health care centers (PHCCs). However, there was also a reference to a gap in how comprehensive CMR services were at the district hospital. In terms of specific components of CMR, such as emergency contraception (EC), more than half of KIs in both Kathmandu and Sindhupalchowk reported it is available or partially available. In Kathmandu, most KIs reported post exposure prophylaxis (PEP) was available or partially available; however, only one KI in Sindhupalchowk said PEP was available. Most KIs in Kathmandu and Sindhupalchowk said that syndromic management of sexually transmitted infections (STIs) was available or partially available, but several KIs questioned the quality of the services. Just over half of KIs in Kathmandu reported that psychosocial support was available or partially available to survivors while all KIs in Sindhupalchowk reported psychosocial support was at least partially available. The majority of KIs in Kathmandu and Sindhupalchowk reported that a referral system for survivors of sexual violence was established, with most reporting that the system includes health, police, legal, and rehabilitation support but most questioned the quality of care within the referral system. Finally, the majority of KIs in Kathmandu and Sindhupalchowk also reported that information, education and communication (IEC) about the availability and benefits of seeking care was undertaken through community

health workers, peer educators, social mobilizers, and radio messages. It seems that this concerted effort at IEC on the MISIP was reinforced by the existence of a National Health Information and Communication Center in Nepal.

Reduce HIV transmission

All KIs in Kathmandu reported that safe blood transfusion was available, while all KIs in Sindhupalchowk said safe blood transfusion was not available. However, it is important to note that the emergency response resulted in a temporary field hospital in Sindhupalchowk supported by Norwegian Red Cross (NRC) that offered safe blood transfusion. All KIs said the practice of standard precautions at health facilities was available or partially available based on the quality of services. KIs said the quality of these services varied and, for example, would not be as good in rural areas or where there is a lack of government or NGO support. All KIs reported that free condoms were made available through health facilities, community-based organizations, mobile health camps, condom boxes, and community-based distribution by FCHVs and adolescents.

Prevent excess maternal and newborn morbidity and mortality

All KIs in Kathmandu and Sindhupalchowk said that basic emergency obstetric care (BEmOC) was available. This reported coverage of BEmOC could be the result of government investments over recent years in promoting health facility deliveries through incentives to women, such as transportation allowances and reimbursing providers for the cost of safe delivery and EmOC. Yet, KIs in Sindhupalchowk commented that many health facilities sustained damage from the earthquake and that there is a shortage of human resources.

Comprehensive emergency obstetric care (CEmOC) was also reported available in Kathmandu but not available in Sindhupalchowk, though according to the District Health Officer, the district is planning to establish CEmOC. Newborn care services were also reported largely available or partially available, though less than reported for maternal health. There were also concerns about lack of and malfunctioning equipment for newborn care. The overall positive feedback from KIs on newborn care may be due to the focused attention to newborn care in more recent years by the government and partners such as UNICEF and Save the

Children. Most RH KIs said there was a 24/7 emergency referral system that involved the use of stretchers from the community, ambulances, and helicopters supported by NGOs. While there was a period of time that referrals could be taken to the field hospital in Sindhupalchowk, once that was dismantled, referrals reverted to other districts such as Kavre and Dhulikhel district hospitals where CEmOC is available. The RH sub-cluster reportedly invested in IEC messaging disseminated on the radio and television that included preparing for delivery, avoiding delays, and use of maternity transition homes. Clean delivery kits (CDKs) were also largely available and distributed to health facilities, especially damaged facilities and to pregnant women in the RH camps (mobile services in rural areas) and through FCHVs. There were concerns by government representatives that the CDKs might work against promoting health facility deliveries and lower the quality of provider's care.

Plan for comprehensive RH services integrated into primary health care

It is clear from RH KIs that some level of assessing staff capacity and providing training or mentorships was undertaken during the response phase on the following topics: RH kits, CMR, standard precautions, family planning, and quality assurance in maternal and newborn care. At the time of this assessment, KIs reported that assessing human resource and training needs was ongoing in the transition phase at the national and district levels. Data was collected by the RH sub-cluster utilizing a template and findings were aggregated and shared in the UNFPA annual report. Key informants also report that identification of future sites for service delivery was part of national rebuilding and district response plans. There is some concern that the number of new birthing centers not outpace their use and both stretch human resource capacity and reduce the opportunity for existing staff to utilize and maintain their skills.

Additional priorities of the MISP

Contraceptives, including condoms, pills, and injectables, were reportedly largely available to meet demand. According to KIs, there was a national shortage of injectables and implants during the earthquake, and UNFPA headquarters provided support to fill the gap. Although long-acting methods are not currently part of the MISP standard, with the exception of IUDs for EC, this finding supports the need to consider

implants and other long-acting methods in the MISP standard and RH Kits in order to position them where there is an existing demand and skilled providers. Dedicated EC pills as a component of family planning were also reported less consistently available, with several KIs commenting that a dedicated EC product (Prostinor) is only available in the private sector through shops. Some KIs said that EC using the Yuzpe method of oral contraceptive pills was available, while few said intra-uterine devices (IUDs) as a method of EC were available. The majority of RH KIs in Kathmandu and Sindhupalchowk said community awareness through IEC about the benefits and location of family planning services was undertaken through social mobilization and FCHVs.

The majority of RH KIs in Kathmandu and Sindhupalchowk said ARVs were available or partially available for continuing users, including PMTCT. One KI said that there were few reports of treatment disruption. In addition, most KIs reported syndromic management of STIs was available or partially available based on questions regarding the quality of these services. One half of KIs said that menstrual hygiene supplies were available and half said that menstrual hygiene supplies were partially available through dignity kits distributed in RH camps (mobile services), including to adolescents, shelter homes, or through a few organizations.

Engagement of communities in RH programming

Three-quarters of general RH KIs in both Kathmandu and Sindhupalchowk reported that communities were engaged in RH programming. Affected communities have helped one another and provided land and other support to temporary clinics where these were destroyed and mobile clinics. Adolescents, community mobilizers, women's groups, and FCHVs were particularly engaged in RH camp education and counseling; baby and mother's units; women's groups; peer education and counseling; village development committees (VDCs); female-friendly spaces (FFSs); and even with adolescent representation in the RH sub-cluster. One KI mentioned that there was a gap in engaging LGBTI persons and no one mentioned the specific engagement of people with disabilities in RH programming.

Addressing the RH needs of adolescents and people with disabilities

Most RH KIs reported that they have specifically focused on adolescents in a way that reportedly builds on an existing national ASRH package by designating adolescent corners in RH camps where adolescents could access condoms and sanitary pads. However, most RH KIs did not know if agencies reached out to people with disabilities to address their RH needs, though one KI in Kathmandu reported its organization provided counseling on sexual hygiene and family planning to people with disabilities and that they worked with Handicap International and local NGOs. An RH KI from Sindhupalchowk said there was an assessment of needs; provision of equipment and supplies; and training of staff on continuing services.

Disaster risk reduction, including preparedness

Lead (FHD and UNFPA) RH agency representatives explained that pre-crisis there was a District RH Coordination Committee in the FHD with different RH sub-committees, including safe motherhood, family planning, adolescent health, and safe abortion care. They also reported that as a result of previous emergencies, the cluster system was in place in Nepal and RH was covered by the Health and Nutrition Cluster as a standing agenda item.

All KIs in Kathmandu and half of KIs in Sindhupalchowk reported making prior preparation or arrangements for RH activities for this humanitarian crisis. Kathmandu KIs cited several emergency preparedness initiatives and activities, including pre-positioning supplies; dedicating financial resources to RH for capacity development of health staff; hosting and participating in MISP trainings and emergency planning workshops and earthquake drills; supporting districts to develop emergency preparedness plans (EPPs); undertaking assessments of birthing centers; and supporting hospital preparedness for emergency trauma care. A KI from a lead RH organization in Sindhupalchowk said that financial resources were dedicated to RH for capacity development on ASRH and MISP, including for the focal point of the district rapid response team (RRT).

Most KIs said that personnel employed by their agency are required to sign a CoC against SEA. Most RH KIs also said that their agency

has made available opportunities for staff to be trained in the MISP. Representatives of the lead RH agencies reported that inter-agency RH kits 1-13 were prepositioned for the emergency based on experience from previous emergencies and that a logistics system was established in preparation for emergency distribution of health supplies, including RH supplies. However, there were reports of logistic challenges such as clearance processes, packaging, orientation to the kits and lessons identified and shared.

Although KIs reported steady progress in emergency preparedness, KIs had a lot of suggestions for further improvements, including more advocacy, training, discussion, and dissemination of information on the MISP at all levels and identifying established focal points for the MISP. Other suggestions included establishing a designated emergency fund; planning to involve other stakeholders in the sub-cluster, such as GBV, HIV, child health, LGBTI, and others who are interested; improving services for adolescents and newborns; and better integrating family planning. It was also suggested that more consideration needs to be given to how to assist families that do not want to leave their homes to participate in RH camps and distributions. All RH KIs in Sindhupalchowk said there was a need for attention to human resource capacity development and staff incentive packages.

Key facilitating factors and barriers to MISP implementation in this crisis

Key facilitating factors to MISP implementation cited by KIs in Kathmandu included that MISP was a part of the Nepal Disaster Management Plan: pre-positioning of emergency kits and supplies, training of health providers, and an understanding that RH is a required service; immediate regulatory action and strong leadership by the DoHS and the Health Emergency Operations Center (HEOC); established strategic relationships of UNFPA and other UN agencies and NGOs with the government and existing systems and relationships with the District Health Officer; RH sub-cluster highly regarded in the health cluster, dynamic leadership of the RH sub-cluster with good planning, coordination and action; agencies with staff who already knew the MISP and the enthusiasm of all partners.

Key facilitating factors shared by KIs in Sindhupalchowk included the

overall health system re-establishing health services; DHO focal points, along with the support of the community taking responsibility for RH; the presence and timely response of UN agencies, including WHO, for coordination with the DHO, quick response to gaps and intensive volunteering of NGOs. In addition, KIs cited regular RH and protection meetings with the involvement of the Women Development Officer; supply of RH kits, RH camps and medical camp kits; mobile clinics; the temporary field hospital; helicopter transport; and the intensive volunteering efforts of NGOs.

RH KIs in Kathamandu cited overarching factors that served as barriers to an effective RH response, such as the monsoons and related logistical challenges, as well as the status of the population who were busy with their own lives; and the challenge of multiple coordination meetings and competing needs. Specific to RH were barriers in understanding of the MISP for RH at all policy levels, with many people understanding why it is important but some still questioning these services in relation to basic needs; and the size of the responsible team, with an insufficient number of people trained on the MISP. KIs also cited the following gaps: communication from the national level to district levels; planning and preparedness; designated funding for emergency preparedness; quality of care; engagement of all stakeholders in coordination meetings, including inter-sectoral coordination; logistics; delegating and sharing responsibility; and care for rape survivors, with a focus on the health response.

In Sindhupalchowk, overarching factors reported as barriers to an effective RH response in this emergency included the destruction of health facilities with many birthing centers partially or completely damaged; transport challenges to ensure equipment and supplies due to road blockages; confusion about roles and responsibilities for coordination at FHD and HEOC and gaps in human resources. Barriers that were specific to the MISP included lack of funding for emergency preparedness; delays in RH coordination; lack of awareness about and training on the MISP.

General RH Key Informant Interviews Conclusion

Despite the gaps in knowledge about the specific objectives and priority RH activities of the MISP among the majority of KIs, knowledgeable key personnel in the lead RH agencies (FHD and UNFPA) and NGO

members of the RH sub-cluster, such as Care, FPAN, and Save the Children, were reported to be able to ensure largely sufficient dedicated funding, consistent coordination, and sufficient supplies to facilitate implementation of the MISP. In addition, all MISP services were reported to be available, while some services were partially available. A partially available determination was based on the availability of services at a limited number of facilities and questionable comprehensiveness of the services and therefore quality of these services where they were available, including CMR, standard precautions and syndromic management of STIs. The achievement by the DoHS/FHD, UNFPA and sub-cluster members is remarkable.

Successful reports appear to be associated with investments in RH by the government of Nepal and partners in the stable phase; disaster risk reduction commitments that include the MISP and the implementation of RH emergency preparedness and contingency planning, including training on the MISP and pre-positioning RH kits and supplies; generous donor support, community activism, engaging the community in the response particularly, adolescents and FCHVs; RH IEC that included the use of media; emergency referral mechanisms; and through establishing a large number of innovative initiatives, such as RH camps, female-friendly spaces, promoting the use of maternity transition or shelter homes established before the earthquake; and engaging the national midwives association in Nepal.

General RH Key Informant Interviews Recommendations

The DoHS FHD and partners should:

- Continue emergency preparedness and contingency planning on the MISP, including advocacy with policy makers and training of trainers (TOTs) on the MISP for DRR personnel, RH coordinators, managers, and directors. An immediate option is to facilitate strategic dissemination of the MISP distance learning module (DLM) in English and Nepali. The MISP DLM is a self-administered user-friendly course that takes approximately four hours to complete and offers a certificate of completion.
- Establish a fund for emergency preparedness activities.

- Continue to advocate to address RH kit logistics in Nepal and follow up on recommended changes to the kits through UNFPA headquarters and the Inter-agency Working Group on Reproductive Health (IAWG) on RH in Crises logistics working group. Identify and utilize a video on the RH kit contents in all MISP orientations and trainings.
- Maintain adequate stocks of contraception, including injectables and implants.
- Continue to invest in establishing, monitoring, and supporting good quality comprehensive RH services, including CEmOC, with sufficient numbers of qualified staff, including skilled birth attendants (SBAs), particularly in Sindhupalchowk.
- Strengthen RH coordination, with improved inclusion of GBV and HIV representatives, as well as people with disabilities and LGBTI individuals, and undertake creative participatory approaches to RH coordination meetings.
- Strengthen communication between national and district levels on roles and responsibilities in an emergency.
- Continue to support enforcement of agency CoCs against SEA.
- Inform providers and communities specifically about the benefits and location of comprehensive CMR services and consider establishing an OSCMC in Sindhupalchowk. Strengthen psychosocial support for survivors.
- Continue efforts to strengthen newborn care services, such as by mandating a newborn corner in every birthing facility, and address reported newborn equipment gaps in Sindhupalchowk.

Summary of GBV KII Findings and Discussion

Awareness and knowledge of the MISIP

Similar to RH KIIs, the majority of GBV KIIs had heard of the MISIP, while less than half were aware of the priority objectives and activities and only one GBV KII had been trained in the MISIP. The findings also show that less than half of GBV KIIs could identify the priority activities to prevent and respond to sexual violence. Some of the activities cited support for the priority activities of the MISIP, such as use of media, particularly where the messages are focused on the benefits and location for survivors to seek care, and safe shelters, while other activities, such as general GBV awareness raising, community education and campaigns to engage men or provide training in self-defense, were more relevant to a stable phase. It is understandable that GBV KIIs would not be fully trained in the MISIP standard given the scope of the GBV technical area. Yet it is important that GBV KIIs have knowledge about the overall priority objectives of the MISIP and, in particular, the objective and priority activities to prevent and respond to sexual violence in order to collaboratively focus on them in an emergency.

Coordination

The majority of GBV KIIs rated as good regular coordination by national and international lead agencies and focal points for GBV in Kathmandu and Sindhupalchowk. It was reportedly more likely for an RH focal point to participate in GBV meetings than for a GBV focal point to participate in RH meetings and many GBV KIIs recognized there was a need for better integration of RH and GBV coordination to achieve a more effective response. One suggestion to improve coordination was to establish a legal link between the DoHS and the Ministry of Women Children and Social Welfare (MOWCSW). Another was to include members of the community in GBV coordination meetings.

GBV concerns and needs

All GBV KIIs reported hearing of incidents of sexual violence, with known problems of GBV prior to the crisis and as result of the earthquake and subsequent displacement. Among the types of GBV cited were domestic violence, incest, rape, including gang-rape, SEA, and trafficking, including child trafficking.

Response

According to GBV KIs there appears to have been a clear national strategy and funding for an immediate response to address GBV in the crisis that encompassed designated FFS's for women and children, CMR services, including supplies and dignity kits. GBV stakeholders in both Kathmandu and Sindhupalchowk reported that a wide variety of donors, in addition to UNFPA, contributed to the GBV response. Funding was reported slightly more sufficient in Kathmandu, while additional funding was reportedly required to leverage and sustain GBV initiatives. Funding was reported less sufficient in Sindhupalchowk, where more than half of respondents reported that funding was insufficient to address RH-related GBV services, such as strengthening district referral mechanisms and the DHO, though some reported needs by KIs from local organizations were focused on longer-term response, such as economic support for women.

Protection measures were reported to be in place to varying degrees at health facilities, with little attention reported to address this in the crisis response, apart from the distribution of flash lights in dignity kits. GBV KIs reported focusing on broader protection initiatives, such as FFS's, safe homes, and through inter-sectoral coordination on protection.

Care for survivors of sexual violence was reported to be available in both districts in several settings in the emergency response and supported with the deployment of staff and dissemination of post-rape kits to districts. CMR was reportedly more available in Kathmandu at OSCMCs and other public facilities than in Sindhupalchowk, where the majority of KIs reported CMR was partially available at PHCCs, MOWCSW, the district hospital, and a hostel. The most notable gap, with respect to the specific components of CMR protocol, including treatment of injuries, EC, PEP, prophylactic STI treatment, and psychosocial counseling, was a lack of knowledge among GBV KIs about what CMR components were available. GBV KIs were most likely to report the availability of treatment of injuries and or psychosocial support and knew less about the availability of EC, PEP, and prophylaxis for STIs.

Almost all GBV KIs in Kathmandu and Sindhupalchowk reported that IEC was undertaken through the dissemination of materials, peer educators, community health workers, and on the radio about the benefits of

seeking care and the location of care for survivors of sexual violence. All GBV KIs in both districts reported that a referral system was established. While the referral system was rated slightly better in Kathmandu than Sindhupalchowk, GBV KIs in both districts expressed concern about the quality of care in the system.

All GBV KIs reported engaging communities in the response through a variety of mechanisms, including FFSs, VDCs, women's groups, and distribution of dignity kits, FCHVs, adolescents and awareness-raising events.

Disaster risk reduction, including preparedness

GBV KIs reported a number of measures to address DRR, including emergency preparedness that spanned positive changes in the legal framework and inclusion of GBV in the national disaster policy to ensuring dedicated financial resources, supporting training of providers on CMR, pre-positioning post-rape kits, establishing referral systems, determining the content of dignity kits, and supporting district EPPs. GBV KIs reported awareness about the importance of a CoC and some activity to address this, including legislative action, while a national agency working on GBV appeared to have the most progressive policy, where 100 percent of its staff sign a CoC against SEA.

Only one GBV KI reported making opportunities for their staff to be trained in CMR, although other GBV KIs reported supporting training of providers, and this is likely because CMR falls under the remit of health providers versus GBV staff, unless it is a full service GBV provider.

A number of recommendations on preparedness initiatives to both improve protection measures at health facilities and provide care to sexual violence survivors were shared by GBV KIs and are included in the recommendations section of this report

Key facilitating factors and barriers to prevent and manage sexual violence in this crisis

GBV KIs in Kathmandu reported a number of key facilitating factors to prevent and manage sexual violence in this crisis, including: leadership of the MOWCSW; CMR protocol work pre-crisis; FFS's and referral systems established; mass awareness campaigns on radio and tele-

vision, along with IEC materials; strong ownership of the principles of working with survivors; GBV programs pre-crisis that enhanced the government and communities capacities; and the immediate response of standing together with women.

GBV KIs in Sindhupalchowk also reported a number of factors that have helped facilitate the RH-related GBV response in the emergency. Similar to Kathmandu, GBV KIs acknowledged the support provided from the government and the importance of immediate radio announcements. GBV KIs in Sindhupalchowk also noted the rapid coordination of Protection and GBV clusters, support from NGOs at the national and international levels, and coordination among agencies and police.

GBV KIs in Kathmandu also shared barriers to prevent and respond to sexual violence in response to this emergency, including challenges with the amount of time for coordination and meetings within and across multiple clusters versus time on service delivery; limited capacity of government to provide services in the emergency and different approaches by different partners; limited attention to listen and learn about existing national capacity versus international experts and to allow for inputs and more active participation of national actors; concerns about the quality of services in the referral pathways, particularly police and legal referrals with assessment and intervention difficult; the importance of recognizing that sexual violence is not just about physical needs but it also requires psychological support and a human approach to communicate that survivors are not alone and to convey solidarity with them; and the fears of survivors themselves to disrupt the status quo in their families and households.

GBV KIs in Sindhupalchowk cited barriers that included the geographic context, resulting in limited access to some communities and communication modalities. Other barriers were viewed to be associated with the lower education and economic background of some victims, as well as the priorities communities faced to meet their basic and survival needs. GBV KIs also reported the lack of adequate numbers of qualified personnel to provide CMR; the requirement of physicians to attend court; and some inappropriate relief items as barriers to the response to sexual violence.

GBV KIIs Conclusion

As with general RH KIIs, most GBV KIIs had limited knowledge of the MISIP, including on the objectives and priority activities to prevent and manage the consequences of sexual violence. Yet, pre-existing national services, knowledge of the MISIP, and leadership by the MOWCSW and UNFPA, along with sub-cluster partners to invest in DRR and emergency preparedness, along with immediate and innovative actions such as mobile RH camps and the utilization of protection check-lists at the onset of the crisis resulted in coordinated funded initiatives to prevent and respond to sexual violence in both Kathmandu and Sindhupalchowk. The majority of GBV KIIs reported that the linkages between GBV and RH were good, but some comments indicated that coordinated efforts could be strengthened. While there was reportedly limited attention to protection interventions in access to existing health facilities, activities that engaged the community were undertaken to protect women and children generally through FFSs, the provision of dignity kits with flashlights, and menstrual hygiene supplies. Care for survivors of sexual violence was reportedly available or partially available in several sites in Kathmandu and Sindhupalchowk, likely due to an established CMR protocol; capacity development on CMR pre-crisis and surge capacity support to districts along with mobile camps. These efforts were further leveraged through IEC that engaged both the community and the media.

GBV KII Recommendations

The DoHS and MOWCSW with partners should:

- Strengthen the assessment of and technical support to the referral system, particularly police and legal systems, to ensure that a survivor-centered approach and guiding principles of care are adhered to and survivors receive good quality care.
- Ensure that organizations reporting they provide CMR are able to provide full services per the Nepal CMR protocol or that they refer survivors where they can access minimum standards of CMR.
- Inform all GBV personnel about where comprehensive CMR is available and what clinical care is composed of in each setting where it is offered.

- Train more providers, particularly female providers, in CMR, with emphasis on communication and interpersonal skills for psychosocial support and include the contents of post-rape kits in the training.
- Scale up the availability of CMR services, including at health posts and establish an OSCMC and a long-term safe shelter that offers economic support in Sindhupalchowk.
- Advocate for separate rooms for women and children at health facilities, the availability and use of sex-separated latrines with locks (that work) inside, and lighting and guards as needed. Support whole-site orientation for all staff at facilities, including security guards and cleaners.
- Continue to advocate and provide technical and funding support for agencies working on GBV, including local NGOs.
- Provide orientation on the MISP and training on the priority activities to prevent and respond to sexual violence, including an orientation to the post-rape kits for all national and international actors working on GBV.
- Strengthen linkages between the GBV and RH sectors by supporting joint assessment missions, ensuring GBV and RH focal points participate in the other sector's meetings and consider a committee by law that includes both the DoHS and MOWCSW.
- Advocate to address the legal barriers that require physicians to attend court on behalf of survivors.

HIV KII Summary of Findings and Discussion

Awareness and knowledge of the MISP and additional priorities

HIV KIs were even less aware of the MISP than the GBV or RH KIs yet they were aware of some key priority activities at the onset of humanitarian emergencies and also part of the MISP such as ensuring the availability of condoms, contraceptives and menstrual hygiene protection materials and enforcing standard precautions. Yet, critical priority activities such as ensuring safe blood transfusion were not mentioned while other activities more conducive to the recovery or stable phase were included such as safe sex education and establishing voluntary counseling and testing (VCT) services. With gaps in awareness and knowledge about the priority MISP activities particularly for HIV it is less likely that partners will be collaboratively focused to address these priorities in an emergency setting.

Coordination

While all HIV KIs reported there were national and international entities responsible for coordination, it wasn't clear across KIs who the entities or the focal points were. Although monthly HIV meetings are held at the national level with UNAIDS and variety of working groups for HIV treatment, care and support it was unclear how coordination occurred in Sindhupalchowk though there were reported linkages to the DHO. There appeared to be some limited integration of HIV with RH coordination and vice versa in both Kathmandu and Sindhupalchowk, with opportunities to strengthen these efforts, particularly among local NGOs and in relation to GBV.

According to the key informant in Kathmandu existing funds through the Global Fund were used to address the emergency and recommended that emergency funds should go to the government. All KIs in Sindhupalchowk had received some funds but it was insufficient for two of three local NGOs to meet their HIV programming needs.

HIV concerns and needs

Reports of HIV transmission were not directly attributed to the emergency such as unsafe blood transfusion, lack condoms or standard precautions but focused on the longer-standing issue of sex trafficking

and the risk it poses to families. It was also well understood by HIV KIs that people on ARVs need to continue to access them and nutritious food in the crisis while the cost of transport to do so was a recognized challenge. Other concerns were for people living with HIV (PLWHIV) who do not have family support and therefore need social support.

Response

Safe blood transfusion was available in Kathmandu and during the immediate response in Sindhupalchowk through a field hospital that had been deconstructed by the time of the assessment and the district had reverted to its pre-crisis status without safe blood transfusion. KIs informants reported limited support for adherence to standard precautions which was not specific to the crisis. Condoms were reportedly made available or partially available by KIs although one KI thought that condoms were more available before the earthquake than after. However, KIs reported a good deal of activity around ensuring ARVs were available to continuing users by supporting their transport to access medicines, care and nutritious food though it is unclear of ARVs for PMTCT in Sindhupalchowk. Referrals systems were reportedly established and rated average or excellent in both Kathmandu and Sindhupalchowk.

Engagement of communities in programming

Communities were reportedly engaged in HIV programming through program implementation such as awareness raising and feedback mechanisms though one KI called attention to the fact that people were busy with other needs in the crisis and another KI explained it was more challenging to engage key community representatives in remote areas.

Disaster risk reduction, including preparedness

Half of the KIs reported undertaking preparedness activities such as training RRTs and pre-positioning condoms and medicines for ART and other HIV-related illnesses at the national level. In Sindhupalchowk, one KI reported training National Red Cross personnel on counseling, including for PLWHIV. Most of the KIs seemed to understand what a CoC against SEA was and half of KIs had some level of institutional commitment to ensure staff were compliant with a CoC against SEA.

All HIV KIs had recommendations for improving MISP-related HIV activ-

ities such as ensuring a blood bank in every district; improving condom distribution through CHWS and peer educators and at all health facilities and local spots where people congregate like the bus park. Suggestions to improve standard precautions at health facilities encompassed human resource capacity development; ensuring adequate supplies; and instituting monitoring and evaluation mechanisms. According to KIs attention is also required to stay abreast of changing ART drug regimens over the coming years and to scale up PMTCT. Other KIs suggested increasing human resource capacity to improve the availability of ARVs at the District level 24 hours/day/7 days/week and even at local level so people don't have to travel so far to access them and to increase the availability of laboratory technicians and relevant supplies.

Key facilitating factors and barriers to prevent the transmission of HIV

Many factors were identified by KIs as facilitating factors to prevent the transmission of HIV in this crisis. KIs reported initiatives undertaken pre-crisis resulting in HIV awareness and education, promotion of condoms and positive health worker attitudes as well as those taken at the onset of the crisis such as the establishment of a field hospital where safe blood transfusion was available for EmOC and other emergencies, activation of disaster RRTs, district coordination, and decisions undertaken at the national level to those taken by individuals to help PLWHIV.

Barriers included those ranging from the geographical terrain to understanding the needs of PLWHIV and challenge of enough qualified human resources to assist them. In addition, KIs said HIV might not have been viewed as a priority compared to other areas such as GBV while gaps in coordination between the district hospital and NGOs and funding were also cited as barriers.

HIV KIs Conclusion

The investments by the government of Nepal and its partners in HIV programming prior to the crisis clearly contributed to preventing the transmission of HIV during and immediately after the crisis. The majority of key activities were in place to prevent the transmission of HIV, including safe blood transfusion, standard precautions pre-crisis,

and condoms. Where there were known gaps such as safe blood transfusion in Sindhupalchowk the situation was addressed. Attention was also given to supporting local NGOs working on HIV in Sindhupalchowk though there appeared to be a need for more coordination, funding and support of these local efforts.

HIV KIIs Recommendations

The DoHS FHD and partners should:

- Strengthen coordination between RH, HIV and GBV, including local NGOs within Sindhupalchowk district to achieve more integrated efforts to address comprehensive RH in the stable phase and for preparedness planning.
- Provide an orientation to the MISP using the MISP one-pagers (advocacy and cheat sheets) and the MISP distance learning module and other resources and available at: <http://iawg.net/?s=MISP+Resources&submit=> for all government representatives and local and international NGOs working on HIV.
- Strengthen the availability of, blood transfusion services to Sindhupalchowk; condoms; adherence to standard precautions; and ARV therapy.
- Provide sustainable funding to local NGOs working with PLWHIV
- Explore options such as cash voucher systems for transport for PLWHIV to access ART centers
- Explore income generation projects for PLWHIV

Key Informant Interviews Annex I

General RH Key Informant Interviews Detailed Findings

A. Awareness and Knowledge of the MISP and Additional Priorities

1. Objectives and additional priority activities of the MISP

The majority (10/12) of RH KIs, (7/8 in Kathmandu and 3/4 in Sindhupalchowk) had heard of the MISP for RH. However, less than half (5/12) RH KIs had received training in the MISP (4/8 in Kathmandu and 1/4 in Sindhupalchowk). Among those trained in the MISP, 4/5 KIs had participated in a MISP training course. One KI reported attending a training conducted by the International Planned Parenthood Foundation (IPPF) Sexual and Reproductive Health Programme in Crisis and Post-Crisis (SPRINT) initiative in August 2015 and another had attended a MISP training of trainers (TOT) in Malaysia. One KI reported completing the MISP DLM.

Given that fewer than half of RH KIs had been trained in the MISP, the survey question, "Please name all of the objectives and additional priorities of the MISP that you know," was adapted to ask what the KI thinks are the priority SRH activities in an emergency among participants who were not trained in the MISP. The most frequently (10) cited priority activity among RH KIs in both Kathmandu and Sindhupalchowk was to ensure there are sufficient contraceptives to meet demand followed by nine (9) references each to activities to prevent and manage the consequences of sexual violence and to prevent excess maternal and newborn morbidity and mortality. The least cited priority activities of the MISP for RH in emergencies were to ensure culturally appropriate menstrual hygiene materials (2 mentions), followed by the need to ensure ARVs are available to continue treatment for people already on ARVs, including for PMTCT (3 mentions), and to ensure treatment for STIs is available to patients presenting with symptoms (4 mentions).

Reproductive health KIs in Kathmandu and Sindhupalchowk added other specific activities contained in the MISP or as priority RH activities in an emergency include addressing the needs of adolescents and

preparedness through pre-positioning of supplies for the MISP. Of note, a number of activities specifically not part of the MISP were mentioned as priority MISP or RH activities, including antenatal care, postnatal care, cervical cancer, prolapse, VCT, and school and non-school child health and family treatment.

2. Knowledge of specific activities within the key objectives of the MISP

Ensure the health sector/cluster identifies an organization to lead implementation of the MISP

Reproductive health KIs in Kathmandu and Sindhupalchowk reported knowledge about the activities the lead RH organization should undertake in an emergency that included: shares information (10 mentions); nominates an RH officer and hosts regular stakeholder meetings (8 mentions); and reports back to the health cluster (2 mentions). Other responsibilities reported by KIs in Kathmandu and Sindhupalchowk included: conducting advocacy for RH and supporting the government; determining the four W's of who is doing what, where, and when (4Ws); analyzing the situation to avoid duplication; managing logistics; and determining which partners would be allocated to which districts. Additional responses included supporting birthing centers with supplies and equipment; securing family planning supplies to address shortages, particularly implants and injectables; and making linkages to other services, such as psychosocial and legal services.

Prevent and manage the consequences of sexual violence

Specific activities RH KIs in both Kathmandu and Sindhupalchowk most frequently cited to prevent and manage the consequences of sexual violence included making clinical care available for survivors of rape (10) and putting measures in place to protect affected populations, particularly women and girls, from sexual violence when they access health services (8). Less frequently cited was the activity to ensure the community is aware of the availability and benefits of services (6). Key informants in both Kathmandu and Sindhupalchowk also knew that specific protection activities would include separate shelters for men and women; community education and awareness raising, including through mass media, about what GBV is and where a person needs to go for care. Other activities mentioned included establishing community

involvement through watch groups; facilitating health care providers and families to take special precautions for gender-sensitive services; and engaging women and development organizations and VDCs. KIs also added activities such as establishing national health sector policy with long-term plans and referral mechanisms, including for legal services; safe spaces; counseling services; and crisis management centers such as OSCMCs.

Reduce HIV transmission

The most frequently (11/12) cited activity to reduce HIV transmission reported by RH KIs in Kathmandu and Sindhupalchowk included making free condoms available. Fewer KIs reported ensuring safe transfusion practice (4/12) and facilitating and enforcing adherence to standard precautions (3/12).

Other MISP activities to reduce HIV transmission reported by RH KIs included ARVs for continuing use, post-exposure prophylaxis (PEP) and contraceptives. Other RH KIs said considering adolescents and especially vulnerable groups, including PLWHIV, and contraceptives were priority activities to reduce HIV transmission. Health education in schools, community counseling, and VCT were incorrectly mentioned as part of MISP activities to reduce HIV transmission at the onset of an emergency.

Prevent excess maternal and newborn morbidity and mortality

The most frequently (10/12) mentioned activities to prevent excess maternal and newborn morbidity and mortality by KIs in Kathmandu and Sindhupalchowk included ensuring the availability of SBAs and supplies for normal births. Less frequently mentioned were ensuring the availability of BEmOC and newborn care (5/12) and CEmOC and newborn care (6/12). Just (3/12) KIs mentioned ensuring a 24 hour 7 day a week referral system to support EmOC services, while (5/12) KIs mentioned the distribution of CDKs.

Other MISP-related activities mentioned by RH KIs in Kathmandu and Sindhupalchowk included service providers educating clients about the danger signs of pregnancy and establishing shelter lodging for expectant mothers to support safe delivery at hospitals. Non-MISP-related activities mentioned by KI were antenatal and post-natal care.

Plan for comprehensive reproductive health services integrated into primary health care services as soon as the situation permits.

The majority (7/12) of RH KIs in Kathmandu and Sindhupalchowk cited assessing staff capacity to provide comprehensive RH services and planning for training and retraining of staff as key activities of planning for comprehensive RH services followed by (6/12) citing the need to coordinate ordering RH equipment and supplies based on estimated and observed consumption and identifying suitable sites for future service delivery of comprehensive RH. The least frequently (3/12) cited activity was the collection of existing background data.

Other comments from RH KIs in Kathmandu were that planning should address immediate, medium- and long-term needs, including comprehensive short- and long-term district health plans at multiple levels engaging the community through FCHVs and mothers' groups. Two KIs in Kathmandu reported that a lot of birthing centers needed to be rehabilitated, and one said that there should be one SBA at each facility with the skills to address and manage complications. This KI also said that the referral system was poor during emergencies and therefore, 24-hour delivery services should be strengthened to provide comprehensive RH.

KIs in Sindhupalchowk said comprehensive RH should address antenatal and postnatal care, family planning services, nutrition, cervical cancer screening, and uterine prolapse, and expand the availability of BEmOC to all PHCCs and VCT for HIV to more health posts. They also said there was a need to increase the number of SBAs. Finally, one KI said that planning for comprehensive RH in Sindhupalchowk should include making safe blood transfusion available and improving communication and transportation.

B. Reproductive Health Concerns and Needs

Incidents of sexual violence

A large number (10/12) of RH KIs in Kathmandu (8/8) and Sindhupalchowk (2/4) had heard of incidents of sexual violence in the setting. One KI in Kathmandu reported that sexual violence is a sensitive issue and although she had heard of anecdotal reports of sexual violence, "the aim was not to track the number of survivors but to ensure that care is

available for them.” Another said, “We have heard about incidents, but we are at central level.” Another said that the risks were heightened both because boys and girls were together inside tents and then when they went outside the tents girls were raped, adding, “Community groups have to make rounds.” Another KI said some people remain displaced and a couple of the rape cases have occurred when outsiders came to areas where people were displaced. A KI in Kathmandu said there is limited reliable data, but stories have come from the hospital. One person had heard of two or three cases of rape.

One RH KI in Sindhupalchowk said that cases have increased and that survivors are referred to Kathmandu and some to OSCMCs. Another noted that there were no OSCMCs in Sindhupalchowk. One KI had heard of domestic violence where the survivor was referred to the Women and Children’s Office. And one KI had heard about sexual violence from counterparts and the media, but not directly.

Incidents of maternal mortality

Some (3/12) RH KIs in Kathmandu (2/8) and Sindhupalchowk (1/4) had heard of incidents of maternal mortality. One RH KI in Kathmandu commented that the problem was worse after the earthquake as a result of landslides, floods, and road and airport obstructions. Another KI recalled one maternal death at the new airport and one death due to late arrival at the health facility. In Sindhupalchowk, an RH KI commented that reporting and recording mechanisms were destroyed and that they are now trying to introduce new forms through the government health information system.

Incidents of newborn mortality

One half (6/12) of RH KIs in Kathmandu (4/8) and Sindhupalchowk (2/4) had heard of incidents of newborn mortality. One RH KI in Kathmandu said that newborn mortality was worse after the earthquake, while another commented that some shelter homes have reported newborn mortality. A third KI in Kathmandu said they had heard of a still birth following a C-section in the hospital, while a fourth had only heard about newborn mortality in the newspaper. In Sindhupalchowk, one RH KI had heard of a few cases of newborn mortality but did not know the details, while another reported that there were a few cases of meconium aspiration syndrome. One RH KI in Sindhupalchowk reported that just a

day before the interview a newborn that was born flaccid died. One said there were a lot of cases of miscarriages and pre-term deliveries.

Incidents of unplanned pregnancy

Two RH KIs had also heard of some incidents of unplanned pregnancy in Kathmandu (1/8) and Sindhupalchowk (1/4). One KI in Kathmandu had heard of incidents of unplanned pregnancy from female health providers and news channels. A KI in Sindhupalchowk had heard of unwanted pregnancies and abortion because the person missed family planning due to transportation problems. Another KI in Sindhupalchowk had not heard of unplanned pregnancy but had heard that a woman committed suicide when she learned she was pregnant.

Incidents of unsafe abortion

No (0/8) RH KI in Kathmandu had heard of incidents of unsafe abortion, though two of them commented that they believed the number of women asking for safe abortions had increased, with one person adding that some women were requesting abortions because they feared the baby was deformed from the earthquake. One RH KI said that UNFPA responded by providing supportive counseling and offering ultrasounds. However, an RH KI who provides abortion services said their agency statistics did not reflect an increased demand for abortions. Half (2/4) of RH KIs in Sindhupalchowk had heard of incidents of unsafe abortion. One of these KI commented that the woman presented for post-abortion care after a self-abortion and the other KI said unsafe abortion was associated with a lack of infection prevention in health facilities.

C. Response

1. Ensure the health sector/cluster identifies an organization to lead implementation of the MISIP

- RH Officer(s) in place
- Meetings to discuss RH implementation held
- RH Officer reports back to health cluster/sector
- RH kits and supplies available and used

The majority (11/12) of RH KIs reported that their response for RH services started one to two weeks after the earthquake. In Kathmandu, many RH KIs said they started the response immediately or within days. One KI commented that initially they focused on treatment for trauma but that the RH sub-cluster was established within a week and planning at the central level was fast. One KI said they had a global MOU with UNFPA, which facilitated their quick response. Another KI in Kathmandu said that their initial activities included contacting nurses at birthing centers to check on their well-being and that of their families, and then they moved to strengthen birthing centers and set up tents in collaboration with UNICEF and GIZ. One RH KI in Sindhupalchowk said their response started immediately after the earthquake.

All (12/12) RH KIs in Kathmandu and Sindhupalchowk reported that there were designated national and international agencies responsible for RH coordination in this crisis. All (8/8) KI in Kathmandu also reported that the Family Health Division (FHD) was the designated national entity and the majority (7/8) cited UNFPA as the designated international entity responsible for RH coordination in the crisis. While KIs varied in naming the designated RH focal point within the FHD, the majority of KIs were able to identify the focal point within UNFPA. All (4/4) KIs in Sindhupalchowk also identified the FHD as the designated national entity for RH in this crisis, with half of respondents reporting district versus national responsibility with a related focal point. Most 3/4 KIs identified UNFPA and its designated focal point, while one KI from Sindhupalchowk noted responsibility by another UN agency, such as the WHO, through the health cluster, as an additional international agency responsible for RH in the crisis.

The majority (11/12) of RH KIs in Kathmandu and Sindhupalchowk reported that RH coordination meetings were hosted on a regular basis, while one RH KI in Kathmandu did not know. Several RH KIs in Kathmandu commented that the RH coordination meetings in Kathmandu were hosted every day in the beginning, then weekly, and then they progressed to biweekly or monthly according to need. An RH KI in Sindhupalchowk said that RH was initially started in the Health Cluster meeting and a separate RH working group in Sindhupalchowk was established later – on June 23, 2015 – and meetings were held almost daily in the beginning and then progressed to weekly. All (4/4) RH KIs reported that RH working group meetings in Sindhupalchowk were currently hosted biweekly.

The majority (11/12) of RH KIs also reported that meetings organized by the RH lead agencies include all of the stakeholders. Yet with further prompting, KIs commented that private sector representatives were missing from the RH meetings. One KI in Kathmandu added that there are many new international and local NGOs active in RH at the national and district levels. Another commented that representatives from HIV were missing. One RH KI in Sindhupalchowk said LGBTI representatives were missing from the group. Another commented the DHO was missing and one suggested that a District Women and Children's Office representative could attend more regularly. One KI said that sometimes all the stakeholders are there and sometimes they are not. Finally, one KI said that with representation from RH, Health, Nutrition, and Protection all of the stakeholders were present.

On a scale of 1 to 5, where 1 is very poor, 2 is fair, 3 is average, 4 is good, and 5 is excellent, 7/8 RH KIs in Kathmandu ranked the effectiveness of RH coordination in Kathmandu as good or excellent and one person ranked it average. All (4/4) RH KIs in Sindhupalchowk ranked the effectiveness of RH coordination as good. Four KIs in Kathmandu added positive comments to the rating of the RH sub-cluster stating that there were very good inputs and participation; useful protocols and knowledge management; and that this particular sub-cluster was very active. One further noted that the RH sub-cluster linked to the protection cluster and considered GBV and people with disabilities. One general RH KI in Kathmandu said the RH sub-cluster was very functional: "We know what we are doing."

Reproductive health KIs from the lead RH agencies (FHD and UNFPA) reported that they either attend the health cluster meetings most of the time or always. One KI said that there is a standing line item on the health cluster meetings' agenda for RH.

The most frequently cited RH coordination meeting agenda items included MISP implementation and information on RH kits and supplies (11); general topics on the RH situation of the affected populations (10); RH protocols, data collection issues on RH indicators, and using data for action (9); information and orientation to the MISP for staff not familiar with it (7); and, information on RH funding (5). RH KIs in Kathmandu also commented that the agenda included updates from the

districts, including information on the 4W's; supplies and RH kit needs based on specifically developed templates; RH protocols; and use of RH kits through teaching materials such as job aids. KIs also said the meetings included finalizing previous minutes; obtaining information from members; an FHD component; engagement of FHCVs and adolescent RH; referral guidelines; commitments to the RH sub-cluster action plan and the transition. However, these KI also noted that there was limited orientation to the MISP and discussion around use of data in the meetings. In Sindhupalchowk, KIs also commented that the agenda included the 4W's, discussion of needs assessments, awareness activities, and transportation to health facilities. One KI said yes, on using data for action, but added "except for GBV." All (12/12) KIs said that RH sub-cluster meeting minutes were written and emailed, while 4/12 said that they were also initially uploaded to UN Office for the Coordination of Humanitarian Affairs (OCHA) and government websites.

In response to a question about how RH coordination meetings could be improved, one RH KI in Kathmandu said they could be improved through the participation of representatives from other Ministries and sub-clusters to support inter-sectoral coordination, particularly on assessments and information sharing. Another KI in Kathmandu said they could be improved if participants had more input on the agenda and greater participation was solicited so that the conversation is not so one-sided. One KI commented that it would be useful to have one uniform template on the 4W's because there were many versions, with many partners having their own agendas. It was also suggested there should be more information sharing about the MISP because many partners are not aware of what is included in the MISP. One KI suggested that during the current transition phase the RH sub-cluster should be integrated back into the health cluster. One general RH KI in Sindhupalchowk added that meetings could be improved if they were led by the government and include the regular presence of the DHO. One KI said that the meetings could be improved with regular participation of agencies and added that the role of government is to take leadership. One said that the meetings could be improved if GBV representatives participated in the RH sub-cluster meetings. One KI said the meetings are "quite sufficient."

Among RH KIs representing the lead RH agencies (FHD and UNFPA) in Kathmandu, 2/2 said that MISP indicators are collected, particularly the

coverage of CDKs, but also condom distribution, coverage of HIV rapid tests for safe blood transfusion, and the number of reported rape cases. One representative said MISP indicators were not collected. Another KI added that the Ministry sent out data collection formats to districts but that sexual violence data is very limited, with improved reporting over time. However, a lead agency representative in Sindhupalchowk said MISP indicators are not collected.

Most (9/12) RH KIs reported that Ministry of Health (MOH) protocols are used for clinical management of rape (CMR), though in three instances the response was not applicable (to the KIs' work). Most (10/12) KIs also reported using MOH protocols for EmOC, while one KI in Kathmandu cited WHO protocols and one KI in Sindhupalchowk did not know. All (12/12) RH KIs reported using MOH protocols for newborn care and one KI commented that the newborn care protocol was recently completed. 10/12 KIs used MOH protocols for family planning, while 1/12 KIs reported these protocols were not applicable to their work. The majority (10/12) also used MOH protocols for HIV prevention and treatment of STIs, while one reported it was not applicable and one in Kathmandu reported other protocols were used. Finally, 9/11 KIs, with one KI response missing, reported following MOH protocols, while 2/11 KIs, with one KI response missing, reported they were not applicable to their work. One RH KI in Kathmandu commented that as soon as a new international protocol comes out it is adapted to Nepal and there are consultative partners for DoHS/FHD to facilitate this.

Most (7/8) RH KIs in Kathmandu received funding to support the RH response in this emergency, with the lead international agency UNFPA reporting it had secured USD 5-6 million, including headquarters support, and UNICEF reporting USD 6-8 million to support RH. Two of the most active international and national NGOs working on RH also reported receiving approximately USD 500,000 each for RH response. One RH KI in Kathmandu that did not receive funding said that the DoHS had received funding for the emergency but not specific to RH. Half (2/4) of the KIs in Sindhupalchowk reported receiving funding designated for the RH response, while 1/4 said they did not receive funding and 1/4 said they did not know. One RH KI in Sindhupalchowk said they had received US\$15,000 for the whole district for surgical materials, while another said they received funding for primary health care but not specific to RH.

Sources of funding included: flash, cap or central emergency fund appeals and funding from the following donors: Australia; Austria; CARE; DFID; Holland; GIZ; IPPF; Japan; UNFPA; UNICEF; and WHO. Among the KIs in Sindhupalchowk receiving funds, the lead international agency for RH (UNFPA) reported receiving USD 560,000 (USD 200,000 UNFPA; USD 160,000 from USAID; USD 100,000 from Japan and USD 100,000 from IPPF). One RH KI had received funds from the MOH; another KI received funds from the Central Emergency Response Fund for equipment for maternal birthing centers and additional supplies and logistics support from UNFPA.

The majority (10/12) of RH KIs in Kathmandu and Sindhupalchowk reported that funding was sufficient to meet the RH programs goals; one RH KI each in Kathmandu and Sindhupalchowk reported that they did not know. One RH KI in Kathmandu said that the DoHS faces budget cuts this year. Another KI said that funding was sufficient for health overall; however, this KI also said there is an acute gap in the quality of care. One RH KI in Sindhupalchowk said funding was sufficient for the immediate response but not for comprehensive services and more training is needed for emergency response.

The majority (8/12) RH KIs said that inter-agency RH kits were available for the response generally while one RH KI in Kathmandu said they were not and three in Kathmandu did not know. A slightly greater majority (9/12) of RH KIs reported that RH kits and supplies generally were adequate for this emergency, while one RH KI in Kathmandu said they were not and two KIs in Kathmandu did not know. One RH KI in Kathmandu added that there were UNICEF, WHO, and UNFPA kits. A variety of mechanisms were reportedly used to distribute the kits, including picking them up from UNFPA or the DHO storage or having them delivered through DHO or World Food Programme transport. One RH KI said that the Logistics Management Central Authority supported transport to districts and the districts were then assisted to distribute the kits to health facilities. Another KI said that they initially used the DoHS system then reverted to a UNFPA system with partners.

An RH KI from UNFPA in Kathmandu identified several challenges, key lessons, and recommendations regarding use of IAWG on RH in Crisis RH kits. The challenges included that their initial calculation of need was

not accurate once they learned that more than 700 health facilities were destroyed or partially damaged. Customs clearance, storage, transport, and maintenance of the cold chain were also challenges. More specifically, the name “RH Kit” was a problem, labeling on kits was in too small a font, there is wastage with kits, the rape kit does not have all the necessary supplies, implants are very popular in Nepal but are not included in the kits, some kits were unopened, and there is an absence of material that demonstrates what is in the kits.

A variety of recommendations were provided by UNFPA Nepal to improve the kit contents, such as including different condom sizes, labeling, specifically the number of pieces inside each kit, larger font with more clear expiry dates and improved numbering of the kits, smaller “mini” kits for lower population areas to avoid waste, post-rape should include supplies such as: more gloves; swabs; minimum slides for forensic evidence; supplies for injuries; and a speculum. Also, consider adding implants to the family planning kit and note that Methergine/ Ergometrine require a cold chain in the next revision of the IAWG RH Kit manual. These recommendations were shared with UNFPA headquarters by UNFPA Nepal and the IAWG logistics sub-working group, which is working to improve the availability of commodities and supplies in humanitarian emergencies.

Another RH KI in Kathmandu commented that there were not enough of kit 10 (vacuum extraction for delivery) with the first order of kits, but that UNICEF had supplies. An RH KI in Kathmandu commented that there was a lack of understanding about what kits UNFPA sent to districts beyond the hygiene and delivery kits. This KI also said, “stores are full of kits at the district level and they should be sent out to health facilities instead of remaining in stores,” and added that there have been problems because people don’t know what is in Kit 6 (clean delivery kit). Another RH KI in Kathmandu said supplies were adequate at the Kathmandu level but reported uncertainty beyond Kathmandu currently, with the transition from emergency context to stabilization and the need to ensure comprehensive RH.

One RH KI in Sindhupalchowk reported that the distribution and logistics of supplies were a problem because it took time to get the kits; there was a lack of orientation to the kits; there were gaps in monitoring the receipt and

proper use of the kits; and the rainy season was a problem for transport of the kits. An RH KI in Kathmandu said the supplies were not inadequate, but were a challenge because the monsoon season affected transport to inaccessible areas. Another KI said the only challenge was in the beginning when information about who got what supplies was delayed. One RH KI in Sindhupalchowk added that some of the kits are stored in the district hospital because they require transport. However, another KI commented that most kits were distributed to health facilities from the district, while some kits remain in the district warehouse to distribute after new facilities are established. Another RH KI in Sindhupalchowk said there are enough kits up to district level but not to primary health care levels.

2. Prevent and manage the consequences of sexual violence

- Protection measures in place at health facilities
- Clinical management of rape, including psychosocial services
- Community awareness raising about services

There were mixed findings regarding the extent protection measures were reported in place at health facilities in Kathmandu and Sindhupalchowk, including sex-separated latrines that lock from the inside, presence of guards, and adequate lighting. In Kathmandu, 2/8 KIs reported sex-specific latrines were available or partially available while 5/8 said locks inside of latrines and guards were available or partially available. Three-quarters (6/8) of KIs in Kathmandu said lighting at health facilities was available or partially available. Two KIs in Kathmandu commented that the extent protection measures are in place depends on the level of the health facility, with higher-level facilities having protection measures such as sex separated latrines and guards. Another KI commented that protection at health facilities was recognized as a concern in the crisis and efforts were made to address lighting at medical camps.

In Sindhupalchowk, 3/4 RH KIs said separated sex-specific latrines with locks inside were in place. No (0/4) KIs said guards were available at health facilities while 1/4 said guards were partially available. No (0/4) RH KIs said there was adequate lighting at health facilities. An RH KI in Sindhupalchowk said that immediately post-earthquake there were just tarpaulin for latrines. Another KI commented that in the first eight weeks

the latrines were separated by sex but that “they made temporary structures and they should make permanent structures from the start.”

With regard to CMR, 7/12 RH KIs in Kathmandu and Sindhupalchowk said CMR was available and 4/12 KIs said it was partially available, while 1/12 did not know. In Kathmandu, 6/8 KIs said CMR was available, 1/8 said it was partially available, and 1/8 did not know. One RH KI in Kathmandu commented that before the earthquake, CMR was only available at OSCMCs. Another KI said there are a few earthquake-affected districts with OSCMCs. A third KI in Kathmandu added that trainings have been undertaken and in theory there are human resources at OSCMCs. And one KI added, “Services are available, but it is not clear if women are raped – it is so complicated with back and forth between family and police.” In Sindhupalchowk, 1/4 KIs said CMR was available, 2/4 KIs said CMR was partially available, and 1/4 KIs said CMR was not available. One RH KI in Sindhupalchowk commented that CMR was only partially available at the district hospital and PHCCs. Two additional KIs in Sindhupalchowk said CMR was only partially available at the district hospital.

Considering EC as a component of CMR, 4/12 RH KIs in Kathmandu and Sindhupalchowk said that EC is available, 5/12 said it is partially available, and 3/12 said they did not know. In Kathmandu, specifically, 2/8 KIs said EC is available, 4/8 KIs said EC is partially available, and 2/8 did not know. One RH KI in Kathmandu commented that EC is still not on the government’s essential drug list. Another said EC was only available in places where UNFPA provides services and that it was introduced in two districts. A third KI in Kathmandu commented that there is a low level of knowledge about EC at health facilities but it is available at referral sites. In Sindhupalchowk, 2/4 KIs said EC is available, 1/4 said EC is partially available, and 1/4 did not know. One RH KI in Sindhupalchowk commented that EC was available because it had been integrated into family planning programs, while another said EC was only partially available at the DHO and PHCCs.

Regarding PEP as a component of CMR, 3/12 RH KIs in Kathmandu and Sindhupalchowk said it was available, 4/12 said it was partially available, 2/12 said it was not available, and 3/12 did not know. In Kathmandu, specifically, 2/8 KIs said PEP was available, 4/8 said it was partially available, and 2/8 did not know. One RH KI in Kathmandu commented that

only a doctor can provide PEP and that PEP cannot be stocked without doctors. However, this KI added that trained paramedics could also start PEP under the support of the director of NCASC. In Sindhupalchowk, 1/4 KIs said PEP was available, 2/4 said PEP was not available, and 1/4 did not know. One RH KI in Sindhupalchowk commented that PEP is not available but planned for the future.

Regarding prophylaxis for STIs as a component of CMR, 6/12 RH KIs in Kathmandu and Sindhupalchowk said it was available, 4/12 said it was partially available, and 2/12 did not know if it is available. In Kathmandu, 4/8 KIs said prophylaxis for STIs is available, 3/8 said it is partially available, and 1/8 did not know. One RH KI in Kathmandu commented that there is a national protocol and in most places drugs are available. In Sindhupalchowk, 2/4 KIs said prophylaxis for STIs is available, 1/4 said it is partially available, and 1/4 did not know. One KI in Sindhupalchowk commented, "Theoretically it should be available, but it is not enough."

With regard to psychosocial support as a component of CMR, 3/12 RH KIs in Kathmandu and Sindhupalchowk said psychosocial support is available, 6/12 said it is partially available, 1/12 said it is not, while 2/12 did not know. In Kathmandu, specifically, 1/8 KIs said psychosocial support is available, 4/8 said it is partially available, 1/8 said it is not available, and 2/8 did not know. One RH KI in Kathmandu added that psychosocial support for survivors was limited. One KI added, "Mental health is a neglected huge problem -- suicide was a leading cause of death for women of reproductive age in several years (1998; 2008; 2010)." In Sindhupalchowk, 2/4 RH KIs said psychosocial support is available for survivors and 2/4 KIs said it is partially available. One RH KI in Sindhupalchowk said there is a gap in how to provide this care after an emergency, although staff have been trained to address it. Another KI from Sindhupalchowk said that psychosocial support for survivors started in the second week of the crisis.

Regarding a referral system for CMR, 7/12 RH KIs in Kathmandu and Sindhupalchowk said that a referral system for survivors of sexual violence was established, 4/12 said it was partially established, and 1/12 did not know. In Kathmandu, specifically, 5/8 KIs said a referral system for CMR was established and 3/8 said it was partially established. One RH KI in Kathmandu commented that the referral system

includes legal, health, police, and a rehabilitation center, while another KI mentioned the availability of OSCMCs. In Sindhupalchowk, 2/4 RH KIs said a referral system for CMR was established, 1/4 said it was partially established, and 1/4 did not know. One RH KI in Sindhupalchowk said, “People don’t want to go to the police or the hospital. We refer cases to the district hospital but many cases don’t disclose. Health professionals don’t know how to approach survivors or others.”

The majority (10/12) of RH KIs in Kathmandu and Sindhupalchowk reported that community IEC materials about the availability and benefits of care after rape were available. In addition, 7/12 KIs reported peer educators were engaged or partially engaged in IEC about the availability and benefits of care after rape and 10/12 KIs said community health workers (CHWs) were also engaged in IEC mechanisms. The majority (11/12) of KIs reported that radio was used to disseminate messages, while two KIs reported cell phones were also used. In Kathmandu, an RH KI commented that community-awareness mechanisms to provide IEC about the availability and benefits of care after rape were undertaken as part of antenatal care; through peer educators; community social mobilizers, through the GBV sub-cluster, the Women and Children’s Office and OSCMCs. Another KI said there is a National Health Information and Communication Center and volunteers who undertake this work. RH KIs in Sindhupalchowk commented that IEC was undertaken via television broadcast, discussed in small groups and by community health volunteers and social mobilizers.

3. Reduce HIV transmission

- Safe and rational blood transfusion in place
- Standard precautions practiced
- Free condoms available

The majority (7/8) of RH KIs in Kathmandu reported that safe blood transfusion was available, and 1/8 reported that was partially available. All (4/4) RH KIs in Sindhupalchowk said safe blood transfusion was not available. However, two KIs in Sindhupalchowk reported that a temporary field hospital was established by NRC that provided safe blood transfusion services. In Sindhupalchowk, one RH KI said most village

members access safe blood transfusion in other districts, for example, Dhulikhel or Kathmandu, by ambulance and they have looked at alternatives to a blood bank, such as community donors and blood grouping. One KI said there is currently no comprehensive EmOC at the district hospital, but there are plans to upgrade the hospital, while another KI commented that the building collapsed during the earthquake and the laboratory was hardly functioning.

The majority (6/11, with one KI response missing) of RH KIs in Kathmandu and Sindhupalchowk reported that the practice of standard precautions is followed, while 5/11, with one KI response missing, reported it is partially followed. One RH KI in Kathmandu said, “In most places infection prevention is not only about knowledge, it is also about attitude, though it is a logistics issue sometimes.” Another KI said they had undertaken re-trainings with onsite training on standard precautions after the earthquake. Another KI said that rural areas were very different (not as good) on following standard precautions. In Sindhupalchowk, two RH KIs said that standard precautions were followed only partially depending on the place and if there is support from the DHO or NGOs.

All (12/12) RH KIs in Kathmandu and Sindhupalchowk said that condoms were available. The majority said they were made available in clinics (12/12) and through community-based distribution (7/12), while one RH KI said they were distributed to sex workers. In Kathmandu, one RH KI said condoms were made available at the DHO to distribute and were available through health facilities, mobile health camps, condom boxes, and community-based distribution by FCHVs. An RH KI in Sindhupalchowk commented that condoms were made available at health facilities, primary health care outreach clinics, through mobile RH health camps, including from adolescents, and from community-based organizations.

4. Prevent excess maternal and newborn morbidity and mortality

- Emergency obstetric and newborn care services available
- 24/7 referral system established
- Clean delivery kits provided to birth attendants and visibly pregnant women
- Community awareness about services

All (12/12) RH KIs in Kathmandu and Sindhupalchowk said that BEmOC was available. One RH KI in Kathmandu said that a lot of progress has been made on EmOC, with maternal care incentives such as transportation allowances for women and through service delivery packages, whereby the health facility gets what it costs for safe delivery and EmOC. According to this KI, the service delivery packages were piloted and subsequently expanded to the whole country in 2009-2010. Another RH KI in Kathmandu said that where health facilities were destroyed or damaged, services were established in a tent. Two RH KIs in Sindhupalchowk said BEmOC is provided at 20 health facilities/birthing centers and one KI added that many sustained damage during the earthquake and now there is a challenge of human resources. One RH KI said that there are four BEmOC facilities, including the DHO in Sindhupalchowk.

With regard to CEmOC, 7/8 RH KIs in Kathmandu said it is available, while 1/8 said it is partially available. However, all (4/4) RH KIs in Sindhupalchowk said CEmOC is not available in Sindhupalchowk.

Two RH KIs in Sindhupalchowk said that at the beginning of the response, NGOs supported the availability of CEmOC at a field hospital in Sindhupalchowk that was subsequently dismantled, while another KI commented that the District is planning to establish CEmOC.

All RH KIs in Kathmandu and Sindhupalchowk report that newborn care services, including emergency newborn care services, were available (8/12) or partially (4/12) available. In Kathmandu, specifically, RH KIs reported newborn care services, including emergency newborn services, are available (5/8) or partially (3/8) available. One KI in Kathmandu said newborn care services had been neglected until the last one or two years, when there has been more focus led by Save the Children and UNICEF. This KI further explained that there has been a gap for newborns within the FHD, which focuses on the mother and the Child Health Division, which focuses on the child. Another KI in Kathmandu said that while materials and supplies are available, staff are not organized enough to provide the care. Among RH KIs in Sindhupalchowk, 3/4 report that newborn care services, including emergency newborn care services, are available or partially (1/4) available. One KI in Sindhupalchowk added that newborn care services are available at the district hospital and birthing centers. One KI in Sindhupalchowk said although

these services are available, a lot of equipment is missing or not working, such as automatic and manual suction machines. Another KI said that emergency newborn care is only partially available because there is no neonatal intensive care unit at the district hospital.

Most (10/12) RH KIs report the availability of a 24 hours per day referral system for maternal and newborn emergencies, while one KI each in Kathmandu and Sindhupalchowk reported it is partially available. One RH KI in Kathmandu said that the referral system was a challenge before the earthquake due to the terrain in Nepal and because of communication gaps, causing delays in access to care. This KI added that it is also a challenge to get feedback on the outcomes of referrals and that the government was working on national guidelines for referral before the earthquake. Another RH KI in Kathmandu said birthing centers have ambulances, but at the community level, stretchers are carried to an ambulance or carried all the way. A third KI in Kathmandu said that there is a 24/7 referral system in Kathmandu but that for earthquake-affected areas transportation could be a problem. In Sindhupalchowk, two RH KIs said that the referral system was implemented through use of stretchers, ambulances, and helicopters. One KI said that VDCs refer women to the district but that most referrals go to Kavre or Dhulikhel district hospitals, while another KI said that referral services were supported by NGOs such as the Association of Medical Doctors of Asia and the NRC.

The majority (11/12) of RH KIs said that community awareness (IEC) mechanisms about benefits and location of maternal and newborn services were available, while one RH KI in Sindhupalchowk did not know.

One RH KI in Kathmandu said that the RH sub-cluster developed messages used across the cluster and through the media. Messages included avoiding delays, preparing for delivery, and use of maternity transition homes established before the earthquake. According to one KI, UNFPA and UNICEF established 15 and 22 waiting homes, respectively, in the 14 most affected districts. Another RH KI added that messages were also disseminated through television. One RH KI in Sindhupalchowk said that IEC programs were implemented before and after the earthquake using social mobilizers.

RH KIs reported that CDKs were largely (10/12) available or partially

(2/12) available. 5/12 RH KIs reported that CDKS have been distributed to the 14 most crisis-affected districts at health facilities, including damaged facilities, to pregnant women in the RH camps (mobile RH services in rural locations), and through FCHV packages to distribute to communities. One RH KI in Kathmandu reported that when the crisis first happened, NRC distributed CDKS to district health workers and FCHVs, as well as to international NGOs. This RH KI added that all partners received CDKS where health facilities were completely destroyed and they were also distributed at RH camps. Two RH KIs in Kathmandu said that the government raised concerns about CDKS because it wants to facilitate health facility deliveries and that CDKS may be used as though they are sterile (free from germs or organisms) and not just clean. Another KI in Kathmandu expressed concerns that health providers' practice of safe deliveries may decrease if women do not seek skilled birth attendance, while another KI said that the use of CDKS has to be strategic. In Sindhupalchowk, one RH KI reported that CDKS were distributed to VDCs and agencies to distribute, while another KI said that CDKS included clothes for the mother.

5. Plan for comprehensive RH services to be integrated into primary health care

- Background data collected
- Sites for future delivery of comprehensive RH
- Staff capacity assessed and trainings planned
- RH equipment and supplies ordered

The majority (10/12) of RH KIs reported that staff capacity had been assessed and trainings planned, though one KI in Kathmandu said this had been done partially and one said it had not happened. One RH KI in Kathmandu said that staff capacity was assessed and trainings were undertaken by UNFPA, particularly for CMR that included a multi-sectoral approach. Another RH KI in Kathmandu did not feel that capacity was assessed across the board but that many facilities have onsite supervision and coaching. In addition, this KI reported that the Canadian Red Cross and UNICEF engaged the National Midwives Association in Nepal. One KI in Kathmandu also said there were MISP trainings and

sensitization activities at the DHO, as well as a brief of the RH Kits. Another KI in Kathmandu said that training and onsite coaching were undertaken for infection prevention, maternal and newborn health quality assurance and family planning. One RH KI in Sindhupalchowk said that UNICEF and Médecins du Monde deployed five SBAs and provided onsite mentorship and coaching during the emergency response. One KI in Sindhupalchowk commented that assessing staff capacity has been done and added that there are staff shortages and two staff are currently working without pay. Two KIs in Sindhupalchowk said they are now discussing staff capacity and training needs during the transition phase at the national and district levels.

Most (10/12) RH KIs reported that background data has been collected for planning comprehensive RH services, though one RH KI in Kathmandu said it had only been partially collected and one in Sindhupalchowk said it had not been collected.

RH KIs in Kathmandu reported that data was collected from districts and partners and through rapid assessments where the RH sub-cluster developed and implemented a template and findings were subsequently shared in the UNFPA annual report. One RH KI said that the health information management system will include data on pregnancy and delivery at the end of September. One RH KI in Sindhupalchowk said, “Data is hard to come by.”

All (12/12) RH KIs in Kathmandu and Sindhupalchowk said that identifying sites for future delivery of services was part of the planning for comprehensive RH services. Two RH KIs in Kathmandu commented that identification of future sites was part of national rebuilding and district response plans, while one KI said there was a plan to increase the number of birthing centers from before the earthquake. Two other RH KIs in Kathmandu reported that there is a need for more strategic planning around the location of birth centers. One of these KIs further explained that “birthing centers have mushroomed” and the government is staffing the facilities with two personnel per facility, which results in fewer deliveries per staff with the risks that staff skills are not used regularly and may be lost. In Sindhupalchowk, one RH KI said that approximately 75 buildings are being rebuilt and reconstructed with support from a variety of agencies, while another KI said that the government is extending safe

birthing centers in the district, but it is going slowly.

The majority (8/12) of RH KIs in Kathmandu and Sindhupalchowk reported that inter-agency RH kits were available for the response generally, while 1/12 said they were not and 3/12 did not know. Further, 9/12 stated that RH kits and supplies were adequate for this emergency generally, while 1/12 said they were not and 3/12 did not know. One RH KI in Kathmandu commented, “Equipment and logistics were not a problem this time” and explained that the RH sub-cluster held a number of meetings to share information about what was planned and procured, and used a template to organize and map equipment and supply needs.

One RH KI in Sindhupalchowk said, “The government provided fine and requested agencies to provide RH kits.” A lead agency KI in Sindhupalchowk commented that UNFPA provided RH Kits 1-13. Another KI from Sindhupalchowk commented, “There are problems with transportation to some places.” And another KI in Sindhupalchowk said that the equipment and supplies were implemented through a logistics management system.

6. Additional priorities of the MISIP

- Ensure contraceptives to meet demand
- Ensure syndromic management of STIs to those presenting with symptoms
- Ensure antiretrovirals are available to continuing users and to prevent mother-to-child transmission (PMTCT)
- Ensure menstrual hygiene materials are available

The majority (10/12) of RH KIs in Kathmandu and Sindhupalchowk reported that contraceptives were available to meet demand, although one RH KI in Kathmandu said partially and one RH KI in Kathmandu did not know. Specifically, the majority (10/12) of RH KIs in Kathmandu and Sindhupalchowk said male condoms were available, one KI in Kathmandu said partially, and another did not know. The majority (8/12) of KIs in Kathmandu and Sindhupalchowk said that female condoms were not available, one KI in Kathmandu said they were, one said partially, and 2/12 KIs did not know. The majority (11/12) of RH KIs said contraceptive pills were available, and one KI in Kathmandu did not know. The

majority (10/12) also said injectables were available, although 1/12 KIs in Kathmandu said partially and one KI in Kathmandu did not know. There was less consistency about the availability of IUDs, with half (6/12) of RH KIs in Kathmandu and Sindhupalchowk saying IUDs were available, 5/12 KIs saying they were partially available, and 1/12 did not know.

One RH KI in Kathmandu commented that contraceptive pills and injectables are available at the health post level and that bimonthly community outreach from health posts is undertaken. Another RH KI in Kathmandu reported that there was a national shortage of injectables and implants during the earthquake and UNFPA headquarters provided support to fill the gap. Another RH KI in Kathmandu said, "There is a huge demand for implants but they are not part of the RH kits, so to meet the demand for implants requires the normal government system for commodities." This KI also added that there is a limited number of trained government providers, adding, "Demand is good but supply is limited." One KI in Kathmandu commented that there was a gap in contraceptive availability after the crisis because health workers left after the emergency and the distribution system is through the health posts and FCHVs. Finally, one KI said contraceptives are available but not necessarily used, as the supplies went to district headquarters through kits. In Sindhupalchowk, one RH KI reported that IUDs are only available at the district hospital and another KI reported access to permanent methods, such as sterilization, is available through government-supported mobile camps.

Dedicated EC pills as a component of family planning were also reported as being less consistently available, with 4/12 KIs stating they are available, 2/12 KIs stating they are partially available, 2/12 KIs stating they are not available and 2/12 KIs stating that they do not know. Several KIs in Kathmandu commented that a dedicated EC product (Prostinor) is only available in the private sector through shops, although one KI said DoHS provides information about Prostinor. One half (6/12) of KIs (5 from Kathmandu and 1 from Sindhupalchowk) said that EC using the Yuzpe method of oral contraceptive pills was available, 3/12 said it was partially available, and 3/12 did not know. Fewer (2/12) KIs reported that the IUD as a method of EC was available, while 4/12 KIs said it was partially available, 2/12 KIs said it was not available and 3/12 KIs did not know.

The majority (10/12) of RH KIs in Kathmandu and Sindhupalchowk said community awareness through IEC about the benefits and location of family planning services was available, although one KI in Kathmandu said no and one KI in Sindhupalchowk did not know. One RH KI commented that IEC about the benefits and location of family planning services was undertaken as part of the government social mobilization package and another KI said it was undertaken through FCHVs.

The majority 9/12 of RH KIs in Kathmandu and Sindhupalchowk said ARVs were available for continuing users, including PMTCT, while 3/12 reported they were partially available. One KI in Kathmandu commented that ARVs were available through the NCASC. Another KI in Kathmandu said ARVs were available partially at the district level and in one to two facilities. In addition, a KI in Kathmandu commented that they were very few people on ARVs whose treatment was disrupted. In Sindhupalchowk, one KI said that ARVs were available for continuing users but they were unsure if they were available for PMTCT.

One half (6/12) of RH KIs said that syndromic management of STIs was available, while 5/12 said it was partially available and one KI in Sindhupalchowk did not know. One RH KI in Kathmandu commented that it is very difficult to obtain information about STIs at the health post level. One RH KI in Sindhupalchowk said they didn't know whether the services were available but that there is a national plan for these services.

One-half (6/12) RH KIs said that menstrual hygiene supplies were available, and half said that they were partially available. One RH KI in Kathmandu commented that menstrual hygiene supplies were distributed through dignity kits and organized and distributed in RH camps. One RH KI in Kathmandu said menstrual hygiene was a big challenge to address and added that UNICEF distributed two washable pads to women and girls of reproductive age at shelter homes. One RH KI said distribution did happen but it was limited through very few organizations. Three KIs in Sindhupalchowk said menstrual hygiene supplies were distributed, including as part of dignity kits and for adolescents.

Engagement of communities in RH programming

Three-quarters (8/12) of RH KIs in Kathmandu and Sindhupalchowk reported that communities were engaged in RH programming, while one

KI in Sindhupalchowk said they were not and three KIs in Kathmandu did not know. One half (6/12) of RH KIs said communities were engaged specifically in implementation and consultation. One RH KI in Kathmandu said that affected communities support safety and security for themselves and each other and another said that affected communities assist with mobile clinics, which have served 8,000 people. One KI in Sindhupalchowk said adolescents are engaged in RH programming through the involvement of both community mobilizers and FCHVs. Another said communities are engaged through RH camp education and counseling. Yet another said they are engaged through the implementation of baby and mother units and women's groups, adding that there are women's groups in 10 health facilities and mother and baby units in two birthing centers to support maternal health. One KI in Sindhupalchowk said that affected communities are engaged in RH programming through VDCs and female-friendly spaces (FFSs).

Addressing the RH needs of adolescents and people with disabilities

The majority (9/12) of RH KIs also said that agencies are conducting adolescent interventions with half (6/12) reporting it is done through adolescent-friendly services and involving adolescents in RH programming, 5/12 reporting it is undertaken through consultations, and 2/12 KIs stating that adolescents are engaged through IEC. One RH KI in Kathmandu reported, "Adolescents are part of the RH sub-cluster." Another RH KI explained that in Nepal adolescent sexual and reproductive health (ASRH) is a package, including SRH messages, hygiene, and delaying pregnancy for married adolescents. Other KIs said adolescents have been engaged through consultations on menstrual hygiene management; through peer educator counseling on SRH; and mobilized in RH camps. One RH KI in Kathmandu said, "It is exciting to see young people in our adolescent corners. When we set up RH camps (mobile RH services), adolescents know where to go. They would come to the adolescent corners for condoms and sanitary pads. They really liked it." One RH KI in Sindhupalchowk explained that the child protection department engages adolescents and that adolescents are also engaged as community mobilizers through VDCs. One RH KI said the government has a plan to have an adolescent center in every facility.

Most (7/12) RH KIs did not know if agencies reached out to people with

disabilities to address their RH needs; however, 3/12 said they did, and 2/12 said they did not. One RH KI from Kathmandu reported that Handicap International was present in Nepal, but was unsure if they focused on RH. Another KI from an international NGO reported their organization provided counseling on sexual hygiene and family planning and that they worked with Handicap International and local NGOs. Another KI in Kathmandu commented that their agency had referred one paralyzed woman to the hospital. One RH KI from Sindhupalchowk said there was an assessment of needs; provision of equipment and supplies; and training of staff on continuing services

D. Disaster Risk Reduction, Including Preparedness

Lead (FHD and UNFPA) RH agency representatives were asked if there was a pre-crisis national RH coordination mechanism: 2/4 KIs said yes, 1/4 KIs said no, and 1/4 did not know. One KI in Kathmandu said that there is a District RH Coordination Committee in the FHD with different sub-committees, including, safe motherhood, family planning, adolescent health, and safe abortion care. Another KI said that RH was covered by the Health and Nutrition Cluster as a standing agenda item before the crisis.

In terms of whether organizations themselves made any prior preparation or arrangements for RH activities for this humanitarian crisis, 9/12 KIs said yes, while 3/12 KIs in Kathmandu said no. Kathmandu KIs cited several emergency preparedness initiatives and activities, including pre-positioning RH supplies (tents, newborn care); dedicating financial resources to RH for capacity development of health staff; participating in MISP training; supporting districts to develop EPPs; hosting and participating in emergency planning workshops and earthquake drills; undertaking assessments of birthing centers; and supporting hospital preparedness for emergency trauma care. One KI in Kathmandu that said they had not made prior preparations but they have now started. Another RH KI said, “No, it is the responsibility of the Disaster Management Section.”

One RH KI in Sindhupalchowk said meetings were held to prepare for a detailed contingency planning meeting that had been scheduled for April 27 (the earthquake happened on April 25). Another KI said that financial resources were dedicated to RH for capacity development, including on ASRH and the MISP. This KI also added that the National Red Cross

provided a MISP training and was planning a TOT with a MISP Facilitator Participants Manual developed by the National Health Training Center. There was also a training for the District Rapid Response Team (RTT) with a focal person for the MISP. This KI also reported working with the Red Cross to prepare a district disaster contingency plan.

Most (8/11, with one KI response missing) RH KIs said that personnel employed by their agency are required to sign a CoC against SEA, while one KI each in Kathmandu and Sindhupalchowk said no and one in Kathmandu did not know. One RH KI in Kathmandu commented that their agency has SEA reporting and complaints mechanisms. One RH KI in Sindhupalchowk said they did not, and that they refer this issue to the government.

Most (9/12) RH KIs said that their agency has made available opportunities for staff to be trained in the MISP, although 2/12 KIs in Kathmandu and 1/12 KIs in Sindhupalchowk said their agencies had not provided any opportunities. Several RH KIs in Kathmandu said they provided opportunities for staff to be trained in the MISP one or two times. One RH KI said, “No, but we would be open to this.” One KI said that there is a tripartite agreement between the Epidemiology and Disease Division (EDD) under DoHS/FHD with the Red Cross and UNFPA and that the EDD is responsible for preparedness and had therefore undertaken MISP trainings.

Half (2/4) of the RH KIs from the lead (FHD, UNFPA) RH agencies representing both Kathmandu and Sindhupalchowk reported that a logistics system was established in preparation for emergency distribution of health supplies, including RH supplies, 1/4 KIs said no and 1/4 KIs did not know. In addition, 3/4 representatives of the lead RH organizations reported all RH kits (1-13) were prepositioned before the emergency. However, one lead agency KI in Kathmandu said that logistics and supplies were a challenge that could be improved. Another KI added that the Logistics Division took responsibility for other areas, but not RH: “In general, we have problems with procurement and supplies below district level.” One KI in Kathmandu commented that when the earthquake occurred, the DoHS focused on distributing what they had and health facility distributions were undertaken by UNFPA: “A national logistics supply system for RH would be useful.” One RH KI in Kath-

mandu reported that UNFPA had an agreement with the National Red Cross to pre-position kits in November 2013 in Kathmandu Valley. The kits were used in the flood-affected areas and, therefore, the replenishment stock was en route to UNFPA at the time of the earthquake. RH kits were distributed to district and regional offices and to INGOs. One RH KI in Sindhupalchowk said that after the floods in Nepal five years ago, RH kits were introduced with adequate pre-positioning and replacement of kits close to expiration.

The majority 9/9 RH KIs, with 3/12 missing in Kathmandu and Sindhupalchowk said there was a need for more advocacy, training, discussion, and dissemination of information on the MISP. One RH KI in Kathmandu commented that there is a need for a common understanding of the MISP by all stakeholders at three levels: 1) policy level; 2) manager level to coordinate MISP response; and 3) service provider level. Another RH KI suggested there is a need for advocacy with district health officers and local development officers. One KI further suggested that there is a need for more MISP TOTs at the district level. One KI suggested providing orientation to the MISP via email during emergencies when there are newcomers to the issue.

Several general RH KIs in Kathmandu commented that there is a need for more preparedness and crisis management planning, including established focal points. Other RH KI suggestions included: establish a designated emergency fund; plan to involve others in coordination of the sub-cluster because there are many interested groups; undertake advocacy on sexual violence; support program managers to do more; link with child health; better address the needs of adolescents; integrate family planning and establish a newborn corner at every birthing center with all equipment and supplies. One KI said that more consideration needs to be given to how to assist families that do not want to leave their homes to participate in RH camps and distributions, otherwise they are not reached.

All (4/4) RH KIs in Sindhupalchowk said attention needed to be paid to human resource capacity development and availability. One KI added that there is a need to support a regular supply of qualified government RH staff because currently only 30 percent are qualified staff and the government has been recruiting on a temporary basis to fill gaps. This

KI added that the government should have sufficient OBGYN staff and use external support for capacity development and establish comprehensive EmOC services at the district hospital. Another KI said most SBAs are on a contract basis and some birthing centers do not have SBAs. UNICEF supported deployment of SBAs in the emergency. One KI said there is a need to support health workers' lodging and to provide an incentive package for health workers. One KI also said more training is required on the MISP because "RH is still not a priority for everyone." Other KI suggestions included better coordination with the DHO and GBV and HIV representatives; and better monitoring, supervision, and data recording and reporting.

E. Key Facilitating Factors and Barriers to MISP Implementation in This Crisis

General RH KIs in Kathamandu shared many key factors that they believed helped facilitate the RH response in this emergency, including:

- It was already perceived that RH is a required service;
- Immediate regulatory action by DoHS;
- Excellent government leadership, including through the Health Emergency Operations Center (HEOC);
- Good planning, coordination, and action;
- Dynamic person leading the RH sub-cluster;
- RH sub-cluster highly regarded in the health cluster;
- Strong leadership from DoHS;
- MISP as part of the Nepal Disaster Management Plan;
- Pre-positioning of emergency kits and supplies;
- Training of health providers;
- Planning who should do what;
- Enthusiasm of partners;
- Agencies and people who already know about the MISP such as IPPF/FPAN and Save the Children;
- UNFPA and UN agencies established strategic relationships with the government and NGOs;
- Existing systems and relationships with the district health officer.

General RH KIs in Sindhupalchowk also shared many key factors that they believed helped facilitate the RH response in this emergency, including:

- Presence and timely response of UN agencies for coordination with the DHO, human resources, logistics, and tent facilities;
- Health system was able to re-establish services;
- RH kits supplied;
- Regular RH meetings;
- Regular protection meetings with the involvement of the Women Development Officer;
- RH camps benefited 4,000 people in camps;
- Medical Camp Kit (MCK);
- Field hospital: Médecins du Monde, helicopter transport, and mobile clinics;
- No maternal or newborn deaths;
- Intensive volunteering of NGOs;
- Gaps were addressed quickly;
- WHO support;
- “Health and RH were the responsibility of the whole society not just the DHO. The whole community took responsibility. 40% of the community provided their own land to support health services”;
- Involvement of DHO staff focal persons.

General RH KIs in Kathamandu shared many key factors that they believed were barriers to an effective RH response in this emergency, including:

- Monsoons and related logistical challenges;
- Multiple coordination meetings: “Coordination is challenged by so many competing needs so the question is how we can coordinate better?”;
- RH is not understood at all policy levels. “People need food, water, and shelter but some still ask why RH?” Many people know why it is important but it is inconsistent.”
- Size of the team; not enough people are trained on the MISP;

- Gaps in communication from the National Ministry to district levels;
- Gaps in planning and preparedness;
- Gaps in designated funding;
- Gaps in quality of care;
- Gaps in engagement of all stakeholders;
- Gaps in inter-sectoral coordination;
- Gaps in logistics;
- Gaps in delegating and sharing responsibility;
- People were busy with their own lives and trying to move forward;
- Care for rape survivors more focused on by social organizations with a need to do more to systematize the health response in curricula/ training and awareness raising.

General RH KIs in Sindhupalchowk also shared key factors that they believed were barriers to an effective RH response in this emergency, including:

- Destruction of most health facilities, with many birthing centers partially or completely damaged;
- Transport challenges to ensure equipment and supplies due to road blockages;
- Lack of adequate human resources;
- Lack of awareness about and training on the MISIP;
- Gaps in coordination in the beginning though later resolved;
- Lack of funding for emergency preparedness;
- Management problems at FHD and confusion about the responsibility of HEOC to coordinate;
- Gaps in human resources and constraints with staff where contracts had to be extended.

Key Informant Interviews Annex II

GBV Key Informant Interviews Detailed Findings

A. Awareness and Knowledge of the MISP and Additional Priorities

The majority (7/10) of GBV KIs had heard of the MISP, while 1/5 in Kathmandu and 2/5 in Sindhupalchowk had not heard of the MISP. Only one GBV KI from Kathmandu had received training on the MISP through a five-day UNFPA IPPF/SPRINT course. As the majority of GBV KIs had not been trained in the MISP, the question to name all the objectives and additional priorities of the MISP was revised to: What do you think are the priority activities for RH, including GBV, in an emergency? The most frequently (4) cited activities were in the “Other” category of activities, followed by three mentions of “to prevent and manage the consequences of sexual violence and to reduce HIV transmission,” two mentions of “to prevent excess maternal and newborn morbidity and mortality” and one mention of “to ensure culturally appropriate menstrual hygiene protection materials.” One GBV KI in Sindhupalchowk cited “safe shelter and care for pregnant and lactating women,” while two others cited “economic or financial support.” One KI added “security, health, medicine and food,” another said “family support,” and one mentioned the “need for attention to adolescents.”

When asked specifically about MISP or priority activities to prevent and manage the consequences of sexual violence, 4/10 GBV KIs (2/5 in Kathmandu and 2/5 in Sindhupalchowk) reported putting measures in place to protect affected populations, particularly women and girls, from sexual violence and to make clinical care available to survivors of sexual violence. Slightly fewer (3/10) of GBV KIs (2/5 in Kathmandu and 1/5 in Sindhupalchowk) reported ensuring that the community is aware of the benefits and availability of clinical services.

One GBV KI in Kathmandu mentioned GBV screening with a referral system. Another GBV KI said mobilizing the media was an important activity to prevent and manage the consequences of sexual violence. Other activities cited by GBV KIs in Sindhupalchowk included overall security, awareness raising, accessible health facilities, and timeliness

of care; safe spaces and shelter, counseling support, and education; addressing women's issues facilitated by women's groups and linked through referrals to the Women and Children's Office and UNFPA. One GBV KI in Sindhupalchowk said women should know self-defense. This KI further added that it was important to make men more aware and engage them in campaigns because they lack education about GBV. One GBV KI in Sindhupalchowk said, "Not all survivors need medicine support – counseling is the main medicine."

B. Coordination

The majority (9/10) of GBV KIs in Kathmandu and Sindhupalchowk reported that there were both national (9/10) and international (10/10) entities and focal points (9/10) and (8/9 with one response missing) in Kathmandu and Sindhupalchowk, respectively, responsible for GBV coordination in this crisis. Further, the majority (4/5) of GBV KIs in Kathmandu identified the MOWCSW as the national entity and the UNFPA (5/5) as the international entity responsible for GBV coordination in the crisis, with one KI reporting that UNICEF co-chaired international coordination. One GBV KI in Kathmandu reported that the Department of Women and Children is the lead in the National Disaster Response Framework and co-lead of the Protection Cluster. UNICEF and UNFPA lead the GBV sub-cluster. There were mixed responses from GBV KIs in Sindhupalchowk about which entity was responsible for national GBV coordination, including MOWCSW, GBV and Protection Cluster, National and District Protection, and the Women Development Committee, with all (5/5) identifying UNFPA as the designated international agency responsible for GBV coordination.

All (10/10) of GBV KIs in Kathmandu and Sindhupalchowk reported that GBV coordination meetings are held. The majority (7/10) reported that coordination meetings were originally held weekly and are now biweekly. One GBV KI in Kathmandu reported that initially the GBV Sub-cluster and the Protection Cluster meetings were hosted together and subsequently split. Several GBV KIs in Kathmandu reported that coordination meetings were held daily in the beginning and progressed to weekly meetings and one GBV KI reported they are now held monthly, based on demand.

One GBV KI in Sindhupalchowk reported that there are three sub-clus-

ters: Protection, GBV and Psychosocial. Another KI said that there was a plan to continue as a GBV sub-cluster until September 30 (2015) with the possibility of establishing a working group, while another GBV KI reported there is a plan to merge with the Protection Cluster. One GBV KI in Sindhupalchowk added: “In terms of stakeholders, we could have more representation from the community.”

The majority (7/10) of GBV KIs reported that an RH focal point participates in GBV coordination meetings biweekly. One GBV KI in Kathmandu reported that representatives of the DoHS’s participate in the GBV coordination meetings. Some (2/5) of GBV KIs in Sindhupalchowk also said an RH focal point participates in the GBV coordination meetings sometimes but not regularly. Fewer (4/10) of GBV KIs report that a GBV focal point participates in the RH coordination meetings. One GBV KI in Kathmandu said that UNFPA has intra-agency cross-sectoral meetings but does not hold such meetings for inter-cluster coordination.

On a scale of 1 to 5, where 1 is very poor and 5 is excellent, the majority (7/9) of GBV KIs rated the coordination efforts between the RH and GBV sectors as good, while 2/9, with one KI each in Kathmandu and Sindhupalchowk, rated GBV coordination as average. In response to the question about how coordination between the GBV and RH sectors could be improved, one GBV KI in Kathmandu suggested that coordination could be improved by undertaking joint assessment missions to assess RH GBV interventions and vice-versa. One GBV KI commented that GBV is directly related to RH and the immediate intervention is for RH services. This KI also said that there should be a committee by law that includes both the DoHS and MOWCSW. Another said, “They are so linked that I feel they are coordinating.” Another suggested that GBV be brought into RH and that they don’t need to be separate. “In female-friendly spaces women have RH issues and want services, but we are not mandated.”

One GBV KI in Sindhupalchowk said that there is an existing referral mechanism between GBV and RH, but coordination between NGOs and the government could be improved. Another GBV KI suggested organizing GBV and RH meetings together, and a third suggested that RH and GBV actors should recognize how each area of expertise is part of the other area of expertise.

C. GBV Concerns and Needs

All (10/10) of GBV KIs had heard of incidents of sexual violence in the setting. One GBV KI in Kathmandu said there were some cases in the camp setting, with different people coming in to them – if so it is outsiders causing rape – also, men who use alcohol. Another GBV KI said, “We coordinate with police. The incident is reported to the police first and then referred to the hospital. We are trying to sensitize the police and there is a women and children’s police branch. The quality of the response depends on the person and how active they are. Female and male police have been trained, we try to educate them about the referral system.” Another GBV KI said, “Sexual violence as a direct cause of the earthquake related to women in camps with strangers – I heard reports from three different female-friendly spaces. There is also incest.” Another GBV KI in Kathmandu said there had been a few cases of rape, gang rape, rape in domestic violence, and incest. One added that because it was “particularly focused on minors that brought it to our attention.” One GBV KI in Kathmandu said, “If you compare worldwide, it is minimal, but it is definitely happening and among adolescent girls and through incest.”

Two GBV KIs in Sindhupalchowk said they heard of incidents of sexual violence, but said they did not know any specifics. One GBV KI said they heard of two women, and both of them got pregnant. One KI said there was a record of 54 GBV cases since the earthquake, including two cases of sexual violence, one gang rape, and one situation of incest.

Approximately half (5/9) of GBV KIs (4/5 and 1/4 in Kathmandu and Sindhupalchowk, respectively), with one response missing from Sindhupalchowk, said they had heard of incidents of SEA in this setting. One GBV KI in Kathmandu said people approach others with “If you come with me I will give you a job.” One said there is talk of trafficking and there were a lot of cases, while a KI from a lead GBV agency said, “725 cases of trafficking were intercepted after the earthquake, but this does not mean cases have increased – we are trying to compare with numbers before the earthquake.” One GBV KI said there were very few case in camp settings, but added that maybe many are not reported. Another GBV KI said there were a couple of incidents related to distributions and that another situation was related to a store in a girl’s house.

One GBV KI from Sindhupalchowk said, “There were rumors in the camp of child trafficking and molestation. It happens to people who have no money and they are poor.”

D. Response

A lead agency GBV KI explained that the GBV response in the emergency response has three components, including:

1. Dignity Kits: flashlight; clothes; scarf; sari; hygiene kits for women of reproductive age and pregnant and lactating women to help them access care.
2. Female-friendly Spaces (FFS): Prevention and response; awareness raising and referral.
3. Clinical Management of Rape (CMR): recognized the link of existing emergency and future capacity because according to this KI things have happened faster as a result of the earthquake.

This KI also added that there are 17 established OSCMCs in Nepal, but only three are in earthquake-affected districts, while there is a commitment to establishing these in other districts. According to this KI, GBV coordination addressed the five W’s (Who is doing What? Where? When? Why?); established targets for the number of women- and child-friendly spaces; and coordinated the distribution of dignity kits, including sanitary supplies.

The majority (8/10) of GBV KIs reported that their agency’s implementation of GBV services started within 1-2 weeks of the earthquake, while 1/10 said within 3-4 weeks and 1/10 reported after four weeks. Two GBV KIs in Kathmandu added that their response started from day one as they mobilized existing resources and worked to ensure a referral pathway. Another KI said the Protection Cluster was activated immediately at central and district levels.

One GBV KI in Kathmandu reported that FFS were established for women and children. One KI said that UNFPA works with district committees and women’s groups and cooperatives at the community level. Another GBV KI in Kathmandu commented that the government stopped opening orphanages due to the illegal transfer of children from district to district.

The majority (9/10) of GBV KIs reported receiving funding for the RH-related GBV response during this humanitarian crisis. The reported received amounts among 2/5 GBV KIs in Kathmandu range from US\$400,000 - US\$2.5 million among lead UN GBV agencies. Some (2/5) of GBV KIs did not know how much their organization received and 1/5 KIs said that the government requires a MoU to receive funds and therefore they had not received funding but reported receiving in-kind support for items such as assistive devices for persons with disabilities; dignity kits for pregnant and lactating women; and children's kits. Among the four GBV KIs in Kathmandu that reported receiving funding, 4/4 said they received funds from UNFPA while 2/4 that received funding also reported receiving funds through flash, cap, or other donor appeals, and 1/4 reported receiving support from the DoHS. GBV KIs in Kathmandu reported other donors that supported RH-related GBV programming included: Australia, Danish Church Aid, DFID, International Medical Corps, Japan, UNICEF, and UN Women. One GBV KI said UNFPA supported local and international NGOs and the government with trainings, including TOTs. Another GBV KI in Kathmandu said funding is built within existing sources of basket funds from management. Just over half (3/5) of GBV KIs in Kathmandu reported that funding was sufficient to meet their RH-related GBV program goals while 2/5 said it was not sufficient. One GBV KI in Kathmandu commented that although funding was sufficient to meet their RH-related GBV program, they could do more, such as training people one for each affected district as a "master trainer." One GBV KI said that all donor funds go to the Prime Minister's Fund but in general they could use more support.

With one missing response, 4/4 GBV KIs in Sindhupalchowk reported receiving funding for their RH-related GBV response during this humanitarian crisis. The reported amounts received among 3/4 GBV KIs ranged from US\$30,000 to US\$66,000, while 1/4 GBV KIs did not know. 1/4 GBV KIs reported receiving funds from UNFPA. Other donors reported by GBV KIs in Sindhupalchowk included CARE Nepal, Combatting Trafficking in Persons, DFID, European Commission, International Organization for Migration, Japan, UNICEF, and UN Women. The majority (4/4) of GBV KIs in Sindhupalchowk said that their funding was not sufficient to meet their reproductive health-related GBV program goals. The GBV KI who said it was sufficient added that it was "sufficient for the emergency, but not to continue after the emergency and to establish

strong referral mechanisms at district and national levels along with a need to strengthen the District Health Office.” The amounts cited by KIs in response to how much more does your agency need ranged from US\$20,000 to US\$80,000 per year among three organizations, totaling US\$160,000 per year, which does not include an amount toward economic programming recommended by one local NGO GBV KI because the KI did not know how much would be needed.

Some (3/10) of GBV KIs reported their agency ordered Inter-agency RH kit 3 for post-rape treatment, while the majority (6/10) said they had not ordered post-rape kit 3. Among those that ordered the kit were 1/5 KIs in Kathmandu and 2/5 KIs in Sindhupalchowk. One GBV KI in Kathmandu commented that UNFPA provides the kits directly to NGOs. Another KI said that RH Kits for post-rape treatment were pre-positioned at OSCMCs. One GBV KI in Sindhupalchowk said that RH kit 3 for post-rape treatment has been ordered by health posts.

Just 1/10 GBV KIs from Kathmandu reported issues or challenges with the kits, while 3/10 KIs said there were none, 2/10 said it was not applicable to them, and 4/10 said they did not know. A GBV KI in Kathmandu noted that customs clearance posed challenges and explained that UNFPA has a tripartite agreement with DoHS and the National Red Cross. This GBV KI also suggested that future MISP trainings should include orientation to the kit. One GBV KI in Sindhupalchowk commented that they received dignity kits from UNFPA, but that the clothes were not comfortable for all religions/castes.

Protection measures at health facilities

With regard to the priority MISP activity of ensuring protection measures at health facilities, less than half of GBV KIs from Kathmandu reported that guards were available (1/10) or partially (3/10) available at health facilities. All (5/5) of GBV KIs in Sindhupalchowk reported guards were not available at health facilities. One GBV KI in Kathmandu commented that there are guards at hospitals but not at health centers and health posts. Another KI commented that it depends on the health facility and explained that it was more likely there would be guards and other protection measures at larger facilities than smaller facilities. One GBV KI in Sindhupalchowk commented, “If a citizen needs a guard system, there are special protection services available to survivors.”

The majority (9/10) of GBV KIs reported that separated sex-specific latrines were available (4/10) or partially available (5/10) at health facilities, while one KI in Kathmandu did not know. A KI in Sindhupalchowk commented, “There are sex-segregated latrines but they are not respected, everyone uses both.” Half (5/10) of KIs reported that latrines with locks inside are available (2/10) or partially available (3/10). Some (2/5) KIs from Sindhupalchowk said latrines with lock inside are not available and 2/5 and 1/5 in Kathmandu and Sindhupalchowk, respectively, did not know. One GBV KI reported that there are very few latrines with locks inside and another said they are available but most of the locks are broken. The majority (8/10) of GBV KIs also reported that lighting was available (2/10) or partially available (6/10) at health facilities, while 1/10 in Sindhupalchowk said it was not available, and 1/10 in Kathmandu did not know.

Clinical management of rape

The majority (9/10) of GBV KIs reported that CMR is available (4/5 Kathmandu and 1/5 Sindhupalchowk) or partially available (1/5) and (3/5) in Kathmandu and Sindhupalchowk, respectively, while 1/5 KIs in Sindhupalchowk said CMR is not available.

With regard to the specific components of the standard protocol for CMR, treatment of injuries was reported to be largely available (6/10) or partially available (3/10) in Kathmandu and Sindhupalchowk, while 1/10 KIs in Kathmandu did not know. Fewer KIs reported that EC was available (5/10) or partially available (1/10), while 4/10 KIs did not know. Half (5/10) of GBV KIs reported that post-exposure prophylaxis (PEP) to prevent the transmission of HIV was available (3/10) or partially available (2/10), while 1/10 KIs in Kathmandu said it is not available and 4/10 KIs did not know. In terms of prophylaxis treatment for STIs, less than half of KIs said this care was available (2/10) or partially available (2/10), while half (5/10) of GBV KIs did not know. The majority of GBV KIs reported that psychosocial support was available (7/10) or partially available (2/10), and (1/10) of GBV KIs in Sindhupalchowk said it was not available.

A GBV KI in Kathmandu commented that CMR is available at central and district levels. One GBV KI said that CMR used to be ad hoc, but that there are now guidelines and counselors that have been deployed to districts who are also available for standby deployment. One GBV KI

in Sindhupalchowk said that there are three centers for CMR in Sindhupalchowk, including the district hospital, MOWCSW, and PHCCs. This KI added that there is a different system for children less than 18 years, who are required to go to child welfare, where they are referred to the police who then refer them for legal aid. If the survivor is a woman, she is referred first for health services, then legal, and then the police. Another GBV KI in Sindhupalchowk said CMR is partially available at the district hospital and another KI said it was available at the PHCC level. One GBV KI said that the Women Development Committee established CMR with referral to health, legal, and police. Finally, one KI said they refer to Dhulikhel Hospital or Kathmandu and that plans are underway to establish an OSCMC in Sindhupalchowk and that the district also needs a shelter home.

The majority, (9/9 with one response from Kathmandu missing) of GBV KIs reported community awareness mechanisms through IEC about the availability and benefits of care after rape have been undertaken. All (9/9) of the recorded GBV KIs reported community awareness included IEC materials; peer educators; community health workers; and radio, while one KI added through cell phones. One GBV KI in Kathmandu said that in accessible areas, survivors know where to go, but it is more of a challenge in remote areas. This KI added that the Protection Cluster endorsed the IEC messaging. Another GBV KI commented that IEC is also undertaken through social mobilizers and community orientation. Four GBV KIs in Sindhupalchowk added that IEC is undertaken with social mobilizers, including adolescents and FCHVs, and through NGOs, women's groups, and in schools.

In response to the question about what RH-related GBV services or activities their organization was specifically providing or undertaking in this setting, all (10/10) GBV KIs said their organization was not specifically involved in protection measures such as guards, lighting, sex-separated latrines that lock from the inside, or adequate lighting at health facilities. One GBV KI in Kathmandu reported focusing on policy with the MOWSW and working closely with UNFPA. This KI further reported that a GBV fund provides support to victim rescue; health; psychosocial; and legal aid. Another GBV KI from a lead GBV organization reported that a protection checklist was implemented before and after the earthquake and advocacy was undertaken with WASH, Camp

Coordination Camp Management, and Health clusters. Another GBV KI said they collected CMR information at the central level and in 14 earthquake-affected districts. One GBV KI said that UNICEF and UNFPA used mobile health camps as an entry point to document survivors and to provide support for comprehensive services, including RH services, psychosocial support, and legal services.

A GBV KI from a local NGO in Sindhupalchowk reported that their organization provided orientation to GBV at RH camps and that they worked with VDCs on GBV orientation. One key informant said their organization undertakes community awareness-raising on GBV, counseling, and referral, and also distributed solar lights and dignity kits. In addition, they link community members with other organizations. A KI from a local NGO reported that they undertake community awareness within six VDCs in coordination with other NGOs and that they focus on trafficking and adolescents. One GBV KI said they are working on protection measures in schools and another said they are working with an adolescent girls group.

Just under half (4/10) of GBV KIs (3/5 KIs in Kathmandu and 1/5 KIs in Sindhupalchowk) reported their organization was providing CMR services. A GBV KI from a local NGO in Sindhupalchowk said they have their own hostel where they provide CMR. Within the specific components of CMR, all of those who provide CMR said they provide treatment of injuries and EC, while 3/10 (3/5 Kathmandu, 0/5 Sindhupalchowk) reported that they provide PEP and prophylaxis treatment for STIs. More than half (6/10) of GBV KIs (3/5 Kathmandu, 3/5 Sindhupalchowk) reported that their organization provides psychosocial support, while 4/10 said they do not. The majority (8/10) of GBV KIs reported their organization is providing support to the referral system, while 1/10 in Sindhupalchowk said their organization is not directly involved in supporting the referral system and 1/10 in Kathmandu said they do not know if their organization provides support to the referral system. The majority (7/10) of GBV KIs report that the DoHS protocols, while 1/10 KIs said they used a different protocol, 1/10 KIs reported the question was not applicable to them, and 1/10 KI said they did not know. A GBV KI in Kathmandu reported that the DoHS just endorsed its own protocol on CMR.

The majority, (7/9 with one response missing from Kathmandu) of GBV KIs

reported that their organization provides IEC materials about the benefits and location of CMR services, while 2/9 KIs said they do not provide IEC materials. Two thirds, (6/9 with one response missing) of GBV KIs report their organization supports peer educators to undertake IEC on the benefits and location of CMR services; 7/9 GBV KIs report their organization undertakes IEC through community health workers; and 7/9 report their organization supports IEC via radio and 1/9 via cell phone.

All (10/10) GBV KIs reported that there is a GBV referral system composed of health, police, legal, protection, and psychosocial support. One GBV KI in Kathmandu said safe homes were part of the referral system and added that 17 districts had official safe homes. However, none were in the crisis-affected districts, though some NGOs have established safe homes. On a scale of 1 to 5, where 1 is “very poor” and 5 is excellent, the majority (4/5) of GBV KIs in Kathmandu rated the referral system as average and 1/5 KIs rated it as good. In Sindhupalchowk, 2/5 KIs rated the referral system as average, 2/5 KIs rated it as poor, and 1/5 rate it as good. One GBV KI in Kathmandu who rated the referral system as good added that it varies between districts. Another GBV KI in Kathmandu said, “Donors came in and did the referral system. It is an ‘outsider thing’ not an ‘insider thing’ so government agencies are not prepared and we end up doing it all.” One GBV KI in Sindhupalchowk added, “The referral system is good, the response system is poor” and explained that the referral system is recently established. One GBV KI said that initially their organization had its own referral pathway.

Engagement of communities in RH programming

All (10/10) GBV KIs reported that they have engaged affected communities in RH-related GBV programming. GBV KIs in Kathmandu reported that communities were engaged in RH-related GBV programming through FFSs; orientation programs and counseling; women’s cooperatives; awareness raising; distribution of dignity kits; by identifying survivors; and as staff in their projects. One GBV KI said that there is a focused program on skills development; family support; and children’s education. GBV KIs in Sindhupalchowk engaged communities in RH-related GBV programming through women’s groups and GBV watch groups; savings and credit programs; community groups, public events; and GBV orientation projects for adolescent girls and FCHVs.

E. Disaster Risk Reduction, Including Preparedness

The majority (7/10) of GBV KIs (4/5 KIs in Kathmandu and 3/5 KIs and Sindhupalchowk) reported that their organization made prior preparations or arrangements for RH-related GBV services. Several (3/10) KIs said financial resources were dedicated to RH-GBV related services and that they had developed IEC materials and 2/10 KIs reported undertaking capacity development on CMR with DoHS and other national actors. One GBV KI reported that they established a CoC against SEA with DoHS at the district level but not at the central level. Another GBV KI reported that they had pre-positioned post-rape kits at OSCMCs; undertaken UNFPA trainings; established a pre-agreement on the content of dignity kits; and supported districts to develop EPPs, including the MISP. Another GBV KI said they influenced the law to make it mandatory to have GBV services in institutional shelter arrangements. Another said they had implemented capacity development with DoHS and national actors on protection and GBV.

In Sindhupalchowk, 2/5 GBV KIs reported on specific preparedness activities. One KI said they had established a referral and response system before the earthquake. Another said they coordinated with UNICEF and the Red Cross to provide training to the government on why it is necessary to address GBV and to include it in the National Disaster Policy.

Just under half (4/10) of GBV KIs reported that personnel employed by their agency are required to sign a CoC against SEA and 6/10 GBV KIs reported they are not required to sign. When asked if they had signed a CoC against SEA, 3/10 KIs said yes, 6/10 said no, and one response was missing. Among the GBV KIs in Kathmandu who have not signed a CoC against SEA, one said it was because the CoC is for people working at the operational level in humanitarian contexts. Another reported that very recently the legislative department made it a mandatory act to prepare a CoC. Another GBV KI said that the CoC is part of orientation and the UNSG Bulletin <https://oios.un.org/resources/2015/01/ST-SGB-2003-13.pdf> on this issue was circulated widely internally. This KI reported its agency was in the process of establishing a CoC for staff and partners. One national GBV KI reported that although 100 percent of its staff are women, signing a CoC is its policy.

Among GBV KIs from Kathmandu, 1/10 reported that they made available opportunities for staff to be trained in CMR, 6/10 had not, 2/10 did not know, and 1/10 said it was not applicable. One GBV KI in Kathmandu said they had not made available internal opportunities for their staff to be trained in CMR, but they have hosted trainings for health professionals. Another GBV KI from a national NGO in Kathmandu said CMR is part of training of health personnel.

All (10/10) GBV KIs had suggestions for improving protection mechanisms at health centers.

One GBV KI in Kathmandu suggested a whole-site orientation for all workers at facilities, including security guards and cleaners: “Women don’t want to go to the health facility because it is not anonymous because of the stigma.” Another GBV KI said information sharing and referring cases should be improved because some women may not want to report to police since they don’t want to take legal action on sexual violence occurring in their own homes. Another GBV KI suggested prompt responses from health facilities and separate rooms for women and children. One GBV KI said, “Health staff should be responsible for safe access to health facilities.” Another added that “we orient health personnel technically without thinking of social aspects for women-friendly providers.” This KI also said providers lack sensitivity, that they need to be quiet and listen, and that there is a need for a lot of training of health personnel.

One GBV KI in Sindhupalchowk said security at health centers and shelters, including guards, adequate lighting, and sex-segregated latrines, should be improved. In addition, this KI said there are “no mechanisms to prioritize cases of GBV when we are working to address survival needs.” Another GBV KI in Sindhupalchowk suggested that “free medicines provided at health facilities and additional technical assistance which is not widely available in this district.” One GBV KI in Sindhupalchowk mentioned the need for technical assistance. Another GBV KI in Sindhupalchowk said there should be improved facilities with confidential space for survivors.

The majority (9/10) of GBV KIs also had suggestions for improving provision of clinical management of survivors of sexual violence, with 6/10 suggesting improved availability of CMR at health facilities and

more providers skilled in CMR through additional trainings. One GBV KI in Kathmandu suggested that the volume of training on CMR should be increased to address turnover and that there is a need to meet survivors earlier. Another said, “Sometimes GBV services are not friendly.” Another said that there is a need for more orientation programs for staff and more uniformity of integrated services through improved coordination; communication; collaboration and capacity development to scale human resources: “We need to make every citizen aware of GBV and rights and responsibilities to prevent GBV.” Another said, “Plan and implement long-term support of women to build their agency.”

Several GBV KIs in Sindhupalchowk suggested that an OSCMC should be established in Sindhupalchowk. Two said services should be available at health-post level with designated skilled personnel, though one KI noted that the health-post hours were a problem since they are only open from 10am – 3:00 pm: “Emergency services should be available at health posts; even the district hospital is not capable of assisting survivors.” Another KI commented that there should be better coordination between health and GBV; more resources as “there are no resources for survivors – not even transport”; and a system established for GBV response. Another suggested safe shelters for survivors and economic support were critical. Another suggested it was important to simplify legal barriers so physicians do not have to go to court to testify as it is an unwelcome burden and that there needs to be more training and sensitization of health and police personnel: “Health personnel are not sensitive to women.”

F. Key Facilitating Factors and Barriers to MISIP Implementation in This Crisis

GBV KIs in Kathmandu reported the following factors as having helped facilitate the RH-related GBV response in the emergency:

- Female-friendly spaces;
- Referral system;
- Principles of working with survivors;
- Work on CMR protocol pre-crisis;
- Good partnership and ownership by the MOWCSW;

- Excellent support from surge for programming and coordination;
- Mass awareness and sensitization through radio, television, and IEC materials;
- Programs prior to earthquake;
- “A proactive immediate response of standing together with women.”

GBV KIs in Sindhupalchowk reported the following factors as having helped facilitate the RH-related GBV response in the emergency:

- Coordination among agencies and the police;
- Support from government;
- Support from NGOs at national and international levels;
- Quick coordination of Protection and GBV clusters; and
- Quick radio announcements.

GBV KIs in Kathmandu identified the following areas as barriers to an effective RH-related GBV response to this emergency:

- Challenges with coordination in an emergency when everyone is very busy and particularly difficult to coordinate within all the clusters, e.g., Health; Shelter;
- The variety of types of services agencies offer, because some partners have the same objectives but services are different: “Every organization providing support in their own way”;
- Limited government capacity to provide services in an emergency;
- Quality of services in the referral pathway is a concern and an assessment of these services is difficult. For example, “the police want to be the entry point and they want everything to start with a police report”;
- People not willing to report cases because of fear of retribution: “People are very scared and don’t want to spoil harmony of the household”;
- People don’t trust the existing legal system if a trial goes on for years and years;
- Meetings versus work in the field;
- No space to LISTEN to national people and to recognize their unique situation;

- Felt constrained by international experts – there was not enough “space” to say what we could use support for or to tap our expertise;
- The way relief is distributed overtook the situation;
- The issue is not just about physical needs; a human approach is important to touch values such as solidarity, e.g., “You are not alone.”

GBV KIs in Sindhupalchowk identified the following issues as barriers to an effective reproductive health-related GBV response to this emergency:

- Insufficient number of dedicated human resources with expertise and experience for response: “One person received the wrong treatment for CMR”;
- The education and economic background of victims in this emergency;
- Lack of support from NGOs for technical assistance; economic programming; and education opportunities;
- Geographic area resulting in a lack of access to some populations and communication services (Internet);
- Inappropriate relief items;
- People themselves are prioritizing things – the population is not open to awareness raising until their basic needs are met;
- The requirement that doctors have to go to court, and they do not want to do that.

Key Informant Interviews Annex III

HIV Key Informant Interviews Detailed Findings

A. Awareness and Knowledge of the MISP and Additional Priorities

As only 1/4 HIV KIs from Kathmandu had heard of the MISP and no HIV KIs had been trained in the MISP, the question to please name all the objectives and additional priorities of the MISP that the KI knows was rephrased to “What do you think are the priority RH services in the emergency response?” One HIV KI in Sindhupalchowk mentioned to reduce HIV transmission and one HIV KI in Sindhupalchowk mentioned to ensure culturally appropriate menstrual protection materials are distributed to women and girls. Other priorities mentioned by the HIV KI in Kathmandu included establishing temporary settlements; the placement of vulnerable groups; addressing basic health needs; donors; and local health department and disaster teams. Other priorities mentioned by the HIV KIs in Sindhupalchowk included nutrition, psychosocial, and economic support; addressing damaged health facilities and ensuring a referral system; ensuring the availability of condoms; establishing VCT; and addressing uterine prolapse.

The question what are the MISP activities to reduce HIV transmission was also revised to, What do you think are the priority activities in an emergency to reduce HIV transmission? The HIV KI in Kathmandu said to make condoms available and one HIV KI in Sindhupalchowk said to facilitate and enforce standard precautions. Priority activities to reduce HIV transmission suggested by the HIV KI in Kathmandu included formal and informal education to sensitize health workers. HIV KIs in Sindhupalchowk suggested other HIV-related MISP activities should include contraceptives; safe sex education; sterile syringes for injecting drug users; awareness raising, noting migrants return to villages; female sex workers; and VCT in the camp.

B. Coordination

All (4/4) HIV KIs reported there were national and international entities responsible for HIV coordination in the crisis, though there was vari-

ance in the names of the entities. The HIV KI in Kathmandu reported the National Centre for AIDS and STD Control (NCASS) and specifically the policy and planning unit for humanitarian emergencies as the national entity responsible for HIV coordination in this crisis, but was unsure of the international entity citing the involvement of several agencies (UNAIDS, WHO, UNICEF, UNFPA and Save the Children). Two HIV KIs in Sindhupalchowk reported the responsible national entity was the National Association of People Living with HIV in Nepal and one cited the National Red Cross, while 2/3 HIV KIs in Sindhupalchowk identified Save the Children as the international agency leading HIV coordination in this crisis. In terms of whether there were national and international HIV focal points for the crisis, 3/4 HIV KIs said yes and 1/3 KIs in Sindhupalchowk did not know. There was also wide variation in the names of national and international focal points for the crisis.

Some (3/4) HIV KIs reported that HIV coordination meetings are held while 1/3 KIs in Sindhupalchowk said no. The HIV KI in Kathmandu reported that HIV coordination meetings are held monthly with UNAIDS. This KI added that there are a few HIV working groups, including for treatment, care, and support. 2/3 HIV KIs in Sindhupalchowk reported that HIV coordination meetings are held while 1/3 said no. One HIV KI reported they started meeting June 16th. Another said meetings are held once every six months. One KI reported that they have been working with the DHO since 2009.

In response to the question of whether an RH focal point participates in HIV coordination meetings, the HIV KI in Kathmandu reported yes and added that the NCASS coordinates on PMTCT transmission with UNFPA and 1/3 HIV KIs in Sindhupalchowk said yes and 2/3 said no. In response to whether the HIV focal point participates in the RH coordination meetings, the HIV KI in Kathmandu said yes and 1/3 KIs in Sindhupalchowk said sometimes, while 2/3 KIs in Sindhupalchowk said no. The HIV KIs who reported that the HIV focal point participates or sometimes participates in the RH meetings said yes, they report back to the HIV coordination group. In response to the question about whether the KI participates in the RH meetings, 2/4 HIV KI said yes, with 1/4 KIs each from Kathmandu and Sindhupalchowk. On a scale of 1 to 5, where 1 is very poor and 5 is excellent, 2/4 KIs, one each from Kathmandu and Sindhupalchowk, rated coordination efforts between the RH and HIV

sectors as average, while 2/3 KIs in Sindhupalchowk rated the coordination efforts between RH and HIV sectors as poor. One HIV KI from a local NGO in Sindhupalchowk said, “They did not call us to attend the meeting.”

The HIV KI in Kathmandu said that coordination between HIV and RH sectors could be improved with an understanding of the causes of maternal mortality; supporting a maternal and newborn focus; and addressing adolescent health through the primary education curriculum. One HIV KI in Sindhupalchowk said that coordination could be improved by including them in the meetings and listening to the voices PLWHIV.

All (3/3) HIV KIs in Sindhupalchowk reported that they had received some funding for the HIV response during the humanitarian crisis; one did not know how much, one indicated it was US\$4,000, and another reported it was US\$22,000. The HIV KI in Kathmandu said they received partial funding for the HIV response during the humanitarian crisis but did not indicate how much. One HIV KI said the funds were remaining funds from the Global Fund and not new money and not for the emergency per se, adding that emergency funds should come to the government. This HIV KI also noted that ART centers were damaged in three districts, with two ART centers totally collapsed and the third partially collapsed.

Two HIV KI in Sindhupalchowk reported that they had received funding from the Global Fund through Save the Children, while one HIV KI reported they had received funding through the NRC. Two of three HIV KIs in Sindhupalchowk said that funding was not sufficient to meet their MISP-related HIV program goals – with one reporting they would need approximately US\$24,000 per year and another reporting a need for US\$150,000 per year.

One HIV KI reported that in the past, HIV work was undertaken by the local organization Miremire, but despite their longstanding work on HIV/AIDS prevention, treatment, and care in the district, the complete destruction of their inpatient facility in the earthquake meant they were not awarded the partnership with organizations leading HIV/AIDS work in Nepal this year. Instead, another organization not based in the district was awarded the bid. Another KI explained this was because the services are funded through a “bidding” process and therefore it was a financial rationale – a decision to go with lowest bid for service provider.

The KI said it was a deep disappointment to Miremire that they did not receive the US\$4,000 award.

One HIV KI in Kathmandu reported ordering Inter-agency Kit 1 condoms, while 3/3 HIV KIs in Sindhupalchowk said they had not ordered them. No HIV KI reported ordering Inter-agency Kit 12 safe blood transfusion. In addition, one HIV KI in Sindhupalchowk commented that they had received 28 dignity kits one week prior to the interview from the Women and Children's Welfare Office.

C. HIV Concerns and Needs

Some (3/4) HIV KIs had heard of incidents of HIV transmission in both Kathmandu and Sindhupalchowk, while 1/4 KI said they had not. The HIV KI in Kathmandu commented that ART centers were affected, though all people on ARVs were able to continue treatment with the help of NGOs. One HIV KI in Sindhupalchowk reported that almost all transmission is from sex due to trafficking and added that people who lack education are trafficked and come back to Nepal and then unknowingly transmit HIV to their family. This KI said there is a need to provide education to all ages to prevent HIV and the measures to take if you are infected. One KI had heard of incidents of transmission but did not know when it was transmitted. One HIV KI had not heard of incidents of HIV, but they are focused on caring for people already positive.

In terms of concerns about PLWHIV, the HIV KI in Kathmandu reported that it was important that if someone is on ART they continue with regular check-ups and good nutrition. An HIV KI in Sindhupalchowk reported that some PLWHIV do not have family support, so organizations are trying to help. Another KI added that everyone must be educated about HIV. A third HIV KI in Sindhupalchowk noted the need for community-based services for the continuation of ARVs and the provision of nutritious foods because people lack money, including to travel. It was also noted that PLWHIV need income-generating support.

D. Response

Most (3/4) HIV KIs said that their HIV response started with 1-2 weeks of the crisis, while 1/4 HIV KIs from Sindhupalchowk reported their response began after 4 weeks.

The HIV KI from Kathmandu said safe blood transfusion was available in the setting, while all three HIV KIs from Sindhupalchowk reported safe blood transfusion was not available in the setting. One HIV KI in Sindhupalchowk reported that immediately after the earthquake the NRC supported a field hospital and together with the DHO provided transfusions, but the field hospital has been dismantled and safe blood transfusion is no longer available in Sindhupalchowk. All (4/4) HIV KIs said adherence to standard precautions was available (2/4) or partially available (2/4) based on the quality of the practice, with KIs from Sindhupalchowk reporting standard precautions were partially practiced. The HIV KI from Kathmandu said condoms were available and 3/3 from Sindhupalchowk said they were partially available in the setting. One HIV KI in Sindhupalchowk reported that free condoms were more available before the earthquake than they were at the time of the assessment and added that the government is responsible to provide them. All (4/4) HIV KIs reported there are ARVs for continuing users, while 2/4 reported there are ARVs for PMTCT, with 2/4 HIV KIs in Sindhupalchowk reporting that PMTCT is not available.

In response to the question about what MISP-related HIV services or activities their organization is providing or undertaking in this setting, the HIV KI in Kathmandu said their organization oversees safe blood transfusion, which is provided by the Red Cross. The organization also supports adherence to standard precautions through curriculum revisions and training; free condoms through targeted interventions; and the provision of ARVs for continuing users, including for PMTCT, through a two-tiered supply chain at a service center. This KI's organization also supports provider-initiated testing and counseling. Among HIV KIs in Sindhupalchowk, 0/3 said that they provide safe blood transfusion. In addition, 2/3 KIs in Sindhupalchowk said their organizations do not provide or support the practice of standard precautions, while 1/3 said they do this partially. All HIV KIs in Sindhupalchowk make free condoms available, 2/3 fully available, 1/3 partially available. All 3/3 HIV KIs in Sindhupalchowk said that they make ARVs available, (2/3) to continuing users or partially available (1/3), while only 1/3 KIs said they make ARVs available for PMTCT. Some (2/3) KIs in Sindhupalchowk said they transport PLWHIV to access ARVs and nutritional support at the district hospital. The majority (3/4) of HIV KIs said they follow MOH protocols for HIV prevention and treatment, while 1/4 HIV KIs said the protocols

were not applicable to its agency mandate.

All (4/4) HIV KIs said that HIV referral protocols were established. The HIV KI in Kathmandu reported a number of referral mechanisms, including: referral guidelines for patients with chronic conditions, specific viral counts and nutritional vulnerability; referral pathways to support laboratory testing at the central level with associated funds for transport; referral mechanisms for services at equipped hospitals with good quality HIV care; referral systems at all VCT centers – if people need more help, they are referred to the community care centers. This KI added that there are also District Health Coordination Committees to generate resources to address HIV at the district level. One HIV KI in Sindhupalchowk said there are three referral sources, including the district hospital and two PHCCs (Melamchi and Barabise). On a scale of 1 to 5, where 1 is “very poor” and 5 is “excellent,” 2/4 HIV KIs (one each from Kathmandu and Sindhupalchowk) reported the referral system as average and 2/4 HIV KIs (both from Sindhupalchowk) rated the referral system as excellent.

E. Engagement of Communities in Programming

Most (3/4) HIV KIs reported that affected communities are engaged in HIV programming and specifically on program implementation but also through feedback mechanisms. One HIV KI in Sindhupalchowk said that affected communities were not engaged in MISP-related HIV programming “because they are busy with other needs.” Another said they are also undertaking awareness raising and recognized people of the community are engaged. This KI added that it was more likely that they would be engaged if they are in the central area of Sindhupalchowk versus the remote areas and added that the lack of community engagement in the remote areas was a problem.

F. Disaster Risk Reduction, Including Preparedness

Half (2/4) of the HIV KIs reported they had made prior preparations or arrangements for MISP-related HIV activities for this humanitarian crisis, while 2/4 reported they did not. The HIV KI in Kathmandu said that prior preparations for MISP-related HIV activities included RRTs at national, regional, and district levels; provision of condoms, ART drugs, and drugs for other HIV-related problems. An HIV KI in Sindhupalchowk said that they trained Red Cross personnel on counseling, including PLWHIV.

Half (2/4) of the HIV/KIs reported that personnel employed by their agency are required to sign a CoC against SEA, while 1/4 said no and 1/4 did not know. The HIV KI in Kathmandu said at the central level there is a policy and a MoU on the CoC against SEA but they are not required to sign a document. One KI added they are not required to sign a document but there is a zero tolerance policy.

No HIV/KIs had made available opportunities for staff to be trained in MISP-related HIV activities. One HIV KI in Sindhupalchowk said that they have provided basic training for HIV.

All HIV/KIs had suggestions for improving MISP-related HIV activities. One HIV KI in Sindhupalchowk suggested establishing a blood bank in every district, including Sindhupalchowk. HIV KIs also suggested condom distribution could be improved by providing community health workers (CHWs) with access to condoms; improving the availability of free condoms at every health post, PHCC, and district hospital; and through peer to peer and NGO distributions. Another KI said that the government should coordinate to make condoms available to local organizations and “promote condoms in local places where people are, like the bus park.” HIV KIs had several suggestions to improve adherence to standard precautions at health facilities, including human resource capacity development, such as through a pre-service curriculum; ensuring sufficient supplies; and improving the monitoring and evaluation system for the practice of standard precautions. While some (3/4) HIV KIs reported that medical waste management was okay, they said it could be improved through well-coordinated mechanisms for segregation of reusable supplies and disposables according to standards following a holistic approach for each city and not only health supplies. HIV KIs in Sindhupalchowk suggested that there should be categories for recycled and landfill and further training on medical waste management and support to the DHO.

All (4/4) HIV KIs had suggestions for improving ARV treatment, including PMTCT. The HIV KI in Kathmandu said that the most important issue for ARV treatment is changing regimes because it is expensive and challenging and may need support for many years and that it was also important to scale up PMTCT so every woman is tracked and supported. One HIV KI in Sindhupalchowk suggested that ARVs are available at

the district hospital 24 hours/day and added that there should be good coordination between DHOs and local NGOs, especially for access to ARVs. Another HIV KI in Sindhupalchowk reported there was a need to improve trained manpower so ARVs are available at the local level and people do not have to walk so far, while a third HIV KI suggested there is need more trained lab technicians and supplies.

In terms of overarching recommendations, one HIV KI said that they could improve coordination within the HEOC RRT and how it is activated; integrate the MISP to the HEOC; ensure the regional to district response is maintained to avoid expirations of any drugs; and pre-identify focal persons.

G. Key Facilitating Factors and Barriers to Prevent the Transmission of HIV

The HIV KI in Kathmandu reported the following factors as having helped facilitate the RH-related HIV response in the emergency:

- Establishment of field hospital in Sindhupalchowk with referral to the district hospital

HIV KIs in Sindhupalchowk reported the following factors as having helped facilitate the RH-related HIV response the emergency:

- HIV awareness exists;
- Education campaigns, including by NGOs;
- Promotion of condom use;
- Provision of ARVs;
- Health worker attitudes;
- Coordination at district level superb;
- District Disaster Response Teams did a very good job; and the distribution of food;
- National-level decisions; and,
- Individual responsibility taken to help PLWHIV.

HIV KIs in Kathmandu identified the following areas as barriers to an effective reproductive health-related HIV response to this emergency:

- Situation itself, with primary needs of people different from our

- perspectives;
- Challenge of human resources and sensitizing some to HIV; and,
 - The engagement of other sectors.

GBV KIs in Sindhupalchowk identified the following areas as barriers to an effective reproductive health-related GBV response to this emergency:

- Gaps in the availability of some materials;
- Accessibility to remote areas;
- Family members that were not dedicated to help;
- Lack of coordination between district hospital and NGOs;
- HIV not considered a major issue;
- Lack of concern about HIV in relation to GBV;
- Lack of adequate funding.
- Financial support to continue community-based care project for treatment, care, and support adding, “We cannot always do with our own pocket money.”

HEALTH FACILITIES ASSESSMENT

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Methodology

The purpose: To assess service availability, quality and utilization of reproductive health (RH) services. Selection criteria for the health facilities assessed included facilities that:

- are serving populations affected by the recent earthquakes
- have provided maternity and/or basic emergency obstetrics care (BEmONC) services in the past six months
- are currently operating
- are accessible by the evaluation team within the assessment time-frame

Health facility assessments were conducted from 17-22 September 2015 in two districts of Nepal affected by earthquake: Kathmandu and Sindhupalchowk. The assessments consisted of semi-structured face-to-face interviews (Annex 1) with health facility representatives and direct on-site observation.

Study participants included medical officers, nurse or midwife in-charge, auxiliary nurse midwives (ANM) in charge of health primary health care centers (PHCCs), and health posts. One interview was conducted per facility. The health providers were interviewed at a time convenient for them in a private space within the health facility. The assessments were conducted by two teams consisting of the main researcher and a research assistant who was also an interpreter. Interviews were for a duration of one and a half to two hours. A total of 17 facilities were assessed: nine facilities in Kathmandu district and eight in Sindhupalchowk district.

The areas of assessment included:

- A. General information
- B. Facility and security
- C. Transport & communication (referral system)
- D. Human resources
- E. Prevention of excess maternal and newborn health morbidity & mortality
 - a. Availability of abortion services
- F. Prevention and response to sexual violence
- G. Reduce transmission of HIV
 - a. Standard precautions
 - b. Blood transfusion

- H. Planning for comprehensive RH services
- I. Additional priority RH services
 - Contraception to meet demand
 - Availability of antiretroviral drugs for continuing users, including prevention of mother-to-child transmission (PMTCT)
 - Syndromic treatment of sexually transmitted infections (STIs)
 - Culturally appropriate menstrual materials

In **Kathmandu** district, four hospitals, one maternity center, one primary health center, and three health posts were assessed. Two of the hospitals were national-level hospitals (civil service center hospital and Nepal Medical College Teaching Hospital), one a regional hospital (OM Hospital and Research Center), and one maternity center/hospital (Table 1, page 142). Three hospitals were private: OM Hospital and Research Center, Sankapur and Nepal Medical College Teaching Hospital. The maternity center/hospital is a government-run hospital. The remaining health posts and primary health centers are all run by the government.

In **Sindhupalchowk** district, all eight facilities assessed are government run. They consisted of one district hospital, two PHCCs and five health posts.

Table 1: Health Facilities Assessed

KATHMANDU	SINDHUPALCHOWK
Hospitals	
OM Hospital and Research Center	Chautara District Hospital
Sankapur Hospital	
Nepal Medical College Teaching Hospital	
Civil Service Hospital	
Maternity Hospital	
Maternity Center/Hospital	NONE
Primary Health Care Centers (PHCCs)	
Gokarna PHCC	Melamchi PHCC
	Barabise PHCC
Health Posts	
Naglebuse Health Post	Thulosimaon Health Post
Lepsiphedi Health Post	Bandegau Health Post
Sundariha Health Post	Sindhukot Health Post
	Lisankhu Health Post
	Dandapakhar Health Post

In this report, due the low number of facilities assessed, numbers rather than percentages are used.

Findings

A. General Information

Of the 17 health facilities visited in Kathmandu and Sindhupalchowk, 16 were open. One facility in Sindhupalchowk was not open because, due to unforeseen circumstances, the researcher arrived after working hours. In Kathmandu, six of the nine facilities visited had signs posted indicating when the facility opens and closes; in Sindhupalchowk, only one of eight facilities visited had signs. In general, facility representatives indicated that the communities are aware of the official operating hours (10 am - 5 pm). These are official working hours in Nepal. All health facilities,

including the PHCCs and health posts, are open 24 hours for emergencies and deliveries. The hospitals offer more services than PHCCs and health posts. In Kathmandu, one PHCC (Gokarna) and one health post (Sundharijal) were not open for services other than emergencies and deliveries at the weekend. In Sindhupalchowk, only one facility (Sidhukot health post) was not open for services over the weekend.

According to health facility study participants in Sindhupalchowk, communities using the facilities knew of the sexual and reproductive health services (SRH) that were available. At the health posts and PHCCs, there are female community health volunteers (FCHVs) who create awareness about the SRH services in the villages, and also refer patients to the facilities. The hospitals in Kathmandu do not have FCHVs; patients attend hospitals when they are sick and depending on the need, they are informed of the services available.

According to health facility participants, although adolescents could access SRH services at some of the health facilities, there were no adolescent-“specific” or adolescent-“friendly” SRH services. In Kathmandu, adolescents could not access SRH services without parental consent at two-thirds (six out of the nine) facilities assessed. In Sindhupalchowk adolescents could not access SRH services without parental consent in one quarter (two out of the eight facilities assessed). Only one facility in Kathmandu, Nepal Medical College Teaching Hospital, appeared to address the specific access needs of the disabled through separate toilets with wooden ramps.

Damage after the earthquake

In Kathmandu, the maternity hospital showed signs of damage as a result of the earthquake although most of the hospital was functioning. Nanglebuse health post had cracks on the wall in some rooms, but it was fully functional post-earthquake.

In Sindhupalchowk, the Chautara hospital building was severely damaged and could no longer be used. Tents were set up for outpatient departments, in-patient departments (female/male wards and emergency room). A container was used as a maternity/delivery ward. The PHCCs and health posts visited did not show damage, although a few, such as Melamachi PHCC, were overwhelmed with patients and had to set up

additional tents.

Following the earthquake, health providers cared for patients outside the buildings in tents. The government mandated all health facilities (including private facilities) to provide health services for free for three months. Many patients seen were due to injuries, as expected following an earthquake.

B. Facility and Security

The number of beds at each facility varied depending on the type and level of facility. For example, in Kathmandu, the number of beds ranged from 50 to 500 (Table 2). At the health posts in Kathmandu, the number of beds ranged from one to three. In Sindhupalchowk, Chautara district hospital had 35 beds. At the PHCCs and health posts, the number of beds ranged from one to four.

Municipal power lines were the source of power at all facilities in Kathmandu and Sindhupalchowk. One facility, Thulosimaon health post in Sindhupalchowk, had no power but had some form of emergency lighting (type not specified). Solar power and generators were used in some facilities for backup. In Kathmandu, generators were used as back-up at OM Hospital and Research Center, Sankapur and Nepal Medical College Teaching Hospital, while Lepsiphedi health post had only solar as power backup. In Sindhupalchowk, five health facilities had solar backups in addition to power lines (Melamchi PHCC, Sindhukot Health Post, Barabise PHCC, Lisankhu Health Post, Dandapakhar Health Post and Chautara District Hospital). Chautara District Hospital and Melamchi PHCCC also had generators in addition to solar backups. All the facilities in Kathmandu had adequate lighting. In Sindhupalchowk all had power except Thulosimaon Health Post, where there was no power. Two-thirds (six of nine) facilities in Kathmandu had a security guard, while in Sindhupalchowk, none of the facilities had designated security guards. For the most part, health providers were residing within the health facility compounds in both Kathmandu and Sindhupalchowk.

Table 2: Number of beds per facility

KATHMANDU		
Hospital		# of Beds
	OM Hospital and Research Center	500
	Sankapur Hospital	50
	Nepal Medical College & Teaching Hospital	750
	Civil Service Hospital	140
Maternity Hospital	Maternity Center	300
Primary Health Care Center (PHCC)		
	Gokarna PHCC	3
Health Posts		
	Naglebuse Health Post	0
	Lepsiphedhi Health Post	0
	Sundariha Health Post	1
SINDHUPALCHOWK		
Hospital	Chautara District Hospital	35
PHCC		
	Melamchi PHCC	20
	Barabise PHCC	2
Health Posts		
	Thulosimaon Health Post	2
	Bandegau Health Post	1
	Sindhukot Health Post	2
	Lisankhu Health Post	3
	Dandapakhar Health Post	4

Clean water. All facilities in both districts had clean water. Sources of water differed, with a mixture of inside plumbing, outdoor pumps, and roof catchment water tanks. All water systems were reported to be functioning well both during the day and at night.

Latrines: Slightly more than half (5 of 9) of the health facilities in Kathmandu had sex-segregated latrines. In Sindhupalchowk, only one-quarter (2 of 8) of the facilities had sex-segregated latrines. All latrines at the facilities in both districts locked from inside. However, only two of 17 facilities (or 12 percent), Maternity Center and OM Hospital and Research Center in Kathmandu, had dedicated private rooms to examine sexual violence survivors. At the other facilities, sexual violence survivors were examined in private rooms in outpatient departments and birthing centers.

C. Communications and Transport

Communication. All facilities had a method of telecommunication via either landline, mobile phones or both (Table 3). Mobile phones were reported to be personal. The mobile phone network in Kathmandu and Sindhupalchowk is working well.

Table 3: Availability of Telecommunication

KATHMANDU			
		Landline	Mobile phones
Hospital	OM Hospital and Research Center	✓	✓
	Sankapur Hospital	✓	
	Nepal Medical Teaching Hospital	✓	
	Civil Service Hospital	✓	✓
Maternity Hospital	Maternity Center	✓	✓
Primary Health Care Center (PHCC)	Gokarna PHCC	✓	✓
Health Posts	Nagnlebuse Health Post		✓
	Lepsiphedhi Health Post		✓
	Sundarijal Health Post		✓
SINDHUPALCHOWK			
Hospital	Chautara District Hospital	✓	✓

Primary health care center (PHCCC)	Melamchi PHCC	✓	✓
	Barabise PHCC	✓	✓
Health Posts	Thulosimaon Health Post		✓
	Bandegau Health Post		✓
	Sindhukot Health Post		✓
	Lisankhu Health Post		✓
	Dandapakhar Health Post		✓

Transport: Seven of the nine facilities in Kathmandu had designated ambulances to transfer patients. However, Nanglebuse health post and Lepsiphedhi health post shared one ambulance, which was kept at the health office nearby. In Sindhupalchowk, 50 percent of health facilities had designated ambulances for transport. Facilities that did not have their own ambulance called for one from other facilities which had them. Only three facilities in Kathmandu and three in Sindhupalchowk had a referral protocol. The nearest hospital for referral ranged from 3 to 25 km in Kathmandu and 18-95 km in Sindhupalchowk. Choice of facility for referral depends on the health problem and distance from the referring facility. Kathmandu had a variety of hospitals to choose from, while in Sindhupalchowk most referrals were to Chautara District Hospital or Dhulikle Teaching Hospital.

C. Human Resources

The human resource availability depends on the level of health facility. All five hospitals in Kathmandu reported having obstetricians/gynecologists, pediatricians, general doctors, nurse midwives, general nurses, and medical assistants. The PHCCs have general medical doctors, nurse midwives, general nurses, and medical assistants. In Kathmandu, same health personnel were available during night hours at the hospitals. At the health posts in Kathmandu district there were ANMs and auxiliary volunteers (women and men). At the health post, only the auxiliary midwives were available during night hours for emergencies. Some

lived in the compound or close by and could be called at any time.

In Sindhupalchowk, the health posts and PHCCs were mainly staffed by two health personnel responsible for providing maternal/child health services and obstetric first aid. These include general nurses, auxiliary midwives and auxiliary health workers. The exception was Melamchi PHCC, which had five skilled birth attendants (three general medical doctors and two nurse midwives), some of whom are living at the health facility compound or nearby to assist with any emergency cases or deliveries at night.

It is important to note that in Nepal, doctors, nurses, nurse midwives, physicians, gynecologists, and obstetricians receive additional 18 months training to identify, manage, and refer obstetric complications in women and children. Any personnel who receive this training get an additional title of “skilled birth attendant (SBA).” There are also ANMs who have not undergone the skilled birth attendant training and do not hold this title.

E. Prevention of Excess Maternal and Newborn Morbidity and Mortality

Normal deliveries were conducted at all the facilities assessed. Study participants stated that the Nepal government is encouraging women to deliver at health facilities. If a woman delivers at a health facility she is reportedly given NPR 1,000 (~USD 10), baby clothes and also clothes for the mother. If she completes the required four antenatal clinic visits, she receives an additional NPR 500. Nurse midwives, nurses, and SBAs conducted normal deliveries in both Kathmandu and Sindhupalchowk. In Kathmandu, all the representatives interviewed stated that all women are supposed to deliver in the health facility and therefore they did not keep numbers of those delivering in the community. In Sindhupalchowk, 11 percent to 90 percent of women (Table 4) have their deliveries attended by an SBA and the rest deliver their babies in the community with the help of a traditional birth attendant (TBA) or a relative.

Table 4: Percentage of births attended by an SBA as reported by study participants

SINDHUPALCHOWK		
	Delivered by SBA (%)	Comments
Chautara District Hospital	± 37	
Melamchi PHCC	± 70-80	
Barabise PHCC	30-90	
Thulosimaon Health Post	20	Rest are delivered at home by mother-in-law and/or TBA
Bandegau Health Post	11	Record from the health post
Sindhukot Health Post	32	
Lisankhu Health Post	75-80	
Dandapakhar Health Post	30	

Clean delivery kits. In Kathmandu, no clean delivery kits had been distributed, while in Sindhupalchowk, the kits were distributed to visibly pregnant women. It was reported that at Chautara District Hospital, 1,500 kits had been distributed (timeline not indicated). At the health centers and health posts, kits distributed ranged from 6-25 in the three months preceding the assessment period.

Emergency Obstetrics and Newborn care (EmONC) Signal Functions

In Kathmandu, the five hospitals offered all the signal functions of Basic Emergency Obstetrics Care (BEmONC) (Box 1).

Box 1: Basic Emergency Obstetrics and Newborn Care

- » Parenteral antibiotics
- » Parenteral uterotonic drugs (oxytocin)
- » Parenteral anticonvulsant drugs
- » Manual removal of retained products of conception using appropriate technology
- » Manual removal of placenta
- » Assisted vaginal delivery (vacuum or forceps delivery)
- » Newborn resuscitation

Only Gorkana PHCC in Kathmandu did not have Basic EmONC. All obstetric emergencies are referred to the maternity center or a nearby hospital within Kathmandu. The three health posts in Kathmandu district offered 3-4 functions of BEmONC, including parenteral antibiotics, parenteral uterotonic drugs (oxytocin), parenteral anticonvulsant drugs, and manual removal of retained products of conception using appropriate technology (manual vacuum aspiration [MVA]).

In Sindhupalchowk, Chautara District Hospital offered all functions of Basic EmONC (Box 1). The two PHCCs (Melamchi and Barabise) also offered all the signal functions for Basic EmONC. The health posts had some signal functions but not all: parenteral antibiotics, parenteral uterotonic drugs (oxytocin), parenteral anticonvulsant drugs, manual removal of retained products of conception using MVA manual removal of placenta and newborn resuscitation. Among the health posts which did not provide all the signal functions. The reasons given included gaps in training, supplies and equipment and lack of authorization to provide care.

Cesarean section was done at the five hospitals assessed in Kathmandu. There was no Cesarean section at Chautara district hospital, therefore none in Sindhupalchowk,.

Misoprostol: in Kathmandu, seven out of nine health facilities used misoprostol for postpartum hemorrhage (PPH). In Sidhupalchowk, only

two of eight facilities used misoprostol for PPH.

Elements of newborn care. At hospitals assessed in Kathmandu, the representatives stated that there were health providers trained on elements of newborn care as shown in box 2 below. These elements were also offered at the hospitals.

Box 2: Elements of Newborn Care provided at the hospitals assessed in Kathmandu

- » Encourage breastfeeding (early and exclusive)
- » Newborn infection management (including injections & antibiotics)
- » Thermal care (including immediate drying and skin-to-skin care)
- » Sterile cord cutting and appropriate cord care
- » Kangaroo care for low birth weight babies
- » Management of low birth weight/preterm babies
- » Special delivery care practices for preventing mother-to-child Transmission of HIV
- » Thermal protection (delayed bath, drying, skin-to-skin contact)
- » Prevention of infection (cleanliness, hygienic cord cutting and care, eye care)
- » Management of newborn sepsis
- » Newborn resuscitation

PMTCT was only available at the hospitals in Kathmandu. In Sindhupalchowk, PMTCT is available at Chautara District hospital. In Sindhupalchowk, Bandegau Health Post and Melamchi PHCC did provide some management of newborn sepsis and management of low birth weight/preterm babies. The remaining facilities provided the other elements of Newborn Care but not management of Newborn Sepsis and Management of low birth weight and preterm babies.

In Kathmandu three health posts reported not having done newborn resuscitation in the last 30 days: Nagnlebuse health post, Lepsiphedhi health post and Sundariha Health Post. In Sindhupalchowk, Chautara district hospital and Barabise PHCC had provided newborn resuscitation in the last 30 days. For the facilities that do not offer resuscitation, a lack of training and authorization to provide services were the reasons mentioned.

Maternal and newborn deaths. In both districts, study participants had heard of maternal or newborn deaths. Participants from three hospitals (Maternity Center/hospital, OM Hops & Research and Civil Service) in Kathmandu reported having heard of a maternal death and study participants from two hospitals reported having heard of a newborn death. In Sindhupalchowk one health post (Thulosimoan) reported having seen a newborn death. In Sankapuur and Thulosimoan, each facility reported referring newborns with neonatal sepsis, low birth weight/preterm and birth asphyxia.

Abortion services. At the five hospitals in Kathmandu, the following abortion care services were provided:

Box 3: Elements of Post-abortion Care

- » Treatment of retained products
- » Counseling
- » Post-abortion family planning
- » SRH and other health services
- » Community/provider partnerships
- » Safe abortion care

None of these services were available either at the health primary health care centers (PHCCs) or health posts in Kathmandu. In Sindhupalchowk, the two PHCCs (Melamchi and Barabise) and the Chautara District Hospital, offered treatment of retained products, post-abortion family planning, SRH and other health services. One health post in Sindhupalchowk (Thulosimaon) offered counseling post-abortion care

counseling while another (Bandegu) offered counseling and family planning. Three health posts in Sindhupalchowk (Sindhukot, Lisankhu and Dandapakhar) did not offer any of the elements of post-abortion care.

All five hospitals in Kathmandu provided the following safe abortion care services: medical abortion, manual vacuum aspiration, dilatation & curettage and evaluation. Of note is that at the PHCCs and health posts assessed in Kathmandu, safe abortion care was not provided. In Sindhupalchowk the two PHCCs (Melanmchi and Barabise) and the District hospital provide medical abortion and manual vacuum aspiration. In addition, dilatation and curettage/evacuation is also provided at the District hospital as needed. At facilities where elements of safe abortion is not provided in both districts, reasons varied and included a gap in training, supplies and equipment; and management issues; no indication or clients; and, a lack of authorization to provide SAC services. None of the study participants had seen a maternal death at the facility in the last 30 days.

F. Prevention and Response to Sexual Violence

It should be noted that study participant's at all facilities assessed lamented that patients who have survived sexual violence are usually very reluctant to come forward for care. Sexual violence is very much stigmatized among communities in Nepal and survivors if known are frowned upon by community members, especially if they come forward.

One-third (three of nine) of the assessed health facilities, all hospitals (Maternity Center/Hospital), OM Hospital and Research Center and Nepal Medical College and Teaching), had the capacity to provide clinical management of rape (CMR). Some CMR services were available at four of eight assessed facilities in Sindhupalchowk (Thulosimaon health post, Melamchi and Barabise PHCCs and Chautara District Hospital). At the facilities where sexual violence services are not provided, reasons given included gaps in training, supplies and equipment and no indication/no clients.

In terms of specific CMR services, Maternity Center, OM Hospital & Research and Nepal Medical and Teaching Hospital and Chautara District Hospital in Sindhupalchowk offered services in box 4 below:

Box 4: Sexual Violence Services

1. Confidential history and examination
2. Forensic evidence collection
3. Provision of Post Exposure Prophylaxis (PEP) within 72 hours
4. Provision of Emergency contraception within 120 hours
5. Provision of antibiotics to prevent STIs
6. Psychosocial counseling

At the health post and PHCCs in Sindhupalchowk the services offered did not include provision of PEP and psychosocial counseling while forensic evidence collection was limited to collection of high vaginal swabs.

Only two of nine facilities in Kathmandu and two of eight facilities in Sindhupalchowk informed the communities about the availability and benefits of sexual violence services. The information given to community members include: location of services, benefits of clinical care and the hours of service. Despite availability of services, only the maternity center/hospital in Kathmandu and Chautara District Hospital in Sindhupalchowk reported having cared for sexual violence survivors. The maternity center saw 214 survivors of sexual violence in one year and at Chautara District Hospital, they reported approximately 15-25 survivors (in one year). No survivor had presented at any of the facilities within five days of sexual assault.

At the Maternity Center, OM Hospital and Research Center, Nepal Medical Teach Hospital and Chautara District Hospital there were health providers trained on confidential history and examination, including: forensic evidence collection; provision of PEP, emergency contraception, and antibiotics to prevent STIs, psychosocial counseling and care of child survivors. At Thulosimaon health post, and Melamchi and Barabise PHCCs services included confidential history and examination and the provision of emergency contraception and of antibiotics to prevent STIs. There were no standard operating procedures for referral of survivors of sexual violence. Only one facility Melamchi had referred a sexual violence survivor. No specifics were given on where the survivors were transferred.

G. Reduce Transmission of HIV

a. Blood transfusions

All the five hospitals in Kathmandu provide blood transfusions to patients that need it. Safe blood transfusion services were not available in Sindhupalchowk including at the Chautara district hospital. None of the PHCCs and health posts in Kathmandu and Sindhupalchowk had the capability to provide blood transfusions. The reasons given for not providing blood transfusions include gaps in training, equipment, supplies and lack of authorization to provide these services. Among the five hospitals in Kathmandu that provide safe blood transfusion services, only one, the Maternity center/hospital had a blood bank in the facility. The rest utilized an external blood bank. All blood was screened for the transfusion transmissible disease including HIV, Syphilis, Hepatitis B and Hepatitis C. At the OM Hospital and Research Center, the representative mentioned that they also screen for Malaria. Only one facility (civil service hospital in Kathmandu) had a written protocol for blood transfusions.

Rapid HIV tests were available at five facilities in Kathmandu: maternity center, civil service hospital, Sankapur private hospital, Gokarna primary health care center and Nepal medical college teaching hospital. In Sindhupalchowk, they were available at the two PHCCS (Melamchi and Barabise) and Chautara District Hospital. In Kathmandu, facilities which did not have rapid HIV tests stated that they were not authorized to keep them due to facility level. In Sindhupalchowk study participants cited gaps in training supplies, and equipment and a lack of authorization for rapid HIV testing.

b. Standard precautions

All nine of the health facilities in Kathmandu used autoclave while seven of nine also used high level disinfection for sterilization of equipment. Only two facilities did not add high level disinfection: OM Hospital and Research Center and the Civil Service Hospital. One health post, Nagnlebusse uses high chemical disinfectant and boiling only, no autoclave. In Sindhupalchowk, at Melamchi PHCC, pressure cooker was used for sterilization. The rest of the facilities in Sindhupalchowk used autoclave for sterilization.

Medical Waste Disposal. All health facilities in Kathmandu burned and incinerated medical waste. At Sankapur hospital waste was collected by the municipal and at Nepal medical college teaching hospital waste was decomposed. In Sindhupalchowk the waste disposal methods were more mixed. The waste disposal sites were at least 50 meters away. All facilities in both districts had sharps disposal bins/boxes in the facility.

Table 4: Medical Waste Disposal

<p>Kathmandu:</p> <ul style="list-style-type: none"> • Maternity Center • OM Hosp & Research • Civil Service • Nagnlebuse Health Post • Lepsiphedhi Health Post • Gokarna PHCC • Sundariha Health Post • Melamchi PHCC <p>Sindhupalchowk:</p> <ul style="list-style-type: none"> • Chautara District Hospital • Melamchi PHCC 	Burned Incinerated
<p>Sindhuplachowk:</p> <ul style="list-style-type: none"> • Bandegau Health Post • Sindhukot Health Post • Barabise PHCC • Dandapakhar Health Post 	Waste Pit
<p>Sindhuplachowk:</p> <ul style="list-style-type: none"> • Thulosimaon Health Post • Lisankhu Health Post 	Pit Latrine
<p>Kathmandu:</p> <ul style="list-style-type: none"> • Sankapur Hospital 	Municipal Collection
<ul style="list-style-type: none"> • Nepal Teaching Hospital 	Decompose medical waste

There were no standard precaution protocols posted on the walls at facilities in Kathmandu. In Sindhupalchowk there were protocols available at the Chautara District Hospital, the two PHCCs (Melamchi, Barabise) and one (Lisankhu) Health Post. The protocols only posted at Melamchi and Lisankhu facilities.

Post occupational exposure treatment. Only Maternity Center, OM Hospital and Research Center in Kathmandu and Chautara District Hospital in Sindhupalchowk had post occupational exposure treatment for their staff. At Kathmandu facilities they had: post exposure prophylaxis (PEP), Hep B vaccine and Hep B immunoglobulin. In Chautara District Hospital there was only PEP. Fifteen of 17 (88%) of health facilities assessed in both districts had adequate supplies to practice standard precautions.

Condom distribution. All facilities reported giving free male condoms. None of the facilities had female condoms.

Reproductive health supplies. Reproductive health supplies for all government facilities came from the district public health office, while the private health facilities had their own private supplies. Fifteen of the 17 facilities indicated that the supplies chain was reliable. All facilities had general commodities register which included SRH commodities though there was not a register specific to SRH supplies. At PHCCs and health posts they did not have full pharmacies. Instead they had small pharmacies or drug cupboards. Nearly two-thirds (11 of 17) health facilities assessed indicated that they sometimes experience shortages of drugs and supplies.

Data. Data collection for various MISP indicators was varied and for the most part not readily available during assessment therefore not included in this report. Most facilities collected disaggregated data by sex and age. Three of 17 facilities: OM Hospital and Research Center, Civil Service in Kathmandu and Chautara District Hospital in Sindhupalchowk collected disaggregated data by disability.

1. Additional Priority Reproductive Health Services

Contraception: All facilities provided male condoms, pills and injectable contraceptives. In Kathmandu emergency contraception was available only at the hospital level (Maternity center, OM Research, Sankapur) and Nepal Medical College Teaching Hospital. Interestingly, in Sindhupalchowk, 78% (seven of nine) facilities except Dandakapur and Bendegu health posts had emergency contraceptives available. Intra Uterine contraceptive Devices (IUCDs) were generally available except in Nangleduse and Sunddhuriha health posts in Kathmandu) and

Bendegau and Lisankhu health posts in Sindupalchowk. Implants were provided at Lepsiphedhi Health Post and Sankapur Hospital (Kathmandu) and at Sindhukot health post, Melamchi, and Barabise PHCCs and Chautara District Hospital in Sindhupalchowk. Data on contraceptives were not uniformly collected and therefore will not be reported here. Four facilities in Kathmandu and five in Sindhupalchowk had reported incidents of unplanned pregnancy. It was not immediately clear what services these women received at the facility. Four of nine facilities in Kathmandu and two of eight facilities in Sindhupalchowk had heard of incidents of unsafe abortion.

Antiretrovirals: Only the Maternity Center/Hospital in Kathmandu and Chautara District Hospital in Sindhupalchowk reported having antiretroviral (ARV) drugs for continuing users. All facilities in Sindhupalchowk had a referral system for ARVs for continuing users including for PMTCT. In Kathmandu, only four hospital facilities had a referral system (Maternity Center, OM Research, Sankapur, and Nepal Medical College Teaching Hospital). The majority of HIV patient referrals were made to: Teku Hospital, Nepal Medical College Teaching Hospital, Maternity Center/Hospital and Chautara District Hospital. During labor, antiretroviral were given to mothers at: maternity center, OM and Nepal teaching hospital and Chautara District Hospital. These hospitals also gave ARVs to newborns.

Syndromic treatment of STIs was available at all facilities except in Sundariha health post (Kathmandu) and Sindhukot health post in Sindhupalchowk. All the syndromic treatment for STI protocols used were from MoH and WHO. Supplies were mostly reported by clinics as not being adequate, except in maternity center, Gokarna PHCC and Nepal Teaching College Medical Center; In Sindhupalchowk, only Lisankhu health post and Chautara District hospital had sufficient supplies. Most supplies reported as not adequate were antibiotics to treat STIs.

Menstrual materials. Culturally appropriate menstrual materials were not distributed at health facilities. Patients were expected to come to the facilities with menstrual hygiene supplies to use after giving birth.

Conclusion

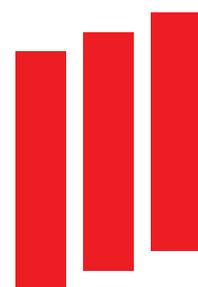
In general the health facilities were well equipped for MISP implementation.

Recommendations:

- Strengthen the existing health facilities with human resources and equipment and supplies) to perform complete BEmONC and CEmONC.
- Strengthen referral systems to ensure women reach the referral hospital in less time, particularly in Sinduhupalchowk considering the distances and bad road conditions.
- Strengthen prevention and response to sexual violence. Create awareness about gender and gender-based violence at the community level given the high levels of stigma reported and to encourage use of CMR services while also further preparing providers to address CMR.
- Strengthen the availability of antibiotics for syndromic management of STIs.
- Make culturally appropriate menstrual hygiene supplies available at health facilities.

Study Limitation

- Time constraint: not all facilities could be visited because of unforeseen national holidays and weekend closures of some facilities.
- Difficult access due to geographical terrain and bad road conditions particularly in Sinhupalchowk District limited the number of facilities accessible for study.
- Language differences and reliance on interpretation means that there is a risk for misunderstanding of information given.



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