

**Assessment of the Impact of COVID-19 Pandemic on
Functionality and Utilization of RMNCAH Services by Clients in
Public Sector Health Facilities of Nepal**

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-The CREHPA Team

Abbreviations and Acronyms

AFHS	Adolescent Friendly Health Services
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CREHPA	Centre for Research on Environment Health and Population Activities
ECP	Emergency Contraceptive Pill
FCHV	Female Community Health Volunteer
FP	Family Planning
FWD	Family Welfare Division
GBV	Gender Based Violence
GoN	Government of Nepal
HF	Health Facility
HMIS	Health Management Information System
HP	Health Post
HW	Health Worker
IPC	Infection Prevention and Control
IUCD	Intra-uterine Contraceptive Device
LARC	Long Acting Reversible Contraceptive
MA	Medical Abortion
MoHP	Ministry of Health and Population
MVA	Manual Vacuum Aspiration
OCMC	One Stop Crisis Management Center
PHCC	Primary Health Care Center
PNC	Postnatal Care
PPE	Personal Protective Equipment
RH	Reproductive Health
RHRWG	Reproductive Health and Rights Working Group
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RTI	Reproductive Tract Infection
SARC	Short Acting Reversible Contraceptive
SAS	Safe Abortion Service
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UHC	Urban Health Center
UNFPA	United Nations Population Fund
UTI	Urinary Tract Infection
VSC	Voluntary Surgical Contraception

Executive Summary

This study assessed the functionality and utilization of essential reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services amidst COVID-19 pandemic and restrictive measures being implemented at the federal, provincial and local levels.

A national representative sample of 424 public health facilities was drawn from all the seven provinces of the country to represent the four categories/levels of public health system: i) COVID hospital/Non-COVID hospitals, ii) primary health care centers (PHCC), iii) health post (HP) and iv) urban health centers (UHC). Probability proportionate to size (PPS) technique was used for allocating health facility (HF) sample across the seven provinces. In addition to interviewing facility in-charges and service providers at each HF, client exit interviews and interview of FCHVs were carried out to obtain their awareness, perceptions and constraints in service utilization during the lockdown period. Two rounds of assessment were carried out between September and November 2020 to identify changes or improvements in the service delivery of essential RMNCAH services. The Round 2 Assessment covered a sub-sample of 140 HFs (33%).

Functionality and Preparedness of Health Facilities for RMNCAH Services

- Approximately about a half (57%) of the HFs had sufficient stock of PPE during the time of Round 1 assessment. During Round 2 assessment, the percentage of HFs reporting that they were ‘prepared to a large extent’ with the stock of PPE declined sharply by half (from 57% to 28%).
- As compared to Round 1(28%), higher percentage of HFs reported about receiving the RMNCAH Interim Guidance in Round 2 (39%).
- In terms of rating the Government’s response to the COVID-19 pandemic, only 18 percent of health providers had rated Government’s response to COVID-19 pandemic as “good” in Round 1 which slightly increased to 23 percent in Round 2.
- Large majority of FCHVs (71%) responded affirmatively saying that clients were able to access health services from nearby HFs during the five months lockdown period.
- Majority of FCHVs continued to perform their 13 out of 16 tasks pertaining to RMNCAH services all the time.
- Nearly all FCHVs (91%) visited the clients at their homes and had used mask (97%) while meeting their clients.
- Nearly all clients (96%) were aware of the precautionary measures for COVID-19. Almost all clients mentioned ‘wearing mask always’ (92%) and regular washing of hands with soaps or with alcohol-based hand-rubs (76%) as precautionary measures. The three main sources of knowledge about the precautionary measures as reported by clients were television, radio and through phones/caller tune.

Functionality and Utilization of Maternal Health Services

- The functionality and utilization of maternal health services was disrupted initially in around 20 percent of HFs in Round 1 which improved in Round 2.
- ANC service was disrupted initially in 20 percent of the HFs during the lockdowns (Round 1). The situation improved in Round 2.
- Institutional delivery service was halted in 10 percent of the HFs during initial lockdown period. Trend analysis revealed that there has been a 19 percent decline in

institutional delivery during the 5 months' lockdown as compared to the corresponding period in the previous year.

- More than two fifth of the health facilities (44%) were unable to provide 'Aama' transportation incentives to mothers of newborns at times of discharge in Round 1. The situation improved considerably two months later (during Round 2). Few health facilities did not provide the 'Aama' incentives at all.

Functionality and Utilization of Family Planning Services

- Provision of SARC methods (oral pills and DMPA) were halted initially at nearly one third of the HFs in Round 1. There has been a spectacular decline in the percentage of HFs that faced disruption of SARC services in Round 2 from 31 percent in Round 1 to 7 percent. Nearly 93 percent of the HFs provided SARC services without disruption during Round 2.
- Around 19 percent HFs experienced disruption in LARC services in Round 1 which decreased to 15 percent in Round 2.

Functionality and Utilization of Safe Abortion Services (SAS)

- Only 34 percent of the 139 accredited SAS centers were able to provide abortion service without any disruption during the lock down period (Round 1).
- SAS facilities remained non-functional at nearly three fourth of the 46 accredited SAS centers revisited in Round 2 and 21 percent of the accredited facilities were providing SAS without interruption in this round.
- Similar to Round 1, all six accredited hospitals covered in Round 2 provided second trimester abortion and all sampled SAS centers had a trained MA provider.
- In Round 1, only 64 percent of SAS centers had trained MVA providers which increased to 76 percent in Round 2.

Functionality and Utilization of Child Health and Immunization Services

- Immunization service at most of the HFs (81%) was halted initially and resumed later during the lockdown period. This status improved to a greater extent in Round 2 where 76 percent of HFs provided immunization service without interruption.
- HFs of nearly all provinces (98%) implemented the Vitamin A supplementation programme in Asadh this year.
- An eight percent reduction of HFs providing Vitamin-A supplementation to mothers of newborn from 96 percent in Round 1 to 88 percent in Round 2 was reported.

Functionality and Utilization of Adolescent Friendly Health Services

- The flow of adolescent clients seeking FP services remained same in three quarters of HFs throughout 5 months' lockdown period in comparison to period prior to lockdown. However, a slight increase in adolescent client flow for FP services was reported in Round 2.

One Stop Crisis Management Center

- Surge in GBV cases seeking care at OCMC during the lockdown period (Round 1) was evident.

- Majority of the survivors seeking care at OCMC during 5 month's lockdown period (Round 1) were cases of sexual violence and physical violence while the majority of survivors seeking care at OCMC during Round 2 were cases of physical violence.

Way Forward:

- All public health facilities should be provided with an electronic copy of the RMNCAH Interim Guidance to enable them to understand the guiding principles for the provision of these essential services during the COVID-19 pandemic. Implementation of the Guidance needs to be monitored by the municipality/local government.
- PPE has become a basic necessity and part of the basic supply chain at all levels of health facilities. Hence, the existing mechanisms for the procurement and distribution of PPE should to be strengthened through coordination with the procurement units of concerned department/office at the province and local government levels;
- Establish regular policy dialogues between local government and health facilities for mitigating challenges faced by health facilities in stable provision of services such as on commodities supply chain, timely payment of reimbursable funds to health facilities as specified in the Safe Motherhood and Reproductive Health and Rights (SMRHR) Act 2018 and in the RMNCAH Interim Guidance. Women should be provided with contraceptives of their choice and not compel them to use alternative methods/less reliable methods;
- Ensure availability of at least one trained service provider for the provision of LARC at all accredited health facilities by providing competency-based trainings to additional cadre of service providers who are untrained and posted/newly transferred at the health facilities.
- Strengthen coordination between the local government and accredited SAS centers for SAS center expansion at all HPs and sustained presence of trained SAS providers through recruitment of ANMs from the local communities. SAS facilities should maintain sufficient stock of MA drugs, and supplies for pain management, etc. Periodic monitoring of free abortion service needs strengthening to ensure that women are not charged service fee or asked to purchase MA drugs from the open market. Women's right to legal, safe and free abortion should be respected at all public health facilities.
- In view of the rising number of GBV case referrals at OCMC and to reduce the hospital burden in dealing with the survivors as well as to improve service access, the possibilities of establishing OCMC at each *Palika* hospital (upgraded PHCC/HP) in a phased manner needs to be explored.

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Chapter 1

Introduction

1.1 Background

COVID-19 was declared a global pandemic by the World Health Organization (WHO) on 11 March 2020. The first case in Nepal was confirmed on 23 January 2020 when a 31-year-old student, who had returned to Kathmandu from Wuhan on 9 January 2020, tested positive for the disease [1]. The Government of Nepal (GoN) commenced nation-wide lockdown since 24 March and has extended to mid July 2020. All non-essential travel was restricted and borders including inter-district travel were closed.

The Constitution of Nepal mandates round the clock delivery of basic health care services including maternal and neonatal health services. Hence, MoHP has instructed health facilities and care providers to continue basic health care support including sexual and reproductive health services (SRH) and Maternal, Newborn, child and Adolescent Health (RMNCAH). The response to the COVID-19 public health emergency has an unprecedented impact on the health systems and its capacity to continue lifesaving essential services including for Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH).

In April 2020, UNFPA conducted a rapid assessment of the RMNCAH service functionality in 146 health facilities. The assessment showed low utilization of services at the health facilities, especially safe delivery, FP and ANC services during the lockdown. The reasons reported for low utilization are due to the fear of disease transmission, lack of transportation and travel restrictions. Similarly, health service providers also expressed that they were feeling unsafe due to fear of disease transmission, lack of Personal Protective Equipment (PPE), and inadequate supplies and commodities. Pregnant women with respiratory illnesses must be treated with utmost priority due to increased risk of adverse outcomes and antenatal, neonatal and maternal health units must be segregated from identified COVID-19 cases. Provision of family planning and other sexual and reproductive health commodities may be impacted as supply chains undergo strains from pandemic response. Therefore, it is considered critical to ensure continuity of sexual and reproductive health and newborn care services in case of severe facility service interruption or other disruption in access for women and girls of reproductive age.

The Government of Nepal, Ministry of Health and Population (MoHP) has instructed health facilities and service providers to continue essential health services including RMNCAH in response to the public appeal by the Reproductive Health and Rights Working Group (RHRWG) against the major public hospitals halting material including institutional deliveries and safe abortion services because of overwhelming cases of COVID-19 referred to these hospitals. The impact of COVID-19 on the utilization of lifesaving SRH services has been significant and is likely to be an even greater challenge for underserved and vulnerable groups including the people with disabilities, migrants and returnees, women and girls in quarantine sites. It is essential to maintain and strengthen the provision of essential SRH information and services to avert an increase in maternal morbidity and mortality, unintended pregnancies, and unsafe abortion, which was already high in Nepal compared to other countries in the region.

Therefore, under the Reproductive Health (RH) sub-cluster, led by FWD/MoHP and co-led by UNFPA [4], decision was taken to undertake a comprehensive assessment of the impact of COVID-19 on essential RMNCAH services delivery and utilization. The findings from this nationally representative assessment is intended to guide MoHP and RH Sub Cluster partners on COVID-19 emergency preparedness and response plan by identifying priorities and interventions for sustained provision of RMNCAH services. The assessment is repeated in a gap of 2 months following a standard methodology to allow comparison of functionality and utilization of RMNCAH services over the period of COVID-19 pandemic and beyond.

1.2 Objectives of the Assessment

The main objective of the study is to assess the **functionality and utilization of essential reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services** amidst COVID-19 pandemic and restrictive measures being implemented at the federal, provincial and local levels.

The specific objectives of the study are:

- 1) To assess the service availability and readiness of health facilities in relation to RMNCAH care amidst COVID-19 pandemic and restrictive measures being implemented at the federal, provincial and local level
- 2) To assess the perception of health workers about the work environment and possible options for improving RMNCAH service delivery in the COVID-19 context
- 3) To examine key RMNCH service delivery data from all HFs surveyed, during the lockdown period, compare with the HMIS data from the same period of last fiscal year to determine the impact of COVID-19
- 4) To assess the perception of the clients of RMNACH services and the barriers faced in utilizing RMNCH services due to COVID-19
- 5) To identify emerging needs in relation to COVID-19 that may need to be addressed in the provision of essential RMNCAH services to vulnerable groups.

1.3 Study Design and Method

A facility-based mixed method design (a combination of qualitative and quantitative research techniques) was used for assessing the ‘functionality’ and health system capacity in delivering RMNCAH services and utilization during the COVID-19 crisis. The quantitative research component of the assessment included a sample survey of public health facilities. The qualitative research component comprised of facility observation and exit interviews of clients seeking RMNCAH service at the sampled health facilities and semi-structured interviews of female community health volunteers.

Sampling Technique: A national representative sample of public health facilities has been drawn from all the seven provinces of the country to represent the four categories/levels of public health system: i) COVID hospitals/non-COVID hospitals, ii) primary health care centers (PHCC), iii) health post (HP) and iv) urban health centers (UHC). The sample frame was based on the 2074-75 HMIS database that provides municipality-wise distribution of government and non-government health facilities in each of the seven provinces. [5] There are 125 hospitals (apex, province and district hospitals), 192 PHCCs, 3808 health posts (HP)

and 374 urban health centers (UHC) in the country. Based on the standard sample size estimation technique adopted by UNFPA in 2016, the required number of public health facilities falling under first four categories has been estimated at 424. The sampling technique used for size estimation is appropriate for obtaining the minimal sample size requirement at each category of public health facilities. This technique adopts an approach that gives large facilities a higher probability of inclusion in the survey because of their small number and provides a guide for choosing a sample of the primary facilities. The steps adopted for the sample size estimation are: *First*, the relative proportion for each level of service delivery point (SDP) was calculated from the list of four types of SDPs that has the numeric distribution of each type of SDPs considered in the study. This was followed by applying the formula above to obtain the minimal sample size for each type of SDP by proposing the use of a confidence interval. The estimated facility-wise sample for the country based on 95 % confidence interval (Z-score = 1.96) and 5 per cent confidence limit) is shown in Table 1.1.

As indicated in the Table 1.1 below, the sample size for each of the four level of health facility ranges from 41 (hospital level) to 201 (health post level). Probability proportionate to size (PPS) technique was used for the allocation of the required sample at each level of health facility across the seven provinces of the country (see Map and the Annex 1.1). Accordingly, Bagmati Province has the largest share of the health facility sample (92 facilities), followed by Province 1 (69) and Lumbini Province (68). On the other hand, Karnali and Sudurpaschim Province have relatively lower number of health facility sample (32 and 48 respectively).

Table 1.1 Distribution of sampled public health facilities across the seven provinces

Level of Public Health Facility	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpaschim Province	Total
COVID hospital/Non-COVID hospital	(18) 6	(13) 4	(33) 10	(15) 5	(20) 7	(12) 4	(14) 5	(125) 41
PHC	(40) 13	(32) 11	(43) 14	(24) 8	(30) 10	(13) 4	(16) 5	(198) 65
HP	(648) 34	(745) 39	(640) 34	(491) 26	(570) 30	(336) 18	(378) 20	(3,808) 201
UHC	(52) 16	(17) 6	(110) 34	(52) 16	(68) 21	(18) 6	(57) 18	(374) 117
Total	(758) 69	(807) 60	(826) 92	(582) 55	(688) 68	(379) 32	(465) 48	(4,505) 424

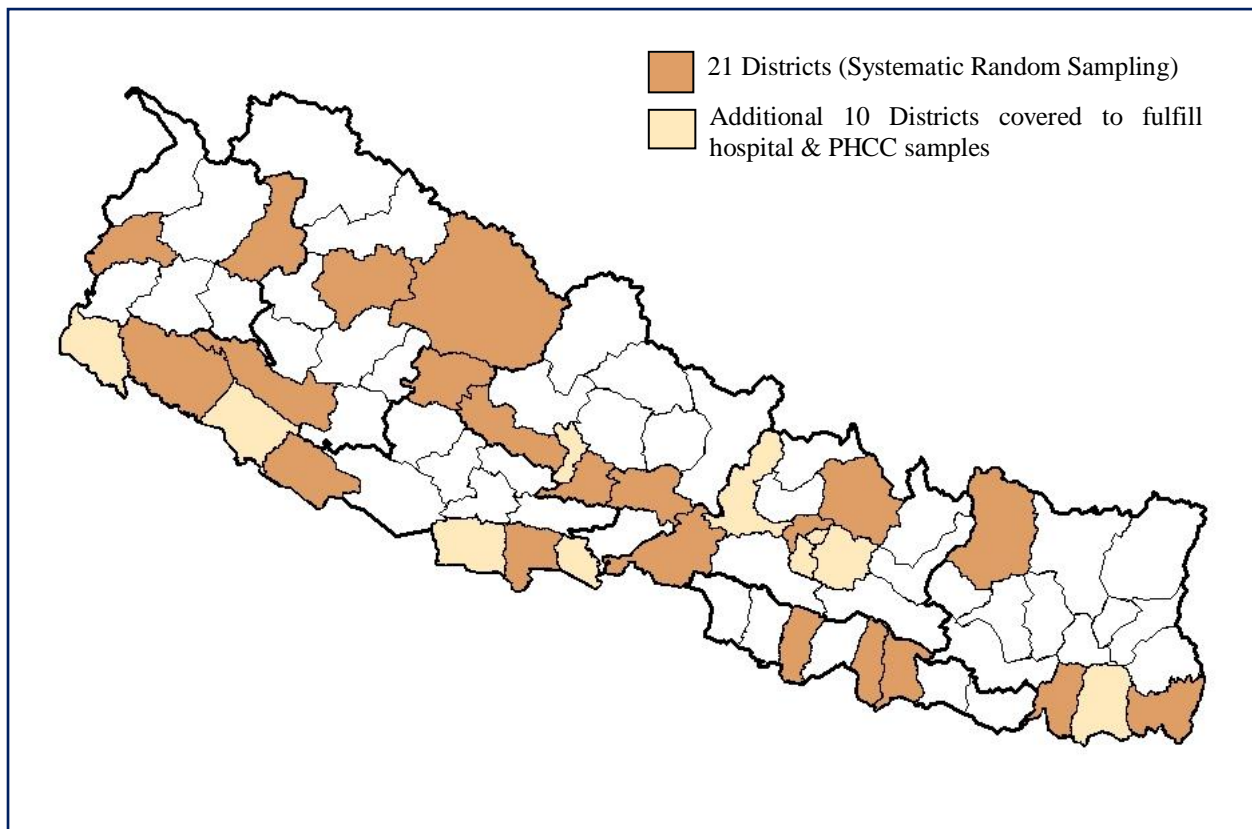
Figures in parenthesis are total number of public health facilities within the province

A province and district wise stratified sample was derived for representing hospitals, PHCCs and HPs. Two rounds of assessment were carried out. In the Round 1 Assessment, all the 424 sampled public health facilities were covered. In Round 2 Assessment, a sub-sampled of 140 public health facilities (33%) was covered.

The facility level sample in each of the 21 districts was selected randomly in situations where the number of health facilities of a specific category was more than the desired sample in the district. However, in five provinces, the numbers of hospitals and/or PHCCs were less than the desired number of samples. In such provinces, the hospitals and PHCCs were covered from the adjoining district(s) to achieve the total sample size. For the remaining two categories of health facilities (health posts and urban health centers) where the numbers far exceed the desired sample, selection of these facilities was done randomly by the study team at the district itself in consultation with the district based health office. The district-wise allocation of 424 health facilities for Round 1 Assessment and a sub-sample of 140 facilities

representing the same 21 sampled districts for Round 2 Assessment are appended (Annex 1.2).

Map 1: Location of the districts covered in each province



At each sampled health facility, the concerned in-charges (hospital director/Medical Superintendent; Medical Officer/HA In-charge, etc.) were selected mandatorily. In his/her absence, the senior most medical officer was interviewed. In addition, one to two health worker/service provider responsible for the provision of maternal care (ANC/ delivery/ neonatal/PNC), family planning, safe abortion and adolescent SRH service was interviewed.

Clients for the exit interviews were purposively selected among RMNCAH care seekers at each sampled facility. Likewise, one FCHV from each municipal ward located at 0.5 – 1.0-hour walking distance from the sampled health facility was purposively selected in consultation with the health facility staff and the ward representatives. Criteria such as marital status (currently married); age (20-44); and recommended as ‘hard working’ by the municipal ward representative or by the health facility personnel formed the basis of FCHV selection.

1.4 Data Collection Technique and Tools

The three sets of questionnaires were administered to collect information from the three categories of study participants, viz: 1) Health facility In-charge & service providers; 2) clients seeking RMNCAH services (exit interview); and 3) FCHVs. Face-to-face interviews

were conducted with almost all study participants. Only in a few cases, (< 5%) interviews were done remotely through phones.

A written informed consent was obtained prior to face to face interviews and verbal informed consent was obtained prior to remote interviews. In regards to the present COVID-19 situation, two meters distance was maintained in between the interviewer and interviewee during interview process. The interviewer used personal protective equipment masks, gloves and face shield during data collection period. All data were collected electronically using aneroid cell-phones or tablets. The three sets of questionnaires in Nepali were uploaded on the cell-phones and tablets after installing KoBo Tool software that has features for collecting information both online and offline and more options in terms of questionnaire design and response options. All data collected from the field were transferred to the main server at CREHPA each day.

The questionnaire for health facility in-charges and service providers explored service functionality due to COVID-19 crisis, constraints faced in offering all range of essential RMNCAH care to clients; demand and utilization of these essential services, ability of the health staff to observe precautionary measures including infection prevention during the Covid-19 crisis.

The questionnaires for clients seeking RMNCAH care were administered to the clients after they had obtained the service from the health facility (exit interviews). The type of service sought and ability to receive the desired service, difficulties encountered in arriving at the health facility, measures taken by clients as well as by the service providers to prevent transmission of the infections, etc., were solicited from the clients. Likewise, the FCHV questionnaire solicited information on clients' RMNCAH service seeking behavior amidst the COVID-19 crisis, ability of FCHVs to discharge their regular tasks, reasons for clients who have discontinued follow-up visits (default clients) for routine ANC, PNC and FP services and barriers to service utilization by the women. In addition, retrospective HMIS and other service records pertaining to RMNCAH were extracted for all the 21 sampled districts for comparing the pre-pandemic situation (Mid-March to Mid-August 2019) with the current COVID-19 induced 5 months of lockdown period and beyond (Mid-March- Mid-August 2020).

1.5 Data Management and Analysis

All the obtained data were de-identified in order to maintain the confidentiality of the research participants. After de-identification, the data was cleaned. All cleaned data were labeled and transferred to SPSS for tabulation (frequencies and other descriptive tables/cross-tabs). Data were analyzed according to the key indicators against each of the seven themes under RMNCAH services. The domain of analysis is the 'Province' and disaggregated by four levels of health facilities. Some of the key data representing the key indicators (variables) were compiled to indicate national scenarios. Data obtained from FCHVs' interviews and clients' exit interviews were analyzed separately to portray the service utilization and constraints encountered by clients in accessing the RMNCAH service during the lockdown period. A Web-based Dashboard has been developed for the FWD/MoHP that upload the key indicators based on the Round 1 assessment results and some of the key results were updated based on the Round 2 assessment findings. Information in the dashboard features national and province level scenarios as well as those at the different health facility levels on the impact of COVID-19 crisis on RMNCAH service.

1.6 Limitation of the Study

This study is limited to the public health system and hence, the findings do not reflect the functionality and utilization of RMNCAH services provided at private hospitals, private medical colleges, NGO clinics, etc., amidst COVID-19 pandemic and lockdowns. The sample for Round 2 assessment covered only a third (140) of the total 424 sampled health facilities and solicited fewer information from the study participants than in the Round 1 assessment.

Chapter 2

Functionality and Utilization of RMNCAH Services

COVID-19 pandemic has strained the country's health systems and disrupted essential health services including Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH). The government of Nepal has instructed all public health facilities to abide by the Interim Guidance developed by the Reproductive Health (RH) sub-cluster for ensuring continued access to the essential RMNCAH services, measures for staff and client protection from COVID-19, un-interrupted availability of equipment and commodities necessary for the essential services, etc. This chapter assesses the functionality of RMNCAH services, adoption of basic precautionary measures by the service providers against COVID-19 transmission, extent of utilization of the essential services by clients and types of services disruptions encountered in the delivery of the RMNCAH services.,

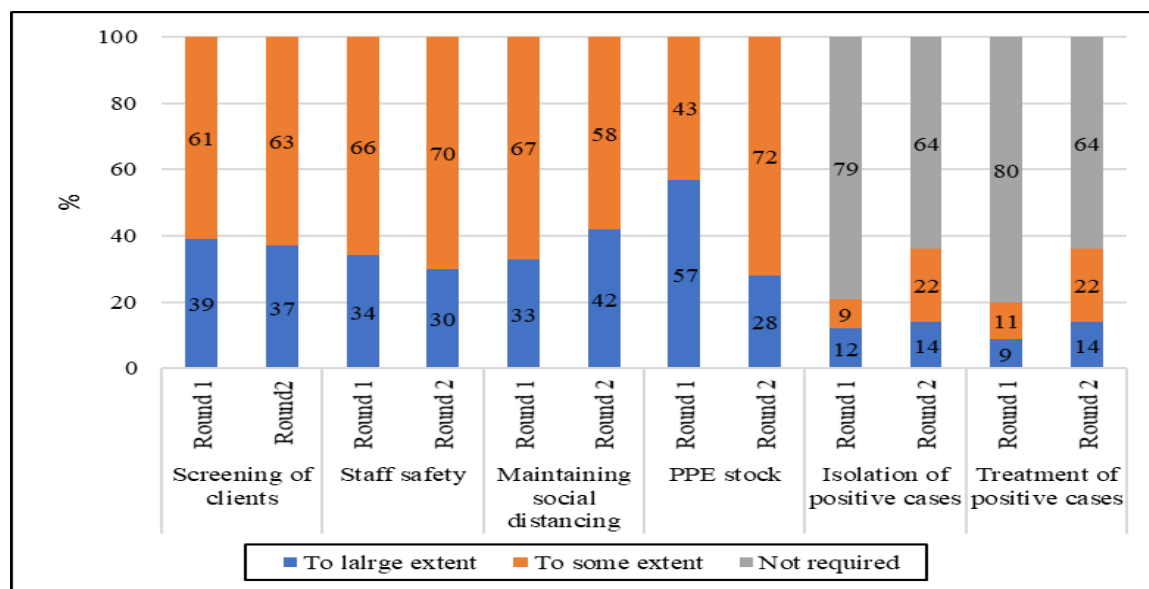
2.1 Health Facilities' Preparedness in Dealing with Clients

Service providers (facility in-charge) of public health facilities were asked to state the extent of preparedness of their health facilities (HFs) to deal with clients/patients in the context of COVID-19 pandemic lockdown period. HFs' preparedness was asked on the six preventive/precautionary measures. These were: screening of clients, staff safety, maintaining social distancing, adequacy of PPE, and in isolation and treatment of COVID-19 positive cases. Furthermore, the service providers were asked to give their response regarding their level of preparedness either by saying "to a large extent"; "to some extent only" or saying "not required" at all, against each of these six precautionary measures and interventions. The findings are presented in Figure 2.1 below and Annex 2.1 and 2.2.

As shown in Figure 2.1, in Round 1 Assessment (September 2020), more than half of the HFs were prepared but 'to some extent only' for screening of clients, staff safety and in maintaining physical distancing in the context of COVID-19 pandemic. Only about a third to less than two fifths of the HFs were prepared to a large extent in screening of clients (39%), ensuring staff safety (34%) and maintaining social distancing (33%). More than a half (57%) of the health facilities had sufficient stock of personal protection equipment (PPE). Isolation of COVID-19 positive cases and their treatment were the tasks mainly for COVID hospitals and non-COVID hospitals.

During Round 2 Assessment (November 2020) the percentage of HFs reporting that they were 'prepared to a large extent' with the stock of PPE declined sharply by half (from 57% to 28%). Those reporting about HFs preparedness to a large extent on clients' screening and staff safety also decreased marginally by 2 and 4 percent respectively as compared to the previous round (Round 1). However, percentages of the service providers saying that their HFs were prepared to a large extent for isolation and treatment of COVID 19 infected clients increased slightly by 2 to 5 percent only (Figure 2.1).

Figure 2.1 Health facility’s preparedness in dealing with clients in the context of COVID-19 pandemic in Round 1 and Round 2 Assessment



Province-wise assessment showed that in Round 1, more than fifty percent of the HFs across all the provinces were prepared “only to some extent” for screening of clients, staff safety and maintaining social distancing. More than half of the HFs in Province 1, Karnali and Sudurpaschim provinces said that their preparedness with PPE stock was to “some extent only”. The majority of HFs in Province 2 (90%) and Lumbini Province (93%) mentioned they were not required to prepare for isolation and treatment of COVID-19 positive cases (Annex 2.1).

In Round 2, the province-wise reporting of HFs’ level of preparedness (to some extent only) for screening of clients and staff safety did not change much from the previous round of assessment. Comparatively, the highest number of facilities (43%) in Bagmati Province reported of adequate PPE stock in Round 2.

Facility-wise analysis shows, most peripheral health facilities (PHCC, HP and UHC) in both the rounds of assessment (Round 1 and 2) reported that they were not required to deal with clients for isolation and for treatment of COVID-19 positive cases. On the contrary, 80 percent of the COVID hospitals and about half this proportion of non-COVID hospitals had to deal with isolation and for treatment of COVID-19 positive cases. The proportion of COVID hospitals saying so increased to 89 percent in Round 2. Only 40 percent of the non-COVID hospital reported about their preparedness to dealing with isolation and treatment of COVID patients during Round 2 (Annex 2.2).

2.2 Extent of Adequacy of PPE at Health facilities

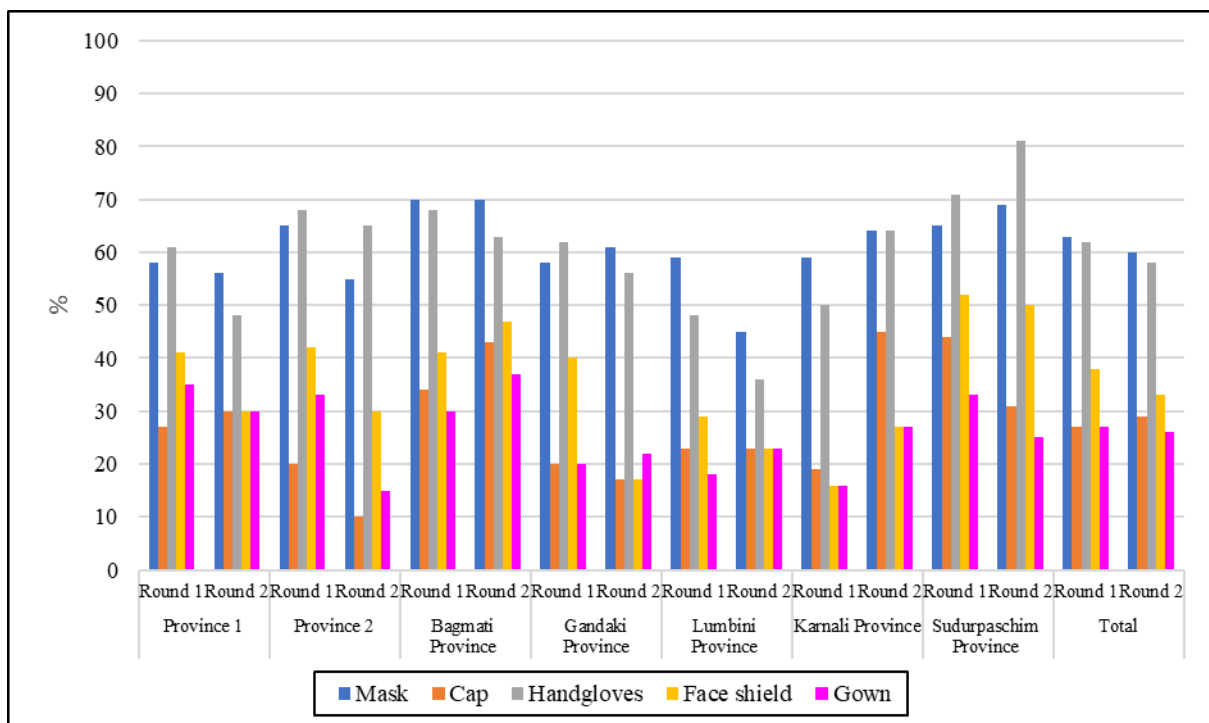
Adequate stock of PPE was reported by 40 percent of the COVID hospitals and 55 percent of non-COVID hospitals during Round 1 assessment (Annex 2.2). In Round 2, the proportion of COVID hospitals reporting sufficient stock of PPE increased by more than two folds (89%). On the other hand, the proportion dwindled for non-COVID hospitals (40%) in Round 2.

COVID Hospitals' preparedness for screening clients to a large extent also increased sharply from 60 percent in Round 1 to 89 percent in Round 2 (Annex 2.1).

Less than 50 percent of health facilities across all provinces in Round 1 had inadequate availability of caps, gowns and face shield. Relatively, a higher percentage of HFs of Lumbini and Karnali provinces reported shortages of face-shields and gowns. In contrast, face masks and hand gloves were adequately available in more than half of HFs of all provinces (Figure 2.2) More than 70 percent of the HFs in all provinces reported adequate availability of IPCs except sanitizers and disinfectants. More than 3/5th of HFs in Province 1, Bagmati, Gandaki and Sudurpaschim province had adequate availability of IPCs. (Figure 2.2).

In Round 2, the proportion of HFs indicating the adequacy of masks and hand gloves have shrunk marginally at all provinces, particularly in Province 1 (hand gloves), Province 2 (facemasks) and in Gandaki Province (hand gloves). No noticeable change in percentages of HFs reporting adequacy of other three PPE items (caps, face shields and gowns) was apparent in Round 2 assessment (Figure 2.2).

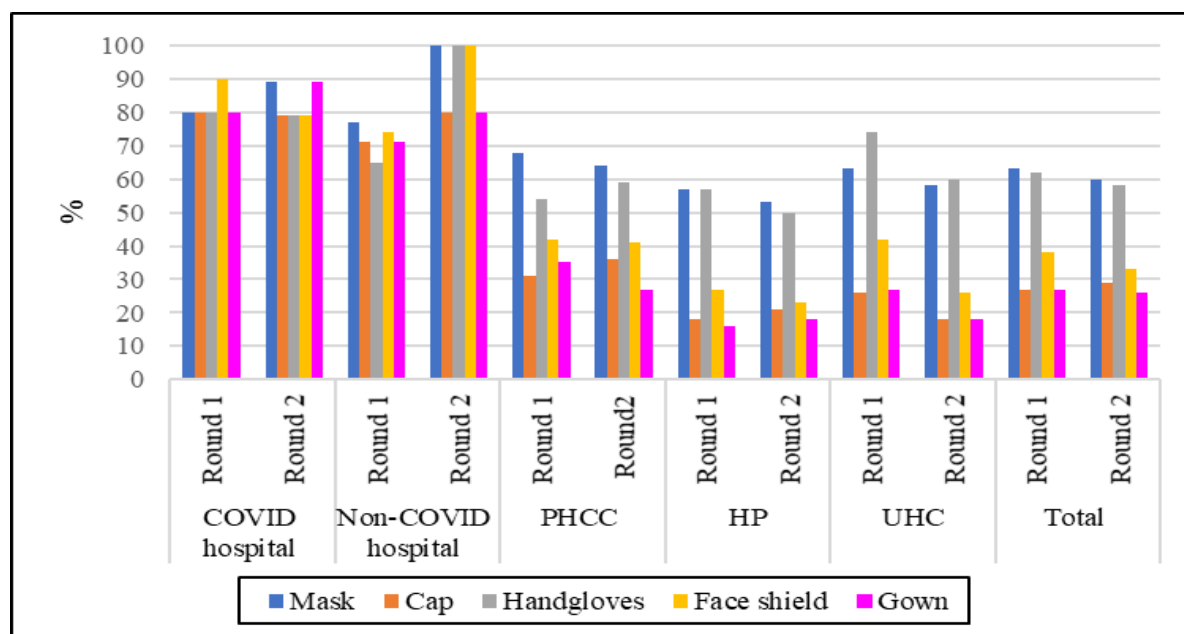
Figure 2.2 Province wise percentages of health facilities reporting adequate availability of specific PPE in Round 1 and Round 2 Assessment



In Round 1, most COVID hospitals (80%) and nearly three-fourths of non-COVID hospitals reported about having an adequate availability of all 5 sets of PPE and four types of infection prevention & control (IPC) measures. Comparatively, availability of PPE at PHCC, HP and UHC was low, excepting face masks and hand gloves (Figure 2.3). For instance, more than half of the PHCC and lower health facilities (HP and UHC) had inadequate availability of caps, face shields and gowns.

In Round 2, all non-COVID hospitals reported about having adequate availability of facemasks (100%); hand gloves (100%) and face shields (100%). Eighty per cent of these hospitals had adequate availability of the other three PPE items (caps and gowns) (Figure 2.3). These PPE items were adequately available between 80 to 90 percent of the COVID hospitals which is noteworthy too. In comparison, the percentages of peripheral HFs (PHCC, HP and UHC) reporting adequacy of PPE have declined marginally in Round 2 for almost all the five PPE items (Figure 2.3).

Figure 2.3 Health facility wise reporting of adequate availability of specific PPE in Round 1 and Round 2 Assessment

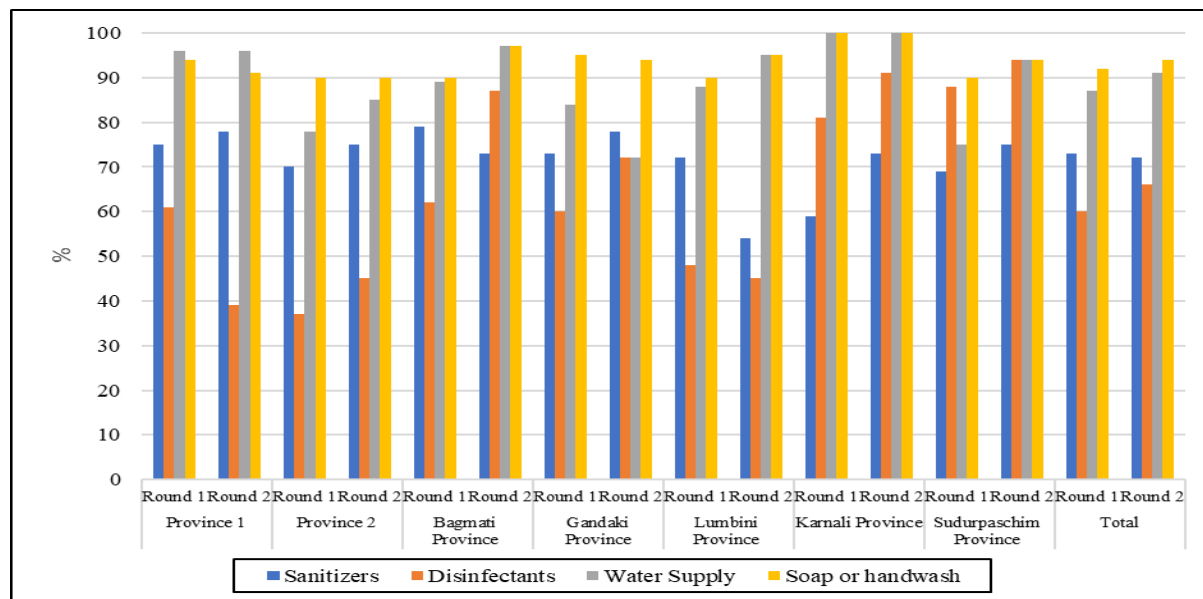


Sanitizers are adequately available only about three fourth or less of all health facilities while disinfectants at less than two thirds of the health facilities. Most provinces reported about adequate water supply and soap/hand wash. Comparatively, disinfectants were reportedly in short supply in Province 2 and Lumbini Province during Round 1 (Figure 2.4).

In Round 2, Lumbini Province is joined by Province 1 and Province 2 as provinces indicating low percentages of HFs (below 50%) with short-supply of disinfectants. Lumbini Province

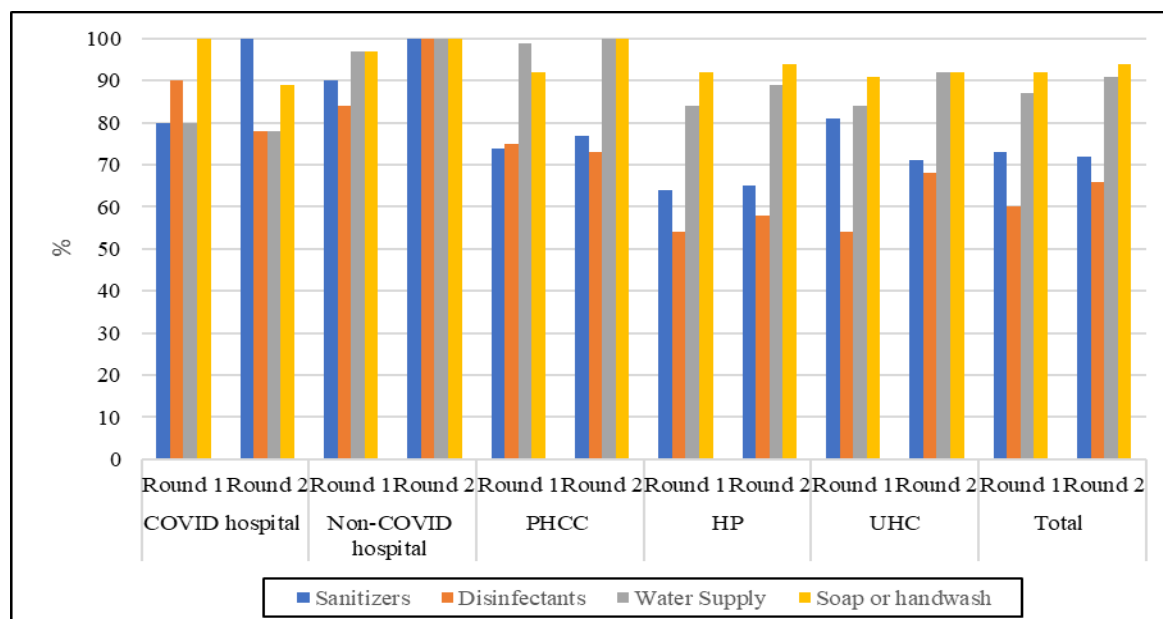
also represented the only province with shortages of sanitizers. Approximately half of the HFs in this province reported of having adequate availability of sanitizers (Figure 2.4).

Figure 2.4 Province wise percentages of Health facilities reporting adequate availability of IPC measures in Round 1 and Round 2 Assessment



At the HF levels, more than 3/4 of the PHCCs, HPs and UHCs reported about adequate availability of IPC materials excepting Sanitizers and disinfectants (Figure 2.5). In Round 2, the percentage of HPs reporting adequate supply of IPC items particularly disinfectant and sanitizers were low as compared to other category of HFs (Figure 2.5).

Figure 2.5 Health facility wise reporting on adequate availability of IPC measures in Round 1 and Round 2 Assessment



2.3 Availability of RMNCAH Interim Guidance

Overall, only 28 per cent (out of total 424 HF) reported about receiving the RMNCAH Interim Guidance (IG) in Round 1. This figure increased to 39 per cent (out of 140 HF) in Round 2 (Figure 2.6).

Province 2 has comparatively the highest percentage of HF receiving the IG in both the Rounds of the assessment (58% in Round 1 and 75% in Round 2). On the other hand, Sudurpaschim Province has the lowest percentage of HF reporting the receipt of IG in both the rounds (15% in Round 1; 25 % in Round 2). In Gandaki Province, the percentage of the HF receiving the IG declined from 27% in Round 1 to 22 percent in Round 2. In the remaining provinces, the percentages have increased marginally in Round 2 (Figure 2.6).

Facility-wise comparison shows that four-fifths of the COVID hospitals (80%) and nearly a half of the non-COVID hospitals (48%) reported about receiving the IG in Round 1. On the contrary, the large majority of health providers from UHC (83%) and HPs (74%) reported about not receiving the IG at the time of Round 1 Assessment.

In Round 2, the availability of IG increased only at non-COVID hospitals, PHCC and HP only. In fact, the proportion of non-COVID hospitals receiving the IG in Round 2 increased by nearly two folds (from 48 to 80 %) (Figure 2.7).

Figure 2.6 Province wise percentages of health facilities in receipt of RMNCAH Interim Guidance in Round 1 and Round 2 Assessment

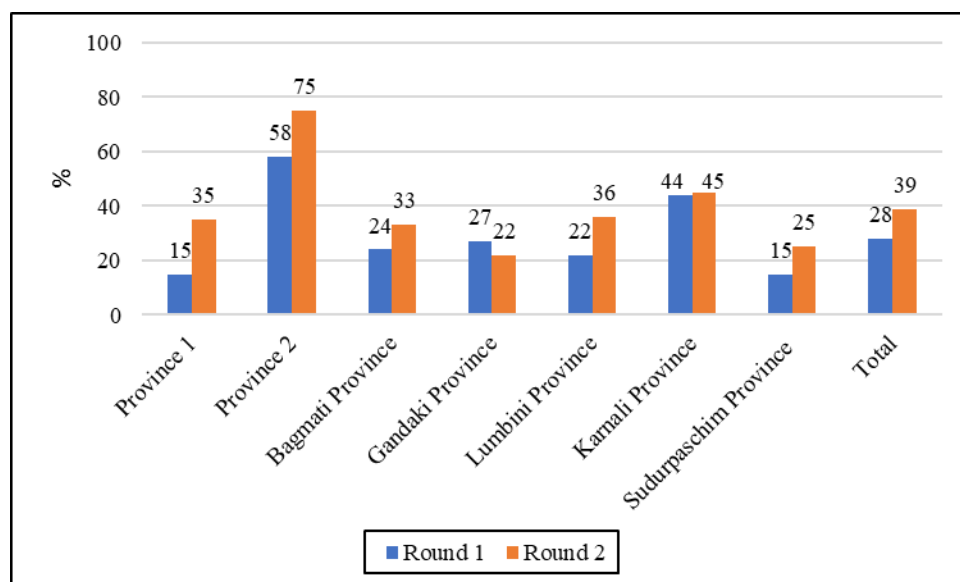
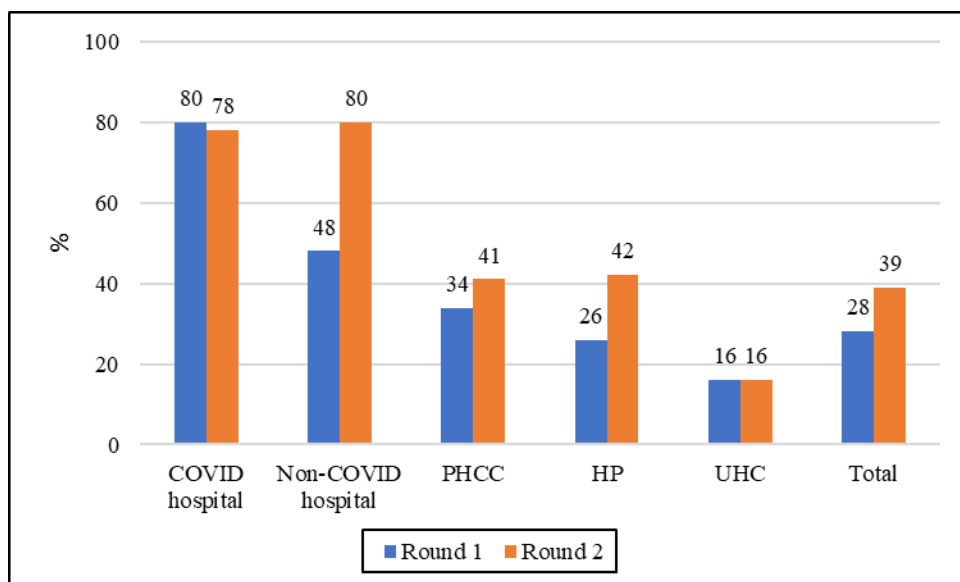


Figure 2.7 Health facility wise percentages reporting the receipt of RMNCAH Interim Guidance in Round 1 and Round 2 Assessment



2.4 Orientation on RMNCAH Interim Guidance

Information on service providers' orientation on RMNCAH Interim Guidance was solicited during Round 2 Assessment. As shown in Figure 2.8, more than half (59%) had received the orientation. The highest percentage of service providers in Karnali Province (80%) followed by Province 2 (67%) had received the orientation. At the time of the present assessment (Round2), none of the service providers in Gandaki province had received the orientation (Figure 2.8). Likewise, all the service providers in PHCC (100%) had received the orientation followed by COVID hospitals (57%) and health posts (57%) (Figure 2.9).

Figure 2.8 Province-wise percentage of service providers receiving orientation on RMNCAH interim guideline: Round 2 Assessment

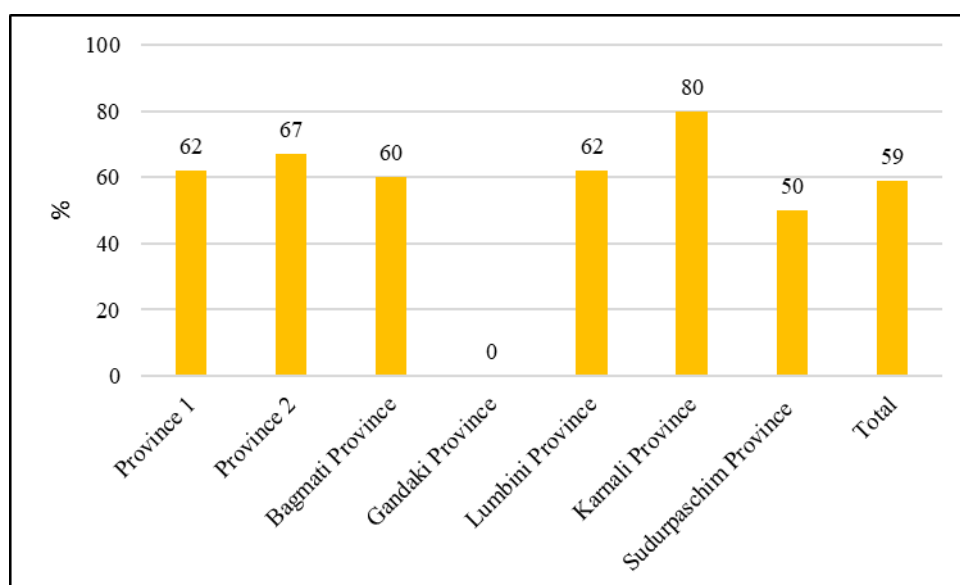
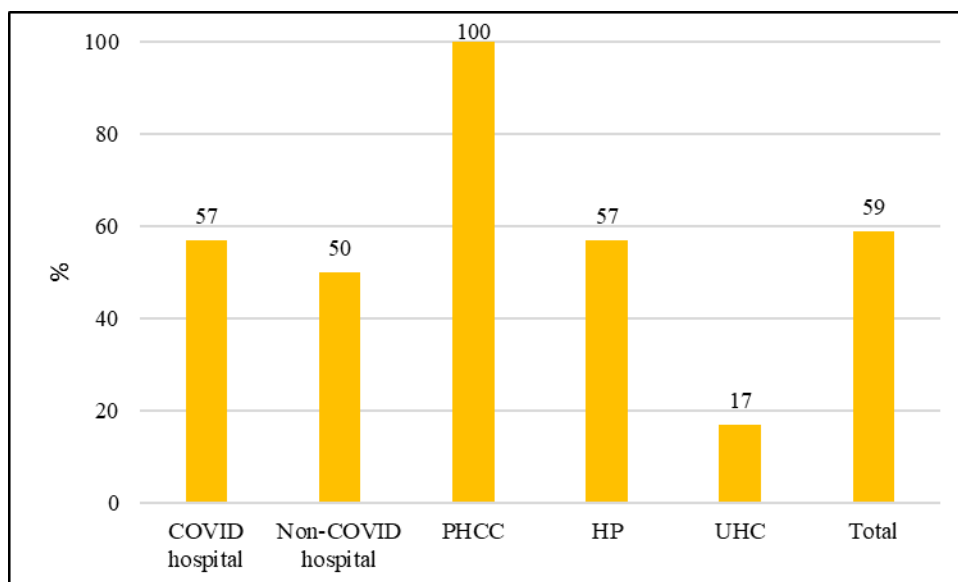


Figure 2.9 Health facility-wise percentage of service providers receiving orientation on RMNCAH interim guideline: Round 2 Assessment



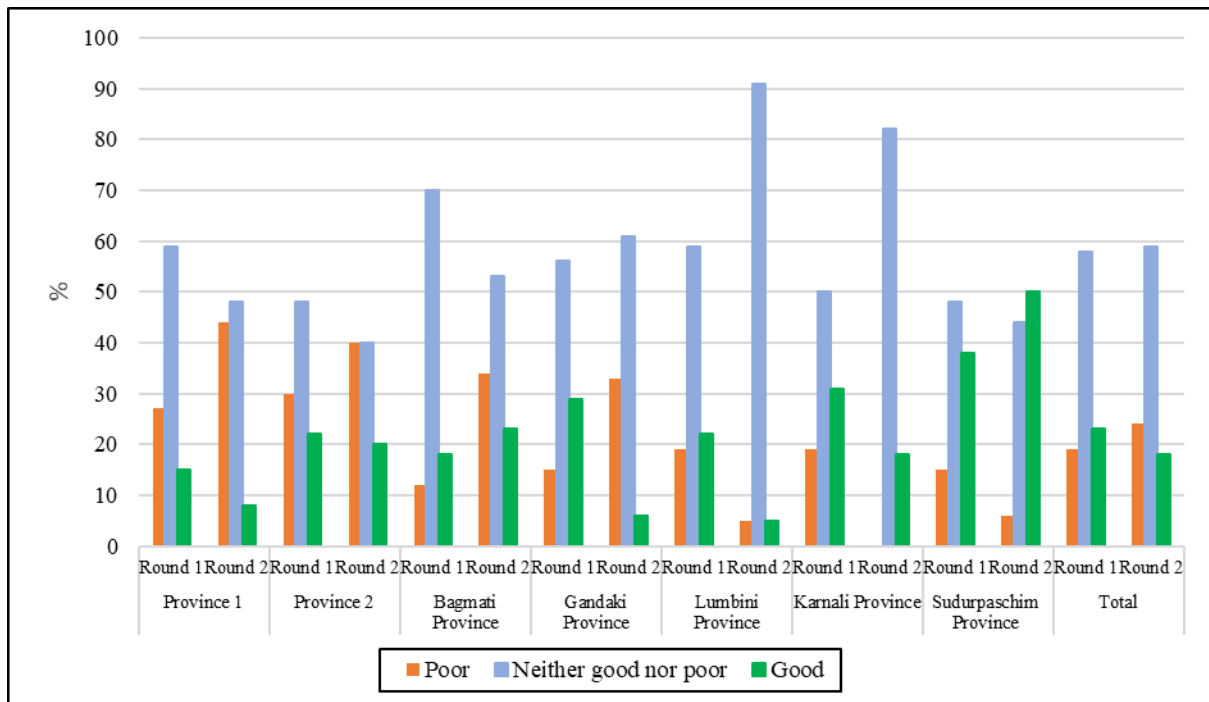
2.5 Service Providers' Rating of the Activities of the Government in Response to COVID-19 Pandemic

Service providers gave their views on the government response to COVID-19 pandemic. This was conducted using Likert Scale on the basis of a five-point scale as follows: (1=Very Poor; 2=Poor; 3=; 4=Good; and 5= Very Good). For the purpose of the present analysis, the five-point rating scale has been merged into three scales: 'Poor'; 'Neither good nor Poor' and 'Good'.

Overall, the majority of the service providers (58%) rated the activities of the Government in response to the pandemic as 'average' ('neither good nor poor') and only about a quarter of the them (23%) rated the activities of the Government as "good". Comparatively, a higher percentage of service providers of Sudurpaschim Province (38%) and Karnali Province (31%) rated the government's activities in response to the pandemic as "good". On the other hand, the percentage of service providers rating the Government activities as "poor" was the highest in Province 2 (30%), followed by Province 1 (26%) (Figure 2.10).

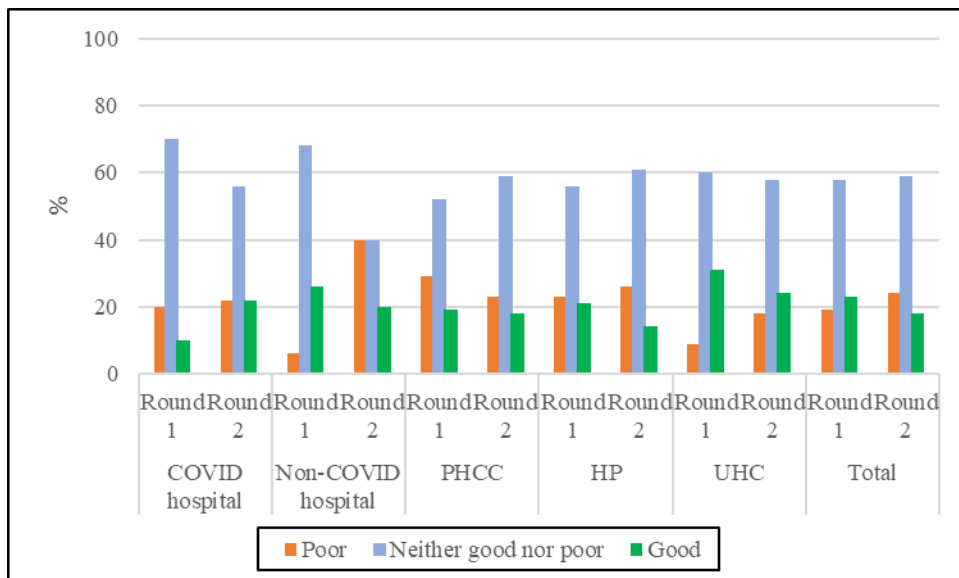
In Round 2, a higher percentage of service providers of Sudurpaschim Province (50%) rated the government's activities in response to COVID 19 as "good". Those service providers rating the government's activities as "poor" was highest in Province 1 (44%) followed by Province 2 (40%) (Figure 2.10).

Figure 2.10 Province-wise service providers' rating of the activities of the government in response to COVID-19 pandemic in Round 1 and Round 2 Assessment



As shown in Figure 2.11 below, service providers' rating of the activities of the government varied according to the levels of the health facility they served. Relatively, a higher percentage of those serving at UHCs (31%) and non-COVID hospitals (26%) rated the government activities as "good" in Round 1. Whereas approximately every third service provider based at PHCC (29%) rated the government activities as "poor". On the other hand, the large majority of the service providers from COVID hospitals (70%) and non-COVID hospitals (68%) rated the government activities as 'average'.

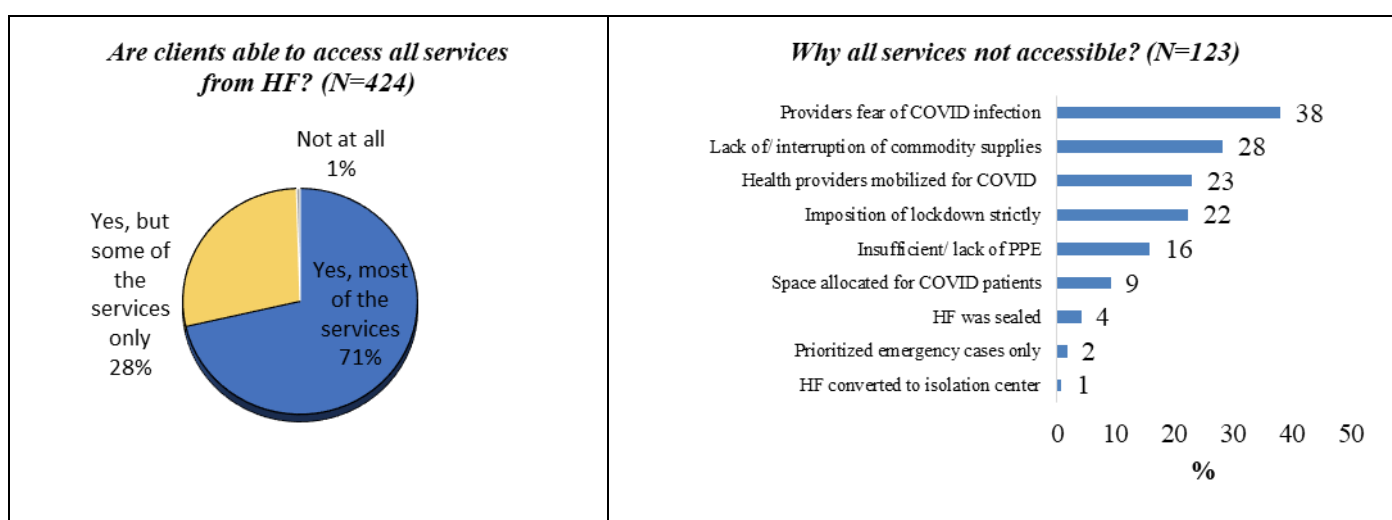
Figure 2.11 Health facility-wise rating of the activities of the government in response to COVID-19 pandemic in Round 1 and Round 2 Assessment



In Round 2, the overall percentages of HFs categorizing government’s activities as “good” dwindled to 18 from 23 percent. Facility wise decline in the percentage of service providers rating the government response as “good” declined by between 1 percent to 7 percent except at COVID hospitals where the percentage increased by more than two folds (from 10 to 22%). (Figure 2.11)

In both the rounds of assessment, all FCHVs (424) were asked to share their impression regarding clients’ ability to access services from the health facilities nearest to them during the lockdown period. The large majority of them (71%) responded affirmatively saying that clients were able to access most of the health services from health facilities located at their vicinities during the five months lockdown period. Only about a quarter of the FCHVs said that the clients were able to access some services from a health facility during the lockdowns. Fear of contracting COVID-19 from clients to the providers (38%), lack of/interruptions of commodity supplies (28%), mobilization of health providers for COVID-19 testing & treatment (23%) and imposition of lockdowns strictly (22%) were the main reasons cited by the FCHVs for client’s limited access to health services in Round 1. In addition, 16 percent of the FCHVs perceived that the lack of or insufficient supply of PPE at the health facility hampered clients’ access (Figure 2.12).

Figure 2.12 Clients’ ability to access health services from a nearby health facility during 5 months’ lockdown period: FCHVs’ Perspectives in Round 1 Assessment



Similar to the Round 1 assessment, the large majority of FCHVs (87%) in Round 2 stated that their clients were able to access most of the health services from the nearby located health facilities during the three months’ period. Meanwhile, the remaining FCHVs mentioned that clients were able to access only some of the services during the three months’ period. Unlike in Round 1, there were no FCHVs reporting non-provision on services during the period.

In Province 2, Karnali province and Sudurpaschim province, all (100%) FCHVs reported that clients were able to receive most of the services from the nearby health facility. FCHVs from Province 1 (22%) and Gandaki province (27%) reported that clients were only able to receive some of the services during the three months’ period.

2.6 FCHVs' Knowledge about Mode of transmission and Symptoms of COVID-19

Knowledge about mode of transmission of COVID-19 as well as symptoms of its infection was very high among the FCHVs interviewed. The two most frequently cited responses regarding mode of transmission were: physical contact/touching (82%) and through sneezing/coughing (81%). In addition, more than half of the FCHVs reported that the disease could also spread through the items used by the infected person.

Likewise, an overwhelming large majority of the FCHVs identified fever or chills (98%) and dry cough (78%) as signs/symptoms of COVID-19 infections. Over half of the FCHVs also cited 'shortness of breath/difficulty in breathing' (56%) and headache (53%) as COVID symptoms. A negligible percentage of the FCHVs (1%) did not cite any symptom (Table 2.1).

In Round 2, there has been conspicuous increase in the percentages of FCHVs' having knowledge on mode of transmission and symptoms of COVID-19 infection. The most frequently cited reason for modes of transmission was physical contact and touching (91%) followed by sneezing/coughing (86%). Similarly, large majority of FCHVs were also aware regarding the symptoms of COVID-19 with the most commonly cited symptoms being fever/chills (96%) followed by dry cough (86%) (Table 2.1).

Province wise, the highest awareness regarding transmission of COVID-19 by physical contact was in province 1 (96%) followed by province 2 (95%). All FCHVs (100%) from Karnali province were aware that COVID-19 was transmitted by sneezing and coughing. Only 41 percent of FCHV from Lumbini province stated that COVID-19 could be transmitted through items used by infected person (Annex 2.5).

Table 2.1 Percentage distribution of FCHVs according to their knowledge on mode of transmission and symptoms of COVID-19 infection: Round 1 and Round 2 Assessment

Modes of COVID-19 transmission	Round 1	Round 2
Physical contact / touching	81.8	91.4
Items used by infected person	56.8	63.6
Sneezing / coughing	80.9	85.7
Other modes	13.9	9.2
Symptoms of COVID-19 Infections	%	
Fever or chills	97.9	95.7
Dry cough	78.1	72.9
Fatigue/ Tiredness	16.5	27.9
Muscles or body aches	17.0	35.0
Headache	52.8	66.4
Shortness of breath or difficulty breathing	56.4	66.4
Sore throat	39.2	56.4
Loss of taste or smell	6.8	25.0
Congestion or running nose	48.1	52.1
Nausea or vomiting	9.4	14.3
Diarrhea	11.3	8.6
Other	2.3	-
Don't know	1.2	-
Total N =	424	140

Percentages total may have exceeded 100 due to multiple responses

2.7 FCHVs' Abilities to Perform Regular Tasks

The ability of FCHVs to perform their regular tasks during the five months lockdown period was solicited by the study. In all, 16 tasks pertaining to RMNCAH services were listed and for each task, FCHVs were asked to mention whether they were able to '*provide the task all the time during lockdown period*'; '*halted the task initially but resumed later*' or '*halted and not resumed yet*'.

As evident from Table 2.2, the large majority of the FCHV (75-97%) reported that they continued to perform their 13 out of 16 tasks all the time during the lockdown period. However, the majority of the FCHVs reported that 'distribution of CHS gel "Naavi Malam" (74%)' and Cotrim/Amoxicillin tabs' (69%) did not fall under their task. In addition, nearly a third to a sixth of the FCHVs stated that conducting pregnancy tests (32%) and referrals of clients for safe abortion service (SAS) (19%) were not usually done by them.

Approximately one-sixth to one-tenth of the FCHVs reported that they had to halt some of their tasks such as promotion/motivation of parents for childhood immunization (17%) and distribution of Vitamin A (13%), Albendazole (11%) and condoms and oral pills (9%) at initial period of lockdowns and then resumed later (Table 2.2).

Province wise distribution shows there was some interruption in distribution of oral pills and condom by 43 percent of FCHVs in Province 2 during 5 months of lockdown, while this interruption occurred in less than 20 percent of FCHVs in other provinces (Annex 2.7).

Table 2.2 FCHVs ability to perform the assigned tasks during the lockdown period (Round 1 and Round 2 Assessment)

Tasks	Provide all time		Halted initial but resumed later		Halted and not resumed yet		Not included in my task/ not usually sought service from me	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Referral for ANC/PNC care during lockdown period	96.5	98.6	2.8	-	-	-	0.7	1.4
Referred for institutional delivery during lockdown period	96.2	95.7	2.1	-	0.2	0.7	1.4	3.6
Referred of new FP clients during lockdown period	93.4	98.6	4.7	-	0.9		0.9	1.4
Promotion/counseling couples for FP use during lockdown period	91.0	100.0	8.0	-	0.7		0.2	0
Referral for danger signs as per IMNCI protocol during lockdown period	90.8	91.4	2.8	-	0.2	0.7	6.1	7.9
Counseling on other health, nutrition and WASH during lockdown period	89.9	95.0	3.5	-	0.2	5.0	6.4	0
Distributed Albendazole during lockdown period	88.2	80.0	10.8	1.4	0	10.0	0.9	8.6
Distributed Vitamin A during lockdown	87.0	68.6	12.5	1.4	0.5	15.0	0	15.0
Referral for LARC service during lockdown period	85.4	85.0	5.2	-	1.7	1.4	7.8	13.6
Distributed Zinc tab and ORS during lockdown period	84.9	88.6	4.7	-	4.2	7.1	6.1	4.3
Promotion/ motivation for childhood immunization during lockdown period	82.8	99.3	16.7	1.4	0.2	0	0.2	0
Distributed condoms and oral pills during lockdown period	81.4	86.4	9.2	1.4	4.2	5.7	5.2	5.7
Referral for safe abortion care during lockdown period	76.9	74.3	3.1	-	1.4	0.7	18.6	25.0
Did pregnancy testing during lockdown period	59.9	40.0	4.5	-	4.0	12.1	31.6	47.9
Distribution of CHS gel (Naavi Malam) during lockdown period	23.3	23.6	1.7	-	6.4	17.1	68.6	59.3
Distribution of Cotrim/ Amoxicillin tabs during lockdown period	13.7	5.7	2.1	-	10.1	22.9	74.1	71.4

In Round 2, a large majority of FCHVs (74-100%) reported that they were able to perform 13 out of 16 amenities pertaining to RMNCAH service during the three months' period. All FCHVs (100%) were able to provide family planning promotion and counselling during the period. Similar to Round 1, majority of FCHVs reported that distribution of CHS gel "Naavi Malam" (59%), Cotrim/Amoxicillin tablets (71%) and pregnancy testing (50%) did not fall under their tasks. FCHVs also reported that services like Distribution of Cotrim/amoxicillin tablets (23%), distribution of CHS gel (17%), distribution of vitamin A (15%) and pregnancy testing services had been halted and not resumed yet (Table 2.2)

The mode of contacting clients by FCHVs during the lockdown period was mostly through personal visits and by phones. Nearly all FCHVs (91%) mentioned saying that they visited the clients at their homes during the lockdown period. Another half of them also said that they contacted their clients through phones (51%). (Table not shown).

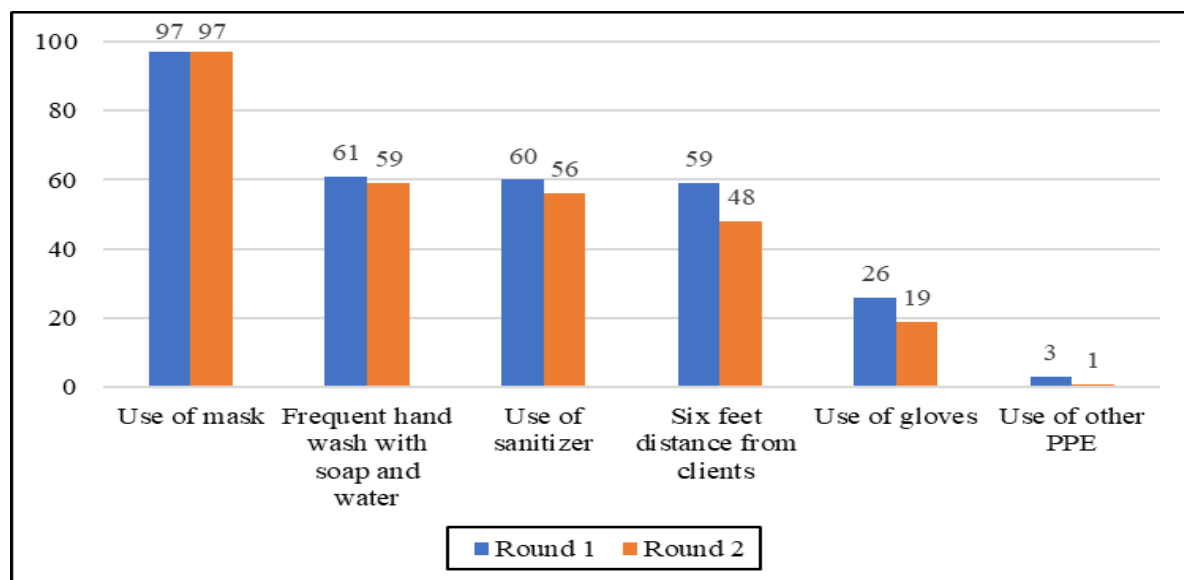
When asked about the range of precautionary measures adopted by FCHVs when they meet their clients, nearly all said that they use masks (97%). Adoptions of other essential precautions such as social distancing i.e. keeping six feet apart from the clients (60%), frequently washing hands with soap and water (59%) and use of sanitizer (61%) were not commonly practiced among the FCHVs. Moreover, only about a quarter of the FCHVs used hand gloves at the time of meeting the clients (Figure 2.14).

All the FCHVs in Karnali Province and Sudurpaschim Province used masks while meeting their clients and more than 90 percent of FCHVs in other provinces used masks. Use of gloves was least by FCHVs (3%) in Karnali province. Frequent hand washing, use of sanitizer and maintenance of 2 meters of physical distance was least by FCHVs in Sudurpaschim province (Annex 2.8).

FCHVs were reassessed regarding precautionary measures adopted by them while meeting clients in Round 2. Similar to Round 1, nearly all FCHVs reported regarding use of masks (97%). However, adoption of other precautionary measures such as frequent hand wash (59%), use of sanitizers (56%), maintaining physical distance (48%) and use of gloves (19%) were not commonly practiced (Figure 2.13).

All (100%) FCHVs from province 2, Lumbini province, Karnali province and Sudurpaschim province reported using masks while attending clients. Use of sanitizers was highest in Bagmati province (70%) followed by Sudurpaschim province (69%). Use of other PPE items was found among FCHVs only in province 2 and Karnali province (9%). Frequent hand wash was practiced most by FCHVs in Karnali province (91%) and the least in Gandaki province (22%) (Annex 2.8).

Figure 2.13 Precautionary measures adopted by FCHVs at the time of meeting clients: Round 1 and Round 2 Assessment



2.8 Clients' Knowledge about Precautionary Measures against COVID-19

In all, 479 clients (455 female and 24 male) who had received RMNCAH related information and services at the sampled health facilities were interviewed. As evident from Table 2.3, nearly all clients (96%) were aware of the precautionary measures to protect oneself from COVID-19.

Almost all clients mentioned 'wearing mask always' (92%) and regular washing of hands with soaps or with alcohol-based hand-rubs (76%) as precautionary measures. In addition, more than half of the clients (55%) cited physical distancing (2 meters or 6 feet apart) and avoiding crowded places and hand-shakes (50%).

More than 90 percent of clients in all provinces except Bagmati and Gandaki Province mentioned wearing a mask as one of the precautionary measures. Almost all clients in Karnali province mentioned wearing a mask (100%), regular hand washing (97%) and maintaining 2 meters of physical distancing (97%) as precautionary measures (Annex 2.9)

The three main sources of knowledge about the precautionary measures as reported by the clients consisted of television (68%); radio (56%) and through phones/caller tune (48%) (Table not shown).

A total of 191 clients who had received RMNCAH related services were interviewed in Round 2. Majority (96%) of clients were aware about had using masks as a precaution against COVID-19 while around three quarters of them were aware regarding frequent hand washing as a precaution against COVID-19. Around half of the clients were aware regarding avoiding crowded places and maintaining two meters' distance as a precaution against COVID-19.

All (100%) clients from Karnali province and Sudurpaschim provinces who were aware about precautionary measures against COVID-19 had knowledge regarding using masks to

prevent oneself from COVID-19 infection. The highest awareness in terms of frequent hand wash was found among clients in Bagmati province (97%) followed by Gandaki province (85%). The lowest awareness in terms of maintaining physical distance was in Karnali province (86%) followed by Gandaki Province (73.1%) (Annex 2.9)

Table 2.3 Clients’ knowledge about precautionary measures against COVID-19: Round 1 and Round 2 Assessment

Precautionary measures	Round 1	Round 2
Wearing mask always	92.2	96.1
Regularly and thoroughly washing hands with an alcohol-based hand rub or with soap and water	75.6	74.5
Maintaining 2 meters (6 feet) distance between myself and others	54.9	56.9
Avoiding crowded places and handshake	49.7	50.8
Avoiding touching eyes, nose and mouth	10.5	8.8
Staying home	10.9	13.2
Eat healthy, nutritional food, liquid items and drink hot water	1.7	0.5
Change dress and bath after coming from outside	0.9	-
Maintain sanitization	1.3	-
Total	459	181

Percentage total may have exceeded 100 due to multiple responses

2.9 Clients’ Perspectives on Precautionary Measures adopted by Health Providers

All clients were asked about the types of precautionary measures adopted by the health providers while attending them at the health facility. According to the clients reporting in both the rounds, almost all health providers had used face masks (98%) and more than half had used hand sanitizers (58% in Round 1 and 65% in Round 2). However, the percentages of clients reporting about using hand gloves by service providers decreased significantly from 54 percent in Round 1 to 39 percent in Round 2. Use of other PPE items and maintenance of physical distancing by the health providers was also less adhered to according to the clients interviewed in both the rounds. (Table 2.4)

Table 2.4 Clients’ perspective on the precautionary measures used by health providers while attending clients: Round 1 and Round 2 Assessment

Precautionary measures used by health providers	Round 1	Round 2
Used mask	97.9	98.4
Washed hands with soap and water	25.1	28.2
Sanitized hands	57.8	65.4
Used gloves	53.9	38.8
Used special cover-all	14.8	10.1
Kept six feet apart from other patients/ visitors	12.3	3.2
Used cap	8.8	3.7
Used face shield	7.5	8.5
Did not use any precautionary measure	0.2	-
Did not see the service provider	0.6	0.5
Total N =	479	188

Percentage total may have exceeded 100 due to multiple responses

Province wise distribution indicates that all the health service providers in Lumbini, Karnali and Sudurpaschim provinces used masks while attending the clients. Only one provider in Bagmati province had not use any precautionary measures. More than half of the service providers across all provinces did not wash hands. A very low percentage service providers in Lumbini province (10%) was observed washing hands. Maintenance of physical distancing of six feet was ignored at most of the HFs of 7 provinces (Annex: 2.11)

In Karnali province, all (100%) clients stated that hand sanitizing was practiced by service provider while attending the clients. The use of gloves was reported to be highest in Bagmati province (70%) followed by Gandaki province (57%). Use of face shields was found to be low with less than 15 percent of service providers across all provinces using face shields while attending clients (Annex 2.11).

All the health service providers in COVID hospital used masks while attending patients while more than 95 percent of health service providers in other facilities used masks. More than 70 percent of health service providers across all levels of facilities had skipped hand washing. Sanitizer use was observed in more than half of the health service providers across all levels of facilities excepting UHCs. Maintenance of physical distancing of six feet was reported in one sixth of the UHCs (18%) (Annex: 2.12).

Use of sanitizers was highest in COVID hospitals (91%) followed by UHCs (77%) and PHCCs (74%). Use of gloves was found to be highest in non-COVID hospitals (71%) as compared to any other health facility type (Annex 2.12).

Chapter 3

Functionality and Utilization of Maternal Health Service

All the 424 sampled health facilities were accredited for providing antenatal (ANC) and post-natal (PNC) services, while 209 health facilities were accredited for providing institutional delivery services. Only 32 out of 41 hospitals in the sample were accredited for performing caesarean section deliveries.

This chapter discusses the functionality and utilization of these maternal health services particularly, during Round 1 and Round 2. Reasons for increase or decrease in clients seeking maternal health services during the lockdown period and monthly trends of specific maternal services (ANC, Institutional delivery, C-Section and PNC) are also discussed. Trend analysis comparing the data on utilization of maternal health services during the five months' lockdown period with the data of the corresponding period of the previous year is also presented.

FCHVs' perspectives on accessibility, functionality and utilization of maternal health services are also discussed in this chapter.

3.1 Antenatal Care

3.1.1 Functionality of ANC Services

More than three quarters (76%) of the health facilities had been providing ANC services to clients without any disruption during the lockdown period while only around 20 percent of the facilities had ANC service disrupted initially but could resumed later. A negligible number of health facilities (1%) had halted the ANC service throughout the 5 months of lockdown period (Table 3.1).

Most of the ANC services at health facilities of Bagmati (85%) and Karnali (84%) provinces were functional and without any disruption during the lockdown period. In Province 1, more than a third (35%) of the health facilities had halted ANC services in the initial phase of the lockdown period but later resumed their services.

Health facility-wise, there was no disruption of ANC services at most of the PHCCs (86%) and HPs (78%). On the contrary, 40 percent of COVID designated hospitals had to halt the ANC services during initial period of the lockdown due to the need to allocate human resources and hospital spaces for isolation and treatment of COVID 19 patients. The service was resumed at later period, however. ANC services was non-functional in nine percent of UHCs while a fifth of the UHC had their ANC services disrupted.

The major barriers for service provision as reported by the service providers in Round 1 were fear of COVID infection among health service providers and mobilization of health service providers for COVID-19 testing and treatment.

In Round 2, most (87%) of the facilities provided ANC service without interruption, while the service was halted in 9 percent of facilities which was resumed later on. Service in one facility had not been resumed yet. Province wise comparison shows there was no interruption

in ANC service during Round 2 in Karnali and Sudurpaschim Province. ANC service in one health facility in Bagmati Province has not been resumed yet. The ANC service in one PHCC was halted and not yet resumed.

Table 3.1 Province wise functionality of ANC services during Round 1 Assessment

ANC Services	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpaschim Province	Total
Provided service at all times without interruption	65.2	80.0	84.8	78.2	67.6	84.4	77.1	76.4
Halted initially but resumed	34.8	18.3	10.9	10.9	29.4	9.40	18.8	19.6
Halted and not resumed yet	-	1.7	1.1	-	2.9	-	-	0.9
Nonfunctional before lockdown	-	-	3.3	10.9	-	6.3	4.2	3.1
Total (N)	69	60	92	55	68	32	48	424

Table 3.2 Facility wise functionality of ANC services during Round 1 Assessment

ANC Services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Provided services at all times without interruption	60.0	71.0	86.2	78.1	70.9	76.4
Halted initially but resumed	40.0	29.0	13.8	18.9	19.7	19.6
Halted and not resumed yet	-	-	-	2.0	-	0.9
Non-functional before lockdown	-	-	-	1.0	9.4	3.1
Total (N)	10	31	65	201	117	424

3.1.2 Extent of utilization of ANC during COVID-19 lockdown period

Highest decrease in ANC clients occurred in the month of Chaitra with 35 percent of health service providers reporting decrease in ANC clients on that month. The highest increase in ANC clients was reported three months later i.e. in the months of Asadh and Shrawan (38%). The major reasons for increase in clients seeking ANC service was cited as an increase in the number of pregnancies during the lockdown period. Other reasons for increase were denial of service from nearby facilities and increase in referral of ANC clients from other health facilities (Table 3.3).

Table 3.3 Reasons for increase, decrease and halt of ANC services by Facility in Round 1

	COVID hospital	Non- COVID Hospital	PHCC	HP	UHC	Total
Reasons for Increase						
Increase in number of pregnant women	33.3	58.8	69.0	65.8	55.8	62.2
Due to denial of service from nearby health facility	33.3	52.9	20.7	17.7	25.0	23.9
Increase in referral of pregnant women to this facility	100.0	47.1	27.6	15.2	11.5	20.6
Unable to travel to other HF due to lockdown	-	5.9	6.9	11.4	11.5	10.0
Total (n)	3	17	29	79	52	180
Reasons for Decrease						
Fear of infection among clients	100.0	78.6	64.5	74.7	66.7	72.6
Social restrictions due to COVID-19	71.4	57.1	58.1	58.6	58.3	58.9
Fear of infection among providers	42.9	14.3	32.3	37.9	30.6	33.7
Lack of transportation	85.7	28.6	45.2	23.0	25.0	30.3
Non-availability of service provider	14.3	-	16.1	8.0	-	7.4
Total (n)	7	14	31	87	36	175

Percentage total may have exceeded 100 due to multiple responses

Two-fifths (41%) of the health providers reported that there was a decline in utilization of ANC services during the 5 months' lockdown period. Highest decline was occurred in the month of Chaitra (35%) and lowest decline in the month of Shrawan (15%) (Figure 3.1). Fear of infection among clients and social restrictions due to COVID-19 were cited as the major reasons for decline in ANC clients during the lockdown period. ANC service in few (2%) health facilities was halted over the 5 months' lockdown period due to COVID-19 pandemic lockdowns.

Province-wise comparison shows, the highest (53%) increase in flow of ANC clients was reported in Gandaki Province in the month of Baisakh while the highest (63%) decline was reported in Province 2 in the same month (Baisakh) (Annex 3.1).

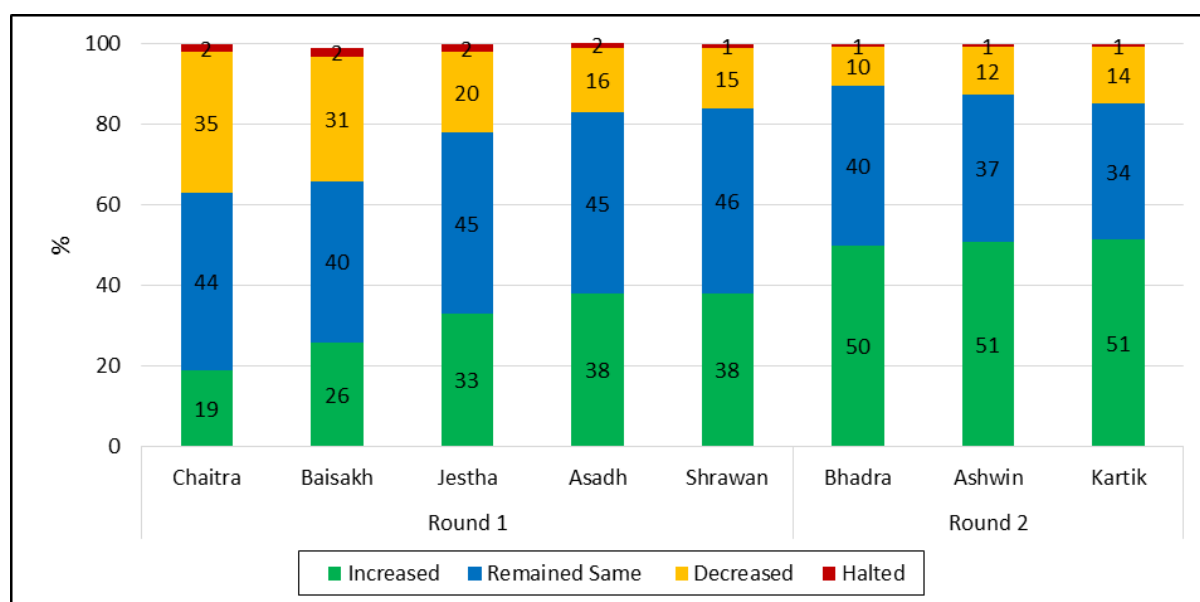
A gradual increase in the number of service providers reporting an increase in utilization of ANC services occurred between the Chaitra (Round 1) and Kartik (Round 2). An average of 12 percent service providers reported decline in flow of ANC clients between during the three months' period. As compared to the 5 month's lockdown period, the number of service providers reporting halt in ANC service declined from an average of two percent to one percent implying that ANC services (Figure 3.1)

In terms of province, only Bagmati province reported halt in utilization of ANC services between Bhadra and Kartik. The highest decline in utilization of ANC services also occurred in Bagmati province with an average of 31 percent service providers reporting decline in utilization of ANC services between Bhadra and Kartik. Highest increase in flow of clients seeking ANC services was reported in province 2 and Lumbini province in the months and

Bhadra and Ashwin and in province 1, province 2 and Lumbini province in the month of Kartik. (Annex 3.1a).

Round 2 Assessment further showed that the utilization of ANC services was highest in COVID hospitals in the month of Bhadra with 80 percent of service providers reporting a surge in clients seeking ANC services while in the months of Ashwin and Kartik non-COVID hospitals reported the highest (80%) increase in flow of clients seeking ANC care in the months of Ashwin and Kartik. Non-COVID hospitals also reported no decline in flow of clients seeking ANC services during the three months' period. Halt in utilization of ANC services was only reported in UHCs over the three months' period (Annex 3.2a).

Figure 3.1 Extent of utilization of ANC services during Round 1 and Round 2 Assessment



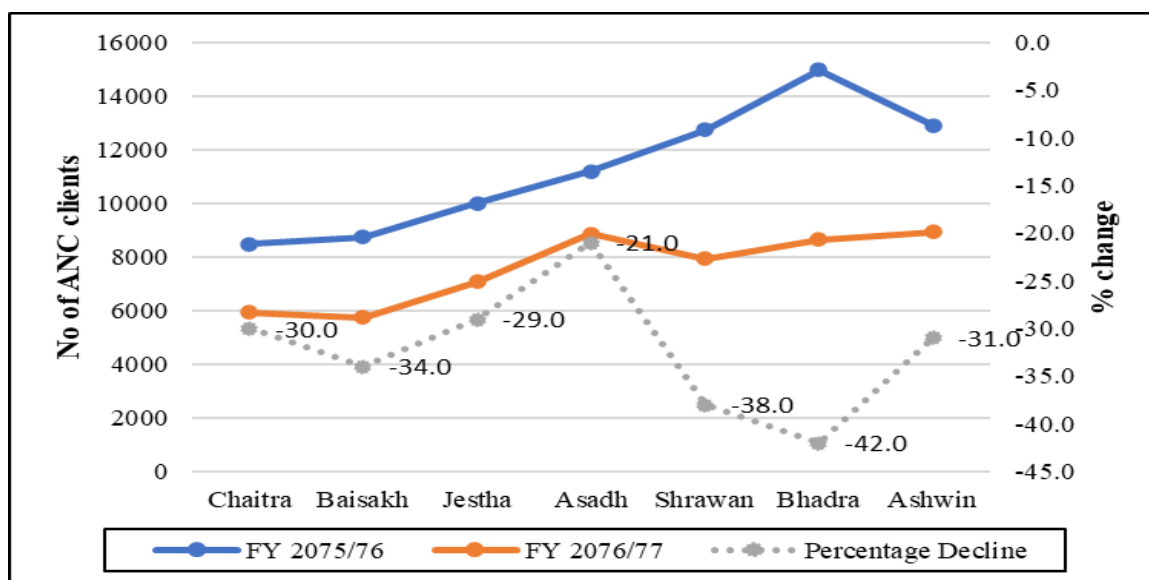
3.1.3 Trends in ANC clients' Flow

There has been an overall decline of 30 percent in utilization of ANC services across all provinces during the five months of lockdown period as compared to the corresponding period of the previous year. The highest decline occurred in Province 1 with an average decline of 60 percent over the lockdown period. Utilization of ANC services was slightly higher only in Province 2 in the month of Baisakh (1.1%) and Asadh (4.9%) and in Sudurpaschim province in the month of Jestha. The lowest decline was seen in Sudurpaschim province with an average decline of 6 percent over the lockdown period.

The overall decline in utilization of ANC services continued for two months' post lockdown i.e. Bhadra and Ashwin. The utilization of ANC services increased in Sudurpaschim period during Bhadra and Ashwin. The highest decline in ANC service was still evident in Province 1. (Annex 3.3)¹

¹ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

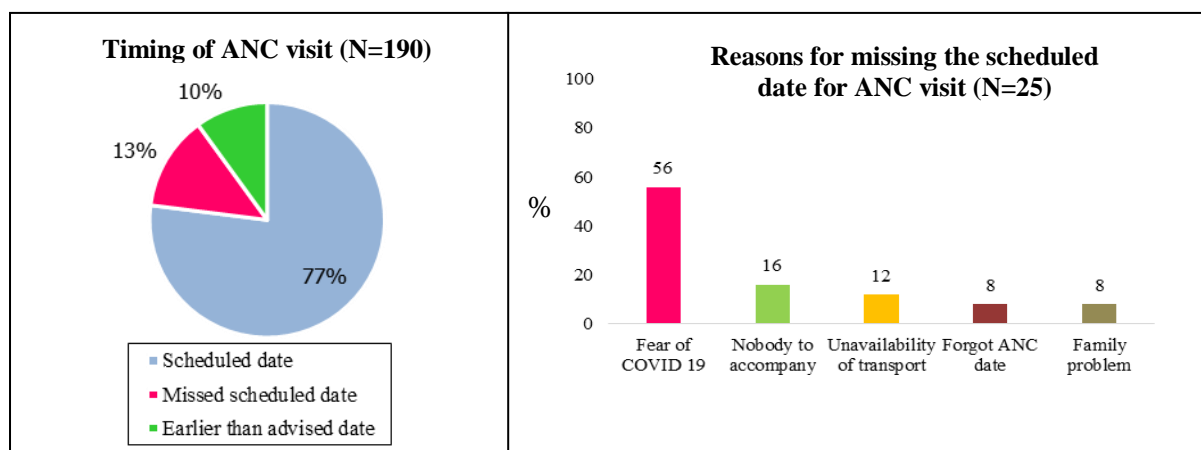
Figure 3.2 Trend in utilization of ANC services



3.1.4 Timing of ANC visits and reasons for missing the scheduled date for ANC visits

Over three quarters (77%) of clients reported that they had come for their ANC visit as per their scheduled date. Only 13 percent of the clients reported that they had missed the scheduled date of ANC visit. The most cited reason for missing the scheduled date was fear of COVID-19 infection. Other reasons were, ‘no one to accompany the client to the health facility’ and ‘unavailability of transportation’ among others (Figure 3.3).

Figure 3.3 Timing of ANC visits and reasons for missing out the scheduled date for ANC visit during Round 1 Assessment



The timing of seeking routine ANC during Round 2 was similar to Round 1. For instance, of the 60 clients who had sought ANC care at the HFs during the facility observation, 78 percent (77% in Round 1) had come as per their scheduled dates. Only 12 percent of them reported of missing their scheduled date (13% in Round 1). The most cited reason for missing the

scheduled date in this round was fear of COVID 19 infections (29%) and busy with household work (29%) (Table not shown).

3.2 Institutional Delivery

3.2.1 Functionality of Institutional Delivery Services

Large majority (86%) of the health facilities were able to provide delivery services without interruption. Only 9 percent of the facilities reported about interruption of the service for during the initial period of lockdown and had resumed subsequently.

Province-wise comparison shows, delivery services at health facilities of Karnali and Sudurpaschim provinces experienced least interruptions, with over 95 percent health facilities reporting continues or uninterrupted provision of the delivery services during the lockdown period (Table 3.4). In Province 2, roughly one in five health facilities had their delivery services interrupted during the initial period.

Very few health facilities, particularly, HP (7%) and UHC (9%) were non-functional even before the lockdown period. However, institutional delivery services were also least interrupted in UHCs and health posts with 91 percent UHCs and 87 percent health posts reporting that institutional delivery services were provided without interruption during the lockdown period. The most interruption occurred in COVID hospitals with almost a third of COVID hospitals (30%) halting the delivery service during the initial period of the lockdown due to the need to provide spaces to accommodate COVID patients (Table 3.5).

Of the total 140 HF's covered in Round 2, 65 HF's were accredited for institutional delivery. The service at one health facility was not functional even before COVID 19. About 88 percent of the facilities were able to provide the institutional delivery service without interruption during the three months' period which is a slight improvement from Round 1. Service in four facilities was halted for some time which was resumed later on. The service in three facilities had not resumed yet. Province wise comparison shows there was no interruption in institutional delivery service during three months' period in Lumbini, Karnali and Sudurpaschim Province. One health facility in Bagmati and two health facilities in Gandaki Province had not yet resumed the service. The institutional delivery service in one PHCC and two health posts was halted and had not resumed yet.

Table 3.4 Province wise functionality of Institutional Delivery services during Round 1 Assessment

Institutional Delivery	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpaschim Province	Total
Provided service at all times without interruption	80.0	76.2	88.6	76.9	81.5	95.8	95.1	85.6
Halted initially but resumed	11.4	19.0	5.7	11.5	14.8	4.2	2.4	9.1
Halted and not resumed yet	-	-	2.9	3.8	3.7	-	-	1.4
Nonfunctional before lockdown	8.6	4.8	2.9	7.7	-	-	2.4	3.8
Total (N)	35	21	35	26	27	24	41	209

Table 3.5 Facility wise functionality of Institutional Delivery services during Round 1 Assessment

Institutional Delivery	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Provided services at all times without interruption	70.0	87.1	83.6	87.5	90.9	85.6
Halted initially but resumed	30.0	12.9	13.1	4.2	-	9.1
Halted and not resumed yet	-	-	3.3	1.0	-	1.4
Non-functional before lockdown	-	-	-	7.3	9.1	3.8
Total (N)	10	31	61	96	11	209

3.2.2 Extent of Utilization of Institutional Delivery Services during the lockdown period

Overall, 60 percent of service providers from 209 accredited facilities reported that the flow of clients seeking institutional delivery services remained unchanged during the lockdown period. An overall increase of 20% clients seeking institutional delivery was reported between the months of Chaitra (13%) and Shrawan (33%) as compared to five months' period prior to the lockdown (Figure 3.4). The major reasons for increase were cited as 'increase in referral of clients' and 'denial of service' at nearby birthing centers.

Only fifteen percent of the service providers reported a decline of clients seeking delivery services throughout the lockdown period. The highest decline in clients was reported in the month of Baisakh (20%) and the lowest in the month of Shrawan (11%). The major reasons for the decline as cited by the service providers were 'fear of infection among clients' (63%) and 'the need to observe social restrictions due to COVID 19 pandemic' (44%) and lack of transportation facilities during lockdown (35%). About a quarter of the service providers (23%) also said that providers themselves did not entertain delivery cases for fear of contracting the coronavirus (Table 3.6).

The highest (58%) increase in utilization of institutional delivery was reported in Bagmati province in the month of Asadh while the highest decrease was reported in Karnali province in the month of Chaitra. (Annex 3.4)

Round 2 data showed, the number of service providers reporting an increase in flow of clients seeking institutional delivery services increased from 38 percent in Bhadra to 41 percent in Ashwin and Kartik. The highest decrease in flow of clients seeking institutional delivery services was reported in the month of Kartik with 15 percent of service providers reporting a decrease in utilization of institutional delivery services. Unlike in Round 1, there were no service providers reporting halting of institutional delivery services during the period between Bhadra and Ashwin (Figure 3.4).

All (100%) of service providers in Round 2 Assessment reported about increase in utilization of institutional delivery services in province 2 during the period between Bhadra and Kartik. The highest decrease in utilization of institutional delivery services was reported in Gandaki province with 50 percent of service providers reporting decrease in the month of Bhadra and

Ashwin and 65 percent of service providers reporting decrease in the month of Kartik (Annex 3.4a).

Non-COVID hospitals reported the highest increase in clients seeking institutional delivery services with 60 percent of service providers reporting increase in utilization of institutional delivery services during the three months' period. Only 20 percent of service providers from COVID hospitals reported an increase in flow of clients seeking institutional delivery services during the three months' period while the highest decline of 33 percent in utilization of institutional delivery services was also reported among COVID hospitals as compared to any other health facility type. Only UHCs reported a halt in utilization of institutional delivery services during the three months' period (Annex 3.5a)

Figure 3.4 Utilization of institutional delivery services during Round 1 and Round 2 Assessment

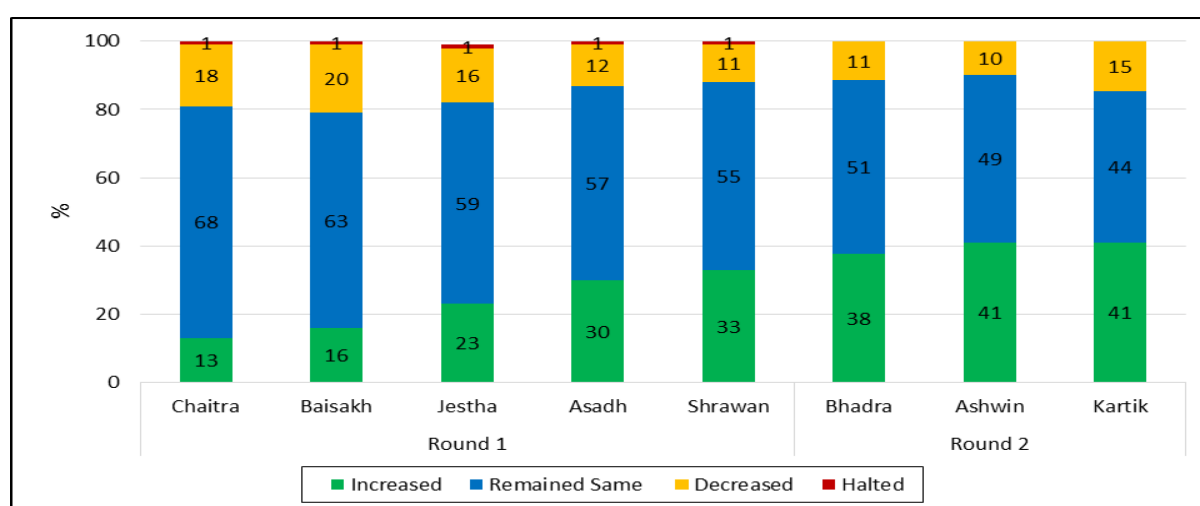


Table 3.6 Reasons for increase, decrease and halting of Institutional Delivery Services: Round 1 Assessment

	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Reasons for increase						
Increase in referral of clients	100.0	66.7	66.7	26.3	50.0	55.7
Due to denial of service from nearby health facility	66.7	71.4	57.1	21.1	-	47.1
Clients afraid to go to other health facilities	-	14.3	28.6	15.8	-	17.1
Fear of worsening of COVID-19 infection	-	-	14.3	26.3	-	11.4
Total (n)	3	21	21	19	6	70
Reasons for decrease						
Fear of infection among clients	100.0	25.0	78.3	50.0	100.0	63.5
Social restrictions due to COVID-19	100.0	25.0	56.5	31.8	-	44.2
Lack of transportation	50.0	75.0	34.8	27.3	-	34.6
Fear of infection among providers	-	25.0	26.1	22.7	-	23.1
clients gone to nearby higher health facility	-	50.0	8.7	4.5	-	9.6
Non availability of service provider	-	-	13.0	4.5	-	7.7
HF sealed	-	-	8.7	9.1	-	7.7
Total (n)	2	4	23	22	1	52

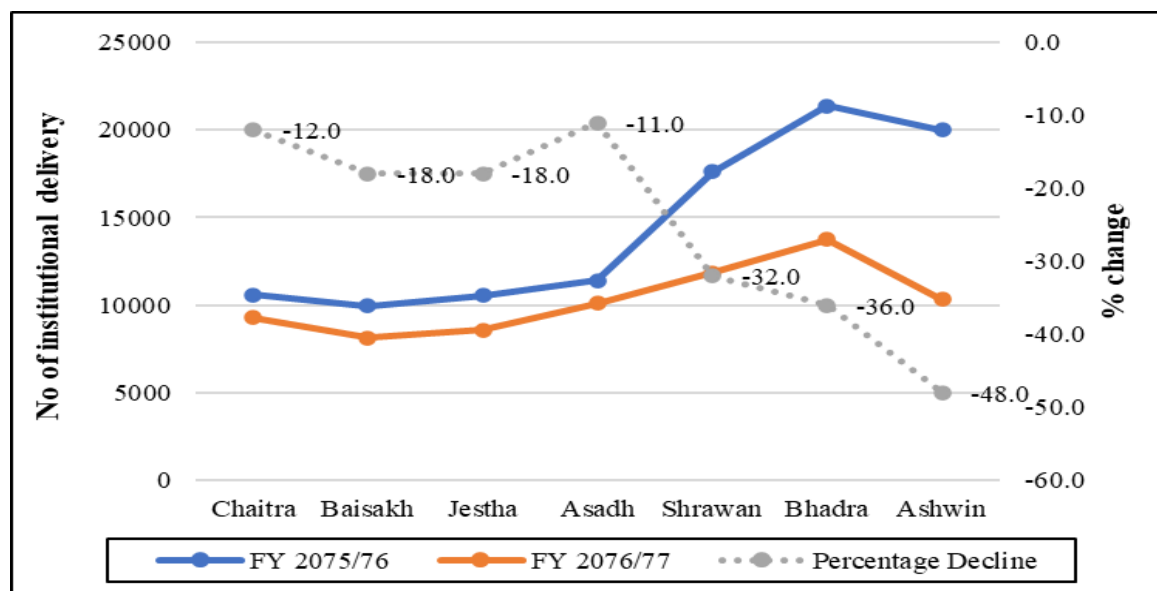
Percentage total may have exceeded 100 due to multiple responses

3.2.3 Trends in Client Flow for Institutional Delivery

There has been an overall 19 percent decline in utilization of institutional delivery services by expectant mothers during the COVID-19 lockdown period as compared to the same period of previous year. Utilization of institutional delivery services had decreased in all provinces except for Gandaki and Karnali provinces. Gandaki province, in particular, showed an increase in utilization of institutional delivery service in the month of Baisakh (6%), Jestha (16%) and Shrawan (17%) while Karnali province showed an increase in utilization of institutional delivery services in the month of Asadh (10%). The highest decline in utilization of institutional delivery services occurred in Province 1 and Province 2 with an overall decline of 27%.

The decline in utilization of institutional delivery services in two months' post lockdown in comparison to the same period last year was 42 percent in average. The increase in utilization of institutional delivery in Gandaki province and Sudurpaschim province was observed in the month of Bhadra while the utilization remained same in Gandaki province and decreased in Sudurpaschim province in corresponding month (Ashwin). The decline in utilization of institutional delivery in Bhadra and Ashwin was highest in Bagmati province with an average of 58 percent decline. (Annex 3.6)²

Figure 3.5 Trend analysis on utilization of Institutional Delivery services



3.2.4 FCHV's perception on utilization of Institutional Delivery services during the lockdown period

Utilization of institutional delivery services was reported to be high with 95 percent of FCHVs claiming that institutional delivery service was provided to clients during the

² The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

lockdown period (Table 3.7). However, FCHVs also reported instances of denial of institutional delivery services during the lockdown period. They reported that fear of COVID-19 transmission among providers, non-availability of service providers and non-availability of commodities as major reasons for denial of institutional delivery services to expectant mothers during the lockdown period (Table 3.8).

Table 3.7 FCHVs’ Perspectives on Institutional Delivery during the lockdown period: Round 1 Assessment

Institutional delivery service provision during lockdown	N	%
Yes	405	95.5
No	19	4.5
Total	424	100.0

Table 3.8 Reasons for non-admission of clients seeking Institutional Delivery services: Round 1 Assessment

Reasons for denial of institutional delivery	%
Fear of transmission of COVID-19 among providers	52.6
Non availability of service providers	26.3
Non availability of commodities	15.8
Social restrictions due to COVID-19	10.5
Lack of PPE	10.5
Health facility was converted into isolation center	10.5
PHC was sealed in that time	10.5
Don't know	5.3

Percentage total may exceed 100 due to multiple responses

3.2.5 Home delivery practice during the lockdown period

An average of 13 percent service providers believed that home deliveries have increased during the lockdown period (Figure 3.6). A higher proportion of the service providers of Province 2 mentioned about the increase in home deliveries during the five months of lockdown period (50-60%) while the service providers of Sudurpaschim Province reported a steady decline in home deliveries service utilization during the lockdown period (Annex 3.7).

Factors that heightened home deliveries during the lockdowns as perceptive by the majority of the service providers in Round 1 were: fear of coronavirus infection (77%), lack of transportation during lockdowns (55%) and the need to observe social restrictions during the lockdowns (40%) (Table 3.9).

Table 3.9 Reasons for increase in Home Deliveries: Service Providers’ perspectives

Reasons for Increase	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Fear of infection	100.0	33.3	100.0	72.7	81.3	77.1
Lack of transportation	50.0	50.0	53.3	61.4	43.8	55.4
Social restrictions due to COVID-19	100.0	33.3	33.3	38.6	43.8	39.8
Delivery service halted at the health facility	-	33.3	20.0	18.2	6.3	16.9
Fear of COVID-19 infection	-	-	6.7	-	12.5	3.6
Total (n)	2	6	15	44	16	83

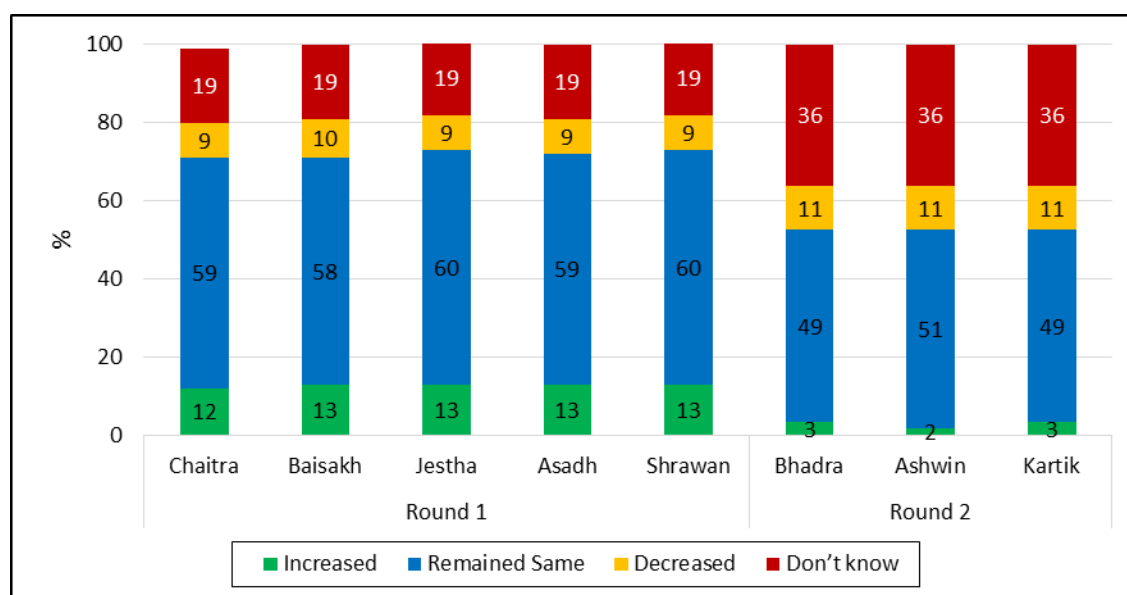
Percentage total may have exceeded 100 due to multiple responses

In Round 2, a negligible proportion of service providers (3%) reported about an increase in home deliveries (this percentage was 13 in Round 1). While, 36 percent of service providers claimed that they were unaware about any report of home deliveries during Bhadra and Kartik (Figure 3.6).

The highest decline in utilization of home deliveries was reported by service providers of Province 2 with 40 percent of service providers reporting decline in utilization of home delivery during **the period between Bhadra and Kartik. Majority (79%) of service providers from Sudurpaschim** province reported no change in utilization of home delivery services during the three months’ period (Annex 3.7a).

The highest (20%) increase in utilization of home deliveries was reported by service providers of non-COVID hospitals while no COVID hospitals reported an increase in home deliveries during the period between Bhadra and Kartik. All (100%) UHCs reported no change in utilization of home delivery service during the period (Annex 3.8a).

Figure 3.6 Home delivery practice during COVID-19 pandemic period: Service Providers’ perspectives services during Round 1 and Round 2 Assessment



3.2.6 Home Delivery practice during the lockdown period: FCHVs perspectives

Majority (82%) of the FCHVs stated there had been no reports of home delivery during the lockdown period while only 18 percent of them stated that they had been reported about home deliveries during the lockdown period (Table 3.10). FCHVs resonated with service providers' views such as lack of public transportation during lockdowns, fear of COVID transmission among clients and family members' reluctance to visit the health facility for an increase in home deliveries during the lockdown period (Table 3.11).

Table 3.10 Utilization of Home Delivery services during lockdown

Home delivery reported during lockdown	%
Yes	18.2
No	81.8
Total	424

Table 3.11 Reasons for Home Delivery services during lockdown

Reasons for home delivery	%
Lack of public transportation due to lockdown	44.2
Fear of transmission of COVID-19 among client	37.7
Family member are unwilling to visit HF due to COVID-19	20.8
Lack of money	15.6
Short labor pain (no time to go hospital)	15.6
Social restriction due to COVID-19	13.0
Non availability of service providers	9.1
Home delivery trend (no need to go hospital in normal case)	7.8
Premature birth	7.8
Hospital was sealed	2.6
Don't know	3.9

3.2.7 Provision of 'Aama' transport incentives to mothers of newborns

As per the Government's Safe Motherhood Programme (Aama Programme), it is mandatory for all health facilities/birthing centers to provide 'Aama' transport incentives to all mothers who have received delivery care at the birthing centers. The incentive is supposed to be handed over to a mother at the time of her discharge.

As shown in Table 3.12, more than half (55%) of the health facilities covered in Round 1 were able to provide 'Aama' transport incentives instantly to the mothers on discharge during the lockdown period while 44 percent reported of providing it at later dates. Highest number of health facilities in Gandaki Province (74%) and Lumbini Province (73%) provided the transportation incentive instantly whereas only 20 percent of facilities in Province 2 did so. Few health facilities in Province 1, 2 and Lumbini Province didn't provide the incentive at all. Most COVID hospitals (90%) and non-COVID hospitals (81%) were able to provide transport incentives instantly to the mothers of newborn during lockdown period. On the other hand, approximately half of PHCCs (48%) and health posts (51%) provided the transport incentives at later dates. There were few PHCCs and Health Posts that did not provide the incentives at all to mothers. The reasons cited for not providing the incentive

instantly to the mothers were: ‘delay in provision of refundable money from the government’ and ‘shortage of money at the facility’ to pay to the mothers.

In Round 2, nearly two thirds of sampled HFs (64%) were able to provide the “Aama” transportation incentive instantly to mothers upon discharge. This figure is slightly higher by 9 percentage point than the figure in Round 1. All the facilities in Lumbini Province and 87% of health facilities in Gandaki Province provided the transportation incentive instantly whereas only 20 percent of health facilities in Province 2 did so (as in Round 1). Still, few health facilities in Bagmati and Sudurpaschim province did not provide the incentive at all. All COVID hospitals and majority of non-COVID hospitals (80%) were able to provide the incentive instantly (Table 3.12).

Table 3.12 Province and facility-wise instant provision of ‘Aama’ transport incentives to mothers of newborns services during Round 1 and Round 2 Assessment

	Provided Instantly	Provided at Later Days	Not Providing Incentives
ROUND 1			
By Province			
Province 1 (n=32)	62.5	34.4	3.1
Province 2 (n=20)	20.0	75.0	5.0
Bagmati Province (n=33)	66.7	33.3	-
Gandaki Province (n=23)	73.9	26.1	-
Lumbini Province 5 (n=26)	73.1	23.1	3.8
Karnali Province (n=24)	45.8	54.2	-
Sudurpaschim Province (n=40)	37.5	62.5	-
Total	108 (54.5%)	87 (43.9%)	3 (1.5%)
By Facility			
COVID hospitals (n=10)	90.0	10.0	-
Non-COVID hospitals (n=31)	80.6	19.4	-
PHCC (n=59)	49.2	47.5	3.4
HPs (n=88)	47.7	51.1	1.1
UHCs (n=10)	30.0	70.0	-
Total	108 (54.5%)	87 (43.9%)	3 (1.5%)
ROUND 2			
By Province			
Province 1 (n=9)	66.7	33.3	-
Province 2 (n=5)	20.0	80.0	-
Bagmati Province (n=9)	77.8	11.1	11.1
Gandaki Province (n=8)	87.5	12.5	-
Lumbini Province 5 (n=9)	100.0	-	-
Karnali Province (n=7)	42.9	57.1	-
Sudurpaschim Province (n=14)	42.9	35.7	21.4
Total (n=61)	63.9	29.5	6.6
By Facility			
COVID hospitals (n=9)	100.0	-	-
Non-COVID hospitals (n=5)	80.0	20.0	-
PHCC (n=20)	60.0	35.0	5.0
HPs (n=24)	58.3	29.2	12.5
UHCs (n=3)	-	100	-
Total (n=61)	63.9	29.5	6.6

3.3 Caesarean Section (C-Section) Deliveries

The maternal units at 22 (69%) out of 32 hospitals accredited for C-Section conducted caesarean section (CS) deliveries without any interruption during the 5 months' lockdown period (Table 3.14). There was no interruption in the provision of C-Section deliveries in hospitals of Karnali Province and Sudurpaschim Province throughout the 5 months' lockdown period (Table 3.13). While in the remaining provinces, all CS procedures were halted initially and then resumed later. Seventy percent of COVID hospitals and 82 percent of non-COVID hospitals provided C-Section services to clients without any interruption throughout the lockdown period. In the remaining hospitals, C-section service was halted initially but was resumed later on (Table 3.14).

Table 3.13 Province-wise provision of C-Section deliveries by hospitals during Round 1 Assessment

Caesarean Section	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpaschim Province	Total
Provided service at all times without interruption	4	2	7	3	3	2	4	25 (78%)
Halted initially but resumed	1	1	-	2	2	1	-	7 (22%)
Total (n)	5	3	7	5	5	3	4	32

Table 3.14 Facility-wise provision of C-Section deliveries during Round 1 Assessment

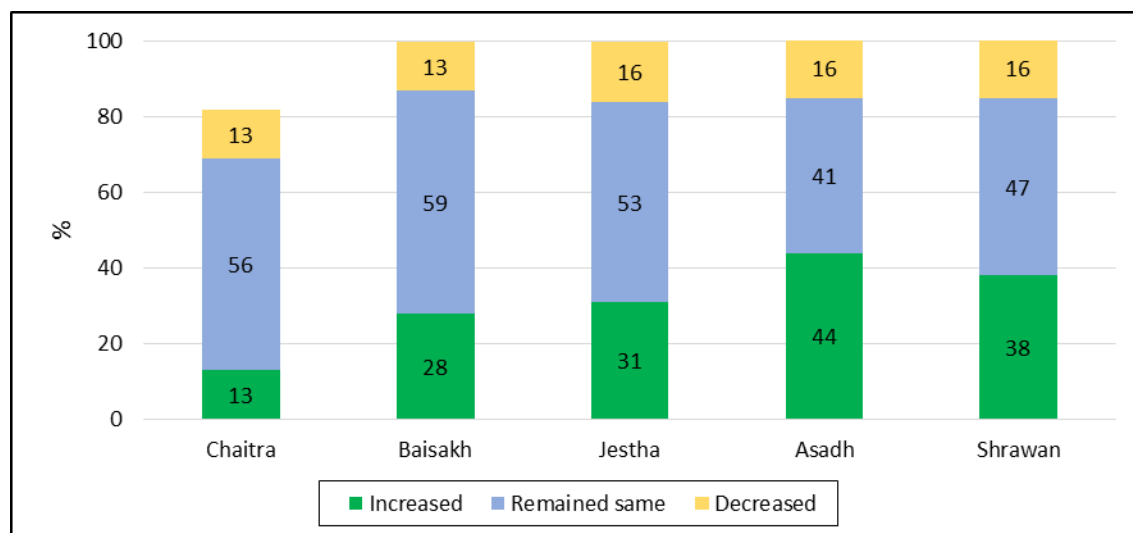
Caesarean Section	COVID hospital	Non- COVID hospital	PHCC	Health Post	UHC	Total
Provided services at all times without interruption	70.0	81.8	-	-	-	78.1
Halted initially but resumed	30.0	18.2	-	-	-	21.9
Total (n)	10	22	-	-	-	32

3.3.1 Caseloads for C-Section deliveries during the lockdown period: Round 1 Assessment

Majority of the service providers informed that the number of expecting mothers requiring C-Section remained the same throughout the lockdown period. Among the 32 HFs accredited to provide C-Section procedures, less than half of the service providers of these HFs (44%) said that C-Section deliveries have increased (Figure 3.7). C-Section deliveries were high during the month of Asadh. Increase in referrals and denial of service from nearby facilities were cited as the major reason for increase in C-Section deliveries.

All service providers (100%) of Karnali province reported about an increase in utilization of C-Section in the month of Asadh and Shrawan, while all service providers (100%) in Province 2 reported no change in utilization of C-Section during the lockdown period as compared to months prior to lockdown (Annex 3.9). The highest number (20%) of service providers from COVID hospitals reported a decline in C-Section deliveries in the month of Jestha (Annex 3.10).

Figure 3.7 Flow of clients seeking C-Section deliveries during Round 1 Assessment



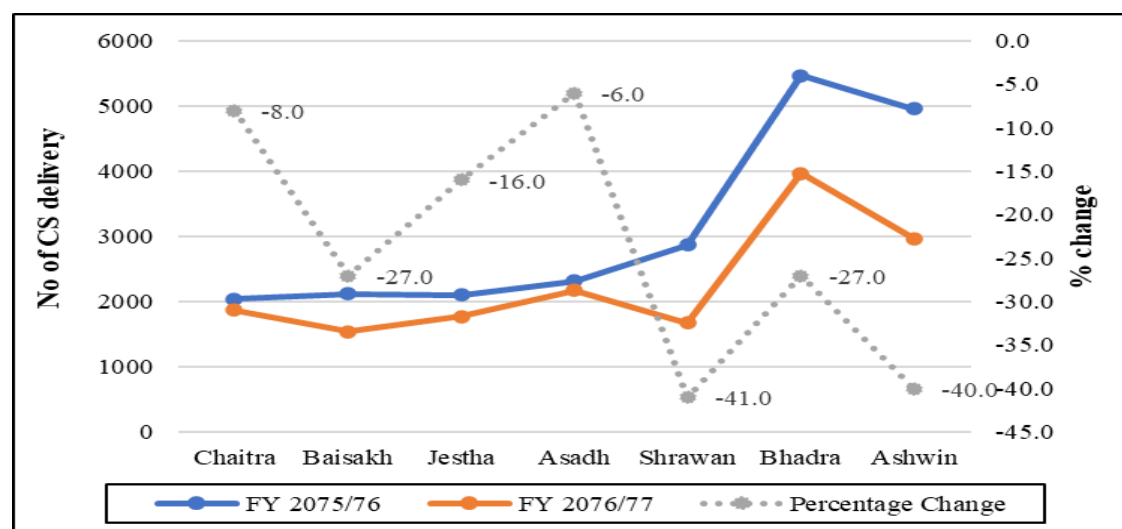
3.3.2 Trend in Number of C-Section Clients

There has been an overall declining trend in the number of C-Section deliveries during the five months of lockdown period as compared to corresponding months of the previous year that even showed a sharp decline in C-Section deliveries particularly in the month of Shrawan of the previous year (Figure 3.8). An overall decline in number of C-Section deliveries was observed across all provinces except for Gandaki province where the proportion soared steeply by an average of 108 percent. The highest decline in utilization of C-Section services was observed in Province 2 with an average decline of 55 percent during the lockdown period (Annex 3.11)

There was an average of 33 percent decline in number of caesarean section post two months of lockdown in comparison to same period in previous year. The increase in number of caesarean sections was observed in Gandaki and Karnali province in the months of Bhadra and Ashwin. The number hiked sharply in Gandaki province with 259 percent increase. The highest decline in utilization of C- Section during two months was observed in Province 2 which corroborated with the trend during the lockdown period. (Annex 3.11)³

³ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Figure 3.8 Trend analysis on utilization of C-Section services



3.3.3 Blood supply for obstetric patients during the lockdown period

During the lockdown period, nearly a third of the service providers (31%) reported that their hospitals experienced shortage of blood supplies at their obstetric units for conducting C-section procedures. Province-wise, blood supplies did not pose a problem for Province 2 and Sudurpaschim Province. On the other hand, 4 out of 7 Hospitals of Bagmati Province and 3 out of 5 hospitals of Gandaki Province reported about the shortages of blood for their obstetric units during the 5 months' lockdown period (Table 3.15).

Table 3.15 Province-wise number of hospitals facing blood shortages for obstetric patients

	Number hospitals providing C-Section	Difficulty faced in obtaining blood for obstetric patients during the Lockdown	
		Yes	No
By province			
Province 1	5	1	4
Province 2	3	-	3
Bagmati Province	7	4	3
Gandaki Province	5	3	2
Lumbini Province	5	1	4
Karnali Province	3	1	2
Sudurpaschim Province	4	-	4
Total	32 (100.0%)	10 (31.3%)	22 (68.7%)
By health facility			
COVID hospital	10	2	8
Non-COVID hospital	22	8	14
Total (n=32)	32 (100.0%)	10 (31.3%)	22 (68.7%)

3.4 Postnatal Care

3.4.1 Functionality of PNC Services

Around three quarters (74%) of the 424 health facilities provided PNC services to clients without any interruption during the lockdown period. Only around 17 percent of the facilities reported that service was initially interrupted but resumed later during the lockdown period.

Six out of 10 COVID hospitals reported interruption of PNC services during the lockdown period. Health facilities of Province 2 (82%) and Karnali Province (81%) reported no interruption in PNC services while relatively lesser proportion of health facilities in Gandaki Province (60%) reported no interruption in PNC service provision during the 5 months' lockdown period (Table 3.16). Most PNC services were provided uninterrupted at non-COVID hospitals and PHCCs (81 and 82 percent respectively) during the lockdown period. ON the other hand, only three-fifths of the COVID hospitals (60%) and UHC (63%) were able to provide the PNC service uninterrupted. One fifth of the UHC had halted PNC provision even prior to the lockdowns (Table 3.17).

In Round 2, PNC service was found halted in five HFs even before COVID 19 lockdowns. Around 88 percent of health facilities provided PNC service without any kind of interruption during three months' period. The service was halted in 8 percent of facilities which was resumed later on.

The service in one health facility has not resumed yet. All the health facilities in Lumbini and Sudurpaschim province provided the service without interruption during three months period. The PNC service in one PHCC was halted and hasn't resumed yet.

Table 3.16 Province wise functionality of PNC services during Round 1 Assessment

PNC Services	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpasch in Province	Total
Provided service at all times without interruption	68.1	81.7	80.4	60.0	69.1	81.3	79.2	74.1
Halted initially but resumed	27.5	16.7	12.0	10.9	19.1	9.4	4.2	16.5
Halted and not resumed yet	-	1.7	2.2	1.8	4.4	-	-	1.7
Nonfunctional before lockdown	4.3	-	5.4	27.3	7.4	9.4	4.2	7.8
Total (N)	69	60	92	55	68	32	48	424

Table 3.17 Facility wise functionality of PNC services during Round 1 Assessment

PNC Services	COVID hospital	Non-COVID hospital	PHCC	Health Post	UHC	Total
Provided services at all times without interruption	60.0	80.6	81.5	77.6	63.2	74.1
Halted initially but resumed	40.0	19.4	15.4	14.9	17.1	16.5
Halted and not resumed yet	-	-	3.1	2.5	-	1.7
Non-functional before lockdown	-	-	-	5.0	19.7	7.8
Total (N)	10	31	65	201	117	424

3.4.2 Extent of utilization of PNC service during the lockdown period

Two thirds of the service providers reported that the utilization of PNC services during the lockdown period remained unchanged (Figure 3.9). Only about 10 percent of service providers reported about an increase in PNC clients during the lockdown period. According to them, their PNC unit experienced gradual increase in PNC clients between the months of Chaitra and Shrawan. The major reasons for increase cited by the service providers were ‘increase in referral of clients’ and ‘denial of service’ by nearby facilities (Table 3.18).

About a quarter (28%) of the service providers reported that there had been a decrease in clients seeking PNC service during the lockdown period. The major reasons cited by the service provider for the decrease in PNC clients were fear of COVID-19 infection among clients and social restrictions to be maintained by all. Likewise, only two percent of the health facilities reported halting of PNC service during the lockdown period due to reasons such as fear of infection among clients, social restrictions due to COVID-19 and lack of adequate PPE in the health facility.

All health facilities reported about a slight increase in utilization of PNC services except for Karnali province. The highest numbers of service providers reporting increase in utilization of ANC services was in Bagmati province in the month of Asadh. Few (2%) of service providers from province 1 also reported halt in PNC service during the lockdown period. (Annex 3.12)

Figure 3.9 Utilization of PNC service during Round 1 and Round 2 Assessment

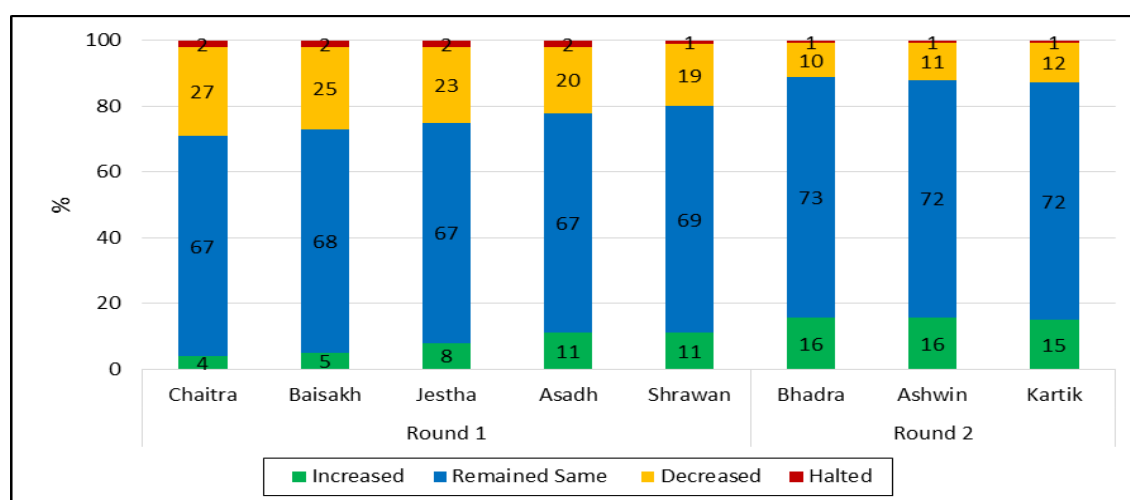


Table 3.18 Reasons for the increase and decrease of PNC services

	COVID Hospital	Non- COVID hospital	PHCC	HP	UHC	Total
Reasons for Increase						
Increase in referral of clients	-	60.0	44.4	23.5	15.4	29.5
Fear of worsening of COVID-19 infection	-			23.5	7.7	11.4
Due to denial of service from nearby health facility	-	20.0	11.1	5.9	30.8	15.9
Increase in delivery clients	-	40.0	22.2	11.8	15.4	18.2
Clients afraid to go to higher facilities	-	20.0		11.8	15.4	11.4
Clients afraid to go to other facilities	-	-		23.5	-	9.1
Total (n)	-	5	9	17	13	44
Reasons for Decrease						
Lack of transportation	60.0	37.5	30.4	31.0	8.3	28.0
Fear of infection among clients	100.0	75.0	69.6	69.0	66.7	70.3
Fear of infection among providers	80.0	12.5	39.1	31.0	20.8	31.4
Social restrictions due to COVID-19	80.0	37.5	34.8	41.4	20.8	37.3
Non availability of service provider	40.0	-	26.1	3.4	8.3	10.2
No client flow	-	12.5		12.1	8.3	8.5
Total (n)	5	8	23	58	24	118

Percentage total may have exceeded 100 due to multiple responses

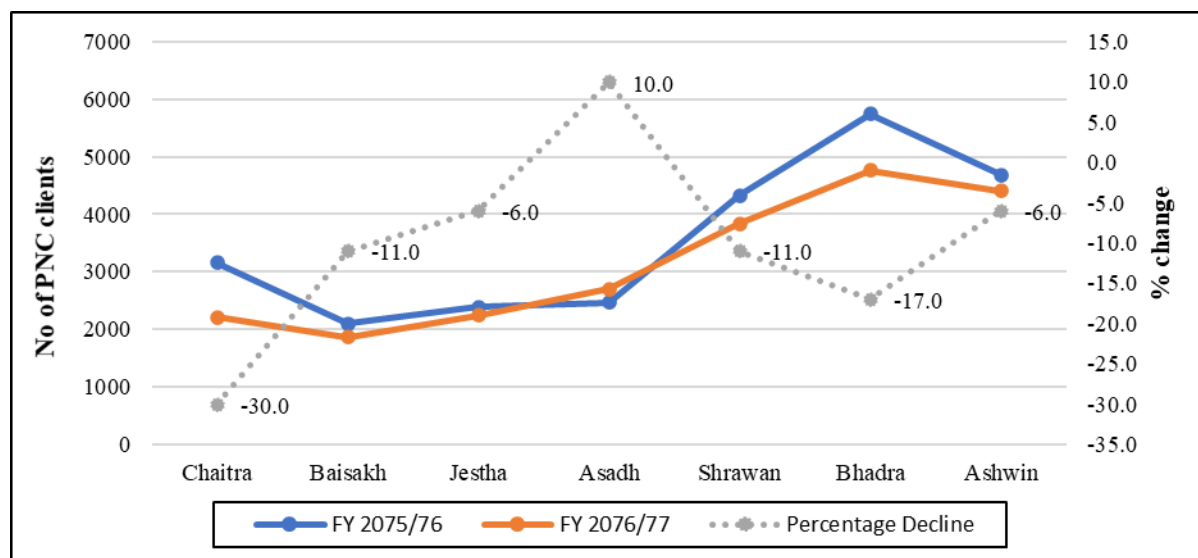
3.4.3 Trend in Client Flow for PNC

The trend analysis illustrates that except for the month of Asadh, the number of PNC clients was marginally lower during the lockdown as compared to the corresponding months of the previous year. A 30 percent decline in number of PNC clients is observed in the month of Chaitra when compared to other months during the lockdown period while a 10 percent increase in PNC clients was recorded in the month of Asadh (Figure 3.10). An average increase of 43 percent in utilization of PNC services can be observed in Bagmati province.

The highest decline in utilization on PNC services occurred in Province 2 with an average decline of 39 percent over the lockdown period as compared to previous year

An overall decline of 11 percent on utilization of PNC services was observed during two months' period post lockdown as compared to the corresponding months of the previous year. An increase in utilization of PNC services in Gandaki and Sudurpaschim province was observed during the same period. There was a sharp decline in utilization of PNC services in Bagmati province during the period with an average of 44 percent (Annex 3.14)⁴.

Figure 3.10 Trend analysis on utilization of PNC services



⁴ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Chapter 4

Functionality and Utilization of Family Planning Services

Family planning program is one of the priority programs of the government of Nepal. The government has committed to ensuring access to minimum of five family planning methods i.e. Condom, Pills, Depo, Implant and IUCD through all public health facilities in addition to information and education on those family planning methods to clients.

This chapter explains provision, functionality and utilization of various family planning services being provided by public health facilities during the 5 months' lockdown period, particularly on family planning counselling, short acting reversible contraceptive (SARC), long acting reversible contraceptive (LARC) and voluntary surgical contraception (VSC) services.

4.1 Functionality of Family Planning Counseling Services

The service providers from nearly all sampled health facilities (98%) reported that they were able to provide FP counseling services during the five months of lockdown period (Round 1 assessment period). Only 10 health facilities (2%) reported about disruptions of FP counseling during the lockdown period. Except one, all these health facilities resumed the services after a certain period of time. Province-wise comparison shows, all health facilities of Karnali and Sudurpaschim provinces were able to provide FP counseling service without any disruption.

In Round 2, disruption of FP counseling service increased in Province 1 (from 3 % to 17 %) and Bagmati province (2% to 10%) although the percentages of the HFs experiencing the disruptions in these two provinces are low (Table 4.1).

Table 4.1 Province-wise reporting of disruption of family planning counseling services in Round 1 and Round 2 Assessment

Disruption of FP counselling services	Province 1	Province2	Bagmati province	Gandaki Province	Lumbini province	Karnali Province	Sudurpaschim province	Total
	%	%	%	%	%	%	%	%
Round 1 (n=424)								
Disruption	2.9	1.7	2.2	1.8	4.4	-	-	2.1
No disruption	97.1	98.3	97.8	98.2	95.6	100.0	100.0	97.9
Round 2 (n=140)								
Disruption	17.4	5.0	10.0	-	-	-	-	5.7
No disruption	82.6	95.0	90.0	100.0	100.0	100.0	100.0	94.3

4.2 Functionality of SARC Services

All 424 health facilities covered in Round 1 Assessment had provision for SARC services that include male condoms, oral contraceptive pills and Depo Provera (DMPA). However, during the 5 months' lockdown period, SARC services were halted initially at nearly one third of the health facilities but resumed the services later. The percentage of the health facilities experiencing disruptions in the provision of oral pills were higher (20%) than DMPA (17%) and male condom distribution (7%). Compared to other provinces, a higher percentage of health facilities of Lumbini province (54%) and Province 1 (46%) had SARC service disruptions (Table 4.2). On the contrary, very few health facilities of Gandaki province (6%) reported about the SARC service disruption.

There has been a spectacular decline in the percentage of HFs that faced disruption of SARC services in Round 2 from 31 percent in Round 1 to 7 percent. Nearly 93 percent of the health facilities provided SARC services without disruption during 3 months' period of Bhadra-Kartik. Across provinces, none of the health facilities in Gandaki, Lumbini, Karnali and Sudurpaschim Province had the disruption while Province 1 (17%) had the highest number of health facilities suffering SARC service disruption. Interestingly, in Round 2, none of the HFs facilities of Lumbini, Karnali and Sudurpaschim provinces reported of any SARC service disruptions (Table 4.2).

Table 4.2 Province-wise reporting of disruption of SARC services in Round 1 and Round 2 Assessment

Disruption of SARC services	Province 1	Province 2	Bagmati province	Gandaki Province	Lumbini province	Karnali Province	Sudurpaschim province	Total
	%	%	%	%	%	%	%	%
Round 1 (n=424)								
Disruption	46.4	33.3	30.4	5.5	54.4	14.6	14.6	31.1
No disruption	53.6	66.7	69.6	94.5	45.6	85.4	85.4	68.9
Round 2 (n=140)								
Disruption	17.4	10.0	13.3	-	-	-	-	7.1
No disruption	82.6	90.0	86.7	100.0	100.0	100.0	100.0	92.9

As evident from Table 4.3, in terms of category of health facilities, more than one third of the health posts, one fourth of general hospitals, PHCC, and UHC had disruption of SARC services respectively in Round 1. Relatively, COVID hospital (11%) and non-COVID hospitals (20%) continued to experience some disruptions in SARC service delivery although the proportion have considerably reduced in Round 2 (Table 4.3)

Table 4.3 Facility-wise reporting of disruption of SARC services in Round 1 and Round 2 Assessment

Disruption of SARC services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Round 1 (n=424)						
Disruption	20.0	25.8	29.2	36.3	25.6	31.1
No disruption	80.0	74.2	70.8	63.7	74.4	68.9
Round 2 (n=140)						
Disruption	11.1	20.0	9.1	6.1	5.3	7.1
No disruption	88.9	80.0	90.9	93.9	94.7	92.9

Almost all FCHVs (97%) reported that they distributed condoms and oral pills and provided related information on FP to clients even during the 5 months' lockdown period. Very few FCHVs (3%) who were unable to perform these tasks complained about lack of enough stock of condoms and pills, difficulty in mobility, fear of transmission of COVID-19 and lack of mask and other PPE during the lockdown period. Furthermore, about 18% of the total FCHVs faced difficulties while obtaining condoms and pills during the lockdown period.

A total of 179 clients had sought FP services at different health facilities at the time of Round 1 data collection. Nearly all (94%) reported that they received the desired FP services. Those who could not receive desired FP services (6%) cited unavailability of the FP method of their choices, unavailability of trained providers and service providers' fear of contracting COVID-19 from the clients as the reasons.

In Round 2, a total of 81 clients had received FP services. Of them, 95 percent received FP services as desired which is similar to that of Round 1. All of them mentioned that they did not visit on an appropriate time for receiving their desired FP method (for e.g. For DMPA & Implant, visit should be during menstruation) and hence service provider offered them with SARC methods. None of them cited about the unavailability of trained providers or unavailability of FP methods as in the Round 1.

4.3 Functionality of LARC Services

Only 246 health facilities (58%) offered LARC services (implant and IUCD insertion and removal). These include all COVID/non-COVID hospitals and PHCCs, and 59 percent of HP and 20 percent of UHC. However, LARC service was non-functional in 25 facilities (10%) much before COVID-19 pandemic period.

During the five months of lockdown period (Round 1 Assessment), LARC service was disrupted at 19 percent of health facilities. Among those reporting LARC disruptions, 16 percent experienced the disruption during the initial period only. Very few (4%) had not resumed the LARC services throughout the 5 months of lockdown period.

Across the provinces, LARC services were disrupted mostly in Province 1 (39%) and Lumbini Province (31%) during the five months' lockdown period. The least service disruption was reported from Gandaki Province (12%), Karnali Province (11%) and in Province 2 (10%) (Table 4.4). In terms of health facility category, COVID hospitals

experienced LARC disruption (40%) the most, while health posts experienced the least disruptions of this service (18%) (Table 4.5).

In Round 2, the percentage of HFs that experienced LARC services disruptions slightly decreased to from 19 percent to 15 percent. All provinces had experienced reduction in LARC service disruption except in Province 2 (increased from 10.3 to 18.2%) and Bagmati Province (17.2% to 21.1%) that had a slight increase in the number of health facilities with LARC service disruption (Table 4.4).

Facility-wise, there has been a drastic decrease in percentage of COVID hospitals (from 40% to 11%) and at UHC (22% to 0%) reporting about LARC service disruption in Round 2 as compared to Round 1 (Table 4.5). No conspicuous difference is observed in Round 2 across other HFs.

Table 4.4 Province-wise reporting of disruption of LARC services in Round 1 and Round 2 Assessment

Disruption of LARC services	Province 1	Province 2	Bagmati province	Gandaki Province	Lumbini province	Karnali Province	Sudurpaschim province	Total
	%	%	%	%	%	%	%	%
Round 1 (n=247)								
Disruption	39.1	10.3	17.2	12.0	30.8	10.5	-	19.4
No disruption/ Provided all times without interruption	50.0	72.4	67.2	84.0	66.7	73.7	96.8	70.4
Service not functional even before lockdown	10.9	17.2	15.5	4.0	2.6	15.8	3.2	10.1
Total LARC accredited facilities (n)	46	29	58	25	39	19	31	247
Round 2 (n=85)								
Disruption	30.8	18.2	21.1	-	20.0	-	-	15.3
No disruption/ Provided all times without interruption	61.5	54.5	47.4	71.4	73.3	85.7	92.3	67.1
Service not functional even before lockdown	7.7	27.3	31.6	28.6	6.7	14.3	7.7	17.6
Total LARC accredited facilities (n)	13	11	19	7	15	7	13	85

Table 4.5 Facility-wise reporting of disruption of LARC services in Round 1 and Round 2 Assessment

Disruption of LARC services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Round 1 (n=247)						
Disruption	40.0	19.4	18.5	17.8	21.7	19.4
No disruption/ Provided all times without interruption	50.0	80.6	76.9	68.6	56.5	70.4
Service not functional even before lockdown	10.0	-	4.6	13.6	21.7	10.1
Total LARC accredited facilities (n)	10	31	65	118	23	247
Round 2 (n=85)						
Disruption	11.1	20.0	18.2	17.9	-	15.3
No disruption/ Provided all times without interruption	88.9	60.0	77.3	61.5	50.0	67.1
Service not functional even before lockdown	-	20.0	4.5	20.5	50.0	17.6
Total LARC accredited facilities (n)	9	5	22	39	10	85

4.4 Functionality and Utilization of VSC Services during the 5 Months' Lockdown Period

Only 39 HFs out of 424 (9%) had provision of VSC services in Round 1 assessment. Of these 39 HFs, the services were not functioning in 12 facilities (31%) even before COVID-19 pandemic period.

More than half of the 27 HFs which were functional were providing VSC services without any interruption in Round 1. Only three health facilities had reported disruptions of VSC services (COVID hospitals) that resumed the services later.

Unlike in Round 1, VSC services were functional in Round 2. All the HFs provided VSC services during the month of Bhadra, Ashwin and Kartik without disruptions.

4.5 Reasons for Disruption of Family Planning Services

Out of the 151 health facilities where family planning services were disrupted in Round 1, stock out of commodities/equipment/supplies (52%) was the major reason for the disruption. Likewise, fear of transmission of COVID-19 among service providers (30%) and unavailability of trained providers (9%) were other key factors for disruption of family planning services (Table 4.6).

Few health facilities (8%) particularly PHCC, HP and UHC experienced disruption of family planning service particularly LARC service, since the health providers abstained from providing any FP services that involved physical contact or 'touching' the clients. For this reason, some service providers persuaded their clients seeking LARC methods to use the SARC method until sometime.

Among 16 health facilities that had faced FP disruption in Round 2, most of them cited fear of COVID transmission as the major reason for the disruption. Stock out of FP commodities/equipment/supplies still remained as one of the important reasons for the disruption though the percentage has reduced substantially in Round 2 as compared to Round 1 situation (Table 4.6a).

Table 4.6 Reasons for disruption of family planning services (n=151)

Reasons for disruption of any family planning services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Commodities/equipment/supplies are out of stock	-	20.0	36.4	65.5	44.1	51.9
Fear of Transmission of COVID-19 among providers	50.0	10.0	31.8	33.3	23.5	29.9
Social restrictions due to COVID-19	25.0	10.0	13.6	9.5	17.6	12.3
Lack of PPE	25.0	-	18.2	13.1		10.4
Unavailability of trained staff	25.0	20.0	9.1	6.0	11.8	9.1
Only providing non-touchable FP services due to fear	-	-	18.2	3.6	14.7	7.8
HF's sealed	25.0	30.0	-	1.2	2.9	3.9
Municipality/Provincial/central level directed to stop services	-	-	4.5	1.2	2.9	1.9

Percentage total may have exceeded 100 due to multiple responses

Table 4.6a Reasons for disruption of family planning services during Round 2 Assessment (N=16)

Reasons for disruption of any family planning services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Fear of Transmission of COVID among providers	-	-	25.0	25.0	50.0	25.0
Commodities/equipment/necessary supplies are out of stock	-	-	-	25.0	50.0	18.8
HF's sealed	-	-	25.0	25.0	-	18.8
Unavailability of trained staff	100.0	-	-	12.5	-	12.5
HWs infected by COVID19	-	100.0	-	12.5	-	12.5
HF's operating as isolation center	-	-	25.0	-	-	6.3
Lack of PPE	-	-	25.0	-	-	6.3

Percentage total may have exceeded 100 due to multiple responses

4.6 Reasons for Stock out of FP Commodities during Lockdown Period

During the 5 months of lockdown period, a total of 78 health facilities had experienced stock out of FP contraceptive commodities. The reasons for FP commodities stock out were solicited from the service providers. About a third of the service providers reported that the municipality/district itself had shortages of oral pills during the lockdowns (36%) while almost the same proportion of the service providers cited non-supply of FP commodities to their health facilities from their municipality offices (35%). About a sixth of the service providers reported that they were unable to fetch the commodities due to lockdowns (17%) (Table 4.7). In Round 2, only 3 HF's mentioned about the stock out of SARC devices, particularly Pills and DMPA. They cited non-supply of devices from municipality as the major reason (Table not shown).

Table 4.7 Reasons for stock out of FP commodities at health facilities during Round 1 Assessment (n=78)

Reasons for stock out of FP commodities (n=78)	%
Shortage of pills at municipality/district office	35.9
Devices not supplied from Municipality	34.6
Couldn't bring/refill due to lockdown/transport	16.7
Devices not supplied on time	9.0
Delay in purchase by Municipality because of lockdown	3.8
Others	11.5

Percentage total may have exceeded 100 due to multiple responses

4.7 Flow of FP New Clients during the Lockdown Period

Less than a fifth of the service providers (19%) had reported an increase in the flow of FP new clients at their health facilities during the initial months of the lockdown (mid-March-mid-April). This proportion began to surge progressively from the second month onwards. As evident from Figure 4.1, the percentage of service providers reporting an increase in FP new clients doubled during the fifth month (38%) of the lockdown period when compared to the initial/first month's percentage figure. Compared to other provinces, the flow of FP new clients in Karnali province and Sudurpaschim province was high in the last three months i.e. Jestha, Asadh and Shrawan. However, more health facilities in Lumbini province, compared to others, had increased flow of clients in the first two months of lockdown period. (Annex 4.1). Likewise, across health facilities, providers from majority of COVID hospitals and non-COVID hospitals reported of decreased flow of FP new clients across all the months of lockdown period. (Annex 4.2).

Service providers from all levels of HFs believed that the increase in FP new clients was triggered by the foreign migrant returnees (77%) during the lockdowns (Table 4.8). In addition, they associated the increase in FP contraceptives off-take to an increase in sexual activities (41%) and people returning back to their village or home to unite with their families during lockdowns (16%).

Similarly, the percentage of providers reporting a decline in FP new clients in Round 1 gradually decreased as the lockdown eased since the month of Jestha (15%) and beyond (Figure 4.1). Those citing decline in FP clients identified factors such as fear of transmission of COVID-19 among clients (80%), social restrictions (59%) and lack of transportation (29%) (Table 4.9). Particularly at the COVID hospitals, the reason for decrease was fear of transmission of the infections among clients.

In Round 2, the percentage of HFs reporting of increase in flow of new FP clients has slightly increased in the last three months (Bhadra, Ashwin, Kartik) compared to the initial 5 months (Round 1). However, the percentages across the three months are relatively similar. This might be due to the increase in facilities providing FP services without disruption in the three months' period and also the ease of lockdowns (Table 4.1).

Figure 4.1 Flow of family planning new clients during Round 1 and Round 2 Assessment

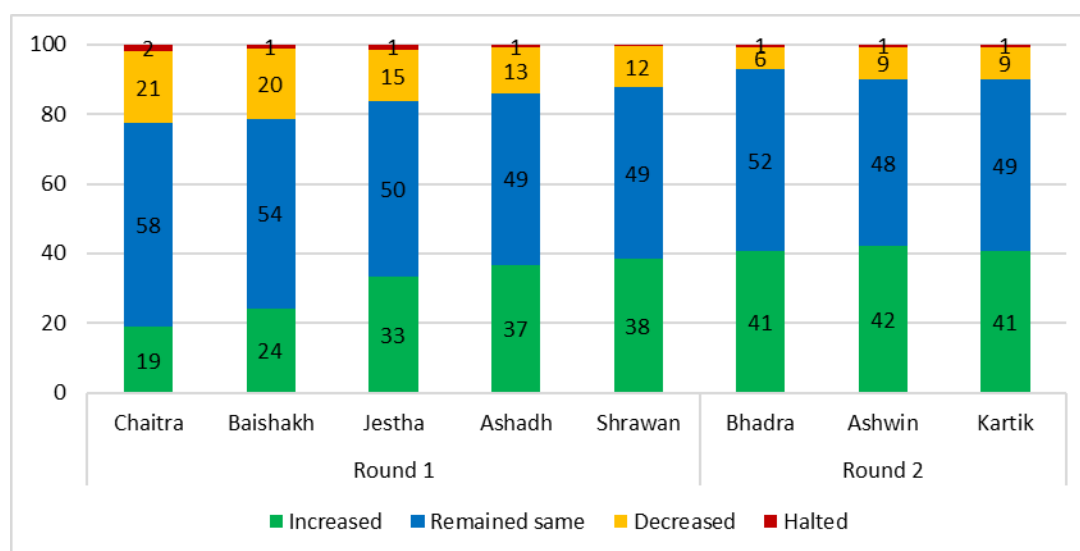


Table 4.8 Reasons for increase in family planning new clients during the lockdown period (Round 1)

Reasons for Increase (n=183)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Return of the foreign migrants	100.0	63.6	76.0	79.3	73.6	76.5
Fear of worsening of COVID-19 infection	50.0	-	8.0	5.4	5.7	6.0
Increase in sexual activity	-	36.4	40.0	42.4	41.5	41.0
People returning back to their village/home place/home district	-	27.3	16.0	21.7	5.7	16.4
Other HF's stopped providing services	-	-	8.0	1.1	11.3	4.9

Table 4.9 Reasons for decrease in FP new clients during the lockdown period (Round 1)

Reasons for Decrease (n=106)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Fear of transmission of COVID-19 among clients	100.0	75.0	92.3	77.6	76.2	80.2
Social restrictions due to COVID-19	71.4	43.8	46.2	65.3	57.1	58.5
Lack of transportation	42.9	43.8	53.8	22.4	14.3	29.2
Lack of PPE	-	6.3	15.4	8.2	-	6.6
Stock out of FP commodities	-	-	7.7	10.2	-	5.7

The flow of follow-up clients remained unchanged for the majority of the health facilities (more than 75%) during all five months of lockdown period (Figure 4.2). Very few service providers perceived the increase in follow-up clients at their facility during the lockdown (Annex 4.3). However, service providers from nearly half of the COVID hospitals perceived that flow of FP follow-up clients decreased across all 5 months during the lockdown period (Annex 4.4).

The main reason for an increase in FP follow-up clients during lockdown period as cited by over half of the service providers was clients' fear of worsening of COVID-19 infection in coming days (54%) (Table 4.9). The reasons cited by providers for the increase in follow-up clients was similar across all health facilities, such as arrival of foreign labor migrants and people returning back to their village or home place.

Figure 4.2 Provider's perception on flow of FP follow-up clients in Round 1

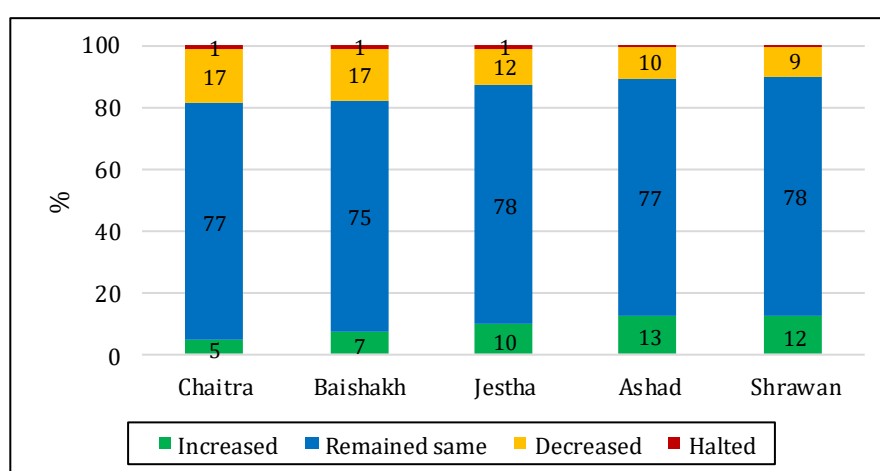


Table 4.10 Reasons for increase in family planning follow-up clients during the lockdown period (Round 1)

Reasons for Increase (n=183)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Fear of worsening of COVID 19 infection	100.0	50.0	33.3	59.5	46.7	54.1
Arrival of foreign labor migrants	100.0	-	16.7	27.0	20.0	24.6
People returning back to their village/home place/home district	-	50.0	16.7	18.9	6.7	16.4
Clients of other HF's also visited because of lockdown/no transportation	-	-	-	10.8	13.3	9.8
Other HF's stopped providing services	-	-	33.3	2.7	13.3	8.2

Table 4.11 Reasons for decrease in FP follow-up clients during the lockdown period (Round 1)

Reasons for Decrease (n=106)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Fear of transmission of COVID-19 among clients	100.0	64.3	86.7	69.7	63.0	71.3
Social restrictions due to COVID-19	60.0	64.3	40.0	54.5	40.7	50.0
Lack of transportation	40.0	57.1	46.7	30.3	18.5	34.0
Lack of PPE	-	7.1	13.3	12.1	-	6.4
Stock out of FP commodities	-	-	-	15.2	3.7	6.4
People went back to their village/home place/home district	-	-	6.7	3.0	7.4	5.3

Default clients are expected to be high during emergencies. Contacting and follow up with default FP clients remains an important challenge for all outreach health facilities offering the FP services. We had asked the providers from all 424 health facilities about the means of contacting their default clients during the lockdown period. The majority of the health providers (63%) reported that they had persuaded FCHVs for contacting/motivating such clients through home visits. Similarly, 42 percent of the health facilities mentioned that they contacted their default clients through phones. Few service providers also reported that they provided a note/card with follow-up date written on it as reminders and informed them about the scheduled date for follow-up visits during counseling sessions (Table 4.11).

The ways of contacting default clients in the last three months' period (Round 2) was similar to the initial 5 months of lockdown period (Round 1) i.e. asking FCHVs to contact the defaulter, contacting defaulters through telephone, providing a written note/card to the clients and inform them about the visit date during counseling (Table 4.12).

Table 4.12 Ways of contacting default FP clients in Round 1 and Round 2 Assessment

Ways of contacting default clients (n=424)	Round 1 (n=424) %	Round 2 (n=140) %
Ask FCHV to contact the defaulter	63.0	53.6
Contact defaulters through telephone	42.0	32.1
A written note/card with follow-up date is given	2.4	7.1
Inform about the visit date during counseling	1.2	0.7

The types of suggestions health providers gave to those clients (default) who could not avail family planning services from their facilities during the lockdown period was also solicited in the present study. Majority of them cited that they referred their clients to another government facility (57%) or at NGO/Private FP clinics (29%). (Table 4.12) Few of them advised to use alternative methods (11%) while about 9% of them advised to use pills/condom instead of IUCD/Implant/DMPA.

Table 4.13 Alternatives offered to clients who were unable to receive the FP of their choice in Round 1

Alternatives offered to clients who were unable to receive the FP of their choice (n=205)	%
Referred to another government facility	57.1
Referred to NGO/Private FP clinics	29.3
Advised to use alternative methods	11.2
IUCD/Implant/DMPA clients suggested to use pills/condom for some duration	8.8

4.8 Trends in Number of Users of Family Planning Services

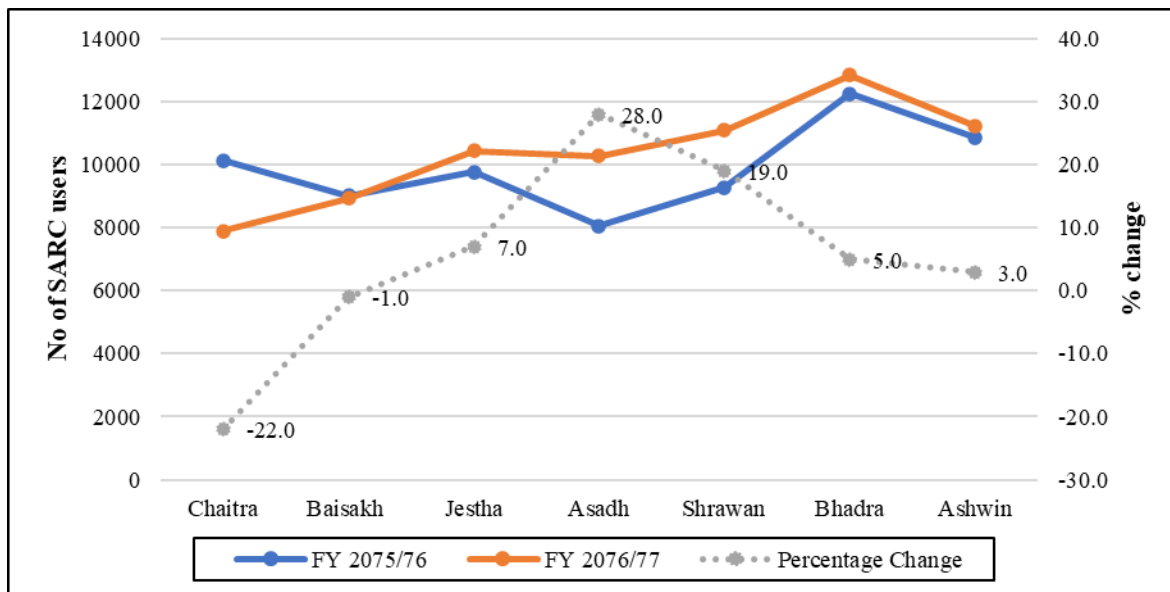
SARC new users initially declined in the first month of lockdown i.e. Chaitra and later surpassed the previous years' figures from the month of Jestha (Figure 4.3). There was decline in SARC users in the month of Chaitra across all the provinces except Gandaki Province. The number of SARC users increased in the whole period of lockdown in Gandaki province compared to corresponding months of previous year. A decline in number of SARC users in either of the months (Bhadra or Ashwin) was observed across all provinces except Karnali and Sudurpachim province. In contrast to increase in SARC users in lockdown period in Gandaki Province, a decrease in the months of Bhadra and Ashwin was observed (Annex 4.5).⁵

In terms of LARC, the flow of new clients seeking LARC services during the five month's lockdown period in comparison to the corresponding months of the previous year was lower in all months and equal in the month of Shrawan. However, the trend line shows an unusual spike in the flow of clients during the month of Bhadra (424 %) (Figure 4.4). In the month of Ashwin however the flow of new clients seeking LARC services was close to the figures of the corresponding period of the previous year. This overall spike in the month of Bhadra is attributed to the extreme incase in the reported new LARC users in Bagmati province in the same month (2068 %) (Annex 4.6). Bagmati province shows the most unusual trend in flow of new LARC clients as compared to the rest of the provinces. In province 2, the flow of clients is low in all months except for Ashwin as compared to the previous year (Annex 4.6).⁶

⁵ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

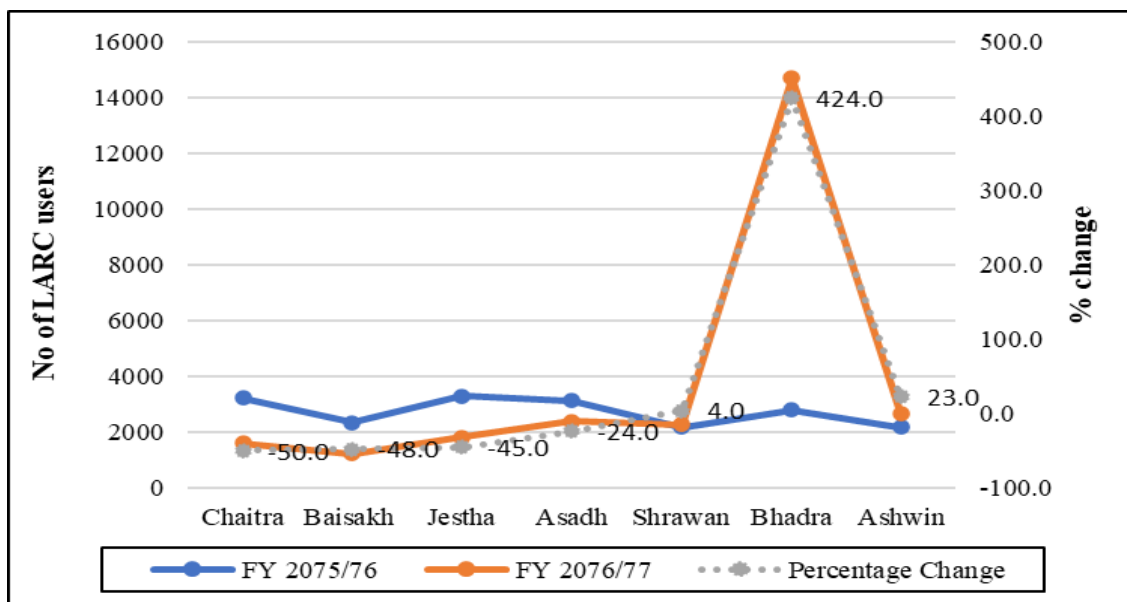
⁶ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Figure 4.3 Trends of SARC (Depo & Pills) users



Source: HMIS database

Figure 4.4 Trends of LARC (IUCD & Implant) users



Source: HMIS database

Chapter 5

Functionality and Utilization of Safe Abortion Services

Nepal amended its Country Code (*Muluki Ain*) in 2002 to allow abortion on certain grounds and ensure Nepalese women's right to decide on their fertility choices. The *Safe Motherhood and Reproductive Health Rights Act, 2018* that has replaced the *Muluki Ain* further guaranteed women's rights to legal and safe abortion care on wider grounds. Surgical abortion using manual vacuum aspiration (MVA) has been legally available in Nepal since abortion service was first introduced in the country in March of 2004 for termination of pregnancies up to 12 weeks of gestational age. Medical abortion (MA) using a combined regimen of mifepristone (200 mg x1 tab) and misoprostol (200 mg x 4 tabs) was introduced in 2009 and scaled up throughout the country. The *Safe Abortion Programme Implementation Guideline, 2073* allows MA service provision by auxiliary nurse-midwives (ANMs) trained in skill birth attendance (SBA) to expand SAS through outreach public facilities (PHCC and Health Post), NGO and private clinics. Since 2017 the government has made safe abortion service (SAS) free in all government health facilities.

This chapter presents the functionality and utilization of public SAS during the lockdown period, barriers to SAS provision and compares the trends in MVA and MA client flow during the 5 months of Lockdown period vis-à-vis corresponding months one year ago.

5.1 Accreditation status of SAS

None of the 117 sampled UHC was accredited for SAS. Of the remaining health facilities (307), only 139 public health facilities (45%) were accredited (Table 5.1). In terms of category of health facilities, nearly all hospitals (40 out of 41 sampled hospitals including COVID hospitals) are accredited. Of the total 65 sampled PHCCs, 56 (86%) are accredited. On the contrary for MA service provision, only 43 HPs (21%) out of the total 201 health posts in the sample are accredited.

Province-wise distribution of accredited SAS centers showed, the proportion of SAS accredited HFs are relatively low in Gandaki and Bagmati (24% each) and also in Province 2 (28%). In the remaining four provinces, between 30 to 50 percent of the health facilities are accredited for providing SAS (Table 5.1).

Table 5.1 Facility-wise safe abortion service (SAS) accreditation status and province-wise distribution

Types of facility	Accredited n (%)	Not accredited n (%)	Total n (%)
Hospital	40 (97.6)	1 (2.4)	41 (100)
PHCC	56 (86.2)	9 (13.8)	65 (100)
HP	43 (21.4)	158 (78.6)	201 (100)
UHC	-	117 (100)	117 (100)
Provinces			
Province 1	29 (42.0)	40 (58.0)	69 (100)
Province 2	17 (28.3)	43 (71.7)	60 (100)
Bagmati Province	22 (23.9)	70 (76.1)	92 (100)
Gandaki Province	13 (23.6)	42 (76.4)	55 (100)
Lumbini Province	21 (30.9)	47 (69.1)	68 (100)
Karnali Province	16 (50.0)	16 (50)	32 (100)
Sudurpaschim Province	21 (43.8)	27 (56.3)	48 (100)
Total	139 (32.8)	285 (67.2)	424 (100)

5.2 Functionality of Safe Abortion Services (SAS)

More than half (75 SAS centers) of the 139 SAS centers provided safe abortion care during 5 months' lockdown period. The service was halted initially at 10% (14 SAS centers) of the SAS centers and resumed later on. However, one third of the accredited health facilities (47 SAS centers) had discontinued SAS provision even before the lockdown and while 3 SAS facilities that had halted the service during the lockdown had not resumed the service yet. Second trimester abortion (13 – 28 weeks) was confined only to hospital settings. Almost all accredited hospitals provided second trimester abortion without interruption during 5 months' lockdown period.

SAS provision continued to remained non-functional at nearly three fourth of the 46 accredited SAS centers revisited in Round 2. About 21 percent of the accredited facilities were providing SAS without any interruption during the three months' period. Similar to Round 1, all six accredited hospitals covered in Round 2 provided second trimester abortion.

All SAS (MA, MVA and Second Trimester) should be provided free of costs at all public facilities. However, two health facilities (one COVID hospital and one HP) covered in Round 1 have been charging fees to clients. Replenishments of medicines and equipment were the responses given by the service providers when asked for the reason for charging abortion fee. One provider has been charging the abortion fee to women as punishment for the act (abortion).

5.3 Availability of trained providers for MA and MVA

Trained service providers for Medical abortion (MA) were not available at 24 percent of the SAS centers while trained providers for Manual Vacuum Aspiration (MVA) was unavailable at 36 percent of the MVA accredited SAS centers. Province-wise comparison shows, all the 13 MA accredited SAS centers of Gandaki Province (100%) had trained health providers in place (Table 5.2). Similarly, all the 6 MVA accredited SAS centers of Sudurpaschim Province (100%) had trained providers in place (Table 5.3). On the contrary, one third of the MA centers in Lumbini Province and two-third of the MVA accredited SAS centers of Province 1 did not have a trained provider at the time of the present assessment (Table 5.2 & 5.3)

All sampled health facilities of Round 2 had trained providers in place for MA service (Table 5.2). Likewise, for MVA service, there has been a slight increase in health facilities (76% in Round 2 from 64%) where service providers were available during the last three months (Bhadra-Aswin) as compared to Round 1 status (Table 5.3).

Table 5.2 Percentage of trained providers available for providing MA services by province in Round 1 and Round 2 Assessment

Presence of a trained providers	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini province	Karnali province	Sudur paschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1								
Yes (%)	79.3	70.6	72.7	100.0	66.7	81.3	71.4	76.3
No (%)	20.7	29.4	27.3	-	33.3	18.8	28.6	23.7
Total (n)	29	17	22	13	21	16	21	139
ROUND 2								
Yes (%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No (%)	-	-	-	-	-	-	-	-
Total (n)	4	5	4	4	6	5	6	34

Table 5.3 Percentage of trained providers available MVA services by province in Round 1 and Round 2 Assessment

Presence of a trained providers	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini province	Karnali province	Sudur paschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1								
Yes (%)	35.3	55.6	66.7	80.0	72.7	71.4	100.0	64.0
No (%)	64.7	44.4	33.3	20.0	27.3	28.6	-	36.0
Total (n)	17	9	15	10	11	7	6	75
ROUND 2								
Yes	66.7	20.0	100.0	75.0	100.0	100.0	100.0	76.0
No	33.3	80.0	-	25.0	-	-	-	24.0
Total (n)	3	5	4	4	4	1	4	25

Facility-wise assessment showed all 10 COVID hospitals had trained MVA as well as MA providers in place (Table 5.3 & 5.4). On the other hand, 3 non-COVID hospitals (10%) did not have a trained MVA provider and only one hospital did not have a trained MA provider. Over a quarter of the PHCC (29%) did not have the trained MA providers and two thirds (67%) did not have a trained MVA provider in place. Likewise, 16 out of 43 health posts (37%) accredited for MA did not have a trained MA provider in place at the time of the present assessment (Table 5.3 & 5.4).

Table 5.3 Facility-wise presence of a trained MA service providers in Round 1 and Round 2 Assessment

Presence of a trained providers	COVID hospital	Non-COVID hospital	PHCC	HP	Total
	%	%	%	%	%
ROUND 1					
Yes	100.0	96.7	71.4	62.8	76.3
No		3.3	28.6	37.2	23.7
Total (n)	10	30	56	43	139
ROUND 2					
Yes	100.0	100.0	100.0	100.0	100.0
No	-	-	-	-	-
Total (n)	9	5	13	7	34

Table 5.4 Facility-wise presence of a trained MVA service provider in Round 1 and Round 2 Assessment

Presence of a trained providers	COVID hospital	Non-COVID hospital	PHCC	HP	Total
	%	%	%	%	%
ROUND 1					
Yes	100.0	100.0	100.0	NA	64.0
No	-	-	-	NA	36.0
Total (n)	10	29	36		75
ROUND 2					
Yes	100.0	80.0	54.5	-	76.0
No	-	20.0	45.5	-	24.0
Total (n)	9	5	11	-	25

5.4 Utilization of SAS during the Lockdown Period

Service providers of most of the SAS centers of Karnali Province perceived that MVA clients had increased in their facilities (60%) while none of the health facilities had experienced the increased MVA clients flow in Sudurpaschim Province. Decline in MVA clients was reported to be relatively high (33%) in SAS centers of Lumbini Province. In Province 2, MVA services were halted in 50% of the health facilities, while none of the MVA services of Gandaki Province was halted during the 5 months' lockdown period.

The percentage of service providers who perceived that flow of MA clients has increased at their SAS centers has increased by 4 percentage points in Round 2. However, the percentages (47%) of service providers perceiving that the clients have remained same throughout the lockdown period have remained the same in the current round.

Health providers who cited increase in flow of MVA clients have drastically decreased from 26 percent to 4 percent. However, only few providers from Lumbini province perceived of increase in flow of MVA clients during the 3 months' period (Round 2).

The majority of the service providers (40 service providers) linked the increase in SAS clients during lockdown period to non-use of contraceptives especially among foreign labor migrant returnees (75%) and also to the discontinuation of FP use among couples (70%). Few service providers also mentioned that the surge in SAS clients was due to increased referral to their facilities (8%) and also because the clients could not go anywhere else due to the lockdown (8%). Of the 13 providers who mentioned a decrease in SAS clients during lockdown period, most of them cited 'fear of COVID-19' (69%), 'social restrictions due to COVID-19' (53%) and 'unavailability of transports' (46%) as major reasons. However, few of them also linked a decrease in SAS clients to the stock-out of MA drugs at their SAS centers (Table 5.5).

Table 5.5 Reasons for increase/decrease in SAS clients during the lockdown period: Service Providers' Perspectives (Round 1 Assessment)

Reasons for increase in SAS clients* (n=40)	%
Non-use of FP among foreign labor migrants returnees	75.0
Discontinuation of FP use	70.0
Could not go anywhere	7.5
Refer from another health facilities	7.5
FP methods not access in peripheral level /lack of access	5.0
Reasons for decrease in SAS clients* (n=13)	%
Fear of COVID-19	69.2
Social restrictions due to COVID-19	53.8
Unavailability of transports	46.2
Lack of regular supply of MA/ stock-out of MA drugs	7.7

Two-fifths of the SAS providers reported about challenges they faced while providing safe abortion care to clients during the pandemic situation. Of the challenges mentioned, 41 percent of them reported about their own fear of contracting coronavirus while serving the clients. In addition, the service providers cited about women seeking abortion late in their pregnancy (high gestational age) (39%), lack of PPE (22%), unavailability of trained providers (17%) and lack of equipment and drugs (17%) (Table 5.6).

Table 5.6 Challenges faced by service providers in SAS provision during the lockdown period : Service Providers’ Perspectives in Round 1 Assessment

Challenges faced by Health facilities* (n=36)	%
Fear of transmission of COVID-19 among providers	41.7
High gestational age	38.9
Lack of PPE	22.2
Unavailability of trained providers	16.7
Delay in re-supplies of equipment and drugs	16.7
Social restrictions due to COVID-19	13.9
Lack of MA drugs	13.9
Self-medication practice	5.6

Percentages total may have exceeded 100 due to multiple responses

5.5 FCHVs’ Perspectives on functionality of SAS during the Lockdown Period

All 424 FCHVs in Round 1 were asked if clients were able to obtain safe abortion service from nearby SAS centers during the lockdown period. More than half of the FCHVs (57%) responded affirmatively. As many as 67 FCHVs (16%) reported that SAS centers did not provide abortion service during the lockdown. Over a quarter of the FCHVs had no idea (did not know) regarding SAS status during the lockdown period.

In Round 2, more than half of the FCHVs (60% of 140 FCHVs interviewed) responded that women were provided with SAS from the facility. This is a slight increase in the percentage as compared to Round 1. Similarly, only 9% of them perceived that the SAS centers did not provide the services in the 3 months’ period.

Close to two fifths (39%) of the FCHVs reported that the health facilities had halted SAS much before the lockdown. Another one-third of the FCHVs mentioned that the SAS centers lacked trained service providers while another similar proportion of FCHVs (33%) cited non-availability of abortion commodities at the facility as the reasons that deprived clients from obtaining SAS during the lockdown period (Table 5.7).

Table 5.7 Provision of SAS during the lockdown period: FCHVs’ perspectives (Round 1 and Round 2 Assessment)

Were women provided safe abortion services during lockdown?	Round 1 %	Round 2 %
Yes	56.8	60
No	15.8	8.6
Don't know	27.4	31.4
Total N=	424 (100%)	140 (100%)
Reasons for not providing SAS during lockdown (N=67)	%	[not asked]
Fear of transmission of COVID among providers	6.0	
Non-availability of service providers	32.8	
Non-availability of commodities	32.8	
Lack of PPE	4.5	
SAS halted much before the lockdown	38.8	
Hospital was sealed	3.0	
Lack of trained health service providers	4.5	
Don't know	1.5	
Total N=	67	

Percentages total may have exceeded 100 due to multiple responses

5.6 Roles of FCHVs on SAS

Over a quarter of the FCHVs (28%) reported that they were approached by women for abortion related information and advice during the 5 months' lockdown period. Most of the FCHVs referred their clients to a SAS facility (81%). In addition, over a half of the FCHVs provided information about safe abortion and place/health facility where one could obtain SAS (54%).

In Round 2, more than one third of the FCHVs (34%) said that they were approached by women for information on SAS during the 3 months' lockdown period which was more than the initial 5 months of lockdown period. In terms of responses that were given to the clients, most of them referred the clients to the facility having SAS provision 63% and about half of them provided information about safe abortion services and the centers where SAS is available. (Table 5.8)

Table 5.8 Information on safe abortion shared to clients during the lockdown period: FCHVs' Perspectives

Has anyone approached you for information on SAS during lockdown	Round 1 %	Round 2 %
Yes	28.8	34.3
No	71.2	65.7
Total N	424 (100%)	140 (100%)
Responses given to clients who approached FCHVs for information on SAS	%	%
Provided information about the safe abortion services and centers	54.1	50.0
Referred to related facility	81.1	62.5
Referred to related health professional	0.8	-
FCHV took her to the hospital/SAS centers	2.5	4.2
Suggest to follow the husband decision	0.8	-
Not suggested to abort in this COVID crisis	-	2.1
FCHV gave medicine to clients for abortion	-	2.1
Total N	122	48

Percentages total may have exceeded 100 due to multiple responses

The present assessment also inquired clients about types of safe abortion services that they received from the health facility. Among 13 the clients who visited for safe abortion services, majority of them (69%) sought medical abortion services while 15% of them obtained information on SAS. Few of them obtained services in the case of complications on miscarriage (8%) and post abortion care advice (8%). Eighty percent of the FCHVs believed that SAS is provided free of cost at all public health (SAS) facilities.

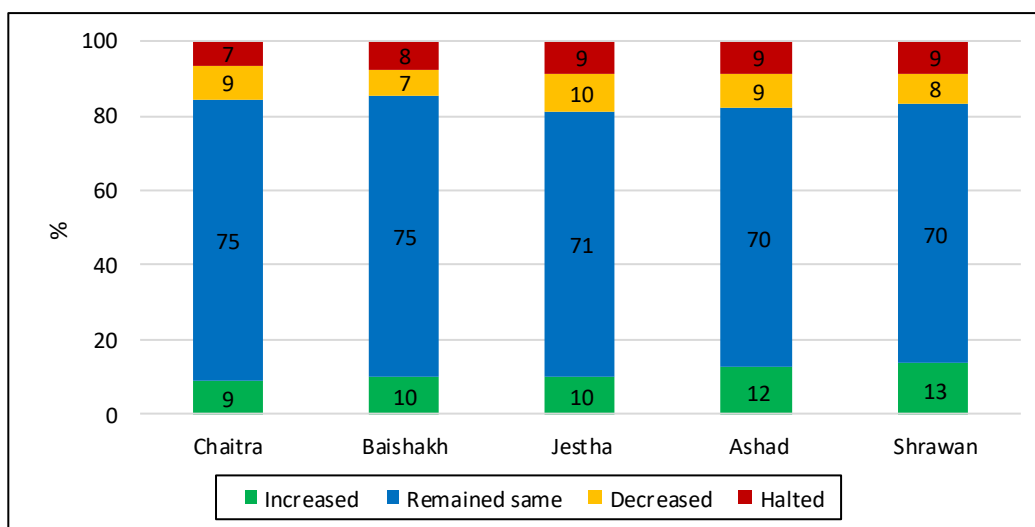
5.7 Utilization of Post-Abortion Care services during the lockdown period

The large majority of health care providers (70%) perceived that there was no change in flow of PAC clients at health facilities across all five months during the lockdown period. (Figure 5.1) However, few of them mentioned that there has been increase in PAC clients which was nearly consistent across all five months.

This slight increase in PAC clients were due to proximity of health facility (71%); due to abortion performed without consultation of trained service providers (50%) and increase in referral from nearby health institutions (7%). Reasons for the slight decrease in PAC clients

cited by providers were lack of transportation (73%), fear of infection among clients (64%) and non-availability of trained providers (55%).

Figure 5.1 Providers perspective on flow of PAC clients in Round 1 Assessment



5.8 Trends in SAS Client flow

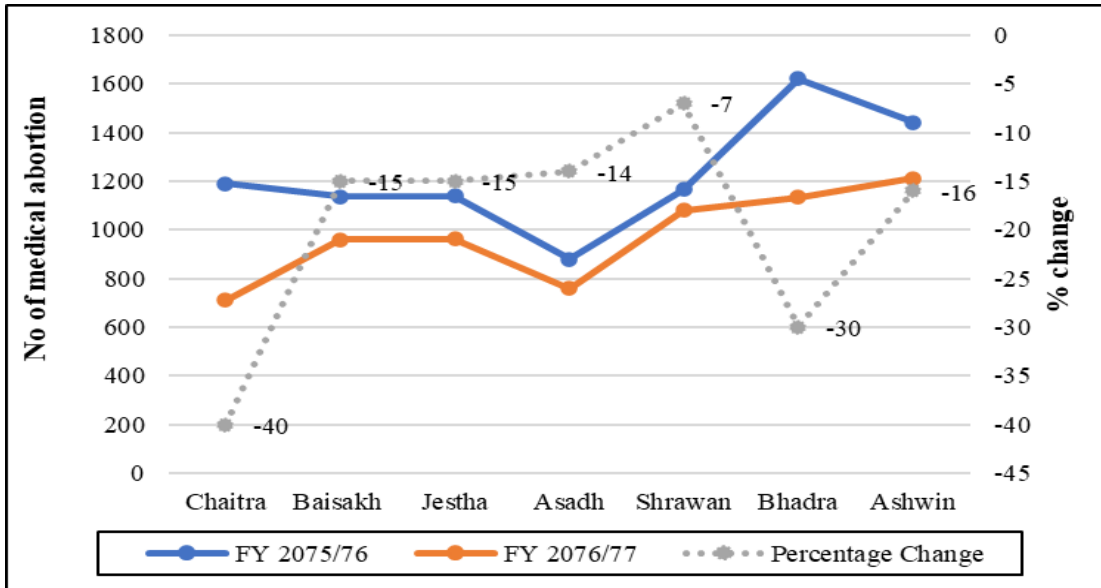
The number of women who received MA declined during the 5 months' lockdown period when compared to the corresponding months of the previous year (FY 2075/76). (Figure 5.2).

A sharp decline in number of MA clients was observed during the month of Chaitra, thereafter, the trend followed the previous year's pattern but maintaining the gaps constantly over next four months which again significantly decreased in the month of Bhadra. In province 2, there was a sharp decrease in number of MA clients in the month of Chaitra which then followed a fluctuating trend with passing months. There was no any difference in the month of Ashwin. There was a decline in number of MA client in the month of Chaitra which then increased and reached to a maximum level in the month of Asadh and then followed a decreasing trend with a sharp decline in the month of Bhadra in Bagmati Province (Annex 5.7).

A sharp decline in number of MVA clients was observed in the month of Asadh (76%) followed by Bhadra (65%). There was a stark increase in number of MVA clients in the month of Baisakh in Province 2. Likewise there was a huge increase in number of MVA clients in the month of Jestha and Shrawan in Lumbini Province which decreased in Bhadra and Ashwin (Annex 5.8).⁷

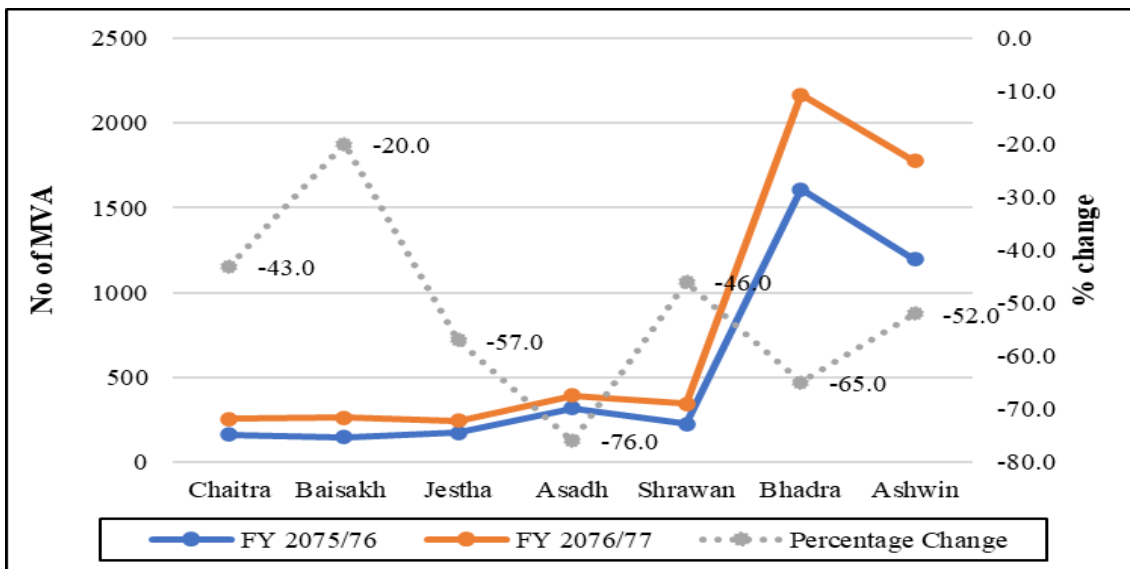
⁷ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months

Figure 5.2 Trends in number of women who received medical abortion



Source: HMIS database

Figure 5.3 Trends in number of women who received MVA



Source: HMIS database

Chapter 6

Functionality and Utilization of Child Health and Immunization Services

This chapter discusses the functionality, utilization and provision of childhood immunization, vitamin A supplementation for children and for mothers of newborns, and care for childhood illness during the five months of lockdown period. FCHVs' perspectives on accessibility to immunization services for children are also discussed in this chapter.

6.1 Functionality of Routine Immunization Services

All the 424 health facilities covered in Round 1 were accredited for providing routine immunization services. Out of 424 health facilities the routine immunization services were not operative (nonfunctional) in 11 facilities. Immunization service at most of the health facilities (81%) was halted initially and resumed later during the lockdown period (Table 6.1). In 8 health facilities, the service has not resumed yet after it was halted during the lockdown (Table 6.1).

The immunization service at most of the health facilities in all provinces were halted initially and resumed later during lockdown period. Routine immunization services in few health facilities in Province 1 (3), Bagmati province (4), Lumbini Province (1) was halted during lockdown which has not been resumed yet (Table 6.2).

Table 6.1 Health facility wise functionality of routine immunization service in Round 1 Assessment

	COVID hospital (n=10)	Non-COVID hospital (n=31)	PHCC (n=65)	Health Post (n=201)	UHC (n=117)	Total (n=424)
Provided at all time without interruption	20.0	22.6	9.2	11.4	18.8	14.2
Halted initially but resumed now	70.0	67.7	90.8	86.1	72.6	81.4
Halted and not resumed yet	-	6.5	-	2.5	0.9	1.9
Service not functional before lockdown	10.0	3.2	-	-	7.7	2.6

Table 6.2 Province wise functionality of routine immunization service in Round 1 Assessment

	Province 1 (n=69)	Province 2 (n=60)	Bagmati Province (n=92)	Gandaki Province (n=55)	Lumbini Province (n=68)	Karnali Province (n=32)	Sudur paschim Province (n=48)	Total (n=180)
Provided at all time without interruption	8.7	13.3	13.0	10.9	8.8	28.1	27.1	14.2
Halted initially but resumed now	87.0	86.7	77.2	87.3	86.8	71.9	66.7	81.4
Halted and not resumed yet	4.3	-	4.3	-	1.5	-	-	1.9
Service not functional before lockdown	-	-	5.4	1.8	2.9	-	6.3	2.6

Overall, only about 15 percent out of 413 health facilities were able to provide routine immunization without interruption during Round 1 assessment. This scenario dramatically altered after the lockdowns were called off by the government in July 2020.

As evident from Table 6.3, more than three quarters of the HFs (76%) covered in Round 2 provided the routine immunization service without interruptions. Province-wise comparison shows that the disruption in routine immunization service was highest in Province 1 and Lumbini Province during first five months of lockdown period (Round 1) with only 9 percent of health facilities providing the regular service. In contrast, higher number of health facilities in Sudurpaschim Province (29%) and Karnali Province (28%) provided uninterrupted routine immunization services during the lockdown period.

Province wise comparison of Round 2 data shows that all HFs of Karnali (100%), 95 percent of those in Province 2 were able to offer routine immunization service without interruptions. On the contrary, less than half of the HFs in Province 1 was able to do so in Round 2 (Table 6.3).

Table 6.3 Province wise uninterrupted operation of routine immunization service in Round 1 and Round 2 Assessment

Province (N=413)	Round 1 (n=413)	Round 2 (n=140)
Province 1	8.7	47.8
Province 2	13.3	95.0
Bagmati Province	13.8	66.7
Gandaki Province	11.1	88.9
Lumbini Province	9.1	68.2
Karnali Province	28.1	100
Sudur paschim Province	28.9	87.5
Total	14.5	75.7

In terms of HFs, nearly all PHCCs (91%), and most of the non-COVID hospitals (80%) and COVID hospitals (78%) provided routine immunization service uninterrupted throughout in Round 2 (Table 6.4).

Table 6.4 Health facility wise uninterrupted operation of routine immunization service in Round 1 and Round 2 Assessment

Type of HFs	Round 1 (n=413)	Round 2 (n=140)
COVID hospital	22.2	77.8
Non-COVID hospital	23.3	80.0
PHCC	9.2	90.9
HP	11.4	75.8
UHC	20.4	65.8
Total	14.5	75.7

It may be pointed out that during the early stages of lockdown (Round 1) nearly half of the service providers (49%) reported that they received instructions from their district health office/local government to halt their routine immunization programme during the lockdown. This reason was also cited by around one sixth of the HFs in Round 2. Another two-fifth of the services providers cited about the strict implementation of the lockdown for halting the immunization services. Other reasons cited for interruption were: fear of COVID-19 transmission (23%), lack of PPE (10%) and lack of vaccine stocks (18%). However, lack of vaccine stock and PPE did not emerge as barriers for HFs in Round 2 assessment (Table 6.5).

Table 6.5 Reasons for disruption in routine immunization services in Round 1 and Round 2 Assessment

Reasons for not providing immunization services (N=364)	Round 1 (n=364)	Round 2 (n=34)
Service halted as per instruction from Health Office/local government	48.6	17.6
Due to strict implementation of lockdown	40.1	-
Fear of transmission of COVID-19 among providers	23.1	5.9
Lack of vaccine stock	18.1	-
Lack of PPE	10.2	-
Social restrictions due to COVID-19	-	32.4
Due to increase in COVID-19 cases	-	29.4
Staffs infected with COVID-19	-	17.6

Of the total 140 facilities re-visited in Round 2, immunization service in one facility was halted during the period between Bhadra- Kartik which had not been resumed yet. About a quarter of health facilities (24%) had disruption in immunization service during the period between Bhadra-Kartik.

Province wise, no disruption of the immunization service was reported in Karnali province. The highest disruption was observed in Province 1 where only 48 percent of facilities provided uninterrupted routine immunization service. More than two third of all the types of health facilities had provided uninterrupted routine immunization services during this period. The reasons cited for disruption of routine immunization services in Round 2 was social restrictions due to COVID 19 (32%), increase in COVID positive cases (29%), instruction

from district health office/local government to halt their routine immunization programme (18%) and staff infected by COVID 19 (18%).

6.2 Extent of Utilization of Child Health Services

6.2.1 Vitamin A supplementation to children

Vitamin A supplementation is a bi-annual programme of the Government and covers all children aged 6 to 59 months. This programme is carried out in the month of Baisakh (Mid-April-Mid-May) and Kartik (Mid-October – Mid-November) every year. Due to COVID-19 pandemic, the government had re-scheduled the Vitamin A supplementation programme for from the month of Baisakh to Asadh (Mid-June-Mid-July). The health facilities of nearly all provinces (98%) implemented the programme in Asadh this year. Comparatively, all the health facilities of Province 1 (100%) and Karnali Province (100%) had conducted the programme at their locations (Table 6.6)

At the health facility level, all PHCC (100%) and HP (100%) implemented the program in the month of Asadh this year. Two non-COVID hospitals, one COVID hospital and six UHCs were unable to implement this programme (Table 6.7).

Table 6.6 Province wise distribution of Vitamin A to children in the month of Asadh (Round 1 Assessment)

Province (N=424)	%
Province 1 (n=69)	100.0
Province 2 (n=60)	98.3
Bagmati Province (n=92)	97.8
Gandaki Province (n=55)	98.2
Lumbini Province (n=68)	95.6
Karnali Province (n=32)	100.0
Sudurpaschim Province (n=48)	95.8
Total	97.9

Table 6.7 Health facility wise distribution of Vitamin A to children in the month of Asadh (Round 1 Assessment)

Type of HFs (n=424)	%
COVID hospital (n=10)	90.0
Non-COVID hospital (n=31)	93.5
PHCC (n=65)	100.0
HP (n=201)	100.0
UHC (n=117)	94.9
Total	97.9

6.2.2 Availability of services for childhood illness

Of the 424 health facilities, 63 facilities (15%) reported difficulty in providing services for childhood illness. Province-wise, the percentage of health facilities reporting difficulties in providing child health services was relatively high in Lumbini Province (25%) followed by Sudurpaschim province (23%) and least in Karnali Province (6%) and Gandaki Province (7%) (Table 6.8). The percentages of health facilities reporting the difficulty was highest for COVID hospitals (20%) and the least for PHCCs (12%) (Table 6.9).

The major difficulty reported by health service providers was fear of transmission of COVID 19 among providers followed by commodity stock out and lack of PPE. (Table 6.10).

Table 6.8 Province wise reporting of difficulty in service provision for childhood illness in Round 1 Assessment

Province (N=424)	%
Province 1	15.9
Province 2	10.0
Bagmati Province	13.0
Gandaki Province	7.3
Lumbini Province	25.0
Karnali Province	6.3
Sudurpaschim Province	22.9
Total	14.9

Table 6.9 Health facility wise reporting of difficulty in service provision for childhood illness in Round 1 Assessment

Type of HFs (N=424)	%
COVID hospital (n=10)	20.0
Non-COVID hospital (n=31)	16.1
PHCC (n=65)	12.3
HP (n=201)	16.4
UHC (n=117)	12.8
Total	14.9

Table 6.10 Reasons for difficulty in service provision for childhood illness as reported in Round 1 Assessment

Difficulties (n=63)	%
Fear of Transmission of COVID-19 among providers	49.2
Commodities/equipment/necessary supplies are out of stock	39.7
Lack of PPE	34.9
Social restrictions due to COVID-19	23.8
Unavailability of staffs	14.3
Fear of COVID-19 among clients	4.8

6.2.3 Cold chain

The service providers from all the facilities in all provinces reported that they were able to maintain cold chain at the time of immunization during the 5 months' lockdown period.

6.3 Vitamin-A Supplementation to Mothers of Newborn

Birthing centers of 198 health facilities were functional during the lockdown period. Of them, more than 95% had provided Vitamin A supplementation to the mothers of newborn during the lockdown period. All mothers (100%) in Province 2, Gandaki Province, Karnali province and Sudurpaschim Province received Vitamin A supplementation during the lockdown period. Three health facilities in Province 1 and Lumbini Province and one facility in Bagmati Province couldn't provide Vitamin A to mothers.

Round 2 Assessment indicated an eight percent reduction of HFs providing Vit-A supplementation to mothers of newborn from 96.5 to 88.5 (Table 6.11). The reduction was the highest in province 2 (40% reduction), while three provinces (Bagmati, Karnal and Sudurpaschim) had maintained their 'cent percent' status quo in Round 2.

Health facility wise distribution shows, one COVID hospital and non-COVID hospital, two PHCCs and three Health Posts were unable to distribute Vitamin A supplements to mothers of newborn delivered at the facility (Table 6.12).

Table 6.11 Province wise distribution of Vitamin A supplementation to mothers of newborn in Round 1 and Round 2 Assessment

Province	Round 1 (n=198)	Round 2 (n= 61)
Province 1	90.6	88.9
Province 2	100.0	60.0
Bagmati Province	96.9	100.0
Gandaki Province	100.0	87.5
Lumbini Province	88.5	66.7
Karnali Province	100.0	100.0
Sudurpaschim Province	100.0	100.0
Total	96.5	88.5

Table 6.12 Health facility wise distribution of Vitamin A supplementation to mothers of newborn in Round 1 and Round 2 Assessment

Type of Health Facility	Round 1 (n=198)	Round 2 (n= 61)
COVID hospital	90.0	77.8
Non-COVID hospital	96.8	100
PHCC	96.6	80.0
HP	96.6	95.8
UHC	100	100
Total	96.5	88.5

6.4 FCHV's Perspectives on Utilization of Child Health Services

In Round 1 assessment, a large majority of FCHVs (71%) reported that children in their area received immunization services during 5 months' lockdown period. Children's inability to receive the immunization during the lockdown period was reported by about two thirds of the FCHVs of Province 1 (55%) followed by Lumbini (50%) and Gandaki (44%). While nearly universal coverage was reported by FCHVs of Karnali Province (98%), Province 2 (97%) and Sudurpaschim Province (96%).

It is noteworthy to find that in Round 2, all the FCHVs of Gandaki (100%), Karnali (100%) and Sudurpaschim (100%) provinces mentioned that newborn and children in their area received the immunization service. However, it was dismaying to find a relatively low percentage of FCHVs of Province 1 (57%) reporting on immunization as compared to other provinces in Round 2 (Table 6.13).

Instructions from the local government to halt the childhood immunization programme due to COVID-19 pandemic was cited as the major reason by the FCHVs for children's inability to receive immunization service during 5 months' lockdown period (Table 6.14).

All FCHVs across all provinces reported about providing Vitamin A supplementation to children during the month of Asadh (July 2020). Decline in the number of children seeking health attention for childhood illnesses during lockdown period was reported by 29 percent of the FCHVs (Table not shown).

Table 6.13 Percentages of new-born and children receiving immunization services: FCHVs perspective in Round 1 and Round 2 Assessment

Province	Round 1 (N=424)	Round 2 (N=140)
Province 1	44.9	56.5
Province 2	96.7	95.0
Bagmati Province	75.0	66.7
Gandaki Province	56.4	100.0
Lumbini Province	50.0	77.3
Karnali Province	97.9	100.0
Sudurpaschim Province	95.8	100.0
Total	70.8	81.4

Table 6.14 Reasons for not receiving immunization services: FCHVs' perspectives: Round 1 Assessment

Reasons for not receiving immunization (n=124)	%
Local Government halted immunization programme	54.0
No PHC-ORC clinics	21.0
Fear of visiting health facility due to COVID	19.4
Strict lockdown	16.9

Chapter 7

Functionality and Utilization of Adolescent Friendly Health Services

7.1 Functionality of ASRH Services

A total of 180 out of 424 health facilities covered in Round 1 were certified for providing Adolescent Friendly Health Services (AFHS). Of these 180 health facilities 77 percent were able to provide the service without interruption during 5 months' lockdown period. Fourteen percent of the AFHS were halted during the initial period and then resumed the service later. About 8 percent of the AFHS was non-functional even before the lockdown period (5 each of PHCCs and HPs and in each of other health facilities). Four health facilities that had halted the AFHS could not resume this service at the time of the present assessment.

A total of 52 out of 140 HFs covered in Round 2 were accredited for providing AFHS. Of these, 77 percent were providing services without interruption during the period between Bhadra- Kartik. AFHS was interrupted in eight percent of the facilities for some time and then resumed later. The service was not yet resumed in 12 percent of the facilities after it was halted during this period. Few health facilities (4%) reported about AFHS services being non-functional even before the COVID-19 lockdowns.

Province-wise comparison shows, in Round 1, nearly all AFHS of Karnali Province (95%) and Gandaki Province (94%) were functional without any interruptions during the lockdown period. On the other hand, three provinces, viz., Province 1 (64%), Sudurpaschim Province (65%) and Lumbini Province (69%) had lower percentages of health facilities providing AFHS throughout the lockdown period without interruption (Table 7.1).

In Round 2, all the facilities in Karnali and Lumbini province provided the AFHS service without interruption during the period between Bhadra-Kartik. A quarter of health facilities in Province 1 had halted the service during this period initially and was resumed later (Table 7.1).

A higher percentage of health posts (86%) provided AFHS throughout the lockdown period (Round 1) in comparison to other health facilities. Only about half of COVID hospitals (56%) did so. The percentages of HFs functioning with interruption in Round 2 ranged from 50 (non-COVID) to 100 (UHC) though the number of these two levels of HFs was 2 each (Table 7.2)

Table 7.1 Province wise functionality of AFHS in Round 1 and Round 2 Assessment

ROUND 1								
	Province 1 (n=28)	Province 2 (n=20)	Bagmati Province (n=46)	Gandaki Province (n=16)	Lumbini Province (n=29)	Karnali Province (n=21)	Sudurpaschim Province (n=20)	Total (n=180)
Provided at all time without interruption	64.3	75.0	80.4	93.8	69.0	95.2	65.0	76.7
Halted initially but resumed now	21.4	10.0	8.7	6.3	20.7	4.8	20.0	13.3
Halted and not resumed yet	-	-	6.5	-	-	-	5.0	2.2
Service not functional before lockdown	14.3	15.0	4.3	-	10.3	-	10.0	7.8
ROUND 2								
	Province 1 (n=8)	Province 2 (n=5)	Bagmati Province (n=13)	Gandaki Province (n=2)	Lumbini Province (n=10)	Karnali Province (n=6)	Sudurpaschim Province (n=8)	Total (n=52)
Provided at all time without interruption	3 (37.5)	2 (40.0)	11 (84.6)	1 (50.0)	10 (100)	6 (100)	7 (87.5)	76.9
Halted initially but resumed now	2 (25.0)	1 (20.0)	1 (7.7)	-	-	-	-	7.7
Halted and not resumed yet	1 (12.5)	2 (40.0)	1 (7.7)	1 (50.0)	--	-	1 (12.5)	11.5
Service not functional before COVID-19	2 (25.0)	-	-	-	-	-	-	3.8

Table 7.2 Facility wise Functionality of AFHS in Round 1 and Round 2 Assessment

ROUND 1						
	COVID hospital (n=9)	Non- COVID hospital (n=18)	PHCC (n=48)	Health Post (n=84)	UHC (n=21)	Total % (n=180)
Provided at all time without interruption	55.6	66.7	68.8	85.7	76.2	76.7
Halted initially but resumed now	22.2	16.7	20.8	7.1	14.3	13.3
Halted and not resumed yet	11.1	5.6	-	1.2	4.8	2.2
Service not functional before lockdown	11.1	11.1	10.4	6.0	4.8	7.8
ROUND 2						
	COVID hospital (n=8)	Non- COVID hospital (n=2)	PHCC (n=15)	HP (n=25)	UHC (n=2)	Total % (n=52)
Provided at all time without interruption	6(75.0)	1 (50.0)	11 (73.3)	20 (80.0)	2 (100.0)	76.9
Halted initially but resumed now	1(12.5)	1 (50.0)	1 (6.7)	1 (4.0)	-	7.7
Halted and not resumed yet	-	-	3 (20.0)	3 (12.0)	-	11.5
Service not functional before COVID-19	1(12.5)	-	-	1 (4.0)	-	3.8

7.2 Range of SRH Services sought by Adolescent Girls

An overwhelmingly large percentage of service providers (84.0%) in Round 1 reported that adolescent girls mostly visited their health facilities (at any time) for menstruation related matters. Over a third of the services providers (36%) also mentioned about treatment for the problem of urinary tract infection/reproductive tract infection (UTI/RTI). Adolescent girls seeking FP contraceptives (25%), pregnancy tests (24%), treatment of STIs (23%) were mentioned by a quarter of the service providers. In addition, few service providers reported that adolescent girls sought abortion (11%) and emergency contraceptives (8%) from their facilities.

A high percentage of service providers of Province 2 than in other provinces mentioned about adolescent girls seeking FP contraceptives (53%), pregnancy tests (35%) and for safe abortion (24%) (Table 7.3). Whereas, the percentages of service providers mentioning UTI/RTI treatment seeking among adolescent girls were high for Lumbini Province (46%), Karnali Province (43%) and Province 1 (42%). Lumbini Province also had a higher percentage of service providers reporting about adolescent girls seeking treatment for STIs (35%) than in other provinces.

The two most SRH related problems for which adolescent girls visited the AFHS as mentioned by the service providers in Round 2 Assessment were UTI/RTI (94%) and menstrual related (88%) (Table 7.3a). Two in five girls (42%) came for the treatment for STIs while one in six came for pregnancy tests. None of the adolescent girls sought service in Province 2, COVID hospitals and UHCs. The highest number of service providers in Lumbini and Karnali Province mentioned adolescent girls sought service for UTI/RTI.

Table 7.3 Province wise classification of SRH matters for which adolescent girls sought services: Round 1 and Round 2 Assessment

ROUND 1								
SRH related matters	Province 1 (n=24)	Province 2 (n=17)	Bagmati Province (n=41)	Gandaki Province (n=16)	Lumbini Province (n=26)	Karnali Province (n=21)	Sudurpaschim Province (n=17)	Total (n=162)
Menstruation related problems/ concerns	79.2	76.5	90.2	81.3	80.8	90.5	82.4	84.0
UTI/RTI	41.7	35.3	31.7	12.5	46.2	42.9	35.3	35.8
FP Contraceptives	20.8	52.9	14.6	31.3	23.1	28.6	17.6	24.7
STI	20.8	17.6	22.0	6.3	34.6	23.8	29.4	22.8
Pregnancy test	20.8	35.3	26.8	6.3	34.6	14.3	17.6	23.5
Abortion	20.8	23.5	7.3	-	11.5	4.8	11.8	11.1
EC	12.5	-	7.3	6.3	15.4	9.5	-	8.0
ROUND 2								
SRH related matters	Province 1 (n=1)	Province 2 (n=)	Bagmati Province (n=2)	Gandaki Province (n=1)	Lumbini Province (n=5)	Karnali Province (n=5)	Sudurpaschim Province (n=3)	Total (n=17)
Menstruation related problems/ concerns	-	-	2	1	4	5	3	88.2
UTI/RTI	1	-	2	-	5	5	3	94.1
FP Contraceptives	-	-	1	-	-	1	-	11.8
STI	-	-	1	1	1	1	3	41.2
Pregnancy test	-	-	-	-	-	2	1	17.6
GBV	-	-	-	-	-	-	1	5.9

More than two third service providers across all level of health facilities in Round 1 stated adolescent girls visit their facilities to seek service for menstruation related problems. The percentages of service providers citing about SRH service seeking behaviors of adolescent girls were very high for COVID hospitals followed by non-COVID hospitals in Round 1 (Table 7.4). Round 2 results also corroborate previous round's results regarding almost all non-COVID hospitals, PHCC and HP provided services for menstrual related and UTI/RTI care to adolescent clients (Table 7.4).

Table 7.4 Health facility wise classification of SRH matters for which adolescent girls sought services: Round 1 and Round 2 Assessment

ROUND 1						
SRH related matters	COVID hospital (n=7)	Non- COVID hospital (n=15)	PHCC (n=43)	HP (n=78)	UHC (n=19)	Total (n=162)
Menstruation related problems/concerns	100.0	86.7	88.4	78.2	89.5	84.0
UTI/RTI	71.4	46.7	35.4	37.2	30.8	35.8
FP Contraceptives	42.9	40.0	22.9	20.5	21.1	24.7
STI	57.1	60.0	18.8	14.1	26.3	22.8
Pregnancy test	57.1	53.3	25.0	27.9	14.1	23.5
Abortion	42.9	26.7	14.6	5.1	-	11.1
EC	28.6	20.0	8.3	3.8	5.3	8.0
ROUND 2						
SRH related matters	COVID hospital	Non- COVID hospital (n=5)	PHCC (n=5)	HP (n=7)	UHC	Total (n=17)
Menstruation related problems/concerns	-	100.0	80.0	85.7	-	88.2
UTI/RTI	-	100.0	80.0	100.0	-	94.1
FP Contraceptives	-	-	20.0	14.3	-	11.8
STI	-	40.0	60.0	28.6	-	41.2
Pregnancy test	-	40.0	-	14.3	-	17.6
GBV	-	20.0	-	-	-	5.9

7.3 Range of SRH Services Sought by Adolescent Boys

Half of the service providers in Round 1 reported that most of the adolescent boys visit their facility to seek family planning commodities. Other matters that adolescent boys sought service were STI and UTI. As compared to other provinces, fewer percentages of service providers for Province 1 and Gandaki Province reported about adolescent boys visiting their facilities for FP contraceptives (21%) and for STIs (6%) respectively in Round 1 assessment. On the other hand, Karnali Province (86%) and Province 2 (71%) had higher percentage of service providers reporting about adolescent boys seeking FP services at the health facilities (Table 7.5).

Table 7.5 Province wise classification of SRH matters for which adolescent boys sought service: Round 1 and Round 2 Assessment

ROUND 1								
SRH related matters	Province 1 (n=24)	Province 2 (n=17)	Bagmati Province (n=41)	Gandaki Province (n=16)	Lumbini Province (n=26)	Karnali Province (n=21)	Sudurpaschim Province (n=17)	Total (n=162)
FP Contraceptives	20.8	70.6	39.0	50.0	53.8	85.7	47.1.0	50.0
STI	37.5	35.3	31.7	6.3	30.8	23.8	35.3	29.6
UTI	41.7	5.9	26.8	18.8	34.6	4.8	29.4	24.7
ROUND 2								
SRH related matters	Province 1 (n=2)	Province 2 (n=1)	Bagmati Province (n=4)	Gandaki Province (n=1)	Lumbini Province (n=6)	Karnali Province (n=6)	Sudurpaschim Province (n=4)	Total (n=24)
FP Contraceptives	-	1 (100.0)	3 (75.0)	1 (100.0)	3 (50.0)	5 (83.3)	3 (75.0)	16 (66.7)
STI	1 (50.0)	-	2 (50.0)		2 (33.3)	3 (50.0)	4 (100.0)	12 (50.0)
UTI	2 (100.0)	-	1 (25.0)	1 (100.0)	5 (83.3)	3 (50.0)	1 (50.0)	13(54.2)

Percentages total may have exceeded 100 due to multiple response

The percentage of service providers saying adolescent boys seeking family planning commodities was quite high for non-COVID hospitals (67%) and UHC (68%). Adolescent boys seeking treatment for STIs and UTIs were higher at hospital level. For instance, approximately three fourths of the service providers based at COVID hospitals (71%) and half of those at non-COVID hospitals (53%) said that adolescent boys sought treatment for STIs. Likewise, two thirds of the service providers based at non-COVID hospitals (67%) and over a half of those at COVID hospitals mentioned that the adolescent boys usually visit their facilities for treatment of UTI (Table 7.6).

In Round 2, about two third of the services providers mentioned about adolescent boys seeking FP contraceptives from their AFHS. The proportion of service providers saying so was similar to that of Round 1. A very high proportion of service providers from all the seven provinces except in Province 1 reported about adolescent boys seeking FP commodities and for treatment of UTIs from their HFs (Table 7.6).

Table 7.6 Health facility wise classification of SRH matters for which adolescent boys sought services in Round 1 and Round 2 Assessment

SRH related matters	COVID hospital (n=7)	Non-COVID hospital (n=15)	PHCC (n=43)	HP (n=78)	UHC (n=19)	Total (n=162)
Round 1						
FP Contraceptives	57.1	66.7	46.5	46.2	68.4	50.0
STI	71.4	53.3	23.3	24.4	31.6	29.6
UTI	57.1	66.7	32.6	11.5	15.8	24.7
Round 2						(n=24)
FP Contraceptives	2 (40.0)	1 (100.0)	4 (80.0)	8(66.7)	1 (100)	16 (66.7)
STI	4 (80.0)	1 (100.0)	3 (60.0)	4 (33.3)	-	12 (50.0)
UTI	5 (100.0)	1 (100.0)	3(60.0)	4 (33.3)	-	13(54.2)

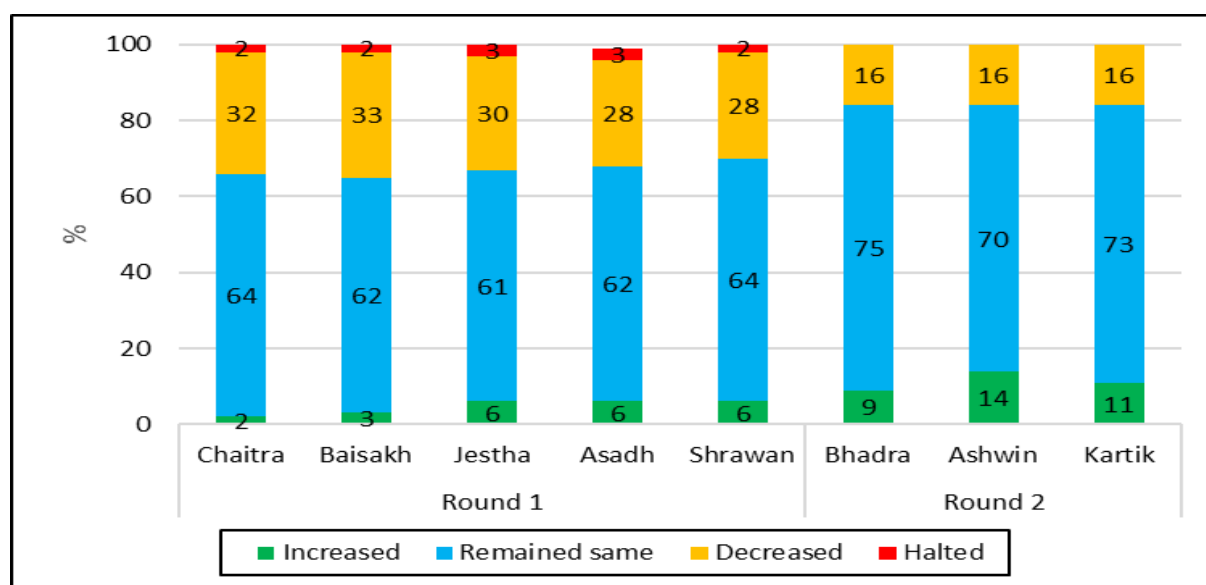
Percentages total may have exceeded 100 due to multiple response

7.4 Extent of Care Seeking for Menstruation related Matters during the Lockdown Period

More than 60 percent of health service providers reported that the flow of adolescent girls seeking care for menstruation related services at their facilities had remained unchanged during the 5 months' lockdown period. An average of 30 percent of the health service providers reported decrease in flow of adolescent girls during the lockdown period. The percentages of service providers mentioning an increase was negligible (Figure 7.1). The highest decrease in adolescent girls seeking care for menstrual related care was reported in Lumbini Province in first two months of lockdown while the decrease was high in Sudurpaschim Province in later three months (Annex 7.1). The highest decrease in flow of adolescent girls seeking service was reported by COVID hospitals in the first two months of the lockdown while PHCCs experienced the decrease in the later three months (Annex 7.2).

In Round 2, a higher number of service providers mentioned the flow of adolescent girls seeking care for menstruation related services in the months of Bhadra and Ashwin has increased in comparison to first five months' lockdown period and slightly decreased in the month of Kartik. Province-wise, there was an increase in adolescent girls seeking menstruation related care in Sudurpaschim Province in Round 2 in comparison to other provinces while the number of clients remained same throughout the three months' period in Province 2 and Gandaki Province. Increase in adolescent girls seeking care for menstruation related problems was evident in Round 2 (Ashwin and Kartik) in Province 1 (Figure 7.1).

Figure 7.1 Extent of care seeking for menstrual related matters by adolescent girls in Round 1 and Round 2 Assessment



The most common reason for the decrease in menstruation related care seeking among the adolescent girls during the lockdown period was the fear of contracting COVID-19 by the girls (76%). Social restrictions due to COVID-19 (67%), lack of transportation (38%) and closure of schools/ colleges (22%) were other reasons responsible for the decrease in flow of the adolescent girls seeking service (Table 7.7). Very few health service providers attributed halting of the ASRH services during lockdown to non-availability of trained service providers and fear of infection among service providers.

Table 7.7 Reasons for decrease in utilization of service for menstruation related problems in Round 1 Assessment

Reasons	COVID hospital (5)	Non-COVID hospital (5)	PHCC (22)	HP (21)	UHC (5)	Total (58)
Fear of infection among clients	100.0	80.0	72.7	71.4	80.0	75.9
Social restrictions due to COVID-19	80.0	40.0	54.5	81.9	80.0	67.2
Lack of transportation	60.0	80.0	31.8	28.6	40.0	37.9
Closure of schools		-	27.3	33.3		22.4

7.5 Extent of Utilization of STI Services

More than two thirds (70%) of the service providers in Round 1 stated that the flow of the adolescent clients seeking STI related services remained the same during the five months' lockdown period in comparison to the period prior to lockdown (Figure 7.2). About a quarter of the service providers mentioned decrease in flow of adolescent clients seeking STI related services throughout the lockdown. Overall, 69 percent of the service providers linked the

decrease in flow of the adolescent clients to fear of COVID 19 infection and the social restrictions due to clamping lockdowns (Table 7.8).

Table 7.8 Reasons for decrease in utilization of service for STIs by adolescent clients: Round 1 Assessment

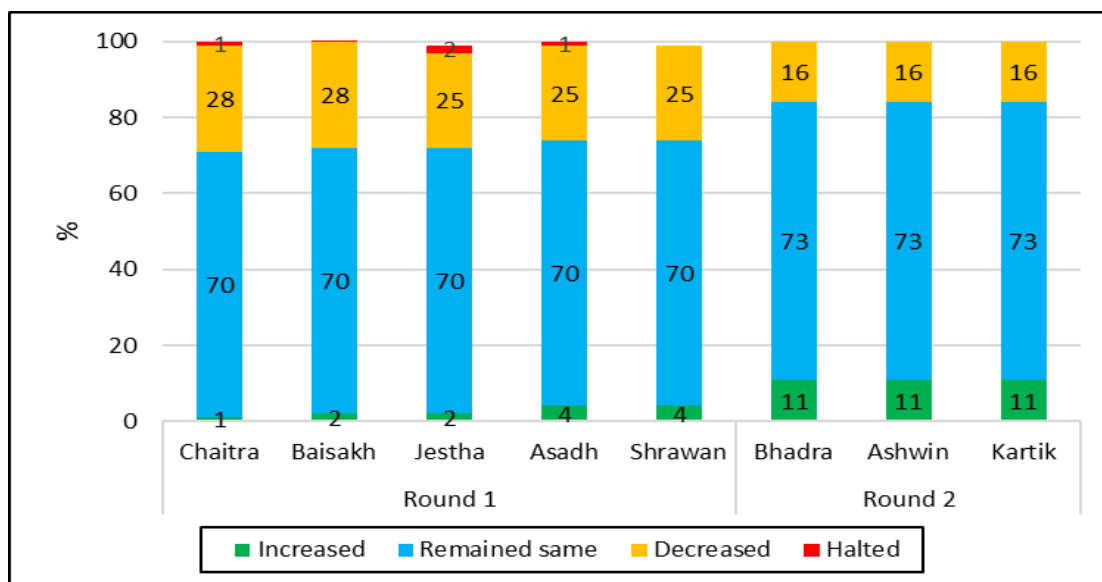
Reasons	COVID hospital (3)	Non-COVID hospital (3)	PHCC (19)	HP (20)	UHC (3)	Total (48)
Fear of infection among clients	100.0	66.7	63.2	65.0	100.0	68.8
Social restrictions due to COVID-19	100.0	66.7	57.9	70.0	100.0	68.8
Lack of transportation	100.0	66.7	31.6	25.0	33.3	35.4

The extent of service utilization by adolescents remained same throughout the 5 months' lockdown period in Sudurpaschim province with highest decrease in comparison to other provinces (Annex 7.3). Likewise, the highest decrease in flow of adolescent clients seeking STI service during first two months of lockdown was observed in COVID hospitals while the decrease was evident in PHCC in the later 3 months (Annex 7.4).

In Round 2, a higher percentage of service providers mentioned about an increase in adolescent clients seeking STI services post 5 months' lockdown. The proportion of service seekers was consistent throughout the three months (Bhadra, Ashwin, Kartik). There has been an increase in adolescent clients seeking STI related service in Karnali and Sudurpaschim provinces later three months, while the number of STI service seeker remained the same throughout the three months' period in Province 2 and Gandaki Province.

Facility-wise comparison shows that there has been a marginal increase in adolescent clients seeking STI related service at PHCC and Health Posts, while it remained the same in non-COVID Hospitals and UHC.

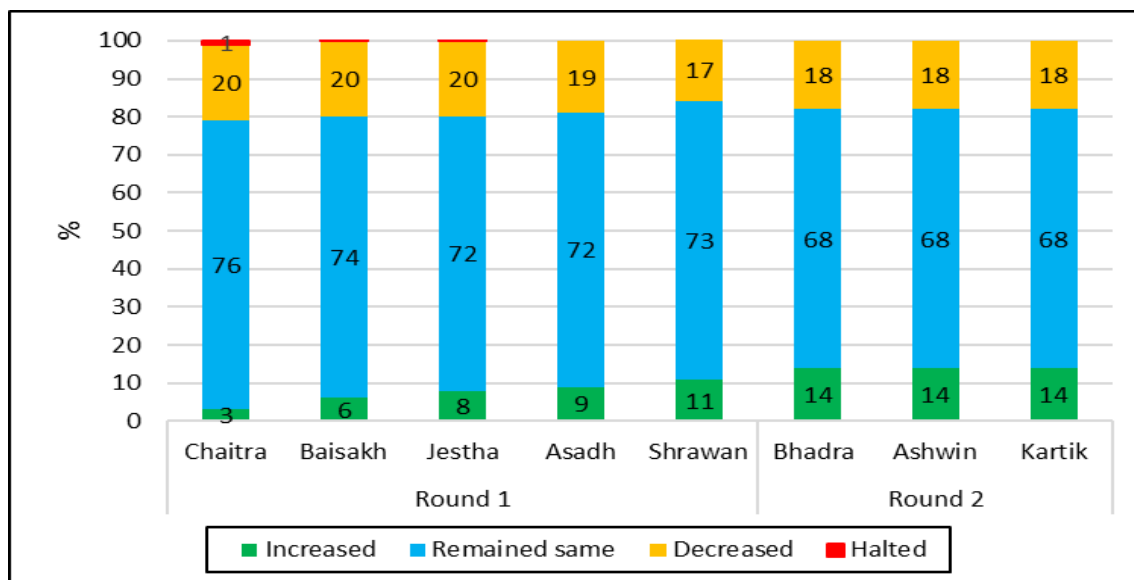
Figure 7.2 Extent of utilization of STI services by adolescents in Round 1 and Round 2 Assessment



7.6 Extent of Utilization of FP Services

Overall, about three quarters service providers (73%) reported that the flow of adolescent clients seeking FP services remained the same throughout 5 months' lockdown period (Round 1 assessment) in comparison to the period prior to lockdown. A fifth of them reported about the decline in client flow the first three months of lockdown (Chaitra, Baisakh and Jestha) which slightly picked up from the month of Asadh (Figure 7.3).

Figure 7.3 Extent of utilization of FP services by adolescent clients in Round 1 and Round 2 Assessment



There was slight increase in clients seeking FP services in Bagmati province in comparison to other provinces in the month of Asadh (Annex 7.5) A consistent decrease in adolescent clients seeking FP services in PHCC throughout the lockdown was apparent while the decrease was consistent for COVID hospitals and non-COVID hospitals for initial three and four months respectively (Annex 7.6).

The status of adolescent client flow seeking FP service was same throughout the lockdown period (Round 1) in Gandaki Province (Annex: 7.5). Social restrictions due to COVID-19, fear of COVID transmission and lack of transportation were the reasons attributed for the decrease in flow of the clients (Table 7.9).

In Round 2, a higher number of service providers stated about an increase in adolescent client flow for FP services. Province-wise, Karnali experienced such a trend as compared to other provinces. The proportion of adolescent client seeking FP services remained same throughout the three months' period in Province 2 and Gandaki Province. A slight increase in adolescent clients seeking FP service was reported by service providers of PHCC and Health Posts (Table not shown).

Table 7.9 Reasons for decrease in utilization of FP services in Round 1 Assessment

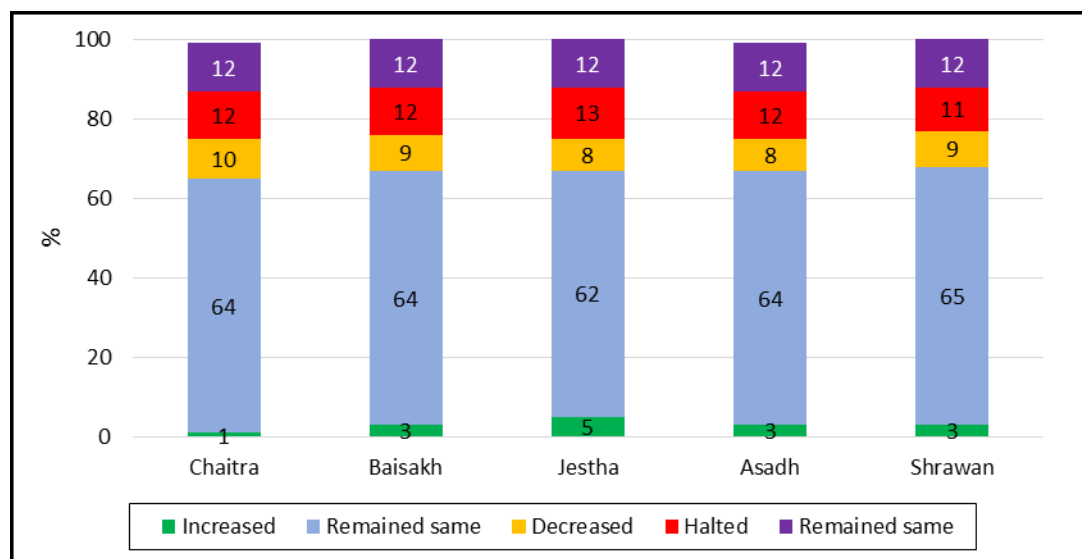
Reasons	COVID hospital (2)	Non-COVID hospital (3)	PHCC (10)	HP (19)	UHC (3)	Total (37)
Social restrictions due to COVID -19	100.0	100.0	90.0	73.7	33.3	78.4
Fear of transmission of COVID -19 among clients	100.0	33.3	80.0	57.9	100.0	67.6
Lack of transportation	100.0	100.0	40.0	10.5	-	29.7

7.7 Extent of Use for Emergency Contraceptive Pills (ECP)

A slightly more than 3/5th of the health service providers reported that the flow of adolescents seeking emergency contraceptive pills (ECP) had remained same during the 5 months' lockdown period (Round 1) In an average, 9 percent of service providers stated a decrease in flow of adolescents seeking ECP during lockdown while 12 percent reported about halting of ECP provision (Figure 7.4). There was a negligible increase in flow of adolescent clients seeking ECP in Bagmati province and UHCs throughout the lockdown period (Annex 7.7 &7.8).

More than half of the health service providers attributed social restrictions on mobility due to COVID-19 as a major reason for decrease in flow of adolescents seeking ECP. Fear of transmission of COVID-19 among service providers and non-availability of trained service providers were the other reasons cited. There was no provision of ECP at 12 percent of the HFs (Table not shown)

Figure 7.4 Emergency Contraceptive Pills use among adolescent clients in Round 1 Assessment



7.8 Types of SRH Services Sought by Married Adolescent Girls: FCHVs' Perspectives

Of the total 424 FCHVs, 186 FCHVs (44%) mentioned that married adolescent girls sought SRH services from them during 5 months' lockdown. Family planning advice and commodities was the most common service sought by married adolescent girls from the FCHVs (71% of the FCHVs said so). About 39 percent of FCHVs stated that the young married adolescent girls sought routine ANC from them (Table 7.10).

Most of the FCHVs in Province 2 and Sudurpaschim province mentioned married adolescent girls sought temporary family planning commodities from them (Annex 7.9).

Of the 140 FCHVs covered in Round 2, 54 FCHVs (39 percent) mentioned young married adolescent girls sought service from them during the period between Bhadra- Kartik. Most of the FCHVs stated girls sought FP commodities from them as in Round 1. About half of the FCHVs mentioned that young girls also came to them for pregnancy confirmation.

All the FCHVs in Sudurpaschim Province (as in Round 1) and a large majority of FCHVs in Province 1 and Karnali Province mentioned that the young married girls sought family planning advice and commodities from them (Table 7.10)

Table 7.10 Types of SRH services sought by married adolescent girls from FCHVs: Round 1 and Round 2 Assessment

Services sought by young married adolescents (n=186)	Round 1 (n =186)	Round 2 (n =54)
Temporary FP	70.9	63.0
Routine ANC	38.7	44.4
Pregnancy confirmation	38.1	50.0
AFHS	14.5	1.9
Childhood immunization	13.4	27.8
Normal delivery/BEONC	7.5	7.4
PNC	6.5	-
LARC	5.4	-
EC	5.9	-
SAS	4.8	9.3

FCHVs identified various challenges/obstacles those had hindered SRH service seeking among the married adolescent girls during the 5 months of lockdown period. Of these, the most common obstacle eluding married adolescent girls from seeking care (50%) was the fear of contracting COVID-19 (50%). Lack of transport (30%) and strict implementation of lockdown (24%) were other main reasons (Table 7.11).

Table 7.11 Challenges faced by married adolescent girls seeking SRH services during the lockdown period: FCHVs' Perspectives in Round 1 Assessment

Challenges faced by adolescent girls	%
Fear of transmission of COVID-19	50.0
Lack of transport	29.6
Strict implementation of lockdown and social distancing	23.7
Absence of female service providers	7.0
Lack of medicine/FP methods	3.8
Lack of service providers	1.1

Chapter 8

One Stop Crisis Management Center

8.1 Functionality of OCMC Service

One stop crisis management center (OCMC) is established at hospital level (where most services are integrated) but at a limited number of facilities to provide psycho-social counseling, treatment, security/safety, legal support and rehabilitation for survivors of gender-based violence (GBV). Of the 41 hospitals covered in Round 1 Assessment, 26 hospitals were accredited for providing OCMC service. Of these, three OCMC hospitals each were located in Province 1, Province 2, Karnali and Sudurpaschim province, five OCMC hospitals each in Bagmati and Lumbini Province, four hospitals in Gandaki Province. Nine of the 26 OCMC were based at COVID hospitals and 17 at non-COVID hospitals.

OCMCs in all 26 facilities covered in Round 1 were functional. Operation of OCMC was disrupted for some time at 15 percent of the hospitals which was resumed later on.

All the 13 OCMC covered in Round 2 were functional. Operation of OCMC was disrupted for some time in one facility during the period between Bhadra- Kartik but was resumed subsequently at later months.

8.2 Utilization of OCMC Service

An increasing number of service providers reported about the surge of GBV cases seeking care at their OCMC during the five months of lockdown period. As evident from Table 8.1, only 15 percent of the service providers had reported about the increase in GBV cases during the third month and further increased to 31 percent and 39 percent in the fourth and the fifth month. Inversely, the percentage of service providers reporting the GBV cases as “remained the same” declined each month from the second month onwards (Figure 8.1). The increase in number of GBV clients during all months of lockdown was observed in Province 2 and Lumbini Province (Annex 9.1). The most common reason cited by health care providers for increase in GBV cases was frustration/stress during lockdown period (64%). Unemployment (27%) and increased awareness about place for seeking care and support (27%) had also contributed to the increase in GBV survivors visiting the OCMC (Table 8.1).

A significant number of the service providers mentioned of increase in cases of GBV during the month of Ashwin (46%) and Kartik (54%) in comparison to the lockdown period. The number of GBV cases seeking care increased throughout the three months’ period in Lumbini Province while it remained same in Province 2.

Figure 8.1 Extent of utilization of OCMC: Round 1 and Round 2 Assessment

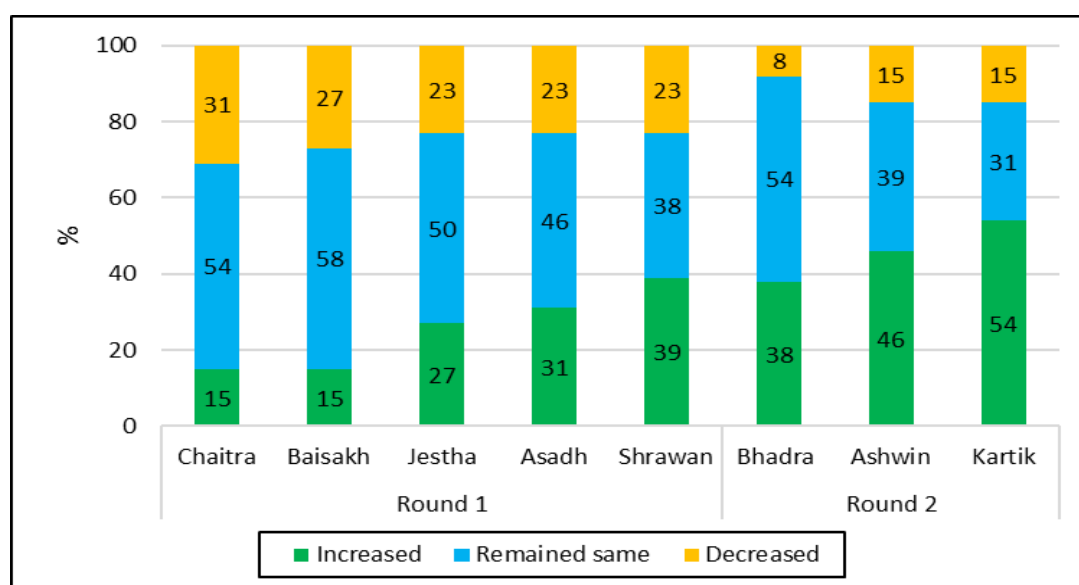


Table 8.1 Reasons for increase in number of GBV survivors during the lockdown period: Round 1 Assessment

Reasons for increase in GBV survivors (n=26)	%
Frustration/stress most of the time during lockdown	63.6
Unemployment	27.3
Awareness about place for redressing Violence	27.3

8.3 Types of GBV Cases Seeking Care at OCMC during the Lockdown Period

During the five months of lockdown period, all the 26 OCMCs (100%) received cases of sexual violence. Physical violence was reported in 24 (92 %) OCMCs while slightly more than half of the OCMCs (57.7%) i.e., 15 centers reported cases of emotional violence (Table 8.2).

All of the OCMCs except few in Province 1 and Karnali Province reported cases of physical violence. Emotional violence was least reported in Sudurpaschim province while Bagmati province reported highest number of cases of emotional violence (Table 8.2).

During three months' period (Round 2), all the 13 OCMCs (100%) received cases of physical violence. Sexual violence was reported in 12 (92%) of OCMCs while emotional violence was reported in 11 (85%) OCMCs.

All the OCMCs across all provinces excepting Sudurpaschim Province reported cases of Sexual violence. No case of emotional violence was reported in Province 1.

Table 8.2 Province wise distribution of type of Gender based violence reported in Round 1 and Round 2 Assessment

Types of violence	Province 1 (n=3)	Province 2 (n=3)	Bagmati Province (n=5)	Gandaki Province (n=4)	Lumbini Province (n=5)	Karnali Province (n=3)	Sudurpaschim Province (n=3)	Total (n=26)
Round 1								
Physical violence	2	3	5	4	5	2	3	24 (92.3)
Emotional violence	-	2	4	3	3	2	1	15 (57.7)
Sexual violence	3	3	5	4	5	3	2	26 (100.0)
Round 2								
Physical violence	2	1	3	2	3	1	1	100
Emotional violence	2	1	2	2	3	1	1	84.6
Sexual violence	2	1	2	2	3	1	1	92.3

Table 8.3 Distribution of OCMC facilities according to type of Gender based violence reported in Round 1 and Round 2 Assessment

Types of violence	COVID hospital (n=9)	Non-COVID hospital (n=17)	Total (n=26)
Round 1			
Physical violence	8	16	24 (92.0)
Emotional violence	5	10	15 (56.0)
Sexual violence	9	17	26 (100.0)
Round 2			
Physical violence	9	4	13 (100.0)
Emotional violence	7	4	11 (85.0)
Sexual violence	8	4	12 (92.0)

8.4 Type of Gender Based Violence Reported during Lockdown Period

Majority of the OCMCs (19) reported increase in cases of physical violence and sexual violence during COVID-19 lockdowns. Province-wise, excepting Bagmati province, the OCMCs from all the six provinces reported about the increase in physical as well as sexual violence during the lockdown period (Table 8.4).

Table 8.4 Province wise distribution of increase in type of Gender based violence reported in Round 1 Assessment

Types of violence	Province 1 (n=3)	Province 2 (n=3)	Bagmati Province (n=5)	Gandaki Province (n=4)	Lumbini Province (n=5)	Karnali Province (n=3)	Sudurpaschim Province (n=3)	Total (n=26)
Physical violence	2	2	4	4	3	2	2	19 (73.1)
Emotional violence	-	2	4	3	2	2	1	14 (53.8)
Sexual violence	3	2	3	4	3	2	2	19 (73.1)

Table 8.5 Distribution of OCMC facilities according to increase in type of Gender based violence reported during the lockdown period: Round 1 Assessment

Types of violence frequently reported	COVID hospital (n=9)	Non-COVID hospital (n=17)	Total (n=26)
Physical violence	6 (66.7)	13 (76.5)	19 (73.1)
Emotional violence	5 (55.6)	9 (52.9)	14 (53.8)
Sexual violence	6 (66.7)	13 (76.5)	19 (73.1)

Chapter 9

Conclusions, Discussions and Way Forward

Public health facilities' preparedness for screening of clients, staff safety and in maintaining physical distancing in the context of COVID-19 pandemic was far from desired. A significant proportion of the health facilities including COVID designated hospitals reported about lack of sufficient stock of PPE. In fact, there was a fifty percent decrease in reporting about having adequate stock of PPE in Round 2. Many health facilities had not received the RMNCAH Interim Guidance especially by those facilities located at peripheral areas (PHCC, HP and UHC). Many health facilities are yet to receive an orientation on the Interim Guidance. Perhaps for these reasons, the majority of the service providers rated the activities of the Govt in response to the COVID-19 pandemic as 'average'. Only about one third of the service providers especially those from Sudarpaschim Province and Karnali Province rated the government's response as "good".

Most FCHVs were able to perform their tasks during the lockdown without much hinderances. Few of them could not conduct advocacy for childhood immunization, distribution of Vitamin A, Albendazole, condoms and oral pills during the initial period of lockdowns. The mode of contacting clients by FCHVs during the lockdown was personal visits and through phones. Though use of face masks by FCHVs was nearly universal, adherence to other precautionary measures such as social distancing, frequently washing hands with soap and water, and use of sanitizer was poor.

Knowledge that wearing face masks and washing hands with soaps and water or by alcohol based hand-rubs can prevent COVID-19 infections was very high among clients. Most of the clients had learned about these precautionary measures from the TV, radio and through phones (caller tune). Most of the clients had observed their health providers using a face masks while attending them but only half of them had seen their providers using hand sanitizers and hand gloves. Use of other PPE items by the health providers such as face shields, caps or special cover all or gowns was seen by few clients.

Due to fear of COVID-19 infection, ANC service utilization had declined in the first two months of the lockdown but increased at later months. Some of the health facilities had halted the ANC service initially due to this fear and also due to strict imposition of lockdown. As a result, some ANC clients were unable to visit for ANC follow-up care on their scheduled dates. It is encouraging to find that most FCHVs had been conducting home visits throughout and without disruptions by the lockdown. They were even making virtual contacts with their clients/default clients for the purpose of motivating them for routine ANC.

Most health facilities provided delivery services without interruption. The number of expectant mothers seeking institutional deliveries increased steadily especially at hospitals and PHCCs from the third month onwards due to increase in referral of clients and denial of service from nearby health facilities.

Fear of COVID-19 dissuaded some expectant mothers from seeking delivery care at birthing centers (institutional delivery). Trend analysis indicated a decline in institutional delivery during the 5 months' lockdown period as compared to the corresponding period of the

previous year. A sharp decline in institutional delivery occurred in the month of Shrawan as compared to other months. An increase in number of expectant women resorting to home delivery during the lockdown period indicates that due the fear of contracting the COVID-19 infections and other associated factors restricting mobility, women are endangering their health and lives (by not seeking institutional delivery care). Nepal continues to experience high maternal mortality ratios (MMR) and the primary cause of the high MMR is post-partum hemorrhage.

Excepting the hospitals, the majority of the health facilities (PHCC and HP) were unable to provide 'Aama' transportation incentives to mothers of newborns at times of discharge in Round 1. The situation improved considerably two months later, however. Few health facilities did not provide the 'Aama' incentives at all. Delayed provision of refundable money from the government; and shortage of money at the facility hampered incentives distribution to mothers.

Family planning services were disrupted at more than one thirds of the facilities during 5 months' lockdown period. A higher percentage of health facilities of Lumbini province and Province 1 had disruption of SARC services. In terms of category of health facilities, disruptions of SARC were high at health post level.

Stock out of commodities & supplies, and fear of contracting COVID-19 among the providers were the two major reasons for FP service disruption. A significant number of health facilities had experienced stock out of FP contraceptive commodities leading to FP service disruptions. Clients who could not avail FP services were suggested either to visit another HF or use alternative methods so as to avoid touching the clients. In particular, users of LARC method were often suggested to switch over to SARC methods particularly, condom and Pills, for the same reason.

Studies have shown that many peripheral public SAS facilities such as PHCCs and HPs are unable to continue with safe MA service owing to a multitude of barriers these facilities encounter in the provision of free MA service since the country introduced a three-tier federal structure of governance that shifted the responsibility of managing SAS clinics (MA drug and equipment supplies) from the central and district health offices level to the local government. These administrative and policy barriers are resonated by the present study also. Only one in five HP had been accredited for provision of Safe MA service which is quite low. One third of the accredited facilities (34%) had stopped SAS (MA) even much before the lockdowns. Lack of MA drugs and/or absence of trained provider continue to impede free and safe abortion care for women. It was also highly dismaying to find clients being charge abortion fee (Rs 500) just to "punish" them. Such an action is against women's abortion rights guaranteed by our country's law.

HMIS trend indicated a decline in number of women utilizing SAS. Clients flow remained almost the same during the 5 months' lockdowns in nearly half of HFs providing MVA. Due to non-use of contraceptives or method discontinuation, many women are exposed to unintended pregnancies resulting to increase in SAS clients during lockdown period.

Routine immunization service was halted in nearly half of the health facilities after receiving instructions from respective health office/local government to halt the service during lockdowns. Due to the lockdowns, nearly all health facilities carried out the Vitamin A

supplementation programme in the month of Ashad this year as per the government instructions.

There were few health facilities including hospitals where the immunization service has not yet resumed yet after it was halted during the lockdown period. Eleven health facilities including two hospitals had stopped offering immunization service even much before the lockdown period. Cold chain was maintained throughout the lockdown period in all health facilities.

Utilization of AFHS by adolescent girls had remained the same in the majority of the facilities providing AFHS with little or no effect of the lockdowns. Most of the girls sought services and information on menstruation related issues from the health facilities during the lockdowns. FCHVs were usually approached by adolescent girls usually for FP (SARC) methods and ANC during the lockdowns. Various challenges/obstacles hindering adolescent girls from SRH service during the lockdown period were ‘fear of contracting COVID-19’ ‘lack of transportation’ and ‘strict implementation of lockdown’.

Surge in GBV cases seeking care at OCMC during the lockdown period was evident. Majority of the survivors seeking care at OCMC during 5 month’s lockdown period were cases of sexual violence and physical violence. OCMCs in all provinces (except in Bagmati Province) experienced an increase in physical and sexual violence during the 5 months of lockdown period.

Way Forward:

- All public health facilities should be provided with an electronic copy of the RMNCAH Interim Guidance to enable them to understand the guiding principles for the provision of these essential services during the COVID-19 pandemic. Implementation of the Guidance needs to be monitored by the municipality/local government.
- PPE has become a basic necessity and part of the basic supply chain at all levels of health facilities. Hence, the existing mechanisms for the procurement and distribution of PPE should to be strengthened through coordination with the procurement units of concerned department/office at the province and local government levels;
- Establish regular policy dialogues between local government and health facilities for mitigating challenges faced by health facilities in stable provision of services such as on commodities supply chain, timely payment of reimbursable funds to health facilities as specified in the Safe Motherhood and Reproductive Health and Rights (SMRHR) Act 2018 and in the RMNCAH Interim Guidance. Women should be provided with contraceptives of their choice and not compel them to use alternative methods/less reliable methods;
- Ensure availability of at least one trained service provider for the provision of LARC at all accredited health facilities by providing competency-based trainings to additional cadre of service providers who are untrained and posted/newly transferred at the health facilities.
- Strengthen coordination between the local government and accredited SAS centers for SAS center expansion at all HPs and sustained presence of trained SAS providers through recruitment of ANMs from the local communities. SAS facilities should

maintain sufficient stock of MA drugs, and supplies for pain management, etc. Periodic monitoring of free abortion service needs strengthening to ensure that women are not charged service fee or asked to purchase MA drugs from the open market. Women's right to legal, safe and free abortion should be respected at all public health facilities.

- In view of the rising number of GBV case referrals at OCMC and to reduce the hospital burden in dealing with the survivors as well as to improve service access, the possibilities of establishing OCMC at each *Palika* hospital (upgraded PHCC/HP) in a phased manner needs to be explored.

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Annexes

Annex 1.1: Sample distribution of public health facilities at district and province level

Province/District	COVID hospital	Non-COVID hospital	PHCC	Health Post	UHC	Total
Province 1						
Jhapa	2	-	6	12	10	30
Sunsari	-	2	4	13	5	24
Solukhumbu	-	1	2	9	1	13
<i>Morang</i>	-	1	1	-	-	2
Total	2	4	13	34	16	69
Province 2						
Dhanusha	-	1	5	14	3	23
Mahottari	-	1	3	12	3	19
Rautahat	-	2	3	13	-	18
Total	-	4	11	39	6	60
Bagmati Province						
Kathmandu	-	1	8	11	21	41
Chitwan	-	3	3	8	10	24
Sindhupalchowk	-	2	3	15	3	23
<i>Kavre</i>	-	1	-	-	-	1
<i>Dhading</i>	-	1	-	-	-	1
<i>Bhaktapur</i>	1	-	-	-	-	1
<i>Lalitpur</i>	-	1	-	-	-	1
Total	1	9	14	34	34	92
Gandaki Province						
Tanahun	-	2	2	7	7	18
Syangja	-	1	3	10	7	21
Baglung	1	-	2	7	1	11
<i>Parbat</i>	-	1	1	2	1	5
Total	1	4	8	26	16	55
Lumbini Province						
Rupandehi	2	-	5	15	14	36
Rukum East	-	-	1	4	-	5
Banke	1	-	3	11	7	22
<i>Bardiya</i>	-	1	1	-	-	2
<i>Nawalparasi</i>	-	2	-	-	-	2
<i>Kapilvastu</i>	-	1	-	-	-	1
Total	3	4	10	30	21	68
Karnali Province						
Surkhet	1	1	3	8	5	18
Jumla	1	-	1	6	1	9
Dolpa	-	1	-	4	-	5
Total	2	2	4	18	6	32
Sudurpaschim Province						
Kailali	-	2	3	6	7	18
Baitadi	1	-	2	10	-	13
Bajura	-	1	-	4	11	16
<i>Kanchanpur</i>	-	1	-	-	-	1
Total	1	4	5	20	18	48
Grand Total	10	31	65	201	117	424

Note: The names of districts appearing in italics are additional districts covered to achieve the allocated sample.

Annex 1.2: District-wise distribution of public health facilities at 21 sampled districts: Round 2

Province and District Name	Hospital	PHCC	HP	UHC	Total HF
Province 1 (n=69)					
Jhapa	1	2	4	3	10
Sunsari	1	1	4	2	8
Solukhumbu	-	1	3	1	5
Total	2	4	11	6	23
Province 2 (n= 60)					
Dhanusa	-	2	4	1	7
Rautahat	1	1	5	-	7
Mahottari	-	1	4	1	6
Total	1	4	13	2	20
Bagmati Province (n=92)					
Sindhupalchowk	1	1	4	1	7
Kathmandu	1	3	4	7	15
Chitwan	1	1	3	3	8
Total	3	5	11	11	30
Gandaki Province (n=54)					
Tanahu	1	1	2	2	6
Baglung	1	1	3	1	6
Syangja	-	1	3	2	6
Total	2	3	8	5	18
Lumbini Province (n=68)					
Rupandehi	2	2	5	4	13
Rukum East	-	-	1	-	1
Banke	1	1	4	2	8
Total	3	3	10	6	22
Karnali Province (n=32)					
Dolpa	-	-	1	-	1
Jumla	-	-	2	1	3
Surkhet	1	1	3	2	7
Total	1	1	6	3	11
Sudurpaschim Province (n=49)					
Bajura	-	-	2	3	5
Baitadi	1	1	3	-	5
Kailali	1	1	2	2	6
Total	2	2	7	5	16
Grand Total	14	22	66	38	140

Annex 2.1: Province wise preparedness in dealing with clients in the context of COVID-19 pandemic

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudur paschim Province		Total	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Screening of clients																
To large extent	46.4	17.4	40.0	20.0	38.0	43.3	49.1	72.2	35.3	50.0	21.9	27.3	31.3	25.0	38.7	37.1
To some extent	53.6	82.6	60.0	80.0	62.0	56.7	50.9	27.8	64.7	50.0	78.1	72.7	68.8	75.0	61.3	62.9
Staff safety																
To large extent	26.1	13.0	40.0	15.0	40.2	40.0	49.1	55.6	38.2	31.8	18.8	36.4	14.6	18.8	34.2	30.0
To some extent	73.9	87.0	60.0	85.0	59.8	60.0	50.9	44.4	61.8	68.2	81.3	63.6	85.4	81.3	65.8	70.0
Maintaining social distancing																
To large extent	33.3	30.4	28.3	45.0	37.0	53.3	45.5	88.9	35.3	31.8	9.4	27.3	25.0	6.3	32.5	42.1
To some extent	66.7	69.6	71.7	55.0	63.0	46.7	54.5	11.1	64.7	68.2	90.6	72.7	75.0	93.8	67.5	57.9
PPE stock																
To large extent	43.5	26.1	68.3	15.0	55.4	43.3	70.9	38.9	67.6	27.3	37.5	18.2	43.8	12.5	56.6	27.9
To some extent	56.5	73.9	31.7	85.0	44.6	56.7	29.1	61.1	32.4	72.7	62.5	81.8	56.3	87.5	43.4	72.1
Isolations of positive cases																
To large extent	7.2	4.3	10.0	-	16.3	26.7	9.1	5.6	5.9	18.2	15.6	18.2	20.8	25.0	11.8	14.3
To some extent	8.7	8.7	-	5.0	15.2	20.0	1.8	-	1.5	27.3	21.9	81.8	22.9	43.8	9.4	22.1
Not required	84.1	87.0	90.0	95.0	68.5	53.3	89.1	94.4	92.6	54.5	62.5	-	56.3	31.3	78.8	63.6
Treatment of positive cases																
To large extent	1.4	4.3	10.0	-	13.0	26.7	9.1	5.6	5.9	13.6	12.5	18.2	16.7	25.0	9.4	13.6
To some extent	13.0	4.3		5.0	16.3	20.0	1.8	-	1.5	31.8	25.0	81.8	22.9	43.8	10.6	22.1
Not required	85.5	91.3	90.0	95.0	70.7	53.3	89.1	94.4	92.6	54.5	62.5	-	60.4	31.3	80.0	64.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	69.0	23.0	60.0	20.0	92.0	30.0	55.0	18.0	68.0	22.0	32.0	11.0	48.0	16.0	424.0	140.0

Annex 2.2: Health facility wise preparedness in dealing with clients in the context of COVID-19 pandemic

	COVID hospital		Non-COVID hospital		PHCC		HP		UHC		Total	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Screening of clients												
To large extent	60.0	88.9	48.4	80	49.2	36.4	35.8	27.3	33.3	36.8	38.7	37.1
To some extent	40.0	11.1	51.6	20	50.8	63.6	64.2	72.7	66.7	63.2	61.3	62.9
Staff safety												
To large extent	80.0	77.8	58.1	60	35.4	36.4	30.3	22.7	29.9	23.7	34.2	30
To some extent	20.0	22.2	41.9	40	64.6	63.6	69.7	77.3	70.1	76.3	65.8	70
Maintaining social distancing												
To large extent	60.0	44.4	54.8	40	35.4	54.5	27.4	37.9	31.6	42.1	32.5	42.1
To some extent	40.0	55.6	45.2	60	64.6	45.5	72.6	62.1	68.4	57.9	67.5	57.9
PPE stock												
To large extent	40.0	88.9	54.8	40	53.8	40.9	62.7	16.7	49.6	23.7	56.6	27.9
To some extent	60.0	11.1	45.2	60	46.2	59.1	37.3	83.3	50.4	76.3	43.4	72.1
Isolations of positive cases												
To large extent	80.0	88.9	45.2	40	24.6	22.7	5.0	4.5	1.7	5.3	11.8	14.3
To some extent	20.0	-	29.0	20	15.4	27.3	7.0	22.7	4.3	23.7	9.4	22.1
Not required	-	11.1	25.8	40	60.0	50	88.1	72.7	94.0	71.1	78.8	63.6
Treatment of positive cases												
To large extent	70.0	88.9	38.7	40	20.0	22.7	3.5	3	0.9	5.3	9.4	13.6
To some extent	30.0	-	29.0	20	16.9	22.7	8.0	24.2	5.1	23.7	10.6	22.1
Not required	-	11.1	32.3	40	63.1	54.5	88.6	72.7	94.0	71.1	80.0	64.3
Total	100.0	100	100.0	100	100.0	100	100.0	100	100.0	100	100.0	100
N	10.0	9	31.0	5	65.0	22	201.0	66	117.0	38	424.0	140

Annex 2.3: Province -wise rating of the activities of the government in response to COVID-19 pandemic

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudur paschim Province	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Very Good	2.9	-	1.7	-	1.1	3.3	7.3	-	-	-	-	-	2.1	-
Good	11.6	8.7	20	20	17.4	20	21.8	5.6	22.1	4.5	31.1	18.2	35.4	50
Neither good nor poor	59.4	47.8	48.3	40	69.6	53.3	56.4	61.1	58.8	90.9	50	81.8	47.9	43.8
Poor	17.4	34.8	16.7	35	9.8	20	14.5	27.8	10.3	4.5	9.4	-	14.6	6.3
Very Poor	8.7	8.7	13.3	5	2.2	3.3	-	5.6	8.8	-	9.4	-	-	-
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
N (424/140)	69	23	60	20	92	30	55	18	68	22	32	11	48	16

Annex 2.4: Health facility-wise rating of the activities of the government in response to COVID-19 pandemic

	COVID hospital		Non -COVID hospital		PHCC		Health Post		UHC	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Very Good	-	-	-	-	-	4.5	3	-	2.6	-
Good	10	22.2	25.8	20	18.5	13.6	17.9	13.6	28.2	23.7
Neither good nor poor	70	55.6	67.7	40	52.3	59.1	55.7	60.6	59.8	57.9
Poor	10	11.1	6.5	40	21.5	18.2	14.4	21.2	8.5	18.4
Very Poor	10	11.1	-	-	7.7	4.5	9	4.5	0.9	-
Total	100	100	100	100	100	100	100	100	100	100
N (424/140)	10	9	31	5	65	22	201	66	117	38

Annex 2.5: Province wise distribution of FCHV according to knowledge on mode of transmission of COVID-19 infection

Modes of COVID-19 transmission	Province 1		Province 2 (n=60)		Bagmati Province (n=92)		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=96)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Physical contact / touching	81.2	95.7	73.3	95	88	80	83.6	94.4	89.7	95.5	84.4	90.9	68.8	93.8	82.1	91.4
Items used by infected person	46.4	78.3	75	85	57.6	46.7	50.9	61.1	33.8	40.9	78.1	72.7	72.9	75	56.8	63.6
Sneezing/ coughing	81.2	91.3	93.3	100	94.6	96.7	58.2	72.2	82.4	81.8	56.2	100	79.2	50	80.9	85.7

Annex 2.6: Province wise distribution of FCHV according to knowledge on symptoms of COVID -19 infection

Symptoms of COVID-19 infections	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=69)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Fever or chills	100	100	96.7	95	98.9	96.7	94.5	100	97.1	86.4	96.9	100	100	93.8	97.9	95.7
Dry cough	78.3	69.6	85	85	76.1	70	76.4	77.8	82.4	72.7	84.4	100	64.6	43.8	78.1	72.9
Fatigue/ Tiredness	13	47.8	15	30	30.4	33.3	18.2	22.2	7.4	0	9.4	54.5	12.5	12.5	16.5	27.9
Muscles or body aches	26.1	-	11.7	-	31.5	-	10.9	-	11.8	-	0	-	8.3	-	16.9	-
Headache	56.5	-	43.3	-	59.8	-	36.4	-	41.2	-	50	-	83.3	-	52.8	-
Shortness of breath or difficulty breathing	56.5	-	65	-	72.8	-	32.7	-	36.8	-	87.5	-	47.9	-	56.4	-
Sore throat	43.5	-	38.3	-	40.2	-	36.4	-	35.3	-	25	-	50	-	27.4	-
Loss of taste or smell	11.6	-	8.3	-	7.6	-	7.3	-	2.9	-	3.1	-	4.2	-	6.8	-
Congestion or running nose	62.3	-	48.3	-	35.9	-	54.5	-	54.4	-	37.5	-	41.7	-	48.1	-
Nausea or vomiting	10.1	-	6.7	-	16.3	-	7.3	-	8.8	-	6.2	-	4.2	-	9.4	-
Diarrhea	17.4	-	6.7	-	12	-	10.9	-	7.4	-	6.2	-	16.7	-	11.3	-
Don't know	0	-	3.3	-	1.1	-	0	-	2.9	-	0	-	0	-	1.2	-

Annex 2.7: FCHVs ability to perform the assigned tasks during the lockdown period

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=69)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Promotion/counseling couples for FP use																
Provided at all times	85.5	100.0	88.3	100.0	94.6	100.0	89.1	100.0	88.2	100.0	96.9	100.0	97.9	100.0	91.0	100.0
Halted initially but resumed later	14.5	-	10.0	-	4.3	-	7.3	-	11.8	-	3.1	-	2.1	-	8.0	-
Halted and not resumed yet	0.0	-	1.7	-	1.1	-	1.8	-	0.0	-	0.0	-	0.0	-	0.7	-
NA (Not included in my task/ not sought service)	0.0	-	0.0	-	0.0	-	1.8	-	0.0	-	0.0	-	0.0	-	0.2	-
Distribution of Condoms and oral pills																
Provided at all times	84.1	73.9	56.7	85.0	81.5	90.0	92.7	77.8	82.4	100.0	87.5	81.8	89.6	93.8	81.4	86.4
Halted initially but resumed later	8.7	8.7	23.3	0.0	7.6	0.0	0.0	0.0	8.8	0.0	3.1	9.1	10.4	0.0	9.2	2.1
Halted and not resumed yet	2.9	13.0	20.0	15.0	1.1	0.0	0.0	11.1	4.4	0.0	0.0	0.0	0.0	0.0	4.2	5.7
NA (Not included in my task/ not sought service)	4.3	4.3	0.0	0.0	9.8	10.0	7.3	11.1	4.4	0.0	9.4	9.1	0.0	6.2	5.2	5.7
Referral of new FP clients																
Provided at all times	87.0	100.0	90.0	100.0	95.7	100.0	96.4	94.4	92.6	100.0	96.9	100.0	97.9	93.8	93.4	98.6
Halted initially but resumed later	11.6	-	6.7	-	2.2	-	0.0	-	7.4	-	3.1	-	0.0	-	4.7	-
Halted and not resumed yet	0.0	-	3.3	-	1.1	-	0.0	-	0.0	-	0.0	-	2.1	-	0.9	-

NA (Not included in my task/ not sought service	1.4	0.0	0.0	0.0	1.1	0.0	3.6	5.6	0.0	0.0	0.0	0.0	0.0	6.2	0.9	1.4
Referral for LARC service																
Provided at all times	81.2	95.7	86.7	95.0	92.4	96.7	76.4	55.6	88.2	95.5	87.5	54.5	81.2	75.0	85.4	85.0
Halted initially but resumed later	10.1	-	10.0	-	2.2	-	1.8	-	7.4	-	0.0	-	2.1	-	5.2	-
Halted and not resumed yet	2.9	4.3	0.0	5.0	3.3	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	1.7	1.4
NA (Not included in my task/ not sought service	5.8	0.0	3.3	0.0	2.2	3.3	21.8	44.4	1.5	4.5	12.5	45.5	16.7	25.0	7.8	13.6
Referral for ANC/PNC																
Provided at all times	94.2	95.7	91.7	100.0	97.8	100.0	96.4	94.4	98.5	100.0	100.0	100.0	97.9	100.0	96.5	98.6
Halted initially but resumed later	5.8	-	8.3	-	2.2	-	0.0	-	1.5	-	0.0	-	0.0	-	2.8	-
NA (Not included in my task/ not sought service	0.0	4.3	0.0	0.0	0.0	0.0	3.6	5.6	0.0	0.0	0.0	0.0	2.1	0.0	0.7	1.4
Referral for institutional delivery																
Provided at all times	89.9	100.0	95.0	95.0	100.0	100.0	94.5	77.8	97.1	100.0	100.0	90.9	97.9	100.0	96.2	95.7
Halted initially but resumed later	5.8	-	5.0	-	0.0	-	0.0	-	2.9	-	0.0	-	0.0	-	2.1	-
Halted and not resumed yet	1.4	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.7
NA (Not included in my task/ not sought service	2.9	0.0	0.0	0.0	0.0	0.0	5.5	22.2	0.0	0.0	0.0	9.1	2.1	0.0	1.4	3.6
Pregnancy testing																
Provided at all times	55.1	34.8	50.0	50.0	54.3	26.7	65.5	44.4	60.3	45.5	78.1	54.5	70.8	37.5	59.9	40.0
Halted initially but resumed later	7.2	-	10.0	-	2.2	-	0.0	-	5.9	-	3.1	-	2.1	-	4.5	-

Halted and not resumed yet	0.0	0.0	25.0	30.0	1.1	33.3	0.0	5.6	1.5	0.0	0.0	0.0	0.0	0.0	4.0	12.1
NA (Not included in my task/ not sought service)	37.7	65.2	15.0	20.0	42.4	40.0	34.5	50.0	32.4	54.5	18.8	45.5	27.1	62.5	31.6	47.9
Referral for safe abortion care																
Provided at all times	78.3	82.6	90.0	100.0	66.3	76.7	69.1	44.4	94.1	100.0	81.2	54.5	60.4	37.5	76.9	74.3
Halted initially but resumed later	7.2	-	8.3	-	1.1	-	0.0	-	2.9	-	0.0	-	0.0	-	3.1	-
Halted and not resumed yet	0.0	0.0	0.0	0.0	4.3	0.0	0.0	5.6	2.9	0.0	0.0	0.0	0.0	0.0	1.4	0.7
NA (Not included in my task/ not sought service)	14.5	17.4	1.7	0.0	28.3	23.3	30.9	50.0	0.0	0.0	18.8	45.5	39.6	62.5	18.6	25.0
Promotion /motivation for childhood immunization																
Provided at all times	60.9	100.0	90.0	100.0	85.9	96.7	74.5	100.0	92.6	100.0	87.5	100.0	91.7	100.0	82.8	99.3
Halted initially but resumed later	37.7	0.0	8.3	0.0	14.1	3.3	25.5	0.0	7.4	0.0	12.5	0.0	8.3	0.0	16.7	0.7
Halted and not resumed yet	0.0	-	1.7	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.2	-
NA (Not included in my task/ not sought service)	1.4	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.2	-
Distribution of Vitamin A																
Provided at all times	62.3	34.8	78.3	100.0	95.7	90.0	98.2	72.2	91.2	63.6	96.9	72.7	91.7	37.5	87.0	68.6
Halted initially but resumed later	37.7	0.0	21.7	0.0	4.3	0.0	1.8	0.0	5.9	9.1	3.1	0.0	8.3	0.0	12.5	1.4
Halted and not resumed yet	0.0	65.2	0.0	0.0	0.0	0.0	0.0	0.0	2.9	27.3	0.0	0.0	0.0	0.0	0.5	15.0
NA (Not included in my task/ not sought service)	-	0.0	-	0.0	-	10.0	-	27.8	-	0.0	-	27.3	-	62.5	-	15.0

Distribution of Albendazole																
Provided at all times	65.2	73.9	78.3	90.0	94.6	86.7	98.2	94.4	95.6	63.6	96.9	100.0	93.8	56.2	88.2	80.0
Halted initially but resumed later	31.9	0.0	21.7	0.0	3.3	0.0	1.8	0.0	4.4	9.1	3.1	0.0	6.2	0.0	10.8	1.4
Halted and not resumed yet	-	26.1	-	10.0	-	0.0	-	0.0	-	27.3	-	0.0	-	0.0	-	10.0
NA (Not included in my task/ not sought service)	2.9	0.0	0.0	0.0	2.2	13.3	0.0	5.6	0.0	0.0	0.0	0.0	0.0	43.8	0.9	8.6
Distribution of Zinc tab and ORS																
Provided at all times	91.3	91.3	43.3	70.0	92.4	86.7	92.7	88.9	92.6	90.9	90.6	100.0	89.6	100.0	84.9	88.6
Halted initially but resumed later	4.3	-	11.7	-	3.3	-	0.0	-	4.4	-	3.1	-	6.2	-	4.7	-
Halted and not resumed yet	1.4	4.3	20.0	30.0	2.2	0.0	1.8	5.6	1.5	9.1	3.1	0.0	0.0	0.0	4.2	7.1
NA (Not included in my task/ not sought service)	2.9	4.3	25.0	0.0	2.2	13.3	5.5	5.6	1.5	0.0	3.1	0.0	4.2	0.0	6.1	4.3
Distribution of Cotrim/Amoxicillin tabs																
Provided at all times	1.4	0.0	23.3	20.0	21.7	0.0	10.9	11.1	4.4	9.1	12.5	0.0	20.8	0.0	13.7	5.7
Halted initially but resumed later	1.4	-	5.0	-	3.3	-	1.8	-	0.0	-	0.0	-	2.1	-	2.1	-
Halted and not resumed yet	0.0	4.3	33.3	65.0	2.2	23.3	38.2	11.1	0.0	31.8	0.0	18.2	0.0	0.0	10.1	22.9
NA (Not included in my task/ not sought service)	97.1	95.7	38.3	15.0	72.8	76.7	49.1	77.8	95.6	59.1	87.5	81.8	77.1	100.0	74.1	71.4

Distribution of CHX gel (Naavi Malam)																
Provided at all times	15.9	17.4	35.0	45.0	20.7	6.7	40.0	50.0	19.1	40.9	21.9	0.0	12.5	0.0	23.3	23.6
Halted initially but resumed later	2.9	-	5.0	-	2.2	-	0.0	-	0.0	-	0.0	-	0.0	-	1.7	-
Halted and not resumed yet	2.9	0.0	23.3	55.0	0.0	13.3	16.4	11.1	1.5	31.8	3.1	0.0	0.0	0.0	6.4	17.1
NA (Not included in my task/ not sought service)	78.3	82.6	36.7	0.0	77.2	80.0	43.6	38.9	79.4	27.3	75.0	100.0	87.5	100.0	68.6	59.3
Counseling on other health, nutrition and WASH issues																
Provided at all times	85.5	100.0	56.7	65.0	98.9	100.0	100.0	100.0	94.1	100.0	100.0	100.0	95.8	100.0	89.9	95.0
Halted initially but resumed later	10.1	-	5.0	-	1.1	-	0.0	-	4.4	-	0.0	-	2.1	-	3.5	-
Halted and not resumed yet	1.4	0.0	0.0	35.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	5.0
NA (Not included in my task/ not sought service)	2.9	-	38.3	-	0.0	-	0.0	-	1.5	-	0.0	-	2.1	-	6.4	-
Referral for danger signs as per IMNCI protocol																
Provided at all times	89.9	100.0	91.7	95.0	96.7	100.0	98.2	100.0	82.4	100.0	96.9	90.9	79.2	37.5	90.8	91.4
Halted initially but resumed later	7.2	-	5.0	-	2.2	-	0.0	-	1.5	-	0.0	-	2.1	-	2.8	-
Halted and not resumed yet	0.0	0.0	0.0	5.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.2	0.7
NA (Not included in my task/ not sought service)	2.9	0.0	3.3	0.0	1.1	0.0	1.8	0.0	14.7	0.0	3.1	9.1	18.8	62.5	6.1	7.9

Annex 2.8: Province wise distribution of precautionary measures used by FCHVs

Precautionary measures used by FCHVs	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=69)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Used of mask	95.7	91.3	98.3	100.0	98.9	96.7	90.9	94.4	97.1	100.0	100.0	100.0	100.0	100.0	97.1	97.1
Use of gloves	17.4	30.4	38.3	25.0	40.2	30.0	41.8	11.1	11.8	9.1	3.1	0.0	14.6	6.2	26.1	18.6
Use of sanitizer	46.4	47.8	65.0	35.0	65.2	70.0	72.7	61.1	58.8	59.1	87.5	45.5	39.6	68.8	60.8	56.4
Maintenance of 2 meters distance from clients	71.0	47.8	50.0	65.0	57.6	46.7	52.7	72.2	77.9	54.5	56.2	9.1	43.8	18.8	59.6	47.9
Frequent hand wash with soap and water	72.5	73.9	56.7	70.0	58.7	60.0	47.3	22.2	57.4	50.0	75.0	90.9	47.9	50.0	58.9	58.6
Use of other PPE	2.9	0.0	5.0	5.0	6.5	0.0	1.8	0.0	0.0	0.0	0.0	9.1	0.0	0.0	2.8	1.4

Annex 2.9: Province wise distribution of client's knowledge about precautionary measures against COVID-19

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=48)	Round 2 (n=33)	Round 1 (n=76)	Round 2 (n=32)	Round 1 (n=107)	Round 2 (n=31)	Round 1 (n=57)	Round 2 (n=26)	Round 1 (n=87)	Round 2 (n=31)	Round 1 (n=30)	Round 2 (n=7)	Round 1 (n=54)	Round 2 (n=21)	Round 1 (n=459)	Round 2 (n=181)
Always wearing a mask	100	90.9	90.8	96.9	87.9	96.8	86	96.2	93.1	96.8	100	100	96.3	100	92.1	96.1
Regularly and thoroughly washing/cleaning hands with soap and water or alcohol hand rub	79.2	72.7	71.1	59.4	69.2	96.8	59.6	84.6	89.7	71	96.7	42.9	74.1	71.4	75.6	74.5
Maintaining 2 meters (6 feet) distance	62.5	36.4	53.9	68.8	57	67.7	61.4	73.1	47.1	48.4	96.7	85.7	27.8	38.1	54.9	56.9
Avoiding crowded places/handshakes	56.2	60.6	43.4	50	65.4	51.6	43.9	23.1	36.8	67.7	33.3	42.9	57.4	47.6	49.7	50.8
Avoid touching eyes, nose and mouth	4.2	0	3.9	3.1	22.4	19.4	12.3	0	8	16.1	10	57.1	3.7	0	10.5	8.8
Staying home	10.4	60.6	7.9	0	16.8	12.9	5.3	0	13.8	0	3.3	0	9.3	0	10.9	13.2
Eating healthy, nutritional food, liquid items and drinking hot water	4.2	3	0	0	1.9	0	0	0	3.4	0	0	0	1.9	0	1.8	0.5
Change dress and bath after coming from outside	0	-	0	-	0.9	-	0	-	3.4	-	0	-	0	-	0.9	-
Maintaining sanitization	0	-	0	-	0	-	0	-	6.9	-	0	-	0	-	1.3	-

Annex 2.10: Health facility -wise knowledge about precautionary measures against COVID-19 among the clients

	COVID hospital		Non- COVID hospital		PHCC		HP		UHC		Total	
	Round 1 (n=24)	Round 2 (n=22)	Round 1 (n=91)	Round 2 (n=14)	Round 1 (n=94)	Round 2 (n=40)	Round 1 (n=172)	Round 2 (n=67)	Round 1 (n=48)	Round 2 (n=38)	Round 1 (n=459)	Round 2 (n=181)
Always wearing a mask	87.5	100	92.3	92.9	96.8	95	93	97	85.9	94.7	92.1	174 (96.1)
Regularly and thoroughly washing/cleaning hands with soap and water or alcohol hand rub	79.2	72.7	71.4	50	79.8	75	80.2	77.6	64.1	78.9	75.6	135 (74.5)
Maintaining 2 meters (6 feet) distance	62.5	50	57.1	57.1	47.9	62.5	58.1	52.2	51.3	63.2	54.9	103 (56.9)
Avoiding crowded places/ handshakes	66.7	50	57.1	50	41.5	47.5	44.8	47.8	56.4	60.5	49.7	92 (50.8)
Avoid touching eyes, nose and mouth	12.5	22.7	17.6	0	5.3	10	7	6	15.4	7.9	10.5	16 (8.8)
Staying home	20.8	18.2	8.8	35.7	13.8	12.5	7	6	15.4	15.8	10.9	24 (13.2)
Eating healthy, nutritional food, liquid items and drinking hot water	0	0	3.3	0	2.1	0	0.6	1.5	2.6	0	1.8	1 (0.5)
Change dress and bath after from outside	0	-	1.1	-	2.1	-	0.6	-	0	-	0.9	-
Maintaining sanitization	0	-	0	-	2.1	-	2.3	-	0	-	1.3	-

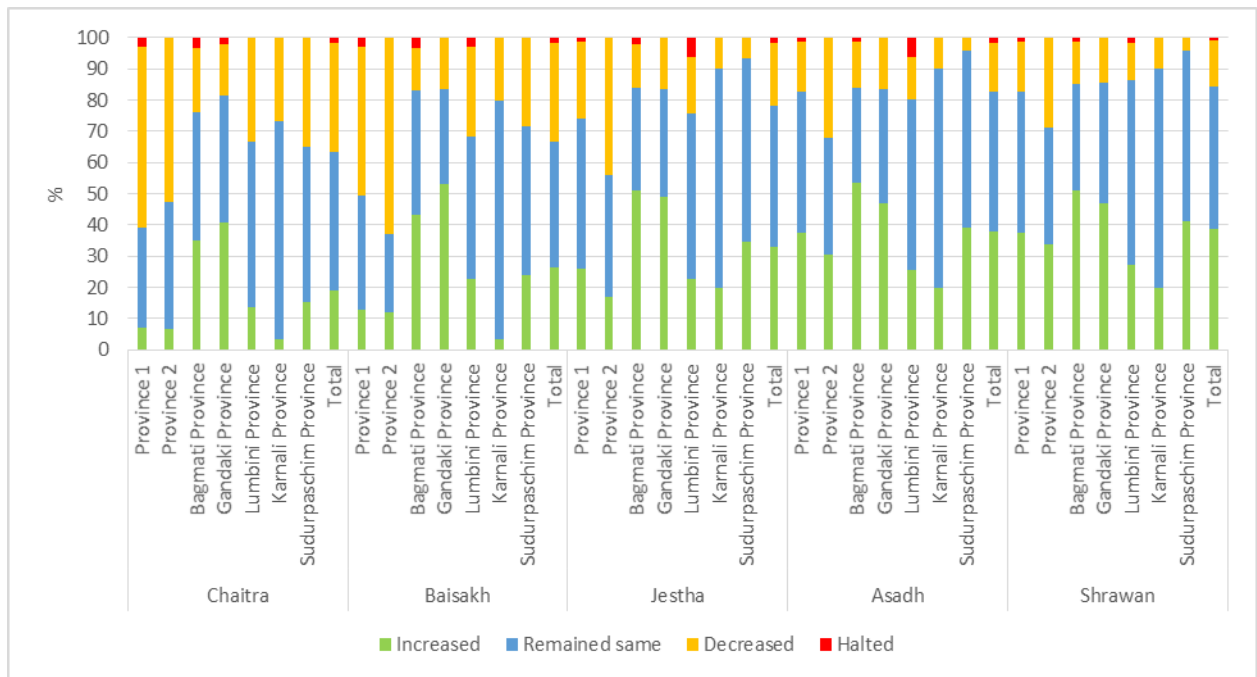
Annex 2.11: Province wise distribution of precautionary measures used by health providers while attending clients

	Province 1 (n=50)		Province 2 (n=79)		Bagmati Province (n=109)		Gandaki Province (n=62)		Lumbini Province (n=94)		Karnali Province (n=30)		Sudurpaschim Province (n=55)		Total	
	Round 1 (n=50)	Round 2 (n=33)	Round 1 (n=79)	Round 2 (n=32)	Round 1 (n=109)	Round 2 (n=33)	Round 1 (n=62)	Round 2 (n=28)	Round 1 (n=94)	Round 2 (n=32)	Round 1 (n=30)	Round 2 (n=7)	Round 1 (n=55)	Round 2 (n=23)	Round 1 (n=479)	Round 2 (n=188)
Used mask	98	100	94.9	100	99.1	90.9	98.4	100	100	100	100	100	100	100	97.9	98.4
Hand washing with soap and water	46.9	36.4	25.3	18.8	23.1	39.4	22.6	10.7	9.6	37.5	63.3	100	18.5	0	25.1	28.2
Sanitized hands	59.2	72.7	57	40.6	61.1	69.7	46.8	67.9	70.2	87.5	80	100	33.3	39.1	57.8	65.4
Use of gloves	65.3	39.4	60.8	15.6	62	69.7	56.5	57.1	30.9	31.2	93.3	42.9	35.2	13	53.8	38.8
Use of special cover-all	20.4	15.2	12.7	3.1	14.8	9.1	22.6	7.1	12.8	21.9	10	14.3	11.1	0	14.8	10.1
Face shield	12.2	12.1	6.3	3.1	11.1	15.2	1.6	3.6	8.5	12.5	10	14.3	1.9	0	7.6	8.5
Cap	6.1	9.1	10.1	0	9.3	9.1	0	0	10.6	0	13.3	14.3	13	0	8.8	3.7
Kept six feet apart from other patients/ visitors	8.2	6.1	8.9	0	25.9	12.1	3.2	0	16	0	3.3	0	3.7	0	12.3	3.2
Did not use any precautionary measures	0	-	0	-	0.9	-	0	-	0	-	0	-	0	-	0.2	-

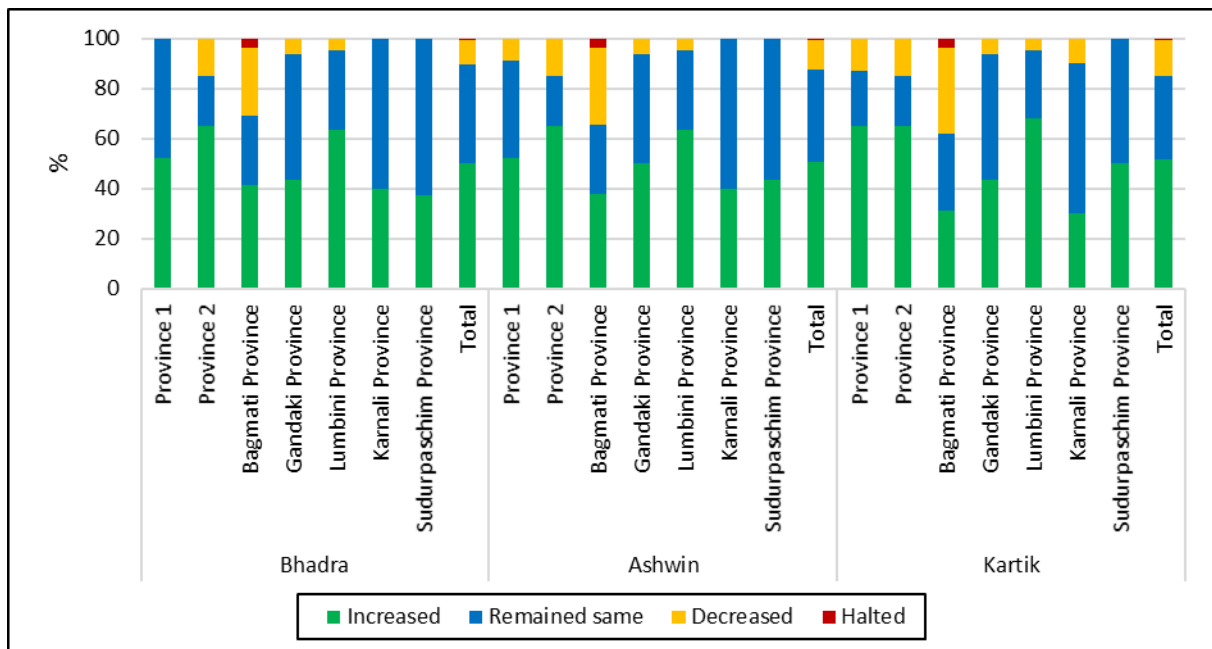
Annex 2.12: Health facility wise precautionary measures used by health providers while attending clients

	COVID hospital		Non -COVID hospital		PHCC		HP		UHC		Total	
	Round 1 (n=24)	Round 2 (n=23)	Round 1 (n=91)	Round 2 (n=14)	Round 1 (n=94)	Round 2 (n=42)	Round 1 (n=172)	Round 2 (n=70)	Round 1 (n=48)	Round 2 (n=39)	Round 1 (n=459)	Round 2 (n=188)
Used mask	100	100	98.9	100	99	97.6	97.2	98.6	96.4	97.4	97.9	98.4
Washed hands with soap and water	20	34.8	26.1	28.6	26.3	38.1	28.9	21.4	15.7	25.6	25.1	28.2
Sanitized hands	56	91.3	69.6	50	61.6	73.8	58.3	48.6	39.8	76.9	57.8	65.4
Used gloves	60	65.2	76.1	71.4	51.5	35.7	49.4	24.3	39.8	41	53.8	38.8
Used special cover-all	48	39.1	40.2	21.4	10.1	11.9	5	0	3.6	5.1	14.8	10.1
Used face shield	32	21.7	18.5	14.3	8.1	11.9	0.6	2.9	2.4	5.1	7.6	8.5
Used cap	32	8.7	22.8	14.3	7.1	4.8	2.2	0	2.4	2.6	8.8	3.7
Kept six feet apart from other patients/ visitors	12	0	7.6	0	15.2	4.8	10.6	2.9	18.1	5.1	12.3	3.2
Did not use any precautionary measures	0	-	0	-	0	-	0.6	-	0	-	0.2	-

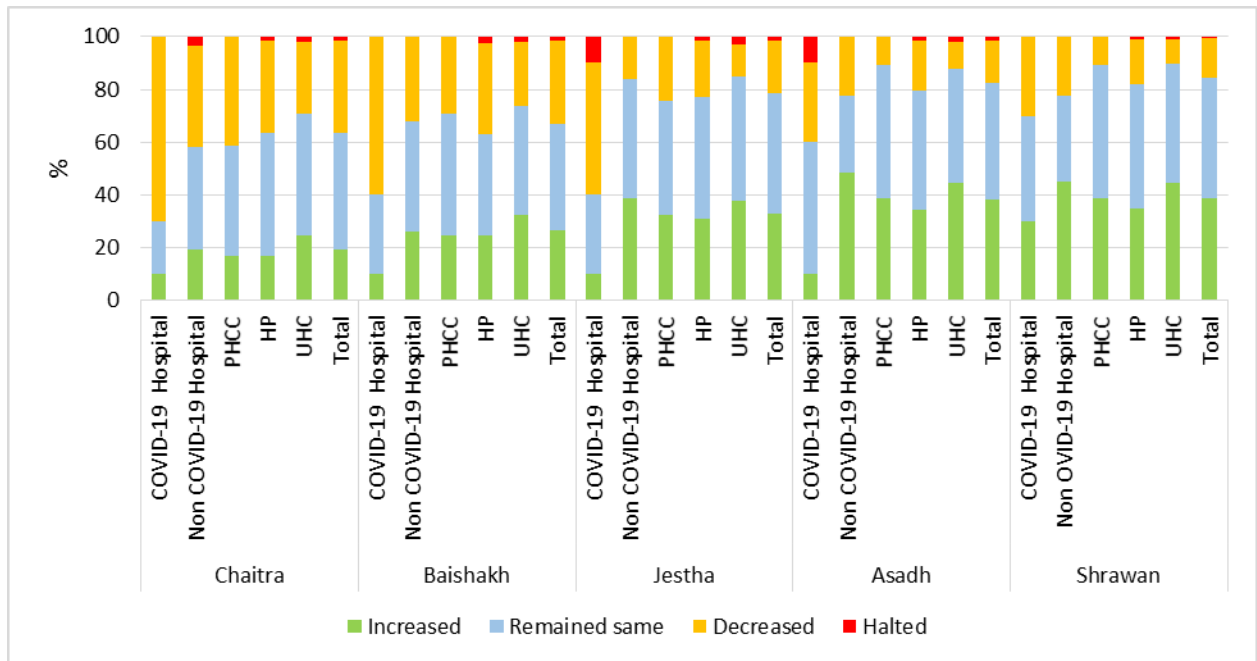
Annex 3.1: Province wise extent of utilization of ANC during 5 months' lockdown period



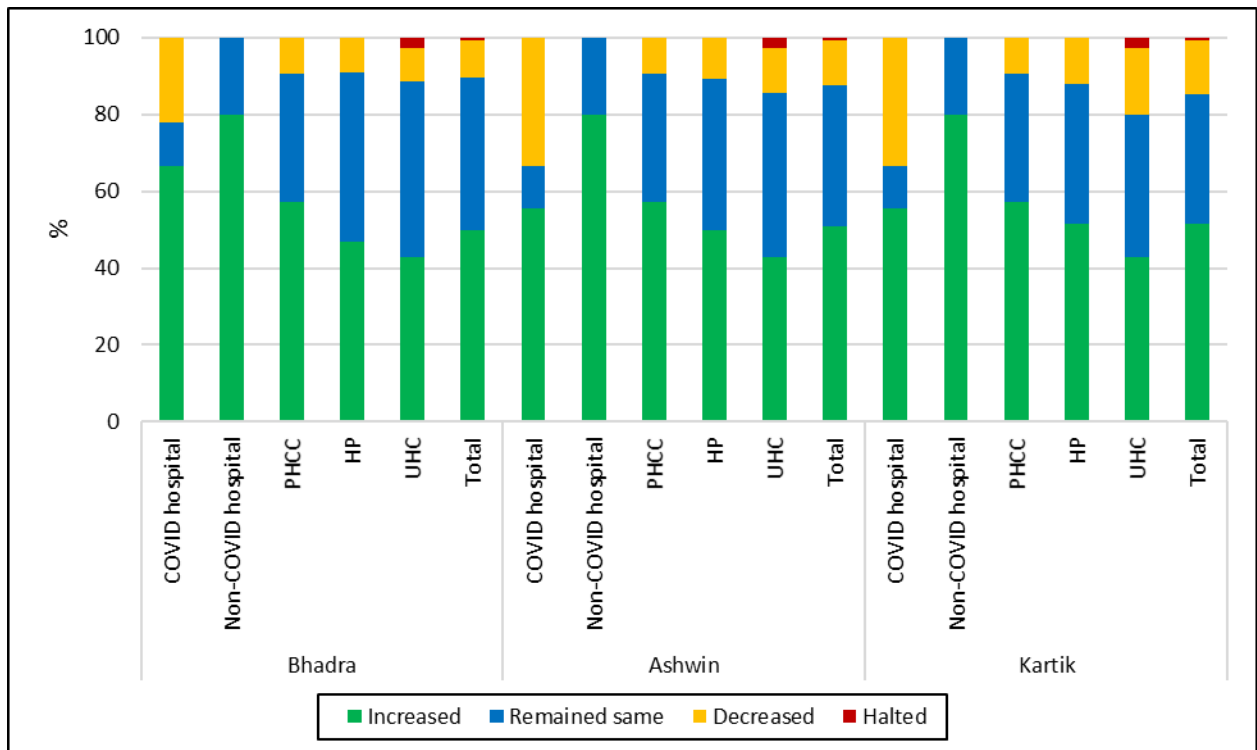
Annex 3.1a: Province wise extent of utilization of ANC during during the period between Bhadra-Kartik



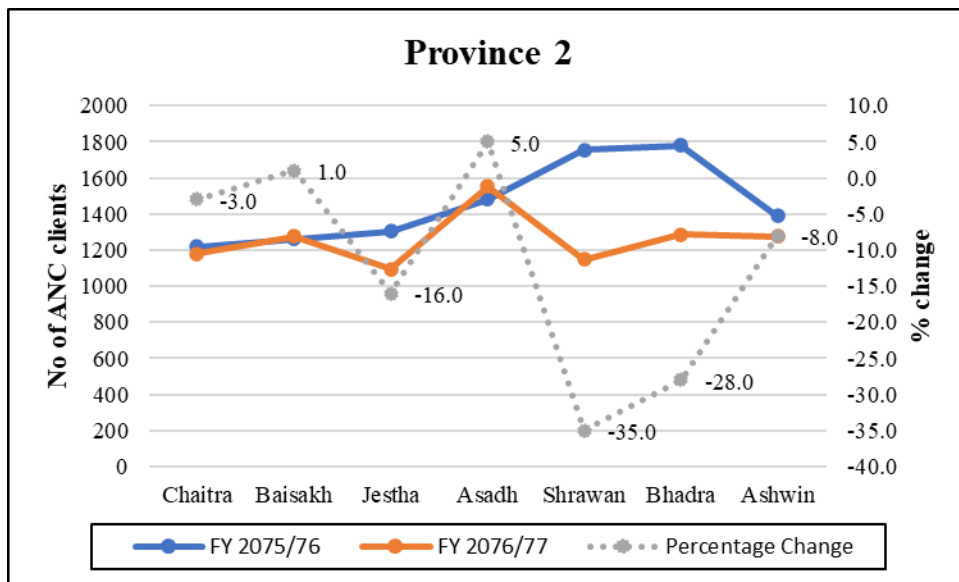
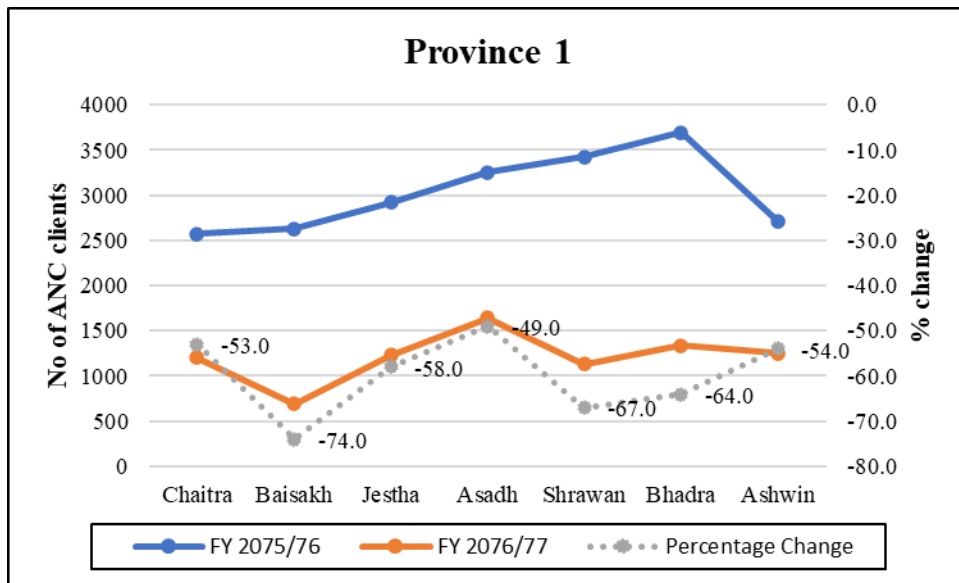
Annex 3.2: Facility wise extent of utilization of ANC during 5 months' lockdown period

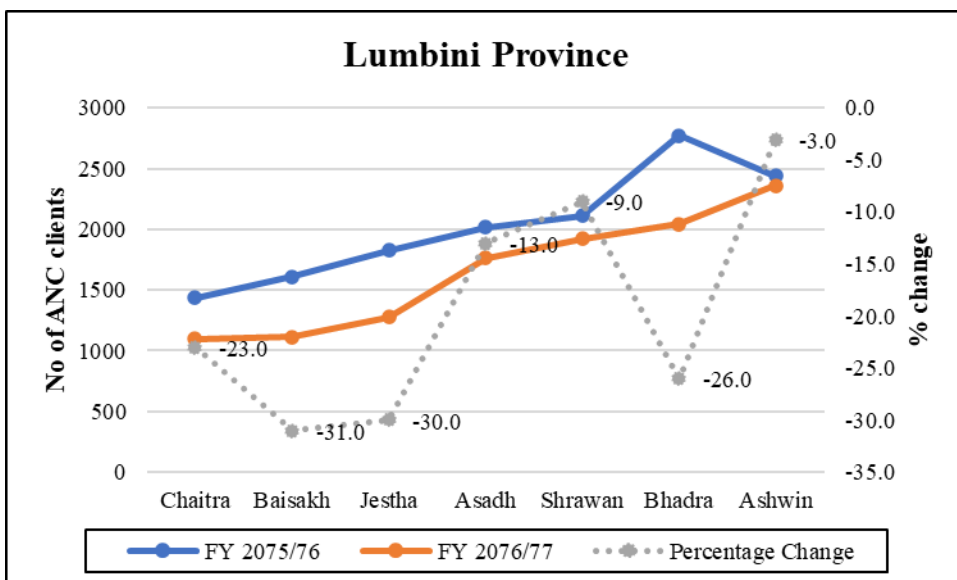
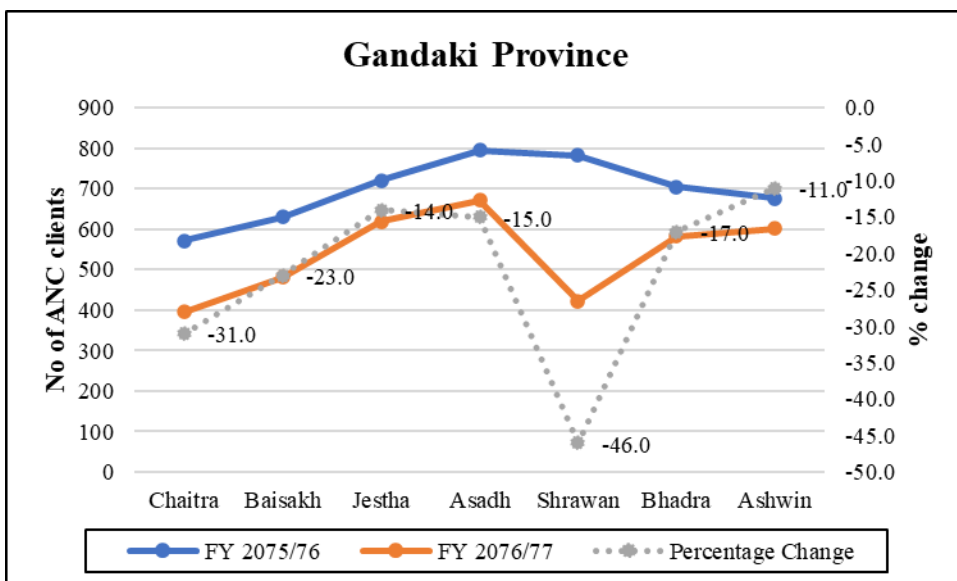
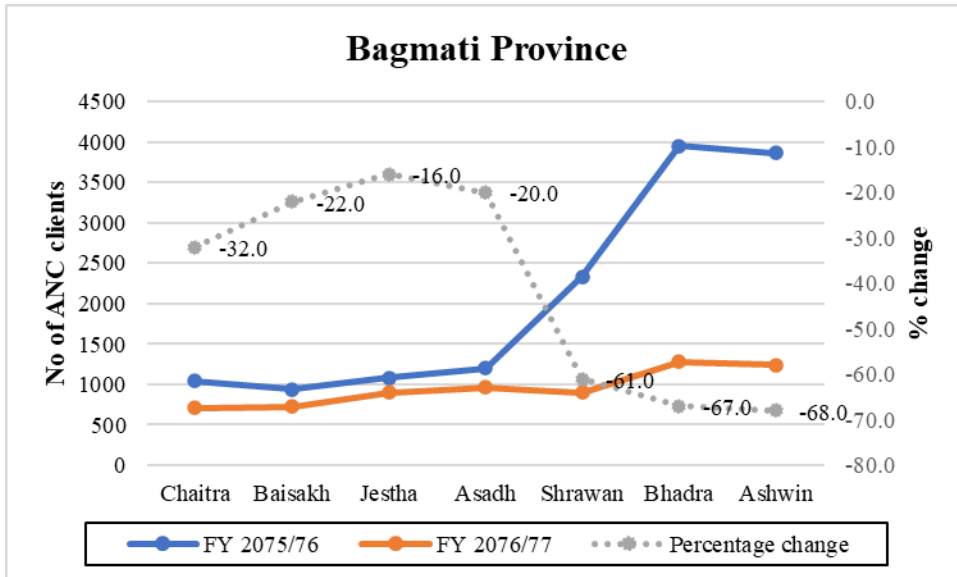


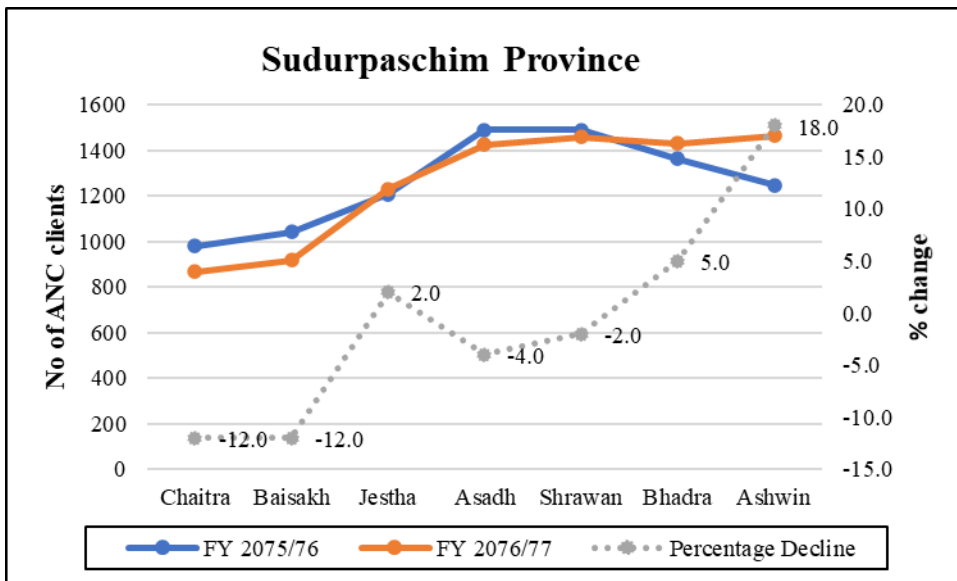
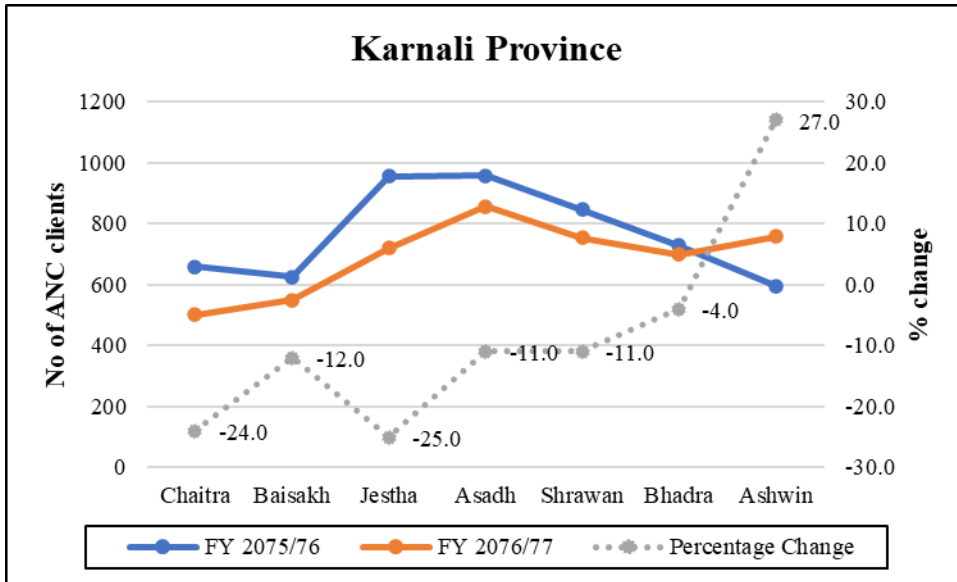
Annex 3.2a: Facility wise extent of utilization of ANC during during the period between Bhadra-Kartik



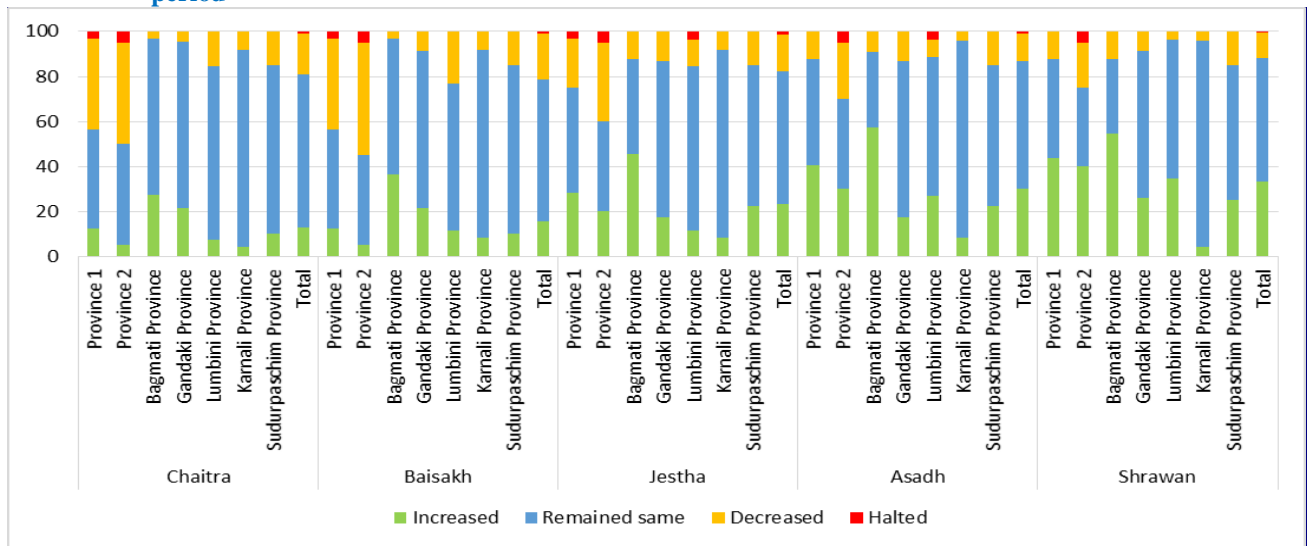
Annex 3.3: Percentage change in utilization of ANC services during COVID-19 pandemic period as compared to corresponding months of previous year



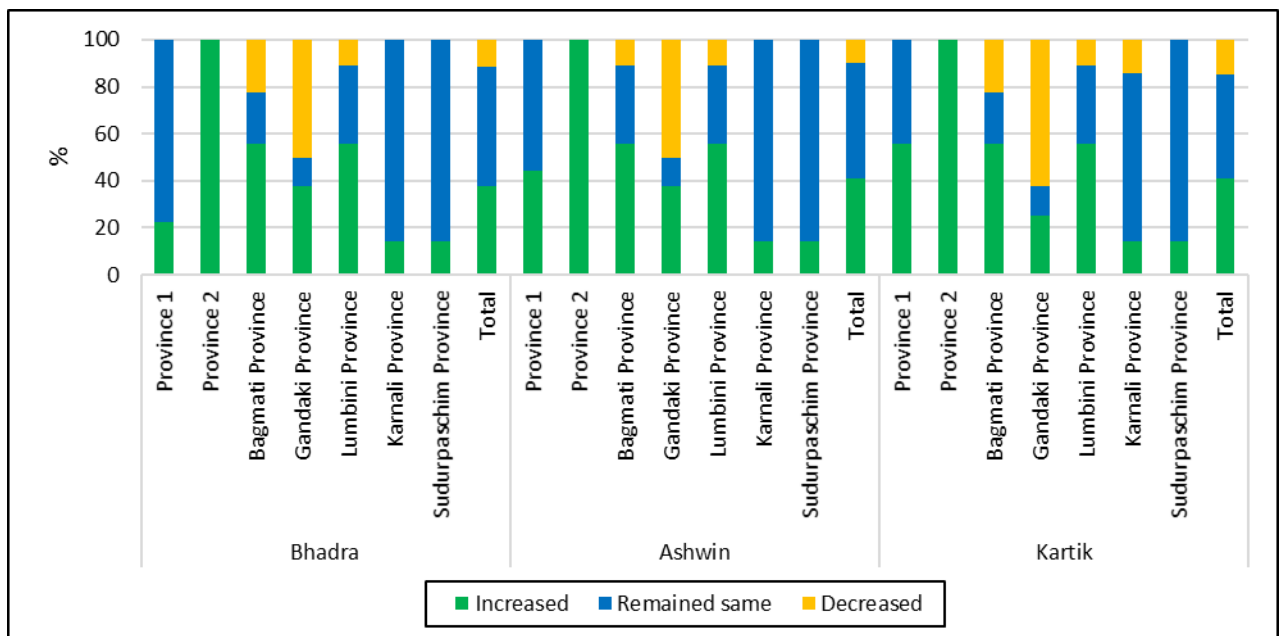




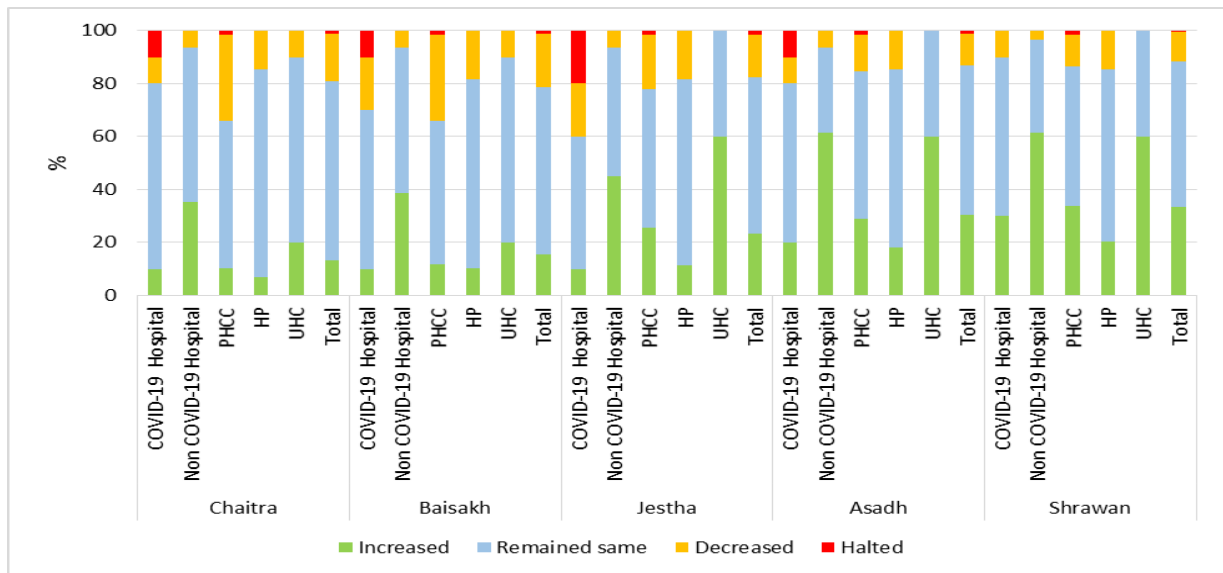
Annex 3.4: Province wise extent of Utilization of Institutional Delivery services during the lockdown period



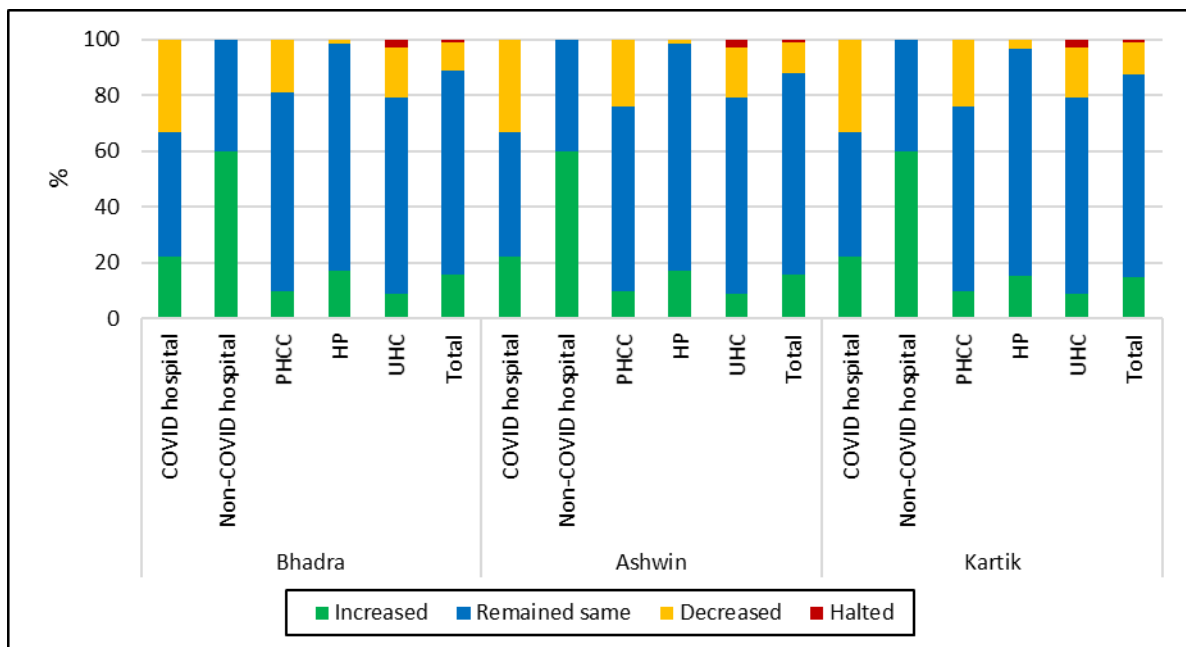
Annex 3.4a: Province wise extent of Utilization of Institutional Delivery services during the period between Bhadra-Kartik



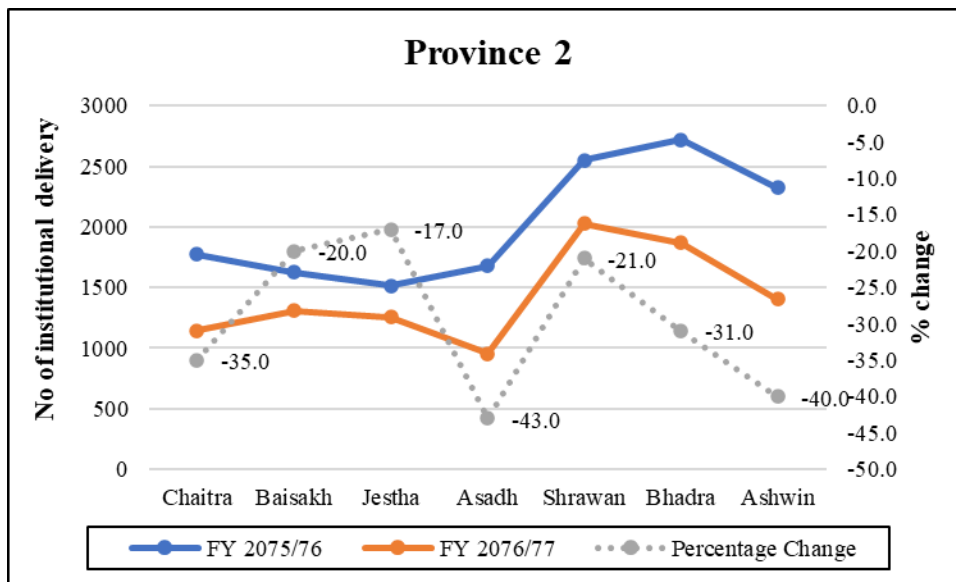
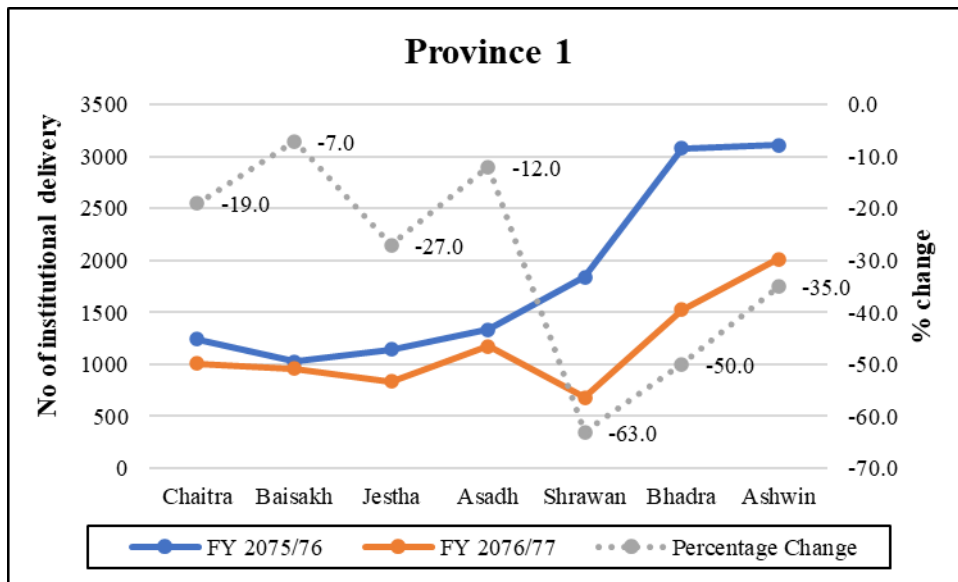
Annex 3.5: Health facility wise extent of Utilization of Institutional Delivery services during the lockdown period

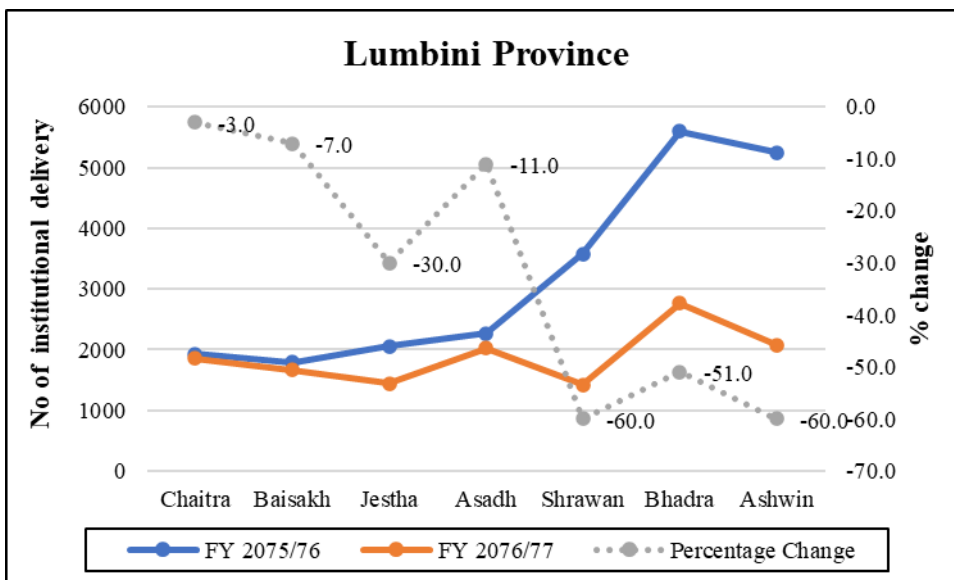
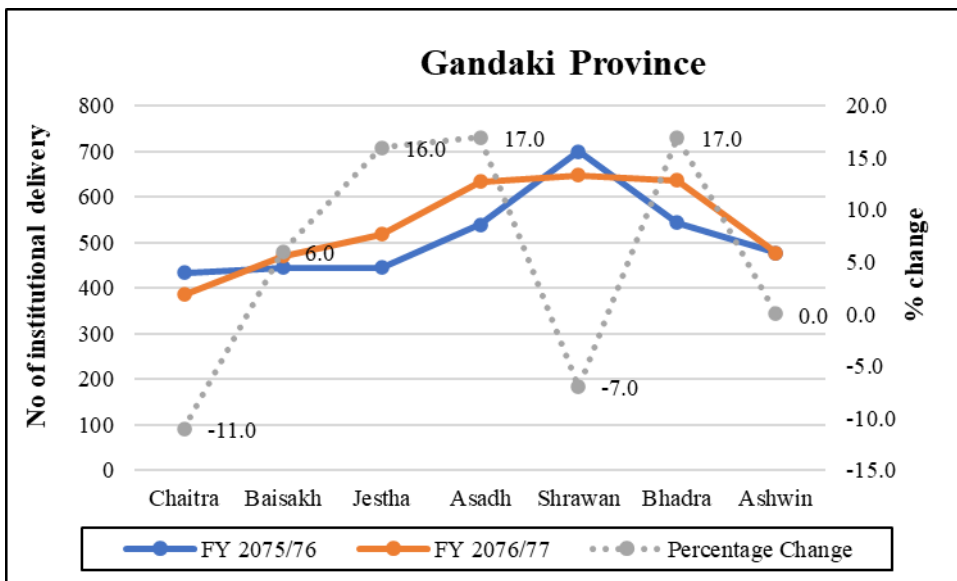
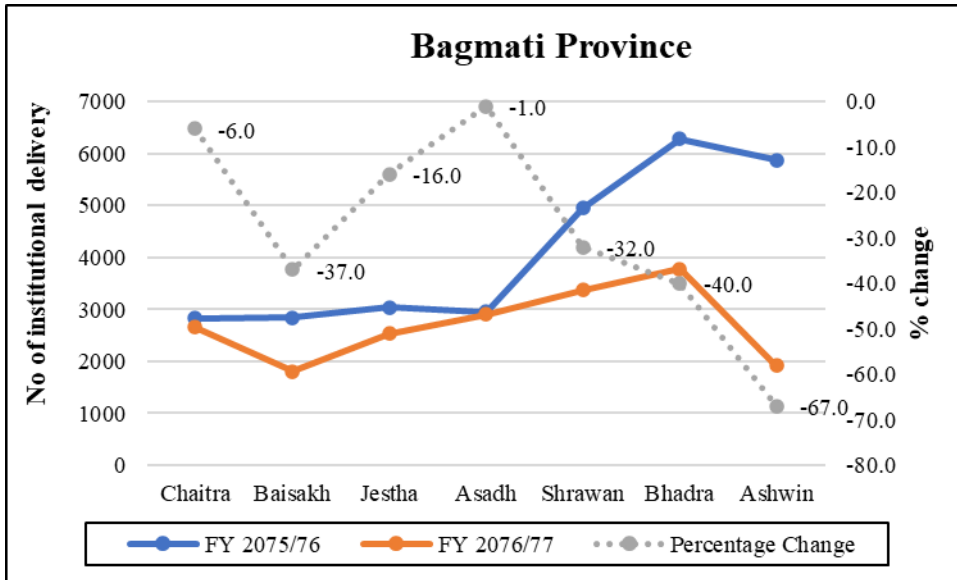


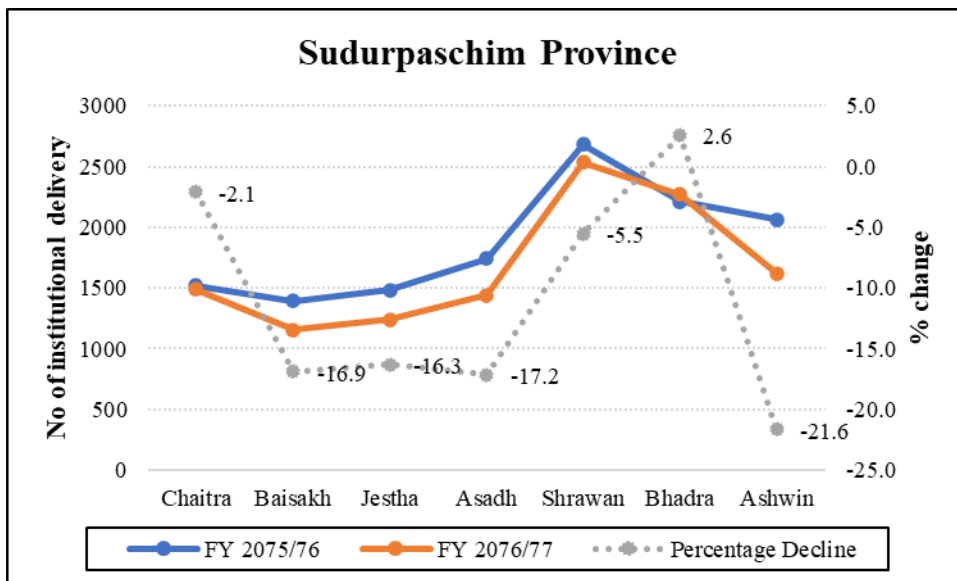
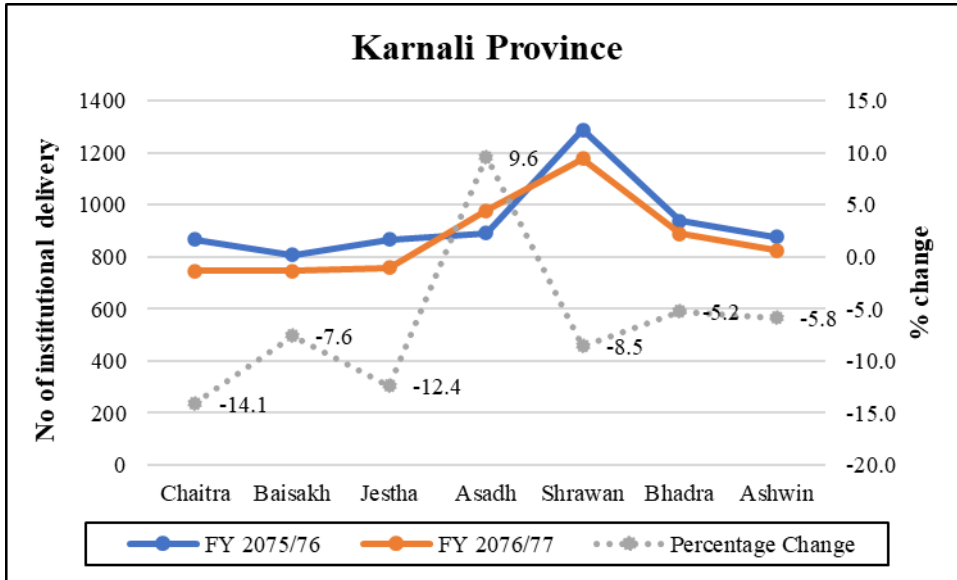
Annex 3.5a: Health facility wise extent of Utilization of Institutional Delivery services during the period between Bhadra-Kartik



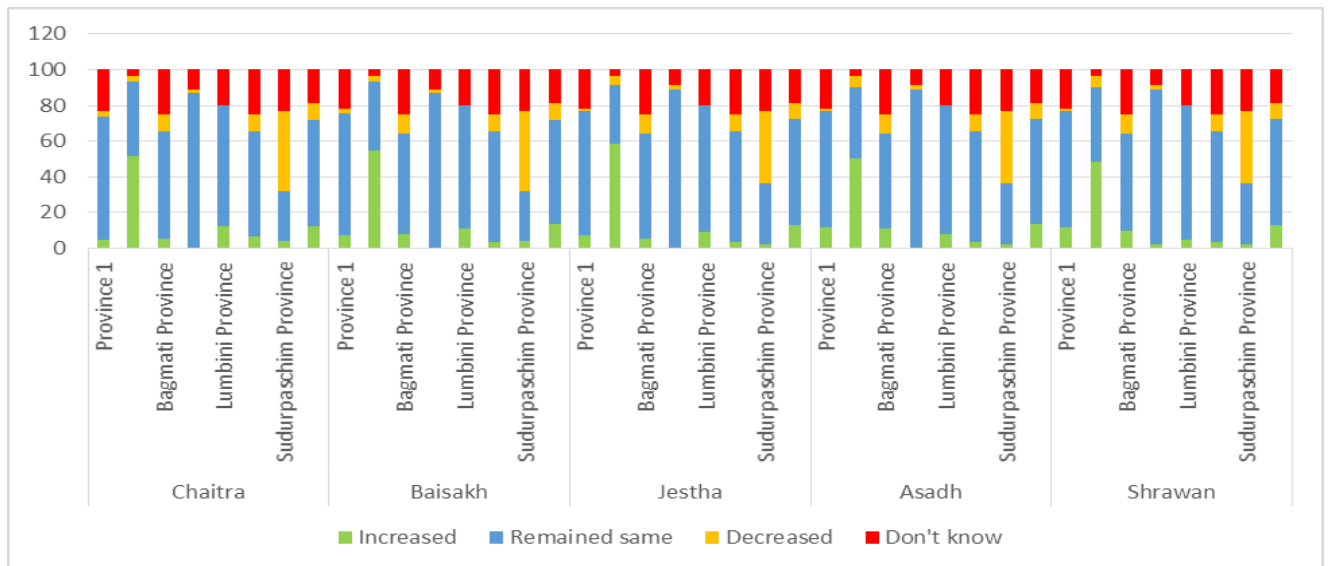
Annex 3.6: Percentage change in utilization of Institutional Delivery services during COVID-19 pandemic period as compared to corresponding months of previous year



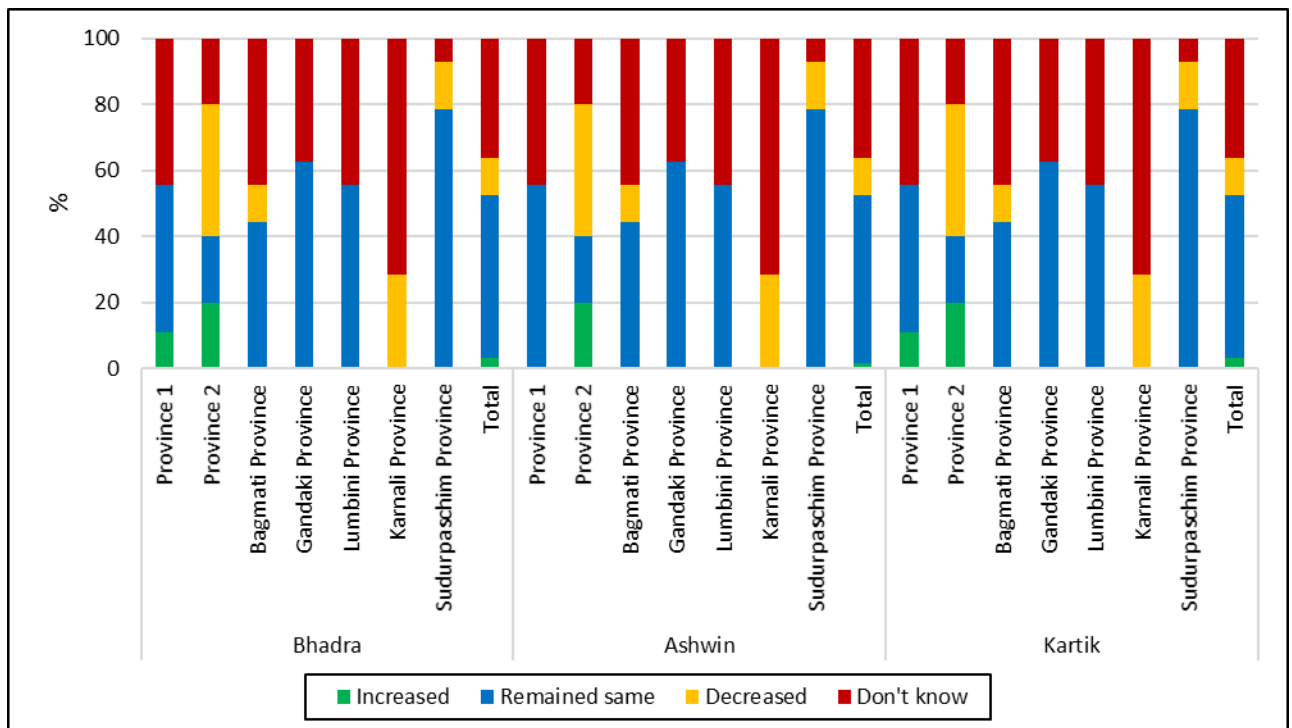




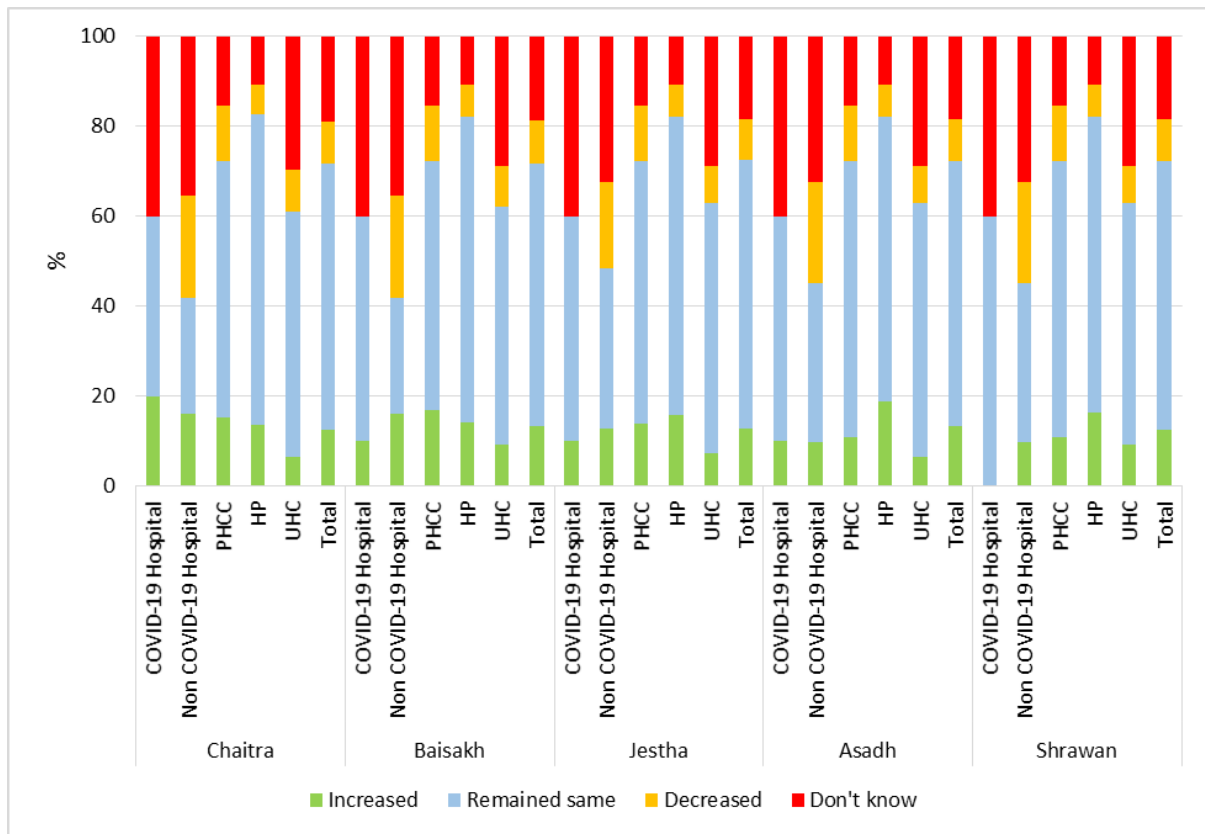
Annex 3.7: Province wise percentage reporting of home delivery during 5 months' lockdown period



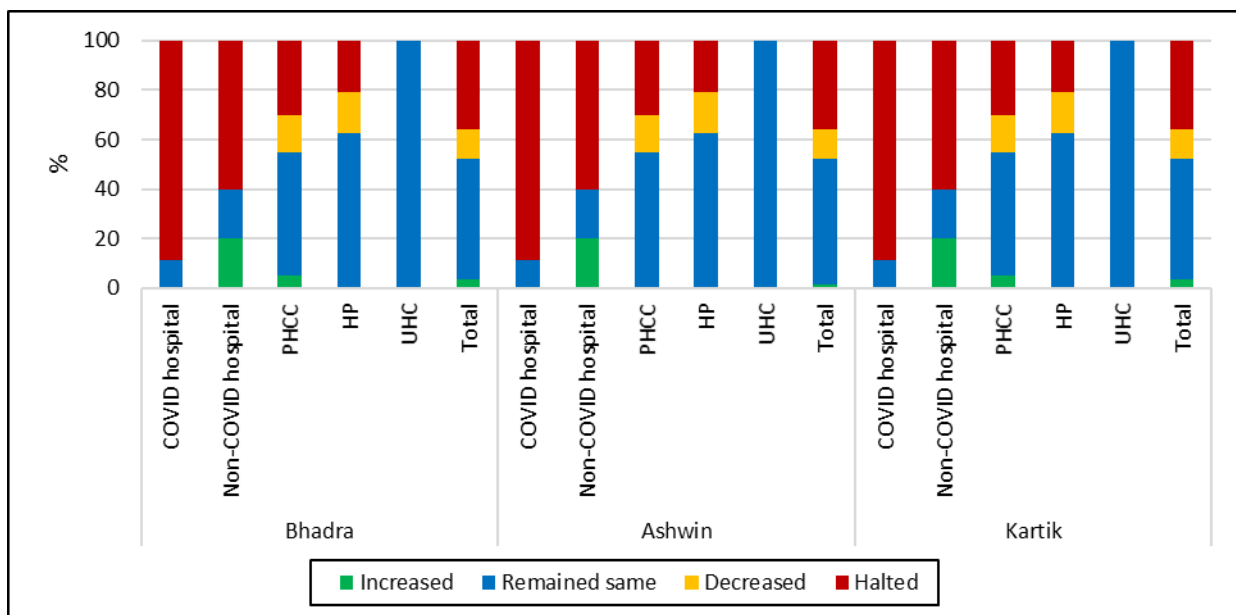
Annex 3.7a: Province wise percentage reporting of home delivery during during the period between Bhadra-Kartik



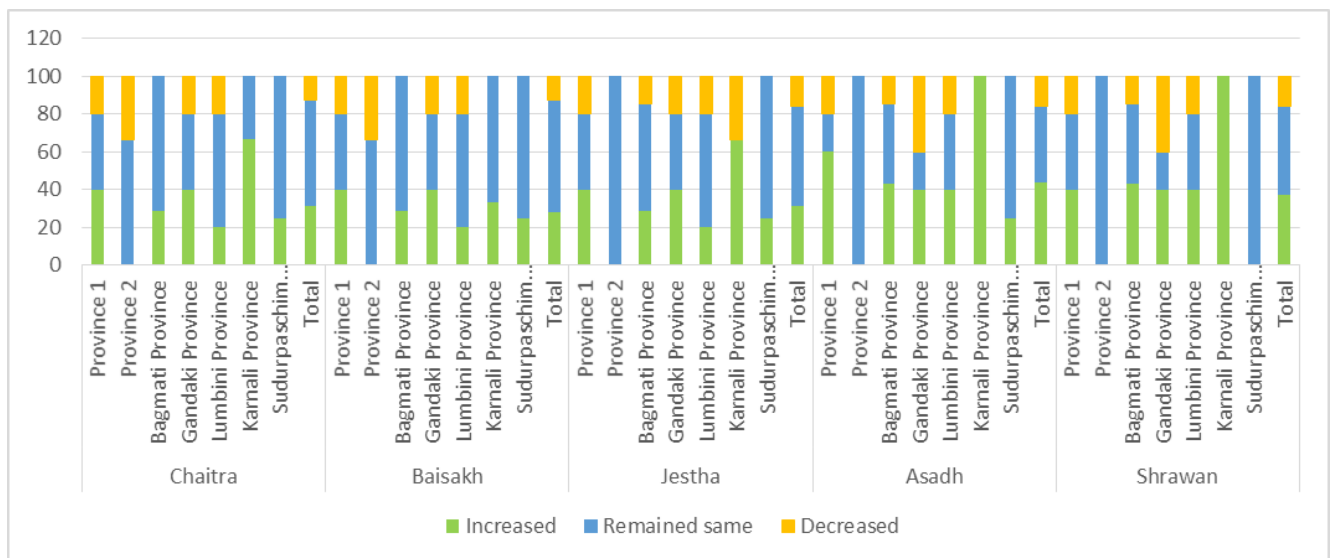
Annex 3.8: Health facility wise percentage reporting of home delivery during 5 months' lockdown period



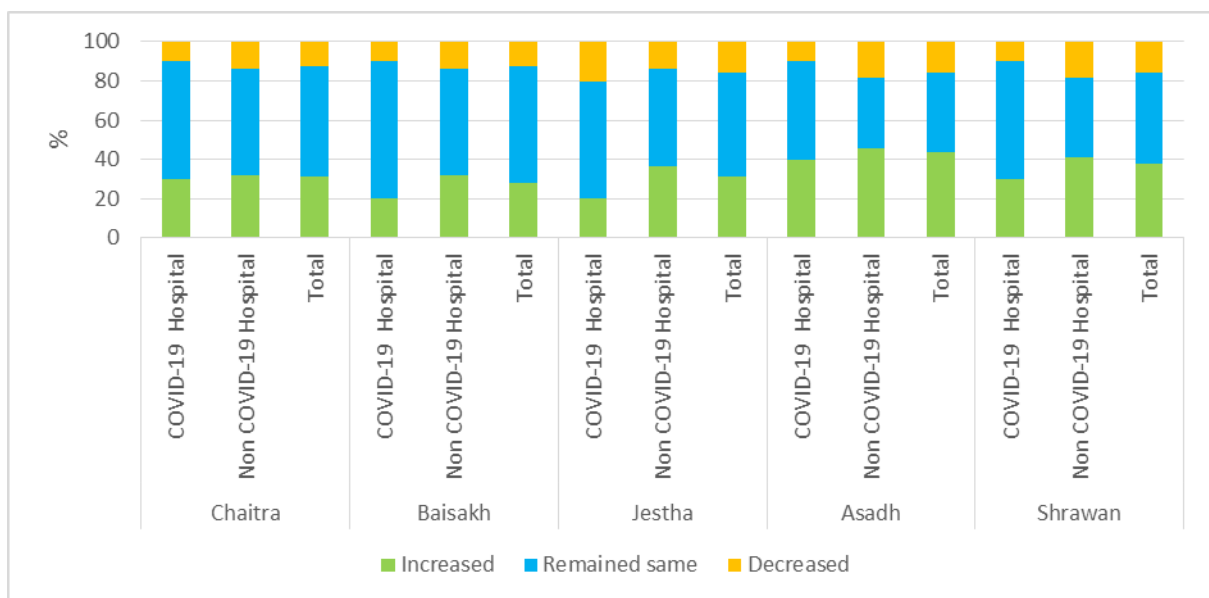
Annex 3.8a: Health facility wise percentage reporting of home delivery during during the period between Bhadra-Kartik



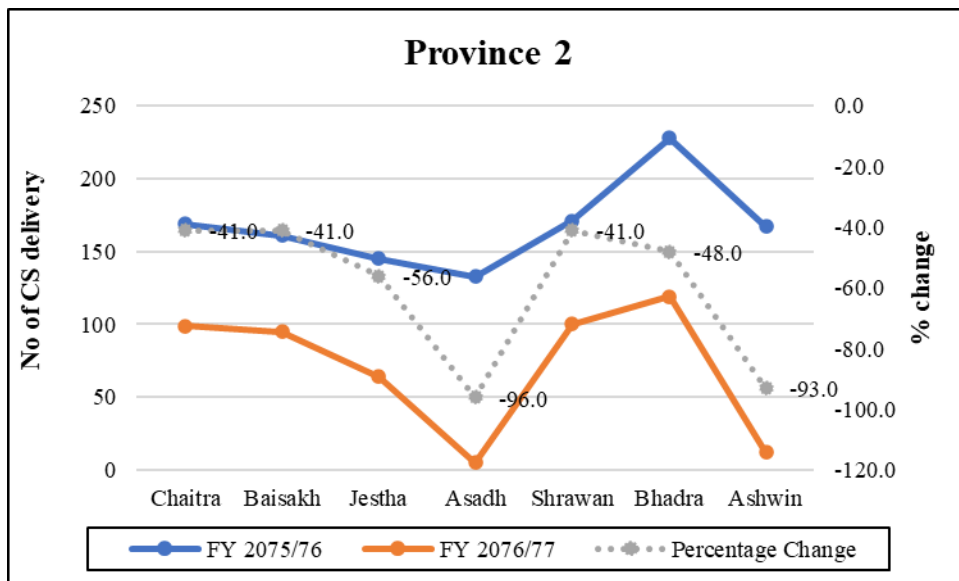
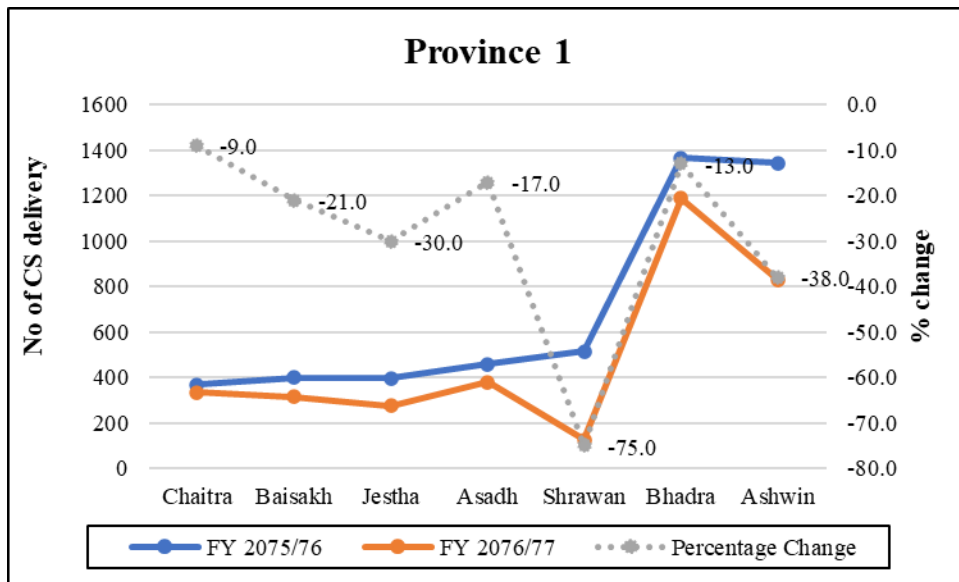
Annex 3.9: Province wise extent of Utilization of C Section during 5 months' lockdown period

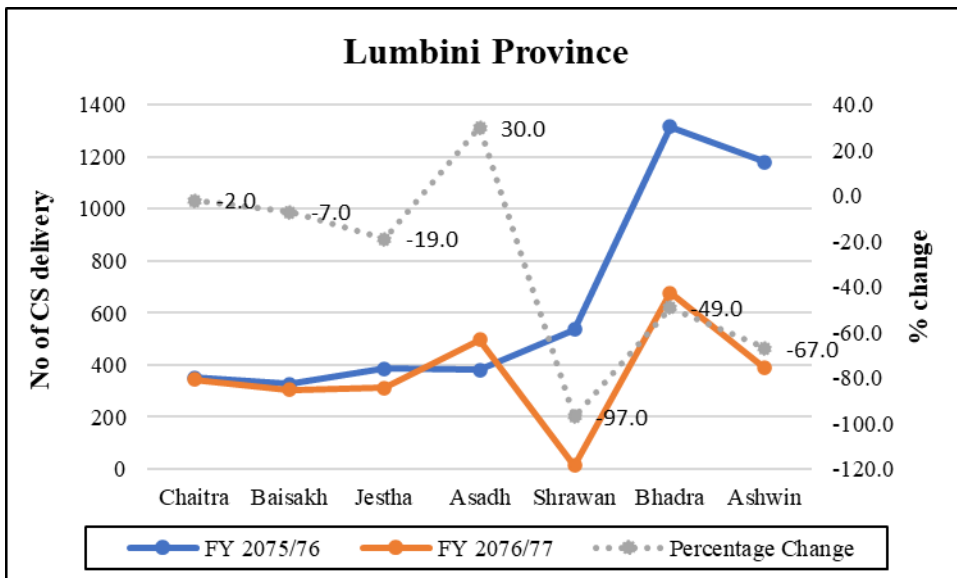
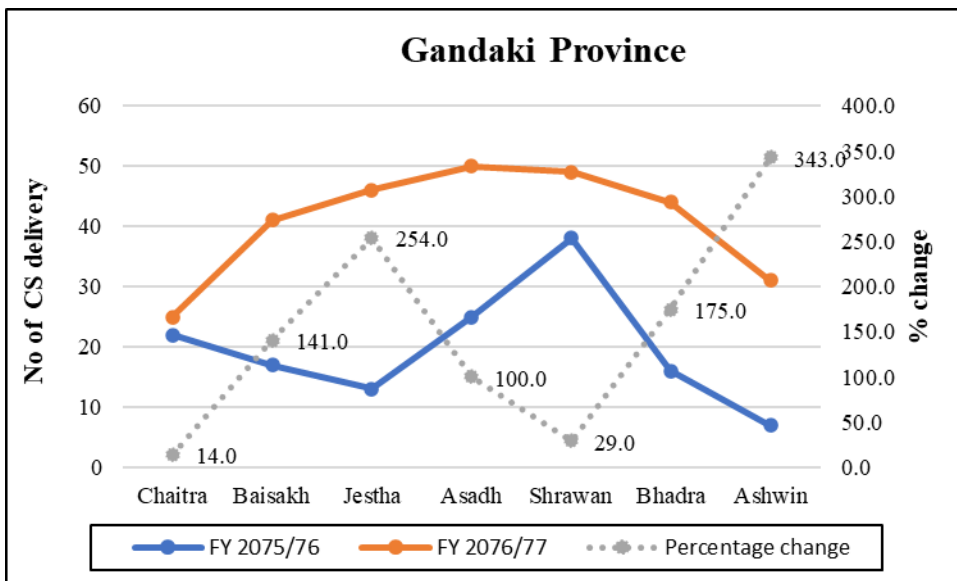
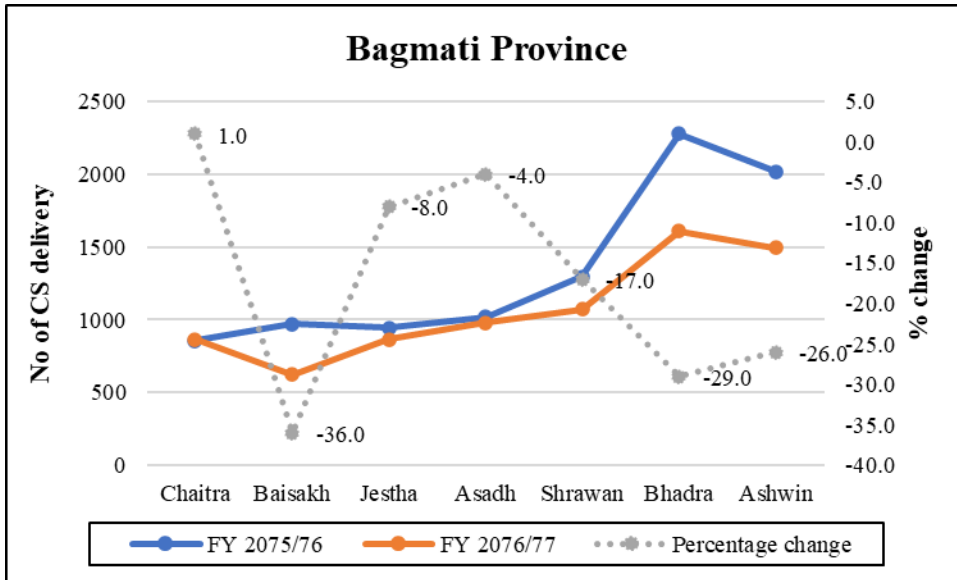


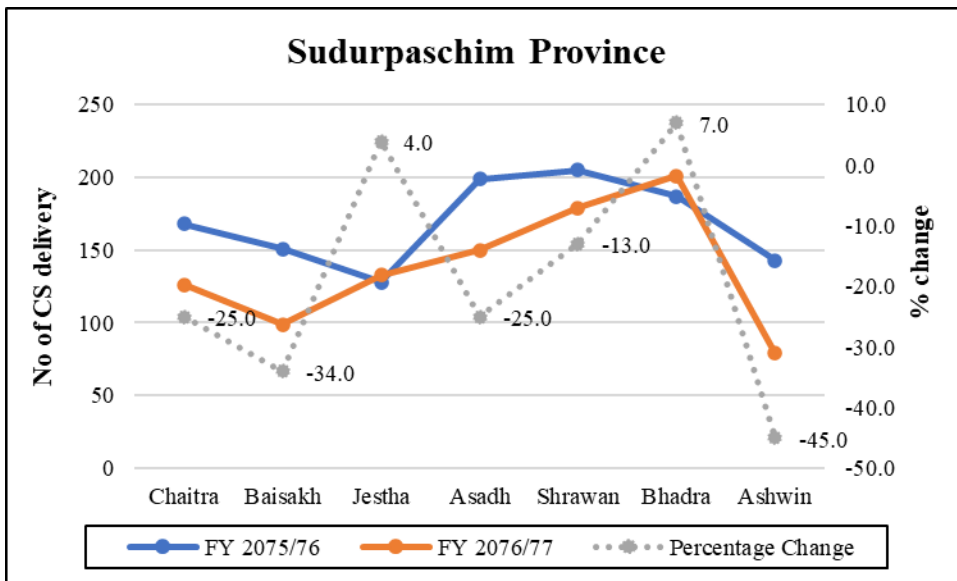
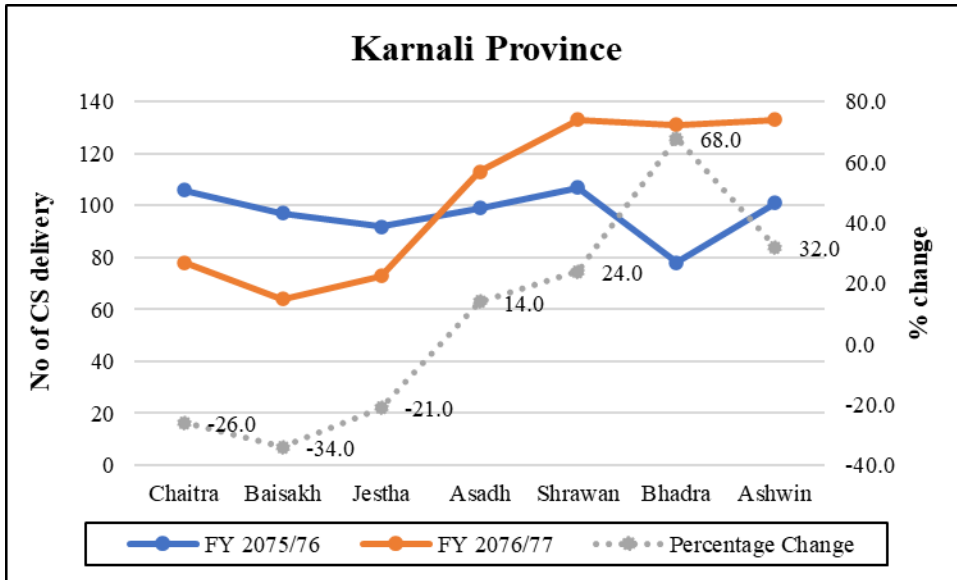
Annex 3.10: Health facility wise extent of Utilization of C Section during 5 months' lockdown period



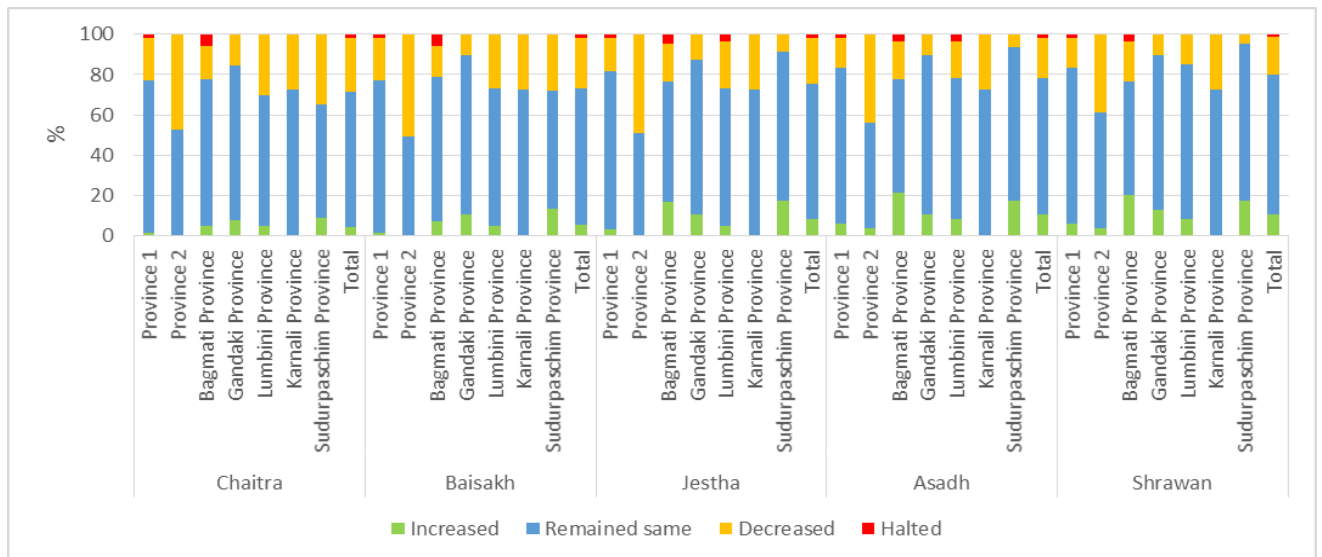
Annex 3.11: Percentage change in utilization of Caesarean Section services during COVID-19 pandemic period as compared to corresponding months of previous year



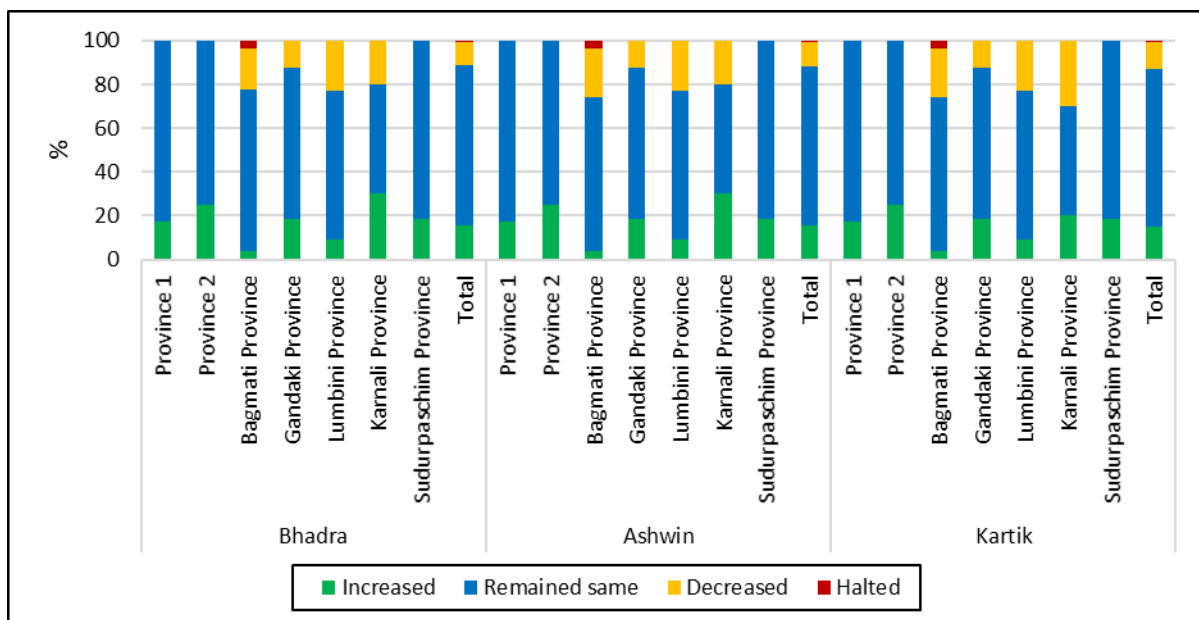




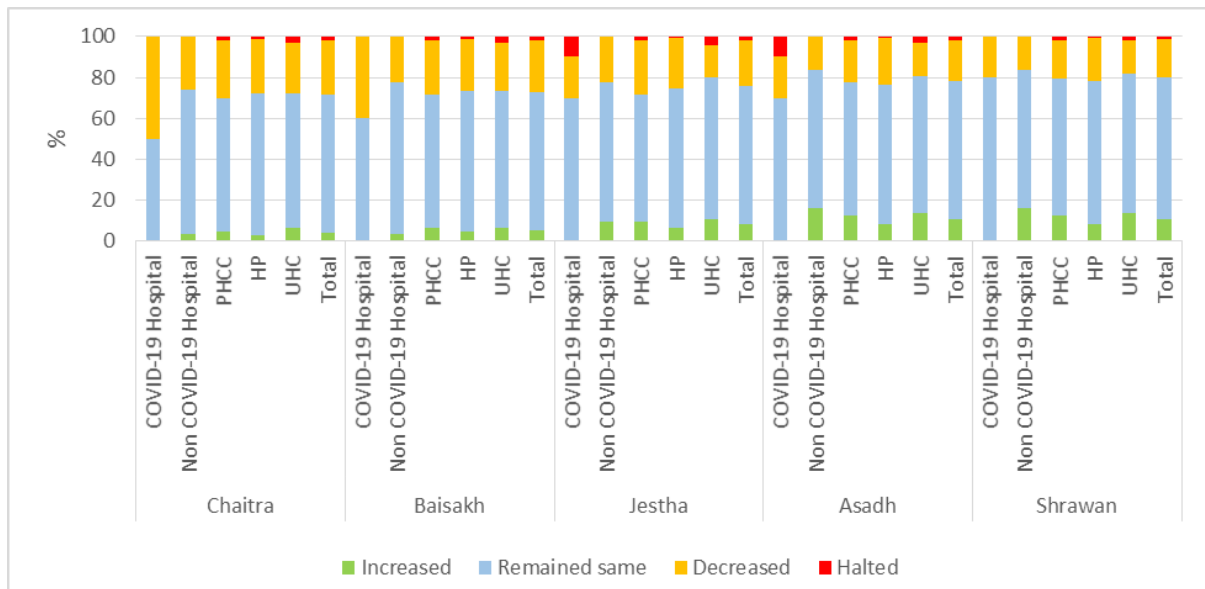
Annex 3.12: Province wise extent of utilization of PNC services during the 5 months' lockdown period



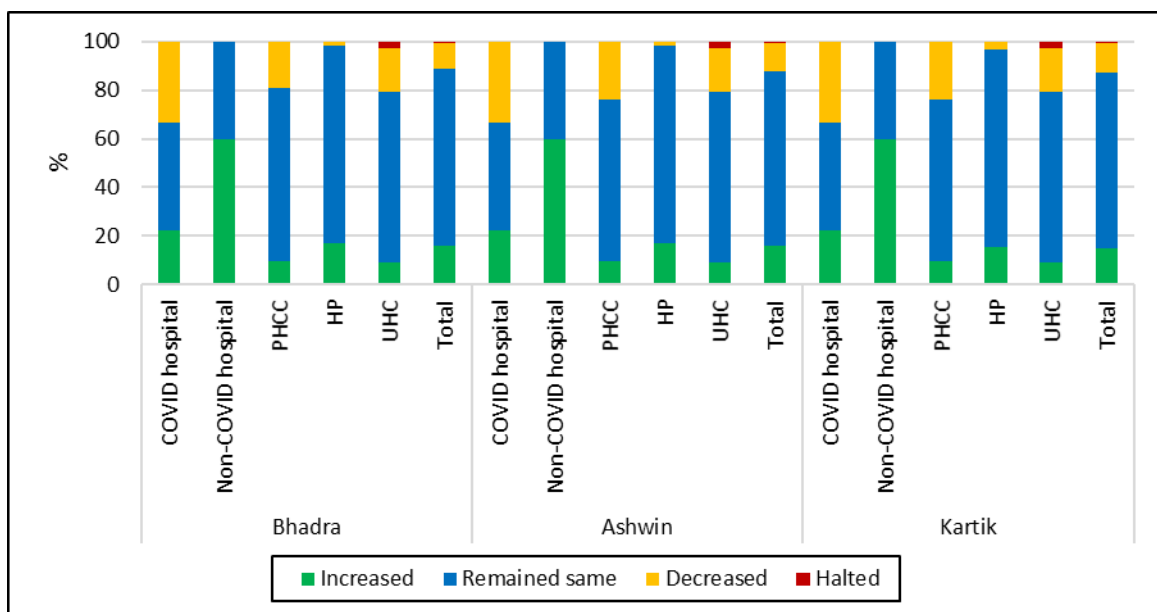
Annex 3.12a: Province wise extent of utilization of PNC services during the period between Bhadra-Kartik



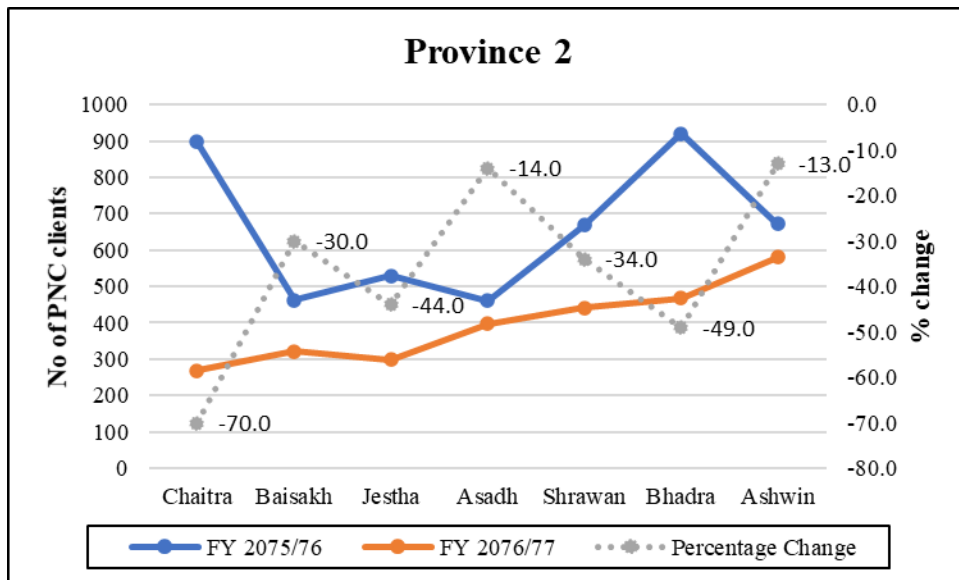
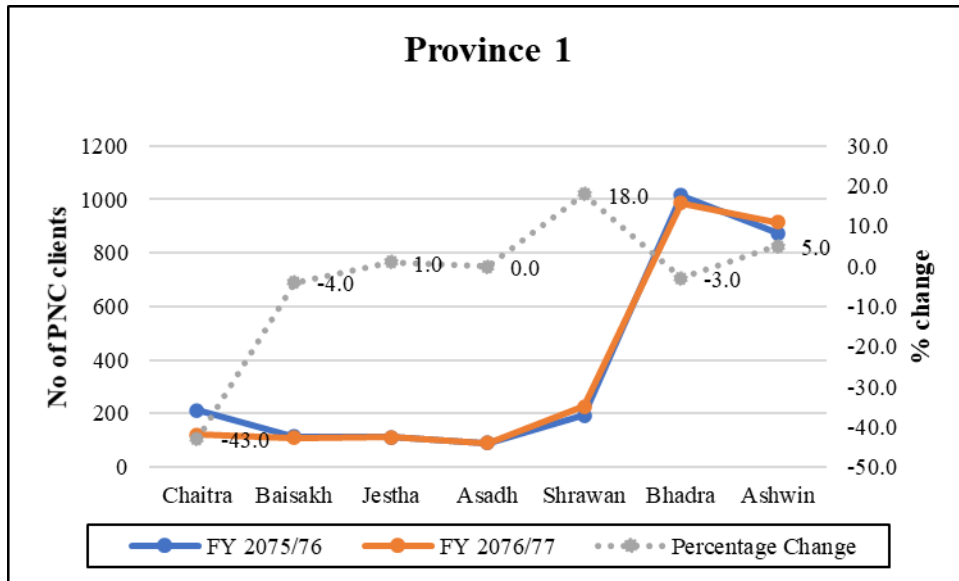
Annex 3.13: Health facility wise extent of utilization of PNC services during the 5 months' lockdown period

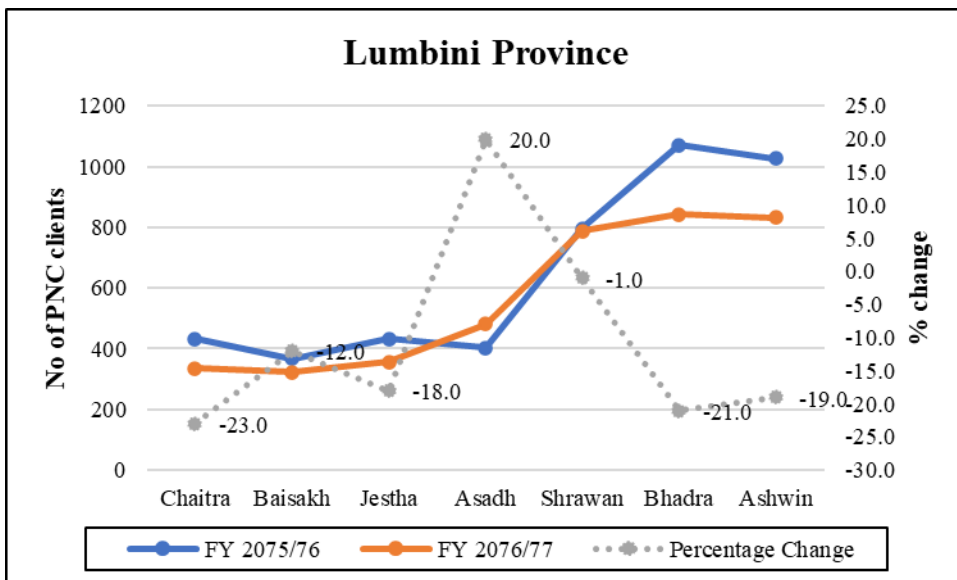
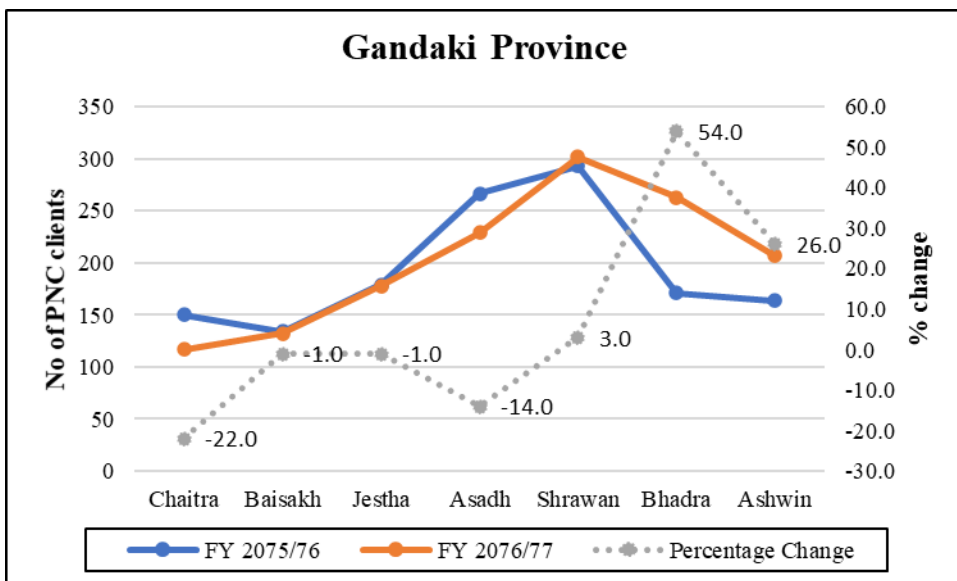
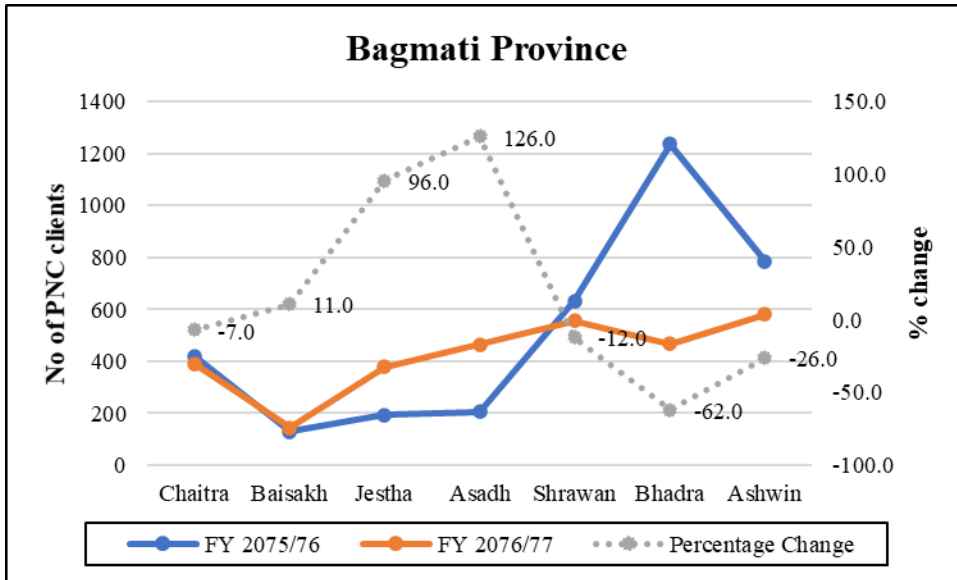


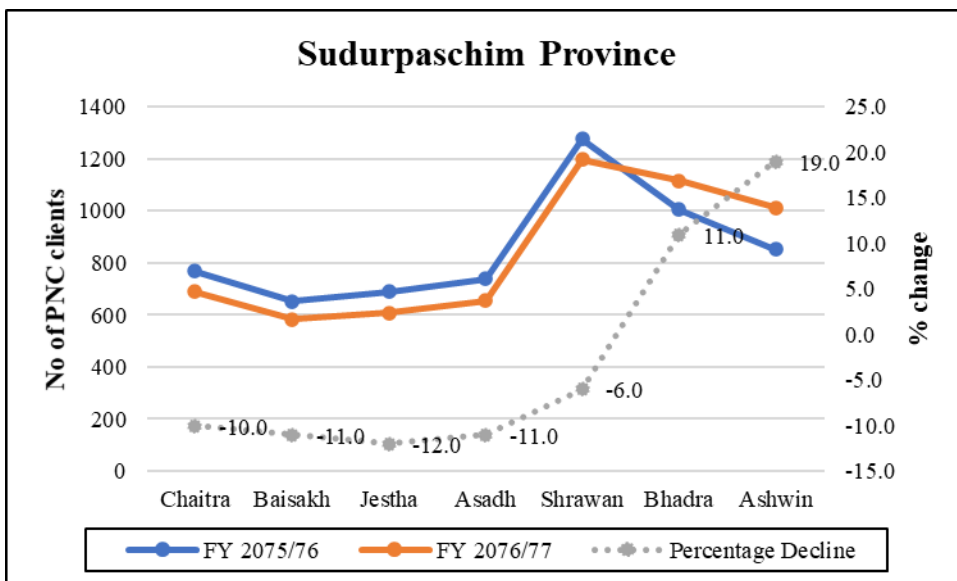
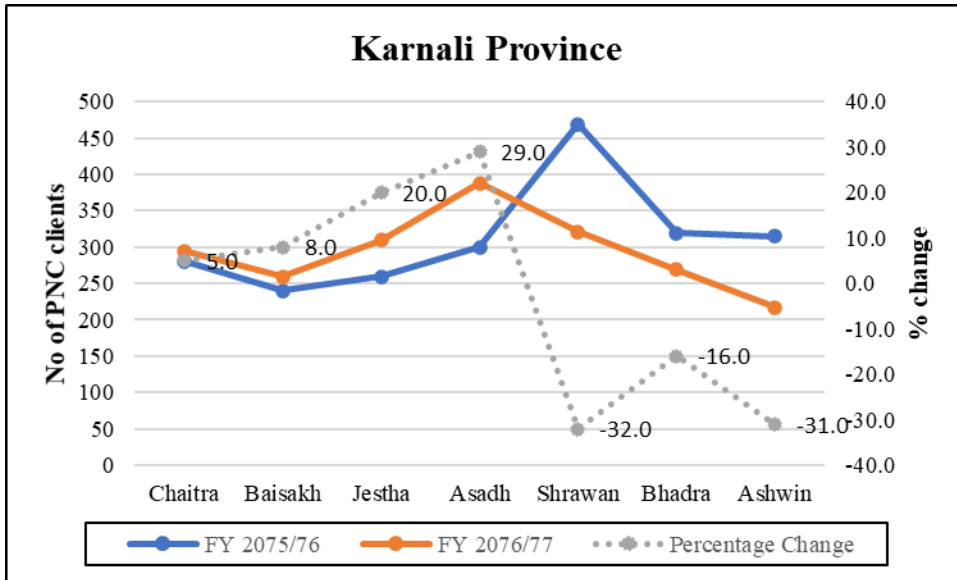
Annex 3.13a: Health facility wise extent of utilization of PNC services during the period between Bhadra-Kartik



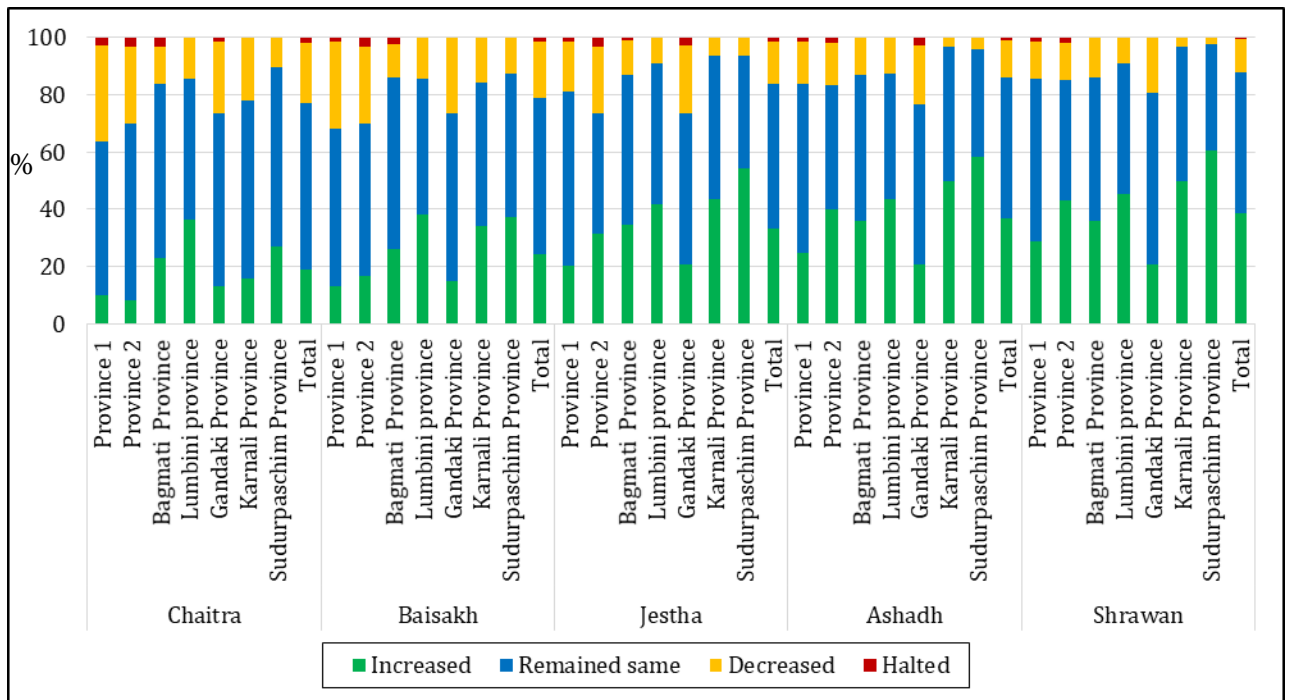
Annex 3.14: Percentage change in utilization of PNC services during COVID-19 pandemic period as compared to corresponding months of previous year



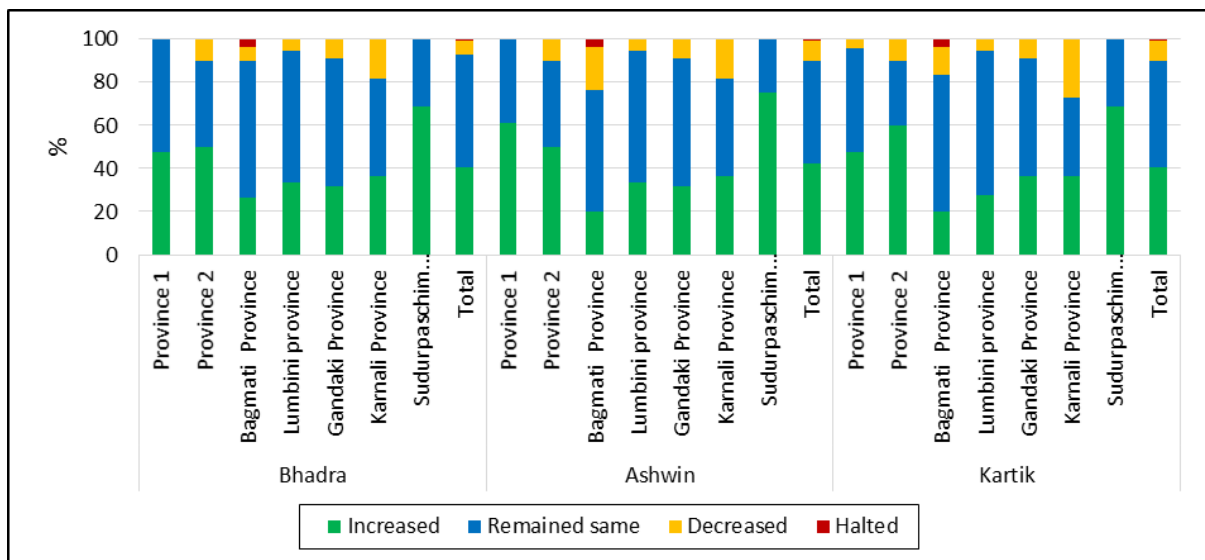




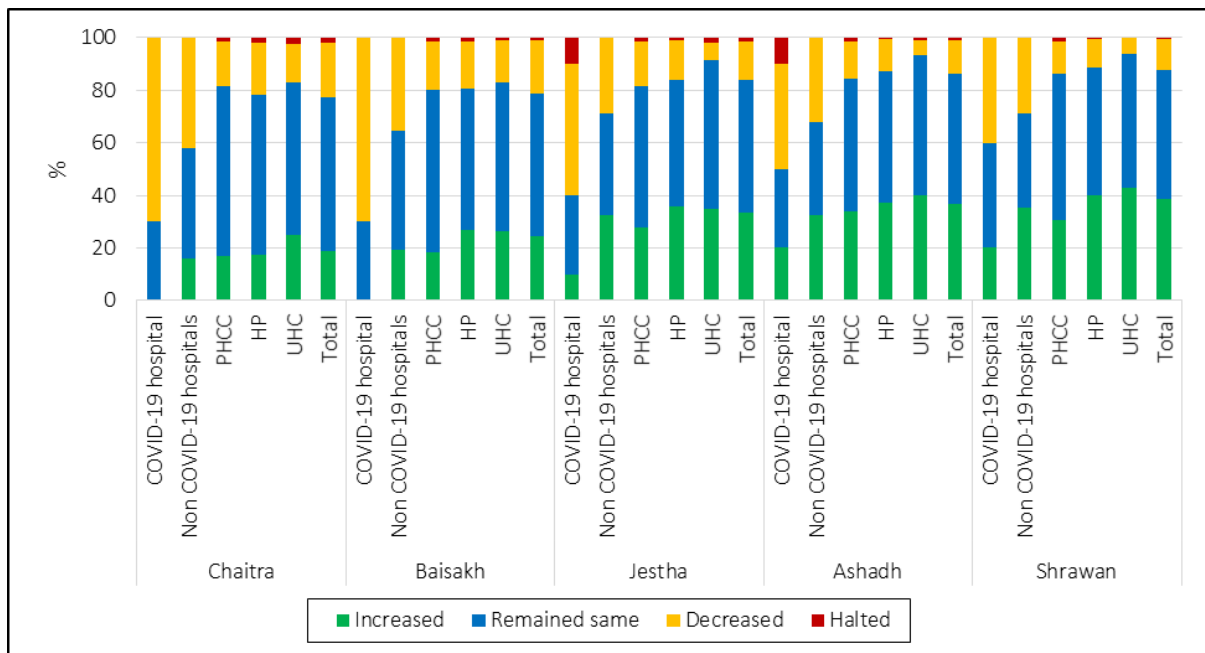
Annex 4.1 Flow of family planning new clients during the 5 months of lockdown period by province (N=424)



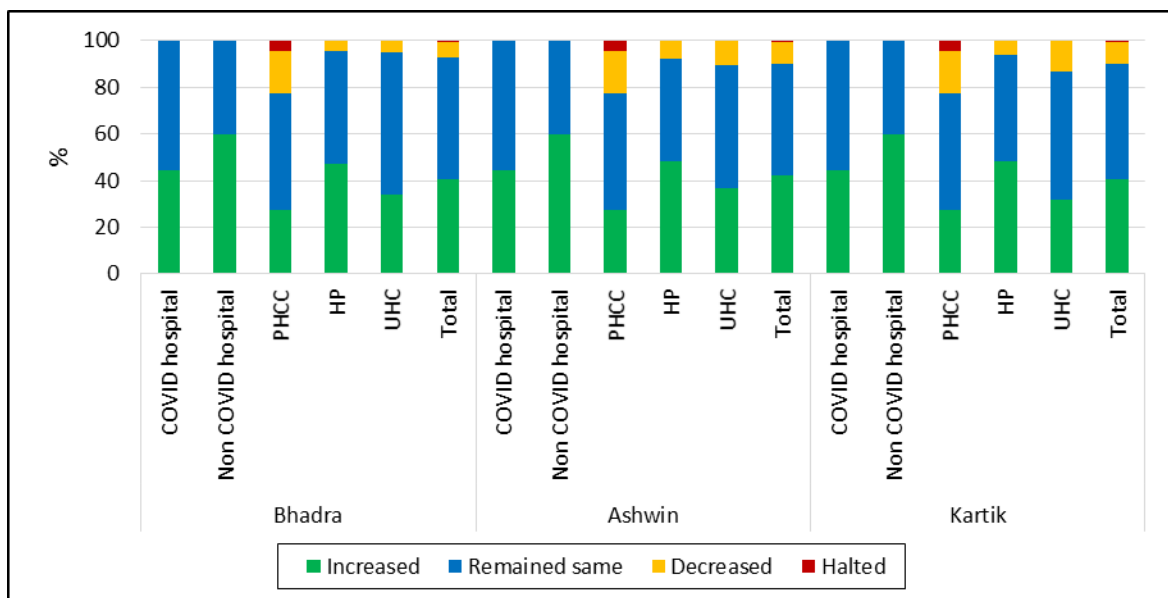
Annex 4.1a Flow of family planning new clients during the during the period between Bhadra-Kartik by province (N=140)



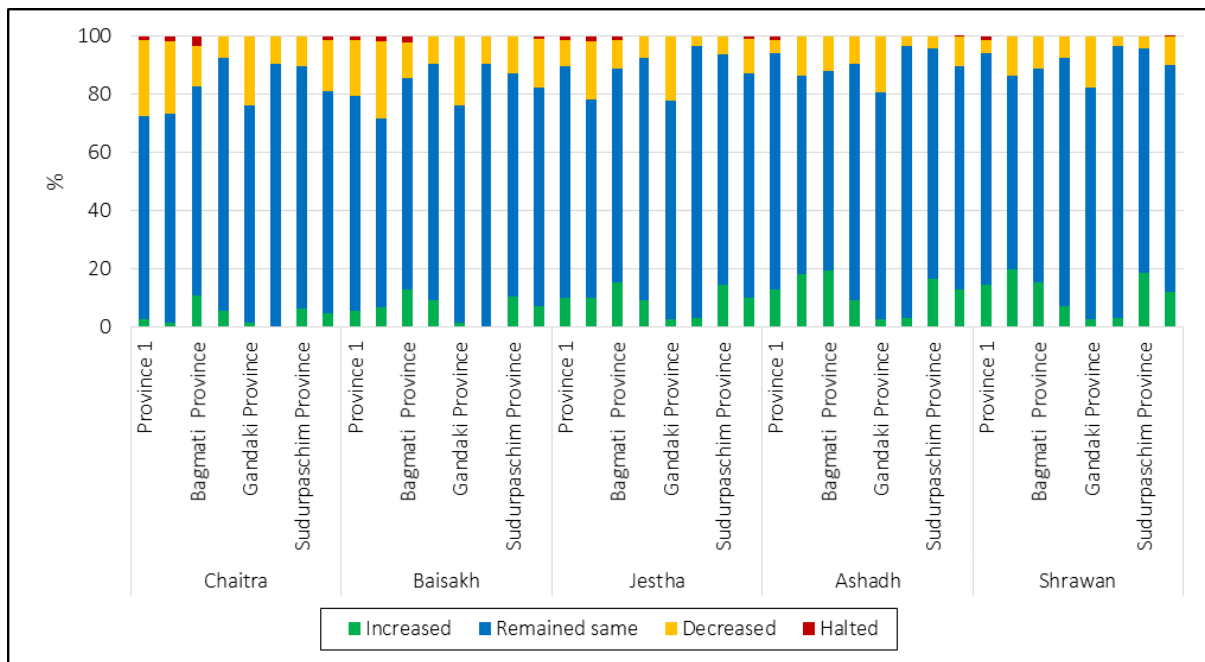
Annex 4.2 Flow of family planning new clients during the 5 months of lockdown period by types of HF's (N=424)



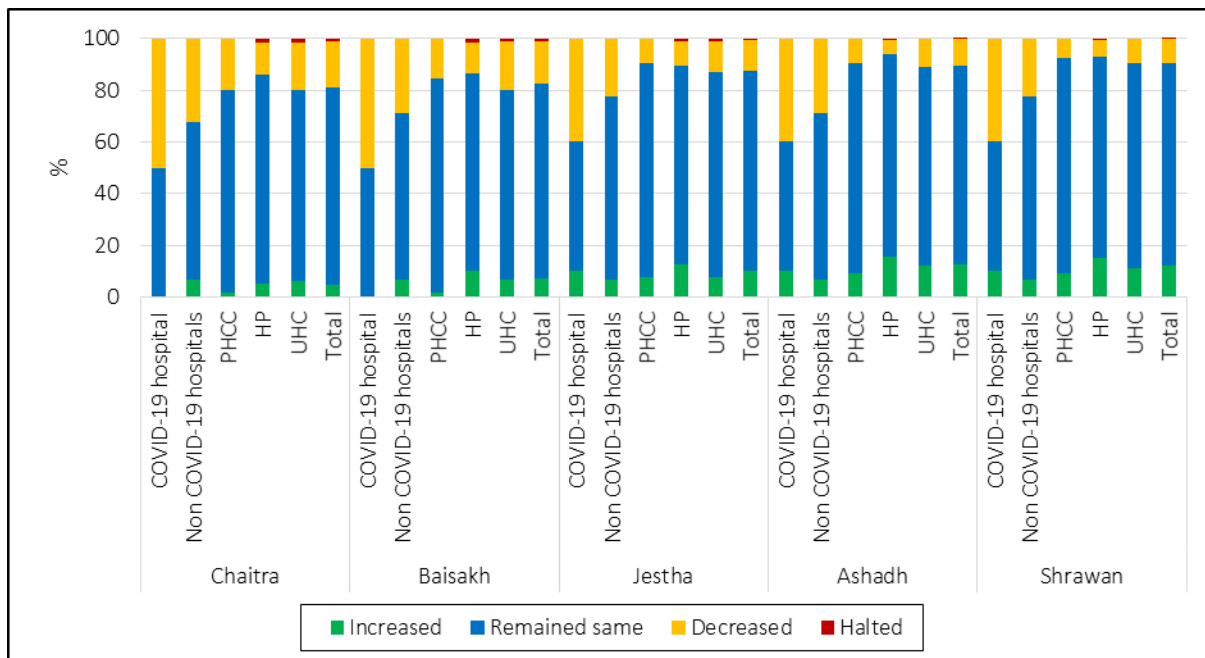
Annex 4.2a Flow of family planning new clients during the 5 months of lockdown period by types of HF's (N=140)



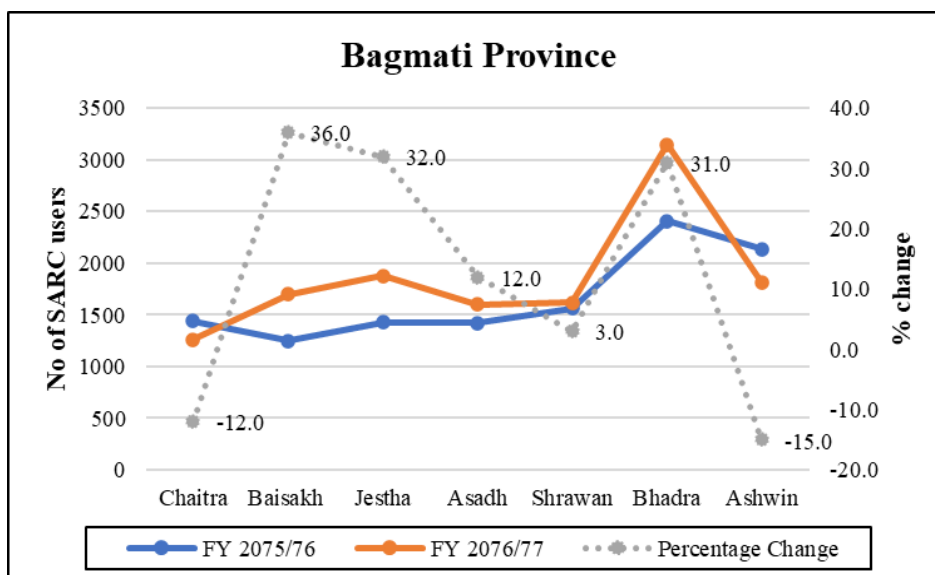
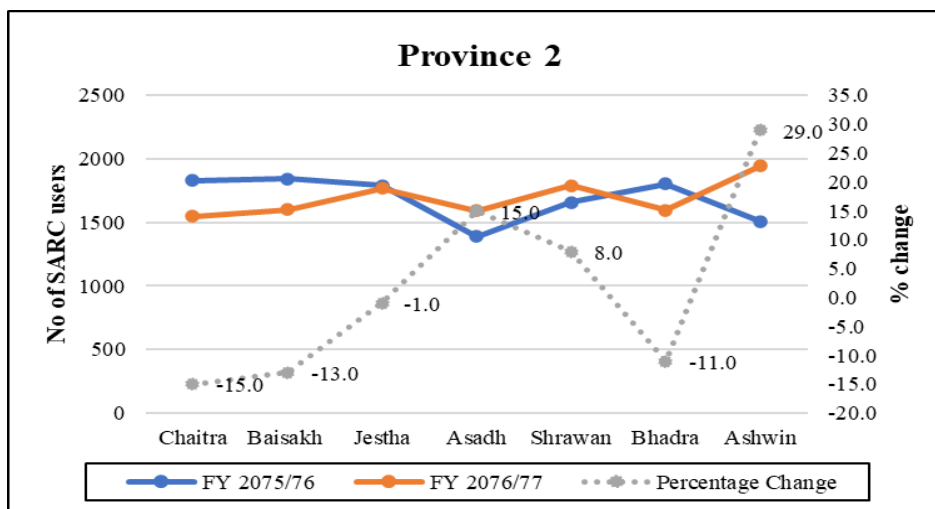
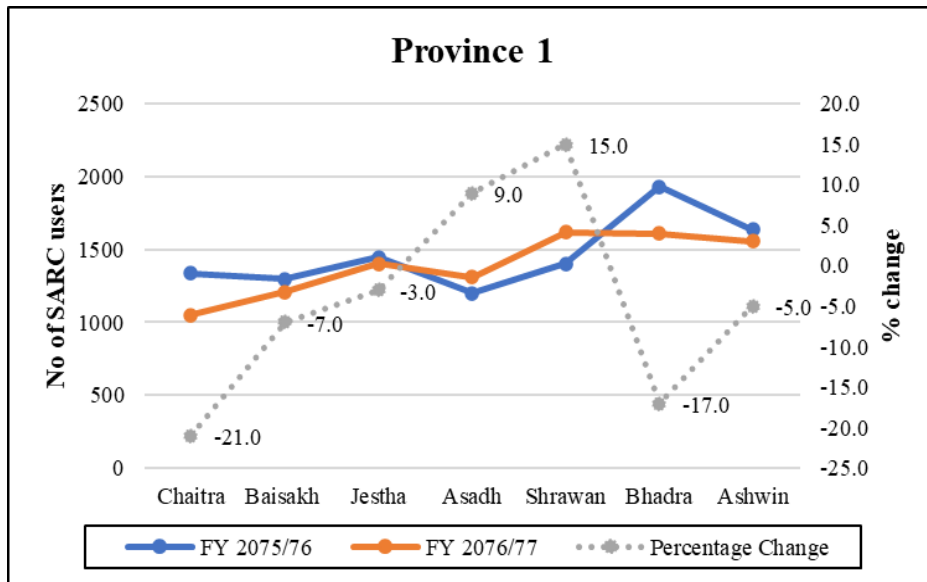
Annex 4.3 Provider's perception on flow of FP follow-up clients by province (n=424)

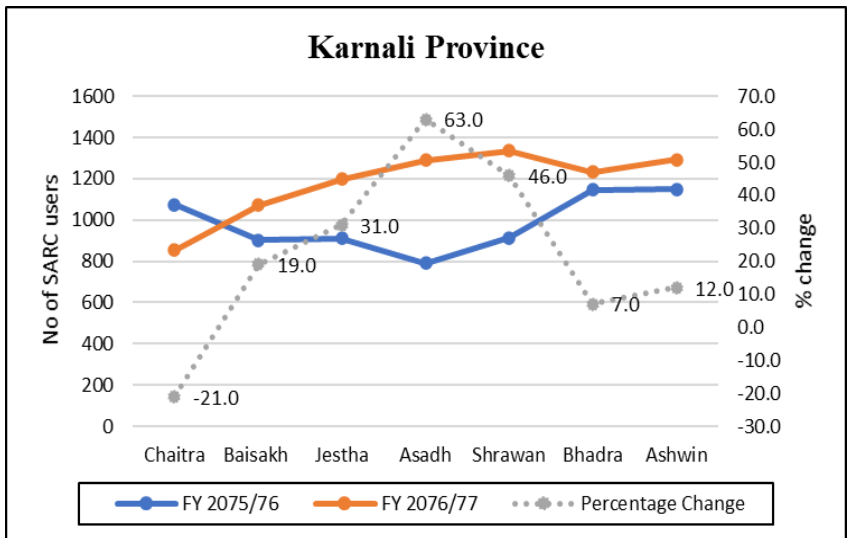
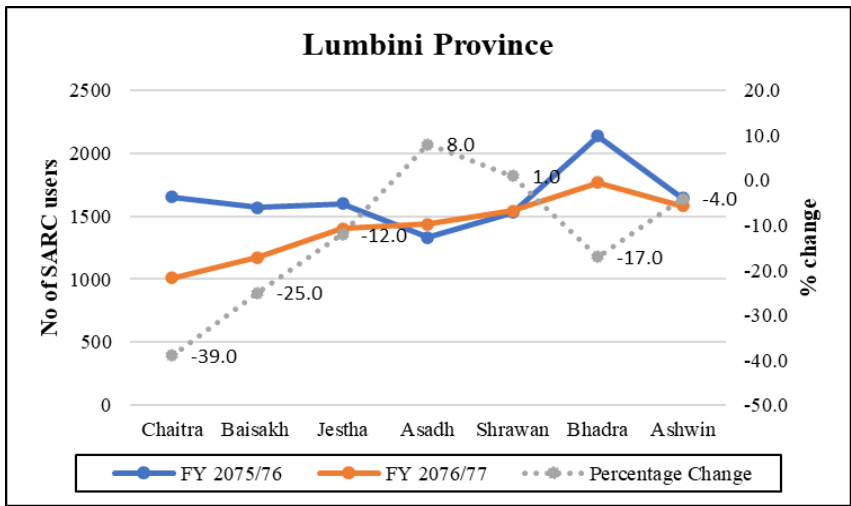
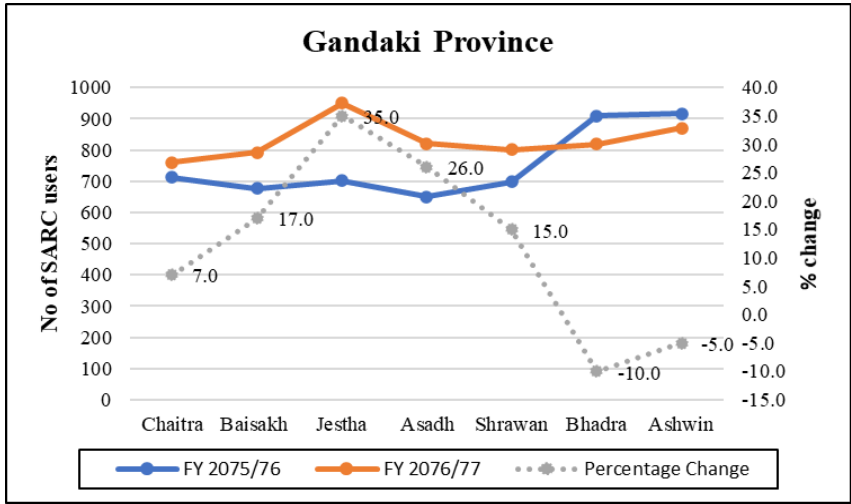


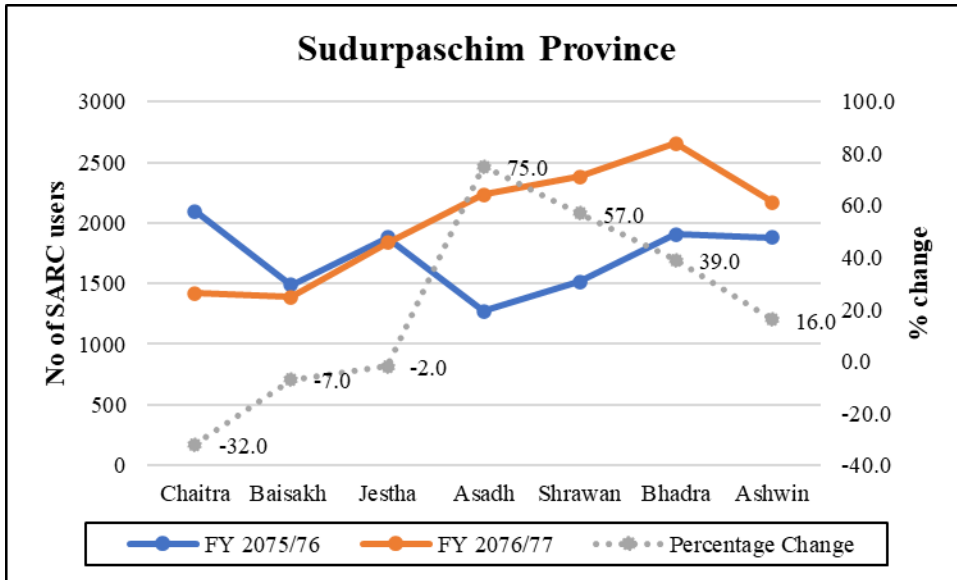
Annex 4.4 Provider's perception on flow of FP follow-up clients by type of health facility (n=424)



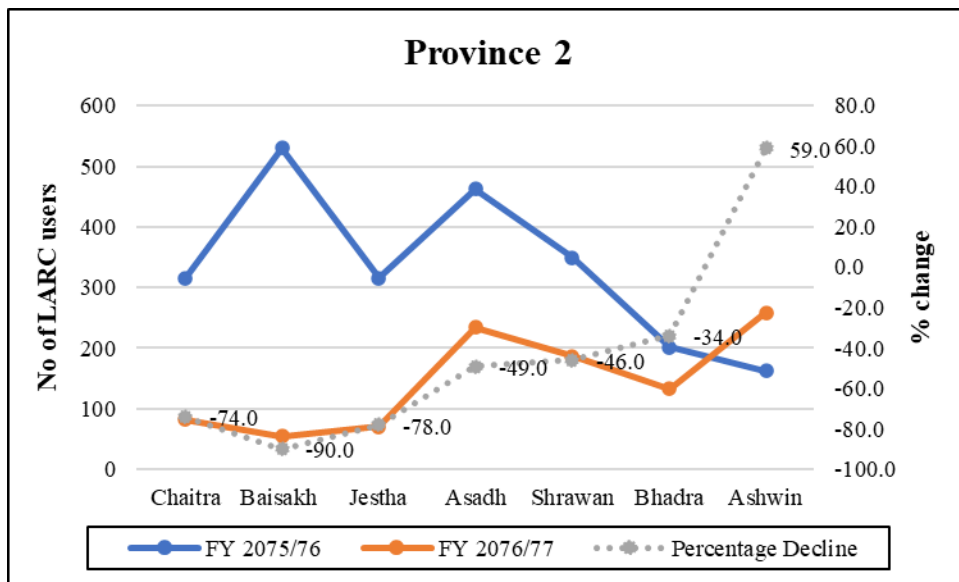
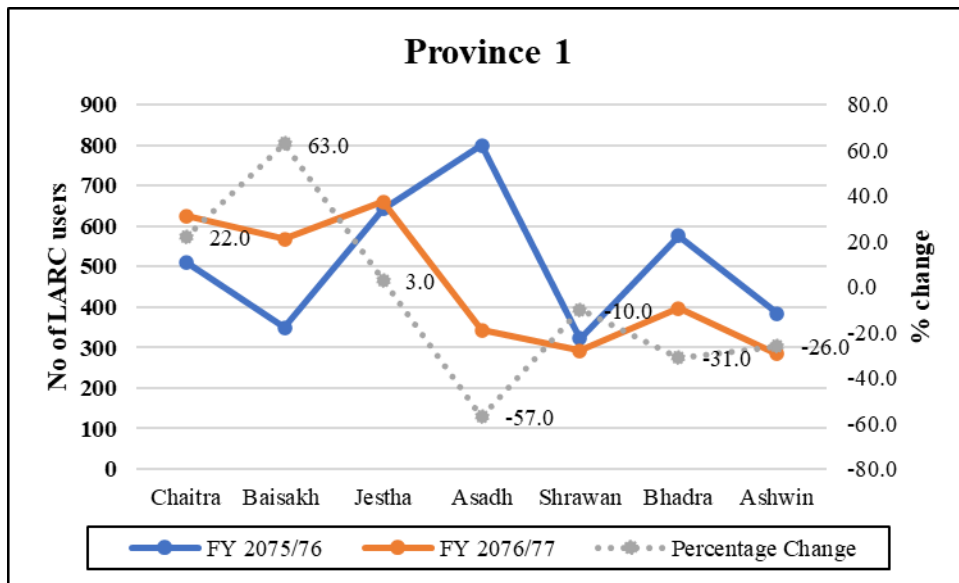
Annex 4.5 : Percentage change in utilization of SARC services (Pills and Depo) during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]

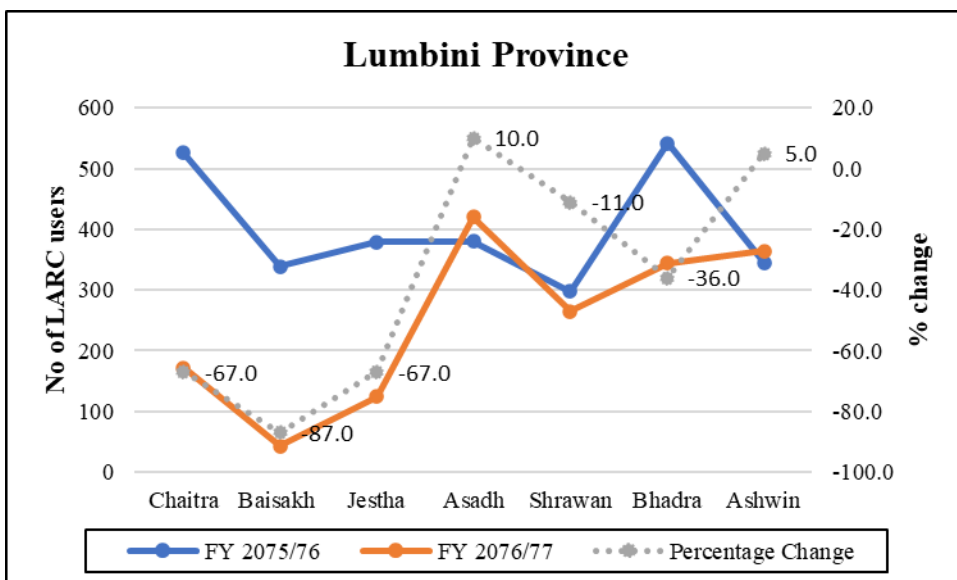
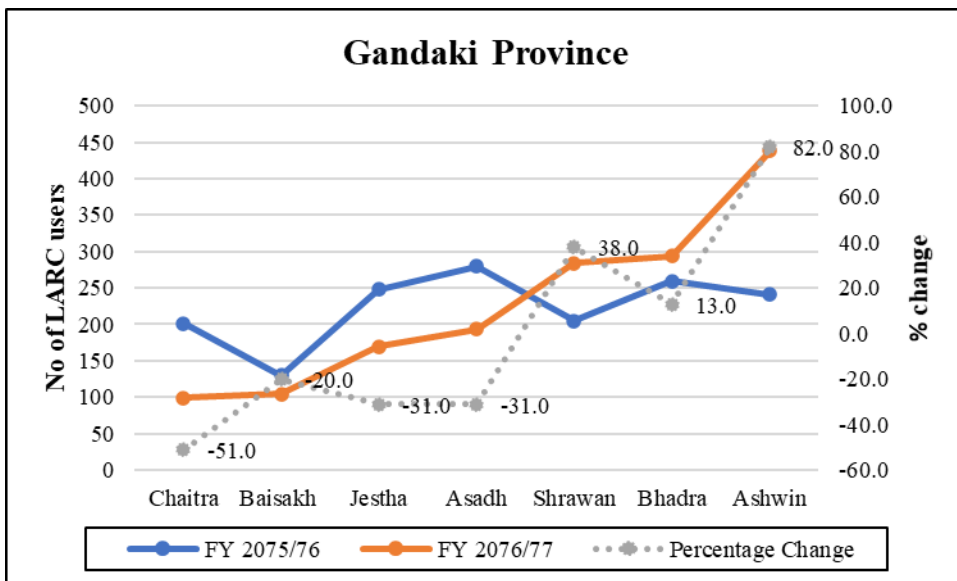
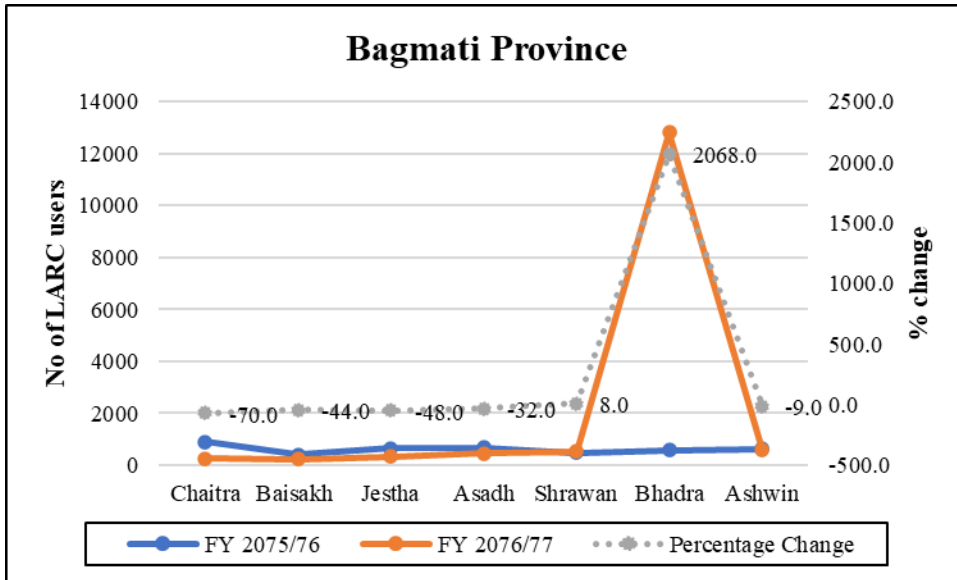


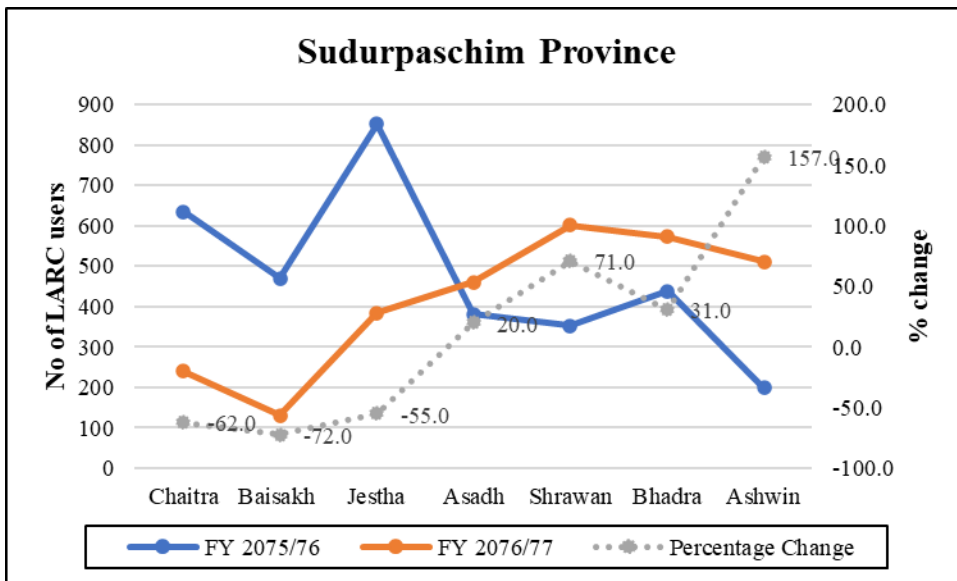
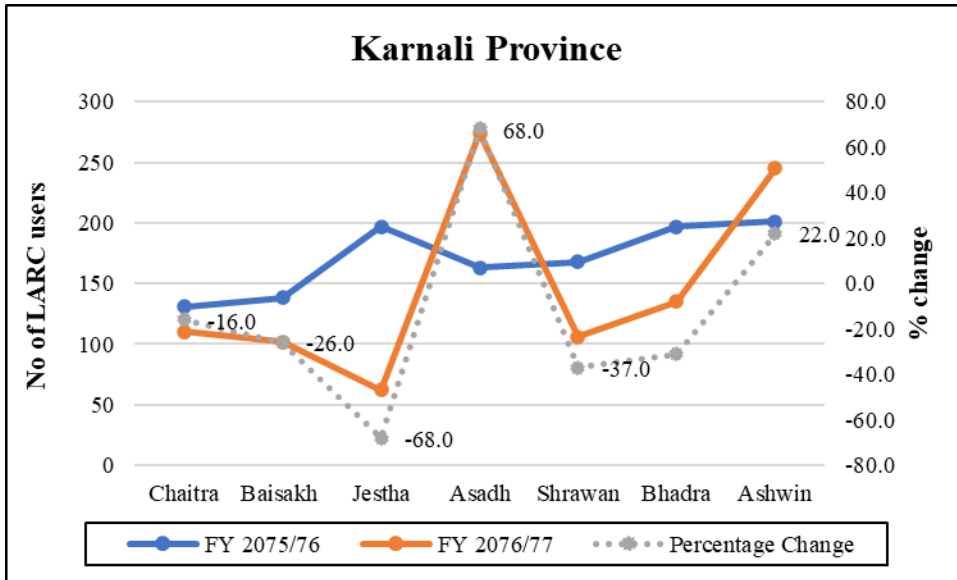




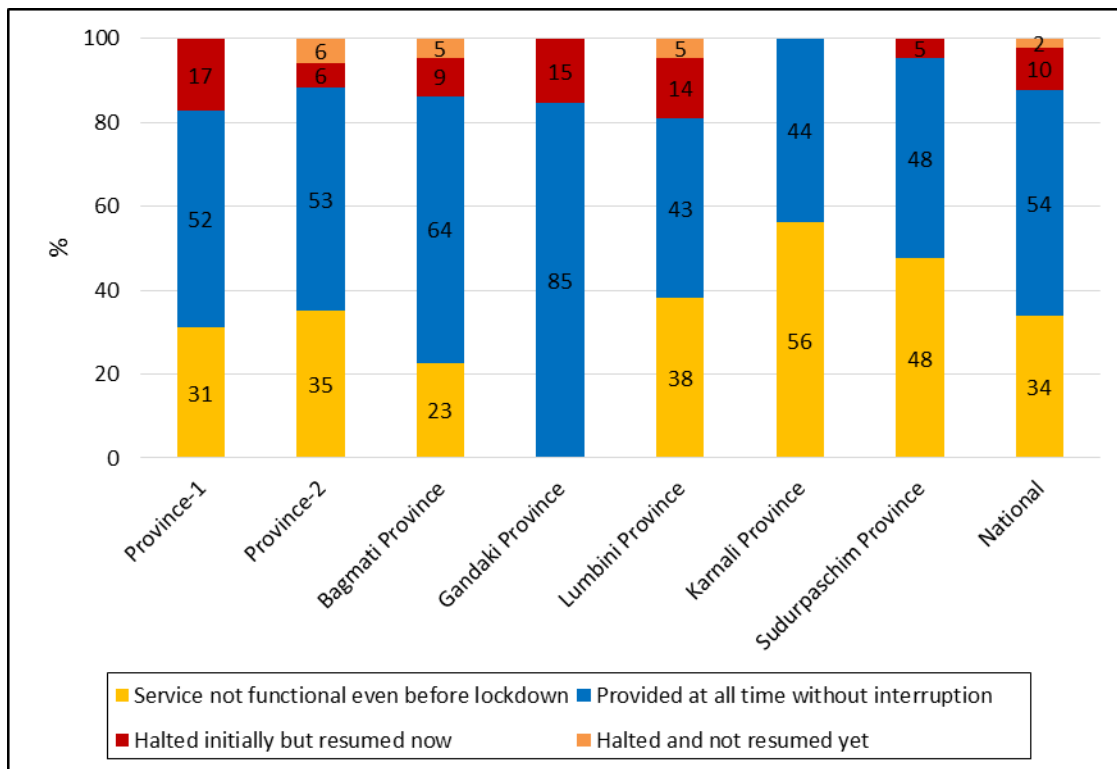
Annex 4.6 : Percentage change in utilization of LARC services (Implant and IUCD)during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]



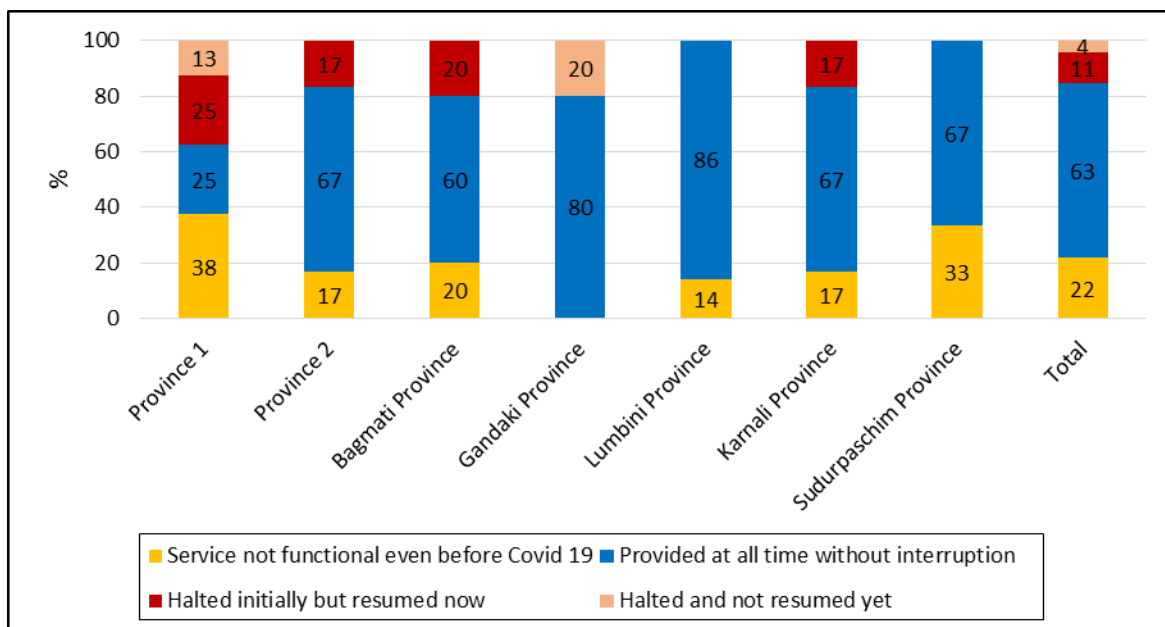




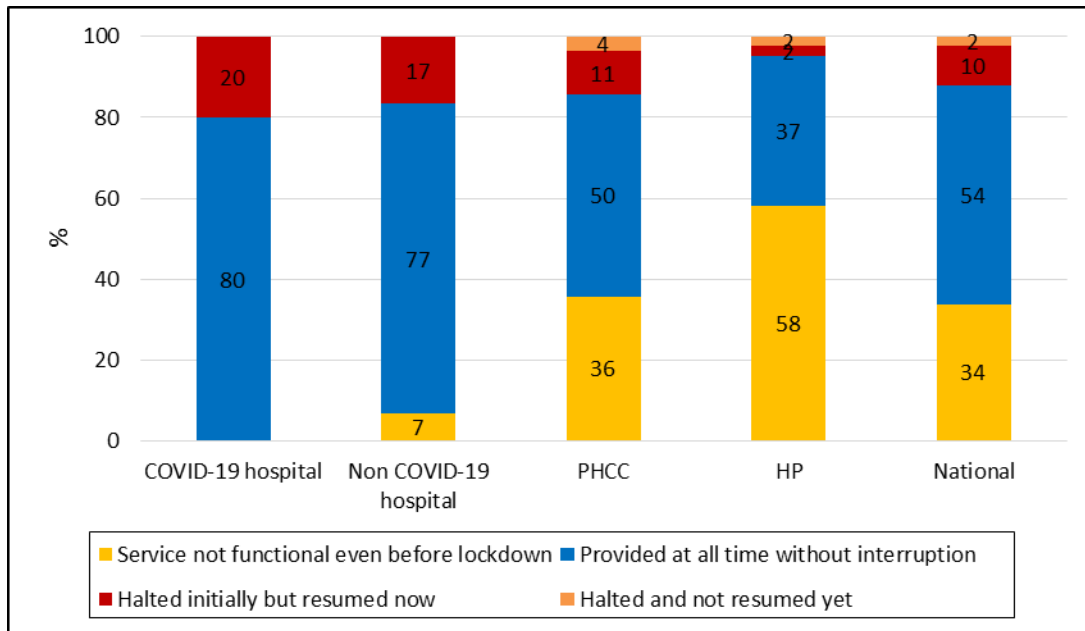
Annex 5.1 Functionality of Safe Abortion services by province (n=139)



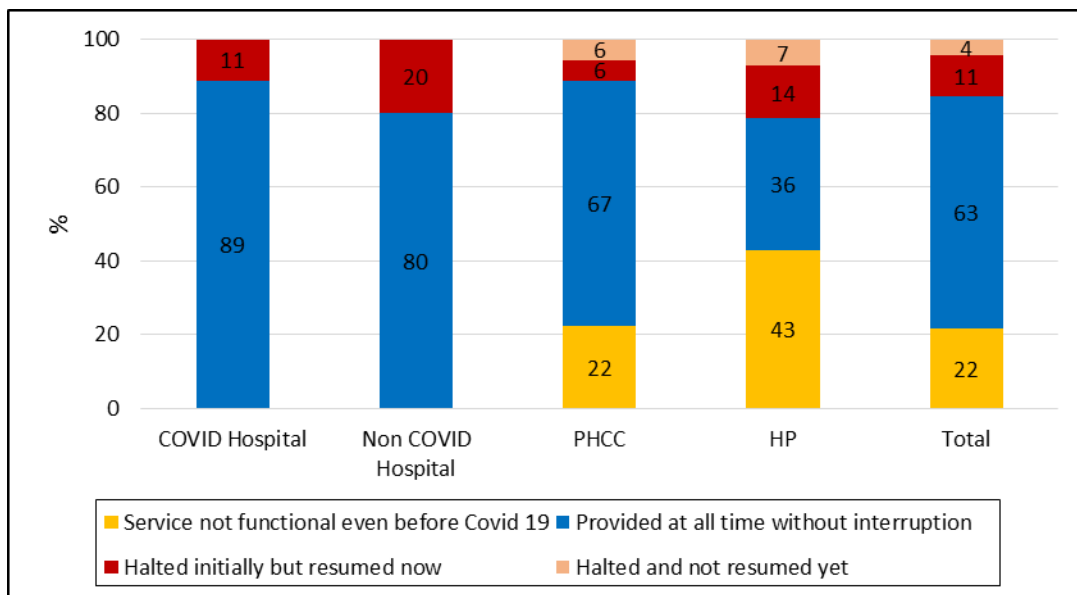
Annex 5.1a Functionality of Safe Abortion services by province- Round 2 (n=46)



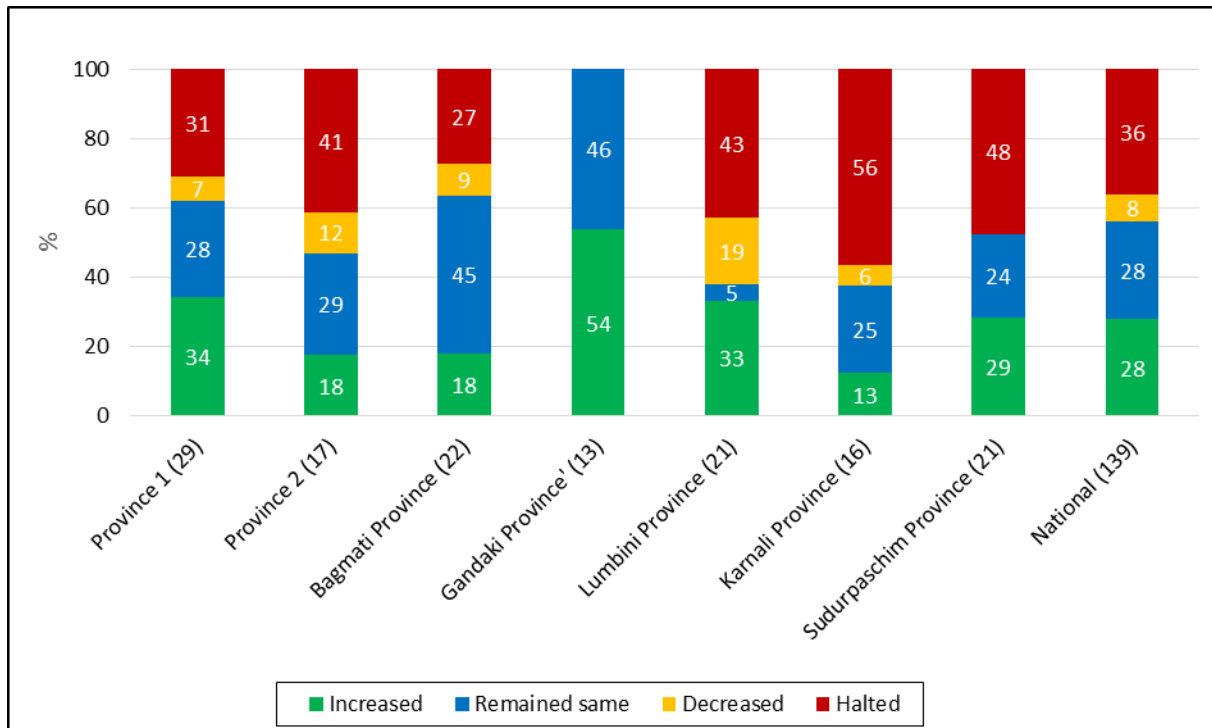
Annex 5.2 Functionality of Safe Abortion services by health facilities (n=139)



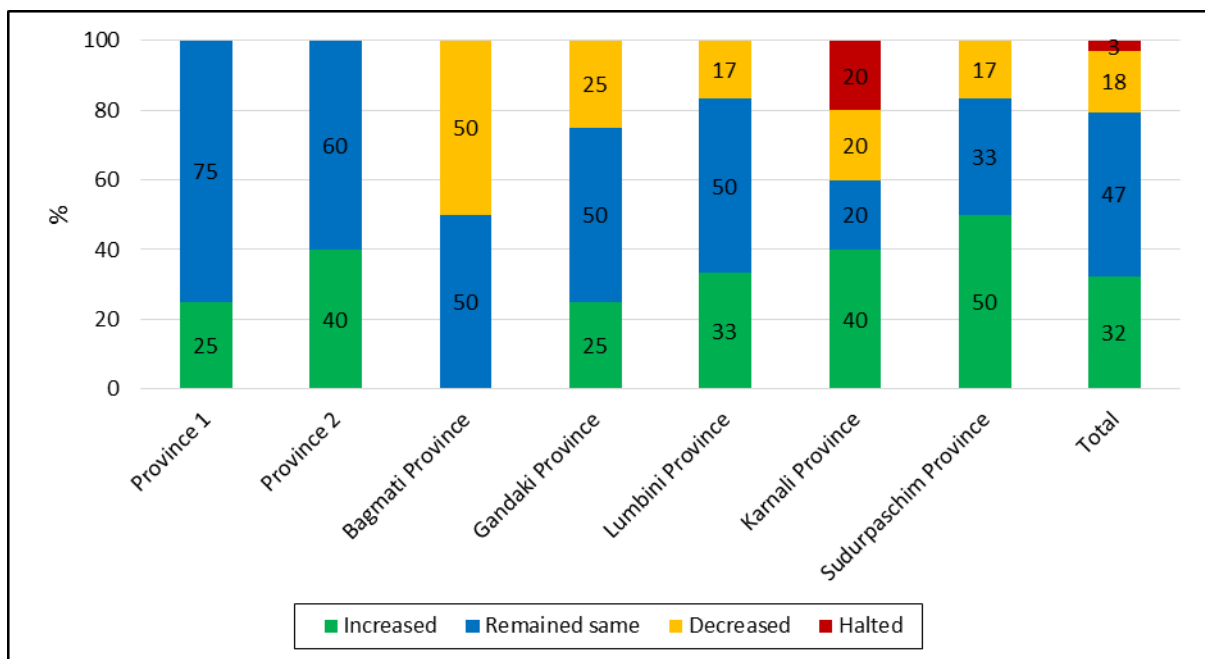
Annex 5.2a Functionality of Safe Abortion services by health facilities- Round 2 (n=46)



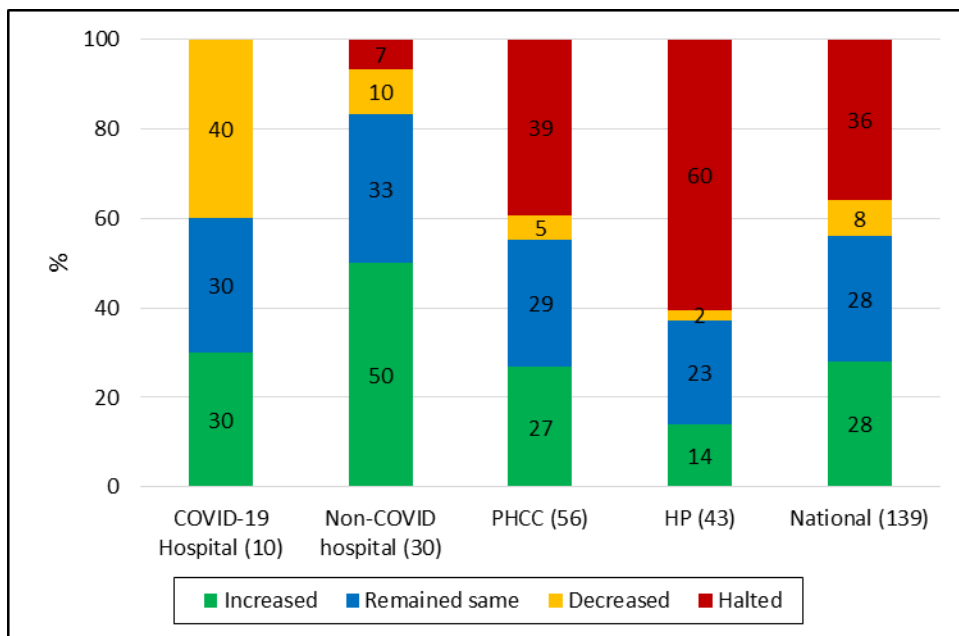
Annex 5.3 Providers' perception on flow of MA clients during lockdown period by province (n=139)



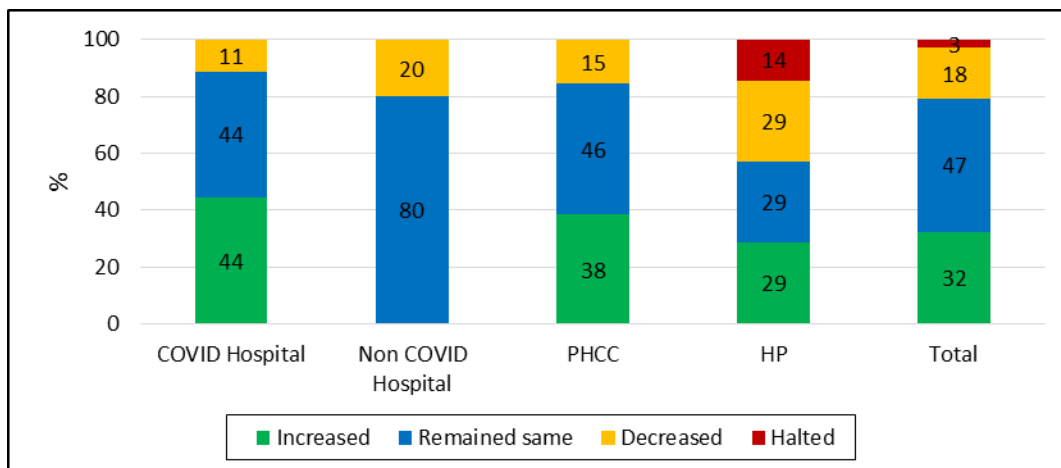
Annex 5.3a Providers' perception on flow of MA clients during lockdown period by province- Round 2 (n=34)



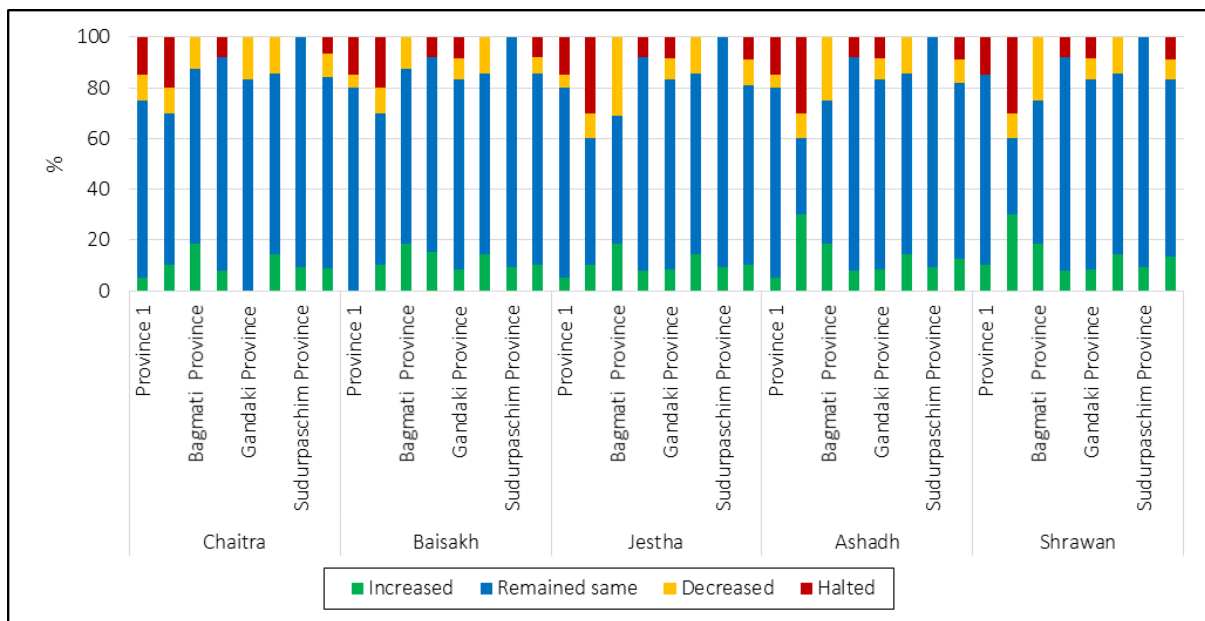
Annex 5.4 Providers' perception on flow of MA clients during lockdown period by facility (n=139)



Annex 5.4a Providers' perception on flow of MA clients during lockdown period by facility- Round 2 (n=34)



Annex 5.5 PAC clients during 5 months' lockdown period: Providers Perspectives by province



Annex 5.6 PAC clients during 5 months' lockdown period: Providers Perspectives by type of health facility

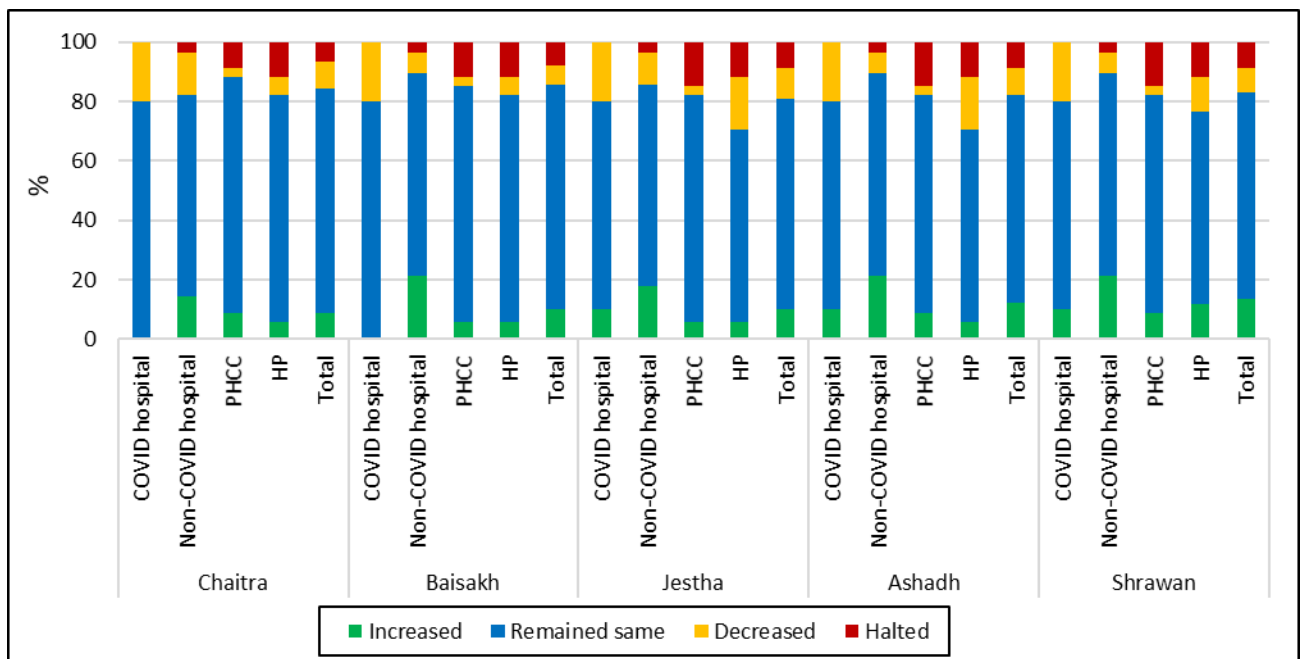
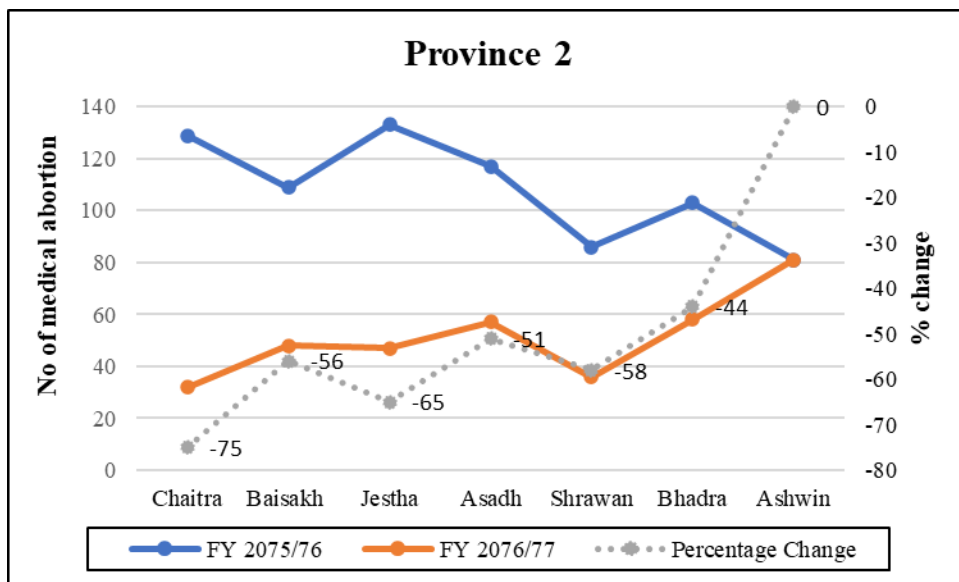
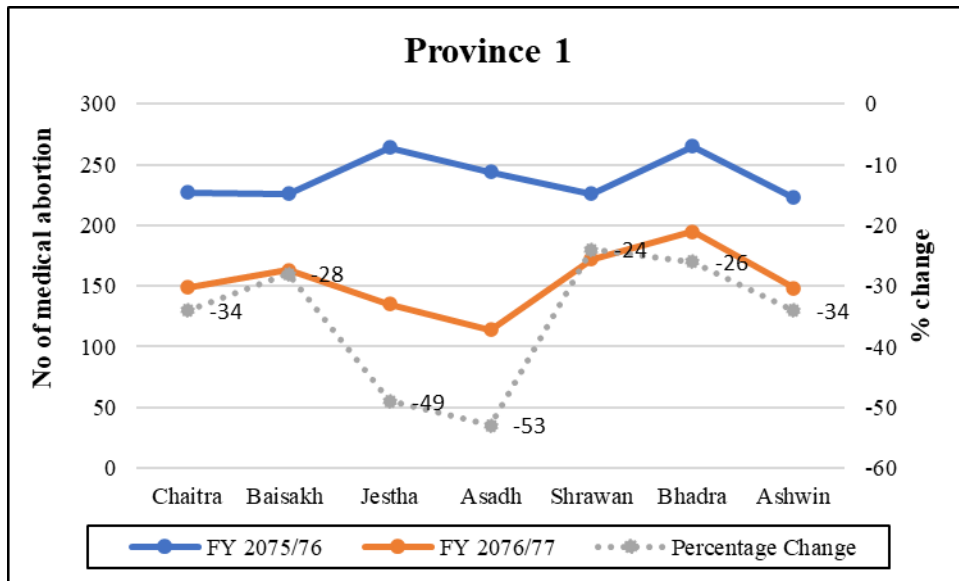
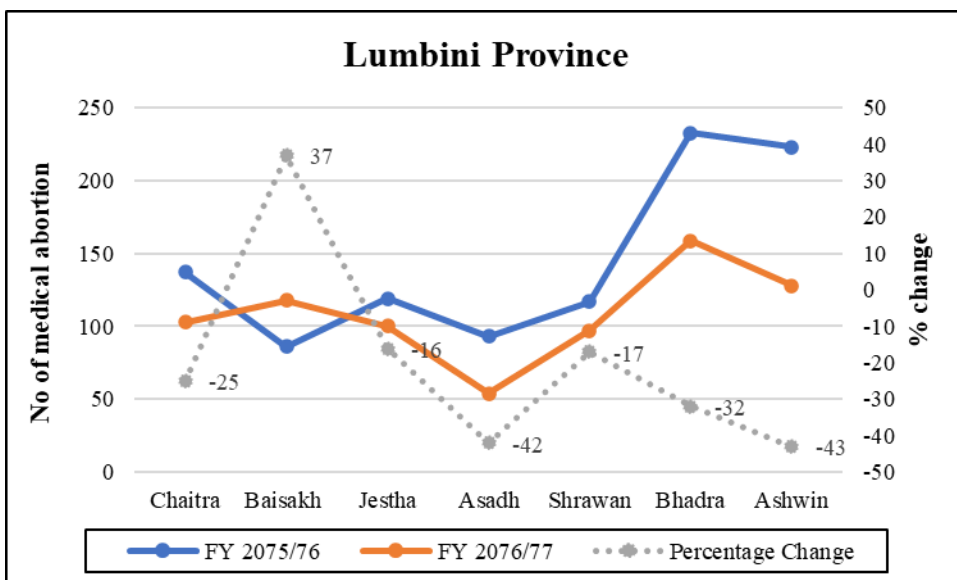
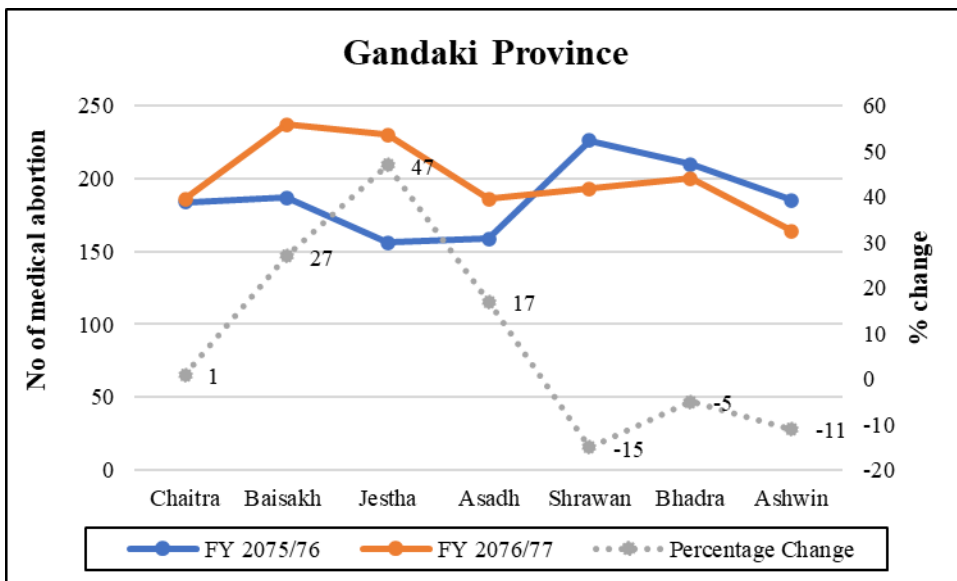
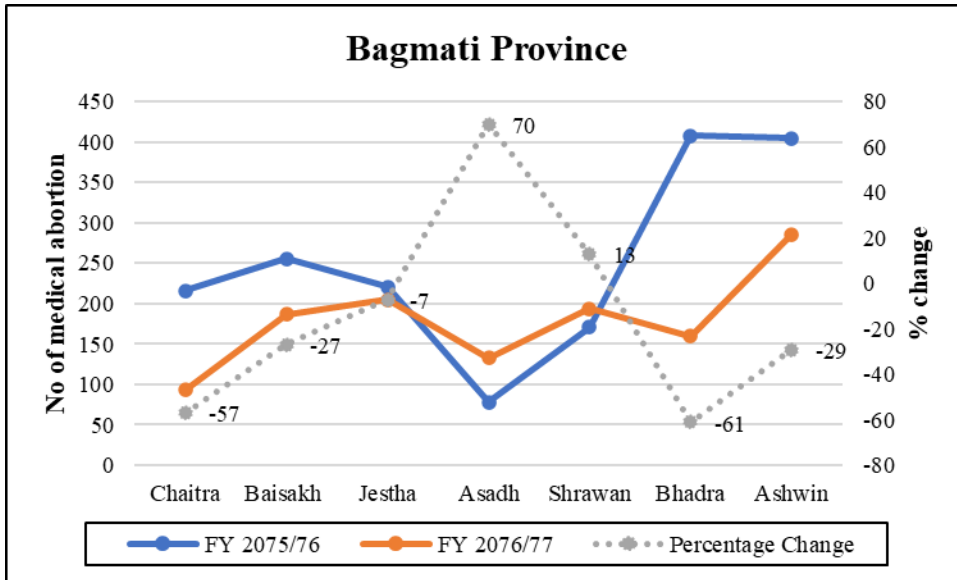


Figure 5.7 : Percentage change in utilization of Medical abortion services (MA) during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]





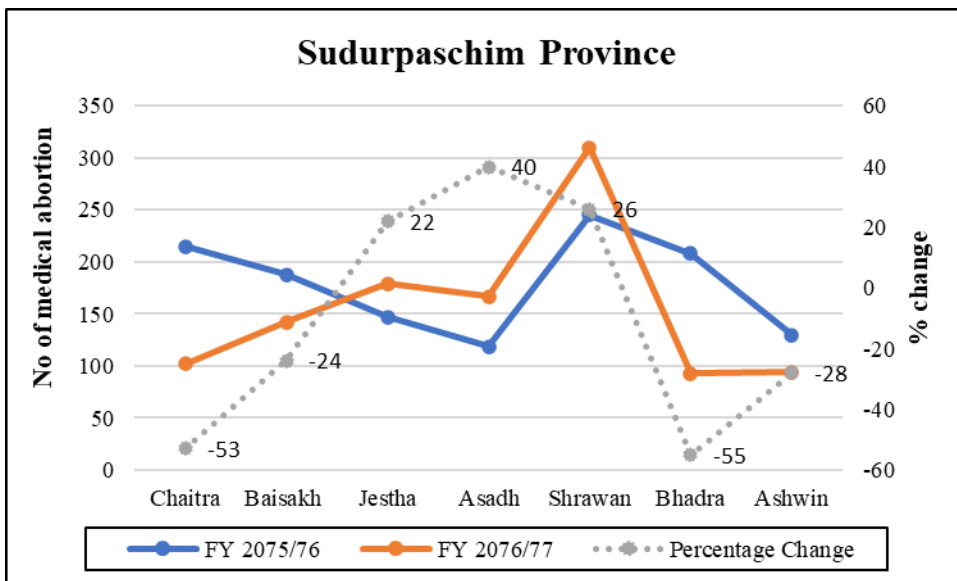
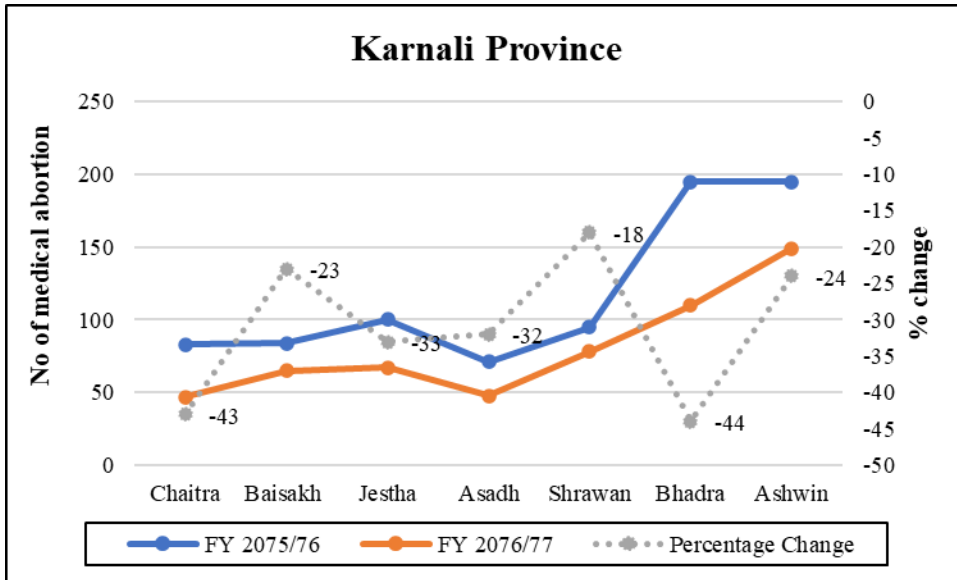
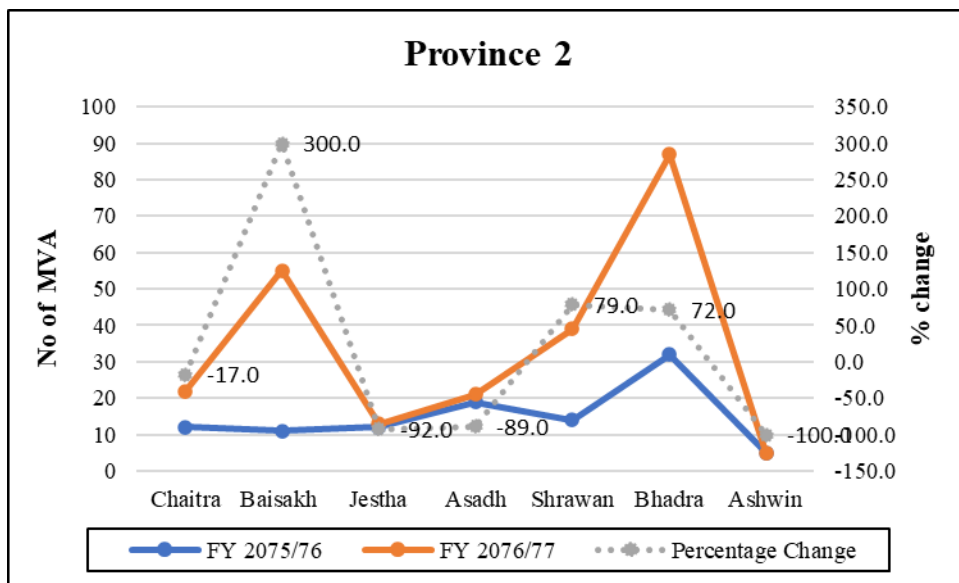
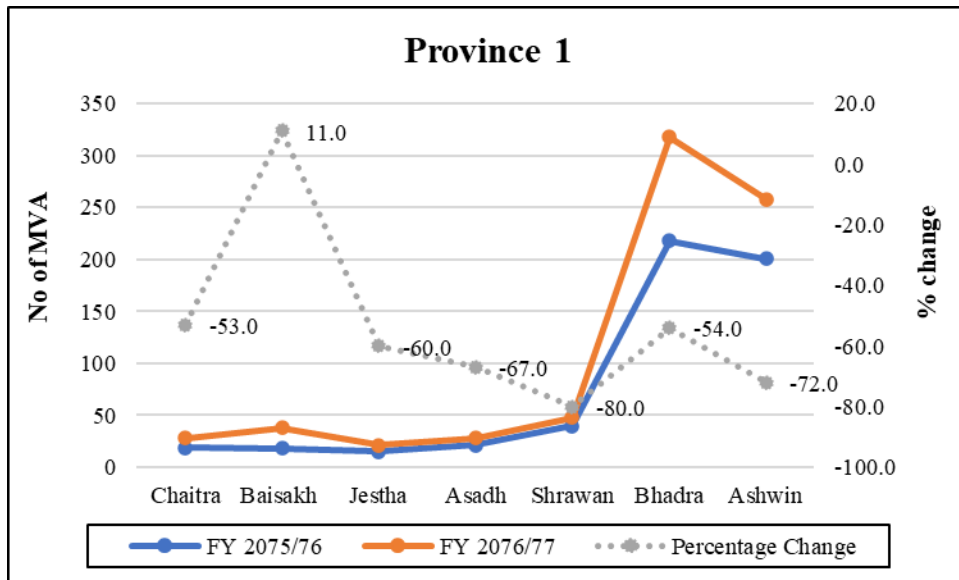
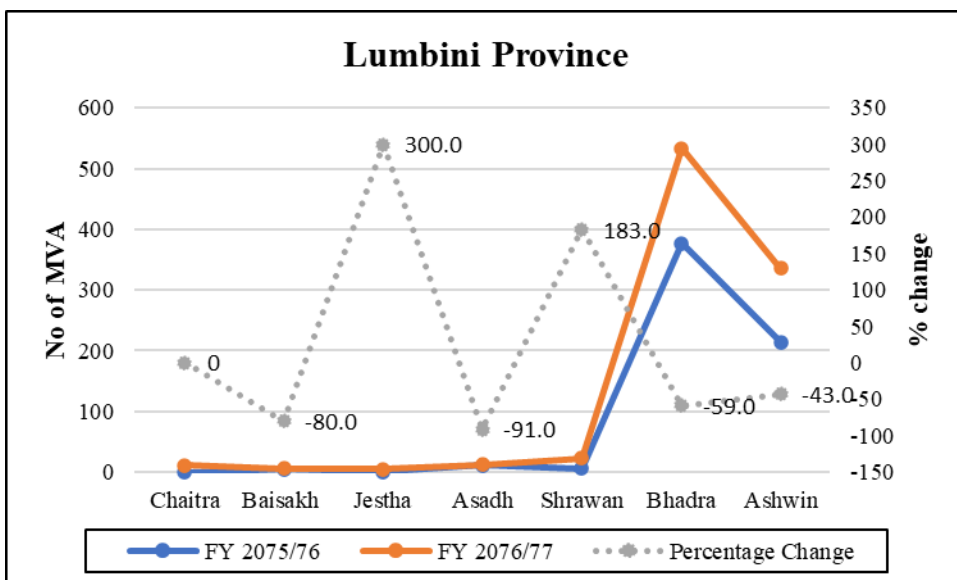
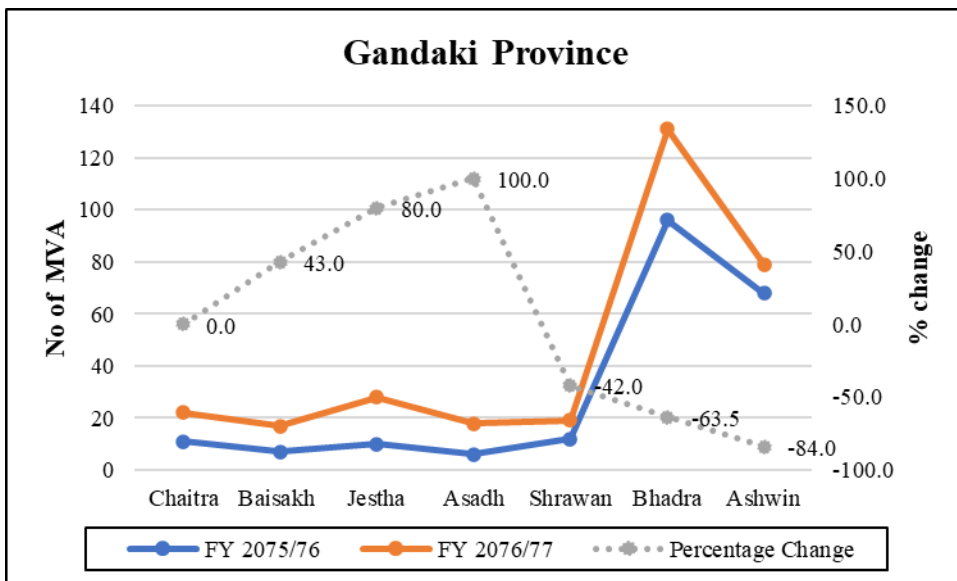
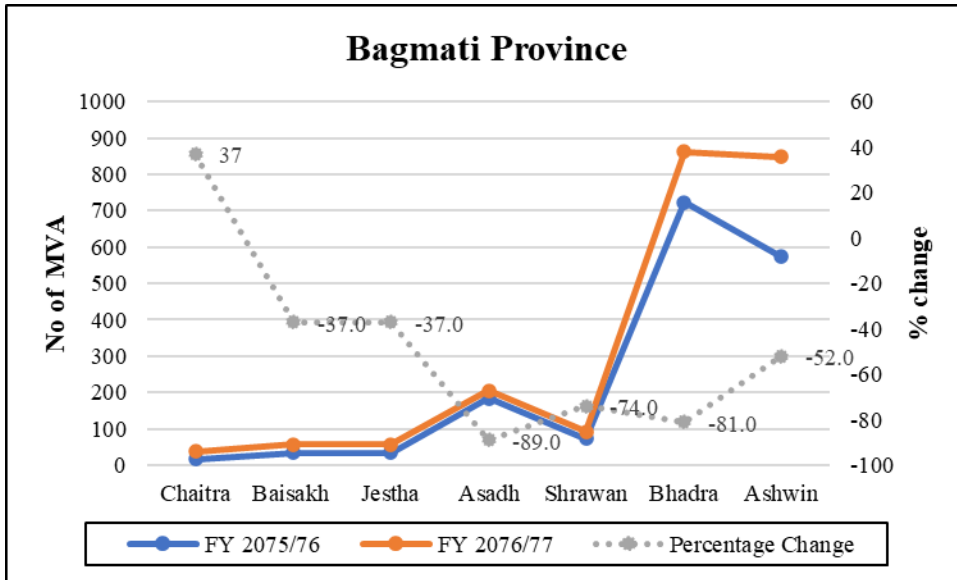
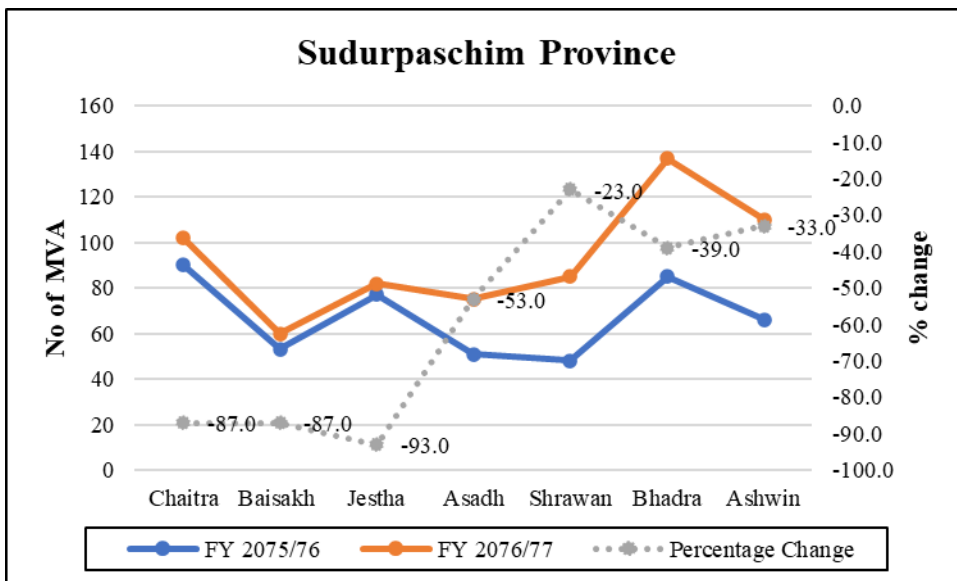
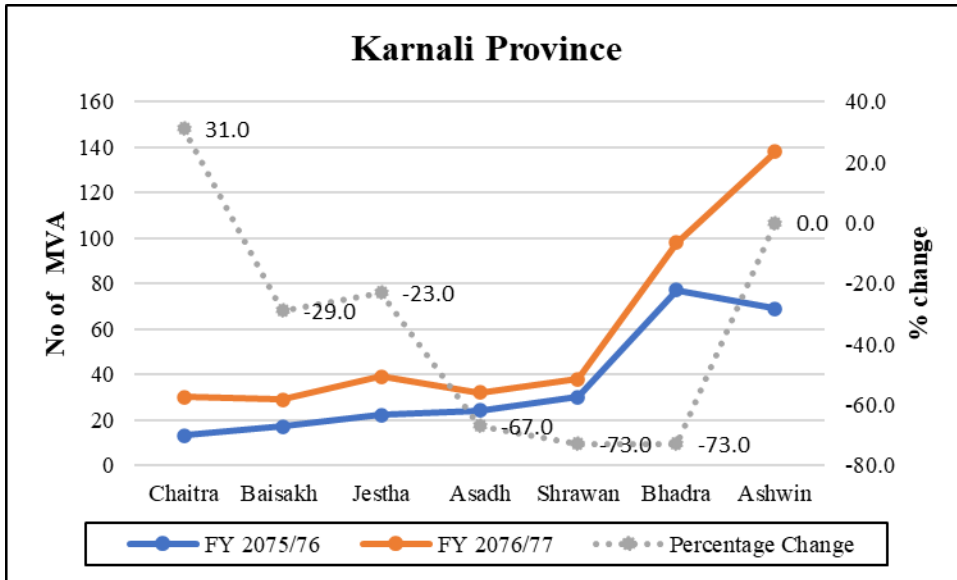


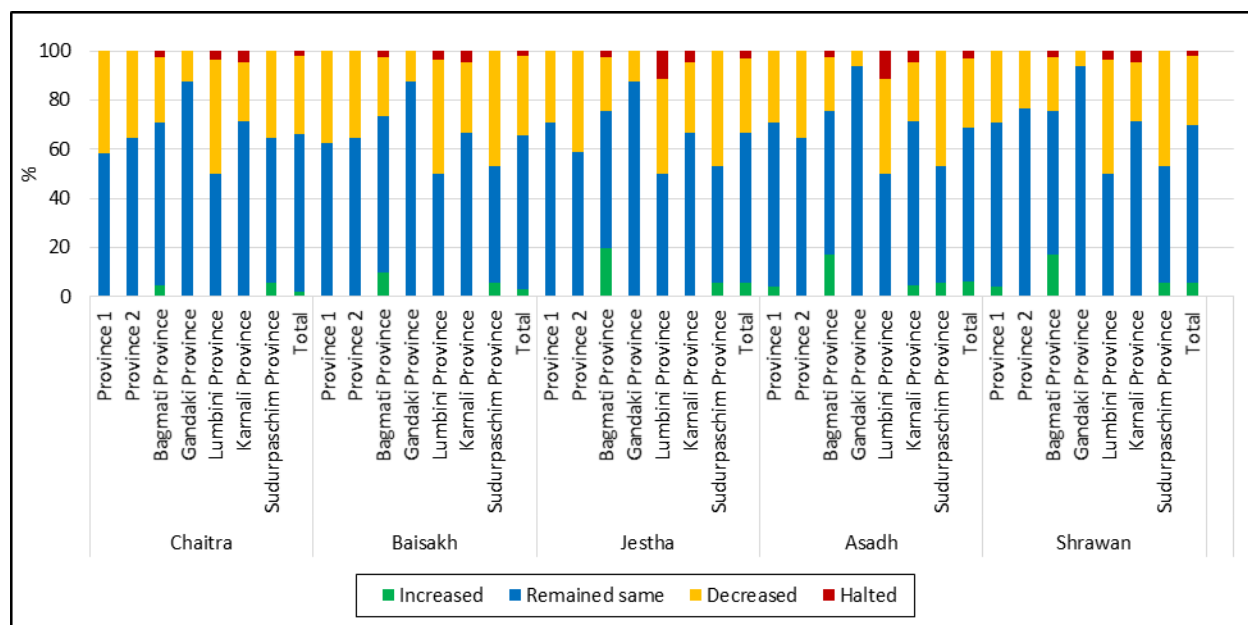
Figure 5.8 : Percentage change in utilization of MVA services during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]



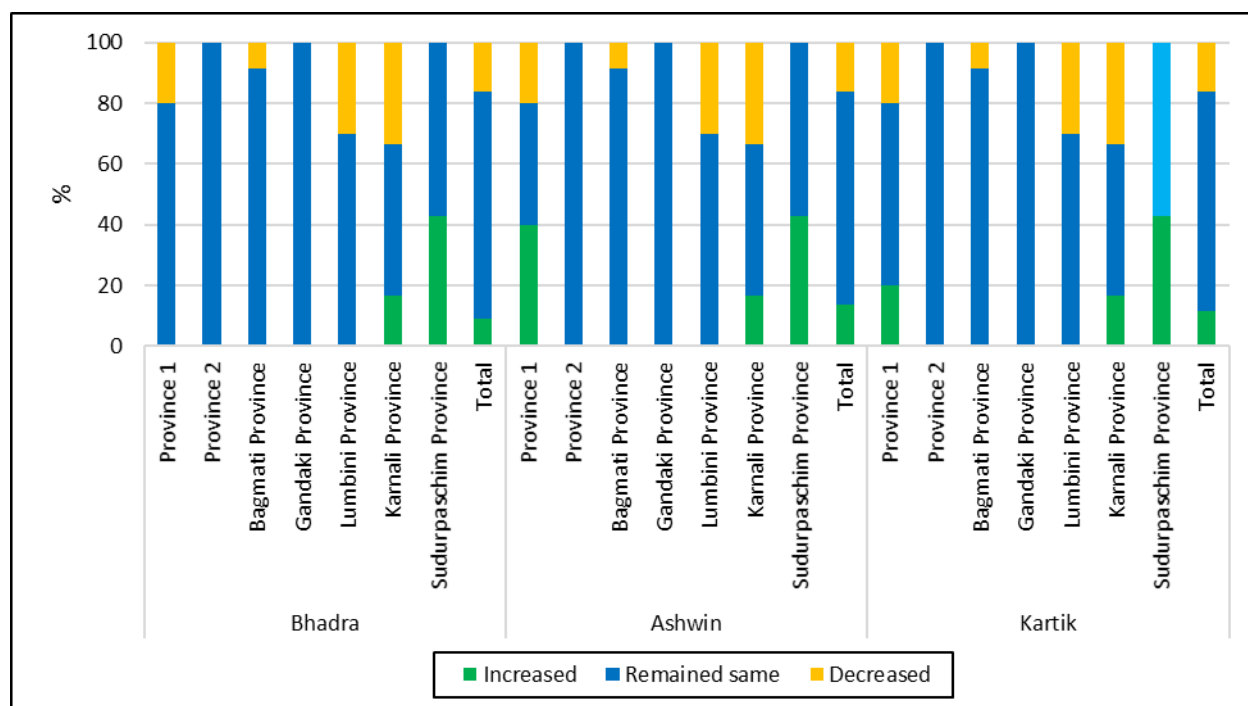




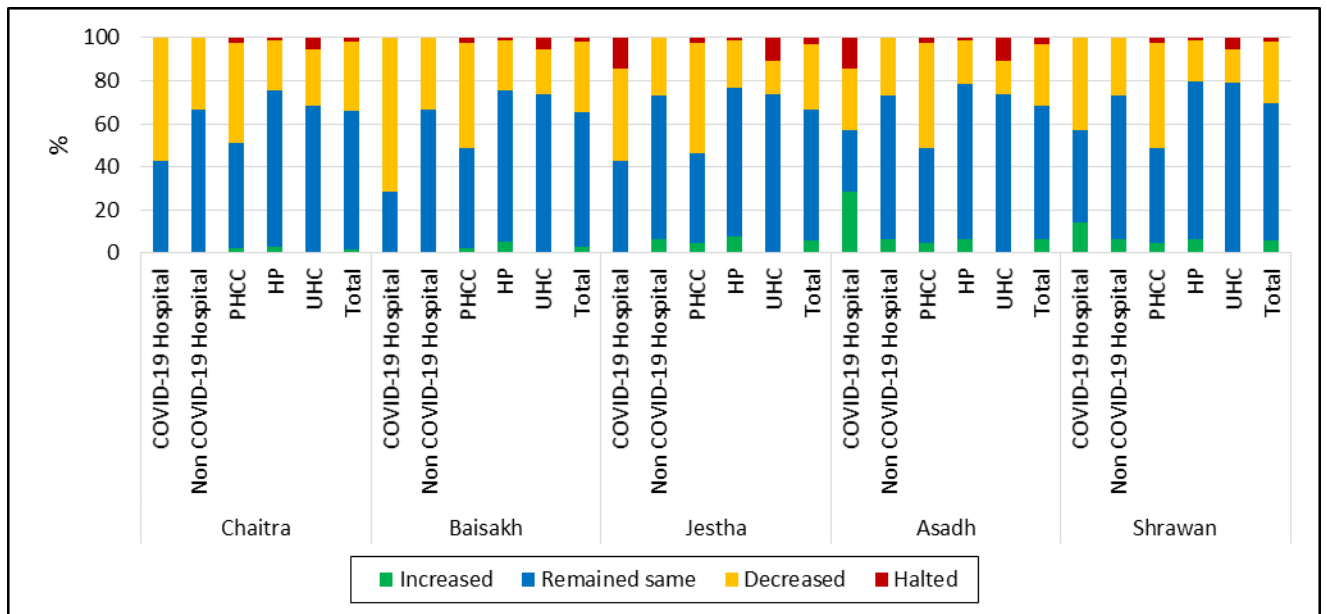
Annex 7.1: Province wise extent of care seeking for menstrual related matters by adolescent girls during 5 months lockdown period



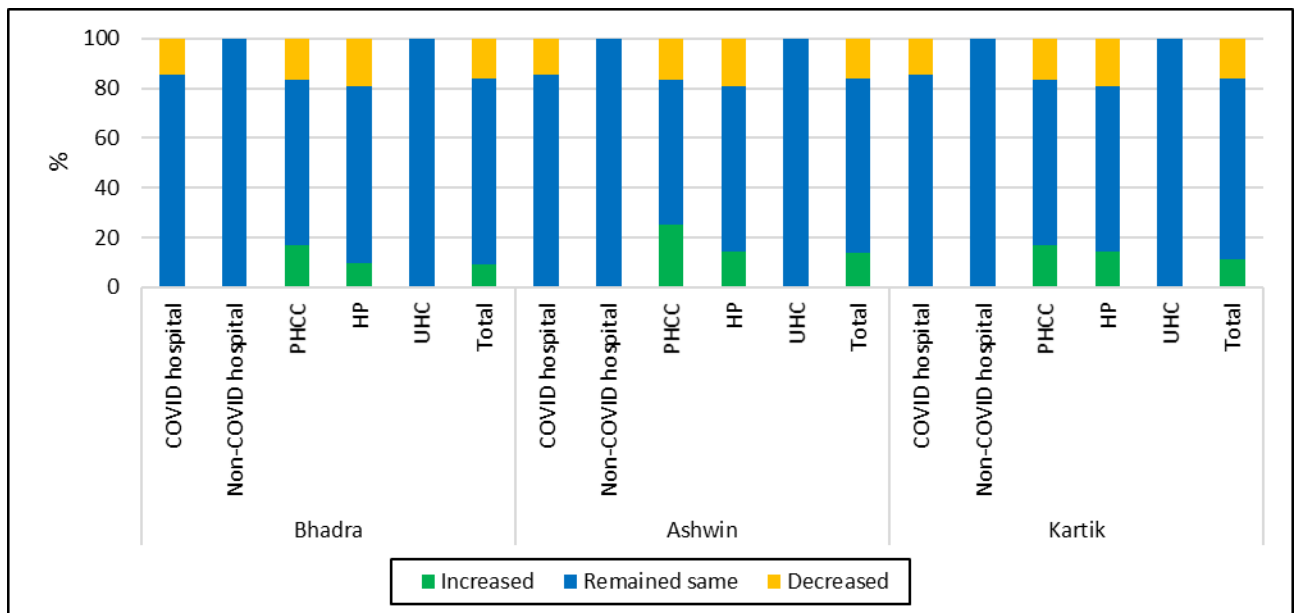
Annex 7.1a : Province wise extent of care seeking for menstrual related matters by adolescent girls during the period between Bhadra-Kartik



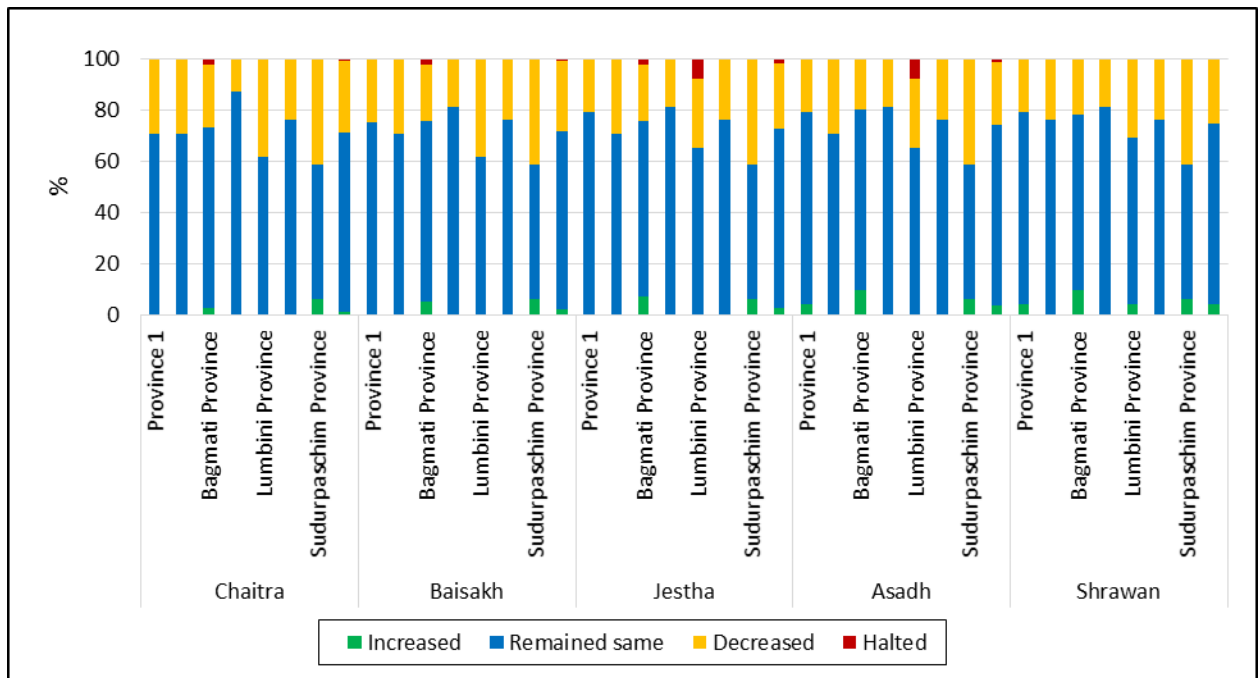
Annex 7.2: Health facility wise extent of care seeking for menstrual related matters by adolescent girls during 5 months lockdown period



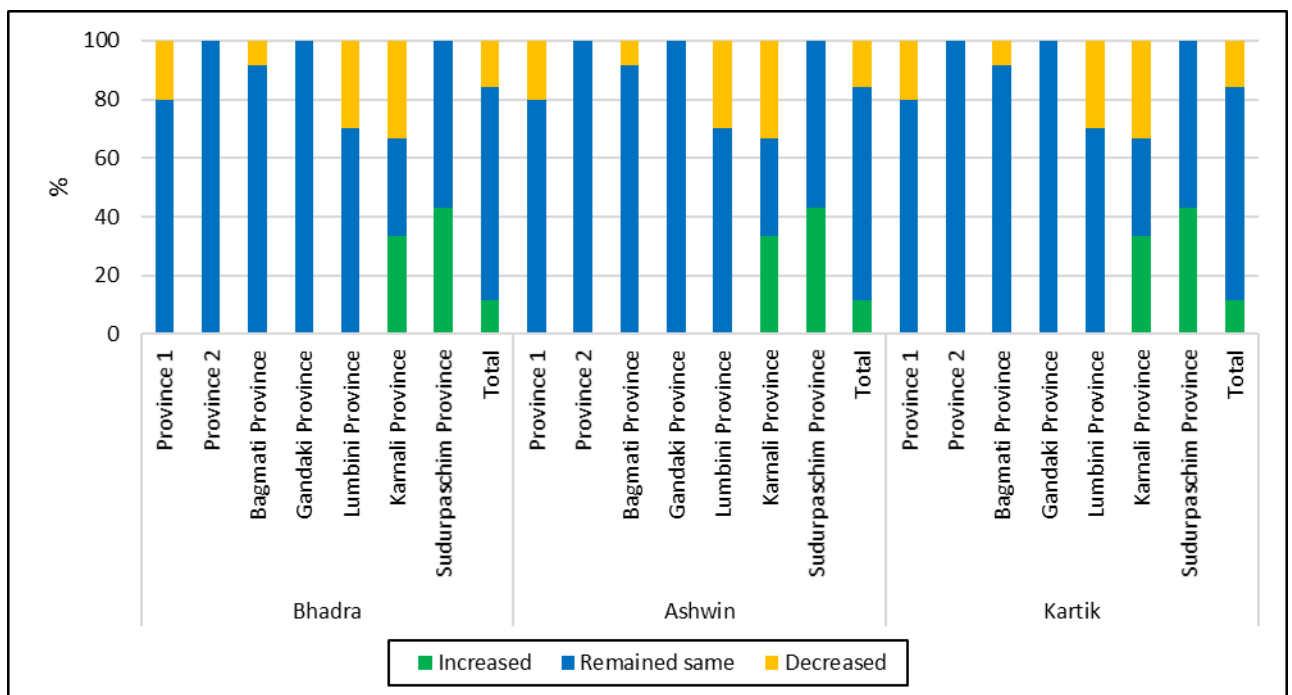
Annex 7.2a : Health facility wise extent of care seeking for menstrual related matters by adolescent girls during the period between Bhadra-Kartik



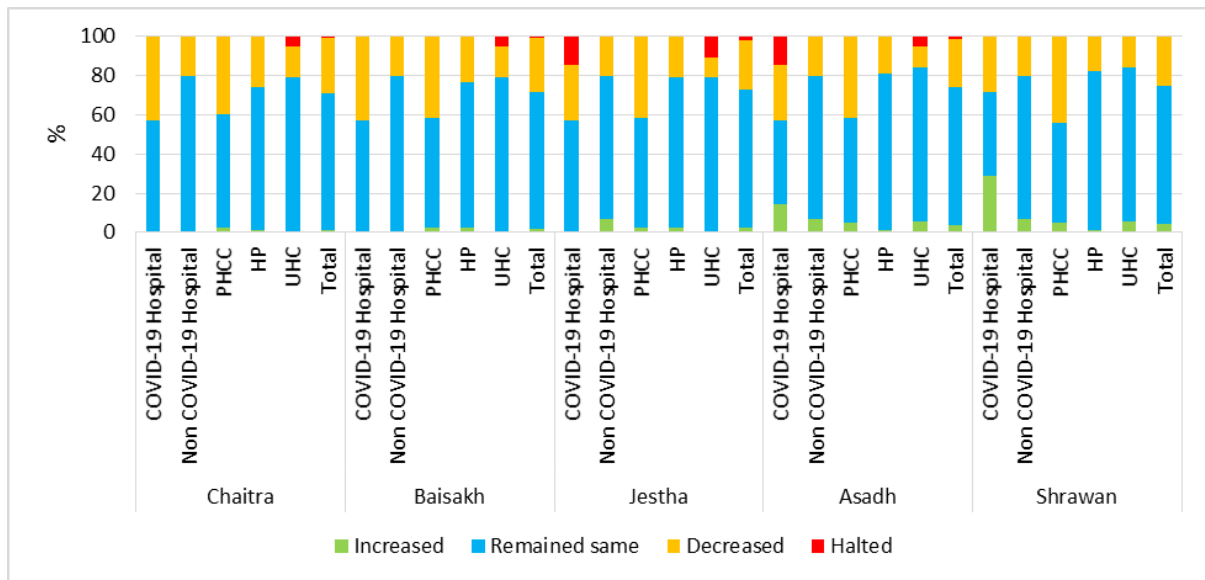
Annex 7.3: Province-wise extent of utilization of STI service by adolescents during 5 months lockdown period



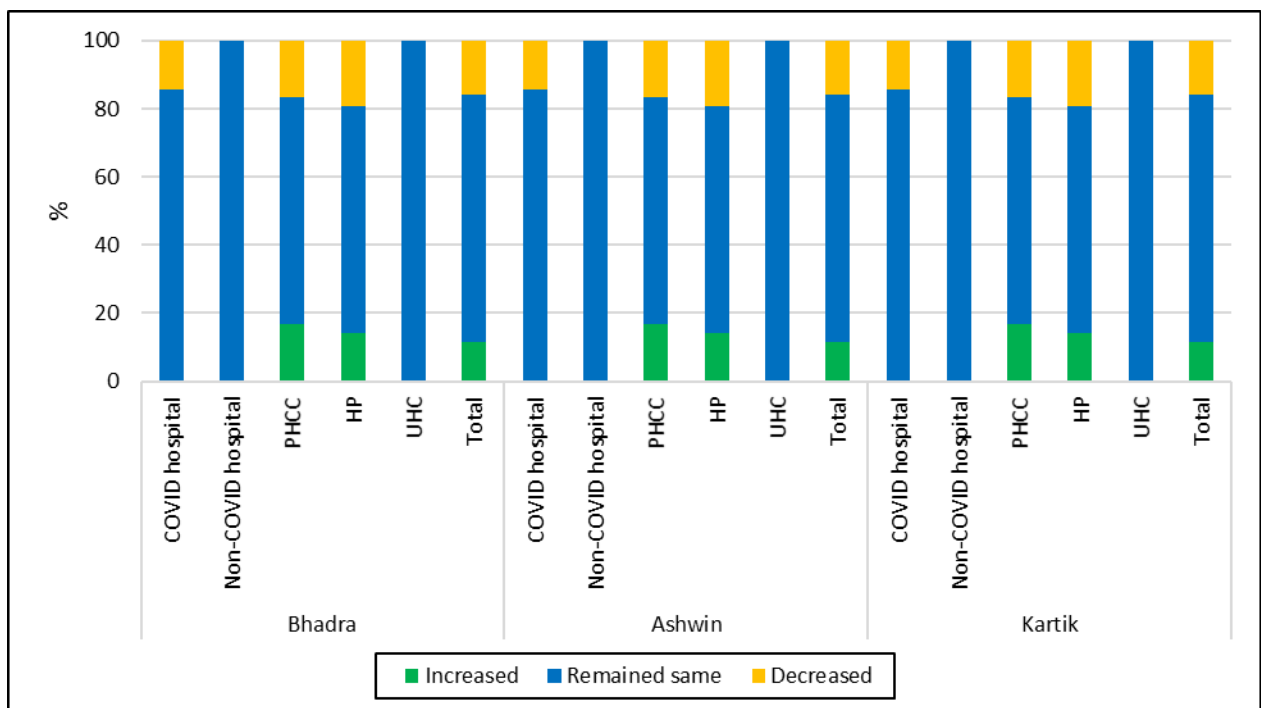
Annex 7.3a: Province-wise extent of utilization of STI service by adolescents during the period between Bhadra-Kartik



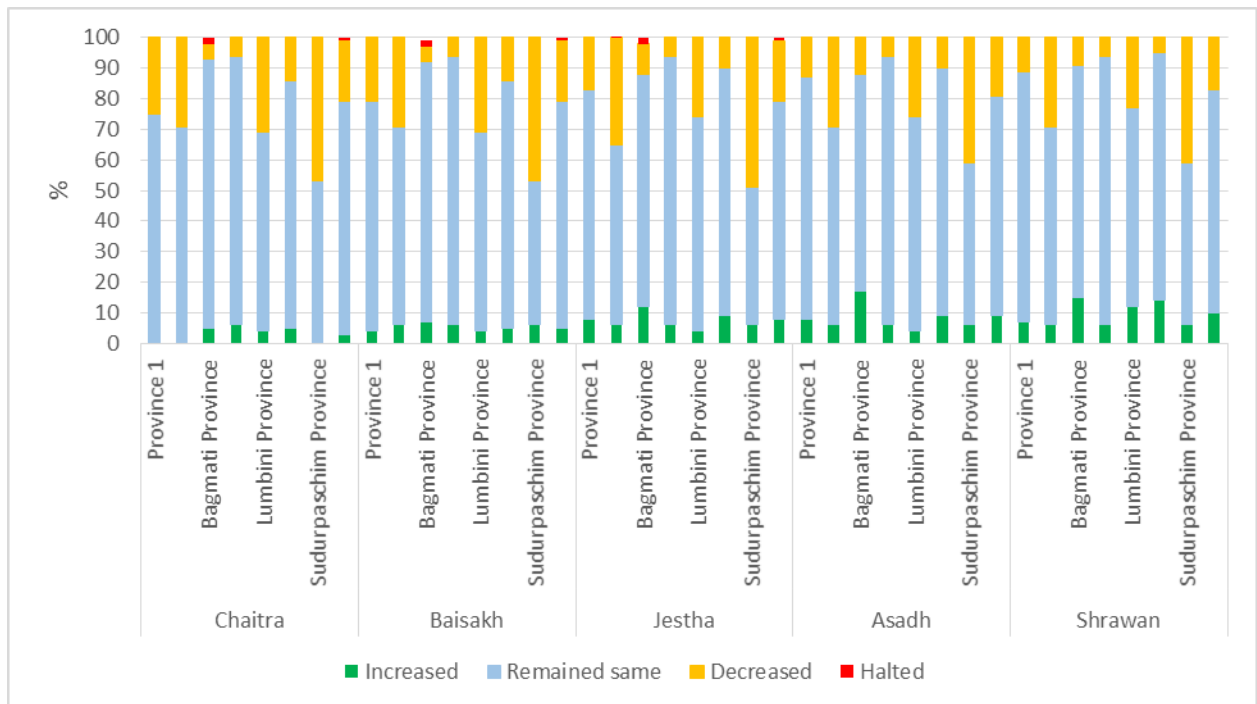
Annex 7.4: Health facility wise extent of utilization of STI service by adolescents during 5 months lockdown period



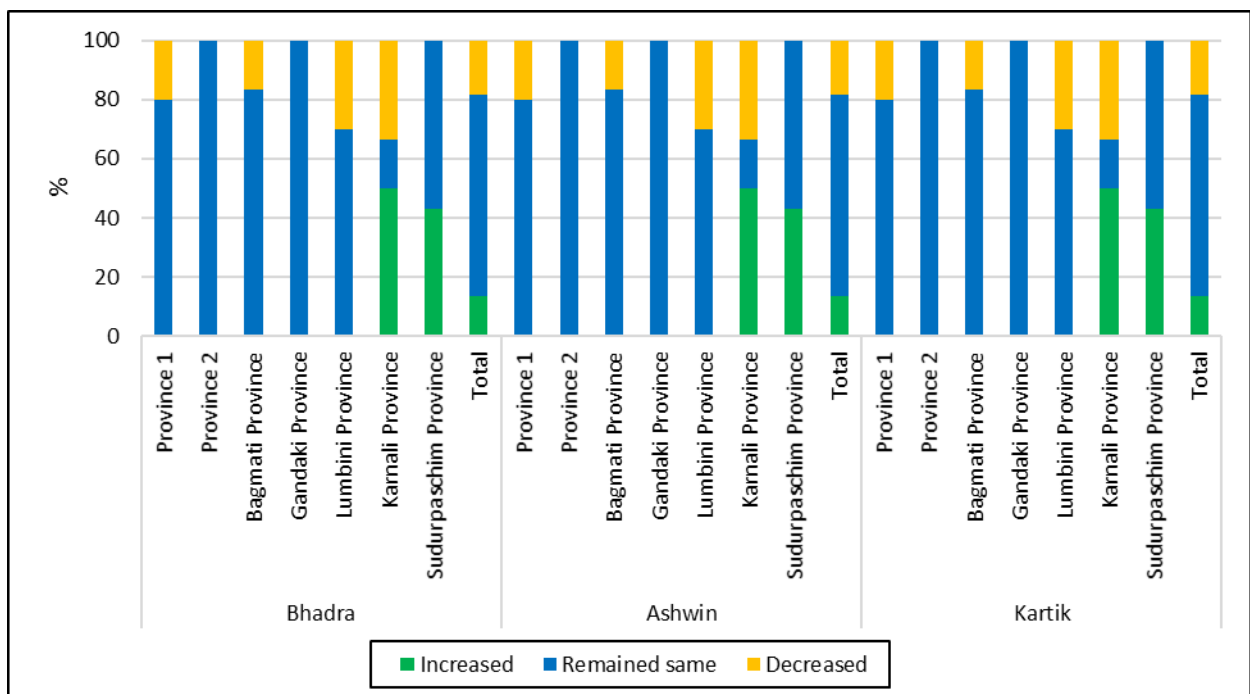
Annex 7.4a: Health facility wise extent of utilization of STI service by adolescents during the period between Bhadra-Kartik



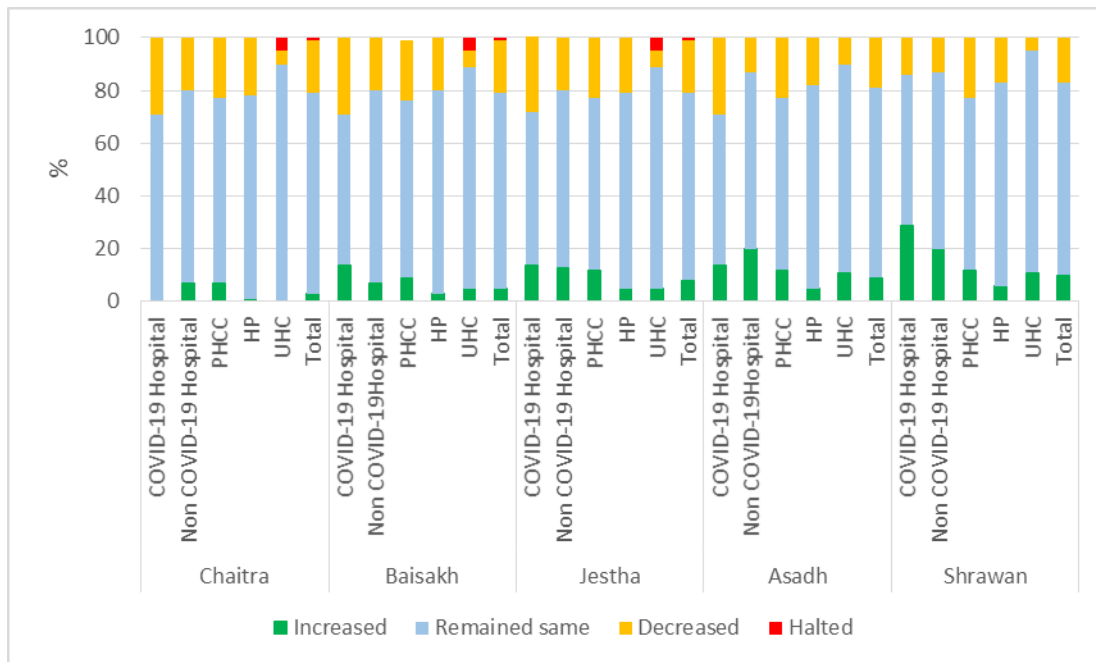
Annex 7.5: Province wise flow of adolescent clients seeking FP contraceptives during 5 months' lockdown period



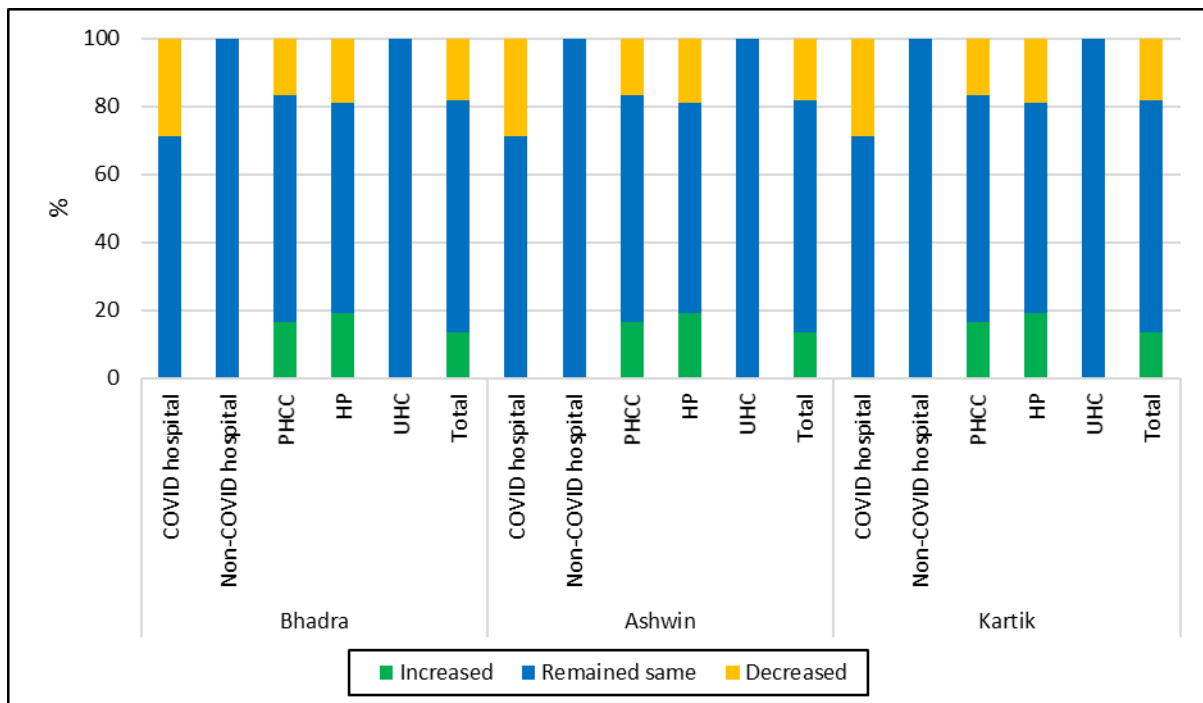
Annex 7.5a: Province wise flow of adolescent clients seeking FP contraceptives during the period between Bhadra-Kartik



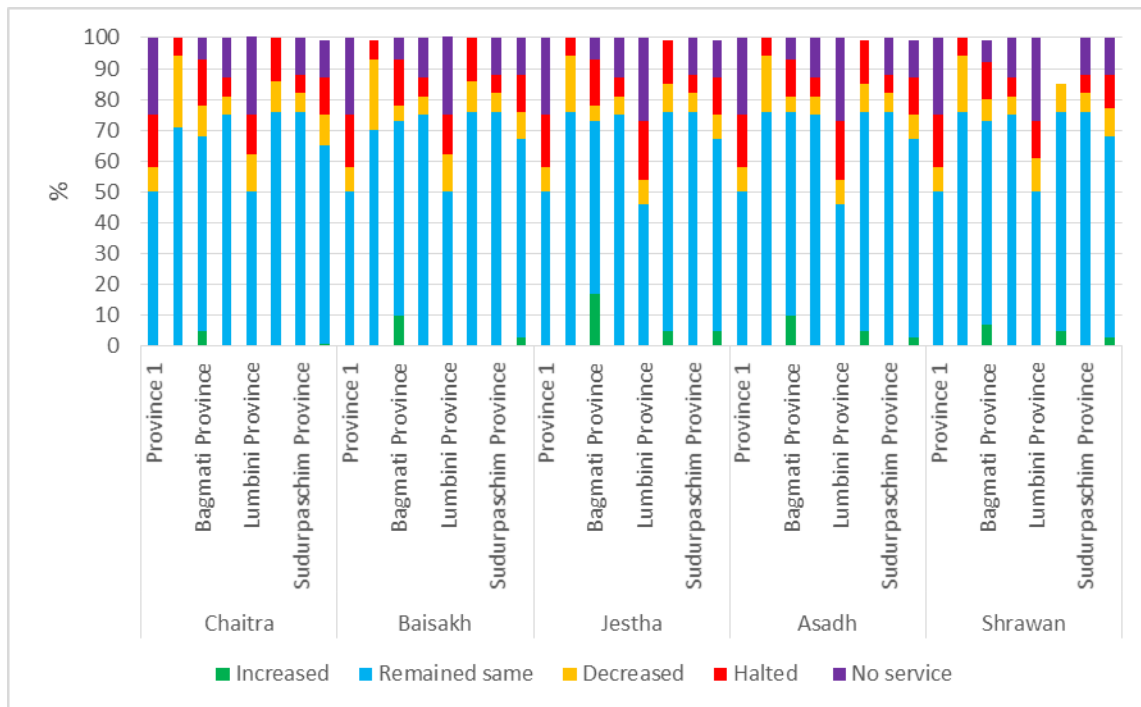
Annex 7.6: Health facility wise flow of adolescent clients seeking FP contraceptives during 5 months' lockdown period



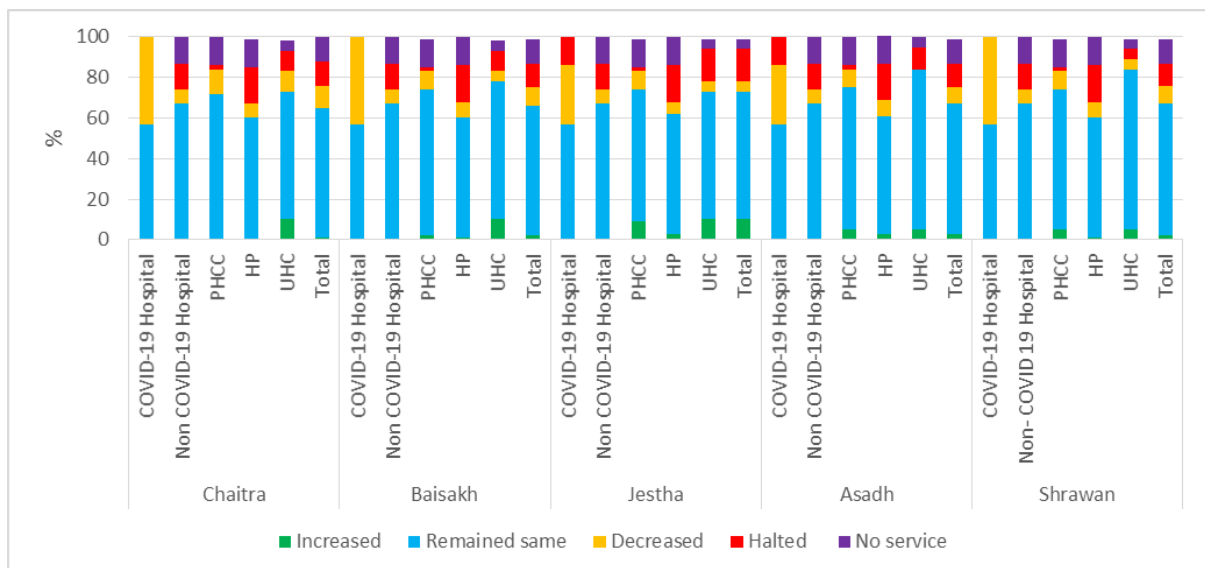
Annex 7.6a: Health facility wise flow of adolescent clients seeking FP contraceptives during the period between Bhadra-Kartik



Annex 7.7: Province wise flow of adolescent clients seeking Emergency Contraceptive during 5 months' lockdown period



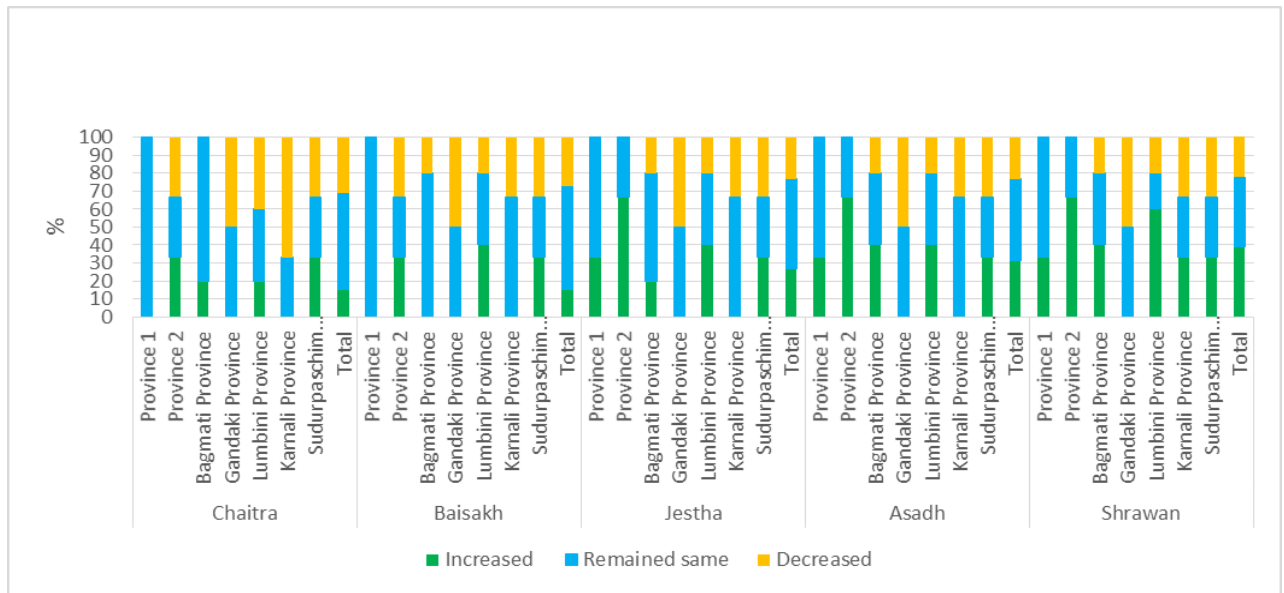
Annex 7.8: Health facility wise flow of adolescent clients seeking Emergency Contraceptives during 5 months' lockdown period



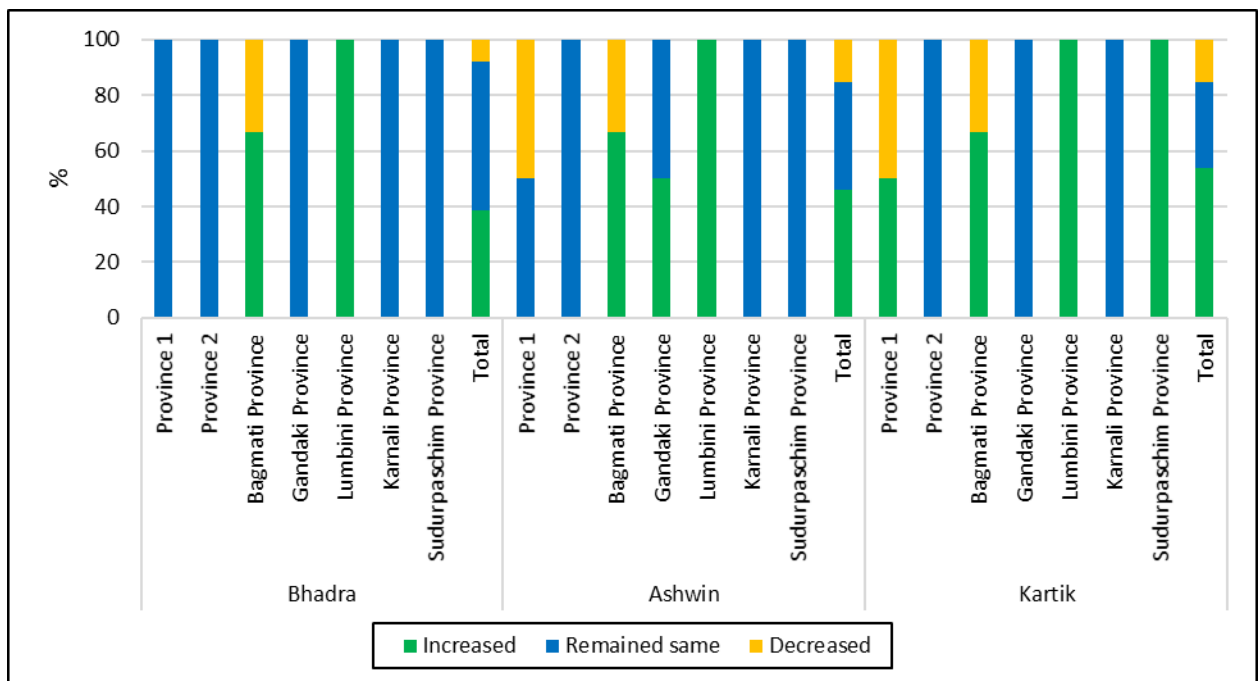
Annex 7.9: Types of SRH services sought by married adolescent girls from FCHVs during 5 months' lockdown period

Types of SRH services sought	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=29)	Round 2 (n=10)	Round 1 (n=38)	Round 2 (n=11)	Round 1 (n=40)	Round 2 (n=8)	Round 1 (n=11)	Round 2 (n=3)	Round 1 (n=28)	Round 2 (n=11)	Round 1 (n=19)	Round 2 (n=6)	Round 1 (n=21)	Round 2 (n=5)	Round 1 (n=186)	Round 2 (n=64)
Temporary FP	51.7	80	86.8	63.6	67.5	37.5	54.5	0	75	54.5	68.4	83.3	81	100	70.9	63
Routine ANC	48.3	20	63.2	90.9	22.5	37.5	27.3	0	53.6	54.5	15.8	16.7	19	40	38.7	44.4
AFHS	13.8	0	21.1	0	22.5	0	0	0	14.3	9.1	0	0	9.5	0	14.5	1.9
Childhood immunization	10.3	10	13.2	36.4	32.5	12.5	0	33.3	10.7	63.6	5.3	0	0	20	13.4	27.8
Pregnancy confirmation	31	40	21.1	36.4	37.5	37.5	36.4	33.3	35.7	72.7	73.7	83.3	52.4	40	38.2	50
Normal delivery/BEONC	10.3	0	21.1	36.4	0	0	0	0	7.1	0	0	0	4.8	0	7.5	7.4
PNC	0	-	7.9	-	15	-	0	-	10.7	-	0	-	0	-	6.5	-
Not visited yet	-	10	-	0	-	25	-	33.3	-	0	-	0	-	0	-	7.4
PAC	-	0	-	9.1	-	0	-	0	-	18.2	-	0	-	0	-	5.6
LARC	0	-	7.9	-	5	-	18.2	-	10.7	-	0	-	0	-	5.4	-
FCHV gives counselling by reaching their homes	-	10	-	0	-	0	-	0	-	9.1	-	0	-	0	-	3.7
EC	3.4	-	13.2	-	5	-	18.2	-	0	-	5.3	-	0	-	5.9	-
SAS	6.9	0	7.9	45.5	5	0	0	0	7.1	0	0	0	0	0	4.8	9.3

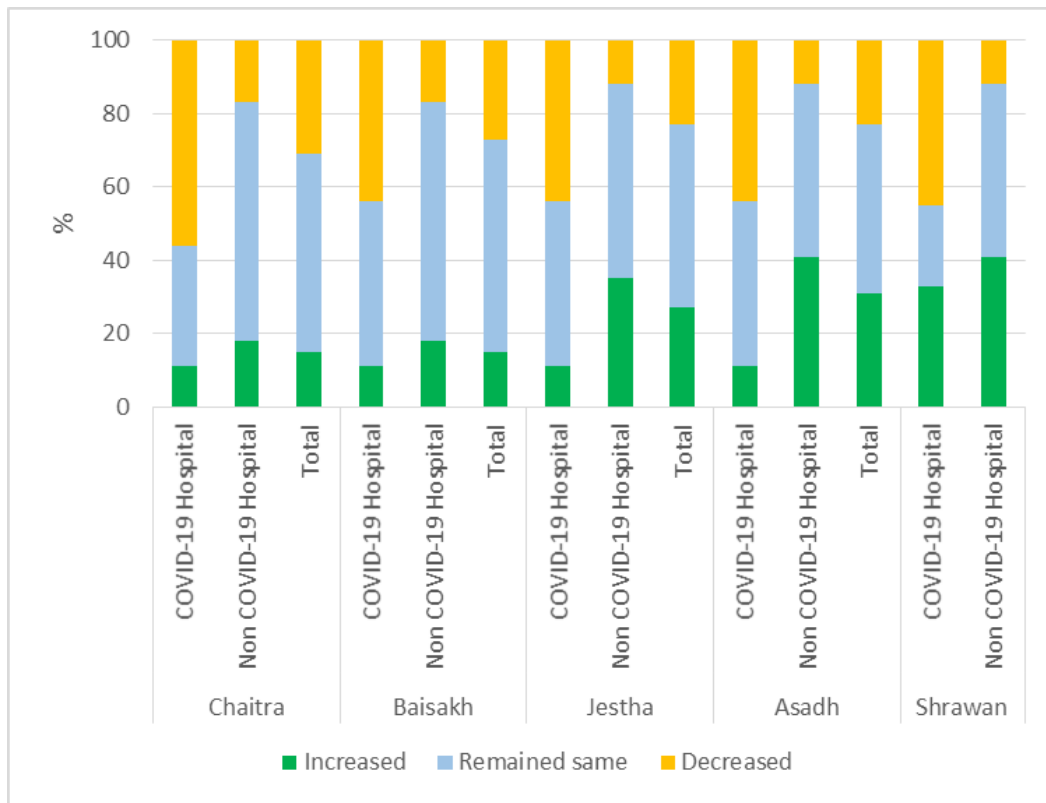
Annex 9.1: Province wise flow of GBV cases during 5 months' lockdown period



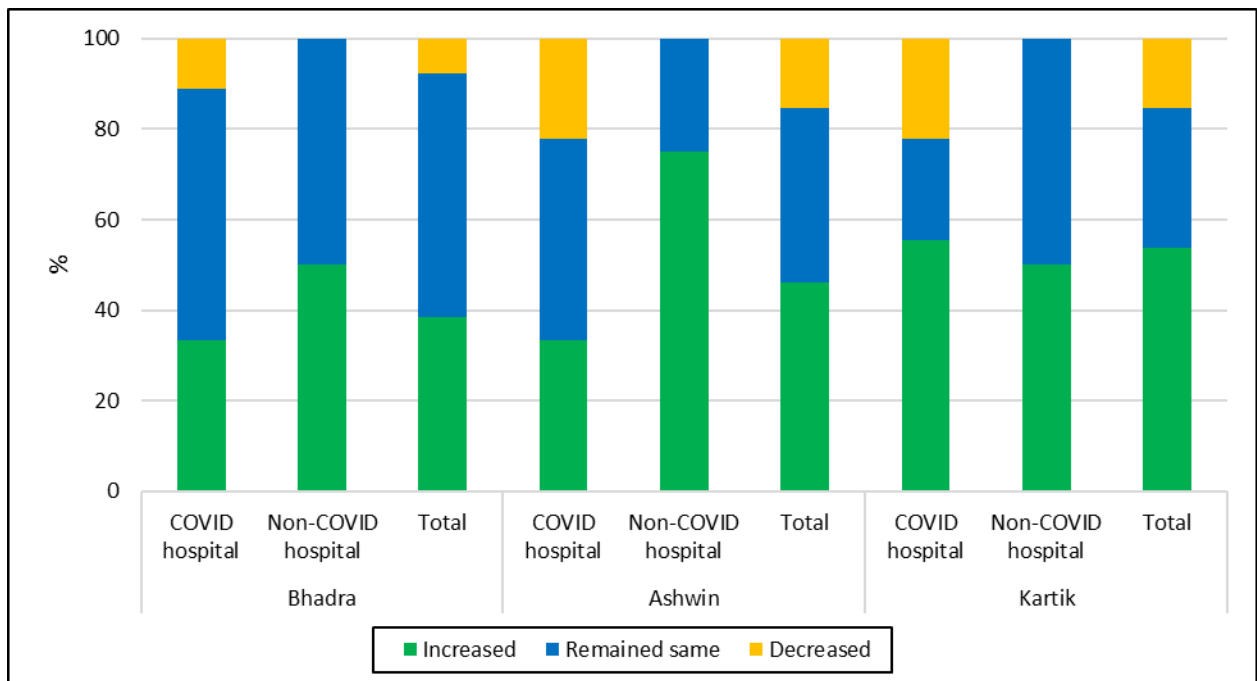
Annex 9.1a: Province wise flow of GBV cases during the period between Bhadra-Kartik



Annex 9.2: Health facility wise flow of GBV cases during 5 months' lockdown period



Annex 9.2a: Health facility wise flow of GBV cases during the period between Bhadra-Kartik



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