# Gender Based Violence Prevention and Response Project (GBVPR)
# Phase II

# PROGRAMME DOCUMENT

## 5 August 2020 – 4 August 2024

*Submitted to the Swiss Agency for Development and Cooperation Nepal, and the Norwegian Embassy in Kathmandu*

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*by*

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**ABBREVIATIONS**

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| CBO | Community Based Organisations |
| CEDAW | Convention on the Elimination of all Forms of Discrimination Against Women |
| COSO | Committee of Sponsoring Organizations of the Treadway Commissions |
| CPSW | Community Based Psychosocial Workers |
| DCC | District Coordination Committees |
| ERM | Enterprise Risk Management |
| DFID | UK Department for International Development |
| FCA | Foreign Currency Account |
| FCGO | Financial Controller General's Office |
| FCHV | Female Community Health Worker |
| FWLD | Forum for Women, Law and Development |
| GBV | Gender-Based Violence |
| GBVPR | Gender-Based Violence Prevention and Response (Project) |
| GESI | Gender Equality and Social Inclusion |
| GEWE | Gender Equality and Women's Empowerment |
| GoN | Government of Nepal |
| GRB | Gender Responsive Budgeting |
| GTA | Gender Transformative Approach |
| HH | Households |
| ICF | Internal Control Framework |
| I/NGO | International/Non-Governmental Organization |
| IP | Implementing Partner |
| IRC | International Rescue Committee |
| LG | Local Government |
| LISA | Local Government Institutional Self-Assessment |
| MEL | Monitoring Evaluation and Learning |
| MoF | Ministry of Finance |
| MOHAP | Ministry of Home Affairs and the Police |
| MoHP | Ministry of Health and Population |
| MoWCSW | Ministry of Women, Children and Social Welfare |
| MoWCSC | Ministry of Women, Children and Senior Citizen |
| NDHS | National Demographic and Health Survey |
| NOR | Norwegian Embassy in Kathmandu |
| NWC | National Women's Commission |
| OCMC | One Stop Crisis Management Centre |
| PMC | Project Management Committee |
| PPSC | Provincial Project Steering Committee |
| PSC | Project Steering Committee |
| SDC | Swiss Agency for Development and Cooperation |
| SDG | Sustainable Development Goals |
| SOP | Standard Operating Procedures |
| UNDAF | United Nations Development Assistance Framework |
| UNFPA | United Nations Population Fund |

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| UNV | United Nations Volunteer |
| VSO | Voluntary Service Overseas |
| WCO | Women and Children Office |
| WOREC | Women's Rehabilitation Centre |

## 1. Programme Summary

| Project Title | Gender Based Violence Prevention and Response (GBVPR): Phase II |
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| **Donors** | Swiss Agency for Development and Corporation (SDC) and Royal Norwegian Embassy in Nepal (NOR) |
| **Goal** | To reduce all forms of gender-based violence (GBV) and discrimination against women and girls in provinces 1 and 7 in Nepal. |
| **Timeline** | **Start Date:** 5 August 2020<br>**End Date:** 4 August 2024 |
| **Outcomes** | **Outcome 1:** Women and men, including girls and boys increasingly prevent, report and address gender-based violence<br>**Outcome 2:** Local governments, legal authorities and health facilities provide effective (multi-sectoral) survivor-centred responses to Gender Based Violence.<br>**Outcome 3:** Local, provincial and federal governments adopt and implement policies and budgets for the promotion of gender equality and the empowerment of all women and girls |
| **Targeted Groups** | **Beneficiaries:** GBV survivors (women and girls), adolescent boys and girls, families, including newlywed couples, and local communities<br>**Service Providers:** Police, Health Workers, Female Community Health Volunteers (FCHV), Teachers, Judicial Committee (Members), Mediation Committee (members), Hospital and OCMC staff, and Community Psycho Social Workers (CPSWs)<br>**TOTAL REACH**: 292,802 (Beneficiaries + Service Providers) |
| **Partners** | **Federal level:** Ministry of Women, Children and Senior Citizens (MOWCSC), Ministry of Health and Population (MoHP), Ministry of Home Affairs and the Police (MOHAP), and National Women's Commission (NWC)<br>**Provincial level**: Provincial Social Development Committee, Ministry of Social Development and Hospital/One Stop Crisis Management Centres<br>**Local level**: Local Governments, Judicial Committees, Mediation Committees, Safe Houses/ Service Centres and Courts<br>**Development Partners:** World Bank, UK Department for International Development, UN Women, USAID<br>**NGOs and women's rights organisations:** to be determined through a competitive procurement process |
| **Geographical Locations** | Province 1 (3 Districts; 8 Municipalities; 1 Metropolitan City)<br>**Morang District*:*** Biratnagar Metropolitan city<br>**Okhaldhunga District*:*** Sidhicharan, Manebhanjyang, Molung and Chisankhugadhi municipalities (4)<br>**Udaypur District:** Katari, Triyuga, Chaudandhigadhi and Belaka municipalities (4) |

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| | Province 7 (5 Districts; 9 Municipalities; 1 Metropolitan City)<br>**Kailali District:** Dhangadhi Sub-Metropolitan City<br>**Achham District:** Mangalsen, Kamalbazar and Sanfebagar municipalities (3)<br>**Baitadi District*:*** Patan and Dasrathchand municipalities (2)<br>**Bajhang District*:*** Jaya Prithvi and Bitthadhchir municipalities (2)<br>**Bajura District:** Budhimalika and Budhiganga municipalities (2)<br><br>**Total:** 8 Districts, 17 Municipalities and 2 Metropolitan Cities |
| **Results from Phase I** | • With the advocacy efforts by the project, a total budget of NPR 5,181,000 was allocated to strengthen the GBV response mechanisms, especially for the safe house operation, by 39 local (out of 41), provincial and federal governments in Province 7<br>• A framework on Gender Equality and Women's Empowerment for MoSD in Province 1 and in ten Palikas was drafted with the support of the Gender and GBV National expert.<br>• An 80% increase among trained women, girls, men and boys participating in the project on GBV awareness knowledge of response services available shown by the pre/post-tests<br>• Out of 94, 87 women and girls expressed satisfaction with the services offered by the safe homes during the exit interviews where quality of service, positive behaviour by staff, feeling of safety and recreational activities were positively evaluated<br>• Continued advocacy with Local Governments (LGs) has resulted in cost-sharing for GBVPR initiatives of the project in the 20 LGs of Province 1 and Sudurpaschim Provinces;<br>• LGs have also invested in safe house construction and maintenance for effective service delivery. Inter-governmental coordination has been strengthened to mobilized joint resources for shared services like safe houses and OCMCs;<br>• LGs allocated their own resources for the development of guidelines and operation of safe houses, and capacity building of health workers on the health response to GBV<br>• Capacity development interventions among Nepal Police, Judicial Committees, health service providers, LG officials, and other relevant stakeholders have contributed to gender-sensitive service delivery, and knowledge on the importance of gender equality, Gender Responsive Budgeting, Sexual and Reproductive Health Rights and other GBV related issues and related mechanisms to prevent and respond to GBV;<br>• With improved services delivery through adherence to the OCMC Operation Guidelines, more than 1,500 GBV survivors and 300 dependent children received multi-sectoral services in the seven OCMCs of the project districts;<br>• Mobilization and capacity enhancement of CPSWs and CPSW Coordinators helped strengthen the link between survivors and services that resulted in increased reporting in OCMCs, safe houses and other service centres;<br>• Thirty-three episodes of the studio-based television program "Samakon" supported by the project helped advocate for the importance of GBVPR interventions while promoting accountability of service providers; |

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| | • Trained journalists increased in reporting of GBV cases in local and national media resulted in stronger accountability measures for LGs to take responsibility on GBV prevention and response. |

## 2. Context

Nepal's significant achievements in the social sector over the past decade years are acknowledged in its human assets index rating, which is above the level required for its graduation from LDC status. Nonetheless, as noted in United Nations Development Assistance Framework (UNDAF) 2018-2022, social development challenges and disparities remain, including child marriage, maternal mortality and gender-based violence. The Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) Committee noted that patriarchal attitudes and deep-rooted stereotypes remain entrenched in institutions and structures of the Nepalese society. The 2015 Constitution establishes social security as a fundamental right of Nepali citizens and provides a broad framework for the social security system. Coverage, however, is limited.

Despite a relatively supportive policy and legal environment that has driven progress on gender equality in Nepal, social norms remain "sticky", reinforcing unjust practices towards women and girls[1]. According to a perception survey, although a substantial majority of Nepalis overall (86.8%) believe the status of women has improved in the last five years, just 47.9% of women would choose to be reborn as a woman, compared to 64.7 % of men who would choose to be reborn as a man[2]. Only 56.1% of male respondents agree that women have the right to decide how many children they will bear; 25.4% of female respondents and 31% male respondents believe that it is acceptable for their husband to punish them for disobedience. Almost a third of male respondents (29.8%) believe that when jobs are limited, men have more right to a job than women, compared to a fifth of female respondents (20.9%).

While legislative measures have allowed for change in norms related to women in leadership positions with women being elected to co-leading positions in local governments (deputy mayors), deeply internalized discrimination manifests in Nepali women accepting men's superiority as a matter of fact. According to a UNDP survey, not only men but women also retain more traditional views of masculinities. Interestingly, both transgender Nepalese and cisgenders also display the same attitudes concerning what it means to be a man and a woman in their everyday life[3]. Yet another survey found that even elected women representatives consider themselves less capable than their men peers[4]. Elected women representatives continue to face discrimination and violence at home and in the public office. It is not uncommon to find elected male representatives and even junior officers of the local and provincial governments undermining the authority of women deputy mayors or parliamentarians during meetings. In at least one of the project locations of Phase I of the Gender Based Violence Prevention and Response (GBVPR) project, an elected woman representative reported domestic violence and accessed services from the project.

[1] Overseas Development Institute, 2017: Understanding intimate partner violence in Nepal through a male lens
[2] Asia Foundation, 2018: A Survey of the Nepali People in 2018
[3] UNDP, 2014: Nepali Masculinities: Gender Based Violence
[4] Asia Foundation, 2018: Nepal's Locally Elected Women Representatives: Exploratory Study of Needs and Capacity

### 2.1 Gender-based Violence: Situation Analysis

According to the 2016 Nepal Demographic and Health Survey (DHS), one in five women in Nepal aged 15-49 have experienced physical violence since the age of 15 and at least one in four (26%) ever married women have ever experienced spousal physical, sexual, or emotional violence. The most common type of spousal violence is physical violence (23%), followed by emotional violence (12%). Of those experiencing physical or sexual violence a majority (66%) have not sought any help or talked with anyone about resisting or stopping the violence they experience. 84% women reported that their current husbands were the perpetrators of violence against them, 11% reported former husbands and only 7% reported their mothers-in-law as perpetrators. Although reported experiences of violence do not seem to vary by urban-rural locations, more women in *Terai* (1 in 3) reported violence than in the hills and mountains (1 in 5), with Province 2 topping the list with 37% women reporting spousal violence.

These already alarming figures are at best conservative estimates, given how challenging it is to generate accurate data on violence against women and girls. This is because of the intensely personal nature of self-reporting that is required, as well as the fear of potential retribution. Also, in the Nepal context, where social norms normalize violence, women and girls do not label their experience as a violation and as something "wrong". In the experience of UNFPA and other development partners working to end GBV, women and girls' initial response is to deny inequality, discrimination and violence in their lives, and it is only after sustained sharing of information and reflections with them that their lived experiences are understood as violations. Evidence from the GBVPR project suggests that a majority of the women accessing One Stop Crisis Management Centres (OCMCs) were referred from the out-patient-department of the hospitals, complaining of somatic symptoms which were later investigated by doctors to be indicative of gender-based violence. Regardless of the under-estimation of official data on gender-based discrimination and violence against women, development partners in Nepal and the Government of Nepal agree that the problem is significant enough to warrant prioritization in their plans and budgets (not withstanding insufficient efforts).

While all evidence indicates that high prevalence and acceptance of violence against women and girls in Nepal, as in many parts of the globe, are rooted in patriarchal social norms that value men and boys over women and girls; popular narratives on violence against women and girls, especially among men are at best ill-informed, and at worst, harmful. Focus-group discussions with men, including elected representatives, reveals that there is either a strong denial of discrimination and violence against women and girls, or blaming of women and girls for their incompetence and illiteracy. Women on the other hand, move from denial to acknowledging the inequalities and violence but tend to justify them—"if girls are sent out, they will run away or some harm

***Table 1: Popular narrative from the field on women and girls (by men)***

*"Women are uneducated, they do not understand, we (men) have a responsibility to make them understand (including by beating them to teach them a lesson)"; "women misuse the hard-earned money of their husbands and that is why husbands get angry"; women whose husbands have migrated, blow away the remittance, become sexually wayward, and elope with other men"*

will come to them; if we do not follow rules of segregation during menstruation, we will be punished by the gods; men beat women only when and because they are under the influence of alcohol".

Traditional forms of violence against women continue and newer forms are being reported—extramarital affairs, polygamy, sexual coercion, exertion of control in mobility and social interactions and crimes such as acid attacks due to suspicion and jealousy, and victimisation using phones and social media[5]. Popular view in public policy discourse in Nepal has been that women's empowerment is key to eliminating violence and this view is echoed across the country, across all three tiers of government. However, while empowering women must be a goal in itself, it is not enough for stopping the violence. It does seem to correlate positively with higher reporting, but does not necessarily mean "empowered" women are not being violated. Indeed, women who are getting educated and employed are disproportionately represented among those reporting violence (NHDS, 2016). This does not mean that education or employment is a driver of violence but suggests that perhaps educated and financially independent women are more likely to report.

Regardless, it is clear that violence against women continues even when women are getting educated and going out to work; therefore, women's empowerment alone is not abating violence and interventions need to focus on those committing the violence to stop. In GBVPR project locations, men and women report that familial conflicts are the root cause of violence and they link familial conflicts to poverty and alcohol abuse. There are also reports of how micro-credit initiatives that exclusively focus on women are seen as fueling discord between couples: men believe that women take loans, "blow the money away" and then demand from husbands to repay the loans. Widespread male underemployment and related stress are also reported as contributors of violence against women and girls.

### 2.2 Geographical context

The geographic coverage of Phase II of the project will continue to be implemented in the same municipalities and districts in Provinces 1 and 7 as Phase I, and exit from Province 3[6]. Provinces 1 and 7 were initially selected during the first phase of programming for various reasons including being geographical priority areas of operation for both donors; prevalence of harmful practices e.g. *Chhaupadi* in Province 7. In addition to the existing municipalities (also known as *Palikas* in Nepali) participating in Phase I, the project will be expanded to the 2 provincial capitals of Provinces 1 and 7 to facilitate stronger collaboration with provincial governments. Phase II will reduce the number of municipalities from 20 in Phase I to 19 in phase II, and will reduce the number of participating wards from 113 (SDC funded) wards in Phase I to 87 wards in the second phase. This is to allow the project to respond to the MTR recommendation to deepen the level of interventions to ensure a saturated, whole-community approach. The sections below will outline some contextual practices and analysis of GBV in Provinces 1 and 7 to

[5] Overseas Development Institute, 2017: Understanding intimate partner violence in Nepal through a male lens

[6] Following federalization and decentralization in Nepal, Sindhuli district has become part of Province 3, which is not a focus province for UNFPA. Activities will therefore cease at the end of Phase I.

further highlight why continued implementation in these areas remain relevant to address GBV and harmful practices which remain prevalent in these regions.

**Province 1**

In 2017, UNFPA commissioned a Situational Assessment for Improved Gender Based Violence Prevention and Response in Selected Districts of Nepal which conducted surveys in Sindhuli (Province 3), Udayapur and Okhaldhunga (Province 1). The study revealed high prevalence of GBV in the project districts, especially in the form of spousal violence that was often fuelled by alcohol. It also showed that the most common forms of GBV were emotional violence, followed by physical and sexual violence. Most of the perpetrators identified were men and boys close to the victims, such as husbands, in-laws (including female in-laws), neighbours, intimate friends, or as relayed by the respondents, unknown boys and men with “bad moral character” that were often perpetrators of sexual violence.

This pattern of data was identified in all the study districts, with many women perceiving husbands beating their wives as "part of life when you are living together". The study revealed that although women were aware of GBV and are aware of their rights, most of them were forced to accept violence as a part of life because they had no other choice than to return to their common home (or husbands' home with in-laws). The study also stated that spousal violence was prevalent across all social and economic groups, and perpetrators include people in community leadership positions like teachers and government officials (*janne bujhne, thula maanchhe*).

The most common type of physical violence that was reported by respondents in all districts is hitting or slapping as responded by an overwhelming majority of the respondents (98%) followed by pulling hair, pushing or shoving, throwing things at women and girls, choking, burning and stabbing. When asked about the perpetrators of physical violence, the majority of respondents (94%) reported that husbands are the main perpetrators of physical violence, and this proportion was similar for males and females. Other frequently cited perpetrators of physical violence were reported to be mother-in-law (30%), neighbours (26%), sister-in-law (16%) and intimate friend or partner (14%).

**Province 7**

While all legally recognized and prohibited forms of domestic violence (physical, mental, sexual and economic) and harmful practices are common across the country, albeit in different degrees, there are manifestations that are culturally specific. The harmful practice of the physical segregation of women and girls in a cow shed outside the house during their menstruation (*Chhaupadi*) is more prevalent in the communities of the Far West (Provinces 6 and 7). Variations of the practice are common in many other parts of the country though not as severe. For instance, menstruating women, though not confined in a shed outside the house, are prohibited from worshipping, cooking, and even touching male members of the family. The practice is known to be common across class, education backgrounds and caste groups, and despite several interventions, including legal prohibition of physical confinement, the practice continues primarily due to fear of retribution by the gods.

Elsewhere, in Province 2 for instance, although the practice of *Chhaupadi* is not common, among Muslim and Dalit communities, girls are still not allowed to go to school[7] and are married at an early age[8]. In heavy out-migration communities, women left behind by migrant husbands are often harassed by husbands, in-laws and members of the community and the popular narrative that left behind women are sexually promiscuous, indulging in "illicit" relationships with other men, puts them at even greater risk of violence.

The Nepal DHS of 2016 found that 34% of women in the Far West region (including Province 7) are 'most likely to have attitudes justifying wife beating under any one specific circumstance'. The DHS also found that Province 7 performs lowest in the percentage of women who own land alone, with only 2.8% of women, compared to the next lowest figures of 5.6% in Province 5. In Province 1 similarly 24% of men (3rd highest percentage across all 7 Provinces) were found to agree that a husband is justified in hitting or beating his wife for specific reasons. Provinces 1 and 7 will therefore continue as the geographical target areas of the project, not only to address GBV and harmful practices experienced in both regions, but to also allow continuity of activities and build on the successes and gains made in Phase I.

### 2.3 Response to Gender-based Violence: Policy Frameworks and Services

Over the past 20 years, Nepal has made significant strides towards ensuring gender equality and ending gender-based discrimination and violence through policy and legislative measures. Nepal is party to seven of the nine principal international treaties, including the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), which it ratified in 1991, together with the Optional Protocol thereto, which it ratified in 2007. Most recent of the legal developments in the area of gender equality and gender-based violence involve the promulgation of the new *Constitution* in 2015, which has been recognised by the UN Special Rapporteur on Violence Against Women as having brought "many progressive provisions with the aspiration of achieving an equitable society in accordance with the principles of inclusion and proportional participation of women"[9]. Article 38 (3) of the Constitution prohibits physical, mental, sexual, psychological or other forms of violence or exploitation against women, on the grounds of religion or social or cultural tradition or practice, or on any other grounds.

In 2009, the *Domestic Violence (Offence and Punishment) Act, 2066* prohibited any form of domestic violence including against women, and makes provision for safe houses for survivors. It has also given the police powers to mediate a reconciliation in cases of domestic violence, and even though the choice for mediation is vested with women, police and courts typically offer mediation as a first step. However, a study supported by the World Bank has recently concluded that mediation processes are not gender sensitive nor survivor-centred, mediators are not trained on root causes of violence against women, while

[7] Ministry of Education, Government of Nepal, 2016: School Sector Development Plan 2016/17-2022/23
[8] NDHS 2016, Report of the Special Rapporteur on violence against women, its causes and consequences
[9] Visit to Nepal: Report of the Special Rapporteur on violence against women, its causes and consequences. Human Rights Council Forty-first session, 24 June–12 July 2019, Agenda item 3, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development.

the mandatory provision of a psychosocial counselor during mediation processes is not being honoured. There have been other substantial reforms of the legal system, including the adoption the *Sexual Harassment at the Workplace (Elimination) Act of 2015* and the *National Penal (Code) Act 2017,* which replaced the Civil Code, 2021 (1974) and criminalises discriminatory behaviour based on sex, gender and caste untouchability; forced marriage, child marriage, polygamy, incest, forced abortion, acid attacks, dowry and *Chhaupadi.* The *Act to Amend Some of the Nepal Acts for Maintaining Gender Equality, 2063 (2006)* has reviewed several legislations from a gender lens and made amendments to them; *Human Trafficking and Transportation (Control) Act, 2007* prohibits human trafficking and provides for services for rescue and rehabilitation of survivors; and the *National Women's Commission (NWC) Act, 2007* gives authority to NWC, among other things, to investigate and mediate in cases of GBV.

In addition to these laws, some **policies and guidelines** have been enacted for promoting gender equality and providing services to survivors of violence. Key among them are the *Affirmative Action Policy, 2007*, which paved the way for women's representation among elected representatives and in civil administration; *The National Minimum Standard (NMS) for Victim Care and Protection*, 2012 for services to survivors of human trafficking; *Standard Operating Procedure (SOP) Guidelines for Operation of Psychosocial Counselling Services*, 2012 for survivors of human trafficking at the rehabilitation centres; *Hospital Based One-stop Crisis Management Centre (OCMC) Operational Manual 2067*, outlining roles and responsibilities for integrated services to survivors of GBV through hospital based OCMCs. The last *National Strategy and Plan of Action for Gender Empowerment and Ending Gender-Based Violence (2012-2017)*, has not yet been replaced by a new one, although the Ministry of Women, Children and Senior Citizens (formerly the Ministry of Women, Children and Social Welfare - MoWCSW) has drafted one-year Action Plan (2019-2020) for campaigns to be implemented by all the three tiers of the government (on ending violence against women. In this regard, local and provincial governments are in the process of drafting their own frameworks on gender equality and guidelines for services.

**Response services** for survivors of GBV are managed by different ministries, and the **police and legal services** are provided through women and children service centres established at the district police offices and district courts. Police operates under the Ministry of Home Affairs, and the Courts under the Ministry of Law, Justice and Parliamentary Affairs. Several NGOs, including Legal Aid Consultancy Centre (LAACC) are also engaged in providing free legal services to survivors through their chapters in districts. **Shelter homes for survivors** have been under the mandate of the Ministry of Women, Children and Senior Citizens (MoWCSC) and now also under the mandate of local governments. So far very few shelter homes are available in the country, a majority being run by NGOs. Only 21 short term shelter homes located at district headquarters have been supported by MoWCSC (7 of these in Province 1 and 5 in Province 7). A few shelter homes also provide **skills and vocational training to survivors** to build their financial resilience. **Medical and psychosocial services** are provided through Hospital Based OCMCs which fall within the mandate of Ministry of Health and Population (MoHP). The OCMC are also responsible for providing integrated services as per clause 3 of the National Action Plan 2010 against GBV. With UNFPA support in several of the GBVPR project locations, community based psychosocial workers are providing **front line services and referrals** to GBV survivors at the community level.

**Coordination between all these services** has been a challenge, and although OCMCs have been entrusted with the responsibility of providing integrated services by coordinating with different service providers with the support of district coordination committees, at best this has resulted in improved referrals across services but not necessarily a *coordinated* response. According to a review commissioned by the MoWCSW and supported by UN Women[10], lack of coordination in implementation of the multisectoral action plans has been a major challenge to ending violence against women and girls. The UN Special Rapporteur on Violence Against Women also expressed concern that lack of effective coordination between mechanisms on violence against women presents additional challenges in assessing the extent to which the right of women to be free from violence is protected throughout the country.

### 2.4 UNFPA's Work in Nepal

UNFPA is a leading player in the area of Gender-based Violence prevention and response in Nepal. Active in Nepal since 1971, UNFPA has among other programmes, enhanced the national response to gender-based violence in partnership with donor partners, civil society and government stakeholders. The country office manages a portfolio of GBV programmes focused both on multi-sectoral essential services and on prevention. UNFPA also implements programmes to address harmful practices such as prevention of early marriage by working at all levels: at community level to empower adolescent girls with life skills training and support, as well as with parents, community and influential members to create an enabling local environment. At policy level UNFPA works with government stakeholders to address legislative and policy gaps and build the evidence base on early marriage. UNFPA also works to ensure that girls who are already married can receive family planning support to prevent early pregnancy, which can have serious health implications.

UNFPA is committed to align with and support the principles and values of federalism as enshrined in the Constitution of Nepal. In Phase I, UNFPA already made the shifts to working closely with local governments in pursuit of the goal of ending violence against women and girls and as a result in many of the municipalities where Phase I has been implemented, UNFPA and local governments have collaborated on developing policies and in sharing costs of response services such as shelter homes and community based psychosocial workers. Going forward, based on the feedback and suggestions of local, provincial and federal governments, UNFPA will deepen engagement with all 3 tiers of government and in promoting inter-governmental dialogue and coordination that is necessary for multi-sectoral coordinated response.

UNFPA will specifically work with departments and Ministries that have the mandate to promote gender equality and to prevent and respond to GBV. These will include the local governments at municipality and ward levels, their judicial committees and division for social development; Ministry of Social Development

[10] SAHAVAGI, DIDIBAHINI & FEDO. (2015) Progress of Women in Nepal (1995-2015) – Substantive Equality: Non-negotiable. Kathmandu

at the provincial level, including the sections on women, health and education; Ministry of Health and Population, Ministry of Women, Children and Senior Citizens, and the Ministry of Education.

### 2.5 Stakeholder Analysis

Stakeholders involved in promoting gender equality and ending GBV have increased since the design of Phase I, with the adoption of a federal structure in Nepal in 2017. The power and mandate for addressing GBV, previously vested with the central government, is now devolved to the local (municipalities) and provincial governments. Federal ministries are still responsible for drafting policies and standards, and provincial and local governments have the authority for adapting federal policies and laws in the local context and developing their own regulations (province) and implementation modalities (local). Additionally, the federal system in Nepal is based on the guiding principle of co-existence, co-operation and co-ordination (3Cs) between the three tiers of government, offering a unique opportunity for strengthening multi-sectoral coordination. At the local level, with gender equality and GBV prevention and response being made a part of a broader functional area of the "social development sector" including education, health and others, an integrated approach to gender equality and a multisectoral model for GBV prevention and response at the local level seems more achievable.

***Table 2: Stakeholder Analysis***

| Stakeholder group | Importance | Situation | Strength/weakness/power relation | Opportunities for GBVPR Phase 2 |
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| **Federal Government** | | | | |
| **Ministry of Women, Children and Senior Citizens** | **High** | The MoWCSC has been the focal ministry for gender mainstreaming, women's empowerment and social inclusion. The ministry also provides shelter services in 21 districts for GBV survivors and used to manage the GBV elimination fund. While their relationship with local and provincial governments is still evolving, the erstwhile Women and Children Officers based at the district offices have now been absorbed into the social development sections of the provincial and local governments. The MoWCSC has to now work in collaboration with provincial and local governments and agenda at each level will influence what the Ministry is able to accomplish. | **Strengths:** In the new federal structure, it continues to be the nodal agency for drafting policies and standards. It still has influence over guidelines for shelter services.<br><br>**Weaknesses:** Under the federal structure, MoWCSC has lesser direct line control over departments related to women at the provincial and local levels and they seem to be struggling to establish themselves in the new structure. They also have limited funding which limits their influence and capacity to actively engage at provincial and local government levels. | The MoWCSC as a Line Ministry on GBV issues will facilitate entry of the project's details into the Line Ministry Budget Information System (LMBIS) with the Ministry of Finance as On Budget Off Treasury support. They will play a key role in the oversight of the project as co-chairs of the Project Advisory Committee with the MoHP.<br><br>On a policy and advocacy level, the MoWCSC will be a key partner to facilitate the adoption of the national Gender Equality and Women's Empowerment (GEWE) policies by Provincial and Local Governments. In addition, their support and engagement in implementing international standards on managing safe houses and shelter homes will be instrumental, particularly as they are planning to open safe houses for women in 53 districts under the President's programme for the upliftment of women. The Ministry has |

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| | | | | asked for UNFPA's support in drafting their new policies, strategies and UNFPA will continue to work with MoWCSC to develop and promote protocols for multi-sectoral coordinated response and guidelines for shelter homes and safe houses.<br><br>However, given line ministries' reduced control over provincial and local level government, the MoWCSC will have some limitations on their ability to directly influence Palikas. However, their participation on the PAC will help maintain their lines of communication open with Palikas and Provincial Governments to ensure project activities are adequately supported at all levels of government. |
| **Ministry of Health and Population** | **High importance** | Government of Nepal has appointed the MoHP as the executive body with chief responsibilities to implement Clause 3 of the *National Action Plan 2010 against GBV* to effectively provide integrated services to survivors of GBV by establishing a Hospital Based OCMC. MoHP has been very supportive of the GBVPR project and appreciates UNFPA and the project's contribution in providing technical assistance, case managers and outreach | **Strengths:** MoHP has been allocating annual budget for the operation of the OCMCs since inception. The MoHP has been revising the OCMC Guidelines to authorise provincial governments to establish OCMCs as required, and to allow them to be established in community hospitals and privately-run medical colleges. The guidelines also outline the required members of the GBV Management Advisory Committee, GBV Management Coordination Committee | The MoHP as a Line Ministry on OCMC and District Hospital interventions will also facilitate entry of the project's details into the Line Ministry Budget Information System (LMBIS) with the Ministry of Finance as On Budget Off Treasury support. They will play a key role in the oversight of the project as co-chairs of the Project Advisory Committee with the MoHP. Furthermore, funds will be channelled to OCMCs (which fall under the MoHP |

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| | | counsellors in 8 of the OCMCs under GBVPR project.<br><br>MoHP has issued the National Health Policy-2076 (2019) for the effective development, extension, coordination, operation and management of the health sector at the federal, state and local level. Safe Motherhood and Reproductive Rights Act-2075 (2018) has guided to implement the Constitution mandated free primary health care and emergency health services and control quality of health services. Heath Insurance By-laws-2075 (2018) has been enacted to substantiate Health Insurance Act-2074. MoHP has issued the Guideline for the treatment and rehabilitation of the disabled and people living with mental illness in seven health facilities, rehabilitation centres and other philanthropic organizations. MoHP has also upgraded the Minimum Service Standard of the Health Posts to the specialized health facilities with the support of development partners including UNFPA (and the GBVPR project) and DFID, and as part of the Nepal Health Sector Programme (2015 – 2020), plans to cover the entire country progressively. | and Case Management Committee. According to the guidelines OCMCs are led by the permanent staff nurse of the health facilities and annual budgets are allocated by the MoHP and Ministry of Social Development. The MoHP has been developing an online reporting software for OCMCs to be in use from the next fiscal year, for which UNFPA and IPs CVICT, Jhpiego and CMC Nepal are advocating for OCMC data management. There is new GBV Management Advisory Committee led by the Chief of District Coordination Committee which is a good start of adjusting in line to the federal structures. Technical backstopping to the project focused OCMCs has been highly appreciated by the local authorities especially the clinical supervision.<br><br>**Weaknesses:** MoHP has deployed staff nurse to OCMC and out of which only 50% OCMC are having staff nurse whereas remaining OCMCs have no certified staff nurses due to staff adjustment and ad hoc deployment of ANM (Auxiliary Nurse Midwife). In addition, MoHP has not envisioned trained Case Workers and Psychosocial Counsellors within OCMC human resource structure. However, project has been showing its success on effective and efficient service delivery in | though governed at Provincial levels) through UNFPA's IPs.<br><br>The project will therefore continue to work closely with MoHP for the institutionalisation of adequate and trained staff in all OCMCs, institutionalising training on survivor-centered and gender transformative capacity building of all health workers, and for the development of protocols for multi-sectoral and inter-governmental coordinated response. OCMCs are now under Provincial Governments (PG) hence the project will do upstream policy advocacy with the PGs for further resource mobilization to strengthen the multi-sectoral services and referral mechanism.<br><br>The project will further collaborate with the MoHP on advocating for the retention of trained staff at OCMCs. Currently, the project faces risk of attrition of trained staff due to staff being moved to other locations. It will therefore be crucial for UNFPA to lobby the MoHP to support this initiative and influence Provincial |

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| | | | OCMC and affordable and accessible services for GBV survivors ensuring mental and psychosocial well-being in phase I. Despite agreeing to the model established by the project and the need for full time qualified staffing at OCMCs, MoHP has still not been able to make these changes in their guidelines and will need to work with local and provincial government as well as negotiate for greater central funds for the OCMC. | Governments to retain project trained staff in project locations. |
| **Ministry of Home Affairs and the Police** | **Medium** | Police at local and provincial levels, and Women and Children Service Centres at the police stations at district level are under the MoHA and provide specialised services for women and children. Under federal structure provincial and local governments are also authorised to appoint their own police.<br><br>The Nepal Police Academy, under the MoHA and with the support of DFID, has been responsible for training police at all levels on gender sensitive investigation and services to GBV survivors | **Strengths:** The police have a wide network are a key player in the response referral chain-they have the authority to investigate cases and refer them to the courts. According to an assessment by DFID, women most commonly first sought help from the police, whereas men most commonly sought help first through mediation[11].<br><br>**Weaknesses: T**he *Domestic Violence Act* requires that if the victim so desires, the police must conduct reconciliation between the parties within thirty days from the date of registration of the complaint. All authorities, including police, courts and other bodies tend to | The police at the local levels will continue to be an important stakeholder for this project. They will continue to be engaged in the referral mechanism and in inter-agency coordinated response. However, following recommendations from the Phase I MTR, the project will not invest in building capacities of the police. However, we will seek synergies and collaboration with DFID's Peace, Justice and Security programme which in its current phase is working with Police on training and capacity building on GBV response. However, as the |

[11] Palladium, 2018: Experiences and outcomes of justice seekers in Nepal. Monitoring, Evaluation and Learning (MEL) Component, DFID Integrated Programme for Strengthening Security and Justice (IP-SSJ)

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| | | | automatically refer cases for mediation and in the case of the police, conduct mediation themselves[12]. There is little training on gender-sensitive mediation and the results tend to promote reconciliation over retributive justice. | next phase of DFID's programme is currently under design, it is not clear which areas we can effectively collaborate. At this time, DFID is not engaging with potential IPs (such as UNFPA) to avoid conflict of interest |
| **National Women's Commission:** | **Low** | The NWC is a constitutional body mandated to investigate cases of victimization of women as a result of any kind of violence, harmful practices or other constraints to women's enjoyment of their human rights. However, the commission lacks the capacity and resources to fulfil its mandate, despite support from donors over several years. With the support of World Bank, the NWC has piloted (in 4 districts) helpline services for GBV survivors under the project "Integrated Platform for Gender Based Violence Prevention and Response in Nepal". | **Strengths**: The NWC can also formulate national policies and programs concerning the right and interest of women and submit it to the GoN for implementation.<br><br>**Weaknesses:** The NWC remains centralised and does not have a structure at the local level and outreach is limited. They have been fraught with lack of leadership delays in appointments and quick transfers of Chairpersons and senior officers. NWC has low interest and low influence in the project | UNFPA will explore collaboration with the helpline programme of the NWC as it expands in its second phase from 2020 onwards, to possibly cover locations of the GBVPR project. Areas of collaboration could include connecting service providers along response continuum in project locations with the hotline service |
| **Provincial Government** | | | | |
| **Ministry of Social Development:** | **High** | MoSD is mandated to oversee the education, health, women, children, and senior citizen, social security and labour | **Strengths:** With all social sectors now under one single ministry at the provincial level, there is greater opportunity for integrated, coordinated programmes and | The MoSD will be a key stakeholder for the project at the Provincial Level as their focal areas cover both health and gender/women's issues, which cuts |

[12] Palladium, 2018: Experiences and outcomes of justice seekers in Nepal. Monitoring, Evaluation and Learning (MEL) Component, DFID Integrated Programme for Strengthening Security and Justice (IP-SSJ)

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| | | and employment sectors. One of its goals is to eliminate violence from the society. It is responsible for developing and implementing provincial policies, laws, standards and plans on women's rights and women's empowerment, within the overall framework provided by federal Ministries. The Women's Development Division within the Ministry plays a crucial role to monitor and evaluate programmes on women. MoSD is responsible for gender equality, women's empowerment and GBV issues. The Health Service Directorate and Health Service Division are responsible for strengthening the capacity of OCMCs to provide multi-sectoral services for GBV survivors. The Social Development Division (SDD) and Gender Empowerment and Mainstreaming Division (GEMD) under MoSD are responsible for the development and implementation of the provincial level strategy for GBV prevention and response. The MoSD has enacted the Social Development Organization Act, 2075 and related by-laws which make registration mandatory for all NGOs and INGOs to increase accountability and ensure they contribute to the priorities of the local governments. The GEMD, under the SDD, | policies across health, education, women departments.<br><br>**Weaknesses:** Provincial governments are struggling to establish themselves with the federal and local governments. It is still early stages and mechanisms for coordination with local governments are still evolving. | across the project's main streams of work. It will also play a crucial role in the project oversight structures as chair of the Provincial Project Steering Committee (PPSC) which will meet annually in each Province.<br><br>In addition to their role in the project's oversight, the MoSD will also be an important stakeholder on the operationalising of the Essential Services Package on GBV which requires a coordinated response to GBV at Provincial and local government levels. MoSD can therefore create a platform for all LGs where the service centres (OCMC, safe houses, etc.) are located that help standardize the services and strengthen the multi-sectoral response mechanism in the project areas. On a policy and advocacy level, the MoSD will also be a key partner to facilitate the adoption of the national Gender Equality and Women's Empowerment (GEWE) policies by Provincial and Local Governments. MoSD is also a key ally in lobbying for the retention of project trained OCMC staff in project supported OCMC locations. |

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| | | has drafted the Domestic Violence Bill to ensure the rights of survivors of all forms of violence and submitted it to the State Assembly of State 1. | | The MoSD also approved the Hospital Operation and Management Committee Formation Guidelines-2075, which is an opportunity to influence inter-municipal cooperation for shared contribution to OCMCs. The MoSD has also prepared and approved the Provincial Domestic Violence Act, 2075 and related by-laws, the Disability Prevention and Rehabilitation Programme Operations Guidelines, 2076 and the School Level Education Improvement Guidelines, 2076. The MoSD of Province 1 is operating a referral shelter home in Biratnagar, an opportunity for the project to link district based safe houses with a provincial shelter home to ensure long term services for GBV services at the provincial level instead of Kathmandu-based shelter homes. The MoSD in Province 1 has appointed school nurses on a contractual basis, one in each of the 14 districts and the National Planning Commission has hired 64 State Development Volunteers in the areas of health, veterinary services, agriculture, engineering and teaching in Province 1. However, there is no provision for |

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| | | | | social mobilizers and the project could lobby Community Psychosocial Workers to act as social mobilizers due to their knowledge of community psychosocial first aid and referrals. |
| **Provincial Social Development Committee:** | **Medium** | The provincial social development committees have been formed and are aware about the status of gender-based discrimination and violence in their respective provinces. Their role is to define the priorities of the provincial government in matters pertaining the social sector, including the sub-section on gender/women. | **Strengths:** They have the mandate to develop coordinated and common gender programmes in their province.<br><br>**Weaknesses:** They are still developing their guidelines, priorities and programmes | Although the project has not directly collaborated with them so far, UNFPA has a good rapport with the Committee and they have expressed interest in working together. Project can capacitate committee members on GBVPR and support on drafting provincial policies and implement them accordingly.<br><br>Opportunities for collaboration include engagement on the adoption of national GEWE policies at Provincial and LG levels as the committee plays a key role in defining the priorities of the provincial governments in the social sector. In addition, members of the PSDC will likely also participate in the Provincial Project Steering Committee which provides a good avenue for influencing and engaging them on the Essential Services Packages adoption to ensure effective multisectoral coordination at the Provincial and LG levels. |

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| **Hospital/One Stop Crisis Management Centres** | **High** | At present, Total 68 (MoHP has established 63 and Karnali Province Government has established 5) hospital based OCMCs have been established in 66 districts of Nepal. GBV Management Coordination Committee is led by the Chief District Officers of the respective districts, Case Management Committee is led by the Medical Officer and OCMC is led by a permanent staff nurse of the respective health facility.<br><br>Provincial Governments (PG) have been receiving conditional grants from the MoHP which they provide to OCMCs OCMC grants cover staff nurses, operational and referral costs. In the long run, the provincial government will be responsible to manage OCMC from its equalization grant since this is the mandate of provincial government. | **Strengths:** As a separate dedicated service point, OCMC has been acknowledged by local and provincial governments with a good reputation, and building trust among other service providers (legal entity, police and court) as well as GBV survivors.<br><br>**Weaknesses:** There is no provision of Case Workers/Managers and trained psychosocial counsellors whereas trained staff nurses have not fully deployed in all 68 OCMCs. | OCMCs are a key central point of the project that provide services to women, not only to address physical injuries but also provide counselling and referral services in a safe and trusted environment. UNFPA will directly support the training and capacity building needs of OCMC staff on both the Gender Transformative Approach, but also on strengthening their collaboration and knowledge of other referral pathways. OCMC representatives will also participate in the Provincial Project Steering Committee (PPSC) which provides them the opportunity to influence decision makers on ensuring adequate services in OCMCs, as well as lobbying for the retention of project trained staff in OCMCs project locations. |
| **Local Government** | | | | |
| **Local governments** | **High** | Local governments are constitutional body and are responsible to regulate and implement policies that falls under its jurisdiction. The local government operation act provisions local government to consider gender and social inclusion | **Strengths**: LG can formulate its own regulation and guideline in regard to gender equality and GBV and allocate budgets. Each local government has provision of woman development officer (WDO) previously working in Women and | LGs will be instrumental in the development of the guidelines and policies regarding GE and GBV, as well as the adoption of the national GEWE policy. They are also a key partner in the institutionalization of GBV services at the local level. In addition, they will |

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| | | while formulating long term development plan under its jurisdiction; the LGOA also mandates the local government to eliminate all type of social ill traditions in the its constituency.<br><br>They have high importance and high influence in the project since all services are provided at the local levels. They are now in-charge of safe houses (service centres service centres/*seva kendra*, have been established in 21 districts by the erstwhile MoWCSW are now under LG) Of these 5 fall under the project location for Phase II- one each in Okhaldhunga (in Province 1) and four in Province 7—one each in Accham, Bajura, Bhajang and Baitadi. The GBVPR has been supporting all 5 service centres during Phase I in terms of providing technical training to its staff and providing additional staff.<br><br>LG in the project locations have shown high interest in institutionalising the services of CPSW with some financing their salaries 100% while others at different ranges of cost sharing | Children Office. They can be an ally for institutionalizing the policy in the LG.<br><br>So far, 3 LGs have endorsed the GE Policy Framework which were developed with the technical support from the project. Local Governments in project locations have high interest in supporting shelter services as well as CPSW have been in the process of developing guidelines for the management and services provided at the shelters, as well as progressively contributing financially for the running of these shelter homes.<br><br>**Weaknesses**: Each LG have different level of institutional and human resource capacities. Many WDO positions are vacant as WDO are not willing to be posted in remote LG.<br><br>Confusions with federal and provincial governments regarding responsibilities related to GBV based on unbundling report. | participate in the PPSC as well as the Project Management Committee oversight structures, which also provides them an opportunity for continued lobbying and engagement with other LGs and Provincial authorities.<br><br>UNFPA will ensure regular interaction and follow-up to facilitate cost-sharing modalities as well as discussing sustainability measures for the project to allow for a responsible exit. Advocacy with Government partners for cost-sharing of CPSWs, OCMC case managers and safe houses is therefore a key priority in Phase II. UNFPA will proactively engage and communicate with different levels of government to understand the evolving responsibility of different spheres of government in regard to GE and GBV. There is need to develop a critical understanding of GBV issues among all service providers so that their own patriarchal biases and values do not influence their service provision. LGs are therefore key beneficiary targets in Outcome 3 activities and the project will provide training on GTA and awareness of GBV |

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| **Judicial Committee** | **High** | Judicial committee is the constitutional mandate of local government. The LGOA provisions judicial committee to settle disputes through mediation also related to GBV, divorce between wife and husband, physical assault. The act encourages the process to settle the disputes through reconciliation and reconcile with the consensus of both parties. The judicial committee can also issue an interim protection order to the concerned party in the dispute related to the husband and wife. The committee is made responsible in the following areas that directly relates with GBV cases: a) To allow the victim to live in the house he/she has being staying, provide food and clothing, to not physically assault and to behave in a decent and civilized manner, (b) To carry out treatment if the victim has suffered physical or mental injury, (c) To make arrangement for separate accommodation if it is deemed necessary for the victim and to make proper arrangement of subsistence in such separate accommodation, (d) To not slur, | **Strengths**: JC have the right to settle and mediate the issues on GBV.<br><br>**Weaknesses**: The member of JC are not capacitated and capable enough to provide the services in above mentioned areas. | UNFPA will proactively engage with JC members to strengthen their understanding on GTA and GBV in order for them to facilitate more survivor friendly mediations. The project will also inform them of the appropriate referral pathways and channels if survivors require additional services. |

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| | | threaten or behave in an uncivilized way with the victim, (e) To carry out other necessary and appropriate matters for the interest and security of the victim. | | |
| **District Courts** | **Medium** | GBV cases are required by law to be referred by police or local body to District Courts with the survivor's consent, after efforts at reconciliation fail. The District Attorney and Bar Association members may be knowledgeable about the laws but more often than not, courts refer women survivors to mediation processes, without necessarily explaining the process to survivors. | **Strengths:** Phase I interfaced with the courts through the referral pathway via CPSWs, Shelter staff and OCMC case managers who have even accompanied survivors to courts and facilitated legal aid through the project. There is therefore a willingness to engage, and relationships already established with service providers in the project that can be capitalised on in Phase II.<br><br>**Weaknesses:** In general, it is found that courts tend to pursue restorative justice through reconciliation than retributive justice. GBVPR Phase I was not designed with focussed interventions with formal justice sector, which has been the focus of DFID supported nation-wide access to justice programme (IPSJJ). | In Phase II, GBVPR will continue interface with courts in referrals, providing support to survivors in terms of information and accompanying through the court process. Additionally, in Phase II, courts and police will be included in the dialogues facilitated by GBVPR for coordinated multi-sectoral response. The project will also work with lawyers in the safe houses and shelters, which provides a string link with the District Courts and helps facilitate survivor-centred approaches when dealing with GBV cases. |
| **Civil Society and Development Partners** | | | | |
| **I/NGOs and Women's Rights Organisations** | **High** | Various I/NGOs and women's rights organisations are engaged in policy advocacy, campaigns and delivery of support services to survivors of violence against women and girls. These include | **Strengths:** These organisations are recognised as leading voices in the women's rights movement in Nepal. Some coordination exists among them which can be an entry point to better understand the NGO landscape and | Several initiatives, some successful, have been implemented by development partners and INGOs in partnership with local organisations, but the challenge of sustaining results and NGO activities after projects end |

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| | | Women's Rehabilitation Centre (WOREC), Saathi, Apeiron, Shakti Samuha, Forum for Women, Law and Development (FWLD) etc. | opportunities for collaboration in our project locations.<br><br>**Weaknesses:** all are based in Kathmandu with few having outreach/offices in few parts of the country. Their ability to have a presence in different parts of the country depends on resources available through grants. As such, many exit from locations after the end of project period. Locally based organisations have fewer resources and trained staff, who again, they are able to retain only so long as they receive grants. However, high competition for grants between them sometimes makes it difficult to coordinate amongst themselves. | remains. Among the INGOs that are implementing projects to promote gender equality, women's empowerment and to eliminate violence against women and girls are CARE, Oxfam, Action Aid and VSO. In addition to their long history of implementing projects on social norms, albeit in specific locations, VSO and Equal Access are now also partners of DFIDs pilot initiatives on changing social norms. They will be important allies for the project, especially in the components on social norm change. UNFPA will collaborate with these organisations for sharing experiences, models and knowledge products, and will also engage with them in early market engagement to generate interest among qualified institutions to submit their tenders for implementing the project. |
| **World Bank** | **Low** | The Integrated Platform for Gender Based Violence Prevention and Response in Nepal (IPGBVPR entitled Sambodhan - May 2016-June 2020) is a World Bank Group supported stand-alone project, implemented by the National Women's Commission (NWC) with the technical support of CARE Nepal. As a key part of the project, the NWC established a 24-hour toll-free helpline ('Khabar Garaun 1145') for | **Strengths:** The Sambodan project has established referral services include shelter, psychosocial support, health, legal, para-legal, mediation and child protection run by both Government and civil society. This is a strong entry point for collaboration, though there are risks of parallel structures created by Sambodan adversely affecting the GBVPR project. | The World Bank is currently evaluating the impact of the helpline services and reviewing the institutional set up for sustaining and expanding the service nation-wide. Based on how the helpline services evolve, UNFPA will explore possible links in project locations in Phase II. The World Bank has already approached UNFPA to seek collaboration on this and their new construction projects which have a GBV component as part of their |

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| | | GBV survivors in December 2017. The helpline offers GBV survivors and others a platform to report incidents and to seek help to receive coordinated services. The project outreach is specifically in Kathmandu Valley (Kathmandu, Lalitpur and Bhaktapur) and Nuwakot, though calls are received from all over the country. A GBV Service Directory has also been prepared which includes over 450 services for GBV survivors in 77 districts across Nepal. | **Weaknesses:** Anecdotal reviews from World Bank staff indicate weaknesses in the helpline operations and effectiveness of referral pathways for survivors using the service. Helpline project outreach is also not in the GBVPR Phase II project locations. Data management is also weak and the management information system for GBV is still it its nascent stages. | safeguarding requirements. UNFPA will also seek to minimise the promotion of parallel referral pathways, and create stronger linkages between the initiatives introduced by the Sambodan project with existing GBVPR mechanisms. |
| **UK Department for International Development (DFID)** | **High** | DFID is supporting an Integrated Programme for Strengthening Security and Justice (IP-SSJ, 2015-20) in collaboration with UNOPS, ADB, CARE, VSO and previously also with UNICEF. Presently in preparation for their next phase, they are piloting tailored or targeted initiatives to influence social norms related to breaking the culture of silence around GBV or reporting of GBV incidences in formal and informal institutions. DFID also supports the MoHP in rolling out OCMCs across the country, though it does not include provision of case managers. | **Strengths:** The pilots are accompanied by the 'What Works to Prevent Violence against Women and Girls' research that is expected to conclude with models that work and inform programming of DFID's next phase. This provides strong opportunities to collaborate on knowledge building, particularly on GBVPR's planned operational research. | UNFPA will work closely with DFID and other development partners to discuss effective models for OCMC and collectively advocate with the MoHP on this, as well as, consult on methods of intervention to change social norms and for operational research on the same. DFID is also planning to establish regional knowledge hubs on GBV which provides a platform for UNFPA and the GBVPR project to share findings and knowledge from the project, while also learning from other players in the sector. |
| **Unites States Agency for International** | **Low** | The "Hamro Samman" Project (2017- 2021) is a five-year Counter Trafficking in Persons project (CTIP) implemented by Winrock | **Strengths:** One of its programme priorities is to reduce vulnerability to trafficking by expanding livelihood | Over the project's remaining year, the partnership with DFID will expand on Hamro Samman's past success by combining USAID's and DFID's |

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| **Development (USAID)** | | International with the support of USAID. Its goal is to reduce the prevalence of human trafficking in 10 strategically selected districts of Nepal in Province 3, 5 and 7. | options to survivors and at-risk populations through skill-building and employment opportunities. This could be an opportunity for livelihoods referral pathways for survivors in safe houses and OCMCs.<br><br>**Weaknesses:** Indirect link to the GBVPR project, which could minimise collaboration opportunities. | technical expertise to address human trafficking, specifically in the foreign labour migration process and entertainment sectors. |
| **UN Women** | **Low** | UN Women in Nepal focuses on peace and security, leadership and participation, economic empowerment, national planning and budgeting, and GBV. | **Strengths:** strong opportunities for collaboration with UN Women as a sister UN agency, particularly on advocacy and engagement with government at the federal level.<br><br>**Weaknesses:** UN Women does not implement dedicated projects in the area of GBV which limits some partnership opportunities. | UN Women's plan to convene a national GBV summit in Nepal provides an opportunity to engage with policy makers, donors and key stakeholders about the GBVPR Phase II project, and seek opportunities for collaboration and engagement in Provinces 1 and 7. Collaboration under the framework of Essential Services Package for Women and Girls Subject to Violence will be explored by UNFPA. |
| **UNICEF** | **Medium** | UNICEF, through funding from the EU, is implementing a nutrition project which, among other initiatives, will explore the opportunity to expand the role of female community health volunteers (FCHV) into both GBV screening and nutrition components. | **Strengths:** UNICEF's project is nationwide, which provides opportunities for working in common locations in Provinces 1 and 7. UNICEF is also open to collaboration on joint collaboration on working with FCHVs on nutrition and GBV screening and referrals.<br><br>**Weaknesses:** the nutrition project does not cover all GBVPR locations so there is limited overlap. However, where the two | UNFPA has engaged with UNICEF and donors for both projects to explore opportunities to collaborate on the expansion of the role of female community health volunteers into both GBV screening and nutrition components. This can help further leverage awareness raising and strengthening of referral pathways beyond our current collaboration with FCHVs. In addition, opportunities for further collaboration also extend to |

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| | | | projects do coincide, strong efforts for collaboration will be made to maximise on the opportunity. | data collection and analysis on links between GBV and Nutrition, as well as influencing Deputy Mayors and Nutrition committees on the GBV referral pathways and the importance of addressing GBV at LG levels. |

## 3. Problem Statement and Theory of Change

### 3.1 Problem Statement

There is high prevalence and acceptance of violence against women and girls in Nepal on account of social norms that value men and boys over women and girls; bestowing privileges to men and boys while denying equal opportunities to women and girls; and that vest the power and decision making with men and boys over women and girls. Under such social norms, wives are expected to be subservient to husbands and other members of their marital home, sons are preferred over daughters, property is transferred from fathers to sons (despite the country's equal property rights laws, in practice male heirs are still preferred), citizenship is largely passed on by fathers, brothers control the mobility of sisters and older mothers and grandmothers are often at the mercy of decisions made by their husbands, sons and brothers over matters concerning their lives. Women and girls' agency is constrained and assertions by women and girls are met with scorn and often harmful consequences for women. Violence against women and girls, be it emotional, physical, sexual or financial is borne from these social norms that dictate how men and boys need to control women and girls.

These social norms have created dominant and hegemonic social constructions of male sexual entitlement and masculinity, which then perpetuate violence against women and girls. From a very young age, male and female children learn about gender roles determined by these social norms--boys grow up with a sense of entitlement that is socially communicated to them and girls grow up with lower aspirations and self-esteem. Notwithstanding other intersectional identities, women across socio-economic categories, are treated as inferior to men, which translates into perceptions about their own worth, role and capacities. While liberal ideals of equality and justice are being progressively adopted in policy and legislation, these have been insufficient in changing gender and social norms. For women and girls, the consequences of resisting and attempting to subvert the imposition of gendered roles and expectations, include social boycott, stigmatization, harassment and physical or sexual violence. While men and boys who try to subvert social norms of masculinity are also met with scorn and often harmful consequences, they are relatively and proportionately less harmed.

These norms percolate every sphere of public and private life, and structural discrimination against women and girls is institutionalized (and manifested throughout) policies, legislation, programmes and institutions such as family, matrimony and governments. These manifestations include for instance, unequal pay for equal work, the shifting of women from their maternal homes to the homes of their husbands, greater employment of men in the formal sector than women, greater participation in decision-making and leadership roles in public life by men compared to women, and so on. For instance, the female labour force participation rate (LFPR) was only 26.3% compared to the male LFPR (53.8%)[13]. Ending violence against women and girls therefore requires changing the mind set and norms that discriminate

[13] Report on the Nepal Labour Force Survey 2017/18

against women and girls, and replacing them with liberal norms of equality and non-discrimination in the private and public sphere.

Challenging and shifting social norms requires changes through socio-economic and political structural interventions, and changes in behaviours among all people (men, women, boys and girls and gender non-confirming persons). Both are interlinked: structural change is possible when decision-makers overcome their own limited perceptions of gendered roles and discrimination and make decisions on policies, legislation and programmes that promote gender equality. Likewise, individuals can be required to change behaviours by policies. However, social norms, especially traditional ones that have gone unquestioned for a long time are internalized, and behaviours of individuals may change superficially at best through changes in structures. For real change to happen, positive behaviours and attitudes need to be internalized and for internalization, conversations and reflections with individuals and groups (since norms are of a collective) are important.

For this reason, any programme that aims to end discrimination and violence against women and girls needs to address social norms, facilitate critical reflection on existing social norms and liberal values, and create spaces for newer norms to be established. For instance, in order for violence against women and girls to stop, the norm that it is acceptable and even desirable for men and boys to be physically aggressive towards women needs to be challenged. Men and boys, women and girls both will need to reflect on why this norm is harmful and wrongs women and girls. Bystanders will need to reflect on why it is wrong for them to condone this behaviour. And service providers will need to reflect on why it is wrong for them to lecture women on being obedient wives. The norms need to shift from, for instance, “violence by man over woman is acceptable” and “women and girls need to be subservient”, to “violence is not acceptable” and “violators need to stop”.

### 3.2 Gaps to be addressed

Some of the gaps identified at the start of Phase I of GBVPR in 2016 have been addressed while others remain and newer ones have emerged. New insights on NGO capacities to change social norms and newer capacity gaps in the changed context of governance in Nepal have emerged. Given below is a brief description of the gaps from before Phase I and the current situation.

i. **Lack of awareness among women and girls on women’s rights:** To some extent, this gap has been addressed in project locations where interventions have been carried out in the communities with women’s cooperatives and girls’ groups. Among these groups there is an increased awareness on women’s rights but this has not been enough to either change social norms or reduce violence against women and girls. There is still ***limited critical understanding of root causes of GBV and reflection on personal beliefs and values***. One important lesson learnt from Phase I has been that even where communities may be “aware” of women’s rights, women and girls, men and boys continue to hold patriarchal notions of women and men’s position in home and the society. For such notions to change, deep introspection and reflection is required at individual, family and societal level, which will be the focus of Phase II

ii. **Men are not sufficiently engaged:** In Phase I, the project ***did not manage to sufficiently engage with men due to limited capacities of implementing partners on this issue***. Pilots have been introduced with engaging boys, towards end of Phase I. Results will feed into next phase**.** UNFPA has been studying and exploring different approaches of engaging with men and boys and will identify experienced IPs for engaging with men and boys in Phase II.

iii. **Ability and capacity of I/NGOs (implementing partners) to facilitate social norm change:** experience from Phase I, including recent pilots, has confirmed that there is a dearth of availability of skilled facilitators among existing implementing partners for this task. They tend to rely on external gender (consultant) experts and master trainers who tend to be from privileged backgrounds and are too few to be able to transfer their skills to a large number of community mobilisers. And often, experts and trainers struggle to contextualize their knowledge in underprivileged, marginalised communities, and they lack skills for transferring knowledge and facilitation skills to those that come from a background with lesser education and experience than them.

A related challenge that is now better understood is that interventions to build capacities of IPs and their staff (ToT-Training of Trainers) and through them for community facilitators and CBOs tend to be limited to one-off events (e.g., for 5 days, 12-days, or 3 weeks training) without any follow up with mentoring/coaching. Also, very few men have been trained as community facilitators on gender transformation for men's groups. Finally, trainings on gender have tended to focus more on theoretical underpinnings of gender inequality and human rights than on facilitating reflections on personal values and beliefs and promoting new ways of thinking and behaving in our personal lives. Trainings have been useful in mobilising and shaping community leaders on various aspects but few on changing gender/social norms and behaviours.

To address these gaps, in Phase II the project will identify NGOs or private sector companies with better experience and skills in facilitating social norm change and ensure the selection of facilitators (master trainers as well as community facilitators) who have themselves undergone gender transformative trainings. Facilitator IP (implementing partner) selection will also include criteria such as diverse representation from different groups, and experience and ability to facilitate complex reflections among those with less experience in formal education and learning processes. UNFPA will centrally manage and provide quality control for the development of content and methodology and implementation of training programmes—across thematic areas of prevention, response, and across project locations. In this way consistency and quality of training will be ensured.

iv. **Very few Women's Cooperatives have GBV Watch groups:** This approach was dropped after the mid-term review due to ineffective modality**.** UNFPA plans to work with different types of existing or new Community Based Organisations (CBOs) of women and men, boys and girls in Phase II. They have varying exposure to examining issues of GBV and ***CBOs have low capacities in addressing GBV.*** In Phase II, UNFPA will work intensively with these groups to build their understanding and capacities to intervene.

v. **Limited psychosocial support is available for survivors of GBV:** In all project locations of phase I, interventions focused on building psychosocial support capacity at community level and in the case of Province 1, CPSWs have been institutionalised with the local governments in cost-share modality with the project. In Province 7, ***there is still limited availability of psychosocial support*** and UNFPA will advocate with local governments (LG) in selected locations for adopting the successful model from Province 1. There is need to continue to provide technical support to LG for full institutionalisation even in Province 1, and to now assess the impact of CPSWs on GBV survivors and the uptake of services.

vi. **Inadequate (response) services for GBV survivors (Shelters and OCMCs):** When Phase I was designed**,** there were no OCMCs and shelters in the selected districts. With the help of the GBVPR project now, at least in Province 1 locations, there are functioning OCMCs with case managers and outreach counsellors. Both Province 1 and 7 have 1 shelter per district staffed by trained personnel, with 1 referral hospital in the region (Province 7) and one in Kathmandu (serving Province 1) that are now linked with the short stay shelter homes. There is growing contribution from local governments to support shelter homes though it is a long way from full financial support to allow UNFPA to exit.

vii. **Access to OCMCs and shelters still remains an issue:** While there is a general improvement in the access to services for survivors of GBV; more hospitals establishing the One-Stop Crisis Management Centres; increase in number of women and children service centres in police stations; and more NGOs and governments establishing shelter homes, these numbers are far below the requirement in Nepal. In her recent visit to Nepal, the UN Special Rapporteur on Violence Against Women expressed concern over the "dire shortage of adequate shelters across the country", limited support provided to the shelters that are in place and "the lack of effective coordination between mechanisms" on violence against women[14]. Short term shelter homes are typically unable to support women in building financial resilience through facilitating vocational training/employment. Most women do not prefer to go to referral shelters that are far away, and in the absence of viable alternatives have to return home.

    Not all OCMCs in current or new locations have adequate and trained staff. Staffing at OCMCs supported in Phase I is co-funded by the project, with the government funding only the salaries of the staff nurses while the project funds 2 key positions: the case manager and the outreach counsellors. This co-funding structure will likely continue until the Ministry of Health and Population (MoHP) secures funds to take over these costs, though it has expressed high interest. Advocacy with Government partners for cost-sharing of such activities is therefore a key priority in Phase II. There is need to develop a critical understanding of GBV issues among all service providers so that their own patriarchal biases and values do not influence their service provision. Therefore, all service providers need training in gender-transformative and survivor-centered responses. Coordination among service providers is limited to referrals and there is need to build capacities in coordinated response.

[14] Visit to Nepal: Report of the Special Rapporteur on violence against women, its causes and consequences. Human Rights Council Forty-first session, 24 June–12 July 2019, Agenda item 3, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development.

viii. **Weak implementation of laws and policies; lack of gender sensitivity by police and lawyers:** this remains a concern, although there seems to be greater reporting of cases of domestic violence. However, at all service provider levels, including with judicial committees, ***most cases are still mediated for reconciliation*** by the police instead of being referred through the legal system. There have been several trainings conducted by the Nepal Police Academy with the support of DFID and its partners, and also under GBVPR. In project locations, regular engagement with police through one-stop service coordination has improved police coordination and referral. It remains to be assessed whether trainings have resulted in more sensitive handling of cases. The project will continue to link police with existing trainings and include them in multi-sectoral dialogue in Phase II.

ix. **Coordination in districts is weak and limited resources are under-utilized:** coordination efforts had improved at the district level with the intervention of the project, specifically through the District Coordination Committees (DCC). However, in the changed context, ***new mechanisms for coordination are still evolving***. There are also ***no protocols to guide multisectoral coordinated responses*** which is a requirement by international standards. Nonetheless, individual service providers report that there is improvement in communication, referral and coordination between different services**.** Multi-sectoral coordinated responses require inter-governmental cooperation, horizontal and vertical, in the changed context. Guidelines for such mechanisms are not yet developed and different levels of government in different locations have differing opinions on what mechanisms should be put in place. This poses a challenge for the provision of coordinated services (medical, psycho-social, police, security, legal, shelter, and skills training) for survivors**.** The Project will collaborate with all levels of governments and facilitate multi-sectoral coordination in the spirit of the constitution and support development of protocols and guidelines as per international standards. The project's Provincial Gender Coordinators in each Province, and the District level staff will have a key role in this coordination, as well as using the project oversight structures such as the Provincial Project Steering Committees (PPSC) and Project management Committees (PMCs) as entry points for collaboration.

x. **The capacity of Women and Children Officers (WCOs) at the districts is not adequate to meet the demands of their mandate***:* the project invested in building capacities of WCOs but their mandate has now changed with their integration in local and provincial governments. WCOs are no longer reporting to the MoWCSC but to the local and provincial governments, where they are placed within the broader "social development" sub-sector. They receive their mandates from these respective governments, generally serving as the focal persons on all things related to women and/or gender. Hence, they continue to be relevant for the project but they do not feel well integrated in their new roles, and many have lost contact with MoWCSC. There is also a sense of feeling undermined and not having clear roles and power. The project will continue to support WCOs as part of support to local and provincial governments in Outcome 3 activities and the social development sections where the WCOs are now placed.

xi. **New gap - confusion on the roles of different levels of government in drafting laws and policies:** some local and provincial governments aspire to establish their own laws while also being concerned about lack of capacities for the same. The devolution of powers provides a unique opportunity for

drafting of policies and laws in a bottom up manner, but in the absence of concerted technical support, policies and laws are at risk of dilution.

xii. **New gap - local governments have varying levels of capacities and understanding** on how to address gender equality and GBV. In the devolved structure of governance, the primary responsibility for providing services lies with the local governments. While they demonstrate great enthusiasm for taking action in these areas, and in project locations of GBVPR some have also cost-shared CPSW and shelter services with the project, LGs report low technical and financial capacities for addressing gender inequalities and GBV. Deputy mayors are mandated to lead the Judicial Committees as well as lead the social development division where all social sectors have been put under one umbrella but not all of them have the technical capacities in these areas. Moreover, most elected women representatives are undermined by their male colleagues. In the project locations of GBVPR, UNFPA has been working closely with local governments to strengthen their understanding on gender inequality as well as policy, programmes and budgets on prevention and response to GBV.

    In provinces and municipalities where there are very few interventions on gender-based violence the understanding and provisioning of services is even lower. At the provincial level as well, there is growing interest and political will for addressing gender-based discrimination and violence, and similar to local governments, there is expressed need for technical support in designing appropriate programmes and guidelines for services. At the federal level, MoWCSC has expressed the need for technical assistance in drafting their national policy framework, and the MoHP acknowledge the impact of OCMC models developed with the assistance of UNFPA and the project, and has expressed interest in expanding the model nationwide.

### 3.3 Lessons Learnt from Phase I and Rationale for Phase II

Since 2016, the project has implemented GBV Prevention and Response projects in 9 municipalities[15] across Province 1 and 3 (previously categorised as 3 districts) with the support of SDC, and in 8 municipalities[16] in Province 7 (previously categorised as 4 districts). Taking the One Stop Crisis Management Centres (OCMCs) at district hospitals as the centre of service coordination, the project targeted health workers, psychosocial counsellors, police and justice sector officials, and safe houses, in order to ensure a minimum standard of services and effective coordination between them. A Mid-Term Review of the SDC supported project concluded that the GBVPR has been successful in introducing a multi-sectoral response model with trained service providers which has led to increased service seeking behaviour among survivors of GBV. In particular, the introduction of community-based psychosocial workers for outreach and psychosocial 'first aid' and referral at community level has led to a significant increase in service seeking behaviour among women in the target communities.

[15] Mangalsen, Kamalbazar, Sanfebagar, Patan, Dasrathchand, Jaya Prithvi, Bitthadhchir, Budhimalika and Budhiganga municipalities

[16] Sidhicharan, Manebhanjyang, Molung, Chisankhugadhi, Katari, Triyuga, Chaudandhigadhi and Belaka municipalities

On the prevention side, however, the MTR found room for improvement. The GBV Prevention and Response project took several community-level approaches – including 'couple's trainings' aimed at speaking with men and women together to help them build better and more harmonious communication and conflict resolution strategies in the home. The MTR found that this approach should be reviewed: due to a number of factors including high outmigration, many of the couples trained were either elderly, or not 'couples' but rather men and women from the same household. More seriously, although the trained couples spoke positively about the training, the MTR raised questions about whether the facilitators were in fact promoting a 'social harmony' approach rather than a 'justice and equality' approach, whereby social harmony is maintained by teaching women to obey and fit traditional social roles/models, rather than by promoting greater equality at household level. This illustrated the extent to which unrecognized biases (e.g. among facilitators, community leaders etc.) may solidify traditional norms rather than encourage new thinking and reflection.

The MTR recommended that the project should seek to institutionalise the response mechanisms with the newly formed local governments and; on the prevention side, for sustained change to take root at both community and decision-making levels, more time and a strong focus on primary prevention, through changing social norms was required. Accordingly, UNFPA began the process of advocating with local governments and by the last year of the project, there has been significant success in advocacy with local governments to institutionalise the response mechanism: all 10 participating local governments in Province 1 and 3 made related commitments and budget allocations in their annual plans and budgets. Costs for the salaries of CPSW trained under the project and for partial costs of shelters are now co-shared by the project and the local government. Since mid-2018, at the behest of the elected local representatives, the GBVPR project has also provided technical assistance to local governments to expand their understanding on gender equality and support them in gender responsive planning and budgeting.

Similarly, the NOR-funded project has achieved significant results, particularly as concerns increase in service-seeking and reporting and prospects for cost-sharing with local governments appear promising. It is expected that the results of such interventions will begin to emerge in the plans and budgets developed by local governments in the FY 2019-2020 and that improvements in abilities, plans and budgets will be incremental. Phase II of the project will continue to monitor this actively. Local government will require continued technical support as they build their program, gradually expanding their understanding and strengthening interventions, both for prevention and response. A needs assessment carried out by the GBVPR project in 2019 indicated that while advocacy with and capacity building of elected representatives at the municipality level was being requested and appreciated, there is also need to strengthen capacities at the even smaller administrative units, the wards, that are closer to the communities. In Phase II therefore, the project will also include wards in interventions to strengthen capacities at the municipalities, as well as work with governments at the provincial and federal level.

Another follow up to the MTR recommendations was the drafting of a working strategy on prevention of GBV and a set of approaches are being piloted during the cost extension period of the project (July 2019-June 2020), accompanied by a rigorous learning component. Based on the lessons learned from all the pilots, a more comprehensive prevention strategy is expected to emerge and will inform strategies in the proposed second phase.

The first phase was marked by several changes in direction, in part due to changes in governance and implication for the project implementation strategy, as well as in part informed by a timely mid-term review that suggested course correction. In effect, the project has gradually been able to roll out all of its components and results are just emerging. This is the time for continued efforts to sustain emerging results, to learn from pilots and expand a comprehensive model of response *and* prevention, saturating entire communities through a whole-community approach and making more sustainable shifts in both the minds and behaviours of individuals as well as in governance and quality of response services. The preparedness of UNFPA in taking forward a phase II is complemented by the high level of willingness and interest expressed by local governments as is evident from the institutionalisation of the response mechanism. In the course of the MTR as well as subsequent interactions with the elected representatives, including with provincial and federal governments during the mission for development of this programme document (ProDoc), the need for support has been explicitly expressed.

The design of Phase II is built on lessons from Phase I and will continue to evolve as results of the pilots in Phase I emerge, as well as pilots simultaneously being tested by other development partners. It will retain the dual focus of i) primary prevention and ii) providing accessible survivor-centred and coordinated response, focussing on psychosocial healing of survivors, are backed by research and evidence. A key concern is stopping violence before it occurs; in addition, a compassionate and competent response is seen to improve reporting and help seeking, preventing repeat violations; and ensuring a life of dignity for survivors. Ongoing interventions have witnessed a dramatic increase in reporting and help-seeking behaviour among victims/survivors, demonstrating that services and support must be in place before women are willing to report or seek help

### 3.4 Theory of Change

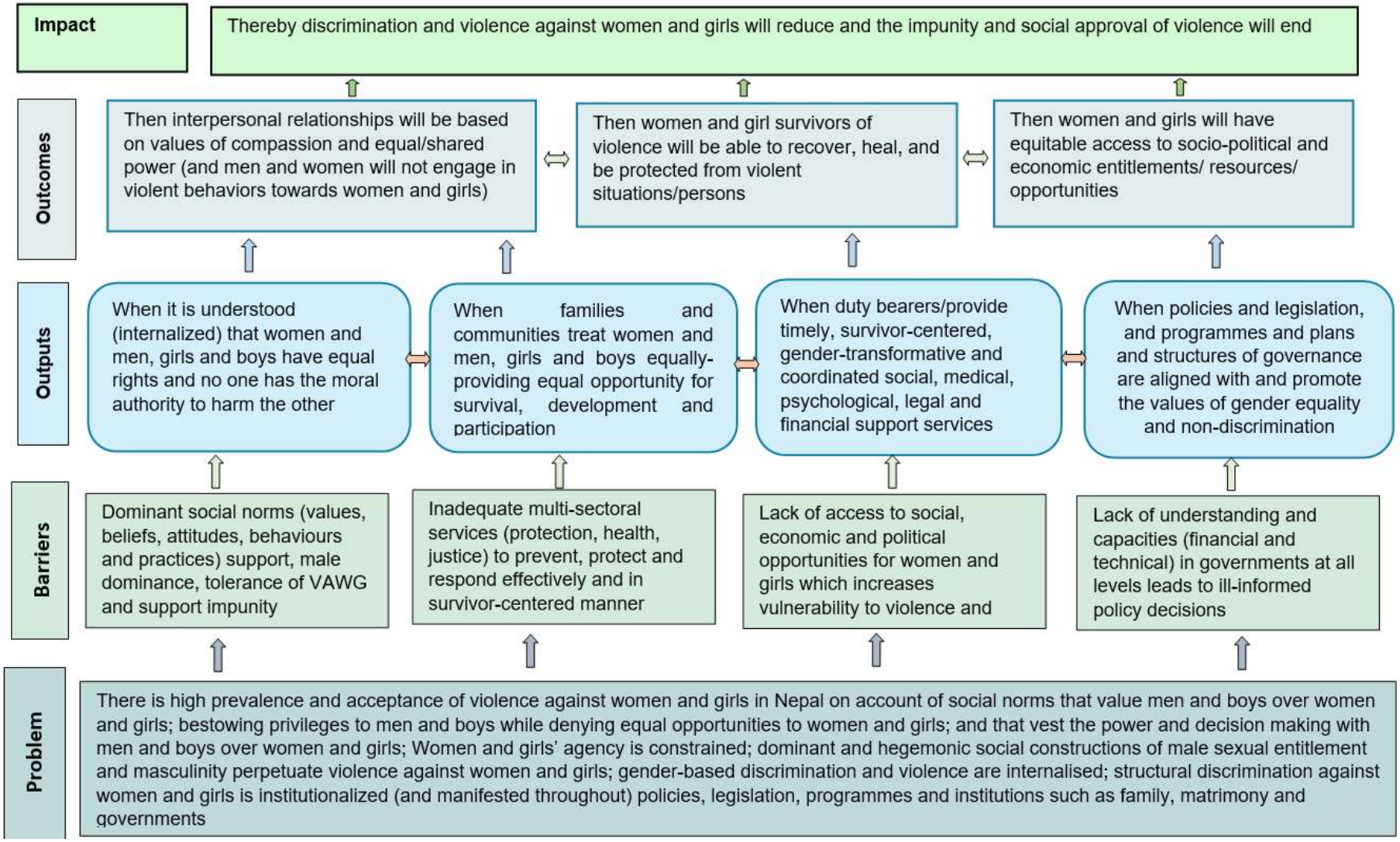
This (working) Theory of Change is based on growing evidence from the experience of a range of actors delivering programmes and services addressing violence against women and girls, including development partners, women's rights organisations and other NGOs. It is also inspired by the UN framework for action to prevent violence against women (2015) and a recently launched framework for preventing violence against women and girls called RESPECT[17]. The RESPECT framework suggests that successful prevention requires political commitment and leadership; implementing laws and policies that promote gender equality; investing in women's organizations; and allocating resources to prevention. It also requires addressing the multiple forms of discrimination faced by women. See section 4.2 for how Phase II will adopt pathways recommended in the RESPECT framework.

The Theory of Change states that when it is understood (and internalized) that women and men, girls and boys have equal rights, and no one has the moral authority to harm the other; and when families and communities treat women and men, girls and boys equally; providing equal opportunity for survival, development and participation; then interpersonal relationships will be based on values of compassion

[17] RESPECT women: Preventing violence against women. Geneva: World Health Organization; 2019 (WHO/RHR/18.19).

and equal/shared power (and men and women will not engage in violent behaviours towards women and girls). When duty bearers/service providers provide timely, gender-transformative, coordinated and survivor-centered social, medical, psychological, legal and financial support, then women and girls survivors of violence will be able to recover, heal, and be protected from violent situations/persons. When policies and legislation, programmes, plans and structures of governance are aligned with, and promote the values of gender equality and non-discrimination, then women and girls will have equitable access to socio-political and economic entitlements/resources/opportunities. When all these 3 conditions are met, then discrimination and violence against women and girls, social approval of discrimination and violence and perpetrator impunity will end.

***Figure 1: Theory of Change***



## 4. Proposed Interventions and Strategies

### 4.1 Levels of Interventions

The intervention strategies of the project, that is, its action areas, are derived from a joint UN Framework-RESPECT. These actions will be implemented at 3 levels, micro, meso and macro and the philosophy, methodology and content of interventions will be guided by established *approaches*, including REFLECT Methodology; Gender Transformative Approach and Survivor-Centered Approach. These approaches are the core of all interventions and will be uniformly applied across intervention areas and target groups: with rights holders, as well as with duty bearers-both service providers and policy makers. The following table summarises the what, how and with whom, followed by brief description of the strategies and approaches listed.

***Table 3: Outline of Interventions and Strategies***

| | |
|---|---|
| **What**<br><br>(Strategy) | **RESPECT Framework:**<br><br>• **R**elationship skills strengthening<br>• **E**mpowerment of women<br>• **S**ervices ensured<br>• **P**overty reduced<br>• **E**nvironments made safe<br>• **C**hild/adolescent abuse prevented<br>• **T**ransformed attitudes, beliefs and norms |
| **How**<br><br>(Approach) | **Through:**<br><br>• **REFLECT** participatory learning methods<br>• That have **Gender Transformative** content<br>• Are provided in an **Iterative** manner<br>• Services that are **survivor-centered**<br>• And **coordinated** across multiple-sectors |
| **Who**<br><br>(Intervention) | **With:**<br>• Community-wide (rights holders and all duty bearers in selected locations)<br>• Specific approach on working with men and boys |

***At the micro level:*** the project will mobilize existing (or new[18]) groups of women, men, adolescent boys and girls for group education following gender transformative and iterative capacity building approaches (see below for description of the approaches). While men and women will participate in group education in the community setting, adolescent boys and girls will participate through after-school and community-

[18] The project aims to mobilise existing groups as far as possible and only create new ones where groups are not yet formed.

based interventions. In addition, men, women, boys and girls will participate in family dialogues and in community campaigns to end gender-based discrimination and violence against women and girls. Religious leaders will be mobilised to reflect on harmful practices and campaign for promotion of egalitarian norms and violence free families and communities. The focus of interventions at the micro level is primarily to facilitate change in perspective, understanding and behaviour among men, women, boys and girls through critical self-reflection and mobilization of peer groups. A key strategy would be to "saturate" communities, reach out to largest number of people across cohorts, through different entry points—the community, family, schools, health facilities and local governments.

***At the meso level:*** the project will enhance survivor centered and multisectoral coordinated response along the referral pathway for GBV survivors. The project will continue to improve access to existing government and NGO run services as well as quality of services by supporting human resources required to provide comprehensive services. This will include complementing existing staff provision where limited and in cost-sharing with governments, training of all staff and their managers on gender transformative, survivor centered and multi-sectoral coordinated responses as per international guidelines. Specifically, the project will continue to provide case managers at OCMCs to provide one-stop service to survivors and outreach counselors with the mandate to provide outreach services. Similarly, based on the promising practice that emerged in Phase I, the project will provide community-based psychosocial workers in each of the project wards with the mandate to provide front line psychosocial service and referral to survivors, on a cost-sharing basis with local governments. UNFPA, in collaboration with other development partners, will advocate with governments for full inclusion of these personnel as regular staff.

***At the macro level:*** the project will intervene to strengthen the policy framework that will enable prevention and effective response to GBV. The project will support governments at different levels to review and strengthen guidelines for the different response services and for their multi-sectoral coordination, as well as promote horizontal and vertical policy dialogue between governments. In the spirit of the 3Cs of the Constitution of Nepal (co-existence, co-operation and co-ordination), the project will provide technical assistance to local governments to develop protocols for effective multi-sectoral coordination and response. Based on promising practices from Phase I, UNFPA will advocate with different tiers of the government for the institutionalization of adequate staff for OCMCs and community based psychosocial workers, as well as for adequate and well-functioning shelter homes. The constitution has provisions for intergovernmental coordination, however they still need to unfold in practice and UNFPA will continue to collaborate with all the tiers of government and support their evolving mechanisms[19]. An advocacy strategy will be developed during the inception phase for a) disseminating messages regarding GBV and gender equality, b) upscaling GBV services (MoWCSC) and c) policy development, covering the key actors that need to be mobilized.

[19] One such mechanism could be the provincial coordination council which includes representation from provincial and local governments.

### 4.2 Strategic Framework

**RESPECT**—the joint UN framework for preventing violence against women and girls which recommends 7 concurrent pathways to prevention and response: R - Relationship skills strengthened, E - Empowerment of women, S - Services ensured, P - Poverty reduced, E - Environments made safe, C - Child and adolescent abuse prevented and T - Transformed attitudes, beliefs and norms. The RESPECT framework suggests that successful prevention requires political commitment and leadership; implementing laws and policies that promote gender equality; investing in women's organizations; and allocating resources to prevention. It also requires addressing the multiple forms of discrimination faced by women. The following table illustrates how each of the 7 strategies will be applied at the micro level- level of individuals, their social networks such as family, CBO and peer groups; at the meso level- level of response services, and macro level- level of policy making:

***Table 4: Application of RESPECT strategies in the project***

| Areas of Interventions | | | |
|---|---|---|---|
| **Strategies (RESPECT)** | **Micro Level**<br>**Outcome 1** | **Meso Level**<br>**Outcome 2** | **Macro Level**<br>**Outcome 3** |
| **R – Relationship skills strengthened: This refers to strategies to improve skills in interpersonal communication, conflict management and shared decision-making.** | • Iterative gender transformative group-based workshops (sustained engagement) with men and women, boys and girls, including mixed gender groups<br>• Iterative family dialogues (sustained engagement)<br>• Iterative sessions with couples | Gender transformative counselling to survivors and perpetrators (and their families) – at shelters, OCMC and through CPSW | N/A |
| **E – Empowerment of women:**<br>**This refers to economic and social empowerment strategies including those that build skills in self-efficacy, assertiveness, negotiation, and self-confidence.** | • Social empowerment through mobilisation of women and girls' groups in communities as a support network (sustained engagement)<br>• Social and financial skills education and sustained engagement for girls (Rupantaran) | • Linking women survivors at shelter homes with existing economic empowerment initiatives (vocational training, income generating projects etc.) of government and other development partners for economic self-reliance<br>• Linking girls with existing skills and employment development funded by government and | Through capacity support to local governments in making policies and plans to promote gender equality and for budget allocation for gender equality and women's empowerment, including the promotion of Gender Responsive Budgeting (GRB) tools |

| | | | |
|---|---|---|---|
| | | development partners (SDC/NOR) | |
| **S – Services ensured: This refers to a range of services including health, police, legal, and social services for survivors of violence.** | N/A | Building capacities of service providers/governments to provide survivor-centred, multi sectoral response through referral network of community-based psychosocial workers, shelters, one-stop crisis management centres, police and formal and informal justice systems | N/A |
| **P – Poverty reduced: This refers to strategies targeted to women or the household, whose primary aim is to alleviate poverty.** | N/A | N/A | • Capacity support to governments for appropriate policy design<br>• Linking women survivors with existing skills and vocational training<br>• Linking adolescent girls and boys with career counselling and existing skills and vocational training |
| **E – Environments made safe: This refers to efforts to create safe schools, public spaces and work environments, among others.** | Promoting bystander intervention through group workshops | Support to service providers in ensuring safety for survivors | Support to governments for initiatives on safe municipalities |
| **C – Child and adolescent abuse prevented: This includes strategies that establish nurturing family relationships.** | Iterative family dialogues | N/A | N/A |

| | | | |
|---|---|---|---|
| **T – Transformed attitudes, beliefs and norms:**<br>**This refers to strategies that challenge harmful gender attitudes, beliefs, norms and stereotypes.** | • Iterative gender transformative group-based workshops with men and women, boys and girls, including mixed gender groups (sustained engagement)<br>• Mobilising Opinion Leaders (including religious, community and other influential leaders) | • Iterative gender transformative group-based workshops with service providers (sustained engagement) | Iterative gender transformative group-based workshops with elected representatives (sustained engagement) |

### 4.3 Approaches

i. **REFLECT**[20] is a participatory learning **method** of facilitating group learning and action and will be applied to all group education interventions with men, women, boys and girls. It was originally developed by ActionAid in the early 90s to support adult literacy and has since been adapted and applied in different programmes across the world, such as SASA! and Promundo. It has also been adapted and applied by various organisations in Nepal, including for changing social norms around gender by organisations such as CARE, ActionAid and UNFPAs partners such as WOREC. Under this approach, groups of learners, are convened to learn about new concepts through participatory methods such as games, role plays, discussions and critically analyse different aspects of their own lives. These become the basis for a process of learning new words, gaining awareness of what causes underlying problems, and identifying action points and taking them forward. Reflect involves a continual cycle of reflection and action, neither are taken in isolation. The focus of this approach is on methods of learning and it can be applied to any content, including gender, citizenship, land rights, human rights, local level development planning and so on.

ii. **Gender Transformative Approach (GTA)** provides content and tools explicitly concerned with transforming understanding, attitudes and behaviours specifically related to gender. While the method for conducting group-education is guided by the REFLECT methodology, the content for group education for rights holders and duty bearers on gender will be guided by a gender-transformative approach where participants- rights holders as well as duty bearer's improve their understanding on root causes of inequalities and are enabled to intervene to transform gender roles, norms and power relations in their own personal lives, in the way in which service providers deliver (communicate) services and in the way in which policies, standards, plans and budgets are drafted and executed. It is based on the understanding that men and women both hold traditional views of hegemonic masculinities, femininities, and internalized values of oppressing and being oppressed, respectively and that unless these views are critically examined, they cannot progress towards gender equality.

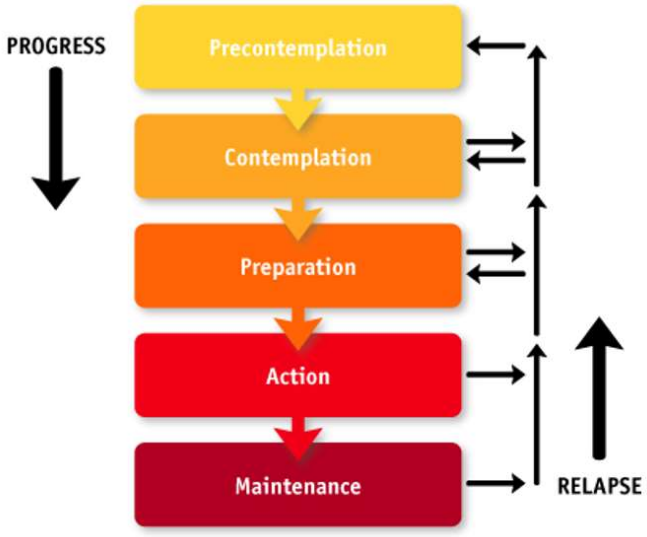
   A gender-transformative approach facilitates men and women (and boys and girls and non-binary individuals) to critically examine these views and values. It promotes the examination of inequalities and gender roles, norms and dynamics by recognizing and strengthening positive norms that support

20 Download available from https://www.actionaid.org.uk/sites/default/files/doc_lib/190_1_reflect_full.pdf

equality and build an enabling environment, promotes the relative position of women, girls and marginalized groups, and transforms the underlying social structures, policies and broadly held social norms that perpetuate and legitimize gender inequalities[21]. This kind of content is expected to change perceptions, attitudes and, in the long term, behaviours of individuals—rights holders as well as duty bearers. The GTA will be a common thread across all interventions in Phase II and will be applied in all the models, guidelines, training modules, methodologies, critical reflection sessions with rights holders and duty bearers and technical assistance. A resource on the Gender Transformative Approach, including materials, methodology and a pool of master trainers derived from training institutions will drive this approach throughout the project.

iii. **Iterative approach to building capacities:** For most individuals, behaviour change occurs gradually with the person progressing from being uninterested, unaware, or unwilling to make a change (pre-contemplation), to considering a change (contemplation), to deciding and preparing to make a change (preparation). This is followed by definitive action, and attempts to maintain the new behaviour over time (maintenance). People can progress in both directions in the stages of change. Most people will "recycle" through the stages of change several times before the change becomes fully established. For this kind of change to happen, sustained investments over time are required. Through a pre-determined sequence of iterative trainings, individuals and groups of community women, men, girls and boys will be able to reflect and deliberate collectively on social norms, analyse barriers to change and make action plans for shared commitments on what beliefs and practices need to be changed for imbibing sustainable norms change.

*Figure 2: Stages of change Model*




*Source: Adapted from DiClimente and Prochaska, 1998*

Lessons learnt from Phase I suggest that where capacity building has been sustained, results were far more effective in transforming perspectives and behaviours than a once-off, 10-day workshop for female community leaders who were expected to facilitate norm change. Sustained activities included a 10-day training sessions followed by regular mentoring/coaching and supervision throughout the project period (e.g. CPSWs) and engaging girls in learning and discussions once per week, for a whole year (Rupantaran). Based on the understanding of what it takes to change behaviour and lessons from Phase I, UNFPA will promote the gender transformative approach through iterative capacity building of rights-holders as well as service providers and elected representatives. Iterative capacity building relies on skilled facilitators and there is a dearth of master trainers on the gender transformative approach in Nepal, which has negatively affected the quality

21 From UNFPA, UNICEF and UN Women's joint technical note on gender-transformative approaches in the global programme to end child marriage. Phase II: a summary for practitioners

of training and facilitation at the community level. Accordingly, in Phase II, iterative training will be used for developing a pool of master trainers (selected at institutional rather than individual level) who would then provide iterative training and mentoring to community-based facilitators and trainers of service providers.

iv. **Survivor-Centered Responses:** Survivor-centered approaches place the rights, needs and desires of women and girl survivors at the centre of service delivery. This requires consideration of the multiple needs of survivors, the various risks and vulnerabilities, the impact of decisions and actions taken, and ensures that services are tailored to the unique requirements of each individual woman and girl[22]. The approach ensures that the burden of identifying and accessing services is not on the survivors, that survivors' needs and wishes are respected by all service providers and that she is provided with timely and quality services in a safe, confidential and non -judgmental manner. At each step in the referral pathway, the survivor should be supported with information and in making a plan for their safety (skills, negotiation, who to reach for intervention/support, etc.). At each stage, all service providers should adopt a gender transformative approach and offer encouragement, empathy and respect her wishes and needs.

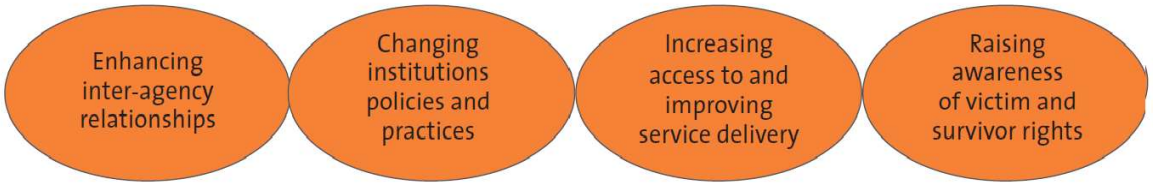
   Service providers are also required to interact with survivors in ways that increase their power in personal, interpersonal and social arenas (service provider as facilitator, survivor as decision-maker). In Phase I, UNFPA has been successful in creating greater access to services, establishing referral pathways and enabling service providers to provide multiple services to survivors. While the survivor-centered response was a guiding principle in Phase I as well, embedding it was challenging given the various biases and pressures that influenced service providers. For this reason, in Phase II UNFPA will work with all levels of governments and all service providers to deepen their understanding on the delivery of the survivor-centered response as elaborated in the UN Essential Services Package for Women and Girls Subject to Violence (UN ESP).

v. **Multi-sectoral Coordinated Responses:** Given that the needs of survivors are multiple (shelter, psychosocial, medical, legal, financial, etc.) and that these needs fall under the mandate of different agencies, a prerequisite of the survivor-centered approach is a multisectoral response, as opposed to individual needs being met in silos by different agencies, often with different perspectives and messaging. A multisectoral coordinated response is recommended by international standards to ensure that the response to violence against women and girls is comprehensive, multidisciplinary, coordinated, systematic and sustained – see Figure 2 below.

***Figure 3: Common Components of a Coordinated Response[23]***

[22] Essential Services Package Module 1

[23] Essential Services Package Module 5




Multisectoral responses need to be geared towards restoring dignity to survivors and improving her sense of self-efficacy and hopefulness. It is a process that is governed by laws and policies and involves a collaborative effort by multi-disciplinary teams, personnel and institutions from relevant sectors to implement laws, policies, protocols and agreements, while communicating and collaborating to prevent and respond to violence against women and girls. In Phase I, prior to the adoption of federalism in Nepal, UNFPA facilitated multi-sectoral coordination at the local level through the District Coordination Committees. In the new governance structure, new mechanisms for coordination are evolving and UNFPA will work with these mechanisms to develop protocols as per UN ESP and build common perspectives and capacities so that survivors receive a coordinated and survivor centered response.

vi. **Whole Community Approach:** This means, all people and all services and governments in target locations will be covered by one intervention or another related to the project objectives. So for instance, in a selected ward and its selected population, men, women, boys and girls will be reached out through group education and/or family dialogue; service providers catering to the selected population, such as all health facilities, shelters, justice sector, schools will be reached out through capacity strengthening interventions and all relevant government offices such as ward offices and *Palika* will be reached out through policy dialogues and interventions to strengthen systems, mechanisms and policies. This approach is based on an understanding that no single intervention, however powerful, can eliminate violence against girls and women, and that change needs to happen at the individual, relationship, community and societal levels. This socio-ecological understanding of GBV views interpersonal violence as the outcome of interaction among all the four levels. While UNFPA attempted to address all 4 levels in Phase I, integration efforts required strengthening. Based on lessons learned from Phase I and global evidence, in Phase II UNFPA will adopt a "whole community" approach: at the relationship level (through interventions with families and in afterschool activities); at the community level (through promoting social networks and services) and at the societal level (through promotion of laws, policies, plans). The whole community approach is expected to "saturate" communities in a way that higher numbers of rights holders and duty bearers in a community are reached through one or more interventions. This will achieve complementarity among all interventions for women and men, girls and boys and interventions for service providers (health and psychosocial, shelter, legal/police, local governments) and elected representatives of the community.

vii. **Working with men and boys:** A key component of whole-community approach in phase II will be working with men and boys who have been traditionally excluded in interventions to end violence against women and girls, despite evidence that men and boys form the large majority of perpetrators of this violence. In Phase II, UNFPA will deepen engagement with men and boys to facilitate change in their attitudes and behaviours through critical reflection group education to prevent them from violating women and girls and to encourage them to take actions to address GBV in the community. UNFPA will not engage men and boys in isolation but as part of whole-community approach. According to an assessment conducted by UNDP, GBV programmes in Nepal have made substantial progress in providing a coordinated response to GBV victims, however, most prevention efforts have not actively employed gender transformative programming approaches including those designed to target men.

Phase I interventions also faced challenges with engaging men and boys, in part due to lack of experience among implementing partners on working with men and boys. Towards the end of Phase I, the project has piloted interventions with young boys that focus on critical reflection on hegemonic notions of masculinities and the results are promising. Simultaneously, other development partners have piloted similar interventions with men and found varying degrees of success. CARE in Nepal for instance has described its model of engaging men (and women) as "synchronisation" (see figure)[24]. Based on these evolving models, the project will focus on engaging men and boys through transformative group education in communities and schools respectively, as well as through facilitated dialogues among family members. Elected men representatives as well as men in service provision (doctors, health workers, police, lawyers, etc.) will be engaged in transformative group education through iterative trainings to critically reflect on their own notions and values on gender inequality and GBV, change their perspectives and consequently transform the way in which they receive and respond to information and cases on GBV.

*Fig 4: CARE Syncronisation Model*


Since models for correctional and therapeutic interventions for perpetrators have not met with much success, the project will not specifically work with perpetrators but will focus on working with men in the general population which will inevitably include current/former perpetrators. UNFPA will also build the capacities of service providers along the referral pathway (except the police and courts), from CPSWs to health workers including at OCMCs and shelters on dealing with perpetrators they

[24] Men and women in same sex groups go through processes of conscientisation (reflect on hegemonic masculinities, gender, power and privilege in their lives); intimate dialogue (conversations with intimate partners and within families); building the base (building male allies for social support and solidarity); stepping out, stepping up (men undertake campaigns and facilitate discussions around gender and masculinities); and alliances for advocacy ( male allies join women led feminist movements for social and policy change)

come into contact with, to protect themselves, protect survivors from further harm and to convey key messages to the perpetrators.

### 4.4 Project Goal, Outcomes and Activities

The **Goal** of the project is to reduce all forms of gender-based violence and discrimination against women and girls in 2 provinces in Nepal. To achieve this goal, the project will pursue outcomes in 3 areas: primary prevention through changing social norms at the community level; multi-sectoral, survivor-centered services for survivors; and local and provincial governments adopting and implementing policies and budgets for the promotion of gender equality and the empowerment of all women and girls.

The section below provides details of all activities and interventions to be implemented in the project. All beneficiary reach numbers and figures are collectively presented in Section 4.5 in the Beneficiaries and Target Groups sections.

**Outcome 1: Women and men, including girls and boys increasingly prevent, report and address gender-based violence**

This outcome area focuses on transforming attitudes, beliefs and norms that perpetuate gender inequality, discrimination and violence against women. It is now widely recognized that violence against women is preventable, and there is now more information than ever before about what works to prevent violence against women. Under this outcome, UNFPA will implement 5 of the 7 strategies for prevention of violence against women and girls that have recently been adopted by several UN agencies, including UNFPA[25]:

- strengthening relationship skills,
- empowering women,
- making environments safe,
- preventing child and adolescent abuse, and
- transforming attitudes, beliefs and norms.

Models for interventions will evolve from recent pilots in Nepal by UNFPA, global lessons from UNFPA projects and other development partners such as DFID.

**Output 1.1: Community facilitators have the capacities to conduct reflective sessions with target groups on social norms**

Experience across the world has demonstrated that changing attitudes, beliefs and norms requires deep critical reflections by individuals, as an individual exercise, as well as a group exercise, for both men and

25 WHO with UN Women, together with, the Office of the High Commissioner for Human Rights (OHCHR), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Office on Drugs and Crime (UNODC), the Government of the Netherlands, Swedish International Development Cooperation Agency (SIDA), UK Aid, United States Agency for International Development (USAID) and the World Bank Group have developed RESPECT women: preventing violence against women – a framework aimed primarily at policy-makers.

women, as well as adolescents. These reflections need to be facilitated by skilled mobilisers who have themselves undergone intensive reflection and changes in their own lives to be able to mobilise and influence others.

**Proposed Activities**

i. **Revision and adaptation of existing training modules for gender transformative training on GBV Prevention:** the project will develop an iterative training framework and model outlining methods, tools and curricula for gender transformative trainings in consultation with gender experts, the selected IP that will provide a cohort of master trainers and facilitators, with the support of international experts/agencies. The model will include both classroom and application-based learning, with participatory and reflective learning methods that enable critical reflection for gender transformation. Curricula will be designed to promote gender transformative reflections and gender equality among participants.

ii. **Training of Master Trainers, Community level and Peer Facilitators:** the project will invest in recruiting an IP to provide and develop a pool of mixed gender facilitators for transforming attitudes, beliefs and norms. This training will build on current subject-specific trainings for facilitators and will complement and strengthen existing subject specific training on, for instance, safe house staff to deliver quality services that meet international standards or health workers' training on clinical protocols on managing GBV. A pool of Master Trainers from among existing gender trainers in Nepal and NGOs will be engaged in the development and application of the course as designers and pilot participants, and the trainers will (as much as is feasible) be sourced institutionally rather than individually. They will then, as master trainers for training community-based facilitators, facilitate 10-12 session modules with families and community groups (see below in Output 1.2) and 15-50 session modules with adolescent boys and girls. Master trainers will also train service providers (see under Outcome 2) such as community-based psychosocial workers, case managers, health workers, counselors, shelter coordinators, and management and supervisory staff of the different service providers, such as hospital superintendents. Some Master Trainers will provide regular mentoring (on site and off site) for the facilitators and service providers.

The iterative training process will include an assessment of the impact of facilitation at the local level, reviewing whether the facilitation is leading to reflection among participants, and if the reflection is leading to changes in attitudes, the kinds of changes that are perceptible, and opportunities for improvement. Such assessments will be conducted by Master Trainers during their on-site mentoring, where they will engage in in-depth discussions on personal changes and successes achieved in transforming social norms among target groups over a period of six to eight months. These assessments will also be validated by third party observation and assessment through operational/action research that will accompany Phase II. This data will be collated to analyze and assess what is working and what is not – thereby contributing to the global evidence base.

**Output 1.2: Individual and groups of men, women, boys and girls have enhanced capacity to challenge discriminatory social norms**

In Phase II, the project will adopt a whole-of-community approach as per the global evidence base on what works to prevent GBV. Piloted interventions to change social norms from Phase I will be deepened based on emerging lessons that are being tracked through the operational research and ongoing project monitoring. An important component in Phase II will be mobilising men and women in communities to form support networks for survivors.

**Proposed Activities**

i. **Family Dialogues:** Gender transformative family dialogues will be facilitated by trained community facilitators at the household and community level through a mix of group based, same-sex workshops (mothers, daughters, sisters, female in-laws, and fathers, sons, brothers, male in-laws), couple workshops (married or unmarried cohabiting couples) and dialogues within households. Families will be selected in consultation with Palikas, as per their mapping according to economic status, caste and ethnicity, among other markers. Based on lessons generated from the curricula and methods piloted in Phase I by UNFPA and by DFID in its 2018 pilot, as well as international promising practices, a revised curricula and method will guide interventions with families. The curriculum will enable family members to improve their interpersonal communication, conflict management and shared decision-making.

   Sessions will include topics on relationships, traditional notions of masculinities and femininities, harmful practices, power dynamics, household roles and responsibilities, social and gender norms, alcohol use, sexual desire and consent (with couples only), effective communication, joint decision-making, conflict resolution, collective action for social norm change and survivor support. Part of the curriculum will require participants to plan and execute collective action in the community (peer effect) to promote new social norms. Collective actions could include holding discussions with their neighbours, conducting awareness through local art forms such as theater, songs and dance, making representations to public institutions such as schools or health facilities and to local governments.

ii. **Group discussions with men and women's groups (age 18-45):** households not participating in family dialogues will be reached through existing Community Based Organisations (CBOs) they are a part of, such as mother's groups or forest user's groups. New groups will only be mobilised where none already exist. The selection of members will prioritize coverage of the most vulnerable communities. Same-sex group education sessions will be interspersed with mixed group discussions. Each group will participate in fortnightly sessions over 6 months, which will be facilitated by community facilitators trained in the curriculum and methodology that will be finalized during the project's inception phase, based on lessons learned from models piloted by the project in Phase I.

   Sessions will include topics on social and gender norms, traditional notions of masculinities and femininities, relationships, power dynamics, household roles and responsibilities, alcohol use, consent, effective communication, joint decision-making, conflict resolution, collective action for social norm change, and survivor support.

iii. **Revised Rupantaran Package for Adolescent Girls and Boys (age 12-18):** this is the Government of Nepal's approved package for intervention with adolescents, which will be revised and adapted to contain a stronger GBV prevention focus for adolescents. It will be implemented through out-of-school, group-based education. Same-sex group discussions will be interspersed with mixed-sex discussions. The project will train peer educators among adolescent boys and girls to implement the revised Rupantaran curriculum. Based on lessons learnt from Phase I, mentoring and supervision of trained peer educators will be built into the intervention. Adolescent peer groups will continue to be supported in conducting campaigns, community theater and peer education in their communities. Each year, 40 adolescents (20 girls and 20 boys) from 83 schools will graduate from the Revised Rupantaran package as schools remain a crucial entry point for this demographic. In addition, based on pilots introduced in Phase I in response to demand from adolescent girls, GBVPR had linked adolescent girls and boys with SDC funded project ENSSURE for career counseling and at least 15 girls who received such counseling were selected for and provided with vocational training. Based on this promising practice, in Phase II, the project will continue to refer adolescents in all project locations with ENSSURE and similar such initiatives.

iv. **Dialogues with opinion leaders (elected, religious, traditional and other influential community leaders):** based on learning from Phase I, the project will pilot interventions with opinion leaders, strategically engaging with them in dialogues to facilitate critical reflection. Religious leaders, together with scholars and other influential leaders, who together make 'opinion leaders' in their communities, will be mobilised to influence communities to give up harmful social norms that violate women and girls. Networks of religious leaders will be supported to campaign for gender transformative norms through mass media, community and religious functions. Messages that challenge religious and superstitious beliefs will be developed in consultation with scholars and will be disseminated throughout the communities through schools, community dialogues, family dialogues and in the mass media (radio/TV/community theater).

v. **Operational research:** since interventions to change social norms around gender and GBV are still evolving and contextual, operations research will be a critical component in Phase II, accompanying all interventions and cutting across all 3 outcomes. It will deepen understanding on key drivers for GBV in the different contexts of project locations to evolve and tailor our approaches and it will test assumptions made in this project. The operational research is expected to feed into the global evidence base on what is working to prevent GBV and give insights into how, in addition to changing norms and behaviours at the community level, gender-transformative, multi-sectoral and survivor centered response contributes to preventing GBV. See Section 5.6 on the Monitoring, Evaluation and Learning (MEL) framework for a detailed outline of the planned operational research.

**Outcome 2: Local governments, legal authorities and health facilities provide effective (multi-sectoral) survivor-centred responses to gender-based violence**

The purpose of this outcome is to ensure the availability and quality of multisectoral responses geared towards restoring dignity to survivors, improve their sense of self-efficacy[26] and hopefulness[27] (indicators of wellbeing). It will ensure that the burden of identifying and accessing services is not on the survivors, that their needs and wishes are respected by all service providers, and the provision of timely and quality services in a safe, confidential and non -judgmental manner. At each step in the referral pathway, the survivor should be supported with information and in making a plan for their safety (skills, negotiation, who to reach for intervention/support, etc.). At each stage, all service providers should adopt a gender transformative approach[28] and offer encouragement, empathy and respect her wishes and needs. Service providers should interact with survivors in ways that increase their power in personal, interpersonal and social arenas (service provider as facilitator, survivor as decision-maker). In Phase II the project will also enhance capacities of service providers in dealing with perpetrators[29] they come into contact with—to protect themselves, protect survivors from further harm and to convey key messages to the perpetrators.

**Output 2.1: Government and non-governmental actors have enhanced capacities for the provision of quality services through temporary shelter homes for survivors**

In a recent visit to Nepal, the Special Rapporteur on Violence against Women commented on the scarcity of safe houses and shelter homes[30] for women survivors of GBV, and urged the Government of Nepal to ensure sustainable funding for a sufficient number of safe shelters throughout the country[31]. Shelter services for women survivors of violence in Nepal (which provide longer term support of up to 6 months' stay) are limited and have historically been provided by NGOs. In Phase I, the project supported 8 shelters (5 in Province 1; 2 in Province 2 and 1 in Province 3). In Phase two, the project will continue to support 8 shelters (the 5 in Province 7, and increase from 2 to 3 shelters in Province 1).

After 2009, as per provisions in the Domestic Violence (Offence and Punishment) Act, 2009, the MoWCSC established a special fund for providing temporary shelter services of up to 45 days' stay through women's service centres, commonly referred to as safe houses (*seva kendra*) for women survivors of violence. So

[26] Belief that one is competent and able to perform the actions needed to achieve goals important to them

[27] Perceived availability of successful pathways related to goals

[28] Gender transformative approaches: programmes and interventions that create opportunities for individuals to actively challenge gender norms, promote positions of social and political influence for women in communities, and address power inequity between persons of different genders. They create an enabling environment for gender transformation by going beyond just including women as participants. They are part of a continuum of gender integration, or the integration of gender issues into all aspects of programme and policy conceptualization, development, implementation and evaluation. (quoted by UNFPA, http://www.healthconmcapacity.org/wp

[30] The **Women's Service Centres**, also called safe houses were set up under the President's Women Upliftment Programme and provide shelter support for up to 45 days including referrals for psychosocial, medical, legal and rehabilitation services. These differ from **Rehabilitation Centres,** also known as shelters/shelter homes which provide up to six months' support to GBV survivors and are run by NGOs with partial funding from the Government.

[31] Human Rights Council, Forty-first session, 24 June–12 July 2019: Visit to Nepal: Report of the Special Rapporteur on violence against women, its causes and consequences

far, 21 safe houses at the district level have been established to provide interim shelter, psychosocial support, legal counseling, skills training and financial support, among others, to women survivors of violence. These safe houses are operated by the women's cooperatives in the respective districts. In 2017, the President of Nepal launched a programme for the upliftment of women that aims to open safe houses for women in 53 districts (under the MoWCSC). The MoWCSC is yet to draft guidelines for these shelters and so far, the guidelines for existing safe houses are defined in the *Terms of Reference for Service Centres for women survivors of domestic violence, 2011*. In addition, some local and provincial governments are planning to or have already initiated the construction of new safe houses.

**Proposed Activities**

The activities in this Output will focus on improving the quality of services in existing shelter homes and expanding training and mentoring support to any new or existing shelter home supported by the local government or NGOs in the district through the following activities:

i. **Aligning existing guidelines and trainings to international standards** such as the UN Essential services package;
ii. **Introducing specific standards for the care and protection of survivors under 18**, and for children accompanying survivors;
iii. **Strengthening the capacity of shelter staff to intervene using a gender transformative approach** and develop survivor-centered individual case plans, including plans for follow up;
iv. **Apply gender transformative and survivor centered approaches** to dealing with perpetrators and their families; and
v. Introduce procedures **for systematic follow up** with survivors

**Output 2.2: The health sector has enhanced capacities for the provision of quality services through one-stop crisis management centers, health posts and network of female community health workers**

The Ministry of Health and Population is the lead agency at federal level responsible for ensuring the health sector's response to GBV. One of its key services is the One-Stop Crisis Management Centres (OCMC) based at District and Zonal Hospitals. In the current federal structure, geographically hospitals fall under a single municipality or province but serve citizens from a cluster of municipalities and across provinces. The funding support for them comes directly from the MoHP through either the Provincial government or the municipalities based on the location and size of the hospital.

The mandate and activities of the health sector to prevent and respond to GBV are guided by two policy documents that were developed with the support of UNFPA and its partner JHPIEGO: the Clinical Protocol on Gender-Based Violence 2015[32] and the Operational Manual for Hospital Based One-stop Crisis

[32] This protocol is the first national guideline for healthcare providers on management of gender-based violence (GBV) in Nepal. It aims at equipping health service providers with the best possible care to GBV survivors and empowering them to identify GBV survivors, manage cases and make appropriate referrals. The protocol is developed by the Ministry of Health and Population with technical and financial assistance from UNFPA, the United Nations Population Fund, and also with Jhpiego's technical support.

Management Centers, 2016 (revised)[33]. UNFPA has also supported the MoHP in developing a Competency-Based Training Package for Blended Learning and On-the-Job Training for health workers to improve the quality of services provided to GBV survivors at all levels of health facilities which includes health posts, primary health centers, district hospitals, and referral hospitals. Services provided at OCMCs include: medical services, including forensic investigation (e.g. rape kits), in-patient care for survivors requiring prolonged medical care; psychosocial counseling by trained case managers where available or on ad hoc basis by staff nurses or attending doctors (who have not received training on counselling), referrals to police, shelters and legal services.

OCMCs also refer cases to larger or specialized hospitals if they do not have the capacity to address specific needs, such as survivors with disabilities or complex medical cases. Thus far, with the support of UNFPA (through a separate project), the MoHP has adopted and is implementing training on clinical protocols for addressing GBV for all district and zonal hospitals in Nepal. This protocol and training for health workers needs to be reviewed through a gender transformative lens, and updated with the latest guidelines from WHO on intimate partner violence, GBV quality assurance tools for health facilities and for responding to children and adolescent survivors of GBV[34]. Experience shows that OCMCs often interface with family members of survivors and perpetrators but do not have a strategic approach or training on dealing with them, particularly with perpetrators. Going forward, capacities of health sector and OCMC staff will be enhanced in intervening with families, counseling couples, and working with perpetrators, using a gender transformative and survivor-centered approach.

The Government of Nepal has established 55 OCMCs and planned to expand to 62 by June 2020, aiming for full coverage (all 77 districts) in subsequent financial years. While the OCMC guidelines require each OCMC to be staffed with 4 personnel—a medical officer from the hospital, and 3 other staff including a staff nurse and psychosocial counselors, most OCMCs have not yet filled these positions. At best, a staff nurse and a medical officer have been appointed to also look after the OCMC. Dedicated full time staffing of OCMCs is lacking.

**Proposed Activities**

In Phase II, the project will build on gains made in Phase I and focus on improving the quality of services in existing OCMCs, while expanding the model to newer OCMCs in the referral pathways. Similar to the planned improvements to shelter homes as outlined in Output 2.1, the focus will be on enhancing the quality of services being provided through:

i. **Aligning existing guidelines and trainings to international standards** such as UN Essential services package and the most recent WHO guideline on Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence[35];

[33] The manual aims to contribute in preventing GBV by establishing the hospital based OCMC, through which the survivors, the potential survivors and those affected by GBV shall receive properly managed treatment, care and support services in an integrated way.

[34] A manual for health managers: Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence, GBV quality assurance tool and Responding to children and adolescents who have been sexually abused

[35] Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers. https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/

ii. **Introducing specific standards for the care and protection of survivors** under 18, and for children accompanying survivors
iii. **Improving the capacity of health workers** through training and continuous mentoring to intervene using a gender transformative approach and develop survivor-centered individual case plans including plans for follow up,
iv. **Introducing a gender transformative and survivor centered approach** to dealing with perpetrators and their families
v. **Introducing data management systems and mechanisms** for the improved tracking and monitoring of services to maximize the use of data to inform interventions
vi. Creating processes for **systematic follow ups** with survivors

The project will continue to provide 2 case managers at each OCMC and a counselor in each district while advocating with the governments at all levels to institutionalize this model. As in the case of cost-sharing demonstrated in Phase I for CPSW and shelter homes, a cost sharing model for OCMCs will be proposed. Project support to OCMCs will expand to support and strengthen referral pathways to the 2 zonal hospitals at Biratnagar (Province 1) and Dhangadi (Province 7). In total, 8 OCMCs will be supported in Phase II, up from 7 from Phase I.

**Output 2.3: Local governments have enhanced capacities to provide community-based psychosocial services which are institutionally linked through the referral pathways**

Community-based psychosocial workers were piloted in Phase I, and women from communities with some previous experience in psychosocial care work were trained and appointed on an honorarium basis to provide front-line psychosocial services to survivors in the communities. Their role included generating awareness about GBV, providing psychosocial support and education to communities through sharing of information at meetings of various community based organisations, identification of survivors, first aid counseling[36] (mostly listening, acknowledging) and most significantly, linking survivors to counselors/case managers at the OCMC.

**Proposed Activities**

i. **Psychosocial support and referral services for GBV Survivors at community level:** Community-based Psychosocial Workers (CPSWs) who are based at ward offices and who report to the local government (municipality) will provide psychosocial support (emotional support/psychological first aid) at community level to GBV survivors. They will coordinate and refer survivors to OCMCs for further intervention, follow up on referred GBV cases back in their homes/communities and conduct awareness sessions with community based organizations. CPSWs will also support survivors who have opted for mediation through community mediation centres or Judicial Committees, and accompany and support GBV survivors as required as they access formal justice systems (police and courts). They

[36] Psychological first aid (PFA) includes assessing needs and concerns; helping people address basic needs; listening to and comforting people and helping them feel calm; helping connect to information, services and social support; and protecting people from further harm

will work closely with OCMC case managers and shelter home coordinators, while reporting to the ward office for administrative purposes, and to UNFPA implementing partners for programmatic purposes.

ii. **Appointment, training and mentoring of Community-based Psychosocial Workers (CPSWs):** based on the promising Phase I results from placing one CPSW per ward, the project will support local governments to appoint one CPSW per ward or two, depending on number of households per ward. CPSWs will be appointed by local governments, with technical support from the project in their selection, training and mentoring. The project will offer cost sharing support to participating local governments with the goal of influencing full adoption by local governments by the end of the project. Local governments who have been participating in Phase I will be supported to take on full cost sharing earlier than local governments that join the project in Phase II. Training and mentoring of CPSWs will be provided by implementing partners specializing in psychosocial/mental health interventions. As per model developed in Phase I, each project district will have at least 1 professional psychologist to oversee and support psychosocial interventions including through CPSW, OCMC and Shelters.

    By the end of Phase II there will be between about 113 CPSW supported across the Provinces 1 and 7 in Phase II. Each CPSW is responsible for making at least 10 home visits a month, as well as to conduct awareness sessions in 4 CBOs per month.

**Output 2.4: Informal and quasi-justice systems strengthened to mediate GBV cases through a gender transformative approach**

Informal justice systems such as community mediation centres, and quasi-judicial bodies such as the Judicial Committees headed by local government Deputy Mayors have been vested with the authority to mediate in cases of (non-criminal) conflict in the community, including GBV cases. There is a lot of confusion on the scope of their work, roles and responsibilities and in the absence of training on gender equality principles and how to ensure gender-sensitive due process, mediations tend to conclude with survivors reconciling with perpetrators and being returned home, with little follow up on possible repeat offenses.

**Proposed Activities**

i. **Technical assistance and training on gender transformative and survivor centered approaches to community mediation:** UNFPA believes that current approaches to community mediation of GBV cases are undesirable, and in some cases may even be harmful for women and girl survivors. However, until such a time that this provision is removed from Nepal's legislation on domestic violence, the project will provide technical assistance to local governments, quasi and informal justice systems to bring in gender transformative and survivor centered approaches in their processes[37]. This support will comprise of training on gender transformative and survivor centered approaches to community mediation.

[37] UNFPA will draw upon the model developed by the International Rescue Committee (IRC) on survivor-centered mediation.

ii. **Advocacy with local governments for the presence of CPSWs during mediation sessions:** to ensure that the mandatory provision of psychosocial services to survivors is honoured. In addition to building capacities of local governments to train and support community psychosocial workers, in Phase II the project will also enhance the capacities of community mediators and judicial committees to mediate using survivor-centered and gender transformative approaches towards both survivors and perpetrators.

**Outcome 3: Local, provincial and federal governments adopt and implement policies and budgets for the promotion of gender equality and the empowerment of all women and girls**

The purpose of this outcome is to enable local and provincial governments to formulate policies, budgets, plans, protocols and guidelines for gender responsive services to its citizenry. At provincial levels the Ministry of Social Development is responsible for the thematic area of gender equality and women's empowerment (GEWE), and at the local level, *the Local Government Operational Act (2074/2017)* provides the framework for local governments to consider gender and social inclusion while formulating long term development plans under their jurisdiction. Under the same act *(Section 12(32))* ward committees are entrusted with responsibilities to abolish harmful traditions and superstitions such as child marriage, violence against women, untouchability, the dowry, *haliya*, *Chhaupadi*, and *kamlari* systems, child labour and human trafficking. In Phase II, the project will collaborate with the Provincial and Local Government Program (PLGSP) and the State Support Program (SSP) as they evolve, to integrate gender equality and GBV agendas in the capacity building initiatives of these programmes.

**Output 3.1: Local and provincial governments have improved capacities to implement gender responsive plans, policies, legislation and budgets**

The Project will work with governments at all levels to ensure that gender equality and women's empowerment programmes are budgeted for, and for costs related to multi-sectoral, survivor-centred responses to GBV are absorbed in government plans, budgets and services and are sustained after Phase II ends.

**Proposed Activities**

i. **Learner-centered training and mentoring on gender transformative approaches:** for local and provincial government representatives. This intervention will train and mentor elected representatives and administrative officials at ward, local and provincial levels to build the capacity of local and provincial governments to develop policies, plans and strategies, and gender responsive budgeting.

ii. **Technical assistance to draft plans, policies and legislation in collaboration with PLGSP and SSP:** the project will aim to influence the Innovative Challenge Fund of PLGSP to promote and establish models in the respective local governments that works on prevention, response and governance on Gender

Equality and Women's Empowerment (GEWE) and ending GBV. The project will support local governments developing plans to submit the ideas to the Innovative Challenge Fund.

**Output 3.2: Local and provincial governments have improved collaboration and coordination on shared multi-sectoral services on GBV**

Responding to GBV requires the provision of specialized services (medical, legal, psychosocial, safe accommodation) to survivors in an accessible and effective manner. Given that these services are managed and governed by different agencies/departments and tiers of governments, it requires coordination and collaboration at both conceptual and design level, as well as in execution.

**Proposed Activities**

i. **Supporting local governments to develop guidelines for horizontal (inter-municipal and inter-provincial) and vertical (municipal-provincial) collaboration on shared services:** this will ensure that a coordinated response is conceptualized and executed while keeping the survivor at the center of design and implementation. Basing on global good practice, the project will introduce protocols for multi-sectoral collaboration and accountability as per standards set in the UN Essential Service Package for Women and Girls subject to violence. Local governments hosting shelter services will be supported, for instance, to collaborate with other local governments to share the cost of shelter services for cost minimization and effective service delivery.

ii. **Data management support:** a key component of effective coordination and multisectoral response is data management and in Phase II, the recently piloted data management system (Case Management System) of the National Women's Commission, supported by the World Bank will be adopted on a pilot basis in select locations and then expanded to all project locations. The project will consult with MoHP, MoWCSC and NWC as well as with local and provincial governments to identify the most effective and efficient base for managing multisectoral data. The project will also seek to ensure that GEWE indicators are incorporated into Local Government's self-reporting database the Local Government Institutional Self-Assessment (LISA) through liaison with other UN agencies and development partners.

iii. **Promoting coherence, learning and coordinated responses across among providers:** the project will facilitate bi-annual joint monitoring visits (horizontally and vertically), as well as quarterly review and planning meetings between service providers to promote coherence, learning and coordinated response. The project will provide support in development of monitoring reports and facilitate presentation of reports to respective coordinating bodies. The project will also ensure the feedback is incorporated in the planning and budgeting of the respective governments. The project will also collaborate with PLGSP while drafting provincial law governing intergovernmental coordination mechanisms and ensure the policies are responsive to advancing gender equality and ending GBV.

### 4.5 Beneficiaries and Target Groups

Women and girl survivors of GBV are the primary direct beneficiaries of the project. They will be reached through multiple-response services supported directly by the project-services from the health sector, including OCMC, shelters, community based psychosocial workers and through linked referrals with police and legal system. In order to ensure that violence is prevented and reduced, the project will also work with directly with general population of men, women, boys and girls to influence and change attitudes, behaviours and social norms that promote GBV.

Since most GBV occurs within household settings, and since norms and behaviours are first learnt at home, families as a unit will be an important target for the project whereby entire families will participate in dialogues to reflect on power dynamics and inequitable relationships between parents and children, spouses, in-laws, siblings and so on. Men and women will also be reached out through gender-specific CBOs where they will collectively reflect on social norms and behaviour and facilitated to change social norms. Similarly, the project will directly benefit adolescent boys and girls through group education programme (e.g. the revised Rupantaran Package) where they will collectively learn about and reflect on gender equitable social norms; facilitated by their peers and mentored by their teachers.

In order that women and girl survivors receive good quality services, the project will directly intervene with service providers to strengthen their capacities. Services that will be directly benefit include the health sector services delivered through health workers in the district hospitals, health posts, FCHVs and staff of the OCMC; safe houses; community based psychosocial workers and their supervisors appointed by the local government; community mediators and judicial committees. Finally, in order to institutionalize effective multisectoral services and for gender equitable policy environment, the project will directly work with elected representatives at local and provincial levels to strengthen their capacities in coordination and policy making.

Activities are planned to in such a way that the interventions reach all major beneficiaries at the latest by the third year. In the final year, rather than reaching out to new beneficiaries, the project will focus on strengthening services, mentoring and follow up, and working towards a responsible exit keeping and fostering sustainability. Hence, beneficiary figures are lower in year 4 than in preceding years.

The table below provides a summary of beneficiaries and service providers across all 3 outcomes.

***Table 5: Beneficiaries Reach Summary***

| Beneficiaries (P1 & P7) | Year 1 | Year 2 | Year 3 | Year 4 | Total | Remarks |
|---|---|---|---|---|---|---|
| **Primary Beneficiaries** | | | | | | |
| **SGBV survivors (women and girls) reached with multisectoral services (OCMC, psychosocial support, police and legal, health and safe homes)** | 2,300 | 2,650 | 3,100 | 3,450 | 11,500 | Annual target has been set starting from 20% and by year 4 all targets will be reached .For 4th year only 10% target has been set so follow up and backstopping support could be provided to previous year beneficiaries |
| **Adolescent boys and girls reached through the Revised Rupantaran or other initiatives** | 1,660 | 4,980 | 4,980 | 1,660 | 13,280 | 2 groups*20 participants*83 schools |

| | | | | | | |
|---|---|---|---|---|---|---|
| **Newlywed couples** | 3,480 | 6,960 | 5,220 | 1,740 | 17,400 | 20 couples (40 persons) *87 wards/6 months; reached through inter-personal communication tools and other intensive group interventions over sustained periods |
| **Communities reached** | 49,720 | 99,441 | 74,580 | 24,860 | 248,601 | |
| **Total Beneficiaries** | **57,160** | **114,031** | **87,880** | **31,710** | **290,781** | |
| ***Service providers*** | | | | | | |
| **Health workers** | 140 | 250 | 121 | 0 | 511 | 5 health workers* 91 health facilities; 12 pax*8 OCMC (additional 30% dropout allowance) |
| **FCHVs** | 87 | 87 | 87 | 87 | 87 | 1 FCHV*87 Wards (1 FCHV per ward)-training conduction in Y-1 and then continuous mobilization and backstopping |
| **Rupantaran Teachers(for mentoring)** | 166 | 0 | 166 | 0 | 166 | 5days training for 2 teacher/83 schools,166 people with refresher in Y3 |
| **Peer Facilitators -83*2** | 166 | 0 | 166 | 0 | 216 | 2 peer educators*83 schools (30% dropout has been added in total) |
| **Judicial Committee (Members)** | 57 | 0 | 57 | 0 | 114 | 3 members*19 LGs (existing and newly elected members after next election of JC in 19 *Palika*s, training and mentoring each year) |
| **Mediation Committee (member)** | 19 | 0 | 19 | 0 | 38 | 1 member*19 LGs (training and mentoring to existing and newly appointed mediation committee members) |
| **CPSWs** | 87 | 0 | 87 | 0 | 113 | 1 CPSW*87 wards (1 per ward) annual training and refresher (incl. 30% drop out) |
| **Elected members-19 *Palika*s, 87 wards** | 106 | 285 | 215 | 170 | 776 | Representatives, deputy representatives, GoN staff and ward and committee members plus |
| **Total service providers** | **828** | **622** | **918** | **257** | **2,021** | |
| **TOTAL REACH** | **57,988** | **114,653** | **88,798** | **31,967** | **292,802** | |

## 5. Management and Reporting

### 5.1 Inception Period

The programme will deliver a 6-month inception phase through the form of an agreed action plan with clear milestones and activities. This will be a two-phased inception period, with some preparatory activities happening prior to the formal project start date of 5 August 2020, and other activities occurring after this date. This is largely to maximise on UNFPA's ability to carry out some inception activities during the ongoing Phase I that have indirect cost implications (largely staff time) which is already covered under the current agreements with both donors. Other activities can only be implemented after the official start date of the project as they require significant budget availability, or involve entering into agreements which will be based on the contract between the donors and UNFPA.

Broadly, the inception phase will address the following:

- Set up governance, monitoring and evaluation structures drawing on lessons from phase 1 and ongoing pilot interventions
- Prepare annual action plan, budgets and forecasts
- Procurement of IPs, recruitment of staff and development of relevant TORs with stakeholders
- Further analysis of the context and available technical resources, manuals and tools to inform training and capacity building activities

The inception phase will commence once both donors have confirmed the availability of funds for phase II through signed formal agreements, and this is currently estimated for May or June 2020, donor procedures depending. UNFPA will also assess whether there are any savings from Phase I that can be utilised to cover some inception activities prior to the project's start date. However, the inception phase will be affected by the ongoing COVID-19 lockdown and the timelines may need to be revised depending on the protracted nature of the crisis. UNFPA will continue to update and engage with the donor partners regarding these timelines.

The table below shows the anticipated Inception Phase timeline of activities and will remain a living document that will be regularly updated and edited to respond to the ever-changing COVID-19 context.

***Table 7: Inception Phase Gantt Chart***

## GBV Prevention and Response Phase II Inception Phase Gantt Chart

| | Activity | Cost Implications | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Development of a Project Steering Committee (PSC) and agree ToRs | Indirect (staff time) | | ■ | | | | | | |
| 2 | Set up a Donor coordination mechanism for GBV and agree ToRs | Indirect (staff time) | | | ■ | ■ | | | | |
| 3 | Agree Inception Phase Milestones after NOR+SDC ProDoc Approvals | Indirect (staff time) | | ■ | | | | | | |
| 4 | Extensive study and review of relevant and available documents and data | Direct | | | | ■ | ■ | ■ | ■ | ■ |
| 5 | Development/adaptation/revision and testing of training manuals, tools and resources | Direct | | | | ■ | ■ | ■ | ■ | ■ |
| 6 | Collection of remaining baseline data and indicators and finalise log frame | Direct | | | ■ | ■ | | | | |
| 7 | Seek Government Approval to work in non-UNFPA designated district (Morang) | Indirect (staff time) | | ■ | ■ | | | | | |
| 8 | Recruitment and selection of UNFPA project staff | Indirect (staff time) | ■ | ■ | ■ | ■ | | | | |
| 9 | Procurement of Implementing Partners | Indirect (staff time) | | ■ | ■ | ■ | ■ | | | |
| 10 | Signing of agreements with Implementing Partners | Direct | | | | ■ | ■ | | | |
| 11 | Development of all necessary TORs | Indirect (staff time) | ■ | ■ | ■ | | | | | |
| 12 | Develop advocacy messaging for 7-step process to influence Palikas' budgets and cost sharing | Indirect (staff time) | ■ | ■ | | | | | | |
| 13 | Develop cost sharing strategies with Palikas | Indirect (staff time) | | ■ | | | | | | |
| 14 | Sign/renew agreements with Palikas and Provincial Governments | Direct | | | ■ | ■ | | | | |
| 15 | Develop formats for monitoring and reporting with IPs | Indirect (staff time) | | | ■ | | | | | |
| 16 | Preparatory training, orientation and capacity building of UNFPA staff | Direct | | | ■ | ■ | | | | |
| 17 | Preparatory training, orientation and capacity building of IPs | Direct | | | | ■ | ■ | | | |
| 18 | Develop a detailed project work plan and get PMC sign off | Direct | | | | | | | ■ | ■ |
| 19 | Selection of target beneficiary/participants and related briefing/information sharing | Direct | | | | | | ■ | ■ | ■ |
| 20 | Procurement of overheads and logistical requirements (esp. Province 1) | Direct | | | | | | ■ | ■ | |
| 21 | Submit Inception Phase Report | Direct | | | | | | | | ■ |

## 5.2 Risk analysis

***Table 8: Risk Assessment and Mitigation Measures***

| Main Risks | Gross Probability | Gross Impact | Mitigation Measures | Residual risk |
|---|---|---|---|---|
| Aid diversion and misuse of funds through theft or corruption | **Medium** | **High:** Funds lost through corrupt means negatively affect the quality and number of activities implemented, thereby risking the success of the project. Theft and bribery undermine the integrity of the project, partnership with Government, and it carriesalso carry reputational risk for the partners, UNFPA and donors. | UNFPA has strong measures to mitigate aid diversion and theft, including:<br>• Regular spot checks of implementing partners' (IPs) finance management and reporting<br>• Annual audit and analysis of findings, including monitoring partners' implementation of auditors' recommendations<br>• Robust UN system for budget and finance management with appropriate checks and balances to ensure clear segregation of duties<br>• Regular awareness raising, training and capacity building among staff and IPs of UN system's zero tolerance to theft, bribery, corruption and aid diversion | **Medium** |
| Partners lack skills and experience to manage a project of this level of complexity | **High** | **High:** GBV Prevention is highly complex and there are limited local players who are highly experienced in this field.<br>Lack of capacities will constrain achievement of project results; undermine trust and confidence in | • Early market engagement and a competitive tender process will seek out the most experienced and competent suppliers.<br>• The development of clear ToRs and a clear inception phase will allow for the UNFPA and IPs to plan and deliver the programme effectively.<br>• UNFPA will also provide intensive engagement and support to IPs to ensure smooth programme delivery, | **Medium** |

| | | | | |
|---|---|---|---|---|
| | | the approaches and interventions proposed; and let down the main beneficiaries. | identification and management of risks, and provide technical support and backstopping to manage quality of activity implementation.<br>• UNFPA will conduct due diligence-related assessments of the contracted implementing partners to provide assurance that the partners have the right capacity and ability to implement the project. | |
| Project has a negative impacts on human rights, women's rights and gender equality | **Unlikely** | **Low:**<br>This risk is highly unlikely as the project activities are centered around a human and women's rights based approach, and will actively address existing gender inequalities | UNFPA will ensure that all training activities, and training tools, manuals and materials contain easy to understand, relatable information on the importance of human and women's rights as a central theme in GBV prevention and response. The gender transformative approach that the project will implement is also focused on promoting women's empowerment and gender equality. | **Low** |
| Project is (mis)perceived as causing increased incidence of violence against women and girls due to increased reporting and discussions. | **Medium** | **Medium:**<br>Misconceptions could negatively affect participation in project interventions | The project will work closely with influential leaders in the community, including local elected representatives at the ward and municipality level to clarify the link between activity implementation and increased reporting. IPs will also emphasize the benefits of increased reporting in breaking the culture of silence associated with GBV. | **Low** |
| Safeguarding risks through threats to service providers along the referral continuum from perpetrators of GBV against women and girls. | **Low** | **Medium:**<br>While such threats and interference are reported by different service providers, these are infrequent but are taken | The project will work closely with ward level elected representatives and their offices where CPSWs are based and advocate with them to take responsibility for safety of CPSW. Likewise, advocacy with local governments for instituting safeguards and protocols to protect service providers will be maintained. | **Low** |

| | | | | |
|---|---|---|---|---|
| | | seriously as they can result in survivors being victimized or discontinuing service. | Additionally, all service providers will be trained on working with perpetrators to reduce the risk of violence. | |
| Local governments might not prioritize the cost of CPSW and Shelter services and federal and provincial governments may not prioritize costs for full staffing of OCMC. | **Medium** | **High:**<br>Minimizing or discontinuity of the budget contribution from the local government will affect the sustainability of the project and have a negative impact on the outcome of the program and services to the people. | The project will provide support to develop policies and strategy for institutionalizing the GBV services at the local level, provincial and federal levels. The project will regularly consult and advocate with local government officials during the planning and budgeting process to secure funding for GBV prevention and response interventions. | **Medium** |
| High turnover of volunteer workforce and trained service providers (CPSWs; OCMC and Safe House staff and case managers) | **Medium** | **High:**<br>Loss of trained staff results in gaps in implementation, risk of low quality service provision and high training costs | UNFPA and its partners will put into place several measures to reduce turnover, including:<br>• Provide adequate budget for CPSW volunteer allowances to be pegged at minimum wage to ensure their working costs are catered for, and that they are motivated to continue their work<br>• Actively lobby local government partners to retain project-trained staff in OCMCs in the project location to reduce the risk of losing capable staff to other districts or *Palika*s.<br>• Provide budget for additional and/or refresher training sessions for new volunteers and staff and put in place a roster of trained staff and volunteers to minimize gaps in service provision<br>• Provide in-kind capacity building opportunities such as peer network meetings and forums of CPSWs, OCMC | **Low** |

| | | | | |
|---|---|---|---|---|
| | | | and Safe House staff to share information and learning, and build motivation and engagement and thereby reduce attrition rates | |
| Low interest for intergovernmental collaboration for shared services at local level. | **Medium** | **High:**<br>Local government might not be interested to collaborate with other LG to share the cost of Shelter services. This will affect the services for the GBV survivors as the shelter services might discontinue. | The project will provide support in Outcome 3 activities to develop the policies on intergovernmental collaboration. The project will ensure regular communication with the local government about the benefits of the shared services and organise joint monitoring visits between local governments for demonstrating success stories and best practice on cost sharing. | **Medium** |
| New leaders (after the election in 2022) at local and provincial level demonstrate low understanding and interest on gender equality and GBV services | **Medium** | **High:**<br>New leadership after the election at the local and provincial level might not share the similar understanding on the GESI policies and plans. The LG budget allocated for GBV services might not continue. | The project will develop an action plan prior to the election and implement the plan to introduce the project and its achievements to the new leadership. Advocacy and governance activities will be ramped up post-elections to strengthen relationships with any new officials, aided by the development of advocacy messages for IPs and UNFPA staff at local and provincial levels The election year will follow adaptive programming to strengthen the collaboration with new leadership at local and provincial level. | **Medium** |
| Channelling funds through government systems may result in bottlenecks and disbursement delays to local governments, thereby affecting delivery | **Medium** | **Medium:**<br>Delays in funds disbursement can affect coordination efforts and quality provision of response services at local government levels. | The funds flow strategy adopted by the project will spread the risk of monumental delays in disbursement of funds from federal to local government structures by providing multiple channels to provide funds both at federal and provincial levels to minimize the risk of delays. In addition, the majority of funding will be borne | **Low** |

| | | | | |
|---|---|---|---|---|
| | | | by IPs (NGOs), with a small proportion of the budget flowing through government systems. | |
| Project has adverse effect on the climate and the environment | **Low:** | **Low:**<br>The likelihood is low as the project is largely service-delivery based, with minimal activities that would impact the environment | Activities that could affect the environment include air pollution through travel to project locations. Mitigation measures will include ensuring project vehicles are well maintained to reduce their pollution capacity, not undertaking unnecessary travel and maximizing the use of printed materials. | **Low** |
| High COVID-19 infection rates result in a protracted lockdown and humanitarian crisis | **High:** | **High:**<br>A protracted lockdown will affect the programme's start dates, access to participants, and may result in funds being reprogrammed to respond to the crisis.<br>Additional risks include health and safety concerns for staff, IPs and participants in the field; diversion of efforts to address crisis, resulting in suspension of activities; or risk of increase in the incidence of GBV, which often worsens in humanitarian crisis settings. | UNFPA is well placed in the UN Protection Cluster in Humanitarian Crises/Emergencies to be able to provide support in response to natural disasters that may occur.<br>UNFPA's protocols for addressing GBV in humanitarian responses are also robust and would be prioritized to reduce risk to vulnerable groups in affected areas. However, if the crisis experienced is significant, there may be limitations to how far project activities can continue in reality, therefore the residual risk may remain high.<br>UNFPA will maintain close engagement and consultation with both donors if timelines are affected by the COVID-19, or any other crisis. | **High** |
| Severe humanitarian crisis caused by natural disasters (e.g. earthquakes, monsoon floods etc.) adversely affects project's ability to implement activities as planned. | **Low** | | | |

### 5.4 Project Oversight: Institutional Arrangements

In addition to the strategic and technical oversight provided by the Project Steering Committee as defined in the previous section (6.3), the project will also seek the engagement and ownership of Government stakeholders at Federal, Provincial and Local Government levels as outlined below.

***Figure 8: Project Oversight Arrangements***

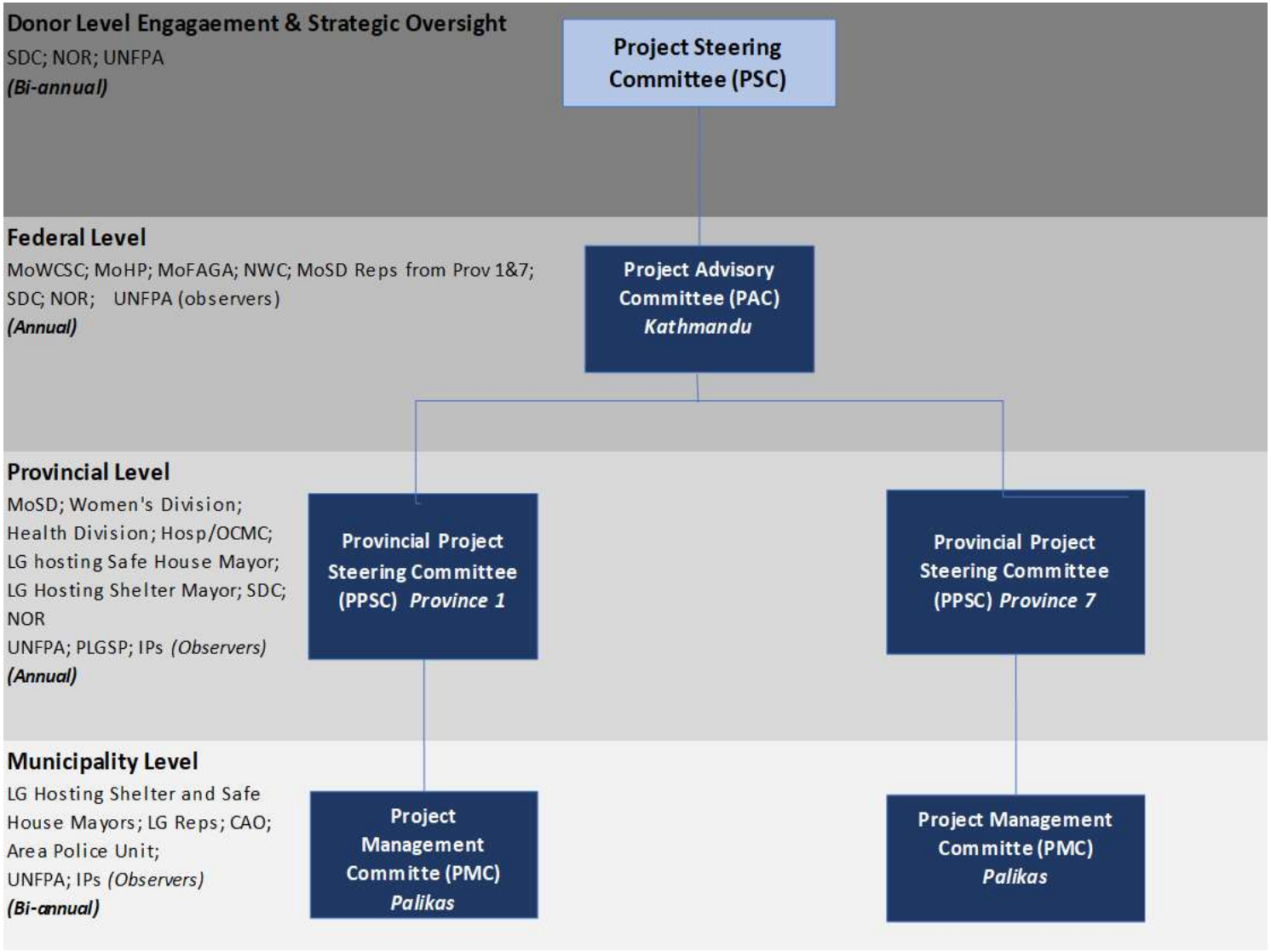



Figure 8 above outlines the institutional arrangements detailed below, for which UNFPA and IPs will provide secretariat services to organise, coordinate and follow up on meetings, resolutions and decisions. Members will have the ability to cast votes and make decisions (collectively), while observers are unable to vote/make decisions but can attend meetings. UNFPA will commence consultations with Government stakeholders in advance during the inception phase to ensure that the recommended structure receives Government endorsement before SDC and NOR issue the grant contracts.

A **Project Advisory Committee (PAC),** based in

Kathmandu, will advise the project on issues related to federal level policies and co-ordination between the federal, province and local governments. It will comprise the following:

- Ministry of Women Children and Senior Citizen (MoWCSS), Representative – Chair
- Ministry of Health and Population, Representative – Member
- Ministry of Federal Affairs and General Administration, Representative – Invitee
- National Women Commission, Representative – Member
- Ministry of Social Development Ministry (MoSD), Province 1 and 7, Representative – Member
- Swiss Agency for Development and Cooperation (SDC), Representative – Member
- Royal Norwegian Embassy, Representative – Member
- United Nations Population Fund(UNFPA), Deputy Representative and GBVPR Team Leader – *Observers*

The PAC will meet at least **once a year** and its main tasks consist of the following:

- Review the progress of project implementation and its results;
- Coordination between sectoral ministries at the federal level, and with provinces;
- Sharing of information and good practices;
- Stocktaking and resolution of policy issues;
- Coordination between and with other development programmes at the federal level.

The **Provincial Project Steering Committee (PPSC)** constitutes the steering mechanism for the GBV project. Each province will host one PPSC meeting annually which will be organised to coincide with the NOR/SDC/UNFPA bi-annual joint provincial visits, and where feasible, to coincide with the provincial government's annual meetings to discuss and oversee donor and development funding to maximise on their availability. Membership will consist of the following:

- Ministry of Social Development Ministry (MoSD), Secretary – Chair of PPSC
- Women Division, Undersecretary – Member
- Health Division, Undersecretary – Member
- Hospital/ OCMC, Representative – Member
- Local government hosting Safe House, Mayor (on a rotational basis) – Member
- Local government hosting Shelter Home, Mayor – Member
- Swiss Agency for Development and Cooperation (SDC), Representative – Member

- Royal Norwegian Embassy, Representative – Member
- GBV Project, Team Leader – *Observer*
- Provincial and Local Government Program (PLGSP), Team Leader – *Observer*
- Provincial Support Program (PSP), Team Leader (in the context of province 1) – *Observer*

The PPSC will meet at least once a year and has mainly a strategic function. Its main tasks are:

- Review and assess the overall implementation of the project and its results;
- Resolution of policy issues, coordination within the MoSD at the province level and with local governments;
- Endorse the Yearly Plan of Operations and the annual operational and financial reports;
- Coordination between and with other development programmes;
- Contribution to sharing and dissemination of learnings from the project.

The **Project Management Committee (PMC)** is the coordination mechanism between local municipalities and will include the following members:

i. Local government hosting Shelter Services, Mayor – Chairperson

- Participating local governments, Representative – Members
- Chief Administrative Officer (CAO) (rotational) – Member
- Judicial committee (on a rotational basis) – Members
- Area Police Unit (Elaka), Inspector – Member
- Service providers – *Observer*
- District coordinator, GBV Project – *Observer*

The PMC will meet biannually and the main tasks of the PMC include:

- Ensure overall coordination between the local municipalities;
- Monitor progress of the project;
- Resolve issues related to project implementation at the local level.

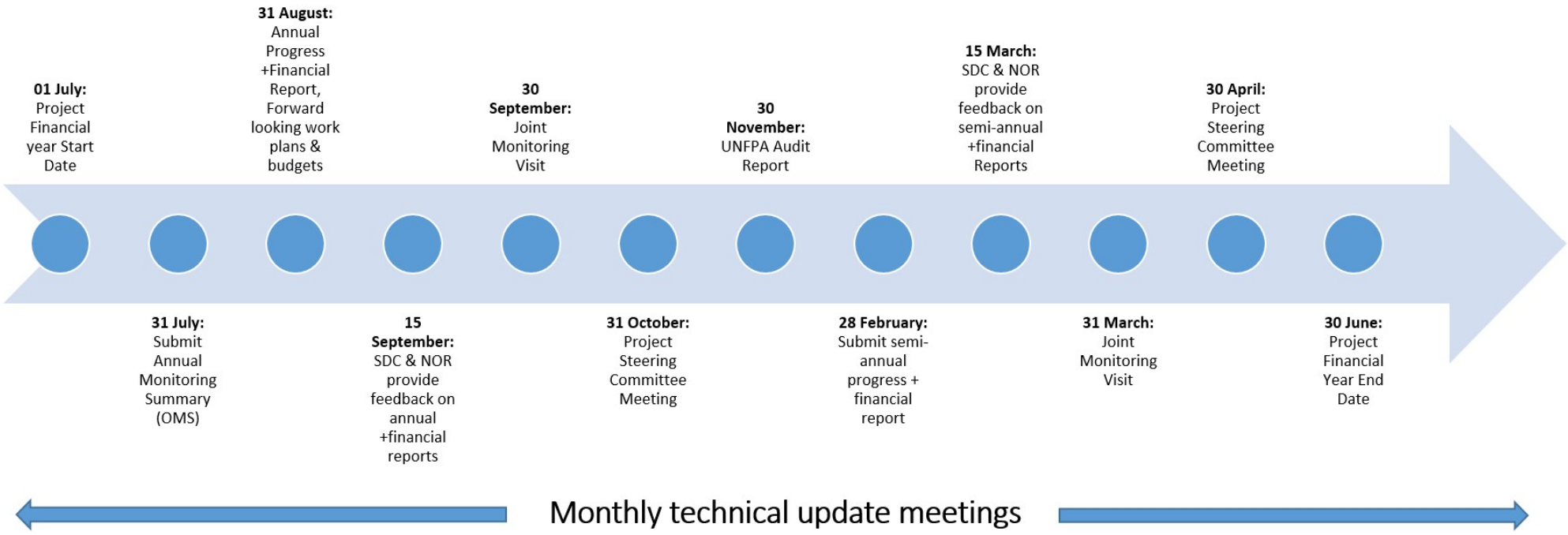
These institutional arrangements are therefore decentralized in alignment with the federal system and will allow space for federal, provincial and local government to engage both collectively and individually at their levels, taking into account the local contexts and needs. Within this structure,

implementing partners (IPs) will support the capacity and institutional development of provincial and local governments in conjunction with the UNFPA staff, with UNFPA in Kathmandu playing a central role in the oversight, coordination and supervision of implementing partners, throughout all implementation levels. UNFPA staff in provincial and local government locations are also responsible for managing relationships with Government, as well as monitoring of IPs at their respective levels, and feed this information up through the internal UNFPA reporting to ensure that the country office in Kathmandu is up to date with all engagements at the decentralised levels.

### 6.3 Reporting and Monitoring

As the project anticipates to receive joint funding from SDC and NOR, all activities, monitoring and reporting will also be done jointly. A Project Steering Committee (PSC) comprising of technical and operational leads in SDC, NOR and UNFPA will be formed and will be responsible for all project high-level decision making and approvals processes. The PSC will meet bi-annually and also conduct two joint project monitoring missions (one in each Province) each year. When necessary, it can also call for ad-hoc meetings if decisions need to be made outside its standard meeting times. Monthly technical and operational meetings will be held throughout the reporting year. The end of phase report will be required 9 months prior to the end of the project, and a final end of project report will be due 3 months after the end of the project. The figure below shows the annual project reporting and monitoring timeline and accompanying deadlines.

***Figure 7: Project Annual Reporting Timeline***



### 6.5 Phasing Out and Exit Strategy

Phasing out and exit strategies for outcome 2 and 3 are relatively straightforward since they are linked with public institutions and have a clear legal and policy mandate. Phasing out for outcome 1, which pertains interventions to change individual behaviours and social norms is far more complex, since behaviors and norms are dynamic and subject to multiple factors, as they emerge in the lives of people. A useful strategy for ensuring the positive behaviours continue and negative ones reduce is through official positions taken by a society, such as through (implementation of) its laws, policies and regulations. For example, through family dialogues, the project seeks to influence adults in the families to treat boys and girls equally and hence send girls to school. Such intervention could change behaviour of individual family participating in the project but not necessarily for other families who are not participating or families that come after project ends. To sustain impact for participating family as well for non-participating and future families, government interventions to promote girl's education are necessary (such as through transfers, providing good quality education for free, etc.). As such, sustaining results of outcome 1 is linked to successful achievement of outcome 3- whereby governments, through their policies and allocation of resources, for instance, support a new social norm.

In Phase II, the project will advocate with governments for reviewing the role of CPSW, going beyond just the mandate of GBV prevention and response, to functioning as social workers, with GBV being one of their focus areas. While intensive reflection workshops with specific cohorts will end with the project, CPSWs who would by then be fully institutionalized, could continue to reinforce key messages through their home visits and regular sessions with CBOs, long after the project has ended. Since they are already monitored by local governments in locations where they have been institutionalized, the local government will continue to provide mandate and be held responsible for continuing to support positive messaging through CPSWs. Additionally, the gender transformative training of health sector staff, which will be institutionalized in their regular trainings, will ensure that key messages (on positive social norms) continue to be disseminated through health sector staff, including FCHVs, long after the project has ended. Finally, the project strategy of facilitating critical reflection among younger generation (through family dialogue and peer group education in community and schools) will influence their behaviours as adults, in families and CBOs that they participate in long after the project ends.

The first phase of the GBVPR project was successful in demonstrating response models, specifically the CPSW model as front line psychosocial first responders, and leveraging this success with local governments to adopt the model into their systems. As a result, in 10 of 11 municipalities in Province 1 and 3 of 9 municipalities in Province 7, local governments adopted CPSWs as full time staff and cost shared their salaries with the project. In three of four shelters supported by the project in Province 1, local governments have contributed towards building and/or running costs of shelters, with high interest in fully absorbing shelter services through cost-sharing with local governments in neighboring municipalities. With each progressive year, local governments' cost share towards CPSWs and shelters have increased and it is likely that by the end of Phase II, the majority of local governments from Phase I would have fully absorbed the CPSW and shelter services.

Applying a similar cost sharing model with new local governments joining phase II, UNFPA expects that by end of the four-year implementation period, through evidence based advocacy (including visits to demonstration models) and development of policies to promote gender equality and eliminate GBV, the

project will be able to fully institutionalize the services of CPSWs and shelter homes. UNFPA will continue to provide technical support to local governments for training and mentoring of staff through implementing partners and advocate with provincial and local governments to partner directly with technical support agencies for continued training and mentoring after the end of Phase II.

Where the project currently funds the salaries of two case managers and one outreach counselor for each of the OCMCs supported in Phase I, the project will advocate with other development partners, (including DFID and the World Bank) the Ministry of Health and Population, provincial and local governments to collaboratively share costs for full staffing of the OCMCs and regular training and mentoring by technical expert agencies. The Blended Learning Module for Clinical Management of GBV and Clinical protocols for GBV Management are already institutionalized with the MoHP and the project will advocate for institutionalization of gender-transformative training for health workers by end of Phase II based on the evidence generated. MoHP and provincial governments in Province 1 have already expressed interest and willingness to provide funding for full staffing of OCMC as per the project model and UNFPA will build upon this interest, through visits to OCMCs supported by the project to solidify commitments of MoHP as well as Provincial governments for institutionalization of the model by end of Phase II. Facilitating inter-governmental coordination and collaboration will be a key strategy for ensuring institutionalization of services with governments. A more detailed sustainability assessment will be carried out as part of the Mid Term Review to provide insights into mechanisms that are already working, and how these may be strengthened, as well as recommendations for activities to be further supported to enable a sustainable exit.

### 6.6 Monitoring Evaluation and Learning

The Monitoring, Evaluation and Learning (MEL) Plan for Phase II comprises four core areas:

**i. Baseline and Endline surveys**

Baseline data collection for all indicators in the logical framework will be completed within the first 6 months of the project implementation. Target and milestones for four-year period will be set/ adjusted once the baseline results are available. End line data collection will be completed by the third quarter of the final year so that results can be assessed for next steps.

**ii. Ongoing monitoring of results (Quarterly)**

Monitoring will be mandatory for all programme activities regardless of whether implemented by IPs or by UNFPA directly. Regular monitoring includes an assessment of how the implementation of activities (programmatically and financially) is progressing compared to what was planned, and on progress made towards results. Monitoring activities will also aid project steering and decision making. The planned monitoring activities are as follows:

- **Quarterly submission of monitoring data** and reports by IPs, tracking progress against results and reporting any concerns or case studies.

- **Quarterly review planning meetings with all IPs** will help partners (a) to get accurate assessment of implementation in line with what was agreed in the work plan; (b) to assess if project is on track to achieve results and outputs (c) to identify and resolve implementation obstacles, and (d) to discuss and elaborate on collaboration between IPs and harmonisation of approaches. One of these meetings will serve as an annual review and planning meeting which will assess yearly progress against results and expenditure in preparation for the submission of the annual Outcome Monitoring Summary (OMS).
- **Quarterly site-visits to the office of the IPs and/or to the implementation site(s)** with the purpose of verifying records and documents as well as quality of activity implementation (e.g. monitoring of trainings). Site visits will be documented as per prescribed format for mission reports by concerned staff. Follow up on the recommendations and action points listed in the monitoring will be done on a quarterly basis.
- **Tracking of key programmatic/financial data** will be done on a quarterly basis to ensure funds are spent as planned within given timelines.
- **Joint monitoring visits with SDC and NOR,** bi-annually will enable partners to jointly review and reflect on progress and feed in learning from the project into interventions and activities.
- **The Outcome Monitoring Summary (OMS)** will be submitted on a yearly basis by tracking results on outcome and output levels in preparation for the submission of the annual progress report, informed by regular monitoring and monitoring visits by IPs and UNFPA.

### iii. External Reviews

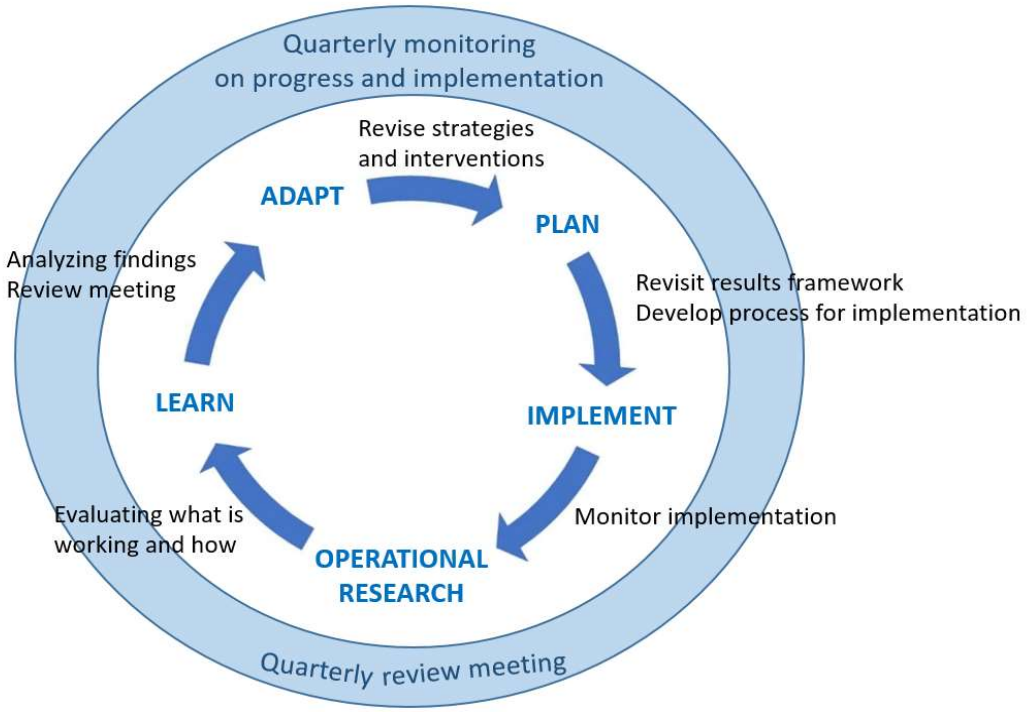
A **mid-term review** will be conducted at the end of second year/beginning of the third year of the project, primarily to assess (i) how the project is faring after election of new governments in 2022 and (ii) if services are being institutionalised and whether the project is on track for completion of Phase II. In the last quarter of Phase 2, an **external review** of the project will be undertaken to assess the extent and quality of achievement of outcomes, and elaborate on the end line data that is collected. This will also inform the potential next phase design, if any. It will include site visits, reviewing of monitoring data as well as review of the operational research.

### iv. Operational Research

Longitudinal assessments of this multi-component project will be conducted to understand the impact of the intervention and examine mechanisms of change, with the dual purpose of informing interventions for course corrections as well as for concluding the project with evidence-based documentation. Research tools could include in-depth interviews with participants, focus group discussions with different cohorts including community leaders and observation and different points in the implementation to enable iterative and parallel data analysis and track change over time. Data generated from such research, combined with data collected through ongoing monitoring of intervention activities will provide information on what is working and how, tracking results as they emerge and informing our understanding of the impact of different interventions to change social norms and behaviours. A diagrammatic representation of how this feedback loop will work is outlined in Fig. 9 on the next page.

UNFPA will seek to collaborate with other development partners engaged in similar research and evidence collection such as DFID and contribute towards evidence base for Nepal and global audiences. The operational research is also expected to feed into the global evidence base on what is working to prevent GBV and give insights into how, in addition to changing norms and behaviours at the community level, gender-transformative, multisectoral and survivor centered response contributes to preventing GBV.

***Figure 9: Operational Research Feedback Loop***




To complement regular monitoring, the research will also capture qualitative evidence and validate assumptions on the indicators of:

- The proportion of women survivors who return to report repeated/continued violence (Goal, Indicator 2);
- Percentage (%) of men and boys share in household chores (Outcome 1, Indicator 2);
- # of cases referred by influential leaders (Output 1.2)
- % of budget allocated for GE and WE in governments' plans at local, provincial and federal level (Outcome 3, indicator 2)

The table below summarises the rationale for the operational research and the expected methodology and timelines for implementation.

***Table 8: Operational Research Summary***

| What | Why | When | How | Where | Who |
|---|---|---|---|---|---|
| To assess share men and boys increasing share in household chores | To assess and report on the Outcome 1 indicator | Every year | Sample interviews and FGDs with girls in schools | Selected schools | UNFPA through a research consultant/ agency |
| Assess the effectiveness of prevention and response interventions resulting into reduction of repeated violence | To triangulate and report on the effectiveness of prevention and effectiveness focusing on Goal level indicator 2 | 2nd year and 4th year | Analysis of selected GBV survivors case analysis | Selected OCMCs and shelter homes | |
| Assess whether the community mediators and JCs trained on GTA are working or not | To assess the effectiveness of GTA training and its impact towards handling of GBV cases from GBV-centric approach or not. This will feed information on effectiveness of training under Output 2.4 | 2nd year and 4th year | Analysis of resolved cases by community mediators and JCs | Selected GBV cases resolved by community mediators and JCs | |
| Assess whether the religious and community leaders trained on GTA are working or not | To assess the effectiveness of GTA training and its impact towards referral of GBV cases by the influential leaders under Output 1.2 | 2nd year and 4th year | Analysis of GBV cases referred by influential leaders and referral pathway mechanism | Selected GBV cases referred by influential leaders | |
| To assess the level/% of budget allocated for GE and WE programmes by all three levels of governments | To get data on contribution of govt. from all levels that reflect their commitment as a result of effectiveness advocacy | Every year | Analysis of budget and program documents of all three tiers | 19 *Palikas*, 2 Provinces and federal govt. | |

| | | | | | |
|---|---|---|---|---|---|
| | and awareness raising by the project | | of governments | | |

The operational research will result in the production of policy briefs to inform programming, case studies on promising practices and a final report capturing findings and recommendations from the project. The findings will then be incorporated into programming to refine and improve project interventions and strategies, as well as feed into the global evidence base on effective interventions on GBV. An external research agency will be selected to carry out the research, and the methodology will be developed in partnership with contracted agency and informed by the experience of operations research carried out in the last year of Phase I.

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- END -

## 6. Annexes

### Annex 1: Phase II Logical Framework - August 2020 to August 2024

| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| **Goal: All forms of gender-based violence and discrimination against women and girls are reduced in 2 provinces in Nepal.** | Proportion of women and girls who have experienced any form of discrimination and/or violence - Physical, Sexual, Emotional (Verbal), Economic and Cultural - in previous 12 months | TBD after baseline | 17% reduction from baseline | Survey (Baseline, Endline) | **If** a) interpersonal relationships are based on values of compassion and equal/shared power; b) GBV survivors heal/recover from GBV with high satisfaction on services; and c) the survivors have equitable access to socio-political entitlements/opportunities with gender responsive policies/budget at governments, **then** GBV survivors increasingly report/address GBV and all forms of GBV and discrimination against women and girls will be reduced in 2 provinces in Nepal. |
| | Proportion of reporting women survivors who return to report repeated/continued violence | 64.4% | 47.5% | OCMC, Safe Houses, Police, Health posts, CPSWs and formal and informal justice system | |
| **Outcome 1: Women and men, including girls and boys increasingly prevent, report and address gender-based violence** | | | | | |
| **Outcome 1:** | Percent (%) of women and girls reporting cases on GBV as survivors | 14.4% (NDHS 2016, reporting to doctors, police, lawyer & social org.) | 17.7% | OCMC, Safe Houses, Police, Health Facilities, formal & informal justice system and periodic surveys (NDHS and MICS for province level) | If it is understood and internalized that women and men all have equal rights and opportunities for survival, development and participation at individual and community levels, then survivors will increasingly report/address GBV and interpersonal relationships will be based on values of |

| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| | Percent (%) of men and boys increasing their share in household chores | 2.9% (KAP Survey 2019) | 4.4% | Sample interviews and focus group discussions with girls (i.e. daughters and sisters) in schools | compassion and equal power and shared tasks.<br><br>Risk: (Mis-)perception that the project causes increased incidence of violence against women and girls due to increased reporting and discussions. |
| **Output 1.1 Community facilitators have the capacities to conduct reflective sessions with target groups on social norms** | Percent (%) of facilitators trained with increase understanding on social norm and social norm change | 48% (SMs, Rupantaran Fs & CSE teachers & PEER educators in 2019) | 80% | Training/orientation report with pre and post-test evaluation | If facilitators have increased understanding (and better skills to conduct sessions) on social norms change, then target groups will benefit from reflective sessions on social norms, internalize the equal relationships, and challenge harmful social norms. |
| **Output 1.2. Individual and groups of men, women, boys and girls have enhanced capacity to challenge discriminatory social norms** | Percent (%) of individuals trained in each target groups who are able to identify discriminatory social norms | 33.5% (KAP survey 2019) (average score) | 67.0% | Training/orientation report with Pre and Post training evaluation | If individuals have increased awareness/understanding on GBV, then they will be able to identify and challenge discriminatory social norms. |
| | Number of instances of follow up by CBOs with the justice system | 146 (6 districts of P1&P7 Jul-Dec.19)<br><br>(This is based on follow up | 1,423 | Record keeping by IPs | If the CBOs are sensitized and capacitated on social norms, GBV and GTA, then with their increased understanding, they will be capable to follow up with the justice system on GBV cases. |

| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| | | by IPs, need verification to identify # followed up by CBOs) | | | |
| | Number of cases referred by influential leaders | 45 (6 districts of P1&P7 Jul-Dec.19) | 439 | Record keeping by IPs/case studies based on records from service providers | If religious and community leaders are sensitized on GTA and GBV, they will raise voices on GBV and refer GBV cases to various services. |
| **Outcome 2: Local governments, legal authorities and health facilities provide effective (multi-sectoral) survivor-centred responses to gender-based violence** | | | | | |
| **Outcome 2.** | Percent (%) of GBV survivors reporting satisfaction with services received from OCMC | 82% (2019) | 95.0% | Exit interview report from OCMC | If service providers and governments provide quality, multi-sectoral and survivor-centred response service, then the satisfaction of GBV survivors will increase, and they will be able to successfully recover, heal and be protected from GBV with the provided service.<br>Risk: Safeguarding risks through threats to service providers along the referral continuum from perpetrators of GBV against women and girls. |
| | Percent (%) of GBV survivors reporting satisfaction with services received from shelter homes | 89% (2019) | 95.0% | Exit interview report from Shelter Home | |
| **Output 2.1 Government and non-governmental actors have enhanced** | Number of GBV survivors who received services at a set standard from shelter homes. | 815 (2019) | 3,854 | Shelter homes report by IPs | If government/non-government actors enhance understanding/knowledge on the minimum standard for shelter homes, more GBV survivors will benefit from quality service from shelter homes. |

| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| **capacities for the provision of quality services through temporary shelter homes for survivors** | | | | | |
| **Output 2.2 The health sector has enhanced capacities for the provision of quality services through one-stop crisis management centers, health posts and network of female community health workers** | Number of GBV survivors who received minimum standard services from OCMC | 1,280 (2019) | 6,055 | OCMC report by IPs | If health service providers are well trained and apply the skills as per minimum standard, the quality of health service will increase and more GBV survivors will benefit from OCMC service that meet the set standard. |
| **Output 2.3 Local governments have enhanced capacities to provide community-based** | Number of GBV survivors referred by CPSWs along referral pathway (disaggregated by type of service - shelter, OCMC, police) | 207 (2 districts of P1, Jul-Dec. 2019) | 3,480 | CPSW referral and outreach reports, (triangulated by OCMC and shelter reports on referral), quarterly | If local governments enhance understanding on and support CPSWs, more GBV survivors will benefit from outreach/service from CPSWs and referral pathway will become strengthened. |

| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| **psychosocial services which are institutionally linked through the referral pathways** | | | | | Risk: Local governments not prioritizing the cost of CPSW and Shelter services |
| **Output 2.4 Informal and quasi-justice systems are strengthened to mediate GBV cases through a gender transformative approach** | Number of community mediators and Judicial committee trained on GTA | 35 JCs,<br>0 CMs | 114 JCs,<br>38 CMs | Training, mentoring report, Progress reports, event reports | If informal/quasi justice systems strengthened on GTA, then GBV survivors will benefit from receiving more survivor-centric decisions as trained mediators will have favourable attitudes and appropriate knowledge/skills towards gender social norms/GTA. |
| **Outcome 3: Local, provincial and federal governments adopt and implement policies and budgets for the promotion of gender equality and the empowerment of all women and girls** | | | | | |
| **Outcome 3:** | Number of local and provincial governments assembly who have formulated/updated GEWE policies that are consistent with federal GEWE framework | 0 | 9 local and 2 provincial governments | Policy documents, official records[38], qualitative review by UNFPA | If governments adopt and implement gender responsive policies/legislation/budgeting with strengthened coordination, then GBV survivors will have equitable access to socio-political and justice entitlements/resources/opportunities. |

[38] Metadata needs to define what is GEWE Policy and what type of legislation is being counted

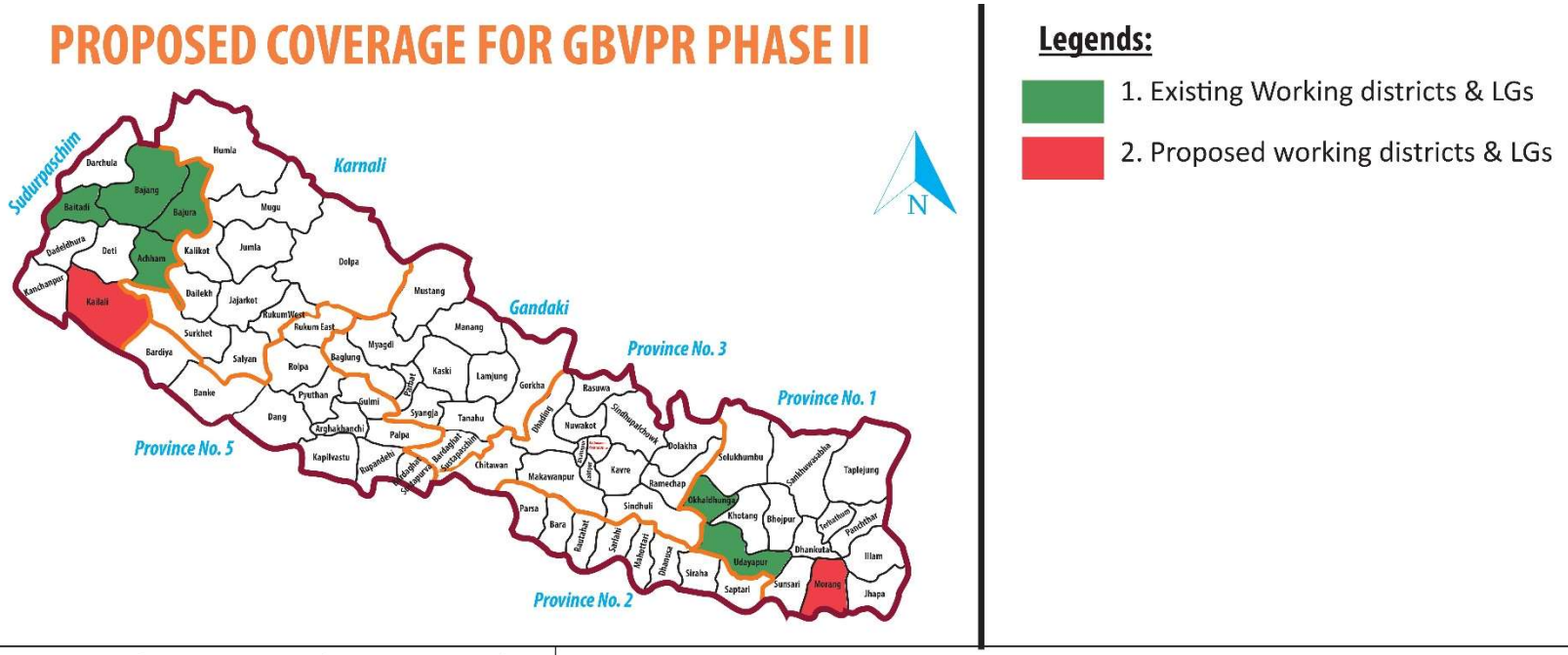
| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| | Percent (%) of budget allocated for GE and WE in governments' plans at local, provincial and federal level | TBD after baseline | 40% increase from baseline | Annual budget and programme of federal, provincial and local governments[39] | Federal GEWE framework is endorsed by the federal government.<br>Risks: delays and bottlenecks due to channelling funds through government systems; new leaders (after the election in 2022) at local and provincial level with low understanding/interest on GE/GBV. |
| **Output 3.1 Local and provincial governments have improved capacities to implement gender responsive plans, policies, legislation and budgets** | Number of LGs and Provincial governments (elected and staff members) trained on GTA | 0 | 776 | Progress reports, event reports | If governments are trained on GTA, then policy/ legislation/ budgeting will be implemented in gender responsive ways. |
| | Percent (%) of local government that allocate budget for GBV programme | 26% LGs (2019) | 56% LGs | Palikas official report | |
| | Number of palikas and wards that adopt ESP protocols developed for effective multi-sectoral coordination/response | 0 | 87 Wards of 19 Palikas | Official documents, meeting minutes, draft policies and qualitative review from UNFPA | If more Palikas and wards adopt ESP protocols, then effective multi-sectoral GBV response and coordination will be in place, and survivors will benefit from the gender responsive protocols. |
| **Output 3.2 Local and provincial** | GEWE indicators are incorporated in the LISA[40] | No | Yes | LISA database | If GEWE indicators are incorporated in the LISA and coordination meetings take place as |

[39] This data will be disaggregated by categories: GRB direct, indirect and neutral

[40] The LISA database is a self-reporting mechanism for Local Government, it is not yet operational, but the project will liaise with other UN Agencies and DP to ensure that GBV indicators are included.

| Results | Indicators | Baseline | Phase target (2020-2024) | Means of verification (MoV) | Assumptions and Risks |
|---|---|---|---|---|---|
| **governments have improved collaboration and coordination on shared multi-sectoral services on GBV** | Number of coordination meetings are held as per standard (ESP) protocol | 0 | 133 (19 LGs*2 per year, but only one in Y1) | Evaluation of coordination meeting reports, quarterly (by IPs) | per ESP protocol, then governments will have improved collaboration and coordination for multi-sectoral GBV services, and survivors will have ensured access to justice and entitlements by the protocol.<br>Risk of low interest for intergovernmental collaboration for shared services at local level. |

## Annex 3: Map of Intervention Areas (Provinces; Districts; Municipalities)




| Province No. 1 (3 Districts, 1 Metropolitan city, 5 Ms, 3 RMs) | | | Sudur Paschim Province (5 Districts, 1 SMC, 8 Ms, 1 RM) | | | | |
|---|---|---|---|---|---|---|---|
| **Morang** | **Okhaldhunga** | **Udaypur** | **Kailali** | **Achham** | **Baitadi** | **Bajhang** | **Bajura** |
| 1. Biratnagar Metropolitan City | 1. Siddhicharan Municipality<br>2. Manebhanjyang Rural Municipality<br>3. Molung Rural Municipality<br>4. Chisankhugadi Rural Municipality | 1. Katari Municipality<br>2. Triyuga Municipality<br>3. Chaudandigadhi Municipality<br>4. Belaka Municipality | 1. Dhangadhi Sub Metropolitan City | 1. Mangalsen Municipality<br>2. Kamalbazaar Municipality<br>3. Sanphebagar Municipality | 1. Patan Municipality<br>2. Dasarathchand Municipality | 1. Jaya Prithwi Municipality<br>2. Bitthadchir Rural Municipality | 1. Badhimalika Municipality<br>2. Budhiganga Municipality |

## Annex 4: Coherence with Strategic Frameworks

The proposed second phase of the GBVPR project (GBVPR Phase II) is fully in line with relevant strategic plans, including the Sustainable Development Goals and the 2030 Agenda, the 15th development Plan of Nepal, the Development Cooperation Strategies of the Governments of Norway and Switzerland, the United Nations Development Assistance Framework (UNDAF), the UNFPA corporate strategic plan and the UNFPA supported Eight Country Programme for Nepal 2018-22.

i. **Sustainable Development Goals (SDGs):** The proposed second phase will contribute towards specific targets for SDG 5 for Nepal: (i) Eliminate gender disparities at all levels of education by 2030 particularly in tertiary level education (ii) Eliminate wage discrimination for similar work. (iii) Eliminate physical and sexual violence. (iv) Eliminate all harmful practices, such as child, early and forced marriage.

ii. **Swiss Cooperation Strategy 2018-21:** Outcome 1.1 of SDC's strategy aims to support the federal state to provide political stability, social inclusion and economic prosperity, amongst others, by fostering capacity and knowledge on federalism among citizens, civil society groups and public decision makers, as well as influencing policy level discourse on Gender Equality and Social Inclusion (GESI) issues. Outcome 1.2 pledges to support subnational governments to ensure inclusive and accountable development, for instance, through support to the establishment of institutions, rules and regulations at all level for the implementation of the constitution. Capacity building of locally elected representatives in order for them to strengthen and run the new local level governments, and the facilitation of public dialogues among public institutions and citizens for sectoral policy formulation and implementation are also prioritised.

   Outcome 1.3 relates to citizens, especially women, influencing the functioning and the decisions of the state. This includes capacity building and empowerment of women to exercise their rights and responsibilities, and meaningfully participate in state restructuring processes, as well as support to the survivors of violence to claim resources from the state. Moreover, the project is coherent with other SDC interventions in Nepal such as the Safer Migration project, the Enhanced Skills for Sustainable and Rewarding Employment (ENSSURE) project and the She Leads project.

iii. **Norway's Action Plan for Women's Rights and Gender Equality in Foreign and Development Policy 2016-2020:** this plan seeks to promote inclusive and equitable quality education for all girls and boys; women's equal participation in political life; full economic rights for women and equal opportunities for women to participate in the labour market; the elimination of violence and harmful practices against girls and women; and sexual and reproductive health and rights for girls and women.

iv. **The 15th plan of the Government Nepal's latest 3-year plan** (approach paper), sub-chapter 7.6, outlines a strategy for gender equality and women's empowerment, including increased access to justice and prevention of SGBV and discrimination.

v. **UN Development Assistance Framework (UNDAF):** The project is fully in line with the UNDAF Outcome 2, which states that "By 2022, there is improved access, availability and utilization of quality basic social

services for all, particularly for vulnerable people". Specifically, Outputs 2.4.1 and 2.4.2, refer to "Government at national and sub-national level have enhanced capacity to formulate, implement and monitor policies related to prevention and response to gender-based violence" and "Women, men, and young people have improved capacity to question and change harmful social and cultural norms which perpetuate son preference, acceptance of gender-based violence, and child marriage", respectively.

vi. **UNFPA's Strategic Plan and Eight Country Programme for Nepal 2018-2022**: Outcome 3 of the Strategic Plan focuses on advancing gender equality and human rights to empower women and girls and marginalized and excluded populations to exercise their reproductive rights free of coercion, discrimination and violence. This means eliminating all forms of discrimination and violence against girls and women, including discriminatory social and gender norms and legal barriers, violence by intimate partners, sexual violence and harmful practices. Under the country programme, outcome 3 on gender equality and women's empowerment states "UNFPA will advocate for legal reform and enforcement of policies to address gender-based violence and harmful practices". The programme will strengthen national capacity to prevent and respond to gender-based violence through a) technical assistance for provision of multi-sectoral services to survivors; b) integration of gender-based violence within the health response and in disaster policies and plans, and c) advocacy for enhanced data collection and analysis to enable appropriate targeting.

## Annex 5: Synergies and Complementarities with Other Initiatives

The project will collaborate with three concurrent SDC initiatives, a joint initiative with multiple development partners including the Norwegian Ministry of Foreign Affairs (NOR), as well as with other development partners as outlined below:

i. **The Provincial and Local Governance Support Programme** (PLGSP) is jointly supported by various development partners including SDC and NOR and has recently been launched. It will be implemented nationwide to improve the state building of local and provincial governments. Within its larger framework, PLGSP will also support local governments to develop GESI strategies and initiate and draft GESI audits and status reports. It will also include the development of training manuals on mainstreaming GESI issues in local governance and the development of a self-assessment tool by the local governments (LISA) to improve their institutional capacity and service provision to their citizens. In Phase II, the GBVPR project will collaborate with the PLGSP, in particular with their GESI expert to provide inputs and build synergy among projects.

ii. **State Support Program** funded by SDC focuses on supporting government of Province 1 to implement federalism through well-functioning, inclusive institutions and systems. It will support the systematic integration of GESI dimensions in provincial policies and legislation, HR system, GESI responsive budgeting and strategic planning processes. SSP will also develop a GESI responsive annual budget

appraisals and train elected government representatives and their administrative officials on GESI tools. In Phase II, the GBVPR project will work closely with the SSP to ensure complementarity and avoid duplication.

iii. **She Leads,** a project to empower elected women representatives in all local governments in Nepal is implemented by the International Foundation for Electoral Systems (IFES) and co-financed by SDC and Australia's Department of Foreign Affairs and Trade (DFAT). It aims to strengthen leadership and the meaningful participation of women in political decision making in Nepal, and envisions creating an enabling environment where local governments, elected representatives, men, social leaders and political party leaders respect women and support women's role in politics. The GBVPR Phase II project will collaborate with She Leads in training elected women representatives and their offices.

iv. **Enhanced Skills for Sustainable and Rewarding Employment (ENSSURE)** is a bilateral initiative between the Government of Nepal and SDC, implemented by the Council for Technical Education and Vocational Training (CTEVT) across Nepal, with technical assistance from Helvetas. The project addresses issues such as unemployment, under employment and unfair pay affecting the Nepali labour market. GBVPR collaborated with ENSSURE in providing career counselling to adolescent boys and girls participating in UNFPA supported *Rupantaran* programme in Phase I. In Phase II, UNFPA will continue to collaborate with ENSSURE for continuing this support to adolescent boys and girls that participate in the community-based and/or school-based interventions of GBVPR Phase II, and to explore linkages with survivors at shelter homes who are in need of skills development and employment (the costs for these services will be borne by ENSSURE)

v. **Action for Development (AfD**) is a Development Management Consulting Firm specializing in labour market related skills and enterprise and vocational training, and self-employment programmes for women GBV survivors in Province 7 financed by NOR under GBVPR Phase I. Going forward, UNFPA will continue to link GBV survivors with AfD and the cost for these services will continue to be borne by AfD through their funding from NOR.

vi. **Other Development Partners** that UNFPA has had several rounds of discussions with include DFID and World Bank who are also working to end violence against women and girls in Nepal. A couple of areas of collaboration have been identified, such as joint advocacy with the Ministry of Health and Population, provincial and local governments for pooling resources to share costs full staffing of the OCMCs and regular training and mentoring by technical expert agencies. Another area of collaboration will be on research and evidence generation, including sharing of methodologies with DFID on operational research to generate evidence on what works to end violence against women and girls. In order to avoid duplication of effort, in Phase II, the project will coordinate with DFID to ensure that the police and courts in the project locations are linked with DFID's programme to strengthen access to justice. As such UNFPA will not conduct separate trainings for the police in the project locations but link them with existing training provided under DFID supported project.

In addition to the World Bank and DFID, other development partners working to end gender-based violence, such as UN Women, UNODC (please add others) have expressed interest in regular consultations amongst each other for sharing, learning and collective advocacy. This was evident in the generous participation by development partners during consultations hosted by UNFPA in preparation for Phase II. UNFPA has offered to co-organise such regular consultations with other development partners. At the provincial and district level as well, UNFPA staff and project teams will continue to organise and/or participate in consultations with project teams of other development partners to exchange information, ideas and identify areas for collaboration.