Health Sector Transition and Recovery Programme

Case Study

Performance of Hospital-Based One Stop Crisis Management Centers (OCMC)

Ministry of Health
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Executive Summary

The Ministry of Health and Population (MoHP) introduced one-stop crisis management centers (OCMCs) in hospitals in 2011 to provide integrated services to survivors of gender based violence (GBV). In 2015, after the devastating earthquake, to address the needs of GBV victims in disaster affected districts, three OCMCs were established. Lack of physical space for dedicated OCMC staff at hospitals post-quake, lack of adequate safe home services and lack of counseling capacity of OCMC staff, affected access and the quality of care provided to GBV survivors. This case study has been carried out to capture the learning from well-performing OCMCs in non-disaster affected districts (Makwanpur and Sunsari) and to investigate the challenges faced in providing GBV services in earthquake affected areas (Dolakha and Sindhupalchowk). The purpose of this study is to capture the:

(i) Pathways and barriers to accessing OCMC services from the survivor's perspective.

(ii) Performance and management of OCMCs in terms of service delivery strengths, constraints and gaps, their effectiveness in terms of coordination with other agencies and areas for improvement.

(iii) The risks of GBV and performance of OCMCs in disaster and non-disaster affected areas.

Findings

A. Pathways and barriers to accessing OCMC services

A total of 16 survivors were interviewed to identify the pathways and barriers to accessing help and OCMC services. The study revealed that most of the perpetrators are intimate partners/husbands alongside family members. The main barriers reported by women were:

Workload at home: Most of the women survivors interviewed belonged to poor families and spent their day working at home and in the field. Going to the hospital could mean being away from home for at least a day, in some cases two days, which poor women cannot afford to take and risks further violence from intimate partners/husbands.

Financial factors: As pointed out by survivors, financial factors are a major barrier to accessing health services including lack of funds to pay for transport, lack of control over how money is spent, and being unable to spend time away from livelihood activities.

Socio–cultural and religious beliefs: Socio-cultural and religious beliefs impact women's service seeking behavior. Most of the survivors interviewed who are married believed, "*women are secondary to men and they have to obey their husbands"*. Survivors generally never talked about the violence experienced

by them openly and never sought any help. Women felt that keeping family dispute inside the family was a way of resolving family conflicts.

Social restrictions and fear: The main reasons for not seeking help were embarrassment, fear of rejection and fear of further violence from the perpetrator.

Son preference: Son preference has deep cultural roots in Nepali culture and society. Two of the survivors interviewed reported that they had suffered emotional and physical violence from their husbands and mother in laws for not being able to bear a son. They also shared that those who had not produced sons were stigmatized and labeled with different derogatory names, such as "Aputo" meaning "man without son"[1].

Ecological barrier: In all three districts, most of the survivors interviewed resided far from the hospital. They said that distances between their home and hospital where OCMC services are provided inhibited access to services.

Uninformed: Lack of awareness and information inhibited women's access to OCMC services. From the information shared by survivors their whole time is spent inside the house doing household chores and in the field fending for food; leaving with literally no time. Women's relatives' lack of exposure to the "outside world" and their rights is another reason for their subjugation and acceptance of violence.

Women with physical disability face additional challenges and social exclusion.

Lack of shelter homes: Inadequate number of shelter homes and lack of shelter homes pose another barrier for women.

Barriers to legal action: Most of the women interviewed lacked knowledge on legal issues and most women were reluctant to take legal action due to the expenses involved in filing a court case and attending court.

B. Performance and management of OCMCs

The OCMC in Sindhupalchowk district was not fully functional at the time of the study and therefore the study mainly focused on the three districts of Makwanpur, Sunsari and Dolakha.

The study found that the performance of OCMCs in terms of the number of clients served, the functionality of the centre compared to the government's guidelines, staff attitudes and multi-sectoral coordination had improved over time in Makwanpur and Sunsari. Achievements include adherence to privacy and confidentiality standards, improved psychosocial counseling, informal follow up of survivors post-treatment and empathetic staff. Good progress has been made in Dolakha since its establishment post earthquake but much remains to be improved.

[1] There is no exact word in English for "*aputo'*

The critical gaps hindering the performance and effectiveness of all OCMCs are:

- Lack of appropriate infrastructure
- Inadequate staffing of the centre
- Insufficient capacity building and training of OCMC staff and supporting hospital teams including doctors to undertake medico-legal examinations
- Low public awareness of OCMCs and the illegality and consequences of GBV
- Insufficient budget to fund comprehensive services to GBV survivors

Good multi-sectoral coordination and district ownership of OCMCs was found in the three districts. However, lack of safe homes for GBV survivors, and insufficient numbers of female police officers to provide a dedicated police presence at the OCMC are gaps that affect the quality of OCMC services and support for survivors.

C. Risks of GBV and performance of OCMCs in disaster vs. non disaster affected districts

The increased risk of GBV in disaster settings is well documented. In Dolakha the number of reported GBV cases increased in the year post-disaster and have since reduced. In contrast in Sindhupalchowk where there was an active presence of community mobilization to prevent GBV this was not found.

In disaster affected districts the immediate focus for health service providers should be on caring for victims of violence and on taking measures to prevent abuse and exploitation by providing immediate health care and psychological support for GBV survivors, including ensuring that Clinical Management of Rape is available in health centres and through mobile teams.

The establishment of OCMCs in the post-disaster context was hampered by the physical devastation, lack of human resources and the strains on the health system in the country. Functioning OCMCs could be a valuable resource in disaster settings both for responding to GBV and mental health clients. However in disaster affected districts without an OCMC, the time it takes to establish an OCMC means they are a long term strategy for responding to GBV and this needs to be complemented by more immediate action to prevent GBV and respond to cases. The location of OCMCs in district headquarters also impedes rural client's access to services especially in a disaster context where movement is more problematic than normal.

D. Recommendations

The following recommendations are based on the findings and observations collected during the study.

Infrastructure

There is need to improve the physical infrastructure as per the Ministry's guidelines so that comprehensive clinical and psychological care can be provided to survivors in one physical location.

Service delivery

a. Establish and strengthen the mechanism to refer clients to referral hospitals

District hospitals may not be able to provide all the medical care survivors need and it is therefore imperative to strengthen the referral mechanism from OCMCs to higher-level hospitals. A memorandum of Understanding (MoU) should be signed with referral hospitals that have advanced facilities, so that survivors can access appropriate care. In addition, well-designed protocols for referral need to be developed and staff at the referring and receiving facility trained in their use. A mechanism should be developed so that survivors receive all necessary services free of cost.

b. Referral to OCMCs

Introduce training and the protocols necessary to guide Village Development Committee (VDC) level health workers and other service providers to refer victims of GBV to OCMCs. Develop local mechanisms that provide support including funding transportation, to enable survivors to access the care they need and protect them from perpetrators.

c. Monitoring and Supervision

The study showed inadequate monitoring and supervision of OCMCs. It is recommended that regular monitoring and supervision from central and district level be introduced with central level stakeholders visiting each OCMC at least two times in a year; this will facilitate problem solving, promote the smooth running of the centres and their effectiveness.

At district level, District Coordination Committees' (DCC) should regularly guide and monitor the OCMCs, and ensure its decisions are followed through. Ownership of a program which is grounded on multi-sectoral coordination can best occur when horizontal programming begins to run effectively.

Awareness raising and information dissemination

Although audio and print media have been used to disseminate information on OCMCs including through locally produced leaflets and brochures, none of the survivors interviewed had prior knowledge of OCMCs. It is recommended that a strategy for raising public awareness at the national and local level be designed and developed to reach a wide section of rural and urban populations, survivors, perpetrators, potential perpetrators, service providers and community and political leaders.

Human resources

a. Capacity building

- Capacity building of OCMC staff should be prioritised. This can range from formal training and orientation to on-the-spot coaching of OCMC staff. Findings revealed none of the staff nurses had received any prior training on GBV and psychosocial counseling before they took up post. Addressing this gap will create better understanding of the value of OCMC services.

- Organization of annual review meetings of OCMC staff for experience sharing is needed. In-country exposure visits to other OCMCs for sharing of best practices will enhance understanding and motivate staff.

- It is recommended that awareness raising and capacity building of all hospital staff on GBV and OCMC is provided – from Medical Superintendent to staff of all different departments. Findings revealed all DHOs had limited understanding of OCMC and its activities.

- Only two doctors across the focal hospitals had received medico-legal training. Other doctors are working without the full knowledge and skills needed for this examination. It is recommended that at least two doctors (one male and one female) should be provided medico-legal training at each hospital.

- Health workers, social workers, and the police need to be better and more frequently trained on GBV so that they can detect and appropriately handle both child and adult cases when they come across them in their line of duty.

Staffing

- OCMCs should be adequately staffed, ideally with at least one medical doctor, three staff nurses including one psychosocial counselor to enable it to run for 24 hours. It is also recommended that in addition to a full time staff, at a minimum, one doctor and one nurse should be on call to OCMC on a 24-hour basis. This will ensure timely response to the medical and psychosocial support needs of the survivors, including the collection and preservation of evidence for legal purposes.

- Retaining of staff has been a problem experienced by OCMCs. A minimum of a two-year contract should be mandated for staff appointed on contract basis. This will help avoid institutional memory loss, as well as enable staff to work confidently without the constant pressure of looking for a new job. Agreements should also be made prior to providing technical training such as psychosocial counseling, to ensure staff's long-term service.

- GoN employees are transferred frequently and this applies to staff working at OCMCs too. It is recommended that for providing efficient and effective services, a mechanism should be designed to transfer staff working at an OCMC to another OCMC.

c. Women doctors

It is recommended that more women doctors be deputed to OCMCs since they are better able to understand and deal with issues faced by women survivors, and female survivors prefer being examined by a woman in situations of GBV.

d. Inclusion of OCMC in nursing and medical training curricula

Curricula for nursing and medical schools should contain information on OCMC. In BSC nursing, there is a course called Community Health Nursing. In that course, students have to study the district and regional level services provided by MoH, however, OCMC is missing. Similarly, OCMCs are not included in the Programs and Polices of MoH at district and community level; this gap needs to be rectified.

Multi-sectoral response and coordination

a. Prevention programs

Prevention programs need to be implemented at the district and community levels by MoH and other agencies. Some potential programs are awareness raising to prevent GBV; information sharing on the physical and mental health consequences of GBV on survivors and their family members, children and communities; gender norms transformative programs with young people; and interventions to reduce alcohol abuse. In addition to preventing the incidence of violence, such programs will raise awareness of women's rights and increase access to OCMCs. Focused preventive and response programs should be targeted to VDCs where the incidence of GBV is recorded to be high.

b. Safe homes

In Makwanpur and Sunsari district there are safe homes run by WCO office. However, a safe home is lacking in the two disaster-affected districts. Safe homes are mandatory for all districts that have OCMC services, as hospitals cannot keep survivors for a longer period of time. Therefore, it is recommended that MoH work in coordination with the Ministry of Women and Children for establishing a safe house for women and children in all districts with an OCMC and where the incidence of GBV, such as in disaster-affected districts is high.

c. Provision of free education for children who are rape survivors or are the children of rape survivors

Due to the stigma attached to rape, rape survivors and their children cannot go to their home immediately after receiving services. It is recommended that such children should be provided with free education at residential schools. An MoU should be signed with schools to provide access to Residential School Education for girls/minors who have survived rape or are the children of rape survivors.

d. Follow-up and rehabilitation mechanism

There is a need to establish a proper mechanism to follow-up GBV survivors and support their rehabilitation. The Women and Children Development Office (WCDO) has a number of networks such as watch-groups, cooperatives and para-legal committees in almost all VDCs of the district. Thus, when a survivor returns home or to their respective VDCs these networks could be a vital source for tracking and monitoring the status of survivors and also the perpetrators. Moreover, information systems from VDC to district level should be established to track the support and follow up that GBV survivors receive from multiple agencies.

Informal follow up already exists in OCMCs, but is insufficient. A formal follow up mechanism could be setup through the formation of a coherent partnership between OCMC, WCO, DPO women cell and NGOs/CBOs working on GBV and women's empowerment.

c. Multi-sectoral coordination

There is need to strengthen the linkages between different service points in order to achieve comprehensive GBV services. This will require better coordination between OCMC, WCO, police department and legal institution in order to enhance the survivors' pursuit of justice and to better respond to their health, shelter, livelihood and protection needs.

d. Capacity building of DCC/CMC member

DCC and CMC members need to be aware of their roles and responsibilities for internalization and the effective functioning of the OCMC. Their ownership, knowledge and capacity can be enhanced through orientation and training on GoN's GBV plans and policies.

e. Organisation of CMC meetings

The DCC meetings are taking place regularly. However CMC meetings have not taken place formally in both Sunsari and Makwanpur Districts. It is recommended that CMC meetings be organised once in a month to reflect on the types of case that have been assisted by the OCMC and also to plan for complicated cases.

Funding

Funding for OCMCs needs to be adequate and sustainable. Where activities are underfunded or funds run out, the brunt is borne by survivors, who may experience a delay in obtaining much-needed medical care, as well as other services.

For disaster affected districts

a. Short term goals

The immediate focus for health service providers should be on caring for victims of violence and on taking measures to prevent abuse and exploitation by:

- Providing immediate health care and psychosocial support for GBV survivors, including ensuring that Clinical Management of Rape (CMR) is available in health centers and through mobile teams.
- Health workers should be trained to identify victims of violence and provide care that ensures their safety, privacy, confidentiality and dignity.
- Establishing a referral system to support GBV survivors' access to quality care and support.
- Ensuring the availability of female-friendly spaces for integrated services and safe shelter for women and girls – with particular focus on marginalized groups and those in need.
- Ensuring humanitarian agencies work with national government plans and policies and national partners, including the Department of Women and Children and civil society organizations.

b. Long term goals

- Community networks and programs that addressed violence before the disaster should be identified and continue to be implemented.
- Efforts to address violence must engage everyone from the community including men, women and children of the affected community in the planning phase, including victims of GBV and persons with disabilities.
- Organize community education and awareness raising programs to prevent violence, inform people about GBV risks and illegality, available GBV services and where they can go for help.
- Establish OCMCs and expand its services to VDC level.

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Acronyms

CDO	Chief District Officer
DHOs/DPHOs	District Health Offices/District Public Health Offices
DPOs	District Police Offices
M&E	Monitoring and Evaluation
GBV	Gender based violence
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MoWC	Ministry of Women and Children
NGO	Non-governmental Organization
NHSP	Nepal Health Sector Program
NHSSP	Nepal Health Sector Support Programme
SGBV	Sexual and gender-based violence
STI	Sexually transmitted Infections
SWAp	Sector-wide approach
ToR	Terms of reference
UNFPA	United Nations Population Fund
WCO	Women and Children offices
WCDO	Women and Children Development Officer

1. BACKGROUND

The Government of Nepal (GoN) is committed to improving the health status of its citizens and has made impressive gains despite conflict and other difficulties. The Nepal Health Sector Programme-1 (NHSP-1), the first health sector-wide approach (SWAp) in Nepal, ran from July 2004 to mid-July 2010. It was very successful and brought about many health improvements. Building on these successes, the Ministry of Health (MoH) and its external development partners (EDP) designed a second health sector programme (NHSP-2, 2010-2015), which began in mid-July 2010. NHSP-2's goal was to improve the health status of the people of Nepal. Its purpose was to improve the use of essential health care and other health services, especially by women and poor and excluded people.

The 7.8 magnitude earthquake that struck Nepal on the 25th April, 2015 and many after-shocks that followed, claimed the lives of more than 9,000 people and left more than 23,000 injured. Thirty one districts were affected, fourteen of them severely. In the immediate aftermath of the earthquake, the NHSSP team worked closely with MoH and Department of Health Service (DoHS) counterparts to address the severe disruption that impacted health service provision and the transition to Nepal's new health sector strategy (NHSS, 2015-2020). From the 27th July, 2015, NHSSP expanded its programme of support by providing the TA component of DFID's Health Sector Transition and Recovery Programme (HSTRP) in support of MoH and DoHS. NHSSP has supported the delivery and mainstreaming of Gender, Equity and Social Inclusion (GESI) processes throughout its assistance.

In 2010, the Government of Nepal launched a multi-sectoral national action plan to address gender based violence (GBV) which included the establishment of hospital based One Stop Crisis Management Centres (OCMC) to provide integrated services to survivors of GBV.OCMCs were designed to follow a multi-sectoral and locally coordinated approach to provide GBV survivors with a comprehensive range of services including health care, medico-legal services, psycho-social counseling, access to safe homes, legal support, personal security and rehabilitation support. As of now, the MOH has established 21OCMCs with technical backstopping support from NHSSP among which, three OCMCs were established after the massive earthquake in three highly affected disaster districts (Sindhupalchwok, Dolokha and Ramechhap).

The two earthquakes in 2015 increased the risk of GBV, which led to the establishment of OCMCs in the three highly disaster affected districts as stated above. These three new OCMCs have started providing services, however, lack of physical space for a dedicated OCMC at hospitals post-quake, lack of adequate safe home services, and lack of counseling capacity of OCMC staffs, has affected access to and the quality of care provided to GBV survivors. This case study has therefore been designed to capture learning from well-performing OCMCs and to investigate the challenges faced in providing GBV services in earthquake-affected areas.

1.1 Objectives

The key objectives of the case study are to identify:

- The pathway and barriers in accessing GBV services at OCMCs in District and referral level hospitals in post disaster and non-disaster settings from the survivor's perspective. This will include how GBV survivors came to hear of OCMCs, service received, challenges they faced in accessing services and their perception of the quality of help they received.
- The constraints, challenges and bottlenecks to provision of GBV services from the perspective of service providers.
- Achievements and strengths of OCMCs.
- The GBV issues perceived to be prevalent in the district and whether the risk of GBV is perceived to be higher in disaster affected areas.

1.2 Methodology and Analysis

Four OCMCs were pre-selected by the MoH and NHSSP to be the focus of the case study. Two of the OCMCs were established before the earthquake that struck on 25th April 2015 and two sites were established after the earthquake. This provided a comparable perspective of OCMCs in disaster affected and districts with non-disaster to understand the respective enabling factors, strengths, achievements, constraints, challenges, and bottlenecks. In line with the objectives, the study investigated:

(i) The pathways and barriers to accessing OCMC services from the survivor's perspective

(ii) The performance and management of OCMCs in terms of service delivery strengths, constraints and gaps, their effectiveness in terms of coordination with other agencies and areas for improvement.

(iii) The risks of GBV in disaster and non-disaster affected areas.

Data collection

A mixture of primary and secondary data was collected. Secondary sources included OCMC case records and reports kept by each OCMC, records kept at District Police Office, District Attorney, Safe Homes, and WCO office and previous OCMC assessment reports.

Primary data was collected through interviews, group discussions and roundtable meetings. A total of 108 persons including 16 survivors were met during visits to the focal districts (*please refer to Annex 2* for the list of persons interviewed minus GBV clients). Exit interviews with GBV clients were held after they had received services and were being discharged from the OCMC. Hospital staff interviewed included emergency department staff, OCMC staff, Medical Superintendent (MESU)/Hospital Director, and Case Management Committee members. Stakeholders outside of the hospital such as Women and Child Officer (WCO), Chief of District Police, officers at the District Attorney General's Office, lawyers from district bar, and NGOs were interviewed.

At the end of each visit to a district, a meeting was organized to share the observations and case study findings and feedback was received which was used to strengthen and verify the findings.

Table 1: List of key stakeholders interviewed

Districts	GBV survivors	OCMC health service providers	Health service providers at hospital				DCC members**	NGOs/CBOs
			Drs.	Paramedics (AHWs, Nurses, ANMs)	Lab staff	Medical recorder		
Makwanpur	6	1	5	4	1	1	8	4
Sunsari	5	1	4	4	1	1	9	3
Dolakha	5	2	4	6	2		7	2
Sindhupalchowk	-	1*	3	3	2	1	6	2***

*A staff nurse had just joined

** DCC members met included Chief District Officer, President of Bar, District Attorney, Chief of DCC, chief of Police, WCDO, representatives of NGOs, and others. CMC members are members of DCC. Coordinators of Safe homes, and representatives of district legal aid office were also interviewed. In all districts, in addition to DCC members and CMC members, hospital pharmacist, police constable at respective hospitals, and police officers at Women cells were interviewed.

***In Sindhupalchowk, OCMC is yet to develop a working relationship with NGOs.

An interview checklist was developed (*Annex4*) for key stakeholder groups. Questions for GBV survivors were tailored to the nature of the case and the services used. The questions were kept short and to the point using simple language (avoiding jargons and words with double meaning). Questions were asked in a logical sequence leaving sensitive or controversial issues until the end of the interview.

Case studies: The fundamental reason for collecting case studies was to verify and substantiate information collected from OCMC personnel, hospital staff, DCC and other stakeholders regarding the type, quality and effectiveness of services provided by OCMCs. Similarly, to unravel the barriers survivors experience in accessing health related services. For this purpose, a tracking tool for case study development was designed (*Annex 5*) to facilitate information collection from survivors. Prior to each interview, consent from each survivor was obtained (*Annex 6*).Exit interviews with GBV clients were mainly held after they had received services and had been discharged from the OCMC. Two of the survivors were interviewed right after getting services from OCMC, one in Makwanpur and the other in Sunsari to provide the research team with more immediate feedback from clients.

Table 2: Case Study districts

Districts	**Region**	**Ecological Zone**	**OCMC established**
Makwanpur	Central	Hill and Terai	28 November 2011
Sunsari	Eastern	Terai	10 January 2012
Dolakha	Eastern	Hill	January 26, 2016
Sindhupalchowk	Eastern	Hill	February 11, 2016

Analysis

A methodology framework (*see annex 1 for the completed assessment matrix)* was designed to triangulate information gathered from secondary sources and primary sources. Qualitative and quantitative data was entered into the assessment matrix after each district visit. Themes were identified from the matrix to extract the study's key findings. Conclusions are based on triangulation of evidence from the data collection methods.

1.3 Ethical Considerations

The study adhered to international best practice by (a)ensuring respondents understood the study's purpose, objectives, and the intended use of findings; (b) respected GBV survivors' rights and welfare by ensuring informed consent and confidentiality. Written informed consent was collected from each participating GBV survivor (*Annex6*). The statement is written in Nepali and was provided in advance of interviews. Caution was taken towards avoiding survivor trauma through interviews and necessary referrals made to OCMC services, as and when required.GBV survivors' anonymity is respected and every effort was made to ensure that sensitive information cannot be traced to its source and thus lead to re-victimization.

2. FINDINGS

Hospital based OCMCs aim to provide integrated, multi-disciplinary services in a single physical location. At OCMCs, survivors of GBV[2] receive medical and psychological support from trained health personnel and a psychosocial councillor and are referred to other service providers for police, legal and social and rehabilitation support. The findings from this study are presented under the following main headings:

- Characteristics of OCMC clients
- Barriers to GBV survivor's accessing OCMC and other GBV services
- Performance of OCMCs
- The risks of GBV and the comparative provision of services in disaster and non-disaster affected areas

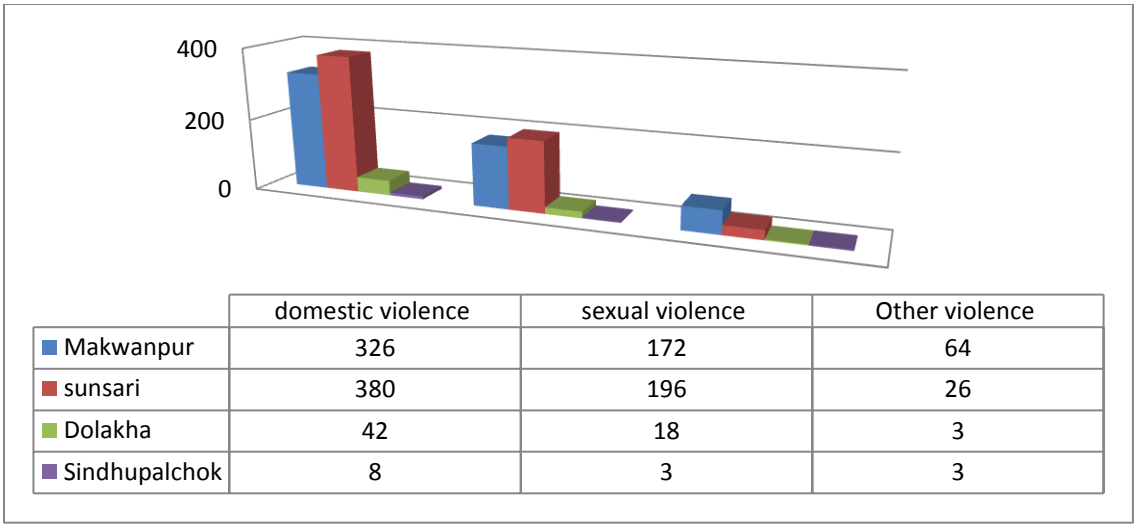
2.1 Characteristics of OCMC clients

Overall, all OCMCs have been providing the basic services needed by GBV survivors. From the data available, a total of 1240 individuals including 1216 (98.06%) women and 24 (1.9%)men have benefited from services at the OCMCs since their establishment[3]. Within this total,756 (61%) women suffered physical assault or domestic violence, followed by 389 (31.37%) cases of sexual violence. The data shows that women were more likely to have suffered physical assault/domestic violence, followed by sexual violence (rape and attempted rape), then mental torture.

Figure 1: Types of GBV cases registered by the four OCMCs (2011 – 2016/017)

[2]Gender-based violence includes physical, sexual and psychological violence such as domestic violence; sexual abuse, including rape and sexual abuse of children by family members; forced pregnancy; sexual slavery; traditional practices harmful to women, such as honor killings, burning or acid throwing, female genital mutilation, dowry-related violence; violence in armed conflict, such as murder and rape; and emotional abuse, such as coercion and abusive language. Trafficking of women and girls for prostitution, forced marriage, sexual harassment and intimidation at work are additional examples of violence against women.

[3]The OCMC in Sindhuapalchowk had not been made functional at the time of the case study visit but records from the hospital report cases of GBV after the Earthquake.



	domestic violence	sexual violence	Other violence
Makwanpur	326	172	64
sunsari	380	196	26
Dolakha	42	18	3
Sindhupalchok	8	3	3

Figure 1 shows the number and type of cases registered by the OCMCs, up to the time of the study. Only Makwanpur OCMC had maintained caste/ethnic wise disaggregated data on cases; data not shown. All four OCMCs have maintained data on the basis of sex and age group. The data suggests that women in the age group of 15-49 are most at risk of GBV.

Table 3: OCMC clients by sex at the four case study OCMCs (2011 onwards)

S.N.	Sex	Makwanpur (2068-2073)	Sunsari (2068-2073)	Dolakha (2072-2073)	Sindhupalchok (2072-2073)	Total
1.	Female	548	591	63	14	**1216**
2.	Transgender	0	0	0	0	**0**
3.	Male	14	11	0	0	**24**

Table 4: OCMC clients by age group at the four case study OCMCs (2011 onwards)

S.N.	Age-Group	Makwanpur (2068-2073)	Sunsari (2068-2073)	Dolakha (2072-2073)	Sindhupalchok (2072-2073)	Total
1	1-14	79	63	12	2	**156**
2	15-49	451	509	46	11	**827**
3	50-65	27	27	4	1	**59**
4	65 above	5	3	1	0	**9**

Based on OCMC records of clients at Makwanpur and Sunsariin 2072-2073 (2015-16) we find that it is mostly intimate partners (husbands), followed by family members, neighbors and occasionally unknown strangers that perpetrated violence. The victims are overwhelmingly women. Data recorded at OCMCs shows that women are most at risk from those who are closest to them, particularly intimate partners/husbands. Intimate partners were the most commonly reported perpetrators of sexual, physical and emotional violence. Followed by family members/in-laws.

Table 5: Types of perpetrators recorded at Makwanpur and Sunsari OCMCs

Type of perpetrators*	**Makwanpur (2072 -2073)**	**Sunsari 2072-2073)**
Husband	99	58
Other family members	70	21
Community people	77	-
Neighbours	0	77
Office staffs	4	-
Teachers	0	3
Other	12	31
Total	**262**	**190**

Interviews with GBV survivors confirmed that women's experiences of violence perpetrated by their husbands included emotional and verbal abuse, physical violence, marital rape, polygamy, and threats. The main reasons as stated by women are: the husband's use of too much alcohol, drugs, forced marriage, son preference, interference by mother-in-laws and other family members, suspicion and infidelity. Marital disputes and verbal abuses were not considered violence. Women who endured persistent physical violence reported to have depressive and suicidal tendencies.

The most vulnerable women seemed to be the ones who were married off at an early age by their parents or the ones who got married without receiving consent from their parents. Most of the survivors who had experienced violence repeatedly had not shared or discussed their experiences with anyone even their family members, even after experiencing violence for very long periods of time (for example 13 years, 16years, 17 years). Women typically only visited a hospital after a violent episode or were taken to hospital in critical conditions. Even after coming to hospital, most of them hid the fact that it was domestic violence or intimate partner violence due to the fear of being stigmatized by society and their own people.

2.2 Barriers to survivor' accessing OCMCs and other GBV services

Based on the interviews conducted with survivors, the following barriers to accessing OCMCs and other GBV services have been identified:

Social, economic and ecological related barriers

Women's workload at home: In rural Nepal women are expected to work from waking until sleeping, fulfilling domestic duties around the home as well as in the field to sustaining their livelihood. Most of the survivors interviewed belonged to very poor families and spent their day doing household chores as well as working in the field. They reported that if they are not working the whole day, it is difficult to arrange foods.

> As in the words of one survivor at Makwanpur, "*my husband does not do anything. I have to work from dawn to dusk to make ends meet. I have three small children. If I don't work, they will go to bed with empty stomach. Moreover, he comes home drunk and demands for food. If I don't prepare food on time, he will start beating me up."*

Most of the women interviewed felt that it was their responsibility to do all household chores, work in the fields, raise cattle and look after children, which left no time/or very limited time to do/or think about other things including accessing health care. Similarly, their inability to perform household chores on time also resulted in violence from intimate partners/husbands. For some women it can take a full day or even two days to visit a hospital and return home and this is time that poor women cannot afford to take from their household and livelihood responsibilities.

Financial factors: As pointed out by survivors, financial factors are a major barrier to accessing health services.

> One survivor said, *"My husband had beaten me severely. Though I was severely wounded, I was not able to come to the hospital due to shortage of funds. Primary health care is also not available in my village. The bus takes Nrs. 500 rupees from nearest bus station that is an hour away from my home to the hospital. After three four days, my sister came from Kathmandu, arranged an ambulance and brought me to the Hetauda hospital".*

Her sister had known about OCMC and so brought her directly there. Domestic work burden compounded with shortage of funds inhibits survivor's access to health services.

Socio–cultural and religious beliefs: Socio-cultural and religious beliefs also impact women's service seeking behavior. Most of the survivors interviewed who are married believed, "*women are secondary to men and they have to obey their husbands"*. Similarly, two of them also believed that "*one of husband's duty is to beat their wife and women are supposed to tolerate. It was written in our fate "* Moreover, they also believed that "*every issue inside house should remain inside, it should not be known*

by anyone else, if it gets spread out family's honor will be washed away". Therefore, survivors almost never talked about the violence experienced by them openly or sought any help. Women felt that keeping family dispute inside the family was a way of resolving family conflicts.

Social restrictions and fear: Survivors reported that very few women sought help from institutions such as the police, the health system and other agencies, such as NGOs and CBOs. They felt that going to the police and hospital was prohibited due to embarrassment, fear of rejection and fear of further violence from the perpetrator. If they did seek help, few of the survivors interviewed revealed to their family and friends with whom they sought help when they faced violence.

> A women police officer at Sunsari police station said, "*Women do not want to come to the police station. Especially women from Muslim and other Terai community, as they are not allowed to go outside and are kept in Burka. Women from other communities also feel reluctant to visit police station as they fear everyone will know and there will be trouble if they file cases in the police station."*

Son preference: Son preference has deep cultural roots in Nepali culture and society. Two of the survivors interviewed reported that they had suffered emotional and physical violence from their husbands and mother in laws for not being able to bear a son.

> According to a survivor in Makwanpur, "*I have four daughters. My husband beats me every day for not bearing a son. My in-laws also supported my husband's beating. They ask their son to leave me and get married to another girl who can bore him a son.*" She also felt that it is important to have at least one son.

Several survivors explained that men without sons felt discriminated against by their family members, in laws and community people. They also shared that those who had not produced sons were stigmatized and labeled with derogatory names such as "Aputo" meaning "man without son"[4].

Ecological barrier: In all three districts, most of the survivors interviewed resided far from the hospital. They said that the distance between their home and the hospital where OCMC services are provided inhibited access to services.

> As stated by a survivor in Makwanpur, "*it takes about 3.5 hours to reach to the hospital from my house. To come to the bus station, I have to walk for like 30 minutes and the bus is not available all the time (only morning and evening). If we get late then the bus will be gone for the day*."

The distance to services was an important barrier for GBV survivors in both Hill and Terai areas. Survivors living in hilly areas said that a one way journey could take between two to three hours of walking even to reach a bus station and going and coming back could take a whole day, at times even two days. Inability to pay expenses involved during the journey (food, transportation fare) as well as

[4] There is no exact word in English for "*aputo'*

women being unable to spend such a long time away from their home duties, inhibited women's access to health services. Moreover, survivors considered lack of private and public transportation services as another barrier. In some parts of Terai and Hills, during the rainy season, it is difficult to cross the river, which also inhibits access to services.

Uninformed: Lack of awareness and information inhibited women's access to OCMC services. From the information shared by survivors their whole time is spent inside the house doing household chores and fending for food in the field, and this literally leaves them no time. Women's relatives' lack of exposure to the "outside world" and their rights is another reason for their subjugation and acceptance of violence.

> District Attorney of Sunsari said, "*Women stay at home and are busy with the household chores. They do not know what is going beyond their house. So, they lack information about their rights and face more violence."*

> A lawyer from Makwanpur also said, "*Most of the women do not know where to go many times, if they experience domestic and sexual violence. They think that seeking help will do further damage. "*

Women with physical disability face additional challenges and social exclusion. They reported that they are prevented from seeking services due to mobility issues, such as lack of disabled-friendly public transport and buildings and are despised for being disabled inside their homes and by the community.

> One survivor said, "due *to my disability, people treat me differently. They despise talking to me and the service providers also never treated nicely. I had to stop going to school as well. Friends in my school used to tease me for not being able to walk properly. I used to fall everywhere. Seeing this, the headmaster of my school called my mother and asked her to stop sending me to school, though I was good at studies, I had to leave school."*

Lack of shelter homes: Almost all providers noted that there are an inadequate number of shelter homes to cope with the number of women who suffer violence. Though there are temporary safe homes run by WCO office in Makwanpur and Sunsari, no shelter homes are available in Dolakha and Sindhupalchowk. In Dolakha, a temporary shelter home was run by an NGO called "Sabal Nepal" supported by UNFPA[5]. However, the funding stopped in December 2016. From that date they have not received any support from other agencies.

> According to the Coordinator of the Safe home, "*we are struggling to arrange funds for the shelter. If we do not receive any money within the end of this month, I will have to close this shelter home. I am in so much mental distress. I don't know where these girls and children will go."*

[5] UNFPA had provided support for the shelter home after the earthquake to provide temporary shelter for women and children affected by the Earthquake.

Nine girls and six children were living in the shelter at the time of the visit. The Coordinator was trying to coordinate with WCO office and other relevant stakeholders in the district. The Women Development Officer said, "*we are trying to resolve this problem. The Ministry of Women and Children has recently approved the proposal of making safe home in Dolakha. I am trying to expedite the process."* The Chief District Officer and other heads of line agencies echoed the same.

Barriers to legal action: *Most of the women interviewed lacked knowledge on legal issues. According to District Attorney of Sindhupalchowk district, "*due to inaccessible terrain and lack of education, most of the women lack awareness on legal issues*."*

Though survivors can file a court case free of cost, silencing of survivors by family and community members play a huge role in weakening the chances of perpetrator's prosecution and conviction. In most of the cases, as told by survivors, they face pressure from perpetrators and community to resolve the case outside the court. The pressure is high, particularly when the perpetrator is a family member.

> According to Lawyer, District Legal Aid Office, Makwanpur, "*we have been helping women survivors to file a court case. However, some survivors are silenced by their family remembers. In some cases, the survivor is not capable of holding the threat and gives up."*

Unsurprisingly, some survivors reported that they were reluctant to take legal action and two of them said that they would settle matters informally. Legal services are provided free of cost, however the duration of a court case takes a long time and it is difficult for poor women to come to the court every month to take a court date. Most of them cannot afford the transportation cost. Women feel reluctant to take legal action due to the expenses involved in filing a court case.

2.3 Performance of OCMCs

This section of the report primarily refers to the three OCMCs of Sunsari, Makwanpur and Dolakha as the Sindhupalchowk OCMC was not fully functional at the time of the study[6].

2.3.1 Trends and types of treatment provided at OCMCs

a. **Medical and other services:**

The OCMCs in Makwanpur, Sunsari and Dolakha and Sindhupalchowkhad provided services to 1240 survivors including 1216 women and 24 men since their establishment. The main support provided by OCMCs is medical treatment. These range from basic medical examination, psychosocial counseling to medico-legal services.

[6] Limited medical services were provided to GBV clients through emergency department as there was no separate physical space for OCMC and no psychosocial counselor. A staff nurse had just been hired to run the OCMC services at the time of the visit.

Table 6: Clinical *services provided* to survivors by the four OCMCs since their establishment

Clinical services	Makwanpur (2068-2073)	Sunsari (2068-2073)	Dolakha (2072-2073)	Sindhupalchowk (2072-2073)	Total
Body check up	473	600	61	14	**1148**
Medical	26	232	12	6	**276**
HIV/VCT	29	31	16	3	**79**
Pregnancy Test	28	70	17	3	**118**
Wound Treatment	316	355	38	10	**719**
Primary pregnancy test	10	38	1	0	**49**
Sexual disease treatment	18	77	0	2	**97**
Mental Health treatment	7	7	1	4	**19**
Psycho-social Counseling	458	248	51		**757**
Other treatments	204	4	0	4	**212**

b. Referral services

Table 7: Referrals by the four OCMCs (2072-2073)

Districts	Police	Court	NGOs	Social institution	Child/women welfare	Home	Other OCMCs
Makwanpur	247	-	103	15	4	-	
Sunsari	196	-	8	7	115	-	-
Dolakha	26	-	8	7	-	10	2
Sindhupalchok	2	-	2	-	1	1	-
Total	**471**	**-**	**121**	**29**	**119**	**11**	**2**

The study found that OCMCs have documented the referrals made by them, but other agencies have not maintained such data; see table 7 above. It was found that referrals for legal counseling had also taken place. Similarly, inter-hospital referrals were also taking place in all the OCMCs when services are not available at the OCMC hospital. OCMC in Makwanpur District has coordinated with Bharatpur Cancer Hospital. Similarly, Sunsari OCMC is coordinating with Koshi Zonal Hospital and Dolakha OCMC is coordinating with Dhulikhel hospital and sending survivors to these Hospitals. In case referral is needed, a Case Management Committee meeting is organized and the meeting decides the graveness of the issue and sends the survivor. It was reported by staff of Makwanpur OCMC and SunsariOCMC that the transportation cost is taken care of by the respective OCMC and the survivor is treated free of cost in the referred hospital. A similar practice was followed at Dolakha hospital.

OCMC staff nurse at Dolakha said, "*so far we have referred two cases to outside hospital. Both cases were sent to Dhulikhel hospital. The cost of ambulance was supported by Women and Child Development Office*. *For both cases CMC meeting was organized and a decision was taken."*

2.3.2 Physical space and location

In Makwanpur and Sunsari the OCMC has adequate dedicated physical space. The physical space of Dolakha OCMC is undersized and the prescribed separate office room and counseling room are not available. In Sindhupalchowk, the allocated premise for OCMC was given to the INGO, Handicap International, for physiotherapy related services[7]. No space has yet been provided at Sindhupalchowk hospital for the OCMC. The hospital is still operating from a tent and there is no additional space available for OCMC and the construction of hospital is underway. According to DHO, "*OCMC will have its own space in our new building which will be completed soon. After that we will be able to provide services to victims of GBV*."

OCMC in Sunsari is located near the Indoor ward, and OCMC in Dolakha is located in front of the lab and next to dental room. Only the OCMC in Makwanpur district is isolated from all other departments and has an appropriately placed counseling room. In Sunsari counseling sessions could easily be overheard by others in adjoining rooms and Dolakha OCMC does not have one.

In all four districts, OCMCs are located in district headquarters. In Makwanpur, Dolakha and Sindhupalchowk which are hilly districts travel time from rural areas can be up to two days. Service providers in Dolakha and Sindhupalchowk recommended expanding services at the local level to increase the flow of women seeking support.

Table 8: Infrastructure and resources at OCMCs

Requirements as per guidelines	Makwanpur	Sunsari	Dolakha	Sindhupalchowk
Rooms: one treatment room with two beds, a separate counseling room and a office room, guard room	1 large room for treatment and office plus 1 counseling room	4 adjoining rooms (1 office, 1 counseling, 1 office and 1 for fridge and medications)	One undersized room; only one bed	No space
Separate toilet	1	1 (not working)	1	NA
Necessary furniture	Yes	Yes	Limited	NA
Computer, printer and phone	Yes	Yes	Yes	NA
Basic medical equipments	Yes	Yes	Yes	NA
IEC materials	Yes	Yes	NO	NA
Training manual; OCMC guideline	Yes	Yes	No	NA

[7] No one was able to tell why the OCMC space was given to Handicap International. As told by Handicap International's therapist, "after the earthquake, need of physic-therapy increased, so, the allocated space for OCMC was given to us and the OCMC took a back stage.

Curtains to maintain confidentiality during the forensic examination	Yes	Yes	Yes	NA

2.3.3 Service delivery:

a. Timeliness of services

Overall, all 16 survivors were satisfied by the services provided to them at Makwanpur, Sunsari and Dolakha OCMCs. All of them reported that services were effective in addressing their medical care needs.

> In the words of a survivor from Makwanpur, "*My husband had beaten me severely. When I regained my consciousness I found myself in the hospital bed. I was brought to the hospital around midnight in ambulance. I stayed in Emergency department that night and the following morning, the OCMC staff came and shifted me to OCMC and rest of my treatment was done there. During day I stayed in OCMC and at night I was shifted to women's ward. Everyone in the hospital treated nicely including doctors and I was provided all medications, food and a pair of clothes free of cost. I am happy with the kind of services I received. I also received the counseling sessions from the psycho-social counselor at OCMC, which was very beneficial. I also received information about other services provided by OCMC and OCMC facilitate to file a divorce case. The case is underway in the court."*

However, two out of the 16 survivors felt that they did not receive all required services in one visit. Some had to come on a subsequent visit to receive necessary tests or collect their report.

> One survivor in Sunsari said, "*I have been visiting OCMC since last three days. One day they carry out the medical examination, and ask to come for another day for urine and blood tests and the following day to take the reports. Though, they said that we will receive all service from one place, it seems not true. My house is far from hospital, takes almost one and half hours in a bicycle."*The survivor and her family members were not very happy about having to make return visits.

The above testimony shows how some survivors have to visit the OCMC several times to complete their treatment, which can create further trauma. One explanation why clients have to return for care is the shortage of staff. All OCMCs are understaffed. Both, Makwanpur and Sunsari OCMC have only one nursing staff. During the case study data collection the nurses at both facilities faced the challenge of having multiple cases to serve at the same time without support, and this has implications for the quality of services they can provide. Similarly, the timely availability of doctors was another barrier experienced by survivors in Sunsari district.

Delays in service delivery were observed during data collection in Sunsari where it was recorded that "*a case had come to OCMC around 1:00 PM in the afternoon. Nurse at OCMC called a doctor who was on duty that day. The doctor came around 4:30 PM. The survivor and her husband had to wait for more than two hours to receive the services."*This problem was not witnessed in Makwanpur OCMC, where

doctors came approximately ten minutes after they received the call from OCMC and conducted the medical examinations required.

b. Confidentiality

OCMCs are trying to maintain client privacy and confidentiality. Both, in Sunsari and Makwanpur OCMC, once the client reaches the OCMC her/his consent is sought before her/his history are taken. For the past three months, Makwanpur OCMC has replaced using client names with a coding system to maintain survivor's privacy.

> According to OCMC staff at Makwanpur, "maintaining *privacy and confidentiality of survivors helps to protect them from potential harms including psychological harm and embarrassment. They feel more comfortable.*"A doctor at the hospital said, "*OCMC has been functioning very effectively in Makwanpur district. We attend to case as soon as it comes and do all the needful. To maintain privacy, the coding system is in place. Even we do not know the names of the survivor. We call them by codes*"

In Makwanpur and Sunsari districts, it was noted that while OCMC patients' examinations were undertaken in the OCMC facility, at night they stayed in the indoor or maternity ward. When asked why staff followed this practice, OCMC staff at Makwanpur hospital stated, "*at night we don't have staff to look after the patients. So, we coordinate with Indoor and keep the survivors there*". The same was the case in Sunsari. Similarly, in Dolakha OCMC, the OCMC focal person stated that, "*all medical examinations take place at OCCMC, but, if survivor has to stay overnight they are kept in Indoor or female ward.*"

Moving GBV clients to indoor and other departments for the night increases the risk that private information about the client will be divulged.

c. Lab and x-ray and pharmacy services

In Makwanpur and Dolakha OCMCs, lab and x-ray services are available 24 hours a day, in Sunsari the lab services are open only until 2:00 PM, which limits access to services of survivors. Even in rape cases, survivors were asked to come back the next day for lab tests. When asked what happens in rape cases as samples not taken immediately may get destroyed, the staff nurse at the OCMC said, "*we do this for the cases who come after four five weeks. It makes no difference if the sample is taken today or tomorrow*. *However, if the case is new, we coordinate with lab and ask for the person to come. In some cases, we have used services from outside the hospital. "*

d. Psychosocial counseling

Counseling is an important part of the GBV services in that it reduces the psychological stress experienced by survivors. The psychosocial counselor at Makwanpur OCMC revealed that she has provided counseling services to 96 survivors in the last six months. The Sunsari OCMC has provided counseling services to 67 survivors in the last six months. Both nurses have received 6 months training in psychosocial counseling.

Nurses at Makwanpur and Sunsari reported that the duration of a counseling session depended on the nature of violence and the survivor's mental and physical condition. It generally took 2-3 hour per session. In some cases, 2- 3 psychosocial counseling sessions have been provided to survivors. Survivors interviewed from both districts reported that counseling had helped them in addressing their mental distress.

In contrast, the psychosocial counselor at Dolakha OCMC had received only five days training, which she thought was not adequate enough to address the needs of the survivor. She said, "*I am able to provide only advices to the survivors. However, I am not competent enough to provide proper counseling to them. If such need arises, we call a psychosocial counselor from Safe home."* There is an urgent need to provide GBV and psychosocial counseling training to the Dolakha OCMC nurse.

e. Attitude of service providers

It was noted during the visit that the focal persons of Makwanpur and Sunsari OCMCs were actively working to deliver services. Despite the shortage of staff they were handling multiple cases and coordinating with doctors and other departments as needed. Both of them showed positive commitment to the cases they handled.

In all the hospitals, the medical officer and staff of other departments held positive attitudes towards OCMC, attitudes which were verified by other staff. In Makwanpur and Sunsari it was reported that in the early years of the OCMCs, the attitude of doctors had been less supportive. Hospital staff held the view that earlier doctors had felt OCMC were an unnecessary burden on them and they disliked coming to undertake medical examinations there.

> According to a doctor in Makwanpur district, "*I had no prior knowledge on OCMC before coming to this hospital, still don't know much about it, but I found it very useful as it helps survivors of violence."*
>
> According to OCMC Focal person, Dolakha, "*if a case comes at night, the emergency people inform us after providing emergency treatment to survivor. Since, I live in the hospital quarter, it is not a problem for me to come and take over the case".*

Apart from the two survivors who had been asked to make repeated visits to Sunsari OCMC due to staff shortages, clients felt OCMCs provided catered to all their medical needs. They also thought that doctors and nurses behaved well toward them.

F. In-house coordination

In the three districts, a cross section of respondents reported that OCMC services are running properly. In Sunsari and Makwanpur, doctors, other hospital staff and representatives of NGOs reported that OCMCs are functioning better than during the initial years after their establishment.

> According to a Program officer of Maiti Nepal*, "in Makwanpur OCMC, the victims brought by us is examined and treated by a doctor without delay and counseling is provided to victims*

depending upon the need. This is in contrast to how services were running shortly after OCMC was established".

Interviews with the medical staff and other service providers at Makwanpur, Sunsari and Dolakha hospitals emergency, indoor and outpatient departments, lab, X-ray and pharmacy, showed they were knowledgeable about OCMC and its activities, and were very supportive. They were of the view that OCMCs were very necessary and useful for GBV survivors. It was found that all departments of all three hospitals including emergency departments are alert to GBV cases and refer to OCMC as soon as such cases have received critical care.

In Dolakha district, paramedics at Emergency department said that, "*when a GBV survivor comes to emergency, she is provided emergency treatments and services. After that, we call the OCMC staff nurse for further screening and treatment."* Staff at Makwanpur and Sunsari hospitals expressed similar opinions.

g. Follow up of survivors

Though OCMC staff are conducting regular follow up over the phone, it remains to be inadequate. A system is yet to be developed. The staff had not received training on how to undertake such follow-up, which is crucial for providing holistic support. A coherent follow-up mechanism should be developed and institutionalized by all OCMCs for the proper management and monitoring of survivors. Moreover, this requires the support of a range of actors including the various networks working with WCOs, such as watch groups, women cooperatives, and VDC para-legal committees who can be mobilized to track and monitor the status of survivors after they are reconciled in society. Such networks can also assist in keeping watch on perpetrators and discouraging repeat violence.

2.3.4 Public awareness raising and information dissemination about GBV and OCMCs

Production of IEC materials and information dissemination plays a vital role in increasing awareness of OCMCs and access to services. In Makwanpur, information is disseminated through, four FM stations, namely, Hetauda FM, Makwanpur FM, Radio Sarobar, and Taha FM and it is played at least four times a day before and after the news bulletin. Similalry, in Sunsari, information is disseminated through three FMs, namely, Saptakoshi FM, Ganatantra FM, and Popular FM, and it is played at least six to eight times a day. Both districts have produced leaflets and brochures and information has been disseminated through printed media as well. In Sunsari, as told by OCMC staff nurse, "last *year with the help from UNFPA, we had produced t-shirts printed with OCMC on back. It was noticed by many people."* In both districts, OCMC focal persons have used different platforms to raise awareness including schools and through NGOs/CBOs.

Such awareness raising initiatives have not taken place in Dolakha district, however, the meeting registers maintained by the OCMC shows that the decision has been taken to use audio and print media for OCMC information dissemination.

A help desk and an information sharing desk is another important requirement at hospitals and service centres which can provide information to women about their rights, available resources and support

services. Many service providers opined that the involvement of audio/visual media would be the most effective strategy to reach women, their families and society.

2.3.5 Human Resource

a. Gaps in human resources

The Operational manual of OCMC says that OCMC shall have one medical officer and three staff nurses working in the hospital including one trained psychosocial counselor, however, all OCMCs are understaffed. Both, Makwanpur and Sunsari OCMC currently have only one nursing staff that is a permanent government employee. A second contract nurse had been hired in the past but had recently left in both cases. Since there is now only one staff at both Sunsari and Makwanpur OCMC, the survivors have to wait for their turn to receive medical and other services.

The twenty-four hours service indicated in the Operational Guideline remains to be initiated in all three districts. The presence of only one staff makes it impossible to provide services during the night-time and cases that are kept overnight are moved to Emergency or Indoor, depending upon the need of the patient.

> According to a survivor (Sunsari), "*when I came no one was at OCMC. I had to wait for more than one hour."*
>
> Similarly, according to Police personnel deputed in Hetauda hospital, "*most of the cases in Makwanpur come after 5:00 PM in the evening. Due to limited staff, OCMC is closed around that time. So, most of the cases that come during night is treated at the Emergency ward. For rape cases we maintain privacy. The medical examination is carried inside the OT or indoor and OCMC person is informed other day. Then she does the needful. "*

Low staff attendance and poor retention of staff nurses pose challenges. One staff nurse at each OCMC is a contract position. There is a risk that knowledge gained by this person, and investment in her/his training may be lost if her annual contract is not renewed or she cannot be retained. The contracted staff nurse hired by OCMCs in Makwanpur and Sunsari have both recently left and the knowledge gained by them has been lost to the OCMCs.

Shortage of doctors and nurses in the hospital is another problem that affects care provided to GBV survivors. For example, there is no female doctor at Sunsari hospital.

> According to one of the survivors, "*I felt shy to show my body to a male doctor and was not able to interact with him properly and tell my problems".*

b. Capacity of service providers

Reflecting the sensitive nature of GBV and the skills required to support survivors, six month psychosocial counseling training was provided to a staff nurse from each OCMC. Both, the staff nurses working at Sunsari and Makwanpur have received this training. They have also received a five day

refresher training. The counselors have been using their skills as evidenced from the interviews with survivors, and feedback and reports received from counselors and doctors.

> According to a survivor from Sunsari who is currently staying at a Safe Home, "*Originally, I am from Baglung and was studying in class ten. I was tricked by my friend who got married to a man from Dharan in coming to Dharan. After coming to Dharan, my friend and her aunt forced me to go with different men. I refused. However, I was tortured for refusing. One day, police raided the place I was staying and brought me to Sunsari. I had lost all my hopes and did not want to live. However, sessions of counseling (3 sessions) with OCMC sister helped me come out from my mental distress and think positively."*

The staff nurse at Dolakha OCMC has received only one five days of counseling training, which is inadequate to prepare her to provide counseling services to survivors.

Medico-legal training has been provided to one doctor at Makwanpur hospital. According to him, "the *training provided knowledge and skills that are necessary to provide care for victims of sexual violence. Moreover, it has also enabled me to undertake investigations of sexual violence without difficulty*". None of the doctors working in Dolakha, Sunsari and Sindhupalchowk received such training. One doctor said, "*Without adequate knowledge on medico-legal investigation we have to take medical examination of survivors".*

None of the OCMCs have systems in place to mentor service providers or monitor their effectiveness so as to build on their strengths and address shortcomings.

The majority of the hospital staff interviewed at Sunsari and Makwanpurwho work outside of the OCMC have limited knowledge about GBV and have not received orientation on GBV and the OCMC. Dolakha OCMC has organized one orientation program for hospital staff. During interviews in Sunsari, Makwanpur and Dolakha hospitals it was found that most staff had limited understanding of GBV but did know that OCMC clients were entitled to free services.

> According to a Lab technician at Sunsari, "*They give us samples we do it free of cost. We only know that OCMC is for women who have suffered domestic violence and rape, no orientation or information has been shared with us about OCMC. I even don't know the full form of it."*

2.3.6 Management of OCMC

The prime responsibility of managing OCMC lies with the Ministry of Health, formerly this was the responsibility of Population Division but has been transferred to Public Health Administration and Monitoring and Evaluation Division (PHAMED). PHAMED is mandated to coordinate the implementation, supervision and monitoring of OCMCs. The study found that the functional coordination and collaboration was inadequate. Staff of OCMCs shared that while people from the Ministry come and ask for information, no proper monitoring has been conducted so far. OCMC staffs are unaware that at district level the core monitoring responsibility lies with the DCC, even the members seem to be unaware about this. The study did not find evidence that monitoring and evaluation has taken place at any level.

According to Hetauda Hospital MESO, "no *monitoring and supervision has been taken place from Central or District level. We are working and providing services, however, we do not know whether we are going on the right direction or not. At times it creates confusion, too."*

OCMC focal point at Dolakha hospital said, '*I learnt so much about OCMCs through this assessment*', and noted that there is a dire need for regular updating, experience sharing and close guidance for effective OCMC management.

Makwanpur, Sunsari and Dolakha OCMCs have been sending monthly reports to the ministry, but have not received any feedback on them.

OCMC staff at Hetauda Hospital shared, "we *have been sending monthly progress report every month but have received no feedback. We are not sure whether anyone reads them or not. We would be very happy to receive feedback to improvise the services provided by us."*

2.3.7 Multi-sector response and coordination with other stakeholders

a. Multi-sectoral response

Across all the districts, service providers recognized the need for multi-sectoral coordination and the need for government and non-governmental agencies to work together.

The study asked service providers what should be done to both prevent GBV and to deliver more effective services for women who have experienced GBV. The majority of interviewees felt that the law needs strengthening, and there should be more concerted advocacy efforts to make women aware of their rights and their protection under the law. Though there are many GoN line agencies and NGOs/CBOs working on the issues of GBV, the gaps still exist. All of them thought education played a vital role. Moreover, robust advocacy to address issues of GBV through different networks and NGOs/CBOs were recommended by some.

As the President of Bar in Sunsari, argued, "Awareness *should be spread through media because there is so much silence surrounding domestic and sexual violence. The issue should be included in school curricula."*

In addition, service providers felt that the current levels of service provision for women who have suffered violence is inadequate, and more shelter homes are needed. The provision of staying at shelter homes should be changed. Women who are in the need of shelter homes should be allowed to stay longer than the current limit of 45 days.

Service providers also reported that the laws that protect women from GBV and implementation of the law is both patchy and inadequate. They felt that these challenges could be effectively overcome

through well-planned awareness raising activities, capacity building of OCMC staff and stakeholders, follow up of survivors, better screening and coordinating strategies.

Currently, there is no female police personnel deputed at any hospital, as per the Operational Manual requirement. There are only one or two women police officers in women cell in all four districts (Makwanpur2, Sunsari2, Dolakha2, and Sindhupalchowk 1). A police officer in Makwanpur said that, "*I would like to see more female police officers recruited to look after women and children's case and a female police officer recruited at each OCMC."*

b. Multi-sectoral coordination

Coordination between OCMC and other stakeholders such as Police, WCO, safe homes, I/NGOs and other likeminded partners in all three districts was reported by the representatives of DPOs, safe home, WCO, and NGOs to be smooth.

> According to OCMC staff in Makwanpur who has been working at the OCMC since its inception, "*in initial years, we experienced difficulty running OCMC. Since, it was a new concept, people took time to understand OCMC and its functions. However, things changed slowly and we able to convenience all concerned stakeholders. "*
>
> According to Police officer at Sunsari, "*Our relationship with OCMC is like flesh and bone. We have great working chemistry; the cooperation is really working well."*

Survivors reported that the OCMC staff in Makwanpur, Sunsari and Dolakha districts provided them with information about legal services, and also linked survivors to women's networks.

> One of the survivors in Sunsari who had experienced severe physical violence shared, "*After the incident I decided not to go home. The staff at OCMC connected me with the safe house coordinator and I lived in safe house for 36 days. After that, I wanted to learn some skills. The safe house coordinator and OCMC focal person connected me to Maiti Nepal. I stayed at Maiti Nepal for six months and learned cutting and boutique training. After the training was completed, Maiti Nepal helped me open a tailoring shop by buying four sewing machines, a table and also paid the rent of shop for six months. Now, I have been been running the tailor shop. I not only have become an independent woman but have been giving trainings to other women, too. Currently, I am providing training to a group of 30 women and earning NRs. 10,000 per month".*

In Sunsari and Makwanpur districts good coordination between OCMC, WCO, police, safe house and local NGOs, had resulted in several survivors being able to learn new skills and become independent. The OCMC in Dolakha is still in the initial phase of establishment, and while they have been able to forge a working relationship with WCO office, safe house and District police office's women cell they are yet to establish a working relationship with NGOs and CBOs operating in the district.

c. Organisation of DCC meetings

For the past two years, DCC meetings are taking place at the stipulated time in Makwanpur and Sunsari and meeting records show increased commitment and ownership among DCC members. For example, in the meetings, biannual reports of activities carried out by OCMCs were shared, issues have been raised, and decisions taken and implemented accordingly. Discussions on the process of promoting ownership, effective coordination and enhancing roles and responsibilities of various stakeholders have also taken place in the meetings.

DCC meetings are taking place on time in Dolakha district, too[8]. The meeting minutes show the participation of all stakeholders. Decisions were taken to produce IEC materials and brochures and to disseminate information through FM radios and print media. Due to regular meetings, members of the DCC reported that they are aware about their roles and responsibilities.

The Women Development Officer of Makwanpur[9]*said that the perception that OCMC is only the hospital's responsibility has changed in Makwanpur district.* It was reported by NGO representatives that OCMC is a regular topic of discussion in all district level meetings. The effective coordination between OCMC, WCDO, DPO and safe house has played a vital role in attaining positive results.

However, the frequent change in government officials affects the effectiveness of OCMC and creates obstacles in implementing decisions made by the committee.

> As told by OCMC staff in Makwanpur, *"the frequent change of Chief District Officer is hampering the effectiveness of OCMC. In this District, the CDO changes every five/six months. It is tiring to provide information all the time."*

In the four districts it was found that CDO's were recently replaced and all of the incumbents had limited information on OCMC and the services provided by them. Implementation of some of the decisions taken at DDC meetings is slow because the stakeholders involved are too busy to allocate time. As reported by OCMC staff in Makwanpur, "*the contracted staff nurse had left the OCMC services in the month of Mangsir (two months back). She was trying to organize a meeting to discuss on the appointment of a new staff. However, the CDO had not given her time due to his busy schedule.*"

d*. Organisation of CMC meetings*

In Makwanpur and Sunsari, OCMC staff said that the Case Management Committee (CMC) is not very functional. Sunsari OCMC focal person said, "informal *coordination is there, however we have not organised formal meetings, if anything complex comes up, we talk on phone and resolve matter."*

The CMC appears to be functional in Dolakha. As told by OCMC focal person, "*we organise CMC meetings if we need solution to a complicated cases. It is also organised if serious cases comes and have to make referrals to another hospital."* Altogether, five CMC meetings have been organised by Dolakha OCMC.

[8] Two meetings have been organized and another one is scheduled soon.
[9] She is in Makwanpur district for the last one and half years.

Similar to the lack of orientation for hospital staff, DCC members, CMC members, NGOs and community leaders have also not been oriented about GBV and OCMC. Stakeholders in Makwanpur and Sunsari were informed about the objectives and functioning of OCMCs by the OCMC focal persons individually and have gathered information through attending DCC meetings.

2.3.7 Budget

a. Transparency

Budgets are provided to all OCMCs as part of the annual work plan and budget. However, identification of budgetary line items and delay in timely budget release has prevented effective budgetary management. OCMC focal persons in Makwanpur and Sunsari reported an improvement in budget transparency and that in contrast to the earlier years, OCMC staff are aware about the budget and its headings.

Staff at Dolakha OCMC said, "*we do not know anything about the budget. It is handled by accountant at DHOs office. We also do not know the budget breakdown and headings."* She added that the process for requesting budget is too long. We have to go through DHOs office and the process is rather long.

b. Inadequate budget

Services provided noted that the resources allocated for OCMC are inadequate to cater to the needs of GBV survivors, or to prevent violence from happening in the first place.

> A doctor at OCMC Dolakha said, "*Budget is not transparent. Everything is free at this hospital but we need money to provide food for patients and to meet other necessary requirements of patients".*
>
> MESO of Hetauda hospital also said, "*budget received by Hetauda Hospital is insufficient for running the services free of cost for the whole year. We are not sure how we will provide support for GBV victims if the budget runs out before the year end*."

MESO of Hetauda also questioned the sustainability of providing comprehensive medical care and other support services beyond the capacity of the hospital. With limited support it is challenging to cater to the needs of many survivors or those who have expensive medical care needs. Referring to a survivor who had visited on the day of the interview and would benefit from surgery, he said, "*We receive very limited funds for OCMC. We can provide general treatment to OCMC patients, however, won't be able to fund for operations that cost more than 10 thousand. Her collar bone has twisted; it won't create much problem, though it will hurt at times. The fund will be gone soon if we start sponsoring such operations, we won't be able to treat other needy ones. We need altogether different mechanism for that*."

2.4 The risk of GBV and performance of OCMCs in disaster and non disaster affected districts

Disasters affect women, men, boy and girls differently. Studies indicate that the risk of intimate partner violence, child abuse and sexual violence increases after disasters. Additional evidence suggests that the long term effects of a disaster can lead to increased levels of crime and community violence. Few studies have compared violence levels before and after a disaster, but the effects of disaster are likely to increase individuals', families' and communities' vulnerability to violence. These effects can have both immediate and a long-term impact on violence such as[10]:

- Increased stress and feelings of powerlessness due to bereavement, loss of property and loss of livelihood
- Mental health problems such as post-traumatic stress disorder
- The scarcity of basic provisions
- Destruction of social networks and disruptions of the economy

The violence experienced by women and girls before disaster can be exacerbated after the disaster is over. Women who were living in a violent relationship before the disaster may experience violence with increasing severity post-disaster, as they may be separated from family, friends and other support systems that previously offered them some measure of protection. After a disaster, women may be forced to rely on a perpetrator for survival or access to services. Displaced women and children are often at risk of sexual violence as they try to meet their basic needs[11].

The experiences for women and girls in Nepal prior to the earthquake included significant levels of GBV. Studies and reports indicate that large numbers of women and children in Nepal experience GBV that results in physical, sexual and psychological damage. The earthquake that struck in April 2015 intensified the pre-existing vulnerabilities and the situation of women and girls was of particular concern. In the immediate aftermath of the earthquake, the Department of Women and Children (DWC) along with I/NGOs and CBOs worked actively in most disaster affected districts in order to protect and prioritize prevention and response to GBV by activating district level protection mechanisms and by mobilizing women's' groups. Temporary shelter homes and mobile clinics were established across all districts to accommodate women and children affected by the disaster.

> As told by safe home co-ordinator of Dolakha district, "*so many I/NGOs extended their help in establishing the temporary shelter homes and providing medications and necessary food for victim's right after the earthquake which helped address the sexual violence and harassment*

[10]For more information on risk factors for violence, see the World report on violence and health (WHO, 2002, www.who.int/violence_injury_prevention/violence/world_report/en/).

[11]World report on violence and health (WHO, 2002).

experienced by women to some extent. However, the devastation caused by earthquake was massive in rural parts of Dolakha which are not easily traversed. This hampered the rehabilitation process sand most cases of GBV occurred in those areas."

Three of the survivors interviewed in Dolakha district also hailed from remote parts of Dolakha. From the district headquarters, it takes 3-5 hours by bus and more than an hour of walking to reach their home. The earthquake destroyed all of their houses and they were living in temporary huts made by GI –sheets at the time of the incident. All three of them experienced sexual violence from their own neighborhood. Though these are only representative cases, the data provided by DPO Dolakha also showed that gender based violence and sexual violence had significantly increased in Dolakha district after the earthquake. According to the data - there were only 85 sexual assault cases registered in the Year 2071/72, however, the number increased significantly and in the year 2072/73, it reached 101 (District Police Office, Dolakha). However, this year (2073/74) the number dropped considerably,and the in last 7 months (from Shrawan to Margh) only 30 cases have been registered. The reasons for increase in sexual assault in the year 2072/73 was given as: a) the consumption of alcohol drastically increased after the earthquake; b) reports of traffickers entering temporary shelters disguised as relief workers; c) single women and girls in the temporary shelters were targeted by perpetrators.

Contrary to Dolakha the number of sexual assault cases decreased after the earthquake in Sindhupalchowk. Only ten cases were registered in the year 2072/73. Whereas the cases registered in the year 2071/72 was 17 and this may reflect underreporting due to the challenges created by the earthquake (District Police Office, Sindhupalchowk).Or the interventions made by I/NGOS and government helped in reducing the numbers. According to acting WCO, in Sindhupalchowk, "*large number of I/NGOs flocked to Sindhupalchowk after the earthquake and are still here. This has led to reduce in sexual violence and other GBV cases. "*Another reason can be attributed to a strong presence of women's network called "*SHAKTISAMUHA*", which specifically focuses its work on GBV and human trafficking. It has expanded its network to all VDCs in the district and a social mobilizer in each VDC is used to educate community people on GBV and trafficking issues.

International research has shown that the incidence of mental illness also increases post disaster. Doctors at Dolakha and Sindhupalchowk hospital reported that cases of mental illness have increased after the earthquake. Provision of mental health care in Nepal is highly centralized with community based mental health care still being developed and trialed in a few districts. The 2015 earthquake has raised attention to the need to strengthen mental health service delivery in the country. In Dolakha for example, a psychiatrist is visiting the hospital each month to provide services.

In disaster situations where the health system is under tremendous stress due to the impact on physical infrastructure and human resources, and there is increased occurrence of GBV and mental illness, an established OCMC with psychosocial counseling capacity has the potential to respond to both GBV and to act as a first line of response to other forms of crisis including mental health. However, in the case of Dolakha and Sindhupalchowk where the OCMC was established after the earthquake, we find that the disaster situation seriously hindered the setting up of the OCMC.

Performance of OCMCs in disaster and non-disaster affected districts: This case study and experiences from across the world indicate that GBV is a very sensitive issue, demanding extensive technical know-how, commitment, patience and coordination to address the needs of the survivor, their family members and the perpetrators[12].

The two non-disaster affected OCMCs, namely Sunsari and Makwanpur, were established five years back, therefore, a system has been built and they have increased the provision of services to GBV survivors and their families over time. Sunsari has increased the number of clients it serves by 26% between year 068/69 and year 072/073, and Makwanpur by 24 % between year2068/69 to year 2072/73. Although gaps remain in the functioning of these two OCMCs, especially due to human resources and budget constraints, both OCMCs have shown that progress has been made in building ownership of the OCMC and multi-sectoral coordination essential to the functioning of the centres.

The OCMC in Dolkaha was established only a year ago after the devastating earthquake but has helped a total of 63survivors in this short span of time. The OCMC in Sindhupalchowk is not fully functional. The hospital is still operating under a tent and there is no allocated space for OCMC services. As told by the hospital staff, "*in the beginning there was space allocated for OCMC services. But, later it was given to Handicap International*." In absence of physical place for OCMC and staff, it was difficult to map the services provided by OCMC in Sindhupalchowk district. A staff nurse on contract was recently appointed to run the services. All service providers interviewed at the hospital, from DHO to Assistant Pharmacist, lacked information on OCMC and were not able to report anything asked to them about it. The DHO of Hospital also lacked information on OCMC.

> He said, "*We have not been able to provide physical space to OCMC, therefore I cannot comment on its services. Once we allocate physical space for it and provide services for survivors, then only I can comment*[13]".

The hospital register showed 14 cases registered in the whole year that was recorded by a doctor who was overseeing the OCMC cases.

She said that "We *have been providing services to survivors without having clear-cut information on GBV and OCMC. Domestic violence cases are treated in the emergency department. Labor room is used for treating rape cases. Rape cases are handled by two doctors, with the help of a staff nurse. The sticks used to take out vaginal swabs are not proper. A cotton roll is wrapped round the stick and swabs are taken. We have not been able to maintain confidentiality and privacy.*

There was confusion among DCC and CMC members in Sindhupalchowk, too. Members who were present at the inauguration of OCMC had limited information. They all echoed, we are happy to be part

[12]MoHP, 2013, OCMC Assessment Report.
[13] The building that will house the OCMC is under construction. It will be ready in a couple of months.

of such an endeavor however, a proper orientation on OCMC and our roles, and responsibilities should be provided. The orientation program was scheduled for 23rd Falgun 2073.

As reported by the studies, GBV cases are increased after a disaster. Therefore, the immediate focus for health service providers should be on caring for victims of violence and on taking measures to prevent further abuse and exploitation by providing immediate health care and psychological support for GBV survivors, including ensuring that Clinical Management of Rape (CMR) is available in health centers and through mobile teams. Establishment of OCMCs should be a longer term goal for disaster affected districts but a different strategy is needed to address the immediate GBV prevention and response needs because as experience shows it takes time to establish such a facility, and women and girls who are displaced by the disaster will find it difficult to access district based OCMC services.

3. RECOMMENDATIONS

The following recommendations are based on the findings and observations collected during the study. Suggestions and feedback received from stakeholders after the presentation of preliminary findings in each district has also been incorporated.

Infrastructure

Infrastructure is inadequate in three out of four OCMCs. There is need to improve the physical infrastructure as per the Ministry's guidelines so that comprehensive clinical and psychological care can be provided to survivors in one physical location.

Service delivery

a. Establish and strengthen the mechanism to refer clients to referral hospitals

District hospitals may not be able to provide all the medical care survivors need and it is therefore imperative to strengthen the referral mechanism from OCMCs to higher-level hospitals. A memorandum of Understanding (MoU) should be signed with referral hospitals that have advanced facilities, so that survivors can access appropriate care. In addition, well-designed protocols for referral need to be developed and staff at the referring and receiving facility trained in their use. A mechanism should be developed so that survivors receive all necessary services free of cost.

b. Referral to OCMCs

Introduce training and the protocols necessary to guide VDC level health workers and other service providers to refer victims of GBV to OCMCs. Develop local mechanisms that provide support including funding transportation, to enable survivors to access the care they need and protect them from perpetrators.

c. Monitoring and Supervision

The study showed inadequate monitoring and supervision of OCMCs. It is recommended that regular monitoring and supervision from central and district level be introduced with central level stakeholders visiting each OCMC at least two times in a year; this will facilitate problem solving, promote the smooth running of the centres and their effectiveness.

At district level, DCCs should regularly guide and monitor the OCMCs, and ensure its decisions are followed through. Ownership of a program which is grounded on multi-sectoral coordination can best occur when horizontal programming begins to run effectively.

Awareness raising and information dissemination

Sunsari and Makwanpur OCMC staff shared that audio and print media have been used to disseminate information on OCMC including through locally produced leaflets and brochures. However, none of the survivors interviewed had prior knowledge of OCMCs. It is recommended that a strategy for raising public awareness at the national and local level be designed and developed to reach a wide section of rural and urban populations, survivors, perpetrators, potential perpetrators, service providers and community and political leaders.

Human resources

a. Capacity building

- Capacity building of OCMC staff should be prioritised. This can range from formal training and orientation on GBV and the delivery of clinical and psychosocial services to GBV survivors and better understanding and empathy towards them, to on-the-spot coaching of OCMC staff. Findings revealed none of the staff nurses had received any prior training on GBV and psychosocial counseling before they took up post. Addressing this gap will create better understanding of the value of OCMC services.

- Organization of annual review meetings of OCMC staff for experience sharing is recommended. In-country exposure visits to other OCMCs for sharing of best practices will enhance understanding and increase motivation.

- It is recommended that awareness raising and capacity building of all hospital staff on GBV and OCMC is provided – from Medical Superintendent to staff of all different departments. Findings revealed all DHOs [DHO - Dolakha (working since last seven months), DHO Sindhupalchowk – (working since last four months (on and off) and Sunsari DHO (working since 2 months)] had limited understanding of OCMC and its activities.

- Only two doctors across the focal hospitals had received medico-legal training. Other doctors are working without the full knowledge and skills required to undertake these examinations. It is recommended that at least two doctors (one male and one female) should be provided medico-legal training at each hospital.

- Health workers, social workers, and the police need to be better and more frequently trained on GBV so that they can detect and appropriately handle both child and adult cases when they come across them in their line of duty.

b. Staffing

- OCMCs should be adequately staffed, ideally with at least one medical doctor, three staff nurses including one psychosocial counselor to make it able to run for 24 hours. It is also recommended that in addition to a full time staff, at a minimum, one doctor and one nurse should be on call

for OCMC on a 24-hour basis. This will ensure timely response to the medical and psychosocial support needs of the survivors, including the collection and preservation of evidence for legal purposes.

- Retaining of staff has been a problem experienced by OCMCs. A minimum of a two year contract should be mandated for staff appointed on contract basis. This will help avoid institutional memory loss, as well as enable staff to work confidently without the constant pressure of looking for a new job. Agreements should also be made prior to providing technical training such as psychosocial counseling, to ensure staff's long term service.

- GoN employees are transferred frequently and this applies to staff working at OCMCs too. It is recommended that a mechanism should be designed to transfer staff working at an OCMC to another OCMC.

c. Women doctors

It is recommended that more women doctors are deputed to OCMCs since they are better able to understand and deal with issues faced by women survivors, and female survivors prefer being examined by a woman in situations of GBV.

d. Inclusion of OCMC in nursing and medical training curricula

Curricula for nursing and medical schools should contain information on OCMC. In BSC nursing, there is a course called Community Health Nursing. In that course, students have to study the district and regional level services provided by MoH, however, OCMC is missing. Similarly, OCMCs are not included in the Programs and Polices of MoH at district and community level; this gap needs to be rectified.

Multi-sectoral response and coordination

a. Prevention programs

Prevention programs must be implemented at the district and community levels by MoH and other agencies. Some potential programs are awareness raising to prevent GBV; information sharing on the physical and mental health consequences of GBV on survivors and their family members, children and communities; gender norms transformative programs with young people; and interventions to reduce alcohol abuse. In addition to preventing the incidence of violence, such programs will raise awareness of women's rights and increase access to OCMCs. Focused preventive and response programs should be targeted to VDCs where the incidence of GBV is recorded to be high.

b. Safe homes

In Makwanpur and Sunsari district there are safe homes run by WCO office. However, a safe home is lacking in the two disaster-affected districts. Safe homes are mandatory for all districts that have OCMC services, as hospitals cannot keep survivors for a longer period of time. Therefore, it is recommended that MoH work in coordination with the Ministry of Women and Children for establishing a safe house

for women and children in all districts with an OCMC and where the incidence of GBV, such as in disaster-affected districts is high.

c. Provision of free education for children who are rape survivors or are the children of rape survivors

Due to the stigma attached to rape, rape survivors and their children cannot go to their home immediately after receiving services. Therefore, it is recommended that such children should be provided with free education at residential schools. An MoU should be signed with schools to provide access to Residential School Education for girls/minors who have survived rape or are the children of rape survivors.

d. Follow-up and rehabilitation mechanism

There is a need to establish a proper mechanism to follow-up GBV survivors and support their rehabilitation. The WCO has a number of networks such as watch-groups, cooperatives and para-legal committees in almost all VDCs of the district. Thus, when a survivor returns home or to their respective VDCs these networks could be a vital source for tracking and monitoring the status of survivors and also the perpetrators. Moreover, information systems from VDC to district level should be established to track the support and follow up that GBV survivors received from multiple agencies.

Informal follow up already exists in OCMCs, but is insufficient. A formal follow up mechanism could be setup through the formation of coherent partnership between OCMC, WCO, DPO women cell and NGOs/ CBOs working on GBV and women's empowerment.

c. Multi-sectoral coordination

There is need to strengthen the linkages between different service points in order to achieve comprehensive GBV services. This will require better coordination between OCMC, WCO, police department and legal institution in order to enhance the survivors' pursuit of justice and to better respond to their health, shelter, livelihood and protection needs.

d. Capacity building of DCC/CMC member

DCC and CMC members need to be aware of their roles and responsibilities for internalization and the effective functioning of the OCMC. Their ownership, knowledge and capacity can be enhanced through orientation and training on GoN's GBV plans and policies.

e. Organisation of CMC meetings – The DCC meetings are taking place regularly. However CMC meetings have not taken place formally in both Sunsari and Makwanpur Districts. It is recommended that CMC meetings be organised once in a month to reflect on the types of case that have been assisted by the OCMC and also to plan for complicated cases.

Funding

Funding for OCMCs needs to be adequate and sustainable. Where activities are underfunded or funds run out, the brunt is borne by survivors, who may experience a delay in obtaining much-needed medical care, as well as other services.

For disaster affected districts

a. Short term goals

The immediate focus for health service providers should be on caring for victims of violence and on taking measures to prevent abuse and exploitation by:

- Providing immediate health care and psychosocial support for GBV survivors, including ensuring that Clinical Management of Rape (CMR) is available in health centers and through mobile teams.
- Health workers should be trained to identify victims of violence and provide care that ensures their safety, privacy, confidentiality and dignity.
- Establishing a referral system to support GBV survivors' access to quality care and support.
- Ensuring the availability of female-friendly spaces for integrated services and safe shelter for women and girls – with particular focus on marginalized groups and those in need.
- Ensuring humanitarian agencies work with national government plans and policies and national partners, including the Department of Women and Children and civil society organizations.

b. Long term goals

- Community networks and programs that addressed violence before the disaster should be identified and implemented.
- Efforts to address violence must engage everyone from the community including men, women and children of the affected community in the planning phase, including victims of GBV and persons with disabilities.
- Organize community education and awareness raising programs which are useful for informing people about GBV and the available services as well as where they can go for care.
- Establish OCMCs and expand its services to VDC level.

4. *ANNEX: 1 ASSESSMENT MATRIX*

Relevant areas	Observations/Districts				Preliminary Findings	Recomm
	Hetauda	**Sunsari**	**Dolakha**	**Sindhupalchowk**		
Achievements and strength of OCMC – Service provider's perspective						
a. positive initiation by GoN of Nepal	●Positive initiation – should be in hospital ●Sensitized all actors involved	●positive ●Sensitized all actors involved	●positive initiation ●sensitized most of the actors involved		●Initiating through hospital is positively taken by all interviewed, as it is perceived as a means through which holistic support can be received by GBV survivors ; a system has been in place and considerable number of women have received services knowingly and unknowingly ●has played a positive role in sensitizing hospital personnel and other involved stakeholders regarding GBV	
b. Physical facility and timely service	●Physical facility at OCMC seems to be on place and allocated space is adequate particularly in terms of privacy ●Provided all kind of services from medical treatment to counseling services including all other required services free of cost ●The quality of services provided have been better	● Physical facility at OCMC sufficient ; allocated space is adequate, particularly in terms of privacy (though counseling room is not very appropriate) ●Provided services to victims free of cost (medical, counseling, as per requirement) ● quality of services provided	●Physical facility at OCMC is undersized ●provided services to victims free of cost ●quality of services provided to victims very good as all kinds of equipments needed are available		●Physical facility were available in all three OCMCs except Sindhupalchowk, the sindhupalchowk hospital is still functioning under the tent ●In Both Hetauda and Sunsari, the allocated place is enough particularly in terms of privacy, however, in Dolakha OCMC room is undersized and do not have a separate counseling room ●All OCMCs have been providing services	

	compared to earlier ●Victims have been receiving services on time	have been better compared to earlier ●victims have been receiving services on time as per their requirement	●victims have been receiving services on time		free of cost from medial treatment to counseling ●The quality of service provided have been better than before and on time	
c. Active OCMC focal person d. Attitude of doctors	●Active OCMC focal person, ●Positive commitment and good attitude and behavior of OCMC staff ●Focal person has a clarity on her role ●Clinically: very positive as they have been providing all required medical services free of cost and a system has been developed. But for night, due to shortage of staff, cases are dealt by emergency staff and are kept in indoor ●Doctors are also positive towards cases, they are more positive towards OCMC ●Team of doctors are used for OCMC cases (three doctors are kept in loop), on physical	● Focal person at OCMC very actively involved in helping all victims ●Focal person has a clarity on her role ●Clinically: active and positive, a system has been developed, but for night due to shortage of staff, cases are handled by emergency, but OCMC staff is called in case of serious cases ●Doctors are relatively positive towards cases ●Team of doctors are used for OCMC cases, in case, of a physical assault, a doctor who is on duty is called, but, for serious cases, such as rape, team of two doctors are called and examination is conducted ●Since Sunsari hospital does	● Focal person at OCMC is activeand has clarity on her role Cynically: a system has been built, as the focal person of OCMC stays in quarter inside the hospital, she is available at night also ●Doctors are positive towards cases ●Team of doctors are used for OCMC cases, in case, of a physical assault, a doctor who is on duty is called, but, for serious cases, such as rape, team of two doctors are called and examination is			

	assault cases, mostly a doctor who is on duty is called, but, in serious cases, such as rape, a team of two doctors, including a female doctor is called, and the patient is examined	not have a female medical doctor, at times it is difficult for carrying out examinations (especially for Terai community)	conducted ● Dolalkha hospital has designated two doctors for carrying out OCMC related examinations,			
e. Maintaining confidentiality and security	●Confidentiality: confidentiality is maintained,, coding system is used since last three months, even doctor's don't know the names of the victims, are (they refer them as case numbers)	● OCMC in Sunsari has tried to maintain confidentiality, as all cases are treated in OCMC ward and are kept there, coding is used for rape cases, however, for other cases, coding system is not in place	The OCMC room in Dolakha is undersized, therefore, it is very difficult to maintain confidentiality, but service providers at Dolakha say that they have been trying to keep cases confidential by treating once case at a time			
a. Capacity building of service providers	●One psychosocial counselor at hospital with six moths psychosocial training and one refresher training ●Two doctors with medico-legal training (who is also the focal point for OCMC)	●One psycho-social counselor at OCMC with six months psycho-social counseling training and a refresher training	● OCMC staff have only received a five day counseling training (not sufficient for counseling)			
b. Improved in-house coordination and coordination with other	● Coordination with doctors and nurses from other department is also better ●Coordination with other departments, such as, emergency, OPD, Indoor,	●Improved coordination with doctors and nurses ●Improved coordination with other departments also, however, the limited opening time of lab poses challenge Coordination with other	● coordination with doctors and nurses from other department is also better ●Coordination with other departments,			

agencies	lab and pharmacy working well ● Coordination with other agencies, such as, Women and Children development office (WCO), Police, safe house run by WCO, and other CBOs and NGOs working on the same issue, is very excellent ●Members are aware of their roles and responsibilities	agencies working very well, such as, WCO office, Safe house, and other CBOs and NGOs ●Members are aware of their roles and responsibilities ●link developed by OCMC due to focal person's personal networking	such as, emergency, OPD, Indoor, lab and pharmacy working well ●Coordination with other agencies, such as WCO and Police is also working well, however, the lack of Safe house, poses a challenge for victims requiring rehabilitation services			
c. Organization of DCC and CMC meetings	●Increased ownership among DCC members ; DCC meetings are taking place on stipulated time since last three years, issues have been raised, decisions are taken and implemented accordingly; however, CMC meetings have not been organized formally (though informal meetings are taking place)	● Increased ownership among DCC members; DCC meetings are taking place regularly since last two years on stipulated time, however, CMC meetings have not taken place	Increased ownership among DCC members; DCC and CMC meetings are taking place			
d. Productionof IEC materialsandinformationsdessi	●IEC materials such as, leaflets and brochure of OCMC has been developed and circulated accordingly ●Information through FM radios (Hetauda FM, Makwanpur FM,	●IEC materials such as, leaflets and brochure of OCMC has been developed and circulated accordingly ●Information through FM radios (Saptakoshi FM, Ganatantra FM, and Popular	●Decision has been taken to produce leaflets, brochure with information on OCMC ●Decision has also been taken to extend			

minations	Radio Sarobar, Thaha FM – they run it at least four times a day) and print media also circulated ●Information on OCMC circulated through students – given a short orientation on OCMC to students, grade 8, 9 and 10	FM); T- shirt with information on OCMC distributed with help of UNFPA, hoarding board is also kept at the centre of the market with info. On OCMC	information on OCMC through FM radios and they have also been shortlisted			
e. Management of cases	● data maintained as per guidelines ; monthly analysis of data	"	"		Data maintained as per guidelines	
f. Record keeping and Follow-ups	●Records are kept in register; a form has been developed to keep history of survivors ● a consent form is also in place ●Follow-ups have been carried out whenever possible through phones	●Records are maintained in a register Follow-ups have been carried out whenever through phones	Records are maintained in register, however, follow-ups have not been carried out		Very limited follow-up of cases - only by phones	●Need ●Staff up ●DCC follow- update survivo ●Take such as
Constraints, Challenges and bottlenecks from the service provider's point of view						
a. Lack of human resource	●Only one person working at OCMC, she is also transferred from hospital two years ago, however, on request from hospital, she is deputed to work at OCMC	● One person working at OCMC, the staff nurse had left 15 days ago ●lack of doctors and nurses at hospital (only …doctors), no female doctor at the hospital ●Retention of medical staff is another problem at this hospital	● two staff nurses are working for OCMC ●		The Operational manual of OCMC says that OCMC shall have one medical officer (working in the hospital) and three staff nurse working in the hospital including one trained psycho-social counselor, however, lack of human resource makes it difficult for smooth running of the OCMCs	
a. Lack of	●Psychosocial counseling	●Six month psychosocial	● Only two five days t		●Considering sensitive natures of GBV,	●Traini

capacity building of OCMC and other hospital staff	training given to only one person, and one refresher training, however, it is not enough ●require more capacity building training and exposure on to what to do and how to do it ●No orientation to other hospital staff on OCMC ●Medical staff at Emergency and Indoor were of the view that they lacked knowledge on OCMC (knew only that cases with domestic violence and rape should be sent to OCMC) ●Other departments such as, lab, x-ray had little or no information	training given to one person at OCMC, and one refresher training ●No orientation to other hospital staff on OCMC ● Medical staff at other departments lacked knowledge on OCMC	raining given to staff nurse at OCMC; ●More training on counseling, GBV and other relevant areas, required to strengthen the capacity of OCMC ●one time orientation given to other hospital staff		OCMCs are positive initiative. But adequate technical support for capacity building of OCMC and hospital staff is missing ● Only six months trainings and one time refresher training to psychosocial councilor	be en hospita provide them to
b. 24 hour service not available	● due to dearth of human resource at OCMC 24hrs service is not available; cases that come at night are kept in Emergency or Indoor, depending upon the need of the patient ●Only one staff is GoN staff, staff hired on contract basis difficult to retain ●a separate staff has not been appointed and trained	●24hrs service not available ●Only one staff ● cases come at night are kept in Indoor or emergency, if its serious then OCMC staff is called as she lives near by	●24 hrs service available on call basis as the focal person of OCMC lives in doctor's quarter; she is called if case arrives at night		● On call 24 hrs service available in only 2 OCMCs ● One year contracts create uncertainty among staff ●Two OCMCs, Hetauda and Sunsari are running solely on one person, need to hire more staff and develop a system	●timely is essen ● Mini should should councel term se
c. DCC and	● DCC meetings are taking place	DCC meetings are taking place	DCC meetings are taking			

CMC not very effective	regularly, however, changing of CDOs frequentlyaffects effectiveness and creates obstacles in implementing decisions made by the committee ●CMC not functional –though irregular meetings are held, no formal meeting has been organized	regularly, however, changing of CDOs frequently affects effectiveness and creates obstacles in implementing decisions made by the committee ●CMC not functional –though irregular meetings are held, no formal meeting has been organized ●Linkage between hospital personnel, DCC members and CMC is vague – there is little or no sense of unity	place regularly ● Linkage between hospital personnel and other members are confusing			
d. Poor coordination (centre to district)	● coordination between centre, regional and district level not very visible; which is affecting the efficient functioning of OCMCs	"	"		coordination between center, regional and district level is poor It should be strengthened from central to district and district to local levels	Concern Ministry Women and o should level a districts should coordin
e. Lack of supervision and monitoring andfeedback on monthly	●Regular monitoring and supervision by DCC and Central level missing ●No directives from centre – confusion, where are we going? Recommendation: More central level visits. M&E should involve	●Regular monitoring and supervision missing	●No regular monitoring and supervision		Central level supervision not in-depth Supervision and monitoring by central and district level missing	●Need from ce ●A m develop ● One done by

reports	feedbacks from and should be discussed and timeline for implementation monitored in DCC meetings ● Feedback on monthly report not received so far from central level	●Feedback on monthly report not received	● monthly report not sent, has sent whenever asked			●Mecha monthl establis
f. Budget	●Limited budget, not enough for providing all kinds of services for survivors ● have not been able to provide support for bigger costs	●limited, not enough for providing all services for survivors	● budget underutilized		Staff are knowledgeable about budget, however, in Hetauda and Sunsari, due to the flow of survivors, budget seem to be inadequate	Need to
g. Rehabilitation	● Proper rehabilitation missing; safe home is available, but can keep survivor there up to 45 days only ●Few NGOs, CBOs have come for rescue, such as, Maiti Nepal ●no resources for proper rehabilitation, if a survivor cannot go home, WCO office provides only NRS. 10,000 as seed money to help run a business, which seems insufficient	‘’	No rehabilitation home for temporary shelter, too		Medical services, counseling, and shelter home in Hetauda and Sunsari are available, however, rehabilitation centre at Dolkha is not available, need to work towards providing all services which OCMC aims to provide	●There mechan Regular should Women victims with the ●To ens security should ●Mobil funds concern rehabili

5. ANNEX 2: CASES STUDIES

Total sixteen cases were interviewed – six cases from Makwanpur, five cases from Sunsari, and five cases from Dolakha district[14]. The cases were selected based on their diversity and availability. All cases had experienced different sexual and physical violence from perpetrators and their stories are unique in their own way. One to one interviews were held with survivors by holding empathetic, in-depth and confidential interviews. Consent was taken from each survivor before interviewing and a letter was also signed by them.

Dolakha District

Case 1

The survivor is a 19 year old girl, from Thami community, who was living with her mother and a younger brother.Her father had left her mother two years back and eloped with another woman. Her house is in Suspa VDC, which takes almost three hours to reach by bus. The house had been destroyed by the earthquake, so they were residing in a small cottage made by GI- sheets. She belonged to a very poor family, sustaining merely on agriculture done on a few ropanis of land and her mother working on daily wages. She was studying in class eight.

The incident took place on Mangsir 072 (according to the victim). However, the case was registered only on 2073/02/03. The survivor has seizure disorder. She used to get seizures frequently and was taking medications for the same. According to her, she was sexually abused for the first time on Mangsir 10, 2072. On that day, she was alone at her home. Her mother and brother had gone to attend a wedding ceremony of their relatives. The guy from her neighbourhood called her and came to give her company in the evening around 8:00 PM and kept playing with his mobile phone in her cottage. As he used to come every day to her house, his presence did not bother her and she carried out her daily activities. After eating food she went to bed and still the person was playing with his mobile.

He then suddenly entered where she was sleeping and held her. According to her, she then suddenly, lost her consciousness and regained it after 1- 1.5hrs. She found herself naked, clothes scattered all over, and then only she realized that she had been sexually abused. She could not get up properly. It hurt her so much and had problems in walking. However, she did not disclose about the incident to anyone.

After that incident, she repeatedly called him but he didn't receive her calls and totally ignored her. Then, on 8thBaiskh, he called her during night in the field, threatened her, confiscated her mobile, and sexually abused her again.

[14] No cases were available in Sindhupalchowk district. The register was not maintained properly so was unable to locate case.

Her mother came to know about the incident only when she was already six months pregnant. Mother scolded her and brought her to the police to seek legal support. However, the assailant had already eloped with another girl a month ago. Her mother abandoned her, ever since she has been residing in a Safe house run by "Sabal Nepal".

All her ante - partum and post-partum checkups were carried out at OCMC Dolakha. She was given vitamins, such as folic acid and calcium tablets and other necessary medications free of cost. She did not speak much about the incident, so, OCMC staff nurse had provided repeated psycho-social counseling sessions for her at safe home. Few months back, she gave birth to a healthy baby boy and stayed at hospital for a day. According to her, she was treated nicely by everyone at the hospital including doctors, nurses and OCMC staff.

A case has been filed; however, the guy is still absconding. The girl is residing at the Safe house as she has no place to go. However, the safe house is going through problems. The support provided by agencies to the safe house has been stopped since December 2016 and as told by the in-charge of safe house, at the moment, they have been running on their own and she does not know until when she will be able to manage support to these survivors.

Case 2 (The survivor spoke very slowly, and did not want to speak much, she was half-dumb)

The survivor is a 20 year old girl from Tamang community living with her parents and two brothers. She hails from a remote part of Dolakha district, which takes two hours to reach by bus and an hour of walking. Their house was destroyed by the earthquake so all family had been living in a cottage made by galvanised sheets. Family's main sustenance is agriculture. Her main role in the family was rearing animals, cutting grasses and feeding them. She had never attended school.

As told by her, in her neighbourhood, there was an adult boy who runs a small shop. He used to tease her every now and then, telling her to come and stay with him. One night when everyone was fast asleep around 10pm he came in her room fully drunk and started abusing her and raped her and left. She shouted, however no one heard her. This affair continued for some time, he used to look for opportunity, and would come to her house when no one was there. She kept everything hidden from her parents. When asked, why did she not tell anything to her parents? She kept mum.

When her mother and father learned about the incident, they threw her out. A sister from her village brought her to the safe house. When she arrived at the safe house, she was five months pregnant. She lived in Safe house and went regularly to the OCMC for checkups. She had some complications on her pregnancy, so had to stay in hospital for a longer duration. The staff at hospital treated her very nicely. All medications and treatment required for her were provided free, food was also provided free of cost. When the time was due, normal delivery was not possible so she had c-section. After delivery too, she had to stay in hospital for long time. In hospital, she stayed in women's ward. She came back to safe house after staying in hospital for long time. She is still at Safe house with the baby. Says that she loves her baby very much. A case has been filed; however, the perpetrator is still absconding.

Case 3

The survivor is a 15 year old girl from Thami community living with her parents, brother and sister –in-law. She comes from a remote part of Dolakha district, which takes three hours to reach by bus. She has studied up to class seven. Their house was destroyed by the earthquake so all family had been living in a cottage made by GI- sheets. Family's main sustenance is agriculture and are very poor.

As told by her, the assailant is a familiar person and is her neighbour. He used to tease her every now and then. It was the month of Mangsir (2072), she was feeding the chickens he called her to his house for some work. She went there and found out that he was all alone. He immediately locked the door and started molesting and harassing her. She started shouting and screaming but no one could hear her. He forcefully sexually assaulted her and threatened her not to tell about the incident to anyone. After this, she went to her house but could not tell her family members what just happened to her. According to her, he forcefully had sex with her 2-3 more times in the assailant's house when she used to go to his house for watching TV. According to her the last incident of sexual assault was on Mangsir, 2072.

The family members came to know about this only after she was seven months pregnant. They talked to her and she told her parents everything. Her mother brought her to the police station and a case was filed. She then was brought to the hospital for checkups by Police. Her mother accompanied her. Since her house was far away, her mother left her at the safe house. Her general physical examination was conducted at the hospital and ANC package was provided to her. All kinds of tests were carried out, such as, USG, blood, HIV, and urine. Counseling was also conducted. Follow-up checkups were also done unitl the delivery of baby and after delivery, too. Surprisingly, her child was delivered normally. According to her, all staff at hospital including doctors treated her very nicely.

After the case was filed, the perpetrator was immediately brought into custody by the police and has been given 5 years of jail sentence.

Case 4

The survivor is a 15 year old girl from Charikot, Dolakha. She has been living with her parents and a brother. Her family runs a small hotel in Charikot.

According to the survivor the incident took place on 2073/08/30, roughly between 9:00 PM to 10:00 PM. She was at her kitchen room and one of her female friends was doing homework in her bedroom. She then suddenly heard her friend's cry for help. She ran to her bed room, there she saw a man in her bedroom. He was from a nearby community. Her friend was out of the bed and frightened. In a flash of moment, the assailant attacked her instead of her friend. He touched her breast and pushed her on the bed. She tried to escape but he blocked her by his leg. Then her friend tried to pull the attacker but he pushed her as well on the bed and did not allow her to move by putting his hand over her chest. They both shouted and cried for help. Her brother heard the screaming from outside and came for help. He knocked on the door very hard as the attacker had locked the room from inside. After hearing the knock on the door, the attacker himself opened the door. He then started fighting with her brother. The girls called for help and he was caught by other people and took him to the police.

Then the girl was brought to the Dolakha hospital for checkups accompanied by a woman police officer and her parents. At the OCMC, her general check-up was carried out by the doctor as the girl had denied any other sexual misconduct carried out by the attacker at that time on that day. She also confirmed that the attacker had abused her verbally two- three times before in the past, too, when he had visited their hotel.

The case was registered against that guy and he was put in a lock up for three days.

Case 5

This survivor is a 35 years old woman who had been married for last thirteen years and had ten year old daughter and nine year old son. She had studied up to class eight and lives in Charikot. She runs a small retail shop. She is the second wife. Her husband had left his first wife to marry her. After eight years, he again got married to another woman. However, he does not stay with the other wife.

Her life with her husband was going well until 5/6 months of marriage. After that she experienced violence from him regularly. He has the habit of drinking and smoking. At times, he would start drinking from the morning and would beat her whenever he saw her. Her children lived in a constant fear. He used to force her for sex whenever he liked, even in-front of kids, too. Even after experiencing such abuse everyday she never thought of reporting him to the police. Due to constant sexual abuse she had problems in her lower abdomen and uterus. He constantly accused her of having multiple affairs and would hit her if he saw her talking to any strangers. She always wanted to stay separate but for the sake of her kids she has been staying with the same husband. Her husband took loan from the shop and invested in transportation sector, but is not willing to pay it back, every time she goes near him he starts threatening and hitting her.

The major incident which compelled her to go to the hospital and seek police help occurred last month (Margh 20, 2073). She had asked him about the NRS. 20,000 he had taken from her. This made him very angry so he started hitting her with belts, cooker, and utensils, anything he could lay his hand upon. She got severely injured and fainted. He had banged her head on the wall sustaining severe head injuries. She was taken to a nearby hospital by her brother. She had bruises all over her face and body. Her face was swollen and she had fifteen stitches in her head.

She was treated at the hospital and stayed there for a week. The doctors and nurses from OCMC behaved well with her and treated her for her complications. According to her, everyone behaved very nicely and it was free of cost. Police and registered a case against him. She wanted divorce too, but her husband requested her to forgive him for one time.

Makwanpur District

Case 6

The case came when the consultant was visiting Hetauda Hospital

The survivor was a 31 year old woman from Chhatiban VDC, from Tamang (Gole) community, residing with her husband and three daughters aged eleven, eight and three. She had been married for 15 years. The main sustenance of the family is agriculture. Public vehicle is not easily available in her village; she has to walk for more than forty five minutes to reach the nearest bus station. Her husband works as a labourer in construction sites. They are very poor.

Her husband had the habit of drinking and smoking. He used to come drunk once in five six days, verbally abuse her calling her vulgar names, and beat her up with hands and anything he gets his hand to. He used to force her without her consent. He used to accuse her of having affairs and sleeping with others if she refused to sleep with him. Her husband constantly harassed her for not giving birth to a son.

The major incident took place on Poush 29, 2073. On that day her husband was late from work, so she just asked him why you were late. This triggered his mood and he started hitting her everywhere, pulling her hair. This incident broke her hand and bended her neck. Though she was severely wounded, she could not come to the hospital due to shortage of funds. Primary health care is also not available in her village. The bus takes Nrs. 500 rupees from her home to the hospital. Moreover, she could not walk, so was unable to come. After three four days, her sister came from Kathmandu and paid for her transportation and brought her to the Hetauda hospital. Her sister had known about OCMC, so she was brought directly to OCMC.

She received all necessary medical treatment from OCMC free of cost. Tests such as, Urine and Blood were also taken. She had broken arm, so X-ray was also taken. The x-ray of her hand showed that her collar bone had broken. Since, the Hetauda Hospital did not have Orthopaedic doctor, she was taken to a nearby clinic for the necessary medical examination. After all medical examinations, the Orthopaedic doctor told her that she needs an operation which costs around NRs. 50-60 thousand rupees to perfectly fix her bone. If not, the bone will look little twisted and would hurt her at times.

She was given all necessary medications and vitamins also free of cost. She said that she will go to her maternal home that day. The OCMC focal person gave her information about safe house, police, public lawyer, in case if she wants to file a case or stay at safe house. She said that she will go to her maternal house and stay with her parents. She decided to forgive her husband for one time and not file a case. If he repeats that again, she said, she will surely file a case.

When the consultant asked, will OCMC support for her operation?

“The focal person at OCMC said that she will call the case management committee meeting soon and discuss about the problem and will come to a solution.”

However, when asked to MESO, he said that, “we receive very limited funds for OCMC. We can provide general treatment to OCMC patients, however, won’t be able to fund for operations that cost more than 50 thousand. Her collar bone has twisted, it won’t create much problem, though it will hurt at times. The fund will be gone soon if we start sponsoring such operations, we won’t be able to treat other needy ones. We need altogether different mechanism for that.”

Case 7

This survivor was a 36 years old woman, from Sanupokhara, Gadi -2, living with her husband from last seventeen years. It takes about three and half hours by bus to reach the hospital from her house. She had eloped with this man when she was only 19 years old. She has four daughters. After few months of marriage, they had separated from their in-laws, and were living on their own. Though they were living on their own, her mother-in-law used to backbite about her to her husband when she was not around. She also tried telling her husband about her mother-in-law’s unreasonable behaviour, but he never listened to her.

Since last few years, her husband used to beat her up and strangle her neck. He had the habit of drinking alcohol and playing cards. He would drink from the morning and go out with his friends and do nothing. He would come at night and start fighting with her and beat her up. It had become a routine. She had to do all the household chores as well as work in the field, too. He would beat her every day and her neighbours would come to her rescue. Her in-laws also used to beat her and blame her for not giving birth to a son. They used to ask their son to leave her and get married to another girl who can bore him a son.

He used to force her for sex anytime of the day whenever he wanted, did not care for anyone not even kids. He used to have sex even when she was menstruating. She had filed a police complaint twice in the past, but the police would threaten the husband and ask her to reconcile with him.

The major incident happened in Baishak 9, 2073. On that particular day, she had gone to the field in the morning and came back home around five ‘o’clock in the evening. Her husband was sitting there angry. She had no idea what he was angry about. All of a sudden he pulled her hair and strangled her neck. He started beating her up with the sticks he had with him. He continuously beat her up and she felt unconscious. She had bruises and blue marks all over her head and body which were bleeding. He had broken her ribs, too. Her entire body had swollen including legs. Hearing her scream, some neighbours called her younger sister and was rushed to the hospital in ambulance. She reached hospital around midnight. When she regained her consciousness she found herself in hospital. At hospital, she was brought to the Emergency department. She had sustained injuries all over the body so they suggested she be admitted. She was kept in Emergency for that day and the following morning, the OCMC staff was informed about the case and she was shifted to the female ward. OCMC staff facilitated her treatment. During the day, she was kept in OCMC department and at night was shifted to female ward. Due to dearth of human resource at OCMC, they were not able to keep her in OCMC at night. She stayed in hospital for total three days. According to her, everyone at hospital including doctors and

nurses behaved very nicely with her. She was provided all medications, food and a pair of clothes free of cost. She seemed to be satisfied by the service she had received. She also received repeated counseling sessions from the psycho-social counselor at OCMC, which she thought, was highly beneficial. She received information about Safe house, police and legal from OCMC. The OCMC facilitated her to file a divorce case. The case is also going on in the court.

Now, she is living on her own in Hetauda, has not gone back to her home. The OCMC person is facilitating her open a small business with the help from WCO fund. She is planning to open mobile mo: mo shop after receiving the fund.

Case 8

The case had come when the Consultant visited Hetauda Hospital. The case as narrated by her mother:

The survivor is a six year old girl child, from Thingana VDC, Ward no.5, Makwanpur District. Her father has gone to Saudi Arabia for employment and she is living with her mother and a two year old brother. She was accompanied by her mother, a woman police officer and two male police officers, when they visited OCMC.

According to her mother, the perpetrator is a cousin brother of the girl child, who used to stay with them, whenever he was in the village. He is 24 years old. The incident happened one month ago, when he was visiting their house. It was in the afternoon (around three 'o' clock) on 073/09/13, when she had gone to market (the mother), the girl was playing outside. The perpetrator gave her candy and asked her to come to the field with him. She obliged and went with him. He then pulled the girl to nearby bush and raped her. When the mother came back home, the girl complained of pain in her vagina. The mother did not take it seriously. But after a week, she also complained about him to her. She then took notice of that and asked her daughter everything. After learning about everything, she decided to file a case.

The case came around 5:00 PM in the evening when OCMC staff was about to leave. We met the case at the door. After the case arrived, the OCMC was opened and the case was made comfortable and the doctors were called. Doctors came after 10-15 minutes. Two doctors came. Complete examinations were carried out by doctors with the help from staff nurse at OCMC. The vaginal swab was taken by the doctors but for blood and urine, the lab personnel was called. The entire process took about one hour. During the examination, confidentiality was maintained. The curtains were used and everyone except survivor's mother was asked to go outside the OCMC room. The coordination among doctors, OCMC and lab seemed to be working very well. The police personnel, whose is in the hospital duty, seemed to be very active. The girl was given necessary medications free of cost. The Councillor at OCMC took her mother's consent before asking about the case and filing them.

The case has been registered at the District Police Office, Makwanpur. The perpetrator has fled. Further investigation will be carried out after brining the perpetrator in custody.

Case 9

The survivor is an old woman of sixty years, from Chisapani, Hatiya, it takes about one hour by bus to reach her home. She has a son and a daughter. Both her son and daughter are married and are living their life in Kathmandu.

In Hetauda, she lives along with her husband. They both have a small shop which is run by her husband. Every day, a man from her neighbourhood used to come to her house to ask for food. He used to drink alcohol and would come to her house and demand for food. On Kartik 7, 2073, he came drunk at her house at ten 'o' clock in the morning and demanded for food. Her husband denied him food and asked him to leave. He got furious and tried to attack her husband. He retaliated. Then he attacked her and gave a big blow in her eyes and hit her very hard. Later, he was caught by neighbours and was taken to Police.

She came to the hospital for treatment. She came to Emergency department and from there they informed OCMC staff. Before this, she did not know about OCMC. OCMC staff brought her to OCMC department and called doctors. The doctor treated her very nicely and gave required medications. She also got information about Safe home, police and lawyer through OCMC.

Case 10

The survivor is a 34 year old woman from Padampokheri, takes about 1.5 hrs by bus to reach hospital. She had been married for 16 years. She had three children, son (12 years), daughters ten and eight years, respectively.

Her husband started beating her after the first few days of marriage. He had the habit of drinking. He would come home drunk and beat her with anything he could lay his hands upon. He would ask the children to go and buy alcohol for him, and would beat them also if they refused to obey. He used to force her for sex every day and whenever he liked. No days ever passed without getting hurt by him. He used to force her to carry out oral sex, sex during her menstruation, during pregnancy, during illness and day after the delivery of her child. Due to continuous sexual and physical abuse she had developed problems in her lower abdomen and uterus.

She had also thought that it was written in her fate. May be husbands are supposed to treat their wife the way her husband was treating her. Few kicks by husbands are justified. Her in-laws also support their son.

Therefore, she decided to send him to Saudi Arabia for work. He went Saudi for work and stayed there for two years and came back.

After coming back also his habits did not change. She reported to police twice. They only threatened him asked her to reconcile.

The major incident took place, on Poush 15, 2073. On the very day, she was at home doing household chores and feeding the cattle. He came home drunk closed the door and beat her with big wood without

any reason. He also kicked her and hit her on her stomach and head very hard. She sustained many injuries on her head and fell unconscious. Hearing her scream neighbours gathered and called an ambulance. She was brought to the emergency department. From emergency she was referred to OCMC and all her medical examinations were carried out at OCMC by doctors and nurses. She stayed in hospital for a week and got better. According to her, at the OCMC and hospital she was cared by nicely by sisters as well as doctors. During the day, she stayed in OCMC and at night, she was shifted to ward. All medications were provided free of cost, too. The psychosocial councelor at OCMC also gave her sessions of counseling, which she felt was very good.

She has decided to file a divorce case in court with the help from OCMC. OCMC and Safe house have helped her coordinate with lawyer to file a divorce case. She says that " I will die but won't stay with him any longer".

Case 11

The survivor was a 25 year old woman from Chhatiban, Sripur VDC, residing with her father and sister. Her house is far from hospital, takes about 3-4 hrs by bus and from the bus station she has to walk around a half an hour to reach her home. She started school at the age of five but her physical activity was limited due to her nature of disability, though she was good at studies, she had to leave school when she was studying in class five. Her left hand does not work properly and she has problem in walking as one of her leg is thin and short.

According to her, she lived in a joint family, however, after her mother's demise, her brother and sister-in-law separated and she has been living with her father and sister. Though, her brother and sister in law live in a separate house, her sister in law makes her do everything, from washing clothes to cleaning dishes. She used to behave very badly with her. Other family members also despised her for being disable, and called her names.

According to her, one day washing the dishes, her sister in law accused her of stealing her money and hiding it. She denied the charges. However, her sister in law got furious and charged her with a bucket. She punched on her face, kicked her, hit her with brooms, and utensils, etc. Since her father was not at home, no one came for her rescue.

Her head, nose and lips bled, and her face was swollen. She was brought to the hospital by her sister. She went to the Emergency department. OCMC was already closed when she had reached the hospital. So, she was treated at the Emergency, however, she got information about OCMC there. They asked her to come tomorrow at 10:00 when the OCMC is open. She came the following day and got treated some more. She was referred to safe-house where she stayed for 3-4 days. Her brother and his wife were called by the OCMC and provided counselling, too. OCMC treated her very warmly and kindly. She was treated free of cost.

Sunsari District

Case 12 (the case did not speak Nepali so it was difficult to understand). This case also came when the consultant was visiting Sunsari district.

The survivor is a 21 year old girl, from Sardar Community, living with father, mother and a younger sister. She is from Haitmara VDC, in Sunsari district, one hour in cycle to hospital and takes two hours by foot.

The incident took place after the girl had come back from monthly fair. She had met that guy during the month long fair that is organized in Sunsari District every year. She had become friends with him and exchanged her phone number. After she came back to her village, one day the guy called her, asked her to meet. However, she refused to meet. He then, with one of his friends, came to her house around 10:00 PM at night in a motorcycle, grabbed her, closed her mouth with a cloth and took her with him to nearby canal. He with the help of his friend raped her. She should and asked for help but, no one at home heard her. He confiscated her mobile phone also. The following morning she came back home and narrated everything to her parents. The parents scolded her and tried to solve matters through village panchyat. However, the guy refused to take her. After two weeks, they came to Police and filed a case. Along with Police she was brought to Inarwa Hospita on Margh 13, 2073 at night. She was brought to the Emergency department and from there brought to OCMC for medical examinations. Doctors visited her at OCMC and carried out the necessary medical examination with the help of sister (OCMC sister was called when the case arrived) and she was sent back her home. She was asked to come back the following day for blood and urine tests as there is no 24 hrs lab service available at the hospital. However, the girl came back only after three days.

When the girl visited OCMC again – the consultant was there –

The girl came around 3 'o' clock in the afternoon, at that time the lab was already closed. The survivor was sent back again and was asked to come tomorrow by the OCMC sister. The survivor and her parents were not very happy about coming every day at the hospital because they had commute a long way to reach hospital.

When asked to OCMC sister about that – her reply was vague – she said "yes, we are having difficulty due to lab hours. I have to send so many survivors back who visit after 2:00 PM. At times, if the case is really serious we call him. Otherwise, the case is asked to come tomorrow in the morning for necessary tests".

When the consultant inquired with the DHO of Inwra hospital, he said that – lab opening hours are fine. The doctors and nurses can take the samples and keep it in the freeze. The tests can be done the following morning." It's not a big deal.

After the checkups were done, the case was filed in court with the help of Police. However, the boy had run away. The girl did not want to go back home fearing criticisms from her community people. Therefore, the sister at OCMC coordinated with an NGO called Maiti Nepal, which is working on the

issues of women, and sent her to their shelter home where she can learn various skills, such as, knitting, cutting and boutique training.

Case 13

The survivor is an 18 year old girl, from Yadav community, residing with her in-laws and husband. She is from Inarwa, Sunsari. She has studied until class ten. Her family's main sustenance is agriculture.

She had fallen in love with a guy from nearby community since last two years. Everything was going on fine between them. When she reached class ten their relationship took a different route. Their physical intimacy started taking place. After two months, her period stopped, she did her urine test and found out that she was pregnant. When she disclosed this to her boyfriend, he denied the baby as his. She then informed her parents about the incident. Her parents decided to report the incident to police and a case was registered. After the case was registered the guy escaped. He came back after 10-15 days and said that he will get married to her. Her mother –in-law demanded five lakhs rupees in dowry from her parents. Though, her parents were very poor, they agreed for the sake of their daughter's future.

After the case was registered, the Police brought the girl to OCMC for all necessary checkups. Her blood test, urine test and ultra sound tests were carried out with the help of OCMC, she was given all necessary vitamins, calcium and folic acids by OCMC sister.

She got married on Poush 4, 207 and her parents paid two lakhs during the marriage ceremony. However, they still have to pay three lakhs. She does not know how they will pay. She is eight months pregnant now and doing regular checkups. Her baby is also healthy and doing fine.

Case 14

The survivor is a 22 year old girl educated up to class nine and married at 19 years old. She is from Basantapur, Sunsari. It was an arranged marriage and she went to live with her in-laws.

At home she carried out household chores in the mornings and evenings and worked at the field during the day times. Her husband started abusing her after three months of marriage. He had the habit of drinking alcohol, different kind of drugs and weed. He used to come home drunk and fight with her. He would kick on her head and stomach. She got pregnant after few months. Knowing that she is pregnant, he would sit on top of her and hit her. Due to his constant abuse she had miscarriage (four months baby). Too much blood came out and she felt unconscious and was brought to hospital by her maternal uncle.

She was admitted to the Emergency department and from there she was referred to OCMC. She had no prior knowledge of OCMC. All her medical examinations were carried out at OCMC by doctors and she stayed in OCMC for seven days. After that she was taken to safe house where she stayed for thirty six days. According to her, everyone in the hospital and safe house behaved very nicely with her. Counselling was also provided to her by OCMC sister. The coordinator from safe house helped her file case against her husband. The case is still undergoing.

The survivor did not want to go back home and wanted to learn some skills. The safe house coordinator and OCMC focal person connected her with Maiti Nepal. She stayed at Maiti Nepal for six months and learned cutting and boutique training. After the training was completed, the Maiti Nepal helped her open a tailoring shop by buying her four sewing machines, a table and also paid the rent of shop for six months. Now, she has been running the tailor shop. She not only has become an independent woman but has been giving trainings to other women, too. When I met her, she was giving training to a group of 30 women and earning NRs. 10,000 per month for that. She is also spreading awareness about OCMC to women in her community.

Case 15

The survivor is a 15 year old girl, originally from Burtibang, Baglung. She has six members in her family, father, mother, three elder sisters and a young brother. She was also studying in class ten.

According to her, one of her female friends had gotten married and shifted to Itahari. She used to call her frequently on her mobile phone and would ask her to come to Ithari to visit her. She would say that, what would you do by studying more? Just come here, I can fix a job for you in one of the industries here. You can earn lots of money. She agreed to come to Ithari. From Baglung, she went to Pokhara by herself and her friend came to get her in Pokhara. She ran from home on Mangsir 2, 2073, without letting her parents know anything. Her friend took her to Dharan and kept her in her Aunt's house. After 15-20 days, they started mistreating her, did not give her food to eat or water to drink.

After few days, they forced her to go with men. She refused, but they hit her and called her names. One day she was sitting outside, the police raided the house and she was rescued by them and was brought to Safe house run by WCO. From there she was brought to OCMC for medical examinations. All kinds of medical examinations, including pregnancy, blood, urine, HIV and others were carried out with the help from OCMC. Repeated counseling sessions were also provided to her. All doctors and nurses behaved nicely with her at hospital. Initially, she did not speak anything, but after repeated counseling sessions she told her story. She was very worried about the stigma she thought she has brought on herself and her family.

A case on human trafficking has been filed against her friend and the perpetrators who are involved. She told that her friend has been pressurizing to change her statement. However, she is adamant about giving them punishment so that they stop luring innocent girls like her. They have been trying to lure her with money, too.

When the consultant visited safe house, she was staying there. She said that it will take few more days for case to be formally registered in Court. After that she is planning to come to Kathmandu to stay with her sisters and will give SLC from there.

Case 16 – when incident took place she was only 15 years old

The survivor is a 17 year old girl studying in class seven, living with her parents, and five brothers. She is from Belbari, Jhapa, it takes about an hour by bus to come to the hospital.

As told by her, the assailant is a familiar person, 19 years old, and is her neighbour. He used to tease her every now and then. Their family was very close and she used to treat him like her brother. The incident took place when she was visiting her cousin sister. She had gone to graze her sister's bull in the riverside. The boy came along with her. Seeing the opportunity raped her in the banks of the river, and threatened to beat her if told about the incident to anybody. After that too, he used to look for opportunity and conduct sexual intercourse with her. The family came to know about the incident only after she was five months pregnant. She told everything to her parents.

Though, the parents of that guy were ready to keep the girl as their daughter in law, the guy refused to accept her as his bride, so they came to Police asking for help. The police brought the girl to OCMC for medical examination. All kinds of tests were carried out, such as, USG, blood, HIV, and urine. Counseling was also provided. Follow-up checkups were also done until the delivery of baby and after delivery, too. Surprisingly, her child was delivered normally. According to her, all staff at hospital including doctors treated her very nicely. After the delivery of her child, she gave the baby to childless couple as she was unable to keep the child. She told that "by keeping baby with her she will not be able to provide him with anything. She did not want to ruin the baby's future".

Her mother and father did not let her register the court case. So, after the birth of her child, with the help of Safe house coordinator and OCMC focal person she went to Maiti Nepal to learn skills and is still there.

6. *ANNEX 3: LIST OF INTERVIEWEES*

Name	Designation, Organisation
Makwanpur District	
Narayan Prasad Sharma Duwadi	Chief District Officer
DrMitilesh Thakur	Medical Officer – Focal Doctor OCMC
NabarajMahat	Police constable
PabilaThapa	Paramedics, Emergency
Dr Mohammad Jafar	Medical Officer
Dr. Sarbesh Sharma	MESO Hetauda Hospital
Ajmair K.C.	President, District Bar Association
Maya Lama	Program coordinator(Maiti Nepal)
Kalpana Sharma	Chief (AntarDrishti Nepal)
ApsaraBasnet	Advocate, District Legal Aid Office
DeepaKarki	District Police Office, Women Cell
ShyamHariAdhikari	Asst District Attorney
Shanti Bishwakarma	Women and Children Development Officer
BalkumariDhakal	Counselor (OCMC)
DrSushmaHuzdar	Medical Officer, Medicine OPD
Prem Kumar Lama	Chief of Police, DPO
BindaBartaula	Co-Ordinator (Safe house)
Indira Bhattarai	Adimnistrative head (AntarDrishti Nepal)
DevakiKhatiwada	Indoor In-charge
MadhuAryal	Lab Assistant
SushmitaPandey	AHW, Emergency
RatneshowriPrajapati	Staff Nurse, Indoor
Dr. ShovanDevkota	Medical Officer
NabarajMahat	Police Constable
Sunsari District	
LokNathPoudel	Chief District Officer
Posh Raj Pokhrel, SP	Head, District Police Office, Sunsari
Dr. ShyamSundarJha	Medical Officer, OCMC Focal Person
Dinesh Yadav	Paramedics, Emergency
BudanandaJha	Paramedics, Emergency
Dr. MukundaGautam	District Health Officer, Sunsari
BinuBasnet	District Police Office, Sunsari
Pramod Mehta	RTI, Health Assistant

Subarna Tara Sherestha	Indoor, In-charge
SalikramKarki	Lab In -charge
Dr. SubashBasnet	Medical Officer
MeenaBhandari	OCMC Focal Person
Anita Raj Dhami	Safe House Incharge
RajuDhakal	President, Bar Association
Bharat Mani Rijal	District Attorney
Neeta Sigdel	Assistant Women Development Officer
Ramesh Bhattarai	District Incharge, INSEC
SunitaKarki	Program Officer, Maiti Nepal
ShyamDarshanRajbansi	Police Constable
NirmalPaneru	DPO, Sunsari
Dr. BishalSubedi	Medical Officer
DhrubaGhimire	Radiographer
Maya Rai	DDC, Sunsari
MenukaRai	DPO, Sunsari
Dolakha District	
Yagya Raj Bohara	Chief District Officer
KailashDahal	Assistant District Attorney
Dr. RoshanThapa	Medical Officer
Dr. ShraddhaAcharya	Medical Officer
BhusanPrasai	Program Manager, Naya Health Nepal
GauravAcharya	NHSSP, Dolakha
Dr. Rajendra Prasad Sah	DHO, Dolakha
Saraswati GC	DPO, Women Cell
Kamala Parajuli	DPO, Women Cell
SrijanaKarki	Safe House Coordinator
Dr. Richen Jirel	Medical Officer, Acting MESO
Jenny Shrestha	Staff Nurse, OCMC focal point
LaxmiDhakhal	Women and Child Development Officer
Krishna Basnet	President, Bar Association
Sunil Dhakal	Paramedics, Emergency
ShikshaShrestha	OT Nurse
AshmineShiwakoti	Nurse, Labor
RanjanaKafle	Staff Nurse, Indoor
SunitaJirel	CMA, Emergency
SantoshPokhrel	Lab Technician
ParvatiThapa	Lab Assistant
Sharadha Sharma	Staff Nurse, OCMC
Sindhupalchowk District	

AntarBahadurSilwal	Chief District Officer
NaniMayaBasnet	Acting WCDO
SitaKanwar	Public Health Nurse
Dr. Binita Singh	Medical Officer, OCMC focal person
SaruKibanaya	Paramedics, Emergency
SitaShrestha	Senior ANM, Indoor
Chandra Kumar Basnet	Advocate, LACK Helpline
Rohini Raj Joshi	President, Bar
KeshabRijal	
AnjanaGurung	Handicap International, Physio-therapist
AbhkishorPokhrel	District Attorney
Ram Kumar ThapaMagar	DPO, Women Cell
Lalit Narayan Jha	‘’
ParvatiGurung	‘’
Abinash Kumar Kumar Thakur	Lab In-charge
Harisharan Nepal	Volunteer, Lab
MunaDahal	Assistant Pharmacist
Jaya Kumar Yadab	X-ray In-charge
Dr. GarimaPudasini	Medical Officer
Dr, SurendraChaurasiya	DHO
BimalaRayamajhi	Coordinator, Shakti Samuha
Maya Lama	District Legal Aid, Sindhupalchowk Chapter

7. ANNEX: 4 CHECKLIST FOR INTERVIEWS

To be observed during interviews and visits with/of to identify achievements, strengths, constraints and challenges:

- Observation of behaviors and attitude of hospital based service providers toward OCMC cases,
- Appropriate location and condition of OCMC spaces in hospital including counseling facilities; availability of necessary medical equipments; security and privacy to survivors,
- Availability of medical and other OCMC staff,
- Facility for medico-legal services,
- Provision of all other services at OCMC,
- In- hospital coordination (among emergency, out-door, in-door, lab/investigations, pharmacy, etc) and coordination with other agencies.

OCMC staff

1. General information about the person and work experience (past) before joining OCMC?
2. Detailed information on OCMC? Establishment of OCMC, its objectives, activities, who are involved? If case management committee is formed – who are the actors involved?
3. Involvement in OCMC – since when (No. of years/months)? Role in OCMC? Role division of OCMC FP and contracted Staff Nurse?
4. How do you look at OCMC as a concept within hospital? How effective has it been to the section of people it aims to support? Understanding the OCMC?
5. Are you active in committee meetings? How often the committee meetings are organized? Initiatives taken from DHO/Hospital Director, decisions made and implementation of the decisions?
6. Trainings received including psychosocial counseling? Have you received any kind of trainings (pre/post) joining OCMC? Name them? Changes experienced after receiving trainings? Follow up trainings? Competency and confidence to perform the roles? If training in other area is needed? If yes, which?
7. Are there any guidelines/protocols (GBV clinical protocol?) in the OCMC? If yes, have you ever used it and is it related to your work at OCMC? If they are helpful and if they require any additional protocols on GBV services? In what areas?
8. Do you think maintaining privacy, confidentiality is important while dealing with GBV survivors? If yes, why do you think, it is necessary? If no, why? How do you maintain privacy and confidentiality with GBV survivors?

9. Are you in contact with the survivors who've received services from your OCMC? Follow-up and current status? How (ie. Via phone, meeting at hospital or outside, and who initiated this contact)?
10. Any barriers to provide effective service? Elaborate?
11. How are you maintaining the data of survivors who have received the OCMC services? Is there sex, age, and ethnicity disaggregated data? Are there any follow ups undertaken? By whom? Is there any analysis of the data collected?
12. What are the strengths of OCMC? Similarly, gaps and challenges for effectively running OCMC? Can you list out the achievements of OCMC? Supportive environment within the hospital (OPD, Emergency, In-door, lab, pharmacy and other departments)? What else can be done to make OCMC effective and responsive to the user?

Counselor at OCMC

1. How did you learn the counseling skills? Any training? Do you posses any knowledge on GBV and its basic legal provision? No. of trainings? Any refresher training?
2. Please state the number of GBV cases handled by you (i.e. in last month)? How many of them have returned back for follow-up services? Any referral cases?
3. Do you think it's important to take consent with GBV survivors before counseling them?
4. How do you identify whether it is GBV or any other case? If it is GBV, besides treatment, what type of counseling do you provide to the client? If the survivor needs further treatment which is not available in your OCMC, do you make referrals (internal and external)? And Where?
5. Are there any differences in handling the cases (above and below) 18 years of age?
6. If you receive a call from survivor on your off day, what will be your reaction? How will you handle it?
7. No. of cases provided psycho-social counseling services (ask number of times)? How many of them have had shown positive impact?
8. How are you managing/keeping the records of survivors to plan for next visit, refer, follow up and reporting purposes?
9. What are the strengths of OCMC? Similarly, gaps and challenges to provide effective service through OCMC? What can be done to make OCMC effective and responsive?

Emergency/OPD Doctor/Nurse

1. General information and work experience? Since when (the doctor or nurse) are involved in the hospital?
2. Kind of trainings received after joining the hospital (related with clinical management of rape. GBV, forensic?)? Any knowledge on OCMC? Any orientation given on OCMC? If yes, when?
3. Are there any guidelines and protocols in your department (OCMC guidelines, GBV clinical protocal, etc)? If yes, have you ever read and used it?
4. How many cases of GBV have you treated? Treatment and referring (probing)
5. Do you think maintaining privacy, confidentiality is important while dealing with GBV survivors? If yes, why do you think, it's necessary? If no, why? How do you do this?

6. How do you recognize a particular case as an OCMC case? After knowing it, do you instantly refer it to OCMC or send the survivor after conducting basic treatment? How many clients identified as a GBV case in last 6 months and referred to OCMC?
7. What have been the positive and negative changes brought about by OCMCs in the past – which have majorly impacted on the service taking behaviors of GBV survivors? Consequences of these changes (in the community)? What has been your role in bringing those changes?
8. In your opinion, what are the gaps and challenges to delivering services to GBV survivors at the OCMC? We assume that all GBV services fall under the OCMC but it may be that doctors/nurses choose to deliver services without referral to OCMC? What can be done to make OCMC service more effective?

Medical Superintendent/ DHOs

1. How do u look at OCMC as a concept within hospital? Is it functioning as planned? Yes, how? No, why not? What can be done?

2. What are the changes brought about by OCMCs in the past (list both the positive change and negative changes)?

3. What is the knowledge level of various OCMC staff and the service providers? Behavior and attitude of staff?

4. Are there any barriers in providing effective service to GBV survivors (low staff attendance, no mediation, and lack of same sex personnel)?

5. How is the effectiveness/response of DCC, CMC? Decisions made and its implementation?
6. How is the staffing arrangement managed? Their regularity? Timings?
7. Who undertakes the supervision and monitoring of the OCMC – Frequency?
8. How is the budgetary management undertaken? and budget gaps?

a. What is the process of ensuring that GBV survivors access holistic OCMC services?

b. How effective is the coordination with other agencies? Mainly with police, hospital services, WCO/shelter home, attorney, rehabilitation center and NGOs)?

9. Can you identify gaps within OCMC approaches, and what can be done to address the gaps, with specific focus on:

- Health services and availability of drugs and other logistics services
- Psycho-social counseling? How effective has the psycho-social counseling centre/services been? Its outreach?
- Legal service: Bar Association, GoN lawyers
- Safe homes/rehabilitation center
- Security: Nepali police, Women Cell

10. Rehabilitation, reintegration: Any follow ups? By whom? Rehabilitation plan for future jointly by OCMC, WCO, NGOs based on lessons learned

11. How has awareness on OCMC played a key role in addressing GBV successfully? How the potential GBV survivors are informed (through community radio, networks, health structures- PHC, HP, Mothers group, FCHVs, NGOs, etc)
12. Any future road map of DHO/DCC regarding preventive and service delivery to GBV survivors?

CDO/ Police/WCO/ Bar Association/ Attorney General/Safe house/ NGOs

1. How do u look at OCMC as a concept within hospital? Do you think it is necessary? Are you aware of it? Have u attended any of the meetings organized? Do you know you are in the DCC or CMC ?
2. How effective is the coordination among all agencies (OCMC, Police, WCO, Safe house, lawyers, and NGOs working on similar issues)? Are you involved, yes..? No…? Please elaborate?
3. DO you think, effective coordination and collaboration is a pre-requisite between OCMC and other stakeholders for effective service delivery including rehabilitation services, preventive and promotive interventions? Elaborate?
4. Is there one door reporting in the district (OCMC, WCO, Police and NGO)? Is there reporting and documentation available from the various service centres, i.e., safe homes, police, lawyers – regarding survivors referred to or access from OCMC?
5. Can you list the changes brought about by OCMCs in the past? List both the positive change and the negative changes?
6. Can you please tell me what were/are the consequences of the changes to the community? (men, women, adolescents, GBV survivors and their families)?
7. What have been your roles/community roles in bringing about the change? What has OCMC's role been?
8. List the constraints and challenges? What can be done to overcome the constraints and challenges?
9. How can the GBV survivors be motivated to seek support? How can we prevent GBV and deliver more effective intervention?
10. Are there any achievements? Success stories?
11. Has working through OCMC enhanced the knowledge/understanding of GBV among various stakeholders?
12. Women officer at Women Police Cell – Are there enough women officer in women cells? Any training on GBV given (to be asked at department of Police)?
13. What changes (in survivors) can be attributed to the OCMC? To which circumstances can these changes be attributed to? (Probe on: WCO, legal support, counseling, medical service,)
h. How effective have community and NGO interventions been? How have the OCMC mechanisms- Health service, medico-legal services, Psycho-social counseling, Legal service, Safe homes, Security, Rehabilitation – been functional at the district? What have been the highlights and challenges in integrating these approaches?
14. Are there enough resources required for rehabilitation process? Sources: GBV alleviation fund, OCMC, NGOs, etc and recommendations?
15. What are the ongoing supports for GBV survivors? List any?

8. ANNEX: 5 TRACKING TOOL FOR CASE STUDY DEVELOPMENT TO UNDERSTAND THE PATHWAYS AND BARRIERS FROM THE SURVIVOR'S PERSPECTIVE

Background

- Type of GBV; recognize perpetrator?
- Any barriers in coming to OCMC (home, poverty, ecological, caste and ethnicity, community)
- Cause of survivor to reveal the problem/ seek help/file a case
- Who was approached for support prior to reaching out to OCMC- self, family members, community members, NGOs, health workers, police, service providers, etc

13. Initial process of reaching the OCMC

- Information about OCMC? Any past knowledge on OCMC?
- Who made referrals to access services from OCMC (police, safe home, women and children office, NGOs,lawyer, health facilities, hospital- emergency, OPD, etc)Who played active role in bringing survivor to OCMC?

14. After reaching OCMC

- Who received the survivor? OCMCFP/staff nurse, Emergency staff, admin and other support staff ; Initial steps undertaken by OCMC upon receiving survivor
- Attitude and behavior of OCMCstaff or hospital staff (positive, supportive/ encouraging, disparaging/negative, noncommittal, rude, etc.) – identification of personnel
- Type of information collected by OCMC personnel
- Support requested for survivor by survivor/ survivor friend/family/escort/ with or without children

15. Support provided by OCMC

- Registration (location)
- Screening of clients through in-depth insight into client history (location)
- Clinical (medical/surgical treatments for RH concerns) – privacy, length of stay at OCMC,
- Shelter – in WCO/Safe Home or elsewhere?
- Legal counseling and support – Bar association, other GoN lawyers, etc. (additional expenses requirement or not?)
- 24 hours services from OCMC unit or shifted in wards during night?
- Psychological counseling – availability 24 hours?
- Logistics support such as food, clothes
- Others… (e.g. child support, etc.)

16. Additional support (give details)

- Follow up and revisiting by social workers/field workers of suspected cases (from WCO, OCMC and NGOs)
- Referrals to ….
- Perpetrator counseling
- Engaging men (including perpetrator) through group discussions
- Others…..

17. Length of stay

- Length of stay? Who decides?
- Was survivor need for shelter adequately addressed?
- Positives and negatives during stay at OCMC (behavior/attitudes of OCMCand hospital staff, behavior/attitudes of other survivors, privacy and confidentiality, etc.)

    i. Quality of care regarding shelter (security, behaviors, clothes/foods, recreation facility, counseling service), legal counseling/support, psychological counseling/support, medical support (treatment as per guidelines, drugs, medico-legal and referral if needed), others – availability of multi-disciplinary team support at all hours, etc.

18. Quality of care

- Maintenance of confidentiality and confidence building in survivor
- Effectiveness of internal and external referrals

19. In safe homes

- Length of stay at safe home?
- Quality of care and service provided by safe homes
- Support provided to survivor
- Counseling done? Any counselors at safe home
- Protection to survivor (social, political)

20. Current status

a. Reconciliation – compromise (through whose efforts?);
b. Reintegration/Rehabilitation: Further victimization or empowerment (improved status or degeneration); by whom?
c. Follow up visits by social workers/field workers, particularly from OCMC/HP/FCHVs, WCO/Watch Groups, NGOs, etc.
d. Consequences and reactions/support or absence of support of family members/community organizations/local (delve into positive or negative and causes)

21. Overall Perspective of OCMC

a. Strengths (need, effectiveness, holistic support….)
b. Good practices
c. Gaps/challenges/areas for improvemen

9. ANNEX: 6 CONSENT LETTER

सहमतपत्र

नमस्ते । मेरो नाम.....हो । म नेपाल सरकारद्धारा संचालितअस्पतालमाआधारित लैगिक हिंसा सम्बन्धीएकद्धार संकटव्यवस्थापन केन्द्रको संचालन सम्बन्धीअनुगमनगर्न आएकी हु । यी केन्द्रहरुले हिंसा पिडितहरुलाई के कस्ता सविधाहरु दिएकाछन् र ती सेवा सविधामा रहेका सवल र कमजोर पक्षहरुको पहिचान गरी आउँदो दिनमाअझप्रभावकारी बनाउन यस अनुगमनको उद्देश्यहो ।

म आशागर्छुकितपाईले यस अर्न्तवातामा सहभागीभई सहयोग गर्नुहुनेछ । तपाईंले भन्नु'भएका सबै कुराहरुलाई हामीनामनखुलाई प्रतिवेदनमा राख्नेछौं । अर्न्तवार्तामा सहमतहुनुहुन्छभने तल सहीगरिदिनु अनुरोध छ ।

□ सहमत □असहमत

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अर्न्तवार्ताकर्ता अर्न्तवार्ता दिने व्यक्ति