NATIONAL WORKSHOP ON THE
REVIEW AND FUTURE DIRECTION
OF ONE STOP CRISIS MANAGEMENT CENTRES

PROCESS REPORT

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LIST OF ACRONYMS AND ABBREVIATIONS

CBO	community based organisation
CDO	chief district officer
CMC	case management committee (OCMC)
DCC	district coordination committee (OCMC)
DDC	district development committee
DFID	Department for International Development (UK)
DHO	district health office
DPHO	district public health office
DWC	Department of Women and Children
FCHV	female community health volunteer
GBV	gender-based violence
GBVIMS	Gender-based Violence Information Management System
GESI	gender equality and social inclusion
GoN	Government of Nepal
HMIS	Health Management Information System
HW	health worker
IEC	information, education and communication
IRC	International Rescue Committee
LDO	local development officer
MoHP	Ministry of Health and Population
MoWCSW	Ministry of Women, Children and Social Welfare
M&E	monitoring and evaluation
NGO	non-governmental organisation
NHSP	Nepal Health Sector Programme
NHSSP	Nepal Health Sector Support Programme
OCMC	one-stop crisis management centre
OPMCM	Office of the Prime Minister and Council of Ministers
SSU	social service unit
TOR	terms of reference
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VDC	village development committee
WCO	women and children's office
WDO	women's development office

EXECUTIVE SUMMARY

Over the last three years, the Ministry of Health and Population (MoHP) has established sixteen one-stop crisis management centres (OCMCs) in each of sixteen districts across Nepal. Each OCMC aims to provide anintegrated package of services forsurvivors of gender based violence (GBV)through a 'one-door' systemthat followsthree coreprinciples:(i) ensuring the security and safety of GBV survivors;(ii) maintaining confidentiality, and (iii) respecting the dignity, rights and wishes of survivors at all times.

OCMCs are designed to follow a multi-sectoraland locally coordinated approach to provide GBV survivors with acomprehensive range of services including health care,psycho-social counselling, access to safe homes,legal protection,personal security and vocational skills training.

The relative newness of OCMCs makes regular supportand review essential. Accordingly, MoHP organised a national review workshop entitled 'The Review and FutureDirection of OCMCs'in Sauraha, Chitwan between 18th and 19th October 2014.The workshop took advantage of the district setting by including key local stakeholders including line agency officials and the Police to share their experiences, insights and recommendations.

The objectives of the workshop were to:

1. Review progress madeto date including good practices, constraints,lessonslearned and recommendations for improvingOCMC performance and scale up;

2. Identify key interventions needed at both policy and operational levels to improve OCMC service delivery;

3. Improve levels of coordination and collaboration among concerned stakeholders.

A total of 82 representatives participated in the event. Participants came from each of the 16 OCMCs represented and from MoHP, the Ministry of Women Children and Social Welfare (MWCSW), the Department of Women and Children (DWC), Police Headquarters,the District Women's Cell, the Women and Children's Office (WCO), the Attorney General's office, World Health Organisation (WHO) and the United Nations Population Fund (UNFPA).

The workshop included progress updates against indicators and expected outputs from MoHP and OCMC officials from central and district levels.Each session sought to identify notable successes, constraints, lessons learned and recommendations for improvements. This workshop process included several plenary discussionsled by panels of expertswhoprovidedsuggestions, feedback and recommendations.

The first day of the workshop began with an opening ceremony followed by presentationsby MoHP and sessions on the recently revised OCMC Guidelines and OCMC Monitoring and Reporting Manual. In addition, each OCMC presented their current operational status, issues arising and recommendations.

Mr. Bimal Prasad Dhakal, Chief Specialist at MoHP, chaired the opening ceremony, welcomed participants and described the workshop's objectives. Mr. T.N. Sharma, Joint Secretary of MoHP, presented the current status of OCMCs focussing on progress made,key achievements, constraints,challenges faced and lessonslearned. He noted that while several positive changes hadoccurred within a short period,many challenges remained which wereslowly being addressed.

His presentation suggested that several positive outcomes are evident as shown by the number of GBV cases being reported and service records;the number of publications and training tools being developed; the number of staff trained and the extent of coordination and collaboration at local and national levelsintended to minimise GBV.He emphasised that future improvements will depend on strengthening coordination, implementation and management arrangements and made a series of recommendations as follows:

Recommendations from Mr. T. N. Sharma, Joint Secretary of MoHP
1) prepare and implement a set of umbrella OCMC Guidelines
2) form a GBV focal committees in each district
3) prepare integrated OCMC work plans for districts
4) designate the women’s development office (WDO) as the GBV communications focal point
5) sensitize and ensure that all district level stakeholders participate - not just health workers
6) introduce multi-year contracting of OCMC staff to improve their retention
7) make all health services free for GBV survivors, not just OCMC services
8) introduce a ‘one window’ reporting system
9) offer girls/minors who are rape survivors free residential school education
10) establish a partnership with the Council for Technical Education and Vocational Training (CTEVT) in order to offerlivelihoods related skills training for GBV survivors, and
11) establish and mobilize a GBV Alleviation Fund.

The second session,led by NHSSP’s Gender Equality and Social Inclusion (GESI) adviser, Mr. Sitaram Prasai, described the provisions inMoHP’s revised OCMC Guidelines and OCMC Monitoring and Reporting Manual. Representatives from the 16 OCMCs then presentedupdateson progress made highlighting good practices, problemsand challenges faced,lessons learned and recommendations arising. The latter stressed the importance of improving:teamwork and internal coordination for service delivery, district level coordination between agencies and increasing public awareness on the availability of OCMC services.

The district presentationsshowed that OCMCs have provided essential services required by GBV survivors with 2,273 individuals (2,133 (94%) women and 140 (6%) men))accessing services until October 2014. Ahigh percentage of women receiving services (53.6%)were victims of physical assaultor domestic violence, while 26.% had experienced sexual violence. 16% had suffered extreme mental abuse and 4.8% ‘other types of violence[1]’.

The highest number of cases of physical assault and domestic violence were reported in Dang district, with 213 of 474 cases(45%).Other districts totalled 176 in Baglung, 167 in Kanchanpur, 128 in Makwanpur and 110 in Doti.

Sexual violence accounted for 26% of all reported GBV cases. In Kathmandu (Maternity Hospital)295 of a total of 356(83%) cases related to sexual violence, mostly rape. Rape cases in other districts were also high, notably in Sunsari (67 cases), Makwanpur (60 cases) and Bardiya (55 cases).

Extreme mental abuse, or ‘mental torture’ was reported by 455 (16%) of all women including in Dang (168) and Kanchanpur (130). Full data are included in Annex 2, Table 1.

The breakdown of referrals to OCMCs shows that self-referrals were the most common (907 cases) closely followed by the Police (783 cases). Referrals from local agencies/safe homes (212), NGOs

[1]Social/psychological, trafficking, witchcraft, child marriage, poisoning, attempted suicide.

(95)and other sources[2] (90) made up the balance (see Annex 2, Table 2).

Comparing referral data with the previous year, when fewer than a dozen women self-referred, suggests that community level awareness of OCMCsand above has increased significantly. District stakeholders further reported that women are becoming more vocal and assertive in seekingGBV services and that local inter-agency collaboration has improved, even if further improvements are needed in this area.

The breakdown of OCMC data by age-group shows that violence is common among women between the ages of 15 and 49 years with 1645 women in this category. This was followed by 312females between the ages of 0-14, 110between 50 and 65 years and 29above 65 years. These data suggest that married women are the prime targets of violence(see Annex 2, Table 4).

District data showed that the main services provided by OCMCs were medical treatment, ranging from basic medical check-ups to psycho-social counselling and medico-legal services.

Each district made its presentation using the four standard OCMC annual review formats: 1 (budget and expenditure); 2 (good practices, difficulties faced, lessons and recommendations); 3 (OCMC capacity), and 4(OCMC coordination and collaboration).

Regarding financial management, OCMC budgets were under-utilized, with the exception ofDang and Sunsari districts. The main reasons given for underspendswere delays in funds release and in hiring local staff, inflexible budget headings and infrequent OCMC District Coordination Committee (DCC)meetings. The lack of knowledge of OCMC staff on their budgets also contributed significantly to the under-spends.It was noted that non-transparent budget management was common in most districts and especially in Sunsari.

A key recommendation made by OCMC staff was improved flexibility of budget headings to allow expenditure on priority activities such as survivor rehabilitation, transportation for referrals, and meeting the various practical and logistical needs of survivors.

District presentationsalso highlighted limited horizontal coordination and collaboration between district coordination committee (DCC) members. This was felt to have limited local ownership of OCMC services, which, in turn, has impacted stakeholdercommitment and service availability. Further, it has led to a misperception that OCMCs are the responsibility of hospitals alone. There is a clear need for more effective coordination and collaboration including regular information sharing if OCMC ownership across sectors is to be achieved at both district and central levels.

OCMC staff stressed the need for effective capacity enhancement of service providers and other stakeholders including periodicrefresher training.High staff turnover levels coupled with inadequate handover arrangements are also believed to have had a negative impact on the availability of OCMCservices.

A further key recommendation proposed to improve staff retention and service continuity was the issuing of multi-year contractsto locally recruited staff.

Overall, the effectiveness of the clinical services available at OCMCs areseen to be encouraging. This is despite OCMC's relative newness, limited awareness and capacity building of hospital staff and other stakeholders.

[2] Neighbours, friends/relatives, child centres

Reported good practices at OCMCs include:

Good Practices in OCMCs as Reported by District Representatives
1. Good coordination between hospital units leading to the effective referral of GBV cases to OCMCs
2. 24 hours OCMC services at hospitals
3. OCMC information dissemination through various media including FM radio, brochures/pamphlets
4. Cases referred from hospitals treated seriously by Police, safe homes, WDOs, rehab. centres and attorneys
5. Orientation on OCMC services provided to staff at local WDO, DPHO, DEO offices
6. Coordination and support provided by WDO, Police and others for long-term rehabilitation cases
7.Support provided by UNFPA, WOREC for the effective functioning and management of OCMCs
8. Felicitation of OCMC staff by WDO and others for their good work.

The districts also recommended the following:

Recommendations from District Level Participants	
a)	Improve integration of OCMCs in hospital structure by treating them as ahospital unit, not a separate entity
b)	Improve the communication, coordination and collaboration between stakeholders
c)	Widely disseminate information on OCMCsusing various via and communication methods
d)	Issue multi-year contracts to OCMC staff nursesin order to retain staff
e)	Expand orientation and training on OCMCs to the maximum number of health staff andlocal stakeholders
f)	Provide GBV sensitization training for OPD, in-patient, emergency and laboratory staff in hospitalshaving OCMCs
g)	Provide OCMC orientation to all district coordination committee members
h)	Ensure the timely release of OCMC budgets
i)	Develop referral and clinical protocols plus a separate protocol for rape and cases involving serious injuries or psychological trauma. These should include treatment at specialised centres or high level legal advice
j)	Ensure the availability of post-rape kits at all OCMCs
k)	Ensure regular supervision and monitoring visits from central and regional levels
l)	Develop umbrella guidelines for effective communication, coordination and collaboration among stakeholders

Day 2 began with a recap of the key issues and recommendations from the previous day by Mr. Sitaram Prasai, followed by a presentation on the WHO's clinical guidelines by Dr. Meera Uphadyaya and draft national GBV clinical protocols by Dr. Saroja Pandey.

MWCSW also presented progress and issues arising in addressing GBV from its perspective, followed by a similar presentation by the WDO on service centres. The day concluded with group work on health system responsesincluding inter-agency communications, coordination and collaboration at district and central levels. Key issues identified included:

a) OCMC working modality:GBV responses need to be fully integrated within the health system during piloting and then expanded in a phase wise manner to all 75 districts.

b) Coordination and collaboration: The efficient and effective functioning of OCMCs depends on the coordination of all:hospitals, counsellors, safe homes, police offices, legal aid committees, public lawyers and rehabilitation centres. There should be effective coordination and collaboration between:

i) Departments/units within hospitals and the D(P)HO

ii) Coordination between the Ministry, departments and districts

iii) Division of roles with clear definition shared by the different ministries and add ToRs for doctors

iv)Develop comprehensive umbrella guidelines approved by either OPMCM or cabinet

v) All health workers in hospitals/ D(P)HOs should be responsible for OCMC cases

vi) Effectivecoordination and collaboration among district level GOs and NGOs is needed. Thevariouslocal committees working for GBV should be merged into a single entity.

c) Follow up Support to Survivors: Regular mandatory monitoring and follow-up of survivors should be carried out by OCMCsto ensure effective reconciliation with families and local communities**.**

d) Preventive measures:
Focused advocacy and sensitization campaigns on OCMC activities including:
i) use of local FM/leaflets/posters
ii) interactionswith journalists and advocacy
iii) incorporation of GBV issues in health related materials
iv)incorporation of GBV in high school curricula including
v) continuous partnership mapping (DDC, VDC, Municipality, NGOs, CBOs, para-legal committees and user groups) and
vi)socialmobilization activities during FCHV/HW orientation, GBV orientation for mothers and watch groups at a community level.

e) Health Services Quality Improvements
i) Staff,preferably female, are trained, skilled and permanent (not contracted)
ii) OCMCs are equipped with all necessary instruments, staff and medicines at all times and an emergency fund for medicines is available for use
iii) All staff have clearly defined roles and responsibilities
iv) Monitoring of client satisfaction
v) Uniformity of servicesprovided
vi) Comprehensive services are available (i.e. OCMCs are truly one stop centres)
vii) The security, safety and privacy of clients and companions is protected at all times
viii) The core principles for working with GBV survivors are followed at all times (security and safety, confidentiality, respect for dignity, guarantee of rights and compliance with survivor wishes)
ix) A one window consolidated recording and reporting system at district level.

Following group presentations, the following decisions and recommendations were made during the plenary session:

Decisions and Recommendations

• Government needs to decide on the future of OCMCs including providing further guidance on their integration with other local services, the duration of the pilot phase and plans for scaling-up
• A list of essential medicines should be prepared and minimum stocks maintained at all times
• All available OCMC services should be described to GBV survivors; all required clinical equipment should be permanently stationed in OCMCs and physical and information privacy should be maintained
• Stakeholder meetings should be conducted on a regular basis and a single district GBV Committee formed to facilitate coordination on GBV issues and prevent duplication of activities
• Specialised training on medico-legal and clinical protocols, and sensitization on GBVshould be provided to all OCMC staff and other medical service providers
• GBV sensitization/orientation training should be carried out for watch groups. Neighbours should be informed of the need to be alert and intervene in the event of a GBV incident
• OCMC umbrella guidelines should be developed to ensure effective teamwork and coordination
• The WDO should act as focal point for regular coordination at district level
• An integrated work plan should be prepared by agencies working on GBV at district level and approvedby the district coordination committee
• A one-window reporting system should be developed to avoid duplication of reporting and to ensure easy authentication of data reported
• Opportunities to provide GBV and OCMC training to FCHVs should be explored
• Regular follow-up of GBV survivors should be carried out by phone, homevisits or methods
• The scope for assigning doctors at all OCMCs should be explored
• Links with hospital social service units should be strengthened to ensure access to free services
• GBV alleviation funds should be used in a coordinated manner
• An MoU with the CTEVT for livelihood generation programs for survivors should be signed
• The scope for signing MoUs with residential schools should be explored for rape survivors who are minors.The DCC and WDO should take a lead based on the Prime Minister Office's decision
• The confidentiality of survivors should be safeguarded at all times as enshrined by the guideline
• Focal GBV committees should be formed at district level
• Separate counselling rooms should be made available in hospitals
• Unspent budgetsfrom various budget lines should be utilized as per the needs of survivors with the permission of the DCC
• A rapid situation analysis in a few districts should be conducted to understand the GBV system response. This will provide insights to decide whether OCMCs should be hospital-based, expanded, or scaled up as a special program.

1. INTRODUCTION

On 18th and 19thOctober 2014, Population Division of the Ministry of Health and Population (MoHP) organised a national level workshop entitled"**Review and Future Direction on One-stop Crisis Management Centres(OCMCs)"**.This workshop sought to review progress of the OCMCs to date, identify constraints and lessons learned, and plan for scaling-up.

The workshop also sought to strengthen existing OCMCs and provide the information needed fortheir replication across districts. Representatives from OCMCs in sixteen districts participated.

2. WORKSHOP OBJECTIVES

The overall objective of the workshop was to share experiencesbetween OCMC stakeholders and develop an action plan to strengthen and scale-up OCMCs across the country. Specific objectives were to:

- review progress, good practices, constraints, lessons learned and issues, and make recommendations for the effective functioning of OCMCs
- identify key areas of intervention to improve the service delivery of OCMCs (both at the policy and operational levels)
- improve coordination and collaboration among different concerned stakeholders.

3. WORKSHOP OUTPUTS

The workshop reviewed the performance of OCMCs for the 12 month period November 2013 to October 2014. In this context, presentationswere made on the following topics:

a) the revised provisions of the OCMC Guidelinesand Monitoring and Reporting Manual
b) the draft National GBV Clinical Protocol
c) WHO'sClinical Guidelines
d) achievementsto date and issues affecting the WDO's service centres.

Following the presentations, tentative strategies were discussed for reaching thoseGBV survivors who are reluctant to reveal themselves. Discussions also took place on the health system responseto GBV including challenges related to coordination and collaboration at the district and central levels. OCMC policy and strategy related matters also featured. The need for continuous partnership mapping and strengthening to ensure effective and comprehensive servicesare provided to GBV survivors was stressed.

4. WORKSHOP PARTICIPANTS

A total of 82 participants including representatives from MoHP, MWCSW, DWC, Police Head Quarters and District Women and Children Service Centres, District Women and Children Offices, the Attorney General's office, WHO, UNFPA and representatives of 16 OCMCs participated in the event. Annex 1 contains a list of participants and the workshop agenda.

5. WORKSHOP PROCESS

The workshop largely consisted of information sharing sessions led by MoHP and OCMC staff from the centre and districts. The workshop methodology used indicators and expected outputs to measure progress so far. Each session considered key successesand constraints, lessons learned and recommendations. Each presentation was followed by a full discussion session, supported by a fully-fledged panel for feedback and recommendations.

Participants received a resource pack containing various reading materials (MoHP publications) and other relevant technical information on GBV including the National Plan of Action and copies of allpresentations.This report provides an account of key workshop sessions and salient points raised during discussions.

Day I

The agenda for day one included an opening ceremony, a presentation from MoHP on the current status, issues, lessons learned and challenges facing OCMCs,and a presentation on the revised OCMC Guidelines and highlights from the Monitoring and Reporting Manual by NHSSP. Each of the OCMCs also presented their status and issues of concern. Day 1 closed with the showing of a documentary.

Opening Ceremony: Chairing, welcome,introduction and sharing of objectives and remarks.

Mr. Bimal Prasad Dhakal, Acting Secretary, MoHP chaired the event. He inaugurated the programme by candle lighting.Following the programme inauguration, a short introduction was provided by all theparticipants.

Mr. Top Narayan Sharma,Joint Secretary, MoHP: Mr. Sharma outlined the workshop objectives and stressed that itwould highlight the achievements, problems, constraints, resource mobilization strategies and lessons learned to further strengthen and scale-up OCMCs. He further mentioned how essential it was for everyone to think and acton what needs to be done so that GBV survivors no longer remain“survivors” but become confident individuals.

The opening ceremony was marked by the remarks from participants as follows:

Mr. Kedar Bahadur Adhikari, Joint Secretary, MoHP: Mr. Adhikari,while shedding light on the establishment of OCMCs, stated that their purpose was to provide multi-sectoral services to GBV survivors in a confidential and respectful manner. He stressed how violence has many dimensions, forms and causes, and someone who is very close to us often perpetrates it. Furthermore, Mr. Adhikari urgedthat Nepal, being a signatory to many International conventions, hasa moral obligation to fulfil their requirements. He strongly advocated for a strong and durable partnership among with all stakeholders present at the event and proclaimed that we cannot achieve good results if we are fragmented and single-handed, but if we walk and act together, we can surprise the world. He concluded his remarks with a call to work together to eliminate the horrors of GBV and violence against women.

> **“We have gradually been achieving good results as reflected in the social index but we need to further speedup the good work that we have been doing and for which we need multi-sectoral support, coordination and collaboration.”**
>
> Mr. Kedar B Adhikari, Joint Secretary, MoHP

Mr.Padam Bahadur Chand, PPICD Chief, MoHP: Mr. Chand expressed his pleasure in seeing such a vibrant gathering of stakeholders from diverse fields who had come together to share their experience. He stated that he felt the gathering was a testament to the success of OCMCs and that GBV is not only a national issue but one that goes beyond borders, caste, class, status or ethnicity – it's rampant everywhere! He emphasised that handling GBV cases and providing care to survivors should not be the responsibility of any *single* agency/person but that it was everyone's responsibility and that we all are accountable for it. He strongly voiced the opinion that there is a dire need for strong multi-sectoral coordination, support and collaboration between all agencies to combat GBV. He further urged that instead of reviewing the same plans/ideas every year, we should discover innovative ways and strategies to advocate against GBV. He concluded his remarks with the message that it is high time for us to make *ourselves* accountable and responsible in fighting GBV.

"We should work to develop OCMC as a 'model of Asia' where survivors receive multi-services with dignity and respect."

Mr Padam B Chand, Chief, PPICD, MoHP

Mr. Krishna Prasad Poudel,Director General, DWC: Mr Poudel stated that the time has come for us to realise that we must concentrate our effortson not only stopping GBV but also on not letting it take place anywhere.According to Mr Poudel, we should change the strategy and take the perpetrator,and not the women, out of the house when fighting GBV. He further stressed that psycho-social counselling is essential for the perpetrator and survivor in minimizing GBV.He concluded that there should be strong coordination and collaboration between *and* among government and non-government bodies to combat GBV.

"Involvement of neighbours could be one of the key strategies in stopping GBV. Mobilization of women's group, mothers' group and existing local groups would be the most appropriate strategy in combating GBV."

Mr. Krishna Prasad Poudel, Director General, DWC

Mr. Man Bahadur Bishwokarma, Chief District Officer, Chitwan: Mr Bishwokarma stressed that OCMC is a noble concept through which survivors receive multi-faceted service through a one-door system. He opined that OCMCs should be expanded across all districts so that survivors can have access to the services they require. OCMCs should also be equipped with quality andadequate supplies and staff should be trained to manage GBV survivors as per the principles enshrined in the OCMC Guidelines. Furthermore, hestressed that OCMCs should be linked with the reintegration package and livelihood support program in order to break the cycle of violence. As survivors can only stay for a maximum of 45 days at safe homes, a long-term solution should be identified for sustainable development and to improve the livelihoods of survivors, he concluded.

"There has been an absence of proper care and counselling, medicines, sensitized and skilled staff and a support system for networking and referral. The behaviour of OCMC staff can have an adverse effect, which can result in double/multiple victimization of the survivor."

Mr. Man Bahadur Bishwokarma, CDO, Chitwan

Mr. Chiranjabi Parajuli, **Joint Attorney General**: Mr Parajulinoted that GBV survivors are often stigmatised by society and that OCMCs can play a vital role in uplifting their status– psycho-social, physical and emotional.He stated that since government prosecutors are inconstant contact with survivors, they can play an important role in bringingperpetrators to justice and helping survivors chart a new path. They are therefore critical players who can support and suggest survivors for the collection and preservation of evidence and records, to pursue the case. Throughout his remarks, Mr Parajuli highlighted the need for strong and regular coordination, communications and collaboration among all stakeholders for the effective functioning of OCMCs.

Mr. Mingmar Lama, Deputy Inspector General (DIG), Nepal Police: DIG Lama noted that the Nepal Police have been enthusiastic supportersof this noble cause to enable GBV survivors to receive comprehensive support and care. He reported that WCSDswere established to address matters related to women and children and that WCSDshave been supporting OCMCs at large. He further noted that there are 240 Women and Children Service Centres (WCSCs) across the country whose purpose is to provide protection and fair treatment to women and children. Moreover, he emphasised that due to the support from the WCSCs and OCMCs, reporting oncases related toGBV hadincreased by more than 30% and that this may be indicative of growing public trust in the judicial system. He reflected that Police in those districts where WCSCsoperate are now trained in contextual issues related to violent incidences and in gender-sensitive crime investigation. As of now, 3,600 police personnel have been trained and 1,344 policewomen assigned to women and children services which are expected to increase by 60% from the coming year.In concluding, headvocatedimproving services to all survivors and reaching all those who suffer from violence.

> **"A coordinated approach from all relevant stakeholders is a must. The health sector/MoHP should take a lead. For primary care, a GBV survivor will need medical and psycho-social/emotional support. All agencies should be ready at all times to provide support for the effective functioning of OCMCs."**
>
> Mingmar Lama, DIG, Nepal Police

Mr. Ramesh Bikram Singh, Regional Health Director,Central Region: Mr. Singh noted that hospital based OCMCs have been significant in providing services to GBV survivors and helping to minimise violence. He stressed the need for sensitization training of all OCMC staff and specialised training to those who directly deal with the survivors of violence. While concluding, Mr Singh opined that as OCMCs mature each day, the learning and successful innovationshave to be shared with districts so thatGBV survivors receive quality treatment in a respectful manner that protects their dignity.

Closing of the opening ceremony by Dr. Bimal Prasad Dhakal, Chief Specialist, MoHP:Dr.Dhakalbegan his remarks by linking women's health and GBV, and stated that Violence Against Women (VAW) is a pervasive public health problem across the world. He opined that many health care professionals continue to consider VAW to be a social rather than a public health issue. Moreover, he added, that while some health care professionals do view VAW as a public health issue, they do not know how to address it. Accordingly, there is an important need for health care professionals to acquire specialised skills and knowledgein order to recognise thesymptoms of current and previous violence.Dr. Dhakal emphasised the need for all to own the problem and acknowledge what is going on around us, for we all are accountable for both good and bad practices in our community and society. He urged everyone to think about the root causes of VAW/GBV so that it can be uprooted for good.Concluding his opening remarks,Dr. Dhakal said that this review workshopwould be able to address core issues and provide the solid recommendations needed for policy change.

> **"Strong and meaningful multi-sectoral partnerships and collaboration among diverse agencies is a must. The mental state of an individual can play a critical role in violent actions and this needs to be effectively diagnosed. Psychological and psycho-social counselling to families, couples, survivors and perpetrators can help minimise violence and needs to be prioritised."**
>
> Dr Bimal Prasad Dhakal, Chief Specialist, MoHP.

6. DAY 1 SESSION PROCEEDINGS

I. The Current Status, Issues, Lessons Learned and Challenges of OCMCs

(Presentation by Mr. TN Sharma, Joint Secretary, MoHP)

Mr Sharmapresented the current status of OCMCs, progress and achievements, constraints, challenges and lessons learned. Henoted that several positive changeshave taken placeand that while remaining difficulties were significant they are gradually being overcome.Reflecting on thesedifficulties, he acknowledged a number of lapses since not all OCMCs have been functioning flawlessly. Positive outcomes could be measuredby the number of GBV cases being reported, the range of services being provided, resource materials developed, and the number of staff trained,together with the extent ofcoordination and collaboration at the district and central levels. A summary of hismain points are presented below:

Current status of OCMCs

- Piloted in 16 districts
- More than 1,900 GBV survivors have received services
- First draft of National GBV Clinical Protocol completed
- A total of 170 staff (OCMC, Safe Home, Police Cell)have received training on various themes: six-month course on psycho-socialcounselling (20); basic psycho-social counselling training (133); medico-legal training to doctors(17)
- Revised OCMC Guidelinesprepared and pending approval
- Monitoring and Reporting Manual prepared and pending approval
- Preparation for training on GBV,psycho-social counselling and communications training for 22 Police and staff of WCSCs in the Kathmandu Valley and 16 OCMC districts.

Problems/Constraints:

<u>I. Coordination</u>

- Ineffective horizontal coordination between central, regional and local levels
- Absence of formal directivesfrom the concerned ministry/agency resulting in poor or limited coordination among district level agencies
- Ineffective programme implementation, monitoring and reporting due to a lack of coordination between centre and districts
- Duplication of activities, inefficient use of time and resources due to a handful of GBV committees formed under the CDO undermining effective coordination between agencies and creating confusion over roles and responsibilities
- Lack of strong coordination between concerned governmental and non-governmental agencies.

<u>II. Implementation and Management Level:</u>

- Difficulties in ensuring that the full range of OCMC services is made available to all GBV survivors
- The present OCMC Guidelinesare unclear on several issues including referrals and the rehabilitation and management mechanism
- Inadequate budgets for treatment, necessary equipment, management of victims, referrals and legal services

- Almost no female doctors; transfers of psycho-social counsellors and the yearly contracting of staff nurses
- Reports not submitted on a timely basis by some OCMCs
- Lack of clarity regarding the piloting period and the continuation and expansion of OCMCs
- Inadequate coordination and working mechanismsin place between the Women Police, WDO, public prosecutor andhospital at district level
- The emphasis placed on curative rather than preventive measures
- The complexity of some issues related to rehabilitation, follow-up and security following treatment
- The difficulties of identifying and implementing appropriate anti GBV programmes in communities
- Limited promotional activities of OCMCs

Ways forward:

- **Umbrella (integrated) guidelines** should be prepared and implemented to improve teamwork and coordination
- **A single GBVcommittee**should be formed at district level for the effective coordination on GBV services and to prevent the duplication of activities
- **An Integrated Annual Work Plan**for each district should be developed and implemented to improve inter-agency coordination and collaboration
- The WDO should act as a **Focal Point** for district level coordination
- Encourage **Participation and Sensitization**on GBV among all personnelincluding managers, administrators etc and not just health service providers
- **Introduce Multiyear Contracting**for OCMC Staff Nurses to improve staff retention levels
- Ensure GBV survivors receive all **Services Free of Cost** from all health facilities and hospitals (beyond those provided by OCMCs alone)
- **Introduce a One Window Reporting System**to avoid duplication of reporting and protect the authenticity ofdata reported
- Sign a Memorandum of Understanding (MoU)with schools so that GBV survivors who are minors (rape survivors) can receive **Residential School Education**
- Develop**a Partnership with CTEVT** to enable survivors to receive livelihood related training
- **Mobilize GBV Alleviation Funds** to facilitate the rehabilitation of survivors and those suffering from violence in districts.

Feedback from the Panel:

The panel thanked Mr. Sharma for his comprehensive presentation and answered some of the queries raised by participants. These mainly related to resources/funds to sustain OCMCs, compensation for survivors, the capacity building of OCMC staff, protecting survivors' privacy/confidentiality and coordination among the stakeholders/agencies.

The panel recommended basic GBV sensitization training for all OCMC staff and suggested that new avenues be explored to generate local resources to sustain OCMCs. Safeguardingsurvivors'privacy and confidentiality– including their medical records –should also be a high priority that is reflected in revised OCMC guidelines. On compensation for the survivors, the panel recommended that the perpetrator should be responsible and that if he or she does not have resources, they should be made to carry out social work in the community. This should also be reflected in the policy. Finally, the panel called for improvedcoordination among stakeholders working on the same issues.

II. The Provisions of the Revised OCMC Guidelines and Highlights ofthe Monitoring and Reporting Manual

(Presentation by Mr. Sitaram Prasai, Gender and Social Inclusion Advisor, NHSSP)

Mr. Prasai presented the provisions of the revised Guidelines and Monitoring and Reporting Manual. He stressed that OCMCsexist to improve the health care response and other support services for GBV victims and identify on-going challenges and debateson how the health and social sectors should address GBV. He further explained that the revised OCMC guidelines are based on suggestions, experiences and lessons learned from both the field and centre.

He highlighted several of the revisions including: a) the collection and preservation of medical samples for legal testimonies; b) the development of screening and clinical protocols for the identification and screening of GBV survivors; c) referrals including other care and support services available to GBV survivors;d) the preparation of inventories of all additional medicines required for GBV survivors; e)psycho-social counselling training and other training for heads of Women Police Cells, Safe Homes and Rehabilitation Centres;f) the responsibilities of District Police Offices (DPOs) for the safety of GBV survivors and their children; g)safety and confidentiality of documents and information on survivors at OCMCs, Women Police Cells, Safe Homes, Rehabilitation Centres or anywhere else; h)creating an alliance of agencies (DHO, WDO, DDC/VDCs, DPO, NGOs and other social organisations) to raise awareness on GBV issues at community level.In addition, Mr. Prasai discussed revised provisions regarding: 1) Coordination Committee and their roles, responsibilities and jurisdictions; 2) Case Management Committees and their roles, responsibilities and jurisdictions; 3) Human resources; 4) roles and responsibilities of MoHP, MWCSW, DHOs, NGOs and community organisations; 5) reporting and documentation, and 6) implementation of integrated work plans of both governmental and non-governmental agencies.

Feedback from the Panel:

Panel experts Dr. Bimal Prasad Dhakal, Dr. P B Chand and Mr. Krishna Prasad Poudelpraised Mr. Prasai for his excellent presentation and suggested that the following areas should be addressed in the guidelines:

The provision of residential nurse/s for 24 hour attainment/standby at OCMCs for GBV survivors

- A Code of Conduct for OCMC staff
- Integrated guidelinesfor the effective functioning of OCMCs
- GBV survivors are often the victims of trafficking and rape etc which they hide.The guidelines should include strategies to help survivors open up and express their suffering without hesitation
- Ensuring the safety of the person accompanying the survivor since they are also at high risk
- Care and support for the minors of the survivors.

III. The Status of OCMCsand Issues Faced

(Presentations by OCMC officials)

The first round of district level presentationswere from Dang, Doti, Panchthar, Solukhumbu and Sunsari while the second round included Kathmandu, Kavre, Jumla, Saptari, Bardiya and Tanahu. The final round covered Hetauda, Baglung, Sarlahi, Kanchanpur andNawalparasi.

The district presentationscovered: 1) good practices; 2) lessonslearned; 3) problems faced/challenges; and 4) recommendations. The recommendations sought to improve the functional capabilities of OCMCs communication and coordination within the hospital, teamwork and coordination with other stakeholders including support agencies and GBV networks.The main findings of the presentationsare summarised below:

Findings[3]:

Overall, OCMCs have been providing the basic services needed by GBV survivors. From the data available, a total of 2,273 individuals–2173 (96%) women and 100(4%) men –have benefitted from services since theestablishment of OCMCs (see Annex 2, Table 3). Within this total 2833, 1,504(53%) women sufferedphysical assault/domestic violence, followed by sexual violence (26%) (mostly rape cases),mental torture (16%), and other types of violence (4.8%)[4] (see Annex 2, Table 1). The highest number of physical assault/domestic violencecases (213) was recorded in Dang. Comparable data from other districts showed 176cases in Baglung, 167 in Kanchanpur, 128 in Makwanpur and 110 in Doti.

Aside from physical assault/domestic violence cases, sexual violence (mostly rape) was the most common and accounted for 26% of all cases. Kathmandu (Maternity Hospital) reported that among its 356GBV casesreported,295 related to sexual violence, mostly rape. Rape was also prominent in other districtsas follows: Sunsari (67 cases), Makwanpur (60), Bardiya(55) and Baglung(52).

A total of 455 (16%) cases of mental torture were reported with Dang (168), Kanchapur (130) having the highest counts. Data from the other districts are also cause for concern (see Annex 2, Table 1).

In all districts, 907 (43.5%) of cases were self-referrals (including via other hospital units), 783 (37.5%) from the Police, 212 (10.1%) from local agencies (including safe homes), 95 (4.5%) from NGOsand 90(4.3%) from other sources[5] (see Annex 2, Table 2). Earlier data showed that fewer than a dozen cases were self-referrals and this suggests that levels of public awareness of OCMC service availabilitymay have increased.District staff also reported that women are becoming more vocal and assertive in seekingOCMC support services. In addition, while much remains to be done to improve local inter-agency coordination and collaboration,basic cross-sectoral functionality wasreported.

Age related GBV data showed that women in the 15-49years cohort were most likely to be affected. A total of 2,096(78.5%) women were GBV victimsfollowed by 312 (14.9%) from the 0-14 age group, 110(5.3%) from the 50-65 group and 29 (1.4%) from 65 years and above. This suggests that married women and/or those with a family or partner suffer most. The high number of physical assault/domestic violence cases reported correlates with thisdata (see Annex 2, Table 4).

Regarding OCMC service utilization, medical treatment–ranging from basic medical check-ups and psycho-social counselling, to medico-legal services – were the most common.

The districts compiled their data using the OCMC annual review formats 1, 2, 3 and 4 which relate to:a) budget and expenditure; b)good practices, lessons learned, problems and recommendations; c)

[3] The findings are based on the presentations made by the district representatives. Some districts lacked information on the types of services provided, referrals and GBV age categories. Accordingly, these data are not representative of all 16 OCMCs. However, with regard to numbers and the types of violence, it seems that survivors facing multiple forms of violence (e.g. domestic violence and mental abuse) have been counted for both types of violence, hence the total number of beneficiaries is higher than expected in the table 1.

[4] Social/psychological, trafficking, witchcraft, child marriage, poisoning, attempted suicide.

[5] Neighbours, friends/relatives, child centres.

OCMC capacity; and d) OCMC coordination and collaboration. The presentations were also an opportunity for districts to self-evaluate their performance (see Annex 2, Table 5 for capacity, coordination and collaboration indicators).

Regarding financial management, the presentations showed that with the exception ofa few districts including Dang and Sunsari,OCMC budgetshave been under-utilized.Reasons for this include delayed budget release, delayed hiring of staff, strict budget headings and infrequent DCC meetings. Lack of awareness of OCMC staff of their budgets was also reported. Ineffective usage and non-transparent budget management was evident in most of the districts, especially Sunsari.

The district representatives requested that budget headings should be more flexible so that budgets can be used for essential tasks such as rehabilitation, referrals including transportation, and logistical support for survivors.

The presentationsalso revealed limited horizontal coordination and collaboration between those district-level stakeholders represented on DCCs. This resulted in poor ownership and awareness of OCMC services, which, in turn, impactedon stakeholders' commitment and access to services by GBV survivors. It also contributed to the widely heldview that OCMCs are the responsibility of hospitals and OCMC staff alone. There is aclear need formore robust coordination and collaboration, and regular updating among stakeholders in order to promote collective ownership of OCMCs across sectors at both central and district levels.

The districts emphasised the need forcapacity enhancement of service providers and refresher training for staff and stakeholders. Due to the high volume of staff leaving and new individuals starting, and a muddled handover system, the services to survivors at some OCMCshave not been as effective as they should be. Long-term contracts should be signed to improve staff retention, which would help to strengthen the systemin providing a flawless service to the survivors.Nonetheless, the results of the clinical services are encouraging despite the newness of the concept, inadequate capacity building and lack of awareness among stakeholdersand hospital staff.Despite the challenges, a decent number of good practices have been implemented by OCMCs, which have been summarized below:

Good Practices:

- Coordination and referral of GBV cases from other units, departments and emergency sectionsof hospitals to the OCMC.
- 24 hours services for OCMC cases at hospitals.
- Information dissemination about OCMC through various media,such as FM radio, brochures/pamphlets.
- Cases referred from the hospitalsbeing taken seriously by the Police, safe homes, WDO, rehabilitation centres and attorneys.
- At a local level, orientation on OCMC services being provided by WDO, DPHO, and DEO to their staff.
- Coordination and support from WDO, the Police and others for the cases requiringlong-term rehabilitation.
- Support from UNFPA, WOREC for effective functioning and management of OCMC.
- Congratulation of OCMC staffby WDO and others for the good work being done.

OCMC in Dang hospital: OCMC is one of the most important partsof the hospital. The victim/survivor is examined and treated by a doctor and seen by a counsellor within 24 hours in a separate examination room that protects their privacy and confidentiality. Other inter-departments of the hospital including the emergency section are alert to GBV cases and refer to OCMC as soon as such cases arrive. Staff in the hospital aresensitized and trained on handling GBV issues and are well aware of the services required by the survivors. They have enshrined the philosophy of "care and respect to GBV survivors" at all times. Follow-up of the rehabilitated cases is done on a regular basis. In addition, coordination with other stakeholders (Police, WDO, Safe homes, I/NGOs, media and other existing support systems in the district) has been very smooth. During the coordination meeting with district level stakeholders, OCMC activities are updated regularly. Due to good working relationships with them, financial matters have never been an issue. Coordination and collaboration among the agencies has played a great role in achieving good results. Dang hospital is indeed a good example of OCMC integration and response by the government hospital system. (Based on the presentation by the OCMC focal person, Dang Hospital.)

OCMC in Dhulikhel Hospital:The Dhulikhel Community Hospital in Kavre district has set a good example of OCMC integration in their system. Coordination among and within the units and departments of the hospital seems commendable. A special code (OCMC 007) has been assigned by the hospital for GBV cases. Survivors are provided 24 hours services by the hospital through OCMC. Counsellors and concerned service providers have taken specialised training for adequate and accurate service delivery. The guidelines and protocols to serve GBV survivors are in place. Since robust coordination exists between the units and the emergency section, survivors are not made to repeat their traumatic case histories and their confidentiality is well secured at all times. The hospital has developed an effective mechanism for coordination and collaboration with agencies such as TPO Nepal, CVICT and safe homes for referral services required by survivors. (Based on the presentation by the OCMC focal person, Dhulikhel Hospital.)

OCMC at Paropakar Maternity and Women's Hospital: The Maternity Hospital, a public hospital in the heart of the city, has integrated OCMC services quite well within its system. GBV survivors are provided with 24 hours services. Staff are trained and survivors' confidentiality is safeguarded as per the OCMC guidelines. Since large numbers of women receive services from the hospital, GBV cases identified among them are also numerous. The hospital has also established coordination with other agencies for referral and support services required by the survivors. It is essential to build capacity of the hospital (trained human resources and physical facilities, especially additional counselling rooms) for the smooth running of OCMC services and to remove obstacles. Public hospitals like this could be one of the best mediums to support GBV survivorsas they have awider reach.(Based on the presentation by the OCMC focal person, Paropakar Maternity and Women'sHospital.)

Major problems/issues:

- The Piloting phase of OCMC should be integrated into the hospital system
- An unsatisfactory level of coordination between centre, regional and local actors involved
- The need to improve coordination between in-house hospital staff and service providers
- A lack of specialized services in district hospitals
- Information not disseminated widely
- The absence of trained psycho-socialcounsellors, doctors and nurses, and limited medical officers in some OCMCs
- The shortage of physical facilities in some OCMCs (eg, internet, computer and a separate room for counselling at Sarlahi, Maternity hospital)
- A delay in budget release and transparency
- The difficulty of providing 24 hours service to victims due to inadequate human resources (Staff Nurse and Doctor)
- Inadequate orientation and training on GBV of all health staff including FCHVs
- The lack of proper and adequate necessary lab investigation materials, orientation and facilities for lab technicians
- Lack of referral protocols for further treatment, and lack of clinical protocols for treatment and quality care
- Inactive district coordination committeesand OCMCs not functioning well; in districts where the district coordination committee is active, coordination is effective
- The lack of motivation, commitment and pledge of many service providers incombating GBV

Recommendations:

- Integration into the hospital system: treating OCMC as one of the units of the hospital and not a separate entity
- Strong coordination, communication and collaboration among the stakeholdersis crucial
- Information about OCMC should be widely disseminated via media and other methods
- Multi-year contractsfor OCMC staff nurseswould help retain staff
- The maximum number of health staff, as well some leaders of the community, must be well-informed and well-trained about the centre, its function as well as its importance
- GBV sensitization training for health staff of OPD, indoor and emergency, and laboratory staff of the hospital where the centre is established
- Orientation for all members of the district coordination committee
- Timely release of budgets
- Develop a referral and clinical protocol,and a separate protocol on rape and cases with serious injuries or psychological trauma which may need treatment at a more specialised centre or require higher level legal advice
- Availability of a post rape kit
- Regular supervision and monitoring from central and regional levelsis a must
- Development of umbrella guidelines for effective coordination and collaboration among the stakeholders is key

Feedback from the Panel:

The experts on the panelfor the sessions were Dr. Bimal Prasad Dhakal and Mr.Krishna Prasad Poudel for the first round, Dr. PB Chand, Mr. Man Bahadur Bishwokarma and DIG Mingma Lama for the second round, and Mr. PB Chand and Mr. Chiranjabi Adhikari for the concluding round.

Mr.Ramesh Bikram Singh kindly agreed to facilitate the presentation rounds. After each round of presentations, the floor was opened for questions and clarifications. After clarifications, the respective experts summarized the main points raised during the session. They were:

- Coordination and collaboration from all stakeholders is key – support should be provided from all stakeholders, from centre, regional and district line agencies
- Knowledge management and knowledge transfer should be the culture of all OCMCs – the handover process should be smooth:individuals/staff leaving should always let the new individual know the details of the work and documents to ensure a smooth service delivery and follow-up
- Communication from centre to district and district to centre should be vibrant
- Specialised training for certain staff is required, but basic orientation on GBV can be provided by those who have taken training/orientation as part of knowledge transfer for sensitization of all at the centre
- There should be clarity on the activities to be conducted by OCMCs. For this, each OCMC can develop a work plan and follow it
- Budget problems – budgets should be sent on time, and in the case of delay, the hospital management can manage from other funds
- Timely meeting of case management committee is a must
- Coordination and orientation among NGOs, CBOs, inter-departments of hospitals and OCMC should be enhanced
- In-house hospital staff should also be given orientation on OCMC and GBV
- Referral mechanism to be developed
- Recording and reporting of the types of violence, the number of referrals made and the number of cases that have received justice.

7. Day 2: SESSION PROCEEDINGS

I. Recap of Key Issues and Recommendations

(Presentation by Mr. Sitaram Prasai)

Day two started with arecap of key issues raised by OCMCs and recommendations and decisions provided by government and other stakeholders. Mr. Sitaram Prasai facilitated the session. The issues with recommendations are explained below:

Issues	Experience of the OCMCs	Recommendations
a) Future direction of OCMC: should OCMC just be One-stop or should it be hospital-based (owned by hospitals), or should it be internalized by the WCO.	The district presentations revealed that in a few districts (Dang, Kavre, Kathmandu Maternityand Panchthar), OCMC has been owned and internalized by the hospital.	A rapid situation analysis in a few districts should be the first step towards understanding the depth of the system response. This would provide insightsto help understand whether OCMC should be hospital-based, scaled-up as a special program or integrated.
b) Inadequacy of medicines	How to manage medicine scarcity? Survivors are not getting the required medicines in some of the OCMCs.	The creation of an inventory to track the deficiency of required medicines and to maintain an appropriate stock should mitigate the deficiency of medicines.
c) Multi-sectoral coordination and collaboration is vital	The struggle to prevent violence, raise public awareness and advocate legal rights for survivors cannot be won by the health sector/OCMCs alone, much less a single institution.	Regular meetings and sharing of updates among the stakeholders should be maintained. Mainstreaming of all fragmented GBV committees in one GBV Committee to lead the entire programme related to GBV should be prioritised.
d) Analysis and improvement in services	Survivors have not received required services adequately in many OCMCs, as per the guidelines.	All agencies involved in providing services to survivors should keep track of the services being provided. Service providers should analyse the services that are not being provided, including the name of the agency that is accountable for the service as per the guidelines. They should share this at the district coordination committee so that issuescan be addressed on order to reach a solution.
e) Intervention by neighbours'/watch groups: Should neighbours be involved? What should they do?	Neighbours are individuals who can provide testimony of violence and pressurize the perpetrator. They can also talk to the concerned individual or family to	Sensitize neighbours and watch groups about their right to intervene when violence occurs in their community

	resolve the problem. In addition, they can also create an opportunity for service providers to learn more about violence, including its cause and consequences, and ways to break the cycle. They can offer survivors solidarity to confront the situation.	
f) Screening survivors psychological/mental status	GBV has many consequences for women's health, ranging from physical injuries to hidden symptoms. For example, sexual violence may increase the risk of emotional or gynaecological disorders that are otherwise difficult to diagnose or treat, such as depression or chronic pain.	Service providers should try to understand the underlying causes behind many health conditions and thereby provide information that is essential for accurate diagnosis and treatment. Specialised training should be planned for service providers.
g) Poor coordination at all levels	Lack of coordination between the agencies has been affecting the efficient functioning of OCMCs. It should be strengthened from central to district and district to local levels.	Concerned Ministries (MoHP, Ministry of Home/Police, Ministry of Women, Children and Social Welfare, Ministry of Law, Ministry of Local Development) should take a lead at the central level and their counterparts at a district and local level. The district coordination committee should be proactive in accelerating coordination between agencies.
h) **No integrated district work plan on addressing GBV**	Most of the organisations at district level are working on GBV issues but without coordination and collaboration.	It is essential to develop an integrated work plan and for it to be approvedby the district coordination committee to ensure smooth coordination and collaboration.
i) No one- window reporting system	Three different reports (database) are produced from OCMC, WCO and District Police Offices on GBV.	One-window reporting system should be introduced.
j) No training/orientation for FCHVs	FCHVs are important agents who come into direct contact with women and should be sensitized to understand the GBV dynamics so that they can intervene and act as doorstep counsellors.	FCHVs should be trained on GBV issues so that they can be sensitive to women at doorsteps, at the community level.
k) Problem in case registration and legal aid	Survivors are not getting adequate support in terms of case registration,legal aid, and counselling in a timely manner.	Coordination should be strengthened with the concerned stakeholders to ensure case registration and timely legal aid services counselling, in particularthe Police and public prosecutor should be responsible.

l) Capacity development training	GBV isoften not adequately addressed in many settings. The service provider's attitude, knowledge, and skills in relation to GBV can have a major impact on the quality of care. Even without routine screening, clients may disclose experiences of physical or sexual violence, and providers who respond poorly can inflict great emotional harm.	Capacity building training should be provided to staff as per requirements.Health staff should be aware of the epidemiological evidence associated with violence, a human rights framework for understanding violence, and a basic understanding of local legislation. They should be able to respond to survivors in a compassionate way and be prepared to care for women in crisis. Most staff in OCMC, including front office, can benefit from the training set out above. In addition, certain kinds of staff such as doctors/nurses/counsellors may need in-depth training in skills that apply to their particular specialties.
m)Preventive measures	Activities focusing on preventive measures have not been conducted in a planned way at the local level.	Production of IEC materials on OCMC and GBV which take account of the local context (issues, language and methods) should be planned. Information about OCMC/GBV should be included in the school curriculum and shared with school kids, andshould be integrated with social mobilization work (shared with para-legal committees, local networks, community groups and mothersgroups).
n)Lack of proper rehabilitation after medical treatment and no follow-up after OCMC	Treatment, psycho-socialcounselling and shelter are provided but legal support, rehabilitation and security (as provided by thePolice and the community) seems weak or ineffective. So, need to work towards providing all services which OCMC aims to provide.	There should be a tracking mechanism to follow up cases. Regular mandatory monitoring should be carried out by the District Women and Children Office for victims who have been reconciled with their family and community. To ensure that victims feel safe, the security systems of safe houses should be enhanced.
o) Shortage of trained doctors	It is valuable to arrange formore specialised training of doctors in how to document lesions/injuries from physical beatings, using a body map. They also need training in how to provide care for survivors of sexual assault and rape.	It is essential to place two trained doctors in each hospital for medico-legal purposes and proper treatment. The doctors should be trained on collection and preservation of forensic evidence.

p)Establishment and strengthening of the referral mechanismin thereferralhospitals	Even in some district hospitals, quality services in relation to health facilities are not available. Thus, it is mandatory to establish and strengthen the referral mechanism to hospitals providing quality services.	A Memorandum of Understanding (MoU) should be signed with referral hospitals (with advanced facilities) so that survivors are treated well. Moreover, systems in the hospital and staff need to be well aware of the referral system being established to ensure the delivery of proper services to survivors. Provisionshould be made for survivors to receive **Services Free of Cost** from all health agencies and hospitals in addition to OCMCs.
q) Political interference and protection	Many survivors of GBV cannot get access to justice because of bias, political interference and protection of the perpetrator by politicians or so-called "leaders".	Orientation of the concerned authorities/individuals/groups should be carried out to make them aware of the gravity of the problem.
r) Lack of officer level women employees at women police cells has created inconvenience for case registration and process		Provision should be made for the placement of women officers at women police cells.
s) Insufficient resources for rehabilitation	Survivors need services to go far beyond medical care, in addition the duration of care could be unusually long. Hence, the budget provided for the program is not always sufficient for the treatment or support services that the survivor requires.	Mobilization of GBV Alleviation Funds in coordination with concerned agencies to facilitate the rehabilitation of survivors. AnMoU/agreement should be made with agencies such as CTEVT to facilitate a program for thefuture income generation of the survivors.
t) Provision of free education for children (rape survivors)	It isn't always possible for children who survive rape to return immediately to their hometowns, this is for different reasons including the stigma attached to rape. Such children should be provided with free education at residential schools.	AnMoU should be signed with schools to provide access to **Residential School Education** for girls/minors (rape survivors).
u) Mainstreaming of GBV committees	As there are several GBV committees at the district level, duplication of the program is in evidence and use of resources has been inefficient.	Mainstreaming of all fragmented GBV committees into one main GBV Committee to lead the entire program relating to GBV should be prioritized.
v)Strengthening confidentiality	Confidentiality is particularly important when women experience violence because	Confidentiality should be safeguarded at all times. All medical records of the survivors should be stored in a secure

	breaches of confidentiality may have life-threatening consequences for women living in situations of violence.	place with written policies determining who is allowed to accessclients' records. A separate counselling room is a must.

II. Presentation on WHO Clinical Guidelines

(Presentation by Dr. Meera Upadhyaya)

Dr Meera Upadhyaya's presentation concernedthe health sector response to GBV as well asWHO clinical guidelines and their relevance to Nepal. Dr Upadhyaya started her presentation by showing the global picture of violence against women and said that 1 in 3 women throughout the world experience physical or sexual violence by an intimate partner or by another party.Overall, 35% of women worldwide have experienced either physical and/or sexual violence or non-sexual violence by an intimate partner. She further said that gender inequality is the root cause of violence against women and that the cost of intimate partner and sexual violence for countries is very high. There is a clear need to scale up efforts across a range of sectors, both to prevent violence from happening in the first place and to provide the necessary services for women experiencing violence.

Dr Upadhyaya stated that, moreover, combating GBV needs a country-specific, multi-sectorial approach to implement primary prevention and promote gender equality and human rights.Furthermore, she also elaborated on WHO'spolicy, capacity and program development, advocacy and publications on GBV. She further shared WHO's new clinical guidelines on the health sector response to partner and sexual violence against women. These new clinical and policy guidelines emphasisethe urgent need to integrate these issues into clinical training for health care providers. WHO has defined the key elements of a health sector response to violence against women and these have informed the recommendations which require, among others, women-centred care, identification and care for survivors of intimate partner violence, clinical care for survivors of sexual violence, training of health care providers on intimate partner violence and sexual violence, and intervention by health-care workers.

III Presentation of the Draft National GBV Clinical Protocol

(Presentation by Dr. Saroja Pandey)

Dr. Saroja Pandey presented the outline of the Guidelines and Clinical Protocol – Health Response to GBV for Front Line Health Workers. Dr. Pandey stated that the clinical protocol will help service providers at various levels of health facilities to follow rigorous criteria for choosing appropriate procedures for management, including providing immediate health care, adequate psycho-socialcounselling, appropriate collection and preservation of medico-legal evidence (where relevant) and developing systems for referral, proper follow-up and reporting. Below is a summary of the framework of the clinical protocol:

The Guidelines focus on the following:

a) Understanding the context of GBV – definitions and types of violence, prevention and risk factors, ecological model, legal, policy and human rights framework, country context/environment of GBV.

b) Ministry of health framework to address GBV.

c) Facility readiness assessment –infrastructure requirements, institutional policies and mechanisms, capacity-building of staff, M&E, availability of commodities, referral protocols and directories, recording and reporting systems.

d) Guiding principles for working with survivors – confidentiality, ensuring the safety of the survivor, respecting the integrity and authority of the survivor.

e) Medical management of GBV – history taking, examinations (general and genital), evidence collection, treatment, preventive treatment, psychological care and support, follow-up care, and care for child survivors .

f) Ongoing support – developing a safety plan, social work assessment and case management, and referral to networks/partners for other support services.

g) Beyond the clinic – building networks to facilitate referrals, community outreach, advocacy, and education.

h) Self-care of the health provider.

The panel thanked Dr. Pandey for her presentation. Since the outline of the guidelineswas quite comprehensive, the audience didn't have many queries, other than the fact that the guidelines were silent on the matter of clinical waste management, which should be reflected somewhere. The panel member opined that the protocol is merely a guideline and cannot solve everything- for example, there are issues such as rehabilitation which cannot be solved by the MoHP only. Thus,coordinated efforts have to be made to solve the problems of GBV survivors.

IV. Progress Made and Issues Related to GBV by MWCSW

The representative from MWCSW presented on the progress and issues of GBV. The presentation essentially highlightedtheworking areas of the service centres, such as work responsibilities, referral services, duration for safe home services, minimum standards for community service centres and district service centres including expenditure headings. The presentation also covered theformation of a directorate committee for monitoring and evaluating quality care and services provided by district and community service centres.

V. The Achievements and Issues Facing Service Centres

Ms. Bina Shrestha, Women Development Officer of Dang district, represented all WDOs in the 16 OCMC districts, and presented on the achievements and issues of service centres. A joint consultation was organised between them to summarise the achievements and issues.

In her presentation, Ms. Shrestha stated that WCOs have been conducting several programs to minimize GBV by empowering women/girls and children. The programs include integrated development programs; life skills development;disaster management; foreign labour migration; orientation on GBV, trafficking, UN 1325 and 1820, income generation activities and psycho-socialcounselling to various groups and committees. Ms. Shrestha also highlighted the existing structures and mechanisms of the WCOs to minimize GBV. She indicated that there have been success stories, and other cases requiring more time and resources. She mentioned that it takes considerable time and support, and that the coordination required is beyond what we can imagine. She presented on some of the key challenges faced when working with the survivors of GBV at service centres, and they are as follows:

- Absence of legal aid and counsellingin a timely manner
- Social and political protection of perpetrators
- Difficulties caused by the lack of WCO's own building and vehicle for transportation of survivors
- Absence of medico-legal evidenceas well as presentation of false reports,especially in rape cases, which hampers access to justice, and frequent changes of testimony by the survivors due to threats, bribes etc.
- Dearth of skilled human resources
- Problems caused by a lack of guards/Police at service centres impacting the security and safety of survivors
- Limited sensitivity towards safeguardingthe privacy and confidentiality of survivors.

In addition to the challenges, Ms Shrestha highlighted the steps to mitigate them, which were as follows:

- Robust coordination and cooperation of all stakeholders, and expansion and extension of partnerships with concerned agencies
- Community levelmechanism development and mobilization of the community
- Development of skilled human resources in working with the survivors.

The presentation also included recommendations as follows:

- Continuation of OCMC structure and mechanism
- Provision of officer level employees at women police cells
- Provision of skills development training
- Provision of women police at service centres for security/safety and comfort of survivors
- Provision of permanent staff nurses at OCMCsfor enhanced and consistent service delivery and strengthened networking with partners
- Capacity development training forstaffatwomen police cells, safe homes, OCMCs and WDOs
- Free education for children of survivors from the district education office
- GBV cases should be solved by a fast-track system
- Rehabilitation in the family (reunion) and community
- Mobilization of local level mechanismsto monitor rehabilitated survivors on a regular basis
- Strengthening of neighbour's capacity to minimize GBV (by involvement and intervention)
- Compulsory investigation and research to understand the trigger factors for high suicide rates
- Skills development and employment of GBV survivors
- Legal literacy, capacity development, including psycho-socialcounselling training, to service providers
- Provision of women police officers at women police cells and security at safe homes and district service centres
- Provision of a child friendly environment at district safe homes andOCMCs
- Provision of weekly health check-ups for survivors at service centres
- Provision by district hospitals of free health services, including medicines, to survivors during their stay at service centres.

Feedback from the panel:
The experts in the panel for this session were Joint-Secretary TN Sharma and Dr. Tarun Poudel. The panel thanked Ms. Bina Shrestha for her comprehensive presentation and also answered theparticipants'queries on safe homes, GBV during disaster/calamity (manmade or natural) and livelihood training for survivors.On safe homes, the panel suggested that sincesome of the services that safe homes and OCMCs provideare similar, they should be integrated. Integration would be

helpful in saving resources, which could be utilized to reach more survivors as well asprovidingenhanced services to them.Additionally, rigorous monitoring should be carried out at safe homes during such times and referral of survivors should be made to OCMCs on a needs basis. Likewise, as regardslivelihood training for survivors, the suggestion was that in a changed context, it is important that survivors receive training which could immediately place them ina job for example as a waitress, or beautician, or receive training to start a grocery shop etc.

VIWay Forward: Health System Response and Coordination and Collaboration at District and Central Levels

The participants were divided intotwo major groups. The first group was further divided into fivesub-groups and each group wasasked to work on the future direction and modalities of OCMC focusing on a) next steps, b) follow-up patterns, c) capacity building and d) integrated approach.

The second group, representing high-level officials from MoHP, UNFPA, Nepal Police, Public Prosecutor and a few others, worked on the policy and strategic direction of OCMCs. Below is the summary of the key points presented by the groups with regard to future directions and modalities of OCMC:

a) Modality of OCMC:

- GBV should be integrated into the health system, and the piloting phase of OCMC should be concluded. The OCMC concept (not 'one stop' in a real sense but managing the services in an integrated manner) should be extended in a phased wayto all 75 districts
- OCMC should be placed in appropriate areas within the hospital complex
- Well-defined operational guidelines with clear roles and responsibilities should be in place
- There should be a defined description of follow up and rehabilitation.

b)Coordination and collaboration: The efficient and effective functioning of OCMC depends upon coordination from all – hospitals, counsellors, safe homes, Police offices, legal aid committee, lawyers and rehabilitation centres. There should be effective coordination and collaboration between the following:

Departments/units within hospitals and D(P)HO

- Coordination between Ministry, departments and District
- Division of roles with clear definitionsbetween different ministries, and add ToR for doctors
- Develop comprehensive umbrella guidelines which should be approved either by OPMCM or cabinet
- All health workers in hospitals/ D(P)HOs should be responsible for OCMC cases

Among district level GOs and NGOs

- Integration between GOs and NGOs for program and activities
- Different committees working on GBV should be merged into one.

c) Follow up support to survivors

- Regular mandatory monitoring and follow-up of survivors should be carried out bythe OCMC which has been constantly involved with the same family and community.

d) Preventive measures:

- Focused advocacy and sensitization campaigns on OCMC activities, as follows:
  - Use of local FM radio, leaflets and posters
  - Journalist interaction and advocacy
  - Incorporation of GBV in health related materials
  - Incorporation of GBV in high school curricula
- Continuous partnership mapping:
  - Partnerships with local government (DDC, VDC, municipality)
  - NGOs, CBOs, para-legal committees and user groups
- Social mobilization activities and approach
  - Female community health volunteer (FCHV)/health worker (HW
  - GBV orientation for mothers and watch groups at a community level.

e) Quality improvement of health related services

- Trained and skilledpermanent (not contract), preferably female,staff
- Services equipped with all necessary instruments, staff and medicines at all times, and in sufficient quantities, including an emergency fund for medicines
- Clearly defined roles and responsibilities of staff
- Satisfaction of clients
- Uniformity of services
- Comprehensive service- truly one stop!
- Ensure security and safety of clients and accompanying persons
- At all times, follow the widely accepted guiding principles for working with survivors of GBV– security and safety of the survivor, confidentiality and respect for the dignity, rights and wishes of the survivor at all times
- Consolidated recording and reporting system at district level which is aone-window reporting system.

After the presentations from the groups, the panel thanked them and provided feedback on issues raised by the groups, stating that they were very important for planning and preparation for the future direction and strengthening of the OCMC. The panel also stated that some of the issues raised in the session had been already addressed as they were raised during the previous meetings, for example overtime incentives for staff and training. The panel suggested that from the beginning, OCMC should beset up inside the hospital premises, that it should not be thought of otherwise, and to make OCMC really a One Stop Service Centre, the development of an integrated planning matrix at district level is essential. The panel further advised that standardisation of GBV training curricula should be considered.

After the group presentations the following decisions were taken by the plenary.

Recommendations made from the plenary:

1.	Umbrella Guidelines should be developed for effective coordination and teamwork.
2.	A GBV single committee (instead of 4/5) should be formed at district level for effective coordination on GBV issues and also to prevent duplication of activities. Meetings should be conducted among the stakeholders on a regular basis.
3.	An integrated work plan should be developed by agencies working on GBV at the district level with approval from the district coordination committee.
4.	Specialised training should be provided to the OCMC staff and other medical services providers on medico-legal and clinical protocol, and sensitization on GBV. Scope to provide training to FCHVs should be explored.

5.	WDOs should act as the focal point for regular coordination at district level.
6.	Regular follow-up of survivors should be done via phone, home-visit or any other applicable medium.
7.	Scope for anMoU with residential schools should be explored for rape survivors who are minors. DCC and WDO have to take the initiative, based on the Prime Minister's Office decision. AnMoU with CTEVT for a livelihood generation program for survivors should be pursued.
8.	A one window reporting system should be developed to avoid duplication of reporting and to ensure authenticity of data being reported.
9.	All services provided by OCMC should be explained to GBV survivors; all clinical equipment should be kept in OCMCs; and privacy should be maintained (both physical as well as information). Separate counselling rooms should be made available. Lists of required medicines should be prepared and stock maintained at all times.
10.	A decision on the future of OCMCs, further guidance on their integration with other local services and plans for scaling-up are needed. The government has yet to decide on the duration of the OCMC pilot phase.
11.	GBV sensitization/orientation training should be organised for watch groups. Neighbours should be encouraged to be alert and to intervene during the occurrence of incidence of GBV.
12.	Connections should be established with the social service units (SSU) hospitals to enable access to services free of charge.
13.	Utilization of GBV coordinated alleviation funds should be adopted.

After the presentations on decisions from the plenary, a brief closing ceremony was organized.

<u>Closing Ceremony</u>

Mr. TN Sharma, Joint-Secretary of MoHP, chaired the closing ceremony.

Remarks from Ms. Sudha Pant, UNFPA

UNFPA representative Sudha Pant stated “it is an amazing experience to see such a superb gathering of stakeholders from diverse sectors”. She further explained that UNFPA’s partnership with the Nepal government has been very inspiring in the fight against GBV. Ms. Pant opined that the attitude of individuals plays a huge role in combating GBV. It is really crucial to remove the barriers in achieving equity and equality. She further stated that 80% of women are affected everyday and in many ways GBV still remains a private matter in our households. According to Ms. Pant, zero tolerance of violence is essential and in a changed context, we should work together and engage men, boys and youth to eliminate GBV.

Remarks by DIG Mingmar Lama

In his closing remarks, DIG Lama said very passionately that no time should be wasted in getting survivors to the right place where they can access the services they need, regardless of which units, offices or networks the survivor comes to. DIG Lama exclaimed, “the place for integrated services-this is what OCMC stands for!”He suggested that this is the best way to implement the government’s mandate to fight GBV.In concluding the sessionhe said that there is not much clarity at the community level about hospitals being the centre for OCMC and that there needs to be more awareness in relation to thisso that in future we can aim to produce better results.

Vote of thanks by TN Sharma, Joint-Secretary, MoHP

Mr. Sharmathanked all for their active participation and contribution.He stated that the discussion and brainstorming over two days showed that the piloting phase of OCMC had proved to be successful. Furthermore he said that the sharing of challenges, achievements and ways forward of OCMC in such a multidisciplinary forum had been extremely advantageous. According to Mr. Sharma, proper management could overcome the difficulties experienced during our work. The last two days' discussions had shown that wherever the management is good, OCMC is functioning well and wherever the management is weak, OCMC is not functioning well. He continued that we should aim towards enhancing the quality of services that we provide through OCMC and disseminate information about it at the community level. Coordination at all levels needs to be enhanced.

Mr. Sharma reaffirmed the need to create an environment where survivors can live with dignity and respect as enshrined in the Universal Declaration of Human Rights. In addition, being a party to several international conventions, he stated the need to understand and address the problem from the inside and act accordingly. He affirmed that challenges and weaknesses addressed by this forum shall be addressed. The suggestions provided shall be taken to the higher authority and asharing meeting with all concerned ministries and stakeholders shall be organized and a final report will be shared with all concerned parties.

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The workshop ended with much excitement and anticipation of the implementation of the learnings at all levels. It is so true that the "world suffers a lot not because of the violence of bad people, but because of the silence of good people[6]." Therefore, it is so important for all to speak up and act against GBV, which weakens legitimate economics, breaksup families, fuels violence, threatens public health and safety, and shreds the social fabric that is necessary for progress. It undermines the long-term efforts to promote peace and prosperity. Moreover, it is an affront to our values and our commitment to human rights. Hence, the commitment and contribution-- small or big-- from all of us is a MUST in combating GBV.

[6] Dalai Lama

ANNEX 1: WORKSHOP AGENDA AND SCHEDULE

National Workshop on Review and Future Direction of OCMCs
Kartik 1 & 2, 2071, Paradise Hotel, Sauraha, Chitwan

Objectives:

1. Review of progress, good practices, constraints, lessons learnt, issues and recommendations for effective functioning of one-stop crisis management centres (OCMCs).
2. Identify key areas of intervention to improve the service delivery of OCMCs (both at the policy andoperational levels).
3. Improve coordination and collaboration among different concerned stakeholders.

Day	TIME	SESSION
Day 1: Saturday, Kartik 1, 2071 (Oct 18, 2014)	**0730-0830**	**BREAKFAST**
	0830-0850	Registration
	0900-1000	**Opening Ceremony** • Chairing of the session: Dr. Bimal Prasad Dhakal, Chief Specialist, MoHP • Guest of honour to be seated in Dias • Introduction, Welcome and Objectives of the workshop • Remarks by Joint Secretary (MWCSW), DG (DWC), DIG, OAG and others • Opening remarks by the Chairperson
	1000-1030	**TEA BREAK**
	1030-1150	Presentation about the current status, issues, lessons learnt and challenges of the OCMCs: TN Sharma, MoHP
	1150-1230	Presentation about the revised provisions of OCMC Guidelines and highlights on Monitoring and Reporting Manual: Sitaram Prasai, NHSSP
	1230-1330	• Presentation and discussion on the status and issues of first group of 5 OCMCs • Comments from the panel about the presentation of OCMCs
	1330-1430	**LUNCH BREAK**
	1430-1540	• Presentation and discussion on the status and issues of second group of 6 OCMCs • Comments from the panel about the presentation of OCMCs
	1540-1600	**TEA BREAK**
	1600-1700	• Presentation and discussion on the status and issues of third group of 5 OCMCs • Comments from the panel about the presentation of OCMCs
	1700+	• Closing of the day • Documentary show by KOSHIS (NGO)
Day 2: Sunday, Kartik 2, 2071 (Oct 19, 2014)	**0730-0825**	**BREAKFAST**
	0830-0845	Recap of the key issues and recommendations: Sitaram Prasai, NHSSP
	0845-1015	• Presentation on the WHO clinical guidelines by Dr. Meera Upadhyaya • Presentation and discussion on draft national GBV clinical protocol by consultant
	1015-1030	Presentation on the implementation status of National GBV Strategy and Action Plan by

		OPMCM
	1030-1050	**TEA BREAK**
	1050-1110	Presentation about the progress and issues on GBV by MWCSW
	1110-1200	• Presentation on the achievements and issues of Service Centres by WDOs • Comments from the panel about the presentation of WDOs
	1200-1300	Group work on the **way forward -** health system response and coordination and collaboration at the district and central level: • Groups of district level participants for the way forward on **key issues based on presentations in workshop** • One group of central level participants for **the policy and strategic direction** of OCMCs
	1300-1400	**LUNCH BREAK**
	1400-1445	Group work continued…..
	1445-1545	• Presentation of group work outputs to plenary and discussion • Response on the issues/recommendations from the authority, if possible **(TEA SERVED)**
	1545-1615	Closing Ceremony

ANNEX 2: TABLE 1 – TYPES OF GBV

SN	Districts	Physical Assault and Domestic Violence	Sexual Violence (most of rape)	Mental Torture	Others	Total
1.	Bardiya	71	55	-	1	127
2.	Kathmandu (Maternity Hospital)	61	295	-	-	356
3.	Panchthar	58	16	12	-	86
4.	Makwanpur	128	60	-	15	203
5.	Dang	213	29	168	64	474
6.	Solukhumbu	85	19	5	1	110
7.	Doti	110	20	7	2	139
8.	Saptari	61	7	-	2	70
9.	Sarlahi	55	29	3	3	90
10.	Baglung	176	52	70	29	327
11.	Kanchanpur	167	25	130	9	331
12.	Sunsari	97	67	12	-	176
13.	Jumla	60	4	-	-	64
14.	Nawalparasi	35	-	29	-	64
15.	Kavre (Dhulikhel Hospital)	82	34	3	-	119
16.	Tanahu	45	26	16	10	97
	Total	**1504 (53%)**	**738 (26%)**	**455 (16%)**	**136 (4.8%)**	**2833**

ANNEX 2: TABLE 2 – REFERRALS FROM AGENCIES TO OCMCS

SN	Districts	Self (including hospital)	Police	Local Agencies (including safe home)	NGOs	Others
1	Dang	253	36	33	28	4
2	Tanahu	31	49	-	-	5
3	Saptari	44	6	8	12	-
4	Nawalparasi	38	8	10	-	7
5	Jumla	20	6	8	-	-
6	Doti	14	66	16		11
7	Sunsari	57	61	67	1	-
8	Kanchanpur	92	24	13	3	18
9	Baglung	78	38	6	4	45
10	Makawanpur (069/70-070/71)	46	50	11	34	-
11	Kavre (DH)	41	36	7	-	-
12	Kathmandu (Maternity Hospital)	25	301	-	13	-
13	Panchthar	71	9	6	-	-
14	Bardiya	40	65	22	-	-
15	Sarlahi	57	28	5	-	-
	Total	**907 (43.46%)**	**783 (37.52%)**	**212 (10.1%)**	**95 (4.55%)**	**90 (4.3%)**

ANNEX 2:TABLE 3 - BENEFICIARIES

SN	Districts	Female	Male	Third Gender	Total
1	Bardiya	120	7	-	127
2	Kathmandu (Maternity Hospital)	356	-	-	356
3	Panchthar	76	10	-	86
4	Dang	315	26	-	341
5	Doti	100	7	-	107
6	Saptari	63	7	-	70
7	Baglung	156	16	-	172
8	Kanchanpur	136	2	-	138
9	Sunsari	175	1	-	176
10	Jumla	63	1	-	64
11	Nawalparasi	63	1	-	64
12	Tanahu	76	9	-	85
13	Solukhumbu	71	39	-	110
14	Sarlahi	83	7	-	90
15	Kavre (Dhulikhel Hospital)	77	7	-	84
16	Makawanpur	203	-	-	203
	Total	**2133 (94%)**	**140 (6%)**		**2273**

ANNEX 2: TABLE 4 – GBV BY AGE GROUP

SN	Districts	0-14	15 – 49	50 – 65	65+
1	Solukhumbu	8	54	5	4
2	Saptari	3	62	4	1
3	Makawanpur (Hetauda)	30	160	9	4
4	Sarlahi	20	60	9	1
5	Sunsari	18	151	7	
6	Jumla	-	51	13	-
7	Doti	15	80	9	3
8	Dang	32	281	21	7
9	Baglung	10	146	12	4
10	Nawalparasi	-	63	1	-
11	Panchthar	9	67	9	1
12	Tanahu	21	61	2	1
13	Kanchanpur	15	127	2	-
14	Kavre (Dhulikhel Hospital)	21	53	7	3
15	Kathmandu (Maternity Hospital)	110	229	-	-
16	Bardiya	-	-	-	-
SN	**Total**	**312 (14.88%)**	**1645 (78.48%)**	**110 (5.25%)**	**29 (1.38%)**

ANNEX 2: TABLE 5 – SELF EVALUATION OF OCMC STATUS AND PERFORMANCE

SN	Districts	Capacity	Coordination and Collaboration	Remarks
1.	Solukhumbu	75%	69%	Lack of effective coordination among district level stakeholders (including NGOs and networks) and insuffiency of promotion of the OCMC services
	Baglung	87.5%	81.25%	Excellent both in capacity and coordination & collaboration
3.	Saptari	75%	62.5%	Unavailability of psycho-social counsellors and inadequacy ofcollaboration between key stakeholders such as attorneys, bar association, Police, NGOs
4.	Jumla	62.5%	62.5%	Unavailability of psycho-social counsellors; not much clarity at hospitals about OCMC; lack of coordination between key stakeholders including NGOs
5.	Doti	75%	75%	Delay in reporting; no regularity of counsellors; improvement is still needed in collaboration between key stakeholders, NGOs and networks
6.	Makawanpur	77.5%	75%	Not regularity of OCMC staff nurses due to contractual process; no regular service from forensic doctor; effective measures to be adopted for the promotion of OCMC services
7.	Sunsari	82.5%	81.25%	Excellent both in capacity and coordination & collaboration
8.	Kavre	82.5%	71%	No effective coordination with District Women and Children Office, DHO and District Attorney Office; effective measures to be adopted for the promotion of OCMC services
9..	Dang	95%	94%	Excellent both in capacity and coordination & collaboration
10.	Panchthar	85%	84.34%	Excellent both in capacity and coordination & collaboration
11.	Tanahu	75%	56.25%	Lack of space for the OCMC office set up; no effective coordination between key stakeholders and lack of promotion of the OCMC services
12.	Nawalparasi	70%	62.25%	No effective coordination between key stakeholders and lack of promotion of the OCMC services
13.	Kathmandu (Maternity)	85%	70%	No effective coordination between government stakeholders; effective measures to be adopted for the promotion of OCMC services

14.	Kanchanpur	75%	50%	OCMC is not in an appropriate location; lack of forensic doctor; weak coordination between key government and non-governmental agencies and effective measures to be adopted for the promotion of OCMC services

ANNEX 3: LIST OF PARTICIPANTS

S.No.	Name	Post & Organization	Email	Mobile	Office Landline & Fax No.	Signature	
						18-Oct	19-Oct
1.	Bimal Prasad Dhakal	Chief Specialist, PPICD, MoHP					-
2.	Kedar Bdr. Adhikari	Joint Secretary, MoHP					
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