

# **Review of the scale-up, functionality and utilisation, including barriers to access, of One Stop Crisis Management Centres**



Government of Nepal

**Ministry of Health and Population**

**Department of Health Services**

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## Executive Summary

### Background

Gender-based Violence (GBV) is a grave human rights and public health concern which impacts the physical and mental health of the individual survivor and her children, and carries a social and economic cost to society. GBV in Nepal cuts across caste-ethnicity, religion and socioeconomic status and is prevalent in all geographical settings.

The Government of Nepal (GoN) has taken significant steps in reforming laws and policies to combat GBV in the country. However, deeply entrenched social norms that condone Violence Against Women and Girls (VAWG) persist. The Ministry of Health and Population (MoHP) was tasked with Clause 3 of the National Action Plan Against GBV (2010), to provide integrated services to survivors of GBV by establishing hospital based One-stop Crisis Management Centres (OCMCs).

OCMCs provide free hospital-based health services including identification of survivors, treatment, psychosocial counselling and medico-legal services, and coordinate with multisectoral agencies that provide survivors access to safe homes, legal protection, personal security and rehabilitation. They also refer clients for specialist health services as required.

MoHP initiated the establishment of OCMCs in 2011. By the end of 2018/19, 55 OCMCs had been established in 54 districts. Fourteen more OCMCs will be established in 2019/20 and the MoHP intends to complete scale-up across the country in 2020/21. The MoHP has been incrementally providing inputs to strengthen the systems and capacity of OCMCs since their introduction, and intermittent evaluations and reviews have provided critical evidence to guide systems strengthening.

### Purpose of the review

The overall purpose of this review is to: support the MoHP take stock of the OCMC approach; assess OCMC use and barriers to access; review the operational challenges and opportunities within the changed governance context; and make recommendations to strengthen the delivery of OCMCs further.

### Methodology

The review was led by the MoHP. It takes a mixed-methods approach drawing on existing quantitative data on OCMC utilisation collected by the MoHP, mining existing secondary data related to access to and the quality of OCMC services, and undertaking primary data collection.

### International evidence

International evidence shows that integration of GBV into health systems is slow and incremental and requires all elements of the health system to respond to GBV. There is no one model that works for all health systems; rather, the global consensus is that countries need to develop approaches that fit with their health system, and work towards a comprehensive response to GBV that includes multisectoral and multi-level coordination across government spheres.

### Utilisation of OCMCs

MoHP data extracted in March 2020 shows that the total annual number of OCMC clients has increased from 187 in 2011/12 (based on seven reporting facilities) to 6,992 in 2018/19 (based on 45 reporting facilities). Women make up over 90 percent of clients. Based on 2018/19 data, physical assault, sexual assault and rape make up 72 percent of all cases. Rape and sexual assault together are 38 percent of all cases, and physical assault is 34 percent.

The number of cases of physical and sexual violence that are reported to any service provider in Nepal is a small proportion of actual occurrence. To estimate how well OCMCs reach women seeking help for physical or sexual violence, we calculated the number of OCMC clients in one year as a percentage of the estimated number of women seeking help using census data and estimates of physical and sexual violence from the Nepal Demographic and Health Survey (NDHS, 2016). The crude estimation is that OCMCs served between 3–4 percent of women who sought help for physical or sexual violence in 2018/19. Coverage varies by province but the headline message is that coverage is extremely low and there is much more for the government to do to improve survivors' access to services.

#### Stocktaking of OCMC functionality

The OCMC self-assessment scorecard was completed by 50 OCMCs in March 2020. This scorecard is introduced as a management tool in the latest version of the OCMC Operational Manual (2020) (currently waiting for final approval from the MoHP Secretary). The scorecard includes indicators that relate to the capacity of the hospital to deliver OCMC services and the quality of coordination and collaboration of the OCMC within the health service and with external agencies.

For management purposes, the MoHP set an aggregate score of 75 percent as a marker of acceptable functioning. Out of 50 OCMCs that reported, 36 scored 75 percent or above. The indicator with the highest score was on coordination and collaboration within the hospital, and the one with the lowest score was on preparation of a joint action plan with local GBV service providers including police and local government. These themes are returned to in more depth in the findings from the qualitative data.

#### Key issues and findings related to OCMC performance

**Leadership and governance:** There are two strategic governance issues that are impacting the functioning of OCMCs. First, federalism has changed the governance environment for OCMCs with important implications for oversight authority, funding and coordination. The changed context means that while the 'district hospital' remains a valid location to provide and coordinate multisectoral services that are available at this level (e.g. police investigation, legal services, safe home), a mechanism is required to enable all local governments within the orbit of OCMCs to participate in governance functions.

The second strategic issue relates to institutional reforms in the Ministry of Women, Children and Senior Citizens (MoWCSC) and the removal of their service delivery role. MoWCSC funding of safe homes and rehabilitation services has stopped. Without secure funding of these services, this leaves OCMCs without an essential part of the GBV response network and critical services for survivors.

Consultations with provincial and municipal governments found diverse responses to GBV in terms of leadership, funding and coordination. There are positive examples. In Karnali, the Provincial Ministry of Social Development (MoSD) has initiated a Memorandum of Understanding (MoU) between

federal, provincial and local governments to address child marriage and chhaupadi, and agreed division of funding responsibility. In Bharatpur, the District Coordination Committee (DCC) has nurtured collective responsibility for GBV across seven municipalities through a GBV Management Fund that will pool resources. The basket fund will finance GBV prevention and rehabilitation services for the participating municipalities. In other locations, the study collected examples of wasted opportunities, poor communication and coordination between stakeholders, and inefficiencies as municipalities plan to duplicate responsibilities already vested in OCMCs.

*Hospital leadership* commitment to OCMCs is a key enabling factor for their success. Supportive leaders provide resources to OCMCs, generate commitment to GBV across the hospital, motivate staff and improve the quality of care. Where hospital chiefs are uninterested in GBV or see this as a social problem beyond the responsibility of the hospital this is a critical barrier to their effectiveness.

**Human resource availability:** This year, many doctors and staff nurses who have received GBV- and OCMC-related training have been transferred to facilities without an OCMC, as part of the staff adjustment process. This situation, and the general fluidity of staff, especially contract staff, has serious implications for capacity loss and inefficiency.

**Staff capacity and development:** Standards and guidelines and related training on the Clinical Protocol (2015) and OCMC Operational Manual (2016)<sup>1</sup>, medico-legal training of doctors to undertake forensic examinations of rape victims and to prepare medico-legal records that stand up in court, and psychosocial counselling training of nurses have been critical investments. Feedback from doctors and nurses trained was overwhelmingly supportive of the quality of the training and the impact this has had on their care and underlying attitudes towards GBV survivors. For example, doctors reported a new sense of responsibility towards survivors, prioritising justice over protecting themselves from being found at fault in their forensic work.

Despite the rollout of training, this has not covered all OCMC staff and capacity gaps persist. High staff turnover contributes to the challenge. Poor operating conditions and work practices, such as doctors not being covered from their regular duty if they have to attend a court hearing, also impact the extent to which confidentiality and privacy are maintained and skills learned are practised.

**Care and treatment of survivors:** Staff nurses who received psychosocial counselling training note how they have changed the language they use with survivors, become more sensitive to their needs and show respect and empathy. In the Survivor Study (2019)<sup>2</sup>, survivors recall the care and counselling provided by OCMC staff. The study found that OCMC staff spent considerable time and effort finding care and resources to support women and girls who have survived family violence, especially when the survivors are children, and women living with disability and mental illness, who are more difficult to accommodate in the limited care options available.

**Budget allocation and budget management:** The transition to federalism has impacted budget allocations for OCMCs. Federal hospitals receive funding direct from MoHP, while the conditional grant funds for others are sent via the province and have suffered from delays and incompleteness.

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<sup>1</sup> Ministry of Health and Population. 2015. Gender Based Violence Clinical Protocol; Ministry of Health and Population. 2016. One Stop Crisis Management Centre Operational Manual.

<sup>2</sup> MoHP and NHSSP. 2019. Survivor perspectives on the nature, risks and response to Gender-based Violence in Nepal and the implications for One-stop Crisis Management Centres.

Apart from the MoHP conditional grant funding there is wide variation in provincial funding of OCMCs and GBV more broadly. In Sudurpashchim, the province has provided top-up funding to each OCMC additional to the conditional grant provided by MoHP in 2019/20. In Karnali, the provincial government has allocated funds to establish six OCMCs in addition to those funded by the conditional grant from MoHP. In Provinces 2 and 5, there are no provincial initiatives to fund OCMCs additional to the federal grant. Out of the 13 OCMCs studied, only Janakpur OCMC is receiving top-up funding from a municipality, though several municipalities are planning to support other GBV services. Several respondents requested guidance on the responsibility of provinces and municipalities to sustain and ensure the effectiveness of OCMCs and the GBV network of services, and how they can work together to achieve high-quality services for survivors.

*Access to OCMC budgets* by OCMC staff was reported to be an issue in several hospitals. Nurses at reported how accounts officers do not provide allocated petty cash to the OCMC and hinder requests for equipment and other necessary supplies, finding the budget has sometimes been used for other purposes.

**Coordination and collaboration at the operational level** through regular Case Management Committees (CMCs) is uneven. Coordination on a case-by-case basis seems to be the norm. Frequent turnover of staff and the heavy work burden of OCMC Focal Points have a negative impact.

Most clients are referred to the OCMC by the police; of all external agencies, coordination with the police is the strongest. Critical gaps in safe home and rehabilitation services have left many OCMCs without shelter accommodation and rehabilitation care to which they can refer clients. The care of children, women with disabilities and the mentally ill is a particular challenge.

Coordination with local municipality staff was found to be poor. This is partly explained by the lack of perceived authority of OCMC staff to convene meetings with officials from outside agencies, and the more structural problem discussed earlier, that these relationships are yet to be forged at the strategic and governance level.

Case studies of Koshi and Hetauda OCMCs show how active, well-networked OCMC Focal Points are key factors in making coordination with external agencies work well and make referral happen. Both OCMCs have fostered good working relationships within the hospital and with municipalities and service delivery partners. Another point of difference is the support given to GBV survivor networks, which enable survivors to connect, find solidarity and strength. Survivor networks are agents of change in the community, advocating against violence, supporting victims, connecting them to help, and ground-truthing OCMC services.

#### *Survivor perspectives and demand-side barriers to access*

The social norms and gender inequality that trap women and girls into recurring violence are the greatest barrier they face in seeking help. As many of the survivor stories reveal, survivors that reach hospital have typically suffered very serious injuries that have resulted in police involvement or injuries that need hospital-level attention. Community awareness of OCMC services is low, and few women reach them directly.

Survivor stories underline the critical role of safe homes in providing an immediate response to an emergency situation. However, even before the status of safe homes was impacted by federalism,

they were a short-term solution providing shelter for up to six months. Long-term solutions, such as livelihood training and seed money to start businesses, have been in short supply and often relied on funding from Non-governmental Organisations (NGOs). Signs of municipalities filling this gap are encouraging but they will need to be informed by past experience and lessons learned in Nepal on how to make this most effective.

#### Recommendations for the future

Against the backdrop of deep structural change taking place in Nepal, this study shows diverse experience at individual OCMCs and the enabling environment within which they function. Good practices are emerging and innovative solutions to complex problems, such as in Karnali and Bharatpur, inform the strategic roadmap for OCMCs. Further analysis and sense-making of these findings will take place with the Technical Working Group (TWG) once the Coronavirus Disease 2019 (COVID-19) emergency has been contained.

Nepal needs to continue the system-strengthening approach, to adapt to changing conditions and fill critical capacity gaps. In light of the changed governance context, a priority is building local ownership and sustainability of OCMCs as a critical part of a multisectoral response to GBV.

Strategic recommendations for consideration by the TWG follow:

1. Clarify governance arrangements and respective roles and responsibilities of federal, provincial and municipal governments for maximum gain, to avoid duplication of effort, promote efficiency, and clarify accountability.
2. Consider adapting the hospital-based OCMC model to fit different hospital contexts. An advanced model (OCMC+) could be developed for tertiary and provincial-level hospitals and the existing model applied in the rest.
3. Institutionalise OCMCs as a mandatory hospital unit, with associate human resourcing, during the hospital Organisation and Management (O&M) review process led by MoHP or Provincial MoSD. The loss of trained staff needs to be halted with GBV-trained staff only transferred to facilities with an established OCMC.
4. Continue to strengthen the capacity of the health workforce by rolling out training on the Clinical Protocol, psychosocial counselling, OCMC Operational Manual and medico-legal standards. Supportive supervision and monitoring need to be provided on a regular basis from the MoHP and Provincial MoSD to reinforce and support implementation of GBV-related training.
5. Define a rehabilitation package of services at the national level that is guaranteed for survivors. Oversight and responsibility for funding and implementation will differ according to the governance model in operation in specific localities.
6. Develop a plan for rolling out GBV prevention and first-aid care to primary level.
7. Improve referral and coordination at the operational level, especially with all local governments in the district catchment area and Nayeek Samiti (Judicial Committee), as per the referral protocol included in the latest version of the OCMC Operational Manual (2020).
8. Strengthen OCMC evidence and use by expediting online reporting of the OCMC as part of the HMIS. Enhance the capacity of OCMC health providers to convey data, evidence and good practices so that they are better able to advocate within the hospital and with local stakeholders.

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## Acronyms

ADB	Asian Development Bank
AWPB	Annual Work Plan and Budget
CBS	Central Bureau of Statistics
CDO	Chief District Office
CMC	Case Management Committee
CMC-Nepal	Centre for Mental Health and Counselling – Nepal
COVID-19	Coronavirus Disease 2019
CSO	Civil Society Organisation
CVICT	Centre for Victims of Torture
DCC	District Coordination Committee
DFID	UK Department for International Development
EDP	External Development Partner
FPAN	Family Planning Association of Nepal
FY	Fiscal Year
GBV	Gender-based violence
GNS	Gajendra Narayan Singh Hospital
GoN	Government of Nepal
HMIS	Health Management Information System
IEC	Information, Education and Communication
MeSu	Medical Superintendent
MoHP	Ministry of Health and Population
MoSD	Ministry of Social Development
MoU	Memorandum of Understanding
MoWCSC	Ministry of Women, Children and Senior Citizens
NDHS	Nepal Demographic and Health Survey

NGO	Non-governmental Organisation
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPR	Nepalese Rupees
NSSD	Nursing and Social Security Division
O&M	Organisation and Management
OCMC	One-stop Crisis Management Centre
OCMC+	Advanced One-stop Crisis Management Centre
OSCC	One-stop Crisis Centre
PMD	Population Management Division
TPO	Transcultural Psychosocial Organization
TWG	Technical Working Group
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VAWG	Violence Against Women and Girls
WHO	World Health Organization

## **1. Introduction**

### **1.1 Gender-based violence**

Gender Based Violence (GBV) is a grave human rights and public health concern affecting virtually all societies. The United Nations (UN) Declaration on the Elimination of Violence Against Women (1992) defined GBV as “violence that is directed against a woman because she is a woman, or violence that affects women disproportionately. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty.” GBV occurs in private and public spaces. It is inextricably linked to the gender norms and unequal power relations between genders in society. Violence Against Women and Girls (VAWG) is one of the manifestations of this gender inequality.

GBV is a public health priority that impacts the physical and mental health of the individual survivor and her children. It includes violence against men and boys and transgender persons. In Nepal violence is most often perpetrated against women and girls. GBV reduces the survivor’s productivity and the economic well-being of her family. GBV carries a social and economic cost to society too, as survivors make increased demands on health and social services, drop out of education, and miss or underperform at work. Moreover, children who experience and witness violence in the home are more likely to experience violence or be violent perpetrators in their adult life and the harm of GBV continues.

### **1.2 GBV in Nepal**

GBV cuts across caste-ethnicity, religion and socioeconomic status and is prevalent in all geographical settings, though in different forms and magnitude, making prevention and response crucial nationwide<sup>3</sup>. The Nepal Demographic and Health Survey (NDHS, 2016) found that 22 percent of women aged 15–49 had experienced physical violence at some point since age 15, while 7 percent had experienced sexual violence. The main perpetrator of physical or sexual violence was their husband. Women’s experience of spousal violence varies by ecological zone. Close to one-third of women in the Terai (32%) experienced physical, sexual or emotional violence compared to one-fifth in Hill (20%) and Mountain (19%) areas. Divorced, separated or widowed women are more likely to have experienced spousal violence (48%) than currently married women (26%). The education level of the husband affects women’s risk of spousal violence. Forty-four percent of women whose husband has no education had experienced spousal violence compared to 14 percent of women whose husband had completed the school leaving certificate or higher. Reporting violence or seeking help is not common as survivors are reluctant to report incidents to the authorities for fear of stigmatisation, fuelling the violence and lack of support services. Two-thirds of women who have experienced any physical or sexual violence have not informed anyone or sought help.

### **1.3 Policy response to GBV**

The Government of Nepal (GoN) has taken significant steps in reforming laws and policies to combat GBV in the country. However, deeply entrenched social norms that condone VAWG persist, and multisectoral action to prevent, treat and protect survivors remains a high priority. The Constitution protects the equal rights of women, the poor, GBV survivors and other vulnerable populations. The

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<sup>3</sup> Ministry of Health, Nepal; New ERA; and ICF. 2017. Nepal Demographic and Health Survey 2016. Kathmandu, Nepal: Ministry of Health, Nepal.

2008 Domestic Violence Act defines domestic violence as “any form of physical, mental, sexual, and economic abuse perpetrated by any person to the other person with whom he has a family relationship”. This includes acts of reprimand or emotional abuse (Ministry of Law and Justice, 2009). The National Action Plan Against Gender-based Violence, 2010 and the National Strategy and Action Plan for Gender Empowerment to End Gender-based Violence 2012/13–2016/17 identify priority actions and assign responsibilities across government. The Ministry of Health and Population (MoHP) has been assigned as the executive body to implement Clause 3 of the National Action Plan Against GBV, which is to effectively provide integrated services to survivors of GBV by establishing hospital-based One-Stop Crisis Management Centres (OCMCs).

#### **1.4 OCMCs**

Prevention and response to GBV requires multisectoral action and responsibility. OCMCs are designed to follow a multisectoral and locally coordinated approach to provide GBV survivors with a comprehensive range of services, including health care, psychosocial counselling, medico-legal services, access to safe homes, legal protection, personal security and rehabilitation. The three core principles of OCMCs are: (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.

The model recognises survivors’ multifaceted needs and aims to facilitate multisectoral coordination that is responsive to those needs and ensures the security, safety and right to protection and services of GBV survivors. Located at hospitals, OCMCs coordinate services to survivors across the health system including medical, forensic, health and psychosocial care. The centre also acts as the hub for coordinating survivors and ensuring that they receive the services they need from other sectors even though the physical delivery of those services may be outside of the hospital grounds.

The multisectoral function of OCMCs is a strength and a challenge, requiring coordination and collaboration with a range of stakeholders at federal, provincial, district and municipality levels. Stakeholders include the Prime Minister’s Office, the Ministry of Women, Children and Senior Citizens (MoWCSC), Ministry of Education, Ministry of Law and Justice, Nepal Police/Ministry of Home Affairs, the National Planning Commission and National Women’s Commission, the Provincial Ministry of Social Development (MoSD) and local governments, all of whom play key roles to support the OCMCs at large.

MoHP initiated the establishment of OCMCs in 2011. Each year since, a number of new OCMCs have been established in districts where the prevalence of GBV was high based on the number of cases reported to district police and district community-based organisations. Up until the end of Fiscal Year (FY) 2018/19, 55 OCMCs had been established in 54 districts. Fourteen more OCMCs will be established in the year 2019/20. MoHP has committed to complete the scale-up of OCMCs across the country in 2020/21<sup>4,5</sup>. The integrated and specialist services included in the OCMC package, such as forensics and safe homes, has meant that OCMCs have been established at district level in district

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4 With the Prime Minister’s Office mandating the establishment of OCMCs in all 77 districts, MoHP will establish OCMCs in all 77 districts by 2020/21. However, there could be more than one OCMC per district considering the geographical location, population density and the high prevalence of GBV.

5 Integrated services for survivors are only possible at present at the district level where critical medical and forensic resources are available. It is not possible to establish OCMCs in all 753 local governments. However, all local governments have an important role to play in GBV management and are part of the OCMC framework.

hospitals (35 up until 2018/19 and 11 in 2019/20) and in referral hospitals (20 up until 2018/19 and three in 2019/20) in large metropolitan areas. While it is not feasible or appropriate to establish OCMCs in all 753 local governments, all local governments are engaged in GBV prevention and management and are part of the OCMC framework.

### **1.5 Purpose and objectives of the review**

The overall purpose of this review is to: support the MoHP in taking stock of the OCMC approach; assess OCMC use and barriers to access; review the operational challenges and opportunities within the changed governance context; and make recommendations to strengthen the delivery of OCMCs further.

The OCMCs that have been established are at different stages of readiness and capacity to support GBV survivors and contribute to GBV prevention. The transition to federalism has increased the complexity of the multisectoral approach, opening up opportunities for new collaboration while requiring OCMCs to adapt to the changed institutional landscape. Against this backdrop, the review has the following specific objectives, to:

- Assess the number of OCMCs that are functional and providing the comprehensive range of services as stated in the OCMC Operational Guidelines, 2020.
- Identify critical success factors – what is working, where and why? And what is not working well, where and why?
- Explore beneficiary perceptions of the service, and seek, if possible, perceptions of non-users to identify barriers to access and utilisation of the services.
- Identify critical gaps and areas for improvement.
- Document any good practices and lessons learned.
- Document the role of different tiers of government as per the changed context and identify how collaboration and coordination could be strengthened.
- Make recommendations for the future roadmap, including if there is a need to revise the Operational Guideline.

## 2. Methodology

### 2.1 Ministry of Health and Population leadership

The OCMC review was led by MoHP. A multisectoral TWG was formed by the MoHP Secretary. Technical support was provided by the Nepal Health Sector Support Programme (NHSSP). Coronavirus Disease 2019 (COVID-19) and the subsequent lockdown have placed demands on the ministry and government at this time such that the TWG has been unable to meet to review and finalise this report. Once the COVID-19 emergency situation passes, the TWG will reengage with the review and this report will be revised and finalised to incorporate their inputs.

### 2.2 Evidence reviewed

Table 1 below lists the evidence reviewed. This includes the national policies and technical guidelines that provide the norms and standards for how OCMCs operate, the body of evidence that has been collected by the health sector since the piloting of OCMCs in 2011, and national and international research and evidence on health system responses to violence against women.

Table 1: Key evidence reviewed

National policies, laws and guidelines	<ul style="list-style-type: none"> <li>• Constitution of Nepal</li> <li>• Domestic Violence Act, 2008</li> <li>• Approach paper of the 15th plan (2019/20–2023/24)</li> <li>• Office of the Prime Minister and Council of Ministers. <i>National Plan of Action for "Year Against Gender Based Violence, 2010"</i>. Kathmandu: Office of the Prime Minister and Council of Ministers.</li> <li>• National Health Policy, 2019</li> <li>• Health Sector Gender Equality and Social Inclusion Strategy, 2020</li> <li>• One-stop Crisis Management Center Operational Guidelines, 2020 (waiting for approval)</li> <li>• Population Division. 2014. Monitoring and Reporting Manual for One-stop Crisis Management Centres. Kathmandu: Population Division, Ministry of Health and Population, Government of Nepal</li> <li>• Gender-based Violence Clinical Protocol, 2015</li> <li>• Medico-legal Services Guidelines, 2019</li> <li>• Social Service Unit Guidelines, 2015</li> <li>• International Conventions on Elimination of All Forms of Discrimination against Women, 1992</li> <li>• National Strategy and Action Plan for Gender Empowerment to End Gender-based Violence, 2012/13-2016/17</li> </ul>
Research supported by NHSSP/UK Department for International Development (DFID)	<ul style="list-style-type: none"> <li>• MoHP, NHSSP and UNFPA. 2013. Assessment of the Performance of Hospital-based One-stop Crisis Management Centres.</li> <li>• MoHP Population Division. 2014. National Workshop on the Review and Future Direction of One-stop Crisis Management Centres.</li> <li>• MoHP Population Division and NHSSP. 2016. The Piloting of Innovative Good Practices in Nepal's Health Sector. Hospital-based Support for Victims of Gender-based Violence, One-stop Crisis Management Centres.</li> <li>• MoHP and NHSSP. 2016. Case Story of One-stop Crisis Management Centre in Dang.</li> <li>• MoHP and NHSSP. 2017. Case Study: Performance of Hospital-based One-stop Crisis Management Centres.</li> <li>• MoHP and NHSSP. 2018. Support to the rollout of Gender-based Violence Clinical Protocol in three One-stop Crisis Management Centre based hospitals that are developed as training sites.</li> <li>• MoHP. 2019. Trend Analysis of OCMCs.</li> <li>• MoHP and NHSSP. 2019. Improving hospitals' responses to survivors of Gender-based Violence in Nepal.</li> <li>• MoHP and NHSSP. 2019. Survivor perspectives on the nature, risks and response to Gender-based Violence in Nepal and the implications for One-stop Crisis Management Centres.</li> <li>• MoHP and NHSSP. 2019. You are Not Alone.</li> </ul>

Other national studies	<ul style="list-style-type: none"> <li>Office of the Prime Minister and Council of Ministers. 2012. <i>A Study on Gender-based Violence Conducted in Selected Districts of Rural Nepal</i>. Kathmandu: Office of the Prime Minister and the Council of Ministers. Available at: <a href="https://asiafoundation.org/resources/pdfs/OPMCMGECUGBVRResearchFinal.pdf">https://asiafoundation.org/resources/pdfs/OPMCMGECUGBVRResearchFinal.pdf</a> (January 2016)</li> <li>Ajit Pradhan, Pradeep Poudel, Deborah Thomas, Sarah Barnett. 2011. <i>A Review of the Evidence: Suicide Among Women in Nepal</i>. DFID, Options and UNFPA.</li> </ul>
Global reports and good practice guides	<ul style="list-style-type: none"> <li>Bell, E. and Butcher, K. 2015. DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Health Programmes – Part A, London: VAWG Helpdesk.</li> <li>Claudia Garcia-Morena et al. 2015. “The health-systems response to violence against women”. <i>The Lancet</i> 2015; 385:1567-79.</li> <li>Manuela Colombini et al. 2012. “An integrated health sector response to violence against women in Malaysia: lessons for supporting scale-up.” <i>BMC Public Health</i> 2012, 12:548</li> <li>UN Women. 2015. Essential Services Package for Women and Girls Subject to Violence. Core Elements and Quality Guidelines. <a href="https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/essential-services-package-en.pdf?la=en&amp;vs=3648">https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2015/essential-services-package-en.pdf?la=en&amp;vs=3648</a></li> </ul>

### 2.3 Mixed-methods approach

This review takes a mixed-methods approach, drawing on existing quantitative data on OCMC utilisation collected by the MoHP, mining existing secondary data related to access to and the quality of OCMC services, and primary data collection specific to the review. The specific methods are described below:

#### 2.3.1 Mining MoHP data on OCMC use

MoHP data on client use of OCMCs was mined. This data includes the sex of users, the type of violence perpetrated, the agency/department from which the survivor was referred to the OCMC (e.g. police, safe home), and the agency to which the OCMC referred the survivor.

#### 2.3.2 Mining secondary data

Two pieces of evidence pertinent to the OCMC review were mined. First, the 2019 case study “Survivor perspectives on the nature, risks and response to Gender-based Violence in Nepal and the Implications for One-stop Crisis Management Centres” included 45 case stories of survivors’ experiences of violence, their use of OCMCs and other GBV services<sup>6</sup>. The study provided the review with insight into the lived experience of violence, the barriers to accessing help faced by survivors, and the gaps in the government’s multisectoral response to violence from their perspective. The second study looked at the rollout of the Government’s GBV Clinical Protocol at hospital training sites<sup>7</sup>. This 2019 study provided evidence of the supply-side challenges faced by hospitals and staff to deliver health and psychosocial services to GBV survivors.

#### 2.3.3 OCMC self-assessment scorecard

The Revised OCMC Operational Guideline (2020) includes an OCMC self-assessment scorecard to be completed by the OCMC Case Management Committee (CMC); this is intended to stimulate reflection on performance and areas for improvement. It includes assessment against measures of (i) capacity and (ii) coordination and collaboration within the hospital and with external agencies (see Annex 3 for a list of assessment criteria). The self-assessment tool was sent to all OCMCs as part of this review, to

<sup>6</sup> NHSSP. 2019. *Survivor perspectives on the nature, risks and response to Gender-based Violence in Nepal and the Implications for One-stop Crisis Management Centres*.

<sup>7</sup> MoHP and NHSSP. 2018. *Support to the rollout of Gender-based Violence Clinical Protocol in three One-stop Crisis Management Centre based hospitals that are developed as training sites*.

gauge staff perspectives on the capacity and coordination of OCMCs. Some 50 OCMCs completed the scorecard.

#### **2.3.4 Consultations and qualitative data collection**

Consultations at the federal level were held within MoHP and with stakeholders in the MoWCSC, Nepal Police, Office of the Attorney General and the National Women's Commission. Data was collected from interviews and focus group discussions with stakeholders at each sphere of government. Two provincial governments and nine OCMCs across three provinces were the sites of qualitative data collection. This provided a deep dive into the functioning of OCMCs, the coordination mechanism and the governance context, bringing to life the challenges, opportunities and issues faced. In addition, four case studies were prepared of known OCMCs that were either functioning well or had introduced innovative practices and solutions. The OCMC case studies were undertaken at Koshi, Bharatpur, Sindhuli and Hetauda. In addition, consultations were held with Karnali Provincial Government to learn about the innovative governance arrangements being introduced for GBV and OCMCs. The rich qualitative data complemented the findings of the self-assessment scorecard and supported triangulation of findings.

Stakeholders consulted included federal and provincial ministries, elected representatives of municipalities and Ward Chairs, municipality administrative staff, Provincial Health Directorate staff, hospital management and OCMC staff, civil society organisations, including survivor networks, and a small number of OCMC service users. See Annex 1 for a full list of stakeholders consulted.

Table 2: Snapshot of stakeholders consulted

<b>Federal Government of Nepal</b>		
MoHP; MoWCSC; Nepal Police; Office of the Attorney General; National Women Commission		
<b>Province #2</b>	<b>Province #5</b>	<b>Sudurpashchim Province</b>
<b>Provincial MoSD</b>		<b>Provincial MoSD</b>
<b>Kalaiya Hospital and stakeholders:</b> OCMC; Kalaiya Sub-Metropolitan City; District officials; Police	<b>Taulihawa Hospital and stakeholders:</b> OCMC; District Attorney, Kapilvastu Municipality; Safe home; Civil Society Organisations (CSOs) combating GBV	<b>Mahakali Hospital and stakeholders:</b> OCMC; Kanchanpur District; Police; Safe home and rehabilitation; Bhimdatta Municipality
<b>Janakpur Provincial Hospital and stakeholders:</b> OCMC; CMC; District Coordination Committee	<b>Bheri Hospital and stakeholders:</b> OCMC; Nepalgunj Sub- Metropolitan City; Safe home and rehabilitation	<b>Seti Provincial Hospital and stakeholders:</b> OCMC; Safe home and rehabilitation; Dhangadhi Sub-Metropolitan City
<b>Gajendra Narayan Singh (GNS) Hospital and stakeholders:</b> OCMC; Police; Rajibiraj Municipality; District officials; Safe home		
<b>Gaur Hospital and stakeholders:</b> OCMC; Gaur Municipality; District officials; Police		
<b>OCMC Case studies: Bharatpur, Hetauda, Koshi and Sindhuli</b>		
<b>Other stakeholders</b>		
Karnali: Provincial MoSD; Surkhet Provincial Hospital; Birendranagar Municipality; NGOs		
Development Partners: UNFPA, UNICEF, ADB, FPAN, CMC-Nepal, CVICT, TPO, Manav Sewa Ashram, Koshish		
Experts: Dr Harihar Wosti, Forensic Expert, Institute of Medicine, Tribhuvan University Teaching Hospital, Kathmandu		

### **3. International Evidence and Guidance**

#### **3.1 International guidance**

The World Health Assembly adopted a resolution in 2014 to strengthen the role of the health system in responding to VAWG, and against children<sup>8</sup>. The resolution included ensuring that all people at risk and/or affected by violence have timely, effective, and affordable access to health services, including health promotion, curative, rehabilitation and support services that are free of abuse, disrespect and discrimination. It urged member states to develop an effective, national multisectoral response to violence and its prevention and ensure the health system engaged with other sectors such as education, justice, social services and women's affairs. The resolution noted the importance of enhancing the capacities of health and other care workers to identify and provide care and support to survivors through continuing education and by strengthening standard operating procedures.

#### **3.2 Strengthening health systems to respond to GBV**

The social norms and power relations that perpetuate GBV impact the agency and ability of survivors to seek help. They also pervade health systems, the attitudes of health staff and the readiness of health providers to provide care and support. Where social norms and gender roles are rigid, violence against women may be seen as acceptable by male and female health staff and influence conscious or unconscious discrimination against survivors in the health setting. The biomedical model prevalent in most health systems leads health providers to focus on the physical rather than the underlying and emotional consequences of violence experienced by survivors. It may also lead health professionals to perceive GBV-related injuries as a social problem rather than a clinical or health problem and discount GBV as a health sector priority; such mindsets are invisible barriers to integrating the response to GBV into the health system.

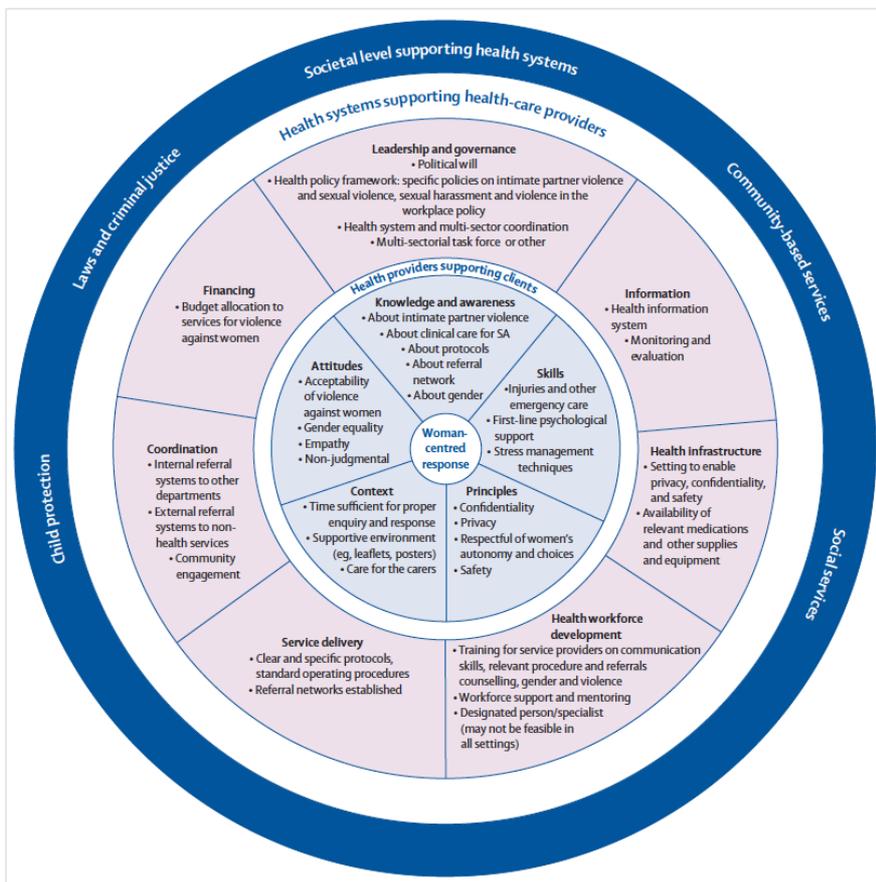
At a minimum, health care professionals need to know how to identify patients experiencing intimate partner violence and provide first-line supportive care, including empathetic listening, ongoing psychological support, referral to other services and comprehensive post-rape care for sexual assault victims. This requires training, supervision and mentoring of health staff to equip them with the skills and non-judgemental attitudes to provide compassionate care, and the provision of standard operating procedures from national agencies. However, systemic constraints common in low- and middle-income countries – such as limited staffing, capacity gaps and lack of forensic and counselling skills in the system, poor coordination within health facilities and weak referral systems out, weak leadership and management, and budget constraints – coalesce to inhibit the capacity of the health system to support these basic norms.

Countries have taken different pathways to addressing GBV within health settings. High-income countries have often established standalone facilities for survivors (such as rape crisis centres) while low- and middle-income countries have tended to adopt more integrated approaches (such as one-stop services) conducive to more resource-constrained environments<sup>9</sup>. There is no one model that works for all health systems; rather, the global consensus is that countries need to develop approaches that fit with the health system, and work towards a comprehensive response to GBV that includes

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<sup>8</sup> World Health Assembly, 24 May 2014, WHA 67.15, Agenda item 14.3.

<sup>9</sup> Claudia Garcia-Morena et al. 2015. "The health-systems response to violence against women". *The Lancet* 2015; 385:1567-79.



multisectoral and multi-level coordination across government spheres<sup>10</sup>. Evidence shows that integration of GBV into health systems is slow and incremental and requires all elements of the health system to respond to GBV.

The systems framework developed by Garcia-Morena et al (2015) shows the ecosystem necessary to support the delivery of women-centred, safe, effective and compassionate health care to survivors. It provides a structure for reviewing how the health system is enabling health providers to deliver client-centred,

safe and effective care and how the health system coordinates and works with other sectoral services to provide essential multisectoral support to survivors. This provides a useful framework for reviewing how the health system is enabling the functionality of OCMCs in Nepal and identifying critical gaps.

Figure 1: Health system response to violence against women developed by Garcia-Morena et al, 2015.

### 3.3 Service delivery and one-stop crisis models

The choice of health service delivery model for responding to GBV depends on the availability of human resources, funding and referral services<sup>11</sup>. The World Health Organization (WHO) recommends that, as much as possible, care for women experiencing intimate partner violence and sexual assault should be

**Lessons from One-stop Crisis Centres (OSCCs) in Malaysia**

Important to:

- g to ensure they have a clear understanding of what to do
- Make changes to care structures to ensure designated OSCC staff have sufficient time to implement the procedures
- Provide privacy, whether linked to a specific OSCC room or not
- Give policy commitment and priority to GBV to support the production of data on violence and its inclusion in health indicators and give the issue visibility at the service delivery level
- Enable replication by building flexibility into the OSCC model and health system to allow adaptation to different types of facilities and levels of care, and according to available resources.

<sup>10</sup> Bell, E. and Butcher, K. (2015) DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Health Programmes – Part A, London: VAWG Helpdesk.

<sup>11</sup> World Health Organization. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization, 2013.

integrated into primary health care services to increase access.

Although there is limited evidence of effectiveness, Garcia-Morena et al (2015) note that one-stop service models are increasingly promoted in low- and middle-income countries. Malaysia has been a pioneer of hospital-based OSCCs. Colombini et al (2012) found that the experience of scaling up OSCCs in Malaysia varied according to the organisational context. Constraints included: lack of dedicated staffing; time pressures on staff, which lowered the quality of interaction with clients and affected staff ability to identify GBV cases and their need for referral to specialist support; and insufficient training. Coordination within hospitals and with external agencies was also sub-optimal in places. This was especially so at lower-level hospitals without in-house specialists, and resulted in fragmented services and delays and the need for ‘many stops’ rather than the ‘one-stop’ service possible in higher-level hospitals. In places where partner agencies such as Non-governmental Organisations (NGOs) were not available to provide shelter and protection, some hospitals chose to admit women on wards to keep them safe.

The researchers found health staff to be empathetic and sensitive to the needs of women. However, providers that focused on the physical aspect of the injury minimised the underlying problem and ignored the emotional care of patients. Providers felt this was due to a feeling of inadequacy and feeling undertrained and unsupported to help women with the non-physical aspects of their injury; this was especially the case at lower-level district hospitals. The lack of political priority given to violence against women and the prioritisation of other competing health demands also left the OSCC invisible in the system.

Colombini et al conclude that the Malaysia experience highlights the importance of a systems approach to strengthening GBV services and the need to adapt the service delivery model to the setting and resources rather than applying a standard approach across the country and to different levels in the health system<sup>12</sup>. These are important findings that we will return to in the review of Nepal’s OCMC experience.

### **3.4 Taking a rights-based approach**

GBV is rooted in gender inequality and the abuse of women’s and girl’s human rights. International experience illustrates that political will and leadership to confront GBV that is anchored in an understanding of gender inequality and rights more broadly provides greater weight to GBV initiatives than those that are disconnected from the causes, and widespread consequences, of gender inequality<sup>13</sup>. Interventions addressing VAWG are more effective when they prioritise women’s needs and rights, are accountable to women, and include women’s empowerment and rights as both means and ends in themselves<sup>14</sup>. This has important implications for how services are delivered to survivors, survivor participation in design and decision-making of GBV services, and the cultural and systems-level changes needed to underpin rights-based approaches.

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<sup>12</sup> Manuela Colombini et al. 2012. “An integrated health sector response to violence against women in Malaysia: lessons for supporting scale-up.” *BMC Public Health* 2012, 12:548

<sup>13</sup> Claudia Garcia-Morena et al. 2015. “The health-systems response to violence against women”. *The Lancet* 2015; 385:1567-79.

<sup>14</sup> Bell, E. and Butcher, K. 2015. DFID Guidance Note on Addressing Violence Against Women and Girls (VAWG) in Health Programmes – Part A, London: VAWG Helpdesk

## 4. One-Stop Crisis Management Centres

This chapter presents the key steps that the government has taken to establish and strengthen OCMCs from their piloting in 2011 to date. It describes the challenges and constraints that have been documented during this time period, and lays the ground for the current strategic review.

### 4.1 The evolution of OCMCs

Following the instructions of the National Action Plan Against Gender-Based Violence, 2010, MoHP initiated the piloting of OCMCs in seven districts in 2011. By the end of the pilot in 2015, 35 OCMCs had been established and various capacity-building and evaluative exercises had been undertaken to identify gaps and ongoing development. Each year an annual review of performance was undertaken by the ministry. This routine exercise was supplemented in 2013 by an independent performance assessment, a 2016 Good Practice Paper, and in 2017 by a case study that investigated the comparative strengths and weaknesses of OCMCs in a sample of disaster- and non-disaster-affected districts.

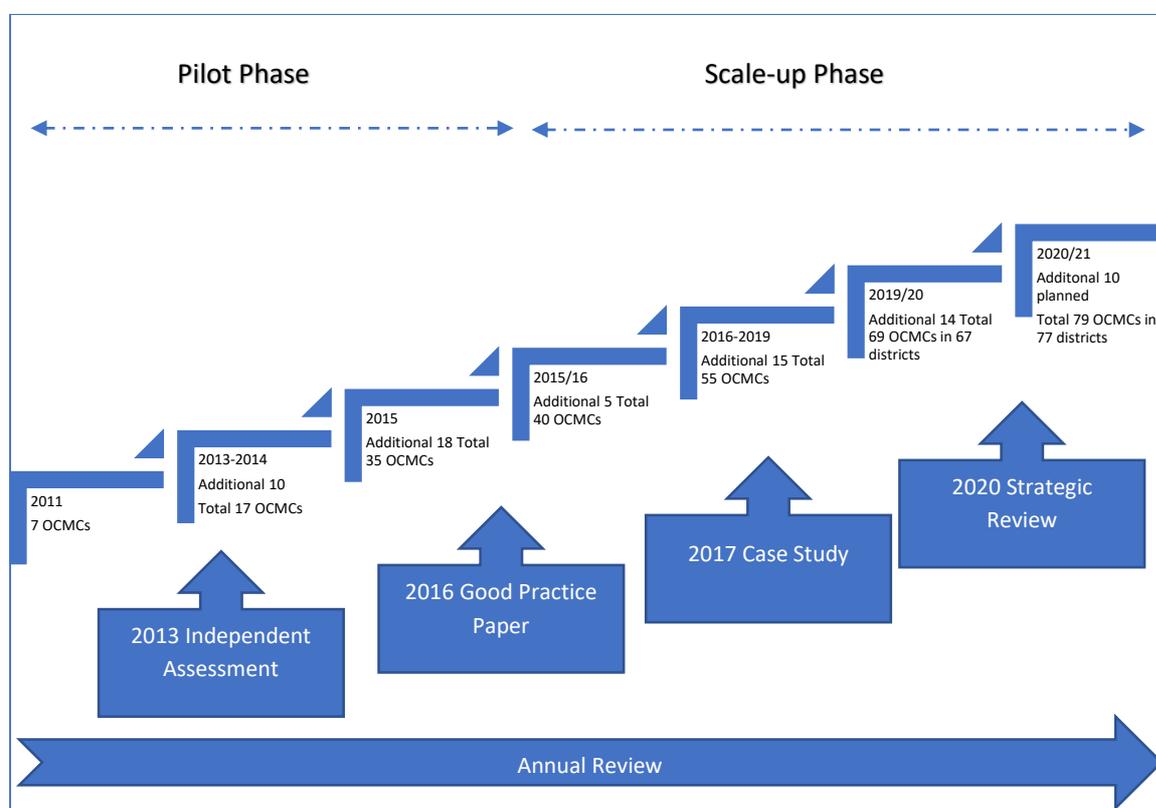


Figure 2: Scaling up and evidence base timeline

### 4.2 Conditions and bottlenecks that affect the functioning of OCMCs

A robust understanding of progress and gaps in the implementation and management of OCMCs has been generated since their introduction. Three sets of conditions have undermined the functionality and responsiveness of OCMCs to provide high-quality care to survivors of violence. They relate to the (i) sociocultural environment, which impacts survivor access to care, (ii) the health system, and (iii) the multisectoral nature of the OCMC model. Studies have shown how the social norms that normalise VAWG, stigma that punishes the survivor, and low awareness of rights and services curtail help seeking. Common health system gaps have been identified, including inadequate infrastructure,

insufficient availability of staff, weak capacity to deliver core services such as forensics and psychosocial counselling, poor coordination within the hospital and with multisectoral agencies that make up the OCMC network, inconsistent reporting and poor quality and use of data, and funding gaps. The structural challenge of multisectoral coordination within government systems and common resource and capacity constraints across sectors have affected the functioning of OCMCs.

Table 3: Conditions and constraints that undermine demand, functionality and quality of OCMC services

Conditions	Constraints
Access to care	<ul style="list-style-type: none"> <li>• Social stigma that punishes the survivor</li> <li>• Social norms that normalise VAWG</li> <li>• Fear help-seeking will escalate violence</li> <li>• Women's lack of financial autonomy and opportunities to be financially independent</li> <li>• Lack of information on rights and services available</li> </ul>
Health system	<ul style="list-style-type: none"> <li>• Lack of staff and challenges related to contracting</li> <li>• Inadequate health provider skills especially medico-legal and psychosocial counselling</li> <li>• Infrastructure gaps</li> <li>• Budget limitations</li> <li>• Poor coordination within the hospital and linkages/referral to other health facilities and non-health services</li> <li>• Weak and compromised hospital leadership</li> </ul>
Multisectoral coordination and collaboration	<ul style="list-style-type: none"> <li>• Sub-optimal ownership of OCMCs by non-health sectors (police, safe home, women development, legal aid, rehabilitation)</li> <li>• Systemic weaknesses in multisectoral coordination at all levels of government</li> <li>• Capacity and budget constraints in all service-providing agencies</li> <li>• Absence of common plans, protocols and systems to formalise coordination</li> </ul>

Strategic reviews and monitoring data have shown improvements over time at some individual OCMCs. However, these positive developments have also been found to be fragile, and changes in key personnel, be it hospital leadership, OCMC Focal Points or Women Development Officers, have reversed improvements in performance. See Annex 2 for key findings and recommendations from the 2016 Good Practice Paper and the 2017 Case Study.

### 4.3 Health system strengthening of OCMCs

MoHP has been incrementally providing inputs to strengthen the systems and capacity of OCMCs in response to monitoring, evaluation and learning. Table 4 shows enabling factors and inputs to the progressive development of OCMCs.

Table 4: Enabling factors and progressive capacity development of OCMCs

Health system building blocks	Enabling factors and progressive capacity development of OCMCs
Leadership and governance	<ul style="list-style-type: none"> <li>• Policies and laws: Constitution; Domestic Violence Law, 2008; National Action Plan Against Gender-based Violence, 2010; National Strategy for Gender Empowerment to End Gender-based Violence 2012; Nepal Health Sector Strategy 2016–2020; Gender Equality and Social Inclusion Strategy of the Health Sector 2009; Gender-responsive Budget Directives 2020; Medico-Legal Service Guidelines 2019.</li> <li>• Leadership and multisectoral coordination led by the Office of the Prime Minister and Council of Ministers since 2010.</li> <li>• MoHP, OCMC Operational Guidelines, 2011 and revised in 2016 and 2020.</li> </ul>

Information and evidence	<ul style="list-style-type: none"> <li>• For policy: NDHS 2011 and 2016.</li> <li>• Annual Reviews of OCMCs led by Population Division.</li> <li>• Piloting of OCMCs from 2011–2015.</li> <li>• Independent performance reviews in 2013 and 2017.</li> <li>• Reporting of services provided to GBV survivors: reporting standardised and strengthened through introduction of the GBV Clinical Protocol, 2015.</li> </ul>
Health infrastructure	<ul style="list-style-type: none"> <li>• OCMC Guideline (2016) and GBV Clinical Protocol (2015) include a standard of three rooms per OCMC. One dedicated for psychosocial counselling, one for admission and one to serve as an office.</li> </ul>
Staffing and health provider capacity building	<ul style="list-style-type: none"> <li>• Orientation of OCMC staff on establishment of each OCMC.</li> <li>• Minimum staffing of one doctor and two staff nurses. Practically this has been a nominated doctor from the existing hospital staff who is the Coordinator of the CMC, one staff nurse from existing permanent staff as the Chief or Focal OCMC and one staff nurse dedicated to OCMC hired on contract basis.</li> <li>• Five-day basic psychosocial counselling training and six-month psychosocial counselling training provided since 2012 to hospital staff by MoHP and NHSSP. Up until 2018, counselling training (both basic and six-month duration) provided to safe home staff from Department of Women Children and Senior Citizens and UNFPA.</li> <li>• GBV Clinical Protocol training. Training sites established in three hospitals in 2018, and rollout via training of trainers and step-down provision of on-the-job training to health providers in hospitals and health centres. Since 2018/19, 99 health providers trained. National Health Training Centre (NHTC) and partners (UNFPA and Plan Nepal) have also provided the same training package in a further 15 hospitals.</li> <li>• Eighteen-day combined autopsy and clinical medico-legal training of medical doctors started in 2018/19.</li> <li>• Five-day GBV medico-legal training of at least one doctor from each hospital and two to three from a referral hospital. In 2018/19, 210 doctors trained and in 2019/20, 136 doctors trained up until February 2020.</li> <li>• Orientation on GBV and OCMCs included in health provider induction training and academic curricula of nursing at Tribhuvan University Teaching Hospital.</li> </ul>
Service delivery and guidelines and protocols	<ul style="list-style-type: none"> <li>• OCMC Operational Manual revised in 2016 and 2020 (submitted to MoHP Secretary and waiting for approval).</li> <li>• Annual revision of Annual Work Plan and Budget (AWPB) OCMC guidelines.</li> <li>• GBV Clinical Protocol, 2015.</li> <li>• Medico-legal Service Guidelines, 2019.</li> <li>• 24-hour service delivery.</li> </ul>
Multisectoral coordination	<ul style="list-style-type: none"> <li>• Participation of OCMC multisectoral stakeholders in OCMC orientations.</li> <li>• CMC at each OCMC: multisectoral committee to facilitate case management.</li> <li>• GBV Management Coordination Committee: multisectoral coordination body for the OCMC at district level.</li> <li>• District Coordination Committee (DCC): The elected constitutional body at the district responsible for coordinating the local governments in the district. All the Mayors and Deputy Mayors are members of district council; this council elects the DCC.</li> </ul>
Financing	<ul style="list-style-type: none"> <li>• Federal conditional grant for OCMCs sent direct to 21 federal hospitals and channeled via provinces for 41 OCMCs in 2019/20.</li> <li>• Karnali provincial government provided funding to establish an additional six OCMCs to those funded by federal conditional grant in 2019/20.</li> <li>• Sudurpashchim provincial government provided funding for one additional OCMC and top-up funding to seven OCMCs funded by federal conditional grant in 2019/2020.</li> <li>• President's Special Fund for 21 safe homes in 2019/20.</li> </ul>

#### **4.3.1 Key revisions introduced by the OCMC Operational Manual (2020)**

To prepare the ground for the changed context, the OCMC Operational Manual was revised in 2020; this has been submitted to the MoHP Secretary and is waiting for approval. The revised manual has made provision for a GBV Advisory Committee, chaired by the District Coordination Chair. It includes Deputy Mayors as members and the District Coordination Officer as Secretary of the committee. This is a political body.

Other key changes introduced are:

- Minimum service standard criteria
- Referral mechanism and guidelines to refer clients to higher-level health services
- Scope to extend OCMCs to private teaching hospitals and community hospitals
- Provision of GBV survivors' network
- Roles and responsibilities of CMC, including monthly meeting
- Introduction of the OCMC self-assessment scorecard
- Provision of OCMC exchanges for learning and capacity enhancement.

## 5. Utilisation of OCMCs

This section of the report analyses utilisation of OCMCs, including the type of violence survivors have experienced. It also estimates the proportion of clients served at OCMCs against the estimated number of women seeking help for GBV.

### 5.1 Analysis of OCMC utilisation data

The number of OCMCs has increased from seven in 2011/12 to the planned 69 by the end of FY 2019/20. MoHP data extracted in March 2020 shows that the total annual number of OCMC clients has increased from 187 in 2011/12 (based on seven reporting facilities) to 6,992 in 2018/19 (based on 45 reporting facilities): see Table 5. In the first half of 2019/20, 4,075 clients have been served; this is an increase on the equivalent number in the first half of 2018/19 (see Figure 4). It is to be noted that there are gaps in the data due to non-reporting of some OCMCs. Comparison against expected numbers, based on NDHS, is in section 5.2.

*Table 5: Total number of OCMC clients by year and number of reporting hospitals*

Year	Total # clients	# hospitals reported data
2011/12	187	7
2012/13	545	12
2013/14	1,049	14
2014/15	1,730	15
2015/16	2,004	17
2016/17	2,924	22
2017/18	4,372	37
2018/19	6,992	45
2019/20 first half	4,075	52

Figure 3: Number of OCMC clients by year from 2068/69 to 2075/76

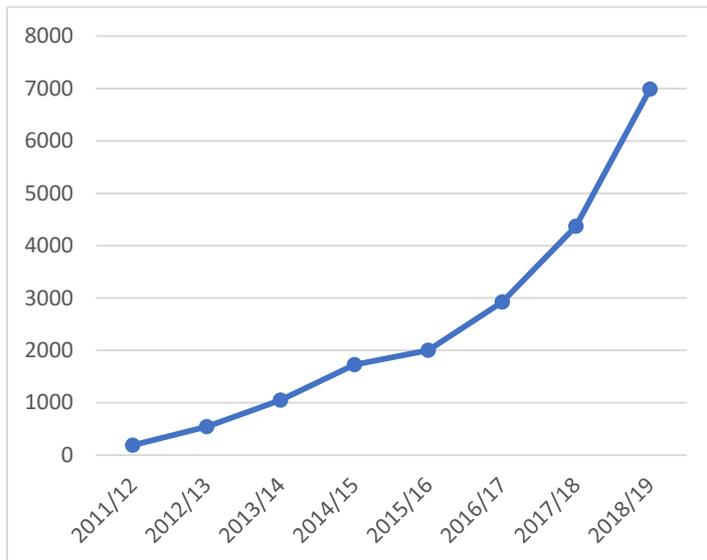
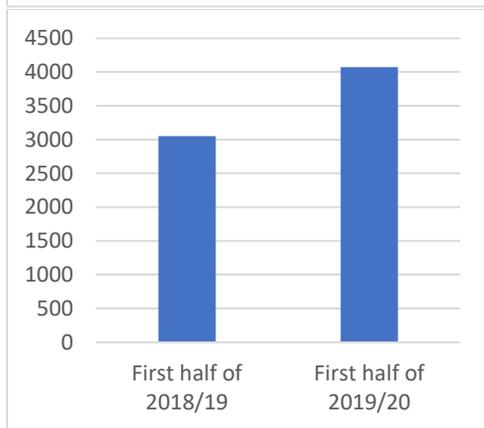
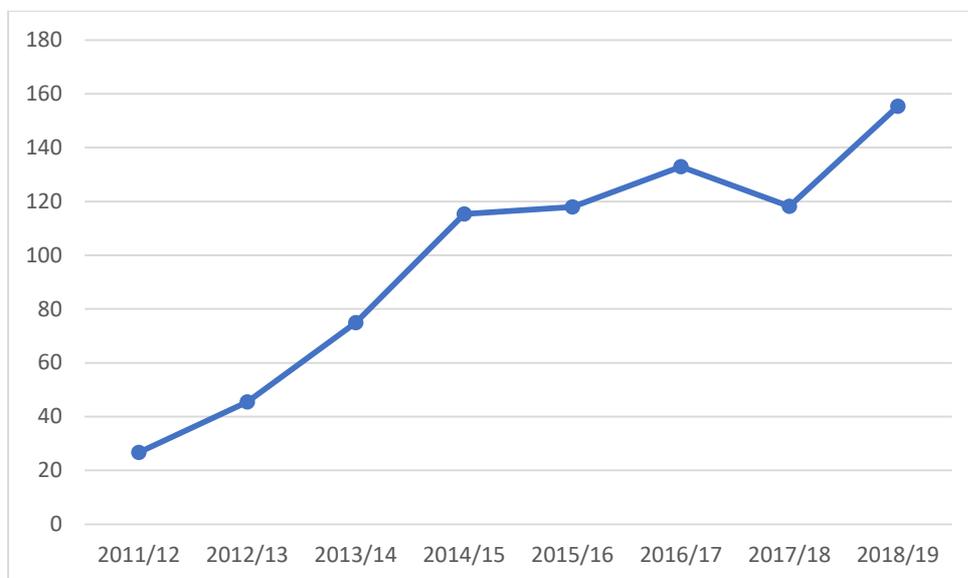


Figure 4: Number of OCMC clients for first half of 2018/19 and 2019/20



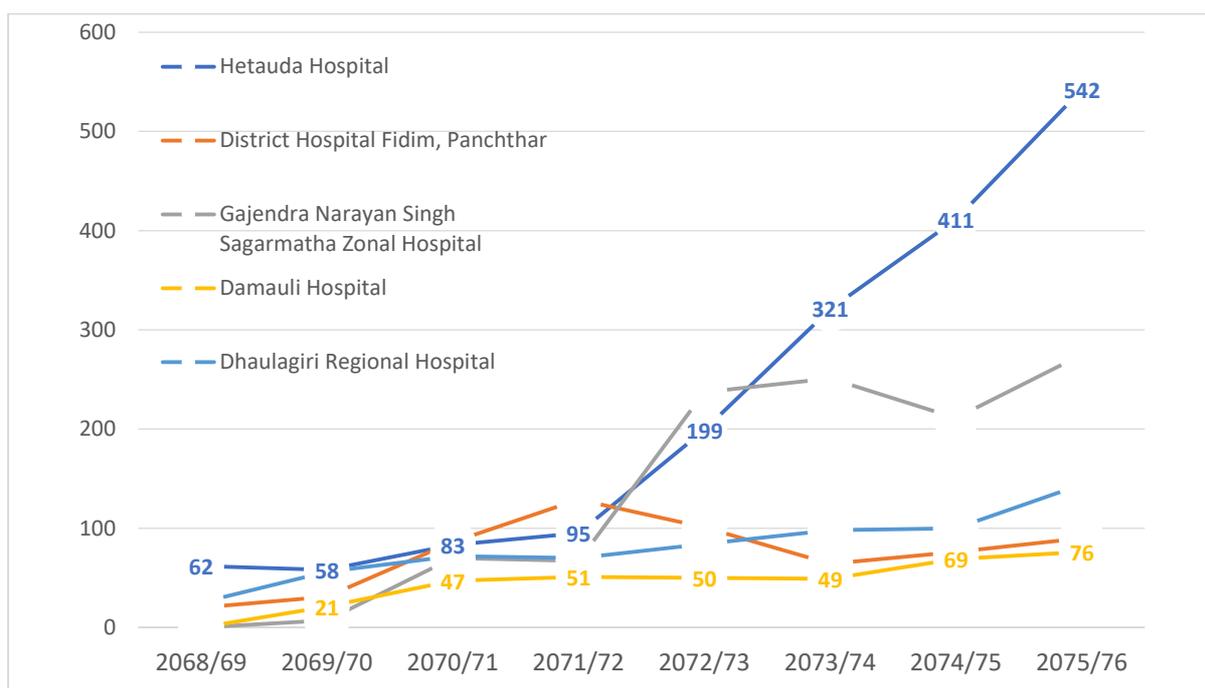
Women make up the overwhelming majority of OCMC clients, representing over 90 percent of clients. The average number of clients served per OCMC has increased over time. This reflects increasing capacity of OCMCs with the introduction of the GBV Clinical Protocol in 2015, revision of the OCMC Operational Manual in 2016 and the introduction of psychosocial counselling training in 2012/13 and medico-legal training in 2018/19. Increased awareness of OCMCs by survivors may have contributed to this increase though is likely to be small given findings from the Survivor Study (2019).

Figure 5: Average number of clients per OCMC by year



Significant diversity in the readiness and use of OCMCs is well known. Figure 6 presents annual client use at five OCMCs that have been operational since 2011/12 and reflects this diversity. Gajendra Narayan Singh hospital (Saptari district) and Hetauda hospital (Makawanpur district) both are highly populated districts compared to other 3 districts. Gajendra Narayan hospital is located in Terai and Hetauda hospital is located at hill. The variation of the cases is due to the population, socio-cultural factor, number of partners working on GBV issues and leadership and initiatives taken by the OCMC focal and hospital chief. OCMCs of Hetauda and Gajendra Narayan hospitals are very active and visible. They possess active multi-sectoral coordination with partners, focal persons are dedicated, hospital chiefs are supportive including effective coordination within the hospital. Initially, Phidim (Panchthar) was active due to similar reasons.

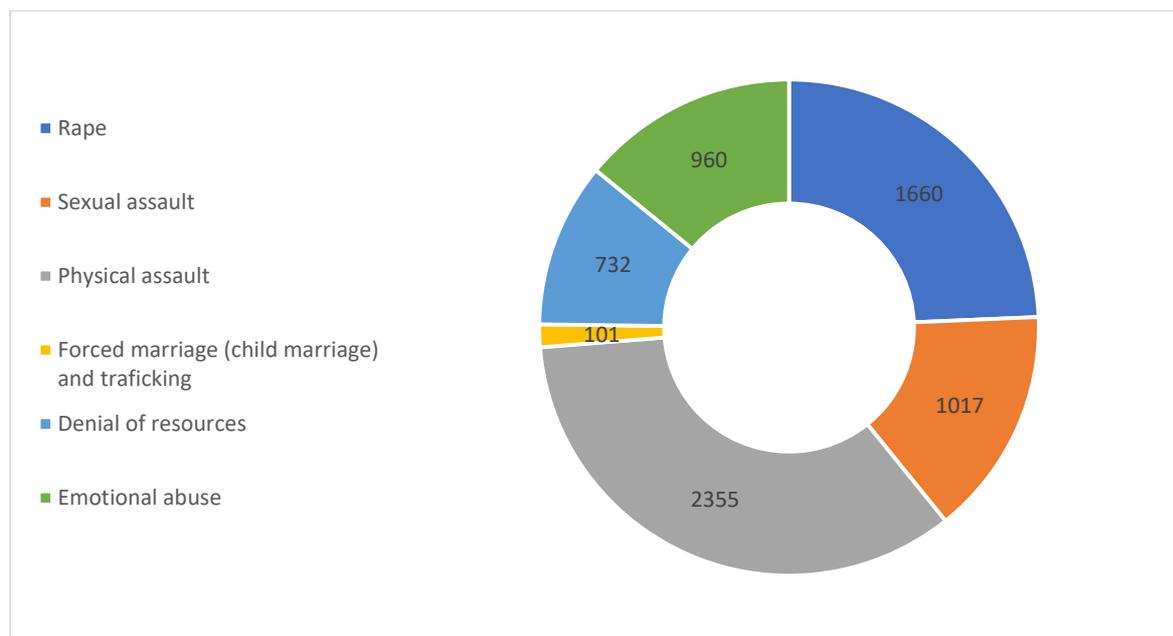
Figure 6: Total number of clients by year at five OCMCs operational since 2011/12 to 2018/19



### 5.1.1 Type of violence

Recording of the type of violence experienced by clients was introduced during the OCMC pilot period. Using 2018/19 as the fullest year of reporting to date, we see that physical assault, sexual assault and rape make up 72 percent of all cases. Rape and sexual assault together are 38 percent of all cases, and physical assault is 34 percent.

Figure 7: Type of violence recorded for all OCMC cases in 2018/19



The heavy weighting of cases resulting from physical and sexual violence rather than emotional abuse is not surprising: prevailing social norms legitimise male control and acceptability of husbands using violence against wives, and 66 percent of women aged 15–49 that have ever experienced any type of physical or sexual violence have never sought help or told anyone<sup>15</sup>. Survivor accounts suggest it is only when violence is severe and injuries require medical attention that medical help is sought. Moreover, that decision itself is often made by neighbours, family and the police, rather than the survivor herself. The barriers to accessing care are discussed further below.

### 5.1.2 Client referral

Figure 8 shows from where clients were referred to OCMCs in the first half of 2019/20. The police refer the most clients to OCMCs in each province. In Provinces 2, 4 and 5, health service providers are the second most common source of referral to the OCMC but in the other provinces this is the women themselves or relatives.

<sup>15</sup> NDHS 2016 found that 29 percent of women and 23 percent of men believe that a husband is justified in beating his wife in at least one of five specified situations.

Figure 8: Referral of clients to OCMCs by province, first half of 2019/20

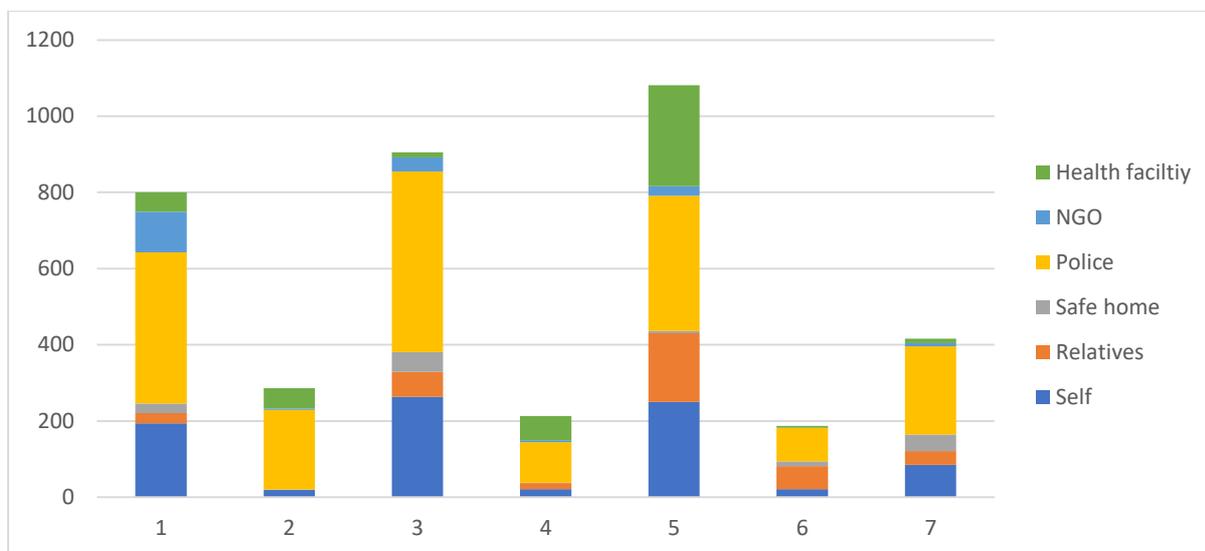
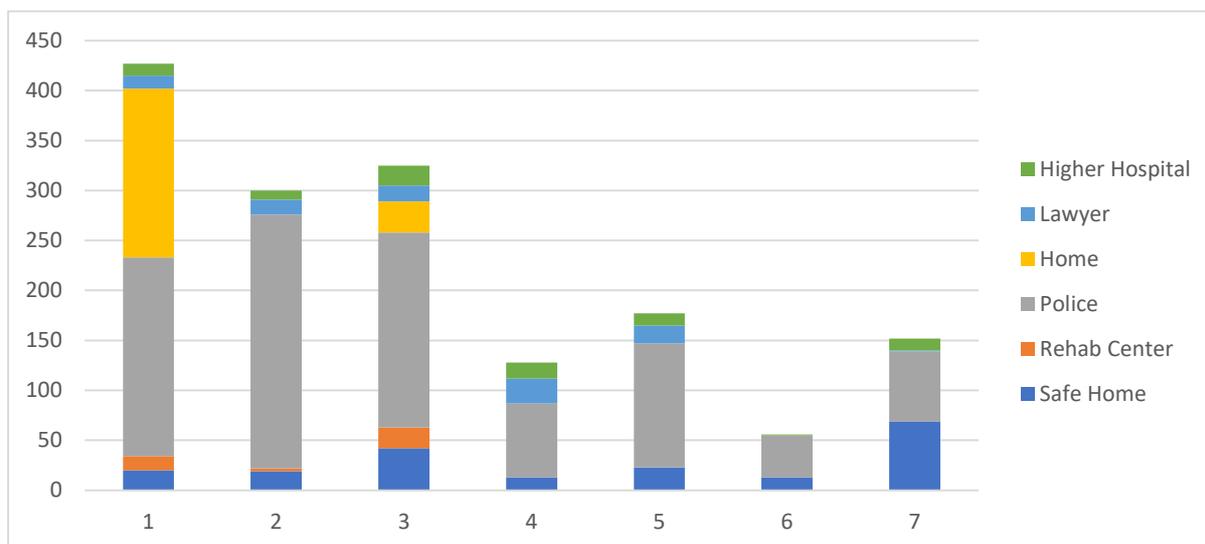


Figure 9 shows the setting to which clients were referred after receiving care at the hospital for the same period in 2019/20. Only 40 percent of clients were recorded as being referred to a destination after treatment. This may reflect poor recording or that OCMC staff were not with the client when discharged or in a position to record where they went after hospital. Bearing this in mind, it is not surprising that most of the cases where referral was recorded was to the police as this would have required completion of documentation.

Figure 9: Referral of clients from OCMCs by province, first half of 2019/20



## 5.2 Clients served at OCMCs against estimated number of women seeking help for GBV

The number of cases of physical and sexual violence that are reported to any service provider in Nepal is a small proportion of actual occurrence. NDHS 2016 provides the most accurate estimate of the prevalence of physical and sexual violence experienced by women, though this itself may be an underestimation given the risk that women underreport out of shame and fear<sup>16</sup>. The survey found

<sup>16</sup> See World Bank Policy Research Paper 8044. 2017. Under-reporting of Gender-based Violence in Kerala, India. An Application of the List Randomization Method. <http://documents.worldbank.org/curated/en/233811493218846386/pdf/WPS8044.pdf>

that 9.1 percent of women aged 15–49 had experienced physical violence and 3.3 percent sexual violence in the past 12 months, with variation by province.

We used NDHS 2016 data to calculate a crude estimate of the number of women aged 15–49 who experienced sexual and physical violence in a 12-month period, by province. First, estimates of the female population aged 15–49 in each province were calculated using data from the Central Bureau of Statistics (CBS)<sup>17</sup>. These estimates were taken from Census 2011 data; CBS has not published more recent population data. While the data is some years out of date, it is sufficient for the crude estimation of this study. Second, we calculated the number of women aged 15–49 per province who are likely to have experienced physical or sexual violence in a 12-month period using the findings from NDHS 2016. See Table 6 below.

*Table 6: Estimation of the number of women aged 15–49 experiencing physical or sexual violence in 12-month period by province*

Province	Estimated number of women aged 15–49	NDHS 2016: percentage of women (15–49) reported physical violence in past 12 months	Estimated number of women (15–49) experienced physical violence in past 12 months	NDHS 2016 percentage of women (15–49) reported sexual violence in past 12 months	Estimated number of women (15–49) experienced sexual violence in past 12 months	Estimated number of women (15–49) experienced physical or sexual violence in past 12 months
Province 1	1,231,572	7	86,210	2.6	32,021	118,231
Province 2	1,396,828	14.3	199,746	3.2	44,698	244,445
Province 3	1,446,546	8.5	122,956	2.2	31,824	154,780
Province 4	682,733	5.1	34,819	2.3	15,703	50,522
Province 5	1,226,657	10	122,666	5.3	65,013	187,679
Province 6	417,297	7	29,211	5.4	22,534	51,745
Province 7	694,008	7	48,581	3.3	22,902	71,483
<b>TOTAL</b>	<b>7,095,641</b>	<b>9.1</b>	<b>644,189</b>	<b>3.3</b>	<b>234,695</b>	<b>878,885</b>

NDHS 2016 found that 22 percent of women aged 15–49 who had ever experienced physical or sexual violence sought help at some time. It does not provide an estimate of help-seeking in a 12-month period. We used this figure as a reasonable value to estimate the number of women experiencing physical or sexual violence who sought help in a 12-month period. To estimate how well OCMCs reach women seeking help for physical or sexual violence, we calculated the number of OCMC clients as a percentage of the estimated number of women seeking help. We chose to use OCMC data from 2018/19 because it is the most recent OCMC data covering a 12-month period and has the largest number of clients treated in that time period. The year does not correspond to the CBS data but given the crude nature of these estimations, provides a more reliable picture than using 2011/12 data when only seven OCMCs were reporting.

The result is shown in Table 7. OCMCs provide services to a very small percentage of the estimated number of women who seek help when they experience physical or sexual violence. Coverage varies

<sup>17</sup> <https://nepalindata.com/resource/excel-distribution-household-and-population-sex-province-and-type-local-unit/>

by province but the headline message is that coverage is extremely low and there is much more for the government to do to improve survivors' access to services.

*Table 7: Crude estimate of OCMC clients as a percentage of estimated number of women seeking help by province*

Province	Estimated number of women experiencing physical or sexual violence who sought help based on a rate of 22%	Total number of OCMC cases by province in 2018/19	OCMC clients as a percentage of number of estimated women seeking help
Province 1	26,011	1,196	4.60
Province 2	53,778	477	0.89
Province 3	34,052	2,366	6.95
Province 4	11,115	381	3.43
Province 5	41,289	1,622	3.93
Province 6	11,384	269	2.36
Province 7	15,726	681	4.33
<b>TOTAL</b>	<b>193,355</b>	<b>6,992</b>	<b>3.62</b>

## 6. Key Findings of the Review

This section of the report is divided into four sections:

- Stocktaking of OCMC functionality based on the OCMC self-assessment scorecard
- Key issues and findings related to OCMC performance
- Survivor perspectives and barriers to access
- Summary of promising and good practices.

### 6.1 Stocktaking of OCMC functionality

The OCMC self-assessment scorecard was completed by 50 OCMCs in March 2020; five did not provide data on time and another seven are in the process of being established. The scorecard was completed by the CMC or OCMC staff themselves if a committee meeting could not be arranged. External validation of the scoring has not been undertaken and in the light of the COVID-19 situation will not be possible in the short term. The possible inflation of scores by staff needs to be factored into interpretation of the findings. Triangulation of the scores in the sites where qualitative data was collected suggests scores are a more accurate reflection of the situation in OCMCs that have capacity and are performing well.

The scorecard includes 18 indicators that were scored on a scale of one to four, with four being the highest. Ten indicators relate to capacity of the hospital to deliver OCMC services and eight to the quality of coordination and collaboration of the OCMC within the health service and with external agencies.

#### 6.1.1 OCMC scorecard results

For management purposes, the MoHP set an aggregate score of 75 percent as a marker of acceptable functioning; this was not conveyed to the OCMCs to avoid influencing the scoring. Out of 50 OCMCs that reported, 36 scored 75 percent or above.

*Table 8: Overview of OCMC self-assessment scores*

Province	Total number of OCMCs including those recently or in the process of being established and non-functional	Number of OCMCs completed scorecard	Number of OCMCs scored 75% and above
Province 1	11	10	6
Province 2	8	6	4
Province 3	13	10	8
Province 4	7	6	3
Province 5	11	9	7
Province 6	4	2	1
Province 7	8	7	7
<b>TOTAL</b>	<b>62</b>	<b>50</b>	<b>36</b>

**At the aggregate level** for all 50 OCMCs, the total score of health service capacity indicators is higher than the total score of coordination and collaboration.

The two indicators with the highest scores are:

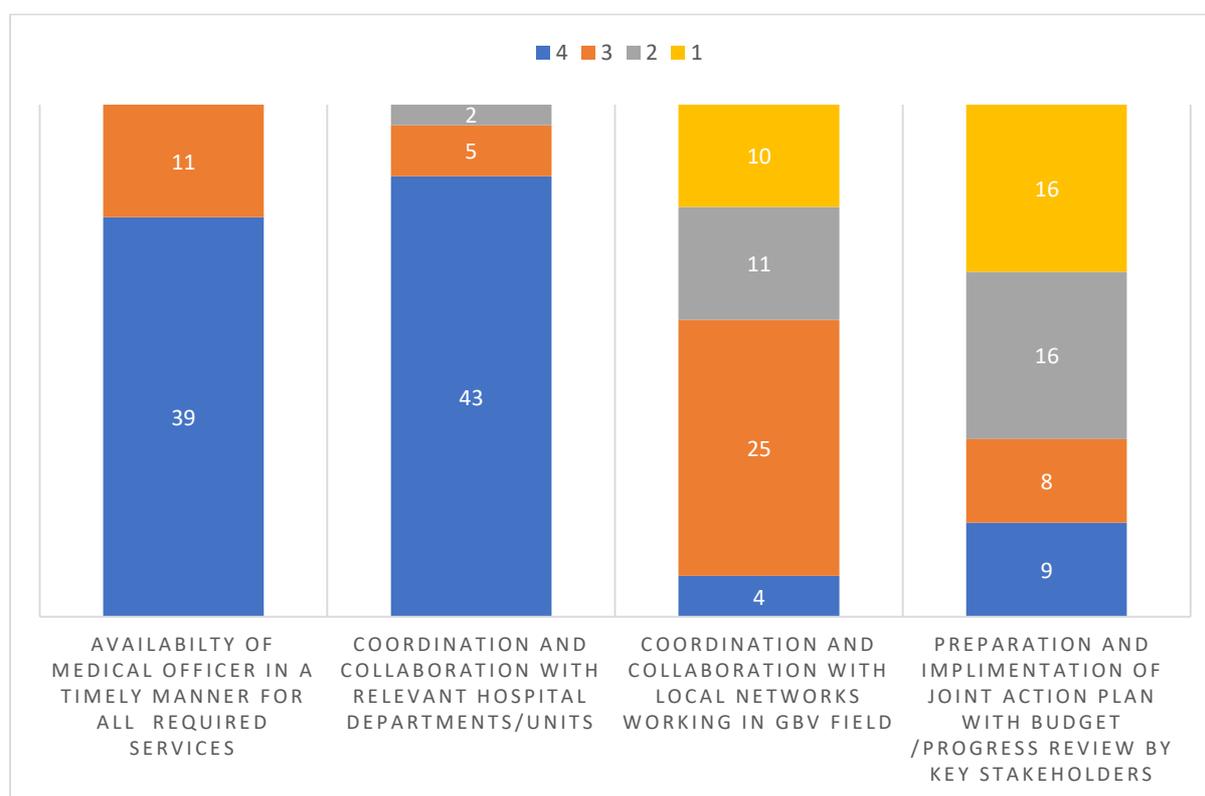
- Coordination and collaboration with relevant hospital departments/units (emergency, indoor, outdoor, laboratory).
- Medical officer is available in a timely manner for all cases requiring medico-legal services.

The two indicators with the lowest scores are:

- Joint action plan with budget and progress review by key stakeholders (OCMC, local government, police, NGOs and other concerned agencies) prepared and implemented at local level.
- State of coordination and collaboration with local networks working in GBV field.

Figure 10 shows the range of scoring for these four marker indicators. We see that both timely availability of medical officers for cases requiring medico-legal services and in-hospital coordination received a score of four from most OCMCs. In contrast, scoring of the lower-performing indicators is more mixed. The worst-performing indicator, the preparation and implementation of a joint action plan and budget, has one as the most common score, i.e. a joint action plan not prepared, no joint progress review.

Figure 10: Scoring of top and bottom two indicators by OCMCs



Coordination within the hospital scored well and this is a considerable improvement on the situation found in earlier evaluations<sup>18</sup>. This likely reflects the continued advocacy efforts with hospital

<sup>18</sup> See MoHP, NHSSP and UNFPA. 2013. Assessment of the Performance of Hospital-based One-stop Crisis Management Centres. MoHP Population Division and NHSSP. 2016. The Piloting of Innovative Good Practices in Nepal's Health Sector. Hospital-based Support for Victims of Gender-based Violence, One-stop Crisis Management Centres. MoHP and NHSSP. 2017. Case Study: Performance of Hospital-based One-stop Crisis Management Centres.

management, training provided to doctors and nurses in the clinical protocol and revised operational manual, and more recent training of doctors on medico-legal standards.

**The top-scoring quintile** includes 15 OCMCs. These are shown in Table 9. Six of these were included in the qualitative data collection and are discussed in more detail below.

Table 9: Top-scoring quintile of OCMCs

	Hospital	District	Total percentage
<b>Province 1</b>	Inaruwa Hospital	Sunsari	88.89
	Panchthar Hospital	Panchthar	86.11
	Udayapur Hospital	Udayapur	91.67
	Koshi Hospital	Morang	91.67
<b>Province 2</b>	GNS Hospital	Saptari	87.50
	Janakpur Hospital	Dhanusha	86.11
<b>Bagmati Province (3)</b>	Paropakar Maternity Hospital	Kathmandu	86.11
	Bharatpur Hospital	Chitwan	84.72
	Hetauda Hospital	Makawanpur	93.06
	Dhading Hospital	Dhading	90.28
	Sindhuli Hospital	Sindhuli	91.67
<b>Gandaki Province (4)</b>	Damauli Hospital	Tanahu	84.72
	Dhaulagiri Hospital	Baglung	95.83
<b>Province 5</b>	Prithivi Chandra Hospital	Nawalparasi	84.72
<b>Karnali Province (6)</b>	Pradeshik Hospital	Surkhet	86.11
<b>Sudurpashchim Province (7)</b>	Mangalsen Hospital	Achham	87.50

The two best- and worst-performing indicators for the top quintile were the same as for the total data set of 50 OCMCs. Two points of difference to note with the larger dataset are that the top 15 also scored highly on strict adherence to service protocols; and scored coordination and collaboration with legal support services as badly as for coordination and collaboration with GBV networks.

**The lowest-scoring quintile** consists of four OCMCs: see Table 10. All four OCMCs score timely availability of a medical officer as four but have shortages in staff nurses and psychosocial counselling. All four score promotion activities, coordination with NGOs and local GBV networks very low.

Table 10: Bottom-scoring quintile of OCMCs

	Hospital	District	Total percentage
<b>Province 1</b>	Ilam Hospital (started 2076)	Ilam	68.60
<b>Province 2</b>	Kalैया Hospital	Bara	62.50
<b>Gandaki Province (4)</b>	Gorkha Hospital	Gorkha	55.56
	Myagdi Hospital	Myagdi	50.00

## **6.2 Key issues and findings related to OCMC performance**

The qualitative data provides rich insight into how OCMCs are functioning within the political and social context in which they operate. To make best use of this data, the findings are presented according to thematic concerns from a systems perspective. Each theme draws out key issues: examples of what is working well, where and why, examples of gaps and bottlenecks where this is not working, and initiatives that are finding solutions to strategic and operational challenges.

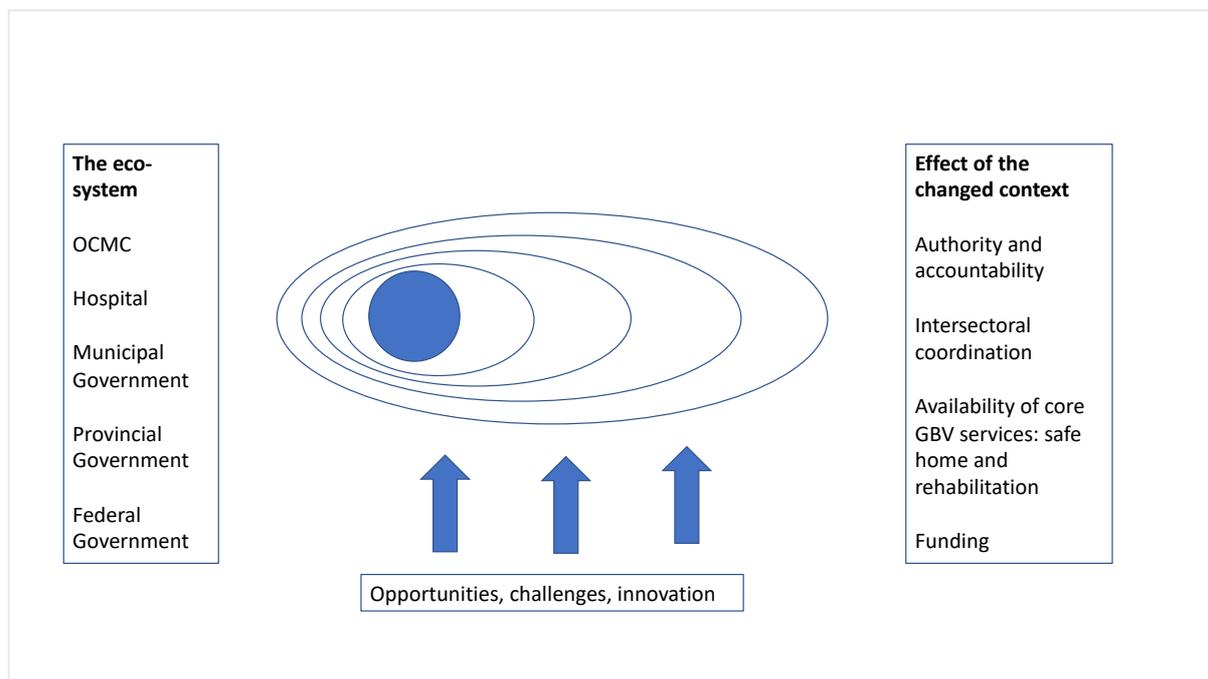
### **6.2.1 Leadership and governance**

**The issue:** There are two overarching, strategic governance issues that are impacting the functioning of OCMCs. First, the move to federalism has changed the governance environment for OCMCs with important implications for oversight authority, funding and coordination at a policy and strategic level as well as for service delivery. This is further complicated by the fact that OCMCs are housed in different types of hospitals: federal hospitals, provincial hospitals, hospitals located in different types of municipal spheres (metropolis, sub-metropolis, municipality) and therefore the hospitals have different accountability relationships and leveraging space. The political economy in which OCMCs exist and its changing nature are important factors that influence the enabling conditions for OCMCs and their capacity to fulfil their mandate.

Federalism has raised opportunities and challenges for government's response to GBV. The changed context means that while the 'district hospital' remains a valid location to provide and coordinate multisectoral services that are available at this level (e.g. police investigation, legal services, safe home), this does not neatly align with the municipal or provincial structure: a mechanism is required to enable all local governments within the orbit of OCMCs to participate in governance functions. OCMCs need to establish relationships and ways of working with all the municipalities they serve and not just the one in which they are located. They need to coordinate with each municipality GBV plan and the service delivery agencies and resources in their catchment area. To respond to this situation, the revised OCMC Operational Manual (2020) introduced the GBV Management Advisory Committee, chaired by the Chief of the DCC and including all Deputy Mayors of metropolitan cities, sub-metropolitan cities, municipalities and village municipalities as members. The role of the province is defined in the revised OCMC Operational Guidelines (2020) to include allocation of conditional grants to OCMCs, providing capacity development for, and coordination among, the OCMCs in the province. Experience shows that provinces have not consistently taken on these roles.

The second strategic issue relates to institutional reforms in MoWCSC and the removal of their service delivery role. Women Development Officers, who were based at district level and who were pivotal in delivery and coordination of GBV-related services and activities, including safe homes and rehabilitation services, are no longer part of the system. MoWCSC funding of safe homes and rehabilitation services has stopped. As an interim measure, a special programme of the President, the President Women Welfare Programme (implemented by MoWCSC) is funding 21 safe homes but the long-term survival of these former district-level services is uncertain; without them, OCMCs are deprived of an essential part of the GBV response network and critical services for survivors. The President's fund does not cover rehabilitation centres. Some local governments and Provincial MoSDs are providing support for safe homes and rehabilitation centres but this has not filled the gap.

Figure 11: The OCMC governance ecosystem



**Findings:** The examples below show how drivers of change and champions are working across the OCMC ecosystem to redefine and operationalise new governance arrangements, and the concerns and gaps to which they are responding.

Provincial and municipal governments

*Karnali MoSD:* The Ministry’s commitment to addressing child marriage and chhaupadi has the political support of the Minister. The Ministry has signed a Memorandum of Understanding (MoU) between three layers of federal, provincial and local governments in Karnali Province to share responsibility and plans to address child marriage and chhaupadi. Funding will be divided, with 50 percent covered by the Federal MoWCSCs, 30 percent by the Provincial MoSD and 20 percent from municipalities. To progress implementation, GBV Committees have been established at provincial and local government. These are separate to the committees proposed for OCMCs as per the OCMC Operational Manual. The Provincial Ministry is also funding campaigns against child marriage and chhaupadi, and plans to fund a lawyer in each district to support GBV survivors. Implementation is currently halted due to the COVID-19 outbreak.

The Provincial MoSD is also providing a grant to Aawaj Nepal, a local NGO, to operate a safe home and rehabilitation centre in Birendranagar Municipality and a grant to Manabwewa Ashram to establish and run a rehabilitation centre in Surkhet for the homeless, people with mental health conditions, and GBV survivors.

*Nepalgunj Sub-metropolitan Municipality, Banke District, Province 5:* Lack of coordination and friction between Nepalgunj Sub-metropolitan City and Bheri Hospital was reported by both municipality and hospital representatives. There is a reported lack of coordination and communication between the two parties and the municipality perceive the OCMC as inactive and underperforming. The municipality reported that it is referring survivors between agencies because the OCMC is not

performing its functions, raising issues of efficiency and possible duplication of effort. Nepalgunj Sub-metropolitan City has established its own GBV Alleviation Fund (Laingik hingsa nibaran kosha) for survivors and is building a safe home, but has determined that it cannot fund the OCMC because of its poor performance. Beneath these operational gaps and wasted opportunities lies the messy playing out of power dynamics: there is a sense, for example, that the expertise of hospital professionals is being sidelined from health policy being made at municipality level.

*Sudurpashchim MoSD* is providing top-up funding to all OCMCs that received conditional grant funding from the MoHP in 2019/20. It has also allocated operational funding for an additional OCMC in the province at Darchula. The Federal MoHP has agreed to include this new OCMC in the 2020/21 conditional grant. In the absence of Women Development Officers, the scope for coordination between OCMCs and the Provincial MoSD was felt to have been severely impacted. This was reported to be a major issue, especially as the ministry is planning GBV initiatives, such as the establishment of Community Service Centres, without coordinating with OCMCs; again, this raises the threat of inefficiency and reduced impact. The MoSD voiced the need for federal government to develop clear policy on the roles and responsibilities of the three tiers of government, to avoid duplication and clarify accountability and monitoring responsibilities.

*Dhangadi Sub-metropolitan Municipality*, Kailali District, Sudurpashchim Province has committed to funding an NGO shelter at provincial level and providing emergency and seed money for livelihood support to survivors, but is not working with the local OCMC at Sethi Hospital or providing funds to it. From the perspective of Sethi Hospital – referral hub for nine districts – the lack of interest in and funding of the OCMC from Dhangadi Municipality was due to the hospital being a provincial facility and accountable to provincial and federal government. The Deputy Mayor was unaware of the GBV Management Advisory Committee or her role on that committee. Lack of awareness of GBV governance and OCMC structures was also reported by the Mayor of Dhangadi Sub-metropolitan City and the Deputy Mayor of Bhimdatta Municipality of Kanchanpur District in Sudurpashchim Province. Out of the 13 in-depth OCMC case studies included in this review only five have established GBV Management Advisory Committees to date.

*Bharatpur initiative to pool local government funding of GBV services:* Bharatpur is leading the way in forging partnerships across municipalities to take shared responsibility for GBV services that are better delivered at an aggregate level, such as shelters and rehabilitation centres. With equivalence between spheres of government, choice of a coordinating body is complicated. In the case of the Chitawan initiative, the DCC has successfully nurtured collective responsibility for GBV across seven municipalities. The DCC has developed guidelines for a GBV Management Fund that will pool resources from the seven municipalities. The basket fund will finance GBV prevention and rehabilitation services that meet the collective need.

The DCC has convened meetings with the participating municipalities and received their endorsement of the concept. Each municipality has now to present the concept to their respective local government boards for approval. Bharatpur Metropolitan Municipality will lead the way in the process; with their approval it is expected that the other municipalities will follow suit.

*Legal Judicial Committee (Nayeek Samiti)*: the new municipal-level Nayeek Samiti under the leadership of the Deputy Mayor, has significant potential to raise the visibility of GBV, improve justice outcomes for survivors and challenge social norms that perpetuate violence. In Janakpur Municipality, the Mayor and Deputy Mayor voiced their support for addressing GBV and making the connection between Nayeek Samiti and OCMCs: see text box below.

“It’s good to have a system like OCMC. I have participated in a few meetings and hear about the survivors being treated well. Yet, it needs to be strengthened well and it should work very closely with the Local Judicial Committee (*Nayak Samiti*) headed by the Deputy Mayor. There are lots of cases coming to the Local Judicial Committee for reconciliation, which require close monitoring and intervention by OCMC as majority of them are related to GBV/domestic violence. We will support OCMC for its well-functioning through resources and other support it may require.

As a Mayor of the city, I am very concerned about the situation of our women and feel myself accountable for what they have been going through. We will prioritise this as one of a key agenda in our work plan and make sure that no survivor is left behind in accessing justice. I believe that justice has to be delivered promptly. Otherwise, justice delayed is justice denied.”

Lal Kishor Shah, Mayor, Janakpur, Province 2

“We are very concerned about the GBV issues in the province. There are many cases related to domestic violence, dowry and child marriage, which needs dire attention. The law is there but socioculturally these practices are so deep-rooted that we are silently accepting it. Being a Chief of the Judicial Committee, I entertain quite a number of cases. I can see that most of these cases have approached to me/the committee after sustaining many years of abuse. There are cases of violence against male also. I believe it’s a high time that we have to start thinking differently. We cannot afford to be doing the same thing to minimise violence, forget eliminating. It is so complex that it takes all your energy and patience. We need multi-pronged approach to handle this issue – advocacy, coordination, care, support, treatment, rehabilitation, empowerment and policies on place.

I am extremely glad that OCMC has been established in Janakpur hospital. I am also in the Advisory Committee of OCMC. I have been attending most of the DCC meetings. We have also extended some financial support to strengthening OCMC (NPR 10 lakhs, this year) and we will continue to support this noble initiative of the federal government. We will further work to institutionalise this so that it can liberally function. We have supported safe home (NPR 4 lakhs, this year) so that survivors can be rehabilitated. I assure you that I am fully committed to work on GBV issues and for that I will draw no lines or limit for the budget or other support it may require.”

Rita Mishra, Deputy Mayor, Janakpur, Province 2

In Birendranagar Municipality (Sukhet) and Biratnagar Metropolis (Province 1), connections between the Deputy Mayor and OCMCs are working well. In other sites, coordination between Nayeek Samiti and OCMCs has not taken off. In Bhimdatta Municipality, the Deputy Mayor noted that the Nayeek Samiti had been informed about the OCMC eight months ago but still no contact had been made by either side.

### Hospital leadership

**The issue:** hospital leadership commitment to OCMCs is a key enabling factor for their success. Where hospital chiefs are uninterested in GBV or see this as a social problem beyond the responsibility of the hospital, this is a critical barrier to their effectiveness. Additionally, accounts officers’ lack of sensitivity regarding GBV issues and hindrance in fund flow for OCMC activities are barriers to their timely completion.

**Findings:** The examples below show how the support of Medical Superintendents (MeSus) can work to provide resources to OCMCs, generate commitment to GBV across the hospital, motivate staff and improve the quality of care.

*Janakpur Hospital:* The MeSu has ensured space, funding and equipment are provided to the OCMC, which was established end of FY 2018/19; he also appointed a committed doctor as the CMC Coordinator. The OCMC has a permanent staff nurse as the OCMC Chief, a dedicated staff nurse on contract, forensic trained doctors in place and is receiving high numbers of referred women from emergency and outpatient departments. This, combined with the political support of the Mayor and Deputy Mayor, has created strong positive conditions. Janakpur OCMC had the highest number of cases in the first six months of 2019/20 out of all OCMCs, serving 465 clients in its first six months of operation.

*Koshi Hospital:* the MeSu in charge during the establishment of Koshi OCMC championed support to the OCMC. He was a psychiatric doctor and insisted on meeting all OCMC clients and providing psychological support where needed. The OCMC has always enjoyed a full staff compliment, has encouraged identification of GBV clients across the hospital and internal referral to the OCMC, and benefitted from staff training on the GBV Clinical Protocol, psychosocial training, and medico-legal training of doctors.

*Lumbini Hospital:* The biomedical mindset of the Hospital In-charge and large competing demands for hospital resources have been a bottleneck to progress at this hospital. This has resulted in staff not being permitted to attend GBV training and hiring of contract staff being blocked. GBV is perceived to be the responsibility of organisations outside the hospital, including NGOs and local government.

## **6.2.2 Human resource availability**

**The issue:** Shortage of staffing has been an issue since the introduction of OCMCs. To address the issue, the revised OCMC Operational Guideline (2016) introduced a minimum of one medical doctor and two to three staff nurses to be either appointed to the OCMC or to be on call, to enable the OCMC to be open 24 hours a day. The staff adjustment process has severely impacted OCMC staffing this FY.

**Findings:** The OCMC scorecard results suggest that staffing has been addressed in most OCMCs. However, in practice gaps remain. OCMC Focal Points at Bheri, Sethi and Mahakali Hospitals noted that even with staff nominated and on call, in reality the OCMC service is not accessible 24 hours a day in either of the hospitals. Consultations with hospital management and MoHP staff note that shortfall of staff is a constraint in almost all OCMCs and hospitals. Given shortfalls in staffing, the standard practice is that after normal office hours GBV cases are taken up by the emergency department and as per the severity of the case, the service provider in emergency contacts the OCMC focal/chief<sup>19</sup>. For OCMCs where inter-departmental coordination at the hospital is good, this works well. But where coordination is weak, gaps exist and often there is demand for extra staff to keep the OCMC staffed 24 hours.

This year, many doctors and staff nurses who have received GBV- and OCMC-related training have been transferred, as part of the staff adjustment process, to facilities without an OCMC. The fact that many OCMC staff are hired on contract basis means that there are often gaps between contract periods. The fluidity of staff, especially contract staff, has serious implications for capacity loss and

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<sup>19</sup> If the GBV case requires immediate attention (e.g. rape, burns, suicide attempt, poisoning etc.) the OCMC person attends the case and proceeds, but if the case can be taken care of by the emergency department then the following day the OCMC staff are informed and the process begins.

inefficiency, with staff trained and then lost to the system. Bheri Hospital recommended an “OCMC squad” to make sure staff trained are retained in OCMC facilities.

To cement the capacity of hospitals to deliver OCMC services, senior management at Bheri and Sethi Hospitals recommended that a separate department be established in the hospital to institutionalise the unit and ensure dedicated staff be appointed.

### **6.2.3 Staff capacity and development**

**The issue:** Strengthening of OCMCs has spearheaded the health sector response to address gaps in front-line hospital care of GBV survivors. This has included introduction of standards and guidelines and related training. Most important have been the:

- GBV Clinical Protocol (2015), which supports hospital staff identify GBV survivors, provide immediate care and refer clients to the OCMC and for specialist care where needed.
- Revised OCMC Operational Manual (2016), which sets out the roles and responsibilities of OCMCs and management and reporting structures.
- Medico-legal training of doctors to undertake forensic examinations of rape victims and to prepare medico-legal records that stand up in court. One doctor from each OCMC has received training.
- Psychosocial counselling training of nurses caring for GBV survivors.

Despite the rollout of training, this has not covered all OCMC staff and capacity gaps persist. High staff turnover contributes to the challenge. Poor operating conditions and perverse incentives also impact the extent to which confidentiality and privacy are maintained and skills learned are practised.

**Findings:** Frequent turnover of staff was a constraint mentioned at several OCMCs, including Bheri, Mahakali and Sindhuli Hospitals, and underlined the need for ongoing training to ensure new staff are trained. Gaur Hospital reported that none of the doctors have received GBV-related training, no dedicated staff are allocated to the OCMC and practices to ensure confidentiality and privacy are not maintained. At Taulihawa Hospital, the OCMC designated rooms have not been made functional, survivors are seen in the labour room or emergency room and privacy and confidentiality are not maintained. Doctors interviewed reported that they are not confident or comfortable managing GBV cases.

At GNS Hospital, all the OCMC staff have been trained and four medical officers have received GBV protocol training. They said they are available and motivated to provide care to survivors but mentioned that they feel there is a lack of back-up support from senior doctors and specialists. Given that senior doctors are generally not included in GBV training, strategies to mobilise their support need to be considered. The out-of-regular working hours financial incentive system paid to OCMC staff at GNS Hospital was said to be working well, and was motivating staff to be on call when off duty. The physical renovations happening at the hospital are, however, impacting availability of space and privacy. The OCMC counsellor mentioned that with the OCMC forced into one room it was not possible to maintain privacy or give high-quality care.

*Medico-legal training:* The majority of rape cases are dismissed due to poor-quality medical reports and documentation. Many doctors that have received GBV medico-legal training have reflected on their lack of skills to undertake examinations and document findings prior to the training. Basic

medical education provides little forensics training to doctors and no experience with GBV survivors. At GNS Hospital, doctors who have not had medico-legal training noted feeling harassed at the time of a court hearing and a lack of support from the Government attorney during trial: they would rather not be involved in medico-legal cases if they had a choice.

The GoN's enhanced emphasis on strengthening forensics and medical investigations across the country has contributed to the prioritisation of GBV medico-legal training of doctors. Interviews with five doctors at Bheri, Mahakali and Surkhet Hospitals who have received this training provide a strong endorsement of the value and impact of the training.

"Before the training it was kind of threat to write finding of OCMC-related cases because we were not sure about what the court was trying to find through the medical report. We used to examine the cases and write report in the way that protect ourselves from the unnecessary Court procedurals but after the training we realised that it is more important for a survivor to get justice. The training has shared important knowledge on how and when is it important to collect evidences. It made us understand about the importance of history-taking part. Sometimes, the examination may not indicate any physical injuries findings but the history-taking of the case can fix if the case was of GBV or sexual assault nature. The training has enabled us to provide service to the survivor and provide authentic finding of the case to the Court confidently. "

Medical Officer, Bheri Hospital, Nepalgunj

A key change noted by all was a shift in attitude towards GBV clients and a new sense of responsibility they felt to support the survivor get justice rather than protecting themselves from being found at fault. However, the fact that doctors are not covered from their regular duty if they have to attend a court hearing at some hospitals is an issue that needs attention.

*Clinical protocol training:* blended step-down training is being rolled out from three selected hospital sites: Koshi, Bharatpur and Lumbini. In 2018/19 and the first half of 2019, 99 staff have been trained. Within four months of completing the training, the three hospitals reported a significant jump in utilisation of OCMCs, primarily because cases were being referred from within the hospital, suggesting an increased awareness and identification of GBV among hospital staff.

"Before, I thought this was not part of my job. I limited myself to medical treatment, but ignored the psychological and legal aspects and simply didn't ask questions about them. Now, when I identify [a case of violence], I make appropriate referrals to legal or psychological services or what survivor wishes."

Medical Officer, OCMC, Bharatpur Hospital

*Psychosocial counselling training:* Four staff nurses that have received psychosocial counselling training were interviewed. They felt that the training had improved their communication skills, made them more compassionate and increased their understanding of the importance of confidentiality.

While participants consider the quality of training provided to be good, there are gaps in coverage and ongoing training will need to be provided in the medium term, including refresher training. Respondents felt that training has contributed to increased internal referrals in hospitals. At Sethi Hospital, for example, the MeSu believes that staff in gynaecology and the emergency department are referring clients to the OCMC because staff there have received OCMC orientation, medico-legal training and psychosocial counselling training. He wants the other departments to be trained so they can also identify GBV survivors.

“Only after the counselling training, I realised that it is necessary to maintain confidentiality of the cases of GBV but before the training due to ignorance we were re-victimising the survivors with our own behaviour. Through the training, I learnt on how to talk with them in friendly manner, so that they have faith in you and they are open and share their feelings with us.”

Staff Nurse, Mahakali Zonal Hospital, Mahendranagar

“The training imparted knowledge on 'communication skill'- on how to communicate with client who are going through traumatic condition. 'Words do have power to heal and hurt' and I started to use the healing language after I received the counselling training. Before the training, we used to pass very insensitive comment over the condition of survivor of GBV, for e.g. if there was a survivor who survived from taking poison, we re-victimised them by passing comments like - if you wanted to die, then why didn't you took enough amount of poison and etc.”

Hospital Nursing Supervisor, Mahakali Zonal Hospital, Mahendranagar

*Children experiencing violence* have special needs given their particular vulnerability. OCMC staff have received basic knowledge on violence against children during the five-day GBV counselling training. Revisions to the GBV Clinical Protocol in 2020 (submitted to the MoHP Secretary and awaiting approval) deepen attention to the specific needs of children. The rollout of the protocol, once approved, will increase the capacity of staff to care more effectively for children who have been violated.

*Rape cases:* There are many challenges to handling rape cases, including the fact that many if not most rape cases report late or after washing and changing their clothes, when evidence has gone. The complex social pressures on victims also mean that survivors and/or family members may drop charges even when evidence is available; several of the survivor case studies in the Survivor Study (2019) documented this outcome. Staff nurses and medical officers trained in the GBV Clinical Protocol or Medico-Legal training are aware of the protocol for protecting evidence of rape and other violence. The Medico-Legal Service Guidelines approved by Cabinet in 2019 will further lift standards on evidence handling.

#### **6.2.4 Care and treatment of survivors**

**The issue:** Compassion, confidentiality and client-centredness are essential values for services to GBV survivors. These characteristics are weak across the health service and given prevailing gender norms and stigmatisation of rape survivors, they demand transformational changes in attitudes and values for many health providers. The GBV-related trainings initiated by MoHP explicitly seek to provoke attitudinal change, and report some success (see box below). But transformational change requires ongoing support and reinforcement to develop and maintain the competencies of staff and be part of continuing professional development.

**Findings:** In all provinces, clients most frequently reach the OCMC after referral by the police. The second most common route is for survivors to be referred by another hospital department, often emergency, or the women approach the OCMC themselves. Sexual and physical violence is the most frequent reason for hospital treatment and police intervention. Through whichever pathway survivors have arrived at the OCMC they all receive the same completely free care and access to information,

counselling, treatment and referral, services that survivors are referred to are also provided free of cost.

Providers report how GBV-related training has triggered reflection and attitude change. Staff nurses undergoing psychosocial counselling training note how they have changed the language they use with survivors, become more sensitive to the needs of survivors and show them respect and empathy to

“I have learned things that I didn’t understand before. I feel like I have become enriched as a person, like I have grown. I began to change. First, by changing at home. I began not to speak so harshly to my daughters, not to fight as much with my wife. Because I thought, how can it be that I argue and I am violent at home and then I am telling women, ‘I know how you feel, if I were in your place, I would feel the same’? How could I be giving them support, when I was living a double standard? So for me the change has been wonderful.”

Medical Officer from Province 2

help ease their pain.

In the Survivor Study (2019), survivors recall the care and counselling provided by OCMC staff. In some districts, NGOs are providing counselling services<sup>20</sup>. In many others, OCMCs are the only source of counselling services at the district level, and this reflects the limitations of the system in which they operate. The Survivor Study (2019) reports how OCMC staff spent considerable time and effort finding care and resources to support women and girls who have survived family violence, especially when the survivors are children, and women living with disability and mental illness who are more difficult to accommodate in the limited care options available. The Survivor Study documented several cases of women with intellectual disabilities being sexually abused. Rehabilitation of intellectually challenged survivors is difficult to find as their needs are complex, and regular safe homes generally cannot accommodate them in the short term either. In such cases, NGOs such as Manav Sewa Ashram, Koshish and Child Workers in Nepal have often been the only agencies willing to care for survivors.

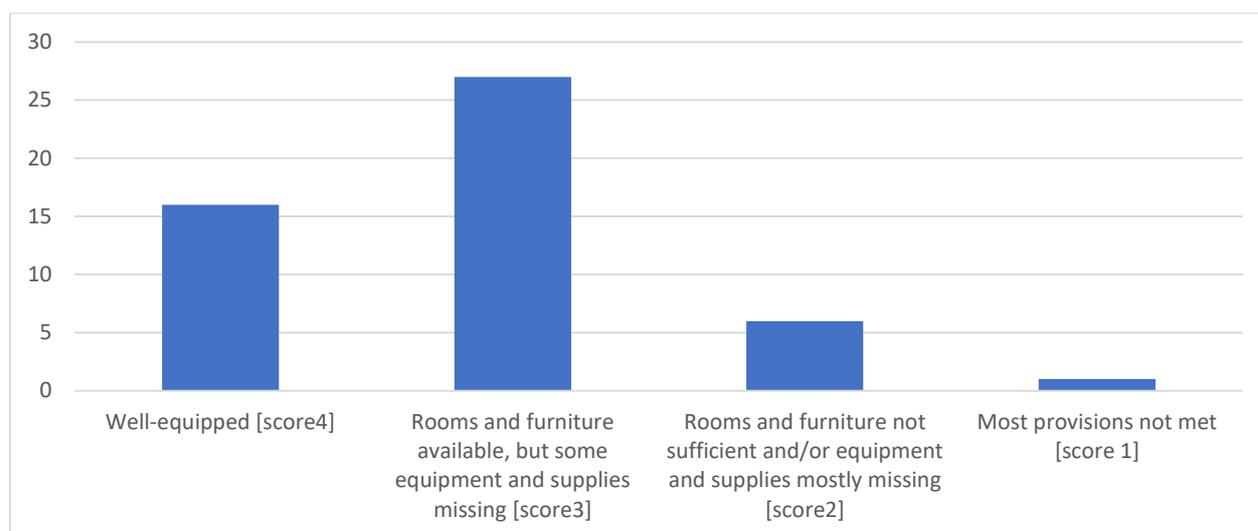
### 6.2.5 Physical environment, equipment and supplies

**The issue:** Securing an appropriate physical space and supplies is a basic requirement to providing private and confidential services to clients.

**Findings:** The OCMC scorecard shows mixed progress on the availability of physical space, equipment and supplies: see Figure 12. Most OCMCs are performing reasonably well on this indicator but eight OCMCs are operating in difficult conditions without adequate space and equipment or supplies [scoring 2 or 1].

<sup>20</sup> Bharatpur, Biratnagar, Hetauda, Saptari, Surkhet.

Figure 12: OCMC self-assessment scorecard for physical environment, equipment and supplies



Visits to OCMCs also uncovered gaps. Taulihawa, GNS and Sethi Hospitals are all operating either without dedicated space or in sub-optimal conditions. Taulihawa has no immediate plans to allocate separate space to the OCMC. Renovation or construction is ongoing or planned at GNS and Sethi to provide OCMC-dedicated space as per the OCMC Manual (2016). Bheri is planning to allocate a separate six-bedded department for the OCMC in the new wing that is being built. New hospital building designs include a designated space for the OCMC: in the long term the space constraint will be addressed.

“Two rooms: the first room was clean but there was no appropriate examination bed, no curtain for privacy; the second room was messy with medicines and other supplies; clatters everywhere. OCMC in hospital need cleaning and arranging the existing set-up so as to make it survivor-friendly, professional and ensuring privacy.”

Field report from Gaur Hospital

As a cross-check of the quality of OCMC scoring, Taulihawa scored itself two on this indicator, which appears accurate. GNS and Sethi both scored themselves three, which is generous: a two may have been more accurate.

### 6.2.6 Record-keeping and reporting

**The issue:** MoHP has invested significant efforts to improve the quality of record-keeping and reporting to reliably inform policy and planning. Reporting standards and requirements are set out in the OCMC Operational Manual (2016 and 2020) and the ministry is planning to introduce online reporting to further improve the quality of reporting.

**Findings:** MoHP report improvements in recording of cases at OCMCs and reporting upwards to the Provincial MoSD and Federal MoHP but there is still room for improvement, with a small number of OCMCs not reporting at all. The reasonably good completion of the self-assessment scorecard, with 50 out of 55 active OCMCs reporting, is a positive sign. Poor record-keeping was found during the field visit to Taulihawa and this appears to be linked to a lack of training of staff.

The challenge of lack of authority to share data and interoperability of data between GBV service providers remains. The 2016 Good Practice Paper identified the risk of duplication because each agency has its own reporting system that uses indicators and data capture specific to its needs. Efforts

to move towards integrated reporting and a common set of guidelines and protocols for all government agencies providing services to GBV survivors was initiated in 2016. However, after initial progress and consensus-building across senior management in relevant ministries and agencies, the MoWCSC decided to put this initiative on hold as priority shifted to governance and institutional reshaping with the move to federalism. Parallel reporting systems continue to be an issue. Some OCMCs are regularly cross-checking data with the police to avoid duplication of reporting but a more systematic response is needed.

The quality of data recording and reporting is one of the strengths of those OCMCs performing well.

### 6.2.7 Budget allocation and budget management

**The issue:** Funding problems have been a persistent issue for OCMCs. The transition to federalism has impacted budget allocations for OCMCs. In several provinces, conditional funds sent from the federal to provincial level have not been passed on to OCMCs either on time or in full, with funds often arriving only midway into the FY at most hospitals. In many cases, the MoHP has intervened to pressurise the province to forward funds. Incomplete and delayed funding has serious implications for retaining contract staff. When funds are transferred to the hospital, opaque financial management procedures within the hospital present an additional barrier. For this review, the two key financing issues explored were: (i) whether provincial and municipal governments were funding OCMCs, and (ii) whether OCMCs were accessing budget allocations once they arrived at the hospital.

Three-quarters of the way into 2019/20, Dhulikhel Hospital has not yet received any budget.

**Findings:** Funding of OCMCs relates closely to the issue of governance and the changing landscape under federalism. In Sudurpashchim, the province has provided top-up funding to each OCMC in addition to the conditional grant provided by MoHP in 2019/20. It has also allocated operational costs for a new OCMC, Darchula, which MoHP has agreed to absorb into the conditional grant in 2020/21. Dhangadi Sub-metropolitan City in Sudurpashchim Province does not provide any funding to the OCMC at Sethi Hospital, though it does plan to develop a GBV Fund to support other GBV services. Bhimdatta Municipality does not fund the OCMC at Mahakali Hospital but it is planning a GBV Fund for other GBV services.

In Karnali Province, the provincial government has allocated funds to establish six OCMCs in addition to those funded by the conditional grant of MoHP. This will take the number of OCMCs in the province to ten from the current four, with one per district.

In Provinces 2 and 5, there are no such provincial initiatives to fund OCMCs in addition to the federal conditional grant. Janakpur OCMC is receiving top-up funding from the municipality. Provincial and municipal government are providing or planning to fund some GBV-related services such as safe homes. The mixed picture of funding allocations for OCMCs and the broader GBV network of services in different provinces and municipalities reflect the fluid and changing shape of governance and ownership of the agenda. While local context is key, there is a clear need for guidance on the responsibility of provinces and municipalities to sustain and ensure the effectiveness of OCMCs and the GBV network of services, and how they can work together to achieve high-quality services for survivors.

*Access to OCMC budgets* by OCMC staff was reported to be an issue in several hospitals, including GNS and Sethi. At Sethi Hospital, the acting MeSu reported that the OCMC fund had only been spent on organising CMC monthly meetings and funds for other activities had not been utilised. OCMC staff in different hospitals reported how it is difficult to navigate the system and that the accounts officer is often a bottleneck. Funds allocated for OCMCs are also used for other purposes. OCMC nurses at several hospitals report how accounts officers do not provide allocated petty cash to the OCMC and hinder requests for equipment and other necessary supplies; they subsequently find out that the budget has been used for other purposes<sup>21</sup>. In contrast, at Koshi Hospital the accounts officer respects the budget allocation for the OCMC, maintains an open process and supports staff to follow procedures and use the budget transparently and for purpose.

### **6.2.8 Multisectoral coordination and collaboration**

**The issue:** Coordination and collaboration of the multiple agencies providing services to survivors have presented the most challenging aspect of the OCMC model to progress. The issues explored by this review are:

- At the strategic level, how are the changing governance arrangements enabling or stalling multisectoral coordination and collaboration through leadership, accountability and funding? This is discussed above.
- At the operational level, where is referral and coordination working, what are the key contributing factors, and what are major bottlenecks?

**Findings:** Coordination and collaboration at the operational level through regular CMCs is very uneven. Coordination on a case-by-case basis seems to be the norm. Frequent turnover of staff and the heavy work burden of OCMC Focal Points also negatively impact the effort invested in coordination as reported by staff at Bheri, Sethi and Mahakali Hospitals.

Most clients are referred to the OCMC by the police and the coordination with police is the strongest out of all external agencies. Most clients who are referred from an OCMC are also referred to the police. Police protection of survivors at the hospital is provided in criminal cases. Police protection of witnesses once they are discharged from the hospital falls to the jurisdiction of the police. Survivor stories illustrate the important role safe homes play in providing protection to survivors after they are discharged from hospital, since many women and girls have no alternative accommodation beyond the family home, which was most often the place of abuse.

Critical gaps in safe home and rehabilitation services constitute a major blow to the GBV service network and have left many OCMCs without shelter accommodation and rehabilitation care to which they can refer clients. This has increased the vulnerability of survivors and added to the stress placed on OCMC staff as they seek to support survivors. The care of children, women with disabilities and the mentally ill presents a particular challenge. This issue was raised by several local governments. At the operational level, this leaves OCMCs and hospitals in the difficult position of discharging clients without a safe or appropriate place to which to refer them.

Coordination with local municipality staff was found to be poor during field visits. This is partly explained by the lack of perceived authority of OCMC staff to convene meetings with officials from

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<sup>21</sup> Including Bheri, Lumbini and Pokhara Hospitals.

outside agencies, and the more structural problem discussed earlier that these relationships are yet to be forged at the strategic and governance level. Without clarification of formal ways of working between hospitals and municipalities at management level, junior staff feel unable to forge operational links. Frequent changes, gaps in staffing and the heavy demands on the district attorney, form another constraint reducing the scope for coordination and collaboration.

Staff at Bheri, Sethi and Mahakali Hospitals note the main role of OCMCs is provision of health care to survivors as there is limited referral to other service providers. In Kalaiya there is no safe home or rehabilitation centre. The female cell at the police station was found to be busy and the officer in charge had no knowledge of the OCMC.

Case studies of Koshi and Hetauda show how active, well-networked OCMC Focal Points are key factors in making coordination with external agencies work well and make referrals happen. Both OCMCs have fostered good working relationships within the hospital and with municipalities and service delivery partners. Koshi holds a monthly one-hour conference among hospital staff from different departments to discuss how they identified and managed GBV clients, how this varied by client, and what they learned. This sharing increases staff understanding of the nature of GBV cases and promotes non-judgemental attitudes and compassion. Hetauda has leveraged support from Hetauda Sub-metropolitan City to fund micro-businesses for survivors. Personal connections were

**Koshi Hospital: factors for success**

Koshi is one of the best-functioning OCMCs in the country. In 2075/6 it served 348 clients. Key contributing factors are:

- Strong hospital leadership
- Dynamic OCMC Focal Point with good networks and connections
- Doctors and nurses received GBV-related training
- Proactive emergency department
- Good coordination across hospital departments
- Supportive and open accounts officer
- Compassionate care, clothes for survivors
- Good follow-up of survivors
- GBV survivors network
- Good data recording and use of data

important to grease working relationships. The other point of difference is the effort Koshi and Hetauda have invested in supporting GBV survivor networks. Koshi funds monthly meetings of the survivor network at the OCMC, enabling survivors to connect, find solidarity and strength. The survivor networks are also agents of change in the community, advocating against violence, supporting victims, connecting them to help, and ground-truthing OCMC services.

### **6.3 Survivor perspectives and demand-side barriers to access**

The Survivor Study (2019), which is based on a sample of 45 cases of GBV collected from 26 OCMCs, presents the most comprehensive study of survivor perspectives on access to OCMC services and the quality of care received.

The case stories show how social norms perpetuate gender inequality and women’s powerlessness, and act to condone male VAWG. Gender-unequal attitudes, values and beliefs put women and girls at risk of violence and impact decisions on whether to speak out about experiences of GBV, seek help and pursue justice. The shame and stigma of GBV for the individual and family is a major reason why GBV remains invisible, and why victims can end up being blamed for the violence, and constrained or denied help or justice. In cases of GBV where women and girls are living with impairment the shame is further amplified.

Case #10: a 13-year-old girl was raped and became pregnant. The girl kept silent on what had happened and it was only when her teacher noticed her growing belly that the mother took her to the hospital. After the girl was found to be pregnant at the OCMC, her mother refused to take her home in fear of the response from her elder brother and the loss of social prestige. The girl was provided shelter in a safe house run by a NGO and is where she and the baby remain. Her family have not visited the survivor due to their sense of shame and have prevented a police case being filed.

Taken from Survivor Study, 2019

In many of the cases of domestic violence, men use sexual and physical violence, and sometimes the denial of rights, to assert their control over women. Traditional social norms that confer authority of parents-in-law over daughters-

in-law is a source of considerable family tension and condone the use of violence to control and exploit women, who are often seen as the property of the family. The dominant belief in the subservience of wives to their husbands and parents-in-law can trap women into a culture of violence in the home.

The social norms and gender inequality that trap women and girls into recurring violence are the greatest barrier they face in seeking help. As many of the GBV cases reveal, the survivors that reach hospital have typically suffered very serious injuries that have resulted in police involvement or injuries that need hospital-level attention. OCMC records confirm that most clients arrive via the police.

Survivor stories underline the critical role of safe homes in providing an immediate response to an emergency situation. However, even before the status of safe homes was impacted by federalism, they were a short-term solution providing shelter for up to six months. After this deadline, women generally returned to the family home as they had no other option, no means of financial independence and security. This was the case even when the conditions that fuelled domestic violence had not changed. In some cases, violence reoccurred but the options available to women to leave the violent home are very limited. Long-term solutions, such as livelihood training and seed money to start businesses, have been in short supply and often relied on NGO funding. Signs of municipalities filling this gap are encouraging but they will need to be informed from past experience and lessons learned in Nepal on how to make this most effective.

Community awareness of OCMC services is low: survivors rarely come direct to the OCMC, and as hospital-based centres, they are out of the reach of the majority of the population that live in rural areas. Better coordination with local government and NGOs is important to raise awareness but looking forward there is the more strategic question of how to bring frontline GBV services to primary health care. The WHO recommends that, as much as possible, care for women experiencing intimate partner violence and sexual assault should be integrated into primary health care services to increase access. With municipalities showing an increasing interest in addressing GBV, and the threat of increasing domestic violence because of the COVID-19 crisis, now is arguably the right time to look beyond hospital-based OCMCs and design strategies for taking frontline care and GBV prevention to the primary level.

#### **6.4 Promising innovation and good practices**

Given the deep structural change taking place in Nepal, teasing out the progress being made by OCMCs, and the factors contributing to their improvement, presents a challenge. The findings above reflect the diversity of experience and further sense-making of these findings will take place with stakeholders once the COVID-19 pandemic has been contained. In the interim, we believe there are

good practices emerging and innovative solutions to complex problems that inform the strategic roadmap that MoHP plans to develop for OCMCs for the next five years.

Governance and strategic coordination:

- Provincial leadership in forging agreements between federal, provincial and municipal governments on GBV priorities and division of funding as per Karnali Province.
- DCC facilitating municipalities to collectively prioritise and fund GBV prevention and services that are most efficiently and responsively provided at an aggregate level, as per Chitawan GBV Management Fund.
- Deputy Mayors leading and mobilising political support and accountability for GBV as per Janakpur.

Systems approach and service delivery model:

- The systems strengthening approach to strengthening GBV services remains valid. The differential capacity, resources and performance of hospitals in delivering GBV services suggests the existing OCMC model be adapted for higher level and higher functioning hospital settings.

Organisation and Management (O&M) changes:

- Development of OCMCs as a separate unit within hospitals where demand for services is high
- Hospital management strengthening coordination across departments to raise attention to GBV, increase identification and referral of survivors, and promote supportive attitudes and respectful care towards survivors.

Capacity development:

- GBV Clinical Protocol, medico-legal and psychosocial counselling training and OCMC orientation have received good feedback and need to continue to be rolled out, with refresher training factored in. Improving health provider awareness and skills increases GBV detection and care of survivors.

Flexibility to enable champions to adapt:

- Effective, well-performing OCMCs have champions that have taken the initiative to build relationships with local stakeholders and foster GBV survivor networks. Enabling local adaptation through management support and ensuring funding is transparent and accessible is important.

GBV survivor networks:

- Survivors are a valuable resource for OCMCs and advocates for social norm change. Involving women's organisations in addressing GBV is global good practice. They bring perspective, voice and can ground services in the lived realities of survivors, and motivate health providers and management.

## **7. Recommendations for the Future**

The findings of this study will be reviewed by the TWG once the COVID-19 emergency has been managed, and will contribute to the development of a national five-year strategic plan. International experience shows there is no single model to institutionalising GBV services into the health system, and context and adaptation is key. Nepal is following good practice by taking a system-strengthening approach and this needs to be continued. In light of the new governance context, a priority for the next phase of integrating GBV services into the health system will be building local ownership and sustainability of OCMCs as a critical part of the multisectoral response to GBV.

Specific recommendations for consideration by the TWG follow. Some are already included in the revised OCMC Operational Manual (2020) awaiting approval by the MoHP Secretary. New proposals that are endorsed by the TWG may be included as amendments to the OCMC AWPB guidelines.

### **7.1 Clarify governance arrangements and roles and responsibilities**

The respective roles and responsibilities of federal, provincial and municipal governments need to be agreed to avoid duplication of effort, promote efficiency, and to clarify accountability. Specifically:

- Coordination at the national level needs enhancing through quarterly review meetings convened by the Population Management Division. The multisectoral meetings need to include: MoHP (Population Management Division and Nursing and Social Security Division), MoWCSC (Women Empowerment Division), National Women Commission (Secretary), Nepal Police (Women Children and Senior Citizen Directorate), Attorney Office (Deputy Attorney General).
- Provincial MoSD to provide leadership and champion GBV prevention and services in the provinces. Responsibilities to include provision of annual budget for the operation and capacity enhancement of OCMCs and support for the establishment of rehabilitation services.
- District Advisory Committee: to coordinate and build collective responsibility and ownership of GBV and OCMCs it is recommended that the GBV Management Advisory Committee included in the revised OCMC Guidelines be formed. The GBV Management Advisory Committee is to be chaired by Chief of the DCC and comprise all Deputy Mayors of metropolitan cities, sub-metropolitan cities, municipalities and village municipalities as members. The DCC shall facilitate the formation and functionality of the GBV Management Advisory Committee and be responsible for overseeing GBV management in the district, including functionality of OCMCs.
- District-level GBV management fund to be established with contributions from all local-level governments in the district. The focus of the fund will be GBV prevention, rescue, capacity enhancement of OCMCs, funding of shelter home and rehabilitation centres, and strengthening survivors' networks.
- Mayors, Deputy Mayors and local government officers to receive orientation on GBV and OCMCs to support municipalities take charge of their response to GBV. In addition, annual workshops are recommended, involving Deputy Mayors and local stakeholders to share experiences, network and develop a joint action plan to address GBV in the district.

## **7.2 Scale up OCMCs and adapt to context**

While endorsing the decision to scale up the OCMC model to all 77 districts in 2020/21, in collaboration with the Provincial MoSD, this study suggests that the model may be best adapted to different operating environments; as recommended by international good practice<sup>22</sup>.

It is recommended that stakeholders consider adapting the hospital-based OCMC model to better fit different hospital contexts. A model Advanced One-stop Crisis Management Centre (OCMC+) could be developed for tertiary and provincial-level hospitals with the capacity to create a separate unit with dedicated staff, specialists in place, increased human resources, and where demand is high, such as at Koshi, Janakpur, Hetauda, Bharatpur, Bheri and Surkhet. OCMC+ hospitals are those with clinical protocol training capacity and specialist expertise to which OCMCs can refer clients needing specialist care. The existing OCMC model would continue to be applied in the remaining hospitals.

## **7.3 Institutionalise OCMCs in the hospital structure and increase human resourcing**

To institutionalise OCMCs as a mandatory hospital unit and service, it is proposed that the OCMC be included in the hospital organogram with staff provision when MoHP or provincial government conduct an O&M review of the hospital. Provision should likewise be made for OCMC human resourcing of one Medical Doctor, two Staff Nurses and one Counsellor. The loss of trained staff needs to be halted, with GBV trained staff only transferred to facilities with an established OCMC.

## **7.4 Continue to develop the capacity of health providers**

To continue to strengthen the health workforce to identify GBV survivors, provide counselling, treatment and referral and maintain confidentiality and quality standards, it is imperative that capacity development continues:

- MoHP to organise annual provincial-based clinical medico-legal training in coordination with Provincial MoSD. Secondly, MoHP and NHTC to organise refresher training-cum-workshops for forensic and GBV medico-legal experts to share GBV-related experience and lessons learned.
- Establish and make functional Forensic Department/Unit at provincial and other strategic hospitals to institutionalise medico-legal services. The following hospitals to be prioritised, given their referral function, capacity and demand: Koshi, GNS, Janakpur, Bharatpur, Lumbini, Pokhara, Surkhet, Bheri and Sethi Hospitals.
- Standardise psychosocial counseling curricula, which are being developed with support from NHSSP. Once ready, roll out training curricula to all provinces in partnership with NHTC/MoHP, Provincial MoSD and External Development Partners (EDPs), so that all OCMC based hospitals are reached.
- Roll out the revised GBV Clinical Protocol (submitted to MoHP Secretary and awaiting approval) in federal, provincial and district hospitals. The following hospitals are recommended as referral hospitals to provide on-the-job training and step-down training to other hospitals.
  - Province1: Koshi Hospital
  - Province 2: GNS Hospital, Janakpur Hospital
  - Bagmati Province: Bharatpur Hospital, Maternity Hospital

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<sup>22</sup> Claudia Garcia-Morena et al. 2015. "The health-systems response to violence against women". The Lancet 2015; 385:1567-79.

- Gandaki Province: Pokhara Hospital
- Province 5: Lumbini Provincial Hospital, Bheri Hospital
- Karnali Province: Surkhet Provincial Hospital
- Sudurpashchim Province: Seti Provincial Hospital.
- Basic training: all clinicians should be given pre-service and in-service training to know when and how to ask about violence, what first-line care to provide, and how to refer for additional support.

Supportive supervision and monitoring need to be provided on a regular basis from the MoHP and Provincial MoSD to reinforce and support implementation of GBV-related training.

### **7.5 Provide a package of rehabilitation services and clarify responsibility for delivery**

A rehabilitation package of services needs to be clearly defined and guaranteed for survivors at the national level. Oversight and responsibility for funding and implementation will differ according to the governance model in operation in specific localities. For example, in districts where there is a GBV Management Fund, such as Chitawan, this will be overseen through that multi-government body. In situations where a municipality is covering the cost of rehabilitation, such as in Surkhet, Hetauda and Bharatpur, then the municipality itself will oversee implementation. In districts where there is no local initiative, then responsibility has to fall to the GBV Advisory Committee to ensure that the rehabilitation package is made available to survivors and responsibility allocated to relevant GBV service providers. The rehabilitation package should include the following:

- Continuing the free school education of child survivors in reputable private or public schools.
- Continuing school education of survivors' children.
- Vocational and skill-based training for survivors considering the job market and their interest.
- Higher-level education support for survivors.
- Seed money for survivors to establish micro-businesses.
- Formation of survivors' network and cooperative development.
- Provide care and rehabilitation of persons with disability including those with intellectual challenges.

Rehabilitation centres need to meet minimum service standards and be gender-, child- and disability-inclusive in terms of infrastructure and services.

### **7.6 Develop a plan for rolling out GBV prevention and first aid care to primary level**

As political will to address GBV increases, and with the increasing capacity of hospitals to operate OCMCs, the next step is to take prevention and first aid care to the primary level. This is especially important to increase access to care. Such a move will be a step-change for the system but with domestic violence increasing, triggered by COVID-19, now is a moment to grasp the political momentum. Practically, this will mean extending the rollout of the clinical protocol and referral mechanism as already intended in the Clinical Protocol Guideline to primary health care providers. It will also mean socialising municipalities and ward committees, who will be key agents to make this happen.

### **7.7 Improve referral and coordination at the operational level**

To improve referral and coordination at the operational level, OCMCs need to coordinate with all local governments in the district catchment area and improve coordination with Nayeek Samiti (Judicial Committee). The referral mechanism included in the revised OCMC Manual (2020) needs to be adopted and put into practice.

### **7.8 Strengthening evidence and its use**

Plans to move to online reporting of the OCMC as part of the Health Management Information System (HMIS) need to be expedited. This will contribute to better-quality data for decision making. The capacity of health providers to convey data, evidence and good practices needs enhancing so that they are better able to advocate within the hospital and with local stakeholders.

In the longer term, harmonisation and interoperability of evidence collection among service providers is required but at this stage in the development of GBV services this is considered a next-generation task.

## Annex 1: Detailed List of Stakeholders Consulted

<b>Federal Government of Nepal</b>  Ministry of Health and Population: <ul style="list-style-type: none"> <li>• Chief, Population Management Division (PMD)</li> <li>• Chief, Nursing and Social Security Division (NSSD)</li> <li>• Chief, GBV and Geriatric Section, NSSD</li> <li>• Chief, Gender Equality and Social Inclusion (GESI) Section, PMD</li> <li>• Community Nursing Officer, GESI Section, PMD</li> <li>• Section Officer, GESI Section, PMD</li> </ul> Ministry of Women, Children and Senior Citizens: <ul style="list-style-type: none"> <li>• Women Empowerment Division</li> </ul> Nepal Police: <ul style="list-style-type: none"> <li>• Women, Children and Senior Citizen Directorate</li> </ul> Office of the Attorney General: <ul style="list-style-type: none"> <li>• Section Officer</li> </ul> National Women Commission: <ul style="list-style-type: none"> <li>• Secretary</li> <li>• Under Secretary</li> </ul>		
<b>Province #2</b>	<b>Province #5</b>	<b>Sudurpashchim Province</b>
<b>Provincial MoSD</b> Chief, Health Service Division Director, Provincial Health Directorate	<b>Provincial MoSD</b> not available	<b>Provincial MoSD</b> Women Development Officer, Social Development Division
<b>Kalैया Hospital</b>  <b>OCMC:</b> Medical Superintendent and OCMC staff  <b>Kalैया Sub-metropolitan City:</b> Mayor, District Attorney: Chief of District Attorney  <b>District:</b> Chief District Office (CDO)  <b>Police:</b> Chief of Women and Children Service Unit	<b>Taulihawa Hospital</b>  <b>OCMC:</b> Chief, doctors and Medical Superintendent  <b>District Attorney</b>  <b>Kapilvastu Municipality:</b> Deputy Mayor  <b>Safe home:</b> Sathi  <b>CSOs supporting GBV:</b> Mahuri Home; Worec; Kalika; Naari Sheepakala; Samajik Bikash Kendra	<b>Mahakali Hospital</b>  <b>Mahakali Hospital:</b> Acting Medical Superintendent  <b>OCMC:</b> Chief and OCMC staff  <b>Police:</b> Inspector, Women Cell – Mahendranagar; Officer, Women Cell – Mahendranagar  <b>Safe home and rehabilitation:</b> Sathi; Alpakalin Sewa; Kendra  <b>Bhimdatta Municipality, Mahendranagar, Kanchanpur:</b> Deputy Mayor; Women Development Officer; Nayeek Samiti
<b>Janakpur Provincial Hospital</b>  <b>Janakpur Provincial Hospital:</b> Medical Superintendent  <b>OCMC:</b> Chief and OCMC staff  <b>OCMC CMC,</b> including Medical Officer, CSO representatives  <b>District Coordination Committee</b> including Chief District Officer,	<b>Bheri Hospital</b>  <b>Bheri Hospital:</b> Medical Superintendent  <b>OCMC:</b> Chief and OCMC staff  <b>Safe home and rehabilitation:</b> Jit Bahadur Budhamagar; Shakti Samuha; Saathi; Maiti Nepal	<b>Seti Provincial Hospital</b>  <b>Seti Provincial Hospital:</b> Acting Medical Superintendent  <b>OCMC:</b> OCMC Focal point  <b>Safe home and rehabilitation:</b> WOREC Nepal; Maiti Nepal  <b>Dhangadhi Sub-metropolitan City:</b> Deputy Mayor; Asst. Women Dev. Supervisor; Officer, Social

District Attorney, District Police Chief, Chief of the Women and Children Cell	<b>Nepalgunj Sub-metropolitan City:</b> Deputy Mayor; Women Development Officer	Development Division; Officer, Health and Social Division
<p><b>Gajendra Narayan Singh Hospital, Rajbiraj</b></p> <p><b>GNS Hospital:</b> Medical Superintendent; four Medical Officers</p> <p><b>OCMC staff</b>, including Counsellor</p> <p><b>Police:</b> District Police Chief and Chief of the Women and Children Cell</p> <p><b>Rajibiraj Municipality:</b> Mayor; Deputy Mayor; District Attorney Officer</p> <p><b>District:</b> CDO</p> <p><b>Safe Home staff</b></p>		
<p><b>Gaur Hospital, Rautahat</b></p> <p><b>OCMC:</b> Chief, Medical Officer and Medical Superintendent</p> <p><b>Gaur Municipality:</b> Mayor and Deputy Mayor</p> <p><b>District:</b> Chief District Office; District Health Officer</p> <p><b>Police:</b> Police Officer</p>		
<p><b>OCMC Case studies</b></p> <p><b>Bharatpur:</b> Mayor, Deputy Mayor, all other key teams of the Local Government, Women and Social Development Officer and Safe Home Chiefs</p> <p><b>Hetauda:</b> OCMC Chief and staff</p> <p><b>Koshi:</b> Province 1 Ministry of Social Development; Biratnagar Metropolis (Deputy Mayor and Social Development Division Chief); Koshi Hospital (Medical Superintendent and OCMC staff; NGOs working in Morang district, safe home in the district.</p> <p><b>Sindhuli:</b> OCMC staff; Mayor, Deputy Mayor; CDO</p>		
<p><b>Other stakeholders</b></p> <p>Karnali Province: Ministry of Social Development (Minister; Chief Social Development Division; Chief Health Service Division; Director, Health Service Directorate); Surkhet Provincial Hospital (Medical Superintendent, Doctors, OCMC staff, CMC members); Birendranagar Municipality (Deputy Mayor)</p> <p>EDPs: UNFPA, UNICEF, ADB</p> <p>NGOs: FPAN, CMC, CVICT, TPO, Manav Sewa Ashram, Koshish, NGOs working in Surkhet of Karnali Province</p> <p>Experts: Dr Harihar Wosti, Forensic Expert, Institute of Medicine, Tribhuvan University Teaching Hospital, Kathmandu</p>		

## Annex 2: Key Findings and Recommendations of 2016 OCMC Good Practice Paper and 2017 OCMC Case Study

2016 Good Practice Paper	2017 Case Study
<b>Barriers to accessing OCMCs</b>	
	<ul style="list-style-type: none"> <li>• Workload at home</li> <li>• Financial factors</li> <li>• Sociocultural and religious beliefs</li> <li>• Social restrictions and fear of further violence</li> <li>• Ecological barrier</li> <li>• Lack of awareness and information about OCMCs</li> <li>• Additional barriers faced by women with disabilities</li> <li>• Lack of shelter homes</li> <li>• Lack of knowledge of legal issues, reluctance to press legal action</li> </ul>
<b>OCMC achievements</b>	
<ul style="list-style-type: none"> <li>• Good coordination between hospital departments</li> <li>• 24/7 services</li> <li>• Hard work and dedication of OCMC Focal Point</li> <li>• Client confidentiality and security maintained</li> <li>• 24/7 laboratory services</li> <li>• GBV community sensitisation</li> <li>• Regular follow-up of survivors</li> <li>• Survivor network</li> </ul>	<p>Sunsari and Makwanpur OCMCs</p> <ul style="list-style-type: none"> <li>• Adhered to privacy and confidentiality standards</li> <li>• Improved provision of psychosocial counselling</li> <li>• Informal follow-up of survivors post-treatment</li> <li>• Empathetic staff</li> </ul>
<b>OCMC challenges and gaps</b>	
<ul style="list-style-type: none"> <li>• Separate agencies follow own guidelines and approaches</li> <li>• Perception OCMC is the hospital responsibility</li> <li>• Delay in fund release and hiring local staff</li> <li>• Inflexible budget headings and lack of transparency in budget management</li> <li>• Infrequent DCC meetings</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of appropriate infrastructure</li> <li>• Inadequate staffing</li> <li>• Insufficient capacity building and training of OCMC staff and supporting hospital teams</li> <li>• Doctors untrained to undertake medico-legal examinations</li> <li>• Low public awareness of OCMCs and the illegality and consequences of GBV</li> <li>• Insufficient budget to fund comprehensive services to GBV survivors</li> </ul>
<b>Key recommendations</b>	
<p>Integrated approach</p> <ul style="list-style-type: none"> <li>• Develop umbrella guidelines covering all agencies</li> <li>• Develop district-level GBV work plans</li> <li>• Make WDO focal point for coordinating GBV activities</li> <li>• Develop one-window reporting system to avoid duplication and ensure authenticity of data</li> </ul> <p>OCMC strengthening</p> <ul style="list-style-type: none"> <li>• Medico-legal training, training on GBV Clinical Protocol, psychosocial counselling and GBV sensitisation</li> <li>• OCMCs to follow up survivors to ensure they are safe</li> </ul>	<p>Capacity building</p> <ul style="list-style-type: none"> <li>• Capacity building of OCMC and hospital staff on GBV, identifying survivors and providing first-line supportive care and referral</li> <li>• Medico-legal training of doctors</li> <li>• Ongoing training of health workers, social workers and the police</li> <li>• Include GBV and OCMCs in nursing and medical basic training</li> </ul> <p>Staffing</p>

<p>Support for survivors</p> <ul style="list-style-type: none"> <li>• Free education of child rape survivors in residential schools</li> <li>• Livelihood training for survivors</li> </ul> <p>Prevention and awareness</p> <ul style="list-style-type: none"> <li>• Increase GBV prevention programmes</li> <li>• GBV sensitisation for watch groups</li> </ul>	<ul style="list-style-type: none"> <li>• Adequate staffing (one doctor and three nurses) to run 24/7 services</li> <li>• Minimum two-year contract of contract staff; ensure GBV-trained staff are transferred to other OCMCs</li> <li>• Depute more women doctors</li> </ul> <p>Infrastructure</p> <ul style="list-style-type: none"> <li>• Improve infrastructure to meet OCMC guideline standards</li> </ul> <p>Referral</p> <ul style="list-style-type: none"> <li>• Establish and strengthen the referral mechanism to higher-level hospitals</li> <li>• Develop local mechanisms for referral to OCMCs from VDCs</li> </ul> <p>Multisectoral services</p> <ul style="list-style-type: none"> <li>• MoWCSC to establish safe homes in all districts</li> <li>• Free education at residential schools for child survivors and children of rape survivors</li> <li>• Establish a formal follow-up mechanism to support survivors in partnership with other agencies</li> </ul> <p>Management</p> <ul style="list-style-type: none"> <li>• Strengthen supervision and monitoring of OCMCs at central and district levels</li> <li>• Strengthen capacity of CMCs and DCCs</li> <li>• Strengthen multisectoral coordination</li> </ul> <p>Prevention and awareness</p> <ul style="list-style-type: none"> <li>• Raise public awareness</li> <li>• Invest in prevention programmes</li> </ul> <p>Funding</p> <ul style="list-style-type: none"> <li>• Make adequate and sustainable</li> </ul>
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### Annex 3: OCMC Performance Annual Self-Assessment Format

Scoring system: 4 = very good, 1 = very poor

OCMC.....District

Date:

#### a) Capacity Assessment Indicators

No.	Indicators (ideal state)	Current status	Score
1	Staff nurse(s) on contract is on duty year round (12 months = 4; 11 months = 3; 10 months = 2; <10 months = 1)		
2	Trained psychosocial counsellor is available year round (12 months = 4; 11 months = 3; 10 months = 2; <10 months = 1)		
3	Doctor(s) trained in medico-legal field are available in OCMC based hospital (2 doctors = 4; 1 doctor mostly available = 3; 1 doctor sometimes available = 2; no doctors available = 1)		
4	Medical officer is available in a timely manner for all cases requiring medico-legal services <ul style="list-style-type: none"> <li>• OCMC medical officer or his/her replacement always available in a timely manner = 4;</li> <li>• No replacement in case of absence of medical officer = 3;</li> <li>• Medical officer available only during duty hours = 2;</li> <li>• Medical officer or his/her replacement mostly not available = 1</li> </ul>		
5	Medical superintendent has given clear written instructions on roles and responsibility of OCMC medical officer, emergency department, psychosocial counsellor and OCMC staff nurse (clear written instructions = 4; clear verbal instructions = 3; unclear instructions = 2; no instructions = 1)		
6	All hospital departments and units are well-informed about OCMC services, staff and their responsibilities (all departments and units = 4; most departments and units = 3; some departments and units = 2; none informed = 1)		
7	The OCMC is well equipped with necessary rooms, furniture, computer, telephone, medical equipment and supplies (including provision for forensic evidence preservations) <ul style="list-style-type: none"> <li>• Well-equipped = 4;</li> <li>• Rooms and furniture available, but some equipment and supplies missing = 3;</li> <li>• Rooms and furniture not sufficient and/or equipment and supplies mostly missing = 2;</li> <li>• Most provisions not met = 1</li> </ul>		
8	OCMC always adheres strictly to medico-legal service guidelines and service protocols (clinical, counselling, confidentiality and forensic evidence preservation) <ul style="list-style-type: none"> <li>• Always adheres strictly to all protocols = 4;</li> <li>• Only protocols related to clinical and counselling are followed = 3;</li> <li>• Protocols mostly not followed = 2;</li> </ul>		

No.	Indicators (ideal state)	Current status	Score
	<ul style="list-style-type: none"> <li>• Protocols rarely followed = 1</li> </ul>		
9	Patient-wise documentation timely and appropriately maintained <ul style="list-style-type: none"> <li>• All done as per reporting format as per OCMC guidelines or online reporting system = 4;</li> <li>• All documentation timely and appropriately in hard copies only = 3;</li> <li>• Some documents not completed on time or appropriately = 2;</li> <li>• Documentation mostly do not meet the guideline requirements = 1</li> </ul>		
10	OCMC provides regular report within specified time to the Population Management Division/MoHP, Provincial Social Development Ministry and GBV Coordination Committee <ul style="list-style-type: none"> <li>• Data and reports always submitted within specified time = 4;</li> <li>• Data and reports mostly submitted within specified time = 3;</li> <li>• Data and reports mostly not submitted within specified time = 2;</li> <li>• Data and reports rarely submitted within specified time = 1;</li> </ul>		
	<b>Total score</b>		
	<b>Percentage (out of 40 full score)</b>		<b>%</b>

#### b) Coordination and Collaboration Assessment Indicators

No.	Indicators	Current status	Score
1	State of coordination and collaboration with relevant hospital departments/units (emergency, indoor, outdoor, laboratory): <ul style="list-style-type: none"> <li>• Indoor and emergency departments take care of GBV cases during off-office hours; all services, including medico-legal and other lab services, are provided on time = 4.</li> <li>• Indoor and emergency departments take care of GBV cases during off-office hours; all services including medico-legal and other lab services are provided on time, but medico-legal protocol not properly followed = 3.</li> <li>• Indoor and emergency departments and lab do not take care of GBV cases during off-office hours; medico-legal protocol is not properly followed although other services are promptly provided = 2.</li> <li>• Indoor and emergency departments and lab do not take care of GBV cases during off-office hours; medico-legal and other services are also not provided on time = 1.</li> </ul>		
2	State of coordination and collaboration with district police offices: <ul style="list-style-type: none"> <li>• Police cooperate in providing treatment and counselling as per clinical protocol to all GBV survivors and also report periodically on status of GBV cases referred from OCMC = 4.</li> <li>• Police cooperate in providing treatment and counselling as per clinical protocol to all GBV survivors but do not report periodically on status of GBV cases referred from OCMC = 3.</li> </ul>		

No.	Indicators	Current status	Score
	<ul style="list-style-type: none"> <li>• Police report periodically on status of GBV cases referred from OCMCs but do not cooperate in providing treatment and counselling as per clinical protocol to all GBV survivors = 2.</li> <li>• Police neither cooperate in providing treatment and counselling as per clinical protocol to all GBV survivors nor report periodically on status of GBV cases referred from OCMC = 1.</li> </ul>		
3	<p>State of coordination and collaboration with legal support offices:</p> <ul style="list-style-type: none"> <li>• District attorney, district bar or private lawyers hired by government/NGO provide timely, appropriate and free-of-cost service to clients in consultation with the police where required and provide monthly status reports to the CMC/OCMC = 4.</li> <li>• District attorney, district bar or private lawyers hired by government/NGO provide timely, appropriate and free-of-cost services to clients in consultation with the police where required but do not provide monthly status reports to CMC/OCMC = 3.</li> <li>• District attorney, district bar or private lawyers hired by government/NGO do not provide timely, appropriate and free-of-cost services to clients in most cases and usually do not consult with the police where required and do not provide monthly status reports to CMC/OCMC = 2.</li> <li>• District attorney, district bar or private lawyers hired by government/NGO rarely provide timely, appropriate and free-of-cost services to clients and rarely consult with police where required and do not provide monthly status reports to CMC/OCMC = 1.</li> </ul>		
4	<p>State of coordination and collaboration with local governments and safe homes/rehabilitation centres:</p> <ul style="list-style-type: none"> <li>• Safe homes/rehabilitation centres refer survivors to OCMC where required, safe homes/rehabilitation centres accept OCMC-referred survivors, local governments actively work to ensure livelihood, reintegration and rehabilitation support required by survivors, and safe homes/rehabilitation centres provide monthly status report to CMC/OCMC = 4.</li> <li>• Safe homes/rehabilitation centres refer survivors to OCMC where required, safe homes/rehabilitation centres accept OCMC-referred survivors, local governments actively work to ensure livelihood, reintegration and rehabilitation support required by survivors, but safe homes/rehabilitation centres do not provide monthly status report to CMC/OCMC = 3.</li> <li>• Safe homes/rehabilitation centres refer survivors to OCMC where required, safe homes/rehabilitation centres accept OCMC-referred survivors but local governments do not actively work to ensure livelihood, reintegration and rehabilitation support required by survivors, and safe homes/rehabilitation centres do not provide monthly status report to CMC/OCMC = 2.</li> <li>• Safe homes/rehabilitation centres rarely refer survivors to OCMC where required, OCMC refers the survivors to safe homes/rehabilitation centres where required but local governments do not actively work to ensure all support required by survivors (livelihood, reintegration and rehabilitation) and safe homes/rehabilitation centres do not provide monthly status report to the CMC/OCMC = 1</li> </ul>		

No.	Indicators	Current status	Score
5	<p>State of coordination and collaboration with local networks working in GBV field:</p> <ul style="list-style-type: none"> <li>• Local networks refer GBV cases to OCMC, monitor and support re-integrated survivors and provide monthly status report (by phone) on survivors = 4.</li> <li>• Local networks refer GBV cases to OCMC, monitor and support re-integrated survivors but do not provide monthly status report (by phone) on survivors = 3.</li> <li>• Local networks monitor and support re-integrated survivors but do not refer GBV cases to OCMC and also do not provide monthly status report (by phone) on survivors = 2.</li> <li>• Local networks rarely refer GBV cases to OCMC, rarely monitor and support re-integrated survivors and do not provide monthly status report (by phone) on survivors = 1.</li> </ul>		
6	<p>Joint action plan with budget and progress review by key stakeholders (OCMC, local level, police, NGOs and other concerned agencies) prepared and implemented at local level:</p> <ul style="list-style-type: none"> <li>• Joint action plan with budget prepared and implemented, joint trimesterly progress review (including expenditure review) held regularly = 4.</li> <li>• Joint action plan with budget prepared and implemented, joint trimesterly progress review (including review of expenditure) either not done or done irregularly = 3.</li> <li>• Joint action plan not prepared but joint progress review (excluding review of budget and expenditure) done at least once a year = 2.</li> <li>• Joint action plan not prepared, no joint progress review = 1.</li> </ul>		
7	<p>State of coordination and collaboration with stakeholder NGOs:</p> <ul style="list-style-type: none"> <li>• Stakeholder NGOs refer survivors to OCMC where required, provide monthly status report to OCMC and actively work to ensure all support required by survivors (legal, livelihood, reintegration, rehabilitation) = 4.</li> <li>• Stakeholder NGOs refer survivors to OCMC where required, actively work to ensure all support required by survivors (legal, livelihood, reintegration and rehabilitation) but do not provide monthly status report to OCMC = 3.</li> <li>• Stakeholder NGOs refer survivors to OCMC where required but mostly do not work to ensure all support required by survivors (legal, livelihood, reintegration and rehabilitation) and also do not provide monthly status report to OCMC = 2.</li> <li>• Stakeholder NGOs rarely refer survivors to OCMC, rarely work to provide legal, livelihood, reintegration and rehabilitation support to survivors nor provide monthly status report to OCMC = 1.</li> </ul>		
8	<p>Promotion of OCMC services and creation of awareness on GBV:</p> <ul style="list-style-type: none"> <li>• OCMC develops appropriate Information, Education and Communication (IEC) materials in locally suitable languages and disseminates them regularly through appropriate combination of local media (FM radio, leaflets, posters, hoarding boards, citizen charter, press meets) in collaboration with local level and NGOs = 4.</li> <li>• OCMC develops appropriate IEC materials in locally suitable languages and disseminates them regularly through appropriate combination of local media (FM radio, leaflets, posters, hoarding boards, citizen charter, press meets) = 3.</li> </ul>		

No.	Indicators	Current status	Score
	<ul style="list-style-type: none"> <li>• OCMC develops some IEC materials and disseminates them irregularly through some local media (FM radio, leaflets, posters, hoarding boards, citizen charter, press meets) = 2.</li> <li>• OCMC rarely develops and disseminates IEC materials = 1.</li> </ul>		
	<b>Total score</b>		
	<b>Percentage (out of 32 full score)</b>		%