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# Assessment of the Performance of Hospital-Based One Stop Crisis Management Centres


Health services to women and children victims of violence
Hospital-based One Stop Crisis Management Centre
Mahakali Zonal Hospital, BS 2068


Population Division
Ministry of Health and Population
Ramshah Path, Kathmandu


Strengthening Health Systems-Improving Services

*ACKNOWLEDGEMENTS*

The Population Division of the Ministry of Health and Population (MoHP) is the Gender Equality and Social Inclusion (GESI) Secretariat for Nepal's health sector. The division's work under this role is crucial for implementing the government's mandate to make quality health services accessible to all citizens, including women, and poor and disadvantaged people.

Large numbers of women and children in Nepal experience gender-based violence (GBV) that results in physical, sexual and psychological damage. The Nepal Demographic and Health Survey (2011) found that more than one in five women aged 15–49 years had experienced physical violence since their fifteenth birthdays, while 9% of them had experienced sexual violence.

MoHP is the main executive body responsible for implementing Clause 3 of the 'National Action Plan 2010 against Gender-Based Violence'. This clause calls for providing integrated services to survivors of gender-based violence by establishing hospital-based one-stop crisis management centres (OCMCs). MoHP has, since 2011, established 15 OCMCs in hospitals to provide integrated services to GBV survivors. Two years after the first OCMCs were established it was time to assess their performance and capacity. The assessment reported in the following pages looked at the functioning and quality of services provided including how the hospitals have been coordinating with other district agencies to provide livelihood, legal and rehabilitation support to GBV survivors, and has identified the strengths, constraints and further support needs of OCMCs.

I would like to extend my sincere appreciation to the team of consultants (lead consultant Pinky Singh Rana, clinical consultant Dr Tara Shakya, research consultant Ruchi Lohani and assistant clinical consultant Laxmi Bista) for the very high quality work they carried out in completing this assignment. I am very grateful to my team in the Population Division for working so hard on this important issue and particularly thank Dr Bhuwan Poudel and Mr Mukunda Sharma for their untiring support for this responsibility of the Population Division.

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I hope this report supports the more effective management and service delivery of OCMCs.

Dr Badri Pokhrel

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*EXECUTIVE SUMMARY*

*Assessment of the Performance of*
*Hospital-Based One Stop Crisis Management Centres*

## A. INTRODUCTION

The Ministry of Health and Population (MoHP) introduced one-stop crisis management centres (OCMCs) in hospitals in 2011 in order to provide integrated services to survivors of gender-based violence (GBV).

The twin purposes of this assessment were to:

- assess the performance of four hospital-based OCMCs in providing services to GBV survivors to identify constraints and gaps; and
- make recommendations to improve the functioning of OCMCs so that they provide better services to survivors of GBV and to other affected persons.

The assessment was supported by the Nepal Health Sector Support Programme (NHSSP) and the United Nations Population Fund (UNFPA). It was carried out by reviewing documents, interviewing central and district level OCMC stakeholders, tracking and collecting case studies from 20 GBV survivors who had received OCMC services, and by making field visits to four OCMCs in order to verify the data collected and to hold discussions with OCMC service providers and other stakeholders.

## B. FINDINGS

*Operational performance and management* — The assessment found a clear consensus among central and district level stakeholders, and particularly among GBV survivors themselves and their families, that OCMCs are a worthwhile and positive government-led initiative. The case studies featured in this report provide particularly compelling testimony to this effect.

However, the assessment also revealed insufficient and inadequate horizontal coordination and collaboration at both central and district levels to allow the provision of fully integrated services (medical, security, legal, shelter, and skills training) for survivors. In addition, there have been only limited efforts to promote OCMC ownership by enabling stakeholders to understand their roles and fulfil their responsibilities.

- The district coordination committees (DCC), which are the main bodies responsible for mobilising survivor support and overseeing OCMC functioning, were largely inactive. Most DCC members believed that OCMC management was the responsibility of hospitals alone.
- No formal meetings of case management committees (CMCs) had taken place in three of the four study districts (Kanchanpur, Makawanpur and Sunsari). Most follow-up communications with survivors had taken place by phone. The CMC in Baglung had met only once in order to discuss a particularly troublesome case.
- There were inadequate links from OCMCs and other stakeholders to legal counselling services (from government lawyers and Bar Association members).
- Local collaboration and coordination with NGOs varied widely. In Makawanpur, Sunsari and Baglung districts, several NGOs were providing shelter and skills training services for GBV survivors, but in Kanchanpur even those NGOs specialising in GBV and women's empowerment were unaware of the OCMC's existence and the services it provides.

In all four districts, OCMC effectiveness was seen to be compromised by the absence of work plans.

*Use of operational manual* — MoHP's OCMC Operational Manual provides guidance on how OCMCs should function. However interviews with OCMC staff revealed that many of them had not seen the manual.

*Infrastructure and physical resources* — The quality and quantity of physical facilities provided for OCMCs varied significantly often depending on the levels of personal understanding, commitment and support of the hospital's medical superintendent and finance officer. The study found that OCMC medical instruments and equipment were frequently shared with in-patient departments and that stocks of medical supplies were often inadequate. Only two OCMCs had separate counselling rooms likely to protect privacy and confidentiality.

*Quality of care* — The quality of care provided to GBV survivors in the four OCMCs ranged from good to almost non-existent, although where services were provided, they almost always greatly appreciated by survivors. One case from Makawanpur highlights the positive role that OCMCs can play. The OCMC staff nurse had supported a young woman suffering from acute depression with repeated counselling, together with her parents. Frequent follow-up improved relations between the survivor and her parents and improved the survivor's outlook on life. By contrast, a case from Kanchanpur showed that despite being admitted to hospital for eight days, a poor GBV survivor did not receive any OCMC services. Up until day four the women had paid her own medication and food bills, only after which did she apply for a needy person's subsidy. Reports from the OCMC indicate that she received counselling but these appear to be misleading since the survivor declared no knowledge of the OCMC.

*Human resources* — All four OCMCs were staffed, but to varying degrees. The presence of three staff nurses, and the sensible division of responsibilities, ensured that 24-hours services were available in Baglung and Sunsari OCMCs. However, 24-hour services were not however in Kanchanpur and Makawanpur OCMCs due to only two staff nurses being available and the long distance to their residences which made it difficult for them to attend at night. It should be noted that the OCMC operational manual requires that three staff nurses be assigned to enable 24-hour service availability.

There is a risk that the specialist knowledge gained by contracted staff nurses may be lost since their contracts must currently be renewed on a yearly basis. Investments in focal points/staff nurses/psycho-social counsellors may similarly be wasted if their retention is not assured through longer contracts. The hospital-based police personnel are providing very useful support, particularly related to referrals, legal protection and the filing of complaints and cases, but they are yet to be considered as OCMC personnel. A NGO volunteer, as specified in the manual, had yet to be appointed in any of the four OCMCs studied.

*Building the capacity of service providers* — MoHP's initiative in providing 6-month psycho-social counselling training to OCMC staff nurses has proven highly effective. Survivors have clearly benefited from the resulting skills of the counsellors, but no other form of capacity building had been provided for DCC members, hospital staff, CMC members, or NGOs.

*Services provided and coordination with other stakeholders* — Medical treatment has been the main service provided by OCMCs including basic check-ups, psycho-social counselling and medico-legal services. The four centres had provided services to 362 survivors (Baglung 117, Kanchanpur 83,

Makawanpur 82 and Sunsari 80) and documented each case by gender, age and ethnicity, although the data recorded varied by district. It is projected that actual demand for OCMC services is greater than is currently apparent given the minimal investments made in awareness raising at district and community levels to date and the tendency among victims of GBV to remain silent out of fear of loss or reputation and family stability.

*Referral services* — The OCMCs are referring survivors to other hospitals for advanced treatment, to safe homes for shelter, to the police for lodging cases against GBV perpetrators and to NGOs for rehabilitation including skills training. It was also found that safe homes and the police are referring survivors to OCMCs and that the OCMCs are documenting them as such. The police and safe homes are not however documenting these cases.

*Financial management* — MoHP has been allocating budgets to OCMCs since 2011/12, but there have been frequent delays in the release of budgets since then. In year 2011/12, a lump sum with no budget breakdown was provided. In addition, the failure of DCCs to meet has meant that budget management has been weak.

A lack of transparency in budget management was apparent at each of the 4 OCMCs reviewed. The allocation of a lump sum in the first year created ambiguity around permissible expenditure items and, as a result, two districts proceeded to provide financial incentives to all OCMC and other hospital staff servicing GBV survivors. The selective award of incentives to health staff in hospitals is seen as contentious and was creating discontent among some hospital staff. Other OCMCs are now communicating with Baglung and Sunsari OCMCs to adopt similar incentive-related practices.

*Monitoring and supervision* — Central level monitoring of OCMC performance is the responsibility of the Office of the Prime Minister and the Council of Ministers (OPMCM) and MoHP. The monthly reporting formats collected by MoHP need to be revised to accommodate more gender disaggregated data on types of violence and survivors in order to better inform follow-up practices. It was noted that OPMCM, MoHP and other stakeholders such as women and children service centres (WCSC), and the Department of Women and Children (DWD) are not currently collaborating on monitoring.

At district level, with the DCCs and CMCs yet to be activated, monitoring and supervision remains inadequate. Medical superintendents and district health offices (DHO) require considerable guidance since they are new to the concept of GBV and the provision of holistic support to survivors. Several district level community based organisations and NGOs can potentially play a catalytic role in this area as a result of previous experiences working with GBV although they have been little involved in OCMCs to date. Similarly, OCMC monitoring of GBV survivors through follow-up remains inadequate partly as a result of OCMC staff not having received adequate guidance in this area.

## C. RECOMMENDATIONS

| | Activities | Target group | Responsibility |
|---|---|---|---|
| **Immediate needs** | | | |
| 1. | Raise awareness and undertake capacity enhancement focusing on building ownership of OCMCs | DCC and CMC members, OCMC staff, hospital staff, NGOs, CBOs, the general public | MoHP, MoWCSW/DWD, WCSC, the legal system, MoPR, GBV networks and committees, NGOs/CBOs |
| 2. | Mobilise GBV networks for prevention, protection, rehab., follow-up and security | NGOs, CBOs, the general public | DCCs, NGOs, CBOs, the general public |
| 3. | IEC strategy and material development | DCC and CMC members, OCMC staff, hospital staff, NGOs, CBOs, the general public | MoHP, NHEICC, NGOs |
| 4. | Fostering inter-sectoral and inter-agency collaboration (referral networks, legal support, and follow-up mechanisms) | Central level sectoral and agency personnel, district line agencies, community service providers | OPMCM, MoHP, MoHA, DCCs, CMCs, NGOs |
| 5. | Revisions to the OCMC operational manual | Add details on responsibilities of stakeholders; recording system; referral mechanisms and funds; follow-up processes; transitional plans for survivors; handling mentally challenged cases; screening protocols; and treatment, management, and clinical concerns | MoHP, DWD, WCSC, legal system, NGOs, CBOs |
| 6 | Make women doctors available at all OCMCs | OCMC | OCMC, MoHP |
| 7 | Enable CMCs to function as executive working bodies | CMC members | Under DCC consent |
| 8 | Improve accountability checks of allocated budgets | OCMC and hospital staff | MoHP, DCC members |
| 9 | Staffing modality needs to be revised to increase number of staff nurses (suggested: 1 staff nurse/psycho-social counsellor; 2 staff nurses on contract and 1 office assistant) | OCMC staff | MoHP in coordination with medical superintendent, stakeholders |
| 10 | Strengthen central and district level monitoring and supervision, and by NGOs | OCMCs, DCCs, CMCs | OPMCM, MoHP, relevant stakeholders, DCC members, local NGOs |
| 11 | Impact evaluations (every 2 years) | OCMCs | Independent and external experts, GoN, NGOs |
| **Long term needs (2013-2016)** | | | |
| 12 | Pre-in-service training for doctors and nurses on GBV and related health aspects | Doctor, nurses, paramedics | MoHP, medical colleges |
| 13 | Improve rehabilitation services and options for GBV survivors | All GBV survivors including mentally challenged survivors | DCCs, CMCs, CTEVT, national and local NGOs, CBOs |
| 14 | Increase coordination with private sector for survivor rehabilitation | GBV survivors | MoHP, private sector organisations, NGOs |

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*LIST OF ACRONYMS*

| | |
|---|---|
| ART | antiretroviral |
| CBO | community based organisation |
| CDO | chief district officer |
| CEDAW | Convention on the Elimination of All Forms of Discrimination against Women |
| CMC | case management committee |
| CTEVT | Council for Technical Education and Vocational Training |
| DCC | district coordination committee |
| DDC | district development committee |
| DEO | district education officer |
| DHO | district health office |
| DPHO | district public health office |
| DPO | district police office |
| DWD | Department of Women and Children |
| GBV | gender based violence |
| GESI | gender equality and social inclusion |
| GoN | Government of Nepal |
| HFOMC | health facility operation and management committee |
| HMIS | Health Management Information System |
| IEC | information, education and communication |
| LDO | local development officer |
| MCH | maternal and child health |
| MDG | Millennium Development Goals |
| MoHA | Ministry of Home Affairs |
| MoFALD | Ministry of Federal Affairs and Local Development |
| MoHP | Ministry of Health and Population |
| MoPR | Ministry of Peace and Reconstruction |
| MoWCSW | Ministry of Women, Children and Social Welfare |
| NGO | non-governmental organisation |
| NHEICC | National Health Education, Information and Communication Centre |
| NHSP | Nepal Health Sector Programme |
| NHSSP | Nepal Health Sector Support Programme |
| NHTC | National Health Training Centre |
| NPR | Nepalese rupees |
| OCMC | one-stop crisis management centre |
| OPMCM | Office of the Prime Minister and Council of Ministers |
| PEP | post exposure prophylaxis |
| PHCC | primary health care centre |
| SHP | sub-health post |
| STI | sexually transmitted infections |
| ToR | terms of reference |
| UNFPA | United Nations Population Fund |
| UNSCR | United Nations Security Council Resolution |
| VCT | voluntary counselling and testing (of HIV) |
| WCO | women and children's office |
| WCSC | women and children service centre |

# 1 INTRODUCTION

## 1.1 OVERVIEW

In 1993 the United Nations Declaration on the Elimination of Violence against Women gave a universal definition of gender based violence (GBV):

> *"Any act of gender-based violence that results in, or is likely to result in physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life."*

The term GBV is often interchangeably used with violence against women, as it has almost always had greater negative impacts on girls and women than on boys and men.

Nepal has ratified various international conventions and introduced national laws and policies in response to this issue. Since 2011, the Ministry of Health and Population (MoHP) has established 15 one-stop crisis management centres (OCMCs) in selected district, zonal, sub-regional and central hospitals. These have been set up in response to Clause 3 of the 'National Action Plan 2010 against Gender Based Violence' (OPMCM 2010)[1], which calls for the provision of integrated services to survivors of GBV by establishing hospital-based OCMCs. It should be noted that OCMCs were set up in districts where the Ministry of Women Children and Social Welfare (MoWCSW) had also set up women service centres (safe homes).

OCMCs are mandated to provide six services to GBV survivors (Box 1). They should also inform and educate survivors about the services available from the centres and other service providers. The centres are also required to coordinate with the National Health Education, Information and Communication Centre (NHEICC) to produce information, education and communication materials against GBV and to promote OCMC services.

**Box 1: Services OCMCs are mandated to provide**

The 'Hospital-based OCMC Operational Manual' (MoHP 2011) says that OCMCs shall provide the following six kinds of services through multi-faceted coordination with other agencies:

- Health services – Immediate treatment of physical and mental health needs of GBV survivors with OCMCs having to stock the equipment and the free health service medicines to provide these services.
- Psycho-social counselling to survivors and perpetrators.
- Legal advice, counselling and support to survivors through district attorneys, paralegal and legal counsellors.
- Safe homes — by directing survivors to safe shelter homes.
- Security – by working with the police and district administration offices to provide security to survivors in hospitals, safe houses, and in their communities.
- Rehabilitation – by providing further counselling to survivors and those affected by GBV after their initial treatment.

OCMCs should also coordinate and collaborate with district health offices/district public health offices (DHOs/DPHOs), women and children offices (WCO) and district police offices in order to raise awareness, advocate against GBV and lobby for support to GBV survivors.

[1] See list of references at Annex 2.

OCMCs are a new and challenging initiative for Nepal's health system. Two years following the establishment of the first centres it is now an appropriate time to assess their early performance and capacity.

This assessment aims to assess the functioning of OCMCs and the quality of services provided, including how respective hospitals coordinate with other district agencies to provide livelihood, legal and rehabilitation support to GBV survivors, and to identify strengths, constraints and any further support needed by OCMCs. The review was conducted between 25 June and 30 August 2013 with support from the Nepal Health Sector Support Programme (NHSSP) and the United Nations Population Fund (UNFPA) through the provision of a clinical consultant. This assignment aligns well with Output 1 of UNFPA's seventh country programme, namely: "Strengthened national and sub-national health system capacity within a coordinated multi-sectoral response to sexual and gender-based violence". A key programme strategy to achieve this output is to "Provide technical assistance to support government to assess the existing one stop crisis management centres (OSCMC) and roll out in 10 UNFPA supported districts gradually."

### 1.2 PURPOSE AND OBJECTIVES

The twin purposes of the assessment are to:

- assess the performance of four hospital-based OCMCs in providing services to GBV survivors to identify constraints and gaps; and
- make recommendations to improve the functioning of OCMCs so that they provide better services to survivors of GBV and to other affected persons.

The current assignment assessed the performance of four OCMCs in terms of:

- ownership and commitment to OCMCs by stakeholders;
- quality of care;
- organisation and management;
- coordination with WCO's women service centres and other district agencies;
- service delivery and coordination under the OCMCs;
- the division of roles and responsibilities; and
- communication and reporting systems.

It also gathered case studies of women GBV survivors within the catchment of the four OCMCs in terms of the:

- multi-sectoral support they received;
- strengths and gaps in the delivery of services they received;
- strength of survivors' voices;
- strength of voices of care and support providers;
- assessed outcomes of support to GBV survivors, and their current status.

## 1.3 METHODOLOGY

An independent assessment team conducted the assessment. The team was made up of a lead consultant (supported by NHSSP), a clinical consultant (supported by UNFPA), a research consultant (supported by NHSSP) and an assistant clinical consultant (supported by Phect-Nepal). The team assessed the performance of the OCMCs in providing services to GBV survivors, their effectiveness in terms of coordination with other agencies to facilitate survivors' access to varied services, the constraints and gaps in ensuring these, as well as possible areas for recommendations. The assessment team worked closely with MoHP's Population Division, NHSSP and UNFPA to build consensus around the assessment process.

### *1.3.1 Data collection methods*

The team initially reviewed all relevant documents and was then briefed by concerned officials in Population Division, NHSSP and UNFPA on the carrying out of the assignment. The team then interviewed key stakeholders in Kathmandu, following which the field visits were undertaken.

A methodology framework (see Annex 1 for the completed assessment matrix) was designed to triangulate information from the desk review, central level interviews and the district level field work. Interviews were then held at the field level. The assessment matrix was used to address the specific objectives and queries as laid out in the terms of reference and proved helpful in tracking whether sufficient evidence was being gathered against each of the specific objectives. It also facilitated the identification of comparative observations and findings.

The mix of review methods was designed to be complementary. Information from the central level and the desk review focused primarily on central level–OCMC coordination mechanisms while interviews with OCMC service providers, other stakeholders within the hospitals and district level stakeholders generated information pertaining to coordination by OCMCs within the hospitals, their management, performance and service provision to GBV survivors. The researchers' participation in OCMC district coordination committee (DCC) meetings also shed light on the performances of the OCMCs as well as the roles of diverse stakeholders. Finally, the voices of GBV survivors who had accessed OCMC services were captured to substantiate information on the quality of services and information received from the OCMCs.

**Document review** — The assessment team conducted a desk review of the national and international documents listed in Annex 2. National level documents were sourced from the Government of Nepal (GoN), NHSSP, UNFPA, other agencies and non-government organisations (NGOs) working in Nepal. The team also reviewed GBV-relevant national action plans, national surveys and monitoring visit reports.

**Interviews with stakeholders** —A series of interviews was undertaken with selected stakeholders. The interviews elicited opinions on services provided, relevance, effectiveness, best practices and overall management of the OCMCs. The team developed an interview checklist (Annex 3) for the identified key stakeholders, which was shaped by the key assessment objectives. The stakeholders from central and field levels are listed in Box 2 and Table 1. A complete list of all those interviewed is included as Annex 4.

**Box 2: Stakeholders interviewed for the assessment**

*At the central level:* key personnel from the Office of the Prime Minister and Council of Ministers (OPMCM), MoHP, the Family Health Division (FHD), the Department of Women and Children (DWD), and women and children service centres (WCSC) of the Nepal Police

*At the district level:*

- representatives from chief district offices, local development offices (LDOs), district development committees (DDCs), district health offices (DHOs), district education offices (DEOs), district attorney general's office, bar association and other offices, and women and children officers (WCOs);
- hospital clinic officials, hospital service delivery staff, and OCMC staff;
- DCC and case management committee (CMC) members;
- paralegal committee representatives and NGO representatives; and
- GBV survivors who had, or had not, accessed services from OCMCs.

**Table 1: List of primary and secondary stakeholders interviewed**

| | Primary stake-holders | Secondary stake-holders | OCMC health service providers | | Health service providers at hospitals | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Districts** | **GBV survivors** | **Central stakeholders (GoN, donors)** | **Staff nurses** | **Office assistants** | **Drs** | **Paramedics (AHWs, nurses, ANMs)** | **Lab. staff** | **VCT/ART staff (HIV)** | **Medical recorders** | **DCC members** | **Other** |
| Kathmandu | 0 | 13 | - | - | - | - | - | - | - | - | - |
| Kanchanpur | 5 | - | 3 | 1 | 4 | 4 | 2 | - | - | 10 | 12 |
| Makawanpur | 5 | - | 2 | 1 | 4 | 4 | 1 | 1 | 1 | 13 | 6 |
| Sunsari | 5 | - | 3 | 1 | 3 | 4 | 2 | 1 | 1 | 8 | - |
| Baglung | 5 | - | 3 | 1 | 3 | 4 | 2 | 1 | 1 | 11 | 6 |

**Case study selection** — The rationale for collecting cases studies was to verify and substantiate information collected from OCMC personnel, hospital staff, DCC and other stakeholders regarding the type, quality and effectiveness of services provided by OCMCs. The research consultant assigned to interview GBV survivors was provided with a list of pre-selected survivors within the catchment of the OCMC. The initial identification of survivors was based on the availability of a contact phone number and the availability and consent of the survivors to be interviewed. For this purpose a tracking tool for case study development (Annex 5) was designed to facilitate information collection from survivors. Upon reaching each field site the final selection of survivors was made based on the different types of GBV, age and ethnicity of survivors. Twenty survivors were interviewed and the findings are attached at Annex 6, but with some minor editing to preserve anonymity. Prior to each interview the research consultant obtained the consent of the survivor (see *Informed Consent Form for Survivors:* Annex 7). Information from these interviews was used to triangulate data from other sources.

**Field and site visits** — The four OCMC sites (see Table 2) were pre-selected for the team to represent a range of performances and ecological zones. The criteria used for site selection were:

- functioning OCMCs;

- extent of coordination within hospitals and with external services, including the safe homes managed by women and children's offices (WCOs); and
- state of resource mobilisation, advocacy and mobilisation, and reporting and documentation.

**Table 2: Assessment districts**

| Districts | Region | Ecological zone | OCMC established |
|---|---|---|---|
| Sunsari | Eastern | Terai plains | 10 January 2012 |
| Hetauda | Central | Hill and Terai | 28 November 2011 |
| Baglung | Western | Hill | 2 January 2012 |
| Kanchanpur | Far-western | Terai plains | 5 December 2011 |

**Analysis** — Triangulation analysis began following the completion of the field visits, data collection and the interviews. The preliminary findings in the assessment matrix were triangulated and key findings identified. Conclusions and recommendations emerged through this analysis.

The assessment team also undertook brainstorming sessions and used SWOT analysis to determine the strengths, weaknesses, opportunities and threats to OCMCs. These helped strengthen the immediate and long term recommendations.

**Recommendations** — Finally, the findings of the assessment were presented to a coordination meeting on strengthening OCMCs in Kathmandu in August 2013. Representatives from OCMC related government agencies, including NHEICC, the Family Health Division (FHD) and the Logistics and Management Department (LMD) attended this meeting. A National Workshop on the Review and Future Direction of OCMCs was held in Pokhara (18-19 August 2013) and attended by representatives of the OPMCM, MoHP, Nepal Police, OCMCs, UNFPA, DWC and WCOs. The purpose of these two meetings was to receive the findings and collect feedback to fine tune the recommendations of the assessment. Feedback and suggestions from both workshop participants are incorporated in this report.

### *1.3.2 Ethical considerations*

The assessment adhered to international best practices by:

- ensuring respondents understood the assessment's purpose, objectives, and the intended use of the findings; and
- respecting the rights and welfare of the interviewed GBV survivors by ensuring their informed consent and right to confidentiality before the interviews.

Respondents were given a written form to sign to acknowledge their informed consent and awareness of the scope and limits of confidentiality. Verbal consent was obtained from respondents who were unable to read and write. The statement highlighted informed consent and confidentiality of their cases to ensure that sensitive information could not be traced to its source and thus lead to re-victimisation. The statement was translated into Nepali and provided to respondents ahead of interviews.

The lead consultant briefed and trained the research consultant on using the tracking tool for the case studies and ensuring sensitivity during interviews. Care was taken to avoid survivor trauma through interviews, and necessary referrals were made to OCMC services, as needed.

### *1.3.3 Limitations of the assessment*

The following limitations were encountered in carrying out the assessment:

- Due to time constraint the assessment team was unable to interview community level GBV stakeholders. Stakeholders were selected purposively for interviewing based on their level of engagement with the programme at district and central levels.
- Some interviewees from district level line agencies were new to OCMCs due to GoN's frequent transferring of its personnel. They thus did not possess an in-depth knowledge of OCMC development or implementation.
- Natural disasters (e.g. floods in Kanchanpur district), the uncertain political situation, and the end of the government's fiscal year during the assessment period, affected the availability of some key government staff for interviews.

The assessment team attempted to minimise the impact of these limitations by the triangulation of methods, data and investigators. Triangulation was achieved through three major approaches — perceptions, validation and documentation. While perceptions were collected through interviews with various stakeholders within and outside the OCMCs, validation of these perceptions was achieved at DCC meetings and debriefing meetings with MoHP, NHSSP and UNFPA; direct observations during field visits; and case study collection. The assessment team employed a range of rapid assessment methods that included in-depth interviews, group discussions among the DCCs, the analysis of secondary data, data consistency checks, observations of clinical settings and logistics systems, observations of clinical and counselling practices (where feasible and appropriate), reviewing facilities and equipment, reviewing the use of human, technical and financial resources, and discussions with beneficiaries. Interviewing a range of stakeholders at different levels from a variety of institutions and reviewing a range of documents achieved data triangulation. Finally, the engagement of a four person assessment team having divergent backgrounds and expertise focusing on complementary programmatic areas ensured a measure of investigator triangulation.

# 2 FINDINGS

## 2.1 BACKGROUND AND INITIATIVES TO CONTROL AND PREVENT GENDER BASED VIOLENCE

Studies and reports indicate that large numbers of women and children in Nepal experience GBV that results in physical, sexual and psychological damage. A study of links between domestic violence and pregnancy in Nepal (Deuba and Rana 2005) highlighted that women are not even spared during pregnancy. The Nepal Demographic and Health Survey, 2011 (MoHP et. al 2012) found that more than one in five women aged 15-49 years had experienced physical violence at some point since turning 15, while 9% had experienced sexual violence. A study in rural Nepal (OPMCM 2012a) found that many women had experienced physical, psychological, sexual and reproductive health problems, with 1 in 25 of the sample having attempted suicide.

Over the years, a number of efforts have been made at policy level to address GBV (Table 3). Nepal has ratified the Convention on the Elimination of All Forms of Discriminations Against Women (CEDAW), Beijing+5, the Millennium Development Goals (MDG), and United Nations security council resolutions (UNSCRs) 1325 and 1820. It has also introduced laws and actions plans to address GBV. Several constructive initiatives introduced by government and NGOs are outlined in Table 3.

**Table 3: Policy responses in Nepal to addressing GBV**

| | Policy responses | Year |
|---|---|---|
| 1 | Ratification of Convention on the Elimination of All Forms of Discriminations Against Women (CEDAW) | 1979 |
| 2 | National Human Rights Act | 1997 |
| 3 | Ministry of Women, Children and Social Welfare (MoWCSW): The Ninth Five Year Plan laid emphasis on increasing services for victims of violence. Women's police cells were set up in several districts. | 1997-2001 |
| 4 | The Local Self Governance Act (LSGA), 1999 introduced mandatory representation of women in local government. | 1999 |
| 5 | Adoption of the National Plan of Action against Trafficking in Children and their Commercial Sexual Exploitation. | 1999 |
| 6 | Ratification of UNSCRs 1325 and 1820 | 2000 |
| 7 | National Women's Commission set up | 2002 |
| 8 | 11$^{th}$ Amendment to the Country Code Bill (Muluki Ain) (Highlights: Decriminalised abortion; gave women the right to alimony; repealed discriminatory laws relating to property rights, abortion rights, adoption rights, punishment in rape cases and age at marriage.) | 2004 |
| 9 | Provision of Citizenship Rights under mother's name | 2006 |
| 10 | Gender Equality Bill passed to amend acts to ensure gender equality. | 2006 |
| 11 | Prevention and Control of Selling and Trafficking of Humans | 2008 |
| 12 | National Women's Commission Act | 2008 |
| 13 | Domestic Violence (Crime and Prevention) Act | 2009 |
| 14 | National Action Plan on UNSCRs 1325 and 1820 | 2011 |
| 15 | National Action Plan Against Gender Based Violence | 2010 |
| 16 | Three Year Human Rights National Action Plan | 2010-2013 |
| 17 | National Strategy and Plan of Action to End Gender Based Violence and Empower Women | 2012 |

OCMCs were introduced in 2011 as another measure to address GBV. This was the first major government initiative designed to support GBV survivors directly and in a coordinated manner through hospitals, safe homes, the police, and other stakeholders such as district attorneys, paralegal committees, district lawyers and NGOs. OCMCs were established to provide holistic support through a one-door system. The initiative envisaged providing GBV survivors free medical and psycho-social

counselling health services on hospital premises without the need for lengthy and expensive processes, and anticipated that once at an OCMC the survivor would have quick and easy access to legal, shelter, security and other measures of support. Hospitals had been identified as suitable focal points for reaching needy GBV survivors taking into account GBV related health consequences and reduced fears that survivors' experiences will be revealed.

To ensure smooth and effective service provision, the overall managerial responsibility for OCMCs was assigned to hospital managers under the guidance, coordination and monitoring of DCCs. DCCs are chaired by chief district officers (CDO) and have 17 other members including local development officers (LDOs), WCOs, district education officers (DEOs), OCMC medical officers and focal persons, medical superintendents, heads of safe homes, presidents of the Nepal Bar Association district units, district attorney generals, etc.

As per the OCMC operation manual (MoHP 2011), the day-to-day functioning of OCMCs was to be undertaken by a medical officer, a staff nurse/psycho-social counsellor/focal person, a police woman and a volunteer from a local NGO. OCMCs can also appoint experts as needed for on-call duties. These include a doctor, staff nurse, district attorney (or a legal practitioner identified by the attorney), and a police officer or other police personnel.

## 2.2 VIEWS ON OCMC RELEVANCE AND OWNERSHIP BY STAKEHOLDERS

The introduction of OCMCs showcases GoN's commitment to address GBV survivors' needs. In keeping with Nepal's laws, plans and policies, OCMCs have been set up to provide survivors with integrated services (physical, psychological, shelter, rehabilitation and other needs). The assessment made the following findings related to the relevance of these OCMCs and levels of ownership by stakeholders.

**Central level** — All central level interviewees said that OCMCs are a worthwhile and positive government initiative. They referred to the noteworthy harmonisation of related agencies during the introduction of OCMCs. Central Government of Nepal (GoN) representatives reported initial enthusiasm and commitment to engage stakeholders by OPMCM and MoHP. However, assessment findings indicate the need for more robust coordination and collaboration and regular updating between stakeholders in order to promote ownership of OCMCs across sectors at the central level.

**District level** — District level GoN stakeholders positively acknowledged the establishment of OCMCs in government hospitals. There was a consensus that this initiative will help survivors. Chief district officers (CDOs), local development officers (LDOs), lawyers, police, WCOs and medical superintendents across all four districts said that GBV survivors are now able to access medical and other services without much difficulty. Most respondents in all four districts claimed that GBV survivors who accessed services — either due to having come for medical treatment, or having been brought by safe homes, NGOs or the police - receive swift services through OCMCs and that this prevents delays and lengthy waits for medical treatment. Free medical services and the provision of other basic necessities such as food and clothes were also accessed by survivors, although the study found that availability varied across the districts.

These findings were verified by survivors, and reflected in statements by NGOs in Baglung and Sunsari districts who said:

*"OCMCs have started facilitating our work. We are now able to leave GBV survivors at OCMCs for their medical and psycho-social counselling without fear of any further risks to them…"*

A few personnel from Sunsari hospital emergency and outpatient departments, who were knowledgeable of OCMCs activities, said the centres were necessary and useful for referring GBV cases to.

However, the assessment team found generally limited horizontal coordination and collaboration between the district-level stakeholders represented on DCCs. This was evident at the DCC meetings attended by the team in the four districts. This has resulted in inadequate ownership and awareness of OCMC services which, in turn, has impacted stakeholders' levels of commitment and access to services by survivors. It has also resulted in the general perception that OCMCs are the responsibility of hospitals and OCMC staff alone.

**GBV survivors** — From among the 20 case study survivors who had availed of OCMC services, 8 were knowledgeable of the OCMCs and the services provided by them and 11 possessed only limited knowledge. One was completely unaware of the OCMC despite having used its services. This indicates that OCMCs are not adequately informing potential users of the services on offer. It also raises the issue that OCMC services received by survivors may not be any different to those available from hospitals without OCMCs.

**OCMC staff** — Among the OCMC staff, the role of staff nurse/psycho-social counsellors/focal points was positively perceived by stakeholders inside and outside the hospitals. These personnel had established links with some relevant stakeholders such as women and children service centres (WCSCs), safe home personnel and WCOs through personal initiatives to address survivor needs. They play a key role in enhancing OCMC relevance at the district level and within hospitals and provide technical know-how. They were generally observed to be committed.[2] Survivors who were knowledgeable about OCMCs felt that OCMC staff nurses and doctors were helpful.

The counselling services provided by the OCMCs were said to be having a positive impact on survivors. Psycho-social counselling had also positively impacted a few survivors as reflected in the case studies and had enabled some survivors to look towards their futures more positively, and to no longer feel suicidal. In a few cases survivors' relatives had also been counselled, enabling the latter to better understand and accept survivors' needs for integrated medical and psychological treatment. The team found psycho-social counselling had taken place more effectively in Makawanpur and Sunsari OCMCs, as evidenced by the detailed profiles and records of survivors appearing on the format provided during psycho-social training. Some survivors had received several counselling sessions and their progress was being followed up by staff nurses. Sunsari and Makawanpur survivors substantiated this by saying that they 'felt better' as a result of psycho-social counselling:

*"The OCMC played a vital role. OCMC nurses coordinated with the police, safe homes, lawyers, women's networks and NGOs. They worked as a pressure group …. and helped restore my dignity in the workplace. I feel empowered these days." — A survivor.*

[2] The focal person in Makawanpur district was the DHO's Family Planning Focal Person.

However, the assessment team noted that there was generally inadequate monitoring of counselling services in terms of whether general counselling or psycho-social counselling was being provided, the capacity of counsellors, and the quality of counselling.

The assessment also found that the extent of coordination within and outside the hospitals varied. This was seen to depend on the initiative of the OCMC focal persons and the support they received from hospital medical superintendents and other stakeholders. The team noted that focal persons, being permanent hospital staff and having good interpersonal skills, generally promoted good coordination. Coordination was less effective in Kanchanpur district as interviews with hospital staff showed they had very limited knowledge about the OCMC. The same was true for DCC members and other NGO stakeholders there.

## 2.3 EFFECTIVENESS OF OCMCS

### *2.3.1 Operational performance and management*

**Central level** — The OCMCs are currently under the aegis of the OPMCM. MoHP's Population Division is coordinating the implementation, supervision and monitoring of OCMCs. But functional coordination and collaboration was inadequate, as reflected in a central level interviewee's statement:

> *"I am not aware of what is happening at the moment. We were involved during the OCMC Operational Manual development process. Since then no one has communicated with us."*

Other key national stakeholders also possessed limited knowledge about the current status of OCMCs.

**District coordination committees** — A total of three meetings of Kanchanpur, Makawanpur and Sunsari DCCs had been held (see Table 2 for dates of establishment). Baglung DCC had met four times, but many of the meetings were said to be conducted more as a formality; and the active involvement of DCC members for effective OCMC functioning was said to be inadequate. The minutes of DCC meetings from three districts (not available from Kanchanpur) show that some members of the committees identified by the operational manual were either not aware of the OCMC (probably due to frequent changes in government officials), were not regularly participating, or had not been updated by their officials who had participated in meetings. The minutes showed that meetings' decisions were mostly about OCMC establishment, the provision of incentives, the decision pertaining to one survivor's case (Baglung district) and awareness raising (in Sunsari and Makawanpur DCCs). However, a number of decisions were made on promoting ownership, coordination and on enhancing roles and responsibilities of stakeholders. In cases where awareness raising was discussed, implementation had yet to occur.

During field visits and the DCC meetings attended by the assessment team in all four districts, there was a prevailing perception that since the OCMC is located within the hospital, the primary responsibility for OCMC management lies with the hospital alone and that other stakeholders should not interfere. OCMCs being in their formative years, DCC members seemed to be unclear about their roles and responsibilities. The team also noted that some stakeholders perceived OCMCs to be donor-driven, meaning they could prove to be temporary. However, the generally positive discussions witnessed at the DCC meetings attended suggest that with adequate orientation and awareness there is a strong possibility for the active involvement of DCC members in supporting the functioning of OCMCs.

The links envisioned for OCMCs to offer holistic support are yet to materialise through DCCs. In all four districts a couple of DCC members were unaware of their OCMC. Some DCC members, namely, WCO, safe home and WCSC representatives were more active, resulting primarily from OCMC personnel seeking shelter and security from them for survivors. However, links were limited between OCMCs and WCSCs, and OCMCs and WCOs. These stakeholders have yet to work as teams, and OCMCs are yet to become one-stop centres. Regular joint meetings would help keep stakeholders updated on cases, inform them of gaps and facilitate various means of addressing challenges, thereby enhancing the quality and holistic nature of the support received by survivors.

Greater coordination was found in Makawanpur and Sunsari where OCMC staff were able to request help from safe homes and the police. However, the role of other DCC members was absent thereby preventing holistic support beyond police and shelter. In Baglung, the team found weak support from the WCO and safe homes. The refusal by the WCO to keep a GBV-cum-mental health patient and her new-born baby in the safe home strained relations. Furthermore, the verbal abuse of a lady doctor by the WCO ended the former's active engagement in the OCMC. During the team's visit to Sunsari OCMC safe home staff had refused to shelter a GBV survivor with the staff blaming the survivor for her predicament.

The links for legal counselling from government lawyers and Bar Association members were inadequate. Some links were found in Kanchanpur where lawyers were at times called by the WCO; but this was not occurring through the OCMC. Another factor behind this inadequacy was said to be the environment:

> *"[that] is not viewed as favourable to survivors. Survivors and their family members generally do not want to seek legal help as they believe they will ultimately lose, either due to perpetrators being financially more powerful or politically affiliated. Even when they decide to register a case, survivors often retract their initial statements - resulting in lawyers being in a weak and false position." — district based lawyers in Baglung and Sunsari*

Collaboration and coordination with NGOs varied. In Makawanpur, Sunsari and Baglung the NGOs Maiti Nepal, Nari Seep Kendra and Koshish were sheltering survivors and helping build their skills. NGOs and CBOs in Makawanpur and Sunsari said OCMCs had helped define their responsibilities in relation to survivor support. The proactive role of OCMC personnel, their interpersonal skills, and effective coordination between OCMC staff has led to these positive developments. However, in Kanchanpur some well-known national NGOs working on GBV, including Saathi, Women for Human Rights (WHR) and the Rural Women's Development and Unity Centre (RUWDUC) were unaware of the OCMC and the services provided.

In a handful of cases paralegal committees had been involved in identifying survivors and referring them to OCMCs. Survivor identification and referral to OCMCs in this regard could easily be increased through strategic planning by DCCs. And CBOs can and should be involved in following up individual cases.

The OCMC operational manual 2011 (page 10) requires thorough reviews by DCC members to ensure that roles, responsibilities and rights are adequately understood and addressed by all stakeholders. The absence of a work plan in all four districts, which the manual notes should be developed by DCCs, is an example of the lack of clarity in the tasks to be carried out.

**Case management committees** — The OCMC manual notes that several key members of the DCC (representatives of the district attorney general, WCO and district police office plus the nurse/counsellor/focal point and the medical officer) should form CMCs. The purpose of these committees is to manage particular GBV incidents swiftly. Members represent organisations that can act to provide immediate initial support to survivors. OCMC focal persons are expected to coordinate and communicate with CMC members to facilitate support for survivors.

The assessment found that no CMC meetings had taken place in Kanchanpur, Makawanpur and Sunsari districts and that most communication took place by phone between OCMC nurses and WCO, safe home and police CMC members. The team found that the trend is to request help or support for specific cases, rather than take a holistic approach through the CMC. Stakeholders felt that formal meetings were time consuming, may not be well attended, and could delay decision making.

However, Baglung CMC had met many times to discuss one particular case (Box 3) and this showcases how CMCs can generate support and services for a survivor. The team also found that this case was the sole reason for Baglung CMC meetings.

**Box 3: Constructive role of Baglung CMC**

Anita (name changed) was three months pregnant and had lost her memory. She was referred to Baglung Hospital from a nearby district. The OCMC in the hospital had kept her for the past 13 months and helped her with medicines, food and other necessities. She was living in the maternity ward. Her child was delivered at the hospital and was also supported by the OCMC and the hospital.

Numerous meetings of the CMC had been held to discuss Anita's case. These meetings brought key stakeholders together and facilitated discussions on her rehabilitation. During the assessment visit Anita was taken by the NGO Koshish for psychiatric treatment.

**Infrastructure and physical resources** — MoHP allocates funds for establishing and running OCMCs. The commitment, understanding and support of the medical superintendents, finance officers, and in some cases DHO focal persons (such as the family planning focal person in Makawanpur district), have played a key role in facilitating the equipping of OCMCs. The team found that the basic infrastructure varied. While rooms had been allocated in all hospitals, some lacked furniture, IEC materials, medical instruments and medicines (see Table 4).

The OCMCs in Baglung and Sunsari were located near the in-patient wards, while in Kanchanpur and Makawanpur districts they were isolated. All OCMCs, except for Kanchanpur, had separate counselling rooms. However, the team found that facilities for maintaining privacy and confidentiality were inadequate, particularly in Sunsari OCMC where counselling sessions could be easily overheard in nearby rooms. Baglung and Makawanpur OCMC counselling rooms were appropriately placed. Another confidentiality based concern was noted from Baglung, Sunsari and Kanchanpur where there was a risk of exchange of information between in-patient and outpatient nurses and OCMC staff.

**Table 4: Infrastructure and resources at the four OCMCs as per requirements and in practice**

| Requirements as per guidelines | Kanchanpur | Makawanpur | Sunsari | Baglung |
|---|---|---|---|---|
| 3 rooms | 3 rooms (2 treatment rooms not being used) | 1 large room for treatment and office plus 1 | 4 adjoining rooms (1 office, 1 counselling room, 1 treatment room and 1 room for | 1 office-cum-treatment room and 1 counselling |

| | | | | |
|---|---|---|---|---|
| | | counselling room | fridge. | room |
| Separate toilet | No | Yes | Non-usable due to lack of cleanliness | No |
| Required furniture | Limited availability of furniture | Yes | Limited furniture | Limited furniture |
| Computer, printer & phone | Computer and phone yes. No printer | Yes | Computer yes. Phone and printer no. | Computer and printer yes. No phone |
| Curtain for privacy at check-ups | Check-ups not conducted at OCMC | No | Yes | Door closed during check ups |
| Basic medical instruments | See Annex 8 | See Annex 8 | See Annex 8 | See Annex 8 |
| Training manual | No | No | No | No |
| IEC materials (print & electronic) | No | Printed leaflet available | Printed leaflet available | Printed leaflet available |
| Treatment protocol | No | No | No | No |
| Case screening protocol | No | No | No | No |

All four OCMCs had two beds. At Makawanpur OCMC the beds were used by survivors referred from the emergency unit, inpatient department, out-patient department, safe homes, and the police. Kanchanpur OCMC was not using the available beds (the room with the beds was 'cloaked' at the time of the team's visit) and the OCMC staff indicated a lack of security for survivors and nurses, as the floor on which it was based was not being used by the hospital. At Sunsari and Baglung, the team found that while patient examinations were undertaken in OCMC beds, they were mostly kept in the out-patient or maternity wards. This occurred either because the OCMCs had yet to be integrated within the hospitals' systems, or it was easier for OCMC staff nurses to keep a check on survivors there.

Medical instruments and equipment were shared with the inpatient departments and there were inadequate medical supplies in the OCMCs. There were also insufficient examination tables, focus lights, and medico-legal investigation materials and no rape or post exposure prophylaxis kits.

**Human resources** — The operational manual says that OCMCs shall have the six personnel and a volunteer listed in Box 4 and that the staff nurse/counsellor shall be hired on contract.

**Box 4: OCMC staffing as per OCMC operational manual (Section 3.7)**

The following human resources shall be required for 24 hour functioning of OCMCs.

- Medical Officer 1
- Staff Nurse (including 1 trained psycho-social counsellor) 3
- Counsellor/Facilitator 1
- Woman Police Sub-inspector/Woman Police Assistant Sub-inspector 1
- Volunteer (identified in coordination with the local NGOs) 1

Baglung and Sunsari OCMCs had three staff nurses (1 focal person and 2 staff nurses) and were providing 24-hours services. The incentive for contracted staff nurses was the opportunity to work at the in-patient wards as well as the OCMCs, as it would help establish links and provide opportunities to learn multiple tasks. They also helped with OCMC administrative tasks. However, with both staff nurses being new (in both districts) and yet to be adequately trained on OCMC objectives and their roles, they were unable to take up their full OCMC responsibilities. The situation was compounded by the division of a single salary between the two contracted staff nurses in Baglung. In Sunsari, the two contracted staff nurses were receiving full payments from within OCMC funds, although this was not provisioned for. The team found that Sunsari district OCMC was dividing the office assistant's salary between two individuals — the office assistant and a person from another hospital department.

**Table 5: Human resources at the four OCMCs**

| District | Focal person/staff nurse | Focal person/staff nurse/psycho-social counsellor | Psycho-social counsellor/staff nurse* | Staff nurse (contracted) | DHO's focal person | Helper |
|---|---|---|---|---|---|---|
| Kanchanpur | 1 | 0 | 1 | 1 | 0 | 1 |
| Makawanpur | 0 | 0 | 1 | 1 | 1[3] | 1 |
| Sunsari | 0 | 1 | 0 | 2 | 0 | 1 |
| Baglung | 0 | 1 | 0 | 2 | 0 | 1 |

Despite these staffing levels, the 24-hour service called for in the operational manual (see Box 4) was not available at Kanchanpur and Makawanpur OCMCs. The presence of only two staff nurses, and the distance from their residences makes it impossible for staff to provide night-time services. The assessment team noted the need for OCMCs to adhere to the manual and ensure full staffing at all OCMCs.

The OCMC focal points played an active role at Baglung, Kanchanpur and Sunsari OCMCs[4]. However, with some staff nurses being on contract there is a risk that the knowledge they gain may be lost due to the annual contract renewal requirement. Furthermore, investment on the focal point/staff nurse/psycho-social counsellors may be wasted if their retention cannot be assured for at least three years.

3 The DHO had appointed the focal person to link the DHO and OCMC. However, it was found that this person's contributions had been limited to financial management.

4 Makawanpur OCMC focal person is the DHO's family planning focal person

Hospital-based police personnel were present in all four hospitals and were referring GBV survivors to the OCMCs. But they were yet to be considered OCMC personnel and were unaware of their critical positions within OCMCs. Further, the team noted that none of them were women. The district police officers said that lack of policewomen prevented their deputation to hospitals, as per the operations manual. At Baglung, the team was told that policewomen could be deputed to the hospital premises, if needed.

NGO volunteers, as mandated in the manual, had not been appointed. The links with NGOs were mostly weak due mainly to the lack of information dissemination by OCMC personnel and DCCs.

**Building the capacity of service providers** — Reflecting the sensitive nature of GBV and the skills required to support survivors, MoHP undertook a positive initiative in providing six-month long psycho-social counselling training to a staff nurse from each OCMC. The counsellors have been using their skills, as evidenced from the case studies, and feedback and reports received from counsellors and doctors. Inputs however varied by district with Makawanpur and Sunsari counsellors more actively undertaking psycho-social counselling. It was noted that no refresher training, mentoring of counsellors, monitoring for ensuring effectiveness and impact had been initiated to build on their strengths and address shortcomings. The psycho-social counsellors reflected positively on the quality and appropriateness of the training, but said that additional on-the-job training, refresher courses, supervision and guidance were needed.

No capacity building activities had been run for DCC members, hospital staff, CMC members, or NGO and community members. Orientations on GBV, the objectives of OCMCs, the roles of DCC and CMC members are needed. The stakeholders who were most knowledgeable about OCMCs were those who had received an orientation during OCMC inauguration.

Interviews with hospital staff revealed that most of them were unaware of GBV issues and they mostly believed that OCMCs only provided medical services. There was also inadequate knowledge on the importance of the medico-legal investigation of GBV cases.

Makawanpur OCMC maintained survivors' confidentiality the most. Generally, the risk of the divulgence of information was seen as high as staff nurses worked in shifts in other hospital departments and may have been inclined to discuss GBV cases. Awareness training and capacity building is needed on this issue.

### *2.3.2 Services provided by the OCMCs*

**Medical and other services** — The four OCMCs had provided services to 362 survivors (Baglung 117, Kanchanpur 83, Makawanpur 82 and Sunsari 80). A core support provided by OCMCs is medical treatment. These range from basic medical check-ups and psycho-social counselling to medico-legal services. A low number of medico-legal examinations was noted for Kanchanpur – resulting from a further 86 cases being recorded at the labour room and not at the OCMC.

The results of the clinical services are encouraging despite the newness of the concept, the lack of capacity building and awareness among DCC members and hospital personnel, delays in budgetary allocations and budgetary constraints.

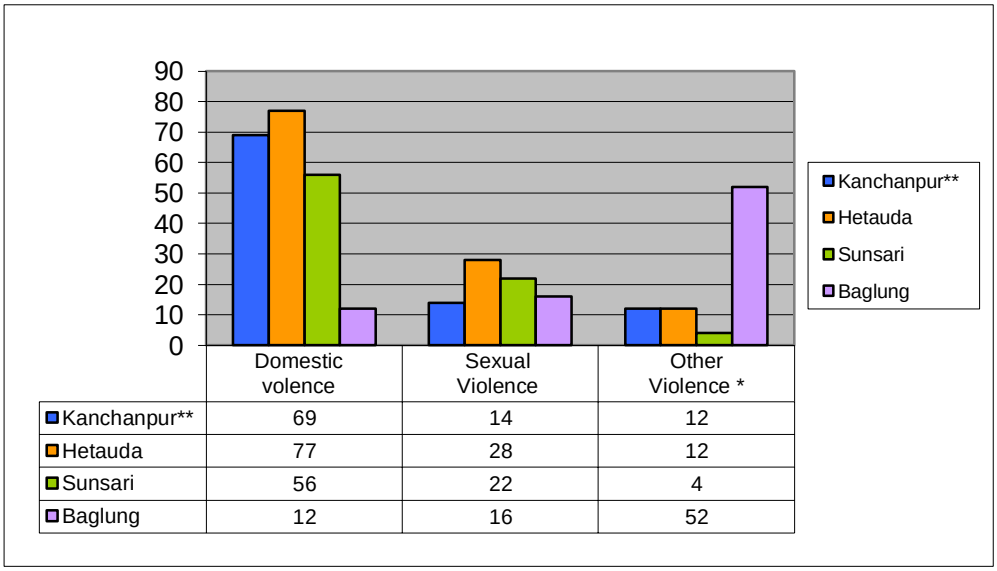
**Table 6: Clinical services provided to survivors by the four OCMCs**

| Clinical Services | Kanchanpur | Makawanpur | Sunsari | Baglung | Total |
|---|---|---|---|---|---|
| Medical | 32 | 60 | 39 | 37 | 168 |
| Pregnancy | 3 | 6 | 24 | 15 | 48 |
| Emergency contraception | 8 | 1 | 0 | 0 | 9 |
| Voluntary counselling and testing for HIV | 1 | 8 | 4 | 7 | 20 |
| STI | 0 | 0 | 0 | 1 | 1 |
| Safe abortions | 1 | 0 | 2 | 3 | 6 |
| Psycho-social counselling | 72 | 43 | 33 | 47 | 195 |
| Medico-legal investigations | 10 (+ 86*) | 2 | 54 | 37 | 103 |

** Rape cases recorded at labour room and not OCMC*

Figure 1 shows the number and type of cases registered by the OCMCs up to the time of the assessment. The team found Makawanpur and Kanchanpur OCMCs to be maintaining caste/ethnic-wise disaggregated data on cases while Sunsari and Baglung OCMCs were not. At all four OCMCs age disaggregation was recorded as per the format (that only indicates 15-49 year olds with no other age groups available!). The team found inadequacy in the disaggregation of data according to type of GBV.

**Figure 1: Types of GBV cases services registered by the four OCMCs (2011-2013)**




| | Domestic volence | Sexual Violence | Other Violence * |
|---|---|---|---|
| Kanchanpur** | 69 | 14 | 12 |
| Hetauda | 77 | 28 | 12 |
| Sunsari | 56 | 22 | 4 |
| Baglung | 12 | 16 | 52 |

** Other violence: social/psychological including trafficking, witchcraft, child marriage, poisoning, attempted suicide.*

*** In Kanchanpur 86 rape cases (sexual violence) were brought by the police and registered in the labour room, but not recorded in the OCMC register.*

Three of the OCMCs (all except Baglung) maintained data on perpetrators. This will prove useful for designing future GBV prevention-based programming. Most perpetrators were family members (Table 7) with husbands as the major perpetrators, followed by family members/in-laws at Kanchanpur, Makawanpur and Sunsari OCMCs.

**Table 7: Type of perpetrators recorded in the four OCMCs (2011 onwards)**

| Type of perpetrators | Kanchanpur (2068-70) | Makawanpur (2069-70) | Sunsari (2069-70) | Baglung |
|---|---|---|---|---|
| Husbands | 35 | 23 | 20 | na |
| Family members/in-laws | 26 | 20 | 17 | na |
| Neighbours | 6 | 14 | 5 | na |
| Other or unknown persons | 13 | 5 | 8 | na |
| Other | 0 | 0 | 2 | na |
| **Total** | **80** | **62** | **52** | na |

**Referrals** — The assessment team found referrals occurring both from the OCMCs and to them for medical, shelter, and police support (Table 8). The OCMCs were documenting this, but other stakeholders were not documenting their referrals to OCMCs. It was found that referrals for legal counselling and services had yet to take place. Oftentimes cases were not reaching the courts as mediation was often preferred and authorities and communities promoted reconciliation and mutual agreement (*mel-milap*). Furthermore, the team found that inter-hospital referrals were not taking place, nor were referral slips available. A few referrals had been made to other organisations from Kanchanpur OCMC but Makawanpur and Baglung OCMCs had a strong tendency to send survivors home, while Sunsari OCMC sent many survivors to the police and safe homes. At the latter it was mostly the police and safe homes that brought survivors to the OCMC in the first place.

**Table 8: Referrals by the four OCMCs, 2011/2013**

| Districts | Police | Safe homes | NGOs | Home or discharged | Other hospital |
|---|---|---|---|---|---|
| Kanchanpur | 8 | 2 | 0 | 0 | 1 |
| Makawanpur | 6 | 4 | 0 | 31 | 2 |
| Sunsari | 33 | 35 | 6 | 7 | 1 |
| Baglung | 15 | 4 | 2 | 38 | 10 |

**Awareness raising** — Only limited efforts have been made to promote demand for the services. There was minimal awareness about the OCMCs in the four districts. This was acknowledged by DCC members, and other district and community NGOs and CBOs. Even 11 of the 20 case studies had limited knowledge of the integrated services provided by OCMCs, while one survivor was entirely ignorant of them.

> *"I stayed in the hospital for a total of 8 days, but no one told me anything about OCMC and its services." — a case study women*

### *2.3.3 Use of the OCMC manual for centre management*

The OCMC operational manual (MoHP 2011) specifies how OCMCs should function, the roles and responsibilities of DCCs and CMCs, reporting and work plan formats and other details. Many stakeholders said they had not seen the manual, while others had not reviewed it thoroughly. The manual has been revised once, but the assessment team believes a more thorough revision is needed. OCMC staff said that it should specify more detailed roles and responsibilities of DCCs and CMCs for better OCMC ownership promotion. Ensuring the maintenance of more disaggregated information

and collecting the contact numbers for following up survivors will help prevent re-victimisation and help address survivors' long term needs.

OCMC staff have been using the manual for information documentation and reporting. But a core component for implementation and operationalisation of OCMCs — programme implementation work plans had not been prepared in all four districts. The manual also contains information on services to be provided to survivors, for which monthly progress reports should be maintained by the OCMCs and submitted to MoHP. However, OCMCs have not received any feedback on their efforts and there has been no guidance and supervision from DCCs or the central level to facilitate their work.

### *2.3.4 Financial management*

MoHP has been allocating budgets to OCMCs since 2011/12. But delayed release, the initial absence of budgetary breakdowns, and infrequent DCC meetings have prevented effective budget management. The lack of knowledge of OCMC staff on their budgets has contributed to ineffective usage with non-transparent budget management evident in all four districts. The situation did however improve in Year 2 with OCMC staff more aware of the financial details.

Detailed records of expenses were not made available to the team for year 1. The provision in year 1 of a lump sum without a breakdown had created ambiguity. For year 2, a breakdown was provided by MoHP to all OCMCs. The absence of a breakdown in year 1 meant that two districts had decided to provide incentives for health staff (OCMC staff in Baglung and all hospital staff involved in servicing survivors in Sunsari). These were provided from the 'Serial No. 1: Counselling Services' and miscellaneous budget lines. The issue of incentives is creating discontent among hospital staff of various departments in Baglung district, who feel they should also be receiving incentives. During the field visit the assessment team noted that such discontent was leading to delayed services (e.g. postponing GBV survivors' x-rays to the following day). Sunsari OCMC staff were facing the challenge of distributing the limited 'incentives' equally without antagonising anyone. Furthermore, the team found that other OCMCs were consulting with Baglung and Sunsari OCMCs to adopt distribute incentive schemes similarly. However the provision of incentives is not mentioned in the manual. The team believes that OCMC and hospital staff should be provided with incentives only for additional work beyond duty hours and that incentives during work hours should *not* be granted.

**Table 9: Budget and expenditure information from the four OCMCs (NPR)**

| District | Year 1 | | Year 2 | |
|---|---|---|---|---|
| | **Allocated budget** | **Expenditure** | **Allocated budget** | **Expenditure** |
| Kanchanpur | 1,230,000 | Na | 571,000 | 313,984 (to June 2013 ) |
| Makawanpur | 1,230,000 | Na | 571,000 | NA |
| Sunsari | 1,230,000 | na | 571,000 | 504,549 (to 16 July 2013) |
| Baglung | 1,230,000 | na | 571,000 | 553,359 |

The team was unable to provide an overall analysis of how and where funds were spent in year 1. This was due to the non-provision of expenditure details to the team as expenses were still occurring during the end of fiscal year 2012/13 (2069/70). A detailed breakdown of expenditure for Year 2 was only available from Baglung OCMC.

### *2.3.5 Monitoring and supervision*

**Central level** — The central level monitoring of OCMCs is the responsibility of the OPMCM and MoHP's Population Division and is intended to take place several times a year. The large number of OCMCs established meant that it had been impossible for the OPMCM to regularly visit them all. There was no plan evident for carrying out monitoring visits and the team was unable to obtain clear information on the number of visits undertaken by the OPMCM or the Population Division.

OCMC staff also had no specific work plans to guide their work. OPMCM, MoHP and other stakeholders such as WCSC, the Department of Women and Children (DWD) are required to collaborate for joint monitoring and prepare visit reports. The findings of monitoring results should be recorded using standard formats which should collect more data on gender, type of violence and other information to enable follow-up.

**District level** — At district level, the core monitoring responsibility lies with the DCCs. The team found that monitoring and supervision is inadequate as the DCCs and CMCs have yet to be activated. Monitoring by the DHO focal person in Makawanpur was limited to budget issues.

Supervision by the medical superintendent and DHO requires guidance as GBV and the provision of holistic support to GBV survivors are new concepts for them. The newness of the initiative demands close supervision, but this is not available to OCMC staff who are mostly implementing on an ad hoc 'learning by doing' basis. Several OCMC staff made statements such as: "We learnt so much more information for running the OCMCs during this assessment." This reflects the need for regular updating, experience-sharing and close guidance for OCMC management and delivery. The DHO and focal points have been discussing OCMCs during DHO and focal points review meetings, but the OCMCs have yet to be prioritised based on need.

District CBOs and NGOs, who can play catalytic roles due to their experiences of working on GBV, have been little involved in monitoring and assisting OCMCs. They could potentially be effective watchdogs able to ensure effective implementation, as well being sources of shelter, skills training, follow-up and rehabilitation support to survivors, and provide guidance to CMCs and OCMCs to enhance overall OCMC management.

**OCMC level** — There was found to be inadequate monitoring of survivors by OCMCs. The staff had not received guidance on how to undertake such follow-up, which is a crucial aspect of integrated support. What little follow-up had occurred was via phone calls from staff nurses/focal persons to ask survivors how they were. Furthermore, the manual does not specify which agency is expected to follow-up survivors after they are discharged.

## 2.4 QUALITY OF CARE

### *2.4.1 Access to OCMC information and services*

**Access to information by the general public** — The ability of the OCMCs to provide quality care begins with survivors and family members' knowledge about OCMCs and their ability to access services. The team found that only limited efforts had gone into raising awareness about OCMCs among potential GBV survivors. Information dissemination had taken place through print media and radio during the establishment period, but the team was unable to see any visible impacts of these initiatives. The only IEC materials seen in the OCMCs were OCMC pamphlets; but most stakeholders across the four

districts said they had not seen them. Except for a few instances in Makawanpur and Sunsari districts where the focal persons/staff nurses had taken the initiative to disseminate information during events and programmes, even GoN and NGO programmes that address women's empowerment were not highlighting the role of OCMCs. The limited knowledge of DCC members about OCMC services had prevented them from disseminating information.

**Access to information and services within the hospitals** — Hospital staff had not been orientated on OCMCs by the medical superintendents, including emergency staff who are key to referring GBV cases to OCMCs. Hospital-based police in Makawanpur and Sunsari had referred serious cases including rape and serious assault to their OCMCs.

Most GBV survivors at the hospitals had not received information about the OCMCs. Some hospital staff had received information from the OCMC focal person/staff nurse. Among the 20 survivors interviewed, one was totally unaware of the OCMC and eight had only limited knowledge despite having received services from the OCMC. However, most survivors who had received psycho-social counselling services were knowledgeable.

The team also found that OCMC services were most available to survivors when the focal person was present, but in his/her absence, GBV survivors did not receive services swiftly. Survivors and service providers substantiated this finding.

### *2.4.2 Availability of integrated services*

The care provided by the OCMCs focused on clinical and, in some instances, psycho-social services. The survivors were not receiving holistic services including legal, shelter, rehabilitation and security services. These should be addressed by DCCs, but this was not happening due to poor coordination among DCC members (see Box 5).

**Box 5: Gaps in effective OCMC functioning**

An example of how OCMCs are not functioning, evidence of poor performance and gaps in implementation and design were evident from a case study in Kanchanpur. The GBV survivor had not received specialised services despite being in the hospital for eight days. She was unaware of the OCMC and its services, and had not received free food or medication until she applied for assistance by completing the needy patient's form four days after admission. The OCMC is meant to provide free services to all GBV survivors, but staff had failed to ensure this. There was no coordination among OCMC staff. There was a separate OCMC room for GBV survivors, but the patient was not taken there. All her treatment took place at the women's ward and she was discharged from there.

When the assessment team asked the OCMC staff nurse about the case, she said that it might have occurred when the psycho-social counsellor was away on training and the other staff member was on maternity leave. Staff were uncertain about what had happened but the written report provided was misleading since it noted that counselling services had been provided. If the psycho-social counsellor was away attending training, it is not clear who could have provided the counselling service.

A mechanism is needed to ensure that all survivors receive proper care and treatment and information on other available services (safe homes, lawyers and police). No follow-ups had been carried out. The survivor returned home to the same life. OCMCs can play a vital role in providing counselling and connecting survivors with other organisations (e.g. rights based organisations, women's networks and WCOs) and through regular follow-up which can result in perpetrators changing their behaviour for fear of punishment.

**Infrastructure** — The team found that all four hospitals had provided physical space for the OCMCs. Baglung, Sunsari and Makawanpur OCMCs were appropriately situated, but Kanchanpur OCMC was located in a place where even nurses do not stay overnight due to lack of security. It was noted that Sunsari OCMC did not provide a private place for confidential counselling sessions while Sunsari and Baglung OCMCs were missing required medicine and equipment including a landline phone. These shortcomings are likely to impact the quality of care.

**Knowledge and training of providers** — Aside from psycho-social counselling training to staff nurses, no GBV-based orientation or training had been provided to any of the stakeholders within or outside of the hospitals. They were therefore untrained and unaware of GBV and its linkages and consequences on survivors' health. The impact of this was apparent in the inability of hospital based service providers to identify GBV symptoms and make referrals to the OCMCs. The provision of services through untrained personnel is a major weakness.

**Monitoring the quality of services** — The quality of services can best be ensured through the consistent supervision and monitoring of service providers. The team found that OCMC staff were not receiving any supervision or guidance either from the central level or from medical superintendents. Superintendents and DCC members lacked technical know-how on supporting GBV survivors. Within the hospitals, the lack of coordination with, and orientation on, other departments prevented swift service provision. This situation was compounded by the dissatisfaction with incentives noted above which was causing some personnel, including as x-ray staff, to delay service provision at Sunsari hospital.

**Rehabilitation** — In some GBV cases, rehabilitation - either through counselling or physical recuperation - is essential. However, despite these services being an OCMC objective, they were found to be missing. The assessment team found that generally, in rape and extreme physical injury cases, survivors brought in by the police were returned to them following treatment. The OCMC staff did not possess the knowledge, experience and links needed to send survivors to rehabilitation centres. There was an inadequate two-way referral system.

**Follow-up of GBV survivors** —Makawanpur OCMC had followed up psycho-social counselling cases but this had not occurred in the other three districts. The risk of re-victimisation is very high, as shown by one survivor's case study. Furthermore, the team noted that the manual does not specify the follow-up mechanisms for collaboration and coordination with DCC members, NGOs, paralegal committees and others.

**Operational manual** — OCMC staff across all four districts had been following the operational manual in order to facilitate their day-to-day work but the manual is missing key guidance related to important issues such as protocols for screening survivors, referral mechanisms, rehabilitation processes and information dissemination. OCMC personnel had not initiated these processes and this had impacted their ability to provide integrated services.

## 2.5 CLINICAL FINDINGS

### *2.5.1 Basic infrastructure and physical resources*

All four OCMCs were located on hospital premises but away from the main hospital entrances and thus not easily accessible for survivors seeking care. Signboards were evident only near to the OCMCs and no direction arrows or signs were placed near the hospital entrance. There was also no

information available in citizen's charters, receptions, outpatient departments, emergency departments and in corridors, thus making it difficult for survivors to locate OCMCs. The absence of information desks in the hospitals aggravated this problem. Further, there was no picture-based information available in the hospitals to guide illiterate survivors.

The operational manual specifies that rooms for examination, counselling, two beds for admission and the office should be separate. However in Baglung and Makawanpur OCMCs, single rooms served as the office, examination room and admission room.

Kanchanpur OCMC staff were operating from a regular ward and so unable to maintain strict patient confidentiality. In Sunsari OCMC, although the room was partitioned, the partition itself was constructed in such a way that it was unable to protect privacy. Baglung, Sunsari and Kanchanpur OCMCs were all located near the regular hospital wards. It was also noted that nurses, medical students, tutors and visitors frequently came into the OCMC to see survivors after hearing their stories, thereby compromising confidentiality.

### *2.5.2 Instruments, equipment and supplies*

The manual states that OCMCs should always have the supplies needed for infection prevention, collecting forensic evidence, medical treatment and free drugs for survivors. The team found that dressing sets, suture sets, speculums, gauze, bandages, swabs and other commodities were usually drawn from inpatient wards. Supplies for infection prevention such as chlorine solution for immersing gloves and instruments were not available at OCMCs, so other hospital departments were used for disinfection.

Rape and post-exposure prophylaxis kits are the most frequently required kits for dealing with rape cases as mentioned in WHO's guidelines on responding to intimate partner violence and sexual violence against women (WHO 2013) and WHO's Clinical Management of Rape Survivors guidelines (WHO 2004). However, neither of these kits were available at all the OCMCs, nor is the need for them specified in the operational manual.

### *2.5.3 Adherence to clinical protocols, guidelines and standards*

GoN in coordination with INGOs and NGOs has developed protocols, guidelines, policies and strategies for providing quality health services and managing GBV. These include the following national guidelines and protocols:

- Guideline on Case Management of Sexually Transmitted Infections (MoHP and NCASC 2009), and
- Reproductive Health Clinical Protocol for Medical Officers (MoHP 2007).

As previously noted OCMCs have been established to provide medical treatment, psycho-social counselling, legal support, shelter, security and rehabilitation services to GBV survivors. For the complete care of survivors, it is essential that standard protocols are followed. Non-adherence may complicate cases. For instance, in a rape case, failures to follow the reproductive health clinical protocol may result in unwanted pregnancies. However the team found that while the OCMC Operational Manual was available at all four OCMCs, other relevant materials, guidelines, and protocols including those for the clinical management of rape survivors, WHO clinical and policy guidelines, sexually transmitted infection (STI) case management guidelines, the reproductive health clinical protocol, HIV/AIDS policy guidelines, the Comprehensive Family Planning and Counselling

Training (COFP) manual, GBV related materials and other relevant training manuals were not available.

### *2.5.4 Knowledge and skills of service providers*

Service providers need updated knowledge and skills to respond appropriately to identifying, managing, documenting and referring survivors. Health service providers should be trained on GBV, the vision and principles of OCMCs, basic counselling, managing STIs, medico-legal matters, forensic evidence gathering, medical training including emergency contraception, and post-exposure prophylaxis. Providers should also possess knowledge on GBV and child rights legal provisions.

The study found that the majority of providers lacked awareness on GBV, sexual and reproductive health, legal provisions on GBV and medico-legal evidence. Most staff relied on past experiences in performing their duties rather than updated knowledge and training.

Study respondents were asked about their knowledge, skills and practices. Their responses were cross-checked with survivors and other service providers' opinions. For instance, lab assistants in two OCMCs said, "We take vaginal swabs for a rape case", but when cross-checked with OCMC service providers and labour room staff, it was found that swabs were not taken by lab assistants but by doctors and nurses. In another example, service providers claimed to distribute emergency contraceptives to rape survivors; yet while cross checking with OCMC records only 9 out of 76 cases of sexual violence had been provided with emergency contraceptives at all four OCMCs. According to OCMC records, not a single survivor had been provided with emergency contraception in Sunsari or Baglung OCMCs.

### *2.5.5 Attitudes of service providers*

Attitudes of service providers towards GBV survivors proved difficult to analyse. These were examined using a questionnaire and by cross-checking with survivors, other service providers and team observations.

Despite inadequate training and on-the-job guidance, providers were found to be committed and performing their duties responsibly, largely following their own initiatives. Even though they were not on duty at night, the focal persons from Baglung and Sunsari OCMCs had provided services at all times as required. The team found that despite the dual workload, staff were initiating and performing necessary activities in coordination with in-patient and out–patient departments. They had also attempted to track survivors. These are indicative of a high level of responsiveness on the part of OCMC service providers. The 20 survivor cases show that they had generally been treated very well, reflecting the positive attitude and behaviour of service providers.

### *2.5.6 Counselling*

It was found that the time taken for counselling sessions was not recorded, although this is not specifically required in the operational guidelines. Psycho-social counsellors said that the duration of a session depended on the nature of the violence and the survivors' personal condition but that it generally took 2-3 hour per session. In some cases, 2-3 psycho-social counselling sessions had been carried out. No records or mechanisms for follow-up were found at Makawanpur OCMC, although seven follow-ups were mentioned in the counselling profiles.

During counselling, survivors were not asked to repeat their stories at every session, but if the OCMC referred the case to other organisations such as a safe home, NGO, police, survivors needed to repeat their stories as there was no other mechanism for information transfer.

### *2.5.7 Other issues*

**Referral pathways** — It was found that referrals were taking place from and to OCMCs and between hospital departments for a few cases where further treatment, investigations and counselling was needed.

**Consent of survivors** — The team found that verbal consent was mostly taken before providing services to survivors, but not a single written consent had been taken. The need for written consent is mentioned in WHO's Clinical Policy Guidelines (2013), but not included in the OCMC manual. Its inclusion is critical for service providers' safety, for legal evidence and for monitoring purposes.

**Forensic evidence and medico-legal issues** — Forensic evidence and medico-legal issues were addressed at all four OCMCs. However, materials used for medico-legal investigations were not sterilised except in Mahakali Zonal Hospital. Service providers were administering vaginal swabs without proper technical knowledge, except for a few providers who had previous knowledge of the procedure. OCMCs were using the police's evidence collection format, which is not however adequately descriptive. For instance, the format does not contain fields for hair, blood stains and nail-related evidence. Although during interviews, respondents claimed that swab slides were preserved for legal proceedings, it was found that slides were not preserved after reporting the results to the police.

**Child protection issues** — Reports from the four OCMCs indicate that 16% of the 362 survivor cases serviced by the OCMCs were under 18 years of age. When asked, "What measures would you take if a raped 15 year old child was brought to you by the police?" more than half of the providers interviewed demonstrated adequate knowledge of child friendly services. However, child rights issues such as maintaining privacy, special counselling, special attention, special consultations and the involvement of guardians were not being adequately addressed. These are essential to minimise child re-victimisation. The study also found that service providers had not been communicating with child rights organisations.

## 2.6 KEY FINDINGS FROM SURVIVOR CASE STUDIES

The assessment tracked 20 survivors from diverse age groups and ethnicities in the four districts. The types of GBV faced and services received from the OCMCs varied. See Table 10 for the main case details and Annex 6 for the case studies, the key findings of which are described below:

**Table 10: Information on the 20 case studies and services they received from the OCMCs**

| | | Background | | | Services availed from OCMC | | | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Age | Ethnicity | Type of GBV | Perpetrator | Brought or referred by | Medical treatment | Survivor counselling | Counselling to family members | Coordination (police, safe home, lawyer, other) | Length of stay and location | |
| **KANCHANPUR DISTRICT** | | | | | | | | | | | |
| 1 | 24 | Dalit | Physical/sexual violence | Husband; father-in-law | Brother | X-ray, blood and urine test, referral for CT scan | X | X | NA | 9 days in female ward | With same husband |
| 2 | 30 | Chhetri | Physical violence | Husband | Sister | Referral for eye check up | X | X | NA | 2 hrs at female ward | With same husband |
| 3 | 35 | Chhetri | Physical/sexual violence | Husband | Son | X-rays, referral for skin grafting to Dhangadi | X | X | NA | 8 days in female ward | With same husband |
| 4 | 24 | Brahmin | Physical violence | Father-in-law | Mother | General treatment | X | X | NA | 4 hrs at OCMC | Maternal home |
| **MAKWANPUR DISTRICT** | | | | | | | | | | | |
| 5 | 27 | Chhetri | Violence at workplace | Colleague | Lab assistant at hospital | General treatment | 2 sessions | | Police, lawyer, women networks, women cell, and NGOs | 4 hrs at OCMC | Family |
| 6 | 16 | Janajati | Rape | Unknown | Brother | All necessary check-ups for rape case treatment; emergency contraception provided | 2 sessions | 2 brothers (1 session each) | Police | 2 hrs every day at OCMC for 2 days | Family |
| 7 | 27 | Janajati | Physical/sexual violence | Husband | Police | Medication blood and urine tests | 5 sessions | Husband | Meeting with psychiatric doctor (trying) | Once a week for 2 hrs at OCMC | Maternal home (husband not in contact) |
| 8 | 19 | Brahmin | Acute depression | Depression caused by isolation | Sister working at hospital | Medicines | 5 sessions | Parents (1 session) | Meeting with psychiatric doctor | 5x2 hrs every day at OCMC | Family |
| 9 | 52 | Janajati | Physical violence | Husband | Safe House | General treatment, medication | 1 session | X | Lawyer | 1 hour for 5 days at OCMC | Separated. Won court case (*mana chamal)* |

| | | Background | | | Services availed from OCMC | | | | | | Status |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Age | Ethnicity | Type of GBV | Perpetrator | Brought or referred by | Medical treatment | Survivor counselling | Counselling to family members | Coordination (police, safe home, lawyer, other) | Length of stay and location | |
| **3. SUNSARI DISTRICT** | | | | | | | | | | | |
| 10 | 16 | Madhesi | Rape | Uncle | Safe House | Check-ups, free medication to survivor and child | 3 sessions | X | NA | NA | Maiti Nepal |
| 11 | 17 | Muslim | Physical violence | Brother; Father | NGO | Check-ups, x-ray, free medication | 1 session | X | Police, Safe House, NGOs and DCC | 9 days at OCMC | Family |
| 12 | 17 | Dalit | Sexual assault | Unknown | Safe house | Blood and urine test, free medication | 1e session | X | NA | 2-3 hrs at OCMC | Maiti Nepal |
| 13 | 16 | Janajati | Mental abuse/physical violence | Employer | Safe house | Check-ups, free medication | 3 sessions | X | NA | 3 x 3 hrs | Maiti Nepal |
| 14 | 37 | Brahmin | Physical/ sexual violence | Husband | Neighbours | Check-ups, free medication, x-rays | 1 session | X | Safe House, police, lawyer and WCO | 4 days at OCMC | Separated from husband |
| 15 | 19 | Chhetri | Physical violence/ mental abuse | In-laws | Safe House | Check-ups, free medication | 1 session | X | NA | 2 days at OCMC | Maternal home |
| **4. BAGLUNG DISTRICT** | | | | | | | | | | | |
| 16 | 17 | Janajati | Attempted rape | Neighbour | Police | Check-ups required for rape examination, blood and urine tests | 1 session | X | NA | 2 times at OCMC | Family |
| 17 | 39* | Brahmin man | Physical violence/ mental abuse | Wife | Self (emergency) | Check-ups, treatment free medication | 2 sessions | X | NA | 2-3 times at OCMC | Divorced |
| 18 | 18 | Janajati | Attempted suicide | Husband, mother in law | Husband | Check-ups, treatment | 1 session | X | NA | 2 days at female ward | With same husband |
| 19 | 25 | Dalit | Physical/sexual violence | Husband | Safe house | Check-ups, treatment, free medication | No | X | NA | 2-3 hours at OCMC | Husband |
| 20 | 17 | Chhetri | Rape | Cousin brother | Safe house | Examination required for rape case, x-rays, blood and urine test | X | X | NA | 5-6 hours at OCMC | Family |

** The only male survivor case study*

**Coordination and functioning** — The survivors' voices revealed variable coordination efforts to address their needs. The Makawanpur and Sunsari cases were generally dealt with proactively by the OCMCs. The ability of survivors to receive holistic services is evidenced by OCMC staff who not only provided case information for legal services, but also linked survivors to women's networks. Other cases highlight survivors' ability to access shelter at safe homes as well as start up small income earning initiatives such as a tailoring shop — all resulting from the links provided by OCMCs. The findings from Sunsari revealed that good coordination between the OCMC, WCO, police, safe home and local NGOs, had resulted in several survivors being rehabilitated by Maiti Nepal and learning useful skills. Constant follow-up by the OCMC is also taking place in a few Makawanpur and Sunsari OCMC cases.

However survivors in Kanchanpur said the OCMC was not working so well. The case of the Kanchanpur school teacher, who was not supported by the OCMC in relation to events surrounding her job transfer, revealed a lack of a communications with the district education office. The psychological trauma she and her daughter underwent had not been addressed and the survivor was unaware of the availability of psycho-social counselling at the OCMC. This case and a few others show survivors paying medical expenses. In a further case, referral to another hospital was not possible due to the survivor's lack of funds. These cases highlight how inadequate coordination can prevent GBV survivors from accessing facilities and the care they need.

The effective functioning of the OCMCs is questionable when looking at the inability of some survivors to access information and free medical, food and other services within the hospitals. Case 1 (Kanchanpur) was admitted to the hospital for eight days with severe injuries, but was still unaware of the OCMC services. Her counselling documents indicate say that she had been counselled, but the survivor was unable to share any related information. She had to pay for all her medication until she applied for needy patients' free care. Similarly, Case 2 (also Kanchanpur) was not informed of the psycho-social counselling services available at the OCMC that she and her children needed. Clearly, the services in at least one OCMC are not reaching survivors.

**Multi-sectoral support** — An overview of the 20 case studies shows that integrated holistic support is, for the most part, not being provided by the OCMCs. The effectiveness of OCMCs initially depends on their staff. Wider multi-sectoral support can be achieved through the active involvement of DCC members, which has yet to occur. Some survivors said that a lack of funds had made it difficult for them to access referral services. The provision of rehabilitation and empowerment-based services was limited. Only in 3 of the 20 cases (all at Sunsari) had rehabilitation opportunities been received. Except for the WCOs, safe homes and WCSCs, most other DCC members were inactive thereby preventing access to many types of multi-sectoral support.

**Behaviour of doctors and nurses** — The 20 case studies collected showed positive aspects and areas for improvement in the behaviours of health staff. A key positive was the supportive behaviour of doctors and staff nurses as described by several Makawanpur survivors. Empathetic psycho-social counselling sessions had benefitted family members as well as survivors:

> *"I felt good after talking to the nurse. She gave us moral support and built our confidence. She appreciated us for bringing our sister to the hospital… because of the OCMC everything went smoothly and we did not have to go through so much hassle by running here and there. The staff of OCMC helped us a lot. My sister also feels better these days. The perpetrator has*

*not been identified and is still missing. We have been following up with the police. The OCMC staff also call us sometimes and ask us about our sister and how she is doing and tell us to bring her here in case complications arise." — Brother of case 6 survivor (Makawanpur)*

Staff nurses also guided survivors on how to care for themselves but such positive behaviour was not seen across all four OCMCs with only a few proactive staff nurses playing such an effective role.

**Referral services** — Survivors said that referrals were occurring from the OCMC to safe homes and the police, and vice versa. A review of the 20 case studies illustrates a combination of positive impacts and the need to address some concerns. Some cases such as case 9 (Makawanpur) highlight the ability of a survivor to access free medical and psycho-social services as a result of referral from a safe home. On the other hand, referrals by OCMCs to other hospitals for cases such as skin grafts (to a Dhangadi hospital), or to an eye hospital, or for psychiatric treatment (a Chitwan hospital (see Box 6)) showed no results due to shortages of funds that prevented survivors from going there. Such survivors need support to access referral services.

**Box 6: Lack of budget means one survivor was unable to access needed treatment**

Case 7 (Makawanpur) cried all the time during the interview as a result of the sexual and physical violence inflicted by her husband. She had developed acute depression. More than medical treatment she needed psychiatric treatment. She thought medicines would not cure her and during the interview repeatedly said, "Can you suggest a place where I can go and have treatment for my complications." She thought she would never get cured and would die. The OCMC staff nurses did whatever was possible from their limited resources. The psycho-social counsellor had counselled her husband and obtained a written agreement that he would stop being abusive. The women had received repeated counselling sessions and had slightly improved. The OCMC tried to arrange a meeting with a psychiatric doctor from Bharatpur hospital for her treatment whenever he was visiting the Makawanpur hospital. But the OCMC did not have funds for referral treatment and she could not afford to go on her own so they could not send her to Bharatpur for psychiatric treatment.

**Outcome of OCMC support to GBV survivors** — The case studies show mixed results in terms of the impact of OCMC support on survivors. Cases where effective psycho-social counselling sessions took place, involving several sessions with the survivor and family members, resulted in positive outcomes. This made family members more supportive of survivors and helped survivors to adopt a more positive outlook. A coordinated CMC effort can also generate more holistic support and pave the way for a better life for survivors, as revealed in one Baglung OCMC case.

However, a pattern of re-victimisation is evident in cases where survivors received nominal or no counselling, were just sheltered at a safe home for a short term, or where reconciliation with perpetrators was prioritised. Case 9 (Makawanpur) highlights how since the safe home and OCMC had no knowledge of alternatives for rehabilitation, it promoted reconciliation, leading to re-victimisation. Such a case raises question on the ability of safe homes and OCMC staff to mediate effectively. But some cases such as Case 12 (Sunsari) show that follow-up can prevent re-victimisation.

# *3 LESSONS LEARNED*

The main lessons learned from the assessment are grouped under the following seven headings.

## 3.1 MANAGEMENT STRUCTURE

- There is a perception that OCMCs are the responsibility of hospitals, and DCC members are only there to be asked for support or advice. Developing more ownership among DCC members is essential to overcome this perception.
- Functional coordination is inadequate at the central level. This was also evident at the district level where horizontal coordination and collaboration was poor in all four districts. This has resulted in a lack of ownership of OCMCs among DCC members.
- The absence of comprehensive guidelines setting minimum service standards for GBV survivors and providing directives to government and non-government actors at national and sub-national level has impacted coordination and collaboration in response to survivors' needs.

## 3.2 PROVISION OF HOLISTIC SERVICES

- MoHP and other OCMC stakeholders need to collaboratively undertake GBV prevention programmes at district and community levels. These should be led by the DWD and national and local NGOs.
- Support from other hospital departments (emergency, inpatient, outpatient, laboratory, x-ray) and from doctors is vital for the effective functioning of OCMCs. However most of these departments did not have a full picture of what OCMCs are for and their links to it. Some who were aware were reluctant to assist without a financial incentive.
- The OCMC Operational Manual provisions free medicine for GBV survivors and MoHP has been providing additional funds for this. However, most hospital staff, including most doctors, were unaware of this provision. Survivors will be more likely to receive this support if appropriate information is disseminated, the provision of free services is monitored by the hospitals, and hospital-in-charges are held more accountable for providing these mandated services.
- Mechanisms for the follow-up and rehabilitation of GBV survivors need to be specified in the operational manual. The provision of follow-up needs to be addressed by OCMCs in collaboration with district and local stakeholders such as women's groups, DWD groups and paralegal committees to prevent the re-victimisation of survivors. This was evident from one case study survivor who claimed, "*My husband started beating me for going to OCMC and for later filing a case against him*".
- STI treatment is provided only in rape cases where there is a history of penetration and smelly discharge. Although this is appropriate, in the case of rape cases, investigation for STIs should be compulsory to prevent survivors contracting STIs.
- Psycho-social counselling should be mandatory in all rape cases. This is currently not the case. In many cases, the police bring cases to the OCMCs only for medical examination and take them back. These survivors miss out on critical counselling.
- OCMC service use can be enhanced through building improved synergies with stakeholders. The extent of survivor service is currently dependent on the initiatives of OCMC staff. A more pro-active role by DCCs and hospitals, DHOs and medical superintendents is vital to promote more synergy for integrated service provision.

- Lack of rehabilitation may compel many GBV survivors to return to their original situation where they often face re-victimisation.
- There were inadequate survivor tracing mechanisms in Kanchanpur and Makawanpur OCMCs for rape cases brought by the police at night. Following clinical examination, in the absence of any visible physical injuries, the police would take the victims back to the police station. These survivors do not have an opportunity for psycho-social counselling. It is not known whether or not the police refer these cases to appropriate places or not.
- The assessment found that the close proximity of OCMC focal persons and staff nurses to regular hospital staff runs the risk of the former speaking about OCMC cases and breaching confidentiality. This risk was seen to be particularly high in Sunsari OCMC where the thin plywood partitions dividing the counselling room and the rest of the OCMC limited privacy during psycho-social counselling. It was also noted that Kanchanpur OCMC office is also being used for counselling purposes. Furthermore, at all four OCMCs, visits by inpatient student nurses and teachers increased the risk of compromising confidentiality.
- Many hospital staff, including some doctors, were not aware of psycho-social counselling, safe home links and legal services provisioned by OCMCs. At some sites, OCMC and hospital staff did not feel able to counsel survivors.
- There is a risk that GBV services may be used by non-GBV patients who become aware of OCMC's facilities, and this could limit access to real survivors who face poverty, remoteness and caste/ethnicity based constraints.
- In Kanchanpur OCMC sterile swabs wrapped in towels, were being used. However, sterile vaginal swab sticks were not being used in Makawanpur, Sunsari and Baglung OCMCs. There the swab sticks were hand made with bamboo or coconut sticks and used when required (= unsterile). At Baglung even though the hospital laboratory had sterile packed swab sticks they had not been supplied to the OCMC.

### 3.3 COMMUNICATION AND COMMUNITY MOBILISATION

- The general public has very little awareness of OCMCs. Government and NGO district level organisations need to use their community level linkages through groups, volunteers, and other personnel to disseminate information about OCMC services to enable survivors to access them.
- Lobbying, advocacy and awareness raising with district and VDC level stakeholders, political leaders, media, I/NGOs, CBOs, and other women-focused stakeholders will improve access to information on OCMCs and their integrated services at local levels.
- The team found that only declared GBV cases brought to the hospitals had been treated by OCMCs. GBV cases in the in- and out-patient wards may not have been identified and thus not had access to OCMC services. This is likely to be the result of other staff not having received appropriate capacity building nor been mobilised to identify GBV symptoms.

### 3.4 HUMAN RESOURCES

- The team found that the presence of a lady doctor is an added advantage at an OCMC. Female doctors tend to be more empathetic and understanding of GBV survivors' needs as most survivors are women. Furthermore, most GBV survivors are likely to be more willing to share their concerns

with female rather than male doctors (as told by OCMC staff nurses in Baglung). Women doctors should also be appointed at other OCMCs.

- The staff nurses in Kanchanpur and Makawanpur OCMCs also had other hospital nursing duties and were unable to stay for night shifts. They were often preoccupied with other nursing duties. Furthermore, their residences were not nearby thus preventing them from providing 24-hour services. At Makawanpur OCMC, although 24 hour service had been provided for a couple of cases it had not been possible to continue this as a matter of routine. Consequently, OCMC services are often unavailable to survivors who come at night.
- Information from staff nurses and the Pokhara OCMC National Review Workshop highlighted that staff nurses feel that the extra duty hours they contribute are not appreciated by the hospitals, DCCs and central level authorities.

### 3.5 CAPACITY

- OCMC staff commitment and capacity building play a critical role in the provision of holistic support to GBV survivors. The clinical knowledge and experience of OCMC staff is advantageous to the health sector as a whole. Doctors were also applying their knowledge of forensic and medico-legal investigation on GBV cases.
- Inter-personal skills and the fortitude displayed by the focal persons/psycho-social counsellors were clearly adding value to services provided. The review team found that the greater these personnel focused on building relations with diverse OCMC stakeholders within and outside of the hospital, the greater the chance of survivors being able to access holistic services.
- Psycho-social counselling is generating positive impacts on survivors of all age, sex and ethnicity. While some survivors did not receive such counselling (see Box 7), the value and positive impacts of counselling were evidenced by other survivors saying that it had helped them deal with their situation by relieving their pains through sharing. Family members were also helped:

  *"…. [the counsellor] helped build our trust and confidence. Because of the OCMC everything went smoothly and we did not have to go through so much hassle …." — relative of a survivor*

**Box 7: Limited access to OCMC services**

Case 16 (Baglung) is a case of attempted rape on a girl working as a dishwasher in a hotel. Though, she was lucky not to have undergone actual penetration, she was pressurised by people around her not to go to court. The check-ups were all conducted at the hospital and general counselling was provided to her. However, she was not aware of the other services provided by the OCMC and she only received free medical treatment and general counselling.

- Survivors' voices revealed the need to ensure a more survivor-friendly environment within some OCMCs. The OCMC staff nurses were at times unable to provide timely services due to their workloads and consequently some survivors had to wait several hours for services. The locations of the OCMC, through the in-patient departments in some instances, created hesitation in accessing the services.

- There is a need to change mind-sets among survivors, hospital personnel and other stakeholders that OCMCs are only for medical treatment. Regular orientation and update programmes by OCMCs and DCCs are needed to orientate hospital personnel and stakeholders. Other stakeholders such as NGOs, CBOs, DHOs, DPOs and WCOs should also reach out to survivors.
- DCCs and CMCs need to play an active role to ensure that OCMC staff are motivated and effectively carry out their responsibilities. Regular DCC meetings will keep members and other stakeholders updated and aware on their roles and responsibilities. The National Review Workshop suggested that team building training programmes should be held for CMCs.
- Chief district officers (CDOs) have a critical role to play in enhancing the capacity of OCMCs. Despite their busy schedules and frequent transfers (Makawanpur OCMC has seen 6 CDOs since its establishment), the team found that CDOs' active leadership and facilitation were vital for encouraging other DCC members' involvement and the effective functioning of OCMCs. The high level position of CDOs ensures that their word and example is followed by DCC members. The team found that the CDOs were generally positive towards OCMCs. Increased ownership is possible if they are regularly updated about OCMCs, their needs, impacts and the changes they can effect on survivors' lives.
- There was no uniformity in the process of clinical recording and reporting. For instance, Baglung OCMC was not maintaining perpetrator information, while the other three were; Makawanpur OCMC was using a history taking form while the rest were not. This type of inconsistency creates a challenge for central level data compilation and analysis. The team however found no central level data capturing, analysis and use. OCMC staff need training on documentation and to incorporate lessons learned in their workaday practices while maintaining uniformity of reporting across the districts.

### 3.6 FINANCING

- The team found that besides government-provided free medicines, survivors were receiving other medicines from pharmacies with the costs later reimbursed by means of 'free/OCMC' chit. This was working well at Makawanpur OCMC. Related challenges included survivors purchasing medicines before reaching the OCMC, and some hospital departments referring survivors to pharmacies that did not accept 'free/OCMC' chits. However, the chit system is useful to support access of GBV survivors to needed medical support.
- OCMC staff were mostly unaware of the details of their OMCM's budget. They were thus unable to request funds according to budget line items and their low position in the hospitals prevents them from enquiring and demanding the details.
- The unavailability of funds for referrals prevents some survivors from accessing holistic support. One survivor said: "*I was asked to go to the eye hospital, but could not due to a lack of funds."*
- Sunsari OCMC plans to provide financial incentives to all hospital staff while Baglung OCMC is providing incentives to doctors and the focal person for involvement in OCMC cases. Makawanpur OCMC plans to provide incentives for rape case management personnel. There is no uniformity in the provision of incentives and this is generating resentment among other hospital personnel. Clear guidelines are needed in this matter before it becomes a major concern.

## 3.7 SUPERVISION AND MONITORING

- Regular guidance, supervision, the development of OCMC work plans, and monitoring from central and district levels are essential in order to eliminate the prevailing perception among OCMC staff that they have to fend for themselves. In-service capacity building, supervision and monitoring will enable staff to achieve higher levels of performance than is currently the case.

## 4 DISCUSSION AND CONCLUSIONS

Experiences from across the world indicate that GBV is a very sensitive issue, demanding extensive technical know-how, commitment, patience and coordination to address the needs of survivors, their family members and the perpetrators. The four OCMCs have made considerable achievements in this regard in the short time since they were established including providing valued support to survivors and their families.

The 20 GBV case study survivors ranged from 15 years to over 50 years of age and included 19 females and one male. All 20 had received medical treatment and many had been referred to safe homes. Some had received psycho-social counselling. Survivors were generally positive about the quality of services received and the behaviour of OCMC personnel.

*Reasonable progress* — The commitment of the focal persons and nurses in dealing with some OCMC cases must be acknowledged and due credit given in the face of considerable administrative and financial challenges including limited support from other hospital departments, and the absence of any work plans or other support. Credit must also go to medical superintendents and some hospital staff, WCOs and members of the police force deputed within hospitals and at the WCSC at a couple of the OCMCs. Their commitment in meeting their obligations has enhanced OCMC staff's capacity to serve GBV survivors. Although many survivors interviewed during this assessment indicated little knowledge of OCMC support and services received, their stories reveal how the OCMCs are functioning despite still being in their infancy. However, the responses from other interviewees both within and outside the hospitals show that a number of issues need addressing to improve the functioning of OCMCs.

*Lack of capacity building* — The only capacity building support provided to OCMC staff and other stakeholders was the initial six month psycho-social counselling training for a staff nurse from each OCMC. Since their establishment the staff and stakeholders have had to learn-by-doing and by sharing experiences with OCMC focal persons from other hospitals. In Kanchanpur, Makawanpur and Sunsari OCMCs the regional gender and social inclusion (GESI) focal persons provided support.

*Need for capacity building* — There is a pressing need to train OCMC personnel and other hospital staff and DCC members on GBV, its types, and the mental, physical and social and family impacts that can occur. This training needs to be incorporated in OCMC work plans. Hospital staff revealed several cases where they came to know of a patient being a GBV survivor only after the patient had been discharged from the hospital. A number of survivors interviewed were unaware of the services and support OCMCs provide and some only became aware after residing in an OCMC for several days. Others had already paid for medical and food expenses before reaching the OCMC. A few could have accessed useful links for their support but were unable to do so due to DCC inaction. The team found that the DCCs and other stakeholders were not discussing and enabling support for specific cases, with few efforts for rehabilitating survivors and helping them identify alternatives to returning to their often abusive spouses.

*Limited awareness* — The assessment team found that only a few DCC members, i.e. WCO, safe home and WCSC personnel were aware of OCMCs. Awareness of the availability of OCMC services needs to reach more stakeholders, including health workers in all types of health facilities, in order for more integrated survivor support to be provided. The assessment found that the incidence of re-victimisation is high if survivors return to abusive spouse and family members. Most need more than

medical support including longer term empowerment and self-sustainability support. This support should be provided in close coordination with NGOs, skills development programmes, small cottage industries, CTEVT and the private sector for on-the-job training opportunities and job placements. Several of the GBV survivors were being supported in this way by Maiti Nepal in Sunsari, while in Baglung, one survivor was being supported by the NGO Koshish. Aside from these cases, no links had been established between survivors and NGOs or CBOs.

The assessment team found that despite the presence of a number of NGOs working on women and GBV issues in the four districts, these organisations did not know about OCMCs. This gap needs bridging so that referrals can be made by NGOs and OCMCs can become critical points for supporting GBV survivors including preventing the re-victimisation that is reported in several of the case studies.

*Inappropriate promotion of reconciliation* — A lack of clarity on proper rehabilitation and follow-up processes means that some DCC members such as the WCOs and safe homes tend to promote the frequently inappropriate reconciliation of survivors and their abusive spouses and relatives. The need for proper understanding of cases is highlighted in one case study where the survivor refused to return to the safe home, after the third reconciliation, fearing she would once again be sent home to the perpetrator (Box 8).

**Box 8: Reconciliation is often inappropriate**

Case 7 (Makawanpur) had been referred to a local safe home three times and each time had been advised to return to her husband and seek reconciliation:

"They reconciled me with my family three times. So, the fourth time, I did not go to take refuge in the safe home fearing that they would again send me home. Instead, I went to my maternal cousin's house and stayed there."

After the repeated violence she suffered, each time the safe house should have asked her opinion instead of repeatedly sending her home. This case highlights the limited capacity of this safe home to mediate effectively.

*Staff behaviour* — The survivors interviewed, in particular those who were aware of the OCMC, said that the behaviour and attitudes of OCMC staff had generally been good, although this is something that can be difficult to accurately recall and survivors may not be aware of the services that should have been provided. Counselling and other support was reported to have had a large positive impact on the number of cases of attempted suicide, acute depression and rape.

*Inadequate guidance* — The contracted staff at two of the OCMCs, who had been recruited only a couple of months before the team's visits, had been oriented by the psycho-social counsellor on the role of the OCMC. There was a clear absence however of guidance to OCMC staff on the provision of integrated support and even the DHO and medical superintendent were unable to provide this information due to their lack of knowledge on GBV.

*Limited powers of OCMC staff* — The above concern was compounded by the unequal power dynamics within hospitals where staff nurses tend to have an inferior status to many administrative and other medical personnel, and cannot demand to see things such as OCMC budget details. Most OCMC focal persons and staff nurses were also ignorant of the previous year's budget. A slight improvement was noted in the current fiscal year as the focal persons and staff nurses were aware of the overall budget, although not its line item details but they lacked any decision making power on the use of the available funds. However, in Baglung and Sunsari OCMCs the encouraging trend was noted of staff being requested to provide details of the expected expenditure to be reimbursed by the

hospital/OCMC. Requested items ranged from free medicine chits for survivors to the provision of laboratory tests and x-rays.

*Incentives* — The contentious issue of financial incentives was frequently mentioned. As previously noted, the DCC of one of the four OCMCs had agreed to provide additional incentives to the psycho-social counsellor and doctors involved in treating OCMC cases. In another case, the decision had been made to share a couple of budgetary line items among all hospital staff involved in supporting OCMC cases including emergency and x-ray department staff. Unfortunately, those not receiving such incentives were found to be delaying service-support to OCMC patients. The incentives issue is being followed closely by other OCMC and hospital staff across the country and a swift decision is required to prevent it further disrupting OCMC service provision.

*Facilities and protocols* — The assessment found that in a number of cases OCMC rooms were unsuited to protecting the confidentiality of survivors. In addition, there were insufficient protocols in place to reliably identify GBV survivors in hospital wards, to treat survivors and to collect rape-related evidence.

*Overcoming challenges* — The assessment found that the OCMCs faced the following major challenges: low levels of GBV and OCMC awareness; inadequate GBV knowledge among hospital staff and other stakeholders; an inability to identify survivors choosing not to divulge details of abuse suffered; and the inactivity of DCCs.

The assessment team believes that these challenges may be overcome as follows: through improved awareness raising activities; capacity building of OCMC staff and stakeholders; survivor follow-up; improved screening and coordinating strategies; and more social protection activities to support survivors. The implementation of these measures will demand consistent and coordinated monitoring from the centre to track indicators and clear directions from ministries and institutions to district line agencies. This will also require that other government agencies, beyond MoHP alone, work more systematically to prevent and address GBV in a holistic manner.

# *5 RECOMMENDATIONS*

It is recommended that lessons learnt, best practices, bottle necks and gaps identified through this assessment are used to scale-up the effectiveness of OCMCs.

The following recommendations are based mainly on the findings and observations of the assessment team. Suggestions received from government during national review workshops have also been incorporated within this listing. Recommendations are divided into those requiring immediate action and those to be addressed in the longer term.

Please also see the recommendations produced by implementing stakeholders and policy makers in the Process Report on the National Workshop on Review and Future Direction of OCMCs (Pokhara, 18-19 August 2013). This report is available at the Population Division.

## 5.1 IMMEDIATE TASKS

### *5.1.1 System strengthening*

*Coordination and monitoring* — The study identified the need for improved coordination, collective ownership and monitoring of OCMCs at the policy level. Issues pertaining to the need for greater policy clarity, improved guidelines, strengthened systems and building capacity to provide strong technical leadership and management must also be addressed.

- Coordinate central level monitoring by OPMCM, MoHP and other key stakeholders. This can happen by central level stakeholders meeting regularly to provide updates on the status of OCMCs and identify areas of potential collaboration. MoHP should take the lead role in coordination efforts. The capacity of OPMCM and MoHP needs strengthening in order to undertake joint monitoring and supervision of OCMCs.
- Hold OCMC DCC meetings regularly to enable DCCs to guide and monitor OCMCs.
- Central level stakeholders (Ministry of Home Affairs [MoHA], Ministry of Federal Affairs and Local Development [MoFALD], DWD, Police Headquarters, Ministry of Education (MoE), Office of Attorney General, and others) should provide clear guidance to their line agencies at district, village development committee (VDC) and community levels in order to promote OCMC ownership and commitment.

*Referral funds* — Several case study survivors were unable to access referral services due to financial constraints and a lack of information (see e.g. Box 5). In order to address this:

- Establish a central level referral fund for survivors that can be mobilised by CMCs.

*Annual work plans* — The absence of work plans has prevented OCMC staff from determining how to move forward.

- All DCCs should develop annual work plans for their OCMCs.
- The implementation of work plans should be regularly checked by DCC members and monitored by MoHP. These plans should initially address OCMCs alone and then be extended to cover all GBV related activities addressed in district GBV work plans once coordination mechanisms are better functioning.
- Develop survivor consent forms and referral slips to facilitate OCMC management, effectiveness and uniformity.

- DWD should oversee support for survivors at safe homes and through GBV programmes while the WCSC should ensure the security of survivors from the hospital to the community level. NGOs should provide GBV technical and psycho-social support to these bodies.

*Staff retention —*

- Mandate three-year contracts for OCMC contracted staff to help avoid institutional memory loss and to enable staff to work confidently without the pressure of job insecurity.
- Ensure staff's long term service through agreements before providing them with technical training such as psycho-social counselling.

*Appointment and salaries* — While recognising the complex management challenges involved, the team found high levels of dissatisfaction among staff nurses and office assistants who received divided OCMC salary payments.

- Do not divide single OCMC salaries between different hospital staff who are not involved in directly delivering OCMC services.

### *5.1.2 Awareness, ownership and capacity building*

*DCC and CMC members —*

- Orientate and train DCC and CMC members on GoN's GBV based plans and policies (National Strategy and Plan of Action to End GBV and Empower Women, 2012; National Action Plan on Implementation of UNSCRs 1325 and 1820) to help ease perceptions that action against GBV is a western inspired influence and to highlight the positive impact OCMCs can have at family, societal and national levels.
- Carry out team building exercises for OCMCs.

*OCMC staff* — Building the capacity of OCMC staff is a priority. The study found that no staff nurses had been trained on GBV. Addressing this gap will create better understanding of the value and impact of OCMCs and improve capacities to deliver respectful, sensitive and quality services.

- Provide OCMC staff with training and orientation on gender and the genesis of GBV in order to improve understanding of, and empathy towards, GBV survivors. In addition, provide on-the-job training on clinical, administrative and psycho-social counselling.
- Organise annual review meetings of OCMC staff in order facilitate experience sharing.
- Organise national and regional exposure visits to other OCMCs for sharing best practices and, in particular, helping medical superintendents and OCMC key personnel to learn from successful initiatives in countries such as Bangladesh.
- Provide greater recognition and appreciation for good work undertaken by OCMC staff, particularly staff nurses. This appreciation should come from the DCCs and MoHP's Population Division in the form of rewards, exposure visits and further training opportunities.

*Hospital staff* — The study found that only very needy survivors requiring treatment were accessing OCMC services. Many were overlooked by hospital staff, since the cause of their problems was not declared. Others were simply unaware of the OCMC's existence.

- Develop a screening protocol that specifies the roles of hospital personnel in identifying GBV survivors. This will also involve training and sensitising staff, establishing monitoring and supervision systems, and providing adequate resources.
- Undertake awareness raising and capacity building on GBV and the OCMC for all hospital staff to provide knowledge of: GBV and its health impacts; the role of the OCMC; how to support GBV survivors; identifying GBV survivors; monitoring; and psycho-social counselling.
- Medical superintendents should brief all hospital staff on how to identify survivors and facilitate support for them.

*OCMC staffing* — The operational manual specifies that OCMCs should be staffed by three full time staff nurses. However this assessment found that in Sunsari and Baglung, OCMC staff nurses work in in-patient and out-patient wards kept them busy and thus unable to give their full attentions to the OCMC. Note that this assessment's recommended increased promotion of OCMC service availability could lead to an increase in service seekers and thus increase the workloads of OCMC staff.

- Ensure 24 hour OCMC services by assigning the eight hour morning session to focal persons and the remaining period to the other two nurses. The implementation of this recommendation will depend on other factors such as MoHP's ability to pay for the contracted nurses and ensure their availability.
- Ensure that contract nursing staff are on duty at the OCMCs for the required times.

*NGOs and CBOs* — The assessment found that Amaa Milan Kendra, Maiti Nepal, Nari Seep Kendra Saathi, RUWDUC, paralegal committees, Women for Human Rights, Inter-party Women's Alliance and other organisations were working on women's empowerment and the prevention of GBV. Some are national organisations with long experience of working with GBV survivors. These stakeholders were keen to collaborate with OCMCs.

- OCMCs should coordinate more closely with CBOs and NGOs to enhance support to survivors. They should work with them on raising awareness in communities, prevention based programmes, building the capacity of OCMC staff, facilitating survivor support and follow-up including providing shelter and skill development opportunities.
- OPMCM in collaboration with the MoHP should encourage DCCs to work with NGOs to monitor OCMC activities.

*IEC strategy and materials* — Except for the OCMC leaflets seen in Baglung and Makawanpur OCMCs the assessment found no other printed information, education and communication (IEC) materials in the OCMCs.

- Develop an OCMC IEC strategy to provide the general public, actual and potential survivors, actual and potential perpetrators, service providers and others with knowledge ranging from GBV prevention to the rehabilitation of survivors.
- MoHP should collaborate with the National Health Education, Information and Communication Centre (NHEICC) and NGOs and CBOs with relevant experience to identify existing materials and develop OCMC-relevant GBV materials. These should be adapted to fit local contexts and produced in culturally relevant languages.

### *5.1.3 Fostering inter-sectoral and inter-agency collaboration for referrals and follow-up*

The level of knowledge and awareness among stakeholders on OCMCs requires enhancing through inter-sectoral and inter-agency collaboration. Stakeholders should work together to maximise survivor support including through improved follow-up in order to prevent further abuse:

- Produce district coordination plans for the provision of a more coordinated approach GBV services.
- Provide regular orientation programmes to VDC secretaries on GBV and the services available at OCMCs and encourage them to refer survivors to OCMCs.
- DHOs should orientate health workers and female community health volunteers (FCHVs) on OCMCs and the services they provide.
- Orientate teachers on OCMCs and encourage them to inform students and youth groups about OCMC services.
- Link OCMCs to government and NGO programmes including local peace committees, safe migration, hospital-based nutrition rehabilitation homes, and HIV/AIDS prevention.

### *5.1.4 Prevention-based programmes*

- MoHP should link GBV prevention programmes at district and community levels with other programmes such as immunisation, family planning, outreach services and various health campaigns. These programmes provide opportunities to provide information on the health consequences of GBV on survivors and their families and will result in lost opportunities and increased costs if they are not exploited.
- Run programmes that engage men and religious leaders in the prevention of GBV; youth based GBV prevention programmes; and community watchdog programmes to prevent GBV and to promote the referral of survivors to OCMCs.
- MoHP should encourage and promote collaboration and coordination between health, WCO, NGO, CBO and police stakeholders in order to integrate OCMC information and messages in their programmes. Such collaborative programmes will help prevent duplication, while enhancing GBV prevention activities.
- Health facility operation and management committees (HFOMCs) and their health facilities (primary health care centres [PHCCs], health posts and sub-health posts [SHPs]) should incorporate GBV components in their outreach programmes.

### *5.1.5 OCMC operational manual*

- Revise the OCMC operational manual to strengthen coordination with other agencies and promote cross-sectoral ownership. The aim is to develop a manual that is owned by all relevant sectors and agencies. This will require a multi-sectoral revision process.
- Incorporate survivor referral guidelines to enable service provider understanding on the links needed for improved survivor support.
- Specify the collection of adequate information on survivors to include age, ethnicity, GBV type, perpetrator information and contact numbers in order to facilitate case analysis and follow-up.
- Include a protocol and establish mechanisms for providing follow-up support to survivors.

- MoHP to clarify the types of incentives that can be provided to personnel for supporting OCMC survivor cases.

### *5.1.6 Clinical recommendations*

- Do not put the words 'gender based violence' on OCMC signboards as this can deter survivors from coming to OCMCs.
- Develop clinical guidelines within the operational manual including i) a screening and treatment/management protocol; ii) a standard investigation format to guide health workers on the minimum investigations required for examining GBV cases; and iii) a written consent form for survivors for physical examination and psycho-social counselling in order to to respect survivors' rights.
- Develop and place referral guidelines in all OCMCs and strengthen OCMC referral mechanisms including for in and out of hospital referrals.
- Clearly define and distinguish between general counselling and psycho-social counselling in order to remove confusion on the type of counselling provided to survivors.
- Train doctors and staff nurses on carrying out forensic investigations for diagnosing cases.
- Ensure that all the instruments, equipment and medicines specified in the operational manual are available in OCMCs including sterile vaginal swab sticks.
- Ensure that all rape survivors undergo routine blood investigations including HbsAg, HIV, VDRL, and urine for pregnancy test. Preserve vaginal swab slides for legal evidence and undertake STI treatment only after investigations.
- Create a separate central level fund for dealing with survivors' mental health needs. The fund should be managed by DWD, and incorporated within the WCO safe home funds and mobilised by OCMC DCCs. *(*The mental health of survivors was a key concern of many stakeholders.)

### *5.1.7 Other recommendations*

- *CMCs as executive working bodies* — Make CMCs the core executive body of OCMCs and ensure that they meet frequently. It was noted that they are more likely to meet frequently since their meetings do not depend on CDOs' busy schedules (the main hindrance to DCC meetings). It is therefore essential that CMCs are given the authority to make decisions pertaining to survivor support, particularly in relation to medical, security, rehabilitation and psycho-social services. They should also regularly report to the DCC and the frequency of this should be specified in the operational manual. Furthermore, follow-up on DCC decisions should form the basis of CMC activities. MoHP must make mandatory the monitoring of funds allocated to OCMCs. The active involvement of DDC stakeholders is likely to improve transparency and accountability.
- *Resourcing OCMCs*— OCMCs should establish stronger links with other initiatives in order to improve access to major clinical equipment and tools, especially those required for the medical treatment of GBV survivors. If funds provided by MoHP are insufficient, links should be established with other funds such as those managed by DDCs and collaboration established with UN agencies and I/NGOs.
- *Evaluating impact* — MoHP should provide for the implementation of impact evaluations of individual OCMCs every two years.

- *Measuring impact* — Include OCMC performance data in GoN's Health Management Information System (HMIS). This would include data on the type of GBV, perpetrator, psycho-social counselling support provided, levels of re-victimisation, follow-up, ethnicity, age and other information. (Data on the number of women GBV survivors and those facing physical violence was said to be already included in HMIS recording.)
- *Women doctors* — Depute more women doctors to OCMCs since they are better able to understand and deal with issues faced by women survivors.

## 5.2 LONGER TERM TASKS (2013-2016)

- *Develop multi-sectoral district GBV plans* that incorporate prevention, treatment, protection and rehabilitation initiatives. These plans should be developed by key stakeholders including OCMC personnel, hospital staff, DCC members, NGOs, politicians and community leaders.
- *Train doctors and nurses* on GBV to better understand the value of OCMCs and deliver quality services. Provide pre-service and in-service training in coordination with medical colleges and incorporate GBV in MBBS, nursing and paramedical course curricula and regular MoHP health worker in-service training courses.
- *Survivors' rehabilitation*— There is a need for CMCs and DCCs to provide more support for rehabilitating survivors. The operational manual should require OCMCs to make transition plans for survivors and OCMCs should strengthen their links with the Council for Technical Education and Vocational Training (CTEVT) and other skills training institutions willing to support GBV survivors, such as Maiti Nepal and Saathi.
- *Coordinating with the private sector* — OCMCs should establish links with private sector companies for survivor rehabilitation, and especially linking them to employment opportunities. Other national level programmes on GBV have identified job placement opportunities for survivors.
- *Centralised database of GBV survivors*— Explore the creation of national and district level databases on GBV survivors using information provided by all key actors.

## *Annex 1: Assessment Matrix*

| Areas | Sub-areas | Observations by district | | | | Preliminary findings | Recommendations |
|---|---|---|---|---|---|---|---|
| | | Kanchanpur | Hetauda | Sunsari | Baglung | | |
| **1. Ownership and commitment to OCMCs including attribution of changes** | | | | | | | |
| **1.1** | **Commitment and ownership by case management committees (CMC)** | • Members uncertain about roles and responsibilities.<br>• Discussions with CMC taking place, though not frequently and usually through telephone, when it occurs.<br>• Vague links between hospital personnel, DCC members and CMC. Little or no sense of unity.<br>• Feeling among other hospital staff that success depends on the 2+2 staff.<br>• CMC not receiving any form of guidance or supervision from DCC. | • OCMC staff committed, working throughout official hours even after office time with no additional incentives.<br>• Focal person is DHO's family planning focal person. Involvement limited to managing budget.<br>• May not be confidentiality of cases.<br>• 2 staff nurses backstopping each other, resulting in effectiveness | • No CMC meetings held (not responsibility of OCMC staff).<br>• Most discussions being held through phone calls.<br>• Committed OCMC staff. | • 3 meetings of CMC held (unlike in other districts)<br>• GBV cases not kept at safe houses but in hospital.<br>• Stakeholders informed that safe home only provides 45 days maintenance.<br>• CDO was aware and positive and wanted focus on sustainability.<br>• Police: limited knowledge<br>• Risk of GBV cases being used for self-promotion by various organisations expressed by stakeholders. | • In 3 districts CMCs function informally through interpersonal communication and phone calls. In one district meetings have been formally conducted, but only for GBV cases. | • The guidelines should clearly specify that CMCs are the working body. Meetings should be held once a month to discuss all cases from that month and other concerns such as monitoring and supervision, and sharing of work plans. Should also meet done as and when required.<br>• CMC as the executive body should update DCC of its on-going activities. |
| **1.2** | **Commitment and ownership by district coordination committee members** | • Ownership by DCC members absent. Feeling that it is hospital and hospital staff's responsibility and DCC should not interfere. Little initiation taken by DCC members.<br>• Hospital commitment limited to providing medical services, which 'they have been doing before also'. Only difference is very limited psycho-social counselling –occurring.<br>• Meetings held before, but coordination limited | • CDO as chair. But constant change of this person affects effectiveness.<br>• Medical superintendent needs to be more active.<br>• Accountant is supportive.<br>• WCO: Felt there is duplication of Safe Home and OCMC committees. Sending safe home residents for medical treatment to OCMC. Different from Kanchanpur.<br>• Police playing positive role but need to document cases sent to OCMC. | • Partial commitment by hospital. Is not a priority<br>• Some members, such as WCO, police, Bar Association, Maiti Nepal are knowledgeable and to some degree supportive.<br>• Except for OCMC staff, ownership by DCC members is limited. | • 4 meetings held. At 2 meetings internal staff met with central level personnel.<br>• Most members unaware of their roles and responsibilities.<br>• Not working as M&E and supervisory body.<br>• No understanding that referral to other bodies by OCMC and vice-versa is part of their responsibilities.<br>• One contracted nurse (no knowledge or involvement). Others involved = medical superintendent, focal person, staff nurse, focal doctor (all had | • DCC meetings being held; but more for formalities sake.<br>• Majority of DCC members unaware of their roles.<br>• In long run 1 admin. staff should be hired. Currently 1 focal person-cum-psycho-social counsellor. One staff nurse needed to look after admin + support OCMC and 1 office assistant needed.<br>• One OCMC does not have a staff nurse as its focal person as per the | • OCMC activities must be shared DCC on quarterly basis by OCMCs.<br>• Decisions made by CMC should be reviewed and implementation ensured by DCCS.<br>• Orientation and training on OCMC as well as roles and responsibilities of DCC members needed to enhance commitment and ownership.<br>• Total 3 staff & 1 office assistant. Morning sessions should be |

| Areas | Sub-areas | Observations by district | | | | Preliminary findings | Recommendations |
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| | | Kanchanpur | Hetauda | Sunsari | Baglung | | |
| | | amongst members.<br>• DCC members expecting OCMC staff to take initiative and ask them to get more involved. Hierarchy prevents OCMC staff from speaking up. | • Cost of lawyer is for printing and court costs, not for counselling and drafting cases. | | ownership and commitment). Medical superintendent informed and updated about details.<br>• Focal person committed, but job description prevents her from full time involvement<br>• Almost all given orientation: lab., community stakeholders, teachers, inter-party alliance members, SHP and health post personnel (unlike in other places). Staff therefore aware and referring directly to staff nurse.<br>• Confidentiality mostly maintained. They do not share outside OCMC staff. Others may know but they don't divulge<br>• Legal counselling: No referrals made by OCMC so far.<br>• 10 cases referred to police.<br>• Psycho-social counsellor has more theoretical knowledge and may be giving general counselling rather than thorough ones. Guidance and mentor needed for psycho-social counsellor, and refresher for all psycho-social counsellors. | guidelines. Uniformity should be ensured by DCC.<br>• DCCs in all 4 districts have not developed work plans. | managed by focal persons, 2 staff nurses should be working shift-wise for rest of day.<br>• Office assistants should be working full time.<br>• DCCs should ensure that OCMC work plans are addressed and reviewed. |
| **1.3** | **Effectiveness of approaches for enhancing ownership and commitment** | • Has sensitised some hospital personnel on GBV.<br>• Has built basic links with safe homes and lawyers (GoN and Bar)<br>• A few cases have unknowingly accessed OCMC support | • Maternal and child health, hospital and most doctors not received info. or orientation. 'We asked focal persons, but no initiative taken.'<br>• Good links with safe home.<br>• One case was compelled | • GBV survivors receiving services and other basic necessities free of cost.<br>• Change: Speedy service to survivors, men becoming more aware and may be working as preventive factor. Survivors with | • Active and regular involvement and knowledge of stakeholders about OCMC leads to better functionality and management of OCMC.<br>• Doctor shows his accountability by going when required and compels others to also go. | • Six months psycho-social counselling training enhanced commitment of focal persons.<br>• Focal person's interpersonal skills have enhanced commitment of police, WCO and legal counsellors. This varied | • Capacity building of OCMC staff and DCC and CMC members needed to enhance OCMC effectiveness. |

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| | | Kanchanpur | Hetauda | Sunsari | Baglung | | |
| | | | to sign an agreement paper to go to a safe home but afterwards decided not to go. | some knowledge are aware where to go.<br>• Except for initial 1 day orientation during inauguration, no other orientation has taken place.<br>• Inpatient staff had some knowledge, but lab. staff unaware. Emergency staff had some knowledge through staff nurse/focal person. | • Lady doctor's active presence and positive attitude.<br>• Orientation and training on OCMC run for all except new hospital staff.<br>• Enhanced referrals and coordination, even through compulsion (had called Maiti Nepal, looked for funds, etc.) | between districts.<br>• Guidelines should clearly define roles and responsibilities of OCMC staff and DCC members. | |
| **1.4** | **Successful approaches** | • OCMC initiation in hospital taken positively by all interviewed as a means through which holistic support can be availed by survivors.<br>• Is a means to enable identification of GBV survivors.<br>• OCMC Staff: positive. | • Active OCMC staff.<br>• Good coordination between safe house and police.<br>• Positive commitment of OCMC staff and good attitude and behaviour.<br>• A central staff member has played positive role in direct supervision of OCMC staff. Also may be due to her being female and based within reach of OCMC staff. | • Active focal person.<br>• Some degree of supervision from GESI focal person.<br>• OCMC staff are working but require more technical backstopping. | • Presence of female doctors.<br>• Handover and takeover of cases by doctors and nurses for overlooking OCMC.<br>• Long term presence of medical superintendent has enhanced commitment.<br>• Maya's case, which brought about regular discussion, indicates regular meetings needed for success of CMC<br>• Good accountability of medical superintendent. | • Being initiated by GoN has had positive impact.<br>• Initiative from within hospital is positive impact<br>• Coordination with police and WCO service centres (sewa kendras) has been initiated. Extent of coordination has varied.<br>• Survivors receiving speedy services.<br>• Provision of free basic necessities, such as medicines, varies in district.<br>• Incentives for doctors, nurses facilitated OCMC implementation.<br>• Good interpersonal skills of focal persons and are permanent staff.<br>• Added value of lady doctors. | • Reward, and appreciate good performing staff.<br>• Orientate all hospital staff on OCMC services to facilitate integration of OCMC as integral hospital activity.<br>• Promote recruitment of lady doctors as focal doctors in OCMCs. |

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| **2. Organisation and management of OCMCs (Cross checking of achievements on outcomes and outputs against indicators in operational manual)** | | | | | | | |
| **2.1** | **Management structure and capacity building of OCMC and hospital staff** | • OCMC focal person possessed good knowledge of roles and responsibilities, but has time constraints due to her operating theatre duties.<br>• 6 month training on psycho-social counselling led to counsellor possessing good knowledge of responsibilities. Records indicate 71(?) cases reviewed, but none of those visited said they had received counselling. Who is receiving it? Evident gap.<br>• New staff provided orientation by OCMC staff, but require more capacity building, training and exposure on to what to do and how to do it.<br>• No orientations for other hospital staff.<br>• Emergency staff complained at previous case management meeting of their lack of knowledge.<br>• Other department staff had little or no information.<br>• Inadequate management support to OCMC staff by DCC. | • Unclear role of focal person.<br>• Clinically: Positive, as cases coming and dealt with systematically. But for night OCMC staff said there is no transport so is difficult.<br>• Have focal doctor who comes when possible.<br>• If focal doctor is absent he delegates. But they ask: 'what benefits do I get?'<br>• Emergency unit takes cases to OCMC.<br>• Cases brought at night are taken to labour or gynae. wards.<br>• Despite inadequate training and orientation, is good that OCMC is working quite well. | • Basic infrastructure (4 rooms, toilet) available, but lack of privacy for counselling.<br>• No electricity in toilet.<br>• DCC meetings not taking place due to busy schedule of CDO and other members despite efforts of OCMC focal person.<br>• OCMC staff too junior in hierarchy for others to listen to them<br>• More training on counselling, GBV, family planning, etc. required to strengthen capacity of OCMC.<br>• Link developed by OCMC due to focal person's personal networking. More OCMC staff are working but need technical backstopping. | • Location is hidden away to an extent. OK if some referral occurs. Not accessible for those coming by self.<br>• Need to pass through male and female wards. High risk of meeting known people<br>• Good for privacy.<br>• No telephone.<br>• No swabs – bring from lab (bamboo stick).<br>• Dirty toilet.<br>• Confidentiality possible, but medical recorder room also there.<br>• No capacity building of OCMC staff except for orientation. Even newly appointed doctor not received orientation.<br>• No refresher training for psycho-social counsellor.<br>• Recommendation: One time orientation is inadequate. If new appointment is taking place immediate knowledge transfer has to occur and orientation as well<br>• Hospital staff have received orientations on OCMC. | • Considering sensitive nature of GBV, OCMCs are a positive initiative. But adequate technical support for capacity building of OCMC and hospital staff missing.<br>• Only training = 6 month training to psycho-social counsellor.<br>• Hospitals have managed OCMCs within existing infrastructure. As result, while there are sufficient rooms, only 1 OCMC location was appropriate.<br>• For swab taking confidentiality maintained in all 4 districts.<br>• Case confidentiality maintained at only 2 OCMCs.<br>• Need for toilets as per guidelines. | • Training and orientation needs providing to all OCMC and hospital staff. Orientation should be provided to DCC members to enable them to oversee OCMCs.<br>• Need exposure visits to in-country OCMCs to share best practices.<br>• Need annual review meetings for OCMC staff.<br>• Address lack of adequate infrastructure including lack of phones, lack of confidentiality, and lack of maintenance.<br>• On the job monitoring of training received by OCMC technical staff. |
| **2.2** | **Arrangement and regularity of human resources at** | • Uncertain, especially as two focal staff are GoN staff and prioritise other duties. Why separate staff not | • 24 hour service not possible with current staff.<br>• Pay not enough.<br>• Short term contract | • Due to working in inpatient ward, possibly available 24 hours.<br>• Staff do not attend | • One person's salary divided into 2<br>• Overall being looked after by focal person. Too many | • 24 hour service available in only 2 OCMCs.<br>• Staff not able to give full work focus on OCMC. | • Monitoring and supervision essential to ensure 24 hour services.<br>• Avoid division of salary |

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| | **OCMCs** | appointed and trained?<br>• Not 24 hours service.<br>• Due to budget delay one staff unpaid for 9 months and had to leave.<br>• New nurse hired on contract one month ago, but only to end of fiscal year. No capacity building of new staff except for orientation by OCMC nurses.<br>• Trust towards focal person and her own commitment, though she has time constraints due to other duties, No clear certainty about support. Pro-activeness of counsellor. | mean that staff feel job insecurity.<br>• Staff feel no appreciation or recognition of their work. No training, awards, etc.<br>• Appropriate training not provided to hospital staff. | regularly.<br>• Staff may not be able to give full focus on OCMC duties.<br>• Short term contracts and uncertainty leading to stress among staff. | responsibilities for one person.<br>• No staff presence in OCMC although they are mostly inpatient staff. Priority not given to OCMC and only gave on as per need basis.<br>• Recommendation: Appoint full time staff.<br>• Staff nurses not involved at all in OCMC. | Divided between hospital and OCMC.<br>• One year contracts create uncertainty among staff. | between two staff. Give full salary to staff to ensure their full devotion.<br>• Minimum of two year contracts should be granted. Agreements should be made prior to psycho-social counselling training to ensure long term service. |
| **2.3** | **Monitoring and supervision** | • Regular monitoring and supervision by DCC and central level missing | • GESI person doing some supervision and monitoring<br>• Medical superintendent only participates in discussions.<br>• Little monitoring or supervision happening. | • None from DCC<br>• Some supervision from GESI focal person.<br>• Central level monitoring and supervision is inadequate.<br>• Work plan missing. | • No monitoring or supervision. History taking form developed by OCMC.<br>• No work plan.<br>• No supervision by DCC and hospitals.<br>• Recommendation: More central level visits. M&E should involve feedbacks and should be discussed and timeline for implementation monitored in DCC meetings. | • District level supervision missing by DCC.<br>• Central level supervision not in-depth.<br>• Limited supervision by district GESI focal persons. | • Need biannual monitoring and supervision from central level.<br>• Need quarterly supervision by DCCs. |

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| **3. Quality of Care /GBV cases** | | | | | | | |
| **3.1** | **GBV survivors' access to OCMCs and knowledge of services** | • Couple of cases came through safe homes.<br>• Only one case has come directly.<br>• Generally it is only extreme cases identified from hospital wards.<br>• Many survivors return home unaware of OCMC and services it provides. | • Psycho-social counselling good for all cases.<br>• Positive reaction by all cases.<br>• Brother of survivor being counselled = positive.<br>• Only 4 rape cases and GBV cases given emergency contraception. No STI treatment or post exposure prophylaxis<br>• MBBS doctors do not possess adequate info on OCMC.<br>• No link with child rights issues. | • Most were brought by service centres (sewa kendras), one through hospital.<br>• Positive feedback on services provided by doctors and OCMC staff<br>• Counselling by focal person undertaken for a few cases.<br>• Other survivor support is limited. | • Psycho-social counsellor should not be given too much responsibilities<br>• OCMC is not easily accessible.<br>• Survivors possess limited knowledge about services provided by OCMC.<br>• If coming from referral from police or safe homes can access, but individual survivors do not find it easy. | • Survivors have had access to OCMCs due to being brought through networking of key stakeholders such as safe homes, police, NGOs.<br>• Most survivors are unaware of OCMC services. | • Need information dissemination and awareness raising on OCMCs at district and community level through various approaches such as media, IEC materials, links with line agencies. Posters should be placed in various places to publicise OCMC service provision.<br>• OCMC should have signboards. But the words GBV should not be put on signboards. |
| **3.2** | **Knowledge of various service providers regarding OCMC** | • Other departments have limited or no information about the OCMC.<br>• Survivors have no information of OCMC, even those who stayed and received services for 6-7 days! | • Knowledge of OCMC only through personal contact with OCMC staff. | • Knowledge of OCMC among the hospital staff. | • Mostly limited to treatment, counselling while some survivors were also aware of availability of legal counselling. | • Among survivors, mostly limited to treatment, counselling. Some also aware of legal counselling<br>• Various service providers do not clear picture of OCMC. Some used past knowledge to enhance OCMC work.<br>• Only a few service providers were aware of OCMC, while most were ignorant. | • Need to provide orientation on OCMC and GBV. |

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| 3.3 | **Behaviour and attitude of service providers** | • A few survivors mentioned positive attitude of focal person. | • Positive perceptions by survivors.<br>• Knowledge has not been received through OCMC; OCMC staff received Population Services International's STI and psycho-social counselling training.<br>• Psycho-social counselling of survivors by OCMC.<br>• Limited capacity to identify types of GBV. More training required.<br>• Issues relating to maintaining confidentiality, and behaviour towards survivors. | • Survivors had positive experiences of behaviour and attitude of service providers. | • Good to have lady doctors in OCMC.<br>• Staff nurses positive about and vice versa.<br>• OCMC staff maintain confidentiality | • Attitude of service providers said to be good towards supporting survivors.<br>• Payment of incentives to doctors and other staff plays vital role. | • Need training and orientation on GBV for better understanding and empathy towards GBV survivors<br>• Ensure knowledge, satisfaction, recognition and appreciation of OCMC work.<br>• Specify incentives in guidelines, if agreed. |
| 3.4 | **Service delivery to GBV survivors by OCMC** | • 81 cases reportedly received OCMC services.<br>• Many survivors ignorant of available services.<br>• Timing of nurse prevents availability of timely and immediate services. Two survivors mentioned waiting several hours to receive services.<br>• Vague how and when psycho-social counselling – is being provided. Timing of staff nurse: survivors cannot avail psycho-social counselling at all times.<br>• Police take cases but feel they are not supported by OCMC. | | • Mostly limited to medicine and change of clothes. | • Nine male cases.<br>• Psycho-social counselling providing to most but not all cases.<br>• Slips for free medicine and other investigations available. Despite being prescribed not being followed through by respective units.<br>• Required equipment for medico-legal investigations available; but yet to be used due to unavailability of appropriate cases.<br>• Non-sterile vaginal swab sticks in use. | • Immediate medical services being provided.<br>• Forensic investigations taking place. Due to lack of training there may be gaps in OCMC staff's ability to collect forensic investigation samples.<br>• Limited holistic support to survivors.<br>• Links with police not uniform across all districts. | • Training required for appropriate forensic investigations<br>• Better links needed with line agencies and other relevant stakeholders.<br>• Need clinical guidelines to define general counselling and psycho-social counselling.<br>• Need written consent of survivors. |

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| | | • Emergency staff lacked knowledge of OCMC.<br>• Police claimed confidentiality not maintained at OCMC even when the police try to maintain it. Other hospital staff openly identify survivors and perpetrators<br>• Survivors not informed about services that can be availed through OCMC.<br>• No trend to call OCMC staff at night. | | | | | |
| **3.5** | **Community interventions** | • Limited information dissemination due to budget constraints.<br>• No linkage. | • Information shared through FCHVs.<br>• No paralegal support. | | • Counsellor has shared some information with community based organisations and stakeholders. | • Only limited activities such as presentations during events and programmes at a few places. | • Stakeholders and their line agencies at VDC and community level should promote OCMCs (e.g., DEO and resource centres). |
| **3.6** | **Civil society interventions** | • Though a couple of networks in the DCC. But major NGOs working on GBV ignorant of OCMC service | • Very good relation with Maiti Nepal, network, and Nari Seep Kendra. | | • Limited to GBV cases. | • More active in some districts linking with Maiti Nepal, Koshish, Seep Kendra, inter-party alliance, to support survivors. | • Encourage active support of civil society for survivors.<br>• Share lessons from Baglung and other districts as role model. |
| **4. Coordination with Women service centres and other district agencies** | | | | | | | |
| **4.1** | **Links and synergies with other GBV and health initiatives** | • Some cases received services. But more could have been done as safe homes also have fund to support survivors. These could have been pooled to enhance support.<br>• No links — only referrals to safe homes in few cases. | | • Good links with safe homes. | • Safe home shirked responsibility for Maya case.<br>• Minimal, negligible links. | | |

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| 4.2 | **Division of roles and responsibilities** | • Uncertain and ambiguous. | • Clear amongst OCMC staff but not among DCC members. | • Clear amongst OCMC staff and partially among others. | • Limited or no knowledge. | | |
| **5. Communication and reporting** | | | | | | | |
| 5.1 | **Management of cases as per age, sex and ethnicity** | • Data maintained as per guidelines. | | " | • Cases recorded according to age and sex but not to ethnicity.<br>• Inadequate disaggregation<br>• Separate profile kept of each survivor | • Data maintained as per guidelines; but format for information collection is inadequate, particularly with reference to age, for further analysis.<br>• Risk of duplication of GBV data.<br>• No space in format for follow-up information | • Guidelines needs revising to ensure adequate information pertaining to age, ethnicity, and GBV type. |
| 5.2 | **Data management and follow-up of cases** | • No analysis and no case follow-up. | • Monthly analysis of data<br>• Not proper data management to put in HMIS. | • On monthly basis. Number are reported, but analysis missing<br>• Limited follow-up. | • Follow-up only in 4-5 cases.<br>• Mentioned if cases come from emergency unit.<br>• Mostly are cases discharged from hospital. | • Very limited follow-up of cases — only by phone. | • Need data to be included in HMIS.<br>• Staff need training on case follow-up.<br>• DCC meetings should monitor follow-up of cases, through regular update and monitoring status of survivors<br>• Need involvement of stakeholders, e.g. CBOs, NGOs for follow-up. |
| 5.3 | **Financial status of OCMC and number of survivors receiving services** | • No budget for 9 months. Management challenge. Loss of impact and staff commitment.<br>• No separation of line items for use by OCMC.<br>• No emergency fund as per guidelines, although some DCC members have discussed this.<br>• Staff lack knowledge of | • Pushing for more budget.<br>• Said have not been able to provide support for bigger costs. | • More transparency needed. Phone line urgently needed. | • Staff have no knowledge of budget. | • Staff have no knowledge of budget, and therefore no decision making power on buying needed things. Lack of budgetary transparency. | • Knowledge and transparency of budget is essential for OCMC staff and DCC member. |

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| | | Kanchanpur | Hetauda | Sunsari | Baglung | | |
| | | budget are therefore have no decision making power on things they need. Lack of budgetary transparency.<br>• Budget of only NPR 500,000. | | | | | |
| **5.4** | **Links with other programmes supported by hospitals, GoN and other agencies** | • No links with other programs such as reproductive health, HIV/AIDS.<br>• No links with DCC members except limited links with WCO, safe homes, lawyers. | | • To some extent with Maiti Nepal and safe homes. | • Links with mothers clubs, but needs further elaboration | • No links with other hospital programmes. | • Develop links with other services to promote quality and type of services for survivors. |
| **6. OCMC relevance** | | | | | | | |
| **6.1** | **Benefits at household, village, district, national** | • NA | | • Positive aspects: Has created change for the easy access of GBV survivors brought to hospitals either through Safe Homs, Police or NGOs | • OCMC at initial phase, so yet to be seen | • Same as above | |
| **6.2** | **Harmonisation at district level** | • Absent | • Only safe home, police. | | • SMBV cases has helped harmonise; Limited | • Same as above | |
| **6.3** | **Harmonisation at national level** | • A gap with FHD – as they are not involved<br>• OPMCM needs to become more involved | • | • Gap between central and district level | • Regular monitoring and supervision | • | • |
| **7. Constraints, gaps and sustainability of OCMC initiatives** | | | | | | | |
| | | | • Retaining staff.<br>• Budgetary constraints.<br>• Complains about OCMC doctors' regularity.<br>• Lack of coordination between DHO and medical superintendent. | • Lesson learnt: OCMC is more effective when there is good coordination between WCO, police, Bar, GoN lawyers, and NGOs.<br>• Has become easier to provide services to | • OCMC and its services have not been introduced effectively, within and outside the hospital.<br>• Unavailability of staff 24 hours.<br>• No GBV knowledge of OCMC staff. | | |

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| | | | • Sole decision making by focal person.<br>• Lack of monitoring and supervision<br>• Lack of recognition, encouragement, awards. | rape victims.<br>• Consent forms not used by rape or physical assault victims<br>• Recommendation: focal person should not be psycho-social counsellor.<br>• Budget transparency is essential | • Staff nurses are serving in two places.<br>• Lack of ownership among staff and DCC members.<br>• Lack of training, refreshers, (mentor), supervision monitoring.<br>• No work plan.<br>• Gaps in guidelines need filling.<br>• Guideline do not clearly delineate roles and responsibilities including for accommodation and treatment. | | |

## *Annex 2: Documents Reviewed*


Deuba, A.R and Rana, P.S. (2005) A Study on Linkages between Domestic Violence and Pregnancy. Samanata –Institute for Social and Gender Equality.

MoHP (2007) Reproductive Health: Clinical Protocols for Medical Officer. Kathmandu: Ministry of Health and Population

MoHP (2011). Hospital Based One-stop Crisis Management Centre (OCMC) Operational Manual, 2067 (official Nepali version). Kathmandu: Ministry of Health and Population.

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MoHP, New ERA, and ICF International Inc. (2012). Nepal Demographic and Health Survey 2011. Kathmandu: Ministry of Health and Population, New ERA, and ICF International, Calverton, Maryland.

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OPMCM (2010). National Action Plan Against Gender-based Violence 2010. Kathmandu: Government of Nepal.

OPMCM (2012a). A Study on Gender-Based Violence Conducted in Selected Rural Districts of Nepal. Kathmandu: Office of the Prime Minister and Council of Ministers.

OPMCM (2012b). National Strategy and Action Plan for Gender Empowerment and to End Gender Based Violence (2012/13 to 2016/17). Kathmandu: Office of the Prime Minister and Council of Ministers.

UNFPA (2007) Community Based Integrated Approach to End Gender Based Violence: A Successful Case Study. United Nations Population Fund.

WHO (2004) Clinical Management of Rape Survivors guidelines. Geneva: World Health Organisation.

WHO (2013) Clinical and Policy Guidelines: Responding to Intimate Partner Violence and Sexual Violence Against Women. Geneva: World Health Organisation.

WHO (2013) Responding to Intimate Partner Violence and Sexual Violence against Women; WHO Clinical and Policy Guidelines


Web Links

Preventing HIV after rape: http://www.shukumisa.org.za/index.php/preventing-hiv-after-rape

How to deal with HIV after rape: http://www.shukumisa.org.za/wp-content/uploads/2011/07/TLAC-bklt-HIV-Rape_English_web.pdf

Preserving and collecting foresnsic evidence; rape kit: http://www.rainn.org/get-information/aftermath-of-sexual-assault/preserving-and-collecting-forensic-evidence

## *Annex 3: Interview Checklist for Stakeholders*

**I. Observations during interviews and visits with/of to identify strengths/gaps:**

- Participate in OCMC District Coordination committee to review progress/gaps in implementation
- Hospital based service providers caring for GBV cases
- Physical condition of OCMC spaces
- Security and privacy to survivors
- Accessibility to nursing and medical staff at night
- Space for medico-legal services
- Provision of all other services t OCMC
- In-hospital coordination

**II. Checklist for Interviews**

**Medical Superintendents/CDOs/LDOs/WCOs/ DHOs/DPHOs/District Police Chiefs/In-charges of police women cells/GoN lawyers/NGOs/Networks working on GBV issues**

A. **Setting the scene:**

1. What have been the positive and negative changes brought about by OCMCs in the past years that have had the biggest impact on GBV survivors?
2. What were /are the consequences of these changes to the villagers? (Men, women, adolescents, DAGs, GBV/DV survivors and their families,)
3. What have been your roles/community roles in bringing about the change? What has OCMC's role been?
4. Have there been any targeted interventions towards GBV survivors?
5. What would the communities need to experience more positive changes?

B. **Commitment and Ownership**

Probe:

1. Composition of OCMC Committee (?) – How are the members identified? How active are they? How do you ensure different stakeholders' participation? Are the OCMC specific guideline on GBV/DV survivors, their screening and support being followed? Do GBV/DV survivors have a voice within the OCMC?
2. How pro-active are the DCCs, CMMs in supporting, supervising and monitoring the OCMC staff?
3. Meeting frequency and discussion on OCMC and GBV survivors' needs by DCC and CMM – percentage of implementation of meeting decisions. (Probe on GBV/DV, UP, psycho-social support, medical services, etc.)
4. Have any VDC funding been mobilised for needs related health service? If yes, how and where? (Probe: What helped you to access? And what prevented you? Who has been prioritised? Where do GBV/DV survivors, their screening and support, support for UP, psycho-social support stand? (what is the role of political parties and their influence?)
5. What are the services being providing on behalf of OCMC in the villages? What are the services they are providing to the villagers on their own?
6. Are there any effective approaches in enhancing ownership and commitment of DCC, CMM members?

C. **Organisation and management of OCMCs – Approaches/Service Provision**

Probe:

1. What is the management structure of the OCMC and is it effectively followed?
2. How is the staffing arrangement managed? Their regularity? Timings? 24 hour service?
3. Who undertakes the supervision and monitoring of the OCMC – district level, central level? Frequency?
4. How is the budgetary management undertaken?
5. What changes (in survivors) can be attributed to the OCMC? To which circumstances can these changes be attributed to? (Probe on: WCO, legal support, counselling, medical service,)

D. **Quality of Care**

Probe:

1. Survivors' Access to OCMC: which schemes have supported these? What have been the catalytic factors?

6. What is the knowledge level of various OCMC staff and the service providers? What is the behaviour and attitude of the staff?
7. Can you identify gaps within OCMC approaches/schemes, and what can be done to address the gaps, with specific focus on:
    - Health service
    a. Psycho-social counselling: How effective has the psycho-social counselling centre/services been? Its outreach?
    - Legal advice: Bar Association, GoN lawyers, NGOs
    - Safe homes
    - Security: Nepali police, Women Cell
    - Rehabilitation, reintegration: Any follow-ups? By whom?
8. How effective have community and NGO interventions been? How have the OCMC mechanisms - Health service, Psycho-social counselling, Legal advice, Safe homes, Security, Rehabilitation – been functional at the district and village levels through them? What effects of these schemes have you observed? What have been the highlights and challenges in integrating these approaches and schemes?
9. What is the number of data vis-a-vis the cost and the number of staff? How e

E. **Coordination with Women service centres and other district agencies**

Probe:

1. What is the linkage/synergy with other GBV, reproductive health initiatives at district and central levels?
2. Are the district agencies and service providers aware of their respective roles and responsibilities? How pro-active are they?
3. What are the constraints and what are the effective aspects?
4. Has working through OCMC and its networks facilitated understanding/addressing of GBV/DV inclusion among various stakeholders? What are the advantages and disadvantages? Are there clinical records of GBV survivors, follow-ups, referrals?
5. Is the OCMC approach different from the NGOs? More effective or otherwise?

F. **Communication and reporting**

Probe:

1. What is the process of ensuring that GBV survivors access holistic OCMC services?
2. How is the OCMC staff maintaining the data? Is there sex, age, ethnicity disaggregated data? Are there any follow-ups undertaken? By whom?
3. Is there any analysis of the data collected?
4. Is there reporting and documentation available from the various service centres, i.e., safe homes, police, lawyers – regarding survivors referred to or access from OCMC?
5. Is there regular reporting to the media, NGO and other stakeholders about the data?

G. **OCMC Relevance**

**Probe:**

1. What is it you like about the OCMC which have resulted in behavioural and attitudinal changes?
2. How has awareness on OCMC played a key role in addressing GBV successfully? (To what extent have GBV and DV issues been linked to health and addressed within the groups? How have they been capacitated to screen/identify GBV cases, make referrals, support survivors' needs, address perpetrators?)
3. Did the availability of OCMC services lead to changes in terms of villagers preventing GBV, supporting GBV survivors, engagement of other stakeholders in their prevention, change in behaviour and attitude regarding gender equality and GBV, reduced DV cases at household and community levels, etc.?
4. Have local resources been used for supporting GBV based health cases? Are there any guidelines which highlight the need for such cases?
5. What is the level of harmonisation at national and district levels?

H. **Sustainability**

Probe:

1. How were GBV related services provided in the villages before OCMC? How is it managed after OCMC interventions?
2. In your opinions will the approaches and schemes continue? If yes/ no – why?

3. What are the possible risks with regards to different schemes/areas? How can they avoid/mitigate these risks? For instance on:
    - Health service
    - Psycho-social counselling
    - Legal advice
    - Safe homes
    - Security
    - Rehabilitation
    - Access by GBV/DV/UP survivors to Emergency Funds
    - Are key mobilisers (MG/FCHV/HFOMC) adequately aware of the need for sustenance of the GBV/DV/UP/psychosocial support programme?

## *Annex 4: List of Interviewees*

| Name | Designation, Organisation |
|---|---|
| **Kathmandu** | |
| Raju Man Singh Malla | Secretary, Office of Prime Minister and Council of Ministers (OPMCM) |
| Dr. Senendra Raj Upreti | Family Health Division, MoHP |
| Bimala Thapa | DIG, WCSC, Nepal Police |
| Durga Singh, Nepal Police | DSP, WCSC, Nepal Police |
| Ranju Singh, Nepal Police | DSP, WCSC, Nepal Police |
| Dr. Badri Pokhrel | Chief, Population Division, MoHP |
| Dr. Bhuwan Poudel | Population Division, MoHP |
| Mukunda Sharma | Section Officer, MoHP |
| Padam Raj Bhatta | Director, Women and Children Department |
| SItaram Prasai | GESI Advisor, NHSSP/MoHP |
| Dr Nancy Gerein | International Lead, NHSSP |
| Greg Whiteside | Senior Quality Assurance Advisor, NHSSP |
| Deborah Thomas | Consultant, NHSSP |
| Dr. Karuna Onta | DFID |
| Catherine | Deputy Representative, UNFPA |
| Sudha Pant | Programme Officer, UNFPA |
| Dr. Shilu Adhikari | UNFPA |
| **Kanchanpur District** | |
| Parashuram Aryal | Chief District Officer |
| Sita Khadka | Psycho-Social Counsellor, OCMC |
| Nirmala Pant | Staff Nurse |
| Bhawana Sharma | Staff Nurse, OCMC |
| Ramesh Nighi | Office Assistant, OCMC |
| Dr. Arjun Prasad Shrestha | Mahakali Zonal Hospital |
| Tapashya Bhatta | Safe Home |
| Bhuwan Raj Chataut | Child Rights Officer, DCWA |
| Dr. Ram Bihari Choudhary | Medical Officer, Mahakali Zonal Hospital |
| Umesh Prasad Bisht | District Bar |
| Poonam Chand | Lawyer, , LACC |
| Maheshwari Bhatta | WCDO Officer, WCO Office |
| Urmila Shahi | Saathi |
| Sabitra Bhatta | Saathi |
| Indra Bhatta | Nutrition Rehabilitation Home, Mahakali Zonal Hospital |
| Ramesh Chand | Rural Women's Development and Unity Centre |
| Pashupati Singh | Public Health Nurse, DHO |
| Dambara Pant Lekhak | WCDO Officer, WCO Office |
| Pushpa Bam | Women and Children Officer |
| SP Binod Sharma | Nepal Police |
| Sharada Chhetri | District WCSC |
| Kalawati Joshi | District WCSC |
| Rakesh Srivastava | District Education Officer |
| Ama Prasad Bhatta | Under Secretary, DEO Office |
| Sita Bohora | Women for Human Rights |
| Basanti Joshi | Women for Human Rights (WHR) |
| Laxmi B.K. | Feminist Dalit Organsation (FEDO) |
| Bed prakhash Bhatta | AHW Emergency |

| Name | Designation, Organisation |
|---|---|
| Dharmananda Bhatta | Sn. AHW Emergency |
| Dr. N. Ansari | Mahakali Zonal Hospital |
| Dr. Biswombhar Joshi | Mahakali Zonal Hospital |
| Indudhar Paudel | Indoor In-charge |
| Kaushilya Rokkaya | Indoor staff |
| Mahesh Raj Joshi | Lab In-charge |
| Jay Singh Baral | Labortory Technician |
| **Makawanpur District** | |
| Ek Nath Aryal | Chief District Officer |
| Ganesh Kumar Poudel | OCMC Focal Person, DHO |
| Bal Kumari Dhakal | Psycho-social Counsellor, OCMC |
| Uma Gautam | Staff Nurse, OCMC |
| Pratima Mishra | WCO |
| Brinda Bartaula | Safe Home |
| Dr. Hari Bahadur Khadka | Acting Medical SUprinendent/Paediatrician |
| Ajmir K.C., Lawyer | Advocate, President, Nepal Bar Association |
| Ratnaa Lama | Nurse, Maternal and Child Health Clinic |
| Yashodha Rajbhandari | Public Health Nurse, DHO |
| Bhuwan Prakash Bishta | Local Development Officer |
| Madhusudan Koirala | District Health Officer |
| Khadga Bahadur Kamaal | District Education Officer |
| ASI Asha Kumari Lama | District WCSC |
| SP Gupta Bahadur Shrestha | District Police Office |
| Constable Sumin Gurung | Hospital based Police |
| Constable Krishna Kandel | Hospital based Police |
| Prakash Poudel | President, Hospital Development Committee |
| Members of women's network: | |
| Mr. Yuvaraj Gurung | Chief, Skill Development Training Centre |
| Dr. Raj Dangol | Doctor in Emergency |
| Dr. Basim Rai | Hospital |
| Dr. Mithilesh Thakur | Focal Doctor |
| Dhana Rai | Indoor Sister In-charge |
| Rajesh Kumar Yadav | Counsellor, ART |
| Indira Upreti | |
| Sushil Acharya | Laboratory Technician |
| Sushila Gautam | OCMC helper |
| Medical recorder | Hospital |
| Sunsari District | |
| Bimba Bhattarai | GESI Focal Person |
| Richa charya | Focal Person/Psycho-social Counsellor |
| Bidya Pokharel | Staff Nurse, OCMC |
| Inkita Pradhan | Staff Nurse, OCMC |
| Sunita Pradhan | Office Assistant/Helper |
| Dr. Shree Ram Shah | Former DHO |
| Dr. Jay Shankar Mehta | Hospital |
| G. Jha | Senior AHW Emergency |
| Subarna Tara Shrestha | Indoor Staff |
| Shaligram Karki | Laboratory In-charge |
| Menuka Adhikari | Laboratory Assistant |
| Bal Kumari Khatiwada | Medical Recorder |

| Name | Designation, Organisation |
|---|---|
| | VCT In-charge |
| Bimala Rai | Programme Chief, Safe Home |
| ASI Kopila Bhujel | District WCSC |
| SP Ganesh Thapa Chhetri | District Police Office |
| Laxman Kumar Thapa | Chief District Officer |
| Mr. | Local Development Officer |
| Dr. Mahesh Prasad Khanal | District Health Officer/Medical Superintendent |
| | Safe Home In charge |
| | Women and Children Officer |
| **Baglung District** | |
| Devi Bhattarai | Staff Nurse/Psycho-Social Counsellor/Focal Person |
| Radha K.C. | Staff Nurse |
| Laxmi G.C. K.C., WCO | Women and Children Officer |
| Parbati Sapkpota | Child Rights Officer |
| Sharmila Thapa | Coordinator , Sewa Kendra |
| Inspector Ram Bahadur K.C | District Police Office |
| Gyanu D. Thapa Magar | President, Ama Milan Kendra |
| Sitarm Thapa | Satkarma Nepal |
| SI Shailendra Khadka | District Police Office |
| Tara Subedi | WCSC, District level |
| Ramanath Poudel | District Attorney, 9841-456230 |
| Tara Nath Sharma | Advocate, GoN |
| Mr. Kharel | Chief District Officer |
| Punya Poudel | Local Development Officer |
| Kashi Ram Sharma | Deputy CDO |
| Mana K.C. | Secretary of Inter-Party Women's Alliance/ Teacher/ Media Person |
| Dev Bahadur Shrestha | Former Hospital Management Committee President |
| Dr. Tarun Poudel | Medical Superintendent |
| Hawaldar Ram Bahadur Poudel | Hospital |
| Dharana Sharma | Staff Nurse, OCMC |
| Kamal B.K. | OCMC Helper |
| Pratima | Koshish (NGO) |
| Mr. Koirala | Koshish (NGO) |
| Dr. Rashmi Sharma | Focal Doctor |
| Dr. Tripti Adhikari | Ex Focal Doctor |
| Uma Pun | Indoor staff |
| Shiva K.C. | Laboratory in-charge |
| Rishi Ram Sharma | VCT Counsellor |
| Saroj K.C. | AHW, Emergency |
| Ram Prasad Khanal | AHW Emergency |
| Tirtha Raj Gautam | Medical Recorder |
| Khadga Bir Thapa | X-ray department |

## *Annex 5: Tracking Tool for Case Study Development*

1. **Background of case**
    - Type of GBV
    - Identity of perpetrator, to facilitate addressing of survivor needs
    - Cause for survivor to reveal problem/ file case
    - Who was approached for support prior to reaching out to OCMC – family members, community members, CBOs, NGOs, front line health workers, service providers, etc.

2. **Initial process of reaching the OCMC**
    - Who made referrals to access services from OCMC (legal, psychological, medical, economic, emergency, etc.)
    - How was knowledge availed?
    - Who provided information on OCMC? Any past knowledge of OCMC? (e.g. through dissemination program at VDC level, posters, FCHVs, etc.)
    - Who was/were catalytic in reaching survivor to OCMC?
    - Distance of survivor's location from OCMC – ease or challenges in reaching OCMC

3. **Initial reactions at OCMC during receipt of survivor**
    - Who received the survivor? OCMC technical personnel, Emergency staff, admin and other support staff (male , female); Initial steps undertaken by OCMC upon receiving survivor
    - Attitude and behaviour of OCMC personnel (positive, supportive/ encouraging, disparaging/negative, non-committal, rude, etc.) – identification of personnel
    - Type of information collected by OCMC personnel
    - Support requested for survivor by survivor/ survivor friend/family/escort/ with or without children

4. **Initial support provided by OCMC**
    - Registration (location)
    - Screening of clients through in-depth insight into client history (location)
    - Clinical (medical/surgical treatments for reproductive health concerns) – privacy, length of stay at OCMC,
    - Shelter – in WCDO Safe Homes or elsewhere?
    - Legal advice and support – Bar association, other GoN lawyers, NGO lawyers, etc. (additional expenses requirement or not?)
    - Psychological counselling – availability 24 hours?
    - Others… (e.g. child support, etc.)

5. **Additional support (give details)**
    - Follow-up and revisiting by social workers/field workers of suspected cases
    - Referrals to ….
    - Perpetrator counselling
    - Engaging men (including perpetrator) through group discussions
    - Others…..

6. **Length of stay**
    - Decision maker/s regarding survivor's length of stay at OCMC
    - Length of stay
    - Was survivor need for shelter adequately addressed?
    - Positives and negatives during stay at OCMC (behaviour/attitudes of OCMC personnel, behaviour/attitudes of other survivors, privacy and confidentiality, etc.)
        - Quality of care regarding shelter, legal counselling/support, psychological counselling /support, medical support, others – availability of multi-disciplinary team support at all hours, etc.

7. **Quality of care**
    - Trained capacity of OCMC personnel
    - Maintenance of confidentiality and confidence building in survivor
    - Effectiveness of internal and external referrals

**8. Current status of survivor**

- Reconciliation – compromise (through whose efforts?).
- Reintegration/Rehabilitation: Further victimisation or empowerment (improved status or degeneration); by whom?
- Follow-up visits by social workers/field workers, particularly from OCMC/HP/SHP/FCHVs, etc.
- Consequences and reactions/support or absence of support of family members/community members/community organisations/local (delve into positive or negative and causes)

**9. Overall Perspective of OCMC**

- Strengths (need, effectiveness, holistic support….)
- Gaps/challenges/areas for improvement.

## *Annex 6: Case Studies of Survivors*

**KANCHANPUR DISTRICT**

In Mahakali Zonal Hospital, the roster maintained at the OCMC showed 83 cases registered up to 26 June 2013. OCMC staff provided 11 cases to the researchers. As informed by OCMC staff, these cases were selected based on their diversity and availability. However, most cases lacked proper addresses and phone numbers. Without these numbers, it was very difficult to track the cases. However, where addresses were given, attempts were made to track the cases. Unfortunately, the researchers could only meet four cases as most of the others had moved to other districts and one other declined her consent to being interviewed. All four cases had suffered extreme physical and sexual violence from their husbands and in-laws before going to the OCMC. One-to-one meetings were held with survivors by holding empathetic, in-depth, confidential interviews.

### Case 1 — registered at OCMC 11/6/2012

This survivor was a 24 year old woman. The eldest of two sisters, she married at 15 years old to a man chosen by her parents. There were five people in her new home with the father-in-law, mother-in-law, husband and his two sisters. She had been married for ten years and had three sons.

Her relationship with her husband was fine until the birth of their first child. They used to only have verbal fights. After the birth of their first child their relationship deteriorated and he started abusing her physically. He would come home drunk and start verbal fights and start hitting her with whatever was available. He would accuse her of having affairs with anyone and everyone she spoke to. She had also experienced attempted sexual assaults from her father-in-law. She said:

> *"my father-in-law would come at night to my bed whenever my husband was not around… it happened two-three times... I did not let him touch me and had fights with him."*

She repeatedly complained to her mother-in-law and husband, but they refused to believe her and blamed her for insulting the father-in-law. One day her younger sister came for a visit and stayed. At night her father-in-law came to her bed and molested her. She screamed and everyone in the house knew the truth. The mother-in-law scolded her husband.

Following this, she separated from her in-laws, took her share of property and built a separate house. However, her husband's behaviour did not change. He would come home drunk, beat her and force her to have sex whenever he wanted. She experienced marital rape all the time. He would demand sex with her during her menstrual periods and even 9-10 days following birth. Sympathising with her situation, her neighbours suggested she file a case against him or return to her maternal house. But, she never considered doing this. She had once gone to her maternal home after a major fight, but, after a month, her parents had insisted her life was with her husband and sent her back.

A year ago her sister-in-law had a child. She had experienced some complications while giving birth, and was unable to feed the baby. The woman went to help her – mainly to feed the baby. She stayed with her for one week in a hospital. However, this infuriated her husband who got very angry for helping her brother's family, and demanded she return home immediately.

She returned only after a week. On the same day, her husband went outside for the entire day and returned in the evening heavily drunk. She was preparing to cook supper and was holding an iron pot.

He grabbed the pot and started beating her with it. She started bleeding from her head and all over. Some neighbours and her relatives separated them. Her maternal uncle and aunt told her to run away. The incident took place at eight o'clock at night. Bleeding all over and half-conscious she left for the hospital but soon after fainted. Her neighbours called her brother and explained what had happened. Her brother came immediately, brought an ambulance and took her the two hours to hospital.

She reached the hospital around midnight in a bad state. But, her treatment started only at 3 o'clock in the morning:

> *"I learned from my brother that the doctor denied treating me because he thought it was a police case. They were asked either to register the case first or bring her husband there. The doctors feared the consequences."*

It took an hour to register the case at the police station helped by the hospital police.

Her treatment started around 3 o'clock in the morning. Emergency personnel did the check-ups and gave her medicine. She was bleeding and had bruises all over her head and body. Blood and urine tests and x-rays were conducted. She vomited all the time, so referral was made for a CT scan, as this service was not available in the hospital. The following day, she was taken over the border to India by her brother for a scan and returned back to the hospital the day after. Since the vomiting had not stopped the health assistant at the emergency ward suggested admitting her to the hospital. She stayed for 8 days. She had to pay for medication and food for four days. On the fifth day she was asked to fill in a form for the poor and needy by a nurse, after which medication and food was provided free of cost. The doctor used to come every day at 10 am for check-ups. The rest of the time, the nurses took care of her. They cleaned her wounds. According to her:

> *"The doctors and nurses behaved kindly towards me. I was bed-ridden, and the nurses helped me go to the toilet and assisted me when I vomited."*

But she had received no information about the OCMC and its services. She said:

> *"No one informed me about the OCMC. I have no idea what an OCMC is. No one came and talked to me separately. I was not counselled for anything, although I was in hospital for 8 days."*

She returned home after staying in the hospital for eight days. Her husband had run away fearing arrest. Police from the local police station searched for him and he was brought to the station on the eleventh day. He had been hiding at his sister's home. He was locked up for two days but was released when, according to the woman:

> *"He vowed not to harm me in front of police and said that he would keep me happy. He gave the consent in written. So we came back home."*

After their return home he soon started beating her again saying, "Because of you I was locked up." She says,

> *"Nothing has changed. I cannot leave him because I have three children and nowhere to go, I don't want to put their father's name at stake by filing a case against him. People will talk bad if I do that. If I leave him he will get married again and my children will be orphaned. I*

*am not economically stable. I have to stay with him for the sake of my kids. However, if he continues beating me I will file a case against him and stay with my children."*

***Observation:*** This was a case of physical and sexual violence inflicted on the survivor by her husband, and attempted sexual violence by the father-in-law. Despite going through torture and discrimination all her life she did not seek support mainly due to fear of social stigma. The survivor was brought to the hospital after being severely beaten. Her treatment did not start on time. The consequence of that could have been grave. Although it was a GBV case, she did not receive any kind of support from the hospital OCMC, even after eight days there. The victim was unaware of services provided by the OCMC. She also did not receive food and medication free of cost before filling out the form for poor people after four days. The OCMC is meant to provide free services to all GBV survivors, but OCMC staff had not provided any services to her. The coordination among OCMC staff was missing. Although there is a separate room for GBV survivors at the OCMC she was not taken there. All her treatment took place on the women's ward and she was discharged from there.

When the team inquired with the staff nurse at the OCMC about the case, one OCMC staff said that she might have come when both of them were out of the hospital. One counsellor had gone for training and the other was on maternity leave (they were uncertain about what had happened). The report provided by OCMC staff is misleading as it says counselling was provided to the survivor. If the counsellor was attending training, it is not clear who provided her counselling. A strong mechanism needs to be in place to make sure that all survivors receive proper care and treatment, as well as information on other available services (safe home, lawyer and police). No follow-up has been carried out so far. The survivor returned home after the treatment and was living as before. The OCMC can play a vital role by providing her counselling and connecting her with other organisations (rights based organisations, women's network and women development office) and by doing regular follow-ups which could make the perpetrator change his habit and stop torturing her, fearing punishment.

**Case 2 — registered at OCMC 22/4/2013**

This survivor was a 30 year old woman. Her parents had died when she was young and she had gone to live with her uncle and aunt. She eloped when she was 13 years old and had been married for 17 years. She had two sons and two daughters.

After a few months of marriage, they had separated from their in-laws and her husband had started a grocery shop. He used to drink alcohol but they never had major fights. Physical abuse began after she had her third child. He would come home drunk and beat her up. This had become his daily routine. Her in-laws and neighbours came and supported her many times, but he would beat them also. They all feared him.

A major incident had occurred several months back when according to her:

*"He tied my hands and legs and beat me with a belt. I was severely injured. There were cuts all over my head and body. I sustained an injury in my eyes, too. So, I ran away to my cousin sister's house. There I decided to file a case against him. I took my niece with me to the police station. They registered my case and brought me to Mahakali Zonal Hospital for treatment."*

After the case was registered, her husband was arrested and locked up. But he was released after an hour with the help of an on-duty police friend.

It took her half an hour by rickshaw to reach the hospital. She was brought to the emergency department for check-ups where she had to pay NPR 110 to register. She was taken to the women's ward for her check-up. Though she had to pay to register the medications were provided free of cost. The nurses cleaned her injuries. She stayed at the hospital for almost two hours. Before coming to the hospital she had no prior knowledge of the OCMC. The doctors and nurses informed her about the safe home run by the Women Development Office, where she could stay for free for up to thirty days. But the nurses did not say anything about the OCMC services. She also had no idea about OCMC counselling services. Since she had also sustained injuries to her eyes, the doctors had referred her to the eye hospital; but she did not go as she did not have enough money.

After being discharged she went to her sister's house. A few days later, her husband came begging her to return home. He promised never to hurt her again and to treat her well. So she returned. But, after some days he started the same routine again. She said she stays with him as she has nowhere else to go. She believes that if she leaves him it will be difficult for her children. Seeing her everyday trauma the children have developed a fear of their father. Her eldest son lost his interest in studies and blamed the parents for his bad results at school. She did not know how to move ahead with her life. According to her:

> *"I have nowhere to go. I went to stay with my sister for a few days; but I cannot stay with her forever. I have four children. I have no maternal home and am scared of my husband. I am coping with life. One day, he will beat me and I will die like that."*

No one from the hospital has done any follow-ups after she returned from the hospital.

***Observation:*** When the researchers visited the victim her lips were bleeding and swollen. She had bruises on her forehead and blue marks on her ankle. Her life had not changed at all. She had reported to the police, but there was no support. The police did not take action and let the perpetrator go free (the police on duty was her husband's friend) after locking him up for a few hours. The woman is illiterate and lack of exposure to wider networks limited her knowledge. She had no prior knowledge of the OCMC. When she went for check-ups, OCMC staff provided her with some information about the safe home and free medical services, but no other information was provided. She was also not taken to the OCMC ward for check-ups. A referral was made to an eye hospital, but, lack of funds prevented her from going. Her history was taken at the women's ward, which raises the question about privacy. No psycho-social counselling was provided. Clearly, the counselling service of the OCMC needs to be strengthened. Furthermore, as the survivor is illiterate she did not know where to go for help. Continuous follow-up and linking her with women's organisations and the WCO office could greatly improve her life.

### Case 3 — registered at OCMC 20/2/2013

This survivor was a 35 year old woman who had been married for 23 years, and had 20 and 18 year old sons. Her life with her husband was going well until the birth of their first child. Her life changed as she experienced violence from her husband regularly:

*"He would start drinking from morning and would beat me and the children whenever he saw us. My children lived in constant fear. He used to force for sex whenever he liked. I never enjoyed having sex with him. He used to rape me every day and if I said 'no' he would accuse me by saying, 'Who did you sleep with that you do not want to have sex with me?'"*

Due to the constant sexual abuse she had problems in her lower abdomen and uterus. Even after undergoing treatment she faced problems. He constantly accused her of having affairs. He would not let her talk to anyone in the village.

Even after experiencing such abuse everyday she never thought of reporting him to the police or seeking help from other organisations. She feared what the society and community would say and had thought:

*"If I complain to the police and get help from other organisations, I will not be able to show my face to my parents. People will talk negatively about me. My parents will die of shame."*

She quietly endured all the pains. Once she had gone to her maternal home after repeated fights. However, after staying for a couple of months her parents had sent her back saying that she should work to improve her own house. After this she decided not to go back to her parents' house after fights.

The major incident which compelled her to go to hospital occurred the previous year:

*"It was around 7pm when he came home drunk. I was sitting watching TV. He initiated a fight and kicked me. I don't know what happened after that".*

She had fallen unconscious. He had banged her head on the corner of the wooden bed sustaining severe head injuries. She was taken to a nearby medical facility by her son. However, it was a major injury, and so they asked her to be taken to the zonal hospital.

It was a long way from her home. It took almost an hour to reach the hospital by motorbike. The emergency ward personnel cleaned and stitched up the wound on her head. She stayed in the emergency ward overnight and paid all costs. She returned home the next day. After a few days she returned to the hospital to remove her stitches. However they had become infected. According to her, they had not cleaned the wound properly and so it got infected. So, the doctor referred her the district hospital as skin grafting was not available at the zonal hospital. At the district hospital, skin from her thigh was grafted on her forehead. She stayed at the hospital for two days and was asked to return after three days, but she could not afford to return and went back to the zonal hospital for a regular dressing with her son. The doctor suggested she get admitted in the hospital until the wound improved, so she was admitted and stayed for nine days. The doctors and nurses behaved well. After 4-5 days stay she was asked to fill the form for poor people and food and medications were then provided free of cost. She stayed in the women's ward and received information about the OCMC from nurses.

Before coming to the hospital she had not known about the OCMC. The nurses provided her information about shelter homes, legal services and OCMC services. According to her, one of the nurses took her history keeping her alone in the room. However, no psycho-social counselling was provided. They asked her to come to the OCMC again if anything happened to her. She thinks the services provided by the doctors and nurse was satisfactory. She thought the external referral was not

a good idea as she had to go, come back and spend a lot of money. She also said that the district hospital doctors did not treat her properly. She had to wait a long time to get treatment and due to a shortage of funds had returned to zonal hospital.

She was discharged from hospital after 9 days and returned home. Her son had come to get her. Currently her husband had not stopped the violence. She was living the same life. But she did not want to report to the police or go to court. She feared what society and her near ones would think. She believed her life will continue in the same way. No follow-ups had been undertaken by anyone.

**Observation:** This was a case of extreme physical torture and sexual violence by the spouse. The survivor never reported the incident believing disputes between husbands and wives should stay private. However, she had been compelled to seek medical treatment at the hospital. Carelessness by the service provider at the district hospital compelled her to go through much pain and make repeat visits to hospitals. She spent a lot of money. She had no prior knowledge of the OCMC. Although the OCMC had been established to provide free medical treatment, counselling services and legal services on-site free of charge, she had not received free medical treatment at the OCMC. She only received free food and treatment after four days at the hospital. She was given medicines free that were available in the hospital; the others she had to purchase. Although she received information about the safe home and other OCMC services, she had no idea about the OCMC's psycho-social counselling service. Additionally, GBV victims are supposed to receive treatment maintaining confidentiality and privacy. But privacy was not maintained as she was kept in the women's ward. After receiving treatment she returned home and was living the same life. She did not want to file a case against her husband. Unless her mind-set and that of her husband is changed, and she becomes economically empowered the violence is not going to end. Regular follow-ups and timely counselling services could have helped her to some extent.

**Case 4 — registered at OCMC 3/6/2013**

This survivor was a 24 year old woman educated up to grade 12 and married at 19 years old. It was an arranged marriage and she went to live in a large joint family. She had a six-year-old daughter.

At home she carried out her household chores in the mornings and evenings, and taught in a school in the afternoon. Her husband started abusing her immediately after marriage. He had the habit of drinking alcohol. He used to come home drunk and fight with her. When she was pregnant he would sit on top of her and would beat her saying, "I will kill this child". She received no support from her husband's family members — her in-laws used to say she should tolerate and not complain. Her husband came to Kathmandu after six months of their marriage to take language classes in an attempt to go abroad to work. He came home once every few months but behaved badly with her. It has been five years since he went abroad to work. He used to call her at times and initially sent NPR 25,000 but nothing later on. He had not phoned for the past three years.

After her husband had gone away, she continued staying with her in-laws. However, they behaved badly towards here. She had to give all her salary to her father-in-law. She was accused of having affairs if she was seen talking to strangers. They also tried to take her daughter away from her. One day her father-in-law said:

*"I want to take your daughter to (district headquarters). She will have a better education there. But you will have to stay in the village only."*

Her refusal made him very unhappy and he threatened her saying: "Now you'll see the consequences of not giving your daughter". It was becoming difficult for her to stay in that house. One day, while she was preparing to send her daughter to school her mother-in-law asked her not to send her to school. When she refused, saying she would miss classes and lag behind her mother-in-law became angry and pulled her hair for talking back. Her mother-in-law accused her for touching her during the menstruation period (though she had not touched her). On the same day, her father-in-law returned from the district headquarters. In a fit of anger he poured two mugs of water over her head saying:

*"You are dead for us. I am not going to let my son to be with you. Do whatever you can."*

He punched her on the face. Her lips bled and her face was swollen. She was also verbally abused by her brother-in-law, who called her a whore and threatened to kill her. She then went to her maternal home and went to the hospital with her mother and sister.

She went to the emergency department and was then taken to the OCMC ward. She felt awkward at first, as they did not treat her in emergency. At the OCMC she had to wait 2-3 hours as one of the nurses was in the operation theatre. She did not meet the psycho-social counsellor. The OCMC signboard made her uncomfortable as she feared people would think she was a victim of domestic violence. At the OCMC she was treated by a nurse, who took her history without her consent. She had to buy the medicines and eardrops for her ears. The history taking was done in front of everyone. No counselling was conducted and no proper information about OCMC services was shared. The nurse told her if she wanted to contact a lawyer, she could connect her to the lawyer. She was unaware of OCMC counselling services. No information was given about the safe home run by the WCO office. She said, "I wish they had given me free medication."

From the hospital she returned to her maternal home. Her daughter was suffering along with her. Her daughter had been unable to sleep for days after she witnessed her mother being beaten. She cried all the time and would not eat. At present her daughter is scared of strangers and has stopped going to school.

The woman has taken leave from the school. She wanted to get a transfer near to her maternal home. She feared returning to her in-laws' house, thinking they might kill her. Her only economic support was her job at school that she did not want to lose. So, she spoke to the district education officer about it, but had heard nothing so far. She wanted to reconcile with her family, therefore, had not registered a case with the police.

***Observation**:* This is a case of domestic violence perpetrated by in-laws in the absence of the husband. The survivor had experienced regular and on-going discrimination and torture. She came to the hospital for a check-up. Beforehand she had no idea about the OCMC. She was taken to the OCMC from the emergency department, but had to wait for two/three hours for the nurse to come. She was told that the nurse was busy in an operation. She did not meet with the psycho-social counsellor and had no idea about psycho-social counselling and other OCMC services. She only knew she could be connected to a lawyer in case she wanted to file a case. Medication was not provided free of cost.

The victim said that while staying with her in-laws her daughter had gone through such mental trauma that she had not eaten or slept for days. The psycho-social counselling service at the OCMC could have

helped them come out of their anxieties; but had not been provided to her. The victim was trying to get transferred to teach in another school. Since the district education officer (DEO) is a member of the DCC, the OCMC could help connect the victim to the DEO and thus play a crucial role. However, no such information was provided to her by OCMC staff.

The OCMC at the hospital has not been very active helping victims except for providing medical treatment. The researchers raised this issue at the DCC meeting and the DEO undertook to look into the issue.

**MAKWANPUR DISTRICT**

The file maintained at Hetauda Hospital OCMC shows 117 cases registered until July 2013. The OCMC staff provided 8 cases to the researchers which were selected on the basis of diversity and availability. Of these eight, two survivors had relocated and one case did not pick up her phone. Five cases were tracked and in-depth interviews conducted.

**Case 5 — reported to OCMC on 3/1/13**

This survivor was a 27 year old woman who was living with her sister's family. She had worked in a company for five years doing marketing, collecting fees and working at reception.

The incident took place when she had gone for monthly money collection. The monthly charge is NPR 450 per household. But one customer paid her only NPR 400 saying other cable companies charged only this amount. She spoke to her employer about the incident. She came to the office around 2 o'clock after finishing her round and went to the accountant's room to handover the money. The accountant became angry and accused her of always bringing less money (though she claims she had never brought less money before) and started using abusive language. She replied saying:

*"Do not use such abusive words... If you keep on abusing me I will call the police".*

However, the accountant hit her on the nose, which started bleeding. He pulled her and kicked her on her arms and legs. She was taken aback as her relationship with him had been fine before.

It was lunchtime and no one else was there. After some time the staff came back and stopped the fight. After hearing the narrative from her, the office staff including the management asked the accountant to apologise to her. The accountant asked her forgiveness. But she did not forgive him. She said instead, "You have done this to me, now look what I will do to you". Hearing her say this, the office management asked her to reconcile with the accountant and forgive him. They tried to dismiss the incident saying that if the story went around the reputation of office would be tarnished and asked her to keep quiet about the incident.

But she decided not to forgive the accountant. Her nose was still bleeding. She went to a clinic and found she had sustained a broken nose. She also needed stitches. The medical person asked her how the incident happened. To save her job she lied by saying she had fallen from stairs. However, he did not believe her and asked her to go to the OCMC for help. She went there.

This was the first she had heard of the OCMC and its services. She went there and told her entire story. Afterwards the OCMC nurse coordinated with the Women Development Office and police

women's cell, and helped her register a public litigation case against the accountant. The accountant was brought to the district police station and locked up for nine days. On the tenth day he was freed on bail. He repeatedly apologised and asked for forgiveness and promised never to repeat such a crime. According to her:

> *"in this entire process the OCMC played a very vital role. The nurses working at the OCMC coordinated with the women's network, such as, Maiti Nepal, Nari Seep Srijana and other rights based organisations asking for their help. They all came to the district police station and worked as a pressure group. They made the accountant pay all the bills incurred during the check-ups and gave me so much strength."*

After the incident, people at her office did not behave very well with her. They blamed her for spoiling the office's reputation and the office management tried to sack her. However, the OCMC came to her rescue. The staff nurses coordinated with the WCO office, women cell, and other rights based organisations. They went to her office and spoke to the management on her behalf. She was reinstated in her job and the people at her office including the office management started treated her well. Now, no one in the office says anything disrespectful to her or other female staff.

**Observation:** This was the case of physical violence from a male colleague and discrimination from employers. For this case the OCMC played a very active role and supported the victim from conducting psycho-social counselling to coordinating with stakeholders to help the victim get justice. With the help of the OCMC the victim filed a case against the perpetrator, punished and got her self–esteem back. Due to pressure created by the OCMC and its partner organisations she was able to be reinstated her job:

> *"I feel more empowered now. The other women in my office have also gained their self-respect because of OCMC. Men at my office now respect all women working there."*

The constant follow-up from staff of OCMC has also helped regain her confidence.

### Case 6 — registered at OCMC 7/8/2012

This survivor was a 16 year old girl studying in class six. The incident took place on 6/4/2012 (22/04/2069). The survivor was at home, sleeping due to pain in her lower abdomen. Her mother was downstairs and her father at a shop nearby. Around 4 pm an unknown man wearing a doctor's white robe came and spoke to her mother and asked if anyone was sick. He claimed to be a doctor visiting homes for medical examinations. Since the daughter was in pain due to her menstrual period, her mother suggested he check her. She also asked her daughter in-law if she wanted to be examined. Her She refused and the man was sent upstairs to the survivor for a check-up. The mother and the sister in law went up to the attic for some work.

The man went to the girl and asked her to lie down and open the clothes she was wearing underneath. He informed her he was sent by her mother to do a check-up. He also unbuttoned his pants and underwear. When he opened his clothes she cried out in fear. He told her not to cry as he was there for check-ups only. She could not scream out of fear — she only cried. After that he put a lubricant in her vagina for penetration. She had no idea about what he had done to her. She did not realise it was rape. She came to know it was rape after watching a TV programme.

After he was gone, she shared the incident with her sister-in-law who informed her mother. Her mother scolded her for not informing them while the perpetrator was there. When her father heard the story, he scolded her mother for letting anyone go without doing proper investigation and not being there with the daughter during the check-up. Later, her mother called her elder brother who lived not too far away. He came home and took his sister with him. That night they stayed at a monastery where he was studying and the following morning he took her to the hospital for a check-up. The entire family supported her and did not blame her and maintained privacy and did not tell the neighbours.

She was taken to the emergency room and explained to the doctor what had happened. He immediately sent here to the OCMC. The OCMC called the hospital police and took her to the district police station to file a rape case. At the police station, the woman police officer asked her about the incident. She shared her entire story, and was then brought back to hospital and to the OCMC for check-ups. All required tests and check-ups were done by the doctor. The doctor also gave her emergency contraceptives to avoid pregnancy. At the OCMC, all necessary check-ups were conducted by a male doctor. She said she had feared the doctor who did her check-ups. According to her:

> *"The sisters at the OCMC behaved nicely. The doctor did not talk too much. He came, did the necessary check-ups and went away."*

The sisters at the OCMC conducted two sessions of counselling for here and gave her guidance about what to do when strangers came to her. She says the counselling sessions helped her. However, she said that, at times she still gets frightened if she sees a man when she is alone and at times has bad dreams. The sister also conducted one session of counselling with her two brothers. Her brother said:

> *"I really felt good after talking to the sister. She gave us moral confidence and built our trust. She appreciated us for bringing our sister to the hospital... because of the OCMC everything went smoothly and we did not have to go through the hassle of running here and there. The OCMC staff helped us a lot. My sister feels better these days. The perpetrator has not been identified and is still at large. We have been following up with the police. The OCMC staff also call us sometime and ask us about our sister and how she is doing and tell us to bring her here in case any complications arises. So far it has been a good experience. "*

With the support of her family, the survivor is now leading a normal life, is studying at school and no one in her village knows about what happened. So, it has been easy for her to return to a normal life.

**Observation:** This was a case of underage rape due to ignorance of her parents. The OCMC had provided all necessary treatment and had facilitated registering the case with the police. The repeated counselling sessions provided to the victim had helped her lead a normal life. Similarly, counselling provided to her family members (brothers) proved to be a very effective to pacify their anger. The brother also said that the counselling done by the psycho-social counsellor helped boost their moral and confidence.

### Case 7 — registered at OCMC 14/12/2012

This survivor was a 27 year old woman who had a love marriage at age 17. She had one daughter and a son. The son died when he was four years old after accidentally consuming poison. After her marriage, two-three months went by smoothly. However, according to her:

*"He started beating me severely after that. I was pregnant with a daughter."*

They were staying in Kathmandu. He worked as a daily wage labourer. In the evening he came home drunk and beat her up. He had the habit of playing cards, too. Sometimes he would play cards with his friends for the whole day and send her to work. He would take all the money she earned. They lived like this for 5-6 months and after that her brother-in-law suggested they go home. He brought her back home. At the village she lived with her mother-in-law and younger brother-in-law. She did all household chores including working in the field. But her mother-in-law never supported her and used to complain about her to her husband. He also used to listen to his mother and beat her. He never let her speak to others in the village including neighbours, and would beat her if he saw her talking to anyone, be it a man or a woman.

After two months she gave birth to a baby girl. The delivery was a very complicated. Her husband left home 7-8 days after the daughter's birth. Post-delivery she did not receive proper care and food. Her mother-in-law mentally tortured her for not doing household chores. So, she had to work within a few days of delivery and as a result her bleeding did not stop and her uterus prolapsed.

The husband came home after a month or so but did not bring anything for her and the daughter. He came home drunk and fought with her. He demanded sex from her anytime of the day, anywhere and in all positions. He used to force her to carry out oral sex, anal sex, sex during her menstruation and during pregnancy and five days after her delivery. He threatened her to keep her mouth shut saying, "if you share this with anyone I will kill you". Out of fear she never told anyone. He used to do it in front of their daughter. He would beat her in front of the daughter, which made her very fearful and quite:

*"My daughter has become very quiet. She does not speak much and fears a lot if she sees her father."*

Looking at her pathetic situation the neighbours and community people suggested she go to the police. The neighbours helped her file a complaint against her husband. However, no action was taken against him as he was friends with the police, although the police made him promise in front of everyone that he would never beat her and would keep her happy. Following this he treated her OK for a few days and took her to her maternal home for a visit. She stayed there a few days and returned with him when he came to get her. After reaching home, he went away for a few hours, came back drunk and started verbally and physically abusing her. She again went to the police and filed a case against him. However, the local police did not take the case seriously and told her to go and get treatment.

She went to the hospital for treatment with her daughter. She went to the emergency department, from where she was sent to the OCMC. She had no prior knowledge of the OCMC. She had symptoms of acute depression, and cuts and bruises all over her body. Treatment and tests were done. The check-up was done by a doctor. She was provided free medication and food. At night she was kept in the female ward and during the day was brought to the OCMC room. She stayed at the OCMC for three days and received repeated counselling sessions and was given information about the activities of the OCMC. However, she still feels she has many problems inside:

*"All my body is always in a pain. From my head to toe, it all hurts. I feel like something is very wrong inside me. I was fair and healthy before. However, these days I have become black, thin and pale. My internal organs may have stopped functioning."*

While she was at the OCMC, her husband visited her. The psycho-social counsellor took one session of counselling with him and took a written consent from him in which he wrote:

*"I will stop smoking cigarettes, playing cards and drinking alcohol and will never hurt her again and always love her and do according to her wishes."*

However, he did not stick to the agreement. Instead he left her.

The OCMC staff coordinated with the WCO safe home and she later stayed there for four days. During her stay at the safe house the OCMC psycho-social counsellor counselled her. Since she knew sewing and cutting, the WCO office provided her a sewing machine and other equipment worth NPR 15,000 to open a tailor shop. She is currently living at her maternal home with her daughter. She has opened a tailoring shop. She comes to the OCMC for regular check-ups and counselling. She said, her husband sometimes calls her and threatens that he will come and kill her. She was in deep fear.

**Observation:** The survivor cried all the time while being interviewed. This case had multiple symptoms. She had psycho-social problems and suicidal tendencies. More than medical treatment she needed psychiatric treatment. Due to continuous sexual and physical abuse she had developed psycho-social problems and depression. She thinks medicines will not cure her and kept on asking:

*"Can you suggest me a place where I can go and treat all my complications?"*

She thinks she will never be cured and will die like this. The OCMC staff nurses had done whatever was possible with their limited resources. The psycho-social counsellor had counselled her husband too and had taken a written consent from him and had also provided repeated counselling sessions to her. The survivor has become a little better. The OCMC is also trying to arrange a meeting with a psychiatric doctor from another hospital whenever he is in district for her psychiatric treatment. The OCMC did not have money to support her referral to this other hospital and she couldn't afford to go herself.

## Case 8 — registered at OCMC 31/12/2012

This survivor was a 19 year old woman who was studying nursing and was originally from another district. She was an only child and her parents live separately. Her father lived in Nepal and her mother was in India for work. The woman had lived in India and studied there up until grade four. In India, she stayed with her maternal grandparents. Her mother would come occasionally to visit her. As a child she had a very lonely life. Her grandfather did not allow her to go outside and play with other children. He would bring all her toys at home and tell her to play with them. He used to sometimes play with her. Initially, she missed playing outside with friends but eventually started playing alone. She developed a habit of painting to spend her time and she won medals for her paintings. She started singing as well. When she finished grade four, her father came to India to visit her. Seeing her father, she insisted that she wanted to return to Nepal with him. She did not listen to anyone, even her mother, and came back to Nepal with her father.

After her return to Nepal her life changed upside down. In India, she was the only girl and was loved by all. In Nepal there were many children in the house and she was not treated as special by anyone and that hurt her a lot. In India, she never did any household chores, but, in Nepal she had to wash many dishes and do other household work. Her father did not give her much time. He would leave in the morning and come back at night. She did not like living in a joint family. The situation made her vulnerable. People at home used to talk about her. Someone at the house once had told her that after her birth her father had gone to jail for fraud and her mother had nearly died giving birth to her — it was said that she had not brought luck to her parents. This information stayed with her and she started blaming herself for all the bad things that had happened between her parents. She started staying alone, not talking to anyone. She refused to go back to India. Her life became worse. She had to wash all the dishes and nobody loved her. Her father thought that a girl should know all household work and forced her to do all the work. Her aunt used to divide household work for her. She had to wash all the dishes in the morning and at night. She would come back from school wash the dishes and finish her homework. This would leave her less time for study. She hated it. She started staying with friends at school more and spending less time at home.

She fell in love with a boy when she was in grade eight, and broke up with him in class ten. After that she became more isolated and started spending her days alone. She used to miss her mother a lot and wanted to go back to her; however, her studies came in between. One day she decided to leave home and went to Om Shanti Ashram and stayed there for a night and the next day she left for India to search for her mother. But at the border, staff from Maiti Nepal rescued her. Her father lodged a complaint in the local police station and was searching for her. According to her:

> *"everyone in school and at home thought I had eloped with a boy. But it was not true. After that people started talking about me. This hurt me. They would say, 'she eloped with a boy but her father brought her back. What a characterless girl!'".*

She passed her school leaving certificate (SLC) following which she was keen to go to India to her mother; but she decided to study nursing and came to the district headquarters for this.

During her first year of study, she focused on her studies but soon lost focus. She started spending more time with friends and less on studies. She did not pay attention in class. Looking at her situation, a teacher at the hospital suggested she go to the OCMC. Before coming to the OCMC she had not heard of it. She went and met the psycho-social counsellor. After repeated sessions she felt better. Before coming to OCMC, according to her:

> *"I felt very depressed and lonely. Nothing excited me. I wanted to end my life and commit suicide. I had bought a bottle of rat poison and kept it. However, after repeated sessions I feel empowered. The sisters at OCMC arranged my visit with a psychiatric doctor, and I took medications prescribed by him. I felt much better after that."*

Free food and medications were provided to her whenever she came for sessions and all the information regarding OCMC support was shared with her. She felt much better and empowered after repeated sessions. She went home after that and opened up to her father about matters she had kept within for years. Her mother came from India to visit her being concerned about her situation and stayed with her for a month. With a request from the psycho-social counsellor she prolonged her visit and stayed with her 15 more days. The parents visited the psycho-social counsellor nurse. According to her:

*"The psycho-social counsellor nurse also took sessions with them. After those sessions, my mother and father changed their attitude towards me and have become more loving and caring. Now, I feel more positive about life."*

She has been visiting the OCMC regularly and talks to the staff nurses about all her problems.

**Observation:** This was a case of depression requiring psychiatric treatment. The separation of her parents (mother in India and father in Nepal) had made her vulnerable and she had started showing suicidal tendencies. The OCMC played a catalytic role in saving her life by providing treatment and counselling. Besides counselling the timely psychiatric treatment played a major role. Counselling provided to her parents was effective as their behaviour towards their daughter changed and they understood her feelings better. The OCMC's support was very beneficial for the medical and psycho-social needs of this survivor.

**Case 9 — registered at OCMC 27/4/2012**

This survivor was a 52 year old woman who had been married for 32 years, and had four children and two grandchildren. All her sons and daughters were married and she had been living with them. However, she had been compelled by her husband to leave the home and had been taking refuge in her maternal brother's home for the past six months.

She had married at age 19, lived with her in-laws for ten years and separated after that. Her husband behaved well during the first few years. However, after the birth of second child he started beating her. He started drinking alcohol at the age of 22 through his friends' influence. He started coming home late drunk and fought with her. He would beat her and if anyone from home came to her rescue he would beat that person too. He had beaten his mother several times. He worked as a security guard but never brought any salary home. After the birth of their fourth child he started physically abusing her more. He never allowed her to go to her maternal home.

Whenever he was drunk he used to accuse her of having affairs with others and abused her for anything and everything. He accused her of having an affair with a 13 year old child. He used to blame her for having relationships with her own sons. According to her, "He was kind of crazy." She thinks she was too naive and obedient as she stayed with him even after bearing so much of pain. He used to drink anytime, and sometimes drink from the morning till late in the evening and would come home and fight. Afraid to live alone with him she asked her son to get married thinking that he would not beat her in front of a daughter-in-law. However, the situation did not change. The son and daughter-in-law tried to protect her many times but he would also beat them up. She thinks she is still alive because her son and daughter-in-law saved her many times. Despite such suffering for so long she never lodged a complaint with the police. She thought he might change some day but he did not. The situation became worse:

*"One day in Baisakh 2069 [April/May 2012] I was playing with my grandson inside the house. All of a sudden he came home drunk, took the child from me and brought a khukuri knife and tried to cut my neck. My neck started bleeding and I could not tolerate that. So I went and complained about him at a community interaction program, from where they sent me to the safe home run by the WCO".*

She stayed at the safe home for 8 days during which time she went to the OCMC with safe home staff for treatment. She had no prior knowledge of the OCMC. She was brought to the OCMC for treatment for five days. The doctor looked at her cuts and bruises and gave her medication. Every day the nurses at the OCMC cleaned her wounds. The OCMC team behaved nicely with her and provided medications. One-to-one counselling was also undertaken and information about OCMC activities was shared with her. The incident was reported to the district police office. The police brought her husband to her and he apologised to her and promised never to beat her again.

He behaved nicely for a few days, but after that again got drunk and beat her severely. Her family members tried to save her, but in vain. Within two months, she came to the safe home three times. The same story repeated again and again. She came to the safe home and stayed for eight days and on the ninth day he was brought to the district police station. He apologised to her and asked her to come home. In front of everyone (police, staff of safe house) he gave a written statement not to harm her anymore and to let her live the way she wanted and if she wanted to live separately he would give her a share of the property also. He also agreed to give her half his salary. They returned home.

However, after 2-3 days he came home drunk and beat her severely for making him go to the police station repeatedly. He pulled her hair so brutally that chunks came out. He said he would kill her this time so he could live happily. Fearing for her safety she ran away and this time decided not to go to the safe home fearing they would again try to reconcile her and send her back home. Instead she went to her maternal brother's house and asked for his help to file a court case against her husband. Her maternal brother agreed to help. To file the case she required evidence. She went to the safe home to collect the evidences kept by them. When she told them her entire story and asked for the evidences they apologised for not asking her intentions earlier and promised to help her file the case. The safe home and OCMC staff arranged a lawyer for her. A case for alimony (*mana chamal)* was registered against her husband. The court ordered her husband to pay her NPR 4,000 per month (half his income) and since the previous month she had started getting this amount. It is deposited in her bank account directly by his office. However, she is worried for her life:

> *"I cannot stay at my cousin's house all my life. I want to go back to my son and live my life. However, I cannot go there as he will not let me live. When I think of the future I feel so sad."*

The OCMC staff was in constant touch until the verdict of the court came.

**Observation:** This was a case of domestic violence including physical violence. The survivor had been living in violence all her life and had come to the OCMC only after she was severely traumatised. This woman had experienced severe mental distress as a result of violence. The OCMC provided her with medical treatment and psycho-social counselling. She was told about the other services provided by the OCMC.

It must be highlighted that the women had come to the safe home three times and each time staff had encouraged her to reconcile with her husband. The safe house should have asked her opinion instead of repeatedly sending her home. The safe house person said that they give preference to reconciliation as they cannot provide permanent solution to victim's problem. But, she admitted they had been mistaken by sending her back to the perpetrator three times. However, later after knowing her intentions, the safe home helped her file a case against him. The perpetrator now has to give half his salary to her. However, due to him, she has not been able to go home and stay with her son and daughter-in-law and fears for her future.

**SUNSARI DISTRICT**

The file maintained by the OCMC at Inarwa Hospital showed a total of 82 cases registered until July 2013. Of these cases, OCMC staff identified 9 cases for the assessment based on diversity and availability. Of the nine cases, two had relocated elsewhere and one declined to be interviewed. Six cases were tracked and in-depth one-to-one interviews conducted.

## Case 10 — registered at OCMC 12/3/2013

This survivor was a 16 year old woman. Her mother died when she was very young. She had studied only until class four. Her father stopped her schooling saying she should work at home. Two years earlier her father converted to Islam to marry a Muslim woman and left home. After her father left, she lived with her elder brothers and grandmother. They lived in one house, while her uncle and aunt lived nearby in another house. She used to work at her uncle's house during the day and would come home at night to sleep. Her brothers worked as wage labourers and would come home only at night.

One day, in the afternoon, she finished her household chores at her uncle's house and was resting when her uncle came in suddenly. Nobody else was at home. Her grandmother had gone to her cousin's house and her brothers were at work. The uncle raped her and threatened to kill her if she informed anybody. She screamed and cried but no one came to her rescue:

*"It hurt me so much down there and I bled badly. I could not walk properly for several days."*

She was repeatedly threatened by her uncle to keep it secret so did not tell anyone, not even her grandmother. She did not know what her uncle had done to her (*cried*…). She said that her uncle had raped her only once... but when asked if he came again and again, she kept quiet and only cried.

Time passed and her menstrual periods stopped. She did not care about it, as she had no proper knowledge of the consequences. She only came to know about her pregnancy when the baby started moving in her stomach. She felt something moving. She feared only after that and informed her uncle who again asked her to keep quiet, threatening to kill her if she told anyone. As shared by the survivor, her stomach did not grow big so no one noticed her pregnancy. Her grandmother came to know about it only when the labour pain started. She scolded and abused her for being characterless and for carrying an illegitimate child. She repeatedly asked her, "Whose baby are you carrying?" She gave birth to a baby girl at home with the help of a community birth attendant. The baby weighed only 1 kg. She did not know why she was not taken to the hospital for the delivery. She said it could be because there was nobody at home then except for her grandmother and the hospital was an hour's drive away and no transport was available.

After giving birth, she informed everyone that it was her uncle who had impregnated her. The grandmother called one of her brothers. The grandmother and brother scolded her for bringing shame to the family, and her brother went to his uncle's home saying he would kill him. However, the neighbours stopped him. But one of her brothers went to the police station to report the case. The police arrived and following interrogation the perpetrator admitted to the crime. When the police were asked if any medical examination was conducted to determine that the child was her uncle's, the police who handled the case responded:

*"They do these examinations if the perpetrator denies the crime. However, in this case, the uncle accepted he had conducted the heinous crime".*

The uncle was arrested and a case of under-age rape and incest were filed against him. He was transferred to the district police station and jailed for a month. After a month, he was transferred to another police station in Sunsari and kept in a lockup.

The young survivor did not know how to care for her child. The baby was very small and needed extra care, which she was unable to provide. Looking at her helpless situation, a village worker suggested she take refuge in the safe home run by the WDC in Inaruwa. The grandmother was old and not able to help care for the child. Moreover, she scolded the survivor for having an illicit relationship with her uncle. Local people talked ill about her. So, 10 days later she was taken to the Safe Home run by the women development office. The local NGO WOREC helped her go to the safe home.

Her baby developed a cord infection at the safe home and the baby and mother were taken to the Inarwa OCMC. Mother and baby were treated there. They were treated by doctors and provided medication free of cost. She said the attitude and behaviour of doctors and nurses towards her was nice. They taught her the correct way to hold the baby and change her nappies. She then went back to the safe home. She said that the quality of services provided to her and her baby was good. It made her feel special. The staff nurses at the OCMC gave her tips about cleaning and keeping the baby safe. She said that the safe home personnel treated her nicely. They called the OCMC staff nurse for repeated psycho-social counselling sessions for her at the safe home. Afterwards she felt better and started looking positively towards life. Otherwise, she would sit quietly all the time and cry.

Since the survivor was young, she did not have any means to support the baby. She feared that if she took the baby home her community people would talk ill of her. Therefore, she decided to give the baby for adoption:

*"I cannot look after the baby; everyone in the community knows how she was born. I will be ostracised by my community if I go back with the baby."*

The WCO helped initiate the adoption process. After one and half months stay at the safe house the baby was adopted by a childless couple. The safe house staff said:

*"After the baby was taken away, she stood quietly for some time. She looked relieved after that. She looked happier and relaxed after the baby was gone."*

They thought that as she was so young the child might have been a burden to her. Though the safe home did not have provision to keep survivors for more than a month, in some cases they keep them for 45 days. So they kept her for two months on humanitarian grounds. However, even after two months she did not want to return home and wanted to learn skills and become independent. The safe house linked her up with Maiti Nepal and took her to their place for skills development training. Since the past one month she had been staying at Maiti Nepal. She said that life there was good as she had a place to stay and the opportunity to learn sewing and knitting. She wanted to become independent.

Her uncle is still locked up as the case is underway. The public prosecutor is seeking maximum punishment for her uncle.

**Observation:** The survivor cried all the time during the interview. She did not speak Nepali fluently, so it was difficult to get information from her. The researcher visited her twice. Later, the information given by her was confirmed by the OCMC staff nurse, safe home staff and the police. This case highlights how girls are not safe even at home. She was too young to understand what her uncle did to her. She benefited from the services provided by the OCMC, especially the psycho-social counselling. It helped her change her attitude and outlook. There was good coordination between the safe home, OCMC and police and their links with NGOs working in the area worked well and helped the victim get a safe landing. She gave her baby for adoption and is learning skills at Maiti Nepal. At times, follow-ups have been carried out by the OCMC staff to see how she is doing.

**Case 11 — registered at OCMC 10/7/2013**

This survivor was a 17 year old woman who lived in a big family. She completed her primary education but was married at a very young age (she says she has no memory of her marriage). It was an arranged marriage organised by her parents. She said that girls in her community are married very young for religious reasons.

Since she was married at a very young age she could not stay with her in-laws and came back to her father's home. She divorced her first husband and was living at the maternal home. At home she engaged herself in household chores. According to her, she was often beaten by her middle brother and father for asking for shampoo, clothes and money. They used to beat her and she would run away to the district police station. She had registered cases against her father and brother more than four times. The WDO had helped each time to hire a person to write her application. However, the family members would come and apologise before the police, promise never to harm her again and take her back home. According to the safe home staff:

*"Once we tried to take her to the Safe Home also. But she ran away."*

Five months back, her marriage was again organised by her parents. She was married to a person who worked as a tailor master. She went with him, but after a month came back home saying she did not want to stay with her husband. According to her:

*"He used to beat me, would come home drunk and would force himself upon me."*

She hated going to bed with him and did not like his appearance. She said he was "bald, very thin and old". She had gone to his house in Birpur, India and stayed there for 2-3 days. She hated staying in India and returned home with her brother. He came to take her home and she again went with him to the district headquarters. After a few days, according to her, he left her alone and went away without paying rent or leaving any money. To pay the rent she had to work in other people's homes. Then one day she returned to her maternal home. She was asked by her father to return to her husband. However, she refused and said she would never return to him. Because of this her father and brothers beat her:

*"My father and brother abused me verbally by calling me foul words, tied my hands and feet with a rope, put a handkerchief in my mouth, and beat me with an electric wire and kicked me over my body including my sensitive parts. My mother and other brothers came to my rescue but they were also threatened. Thus even my mother fears to help me. She is old and frail. The brother who beat me is very strong and everyone in the family fears him."*

According to her, she was beaten severely at night and left alone. She could not sleep the entire night due to the pain and ran away from home at around 4 am. Someone from her village saw her walking in such a bad condition, stopped her and requested a village heath worker to take her to the hospital. Along with the health worker, she went to the district police station. The police asked her to get medical treatment first and sent her to the OCMC with a constable. With the help of the woman and a police constable, she was brought to the OCMC. She was admitted there on 10 July 2013. She had cuts and bruises all over her body and bruises on her thighs, legs and stomach.

A thorough check-up was conducted by a doctor and a chest x-ray was taken to see if her bones were intact. She was in a very weak condition, so was given glucose to gain some strength. Her cuts and wounds were treated. Free medication, food and clothes were provided. All basic necessities were taken care of by the OCMC staff. For her security one of the nurses and a support staff stayed with her all the time. At night she was kept in the female ward, while in the afternoon she was brought back to the OCMC. According to a staff nurse she was shifted to the female ward at night for her safety as at night the OCMC is usually empty. Before coming to the OCMC she had no knowledge about the OCMC.

Her treatment was on-going. She was slightly better. She said that she has been receiving treatment and had also received one session of psycho-social counselling. Since she did not want to return home, the OCMC staff nurse was coordinating with various organisations to help her.

While the team were there the staff nurses called the safe home staff to take her. The safe home staff arrived, but upon seeing her, claimed they had tried to take her to the safe home in the past as well but she had run away:

> *"The case is a very difficult person; not in a good state of mind. If we take her to the safe home, she will again run away. We should provide her treatment first. We should consult a psychiatric doctor before doing anything else."*

The following day, her brothers came to visit her and the researcher had the opportunity to talk to them. They said that her husband's home was her real home and that the father and brother beat her because she did not want to return to her husband's home:

> *"We are not very rich and have a big family. We have arranged her marriage twice and in our community we have to 'buy' the groom. We have already invested 5-6 lakhs on her. We can't afford more than that. Moreover, she has already married twice. It is not good for her as well as for family to change husband all the time."*

They said that whatever she has said about her husband was all lies. He had not run away. He was ready to accept her and had been waiting one and a half months to take her home. She was the one who did not want to go with him. One of her brothers asked the husband to come to the hospital. The researcher also met the husband. The husband said he loved her and wanted to take her back. He claimed he did not have any bad habits, such as drinking alcohol and taking drugs. He said that his religion prohibited him from take such things. He said:

> *"I love her and if she wants to return I will take her and forgive her for everything she did."*

However, she did not want to go back with her husband:

> *"I don't want to go with my husband or to my father's home. I hate my husband. If I go to my father's home they will again beat me up and I will again land in trouble. So I want the police*

*and NGOs to help me. I want them to ask my father to make my citizenship and give me my share of property (her father had 5 bigha of land). I will take my share and live by myself."*

The OCMC staff had tried their best to resolve the case. They were struggling as they could not keep her at the OCMC for a long time and the safe home was not ready to take the case. The issue was raised at the DCC meeting where the members suggested calling a meeting of the case management committee. They have decided to call the CMM meeting to discuss how to rehabilitate the survivor.

**Observation:** This interview was conducted with the survivor while she was at the OCMC. A series of meetings was held with her. A meeting with her brothers, husband, safe home staff, police from the women cell were also conducted to verify the information. When the assessment team left the district, the OCMC staff were still trying to resolve her case and provide her with a safe landing. A CMM meeting was supposed to take place to discuss her case. However, when the researcher called the OCMC staff to ask her status, she said:

*"Her father came the next morning to the OCMC and asked the victim to come with him. The OCMC staff organised a meeting with police and the WCO office. With their consent the OCMC team sent her back with her father. The OCMC staff is constantly following up to know her status. It has been learnt that the violence has not been repeated and the brother who had harmed her had become kind and had not harmed her again".*

When the researcher spoke to the women, she said that she despised her husband very much and did not want to go with him at any cost. However, her parents wanted her to reconcile with him. This case shows that continuous follow-up from concerned people helps a survivor from becoming re-victimised. The OCMC could be one of the best places for survivors who experience trauma and violence in their lives to come.

**Case 12 — registered at OCMC 5/4/2012**

This survivor was a 17 year old woman from another district. She was living in Maiti Nepal, Itahari.

Her mother and father had separated when she was eight years old and the mother the children with her father. The reason for their separation was her father's drinking habit. He used to drink alcohol and beat up her mother daily. Due to this abuse her mother had suffered a miscarriage. After that, she left him and went back to her maternal home. The survivor then had to do all the household chores her mother used to do. When she was sixteen years old, her father arranged a husband for her and asked her to go with him (she did not know where). She had known the man since childhood and used to call him *dai* (brother). He was married and lived with his wife and two children. He used to come to her home and talk to her father. All others at home opposed her going with the man; however her father did not listen. He said that he was head of the household and everyone should listen to him. She said:

*"Though they did not say anything in front of me, I think my father took money from that person and sold me."*

When she asked where they were going, he said he would leave her at her maternal uncle's house and return later. She believed him and went along. They travelled on a bus for two days. According to her, "He behaved nicely and did not harm me in any way". The next day they reached a place called "Kalo

Bazar". The bus stopped for some time. She ran away from there into the jungle. After walking for an hour she reached a village called Bharol. She was alone and without food and drink. She told her story to a local woman. With her help she reached a community safe home run by the women development office. She stayed there for 2-3 days and then moved to a local WCO safe home.

According to her, everyone treated her nicely at the safe home, which provided her with basic necessities. She stayed there for two months. During her stay, her menstrual cycle stopped and so the safe home staff took her to the OCMC "fearing she might be hiding something from us".

At the OCMC ward her general check-up was carried out by the doctors. Blood and urine tests were conducted. The blood test was taken twice. She said that the doctors and nurses behaved nicely with her. The reports all came up negative. All her check-ups and test were done for free. One session of psycho-social counselling was also conducted for her. During the session the information about OCMC and its services were given to her. According to the staff nurse:

> *"We give overall information about the OCMC and its activities to all victims after they are brought to the OCMC. For the cases which come from the safe home we provide treatment and give general information only because the safe home has its own lawyer and they have a direct connection with the police department".*

As she had nowhere else to go she stayed at the safe home for two and a half months. During her stay, she visited the district police station twice to see if they could help her find her house. She talked with the police inspector. However, they could not locate her house.

She changed her mind and told the safe home staff that she wanted to learn skills. They had connected her with Maiti Nepal six months previously where she had learned knitting, cutting and boutique training. Since she has no one and nowhere to go, after her graduation she will be shifted to Maiti Nepal Central Office in Kathmandu. She says she wants to learn more and be independent.

**Observations:** The Safe Home played a vital role in giving a safe landing to this case by providing her with proper rehabilitation. Otherwise, anything could have happened to her. Although, in this case the OCMC's role was limited to treatment and counselling, having an OCMC at the hospital was very effective as the survivor could come directly and receive treatment in private.

### Case 13 — registered at OCMC 2/6/2012

This survivor was a 16 year old woman from another district who was living in Maiti Nepal, Itahari. Her mother had committed suicide when the survivor was very young:

> *"I think my mother committed suicide because my father used to fight with her a lot and maybe it was because we were very poor."*

Her father remarried. She lived with her father and stepmother for two years. She has two younger brothers. One brother lives with her grandparents and one with her father. She started working as a domestic help since she was ten years old. She lived for one and a half years at a retired police officer's home and from there was sent to work at his daughter's place as a domestic help. She stayed there for two more years. During this time she became severely ill with tuberculosis. But the employers did not provide her proper treatment, food or clothing. They did not give her any salary either. Therefore, one day she decided not to stay with them. She had told here employees that she

was visiting her brother and would return after a few days. She went to her brother's place but he was not there. She did not have any idea where her uncle had been located to. She did not want to go back but had nowhere to go. She decided to go to the person who had helped her find the job and told him she did not want to go back to the same employers. That person brought her to the local police station where she shared her entire story. The woman police officer brought her to the local WCO safe home.

She stayed there for two months and with the help of people from the safe home and police women's cell was able to collect her salary from her previous employers. They paid her NPR 10,000.

During her stay at the safe home, she developed an ear infection and fever. She was taken to the OCMC for treatment where the doctor gave her medication. She stayed at the OCMC for more than two hours. She said that the behaviour of the doctor and nurses was good and she received one session of psycho-social counselling. The staff nurse informed her about the OCMC. She was subsequently brought to the OCMC two or three times for psycho-social counselling. She said that these sessions helped her to overcome her anxieties. Before that she had had no appetite and used to worry a lot. She also worried a lot about her brother and where he was. It used to pain her a lot. The counselling helped her regain her appetite, confidence and a more positive outlook.

She decided to work hard and requested the safe home to send her to a place where she could learn skills. Maiti Nepal has empowered her by providing her with skills and education.

**Observations:** This case shows good coordination between the OCMC and the safe home. The survivor was brought from the safe home for treatment and the OCMC staff repeatedly provided her counselling. She received treatment and counselling without any obstacles. Prior to this the victim used to be emotionally unstable, at times hyperactive and at time very quiet. After the counselling she improved and it helped her passage from the safe home to Maiti Nepal for proper rehabilitation. Though the role of OCMC was limited to treatment and counselling, it proved to be effective.

**Case 14 — registered at OCMC 2/3/2013**

This survivor was a 35 year old woman who had been married for 22 years. It was an arranged marriage organised by her parents. She had a daughter (21 year old) and a son (19 year old). Their main sustenance was agriculture. Her husband had the habit of drinking and smoking which she did not know before the marriage. He started beating her after the first few days of marriage. He used to come home drunk, verbally abuse her calling her vulgar names, and beat her up with a bamboo stick (*katbas ko latthi*). She experienced marital rape as well:

> *"He used to force her without her consent. If I were to tell you the truth, these two children are products of the marital rape I experienced every day in my life. He used to accuse me of having affairs and sleeping with others if I refused to sleep with him."*

Her in-laws were also not able to stop him. The neighbours and community people also tried to stop him, but he could not be stopped by anyone. He would ask the children to go and buy alcohol for him, and would beat then if they refused. They lived a very fearful life. He did not allow her to go to her maternal home either. He used to say if you want to go to your mother and father, go forever. Do not come back. Fearing that, she completely stopped visiting her maternal home. Moreover, he did not allow her parents to visit her either. However, even after living in violence all these years, she never

lodged a complaint against him at a police station thinking it would compromise her children's safety and security. She feared that if she did any such thing he would kill her as well as her kids.

After ten years of marriage, he decided to go abroad to earn money. So, they arranged funds for him, he went to Saudi Arabia for work. He used to call home once in every six months or so and came home after 3-4 years, but sent money only a few times. Since the past six years he had stopped sending money or calling home. She said:

> *"I experienced so much trouble sending the children to school. Due to a lack of funds, I had to stop my son from going to college. Instead I took a loan from a local money lender and sent him to Dubai to work".*

On 17th of Falgun 2069, her husband returned home. On that day, as she said:

> *"I had gone to the field in the morning and came back home around four o'clock in the afternoon. He was at home. I had no idea that he had come. I said to him, 'Oh you have come; had I known you were coming I would not have gone to the field.' He had locked the rooms and was staying outside. I asked him to give me keys so that I could go and cook something as I had not eaten anything the entire day. He did not say a word. He said, "I want a decision from you". When I responded, "What kind of decision are you demanding? I am the one who is looking after the house in your absence. What kind of decision do you need?" All of a sudden he pulled my hair and started beating me up with the sticks he had brought. He said, "You whore, I am here today to kill you. I will rest only after killing you."*

He continuously beat her up and she fell unconscious. She had bruises and cuts all over her body, which were bleeding. Her legs were also swollen. Hearing her scream the community people gathered. A policeman from the local police station was called and he was taken to the police station and locked up. She was brought to the hospital on a motorbike by the local people. Around 8 o'clock she reached the hospital. It took her about one hour to reach the hospital.

At the hospital, she was brought to the emergency department. She had sustained injuries all over the body so they suggested she be admitted. That night she stayed in the emergency ward and in the morning she was told by the emergency staff about the OCMC department. She was shifted to the OCMC. Before coming to the hospital she had not heard about OCMCs. She stayed at the OCMC for four days. In the afternoons she stayed at the OCMC and at night she was shifted to the female ward. She was treated for her injuries and an X-ray of her leg was also taken to ensure that it was not broken. All medication was provided free of cost, however she did not know whether she paid money for the x-ray, as this was done at night while she was still in the emergency room. She thinks they might have paid NPR 150 for the x-ray. According to her, the doctors made timely visits to her and carried out the necessary check-ups. The nurses also behaved well and provided OCMC services (legal, safe home, police) to her. One-to-one counselling was also conducted by the psycho-social counsellor in a separate room. During her stay at the OCMC, doctors came to see her a couple of times at night and at six o' clock in the morning as well.

While she was at the hospital, the community people and the staff of OCMC asked her what she wanted to do. She informed her parents, community people and neighbours that she did not want to stay with her husband. She said, "I will take my share of property and live separately." She wanted a divorce; however her children requested her not to divorce. So, she said:

*"I will not divorce you but will take my share of property and live with the children".*

From the local police station the perpetrator was transferred to the district police station. He agreed to give her share of the property at the police station. After that agreement, they went to court and filed a property related case for *ansa mudda*. The public lawyer was recommended by the OCMC and the safe home took up the case. The decision was made in her favour and she received her share of the property. After the case was finalised, he remarried and was staying with his new wife.

The staff nurse from the OCMC calls her sometimes to ask her how she is doing.

**Observation:** This was a case of extreme physical and sexual violence inflicted by the husband. Despite experiencing violence all her life the victim had not reported the case anywhere. She was reluctant to seek care and report the case due to fear of retaliation and retribution from her husband and also the fear of social stigma. The husband, on the other hand, had taken advantage of her inaction and inflicted more violence on her. This time also, the severe beatings by her husband had compelled her to seek medical services at the hospital. She came to know about the OCMC after coming to the hospital and the OCMC provided all services to her - from medication, treatment, and counselling to connecting her to the police and a lawyer. The woman was able to receive all kinds of services from the same place. Similarly, continuous follow-ups were carried out by the OCMC staff, which helped her regain confidence and become positive towards life. When interviewed, she said the OCMC staff were trying to link her with the WCO office as she had requested help in finding an organisation that could help her raise some funds for income generating activities.

**Case 15 — registered at OCMC 12/10/2012**

This survivor was a 19 year old woman. She fell in love with a man from her neighbourhood when she was in class seven. The man had gone away to study; however, they had maintained a long distance relationship by phone. The man returned after completing his SLC. Their relationship deepened after his return. They started studying together in class 11, in the same college. During that time the relationship with him took a different route. Their physical intimacy started taking place. After two months, her periods stopped. She did not worry much because they tended to be irregular. However, after another two months, she feared that she might be pregnant. She went to a clinic and had a urine test - the result was negative. However, she still had doubts and then started showing the symptoms of a pregnant woman. They decided to elope and stayed in the district headquarters. However, her parents reported at the police station saying her daughter had gone missing and gave photographs of the man saying he may have kidnapped her. The police arrested the man, but she came to the police station for his rescue. His family was also called to the police station and the rituals of her marriage took place in the police station before both families. However, her mother-in-law refused to take her home saying she was of another caste so she could not live with them (the girl belonged to Chhetri community; the man was a Brahmin). However, she said:

*"If my son wants to keep her somewhere else I have no problem".*

After that, the couple went to another town and started living there by themselves. He worked in an agriculture department, so they had no financial problems. Their life was going on well. He used to love her very much and had never said any bad words or even raised a hand on her. He used to behave well with her parents whenever they visited them. They were living happily. When she was

eight months pregnant, one day, he said to her that he was going away with friends for one night and would return the next day. She agreed. He went but never returned. She tried calling him several times but his phone was unreachable. She called her parents and her father came to collect her. After her return, she lodged a complaint at the police station demanding that she be allowed to stay at her husband's home. Her in-laws were called to the police station and they agreed to bring her home.

She went to her husband's house to live. However, her mother-in-law disliked her and verbally abused her all the time calling her names and saying, "You whore, you must be carrying someone else's child and now blaming my son". She was not given a room to sleep. A bed for her was kept in a corridor and there was no mattress. She lived there for two days like that. On the third day, the Durga Puja began. She learnt that her husband used to carry out all the Dashain rituals when he was home. So, her husband's younger brother started screaming at her saying,

> *"You whore! Where did you send my brother? What have you done to him? Go away from our home. You came to our house to spoil our peace."*

With these words he brought a khukuri knife and said, "I will kill you right now, right here". Her elder brother-in-law intervened and stopped him.

Following the incident she was too frightened living with him. She came to her maternal home and again went to the police station to lodge a complaint against her brother-in-law. The police locked him up in jail for a couple of hours but his family used their influence (they knew the senior police officer) to secure his release. The police asked her in-laws to take her home. However, her mother-in-law refused saying:

> *"No, we will not take her home. I am ready to bear whatever punishment I have to endure…, She is a whore, we don't know whose baby she is carrying. She is just blaming my son but carrying someone else's child. I will not take her home at any cost."*

After hearing this, the police kept the entire family for two days in a lock up. According to her, "They were released after using their relationship with the senior police officer".

After her family refused to take her, the woman went to the safe home run by the WCO to take refuge. She was nine months pregnant. The women police officer from the WCSC Women's Cell suggested she file a case against her in-laws demanding reinstatement of the relationship and property rights. The case was registered with the help of the safe house and is currently on going in court.

She had no prior knowledge of the OCMC, and came there with staff from the safe home. They also brought her to the OCMC for regular pregnancy check-up. At the OCMC all necessary tests, such as ultra sound, video x-ray, urine and blood test were conducted. The check-ups were carried out by the doctor and the ultrasound report was also checked by the doctor. She found the attitudes of doctor and nurses towards her positive. The necessary iron tablets and calcium tablets were provided free of cost. Information about OCMC activities was provided by one of the staff nurses working at the OCMC. Counselling services were also provided. During the counselling session she thought privacy was maintained as no other person was allowed to come inside the room. The baby was also delivered with the help of OCMC staff at the hospital delivery room. After the delivery, both mother and baby were kept in the OCMC ward. Following the birth of her daughter, she stayed at OCMC for two days after the delivery.

After discharge from the OCMC, she went to stay with her parents as they thought she needed care and support. She is still living with her parents and the case is still in the court. Her baby is now six months old and in good health. She is thinking of continuing her studies and working as a teacher in the near future. Since her husband had left her, she did not want to go back to him even if he returned. She wanted to raise her daughter and live her life independently.

**Observation:** This was a case of physical assault, verbal abuse and mental distress inflected upon the victim by her in-laws. The woman was able to receive treatment and counselling service from the OCMC whose staff provided medical and counselling services. Since the safe home worked in close coordination with OCMC, the lawyer was referred by the safe home. Although the OCMC's role was limited to providing medical treatment and counselling services, it proved to be effective.

**BAGLUNG DISTRICT**

The file at Dhaulagari Zonal Hospital OCMC showed a total of 81 cases registered up to July 2013. 71 cases were women and 10 men. The OCMC staff provided five cases to the researchers, one of which was a man. One to one interviews were conducted with six cases.

**Case 16 — registered at OCMC 20/7/2012**

This survivor was 17 year old woman with six members in her family including mother, father, a younger brother and a younger sister. She was studying in class 12. She went to a morning college and helped her mother during the day with the household chores, bringing fodder and helping in the fields.

One year back she moved to a local bazaar to continue her studies (11$^{th}$ grade). Since her parents could not afford to give her much money, she started working as a dish and clothes washer in one of the hotels owned by a neighbour. Her job started at 6am ended at 10pm. She was staying in a rented room near the hotel. In the same hotel, the owner's relative was also staying. She said that "he was waiting for his visa to go to a foreign country." He used to call her bahini and would come and talk to her at times. He seemed to always be around. One day he came to her and requested her to accompany him to a market. According to her:

> *"he came to me and asked me to go to the market with him to buy a pair of bras for his wife. I denied him many times but he insisted saying that since it is a 'girly' thing he felt embarrassed to go and buy them himself."*

So, after repeated requests she went along with him. However, instead of taking her to the market he took her to a hotel. He stopped in the hotel and asked her to have a cold drink. He said, "Let's sit in this room for some time and have cold drinks and we will go afterwards." Hearing that from him, she felt scared and wanted to leave the room. However, he did not let her go out of the room and caught her forcefully and pushed her down on the bed. As he was forcing her to open her pants the civil police knocked on their door and caught both of them. They were both put in a police van and taken to the police station. The man was put into the lockup.

The police interrogated both of them and filed a case of attempted rape against the man. They then called the safe house run by the WCO office and sent her for the necessary check-ups. The staff of the

safe house brought her to the OCMC where all medical check-ups and tests (blood and urine) were conducted and a report was provided. All the check-ups were carried out by a lady doctor. She felt that the doctor and nurses who helped her all behaved nicely and her privacy was protected since they did not let other people enter the room. After the check-up was completed, one session of psycho-social counselling was carried out. All check-ups were conducted free of cost. Since she was doing fine, no medications were provided. The one-to-one counselling session lasted over an hour but after talking to the counsellor she felt much better. However, she was not very sure where the check-ups were carried out, whether at the OCMC room or another room. She did not have much knowledge about the OCMC and its activities other than its medical activities. Others information was not provided to her.

After the check-up was completed, she was brought back to the safe house for one day. On the next day, her parents were called by the police following which she decided not to file a case of rape against the perpetrator. According to her:

> *"since I had already earned so much shame on my name I did not want to prolong it by filing a case against him. The hotel uncle also suggested that it would be bad for my reputation if I filed a case against him - I would have to go through so many hurdles in court. I therefore decided to reconcile (milapatra). So, in presence of the WCO, her parents, the hotel uncle and police we came to an agreement whereby he would pay us NPR 50,000 in return for withdrawing the case. The case was withdrawn and he paid us the sum."*

After that, she worked at the hotel for another six months and then went back to her home. She is currently studying in class 12. Her life is going on as usual at home. Since so many people in her community do not know what happened, she has not faced criticisms from many people. She is leading a normal life.

**Observations:** This was a case of attempted rape. The girl was working as a dishwasher in a hotel and the perpetrator tried to use her for his sexual pleasure. Though, she was lucky not to have gone through the trauma, she was influenced by people not to go to the court. The check-ups were all conducted at the hospital and general counselling was also provided to her. However, she was not aware of the services provided at the OCMC. The OCMC's role was limited to providing medical treatment and general counselling which proved to be beneficial. The treatment was also free of cost.

### Case 17 — registered at OCMC 21/5/2012

This survivor was a 39 year old man. He was a vegetable seller in a local market and lived with his old mother. He married in 2061 a 15 year old girl from an adjoining village. It was an arranged married organised by his aunty. According to him:

> *"my wife had a habit of going to village all the time, she would never cook, clean and wash the dishes. My mother used to do everything".*

Although, she did not help her mother-in-law with household chores, their life was harmonious. He used to love her so much and she also seemed to be doing well. Their relationship went smoothly for the first two/three years of marriage. After that she started treating him indifferently. He came to her whenever she wanted but, if she had no mood, he had to sleep alone. This had become the routine of their life.

In 2068 she gave birth to a baby boy and the mother and baby were doing fine. He was very happy to have a son. Life was going on. However, in 2069:

> *"one day it was 8pm and we were all preparing to sleep. She was sleeping in one bed and I was sleeping in another. Her phone rang. She went outside saying "hello hello". I thought she must have gone to the toilet and waited for her. However, she did not return after five minutes or so. Then I started getting worried because it was night time. I went outside in search of her. I looked around everywhere, near the river, too, but she was nowhere to be seen. Near my house there is a corner and when I was coming back I saw something moving there. When I got close my heart sank at the very moment since my wife was having sex with another man from the village. When they saw me the man ran away. On the spot I gave her a big kick. Before that I had never beaten her or said any bad words to her."*

Right after the incident, he went to the house of that man and told his father everything. However, the father didn't believe him. He then went to every household in the village and told everyone what his wife had done. He decided not to stay with her and divorce her. However, he did not report the incident to the police, but went to the Maoist party's district wing and urged them to help him with the case. The reason he gave for not reporting to the police was that he did not trust them. He believed in the Maoist party. The party arranged a lawyer for him and he filed a case at the district court. To file for divorce, guardians of both parties should be present. He asked her to go and bring her guardians. She went to her maternal home but did not return on time (35 days passed) and he was therefore not able to file the case for divorce. He had decided that he would not stay with her at any cost so he once again filed for divorce with the help of the Maoist party. The party asked both of them to come to the party office, which they did, and they were asked if they really wanted to divorce? They both said yes. They were then asked about their child. He told them:

> *"I will not give an inch of land to this woman. But I am ready to keep all my property in my mother's and son's names. And, if she allows me I will keep the child."*

The process of divorce was proceeding but until the divorce was settled they had to stay together in the same house. However, according to him:

> *"I did not stay with her in the same room. She cooked by herself and ate. We did not speak to each other. She used to get so angry with me for refusing to stay with her. One day when I was sleeping in my room, she came from behind silently and beat me with a piece of wood (chirpat). She beat me on my arms and forehead. I tried to retaliate and beat her. However, she had already done me more harm. My forearm and forehead were swollen and I had bruises all over my face and hands. My neighbours intervened and stopped the fight. She then left my home and went to stay with her aunt".*

He came to the hospital for treatment to the emergency unit where he met with a staff nurse working at the OCMC who took him there for all the necessary check-ups including an x-ray. According to him:

> *"the doctor thoroughly looked at my wounds and treated them. I was given painkillers, too. The doctor behaved nicely with me and also asked what had happened. After the check-up, one of the nurses brought me to the psycho-social counselling room and we talked for almost an hour. After talking to her, I felt better. She told me that from this section of hospital treatment is provided free of cost."*

He has received two sessions of counselling and privacy was maintained during both sessions. He did not pay for the medicines, but had to pay for the emergency ticket.

After this incident, he again went to the Maoist party and requested them to help expedite the process for divorce and described the entire incident. The party facilitated the process and they went to court again and finally were granted the divorce.

Currently, he is staying with his mother and sells vegetable in a nearby market. He is planning to get married again to a nice woman who understands him and his mother; someone who is more responsible and mature. His former wife has already married and their son is living with her.

**Observations:** This case was of domestic violence inflected upon a man by his spouse. The woman had taken advantage of her husband and cheated on him. The man had experienced repeated torture and discrimination from his wife as well as physical assault. At the OCMC he received all required treatment and counselling services. The counselling was carried out by the psycho-social counsellor who helped relieve him of anxieties and depression. Although he was not aware of the other services provided by the OCMC, he seemed to have benefited from the services he was able to receive.

**Case 18 — registered at OCMC 29/4/13**

This survivor was an 18 year old Janajati woman who had a love marriage while she was studying in class eight. She had been married for one year and was living with her in-laws. Her husband was working as a jeep driver in Baglung and comes home once a week.

At home she is mostly busy with household chores like cooking, cleaning, washing the dishes. She also works in the fields and said:

> *"Here I have to work a lot. Although I am engaged in work from 4:30 AM to 10:00 PM, my mother-in-law is rarely happy. She scolds me all the time for not doing things in the right way and for being late. Life was much happier before marriage."*

Her husband also has a drinking habit and beats her whenever they have an argument. She had also tried to tell her husband about her mother-in-law's unreasonable behaviour, but he always told her to shut up saying "she is not bad from the heart; it is just her habit". He never listened to her and said, "don't strain yourself with all this nonsense". She felt she had overly compromised her life.

On Baishakh 2070, her husband came home for four days. On the third day they had a big fight about her male friend whom her husband also knew him. They had been friends since their childhood. He used to call her at times and would ask how her life was going and other things. On that particular day he had called and she spoke to him about general things. After she was finished talking, her husband started a fight saying:

> *"you whore you always talk to other people without my permission, you must be having an affair with him".*

She denied having any kind of affair with him. However, her mother-in-law also came in and supported her son saying that the friend had also called her before. She encouraged her son to beat her. After abusing her verbally, he punched her in the nose and slapped her on her face and mouth and pulled her hair. He also kicked her everywhere on her body. She had bruises all over. Her in-laws

did not intervene when he was beating her. Her house is in an isolated place and so no one came to help her. She was wounded on inside and felt helpless and wanted to end her life, so she took rat poison. After learning that she had taken the poison, her husband rushed her to the hospital in a jeep. It took her an hour to reach to the hospital.

At the hospital, she was rushed to emergency and her treatment started soon after. She was given two doses of liquid glucose and a medicine to make her vomit. She vomited all the toxins and received treatment for her cuts and bruises. All her treatment was carried out by doctors in the emergency room. The doctors and nurses treated her nicely. Her husband bought the medications, but the money spent was refunded later. She stayed in the hospital for one day. At night she was kept in a female ward. On the next day, she was brought to the counselling room at the OCMC and a general counselling was done. She says she completed two sessions of counselling and privacy was maintained during both sessions. After the sessions she felt a little better. However, she did not know much about the OCMC and its services nor why it was there. She only knew that at the OCMC, women can get free treatment. The staff nurse followed up with her by phone on several occasions.

Currently, she is living with her in-laws. The family, including the mother-in-law is now behaving nicely with her.

**Observations:** The above is a case of attempted suicide as a result of persistent mental harassment her mother-in-law and physical assault by her husband. Due to this harassment she had become traumatised and became scared of even small things. She did not receive love and care from her in-laws and family and the physical violence inflicted on her by her husband compounded her stress. So, she had attempted suicide and was brought to the hospital. The treatment and general counselling provided to her by the staff nurse at the OCMC had helped her to some extent. However, no information about the OCMC and its services were provided to her. The role of the OCMC was limited to providing treatment and general counselling.

### Case 19 — registered at OCMC 27/1/13

This survivor was a 25 year old woman who married at 15 years old. It was a love marriage without the consent of her parents while she was studying in class eight. She had two sons, aged 8 and 3 years.

She lived in a joint family with her husband. After marriage, her happiness lasted only for three months. Her husband started beating her right after that. He had the habit of drinking alcohol and playing cards. He used to drink from the morning and go out with his friends and do nothing. He would come home at night and start fighting with her and beat her up. It had become a routine. Her in-laws also did not support her. They also used to drink alcohol from the morning and supported their son. She had to do all the household chores as well as work in the field. She was not allowed to go inside their room and they used to accuse her of stealing money, food and other items. Her in-laws also used to beat her. Her husband used to beat her every day and her neighbours would come to her rescue. They used to advise her not to stay with him but she had married without taking permission from her parents and so she was not allowed at her maternal home. She had nowhere to go. She had no support. Her in-laws also used to blame her for not bringing any dowry. They used to ask their son to leave her and get married to another girl. He also used to abuse her saying:

*"you are too small for me you don't have big boobs… I got married with you thinking you'll grow. But, you never did. He used to force me for sex at any time of the day whenever he wanted… be it morning… or afternoon… he did not care for anyone. He used to have sex with me when I was menstruating and after child birth (four/five days after the baby was born) (Cried)."*

On Magh 2069, she was severely beaten by him. According to her:

*"on that particular day he had gone out early in the morning and had not come home until midnight. I was asleep. Around midnight, he came home and asked me to open the door. Since I was asleep I did not hear him. He broke the door, came directly to me and started beating me. He punched me in my head, pulled my hair and kicked me all over my body. He kicked my pelvis more than 50 times and I became unconscious. I did not know what happened after that. When I woke the next morning, I was bleeding from everywhere and it hurt a lot inside my vagina. In the morning, neighbours came to me and asked me not to stay with this abuser and go to my maternal home. However, I declined since I knew I was not welcome by my father. With the help of one of my relatives I came to the safe house in the district headquarters:*

*"It was three hours walk from my home to the safe house and I arrived there in a half conscious state. From the safe house I was taken to the OCMC for treatment. In the hospital, I was kept in a female ward and received treatment there. The examination was conducted by a doctor and medicines were provided. All the cuts and bruises were cleaned by nurses and medicines were applied. All the treatment was provided free of cost."*

The doctor and nurses behaved nicely with her. However, information about the services provided at the OCMC was not shared with her. She said,

*"no one gave me any information regarding the OCMC and its services but I was happy to receive free treatment."*

Her vagina hurt a lot. However, she only asked for medicine and did not allow the doctor to examine it. After the treatment, she returned to the safe home with a staff member and stayed there for five days. With the help of safe home staff she filed an application against her husband at a local police station. The next day he was apprehended by the police and kept in a lockup for five days. All the concerned officials, including the police, asked her what she wanted to do. Did she want to stay together with him or to separate? In front of the police and staff of the safe house he apologised to her and said that he would never hurt her again. They reconciled and returned home. However, he physically attacked her again blaming her for putting him in a lock up for five days. Her in-laws also blamed her and abused her verbally.

She separated from her in-laws after this. Her husband has now gone to Malaysia for work and she says that now she can breathe normally. He has called her once since leaving. However, her in-laws frequently call him and she fears that they might be saying bad things about her:

*"I have fear inside of me; my heart beats very fast and I am fearful all the time. If people talk with a loud voice I get very disturbed".*

**Observations:** This was a case of both physical assault and sexual violence perpetrated by the women's husband and in-laws. The survivor had lived with violence all her married life and expected to live like this all her life. She had experienced severe violence and so had many health problems. She had no prior knowledge of OCMC but the OCMC provided her with an opportunity to get help free of cost. Having all services located at one site helped ensure privacy and confidentiality. However, she only received medical services from the OCMC. Information about other services was not provided to her. She still suffers from acute anxiety and fear and the psycho-social counselling service at the OCMC could have helped her. However, she did not know it was available. No effort was made by the OCMC to provide counselling to victims due to understaffing and a lack of time. The absence of a telephone at the OCMC also meant that they could not follow-up with survivors. The women had returned to her house but was again victimised by her husband and in-laws. In this case, regular follow-ups might have helped reduce the victimisation since perpetrators often stop violence out of fear of being monitored.

**Case 20 — registered at OCMC 22/7/13**

This survivor was a 17 year old woman. She was studying in class ten and had a mother, father, 3 sisters and 3 brothers. She helped her mother with the household chores, bringing fodder and working in the fields.

The incident took place on 1st Sarwan 2070. It was around 7 pm. She had guests at home. Her mother suggested that she bring some food for her guests. So she went to her aunt's house to see if they had what was needed. It was a ten-minute walk from her house. She went there but could not find what was needed and so she returned came back. On her way back she met a cousin brother. He asked her where she was coming from. She said she had gone to her aunt's place to get some food items but she did not have them. He said that he had what she needed at his house and so she agreed to go along with him to get it. After walking for five minutes, he suddenly demanded sex with her. She was surprised as well as angry and told him,

> *"I am your sister. How can you say such things to me?" However, he replied saying: "People have started having sex with their own daughters - you are only a sister. So, it does not matter… today at any cost will do it with you. I would not have left even my own sister."*

After that he caught her from behind and pushed her down the alley. He then wrapped her hair with his hand (she has a long hair) and forcefully opened her pants (*suruwal*). He penetrated her. She cried and yelled for help but no one heard her. After sometime, he said let's move to the corner. She said okay and she ran away without wearing her clothes. She went home and told her mother about the incident. Her mother told it to her father. They both supported her and brought her to the perpetrators house and described the incident to his parents. At first they denied it had happened, but afterwards they promised to bring their son in front of them and pleaded that the women's parents not go to the police. They waited for the day, but the next day the man's mother changed her words and said that the assault never happened. Instead she said that the girl's parents were blaming them as a part of their own personal feud.

Following this, the family decided to register the case at a local police station. Since there wasn't a health centre in the area, the police requested them to go to a local health post for a check-up. They went to the health post where the necessary medical examinations were carried out. After this, the

police asked them to go to the district headquarters to file a case at the district court. At the district police station she was asked to go for a second medical examination. While there, the woman met a staff member from the local safe house who then took her to the OCMC.

At the OCMC, a female doctor was called and she conducted all the necessary check-ups and tests (blood, urine). Several x–rays were also taken as she had injuries to her elbows and thighs. She spent five hours at the hospital. She said that the doctor behaved nicely with her but the family did not know about the OCMC before coming to the hospital. She also said that although her history was taken, no counselling was provided. Information about the OCMC and its activities was also not shared with her. Following the check-ups they went to a local hotel where they were staying.

**Observations:** The case occurred while the team was in the district headquarters carrying out the OCMC review. All her check-ups were carried out at the OCMC but she had to wait for some time for the doctor. They were asked to pay money for blood and urine test. The staff nurse from the OCMC had to repeatedly call the concerned departments to get them to carry out the tests for free. The official in charge of x–rays twice sent the victim away and asked her to come the following morning. The staff nurse at OCMC had to call him many times to do it for free. The victim had to wait many hours to receive this service. Once the check-ups were completed the family went back to the hotel where they were staying. The safe home did not offer them food and accommodation. The next day, they were asked to do a different type of blood test which was not available in the hospital. For that they had to pay NPR 450. This suggests that coordination between the OCMC and other hospital departments is inadequate. The staff of other departments had not internalised the OCMC as being their own. Survivors were not receiving timely attention for services, many of which should have been provided by the OCMC. This needs to be improved in the future. With the help of safe house staff they successfully filed the case at the police station and then returned home. The OCMC's role was limited to the provision of medical treatment but it could have done more.

***Annex 7: Informed Consent Form for Survivors***

# सहमत पत्र

नमस्ते । मेरो नाम.....हो । म नेपाल सरकारद्धारा संचालित अस्पतालमा आधारित लैगिक हिंसा सम्बन्धी एकद्धार संकट व्यवस्थापन केन्द्रको संचालन सम्बन्धी अनुगमन गर्न आएकी हुँ । यी केन्द्रहरुले हिंसा पिडितहरुलाई के केस्ता सुविधाहरु दिएका छन् र ती सेवा सुविधामा रहेका सवल र कमजोर पक्षहरुको पहिचान गरी आउँदा दिनमा अझ प्रभावकारी बनाउने यस अनुगमनको उद्देश्य हो ।

म आशा गर्छु कि तपाईले यस अन्तर्वार्तामा सहभागी भई सहयोग गर्नुहुनेछ । तपाईले भन्नु भएका सबै कुराहरुलाई हामी नाम नखुलाई प्रतिवेदनमा राख्नेछौं । अर्न्तवार्तामा सहमत हुनुहुन्छ भने तल सही गरिदिन अनुरोध छ ।

□ सहमत □ असहमत

..... .....

अन्तर्वार्ता लिने व्यक्ति अन्तर्वार्ता दिने व्यक्ति

रुची लोहनी

## *Annex 8: Details of Clinical Instruments and Equipment*

| | Examination Room | Kanchanpur | Hetauda | Sunsari | Baglung |
|---|---|---|---|---|---|
| 1 | Examination bed | ✓ | ✓ | 1 | 1 |
| 2 | Desk | ✓ | ✓ | x | 1 |
| 3 | Chair | 3 | 3 | 7 | 6 |
| 4 | File cabinet | ✓ | ✓ | 1 | 1 |
| 5 | Portable focus light | ✓ | x | x | x |
| 6 | Bathroom | x | ✓ | ✓ | x |
| 7 | Sufficient water, towel, soap, bucket, mug for survivors to take bath | ✓ | ✓ | ✓ | x |
| 8 | Sufficient water, towel, Soap, Bucket, Mug for staff to wash hand before and after procedure. | ✓ | ✓ | x | ✓ |
| 9 | Refrigerator | x | ✓ | Not in condition | ✓ |
| 10 | Telephone | ✓ | ✓ | x | x |
| 11 | Computer | ✓ | ✓ | 1 | 1 |
| 12 | Printer | Not in condition | ✓ | x | 1 |
| **Medical instruments** | | | | | |
| 1 | B.P. Instrument | ✓ | ✓ | 1 | 1 |
| 2 | Torch | ✓ | ✓ | x | 1 |
| 3 | Tongue depressor | x | x | x | x |
| 4 | Tourniquet | x | x | x | x |
| 5 | Gloves | ✓ | ✓ | ✓ | ✓ |
| 6 | Syringe | x | ✓ | ✓ | ✓ |
| 7 | Gauge, cotton and bandage | x | ✓ | ✓ | ✓ |
| 8 | Bottles | x | ✓ | x | x |
| 9 | Big, medium and small mirrors | x | ✓ | x | ✓ |
| 10 | Speculum | 2 | ✓ | 3 | ✓ |
| 11 | Chlorine | x | x | x | x |
| 12 | Protoscope/anoscop | x | x | x | x |
| 13 | Pregnancy Test kit | x | x | x | ✓ |
| 14 | Pap smear test | x | x | x | x |
| 15 | Lubricant | x | x | x | x |
| 16 | Normal saline | x | ✓ | ✓ | ✓ |
| 17 | Sterilise, Container for sharp seizure, instruments | ✓ | ✓ | ✓ | ✓ |
| 18 | Height measurement | x | x | x | ✓ |
| 19 | Weight machine | ✓ | ✓ | ✓ | ✓ |
| 20 | Mat for counselling room | x | ✓ | 20 | 10 |
| **Equipment for collecting legal evidence** | | | | | |
| 1 | Vaginal swab/ Test tube, clean for blood sample | x | ✓ | X (from indoor ward) | x |
| 2 | Container for examination collection | x | | x | x |
| 3 | Towel | x | x | x | x |

| | Examination Room | Kanchanpur | Hetauda | Sunsari | Baglung |
|---|---|---|---|---|---|
| 4 | Microscope slide | x | x | x | x |
| 5 | Bottle/Vial for blood collection | x Lab | x Lab | x Lab | x Lab |
| 6 | Urine container | x | x | x | x |
| 7 | Cotton or plastic cover | x | x | x | ✓ |
| 8 | Paper bag | x | ✓ | x | x |
| 9 | Slide for Pap smear | x | x | x | x |
| 10 | Fixing Bag, Hair spray, Alcohol | x | x | x | x |
| **Medicine for treatment** | | | | | |
| 1 | Cetamol, Amoxyciline, Metron, Cifran, Doxycycline | ✓ | ✓ | ✓ | ✓ |
| 2 | IP pills, IUCD | x | ✓ | x | ✓ |
| 3 | Dressing set | 2 | 2 | x | 1 |
| 4 | Suture set | 1 | 1 | x | 1 |
| 5 | T.T, Hepatitis immunisation | x | x | x | x |
| 6 | STI treatment medicine | ✓ | x | x | ✓ |
| | Clothes | x | ✓ | ✓ | ✓ |
| 1 | Bed-sit and blankets | x | ✓ | ✓ | ✓ |
| 2 | Towel | x | ✓ | ✓ | ✓ |
| 3 | Clothes for patient for changing | x | ✓ | ✓ | ✓ |
| 4 | Gown for patient | x | ✓ | ✓ | ✓ |
| 5 | Pads | 5 | ✓ | ✓ | ✓ |
| | Stationary | | | | |
| 1 | Examination form , Register | x | x | x | ✓ |
| 2 | Measurement, calibre | x | x | x | ✓ |
| 3 | Pen, pencil, paper, gum | x | x | x | ✓ |
| 4 | Consent form | x | x | x | x |
| 5 | Referral form | x | ✓ | x | ✓ |
| | **Other necessary equipment** | | | | |
| 1 | Information book | ✓ | ✓ | x | x |
| 2 | Camera/movie camera | x | x | x | ✓ |
| 3 | Colposcopy machine or magnified glasses | x | x | x | x |
| 4 | Microscope | x | x | x | x |