DIGNITY FIRST

UNFPA NEPAL 12 MONTH EARTHQUAKE REPORT

July 2016

CONTENTS

LIST OF ACRONYMS			
ADRA	Adventist Development and Relief Agency	**JHPIEGO**	Johns Hopkins Program for International Education in Gynecology and Obstetrics (former title now referred only as JPHIEGO
AIDS	Acquired Immune Deficiency Syndrome	**MCK**	Medical Camp Kit
ASRH	Adolescent Sexual and Reproductive Health	**MIDSON**	Midwifery Society of Nepal
CARE	Community Awareness for Rights and Equality	**MISP**	Minimum Initial Service Package
CANADEM	International Civilian Response Corps	**NHTC**	National Health Training Center
CCCM	Camp Coordination and Camp Management	**NMC**	National Women Commission
CERF	Central Emergency Response Fund	**OCHA**	Office for the Coordination of Humanitarian Affairs
CM	Case Manager	**OCMC**	One Stop Crisis Management Center
CMR	Clinical Management of Rape	**PDNA**	Post Disaster Needs Assessment
CVICT	Center for Victims of Torture	**PFA**	Psychosocial First Aid
DFID	Department for International Development	**PSC**	Psychosocial Counselor
FFS	Female Friendly Space	**REDR**	Register of Engineers for Disaster Relief (former title)
FCHV	Female Community Health Volunteer	**RH**	Reproductive Health
FHD	Family Health Division	**RH KITS**	Reproductive Health Kits (reproductive health emergency supplies)
FP	Family Planning	**SDC**	Swiss Agency for Development and Cooperation
FPAN	Family Planning Association of Nepal	**SRH**	Sexual and Reproductive Health
GBV	Gender Based Violence	**STI**	Sexually Transmitted Infection
GBVIMS	Gender Based Violence Information Management System	**UNICEF**	United Nations Children's Fund
GIZ	Deutsche Gesellschaft für Internationale Zusammenarbeit	**WHO**	World Health Organization
HIV	Human Immunodeficiency Virus	**WASH**	Water, Sanitation and Hygiene
IASC	Inter Agency Standing Committee	**WOREC**	Women's Rehabilitation Center
IEC	Information, Education and Communication	**IP**	Implementing Partner
IOM	International Organization for Migration	**WFP**	World Food Programme

01 EXECUTIVE SUMMARY

USD 2.5 million mobilized for prevention of gender-based violence

USD 2.3 million mobilized for sexual and reproductive health

SUPPORTED BY:

Australian AID; giz Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ); From the People of Japan; Schweizerische Eidgenossenschaft Confédération suisse Confederazione Svizzera Confederaziun svizra Embassy of Switzerland in Nepal; UKaid from the British people; United Nations CERF Central Emergency Response Fund; OCHA

In the immediate aftermath of the earthquake on 25 April 2015, UNFPA, the United Nations Population Fund, in coordination with the Ministry of Health and Population, the Ministry of Women, Children and Social Welfare, and many other partners, reached out to the most vulnerable populations in the 14 most-affected districts to deliver SRH services, with a special programme for adolescents, and to prevent and respond to GBV.

UNFPA's integrated RH and GBV response focused on conducting mobile RH camps, establishing FFS, delivering Dignity Kits, providing life-saving reproductive health equipment and supplies and building the capacity of the health service providers.

The emergency Flash Appeal phase officially ended on 30 September 2015, with the majority of goals being met. However, a number of interventions continued given the needs that had emerged as part of the transition from relief, to recovery and through to reconstruction.

UNFPA's regular programmes continued in its 18 priority districts even during the course of the earthquake response. Humanitarian preparedness programmes will continue in selected earthquake-affected districts in 2016.

The period August 2015 through mid-February 2016 was a period of significant political unrest in Nepal, with demonstrations in several parts of the plain areas, border obstructions, strikes and fuel shortage that impacted development activities. While some delays were observed in distributions of relief items (RH Kits, Dignity Kits, FCHV motivational package, medical equipment etc), monitoring of the majority of the activities remain on track.

02 BACKGROUND

The 7.8 magnitude earthquake that hit Nepal on 25 April 2015 and the numerous aftershocks that followed including one measuring 7.3 on Richter scale caused widespread destruction and loss of life.

Nearly 9,000 people were killed and more than 22,000 others were injured. More than 600,000 houses were destroyed and another 290,000 were damaged, leaving hundreds of thousands of families without a roof over their heads. Pre-existing vulnerabilities were further exacerbated. Damage to infrastructure interrupted the delivery of basic social services including healthcare.

Access to SRH services were thus interrupted, putting the health and lives of pregnant women and their unborn babies as well as newborns at risk. Nearly 84% (375 out of 446) of the completely damaged health facilities were from 14 of the most affected districts. Hospitals were understaffed and overwhelmed.

In the 14 most affected districts a total of 1.4 million women and girls of reproductive age were affected.

An estimated 93,000 among them were pregnant at the time of the earthquake, with 10,000 delivering each month requiring emergency obstetric care and 1,000 to 1,500 at risk of pregnancy related complications necessitating Cesarean Sections.

In addition, in the aftermath of the earthquake, pre-existing vulnerabilities affecting women and adolescent girls were exacerbated exposing them to an increased likelihood of GBV.

Without adequate prevention, response and data collection mechanisms in place, GBV would increase and also go underreported. Based on estimated numbers of affected people and using calculations from the MISP, around 28,000 women potentially required post-rape treatment.

14

FFS established, providing services to 147,337 women and adolescent girls (FFS: 66,712, Outreach: 80,625)

56,000

Dignity Kits and motivational packages (3,000+) were distributed to earthquake affected women, girls and Female Community Health

1,127

Women and adolescent girls, and their newborns, benefitting from temporary shelter in the transition homes

14

Transition homes established providing temporary shelter and services for pregnant and postpar-

104,740

Earthquake affected population (85% women/adolescent girls) reached with RH and GBV services

4,231

Adolescent (72% girls) reached through adolescent SRH awareness sessions and referral

15,368

Adolescent girls, women & survivors of GBV reached with psychosocial counseling services and psychological first aid

143,686

Estimated affected population reached with emergency RH Kits (drugs and supplies) and medical equipment

80

Maternal units set up and supported with equipment at partially damaged health facilities in addition to 213 health facilities

132

RH Camps conducted across 14 districts in 128 VDCs

491

Adolescent volunteers (56% girls) trained as trainers on ASRH and engaged

262

Health service providers were trained on Clinical Management of Rape (CMR)

The **Nepal** earthquake affected
5.6 million people
in the 14 most-affected districts
including
93,000 pregnant women

UNFPA responded in the 14 most-affected districts where:

5.6 million people were affected

1.4 million women were of reproductive age

93,000 women were pregnant

1,500 women were likely to experience complications requiring Caesarean section

28,000 women were at risk of sexual violence

UNFPA provided:

Dignity kits

Female-friendly Spaces

Mobile reproductive health camps

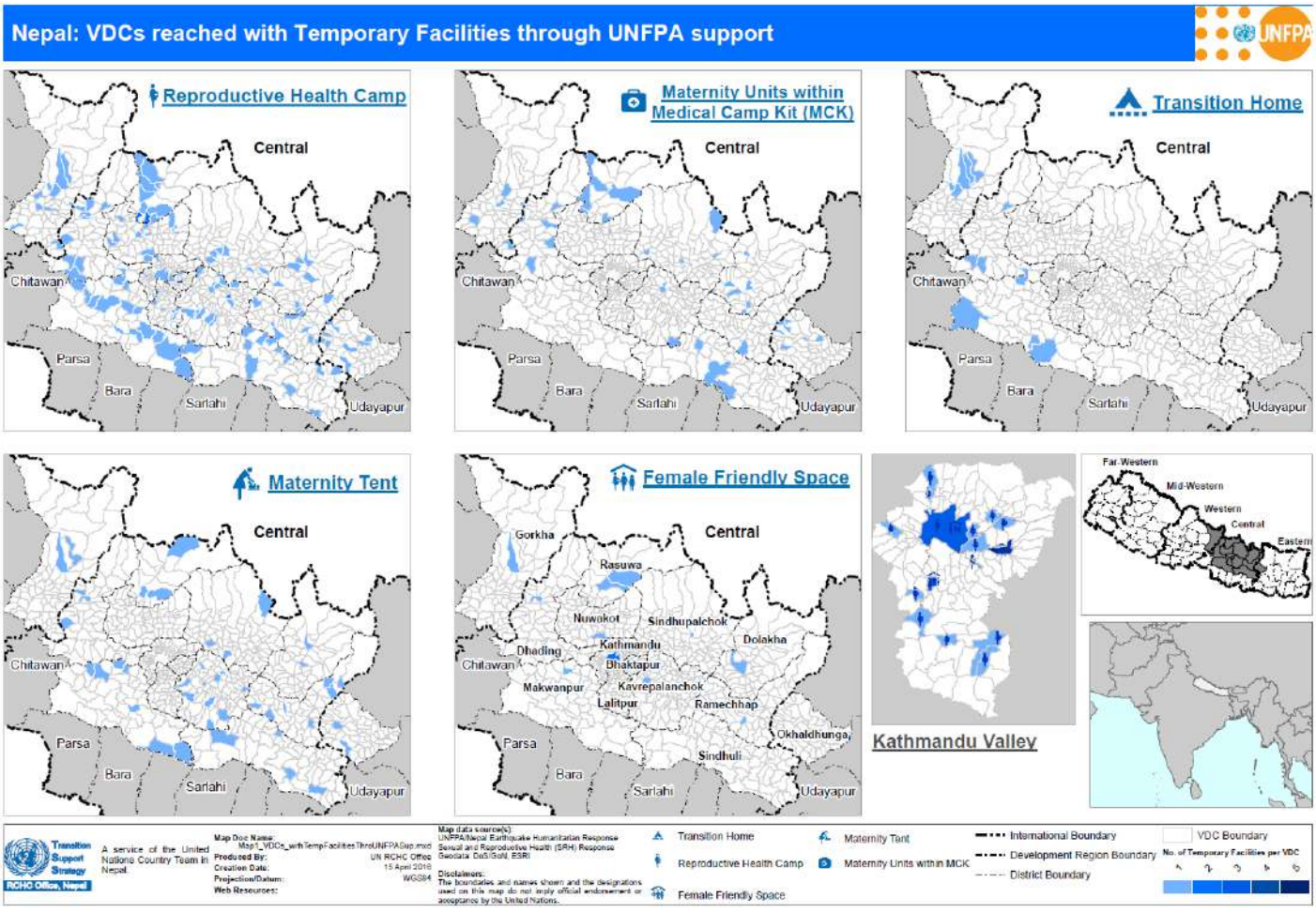
Psychosocial support

Reproductive health kits

Clinical Management of Rape

Protection and awareness messages

Data from the Health Management Information System.
Map boundaries do not imply endorsement or acceptance by the United Nations.



03 UNFPA STRATEGY

The UNFPA response to Nepal's earthquake targeted women and girls in the 14 most affected districts. It aimed to effectively implement MISP for RH and GBV.

MISP is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess maternal and newborn morbidity and mortality; plan for comprehensive RH services and make contraceptives available to meet demand.

UNFPA implemented the emergency response under the overall leadership and in close coordination with the Ministry of Health and the Ministry of Women, Children and Social Welfare.

It also collaborated closely with various implementing partners and other stakeholders. The key components of the strategy were a) provision of RH care and b) GBV prevention and response. In addition, a strong emphasis was placed on targeting adolescents and young people. Each of these components is described in detail below.

UNFPA also acted as co-lead for the sub-clusters on RH and GBV led by the Family Health Division and the Department of Women and Children respectively and ensured effective coordination between humanitarian partners working in the two areas. UNFPA's coordination role helped ensure proper integration of RH and GBV interventions.

In articulating its strategy, UNFPA took as its guiding principle the concept of "Dignity First", which was shared as part of a campaign. It upheld the need to empower women and girls, supporting them to maintain their self-respect and the ability to provide for their families by supporting their needs for safety, security, hygiene, health and information.

Through the campaign humanitarian actors were reminded that women and girls deserved a special attention and their dignity needed to be preserved and respected. To help ensure that gender, SRH and related issues were addressed in the recovery phase, UNFPA was also actively involved in inter-agency and government-led assessments, including the PDNA (see page 26).

UNFPA delivered Dignity Kits, supported RH services and GBV prevention and response in the 14 most affected districts. These districts had 5,6 million affected persons, of whom 1,4 million were women of reproductive age (15-49 years) and 93,000 were pregnant.

Upon completion of the first response phase (December 2015), UNFPA has also developed its transition plan, which includes plans for continuation of some key interventions, handover of others and discontinuation of others due to the changing conditions in the districts.

04 REPRODUCTIVE HEALTH RESPONSE

A pregnant woman undergoing a pre-natal check-in a Mobile RH Camp in Rasuwa district.

The UNFPA RH response was guided by the MISP, which helps to ensure coordination of RH activities and efficient use of resources to implement life-saving RH interventions at all levels and through different sectors. The primary target group for the response is women of reproductive age, particularly earthquake-affected pregnant and lactating women as well as adolescent girls.

MISP FOR REPRODUCTIVE HEALTH CRISIS: OBJECTIVES

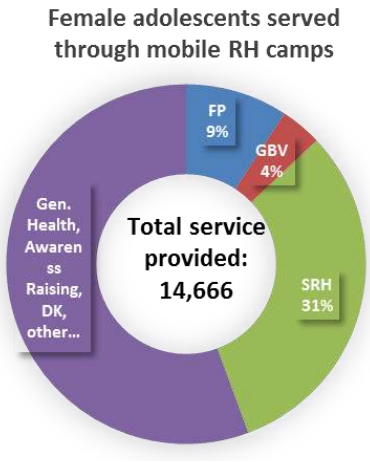
- Coordinate the RH response through the RH Sub-Cluster.
- Prevent sexual violence and assist survivors, including clinical management of rape (CMR) and identification of multi-sectoral referral pathways.
- Reduce transmission of HIV.
- Prevent maternal and neonatal mortality and morbidity (including ensuring emergency obstetric and newborn care services are available and clean delivery kits are provided to birth attendants & visibly pregnant women).
- Plan for comprehensive RH services as the situation permits.

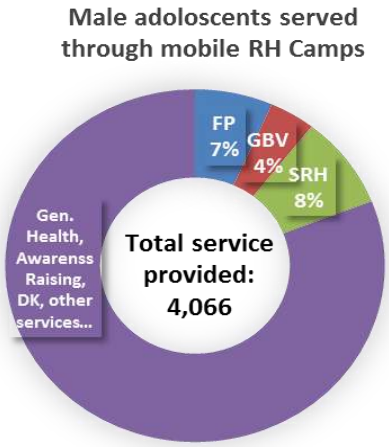
ADDITIONAL MISP PRIORITIES

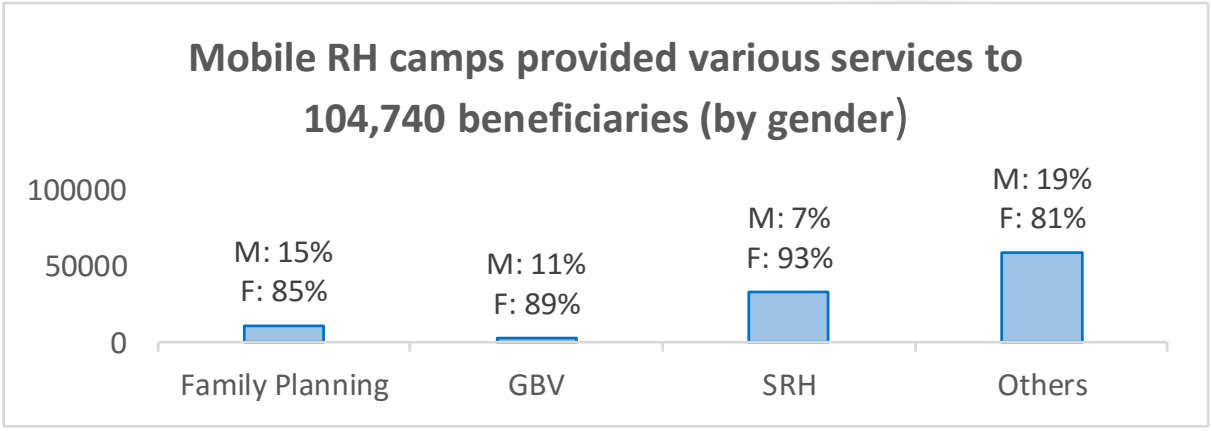
- Continue family planning.
- Manage symptoms of sexually transmitted infections (STIs).
- Continue HIV care and treatment.
- Distribute hygiene kits and menstrual protection materials.

04 REPRODUCTIVE HEALTH RESPONSE

CONDUCTING LIFE-SAVING ACTIVITIES: MOBILE REPRODUCTIVE HEALTH CAMPS







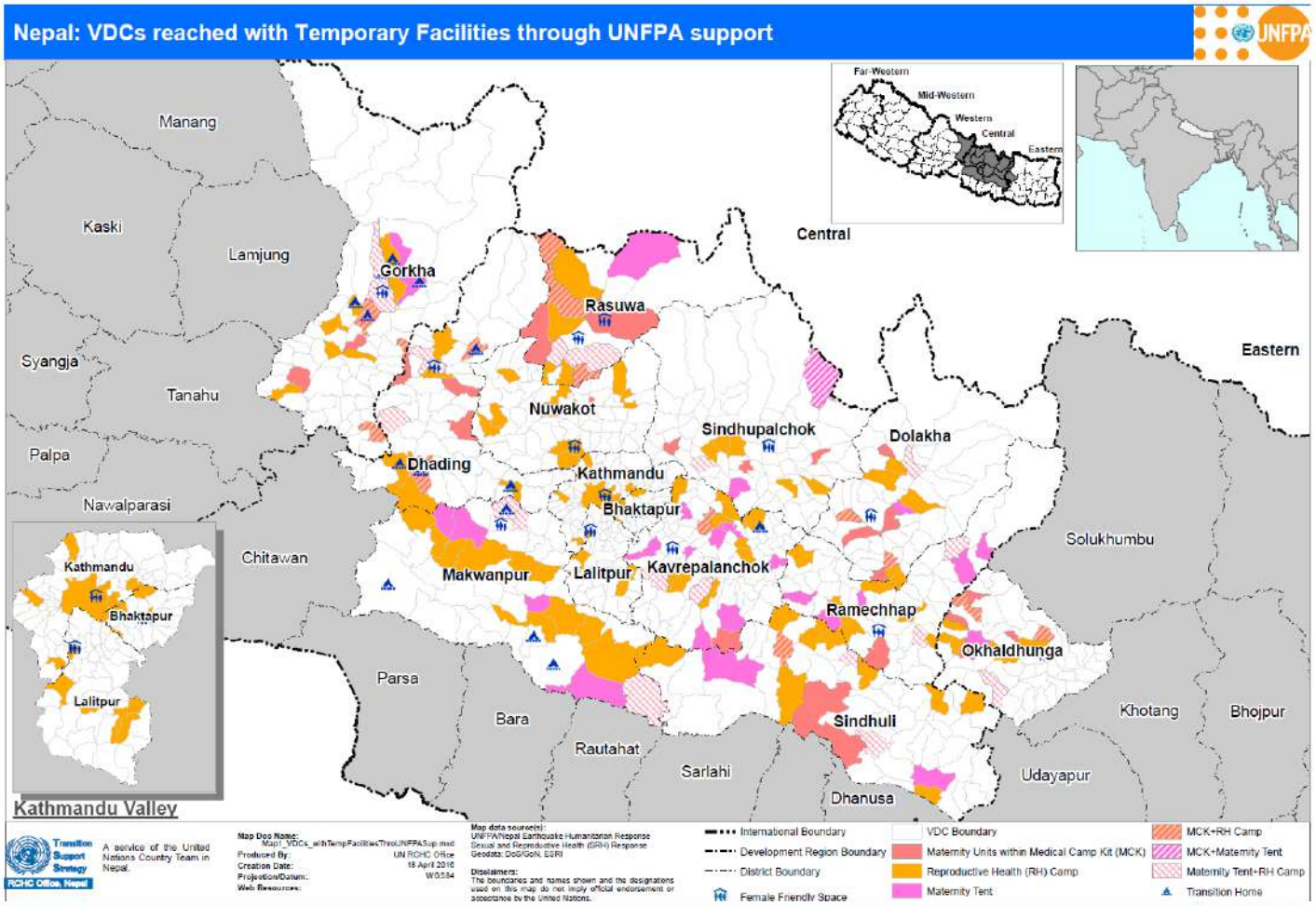
UNFPA Humanitarian Database as of 19 April 2016

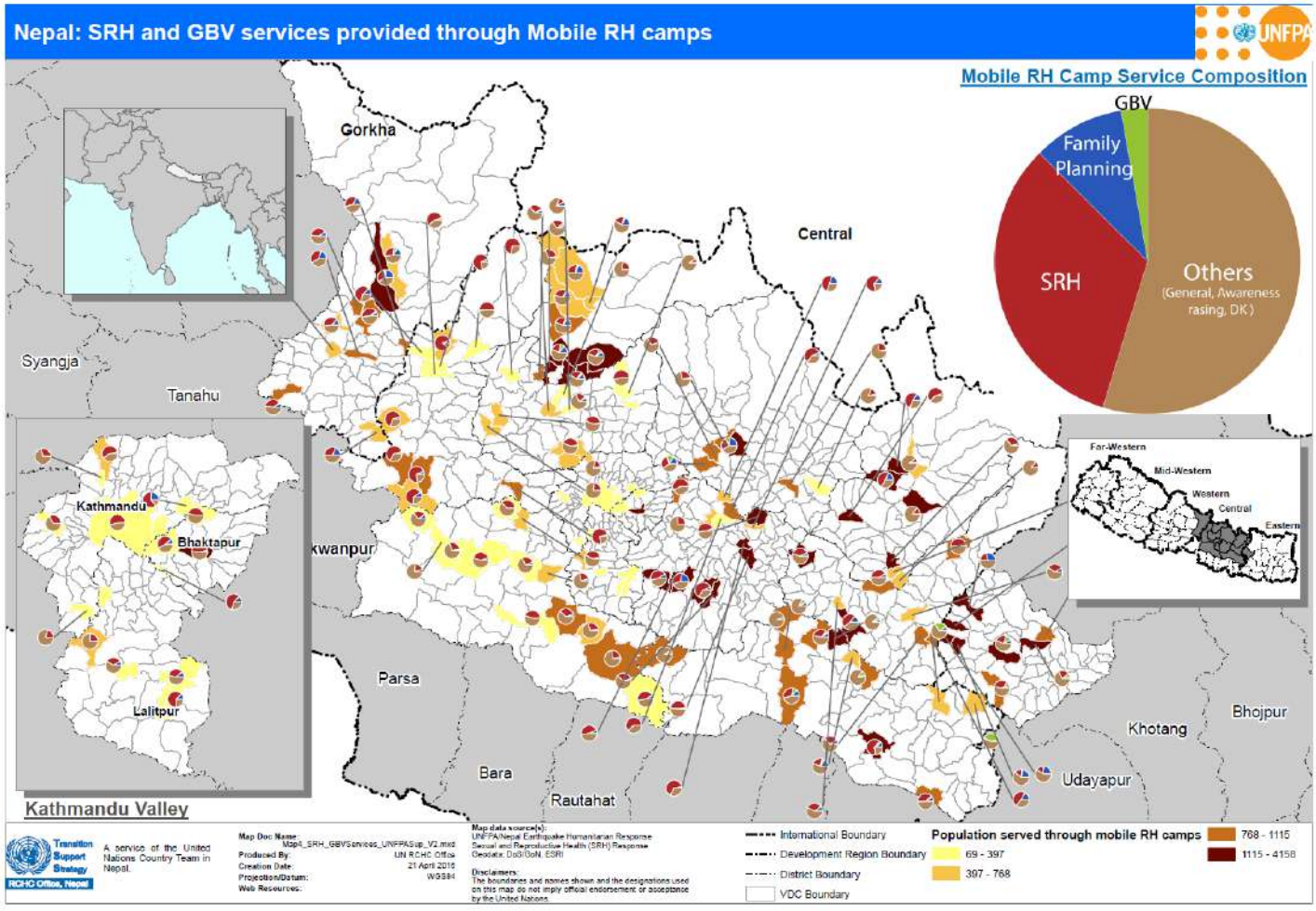
132 RH camps conducted; 118% of target (112)

9,375 Women and girls treated for uterine prolapse

3,445 Women and girls received STI treatment

14,666 Adolescent girls attended RH camps


Nepal: VDCs reached with Temporary Facilities through UNFPA support
Manang
Kaski
Lamjung
Gorkha
Rasuwa
Syangja
Tanahu
Nuwakot
Sindhupalchok
Dolakha
Palpa
Dhading
Kathmandu
Bhaktapur
Nawalparasi
Chitawan
Makwanpur
Lalitpur
Kavrepalanchok
Ramechhap
Solukhumbu
Okhaldhunga
Parsa
Bara
Rautahat
Sindhuli
Khotang
Bhojpur
Sarlahi
Udayapur
Dhanusa
Central
Eastern
Far-Western
Mid-Western
Western
Central
Eastern
Kathmandu Valley
International Boundary
Development Region Boundary
District Boundary
Female Friendly Space
VDC Boundary
Maternity Units within Medical Camp Kit (MCK)
Reproductive Health (RH) Camp
Maternity Tent
MCK+RH Camp
MCK+Maternity Tent
Maternity Tent+RH Camp
Transition Home


Nepal: SRH and GBV services provided through Mobile RH camps
Mobile RH Camp Service Composition
GBV
Family Planning
SRH
Others
(General, Awareness rasing, DK)
Gorkha
Central
Syangja
Tanahu
Kathmandu
Bhaktapur
Lalitpur
Parsa
Bara
Rautahat
Udayapur
Khotang
Bhojpur
Kathmandu Valley
Far-Western
Mid-Western
Western
Central
Eastern
International Boundary
Development Region Boundary
District Boundary
VDC Boundary
Population served through mobile RH camps
69 - 397
397 - 768
768 - 1115
1115 - 4158

04 REPRODUCTIVE HEALTH RESPONSE

CONDUCTING LIFE-SAVING ACTIVITIES: SUPPORDTING HEALTH SERVICE RECOVERY

80 Birthing facilities rehabilitated within 3 months

3,000 FCHVs provided with motivational packages

1,127 Pregnant women used maternity tents and transition homes

UNFPA conducted a series of other life-saving initiatives. For instance, it worked alongside the District Health Offices and WHO in the 14 most affected districts to rehabilitate damaged birthing facilities, or establish temporary maternity units where facilities had been destroyed.
Eighty birthing facilities rehabilitated and supported with RH kits, furniture and other essential instrument/ equipment and supplies including delivery tables, instrument trolleys, revolving stools, IV stands and examination lights at partially/ totally damaged health facilities.

Additionally, in sites that have been seriously damaged by the quake, UNFPA provided 118 tents to District Health Offices for Maternity Units, mobile RH Camps, Female Friendly Spaces and Transition Homes. 37 sites were supported in collaboration with AmeriCares, FairMed, IOM, UNICEF and WFP as part of Medical Camp Kits (MCKs) managed by WHO.

UNFPA established 14 transition homes in 4 districts to provide temporary shelter and services for 1,127 pregnant and postpartum mothers and their newborns before they are ready to safely return to their community.

UNFPA collaborated closely with FCHVs who are considered the backbone of community health interventions in Nepal. Their major role is the promotion of safe motherhood, child health, family planning, and other community based health services to encourage health and healthy behavior of mothers and other community members, with support from health workers and health facilities. There are 51,470 FCHVs (47,328 FCHVs at rural level and 4,142 at urban level) working all over the country. In the 14 hardest hit districts, the earthquake has affected 10,327 FCHVs directly or indirectly.

In addition, UNFPA provided motivational packages to almost 3,000 FCHVs in 3 districts (Sindhuli, Okhaldhunga and Kathmandu. The content of the package - including a solar lamp, hygiene items, clothes, medicines and other basic supplies ñ was agreed upon in the RH sub-cluster, with several partners supporting FCHVs in different districts. These packages were intended to encourage them to continue their services to their communities.

In addition to working alongside Female Community Health Volunteers to promote the utilization of services at reproductive health camps, UNFPA provided motivational packages to almost 3,000 FCHVs in Sindhuli, Okhaldhunga and Kathmandu districts.

04 REPRODUCTIVE HEALTH RESPONSE

DELIVERING LIFE-SAVING RH SUPPLIES

1,331 Sets of ERH Kits distributed to continue provision of life saving RH services from 213 health facilities to reach over 144,186 direct beneficiaries in 14 districts

22,000 Women safely giving birth with clean delivery kits

163 Health care service providers are trained on ERH Kits contents and its utilization

Following the earthquake many health facilities were destroyed with supplies and drugs in these facilities being damaged. Given the increased caseload resulting from the crisis, there was also a need to provide medical equipment and supplies to ensure continued provision of life-saving RH interventions.

UNFPA delivered much-needed emergency health supplies (RH kits) to district hospitals, health facilities and a number of International and NGOs active in this field. These pre-packaged kits, in line with MISP IASC Guidelines, included clean individual delivery kits, contraceptives, drugs and supplies for STIs treatment, clinical delivery assistance instruments and equipment and supplies for the management of obstetric complications, including for assisted deliveries and C-sections.

This involved international procurement, transportation, warehousing and distribution of RH Kits along with orientation on their use and monitoring of utilization at field level.

The emergency RH Kits are designed to serve varying population sizes with services being provided at community, primary health care and referral hospital levels. UNFPA provided 1,331 RH kits (see Annex I) and trained 618 health service providers, key stakeholders and RRT members reaching to estimated 144,186 direct beneficiaries from 14 most affected districts. This includes 68 post-rape treatment kits that were provided to One Stop Crisis Management Centers (OCMCs), district hospitals and national partners, 6 additional Kits are prepositioned at Nepal Red Cross Society.

Kit 3 is designed to manage the immediate consequences of sexual violence. It contains medicines and medical devices to treat up to 50 women and 10 children. Alongside the distribution of post-rape treatment kits, UNFPA also trained 261 health care personnel on the clinical management of rape.

RH Kits are distributed in blocks; 3 blocks consisting of 6,5 and 2 kits as detailed in this infographic. Individual kits in some cases consist of up to 35 boxes of equipment.

04 REPRODUCTIVE HEALTH RESPONSE

SEXUAL REPRODUCTIVE HEALTH CARE SERVICES FOR YOUNG PEOPLE/ADOLESCENTS

UNFPA recognizes the pivotal role that young people can play in Nepal's development and as such has played a lead role in youth engagement for several years in the country, strengthening national and district level youth networks in its programme districts.

UNFPA's focus through these platforms was to capacitate young people with skills and tools for them to participate in decision-making processes in their communities. Adolescents and young people are thus a key target group for UNFPA.

They were both recipients of aid and crucial actors in better coordinating life-saving responses on the ground and expanding the reach of UNFPA's relief work. By engaging its existing youth network partners, UNFPA helped ensure youth participation in the humanitarian response. UNFPA maintained the focus on youth and adolescents throughout its humanitarian response by implementing a four-pillar approach:

Training youth facilitators to run adolescent corners in RH camps

UNFPA set up adolescent friendly corners in its mobile RH camps with trained youth staff in order to create an appropriate environment to provide ASRH information. The topics covered in these corners included: consequences of child marriage and adolescent pregnancy, childbirth, danger signs during pregnancy, family planning methods, issues relating to menstrual management, consequences of unsafe abortion, GBV and risk of STIs, HIV and AIDS. 18,782 adolescents aged under 20 received ASRH services through the RH camps.

Including adolescents as a target group in Dignity Kit distribution

Over 5,000 adolescents aged under 20 received dignity kits.

Conducting activities targeted towards adolescents in FFS

In an effort to meet the needs of adolescent girls, FFSs ran a variety of activities specifically aimed at them. These included yoga, dance classes, as well as discussion groups and drama sessions aimed at creating awareness on GBV, menstrual management and other relevant issues.

Establishing Youth Leads in Emergencies project for 19-24 years

In June 2015, UNFPA launched its Youth Leads project in response to the earthquake, aimed at empowering youth living in the displacement sites across the 14 most earthquake affected districts.

In the pilot phase, 133 young people, were trained on need assessment, leadership and life skills, peer education, ASRH and menstrual hygiene. They in turn carried out the initial phases of the project, including a comprehensive need assessment focused on displacement sites in the Kathmandu Valley, that included focus group discussions with 108 female and 64 males, and In depth interviews with 400 youths. The aim was to better understand the daily situation for this group and their knowledge and attitudes towards ASRH, GBV, migration and other topics, so as to inform the next project phase. They then raised awareness and disseminated in RH and GBV-related information through camps and schools.

491 trained youth facilitators delivered adolescent sexual and reproductive health awareness-raising sessions through RH camp outreach to around 4,300 youths (10-24 years) in 14 districts.

05 PREVENTION & RESPONSE TO GBV

UNFPA's response focused on prevention and response to gender-based violence in the 14 most affected districts.

14 **FFS established; 100% of target (14)**

UNFPA's response focused on prevention and response to GBV in the 14 most affected districts. The objective was to ensure a coordinated GBV response (under the Protection Cluster) to establish and scale up life-saving GBV services through a multi-sectoral approach, establish referral systems and implement prevention initiatives within an integrated RH/GBV humanitarian response.

GBV is a sensitive and very underreported issue, with adequate services often lacking or non-existent. GBV survivors can feel they have little or no incentive to report incidents; hence it was essential for UNFPA to treat availability of quality services and effective referral systems as a matter of absolute priority.

In this context, the Clinical Management of Rape was a cornerstone of UNFPA's GBV programme, supported by the key activities on prevention, management, and referral by establishing Female Friendly Spaces, distributing Dignity Kits, co-leading the GBV sub-cluster, provision of psychosocial support and deployment of GBV Specialists to district coordination hubs.

05 PREVENTION & RESPONSE TO GBV

MULTI-SECTORAL RESPONSE TO GBV: FEMALE-FRIENDLY SPACES

14

FFS established in 14 districts provided services (information, psychosocial counseling, referral, DKs, medical/legal/ other services) to 147,337 women and adolescent girls

UNFPA supported a multi-sectorial response to GBV through the establishment and operationalization of 14 FFSs in 14 districts out of the total 100 supported across the overall response.

Located within a short distance from health facilities and/or next to child friendly spaces, FFSs provide a multi-sectoral response to GBV survivors as well as guidance on SRH services.

FFSs support the resilience and well -being of women and girls through community organized activities conducted in a friendly and stimulating environment.

FFSs mobilized communities around the protection and well-being of women and girls, providing services ranging from psychosocial support, individual case management, recreational services, awareness raising sessions on SRH and GBV, referral to legal aid, health response, police and socio-economic support.

UNFPA also trained and mobilized 20 Psychosocial Counselors (PSC), 14 Case Managers (CM) and 79 Psychosocial First Aid volunteers (PFA). Of the recorded 674 GBV cases, 654 survivors of GBV were referred for various multi-sectorial services from 14 earthquake-affected districts. In addition, FFSs also served as an entry point for distributing Dignity Kits. UNFPA also supported six FFS as part of the transition into recovery and rehabilitation strategy in 2016.

UNFPA's multi-sectoral response to GBV was linked with its RH camps and maternity spaces as part of its integrated humanitarian response approach. UNFPA encouraged its mobile RH teams to integrate psychosocial counseling and conduct treatment and referral for GBV survivors by training 262 health service providers on CMR. In addition, UNFPA strengthened the response to GBV by enabling access to multi-sectoral services through links with Women Service Centers and other service providers.

Female Friendly Spaces Services:

While service provision was responsive to demand in many cases, a few core services were consistently supplied through the FFS:

- Case Management and Referral for GBV
- Safe Space to rest, talk etc.
- Psychosocial counseling
- Awareness raising on GBV prevention and SRH
- Outreach activities

Other services included:

- Recreational activities such as yoga, dance, henna, film screenings
- Links to livelihoods activities i.e. small cottage industries
- Information on disaster preparedness and resilience
- Accommodation/shelter
- Dignity Kit distribution

FFS providing shelter

While not intended to provide emergency accommodation initially, the FFS did in fact accommodate several women and girls (mostly GBV survivors) for varying amounts of time throughout the reporting period. This highlighted a clear need for long-term solutions to house GBV survivors on a short and long term basis. In many cases, the districts where FFS were set up previously had no safe house facilities.

Many of the GBV cases seen through the FFS stemmed from incidents occurring before the earthquake; the FFSs have highlighted a major gap in services that pre-dated the earthquake. UNFPA responded to the emerging need by coordinating with DWC and GBV Sub Cluster partners to create a transition plan and secure funding commitments to establish more permanent housing.

SERVICES PROVIDED THROUGH FFS as of 31 July 2016

15368 Psychosocial counseling Sessions, PFA, CM services were delivered to women and girls

684 Women and girls provided with life-saving emergency shelter

125,973 women and girls reached through awareness raising activities

7,210 Women and girls receiving recreational services through FFS

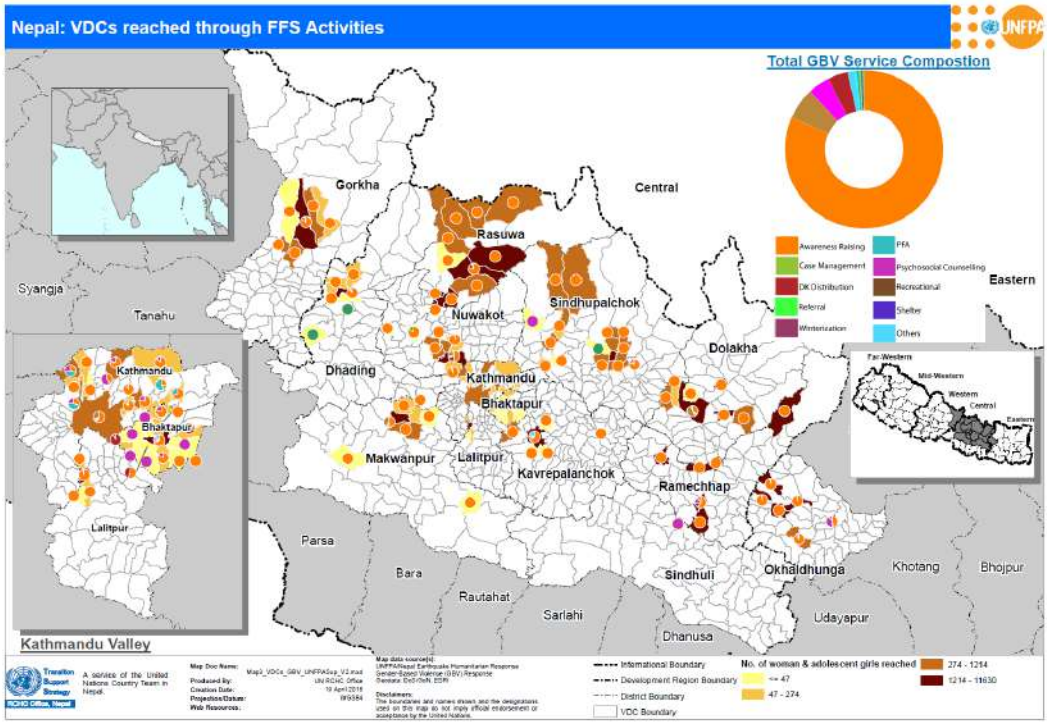
DEMOGRAPHICS OF WOMEN REACHED THROUGH MULTI-SECTORAL FFS ACTIVITIES (incl. Outreach) as of 31 July 2016

12,173 Women and girls from female headed households

18,009 Pregnant/lactating women and girls

1,472 Disabled women and girls

41,031 Adolescent girls (aged under 20)



FFS EXIT STRATEGY

As mentioned above, the establishment of the FFS highlighted pre-existing service gaps, and the potential dangers brought about through a sudden cessation in service provision. UNFPA responded to this emerging need by facilitating a two day workshop with the DWC, international and national partners to establish the real need, and lobby on a coordinated basis for additional funding to ensure continuity.

The DWC agreed to set up a OCMC linking with safe houses in each of the 14 districts as a direct result of the increased focus on the issue through earthquake response activities. Ministry of Health has set up OCMCs in Dolakha, Ramechhap and Sindhulpalchok. UNFPA handed over 12 FFS to Women and Children Office, Women Cooperatives/Committees. UNFPA is continuing to support six FFSs as part of the transition into recovery and rehabilitation strategy till July 2016, three until December 2016 with funding from Japan and Global Grant Giving and one with the funding from SDC under the GBV prevention and response project in Okhaldhunga. Social Mobilizers selected by WCOs received 6 months psychosocial counselling and are providing counselling services in FFS, Safe Houses/Counselling centres in all the 14 districts through Japan funding.

GBV INFORMATION MANAGEMENT SYSTEM AND GBV CASE DATA

UNFPA was actively supporting the National Womenís Commission (NWC) pre-earthquake in the roll-out and management of the GBVIMS in partnership with eight national partners. During the emergency response several new actors in the sector arrived in country, and via the GBV Sub-Cluster the need to enroll more agencies in the system became clear.

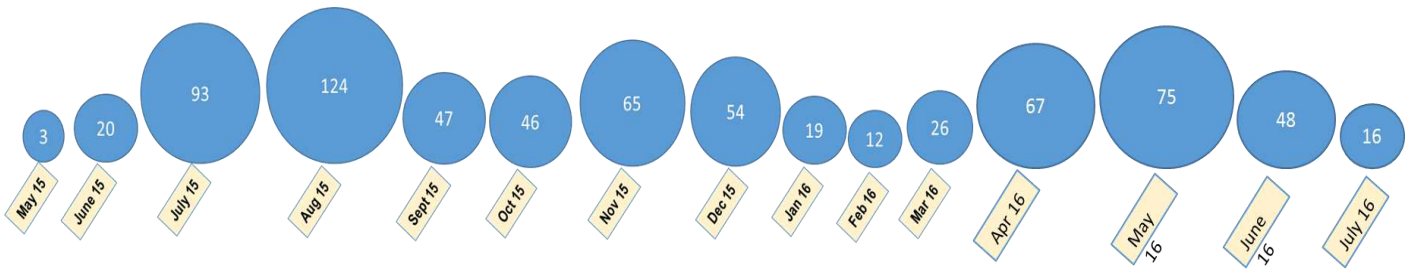
Thus UNFPA conducted a comprehensive 3–day training for around 40 international and national partners on the GBVIMS, placing some of them in the position of being able to sign the Information Sharing Protocol with the NWC. In addition, UNFPA partners have used the system through the FFS services, and have provided some GBV incidence data using the GBVIMS intake sheet. It should be noted that these figures do not indicate prevalence, and should not be taken as such.

674 GBV cases responded to through FFS & Outreach services

8% GBV survivors are adolescents (<20)

33% Cases referred for multisectoral services within 72 hours incident

NUMBER OF GBV CASES REPORTED THROUGH FFS EACH MONTH



UNFPA Humanitarian Database as of 31 July 2016

05 PREVENTION & RESPONSE TO GBV

THE RIGHT TO DIGNITY FOR WOMEN AND ADOLESCENT GIRLS

The provision of Dignity Kits is an essential component of UNFPA's humanitarian response. By providing women with essential hygiene and safety supplies, UNFPA has helped to create an enabling environment in which women are supported to maintain a sense of security and well-being and to participate more actively in the response. Women and girls of reproductive age are often neglected in their needs especially as it relates to menstrual hygiene.

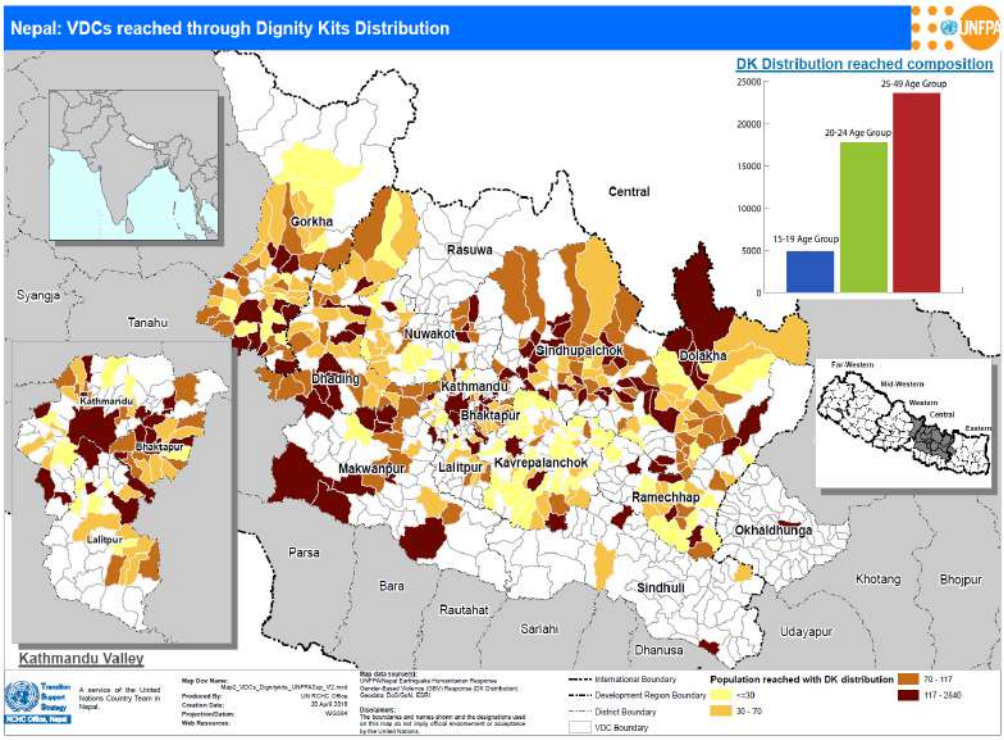
Without access to sanitary supplies, women and adolescent girls are severely restricted in their mobility, unable to seek basic services ñ including humanitarian aid.

Dignity Kits help address these hygiene needs and provide an entry point to raise awareness on GBV. In line with this vision, UNFPA procured and distributed approximately 56,000 dignity and motivational kits in the worst affected districts including about 3,000 motivational kits for FCHVs in Sindhuli, Okhaldunga and Kathmandu.

In addition, it is prepositioning dignity kits in several of its programme districts through its regular programme. The content was agreed by the Government taking into account Nepalís socioocultural context. The kits included a sari, petticoat and shawl, or kurta as well as sanitary pads, other hygiene items and a flashlight for protection purposes.

In addition to being a set of supplies, the kits were also used as an entry point for dialogue and messaging around key protection issues such as GBV prevention, referral to services including CMR, psychosocial support, trafficking prevention, dangers of child marriage, where to seek RH care and other. UNFPA distributed dignity kits through the local government, its mobile RH camps, FFSs, and partners.

Planning and distribution was conducted in coordination with the Department of Women and Children at the central level, the Women Children Offices at the district level and also as part of the GBV Sub-cluster to ensure that the most affected areas were covered.



Over 56,000 dignity and motivational kits were procured for the emergency response

88% Respondents rated dignity kits as ìusefulî or ìvery usefulî

75% Respondents said there were enough kits distributed to meet the need. Results from Post Distribution

In a joint effort with the Ministry of Women and Children and Social Welfare, UNFPA launched the Dignity First campaign on 23rd May 2015. This advocacy campaign aims to ensure that the special needs of earthquake-affected women and adolescent girls are not forgotten in the humanitarian response.

The Secretary of the Ministry of Women and Children and Social Welfare, Dhana Bahadur Tamang, UNFPA Nepal Goodwill Ambassador Manisha Koirala and UNFPA Representative for Nepal Giulia Vallese jointly launched the campaign by pronouncing "Dignity First" and its Nepali version "Vipatma parda jahile; Mahila ko maryada pahile".

After its launch, UNFPA Nepal has been continuously advocating in the center as well as in districts that the special needs of women and girls should not be forgotten in any humanitarian response and that preserving their dignity is not just a reproductive health issue, but a human rights one.

"Dignity First" messages have been taken to community people, including those affected by the earthquake, through different mediums. Some of the prominent tools that have been used so far are posters, pocket cards, audio-visual presentations, t-shirts, note books, social media and radio programmes.

By reaching women and girls through the campaign UNFPA Nepal is also focusing on empowering them to play a role in rebuilding their lives and restoring their physical health and wellbeing.

"Dignity First" also encourages humanitarian actors and policy makers to work towards preserving the dignity of pregnant women, new mothers and their infants, and girls during humanitarian crises as well as under normal circumstances.

UNFPA Nepal also encouraged governmental and non-governmental partners to continue advocating for women and girls, their sexual and reproductive health as well as protection issues and special needs. Preserving and protecting the dignity of women and girls in humanitarian crises and during normal circumstances is not just a reproductive health and protection issue, but a human rights issue.

Dignity Kits and IEC materials ready for distribution in earthquake affected districts.

05 PREVENTION & RESPONSE TO GBV

CLINICAL MANAGEMENT OF RAPE (CMR)

Vulnerable women taking part in knitting and yoga workshops in FFS.

262 Health workers trained on CMR and GBV

8 Districts started rolling out the Protocol

4,200 Estimated direct beneficiaries reached by distribution of 70 rape treatment kits

It is widely recognized that in the aftermath of a crisis, incidence of GBV, in particular sexual violence, can dramatically increase.

In June 2014, as part of its regular GBV response and prevention programming, a working group began supporting the process of developing a protocol on the Clinical Management of Rape. The group was led by the Population Division, MoHP, with substantial support from UNFPA and Jhpiego. Consultants were hired to develop the guideline and a technical working group was formed under the leadership of Population Division.

The protocol was finalized through an extensive consultative process with a range of different stakeholders, such as FHD, NHTC, NHEICC, Child Health Division, Curative Division, UNFPA, UNICEF, WHO and Nepal Health Sector Support Programme, DFID. The clinical protocol is expected to help service providers at various levels of health facilities to follow rigorous criteria for choosing appropriate procedures for management which include providing immediate health care, adequate psychosocial counselling, appropriate collection and preservation of medico-legal evidences (where relevant) and developing systems for proper follow up and reporting.

The protocol was endorsed by Ministry of Health and Population in August 2015 and shortly after a Training of Trainers was conducted by UNFPA for 12 doctors on CMR, preparing them for conducting CMR training in the 14 most affected districts.

So far close to 100 health workers have been trained on CMR in 8 districts: Kavre, Ramechhap, Dhading, Nuwakot, Rasuwa, Sindhuli, Sindupalchock and Gorkha. The training is aimed at capacitating health-care providers on how to provide quality care to rape survivors in humanitarian settings. In addition to the training, each district hospital was provided with a post rape treatment kit. 130 trained immediately through the emergency response with 100 trained on the Endorsed Protocol.

One rape kit is sufficient to cover a population of 10,000 for a period of 3 months, and contains emergency contraception, Post-Exposure Prophylaxis, several other items, and comprehensive instructions on usage. In addition to the work on the clinical protocol, UNFPA supported a series of orientation sessions for implementing par tners who were conducting the RH mobile camps on GBV in emergencies, including clinical management of rape.

UNFPA, in partnership with ADRA, the Family Health Division and the Population Division is also working to strengthen the capacity of district health workers to provide quality care to survivors of GBV.

06 REPRODUCTIVE HEALTH SUB-CLUSTER

16 Sub-cluster meeting in Kathmandu

32 Participating agencies

4 Days after the earthquake first meeting held

The RH Sub-cluster was activated within days of the earthquake disaster under the overall leadership of the Family Health Division, Ministry of Health and Population, as part of the Health Cluster.

UNFPA co-led the RH Sub-cluster at the central level and with the respective District Health Offices in the two humanitarian hubs set up in Gorkha and Sindupalchok (Chautara). A total of 32 partners participate in the RH Sub-cluster meetings held regularly at the central level (Kathmandu) and in the humanitarian hubs.

The RH Sub-cluster has been vital in promoting coordination amongst the various humanitarian actors in the 14 most-affected districts. It successfully led the implementation of the MISP for RH in crisis.

The Sub-cluster has developed checklists, flowcharts and simple guidelines to ensure implementation of the humanitarian RH response and provision of quality care in accordance with national standards and protocols.

Women with their babies at a mobile RH camp in Dhunche, Rasuwa.

Its meetings have proved to be valuable platforms for sharing of findings, updates and experiences from the field, while ensuring that the overall RH response is coordinated and aligned with national needs and priorities.

In line with its integrated humanitarian response approach to prevent and respond to GBV, the RH Sub-cluster established close linkages with other clusters, in particular, the GBV Sub-cluster. The RH Sub Cluster was integrated into the Health Cluster in December 2015.

KEY ACHIEVEMENTS

- Identification of a focal partner organization for each affected district facilitated effective coordination and implementation of the RH, MNH & Child health services.
- Supported district health offices rehabilitate damaged health facilities ensuring rapid re-establishment of health services even while functioning under tents.
- Motivational packages containing personal items as well as supplies and job-aids distributed to FCHVs in 14 districts to enable them to reinitiate/continue their community- based services.
- Based on the national standards simplified algorithm of care and job-aids were developed/reprinted and distributed to service providing agencies, including FMTs, and other sub-clusters.
- Program Plan on Menstrual Health Management developed and is being implemented.
- An operational guideline on Transitional Homes is drafted for finalization.
- Developed key RH and ASRH messaging to be aired through the local FM radio in the districts.
- Developed checklists, flowcharts and simple guidelines to ensure implementation of the humanitarian RH response and provision of quality care in accordance with national standards and protocols including on preparedness for accessing RH services during the monsoon and winter.
- Facilitated participation of 32 partners in the RH Sub-cluster meetings regularly at the central level (Kathmandu) and 10 partners in the humanitarian hubs.
- Trained 455 health service providers, the rapid response team (RRT) and key stakeholders on Minimum Initial Service for SRH including ERH kits.

07 GENDER BASED VIOLENCE SUB-CLUSTER

36 Meetings in 6 districts

8 Districts received training in GBV

30+ Participating agencies

The GBV Sub-cluster was activated within days of the earthquake disaster under the overall leadership of Department of Women and Children, Ministry of Women Children and Social Welfare, as part of the Protection Cluster. UNFPA co-led the GBV Sub cluster at the central level and with the respective women and children offices in the two humanitarian hubs set up in Gorkha and Sindupalchok (Chautara).

A total of 29 partners participate in the GBV Sub-cluster meetings held regularly at the central level (Kathmandu) and in the humanitarian hubs.

The GBV Sub-cluster has been vital in promoting coordination amongst the various humanitarian actors in the 14 most-affected districts.

It successfully led the implementation of the GBV prevention and response activities. The Sub-cluster has developed checklists, 4WS, FFS operational guidelines, referral pathways and tools to monitor distribution of Dignity Kits and feedback from the community.

Girls waiting to learn about GBV prevention and response during a camp in Kavre.

Its meetings have proved to be valuable platforms for sharing of status of implementation, challenges, updates and experiences from the field, while ensuring that the overall GBV prevention and response is coordinated and aligned with national needs and priorities.

In line with its integrated humanitarian response approach to prevent and respond to GBV, the GBV Sub-cluster established close linkages with other clusters. GBV Sub Cluster was integrated into the Protection Cluster in December 2015.

Women taking part in a laughter therapy at a FFS in Chhuchepati, Kathmandu.

KEY ACHIEVEMENTS

- Endorsement of Key documents by DWC: GBV Messaging, Referral Pathway, Emergency GBV IMS intake and consent form.
- Mainstreaming of GBV through the CCCM Displacement Tracking Matrix.
- Advocacy with WASH and Shelter clusters.
- Drew focus to lack of GBV services and increased risks in the under-served displacement sites.
- Distributed 600 Winterization packages to lactating, pregnant and other vulnerable women and girls during winter in 6 districts.
- Trained 292 men and women from 31 agencies across 8 districts on GBV in Emergencies.
- Facilitated WCO to keep systematic record of GBV cases after EQ.
- Capacitated 350 protection cluster members, cluster co-leads, Female Community Health Volunteers, Nepal Scout members, relevant stakeholders and enumerators of common feedback project in GBV in humanitarian setting.

08 OTHER ACTIVITIES

5,110 episodes on SRH, GBV & ASRH messaging aired on local FM radios in 14 most-affected districts

In addition to its field based and coordination interventions, UNFPA reached out to the most vulnerable affected population by airing radio messages related to SRH, GBV and ASRH through 18 FM stations and in local languages (including Tamang). Over 5,110 messages in 14 districts were broadcasted.

Compelling stories, information and videos from the field about UNFPAís interventions can be read on:

http://nepal.unfpa.org/news

facebook.com/UNFPANepal

twitter.com/UNFPANepal

youtube.com/UNFPAinNepal/videos

UNFPA has also played an active role ever since the Communicating with Communities group was formed under OCHAís leadership. UNFPA provided technical inputs in finalizing common messages, mapping out communication interventions in the affected districts and communicating with communities together with other partners via FM radios.

The project collected data from UNFPA interventions, particularly RH camps and FFSs, hence giving a voice to many vulnerable people who may otherwise not have been heard.

UNFPA contributed to the development of the questionnaire and included questions specific TO UNFPAís focus areas.

Adolescents attending a RH and GBV session in Makwanpur district.

UNFPA has participated actively as a partner in the Community Feedback project which aims to gain insights into community feelings about the emergency response, and adjust accordingly. A round of questionnaires (including some additional UNFPA-specific questions) were administered at an RH camp in Dolakha.

Although the sample size was small, a striking issue was that the large majority (90%) of respondents felt that their voices had been insufficiently heard in the overall emergency operation. This is in line with the overall feedback across the affected districts, and tends to be more prevalent among women. In response, UNFPA scaled up efforts to communicate via local FM stations and on local radio. Fifty percent of women stated that they felt their health needs were being met. UNFPA supported to train enumerators to collect the GBV information from the EQ affected districts.

Communicating with communities

In an effort to communicate better with the earthquake affected communities, UNFPA trained 75 members of Nepal Scouts to act as enumerators in the Communicating with Communities project.

Keeping in mind the increasing risks of several forms of violence which many displaced women and girls were facing in the post-earthquake situation, the training was, among other things, on enhancing their skills and knowledge to prevent and respond to GBV.

09 POST DISASTER NEEDS ASSESSMENT (PDNA)

The key objective of the Post Disaster Needs Assessment (PDNA) for the Government of Nepal was to assess the impact of the earthquake and define a recovery strategy ñ including its funding implications, from restoration of livelihoods, economy and services to rehabilitation and reconstruction of housing and infrastructure.

WHO LED IT?

It was conducted by the National Planning Commission together with various ministries and with support from the private sector and civil society as well as bilateral, multilateral and development partners.

UNFPA CONTRIBUTION

UNFPA contributed to the PDNA in three sectors: 1) Health and Population; 2) Gender, elderly, person with disabilities, and childrenís welfare; and 3) Human Development Impact Assessment as a core team member in the respective sectors teams. In addition, UNFPA mobilized 42 youth in six most affected districts to collect primary data related to impact on human development from about 400 affected households.

WHAT DID IT ACHIEVE

UNFPAís involvement in the core teams contributed to the integration of population/migration/displacement, SRH, GBV and social protection issues as priority in the immediate response, recovery and reconstruction plans and strategies.

These dimensions were fully integrated in the PDNAís:

I. assessment of the damage and recovery needs in affected areas
II. the socio-economic analysis of the impacts of the quake.
III. the summary of priority recovery and reconstruction needs in the short and medium term
IV. the long-term recovery strategy which seeks to address these needs, reducing disaster risks and promoting resilience.

Nurses, who were part of a RH camp in Kavre, sharing information on ASRH.

Pregnant and new mothers with Dignity Kits in Ramechhap district.

10 LOGISTICS CLUSTER

UNFPA participated as an active member in the Logistics Cluster. Under the leadership of the World Food Programme, the Cluster stored (in the Humanitarian Staging Area) and transported UNFPA supplies by road from Kathmandu to target locations, airlifted staff and supplies to hard to reach areas and provided advocacy and assistance with government procedures as well as overall excellent coordination of logistical issues amongst agencies and partners.

UNFPA became the 3rd agency to benefit the most from the services provided by the Cluster. The Cluster helped in the distribution of the dignity kits and motivational packages, RH kits containing life saving RH supplies, many FFSs and maternity tents as well as medical equipment in a swift and cost-effective manner.

DATA IN EMERGENCY

Under the auspices of the Ministry of Population and Environment, UNFPA and IOM supported a sample survey on socio-economic impact of the Nepal earthquake in 14 most affected districts which was successfully carried out by the Central Department of Population Studies/Tribhuvan University between August and December 2015.

The purpose of the study was to assess the socio-demographic impact of the earthquake, with a focus on cultural diversity pertaining to household settings including caste/ethnicity, population dynamics (fertility, mortality, migration), that is, population size, composition and distribution.

The fieldwork was carried out during 20 November to 15 December 2015 with a total of 3,000 households surveyed, which was a statistically representative number. The sample size was drawn from three domains: 7 'severely hit' districts, 4 'crisis hit' out of the Kathmandu valley, and 3 'crisis hit' within the valley. The sample size was determined at 3,000 households from 150 Primary Sampling Units of 20 households each.

To substantiate the findings of the quantitative survey the survey team carried out 37 focus group discussions among community representatives, 43 key informant interviews, case studies and participatory observations. The survey results were finalized in April 2016, with policy recommendations included in each of the section of the study.

The findings are expected to contribute to informing the development of more cost-effective government policies on population dynamics in a post disaster context.

11 MONITORING AND EVALUATION

An orientation on GBV/SRH activity monitoring tools for data collection in Kavre district.

In order to support the earthquake response, UNFPA Nepal revisited its Country Programme Resources and Results Framework with a view to integrate emergency-related activities and indicators in its current country programme (2013-2017).

The office established an overall results-based monitoring and reporting system, including a mechanism for communicating with affected populations to promote participatory planning and feedback mechanisms. This was meant to improve responsiveness and adjust strategies as per the needs identified by the communities.

This is particularly important in Nepal, where additional efforts must be made to ensure that support reaches the most vulnerable populations based on an analysis of caste, ethnicity, religion, geographic location etc. In addition, review meetings with implementing partners were held regularly to review progress, challenges, lessons learned and to discuss and develop an exit strategy in the transition phase.

The Women Refugee Commission carried out a MISP assessment in Nepal in September 2015 which provided very useful and positive insights on UNFPAís humanitarian response and coordination efforts.

The evaluation of the earthquake response has been integrated into the CP evaluation starting August 2016 in close coordination with the Government of Nepal, the UNFPA Evaluation Office and UNFPAís Asia Pacific Regional Office (with the Ministry of Finance chairing the Evaluation Reference Committee).

Nepal was selected as one of the countries to be included in the highly vulnerable context evaluations by the UNFPA Evaluation Division in 2016. As such, the Nepal CO will also provide the meta analysis on the humanitarian response through 7th Country Programme Evaluation.

SURGE PERSONNEL

Additional personnel were also deployed to support the work of the country office throughout the earthquake response. This included staff from other UNFPA offices, temporary redeployment of national personnel to affected districts, national and international consultants as well as personnel seconded and supported by stand-by partners.

In total, UNFPA mobilized 43 surge personnel, of which 17 were existing UNFPA personnel from other offices, 5 were international consultants, 15 were national consultants and 6 were supported by partners such as the Norwegian Refugee Council (2), CANADEM (funded by DFID) (2), REDR (Australia) (1) and the Inter-Agency Regional Emergency GBV (1).

In addition, the UN Resident Coordinatorís office seconded one of its staff to UNFPA while UNFPA seconded its youth officer to the UNRC office for almost 2 months respectively to support a coordinated response.

12 DONORS AND PARTNERS

A representative from the Midwifery Association of Nepal attending to a new mother in Nuwakot district.

UNFPAí s resource mobilization and partnerships strategy facilitated the response to the immediate SRH needs of the most vulnerable and to prevent and respond to GBV right in the aftermath of the crisis.

UNFPA was able to mobilize over USD 2.5 million for prevention and response to GBV and USD 2.3 million for delivery of SRH services in addition to reprogramming some of its regular programme funds and devote considerable staff time to the response. UNFPA received funding from CERF, DFAT (Australia), DFID (United Kingdom), GIZ (Germany), Japan, OCHA and SDC (Switzerland) among other development partners (see Table next page).

Aside from the generous contributions of these development partners, UNFPA mobilized internal support through its Thematic Trust Funds including the Global Programme on Reproductive Health Commodity Security also referred to as UNFPA supplies (see table next page), and the UNFPA Emergency Response Fund which were crucial in enabling a fast delivery of SRH and GBV services throughout the response.

In addition, UNFPA forged additional strategic partnerships that reinforced its response on the ground. For instance, the WHO donated 35 tents which were used as FFSs, maternity units and other related purposes.

In order to strengthen a sense of security of women and adolescent girls residing in camps UNFPA distributed 1,056 lamps donated by Luminaid.

These were solar-powered, inflatable lights that pack flat and inflate to create a lightweight, waterproof lantern, In addition, UNFPA received 1,250 Waka-Waka lamps, which consisted of solar powered devices that provide light and power as well as 800 mobile charging cables.

UNFPA will continue to work closely with the Ministry of Health and the District health Offices to inter link and integrate the related GBV interventions within the RH response.

In addition, coordination and cooperation with the Ministry of Women, Children and Social Welfare - and consequently the Women and Children Offices at the district level continues to be essential for the integrated approaching to preventing and responding to violence, including CMR.. UNFPA is also working with national and international partners. NGO partners include ADRA, FPAN, CARE, CVICT, MIDSON and WOREC.

In addition, on-going engagement with youth networks is helping to increase the reach of UNFPAís humanitarian activities. RH kits were also distributed to 16 partners and different levels of health facilities in 14 districts.

Dignity kits were provided directly by UNFPA or through its implementing partners, youth networks and the Government. In addition, UNFPA also partnered with WHO in setting up and supporting Medical Camp Kits. Other collaborating partners in this initiative are AmeriCares, FairMed, WFP, UNICEF and IOM.

CONTRIBUTIONS MOBILIZED FOR THE EARTHQUAKE RESPONSE*	USD
JAPAN	1,000,000
UNITED KINGDOM (DFID)	777,738
CENTRAL EMERGENCY RESPPONSE FUND	753,815
EMERGENCY RESONSE FUND	605,000
GLOBAL PROGRAMME ON REPRODUCTIVE HEALTH COMMODITY SECURITY	500,000
AUSTRALIA (DFAT)	401,606
SWITZERLAND (SDC/EMBASSY OF NEPAL)	273,973
GERMANY (GIZ)	110,645
UN OFFICE FOR THE COORDINATION OF HUMANITARIAN AFFAIRS (OCHA)	100,000
AUSTRALIA (DFAT) REGIONAL FUNDS	56,912
WAKA-WAKA (value of in-kind contribution)	52,000
MATERNAL HEALTH THEMATIC FUND	44,950
FRIENDS OF UNFPA	48,906
GLOBAL GRANT GIVING	45,000
UNFPA THAILAND (Country Office)	30,000
WORLD HEALTH ORGANIZATION (value of in-kind contribution)	27,405
UNITED BUDGET RESULTS ACCOUNTABILITY FRAMEWORK (UBRAF)	20,000
FRIENDS OF UN ASIA PACIFIC	10,313
LUMINAID (value of in-kind contribution)	10,055
UNFPA Vietnam (Country Office)	5,042
GRAND TOTAL	4,867,928
UNFPA'S REGULAR RESOURCES USED FOR THE EARTHQUAKE RESPONSE	143,580

**Amounts reflect contributions received based on the exchange rate applicable at the time of receipt.*

13 LESSONS LEARNED

In terms of overarching strategic issues it is important to mention that the immediate activation and effectiveness of the different Clusters and Sub-clusters was pivotal in supporting well-coordinated and integrated SRH and GBV responses.

The strategic leadership of the Government in both the GBV and RH Sub-clusters was clear and coherent, providing an important sense of ownership to the national counterpart whereas international and humanitarian partners brought specific technical know-how and tools. The collaboration between both sides therefore, was essential in the successful roll out of the SRH and GBV humanitarian responses.

Despite the clear commitment of the national partners, there remains a need to strengthen capacity at the local level to facilitate coordination both between actors at district level and between district and central levels.

It will also be important, in any future emergency, to ensure adequate information management capacity on the government side in order to ensure that the often-overwhelming amount of information can be coherently handled for optimal coordination.

In terms of its interventions, one of the major lessons learned has been the necessity to tailor field interventions to the evolving needs on the ground. Nothing illustrates better this fact than UNFPAís mobile RH camps, whose budget had to be increased to attend to the ever-increasing number of people and services requested on the ground.

Another example was the need to customize the original contents of UNFPAís dignity kits according to Nepalís sociocultural context. Hence, the kits included new items such as a sari, petticoat and shawl, or kurta, which are considered important supplies for Nepali women and adolescent girls.

Aside from the fact that the items included in the kits were useful, the distribution of kits effectively also gave the Ministry of Women, Children and Social Welfare/Department of Women and Children, a more prominent role to play in the early days of the response. It became helpful to have a tangible item for distribution as it facilitated dialogue around other interventions such as referral pathways and strengthening of the CMR services.

Volunteers packaging Dignity Kits for earthquake-affected populations.

UNFPA also observed the need to preposition RH Kits, Dignity Kits and tents to enable an even faster response in future emergencies.

Due to the logistical difficulties to procure locally as a result of the destruction and chaos created by the earthquake, prepositioning of these supplies became ever crucial. For instance, UNFPA had already prepositioned life-saving reproductive emergency health supplies with support from the Australian Government which enabled it to deploy them timely immediately after the Earthquake.

UNFPA later received support from other development partners, enabling substantial further procurement and distribution to numerous partners from the RH Sub-cluster, including the Ministry of Health. Setting up transition homes close to well-functioning birthing facilities (EmONC) allowed pregnant women, postpartum mothers and their children to access temporary shelters before being ready to return to their communities.

Locating these transition homes near the health facilities contributed to preventing maternal and neonatal deaths and disabilities by allowing pregnant, postpartum women and newborns to access immediate healthcare, in case of any complication arising during their stay at the transition home. In addition, it also contributed to an increase in the number of skilled birth assisted deliveries.

CMR needs to be strongly emphasized from the very beginning of the response, along with clear advocacy as to why services must be provided regardless of number of reported cases.

This is not always clear to members of the humanitarian community, who may request ëevidenceí of ësufficientí number of cases to justify investment in service delivery. Training humanitarian actors on these issues prior to a future emergency will be helpful, as the process of advocating for the need takes up valuable time in the early phase of an emergency.

It has been observed that FFSs are likely to uncover service delivery gaps, which may to a great extent be unrelated to the earthquake. In Nepal, a large percentage of women who came to these FFSs with GBV cases had experienced GBV for a long time before the earthquake happened.

Typically, a FFS will see a small number of cases initially but these will increase dramatically as the FFS becomes better known and the staff more trusted. This will tend to happen around the same time that funding is running out and the FFS is looking to close.

As such continued support as well as a strategy to institutionalize such support would be required. To that end, UNFPA facilitated a study tour of officials from the Ministry of Women, Children and Social Welfare to the Philippines to learn how they institutionalized the FFSs following the typhoon that devastated Tacloban.

While services in some FFSs continue, many others are no longer providing services or funding will end soon. This situation raises ethical issues about shutting down the services at the end of the emergency phase.

Hence, a discussion needs to take place with actors involved in providing services as to how these can be taken over by government/NGOs, who could own them and pay for the services. The need to establish links with livelihoods programmes becomes increasingly apparent as time passes, and some women desperately need alternatives to returning home. Many of Nepalís FFSs have created such linkages, however this has been somewhat limited and could be taken into account at the outset of planning an FFS.

Last but not least, UNFPA realized that to optimize the usage of RH kits, there is a need to develop more visual materials to explain their content and use. Furthermore, they should be opened and their content explained systematically to partners receiving it, as this was shown to encourage immediate and better use of the kits in the response.

14 CHALLENGES

Prioritizing SRH and GBV at the onset of the response and obtaining adequate funding remain a challenge. The significant need for these services to be continued in the long-term, echoed by all partners, will place increasing demand on an ever-shrinking pot of resources. This challenge will be exacerbated in the coming months by the need for winterization activities and the on-going fuel crisis, presenting serious concerns regarding the delivery of SRH and GBV services to meet the needs of women, adolescents and youth.

The monsoon season and the change in weather impacted negatively those still residing in the displacement sites. As of March 2016, around 60,000 people were still accommodated in many displacement sites (as per IOM data), 91% of sites reported of not having adequate lighting at nighttime, resulting in an increased risk of GBV for women and girls (although some improvement was seen in the availability of separate latrines and bathing areas within the sites). In 50% of sites women and girls did not have access to feminine hygiene products, nor did they have any kind of referral system for GBV survivors.

In 37% of sites women reported having no access to antenatal care, however perhaps more poignant is the continued challenge in incorporating data collection on specific information on the availability of SRH services, such as availability of contraception, STI treatment and post-rape kits.

Given that UNFPA continued to support six FFSs beyond December 2016, it purchased six thermal tents to provide protection and shelter during the winter season.

In addition to these issues, UNFPA had to face important logistical challenges associated with the large volume of procurement, delays in the arrival of essential supplies - due to customs clearances - and their transport to hard to reach areas as a result of the geographical complexity of the terrain. The rainfalls and landslides of the monsoon season have also hampered access and delivery of supplies to targeted areas. Missions risked being trapped in between landslides or being directly caught by one. The resulting necessary careful planning and precaution often delayed the execution of activities.

Demonstrations in the Terai began at the beginning of August 2015 against the new constitution, with local strikes preventing transport and sporadic violence. The restrictions continued through September, with obstructions at the Indian border preventing fuel and other essential commodities from entering the country through border points with India. This has led to hardship throughout the country, delays in the implementation of earthquake-related activities, reduction to a minimum of monitoring activities and affected the population and the economy in a major way with an estimated 1 million additional poor, skyrocketing inflation and a thriving black market.

15 WAY FORWARD

An adolescent girl collecting data.

The Flash Appeal officially ended on 30 September. However, the response is far from over with many activities continuing given the ongoing needs.

While UNFPA is continuing to work primarily in its 18 districts (which include one of the earthquake affected districts), it is also implementing key activities related to the post-earthquake response in selected earthquake-affected districts, focusing on disaster risk reduction, capacity building on MISP-related areas, GBV response through CMR and service provision through the FFSs.

However, additional funds would need to be raised to fully implement the transition plan put together as part of the recovery phase.

The Country Programme evaluation will further inform the overall direction of the preparedness and recovery and the new Country programme strategies and plans, including shifting district priorities and working modalities.

In addition, UNFPA is undertaking considerable efforts in contingency planning, to ensure the valuable lessons from the earthquake are integrated into preparedness activities.

IMPLEMENTING PARTNERS:

Kits #	Name of RH Kit	Emergency RH kits procured/distributed				Profile of beneficiaries
		Kits Procured	Total Population Covered	Health Facilities benefiting from RH kits	Direct beneficiaries of RH kits	
RH KIT 0	Administration & Training Kit	18	180,000		0	SRH Coordinator and Health Service Providers/Workers
RH KIT 1A	Male Condoms	34.5	345,000		13,800	Sexually active men using condoms
RH KIT 1B	Female Condoms	0	-		-	Sexually active women using female condoms
RH KIT 2A	Clean Delivery - Individual	107	1,070,000		21,400	Pregnant women
RH KIT 2B	Clean Delivery - For Use By Birth Attendants	125	1,250,000		625	Birth Attendants
RH KIT 3	Rape Treatment	68	680,000		4,080	GBV survivors
RH KIT 4	Oral & Injectable Contraception	128	1,280,000		48,000	Women of reproductive age (WRA)
RH KIT 5	Treatment of STI	121	1,210,000		33,275	People with STIs
	Total Block One	**602**	**6,015,000**		**121,180**	
RHKIT6A	Clinical Delivery Assistance - Reusable Equipment	128	3,840,000	128	-	Pregnant women seeking assisted deliveries in health facilities
RHKIT6B	Clinical Delivery Assistance - Drug & Disposable Equipment	128	3,840,000		5,760	Pregnant women seeking assisted deliveries in health facilities
RH KIT 7	Intra Uterine Devices (IUD)	82	2,460,000		1,153	Women of reproductive age (WRA)
RH KIT 8	Management of Complications of Miscarriage	128	3,840,000		7,680	Women with miscarriage or complications from abortion
RH KIT 9	Suture of Tears (Cervical & Vaginal) and Vaginal Examination	128	3,840,000		5,760	Pregnant women seeking assisted deliveries in health facilities
RH KIT 10 A	Vacuum Extraction Delivery - (HM Healthcare model	0	-	-	-	Pregnant women seeking assisted deliveries in health facilities
RH KIT 10 B	Vacuum Extraction Delivery (model Medela)	75	2,250,000	75	-	Pregnant women seeking assisted deliveries in health facilities
	Total Block Two	**669**	**20,070,000**		**20,353**	
RH KIT 11A	Referral Level for RH - Reusable Equipment	13	1,950,000	13	-	Pregnant women and complicated deliveries in health facilities
RH KIT 11B	Referral Level for RH - Drugs & Disposable Equipment	13	1,950,000		1,365	Pregnant women and complicated deliveries in health facilities
RHKIT12	Blood Transfusion	9	1,350,000		945	Pregnant women and complicated deliveries in health facilities
	Total Block Three	35	1,950,000		2,310	
	Grand Total	**1,306**	**28,035,000**	**216**	**143,843**	

No.	Code	Indicators	Actual
SEXUAL AND REPRODUCTIVE HEALTH			
1	RHEQ_P1	No. of RH camps conducted	132
2	RHEQ_P4	No. of individual maternity tents/units set up and operationalized (excluding MCKs)	43
3	RHEQ_P5	No. of transition homes set up for pregnant and postpartum women in targeted affected districts	14
		No. of pregnant and postpartum women accessing services through TH/Mt	1,127
4	RHEQ_P6	No. of maternity units set up as a part of WHO Medical Camp Kit (MCK) to revitalize Reproductive Health services	37
RH CAMP SERVICES			
5	RHEQ_P7	No. of total service provided to affected populations with SRH, GBV, FP, Other (DK, IEC/Awareness raising, PSC, General health) services through RH camps	104,740
		Women and girls	89,241
		Men and boys	15,499
	RHEQ_P8	No. of Family Planning (FP) Service users through Mobile RH camps	10,199
		Women and girls reached	8,679
		Men and boys reached	1,520
	RHEQ_P8	No. of affected population reached with Other services (General health care services, IEC Dist/Awareness Sessions, DK Distribution, Others) through mo-	57,980
		Women and girls reached	46,470
		Men and boys reached	11,510
	RHEQ_P8	No. of affected population reached with SRH services through RH camps	33,762
		Women and girls reached	31,590
		Men and boys reached	2,172
	RHEQ_P8	No. of affected population reached with GBV services through RH camps	2,799
	RHEQ_P9	No. of complicated cases referred for CEmoNC services from RH camps	4
RH KIT DISTRIBUTION			
6	RHEQ_P2	RHEQ_P2: No. of partners, other than IPs and EQ affected district health facilities provided with RH KITs (disaggregated by types particularly post-rape treatment kit)	1,331
		UNFPA Ips	646
		Distribution Status beyond IP: DHO	186
		Distribution Status beyond IP: UN, I/NGO, Private, Comm. Hospital, OCMCs	499
CAPACITY BUILDING			
7	RHEQ_P3	No. of HW oriented on RH kits	163
		No of Youth Facilitators, Volunteers Trained / Mobilized	491
ASRH AWARENESS RAISING (OUTSIDE RH CAMPS)			
		No. of adolescents and young people (10-24 yrs.) reached with ASRH awareness-raising sessions, IEC materials (outside RH Camps)	4,231
	RHEQ_P10	No. of affected population reached with awareness-raising sessions, IEC materials on SRH and GBV through mobile RH camps	8,782
RADIO MESSAGING			
8	RHEQ_P11	No. of episodes airing SRH, GBV and ASRH messages in local FM radios	7,803

No.	Code	Indicators	Actual
		GENDER-BASED VIOLENCE	
FEMALE-FRIENDLY SPACE			
9	GBVEQ_P1	No. of female-friendly spaces (FFS) established	14
10	GBVEQ_P3	No. of affected women and adolescent girls in targeted districts accessing female-friendly spaces	66,712
		Psychosocial Counselling	5,251
		DK Distribution	4,674
		Awareness-raising	46,971
		Case Management	113
		Recreational	6,962
		Referral	812
		Shelter	684
		Others	1,245
		Women (25-49) reached	*34,397*
		Young Women (20-24) reached	*9,266*
		Adolescent girls (15-19yo) reached	*23,049*
		No of women and adolescent girls reached with awareness raising on SRH, GBV through FFS Outreach activities	80,625
11	GBVEQ_P7	No. of adolescent girls, women, survivors of GBV reached with psychosocial counselling services	15,357
		RH Camp	9,033
		FFS	5,251
		PFA Volunteer, Outreach Workers	1,084
12	GBVEQ_P6	No. of reported rape cases receiving post-rape care within 72 hours from RH camps, OCMC, etc.	
		No. of GBV cases referred for multi-sectoral services (only for GBV survivors that were provided services in FFS by PSC, CM and Outreach workers) Total No of GBV cases recorded through FFS-GBVIMS: 674 (Jan-July 2016 from 6 FFS)	654
DIGNITY KIT DISTRIBUTION *(inside and outside FFS)*			
13	GBVEQ_P2	No. of dignity kits distributed to female vulnerable groups	55,151
		FFS	4,674
		RH Camp	5,630
		Outreach	0
		Outside FFS and Outside RH Camp, beyond IP	44,847
RH KIT DISTRIBUTION			
14	RHEQ_P2	No. post-rape treatment kit (RH Kit 3) provided in RH camps and OCMC	74 (6 prepositioned)
CAPACITY BUILDING			
15	GBVEQ_P4	No. of health service providers trained, oriented to implement GBV Response and Clinical management of Rape	262
16	GBVEQ_P5	No. of trained psychosocial counsellors, case managers, and PFA volunteers in place for the provision of services	105
		Psychosocial Counselors	12
		Case Managers	14
		PFA Volunteers	79