UNITED NATIONS POPULATION FUND

NEPAL EARTHQUAKE

100 DAYS INTO THE HUMANITARIAN RESPONSE

INDEX

LIST OF ACRONYMS

ADRA	Adventist Development and Relief Agency.	**JPHIEGO**	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	Canada's Civilian Reserve.	**OCHA**	Office for the Coordinaton of Humanitarian Affairs.
CERF	Central Emergency Response Fund.	**OCMC**	One Stop Crisis Management Center.
CM	Case Manager.	**PDNA**	Post Disaster Needs Assessment.
CMR	Clinical Management of Rape.	**PFA**	Psychosocial First Aid.
CVICT	Center for Victims of Torture.	**PSC**	Psychosocial Counselor.
DFID	Department for International Development.	**REDR**	Register of Engineers for Disaster Relief (former title)
FFS	Female Friendly Space.	**RH**	Reproductive Health.
FCHV	Female Community Health Volunteer.	**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.	**UNRC**	United Nations Resident Coordinator.
HIV	Human Immunodeficiency Virus.	**WASH**	Water, Sanitation and Hygiene.
IEC	Information, Education and Communication.	**WOREC**	Women's Rehabilitation Center.
IOM	International Organization for Migration.	**WHO**	World Health Organization.
IP	Implementing Partner.	**WFP**	World Food Programme.

NEPAL EARTHQUAKE
HUMANITARIAN RESPONSE

1. EXECUTIVE SUMMARY

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HUMANITARIAN RESPONSE REPORT

(as of 19th August 2015)

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 | CENTRAL EMERGENCY RESPONSE FUND United Nations | OCHA

In the immediate aftermath of the earthquake on 25th April 2015, the United Nations Population Fund (UNFPA), 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 population in the 14 most-affected districts to deliver adolescent sexual and sexual reproductive health (ASRH/SRH) services and to prevent and respond to gender-based violence (GBV). UNFPA's integrated RH and GBV response focused on conducting mobile reproductive health camps (mobile RH camps), supporting female-friendly spaces (FFS), delivering dignity kits, providing life-saving reproductive health supplies (RH Kits) and building the capacity of health service providers. 100 days into the earthquake response, many urgent needs have been met, however UNFPA continues to work in the 14 most-affected districts in support of vulnerable women and girls.

891 RH kits delivered to health care providers in **14** affected districts to cover over **115,000** individuals over a period of **3** months	**56,000** dignity kits and motivational packages are being distributed to earthquake affected women and adolescent girls in **14** affected districts	Nearly **4,500** affected people accessed family planning services through mobile RH camps in **12** districts	Over **9,000** women and adolescent girls accessed **14** female friendly spaces established and operational in **13** districts
Almost **22,000** affected persons reached with sexual and reproductive health services with mobile RH camps; 70% were women and adolescent girls	Close to **1,500** youths (10-24 years) reached with adolescent sexual and reproductive health awareness-raising sessions	Over **8,000** women and adolescent girls reached with psychological counseling, case management and psychological first aid	**61,000** sexual and reproductive health, gender-based violence, family planning and other services (including general health) were provided through mobile RH camps in **14** affected districts; 30% of the services provided to women and adolescent girls
24 maternity units as part of medical camp clinics set up by WHO for seriously or partially damaged health facilities	**27** transition homes and maternity tents established providing temporary shelter and services for pregnant and postpartum women and their newborns	**181** youth volunteers and female community health volunteers trained on adolescent sexual and reproductive health to conduct awareness-raising sessions on SRH/GBV issues	**130** health services providers trained in clinical management of rape and gender based violence response, **105** on RH kits and **91** trained as psychosocial counselors and case managers

2. BACKGROUND

The 7.8 magnitude earthquake that hit Nepal on 25 April 2015 and the numerous aftershocks that followed – including one measuring 7.3 – 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.

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. 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. 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 and 1,000 to 1,500 at risk of pregnancy related complications requiring emergency obstetric care.

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 Minimum Initial Service Package (MISP), around 28,000 women would have required post-rape treatment.

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 a 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

Prevention & Response to gender-based violence

Figures and map as of 20 August 2015.
Data from the Health Management Information System.
Map boundaries do not imply endorsement or acceptance by the United Nations.

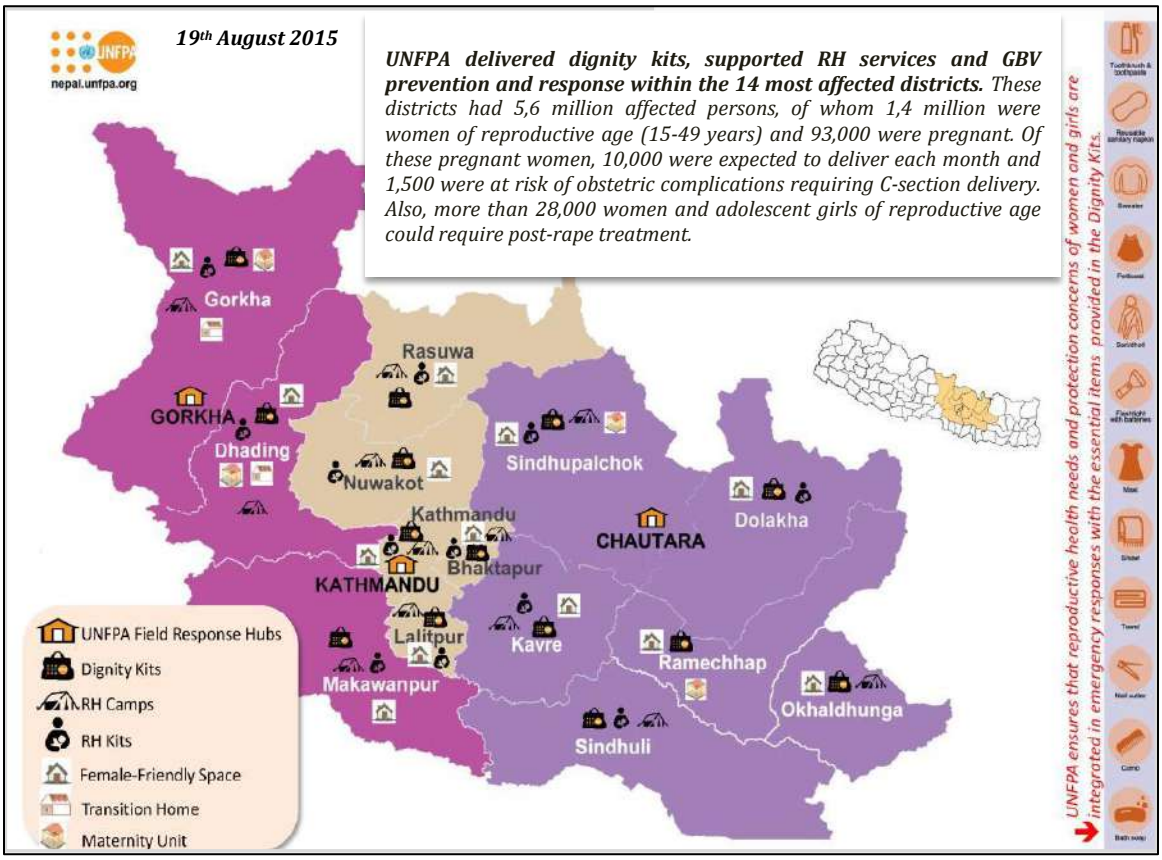
3. UNFPA STRATEGY

The UNFPA response to Nepal's earthquake targeted women and girls in the 14 most affected districts. It aimed to effectively provide the MISP for RH, a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce Human Immunodeficiency Virus (HIV) transmission; prevent excess maternal and newborn morbidity and mortality; plan for comprehensive RH services and making contraceptives available to meet demand.

UNFPA implemented the emergency response under the overall leadership and in close coordination with the Ministry of Health and Population 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 also helped ensure proper integration of RH and GBV interventions.

In articulating its strategy, UNFPA took as its guiding principle the concept of "Dignity First". 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. The campaign aimed to remind actors in the humanitarian community that women and girls deserved special attention, that their dignity needed to be preserved and respected.

To help ensure that gender, RH, and related issues were adequately addressed in the recovery phase, UNFPA was also actively involved in inter-agency and government led assessments, including the Post Disaster Needs Assessment (PDNA) *(see page 19).*



Geographical coverage of RH/GBV interventions of UNFPA's humanitarian response to Nepal's earthquake in the 14 most affected districts, namely: Bhaktapur, Dhading, Dolakha, Gorkha, Kathmandu, Kavrepalanchowk, Lalitpur, Makwanpur, Nuwakot, Okhaldhunga, Ramechhap, Rasuwa, Sindhuli and Sindhupalchowk.

4. REPRODUCTIVE HEALTH RESPONSE

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.

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MINIMUM INITIAL SERVICE PACKAGE FOR REPRODUCTIVE HEALTH CRISIS

1. *Coordinate the RH response.*
2. *Prevent sexual violence and assist survivors, including clinical management of rape (CMR) and identification of multi-sectorial referral pathways.*
3. *Reduce transmission of HIV.*
4. *Prevent excess 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 and visibly pregnant women)*
5. *Plan for comprehensive RH services, integrated into primary health care.*

Additional priorities

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

Registration during a mobile RH camp prior to being referred to SRH and/or GBV services as needed.

CONDUCTING LIFE-SAVING ACTIVITIES: MOBILE REPRODUCTIVE HEALTH CAMPS

61,000 SRH, GBV, family planning and other services (including general health) provided with mobile RH camps in 14 districts; 80% of the services provided to women and adolescent girls.

In the aftermath of the earthquake disaster UNFPA worked alongside district health officers and various partners to support mobile RH camps in the most affected districts, reaching primarily remote areas where access to health facilities was difficult. These camps – lasting on average three days – were carried out by a team of health professionals and provided life-saving healthcare support ranging from antenatal and postnatal checkups, safe delivery, family planning, essential drugs, lab testing facilities including for HIV, management of STIs, psychosocial support, health response to GBV and referrals.

women and girls. In addition, there were dedicated corner for adolescents as well.

Advanced information on the camps was disseminated through local FM radio and through outreach from local health offices and Female Community Health Volunteers (FCHVs). In close coordination with the Ministry of Health and Population, UNFPA and its partners provided **61,000 SRH, GBV, family planning and other services (including general health) with mobile RH camps in 14 districts; 80% of the services provided were to women and adolescent girls.** Mobile RH camps were also part of the **"Dignity First" campaign** launched by the Government and UNFPA. "Dignity First" advocates for women and girls not to be forgotten during the relief and recovery phases and encompasses UNFPA's lifesaving interventions to restore the dignity of earthquake-affected women *(see page 13).*

UNFPA's mobile RH camp in Rasuwa district (top and bottom page).
Implementing Partners: ADRA, CARE, District Health Office (Sindhuli), FPAN and MIDSON.

UNFPA conducted a series of other life-saving initiatives. For instance, UNFPA is supporting District Health Offices in the 14 most affected districts to **rehabilitate 80 damaged birthing facilities.** This included provision of RH kits, furniture and other essential instrument/equipment and supplies including delivery tables, instrument trolleys, IV stands and examination lights. Additionally, in sites that have been seriously damaged by the earthquake, UNFPA provided **118 tents** to District Health Offices for FFFs, maternity units, mobile RH camps and transition homes. **24 sites** were supported in collaboration with AmeriCares, FairMed, IOM, UNICEF and WFP as part of the **Medical Camp Kits (MCKs)**. UNFPA also established **21 transition homes in 5 districts** to provide temporary shelter where pregnant women with or without obstetric complications and post-natal mothers (and their babies) are cared for before they are ready to safely return to their community.

UNFPA also collaborated closely with the **Female Community Health Volunteers (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 community people with support from health workers and health facilities At present there are 51,470 FCHVs (47,328 FCHVs at rural/Village Development Committee level and 4,142 at urban/municipality level) actively working all over the country. In the 14 hardest hit districts, the earthquake has affected 10,327 FCHVs directly or indirectly.

In addition to working alongside them to promote the RH mobile camps, UNFPA provided 'motivational packages' to almost **3,000 FCHVs in 3 districts**. The content of the package - including a solar lamp, hygiene items, clothes, medicines and other basic supplies – 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.

UNFPA's maternity tents established within a medical military hospital (top left page).
UNFPA supported Female Community Health Volunteers (top and bottom page).

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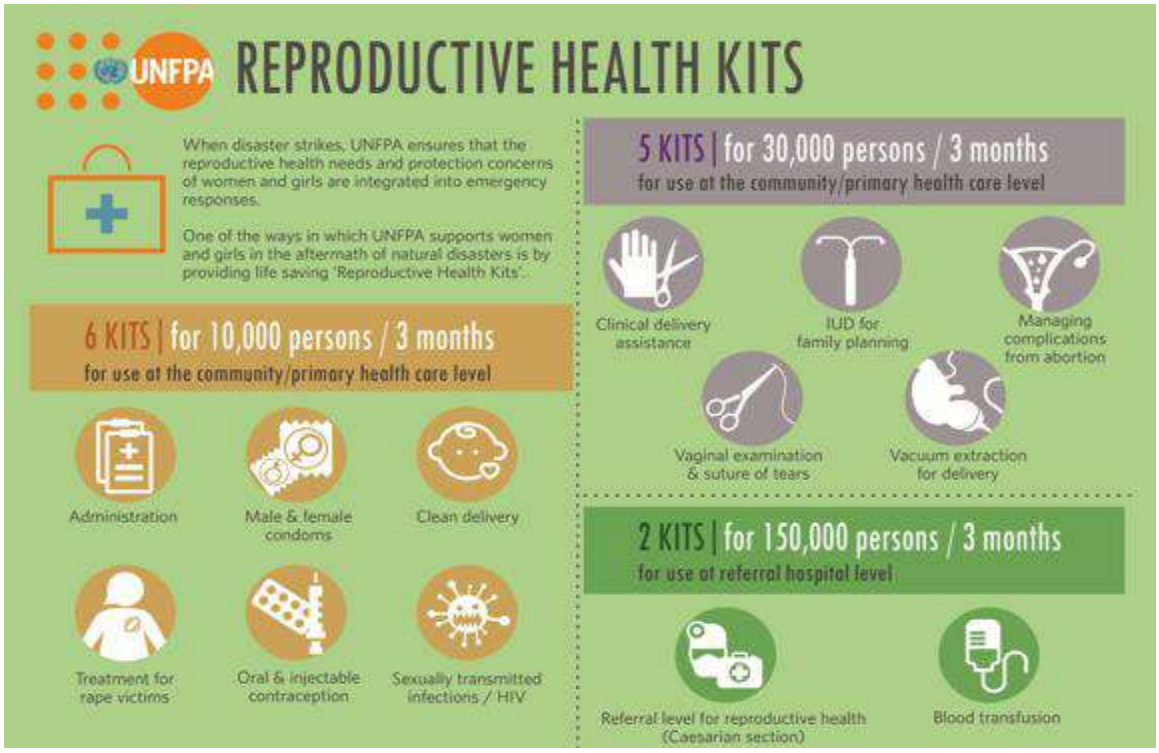
DELIVERING EMERGENCY LIFE-SAVING REPRODUCTIVE HEALTH SUPPLIES

Emergency reproductive health supplies (891 RH kits) delivered to health care providers/facilities in 14 affected districts to cover an estimated 115,000 affected population over a period of 3 months.

Following the earthquake many health facilities were damaged or destroyed. 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 National NGOs active in this field. These prepackaged kits included equipment and supplies containing clean individual delivery kits, contraceptives, equipment, drugs and supplies for STIs treatment, clinical delivery assistance kits 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 technical orientation on monitoring and 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 **891 RH kits** *(see Annex I)* and **trained 105 health care service providers** on their use, covering more than **115,000 individuals** over a period of **3 months** in all **14 most affected districts**. In addition **47 Post-rape treatment kits** were also provided to One Stop Crisis Management Centers (OCMCs), district hospitals and national partners. They are designed to manage the immediate consequences of sexual violence. Each kit 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 130 health care personnel on the clinical management of rape**.



Beneficiaries displaying UNFPA's clean delivery kits (top page). Info-graphic of UNFPA's RH Kits (bottom page)
Implementing Partners: ADRA, CARE, District Health Office (Sindhuli), FPAN and MIDSON.

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ADOLESCENT & SEXUAL REPRODUCTIVE HEALTH CARE SERVICES FOR YOUNG PEOPLE

181 youth facilitators trained and close to 1,500 youths (10-24 years) reached with adolescent sexual and reproductive health awareness-raising sessions in 14 districts.

UNFPA 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, including them as volunteers and peer educators.

In the most-affected 14 districts, young people were mobilized in the areas where UNFPA-mobile RH camps were organized, dignity kits distributed and FFSs were set up.

UNFPA also arranged adolescent friendly corners in its mobile RH camps with trained youth staff in order to create an appropriate environment to provide ASRH information and services tailored to their needs. 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 hygiene, consequences of unsafe abortion, GBV and risk of STIs, HIV and AIDS. UNFPA trained over **180 youth facilitators and volunteers** who conducted ASRH raising awareness reaching over **1,500 youths** with ASRH and GBV messages, in addition to those boys and girls reached within the mobile RH camp facilities.

Youth volunteer interacting with affected population (top page) and adolescent friendly corner (bottom page). Implementing Partners: ADRA, CARE, CVICT, District Health Office (Sindhuli), FPAN, MIDSON, and WOREC.

5. PREVENTION & RESPONSE TO GENDER BASED VIOLENCE

UNFPA's response focused both on prevention and response to GBV in the 14 affected districts identified by the Government. 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, referral systems and prevention initiatives within an integrated RH/GBV humanitarian response.

GBV is a sensitive and very underreported issue. Where adequate services are lacking or non-existent. GBV survivors 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 CMR was a cornerstone of UNFPA's GBV programme, as well as that of the GBV Sub-cluster. Additionally, activities aimed at preventing GBV, providing accurate and timely information and a safe space as well as psychosocial support and referrals, were priority too.

GBV RESPONSE PRIORITY ACTIONS

1. *Establish referral systems and pathways at the local level to ensure survivors can access essential services.*
2. *Produce and distribute referral cards with essential referral information and protection messages.*
3. *Document GBV cases using the Gender Based Violence Information Management System (GBVIMS) and train case managers in safe/ethical GBV data management.*
4. *Support the development of GBV action plans (which feed into overall protection plans) at district level.*
5. *Develop and disseminate GBV advocacy notes for use of all cluster members in ensuring the partners and donors understand the imperative of GBV in emergencies, particularly in the aftermath of the crisis.*
6. *Develop and disseminate messages on GBV prevention and response to be aired on FM radios at the district level, in local languages, providing life-saving information about rights, vulnerabilities and risks as well as existing services for survivors.*

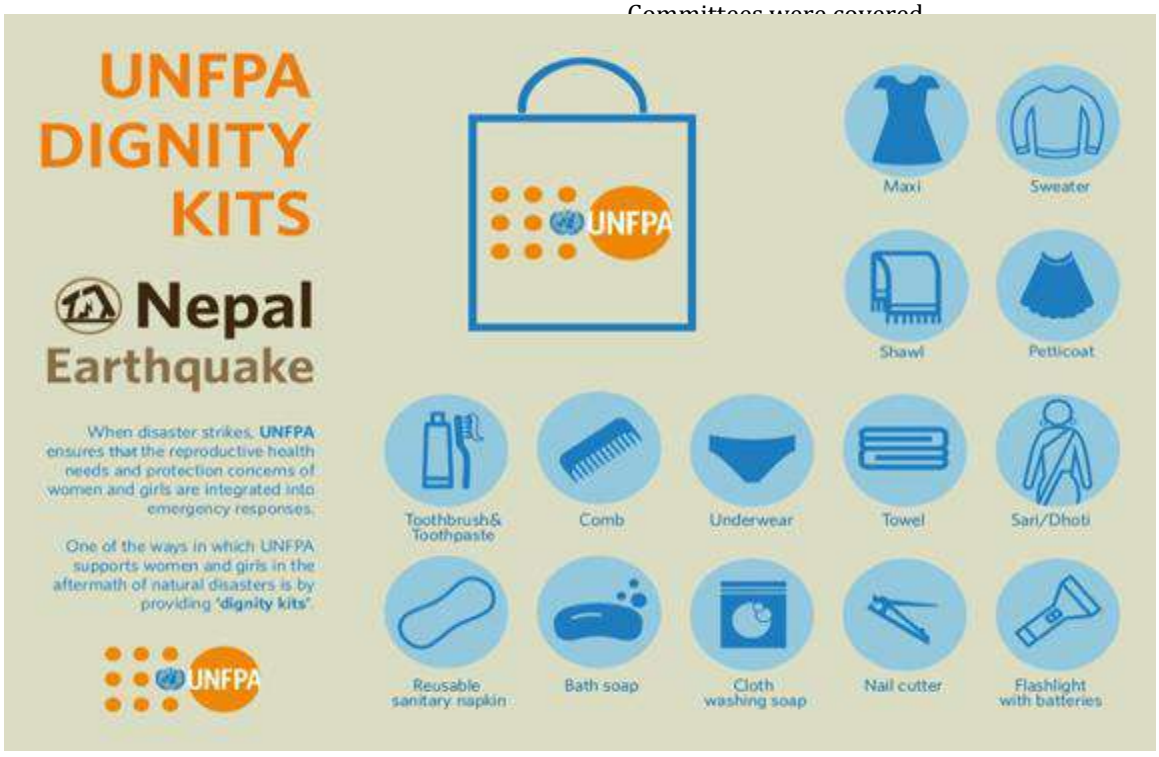
Women and adolescent girls attending an integrated SRH/GBV awareness raising session.

THE RIGHT TO DIGNITY FOR WOMEN AND ADOLESCENT GIRLS

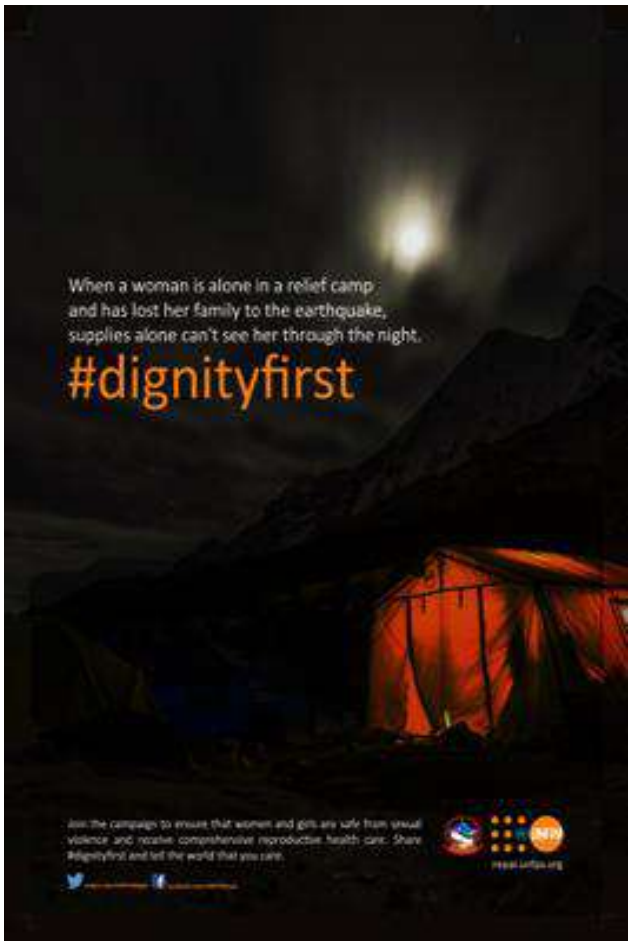
Almost 56,000 dignity and motivational kits procured and distributed to women and adolescent girls.

The provision of dignity kits is an essential component of UNFPA's humanitarian response. Dignity is a right; it cannot be provided in a kit. 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 – 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 is **distributing approximately 56,000 dignity and motivational kits in the worst affected districts including 3000 for FCHVs.** 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 Nepal's sociocultural 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 (co-led by UNFPA) to ensure that the most affected Village Development Committees were covered.



Dignity kits on display during the launch of the Dignity First campaign (top page). Info-graphic of UNFPA's Dignity kits (bottom page). Action Works Nepal (AWON), ADRA, CARE, CVICT Department of Women and Children District Health Office (Sindhuli), Federation of Business & Professional Women, FPAN Greentara GOAL, HERD, Hillary Foundation, Kamdhenu Association, Ministry of Women Children and Social Welfare, Ministry of Health and Population, Mission East, MIDSON, Nepal Red Cross Society, Planet Enfant, Relief Trust Fund



In a joint effort with the Nepalese 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 the UNFPA's Representative for Nepal, Giulia Vallese, jointly launched the campaign by pronouncing "Dignity First" and its Nepali version "Vipatma parda jahile; Mahila ko maryada pahile".

Affected women with their newborns and dignity kits (bottom page)

MULTI-SECTORAL RESPONSE TO GENDER BASED VIOLENCE: FEMALE FRIENDLY SPACES

14 Female friendly spaces established and accessed by over 9,000 women and adolescent girls in 13 districts.

UNFPA supported a multi-sectoral response to GBV through the establishment and operationalization of **14 FFSs in 13 districts out of the total 83 supported by the GBV Sub-cluster**. Located within a short distance from health facilities and/or next to child friendly spaces, FFSs provide a multi-sectoral response and referral services to GBV survivors as well as guidance on SRH services. FFSs supported 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 **12 psychosocial counselors (PSC)**, **14 case managers (CM) and 65 psychosocial first aid volunteers (PFA)**. In total, mobile RH camps and FFSs provided **psychosocial support to over 8,000** earthquake-affected women and adolescent girls including survivors of GBV in **13** districts. **68 survivors of GBV were referred** for various multi-sectorial services from 10 earthquake-affected districts. In addition, FFSs also served as an entry point for distributing dignity kits.

UNFPA's multi-sectoral response to GBV was linked with its mobile 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 130 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.

Affected women and adolescent girls in UNFPA's FFSs (top and bottom page)
Implementing partners: CARE, CVICT, FPAN, Women Health Office (Sindhuli) and WOREC.

CLINICAL MANAGEMENT OF RAPE

It is demonstrated that in the aftermath of a crisis GBV, in particular sexual violence, tend to increase. Rape is a form of sexual violence, a public health problem, a human rights' violation and a traumatic experience, both emotionally and physically. Prior to the earthquake and as part of its regular programme UNFPA was actively involved in providing a health response to GBV as well as strengthening a multi-sectoral coordinated approach to GBV. As part of its programme, UNFPA had supported the development of a clinical protocol on GBV, which was being finalized when the earthquake struck. That was to be followed by the development of a competency-based training package. As part of the earthquake response, UNFPA supported survivors of rape and other forms of violence through SRH services, psychosocial support, prevention and management of pregnancy and STIs and referrals to safe spaces.

In addition of using the clinical protocol, UNFPA supported a series of orientation sessions for implementing partners 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.

A three days training of trainers workshop will take place in Kathmandu, followed by district level trainings to doctors, nurses and paramedics in the 14 most affected districts.

Women and girls attending health education sessions at a UNFPA-supported RH camp and FFS (top right and bottom page). ADRA, FPAN and the Family Health Division carried out the orientation on CMR during the emergency. The Population Division under the Ministry of Health and Population led the development of the clinical protocol with technical support from JHPIEGO and UNFPA, while the National Health Training Centre and JHPIEGO are developing the competency based clinical training package.

6. REPRODUCTIVE HEALTH SUB-CLUSTER

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 leads 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, providing quality of care in accordance with national standards and protocols.

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.

Pregnant woman undergoing an ultra-sonogram (USG) at one of UNFPA's mobile RH camps.

7. GENDER BASED VIOLENCE SUB-CLUSTER

Under the direction of the Department of Women and Children, UNFPA co-led the GBV Sub-cluster both at the central level and in the two humanitarian hubs at Gorkha and Sindupalchowk (Chautara). The Sub-cluster coordinated the GBV humanitarian response in the 14 most affected districts. The Sub-cluster mapped available services at district level in all 14 districts, and identified gaps in service delivery. This enabled partners to focus more effectively on the Village Development Committees where services and support were needed most. Using the protection mechanisms at district level, the Sub-cluster helped to ensure that cases of GBV were followed up and that survivors were treated with respect and confidentiality.

Additionally, the Cluster developed protection messages to be aired on national and local radio about where to seek services, prevention and response to trafficking and GBV. The Government endorsed these messages as well as other related M&E tools and referral guidelines. In addition, the GBV Sub-cluster used the GBV Information Management System (GBVIMS) that had been re-launched in 2014 by the National Women Commission and already used by a number of service providers from different partners to collect, store, analyze and to enable the safe and ethical sharing of reported GBV incident data for broader trends analysis and improved GBV coordination

In line with the Inter Agency Standing Committee guidelines outlining procedures for providing an integrated humanitarian response, the Sub-cluster advocated for gender, protection and GBV mainstreaming across the clusters, in partnership with the larger Protection Cluster and the Gender Working group. Furthermore, links were strengthened with the education, shelter, nutrition, food security and WASH Clusters, enabling an integrated response that considered and prioritized the different needs of men, women, boys and girls.

Women and adolescent girls attending raising awareness sessions on prevention and response to GBV (top and bottom page)

8. OTHER ACTIVITIES

In addition to its field based and coordination interventions, UNFPA also reached out to the most vulnerable affected population by **airing radio messages related to SRH, GBV and ASRH** on **18 local 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 UNFPA's interventions can be viewed or read on nepal.unfpa.org, facebook.com/UNFPANepal, twitter.com/UNFPANepal and youtube.com/UNFPAinNepal/videos.

UNFPA has also played an active role ever since the **Communicating with Communities** group was formed under OCHA's 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 UNFPA's focus areas.

Engaging scouts to communicate with communities

*As part of communicating with the earthquake affected communities, **UNFPA trained 75 members of Nepal Scouts** out of over 57,000 volunteers that the groups has all across Nepal (of which around 60% were originally from the most affected districts). Keeping in mind the increasing risks of several forms of violence which many displaced women and girls are facing in the current situation, the training was, among other things, on enhancing their skills and knowledge to prevent and respond to GBV.*

UNFPA trained Nepal Scout members in the framework of the CwC initiative.

9. POST DISASTER NEEDS ASSESSMENT

The key objective of the Post Disaster Needs Assessment (PDNA) was for the Government of Nepal to assess the impact of the earthquake and define a recovery strategy – 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 with the participation of various ministries, 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 children's 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 of the most affected districts to collect primary data related to impact on human development from about 400 affected households.

What did it achieve?

UNFPA's 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 PDNA's i) assessment of the damage and recovery needs in affected areas, ii) the socio-economic analysis of the impacts of the earthquake, iii) the summary of priority recovery and reconstruction needs in the short and medium term and iv) the long-term recovery strategy which seeks to address these needs, reducing disaster risks and promoting resilience.

Youth enumerator conducting a focus group discussion with women and adolescents in a displaced camp (top left)
Youth enumerator interviewing a household female member in a displaced camp in (medium right)
UNFPA staff in a field monitoring visit during the PDNA field survey (bottom left)
Data collection training to youth enumerators before departure for a field survey (bottom right)

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.

Storage of dignity kits and UNFPA supplies prior to transporting them to targeted locations.

11. MONITORING & EVALUATION

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. An impact evaluation is planned for the end of 2015, with the results feeding into the overall Country Programme Evaluation. The evaluation will be conducted in close coordination with the UNFPA Evaluation Office and UNFPA's Asia Pacific Regional Office. Additional personnel were also deployed to support the work of the

country office. 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 **42 surge personnel,** of which 16 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 Coordinator's 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 & PARTNERS

UNFPA'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. UNFPA received funding from CERF (Central Emergency Response Funds), 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 the Global Programme on Reproductive Health Commodity Security and the 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 are being 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 over 1,000 LuminAids - solar-powered, inflatable lights that pack flat and inflate to create a lightweight, waterproof lantern - and 1,250 Waka-Wakas, which consist of solar powered devices that provide light and power.

Partners from "Midwives for a better tomorrow "attending a woman with her newborn.

CONTRIBUTIONS MOBILIZED FOR THE EARTHQUAKE RESPONSE	USD
JAPAN	1,000,000
UNITED KINGDOM (DFID)	777,604
CENTRAL EMERGENCY RESPONSE FUND	753,815
EMERGENCY RELIEF FUND	605,000
GLOBAL PROGRAMME ON REPRODUCTIVE HEALTH COMMODIY SECURITY	500,000
AUSTRALIA (DFAT)	401,606
SWITZERLAND (EMBASSY OF NEPAL)	273,972
GERMANY (GIZ)	113,244
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	41,010
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	4,822,928

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

UNFPA will continue to work closely with the Ministry of Health and Population 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 approach 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, engagement with youth networks is helping to increase the reach of UNFPA's 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.

Earthquake affected woman and her newborn being attended at one of UNFPA's mobile RH camps.

13. LESSONS LEARNED

Packaging of UNFPA's dignity kits for earthquake-affected populations.

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 of 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 capacities 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 UNFPA's ***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 UNFPA's ***dignity kits*** according to Nepal's sociocultural context. Hence, the kits included new items such as a sari, petticoat and shawl, or kurta, which are considered important supplies by 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 in the early days of the response. It became helpful to have a physical item for distribution as it facilitated dialogue around other interventions such as referral pathways and strengthening of the CMR

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 generated by the earthquake, prepositioning becomes crucial. For instance, UNFPA had already prepositioned ***life-saving reproductive emergency health supplies with support from the Australian Government and*** was able to deploy these rapidly, order many more and distribute them to numerous partners from the RH Sub-cluster, including the Ministry of Health and Population.

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 complications 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 'evidence' of 'sufficient' number of cases to justify investment in service delivery. Training humanitarian actors on these issues prior to a future emergency will be helpful, as this issue takes up a lot of the time in the early days of the crisis.

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 the women who came to the FFSs with GBV cases had experienced GBV 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. 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 local government/NGOs, who could own them and pay for the services.

The need to establish links with ***livelihoods programming*** becomes increasingly apparent as time goes on, and some women desperately need alternatives to returning home. Many of Nepal's 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 there is a **need to develop more visual materials** to explain the content and use of the RH kits. Furthermore, they should be opened and their content explained systematically to partners receiving it.

Earthquake-affected women supplied with UNFPA's sanitary pads.

14. CHALLENGES

In a context of reduced funding for SRH and GBV and an increasing focus on physical rehabilitation and construction, addressing the SRH specific needs of women, adolescents and youth and preventing and responding to GBV will remain a challenge in the months to come.

Though the Government stated that the relief operations were over as of 22nd June and that recovery led activities would be scaled up, it is estimated that 2.8 million people are still in need of vital humanitarian assistance. People are still arriving in displacement sites and the number of those settling in spontaneous sites (over 117,700 already) is expected to further increase as a result of the monsoon season. An IOM assessment of 77 spontaneous displacement sites of more than 50 households (i.e. survey of approximately 49,000 people including over 7,000 each in Bhaktapur, Kathmandu and Nuwakot) found that only 43% of sites had access to health services and that over 45% of sites reported that women did not feel safe. The PDNA concluded that basic health services including programmes for safe motherhood, medical care, prevention and treatment of communicable diseases and child and neonatal services were affected. The Ministry of Health and Population confirmed that several development goals in the health sector were likely to be derailed having a long-term social and economic impact.

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After the commencement of the new fiscal year in mid-July, it was announced that each Ministry would need to cut their budget by 15% (as opposed to increasing it by 10%). In addition, 50% of the budget was to be allocated to the earthquake-affected districts. Given that 17 out of 18 districts covered by UNFPA's regular programme are not within the most affected ones, UNFPA will need to work closely with local authorities to ensure that related interventions won't be affected.

Within a context of diminishing national funding for SRH and GBV related programmes, the priority accorded to physical rehabilitation and construction represents another challenge in the efforts to address the needs of women, adolescent girls and youth.

Logistical challenges when delivering emergency life-saving reproductive health supplies to affected communities in hard to reach areas.

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 heavy rainfalls and landslides of the monsoon season have also been hampering access and delivery of supplies to targeted areas. Missions risk getting trapped in between landslides or being directly caught by one. The resulting necessary careful planning and precaution often delay the execution of activities.

15. WAY FORWARD

The Flash Appeal will come officially to an end on 30 September. However, the response is far from over. UNFPA will therefore continue to work alongside other actors to review whether new districts are to be covered as part of the 'regular' programme, in which case, additional resources would need to be mobilized. UNFPA, in consultation with the Government, UN Agencies, humanitarian partners and implementing partners, is currently in the process of determining how to move forward in the most coordinated and strategic way. This may include incorporating some of the earthquake-affected districts into the UNFPA country programme and continue certain activities for a time before phasing out and handing over to its partners *(below).*

Delivering UNFPA's emergency life-saving reproductive health supplies to hard to reach areas (top and bottom page)

NEPAL EARTHQUAKE
HUMANITARIAN RESPONSE

ANNEX I. COVERAGE OF EMERGENCY REPRODUCTIVE HEALTH SUPPLIES (as of 19th Aug 2015)

Kits #	Name of RH its	# of kits distributed	Health facilities	Direct beneficiaries	Beneficiaries
KIT 0	Administration & Training kit	**19**		**0**	SRH coordinator and health service providers/workers
KIT 1A	Male Condoms	**25.5**		**10,200**	Sexually active men
KIT 2A	Clean delivery - individual	**79.5**		**15,900**	Pregnant women
KIT 2B	Clean delivery (for use by birth attendants)	**91**		**455**	Birth attendants
KIT 3	Rape treatment	**53**		**3,180**	GBV survivors
KIT 4	Oral & injectable contraception	**110**		**41,250**	Women of reproductive age
KIT 5	Treatment of STIs	**107**		**29,425**	People with STIs
	TOTAL BLOCK I	**485**		**100,410**	
KIT 6A	Clinical delivery assistance - reusable equipment	**95**	**95**	**-**	Pregnant women with assisted deliveries in health facilities
KIT 6B	Clinical delivery assistance - drug & disposable equipment	**95**		**4,275**	Pregnant women with assisted deliveries in health facilities
KIT 7	Intra uterine devices	**78**		**4,680**	Women of reproductive age
KIT 8	Management of complications of miscarriage	**53**		**3,180**	Women with miscarriage or suffering from complications of abortion
KIT 9	Suture of tears (cervical & vaginal) and vaginal examination	**34**		**1,530**	Pregnant women with assisted delivery in health facility
KIT 10	Vacuum extraction delivery	**31**		**279**	Pregnant women with assisted delivery in health facility
	TOTAL BLOCK II	**386**		**13,944**	
KIT11A	Referral level for RH – reusable equipment	**7**	**7**	**-**	Pregnant women and complicated deliveries in health facilities
KIT11B	Referral level for RH - drugs & disposable equipment	**7**		**735**	Pregnant women and complicated deliveries in health facilities
KIT 12	Blood transfusion	**6**		**600**	Pregnant women and complicated deliveries in health facilities
	TOTAL BLOCK III	**20**		**1,335**	
	GRAND TOTAL	**891**	**102**	**115,689**	

ANNEX II. MONITORING & EVALUATION INDICATORS (as of 19th Aug 2015)

SEXUAL AND REPRODUCTIVE HEALTH		
TEMPORARY FACILITIES		
1	**No. of RH camps conducted**	**93**
2	**No. of maternity tents set up and operationalized**	**6**
3	**No. of transition homes set up for pregnant and postpartum women in targeted affected districts**	**21**
4	**No. of pregnant and postpartum women accessing services through transition homes and maternity tents.**	**49**
MOBILE RH CAMP SERVICES		
5	**No. of total services provided to affected populations with SRH, GBV, FP, Other (Dignity kit, IEC/Awareness raising, PSC, general health) through mobile RH camps**	**60,439**
	Women and girls	*49,613*
	Men and boys	*10,826*
6	**No. of FP service users through mobile RH camps**	**4,369**
	Women and girls reached	*3,255*
	Men and boys reached	*1,114*
7	**No. of affected population reached with awareness-raising sessions and IEC materials distributed on SRH and GBV through mobile RH camps**	**4,830**
	Women and girls reached	*3,645*
	Men and boys reached	*1,185*
8	**No. of affected population reached with SRH services through mobile RH camps**	**20,015**
	Women and girls reached	*18,358*
	Men and boys reached	*1,657*
9	**No. of affected population reached with GBV services through mobile RH camps**	**1,972**
RH KIT DISTRIBUTION		
10	**No. of partners, other than IPs and earthquake-affected district health facilities provided with RH kits**	**891**
	UNFPA IPs	*431*
	Distribution Status beyond IP: District Health Offices	*110*
	Distribution Status beyond IP: UN, I/NGO, Private, Comm. Hospital, OCMCs	*350*
CAPACITY BUILDING		
11	**No. of health workers oriented on RH kits**	**105**
12	**No of youth facilitators, volunteers trained / mobilized**	**181**
ASRH AWARENESS RAISING (OUTSIDE RH CAMPS)		
13	**No. of adolescents (10-24 years) reached through ASRH awareness-raising sessions (outside mobile RH camps)**	**1,455**
RADIO MESSAGING		
14	**No. of episodes airing SRH, GBV and ASRH messages in local FM radios**	**5,110**

GENDER BASED VIOLENCE		
FEMALE-FRIENDLY SPACE		
15	**No. of FFSs established**	**14**
16	**No. of affected women and adolescent girls in targeted districts accessing FFSs**	**9,022**
17	**No. of adolescent girls, women, survivors of GBV reached with psychosocial counseling, case management and PFA**	**8,001**
	RH Camp	*4,086*
	FFS	*2,194*
	PFA Volunteer, Outreach Workers	*1,721*
18	**No. of GBV cases referred for services (only for GBV survivors that were provided services in FFS by PSC, CM and outreach workers)**	**68**
DIGNITY KIT DISTRIBUTION *(inside and outside FFS)*		
19	**No. of dignity kits distributed to female vulnerable groups**	**11,268**
	FFS	504
	RH Camp	937
	Outside FFS and Outside RH Camp, beyond IP	9,827
RH KIT DISTRIBUTION		
20	**No. post-rape treatment kit (RH Kit 3) provided in RH camps and OCMC**	**47**
CAPACITY BUILDING		
21	**No. of health service providers trained, oriented to implement GBV response and CMR**	**130**
22	**No. of trained PSC, CMs, and PFA volunteers in place for the provision of services**	**91**
	Psychosocial Counselors	*12*
	Case Managers	*14*
	PFA Volunteers	*65*