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Evaluation of the MISP for Reproductive Health Services in Post-earthquake Nepal

May 2016

WOMEN'S REFUGEE COMMISSION

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The Women's Refugee Commission improves the lives and protects the rights of women, children, and youth displaced by conflict and crisis. We research their needs, identify solutions, and advocate for programs and policies to strengthen their resilience and drive change in humanitarian practice.

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Acronyms & Abbreviations

ARV	Antiretroviral
CDK	Clean delivery kit
CEmOC	Comprehensive emergency obstetric care
CMR	Clinical management of rape survivors
CoC	Code of conduct
DHO	District Health Office
DoHS	Department of Health Services
EC	Emergency contraception
EDRM-H	Emergency and disaster risk management for health
FCHV	Female community health volunteer
FFS	Female-friendly space
FGD	Focus group discussion
FHD	Family Health Division
FPAN	Family Planning Association Nepal
GBV	Gender-based violence
HFA	Health facility assessments
IEC	Information, education, and communication
IAWG	Inter-agency Working Group (on Reproductive Health in Crises)
IUD	Intrauterine device
KI	Key informant
KII	Key informant interview
LGBTI	Lesbian, gay, bisexual, transgender and intersex
MISP	Minimum Initial Service Package
MOH	Ministry of Health
OSCMC	One-stop crisis management center
PHCC	Primary health care centers
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child treatment
RH	Reproductive health
SEA	Sexual exploitation and abuse
SPRINT	Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations
STI	Sexually transmitted infection
UNFPA	United Nations Population Fund

Executive Summary

In April and May 2015, two devastating earthquakes hit central Nepal. More than 5 million people were affected, of whom 1.4 million were estimated to be women of reproductive age. More than 90,000 women were estimated to be pregnant, and 10,300 were expected to give birth over one month. Approximately 4,500 women were predicted to suffer complications from pregnancy and childbirth, and an estimated 28,000 women were presumed to experience sexual violence.

The Minimum Initial Service Package (MISP) is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess newborn and maternal morbidity and mortality; and, plan for comprehensive reproductive health services. Additional priority activities include: ensure contraceptives are available to meet demand; ensure people presenting with symptoms of sexually transmitted infections (STIs) receive treatment; ensure people on antiretrovirals (ARVs), including for prevention of mother-to-child treatment, continue treatment; and address menstrual hygiene.

In September 2015, the Women's Refugee Commission led a mission to Nepal to evaluate the implementation of the MISP in the six months following the earthquake in the capital, Kathmandu, and in Sindhupalchowk, a rural district. The evaluation explored awareness of the MISP; implementation of the standard; and factors that influenced implementation.

The evaluation found that all MISP services and priority activities were largely available in both Kathmandu and Sindhupalchowk. Some services were only partially available based on the availability at a limited number of facilities in the district. Some services, where they were available, were of questionable comprehensiveness/quality. There was a major gap in community knowledge about culturally sensitive reproductive health issues, the benefits of seeking care, and the location of services for sexual violence, STIs, and HIV. Many key informants were not aware of what services were available at each health facility for the comprehensive management of rape (CRM), specifically the use of emergency contraceptives (EC) and post-exposure prophylactics (PEP).

Recommendations

Based on the findings, the evaluation team recommends that the Family Health Division of the Department of Health Services and partners should:

- **Establish a fund to finance emergency preparedness activities, as well as continue emergency preparedness and contingency planning on the MISP** through advocacy with policy makers and training of trainers on emergency and disaster risk management for health personnel, reproductive health (RH) coordinators, managers, and directors. An immediate option is to facilitate strategic dissemination of the MISP module in Nepali.
- **Strengthen RH coordination,** with inclusion of gender-based violence (GBV) and HIV representatives, as well as persons with disabilities and lesbian, gay, bisexual, transgender and intersex (LGBTI), developing more inclusive and participatory approaches in RH coordination meetings. Further, provide a MISP orientation to HIV and GBV staff and strengthen coordination between the sectors, particularly in Sindhupalchowk, to address transitioning to comprehensive RH and for preparedness planning. Communication between national and district levels on roles and responsibilities should also be strengthened from acute emergency response through recovery.
- **Continue to address supply chain challenges for emergency response,** including RH kit logistics through identifying and utilizing a video on the RH Kit contents in all MISP orientations and trainings, and improve commodity forecasting in the stable phase to prevent stock-outs.
- **Strengthen the GBV care and referral systems** through:
  - » scaling up availability of CMR services at health posts;
  - » ensuring organizations that report they provide CMR are able to provide services per the Nepal CMR protocol;
  - » providing whole-site orientation at facilities, inclusive of guards and cleaners, and mandating all staff to sign codes of conduct (CoCs);
  - » informing RH, GBV, and HIV personnel what clinical care comprises and what is part of the RH Kits;
  - » training female providers in CMR with an emphasis on communication and psychosocial support;
  - » strengthening assessments of police and legal systems and their capacity to provide survivor-centered care; and
  - » establishing one-stop crisis management center (OSCMCs) in Sindhupalchowk and services that offer long-term safe shelter and economic support.

Pilot use of social media as a method to inform communities about services.

- **Facilitate activities to prevent maternal and newborn death and disability** through:
  - » enhancing community knowledge around newborn danger signs and how to access free services; improving access to free ambulances to health facilities and stretchers where roads are impassable;
  - » mandating newborn corners in every birthing facility, especially in Sindhupalchowk; and
  - » reducing costs incurred by communities when emergencies occur outside of health posts or primary health care centers (PHCC) working hours, or when complications demand accessing hospitals in other districts.
- **Strengthen HIV prevention and treatment,** particularly safe and rational blood transfusion in Sindhupalchowk, availability of condoms, adherence to standard precautions, and ARV therapy.
- **Improve community awareness** through disseminating information on available services and reduce stigma associated with sexual violence, abortion, and HIV/STIs. Further, improve community knowledge around HIV and STI prevention and treatment services.
- **Ensure culturally appropriate menstrual hygiene products** for communities are available on a long-term basis.
- **Engage at-risk groups and enhance community participation and adolescent-friendly services.**
- **Continue to invest in establishing, monitoring, and supporting good quality comprehensive RH services,** including comprehensive emergency obstetric care (CEmOC), with sufficient numbers of qualified staff for skilled delivery, particularly in Sindhupalchowk. Maintain adequate stocks of contraception, including injectables and implants and provide sustainable funding to local NGOs working with people living with HIV (PLHIV).

Introduction

The two devastating earthquakes of April and May 2015 in central Nepal affected 35 of 75 districts in the country. According to the Government of Nepal, Ministry of Health (MOH), and UNFPA, 5.6 million people were affected within the 14 most impacted districts, of whom 1.4 million were estimated to be women of reproductive age. Ninety three thousand women were estimated to be pregnant,[1] and 10,300 were expected to give birth over one month.[2] Approximately 4,500 women were predicted to suffer complications from pregnancy and childbirth,[3] and, using the MISP calculator,[4] an estimated 28,000 women were presumed to experience sexual violence.[5]

The MISP—a standard of care in humanitarian emergencies—is a coordinated set of priority activities designed to prevent and manage the consequences of sexual violence; reduce HIV transmission; prevent excess newborn and maternal morbidity and mortality; and, plan for comprehensive RH services. Additional priority activities include: ensure contraceptives are available to meet demand; ensure people presenting with symptoms of STIs receive treatment; ensure people on ARVs, including for prevention of mother-to-child treatment (PMTCT), continue treatment; address menstrual hygiene.

To support implementation of the MISP, the Inter-agency Working Group (IAWG) on Reproductive Health in Crises designed a pre-packaged set of Inter-agency RH Kits that contain essential drugs, supplies, and equipment. The 13 inter-agency RH Kits, divided into three blocks that target different health service delivery levels, are intended for the early stage of an emergency.

Purpose of Evaluation

The purpose of this evaluation was to document the implementation of the MISP within six months after the earthquake in one urban district (Kathmandu) and one rural district (Sindhupalchowk). The evaluation explored awareness of the MISP; implementation of the standard; and factors that influenced implementation. The inter-agency evaluation was led by the Women's Refugee Commission, in partnership with

1 Ministry of Health and Population, "Nepal: Update from the RH Sub-Cluster" PowerPoint, May 11, 2015.
2 United Nations Population Fund, Nepal Earthquake 100 Days into the Humanitarian Response (August 27, 2015).
3 Ibid.
4 http://www.iawg.net/resources/calculator.html
5 See note 1.

the Family Health Division (FHD)/Department of Health Services (DoHS) Nepal and the RH Sub-cluster, Boston University School of Public Health/Department of Global Health, Johns Hopkins University School of Public Health, UNFPA Nepal, SPRINT (Sexual and Reproductive Health Programme in Crisis and Post-Crisis Situations) Initiative, and the FPAN. The evaluation was approved by the Nepal Health Research Council.

Methodology

The evaluation assessed the implementation of the MISP for RH using both quantitative and qualitative methods: a document review of secondary data, focus group discussions (FGDs), key informant interviews (KIIs), and health facility assessments (HFAs) with health provider interviews. Thirty-two FGDs were conducted in Kathmandu and Sindhupalchowk among 320 women and men aged 18-24 and 25-49. Twenty-six KII respondents, composed of health, RH, gender-based violence (GBV) and HIV coordinators, managers, directors, and program focal points, were interviewed in the two locations. To assess service availability quality and utilization of RH services, 17 hospitals, primary health care centers (PHCCs), and health posts were assessed in both districts. Health facility assessments consisted of semi-structured face-to-face interviews with one health facility representative and direct onsite observation. Respondents included medical officers, health assistants, nurses, and auxiliary nurse midwives who were in charge of hospitals, PHCCs, and health posts.

Reproductive health supplies for use in the post-earthquake response in Nepal.
© Rosilawati Anggraini, UNFPA

Findings

Overarching concerns and needs

In Kathmandu, FGD participants expressed concern about the distance to health facilities, the limited operating hours at health posts, and the restricted number of available medicines. In Sindhupalchowk, the primary concern was the need for permanent housing with sufficient space for families, and the need for improved living conditions.

GBV: The majority of FGD participants in both districts said that sexual violence did not occur in their communities, and even if violence did occur, reporting would be rare due to subsequent blame and shame. Nevertheless, the majority of RH and GBV key informants (KIs) had heard of incidents of sexual violence post-earthquake, reportedly associated with displacement in the camps. KIs reported that sexual exploitation and abuse (SEA) occurred after the earthquake, compounded by the long-standing issue of trafficking in Nepal. The types of GBV cited by KIs were domestic violence, incest, rape, including gang rape, SEA, and trafficking, particularly among children.

> *"There were rumors in the camp of child trafficking and molestation. It happens to people who have no money and they are poor."*
>
> GBV KI, Sindhupalchowk

HIV: KIs did not directly attribute any cases of HIV to the emergency response practices. However, KIs reported on HIV transmission in the context of the long-standing issue of sex trafficking and the risks it poses to families.

Maternal and newborn health: KIs had heard of a few incidents of maternal death that may have been a result of transportation obstructions. Twice as many KIs had heard of newborn deaths as compared to maternal deaths that occurred after the earthquake. A few FGD participants reported incidents of unsafe abortion, including one that resulted in suicide. In both districts, participants in the HFAs were aware of maternal or newborn deaths that occurred in the setting, although they did not specify the periods when the deaths occurred. HFA participants in Kathmandu and Sindhupalchowk also reported incidents of unplanned pregnancy and unsafe abortion.

Supplies for maternal health care. © Rosilawati Anggraini, UNFPA

Awareness and knowledge of the MISP and additional priority activities

Lead agency representatives from the FHD, Epidemiology and Disease Control Division, UNFPA, UNICEF, and WHO demonstrated high levels of awareness about the MISP, including the objectives and relevant activities for each activity. However, RH and GBV KIs who were not representing a lead agency or other UN agency were aware that MISP is a standard, but were less aware of the objectives and priority activities. Many KIs could cite some but not all activities, such as CMR or making free condoms available. However, they were less aware of ensuring communities are aware of the benefits and location for seeking CMR services; providing safe blood transfusion; and enforcing respect for standard precautions. Many KIs had a limited understanding about what activities are *not* part of the MISP, such as antenatal and postnatal care and cervical cancer screening.

Minimum Initial Service Package (MISP) for Reproductive Health

Additional Priorities

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

Objective 1

Ensure health cluster/sector identifies agency to LEAD implementation of MISP

- RH Officer in place
- Meetings to discuss RH implementation held
- RH Officer reports back to health cluster/sector
- RH kits and supplies available & used

RH Kit 0

Objective 5

Plan for COMPREHENSIVE RH services, integrated into primary health care

- Background data collected
- Sites identified for future delivery of comprehensive RH
- Staff capacity assessed and trainings planned
- RH equipment and supplies ordered

RH Kit 4 | RH Kit 5 | RH Kit 7

Objective 2

Prevent SEXUAL VIOLENCE & assist survivors

- Protection system in place especially for women & girls
- Medical services & psychosocial support available for survivors
- Community aware of services

RH Kit 3 | RH Kit 9

GOAL

Decrease mortality, morbidity & disability in crisis-affected populations (refugees/IDPs or populations hosting them)

Objective 4

Prevent excess MATERNAL & NEONATAL mortality & morbidity

- EmONC services available
- 24/7 referral system established
- Clean delivery kits provided to birth attendants and visibly pregnant women
- Community aware of services

RH Kit 12

RH Kit 2 | RH Kit 6 | RH Kit 8 | RH Kit 9 | RH Kit 10 | RH Kit 11

Objective 3

Reduce transmission of HIV

- Safe and rational blood transfusion in place
- Standard precautions practiced
- Free condoms available

RH Kit 1 | Standard precautions through kits 1-12 | RH Kit 12

MISP Objective 1: Ensure the health cluster/sector identifies an agency(cies) to lead implementation of the MISP

RH coordination: Pre-crisis, a National RH Coordination Committee existed within DoHS with sub-committees for safe motherhood; family planning; adolescent health; and safe abortion care under FHD. As a result of previous emergencies, the cluster system was in place in Nepal, and RH was covered by the health cluster as a standing agenda item. RH coordination at the national level was established through the formation of the RH sub-cluster four days after the earthquake and was led by the Family Health Division (FHD), with UNFPA as co-lead. In Sindhupalchowk, RH coordination was a part of health cluster responsibility initially, with the RH sub-cluster established approximately two months later. Overall, KIs reported that key stakeholders were present in the RH sub-cluster meetings, with the notable inclusion of adolescents.

Minutes from RH sub-cluster meetings were posted to the UN Office for the Coordination of Humanitarian Affairs website through the health cluster. Effective leadership and function of the RH sub-cluster resulted in dedicated funding for programs and commodities and supplies in Kathmandu and Sindhupalchowk. Indeed, the April 2015 flash appeal showed that UNFPA and WHO mounted multi-million dollar requests to support implementation of the MISP and the subsequent contributions from multiple donors for the initial response exceeded US$4.8 million. The Australian government's Department of Foreign Affairs and Trade and the International Planned Parenthood Federation-South Asia Region also provided funding to specifically address RH needs in Nepal through FPAN, IPPF's member association.

"Coordination could be improved through the participation of representatives from other Ministries and sub-clusters to support inter-sectoral coordination, particularly on assessments and information sharing."

RH KI Kathmandu

Coordination of the RH sub-cluster was rated good to excellent by RH KIs and included suggestions for the following: inter-sectoral participation from GBV and HIV; orientations to the MISP; and more inclusion and participation from the FHD, District Health Office (DHO), and the District Women and Children's Office, the lesbian, gay, bisexual, transgender and intersex (LGBTI) community, PLHIV, new local and international NGOs, and the private sector.

GBV coordination: GBV coordination occurred separately, with the Department of Women and Children in the Ministry of Women, Children, and Social Welfare estab-

lishing a GBV sub-cluster under the protection cluster co-led by UNFPA. According to KIs, funding was sufficient in Kathmandu, although less adequate according to local organizations in Sindhupalchowk.

HIV coordination: Unlike RH and GBV, HIV coordination was primarily based on coordination that existed at both the national level and in Sindhupalchowk before the crisis. Although monthly HIV meetings were held in Kathmandu with UNAIDS and a variety of working groups, coordination mechanisms were less clear in Sindhupalchowk. There were reports of limited integration of HIV with RH coordination and vice versa in both Kathmandu and Sindhupalchowk. Local NGOs described an interest to strengthen these efforts.

MISP Objective 2: Prevent and manage the consequences of sexual violence

Prevention: Health facility assessments indicated that slightly more than half of health facilities in Kathmandu and one-quarter in Sindhupalchowk had sex-segregated latrines. In both districts, all latrines in the health facilities locked from the inside. Lighting was not reported as a problem at any health facility. Similarly, no FGD participants in Kathmandu expressed safety concerns when accessing health services after the earthquake.

Clinical care and psychosocial support: KIs reported that CMR services were more available in Kathmandu at one-stop crisis management centers (OSCMCs) and other public facilities than in Sindhupalchowk, where CMR was reported partially (not including PEP at PHCCs or other components of CMR) available at the PHCCs and the district hospital. Awareness gaps among RH and GBV KIs about the availability and location of CMR components in the district were apparent. Health facility assessments also demonstrated variation in the availability of CMR: full CMR services were available at three of the assessed health facilities in Kathmandu, and were partially available at three facilities in Sindhupalchowk. Partial CMR services lacked PEP and psychosocial counseling and had limited collection of forensic evidence.

> *"Women don't want to go to the health facility because it is not anonymous because of the stigma."*
>
> GBV KI, Kathmandu

> *"Women remain silent [so] that others would [not] know about it. Otherwise they will be blamed and disgraced, even if they are innocent."*
>
> Sindhupalchowk, female participant, age group 18-24

> *"We orient health personnel technically without thinking of social aspects for women-friendly providers. Providers lack sensitivity, that they need to*

be quiet and listen, and that there is a need for a lot of training of health personnel."

GBV KI, Kathmandu

Health facility assessment participants at the maternity center reported 214 sexual violence cases in one year and at Chautara District Hospital they reported 15-25 cases in one year. None of the cases had presented at the facilities within five days of sexual assault, reportedly due to shame and stigma. In terms of referral systems, all GBV KIs reported that there is a GBV referral system. The system was rated slightly better by KIs in Kathmandu than in Sindhupalchowk; nevertheless, GBV KIs expressed concern about the quality of care across the referral system.

"Donors came in and did the referral system. It is an 'outsider thing' not an 'insider thing' so government agencies are not prepared and we end up doing it all. Initially, we had our own referral pathway."

GBV KI, Kathmandu

"The referral system is good, the response system is poor."

GBV KI, Sindhupalchowk

One GBV KI said that initially their organization had its own referral pathway.

Community awareness of services: In Kathmandu, FGD participants reported that people who experience GBV should consult with the police, obtain health treatment, and receive "financial empowerment" and counseling. In Sindhupalchowk, FGD participants had less knowledge about what services were available to GBV survivors. FGD participants who spoke of services for survivors of GBV mentioned accessing women's rights organizations and reporting incidents to the police. Although almost all GBV KIs in Kathmandu and Sindhupalchowk reported that information, education, and communication (IEC) was undertaken about seeking health care after experiencing sexual assault and locations of clinical services were made available through materials, peer educators, community health workers, and the radio, not all FGD participants in Kathmandu and Sindhupalchowk were aware of this information.

MISP Objective 3: Reduce HIV transmission

Awareness of HIV: In both districts, FGD participants had mixed knowledge about the prevention and transmission of HIV and other STIs. Awareness was higher among 18- to 24-year-old women and men than among older groups in Kathmandu; however, among older groups, male participants were more aware of HIV transmission mecha-

nisms and prevention strategies than female participants in both districts. The majority of groups were unaware of where to access such services or they felt there was stigma, which prevented people from accessing care for HIV.

> *"In my opinion, people are afraid to do the test here because other villagers might know about them and so they go to Dhulikhel and Kathmandu to do the test for STI."*
>
> Badegaun, Sindhupalchowk, male participant, age group 18-24

> *"We don't have treatment for STIs here. For this we can go to Dhulikhel and Kathmandu for the treatment."*
>
> Melamchi, Sindhupalchowk, male participant, age group 18-24

> *"We don't have any health services related to HIV and thus, we go to Dhulikhel hospital for the treatment."*
>
> Barabise, Sindhapalchowk, male participant, age group 24-49

Free condoms available: All KIs reported that free condoms were made available through health facilities, community-based organizations, mobile RH camps, condom boxes, and community-based distribution conducted by female community health volunteers (FCHVs) and adolescents. The majority of FGD participants in Kathmandu and Sindhupalchowk were aware that they could access free condoms from health posts and other government facilities. In Kathmandu, some groups reported the available condoms were of low quality and preferred to purchase male condoms from the pharmacy. In the Chuchepati displacement camp, FGD participants stated that condoms were not freely available or accessible because agencies were concerned that the community would misuse or sell the condoms.

> *"The government should coordinate to make condoms available to local organizations and promote condoms in local places where people are, like the bus park."*
>
> HIV KI, Sindhupalchowk

Safe and rational blood transfusion: KIs and HFA participants reported that safe blood transfusion was available in Kathmandu but not in Sindhupalchowk. KIs in Sindhupalchowk reported that the Norwegian Red Cross provided safe blood transfusion at a temporary field hospital in Sindhupalchowk early in the crisis.

Standard precautions: All KIs said the practice of standard precautions at health facilities was available or partially available, with varying quality in rural areas and that the national standards were followed at mobile RH camps. Infection prevention standards were adhered to in most of the health facilities assessed in both districts in terms of use of autoclaves for sterilization, among other practices: 15 out of 17 (88 percent) of health facilities assessed in both districts had adequate supplies to practice standard precautions. A lack of visible protocols at facilities was observed in Kathmandu. Facility assessments revealed that only two hospitals in Kathmandu and Chautara District Hospital in Sindhupalchowk offered this post-occupational exposure treatment for staff.

Standard precautions are posted at Lisamkhu Health Post, but are generally not visibly displayed © Rosilawati Anggraini, UNFPA

MISP Objective 4: Prevent excess maternal and newborn morbidity and mortality

Community awareness and perspectives: FGD participants in both districts were able to describe basic danger signs during pregnancy and among newborns, although women in Kathmandu were more familiar than men in Kathmandu with newborn danger signs such as jaundice, trouble breathing, and inability to nurse. Both female and male groups in Sindhupalchowk included non-danger signs such as blisters and colds as danger signs. All participants, whether they lived near or far from a facility, knew where to go to receive maternal and newborn care immediately after the earthquake. In Kathmandu, the majority of participants mentioned that women would deliver at a hospital—government or private—and not at home. A few groups reported there was a high cost for medicines and overnight stay after the earthquake, despite government incentives for facility-based deliveries. In Sindhupalchowk, mixed responses were received around the quality of the nearest health post for conducting deliveries. As a result, some respondents would bypass health posts and deliver at district health facilities for higher quality RH services. Reported quality and accessibility concerns from FGDs related to the lack of provider knowledge, availability of medicines, long wait times, limited staff during holidays and evenings, distances to public facilities, and costs of care associated with referrals to expensive facilities for advanced care and during evening hours.

> *"Apart from the health post, if we have to take emergency services we have to bear the cost of transportation and treatment. We get basic services from this health post; to get emergency services, we have to go to the other clinic."*
>
> Dadapakha, Sindhupalchowk, male participant, age group 18-24

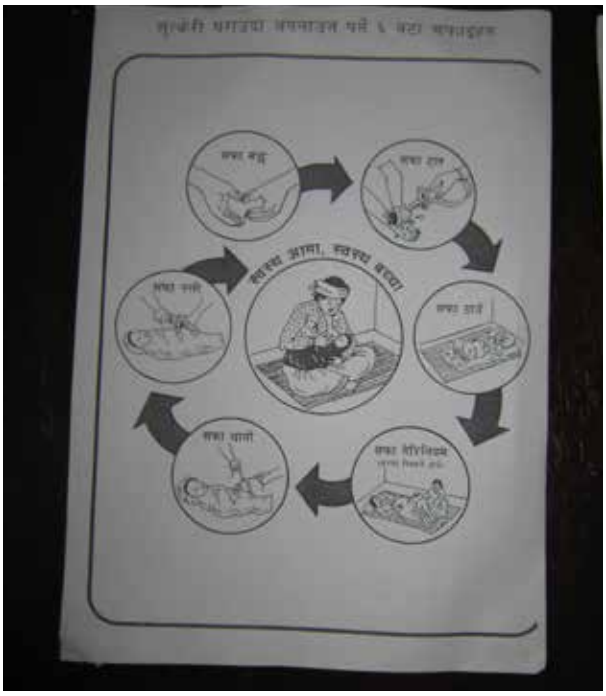
Normal deliveries: Health facility assessments showed that normal deliveries were conducted at all the assessed facilities, and they were encouraged by government maternity care incentives. While facility-based deliveries were reportedly the norm in Kathmandu, in Sindhupalchowk there was a wide range of responses regarding the use of a skilled birth attendant during delivery and some preferred the use of a traditional birth attendant or a relative in the community.

> *"When jaundice is seen in babies or when the baby has blisters, either they are taken to the health post or some are kept in the home. Some are given herbal medicines. There are problems in the home. It is very expensive to go to Kathmandu for treatment. Most people don't take*

their kids for treatment to Kathmandu. They go only when the condition is severe. It is because of financial crisis and many people don't have money."

Badegaun, Sindhupalchowk, female, age group 25-49

Basic and comprehensive emergency obstetric and newborn care: All KIs confirmed basic emergency obstetric care availability, despite heavy damage and human resource shortages in Sindhupalchowk. Comprehensive emergency obstetric care (CEmOC) was reportedly available in Kathmandu, but not regularly in Sindhupalchowk. Although immediately after the earthquake the Red Cross established a temporary field hospital that supported CEmOC, it was dismantled by the time of this assessment. Newborn care services (management of newborn sepsis, newborn resuscitation, and low birth weight/pre-term babies) were reported to be available or partially available (some, but not all the elements of care) in Sindhupalchowk based on associated concerns about lack of functioning equipment for newborn care. Facility assessments showed variations in the comprehensiveness of these services in both districts, based on the level of the facility.



Information on newborn care at Lisamkhu Health Post.

© Rosilawati Anggraini, UNFPA

Referral systems for pregnancy complications: RH KIs reported the existence of 24-hour, seven day per week emergency referral systems. For some time, referrals could be taken to the field hospital in Sindhupalchowk. Once that was dismantled, referrals reverted to Dhulikhel District Hospital in Kavre, where CEmOC was available. The RH sub-cluster conducted IEC messaging on radio and television that included preparing for delivery, avoiding delays, and promulgating the use of maternity transition homes. At the community level, FGD participants in Sindhupalchowk reported the use of ambulances when close to a road, or stretchers when far from a road or where roads were blocked. As a result of damage, complicated cases were often taken directly to neighboring district hospitals. Ambulances often charged by distance; other costs reported pertained to emergencies outside of facility working hours as well as food and transport for family members.

Clean delivery kits (CDKs): RH KIs reported that CDKs were largely available and distributed to health facilities and to pregnant women in the RH camps through FCHVs. However, the government had concerns that CDKs might undermine efforts to promote facility-based deliveries. Health facility informants reported that while no CDKs had been distributed in Kathmandu, they were distributed to visibly pregnant women in Sindhupalchowk. Chautara District Hospital reportedly distributed 1,500 kits.

MISP Objective 5: Plan for comprehensive RH services integrated into primary health care

Human resources: RH KIs reported that during the immediate response, staff capacity assessments and training/mentorship took place on RH Kits, CMR, standard precautions, family planning, and quality assurance for maternal and newborn care. At the time of the assessment, KIs reported a continued need for human resource assessments and training at the national and district levels.

Data: According to the KIs, the RH sub-cluster used a standard template to collect data, and findings were aggregated and shared during the health cluster meetings. Most facilities collected data disaggregated by sex and age, while a few facilities collected data disaggregated by disability, and these were shared with the MOH, health cluster, and RH sub-cluster on a weekly and then a monthly basis.

Comprehensive service delivery sites: KIs reported that identification of future sites for service delivery was part of national rebuilding and district response plans. Some concerns were raised around the number of new birthing centers and risks of stretching human resource capacity and reducing the opportunity for existing staff to use and maintain their skills.

Supplies: RH supplies for all government facilities came from the district public health office; private facilities reported their own supplies. Fifteen of the 17 assessed facilities indicated that the supply chain was reliable. All facilities had a general commodities register that included SRH commodities. However, early on, two-thirds (11) of facilities indicated that they experienced shortages of drugs and supplies.

> *"In general, we have problems with procurement and supplies below district level."*
>
> RH KI, Kathmandu

Additional priorities of the MISP

Community awareness around family planning: All FGDs were highly aware of both short- and long-term methods of family planning, and the majority of groups knew where to obtain free methods. In Kathmandu, the primary methods reportedly used in the community included Depo-Provera, oral contraceptive pills, implants, and the copper intrauterine device (IUD). In Sindhupalchowk, men reported using condoms or having a vasectomy. Across male and female FGDs in both districts, the majority of participants did not know about EC and the few participants who did noted the high cost.

Family planning availability: KIs reported that condoms, pills, and injectables were largely available to meet demand, and IEC efforts were undertaken through social mobilization and FCHVs. Immediately following the earthquake, a national shortage of injectables and implants prompted UNFPA headquarters to fill the gap. Dedicated EC pills (Prostinor) as a component of family planning was reportedly only available through the UNFPA-supplied RH Kits and in shops through the private sector. Mixed feedback was received around the availability of EC via the Yuzpe method and of IUDs as a method of EC. In Kathmandu, EC was available only at the hospital level, whereas in Sindhupalchowk, 78 percent (7 out of 9) facilities had EC. IUDs were generally available except in some health posts; implants were provided at several facilities in both Kathmandu and Sindhupalchowk.

> *"There is a huge demand for implants, but they are not part of the RH kits, so to meet the demand for implants requires the normal government system for commodities."*
>
> RH KI, Kathmandu

STIs: Most FGD participants in Kathmandu and Sindhupalchowk had limited knowledge about STIs, the types of services available, and where to access these services.

Privacy was also a concern among FGD participants in Sindhupalchowk. The majority of KIs reported that the syndromic management of STIs was available or partially available, although the quality of care was questionable. Health facility assessments showed that syndromic treatment was available with the exception of one of the assessed health posts in Kathmandu and one in Sindhupalchowk. Supplies to treat STIs (antibiotics) were mostly reported to be inadequate by clinics, with the exception of two of the assessed facilities in each district.

ARVs: The majority of RH KIs said ARVs were available or partially available for continuing users, including for PMTCT. There were only a few reports of disruption in access to ongoing ARV therapy by people taking ARVs. KIs in Sindhupalchowk supported transport for ARV users to access medicines, care, and nutritious food. Referral systems for HIV were reportedly established and rated average or excellent in both districts. Facility assessments showed that all assessed facilities in Sindhupalchowk had an ARV referral system, including for PMTCT. In Kathmandu, only four hospital facilities had a referral system.

> *"There is a need to improve trained manpower so ARVs are available at the local level and people do not have to walk so far."*
>
> HIV KI, Sindhupalchowk

Menstrual hygiene: The majority of women in all eight FGDs in Kathmandu said they had not received menstrual supplies since the earthquake; the exception was FGD participants in both displacement camps, who confirmed that they had received one or two distributions of sanitary pads. Both sites reported waste disposal issues for the sanitary pads and recommended that future distributions include disposal instructions. In Sindhupalchowk, all but one FGD among women said they had received sanitary pads after the earthquake. Challenges raised by women consisted of the lack of privacy and the quantity of sanitary pads or cloths. Despite inconsistent supplies reported at the community level, all RH KIs confirmed that menstrual hygiene supplies were available or partially available through dignity kits distributed to adolescents and at shelter homes. Culturally appropriate menstrual hygiene supplies were not distributed at health facilities for women after delivery; pregnant women were expected to bring their own hygiene supplies for use after giving birth.

Addressing the RH needs of adolescents

While KIs reported building on an existing national adolescent SRH package by designating adolescent corners in the camps, the majority of FGD participants in Kathmandu did not know of any adolescent programs or centers, aside from weekly

RH education sessions for adolescent girls held at the FPAN clinic. Indeed, facility assessments showed a lack of adolescent-specific or adolescent-friendly SRH services. Further, in Kathmandu, adolescents were not permitted to access SRH services without parental consent at two-thirds of the facilities assessed. In Sindhupalchowk, this was the case in one quarter of the assessed facilities. FGD participants reported a desire for adolescent-only programs because most adolescents feel shy accessing RH services from the health posts or hospitals.

Addressing the RH needs of people with disabilities

Most RH KIs did not know if agencies addressed the RH needs of persons with disabilities. Only one KI in Kathmandu reported its organization provided counseling on sexual hygiene and family planning to persons with disabilities; a KI in Sindhupalchowk mentioned that a needs assessment, provision of equipment and supplies, and staff training had been undertaken to address the needs of persons with disabilities. Only one assessed hospital had accessible toilets and wooden ramps.

Engagement of communities in RH programming

Three-quarters of KIs in both Kathmandu and Sindhupalchowk reported that communities were engaged in RH programming: adolescents, community mobilizers, women's groups, and FCHVs were particularly engaged in RH camp education and counseling; baby and mothers units, women's groups, peer education and counseling, village development committees and in female-friendly spaces (FFSs). Adolescents were even represented in the RH sub-cluster. Indeed, at the community level in Kathmandu, most FGD participants reported that they actively participated in the response through distributing materials, disseminating information about distributions, and identifying those in most need. In Sindhupalchowk, inclusion within service delivery was noted only by men, and primarily in regard to their involvement in water and sanitation programs. Participants of one male youth group in Kathmandu felt that social media should have been used to share information on services and distributions. Additionally, one KI mentioned gaps in engaging LGBTI persons. No respondent mentioned engagement of persons with disabilities in RH programming.

Disaster risk reduction, including preparedness

RH: Preparedness activities reported by RH KIs included: pre-positioning RH Kits 1-11 and other supplies; establishing a logistics system; dedicating financial resources for health staff development; hosting and participating in MISP trainings, implementing emergency planning workshops and earthquake drills; supporting district emergency

preparedness planning; undertaking birthing centers assessments; and supporting hospital preparedness for emergency trauma care. One KI in Sindhupalchowk noted that financial resources were dedicated to building capacity on adolescent SRH and the MISP, including for the district rapid response team. Despite preparedness efforts, responding agencies experienced logistical challenges around clearance processes, packaging, transportation, and RH Kit orientations.

> *"A national logistics supply system for RH would be useful."*
>
> RH KI, Kathmandu

GBV and HIV: RH, GBV, and HIV KIs reported activities around instituting a Code of Conduct (CoC) on preventing SEA. GBV KIs further reported preparedness activities spanning advocacy around the legal framework and inclusion of GBV in the national disaster policy to ensure dedicated financial resources, training on CMR for providers, pre-positioning of post-rape kits, referral systems, and support to district emergency preparedness planning. Similarly in the HIV sector, HIV KIs reported trainings and pre-positioning of condoms and medicines (for ARV therapy) at the national level as part of preparedness efforts.

Key facilitating factors and barriers to MISP implementation in this crisis

Facilitating factors for RH: Key factors that facilitated MISP implementation as cited by RH KIs included:

- The MISP as a part of the Nepal Disaster Management Plan, pre-positioning of emergency kits and supplies, training of health providers, and an understanding of RH as a required service;
- Immediate regulatory action and strong leadership by the MOH/FHD and the Health Emergency Operations Center at the national level;
- Established strategic relationships between the government, UNFPA, and NGOs, and enthusiasm of all stakeholders, particularly among those who were knowledgeable about the MISP;
- RH sub-cluster highly regarded in the health cluster and dynamic leadership of the RH sub-cluster with good planning, coordination, and action;
- District Health Office (DHO) focal points taking responsibility and leading the overall health system recovery; and
- In rural communities, supplies of RH kits, RH camps (mobile services to remote

locations) and medical camp kits; temporary field hospitals and helicopter transport; and intensive volunteer efforts.

"Health and reproductive health were the responsibility of the whole society, not just the DHO. The whole community took responsibility – forty percent of the community provided their own land to support health services."

RH KI Sindhupalchowk

Facilitating factors for GBV: GBV KIs cited the following key facilitating factors to prevent and manage sexual violence:

- Leadership of the Ministry of Women, Children, and Social Welfare/Department of Women and Children supported by UNFPA as co-lead;
- Advocacy around the CMR protocol pre-crisis, as well as GBV programs pre-crisis that enhanced government and community capacities;
- Strong ownership of the principles of working with survivors;
- Establishment of FFSs and referral systems, as well as mass awareness campaigns on the radio and television with IEC materials; and
- Rapid coordination with protection and GBV clusters, and with agencies and the police.

Facilitating factors for HIV: HIV KIs reported:

- Initiatives undertaken pre-crisis resulting in HIV awareness and education, promotion of condoms and positive health worker attitudes; and
- The establishment of a field hospital where safe blood transfusion was available for EmOC and other emergencies, activation of disaster rapid response teams, district coordination, and decisions undertaken at the national level to those taken by individuals to help PLHIV.

Barriers for RH: RH KIs in Kathmandu shared the following overarching barriers that influenced implementation:

- Monsoon- and damage-related logistical challenges, and communities busy with their own lives;
- Understanding of the MISP at all levels with many stakeholders acknowledging its importance, but some still questioning these services in relation to food, water, and shelter;

- Lack of communication from the national level to district levels and from the district to the national level;
- Lack of designated funding for emergency preparedness;
- Confusion about roles and responsibilities for coordination, and gaps in human resources; and
- Engagement of all stakeholders in coordination meetings, including inter-sectoral (GBV, HIV and RH) coordination and the challenge of multiple coordination meetings and competing needs.

Barriers for GBV: GBV KIs in Kathmandu shared barriers such as:

- Accessibility of communities; community norms around survivor reporting; and lower education and economic backgrounds of some survivors and priorities to meet basic and survival needs;
- Amount of time for coordination and meetings versus time allotted to service delivery;
- Limited capacity of the government to provide services and different approaches by different partners, compounded by limited attention to listen to and learn about existing national capacity and allow for more active national participation;
- Limited numbers of qualified personnel to provide CMR, and concerns about service quality in the referral pathway, particularly police and legal capacity; and
- Recognition beyond the physical needs of survivors for a human approach.

Barriers for HIV: HIV KIs identified barriers ranging from geographical terrain; limited understanding of the needs of PLHIV; lack of funding and qualified human resources; to coordination gaps between the district hospital and NGOs. HIV was reportedly viewed as a lesser priority than GBV.

Conclusion

All MISP services and priority activities were largely available in both Kathmandu and Sindhupalchowk, while some services were partially available based on the availability at a limited number of facilities in the district and questionable comprehensiveness/quality of some services where they were available, specifically CMR, standard precautions, and syndromic management of STIs. Community knowledge about culturally sensitive RH issues, the benefits of seeking care, and the location of services for

sexual violence, STIs, and HIV were a major gap, especially when compared to family planning or maternal health. In addition, many KIs themselves were also not aware of what services for CMR and specifically EC and PEP were available at each health facility.

The availability of the MISP in the two districts assessed by the evaluation team five months post-earthquake may be attributed to three key factors:

- Commitments and investments in RH by the Government of Nepal and partners pre-crisis;
- Emergency and disaster risk management for health (EDRM-H) initiatives that include the MISP, with implementation of RH preparedness activities, including pre-positioning of supplies; and
- Leadership and collaboration among partners in the immediate response to secure donor support and to implement coordinated and innovative strategies to effectively reach affected communities.

Nepal's policy and institutionalization of the MISP in EDRM-H initiatives, along with experience from previous disasters, set the stage for the immediate activation of coordination mechanisms. While the majority of KIs were not trained in the MISP, lead agency staff from the FHD, WHO, UNFPA, UNICEF, and FPAN, among others, were able to drive attention to the priority activities at the national and district levels. Additionally, community IEC for maternal and newborn care, HIV, and family planning, as well as engagement of village development committees, FCHVs, and other social mobilizers were likely resumed in the immediate aftermath due to their availability before the earthquake. Coordination and community outreach undertaken by the RH and GBV sub-clusters to gather, synthesize, and act on information through FFS, transition shelters for pregnant and postpartum women, and mobile RH camps with adolescent corners are good practices that inform learning and deserve championing.

In terms of technical areas, variability was seen in awareness around CMR at provider and community levels and enforcement of standard precautions. These areas also appear to have been challenged before the earthquake. However, gaps in awareness about the MISP standard among RH stakeholders reduce opportunities to collectively convince all stakeholders about the life-saving priority activities as well as embark on immediate, coordinated, good quality action. Similarly, addressing comprehensive RH at the onset of an emergency and areas that are not a part of the MISP dilutes the concept of triage.

It is understandable that GBV and HIV stakeholders would not be fully trained in the

MISP given the scope of their technical areas; yet, it is important that they be aware of the overall priority objectives in order to collaboratively focus on them in an emergency. Strengthening integration of GBV and HIV with RH coordination will further leverage overall coordination and facilitate a holistic approach for SRH.

Although long-acting methods are not explicitly part of the MISP—with the exception of IUDs for EC—the popularity and stock-outs of implants supports the need to consider implants and other long-acting methods in the MISP and RH Kits. This would help position them to meet existing demand.

For more detailed findings, please read our white papers on focus group discussions, key informant interviews, health facility assessments, and a literature review, at http://wrc.ms/MISP-Nepal-15.

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