Evaluation Report
"Ensuring recognition of sexual violence as a tool of conflict in the Nepal peace building process through documentation and provision of comprehensive services to women and girl survivors"

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SGBV evaluation project

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Abbreviations and Acronyms

ADRA	Adventist Development and Relief Agency Nepal
AF	Advocacy Forum
AHW	Auxiliary Health Worker
ANC	Antenatal Care
ANM	Auxiliary Nurse Midwife
BBC	British Broadcasting Corporation
BCC	Behaviour Change Communication
CDR	Central Development Region
CEDAW	Committee on the Elimination of Discrimination against Women
CMC	Centre for Mental Health and Counselling
CPA	Comprehensive Peace Accord
CPN	Communist Party of Nepal
CPSW	community Psychosocial Worker
CWIN	Child Workers in Nepal Concerned Centres
DAC	Development Assistance Committee
DAO	District Administration Office
DDC	District Development Committee
DEO	District Education Officer
DHO	District Health Officer
DPHO	District Public Health Officer
DOHS	Department of Health Services
EDR	Eastern Development Region
ERC	Evaluation Reference Committee
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FIR	First Information Report
FM	Frequency Modulator
FWDR	Far-Western Development Region
GBV	Gender Based Violence
HCP	Health Care Provider
HHESS	Himalayan Health and Environmental Services Solukhumbu
HimRights	Himalayan Human Rights Monitors
IEC	Information, Education and Communication
MDG	Millennium Development Goals
M&E	Monitoring and Evaluation
MOAC	Ministry of Agriculture and Cooperatives
MOE	Ministry of Education
MoHP	Ministry of Health and Population
MOPR	Ministry of Peace and Reconstruction
MWCSW	Ministry of Women, Children and Social Welfare
NAP	National Action Plan
NDHS	Nepal Demographic and Health Survey
NGO	Non-governmental Organization

NPC	National Planning Commission
NTV	Nepal Television
OECD	Organization for Economic Cooperation and Development
PHD	Population, Health and Development
PNC	Postnatal Care
SBA	Skilled Birth Attendant
SBV	Sexual Based Violence
SCF	SAVE THE CHILDREN
SGBV	Sexual and Gender Based Violence
SLC	School Leaving Certificate
SPSS	Statistical Packages for Social Sciences
TBA	Traditional Birth Attendant
TOT	Training of Trainers
TPO	Transcultural Psychosocial Organization
TRC	Truth and Reconciliation Commission
TV	Television
UN	United Nations
UNEG	United Nations Evaluation Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNPFN	United Nations Peace Fund for Nepal
UP	Uterine Prolapse
VDC	Village Development Committee
VHW	Village Health Worker
WCO	Women and Children Officer
WDR	Western Development Region
WHO	World Health Organization

Executive Summary

A decade long (1996-2006) armed conflict in the country and subsequent civil unrest in the Terai mostly affected women and children. Nepal is committed to implement several UN Security Council Resolutions including UNSCR 1325, 1612, 1820 and 1882. In this respect with the objective of contributing to peace building in Nepal, UNFPA and UNICEF jointly implemented since April 2010 a two-year project funded by the UNPFN. The main objective of the project has been to support sustainable peace by improving access to transitional justice and other peace building activities for survivors of sexual and gender based violence (SGBV) in most conflict affected districts.

The project aimed at ensuring recognition of sexual violence as a tool of conflict in the Nepal peace building process by documenting conflict-related sexual violence incidents by providing comprehensive services to women and girl survivors. The incidents of sexual violence have not been officially recognized by the Government, and survivors remain silent and continue to suffer from physical and psychological effects of the violence. Survivors of sexual violence often face ostracism.

The project used reproductive health camp as an entry point to document potential cases of survivors of SGBV. These camps offered an environment where confidentiality and safety are ensured and survivors can access psycho-social and legal counselling services in addition to medical services. During the project period, over 36,471 women and girls have benefited from mobile reproductive health camps in 14 of the most conflict affected districts of the country (Saptari, Siraha, Dhanusa, Mahottari, Bardiya, Dang, Kalikot, Rolpa, Rukum, Surkhet, Achham, Bajura, Kanchanpur and Kapilvastu.)

The project deployed two multi-disciplinary teams comprising of six different NGOs to conflict affected areas. Each team conducted mobile reproductive health camps (6 days initially and follow-up camp for 4 days) in two VDCs of each district. Clients and survivors who participated in the camps were referred to various services based on their needs, encompassing psychosocial and legal support, shelter and rehabilitation and uterus prolapse surgeries. The mobile camps ended in February 2012.The project also has additional components including policy and media advocacy. Through three civil society organization partners, radio interviews, radio dramas and TV serials were aired to raise awareness on the issues of sexual and gender based violence.

UNFPA and UNICEF Nepal focussed on three outcomes under district wide approach. They include:

(a) Identify and document incidences of sexual and gender based violence against women and girls during the time of conflict and post conflict in Nepal;
(b) Support access to reproductive health care and psycho-social counseling for victims of sexual violence in target areas; and
(c) Promote recognition of the incidence of sexual violence in Nepal peace process through access to justice for victims of sexual violence, including through participation in transitional justice processes.

As per the requirement of UN Peace Fund, UNFPA Country Office jointly with UNICEF conducted a final evaluation of the project with dual propose to:

- Determine the extent to which whether the objectives and performance indicators outlined in the project proposals were achieved with the allotted timeline and analyse the associated risk factors; in particular, to assess relevance, effectiveness, efficiency, impact and sustainability of the project;

- Document lessons learnt and recommendations in assess the project contribution to the Nepal's peace process and to utilise the results to improve the performance of implementation of a future similar project.

The evaluation team employed three methods of data collection to conduct the evaluation:

- Rapid assessment methods (in-depth interviews, FGD)
- Analysis of secondary data and reviews
- Field visits in six districts of different regions, observation of ongoing RH camps and logistics systems, and opportunistic discussions with beneficiaries where feasible.

Data triangulation was achieved by survey of clients, FGD, in-depth interview of a range of stakeholders at different levels from a variety of institutions, and review of programme documents. Finally, the engagement of evaluation team with divergent backgrounds and expertise focusing on complementary programmatic areas helped to ensure a measure of investigator triangulation.

The strong culture of silence on sexual violence poses severe constraints on the assessment of effectiveness and impact of the project; in other words, as people do not openly talk about SGBV, the project might have left out number of women and girls affected by SGBV. In addition to the analysis of periodic project progress reports and documentation of sexual violence cases, the evaluation also heavily relied on responses of internal and external stakeholders, partner agencies, service providers, and project beneficiaries.

Findings and Conclusions

The evaluation concludes that the project focused on seven major areas which includes provision of health services through reproductive health camps, conducting focus group discussions among women and girls, capacity building/ raising awareness through media psycho-social counseling, legal counseling and provision of livelihood support to women/girls in project districts. The evaluation examined key project activities (results) based on the OECD/DAC evaluation criteria.

Effectiveness

The team approach comprising of several implementing partners and providing a number of services including psycho-social counselling, livelihood supports from one outlet has worked well. Despite the sensitivity of the issue of sexual violence persistent efforts made by all partners including support from the Government made it possible to implement planned activities in the target districts.

Using unique (RH camp as entry point) project implementation strategy the project was successful in minimizing backlash on the sensitive issue such as sexual violence. The project raised awareness of people about SGBV at national level - policy makers and program managers of government, I/NGO and other implementing partners; at district level - stakeholders and partner organizations sensitized through orientation programme; and at VDC level - health service providers, teachers, and the CBOs. However, the information that was withheld was documentation for TRC purposes and this was to ensure safety and confidentiality of staff and women. The joint UNICEF/UNFPA project implemented mainly by six partners took sometime to arrive at implementation modality because many implementers working together took time to make decisions. Eventually implementation of project activities was prevented from going off the track following increased understandings among the partners.

For girls and women survivors of SGBV, the project adopted "*do no harm*" approach. At the service delivery point a female PHN explained about the availability of a number of services to

the client and it was up to her to decide which service she wanted to utilize. The client was enabled to speak out about her problems to the PHN who later directed her to the appropriate service or counselling desk. Furthermore, as the service provider/counsellor was a female, the client had minimum inhibitions to put her problems before the desk attendee. Overall, therefore, the SDP was client-friendly.

The project has provided RH and related services to 36,471girls and women in total and of them 3,551 received psychosocial counselling, 1,000 given legal counselling, 821 cases of SGBV documented covering both conflict and post conflict periods and 70 cases were identified as potentially eligible for consideration in a transitional justice process. During the conflict period incidence of SGBV was nearly double (66%) than in the post conflict period (34%).

The target of RH camps was to reach 21,000 clients during the project period in 14 districts and the achievements at the end of the project were 27,525 received reproductive health related services, 14,413 received general health services which come to 131% achievement. No targets were set for other indicators such as number of SGBV clients to reach, number of SGBV clients to counsel and so on.

Eighty six percent of sample survey respondents said that the camp activities and services were good. Reasons for finding camp good were that the services and drugs were free and readily available; there was good counselling, no wait time for service, and good provider behaviour.

The project was successful in reaching out to the more vulnerable populations of Dalit and Janajati categories because 66% of clients were from disadvantaged communities (Dalit/ Janajati) and 34% were from the relatively more advantaged communities of Brahmin, Chhetri and Thakuri. Although 917 women were referred by RH camps for UP surgery in hospitals only 74% went to the hospitals despite the fact that they were assured of free transportation and services. In addition, 11% women who reached hospital for surgery were rejected for UP surgery on grounds of contraindications.

Out of the 1,000 cases of SGBV identified in 14 districts during the project period, 70 cases have been identified as potentially eligible for consideration in a transitional justice process as agreed upon by the signatories to the Comprehensive Peace Agreement (CPA).

The project faced some challenges too. It was difficult to track SGBV survivors as the project was implemented only after about 5 years of cessation of conflict. Some victims who were documented did not want to lodge complaint despite receiving legal counselling for fear of re-victimization, family discord, and poverty.

The Law of the Land hindered some clients to lodge complaints to the police. Political vested interests also hindered lodging of complaints. Another issue is the formation of TRC which is expected to provide compensation rescue package for survivors; the government has not yet formed it. Maintaining confidentiality of victims, despite efforts made in this respect has remained a challenge.

Relevance

The project outcomes and outputs are aligned with UNSCR 1820 in that it has advocated for the benefit of women and girls affected by sexual violence in armed conflict and post conflict situations. The project outcomes and outputs are relevant to NAP on implementation of UNSCR 1820 and they contribute to the implementation of the strategic objectives of 5 pillars: participation, protection and prevention, promotion, relief and recovery, resource mobilization

and monitoring and evaluation. In particular, outcomes 1, 2, 3 and the six outputs of the project contributed to the NAP strategic objective adopted under 2nd pillar 'protection and prevention'. Under this pillar, Strategic Objective 2: to address the special needs of conflict –affected women and girls and Specific actions: Provide prompt and free medical service & psycho-social and legal counselling to women and girls victims of SGBV during the time of conflict. Likewise, the project outcomes and outputs have contributed to NAP's 3rd pillar 'promotion' with the objective of (i) raising awareness by collecting data on all forms of SGBV against women and girls and NAP's 4th pillar with the strategic objective of (i) formulating and implementing relief and recovery programme with the participation of women and girls affected by conflict as per their needs and condition.

Efficiency

Efficiency of the project here deals with human, technical and financial. The project was financed by UNPFN and the total fund was US$2.1 million and of that UNFPA received 66% and the rest by UNICEF. The use of human and technical inputs was efficient. The human resources comprised mainly of females; nearly 70% and this is good in view of the fact that the beneficiaries were females.

The use of human and technical resources was good without compromising for quality services. Despite the fact that most RH camps were held in remote VDCs the camp managed to utilize the services of medical doctors, PHNs and nurses throughout and this combination of human resources remained unchanged until the end of the project.

Impact

The project was implemented for two years. Therefore, it was too early to measure the true impact of the project. However the evaluation noted that impact of media campaign was already noticeable because Katha Mitho Sarangiko radio series has become very popular and it is raising awareness in gender issues. The success of the project to reach out to conflict affected sexual and gender based violence victims through RH camp was noteworthy. This eventually will support to raise the voice of SBGV survivors, to include them in the reparation policy of MOPR and to support transitional justice process.

Both the results of the FGD sessions and the stakeholder interviews in the community indicated the positive impact of RH services in the lives of women and girls. Most of the in-depth interview and FGD participants said that their RH status has improved after attending the camp.

The FGD participants did not want to discuss in the group about the short or long term impact in their lives of other services like psychosocial, legal or livelihood that were provided in the camp. Most VDC level stakeholders however were positive about the impact of services other than RH in the lives of women and girls.

Sustainability

The project initiated a number of strategies for sustaining the gains of the project. They include the transfer of knowledge and skills to the DHO and health facility level staff, provision of equipment support to the health facilities, training and orientation to local level FCHVs and CPSWs on RH and SGBV issues and basic knowledge on how to manage them. These activities have enhanced the capacity of government, non-government and civil society organizations at various levels to deliver programmes in the areas of RH, SGBV, psychosocial counselling, documentation of cases, and planning and management of livelihood support. At the community level, stakeholders have been given capacity building training on SGBV issues.

These orientations together with their involvement in camp activities have sensitised the community level stakeholders on RH and SGBV issues and also enhanced their capacity to contribute in similar activities in future as well.

RECOMMENDATIONS

Nepalese society is desperately waiting for a peaceful living after more than a decade long conflict and political uncertainty in the country. The joint project was aimed at contributing to this end. After completing piloting of the model in Achham the project was implemented for about two years and this phase too was more like a bigger piloting phase. The team has attempted to provide a number of recommendations based on discussions with stakeholders and beneficiaries, data analysis, lessons learned and the conclusions drawn.

1. The UNFPA and UNICEF should make efforts to prepare or ask IPs to prepare project proposal with results framework based on baseline data or secondary data analysis so that indicators for the project become more scientific in the sense that when endline data are compared with the baseline indicators the results are consistent.

2. Either UNFPA or UNICEF should decide which agency should take the lead in coordinating with the Ministry of Peace and Reconstruction for their active involvement in the project. The Ministry's active participation is needed to implement some major recommendations made by the project such as formation of TRC. One of the main recommendations of the evaluation of this project is that TRC should be formed by the Government to establish peace and justice in the country or to ensure that SGBV survivors get reparation and justice.

3. UNFPA or UNICEF singly or jointly or for that matter UN should commission a national level research to explore the nature and extent of SGBV in Nepal. The NDHS 2011 study was limited to domestic violence and therefore does not cover violence outside the home. Nationally representative study should involve a large number of stakeholders - the UN bodies, sectoral ministries, NGOs, the private sector and the subject matter specialists. UNFPA should continue to ensure that authentic nationally representative data on GBV is collected and analysed to guide future programs.

4. To strengthen the integrated model - the model that provides health services, legal counselling, psycho-social support and imparts income generation skills to women and girls affected by conflict it is necessary to orient and train medical team on post rape care protocols. Although 6-day basic SGBV orientation and 4-day advance training were given to field team members in the past, they need more thorough training and education on the dynamics of SGBV.

5. Since large numbers of implementing partners with their own policies will be difficult to manage operationally and programmatically, future projects should explore if less partners can be involved without compromising on the quality of interventions.

6. The project needs to improve recording, reporting and analysis of project monitoring data. This is important in view of the fact that upon request by evaluation team for data from different project districts and over time the data supplied was not consistent; the data was kept in bits and pieces which did not give consistent picture. The M&E group should make efforts to collect monitoring data, make them consistent over time and should be broken down by major categories of interest.

7. UNFPA received 66% of the total project budget and spent it mainly through its two implementing partners meeting the costs of their RH camp activities. Most of this budget was spent for screening and providing treatment to women suffering from uterine prolapse and these women did not have much to do with conflict. The RH camp was synonymous with UP camp which was not the goal of the SGBV project. The proportion of women and girls receiving psychosocial support through RH camps was about 10%. However, as the focus of the project is on SGBV, some ways should be found out to reach more girls and women who are subject to SGBV or to prevent incidents that lead to SGBV. In other words, efforts should be made to increase the 10%.

8. UNFPA should set target for UP surgery based on demographic profile of districts and not the same target (50 cases in every district). For instance for Kalikot the target set was 50 and for Kanchanpur too the target was 50 but the size of population in Kanchanpur is nearly four times larger.

9. Project should be designed in such a way that the proportion of referred cases ending up in surgery is maximum. Although the incentive package was good it was found that overall in 14 districts 26% of referred cases did not go to the surgery centers. The referred clients need to be closely followed-up until they arrive at the surgery centers; the clients need to be convinced that it is to their advantage to visit the surgery centre.

SECTION 1: INTRODUCTION

1.1 Background

Violence against women (VAW) or Gender-based violence (GBV) is a world-wide problem and is recognized as an important issue on the international arena. In 1979, the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, also called the Women's Convention) was adopted. This is the first international treaty in which member countries assume the legal duty to eliminate all forms of discrimination against women. VAW was given due attention at the UN World Conference on Human Rights in1993, the ICPD 1994, and the Fourth World Conference on women in Beijing 1994. Toady VAW is widely recognized as a human rights and public health issue (Ruchira Tabassum Naved. 2003).

Examination of VAW calls for a life cycle approach. While in mother's womb a girl risks becoming a target of sex selective abortion, during childhood she faces neglect, discrimination and abuse which are often manifested in infanticide, differential access to food, health care and education, incest and sexual abuse. During adolescence and reproductive age she faces sexual harassment and violence and has to accept marriage early in age and unwillingly. Once married she encounters myriads of problems such as marital rape, physical and psychological violence, coerced pregnancy and abortion. In old age, a woman suffers from violence mostly in the forms of deprivation of support and care (UNICEF. 2001).

A national study on violence in 5 districts of Nepal selected to represent diverse ethnic groups, topography and urban-rural divide with a sample size of 1,250 men and women found that 77% of violence against women was reported as being from within the family, whereas only 13% of perpetrators were outsiders (SAATHI. 1997). Another research carried out in 2008 in Surkhet and Dang districts revealed that 81% of women faced domestic violence frequently (SAATHI/UNFPA. 2008) although NDHS 2011 - a nationally representative sample survey shows that 22 percent women age 15-49 have experienced physical violence since age 15 (MOHP, New ERA, and ICF International Inc. 2012)[1]. Forced and early marriage is still a pervasive phenomenon despite the legal age for marriage is 18; nearly one in five women were married by age 15 (MOHP, New ERA, and ICF International Inc. 2012). Because of the clandestine nature of trafficking reliable statistics are hard to come by but the available data paint a bleak picture. Over 200,000 Nepali sex workers are employed in India, 20% of who are under the age of 16 (Roma Bhattacharya. 2003). Clearly, Nepali women and girls are vulnerable to both domestic violence and public violence.

The term sexual and gender based violence (SGBV), in its widest sense, refers to the physical, emotional or sexual abuse of a survivor and SGBV is endemic in communities around the world, cutting across class, race, age, religion and national boundaries. Exposure to gender-based violence and sexual coercion significantly increases girls' and women's chances of early sexual debut, experiencing forced sex, engaging in transactional sex, and non-use of condoms. The impact of SGBV resonates in all areas of health and social programming: survivors of sexual violence experience increased rates of morbidity and mortality, and violence has been shown to exacerbate HIV transmission, among other health conditions (IGWG of USAID, 2006). While girls are the most visible survivors of sexual violence, they are far from being the only ones who suffer from the consequences: children of both sexes constitute the majority of abuse survivors,

[1] Lower prevalence of physical violence reported by NDHS 2011 compared to SAATHI/UNFPA studies could be due partly to differences in methodology; the former refers to violence taking place in the last 12 months but even then the NDHS finding appears low given the plight of women in Nepal.

and adult men and the handicapped are minority groups who are often neglected in research and interventions.

Documentation of sexual violence is difficult in Nepal, the main reason being risk of causing harm to the victims due to cultural taboos and lack of long term support system for the victims. Various studies have been undertaken to examine the level and magnitude of different forms of gender based violence or violence against women in Nepal and some of these studies were carried out in the context of conflict while some were done under general circumstances. Several of the conflict and gender based violence studies, have been conducted at micro level (Berryman, E.2002; Dawadee, B. 2003; and INSEC, 2003). These micro level studies do, nevertheless, indicate that conflict affects women heavily. For instance, Berrymen (2002) showed that during Maoist insurgency the vulnerable groups such as women, children and elderly were most affected as they could not access health care. Dawadee (2003) examined the types of problems faced by women affected by conflict. Of the 142 women studied from Banke, Bardiya, Dang, Rolpa, Salyan and Udayapur 43% reported their husbands kidnapped and/or missing, 37% became widowed as their husbands were killed, 11% were put in jail, 5% were raped, and 4% were killed and/or missing.

The incidence of sexual violence is reported from time to time in daily newspapers. The Gorkhaptra (April 3, 2012) quoting INSEC Annual Report 2011 reported that during 2011 a total of 464 rape cases were documented and if this number is used to the prevalence of rape in Nepal comes to 5 per 100000 women aged 10-59. This figure is certainly grossly under-reported.

Signing of the comprehensive Peace Agreement (CPA) between Government of Nepal and Communist party (MAOIST) in 2006, marked an official end of 10 year armed conflict. In spite of this 'positive development' in peace process, violence and human rights violations continue. A recent World Bank (2006 report) suggests that the process of militarization has adversely affected the situation for women and children in the worst affected areas of the conflict, creating terror and forced displacements. During armed conflict, women were killed, tortured, raped, forced into prostitution, imprisoned etc. these impacts were observed in Nepal at different levels and in varying degrees depending on class, caste and status of women.

Many efforts have been made to strengthen the capacity of the government machinery to understand and deal with gender mainstreaming, particularly in MWCSW, MOAC, education, police forces, etc. Gender focal points have been appointed in all ministries and major departments. Notable institutional reforms in the education and health sectors have been the decentralisation of management functions to the DDC, VDC, and community levels. Other important institutional reforms include integration of gender issues into the formal and non-formal education system and integration of reproductive health services throughout the public-sector health system.

Most programmes/projects have gender sensitisation components, providing gender training to personnel at all levels and to local women leaders. Health policies and programmes have now been made much more gender sensitive by taking a life cycle and rights approach to women's health and integrating reproductive health services into the regular health system, emphasising quality of care, local participation and outreach, and broadening the scope of family planning and health programmes to include safe motherhood and adolescent health. The government has given high priority to gender-based violence (GBV). The Prime Minister has declared 2010 as gender-based violence free year.

The government of Nepal has taken several initiatives to address women empowerment including sexual and gender based violence. Women's representation in political participation has been improved both at the grassroots level in locally elected VDC assemblies and in the national parliament. A number of laws and acts have been passed and enacted to address the SGBV and improve the status of women in Nepal which are:

Date	Law/Act
May 30, 2006	The House of Representatives resolution in favour of proportionate representation of women in all parts of the State structure calling for guaranteeing at least 33 per cent participation of women for the time being with the aim of achieving proportionate representation ultimately.
Nov 26, 2006	'The Citizenship Act 2006' allows equal rights to women to acquire citizenship
Dec 18, 2006	The House ratified the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination Against Women 1999
Dec 28, 2006	'The National Women's Commission Act 2006' established with the mandate to ensure women's rights
no date	Gender-responsive budgeting and audit systems introduced in the government mechanism
2006	The Government initiative to adopt the Zero Tolerance policy at work places
no date	The Ministry of Local Development decision to require all 3,913 Village Development Committees to earmark at least 15% (out of the yearly block grant) for funding projects designed to empower women, children and other disadvantaged groups
no date	CEDAW plan of action to 'guarantee women's RH rights' and BPFA plan of action on 'women and health' guide the concerned ministries to work for ensuring women's rights
no date	The Ministry of Women, Children and Social Welfare conducts regular meetings with Gender Focal Points of sectoral ministries to share new polices, dimensions, legislation and sectoral initiatives in line with gender-responsiveness
no date	A National Coalition Committee representing 34 different GOs, I/NGOs and donor agencies formed to work together on violence against women (including violence during pregnancy)
no date	A Caucus of women Parliamentarians formed
Jan 14, 2008	A Gender Stakeholders' Group formed by the Department of Women Development for regular consultation with representatives of GOs, I/NGOs and aid agencies

1.2 Programme overview

More than a decade long armed conflict and subsequent civil unrest movements in the Terai have mostly affected women and children (MOPR. 2011). Nepal understands the responsibility of every member state of the UN to implement the Resolutions 1325, 1820 and 1612 adopted by the Security Council as per Article 25 of the UN Charter. Moreover, the significance of these UN Resolutions is felt to be more in the case of Nepal as it is engaged in the peace process after a decade long armed conflict. It is in this context that the need for a separate National Action Plan has been felt for the implementation of UNSCR 1325 & 1820.

With the objective of contributing to peace building in Nepal, UNFPA and UNICEF jointly implemented a two-year project funded by the United Nations Peace Fund for Nepal (UNPFN) in April 2010. The main objective of the project is to support sustainable peace by improving access to transitional justice and other peace building activities for survivors of sexual and gender based violence in most conflict affected districts.

In order to fulfil the objectives the project has identified three outcomes: (a) identify and document incidences of sexual and gender based violence against women and girls during the time of conflict and post conflict in Nepal; (b) support access to reproductive health care and psycho-social counselling for victims of sexual violence in target areas; and (c) promote recognition of the incidence of sexual violence in Nepal peace process through access to justice for victims of sexual violence, including through participation in transitional justice processes.

1.2.1 Programme approach and implementation

The project aimed at ensuring recognition of sexual violence as a tool of conflict in the Nepal peace building process by documenting conflict-related sexual violence incidents through the provision of comprehensive services to women and girl survivors. In Nepal's decade long armed conflict women and girls experienced sexual violence perpetrated by both sides: Government security forces and the Maoist Army. Although many other forms of human rights violation have been documented, information on the use of sexual violence as a tool of conflict has been scarce. As a result, the incidents of sexual violence have not been officially recognized by the Government[2], and survivors remain silent and continue to suffer from physical and psychological effect of the violence. Survivors of sexual violence often face severe stigmatization. There is a strong culture of silence and a sense of shame, which prevents victims from speaking up.

The project operated in a unique way to document cases of sexual and gender based violence, using reproductive health camps for women and girls as the entry point to potential survivors. These camps offered an environment where confidentiality and safety are ensured and survivors can access psycho-social and legal counselling services in addition to medical services.

The project adopted a holistic approach to documenting sexual violence that combines information gathering with service delivery in a way that avoids re-traumatizing or stigmatizing the survivors. The approach has been endorsed by the UNSCR 1888 and emphasizes the need for a holistic response to survivors of sexual violence. The project made efforts to reduce the vulnerability of survivors and women by adopting a do-no-harm approach which include:

- The documentation of cases of sexual violence, combined with psycho-social counselling services to reduce and possibly avoid the secondary and tertiary re-victimization of survivors,
- The provision of reproductive health services to all women in general, and to victims of sexual violence in particular,
- The training of all staff directly engaged in the implementation of the Programme to ensure that they have the necessary technical and ethical skills, including capacity to maintain confidentiality, to deal with survivors.

A Project Review Board comprising of UNFPA, UNICEF, Advocacy Forum, TPO, Save the Children/CWIN, ADRA and HHESS was established to evaluate progress and suggest modifications in the implementation of the project established on 6th September, 2010. The Board acted as a mechanism to support and provide oversight to the project and also supported the development of quarterly updates to UN Peace Fund for Nepal and to the Steering Committee.

In 2011, a Steering Committee was set up with the participation of Ministry of Peace & Reconstruction Ministry of Health and Population, Department of Women/Ministry of Women Children and Social Welfare, and Department of Education/ Ministry of Education. The Steering Committee provided advice and overall guidance to the project.

Mapping of reproductive health and gender based violence services in all 14 project districts was conducted and a report was drafted in 2010. Governmental offices and over 100 non-governmental organizations were identified, to whom project would be able to refer the reproductive health and gender-based violence survivors. Also potential conflict affected 28 VDCs to conduct reproductive health camps were identified.

[2] Sexual violence survivors are among two categories of victims who are not included as beneficiaries of the Government Interim Relief and Rehabilitation programme.

Capacity building of project staffs and stakeholders was carried out. Two mobile health camp teams, each consisting of 11 to 13 members (health personnel, psycho-social counsellor, lawyer and documentation officer) have undergone 10-day of intensive training related to SGBV. A total of 27 project staffs from ADRA, HHESS, TPO Nepal, Advocacy Forum, Save the Children/CWIN were trained.

In all project districts, a 2-day district level orientation on the concepts of gender, gender-based violence (GBV) and laws related to it, GBV and reproductive health impact was conducted before starting the mobile RH camp. The orientation sensitized the participants and helped them to get clarity on the basic concepts of GBV, its effects, psychological, legal and RH needs of survivors. The participants were district health officers and health post in-charges, women development officers, local development officers, district administration officers and local civil society groups, representatives from Bars etc. In all selected VDCs of 14 project districts, one-day orientation was provided to the VDC level stakeholders prior to conducting the mobile RH camps.

Sancharika Samuha and BBC World Trust were contracted by the project to carry out awareness raising activities. Various means of mass communication, such as newspaper feature articles, national as well as community radio programmes were utilized to discuss different aspects of SGBV and disseminate information in order to raise awareness among the general public. Sancharika Samuha carried out media campaign (radio programme) on SGBV and BBCWT has been sponsoring a popular radio series known as Katha Mitho Sarangiko (*Sweet Tales of the Sarangi)* and a radio magazine *(Sarangiko bhalakushari)* addressing SGBV. Interviews were also conducted with duty bearers from the multi-sectoral SGBV response model.

By the end of the project period, 36,471women and girls have benefited from mobile reproductive health camps in 14 of the most conflict affected districts of the country (Saptari, Siraha, Dhanusa, Mahottari, Bardiya, Dang, Kalikot, Rolpa, Rukum, Surkhet, Achham, Bajura, Kanchanpur and Kapilvastu.)

The project deployed two multi-disciplinary teams comprising of four different NGOs to most conflict affected. Each team conducted mobile RH camps (6 days initially and follow-up camp for 4 days) in two VDCs in each district. Clients and survivors who participated in the camps were referred to various services based on their needs, encompassing psychosocial and legal support, shelter and rehabilitation and uterus prolapse surgeries. The mobile camps ended in February 2012; the last follow-up RH camp was held in Rolpa from February 11 to 14, 2012. The project also has additional components including policy and media advocacy. Through three civil society organization partners, radio interviews, radio dramas and TV serials were aired to raise awareness on the issue of sexual and gender based violence.

All implementing partners jointly conducted training on GBV including sexual violence for district level stakeholders such as DAO, DDC, WCO, DPHO, DPO, and other likeminded organizations of 14 project districts. Training on GBV including sexual violence was also conducted for grassroots stakeholders.

1.3 Project evaluation

1.3.1 Need for the evaluation

Sexual and gender based violence already constitute an important area of work for both UNICEF and UNFPA; both organizations are committed to ensuring that results of this project are used in the most strategic and effective way possible after the end of the project. It is in this context that UNICEF and UNFPA have commissioned an end of project evaluation exercise which is aimed at

generating an independent assessment of successes, challenges and lessons learned to feed into the future programme activities. The evaluation Terms of Reference are set out in **Annex I**.

1.3.2 Purpose of the evaluation

The purpose of the evaluation is twofold:

- Determine the extent to which whether the objectives and performance indicators outlined in the project proposals were achieved with the allotted timeline and analyse the associated risk factors; in particular, to assess te relevance, effectiveness, efficiency, impact and sustainability of the project;
- To document lessons learnt and recommendations in assess the project contribution to the Nepal's peace process and to utilise the results to improve the performance of implementation of a future similar project.

1.3.3 Specific objectives of the evaluation

The specific objectives of the evaluation as outlined in the TOR are to:

(a) assess project effectiveness of the project in terms of progress made towards the outcomes within the given timeframe;
(b) assess project relevance in line with Nepal's peace process, national Plans, UNFPA/ UNICEF goals, and beneficiaries needs;
(c) assess the efficiency of the project;
(d) assess the programme impact;
(e) assess analyze the sustainability of the results achieved and the strategies used by the project; and
(f) analyze the overall project management

1.3.4 Scope of Evaluation

The evaluation mainly covers the last month of the implementation (February 2012), including assessing some on-going mobile camps, completed camps as well as project activities which are outside of the camp settings. As the mobile camps came to an end in February 2012, the UNFPA and UNICEF joint project will end in April 2012. As indicated above, 36,471women and girls have benefited from mobile reproductive health camps in 14 of the most conflict affected districts of the country (Saptari, Siraha, Dhanusa, Mahottari, Bardiya, Dang, Kalikot, Rolpa, Rukum, Surkhet, Achham, Bajura, Kanchanpur and Kapilvastu). Of the 14 districts the evaluation covered 6 districts for field work.

In all the field workers talked to beneficiaries of the project from 29 VDCs of the six districts. The names of sample VDCs visited for field work are included in the document as **Annex II**.

SECTION 2: STUDY METHODOLOGY

2.1 Data collection methods

The evaluation team collected information from multiple sources so that all affected people and stakeholders are considered and that it is accurate. The study thus utilized quantitative as well as qualitative research methods including document/desk review, key informant in-depth interviews (IDIs); focus group discussions (FGDs); and individual interviews using semi-structured questionnaire. The evaluation team worked with UNFPA, UNCIEF and its counterparts, HHESS, ADRA, TPO, SC, AAF, CWIN to build consensus around the evaluation scope and process.

Four primary methods of data collection were employed in this evaluation, namely key informant interviews, document review, field and site visits, and focus group discussions (see Table 1).

Table 1: Methods, tools and sample covered

Method/tool	Sample covered	No.
Document review	UNFPA policy on humanitarian assistance, Funding proposal, agreement with donor, annual work plans, country programme document, minutes of annual programme review meetings, quarterly progress reports, monitoring visit reports, etc	
Key informant interview	Steering Committee Members (2), UNPFN (2), UNICEF (2), UNFPA (3), ADRA staff (1), HHESS (2), TPO (1), AF (1), CWIN (2), SAVE THE CHILDREN (1), HimRights (1), Sancharika Samuha (1), DHOs (6), DEO (6), Women protection cell-Nepal Police (5), WCOs (6), Camp Management Committee Members (6), Media houses (5) and Community Leaders (6).	59
Focused group discussion	Women who attended RH services who were not sampled in individual interviews	12
Individual interviews with service recipients/clients	Women who attended RH mobile camps	360
Case studies	6 case stuidies of clients who had receivced RH services, 5 case studies of clients who received psycho-social counselling and service, 6 case studies of clients who received legal counselling and support, and 4 case studies of clients who received livelihood support	21

i. Document review

The evaluation team reviewed and analyzed UNFPA/UNICEF, UNPFN project documents and annual and quarterly reports, monitoring trip reports and minutes of project board meetings. A list of reviewed documents is given in **Annex III**.

ii. Key informant interviews

The semi-structured interview guides included the key evaluation questions and utilized a combination of open-ended and probing questions. Where appropriate, responses were documented and verified and wherever possible the ET triangulated data using range of data sources. These interviews also ensured the ownership and accountability of stakeholders towards programme inputs and desired results. The list of stakeholders contacted for interview is included in the document as **Annex IV**.

(iii) Focus group discussion (FGDs)

In course of the programme evaluation a total of 12 FGD sessions, 2 each in the 6 sample districts were conducted among girls and women who had attended the RH camps organized by the programme implementing partners (ADRA and HHESS). In order to capture the perspectives of adolescent girls and adult females on SBV, GBV, RH and related issues, one out of two FGDs in each district was conducted among adolescent girls who were below 17 years of age and another among those who were 18 years of age or more.

(iv) Survey of girls and women

In order to capture the opinions and the experiences of girls and women benefiting from the project, a quantitative survey in 6 sample districts was conducted from 1st week of February to 1st week of March, 2012. The number of district to cover from among the 14 project districts and the sample size were agreed upon by the Evaluation Reference Committee. The Terai districts were Saptari from the EDR, Dhanusha from CDR, Kapilvastu from WDR and the hill districts were Rolpa and Surkeht from the MWDR. In each project district the programme was focused in two VDCs and it was decided that 60 girls and or women attending RH camps would be interviewed. One semi-structured questionnaire was developed which included information such as background characteristics of the respondents (age, ethnicity, religion, literacy and education, marital status, and income), type of service received at the RH camp (safe motherhood, gynaecology, UP, psycho-social, legal, and livelihood), level of satisfaction from the service received, and the effect in their lives after receiving the services at the RH camp.

(v) Case studies

In all 21 case studies of girls and women who participated in RH camps have been conducted. The criteria for selecting case studies were based on services received at the camp site and the servcies received were RH (obstretics, gynocological and uterine prolapse), and psycho-social counselling, legal support and livelihood support. The breakdown of 21 case studeis are 6 case stuidies of clients who had receivced RH services, 5 case studies of clients who received psycho-social counselling and service, 6 case studies of clients who received legal counselling and support, and 4 case studies of clients who received livelihood support.

(vi) Field observation

The senior research team members including the Team Leader visited four districts to supervise and monitor the field activities. At the time when field data collection was going on, the last of 28 RH camps of the SGBV project was held in Sulichaur VDC of Rolpa district. The Team Leader observed the last RH camp in Rolpa organized by HHESS and collected information on RH camp activities such as service provision, quality of care and screening process for referring women with UP for surgery, the other component of service being provided in the camp setting.

Overall, the evaluation focused on assessing 6 major components of the project activities: psychosocial, legal support, livelihood, RH, and UP surgeries. In addition, the evaluation assessed the policy and media advocacy activities implemented through civil society organizations and media partners in order to raise awareness on the issue of SGBV. The evaluation was carried out as per the **OECD/DAC** criteria including relevance, effectiveness, efficiency, impact, sustainability, and management systems (OECD. 2008).

Triangulation

Triangulation was achieved through three major evaluation approaches: *Perceptions*, *Validation* and Documentation. Perceptions was elicited though interviews with internal and external stakeholders and key informants. Validation was achieved through meetings with project staff and service providers (RH camps); through direct observation during field visits; and by

beneficiary assessments. Documentation included review programme-related documentation, relevant policies, strategies and action plans, national statistics, and others

Data analysis
This project was evaluated employing largely the qualitative methods. However routine data and quantitative data collected from project districts, annual reports, and field visit reports were complemented to the findings. The evaluation employed range of complementary methodologies, drew on a range of data sources and used a range of analytical approaches. The data analysis fully represented the three result areas and the log frame.

Involvement of key informant interviews, FGDs, group meetings, document reviews, and field visits led to the identification of specific findings by each result. These were cross-checked with each other in order to obtain conclusions.

Triangulation analysis started at the end of the evaluation once preliminary findings were obtained. While triangulating, the findings derived from the FGDs, interviews and document review were clubbed under the evaluation criteria: design and relevance, effectiveness, efficiency, impact, sustainability, and coordination mechanisms.

2.2 Ethical considerations, stakeholder involvement, quality control, gender and youth mainstreaming

UNFPA's Division of Oversight Services (DOS) provided guidance related to ethical considerations for evaluators. This guidance notes:

(i) Ethical considerations

The evaluation has made an attempt to adhere to international best practices and conduct in full compliance with UNFPA's *Evaluation Guidelines* and the UN Evaluation Group's (UNEG) *Code of Conduct for Evaluation in the UN System*. In line with the UNEG Code of Conduct, the evaluation team attempted to:

(a) Ensure that respondents understand the evaluation's purpose, objectives, and the intended use of findings;
(b) Be sensitive to cultural norms and gender roles during interactions with all respondents; and,
(c) Respect respondent's rights and welfare by ensuring informed consent and rights to confidentiality before interviews and discussions.

Key informants and stakeholders identified for the evaluation were informed of the evaluation purpose, rights and obligations of participating in the evaluation and agreed to participate voluntarily. Key informants and other stakeholders including programme beneficiaries however had the right to refuse interview or the discussion sessions. Their consent was taken prior to proceeding for interview.

In order to ensure respondents' informed consent and their awareness of the scope and limits of confidentiality, respondents were given a written statement (**Annex V**) explaining the evaluation process before any substantive discussion occurred. The statement addressed informed consent, anonymity, and confidentiality to ensure that sensitive information cannot be traced to its source (without the respondent's approval). When appropriate, the statement was translated into Nepali and provided to respondents in advance of interviews. In addition, respondents were given the time and information to decide whether they agree to be interviewed and to make this decision independently without any pressure.

The evaluation attempted to adhere to international best practices and it was conducted in full compliance with UFNPA's Evaluation Guidelines and the UN Evaluation Groups guidelines. To the extent possible, the evaluators attempted to ensure privacy during all interviews with beneficiaries and members of the public. To ensure confidentiality of data the evaluators coded all data sources, and did not directly quote data sources without their expressed permission.

(ii) Stakeholder involvement

As per the requirement of UNFPA and UNEG''s evaluation policy and guidelines, the stakeholders were involved meaningfully in the evaluation process. Government counterparts, project partners and key stakeholders were involved at key stages of the evaluation and were consulted throughout the evaluation process. A key part of this process involved an initial briefing and discussion with the evaluation management committee, which was established specifically for the purpose of this evaluation and ensure the quality evaluation, is completed, meaningful participation of stakeholders etc. The EMC comprised of Gender PM (UNFPA), PM (UNFPA), PM (UNICEF), SGV focal point (UNICEF), representative from Government and UNFPA M&E Officer. Where feasible, the evaluation team provided a debriefing to the EMC before and after completion of fieldwork and when sharing the draft report.

(iii) Quality control

The evaluation team adhered to the Standards for Evaluation in the UN System and UNFPA's Evaluation Quality Standards. The evaluation was conducted in full compliance with the UN Evaluation Group's *Standards for Evaluation in the UN System*, and its *Norms for Evaluation in the UN System.* UNFPA's Division of Oversight Services (DOS) assesses evaluations completed for the agency using eight quality assessment criteria, addressing issues such as the structure and clarity of reporting, design and methodology, and findings and analysis. The evaluation team made an attempt to ensure that the evaluation meets the expectations associated with the quality assessment criteria.

One DOS criterion addresses the methods used in the evaluation. These methods are expected to: (a) be valid and logically linked to the evaluation's objectives; (b) be consistent with good practice and include, where appropriate, explicit efforts to test counterfactuals and triangulate among methods and data sources; and, (c) control bias, and acknowledge limitations due to uncontrolled bias.

(iv) Gender and youth mainstreaming

The evaluation team attempted to ensure as far as possible that young people and both men and women have equal opportunities to influence the finalization of design, decision-making and implementation of the evaluation. The evaluation adopted gender and social inclusion approaches in the formation of evaluation team. Likewise, all members of the evaluation team ensured gender and youth considerations at every step of evaluation, including individual data collection; ensured that young and old women are adequately represented among those interviewed. The SGBV specialist had overall responsibility of ensuring that the evaluation approach and analysis reflects mainstreaming of gender concerns and adequately addresses SGBV issues. The socio-psychological, RH, and legal consultant had overall responsibility of ensuring that the evaluation approach and analysis reflects the relevant issues in the evaluation findings and recommendations where appropriate.

(v) Conflict of interest

None of the evaluation team members has any known or potential conflicts of interest or any prior or present connection to UNFPA/UNICEF Nepal that would affect their judgment or ability to provide a credible and independent evaluation.

SECTION 3: EVALUATION FINDINGS

The findings of the evaluation include findings based on sample survey of beneficiaries and the key evaluation criteria: relevance, effectiveness, efficiency, impact, sustainability, and coordination mechanisms.

3.1 Findings based on sample survey data of beneficiaries of 6 districts

As mentioned earlier, in the course of assessment of the project, a quantitative survey focusing on RH, psych-social, legal and livelihood services, counselling and support provided by the camps was conducted which interviewed 360 girls and women from 6 of 14 project districts. These respondents were attendees of RH camps in the recent past. Of the total respondents 14.2 percent were under age 18 and the rest were aged 18 or more (**Annex VI**, Table 3.1).

The respondents have high fertility (average children ever born 2.73) and many children died during infancy (average children dead 0.44) (**Annex VI**, Tables 3.7). Most (56%) women/girls do farming or wage labouring for their living and about 2 in 3 respondents live on less than Rs.6,000/ a month supporting an average family of 6.3 members. The largest proportion of respondents was Dalit (26%), followed by Janjati (22%), Terai Middle Castes (18%), Chhetri/Bahun (33%) and Muslims (2%, Annex VI, Tables 3.8 to 3.12). Of the total respondents slightly less than half (49%) of them received only RH services or counselling, 29% received psycho-social counselling, 16% received legal counselling on SGBV and 6% received livelihood support as they were victims of SGBV (**Annex VI**, Tables 3.13).

a. Respondents' perception on RH services, counselling and group education

RH services included gynaecological, obstetrics and UP services and counselling. Among the gynaecological serves the services received by respondents included but not limited to, free medicines, HIV testing, free health checked-up, health information, quick health service; no long queue, advice to keep private parts clean, advice to take rest, advice to use FP methods, and psychosocial counselling (**Annex** VI, Table 3.15).

UP clients received services/counselling such as pelvis floor exercise, ring pessary insertion, referral slip for UP surgery, and medical prescription/medicines (**Annex** VI, Table 3.15).

The gynaecological services and counselling received at the RH camp was rated by the respondents and the level of satisfaction was very high; 83% of them said that the service was good or very good (**Annex** VI, Table 3.16). Similarly respondents receiving UP surgeries and counselling rated UP service/counselling highly (70%, **Annex** VI, Table 3.17). Clients waiting for their turn at camp service centres had the opportunity to take part in group education, they could read posters, and pamphlets if literate or educated, interact with group instructor about health concerns.

b. Perception on psychosocial counselling and support

Before coming to the RH camp nearly half (48%) of respondents who were victims of SGBV shared their psycho-social problems with friends. Another 24% shared with husband, and still another 22% shared with other family members (**Annex** VI, Table 3.18). However, nearly one in five did not share their problem with anybody. In the camp they put their psycho-social problems to the counsellor and after explaining their problems to the counsellor they had different feelings and experiences than what they felt before talking to the counsellor. The respondents said that after mentioning psycho-social problems at camp they felt hopeful as the camp assured to help

them, got relief/satisfaction, encouraged to talk to husband and felt that the psychosocial support was good. A few felt no difference (**Annex** VI, Table 3.19).

At the camp women and girls got a number of psychosocial counselling and support. During the counselling they learned that sending daughter to school, taking rest from time to time, talking to husband/parents, living in harmony with family members, avoiding child marriage, engaging in income generating activities, working for children's future, and not worrying about problems but keep on working as usual were important in life (**Annex** VI, Table 3.20). The respondents who got psycho-social service/counselling at RH camp some 95 percent said that they were good or very good (Annex **VI**, Table 3.21).

c. Perception on legal support

The respondents receiving legal counselling/service mentioned that the type of services/counselling they received included advice to lodge a complaint, to go to other place for service if nearby place cannot do the job, got a referral slip (4 out of 57 respondents who had psychosocial counselling support) to go elsewhere, and the provider committed to help them later (**Annex** VI, Table 3.22). Some women did lodge complains in Police, some said they were empowered to claim their rights and some said they developed confidence in themselves (**Annex** VI, Table 23).

d. Perception on livelihood support

Twenty survey respondents were interviewed on livelihood support. They said they got assurance for help in future but no support was provided until the time of data collection. Some said that they would be given training on sewing and some said they would be sent to adult literacy classes. Another income generating activity promised was to fund to raise livestock (**Annex** VI, Table 3.24).

e. Perception on overall camp services

The respondents also rated the overall camp services. Overall, 86% respondents said that the camp activities and services were good or very good (**Annex** VI, Table 3.25). Reasons for finding camp good were that the services and drugs were free, good counselling, did not have to wait long for service, good provider behaviour, health improved, got referral service, received free surgery, camp appropriate for sharing problems, camp arranged for treatment even outside the camp, got assurance for financial assistance and they did not have to go far for treatment and services (**Annex** VI, Table 3.26).

A few respondents who mentioned that the service was not up to their liking said that there is a need to give effective medicine, good counseling, provide financial assistance to the poor, regular setting up of camp and surgical facility should be made available in the camp (**Annex** VI, Table 3.27). A few clients mentioned that the medicines they received did not help them cure. Some thought that counselling was not satisfactory. In this respect field observation of counselling session in one of the RH camp settings by psychosocial specialist is worth noting. The specialist observed counselling for two days and found that the counsellor in the camp was using same stereotype technique to counsel all clients without understanding the type of client. The counsellor was too rigid and assumed that she knew everything but she did not know what was the background of the client. She started telling the client that her husband is dominating and therefore she needed to get permission from him to plan her family. In return the client told her that her husband would do anything she asked him although the client was an illiterate village woman. The counsellor did not know that in a Magar community woman's say in the family is as equally important as that of husband.

In addition, the counsellor was found using high sounding words with the village woman. When asking about the contraceptive method the client was using, the counsellor used the following sentence, *"Tapaile pariwarniyozanko kun sadhan prayog garnubhayeko chha?"* The counsellor should have used the following sentence instead: *"Tapaile bachha napaunako lagi sui lagaunu bhayeko cha ki chhakki khanu bhayeko chha?"*

The study respondents from six districts were inquired about the source of information about RH camp and in response nearly 4 in 5 said it was "friends/neighbour" as the main source. Other sources were FCHV (69%), miking (36%), FM radio (36%), health provider (18%), TBA (10%), student (9%), street drama (8%), posters/pamphlet (7%), VDC representative (4%), NGO worker (4%), TV (3%), in that orders (**Annex** VI, Table 3.28).

3.2 Case studies

Case studies of direct beneficiaries of the project have also been collected. A large number of women and girls who survived sexual and gender based violence during the conflict and post conflict periods have also had their hopes raised following their visit to RH camps where they received different services, education and counselling. It has been seen that the project has reached a large number of girls and women who were affected by SGBV but a few case studies

Box 1: RH/Uterine Prolapse case study

A woman suffering from uterine prolapse, ostracism in the family and society acquired new life after UP surgery.

A 30-year old Dalit married woman living in a mountain village experienced uterine prolapse at the age of 16 after giving birth to her first child. She had difficulty in walking, doing physical work and she used to bleed a lot. She lived a horrible life for 14 years. For that long time she did not attempt to go for treatment because she had no money even to pay for transportation.

Only some six months ago she got good counselling from health provider in a RH camp. After examining her case the doctor at the camp referred her for surgery to Kohalpur Teaching hospital. She heard about the camp from her friends and also got to know that the service was free of cost.

She went to Kohalpur Medical College with another person accompanying her to help her while she was there. She was again examined by the doctor in the hospital. Finally she had the UP surgery. She returned home but she paid nothing; it was all free. She is now very happy although she thinks she is not completely healed.

She is, however, very thankful to the RH camp which provided UP surgery for her free of cost. She recommends that such camps should continue and expand to other areas of the country where many women are suffering from uterine prolapse.

are presented here as illustrations.

Box 2: Psychosocial case study, survivor of gender based violence

A 30-year old married woman living in a mountain village after giving birth to 4 children - 2 sons and 2 daughters still suffers from gender based violence from her husband. Before visiting the RH camp she lived a difficult life; her husband married another woman leaving her behind. She said it was her destiny as planned by god.

At the camp she mentioned every inner feeling/ problem to the psycho-social counsellor but before that she did not share her feelings with anybody because she thought nothing would happen. The counsellor told her that she should not keep worrying for things that happened in the past; worrying can be harmful to her health. This is her first visit and she hopes that the counselling would help her to live a better life.

The woman said that as she was able to share her feelings with another woman at the camp she found it very relieving. She can now start her life new.

At the camp in addition to good counselling, she had free health check-up and also got some drugs free of cost. All these have helped her to forget worries and begin new life; now she is inspired to live, she is hopeful.

The case studies - Boxes 1 to 4 were collected by PHD Group field workers in February and March 2012.

Box 3: Legal support case study of a woman who survived sexual violence during conflict
In the month of Fagun 2059 or 13 February to 14 March 2003, three uniformed personnel on the excuse of searching for Maoist rebels forcibly entered the house in a village in Far Western region of Nepal. One of them stood outside the house, one stood as a guard on the entrance of the house, and one came inside where there were two children and one middle aged woman. Ignoring the children the guy who had entered the house pointed the gun at the woman and raped her. The victim due to fear and threats did not tell anybody about the incident nor did she report the police. The victim was a farmer 35 years old woman from Terai Janajati group with 6 children. During the post-conflict period different organizations talked to her and gave assurance of support but nothing happened.
The victimised woman talked to UNICEF/ UNFPA project personnel; she told them that after she was raped her husband was also bitten badly and made him nearly lose his mind. At the RH camp organized by ADRA she mentioned all about her horrible life and d the camp legal counsellor assured her of help. However, so far she has not had any concrete help from the camp organizers except verbal assurance. However, she said because the camp personnel told her that it would take some time to process the case the woman is relieved of her mental tensions and now she is gratified.

Box 4: Livelihood case study survivor of physical violence during conflict period
A 31-year old Terai Janajti married woman with four children and husband living in Western Terai region survived physical violence from the Maoist rebels during the conflict period. On Poush 9, 2058 or 24 December 2002 a couple of Maoists visited her home at 11 at night, tied her with ropes in the house and took her husband about 100 meters away and physically assaulted him very badly. The next morning local police rescued him and helped the victim to bring to the district hospital. Her husband was taken to India for further treatment; the family spent whatever they had and became very poor. After treatment the family moved away from their usual place of residence and moved to the town for fear of life from the rebels
Later political leaders from Democratic parties helped the displaced family to some extent. The woman started a moving cart shop in the new place but the income was too little to support the family. On Asar 6, 2068 or 20 June 2011, at the ADRA RH camp the victimised woman shared her problems with the counsellor. She requested for some economic help so that she could make her shop slightly bigger. The counsellor promised to help her to increase her income for the family so that they can survive better. Because of this assurance she is encouraged to live and has become hopeful of her life. However, she has not got any support so far.

3.3 Effectiveness

3.3.1 Findings based on project service data and reports provided by UNICEF, UNFPA and implementing partners

This section explores: (i) to what extent attempts to address the evaluation TOR questions under 'effectiveness': *assess effectiveness of the project in terms of progress made towards the outcomes within the given timeframe; how and to what extent clients benefited from the medical, psychosocial, legal, documentation, shelter, livelihood and referral services? What are the perspectives of stakeholders if any project components can be replicated? Are there any good examples (case studies) of women and girls who have benefited from the project?* These issues are examined, as far as possible, one by one as follows:

In assessing the effectiveness of SGBV project, the evaluation team has taken into account the log frame outcomes shown in the project proposal and accordingly they are presented below:

Outcome 1*: Identify and document incidences of sexual violence against women and girls during the time of conflict and post conflict in Nepal.*

In order to identify and document the incidences of sexual violence against women and girls during the time of conflict and post conflict in project districts RH camps were organized by implementing partners. The RH camps served as an entry point for the main activities of the project: the documentation of sexual violence cases during the conflict and post conflict period and the surgical correction of third degree utero vaginal prolapse cases. In 14 districts 2 RH camps each were organized in two phases by UNFPA implementing partners ADRA and HHESS. Each IP was responsible for seven districts to conduct 6-day first phase and 4-day second phase camps.

The RH mobile camp mechanism, as an entry point worked very well. If women were to seek SGBV services directly they would most likely not participate due to the threat of confidentiality. Through local FM radio, miking, posters and pamphlets women of the camp site districts were requested to seek free health services and counselling on RH, UP, STD/HIV/AIDS, general health problems, and sexual and gender based violence. In several districts, while organizing RH camp the project team also visited school in the surrounding. This also encouraged adolescents and youth to visit RH camp. At the camp after registering her name the client met PHN who explained to her different services available at the site. The client was provided with choices such as RH service, psycho social counseling, legal support and documentation of stories of women who had experienced SGBV. The survivors of SGBV had a good opportunity to seek legal counseling and services at the camp site.

Because the camp lasted for 6 days in first phase it provided an opportunity for women to think before deciding to seek services. If the camps were organized only for a few days such an opportunity would have been lost. In addition, the project RH camp provided integrated services. In regard to RH health problems, they were provided laboratory service, counseling, medications, and screening for surgical treatment of UP. The follow up camp provided clients with an opportunity to do follow up visit in the same sites.

Result 1: Identification and documentation incidences of sexual violence against women and girls

Results 1 related to outcome 1: Identification of SGBV survivors and provision of legal support

The project aimed to identify as many cases of survivors of SGBV as possible in 14 project districts. As mentioned above various activities were conducted to identify and document cases of survivors of SGBV. During the project period, Advocacy Forum (AF) met a total of 3,581 women and girls attending RH camps to screen for legal counselling and 1,000 clients were identified requiring legal counselling (Table 3.1).

Before providing legal support activities, AF conducted small group discussions with women to provide information about women legal rights on education, health, social activities, property and domestic and sexual violence. The 1,000 women and girls who survived SGBV were provided legal counselling and some were referred to appropriate agencies for support as required.

The 1,000 girls/women who suffered from different types of SGBV received legal counselling and of them 49 belonged to conflict period (Table 3.1). The most rampant gender based violence is ‘domestic violence’ (n=325, 32.5%), followed by 'polygamy' (n=138, 13.8%), ‘physical assault and battery’ (n=105, 10.5%). Sexual violence comprising of rape, statutory rape, attempted rape and harassment are 5.1%, 0.6%, 0.8% and 2.1% respectively.

Table 3.1 Number of women/girls affected by SGBV who received legal counselling from Advocacy Forum in camps, 2010-2012

SGBV Type	No. of legal counselling (new clients only)	Cases from conflict period
Rape	51	20
Statutory rape	6	6
Attempted rape	8	2
Sexual harassment	21	21
Domestic violence	325	
Non SGBV (Torture/disappearance)	237	237 Conflict related non-
Polygamy	138	
Physical assault and battery	105	
Psychological and emotional abuse	17	
Other SGBV	15	
Denial of resources	13	
Forced marriage	3	
False marriage	2	
Type unknown	59	
TOTAL	**1,000**	**49 Conflict related SV cases**

Source: AF. March 2012

Results 2 related to outcome 1: Documentation of SGBV survivors

CWIN has documented incidences of sexual violence against women and girls during the time of conflict and post conflict periods and for this activity FGD, interaction and interview techniques were used. Case studies of SGBV have also been prepared. During the project period CWIN in collaboration with ADRA and HHESS documented 821 cases of SGBV covering both conflict and post conflict periods (Table 3.2). Of the total cases documented proportionately more belonged to conflict period than the post conflict period.

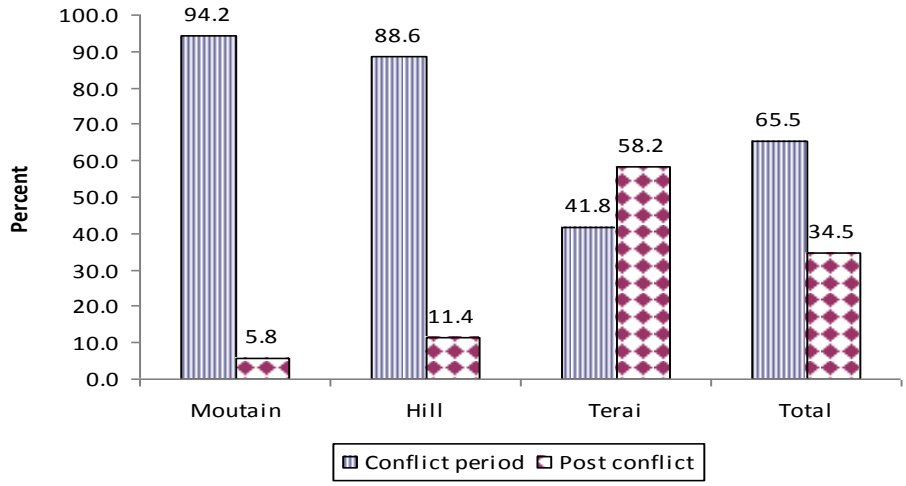
Table 3.2 Distribution of women/girls affected by SGBV who have been documented by CWIN according to district, 2010-2012

District	During Conflict		Post Conflict		Total	
	N	%	N	%	N	%
Achham	32	88.9	4	11.1	36	100.0
Kanchanpur	20	46.5	23	53.5	43	100.0
Bajura	64	87.7	9	12.3	73	100.0
Saptari	2	3.3	59	96.7	61	100.0
Siraha	2	4.7	41	95.3	43	100.0
Mahottari	0	0.0	45	100.0	45	100.0
Dhanusha	10	25.6	29	74.4	39	100.0
Bardiya	59	95.2	3	4.8	62	100.0
Dang	51	68.9	23	31.1	74	100.0
Kapilbastu	35	57.4	26	42.6	61	100.0
Surkhet	55	100.0	0	0.0	55	100.0
Kalikot	116	98.3	2	1.7	118	100.0
Rukum	68	84.0	13	16.0	81	100.0
Rolpa	24	80.0	6	20.0	30	100.0
Total	**538**	**65.5**	**283**	**34.5**	**821**	**100.0**

It is seen in Table 3.2 that during the conflict period incidence of SGBV was nearly double (66%) than in the post conflict period (34%). Mainly hill and Mountain districts were affected by conflict during the conflict period while in the Terai districts women and girls were sexually victimised in the post conflict period. In the high Mountain districts of Kalikot and Bajura a total

191 girls and women were sexually raped or assaulted and of them 94% took place during the conflict period and in 4 hill district of Achham, Surkhet , Rukum and Rolpa of the total SGBV cases 89% took place during the conflict period (Figure 3.1).

Figure 3.1 SGBV trend in percent during conflict and post conflict periods, 14 districts, Nepal



Source: AF. March 2012.

During the post conflict period SGBV cases proportionately increased in the Terai because local groups started revolting against the establishment during the post conflict period and as a result proportionately more (58%) SGBV cases were reported in the post conflict period. Women participating in group discussions vibrantly reported: **"Both the parties (army and Maoists) interrogated, threatened and tortured women of our villages asking them about the whereabouts of their husbands and asking them to bring them before the army or Maoists. Many of our village sisters (*didbahiniharu*) were raped".**

Of the total SGBV victims, most (36%) were physically assaulted, followed by domestic violence (28%), other forms of violence (17%), rape (7%), and attempted rape (5%) and so on. About one in eight women and girls affected by SGBV were under the age 18. This is a serious issue of child rights.

Relatively higher proportions of under 18 girls were victims of SGBV in hill and Mountain districts of Kalikot, Surkeht and Rolpa. In the Terai too child victims of SGBV were fairly high in Saptari, Mahottari, Dhanusha and Kapilvastu. Women and girls of all caste/ethnic groups were victims of SGBV but higher proportions of Janjati (31%), Chhetri (29%) and Dalit (28%) were victims of SGBV than other groups (Table 3.3).

Table 3.3Caste/ethnicity of girls/women affected by SGBV

Caste/ethnicity	N	%
Brahmin	81	9.9
Chhetri	241	29.4
Janajati	255	31.1
Dalit	228	27.8
Religious minority	16	1.9
Total	821	100.0

Outcome 2: ***Support access to reproductive health care and psycho-social counseling for victims of sexual violence in target areas***

Outcome 2 requires that women attending RH camps receive reproductive health services and psycho-social counseling.

As mentioned earlier in order to attract women and girls affected by SGBV, RH camps were organized as entry points because going out from home to seek RH services is comfortable to approach the reproductive health camps for women and girls. Therefore establishment of reproductive health camps was necessary in project districts. The IPs (ADRA, HHESS, TPO, AF, CWIN, Sancharika Samuha, and SAVE THE CHILDREN) of UNFPA and UNICEF worked very well with diverse responsibilities to full fill common objectives of the project. The team provided services under one umbrella. The strengths of each IP complemented each other.

Prior to setting up of RH camps for project activities the whole of the team members were trained on SGBV and the nature of the RH services in the beginning of the project as orientation training followed by follow-up trainings with simulation, demonstration and intensive role plays. It provided a forum for clarity of each components of the implementation strategy and helped the participants to get familiarized not only with whole of the members but also with the central level officials from donor and IP agencies. Furthermore, it helped to develop confidence among the team members of each organization.

In 14 SGBV project districts one community psychosocial worker (CPSW) each was locally recruited. TPO gave 10-day basic psychosocial training to all 14 districts CPSWs before assigning them work in the districts. One trainee in Bajura could not continue the job because the programme did not continue in her VDC after the training. In order to make people aware on psychosocial issues and consequences of SGBV on psychosocial wellbeing, orientations on psychosocial issues to women/girl RH camp clients were also conducted. During the project period about 700 people participated in orientation programmes.

Results 1 related to outcome 2: Number of women and girls who received reproductive health services in 14 project districts

The two rounds (first round and follow-up) of RH camps organized jointly by ADRA, Save the Children, TPO, CWIN, and Advocacy Forum in conflict affected VDCs of 7 districts and similar RH camps jointly organized by HHESS, Save the Children, TPO, CWIN, and Advocacy Forum in conflict affected VDCs of another 7 districts attracted a large number of clients. The girls and women visiting the camps received a number of services including medical, psychosocial, legal, documentation, shelter, livelihood and referral services.

During the project period a cumulative total of 36,471 women/girls were registered in 14 project districts (Table 3.4). Of them the highest number (n=3,755) of women/girls registered was in Bardiya district and the lowest number (n=1,607) was registered in Dang district.

Table 3.4 Distribution of project clients by district

SN	District	Number	SN	District	Number	SN	District	Number
1	Achham	2,315	6	Mahottari	2,732	11	Surkhet	2,785
2	Kanchanpur	3,106	7	Dhanusha	2,468	12	Kalikot	2,049
3	Bajura	2,403	8	Bardiya	3,755	13	Rukum	2,502
4	Siraha	2,640	9	Dang	2,435	14	Rolpa	1,607
5	Saptari	2,808	10	Kapilvastu	2,866			
				Total				**36,471**

The target of RH camps was to reach 21,000 during the project period in 14 districts[3] and the achievements at the end of the project was 36,471 which when translated into percentage comes to 175% achievement. No targets were set for other indicators such as number of SGBV clients to reach, number of SGBV clients to counsel and so on. The target set for expected RH clients was too low if current data of women age 15-49 is to take into consideration. The evaluation team has estimated that some 59,000 women of reproductive age should have been set as the target in 28 VDCs of 14 districts[4]. If this more realistic target was set in the beginning of the project the achievement would have been 61.8%. Target set for uterine prolapse was 50 cases for every district regardless of population size which was not technically sound.

Among the total women/girls registered in the RH camps, 66% were from disadvantaged communities (Dalit/ Janajati) and 34% were from the relatively more advantaged communities of Brahmin, Chhetri, Thakuri etc. Therefore, the project was successful in reaching out to the more vulnerable populations of Dalit and Janajati categories.

Women and girls received 7 different types of RH services including gynaecological, treatment of RTI & STI, obstetric - ANC & postnatal care, abortion, family planning, VCT related to HIV/AIDS, RH counselling, and blood, urine & pregnancy tests. Overall, 81 percent of girls and women registered at the camps received RH services. Some 38 percent of them received general health services and some 68 percent got orientation on health issues (UNFPN. Annual Report 2011). Similar data are not available for end of project. It must be noted that many of the clients registered at camps received not only one type of service but multiple services depending on their needs and problems.

The general health services included services for back ache, haemorrhoids, headache, viral fever, hernia, conjunctivitis, tonsillitis, pharyngitis, anaemia etc.

Orientation on health issues was also done to women/girls when they were waiting to get various services. Around 68% of the women/girls attending RH camps were given orientation on various aspects of health issues. Different types of IEC materials were used for this purpose (UNFPN. Annual Report 2011).

Many women in Nepal suffer from uterine prolapse (UP), also called pelvic organ prolapse (POP) or prolapse of the uterus. Services related to uterine prolapse formed a major part of overall RH services. UP services included counselling, Ring Pessary insertion, Pelvic Floor Exercise, and Referral for Surgery.

Table 3.5 shows number of women who accessed uterine prolapse services. In 28 RH camps held in 14 project districts in all 917 women were found suffering from 3rd and fourth degree UP problem and therefore they were referred for surgery. The government of Nepal has made all services related to UP free since 2009 (MOHP. 2009). Although 917 women were referred by RH camps for surgery in hospitals only 74% went to the hospitals they were referred for surgery despite the fact that they were assured of transportation and surgical services free of costs (Table 3.5).

[3] In one VDC 2 rounds of RH camps were conducted. In the first round camp was conducted for 6 days and in the second round it was conducted for 4 days and therefore, in all, camp was conducted for 10 days in one VDC. The plan was to see 150 clients a day by two staffs and when these are taken into account the total target of clients comes to 21,000.

[4] The figure of 59,000 women aged 15-49 was arrived at by using population census data of 2011 of 28 VDCs of 14 districts.

Table 3.5 Distribution of uterine prolapse cumulative number of clients screened, reached hospital, rejected by hospital, surgeries completed according to district, 2010-2012

		Screened for surgery at RH camps	Arrived at hospital		Cancelled due to various medical reasons		Surgeries completed at hospital	
SN	Districts	Number	Number	% of total screened	Number	% of total who arrived at hospital	Number	% of total who arrived at hospital
1	Kalikot	20	14	70.0	0	0.0	14	100.0
2	Dang	46	28	60.9	7	25.0	21	75.0
3	Surkhet	74	49	66.2	9	18.4	40	81.6
4	Kapilbastu	45	24	53.3	6	25.0	18	75.0
5	Bardiya	64	54	84.4	23	42.6	31	57.4
6	Rukum	80	64	80.0	16	25.0	48	75.0
7	Rolpa	30	14	46.7	0	0.0	14	100.0
8	Achham	47	35	74.5	1	2.9	34	97.1
9	Kanchanpur	66	48	72.7	8	16.7	40	83.3
10	Bajura	52	46	88.5	2	4.3	44	95.7
11	Saptari	51	33	64.7	0	0.0	33	100.0
12	Siraha	126	102	81.0	0	0.0	102	100.0
13	Mahottari	89	63	70.8	0	0.0	63	100.0
14	Dhanusha	127	101	79.5	0	0.0	101	100.0
	Total	**917**	**675**	**73.6**	**72**	**10.7**	**603**	**89.3**

Proportion of client screened at RH camps arriving at hospital was lowest from Rolpa and second lowest from Kapilvastu. Very low number of clients turning up at hospital from Rolpa was because, as informed by key informants was that in Rolpa some other organization had conducted UP screening camp and one of them died after UP surgery. This situation affected the RH clients of Rolpa and although clients were referred for surgery several of them did not want to undergo surgery and therefore they did not go to hospital. From the field interviews it is also learned that some clients screened at RH camps for UP surgery in Kapilvastu by ADRA or HHESS instead of going to hospitals they were referred actually went to private clinics or government hospitals nearby.

Finally among those who arrived at hospitals 89% of women were successfully performed surgery; overall, 11% women who reached hospital for surgery were rejected on grounds of contraindications (Table 3.5).

Results 2 related to outcome 2: Women and girls provided with psycho-social counseling in 14 project districts

As mentioned earlier, one of the main purposes of the project was to provide counselling and other support to women and girls who have survived various types of sexual and gender based violence during the conflict and post conflict periods. Women and girls showing up at RH camps were screened for psycho-social counselling and support. In the RH camps organized by two implementing partners, two psychosocial counsellor each from TPO provided psychosocial support activities including emotional support, psycho education to remove clients' misbelieves, psychosocial counselling sessions, strengthening of coping mechanism and imparting information to those who may not need further session but visited psychosocial counsellor during RH camp.

In all, psychosocial counselling and support was provided to 3,551 women and girls during the project period (Table 3.6) and of them 7.3 percent (n=275) were under age 18.
Two clients requiring further counselling were referred to TPO Kathmandu and 375 clients were referred to regional counsellor for follow up.

The TPO organized care for care givers training two times for the members of the project team because they were working with conflict affected people who were also indirectly affected due to the problems they encountered.

Table 3.6 Distribution of number of RH clients receiving psychosocial counselling and support by district, 2010-2012

SN	District	First round Camps	Follow-up Camps	SN	District	First round Camps	Follow-up Camps
1	Kanchanpur	259	55	8	Saptari	91	69
2	Bajura	108	167	9	Dhanusa	188	22
3	Kapilwastu	255	121	10	Mahottari	71	178
4	Dang	272	30	11	Rolpa	145	124
5	Surkhet	357	63	12	Rukum	221	116
6	Achham	192	112	13	Kalikot	100	73
7	Siraha	95	87	14	Bardiya	293	69
		Total				**2,647**	**1,286**

Outcome 3: ***Promote recognition of the incidence of sexual violence in Nepal peace process through access to justice for victims of sexual violence, including through participation in transitional justice processes.***
The outputs for outcome 3 are submission of findings to the TRC and other relevant transitional justice mechanisms and First Information Reports (FIR) filed with the Police. In order to achieve the outputs the activities required were provision of legal counselling to women and girls affected by SGBV and submission of information to Truth Reconciliation Commission (TRC) and other relevant transitional justice mechanism.

Results related to outcome 3:
The Advocacy Forum, out of the 1,000 cases of sexual and gender based violence identified in 14 districts during the project period, has identified 70 cases as potentially eligible for consideration in a transitional justice process as agreed upon by the signatories to the Comprehensive Peace Agreement (CPA).

AF has also selected 5 strong Sexual Violence cases from conflict period and has drafted the FIR. For two "test cases" AF has collected all related evidences and related information for FIR. One test case has been filed which has been endorsed by police and also by Supreme Court. Advocacy Forum has prepared one more case ready to register FIR.

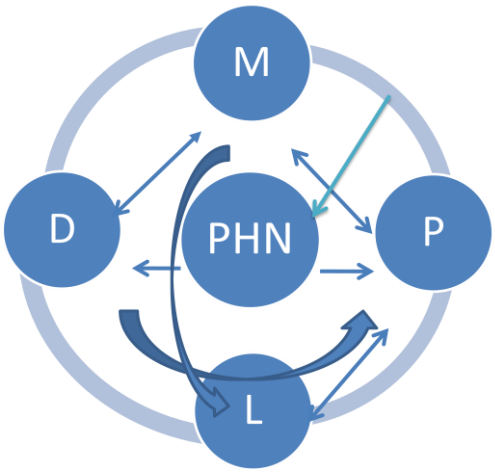
3.3.1a. Livelihood
SAVE THE CHILDREN as one of the implementing partners of the SGBV took the responsibility of providing necessary support to 280 women and girl survivors of SGBV during the time of conflict and post conflict in Nepal in 14 districts, 20 in each. It has provided support in the areas of education, income generation and vocational training or both. It also conducted ToT for the implementing partner NGOs during the planning workshop (at the national level) and capacity strengthening of stakeholders at the district level (in 14 program districts). Criteria for

support were that the victims of SGBV should belong to the conflict period victimized by the either security forces and/ or Maoists. The survivors of SGBV should be rated as having serious problem and facing economic hardship.

3.3.1b Referral mechanism and services

The clients who registered their names at RH camps in the 14 project districts seeking service were referred internally as well as externally. For this, there were series of coordination meetings among the implementing partners to strengthen the referral and follow-up mechanism of the cases referred. ADRA and HHESS developed referral mechanism as shown on the right side for the continuation of the services as required.

Internal referral mechanism worked as follows: a client first registers at the site then she proceeds to PHN (Public Health Nurse) and the latter after listening to the client's problems refers her to the appropriate room medical (m) or psychosocial (p) or legal (L) or documentation (d) room depending on the problem. Once the client discusses her problem with the person in the appropriate room she could still be referred to another room and this way inter room referral also took place.



External referral mechanism varied by type of implementing partner. For instance, Advocacy Forum referred clients requiring legal support to different outside organizations such as District level Bar Associations, Community Based Paralegals, Police Offices, Local Peace Committee, District Court Legal Aid Committee, Advocacy Forum Branch Offices, District level NGOs, and VDC Secretary. In every district external referral matrix was developed after two-day orientation to District level stakeholders and this referral matrix was used in the camp.

CWIN followed the external referral mechanism as shown in the table below.

SERVICE	PURPOSE	ORGNI ZATION	REFERRAL MECHANISM	FOLLOW-UP
IGA	Economic Empowerment	WCO	Debriefing and referral form	Local Stakeholders
LEGAL REMEDIES	Dispute Resolution	WCO, Paralegal	Debriefing and referral form	NA
Psychosocial Counselling and Education Support	Trauma Healing and Continuation of Education	Governm ent School	Debriefing and referral form	NA
Safe House	Trauma Healing and Life Skill Training	Saathi Shelter	Through telephone conversation as recommended by UNFPA	Not successful as no provision for the little children

For instance woman or girl needing economic support was referred to Woman and Child Rights Officer of the local government where she would be given training on income generating skill.

Woman or girl needing shelter would be recommended to Saathi shelter where she would get Trauma Healing and Life Skill Training but this was not successful because the shelter did not have place for a small child that would accompany the mother suffering from SGBV.

During the project period a total of 1,054 women/girls were screened and referred for surgery to three hospitals and of them only 61% (n=645) arrived at the referred hospitals. Of the 645 women reaching the hospitals suffering from third and fourth degree UP, 580 had successful UP surgery.

The psych-social support activities also included referral of clients to other services or counselling centres and follow-up. According to TPO, two clients were referred to Kathmandu office for further services and a total of 350 clients were referred elsewhere. TPO regional counsellor followed up 100 clients in its regional offices and 108 clients were provided with PS follow up services in follow-up RH camps.

AF referred cases for legal services to District level Bar Associations, community based paralegals, Police, Local Peace Committee, District Court Legal Aid Committee, Advocacy Forum Branch Offices , District level NGOs and VDC Secretary. The cases were referred for domestic and sexual violence, issues related to citizenship, property rights, and other gender based violence and crimes.

CWIN referred cases for IGA and legal remedies to WCO, for psychosocial counseling and education support on trauma healing and continuation of education to Government schools. CWIN also referred cases to safe house for trauma healing and life skill training to Saathi Shelter organization. They also referred cases for continuing education to district CWIN offices.

3.3.1c Achievement of RH target and coverage of SGBV cases

As discussed earlier the RH targets for the project was achieved by 175% but this was too high probably because the initial target was set too low. In order to estimate RH target it appears that proper analysis was not done.

With regard to SGBV, no targets were set and as a result it is difficult to examine the achievement of the project in quantitative terms for a number of reasons. Firstly, although 14 districts were identified as most affected by conflict, the project did not specify any target. Secondly, RH camp sites that were identified initially were, according to several district level stakeholders, not ideal to capture as many women and girls affected by conflict.

An attempt has been made here to estimate the coverage of SGBV in 14 districts using data from 2011population census (CBS. 2011), NDHS 2011 and reported data of the project. According to US study nearly 25 percent women report sexual violence in their lifetime (IGWG of USAID 2006) and NDHS 2011 shows that 12 percent women aged 15-49 ever experienced sexual violence and 6 percent women report having experienced sexual violence in 12 months preceding the survey. Overall, the coverage of sexual violence based on life time experience was estimated at 6% while that based on sexual violence prevalence based on last 12 months was 11% (Table 3.7). The number of SGBV survivors that the project reached was 821 during the two-year project period. Given a number of constraints while implementing the project of sensitive nature and the Nepalese women are highly constrained by the culture of silence when it comes to sexual and gender based violence, the coverage rates are satisfactory but with more careful planning and analysis of the situation there is a big potential to increase the reach.

Table 3.7 Estimates of coverage of women and girls who survived SGBV according to 14 project districts

SN	District	Females 15-49 in 2011 in 2 VDCs	12.3% experience SGBV	6.4% experience SGBV last 12 months	SGBV data	% covered with reference to last 12 months	% covered with reference to ever experienced SGBV
1	Saptari	2,845	350	182	61	16.7	8.7
2	Siraha	3,064	377	196	43	11.0	5.7
3	Dhanusha	3,751	461	240	39	8.1	4.2
4	Mahottari	4,218	519	270	45	8.3	4.3
5	Kapilvastu	3,655	450	234	61	13.0	6.8
6	Dang	7,417	912	475	74	7.8	4.1
7	Rolpa	2,364	291	151	30	9.9	5.2
8	Rukum	2,514	309	161	81	25.2	13.1
9	Kalikot	2,312	284	148	118	39.9	20.7
10	Surkhet	3,594	442	230	55	12.0	6.2
11	Bardiya	7,047	867	451	62	6.9	3.6
12	Bajura	2,539	312	162	73	22.5	11.7
13	Achham	1,807	222	116	36	15.6	8.1
14	Kanchanpur	11,983	1,474	767	43	2.8	1.5
	Total	**59,112**	**7,271**	**3,783**	**821**	**10.9**	**5.6**

3.3.1d Difficulties and challenges faced during the project implementation

In course of the implementation the project had to face various constraints and challenges. As indicated above, the launching of project took place with a long gap after the peace process. It was thus difficult for the service providers to trace the victims of conflict and post-conflict period. As a result documentation of sexual violence victims turned out to be a big challenge. The remoteness of the service sites and lack of space in the camp settings in some districts also constrained the service providers especially in maintaining confidentiality. At each of the camps, the turnout of girls and women seeking RH services was high (in some camps the turnout was as high as 400 clients a day) and it proved to be a challenge for the service providers to cope with the high turnout. Within the camp setting, the team was composed of personnel with different background and work settings so it was a challenge at least in the initial stage of project implementation for the camp team to work cohesively and at equal level.

3.3.1e Shortcomings of the programme

Most stakeholders both at district and central level noted that the timing of programme activities was not appropriate. The project activities was initiated after 4 years of the end of conflict and many survivors may have been lost because of many factors such as marriage, migration, fear of re-victimization, lack of faith in organizations and as a coping mechanism some may have compromised with their life after giving up hope of support. They felt that if the project was launched earlier, the project would have been able to trace higher number of SGBV survivors than what has been achieved.

Another issue raised by many stakeholders was that considering the special nature of service being provided, the camp duration was short. This is also substantiated by the fact that the daily turnout of women and girls in nearly all the camps was overwhelmingly high. Since the service providers had to cope with a large number of women and girls in a short period of time, the stakeholders believed that the quality of service may have been compromised.

The discussion results also indicated shortcomings in the planning of referral cases. As the RH camp is a one-time activity, the survivors need to be referred to other facilities for specialized services or for follow up either in the project district or in the facility that is closest to their home.

Referring to other areas or sites is usually characterised by some attrition of cases. For instance, the clients who were referred for uterine prolapse surgery to hospitals some 40% (see Table 3.5) did not go to hospital for surgery although UP surgery, transportation and food and lodging were all paid for by the implementing partners. In case of some programme components the service may not be available in the district – for example psychosocial support services are not available in all project districts. Many stakeholders believed that the alternative locations or facilities for these types of specialised or follow-up services were overlooked in the planning process.

Discussions with district headquarters level stakeholders particularly DPHO revealed that still more girls and women could have been attracted with their participation. Their argument is that despite miking and local FM messages girls and women who are really in need of SGBV services and counselling live in areas which are inaccessible; they are illiterate, poor, do not listen to radio and generally unable to speak out their problems. Some national level NGOs also had the opinion that selection of focus VDCs should have been done differently; mapping was not done in consultation with district level stakeholders and as a result some focus VDCs had to be changed later.

3.4 Relevance

The following sections present the findings from the evaluation, in response to the key questions outlined in the ToR, and related to the evaluation objectives of assessing the relevance of the programme.

3.4.1 Alignment of project outcomes and outputs with UNSCR 1325, 1612, 1820, and 1882

The project outcomes and outputs have been found to be aligned with the UN SCR 1820 which urges national governments, national institutions and civil society networks, among others, to offer activities and advocacy for the benefit of women and girls affected by sexual violence in armed conflict and post conflict situations. The project output 1 of outcome 1 is aligned with UNSCR 1612 which calls for establishment of a monitoring and reporting mechanism on children and armed conflict and underlines the need for collecting timely, objective, accurate and reliable information on the recruitment and use of child soldiers in violation of applicable international law and on other violations and abuses committed against children affected by armed conflict[5]. Likewise, the project output 1 and 2 of outcome 3 is also aligned with UNSCR 1882 which calls for the concerned governments to take decisive and immediate action against persistent perpetrators of violations and abuses committed against children in situations of armed conflict, and further calls upon them to bring to justice those responsible for such violations that are prohibited under applicable international law, including with regard to recruitment and use of children, killing and maiming and rape and other sexual violence, through national justice systems[6].

Likewise, the project outcome and outputs contributes to UNSCR 1325 which, among others, calls for taking special measures to protect women and girls from gender-based violence, particularly rape and other forms of sexual abuse, and all other forms of violence in situations of armed conflict. Output 1 and 2 of outcome 3 is aligned with the emphasis of the UNSCR 1325 on the responsibility of all states to put an end to impunity and to prosecute those responsible for genocide, crimes against humanity, and war crimes including those relating to sexual and other violence against women and girls, and in this regard *stresses* the need to exclude these crimes, where feasible from amnesty provisions.

[5] <http://daccessdds.un.org/doc/UNDOC/GEN/N05/439/59/PDF/N0543959.pdf?OpenElement>
[6] <http://www.un.org/children/conflict/_documents/SC-RESOLUTION1882-2009.pdf>

3.4.2 Contribution to achievement of national strategies and action plans

The evaluation has found that the project outcomes and outputs are relevant to NAP on implementation of UN Security council resolution 1820 and they contribute to the implementation of the strategic objectives of 5 pillars: participation, protection and prevention, promotion, relief and recovery, resource mobilization and monitoring and evaluation. In particular, outcomes 1, 2, 3 and the six outputs of the project contributed to the NAP strategic objective adopted under 2nd pillar 'protection and prevention' which has three strategic objectives: (i) end impunity by instituting necessary reforms in the justice and security system to enable them to promptly respond to cases of sexual and gender-based violence (SGBV) (ii) address the special needs of conflict-affected women and girls and (iii) end impunity by addressing issues of SGBV cases that occurred during conflict and transitional period. Likewise, the project outcomes and outputs have contributed to NAP's 3rd pillar 'promotion' with the objective of (i) raising awareness by collecting data on all forms of SGBV against women and girls and NAP's 4th pillar with the strategic objective of (i) formulating and implementing relief and recovery programme with the participation of women and girls affected by conflict as per their needs and condition (MOPR. 2011).

The project outcomes and outputs are relevant to the **National Plan of Action Against Gender-based Violence** prepared by the Government of Nepal, Of the six objectives of the National Plan of Action on GBV, the project has contributed to achieving the objective of 'ensuring the access of persons affected by gender-based violence to justice' and 'raising public awareness and promoting zero tolerance against gender violence' (MOPR. 2011). Likewise, the Three Year Plan Approach Paper (2011/12 – 2013/14) has set the objective of establishing lasting peace in the country by providing relief and reparation to the conflict-affected people as per the set standards. The objective of the Approach Paper for promoting gender equality and women's empowerment is to put an end to different types of gender-based violence and discrimination against women through social, economic and political empowerment of women from all classes and regions. The plan also aims to develop a mechanism for addressing gender-based violence by encouraging legal aid, social protection and community mobilization for the prevention and control of different forms of gender-based violence and discrimination against women (NPC. 2010). During the implementation period the project has contributed towards realization of these objectives of the Three Year Plan Approach Paper.

Likewise, the project outcomes and outputs are also relevant to the National Plan of Action on Gender Equality and Empowerment of Women which includes activities like protecting women from the impact of conflict, establishing access for conflict-affected women to justice and making arrangements for proper relief and rehabilitation. These activities are also included under the Article 'Women and Armed Conflict', in the Beijing Declaration (MOPR. 2011).

3.4.3 Appropriateness of project strategies and activities in terms of socio-economic and political environment of the country

The evaluation team appreciated the concern of most stakeholders regarding the timing of the project. It would have been more appropriate and timely if the project was launched right after the initiation of the peace process in 2006. The project was launched after a gap of about 4 years of the peace accord which was signed between GoN and the CP-Maoist. With this time lapse most stakeholders believe that the project was not successful in tracing of a larger number of SGBV victims. The stakeholders thus feel that this time lapse resulted in under reporting of the sexual and gender based violence cases that took place in the project districts.

It is however noted that the project adopted a number of good strategies in order to trace as many women and girls as possible who were subjected to SGBV, for example:

- The project covered 14 districts which were most affected by conflict for providing services and support to the girls and women.

- These districts are also among those which are comparatively poor in terms of socio-economic setting and had unstable political situation even after initiation of the peace process (especially some Terai districts where newly formed armed groups were emerging).

- The project adopted innovative and holistic approach for tracing the victims – combining RH services with psychosocial support, legal assistance and livelihood support. This approach improved participation as well as protection of women and girls and effective delivery of services to conflict affected areas. This approach therefore worked well in serving the project purpose.

- Focus on reproductive health in general was a good strategy of the project which allowed women and girls to approach services without having to disclose themselves as the victims of sexual or gender based violence.

- All the service providers received training before the camp activities were initiated and high emphasis was placed on following *do-no-harm* approach and avoiding re-traumatising of victims.

- The district and VDC level stakeholders in each project district were given 2 day orientation on various aspects of the programme. Following this approach the project was able to get cooperation and support of a wider group of stakeholders.

The above strategies enabled the project to provide RH and other services to a large number of poor women and girls who are residing in rural areas of the programme districts.

The project has rightly adopted conflict and culture sensitive and holistic approach. In order to address the issues of sexual and gender based violence it has used the "*do no harm*" approach. The need for a holistic response to victims of sexual violence was emphasised in UNSCR 1888 which stresses the importance of "*increased access of the victims to health care, psychosocial support, legal assistance and socio economic reintegration services for victims of sexual violence, in particular in rural areas*".

The current project financially supported by UNFPN with technical support of UNICEF and UNFPA implemented through INGOS and NGOs in the fields in ensuring recognition of sexual violence as a tool of conflict in the Nepal peace building process through the documentation and provision of comprehensive services to women and girl victims/survivors. The aim is to address the culture of silence around sexual violence during the conflict and post conflict periods, and the provision of reproductive health services is used as the entry point to identify and document incidences of SGBV. Survivors of sexual violence are supported and empowered to participate in transitional justice and other peace building activities.

Discussions with some stakeholders give evidence that the "*do no harm*" approach was derived from a pilot project implemented in Achham district. The approach to documentation of sexual violence builds on the experience and lessons learned from a multi-disciplinary and inter-agency

pilot project implemented in May 2009 when a team consisting of UNFPA, OHCHR, AF, CMC conducted a joint mission to a particularly severely conflict hit area in the District of Achham. The mission set up a medical camp that offered reproductive health services to all women in the area as well as psychosocial counselling, documentation and legal services to women who desired this. During the three-day mission 322 women received reproductive health treatment, of which 61 involved sexually transmitted infections and 24 uterine prolepsis, and 14 women received psychosocial counselling. This model proved highly effective in creating an environment where women felt safe enough to share their experiences of rape and sexual violence and the mission was able to document nine cases[7] of conflict related rapes and six cases of attempted rapes (UNICEF/Nepal. Project Proposal. No date).

The project also adopted gender-friendly approach in that out of the 15 personnel in running the RH camp 12 were females (see table above). This created an opportunity for rural women who are generally inhibited to talk about their reproductive, sexual and gender related problems with providers. One of the district stakeholders while discussing about the project categorically mentioned that women would not go to a health facility where there are only men.

3.5 Impact

It will be too early to assess the impact of a relief project of this nature and size for another year. Despite the brief duration of the project, it contributed to improving access to RH services in conflict-affected areas and amongst disadvantaged populations in the project districts. With respect to SGBV in the 14 project districts women, at least, are now aware that they can go about sharing their problems with concerned authorities although there is no guarantee that the latter would listen to them.

This section attempts to address the evaluation TOR questions under 'impact': *What were the major strengths of the project? What have been its major achievements (was there any changes in the lives of women, girls who participated in the camp? Any changes in the knowledge of service providers observed?). Were there any unintended outcomes – positive and negative?*

These issues are examined, as far as possible, one by one as follows:

3.5.1 Strength of the project

As noted in section 1 the project adopted an innovative and holistic (or integrated) approach for tracking the victims of SGBV – combining RH services with psychosocial support, legal assistance and livelihood support. This approach improved participation as well as protection of women and girls and contributed in effective delivery of services to conflict affected areas. This approach is one of the strength of the project. The evaluation team further noted that the project was implemented with a coordinated effort of multiple agencies with specialized area of work. The inter-agency coordination and collaboration added extra synergy to the project. The discussion with stakeholders also indicated that initially the involvement of multiple agencies in the project was perceived as hindrance but after the implementation this turned out to be strength of the project. The project adopted "*do-no-harm*" approach and the project staff ensured that re-traumatizing does not occur to any of the SGBV victims.

At the local level, mobilization of community service providers like FCHV and school teachers in camp management and information dissemination made it possible to sensitize community people on the type of services available in the RH camps. Moreover, all the service providers in the RH

[7] This can be compared to a total of seven cases documented nationally during the 3 years of monitoring of UNSCR 1612.

camps were females which made it easier for women and girls to discuss about their problems. In this regard, one FGD participant who had attended the RH camp expressed her feeling to the evaluation team:

> *'In the past the health camps also used to have male service providers and in such a situation it was difficult for us to discuss our problems with men. But this time all service providers were females and they understood our problem better…….they were very sympathetic to our situation…….so we openly discussed our RH and other problems with them……' (FGD participant in Rolpa district)*

The referral mechanism for both inside and outside the RH camp was also established and this mechanism worked effectively to serve the needs of women and girls. Overall, these approaches are strength of the project.

3.5.2 Major achievements

Although the project was signed for two years, only about 20 months were used for project implementation. Even then with guidance from UNICEF and UNFPA Country offices and the implementing partners the project activities were successfully carried out. In all, 36,471 women and girl survivors of conflict and post conflict periods benefited from the project. Many of the results of the project have been documented in earlier sections.

More than half of the women and girls who sought services at the camps benefited from RH services and the rest benefited from psychological, legal or livelihood services. The high turnout of women and girls in the RH camps exhibits the severity of RH problems in rural areas of Nepal. The camp operation also shows the evidence of SGBV in rural areas in Nepal.

Of the total RH camp attendees, psycho-social counselling was given to 3,551 women and girls; and, legal counselling was given to 1,000 women and girls. Likewise, a total of 821 cases of SGBV were documented in the project districts. Livelihood support initiative for 280 women and girls (20 women and girls from each of the 14 project districts) is currently underway. This initiative includes provision of education or Income Generation and Vocational Training or both. The delivery of RH and other services are expected to make immediate (in terms of health) and long term (in terms of psychosocial, legal and livelihood) impact in the lives of women and girls.

The FGD sessions and the stakeholder interviews in the community indicated the positive impact of RH services in the lives of women and girls. Most study participants said that their RH status has improved after attending the camps. They said the services provided in camps were effective because of:

- Privacy was maintained by the service providers
- Provision of separate rooms for each type of problems
- Camps had women friendly environment – service provided by female providers
- Availability of different type of services (RH, Psychosocial, legal, livelihood) in one place
- Availability of lab facilities available
- Availability of necessary medicine
- Good referral mechanism in case of severe problem

The FGD participants did not want to discuss in group about the short or long term impact in their lives of psychosocial, legal or livelihood that were provided in the camp. Most community (VDC) level stakeholders however were positive about the impact of services other than RH in the lives of women and girls.

During the project period a total of 603 women suffering from UP were referred to hospitals where they had successful UP surgery. The project has, therefore brought changes for the better in the lives of women suffering from UP. A case study mentioned above shows this.

One of the important achievements of the project was that the project managed to address SGBV issue without ostracizing it in public. The project managed to collect evidence of SGBV during conflict and post conflict periods and detailed documentation of these cases have been done. The documentation can be utilized as a basis for advocating the issue and future programming in Nepal. This can be regarded as an achievement of the project.

Girls and women who were sexually assaulted during the conflict did not have facilities for trauma counselling. The SGBV project provided an opportunity for such women to visit RH camps. In all 821 cases of SGBV covering both conflict and post conflict periods were documented. Of them proportionately more (66%) belonged to conflict period than the post conflict period (34%). About one in eight women and girls affected by SGBV were under the age 18. These cases have been appropriately referred for psychosocial counseling to safe house for trauma healing and life skill training to appropriate organizations. These activities of the project have very much contributed to change life of girls and women for the better.

Women and girls affected by SGBV come from different socio-cultural backgrounds and are mostly poor. The data presented in the earlier section show that the bulk of them belong to disadvantaged groups such as Dalit and Janjati. However, as for SGBV the approach should be inclusive; girls and women who survive SGBV should be given equal opportunity for life change regardless of caste/ethnicity background.

3.5.3 Enhancement in the knowledge of project staff and service providers

The project raised awareness of people about SGBV at three levels: at the national level, policy makers and program managers of government, I/NGO and other implementing partners were sensitised on the issue; at the district level, stakeholder and partner organizations were sensitized through orientation programme; and at the VDC level, health service providers, teachers, and the CBOs were sensitized on SGBV issue.

Prior to the field activity, all the project staff members were provided with 10-day orientation on RH, SV, GBV, psychosocial, legal and livelihood issues. Likewise, the district and VDC level stakeholders also received orientation prior to camp operation. A de-briefing session among these stakeholders was also organized after the camp operation was completed. The project also provided onsite coaching to community health service providers. A total of 102 radio journalists received orientation on various issues in relation to GBV. They were also provided with an information package on SGBV. These training and orientation sessions and onsite coaching have sensitized the stakeholders on these issues. Moreover, the stakeholders were able to internalize the linkages between RH and SGBV and thus increased their commitment in strengthening their work in the area of SGBV. These activities provided a platform for the discussion that the RH and SGBV activities needs to be linked together and needs to be continued in future as well.

3.6 Sustainability

This section addresses two evaluation questions: *to what extent and in what ways the project contributed to enhance national capacities in government, civil society and NGOs to deliver effective service? And, to what extent is the programme owned, willing to continue by other partners (government, INGO, UN)? What has been the exit strategy for UNFPA support to the programme?*

The review indicates that in course of project implementation, the project has initiated a number of strategies for sustaining project activities. They include the transfer of skills through on-site coaching to local health staff, and transfer of knowledge on RH to FCHVs, teachers, and other local stakeholders. These activities have enhanced the capacity of government, non-government and civil society organizations at various levels to deliver programmes in the areas of RH, SGBV, psychosocial counselling, documentation of cases, and planning and management of livelihood support. The community level health service providers were given onsite coaching on ring pessary insertion, identification of prolapse, chlorination, and disposal of hospital wastes. Moreover, the FCHVs based in the camp site areas were also given orientation on different aspects of the programme including SGBV. The project also gave orientation to community level human resources of CBOs, health workers of local health facilities, local government health facility staffs, camp management committee members, political parties, social leaders, teacher, paralegal, VDC secretary and staffs of women organizations (WCOs). Most of them were mobilized in camp activities. Among others, the issues discussed in the orientation also included psychosocial counselling which made them aware about the consequences of SGBV on psychosocial wellbeing. These orientations together with their involvement in camp activities have sensitised the community level stakeholders on RH and SGBV issues and also enhanced their capacity to contribute in similar activities in future as well.

At the district level, the stakeholders representing various organizations (DAO, DDC, WCO, DHO, DPO, INGOs, local NGOs, women groups, and journalists) were given capacity building training. In addition, one de-briefing session at the district level after the completion of camp activities in the district have been organised in each of the project districts. These activities are believed to have sensitized the district level stakeholders on RH and SGBV issues. The de-briefing sessions have also been helpful in making the stakeholders aware on the status of RH and SGBV in the project sites within the district.

At the national level, the staff members from the project implementing partners were provided with 10 day orientation on RH, SGBV, psychosocial, legal and livelihood issues. This training has enhanced the capacity of implementing partners at the national level to plan and implement RH and SGBV programmes. Moreover, with the training and programming experience stakeholders are expected to be able to internalize the linkages between RH and SGBV and thus increased their commitment in strengthening their work in the area of SGBV.

The discussion with stakeholders indicated their willingness to continue the programme in future as well. However, in the resource constrained environment it is difficult to foresee the extent of commitment of stakeholders in carrying on the project activities on their own. It was noted that with some support from UNICEF and UNFPA the stakeholders are in a position to ensure sustainability of some components of the project.

3.7 Efficiency

This section has two sub sections: efficiency and management. First part deals with efficiency of the project which addresses the following evaluation questions: *To what extent have the programme inputs (human, technical, and financial) been used efficiently? How and where could improvements have been made to improve efficiency without compromising quality? To what extent the project adopted the conflict sensitive approach and gender consideration in the project design and implementation?*

Efficiency of the project here deals with human, technical and financial. The project was financed by UNPFN and according to the contract papers the total fund was US$2.1 million and of the total fund UNFPA received 66 percent and the rest by UNICEF (UNPFN. 2012). However, the

information from UNFPA shows only US$ 1,962,617 received from UNPFN and of that $1,291,645 (66%) received by UNFPA and $ 670,972 (34%) by UNICEF (Personal Communication). In January 2012 the budget was revised and it is seen that UNFPA received US$ 1,409,976. The budget line items UNFPA originally allocated the total budget were (a) supplies, commodity, equipment, 13%, (b) personnel 17% (staff, consultant, and travel), (c) training of counterparts, 14% and (d) contracts, 56% but in January 2012 the allocation was drastically revised to allocate a large sum of money for contracts (85% of total revised budget).

Under contracts line item major activities were mapping of conflict affected VDCs, implementation of camps & logistics, travel, medical & other treatment, final evaluation cost, media advocacy, entire staff salary of implementing partners etc. In more detail, the costs included were adding another PHN to each camp team to reduce waiting time for clients and ensure effective orientation on all available services, VDC level orientation and debriefing meeting in all districts to map local services, strengthen linkage with government line offices and hand-over of cases for referral, IP (Saathi) was contracted to provide shelter and rehabilitation services for immediate protection and reduction of final evaluation to contract local consulting firm rather than international.

The project is largely field based and therefore the human resources input are kind of a mobile field team. Two of the evaluation team members observed a follow-up 4-day camp in Rolpa district. In order to conduct the RH camp a field team of 16 persons was mobilized from Kathmandu. The team comprised of the following personnel:

Human Resources of HHESS, TPO, CWIN and AF involved in 4-day follow-up RH camp

Organization	Personnel	Gender	Number
HHESS	Medical doctors	Female	2
HHESS	Camp coordinator	Male	1
HHESS	Assistant camp coordinator	Male	1
HHESS	Health educator	Female	1
HHESS	PHN	Female	2
HHESS	Admin/Finance	Male	1
HHESS	Lab assistant	Male	1
HHESS	Drug Dispenser	Female	1
HHESS	Driver	Male	1
HHESS	RH Counsellor	Female	1
TPO	Psychosocial Counsellor	Female	2
Advocacy Forum	Legal Counsellor	Female	1
CWIN	Documentation Officer	Female	1
	Grand Total		**16**

At the initial stage of the project, prior to organizing the camp in a village of selected district the team held a 2-day orientation and briefing meeting with district level stakeholders attended mainly by representatives from DHO, WCO, police, CDO, DDC, Red Cross, Human Rights District Office, District Bar Association, and Youth Club which are concerned with SGBV in the district. RH camp site stakeholders such as local health facility in-charge, VDC in-charge; youth club member, women community member, teacher, political leader, community member and FCHV also participated in the meeting. In the meeting discussions were held on client screening, its process and time and client information procedure.

Subsequently the team moved to the village to set up RH camp. In order to smoothly conduct the RH camp at the selected VDC or site a local Camp Management Committee is formed comprising of local police, representatives of PHCC, HP, SHP, VDC, Youth Club, Women Organization, Teacher and political leader. On the last day of the camp the camp team visits the DPHO and briefs him/her about the camp. The district level government officials are not involved in the local camp. The camp team moved from district to district in a hired vehicle. RH camp drugs and equipments are all supplied by the project.

For a camp setting mobilization of local stakeholders is a positive aspect of the project. The purpose and objectives of camp setting are better communicated to the public locally. No wonder the turnover of girls and women was extensive.

SECTION FOUR: COORDINATION, MONITORING AND PROJECT MANAGEMENT

4.1 Coordination

The evaluation found adequate coordination taking place between implementing partners while with that of the government in the centre it was still in an early stage although at district level it was good. For coordination of project activities a Project Board Committee was established comprising of UNICEF, UNFPA, ADRA, HHESS, TPO, Advocacy Forum, CWIN and SAVE THE CHILDREN which held meetings regularly to address issues raised during project implementation in 14 districts and guided project implementation.

The good coordination established at central level as PBC was instrumental in steering the project activities smoothly in the 14 project districts. At district level the project team coordinated with District RH Coordination Committee of DPHO/DHO. At RH camp site level a Camp Support Management Committee was formed which was good for convincing local people about the importance of RH camp, to solve project related challenges and issues at local level. Because of all these, no major problem was encountered while implementing the project.

Sometime early in 2011 a Project Steering Committee was established under the chair of Joint Secretary, Ministry of Peace and Reconstruction (MOPR), and other members were Director General, of Department of Women Children, and Senior Administrator of the Ministry of Health and Population, Government of Nepal. The PSC provides advice and overall guidance to the project. The Steering Committee met every six months where it received updates from the project management on the overall progress and findings of the project. In the discussion held between evaluation team members and the Joint Secretary of MOPR it was noted that the Joint Secretary was happy to chair the Committee. However in the next phase the MOPR is interested to spare more time for the project.

4.2 Monitoring

UNFPA and UNICEF staffs regularly monitored project activities in 14 districts. The monitoring visits provided an opportunity to review coverage of clients, quality of services, and budget allocated for camp activities, among others. During the first quarter of 2011 UNFPA and UNICEF staffs monitored RH camps; UNFPA staff monitored in Dang and Surkhet and UNICEF staffs monitored Kapilvastu and Dang (see Table below). According to them overall, camps were successful and the systems were in place. After the field trip, the camp observations and some recommendations to improve the operation of the camp was shared with all implementing partners in project board meeting.

UNFPA and UNICEF staff made second monitoring visits to Saptari, Siraha and Rukum during the April-June 2011(see Table below). According to their field visit report, overall, it was observed that camps were successful and the camp setting was well organized as per the project guidelines and modus operandi to ensure safety and confidentiality of clients. Support and referral mechanism within the camps among health, legal, psychosocial and documentation was excellent. Moreover, group discussions were conducted in a participatory way. The observations and recommendations from the field visits were shared with all implementing partners (IPs) in project board meeting, and the IPs incorporated the recommendations in subsequent camps. It was observed that it is difficult to provide service by a single staff member at the Public Health Nurse (PHN) corner, which is the first point of contact with clients to inform them of all available services and do SGBV screening. Subsequently, an additional resource was made available to hire another PHN for each camp team.

The third monitoring visit was a joint monitoring visit by government officials and UNICEF and UNFPA staffs. Two members of the Steering Committee and its implementing partners conducted a joint monitoring visit to one camp on 21-23 August 2011(see Table below). The team met with the local Camp Coordination Committee members, Women and Children Office and other relevant stakeholders. The team monitored the district level orientation and observed the RH camp. The visit helped to deepen SC members' understanding of the project and increased their support and ownership of the project, and they also provided technical support to improve the operation of the camps. This gave moral support to the project implementing partners. According to camp monitors, overall, camps were successful in reaching out to women and girls in targeted communities and providing quality services. The camp setting was well organized as per the project guidelines and modus operandi to ensure safety and confidentiality of clients.

In addition to monitoring of RH camps from Kathmandu, they were also monitored by district staffs of UNFPA and UNICEF, and their feedback were shared with partners.

Supervision and monitoring visits of the project by UNICEF/UNFPA and IPs

District	Date	Quarter	Supervision/monitoring done by
Dang and Surkhet	January-March, 2011	1st	UNICEF staff
Kapilvastu and Dang	January-March, 2011	2nd	UNFPA staff
Saptari, Siraha & Rukum	April-June, 2011	3rd	UNICEF and UNFPA staffs
Kapilvastu	21-23 August 2011	4th	Joint monitoring visit by Government officials and UNICEF and UNFPA staffs
Rolpa	2nd week Feb., 2012	1st	UNICEF staff
Bardiya	3rd week, Feb. 2012	1st	UNPFN, UNICEF and UNFPA

Respective implementing partner regularly collected service data and shared with the Board. The data collection forms developed for project monitoring was jointly finalized by the Board. Examining the regularly collected data from camps the Board decided on where to take actions.
Data collection by implementing partners as part of monitoring activities has contributed to generating data bank for each partner. These data sets were utilized to monitor, evaluate and analyze project progress.

4.3 Project management

In this project, UNFPA as the lead UN agency on UNSCR 1325 and 1820 in Nepal took the lead in providing reproductive health services through the organization of health camps through its implementing partners in the 14 districts. The health camps served as an entry point for other sexual violence related services and documentation. UNICEF, as the co-chair of UNSCR 1612 Taskforce, took the lead on documentation.

Psycho-social counseling was carried out by TPO/ Nepal, an organization with long standing experience on counseling victims of sexual violence and other human rights abuses in Nepal. Advocacy Forum, a prominent human rights organization in Nepal, provided legal services for those who sought remedies through the justice system.

One national project manager placed at UNFPA and one national project coordinator placed in UNICEF did oversee the every-day management of the project.

SECTION FIVE: CONCLUSIONS AND LESSONS LEARNED

5.1 Conclusions

The SGBV project aimed at ensuring recognition of sexual violence as a tool of conflict in the Nepal peace building process by documenting conflict-related sexual violence incidents through the provision of comprehensive services to women and girl survivors. With the objective of contributing to peace building in Nepal, UNFPA and UNICEF jointly implemented a two-year project funded by the UNPFN since April 2010. The project has supported sustainable peace by improving access to transitional justice and other peace building activities for survivors of sexual and gender based violence in 14 districts rated as most conflict affected.

It is evident that UNFPA and UNICEF joint project implemented by several international and national partners has provided RH services to over 28,000 girls and women and documented 821 cases of SGBV covering both conflict and post conflict periods. Also it has been found that during the conflict period incidence of SGBV was nearly double (66%) than in the post conflict period (34%) supporting the statement that SV is used as a tool of conflict in the Nepalese context.

The team approach comprising of several implementing partners and providing a number of services including psycho-social counselling, moral and for few in desperate need of help, livelihood supports from one outlet has apparently worked well. Given the sensitivity of the issue of sexual violence and involvement of multiple partners delayed implementation project activities at the start but with persistent efforts made by all partners including support from the Government made it possible to implement planned activities in the target districts.

The project implementation strategy was to maintain proper distance from one partner to another and also to keep good workable distance between implementing partners and local government authorities with the objective of minimizing backlash on the sensitive issue such as sexual violence. The results of the project do certainly provide evidence that this strategy worked.

Also at the initial stage of the project cross partner criticisms were at their height, that is because many organizations (ADRA, HHESS, TPO, AF, CWIN and SAVE THE CHILDREN) were implementing the joint project of UNFPA and UNICEF together it was difficult to arrive at fast decision; each issue had to be thoroughly discussed among all parties involved to come to a consensus and this was quite time consuming. However, this actually resulted in unintended positive outcome for the project. Eventually implementation of project activities was prevented from derailing.

For the beneficiaries of the project, i.e., girls and women survivors of sexual and gender based violence, the project adopted "do no harm" approach in that the service seekers were provided the opportunity to enter service delivery point as someone looking for health service or counselling. At the SDP a female PHN followed a "*cafeteria*" approach; she explained to the client that a number of services were available and it was up to her to decide which service or services she wanted to utilize. The client was enabled to speak out about her problems to the PHN who later directed her to the appropriate service or counselling desk. In addition, when the client described her problems to the attendee and if the client required additional attention then she could go to another desk for her needs. Furthermore, as the service provider/counsellor was a female, the woman or girl client had minimum inhibitions to put her problems may they be sensitive before the desk attendee. Overall, therefore, the service point or set up was very client-friendly.

The camp location and timing was well publicised through local FM, miking, posters/pamphlets and through the word of mouth. Involvement of implementing partners in organizing and or celebrating national and international events such as National Immunization Day, World AIDS Day, Human Rights Day and 16-day Fight against Women Violence contributed to boosting work morale of IPs. The planned activities were carried out smoothly by local women and men volunteers, health facility staffs and project staffs together in a friendly environment. In addition, regular visits by central level UN personnel encouraged the working team.

However, the project achievements were not without challenges. It was difficult to track SV survivors as the project was implemented only after about 5 years of cessation of conflict by which time some had already coped with their problems, some got married and did not want to recall the traumatic incidents for fear of re-victimization, some had already lost hope, some did not have faith in any organization - government and non-government, and some wanted to be left alone. Some victims who were documented did not want to lodge complaint despite receiving legal counselling for fear re-victimization, family discord, and poverty as they could not afford to pay for processing expenses. Some clients did not show up in follow-up camp and some of them who were referred to go elsewhere did not do so for want of expenses, did not like the procedure that was too complex for village folks, security reasons and lack of confidence going alone. In some districts language, in the Terai and in high Mountain districts, was a barrier to convince clients about the whole job.

The Law of the Land requires that any complain has to be filed within 35 days of incidence and that was a serious limitation to lodge complaints for those who were willing to do so. Political vested interests also hindered lodging complaints. Another issue is the formation of TRC which is expected to provide compensation package for survivors; the government has not yet formed it. Maintaining confidentiality of victims, despite efforts made in this respect has remained a challenge.

5.2 Lessons learned

A number of lessons were learned by implementing SGBV project in 14 districts where vulnerable women live mostly in remote districts and locations.

1. In course of project implementation it became evident that it is not easy to build partnership among health and non-health organizations. A careful team building planning is required for effective team work in such scenario.
2. Multi-partner approach is a must for addressing issue such as SGBV. Legal and psychosocial aspects need to be institutionalized so that the victims have access to a package of support services.
3. To attract adolescents and youth to RH camps it is worth visiting schools of the local areas.
4. If women of the camp site have had negative experience of camp activities conducted by any organization, the project has to make extra efforts to the target audience to convert negative experience to positive thinking.
5. Celebration of national and international events such as National Immunization Day, World AIDS Day, Human Rights Day and 16-day Fight against Women Violence contributes to encourage project staffs to work hard and also greater numbers of intended audiences are made aware of RH and SGBV issues.
6. Men were not directly involved in project activities. The lesson learned was that it is important to include men and sensitize them on sexual and gender based violence and reproductive health; and reinforce their positive response and attitudes to victims of sexual violence.

SECTION SIX: RECOMMENDATIONS

Nepalese society is desperately waiting for a peaceful living after more than a decade long conflict and political uncertainty in the country. The joint project was aimed at contributing to this end. After completing piloting of the model in Achham the project was implemented for about two years and this phase too was more like a bigger piloting phase. The team has attempted to provide a number of recommendations based on discussions with stakeholders and beneficiaries, data analysis, lessons learned and the conclusions drawn.

The evaluation team is aware that UNFPA Nepal and UNICEF are required to provide a management response to each of the evaluation recommendations. The team has therefore attempted to provide a limited number of strategic recommendations based on the analyses.

RECOMMENDATIONS

Nepalese society is desperately waiting for a peaceful living after more than a decade long conflict and political uncertainty in the country. The joint project was aimed at contributing to this end. After completing piloting of the model in Achham the project was implemented for about two years and this phase too was more like a bigger piloting phase. The team has attempted to provide a number of recommendations based on discussions with stakeholders and beneficiaries, data analysis, lessons learned and the conclusions drawn.

The UNFPA and UNICEF should make efforts to prepare or ask IPs to prepare project proposal with results framework based on baseline data or secondary data analysis so that indicators for the project become more scientific in the sense that when endline data are compared with the baseline indicators the results are consistent.

Either UNFPA or UNICEF should decide which agency should take the lead in coordinating with the Ministry of Peace and Reconstruction for their active involvement in the project. The Ministry's active participation is needed to implement some major recommendations made by the project such as formation of TRC. One of the main recommendations of the evaluation of this project is that TRC should be formed by the Government to establish peace and justice in the country or to ensure that SGBV survivors get reparation and justice.

UNFPA or UNICEF singly or jointly or for that matter UN should commission a national level research to explore the nature and extent of SGBV in Nepal. The NDHS 2011 study was limited to domestic violence and therefore does not cover violence outside the home. Nationally representative study should involve a large number of stakeholders - the UN bodies, sectoral ministries, NGOs, the private sector and the subject matter specialists. UNFPA should continue to ensure that authentic nationally representative data on GBV is collected and analysed to guide future programs.

To strengthen the integrated model - the model that provides health services, legal counselling, psycho-social support and imparts income generation skills to women and girls affected by conflict it is necessary to orient and train medical team on post rape care protocols. Although 6-day basic SGBV orientation and 4-day advance training were

given to field team members in the past, they need more thorough training and education on the dynamics of SGBV.

Since large numbers of implementing partners with their own policies will be difficult to manage operationally and programmatically, future projects should explore if less partners can be involved without compromising on the quality of interventions.

The project needs to improve recording, reporting and analysis of project monitoring data. This is important in view of the fact that upon request by evaluation team for data from different project districts and over time the data supplied was not consistent; the data was kept in bits and pieces which did not give consistent picture. The M&E group should make efforts to collect monitoring data, make them consistent over time and should be broken down by major categories of interest.

UNFPA received 66% of the total project budget and spent it mainly through its two implementing partners meeting the costs of their RH camp activities. Most of this budget was spent for screening and providing treatment to women suffering from uterine prolapse and these women did not have much to do with conflict. The RH camp was synonymous with UP camp which was not the goal of the SGBV project. The proportion of women and girls receiving psychosocial support through RH camps was about 10%. However, as the focus of the project is on SGBV, some ways should be found out to reach more girls and women who are subject to SGBV or to prevent incidents that lead to SGBV. In other words, efforts should be made to increase the 10%.

UNFPA should set target for UP surgery based on demographic profile of districts and not the same target (50 cases in every district). For instance for Kalikot the target set was 50 and for Kanchanpur too the target was 50 but the size of population in Kanchanpur is nearly four times larger.

Project should be designed in such a way that the proportion of referred cases ending up in surgery is maximum. Although the incentive package was good it was found that overall in 14 districts 26 % of referred cases did not go to the surgery centers. The referred clients need to be closely followed-up until they arrive at the surgery centers; the clients need to be convinced that it is to their advantage to visit the surgery centre.