



Assessment of the Impact of COVID-19 Pandemic on Functionality and Utilization of RMNCAH Services by Clients in Public Sector Health Facilities of Nepal

December 2020



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December, 2020



This assessment on the impact of COVID 19 pandemic on functionality and utilization of RMNCAH services in public health facilities in Nepal was implemented by CREHPA under technical assistance of Ministry of Health and Population and United Nations Population Fund. The funding for the study was provided the United Kingdom Agency for International Development (UKAid).

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Forward

The 2020 Assessment of the Impact of COVID-19 Pandemic on Functionality and Utilization of RMNCAH Services by Clients in Public Sector Health Facilities of Nepal is a nationally representative survey covering 424 health facilities of 21 district across all seven provinces in Nepal. The study was implemented by CREHPA in two rounds under the guidance of Ministry of Health and Population and UNFPA with the objective of assessing how essential RMNCAH services were being affected in different levels of public health facilities. We hope that the information in this report will assist policymakers and program managers in policy formulation and designing programs and strategies for improving RMNCAH services in public health facilities in Nepal.

This report provides information on functionality and utilization of maternal health services, family planning services, safe abortion services, child health and immunization services, adolescent friendly health services and OCMC service during the COVID 19 pandemic period. It presents the perspective of health facility in-charge, service providers, FCHVs and exit clients regarding the provision of RMNCAH service. The report also presents trend on utilization of RMNCAH services in the pandemic period with the utilization of the same services in corresponding period of the previous year.

The successful completion of this study was made possible through contribution of a number of organizations and professionals. CREHPA extends its gratitude to Ministry of Health and Population and UNFPA for providing us with the opportunity to conduct this study. We would also like to thank the RH sub-cluster for their support in this study and also acknowledge the financial support provided by UKAid. We are also thankful to the HMIS section for providing us with data on RMNCAH service utilization in selected districts. We are also grateful to the core team of CREHPA for managerial and technical support, training of field researchers and monitoring of fieldwork. Finally, we would also like to thank our field researchers and the respondents who took part in this survey.

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Acknowledgements

The study team is highly grateful to Dr. Bhim Singh Tinkari, Director, Family Welfare Division, MOHP and Chair, RH sub cluster and other members of RH sub cluster for their invaluable inputs on the study and providing useful feedback on the RMNCAH indicators to be covered in the present assessment.

We are thankful to the UNFPA Country Representative, Ms Lubna Baqi for commissioning this study to CREHPA. We would also like to thank Dr. Hasina Begum, Dy. Country Representative, Ms Latika Maskey Pradhan, Assistant Representative; Ms Sudha Pant, Program Officer-Gender; Dr. Neeta Shrestha, RH Specialist; Dr Nepali Sah, M&E Analyst; and Mr Pankaj Bhattarai, Program Officer – all from UNFPA Nepal Country Office, for their guidance and support during different phases of the present assessment.

We would also like to thank the officials at the MHIS Section of MoHP for providing access to the month-wise data on selected RMNCAH indicators. Finally, we would like to thank all health facility in-charge, RMNCAH focal persons at the sampled health facilities, female community health volunteers, and clients who participated in the study.

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Abbreviations and Acronyms

AFHS	Adolescent Friendly Health Services
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
CREHPA	Centre for Research on Environment Health and Population Activities
ECP	Emergency Contraceptive Pill
FCHV	Female Community Health Volunteer
FP	Family Planning
FWD	Family Welfare Division
GBV	Gender Based Violence
GoN	Government of Nepal
HF	Health Facility
HMIS	Health Management Information System
HP	Health Post
HW	Health Worker
IPC	Infection Prevention and Control
IUCD	Intra-uterine Contraceptive Device
LARC	Long Acting Reversible Contraceptive
MA	Medical Abortion
MoHP	Ministry of Health and Population
MVA	Manual Vacuum Aspiration
OCMC	One Stop Crisis Management Center
PHCC	Primary Health Care Center
PNC	Postnatal Care
PPE	Personal Protective Equipment
RH	Reproductive Health
RHRWG	Reproductive Health and Rights Working Group
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RTI	Reproductive Tract Infection
SARC	Short Acting Reversible Contraceptive
SAS	Safe Abortion Service
SDP	Service Delivery Point
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
UHC	Urban Health Center
UNFPA	United Nations Population Fund
UTI	Urinary Tract Infection
VSC	Voluntary Surgical Contraception

Executive Summary

This study assessed the functionality and utilization of essential reproductive, maternal, neonatal, child and adolescent health (RMNCAH) services amidst the COVID-19 pandemic and subsequent restrictive measures being implemented at the federal, provincial, and local levels.

A national representative sample of 424 public health facilities (HFs) was drawn from all the seven provinces of the country to represent the four categories/levels of the public health system: i) COVID hospital/Non-COVID hospitals, ii) primary health care centers (PHCC), iii) health post (HP) and iv) urban health centers (UHC). Probability proportionate to size (PPS) technique was used for allocating HF sample across the seven provinces. In addition to interviewing facility in-charges and service providers at each HF, client exit interviews and interview of FCHVs were carried out to obtain their awareness, perceptions, and constraints in service utilization during the lockdown period. Two rounds of assessment were carried out between September and November 2020 to identify changes or improvements in the service delivery of essential RMNCAH services. The Round 2 Assessment covered a sub-sample of 140 HFs (33%).

Functionality and Preparedness of Health Facilities for RMNCAH Services

- Approximately just over a half (57%) of the HFs had sufficient stock of PPE during the time of Round 1 assessment. During Round 2 assessment, the percentage of HFs reporting that they were ‘prepared to a large extent’ with the stock of PPE declined sharply by half (from 57% to 28%).
- As compared to Round 1 (28%), a higher percentage of HFs reported receiving the RMNCAH Interim Guidance in Round 2 (39%).
- In terms of rating the Government’s response to the COVID-19 pandemic, only 18 percent of service providers had rated the Government’s response to the COVID-19 pandemic as “good” in Round 1 which slightly increased to 23 percent in Round 2.
- A large majority of FCHVs (71%) responded affirmatively saying that clients were able to access health services from nearby HFs during the five-month lockdown period.
- The majority of FCHVs continued to perform their 13 out of 16 tasks pertaining to RMNCAH services all the time.
- Nearly all FCHVs (91%) visited the clients at their homes and had used face mask (97%) while meeting their clients.
- Nearly all clients (96%) were aware of the precautionary measures for COVID-19. Almost all clients mentioned ‘wearing face mask always’ (92%) and regular washing of hands with soap or with alcohol-based hand-rubs (76%) as precautionary measures. The three main sources of knowledge about the precautionary measures as reported by clients were television, radio, and through phones/caller tune.

Functionality and Utilization of Maternal Health Services

- The functionality and utilization of maternal health services was disrupted initially in around 20 percent of HFs in Round 1 which improved in Round 2.
- ANC service was disrupted initially in 20 percent of the HFs during the lockdown (Round 1). The situation improved in Round 2.
- Institutional delivery service was halted in 10 percent of the HFs during the initial lockdown period. Trend analysis revealed that there has been a 19 percent decline in institutional delivery during the five-month lockdown as compared to the corresponding period in the previous year.
- More than two fifths of the HFs (44%) were unable to provide ‘Aama’ transportation incentives to mothers of newborns at times of discharge in Round 1. The situation improved considerably two months later (during Round 2). Few HFs did not provide the ‘Aama’ incentives at all.

Functionality and Utilization of Family Planning Services

- Provision of SARC methods (oral pills and DMPA) were halted initially at nearly a third of the HFs in Round 1. There has been a spectacular decline in the percentage of HFs that faced disruption of SARC services in Round 2 from 31 percent in Round 1 to 7 percent in Round 2. Nearly 93 percent of the HFs provided SARC services without disruption during Round 2.
- Around 19 percent of HFs experienced disruption in LARC services in Round 1 which decreased to 15 percent in Round 2.

Functionality and Utilization of Safe Abortion Services (SAS)

- Only 34 percent of the 139 accredited SAS centers were able to provide abortion service without any disruption during the lock down period (Round 1).
- SAS facilities remained non-functional at nearly three fourths of the 46 accredited SAS centers revisited in Round 2 and 21 percent of the accredited facilities were providing SAS without interruption in this round.
- Similar to Round 1, all six accredited hospitals covered in Round 2 provided second trimester abortion and all sampled SAS centers had a trained MA provider.
- In Round 1, only 64 percent of SAS centers had trained MVA providers which increased to 76 percent in Round 2.

Functionality and Utilization of Child Health and Immunization Services

- Immunization services at most of the HFs (81%) was halted initially and resumed later during the lockdown period. This status improved to a greater extent in Round 2 where 76 percent of HFs provided immunization service without interruption.
- HFs in nearly all provinces (98%) implemented the Vitamin A supplementation programme in Asadh this year.
- An eight percent reduction of HFs providing Vitamin-A supplementation to mothers of newborn from 96 percent in Round 1 to 88 percent in Round 2 was reported.

Functionality and Utilization of Adolescent Friendly Health Services

- The flow of adolescent clients seeking FP services remained the same in three quarters of HFs throughout the five-month lockdown period in comparison to the period prior to lockdown. However, a slight increase in adolescent client flow for FP services was reported in Round 2.

One Stop Crisis Management Center

- A surge in GBV cases seeking care at OCMC during the lockdown period (Round 1) was evident.
- The majority of survivors seeking care at OCMC during the five-month lockdown period (Round 1) were cases of sexual violence and physical violence while the majority of survivors seeking care at OCMC during Round 2 were cases of physical violence.

Way Forward:

- Ensure availability of electronic copies of the RMNCAH Interim Guidance at public sector HFs and provide orientation training to all service providers throughout the seven provinces, to enable them to understand the guiding principles for the provision of these essential services at the time of any natural disasters and pandemics.
- Provide adequate stock of PPE items at all HFs and ensure mandatory use of these items by service providers. Strengthen existing mechanisms for the procurement and distribution of PPE through coordination with the procurement units of concerned departments/offices at the province and local government levels.

- Establish regular policy dialogues between local government and HFs to mitigate any challenges faced by HFs in the stable provision of services such as the presence of trained human resources, commodities supply chain, and timely disbursement/payment of reimbursable funds to HFs as specified in the RMNCAH Interim Guidance and also in the Safe Motherhood and Reproductive Health and Rights (SMRHR) Act 2018.
- Ensure sustained presence of trained service providers for continuous provision of high quality RMNCAH services including LARC, SAS and ASRH services at all levels of public HFs by providing competency-based training to service providers who are either new recruits, untrained, or newly transferred at the HFs.

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Chapter 1

Introduction

1.1 Background

COVID-19 was declared a global pandemic by the World Health Organization (WHO) on 11 March 2020. The first case in Nepal was confirmed on 23 January 2020 when a 31-year-old student, who had returned to Kathmandu from Wuhan on 9 January 2020, tested positive for the disease [1]. The Government of Nepal (GoN) commenced a nation-wide lockdown that started on 24 March and extended to mid July 2020. All non-essential travel was restricted and borders including inter-district travel were closed.

The Constitution of Nepal mandates round the clock delivery of basic health care services including maternal and neonatal health services. Hence, MoHP has instructed health facilities (HFs) and care providers to continue basic health care support including sexual and reproductive health (SRH) services and Maternal, Newborn, child and Adolescent Health (RMNCAH). The response to the COVID-19 public health emergency has had an unprecedented impact on the health system and its capacity to continue lifesaving essential services including for RMNCAH.

In April 2020, the United Nations Population Fund (UNFPA) conducted a rapid assessment of the RMNCAH service functionality in 146 HFs. The assessment showed low utilization of services at the HFs, especially safe delivery, Family Planning (FP) and Antenatal Care (ANC) services during the lockdown. The reasons reported for low utilization are due to the fear of virus transmission, lack of transportation and travel restrictions. Similarly, service providers also expressed that they were feeling unsafe due to a fear of virus transmission, lack of Personal Protective Equipment (PPE), and inadequate supplies and commodities. Pregnant women with respiratory illnesses must be treated with utmost priority due to increased risk of adverse outcomes and antenatal, neonatal, and maternal health units must be segregated from identified COVID-19 cases. Provision of FP and other SRH commodities may be impacted as supply chains undergo strains from the pandemic response. Therefore, it is considered critical to ensure continuity of SRH and newborn care services in case of severe facility service interruption or other disruptions to access for women and girls of reproductive age.

The Government of Nepal, Ministry of Health and Population (MoHP) has instructed HFs and service providers to continue essential health services including RMNCAH. This is in response to the public appeal by the Reproductive Health and Rights Working Group (RHRWG) against the major public hospitals halting services including institutional deliveries and safe abortion services because of the overwhelming number of COVID-19 cases referred to these hospitals. The impact of COVID-19 on the utilization of lifesaving Sexual and Reproductive Health (SRH) services has been significant and is likely to be an even greater challenge for underserved and vulnerable groups including people with disabilities, migrants and returnees, and women and girls in quarantine sites. It is essential to maintain and strengthen the provision of essential SRH information and services to avert an increase in maternal morbidity and mortality, unintended pregnancies, and unsafe abortion, which is already high in Nepal compared to other countries in the region.

Therefore, under the Reproductive Health (RH) sub-cluster, led by FWD/MoHP and co-led by UNFPA [4], the decision was taken to undertake a comprehensive assessment of the impact of COVID-19 on essential RMNCAH service delivery and utilization. The findings from this nationally representative assessment is intended to guide MoHP and the RH Sub Cluster partners on COVID-19 emergency preparedness and response plan by identifying priorities and interventions for sustained provision of RMNCAH services. The assessment is repeated in a gap of 2 months following a standard methodology to allow comparison of functionality and utilization of RMNCAH services over the COVID-19 pandemic and beyond.

1.2 Objectives of the Assessment

The main objective of the study is to assess the **functionality and utilization of essential reproductive, maternal, neonatal, child, and adolescent health (RMNCAH) services** amidst the COVID-19 pandemic and the restrictive measures being implemented at the federal, provincial and local levels.

The specific objectives of the study are:

- 1) To assess the service availability and readiness of HFs in relation to RMNCAH care amidst the COVID-19 pandemic and the restrictive measures being implemented at the federal, provincial and local level;
- 2) To assess the perception of health workers about the work environment and possible options for improving RMNCAH service delivery in the COVID-19 context;
- 3) To examine key RMNCH service delivery data from all HFs surveyed during the lockdown period, compared with the HMIS data from the same period of the last fiscal year to determine the impact of COVID-19;
- 4) To assess the perceptions of the clients of RMNACH services and the barriers faced in utilizing RMNCH services due to COVID-19;
- 5) To identify emerging needs in relation to COVID-19 that may need to be addressed in the provision of essential RMNCAH services to vulnerable groups.

1.3 Study Design and Method

A facility-based mixed method design (a combination of qualitative and quantitative research techniques) was used for assessing the ‘functionality’ and health system capacity in delivering RMNCAH services and utilization during the COVID-19 crisis. The quantitative research component of the assessment included a sample survey of public HFs. The qualitative research component comprised of facility observation, exit interviews of clients seeking RMNCAH services at the sampled HFs, and semi-structured interviews of female community health volunteers.

Sampling Technique: A national representative sample of public HFs has been drawn from all seven provinces of the country to represent the four categories/levels of the public health system: i) COVID hospitals/non-COVID hospitals, ii) primary health care centers (PHCC), iii) health post (HP) and iv) urban health centers (UHC). The sample frame was based on the 2074-75 HMIS database that provides municipality-wise distribution of government and non-government HFs in each of the seven provinces. [5] There are 125 hospitals (apex, province, and district hospitals), 192 PHCCs, 3808 HPs and 374 UHCs in the country. Based on the standard sample size estimation technique adopted by UNFPA in 2016, the required number of public HFs falling under the first four categories has been estimated at 424. The sampling technique used for size estimation is appropriate for obtaining the minimal sample size requirement at each category of public HFs. This technique adopts an approach that gives large facilities a higher probability of inclusion in the survey because of their small number and provides a guide for choosing a sample of the primary facilities. The steps adopted for the sample size estimation are: *First*, the relative proportion for each level of service delivery point (SDP) was calculated from the list of four types of SDPs that has the numeric distribution of each type of SDP considered in the study. This was followed by applying the formula above to obtain the minimal sample size for each type of SDP by proposing the use of a confidence interval. The estimated facility-wise sample for the country based on a 95 % confidence interval (Z-score = 1.96) and 5 percent confidence limit is shown in Table 1.1.

As indicated in the Table 1.1 below, the sample size for each of the four levels of HF ranges from 41 (hospital level) to 201 (health post level). Probability proportionate to size (PPS) technique was used for the allocation of the required sample at each level of HF across the seven provinces of the country

(see Map and the Annex 1.1). Accordingly, Bagmati Province has the largest share of the HF sample (92 facilities), followed by Province 1 (69) and Lumbini Province (68). On the other hand, Karnali and Sudurpashchim Province have relatively lower numbers of HFs in the sample (32 and 48 respectively).

Table 1.1 Distribution of sampled public health facilities across the seven provinces

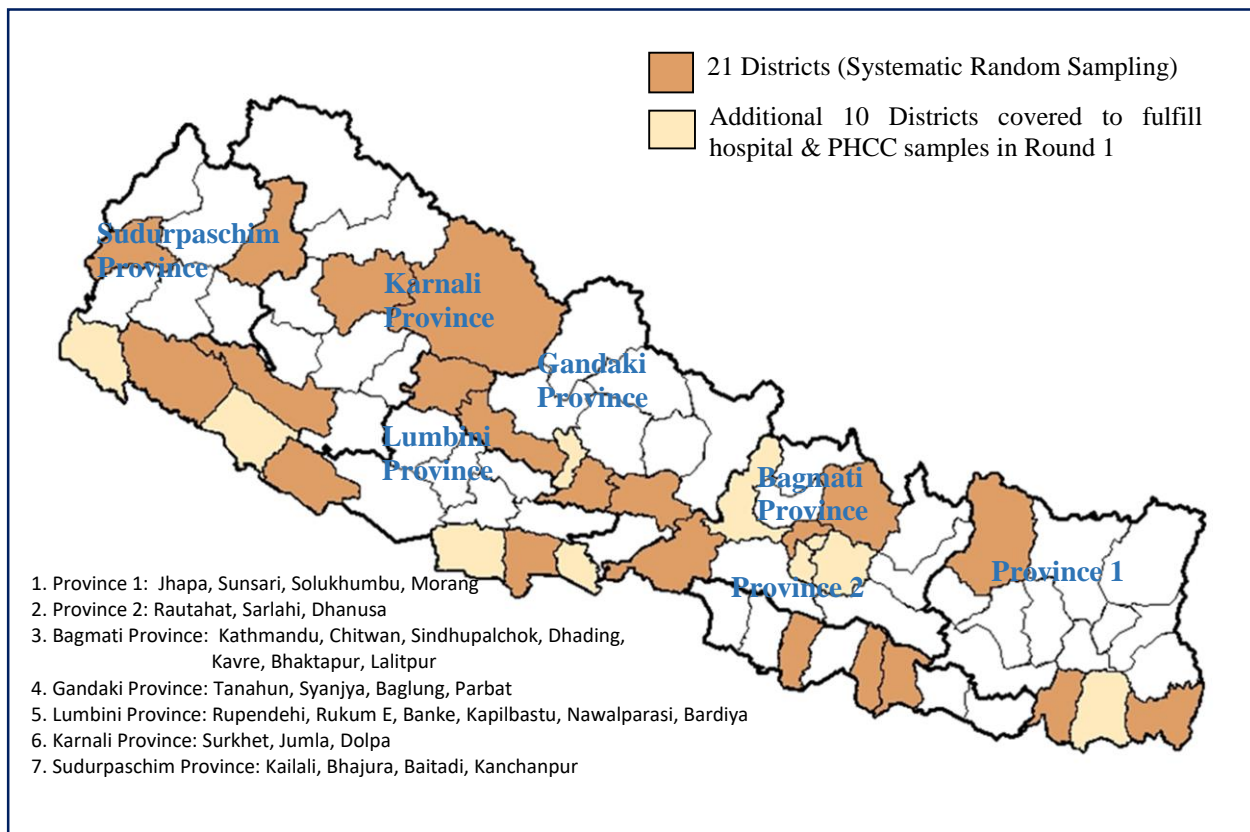
Level of Public Health Facility	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpashchim Province	Total
COVID hospital/Non-COVID hospital	(18) 6	(13) 4	(33) 10	(15) 5	(20) 7	(12) 4	(14) 5	(125) 41
PHC	(40) 13	(32) 11	(43) 14	(24) 8	(30) 10	(13) 4	(16) 5	(198) 65
HP	(648) 34	(745) 39	(640) 34	(491) 26	(570) 30	(336) 18	(378) 20	(3,808) 201
UHC	(52) 16	(17) 6	(110) 34	(52) 16	(68) 21	(18) 6	(57) 18	(374) 117
Total	(758) 69	(807) 60	(826) 92	(582) 55	(688) 68	(379) 32	(465) 48	(4,505) 424

Figures in parenthesis are total number of public health facilities within the province

A province and district-wise stratified sample was derived for representing hospitals, PHCCs and HPs. Two rounds of assessment were carried out. In the Round 1 Assessment, all the 424 sampled public HF health facilities were covered. In the Round 2 Assessment, a sub-sample of 140 public HFs (33%) was covered.

The facility level sample in each of the 21 districts was selected randomly in situations where the number of HFs of a specific category was more than the desired sample in the district. However, in five provinces, the numbers of hospitals and/or PHCCs were less than the desired number of samples. In such provinces, the hospitals and PHCCs were covered from the adjoining district(s) to achieve the total sample size. For the remaining two categories of HFs (HPs and UHCs) where the numbers far exceed the desired sample, selection of these facilities was done randomly by the study team at the district itself in consultation with the district based health office. The district-wise allocation of 424 HFs for the Round 1 Assessment and a sub-sample of 140 facilities representing the same 21 sampled districts for the Round 2 Assessment are appended (Annex 1.2).

Map 1: Location of the districts covered in each province



At each sampled HF, the concerned in-charges (hospital director/Medical Superintendent; Medical Officer/HA In-charge, etc.) were selected mandatorily. In his/her absence, the most senior medical officer was interviewed. In addition, one to two health workers/service providers responsible for the provision of maternal care (ANC/delivery/ neonatal/PNC), family planning, safe abortion and adolescent SRH service was interviewed.

Clients for the exit interviews were purposively selected among RMNCAH care seekers at each sampled facility. Likewise, one Female Community Health Volunteer (FCHV) from each municipal ward located at 0.5 – 1.0-hour walking distance from the sampled HF was purposively selected in consultation with the HF staff and the ward representatives. Criteria such as marital status (currently married); age (20-44); and recommended as ‘hard working’ by the municipal ward representative or by the HF personnel formed the basis of FCHV selection.

1.4 Data Collection Technique and Tools

The three sets of questionnaires were administered to collect information from the three categories of study participants, viz: 1) HF In-charge & service providers; 2) clients seeking RMNCAH services (exit interview); and 3) FCHVs. Face-to-face interviews were conducted with almost all study participants. Only in a few cases, (< 5%) interviews were done remotely through phones.

Written informed consent was obtained prior to face-to-face interviews and verbal informed consent was obtained prior to remote interviews. In regard to the present COVID-19 situation, two meters distance was maintained in between the interviewer and interviewee during the interview process. The interviewer used (PPE), face masks, hand gloves and face shield during the data collection period. All data were collected electronically using aneroid cell-phones or tablets. The three sets of questionnaires in Nepali were uploaded on the cell-phones and tablets after installing KoBo Tool software that has features for collecting information both online and offline and has more options in terms of

questionnaire design and response options. All data collected from the field were transferred to the main server at CREHPA each day.

The questionnaire for HF in-charges and service providers explored service functionality during the COVID-19 crisis, constraints faced in offering all ranges of essential RMNCAH care to clients, demand and utilization of these essential services, and ability of the health staff to observe precautionary measures including infection prevention during the COVID-19 crisis.

The questionnaires for clients seeking RMNCAH care were administered to the clients after they had obtained the service from the HF (exit interviews). The type of service sought and ability to receive the desired service, difficulties encountered in arriving at the HF, measures taken by clients as well as by the service providers to prevent transmission of the infections, etc., were solicited from the clients. Likewise, the FCHV questionnaire solicited information on clients' RMNCAH service seeking behavior amidst the COVID-19 crisis, ability of FCHVs to discharge their regular tasks, reasons for clients who have discontinued follow-up visits (default clients) for routine ANC, PNC and FP services and barriers to service utilization by the women.

Data was collected between September 7 and September 26, 2020 for Round 1 and between November 10 and November 22, 2020 for Round 2. In addition, retrospective HMIS and other service records pertaining to RMNCAH were extracted for all the 21 sampled districts for comparing the pre-pandemic situation (Mid-March to Mid-October 2019) with the current COVID-19 induced five-month lockdown period and beyond (Mid-March- Mid-October 2020).

1.5 Data Management and Analysis

All the obtained data were de-identified in order to maintain the confidentiality of the research participants. After de-identification, the data was cleaned. All cleaned data were labeled and transferred to SPSS for tabulation (frequencies and other descriptive tables/cross-tabs). Data were analyzed according to the key indicators against each of the seven themes under RMNCAH services. The domain of analysis is the 'Province' and disaggregated by four levels of HFs. Some of the key data representing the key indicators (variables) were compiled to indicate national scenarios. Data obtained from FCHVs' interviews and clients' exit interviews were analyzed separately to portray the service utilization and constraints encountered by clients in accessing the RMNCAH service during the lockdown period. A Web-based Dashboard has been developed for the FWD/MoHP that uploaded the key indicators based on the Round 1 assessment results and some of the key results were updated based on the Round 2 assessment findings. Information in the dashboard features national and province level scenarios as well as those at the different HF levels on the impact of COVID-19 on RMNCAH services.

1.6 Limitation of the Study

This study is limited to the public health system and hence, the findings do not reflect the functionality and utilization of RMNCAH services provided at private hospitals, private medical colleges, NGO clinics, etc., amidst the COVID-19 pandemic and lockdowns. The sample for the Round 2 assessment covered only a third (140) of the total 424 sampled HFs and solicited fewer information from the study participants than in the Round 1 assessment.

Chapter 2

Functionality and Utilization of RMNCAH Services

The COVID-19 pandemic has strained the country's health systems and disrupted essential health services including RMNCAH services. The government of Nepal has instructed all public HFs to abide by the Interim Guidance developed by the RH sub-cluster for ensuring continued access to the essential RMNCAH services, measures for staff and client protection from COVID-19, uninterrupted availability of equipment and commodities necessary for the essential services among others. This chapter assesses the functionality of RMNCAH services, adoption of basic precautionary measures by the service providers against COVID-19 transmission, extent of utilization of essential services by clients and types of service disruptions encountered in the delivery of RMNCAH services.

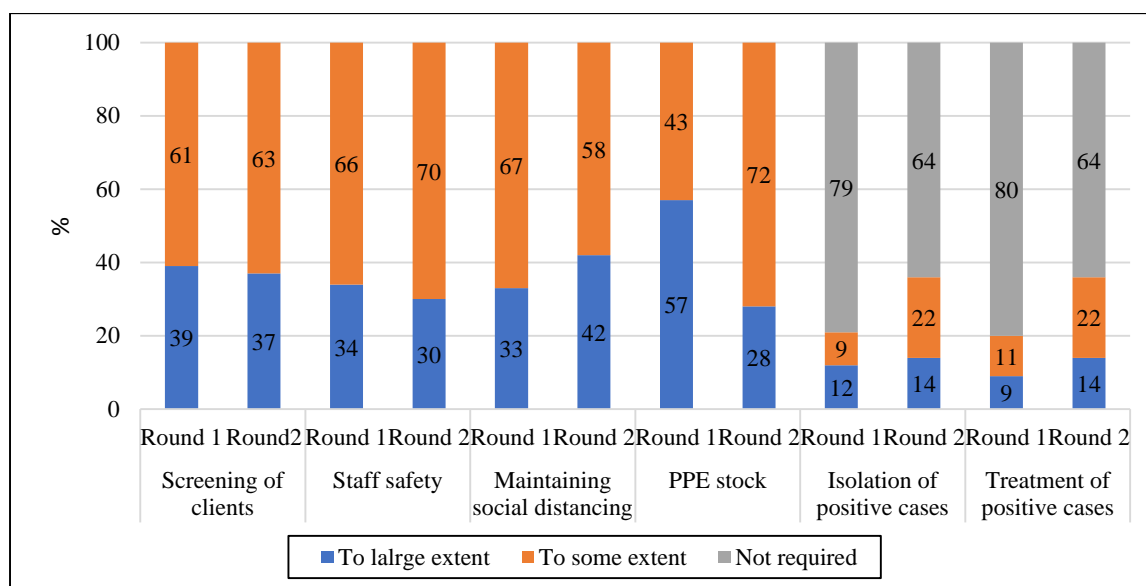
2.1 Health Facilities' Preparedness in Dealing with Clients

Service providers (facility in-charge) of public HFs were asked to state the extent of preparedness of their HFs to deal with clients/patients in the context of the COVID-19 pandemic lockdown period. HFs' preparedness was asked on the six preventive/precautionary measures. These were: screening of clients, staff safety, maintaining social distancing, adequacy of PPE, and in isolation and treatment of COVID-19 positive cases. Furthermore, the service providers were asked to give their response regarding their level of preparedness either by saying "to a large extent"; "to some extent only" or saying "not required at all", against each of these six precautionary measures and interventions. The findings are presented in Figure 2.1 below and Annex 2.1 and 2.2.

As shown in Figure 2.1, in the Round 1 Assessment (September 2020), more than half of the HFs were prepared but 'to some extent only' for screening of clients, staff safety and in maintaining physical distancing in the context of the COVID-19 pandemic. Only about a third to less than two fifths of the HFs were prepared to a large extent in screening of clients (39%), ensuring staff safety (34%) and maintaining social distancing (33%). More than half (57%) of the HFs had sufficient stock of PPE. Isolation of COVID-19 positive cases and their treatment were the tasks mainly for COVID hospitals and non-COVID hospitals.

During the Round 2 Assessment (November 2020) the percentage of HFs reporting that they were 'prepared to a large extent' with the stock of PPE declined sharply by half (from 57% to 28%). Those reporting about HFs preparedness to a large extent on clients' screening and staff safety also decreased marginally by 2 and 4 percent respectively as compared to the previous round (Round 1). However, percentages of the service providers saying that their HFs were prepared to a large extent for isolation and treatment of COVID 19 infected clients increased slightly by 2 to 5 percent only (Figure 2.1).

Figure 2.1 Health facility’s preparedness in dealing with clients in the context of the COVID-19 pandemic: Round 1 and Round 2 Assessment



Province-wise assessment showed that in Round 1, more than fifty percent of the HFs across all the provinces were prepared “only to some extent” for screening of clients, staff safety, and maintaining social distancing. More than half of the HFs in Province 1, Karnali and Sudurpaschim Province said that their preparedness with PPE stock was to “some extent only”. The majority of HFs in Province 2 (90%) and Lumbini Province (93%) mentioned they were not required to prepare for isolation and treatment of COVID-19 positive cases (Annex 2.1).

In Round 2, the province-wise reporting of HFs’ level of preparedness (to some extent only) for screening of clients and staff safety did not change much from the previous round of assessment. Comparatively, the highest number of facilities (43%) in Bagmati Province reported of adequate PPE stock in Round 2.

Facility-wise analysis shows, most peripheral HFs (PHCC, HP and UHC) in both rounds of assessment (Round 1 and 2) reported that they were not required to deal with clients for isolation and for treatment of COVID-19 positive cases. On the contrary, 80 percent of the COVID hospitals and about half of this proportion of non-COVID hospitals had to deal with isolation and for treatment of COVID-19 positive cases. The proportion of COVID hospitals saying so increased to 89 percent in Round 2. Only 40 percent of the non-COVID hospitals reported about their preparedness to deal with isolation and treatment of COVID patients during Round 2 (Annex 2.2).

2.2 Extent of Adequacy of PPE at Health facilities

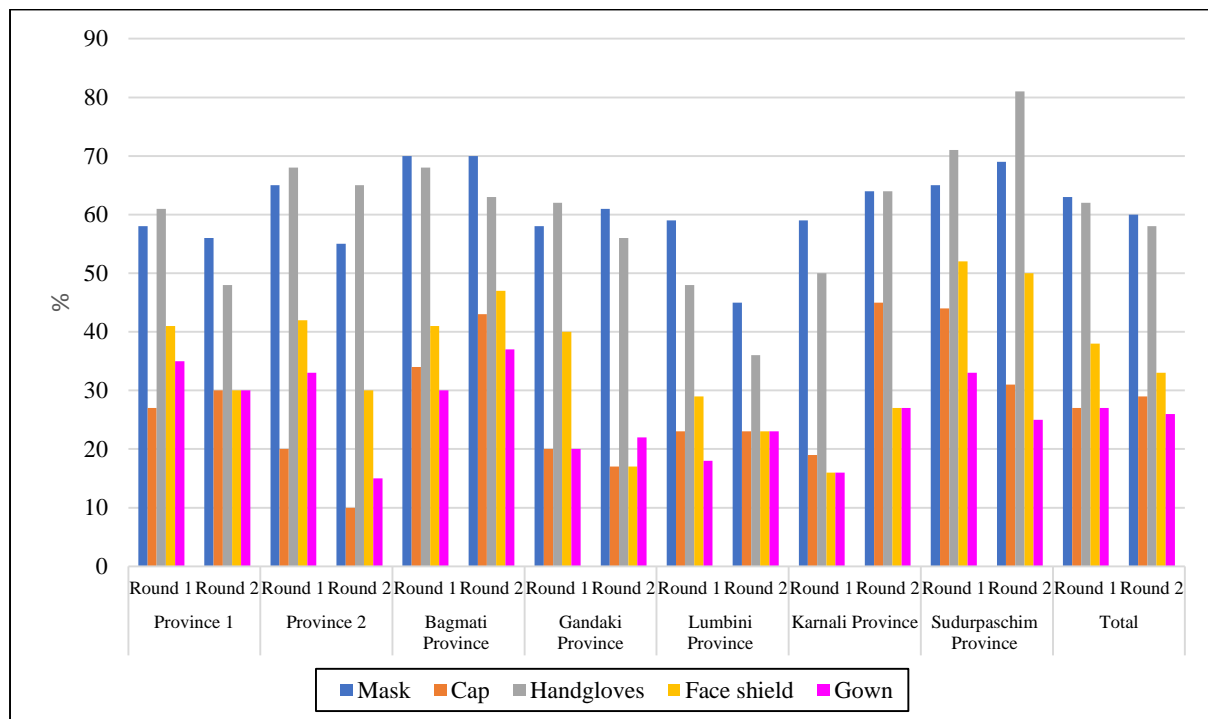
Adequate stock of PPE was reported by 40 percent of the COVID hospitals and 55 percent of non-COVID hospitals during the Round 1 assessment (Annex 2.2). In Round 2, the proportion of COVID hospitals reporting sufficient stock of PPE increased by more than two folds (89%). On the other hand, the proportion dwindled for non-COVID hospitals (40%) in Round 2. COVID hospitals’ preparedness for screening clients to a large extent also increased sharply from 60 percent in Round 1 to 89 percent in Round 2 (Annex 2.1).

Less than 50 percent of HFs across all provinces in Round 1 had inadequate availability of caps, gowns and face shields. Relatively, a higher percentage of HFs of Lumbini and Karnali Provinces reported shortages of face shields and gowns. In contrast, face masks and hand gloves were adequately available

in more than half of HFs of all provinces (Figure 2.2) More than 70 percent of the HFs in all provinces reported adequate availability of Infection Prevention and Control (IPCs) except sanitizers and disinfectants. More than three fifths of HFs in Province 1, Bagmati, Gandaki and Sudurpaschim Province had adequate availability of IPCs. (Figure 2.2).

In Round 2, the proportion of HFs indicating the adequacy of face masks and hand gloves have shrunk marginally at all provinces, particularly in Province 1 (hand gloves), Province 2 (face masks) and in Gandaki Province (hand gloves). No noticeable change in percentages of HFs reporting adequacy of other three PPE items (caps, face shields and gowns) was apparent in the Round 2 assessment (Figure 2.2).

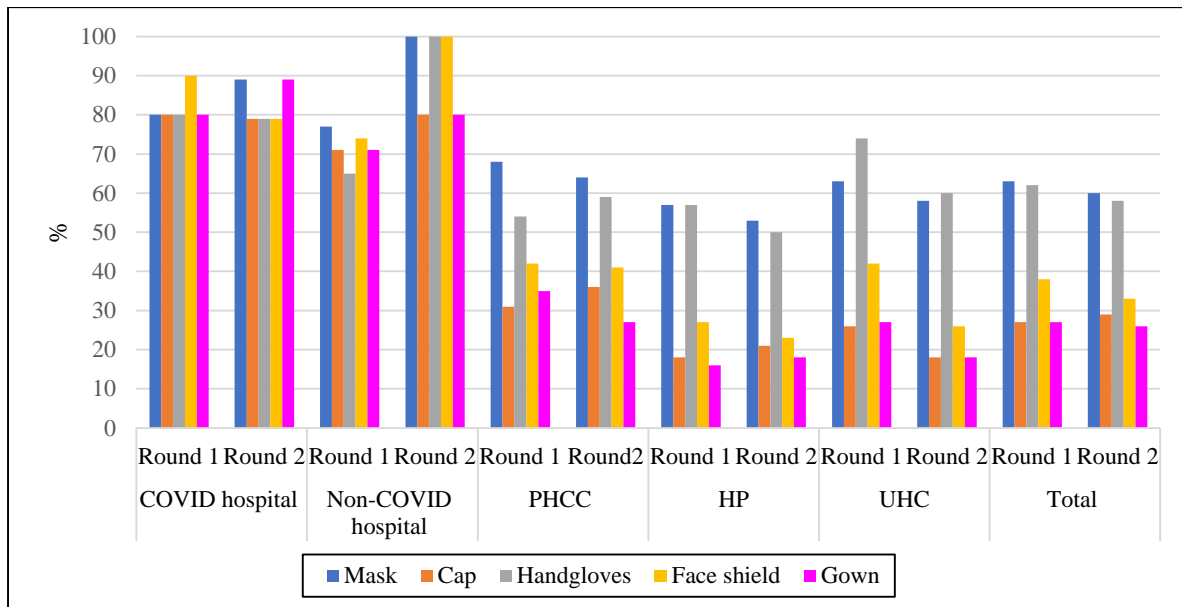
Figure 2.2 Province-wise percentages of health facilities reporting adequate availability of specific PPE: Round 1 and Round 2 Assessment



In Round 1, most COVID hospitals (80%) and nearly three-fourths of non-COVID hospitals reported having adequate availability of all 5 sets of PPE and four types of IPC measures. Comparatively, availability of PPE at PHCC, HP and UHC was low, except face masks and hand gloves (Figure 2.3). For instance, more than half of the PHCC and lower HFs (HP and UHC) had inadequate availability of caps, face shields and gowns.

In Round 2, all non-COVID hospitals reported having adequate availability of face masks (100%), hand gloves (100%), and face shields (100%). Eighty percent of these hospitals had adequate availability of the other three PPE items (caps and gowns) (Figure 2.3). These PPE items were adequately available between 80 to 90 percent of the COVID hospitals which is noteworthy too. In comparison, the percentages of peripheral HFs (PHCC, HP and UHC) reporting adequacy of PPE have declined marginally in Round 2 for almost all five PPE items (Figure 2.3).

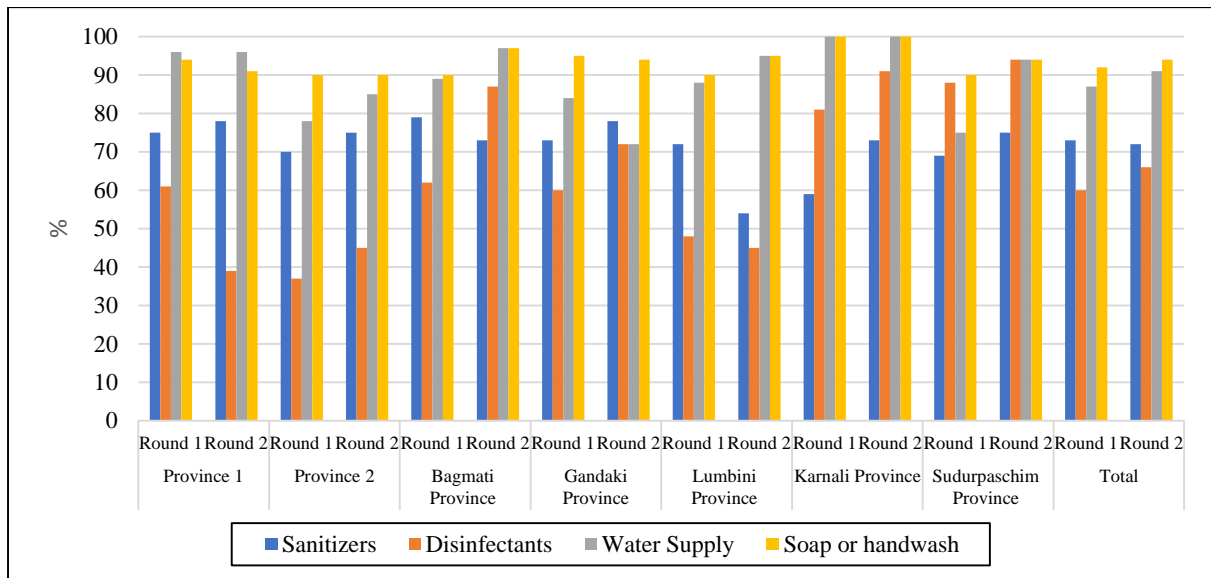
Figure 2.3 Health facility-wise reporting of adequate availability of specific PPE: Round 1 and Round 2 Assessment



Sanitizers are adequately available only in around three fourths or less of all HF's while disinfectants in less than two thirds of HF's. Most provinces reported about adequate water supply and soap/hand wash. Comparatively, disinfectants were reportedly in short supply in Province 2 and Lumbini Province during Round 1 (Figure 2.4).

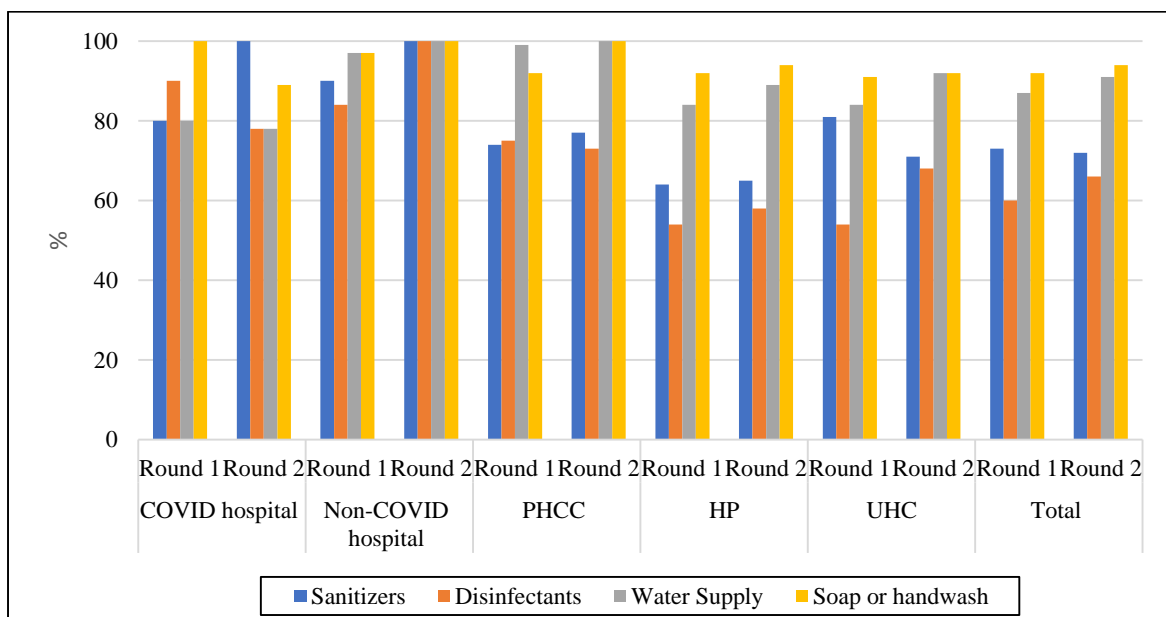
In Round 2, Lumbini Province is joined by Province 1 and Province 2 as provinces indicating low percentages of HF's (below 50%) with a short supply of disinfectants. Lumbini Province also represented the only province with shortages of sanitizers. Approximately half of the HF's in this province reported of having adequate availability of sanitizers (Figure 2.4).

Figure 2.4 Province-wise percentages of Health facilities reporting adequate availability of IPC measures: Round 1 and Round 2 Assessment



At the HF levels, more than three fourths of the PHCCs, HPs and UHCs reported adequate availability of IPC materials except sanitizers and disinfectants (Figure 2.5). In Round 2, the percentage of HPs reporting adequate supplies of IPC items, particularly disinfectant and sanitizers, were low as compared to other categories of HFs (Figure 2.5).

Figure 2.5 Health facility wise reporting on adequate availability of IPC measures: Round 1 and Round 2 Assessment



2.3 Availability of RMNCAH Interim Guidance

Overall, only 28 percent (of all 424 HFs) reported receiving the RMNCAH Interim Guidance (IG) in Round 1. This figure increased to 39 percent (of all 140 HFs) in Round 2 (Figure 2.6).

Province 2 has comparatively the highest percentage of HFs receiving the IG in both rounds of the assessment (58% in Round 1 and 75% in Round 2). On the other hand, Sudurpaschim Province has the lowest percentage of HF reporting the receipt of IG in both the rounds (15% in Round 1 and 25% in Round 2). In Gandaki Province, the percentage of the HFs receiving the IG declined from 27% in Round 1 to 22 percent in Round 2. In the remaining provinces, the percentages have increased marginally in Round 2 (Figure 2.6).

Facility-wise comparison shows that four fifths of the COVID hospitals (80%) and nearly half of the non-COVID hospitals (48%) reported receiving the IG in Round 1. On the contrary, the majority of service providers from UHC (83%) and HPs (74%) reported not receiving the IG at the time of the Round 1 Assessment.

In Round 2, the availability of IG increased only at non-COVID hospitals, PHCC and HP. In fact, the proportion of non-COVID hospitals receiving the IG in Round 2 increased by nearly two folds (from 48 to 80%) (Figure 2.7).

Figure 2.6 Province-wise percentages of health facilities in receipt of RMNCAH Interim Guidance: Round 1 and Round 2 Assessment

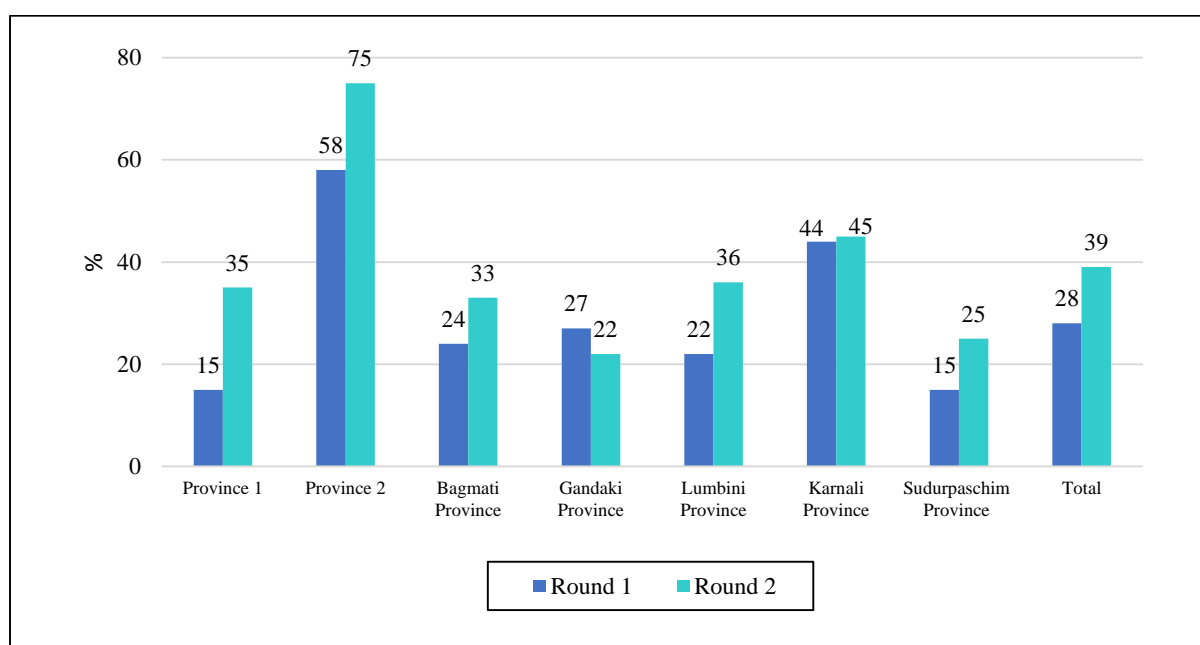
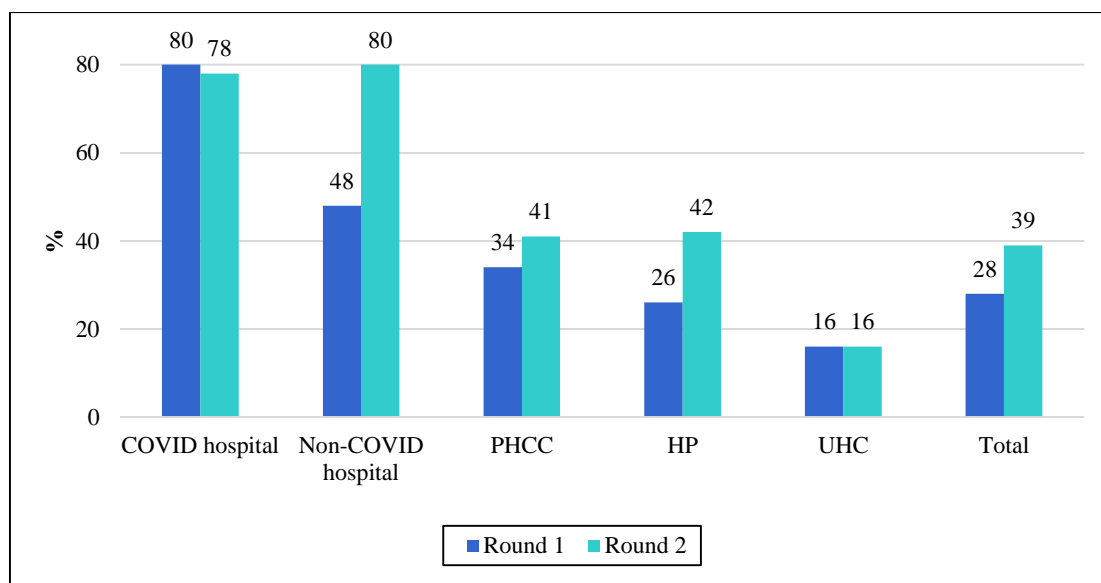


Figure 2.7 Health facility-wise percentages reporting the receipt of RMNCAH Interim Guidance: Round 1 and Round 2 Assessment



2.4 Orientation on RMNCAH Interim Guidance

Information on service providers' orientation on RMNCAH IG was solicited during the Round 2 Assessment. As shown in Figure 2.8, more than half (59%) had received the orientation. The highest percentage of service providers in Karnali Province (80%) followed by Province 2 (67%) had received the orientation. At the time of the present assessment (Round 2), none of the service providers in Gandaki Province had received the orientation (Figure 2.8). Likewise, all the service providers in PHCC (100%) had received the orientation followed by COVID hospitals (57%) and health posts (57%) (Figure 2.9).

Figure 2.8 Province-wise percentage of service providers receiving orientation on RMNCAH interim guideline: Round 2 Assessment

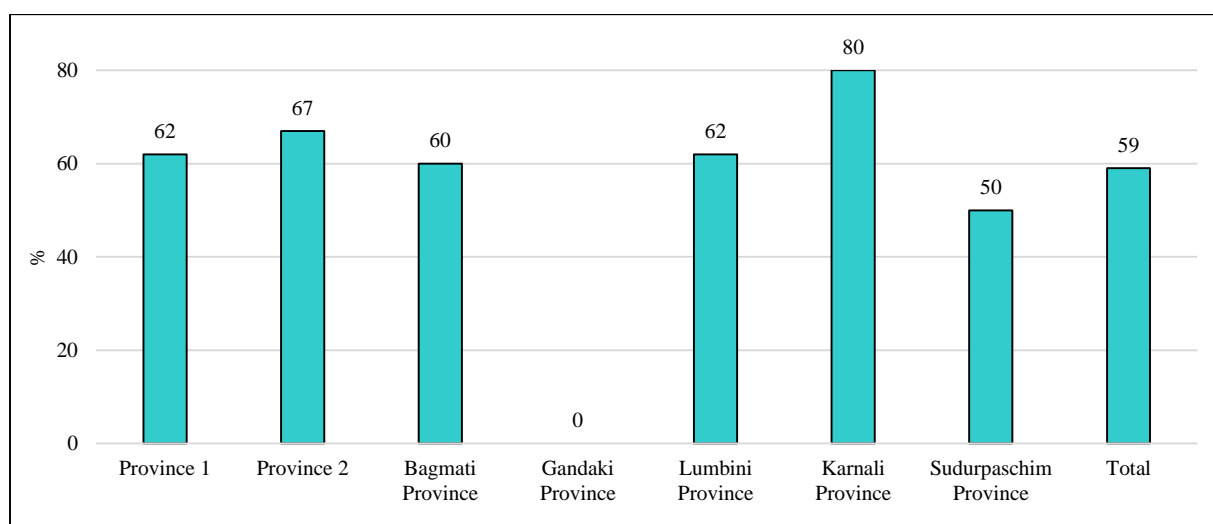
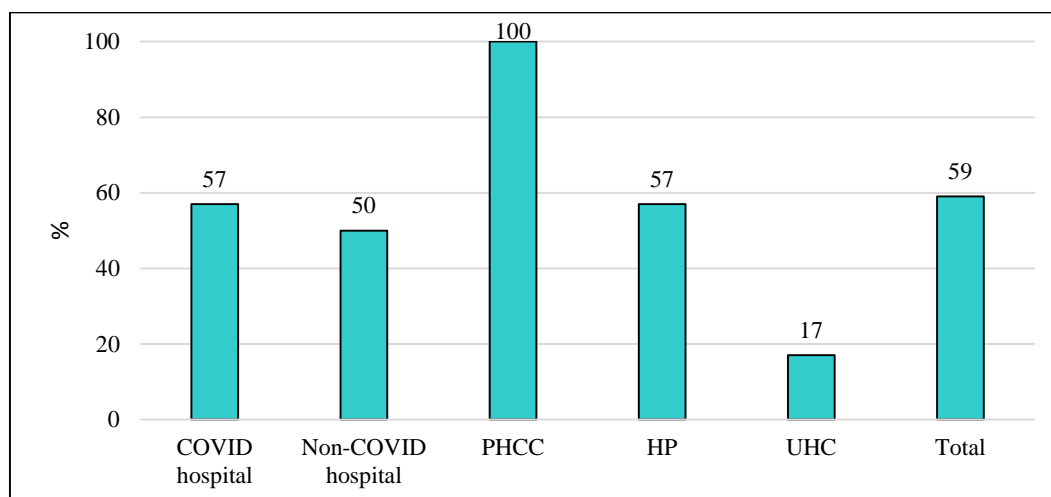


Figure 2.9 Health facility-wise percentage of service providers receiving orientation on RMNCAH interim guideline: Round 2 Assessment



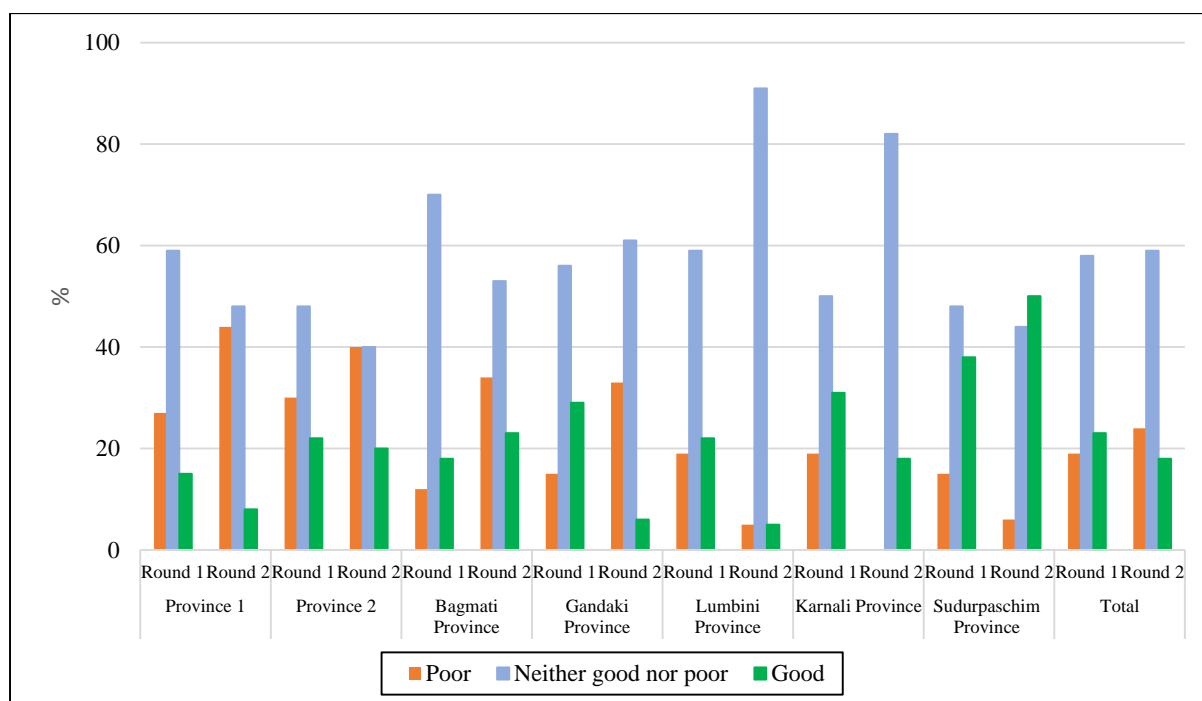
2.5 Service Providers' Rating of the Activities of the Government in Response to the COVID-19 Pandemic

Service providers gave their views on the Government response to the COVID-19 pandemic. This was conducted using Likert Scale on the basis of a five-point scale as follows: (1=Very Poor; 2=Poor; 3=Average; 4=Good; and 5= Very Good). For the purpose of the present analysis, the five-point rating scale has been merged into three scales: 'Poor', 'Neither good nor Poor', and 'Good'.

Overall, the majority of service providers (58%) rated the activities of the Government in response to the pandemic as 'average' ('neither good nor poor') and only about a quarter of the them (23%) rated the activities of the Government as "good". Comparatively, a higher percentage of service providers from Sudurpaschim Province (38%) and Karnali Province (31%) rated the Government's activities in response to the pandemic as "good". On the other hand, the percentage of service providers rating the Government activities as "poor" was the highest in Province 2 (30%), followed by Province 1 (26%) (Figure 2.10).

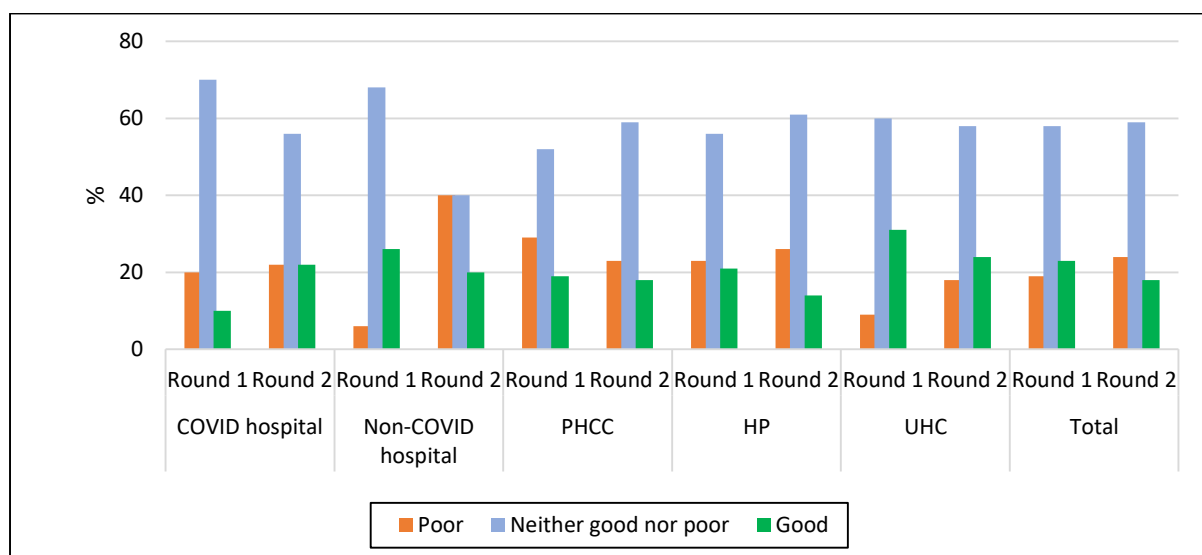
In Round 2, a higher percentage of service providers from Sudurpaschim Province (50%) rated the Government's activities in response to COVID-19 as "good". Those service providers rating the Government's activities as "poor" was highest in Province 1 (44%), followed by Province 2 (40%) (Figure 2.10).

Figure 2.10 Province-wise service providers' rating of the activities of the government in response to COVID-19 pandemic: Round 1 and Round 2 Assessment



As shown in Figure 2.11 below, service providers' rating of the activities of the Government varied according to the levels of the HF they served. Relatively, a higher percentage of those serving at UHCs (31%) and non-COVID hospitals (26%) rated the Government activities as "good" in Round 1. Whereas approximately every third service provider based at PHCC (29%) rated the Government activities as "poor". On the other hand, the large majority of service providers from COVID hospitals (70%) and non-COVID hospitals (68%) rated the Government activities as 'average'.

Figure 2.11 Health facility wise rating of the activities of the government in response to COVID-19 pandemic

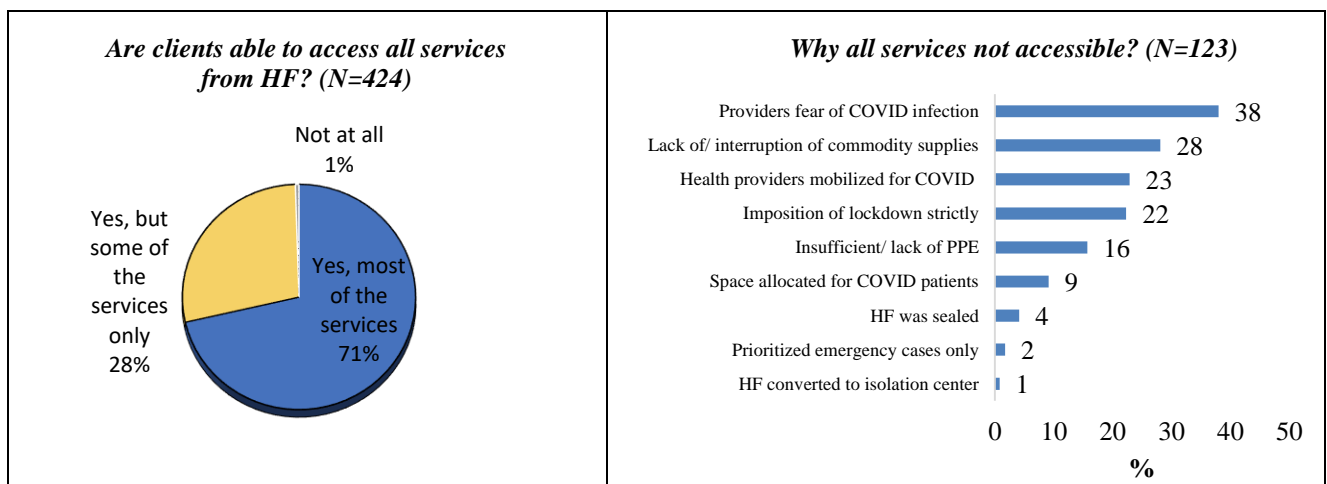


In Round 2, the overall percentages of HFs categorizing Government's activities as "good" dwindled to 18 from 23 percent. Facility-wise decline in the percentage of service providers rating the

Government response as “good” declined by between 1 percent and 7 percent except at COVID hospitals where the percentage increased by more than two fold (from 10 to 22%) (Figure 2.11).

In both rounds of assessment, all FCHVs (424) were asked to share their impression regarding clients’ ability to access services from the HFs nearest to them during the lockdown period. The large majority of them (71%) responded affirmatively saying that clients were able to access most of the health services from HFs located at their vicinities during the five-month lockdown period. Only about a quarter of the FCHVs said that clients were able to access some services from a HF during the lockdown. Fear of contracting COVID-19 from clients to the providers (38%), lack of/interruptions of commodity supplies (28%), mobilization of service providers for COVID-19 testing and treatment (23%), and imposition of lockdown strictly (22%) were the main reasons cited by the FCHVs for client’s limited access to health services in Round 1. In addition, 16 percent of the FCHVs perceived that the lack of or insufficient supply of PPE at the health facility hampered clients’ access (Figure 2.12).

Figure 2.12 Clients’ ability to access health services from a nearby health facility during five-month lockdown period: FCHVs’ Perspectives



Similar to the Round 1 assessment, the large majority of FCHVs (87%) in Round 2 stated that their clients were able to access most of the health services from the nearby HFs during the three month period. Meanwhile, the remaining FCHVs mentioned that clients were able to access only some of the services during the three month period. Unlike in Round 1, there were no FCHVs reporting non-provision on services during the period.

In Province 2, Karnali Province and Sudurpaschim Province, all (100%) FCHVs reported that clients were able to receive most of the services from the nearby HF. FCHVs from Province 1 (22%) and Gandaki Province (27%) reported that clients were only able to receive some of the services during the three month period.

2.6 FCHVs' Knowledge about Mode of Transmission and Symptoms of COVID-19

Knowledge about mode of transmission of COVID-19 as well as symptoms of its infection was very high among the FCHVs interviewed. The two most frequently cited responses regarding mode of transmission were: physical contact/touching (82%) and through sneezing/coughing (81%). In addition, more than half of the FCHVs reported that the disease could also spread through the items used by infected persons.

Likewise, an overwhelming large majority of the FCHVs identified fever or chills (98%) and a dry cough (78%) as signs/symptoms of COVID-19 infection. Over half of the FCHVs also cited 'shortness of breath/difficulty in breathing' (56%) and headache (53%) as COVID-19 symptoms. A negligible percentage of the FCHVs (1%) did not cite any symptom (Table 2.1).

In Round 2, there has been a conspicuous increase in the percentages of FCHVs' having knowledge on mode of transmission and symptoms of COVID-19 infection. The most frequently cited reason for modes of transmission was physical contact and touching (91%) followed by sneezing/coughing (86%). Similarly, a large majority of FCHVs were also aware of the symptoms of COVID-19 with the most commonly cited symptoms being fever/chills (96%) followed by a dry cough (86%) (Table 2.1).

Province-wise, the highest awareness regarding transmission of COVID-19 by physical contact was in Province 1 (96%) followed by Province 2 (95%). All FCHVs (100%) from Karnali Province were aware that COVID-19 was transmitted by sneezing and coughing. Only 41 percent of FCHV from Lumbini Province stated that COVID-19 could be transmitted through items used by infected persons (Annex 2.5).

Table 2.1 Percentage distribution of FCHVs according to their knowledge on mode of transmission and symptoms of COVID-19 infection: Round 1 and Round 2 Assessment

Modes of COVID-19 transmission	Round 1	Round 2
Physical contact/touching	81.8	91.4
Items used by infected person	56.8	63.6
Sneezing/coughing	80.9	85.7
Other modes	13.9	9.2
Symptoms of COVID-19 Infections		
Fever or chills	97.9	95.7
Dry cough	78.1	72.9
Fatigue/Tiredness	16.5	27.9
Muscles or body aches	17.0	35.0
Headache	52.8	66.4
Shortness of breath or difficulty breathing	56.4	66.4
Sore throat	39.2	56.4
Loss of taste or smell	6.8	25.0
Congestion or running nose	48.1	52.1
Nausea or vomiting	9.4	14.3
Diarrhea	11.3	8.6
Other	2.3	-
Don't know	1.2	-
Total	424	140

Percentages total may have exceeded 100 due to multiple responses

2.7 FCHVs' Abilities to Perform Regular Tasks

The ability of FCHVs to perform their regular tasks during the five-month lockdown period was solicited by the study. In all, 16 tasks pertaining to RMNCAH services were listed and for each task, FCHVs were asked to mention whether they were able to '*provide the task all the time during lockdown period*'; '*halted the task initially but resumed later*' or '*halted and not resumed yet*'.

As evident from Table 2.2, the large majority of the FCHV (75-97%) reported that they continued to perform their 13 out of 16 tasks all the time during the lockdown period. However, the majority of the FCHVs reported that 'distribution of CHS gel "Naavi Malam" (74%)' and Cotrim/Amoxicillin tabs' (69%) did not fall under their task. In addition, nearly a third to a sixth of the FCHVs stated that conducting pregnancy tests (32%) and referrals of clients for safe abortion service (SAS) (19%) were not usually done by them.

Approximately one-sixth to one-tenth of the FCHVs reported that they had to halt some of their tasks such as promotion/motivation of parents for childhood immunization (17%) and distribution of Vitamin A (13%), Albendazole (11%), and condoms and oral pills (9%) at the initial lockdown period and then resumed later (Table 2.2).

Province-wise distribution shows that some interruption in distribution of oral pills and condoms was reported by 43 percent of FCHVs in Province 2 during the five-month lockdown period, while this interruption occurred in less than 20 percent of FCHVs in other provinces (Annex 2.7).

Table 2.2 FCHVs ability to perform the assigned tasks during COVID-19 pandemic: Round 1 and Round 2 Assessment

Tasks	Provide all time		Halted initial but resumed later		Halted and not resumed yet		Not included in my task/ not usually sought service from me	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Referral for ANC/PNC care during lockdown period	96.5	98.6	2.8	-	-	-	0.7	1.4
Referred for institutional delivery during lockdown period	96.2	95.7	2.1	-	0.2	0.7	1.4	3.6
Referred of new FP clients during lockdown period	93.4	98.6	4.7	-	0.9		0.9	1.4
Promotion/counseling couples for FP use during lockdown period	91.0	100.0	8.0	-	0.7		0.2	0
Referral for danger signs as per IMNCI protocol during lockdown period	90.8	91.4	2.8	-	0.2	0.7	6.1	7.9
Counseling on other health, nutrition, and WASH during lockdown period	89.9	95.0	3.5	-	0.2	5.0	6.4	0
Distributed Albendazole during lockdown period	88.2	80.0	10.8	1.4	0	10.0	0.9	8.6
Distributed Vitamin A during lockdown	87.0	68.6	12.5	1.4	0.5	15.0	0	15.0
Referral for LARC service during lockdown period	85.4	85.0	5.2	-	1.7	1.4	7.8	13.6
Distributed Zinc tab and ORS during lockdown period	84.9	88.6	4.7	-	4.2	7.1	6.1	4.3
Promotion/ motivation for childhood immunization during lockdown period	82.8	99.3	16.7	1.4	0.2	0	0.2	0
Distributed condoms and oral pills during lockdown period	81.4	86.4	9.2	1.4	4.2	5.7	5.2	5.7
Referral for safe abortion care during lockdown period	76.9	74.3	3.1	-	1.4	0.7	18.6	25.0
Did pregnancy testing during lockdown period	59.9	40.0	4.5	-	4.0	12.1	31.6	47.9
Distribution of CHS gel (Naavi Malam) during lockdown period	23.3	23.6	1.7	-	6.4	17.1	68.6	59.3
Distribution of Cotrim/ Amoxicillin tabs during lockdown period	13.7	5.7	2.1	-	10.1	22.9	74.1	71.4

In Round 2, a large majority of FCHVs (74-100%) reported that they were able to perform 13 out of 16 amenities pertaining to RMNCAH services during the three month' period. All FCHVs (100%) were able to provide FP promotion and counselling during the period. Similar to Round 1, the majority of FCHVs reported that distribution of CHS gel “Naavi Malam” (59%), Cotrim/Amoxicillin tablets (71%), and pregnancy testing (50%) did not fall under their tasks. FCHVs also reported that services like Distribution of Cotrim/amoxicillin tablets (23%), distribution of CHS gel (17%), distribution of vitamin A (15%), and pregnancy testing services had been halted and not resumed yet (Table 2.2).

The mode of contacting clients by FCHVs during the lockdown period was mostly through personal visits and by phones. Nearly all FCHVs (91%) mentioned that they visited the clients at their homes during the lockdown period. Another half of them also said that they contacted their clients through phones (51%). (Table not shown).

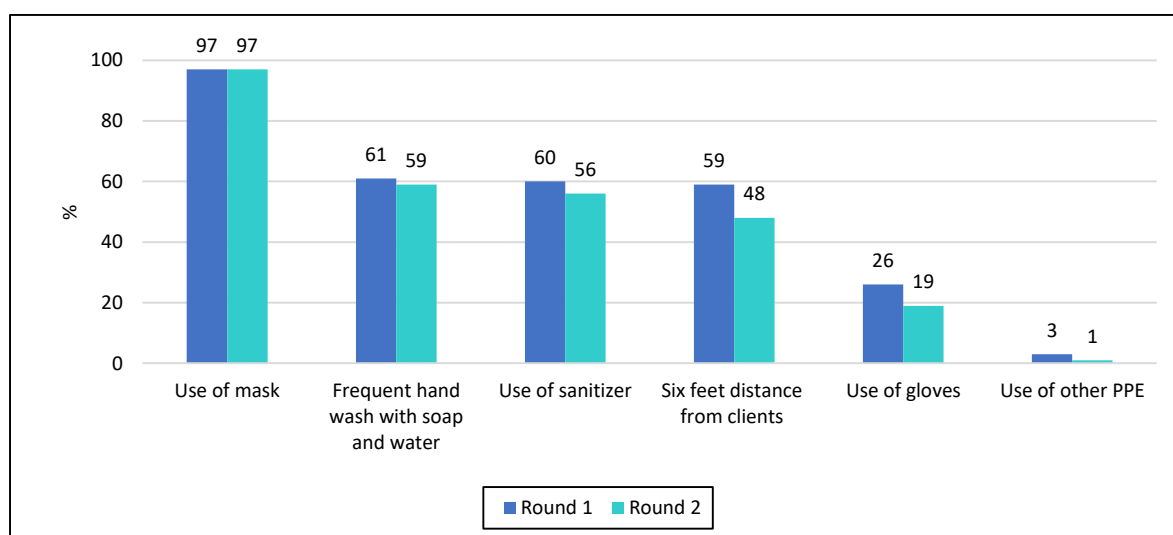
When asked about the range of precautionary measures adopted by FCHVs when they meet their clients, nearly all said that they use face masks (97%). Adoptions of other essential precautions such as social distancing i.e. keeping six feet apart from the clients (60%), frequently washing hands with soap and water (59%), and use of sanitizer (61%) were not commonly practiced among the FCHVs. Moreover, only about a quarter of the FCHVs used hand gloves at the time of meeting their clients (Figure 2.14).

All the FCHVs in Karnali Province and Sudurpaschim Province used face masks while meeting their clients and more than 90 percent of FCHVs in other provinces used face masks. Use of hand gloves by FCHVs was lowest (3%) in Karnali Province. Frequent hand washing, use of sanitizer, and maintenance of 2 meters of physical distance was lowest among FCHVs in Sudurpaschim Province (Annex 2.8).

FCHVs were reassessed regarding precautionary measures adopted by them while meeting clients in Round 2. Similar to Round 1, nearly all FCHVs reported using face masks (97%). However, adoption of other precautionary measures such as frequent hand washing (59%), use of sanitizers (56%), maintaining physical distancing (48%), and use of hand gloves (19%) were not commonly practiced (Figure 2.13).

All (100%) FCHVs from Province 2, Lumbini Province, Karnali Province and Sudurpaschim Province reported using face masks while attending clients. Use of sanitizers was highest in Bagmati Province (70%) followed by Sudurpaschim Province (69%). Use of other PPE items was found among FCHVs only in Province 2 and Karnali Province (9%). Frequent hand washing was practiced most by FCHVs in Karnali Province (91%) and the least in Gandaki Province (22%) (Annex 2.8).

Figure 2.13 Precautionary measures adopted by FCHVs at the time of meeting clients: Round 1 and Round 2 Assessment



2.8 Clients' Knowledge about Precautionary Measures against COVID-19

In all, 479 clients (455 female and 24 male) who had received RMNCAH related information and services at the sampled HFs were interviewed. As evident from Table 2.3, nearly all clients (96%) were aware of the precautionary measures to protect oneself from COVID-19.

Almost all clients mentioned 'wearing face mask always' (92%) and regular washing of hands with soap or with alcohol-based hand-rubs (76%) as precautionary measures. In addition, more than half of the clients (55%) cited physical distancing (2 meters or 6 feet apart) and avoiding crowded places and handshakes (50%).

More than 90 percent of clients in all provinces except Bagmati and Gandaki Province mentioned wearing a face mask as one of the precautionary measures. Almost all clients in Karnali Province mentioned wearing a face mask (100%), regular hand washing (97%), and maintaining 2 meters of physical distancing (97%) as precautionary measures (Annex 2.9)

The three main sources of knowledge about the precautionary measures as reported by the clients consisted of television (68%), radio (56%), and through phones/caller tune (48%) (Table not shown).

A total of 191 clients who had received RMNCAH related services were interviewed in Round 2. The majority (96%) of clients were aware about using face masks as a precaution against COVID-19 while around three quarters of them were aware of frequent hand washing as a precaution against COVID-19. Around half of the clients were aware of avoiding crowded places and maintaining two meters' distance as a precaution against COVID-19.

All (100%) clients from Karnali Province and Sudurpaschim Province who were aware of precautionary measures against COVID-19 had knowledge of using face masks to prevent oneself from COVID-19 infection. The highest awareness in terms of frequent hand washing was found among clients in Bagmati Province (97%) followed by Gandaki Province (85%). The lowest awareness in terms of maintaining physical distancing was in Karnali Province (86%) followed by Gandaki Province (73.1%) (Annex 2.9).

Table 2.3 Clients' knowledge about precautionary measures against COVID-19: Round 1 and Round 2 Assessment

Precautionary measures	Round 1	Round 2
Wearing face mask always	92.2	96.1
Regularly and thoroughly washing hands with an alcohol-based hand rub or with soap and water	75.6	74.5
Maintaining 2 meters (6 feet) distance between myself and others	54.9	56.9
Avoiding crowded places and handshake	49.7	50.8
Avoiding touching eyes, nose, and mouth	10.5	8.8
Staying home	10.9	13.2
Eat healthy, nutritional food, liquid items, and drink hot water	1.7	0.5
Change dress and bath after coming from outside	0.9	-
Maintain sanitization	1.3	-
Total	459	181

Percentage total may have exceeded 100 due to multiple responses

2.9 Clients' Perspectives on Precautionary Measures adopted by Service Providers

All clients were asked about the types of precautionary measures adopted by the service providers attending them at the HF. According to the clients reporting in both rounds, almost all service providers had used face masks (98%) and more than half had used hand sanitizers (58% in Round 1 and 65% in Round 2). However, the percentages of clients reporting service providers using hand gloves decreased significantly from 54 percent in Round 1 to 39 percent in Round 2. Use of other PPE items and maintenance of physical distancing by the service providers was also less adhered to according to the clients interviewed in both rounds (Table 2.4).

Table 2.4 Clients' perspective on the precautionary measures used by service providers while attending clients: Round 1 and Round 2 Assessment

Precautionary measures used by service providers	Round 1	Round 2
Used face mask	97.9	98.4
Washed hands with soap and water	25.1	28.2
Sanitized hands	57.8	65.4
Used hand gloves	53.9	38.8
Used special cover-all	14.8	10.1
Kept six feet apart from other patients/ visitors	12.3	3.2
Used cap	8.8	3.7
Used face shield	7.5	8.5
Did not use any precautionary measure	0.2	-
Did not see the service provider	0.6	0.5
Total	479	188

Percentage total may have exceeded 100 due to multiple responses

Province-wise distribution indicates that all the service providers in Lumbini, Karnali and Sudurpaschim Provinces used face masks while attending the clients. Only one provider in Bagmati Province had not used any precautionary measures. More than half of the service providers across all provinces did not wash hands. A very low percentage of service providers in Lumbini Province (10%) observed washing hands. Maintenance of physical distancing of six feet was ignored at most of the HFs in 7 provinces (Annex: 2.11)

In Karnali Province, all (100%) clients stated that hand sanitizing was practiced by service providers while attending the clients. The use of hand gloves was reported to be highest in Bagmati Province (70%) followed by Gandaki Province (57%). Use of face shields was found to be low with less than 15 percent of service providers across all provinces using face shields while attending clients (Annex 2.11).

All the service providers in COVID hospitals used face masks while attending patients while more than 95 percent of service providers in other facilities used face masks. More than 70 percent of service providers across all levels of facilities had skipped hand washing. Sanitizer use was observed in more than half of the service providers across all levels of facilities except UHCs. Maintenance of physical distancing of six feet was reported in one-sixth of the UHCs (18%) (Annex: 2.12).

Use of sanitizers was highest in COVID hospitals (91%) followed by UHCs (77%) and PHCCs (74%). Use of hand gloves was found to be highest in non-COVID hospitals (71%) as compared to any other HF type (Annex 2.12).

Chapter 3

Functionality and Utilization of Maternal Health Services

All the 424 sampled HFs were accredited for providing antenatal (ANC) and post-natal (PNC) services, while 209 HFs were accredited for providing institutional delivery services. Only 32 out of 41 hospitals in the sample were accredited for performing caesarean section deliveries.

This chapter discusses the functionality and utilization of these maternal health services during Round 1 and Round 2. Reasons for any increase or decrease in clients seeking maternal health services during the lockdown period and monthly trends of specific maternal services (ANC, Institutional delivery, C-Section, and PNC) are also discussed. Trend analysis comparing the data on utilization of maternal health services during the five-month lockdown period with the data of the corresponding period of the previous year is also presented.

FCHVs' perspectives on accessibility, functionality, and utilization of maternal health services are also discussed in this chapter.

3.1 Antenatal Care

3.1.1 Functionality of ANC Services

More than three quarters (76%) of the HFs had provided ANC services to clients without any disruption during the lockdown period while only around 20 percent of the facilities had ANC service disrupted initially but could resume later. A negligible number of HFs (1%) had halted the ANC services throughout the five-month lockdown period (Table 3.1).

Most of the ANC services at HFs in Bagmati Province (85%) and Karnali Province (84%) were functional, without any disruption during the lockdown period. In Province 1, more than a third (35%) of the HFs had halted ANC services in the initial phase of the lockdown period but later resumed their services.

Health facility-wise, there was no disruption of ANC services at most of the PHCCs (86%) and HPs (78%). On the contrary, 40 percent of COVID designated hospitals had to halt their ANC services during the initial period of the lockdown due to the need to allocate human resources and hospital spaces for isolation and treatment of COVID-19 patients. These services were resumed at a later period, however. ANC services were non-functional in nine percent of UHCs while a fifth of the UHC had their ANC services disrupted.

The major barriers for service provision as reported by the service providers in Round 1 were fear of COVID-19 infection among service providers and mobilization of service providers for COVID-19 testing and treatment.

In Round 2, most (87%) of the facilities provided ANC service without interruption, while the service was halted in 9 percent of facilities which was resumed later. Services in one facility had not been resumed yet. Province-wise comparison shows there was no interruption in ANC services during Round 2 in Karnali and Sudurpaschim Province. ANC services in one health facility in Bagmati Province has not been resumed yet. The ANC service in one PHCC was halted and not yet resumed.

Table 3.1 Province-wise functionality of ANC services: Round 1 Assessment

ANC Services	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpashchim Province	Total
Provided service at all times without interruption	65.2	80.0	84.8	78.2	67.6	84.4	77.1	76.4
Halted initially but resumed	34.8	18.3	10.9	10.9	29.4	9.40	18.8	19.6
Halted and not resumed yet	-	1.7	1.1	-	2.9	-	-	0.9
Nonfunctional before lockdown	-	-	3.3	10.9	-	6.3	4.2	3.1
Total (N)	69	60	92	55	68	32	48	424

Table 3.2 Facility wise functionality of ANC services: Round 1 Assessment

ANC Services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Provided services at all times without interruption	60.0	71.0	86.2	78.1	70.9	76.4
Halted initially but resumed	40.0	29.0	13.8	18.9	19.7	19.6
Halted and not resumed yet	-	-	-	2.0	-	0.9
Non-functional before lockdown	-	-	-	1.0	9.4	3.1
Total (N)	10	31	65	201	117	424

3.1.2 Extent of utilization of ANC during the COVID-19 Pandemic

The highest decrease in ANC clients occurred in the month of Chaitra with 35 percent of service providers reporting decreases in ANC clients that month. The highest increase in ANC clients was reported three months later i.e. in the months of Asadh and Shrawan (38%). The major reasons for this increase in clients seeking ANC services was cited as an increase in the number of pregnancies during the lockdown period. Other reasons for the increase were denial of services from nearby facilities and increase in referral of ANC clients from other HF (Table 3.3).

Table 3.3 Reasons for increase, decrease and halt of ANC services by Health Facility: Round 1 Assessment

	COVID hospital	Non-COVID Hospital	PHCC	HP	UHC	Total
Reasons for Increase						
Increase in number of pregnant women	33.3	58.8	69.0	65.8	55.8	62.2
Due to denial of service from nearby health facility	33.3	52.9	20.7	17.7	25.0	23.9
Increase in referral of pregnant women to this facility	100.0	47.1	27.6	15.2	11.5	20.6
Unable to travel to other HF due to lockdown	-	5.9	6.9	11.4	11.5	10.0
Total (n)	3	17	29	79	52	180
Reasons for Decrease						
Fear of infection among clients	100.0	78.6	64.5	74.7	66.7	72.6
Social restrictions due to COVID-19	71.4	57.1	58.1	58.6	58.3	58.9
Fear of infection among providers	42.9	14.3	32.3	37.9	30.6	33.7
Lack of transportation	85.7	28.6	45.2	23.0	25.0	30.3
Non-availability of service provider	14.3	-	16.1	8.0	-	7.4
Total (n)	7	14	31	87	36	175

Percentage total may have exceeded 100 due to multiple responses

Two-fifths (41%) of service providers reported that there was a decline in utilization of ANC services during the five-month lockdown period. The highest decline occurred in the month of Chaitra (35%) and lowest decline in the month of Shrawan (15%) (Figure 3.1). Fear of infection among clients and social restrictions due to COVID-19 were cited as the major reasons for the decline in ANC clients during the lockdown period. ANC service in few (2%) HFs was halted over the five-month lockdown period due to the COVID-19 pandemic lockdown.

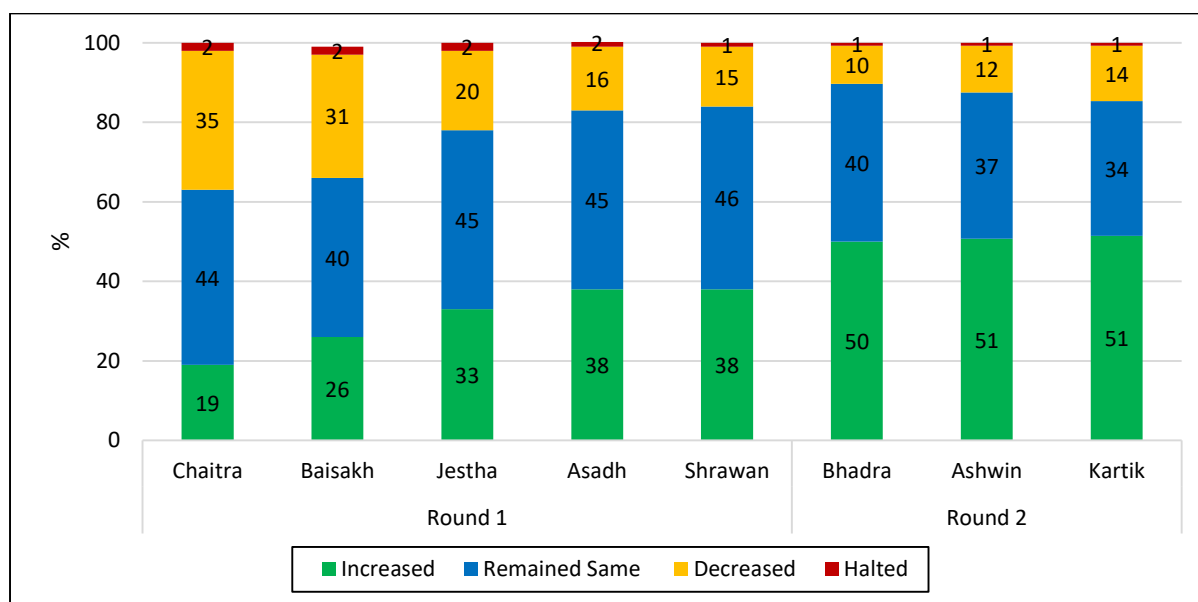
Province-wise comparison shows the highest (53%) increase in flow of ANC clients was reported in Gandaki Province in the month of Baisakh, while the highest (63%) decline was reported in Province 2 in the same month (Baisakh) (Annex 3.1).

A gradual increase in the number of service providers reporting an increase in utilization of ANC services occurred between the Chaitra (Round 1) and Kartik (Round 2). An average of 12 percent of service providers reported a decline in the flow of ANC clients during the three month period. As compared to the five-month lockdown period, the number of service providers reporting a halt in ANC services declined from an average of two percent to one percent implying that ANC services have resumed (Figure 3.1).

In terms of province, only Bagmati Province reported a halt in utilization of ANC services between Bhadra and Kartik. The highest decline in utilization of ANC services also occurred in Bagmati Province with an average of 31 percent of service providers reporting a decline in the utilization of ANC services between Bhadra and Kartik. The highest increase in flows of clients seeking ANC services was reported in Province 2 and Lumbini Province in the months of Bhadra and Ashwin and in Province 1, Province 2, and Lumbini Province in the month of Kartik (Annex 3.1a).

The Round 2 Assessment further showed that the utilization of ANC services was highest in COVID hospitals in the month of Bhadra with 80 percent of service providers reporting a surge in clients seeking ANC services in the months of Ashwin and Kartik. Non-COVID hospitals reported the highest (80%) increase in flow of clients seeking ANC care in the months of Ashwin and Kartik. Non-COVID hospitals also reported no decline in flow of clients seeking ANC services during the three month period. Halt in utilization of ANC services was only reported in UHCs over the three month period (Annex 3.2a).

Figure 3.1 Extent of utilization of ANC services: Round 1 and Round 2 Assessment



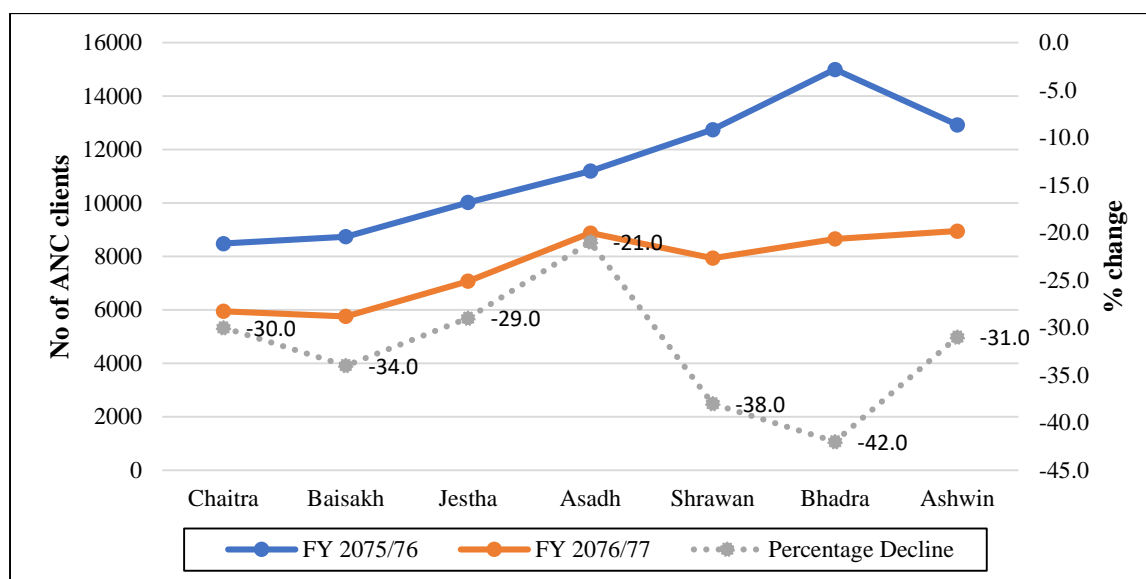
3.1.3 Trend in flow of ANC clients

There has been an overall decline of 30 percent in utilization of ANC services across all provinces during the five-month lockdown period as compared to the corresponding period of the previous year. The highest decline occurred in Province 1 with an average decline of 60 percent over the lockdown period. Utilization of ANC services was slightly higher only in Province 2 in the month of Baisakh (1.1%) and Asadh (4.9%) and in Sudurpaschim Province in the month of Jestha. The lowest decline was seen in Sudurpaschim Province with an average decline of 6 percent over the lockdown period.

The overall decline in utilization of ANC services continued for two months' post lockdown i.e. Bhadra and Ashwin. The utilization of ANC services increased in Sudurpaschim period during Bhadra and Ashwin. The highest decline in ANC services was still evident in Province 1 (Annex 3.3)¹.

¹ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

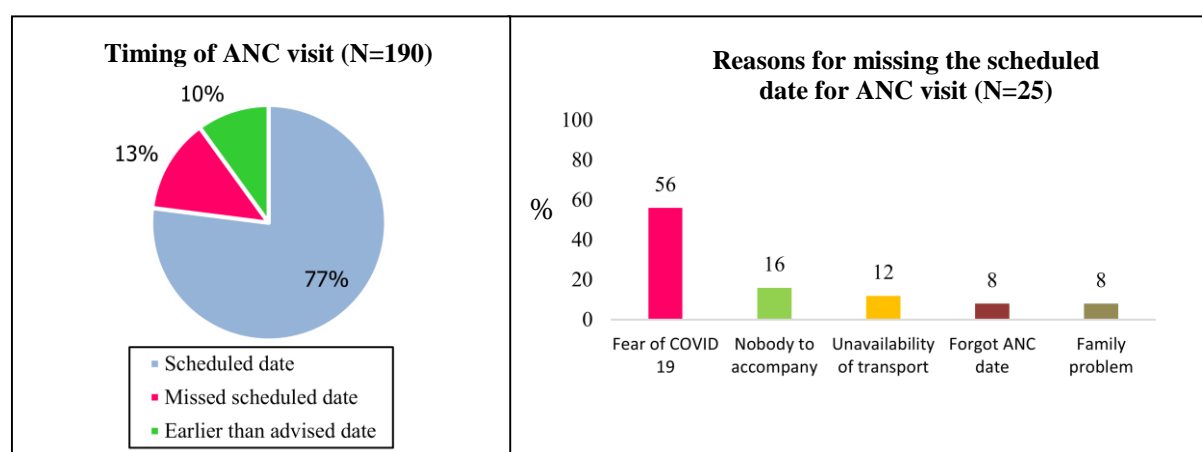
Figure 3.2 Trend analysis in utilization of ANC services



3.1.4 Timing of ANC visits and reasons for missing the scheduled date for ANC visits

Over three quarters (77%) of clients reported that they had come for their ANC visit as per their scheduled date. Only 13 percent of the clients reported that they had missed the scheduled date of their ANC visit. The most cited reason for missing the scheduled date was fear of COVID-19 infection. Other reasons were, ‘no one to accompany the client to the health facility’ and ‘unavailability of transportation’ among others (Figure 3.3).

Figure 3.3 Timing of ANC visits and reasons for missing out the scheduled date for ANC visit: Round 1 Assessment



The timing of seeking routine ANC services during Round 2 was similar to Round 1. For instance, of the 60 clients who had sought ANC care at the HF during the facility observation, 78 percent (77% in Round 1) had come as per their scheduled dates. Only 12 percent of them reported missing their scheduled date (13% in Round 1). The most cited reason for missing the scheduled date in this round was fear of COVID-19 infection (29%) and busy with household work (29%) (Table not shown).

3.2 Institutional Delivery

3.2.1 Functionality of Institutional Delivery Services

The large majority (86%) of HFs were able to provide delivery services without interruption. Only 9 percent of the facilities reported interruption of the service during the initial period of lockdown and had resumed subsequently.

Province-wise comparison shows that delivery services at HFs in Karnali Province and Sudurpaschim Province experienced the least interruptions, with over 95 percent of HFs reporting continued or uninterrupted provision of delivery services during the lockdown period (Table 3.4). In Province 2, roughly one in five HFs had their delivery services interrupted during the initial lockdown period.

Very few HFs, particularly HPs (7%) and UHCs (9%) were non-functional even before the lockdown period. However, institutional delivery services were also least interrupted in UHCs and HPs with 91 percent of UHCs and 87 percent of HPs reporting that institutional delivery services were provided without interruption during the lockdown period. The most interruption occurred in COVID hospitals with almost a third of COVID hospitals (30%) halting the delivery service during the initial lockdown period due to the need to provide spaces to accommodate COVID-19 patients (Table 3.5).

Of the total 140 HFs covered in Round 2, 65 HFs were accredited for institutional delivery. The service at one HF was not functional even before COVID-19. About 88 percent of the facilities were able to provide institutional delivery services without interruption during the three month period which is a slight improvement from Round 1. Services in four facilities was halted for some time which was resumed later on. The services in three facilities had not resumed yet. Province-wise comparison shows there was no interruption in institutional delivery services during three month period in Lumbini, Karnali and Sudurpaschim Province. One HF in Bagmati and two HFs in Gandaki Province had not yet resumed the service. The institutional delivery service in one PHCC and two HPs was halted and had not resumed yet.

Table 3.4 Province-wise functionality of Institutional Delivery services: Round 1 Assessment

Institutional Delivery	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpaschim Province	Total
Provided service at all times without interruption	80.0	76.2	88.6	76.9	81.5	95.8	95.1	85.6
Halted initially but resumed	11.4	19.0	5.7	11.5	14.8	4.2	2.4	9.1
Halted and not resumed yet	-	-	2.9	3.8	3.7	-	-	1.4
Nonfunctional before lockdown	8.6	4.8	2.9	7.7	-	-	2.4	3.8
Total (N)	35	21	35	26	27	24	41	209

Table 3.5 Facility wise functionality of Institutional Delivery services: Round 1 Assessment

Institutional Delivery	COVID hospital	Non-COVID hospital	PHC C	HP	UHC	Total
Provided services at all times without interruption	70.0	87.1	83.6	87.5	90.9	85.6
Halted initially but resumed	30.0	12.9	13.1	4.2	-	9.1
Halted and not resumed yet	-	-	3.3	1.0	-	1.4
Non-functional before lockdown	-	-	-	7.3	9.1	3.8
Total (N)	10	31	61	96	11	209

3.2.2 Extent of Utilization of Institutional Delivery Services during COVID 19 pandemic

Overall, 60 percent of service providers from 209 accredited facilities reported that the flow of clients seeking institutional delivery services remained unchanged during the lockdown period. An overall increase of 20 percent in clients seeking institutional delivery was reported between the months of Chaitra (13%) and Shrawan (33%) as compared to the five-month period prior to the lockdown (Figure 3.4). The major reasons for this increase were cited as ‘increase in referral of clients’ and ‘denial of service’ at nearby birthing centers.

Only fifteen percent of the service providers reported a decline of clients seeking delivery services throughout the lockdown period. The highest decline in clients was reported in the month of Baisakh (20%) and the lowest in the month of Shrawan (11%). The major reasons for the decline as cited by the service providers were ‘fear of infection among clients’ (63%), ‘the need to observe social restrictions due to the COVID-19 pandemic’ (44%), and lack of transportation facilities during lockdown (35%). About a quarter of the service providers (23%) also said that providers themselves did not entertain delivery cases for fear of contracting COVID-19 (Table 3.6).

The highest (58%) increase in utilization of institutional delivery was reported in Bagmati Province in the month of Asadh while the highest decrease was reported in Karnali Province in the month of Chaitra (Annex 3.4)

Round 2 data showed the number of service providers reporting an increase in flow of clients seeking institutional delivery services increased from 38 percent in Bhadra to 41 percent in Ashwin and Kartik. The highest decrease in the flow of clients seeking institutional delivery services was reported in the month of Kartik with 15 percent of service providers reporting a decrease in the utilization of institutional delivery services. Unlike in Round 1, there were no service providers reporting halting of institutional delivery services during the period between Bhadra and Ashwin (Figure 3.4).

All (100%) service providers in the Round 2 Assessment reported an increase in the utilization of institutional delivery services in Province 2 during the period between Bhadra and Kartik. The highest decrease in utilization of institutional delivery services was reported in Gandaki Province with 50 percent of service providers reporting decreases in the month of Bhadra and Ashwin and 65 percent of service providers reporting decreases in the month of Kartik (Annex 3.4a).

Non-COVID hospitals reported the highest increase in clients seeking institutional delivery services with 60 percent of service providers reporting increases in utilization of institutional delivery services during the three month period. Only 20 percent of service providers from COVID hospitals reported an increase in the flow of clients seeking institutional delivery services during the three month period,

while the highest decline of 33 percent in utilization of institutional delivery services was also reported among COVID hospitals as compared to any other health facility type. Only UHCs reported a halt in utilization of institutional delivery services during the three month period (Annex 3.5a)

Figure 3.4 Utilization of institutional delivery services

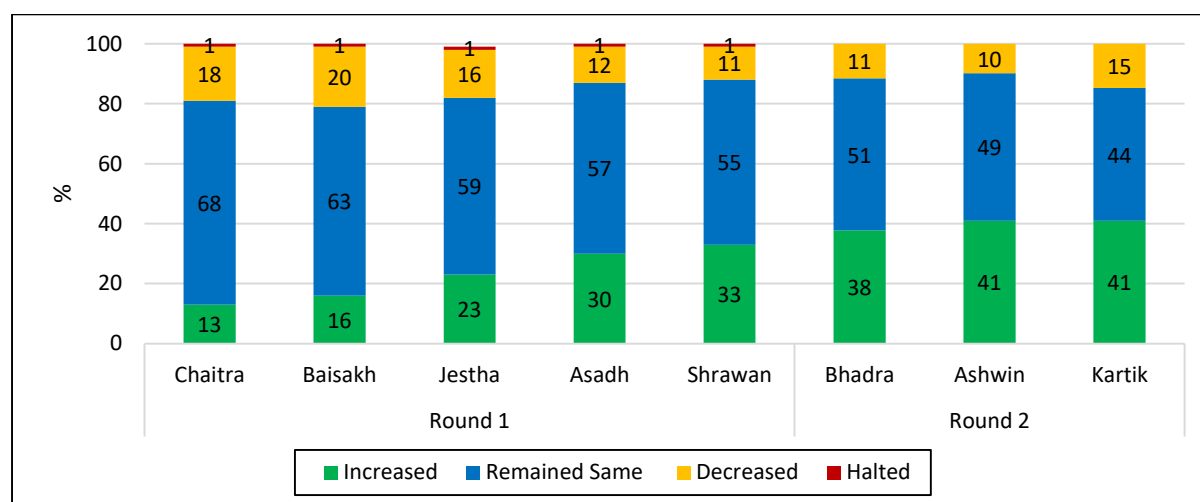


Table 3.6 Reasons for increase, decrease and halting of Institutional Delivery Services: Round 1 Assessment

	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Reasons for increase						
Increase in referral of clients	100.0	66.7	66.7	26.3	50.0	55.7
Due to denial of service from nearby health facility	66.7	71.4	57.1	21.1	-	47.1
Clients afraid to go to other health facilities	-	14.3	28.6	15.8	-	17.1
Fear of worsening of COVID-19 infection	-	-	14.3	26.3	-	11.4
Total (n)	3	21	21	19	6	70
Reasons for decrease						
Fear of infection among clients	100.0	25.0	78.3	50.0	100.0	63.5
Social restrictions due to COVID-19	100.0	25.0	56.5	31.8	-	44.2
Lack of transportation	50.0	75.0	34.8	27.3	-	34.6
Fear of infection among providers	-	25.0	26.1	22.7	-	23.1
clients gone to nearby higher health facility	-	50.0	8.7	4.5	-	9.6
Non availability of service provider	-	-	13.0	4.5	-	7.7
HF sealed	-	-	8.7	9.1	-	7.7
Total (n)	2	4	23	22	1	52

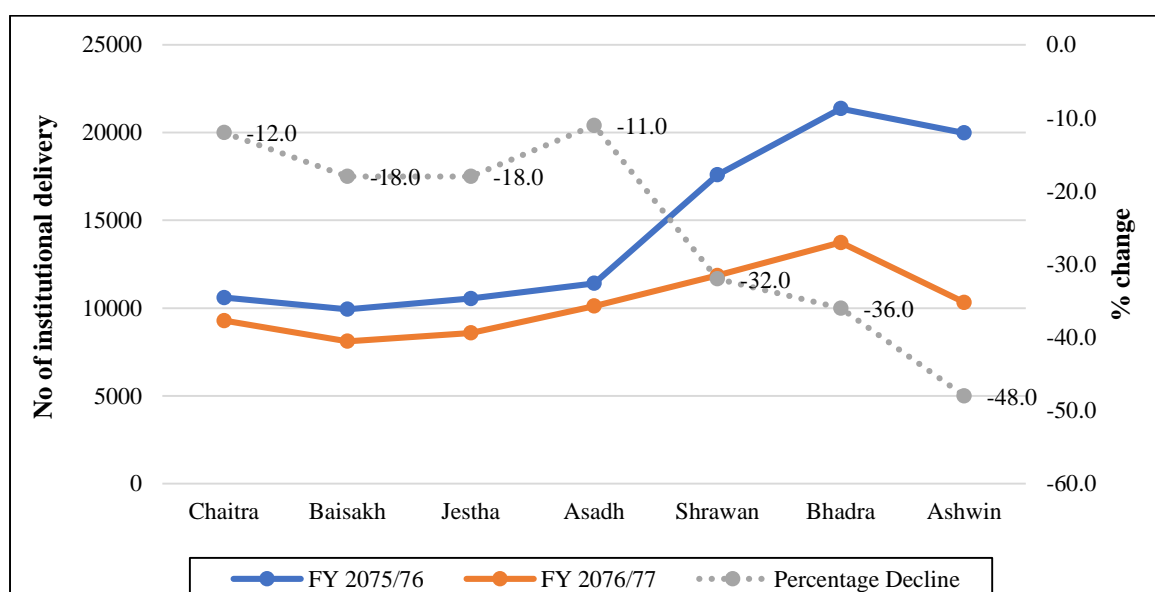
Percentage total may exceed 100 due to multiple responses

3.2.3 Trend in flow of Institutional Delivery clients

There has been an overall 19 percent decline in utilization of institutional delivery services by expectant mothers during the COVID-19 lockdown period as compared to the same period of the previous year. Utilization of institutional delivery services had decreased in all provinces except for Gandaki and Karnali Provinces. Gandaki Province, in particular, showed an increase in utilization of institutional delivery services in the month of Baisakh (6%), Jestha (16%), and Shrawan (17%) while Karnali Province showed an increase in utilization of institutional delivery services in the month of Asadh (10%). The highest decline in utilization of institutional delivery services occurred in Province 1 and Province 2 with an overall decline of 27%.

The decline in utilization of institutional delivery services two months' post lockdown in comparison to the same period last year was 42 percent in average. The increase in utilization of institutional delivery in Gandaki Province and Sudurpaschim Province was observed in the month of Bhadra while the utilization remained the same in Gandaki Province and decreased in Sudurpaschim Province in the corresponding month (Ashwin). The decline in utilization of institutional delivery services in Bhadra and Ashwin was highest in Bagmati Province with an average of a 58 percent decline. (Annex 3.6)²

Figure 3.5 Trend analysis on utilization of Institutional Delivery services



3.2.4 FCHV's perception on utilization of Institutional Delivery services during the lockdown period

Utilization of institutional delivery services was reported to be high with 95 percent of FCHVs claiming that institutional delivery services were provided to clients during the lockdown period (Table 3.7). However, FCHVs also reported instances of denial of institutional delivery services during the lockdown period. They reported that fear of COVID-19 transmission among providers, non-availability of service providers, and non-availability of commodities as major reasons for the denial of institutional delivery services to expectant mothers during the lockdown period (Table 3.8).

² The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Table 3.7 FCHVs' Perspectives on Institutional Delivery: Round 1 Assessment

Institutional delivery service provision during lockdown	N	%
Yes	405	95.5
No	19	4.5
Total	424	100.0

Table 3.8 Reasons for non-admission of clients seeking Institutional Delivery: Round 1 Assessment

Reasons for denial of institutional delivery	%
Fear of transmission of COVID-19 among providers	52.6
Non availability of service providers	26.3
Non availability of commodities	15.8
Social restrictions due to COVID-19	10.5
Lack of PPE	10.5
Health facility was converted into isolation center	10.5
PHC was sealed in that time	10.5
Don't know	5.3

Percentage total may exceed 100 due to multiple responses

3.2.5 Home delivery practice during the lockdown period

An average of 13 percent of service providers believed that home deliveries have increased during the lockdown period (Figure 3.6). A higher proportion of service providers of Province 2 mentioned an increase in home deliveries during the five-month lockdown period (50-60%). While service providers of Sudurpaschim Province reported a steady decline in home delivery service utilization during the lockdown period (Annex 3.7).

Factors that heightened home deliveries during the lockdown as perceived by the majority of the service providers in Round 1 were: fear of COVID-19 infection (77%), lack of transportation during lockdown (55%), and the need to observe social restrictions during the lockdown (40%) (Table 3.9).

Table 3.9 Reasons for increase in Home Deliveries: Service Providers’ perspectives

Reasons for Increase	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Fear of infection	100.0	33.3	100.0	72.7	81.3	77.1
Lack of transportation	50.0	50.0	53.3	61.4	43.8	55.4
Social restrictions due to COVID-19	100.0	33.3	33.3	38.6	43.8	39.8
Delivery service halted at the health facility	-	33.3	20.0	18.2	6.3	16.9
Fear of COVID-19 infection	-	-	6.7	-	12.5	3.6
Total (n)	2	6	15	44	16	83

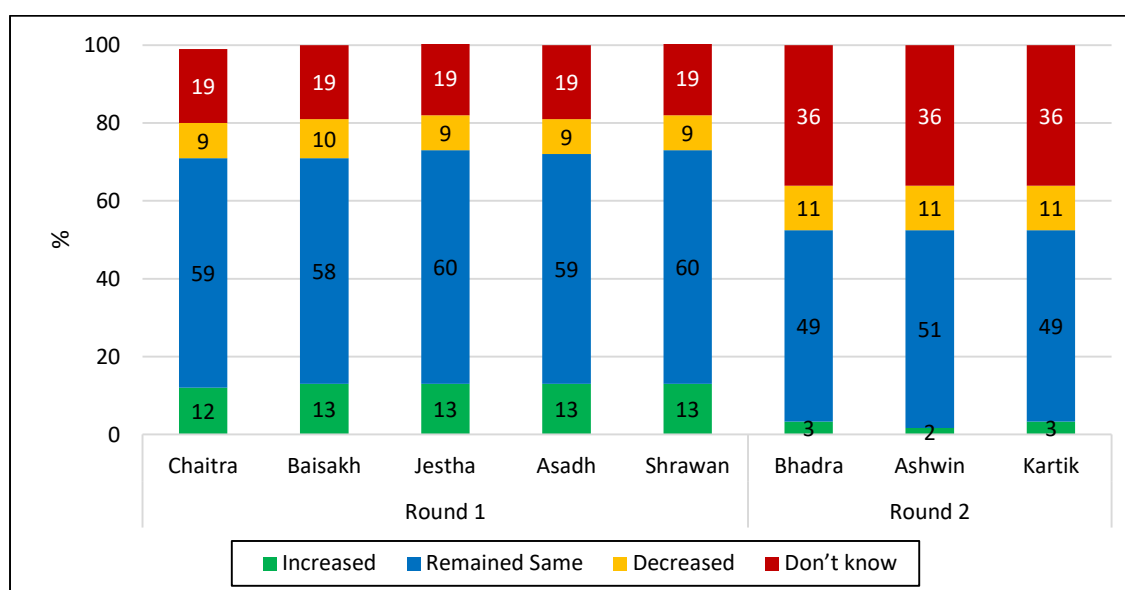
Percentage total may have exceeded 100 due to multiple responses

In Round 2, a negligible proportion of service providers (3%) reported an increase in home deliveries (this percentage was 13 in Round 1). While, 36 percent of service providers claimed that they were unaware about any report of home deliveries during Bhadra and Kartik (Figure 3.6).

The highest decline in utilization of home deliveries was reported by service providers of Province 2 with 40 percent of service providers reporting a decline in utilization of home delivery during the period between Bhadra and Kartik. The majority (79%) of service providers from Sudurpaschim Province reported no change in utilization of home delivery services during the three month period (Annex 3.7a).

The highest (20%) increase in utilization of home deliveries was reported by service providers of non-COVID hospitals while COVID hospitals reported an increase in home deliveries during the period between Bhadra and Kartik. All (100%) UHCs reported no change in utilization of home delivery service during the period (Annex 3.8a).

Figure 3.6 Home delivery practice during COVID-19 pandemic period: Service Providers’ perspectives services during Round 1 and Round 2 Assessment



3.2.6 Home Delivery practice during the lockdown period: FCHVs perspectives

The majority (82%) of FCHVs stated there had been no reports of home delivery during the lockdown period while only 18 percent of them stated that there had been reports of home deliveries during the lockdown period (Table 3.10). FCHVs resonated with service providers' views that a lack of public transportation during lockdown, fear of COVID-19 transmission among clients, and family members' reluctance to visit the HF was cause for an increase in home deliveries during the lockdown period (Table 3.11).

Table 3.10 Utilization of Home Delivery services during lockdown period

Home delivery reported during lockdown	%
Yes	18.2
No	81.8
Total	424

Table 3.11 Reasons for Home Delivery services during lockdown period

Reasons for home delivery	%
Lack of public transportation due to lockdown	44.2
Fear of transmission of COVI-19 among client	37.7
Family member are unwilling to visit HF due to COVID-19	20.8
Lack of money	15.6
Short labor pain (no time to go hospital)	15.6
Social restriction due to COVID-19	13.0
Non availability of service providers	9.1
Home delivery trend (no need to go hospital in normal case)	7.8
Premature birth	7.8
Hospital was sealed	2.6
Don't know	3.9

3.2.7 Provision of 'Aama' transport incentives to mothers of newborns

As per the Government's Safe Motherhood Programme (Aama Programme), it is mandatory for all HFs/birthing centers to provide 'Aama' transport incentives to all mothers who have received delivery care at birthing centers. The incentive is supposed to be handed over to a mother at the time of her discharge.

As shown in Table 3.12, more than half (55%) of the HFs covered in Round 1 were able to provide 'Aama' transport incentives instantly to the mothers on discharge during the lockdown period, while 44 percent reported of providing it at later dates. The highest number of HFs in Gandaki Province (74%) and Lumbini Province (73%) provided the transportation incentive instantly, whereas only 20 percent of facilities in Province 2 did so. Few HFs in Province 1, 2 and Lumbini Province did not provide the incentive at all. Most COVID hospitals (90%) and non-COVID hospitals (81%) were able to provide transport incentives instantly to the mothers of newborns during the lockdown period. On the other hand, approximately half of PHCCs (48%) and HPs (51%) provided the transport incentives at later dates. There were few PHCCs and HPs that did not provide the incentives at all to mothers. The reasons cited for not providing the incentive instantly to the mothers were: 'delay in provision of refundable money from the Government' and 'shortage of money at the facility' to pay to the mothers.

In Round 2, nearly two thirds of sampled HFs (64%) were able to provide the "Aama" transportation incentive instantly to mothers upon discharge. This figure is slightly higher by 9 percentage points than

the figure in Round 1. All the facilities in Lumbini Province and 87 percent of HFs in Gandaki Province provided the transportation incentive instantly, whereas only 20 percent of HFs in Province 2 did so (as in Round 1). Still, few HFs in Bagmati and Sudurpaschim Province did not provide the incentive at all. All COVID hospitals and the majority of non-COVID hospitals (80%) were able to provide the incentive instantly (Table 3.12).

Table 3.12 Province and facility-wise instant provision of ‘Aama’ transport incentives to mothers of newborns services: Round 1 and Round 2 Assessment

	Provided Instantly	Provided at Later Days	Not Providing Incentives
ROUND 1			
By Province			
Province 1 (n=32)	62.5	34.4	3.1
Province 2 (n=20)	20.0	75.0	5.0
Bagmati Province (n=33)	66.7	33.3	-
Gandaki Province (n=23)	73.9	26.1	-
Lumbini Province 5 (n=26)	73.1	23.1	3.8
Karnali Province (n=24)	45.8	54.2	-
Sudurpaschim Province (n=40)	37.5	62.5	-
Total	108 (54.5%)	87 (43.9%)	3 (1.5%)
By Facility			
COVID hospitals (n=10)	90.0	10.0	-
Non-COVID hospitals (n=31)	80.6	19.4	-
PHCC (n=59)	49.2	47.5	3.4
HPs (n=88)	47.7	51.1	1.1
UHCs (n=10)	30.0	70.0	-
Total	108 (54.5%)	87 (43.9%)	3 (1.5%)
ROUND 2			
By Province			
Province 1 (n=9)	66.7	33.3	-
Province 2 (n=5)	20.0	80.0	-
Bagmati Province (n=9)	77.8	11.1	11.1
Gandaki Province (n=8)	87.5	12.5	-
Lumbini Province 5 (n=9)	100.0	-	-
Karnali Province (n=7)	42.9	57.1	-
Sudurpaschim Province (n=14)	42.9	35.7	21.4
Total (n=61)	63.9	29.5	6.6
By Facility			
COVID hospitals (n=9)	100.0	-	-
Non-COVID hospitals (n=5)	80.0	20.0	-
PHCC (n=20)	60.0	35.0	5.0
HPs (n=24)	58.3	29.2	12.5
UHCs (n=3))	-	100	-
Total (n=61)	63.9	29.5	6.6

3.3 Caesarean Section Deliveries

The maternal units at 22 (69%) out of 32 hospitals accredited for C-Section conducted C-Section deliveries without any interruption during the five-month lockdown period (Table 3.14). There was no interruption in the provision of C-Section deliveries in hospitals of Karnali Province and Sudurpaschim Province throughout the five-month’ lockdown period (Table 3.13). While in the remaining provinces, all C-Section procedures were halted initially and then resumed later. Seventy percent of COVID hospitals and 82 percent of non-COVID hospitals provided C-Section services to clients without any interruption throughout the lockdown period. In the remaining hospitals, C-section services were halted initially but was resumed later on (Table 3.14).

Table 3.13 Province-wise provision of C-Section deliveries by hospitals: Round 1 Assessment

Caesarean Section	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpa schim Province	Total
Provided service at all times without interruption	4	2	7	3	3	2	4	25 (78%)
Halted initially but resumed	1	1	-	2	2	1	-	7 (22%)
Total (n)	5	3	7	5	5	3	4	32

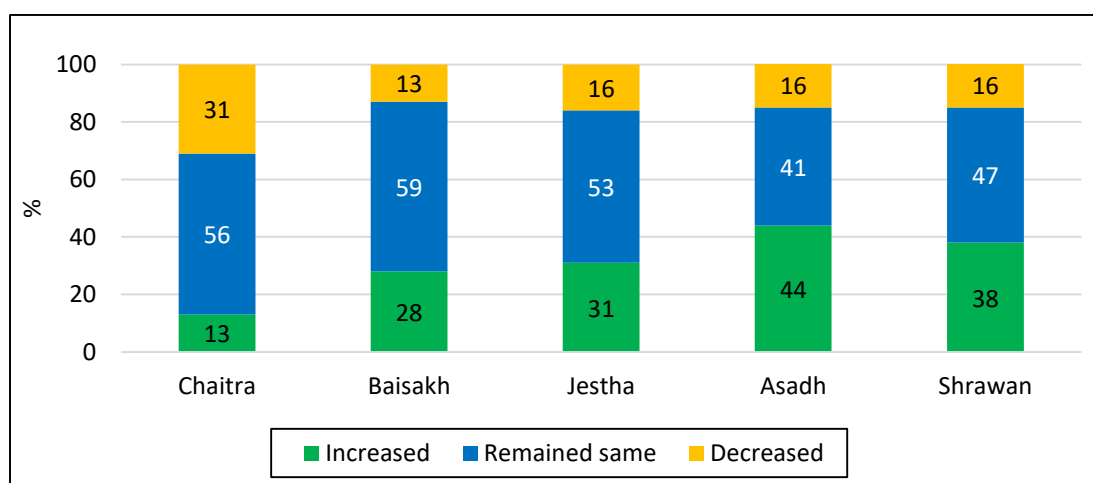
Table 3.14 Facility-wise provision of C-Section deliveries: Round 1 Assessment

Caesarean Section	COVID hospital	Non- COVID hospital	PHCC	Health Post	UHC	Total
Provided services at all times without interruption	70.0	81.8	-	-	-	78.1
Halted initially but resumed	30.0	18.2	-	-	-	21.9
Total (n)	10	22	-	-	-	32

3.3.1 Caseloads for C-Section deliveries during the lockdown period: Round 1 Assessment

The majority of service providers informed that the number of expecting mothers requiring C-Sections remained the same throughout the lockdown period. Among the 32 HFs accredited to provide C-Section procedures, less than half of service providers (44%) said that C-Section deliveries have increased (Figure 3.7). C-Section deliveries were high during the month of Asadh. Increases in referrals and denial of service from nearby facilities were cited as the major reason for increases in C-Section deliveries. All service providers (100%) of Karnali Province reported an increase in utilization of C-Section in the month of Asadh and Shrawan, while all service providers (100%) in Province 2 reported no change in utilization of C-Section during the lockdown period (Annex 3.9). The highest number (20%) of service providers from COVID hospitals reported a decline in C-Section deliveries in the month of Jestha (Annex 3.10).

Figure 3.7 Flow of clients seeking C-Section deliveries: Round 1 Assessment

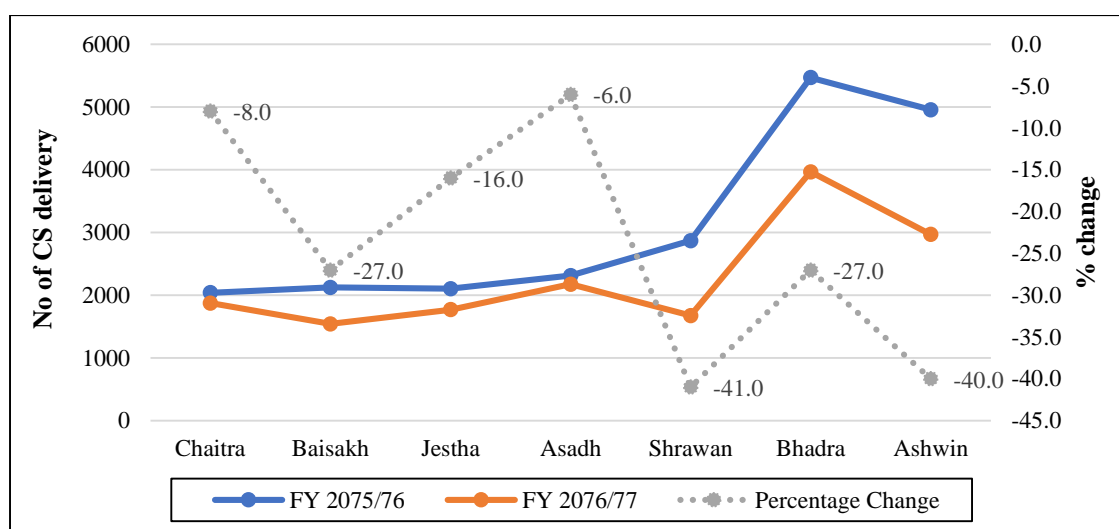


3.3.2 Trend in flow of C-Section Clients

There has been an overall declining trend in the number of C-Section deliveries during the five-month lockdown period as compared to corresponding months of the previous year. This also showed a sharp decline in C-Section deliveries particularly in the month of Shrawan of the previous year (Figure 3.8). An overall decline in number of C-Section deliveries was observed across all provinces except for Gandaki Province where the proportion soared steeply by an average of 108 percent. The highest decline in utilization of C-Section services was observed in Province 2 with an average decline of 55 percent during the lockdown period (Annex 3.11)

There was on average a 33 percent decline in the number of C-Sections two months after the lockdown in comparison to the same period in the previous year. The increase in the number of C-Sections was observed in Gandaki and Karnali Province in the months of Bhadra and Ashwin. The number hiked sharply in Gandaki Province with 259 percent increase. The highest decline in utilization of C-Sections during the two months was observed in Province 2 which corroborated with the trend during the lockdown period (Annex 3.11)³.

Figure 3.8 Trend analysis on utilization of C-Section services



3.3.3 Blood supply for obstetric patients during the lockdown period

During the lockdown period, nearly a third of service providers (31%) reported that their hospitals experienced a shortage of blood supplies at their obstetric units for conducting C-Section procedures. Province-wise, blood supplies did not pose a problem for Province 2 and Sudurpaschim Province. On the other hand, 4 out of 7 hospitals of Bagmati Province and 3 out of 5 hospitals of Gandaki Province reported shortages of blood for their obstetric units during the five-month lockdown period (Table 3.15).

³ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Table 3.15 Province-wise number of hospitals facing blood shortages for obstetric patients

	Number hospitals providing C-Section	Difficulty faced in obtaining blood for obstetric patients during the Lockdown	
		Yes	No
By province			
Province 1	5	1	4
Province 2	3	-	3
Bagmati Province	7	4	3
Gandaki Province	5	3	2
Lumbini Province	5	1	4
Karnali Province	3	1	2
Sudurpaschim Province	4	-	4
Total	32 (100.0%)	10 (31.3%)	22 (68.7%)
By health facility			
COVID hospital	10	2	8
Non-COVID hospital	22	8	14
Total	32 (100.0%)	10 (31.3%)	22 (68.7%)

3.4 Postnatal Care

3.4.1 Functionality of PNC Services

Around three quarters (74%) of the 424 HF provided PNC services to clients without any interruption during the lockdown period. Only around 17 percent of the facilities reported that service was initially interrupted but resumed later during the lockdown period.

Six out of 10 COVID hospitals reported interruption of PNC services during the lockdown period. HF of Province 2 (82%) and Karnali Province (81%) reported no interruption in PNC services, while a relatively smaller proportion of HF in Gandaki Province (60%) reported no interruption in PNC service provision during the five-month lockdown period (Table 3.16). Most PNC services were provided uninterrupted at non-COVID hospitals and PHCCs (81 and 82 percent respectively) during the lockdown period. On the other hand, only three-fifths of COVID hospitals (60%) and UHCs (63%) were able to provide the PNC service uninterrupted. One fifth of UHCs had halted PNC provision even prior to the lockdown (Table 3.17).

In Round 2, PNC services was found halted in five HF even before the COVID-19 lockdown. Around 88 percent of HF provided PNC services without any kind of interruption during the three month period. The service was halted in 8 percent of facilities which was resumed later.

The service in one health facility has not resumed yet. All the HF in Lumbini and Sudurpaschim Province provided the service without interruption during the three month period. The PNC service in one PHCC was halted and has not yet resumed.

Table 3.16 Province-wise functionality of PNC services: Round 1 Assessment

PNC Services	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpasch in Province	Total
Provided service at all times without interruption	68.1	81.7	80.4	60.0	69.1	81.3	79.2	74.1
Halted initially but resumed	27.5	16.7	12.0	10.9	19.1	9.4	4.2	16.5
Halted and not resumed yet	-	1.7	2.2	1.8	4.4	-	-	1.7
Nonfunctional before lockdown	4.3	-	5.4	27.3	7.4	9.4	4.2	7.8
Total (N)	69	60	92	55	68	32	48	424

Table 3.17 Facility wise functionality of PNC services: Round 1 Assessment

PNC Services	COVID hospital	Non-COVID hospital	PHCC	Health Post	UHC	Total
Provided services at all times without interruption	60.0	80.6	81.5	77.6	63.2	74.1
Halted initially but resumed	40.0	19.4	15.4	14.9	17.1	16.5
Halted and not resumed yet	-	-	3.1	2.5	-	1.7
Non-functional before lockdown	-	-	-	5.0	19.7	7.8
Total (N)	10	31	65	201	117	424

3.4.2 Extent of utilization of PNC service during COVID-19 pandemic

Two thirds of service providers reported that the utilization of PNC services during the lockdown period remained unchanged (Figure 3.9). Only about 10 percent of service providers reported an increase in PNC clients during the lockdown period. According to them, their PNC unit experienced gradual increases in PNC clients between the months of Chaitra and Shrawan. The major reasons for these increases cited by the service providers were ‘increase in referral of clients’ and ‘denial of service’ by nearby facilities (Table 3.18).

About a quarter (28%) of service providers reported that there had been a decrease in clients seeking PNC services during the lockdown period. The major reasons cited by the service providers for the decrease in PNC clients were fear of COVID-19 infection among clients and social restrictions to be maintained by all. Likewise, only two percent of the HFs reported halting of PNC services during the lockdown period due to reasons such as fear of infection among clients, social restrictions due to COVID-19 and lack of adequate PPE in the HF.

All HFs reported a slight increase in utilization of PNC services except for Karnali Province. The highest numbers of service providers reporting an increase in utilization of ANC services was in Bagmati Province in the month of Asadh. Few (2%) service providers from Province 1 also reported a halt in PNC services during the lockdown period (Annex 3.12).

Figure 3.9 Utilization of PNC service: Round 1 and Round 2 Assessment

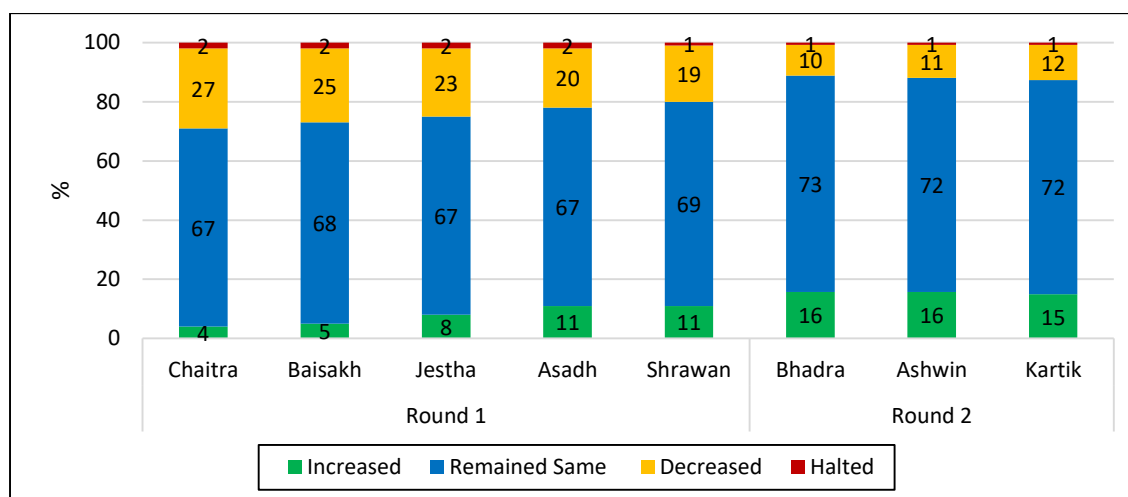


Table 3.18 Reasons for the increase and decrease of PNC services

	COVID Hospital	Non-COVID hospital	PHCC	HP	UHC	Total
Reasons for Increase						
Increase in referral of clients	-	60.0	44.4	23.5	15.4	29.5
Fear of worsening of COVID-19 infection	-			23.5	7.7	11.4
Due to denial of service from nearby health facility	-	20.0	11.1	5.9	30.8	15.9
Increase in delivery clients	-	40.0	22.2	11.8	15.4	18.2
Clients afraid to go to higher facilities	-	20.0		11.8	15.4	11.4
Clients afraid to go to other facilities	-	-		23.5	-	9.1
Total (n)	-	5	9	17	13	44
Reasons for Decrease						
Lack of transportation	60.0	37.5	30.4	31.0	8.3	28.0
Fear of infection among clients	100.0	75.0	69.6	69.0	66.7	70.3
Fear of infection among providers	80.0	12.5	39.1	31.0	20.8	31.4
Social restrictions due to COVID-19	80.0	37.5	34.8	41.4	20.8	37.3
Non availability of service provider	40.0	-	26.1	3.4	8.3	10.2
No client flow	-	12.5		12.1	8.3	8.5
Total (n)	5	8	23	58	24	118

Percentage total may have exceeded 100 due to multiple responses

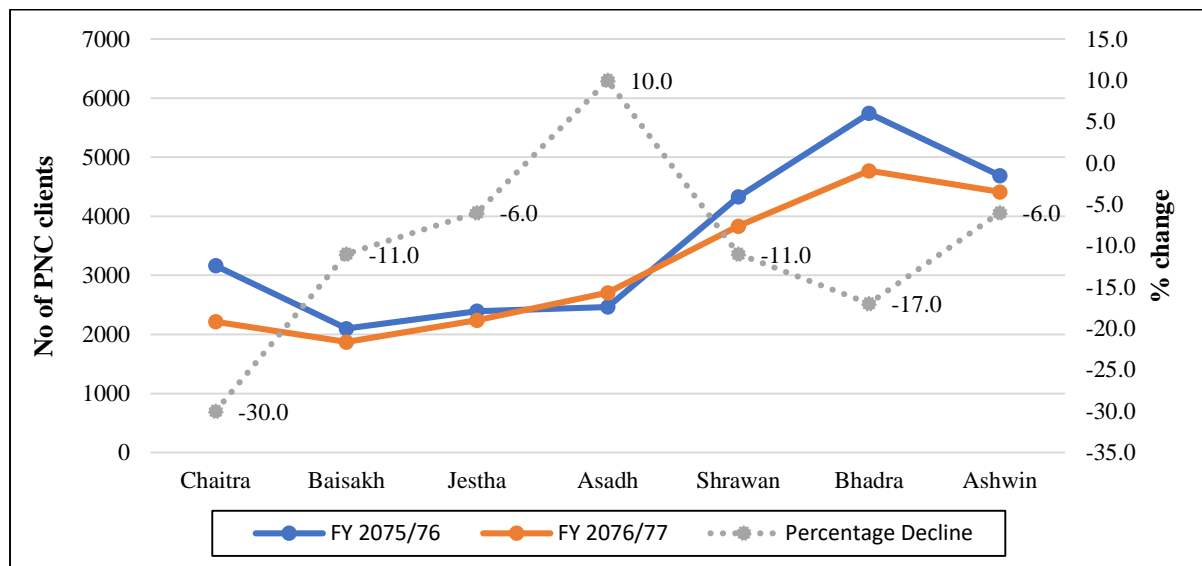
3.4.3 Trend flow of PNC clients

The trend analysis illustrates that except for the month of Asadh, the number of PNC clients was marginally lower during the lockdown as compared to the corresponding months of the previous year. A 30 percent decline in number of PNC clients is observed in the month of Chaitra when compared to other months during the lockdown period, while a 10 percent increase in PNC clients was recorded in

the month of Asadh (Figure 3.10). An average increase of 43 percent in utilization of PNC services can be observed in Bagmati Province. The highest decline in utilization on PNC services occurred in Province 2 with an average decline of 39 percent over the lockdown period as compared to the previous year.

An overall decline of 11 percent on utilization of PNC services was observed during the two month post lockdown period as compared to the corresponding months of the previous year. An increase in utilization of PNC services in Gandaki and Sudurpaschim Province was observed during the same period. There was a sharp decline in utilization of PNC services in Bagmati Province during the period with an average of 44 percent (Annex 3.14)⁴.

Figure 3.10 Trend analysis on utilization of PNC services



⁴ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Chapter 4

Functionality and Utilization of Family Planning Services

Family planning (FP) is one of the priority programs of the Government of Nepal. The Government has committed to ensuring access to a minimum of five family planning methods i.e. Condoms, Pills, Depo, Implant and the Intra-uterine Contraceptive Device (IUCD) through all public HFs in addition to information and education on those FP methods to clients.

This chapter explains provision, functionality and utilization of various FP services being provided by public HFs during the five-month lockdown period, particularly on FP counselling, short acting reversible contraceptive (SARC), long acting reversible contraceptive (LARC), and voluntary surgical contraception (VSC) services.

4.1 Functionality of Family Planning Counseling Services

The service providers from nearly all sampled HFs (98%) reported that they were able to provide FP counseling services during the five-month lockdown period (Round 1 assessment period). Only 10 HFs (2%) reported disruptions in FP counseling during the lockdown period. Except one, all these HF resumed the services after a certain period of time. Province-wise comparison shows all HFs of Karnali and Sudurpaschim Provinces were able to provide FP counseling services without any disruption.

In Round 2, disruption of FP counseling services increased in Province 1 (from 3 % to 17 %) and Bagmati Province (2% to 10%) although the percentages of the HFs experiencing the disruptions in these two provinces are low (Table 4.1).

Table 4.1 Province-wise reporting of disruption of family planning counseling services: Round 1 and Round 2 Assessment

Disruption of FP counselling services	Province 1	Province 2	Bagmati province	Gandaki Province	Lumbini province	Karnali Province	Sudurpaschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1 (n=424)								
Disruption	2.9	1.7	2.2	1.8	4.4	-	-	2.1
No disruption	97.1	98.3	97.8	98.2	95.6	100.0	100.0	97.9
ROUND 2 (n=140)								
Disruption	17.4	5.0	10.0	-	-	-	-	5.7
No disruption	82.6	95.0	90.0	100.0	100.0	100.0	100.0	94.3

4.2 Functionality of SARC Services

All 424 HF's covered in the Round 1 Assessment had provision for SARC services that include male condoms, oral contraceptive pills and Depo Provera (DMPA). However, during the five-month lockdown period, SARC services were halted initially at nearly one third of the HF's but services were resumed later. The percentage of HF's experiencing disruptions in the provision of oral pills were higher (20%) than DMPA (17%) and male condom distribution (7%). Compared to other provinces, a higher percentage of HF's of Lumbini Province (54%) and Province 1 (46%) had SARC service disruptions (Table 4.2). On the contrary, very few HF's of Gandaki Province (6%) reported a SARC service disruption.

There has been a spectacular decline in the percentage of HF's that faced disruption of SARC services in Round 2 from 31 percent in Round 1 to 7 percent. Nearly 93 percent of the HF's provided SARC services without disruption during the 3 month period of Bhadra-Kartik. Across provinces, none of the HF's in Gandaki, Lumbini, Karnali, and Sudurpaschim Province had the disruption while Province 1 (17%) had the highest number of HF's suffering SARC service disruption. Interestingly, in Round 2, none of the HF's of Lumbini, Karnali, and Sudurpaschim Provinces reported any SARC service disruptions (Table 4.2).

Table 4.2 Province-wise reporting of disruption of SARC services: Round 1 and Round 2 Assessment

Disruption of SARC services	Province 1	Province 2	Bagmati province	Gandaki Province	Lumbini province	Karnali Province	Sudurpaschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1 (n=424)								
Disruption	46.4	33.3	30.4	5.5	54.4	14.6	14.6	31.1
No disruption	53.6	66.7	69.6	94.5	45.6	85.4	85.4	68.9
ROUND 2 (n=140)								
Disruption	17.4	10.0	13.3	-	-	-	-	7.1
No disruption	82.6	90.0	86.7	100.0	100.0	100.0	100.0	92.9

As evident from Table 4.3, in terms of category of HF's, more than one third of the HP's, one fourth of general hospitals, PHCC's, and UHC's had a disruption of SARC services respectively in Round 1. Relatively, COVID hospitals (11%) and non-COVID hospitals (20%) continued to experience some disruptions in SARC service delivery, although the proportions have considerably reduced in Round 2 (Table 4.3).

Table 4.3 Facility-wise reporting of disruption of SARC services: Round 1 and Round 2 Assessment

Disruption of SARC services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
ROUND 1 (n=424)						
Disruption	20.0	25.8	29.2	36.3	25.6	31.1
No disruption	80.0	74.2	70.8	63.7	74.4	68.9
ROUND 2 (n=140)						
Disruption	11.1	20.0	9.1	6.1	5.3	7.1
No disruption	88.9	80.0	90.9	93.9	94.7	92.9

Almost all FCHVs (97%) reported that they distributed condoms and oral pills and provided related information on FP to clients even during the five-month lockdown period. Very few FCHVs (3%) who were unable to perform these tasks complained about the lack of stock of condoms and pills, difficulties with mobility, fear of transmission of COVID-19, and lack of face masks and other PPE during the lockdown period. Furthermore, about 18 percent of the total FCHVs faced difficulties while obtaining condoms and pills during the lockdown period.

A total of 179 clients had sought FP services at different HFs at the time of Round 1 data collection. Nearly all (94%) reported that they received the desired FP services. Those who could not receive desired FP services (6%) cited unavailability of the FP method of their choice, unavailability of trained providers and service providers' fear of contracting COVID-19 from the clients as the reasons.

In Round 2, a total of 81 clients had received FP services. Of them, 95 percent received FP services as desired which is similar to that of Round 1. All of them mentioned that they did not visit at an appropriate time for receiving their desired FP method (for e.g. For DMPA & Implant, visit should be during menstruation) and hence service providers instead offered them SARC methods. None of them cited the unavailability of trained providers or unavailability of FP methods as in Round 1.

4.3 Functionality of LARC Services

Only 246 health facilities (58%) offered LARC services (implant and IUCD insertion and removal). These include all COVID/non-COVID hospitals and PHCCs, and 59 percent of HPs and 20 percent of UHCs. However, LARC services were non-functional in 25 facilities (10%) much before the COVID-19 pandemic period.

During the five-month lockdown period (Round 1 Assessment), LARC services were disrupted at 19 percent of HFs. Among those reporting LARC disruptions, 16 percent experienced the disruption during the initial period only. Very few (4%) had not resumed the LARC services throughout the five-month lockdown period.

Across the provinces, LARC services were disrupted mostly in Province 1 (39%) and Lumbini Province (31%) during the five-month lockdown period. The smallest service disruption was reported from Gandaki Province (12%), Karnali Province (11%) and in Province 2 (10%) (Table 4.4). In terms of HF category, COVID hospitals experienced LARC disruption (40%) the most, while HPs experienced the least disruptions of this service (18%) (Table 4.5).

In Round 2, the percentage of HFs that experienced LARC service disruptions slightly decreased from 19 percent to 15 percent. All provinces had experienced a reduction in LARC service disruption except

in Province 2 (increased from 10.3 to 18.2%) and Bagmati Province (17.2% to 21.1%) that had a slight increase in the number of HF's with LARC service disruptions (Table 4.4).

Facility-wise, there has been a drastic decrease in the percentage of COVID hospitals (from 40% to 11%) and UHCs (22% to 0%) reporting LARC service disruptions in Round 2 as compared to Round 1 (Table 4.5). No conspicuous difference is observed in Round 2 across other HF's.

Table 4.4 Province-wise reporting of disruption of LARC services: Round 1 and Round 2 Assessment

Disruption of LARC services	Province 1	Province 2	Bagmati province	Gandaki Province	Lumbini Province	Karnali Province	Sudurpaschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1 (n=247)								
Disruption	39.1	10.3	17.2	12.0	30.8	10.5	-	19.4
No disruption/ Provided all times without interruption	50.0	72.4	67.2	84.0	66.7	73.7	96.8	70.4
Service not functional even before lockdown	10.9	17.2	15.5	4.0	2.6	15.8	3.2	10.1
Total LARC accredited facilities (n)	46	29	58	25	39	19	31	247
ROUND 2 (n=85)								
Disruption	30.8	18.2	21.1	-	20.0	-	-	15.3
No disruption/ Provided all times without interruption	61.5	54.5	47.4	71.4	73.3	85.7	92.3	67.1
Service not functional even before lockdown	7.7	27.3	31.6	28.6	6.7	14.3	7.7	17.6
Total LARC accredited facilities (n)	13	11	19	7	15	7	13	85

Table 4.5 Facility-wise reporting of disruption of LARC services: Round 1 and Round 2 Assessment

Disruption of LARC services	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
ROUND 1 (n=247)						
Disruption	40.0	19.4	18.5	17.8	21.7	19.4
No disruption/ Provided all times without interruption	50.0	80.6	76.9	68.6	56.5	70.4
Service not functional even before lockdown	10.0	-	4.6	13.6	21.7	10.1
Total LARC accredited facilities (n)	10	31	65	118	23	247
ROUND 2 (n=85)						
Disruption	11.1	20.0	18.2	17.9	-	15.3
No disruption/ Provided all times without interruption	88.9	60.0	77.3	61.5	50.0	67.1
Service not functional even before lockdown	-	20.0	4.5	20.5	50.0	17.6
Total LARC accredited facilities (n)	9	5	22	39	10	85

4.4 Functionality and Utilization of VSC Services

Only 39 HF's out of 424 (9%) had provision of VSC services in the Round 1 assessment. Of these 39 HF's, the services were not functioning in 12 facilities (31%) even before the COVID-19 pandemic period.

More than half of the 27 HF's which were functional were providing VSC services without any interruption in Round 1. Only three HF's had reported disruptions of VSC services (COVID hospitals) that resumed the services later.

Unlike in Round 1, VSC services were functional in Round 2. All the HF's provided VSC services during the month of Bhadra, Ashwin and Kartik without disruptions.

4.5 Reasons for Disruption of Family Planning Services

Out of the 151 HF's where FP services were disrupted in Round 1, being out of stock of commodities/equipment/supplies (52%) was the major reason for the disruption. Likewise, fear of transmission of COVID-19 among service providers (30%) and unavailability of trained providers (9%) were other key factors for disruption of FP services (Table 4.6).

Few HF's (8%) particularly PHCC, HP and UHC experienced disruptions in FP services particularly LARC services, since the service providers abstained from providing any FP services that involved

physical contact or ‘touching’ the clients. For this reason, some service providers persuaded their clients seeking LARC methods to use SARCs method.

Among 16 HFs that had faced FP disruption in Round 2, most of them cited fear of COVID transmission as the major reason for the disruption. Commodities/equipment/supplies being out of stock still remained one of the important reasons for the disruption though this percentage has reduced substantially in Round 2 as compared to Round 1 (Table 4.6a).

Table 4.6 Reasons for disruption of family planning services: Round 2 Assessment

Reasons for disruption of any family planning services (n=151)	COVI D hospita l	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Commodities/equipment/supplies are out of stock	-	20.0	36.4	65.5	44.1	51.9
Fear of Transmission of COVID-19 among providers	50.0	10.0	31.8	33.3	23.5	29.9
Social restrictions due to COVID-19	25.0	10.0	13.6	9.5	17.6	12.3
Lack of PPE	25.0	-	18.2	13.1		10.4
Unavailability of trained staff	25.0	20.0	9.1	6.0	11.8	9.1
Only providing non-touchable FP services due to fear	-	-	18.2	3.6	14.7	7.8
HFs sealed	25.0	30.0	-	1.2	2.9	3.9
Municipality/Provincial/central level directed to stop services	-	-	4.5	1.2	2.9	1.9

Percentage total may have exceeded 100 due to multiple responses

Table 4.6a Reasons for disruption of family planning services: Round 2 Assessment

Reasons for disruption of any family planning services (n=16)	COVI D hospita l	Non-COVID hospital	PHC C	HP	UH C	Tota l
	%	%	%	%	%	%
Fear of Transmission of COVID among providers	-	-	25.0	25.0	50.0	25.0
Commodities/equipment/necessary supplies are out of stock	-	-	-	25.0	50.0	18.8
HFs sealed	-	-	25.0	25.0	-	18.8
Unavailability of trained staff	100.0	-	-	12.5	-	12.5
HWs infected by COVID19	-	100.0	-	12.5	-	12.5
HFs operating as isolation center	-	-	25.0	-	-	6.3
Lack of PPE	-	-	25.0	-	-	6.3

Percentage total may have exceeded 100 due to multiple responses

4.6 Reasons for Stock out of family planning commodities during the COVID-19 Pandemic

During the five-month lockdown period, a total of 78 HFs had experienced stock out of FP contraceptive commodities. The reasons for FP commodities stock out were solicited from the service providers. About a third of the service providers reported that the municipality/district itself had shortages of oral

pills during the lockdown (36%), while almost the same proportion of service providers cited non-supply of FP commodities to their HFs from their municipality offices (35%). About a sixth of service providers reported that they were unable to fetch the commodities due to the lockdown (17%) (Table 4.7). In Round 2, only 3 HFs mentioned the stock out of SARC devices, particularly pills and DMPA. They cited non-supply of devices from municipality as the major reason (Table not shown).

Table 4.7 Reasons for stock out of family planning commodities at health facilities: Round 1 Assessment

Reasons for stock out of FP commodities (n=78)	%
Shortage of pills at municipality/district office	35.9
Devices not supplied from Municipality	34.6
Couldn't bring/refill due to lockdown/transport	16.7
Devices not supplied on time	9.0
Delay in purchase by Municipality because of lockdown	3.8
Others	11.5

Percentage total may have exceeded 100 due to multiple responses

4.7 Flow of New Family Planning Clients during the COVID-19 Pandemic

Less than a fifth of service providers (19%) had reported an increase in the flow of new FP clients at their HFs during the initial lockdown period (mid-March-mid-April). This proportion began to surge progressively from the second month onwards. As evident from Figure 4.1, the percentage of service providers reporting an increase in new FP clients doubled during the fifth month (38%) of the lockdown period when compared to the initial/first months percentage figure. Compared to other provinces, the flow of new FP clients in Karnali Province and Sudurpashchim Province was high in the last three months i.e. Jestha, Asadh and Shrawan. However, more HFs in Lumbini Province, compared to others, had an increase in the flow of clients in the first two months of the lockdown period (Annex 4.1). Likewise, across HFs, providers from the majority of COVID hospitals and non-COVID hospitals reported decreases in the flow of new FP clients across all the months of the lockdown period (Annex 4.2).

Service providers from all levels of HFs believed that the increase in new FP clients was triggered by the foreign migrant returnees (77%) during the lockdown (Table 4.8). In addition, they associated the increase in FP contraceptives off-take to an increase in sexual activity (41%) and people returning to their villages or homes to unite with their families during lockdown (16%).

Similarly, the percentage of providers reporting a decline in new FP clients in Round 1 gradually decreased as the lockdown eased since the month of Jestha (15%) and beyond (Figure 4.1). Those citing a decline in FP clients identified factors such as fear of transmission of COVID-19 among clients (80%), social restrictions (59%) and lack of transportation (29%) (Table 4.9). Particularly at the COVID hospitals, the reason for decrease was fear of transmission of infection among clients.

In Round 2, the percentage of HFs reporting of increase in flow of new FP clients has slightly increased in the last three months (Bhadra, Ashwin, Kartik) compared to the initial five-months (Round 1). However, the percentages across the three months are relatively similar. This might be due to the increase in facilities providing FP services without disruption in the three month period and also the ease of the lockdown (Table 4.1).

Figure 4.1 Flow of new family planning clients: Round 1 and Round 2 Assessment

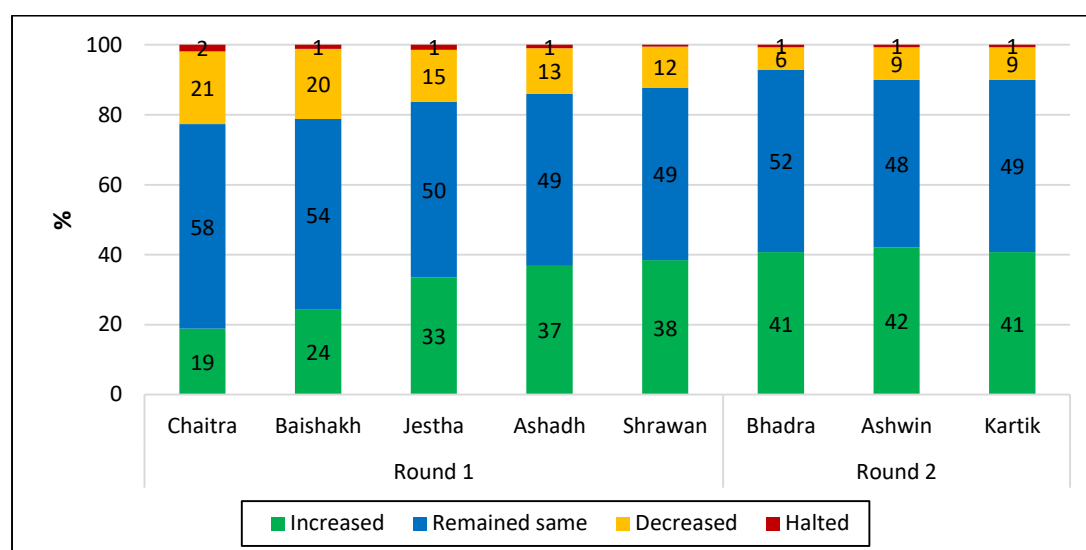


Table 4.8 Reasons for increase in new family planning clients: Round 1 Assessment

Reasons for Increase (n=183)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Return of the foreign migrants	100.0	63.6	76.0	79.3	73.6	76.5
Fear of worsening of COVID-19 infection	50.0	-	8.0	5.4	5.7	6.0
Increase in sexual activity	-	36.4	40.0	42.4	41.5	41.0
People returning back to their village/home place/home district	-	27.3	16.0	21.7	5.7	16.4
Other HFs stopped providing services	-	-	8.0	1.1	11.3	4.9

Table 4.9 Reasons for decrease in new family planning clients: Round 1 assessment

Reasons for Decrease (n=106)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Fear of transmission of COVID-19 among clients	100.0	75.0	92.3	77.6	76.2	80.2
Social restrictions due to COVID-19	71.4	43.8	46.2	65.3	57.1	58.5
Lack of transportation	42.9	43.8	53.8	22.4	14.3	29.2
Lack of PPE	-	6.3	15.4	8.2	-	6.6
Stock out of FP commodities	-	-	7.7	10.2	-	5.7

The flow of follow-up clients remained unchanged for the majority of HFs (more than 75%) during the five-month of the lockdown period (Figure 4.2). Very few service providers perceived the increase in follow-up clients at their facility during the lockdown (Annex 4.3). However, service providers from nearly half of the COVID hospitals perceived that flow of FP follow-up clients decreased across all months of the five-month lockdown period (Annex 4.4).

The main reason for an increase in FP follow-up clients during the lockdown period as cited by over half of the service providers was clients' fear of COVID-19 infection worsening in the coming days (54%) (Table 4.9). The reasons cited by providers for the increase in follow-up clients was similar across all HFs, such as arrival of foreign labor migrants and people returning back to their villages or homes.

Figure 4.2 Provider's perception on flow of family planning follow-up clients: Round 1 Assessment

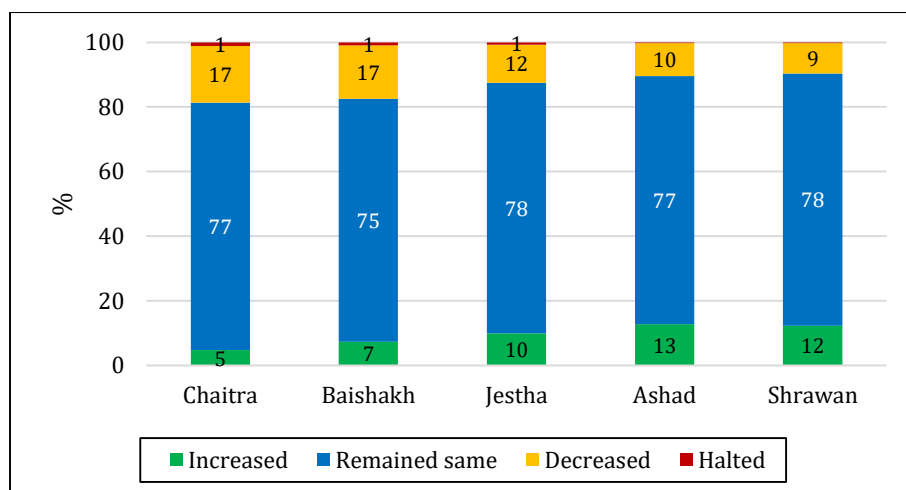


Table 4.10 Reasons for increase in family planning follow-up clients: Round 1 Assessment

Reasons for Increase (n=183)	COVID hospital	Non-COVID hospital	PHC C	HP	UHC	Total
	%	%	%	%	%	%
Fear of worsening of COVID 19 infection	100.0	50.0	33.3	59.5	46.7	54.1
Arrival of foreign labor migrants	100.0	-	16.7	27.0	20.0	24.6
People returning back to their village/home place/home district	-	50.0	16.7	18.9	6.7	16.4
Clients of other HFs also visited because of lockdown/no transportation	-	-	-	10.8	13.3	9.8
Other HFs stopped providing services	-	-	33.3	2.7	13.3	8.2

Table 4.11 Reasons for decrease in family planning follow-up clients: Round 1 Assessment

Reasons for Decrease (n=106)	COVID hospital	Non-COVID hospital	PHCC	HP	UHC	Total
	%	%	%	%	%	%
Fear of transmission of COVID-19 among clients	100.0	64.3	86.7	69.7	63.0	71.3
Social restrictions due to COVID-19	60.0	64.3	40.0	54.5	40.7	50.0
Lack of transportation	40.0	57.1	46.7	30.3	18.5	34.0
Lack of PPE	-	7.1	13.3	12.1	-	6.4
Stock out of FP commodities	-	-	-	15.2	3.7	6.4
People went back to their village/home place/home district	-	-	6.7	3.0	7.4	5.3

Default clients are expected to be high during emergencies. Contacting and follow up with default FP clients remains an important challenge for all outreach HF's offering FP services. We asked the providers from all 424 HF's about the means of contacting their default clients during the lockdown period. The majority of service providers (63%) reported that they had persuaded FCHVs to contact/motivate such clients through home visits. Similarly, 42 percent of HF's mentioned that they contacted their default clients through phones. Few service providers reported that they provided a note/card with follow-up dates written on it as reminders or informed them about the scheduled date for follow-up visits during counseling sessions (Table 4.11).

The means of contacting default clients in the last three month period (Round 2) was similar to the initial five-month lockdown period (Round 1) i.e. asking FCHVs to contact the defaulter, contacting defaulters via the telephone, providing a written note/card to the clients and informing them about the visit date during counseling sessions (Table 4.12).

Table 4.12 Ways of contacting default family planning clients: Round 1 and Round 2 Assessment

Ways of contacting default clients (n=424)	Round 1 (n=424)	Round 2 (n=140)
	%	%
Ask FCHV to contact the defaulter	63.0	53.6
Contact defaulters through telephone	42.0	32.1
A written note/card with follow-up date is given	2.4	7.1
Inform about the visit date during counseling	1.2	0.7

The types of suggestions service providers gave to those clients (default) who could not benefit from FP services from their facilities during the lockdown period was also solicited in the present study. The majority of them cited that they referred their clients to another Government facility (57%) or at NGO/Private FP clinics (29%) (Table 4.12). Few of them advised to use alternative methods (11%) while about 9 percent of them advised clients to use pills/condoms instead of the IUCD/Implant/DMPA.

Table 4.13 Alternatives offered to clients who were unable to receive the family planning method of their choice: Round 1 Assessment

Alternatives offered to clients who were unable to receive the FP of their choice (n=205)	%
Referred to another government facility	57.1
Referred to NGO/Private FP clinics	29.3
Advised to use alternative methods	11.2
IUCD/Implant/DMPA clients suggested to use pills/condoms for some duration	8.8

4.8 Trend in Flow of Family Planning Clients

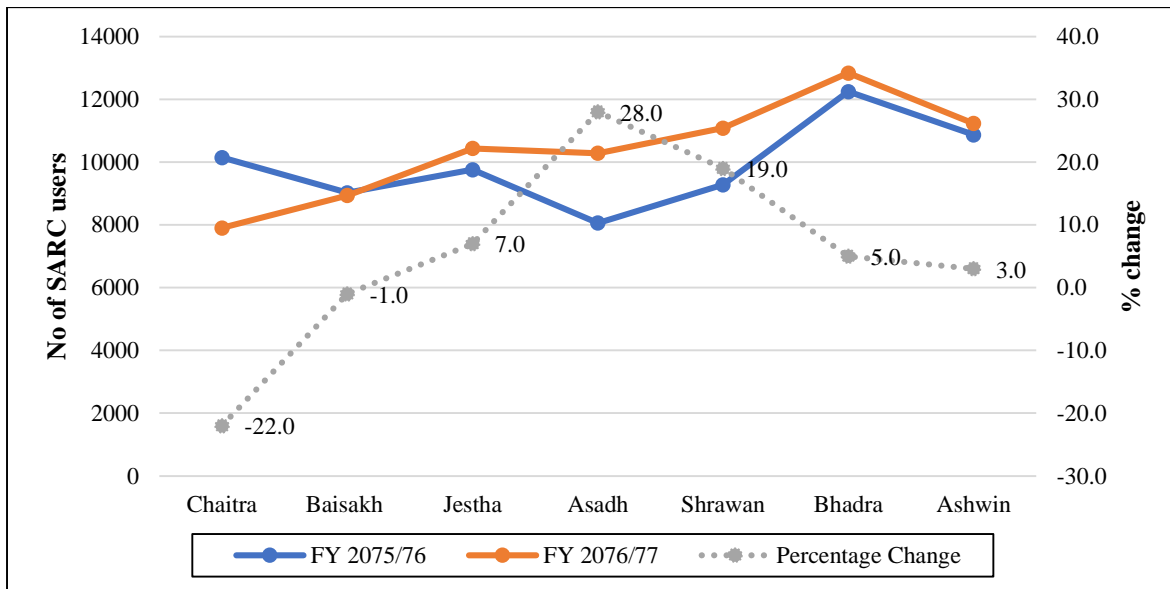
New SARC users initially declined in the first month of lockdown i.e. Chaitra and later surpassed the previous years' figures from the month of Jestha (Figure 4.3). There was a decline in SARC users in the month of Chaitra across all the provinces except Gandaki Province. The number of SARC users increased in the whole period of lockdown in Gandaki Province compared to the corresponding months of the previous year. A decline in the number of SARC users in either of the months (Bhadra or Ashwin) was observed across all provinces except Karnali and Sudurpachim Province. In contrast to the increase in SARC users in the lockdown period in Gandaki Province, a decrease in the months of Bhadra and Ashwin was observed (Annex 4.5).⁵

In terms of LARCs, the flow of new clients seeking LARC services during the five-month lockdown period in comparison to the corresponding months of the previous year was lower in all months and equal in the month of Shrawan. However, the trend line shows an unusual spike in the flow of clients during the month of Bhadra (424 %) (Figure 4.4). In the month of Ashwin however, the flow of new clients seeking LARC services was close to the figures of the corresponding period of the previous year. This overall spike in the month of Bhadra is attributed to the extreme increase in reports of new LARC users in Bagmati Province in the same month (2068 %) (Annex 4.6). Bagmati Province shows the most unusual trend in flows of new LARC clients as compared to the rest of the provinces. In Province 2, the flow of clients is low in all months except for Ashwin as compared to the previous year (Annex 4.6).⁶

⁵ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

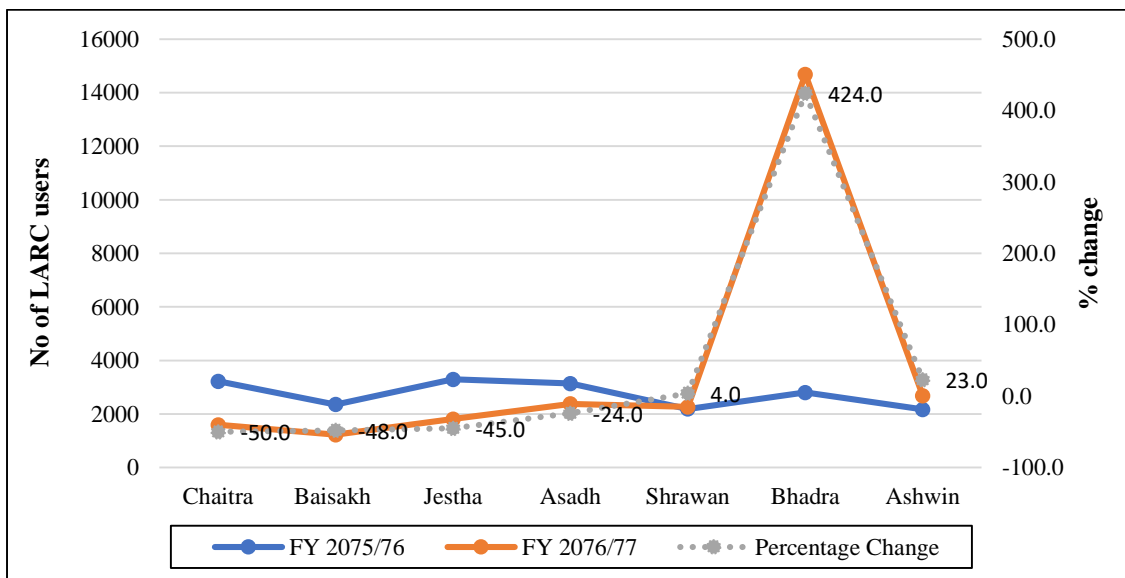
⁶ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months.

Figure 4.3 Trends analysis on utilization of SARC services (Depo & Pills)



Source: HMIS database

Figure 4.4 Trend analysis on utilization of LARC services (IUCD & Implant)



Source: HMIS database

Chapter 5

Functionality and Utilization of Safe Abortion Services

Nepal amended its Country Code (*Muluki Ain*) in 2002 to allow abortion on certain grounds and ensure Nepalese women's right to decide their own fertility choices. The *Safe Motherhood and Reproductive Health Rights Act, 2018* that has replaced the *Muluki Ain* further guaranteed women's rights to legal and safe abortion care on wider grounds. Surgical abortion using manual vacuum aspiration (MVA) has been legally available in Nepal since abortion service was first introduced in the country in March of 2004 for termination of pregnancies up to 12 weeks of gestational age. Medical abortion (MA) using a combined regimen of mifepristone (200 mg x 1 tab) and misoprostol (200 mg x 4 tabs) was introduced in 2009 and scaled up throughout the country. The *Safe Abortion Programme Implementation Guideline, 2073* allows MA service provision by auxiliary nurse-midwives (ANMs) trained in skill birth attendance (SBA) to expand Safe Abortion Services (SAS) through outreach public facilities (PHCC and HPs), NGO and private clinics. Since 2017 the Government has made SAS free in all Government HFs.

This chapter presents the functionality and utilization of public SAS during the lockdown period, barriers to SAS provision and compares the trends in MVA and MA client flow during the five-month lockdown period vis-à-vis corresponding months one year ago.

5.1 Accreditation Status of Safe Abortion Services

None of the 117 sampled UHC were accredited for SAS. Of the remaining HFs (307), only 139 public HFs (45%) were accredited (Table 5.1). In terms of category of HFs, nearly all hospitals (40 out of 41 sampled hospitals including COVID hospitals) are accredited. Of the total 65 sampled PHCCs, 56 (86%) are accredited. On the contrary for MA service provision, only 43 HPs (21%) out of the total 201 HPs in the sample are accredited.

Province-wise distribution of accredited SAS centers showed the proportion of SAS accredited HFs are relatively low in Gandaki and Bagmati (24% each) and also in Province 2 (28%). In the remaining four provinces, between 30 to 50 percent of the HFs are accredited for providing SAS (Table 5.1).

Table 5.1 Facility-wise safe abortion service accreditation status and province-wise distribution

Types of facility	Accredited n (%)	Not accredited n (%)	Total n (%)
Hospital	40 (97.6)	1 (2.4)	41 (100)
PHCC	56 (86.2)	9 (13.8)	65 (100)
HP	43 (21.4)	158 (78.6)	201 (100)
UHC	-	117 (100)	117 (100)
Provinces			
Province 1	29 (42.0)	40 (58.0)	69 (100)
Province 2	17 (28.3)	43 (71.7)	60 (100)
Bagmati Province	22 (23.9)	70 (76.1)	92 (100)
Gandaki Province	13 (23.6)	42 (76.4)	55 (100)
Lumbini Province	21 (30.9)	47 (69.1)	68 (100)
Karnali Province	16 (50.0)	16 (50)	32 (100)
Sudurpaschim Province	21 (43.8)	27 (56.3)	48 (100)
Total	139 (32.8)	285 (67.2)	424 (100)

5.2 Functionality of Safe Abortion Services

More than half (75) of the 139 SAS centers provided safe abortion care during the five-month lockdown period. The service was halted initially at 10% (14) of the SAS centers and resumed later on. However, one third of the accredited HFs (47) had discontinued SAS provision even before the lockdown and 3 SAS facilities that had halted the service during the lockdown had not yet resumed the service. Second trimester abortion (13 – 28 weeks) was confined only to hospital settings. Almost all accredited hospitals provided second trimester abortion without interruption during the five-month lockdown period.

SAS provision continued to remain non-functional at nearly three fourths of the 46 accredited SAS centers revisited in Round 2. About 21 percent of the accredited facilities were providing SAS without any interruption during the three month period. Similar to Round 1, all six accredited hospitals covered in Round 2 provided second trimester abortion.

All SAS (MA, MVA and Second Trimester) should be provided free of cost at all public facilities. However, two health facilities (one COVID hospital and one HP) covered in Round 1 have been charging fees to clients. Replenishments of medicines and equipment were the responses given by the service providers when asked for the reason for charging abortion fees. One provider has been charging an abortion fee to women as punishment for the act (abortion).

5.3 Availability of trained providers for MA and MVA

Trained service providers for MA were not available at 24 percent of the SAS centers while trained providers for MVA were unavailable at 36 percent of the MVA accredited SAS centers. Province-wise comparison shows all 13 MA accredited SAS centers of Gandaki Province (100%) had trained service providers in place (Table 5.2). Similarly, all 6 MVA accredited SAS centers of Sudurpaschim Province (100%) had trained providers in place (Table 5.3). On the contrary, one third of the MA centers in Lumbini Province and two-thirds of the MVA accredited SAS centers of Province 1 did not have a trained provider at the time of the present assessment (Table 5.2 & 5.3).

All sampled HFsin Round 2 had trained providers in place for MA services (Table 5.2). Likewise, for MVA services, there has been a slight increase in HFs (76% in Round 2 from 64% in Round 1) that have service providers available during the last three months (Bhadra-Aswin) as compared to Round 1 status (Table 5.3).

Table 5.2 Percentage of trained providers available for MA services by province: Round 1 and Round 2 Assessment

Presence of a trained providers	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudur paschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1								
Yes (%)	79.3	70.6	72.7	100.0	66.7	81.3	71.4	76.3
No (%)	20.7	29.4	27.3	-	33.3	18.8	28.6	23.7
Total (n)	29	17	22	13	21	16	21	139
ROUND 2								
Yes (%)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
No (%)	-	-	-	-	-	-	-	-
Total (n)	4	5	4	4	6	5	6	34

Table 5.3 Percentage of trained providers available for MVA services by province: Round 1 and Round 2 Assessment

Presence of a trained providers	Province 1	Province 2	Bagmati Province	Gandaki Province	Lumbini Province	Karnali Province	Sudur paschim Province	Total
	%	%	%	%	%	%	%	%
ROUND 1								
Yes (%)	35.3	55.6	66.7	80.0	72.7	71.4	100.0	64.0
No (%)	64.7	44.4	33.3	20.0	27.3	28.6	-	36.0
Total (n)	17	9	15	10	11	7	6	75
ROUND 2								
Yes	66.7	20.0	100.0	75.0	100.0	100.0	100.0	76.0
No	33.3	80.0	-	25.0	-	-	-	24.0
Total (n)	3	5	4	4	4	1	4	25

Facility-wise assessment showed all 10 COVID hospitals had trained MVA as well as MA providers in place (Table 5.4 & 5.5). On the other hand, 3 non-COVID hospitals (10%) did not have trained MVA providers and only one hospital did not have a trained MA provider. Over a quarter of the PHCC (29%) did not have trained MA providers and two thirds (67%) did not have a trained MVA provider in place.

Likewise, 16 out of 43 HPs (37%) accredited for MA did not have a trained MA provider in place at the time of the present assessment (Table 5.4 & 5.5).

Table 5.4 Facility-wise presence of a trained MA service providers: Round 1 and Round 2 Assessment

Presence of a trained providers	COVID hospital	Non-COVID hospital	PHCC	HP	Total
	%	%	%	%	%
ROUND 1					
Yes	100.0	96.7	71.4	62.8	76.3
No		3.3	28.6	37.2	23.7
Total (n)	10	30	56	43	139
ROUND 2					
Yes	100.0	100.0	100.0	100.0	100.0
No	-	-	-	-	-
Total (n)	9	5	13	7	34

Table 5.5 Facility-wise presence of a trained MVA service provider: Round 1 and Round 2 Assessment

Presence of a trained providers	COVID hospital	Non-COVID hospital	PHCC	HP	Total
	%	%	%	%	%
ROUND 1					
Yes	100.0	100.0	100.0	NA	64.0
No	-	-	-	NA	36.0
Total (n)	10	29	36		75
ROUND 2					
Yes	100.0	80.0	54.5	-	76.0
No	-	20.0	45.5	-	24.0
Total (n)	9	5	11	-	25

5.4 Utilization of safe abortion services during the COVID-19 Pandemic

Service providers of most of the SAS centers of Karnali Province perceived that MVA clients had increased in their facilities (60%), while none of the HFs had experienced an increase in MVA client flow in Sudurpaschim Province. Decline in MVA clients was reported to be relatively high (33%) in SAS centers of Lumbini Province. In Province 2, MVA services were halted in 50 percent of HFs, while none of the MVA services of Gandaki Province were halted during the five-month lockdown period.

The percentage of service providers who perceived that flow of MA clients has increased at their SAS centers has increased by 4 percentage points in Round 2. However, the percentage (47%) of service providers perceiving that the clients have remained same throughout the lockdown period have remained the same in the current round.

Service providers who cited increases in the flow of MVA clients have drastically decreased from 26 percent to 4 percent. However, only few providers from Lumbini Province perceived of increase in flow of MVA clients during the three month period (Round 2).

The majority of service providers (40) linked the increase in SAS clients during the lockdown period to none-use of contraceptives especially among foreign labor migrant returnees (75%) and also to the discontinuation of FP use among couples (70%). Few service providers also mentioned that the surge in SAS clients was due to increased referral to their facilities (8%) and also because clients could not go anywhere else due to the lockdown (8%). Of the 13 providers who mentioned a decrease in SAS clients during the lockdown period, most of them cited ‘fear of COVID-19’ (69%), ‘social restrictions due to COVID-19’ (53%) and ‘unavailability of transport’ (46%) as major reasons. However, few of them also linked a decrease in SAS clients to the stock-out of MA drugs at their SAS centers (Table 5.6).

Table 5.6 Reasons for increase/decrease in clients seeking safe abortion services during Round 1 assessment: Service providers’ perspectives

Reasons for increase in SAS clients* (n=40)	%
Non-use of FP among foreign labor migrants returnees	75.0
Discontinuation of FP use	70.0
Could not go anywhere	7.5
Refer from another health facilities	7.5
FP methods not access in peripheral level /lack of access	5.0
Reasons for decrease in SAS clients* (n=13)	%
Fear of COVID-19	69.2
Social restrictions due to COVID-19	53.8
Unavailability of transports	46.2
Lack of regular supply of MA/ stock-out of MA drugs	7.7

Two-fifths of the SAS providers reported about challenges they faced while providing safe abortion care to clients during the pandemic. Of the challenges mentioned, 41 percent of them reported their own fear of contracting COVID-19 while serving the clients. In addition, the service providers cited women seeking abortion late in their pregnancy (high gestational age) (39%), lack of PPE (22%), unavailability of trained providers (17%), and lack of equipment and drugs (17%) (Table 5.7).

Table 5.7 Challenges faced by service providers for safe abortion service provision during Round 1 Assessment: Service Providers’ Perspectives

Challenges faced by Health facilities* (n=36)	%
Fear of transmission of COVID-19 among providers	41.7
High gestational age	38.9
Lack of PPE	22.2
Unavailability of trained providers	16.7
Delay in re-supplies of equipment and drugs	16.7
Social restrictions due to COVID-19	13.9
Lack of MA drugs	13.9
Self-medication practice	5.6

Percentages total may have exceeded 100 due to multiple responses

5.5 FCHVs' Perspectives on functionality of safe abortion services during COVID-19 pandemic

All 424 FCHVs in Round 1 were asked if clients were able to obtain SAS from nearby SAS centers during the lockdown period. More than half of the FCHVs (57%) responded affirmatively. As many as 67 FCHVs (16%) reported that SAS centers did not provide abortion services during the lockdown. Over a quarter of the FCHVs had no idea (did not know) the SAS status during the lockdown period.

In Round 2, more than half of the FCHVs (60% of 140 FCHVs interviewed) responded that women were provided with SAS from the facility. This is a slight increase in the percentage compared to Round 1. Similarly, only 9% of them perceived that the SAS centers did not provide the services in the three month period.

Close to two fifths (39%) of FCHVs reported that the HFs had halted SAS much before the lockdown. Another one-third of FCHVs mentioned that the SAS centers lacked trained service providers while another similar proportion of FCHVs (33%) cited non-availability of abortion commodities at the facility as the reasons for depriving clients from obtaining SAS during the lockdown period (Table 5.8).

Table 5.8 Provision of safe abortion services during COVID-19 pandemic: FCHVs' perspectives

Were women provided safe abortion services during lockdown?	Round 1 %	Round 2 %
Yes	56.8	60
No	15.8	8.6
Don't know	27.4	31.4
Total N	424 (100%)	140 (100%)
Reasons for not providing SAS during lockdown (N=67)	%	[not asked]
SAS halted much before the lockdown	38.8	
Non-availability of service providers	32.8	
Non-availability of commodities	32.8	
Fear of transmission of COVID among providers	6.0	
Lack of PPE	4.5	
Hospital was sealed	3.0	
Lack of trained service providers	4.5	
Don't know	1.5	
Total N	67	

Percentages total may have exceeded 100 due to multiple responses

5.6 Roles of FCHVs on Safe Abortion Services

Over a quarter of the FCHVs (28%) reported that they were approached by women for abortion related information and advice during the five-month lockdown period. Most of the FCHVs referred their clients to a SAS facility (81%). In addition, over half of the FCHVs provided information about safe abortion and place/HF where one could obtain SAS (54%).

In Round 2, more than one third of the FCHVs (34%) said that they were approached by women for information on SAS during the three month lockdown period which was more than the initial five-month lockdown period. In terms of responses that were given to the clients, most of them referred clients to a facility that has SAS provision (63%) and about half of them provided information about SAS and the centers where SAS is available (Table 5.9)

Table 5.9 Information on safe abortion shared to clients during COVID-19 pandemic: FCHVs' Perspectives

Has anyone approached you for information on SAS during lockdown	Round 1 %	Round 2 %
Yes	28.8	34.3
No	71.2	65.7
Total N	424 (100%)	140 (100%)
Responses given to clients who approached FCHVs for information on SAS	%	%
Provided information about the safe abortion services and centers	54.1	50.0
Referred to related facility	81.1	62.5
Referred to related health professional	0.8	-
FCHV took her to the hospital/SAS centers	2.5	4.2
Suggest to follow the husbands decision	0.8	-
Not suggested to abort in this COVID crisis	-	2.1
FCHV gave medicine to clients for abortion	-	2.1
Total N	122	48

Percentages total may have exceeded 100 due to multiple responses

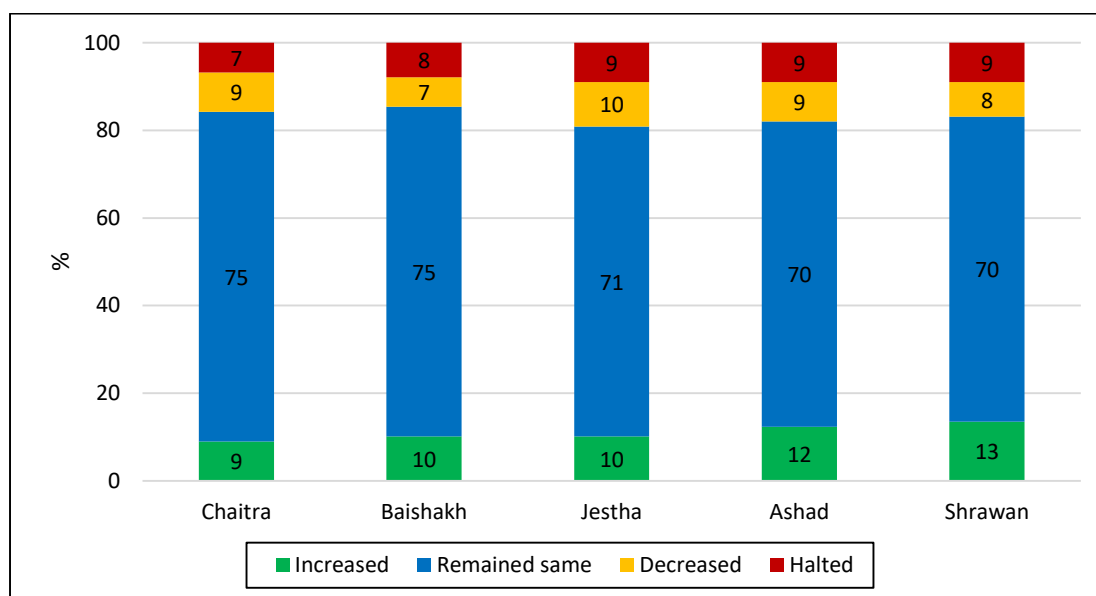
The present assessment also asked clients about types of SAS that they received from the HF. Among 13 the clients who visited SAS, the majority of them (69%) sought medical abortion services while 15 percent of them obtained information on SAS. Few of them obtained services in the case of miscarriage complications (8%) and post abortion care advice (8%). Eighty percent of the FCHVs believed that SAS is provided free of cost at all public health (SAS) facilities.

5.7 Utilization of Post-Abortion Care services: Round 1 Assessment

The large majority of health care providers (70%) perceived that there was no change in flow of Post-Abortion Care (PAC) clients at HFs across all five months of the lockdown period. (Figure 5.1) However, few of them mentioned that there has been an increase in PAC clients which was nearly consistent across all five months.

This slight increase in PAC clients were due to the proximity of the HF (71%), due to abortion performed without consultation of a trained service provider (50%) and increase in referral from nearby health institutions (7%). Reasons for the slight decrease in PAC clients cited by providers were lack of transportation (73%), fear of infection among clients (64%) and non-availability of trained providers (55%).

Figure 5.1 Providers perspective on flow of PAC clients: Round 1 Assessment



5.8 Trend in Flow of Clients Seeking SAS

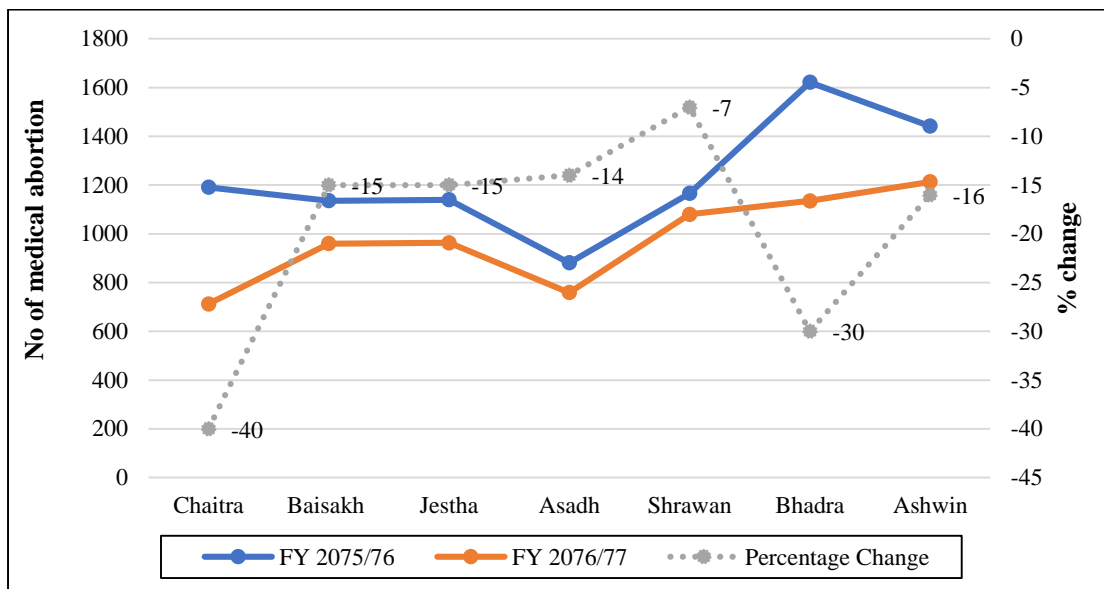
The number of women who received MA declined during the five-month lockdown period when compared to the corresponding months of the previous year (FY 2075/76). (Figure 5.2).

A sharp decline in the number of MA clients was observed during the month of Chaitra, thereafter, the trend followed the previous year’s pattern but maintaining the gaps constantly over next four months which again significantly decreased in the month of Bhadra. In Province 2, there was a sharp decrease in the number of MA clients in the month of Chaitra which then followed a fluctuating trend over the passing months. There was no difference in the month of Ashwin. There was a decline in number of MA clients in the month of Chaitra which then increased and reached a maximum level in the month of Asadh and then followed a decreasing trend with a sharp decline in the month of Bhadra in Bagmati Province (Annex 5.7).

A sharp decline in the number of MVA clients was observed in the month of Asadh (76%) followed by Bhadra (65%). There was a stark increase in the number of MVA clients in the month of Baisakh in Province 2. Likewise there was a huge increase in number of MVA clients in the month of Jestha and Shrawan in Lumbini Province which decreased in Bhadra and Ashwin (Annex 5.8).⁷

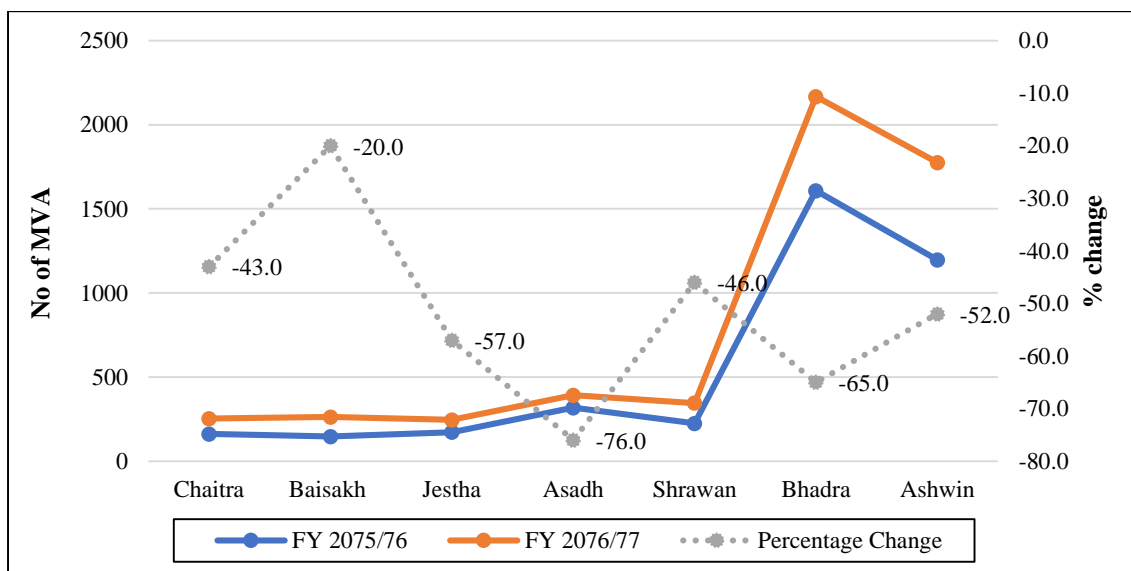
⁷ The data for the months of Shrawan, Bhadra and Ashwin are uncleaned as mentioned by HMIS section. HMIS section is yet to clean the data for these three months

Figure 5.2 Trend analysis on utilization of medical abortion services



Source: HMIS database

Figure 5.3 Trend analysis on utilization of MVA services



Source: HMIS database

Chapter 6

Functionality and Utilization of Child Health and Immunization Services

This chapter discusses the functionality, utilization and provision of childhood immunization, vitamin A supplementation for children and for mothers of newborns, and care for childhood illness during the five-month lockdown period. FCHVs' perspectives on accessibility to immunization services for children are also discussed in this chapter.

6.1 Functionality of Routine Immunization Services

All the 424 HF's covered in Round 1 were accredited for providing routine immunization services. Out of 424 HF's the routine immunization services were not operative (nonfunctional) in 11 facilities. Immunization service at most of the HF's (81%) was halted initially and resumed later during the lockdown period (Table 6.1). In 8 HF's, the service has not resumed after it was halted during the lockdown (Table 6.1).

The immunization services at most of the HF's in all provinces were halted initially and resumed later during lockdown period. Routine immunization services in few HF's in Province 1 (3), Bagmati Province (4), Lumbini Province (1) was halted during the lockdown which has not yet been resumed (Table 6.2).

Table 6.1 Health facility wise functionality of routine immunization service: Round 1 Assessment

	COVID hospital (n=10)	Non-COVID hospital (n=31)	PHCC (n=65)	Health Post (n=201)	UHC (n=117)	Total (n=424)
Provided at all time without interruption	20.0	22.6	9.2	11.4	18.8	14.2
Halted initially but resumed now	70.0	67.7	90.8	86.1	72.6	81.4
Halted and not resumed yet	-	6.5	-	2.5	0.9	1.9
Service not functional before lockdown	10.0	3.2	-	-	7.7	2.6

Table 6.2 Province-wise functionality of routine immunization service: Round 1 Assessment

	Province 1 (n=69)	Province 2 (n=60)	Bagmati Province (n=92)	Gandaki Province (n=55)	Lumbini Province (n=68)	Karnali Province (n=32)	Sudurpaschim Province (n=48)	Total (n=180)
Provided at all time without interruption	8.7	13.3	13.0	10.9	8.8	28.1	27.1	14.2
Halted initially but resumed now	87.0	86.7	77.2	87.3	86.8	71.9	66.7	81.4
Halted and not resumed yet	4.3	-	4.3	-	1.5	-	-	1.9
Service not functional before lockdown	-	-	5.4	1.8	2.9	-	6.3	2.6

Overall, only about 15 percent of the 413 HFIs were able to provide routine immunization without interruption during the Round 1 assessment. This scenario dramatically altered after the lockdown was called off by the Government in July 2020.

As evident from Table 6.3, more than three quarters of the HFIs (76%) covered in Round 2 provided the routine immunization service without interruptions. Province-wise comparison shows that the disruption in routine immunization service was highest in Province 1 and Lumbini Province during first five months of the lockdown period (Round 1) with only 9 percent of HFIs providing the regular service. In contrast, a higher number of HFIs in Sudurpaschim Province (29%) and Karnali Province (28%) provided uninterrupted routine immunization services during the lockdown period.

Province-wise comparison of Round 2 data shows that all HFIs of Karnali (100%) and 95 percent of those in Province 2 were able to offer routine immunization service without interruptions. On the contrary, less than half of the HFIs in Province 1 was able to do so in Round 2 (Table 6.3).

Table 6.3 Province-wise uninterrupted operation of routine immunization service: Round 1 and Round 2 Assessment

Province (N=413)	Round 1 (n=413)	Round 2 (n=140)
Province 1	8.7	47.8
Province 2	13.3	95.0
Bagmati Province	13.8	66.7
Gandaki Province	11.1	88.9
Lumbini Province	9.1	68.2
Karnali Province	28.1	100
Sudurpaschim Province	28.9	87.5
Total	14.5	75.7

In terms of HFs, nearly all PHCCs (91%), and most of the non-COVID hospitals (80%) and COVID hospitals (78%) provided routine immunization services uninterrupted throughout in Round 2 (Table 6.4).

Table 6.4 Health facility wise uninterrupted operation of routine immunization service: Round 1 and Round 2 Assessment

Type of HFs	Round 1 (n=413)	Round 2 (n=140)
COVID hospital	22.2	77.8
Non-COVID hospital	23.3	80.0
PHCC	9.2	90.9
HP	11.4	75.8
UHC	20.4	65.8
Total	14.5	75.7

It may be pointed out that during the early stages of the lockdown (Round 1) nearly half of service providers (49%) reported that they received instructions from their district health office/local government to halt their routine immunization programme during the lockdown. This reason was also cited by around one sixth of the HFs in Round 2. Another two-fifths of service providers cited the strict implementation of the lockdown for halting the immunization services. Other reasons cited for interruption were: fear of COVID-19 transmission (23%), lack of PPE (10%) and lack of vaccine stocks (18%). However, lack of vaccine stocks and PPE did not emerge as barriers for HFs in the Round 2 Assessment (Table 6.5).

Table 6.5 Reasons for disruption in routine immunization services: Round 1 and Round 2 Assessment

Reasons for not providing immunization services (N=364)	Round 1 (n=364)	Round 2 (n=34)
Service halted as per instruction from Health Office/local government	48.6	17.6
Due to strict implementation of lockdown	40.1	-
Fear of transmission of COVID-19 among providers	23.1	5.9
Lack of vaccine stock	18.1	-
Lack of PPE	10.2	-
Social restrictions due to COVID-19	-	32.4
Due to increase in COVID-19 cases	-	29.4
Staffs infected with COVID-19	-	17.6

Of the total 140 facilities re-visited in Round 2, the immunization service in one facility was halted during the period between Bhadra- Kartik which has not been resumed. About a quarter of HFs(24%) had disruption in immunization services during the period between Bhadra-Kartik.

Province wise, no disruption of the immunization service was reported in Karnali Province. The highest disruption was observed in Province 1 where only 48 percent of facilities provided uninterrupted routine immunization services. More than two thirds of all the types of HFs had provided uninterrupted routine immunization services during this period.

The reasons cited for disruption of routine immunization services in Round 2 was social restrictions due to COVID 19 (32%), increase in COVID-19 positive cases (29%), instruction from district health office/local government to halt their routine immunization programme (18%), and staff infected by COVID 19 (18%).

6.2 Extent of Utilization of Child Health Services

6.2.1 Vitamin A supplementation to children

Vitamin A supplementation is a bi-annual programme of the Government and covers all children aged 6 to 59 months. This programme is carried out in the month of Baisakh (Mid-April-Mid-May) and Kartik (Mid-October – Mid-November) every year. Due to COVID-19 pandemic, the Government had re-scheduled the Vitamin A supplementation programme from the month of Baisakh to Asadh (Mid-June-Mid-July). The HFs of nearly all provinces (98%) implemented the programme in Asadh this year. Comparatively, all HFs of Province 1 (100%) and Karnali Province (100%) had conducted the programme at their locations (Table 6.6)

At the HF level, all PHCCs (100%) and HPs (100%) implemented the program in the month of Asadh this year. Two non-COVID hospitals, one COVID hospital and six UHCs were unable to implement this programme (Table 6.7).

Table 6.6 Province-wise distribution of Vitamin A to children in the month of Asadh: Round 1 Assessment

Province (N=424)	%
Province 1 (n=69)	100.0
Province 2 (n=60)	98.3
Bagmati Province (n=92)	97.8
Gandaki Province (n=55)	98.2
Lumbini Province (n=68)	95.6
Karnali Province (n=32)	100.0
Sudurpaschim Province (n=48)	95.8
Total	97.9

Table 6.7 Health facility wise distribution of Vitamin A to children in the month of Asadh: Round 1 Assessment

Type of HFs (n=424)	%
COVID hospital (n=10)	90.0
Non-COVID hospital (n=31)	93.5
PHCC (n=65)	100.0
HP (n=201)	100.0
UHC (n=117)	94.9
Total	97.9

6.2.2 Availability of services for childhood illness

Of the 424 HFs, 63 facilities (15%) reported difficulty in providing services for childhood illness. Province-wise, the percentage of HFs reporting difficulties in providing child health services was relatively high in Lumbini Province (25%) followed by Sudurpaschim Province (23%) and lower in Karnali Province (6%) and Gandaki Province (7%) (Table 6.8). The percentages of HFs reporting the difficulty was higher for COVID hospitals (20%) and lower for PHCCs (12%) (Table 6.9).

The major difficulty reported by service providers was fear of transmission of COVID 19 among providers followed by commodity stock out and lack of PPE. (Table 6.10).

Table 6.8 Province-wise reporting of difficulty in service provision for childhood illness: Round 1 Assessment

Province (N=424)	%
Province 1	15.9
Province 2	10.0
Bagmati Province	13.0
Gandaki Province	7.3
Lumbini Province	25.0
Karnali Province	6.3
Sudurpaschim Province	22.9
Total	14.9

Table 6.9 Health facility wise reporting of difficulty in service provision for childhood illness: Round 1 Assessment

Type of HFs (N=424)	%
COVID hospital (n=10)	20.0
Non-COVID hospital (n=31)	16.1
PHCC (n=65)	12.3
HP (n=201)	16.4
UHC (n=117)	12.8
Total	14.9

Table 6.10 Reasons for difficulty in service provision for childhood illness as reported: Round 1 Assessment

Difficulties (n=63)	%
Fear of Transmission of COVID-19 among providers	49.2
Commodities/equipment/necessary supplies are out of stock	39.7
Lack of PPE	34.9
Social restrictions due to COVID-19	23.8
Unavailability of staffs	14.3
Fear of COVID-19 among clients	4.8

6.2.3 Cold chain

The service providers from all the facilities in all provinces reported that they were able to maintain cold chain at the time of immunization during the five-month lockdown period.

6.3 Vitamin-A Supplementation to Mothers of Newborns

Birth centers of 198 HFs were functional during the lockdown period. Of them, more than 95 percent had provided Vitamin A supplementation to the mothers of newborns during the lockdown period. All mothers (100%) in Province 2, Gandaki Province, Karnali Province and Sudurpaschim Province received Vitamin A supplementation during the lockdown period. Three HFs in Province 1 and Lumbini Province and one facility in Bagmati Province could not provide Vitamin A to mothers.

Round 2 Assessment indicated an eight percentage point reduction of HFs providing Vitamin A supplementation to mothers of newborns from 96.5 to 88.5 percent (Table 6.11). The reduction was the

highest in Province 2 (40% reduction), while three provinces (Bagmati, Karnal and Sudurpaschim) had maintained their ‘percent’ status quo in Round 2.

Health facility wise distribution shows one COVID hospital and non-COVID hospital, two PHCCs and three HPs were unable to distribute Vitamin A supplements to mothers of newborns delivered at the facility (Table 6.12).

Table 6.11 Province-wise distribution of Vitamin A supplementation to mothers of newborns: Round 1 and Round 2 Assessment

Province	Round 1 (n=198)	Round 2 (n= 61)
Province 1	90.6	88.9
Province 2	100.0	60.0
Bagmati Province	96.9	100.0
Gandaki Province	100.0	87.5
Lumbini Province	88.5	66.7
Karnali Province	100.0	100.0
Sudurpaschim Province	100.0	100.0
Total	96.5	88.5

Table 6.12 Health facility wise distribution of Vitamin A supplementation to mothers of newborns: Round 1 and Round 2 Assessment

Type of Health Facility	Round 1 (n=198)	Round 2 (n= 61)
COVID hospital	90.0	77.8
Non-COVID hospital	96.8	100
PHCC	96.6	80.0
HP	96.6	95.8
UHC	100	100
Total	96.5	88.5

6.4 FCHV’s Perspectives on Utilization of Child Health Services

In the Round 1 assessment, a large majority of FCHVs (71%) reported that children in their area received immunization services during the five-month lockdown period. Children’s inability to receive the immunization during the lockdown period was reported by about two thirds of the FCHVs of Province 1 (55%) followed by Lumbini (50%) and Gandaki (44%). While nearly universal coverage was reported by FCHVs of Karnali Province (98%), Province 2 (97%) and Sudurpaschim Province (96%).

It is noteworthy to find that in Round 2, all the FCHVs of Gandaki (100%), Karnali (100%) and Sudurpaschim (100%) provinces mentioned that newborn and children in their area received the immunization service. However, it was dismaying to find a relatively low percentage of FCHVs of Province 1 (57%) reporting children receiving immunization services as compared to other provinces in Round 2 (Table 6.13).

Instructions from the local government to halt the childhood immunization programme due to COVID-19 pandemic was cited as the major reason by the FCHVs for children’s inability to receive immunization service during the five-month lockdown period (Table 6.14).

All FCHVs across all provinces reported providing Vitamin A supplementation to children during the month of Asadh (July 2020). A Decline in the number of children seeking health attention for childhood illnesses during the lockdown period was reported by 29 percent of the FCHVs (Table not shown).

Table 6.13 Percentages of new-born and children receiving immunization services during Round 1 and Round 2 Assessment: FCHVs perspective

Province	Round 1 (N=424)	Round 2 (N=140)
Province 1	44.9	56.5
Province 2	96.7	95.0
Bagmati Province	75.0	66,7
Gandaki Province	56.4	100.0
Lumbini Province	50.0	77.3
Karnali Province	97.9	100.0
Sudurpaschim Province	95.8	100.0
Total	70.8	81.4

Table 6.14 Reasons for not receiving immunization services during Round 1 Assessment: FCHVs' perspectives

Reasons for not receiving immunization (n=124)	%
Local Government halted immunization programme	54.0
No PHC-ORC clinics	21.0
Fear of visiting health facility due to COVID	19.4
Strict lockdown	16.9

Chapter 7

Functionality and Utilization of Adolescent Friendly Health Services

7.1 Functionality of ASRH Services

A total of 180 out of 424 HF's covered in Round 1 were certified for providing Adolescent Friendly Health Services (AFHS). Of these 180 HF's, 77 percent were able to provide the service without interruption during the five-month lockdown period. Fourteen percent of the AFHS were halted during the initial period and then resumed the service later. About 8 percent of the AFHS was non-functional even before the lockdown period (5 each of PHCCs and HPs and in each of other health facilities). Four health facilities that had halted the AFHS could not resume this service at the time of the present assessment.

A total of 52 out of 140 HF's covered in Round 2 were accredited for providing AFHS. Of these, 77 percent were providing services without interruption during the period between Bhadra- Kartik. AFHS was interrupted in eight percent of the facilities for some time and then resumed later. The service was not yet resumed in 12 percent of the facilities after it was halted during this period. Few HF (4%) reported AFHS services being non-functional even before the COVID-19 lockdown.

Province-wise comparison shows in Round 1, nearly all AFHS of Karnali Province (95%) and Gandaki Province (94%) were functional without any interruptions during the lockdown period. On the other hand, three provinces Province 1 (64%), Sudurpaschim Province (65%) and Lumbini Province (69%) had lower percentages of HF's providing AFHS throughout the lockdown period without interruption (Table 7.1).

In Round 2, all the facilities in Karnali and Lumbini Province provided the AFHS service without interruption during the period between Bhadra-Kartik. A quarter of HF's in Province 1 had halted the service during this period initially and was resumed later (Table 7.1).

A higher percentage of HP's (86%) provided AFHS throughout the lockdown period (Round 1) in comparison to other HF's. Only about half of COVID hospitals (56%) did so. The percentages of HF's functioning with interruption in Round 2 ranged from 50 (non-COVID) to 100 (UHC) though the number of these two levels of HF's was 2 each (Table 7.2)

Table 7.1 Province-wise functionality of AFHS: Round 1 and Round 2 Assessment

	Province 1 (n=28)	Province 2 (n=20)	Bagmati Province (n=46)	Gandaki Province (n=16)	Lumbini Province (n=29)	Karnali Province (n=21)	Sudurpaschim Province (n=20)	Total (n=180)
ROUND 1								
Provided at all time without interruption	64.3	75.0	80.4	93.8	69.0	95.2	65.0	76.7
Halted initially but resumed now	21.4	10.0	8.7	6.3	20.7	4.8	20.0	13.3
Halted and not resumed yet	-	-	6.5	-	-		5.0	2.2
Service not functional before lockdown	14.3	15.0	4.3	-	10.3		10.0	7.8
	Province 1 (n=8)	Province 2 (n=5)	Bagmati Province (n=13)	Gandaki Province (n=2)	Lumbini Province (n=10)	Karnali Province (n=6)	Sudurpaschim Province (n=8)	Total (n=52)
ROUND 2								
Provided at all time without interruption	3 (37.5)	2 (40.0)	11 (84.6)	1 (50.0)	10 (100)	6 (100)	7 (87.5)	76.9
Halted initially but resumed now	2 (25.0)	1 (20.0)	1 (7.7)	-	-	-	-	7.7
Halted and not resumed yet	1 (12.5)	2 (40.0)	1 (7.7)	1 (50.0)	--	-	1 (12.5)	11.5
Service not functional before COVID-19	2 (25.0)	-	-	-	-	-	-	3.8

Table 7.2 Facility wise Functionality of AFHS: Round 1 and Round 2 Assessment

	COVID hospital (n=9)	Non- COVID hospital (n=18)	PHCC (n=48)	Health Post (n=84)	UHC (n=21)	Total % (n=180)
ROUND 1						
Provided at all time without interruption	55.6	66.7	68.8	85.7	76.2	76.7
Halted initially but resumed now	22.2	16.7	20.8	7.1	14.3	13.3
Halted and not resumed yet	11.1	5.6	-	1.2	4.8	2.2
Service not functional before lockdown	11.1	11.1	10.4	6.0	4.8	7.8
	COVID hospital (n=8)	Non- COVID hospital (n=2)	PHCC (n=15)	HP (n=25)	UHC (n=2)	Total % (n=52)
ROUND 2						
Provided at all time without interruption	6(75.0)	1 (50.0)	11 (73.3)	20 (80.0)	2 (100.0)	76.9
Halted initially but resumed now	1(12.5)	1 (50.0)	1 (6.7)	1 (4.0)	-	7.7
Halted and not resumed yet	-	-	3 (20.0)	3 (12.0)	-	11.5
Service not functional before COVID-19	1(12.5)		-	1 (4.0)	-	3.8

7.2 Range of SRH Services sought by Adolescent Girls

An overwhelmingly large percentage of service providers (84.0%) in Round 1 reported that adolescent girls mostly visited their HFs (at any time) for menstruation related matters. Over a third of services providers (36%) also mentioned about treatment for the problem of urinary tract infection/reproductive tract infection (UTI/RTI). Adolescent girls seeking FP contraceptives (25%), pregnancy tests (24%), and treatment of STIs (23%) were mentioned by a quarter of the service providers. In addition, few service providers reported that adolescent girls sought abortion (11%) and emergency contraceptives (8%) from their facilities.

A higher percentage of service providers of Province 2 than in other provinces reported adolescent girls seeking FP contraceptives (53%), pregnancy tests (35%) and safe abortion (24%) (Table 7.3). Whereas, the percentages of service providers mentioning UTI/RTI treatment seeking among adolescent girls were high for Lumbini Province (46%), Karnali Province (43%) and Province 1 (42%). Lumbini Province also had a higher percentage of service providers reporting adolescent girls seeking treatment for STIs (35%) than in other provinces.

The SRH related problems for which adolescent girls visited the AFHS for the most as mentioned by the service providers in the Round 2 Assessment were UTI/RTI (94%) and menstrual related (88%) (Table 7.3a). Two in five girls (42%) came for the treatment for STIs while one in six came for pregnancy tests. No adolescent girls sought service in Province 2, COVID hospitals and UHCs. The highest number of service providers in Lumbini and Karnali Province mentioned adolescent girls sought service for UTI/RTI.

Table 7.3 Province-wise classification of SRH matters for which adolescent girls sought services: Round 1 and Round 2 Assessment

SRH related matters	Province 1 (n=24)	Province 2 (n=17)	Bagmati Province (n=41)	Gandaki Province (n=16)	Lumbini Province (n=26)	Karnali Province (n=21)	Sudurpaschim Province (n=17)	Total (n=162)
ROUND 1								
Menstruation related problems/ concerns	79.2	76.5	90.2	81.3	80.8	90.5	82.4	84.0
UTI/RTI	41.7	35.3	31.7	12.5	46.2	42.9	35.3	35.8
FP Contraceptives	20.8	52.9	14.6	31.3	23.1	28.6	17.6	24.7
STI	20.8	17.6	22.0	6.3	34.6	23.8	29.4	22.8
Pregnancy test	20.8	35.3	26.8	6.3	34.6	14.3	17.6	23.5
Abortion	20.8	23.5	7.3	-	11.5	4.8	11.8	11.1
EC	12.5	-	7.3	6.3	15.4	9.5	-	8.0
SRH related matters	Province 1 (n=1)	Province 2 (n=)	Bagmati Province (n=2)	Gandaki Province (n=1)	Lumbini Province (n=5)	Karnali Province (n=5)	Sudurpaschim Province (n=3)	Total (n=17)
ROUND 2								
Menstruation related problems/ concerns	-	-	2	1	4	5	3	88.2
UTI/RTI	1	-	2	-	5	5	3	94.1
FP Contraceptives	-	-	1	-	-	1	-	11.8
STI	-	-	1	1	1	1	3	41.2
Pregnancy test	-	-	-	-	-	2	1	17.6
GBV	-	-	-	-	-	-	1	5.9

More than two thirds of service providers across all levels of HFs in Round 1 stated that adolescent girls visited their facilities to seek service for menstruation related problems. The percentages of service providers citing SRH service seeking behaviors of adolescent girls were very high for COVID hospitals followed by non-COVID hospitals in Round 1 (Table 7.4). Round 2 results also corroborate the previous round's results regarding almost all non-COVID hospitals, PHCC and HP provided services for menstrual related and UTI/RTI care to adolescent girls (Table 7.4).

Table 7.4 Health facility wise classification of SRH matters for which adolescent girls sought services: Round 1 and Round 2 Assessment

SRH related matters	COVID hospital (n=7)	Non-COVID hospital (n=15)	PHCC (n=43)	HP (n=78)	UHC (n=19)	Total (n=162)
ROUND 1						
Menstruation related problems/concerns	100.0	86.7	88.4	78.2	89.5	84.0
UTI/RTI	71.4	46.7	35.4	37.2	30.8	35.8
FP Contraceptives	42.9	40.0	22.9	20.5	21.1	24.7
STI	57.1	60.0	18.8	14.1	26.3	22.8
Pregnancy test	57.1	53.3	25.0	27.9	14.1	23.5
Abortion	42.9	26.7	14.6	5.1	-	11.1
EC	28.6	20.0	8.3	3.8	5.3	8.0
ROUND 2						
SRH related matters	COVID hospital	Non-COVID hospital (n=5)	PHCC (n=5)	HP (n=7)	UHC	Total (n=17)
Menstruation related problems/concerns	-	100.0	80.0	85.7	-	88.2
UTI/RTI	-	100.0	80.0	100.0	-	94.1
FP Contraceptives	-	-	20.0	14.3	-	11.8
STI	-	40.0	60.0	28.6	-	41.2
Pregnancy test	-	40.0	-	14.3	-	17.6
GBV	-	20.0	-	-	-	5.9

7.3 Range of SRH Services Sought by Adolescent Boys

Half of the service providers in Round 1 reported that most of the adolescent boys visited their facility to seek FP commodities. Other matters that adolescent boys sought service for include STI and UTI. As compared to other provinces, fewer percentages of service providers for Province 1 and Gandaki Province reported adolescent boys visiting their facilities for FP contraceptives (21%) and for STIs (6%) respectively in the Round 1 assessment. On the other hand, Karnali Province (86%) and Province 2 (71%) had higher percentages of service providers reporting adolescent boys seeking FP services at the HFs (Table 7.5).

Table 7.5 Province-wise classification of SRH matters for which adolescent boys sought service: Round 1 and Round 2 Assessment

SRH related matters	Province 1 (n=24)	Province 2 (n=17)	Bagmati Province (n=41)	Gandaki Province (n=16)	Lumbini Province (n=26)	Karnali Province (n=21)	Sudurpaschim Province (n=17)	Total (n=162)
ROUND 1								
FP Contraceptives	20.8	70.6	39.0	50.0	53.8	85.7	47.1.0	50.0
STI	37.5	35.3	31.7	6.3	30.8	23.8	35.3	29.6
UTI	41.7	5.9	26.8	18.8	34.6	4.8	29.4	24.7
SRH related matters	Province 1 (n=2)	Province 2 (n=1)	Bagmati Province (n=4)	Gandaki Province (n=1)	Lumbini Province (n=6)	Karnali Province (n=6)	Sudurpaschim Province (n=4)	Total (n=24)
ROUND 2								
FP Contraceptives	-	1 (100.0)	3 (75.0)	1 (100.0)	3 (50.0)	5 (83.3)	3 (75.0)	16 (66.7)
STI	1 (50.0)	-	2 (50.0)		2 (33.3)	3 (50.0)	4 (100.0)	12 (50.0)
UTI	2 (100.0)	-	1 (25.0)	1 (100.0)	5 (83.3)	3 (50.0)	1 (50.0)	13(54.2)

Percentages total may have exceeded 100 due to multiple response

The percentage of service providers saying adolescent boys seeking FP commodities was quite high for non-COVID hospitals (67%) and UHCs (68%). Adolescent boys seeking treatment for STIs and UTIs were higher at a hospital level. For instance, approximately three fourths of service providers based at COVID hospitals (71%) and half of those at non-COVID hospitals (53%) said that adolescent boys sought treatment for STIs. Likewise, two thirds of service providers based at non-COVID hospitals (67%) and over a half of those at COVID hospitals mentioned that adolescent boys usually visit their facilities for treatment of UTIs (Table 7.6).

In Round 2, about two thirds of the services providers reported adolescent boys seeking FP contraceptives from their AFHS. The proportion of service providers saying so was similar to that of Round 1. A very high proportion of service providers from all seven provinces except in Province 1 reported adolescent boys seeking FP commodities and for treatment of UTIs from their HF's (Table 7.6).

Table 7.6 Health facility wise classification of SRH matters for which adolescent boys sought services: Round 1 and Round 2 Assessment

SRH related matters	COVID hospital (n=7)	Non-COVID hospital (n=15)	PHCC (n=43)	HP (n=78)	UHC (n=19)	Total (n=162)
ROUND 1						
FP Contraceptives	57.1	66.7	46.5	46.2	68.4	50.0
STI	71.4	53.3	23.3	24.4	31.6	29.6
UTI	57.1	66.7	32.6	11.5	15.8	24.7
ROUND 2						(n=24)
FP Contraceptives	2 (40.0)	1 (100.0)	4 (80.0)	8(66.7)	1 (100)	16 (66.7)
STI	4 (80.0)	1 (100.0)	3 (60.0)	4 (33.3)	-	12 (50.0)
UTI	5 (100.0)	1 (100.0)	3(60.0)	4 (33.3)	-	13(54.2)

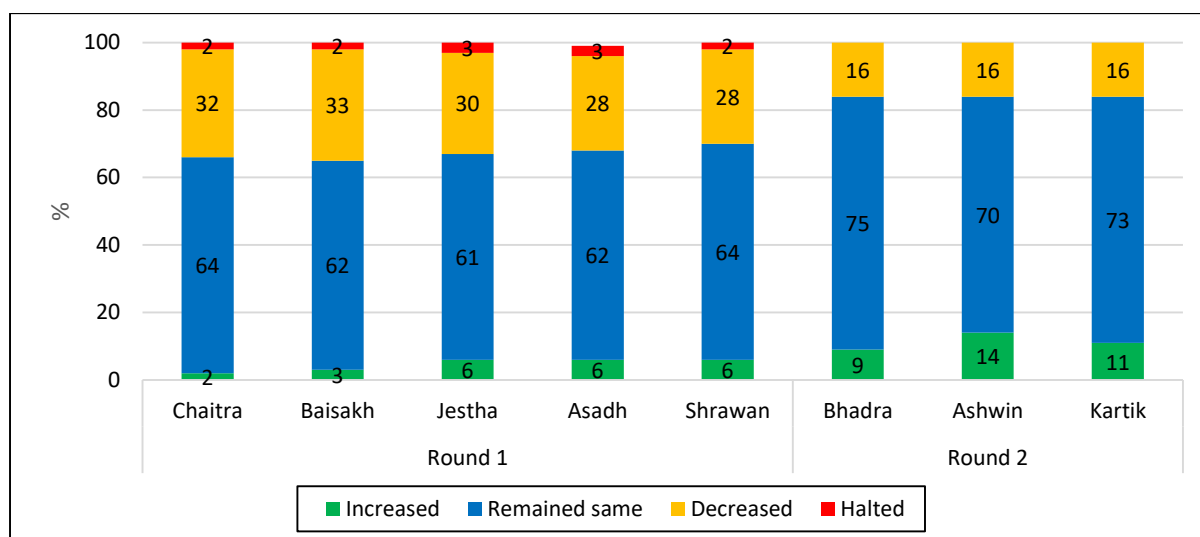
Percentages total may have exceeded 100 due to multiple response

7.4 Extent of Care Seeking for Menstruation related Matters during the COVID-19 pandemic

More than 60 percent of service providers reported that the flow of adolescent girls seeking care for menstruation related services at their facilities had remained unchanged during the five-month lockdown period. An average of 30 percent of service providers reported decreases in the flow of adolescent girls during the lockdown period. The percentages of service providers reporting an increase was negligible (Figure 7.1). The highest decrease in adolescent girls seeking care for menstrual related care was reported in Lumbini Province in the first two months of lockdown while the decrease was high in Sudurpaschim Province in the later three months (Annex 7.1). The highest decrease in the flow of adolescent girls seeking services was reported by COVID hospitals in the first two months of the lockdown while PHCCs experienced a decrease in the later three months (Annex 7.2).

In Round 2, a higher number of service providers reported the flow of adolescent girls seeking care for menstruation related services in the months of Bhadra and Ashwin has increased in comparison to the first five-month lockdown period and slightly decreased in the month of Kartik. Province-wise, there was an increase in adolescent girls seeking menstruation related care in Sudurpaschim Province in Round 2 in comparison to other provinces while the number of clients remained the same throughout the three month' period in Province 2 and Gandaki Province. Increases in adolescent girls seeking care for menstruation related problems was evident in Round 2 (Ashwin and Kartik) in Province 1 (Figure 7.1).

Figure 7.1 Extent of care seeking for menstrual related matters by adolescent girls: Round 1 and Round 2 Assessment



The most common reason for the decrease in menstruation related care seeking among adolescent girls during the lockdown period was the fear of contracting COVID-19 by the girls (76%). Social restrictions due to COVID-19 (67%), lack of transportation (38%) and closure of schools/colleges (22%) were other reasons given for the decrease in flow of the adolescent girls seeking services (Table 7.7). Very few service providers attributed halting of the ASRH services during lockdown to non-availability of trained service providers and fear of infection among service providers.

Table 7.7 Reasons for decrease in utilization of service for menstruation related problems: Round 1 Assessment

Reasons	COVID hospital (5)	Non-COVID hospital (5)	PHCC (22)	HP (21)	UHC (5)	Total (58)
Fear of infection among clients	100.0	80.0	72.7	71.4	80.0	75.9
Social restrictions due to COVID-19	80.0	40.0	54.5	81.9	80.0	67.2
Lack of transportation	60.0	80.0	31.8	28.6	40.0	37.9
Closure of schools		-	27.3	33.3		22.4

7.5 Extent of Utilization of STI Services by adolescents

More than two thirds (70%) of the service providers in Round 1 stated that the flow of the adolescent clients seeking STI related services remained the same during the five-month lockdown period in comparison to the period prior to lockdown (Figure 7.2). About a quarter of service providers mentioned decreases in the flow of adolescent clients seeking STI related services throughout the lockdown. Overall, 69 percent of service providers linked the decrease in flow to a fear of COVID-19 infection and the social restrictions in place due to lockdowns (Table 7.8).

Table 7.8 Reasons for decrease in utilization of service for STIs by adolescent clients: Round 1 Assessment

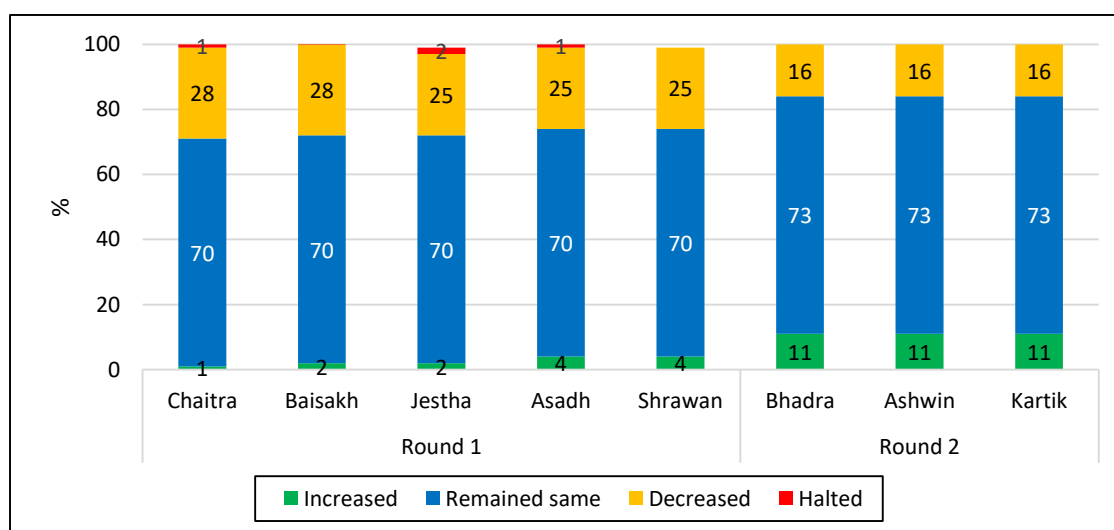
Reasons	COVID hospital (3)	Non-COVID hospital (3)	PHCC (19)	HP (20)	UHC (3)	Total (48)
Fear of infection among clients	100.0	66.7	63.2	65.0	100.0	68.8
Social restrictions due to COVID-19	100.0	66.7	57.9	70.0	100.0	68.8
Lack of transportation	100.0	66.7	31.6	25.0	33.3	35.4

The extent of service utilization by adolescents remained the same throughout the five-month lockdown period in Sudurpaschim Province with highest decreases compared to other provinces (Annex 7.3). Likewise, the highest decrease in flow of adolescent clients seeking STI services during first two months of lockdown was observed in COVID hospitals while the decrease was evident in PHCC in the later 3 months (Annex 7.4).

In Round 2, a higher percentage of service providers mentioned an increase in adolescent clients seeking STI services post the five-month lockdown. The proportion of service seekers was consistent throughout the three months (Bhadra, Ashwin, Kartik). There has been an increase in adolescent clients seeking STI related services in Karnali and Sudurpaschim Provinces in the later three months, while the number of STI service seekers remained the same throughout the three month period in Province 2 and Gandaki Province.

Facility-wise comparison shows that there has been a marginal increase in adolescent clients seeking STI related services at PHCC and HPs, while it remained the same in non-COVID Hospitals and UHCs.

Figure 7.2 Extent of utilization of STI services by adolescents: Round 1 and Round 2 Assessment

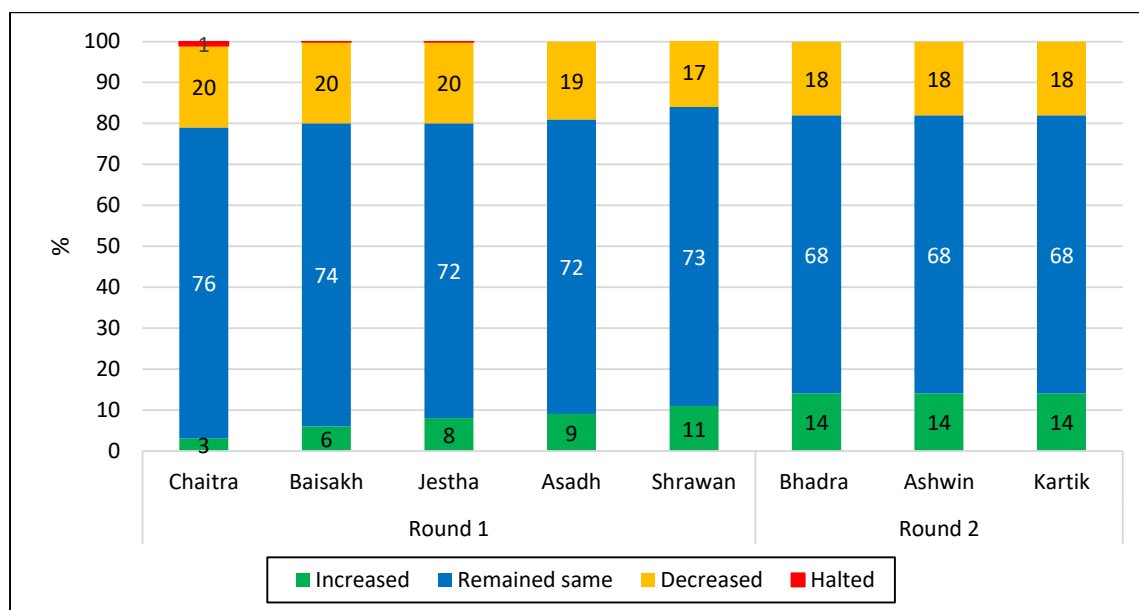


7.6 Extent of Utilization of Family Planning Services by adolescents

Overall, about three quarters of service providers (73%) reported that the flow of adolescent clients seeking FP services remained the same throughout the five-month lockdown period (Round 1

Assessment) in comparison to the period prior to lockdown. A fifth of them reported a decline in client flow during the first three months of lockdown (Chaitra, Baisakh and Jestha) which slightly picked up from the month of Asadh (Figure 7.3).

Figure 7.3 Extent of utilization of FP services by adolescent clients: Round 1 and Round 2 Assessment



There was a slight increase in clients seeking FP services in Bagmati Province in comparison to other provinces in the month of Asadh (Annex 7.5). A consistent decrease in adolescent clients seeking FP services in PHCC throughout the lockdown was apparent while the decrease was consistent for COVID hospitals and non-COVID hospitals for the initial three and four months respectively (Annex 7.6).

The status of adolescent clients seeking FP services was the same throughout the lockdown period (Round 1) in Gandaki Province (Annex: 7.5). Social restrictions due to COVID-19, fear of COVID-19 transmission and lack of transportation were the reasons attributed for the decrease in flow of the clients (Table 7.9).

In Round 2, a higher number of service providers reported an increase in adolescent client flow for FP services. Province-wise, Karnali experienced such a trend, more so than other provinces. The proportion of adolescent clients seeking FP services remained the same throughout the three month period in Province 2 and Gandaki Province. A slight increase in adolescent clients seeking FP services was reported by service providers of PHCC and HPs (Table not shown).

Table 7.9 Reasons for decrease in utilization of family planning services by adolescents: Round 1 Assessment

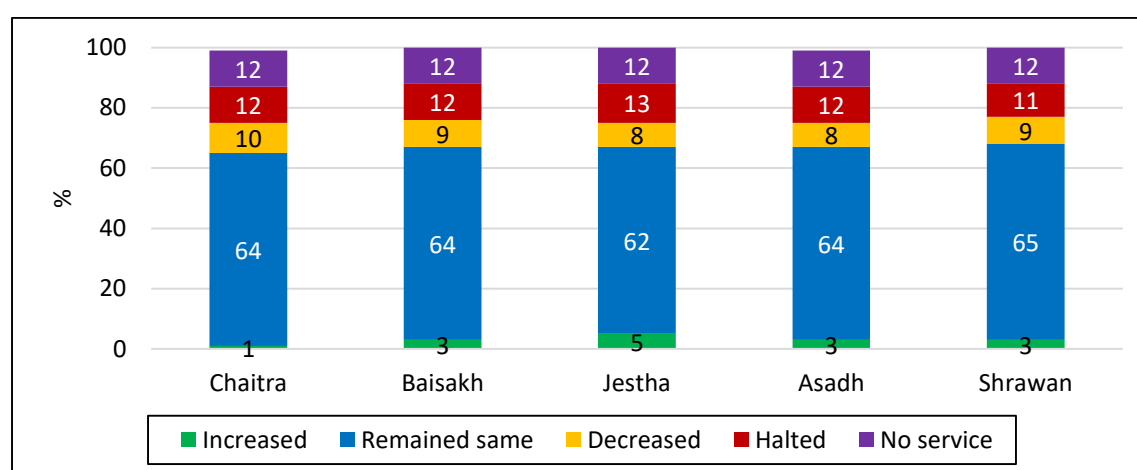
Reasons	COVID hospital (2)	Non-COVID hospital (3)	PHCC (10)	HP (19)	UHC (3)	Total (37)
Social restrictions due to COVID -19	100.0	100.0	90.0	73.7	33.3	78.4
Fear of transmission of COVID -19 among clients	100.0	33.3	80.0	57.9	100.0	67.6
Lack of transportation	100.0	100.0	40.0	10.5	-	29.7

7.7 Extent of Use for Emergency Contraceptive Pills by Adolescents

Slightly more than three fifths of service providers reported that the flow of adolescents seeking emergency contraceptive pills (ECP) had remained the same during the five-month lockdown period (Round 1). On average, 9 percent of service providers stated a decrease in flow of adolescents seeking ECP during lockdown while 12 percent reported halting ECP provision (Figure 7.4). There was a negligible increase in flow of adolescent clients seeking ECP in Bagmati Province and UHCs throughout the lockdown period (Annex 7.7 & 7.8).

More than half of the service providers attributed social restrictions on mobility due to COVID-19 as a major reason for the decrease in flow of adolescents seeking ECP. Fear of transmission of COVID-19 among service providers and non-availability of trained service providers were the other reasons cited. There was no provision of ECP at 12 percent of the HFs (Table not shown).

Figure 7.4 Emergency Contraceptive Pills use among adolescent clients: Round 1 Assessment



7.8 Types of SRH Services Sought by Married Adolescent Girls: FCHVs' Perspectives

Of the total 424 FCHVs, 186 FCHVs (44%) mentioned that married adolescent girls sought SRH services from them during the five-month lockdown. Family planning advice and commodities was the most common service sought by married adolescent girls from the FCHVs (71% of the FCHVs said so). About 39 percent of FCHVs stated that young married adolescent girls sought routine ANC from them (Table 7.10).

Most of the FCHVs in Province 2 and Sudurpaschim Province reported that married adolescent girls sought temporary FP commodities from them (Annex 7.9).

Of the 140 FCHVs covered in Round 2, 54 FCHVs (39 percent) mentioned that young married adolescent girls sought service from them during the period between Bhadra- Kartik. Most of the FCHVs stated girls sought FP commodities from them, as in Round 1. About half of the FCHVs mentioned that young girls also came to them for pregnancy confirmation.

All the FCHVs in Sudurpaschim Province (as in Round 1) and a large majority of FCHVs in Province 1 and Karnali Province mentioned that young married girls sought FP advice and commodities from them (Table 7.10).

Table 7.10 Types of SRH services sought by married adolescent girls from FCHVs: Round 1 and Round 2 Assessment

Services sought by young married adolescents (n=186)	Round 1 (n =186)	Round 2 (n =54)
Temporary FP	70.9	63.0
Routine ANC	38.7	44.4
Pregnancy confirmation	38.1	50.0
AFHS	14.5	1.9
Childhood immunization	13.4	27.8
Normal delivery/BEONC	7.5	7.4
PNC	6.5	-
LARC	5.4	-
EC	5.9	-
SAS	4.8	9.3

FCHVs identified various challenges/obstacles that had hindered SRH service seeking among the married adolescent girls during the five-months of lockdown. Of these, the most common obstacle eluding married adolescent girls from seeking care (50%) was a fear of contracting COVID-19 (50%). Lack of transport (30%) and strict implementation of lockdown (24%) were other main reasons (Table 7.11).

Table 7.11 Challenges faced by married adolescent girls seeking SRH during Round 1 assessment: FCHVs' Perspectives

Challenges faced by adolescent girls	%
Fear of transmission of COVID-19	50.0
Lack of transport	29.6
Strict implementation of lockdown and social distancing	23.7
Absence of female service providers	7.0
Lack of medicine/FP methods	3.8
Lack of service providers	1.1

Chapter 8

One Stop Crisis Management Center

8.1 Functionality of OCMC Service

One stop crisis management center (OCMC) is established at hospital level (where most services are integrated) but at a limited number of facilities to provide psycho-social counseling, treatment, security/safety, legal support, and rehabilitation for survivors of gender-based violence (GBV). Of the 41 hospitals covered in the Round 1 Assessment, 26 hospitals were accredited with providing OCMC services. Of these, three OCMC hospitals each were located in Province 1, Province 2, Karnali and Sudurpaschim Province, five OCMC hospitals each in Bagmati and Lumbini Province, and four hospitals in Gandaki Province. Nine of the 26 OCMC were based at COVID hospitals and 17 at non-COVID hospitals.

OCMCs in all 26 facilities covered in Round 1 were functional. Operation of OCMC was disrupted for some time at 15 percent of the hospitals which was resumed later.

All the 13 OCMC covered in Round 2 were functional. Operation of OCMC was disrupted for some time in one facility during the period between Bhadra- Kartik but was resumed subsequently at later months.

8.2 Utilization of OCMC Service

An increasing number of service providers reported a surge in GBV cases seeking care at their OCMC during the five-month lockdown period. As evident from Table 8.1, only 15 percent of the service providers had reported an increase in GBV cases during the third month which further increased to 31 percent and 39 percent in the fourth and fifth months. Inversely, the percentage of service providers reporting the GBV cases as “remained the same” declined each month from the second month onwards (Figure 8.1). The increase in the number of GBV clients during all months of lockdown was observed in Province 2 and Lumbini Province (Annex 9.1). The most common reason cited by health care providers for increases in GBV cases was frustration/stress during lockdown period (64%). Unemployment (27%) and increased awareness about place for seeking care and support (27%) was also mentioned as contributing to the increase in GBV survivors visiting the OCMC (Table 8.1).

A significant number of service providers mentioned an increase in cases of GBV during the month of Ashwin (46%) and Kartik (54%) in comparison to the lockdown period. The number of GBV cases seeking care increased throughout the three month period in Lumbini Province while it remained unchanged in Province 2.

Figure 8.1 Extent of utilization of OCMC: Round 1 and Round 2 Assessment

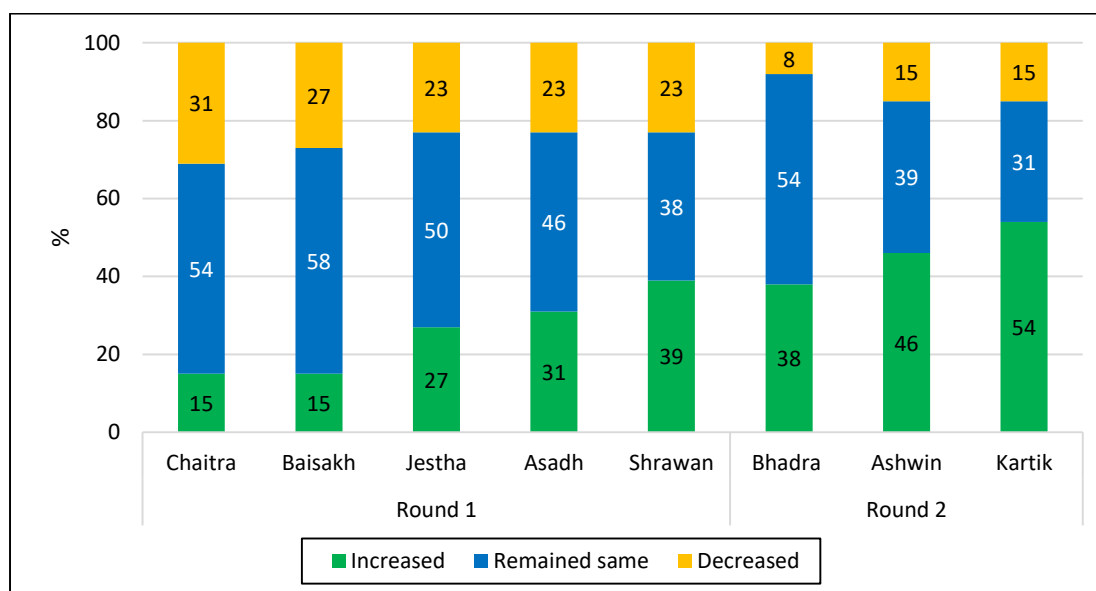


Table 8.1 Reasons for increase in number of GBV survivors: Round 1 assessment

Reasons for increase in GBV survivors (n=26)	%
Frustration/stress most of the time during lockdown	63.6
Unemployment	27.3
Awareness about place for redressing Violence	27.3

8.3 Types of GBV Cases Seeking Care at OCMC during the Lockdown Period

During the five-month lockdown period, all 26 OCMCs (100%) received cases of sexual violence. Physical violence was reported in 24 (92 %) OCMCs while slightly more than half of the OCMCs (57.7%) i.e. 15 centers reported cases of emotional violence (Table 8.2).

All OCMCs except a few in Province 1 and Karnali Province reported cases of physical violence. Emotional violence was least reported in Sudurpaschim Province while Bagmati Province reported the highest number of cases of emotional violence (Table 8.2).

During three month period (Round 2), all 13 OCMCs (100%) received cases of physical violence. Sexual violence was reported in 12 (92%) OCMCs, while emotional violence was reported in 11 (85%) OCMCs.

All OCMCs across all provinces except Sudurpaschim Province reported cases of sexual violence. No case of emotional violence was reported in Province 1.

Table 8.2 Province-wise distribution of type of Gender Based Violence reported: Round 1 and Round 2 Assessment

Types of violence	Province 1 (n=3)	Province 2 (n=3)	Bagmati Province (n=5)	Gandaki Province (n=4)	Lumbini Province (n=5)	Karnali Province (n=3)	Sudurpaschim Province (n=3)	Total (n=26)
ROUND 1								
Physical violence	2	3	5	4	5	2	3	24 (92.3)
Emotional violence	-	2	4	3	3	2	1	15 (57.7)
Sexual violence	3	3	5	4	5	3	2	26 (100.0)
ROUND 2								
Physical violence	2	1	3	2	3	1	1	100
Emotional violence	2	1	2	2	3	1	1	84.6
Sexual violence	2	1	2	2	3	1	1	92.3

Table 8.3 Distribution of OCMC facilities according to type of Gender Based Violence reported: Round 1 and Round 2 Assessment

Types of violence	COVID hospital (n=9)	Non-COVID hospital (n=17)	Total (n=26)
ROUND 1			
Physical violence	8	16	24 (92.0)
Emotional violence	5	10	15 (56.0)
Sexual violence	9	17	26 (100.0)
ROUND 2			
Physical violence	9	4	13 (100.0)
Emotional violence	7	4	11 (85.0)
Sexual violence	8	4	12 (92.0)

8.4 Type of Gender Based Violence Reported during Lockdown Period

Majority of OCMCs (19) reported an increase in cases of physical violence and sexual violence during the COVID-19 lockdown. Province-wise, except Bagmati Province, the OCMCs from all six provinces reported an increase in physical as well as sexual violence during the lockdown period (Table 8.4).

Table 8.4 Province-wise distribution of increase in type of Gender Based Violence reported: Round 1 Assessment

Types of violence	Province 1 (n=3)	Province 2 (n=3)	Bagmati Province (n=5)	Gandaki Province (n=4)	Lumbini Province (n=5)	Karnali Province (n=3)	Sudurpaschim Province (n=3)	Total (n=26)
Physical violence	2	2	4	4	3	2	2	19 (73.1)
Emotional violence	-	2	4	3	2	2	1	14 (53.8)
Sexual violence	3	2	3	4	3	2	2	19 (73.1)

Table 8.5 Distribution of OCMC facilities according to increase in type of Gender Based Violence reported: Round 1 Assessment

Types of violence frequently reported	COVID hospital (n=9)	Non-COVID hospital (n=17)	Total (n=26)
Physical violence	6 (66.7)	13 (76.5)	19 (73.1)
Emotional violence	5 (55.6)	9 (52.9)	14 (53.8)
Sexual violence	6 (66.7)	13 (76.5)	19 (73.1)

Chapter 9

Conclusions, Discussions and Way Forward

Public HFs preparedness for screening of clients, staff safety and in maintaining physical distancing in the context of the COVID-19 pandemic was far from desired. A significant proportion of the HFs including COVID designated hospitals reported a lack of sufficient stock of PPE. In fact, there was a fifty percent decrease in reports of having adequate stock of PPE in Round 2. Many HFs had not received the RMNCAH Interim Guidance especially those facilities located at peripheral areas (PHCCs, HPs and UHCs). Many HFs are yet to receive an orientation on the Interim Guidance. Perhaps for these reasons, the majority of service providers rated the activities of the Government in response to the COVID-19 pandemic as ‘average’. Only about one third of service providers especially those from Sudarparaschim Province and Karnali Province rated the Government’s response as ‘good’.

Most FCHVs were able to perform their tasks during the lockdown without much hinderances. Few of them could not conduct advocacy for childhood immunization, distribution of Vitamin A, Albendazole, condoms and oral pills during the initial period of the lockdown. The mode of contacting clients by FCHVs during the lockdown was personal visits and via the phone. Though use of face masks by FCHVs was nearly universal, adherence to other precautionary measures such as social distancing, frequent washing hands with soap and water, and use of sanitizer was poor.

Knowledge that wearing face masks and washing hand with soap and water or with alcohol based hand-rubs can prevent COVID-19 infections was very high among clients. Most of the clients had learned about these precautionary measures from the TV, radio and through phones (caller tune). Most of the clients had observed their service providers using a face mask while attending them but only half of them had seen their providers using hand sanitizers and hand gloves. Use of other PPE items by service providers such as face shields, caps or special cover alls or gowns was seen by few clients.

Due to a fear of COVID-19 infection, ANC service utilization had declined in the first two months of the lockdown but increased at later months. Some of the HFs had halted the ANC services initially due to this fear and also due to strict imposition of the lockdown. As a result, some ANC clients were unable to visit for ANC follow-up care on their scheduled dates. It is encouraging to find that most FCHVs had been conducting home visits throughout and without disruption by the lockdown. They were even making virtual contacts with their clients/default clients for the purpose of motivating them for routine ANC.

Most health facilities provided delivery services without interruption. The number of expectant mothers seeking institutional deliveries increased steadily, especially at hospitals and PHCCs from the third month onwards due to increases in referral of clients and denial of services from nearby HFs.

Fear of COVID-19 dissuaded some expectant mothers from seeking delivery care at birthing centers (institutional delivery). Trend analysis indicated a decline in institutional delivery during the five-month lockdown period as compared to the corresponding period of the previous year. A sharp decline in institutional delivery occurred in the month of Shrawan as compared to other months. An increase in the number of expectant women resorting to home delivery during the lockdown period indicates that due to a fear of contracting COVID-19 and other associated factors restricting mobility, women are endangering their health and lives by not seeking institutional delivery care. Nepal continues to experience high maternal mortality ratios (MMR) and the primary cause of the high MMR is post-partum hemorrhage.

Excluding the hospitals, the majority of HFs (PHCC and HP) were unable to provide ‘Aama’ transportation incentives to mothers of newborns at times of discharge in Round 1. The situation improved considerably two months later. However, few HFs did not provide the ‘Aama’ incentives at

all. Delayed provision of refundable money from the Government; and shortage of money at the facility hampered incentive distribution to mothers.

Family planning services were disrupted at more than one third of the facilities during the five-month lockdown period. A higher percentage of HFs of Lumbini Province and Province 1 had disruption of SARC services. In terms of category of HFs, disruptions of SARC were high at HP level.

Stock out of commodities and supplies, and fears of contracting COVID-19 among the providers were the two major reasons for FP service disruption. A significant number of HFs had experienced stock out of FP contraceptive commodities leading to FP service disruptions. Clients who could not avail FP services were encouraged by health providers to either visit another HF or use alternative methods of FP, to assist health providers to avoid touching the clients. In particular, users of LARC methods were often suggested to switch over to SARC methods, particularly condom and pills, for the same reason.

Studies have shown that many peripheral public SAS facilities such as PHCCs and HPs are unable to continue with safe MA services. This is owing to a multitude of barriers these facilities encounter in the provision of free MA services since the country introduced a three-tier federal structure of governance that shifted the responsibility of managing SAS clinics (MA drug and equipment supplies) from the central and district health office level to the local government. These administrative and policy barriers are resonated in the present study also. Only one in five HPs had been accredited for provision of safe MA services which is quite low. One third of the accredited facilities (34%) had stopped SAS (MA) before the lockdown. Lack of MA drugs and/or absence of trained providers continue to impede free and safe abortion care for women. It was also highly dismaying to find clients being charged abortion fees (Rs 500) in order to “punish” them. Such an action is against women’s abortion rights guaranteed by our country’s law.

HMIS trends indicated a decline in number of women utilizing SAS. Client flows remained almost the same during the five-month lockdown in nearly half of HFs providing MVA. Due to non-use of contraceptives or method discontinuation, many women are exposed to unintended pregnancies resulting in increases in SAS clients during the lockdown period.

Routine immunization services were halted in nearly half of the HFs after receiving instructions from respective health office/local government to halt the service during the lockdown. Due to the lockdown, nearly all HFs carried out the Vitamin A supplementation programme in the month of Ashad this year as per the Government instructions.

There were few HFs, including hospitals, where the immunization service has not yet resumed after it was halted during the lockdown period. Eleven HFs, including two hospitals, had stopped offering immunization services before the lockdown period. Cold chain was maintained throughout the lockdown period in all HFs.

Utilization of AFHS by adolescent girls had remained the same in the majority of facilities providing AFHS with little or no impact caused by the lockdown. Most of the girls sought services and information on menstruation related issues from the HFs during the lockdown. FCHVs were usually approached by adolescent girls for FP (SARC) methods and ANC during the lockdown. Various challenges/obstacles hindering adolescent girls from SRH services during the lockdown period were ‘fears of contracting COVID-19’ ‘lack of transportation’ and ‘strict implementation of lockdown’.

A surge in GBV cases seeking care at OCMC during the lockdown period was evident. The majority of survivors seeking care at OCMC during the five-month lockdown period were cases of sexual violence and physical violence. OCMCs in all provinces (except in Bagmati Province) experienced an increase in physical and sexual violence during the five -month lockdown period.

Way Forward:

- Ensure availability of electronic copies of the RMNCAH Interim Guidance at public sector HFs and provide orientation training to all service providers throughout the seven provinces, to enable them to understand the guiding principles for the provision of these essential services at the time of any natural disasters and pandemics;
- Provide adequate stock of PPE items at all HFs and ensure mandatory use of these items by service providers. Strengthen existing mechanisms for the procurement and distribution of PPE through coordination with the procurement units of concerned department/office at the province and local government levels;
- Establish regular policy dialogues between local government and HFs for mitigating challenges faced by HFs in stable provision of services such as the presence of trained human resources, commodities supply chain, timely disbursement/payment of reimbursable funds to HFs as specified in the RMNCAH Interim Guidance and also in the Safe Motherhood and Reproductive Health and Rights (SMRHR) Act 2018;
- Ensure sustained presence of trained service providers for continuous provision of high quality RMNCAH services including LARC, SAS and ASRH services at all levels of public HFs by providing competency-based training to additional cadres of service providers, who are either new recruits, untrained, or newly transferred at the health facilities.

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Annexes

Annex 1.1: Sample distribution of public health facilities at district and province level

Province/District	COVID hospital	Non-COVID hospital	PHCC	Health Post	UHC	Total
Province 1						
Jhapa	2	-	6	12	10	30
Sunsari	-	2	4	13	5	24
Solukhumbu	-	1	2	9	1	13
<i>Morang</i>	-	1	1	-	-	2
Total	2	4	13	34	16	69
Province 2						
Dhanusha	-	1	5	14	3	23
Mahottari	-	1	3	12	3	19
Rautahat	-	2	3	13	-	18
Total	-	4	11	39	6	60
Bagmati Province						
Kathmandu	-	1	8	11	21	41
Chitwan	-	3	3	8	10	24
Sindhupalchowk	-	2	3	15	3	23
<i>Kavre</i>	-	1	-	-	-	1
<i>Dhading</i>	-	1	-	-	-	1
<i>Bhaktapur</i>	1	-	-	-	-	1
<i>Lalitpur</i>	-	1	-	-	-	1
Total	1	9	14	34	34	92
Gandaki Province						
Tanahun	-	2	2	7	7	18
Syangja	-	1	3	10	7	21
Baglung	1	-	2	7	1	11
<i>Parbat</i>	-	1	1	2	1	5
Total	1	4	8	26	16	55
Lumbini Province						
Rupandehi	2	-	5	15	14	36
Rukum East	-	-	1	4	-	5
Banke	1	-	3	11	7	22
<i>Bardiya</i>	-	1	1	-	-	2
<i>Nawalparasi</i>	-	2	-	-	-	2
<i>Kapilvastu</i>	-	1	-	-	-	1
Total	3	4	10	30	21	68
Karnali Province						
Surkhet	1	1	3	8	5	18
Jumla	1	-	1	6	1	9
Dolpa	-	1	-	4	-	5
Total	2	2	4	18	6	32
Sudurpaschim Province						
Kailali	-	2	3	6	7	18
Baitadi	1	-	2	10	-	13
Bajura	-	1	-	4	11	16
<i>Kanchanpur</i>	-	1	-	-	-	1
Total	1	4	5	20	18	48
Grand Total	10	31	65	201	117	424

Note: The names of districts appearing in italics are additional districts covered to achieve the allocated sample.

Annex 1.2: District-wise distribution of public health facilities at 21 sampled districts: Round 2

Province and District Name	Hospital	PHCC	HP	UHC	Total HF
Province 1 (n=69)					
Jhapa	1	2	4	3	10
Sunsari	1	1	4	2	8
Solukhumbu	-	1	3	1	5
Total	2	4	11	6	23
Province 2 (n= 60)					
Dhanusa	-	2	4	1	7
Rautahat	1	1	5	-	7
Mahottari	-	1	4	1	6
Total	1	4	13	2	20
Bagmati Province (n=92)					
Sindhupalchowk	1	1	4	1	7
Kathmandu	1	3	4	7	15
Chitwan	1	1	3	3	8
Total	3	5	11	11	30
Gandaki Province (n=54)					
Tanahu	1	1	2	2	6
Baglung	1	1	3	1	6
Syangja	-	1	3	2	6
Total	2	3	8	5	18
Lumbini Province (n=68)					
Rupandehi	2	2	5	4	13
Rukum East	-	-	1	-	1
Banke	1	1	4	2	8
Total	3	3	10	6	22
Karnali Province (n=32)					
Dolpa	-	-	1	-	1
Jumla	-	-	2	1	3
Surkhet	1	1	3	2	7
Total	1	1	6	3	11
Sudurpaschim Province (n=49)					
Bajura	-	-	2	3	5
Baitadi	1	1	3	-	5
Kailali	1	1	2	2	6
Total	2	2	7	5	16
Grand Total	14	22	66	38	140

Annex 2.1: Province-wise preparedness in dealing with clients in the context of COVID-19 pandemic

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudur paschim Province		Total	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Screening of clients																
To large extent	46.4	17.4	40.0	20.0	38.0	43.3	49.1	72.2	35.3	50.0	21.9	27.3	31.3	25.0	38.7	37.1
To some extent	53.6	82.6	60.0	80.0	62.0	56.7	50.9	27.8	64.7	50.0	78.1	72.7	68.8	75.0	61.3	62.9
Staff safety																
To large extent	26.1	13.0	40.0	15.0	40.2	40.0	49.1	55.6	38.2	31.8	18.8	36.4	14.6	18.8	34.2	30.0
To some extent	73.9	87.0	60.0	85.0	59.8	60.0	50.9	44.4	61.8	68.2	81.3	63.6	85.4	81.3	65.8	70.0
Maintaining social distancing																
To large extent	33.3	30.4	28.3	45.0	37.0	53.3	45.5	88.9	35.3	31.8	9.4	27.3	25.0	6.3	32.5	42.1
To some extent	66.7	69.6	71.7	55.0	63.0	46.7	54.5	11.1	64.7	68.2	90.6	72.7	75.0	93.8	67.5	57.9
PPE stock																
To large extent	43.5	26.1	68.3	15.0	55.4	43.3	70.9	38.9	67.6	27.3	37.5	18.2	43.8	12.5	56.6	27.9
To some extent	56.5	73.9	31.7	85.0	44.6	56.7	29.1	61.1	32.4	72.7	62.5	81.8	56.3	87.5	43.4	72.1
Isolations of positive cases																
To large extent	7.2	4.3	10.0	-	16.3	26.7	9.1	5.6	5.9	18.2	15.6	18.2	20.8	25.0	11.8	14.3
To some extent	8.7	8.7	-	5.0	15.2	20.0	1.8	-	1.5	27.3	21.9	81.8	22.9	43.8	9.4	22.1
Not required	84.1	87.0	90.0	95.0	68.5	53.3	89.1	94.4	92.6	54.5	62.5	-	56.3	31.3	78.8	63.6
Treatment of positive cases																
To large extent	1.4	4.3	10.0	-	13.0	26.7	9.1	5.6	5.9	13.6	12.5	18.2	16.7	25.0	9.4	13.6
To some extent	13.0	4.3		5.0	16.3	20.0	1.8	-	1.5	31.8	25.0	81.8	22.9	43.8	10.6	22.1
Not required	85.5	91.3	90.0	95.0	70.7	53.3	89.1	94.4	92.6	54.5	62.5	-	60.4	31.3	80.0	64.3
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
N	69.0	23.0	60.0	20.0	92.0	30.0	55.0	18.0	68.0	22.0	32.0	11.0	48.0	16.0	424.0	140.0

Annex 2.2: Health facility wise preparedness in dealing with clients in the context of COVID-19 pandemic

	COVID hospital		Non-COVID hospital		PHCC		HP		UHC		Total	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Screening of clients												
To large extent	60.0	88.9	48.4	80	49.2	36.4	35.8	27.3	33.3	36.8	38.7	37.1
To some extent	40.0	11.1	51.6	20	50.8	63.6	64.2	72.7	66.7	63.2	61.3	62.9
Staff safety												
To large extent	80.0	77.8	58.1	60	35.4	36.4	30.3	22.7	29.9	23.7	34.2	30
To some extent	20.0	22.2	41.9	40	64.6	63.6	69.7	77.3	70.1	76.3	65.8	70
Maintaining social distancing												
To large extent	60.0	44.4	54.8	40	35.4	54.5	27.4	37.9	31.6	42.1	32.5	42.1
To some extent	40.0	55.6	45.2	60	64.6	45.5	72.6	62.1	68.4	57.9	67.5	57.9
PPE stock												
To large extent	40.0	88.9	54.8	40	53.8	40.9	62.7	16.7	49.6	23.7	56.6	27.9
To some extent	60.0	11.1	45.2	60	46.2	59.1	37.3	83.3	50.4	76.3	43.4	72.1
Isolations of positive cases												
To large extent	80.0	88.9	45.2	40	24.6	22.7	5.0	4.5	1.7	5.3	11.8	14.3
To some extent	20.0	-	29.0	20	15.4	27.3	7.0	22.7	4.3	23.7	9.4	22.1
Not required	-	11.1	25.8	40	60.0	50	88.1	72.7	94.0	71.1	78.8	63.6
Treatment of positive cases												
To large extent	70.0	88.9	38.7	40	20.0	22.7	3.5	3	0.9	5.3	9.4	13.6
To some extent	30.0	-	29.0	20	16.9	22.7	8.0	24.2	5.1	23.7	10.6	22.1
Not required	-	11.1	32.3	40	63.1	54.5	88.6	72.7	94.0	71.1	80.0	64.3
Total	100.0	100	100.0	100	100.0	100	100.0	100	100.0	100	100.0	100
N	10.0	9	31.0	5	65.0	22	201.0	66	117.0	38	424.0	140

Annex 2.3: Province -wise rating of the activities of the government in response to COVID-19 pandemic

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudur paschim Province	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Very Good	2.9	-	1.7	-	1.1	3.3	7.3	-	-	-	-	-	2.1	-
Good	11.6	8.7	20	20	17.4	20	21.8	5.6	22.1	4.5	31.1	18.2	35.4	50
Neither good nor poor	59.4	47.8	48.3	40	69.6	53.3	56.4	61.1	58.8	90.9	50	81.8	47.9	43.8
Poor	17.4	34.8	16.7	35	9.8	20	14.5	27.8	10.3	4.5	9.4	-	14.6	6.3
Very Poor	8.7	8.7	13.3	5	2.2	3.3	-	5.6	8.8	-	9.4	-	-	-
Total	100	100	100	100	100	100	100	100	100	100	100	100	100	100
N (424/140)	69	23	60	20	92	30	55	18	68	22	32	11	48	16

Annex 2.4: Health facility-wise rating of the activities of the government in response to COVID-19 pandemic

	COVID hospital		Non -COVID hospital		PHCC		Health Post		UHC	
	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2	Round 1	Round 2
Very Good	-	-	-	-	-	4.5	3	-	2.6	-
Good	10	22.2	25.8	20	18.5	13.6	17.9	13.6	28.2	23.7
Neither good nor poor	70	55.6	67.7	40	52.3	59.1	55.7	60.6	59.8	57.9
Poor	10	11.1	6.5	40	21.5	18.2	14.4	21.2	8.5	18.4
Very Poor	10	11.1	-	-	7.7	4.5	9	4.5	0.9	-
Total	100	100	100	100	100	100	100	100	100	100
N (424/140)	10	9	31	5	65	22	201	66	117	38

Annex 2.5: Province wise distribution of FCHV according to knowledge on mode of transmission of COVID-19 infection

Modes of COVID-19 transmission	Province 1		Province 2 (n=60)		Bagmati Province (n=92)		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=96)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Physical contact/ touching	81.2	95.7	73.3	95	88	80	83.6	94.4	89.7	95.5	84.4	90.9	68.8	93.8	82.1	91.4
Items used by infected person	46.4	78.3	75	85	57.6	46.7	50.9	61.1	33.8	40.9	78.1	72.7	72.9	75	56.8	63.6
Sneezing/ coughing	81.2	91.3	93.3	100	94.6	96.7	58.2	72.2	82.4	81.8	56.2	100	79.2	50	80.9	85.7

Annex 2.6: Province wise distribution of FCHV according to knowledge on symptoms of COVID -19 infection

Symptoms of COVID-19 infections	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=69)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Fever or chills	100	100	96.7	95	98.9	96.7	94.5	100	97.1	86.4	96.9	100	100	93.8	97.9	95.7
Dry cough	78.3	69.6	85	85	76.1	70	76.4	77.8	82.4	72.7	84.4	100	64.6	43.8	78.1	72.9
Fatigue/ Tiredness	13	47.8	15	30	30.4	33.3	18.2	22.2	7.4	0	9.4	54.5	12.5	12.5	16.5	27.9
Muscles or body aches	26.1	-	11.7	-	31.5	-	10.9	-	11.8	-	0	-	8.3	-	16.9	-
Headache	56.5	-	43.3	-	59.8	-	36.4	-	41.2	-	50	-	83.3	-	52.8	-
Shortness of breath or difficulty breathing	56.5	-	65	-	72.8	-	32.7	-	36.8	-	87.5	-	47.9	-	56.4	-
Sore throat	43.5	-	38.3	-	40.2	-	36.4	-	35.3	-	25	-	50	-	27.4	-
Loss of taste or smell	11.6	-	8.3	-	7.6	-	7.3	-	2.9	-	3.1	-	4.2	-	6.8	-
Congestion or running nose	62.3	-	48.3	-	35.9	-	54.5	-	54.4	-	37.5	-	41.7	-	48.1	-
Nausea or vomiting	10.1	-	6.7	-	16.3	-	7.3	-	8.8	-	6.2	-	4.2	-	9.4	-
Diarrhea	17.4	-	6.7	-	12	-	10.9	-	7.4	-	6.2	-	16.7	-	11.3	-
Don't know	0	-	3.3	-	1.1	-	0	-	2.9	-	0	-	0	-	1.2	-

Annex 2.7: FCHVs ability to perform the assigned tasks during the lockdown period

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=69)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Promotion/counseling couples for FP use																
Provided at all times	85.5	100.0	88.3	100.0	94.6	100.0	89.1	100.0	88.2	100.0	96.9	100.0	97.9	100.0	91.0	100.0
Halted initially but resumed later	14.5	-	10.0	-	4.3	-	7.3	-	11.8	-	3.1	-	2.1	-	8.0	-
Halted and not resumed yet	0.0	-	1.7	-	1.1	-	1.8	-	0.0	-	0.0	-	0.0	-	0.7	-
NA (Not included in my task/ not sought service)	0.0	-	0.0	-	0.0	-	1.8	-	0.0	-	0.0	-	0.0	-	0.2	-
Distribution of Condoms and oral pills																
Provided at all times	84.1	73.9	56.7	85.0	81.5	90.0	92.7	77.8	82.4	100.0	87.5	81.8	89.6	93.8	81.4	86.4
Halted initially but resumed later	8.7	8.7	23.3	0.0	7.6	0.0	0.0	0.0	8.8	0.0	3.1	9.1	10.4	0.0	9.2	2.1
Halted and not resumed yet	2.9	13.0	20.0	15.0	1.1	0.0	0.0	11.1	4.4	0.0	0.0	0.0	0.0	0.0	4.2	5.7
NA (Not included in my task/ not sought service)	4.3	4.3	0.0	0.0	9.8	10.0	7.3	11.1	4.4	0.0	9.4	9.1	0.0	6.2	5.2	5.7
Referral of new FP clients																
Provided at all times	87.0	100.0	90.0	100.0	95.7	100.0	96.4	94.4	92.6	100.0	96.9	100.0	97.9	93.8	93.4	98.6
Halted initially but resumed later	11.6	-	6.7	-	2.2	-	0.0	-	7.4	-	3.1	-	0.0	-	4.7	-
Halted and not resumed yet	0.0	-	3.3	-	1.1	-	0.0	-	0.0	-	0.0	-	2.1	-	0.9	-

NA (Not included in my task/ not sought service	1.4	0.0	0.0	0.0	1.1	0.0	3.6	5.6	0.0	0.0	0.0	0.0	0.0	6.2	0.9	1.4
Referral for LARC service																
Provided at all times	81.2	95.7	86.7	95.0	92.4	96.7	76.4	55.6	88.2	95.5	87.5	54.5	81.2	75.0	85.4	85.0
Halted initially but resumed later	10.1	-	10.0	-	2.2	-	1.8	-	7.4	-	0.0	-	2.1	-	5.2	-
Halted and not resumed yet	2.9	4.3	0.0	5.0	3.3	0.0	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	1.7	1.4
NA (Not included in my task/ not sought service	5.8	0.0	3.3	0.0	2.2	3.3	21.8	44.4	1.5	4.5	12.5	45.5	16.7	25.0	7.8	13.6
Referral for ANC/PNC																
Provided at all times	94.2	95.7	91.7	100.0	97.8	100.0	96.4	94.4	98.5	100.0	100.0	100.0	97.9	100.0	96.5	98.6
Halted initially but resumed later	5.8	-	8.3	-	2.2	-	0.0	-	1.5	-	0.0	-	0.0	-	2.8	-
NA (Not included in my task/ not sought service	0.0	4.3	0.0	0.0	0.0	0.0	3.6	5.6	0.0	0.0	0.0	0.0	2.1	0.0	0.7	1.4
Referral for institutional delivery																
Provided at all times	89.9	100.0	95.0	95.0	100.0	100.0	94.5	77.8	97.1	100.0	100.0	90.9	97.9	100.0	96.2	95.7
Halted initially but resumed later	5.8	-	5.0	-	0.0	-	0.0	-	2.9	-	0.0	-	0.0	-	2.1	-
Halted and not resumed yet	1.4	0.0	0.0	5.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.7
NA (Not included in my task/ not sought service	2.9	0.0	0.0	0.0	0.0	0.0	5.5	22.2	0.0	0.0	0.0	9.1	2.1	0.0	1.4	3.6
Pregnancy testing																
Provided at all times	55.1	34.8	50.0	50.0	54.3	26.7	65.5	44.4	60.3	45.5	78.1	54.5	70.8	37.5	59.9	40.0
Halted initially but resumed later	7.2	-	10.0	-	2.2	-	0.0	-	5.9	-	3.1	-	2.1	-	4.5	-

Halted and not resumed yet	0.0	0.0	25.0	30.0	1.1	33.3	0.0	5.6	1.5	0.0	0.0	0.0	0.0	0.0	4.0	12.1
NA (Not included in my task/ not sought service)	37.7	65.2	15.0	20.0	42.4	40.0	34.5	50.0	32.4	54.5	18.8	45.5	27.1	62.5	31.6	47.9
Referral for safe abortion care																
Provided at all times	78.3	82.6	90.0	100.0	66.3	76.7	69.1	44.4	94.1	100.0	81.2	54.5	60.4	37.5	76.9	74.3
Halted initially but resumed later	7.2	-	8.3	-	1.1	-	0.0	-	2.9	-	0.0	-	0.0	-	3.1	-
Halted and not resumed yet	0.0	0.0	0.0	0.0	4.3	0.0	0.0	5.6	2.9	0.0	0.0	0.0	0.0	0.0	1.4	0.7
NA (Not included in my task/ not sought service)	14.5	17.4	1.7	0.0	28.3	23.3	30.9	50.0	0.0	0.0	18.8	45.5	39.6	62.5	18.6	25.0
Promotion /motivation for childhood immunization																
Provided at all times	60.9	100.0	90.0	100.0	85.9	96.7	74.5	100.0	92.6	100.0	87.5	100.0	91.7	100.0	82.8	99.3
Halted initially but resumed later	37.7	0.0	8.3	0.0	14.1	3.3	25.5	0.0	7.4	0.0	12.5	0.0	8.3	0.0	16.7	0.7
Halted and not resumed yet	0.0	-	1.7	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.2	-
NA (Not included in my task/ not sought service)	1.4	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.0	-	0.2	-
Distribution of Vitamin A																
Provided at all times	62.3	34.8	78.3	100.0	95.7	90.0	98.2	72.2	91.2	63.6	96.9	72.7	91.7	37.5	87.0	68.6
Halted initially but resumed later	37.7	0.0	21.7	0.0	4.3	0.0	1.8	0.0	5.9	9.1	3.1	0.0	8.3	0.0	12.5	1.4
Halted and not resumed yet	0.0	65.2	0.0	0.0	0.0	0.0	0.0	0.0	2.9	27.3	0.0	0.0	0.0	0.0	0.5	15.0
NA (Not included in my task/ not sought service)	-	0.0	-	0.0	-	10.0	-	27.8	-	0.0	-	27.3	-	62.5	-	15.0

Distribution of Albendazole																
Provided at all times	65.2	73.9	78.3	90.0	94.6	86.7	98.2	94.4	95.6	63.6	96.9	100.0	93.8	56.2	88.2	80.0
Halted initially but resumed later	31.9	0.0	21.7	0.0	3.3	0.0	1.8	0.0	4.4	9.1	3.1	0.0	6.2	0.0	10.8	1.4
Halted and not resumed yet	-	26.1	-	10.0	-	0.0	-	0.0	-	27.3	-	0.0	-	0.0	-	10.0
NA (Not included in my task/ not sought service)	2.9	0.0	0.0	0.0	2.2	13.3	0.0	5.6	0.0	0.0	0.0	0.0	0.0	43.8	0.9	8.6
Distribution of Zinc tab and ORS																
Provided at all times	91.3	91.3	43.3	70.0	92.4	86.7	92.7	88.9	92.6	90.9	90.6	100.0	89.6	100.0	84.9	88.6
Halted initially but resumed later	4.3	-	11.7	-	3.3	-	0.0	-	4.4	-	3.1	-	6.2	-	4.7	-
Halted and not resumed yet	1.4	4.3	20.0	30.0	2.2	0.0	1.8	5.6	1.5	9.1	3.1	0.0	0.0	0.0	4.2	7.1
NA (Not included in my task/ not sought service)	2.9	4.3	25.0	0.0	2.2	13.3	5.5	5.6	1.5	0.0	3.1	0.0	4.2	0.0	6.1	4.3
Distribution of Cotrim/Amoxicillin tabs																
Provided at all times	1.4	0.0	23.3	20.0	21.7	0.0	10.9	11.1	4.4	9.1	12.5	0.0	20.8	0.0	13.7	5.7
Halted initially but resumed later	1.4	-	5.0	-	3.3	-	1.8	-	0.0	-	0.0	-	2.1	-	2.1	-
Halted and not resumed yet	0.0	4.3	33.3	65.0	2.2	23.3	38.2	11.1	0.0	31.8	0.0	18.2	0.0	0.0	10.1	22.9
NA (Not included in my task/ not sought service)	97.1	95.7	38.3	15.0	72.8	76.7	49.1	77.8	95.6	59.1	87.5	81.8	77.1	100.0	74.1	71.4

Distribution of CHX gel (Naavi Malam)																
Provided at all times	15.9	17.4	35.0	45.0	20.7	6.7	40.0	50.0	19.1	40.9	21.9	0.0	12.5	0.0	23.3	23.6
Halted initially but resumed later	2.9	-	5.0	-	2.2	-	0.0	-	0.0	-	0.0	-	0.0	-	1.7	-
Halted and not resumed yet	2.9	0.0	23.3	55.0	0.0	13.3	16.4	11.1	1.5	31.8	3.1	0.0	0.0	0.0	6.4	17.1
NA (Not included in my task/ not sought service)	78.3	82.6	36.7	0.0	77.2	80.0	43.6	38.9	79.4	27.3	75.0	100.0	87.5	100.0	68.6	59.3
Counseling on other health, nutrition and WASH issues																
Provided at all times	85.5	100.0	56.7	65.0	98.9	100.0	100.0	100.0	94.1	100.0	100.0	100.0	95.8	100.0	89.9	95.0
Halted initially but resumed later	10.1	-	5.0	-	1.1	-	0.0	-	4.4	-	0.0	-	2.1	-	3.5	-
Halted and not resumed yet	1.4	0.0	0.0	35.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	5.0
NA (Not included in my task/ not sought service)	2.9	-	38.3	-	0.0	-	0.0	-	1.5	-	0.0	-	2.1	-	6.4	-
Referral for danger signs as per IMNCI protocol																
Provided at all times	89.9	100.0	91.7	95.0	96.7	100.0	98.2	100.0	82.4	100.0	96.9	90.9	79.2	37.5	90.8	91.4
Halted initially but resumed later	7.2	-	5.0	-	2.2	-	0.0	-	1.5	-	0.0	-	2.1	-	2.8	-
Halted and not resumed yet	0.0	0.0	0.0	5.0	0.0	0.0	0.0	0.0	1.5	0.0	0.0	0.0	0.0	0.0	0.2	0.7
NA (Not included in my task/ not sought service)	2.9	0.0	3.3	0.0	1.1	0.0	1.8	0.0	14.7	0.0	3.1	9.1	18.8	62.5	6.1	7.9

Annex 2.8: Province-wise distribution of precautionary measures used by FCHVs

Precautionary measures used by FCHVs	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=69)	Round 2 (n=23)	Round 1 (n=60)	Round 2 (n=20)	Round 1 (n=92)	Round 2 (n=30)	Round 1 (n=55)	Round 2 (n=18)	Round 1 (n=68)	Round 2 (n=22)	Round 1 (n=32)	Round 2 (n=11)	Round 1 (n=48)	Round 2 (n=16)	Round 1 (n=424)	Round 2 (n=140)
Used of mask	95.7	91.3	98.3	100.0	98.9	96.7	90.9	94.4	97.1	100.0	100.0	100.0	100.0	100.0	97.1	97.1
Use of gloves	17.4	30.4	38.3	25.0	40.2	30.0	41.8	11.1	11.8	9.1	3.1	0.0	14.6	6.2	26.1	18.6
Use of sanitizer	46.4	47.8	65.0	35.0	65.2	70.0	72.7	61.1	58.8	59.1	87.5	45.5	39.6	68.8	60.8	56.4
Maintenance of 2 meters distance from clients	71.0	47.8	50.0	65.0	57.6	46.7	52.7	72.2	77.9	54.5	56.2	9.1	43.8	18.8	59.6	47.9
Frequent hand wash with soap and water	72.5	73.9	56.7	70.0	58.7	60.0	47.3	22.2	57.4	50.0	75.0	90.9	47.9	50.0	58.9	58.6
Use of other PPE	2.9	0.0	5.0	5.0	6.5	0.0	1.8	0.0	0.0	0.0	0.0	9.1	0.0	0.0	2.8	1.4

Annex 2.9: Province- wise distribution of client’s knowledge about precautionary measures against COVID-19

	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=48)	Round 2 (n=33)	Round 1 (n=76)	Round 2 (n=32)	Round 1 (n=107)	Round 2 (n=31)	Round 1 (n=57)	Round 2 (n=26)	Round 1 (n=87)	Round 2 (n=31)	Round 1 (n=30)	Round 2 (n=7)	Round 1 (n=54)	Round 2 (n=21)	Round 1 (n=459)	Round 2 (n=181)
Always wearing a mask	100	90.9	90.8	96.9	87.9	96.8	86	96.2	93.1	96.8	100	100	96.3	100	92.1	96.1
Regularly and thoroughly washing/cleaning hands with soap and water or alcohol hand rub	79.2	72.7	71.1	59.4	69.2	96.8	59.6	84.6	89.7	71	96.7	42.9	74.1	71.4	75.6	74.5
Maintaining 2 meters (6 feet) distance	62.5	36.4	53.9	68.8	57	67.7	61.4	73.1	47.1	48.4	96.7	85.7	27.8	38.1	54.9	56.9
Avoiding crowded places/handshakes	56.2	60.6	43.4	50	65.4	51.6	43.9	23.1	36.8	67.7	33.3	42.9	57.4	47.6	49.7	50.8
Avoid touching eyes, nose and mouth	4.2	0	3.9	3.1	22.4	19.4	12.3	0	8	16.1	10	57.1	3.7	0	10.5	8.8
Staying home	10.4	60.6	7.9	0	16.8	12.9	5.3	0	13.8	0	3.3	0	9.3	0	10.9	13.2
Eating healthy, nutritional food, liquid items and drinking hot water	4.2	3	0	0	1.9	0	0	0	3.4	0	0	0	1.9	0	1.8	0.5
Change dress and bath after coming from outside	0	-	0	-	0.9	-	0	-	3.4	-	0	-	0	-	0.9	-
Maintaining sanitization	0	-	0	-	0	-	0	-	6.9	-	0	-	0	-	1.3	-

Annex 2.10: Health facility-wise knowledge about precautionary measures against COVID-19 among the clients

	COVID hospital		Non- COVID hospital		PHCC		HP		UHC		Total	
	Round 1 (n=24)	Round 2 (n=22)	Round 1 (n=91)	Round 2 (n=14)	Round 1 (n=94)	Round 2 (n=40)	Round 1 (n=172)	Round 2 (n=67)	Round 1 (n=48)	Round 2 (n=38)	Round 1 (n=459)	Round 2 (n=181)
Always wearing a mask	87.5	100	92.3	92.9	96.8	95	93	97	85.9	94.7	92.1	174 (96.1)
Regularly and thoroughly washing/cleaning hands with soap and water or alcohol hand rub	79.2	72.7	71.4	50	79.8	75	80.2	77.6	64.1	78.9	75.6	135 (74.5)
Maintaining 2 meters (6 feet) distance	62.5	50	57.1	57.1	47.9	62.5	58.1	52.2	51.3	63.2	54.9	103 (56.9)
Avoiding crowded places/handshakes	66.7	50	57.1	50	41.5	47.5	44.8	47.8	56.4	60.5	49.7	92 (50.8)
Avoid touching eyes, nose and mouth	12.5	22.7	17.6	0	5.3	10	7	6	15.4	7.9	10.5	16 (8.8)
Staying home	20.8	18.2	8.8	35.7	13.8	12.5	7	6	15.4	15.8	10.9	24 (13.2)
Eating healthy, nutritional food, liquid items and drinking hot water	0	0	3.3	0	2.1	0	0.6	1.5	2.6	0	1.8	1 (0.5)
Change dress and bath after from outside	0	-	1.1	-	2.1	-	0.6	-	0	-	0.9	-
Maintaining sanitization	0	-	0	-	2.1	-	2.3	-	0	-	1.3	-

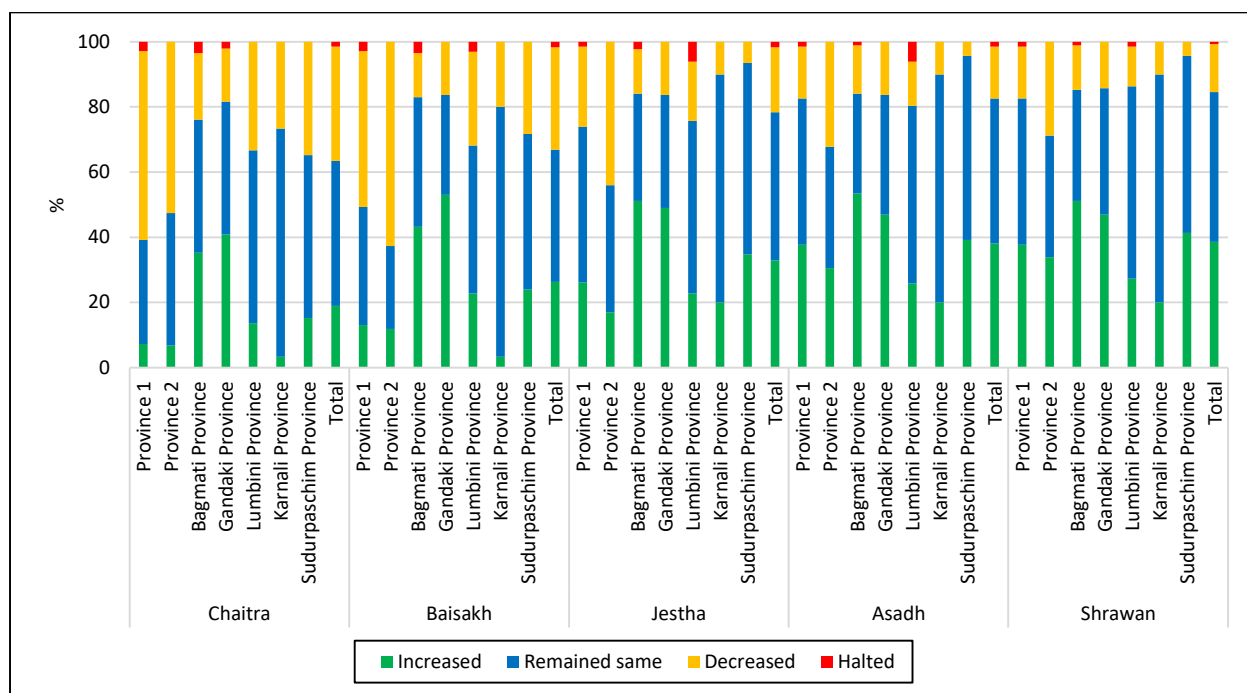
Annex 2.11: Province-wise distribution of precautionary measures used by health providers while attending clients

	Province 1 (n=50)		Province 2 (n=79)		Bagmati Province (n=109)		Gandaki Province (n=62)		Lumbini Province (n=94)		Karnali Province (n=30)		Sudurpaschim Province (n=55)		Total	
	Round 1 (n=50)	Round 2 (n=33)	Round 1 (n=79)	Round 2 (n=32)	Round 1 (n=109)	Round 2 (n=33)	Round 1 (n=62)	Round 2 (n=28)	Round 1 (n=94)	Round 2 (n=32)	Round 1 (n=30)	Round 2 (n=7)	Round 1 (n=55)	Round 2 (n=23)	Round 1 (n=479)	Round 2 (n=188)
Used mask	98	100	94.9	100	99.1	90.9	98.4	100	100	100	100	100	100	100	97.9	98.4
Hand washing with soap and water	46.9	36.4	25.3	18.8	23.1	39.4	22.6	10.7	9.6	37.5	63.3	100	18.5	0	25.1	28.2
Sanitized hands	59.2	72.7	57	40.6	61.1	69.7	46.8	67.9	70.2	87.5	80	100	33.3	39.1	57.8	65.4
Use of gloves	65.3	39.4	60.8	15.6	62	69.7	56.5	57.1	30.9	31.2	93.3	42.9	35.2	13	53.8	38.8
Use of special cover-all	20.4	15.2	12.7	3.1	14.8	9.1	22.6	7.1	12.8	21.9	10	14.3	11.1	0	14.8	10.1
Face shield	12.2	12.1	6.3	3.1	11.1	15.2	1.6	3.6	8.5	12.5	10	14.3	1.9	0	7.6	8.5
Cap	6.1	9.1	10.1	0	9.3	9.1	0	0	10.6	0	13.3	14.3	13	0	8.8	3.7
Kept six feet apart from other patients/ visitors	8.2	6.1	8.9	0	25.9	12.1	3.2	0	16	0	3.3	0	3.7	0	12.3	3.2
Did not use any precautionary measures	0	-	0	-	0.9	-	0	-	0	-	0	-	0	-	0.2	-

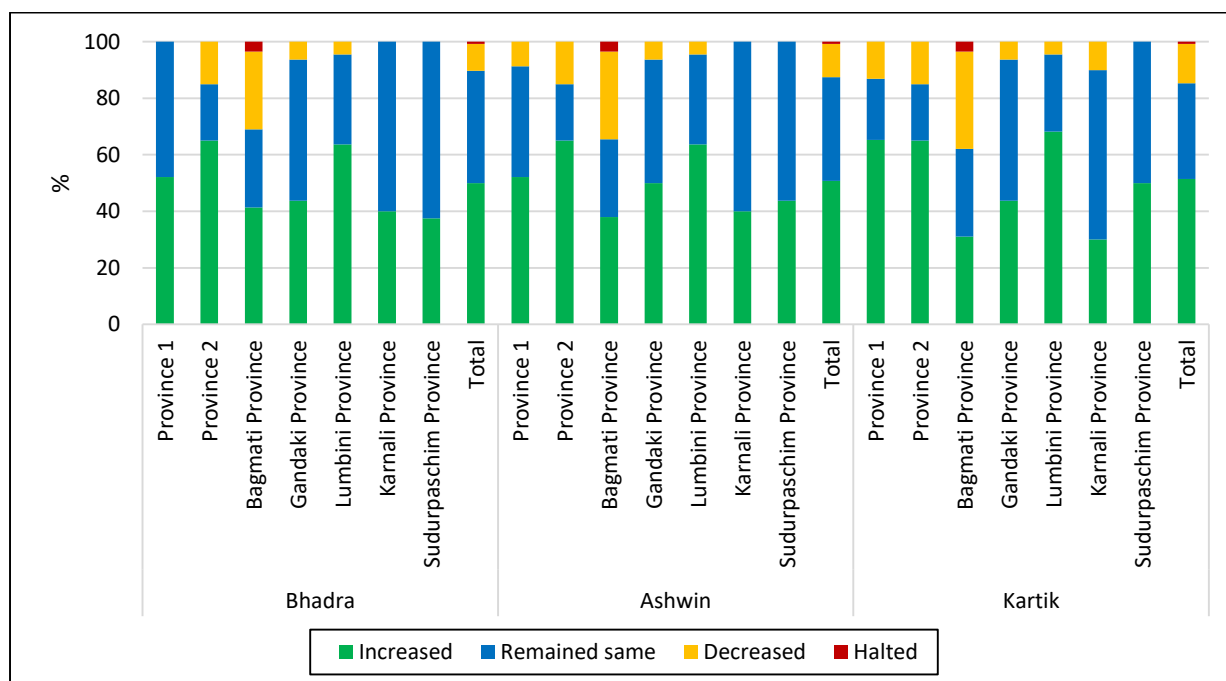
Annex 2.12: Health facility wise precautionary measures used by health providers while attending clients

	COVID hospital		Non -COVID hospital		PHCC		HP		UHC		Total	
	Round 1 (n=24)	Round 2 (n=23)	Round 1 (n=91)	Round 2 (n=14)	Round 1 (n=94)	Round 2 (n=42)	Round 1 (n=172)	Round 2 (n=70)	Round 1 (n=48)	Round 2 (n=39)	Round 1 (n=459)	Round 2 (n=188)
Used mask	100	100	98.9	100	99	97.6	97.2	98.6	96.4	97.4	97.9	98.4
Washed hands with soap and water	20	34.8	26.1	28.6	26.3	38.1	28.9	21.4	15.7	25.6	25.1	28.2
Sanitized hands	56	91.3	69.6	50	61.6	73.8	58.3	48.6	39.8	76.9	57.8	65.4
Used gloves	60	65.2	76.1	71.4	51.5	35.7	49.4	24.3	39.8	41	53.8	38.8
Used special cover-all	48	39.1	40.2	21.4	10.1	11.9	5	0	3.6	5.1	14.8	10.1
Used face shield	32	21.7	18.5	14.3	8.1	11.9	0.6	2.9	2.4	5.1	7.6	8.5
Used cap	32	8.7	22.8	14.3	7.1	4.8	2.2	0	2.4	2.6	8.8	3.7
Kept six feet apart from other patients/ visitors	12	0	7.6	0	15.2	4.8	10.6	2.9	18.1	5.1	12.3	3.2
Did not use any precautionary measures	0	-	0	-	0	-	0.6	-	0	-	0.2	-

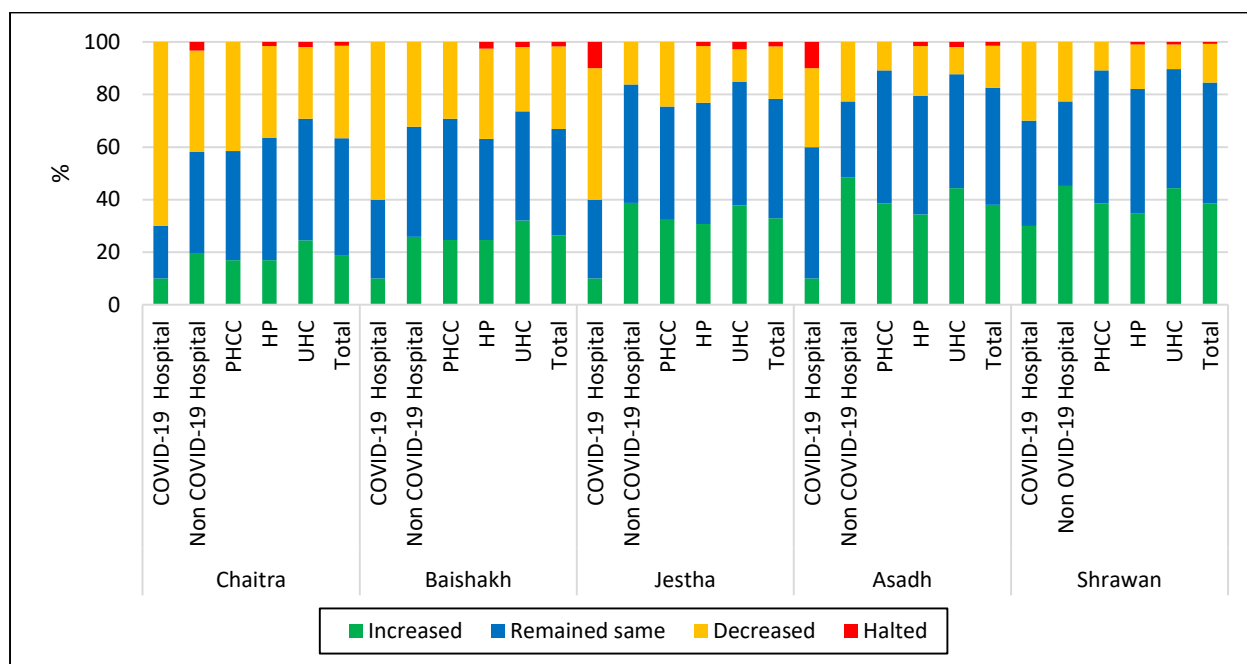
Annex 3.1: Province-wise extent of utilization of ANC during 5 months' lockdown period



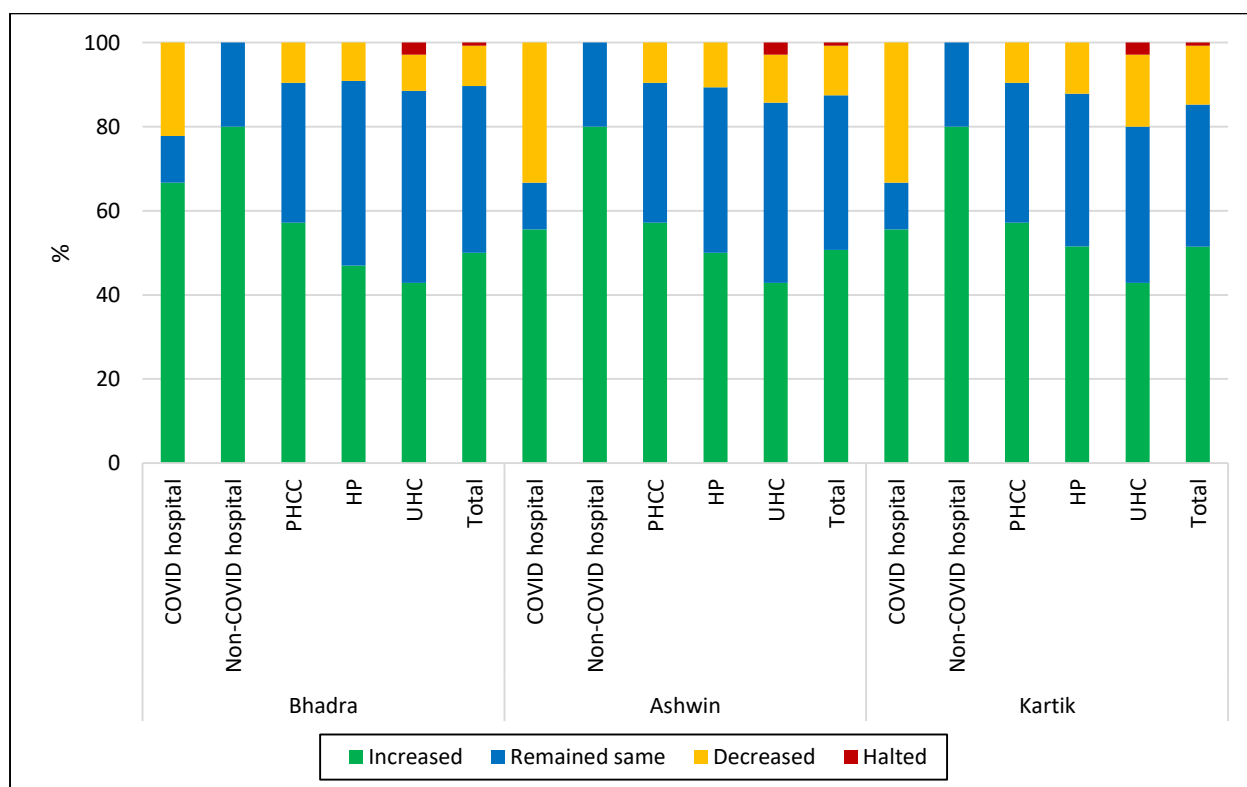
Annex 3.1a: Province-wise extent of utilization of ANC during during the period between Bhadra-Kartik



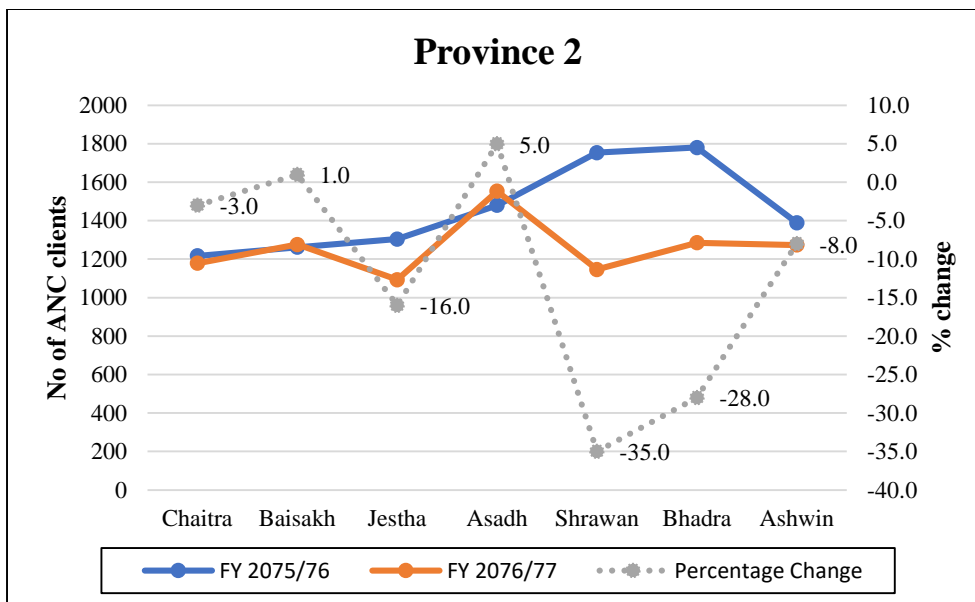
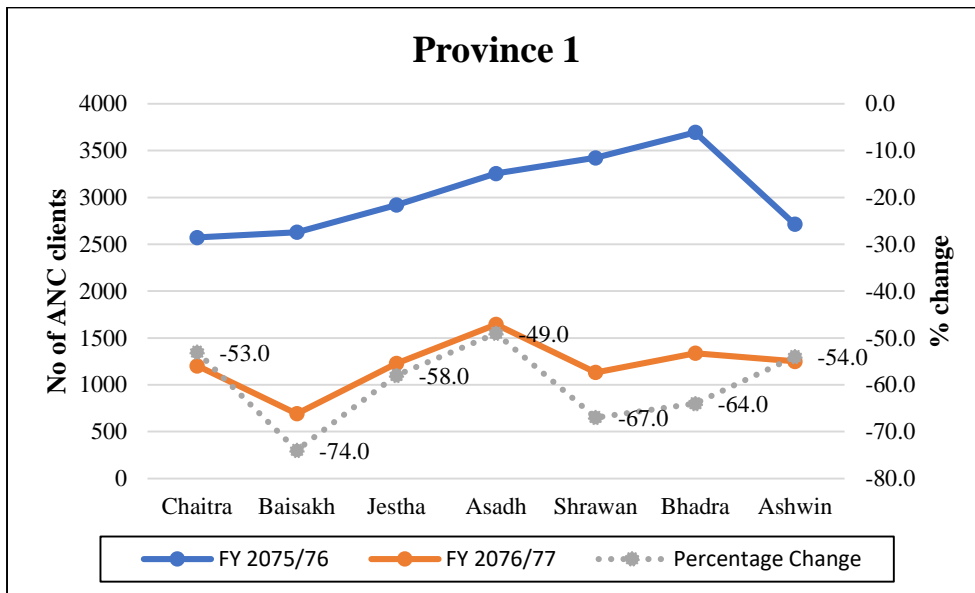
Annex 3.2: Facility wise extent of utilization of ANC during 5 months' lockdown period

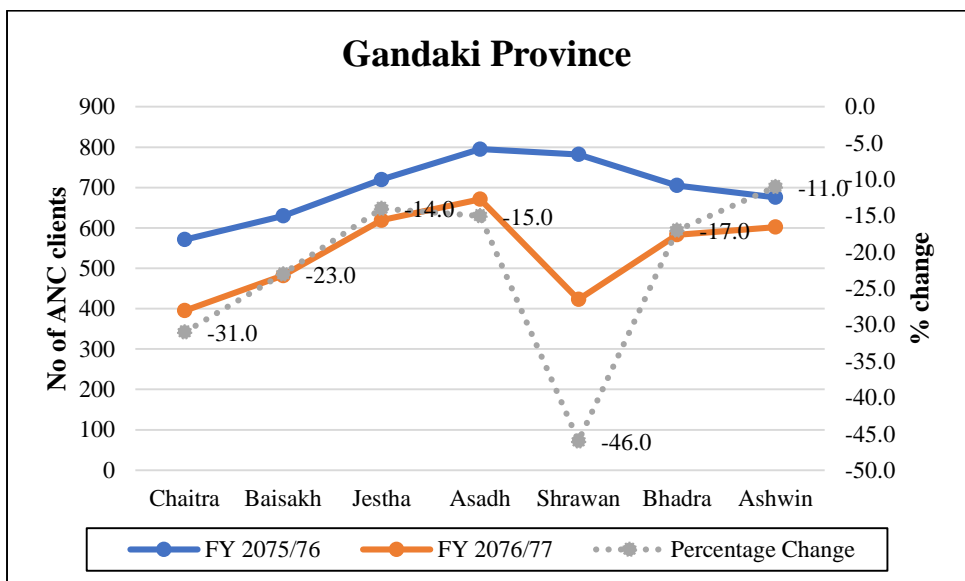
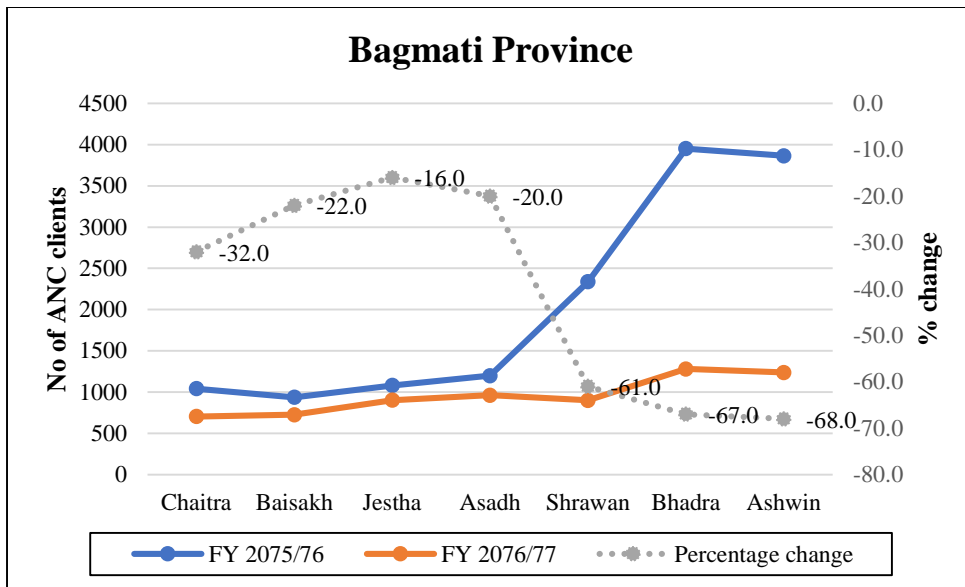


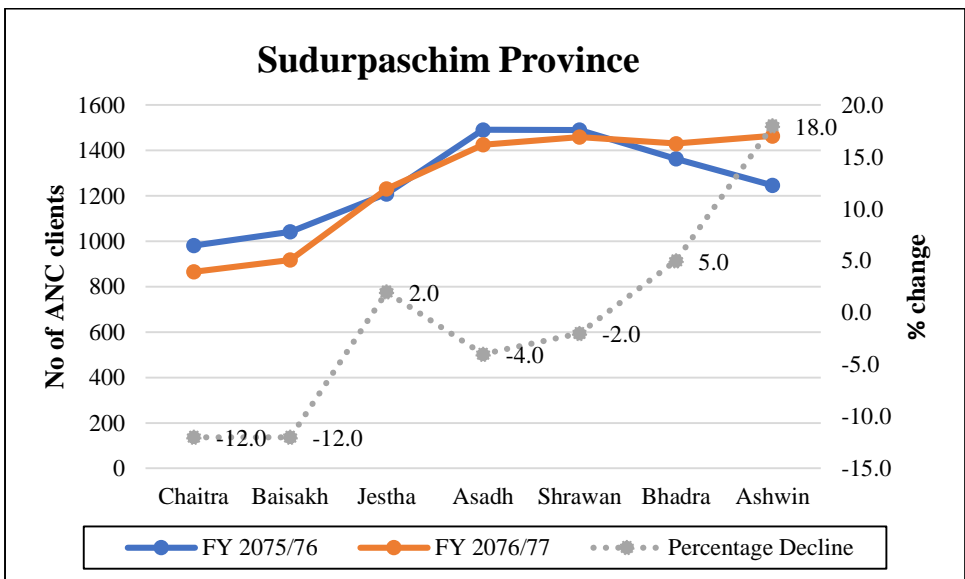
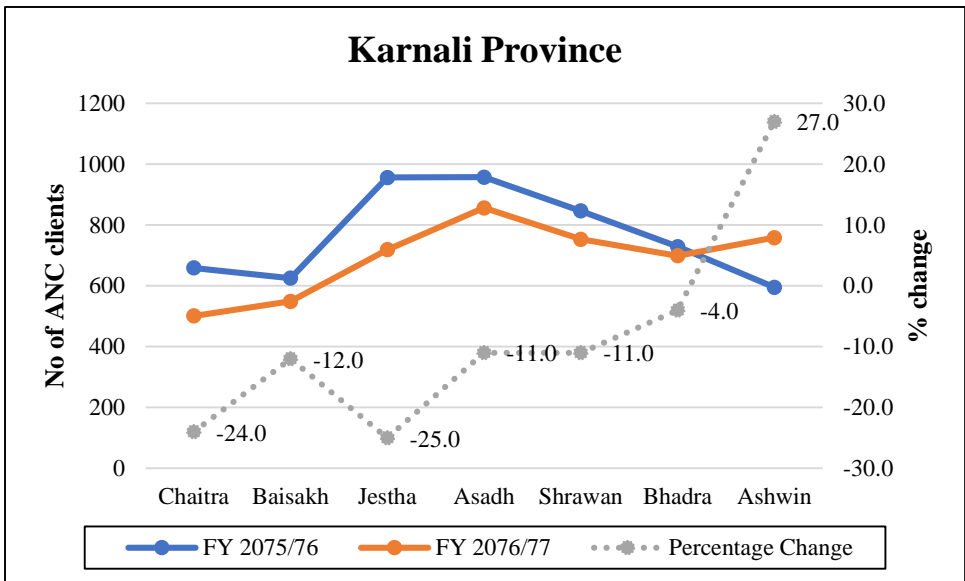
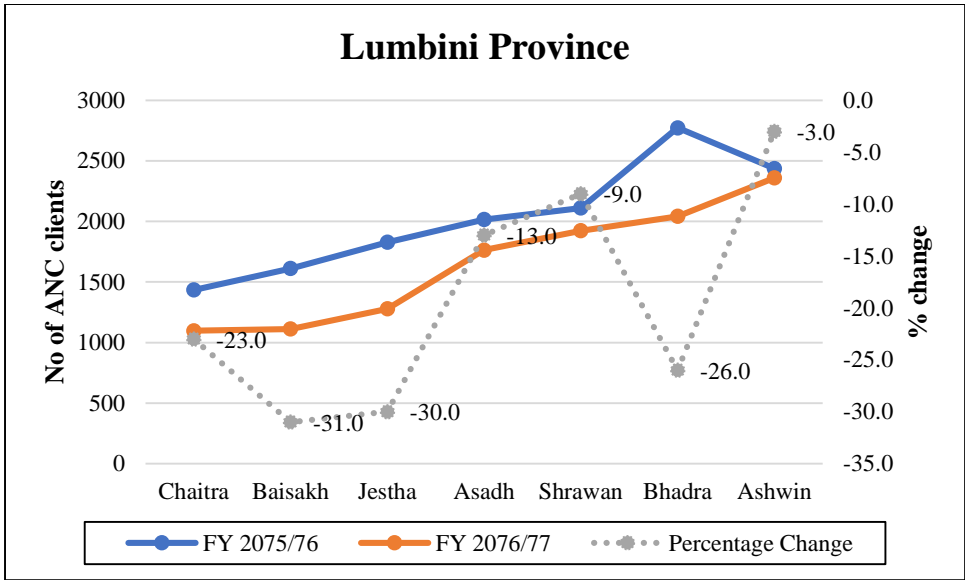
Annex 3.2a: Facility wise extent of utilization of ANC during during the period between Bhadra-Kartik



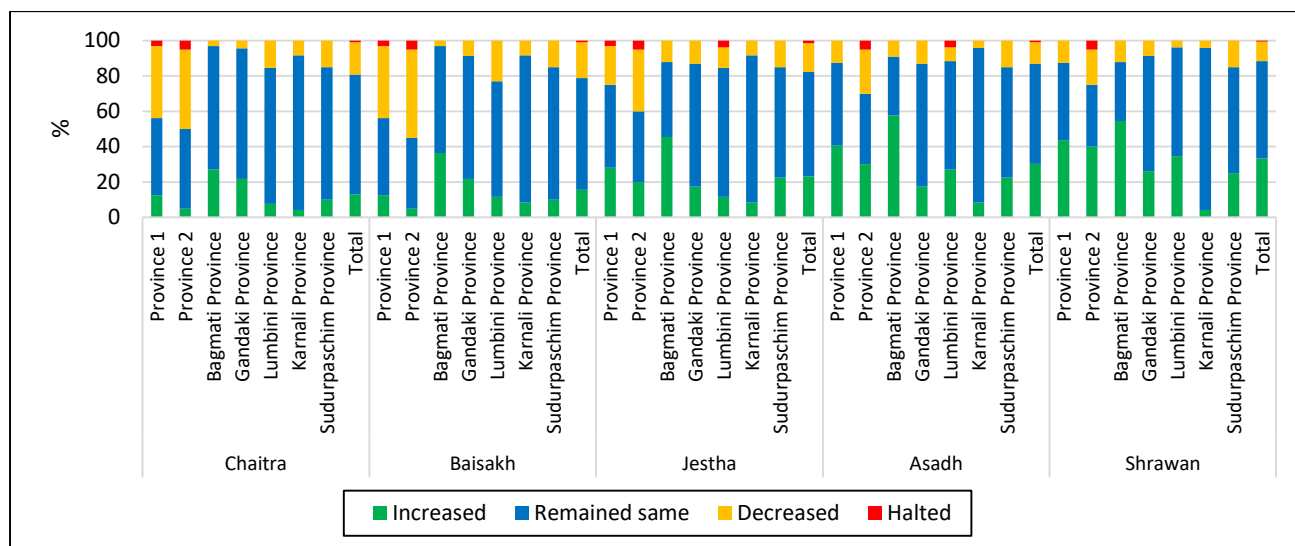
Annex 3.3: Percentage change in utilization of ANC services during COVID-19 pandemic period as compared to corresponding months of previous year



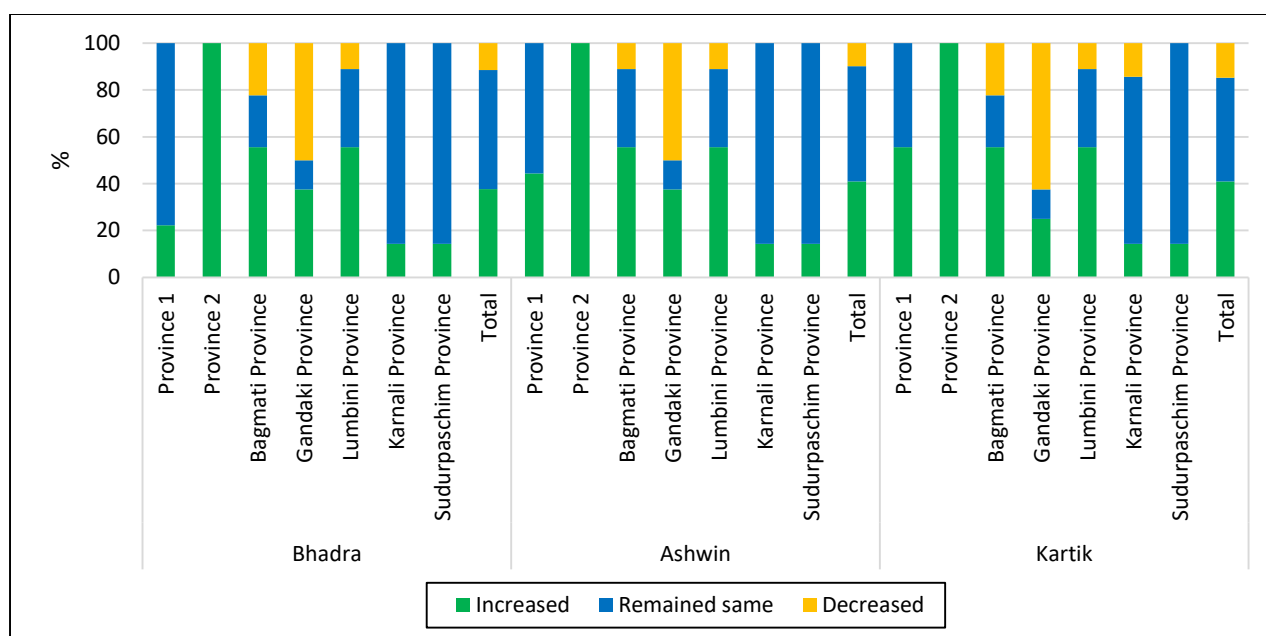




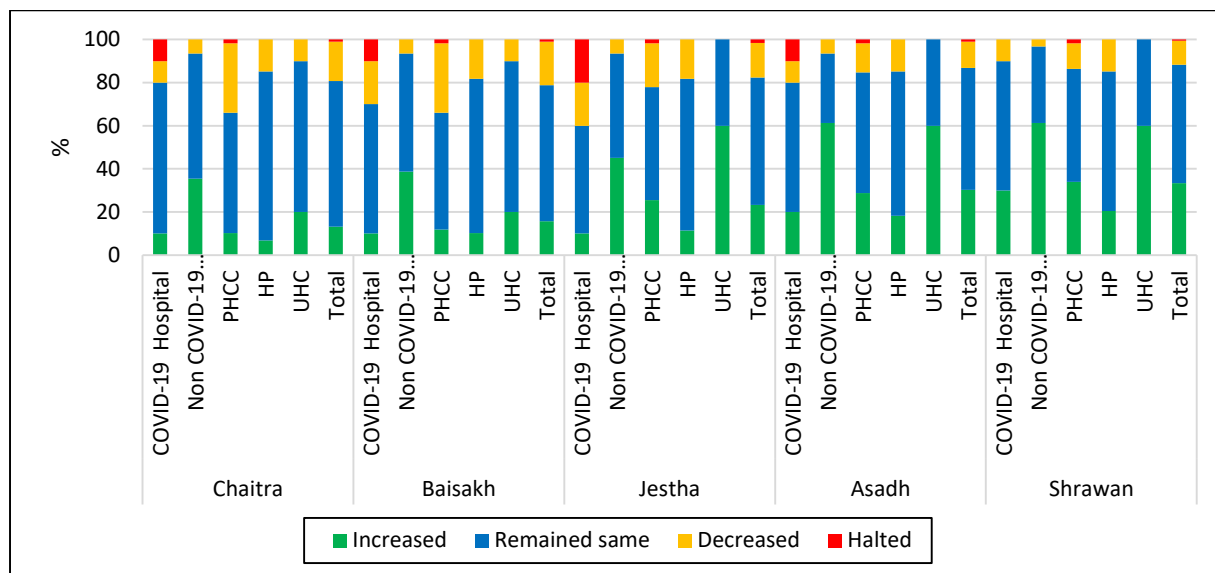
Annex 3.4: Province-wise extent of Utilization of Institutional Delivery services during the lockdown period



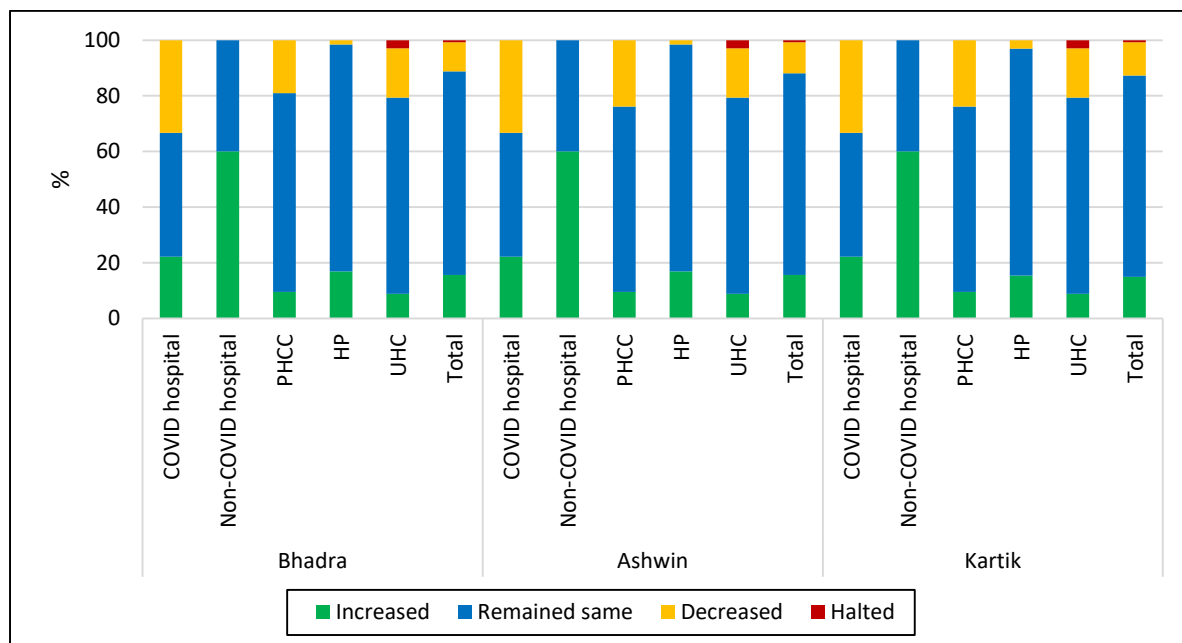
Annex 3.4a: Province-wise extent of Utilization of Institutional Delivery services during the period between Bhadra-Kartik



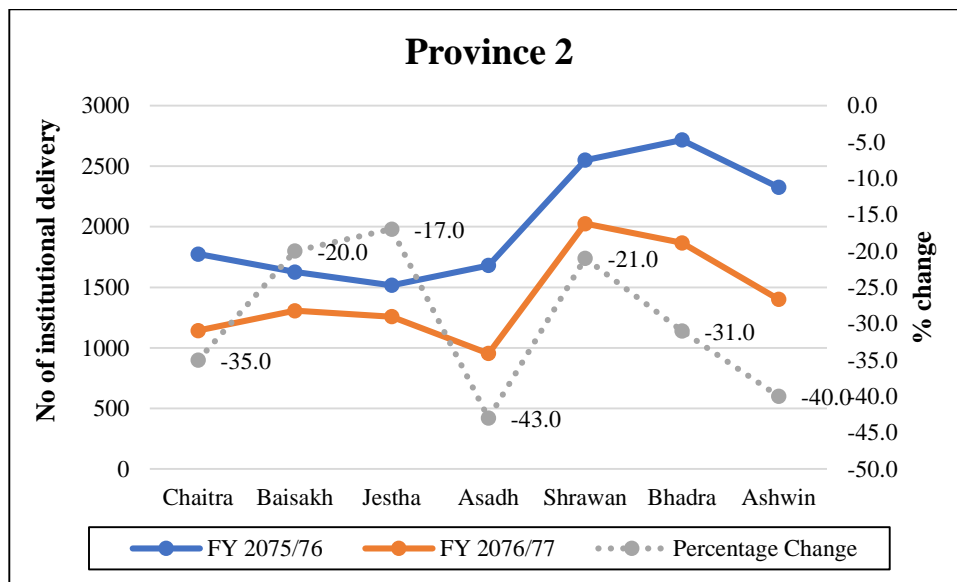
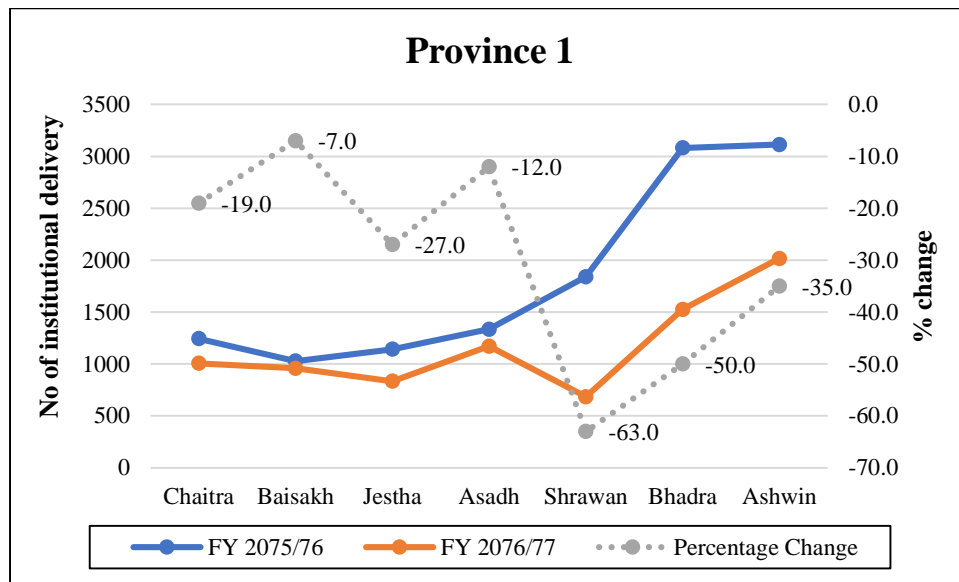
Annex 3.5: Health facility wise extent of Utilization of Institutional Delivery services during the lockdown period

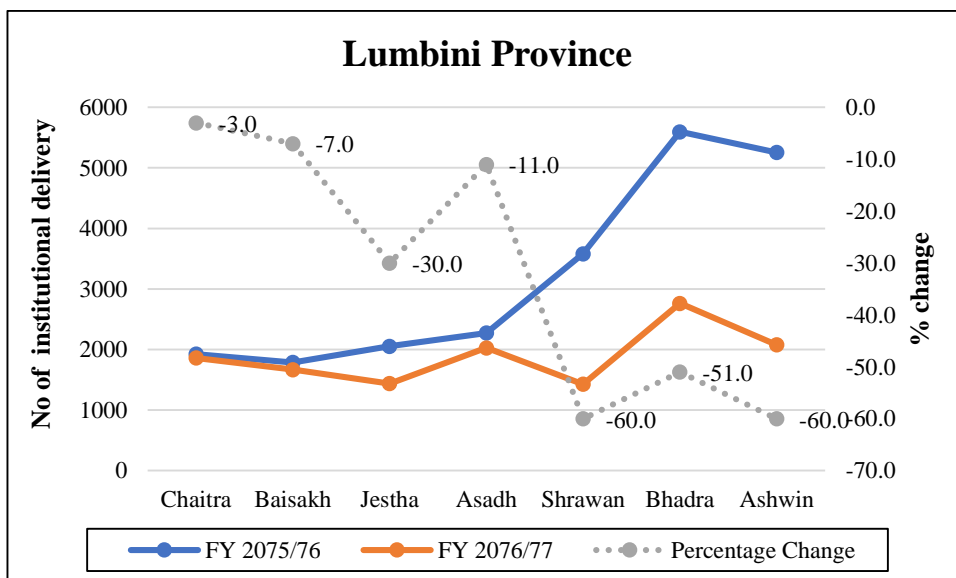
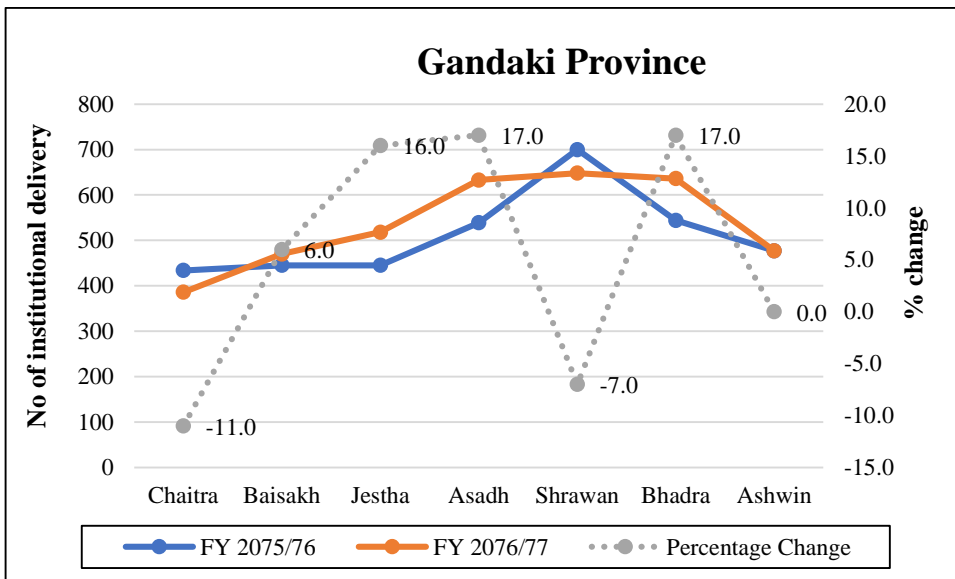
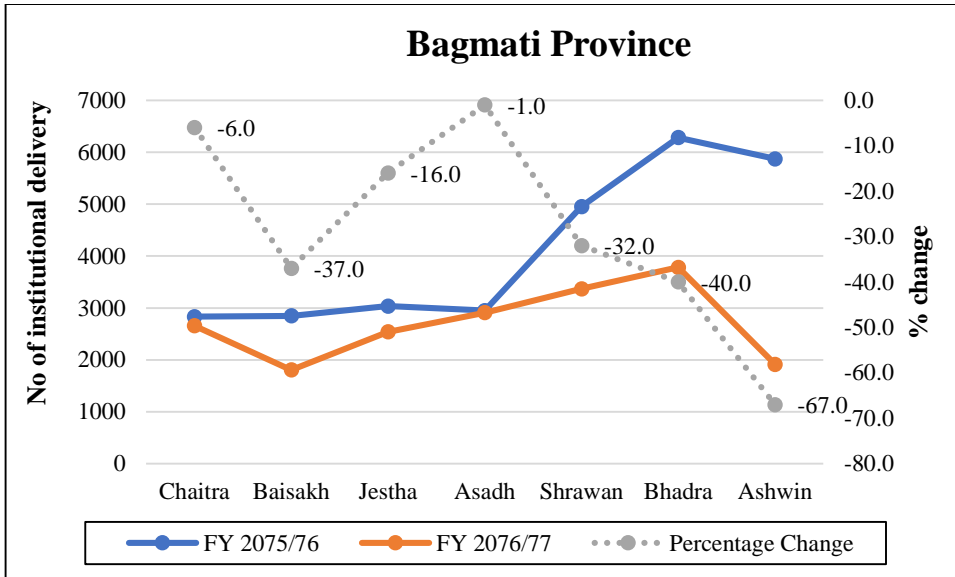


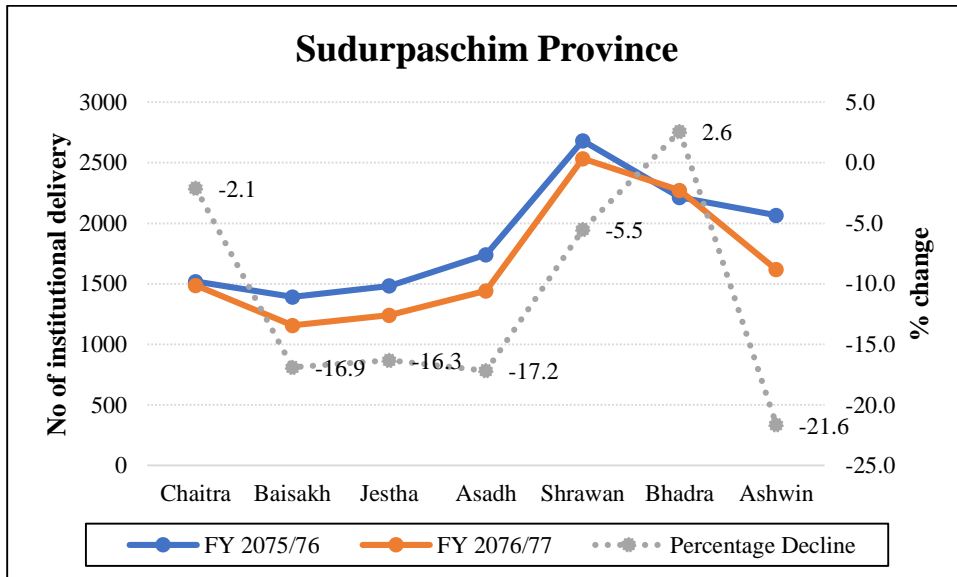
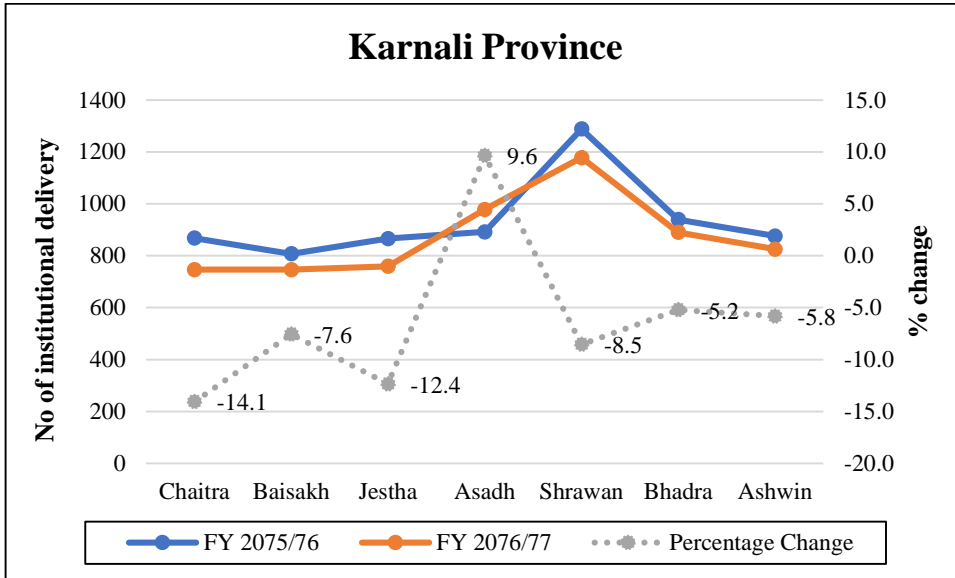
Annex 3.5a: Health facility wise extent of Utilization of Institutional Delivery services during the period between Bhadra-Kartik



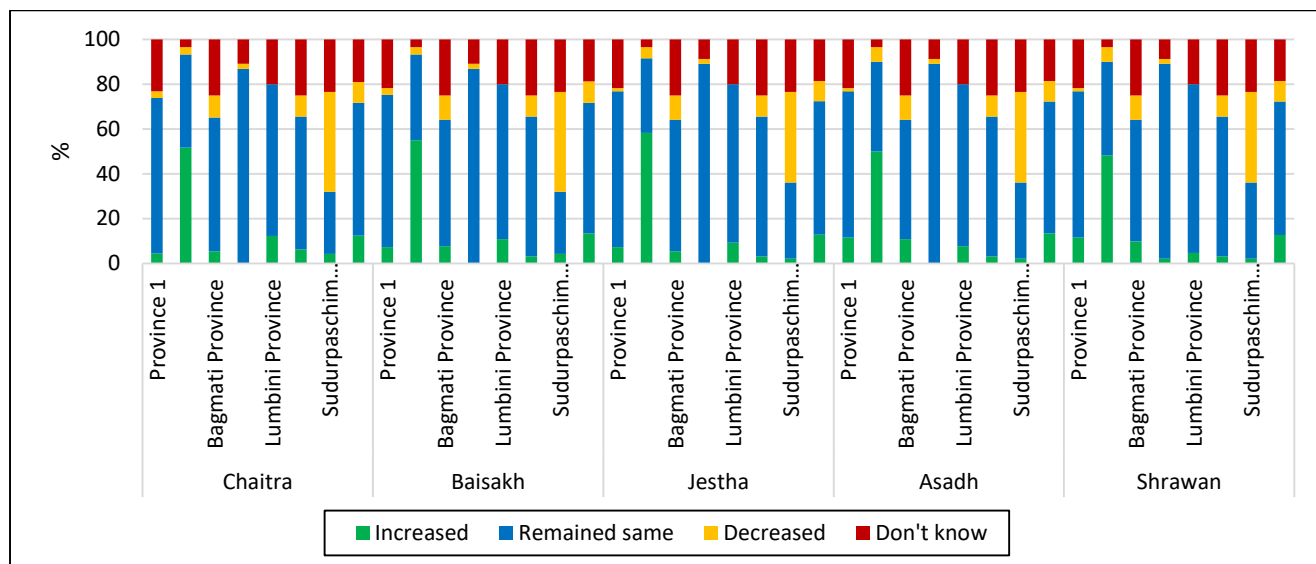
Annex 3.6: Percentage change in utilization of Institutional Delivery services during COVID-19 pandemic period as compared to corresponding months of previous year



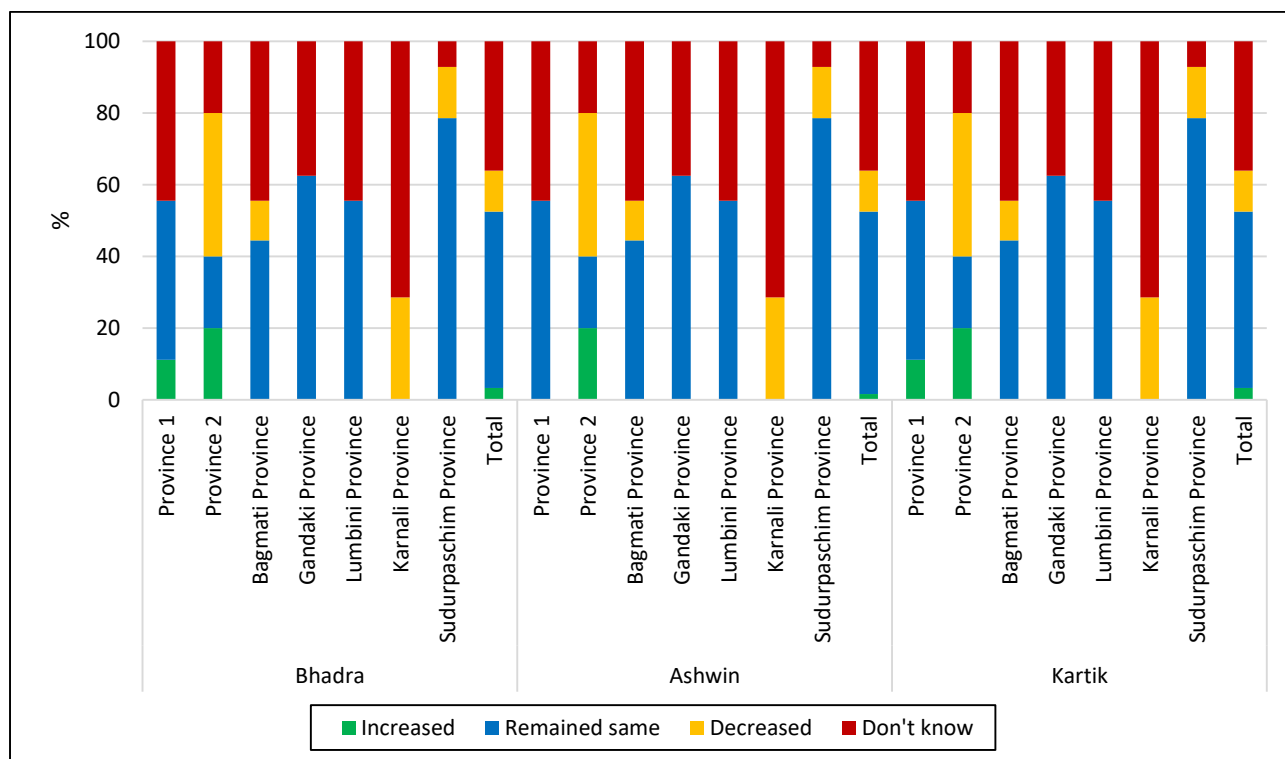




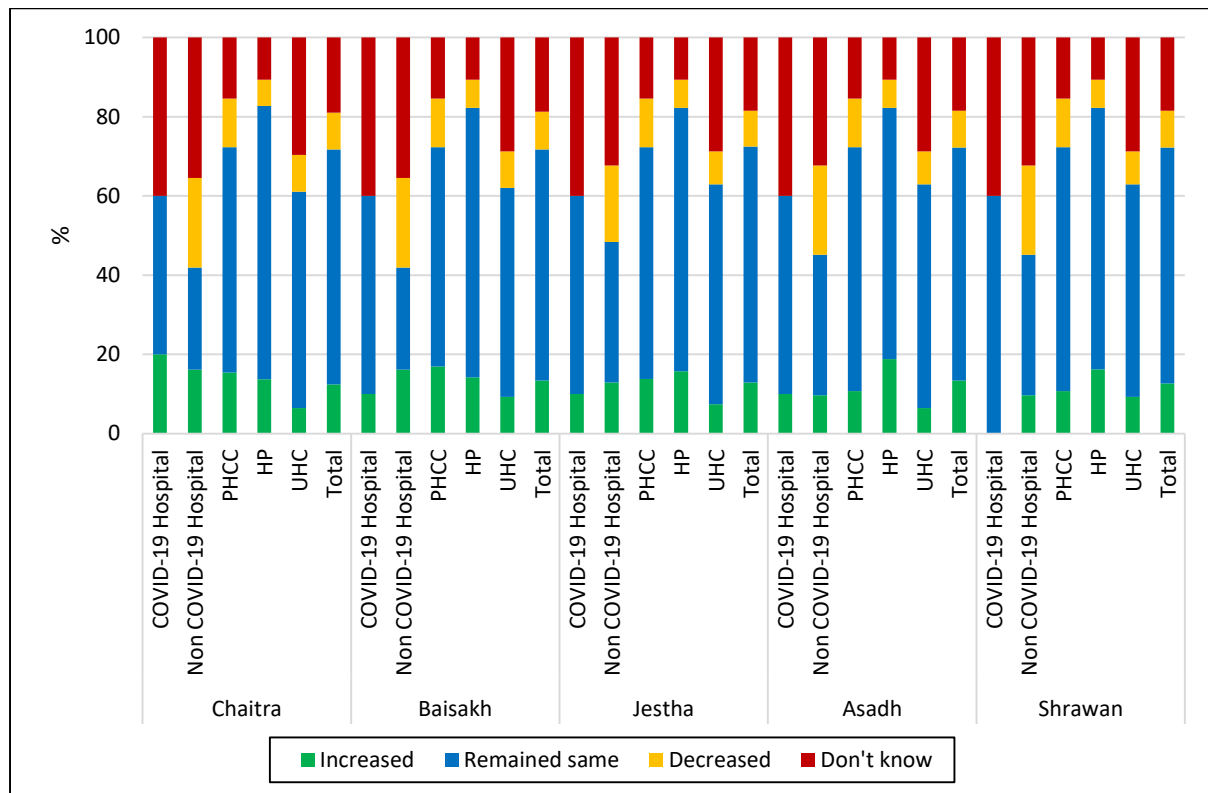
Annex 3.7: Province wise percentage reporting of home delivery during 5 months' lockdown period



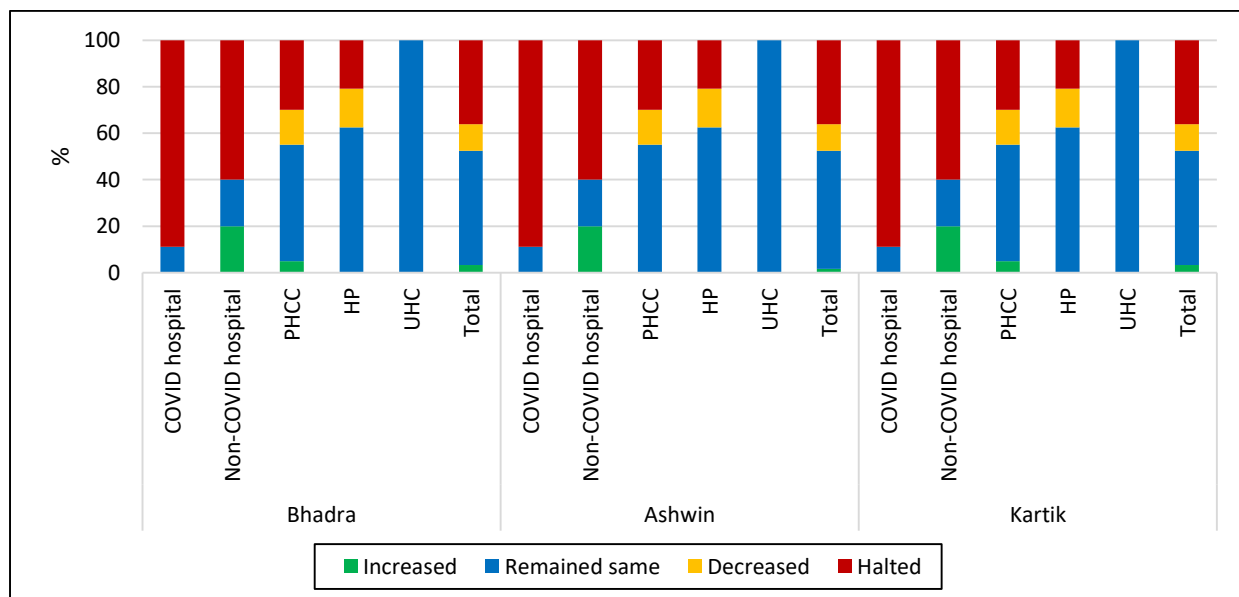
Annex 3.7a: Province wise percentage reporting of home delivery during during the period between Bhadra-Kartik



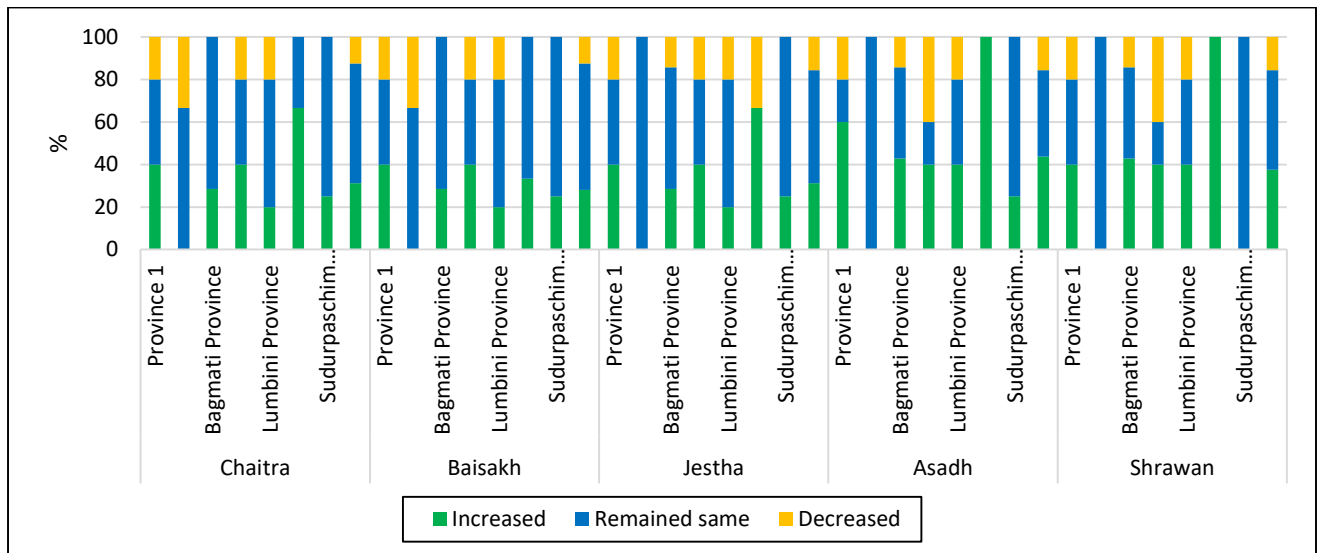
Annex 3.8: Health facility wise percentage reporting of home delivery during 5 months' lockdown period



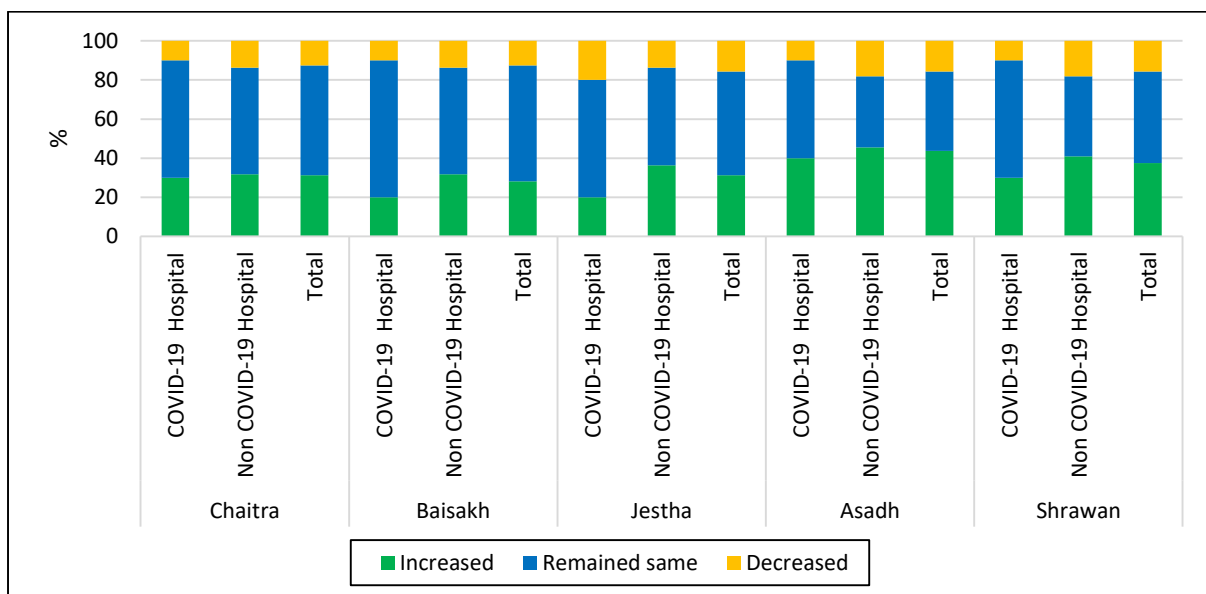
Annex 3.8a: Health facility wise percentage reporting of home delivery during during the period between Bhadra-Kartik



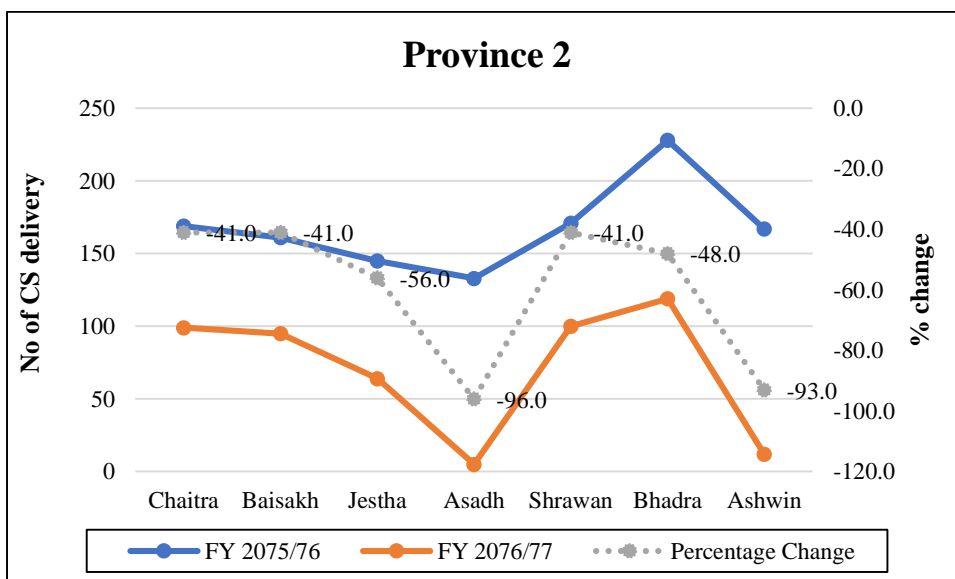
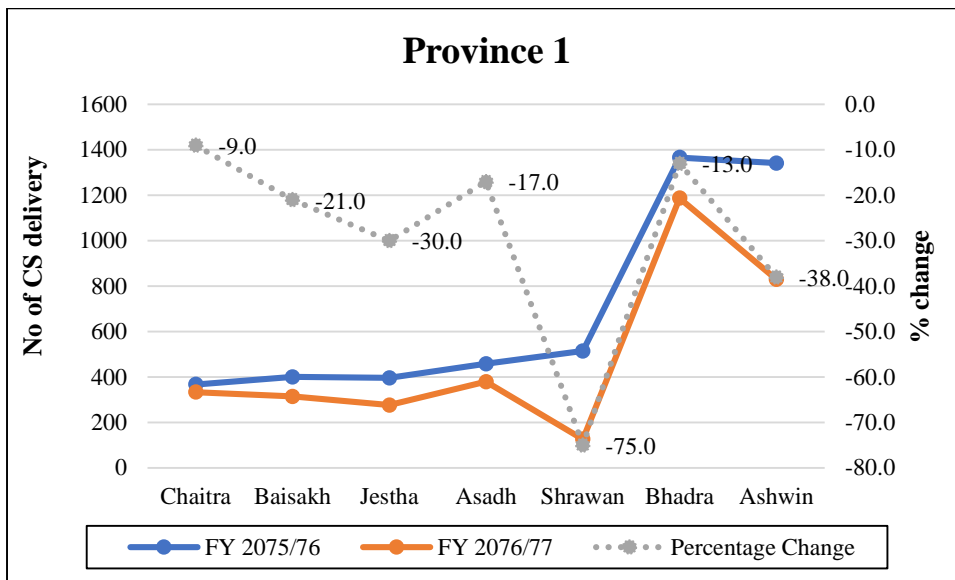
Annex 3.9: Province-wise extent of Utilization of C Section during 5 months' lockdown period

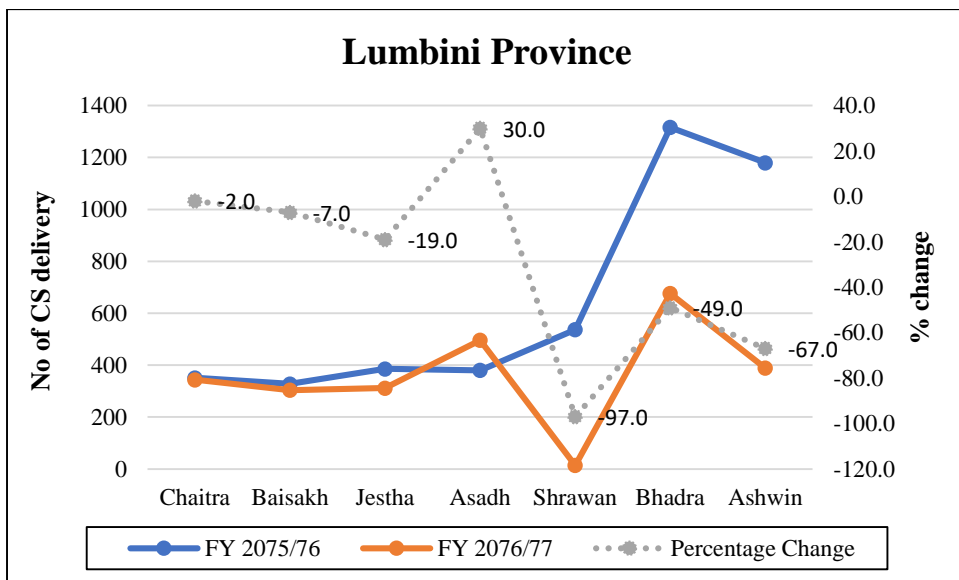
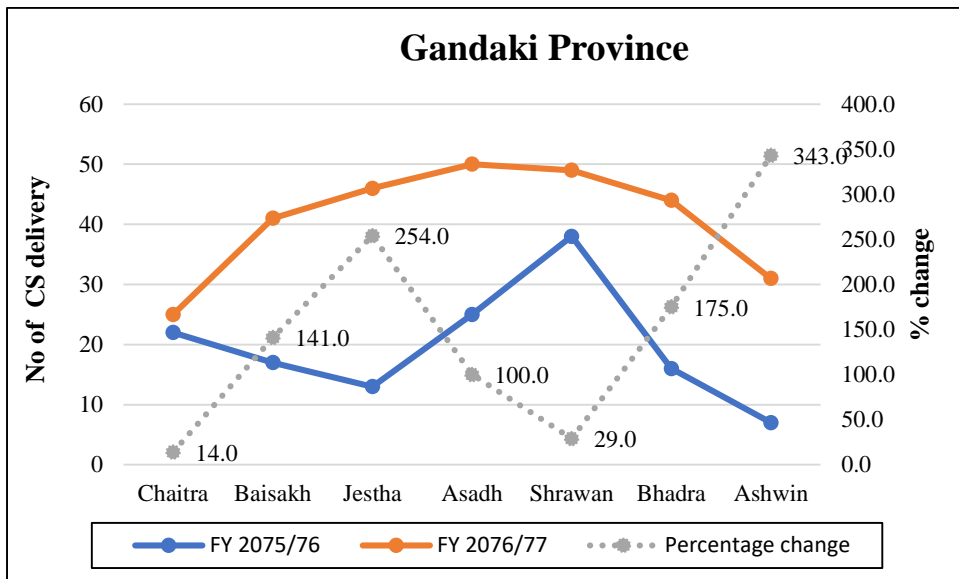
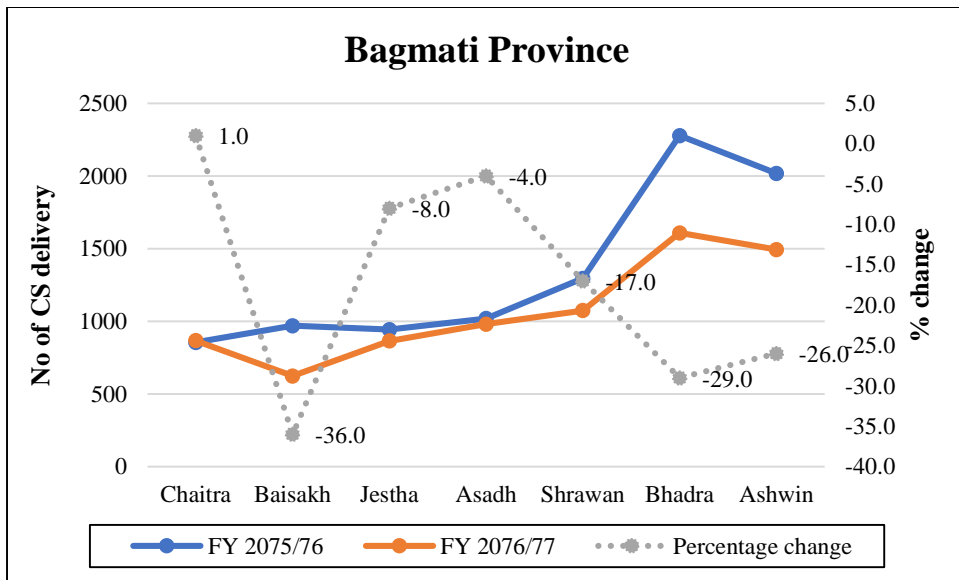


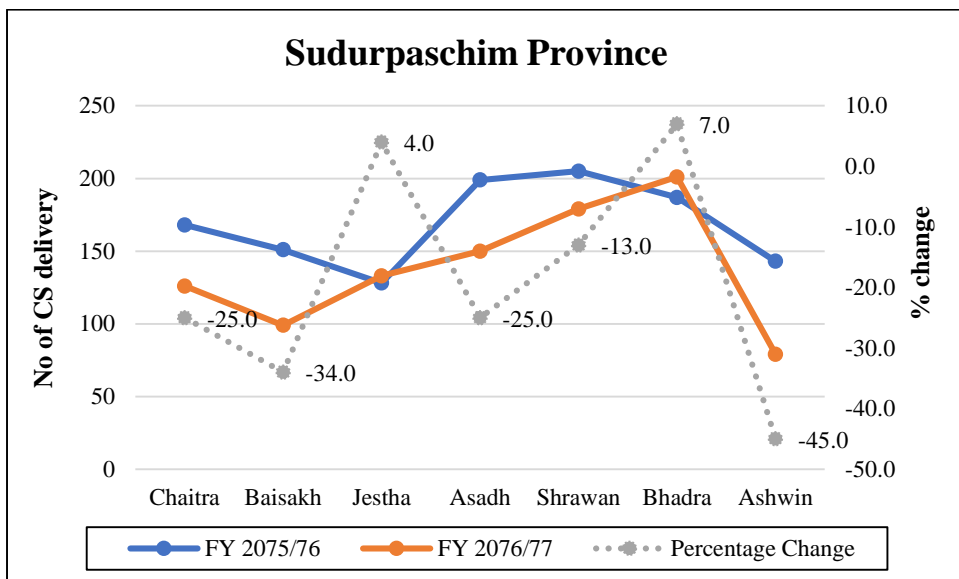
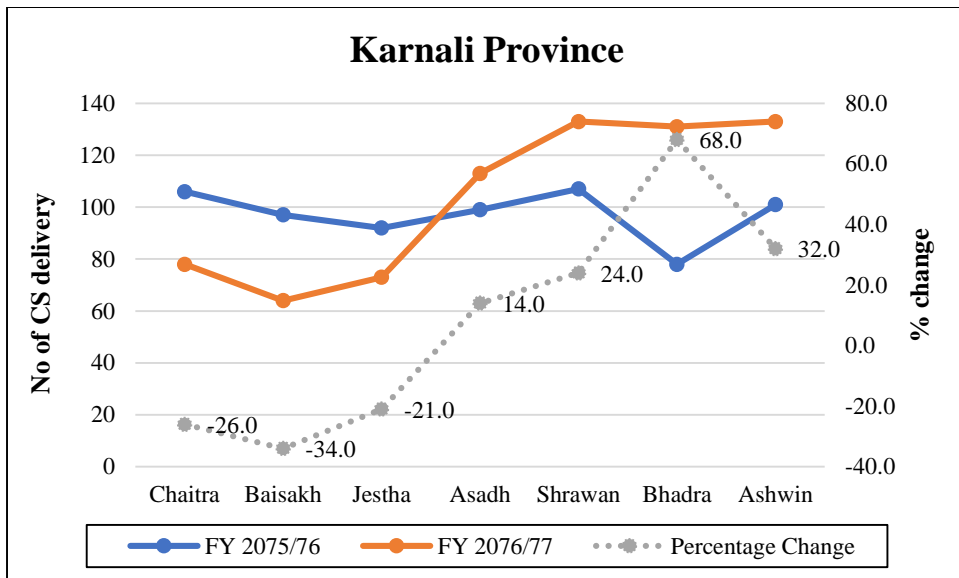
Annex 3.10: Health facility wise extent of Utilization of C Section during 5 months' lockdown period



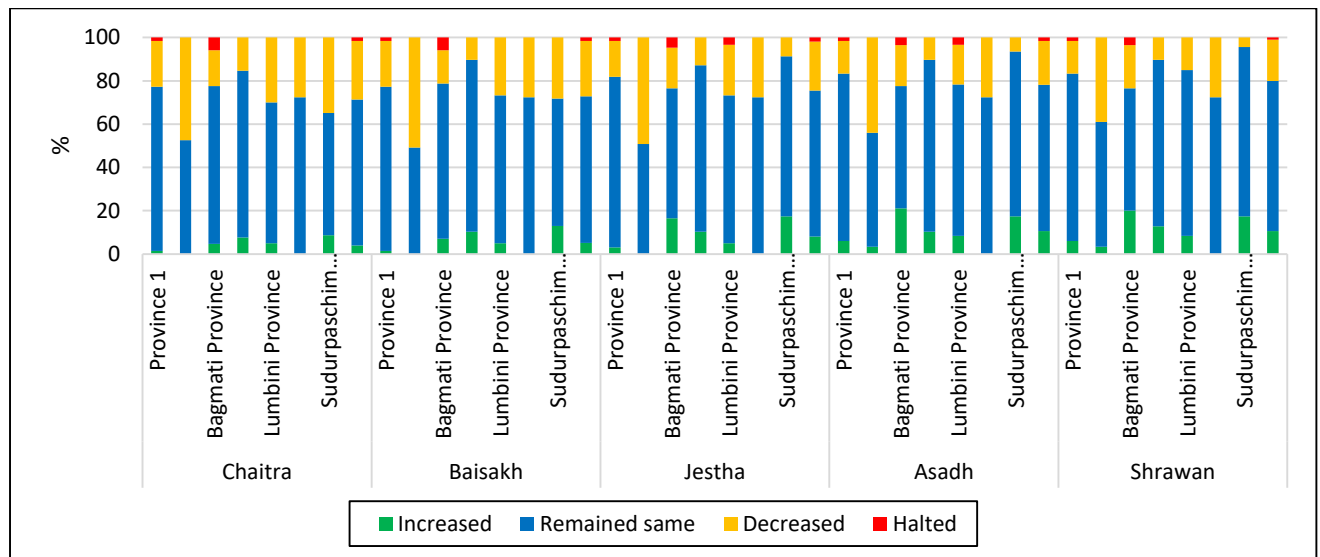
Annex 3.11: Percentage change in utilization of Caesarean Section services during COVID-19 pandemic period as compared to corresponding months of previous year



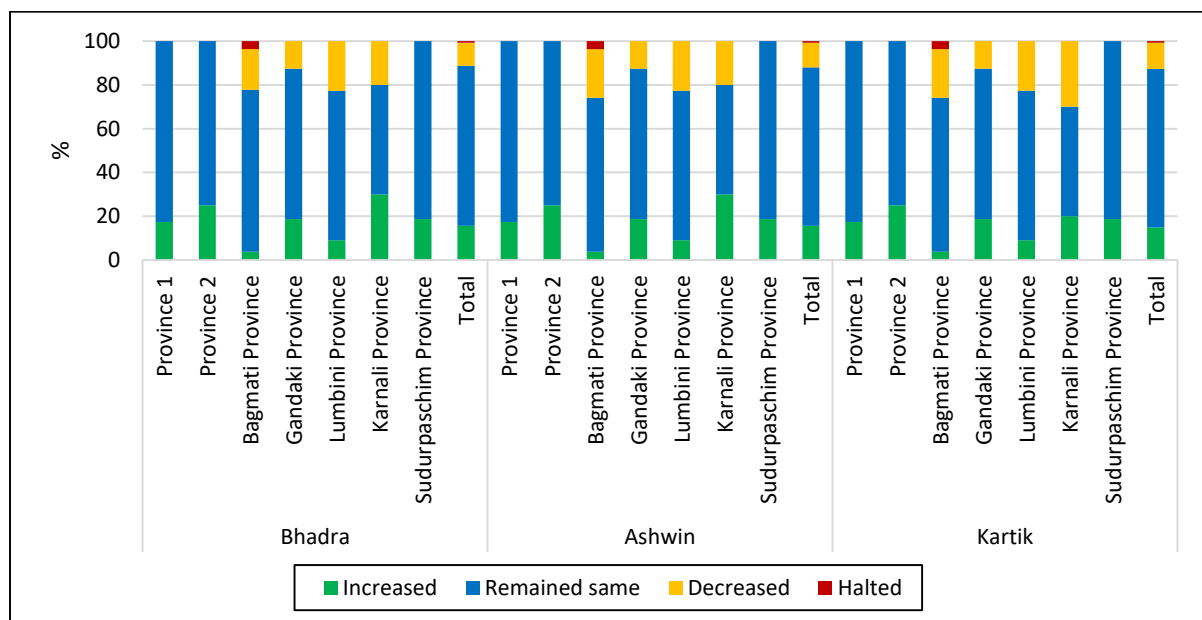




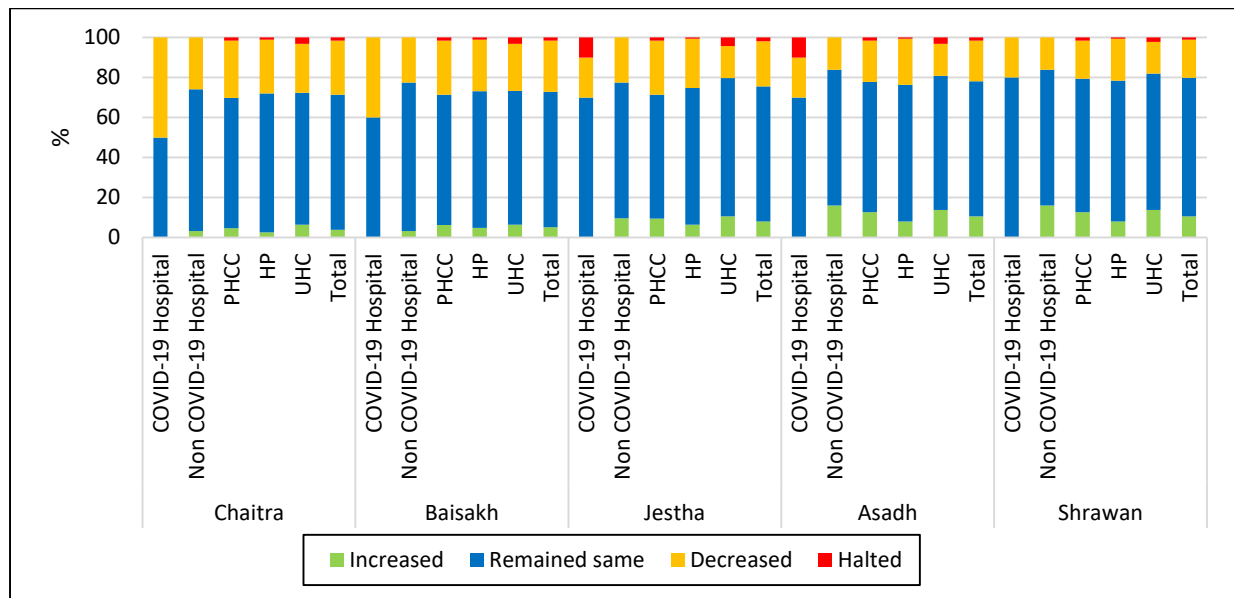
Annex 3.12: Province-wise extent of utilization of PNC services during the 5 months' lockdown period



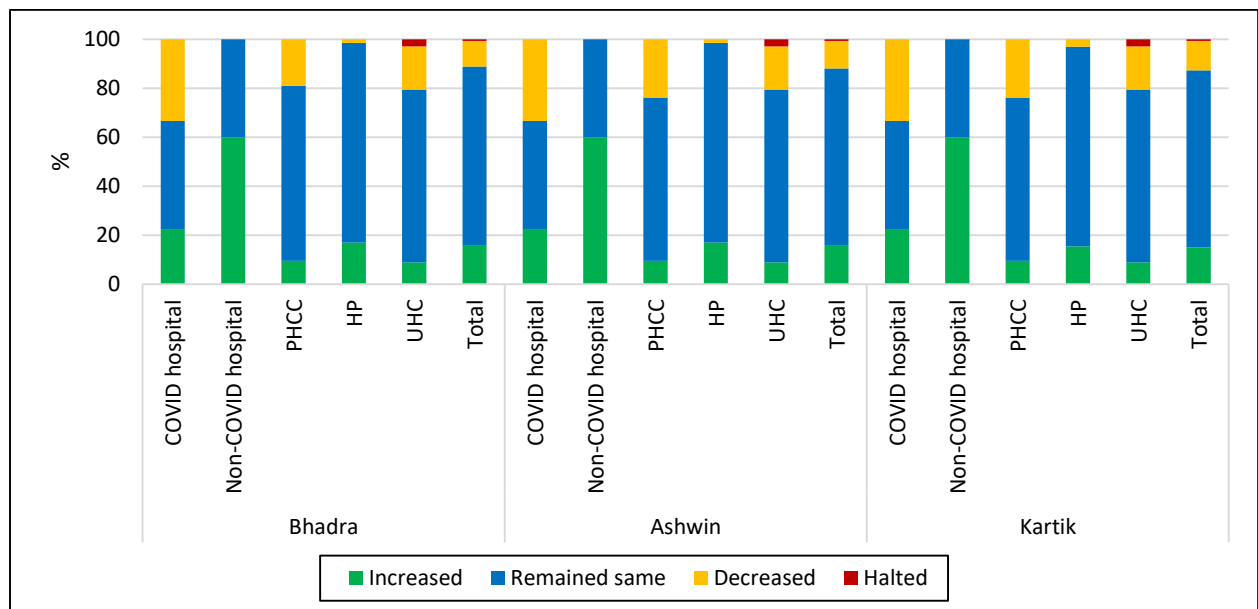
Annex 3.12a: Province-wise extent of utilization of PNC services during the period between Bhadra-Kartik



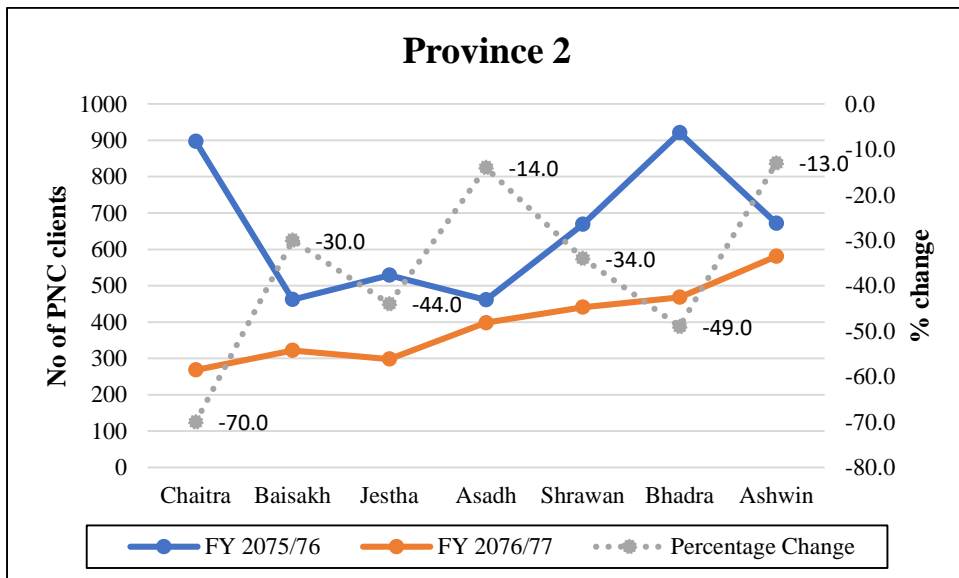
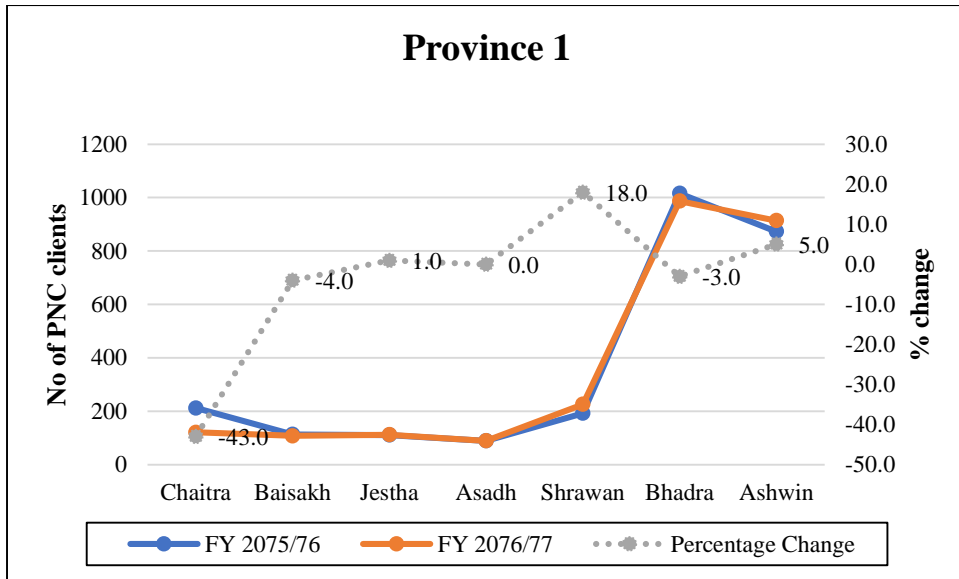
Annex 3.13: Health facility wise extent of utilization of PNC services during the 5 months' lockdown period

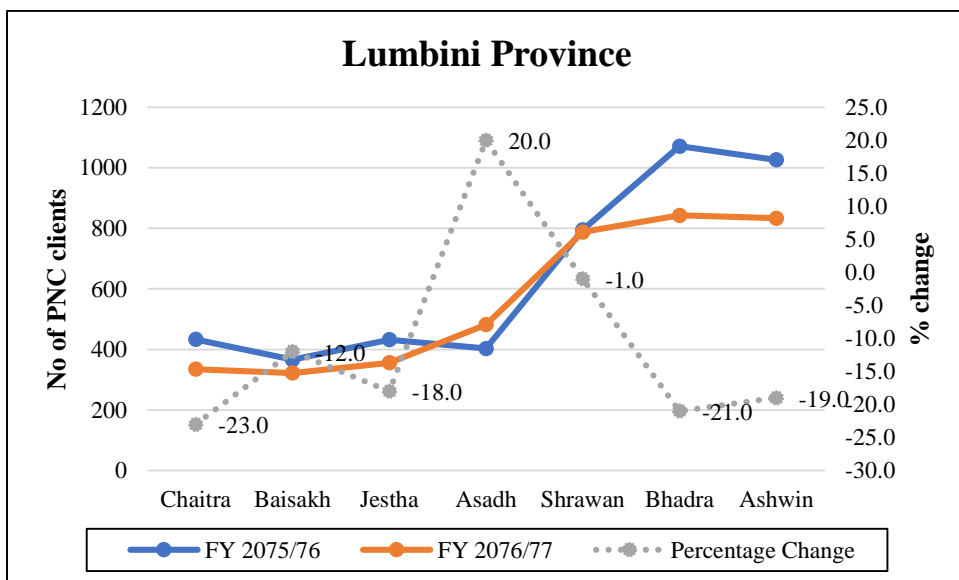
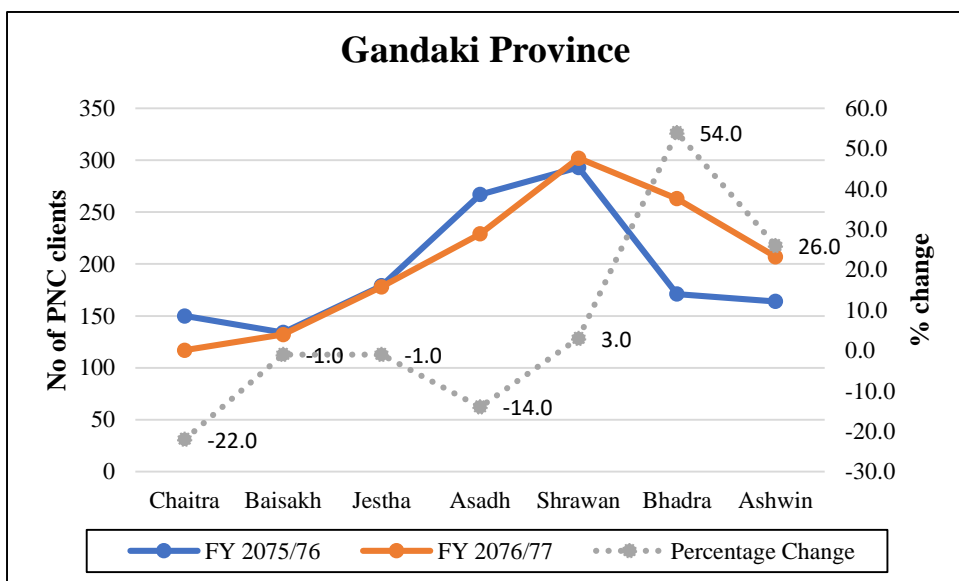
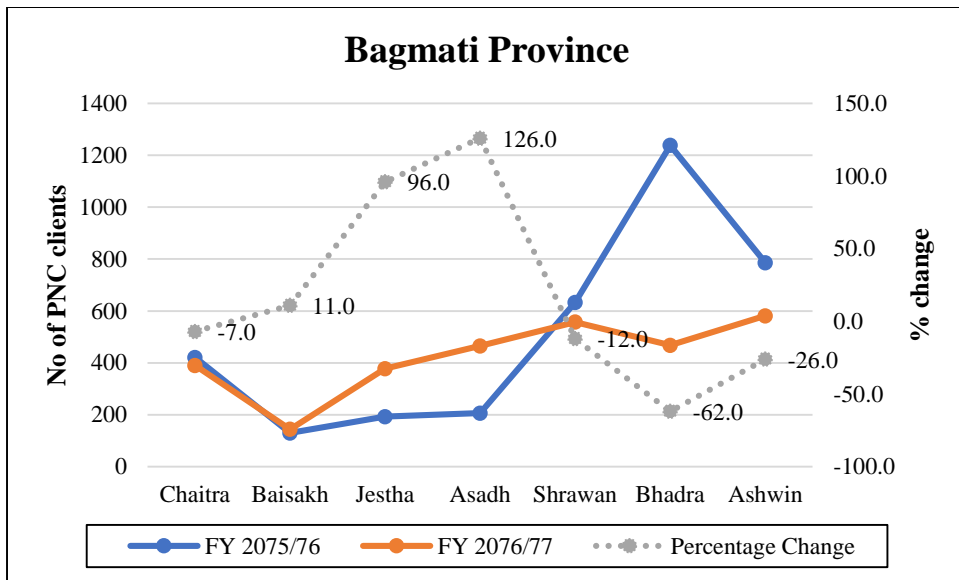


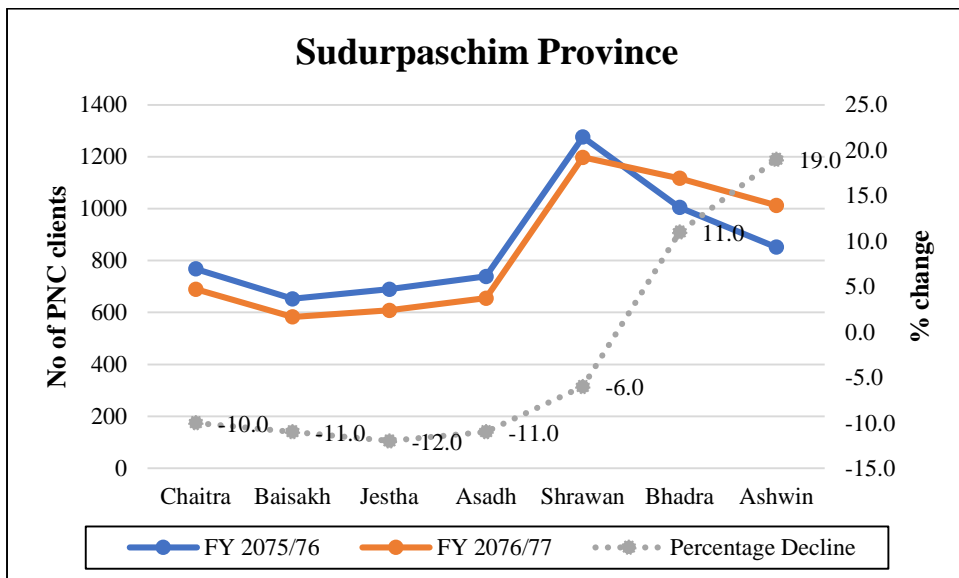
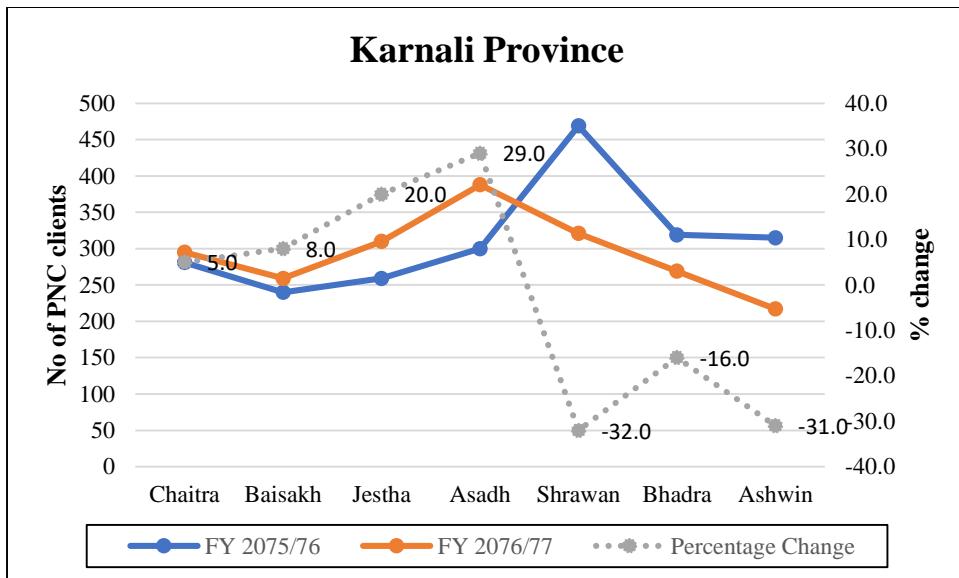
Annex 3.13a: Health facility wise extent of utilization of PNC services during the period between Bhadra-Kartik



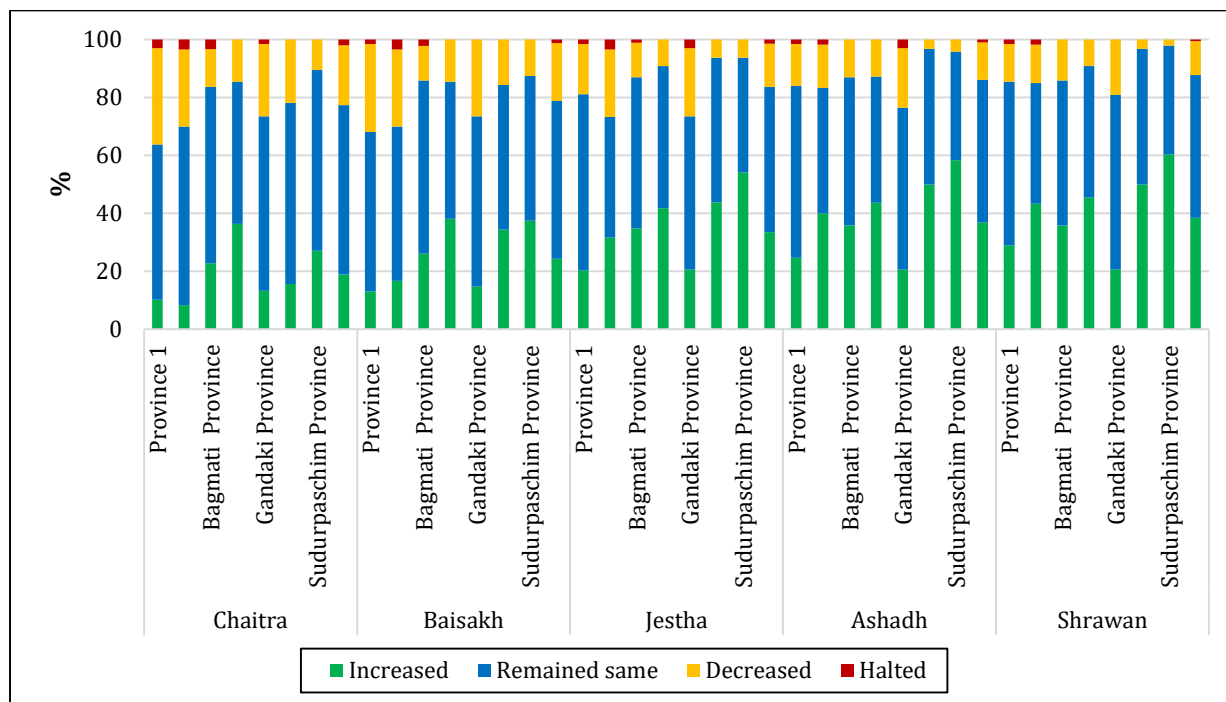
Annex 3.14: Percentage change in utilization of PNC services during COVID-19 pandemic period as compared to corresponding months of previous year



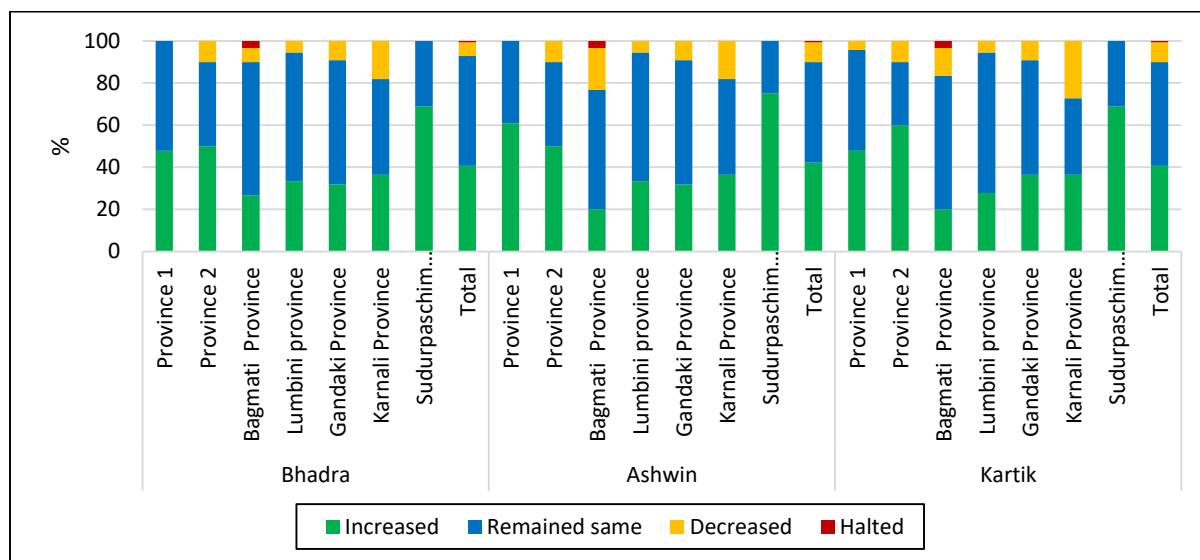




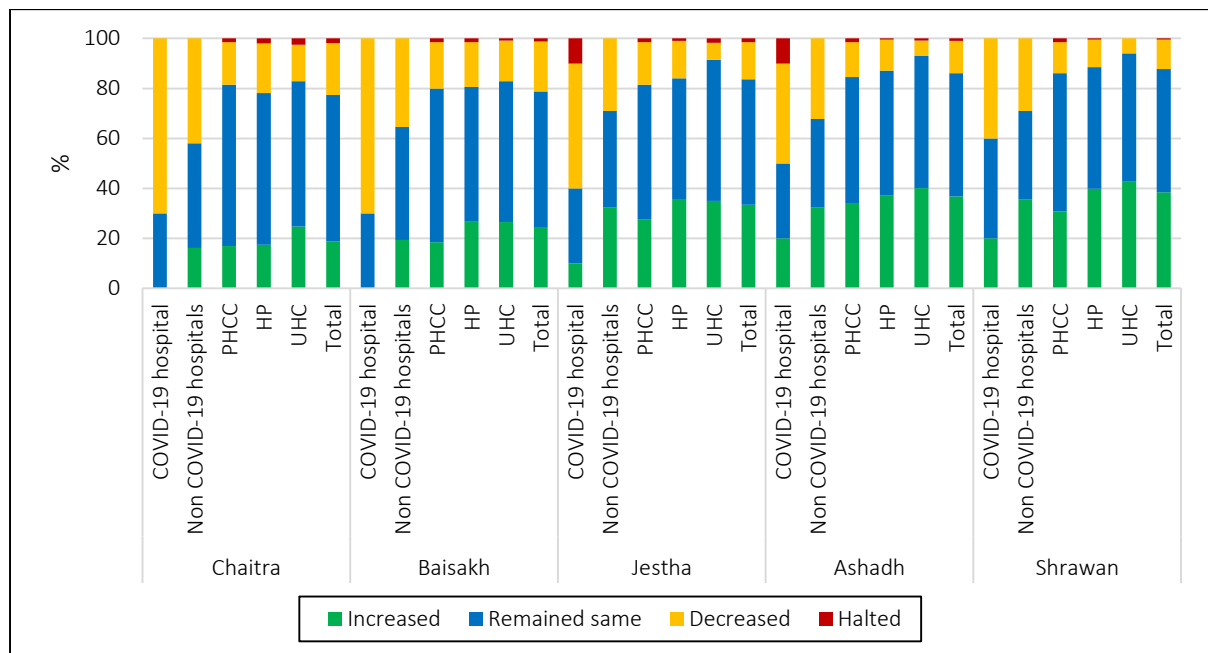
Annex 4.1 Flow of family planning new clients during the 5 months of lockdown period by province



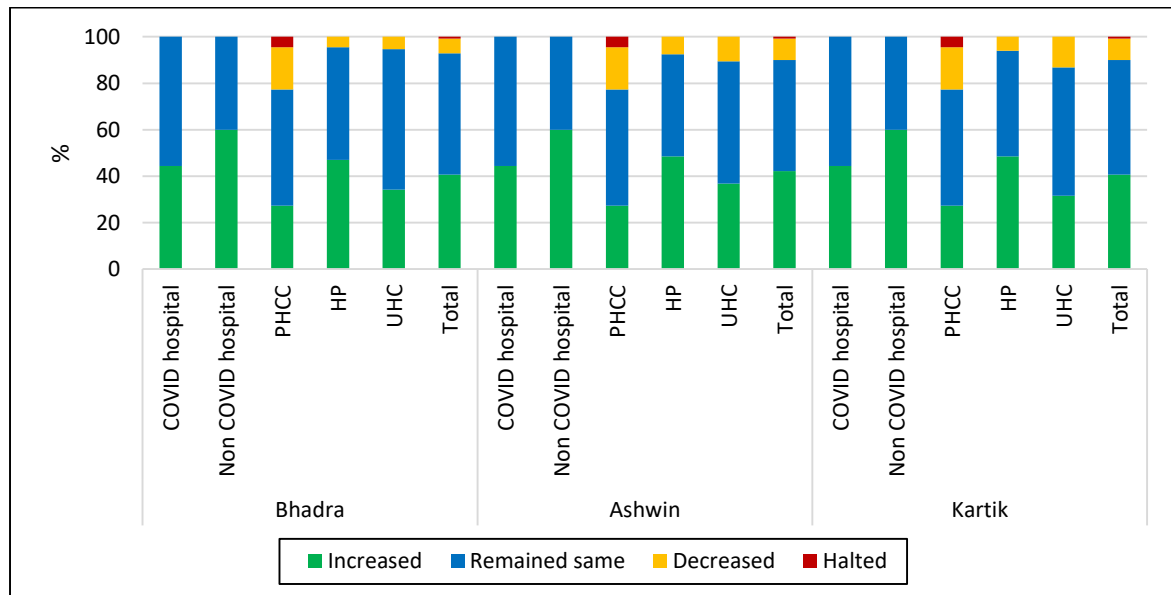
Annex 4.1a Flow of family planning new clients during the during the period between Bhadra-Kartik by province



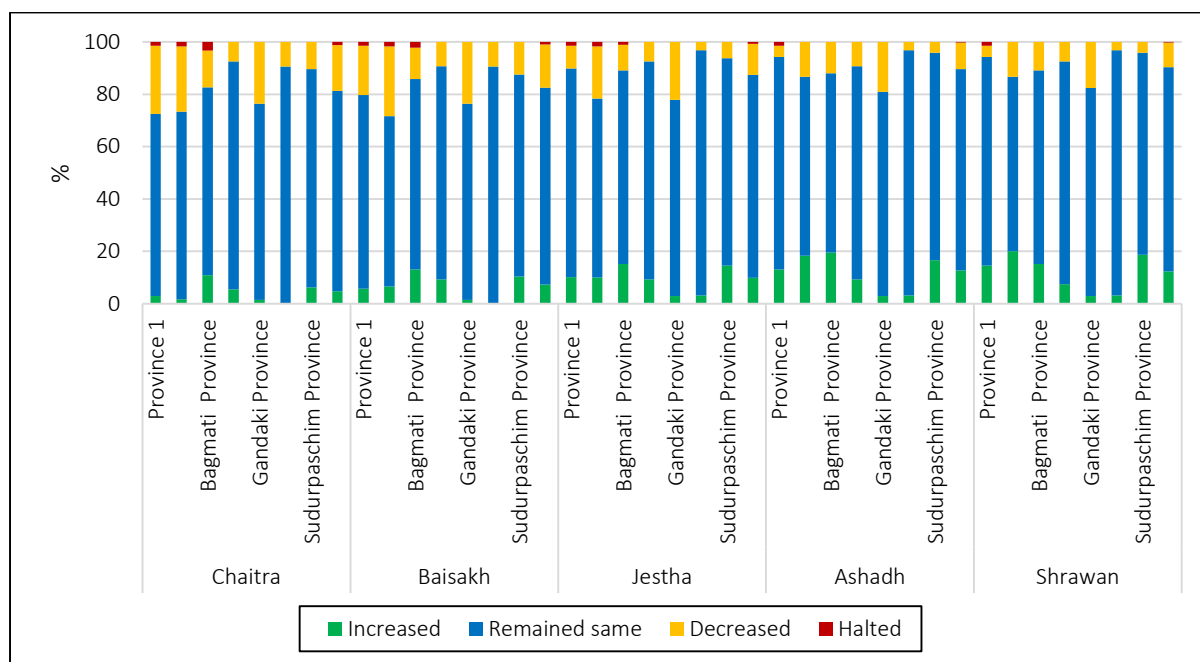
Annex 4.2 Flow of family planning new clients during the 5 months of lockdown period by types of HFs



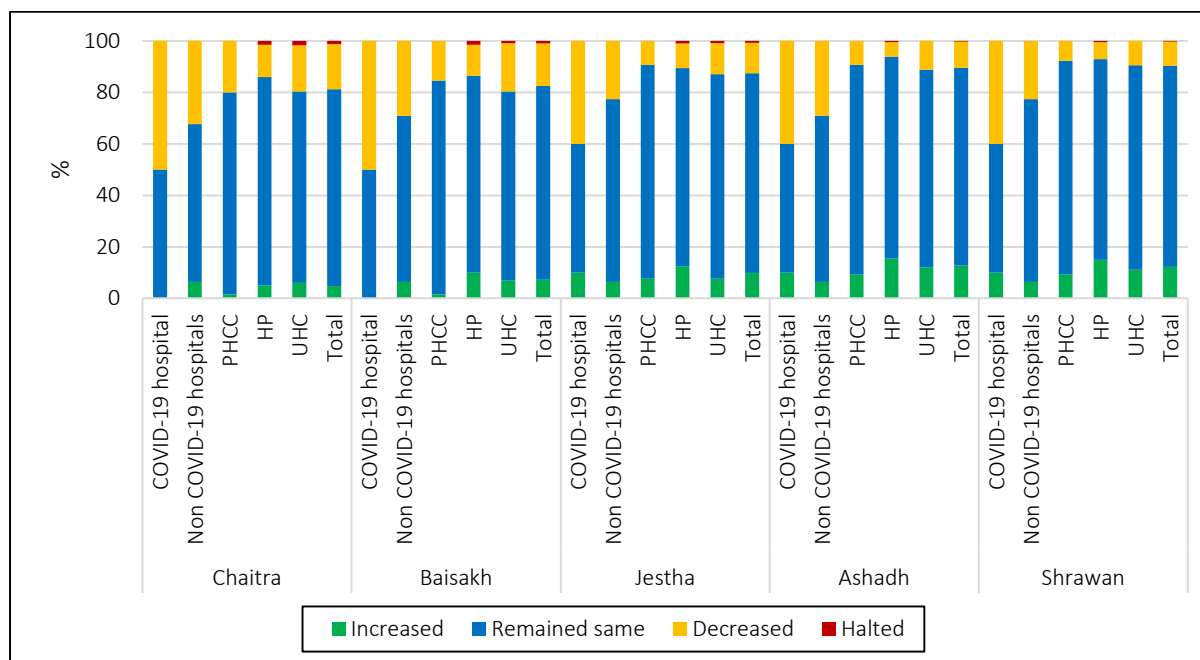
Annex 4.2a Flow of family planning new clients during the period between Bhadra-Kartik



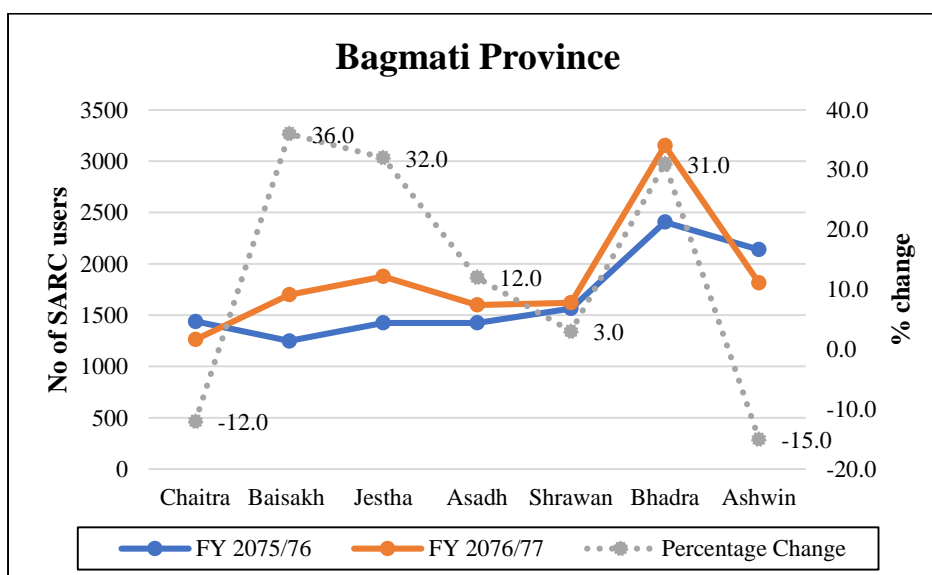
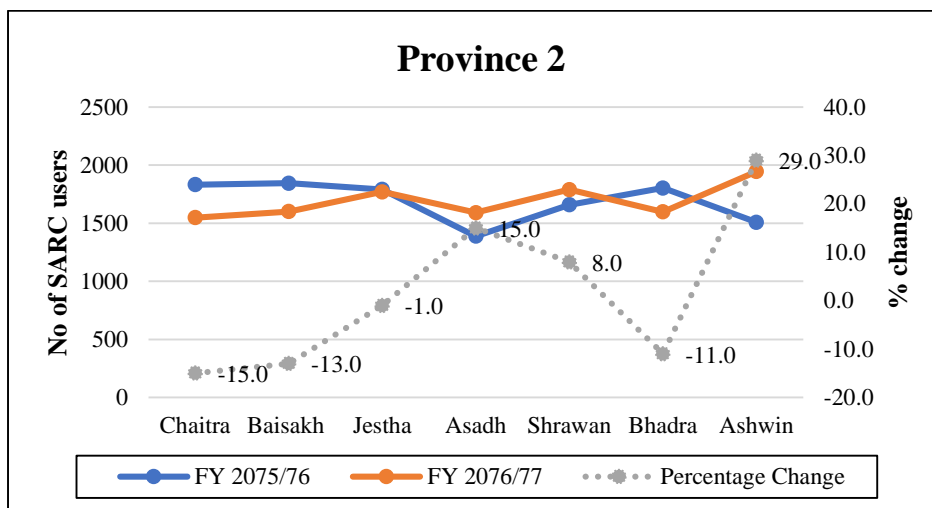
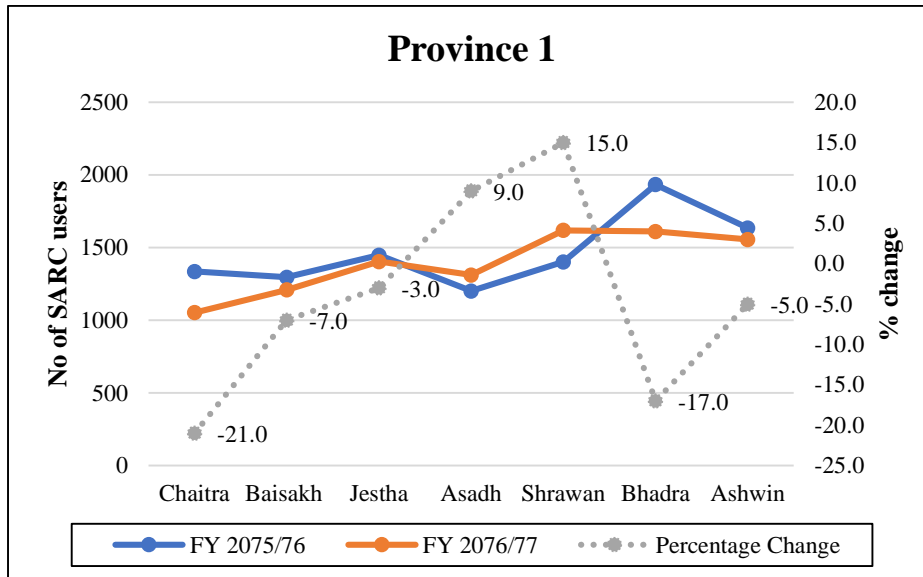
Annex 4.3 Provider's perception on flow of FP follow-up clients by province

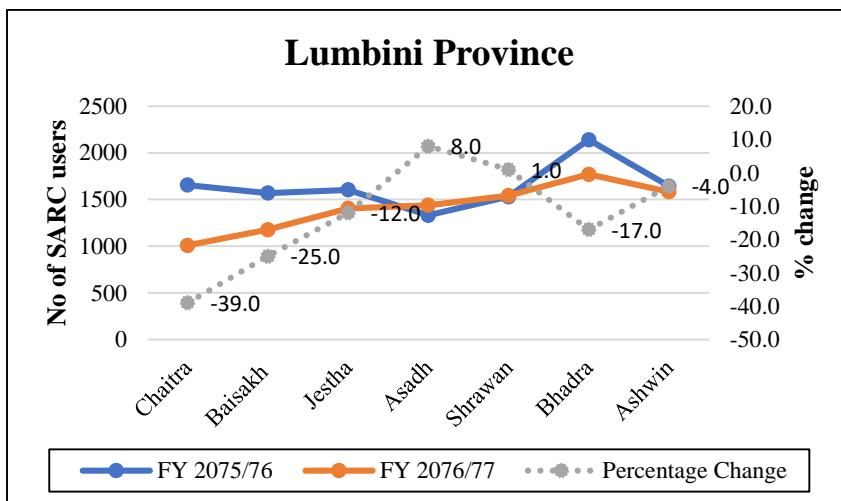
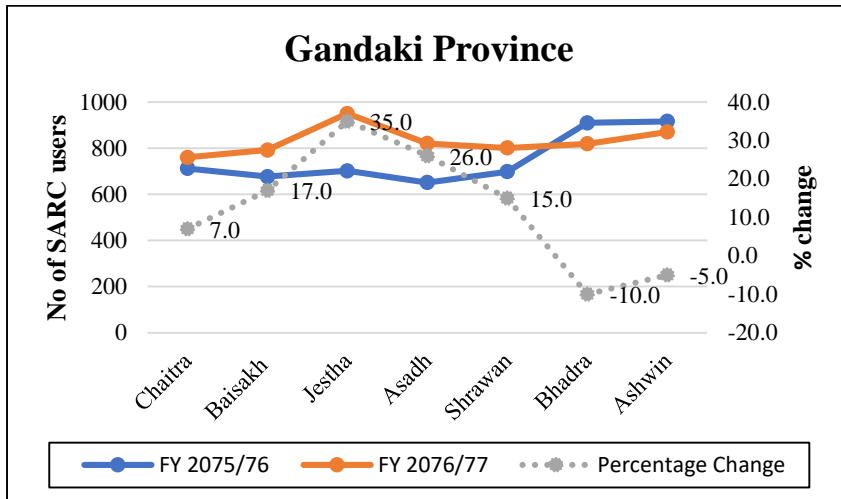


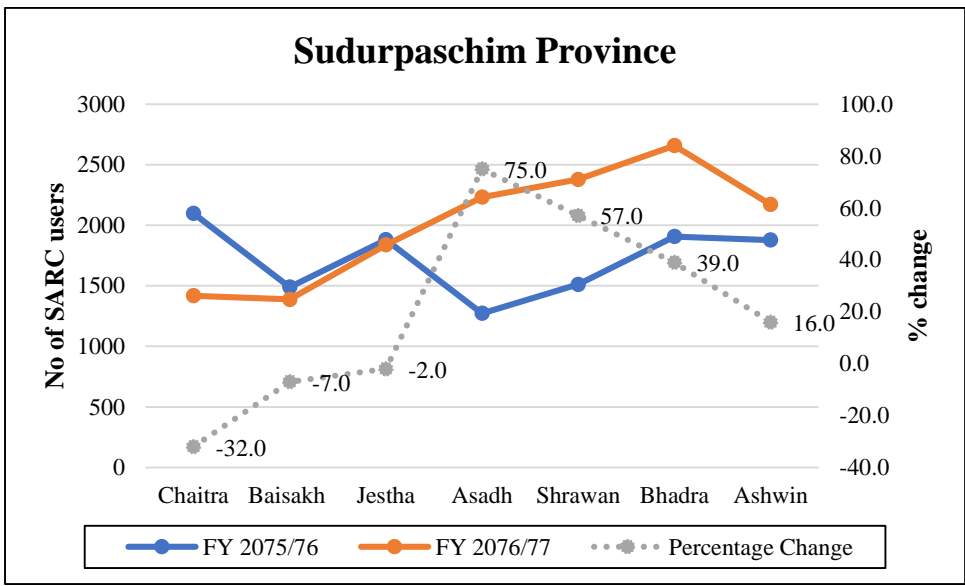
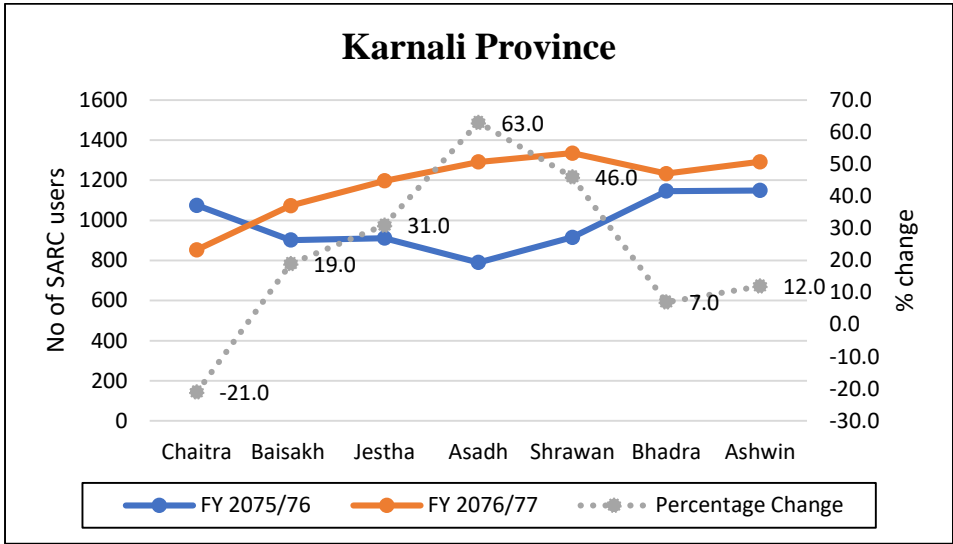
Annex 4.4 Provider's perception on flow of FP follow-up clients by type of health facility



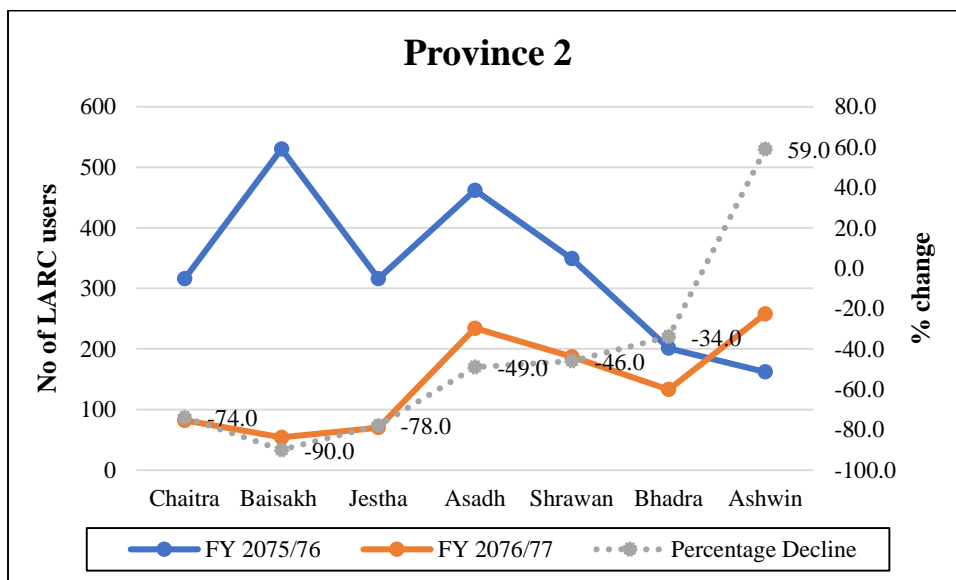
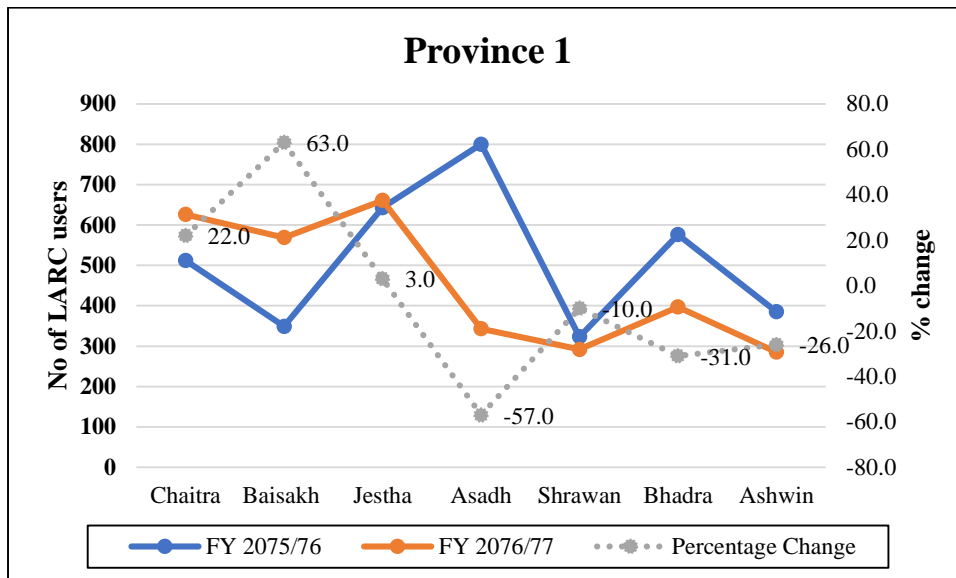
Annex 4.5: Percentage change in utilization of SARC services (Pills and Depo) during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]

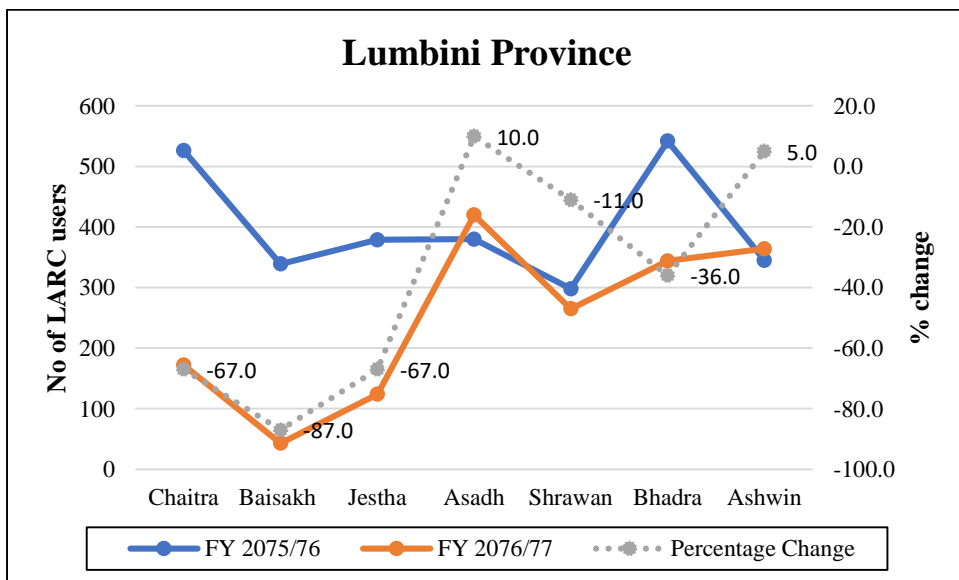
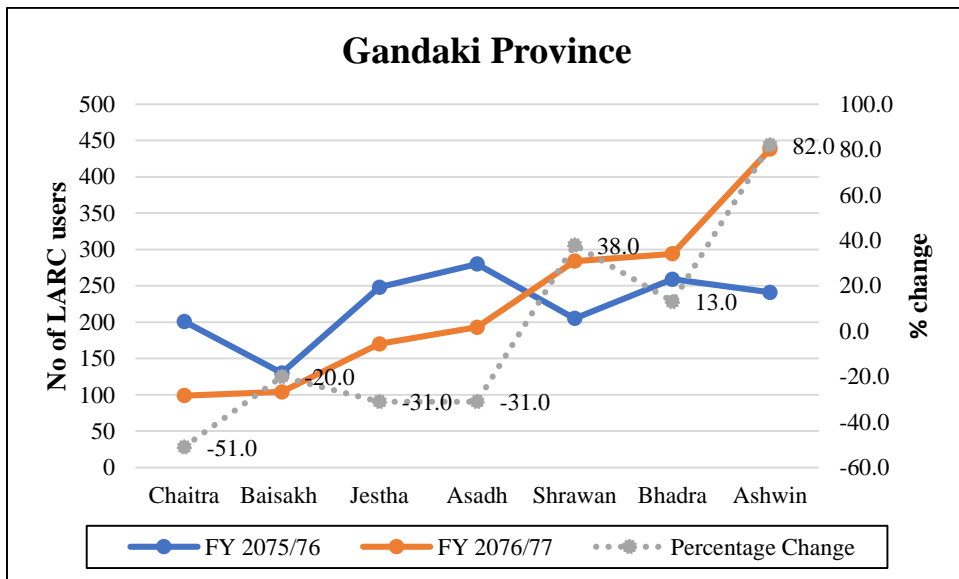
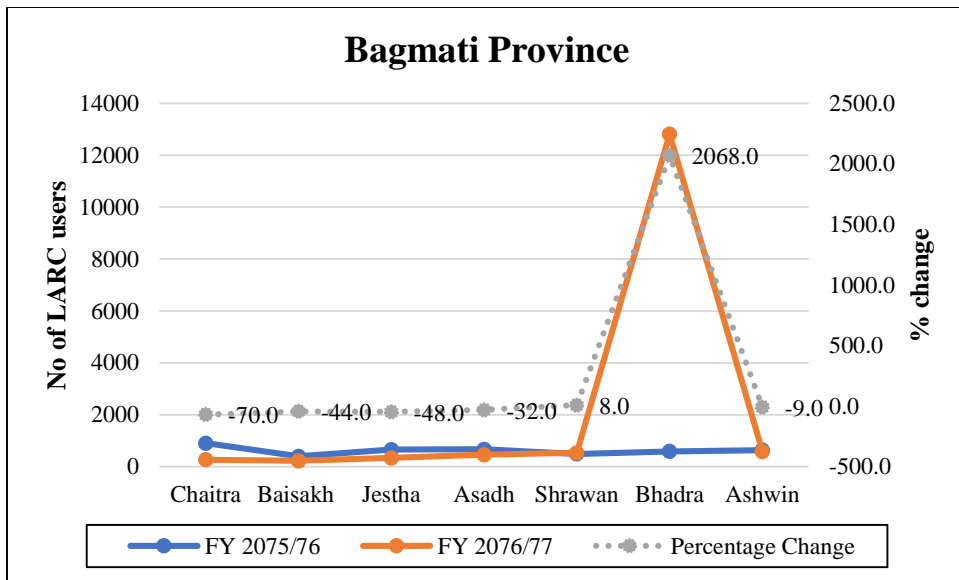


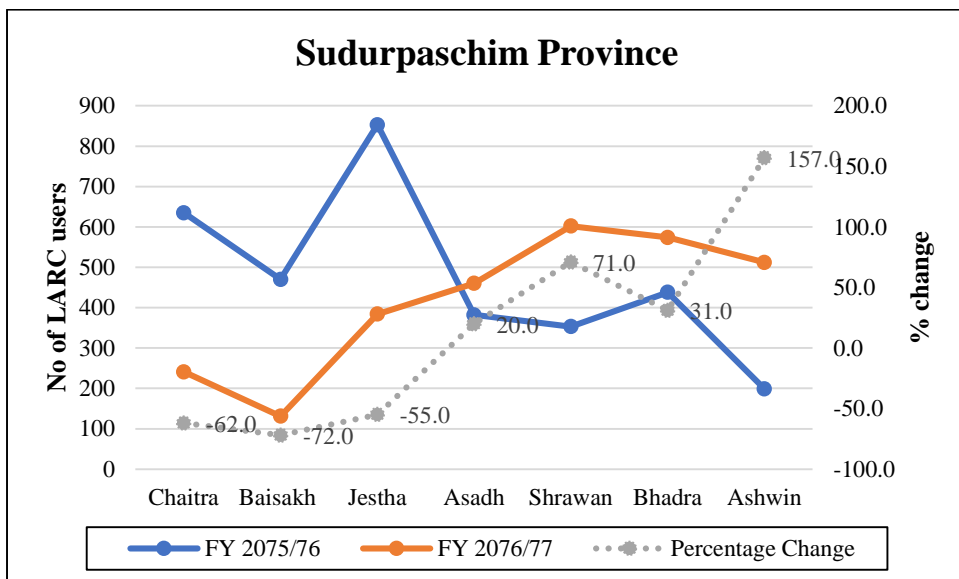
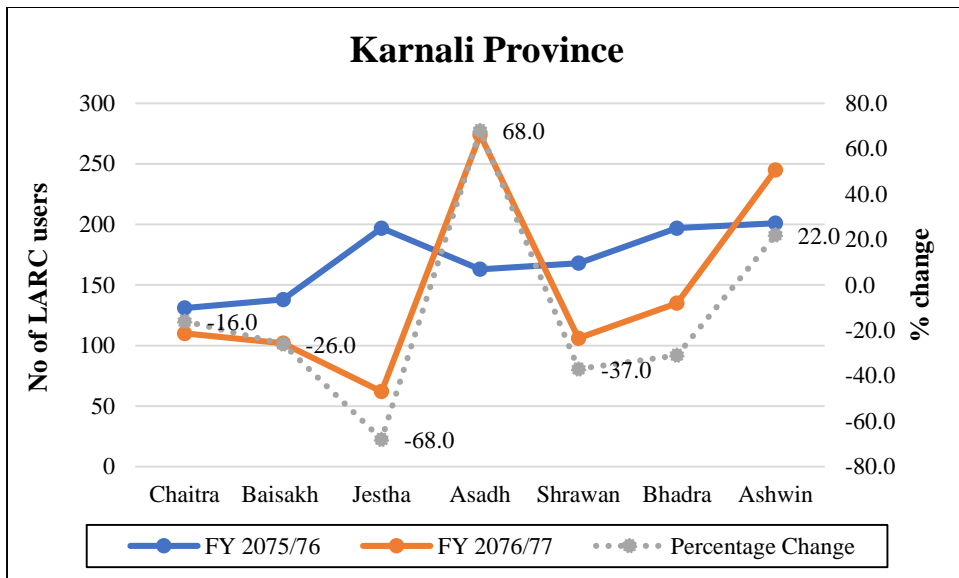




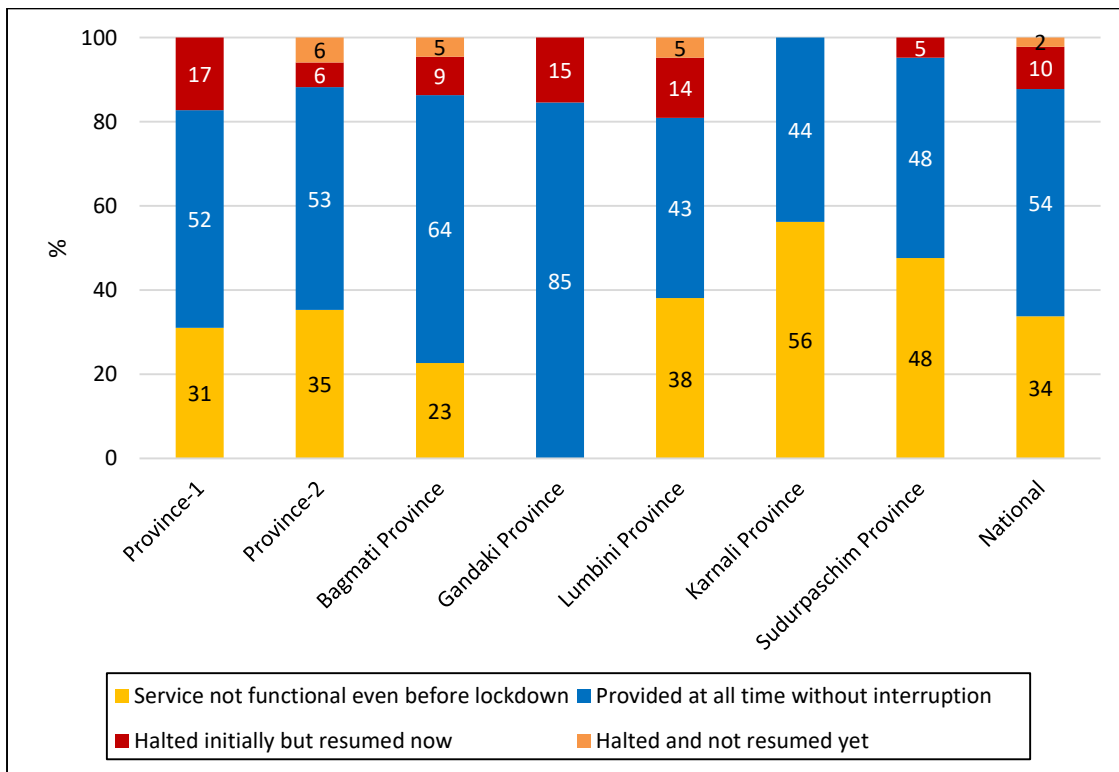
Annex 4.6: Percentage change in utilization of LARC services (Implant and IUCD) during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]



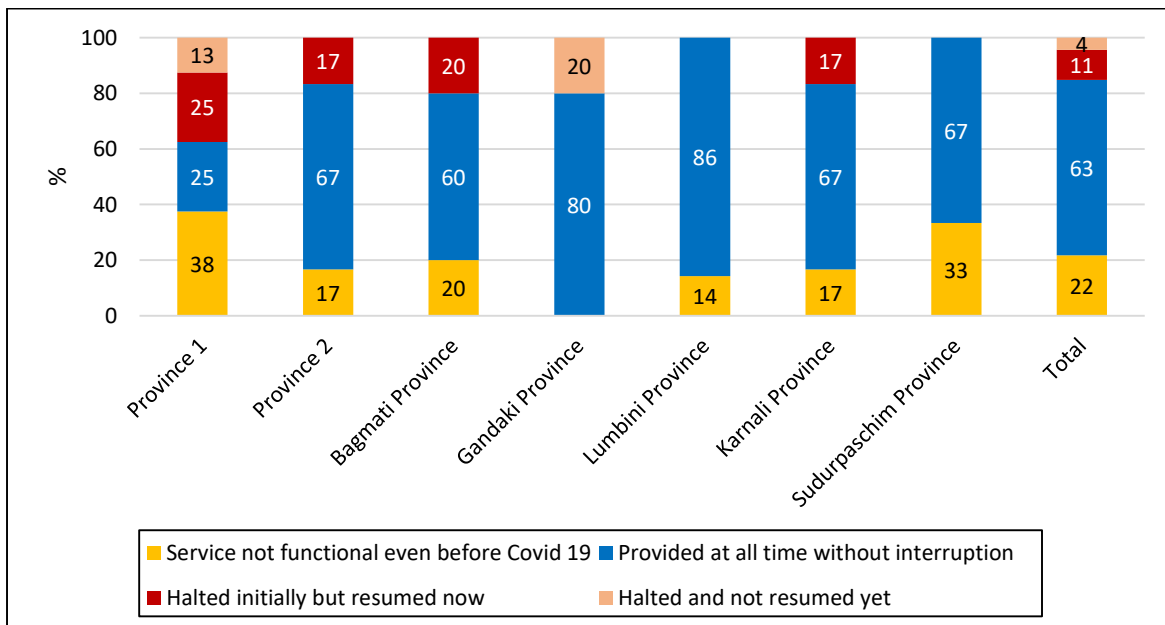




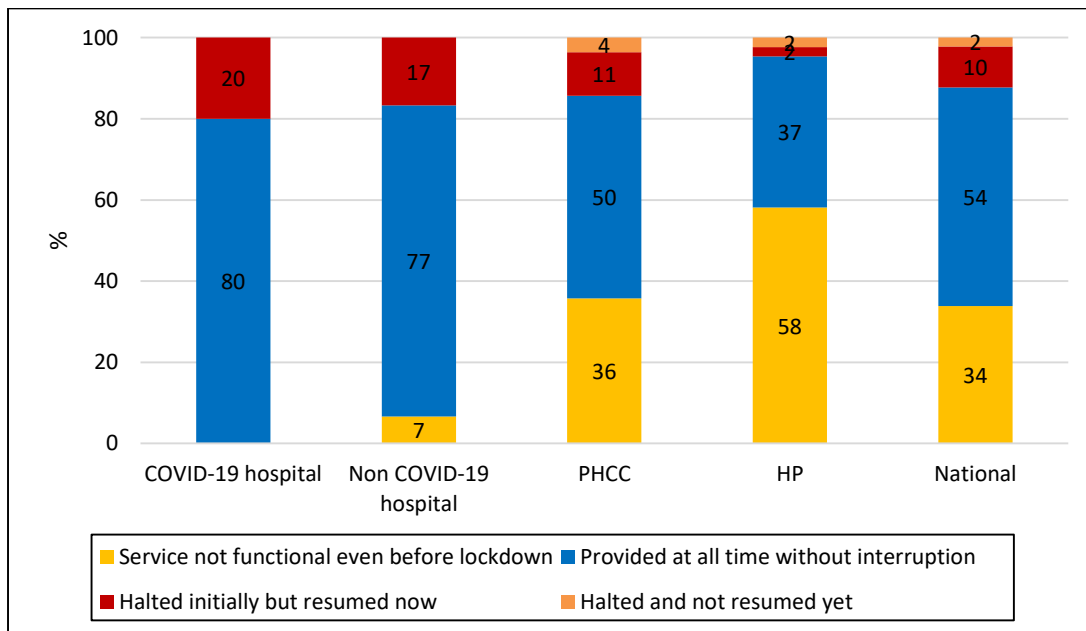
Annex 5.1 Functionality of Safe Abortion services by province during 5 months lockdown period



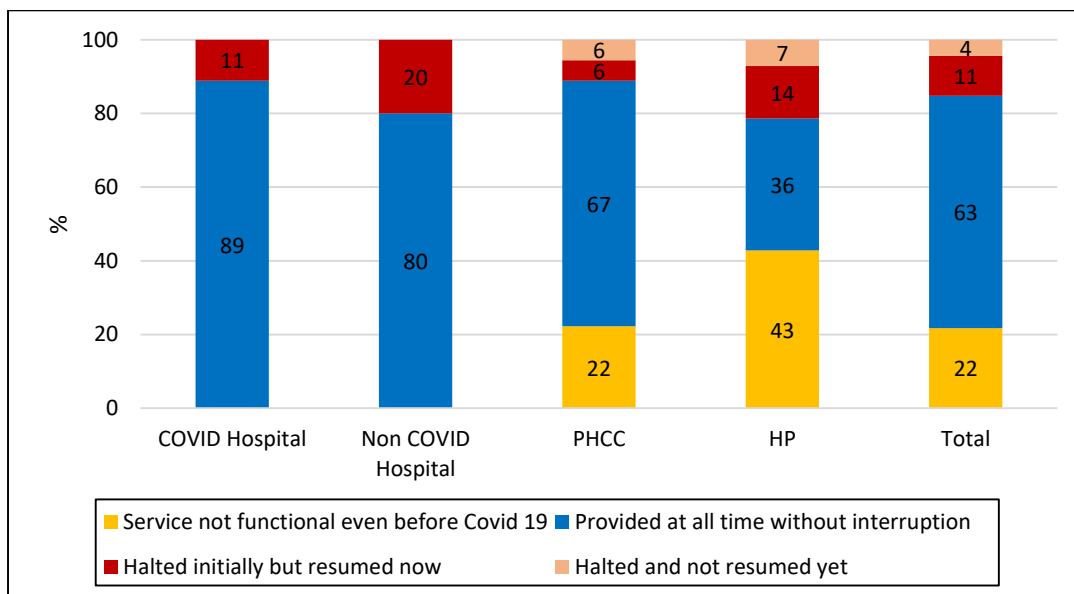
Annex 5.1a Functionality of Safe Abortion services by province during the period between Bhadra-Kartik



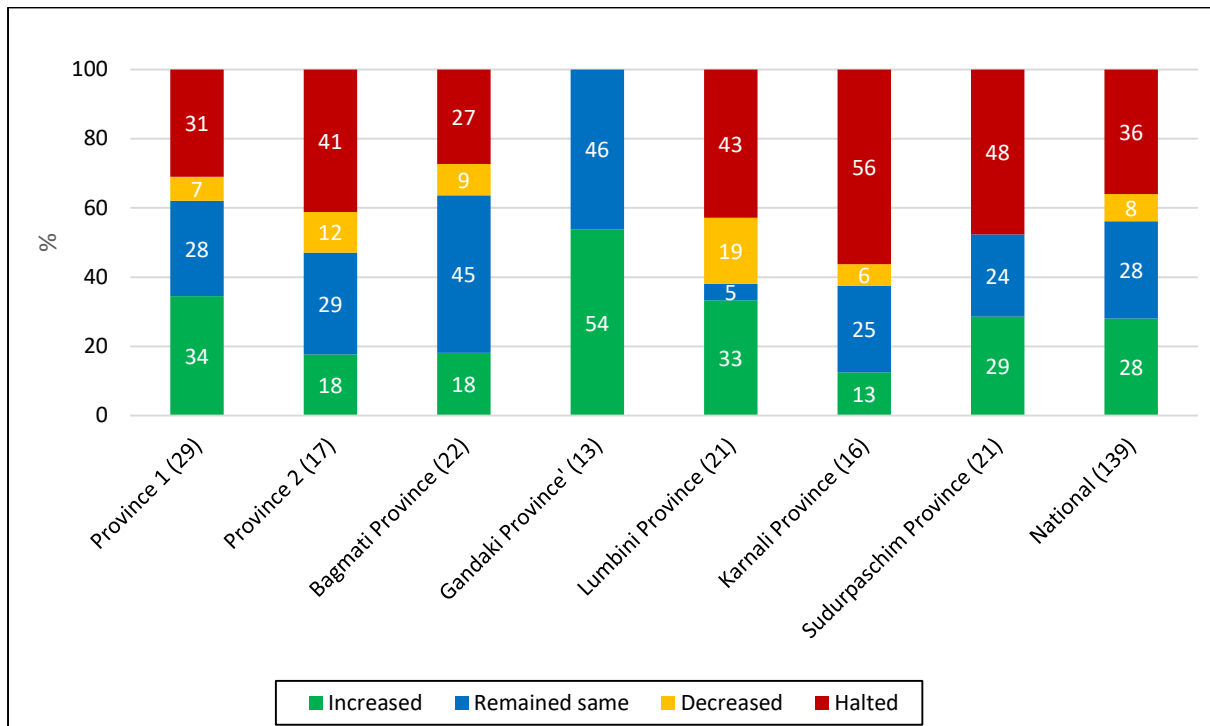
Annex 5.2 Functionality of Safe Abortion services by health facilities during 5 month's lockdown period



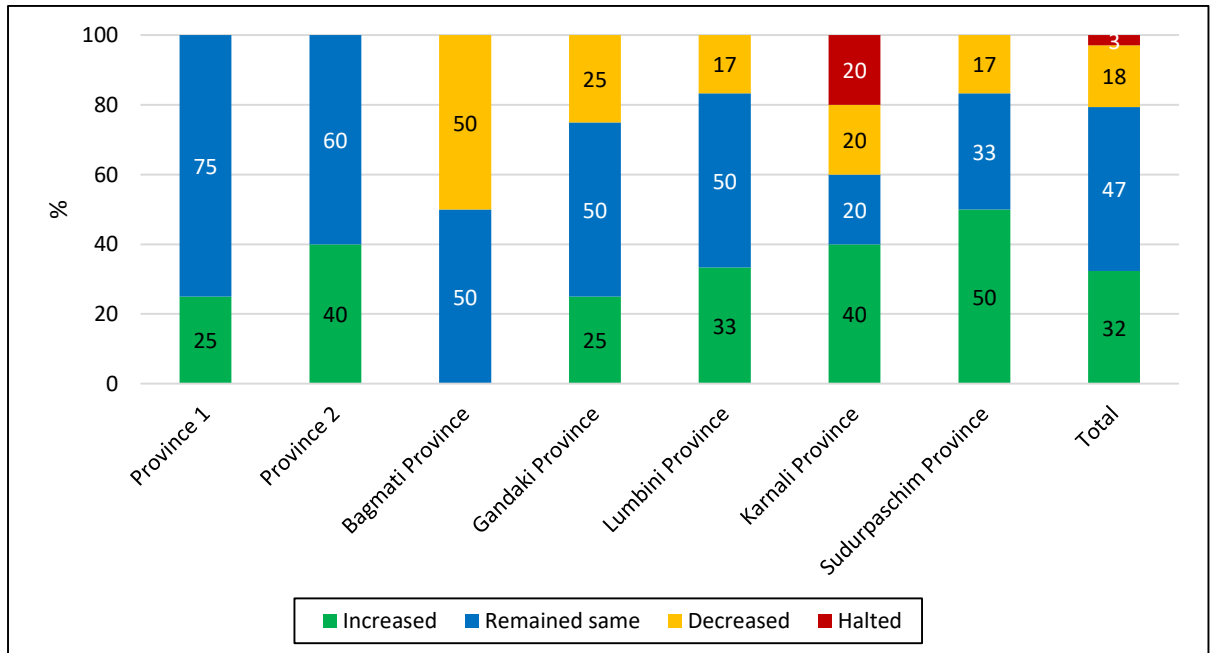
Annex 5.2a Functionality of Safe Abortion services by health facilities during the period between Bhadra-Kartik



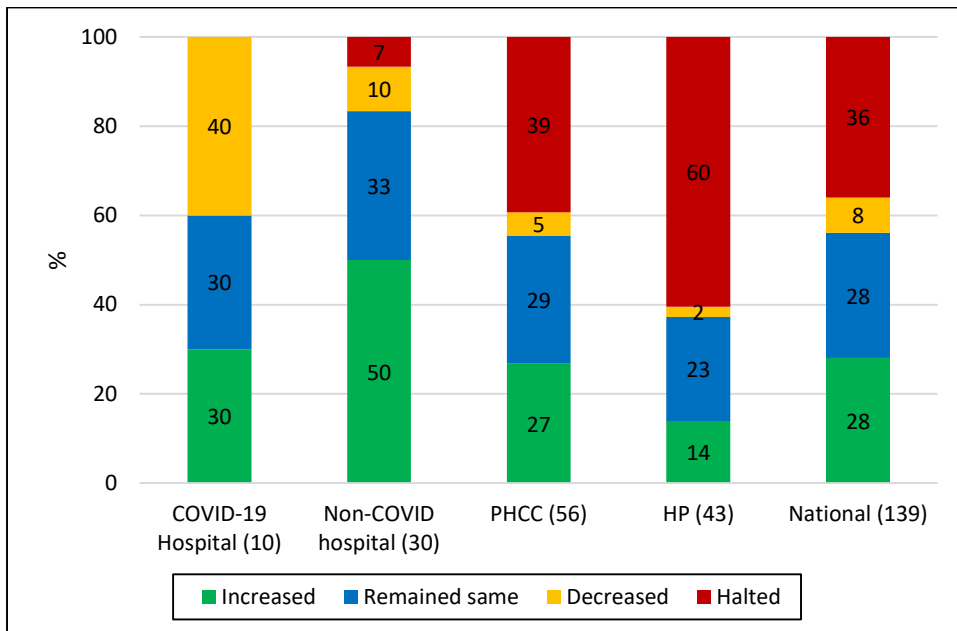
Annex 5.3 Providers' perception on flow of MA clients during lockdown period by province



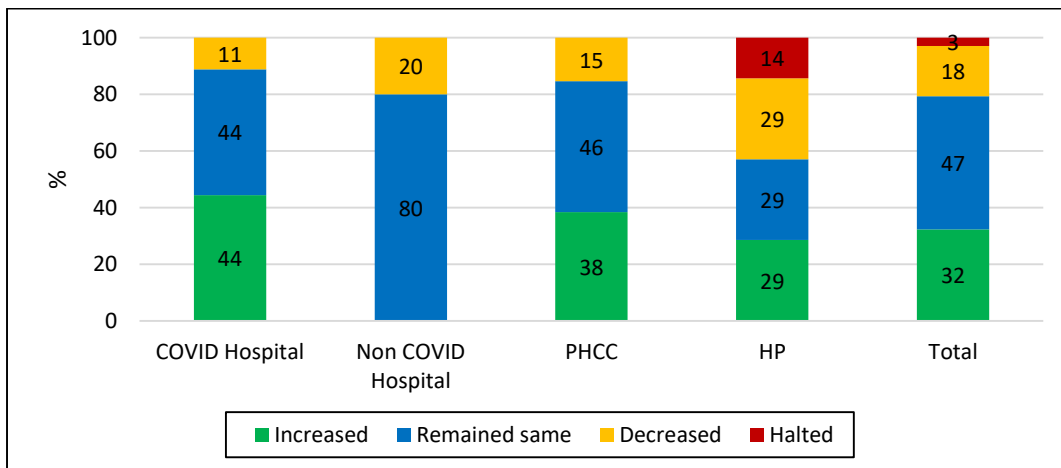
Annex 5.3a Providers' perception on flow of MA clients during lockdown period by province during the period between Bhadra-Kartik



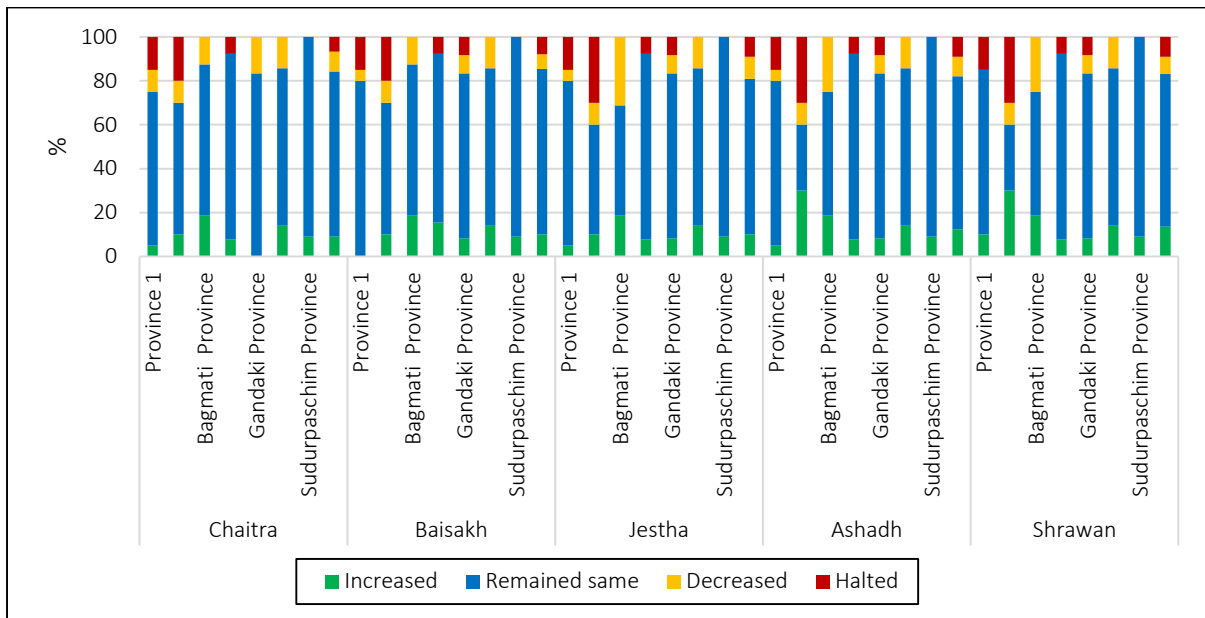
Annex 5.4 Providers' perception on flow of MA clients during lockdown period by facility



Annex 5.4a Providers' perception on flow of MA clients during lockdown period by facility during the period between Bhadra-Kartik



Annex 5.5 PAC clients during 5 months' lockdown period: Providers Perspectives by province



Annex 5.6 PAC clients during 5 months' lockdown period: Providers Perspectives by type of health facility

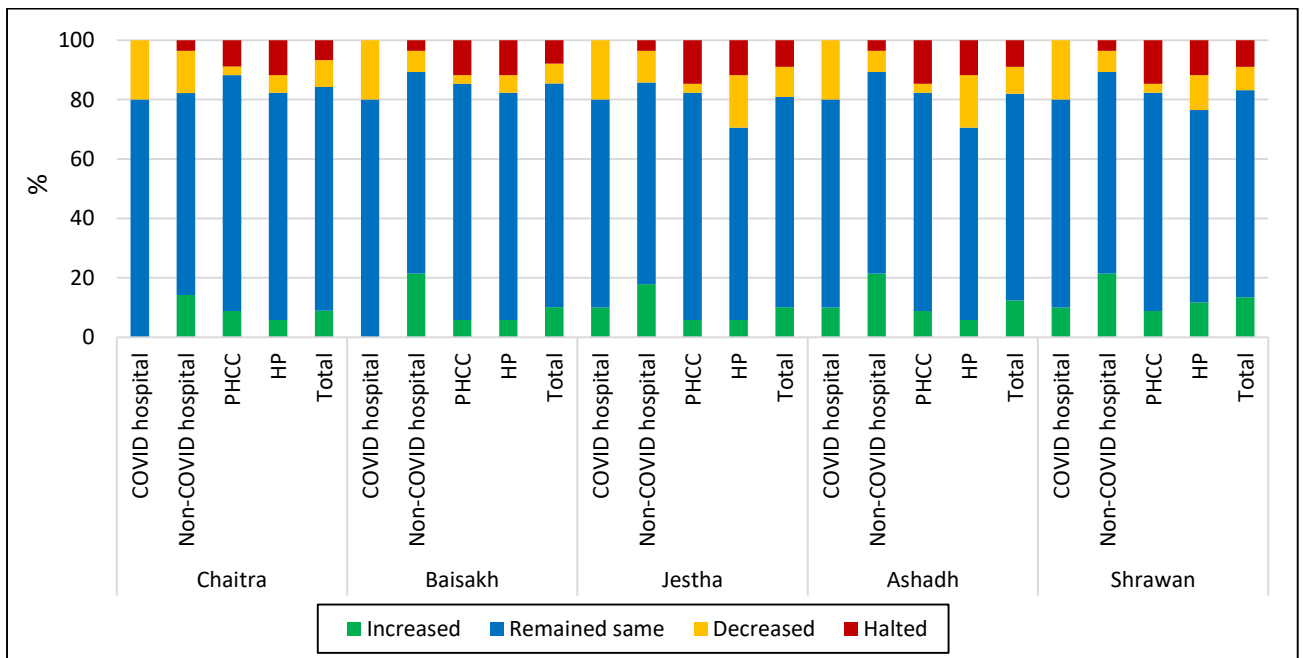
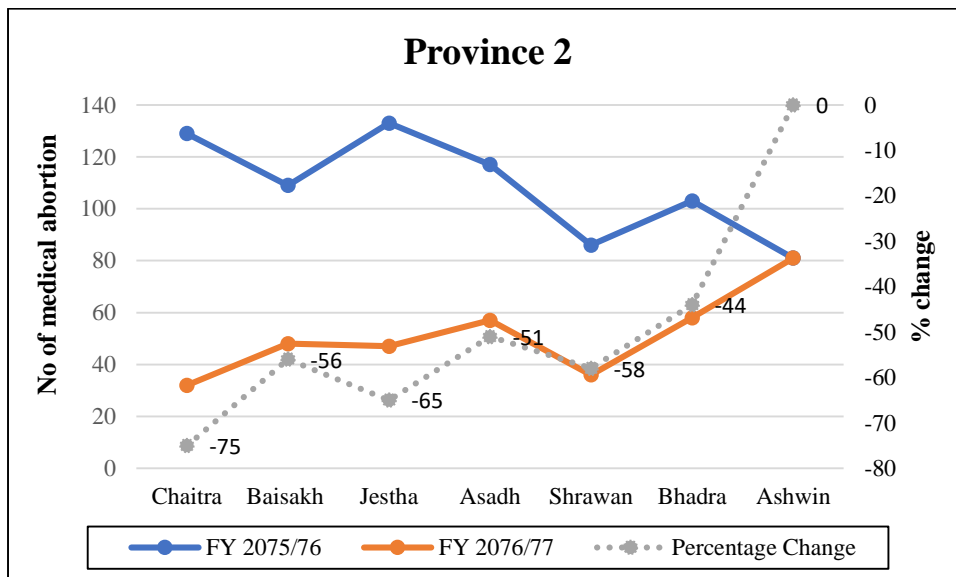
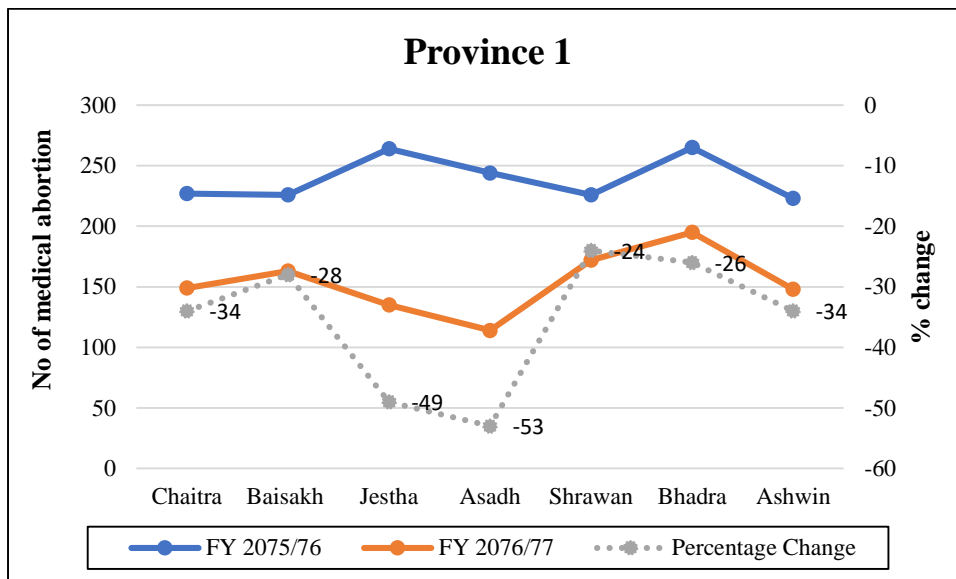
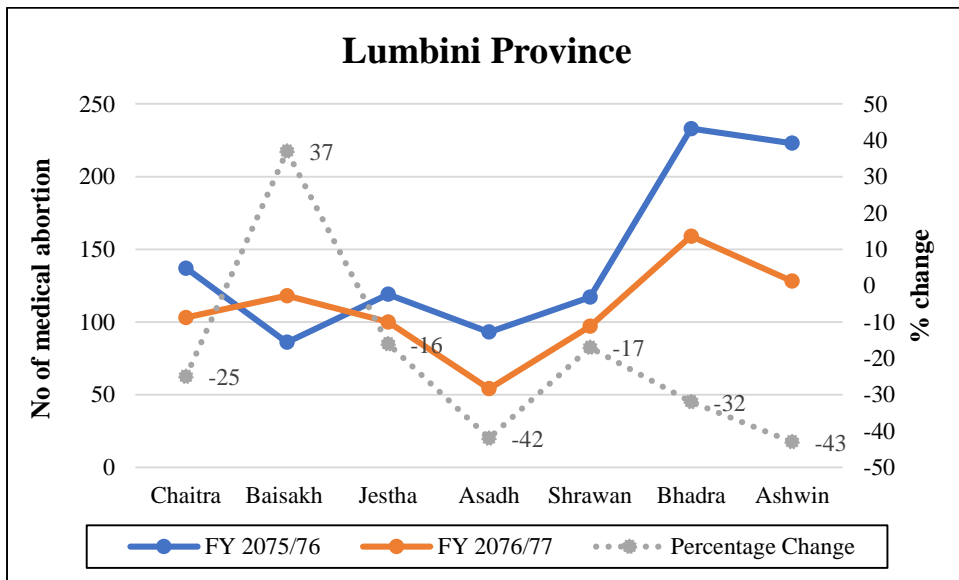
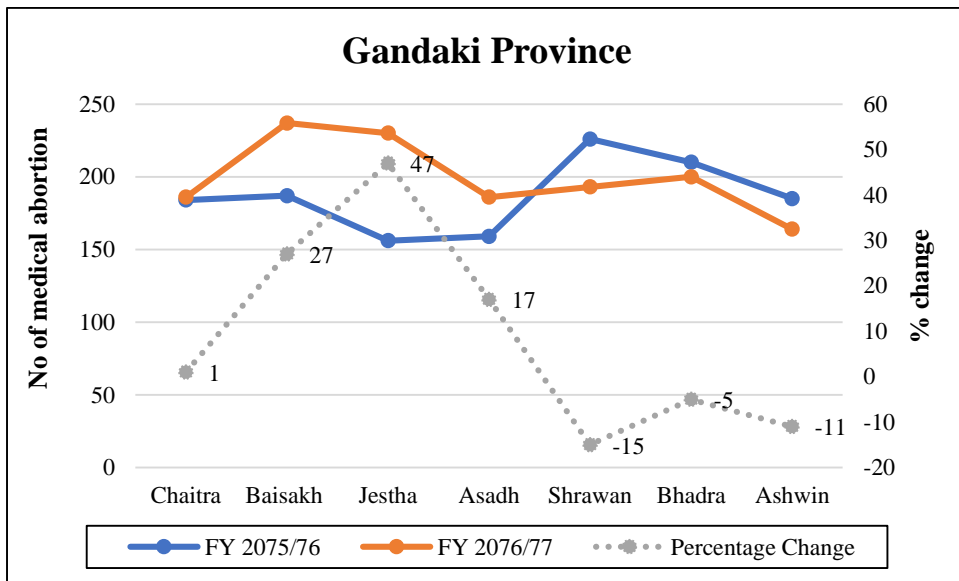
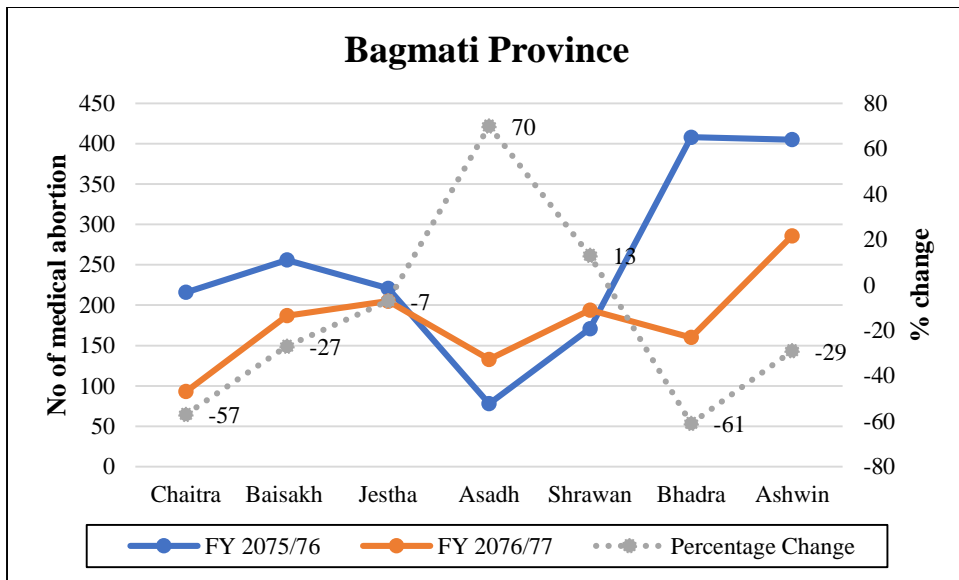


Figure 5.7: Percentage change in utilization of Medical abortion services (MA) during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]





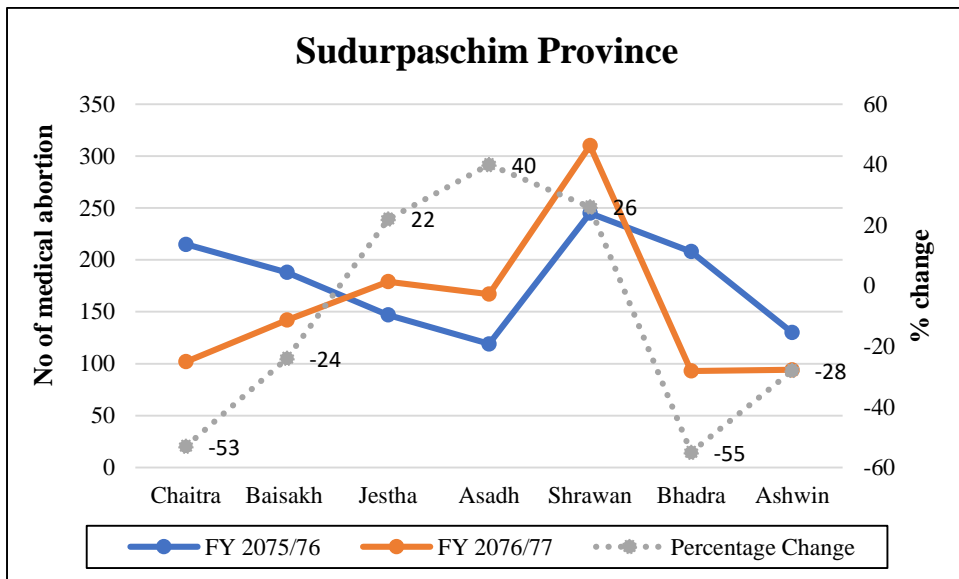
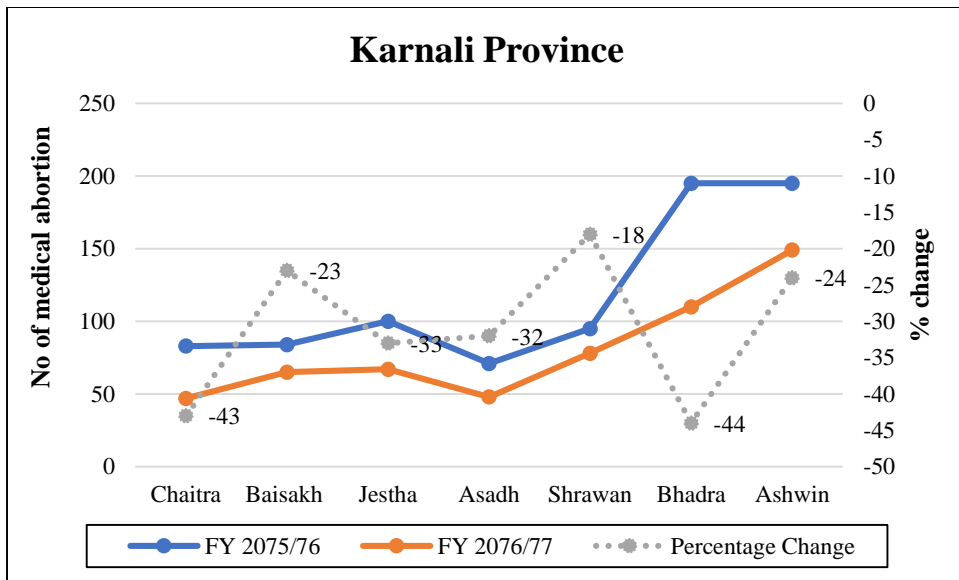
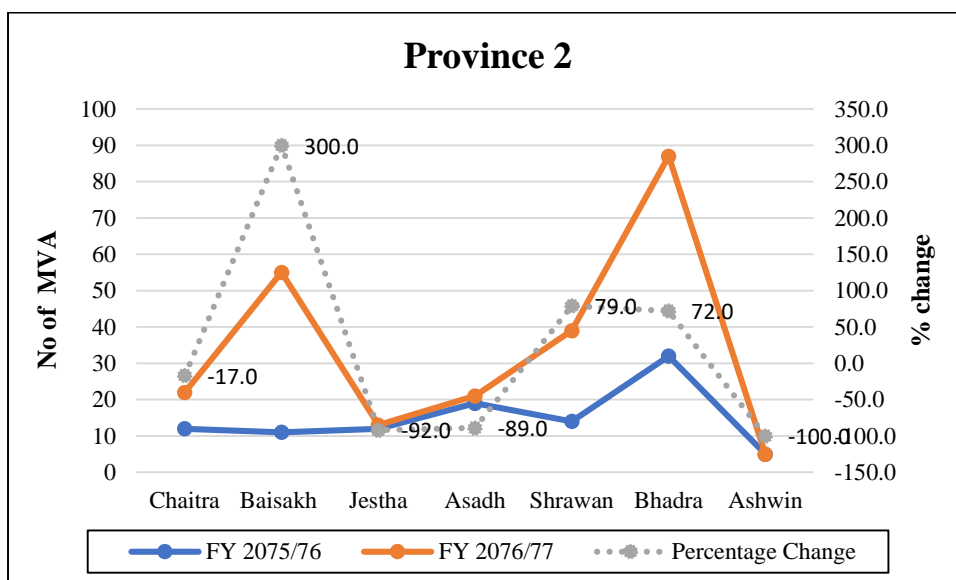
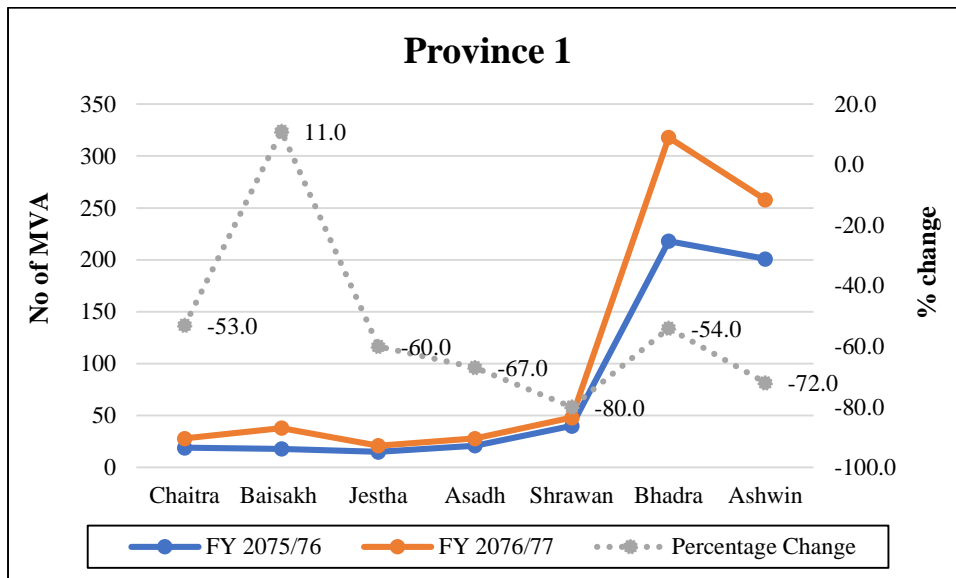
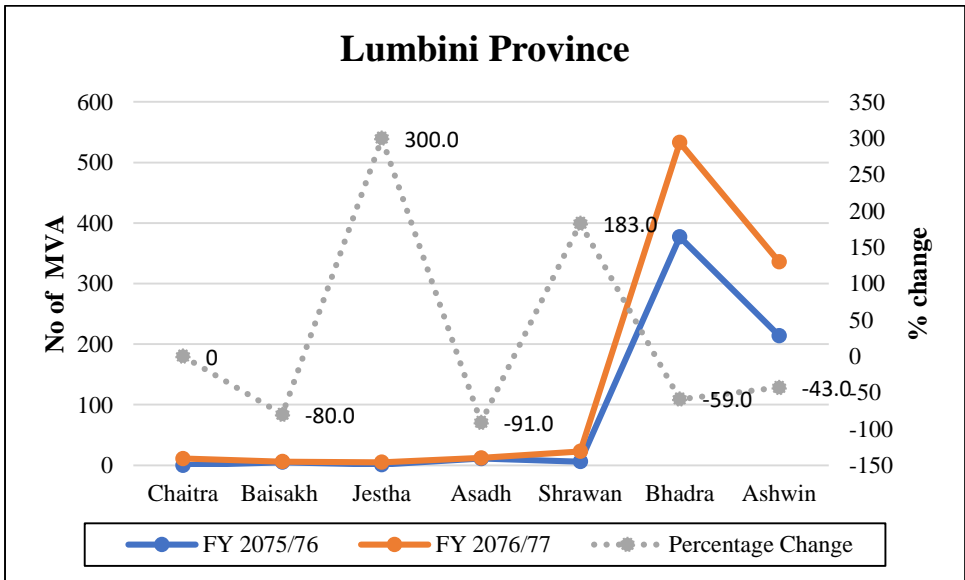
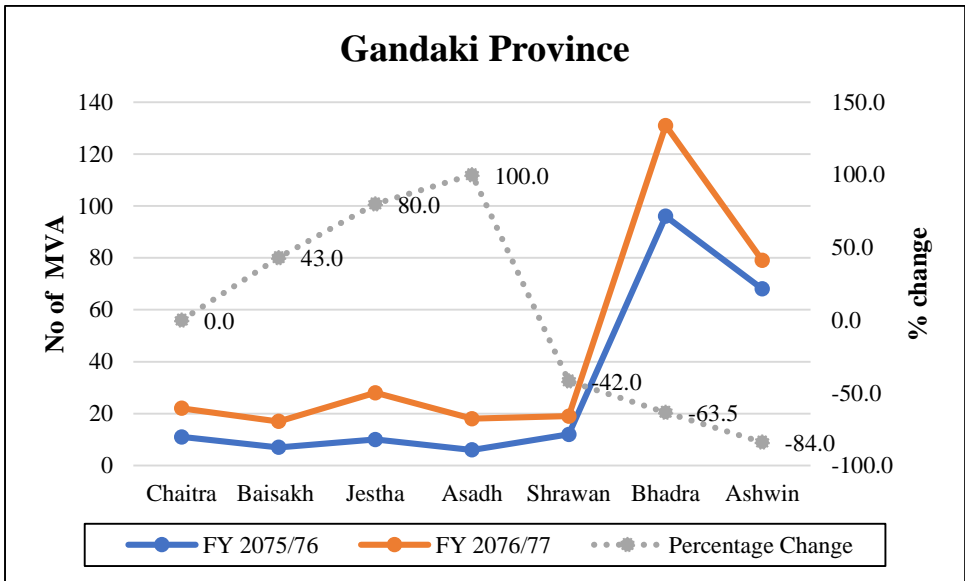
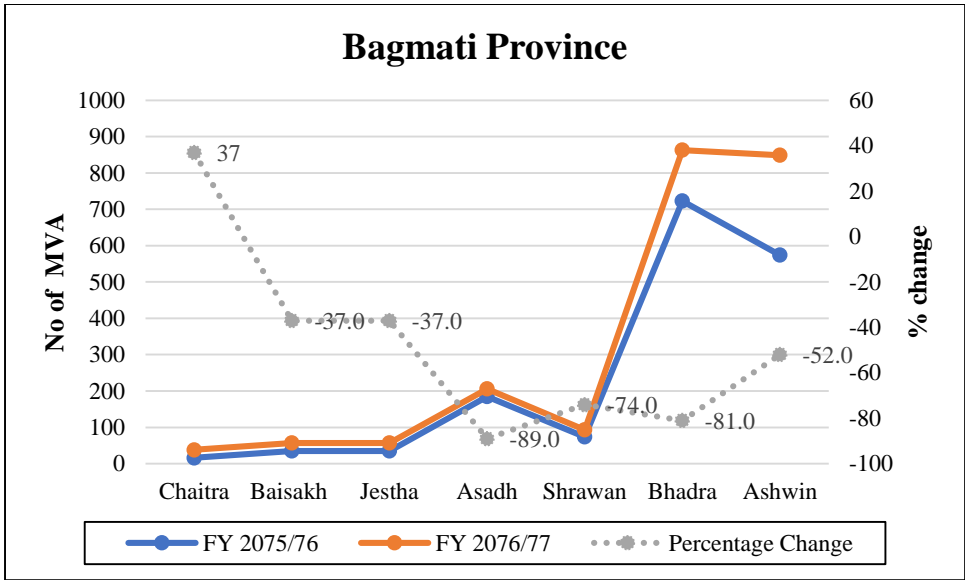
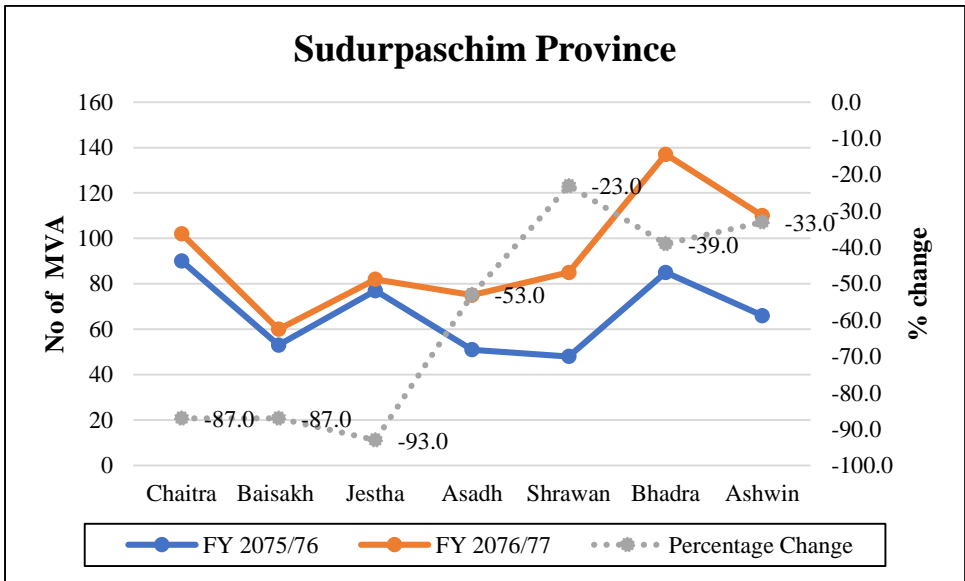
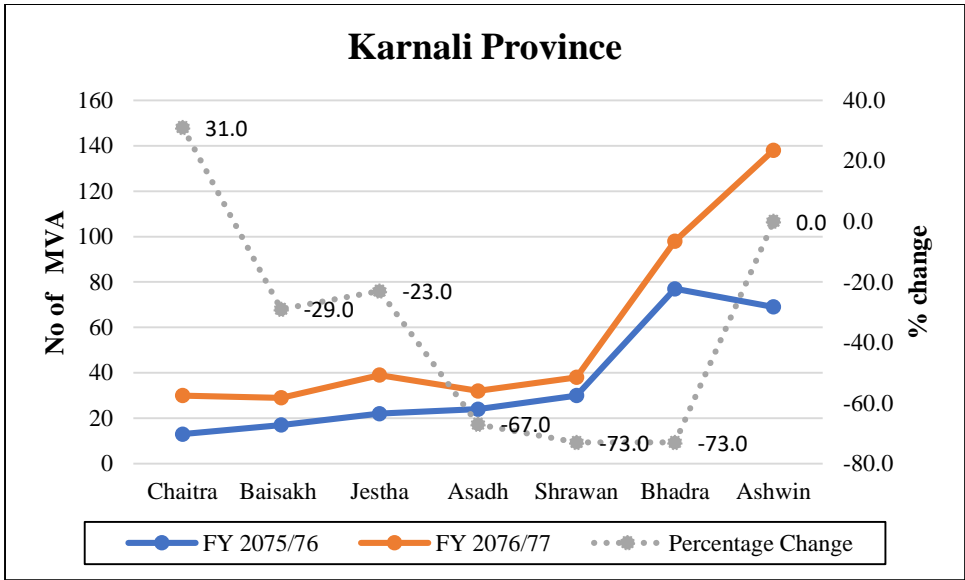


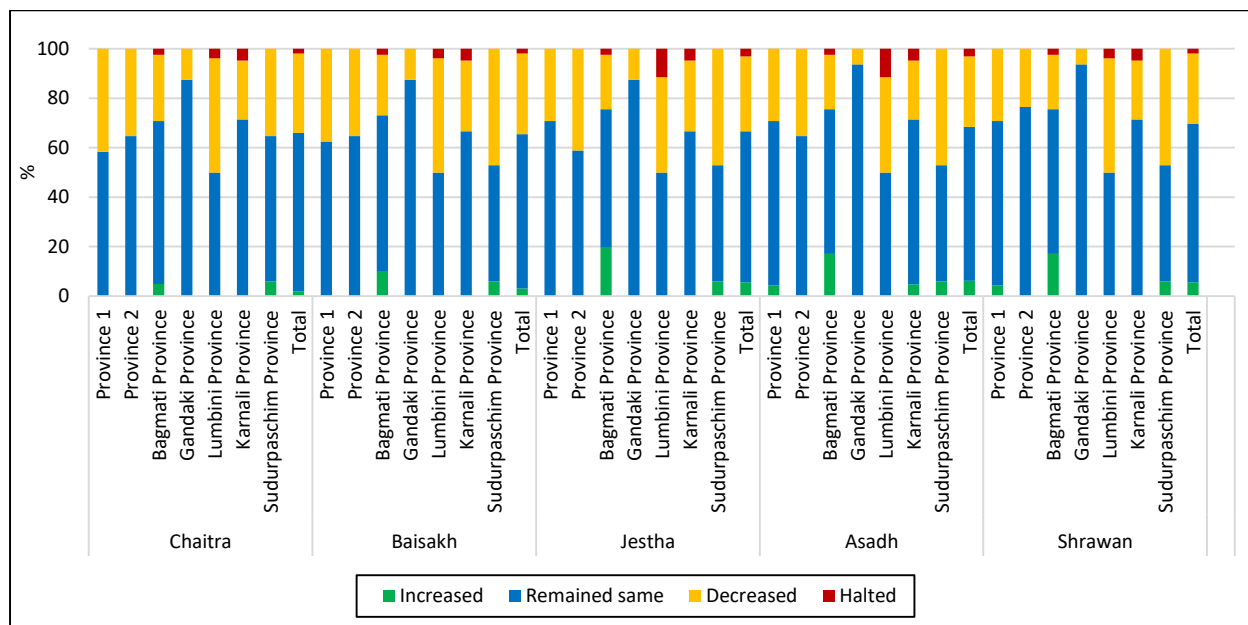
Figure 5.8: Percentage change in utilization of MVA services during COVID-19 pandemic period as compared to corresponding months of previous year [Source: HMIS database]



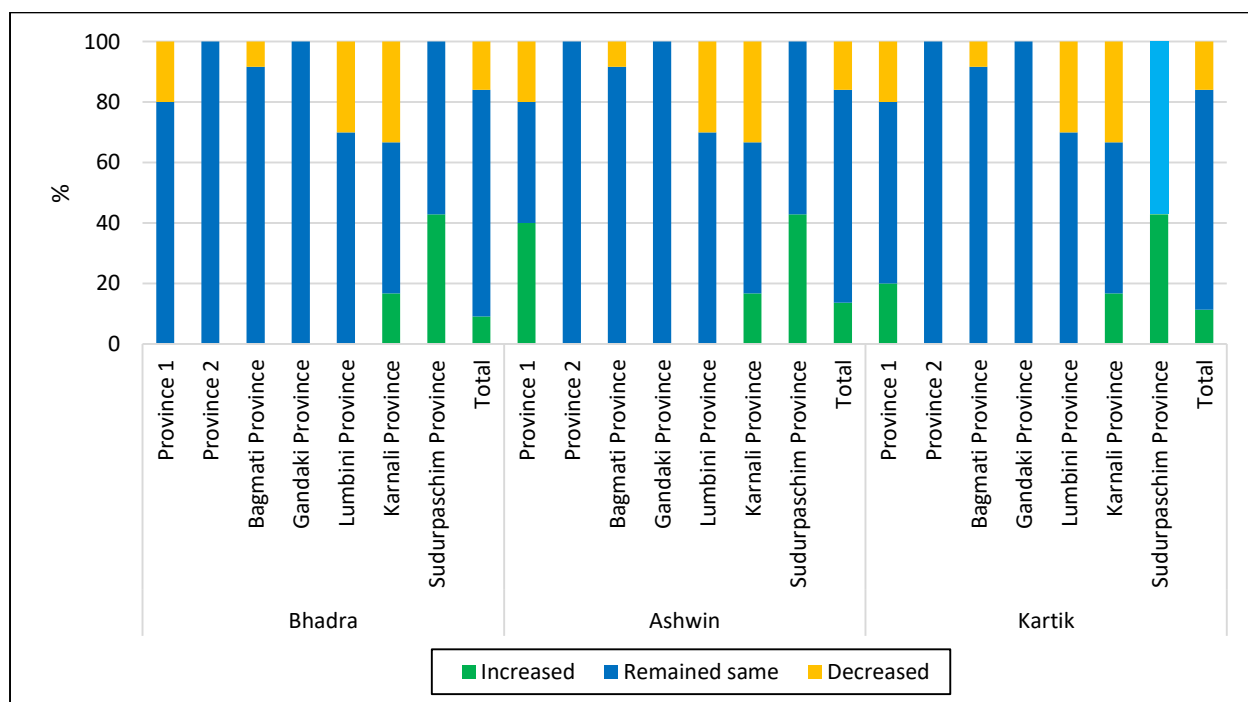




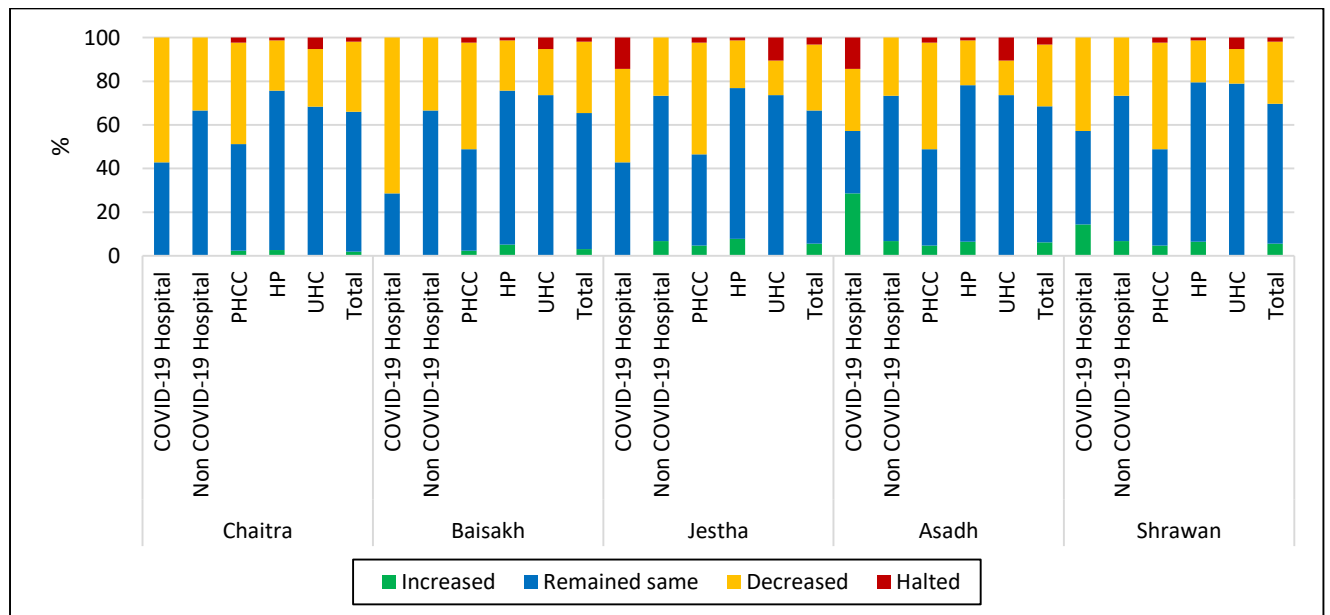
Annex 7.1: Province-wise extent of care seeking for menstrual related matters by adolescent girls during 5 months lockdown period



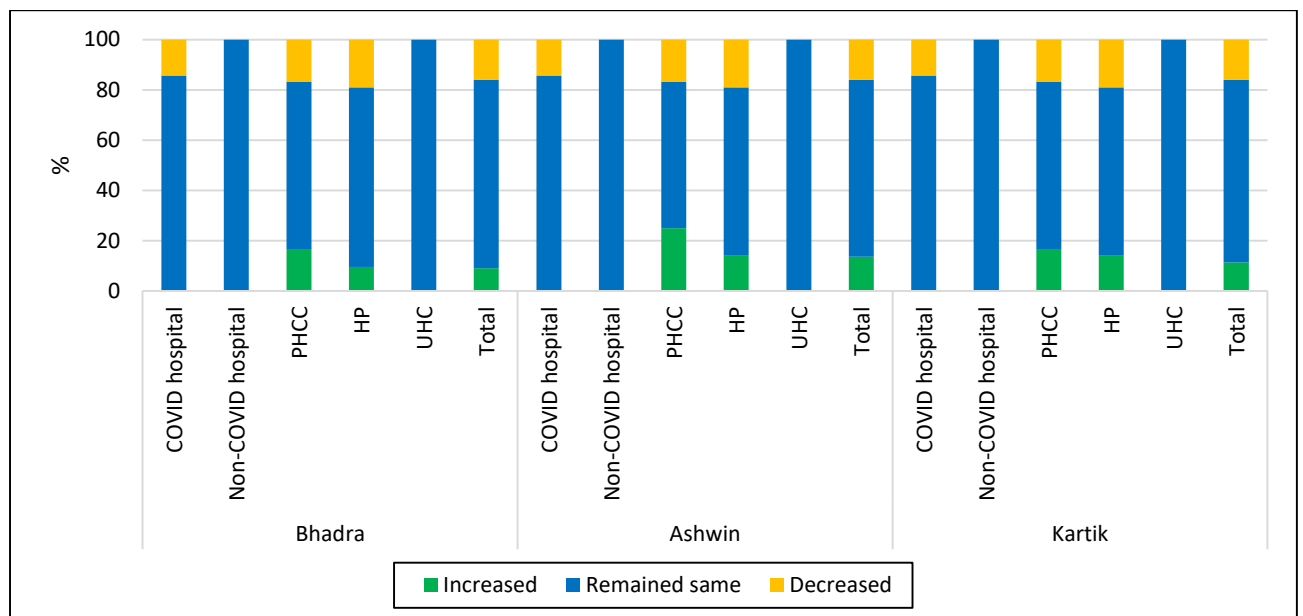
Annex 7.1a : Province-wise extent of care seeking for menstrual related matters by adolescent girls during the period between Bhadra-Kartik



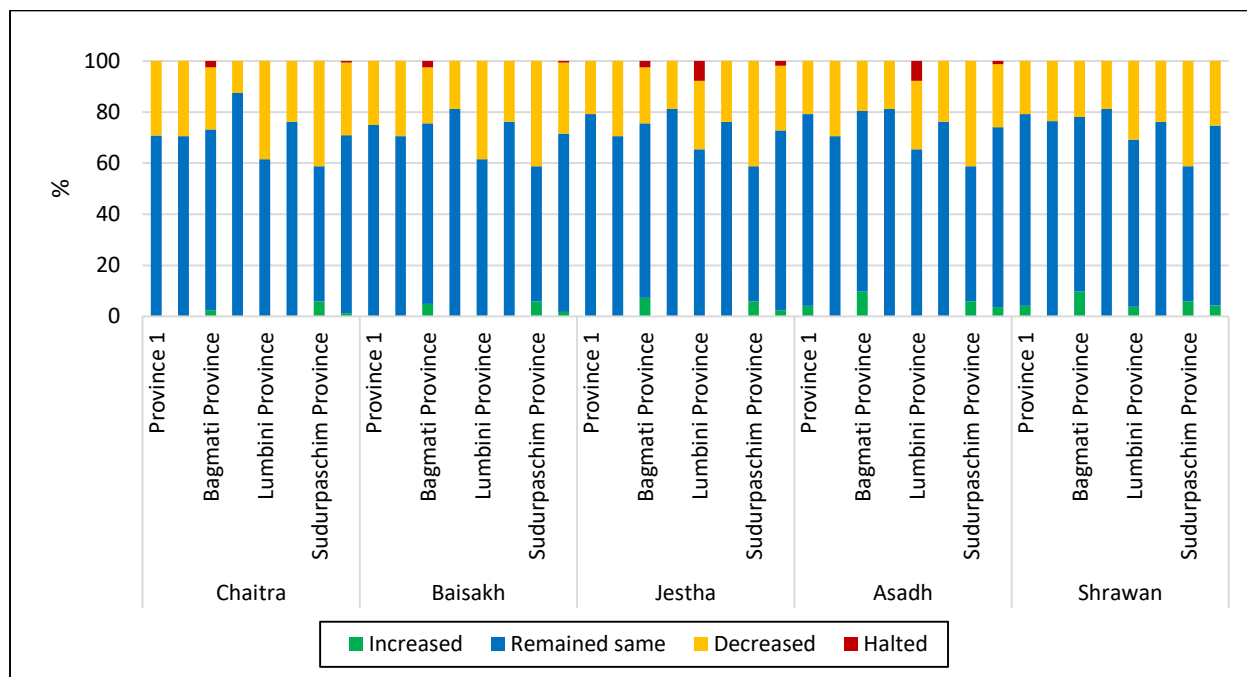
Annex 7.2: Health facility wise extent of care seeking for menstrual related matters by adolescent girls during 5 months lockdown period



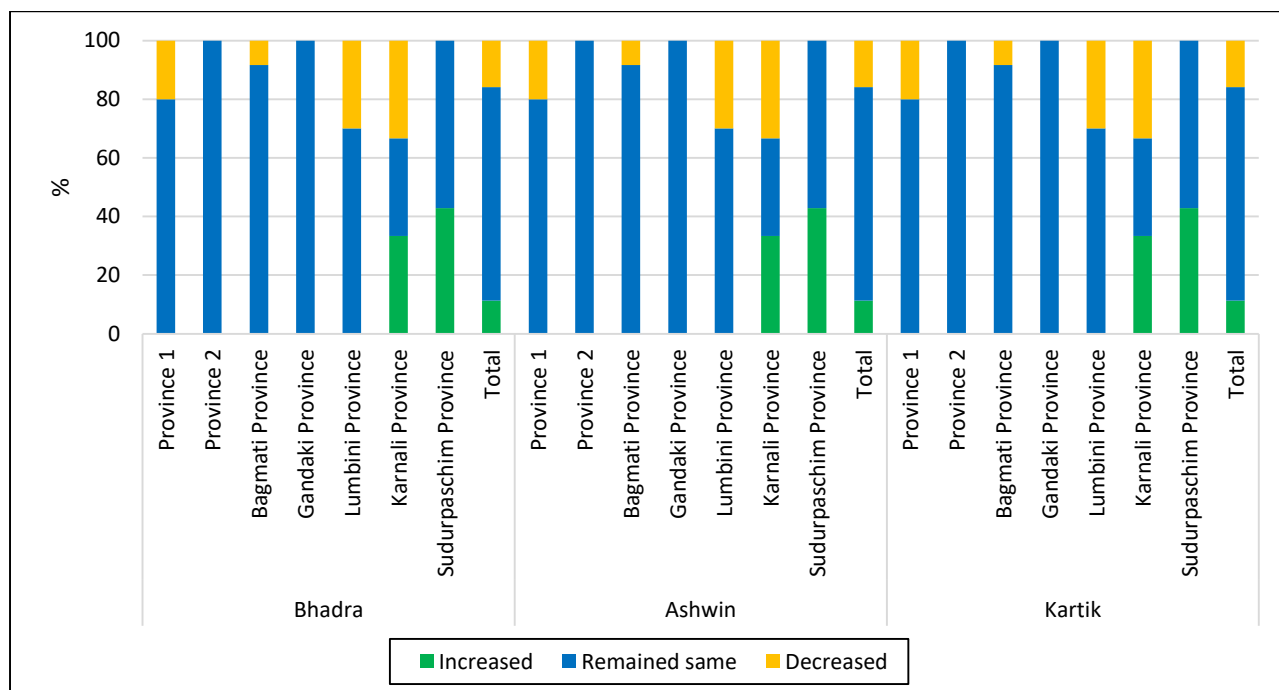
Annex 7.2a : Health facility wise extent of care seeking for menstrual related matters by adolescent girls during the period between Bhadra-Kartik



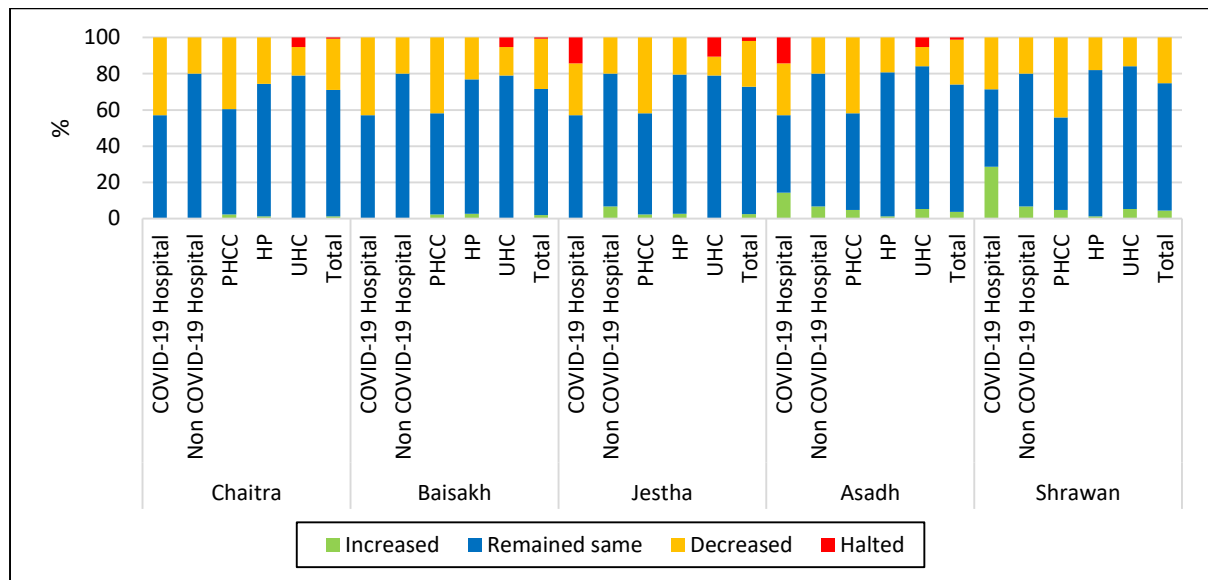
Annex 7.3: Province-wise extent of utilization of STI service by adolescents during 5 months lockdown period



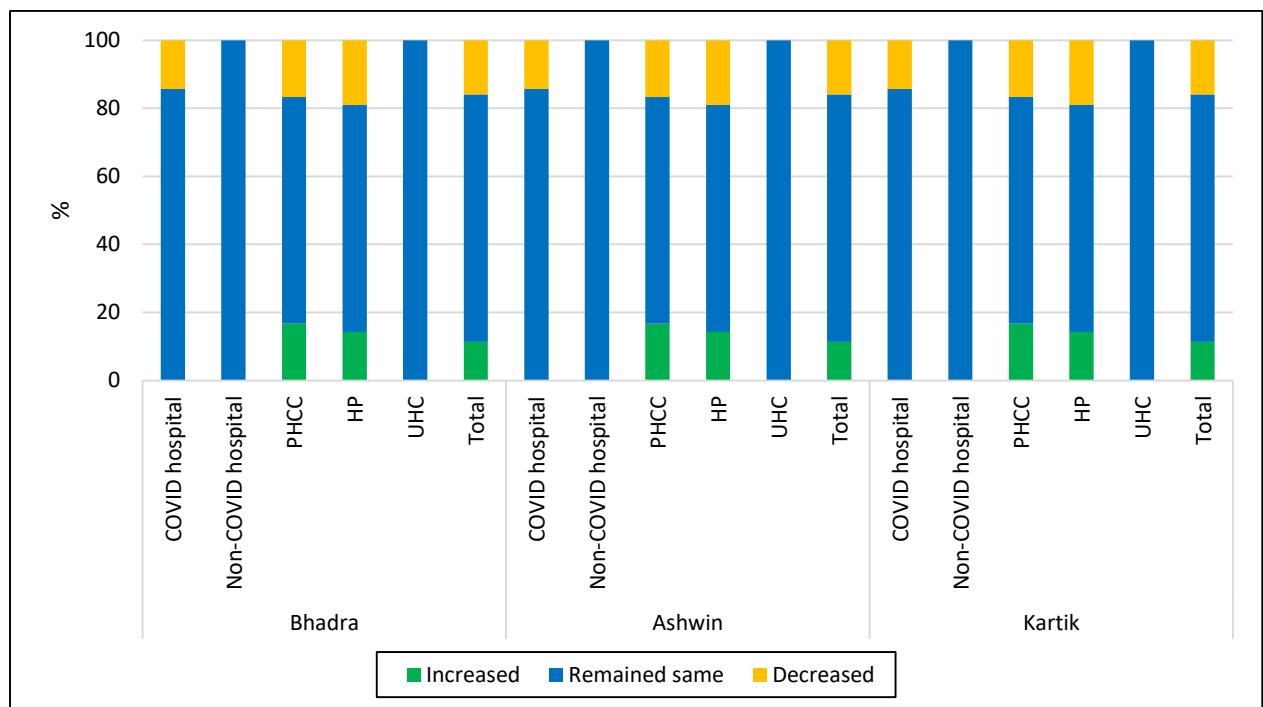
Annex 7.3a: Province-wise extent of utilization of STI service by adolescents during the period between Bhadra-Kartik



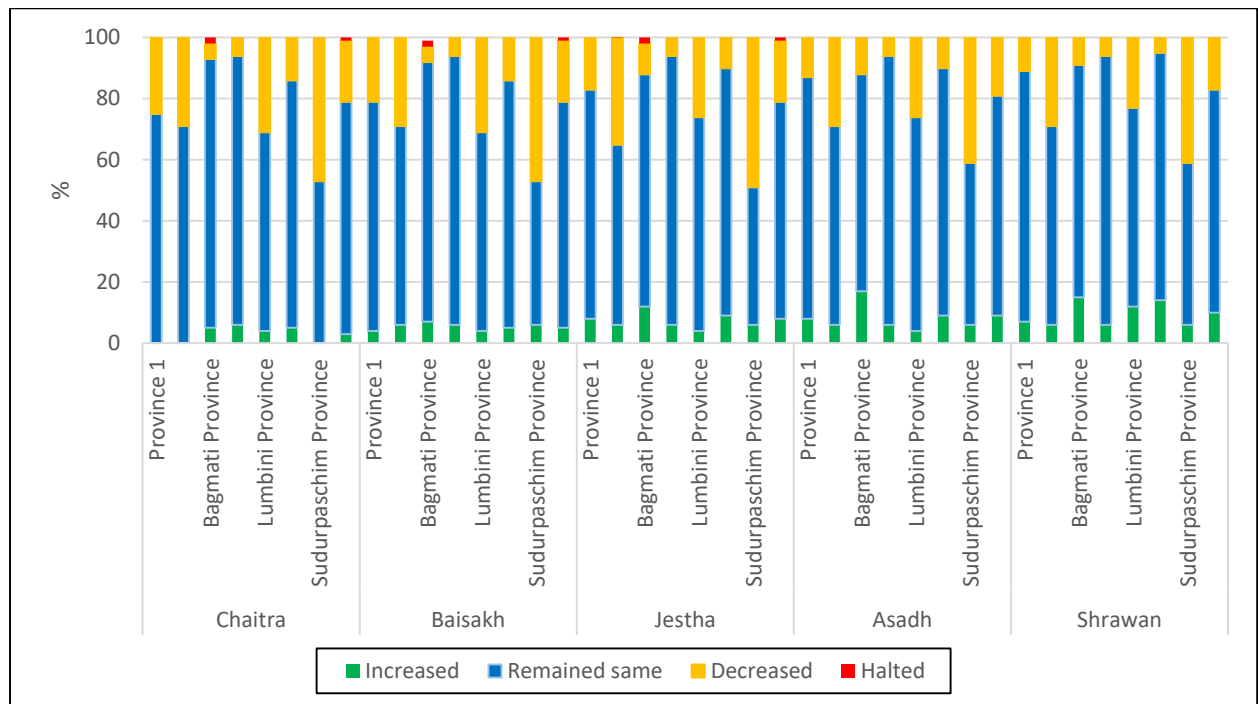
Annex 7.4: Health facility wise extent of utilization of STI service by adolescents during 5 months lockdown period



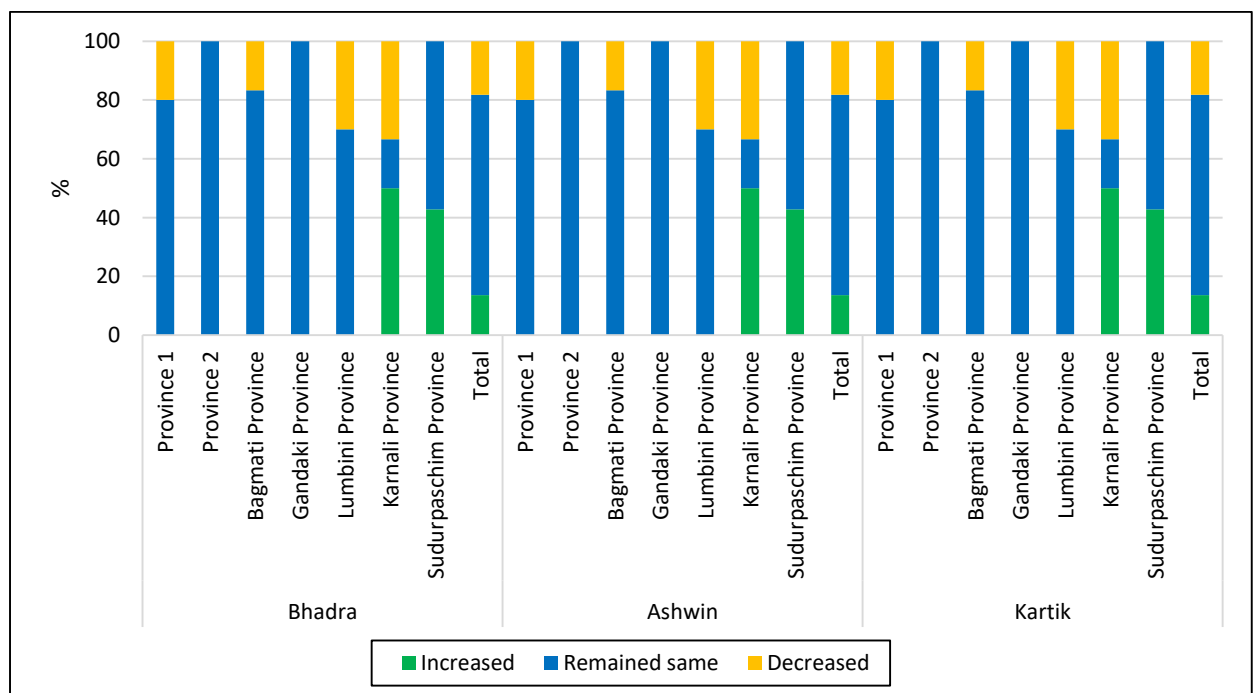
Annex 7.4a: Health facility wise extent of utilization of STI service by adolescents during the period between Bhadra-Kartik



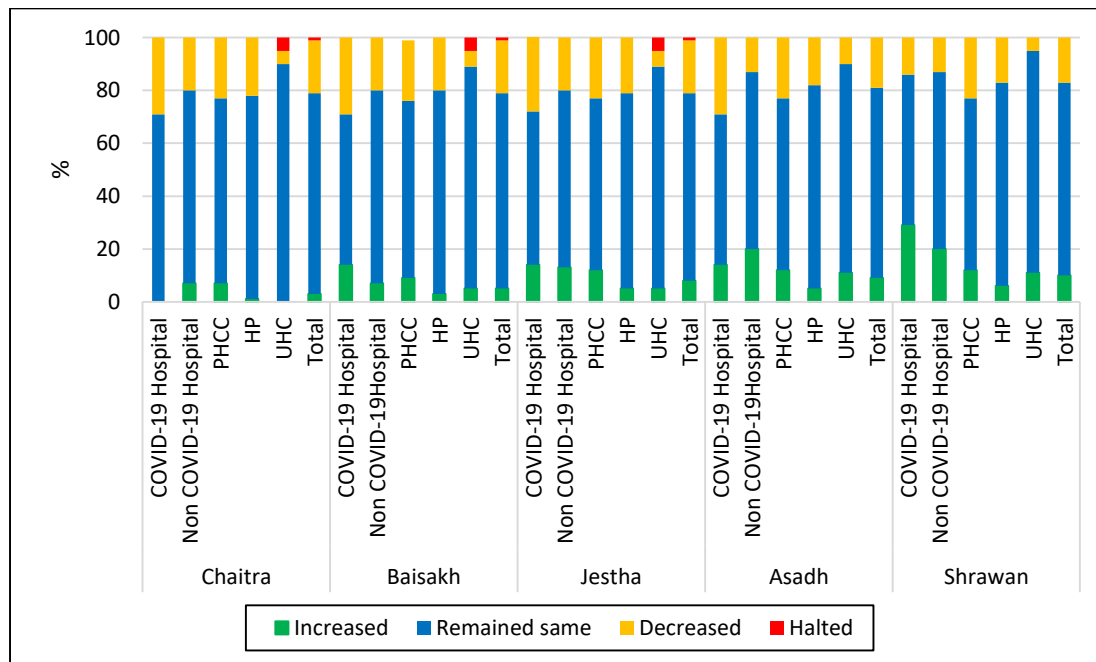
Annex 7.5: Province-wise flow of adolescent clients seeking FP contraceptives during 5 months' lockdown period



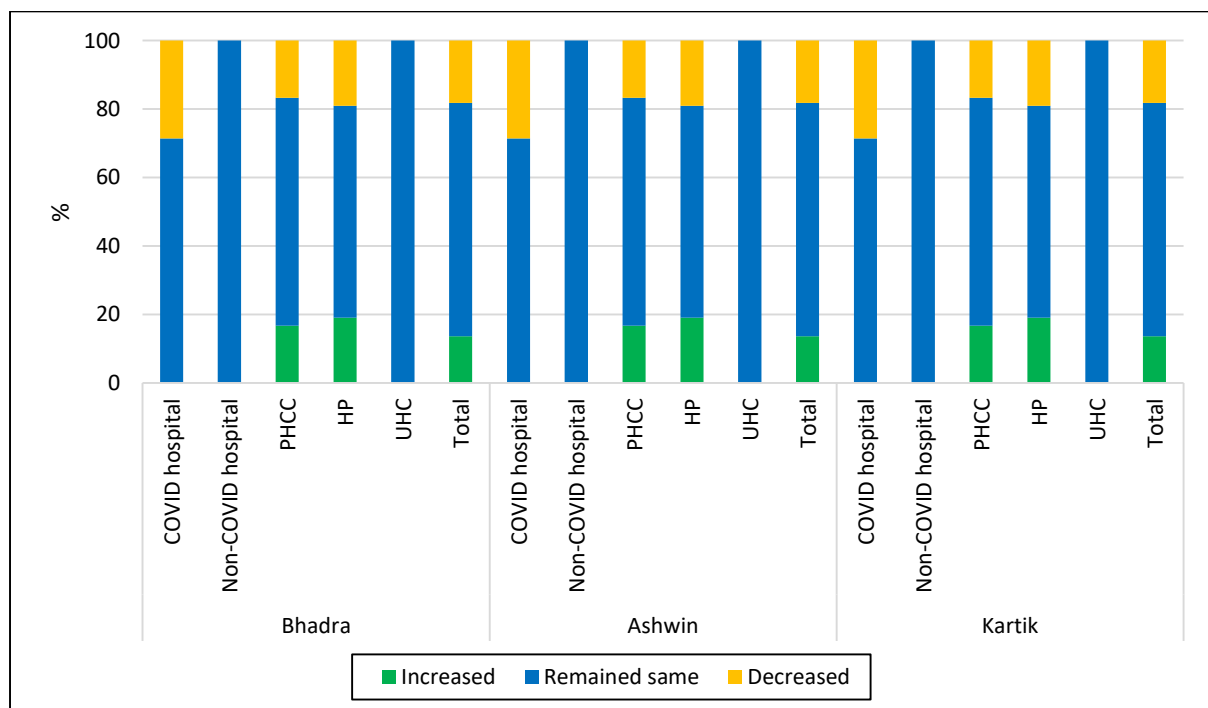
Annex 7.5a: Province-wise flow of adolescent clients seeking FP contraceptives during the period between Bhadra-Kartik



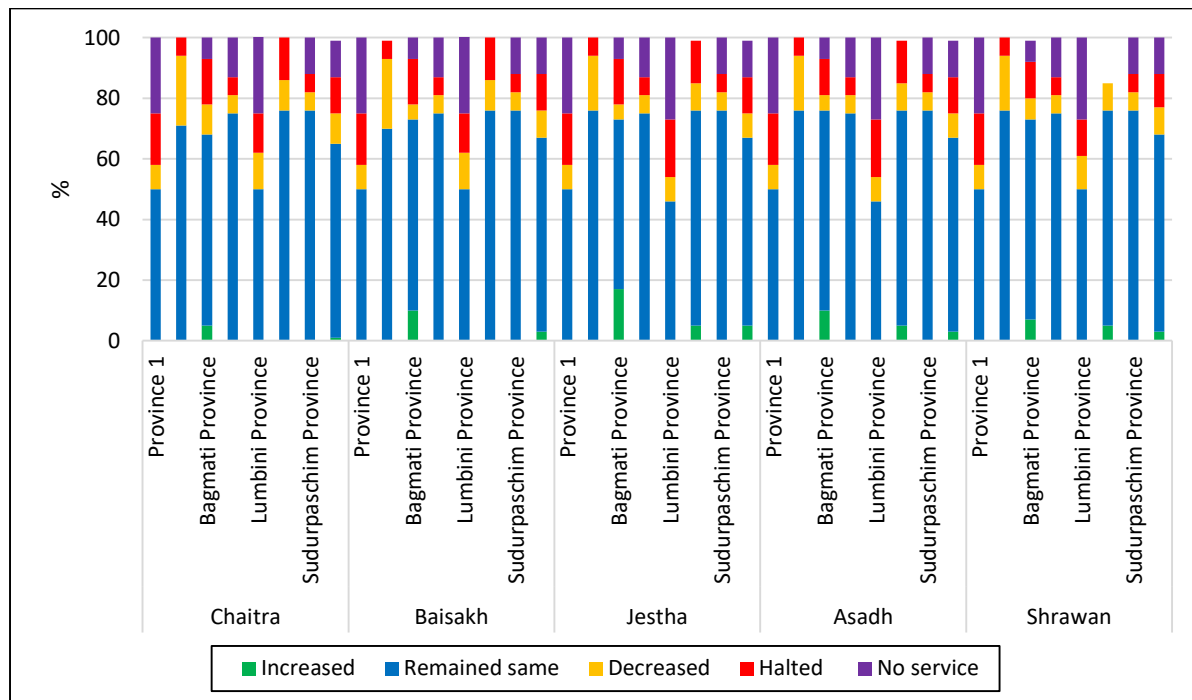
Annex 7.6: Health facility wise flow of adolescent clients seeking FP contraceptives during 5 months' lockdown period



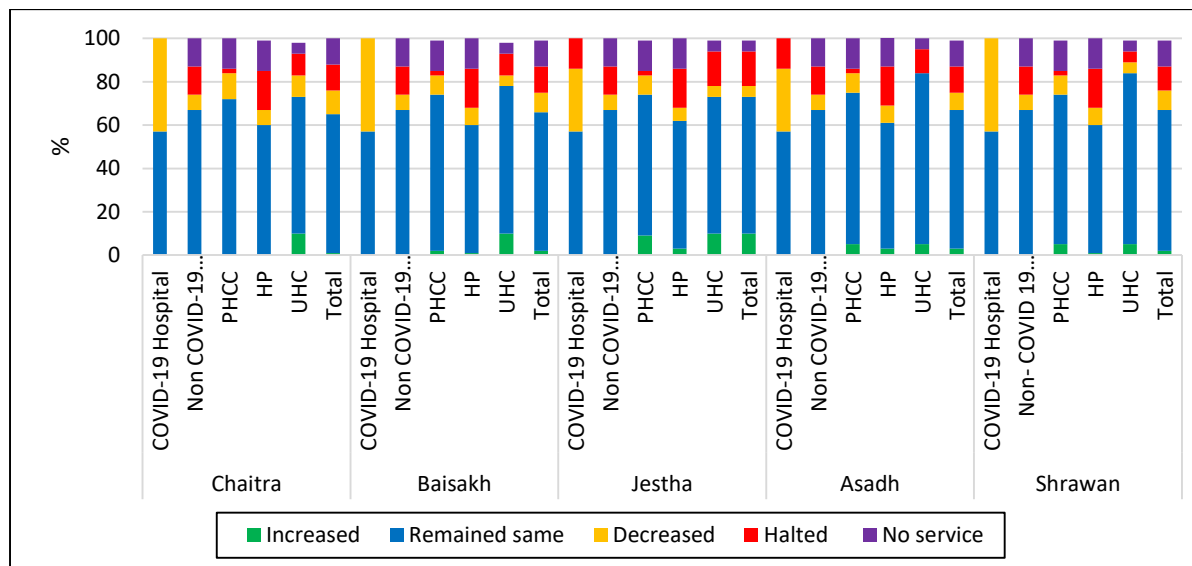
Annex 7.6a: Health facility wise flow of adolescent clients seeking FP contraceptives during the period between Bhadra-Kartik



Annex 7.7: Province-wise flow of adolescent clients seeking Emergency Contraceptive during 5 months' lockdown period



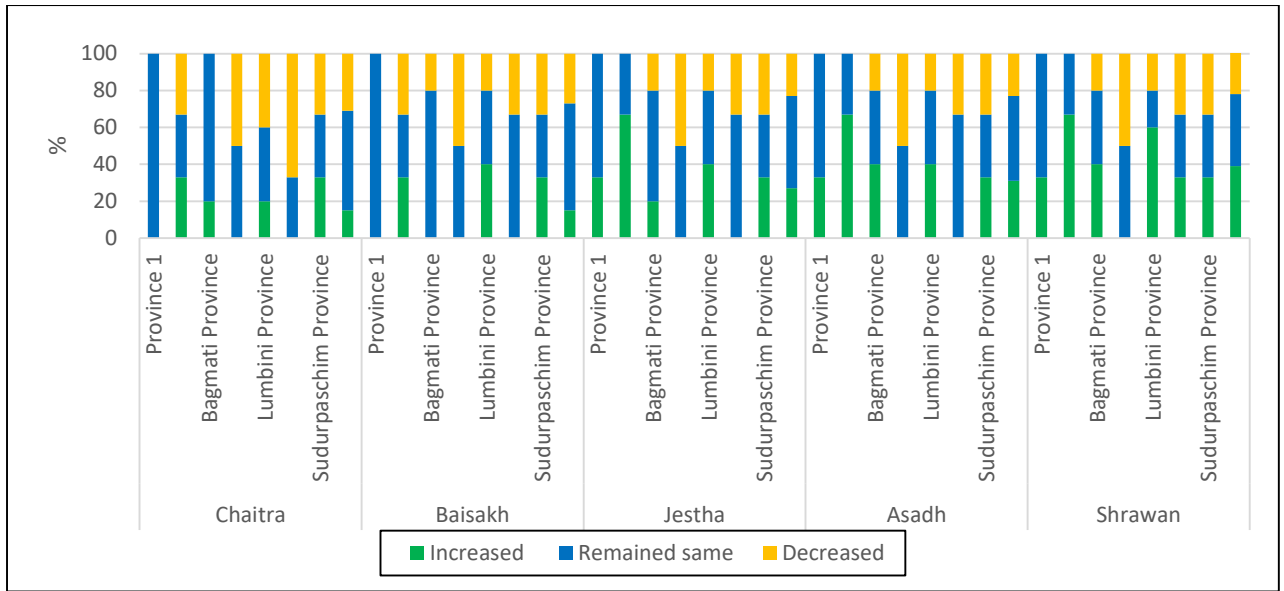
Annex 7.8: Health facility wise flow of adolescent clients seeking Emergency Contraceptives during 5 months' lockdown period



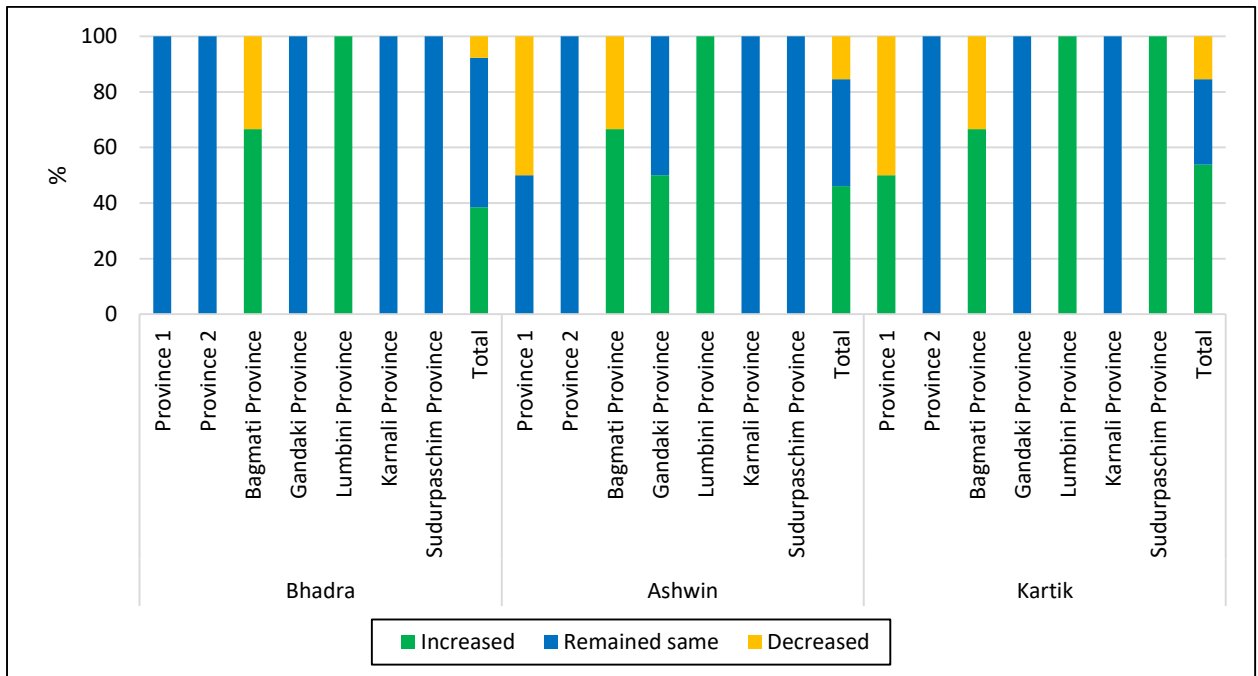
Annex 7.9: Types of SRH services sought by married adolescent girls from FCHVs during 5 months' lockdown period

Types of SRH services sought	Province 1		Province 2		Bagmati Province		Gandaki Province		Lumbini Province		Karnali Province		Sudurpaschim Province		Total	
	Round 1 (n=29)	Round 2 (n=10)	Round 1 (n=38)	Round 2 (n=11)	Round 1 (n=40)	Round 2 (n=8)	Round 1 (n=11)	Round 2 (n=3)	Round 1 (n=28)	Round 2 (n=11)	Round 1 (n=19)	Round 2 (n=6)	Round 1 (n=21)	Round 2 (n=5)	Round 1 (n=186)	Round 2 (n=64)
Temporary FP	51.7	80	86.8	63.6	67.5	37.5	54.5	0	75	54.5	68.4	83.3	81	100	70.9	63
Routine ANC	48.3	20	63.2	90.9	22.5	37.5	27.3	0	53.6	54.5	15.8	16.7	19	40	38.7	44.4
AFHS	13.8	0	21.1	0	22.5	0	0	0	14.3	9.1	0	0	9.5	0	14.5	1.9
Childhood immunization	10.3	10	13.2	36.4	32.5	12.5	0	33.3	10.7	63.6	5.3	0	0	20	13.4	27.8
Pregnancy confirmation	31	40	21.1	36.4	37.5	37.5	36.4	33.3	35.7	72.7	73.7	83.3	52.4	40	38.2	50
Normal delivery/BEONC	10.3	0	21.1	36.4	0	0	0	0	7.1	0	0	0	4.8	0	7.5	7.4
PNC	0	-	7.9	-	15	-	0	-	10.7	-	0	-	0	-	6.5	-
Not visited yet	-	10	-	0	-	25	-	33.3	-	0	-	0	-	0	-	7.4
PAC	-	0	-	9.1	-	0	-	0	-	18.2	-	0	-	0	-	5.6
LARC	0	-	7.9	-	5	-	18.2	-	10.7	-	0	-	0	-	5.4	-
FCHV gives counselling by reaching their homes	-	10	-	0	-	0	-	0	-	9.1	-	0	-	0	-	3.7
EC	3.4	-	13.2	-	5	-	18.2	-	0	-	5.3	-	0	-	5.9	-
SAS	6.9	0	7.9	45.5	5	0	0	0	7.1	0	0	0	0	0	4.8	9.3

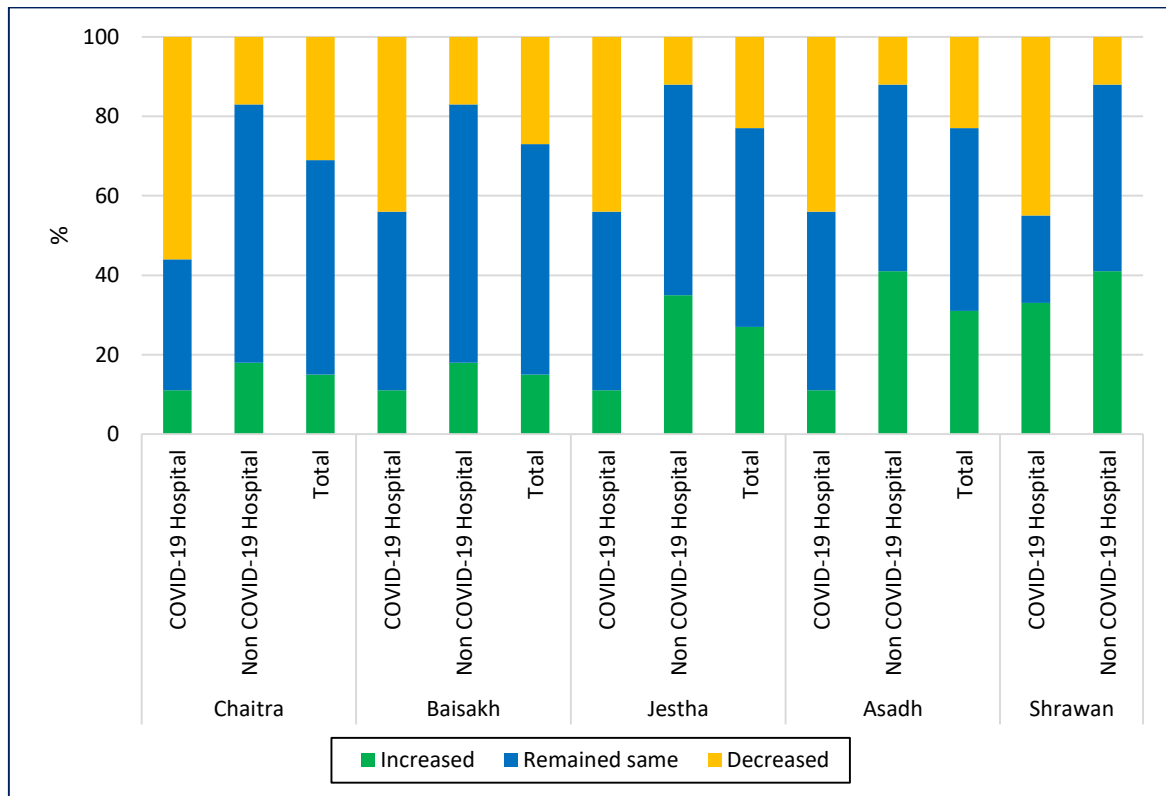
Annex 9.1: Province-wise flow of GBV cases during 5 months' lockdown period



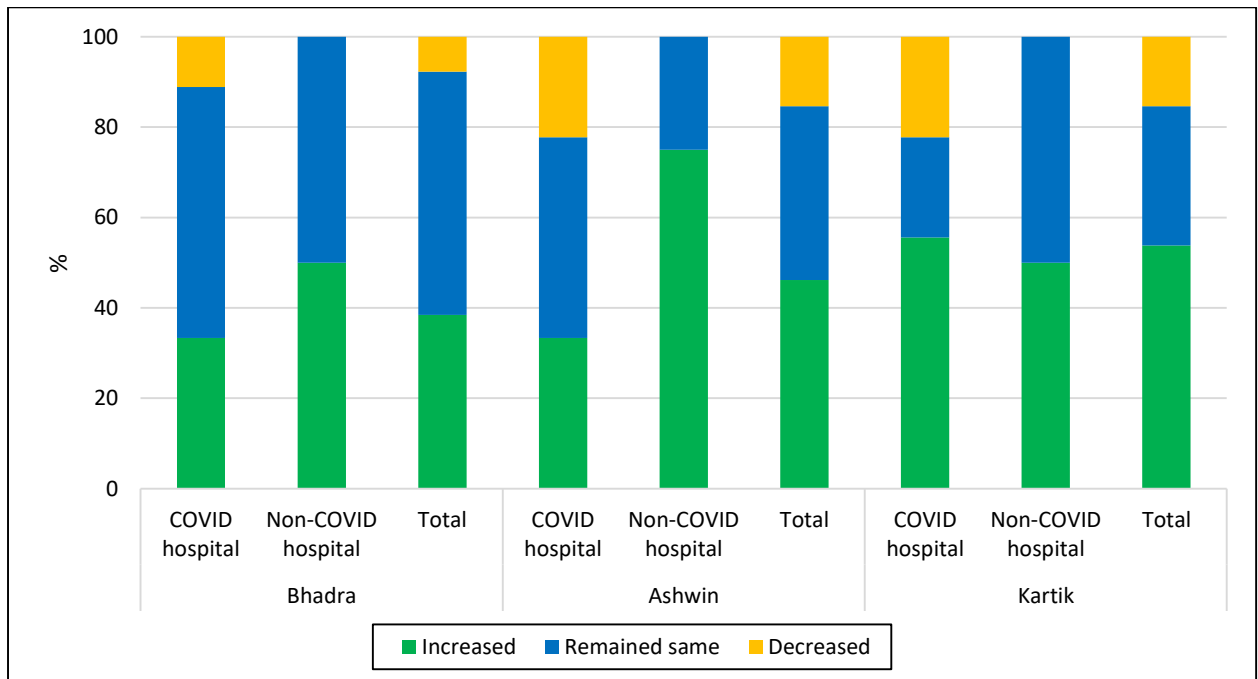
Annex 9.1a: Province-wise flow of GBV cases during the period between Bhadra-Kartik



Annex 9.2: Health facility wise flow of GBV cases during 5 months' lockdown period



Annex 9.2a: Health facility wise flow of GBV cases during the period between Bhadra-Kartik



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