**Nepal Earthquake Recovery Response Restoration of Health Facilities with Improved Access to SRMH and WASH Services**

# Baseline Survey Report

**Submitted to:**
**CARE Nepal, Kathmandu**

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Uma Shankar Prasad
Team Leader

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## List of abbreviations

| | | |
|---|---|---|
| ANC | - | Ante-natal Care |
| CBS | - | Central Bureau of Statistics |
| DEC | - | Disaster Emergency Committee |
| ER | - | Emergency Response |
| FCHV | - | Female Community Health Volunteer |
| FGD | - | Focus Group Discussion |
| GBV | - | Gender-based Violence |
| GESI | - | Gender Equality and Social Inclusion |
| GoN | - | Government of Nepal |
| HH | - | Household |
| IDP | - | Internally Displaced People |
| KAP | - | Knowledge, Attitude and Practice |
| KII | - | Key Informants' Interview |
| M & E | - | Monitoring and Evaluation |
| MoFA | - | Ministry of Foreign Affairs |
| NFI | - | Non-food Item |
| ORC | - | Out-reach Clinic |
| ODF | - | Open Defecation Free |
| ORS | - | Oral Rehydration Solution |
| ORT | - | Oral Rehydration Therapy |
| PHC | - | Primary Health Care |
| PwD | - | Persons with Disability |
| TT | - | Tetanus Toxoid |
| VDC | - | Village Development Committee |
| WASH | - | Water, Sanitation and Hygiene |

# Executive summary

## 1. Background

On 25th April 2015, Nepal was hit by a 7.8 magnitude earthquake which caused massive destruction of private and public infrastructure, injury, and loss of life. As of 12 April 2016, the Government of Nepal (GoN) reported 8,979 lives lost, 22,309 persons injured, 776,895 homes destroyed and a further 298,998 partially damaged. Earthquakes had badly affected health facilities, water supply and sanitation facilities and degraded the community/HHs/ personal hygiene and sanitation status/behaviour. Affected people lack appropriate health facilities, sanitation facilities and water supply infrastructure. They have limited number of latrines available to them, which also increases the practice of open defecation and many health risks resulting from it. People in IDP camps, as in other rural and remote areas, are largely unaware of safe hygiene practices. Loss of assets of vulnerable families, combined with desperation for alternate means of livelihood, may expose women and young girls to disastrous consequences such as GBV and human trafficking. The project aims to restore health facilities, improve access to SRMH services and reduce the mortality and morbidity rate of women of reproductive age, resulting from reproductive emergencies and WASH related diseases in Gorkha district with GBV and protection as a crosscutting issue in Uhiya, Harmi, Gankhu, Barpak, Laprak and Simjung VDCs of Gorkha.

## 2. Objective of the baseline survey

The overall objective of this survey was to establish the baseline values on the project indicators as provided in the project logical framework and monitoring and evaluation (M & E) plan. The baseline survey is part of an initial program assessment to inform setting of benchmarks before project intervention that will determine achievements the project's achievements at the end of the implementation period. The baseline will also provide opportunity to validate design assumptions, updating context information in the target VDCs and inform changes on the design of the project in the logical framework and any necessary alignment on monitoring indicators. The specific objectives of the study were to:

- Gather baseline data on all the relevant outcome indicators mentioned in M & E plan of the projects including KAP survey
- Establish the level of access to drinking water to targeted project VDCs
- Assess availability of drinking water and associated WASH facilities in targeted health facility
- Establish level of access to improved sanitation in the households
- Assess the existing knowledge, attitude and practices of the community on WASH and GBV (on Child marriage, Sexual Violence issues focusing on human trafficking issues)
- Provide recommendations on the sector specific activities for awareness rising on hygiene promotion and GBV for the project to achieve its set targets and objectives
- To identify gaps between project assumptions and field realities

## 3. Methodology

The study was an analytical study based on primary source of information. However, the necessary and required data was also collected through secondary information by reviewing the published and unpublished reports. Primary information was collected through household survey, consultation meetings, key informants' interview (KII) and focus group discussions (FGDs).

Altogether 256 HHs were surveyed. This sample size was calculated using the formula presented below based on the simple random sampling with 6.2% desired precision (d), 95% confidence level (1-α) and estimated value of an indicators is ($p_{srs}$= $q_{srs}$) . The sample was further increased by 2% to account for contingency such as non-response or recording error.

The household were selected based on the three-stage random sampling method. At first stage, 4 VDCs out of 6 from Gorkha were randomly selected. At second stage, 16 wards from Gorkha were selected by using systematic random sampling with probability proportional to size sampling. From each selected ward,

16 HHs were interviewed systematically. For this purpose, HH questionnaire were prepared and finalized through series of consultations with CARE Officials. Eight highly qualified and professional enumerators completed the bachelor's degree and experienced in survey enumeration were oriented and mobilized for field data collection.

The household data was entered by the trained and experienced data entry persons in SPSS. The entered data were cleaned and analyzed by using SPSS and EXCEL. The frequencies and percentage were used for analysis.

## 4. Findings

***Socio-economic and demographic information***

Altogether, 256 respondents were interviewed. Out of them 64.8% were women and remaining 35.2% were men. Almost two third of the respondents were women. Similarly, 32.4% of the respondents were illiterate and 67.6% were literate. Only 7% of the respondents had completed higher secondary education and above.

The percentage of respondents between the age group of 25-34 was highest (26.6%). The average age of the respondent was 41.7 spread over 15 to 85 years. The percentage of respondents of age group 35-44 was 19.9% and 55-64 was 16.8%, however, the percent of respondents of age group 45-54 was only 11.3%.

Out of 256 HHs, 44.1% of the total households were female-headed. This means that out of each 100 HHs, there were 44 female-headed households. Moreover, 3.9% of the households were at least one member with disable and 10.5% HHs with chronic illness

The largest ethnic/caste group in the project area was Janajati 57.8% of all households and the second largest ethnic/caste group was Dalit. Overall, 21.1% of households in project area were identified as Dalit and 20.3% as Brahmin/Chhetri.

The most commonly reported main source of income was agriculture. This was the main source of income for 45.7% of all households in the project area. In addition, the second and third most common sources of income were foreign employment and wage labour respectively. It is noted that only 1.2% of the HHs reported skilled work as a main source of income.

***Health***

Published data on all goal level indicators included in the logical framework of the project are not available in Nepalese context. Therefore, proxy indicators values related to these indicators are included in the report. It is needed to revise the logical framework of the project by considering the availability of information. Therefore, this report provides the revised version of goal level indicators. Regarding percentage of all deaths of women of reproductive age in Gorkha that are caused by reproductive emergencies (maternal mortality) was zero for FY 2014/15. Percentage of obstetric complications among total delivery has been taken as the proxy indicator for morbidity rate among women of reproductive age under this study. The value was 8.7 per cent for FY 2014/15.

Six health facilities namely Laprak, Barpak, Gankhu, Simjung, Uhiya and Harmi were visited during the baseline survey. Among them, Laprak, Barpak and Gankhu had temporary buildings. In Barpak, the health post was providing its services by residing in VDC building. Two health posts' building comprising Simjung and Harmi were *Pakki*. In Uhiya, the building was *Kacchi*. There was no separate toilet as well as bathroom for men and women in all health facilities. There was no safe drinking water facility was available in the health facilities of the project area. Five health facilities had primary health care/outreach clinics (PHC-ORC). Among them, only 4 had basic hygiene and hand washing materials. However, no PHC-ORC had bucket for the collection of waste water and piyush or aqua tablet for water purification. Gankhu and Harmi were using dustbins with different colours for different nature of waste disposal.
Altogether, 81 pregnant women delivered at the 4 health facilities in the last 12 month from the study period. Among them 77 delivered at 2 birthing centres. This reflects that on an average 2.14 deliveries per month

were recorded at the birthing centres health facilities. Out of total 81 deliveries, 38 (47%) were carried out at the health facilities of Barpak whereas 33 (41%) in Simjung and 6 (7.4%) in Harmi. There were functional birthing centres in Barpak and Simjung VDCs only. There was no birthing centre in Uhiya, Gankhu, Laprak and Harmi. During consultation with health officials of the northern belt (Laprak and Barpak), it was pointed out that very few delivery cases come to the health facilities/birthing centres. Most of the cases were delivered at home with the support of health personnel. 77.3% of the HHs received information related to hygiene, sexual and reproductive and maternal health through FCHVs and mothers' groups.

Out of 14 FCHVs interviewed, 11 FCHVs provided piyush or aqua tablet to 657 HHs on regular basis. This shows on an average each FCHV provided piyush or aqua tablets to 60 HHs during last one year from the survey period. Similarly, all FCHVs provided information to 1,352 HHs about hygiene promotion. 63 pregnant and 74 lactating women benefited from 96 hygiene promotion activities which were conducted by 13 FCHVs. On an average 20 patients received oral rehydration therapy (ORT) in the health institutions. It is noted that 3 health posts namely Simjung, Uhiya and Harmi had ORS corner but not well managed as per the Ministry of Health and Population (MoHP) guideline. Therefore, support is needed for strengthening the ORS corner.

All health personnel were found aware about infection. Only 26.6% of the health personnel received training on infection prevention through government organizations. Out of 15 health personnel, 93.3% were aware about washing their hand before starting the check-up of patients, 80% were using gloves and 66.7% were using sterilized equipments. 56.3% of the total 256 respondents told that pregnant women need to take nutritious food and visit health institution at least 4 times for ANC check-up. 91.4% of the respondents were aware that health institution was the suitable place for birthing. 50% of the respondents were aware that mother and child get proper care in the health institutions during delivery. 8.2% of the respondents did not know about the components to be considered for better care of lactating women and child and 91.8% were aware on at least one of the major components. Majority (67.6%) of the respondents were aware that maternity women had to eat nutritious food and mothers needed to feed their own milk to newly born child up to six months (42.6%). 32% strongly agreed about the statement that pregnant and lactating women should examine regularly at the health institutions and 63.2% agreed on the statement. About 5% of the respondents were undecided with the statement. There was no respondent against the statement that pregnant and lactating women should examine regularly at the health institutions.

13.3% of the total HHs had at least one pregnant woman and 11.3% with lactating woman during the last one year from the survey period. The percentage of HHs with neither lactating nor pregnant women was 86.7%. Out of 256 HHs, 34 HHs were with at least one pregnant woman. Out of which, 52.9% had checked up at least 4 antenatal care (ANC), 50.0% had taken iron and folic acid and 44.1% had immunized TT vaccine. Altogether 29 delivery cases of pregnancy were reported during the survey. Among them 51.7% of the respondents told that they had delivered at the health institutions. Out of 256 HHs, 29 HHs were with at least one lactating women. Out of 29 HHs, 44.8% HHs with lactating women were checked up at least one time after birthing. Similarly, 69.0% fed their own milk to child up to six months and 58.6% ate nutritious food. Out 34 HHs with pregnant and lactating women, 64.7% reported that they had received special type of hygiene kit.

***Water, sanitation and hygiene (WASH)***

Altogether 30.5% of households in the project areas were currently using an unimproved source of drinking water. Majority of the HHs (62.1%) were using public tap/standpipe followed by covered spring (23.0%), piped water into house or plot 7.4%. 6.3% of the HHs spent more than half an hour to two hours for fetching water. Similarly, almost one fifth of the HHs had to spend more than 20 minutes and half of the HHs had to spend more than 10 minutes for fetching water. It should also be noted that although high proportion of households using improved sources of drinking water, however during the FGDs with beneficiaries, it was found that there was no easy access and sufficient water quantity in the project area. In Laprak, people have to spend around half an hour to 1.5 hours for fetching water. Mostly women were involved in fetching water which has added over burden to them. Consequently they are not able to engage themselves in income generating activities. Therefore, access of water and water quantity is a major issue for households across the project area. During consultation meetings with CARE and partner staffs, the concern was raised

about the budget allocated for the water schemes to be constructed during the project phase. They told that the amount allocated per water scheme was not sufficient for construction of those water schemes. If the schemes would be constructed with allocated amount of limited NPR 900 thousand, then the scheme might not be sustainably well constructed.
Altogether 50.8% of the respondents in average were aware about the various methods of purification of water. 24.2% of the total respondents strongly agreed on the statement that people became ill if they drank water without purification. 33.2% of the respondents did not use any purification process for drinking water.

Altogether 43% of the respondents in average had the knowledge on various components of personal hygiene including washing hand with soap/ash after toilet, washing hand with soap/ash before and after cooking food, bathing once in a week, brushing teeth every day, urination in the toilet, defecation in the toilet, wearing slipper while going to toilet, cutting nail, wearing clean clothes and cutting hair and beard from time to time when the question was asked without mentioning the options. 30.9% of the respondents strongly agreed on the statement that people became ill if proper personal hygiene was not maintained. Altogether 44.0% of the respondents in average were found to be practicing on the above mentioned various components of personal hygiene.

Altogether 30.0% of the respondents had the knowledge in average on various types of household hygiene comprising covering foods, eating fresh and clean food, keeping kitchen clean, keeping water pot clean, not stir water with hand, using smoke free modern stove, washing fruits and vegetable before eating, using clean bed sheet, keeping house surrounding clean, not keeping livestock's in the kitchen, throwing wastage in pit, keeping livestock's in separate place, encouraging children to use toilet, washing hands with soap after toileting children and bathing children once in a week. About 25.8% of the respondents strongly agreed on the statement that family members could be sick if proper family hygiene was not maintained.Altogether 28% of the respondents in average were found to be practicing on the above mentioned various components of household hygiene.

***Gender-based violence (GBV)***

The project basically focuses on 4 major types of GBV comprising of human trafficking, child marriage, rape and physical and sexual violence. Altogether 35.0% of the total respondents in average had the knowledge about 4 above mentioned major types of GBV. 30.5% of the respondents strongly agreed on the statement that GBV was social and legal crime. Only 8.6% of the respondents replied that their family members faced any of 4 major types of GBV. The proportion might be low because the knowledge on GBV is low in the community and they might be unaware that they are victimized. Additionally, GBV survivors do not like to expose themselves as GBV survivors due to social prestige. Sometimes the criminal activities like rape are not exposed and sometimes solved through community mediation.

During the consultation meetings with different stakeholders during field visit, it was pointed out that people did not openly talk on the matter of GBV due to social prestige and stigma. They wanted to hide the real situation and cases of GBV. It was found that the awareness level on exposing the cases of GBV in the project area was still low. It was noted that the number of cases could increase if awareness campaigns are made. In-depth study on the issue in order to explore the real situation of GBV in the project area is needed.

It was also pointed out that the cases of GBV have slightly increased after earthquake. They had also the concern to launch the case management of GBV victims including referral system. During FGDs with beneficiaries, it was found that the nature of child marriage has changed nowadays. Earlier parent used to force for child marriage. But nowadays, particularly school boys and girls fall in love by watching TV programs and communicating with mobile phones and Facebook.

Altogether 33.0% of the respondents received information on various types of GBV through social mobilizers, self-help groups, door to door and group awareness programs, radio, television and newspapers in average. However, 34.0% of the members of the HHs either did not listen to GBV messages or did not know. Only 35.1% of the member of the HHs used information in educating members of the households and the community about the risks of trafficking.

Altogether 66.8% of the members of the HHs either did not use or receive information regarding child marriage. 18.0% of the members of the HHs shared the information with HHs members and 19.5% with members of the community. Only, 6.3% of the members tried to stop child marriage and 5.9% informed to the security agencies after occurrence of the event.40.6% of the members of the HHs did not share the information regarding rape. Out of 256 HHs, 13.3% of the member of the HHs shared information within their family members and 16% shared in the community. However, only 9.0% of the member of the HHs informed to security agencies after occurrence of the event. 27% of the members of the HHs did not share the information regarding physical and sexual violence. Out of 256 HHs, 23.0% of the member of the HHs shared information within their family members and 13.3% shared in the community. However, only 6.6% of the member of the HHs tried to stop physical and sexual violence at community level and 10.2% informed to security agencies after occurrence of the event. Majority (91.4%) of the respondents in the project area did not receive any IEC materials. Altogether 6.3% of the respondents received poster and 4.7% received brochures as IEC materials. Only 22 (8.6%) respondents received IEC materials. Among them, 3.5% of the respondents conducted awareness program in the society, 3.1% used face to face discussion and 1.2% conducted door to door awareness campaign.

## 4. Baseline value of the indicators of the M & E framework

| Indicator | Base value | Reference |
|---|---|---|
| **Goal** | | |
| **Goal Indicator G.a:** Change in all deaths of women of reproductive age in Gorkha between project baseline and endline that are caused by reproductive emergencies (maternal mortality) | 0 | Section 3.1 II paragraph |
| **Goal Indicator G.b** : Change in % of obstetric complications among total delivery in Gorkha between project baseline and endline | 8.7% | Section 3.1 II paragraph |
| **Outcome 2** | | |
| **Outcome Indicator 2.a:** # of targeted HFs with separate toilets for men and women available | 0 | Table 3.2 |
| **Outcome Indicator 2.b:** # of targeted HFs with separate bathing facilities for men and women available | 0 | Table 3.2 |
| **Outcome Indicator 2.c:** # of targeted HFs with access to improved drinking water | 6 but not sufficient | Table 3.2 |
| **Outcome Indicator 2.d:** # of targeted outreach clinics with basic hygiene and hand-washing supplies | 4 | Table 3.3 |
| **Outcome Indicator 2.e:** # of targeted HFs with functional medical waste disposal system | 2 | Table 3.4 |
| **Outcome 3** | | |
| **Outcome Indicator 3.a:** # of HHs with access to the newly rehabilitated (maintained during the project period) water supply systems | 0 | Activity not started |
| **Outcome Indicator 3.b:** # of HHs reached with hygiene and SRMH information through FCHVs and members of mothers groups | 77.3% | Table 3.6 |
| **Outcome Indicator 3.c:** # of households receiving piyush/aqua tabs | 28.5% | Table 4.6 |
| **Outcome Indicator 3.d:** # of PLW receiving special hygiene kits | 35.3% | Table 3.20 |

## 5. Recommendations

- Support to establish new birthing centre in Gankhu, Uhiya, Barpak and Harmi VDCs and enhance services and equipment facilities in birthing centre of Barpak and Simjung VDCs
- Support to construct buildings of government health facilities in Laprak, Barpak, Gankhu, Harmi and Uhiya VDCs
- Support to construct separate toilet and bathroom for men and women in all health facilities of the project area
- Provide basic hygiene and washing materials in PHC-ORC clinic of Laprak and Barpak and provide additional support needed for improvement of hygiene and hand washing activities in other 4 PHC-ORC clinics.
- Support water supply system in Laprak, Barpak and Gankhu health post
- Provide different coloured dustbins in Laprak, Barpak, Simjung and Uhiya health post for different nature of waste disposal
- Provide capacity enhancement training on infection and its management to health professionals
- Empower all FCHVs distribute piyush and aqua tablets to the all HHs in the project area especially during the rainy season
- Establish ORT corner in Laprak, Barpak and Gankhu health posts and strengthen in other health posts
- Either reduce the number of drinking water schemes or increase the amount of budget allocated for per drinking water scheme in order to make the scheme complete and sustainable
- Replace the program of piyush and watergard distribution with filter distribution
- Add activities of case management and psychological support under GBV
- Focus on domestic violence and child marriage under GBV
- Conduct in-depth study on GBV to explore the real scenario
- Conduct mass awareness programs (group discussions, radio messages, IEC) on WASH, GBV and SRMH so as to increase the knowledge and practices on basic hygiene and maternal child health service utilization

# Chapter – I
# Introduction

## 1.1 Introduction

On 25th April 2015, Nepal was hit by a 7.8 magnitude earthquake which caused massive destruction of private and public infrastructure, injury, and loss of life. The National Seismological Centre has recorded as many as 446 aftershocks with a magnitude of 4 or greater, including a 7.3 magnitude earthquake on 12 May, which caused further destruction in already devastated areas. As of 12 April 2016, the Government of Nepal (GoN) reported 8,979 lives lost, 22,309 persons injured, 776,895 homes destroyed and a further 298,998 partially damaged.

Earthquakes had badly affected health facilities, water supply and sanitation facilities and degraded the community/HHs/ personal hygiene and sanitation status/behaviour. The earthquakes have forced entire communities with fully damaged health posts and households in seismically vulnerable areas to move to temporary camps. Affected people lack appropriate health facilities, sanitation facilities and water supply infrastructure. They have limited number of latrines available to them, which also increases the practice of open defecation and many health risks resulting from it. People in IDP camps, as in other rural and remote areas, are largely unaware of safe hygiene practices.

The earthquakes have also reduced the already narrow asset base and limited access to economic resources of vulnerable groups (including ethnic minorities, people with low-socio-economic status, IDPs), especially those living in rural areas. Loss of assets of vulnerable families, combined with desperation for alternate means of livelihood, may expose women and young girls to disastrous consequences such as GBV and human trafficking.

The project aims to restore health facilities, improve access to SRMH services and reduce the mortality and morbidity rate of women of reproductive age, resulting from reproductive emergencies and WASH related diseases in Gorkha district with GBV and protection as a crosscutting issue in Uhiya, Harmi, Gankhu, Barpak, Laprak and Simjung VDCs of Gorkha.

## 1.2 Purpose and objectives of the survey

The overall objective of this survey was to establish the baseline values on the project indicators as provided in the project logical framework and monitoring and evaluation (M & E) plan. The baseline survey is part of an initial program assessment to inform setting of benchmarks before project intervention that will determine achievements the project's achievements at the end of the implementation period. The baseline will also provide opportunity to validate design assumptions, updating context information in the target VDCs and inform changes on the design of the project in the logical framework and any necessary alignment on monitoring indicators. The specific objectives of the study were to:

- Gather baseline data on all the relevant outcome indicators mentioned in M &E plan of the projects including KAP survey
- Establish the level of access to drinking water to targeted project VDCs
- Assess availability of drinking water and associated WASH facilities in targeted health facility
- Establish level of access to improved sanitation in the households
- Assess the existing knowledge, attitude and practices of the community on WASH and GBV (on Child marriage, Sexual Violence issues focusing on human trafficking issues)
- Provide recommendations on the sector specific activities for awareness rising on hygiene promotion and GBV for the project to achieve its set targets and objectives
- To identify gaps between project assumptions and field realities

## 1.3 Rationale of the study

CARE Nepal aims to carry out the repair and rehabilitation of the health facilities, increasing awareness to improved drinking water, sanitation and hygiene facilities while providing information; to raise community awareness on issues related to GBV and protection (with a focus on human trafficking) in the MoFA project VDCs of Gorkha. To achieve this goal, the project has set out different health related activities with outcome and output level indicators. Therefore, baseline study has provided the present health facility status in the target area against specific proposed indicators. Baseline data is necessary to compare the project results and measure the progress based on the identified benchmark.

## 1.4 Approach

**Project Indicator-based:** The indicators of the log frame of the project were the prime basis for the baseline survey. The tools and techniques used in the study were to identify the baseline values of the project indicators.

**Participatory approach**: The participatory approach was adopted in order to involve all target groups (households and community), implementing partners and local and district level stakeholders in the study.

**Gender Equality and Social Inclusion (GESI)**: GESI including the representation from persons with disability (PwD) approach has been adopted in data collection, analysis and presentation of the findings.

## 1.5 Methodology

### 1.5.1 Study design

The study was an analytical study based on primary source of information. However, the necessary and required data was also collected through secondary information by reviewing the published and unpublished reports. Primary information was collected through household survey, consultation meetings, key informants' interview (KII) and focus group discussions (FGDs).

### 1.5.2 Review of the secondary Information

The following information were collected and reviewed for this study

- Project documents including log-frame and M & E plan
- Review of national policies and strategies related to the health post and health facilities and earthquake affected people including WASH and gender based violence
- Annual report of DPHO, 2071
- District level plan and policies
- List of project beneficiaries
- National Census 2011

### 1.5.3 Collection of primary information

**Consultations**

The following agencies were consulted at district and VDCs level.

- Officials of CARE Nepal and its implementing partners
- DDC, District Public Heath Office, District Water and Sanitation Office, District Women and Children Office, District Urban Development and Building Construction
- VDC Secretary of sample VDCs

**Household survey**

**Sample Size and sampling method:** Altogether256 HHs were surveyed. This sample size was calculated using the formula presented below based on the simple random sampling with 6.2% desired precision (d), 95% confidence level (1-α) and estimated value of an indicators is ($p_{srs}$= $q_{srs}$) . The sample was further increased by 2% to account for contingency such as non-response or recording error.

$$n_{srs} = \frac{N\hat{p}_{srs}\hat{q}_{srs}}{\frac{d^2}{1.64^2}(N-1) + \hat{p}_{srs}\hat{q}_{srs}}$$

The household were selected based on the three-stage random sampling method. At first stage, 4 VDCs out of 6 from Gorkha were randomly selected. At second stage, 16 wards from Gorkha were selected by using systematic random sampling with probability proportional to size sampling. From each selected ward, 16 HHs were interviewed systematically. For this purpose, HH questionnaire were prepared and finalized through series of consultations with CARE Officials.

**Orientation to the enumerators and pre-testing of the questionnaire:** Eight highly qualified and professional enumerators completed the bachelor's degree and experienced in survey enumeration were oriented and mobilized for field data collection. During orientation, enumerators were doing practice in pairs and their concerned were resolved.

**Institutional survey:** The institutional survey was conducted with all six health posts of six project VDCs. Besides this, the officials of the health post also were interviewed.

**Focus group discussions (FGDs):** Altogether, 3 FGDs were accomplished in three project VDCs conducted in Laprak and Barpak and Gankhu of Gorkha districts. The discussion with beneficiaries on focus group was aligned to project log-frame and triangulated it with household questionnaire.

**Key informants interview:** Key informants interview were accomplished with officials of health post, Self Help Group (User Committee and Mother Group), Female Community Health volunteer (FCHV). KII were carried out with the officials of health post of Simjung, Barpak and Laprak VDCs of Gorkha. In addition, 14 FCHVs from 4 VDCs were interviewed.

### 1.5.4 Data management and analysis

The household data was entered by the trained and experienced data entry persons in SPSS. The entered data were cleaned and analyzed by using SPSS (Statistical Package for Social Science) and EXCEL. The frequencies and percentage were used for analysis.

### 1.5.5 Ethical consideration and informed consent

All the respondents involved in the study were fully informed about the nature of the study, research objectives and confidentiality of the collected information. The research assessors solicited each respondent a verbal consent prior to the enrolment in the study. Only those respondents who voluntarily agreed to participate were involved in the study. All study participants were informed of their right to refuse participation and to leave the interview at any time.

## 1.6 Limitation of the study

- There was no PHC-ORC clinic ongoing during the field visits. Therefore, the information on PHC-ORC clinic was gathered by consultation with respective health post in-charges.

# Chapter – II
# Socio-economic and demographic information

This chapter presents the socio-economic and demographic characteristics of the DEC II project intervention area. The socio-economic and demographic characteristics include sex, age, literacy status, ethnicity etc. of the respondents as well as number of pregnant and lactating women, children, aged people etc. in the households.

## 2.1 Sex, age and literacy status of the respondent

Altogether, 256 respondents were interviewed. Out of them 64.8% were women and remaining 35.2% were men. Almost two third of the respondents were women. Similarly, 32.4% of the respondents were illiterate and 67.6% were literate. Only 7% of the respondents were completed higher secondary education. This indicates that the educational status of the respondents was very poor (Table 2.1).

**Table 2.1: Sex and literacy status of the respondents (in %)**

| Categories | Number | Percent |
|---|---|---|
| **Sex** | | |
| Women | 166 | 64.8 |
| Men | 90 | 35.2 |
| **Literacy status** | | |
| Illiterate | 83 | 32.4 |
| Just read and write | 49 | 19.1 |
| Class I-V | 41 | 16.0 |
| Class VI-VIII | 31 | 12.1 |
| Class IX – X | 34 | 13.3 |
| Class XI & above | 18 | 7.0 |
| **N** | **256** | **100.0** |

## 2.2 Age distribution

The percentage of respondents between the age group of 25-34 was the highest (26.6%). The average age of the respondent was 41.7 years spread over 15 to 85 years. The percentage of respondents of age group 35-44 was 19.9% and 55-64 was 16.8%. The percent of respondents with the age group of 45-54 was only 11.3% (Table 2.2).

**Table 2.2: Age distribution of the respondents (in %)**

| Age | Number | Percent |
|---|---|---|
| 15-24 years | 37 | 14.5 |
| 25-34 years | 68 | 26.6 |
| 35-44 years | 51 | 19.9 |
| 45-54 years | 29 | 11.3 |
| 55-64 years | 43 | 16.8 |
| 65+ years | 28 | 10.9 |

## 2.3 Vulnerable groups

Out of 256 HHs, 44.1% of the total households were female-headed. This means that out of each 100 HHs, there were 44 female-headed households. Moreover, 3.9% of the households were at least one member with disable and 10.5% HHs with chronic illness (Table 2.3).

**Table 2.3: HHs with the vulnerable members**

| Vulnerability | Number | Percent |
|---|---|---|
| Female-headed | 113 | 44.1 |
| Chronic illness | 27 | 10.5 |
| Disability | 10 | 3.9 |
| **N** | **256** | **100.0** |

## 2.4 Caste/ethnicity

The largest ethnic/caste group in the project area was Janajati57.8% of all households and the second largest ethnic/caste group was Dalit. Overall, 21.1% of households in project area were identified as Dalit and 20.3% as Brahmin/Chhetri (Table 2.4).

**Table 2.4: Sample households by ethnicity (%)**

| Ethnicity | Number | Percent |
|---|---|---|
| Janajati | 148 | 57.8 |
| Dalit | 54 | 21.1 |
| Brahmin/Chhetri | 52 | 20.3 |
| Others | 2 | 0.8 |
| **N** | **256** | **100** |

## 2.5 Sources of income

The most commonly reported main source of income was agriculture. This was the main source of income for 45.7% of all households in the project area. In addition, the second and third most common sources of income were foreign employment and wage labour respectively. It is noted that only 1.2% of the HHs were reported as the skilled work as a main source of income (Table 2.5).

**Table 2.5: HHs with major source of income (%)**

| Main sources of income | Number | Percent |
|---|---|---|
| Agriculture | 117 | 45.7 |
| Livestock | 8 | 3.1 |
| Wage labour | 38 | 14.8 |
| Business | 22 | 8.6 |
| Paid job/service | 24 | 9.4 |
| Foreign employment | 40 | 15.7 |
| Skilled work | 3 | 1.2 |
| Other | 4 | 1.6 |
| **Total** | **256** | **100.0** |

# Chapter – III
# Health

## 3.1 Mortality and morbidity among women of reproductive age

Published data on all goal level indicators included in the logical framework of the project are not available in Nepalese context. Therefore, proxy indicators values related to these indicators are included in the report. It is also difficult to calculate even from the Health Management Information System (HMIS) of the Department of Health Services, Government of Nepal. Therefore, it is needed to revise the logical framework of the project by considering the availability of information. This report provides the revised version of goal level indicators under executive summary as well as in Chapter 6.

Regarding percentage of all deaths of women of reproductive age in Gorkha that are caused by reproductive emergencies (maternal mortality) was zero for FY 2014/15 which is reported data by health facilities and abstracted from Health Management Information System (HMIS). Percentage of obstetric complications among total delivery has been taken as the proxy indicator for morbidity rate among women of reproductive age under this study. The value was 8.7 per cent for FY 2014/15. It is calculated by dividing maternal morbidity from obstetric complications (599) to expected pregnancy (6,890).

**Table 3.1: Morbidity due to obstetric complications, 2014/15**

| Morbidity due to Obstetric complications | Number |
|---|---|
| Ectopic pregnancy | 1 |
| Abortion Complication | 140 |
| Pregnancy-induced hypertension | 2 |
| Severe/ Pre-eclampsia | 4 |
| Eclampsia | 4 |
| Hyper-mesis gravidarum | 25 |
| Ante- partum haemorrhage | 4 |
| Prolonged labour | 148 |
| Obstructed labour | 181 |
| Ruptured uterus | 0 |
| Post partum haemorrhage | 31 |
| Retained placenta | 19 |
| Puerperal sepsis | 7 |
| Other complications | 33 |
| **Total** | **599** |

***Source:*** Annual Report, Department of Health Services, Government of Nepal, FY 2014/15

## 3.2 Status of basic infrastructure and services in health institutions

Six health facilities were visited during the baseline survey. During the consultation meetings with the health personnel it was pointed out that all the buildings were completely destroyed by the earthquake except Simjung which was also partially destroyed. Table 3.2 shows that during the baseline survey, Laprak, Barpak and Gankhu had temporary buildings. In Barpak, the health post was providing its services by residing in VDC building. Two health posts buildings' comprising Simjung and Harmi were *pakki*. In Uhiya, the building was *Kacchi*[1]. There was no separate toilet as well as bathroom for men and women in all health facilities in the project VDCs. There was no safe drinking water facility in the health institutions of the project area. Staffs were found to be engaged in fetching water for around one hour during the field visit.

**Table 3.2: Status of buildings, drinking water and sanitation facilities at health institutions**

| Items | Laprak | Barpark | Gankhu | Simjung | Uhiya | Harmi | Total |
|---|---|---|---|---|---|---|---|
| Types of buildings | Temporary | Temporary | Temporary | Pakki | Kacchi | Pakki | |
| Separate toilet for men women | No | No | No | No | No | No | 0 |
| Separate bathroom/place for men and women | No | No | No | No | No | No | 0 |
| Facility for safe drinking water | No | No | No | No | No | No | 0 |
| Water supply system | No | No | No | Yes | Yes | Yes | 3 |

Out of 6 health posts, 5 had primary health care/outreach clinic (PHC-ORC) in their catchment area and all were providing monthly services. Among them, only 4 had basic hygiene and hand washing materials with soap, bucket, jug and towel. However, no PHC-ORC had bucket for the collection of waste water and piyush or aqua tablet for water purification (Table 3.3).

**Table 3.3: Status of PHC-ORC clinic**

| Categories | Laprak | Barpark | Gankhu | Simjung | Uhiya | Harmi | Total |
|---|---|---|---|---|---|---|---|
| Health post having PHC-ORC clinic | No | Yes | Yes | Yes | Yes | Yes | 5 |
| PHC-ORC is providing services monthly | No | Yes | Yes | Yes | Yes | Yes | 5 |
| PHC-ORC has basic hygiene and hand washing materials | No | No | Yes | Yes | Yes | Yes | 4 |
| PHC-ORC has soap, bucket, Jug and towel | No | No | Yes | Yes | Yes | Yes | 4 |

[1]Health facilities' buildings were divided into four categories on the basis of types of construction materials used in walls and roof of the residential house. Permanent (Pakki) building referred to that with both walls and roof made of permanent construction material like cement, bonded brick, concrete, stone, slate, tile, galvanized sheet, etc. Semi-permanent (Ardha Pakki) building belonged to the category where either the wall or the roof is constructed with permanent materials and the other is constructed with temporary materials. In temporary (Kachhi) building, non-durable materials like wooden flakes, bamboo, straw/thatch, mud, unbaked bricks, etc. were mainly used in both walls and roof. Temporary building was defined as made temporarily with CGI sheets or residing in rent or other government building.

Table 3.4 shows the waste disposal system. Gankhu and Harmi were using dustbins with different colours for different nature of waste disposal. Rest four were used single dustbin for all types of waste. Out of 6 health facilities, 3 were used to manage their waste daily and 2 of them were twice in a week. All the health facilities were disposed their waste either by burning or buried. Only one health facility had decomposition pit. During consultation with the health personnel of Barpak, the placenta was given to respective client for disposal.

**Table 3.4: Waste disposal system**

| Waste disposal | Laprak | Barpark | Gankhu | Simjung | Uhiya | Harmi | Total |
|---|---|---|---|---|---|---|---|
| Collect waste in coloured dustbin (use of different dustbin for different nature of waste disposal) | No | No | Yes | No | No | Yes | 2 |
| Collect all type of waste in single dustbin | Yes | Yes | No | Yes | Yes | No | 4 |
| Provision of waste management in a week | Twice in a week | Once in week | Twice in a week | daily | daily | daily | |
| **Methods of waste disposal** | | | | | | | |
| Decomposition pit | No | No | Yes | No | No | No | 1 |
| Burning | Yes | Yes | Yes | Yes | Yes | No | 5 |
| Waste buried | No | No | Yes | Yes | Yes | Yes | 4 |
| Placenta pit | No | No | No | Yes | No | No | 1 |

## 3.3 Service delivery

Table 3.5 shows the number of deliveries at the health facilities by VDCs. Altogether, 81 pregnant women were delivered at the 4 health facilities in the last 12 month from the study period. Among them 77 were delivered at 3 birthing centres. This reflects that on an average 2.14 deliveries per month were recorded at the birthing centres and 1.12 deliveries at health facilities. Out of 81 deliveries, 38 (47%) were carried out at the health facilities of Barpak whereas 33 (41%) in Simjung and 6 (7.4%) in Harmi. It was noted that there was functional birthing centre in Barpak and Simjung VDCs only. There was no birthing centre in Uhiya, Gankhu Laprak and Harmi. No deliveries were occurred in the health facilities in Gankhu and Uhiya. In the case of Laprak, 4 deliveries took place at health facilities. The number of deliveries recorded at the health facilities was very low in rainy season (Chaitra, Baishakh, Jestha, Asadh, Shrawan) and was significantly high in winter season (Poush, Magh and Falgun). Literature shows that there is no significant difference in the number of deliveries by month. However, in the case of project area, the number of deliveries during rainy season at the health facilities was low due to the lack of transportation facilities, difficult to travel on trail route etc.

During consultation with health officials of the northern belt (Laprak and Barpak), it was pointed out that very less delivery cases were used to come to the health facilities/birthing centres. Most of the cases were delivered at home with the support of health personnel. In the southern belt like Gankhu VDC, most of the delivery services were used to taken from the health facilities.

**Table 3.5: Number of deliveries recorded at the health facilities by VDCs in last 12 month**

| Month | Laprak | Barpark | Gankhu | Simjung | Harmi | Uhiya | Total |
|---|---|---|---|---|---|---|---|
| Baishakh | - | - | - | 2 | - | - | 2 |
| Jestha | - | - | - | 3 | - | - | 3 |
| Asadh | - | - | - | 4 | 1 | - | 5 |
| Shrawan | - | 5 | - | 1 | 1 | - | 7 |
| Bhadra | - | 5 | - | 1 | - | - | 6 |
| Ashoj | 4 | 2 | - | 2 | - | - | 8 |
| Kartik | - | 4 | - | 4 | 1 | - | 9 |
| Mansir | - | 3 | - | 2 | | - | 5 |
| Poush | - | 3 | - | 5 | 2 | - | 10 |
| Magh | - | 5 | - | 6 | 1 | - | 12 |
| Falgun | - | 8 | - | 2 | - | - | 10 |
| Chaitra | - | 3 | - | 1 | - | - | 4 |
| **Total** | **4** | **38** | **-** | **33** | **6** | **-** | **81** |
| There are 2 functional birthing centres because only in Barpak and Simjung had at least one delivery per month | | | | | | | |

Table 3.6 shows that 77.3% of the HHs was received information related to hygiene, sexual and reproductive and maternal health through FCHV and mother groups.

**Table 3.6: HHs received information related to hygiene, sexual reproductive and maternal health**

| Received information | Number | Percent |
|---|---|---|
| Yes | 198 | 77.3 |
| No | 47 | 18.4 |
| Do not know | 11 | 4.3 |
| **N** | **256** | **100.0** |

Altogether 14 FCHVs comprising 3 from Laprak, 5 from Barpak, 1 from Gankhu and 5 from Harmi were interviewed. Altogether, 11 FCHVs provided piyush or aqua tablet to 657 HHs on regular basis. This shows that the on an average each FCHV provided piyush or aqua tablets to 60 HHs during last one year from the survey period. Similarly, all FCHVs provided information to 1,352 HHs about hygiene promotion including 6 steps of washing hand, use toilet regularly, purification method of drinking water, hygiene maintained during menstruation period etc. The service of hygiene promotion was received by 97 HHs per FCHV during the period of last one year from the survey period. Moreover, 63 pregnant and 74 lactating women were benefited from 96 hygiene promotion activities which were conducted by 13 FCHVs (Table 3.7).

**Table 3.7: Services received by the HHs through FCHVs**

| Measures | Number | Person | Remarks |
|---|---|---|---|
| FCHV provided piyush or aqua tablet to the HHs | 11 | 79.0 | 657 HHs received piyush or aqua tablet |
| FCHVs provided information about hygiene promotion to the HHs | 14 | 100.0 | 1,352 HHs received information |
| FCHVs organized activities about hygiene promotion for pregnant and lactating women | 13 | 93.0 | 63 pregnant and 74 lactating women were benefited from 96 activities |
| **Total Number of FCHV** | **14** | **100.0** | |

Table 3.8 shows that on an average 20 total patients received oral rehydration therapy (ORT) in the health institutions of the project area ranging from 31 in Gankhu, 28 in Barpak, 24 in Laprak, 18 in Simjung, 12 in Uhiya and 8 in Harmi per month. However, during consultation meetings with health personnel, it was pointed out that the problem of water borne diseases was higher in rainy season compared to other seasons. During consultation meeting with partner staffs, it was noted that the concept of establishing ORS corner in the health institutions new. It is noted that 3 health posts namely Simjung, Uhiya and Harmi had ORS corner but not well managed as per the Ministry of Health and Population (MoHP) guideline. Therefore, support is needed for strengthening the ORS corner.

**Table 3.8: Information about ORS treatment**

| Status of ORS treatment | Laprak | Barpark | Gankhu | Simjung | Uhiya | Harmi | Total |
|---|---|---|---|---|---|---|---|
| Patients received ORS treatment per month (in average) | 24 | 28 | 31 | 18 | 12 | 8 | 20 |
| Health facilities having ORS corner | No | No | No | Yes | Yes | Yes | 3 |
| Health facilities having ORS corner as per MoHP guideline | No | No | No | Yes | Yes | Yes | 3 |

## 3.4 Knowledge and attitude

Fifteen service providers from six health posts of six VDCs were interviewed and asked the questions related to infection. Cent percent of the health personnel were found aware about infection. Only 26.6% of the health personnel were received training on infection through government organization (Table 3.9).

**Table 3.9: Knowledge of health personnel about infection and training received**

| Knowledge | Number | Percent |
|---|---|---|
| Knowledge about infection | 15 | 100.0 |
| Infection can take place due to carelessness of health personnel | 15 | 100 |
| Any training received on infection | 4 | 26.6 |
| **N** | **15** | **100** |

The question was asked to the health personnel that what measures to be adopted to prevent infections. Out of 15 health personnel, 93.3% were washing their hand before check-up the patients, 80% were using gloves and 66.7% were using sterilized equipments (Table 3.10).

**Table 3.10: Practice on prevention from infection**

| Measures | Number (N=15) | Percent |
|---|---|---|
| Washing hand before check up | 14 | 93.3 |
| Washing hand after check up | 8 | 53.3 |
| Using sterilized equipment during surgical procedures | 10 | 66.7 |
| Making clean the surrounding environment | 7 | 46.7 |
| Using gloves during check up | 12 | 80.0 |
| Using aprons during check up | 7 | 46.7 |
| Managing medical waste in proper way | 3 | 20.0 |
| **Average** | | **58.1** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

The major components to be considered by a pregnant woman during pregnancy are: visit health institution at least 4 times for ANC check up, take iron and folic acid tablets regularly, have nutritious food, immunize TT vaccine and take care of personal hygiene. Table 3.11 shows that 56.3% of the respondents told that pregnant women need to have nutritious food followed by visit health institution at least 4 times for ANC check up and so on.

**Table 3.11: knowledge about the components to be considered by a pregnant women during pregnancy**

| Things to be considered | Number | Percent |
|---|---|---|
| At least 4 ANC check up during entire pregnancy period | 134 | 52.3 |
| Take iron and folic acid tablets regularly | 118 | 46.1 |
| Take nutritious food | 144 | 56.3 |
| Immunize TT vaccine | 72 | 28.1 |
| Take care of personal hygiene | 121 | 47.3 |
| Do not know | 21 | 8.2 |
| Others | 22 | 8.6 |
| **N** | **256** | **100.0** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Table 3.12 illustrates that 91.4% of the respondents were aware that health institution was the suitable place for birthing. However, still 8.6% of the respondents told that home was the suitable place.

**Table 3.12: Knowledge about the suitable place for birthing**

| Place | Number | Percent |
|---|---|---|
| Home | 22 | 8.6 |
| Health institutions | 234 | 91.4 |
| **N** | **256** | **100.0** |

Table 3.13 illustrates the knowledge on the advantages of birthing child at health institutions. Out of 256, 50% of the respondents were aware that mother and child get proper care in the health institutions. Similarly, 49.2% of the respondents replied that infections and complexities was resolved properly in time at the health institutions and 47.3% told that life of mother could be saved from the risk of excess bleeding during birthing.

**Table 3.13: Knowledge about the advantage of birthing child in health institution**

| Advantage of birthing child in health centre | Number | Percent |
|---|---|---|
| Life of mothers can be saved from the risk of excess bleeding during birthing | 121 | 47.3 |
| Infections and complications of mother and child can be treated properly in time | 126 | 49.2 |
| Mother and child get proper care in the health institution | 129 | 50.4 |
| Infant death rate can be reduced | 33 | 12.9 |
| Mother get the allowance of transportation and a birthing kit | 99 | 38.7 |
| Do not know | 16 | 6.3 |
| Others | 2 | 0.8 |
| **N** | **256** | **100.0** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Table 3.14 depicts that 8.2% of the respondents did not know about the components to be considered for better care of lactating women and child and 91.8% were aware on at least one of the components. Among them, majority (67.6%) of the respondents were aware that maternity women had to eat nutritious food followed by the component that mothers needed to feed their own milk to new born baby up to six month (42.6%) and so on.

**Table 3.14: Knowledge about the components to be considered for better care of lactating women and child**

| Components | Number | Percent |
|---|---|---|
| Lactating mother needs to check up at least 3 times after delivery | 88 | 34.4 |
| Vaccinate the child in proper time | 57 | 22.3 |
| Maternity women need to take nutritious food | 173 | 67.6 |
| Mother need to feed their own milk to newly born child up to six month | 109 | 42.6 |
| Others | 18 | 7.0 |
| Do not know | 21 | 8.2 |
| **N** | **256** | **100.0** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Out of 256 respondents, 32% strongly agreed about the statement that pregnant and lactating women should examine regularly at the health institutions whereas 63.2% agreed on the statement. About 5% of the respondents were undecided with the statement. There was no any person who was against of this statement (Table 3.15).

**Table 3.15: Attitude on the fact that "pregnant and lactating women should examine regularly at the health institutions"**

| Level of attitude | Number | Percent |
|---|---|---|
| Strongly agree | 82 | 32.0 |
| Agree | 162 | 63.3 |
| Undecided | 12 | 4.7 |
| **N** | **256** | **100.0** |

## 3.5 Practice

Only 13.3% of the total HHs had at least one pregnant woman and 11.3% with lactating woman during the last one year from the survey period. The percentage of HHs with neither lactating nor pregnant women was 86.7%.

**Table 3.16: HHS with at least one member with pregnant and lactating women in past one year**

| Pregnant and lactating women | Number | Percent |
|---|---|---|
| HHs with at least one pregnant woman | 34 | 13.3 |
| HHs with at least one lactating woman | 29 | 11.3 |
| None | 222 | 86.7 |
| **N** | **256** | **100.0** |

Out of 256 HHs, 34 HHs were with at least one pregnant woman. Out of which, 52.9% had checked up at least 4 antenatal care (ANC), 50.0% had taken iron and folic acid, 44.1% had immunized TT vaccine and so on (Table 3.17).

**Table 3.17: Activities followed by the pregnant women during pregnancy**

| Activities | Number | Percent |
|---|---|---|
| At least 4 ANC health check up | 18 | 52.9 |
| Taken iron and folic acid tablets regularly | 17 | 50.0 |
| Taken nutritious food | 14 | 41.2 |
| Immunized with TT vaccine | 15 | 44.1 |
| Taken care of personal hygiene | 12 | 35.3 |
| **N** | **34** | **100.0** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Altogether 29 deliveries cases of pregnancy were reported during the survey. Among them 51.7% of the respondents told that they had delivered at the health institutions. However, 48.3% of the members of the HHs still had unsafe deliveries at their own house following traditional techniques (Table 3.18).

**Table 3.18: Place for birthing**

| Place | Number | Percent |
|---|---|---|
| Home | 14 | 48.3 |
| Health institutions | 15 | 51.7 |
| **N** | **29** | **100** |

Out of 256 HHs, 29 HHs were with at least one lactating women. Out of 29 HHs, 44.8% HHs with lactating women were checked up at least 3times after birthing. Similarly, 69.0% were feed their own milk to child up to six months, 58.6% were taken nutritious food (3.19).

**Table 3.19: Activities done for better care of lactating women and child**

| Things | Number | Percent |
|---|---|---|
| A least 3 times check-up the lactating women | 13 | 44.8 |
| Vaccinate the child timely | 10 | 34.5 |
| Lactating women eat nutritional food | 17 | 58.6 |
| Mother feed their own milk to child up to six month | 20 | 69.0 |
| N | 29 | 100.0 |

Out 34 HHs with pregnant and lactating women, 64.7% were reported that they had received special type of hygiene kit that include washing and bathing soap, sanitary pad, bra, handkerchief, nail-cutter, comb, oil, towel etc (Table 3.20).

**Table 3.20: HHs with pregnant and lactating women received special type of hygiene kit**

| Received hygiene kit | Number | Percent |
|---|---|---|
| Yes | 12 | 35.3 |
| No | 22 | 64.7 |
| **N** | **34** | **100.0** |

# Chapter – IV
# Water, sanitation and hygiene (WASH)

## 4.1 Drinking water

This survey found that 69.5% of households in the project areas were currently using an improved source of drinking water[2] (Table 3.1 below) and 30.5% of the HHs was using unimproved sources. Majority of the HHs (62.1%) were using public tap/standpipe followed by protected spring (23.0%), piped water into house or plot 7.4%.

Considering the actual situation of the project area, although protected springs and dug wells were covered, they were not safe during rainy season. It was pointed out during FGDs that the contaminated water was mixed with protected springs and dug wells. Therefore, these sources could not be treated as improved sources. Therefore the improved sources become 65.9% in the project area.

**Table 4.1: Main source of drinking water for households by district**

| Main Source of Drinking Water | Number | Percent |
|---|---|---|
| **Improved sources** | **178** | **69.5** |
| Piped water into house or plot | 19 | 7.4 |
| Public tap/Standpipe | 159 | 62.1 |
| **Unimproved sources** | **78** | **30.5** |
| Covered spring | 59 | 23.0 |
| Covered dug well | 15 | 5.9 |
| Unprotected Spring | 1 | 0.4 |
| Surface Water (river, lake etc) | 3 | 1.2 |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Table 4.2 reveals that 6.3% of the HHs spent more than half an hour to two hours for fetching water. Similarly, almost one fifth of the HHs had to spend more than 20 minutes and half of the HHs had more than 10 minutes for fetching water. Moreover, 34.8% of the respondents told that their main water sources were repaired after earthquake.

[2]Following the WHO/UNICEF (2006) core questions on drinking water and sanitation for household surveys, the type of water source is used as a proxy indicator for whether a household's drinking water is of suitable quality. The water sources likely to be of suitable quality are known as "improved water sources", and they are: piped water into house or plot, public tap/standpipe, tube well/borehole, protected dug well, protected spring and rainwater. Water sources that are likely to be of unsuitable quality are known as "unimproved water sources", and they are: unprotected spring, unprotected dug well, cart with small tank/drum and surface water.

**Table 4.2: Time taken for fetching water and maintenance of main sources**

| Time (in minutes) | Number | Percentage |
|---|---|---|
| Zero | 23 | 9.0 |
| 1-10 | 88 | 34.4 |
| 11-20 | 98 | 38.3 |
| 21-30 | 31 | 12.1 |
| More than 30 | 16 | 6.3 |
| **Maintenance** | | |
| Yes | 89 | 34.8 |
| No | 167 | 65.2 |
| **N** | **256** | **100.0** |

It should also be noted that while the high proportion of households using improved sources of drinking water. However during the FGDs with beneficiaries, it was found that there was no easy access and sufficient water quantity in the project area. In Laprak, people had to spend around half an hour to 1.5 hours for fetching water. Mostly women were involved in fetching water which has added over burden to them. Consequently they are not able to engage themselves in income generating activities. Therefore, access of water and water quantity is a major issue for households across the project area.

It was found that the water source may be a barrier for the elderly, people with disabilities, pregnant and lactating women and other vulnerable people due to long distance. Moreover, the collection of water for household use is typically done by women, and depending on the distances and time involved it can seriously limit the time available for women to engage in other activities including work, education and community life. Girl students were found hampered in their study due to fetching water. Therefore, it is important that any intervention aimed at improving water quality take these dynamics into account.

As result of poor access and low quantity of the availability of the water in the project area, the whole sanitation and hygiene sector has been affected. The problem related with the scarcity of water might affect the whole WASH activities of the project. Therefore, it is very much concerning that water schemes need to be well designed and constructed carefully so that the beneficiaries will have easy access of water.

During the consultation meeting with District Water and Sanitation Officer as well as FGDs with the beneficiaries, it was found that the water sources are getting dry year by year and particularly after the event of earthquake. It is also largely related with the effect of the climate change.

During consultation meetings with CARE and partner staffs, the concern was raised about the budget allocated for the water schemes to be constructed during the project phase. They told that the amount allocated per water scheme was not sufficient for construction of those water schemes. If the schemes would be constructed with allocated amount of limited NPR 900 thousand, then the scheme might not be sustainably well constructed.

Table 4.3 shows that 50.8% of the respondents in average were aware about the various methods of purification of water in the project area. In total, 84.8% of the respondents were aware about filtering of water as the purification method followed by boiling (75.4%), using medicine like Piyush, Aqua tab (32.8%), covering water (15.6%) and so on. During FGD in Barpak and Laprak, it was found that the water was somehow muddy in rainy season. As a result, the people were facing the problem of water borne diseases like diarrhoea, dysentery, worm infestation etc. The level of knowledge towards the purification of drinking water was high. However, the knowledge was not converted into practice on regular basis due to the combined causes of low level of awareness, carelessness and poor economic condition. According to officials of Health Post, Barpak, 4-5 diarrhoea and dysentery patients from Baluwa, Barpak-1 came to the health post every day during the survey period.

**Table 4.3: Knowledge on the methods of purification of drinking water (%)**

| Methods | Number | Percent |
|---|---|---|
| Boiling (i) | 193 | 75.4 |
| Filtering (ii) | 217 | 84.8 |
| Covering water | 40 | 15.6 |
| Sedimentation | 6 | 2.3 |
| Sodis method (iii) | 26 | 10.2 |
| Using medicine like Piyush, Aqua tab (iv) | 84 | 32.8 |
| **Average (i-iv)** | **130** | **50.8** |
| I do not know | 6 | 2.3 |
| **N** | **256** | |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Table 4.4 illustrates 24.2% of the total respondents strongly agreed on the statement that people became ill if they drank water without purification. Very few people in the project area were undecided and disagreed on the subject. The percentage of attitude on the purification of water was consistent with the level of knowledge.

**Table 4.4: Attitude on purification of drinking water (in %)**

| Level | Number | Percent |
|---|---|---|
| Strongly agree | 62 | 24.2 |
| Agree | 181 | 70.7 |
| Neither agree nor disagree | 13 | 5.1 |
| Disagree | 62 | 24.2 |
| **N** | **256** | **100.0** |

Table 4.5 reflects that 33.2% of the respondents did not use any purification process for drinking water. This reveals the fact that two third of the HHs in the project area were to be drinking after purification of either one or various methods. The most common method of purification was filtering (46.9%) followed by boiling (22.3%). Tables 4.3, 4.4 and 4.5 show that there was huge gap between knowledge-attitude and practice on drinking water purification in the study area.

**Table 4.5: HHs practicing the purification methods of drinking water (in %)**

| Methods of purification | Number | Percent |
|---|---|---|
| Boiling | 57 | 22.3 |
| Filtering | 120 | 46.9 |
| Covering water | 19 | 7.4 |
| Sedimentation | 2 | 0.8 |
| Sodis method | 2 | 0.8 |
| Using medicine like piyush, aqua tab | 14 | 5.5 |
| Drinking without purification | 85 | 33.2 |
| **N** | **256** | **100.0** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

It was found during the consultation meetings with the district and local level stakeholders as well as FGDs with beneficiaries in that huge amount of wash kit including piyush tablet was distributed during the

emergency period. However, very few beneficiaries of the project area were found to be using the piyush tablet in practice regularly. It has become a challenge to make them practice on water purification on regular basis. Therefore, it is better to distribute filter instead of piyush tablet. It is also necessary to make them aware on the use of filter and other various methods of drinking water purification.

Table 4.6 shows that 48% of the HHs did not receive piyush and/or aqua tablet from anywhere or did not buy themselves and 52% had received piyush and/or aqua tablet through different sources. It is noted that 10% of the HHs had received these tablets from government organizations, 28% from CARE Nepal, 29% from other INGO and 2.7% bought themselves. Out of total, only 28.5% had used it for purification of drinking water at that period. It does not mean that they regularly purified water by using it. Table 4.5 clearly shows that very less percentage (5.5%) of the HHs regularly used it. During consultation with Officials of Health Post, they told that during rainy season, the water was muddy and it was contaminated. Purification of water in rainy season saves the people from water borne diseases.

**Table 4.6: HHs receiving and using piyush or aqua tablet**

| Particulars | Number | Percent | Remarks |
|---|---|---|---|
| Received and used | 73 | 28.5 | 10% had received from Govt. organization, 28% from CARE Nepal, 29% from other INGO and 2.7% bought own self |
| Received but not used | 60 | 23.4 | |
| Did not receive | 123 | 48.0 | |
| N | 256 | 100.0 | |

## 4.2 Hygiene

During the consultation meetings with various government as well as non-government stakeholders it was found that many programs on WASH including hygiene promotion were conducted by various organizations, social workers, local clubs, ward citizen forums, FCHVs through campaigning, distribution of IEC materials, broadcasting from radio and FM programs during the emergency period.

During FGDs, it was pointed out that after various orientations on hygiene promotion programs by various government as well as non-government agencies, some of them were aware about the 7 important steps of washing hand by soap. However, they told that steps were tedious in practice and therefore 7 steps were not followed properly. Moreover, the scarcity of water had made it more challenging in the project area. Therefore, they simply wash their hands with soap. In this process unless the scarcity of water is solved, the project's targets are difficult to achieve within the stipulated time duration.

Respondents were asked about their knowledge on the various components of personal hygiene maintenance without mentioning the answer options. Altogether 43.0% of the respondents in average had knowledge on various components of personal hygiene comprising use of toilet, washing hand by soap following 7 important steps, drinking safe water, hygiene management during menstruation period, regular health checkup and eating clean and fresh food. Allrespondents were aware about at least one of the options of hygiene promotion. Out of total, 88.7%told about washing hand with soap/ash after toilet followed by bathing once in a week (60.5%), defecation in the toilet (57%), wearing clean clothes (55.9%), brushing teeth everyday (52.7%) and so on (Table 4.7).

**Table 4.7: Knowledge on personal hygiene (in %)**

| Types of personal hygiene | Number | Percent |
|---|---|---|
| Washing hand with soap/ash after toilet | 227 | 88.7 |
| Bathing once in a week | 155 | 60.5 |
| Defecation in the toilet | 146 | 57.0 |
| Wearing clean clothes | 143 | 55.9 |
| Brushing teeth everyday | 135 | 52.7 |
| Washing hand with soap/ash before and after cooking food | 108 | 42.2 |
| Urination in the toilet | 91 | 35.5 |
| Cutting nail | 55 | 21.5 |
| Wearing sleeper while going to toilet | 21 | 8.2 |
| Cutting hair and beard time to time | 20 | 7.8 |
| **Average** | **110** | **43.0** |
| Don't know | 0 | 0 |
| **N** | **256** | **100** |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

During the interview question was asked regarding the attitude about the personal hygiene of the respondents. Out of 256, 30.9% of the respondents strongly agreed on the statement and nearly two third of the respondents agreed about the fact that people can be unhealthy if proper personal hygiene was not maintained. Very few respondents were found undecided about the statement (Table 4.8).

**Table 4.8: Attitude on personal hygiene (in %)**

| Level | Number | Percent |
|---|---|---|
| Strongly agree | 79 | 30.9 |
| Agree | 175 | 68.4 |
| Neither agree nor disagree | 2 | 0.8 |
| **N** | **256** | **100.0** |

Table 4.9 illustrates that 44.0% of the respondents in average were found to be practicing various components of personal hygiene. Majority (86.3%) of the respondents were found washing hand with soap/ash after toilet for keeping themselves healthy and free from different kinds of communicable diseases. Similarly, 59.4% of the respondents were brushing teeth everywhere followed by defecation in the toilet (59.0%), wearing clean clothes (54.7%), bathing once in a weak (52.7%) and so on.

**Table 4.9: Practice on personal hygiene (in %)**

| | Number | Percent |
|---|---|---|
| Washing hand with soap/ash after toilet | 221 | 86.3 |
| Brushing teeth everyday | 152 | 59.4 |
| Defecation in the toilet | 151 | 59.0 |
| Wearing clean clothes | 140 | 54.7 |
| Bathing once in a week | 135 | 52.7 |
| Washing hand with soap/ash before and after cooking food | 112 | 43.8 |

| | | |
|---|---|---|
| Urination in the toilet | 91 | 35.5 |
| Cutting nail | 56 | 21.9 |
| Wearing sleeper while going to toilet | 30 | 11.7 |
| Cutting hair and beard time to time | 26 | 10.2 |
| **Average** | **111** | **44.0** |
| Others | 2 | 0.8 |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Table 4.10reflects thataltogether 30.0% of the respondents had the knowledge in average on various types of household hygiene comprising covering foods, eating fresh and clean food, keeping kitchen clean, keeping water pot clean, not stir water with hand, using smoke free modern stove, washing fruits and vegetable before eating, using clean bed sheet, keeping house surrounding clean, not keeping livestock's in the kitchen, throwing wastage in pit, keeping livestock's in separate place, encouraging children to use toilet, washing hands with soap after toileting children and bathing children once in a week. 99.6% of the respondents had the knowledge on at least one category of maintaining household level hygiene and only 0.4% was not aware about any category. Out of total respondents, 76.6% had the knowledge about keeping house surrounding clean followed by covering foods (56.6%), keeping kitchen clean (54.3%), eating fresh and clean food (53.9%).

**Table 4.10: Knowledge on household level hygiene (in %)**

| Categories | Number | Percent |
|---|---|---|
| Keeping house surrounding clean | 196 | 76.6 |
| Covering foods | 145 | 56.6 |
| Keeping kitchen clean | 139 | 54.3 |
| Eating fresh and clean food | 138 | 53.9 |
| Throwing wastage in pitch | 105 | 41.0 |
| Washing fruits and vegetable before eating | 61 | 23.8 |
| Using clean bed sheet | 58 | 22.7 |
| Washing hands with soap after toileting children | 47 | 18.4 |
| keeping water pot clean | 42 | 16.4 |
| Encouraging children to use toilet | 41 | 16.0 |
| Keeping livestock's in separate place | 39 | 15.2 |
| Using smoke free modern stove | 38 | 14.8 |
| Not keeping livestock's in the kitchen | 37 | 14.5 |
| Bathing children once in a week | 35 | 13.7 |
| Not steer water with hand | 18 | 7.0 |
| **Average** | **76** | **30.0** |
| Don't know | 1 | 0.4 |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

Question was asked regarding the attitude on the maintenance of the household level hygiene. 25.8% of the respondents strongly agreed and 71.5% agreed on the statement that family members could be sick if proper family hygiene was not maintained (Table 4.11). Only 2.7% of the respondents were undecided on the fact.

**Table 4.11: Attitude on household level hygiene (in %)**

| | Number | Percent |
|---|---|---|
| Strongly agree | 25.8 | 25.8 |
| Agree | 71.5 | 71.5 |
| Neither agree nor disagree | 2.7 | 2.7 |
| N | 256 | 100 |

Table 4.12 shows thataltogether 28.0% of the respondents in average were found to be practicing the above mentioned various components of household hygiene. Out of the total respondents, 73.4%were keeping house surrounding clean in order to ensure their family members were healthy followed by covering foods (54.3%), keeping kitchen clean (49.2%), eating fresh and clean food (48.4%).

**Table 4.12: Practice on household level hygiene (in %)**

| HH level hygiene | Number | Percent |
|---|---|---|
| Keeping house surrounding clean | 188 | 73.4 |
| Covering foods | 139 | 54.3 |
| Keeping kitchen clean | 126 | 49.2 |
| Eating fresh and clean food | 124 | 48.4 |
| Throwing wastage in pitch | 88 | 34.4 |
| Washing fruits and vegetable before eating | 56 | 21.9 |
| Using clean bed sheet | 53 | 20.7 |
| Keeping livestock's in separate place | 53 | 20.7 |
| keeping water pot clean | 46 | 18 |
| Washing hands with soap after toileting children | 46 | 18 |
| Using smoke free modern stove | 43 | 16.8 |
| Encouraging children to use toilet | 42 | 16.4 |
| Bathing children once in a week | 35 | 13.7 |
| Not keeping livestock's in the kitchen | 34 | 13.3 |
| Not steer water with hand | 20 | 7.8 |
| **Average** | **73** | **28.0** |
| Others | 3 | 1.2 |

***Note:*** *Percentage add up to more than 100 due to multiple responses*

During field trip observation, it was found that most of the people in the project area were living in temporary shelter made up with CGI sheet. The temporary shelter had limited rooms and space. The water supply system is not properly managed. Most of the people were using common toilets. Therefore, it was difficult for maintaining household as well as personal hygiene properly.

# Chapter – V
# Gender-based violence (GBV)

The project basically focuses on 4 major types GBV comprising human trafficking, child marriage, rape and physical and sexual violence. However, other types of GBV are existing in the project area like polygamy, when questions were asked about the knowledge on various types of gender-based violence.

Altogether 35% of the total respondents in average had the knowledge about 4 major types of GBV.72.6% of the total respondents had the knowledge about GBV and 28.9% were not aware. Similarly, 51.6% of the respondents said that they had the knowledge of physical and sexual violence followed by human trafficking (38.3%), child marriage (30.9%), rape (17.6%) and so on (Table 5.1).

**Table 5.1: Knowledge on the major types of GBV (in %)**

| Types of GBV | Number | Percent |
|---|---|---|
| Human trafficking | 98 | 38.3 |
| Child marriage | 79 | 30.9 |
| Rape | 45 | 17.6 |
| Physical and sexual violence | 132 | 51.6 |
| **Average** | **89** | **35.0** |
| Other Violence | 12 | 4.7 |
| I do not know | 74 | 28.9 |
| N | 256 | 100 |

The question was asked whether the GBV was social and legal offense. Table 5.2 shows that 30.5% of the respondents strongly agreed on the statement that GBV was social and legal crime and 52.7% agreed. However, 16.8% of the respondents were still found unclear on the issue. This reveals the fact that awareness programs on GBV were needed in the project area.

**Table 5.2: Attitude on the major types of GBV (in %)**

| Level of attitude | Number | Percent |
|---|---|---|
| Strongly agree | 78 | 30.5 |
| Agree | 135 | 52.7 |
| Neither agree nor disagree | 43 | 16.8 |
| N | 256 | 100.0 |

Table 5.3 illustrates the fact that 91.4% of the respondents replied that their family members did not face any of 4 major types of GBV. However, 8.6% had faced the problem. The proportion might be low because the knowledge on GBV is low in the community and they might be unaware that they are victimized. Additionally, GBV survivors do not like to expose themselves as GBV survivor due to social prestige. Sometimes the criminal activities like rape are not exposed and sometimes solved through community mediation. Although the GBV problem was found among very few family members of the respondents, the problem is very serious.

During consultation meeting with District Women and Children Officers, it was pointed out that the cases of GBV have been low in the project area. However, the cases of GBV have slightly increased after earthquake. They had also the concern to launch the case management of GBV survivors including referral system. During FGDs with beneficiaries, it was found that the nature of child marriage has changed nowadays.

Earlier parent used to force for child marriage. But nowadays, particularly school boys and girls fall in love by watching TV programs and communicating with mobile phones and Facebook.

**Table 5.3: GBV faced by the family members in last 1 year (in %)**

| Types of GBV | Number | Percent |
|---|---|---|
| Human trafficking | 5 | 2.0 |
| Child marriage | 5 | 2.0 |
| Rape | 2 | 0.8 |
| Physical and sexual violence | 16 | 6.3 |
| No | 234 | 91.4 |
| **N** | **256** | **100.0** |

Table 5.4 provides the information on types of GBV known by family members.Altogether 33% of the respondents received information on various types GBV through social mobilizers, self-help groups, door to door and group awareness programs, radio, television and newspapers in average. 47.3% of the respondents received information on physical and sexual violence from different sources followed by human trafficking (38.7%), child marriage (30.1%) and rape (16.4%). However, 34.0% of the members of the HHs did not listen about the GBV message or did not know.

**Table 5.4: Information received on GBV by family members (in %)**

| Types of GBV | Number | Percent |
|---|---|---|
| Human trafficking | 99 | 38.7 |
| Child marriage | 77 | 30.1 |
| Rape | 42 | 16.4 |
| Physical and sexual violence | 121 | 47.3 |
| **Average** | **85** | **33.0** |
| I do not listen | 61 | 23.8 |
| I do not know | 26 | 10.2 |
| **N** | **256** | **100.0** |

Table 5.5 reveals that the information on 4 major types of GBV received by any of the family members through group awareness program (31.3%), radio/FM (30.5%), self-help group (16.8%) and so on.

**Table 5.5: Sources of information on GBV (in %)**

| Medium of information | Number | Percent |
|---|---|---|
| Social mobilize | 37 | 14.5 |
| Self help group | 43 | 16.8 |
| Door to door program | 12 | 4.7 |
| Group awareness program | 80 | 31.3 |
| Radio/FM | 78 | 30.5 |
| Television | 25 | 9.8 |
| Newspaper | 12 | 4.7 |
| Others | 4 | 1.6 |

| | | |
|---|---|---|
| I do not listen | 61 | 23.8 |
| I do not know | 26 | 10.2 |
| **N** | **256** | **100.0** |

## 5.1 Human trafficking

Table 5.6 reveals that 30.9% of the members of the HHsdid notuse information received through different sources whereas 34.0% of the members of the HHs either did not listen or did not know. Hence, only 35.1% of the member of the HHs used information in educating members of the households and the community about the risks of trafficking.

During KIIs with self-help groups, it was pointed out that human trafficking was a common phenomenon in the project area. Traditionally, the girls were sold to various cities of India by their relatives as well as brokers. However, nowadays the nature has changed and manpower companies are involved in human trafficking in the name of sending them to various countries for foreign employment. The main reasons behind this are greed for money, job, marriage and they are trapped in sexual activities. It can be controlled to some extent by raising awareness in the community.

**Table 5.6: Use of information by family members received on human trafficking (in %)**

| Use of information | Number | Percent |
|---|---|---|
| Educating members of household about the risks of trafficking | 72 | 28.1 |
| Educating members of community about the risks of trafficking | 39 | 15.2 |
| Questioning or refuting claims of wage manipulation/higher wages | 18 | 7.0 |
| Questioning or refuting possibly false stories about successful migration | 9 | 3.5 |
| Others | 1 | 0.4 |
| Not used any where | 79 | 30.9 |
| I do not listen | 61 | 23.8 |
| Don't know | 26 | 10.2 |
| **N** | **256** | **100.0** |

## 5.2 Child marriage

Child marriage is a traditional practice in Nepal. However, the constitution of Nepal 2015 has defined marriage below the age of 20 years as child marriage both in the case of girls as well as boys. The child marriage has a lot of negative consequences including interruption in education, health related problems etc.

Altogether 66.8% of the members of the HHs either did not use or received information regarding child marriage. This means only 33.2% of the members of the HHs shared the information. Table 5.7 shows that 18.0% of the members of the HHs shared the information with HHs members and 19.5% with members of the community. Only, 6.3% of the members were tried to stop child marriage and 5.9% were informed to the security agencies after occurrence of the event.

**Table 5.7: Use of information by family members received on child marriage (in %)**

| Use of information | Number | Percent |
|---|---|---|
| Educating members of household about the risks of child marriage | 46 | 18.0 |
| Educating members of community about the risks of child marriage | 50 | 19.5 |
| Trying to stop child marriage | 16 | 6.3 |
| Informing security agency regarding child marriage | 15 | 5.9 |
| Others | 1 | 0.4 |
| Not used any where | 84 | 32.8 |
| I do not listen | 61 | 23.8 |
| I do not know | 26 | 10.2 |
| **N** | **256** | **100.0** |

## 5.3 Rape

Table 5.8 shows that 40.6% of the members of the HHs did notshare the information regarding rape. Out of 256 HHs, 13.3% of the member of the HHs shared information within their family members and 16% shared in the community. However, only 9.0% of the member of the HHs was informed to security agencies after occurrence of the event.

**Table 5.8: Use of information by family members received on rape (in %)**

| Use of information | Number | Percent |
|---|---|---|
| Educating members of household about the risks of rape | 34 | 13.3 |
| Educating members of community about the risks of rape | 41 | 16.0 |
| Informing security agency regarding rape | 23 | 9.0 |
| Others | 3 | 1.2 |
| Not used any where | 104 | 40.6 |
| I do not listen | 61 | 23.8 |
| I do not know | 26 | 10.2 |
| **N** | **256** | **100.0** |

## 5.4 Physical and sexual violence

Table 5.9 shows that 27% of the members of the HHs did not share the information regarding physical and sexual violence. Out of 256 HHs, 23.0% of the member of the HHs shared information within their family members and 13.3% shared in the community. However, only 6.6% of the member of the HHs tried to stop physical and sexual violence at community level and 10.2% informed to security agencies after occurrence of the event.

**Table 5.9: Use of information by family members received on physical and sexual violence (in %)**

| Use of information | Number | Percent |
|---|---|---|
| Educating members of household about the risk of physical and sexual violence | 59 | 23.0 |
| Educating members of community about the risks of physical and sexual violence | 34 | 13.3 |
| Trying to stop physical and sexual violence at community level | 17 | 6.6 |
| Informing security agency regarding physical and sexual violence | 26 | 10.2 |
| Others | 6 | 2.3 |
| Not used any where | 69 | 27.0 |
| I do not listen | 61 | 23.8 |
| I do not know | 26 | 10.2 |
| **N** | **256** | **100.0** |

## 5.5 IEC materials of GBV

Table 5.10 illustrates that majority (91.4%) of the respondents in the project area did not receive any IEC materials and 8.6% received these materials. Altogether 6.3% of the respondents received poster and 4.7% received brochures as IEC materials.

**Table 5.10: Types of IEC materials received by any member/s of the HH (in %)**

| Types of IEC materials | Number | Percent |
|---|---|---|
| Brochures | 12 | 4.7 |
| Posters | 16 | 6.3 |
| I did not get IEC materials | 234 | 91.4 |
| **N** | **256** | **100** |

Table 5.11 shows the responses on use of received IEC materials. Table 5.11 reveals that 234 (91.4%) respondents did not use any IEC materials and only 22 (8.6%) respondents used at least one IEC material. Among them, 3.5% of the respondents conducted awareness program in the society, 3.1% used in face to face discussion and 1.2% conducted door to door awareness campaign.

**Table 5.11: Use of IEC materials (in %)**

| Use of IEC materials | Number | Percent |
|---|---|---|
| Face to face discussion | 8 | 3.1 |
| Door to door campaign | 3 | 1.2 |
| Raising awareness program | 9 | 3.5 |
| Others | 5 | 2.0 |
| Did nothing | 234 | 91.4 |
| **N** | **256** | **100.0** |

## Chapter – VI
## Baseline value of the indicators of the M & E framework

| Indicator | Base Value |
|---|---|
| **Goal** | |
| **Goal Indicator G.a:** Change in all deaths of women of reproductive age in Gorkha between project baseline and endline that are caused by reproductive emergencies (maternal mortality) | 0 |
| **Goal Indicator G.b** : Change in % of obstetric complications among total delivery in Gorkha between project baseline and endline | 8.7% |
| **Outcome 1** | |
| **Outcome Indicator 1.a:** Change in number of deliveries at targeted health facilities per month | 6.75 |
| **Outcome Indicator 1.b:** Change in number of patients receiving oral rehydration therapy | 20 per month on an average |
| **Outcome Indicator 1.c** :Number of targeted health facilities with functional birthing centres | 2 |
| **Outcome Indicator 1.d:** Change in staff practices on infection prevention between baseline and endline | 58.1 |
| **Output 1** | |
| **Output Indicator 1.1a:** # of semi-permanent (Pre-Fab) building constructed and functioning as health facilities/birthing centres (target: 3) | 0 |
| **Output Indicator 1.2a:** # of newly constructed health facilities received basic equipment and furniture (target: 3) | 0 |
| **Output Indicator 1.3a:** # of health facility staff (including partner staff) trained on infection prevention (target is 30 staff members, from six HFs) | **26.6%** |
| **Output Indicator 1.4a:** # of facilities with oral rehydration therapy corners set up with the necessary supplies (as per GoN/MoHP guideline) | 3 |
| **Outcome 2** | |
| **Outcome Indicator 2.a:** # of targeted HFs with separate toilets for men and women available | 0 |
| **Outcome Indicator 2.b:** # of targeted HFs with separate bathing facilities for men and women available | 0 |
| **Outcome Indicator 2.c:** # of targeted HFs with access to improved drinking water | 6 but not sufficient |
| **Outcome Indicator 2.d:** # of targeted outreach clinics with basic hygiene and hand-washing supplies | 4 |
| **Outcome Indicator 2.e:** # of targeted HFs with functional medical waste disposal system | 2 |
| **Output 2** | |
| **Output Indicator 2.1a:** # of drinking water supply systems established at HFs | 3 |
| **Output Indicator 2.2a:** # of targeted HFs with newly constructed or rehabilitated toilets (separate for female and male, with light) | 0 |
| **Output Indicator 2.3a:** # of targeted HFs with newly constructed or rehabilitated bathing facilities (separate for female and male, with light) | 0 |
| **Output Indicator 2.4a:** # of outreach clinics receiving hygiene and hand washing kits | 4 |
| **Output Indicator 2.5a:** # of targeted HFs with functional incinerator | 0 |
| **Output Indicator 2.5b:** # of targeted HFs with functional decomposition pits | 1 |

| | |
|---|---|
| **Output Indicator 2.5c :** # of targeted HFs segregating waste (using coloured buckets or similar system) | 2 |
| **Outcome 3** | |
| **Outcome Indicator 3.a:** # of HHs with access to the newly rehabilitated water supply systems | 3 |
| **Outcome Indicator 3.b:** # of HHs reached with hygiene and SRMH information through FCHVs and members of mothers groups | 77.3% |
| **Outcome Indicator 3.c:** # of households receiving piyush/aqua tabs | 28.5% |
| **Outcome Indicator 3.d:** # of PLW receiving special hygiene kits | 35.3% |
| **Outcome Indicator 3.e:**# of WASH committees trained | 0 |
| **Output 3** | |
| **Output Indicator 3.1a:** # of community water supply sources rehabilitated (target: 3) | 0 |
| **Indicator 3.3a:** # of FCHVs and members of mothers groups (esp. pregnant and lactating mothers) conducting hygiene promotion activities | 93% FCHV |
| **Output Indicator 3.4a:** # of people receiving piyush/aqua tabs and/or hygiene information through Female Community Health Volunteers (FCHVs) and members of Mothers' Groups' (MGs) | 657 HHs by 14 FCHVs |
| **Output Indicator 3.6a:** # of pregnant and lactating women receiving special hygiene kits | 35.3% |
| **Output Indicator 3.7a:** # of group awareness sessions held for target groups (PLW and other mothers) conducted by FCHVs and members of mother's groups | 92 activities |