

**Gender, equity and human rights focused
assessment on the health sector preparedness and
response for COVID-19 during 2020-21**



**World Health
Organization**

Nepal



नेपाल विकास अनुसन्धान प्रतिष्ठान
Nepal Development Research Institute

Gender, equity and human rights focused assessment on the health sector preparedness and response for COVID-19 during 2020-21

Study Team:

Team Leader	Dr. Rabita Shrestha Mulmi
Research Expert	Dr. Baburam Marasine
Public Health Expert	Mr. Bhim Pd. Shrestha
Field Coordinator	Mr. Rajendra Khatri
Research Associate	Ms. Kabita Yadav

Prepared By:

Nepal Development Research Institute
Shree Durbar Tole, Pulchowk, Lalitpur
P.O. Box: 8975, EPC01, Kathmandu Nepal
Email: info@ndri.org.np
Telephone: +977-1-5537362, 5554975

This report is a product of research on “Gender, equity and human rights focused assessment on the health sector preparedness and response for COVID-19 during 2020-21” carried out by Nepal Development Research Institute with the financial support of WHO Nepal from January 2022 to March 2022.

ACKNOWLEDGEMENT

NDRI expresses its gratitude to the WHO Nepal for awarding Gender, equity and human rights focused assessment on the health sector preparedness and response for COVID-19 during 2020-21 and making congenial environment for this research work in this Pandemic situation.

NDRI highly appreciate WHO team particularly, Dr. Pooja Pradhan, National Professional officer; Dr. Binod Prasad Gupta, National Professional officer; Ms. Bindu Pokhrel Gautam, Gender Expert and Dr. Surakschha Thapa for their kind cooperation in designing research tools, their valuable inputs in data analysis, draft report and finally in shaping this report.

NDRI offers gratitude to the entire research team: Dr. Rabita Shrestha Mulmi, Team Leader; Dr. Baburam Marasine, Research Expert; Mr. Bhim Prasad Shrestha, Public Health Expert; Mr. Rajendra Khatri, Field Coordinator and Ms. Kabita Yadav, Research Associate for their hard work from the inception period to project accomplishment. With great appreciation, I would particularly like to acknowledge the contribution of all our field researchers; without their contribution this study would not have been accomplished. Active contribution of Ms. Manisha Rayamajhi for entire administrative and financial management incurred to this project is acknowledged as well.

We would also like to extend our sincere thanks to federal, provincial and local level governments, all health in charges, service providers and local leaders in relevant districts for their valuable co- operations. Last but not the least, we would also like to thank all the respondents for providing the information regarding Gender, equity and human rights focused assessment on the health sector preparedness and response for COVID-19 during the interview, the in-charge and staffs of relevant health facilities; health posts and district hospitals; for providing information and their cooperation during survey.

*Dr. Shankar Shrestha
Executive Director
Nepal Development Research Institute (NDRI)*

Table of Contents

ACKNOWLEDGEMENT	iii
LIST OF ACRONYMS	vi
EXECUTIVE SUMMARY	vii
PART 1. INTRODUCTION	1
1.1 Background	1
1.2 Nepal's Policy responses to the COVID-19 pandemic	2
1.3 Objectives of the Study	3
PART 2. METHODOLOGY	4
2.1 Study Design	4
2.2 Sampling Strategy	4
2.3 Data collection tools.....	7
2.4 Data Analysis	10
2.5 Ethical clearance	10
2.6 Limitation of the Study	10
PART 3. QUANTITATIVE FINDINGS	11
3.1 Confirmed cases of COVID-19.....	11
3.2 Place Distribution.....	12
3.3 Testing Laboratories.....	12
3.4 Case Management	13
3.5 Vaccination	14
3.6 Recovered Cases	14
3.7 COVID-19 and human suffering.....	15
3.8 Impoverished Citizen chronic disease treatment program	15
3.9 Training of Health care Workers for the Management of COVID-19	16
3.10 Sexual and Gender-based violence.....	16
PART 4: QUALITATIVE FINDINGS	19
4.1 Themes	19
4.1.1 Gender Roles and Responsibilities.....	19
4.1.2 Access to Basic Services (WASH).....	22
4.1.3 Impact of COVID-19 on Essential health services.....	23
4.1.3 Impact of COVID-19 on Essential health services.....	23
Good Practices	25
4.1.4 Community perceptions and experiences on utilizing health services during COVID-19.....	26

4.1.5 COVID-19: testing, isolation, and quarantine centers.....	27
4.1.6 Social Protection concerns	29
4.1.7 Female Health Workers during Pandemic.....	34
4.1.8 Country-level coordination, planning, and monitoring	39
4.1.9 Community Engagement and Risk communication	40
4.1.10 Point of Entry	41
4.2 Health Facilities Observation	44
4.2.1 Types of health facilities:	44
4.2.2 Availability of facilities:.....	44
4.2.3 Infection prevention and control	44
4.2.4 Recording and reporting tools (HMIS)	45
PART 5: CONCLUSION	46
PART 6: RECOMMENDATIONS	47
ANNEXES	49
Annex 1. Final questionnaire for the survey	49
Annex 2. Detail field plan	66
Annex 3. NHRC Approval letter.....	69
Annex 4: Glimpse of the survey.....	71

List of Tables

Table 1: National and Provincial Survey Size	4
Table 2: Sampling Strategy	5
Table 3: Selected Districts and Palikas (Urban/Rural)	7
Table 4: Details of Samples Size	9
Table 5: Provincial Disaggregation of RT-PCR Labs	13
Table 6: Province-wise distribution of Isolation, I.C.U, and Ventilator	13
Table 7: Status of Vaccination against COVID-19.....	14
Table 8: Age Specific Case Fatality Ratio and Co-morbidity of Deaths in RT-PCR confirmed COVID-19cases.....	15
Table 9: Number of beneficiaries treated under Impoverished Citizen Treatment Program	16
Table 10: Trainings conducted on COVID-19 Response management	16
Table 11: Gender based domestic violence in Nepal reported to the police in the FY 2019-20 and 2020-21	17
Table 12: Age-wise breakdown of cases reported to the police in the FY 2019-20 and 2020-21	17
Table 13: Total number of clients attending OCMC	17
Table 14: Availability of facilities	44
Table 15: Infection prevention and control.....	45
Table 16: Recording and reporting tools	45

List of Figures

Figure 1: Map of study Area.....	6
Figure 2:Distribution of RT-PCR positive COVID-19 cases by age and sex.....	11
Figure 3:Province wise distribution of COVID-19 cases and deaths.....	12
Figure 4:Percentage of Test contributed by ownership type.....	12
Figure 5: Recovered cases	14
Figure 6:Types of health facilities observed	44

LIST OF ACRONYMS

AAAQ	Availability, Accessibility, Acceptability and Quality
ANC	Antenatal Care
CBO	Community Based Organization
COVID-19	Coronavirus Disease 2019
DHS	Demographic Health Survey
EDCD	Epidemiology and Disease Control Division
FCHV	Female Community Health Volunteer
FWD	Family Welfare Division
GBV	Gender-Based Violence
GER	Gender, equity and human rights
GESI	Gender Equity and Social Inclusion
HDU	High Dependency Unit
HF	Health Facility
HMIS	Health Management Information System
HEOC	Health Emergency Operation Center
HW	Health Worker
ICU	Intensive Care Unit
KII	Key informant interview
LGBTIQ	Lesbian, gay, bisexual, transgender, intersex and queer individuals
LNOB	Leave No One Behind
MoH	Ministry of Health
MoHFW	Ministry of Health and Family Welfare
MoSD	Ministry of Social Development
MWCD	Ministry of Women and Child Development
NCD	Non-Communicable Diseases
NGO	Nongovernmental Organization
NHEICC	National Health Education, Information and Communication Centre
OCMC	One-stop Crisis Management Centers
PHC	Primary Health Care
PHSM	Public Health and Safety Measures
PoE	Point of Entry
PPE	Personal Protective Equipment
PwD	Person with Disability
SGBV	Sexual and Gender-Based Violence
SRH	Sexual and Reproductive Health
VAWG	Violence Against Women and Girls
WASH	Water, Sanitation and Hygiene for All

EXECUTIVE SUMMARY

Background

COVID-19 has affected millions of people across the globe including Nepal. This unprecedented crisis unfolds against many existing challenges including persistent gender inequalities, existing inequalities in access to health, weak health infrastructures, and a high risk of secondary disasters. The social and economic impacts of COVID-19 are disproportionately felt by those experiencing pre-existing inequities, those living in situations of vulnerability and those who experience discrimination, which are compounded by institutional barriers and cultural norms that limited gender-responsive, equity-enhancing and human rights- promoting outcomes during the pandemic. With the world responding to the COVID-19 virus, it is important to consider response and recovery mechanisms through a gender lens. While women, as caregivers, breadwinners and health care workers, play critical roles in times of crisis, many of the impacts of COVID-19 are affecting women the most, exacerbating pre-existing social and economic inequalities, barriers and discrimination in their homes and communities.

Objectives

The purpose of this Gender, Equity and Human Rights Assessment is to understand how and to what extent gender, equity, inclusion and human rights perspectives are incorporated in COVID-19 response and recovery initiatives/programs and to identify recommendations for addressing the gaps in future planning and program responses for the COVID-19 pandemic in Nepal.

Methods

A mixed method approach using both quantitative and qualitative method of data collection techniques were used. For quantitative data, articles were reviewed using the website of MoHP of Nepal, the WHO and Google to gather the information on the number of deaths, cured, and confirmed cases of COVID-19 and reports describing the approach taken by the government from GER perspective to contain COVID-19 in Nepal. The data were disaggregated based on age and sex.

Similarly, for qualitative data, diverse groups of participants were included in the study ranging from national policy makers to beneficiaries' levels. Policy-level officials in Federal level, Province level and program managers and planners at local level, Health incharge and female health care workers at health facilities, communities and beneficiaries were interviewed. Purposive sampling technique were applied for national and provincial level data collection. The qualitative data were analyzed following the Tanahashi framework and segregated into ten pillars of emergency response.

Results

The findings of this research are categorized into quantitative and qualitative data. The quantitative findings state that a total of 977,937 COVID-19 cases were confirmed through polymerase chain reaction (RT-PCR) by 105 designated functional COVID-19 laboratories nationwide. Overall, the sex-distribution remains skewed towards males, who constitute 59% (575,000/977,937) of the RT-PCR confirmed cases. Amongst the males, 78% (450,291/575,000) are in the economically productive age group (15-54 years). (MoHP Nepal COVID data as reported on 13 March 2022)

Similarly, a total of 11,950 deaths have been reported. Out of the total deaths reported, 7,838 (65.6%) were male and 4,112(34.4%) were female. Amongst the deaths, 3,840 persons (32.1%) had at least one known comorbidity.

The findings of qualitative data are categorized into 10 pillars. Analysis of interview discussions were organized in the following major themes: Impact on gender roles and responsibilities, access to basic services, Access to essential health services, female health workers during pandemic, participation, leadership and decision-making, safety in isolation and quarantine centers, access to information, protection and point of entry .

Key findings

Key findings

Gender Roles and Responsibility

Across the communities, traditional gender roles have been continued and in many cases been reinforced, with the increasing burden of household work and care responsibilities falling on women. Women's unpaid care workload has increased as a result of the lockdown imposed by the government to contain the spread of COVID-19. Domestic workers had to work between 18-22 hours each day, instead of the usual 6-10 hours. Household and care work burden had not been shared equally among other family members owing to the traditional gender division of labour that assigns women the primary role and responsibility of household and care work.

Participation in Decision-making

Most of the respondents participated in the study stated that decisions are being taken by both men and women and COVID-19 situation had not changed the decision-making process in household expenses and savings. Regarding the involvement of female health workers in decision-making process, this study has found the increasing participation and involvement of female health workers in their health facilities.

Mostly, female health workers working in the peripheral health institutions are not directly involved in the leadership role but participate and share their opinions in decision making . However female health workers, program managers and policy makers at higher level were found to be involved in the decision making roles.

Community Participation

After the pandemic, most of the respondent's engagement with social networks has been limited, only few got the opportunity to get involved in pandemic related relief and response work.

Access to basic services (WASH)

Women and girls experienced a disproportionate burden from inadequate water and sanitation facilities, due to both physiological differences such as menstruation, and gender norms that require them to clean, cook and collect the household water. The current relief measures and quarantine services were inadequate to address the specific needs of girls, women with newborn babies and person with disability.

Impact of COVID-19 on Essential Health services

Vulnerable populations (elderly people, pregnant women, adolescent girls, disabled etc.) had experienced problems to access sexual and reproductive health (SRH) including other essential health services, such as immunization, non-communicable disease i.e., cancer, chronic kidney diseases, chronic cardio-vascular diseases and diabetes treatments. They also had difficulty in receiving medical support for early testing and treatment for COVID-19 .The problem is severe especially among pregnant and lactating mothers with limited access to safe delivery services, antenatal care (ANC) or post-natal care (PNC) services. Though the services were available and affordable people were hesitant to take services from the health facility due to geographical difficulties as well as due to fear of contracting COVID-19 infection.

COVID-19: isolation, and quarantine centers

There were no isolation center in most of the study sites. People had been encouraged to isolate themselves at home in those areas, which had further increased their fear of transmitting the infection to other members of the family. The isolation centers that were built in some areas of Kathmandu had taken into account concerns regarding gender sensitivity and safety but did not seem to be disability-friendly. However, in many areas in the country, quarantine centers lack separate toilets for men and women and don't have adequate space for people with no separate sleeping facilities for men and women.

Social Protection concerns

Indigenous women and women with disabilities who are further marginalized, and live in poverty, lacking awareness and education are often considered as weak and this puts them at a heightened risk of neglect, abuse, domestic and sexual violence. Protection concerns, Since the onset of pandemic, reports of violence against women and girls, mostly domestic violence, have increased.

Female health workers during Pandemic

Women as they represent the largest share of health care workforce, are more likely to be front-line health workers (HWs) during the pandemic. As a consequence of this pandemic, female HWs are being faced with a heavy workload / pressure, feel fear of infection due to the contagious nature of the virus. During COVID-19, adequate Personal Protective Equipment (PPE) were not available. PPE supplied by hospitals were inadequate and HWs were compelled to wear same PPE for 5-6 days which caused fear of infection while providing services. Also, female health workers in hospitals faced challenges for wearing PPE during menstruation period.

Community Engagement and Risk communication

Barriers to accessing COVID-19-related information include: literacy, language, access to technology, digital devices and data. These barriers were seen to be greater for the elderly, the poor, people with disabilities, remote communities, and for women, as a result of barriers to their participation in the public sphere.

Point of Entry

The government had implemented preventive measures to the migrants at the point of entry along with infrastructures for case detection like; thermal scanners, health desk, quarantines, isolation and holding centers were established. People were kept in the quarantine centers as needed before they went to their respective homes. Likewise, there was no proper management in the holding centers. All the people; women, elderly and children were kept in one place and there was problem of privacy in the holding centers.

Recommendations

The detailed recommendations of the study are mentioned in the recommendations section. However, some of the key recommendations include:

- Ensure the availability of data and information based on ethnicity, disabilities and at-risk groups. This should include rates of morbidity and mortality, differential care burdens, access to health services (including sexual and reproductive health services).
- Address women's unequal burden of domestic labor/household tasks and unpaid care work by first acknowledging the issue explicitly, and then redistributing responsibilities within families with support from government.
- Include efforts to add more equal representation of women in leadership positions, for example within the COVID-19 taskforces.
- Ensure immediate access to basic services such as food, relief materials, health services, safe, well-equipped, gender and disabled-friendly quarantine services, with special focus on poor, vulnerable, marginalized communities including women, adolescents and sexual minorities.
- Ensure women and girls have access to safe and comprehensive sexual and reproductive health services that are aligned with the Minimum Initial Service Package including dignity kits.
- Ensure that mental health services are not disrupted but are available through alternative modalities such as online/virtual methods if in-person services are not possible. These should be regarded as essential health services, with attention to examining potential gender gaps or disparities in access to, uptake of, and efficacy of these services.
- Prioritize and strengthen services for the prevention of, and response to, GBV in communities affected by COVID-19.
- Ensure gender-sensitive support for frontline health workers, for instance personal protective equipment that are suitable for female health workers, menstrual hygiene management kits, or additional financial support.

PART 1. INTRODUCTION

1.1 Background

The global and national COVID-19 responses have presented unique and rapidly shifting challenges to the promotion and protection of health and of human rights of people around the world. As countries identify ways to address COVID-19, integrating gender-responsive, equity-focused and human rights-based protections and guarantees into our shared responses, it is not only a moral imperative, but is essential to successfully addressing public health concerns.

Existing gender and social inequalities are exacerbated by COVID-19 and are impacting girls and women in ways different to men and boys. Women's and girls' exposure is likely to be affected by social norms and expectations around their caregiving roles, both in terms of caring for sick in the homes as well as in the health work force, which is 70% women.¹ Furthermore, women's and girls' access to essential health services, such as those related to sexual and reproductive health, is likely to be affected by the increased restrictions on mobility and the economic challenges that households are facing. Such restrictions are a violation of their human rights.²

The psychosocial and socio-economic impacts of the pandemic on different groups of the population are varied and unequal. In times of crisis, pre-existing gender and intersectional inequalities often worsen. Since there are other overarching concerns around safety and protection, issues related to the rights of specific groups, gender and intersecting inequalities might get sidelined when responding in emergencies. Therefore, while tackling the COVID-19 pandemic, it is necessary to understand how the outbreak and its consequences affect segments of the population who are at-risk or increasingly vulnerable, such as women, girls, people with disability, people of certain caste and ethnic groups and people of gender and sexual minorities. It is important to understand how the existing institutional barriers and cultural norms determine gendered experience and outcomes of this pandemic. Globally, research is emerging on the implications of public health emergencies on different groups, especially women and girls.

For a more effective and universal health coverage aligned response to COVID-19 and similar health emergencies, there must be implementation and support of gender equality approaches that address the specific health needs of all persons in diverse communities. From a public health perspective, there is also a natural synergy between gender sensitive approaches, the life-course

¹ UNW. Gender Equality Measures in COVID-19 Response. Available at <https://www.unwomen.org/en/news/infocus/in-focus-gender-equality-in-COVID-19-response>

² UNFPA. COVID-19 A gender lens. Available at <https://www.unfpa.org/resources/COVID-19-gender-lens>

approach, and the principles of health equity, as health inequities are rooted in complex processes of disadvantage across life stages and generations.

Prior to COVID-19, Nepal had strengthened its capacity to respond to emergencies and disasters, as well as the commitment to gender equality at the national level. Nonetheless, there are frequent failures in fully activating a timely gendered approach to emergency and disaster response. Statistics shows that a total of 977,937 COVID-19 cases were confirmed through polymerase chain reaction (RT-PCR) of 13 March 2022 and of which COVID-19 cases were higher among the men in all age groups.³ Although sex-disaggregated data show that COVID-19 cases are higher among the men, recognizing the extent of differential impact of outbreaks on women and men and intersections is a fundamental step to understanding the primary and secondary effects of health emergency in different individuals and communities in pre-existing situation of inequities, and for creating effective, equitable and inclusive policies and interventions. Therefore, this study emphasized the key considerations for integrating gender, equity and human rights as a cross-cutting theme in health emergency response, with specific reference to COVID-19.

1.2 Nepal's Policy responses to the COVID-19 pandemic

The COVID-19 pandemic and its subsequent social, health, and economic consequences have necessitated planning at all levels: national, provincial, and local. Planning allows for meaningful policies and guidelines that maximize benefits and minimize obstacles.⁴ Women and other vulnerable and excluded groups have experienced the most severe negative effects of the pandemic

What is meant by vulnerable group?

“A vulnerable group can be defined as a population(women, children, pregnant women, elderly people, disabled people, LGBTIQ etc.). within a country that has specific characteristics that make it at a higher risk of needing humanitarian assistance than others or being excluded from financial and social services.”

due to pre-existing deep-seated inequalities and discriminatory practices. Challenges, such as increasing incidents of maternal deaths due to lack of access to services, loss of livelihood, rising care burden, and swelling statistics on gender-based violence (GBV) threaten to

reverse the progress attained on women empowerment and gender equality. Following the emergence of COVID-19 pandemic, the government of Nepal activated the Infectious Disease Act 2020 (1964) to fight the pandemic. Section 2(1) of the Act enables the Government of Nepal (i.e. the federal executive) to take ‘necessary action’ and ‘issue necessary orders applicable to the general public or a group of any persons’ to ‘root out or prevent’ the development or spread of an

³ Nepal COVID-19 Statistics (edcd.gov.np) accessed on 13 March 2022.

⁴ Cerna L. The nature of policy change and implementation: a review of different theoretical approaches. <https://www.oecd.org/education/ceri/TheNatureofPolicyChangeandImplementation.pdf>.

infectious disease. Since the onset of the pandemic in 2020, the United Nations Country Team (UNCT) in Nepal has been responding to the crises with a focus on the gendered impacts of the pandemic and leaving no one behind, a commitment Nepal pledged to pursue in the 2030 Sustainable Development Agenda.

1.3 Objectives of the Study

This assessment was conducted to understand how and to what extent gender, equity, inclusion and human rights perspectives are incorporated in COVID-19 response and recovery initiatives/programs and to develop recommendations to address the gaps in future planning and program responses to the COVID-19 pandemic in Nepal. Moreover, the specific objectives of the assessment are to measure the following outcomes:

1. To analyze the government's measures and responses to COVID-19 (clinical and public health) from a gender, equity and human rights perspective and identify the gaps and opportunities.
2. To identify the challenges that women and girls, especially from vulnerable groups and communities, the LGBTQI community, older people, those living with disabilities, and those from other socioeconomically disadvantaged groups have faced in complying with the public health and social measures and in accessing COVID-related health services during the COVID- 19 pandemic.
3. To assess GER concerns in community engagement practices, risk communication, laboratories and vaccination, data integration and management, essential health services and system management, health workforce, and clinical care.
4. To identify concerns of women health workers working in COVID-19 pandemic situation.
5. To review good practices promoting gender-responsive, equity-enhancing, inclusive and human rights-based approaches in response to COVID-19, in both clinical and public health aspects.
6. To recommend the action points/recommendations (short and long-term) based on the analysis and findings and inform WHO, government and development partners for interventions.

PART 2. METHODOLOGY

2.1 Study Design

A mixed method approach using both quantitative and qualitative method of data collection techniques were used. For quantitative data, articles were reviewed using the website of MoHP of Nepal, the WHO and Google to gather the information on the number of deaths, cured, and confirmed cases of COVID-19 and reports describing the approach taken by the government from GER perspective to contain COVID-19 in Nepal. The search terms included “COVID-19 in Nepal” , “Gender, Equity and Human rights” and “Prevention and management of COVID-19 in Nepal.”

For qualitative data, diverse type of participants were included in the study ranging from national policy makers to beneficiaries. High-level official in Federal, Province, and local level, Health Incharge and female health workers from health facilities, FCHVs and communities beneficiaries were interviewed. For national and province level, purposive sampling technique were applied as given in the table below.

Table 1: National and Provincial Survey Size

SN.	Level	Participants	Total of KIIs	Remarks
1	National Level	Officials at EDCD, NHTC, NHEICC, FWD, IHIMS Section, GESI Section, MoHP, HEOC	10	1 from each government stakeholder
2	Provincial Level	Officials at MoH and MoSD	7	At least 1 from each Province

In case of local level, a random sampling technique was used. All the districts and local levels were selected based on provincial and ecological terrain. Each province included two districts and two municipalities (one urban and one rural) from each district. All the local level’s survey, health facilities, communities and beneficiaries’ survey were carried out in selected local level. The detailed sampling strategy is given below:

2.2 Sampling Strategy

As per Nepal’s current federal structure, there are 7 provinces, 6 metropolitan cities, 11 sub-metropolitan cities, 276 urban municipalities and 460 rural municipalities. However, some of the federal government’s structure still exists in district headquarters (77 districts). There are three ecological zones i.e. Mountain, Hills and Terai. As per the ecological classification, there are 16 districts in mountain, 40 districts in hills and 21 districts in terai. Two districts form each province

have been selected for this assessment. All the districts according to provincial and ecological order were arranged alphabetically as shown in the table below. A unique number was assigned to each district starting from 1 to highest district number in that particular province and ecological zone. The random numbers were generated in excel sheet. The selected number represented the study district of that particular location. Similarly, all the districts were selected accordingly as shown in table below.

Table 2: Sampling Strategy

Sampling strategy					
Province	Ecological Region	Districts (alphabetic order)	Total districts	Random No.	Selected District
1	Mountain	Sankhuwasabha, Solukhumbu, Taplejung	14	13 and 6	Ilam and Morang
	Hill	Bhojpur, Dhankuta, Ilam , Khotang, Okhaldhunga, Panchthar, Tehrathum, Udaypur			
	Terai	Jhapa, Morang and Sunsari			
Madhesh	Terai	Bara, Dhanusha , Mohattari, Parsa, Rautahat, Saptari, Sarlahi and Siraha,	8	7 and 2	Dhanusha and Sarlahi
Bagmati	Mountain	Dolakha, Rasuwa and Sindhupalchok	13	8 and 2	Rasuwa and Lalitpur
	Hill	Bhaktapur, Dhading, Kathmandu, Kavrepalanchowk, Lalitpur , Makwanpur, Nuwakot, Ramechhap, and Sindhuli			
	Terai	Chitwan			
Gandaki	Mountain	Manang and Mustang	11	1 and 9	Manang and Syangja
	Hill	Baglung, Gorkha, Kaski, Lamjung, Myagdi, Parbat, Syangja and Tanahu			
	Terai	Nawalparasi East			

Lumbini	Hill	Arghakhanchi , Gulmi, Palpa, Pyuthan, Rolpa and Rukum East	12	8 and 1	Arghakhanchi and Bardiya
	Terai	Banke, Bardiya , Dang, Kapilvastu, Nawalparasi and Rupandehi			
Karnali	Mountain	Dolpa , Humla, Jumla, Kalikot and Mugu	10	9 and 1	Dolpa and Salyan
	Hill	Dailekh, Jajarkot, Rukum West, Salyan and Surkhet			
Sudurpaschim	Mountain	Bajhang , Bajura, and Darchula	9	1 and 8	Bajhang and Kailai
	Hill	Achham, Baitadi, Dadeldhura and Doti			
	Terai	Kailali and Kanchanpur			
3 Eco. Zone		77 Districts	77		

After, selecting the 2 districts in each province, the urban and rural municipalities of selected districts were arranged using same technique as described above. A unique number was assigned to all urban and rural palikas separately. Random numbers were generated in excel and respective palikas were selected. Using this random method, 5 districts from terai and 5 districts from hills and 4 districts from mountain were selected as in the map and in the table below.

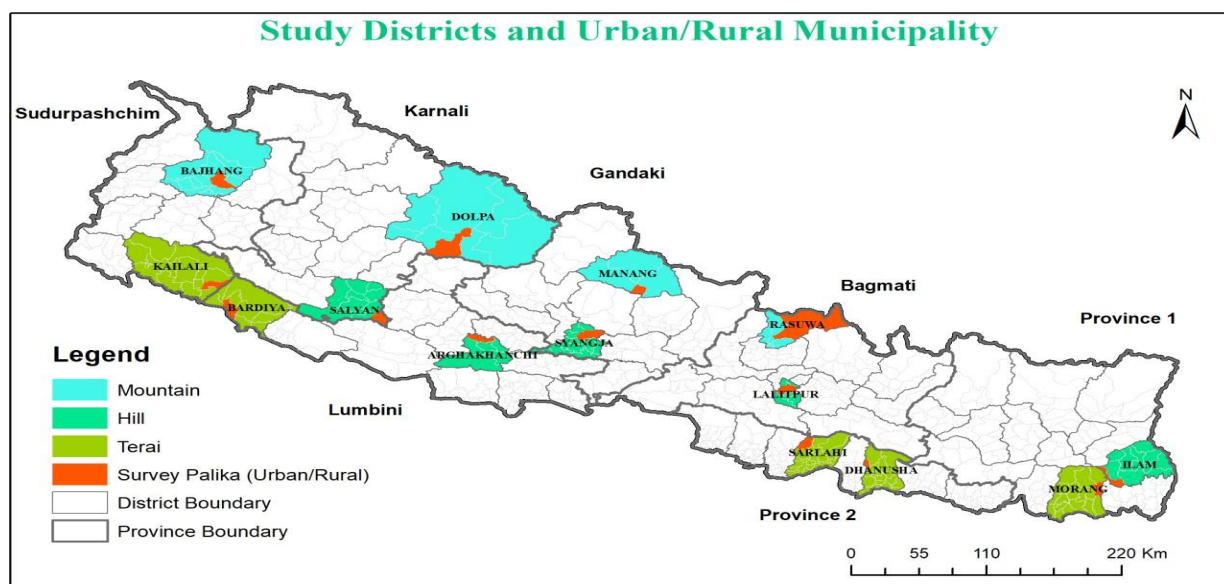


Figure 1: Map of study Area

The selected districts and palikas are as follows.

Table 3: Selected Districts and Palikas (Urban/Rural)

Province	District 1 (Urban Palika)	District 2 (Rural Palika)
Province 1	Morang (Urlabari)	Ilam (Chulachuli)
Madhesh	Sarlahi (Bagmati)	Dhanusha (Bateshwar)
Bagmati	Lalitpur (Godawari)	Rasuwa (Gosaikunda)
Gandaki	Syangja (Putalibazar)	Manang (Nasong)
Lumbini	Bardiya (Madhuvan)	Arghakhanchi (Malarani)
Karnali	Dolpa (Thuli Bheri)	Salyan (Kapurkot)
Sudurpaschim	Bajhang (Jay Prithivi)	Kailali (Janaki)

2.3 Data collection tools

The primary and secondary data were collected as per the objective demands. For this, different tools were used to collect data. The tools were prepared by the team and was finalized in consultation with the WHO technical team. The information was collected through desk review of relevant documents, guiding questionnaire and observations.

Desk Review

The documents related to the “Gender, equity and human rights-focused assessment on the health sector preparedness and response for COVID-19 during 2020-21” were reviewed thoroughly to get better understanding of the study, its components, activities and implementation. For example, following documents were reviewed for the assessment.

- IHIMS/IMU and reviews of communication materials
- Reviewing national health programs to leave no one behind by WHO
- Breaking barriers towards more equitable health systems for everyone. By WHO
- Rapid Gender Analysis Report on COVID-19, 2020. By Ministry of Women, Children and senior citizens, SCN, CARE
- How COVID- 19 worsens gender inequality in Nepal by Luna KC
- Challenges faced by health care professionals during the COVID-19 pandemic: a qualitative inquiry from Bangladesh.
- How COVID-19 impacts women and girls - UN Women
- United Nations System-wide Action Plan for Gender Equality and the Empowerment of Women (UN SWAP).
- Human Right dimension of COVID-19 pandemic, Commissioned by the Independent Panel for pandemic Preparedness and Response.

Focus Group Discussion (FGD)

FGDs were carried out with beneficiaries: Women and mothers' groups, Dalit, ethnic minorities, urban poor, older people, those living with a disability etc., and other women's networks that exist at local level identified as vulnerable population.

Key Informant Interviews (KII)

KIIs were carried out with Officials at EDCD, NHTC, NHEICC, FWD, IHIMS Section, GESI Section, MoHP, Stakeholders at national level and at Provincial Level: Officials at MoSD, PHD, Stakeholders. This was conducted to assess the government's measures and responses to COVID-19 (clinical and public health) from a gender, equity and human rights perspective.

In case of local level survey, mainly KIIs were conducted with health coordinators and health in charge. In addition to that, Mayor/dep. Mayor in Urban municipalities were interviewed. We envisioned that it could help to incorporate local government's attention on COVID-19 response program, preparedness and other health services activities, which may guide us whether the programs/initiations are aligned with GER framework or not and to identify the gaps.

FCHVs were contacted for interview in selected local levels to understand the overall management of the essential drugs and supplies for neonatal and child illness and other reproductive health related issues during COVID-19 pandemic.

In-Depth Interviews (IDI)

In-depth interviews were conducted among female health service providers to understand regarding their burden of care and stigma, pay gap, personal protective equipment and safety gears, ability to meet menstrual hygiene needs during long work shifts, participation in leadership and COVID-19 decision-making roles, gender-friendly workplaces and spaces, etc. Additionally, it helped identify concerns of women health workers working in COVID-19 pandemic situation. In community, in-depth interviews were conducted among women and girls, especially from vulnerable groups and communities to identify the challenges they faced in complying with public health and social measures and in accessing COVID -related health services during COVID-19 pandemic.

Observation

Expert Team including field researchers carried out field visits to inspect recording and reporting system at health facilities to support the information collected through KIIs. A separate checklist was prepared. This tool assessed the good practices promoting gender-responsive, equity-enhancing, inclusive and human rights-based approaches in response to COVID-19, in both clinical and public health aspects.

Table 4: Details of Sample Size

Province	Districts	Selected Palikas	FGDs	KII (Key informant Interview)					IDI (In-depth Interview)			Observation	
			Beneficiaries	Palika Head (mayor / Chairperson)	Palika (Health Coordinator)	FCHV and CICT	Health Post (Health facilities in charge)	District Hospital (In charge)	Health service providers in HP / Female	Health service providers in District Hospital / Female	In community (women and girls only)	Health facilities (reporting and recording system)	District Hospital (reporting and recording system)
1	Ilam	Chulachuli Rural Municipality	1	1	1	2	1	1	1	1	2	1	1
	Morang	Urlabari Municipality	1	1	1	2	1		1		2	1	
Madhesh	Dhanusha	Bateshwar Rural Municipality	1	1	1	2	1	1	1	1	2	1	1
	Sarlahi	Bagmati Municipality	1	1	1	2	1		1		2	1	
Bagmati	Rasuwa	Gosaikunda Rural Municipality	1	1	1	2	1	1	1	1	2	1	1
	Lalitpur	Godawari Municipality	1	1	1	2	1		1		2	1	
Gandaki	Syangja	Putalibazar Municipality	1	1	1	2	1	1	1	1	2	1	1
	Manang	Chame Rural Municipality	1	1	1	2	1		1		2	1	
Lumbini	Arghakhanchi	Malarani Rural Municipality	1	1	1	2	1	1	1	1	2	1	1
	Bardiya	Madhuvan Municipality	1	1	1	2	1		1		2	1	
Karnali	Dolpa	Thuli bheri Municipality	1	1	1	2	1	1	1	1	2	1	1
	Salyan	Kapurkot Rural Municipality	1	1	1	2	1		1		2	1	
Sudurpaschim	Bajhang	Jay Prithivi Municipality	1	1	1	2	1	1	1	1	2	1	1
	Kailali	Janaki Rural Municipality	1	1	1	2	1		1		2	1	
		Total	14	14	14	28	14	7	14	7	28	14	7

2.4 Data Analysis

The analysis of quantitative data involved retrospective analysis of the COVID-19 infection disaggregated based on age and sex in Nepal, analyzing the actions taken by the Government of Nepal (GoN) from GER perspective to inform future decisions. Data used in this study were extracted from relevant reports and websites of the Ministry of Health and Population (MoHP) of Nepal and the WHO.

Qualitative data analysis involved group analysis of the interviews conducted throughout the study districts. KIIs, IDIs and FGDs were separately analyzed. However, each interview was analyzed for any specific cultural and traditional aspects that were unique to participants and to districts/place/religious group as relevant. All the interviews that had been audio-recorded were transcribed and translated. The researchers went through each transcript and field note for analysis. Content (or thematic) analysis method was used for analyzing the qualitative information.

2.5 Ethical clearance

Protocol and data collection instruments for this research were reviewed for adherence to ethical standards by an Ethical Review Board (ERB) in Nepal. The ERB's approval was obtained from Nepal Health Research Council (NHRC), a Government led institution for Independent Review and Approval for conducting health researches in Nepal on 23 February 2022.

Before proceeding the study, the researchers obtained the written informed consent from each participant or legally authorized representative. The researchers clearly stated the objectives, reasons for conducting the study and addressed any queries that participants had. All participants affirmed that they understood the nature of the study, potential risks associated with participation, and that they retained their right to refuse to participate in the study at any time. However, adequate provisions were maintained to protect the privacy and confidentiality of the participants throughout the study.

2.6 Limitation of the Study

The study area was limited to respondents and providers of the selected facilities of 14 districts. So, the findings are indicative rather than conclusive and findings may not be generalized at national context. Also, the study largely focused on women, with few men respondents. It will be important to do a further study on the impacts on different groups of men as was done here for women. Likewise, we couldn't find LGBTIQ community during data collection period in the study areas. Therefore, the perspectives of such community is lacking in our report. The researchers made their best efforts to maintain high quality of the data collected. However, the limited time frame for conducting the study put pressure on the research team to conduct field research, analyze data and write the report.

PART 3. QUANTITATIVE FINDINGS

This section elucidates the quantitative findings of the study. Different articles were reviewed to extract the following information from each: prevalence of COVID-19, place of distribution, testing laboratories, case management, vaccination, COVID-19 and human suffering and gender-based violence. Articles were reviewed using the website of MoHP of Nepal, the WHO, the worldometer official website, and Google to gather the information on the number of deaths, cured, and confirmed cases of COVID-19 and reports describing the approach taken by the government from GER perspective to contain COVID-19 in Nepal. The search terms included “COVID-19 in Nepal” and “Prevention and management of COVID-19 in Nepal.” The data were disaggregated based on age and sex. However, there were no disaggregated data available on COVID-19 infection and vaccination for disabled, pregnant and lactating women.

3.1 Confirmed cases of COVID-19

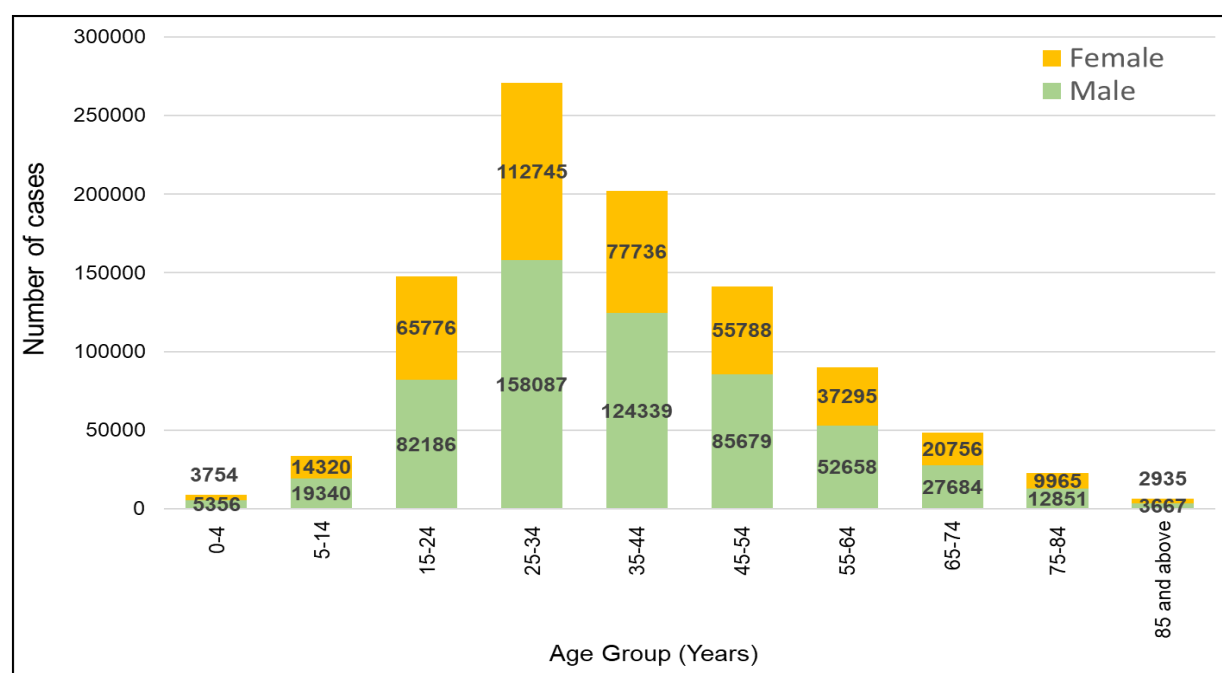


Figure 2: Distribution of RT-PCR positive COVID-19 cases by age and sex

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

Figure 2 shows, the data on the reported confirmed cases of COVID-19. Overall, the sex-distribution remains skewed towards males, who constitute 58% (571,847/972,917) of the RT-PCR confirmed cases. Amongst the males, 78% (450,291/571,847) are in the economically productive age group (15-54 years). The reported confirmed cases are higher in the economically productive age group (15-54 years) for both males and females.

3.2 Place Distribution

Figure 3 below depicts, the province wise distribution of COVID-19 cases and deaths till March 13, 2022. The highest number of COVID-19 cases were reported in Bagmati Province, with 538,633 cases, while the lowest number of cases were recorded in Karnali Province, with 28,157 cases. COVID-19 fatalities were also greater in Bagmati (5,050) than in Karnali Province (486).

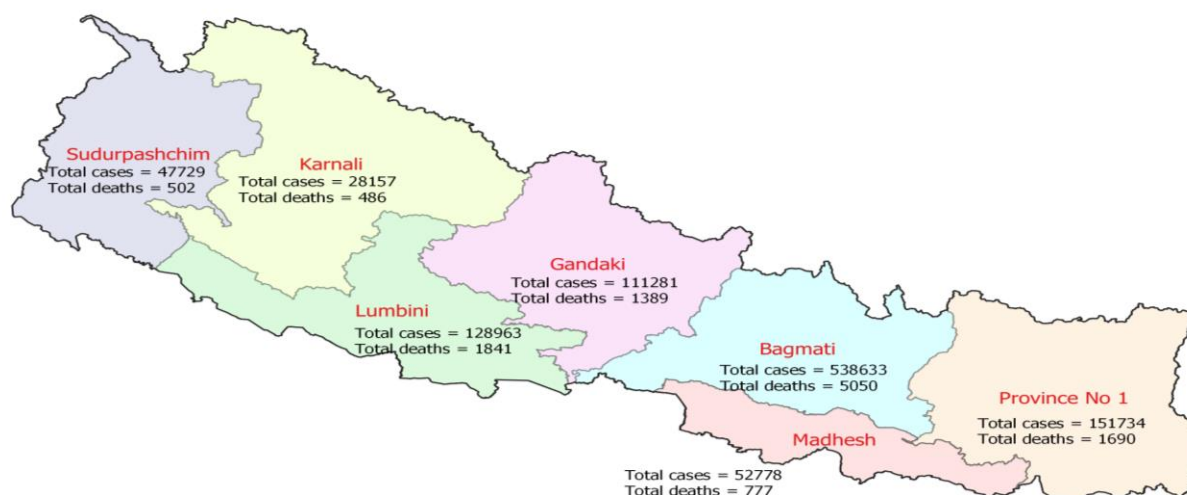


Figure 3: Province wise distribution of COVID-19 cases and deaths

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

3.3 Testing Laboratories

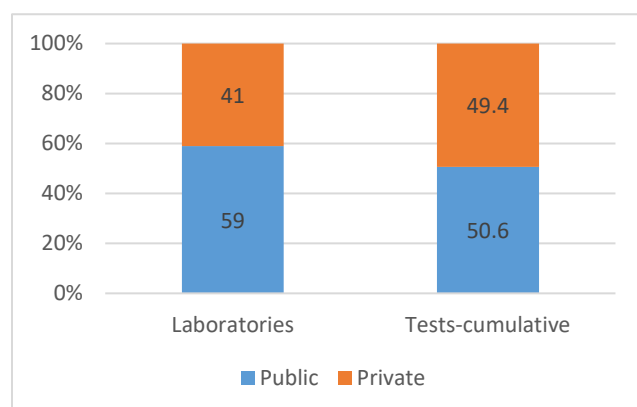


Figure 4: Percentage of Test contributed by ownership type

A total of 105 RT-PCR laboratories have been established covering all provinces. Of which 59% are public and 41% are private. As of 13 March 2022, reported by MoHP, a total of 54,83,746 RT-PCR and 10,94,683 antigen testing has been performed. Half of the laboratories are in operation in Bagmati province.

Table 5: Provincial Disaggregation of RT-PCR Labs

Province	RT-PCR Testing Laboratories					
	Public		Private		Total	
	N	%	N	%	N	%
Province 1	4	44.4	5	55.6	9	8.8
Madhesh	7	70	3	30	10	9.8
Bagmati	28	49.1	29	50.9	57	52.9
Gandaki	4	66.7	2	33.3	6	5.9
Lumbini	8	66.7	4	33.3	12	11.8
Karnali	4	100	0	0	4	3.9
Sudurpaschim	7	100	0	0	7	6.9
Total	62	59	43	41	105	100

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

3.4 Case Management

In Nepal, there are 78 COVID-19 care units (hospitals) that can treat COVID-19 cases as of 13 March 2022. Bagmati is home to over a quarter of these units. On the 20th of November 2021, almost 94 percent of cases were isolated at home. Hospital/institutional isolation accounted for 6% (451) of active cases. 3 percent (234) of the total cases required ICU treatment.

Table 6: Province-wise distribution of Isolation, I.C.U, and Ventilator

Province-wise Hospital Resource Mapping				
Province	Isolation Beds	HDU beds	ICU Beds	Ventilators
Province 1	819	567	342	148
Madhesh	1680	695	396	124
Bagmati	3283	1191	1423	532
Gandaki	651	444	228	82
Lumbini	452	640	239	56
Karnali	607	96	97	35
Sudurpaschim	710	213	72	31
Total	8202	3846	2797	1008

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

3.5 Vaccination

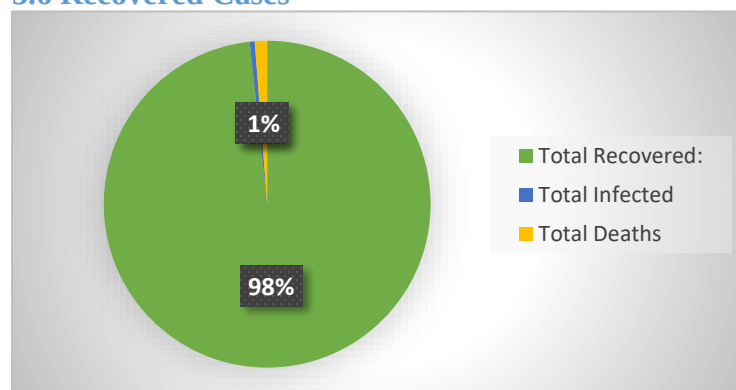
The government of Nepal intends to reduce COVID-19-related morbidity and mortality by vaccinating its inhabitants in phases, when vaccines become available, starting with the highest-risk groups. COVID-19 vaccination campaigns had taken place in all provinces at the same time for the first and second doses of Covishield/AstraZeneca, Sinopharm, and the first dose of Pfizer BioNTech vaccine (from 24 hospitals) to specific target groups as specified by the MoHP and as per the National Deployment and Vaccination Plan. On October 22, 2021, Nepal achieved a milestone by giving 15 million doses of COVID-19 vaccine. Nepal had received/procured a total of 38,791,546 doses of COVID-19 vaccine from various sources as of March 13, 2022. For the COVID-19 vaccination campaign, the Family Welfare Division has distributed vaccine-specific interim guidelines to all provincial, district, and local levels.

Table 7: Status of Vaccination against COVID-19

Province	Covid Shield			Verocell			J & J		Pfizer			Moderna		
	1st dose	2nd dose	Additional dose	1st dose	2nd dose	Additional dose	Fully vaccinated	Additional dose	1st dose	2nd dose	Additional dose	1st dose	2nd dose	Additional dose
Province 1	815439	767206	112431	1725241	1309422	11460	535604	14282	6088	5371	0	538163	326778	16698
Madhesh	1096610	754242	89268	1608726	1383730	33681	685633	16706	7753	6003	0	692645	382848	3226
Bagmati	1149178	794124	416768	2783501	2539435	107462	706594	7759	295583	209527	57117	348943	219069	24179
Gandaki	426625	393606	203174	978969	975393	42518	329136	3615	3449	3186	0	269451	234701	29644
Lumbini	995704	790604	215616	1621478	1485628	45480	477201	7868	5359	5119	0	595734	527163	17658
Karnali	184858	152319	64932	551239	466195	13855	151262	3829	2272	2165	0	238681	183514	5993
Sudurpaschim	379329	289919	114567	921845	786643	26219	278959	9138	3981	3784	0	368402	290384	8690
Total	5047743	3942020	1216756	10190999	8946446	280675	3164389	63197	324485	235155	57117	3052019	2164457	106088

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

3.6 Recovered Cases



Till March 13, 2022, total cases were 977987, out of which 98.3% of cases recovered, 0.5% are active cases and 1.22 % deaths have been reported by MoHP Nepal.

Figure 5: Recovered cases

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

3.7 COVID-19 and human suffering

Table 8 below shows that a total of 11,950 deaths have been reported. Out of the total deaths, 7,838 (65.6%) were male and 4,112 (34.4%) were female. Amongst the deaths, 3,840 persons (32.1%) had at least one known comorbidity. Although the overall case fatality ratio (CFR) across all ages is less than 1%, it progressively increases with age beyond 65 years of age, ranging from 5.2% to 12.2%. However, there is no data available on deaths of disabled, pregnancy and lactating women due to COVID-19.

Table 8: Age Specific Case Fatality Ratio and Co-morbidity of Deaths in RT-PCR confirmed COVID-19 cases

Age Group (Years)	Total confirmed cases	Death (male)	Death (Female)	Deaths with any known comorbid condition	Age specific case fatality ratio (%)
0-4	9110	16	23	13	0.43
4-14	33660	13	7	10	0.06
15-24	147962	91	96	69	0.13
25-34	270832	386	264	149	0.24
35-44	202075	875	450	279	0.66
45-54	141467	1385	643	564	1.43
55-64	89953	1682	796	769	2.75
65-74	48440	1631	884	940	5.19
75-84	22816	1221	654	762	8.22
85+	6602	519	288	274	12.22
Unknown	5020	19	7	11	0.52
National	977937	7838	4112	3840	1.22

(Source: MoHP Nepal COVID-19 data as reported on 13 March 2022)

3.8 Impoverished Citizen chronic disease treatment program

The Impoverished Citizens Service Scheme of Social Health Security Section provides the funding for impoverished Nepalese citizens to treat serious health conditions. Cancer, chronic heart disease, chronic kidney disease needing dialysis or kidney transplant, head injury, spinal injury, Parkinson's disease, Alzheimer's and sickle cell anemia are diseases that can cause catastrophic medical expenditure as these diseases require long term treatment. Due to costly treatment families of these patients can plunge into poverty. Government of Nepal, Ministry of Health and Population has been implementing impoverished citizen treatment program since last 15 years⁵ in order to partially support the treatment and prevent those families from landing into poverty again, and to prevent deprivation of the poor from treatment.

In FY 2019/20, 54,886 patients were provided free treatment by the impoverished citizens

⁵ DoHS, Nepal, Annual Report 2076/77 (2019/20)

services scheme. Majority of patients were those suffering from Cancer (34,667), followed by Kidney disease (7487), Heart disease (5761), Sickle Cell Anemia (3803), Traumatic Spinal Injury (1856), Traumatic Head Injury (840), Parkinson's diseases (364) and Alzheimer's diseases (117) who availed free treatment under the impoverished citizens services scheme.

Table 9: Number of beneficiaries treated under Impoverished Citizen Treatment Program

S. N	Fiscal Year	Number of persons receiving benefits	Remarks
1.	2017/18	22,152	Fiscal year of Nepal starts from mid-July
2.	2018/19	53,330	
3.	2019/20	54,886	
4.	2020/2021	29,346	

(Source: Nursing and Social Security Division/ DoHS)

Table 9 shows that the number of patients under the impoverished citizen scheme dropped sharply in the year 2020/21, during the first and second wave of COVID-19 pandemic and it seems to have affected the access of this group of population to the health services.

3.9 Training of Health care Workers for the Management of COVID-19

Health care workers were trained on the management of COVID-19 cases by National Health Training Centre supported by WHO-Nepal and Nepal Medical Association. A total of 11,678 health workers were trained. Among which, 3565 were MBBS Doctors, 4978 were Nurses, 1316 were Specialists and 1819 were Paramedics. Health care workers from all seven provinces were trained, of which the majority (62.9%) were female.

Regarding testing of COVID-19, 17 laboratory personnel were trained for RT-PCR and RDT test at Bheri hospital by ADRA Nepal

Table 10: Trainings conducted on COVID-19 Response management

S.N.	Types of training on COVID-19	Participants
1.	Counselling	58
2.	Preparedness and essential critical care management	33
3.	Preparedness and response	21
4.	Prevention, control and management	68

3.10 Sexual and Gender-based violence

Table 11: Gender-based violence in Nepal reported to the police in the FY 2019/20 and 2020/21

S. N	Type of Crime	FY 2019/20	FY 2020/21	Remarks
1.	Rape	8,674	2,532	34 male victims
2.	Attempted Rape	3,188	735	
3.	Child Sexual Abuse	256	281	
4.	Domestic Violence	59,764	14,232	

(Source: Nepal Prahari Darpan, Annual Report of Nepal Police 2020 and 2021)

The above table 11 shows the number of cases of sexual and gender-based violence in Nepal that were reported to the police in the FY 2019/20 and 2020/21. Reporting of sexual and domestic violence decreased sharply in the FY 2020/21 as it was difficult to reach the local health facility and staying most of the time inside households also helped to decrease reporting of the cases.

Age group of survivors of sexual violence

The analysis of age groups of cases of sexual violence showed that 11-16 age groups were most affected during COVID-19. Among which, majority of the survivors were females and only 34 were males. Below the age of 18 years 2317 out of 3601 were affected.

Table 12: Age-wise breakdown of cases reported to the police in the FY 2019/20 and 2020/21

S. N	Age group of violence	Number	Remarks
1.	Below 10 years	464	34 males
2.	11-16	1418	
3.	17-18	435	
4.	19-25	588	
5.	26-35	395	
6.	36-45	147	
7.	46-59	94	
8.	Above 60 years	60	
	Total	3601	

(Source: Nepal Prahari Darpan 2021)

One-stop Crisis Management Center (OCMC)

This initiative started in the year 2011 to support the gender-based violence survivors specially rape victims and is led by Ministry of Health Population. All services including curative, social, legal, counseling required for a rape survivor is available from hospitals, where OCMC has been established. The centers provide free health services, identify and treat survivors and offer them psychosocial counselling and medico-legal services. They also act as the coordination hub to multisectoral services including safe homes, personal security and rehabilitation programmes. The programme has also provided forensic training of doctors to improve the quality of medico-legal reporting and the strength of evidence taken to court, introduced psycho-social counselling training of health staff and strengthened the centers reporting systems of cases.

Table 13: Total number of clients attending OCMC

S. N.	Fiscal Year	Number of clients receiving service	Remarks
1.	2017-18	4372	
2.	2018-19	6992	
3.	2019-20	8342	
4.	2020-21	5614	4 province data only

(Source: Nursing and Social Security Division and Annual Report of DoHS 2020/21)

The above table 12 denotes, the number of clients attending OCMCs. The numbers of clients receiving health service from the OCMC site have decreased from 8342 to 5614 in the fiscal year

2020/21 due to COVID-19. During the first and second waves of the pandemic, GBV case reporting was hindered by: (i) lack of knowledge on how to file a complaint from home, (ii) the unwillingness of the police to register cases, (iii) suspension of court and out-patient departments at hospitals, which reduced referrals to One-Stop Crisis Management Centre services.⁶

During lockdown, virtual support had been provided to OCMCs across the country and facilitated the management of 15 rape cases across multiple agencies. The number of functional OCMCs in the country has been increased from 54 at the end of FY 2019/20 to 80, located in 77 districts. Ministry of Health and Population prepared a COVID-19 protocol for OCMCs to help ensure their functionality during the pandemic, introduced a rapid electronic reporting system of cases to higher authorities, and supported the establishment of eight new centers through virtual meetings.

Stocktaking of OCMC functionality

The OCMC self-assessment score card was completed by 50 OCMCs in March 2020. This score card is introduced as a management tool in the latest version of the OCMC Operational Manual (2020) (currently waiting for final approval from the MoHP). The score card includes indicators that relate to the capacity of the hospital to deliver OCMC services and the quality of coordination and collaboration of the OCMC within the health service and with external agencies. For management purposes, the MoHP has set an aggregate score of 75 percent as a marker of acceptable functioning. Out of 50 OCMCs that reported, 36 scored 75 percent or above. The indicator with the highest score was on coordination and collaboration within the hospital, and the one with the lowest score was on preparation of a joint action plan with local GBV service providers including police and local government.⁷

Community awareness of OCMC services is low: survivors rarely come to the OCMC, and as hospital-based centers, they are out of the reach of the majority of the population that live in rural areas. The shame and stigma of GBV for the individual and family is a major reason why GBV remains invisible, and why victims can end up being blamed for the violence, and constrained or denied help or justice. Also, many of the respondents participated in the study were not aware of reporting against violence and hotline number except police. However, awareness are gradually increasing against the GBV and there are changes in trend in reporting against violence.

People are raising their voice against violence. They started sharing their experiences to their friend or mother or neighbor to overcome their pain. FGD, Chulachuli RM, Ilam

⁶ WOREC Nepal, An assessment on risk and preventive measures of gender-based violence during lock-down period of COVID- 19, June 2020.

⁷ Ministry of Health and Population and Nepal Health Sector Support Programme. 2020. Review of the scale-up, functionality and utilisation, including barriers to access, of One Stop Crisis Management Centres. <http://www.nhssp.org.np/Resources/GESI/Scaling%20Up%20OCMCs%20%20-%20Apr>

PART 4: QUALITATIVE FINDINGS

This section includes analysis of the qualitative data collected from KIIs, FGDs and in-depth interview of high-level officials at Federal, Provincial, Local levels, Health facilities, communities and beneficiaries about their understanding on how and to what extent gender, equity, and human rights perspectives are incorporated in COVID-19 response and recovery initiatives. This project aims to understand the primary and secondary effects of a health emergency on different individuals and communities in pre-existing situation of inequities, and for creating effective, equitable and inclusive policies and interventions. The study emphasizes the key considerations for integrating gender, equity and human rights as cross-cutting theme in health emergency response , with specific reference to COVID-19.

4.1 Themes

The study looked at ten pillars (Country-level coordination, planning, and monitoring; Risk communication and community engagement; Surveillance, rapid response teams, and case investigation; Points of entry; National laboratories; Infection prevention and control; Case management; Operational support and logistics; Maintaining essential health services and systems; Vaccination) through which gender, equity and human rights assessment aimed to identify the extent and gaps in the mainstreaming of GER in the different areas of health promotion, prevention and treatment while responding to the COVID- 19 pandemic. It helped to identify the ways and focus of addressing gender, equity and human rights gaps in COVID-19 responses and actions. Moreover, it contributed to the growing discourse on gender, equity and human rights in pandemic situation, women's leadership and participation in decision-making regarding the COVID-19 preparedness, response and recovery. Analysis of interview discussions has been organized in the following major themes, as discussed in the sections that follow:

4.1.1 Gender Roles and Responsibilities

The impact of the pandemic on household division of labour and women's engagement in income generation was analyzed. The first wave of lockdown imposed by the government to prevent the spread of COVID-19, women's workload had increased. Domestic workers had to work between 18-22 hours each day, instead of the usual 6-10 hours⁸. Similar to the first wave of COVID-19, the second wave has disproportionately impacted men and women and their gender roles and responsibility which is discussed in the following sub sections:

Distribution of unpaid care work

Respondents from the study districts confirmed that the unequal gender-based burden of unpaid work carried out by women has increased due to various factors including confinement of family members at home and discriminatory social norms (Like, women have to take responsibilities of

⁸ POURAKHI

domestic work) etc. Also, as a result of the lockdown and the spread of the virus, household chores such as taking care of children and their schoolwork, elderly and sick also added to women's workload. Despite being confined within homes, some of the participants reported that men had also shared their domestic work responsibilities.

"The household work sharing is never equal between men and women. Men do less while women do most of the work in our community during COVID". **Community women, Syangja**

Women who are farmers and work in office are also significantly affected by the increased workload. Women working from home are expected to do domestic chores besides doing their paid work. With the increasing rate of infections in the second wave, care work of women has also drastically magnified. The increased workload has caused mental stress and anxiety and has also led to conflict in the family.

At the same time, many of the respondents reported changes in gender roles during the period of lockdown. The men were also involved in cooking and serving their wives and daughters. However, the practice of playing cards among men in some households had led to women's increased workload as they had to serve food and snacks for them.

"My husband helped me with my household works. At that time, they didn't go outside to work. They helped to cook food, clean house and look after the children. The household workload decreased for me at that time." **Community women, Bateswor RM – 4, Dhanusa**

Decision-making

The findings show that COVID-19 pandemic has not impacted much in decision making practice at the household level. Majority of the respondents from all districts expressed that both men and women used to take major decisions regarding family resources, expenses and saving before the pandemic which remains the same even during the pandemic. In some cases, women's influence on decision making seems to have increased, since they stay at home.

In a nuclear family if the husband is out of country for foreign employment, in such families, women take the decisions on household activities, resource distribution etc. **Community women from Arghakhanchi stated "I always take our family decision. My husband is a foreign employer and I just inform him through phone about my decision."**

Likewise, the thoughts are being changed gradually and voices are being raised like there is no compulsion to obey their family members' decision even if they are staying together. However, in most cases decisions are being taken by mutual discussion among the family members and COVID-19 has not changed the decision making process.

“We take decisions in mutual understanding. It’s not like in old times where women have to obey and agree with everything her husband says.” FGD, Goshainkunda RM, Rasuwa

Similarly, at the community level female participation on different activities like health, social work, politics have increased and voices are being spread and being impacted on decision making process in the community.

“In case of community also, I am involved in many discussions. Whether my views are taken for decisions or not, I keep my views on various topics like health care, pandemic etc. As I said, in our community male and female are equal and no one is scared to put their views”. Community women, Manang

On the other hand, many women representatives are elected (33%) for instance in the local level. Where there is a male member as the Mayor obviously there is a female as Deputy Mayor and are in a position to take decision, share their feelings and justification and gradually changing and influencing the decision making process with the participation of women so as in COVID-19 situation.

“I used to take part in most meetings of our palika, we discuss and make decisions as needed” Deputy Mayor, Jai Prithivi Municipality, Bajhang.



(FGD with Community women in Salyan district, Nepal. Photo Credit: NDRI Nepal/Bhim Pd. Shrestha)

Participation in community groups

After the pandemic, most of the respondents' engagement with social networks has been limited, only few got the opportunity to get involved in pandemic related relief and response work. However, unlike the first wave when they had plenty of opportunities to volunteer in the relief work, they have not been able to carry out those activities this time. In Bardiya, in the hotspot areas of COVID-19 infection, people were so fearful about COVID-19 that they hardly stepped out of the house and had not been able to work on COVID-19 prevention and relief distribution activities.

"I got an opportunity to volunteer in pandemic related social activities. I am also involved with women's networks and cooperatives to distribute masks and lunch for the needy people." **Community woman, Madhuwan Municipality, Bardiya**

4.1.2 Access to Basic Services (WASH)

The second wave of COVID-19 pandemic has made it even more difficult for communities to access basic services. Access to drinking water, sanitation and hygiene along with right to information and awareness have been severely impacted, affecting marginalized and vulnerable groups the most. The key findings, in terms of access to basic services, can be summarized as:

Drinking Water, Sanitation and Hygiene

It was found that the pandemic has brought a huge change in the hygiene and sanitation practices of the communities. Practices such as hand washing, using sanitizers and masks have been adopted by the community members, men, women and adolescents, to a large extent.

"We are using masks, sanitizers and maintaining physical distance when we go outside. We wash our hand by soap and water after we return to home." **Community Women, Bardiya district**

On the other hand, it was reported that people have difficulties in accessing clean and safe drinking water. Many households use the water supplied from the municipality, boil it and use it for drinking. There are also challenges in accessing cleanliness products since the

markets are closed and people have to pay high prices for these products.

Women and adolescent girls were more impacted by these challenges related to health and hygiene since they are traditionally assigned the gender-based role of maintaining hygiene in the house. Lack of access to safe drinking water, hygiene and cleanliness materials, along with problems in waste disposal added an increasing burden to them.

The lockdown has left adolescent girls and women without access to menstrual products like sanitary pads and enhanced the effects of the prevalent stigma towards menstruation. Lockdowns, supply disruptions have resulted in limited availability of menstrual hygiene products and even increased the prices of these products. Likewise, disruptions in access to WASH facilities and waste management have created additional challenges for women and girls in disposal of products and overall menstrual hygiene. Women still have the responsibility of fetching water from the public taps which puts them at more risk on transmission of COVID-19.

“It was difficult to access sanitary pads in general. There was scarcity of water since more water is consumed for bathing, cleaning and maintaining hygiene. All these have made it very difficult for us to maintain hygiene in the house and surrounding, increasing more vulnerability to infection.” **Community women, Arghakhanchi**

4.1.3 Impact of COVID-19 on Essential health services

Most participants in this study agreed that COVID-19 had a visible impact on all aspects of health services delivery. Vulnerable populations (elderly people, pregnant women, adolescent girls, disabled, etc.) had experienced problems to access sexual and reproductive health (SRH) including other essential services, such as immunization, non-communicable disease i.e., cancer and diabetes treatments, and medical and psychological support to survivors of gender-based violence and early testing and treatment for COVID-19. The problem might be severe especially among pregnant and lactating mothers with limited access to safe delivery services, anti-natal care (ANC) or post-natal care (PNC) services. When asked about accessing above mentioned essential services, all were available, physically accessible and affordable to all without discrimination including groups those who were at high risk of being left behind. Adolescent girls were also provided adolescent friendly health services when needed. In most of the HFs, these services were provided free of costs.

All available services were provided, services were very good, emergency delivery services were good, staff were good, there was no discrimination and no change” **FGD, Bardiya**

The disruption in health services was echoed by the health care workers who reflected on how the COVID-19 changed their clinical practice and the quality of services they provided to the patients.

“We couldn’t provide health services openly for so long due to COVID. It was really difficult in the beginning days but later, by using the safety measures, we organized health camps as well. We hired a few people.” **Chairman Chulachuli RM, Ilam**

As a result of the disruption in health services, FCHVs received increased consultation and were burdened to provide services to patients, although they had limited resources and capacities. For those who could not visit HFs, FCHVs were assigned to provide door to door maternal

and child health services. ANC checkup got hampered in the HFs where the staff were infected. In some districts, ANC, PNC, checkups and Iron tablet were distributed by home visits also. Cases like abortions were handled with adolescent friendly counselling. Sanitary pads were distributed for adolescent girls by Kailali Durgauli and Malarani Health Post, Lumbini. In district hospitals such as Malangwa hospital which was dedicated to the COVID-19 treatment, the ANC and PNC services were drastically reduced due to the fear of transmission. Chulachuli Health post, Illam had provided telemedicine program for their patients. By checking the OPD records HWs telephoned for adolescence and pregnant clients for providing Iron, calcium, time for Td vaccine, counselling related to safe abortion and COVID-19 symptoms.

“Due to epidemic, we haven’t stop general supply of regular services. But at the peak of crisis, these services were compromised. Pregnant women did not visit the health facility for check up, even regular immunization program was hold, People fear to come out of home. But after starting the vaccination program, health facility become somehow COVID-friendly, use of mask and social distancing, restructure of HF were done and now services were provided as before.” **Nursing officer, Ministry of Health, Province 1**

“We (FCHVs) were told by health workers to inform community people not to visit health facilities as health service providers would not respond to them at the health facility. We took our life at risks to serve people from our community during this COVID crisis though we are not trained to deal with such health issues.” **FCHV, Godawari Municipality, Lalitpur district**

Disruption in health services was echoed across by other stakeholders who particularly expressed concerns around poor preparedness and arrangements in the hospital for COVID-19 patients, the reluctance of doctors to attend patients, lack of ambulance services amidst the rising cases of COVID-19, and deaths. Nonetheless, few community leaders seemed to defend and asserted that

health services were continuously provided.

For people with non-communicable diseases who had to take regular medicine, local government identified those patients and distributed medicines at their home without any discrimination in Rasuwa district. SRH services was also available and physically accessible to all groups including vulnerable groups. Psychosocial support, counselling and other needed support to survivors of gender-based violence was also provided by the OCMC. Whereas in Syangja, except immediate and emergency health services, access to other health care services were nearly impossible during the pandemic. ANC services was not provided during that time which also increased the chances of complication during delivery. Contraceptives were made easily available for the needy ones who came to hospitals. Implants, Depo injection were given when required. PNC services were stopped as new born and mother were scared of transmission of COVID-19. Like, district hospital in Syangja, in Malarani HP, district hospital in Bardiya, except immediate and emergency health services, access to other health care services were nearly impossible for a month.

*“Before COVID-19, people used to visit health centers/ hospitals for minor SRH problems like vaginal itching, fungal/viral infections but due to fear of COVID all group of women stopped visiting hospital for minor SRH problems.” **Staff Nurse District Hospital, Syangja***

*For disabled people we provide care and health supplies in their home settings. They received the contraceptive from FCHV. We have started the campaign of zero home delivery for which local level provide free ambulance service and additional money to ensure the maximum number of hospital delivery.” **ANM Malarani HP, Lumbini***

The lack of coordination and pre-emptive preparation among the three tiers of government was recognized as one of the main reasons for disruption in health services. In addition to the poor coordination and preparedness, the spread of infection among health workers further risked the capacity to respond to COVID-19 cases among the population.

*“We have three levels of government but there is no adequate coordination amongst them. When COVID cases started to increase, they closed local hospitals and had no plans for COVID-19 hospital, as a result, existing health facilities struggled to meet the needs and therefore it has created serious disruptions in general health services. The number of healthcare workers has started to decrease due to COVID-19 infection and this has directly affected the services in our hospital.” **(Health in charge, Rasuwa district)***



Good Practices

During the COVID-19 crisis, people’s access to basic services became extremely difficult. As a result, local officials and relevant organizations adopted innovative methods to respond to the important health concerns among women and other vulnerable and excluded groups. The services included responses to reproductive, and sexual health concerns which were made available at the community level.

- Free ambulances for pregnant women were deployed in Syangja district, which helped bring at-risk mothers to the hospital for safe deliveries, thereby avoiding complications from giving birth at home without professional support. The service began and continued during the COVID-19 lockdown, with the ambulance making two- way trips from women’s houses to the hospital and vice-versa.
- Outreach clinic was started to provide Family planning services, ANC/PNC service and distributed iron calcium, folic acid, Td vaccine etc. For the pregnant and postpartum women, counselling through phone was also conducted in Bajhang. Some health posts referred complications in pregnancy for treatment to hospitals.

4.1.4 Community perceptions and experiences on utilizing health services during COVID-19

Community members perceived that the risk of transmission of infection was high at the hospitals and therefore expressed concerns about visiting health facilities. These concerns affected people's health-seeking behavior and they were reluctant to seek health care on time or unless absolutely necessary. Fear of transmission was pervasive among health workers as well. Participants

People are very worried and are not willing to go to health facilities even if they have general health problems. They used to contact health personnel through phone calls, but they were not willing to visit any health centers due to fear of getting COVID-19 from health workers. (FCHV, Godawari Municipality, Lalitpur)

perceived the reluctance of health care workers in providing health services due to fear of transmission of COVID-19.

Health workers were very afraid to provide services at the local health facility. They did not touch or examine the patient properly and did not give enough time for consultation with the patient. They just used to give medicine by maintaining the distance. (Community women, Sarlahi district)

When participants had to seek health care for severe cases, the other major barriers were the availability of transportation means, particularly during the lockdown. While few were able to connect to the health care workers remotely through mobile phones, much of the health services were severely hindered by a lack of transportation services. Availability of ambulance services were also constrained during this lockdown and few participants shared their narrative on how some of them had struggled to get an ambulance service.

"The transportation facilities were hugely affected, as a result, people have problems in reaching health facilities and receiving health services in time. One of my neighbors had a leg fracture and he could not reach the hospital due to a lack of transportation services. One pregnant woman in my village had a problem during this lockdown, their families were very worried, as they could not reach the health facility due to lack of transportation." (Community women, Dhanusa district)

Participants claimed that people had to seek private health care services as an alternative option, which was more expensive and unaffordable for many of the vulnerable population from the poor and disadvantaged communities who were worst

Private hospitals were very careless as they were not responding to support during this pandemic situation. Even if people are admitted they have to test for COVID-19 first. People have perceptions that without the COVID-19 test, none of the hospitals will admit patients. So, many people are not going to hospitals even if they need health services. (FGD, Syangja district)

affected and were at higher risk of acquiring COVID-19. Despite these pre-existing barriers, private hospitals were more restrictive in treating patients and often demanded COVID tests (which involved higher costs and was done only in a few designated COVID-19 hospitals/laboratories) before they could admit the patients. Although tests are justifiable and are critical before initiating the treatment to stop further spread of COVID-19, tests as a pre-requisite for health care were discouraged by participants. Even if community members were able to get the test done, the quality of care remained very poor, and sometimes, family members had to visit multiple hospitals to admit patients for treatment. As a result, some of these patients lost their lives in transition.

4.1.5 COVID-19: testing, isolation, and quarantine centers

Participants in this study claimed that the government has not planned well for the COVID-19 pandemic, which has affected the overall health services delivery for the local population. The establishment of COVID-19 dedicated hospitals without allocating health services for non-COVID-19 illnesses was seen to be particularly problematic. This meant the patients using services from those local hospitals had to seek health services from other health care facilities, which were overstretched and far from their usual health service centers.

At the beginning of the outbreak, our district hospital, which is the only major hospital in this district, was made a dedicated isolation center for COVID-19. This has hampered all the secondary level of health care services for thousands of people who used to visit this facility as a referral center from different health posts within the districts. (Community women, Dhanusa)

While COVID-19 designated hospitals already affected the non-COVID-19 health services, participants reported that COVID-19 related health services were inefficient. For instance, the availability of COVID-19 testing was limited including the high costs and long time for the test results.

Participants reported that the isolation and quarantine services were not adequate to provide effective care for COVID-19 patients, which was additionally complicated by the politicization of the services. Specifically, people with power and privilege exercised the health facilities, leaving the poor and vulnerable without services.

People are afraid to stay at the quarantine center and even if they have symptoms, they try to hide them. If someone is close to the local leaders or affiliated with the leader's party then he/she can have all services keeping them on high priority. For normal people, it is really very difficult to survive there. (Community women, Salyan district)

When asked about the differential provision for women in the quarantine packages, separate rooms, separate toilet, separate WASH facilities for women were managed by most of the

quarantine centers (QC). Likewise, some QCs had facility of sanitary pad to women. In the quarantine where there are no separate screening location female clients were checked by female health workers in covered space (covered with curtain in some HFs) with all testing facilities. However, waiting area were not separated for both male and female. Male and female health workers were made available as per the preference and comfort of patient. In Syangja too, men and women sections were not separated and there were no provisions of separate toilets for women and disabled people. Similarly, no covered space for testing facilities, separate screening location was available there.

Also, due to pre-existing inequalities, discrimination and exclusion, the caste system (untouchability) still exists especially in the rural area and has impacted negative thought among people residing in quarantine centers. However, the problem has decreased in the urban area of the country.

In a quarantine center the kitchen for all was the same but when the people from higher cast knew that some scheduled caste was also living together and using same kitchen a big dispute was emerged. The higher cast threw away the foods and created a big problem. When it was reported, the Municipality solved the problem separating the kitchen. “Community women Bajhang.

Pregnant women, elderly people, women and girls, disabled people became even more vulnerable during pandemic as they faced additional vulnerabilities by exposure to higher health-related risks but also experienced difficulties accessing care. In terms of their access to care in quarantine, no separate quarantine areas for pregnant women were found by this study. They were accommodated in the same quarantine where the males were accommodated. They had access to all the care provided by female health workers whenever they needed.

“No special provision of health service was designed targeting the elderly people, pregnant women and girls, disabled people etc. Everyone was given equal care, used same type of toilet and same beds. Disabled used diapers if they had difficulties going to toilet.” Staff nurse, District hospital, Rasuwa

Testing, isolation, and quarantine services were also affected by the lack of coordination between the three tiers of governance with poor accountability and responsibilities by each one of these tiers. Task shifting and blame-game were found prominent among these authorities when discussed the responsibilities; and cited the constraints in the management of COVID-19 testing and management. **Community women from Bardiya district stated** “Our three tiers of government are totally confused about their roles and responsibilities. Suppose if a person is tested positive with COVID-19, there is no clear understanding of where to seek health services. Sometimes local authorities’ say it is not their responsibility, then again provincial government says it is not their

duty and at the end, patients have to lose [their health and lives] because of their conflicts of power clash and ambiguity in policies.”



Good Practices

Protecting the rights of women and excluded people requires dedicated attention during emergencies. Policies and standards have to be quickly adopted and enforced at the frontline to ensure the GESI responsiveness of emergency responses, including in quarantines and isolation facilities.

- The GESI Checklist for Quarantine Centers⁹, which was developed and adopted by the Ministry of Women, Children and Senior Citizen (MoWCSC) with UN Women’s support, ensured that facilities and services in quarantines were sensitive to gender and inclusion concerns. GESI checklist as part of the government’s response to the pandemic, laid an official basis for ensuring the quality of current and forthcoming services and facilities for emergencies.

4.1.6 Social Protection concerns

Income and Livelihood

The study showed that loss of paid work has exacerbated already existing inequality and vulnerability among communities. People, most vulnerable to loss of livelihoods are the poor and marginalized population whose livelihood depends on daily wages. The imposition of lockdown has mostly affected informal sector work and small-scale businesses (street vendors, small shops, etc.). This, in turn, has ultimately resulted in low or no income and also no new opportunities/options of income generation to sustain their livelihood.

“Our source of income was hotel business since its touristic area a lot of people have their hotel/ guest house business. COVID has affected our sector of work up to the point where it I really hard almost impossible for us to recover from the loss. We have not been able to maintain this activity as before since beginning of corona virus till now. We hardly get customer.”

Community women, Manang District

The study also indicated that there is increasing distress among many community members due to the financial crisis caused by the pandemic. People are bothered mostly due to not being able to fulfil their basic necessities, such as food and shelter, due to the loss of work (most of them being women), and not being in a situation of repaying their loans/credits, which has ultimately created

⁹ GESI checklist to monitor quarantine facilities (2020).

stress, anxiety and conflicts among the family members. Among women, who were involved in micro-enterprises such as shops with no alternative source of income seem to have been affected the most during COVID-19 period. In the absence of alternative sources of income, these women were forced to borrow money from informal sources to sustain the basic needs of the family. As a result, women experienced increased stress and worry over loss of income, increased household expenditure and repayment of loan, which had also increased the risks of domestic violence.



(KII with female health worker in Rasuwa district, Nepal)

The increasing financial crisis in most of the low-income households and deprivation of regular access to education has long-term implications in the lives of adolescent girls. The weak economic condition likely to exacerbate vulnerability of adolescent girls, through exposure to dropping out of school, early and self-initiated marriages, suicides and sexual violence. A survey conducted by Room to Read in April-May 2020 revealed that the loss of income among families would negatively influence decisions to send girls back to school.¹⁰

Unpaid Domestic Work

Women and girls around the world spend a total of 12.5 billion hours on unpaid care every day. In Nepal, women spend 268 minutes every day on unpaid work.¹¹ Deeply rooted patriarchal social norms that pressure women to take on domestic roles have put the burden of caring for children and the elderly, including the bulk of household chores, on Nepali women's shoulders. Now with the coronavirus school closure leaving millions of children stuck at home, Nepali women and girls' care duties are skyrocketing. This might prevent them from spending time and resources on education, training, and skill development. Many women work in the service sector and their jobs cannot be done from home. Women and girls living in poverty, from disadvantaged caste groups, or in rural, isolated locations are even more vulnerable and likely to face extreme consequences.

Although Nepal's new 2015 constitution guarantees gender equality in education, work, wages, etc., gender disparity largely exists even today. The Nepal Labor Force Survey 2017-18

¹⁰ Room to Read, Girls' Education Risk Indicator, April-May, 2020.

¹¹ how-COVID-19-worsens-gender-inequality-in-nepal. Accessed from <https://thediplomat.com/2020/06>

reports that for every 100 employed males there were only 59 employed females; the literacy rate for women is 57.4 percent compared to 75.1 percent for men; and the average monthly income for women is 5,834 Nepali rupees less than what men earn.¹² The unequal gender division of labor has long been identified as a factor causing inequality with direct links to lower income, education, and access to medical services for women. A heavy domestic workload aggravated by the COVID-19 crisis could leave women and girls further behind in Nepal. Also, evidence from earlier epidemics suggests that girls are at particular risk of dropping out and not returning to school in the aftermath of the pandemic.

“COVID-19 has influenced the time that women spend doing unpaid work at the household or community levels. Before COVID-19, house wives used to have spare time during day as their children used to go to school. After COVID-19 women have to look after their children all day, work in kitchen all day, had to wash more clothes than before, had to look after the one who were COVID-19 positive and take care of their health due to which I think workload of women was high due to COVID-19. I don't think COVID-19 influenced the time of men and boys who spend doing unpaid work at house hold or community level.” **Community women, Rasuwa district**

Women in Nepal had faced worse economic insecurity in the aftermath of the crisis, as for women finding work is already more challenging than for men. As COVID-19 had taken away many women’s jobs, it is uncertain whether or not women will regain those lost jobs once normality returns. It is also highly likely that women who had entered nontraditional roles prior to the pandemic may roll back to traditional roles in the post-COVID-19 period.

Pre-existing gender inequality is a fundamental cause of the reproduction of gender-related vulnerability during crises. The patriarchal system is still prevalent and is reflected in the Nepali marriage system, caste system, inheritance system, and some discriminatory legal frameworks, all of which limit gender equality. Also, other social factors places women and girls in fragile situations, such as low education, low employment, income insecurity, challenges in entering politics, and unequal citizenship rights.

Gender-based violence

Gender-based violence (GBV) refer to physical, sexual, or psychological coercion and violence. While GBV can be perpetrated against people of all genders, women, and girls (especially adolescents) are more likely to encounter GBV.

Women and girls are at a high risk of sexual assault and exploitation every day and this risk has become even higher during the pandemic crisis. During the lockdown period, women were being physically and psychologically exploited as many women find themselves forced to be confined

¹² Nepal Labor Force Survey 2017-18

with their domestic abusers with the public directive for social isolation.¹³ Indigenous women and women with disabilities who are further marginalized than other women, live in poverty, lacking awareness and education and are often considered as weak, worthless and sometimes sub human, which is putting them at a heightened risk of neglect, abuse, domestic and sexual violence. ¹⁴This phenomenon has been compounded by the COVID-19 situation, disproportionately impacting girls and women with disabilities both directly and indirectly related to the safety and security with an increase in gender-based violence such as domestic violence, harassment, threat, assault, and rape within families and communities even in public quarantine centers.

Significant increases in the number of such cases have been seen during the pandemic, but those cases have not been highlighted with full information. More than 624 cases of violence against women and girls and 61% violence inside the home from 55 districts are reported, however the degree of impact of violence caused to different women based on caste, ethnicity, disability, class remains unknown.¹⁵ The cases and reporting of discrimination and violence on multiple and intersecting identities have not been part of the discussion and reporting, and which pushes one to question the justice system. Most of the cases are not reported, and even if they are, the report is registered after 2-3 weeks and frequently the victim's family members are suggested to have a mutual understanding as a solution to the case (IPWDAN and NIDWAN Report, 2019). The lack of disaggregated data of the reported cases is again an issue.

Gender based violence was already a growing problem in Nepal even before COVID-19. When

"Before the pandemic, we had received training of GBV. Those victims of Violence were kept in the safe house. Yes, I was aware of mobile hotline number. We have OCMC in our hospital and provide the services and support according to the needs of the victim." Staff Nurse, District Hospital Bajhang

accessing the knowledge and ability of HWs to recognize signs of domestic violence and to provide appropriate resources and services, including referrals. Majority of the HWs had no idea in this subject as they did not have to deal with such case. Also, they were not trained in this matter except the HWs from Dolpa and Bajhang. GBV related services was provided from the OCMC in

the district hospitals, where OCMC was established. The staffs working in OCMC team/department handle GBV cases so the HWs from Health Posts have not reported and referred GBV cases till now. In case of referral in such cases, they refer to hospital or report it to the police.

¹³ Dahal Minakasi et al. (2020). Mitigating violence against women and young girls during COVID-19 induced lockdown in Nepal: a wake-up call. Available at: <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-020-00616>

¹⁴ IPWDAN and NIDWAN (2020) Report on Indigenous Peoples with Disabilities in Asia on COVID-19 from Nepal, India, Bangladesh, Vietnam, Indonesia, Myanmar, Pakistan, Philippines and submitted to Special Rapporteur on Indigenous Peoples, Indigenous Peoples section, OHCHR

¹⁵ WOREC (2020). 624 Cases Of Violence Against Women And Girls Committed During Lockdown, 61% Violence Inside Home. WOREC. Available at: <https://www.worecnepal.org/content/158/2020-06-0>

Majority of the health workers were not aware of any mobile hotlines to respond GBV. If they had to deal with such cases, they reported to the police or suggest victim to dial 100 and report their problems.

Regarding the occupational health and safety and safety of workplace, majority of the health workers felt that their workplace is safe and secure as they did not face or experienced any or any kind of abuse, bullying while being on profession by their colleagues. Though sometimes they felt insecure with visitors and patients, especially in the night shift. Additionally, some of them (visitors and patients) underestimate their capability comparing to their male counterparts which made them feel discriminated.

There was a provision of security guards in some HFs to protect from these risks. The HFs where there was no provision of security guards, HWs felt insecure while working at night shifts. Similarly, COVID-19 insurance was provided to the staff to address the occupational health and safety of those working during pandemic. Hospitalized staffs being COVID-19 positive were granted leave for certain days. Health care facilities were provided free of cost to the health workers, support staff, and care workers. However, Mental health support, counselling was not provided to the health workers, support staffs in most of the HFs. Counselling is provided in case of mental health problem, in Bajhang and Dolpa.

“We are like family in this health post and everyone treat each other with love and respect. We support each other in need and our understanding level is very good with all staffs. In my workplace, I feel very safe and there is no such thing as discrimination here. I have never experienced and heard violence or harassment or any kind of abuse, bullying in my workplace.”ANM, Julphal Health Post, Dolpa



Good Practices

The awareness to end GBV, caste-based discrimination, health and relevant laws reached over 110,000 people nationwide in 2020. A nationwide rapid assessment of the impacts of COVID-19 on the lives of Dalit women in 19 districts informed the local government’s COVID-19 response, including on GBV. In addition to providing relief to over 3,000 Dalit and marginalized women, a series of multi-stakeholder virtual dialogues with representatives from all provinces included the topic of GBV prevention amid the pandemic.¹⁶

¹⁶ FEDO inputs to GE Update on Learnings, Good Practices and Recommendations, March 2021, p. 1.

4.1.7 Female Health Workers during Pandemic

The COVID-19 pandemic affected diverse groups of women, girls, men, boys, and persons of all genders differently. Women as they represent the largest share of health care workforce, they are more likely to be front-line health workers (HWs) during the Pandemic. As a consequence of this pandemic, Female HWs faced heavy workload pressure, felt fear of infection due to this virus's contagious nature.

This theme analyses how life has changed in general for female health workers, their experience/feelings while working in close contact with the patients, their family/ community people's behavior towards them and burden of care and stigma during COVID -19. Furthermore, their challenges in meeting menstrual hygiene needs during their work shifts, access to necessary quality assured therapies, equipment, allowance and training and use of logistics management are discussed in this theme.

Burden of work, Stigma and menstrual hygiene needs

Life of female Health workers have reportedly changed in a different way since COVID-19. They had to work more than before. Previously they used to have 6-7 hours shift a day but during the pandemic they had to work almost 24 hours and they had no time for themselves as well as for their family. Some of the interviewed health workers also tested COVID-19 positive which results in anxiety and panic for them. They themselves had fear of contracting the virus and transmitting it their family members. Female health worker who had small children below five years of age were afraid to be in direct contact with their babies.

When talking about stigma, HWs did not feel any differences in the way that their family treated them after COVID-19. But community people treat them differently. They experienced negative behavior such as people in the community did not rent them a room feared of spreading the virus, avoided the things given by them, didn't allow their children to play with others. These behaviors not only affected their mental well-being but also discouraged in many ways.

Many health workers including me fear from working in this pandemic. We can feel discrimination in the society. Every health worker especially nurses feel they were neglected by society during that period of time. When we return to home after duty, many of members of society does not want to talk and come close to us due to fear of COVID-19. Many of our children are also restricted from visiting their friend's house. Staff Nurse, District Hospital, Sarlahi

“At the first wave of COVID-19, I used to work in Kathmandu. When I came back to my home, mostly the educated and renowned person of our village told other people not to go our home, not to sit near and not to meet my family members fearing that I brought Corona from Kathmandu.” **Staff Nurse, Dhanwara Health post, Salyan**



(KII with female health worker in Syangja district, Nepal.)

Regarding burden of care work, as most of the health worker's family members are very supportive and understanding, they did not experience their work as a burden. Instead, they worked hard day and night without even caring their health to help the community people.

“Even though it was challenging to us to deal with people during COVID, we did not take our work as burden. ANM, Godawari Health post, Lalitpur

“I never felt any burden at my work at any time. I always enjoy my work and love to talk with my patients even they love me. Even during COVID, wearing PPE I used to go to COVID wards for their help and entertain them. I did my best from my side then and even now.” **Staff Nurse, District Hospital, Syangja**

Nevertheless, working in close contact with the patients was not easy as they had fear of contracting the virus from the patients and further spreading it to others. Hearing the news of health workers death, they were scared of infected and dying. Despite of having fear, Health workers provided their services in close contact with the patients by applying all the possible safety and preventive measures and did their best to provide services to patients. Majority of them told that after vaccination program they felt quite secured to work confidently.

Deep down our heart there was fear but still by applying all the possible preventive measures, we did our best to provide services to patients. Our dedication towards work was bigger than our fear. **Female Health worker, Sanoshree HP, Bardiya**

With regard to the menstrual hygiene needs during work shifts, it was not very hard to maintain menstrual hygiene needs for the interviewed health workers because they divided their duty hours accordingly to meet the need of menstrual hygiene and changed their work shift which made working hour easy without compromising on it. In addition to this, some of the health workers who had to wear PPE for longer hours especially the HWs who used to work in ICU unit experienced it very hard during menstruation. Some also used diapers instead of sanitary pad to avoid blood leakage during long hour shifts. Some district Hospitals (District hospital in Dolpa, Lumbini and Sarlahi) have managed sanitary pad and other cleaning items which was a good step and those HWs who had a heavy period were allowed to rest during menstruation period in Malangawa hospital, Sarlahi. The menstrual hygiene products were not available at the workplace so they have to manage it by themselves.

“Yes, we experienced it very hard to work with PPE and during menstruation. We were on duty with 6 hours shift where we have to deal with many problems among them menstruation was one of them. Hospital have managed sanitary pad and other cleaning items during that period to us which was a good step and those who cannot work during menstruation were allowed to rest in that time.” **Staff Nurse, Malangwa Hospital, Sarlahi**

“During menstruation we divided our duty hour as per to meet the need of menstrual hygiene. All the necessary stuffs were available in our hospital.”
Staff Nurse, District Hospital Lumbini

“All of my female colleague were supportive of each other when one of us were on our periods. We asked other female staff to take over the duty to change pads during shifts. Pads were not provided for free by health post. We had to buy on our own.” **ANM, Godawari HP, Bagmati.**

Access to necessary quality assured therapies, equipment, allowance and training

Under the access to services the study observed the HWs access in remuneration, allowances, hazard pay, training, other mental and physical health support and their mobilization. Building the capacity of health care workers is the most critical element in strengthening abilities to tackle with COVID -19. Despite acute needs, no any specific trainings, therapies were given to the health care workers except a small orientation class along with the demo of using PPE in some health facilities. Some HFs conducted one day training on how to use PPE and about vaccination. Majority of HW didn't get any training related to COVID-19. Those who got the training was also insufficient for taking care for the COVID patients. In case of equipment like mask, PPE, sanitizer, it was sufficiently available in all HFs except in Dolpa, where HWs faced problem in supplies of mask, PPE, other equipment and human resources as well.

Lumbini and Madhesh Provinces had found providing training, equipment and supplies on COVID-19. In Lumbini province, the district hospital Lumbini provided 3 days training on coping skills and refreshment program such as meditation, essential critical care, sanitation, counseling program. Similarly, in Madhesh province, HWs had access to therapies, training, equipment and supplies. The Nursing in charge in Rangeli Hospital told that “we are receiving trainings that we need from time to time. All the necessary equipment were available.

“No, we were not given any COVID-19 related trainings. Training on recommended use of PPE was also not given. We figured out how to wear PPE ourselves by YouTube videos. We asked municipality to provide us training but they did not consider.” ANM, Godawari HP, Bagmati

“Yes, during COVID-19 pandemic health care worker has access to training. We also have received training on how to use the PPE and its disposable mechanisms. Right now, we also have mental health related training ongoing on how to deal mentally in COVID-19 wards and patients. We feel very motivated with this kind of training and in future we hope many more training will conduct.” Staff Nurse Malangwa Hospital, Sarlahi

Regarding the mobilization, health workers were mobilized according to their vulnerability of exposers to health-related risks i.e., those who were pregnant and have small babies were not deployed to the isolation and quarantine centers. Work was not divided on the basis of gender. Both male and female health workers were equally mobilized in different settings (isolation, quarantine centers and hospital) and shifts (morning, day and night) on rotation basis for providing services to COVID-19 patients. However, in Chulachuli Health post Women health worker did not have to perform night duty. FCHVs were mobilized for field recording and reporting.

Concerning the remuneration and pay both the male and female HWs were paid equally. They got the monthly salary on time. But one of the HW from Syangja told that her friends were not getting salaries from 2-3 months. In case of hazard pay, government had announced to provide additional salary (differs a/c to the announcement of provincial government). But was not provided to the health workers yet in many HFs. The HWs working in the district hospitals in Madhesh province, Lumbini, Dolpa and Bajhang said that they had got the hazard pay in the first wave of COVID-19 which was given according to their risk exposure. In regards to the differential treatment, the healthcare worker did not experience differential treatment regarding remuneration, allowances, working hours, training or other support, based on gender or other identity that they hold. Also, they did not notice adverse impacts of COVID-19 on the remunerations, unfair dismissals and layoffs.

Healthcare workers required mental health support from time to time. In terms of education, training, and mental health support/counselling, majority of the HWs did not have access on it. Even no formal training was provided regarding the use and removal of PPE. It is noteworthy that the HWs from Manang were provided psychosocial counselling, Bajhang were provided training on mental health.

“We received remuneration and hazard pay during first phase of COVID-19 pandemic. We have access to training and mental health support programs where we all are welcomed to be part of training.” **Staff Nurse Malangwa Hospital, Sarlahi**

Use of logistics (PPE) and its management

Women health care worker faced huge challenges while providing health services. During the first wave of COVID-19, adequate Personal Protective Equipment (PPE) was not available. PPE supplied by hospitals were reportedly inadequate or of low-quality. HWs were compelled to wear same PPE for 5, 6 days which developed a fear of being infected while treating people. They were mostly untrained regarding the use (donning, removal and disposal) of PPE especially from Health workers from Health Posts They learned from different sources i.e., YouTube videos and Facebook.

“At first PPE was also not adequately available. We did everything we could like: washing the PPE, autoclave, bought PPE with our own money. There were very limited PPEs so we wore PPE till the PPE had holes on it and were worn out. Even now the PPE is not enough.”
ANM, Godawari HP, Baqmati

It is noteworthy that the HWs from district hospitals i.e. Lumbini, Syangja, Dolpa, Kailali and Sarlahi (Malangwa Hospital) got formal trainings from senior doctors, In-charges and municipality health department.

Decision Making

Regarding health workers' involvement in decision making on health facility activities, resources, distribution systems during COVID-19, out of 21 female health service providers who participated in our study, 9 said they get involved in decision making. Some were being involved in the meetings where they discussed their problems, barriers for the service like resources, training, and involvement of community, coordination etc. They try to find out the problems and way out. Others were involved in staff meeting in the institution regarding coverage of health facility activities and planning about the work plan during COVID-19, resources distribution system during COVID-19, mobilization of the staff and making the duty rooster.

“Health Incharge sir discuss well with us before taking any decision about what to do and how to do. Resource distributions were done by the municipality itself. We were involved in decision-making.” **Senior ANM, Bateswor HP, Dhanusha**

A gradual change has been marked in the participation and involvement of female in decision making process mostly in the health sector. It shows that during the pandemic female health workers have played a remarkable role for the pandemic management by taking care of the patients as a front line health worker and providing counseling. They had shared their problems and needs for upcoming days to be planned and managed in the staff meeting.

“We involve all of our staff in meeting. We also invite female representatives from different committees which have been involved in services. If you see our staff pattern we have less number of female so, we collaborate with other committees which have female representative. They have been included in our meetings for suggestions and their decisions are highly appreciated.” **Health directorate, MoSD, Madesh Province.**

4.1.8 Country-level coordination, planning, and monitoring

Coordination between federal, provincial and local Government is essential for an effective response to the COVID-19 pandemic. Coordination ensures that operations are evidence-based and that programs undertaken respond effectively to the needs and gaps in a way that avoids duplication and successfully supports Government-leadership and response systems.

The policy clearly says that "collaboration with public, non-governmental organizations, private sectors, development partners, academia and professional societies will be promoted" for capacity building, logistic supplies, expansion and up gradation of hospital infrastructure, supply chain management, community engagement and risk communication, human resource mobilization and capacity building, community based risk mapping, referral services including ambulance services, and management of quarantine where necessary.



KII with Federal level Key informant

“Our division had an intact communication and engagement with provincial level. As it is emergency period, so, we also had direct communication with local level. As we have communication system, at that time we communicated directly without going through system as it is a long process. It was essential to communicate directly than from a beaurcatic way. During COVID period, we communicate with different bodies through different way like communicate with CDOs through home ministry, Communicate with local bodies through defense ministry, etc.” **Director, Family Welfare Division, Federal Level**

The experience of dealing with the pandemic also had some significant positives for Nepal’s new federal setup. The COVID-19 pandemic has proved as an opportunity for the subnational governments, especially local governments, to reach out to people and demonstrate the real essence of federalism. It has also helped them, as well as the Federal Government, to find greater clarity regarding their roles and responsibilities and the need for a coordinated approach in times like these. Their performance in response to the pandemic at the community level has helped federalism gain wider prominence in a country with still abundant anti-federal sentiment in the air. Overall, the pandemic has created an opportunity for the state to accelerate the federalization process; the same way the 2015 earthquake presented an opportunity for the political forces to conclude the painfully prolonged constitution making process.

“There was effective coordination in between three tiers of government to manage COVID cases and get success. Province level government followed federal level order whereas local level followed provincial order. Human resources and budget were also splitted accordingly. Every required things like PPE, help on isolation and quarantine center were provided by Federal to provincial and from provincial to local level.” **Director, EDCD, Federal Level**

4.1.9 Community Engagement and Risk communication

Community engagement is important to reduce social stigma and discrimination related to COVID-19. Communities are composed of people with various social categories - male and female, educated and uneducated, adults and elderly, person with disability, and with different cultural and ethnic background. During the pandemic each individual understands information which is relatable to himself/herself. Preference for channels and trusted sources vary between individuals and groups as well as levels of access to radios, mobile phones, smart phones, televisions and internets. Community engagement in building trust in the government and health system response was found to be still low for the prevention and control of COVID-19. Several community stakeholders such as local elected officials, youth organizations, FCHVs etc. were actively involved in COVID-19 management.

“Local elected officials, youth organizations, FCHVs, mothers’ group are being involved in community engagement and risk communication”. **Mayor, Syangja District**

COVID-19 information including social distancing, mental stress caused by complete lockdown,

hotline number to reach out for dealing with mental stress, SRHR and GBV were found to have been disseminated. In case of GBV, this included awareness raising about the potential increases in GBV inside households. Information was provided through Personal Ring Back Tone in mobiles and regular public service announcement through various mediums.

Nonetheless, FCHVs played important role in the prevention of the outbreak by providing information and maintaining the social distance in the community.

*“We had visited house to house for providing information like not to go in a crowd place, use masks, wash hands with soap and water and eat fresh and healthy vegetables.”***FCHV, Janaki RM 1, Kailali**

Women had faced the increased protection risks during the Pandemic including domestic violence. Most of the victims do not know where to report the case except police. They are not aware of hotline number, OCMC. But somehow they are aware of dialing 100. Also children and old age people are at risk as they are facing rude behavior even by their family members. Most cases of violence are solved inside the home or in the community. Very less cases are open and reached to the police and elsewhere.

I don't know where to report. We have to report to the police maybe. We report to the municipality or the police. We haven't been informed about any hotline numbers. **Community woman, Dhanusa District**



Good Practices

Social media especially radio proved to be invaluable in reaching excluded and remote populations during the pandemic. There are around 700 radio stations in Nepal, some of which remained active throughout pandemic. They delivered vital health information, public service announcements, interactive talk shows, and multi-theme learning series. The use of radio optimized to complement online platforms for communication and engagement, including family and community-learning sessions that promote norm change.

- The radio campaign had increased public awareness about the reporting COVID-19 cases. Radio advocacy kept the public and duty bearers informed about the evolving concerns during the pandemic.

4.1.10 Point of Entry

The GoN has provisioned to adapt lockdown and travel restriction measures based on emerging evidence. Whole lockdown in the country, partial lockdown (some essential production activities like agriculture, medicine, medical supplies, and daily essential items were allowed but the movement was restricted within production areas), and specific pocket area lockdown were

provisioned Lockdown and travel restriction declared by Nepal Government became one of the effective interventions to control the transmission of COVID-19. The lockdown lasted for certain period and when it was ending, proper and adequate precautions were not taken. Due to the haphazard end of the lockdown, most of the public vehicles were operated without taking proper measures to prevent the COVID-19. The unplanned ending of the lockdown and the travel restrictions washed away all the measures taken during the lockdown and resulted in the tremendous increase in the positive cases.

The main point of entry (POE) from neighboring countries, especially India, aggravated Nepal's vulnerability towards the COVID cases. The government had implemented preventive measures to the migrants at the point of entry along with infrastructures for case detection like thermal scanners, health desk, quarantines, isolation and holding centers were established. People were kept in the quarantine as needed before they go to their respective destination. Likewise, there was no good management in the holding centers. All the people, women, elders, children were kept in one place and there was a problem of privacy in the holding centers.

"I have very less knowledge on point of entry and holding center as I or none of my friends are working in those areas but some of my family member who came from abroad shared their experience of borders. They shared that it was very difficult in holding centers as hygiene was not maintained, male and female were kept in same room which hampered in privacy" **Staff Nurse, Syangja.**

"It was very strict in the beginning. There were total restrictions for people coming from India but not now. I didn't go anywhere so I have no experience. I think they were infected by COVID." **Community women, Urlabari, Province 1.**

However, there are lots of porous entry points from where people started to enter in to the country escaping from securities and major entry points which has impacted to the people living in the borders area. On the other side, many

people entered into the country continuously which has resulted difficulties to hold all the people at the POE and everyone entered without wearing mask, sanitizer, only limited screening tests were done which has resulted not only fear to the people residing in the border but also have transmitted to their own destination too. Similarly, the travel restriction in the border area as well as in the community had impacted a lot to the people who were suffering from non communicable diseases (NCDs) and having regular medicine.

"Due to travel restriction, it was a bit difficult for people to seek services in emergency cases but they felt that first is to save ourselves from pandemic". **Health section chief, Arghakhanchi**

At Biratnagar, Lumbini and Sarlahi Districts where there were points of entry were, the Provincial government had set up the health desk for screening test. At the health desk, temperature was

measured, masks and sanitizer were provided, and antigen tests were carried out for the symptomatic migrants at the designated health desks. They suggested people who had come from outside to stay in quarantine for the safety of their family and community. Also, health workers visited their houses for follow up and distributed medicine to them. And at holding center they checked the migrants, if tested positive they were sent to quarantine center. Patients with symptoms stayed there for 10 days and send for home isolation. For them who escape form the holding centers were traced. In Biratnagar, they managed holding centers with guards, operated a fever clinic, provided general medical examination and distributed medicines freely. Antigen testing facility was also provided, if anyone got positive, they referred to the COVID ward.

*My husband being an Indian army had experiences at point of entry and holding centers. While returning home from India there was tight check in border as many cases were spread by the people coming from India. As they reached border firstly COVID test was done and if the result was positive, one has to stay in quarantine and even suspected case was found in border they were to stay in quarantine. **Community woman, Rasuwa***

*“Travel restriction has somewhat helped in preventing the spread of the infection. People have understood that its treatment is mainly traveled controlling, no gathering or crowds. Due to restriction it was a bit difficult for people to seek services in emergency cases but they felt that first is to save ourselves from pandemic.” **Health section chief, Arghakhanchi***

A part from international borders and airport it had established holding centers and quarantine at the entry point of the districts like in Kapurkot, Salyan, Patherkot and Arghakhanchi where help desk were established and suspected or positive cases were screened .

4.2 Health Facilities Observation

4.2.1 Types of health facilities:

Among the two types of health facilities observed (n=21): 1) District hospitals and 2) Health posts. The majority were Health posts 14(67%) and around 7(33%) of the Health facilities were district hospital.

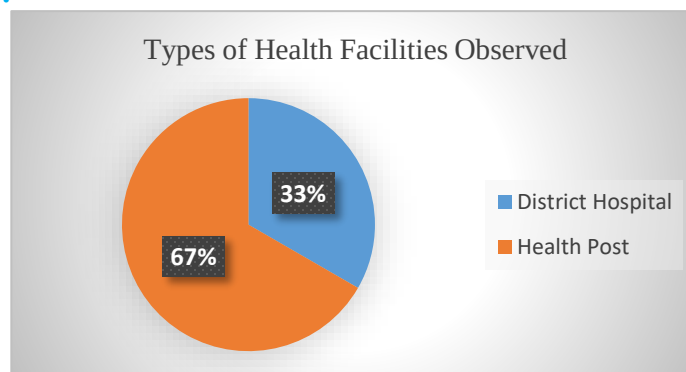


Figure 6: Types of health facilities observed

4.2.2 Availability of facilities:

In all the 21 observed health facilities, maximum had the availability of the hand washing system with soap. So, cleanliness was equally given preference. In case of availability of water to all units 71.4 percent only had it. Majority of the health facilities had toilet facilities but only 28.5% had separate for male and female. Among the 21 Health Facilities, only 19% had disabled friendly toilet.

Table 14: Availability of facilities

Does this facility have the availability of:	Frequency	Percentage
Regular water supply in the institution	21	100
Water distribution to all units	15	71.4
Separate toilet for Male and Female	6	28.5
Disabled friendly toilet	4	19.1
Hand washing station with soap and water	18	85.7

4.2.3 Infection prevention and control

As observed, all the health facilities were well equipped with alcohol based hand sanitizer/hand washing facilities with running water and soap for hand hygiene are available at each entrance and in all common areas. However, only 33.3 % of health facilities had adequate personal protective equipment (PPE) and other infection prevention and control supplies for health care providers. Regarding, early recognition and testing of COVID19, 23.8% had provision of testing of COVID-19.

Table 15: Infection prevention and control

Infection prevention and control (n=21)	Yes %	No %
Disinfection of floors, surface, equipment	21(100%)	0
Alcohol based hand sanitizer/hand washing facilities with running water and soap for hand hygiene are available at each entrance and in all common areas.	21(100%)	0
Personal protective equipment (PPE) and other infection prevention and control supplies for (HCP) protection are available and adequate to staffs.	7(33.3%)	66.7
Screening, early recognition and testing of COVID-19 (Antigen, RT-PCR.)	5(23.8%)	16(76.2%)
Are facilities adequately equipped with supplies and infrastructure to support a robust COVID-19 response or resurgence?	7(33.3%)	14(66.7%)

4.2.4 Recording and reporting tools (HMIS)

The survey also accessed the information on recording and reporting tools. It is impressive to note the majority of health Facility (HF) has provision of HMIS as recording and reporting tools. As per the survey findings, 21 HF have provision of HMIS and had adequate supply of HMIS forms. 19 out of 21 have reporting system.

Table 16: Recording and reporting tools

Health Management Information System (HMIS)	N	%
Yes	21	100
No	0	0
Total	21	100
Adequate supply of HMIS forms		
Yes	21	100
No	0	0
Total	21	100
HMIS Monitoring Sheet		
Daily	2	9.5
Weekly	0	0
Monthly	19	90.5
Total	21	100

PART 5: CONCLUSION

The COVID-19 pandemic magnified gender-based disparities faster than governments, and the humanitarian sector could respond. There is a need for adequate public health preparedness and response plans that not only address community transmission but integrate the rights, needs, and health of women, girls, and gender minorities in humanitarian settings.

The pandemic had impacted community's access to basic and other services such as food, health services including psychosocial counselling and sexual reproductive health services, WASH, income and livelihoods, along with right to information and awareness. In contrast to the first wave, many communities, especially from marginalized and vulnerable backgrounds were deprived of access to health services due to loss of jobs and income as well as scarcity of resources respectively.



Loss of livelihood and income has affected the most marginalized population dependent on daily wages, the hardest hit among them being PwD. It has increased the vulnerability of community members to access risky and informal sources of loans with exorbitant interest rates.

The regular reporting mechanism through local government institutions such as Municipalities and wards have been disrupted due to strict prohibitory measures and priority has been shifted to ensuring health safety. In addition, not many quarantine/holding centers have been set up compared to previous year and most people are isolating at home. The isolation centers that are functional are not equipped to meet the differential needs of PwDs.

Given the complex interplay between gender inequality and COVID-19 in humanitarian settings, national preparedness and response plans that are devoid of critical gender considerations have dire consequences: failure to safeguard the rights and health of women, girls, and PwD neglecting to address gendered chains of transmission, thereby incubating COVID-19 on a bedrock of structural gender inequity. More critical and intersectional approaches to crisis planning should be adopted in the future to mitigate the significant gender disparities exacerbated by significant societal disruptions, especially in the most fragile settings.

PART 6: RECOMMENDATIONS

The short-term recommendations are designed to be able to take immediate attention and action, with the mid and long-term recommendations designed to influence recovery and rehabilitation processes and at the same time to address the impacts in a post-COVID-19 context. The following recommendations, aim to support both short and long term approaches to COVID-19 to be gender-responsive and inclusive in order to ensure the needs, priorities of at-risk groups are integrated into the preparation, response, recovery and rehabilitation processes. Detailed recommendations are given below:

Short-term recommendations

- Strengthen gender data collection and expand research on the gendered impacts of COVID-19, particularly on those most marginalized. More disaggregated data by age, sex, ethnic/social groups and community on cases, deaths, hospitalization and testing are vital to understanding the pandemic's impact on different groups of people.
- Ensure that women and excluded groups are equally represented in planning, decision-making processes, mechanisms, and coordination efforts for COVID-19 response at all levels, including in the COVID-19 Crisis Management Center.
- Promote leadership and encourage participation of vulnerable groups in COVID-19 service delivery. For example, in Nepal, the groups of disabled people have taken leadership and participation in successful vaccine advocacy, data-driven advocacy, risk communication, access audits, identification of vulnerable household of persons with disabilities etc.
- Ensure women and girls have access to safe and comprehensive sexual and reproductive health services that are aligned with the Minimum Initial Service Package including dignity kits.
- Ensure that mental health services are not disrupted but are available through alternative modalities such as online/virtual methods if in-person services are not possible. These should be regarded as essential health services, with attention paid to examining potential gender gaps or disparities in access to, uptake of, and efficacy of these services.
- Ensure immediate access of basic services such as food, health services, safe, well-equipped, gender and disabled-friendly quarantine services, especially focusing on poor, vulnerable, marginalized communities including women, adolescents and sexual minorities.
- Prioritize and strengthen services for prevention of and response to GBV and sexual and reproductive health services in communities affected by COVID-19, with an emphasis on mitigating barriers identified for specific groups in this report.
- Provide gender-sensitive support for frontline health workers to take leadership, participation, and decision making in the process of health emergency planning and

responses, for instance personal protective equipment that are suitable for female bodies, menstrual hygiene management kits, or additional financial support.

- Disseminate simple messages to raise awareness about the negative impacts of COVID-19 to eliminate VAWG; stigma and discrimination against frontline health workers; sharing of household work to lessen the burden of increased household and unpaid care work on women and adolescent girls; and to make aware on discriminatory practices and harmful social norms.
- Prioritize prevention and redress of violence against women and girls in COVID-19 and other emergency responses and ensure that services for survivors are deemed essential and remain accessible and adequately funded.
- Public Private Partnerships are essential to a successful gender-responsive, equity and rights based emergency/pandemic plan. Governments, non governmental organizations, international organizations, the private sector, and civil society all have important roles to play before, during, and after pandemics, and a shared responsibility to find and execute effective solutions.

Mid and Long term Recommendations

- Advocacy around the application of public health and safety measures (PHSM) needs to continue to ensure an inclusive approach, including women, men, girls and boys and people with disabilities.
- To respond to women and girls' urgent needs both during and after the pandemic, there must be more women and girls involved in the policymaking of the COVID-19 era, for example, in agenda-setting, formulating policy options, planning, budgeting, decision making, and implementation. Women must not only be at the table but serve as a leader of the table.
- Ensure government, development partners and NGOs working on emergency/disaster preparedness, response and recovery programs include social norms change, GER and protection issues as integral components of their work by adapting the current district disaster response plans to address these issues also in health emergencies such as the COVID-19 pandemic.
- It is important for national response plans to prioritize support for women by implementing measures that have proven to be effective. These include:
 - Integrating prevention efforts and services to respond to violence against women into COVID-19 response plans
 - Designating gender based violence shelters as essential services and increasing resources to them, and to civil society groups on the front line of response
 - Expanding the capacity of shelters for survivors of violence by re-purposing other spaces, such as empty hotels to accommodate quarantine needs, and integrating considerations of accessibility for all.

ANNEXES

Annex 1. Final questionnaire for the survey

National and provincial level Interview

General Questions

1. How has current pandemic affected your sector of work? What are the current programmes regarding response from your organization? Does adequate budget allocated for COVID-19 prevention and control programme?
2. How do you determine your target population in such response programmes? How do you assess the most effected populations?

Quarantine facilities and management

3. How quarantine centers are being managed in terms of facilities, logistics, human resource (health worker) Sanitation and hygiene ?(Probe: from gender and equity aspect and also AAQ – access, acceptance, quality)

Case Investigation and Contact Tracing

4. Can you please elaborate us about case investigation and contact tracing process in municipal level, provincial level and federal level?
5. What type of challenges that women and girls, especially from vulnerable groups and communities, the LGBTQI community, older people and those living with disabilities have faced in complying with public health and social measures and in accessing Covid-related health services during COVID-19.
6. What improvements are needed to make case investigation and contract tracing more effective in future to cope with similar kind of pandemic?

Human resources

7. How health workers are mobilized for providing services to COVID-19 patients in all sectors? (Hospital setting, quarantine centers, isolation centers, laboratories)?
8. What are the challenges to women health workers for providing services (probe: Health hazards, availability of equipment's-PPE, laboratory test kits)
9. How human resources (doctors, nurses including paramedics, FCHVs) mobilized for the management and prevention of COVID-19?
10. Do the health workers getting facilities according to the guidelines? If not, why? What facilities need to be provided for the motivation?
11. Does the healthcare workforce have access to remuneration, hazard pay, education and training, and mental health support?(Probe: what are provisions/consideration for women health workers for respecting their specific needs and addressing issues.)

Communication and coordination

12. What and how communication and coordination is made among three tiers of government?
13. How updated information about the pandemic (i.e. vaccine messaging; anti-stigma; mental health; socio economic; quarantine and isolation; gender priorities and LGBTQI issues)is available on a regular basis, in all local and indigenous languages, including to persons with disabilities and older persons, to ensure that no particular part of the population is excluded from access to information or stigmatized?
14. How do you ensure women, men, including youth and older persons, from groups at risk of being left behind consulted and participated in decision-making in relation to the responses to the pandemic at community, regional, and national levels?

Treatment management

15. Are the guidelines followed on delivering treatment of COVID-19 and other health services? If not, why ?
16. How do COVID-19 vaccines reach all populations, including those most difficult to reach such as migrants, those affected by humanitarian crises and indigenous taking into account gender, equity, and human rights?
17. Are health facilities, goods, and services (including early testing and treatment for COVID-19 and other essential services, such as immunization, sexual and reproductive health (SRH), no communicable disease such as cancer and diabetes treatments, and medical and psychological support to survivors of gender-based violence) available, physically accessible, culturally acceptable, and affordable to all, without discrimination, including to groups most at-risk of being left behind?

Use of logistics (PPE) and its management

18. According to you, the Personal Protective Equipment (PPE) available to health workers are adequate to protect themselves when managing patients with COVID-19? Have they received formal training in the use of the recommended PPE for airborne transmitted infections?
19. To what extent are health and social care workers (the majority of whom are women), protected during diagnostic, treatment, and vaccine interventions for COVID-19?
20. Are the guidelines set for the use of PPE in the context of COVID-19 being properly implemented? If not, what are the reasons for the poor implementation?

GER related issues

21. How are (GER) concerns/issues being addressed in planning, preparation response and recovery of COVID-19?. What are specific initiatives, provisions and actions taken to address GER concerns/issues? (Probe: What are arrangements from the gender, equity, and human rights (GER) perspective, such as prioritizing vulnerable groups (pregnant women, old age, disable etc) for information access, diagnostic and treatment - behavioral aspects?)

GBV and access to protection and referrals

22. Are there any special measures to ensure women have access to protection during this time of crisis? what are the counselling and referral mechanism for reproductive, maternal, neonatal, adolescent health services and health response to GBV.
23. Is there mechanism to monitor intimate partners' violence and domestic violence in times of crisis?
24. Do women in need have access to psychosocial counseling? Do you see any change in trend in women reporting violence/asking for assistance including psychosocial counseling? What kind of changes have you seen?

Decision Making and Leadership

25. How women have been involved in decision-making on health sector activities in response to COVID-19 at provincial and national level?

Recommendations

26. What are your organizational challenges in response to the current situation taking into account gender, equity, and human rights? What are your recommendations on current response ?

Palika level Interview

General Questions

1. How has current pandemic affected your sector of work? What are the current programmes regarding response from your organization?
2. How do you determine your target population in such response programmes? How do you assess the most effected populations?

Quarantine facilities and management

3. What is the provision of quarantine facilities and how are they being managed in your Palika ? what are provisions/ facilities for making gender responsive, disable friendly, maintaining safety and security and serving to marginalized people in the isolation and quarantine centers ?

Case Investigation and Contact Tracing

4. Can you please elaborate us about case investigation and contact tracing process in municipal level?
5. What type of challenges that women and girls, especially from vulnerable groups and communities, the LGBTQI community, older people and those living with disabilities have

faced in complying with public health and social measures and in accessing Covid-related health services during COVID-19.

6. What improvements are needed to make case investigation and contact tracing more effective in future to cope with similar kind of pandemic?

Points of entry

7. What were the impact of travel restrictions? And to what extent were travel restrictions (including screening, targeted testing, and quarantine) maintained?

Human resources

8. How health workers are mobilized for providing services to COVID-19 patients in all sectors? (Health post setting, quarantine centers, isolation centers , laboratories)?
9. What are the challenges to women health workers for providing services (probe: Health hazards, availability of equipments-PPE, laboratory test kits)
10. How human resources (doctors, nurses including paramedics, FCHVs) mobilized for the management and prevention of COVID-19?
11. Do the health workers getting facilities according to the guidelines? If not, why? What facilities need to be provided for the motivation?
12. Does the healthcare workforce have access to remuneration, hazard pay, education and training, and mental health support?(Probe: what are provisions/consideration for women health workers for respecting their specific needs and addressing issues.)

Communication and coordination

13. What and how communication and coordination is made among three tiers of government?
14. How updated information about the pandemic (i.e. vaccine messaging; anti-stigma; mental health; socio economic; quarantine and isolation; gender priorities and LGBTQI issues)is available on a regular basis, in all local and indigenous languages, including to persons with disabilities and older persons, to ensure that no particular part of the population is excluded from access to information or stigmatized?
15. How do you ensure women, men, including youth and older persons, from groups at risk of being left behind consulted and participated in decision-making in relation to the responses to the pandemic at community level?

Treatment management

16. Are the guidelines followed on delivering treatment of COVID-19 and other health services? If not, why ?
17. How do COVID-19 vaccines reach all populations, including those most difficult to reach such as migrants, those affected by humanitarian crises and indigenous, taking into account gender, equity, and human rights?
18. Are health facilities, goods, and services (including early testing and treatment for COVID-19 and other essential services, such as immunization, sexual and reproductive health (SRH), no communicable disease such as cancer and diabetes treatments, and medical and psychological support to survivors of gender-based violence) available, physically

accessible, culturally acceptable, and affordable to all, without discrimination, including to groups most at-risk of being left behind?

Use of logistics (PPE) and its management

19. According to you, the Personal Protective Equipment (PPE) available to health workers are adequate to protect themselves when managing patients with COVID-19? Have they received formal training in the use of the recommended PPE for airborne transmitted infections?
20. Are the guidelines set for the use of PPE in the context of COVID-19 being properly implemented? If not, what are the reasons for the poor implementation?
21. Is cold-chain available for storage and safe distribution of COVID-19 vaccines?

National laboratories

22. What are the provisions for PCR –Testing at the local level for the identification of cases? (adequate laboratory facilities at local levels)

GER related issues

23. How are (GER) concerns/issues being addressed in planning, preparation response and recovery of COVID-19?. What are specific initiatives, provisions and actions taken to address GER concerns/issues? (Probe: What are arrangements from the gender, equity, and human rights (GER) perspective, such as prioritizing vulnerable groups (pregnant women, old age, disable etc) for information access, diagnostic and treatment - behavioral aspects?)

GBV and access to protection and referrals

24. Are there any special measures to ensure women have access to protection during this time of crisis? what are the counselling and referral mechanism for reproductive, maternal, neonatal, adolescent health services and health response to GBV.
25. Is there mechanism to monitor intimate partners' violence and domestic violence in times of crisis?

Recommendations

26. What are your challenges in response to the current situation taking into account gender, equity, and human rights? What are your recommendations on current response?

Focus group discussion with Beneficiaries

General Questions

1. How has life changed in general for you since COVID-19? What are they? Please describe.
2. Has there been a change in the work paid that men and women do in your community? Please describe the change and the impacts of this change. What do you think are the positive changes?
3. Did you notice any other groups for whom life has been more challenging than before COVID-19 in your community?

4. Did you notice any change in water, hygiene, and sanitation practices since the beginning of the crisis? Are there any notable differences in practices among men, women, girls, and boys, elderly people, and people with disability, LGBTQI

Gender roles and responsibility

5. How has COVID-19 influenced the time that women, men, girls, and boys spend doing unpaid work at the household or community levels? (Probe: water supply, preparing food, looking for firewood, taking care of the sick, taking care of children, washing clothes, etc)?

Access to COVID related services

6. What COVID services and resources safely available to people currently? Are some people less likely to get it than others? Why? (Probe: specifically for health services eg Vaccination, quarantine, contact tracing, treatment)?
7. What are the sleeping arrangements in quarantine centers for women, girls, elderly people, and people with disability, LGBTQI? Are there any specific provisions for different sectionalities of women? Eg: women with disability
8. What are the challenges faced by women, and girls, elderly people, people with disability, LGBTQI marginalized groups in accessing services including access to information quarantine/isolation/shelter/relief, quarantine packages?

Access to essential health services

9. Do you have safe access to health facilities? Did you notice any differences for accessing essential health services before, during and after lockdown period?
10. What essential services and resources safely available to people currently during the COVID-19? Are some people less likely to get it than others? Why? (Probe: specifically for health services eg, Delivery, FP, ANC , SRHR, NCDs)
11. What are barriers for accessing health (essential and other) services? What are factors that enable or constrain to access the services at services point? (information/counseling, facilities, personal behavior of providers, quality etc)
12. What is your experience, perception, expectation, beliefs towards: service quality, Behavior of service, providers, responsiveness of services ?
13. Are the healthcare service points accessible for women, adolescent girls, children and other vulnerable groups within women such as persons with disability?

Other

14. Do you think the corona virus disease is making difference in, how people in the family treat you? What about community people's behaviour towards you?
15. Are there any health beliefs, cultures or practices in your community regarding COVID-19? How people have prepared themselves for, or responding to COVID-19? (Probe: For example beliefs and practices related to marriage, family planning, pregnancy and birth, menstrual hygiene management, hand washing, water use and management).

Points of entry

16. What are your experiences at point of entry and holding centers (personal experience or have knowledge on it), and also in the community at border points? How are vulnerable populations living in communities at borders or points of entry affected?

GBV and access to protection

17. Has the current crisis affected the gender based violence in your community? Do you have any experience of such violence in your community? Are there any measures accessible in the community for the protection and to help during this time of crisis?
18. Do women in need have access to psychosocial counseling? Do you see any change in trend in women reporting violence/asking for assistance including psychosocial counseling? What kind of changes have you seen?
19. Do you or your family have any safety or security concerns since the COVID-19 crisis? If so, do you feel comfortable describing what types of concerns or incidents and who is affected (men, women, boys, girls, without giving personal details of anyone involved)? (Probe: e.g. violence in the home, sexual exploitation or accessing health services etc.)

Decision making

20. Who usually make decision in your family? Has this changed since COVID-19? If so, in what ways has it changed? Do you see any kind of changes in women's decision making in the family and also in the community during the crisis? If yes, what kind of change?
21. Do you see changes in how women are involved in community during the crisis? Has their physical participation, participation in decision-making on community activities, resources, distribution systems, changed? If yes, in what ways?

Access to information

22. Do men, women, boys, and girls in your community have the same access to information about COVID-19 and prevention/response efforts? If not, who has more access? And how can access to information be improved for all? (Note: women and girls are less likely to have access information. Probe: what modes of communication e.g. radio, text messages, etc. can be used to improve access to information?)
23. How updated information about the pandemic (i.e. vaccine messaging; anti-stigma; mental health; socio economic; quarantine and isolation) is available on a regular basis, in all local and indigenous languages, including to persons with disabilities and older persons, to ensure that no particular part of the population is excluded from access to information or stigmatized?

Recommendations

24. What are the challenges (refer to the challenges and worries they spoke about earlier) that you think you can deal with yourself?

IDI _Women Health worker

General Questions

1. How has life changed in general for you since COVID-19? Do you think the new coronavirus disease is making difference in how people in the family treat you? What about community people's behavior towards you?
2. Do you or other women health worker (OWHW) experienced burden of care and stigma? If Yes, how did you (they) manage it?
3. How do you (or OWHW) meet menstrual hygiene needs during long hour work shifts? Are these easily available?
4. During the pandemic, how did you feel when you came in close contact with the patients?
5. How do you observed the impact of the COVID-19 crisis on access to healthcare for women, adolescent girls and pregnant/lactating women? Do, they have access to sexual and reproductive supplies, such as ANC, PNC, and contraceptives, menstrual hygiene

Hospital care and referral

6. Do healthcare workers have access to necessary quality assured therapies, training, equipment, and supplies?
7. How the health workers (both male and female) are mobilized for providing services to COVID-19 patients in all sectors? (Hospital setting, quarantine centers, isolation centers laboratories)?
8. What are the challenges of women healthcare workers for providing services (probe: Health hazards, laboratory test kits, availability of equipment-PPE, training in correct donning, removal and disposal of the PPE, health care waste management and decontamination of hospital, public health lab, essential transport such as Ambulance and quarantine stations)
9. Does the healthcare workforce have access to remuneration, hazard pay, education and training, and mental health support? Is there any differences between male and female health workers remuneration?
10. If you or other health worker ever experienced of differential treatment (remuneration, hazard pay, allowances etc. working hours, training or other support), based on gender or other identity that they hold?
11. If the patients is in deteriorate situation, did you refer any patient to the designated COVID hospital? If yes, how many cases did you refer and where?

Points of entry

12. What are your experiences at point of entry and holding centers (personal experience or have knowledge on it), and also in the community at border points? How are vulnerable populations living in communities at borders or points of entry affected?

Use of logistics (PPE) and its management

13. Do you feel that the Personal Protective Equipment (PPE) and safely gears available to you is gender friendly and adequate to protect you when managing patients with COVID-19? Have you received formal training in the use of the recommended PPE for airborne transmitted infections?

Treatment management

14. Are there differential provisions for women in the quarantine packages? If yes, what are they? Is there a separate testing facility and WASH facilities for female? (Probe: presence of female health worker's, covered space with all testing facilities, Separate screening location, waiting area separate room, toilet facility for female.)
15. Do pregnant women in quarantined areas have access to care? Is there any special provision of health service for elderly people, women and girls, disabled person LGBTQI etc)

GER related issues

16. What are the challenges faced by Women healthcare workers while providing health services? (probe: health hazards, personal protective equipment, violence, payment, shifts, SRH, Menstrual hygiene needs, psychosocial support, incentives)
17. How do you/OWHW feel about workplaces and spaces (gender-friendly, safety and security)? If any kind of harassment/abuse/violence experienced or known while being on profession, what are specific provisions made to protect from these risks?
18. How the occupational health and safety of those working during pandemic (including their mental health needs) particularly of health workers, support staff, and care workers at all levels, is assessed and addressed?

Essential Health Services

19. Are health facilities, goods, and services (including early testing and treatment for COVID-19 and other essential services, such as immunization, sexual and reproductive health (SRH), non-communicable disease such as cancer and diabetes treatments, and medical and psychological support to survivors of gender-based violence) available, physically accessible and affordable to all, without discrimination, including to groups most at-risk of being left behind?(Probe: women, adolescent girls, children and other vulnerable groups within women such as persons with disability)
20. How has access to essential health services like SRH services changed due to the crisis for women? How does this differ for different groups of women? (probe for: access to family planning, MNCH services, clean and safe delivery and access to treatment for complications in pregnancy, family planning and sexually transmitted infections including HIV)
21. How has current livelihood situation affected special nutritional needs of pregnant and breastfeeding women, elderly people and other vulnerable groups?

GBV and access to protection and referrals

22. Are healthcare workers trained to recognize signs of domestic violence and to provide appropriate resources and services, including referrals? Do you know where to refer/orient GBV cases? Are you aware of any mobile hotlines set up in your area to respond to GBV? What are the counselling and referral mechanism for reproductive, maternal, neonatal, adolescent health services and health response to GBV?
23. Do women (older, LGBTQI, HW) in need have access to psychosocial counseling? Do you see any change in trend in women reporting violence/asking for assistance including psychosocial counseling? What kind of changes have you seen?
24. Did you noticed adverse impacts of COVID-19 responses on the employment and the remuneration of health workers/frontline workers (such as unfair dismissals and layoffs, reduced working hours, and modifications to employment types)? If yes, what?

Decision Making and Leadership

25. How have you been involved in decision-making on health facility activities, resources, distribution systems during COVID-19?

Recommendations:

26. What are the challenges in managing the regular health service during the pandemic (specific gender needs of women health worker, Delivery, ANC, NCDs, older people, LGBTQI....) ? What are your recommendations on current response?

IDI for Community Women

General Questions

1. How has life changed in general for you since COVID-19? What are they? Please describe.
2. Has there been a change in the work paid that men and women do in your community? Please describe the change and the impacts of this change. What do you think are the positive changes?
3. Did you notice any other groups for whom life has been more challenging than before COVID-19 in your community?
4. Did you notice any change in water, hygiene, and sanitation practices since the beginning of the crisis? Are there any notable differences in practices among men, women, girls, and boys, elderly people, and people with disability, LGBTQI

Gender role and responsibilities

5. How has COVID-19 influenced the time that women, men, girls, and boys spend doing unpaid work at the household or community levels? (Probe: water supply, preparing food, looking for firewood, taking care of the sick, taking care of children, washing clothes, etc.) Has Household workload increased or decreased for you in this crisis? What? Why?

6. Were you able to carry out an economic activity before coronavirus? If yes, have you been able to maintain this activity since coronavirus prevention measures have been implemented?

Access to health Services

7. Is the availability of essential services at health facility for different diseases as appropriate for the population (that women and girls, especially from vulnerable groups and communities, the LGBTQI community, older people, those living with disabilities)?
8. Do you have safe access to health facilities? Did you notice any differences for accessing essential health services before, during and after lockdown period?
9. What are barriers for accessing health (essential and other) services/ what are factors that enable or constrain to access the services? (Household/family –distance to health facilities, financial access, work burden/time.)
10. What are factors that enable or constrain to access the services at services point? (information/counseling, facilities, personal behavior of providers, quality etc)
11. What is your experience, perception, expectation, beliefs towards: service quality, Behavior of service, providers, responsiveness of services ?
12. What are your experiences while visiting to health clinics/service points? Do you get proper information, counselling and support etc. when you need?
13. Are the healthcare service points accessible for women, adolescent girls, children and other vulnerable groups within women such as persons with disability? (Consider unique barriers faced by each vulnerable sub-group in accessing SRH).
14. Do you have access to menstrual hygiene products? Do you have access to other hygiene products (alcohol, chlorine, and other disinfectants)? If no, why don't you have access to these products?
15. Are there any health beliefs, cultures or practices in your community regarding COVID-19? How people have prepared themselves for, or responding to COVID-19? (Probe. For example beliefs and practices related to marriage, family planning, pregnancy and birth, menstrual hygiene management, disposal of dead bodies, hand washing, water use and management).

Points of entry

16. What are your experiences at point of entry and holding centers (personal experience or have knowledge on it), and also in the community at border points? How are vulnerable populations living in communities at borders or points of entry affected?

Quarantine Management

17. What are the protection risks for women with the type of emergency shelter in which the affected population are staying?
18. What are the sleeping arrangements for women? Where in emergency shelters? Are there any specific provisions for different sectionalities of women? Eg: women with disability
19. What are the challenges faced by women, and girls, elderly people, people with disability, LGBTQI marginalized groups in accessing services including access to information quarantine/isolation/shelter/relief, quarantine packages?

GBV and access to protection

20. Do you think that women and children face increased protection risks as a result of the corona virus epidemic? If yes, which risks? (Probe: Physical, Emotional, Sexual, Economic violence) Do you know where to report violence or get information on services for victims of violence? Are you aware of any mobile hotlines set up in your area to respond to GBV?
21. Are women, and girls, elderly people, people with disability, LGBTIQ at heightened risk of GBV during this crisis? If so, why do you think this happened to them? What are the specific risks for each group? What can be done to mitigate against or reduce GBV during this crisis?

Decision making

22. Have you been involved in discussions and decision-making processes about healthcare in your family/ community? Who is taking decisions related to family resources and assets (e.g financial/income, livelihood, coronavirus in your family/ community before the COVID-19 pandemic? Has this changed since COVID-19? If so, in what ways has it changed?
23. Do you see changes in how women are involved in community during the crisis? Has their physical participation, participation in decision-making on community activities, resources, distribution systems, changed? If yes, in what ways?

Access to information

24. Do men, women, boys, and girls in your community have the same access to information about COVID-19 and prevention/response efforts? If not, who has more access? And how can access to information be improved for all? (Note: women and girls are less likely to have access information. Probe: what modes of communication e.g. radio, text messages, etc. can be used to improve access to information?)
25. How updated information about the pandemic (i.e. vaccine messaging; anti-stigma; mental health; socio economic; quarantine and isolation) is available on a regular basis, in all local and indigenous languages, including to persons with disabilities and older persons, to ensure that no particular part of the population is excluded from access to information or stigmatized?

26. Do you feel you or any of your family members are more stressed than usual during pandemic? What is the stress about? Who is more stressed (men, women, elderly people LGBTQI etc)? What do you/they do when stressed? Can you/ they access mental health and psychosocial support services if you/they need to? (Probe for difference in gender- eg women vs men, boys vs girls and other intersectionalities)

Recommendations

27. What are the challenges (refer to the challenges and worries you spoke about earlier) that you think you can deal with yourself?

FCHV _Key Informant Interview

General Questions:

1. How has current pandemic affected your sector of work? How are you working differently than in previous/other times?
2. What are your roles in response to COVID-19 in the community?
3. How do you determine your target population in such response programmes? How do you assess the most effected populations?
4. Who are the most affected population? What are their challenges?

Access to essential health services and systems

Health/ SRHR

5. Which populations have reduced access to health facilities? Reduced ability to pay for services?
6. How has access to SRHR services changed due to the crisis for women? How does this differ for different groups of women? (probe for: access to family planning, MNCH services, clean and safe delivery and access to treatment for complications in pregnancy and family planning)
7. Are there provisions to ensure women have access to SRHR during this crisis? If yes, what are they? If no, what are the challenges in delivery of SRHR to marginalized population in this crisis?
8. Are the healthcare service points accessible for women, adolescent girls, children and other vulnerable groups within women such as persons with disability?

Use of logistics (PPE) and its management

9. According to you, the Personal Protective Equipment (PPE) available to you are adequate to protect yourself when managing patients with COVID-19 ? Have you received formal training in the use of the recommended PPE for airborne transmitted infections?

Decision Making and Leadership

10. How have you been involved in co-designing solutions and providing ongoing feedback in response to COVID-19?
11. Do you see changes in how women of your community making and meaningful participation in decision-making during COVID-19 responses? Has there participation in decision-making on health activities, resources, distribution systems, changed? If yes, in what ways?

Access to Information

12. How updated information about the pandemic (i.e. vaccine messaging; anti-stigma; mental health; socio economic; quarantine and isolation) is available on a regular basis, in all local and indigenous languages, including to persons with disabilities and older persons, to ensure that no particular part of the population is excluded from access to information or stigmatized?
13. What information often people ask with you about COVID-19 and what difficulties are you finding in relation to providing information?

Recommendations

14. What are your challenges in response to the current situation taking into account gender, equity, and human rights? What are your recommendations on current response?

KII for Health Incharge

General Questions

1. How has current pandemic affected work of your health facility ? How are staffs working differently than in other times?
2. How do you determine your target population in such response programmes? How do you assess the most affected populations?
3. What services and resources safely available to people currently? Are some people less likely to get it than others? Why? (Probe: specifically for health, WASH, SRHR and GBV services)?
4. Does the healthcare workforce have access to remuneration, hazard pay, education and training, and mental health support?
5. Since COVID-19, has there been a change in the work paid of male and female staff in your health facility? Please describe the impacts of this change.
6. Do healthcare workers have access to necessary quality assured therapies, training, equipment, and supplies?
7. Is cold-chain available for storage and safe distribution of COVID-19 vaccines in your working place?

Access to services

Water, Sanitation and Hygiene (WASH)

8. Has access to sanitary facilities by women and adolescent girls changed in your health facility?
9. Are water points and sanitation facilities easily accessible and secure for vulnerable groups who have mobility problems as well as communication problems?

Health/ SRHR

10. How has access to SRHR services changed due to the crisis for women? How does this differ for different groups of women? (probe for: access to family planning, MNCH services, clean and safe delivery and access to treatment for complications in pregnancy and family planning)
11. Are there provisions to ensure women have access to SRHR during this crisis? If yes, what are they? If no, what are the challenges in delivery of SRHR to marginalized population in this crisis?
12. Are the healthcare service points accessible for women, adolescent girls, children and other vulnerable groups within women such as persons with disability?
13. Have there been changes in your safe access to services since COVID-19? (Probe: specifically for health, WASH, SRHR and GBV services)?
14. To what extent do facilities have appropriate staffing available to provide care? Maintained supply chain systems for essential medicines?

Decision Making and Leadership

15. Do you see changes in how women staff of your health facility making and meaningful participation in decision-making during COVID-19 responses? Has there participation in decision-making on health facility activities, resources, distribution systems, changed? If yes, in what ways?

Community engagement and risk communication

16. How updated information about the pandemic (i.e. vaccine messaging; anti-stigma; mental health; socio economic; quarantine and isolation; gender priorities and LGBTQI issues)is available on a regular basis, in all local and indigenous languages, including to persons with disabilities and older persons, to ensure that no particular part of the population is excluded from access to information or stigmatized?

Recommendations

17. What are your health facility challenges in response to the current situation? What are your recommendations on current response?

Observation Checklist
Health Care Facilities for COVID-19 Response

	Yes/ No/	Comments
Availability of basic amenities		
Regular water supply in the institution		
Water storage		
Water distribution to all units		
Separate toilet for Male and Female		
Separate toilet for staff		
Separate toilet for patient and visitors		
Disabled friendly toilet		
Hand washing station with soap and water		
Waste management		
Staff fully aware of and complying with the bin colour codes depending on type of waste		
Incinerator		
Pits		
Drainage system		
Infection prevention and control		
Disinfection of floors, surface, equipment		
Alcohol based hand sanitizer/hand washing facilities with running water and soap for hand hygiene are available at each entrance and in all common areas.		
Personal protective equipment (PPE) and other infection prevention and control supplies for (HCP) protection are available and adequate.		
Screening, early recognition and testing of COVID-19 (Antigen, RT-PCR..)		
Are facilities adequately equipped with supplies and infrastructure to support a robust COVID-19 response or resurgence?		
Physical structure		
Sufficient lighting in the room for the health care		
Waiting room		
Health education materials related to hand washing, mask, and vaccination.		
Coordination/Technical capacity		
Facility has an emergency response plan for COVID-19 in place		
Every staff member has received information about the COVID-19 virus, pandemic and the response and their role		
Facility has an emergency committee that meets at least every week to discuss planning for and/or response to COVID- 19.		
Health workers responding to COVID-19 have access to mental health and psychosocial support services to mitigate/manage occupational distress		
Healthcare workers are trained on		

identifying signs of potential Gender Based Violence (GBV) and referring cases to the appropriate facilities.		
Recording Reporting		
HMIS users manual, different HMIS forms.		
Daily/ weekly/monthly monitoring sheet (COVID)		
Risk Communication		
Available of messages communicated in a clear, accurate and relevant manner to, staff and visitors about disease signs and symptoms, including warning signs of severe disease requiring immediate medical attention.		
Information on COVID-19 accessible through IEC materials		
Referral Mechanism		
Referral linkage to government hospitals in place		
Suspected or confirmed COVID-19 cases transportation system established		
Referred case, accompanying staff (nurse, ambulance driver) provided with PPE and hand-sanitizer		
Referral feedback system and subsequent follow up mechanism in place		

Annex 2. Detail field plan

Field Movement Plan																
				17	18	19	20	21	22	23	24	25	26	27	28	
Federal /Province	District	Group	Activities													
Central Level	Ministries,dept. etc	Central	Central level KIIs	X	X	X	X	X	X	X	X	X	X	X		
1	Ilam	A	Travel and working in Ilam	X	X	X										
	Morang		Travel and working in Morang				X	X	X							
Madhesh	Dhanusha		Provincial KIIs (P.1)					X	X							
	Sarlahi		Travel to Dhanusha and working							X	X	X				
			Provincial KIIs (MP)								X	X				
			travel and working in Sarlahi										X	X	X	
			Travel to KTm													X
Gandaki	Syangja		B	Travel and working in Syangja	X	X	X									
	Manang	Provincial KIIs (GP)				X	X									
Bagmati	Rasuwa	Travel to Manang					X									
	Lalitpur	Working in Manag						X	X							
				Travel to KTM							X					

			Travel to Rasuwa									X					
			Working in Rasuwa									X	X				
			Travel to MKP, Provincial KIIs (BP) hetauda									X	X				
			Working in Lalitpur											X	X		
Lumbini	Bardiya	C	Travel to Bardiya and working	X	X	X	X										
	Arghakhanchi		Travel to Dolpa and working in Dolpa				X	X	X	X							
Karnali	Dolpa		return to Surkhet and KII in Prov. Karnali							X	X						
			Travel to Arghakhanchi					X									
			Working in Arghakhanchi						X	X	X	X					
			Ttavel and Provincial KIIs (lumbini)											X	X	X	
			Travel to KTM														X
Sudur Paschim	Bajhang		D	Travelling to Kailali	X												
	Kailali			Working in Kalali		X	X	X									
		Travelling to Bajhang						X									

Karnali	Salyan		Working in Bajhang					X	X	X	X				
			Provincial KIIs (SP)						X	X	X				
			Travel to Salyan (via dang)									X			
			Working in Salyan										X	X	
			Travel to KTM												X

Annex 3. NHRC Approval letter



Government of Nepal Nepal Health Research Council (NHRC)



Ref. No.: 2190

23 February 2022

Dr. Rabita Shrestha Mulmi

Principal Investigator

Nepal Development Research Institute

Kathmandu

Ref: Approval of research proposal

Dear Dr. Mulmi,

This is to certify that the following protocol and related documents have been reviewed and granted approval through the expedite review process by the Expedited Review Sub-Committee meeting for its implementation.

Protocol Registration No/ Submitted Date	61/2022 P 3 February 2022	Sponsor Protocol No	NA	
Principal Investigator/s	Dr. Rabita Shrestha Mulmi	Sponsor Institution	World Health Organization(WHO)	
Title	Gender, equity and human rights focused assessment on the health sector preparedness and response for COVID-19 during 2020-21			
Protocol Version No	NA	Version Date	NA	
Other Documents	1. Data collection tools 2. Informed Consent Form 3. Donor agreement letter	Risk Category	Minimal risk	
Co-Investigator/s	1. Dr. Baburam Marasini 2. Dr. Puja Pradhan 3. Dr. Binod Prasad Gupta			
Study Site	Ilam, Morang, Dhanusha, Sarlahi, Lalitpur, Rasuwa, Manang, Syangja, Arghakhanchi, Bardiya, Dolpa,Salyan ,Bajhang and Kailali Districts			
Type of Review	☒	Expedited	Duration of Approval 23 February 2022 to 23 February 2023 This approval will be valid only for 12 months	Frequency of continuing review NA
	☐	Full Board		
	Meeting Date: 21 February 2022			



Government of Nepal

Nepal Health Research Council (NHRC)

Estd. 1991

Ref. No.: 2190

Total budget of research	NRs 19,94,266.00
Ethical review processing fee	NRs 59,827.98
<u>Investigator Responsibilities</u> - Any amendments shall be approved from the ERB before implementing them - Submit progress report every 3 months - Submit final report after completion of protocol procedures at the study site - Report protocol deviation / violation within 7 days - Comply with all relevant international and NHRC guidelines - Abide by the principles of Good Clinical Practice and ethical conduct of the research	

If you have any questions, please contact the Ethical Review M & E Section at NHRC.

Thanking you,

Dr. Pradip Gyanwali
Member Secretary

Annex 4: Glimpse of the survey



KII with Provincial level key informant



IDI with Community women



Mixed FGD



IDI with Female health worker



KII with FCHV



KII with FCHV



KII with Health coordinator



Mock session during Training



FGD with Community women in Bardiya



KII with Federal level Key informant