



Rapid Gender Analysis Report on COVID-19 Nepal, 2020

Author
Nepal Research Institute
CARE Nepal



Ministry of Women Children
and Senior Citizen
Government of Nepal

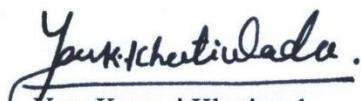
FOREWORD

As the whole world is suffering from the COVID-19 pandemic, for the countries with weak healthcare infrastructure like Nepal is being more challenging to tackle with it . The effect of COVID -19 has become more serious among the women in different ways. The loss of job, limited mobility, over burden of household and care work, domestic and gender based violence leads to psychosocial problem to women during the lockdown and even suicide cases have been reported highly. Similarly reproductive health of women has also been affected during the lockdown.

Realizing this fact, Ministry of Women, Children and Senior Citizen in collaboration with UN Women, Care Nepal and Save the Children has undertaken the rapid gender assessment to explore the gendered dimensions of the pandemic and to highlight the ways in which women and other marginalized people are likely to suffer during the period of lockdown. The findings of the assessment have demonstrated that women in general, have limited access to health and other essential services. The study also reveals that the pandemic is disproportionately affecting women's mental and emotional health. The loss of jobs in the informal sector and losses in paid work time of women during the lockdown is likely to exacerbate the existing income inequalities between men and women.

The ministry is committed to fight against domestic and gender-based violence and will continue to focus on short-term and long-term plans and programs to response these issues. In addition to rescue, relief and rehabilitation, Ministry has focused on livelihood, income generation and entrepreneurship development program for economic empowerment of women.

As this issue is crosscutting and related to every organization and community. I expect the continuous support and cooperation from all levels of government and non government organizations and development partners to cope with this issue and achieving the goals towards the journey of women empowerment and gender equality. I also believe that this report will be useful particularly in our endeavor in putting women and girls at the center in our recovery plans. I would like to thank the entire team for this timely report in spite of the difficult situation of lockdown.



Yam Kumari Khatiwada

Yam Kumari Khatiwada

Secretary

Ministry of Women, Children and Senior Citizen



Acknowledgement

CARE Nepal Central Office
4/288 – SAMATA Bhawan
Dhobighat (opp. DAV School)
P.O. Box 1661, Lalitpur, Nepal
Tel: 977-1-5522800
Fax: 977-1-5521202
Email: npl.carenepal@care.org

CARE is a humanitarian organization established in 1945 and has been operating in 87 different countries in the world. CARE has been working in different districts of Nepal since 1978. From its initial days, CARE has continuously collaborated with the Nepal government, various development partners, private sectors, and civil society organizations to empower and build capacities of the poor, excluded, and vulnerable communities of Nepal to overcome poverty and improve their access to social justice. CARE Nepal is currently implementing 12 projects across 56 districts of Nepal with a major focus on women and adolescent girls in SRHR, GBV, empowerment and leadership, livelihood and natural resources, environmental justice, social norms, education, DRR, and resilience and governance sector.

This 'Rapid Gender Assessment' in the context of COVID-19 has been carried out to assess the situation and context of vulnerable women and adolescent girls to tackle various problems, understand their specific needs, build their capacities and provide systemic recommendations to different related stakeholders. As women and adolescent girls are the impact population of CARE Nepal, recommendations of RGA is equally important for CARE and all development partners to build recommendations in its COVID response program and also to make its entire program gender-responsive.

I am very happy that CARE Nepal could collaborate with the Ministry of Women, Children and Senior Citizens (MoWCSC), UN WOMEN and Save the Children in this effort and provide with technical expertise in conducting the study with final publication. I am grateful for the funding support provided by the UK aid through DFID Nepal to perform the study and I hope that this report shall be equally helpful to our impact groups, facilitators, the stakeholders, and all other concerned organizations including women's rights organizations and networks. I am extremely thankful to all the participants of the study who shared with us their experiences and provided their valuable time and inputs and our partners who helped us gather the information from the field amidst this crisis.

I would like to acknowledge and thank Anita Ghimire and her team, Nepal Research Institute for untiring consultancy support to conduct this study, CARE internal team for technical and management leadership and Christina Haneef, GiE Specialist CARE Asia-Pacific for her expert guidance, review, and input in the entire process of the study.

At last, I would like to thank MOWCSC, UN WOMEN, and Save the Children for a wonderful co-working experience and their trust in CARE Nepal. I am grateful for the funding support provided to perform the study and express my gratitude to the Nepal government for continuous support, suggestions, feedback.

A handwritten signature in black ink, appearing to read "Mona Sherpa".

Mona Sherpa

Assistant Country Director

CARE Nepal

Contents

FOREWORD	ii
Acknowledgement.....	iii
ABBREVIATION.....	v
Executive Summary	vii
RGA Findings.....	vii
Recommendations	ix
1. Introduction	1
1.1 Background Information.....	1
1.2 The Rapid Gender Analysis Objectives	1
2. Methodology	2
3. Demographic Profile	4
4. Findings and Analysis.....	5
4.1 Gender Roles and Responsibilities.....	5
4.1.1 Impact on Control over Resources	6
4.1.2 Division of Domestic Labour.....	7
4.2 Livelihoods and Economic Opportunities	9
4.2.1 Impact on Paid Work and Income	9
4.2.2 Impact on Savings.....	13
4.3 Access to Basic Services.....	14
4.4 Information and Media	19
4.5 Participation	20
4.5.1 Impact on Household Decision-making	21
4.5.2 Impact on Community Level Decision-making	22
4.6 Protection	23
4.6.1 Impact on protection.....	23
4.7 Access to other services	26
4.7.1 Response and Relief.....	26
4.7.2 Perception of Relief and Distribution System	28
5. Conclusions	29
6. Recommendations.....	30
6.1 Short-term recommendations	30
6.2 Mid and Long-term recommendations	31
References	33
Annex	35
Annex 1: Recommendation with Elaboration.....	35
Annex 2: Research questions	45
Annex 3: Demographic profile of respondents	45
Link to Annexes 4-9	46

ABBREVIATION

AES	Adult Entertainment Sector
AMKAS:	Aprabasi Mahila Kamdar Samuha
ANC:	Antenatal Care
BC:	Brahmin and Chettri
CARE:	Cooperative for Assistance and Relief Everywhere
CBS:	Central Bureau of Statistics
CEDAW:	Convention on the Elimination of all Forms of Discrimination Against Women
CFLG:	Child Friendly Local Governance
COVID-19:	Coronavirus Disease
CSO:	Civil Society Organisation
DAG:	Disadvantaged Group
DOI:	Digital Object Identifier
DPO:	District Police Office
FCHVs:	Female Community Health Volunteers
FP:	Family Planning
FWLD:	Forum for Women, Law and Development
GBV:	Gender Based Violence
GESI:	Gender Equality and Social Inclusion
GiE:	Gender In Emergencies
GiHA TT:	Gender in Humanitarian Action Task Team
HEART:	High-Quality Technical Assistance for Results
HHs:	Households
HIV/AIDS:	Human Immunodeficiency Virus/ Acquired Immuno-Deficiency Syndrome
IASC:	Inter-Agency Standing Committee
IDI:	In-Depth Interview
IDWF:	International Domestic Worker's Federation
IFG:	International Forum on Globalisation
ILO:	International Labour Organisation
IMF:	International Monetary Fund
INGO:	International Non-Governmental Organisation
IPV:	Intimate Partner Violence
IOM:	International Organisation for Migration
JCYCN:	Jagriti Child and Youth Concern Nepal
KII:	Key Informant Interview
LFPR:	Labour Force Participation Rate
LG:	Local Government
LGBTIQ+:	Lesbian, Gay, Bisexual, Transgender, Intersex, Questioning (or queer)
MAXQDA:	MAX Qualitative Data Analysis
MHPSS:	Mental health and psychosocial support
MMR:	Maternal Mortality Ratio
MoHP:	Ministry of Health and Population
MOWCSC:	Ministry of Women, Children and Senior Citizens
NC:	Non-community

NGO:	Non-Governmental Organisation
NHRC:	National Human Rights Commission
NNBN:	National Network for Beijing-review Nepal
NPR:	Nepalese rupee
NPRP:	COVID-19 Nepal: Preparedness and Response Plan
NRI:	Nepal Research Institute
NWC:	National Women's Commission
OCHA:	United Nations Office for the Coordination of Humanitarian Affairs
OECD:	Organisation for Economic Co-operation and Development
PNC:	Post-natal Care
PPE:	Personal Protective Equipment
PRBT:	Personal Ring Back Tone
PSA:	Public Service Announcement
PWD:	Person with Disability
RGA:	Rapid Gender Analysis
RNA:	Rapid Needs Assessment
RS:	Rupees
SABAL Nepal:	Sustainable Action for Resilience and Food Security
SAC Nepal:	Social Awareness Centre Nepal
SGBV:	Sexual and Gender based Violence
SDG:	Sustainable Development Goal
SEEDS:	Supporting Entrepreneurs for Environment and Development
SIGI:	Social Institutions and Gender Index
SRHR:	Sexual and Reproductive Health Rights
SSICDC:	Shree Swarna Integrated Community Development Centre
STD:	Sexually Transmitted Disease
SWC:	Social Welfare Council
TPO Nepal:	Transcultural Psychosocial Organisation Nepal
TV:	Television
UN Women:	United Nations Entity for Gender Equality and the Empowerment of Women
UNCRO:	United Nations Confidence Restoration Operation
UNDP:	United Nations Development Programme
UNFPA:	United Nations Population Fund
UNCHR:	United Nations High Commissioner for Refugees
UNICEF:	United Nations Children's Fund
USD:	United States Dollar
VAW:	Violence Against Women
VAWG:	Violence Against Women and Girls
WAC-Nepal:	Working for Access and Creation, Nepal
WASH:	Water, Sanitation and Hygiene
WFDM:	Women Friendly Disaster Management
WFP:	World Food Programme
WHO:	World Health Organisation
WHR:	Women for Human Rights
WOREC:	Women's Rehabilitation Centre

Executive Summary

Following the onset of the global Coronavirus Pandemic, the Ministry of Women, Children and Senior Citizens (MoWCSC) identified the need to study the gender and intersectional impacts of the COVID-19 crisis.

Based on the learnings from a pilot Rapid Gender Analysis (RGA) conducted by CARE Nepal in two districts of Nepal, a Terms of Reference (ToR) was developed to conduct a RGA jointly under the leadership of MoWCSC together with UN WOMEN, Nepal, Save the Children and CARE Nepal being the technical management lead. The objectives of the RGA were primarily to understand the gender differential impacts of COVID-19 on vulnerable and excluded groups and how the existing gender and social inequalities have been exacerbated by the pandemic in the community and in quarantine situations in Nepal. The RGA was conducted using an Intersectional Approach with primary data collection and analysis from 12 districts representing seven Provinces through key informant interviews. Altogether 465 community members representing 17 targeted vulnerable population groups, as well as government and non-government stakeholders relevant to the COVID-19 response, and policymaking at national, district and local level were interviewed. A total of 50 secondary documents using Maxqda software were analysed from 12 districts from 31 May to 17 June, 2020.

The RGA revealed that the most affected groups from COVID-19 includes daily wage-workers, farmers, landless women, women working in the adult entertainment sector, women from Dalit and Madhesi communities, gender and sexual minorities¹, women from geographically disadvantaged locations, women with disabilities, adolescent girls, women headed households, displaced women, and those living with HIV AIDS. Below is a summary of the key findings of the RGA:

RGA Findings

Gender Roles and Responsibilities

- Women's unpaid care workload has increased as a result of the lockdown imposed by the government to contain the spread of COVID-19, as all the family members are staying back at home and more so with the return of migrant family members, school closure and hospitals not prioritising non-COVID-19 patients' admission and care. Domestic workers have to now work between 18-22 hours each day, instead of the usual 6-10 hours². Household and care work burden have 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.
- This, along with a lack of coping strategies has increased emotional and physical problems causing stress and anxiety among women and girls.
- Women are losing control over emergency savings that they traditionally used for household emergencies because men are using the savings to cater to their personal needs. Women's lack of decision-making and ownership of assets has remained unchanged.

Livelihoods and Income

- The number of women not engaged in paid work has increased by 337 %.
- The pandemic is likely to aggravate food insecurity among the already vulnerable groups, such as landless women, women-headed households with no savings, returnee women migrant workers and single women owing to loss of income.

¹gender and sexual minority intends to refer diverse non-binary people including LGBTQ.

² POURAKHI

- 83% of women have lost their jobs. Those hardest hit are women daily wage-workers, women working in the entertainment sector, brick kilns or those who operated their own businesses.
- To date the impact on the agriculture sector does not seem to be severe. However, this study predicts that repercussions may be seen in the coming months, due to loss of investments (by 17%). Nevertheless, positive impacts such as returnee migrant workers (males) supporting women in vegetable farming and sale of vegetables through collective centres in Haat Bazaars have been seen through local government interventions which banned the imports of vegetables, particularly in Rasuwa and Gorkha.
- The current condition of joblessness and loss of income are likely to further impoverish vulnerable groups and push them to accept more risky jobs as a survival strategy.

Participation in decision-making

- There has not been any significant positive change in decision-making of women as a result of the pandemic.
- A total of 64% of the respondents are members of women's organisation but these organisations find it difficult to participate in the design of the COVID-19 response at the local levels, highlighting impacts of gendered norms around participation and decision-making.

Access to Basic and other Services

- Marginalised communities, as well as women and men with chronic illness, older people, pregnant and lactating women, and people living with disabilities find it difficult to access basic services such as food and health services including reproductive health services.
- The current relief measures and quarantine services have failed to address the specific needs of groups such as lactating mothers, pregnant women, women with new-born babies, gender and sexual minorities and Muslim women.

Access to information and media

- Women and girls largely relying on informal sources such as families and friends (72 %) for information followed by radio (59 %) and mobile phones (43%).

Protection

- Intimate Partner Violence (IPV) including marital rape, domestic violence and gender-based violence (GBV) have increased considerably during the lockdown period. Women from marginalised groups including women in the entertainment sector, gender and sexual minorities, wives of migrant workers, displaced women and adolescent girls are the among most affected. Current mechanisms to respond to GBV during the lockdown period have stopped functioning thus exacerbating their vulnerabilities to violence.
- Women who were already in abusive family relationships are trapped now in homes with their perpetrators 24/7 in the house during the lockdown, exposing them to increased control and restriction on mobility by their abusers.
- The stress of losing income, added household work and expenditure, depletion of savings, along with physical violence, has resulted in increasing mental health issues for both women and men with incidences of suicide on the rise.

Recommendations

Short-term Recommendations

- Address the current shortcomings in all quarantine centres and improve the facilities that ensures the safety, security, dignity and specific needs of vulnerable and excluded groups in line with the GESI Monitoring Checklist by linking existing referral service mechanisms with adequate human and financial resources through consultations with local groups.
- Engage women networks and excluded groups in the high-level committee formed for COVID-19 response mechanism and ensure their increased meaningful participation and representation in coordination mechanisms at all levels.
- Provide immediate support to ensure food security of the most vulnerable households, including through unconditional cash transfer and in-kind assistance by adjusting social security allowances, livelihood and relief support provisions to adapt to the needs of marginalised (intersectional) groups that are currently excluded including doing away with cumbersome processes such as presenting identity documents to access relief support/materials.
- Strengthen sex, age, diversity, and disability data recording and analysis for all crisis situation to mainstream gender responsiveness in all humanitarian actions.
- Ensure access to information for all in the community through the use of different information channels and local languages. This includes the use of community counselling and hotline services, collaboration with media houses, and various actors to make information accessible to marginalised people and especially to those that have no access to information.
- Disseminate simple messages to raise awareness about the negative impacts of COVID-19 to eliminate VAWG; stigma and discrimination against frontline health workers, returnee migrant workers, and Muslims in spreading COVID-19; sharing of household work to lessen the burden of increased household and unpaid care work on women and adolescent girls; and, transform social norms.
- 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.
- Conduct orientations to sensitise health workers on ensuring the safety and dignity of patients, as well as on the specific needs of women, girls, LGBTIQ+, elderly people, people living with disability and HIV/AIDS and other vulnerable groups.
- Mobilise FCHVs as essential health workers and other health professionals to resume door-to-door services primarily for pregnant and lactating women, without adding to the increased work-burden and health risks of women and FCHVs.
- Roll out the Comprehensive Essential Package in line with ILOs Social Protection Floor 2012 number 202 for vulnerable and excluded groups to compliment the ongoing efforts of the GoN.
- Recognise GBV services as essential services by rolling out the Comprehensive Essential Packages (health, legal, safe shelter psychosocial counselling, referral, and empowerment) and building the capacities of One-stop Crisis Centres and other service providers for providing services and meaningful support to the GBV survivors and others who are in need of such services by collaborating with various stakeholders including the private sector for providing such comprehensive essential packages (health, legal, safe shelter psychosocial counselling, referral, and empowerment).
- Prioritise GBV cases for adjudication by the judiciary in dealing with impunity specially during crisis situations.

- Focus on inclusion of women in health and other sectors including in the security sector to ensure gender responsiveness in COVID-19 and other humanitarian crisis responses.
- Strengthen monitoring bodies such as the NWC, NHRC and other Commissions to monitor the implementation of GESI issues in line with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) including the Guidance note on CEDAW and COVID-19 and call for joint action in the times of COVID-19 pandemic, statement adopted on 21 April 2020 by the CEDAW committee.
- Roll out gender responsive economic stimulus packages especially for daily wage workers, vulnerable and marginalised groups to prevent them further falling into the destitution trap which forces them to accept risky jobs.
- Emphasise operationalising of local collection centres for marketing of locally produced goods including agricultural products as has been practiced by the local government in Rasuwa.

Mid and Long-term Recommendations

- Increase access to psychosocial counselling throughout the country for people of all ages, along with creating awareness and reducing stigma towards mental health counselling as a part of the current COVID-19 protection messaging.
- Integrate mental health and psychosocial issues in training curriculums and school text-books in partnership with government and non-government entities.
- Ensure government, development partners and NGOs working on disaster preparedness, response and recovery programmes include social norms change, GESI 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.
- Design future programmes to address the long-term social, political and economic impacts of the COVID-19 pandemic on vulnerable and marginalised groups by ensuring universal basic income and livelihood options in public works to address care deficits which includes employment intensive social infrastructure projects and service delivery.
- Collaborate with various stakeholders in scaling up local innovative approaches in agriculture and agro-based industries by linking them with current national agriculture development and livelihoods programmes.
- Ensure the meaningful participation and equal leadership of women and marginalised social groups in disaster response, preparedness and risk reduction at all levels.
- Enhance women, girls, and marginalised groups access to and build their knowledge on digital technologies.
- Promote initiatives that emphasise reducing women's and girls' time use through appropriate and energy saving technologies to lessen their household work-burden.
- Strengthen gender responsive budgeting across sectors/levels in health, protection, education, agriculture, service (including tourism and hospitality sectors) and manufacturing sectors to address the economic and social needs of the most marginalised and vulnerable women especially during humanitarian crisis response and recovery.
- Conduct more in-depth and broad-based analysis of macro-economic framework including trade, monetary and fiscal policies from a GESI lens for informing the government's COVID-19 socio-economic response and recovery framework that is gender transformative.

1. Introduction

1.1 Background Information

The on-going global pandemic of the coronavirus disease (COVID-19) was recognised as a pandemic³ by the World Health Organisation (WHO) on 11 March, 2020. As the COVID-19 pandemic outbreak spread across the world, the Government of Nepal (GoN) took measures to prevent and contain the transmission of COVID-19. These measures included shutdown of schools, closing of borders, suspension of all international flights, imposing quarantines on those returning to Nepal from abroad and lockdowns for the general population. The GoN imposed a complete lockdown except for basic and essential services effective from 24 March, 2020, which remains in effect with varying degrees of flexibility starting from June 2020.

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 side-lined when responding in emergencies. Therefore, in the fight against 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 but there are no studies in Nepal that examine the impact from gender and other intersectional groups⁴ perspective.

Therefore, the Ministry of Women, Children and Senior Citizens (MoWCSC) identified the need to study the gender and intersectional impacts of the COVID-19 crisis. Based on the learnings from a pilot Rapid Gender Analysis (RGA) conducted by CARE Nepal in two districts of Nepal, a Terms of Reference (ToR) was developed to conduct a RGA jointly under the leadership of MoWCSC together with UN WOMEN, Nepal and Save the Children with CARE Nepal being the technical management lead.

1.2 The Rapid Gender Analysis Objectives

The overall objective of this study is to understand how the existing gender discrimination and inequalities have been exacerbated by the COVID-19 pandemic in the community and in quarantine situations, understand local coping mechanisms, and suggest recommendations to address the gender and social inclusion gaps in the government's planning and programme responses to the COVID-19 pandemic in Nepal. The specific objectives of this RGA are to:

- Identify the impacts of COVID-19 on diverse genders in Nepal through an intersectionality approach.
- Identify the challenges women, girls, and the lesbian, gay, bi-sexual, trans, intersex and queer (LGBTIQ+) community face, especially those from vulnerable and excluded groups to access health and other basic social services e.g. livelihoods, water, sanitation and hygiene (WASH), gender-based violence (GBV) protection etc.
- Identify the various capacities and coping strategies of women, girls, and diverse groups in response to the COVID-19 pandemic.

³ World Health Organisation (WHO). Director-General's opening remarks at the media briefing on COVID-19. 2020 March Retrieved from <https://www.who.int/dg/speeches/detail/who-director-general-s-opening-remarks-at-the-media-briefing-on-COVID-19---11-march-2020>

⁴ CARE. Gender Implications of Covid-19 Outbreaks in Development and Humanitarian Settings. 2020; 2019 (2):1–9. Available from: Retrieved from https://www.care-international.org/files/files/Gendered_Implications_of_COVID-19-Full_Paper.pdf

- Analyse the government's relief measures and responses from a gender perspective and highlight the gaps and opportunities.
- Generate evidence to support the development of gender-responsive COVID-19 pandemic response plans and programmes in Nepal to inform the government and development partners.

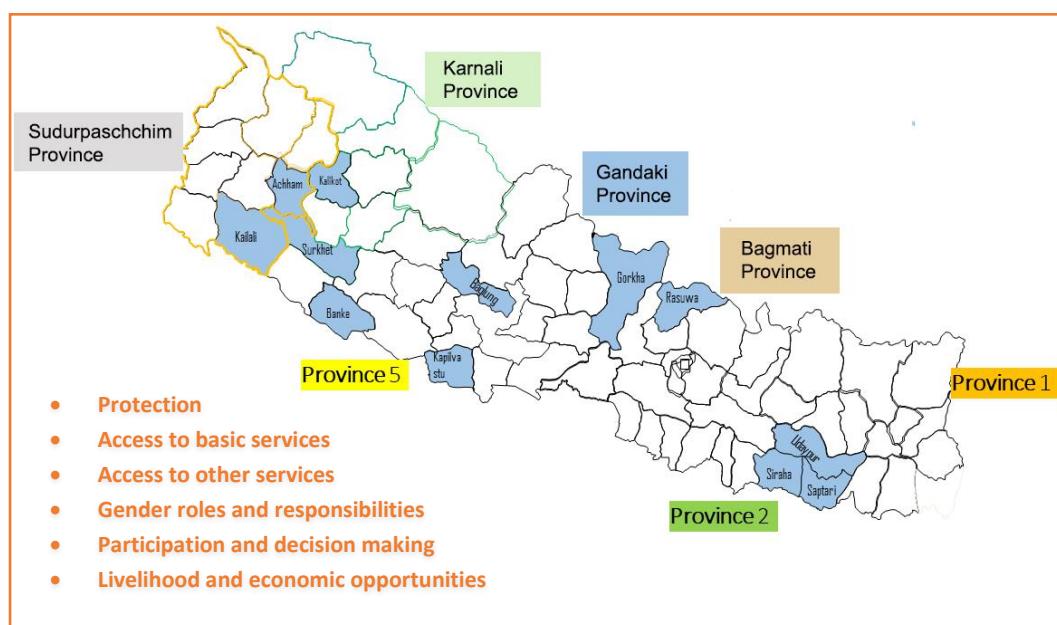
2. Methodology

The RGA is a process that supports the understanding of the different needs, capacities and coping strategies of women, men, boys and girls and people with diverse gender and sexual identities belonging to various groups in any given crisis.

The RGA was built up progressively using a range of primary and secondary information to understand gender roles and relations and how they may change during a crisis. The study adapted CARE's RGA tools.⁵ The findings were then used to undertake an in-depth analysis on gender and power relations using CARE's Good Practice Framework.

The study started with an analysis of existing secondary information (a total of 50 documents)⁶ to understand the gaps in data that need to be fulfilled through primary data. A snapshot of findings from secondary data analysis is given in Annex 5. The analysis was used to inform the research design for primary data collection. This was followed by primary data collection and analysis, triangulating with the secondary data. Details of secondary and primary data collection can be found in Annex 3, 4, 5 and 6.

Primary data collection was conducted in 12 districts identified by the Technical Task Team (TTT) formed from among the members of the RGA consortium. The districts were selected on the basis of their representativeness and unique features (such as province, ecological zone, composition of specific groups of vulnerable populations, vulnerability contexts such as recurring disasters, and ethnic representation among others). One district each from Province 1 and 3 and two from the other Provinces were selected for the purpose of this study. The thematic coverage and the study sites are given in Figure 1.



⁵ For details see [//gender.careinternationalwikis.org/care_rapid_gender_analysis_toolkit](https://gender.careinternationalwikis.org/care_rapid_gender_analysis_toolkit).

⁶ These included: RGA findings from other institutions, government reports, meeting minutes (for example, Gender in Humanitarian Action Task Team (GiHA TT), and policy and programme for COVID-19 response related documents from government, donors, NGOs and INGOs.

Primary data was collected using a mixed methodology. Details of the study tools and the type of respondents are provided in Table 1. The first row indicates the types of tools used, the second row indicates the total number of interviews per tool used and the third row indicates the type of respondents for the interview.

Table 1: Study tool and respective participant type

National level Key Informant Interview	District level Key Informant Interview	Non-community level Key Informant Interview	Community member in depth Interview	Community member survey Interview
15	24	107	110	209
<ul style="list-style-type: none"> • Cluster Lead • Ministry • Members of various organisations (Women right based Organisation) 	<ul style="list-style-type: none"> • Deputy-Mayor or Vice chairperson of Rural/Municipality • Member of District Coordination Committee • Focal person- Women & Children, District Police Office 	<ul style="list-style-type: none"> • Member of Gender Based Violence Committee • Dalit Sadashya (member in ward committee) • Dalit Mahila Sadhasya (women member in ward committee) • Teacher-Principal • Ward President • Social Mobilizer • FCHVs • Women's Cooperative • Journalist • NGO/ INGOs representative 	<ul style="list-style-type: none"> • Women/ Men form Indigenous, Dalit, Muslim, Ethnic Community • Mixed Category • Adolescent Girls/ Boys • Gender and Sexual Minorities • Single Women • Pregnant and Lactating women • Female Community Health Volunteers (FCHVs) • Women living with HIV • Women with bonded labour history • Men/ women Domestic & Wage workers • Women / Men involved in informal sector & small business • Male suffering from other disease apart from COVID- 19 • Male Migrant Returnee • Left-behind Women (from India and other third countries) • Women from migrant household • Women working in brick kilns, stone quarries • Women/ Men with disability due to 2015 earthquake 	

All the interviews were conducted by phone, as travelling to the districts was not possible owing to the lockdown imposed by the government to contain the spread of COVID-19. Details of each respondent are divided by category, ethnicity and gender (Annex-3, Table 2).

All due ethical procedures including those for remote interviews were followed. Questions on GBV were not asked with community participants owing to the sensitivity of the topic and the mode of interview (by phone). The ethical protocol adopted by the RGA was read out to participants and consent taken prior to the interviews. All data have been anonymised.

Limitations:

- Owing to the COVID-19 situation, interviews were conducted by phone and they were often interrupted because of network issues. This meant that the interviews needed to be started afresh at times derailing the rapport and momentum built with the interviewees, necessitating investment of more time in the key informant interviews (KIIs). Consequently, we had to limit the number of participants in each intersectional group in each district.
- 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 we have done here for women.

- Studying change in behaviour as a result of communication programmes was out of the scope of this study, but needs to be studied further.
- Participants were selected using snowball methods and therefore the sampling was not able to identify specific individual needs of some people even within the group.
- The quantitative figures given in tables are from women respondents only. They are derived from survey of community participants. Men participated only in the qualitative interviews.

3. Demographic Profile

Nepal's population of 26.5 million is expected to reach to 30.4 million by the end of 2021. Women make up 54.54% of the current population. The country is largely rural with 80.26% of the population living in rural areas.⁷ It is an ethnically diverse country with more than 60 ethnic groups living in a diverse geographical area.⁸ Agriculture is the main occupation of people with 81% of the working age population engaged in agriculture.⁹ 81% of the population is Hindus, 9% Buddhist and 9% Islam. Of the 29 million people in Nepal, about 900,000 are LGBT (Gurubacharya, 2020).¹⁰ An estimated 506, 258 people are living with some form of disability (271, 731 male and 234,527 female)¹¹ and 29, 503 (17, 587 male and 11, 916 female) are living with HIV AIDS.¹²

Nepal like many other developing countries has a 'youth bulge' comprising of 40.33% between the ages of 16-40¹³ of the total population. 500, 000 people enter the labour market every year.¹⁴ The unemployment rate is 3.3% of the working age population and 96.2% of people work in informal jobs. Women are involved in unpaid care work more than three times than men and spend approximately 6.5 hours in unpaid work and care work, and an additional 2 hours in fuel and water collection.¹⁵ Likewise, there is a significant gender gap in income: 58% of women earn less than NPR 7,600 compared to 42% men, with men occupying 80% of the people who earn NPR 15,000 and above.¹⁶

The female literacy rate is 57.4% much lower than the male literacy rate of 75.1%.¹⁷ The Central Bureau of Statistics (CBS) economic census¹⁸ shows that close to one-fourth of Nepalese women do not own house or land¹⁹ and women own only one-third of businesses.²⁰ While the trend of women's ownership over assets is increasing, this has not made substantive contribution to increasing their decision-making power over the productive use of such resources.²¹

⁷ World Bank Country Profile: Nepal. 2020. Retrieved from <https://data.worldbank.org/country/nepal>

⁸ Mega Publication and Research Centre (MPRC) District profile data. Kathmandu: MPRC. 2013

⁹ CBS, 2019

¹⁰ Gurubacharya B. Nepal census will add 3rd gender, recognizing LGBT minority. 2020. pg 1.

¹¹ CBS and NPC. National Population and Housing Census 2011. Kathmandu: Central Bureau of Statistics. 2011.

¹² GoN, Ministry of Health and Population, National Centre for AIDS and STD Control. Factsheet: 2019 National HIV Estimates. 2019

¹³ Census on Housing and Population 2011, CBS

¹⁴ CBS, 2019

¹⁵ Action Aid. Making care visible Women's unpaid care work in Nepal, Nigeria, Uganda and Kenya. 2013. Retrieved from <https://actionaid.ie/wp-content/uploads/2016/10/Making-Care-Visible.pdf>

¹⁶ CBS. Report on the Nepal Labour Force Survey, 2017/18. Kathmandu, Nepal: Central Bureau of Statistics, National Planning Commission. 2019.

¹⁷ NPC and CBS. 2019. Nepal in Figures. Kathmandu: Nepal Planning Commission and Central Bureau of Statistics. Retrieved from: cbs.gov.np/wp-content/uploads/2019/07/Nepal-in-Figures-2019.pdf

¹⁸ CBS, National Economic Census 2018. Kathmandu, Nepal: Central Bureau of Statistics, National Planning Commission. 2019.

¹⁹ Rijal, S. P. Female Ownership of Fixed Assets in Nepal: A Regional Perspective. *The Third Pole: Journal of Geography*, 17, 2017; 73-82.

²⁰ CBS, National Economic Census 2018. Kathmandu, Nepal: Central Bureau of Statistics, National Planning Commission. 2019.

²¹ Pandey, S. Rising property ownership among women in Kathmandu, Nepal: an exploration of causes and consequences. *International Journal of Social Welfare*, 19(3), 2010; 281-292.

The maternal mortality ratio (MMR) in Nepal decreased from 539 maternal deaths per 100,000 live births to 239 maternal deaths per 100,000 live births between 1996 and 2016.²² 53% of women used some sort of Family Planning (FP) method.²³ 84% of women received Ante-natal Care while 57% received post-natal care within 2 days of delivery.²⁴ Though great strides have been made in maternal health care, there were significant gaps especially in terms of “implementation” and existing “multiple level of barriers” for women and adolescent girls in accessing reproductive health services.²⁵

4. Findings and Analysis

The section below presents the findings that are divided into the following thematic areas:

- Impact on gender roles and responsibilities
- Livelihoods and economic opportunities
- Access to basic services
- Participation, leadership and decision-making
- Information and media
- Protection
- Access to other services

4.1 Gender Roles and Responsibilities

The impact of the pandemic on social norms and practices around control of resources, household division of labour and women's engagement in income generation was analysed.

Key implications

- Gendered norms, which assign the role of main decision-makers to men especially in cases where women do not earn an income, prevail resulting in women losing control over household emergency savings. This has produced stress and anxiety in women regarding meeting of future emergencies.
- The most affected are women in communities (Gorkha and Udayapur) where there has been a high rate of return of men migrant workers with men being prone to gambling and high alcohol consumption.
- Positive instances where women have equitable say/have control over resources are those in indigenous communities or districts where disaster response programmes have integrated social norm change interventions.
- Substantial increase in workload and lack of coping strategies are having the greatest impact on women (and men) with chronic illness, working women, women from water scarce regions and from Hilly districts, single women with small children, pregnant women (in communities such as in Rupandehi that believe pregnant women should not take rest), adolescent girls, women domestic workers (international) and women in communities where men are stigmatised for helping women in household work.
- Increase in workload for adolescent girls is leading to high levels of stress because of reduced education and learning opportunities impacting on their mental wellbeing.

²² Banstola, A. The current state of maternal health in Nepal. 2017. Retrieved from <https://www.mhtf.org/2017/12/29/the-current-state-of-maternal-health-in-nepal/>

²³ Ministry of Health, Nepal; New ERA, and ICF. Nepal Demographic and Health Survey 2016. Ministry of Health, Kathmandu. 2017.

²⁴ Ministry of Health, Nepal; New ERA, and ICF. Nepal Demographic and Health Survey 2016. Ministry of Health, Kathmandu. 2017.

²⁵ Ministry of Health, Nepal; New ERA, and ICF. Nepal Demographic and Health Survey 2016. Ministry of Health, Kathmandu. 2017.

4.1.1 Impact on Control over Resources

When looking at "control over resources", the study examined whether participants perceived any changes in their "say" in the use of resources and what those changes were. Overall the study finds that, as in normal times, women do not have control over resources even during the pandemic. Women respondents felt that men do not consult women for any decisions around sale of livestock even when it is the women who primarily raise them and small assets. However, men respondents felt that decisions were taken jointly. This has particularly become an issue in places where there are high returnee men migrant workers. In Gorkha, for example, men in some areas were found to slaughter livestock that women traditionally reared for household use emergencies, such as meeting children's health and educational needs (stationery, payment of exam fees and annual admission fees for children to study in the next grade). In Udayapur, men have been discreetly selling agricultural produce to meet their immediate needs for cash that women would have normally used for household emergency needs. This is slightly different in indigenous communities of the hill origin, where larger household assets such as family land are controlled by men while women are allowed to manage household income including income of their husbands (Rasuwa and Udayapur) and can give their opinions for sale of small cattle particularly goats and chickens they rear (as "pewa"). However, they would depend on the male members or heed their advice before taking the final decisions.

There are positive examples of changes in the current COVID-19 situation among other groups in some districts. In Gorkha and Rasuwa for example, some women respondents and key informants shared that in some cases, men give their income to women because of the fear that if the money is in their (men's) hands they might spend it on alcohol and gambling out of peer pressure.

"Khelni khani garera sidincha timi raakha bhanera dincha" meaning we will spend it on drinking and playing cards so better for you (wife) to keep it". KII, Man, Community Social Mobiliser, Gorkha.

In other cases, such as in Siraha, according to key informants, instead of focusing on control, both men and women have started to work together to collect resources and spend wisely as they fear that the assets might be lost, if they have to take loans. While it needs further in-depth study, positive changes regarding equitable control over household resources are evident particularly in districts where there were earlier emergencies (such as earthquake or flood) and where recovery interventions have integrated gender equity programming as part of emergency response.²⁶ This reinforces the value of integrating social norm change interventions as a part of emergency response programmes.

Regarding women's own savings, in 51% of the cases, women and men jointly take decisions about women's savings, while in 14% of the cases it is the men who take the decisions and in 7.18% of the cases decisions over women's saving are taken by other family members such as in-laws. Joint decisions, including for property (which is largely owned by men) were largely taken in indigenous communities. For example, in Rasuwa and Udayapur, women keep and manage the household income including income of their husbands. In these cases the male household members are fine with the authority resting on women.

In other cases, the study found a general perception among participants (key informants and women), throughout the study sites, that due to most women not being engaged in full-time paid work and/or earning money they do not have a say or are losing control over resources. For these households, this has not changed during the COVID-19 lockdown. Since men earn money, it is expected and accepted that they make decisions over money and other important assets.

²⁶Ghimire, A. PILOT STUDY: A Strategic Impact Inquiry on CARE Nepal's Gender in Emergencies Programme. CARE: 2019.

As there were few men in the study, it cannot be concluded definitively overall if men felt any change in their control over resources or if not having a job currently had any impact on how they perceived their status with regards to access over resources in the household (for example, if they felt they are losing their control). However, from the interviews that were conducted with men and key informants, this seems not to have changed for men.

In terms of coping strategies, there is no evidence that women were doing anything about their control over resources. However, it is to be inferred from studies on social norms and institutional barriers related to women's access to resources that were conducted in normal times, it can be concluded that as they have been brought up internalising the same gender discriminatory social and institutional structure of the Nepali society, they may accept men taking control over the resources as a norm.

4.1.2 Division of Domestic Labour

In this section the impact of COVID-19 pandemic on household work and the division of household labour (unpaid care work) is discussed. Studies of previous health emergencies show that when the health system is stretched and cannot provide care to people in need, female members of the family act as a substitute for the deficient health care systems through household care.²⁷ In such cases, owing to social norms around care work, women and girls have to bear the burden of taking care of ill family members and the elderly.²⁸ RGAs conducted in other countries, as well as in Nepal, show that household work burden increases for women during pandemics or humanitarian crisis situations.^{29 30 31 32}

This study finds that household labour has involved taking additional care of sick family members, investing more time in looking after children because of closure of schools and having to spend more time in going to the market to purchase household items, while also exacerbating the already large amount of time women spend in producing goods and services for household use. For women, who had to fetch water and collect firewood the workload has increased due to an increase in cooking and cleaning activities. Respondents, both men and women, except for in a few districts, did not feel any change in patterns of help in household work from other family members. In some cases, men felt that since there are more family members at home, women get some help.

Key informants, mostly women also stressed that even if a household identifies itself as flexible or "*liberal*", structural patriarchal mind-sets still drive the majority of day-to-day activities of people. Even when other family members stay at home, cooking, cleaning and washing are seen as a woman's primary responsibility. Households in their expectations around who is supposed to cook a meal or wash the dishes enforce this. Women key informants shared that women who have grown up internalising the same patriarchal values and social norms also accept the idea that household work is the primary responsibility of women.

In Gorkha, for example, men being confined to the house during the lockdown has not only increased cooking, cleaning and washing work for women, but their gambling habits have meant that women have to constantly feed groups of extended male family members who come to play cards. According to key informants, the workload also trickles down to adolescent daughters who are the mothers' chief helping hands rather than their sons. Similar expressions came from Saptari and Udayapur where, due to social norms, men do not share household responsibilities even if they have nothing to do.

²⁷ UN Women. The COVID-19 outbreak and gender: key advocacy points from Asia and the Pacific. Gender in Humanitarian Action Task Team. 2020.

²⁸ Harman S. Ebola, gender and conspicuously invisible women in global health governance, Third World Quarterly, 37:3, 2016; 524-541

²⁹ Care, International Rescue Committee. Global Rapid Gender Analysis for COVID-19. 2020.

³⁰ Samuels, F., Ghimire, A., Tamang A., & Upadhyay, S. Exploring Nepali adolescents' gendered experiences and perspectives. London: Gender and Adolescence: Global Evidence. 2017.

³¹ UN Women. Gender Equality Update no. 14 - Gender in the COVID-19 Response. 2020 April.

³² Office of the Resident Coordinator in Nepal. Key Advocacy messages on gender equality and social inclusion in COVID-19 emergency response. 2020. 2p.

According to both men and women key informants, this is due to a lack of sensitivity or for fear of being ostracised. Women had to juggle their time between added child-care, cooking and cleaning work while also carrying out their usual agricultural work. However, in the two districts of Gorkha and Surkhet, when men are home they engage in agriculture work, where participation of men in growing vegetables has risen sharply during the lockdown period.

According to POURAKHI, an NGO that works on migrants' issues, due to the employers staying at home, domestic workers have to now work between 18-22 hours each day (instead of the usual 6-10 hours). Women household heads shared that they usually do not have any helping hand other than the children and so their workload both inside and outside the home and the related stress had increased.

Apart from Female Community Health Volunteers (FCHVs), key informants shared that life has become particularly difficult for women who have been managing both household and office-work and who are unable to ask family members for help, or for women-headed and single women household with small children who are unable to help.

"In general, all women are facing challenges as they have to manage household work and their professions, simultaneously. As we all are in lockdown situation, we women are facing challenges. We spend six to six and a half hours in the kitchen. Children also expect more time than before, since we are staying at home. There are also expectations that as daughter-in-laws of the house we need to do certain things such as not allowing others to work and do all the work by ourselves. We don't do anything about changing our culture." KII, Woman, National level, Kathmandu

However, there are also districts with positive instances. In Rasuwa, as a result of trainings from different programmes during the earthquake (including CARE's gender in emergency programme) men are conscious about helping women in household work. Therefore, in the current situation, where women's household work has increased, household work and domestic responsibilities are divided. Women, in such instances, did not feel additional work burdens. Apart from working with women in agriculture, men have started undertaking construction work and engaging themselves in community development work such as repairing water lines, cleaning roads etc. during their leisure time. According to the respondents, this change has come about due to restrictions in social gathering. They also note that due to restrictions in social gathering, consumption of alcohol has decreased in the community in Rasuwa. Nevertheless, some key informants such as women social mobilisers and men local leaders also noted that there has been an increase in household work due to family members returning from urban areas.

In Kapilvastu, Accham and Kailali, respondents were of the opinion that due to awareness programmes targeting men, husbands and wives work together, which also translates in husbands supporting household work during the lockdown. In Accham, in particular, respondents also shared that mother-in-laws are now helping daughter-in-laws and are not criticising men for helping their wives. Even when they engage more than before in farm activities, men were found to be helping women in household work and children help in looking after livestock in Accham. However, among Madhesi groups in Kapilvastu, there are beliefs that pregnant women should do more household work so that she remains fit physically and can give birth easily. Owing to this belief, other household members are reluctant to help pregnant women in household work thus making them work more and giving them no rest time, which they need.

In Baglung, due to the return of other family members, women now have helping hands in agriculture, thus decreasing their involvement in out-of-household work. However, due to the increase in the number of family members, their cooking and cleaning chores have increased. With the return of husbands, pregnant women reported feeling a sense of relief as husbands are now helping them in household work.

The study also finds that people with chronic illness, both men and women feel pressurised to perform household work, which has increased as they are staying at home and not in hospital. This is articulated in the quote below from a man with pancreatic cancer:

"At this time, I would have been in a hospital seeking medical assistance. But now since I am at home, I am compelled to do farming and animal husbandry even though my health does not support me". KII, Man, Community member, Gorkha.

Single women with small children are also likely to face more work burden as children now stay at home and they have no one to help with the household work. It is also likely that such households have increased labour of the child as women also need to rely on children in household work.

4.2 Livelihoods and Economic Opportunities

4.2.1 Impact on Paid Work and Income

Key Implications

- Loss of livelihoods has exacerbated already existing inequality and vulnerability, including mental and psychosocial health issues. People most vulnerable to loss of livelihoods are those that were traditionally marginalised population: women engaged in daily-wage labour, farm workers, landless women, those working in the adult entertainment sector (AES), local artisans, and international migrant workers.
- For women working in agriculture, since they cannot use family assets to deal with loss of investment, inability to sell their produce in a timely manner, reduced productivity, and loss of seeds is likely to have a high impact on their income over the coming months.
- Social norms regarding women's lack of access to land and household assets have traditionally marginalised Nepali women. In the current pandemic, repercussions have manifested strongly in women's saving capacity. Inability to save has restricted women's access to saving groups, which were one of the strongest economic and social support mechanisms for women to deal with financial emergencies.
- Groups most vulnerable to loss of savings are those who do not own land, women involved in informal wage labour, LGBTIQ+ groups, families who lost land after being affected by the 2015 earthquake, single women, Dalits, Badis and Mushars and those without citizenship. They do not have access to loans due to lack of collateral.
- Barriers in access to formal and less risky source of loans is likely to push women to resort to borrowing from informal sources (such as local money lenders) increasing their vulnerability to economic exploitation, exorbitant interest rates and increase in sexual violence. This situation may also lead to women and girls seeking risky pathways to find income exacerbating their vulnerabilities to trafficking and human smuggling.

It is expected that the COVID-19 pandemic will bring down the 8.5% projected growth in economy to 2.5%.³³ The recent assessment conducted by the Institute for Integrated Development Studies found that three in every five employees working in formal and informal micro, small and medium enterprises in Nepal have already lost their jobs.³⁴

³³ Ghimire, S. Republica, IMF cuts Nepal's growth forecast to 2.5 per cent due to COVID-19. 2020.

³⁴ UNDP. Three in five employees lost their jobs due to COVID-19 in Nepal. 2020.

The study finds that women not doing any paid work has increased by 337% and income from some sectors such as the entertainment sector and remittances have stopped, while income from sectors such as personal business and daily labour have decreased significantly. Table 2 provides details of changes in livelihoods as found in this study:

Table 2: Change in livelihoods for female participants

Livelihood options	Before	After	% of Change
No Paid Activities	19	83	336.84
Agriculture	83	69	-16.86
Running own business	9	4	-55.55
Running own business	30	10	-66.66
Daily labor	49	17	-65.30
Entertainment Sector	2	0	-100
Remittance	5	0	-100

Owing to the above changes, loss or reduction in income has become common. 3 out of 10 households (HHs) faced a reduction in income. Most affected were those living in Province 5, Sudurpaschim Province, and Province 2.³⁵ As shown in table 2, women migrant workers, people engaged in daily labour (such as those working in brick kilns, AES or those operating their own business are the most likely to lose sources of income first. The difference in income experienced by respondents has been presented in Table 3. 53% of respondents have faced decrease in income with 16% of them experiencing decrease by over NPR 17,000 per month.

Table 3: Difference in income experienced by female respondents

Difference in income	# of respondents	% of respondents
Positive change	1	0.5%
No change in Income	12	6%
Negative change	112	53%
Total Valid Responses	125	
Total Respondents	209	
Average decrease in income among the negative change population		RS. 12,425
<7600	46	37%
=7600-17250	45	36%
<=17250	21	16%
Total Valid Responses	125	

Women working in the AES and international migrants (including those who travelled abroad for domestic work) have not been paid for work they did before the lockdown, as they were unaware of their rights. Only a few received support from organisations and were able to get their payments. The study finds that in the Terai districts of Siraha and Saptari, the police harassed women working in farms further away from their house when they were taking the produce from their farms to sell in the local markets. This has distressed women farmers³⁶ and they ultimately stopped farming or going to harvest their vegetables.

³⁵ World Food Programme (WFP). Nepal COVID-19 Food Security and Vulnerability Update 2. 2020 April. World Food Programme.

³⁶ While the response in the study came from women farmers, we know from secondary data that men farmers were also harassed by local police when they went to collect and sell their produce.

"We don't feel like working and there is no work. Even if we go to work on our agricultural field, police will stop and interrogate us. If you are lucky they will talk to you but if not, they will beat you. When going to sell the vegetables in the market, they throw away our vegetables and break our scales." KII, Woman, Community member, Siraha.

Women thrown-out of rented room

Ganga (name changed) who lived in a rented house in Kathmandu, is now homeless. She was tortured by her landlord as she could not pay her rent due to the loss of her job. She left Kathmandu to take refuge in her maternal home in Bhairahawa but they rejected her. Since then, she has given away her belongings such as beds and fans to other people and lives by the roadside. She was planning to return to Kathmandu again after the lockdown. Her remaining belongings are scattered on the roadside where she is now living. She is sad about her own family members disowning her but does not have much resentment towards the government.

"When my immediate relatives didn't show concern, why should I blame the administration and the police?" At least no one here is torturing me."

She says she is happy on the footpath. She did not want to share much about the various risks of living alone in the footpath.

Story translated from Kathmandu Aja, 19 May 2020, retrieved from:
http://www.kathmanduaaja.com/90?fbclid=IwAR1tLehZEP_HpqISOsfQJ9b-EXOU46CVTbSFr8Yc8eQ8f1_WmZxRnsFzO44

Other groups most vulnerable to loss of livelihoods are women working in daily-wage labour such as construction work (Rasuwa and Gorkha), brick-kilns, women who live by working on sand collection or quarried stones (Siraha and Banke) and local artisans such as blacksmiths. LGBTIQ+ groups who have lost their jobs and do not have family support to lean on, due to stigma and social and family rejection face double challenges. The most vulnerable among the LGBTIQ+ are those living with HIV/AIDS, living in rented spaces, daily wage-workers, migrants working in entertainment sectors in India and trans-women who are involved in the AES.³⁷

The study also finds that social norms around masculinity that expect men to be breadwinners have caused immense stress on men as they are out of jobs or have decreased income. Men who went for foreign employment recently and had not started earning in their new jobs could not pay loans they had taken for migration. Priests in Kapilvastu are also amongst groups that have incurred job losses among men.

According to men respondents, the fact that men are unable to financially provide for their families is causing increased stress levels and has forced them to take physically demanding jobs to meet the current needs as shown below:

"I have not been able to go out and work. I have mental stress because I do not have much savings to support my wife and my child. I am facing problems to pay the rent. I did easy jobs before but now I am compelled to do physical labour (carry loads in the vehicles) to earn some money for the family". KII, Man, Community member, Gorkha

³⁷ Gender in Humanitarian Action Task Team (GiHA TT) Meeting Minutes. Online Zoom. 2 April 2020. 6p.

All men participants shared they were stressed about providing food and education to children. They were also worried what would happen if the family members felt sick in the already dire circumstances.

"We are worried about providing food for the family, from where to earn an income and what to do if someone gets sick now. This is a big challenge for us". KII, Man, Community member, Kailali.

Men community respondents also felt that husbands are more stressed than their wives, as they have the main responsibility to provide for the family. Increase in men's stress has the potential for increased alcoholism, mental health issues, taking risky/unsafe work, as well as an increase in intimate partner violence (IPV) and violence against children.

The COVID-19 pandemic has not only resulted in a shortage of raw materials affecting production of goods but also a loss in markets whereby farm products such as vegetables have to be sold at low prices. While women who have been involved in the agriculture seem to be less affected (-16% change in livelihoods option), they are likely to face significant loss of income in the longer term. They had expected to pay loans taken for agricultural investment through selling of their produce after the harvest but the adverse impact of the lockdown means they will need to take more loans. For the crops that were currently growing, lack of access to pesticides and fertilisers have undermined productivity. Among women who have been engaged in farming, those in urban areas are likely to face more difficulties as their land rent is high and they have no alternate sources to pay the rent.

In the midst of this livelihood crisis, 0.5% experienced an increase in income. Such evidence comes from districts where the local government supported market functions. In Rasuwa, for example, where a large majority of the population is dependent on agriculture, the local government opened local markets (Haat Bazaar) for people to sell their produce and banned vegetable imports into the districts from India. Women were also able to sell vegetables in the collection centres that were made operational even during the lockdown. However, there are still concerns on the low market price due to larger supply of vegetables in the local market, fewer opportunities for exporting to other districts, and/or markets being further away due to a ban on mobility of vehicles. This has particularly affected large-scale farmers who have already made significant investments in vegetable farming. Women respondents engaged in agriculture also shared that unavailability of seeds will affect their harvest for the next season.

"I was a part-time farmer before the lockdown. After lockdown my wife and I started farming as a full time job. Due to closure of hotels and lack of mobility and most people producing vegetables in the kitchen garden after COIVD-19, supply has increased in local market. I visited the nearby agriculture co-operative to sell my products. But they also share similar concern on lack of demand on what they already have collected. We are now forced to sell the products either on unreasonable price or give them to farm animals". KII, Man, Community member, Rasuwa.

For many households throughout the study districts, coping strategies have included using savings, bartering goods with neighbours, taking loans, cutting down on food or compromising the quality of food purchases, selling livestock or eating livestock and cutting off other costs such as clothes and social functions. However, there is a general sense among the economically and socially vulnerable people that the age old practice of feudal system 'Jamindari Pratha' where the landlords and the rich exploit the spaces to take away from the poor will return and they can sense its presence already.

4.2.2 Impact on Savings

Due to loss of jobs and increased cost of food items, household savings have depleted swiftly.³⁸ As shown in Table 4, a large majority (28%) feel that their savings will last only for the next month, while 26% have already used up their savings. Only 5% of respondents felt that their savings would last for up to a year if there were no further emergencies.

Women's saving groups were an important support in cushioning households from economic distress. Loss of potential to save has meant women are unable to borrow money from the saving groups thus losing their traditional support structure when it was most needed.

Table 4: Status of savings of female respondents

	# of respondents	% of respondents
No Savings at all	55	26%
0-1 months	59	28%
1-3 months	41	20%
3-6 months	31	15%
6-12 months	10	5%
Not Responded/ Invalid Data	13	6%
Total Valid Responses	196	
Total Respondents	209	100%

Women from the indigenous and Dalit groups have incurred most of the loss where men are resorting to alcohol and selling household assets and livestock. Here, women's capacity to invest in food and other necessary goods has decreased.

Most vulnerable to loss of savings are those that had precarious earnings, such as women working in agriculture wage labour and precarious jobs in urban areas such as quarrying, brick-kilns, domestic workers (both national and international) and indigenous and Dalit groups, where men are resorting to alcohol and selling household assets and livestock.

Loss of women's saving capacity has also had an institutional impact. Key informants in the study districts were also of the opinion that apart from individual savings, groups savings such as in women's co-operatives have gone down as they could not get repayments on the loans that were released by their organisation earlier.³⁹ As shown in Table 5, the most important coping strategy has been borrowing and loans. Going back to agriculture and thus decreasing expenditure on food items has been another way to reduce depletion of savings. However, this coping mechanism is not available for groups that were already marginalised in terms of access to land, such as families who lost land after being affected by the 2015 earthquake, single women, Dalits, Badis and Mushars and those without citizenship. These groups are also unable to access formal institutional support mechanisms such as banks and savings and are the most vulnerable groups in terms of financial capability to endure the current livelihoods challenges.

³⁸ Gender in Humanitarian Action Task Team (GiHA TT) Meeting. On-line Zoom. 27 April, 2020
³⁹ Gender in Humanitarian Action Task Team (GiHA TT) Meeting. Online Zoom. 27 April, 2020

Table 5: Alternate income sources used by female respondents

Additional Source	# of respondents	% of respondents
Borrowing from others	19	30%
Humanitarian Assistance	6	10%
Loan	18	29%
Others	2	3%
Remittance	3	5%
Social security allowances	4	6%
Support from relatives	8	13%
Total respondents who have additional source of income or need to rely on	63 People	

The study also finds systemic defaults in current programmes that marginalise women. For example, women farmer groups were found to be excluded from the government's current relief measure announcement, which provided loans of NPR 750 per *kattha* of land, as they do not have any land in their names.⁴⁰ This problem is also acute for women who worked on rented land. Consequently, they are also unable to access any loans from local institutions or the subsidised loans announced by the government owing to lack of collateral, even when farming is their primary occupation. All the above might also apply to men and households who do not have access to land. This is an area for further investigation.

Key informants both in the Terai and the Hilly districts also suggested possibilities of conflict in communities if local saving groups, banks and micro-finances decline to give loans to people who are unable to pay their previous loans due to loss of income.

"People are unable to pay loans taken from bank and micro-finance due to lack of income source. They might want more loans but the institutions would not give them. This might cause conflict within the community." KII, Woman, Non-community member, Udayapur.

While it was expected groups that have taken loans from formal institutions at high rates to be significantly affected, key informants felt that this is unlikely in the immediate situation, as time for re-payment of these loans has been extended. The study did not have respondents who had taken big loans as it was more focussed on poor populations. Nevertheless, in the long run, inability to make an income is bound to have critical effects on the people who have invested in small and medium business or as the interest rate accumulates over time and their loans goes up.

4.3 Access to Basic Services

Under the access to basic services the study looked at the impact of COVID-19 pandemic in access to Water, Sanitation, Hygiene (WASH), Food, Health and Sexual and Reproductive Health Services. The impacts on different groups of women are presented in Table 6.

Key Implications:

- Lack of access to basic services is impacted along intersectional lines of vulnerability such as caste-based discrimination (in access to water,) geography (for Maternal and Child Health, FP and other health services), poverty and deprivation (for food security), gender and life cycle for sexual and reproductive health (SRH) and gendered social norms (for nutrition).
- Income is a cross-cutting variable in access to services.

⁴⁰ Ibid

- Food insecurity has increased, disproportionately impacting already vulnerable groups in the population. There are also normative barriers for women's access to food such as women not eating enough during pregnancy, highlighting the importance of relief services that account for social and gendered norms.
- A focus on general and emergency health services has overlooked women's access to maternal and reproductive health care undermining the already marginalised position of RH services and reinforcing women's marginalisation in health services.

Table 6: Access to services and resources

Services	Access to these services
WASH	<p>In urban areas, people likely to be affected are those that had low income and bought small jars of water for daily use. In rural areas and hilly districts such as Baglung, Kalikot, Accham, Surkhet and Gorkha where women have to spend considerable time collecting water from communal sources, face risks of contamination from COVID-19 and an increased work burden, due to additional water being required to meet the consumption needs of family members as they are all staying at home following the lockdown measures to prevent spread of the virus. In some cases this increased demand has led to conflicts among women. The study found that adolescent girls and domestic workers meet the tasks of water collection disproportionately. 67% of adolescent girls and 57% of domestic workers in the study shared that collecting water is their responsibility in the household. Hence, increased usage of water has had the strongest impact on them. Increased demand of water is a problem for Dalit households in the Terai such as the Domes, Chamars and Mushahars who might not have hand pumps in their houses and depend on communal hand pumps. Here they are stigmatised for carrying infections.</p> <p>In other hilly districts such as Rasuwa, however, the 'One house, One tap' policy has meant that additional requirements will not have an impact on the population.</p> <p>Daily wage-workers who have lost their jobs find it difficult to afford soap or sanitizers, face masks, or hand gloves. Stocking of essential hygienic goods by wealthier populations has increased prices of these products making it hard for low-income groups to purchase them.</p> <p>Owing to the rigid segregation social and religious norms, women and girls were already vulnerable during menstruation, especially in the West and far-Western Nepal. Amidst the lockdown, there is an increased lack of hygiene and sanitation facilities and safe shelter during menstruation. There is also lack of adult diapers for women with special disabilities like spinal cord injury, lack of nutritious food and safe shelter, as discussed in the Gender in Humanitarian Action (GiHA TT) meeting. According to the Gender in COVID-19 Response (2020), some organisations are already working to provide essential supplies like soaps and hand sanitizers to those who cannot afford them.</p> <p>There are also more positive scenarios. Handicap International in its Rapid Needs Assessment (RNA) on COVID-19 (2020) found that 92% of its respondents (people with disabilities, including women) were washing hands with soap and water to fight the virus.</p>
Food	The COVID-19 pandemic has further exacerbated food security issues across the country. ⁴¹ Current food insecurity status was found to be more common in 3 provinces - Sudurpaschim

⁴¹ World Food Programme (WFP). Nepal COVID-19 Food Security and Vulnerability Update 2, 16 April, 2020. WFP. 2020 April.

	<p>Province, Province 2, and Karnali Province. Inflation of prices has severely affected people's ability to purchase a variety of food in the region and households with women heads, single women, women daily wage-workers and LGBTIQ+ groups who do not have other support systems to lean on are likely to be vulnerable to food insecurity. Similarly, those who have travelled for foreign employment but have become jobless and left their family members behind are also facing food insecurity issues.</p> <p>"It has been 15 days that I have been surviving on rice and salt or sometimes rice with curry. I have no nutritious food. Many came and collected information on our current status, but we have not received any relief package. I am poor as well as a Dalit, who will come and help me?" KII, Woman, Community member, Kapilvastu</p> <p>"We are in too much tension. We cook only once in 24 hours. We have nothing to eat at home. We have no earnings as we are daily wag- workers." KII, Woman, Community member, Kapilvastu</p> <p>Key informants both men and women throughout the study districts shared that both men and women are more concerned about the availability of food and not focusing on the quality of food they eat in the current situation. According to men community members, one of the coping strategies is to focus less on nutritious quality of food. They have cut down on meat and vegetables, or are trying to cope with less quantity of food. In places where social norms discriminate women from eating first, such as in Terai districts and among non-indigenous groups, women with specific nutritional needs such as the sick and elderly, pregnant and lactating women are likely to face malnourishment. In some districts such as Kapilvastu and Karnali region, there are already harmful beliefs around nutritional food intake by pregnant women for fear that the foetus might become big and cause birthing problems.. The current food scarcity is likely to add another challenge to their access to food.</p> <p>Coping strategies have largely been consuming harvests they had kept aside as seeds (Siraha and Baglung), vegetable planting on previously fallow lands and rearing livestock (Gorkha). In Gorkha, the Prime Minister Employment Programme is planning to supplement the current demand for agricultural inputs to help farmers. Besides this, local government, as well as other stakeholders, have scaled up earlier nutritional programmes such as "Sunaulo Hazaar Din (1000 Golden Days " in some areas during COVID-19, particularly targeting children and women vulnerable to malnourishment (Saptari).</p> <p>Some misconceptions around food have also spread during the lockdown period such as in Surkhet where according to key informants people are consuming garlic and Sichuan pepper to boost up their immunity to fight the virus.</p>
Health Services	The study finds that the lockdown has resulted in obstructions in access to healthcare among elderly women, people with disabilities, pregnant and lactating women, and women who are suffering from long term illnesses such as HIV/AIDS. ⁴² Key informants in many districts shared that people suffering from chronic illnesses are strictly advised to stay at home and that health care centres have run out of medicine related to normal ailments as they have focused on COVID-19. For some elderly people with chronic illnesses, and without income, lack of access to social security allowance has meant they have not been able to buy medicines as revealed by interview with a person living with disability below.

⁴²Nepal COVID-19 Rapid Need Assessment Report, Handicap International, 2020.

"I am not able to buy my medicine for my asthma because I cannot go out and receive my allowances from the local government." KII, Man, Community member, Surkhet

Besides the above-mentioned groups, returnee migrant workers and LGBTIQ+ groups who have been displaced from urban centres where they usually lived, are stigmatised in local areas for carrying the virus and are hesitant to access health services. Besides, the services provided by the caregivers for the elderly men and women have been stopped during the lockdown.

The study finds that with massive shortages of personal protective equipment (PPE), many health centres have remained closed as staff refuse to provide services. Some key informants shared that in places where they are open, the patients are not treated, if they show symptoms of the coronavirus. Key informants across all the study sites shared that there are existing gaps in capacity of health workers to deal with the new transmission challenge posed by the pandemic, lack of medicines and services and nepotism in delivery of services.

"There is not enough medical supplies for the long-term illness. They never listen to us but give priority to their own relatives. Who will consider Dalits and the poor like us?" KII, Woman, Community member, Gorkha"

Other challenges included transportation, shortage of female health workers, inaccessibility to health services and service delivery by health professionals, who are fearful of contracting the virus in the absence of PPE, compromising the quality of health services.

However, there are also positive perceptions. According to respondents, despite the lockdown, the local government and police have been prompt in regulating measures to ensure timely access to health services. People can register their vehicle number via the phone 'number 100' for easy travel and can reach out to local government for medicines. Similarly, passes are only required for people who want to go to the city areas for treatment.

After four weeks of the lockdown, the government opened up immunisation services in all the study areas after suggestions from health experts at the MoHP. Key informants throughout the study districts shared that steps have been taken by the government to strengthen the medical response. In Accham, health workers, volunteers and helpers had been insured to make sure they continue their work while in other districts FCHVs had been deployed at the local level to make sure children got their regular immunisation doses.

In Gorkha, the local government has kept ambulances on standby and coordinates with the police to provide services to people who call the helpline 100. The study reveals that while 63% of people have not visited health facilities, 55% among them have received health services through FCHVs. This indicates the critical role of FCHVs in delivering health services to the local people under lockdown situations. In some hilly districts there is a provision for "heli-rescue" by the President Women Upliftment Programme to transport pregnant women for delivery to hospitals during emergency situation.

Non-government stakeholders, individuals, community groups and the Nepali diaspora organisations such as the Non-Resident Nepali Association have taken the initiative to contribute to the effectiveness of health sector response. According to a woman key informant interviewee some political leaders have rescued migrant women workers in severe heath crisis through their personal efforts by using their personal networks and financial resources as they did not want to

	<p>wait for the institutional rescue process, which could take time. In other cases, local stakeholders have co-ordinated with international organisations like the International Domestic Worker's Federation (IDWF) to rescue women domestic workers facing health crisis.</p> <p>The lockdown has aggravated mental health issues of women, marginalised and stigmatised groups such as LGBTIQ+ and adolescent girls, as well as that of elderly people. Elderly men are stressed owing to fear that young and mobile people who go for work will bring back the disease or because they will be left alone due to social distancing. According to key informants from Baglung, they often find the elderly sitting alone in a room, preferring not to engage with other family members.</p> <p>"Older people prefer to stay alone in their rooms and refuse contact with outsiders. They have more mental health issues than anyone else. Earlier, when anyone got sick, people would visit them as a compassionate gesture. But now, nobody comes to visit a sick person for fear of being infected." KII, Man, non-community member, Baglung.</p> <p>These issues will have long-term implications in the society in days to come but current efforts are limited.</p>
Sexual and Reproductive Health Services	<ul style="list-style-type: none"> ✓ In Kalikot, during the lockdown 20-year old Mina Shahi delivered at home, but due to excess bleeding she had to be rushed to the hospital, but she died on the way. She had given birth to her first baby at the age of 16, which had already caused health complications. ✓ In Sarlahi, delivery services were reduced by around 50 per cent due to fear of the coronavirus. A health official informed that women had also stopped coming for pre and post-delivery due to fear of getting infected from the health officials. In Jhapa, the maternity service remains closed in Damak Hospital after they isolated a Corona positive patient in the hospital. ✓ In Rasuwa, another 20-year old Samjhana Tamang had to take the risk of delivering at home as the hospital was 3 hours walk from her home. They had no ambulance or other means of transportation during the lockdown. Tamang said, 'I thought I would die while delivering. I was lucky that a local health facilitator was beside me.' <p>According to key informants, the current situation has raised further problems for women accessing Sexual Reproductive Health Services.⁴³ The problem is especially severe among pregnant and lactating mothers with limited access to safe delivery services, anti-natal care (ANC) or post-natal care (PNC) services. Another area of concern mentioned by female key informants such as social mobilisers and NGO/INGO respondents was the increased barriers to access contraceptives, which will lead to unplanned pregnancy. A specific group of concern is the teenagers, as they are out of school. There are also concerns that this may lead to greater drop-outs later. It is assumed that adult pregnancy will increase due to lack of access to contraceptives and couples being together for 24 hours a day.⁴⁴ On 27 March, 2020, the Social Welfare Council issued the first notice addressing I/NGOs to draw special attention to children, women (lactating and pregnant), persons living with disabilities and senior citizens. As highlighted in Section 3, Nepal has made remarkable achievement in RH services in the last decade decreasing MMR (from 539 maternal deaths per 100,000 live births to 239 maternal deaths per 100,000 live births),</p>

⁴³ Covid-19 and Women's Human Rights: Guidance: What Is The Impact of Covid-19 On Gender-Based Violence? UNHCR. 2020 April. 10p.
⁴⁴ UNICEF. 2020.

	<p>increasing accessibility of RH services such as reaching 53% women with FP methods, 84% of women with ante-natal services and 57% with post-natal care services within two days of delivery. There has been, however, a detrimental impact on RH services during the lockdown with 30,000 pregnant women giving birth out of health facility and a 200% increase in maternal mortality.⁴⁵ Fear of contracting the virus has led to many expecting mothers to forego the ANC services and rather resort to unattended birth delivery at home.⁴⁶ Furthermore, there are fears that this is not still the full picture of the situation. According to former health secretary the real scenario could be “much more alarming”.⁴⁷</p> <p>Additionally, according to key informants, the growing fear of Coronavirus is likely to divert the attention of the medical community from contraception and STDs.</p>
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4.4 Information and Media

Key implications

- People who already have less access to information due to cross-cutting vulnerabilities such as illiteracy, language, time-poverty, access to internet and airtime and disability are excluded from accessing important information regarding preventive measures against COVID-19 as well as humanitarian support and security issues.
- While government and non-government stakeholders sped up information dissemination through various channels, people tended to place trust in informal sources, which may spread myths and misinformation.
- Women have more access to radio messages than mobile messages, which highlights a gender gap in access to digital technology.

The study finds that while radio is the main source of information during normal times, respondents (men and women) received information about COVID-19 from their family and friends. This is also the second common source of information during other times. Similarly both men and women participants were also found to be receiving information about humanitarian assistance mostly from friends and family.

Table 7 shows the main sources of information for people during normal times and where they receive information about COVID-19 and humanitarian assistance.

Table 7: Sources of information to female respondents and difference during COVID-19 period

	Access Information (normal time)		Receive COVID information		Receive Humanitarian Assistance information	
	No.	%	No.	%	No.	%
Friends & Family	147	70%	151	72%	150	72%
Radio	153	73%	124	59%	120	57%
Mobile	107	51%	89	43%	74	35%
TV	81	39%	51	24%	31	15%
Social Media	55	26%	36	17%	34	16%
Informational Educational Material	12	6%	5	2%	3	1%

⁴⁵ Adhikari A. Nayapatrika. 2020.

⁴⁶ Poudel, A. The Kathmandu Post. 2020.

⁴⁷ Ibid

The study finds that a wide range of stakeholders ranging from government and non-government have been involved in dissemination of information regarding protection from COVID-19. The most common forms of messages the respondents received are about general health (44%) and security (26%).

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. While some NGOs have started giving information in a few local languages for example in case of Province 2, the mainstream language is Nepali. Public Safety Announcements are also given through the print media. The Department of Health Services also runs a hotline. Table 8 demonstrates the kind of information respondents thought was useful to them.

Table 8: Type of messages that female respondents have received during lockdown

Types of messages received by the respondents	Most relevant	Highly relevant	Quite relevant	Less relevant	Least relevant
General Health	91	36	23	5	21
Messages: GBV	21	37	33	27	32
Messages: Security	54	48	34	21	15
Messages: Care work load	19	15	28	28	60
Message: Education	32	31	35	18	39

The study finds that though the government and non-government stakeholders try to provide people with accurate and up-to-date information, disinformation is widespread on social media and on-line portals.

According to key informants, women who have taken up domestic work in foreign employment are groups that might have no access to information as they are locked up in their employer's accommodations. Those who can access social media, have been directly contacting families or organisations like POURAKHI- an organisation of returnee women migrant workers and it is helping them make contacts with shelter homes where possible. Key informants such as social mobilisers, local representatives and FCHVs in several districts shared that they have been going into the community by themselves and informing people about the safety measures to fight the virus.

In some communities, key informants were confident that women and men in the community would dial 100 for the Nepal police helpline. The study found that organisations locally involved in disseminating information includes Red Cross, Women's organisations, Youth organisations and Child Clubs, which has made the community aware in times of crisis. Besides this, the local government's social mobilisers were also found to be actively engaged in all the districts in disseminating information.

4.5 Participation

In this section, we look at the impact of COVID-19 on participation in household and community-level decision-making.

Key Implications

- Women and men both internalise men as being the decision-makers due to their role as breadwinners and being better exposed to the outside world.
- There is a lack of information on decision-making space for groups that are stigmatised such as women working in the AES, LGBTIQ+ groups, women with no income and returnee women migrant

workers. As they are stigmatised in their society for transmitting COVID-19, they might have to face rehabilitation challenges if they go back to their homes.

- Women and women's local organisations are not part of the COVID-19 response. The design and delivery of COVID-19 response has reinforced gender discrimination in local women's decision – making role confining women to participate only in social causes and not in decision-making about community resources.
- Women leaders feel that their voices are less acknowledged in the systems and find resistance from male colleagues in supporting their plans and programmes.
- People living with HIV, LGBTQ+ groups, women and gender and sexual minorities working abroad, women farmers and daily wage-labourers, women and gender and sexual minority groups working in the AES have been side-lined from community decision-making around design and delivery of response. This has which has implications on the challenges they face in resolving their unique physical and mental health issues by response and recovery programmes.

4.5.1 Impact on Household Decision-making

As discussed in section 1.1, women, to varying degrees, traditionally depend on men to make final decisions, particularly on areas of strategic importance in the household, but also on the private lives of women such as mobility (visiting maternal home), reproductive issues (birthing and use of family planning). Table 9 provides the respondents perception on the current status of decision-making. Both men and women key informant interviewees also felt that the return of men migrant workers as a fall-out of loss of jobs owing to the pandemic has meant that they have now taken over the management decisions while women take responsibility of labour.

*"It is pretty common for men to make financial decisions. Due to the increasing return of migrant workers, women will have to manage larger households with reduced income but men will make decisions on where the money is to be spent".
KII, Man, Non-community member, Achham.*

Table 9: Women's participation in decision-making

	No Involvement		Decision Maker		Consulted		Joint Decision	
	Female HH	Male HH	Female HH	Male HH	Female HH	Male HH	Female HH	Male HH
Working to earn money	11	29	29	17	0	9	22	65
Buying/Selling Assets	11	26	22	9	4	12	28	74
Visiting birth relatives	11	12	23	16	1	13	29	80
Migration/Displacement	19	52	16	7	1	7	24	53
Access to healthcare for self	3	13	36	48	1	4	24	58
access to healthcare for children	7	16	22	22	3	10	26	71
To have child or no	27	37	6	14	4	3	19	62
To send children to school	11	18	25	19	5	7	20	69
Total Women Headed Household	68							
Total Women Headed Household	126							

There is an inherent belief that as men are primary breadwinners and guardians and are responsible for the upkeep of the family, they should have more decision-making power. Women also feel that men are in a better position to make decisions as they have better information on how to handle situations:

"Also, we do not know what to suggest, how to handle certain situation and give suggestions to make our opinions and views heard. So, mostly the male member in my family makes the decision and we accept it. This situation had not changed after lockdown". KII, Woman, Community member, Siraha.

Nevertheless, men respondents in the study also mentioned that even though the house and land are in their name (men's name), decisions on expenditure is taken by both husband and wife. They felt that decisions were taken jointly. However, women respondents had different opinions as shown by the quote below:

"Male members make household decisions in which we have not much say; even we raise voice our voice it is mostly unheard or not prioritised." KII, Woman, Community member, Kapilvastu.

This also applies to decision-making around maternal health and FP where according to respondents only around 25% of mothers can make decisions independently on maternal, neo-natal and FP services.

4.5.2 Impact on Community Level Decision-making

According to key informants from the government and district levels, women political representatives, though many women representatives were elected during the recent local elections, they do not feel they have been able to significantly change women's empowerment and represent women's practical gender needs and strategic interests. Women are largely given social responsibilities and men in leadership position largely take decision-making around resources mobilisation. This has not changed in the COVID-19 situation. For example, many Deputy Mayors felt that even when women Deputy Mayors go to monitor response programmes, they are not given opportunities to lead. This is reflected in interviews with women bureaucratic and political representatives at the national, local and district levels as is manifested from the response of a woman respondent below.

"We can see women's participation in different levels. But that participation doesn't make sense when the participant's voice is not heard and implemented. Also people are always ready to question the leadership capacity of women". KII, Woman, National level

Even though, the Disaster Management Act (2017) includes mandatory provision to ensure the participation of women at all levels of institutional mechanisms, the national high level committee formed by the government for COVID-19 response notably the *High- level Coordination Committee To Prevent and Control COVID-19 and the Corona Crisis Management Centre* are led by men and largely made up of men members. It does not include any women or representatives from other minority groups belonging to Dalits, Muslims, ethnicity or those belonging to gender and sexual minorities. In Kapilvastu, a regular community meeting for people with disabilities has stopped due to COVID-19.

Respondents were of the opinion that women were not represented in any levels of decision-making at national, local or provincial levels. For example, despite women constituting a majority of frontline healthcare workers, they are only a few of them in the national health leadership positions. Similarly, while FCHVs were found to be making important contributions in delivery of health services during COVID-19, they are not part of any formal decision-making bodies around policies and resources.

Other factors that impeded women's participation in decision-making were found to be time-poverty due to household work, lack of interest, hesitation and fear of stigmatisation particularly in the case of at-risk or

marginalised groups, lack of strong approachable women leaders, as identified in Surkhet, lack of men's support and empathy and lack of economic and family support (Saptari, Siraha). In districts such as Gorkha, Kapilvastu, Siraha and Saptari, respondents felt that women take a back seat and cannot make their own decisions. For district level key informants this has been an issue of concern.

"Decision-making is always a challenge because of the pre-determined notion that women can't do it properly." KII, Woman, District level, Gorkha.

Furthermore, women from disadvantaged backgrounds believe that women in important positions are backed up by supportive families and have stable financial background. In other cases women feel that men in positions are reluctant to approve plans that are prepared by women.

"Plans proposed by women never get approved and hence women do not have a say in decision making around programmes". KII, Woman, District level, Kalikot.

"For leadership and participation, the poor, elderly and disabled should also get access (pahuch) to education or power. Occupying any post here needs a large amount of money and support of men. We cannot afford that owing to our weak family condition". KII, Non-community woman member, Siraha

However, respondents observed important changes. Some families in Accham now send their widowed daughters-in-law to community meetings and programmes that was not the case before. In Kalikot too, respondents feel that women's participation in public space is changing for the better. To ensure participation of different groups of women, some rural municipalities such as Kalika Rural Municipality of Surkhet have formulated a tole (hamlet) development committee in each tole. In Baglung, initiatives called, '*Laingikta ma adhaarit mahila samiti (Women's Committee based on Gender Equality)*' has helped ensure the FCHVs and women members have the space to voice their concerns regarding the COVID-19 response. However, further details of the mechanisms were not available.

4.6 Protection

Key implications

- Overall violence against women and girls (VAWG) as well as other intersectional groups has increased to a large extent.
- Women who are more vulnerable to violence tended to be based on their age (such as young women), migration status, women from marginalised groups such as Dalits, Madhesis, gender and sexual minorities (LGBTIQ+), adolescent girls whose parents are in India/abroad, women whose husbands are trapped abroad, displaced women and women in the AES.
- The rise in physical and other forms of violence (sexual-including intimate partner violence, psychological and economic) is likely to have long-term implications on the psychosocial health of the vulnerable population.

4.6.1 Impact on protection

VAW cuts across all caste, class, ethnic, minorities and socioeconomic groups. It is experienced most severely by those women who are from marginalised groups such as Dalit, Madhesi, and indigenous communities, religious minorities and LBTQIs, women from geographically disadvantaged locations, women with disabilities, adolescent girls, women of migrant husbands, displaced women, poor women and

women in AES.⁴⁸ Overall VAWG as well as violence in other intersectional groups has increased sharply. Several protection cluster leads observed increase in violence in the COVID-19 context. Owing to a sharp increase in domestic violence and rape cases, the NHRC has formed provincial and district level human rights committees to monitor the situation. There are several reports on a number of women facing violence in the lockdown. The Women's Rehabilitation Centre (WOREC) reports that since the lockdown 336 women and children reported incidences of violence of which more than 55% of cases faced violence from partners and 21% faced violence from other family members.⁴⁹

Decrease in reporting of violence during COVID-19 is noted in the UN Women Gender Equality update 2020 report, which suspects that this could either be due to women's inability to leave the house physically or make phone calls owing to the proximity of the abuser in the house itself. This study finds that in places such as Gorkha where cases of violence would traditionally be reported in local ward offices, are now being resolved in the community itself because women believe that the ward members will not take up their cases. This might also be one of the reasons for not reporting and, therefore, the trend in a decrease in formal reported cases.

The study finds that there are specific exacerbating factors contributing to an increase in VAW. Women whose husbands have lost their livelihoods/jobs or are being laid off temporarily from jobs might feel frustrated when they are unable to carry out their duties as a "man" in the household. Women are more likely to face IPV in such cases. Similarly, women in communities where gambling and alcoholism is high can be more vulnerable to face violence when they try to prevent men from spending money on alcohol and gambling. Due to household stress, children in households where there is frequent disputes among parents might be susceptible to stress and anxiety.

While this was beyond the scope of the study, there were emerging evidence from interviews with key informants that particular groups of children such as those with disability and those living in polygamous households faced increased abuses in the current context when parents were stressed out. In Kalikot, for example, children who faced extreme violence at home were rescued by neighbours and handed over to the police cell which has been sending them to shelter homes in another district, for example to Samajik Sewa Kendra, Dailekh in this particular case. The study finds that there are no formal support mechanisms for such children or child friendly spaces. While there are Child Rights Groups in wards these were not functional during the lockdown period.

Other groups who are susceptible to increased violence are older people and people with chronic illnesses. According to respondents, older people who are abused and neglected by their families are being sent to safe shelter homes in coordination with District Police Office (DPO). However, there might be others who are similarly neglected and abused but out of reach of such help. The Handicap International Nepal COVID-19 Assessment Report 2020 reveals that women living with disabilities are at risk of facing more domestic violence on account of being a burden to the family. They are also subjected to sexual violence. In the Terai districts such as Kapilvastu, key informant interviewees shared that since husbands have returned home and since women live in joint families they are facing double violence as reported below:

"Women are facing different kinds of violence. If we do not listen to our husbands then they beat us. They forcefully try to have sex with us even though we do not agree to it. I am pregnant, but still my husband forces me to have sex. I cannot make decisions over making love. I am having a lot of problem". KII, Woman, Community member, Kapilvastu.

⁴⁸ Civil Society Report on Beijing+25, NNBN, 2019.

⁴⁹ WOREC, 5 May 2020.

Women also reported a rise in domestic violence by mothers-in-law:

"A mother-in-law makes her daughter-in-law eat less during pregnancy saying that the baby inside will get unhealthy. She has to listen to her and eat less. She feels that her baby is not getting the right kind of nutrition. They raise cows in the house but she does not even get to drink milk. She has to bear emotional violence every day". KII, Woman, Community member, Kapilvastu.

According to key informant interviewees, women whose husbands are abroad are reporting that they are facing pressure from house owners and shopkeepers to pay off their debts. Adolescent girls such as in Kailali whose parents are stranded in India, shared that they feared for their safety as they are now alone in the community and due to lockdown they cannot go to their parents.

"I feel unsafe as my parents are working in India". KII, Adolescent girl, Community member, Kailali.

For returnee men and women migrant workers, social stigmatisation of carrying the Coronavirus has led to increased physical and emotional violence in places particularly in Western Nepal where the number of returnees are higher. Muslim women in Udayapur are facing violence and discrimination from other non-Muslim communities. The community people now refuse to buy their vegetables and ostracise them saying they are carrying Corona virus following the incidences where some Muslim men who were infected with COVID-19 had taken refuge in the Masjid instead of staying in the quarantines.

Women who were already facing difficult family relationships are found to be trapped with their perpetrators and are unable to extricate themselves out of such situations. They are exposed to increased control and restriction in mobility by their abusers.⁵⁰ Food insecurity, lack of access to health care, loss of livelihood, return of migrant spouse, inaccess to information regarding where and how to seek help, lack of support by family members and basically those devoid of social capital (networking or membership in social organisations) have been the common exacerbating factors for VAW and IPV.

Traditionally, women have less mobility and leisure time and are unable to share this stress with others. Besides physical violence, stress of losing an income source for the family, added household work and expenditure and depletion of savings are seen as major causes for increased psychosocial stress for women and men.

The study finds that there is a considerable pressure on the pre-existing protection mechanisms. As reported by the DPO of Surkhet the inquiry of cases like rape, witch allegation, and suicide face additional difficulty because of the current lockdown situation and so it is likely that there will be delayed justice which might have detrimental impact on women. In Banke, the Women's Police Cell, which deals with all GBV related cases, has seen a surge in women coming in for help.

According to the national level key informants, existing GBV reporting mechanism such as the National Women's Commission hotline, police hotline and child help hotline have been receiving reports and working towards long term solutions to eliminate VAW and violence against children and figuring out how to respond in the lockdown situation. Currently, observance of the practice of social distancing makes their job harder.

The current VAW redress mechanism is not adequate. According to key informant interviewees working locally, women do not feel safe after they report the cases. Women fear they may be subjected to more

⁵⁰ Covid-19 and Women's Human Rights: Guidance: What Is The Impact Of Covid-19 On Gender-Based Violence? UNHCR. 2020 April. 10p.

violence if the perpetrators come to know of the reporting and there is no means of escape as they live with the perpetrators 24/7 in the house.

Psychosocial problems such as suicides are expected to rise steeply in Nepal and largely among adolescents and young people as an impact of COVID-19. Suicide rate in Nepal is already among the highest in the world. The number of suicides is 24.9 per 100,000, as per the police data and projections calculated by WHO. There has already been increasing reports of suicide cases during the lockdown. Within the time frame of one month from 11 Chaitra to 10 Jestha, 2077 police report confirmed 163 deaths from suicide⁵¹, including suicides when remaining in quarantine.⁵² The Forum for Women, Law and Development (FWLD) has reported 500 cases of suicide during the 50 days of the lockdown period. The major cause of the growing trend of suicide is domestic violence and cybercrime.⁵³ Key informants were of the opinion that people trust NGOs more than government organisations as they believe that NGOs have better resources to follow up the cases regularly which is not possible with limited resources in the government's office.

4.7 Access to other services

Key Implications

- The current quarantine system has raised critical protection issues particularly for women and gender and sexual minority groups who are already vulnerable to sexual abuse. Insensitivity of service providers in dealing with such groups of people is another issue of concern.
- Groups likely to be marginalised due to the gaps in current targeting and information dissemination are single and elderly women who get social security allowances from the government, people who have small landholdings but are unable to earn an income from it due to chronic diseases, people living with HIV/AIDS and with disabilities who are unable to go to the relief centres, gender and sexual minorities who are not aware about the selection criteria and fear stigmatisation, and returnee migrants workers who are currently not living in their district of origin.
- Pregnant women and with small children are likely to be left out as the location of Ward Offices or distribution centres may be too far for them to reach or because of the lack of capacity by Ward Offices to manage overcrowding in the distribution centres. There were no separate provisions for them indicating that overall the current distribution system favours men and stronger people. Thus, management of current services might be deepening gender inequalities and poverty. This is inimical to the achievement of the SDGs, particularly SDG 5 which calls for achieving gender equality and eliminating violence against women and girls and SDG 10 which calls for reducing inequalities based on sex, age, disability, race, class, ethnicity, origin, religion or economic status and who are often exposed to intersecting inequalities and most-at-risk of being left.

4.7.1 Response and Relief

The government of Nepal along with the donor and INGO community started to respond to COVID-19 pandemic early on from 29th March 2020. The Ministry of Finance (MoF) issued the 'The Plan of Action for Relief in response to COVID-19 pandemic affected sectors, which included gender responsive provisions such as special attention to food and other necessities of pregnant women, disabled, elderly and children. A COVID-19 Prevention, Control and Treatment Trust was set up by using the current FYs budget at the local level.⁵⁴ The notice by the Social Welfare Council issued on 3 April 2020 was another important milestone for women and other intersectional groups.

⁵¹ Kantipur Daily, Rise in Incidence of Suicide in Lockdown. 2020.

⁵² Kantipur Daily, Suicide in Quarantine. 2020.

⁵³ FWLD

⁵⁴ Civil Society Policy Update, Analysis of GoN Relief Packages, 2020.

The notice highlighted the importance of using PPE and other health equipment as prescribed by MoHP, food for poor and severely disabled, hygiene and sanitation materials for different groups of women including LGBTIQ+ groups, awareness activities for the benefit of the population at risk. Relief packages were distributed to the most poor and vulnerable households including that for single women and women headed through a one-window relief distribution system as directed by the Ministry of Federal Affairs and General Administration (MoFAGA) on 1 April, 2020.

Currently, several organisations including the donors, INGOs and local community groups participate in the response system meetings, which have a cluster on protection. In each cluster there are spaces for inputs on gender and intersectional issues. Inputs are obtained through regular meetings with concerned groups such as in the GiHA TT Group where concerns of marginalised and vulnerable groups are raised and discussed in the presence of the government bodies as well.

Due to the lack of appropriate space and medical facilities, community buildings, home-stays, hotels, schools and NGO buildings are being used as quarantine centres across different provinces. Key informants throughout the study districts and at the national level raised severe concerns regarding protection and adequate WASH facilities to meet the special needs of vulnerable populations.

The quarantine assessments conducted by NHRC in all the Provinces had similar concerns around protection of women and children, food security, WASH, medical supplies and support, occupancy of spaces (e.g. schools), lack of understanding standards and protocols developed by the government. There were also grievances around management of quarantines. In addition, the idea of self-isolation to control the spread of COVID-19 was not possible for those living in slums and crowded spaces. NHRC has made recommendations to the Provincial government to rectify the lacunae, drawing the attention of the government to the explicit need to maintain WHO's standards in those facilities.⁵⁵

In many quarantine centres, men and women sections are not separated and there are no provisions of separate toilets for women and LGBTIQ+ groups. According to key informants, social leaders in the Muslim community (Kapilvastu) are concerned that COVID-19 virus testing in Muslim communities have been taken without considering the belief and norms of the community. Women are forced to comply with government rules for collecting swabs in public, which is against their local norms. There are no special provisions for groups who have different dietary requirements such as pregnant women, lactating mothers and children under five in quarantines.

The safety and security for women in quarantine is another issue. In some places such as in Bardiya and Kailali there are only two quarantine rooms for women and no specific rooms and toilet facilities for people from the LGBTIQ+ community. Incidences of sexual violence against women in quarantines, has raised serious concerns from different stakeholders about the adequacy of government's protection mechanism. In response, the government committed to deploy adequate women police to ensure protection against sexual violence in the quarantine centres. However, they were yet to be deployed, as at the time of data collection for the study this had not taken place.

Local governments have already provided the first phase of the relief package and are in process of second phase of distribution in most of the study districts. Material support distribution was prioritised to disadvantaged and non-disadvantaged people with low income identified through a local committee group discussion participated in by representatives of all political parties.

⁵⁵ Nepal Press Bulletin, The Kathmandu Post. 2020 May 19.

4.7.2 Perception of Relief and Distribution System

The study finds mixed perceptions about the relief packages and distribution systems. Community members in several study districts such as Kapilvastu, Siraha, Saptari were of the opinion that the distribution was biased with people providing relief materials to their own relatives or to their voting constituencies and leaving out the most needy. Among 58% of respondents who did not get the relief packages, 55% felt that men are prioritised in the distribution system. 18% found that current distribution locations are inconvenient for girls and women and in 22% of the cases, girls and women were not permitted to access services by families because the distribution system did not respect local norms and values. There are also mixed responses around the usefulness of cash and in-kind transfers. 57.42% of respondents favoured in kind support, while 47.3% preferred cash assistance.

However, in some districts like Gorkha and Rasuwa, the elderly felt happy that they were getting some support from the government and in others, community people felt they were targeted to the poorest, who should rightly be getting the relief packages.

Key informant interviewees were concerned about women who have migrated for domestic work in destination countries and who may not have access to information and support from the state as they have used illegal channels to migrate owing to the ban on domestic workers to seek employment abroad especially in the Gulf countries. These women are also less likely to get any information regarding help. Children from such households in the absence of migrant mothers might be living in destitute conditions and the current relief measures are likely to leave them behind. They felt that such groups along with their children and families should be prioritised while providing messages and support packages.

Key informant interviewees assessed the current relief measures to be of a short-term nature. They were of the view that the government at all levels should implement targeted interventions to protect women, women farmers and market vendors and that the current efforts should support economic activities such as cash for work, food for work and cash transfer schemes to alleviate the conditions of poor families.

According to organisations working for persons with disabilities, the current relief distribution system does not ensure safe and easy access to relief measures by persons with disabilities. In local contexts, safe access for persons with disabilities to the relief package whether it is cash or food, during the lockdown period, is essential. Considering the extra cost to be covered by persons with disabilities to cope with such an emergency situation, additional protective and specific measures must be taken along with additional social protection measures and cash transfer.

According to key informants at national and district levels, there is no provision of additional nutritious food for pregnant women, lactating mothers and children under five in districts such as Surkhet, Kalikot, Kailai and Bardiya.

Problems of targeting came from several districts. People receiving social security allowances, people from LGBTIQ+ communities, single women and older people who had no livelihood sources but receiving social security allowances and people who had small landholdings but were receiving medication (such as people living with HIV/ AIDS) and had lost wage labour were denied access to relief packages owing to the eligibility criteria set by the government.

"They denied me relief packages saying that I was getting my old age allowance and that the relief packages are only being distributed only to the extremely vulnerable".

KII, Woman, Community member, Gorkha

"I was denied relief packages as I have 3 kattha land (10,935 sq. feet). My husband is a wage-worker and he has no work now. I am HIV positive and don't have money to buy any medicines". KII, Woman, Community member, Kailali

Additionally, internal migrants who are not currently living in their district of origin and gender and sexual minorities who were not aware of the selection process did not get relief materials in some districts as expressed in the quote below by a gender and sexual minority respondent:

"I wish I was a beneficiary of the relief packages as well". KIII, Sexual minority, Community member, Kailali

The other grievances were about security concerns. Some women did not find the environment secure when they went to collect the relief materials since people were infuriated by the inadequacy and inaccessibility of relief materials and skirmishes often broke out during the relief distribution process.

"There were problems of chaos and fights in the distribution centres at the time of relief distribution. I did not feel secure." KII, Woman, Community member, Saptari.

There were also challenges faced by the Service Providers. Interviews with sectoral leads and co-leads and members from international and national civil society organisations who have been working during the lockdown reveal that they are working under considerable constraints. While this needs a deeper analysis some of the current challenges were as follows:

- Resource constraints to continue the relief programme if the lockdown is extended for longer period.
- Owing to the nature of the COVID-19 pandemic, current interventions are costly. The need for more vehicles, which increases operational costs and expenses for safety materials such as PPE, sanitizers and gloves have imposed immense constraints on resources.
- There is also a realisation of the lack of human resources for example specialists who can provide services with speed to make sectoral responses gender and child friendly.

Some key informants find the new federal structure to be a challenge. According to them, the working modality is not uniform and firmly established. The current working modality is informal and depends on social and political status of the community. They find that in emergency situations such as this, they would prefer to work in a formally defined system where mandates and boundaries are clear. Having said that, some key informant interviewees were also of the opinion that the centralised decision-making and lack of authority to modify standards and guidelines as per local conditions of work hampers quick turnaround to situations as demanded.

Currently there are co-ordination challenges between ministries, different tiers of government, department and actors for the coherent and cohesive planning and implementation of the work, which immobilises response mechanisms.

5. Conclusions

The overall objective of this RGA was to understand if and how existing gender discrimination and inequalities have been exacerbated by the lockdown in the wake of the COVID-19 pandemic in the community and in quarantine situations. The RGA, through its intersectional approach, found that the most affected groups included daily wage-workers, farmers, landless women, women working in the AES, women from Dalit and Madhesi communities, gender and sexual minorities, women from geographically disadvantaged locations, women with disabilities, adolescent girls, wives of migrant husbands, displaced women, and those living with HIV AIDS.

Significant impacts were seen in the increased burden of unpaid care work on women as a result of the lockdown which not only increased risk of transmission of the virus but also increased the indirect impacts such as physical, emotional and psychological stress and impacting further on their time-poorly to be able to engage in income generating activities as well as participate in community-level responses.

Loss of income and employment has had negative impacts on household assets and savings with the lack of decision-making of women in these areas, becoming more pronounced. Findings reveal increases in VAWG, particularly IPV, suicide, maternal deaths and mental health related problems among the general population as resources get diverted in containing the spread of COVID-19. Furthermore, coping strategies in the form of cutting down on food and food consumption could lead to malnourishment among a sizeable group of the population. The pressure to provide for the family and self is forcing people to take up risky jobs as a survival strategy, which may make the marginalised population more vulnerable to COVID-19.

Findings indicate that the current relief measures, response and quarantine services have failed to address specific needs of groups such as lactating mothers, pregnant women and women with new-born babies, gender and sexual minorities and Muslim women including lack of security and safety in quarantine conditions. Attention needs to be placed on mitigating barriers related to access to and availability of services, such as food, health including reproductive health, psychosocial counselling as well as information and updates on COVID-19. 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.

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. Detailed recommendations with identified actors are provided in Annex 1.

6.1 Short-term recommendations

- Address the current shortcomings in all quarantine centres and improve the facilities that ensures the safety, security, dignity and specific needs of vulnerable and excluded groups in line with the GESI Monitoring Checklist by linking existing referral service mechanisms with adequate human and financial resources through consultations with local groups.
- Engage women networks and excluded groups in the high-level committee formed for COVID-19 response mechanism and ensure their increased meaningful participation and representation in coordination mechanisms at all levels.
- Provide immediate support to ensure food security of the most vulnerable households, including through unconditional cash transfer and in-kind assistance by adjusting social security allowances, livelihood and relief support provisions to adapt to the needs of marginalised (intersectional) groups that are currently excluded including doing away with cumbersome processes such as presenting identity documents to access relief support/materials.
- Strengthen sex, age, diversity, and disability data recording and analysis for all crisis situation to mainstream gender responsiveness in all humanitarian actions.
- Ensure access to information for all in the community through the use of different information channels and local languages. This includes the use of community counselling and hotline services, collaboration with media houses, and various actors to make information accessible to marginalised people and especially to those that have no access to information.

- Disseminate simple messages to raise awareness about the negative impacts of COVID-19 to eliminate VAWG; stigma and discrimination against frontline health workers, returnee migrant workers, and Muslims in spreading COVID-19; sharing of household work to lessen the burden of increased household and unpaid care work on women and adolescent girls; and, transform social norms.
- 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.
- Conduct orientations to sensitise health workers on ensuring the safety and dignity of patients, as well as on the specific needs of women, girls, LGBTIQ+, elderly people, people living with disability and HIV/AIDS and other vulnerable groups.
- Mobilise FCHVs as essential health workers and other health professionals to resume door-to-door services primarily for pregnant and lactating women, without adding to the increased work-burden and health risks of women and FCHVs.
- Roll out the Comprehensive Essential Package in line with ILOs Social Protection Floor 2012 number 202 for vulnerable and excluded groups to compliment the ongoing efforts of the GoN.
- Recognise GBV services as essential services by rolling out the Comprehensive Essential Packages (health, legal, safe shelter psychosocial counselling, referral, and empowerment) and building the capacities of One-stop Crisis Centres and other service providers for providing services and meaningful support to the GBV survivors and others who are in need of such services by collaborating with various stakeholders including the private sector for providing such comprehensive essential packages (health, legal, safe shelter psychosocial counselling, referral, and empowerment).
- Prioritise GBV cases for adjudication by the judiciary in dealing with impunity specially during crisis situations.
- Focus on inclusion of women in health and other sectors including in the security sector to ensure gender responsiveness in COVID-19 and other humanitarian crisis responses.
- Strengthen monitoring bodies such as the NWC, NHRC and other Commissions to monitor the implementation of GESI issues in line with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) including the Guidance note on CEDAW and COVID-19 and call for joint action in the times of COVID-19 pandemic, statement adopted on 21 April 2020 by the CEDAW committee.
- Roll out gender responsive economic stimulus packages especially for daily wage workers, vulnerable and marginalised groups to prevent them further falling into the destitution trap which forces them to accept risky jobs.
- Emphasise operationalising of local collection centres for marketing of locally produced goods including agricultural products as has been practiced by the local government in Rasuwa.

6.2 Mid and Long-term recommendations

- Increase access to psychosocial counselling throughout the country for people of all ages, along with creating awareness and reducing stigma towards mental health counselling as a part of the current COVID-19 protection messaging.
- Integrate mental health and psychosocial issues in training curriculums and school text-books in partnership with government and non-government entities.
- Ensure government, development partners and NGOs working on disaster preparedness, response and recovery programmes include social norms change, GESI 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.

- Design future programmes to address the long-term social, political and economic impacts of the COVID-19 pandemic on vulnerable and marginalised groups by ensuring universal basic income and livelihood options in public works to address care deficits which includes employment intensive social infrastructure projects and service delivery.
- Collaborate with various stakeholders in scaling up local innovative approaches in agriculture and agro-based industries by linking them with current national agriculture development and livelihoods programmes.
- Ensure the meaningful participation and equal leadership of women and marginalised social groups in disaster response, preparedness and risk reduction at all levels.
- Enhance women, girls, and marginalised groups access to and build their knowledge on digital technologies.
- Promote initiatives that emphasise reducing women's and girls' time use through appropriate and energy saving technologies to lessen their household work-burden.
- Strengthen gender responsive budgeting across sectors/levels in health, protection, education, agriculture, service (including tourism and hospitality sectors) and manufacturing sectors to address the economic and social needs of the most marginalised and vulnerable women especially during humanitarian crisis response and recovery.
- Conduct more in-depth and broad-based analysis of macro-economic framework including trade, monetary and fiscal policies from a GESI lens for informing the government's COVID-19 socio-economic response and recovery framework that is gender transformative.

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Annex

Annex 1: Recommendation with Elaboration

Recommendation	Elaboration of Recommendation	Actor(s)
Short-term (Immediate) Recommendations		
<p>Address current shortcomings in all quarantine centres and improve the facilities that ensures the safety, security, dignity and specific needs of vulnerable and excluded groups in line with the GESI monitoring Checklist by linking existing referral service mechanisms with adequate human and financial resources through by linking them with existing referral service mechanisms with adequate human and financial resources through consultations with local groups.</p>	<p>There is an urgent need to address the gaps in quarantine centres and improve quarantine facilities to meet specific needs of vulnerable and excluded groups such as lactating and pregnant, women, people with disability, LGBTIQ groups, children, elderly people, single women, women with children, people with health complications etc. Such services should ensure, sex, age, diversity and disability data collection, information and record keeping, provision of dignity and hygiene kits supplies and services; adequate and nutritious food, wash and infrastructure facilities, logistic/transportation support; security and safety, physical distancing; discrimination and stigma free environment, psychosocial and recreational support and prevention against gender-based violence, sexual harassment. It is also important that such facilities have separate and suitable toilets for women, those with disabilities, elderly people and LGBTQI+ that ensures their privacy with running water, soap and towels that are cleaned regularly and safe disposal of used dignity kits. Orient the security personnel on gender sensitive behaviour and practice while communicating with the citizens.</p> <p>Also link quarantines with other referral service mechanisms ensuring allocation of adequate human and financial resources. Such allocations should be done in consultation with local groups. The GESI Monitoring checklist is available at:</p> <p>https://mowcsc.gov.np/uploads/uploads/w6zktY8PZq5imcjW2Nc4IYwjpp2coT22R0wlzPYs.pdf</p>	Government (Local and Federal) with support of development partners (non-government actors)
<p>Engage women networks and excluded groups in the high-level committee formed for COVID-19 response mechanism and ensure their increased meaningful participation and representation in coordination mechanisms at all levels.</p>	<p>Women and excluded groups must be included in all COVID-19 response and co-ordination mechanisms and especially in the High Level Committee formed for the COVID-19 response and co-ordination mechanisms as they bring a different perspective to the design of response and recovery interventions. Participation of women and excluded groups in decision-making, health and security sectors has positive impacts in equitable resource allocation in areas where they are most needed, focus on risks and vulnerabilities of marginalised populations, emphasis on addressing VAWG and generating commitment to gender equality that allows diverse actors to come together and reach consensus on a common agenda.</p>	

<p>Provide immediate support to ensure food security of the most vulnerable households, including through unconditional cash transfer and in-kind assistance by adjusting social security allowances, livelihood and relief support provisions to adapt to the needs of marginalised (intersectional) groups that are currently excluded including doing away with cumbersome processes such as presenting identity documents to access relief support/materials.</p>	<p>Protect vulnerable populations such as returnee women migrant workers, daily wage-workers, those who have lost their earnings and other socially vulnerable groups, home based and domestic workers through unconditional cash and in-kind transfers.</p> <p>The government needs to develop policy and implementation procedures (guidelines) that allow for easy access to relief materials and support.</p>	<p>Government together with stakeholders such as I/NGO, CSOs and issue based organisations</p>
<p>Strengthen sex, age, diversity, and disability data recording and analysis for all crisis situation to mainstream gender responsiveness in all humanitarian actions.</p>	<p>To address the gaps in disaggregation of data, it is important to collect date by age, sex, caste, ethnicity, socio-economic status, health status and spatial disaggregation, which will inform the design of relevant responses. This will help in strengthening gender responsiveness in all humanitarian actions.</p>	<p>All Government, development partners and non-government actors</p>
<p>Ensure access to information for all in the community through the use of different information channels and local languages. This includes the use of community counselling and hotline services, collaboration with media houses, and various actors to make information accessible to marginalised people and especially to those that have no access to information.</p>	<p>Collaborate with organisations who have long-standing experience on community orientation to adapt current communications in local languages making it accessible to people who are not formally educated, those with disabilities, elderly people among others.</p> <p>Collaborate with media houses, and various actors and make information accessible to marginalised people focussing on those have no access to information and raise awareness around relying on formal sources for information on COVID-19.</p>	<p>Governments at all levels, development partners, I/NGOs and media</p>

<p>Disseminate simple messages to raise awareness about the negative impacts of COVID-19 to eliminate VAWG and stigma and discrimination against frontline health workers, returnee migrant workers and Muslims in spreading COVID-19; and sharing of household work to lessen the burden of increased household and unpaid care work on women and adolescent girls; and, transform social norms.</p>	<p>Design messages in simple and easily comprehensible language to create awareness on reducing stigma and discrimination against front health workers, returnee migrant workers and Muslims to communicate that COVID-19 is not attached to specific groups of people to dispel the myths surrounding the virus and its treatment; the importance of not engaging in violence towards women, reducing the work load of women and adolescent girls including child labour to erase the traditional gender division of labour, gender hierarchy and discriminatory practices and attitudes against girls and women as a part of the current COVID-19 protection messaging.</p>	<p>Government together with stakeholders such as I/NGO, CSOs and issue-based organisations</p>
	<p>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.</p> <p>Government and non-government entities need to work together to ensure safe and comprehensive SRHR services that are aligned with the Minimum Initial Service Package (MISP). The MISP is to ensure the availability of RH services that have the most impact on reducing RH-related morbidity and mortality in the early days and weeks of new emergencies. The MISP is a coordinated set of activities designed to prevent and manage the consequences of sexual violence, reduce transmission of human immunodeficiency virus (HIV), prevent excess new-born and maternal morbidity and mortality, and to plan for comprehensive RH services. It also outlines activities for ensuring RH in emergency preparedness and immediate response efforts which are critical for national governments and humanitarian response agencies.</p> <p>For more information and guidance on the design of programs and planning comprehensive RH programmes after the emergency, the following references can be consulted:</p> <p>“Reproductive Health in refugee situations, an Inter-agency Field Manual”</p> <p>“Reproductive Health in Conflict and Displacement, A guide for programme managers”</p> <p>Available on: http://www.who.int/reproductive-health/ under Resources.</p>	<p>Government and development partners organisations and emergency response actors</p>

Conduct orientations to sensitise health workers on ensuring the safety and dignity of patients, as well as on the specific needs of women, girls, LGBTIQ+, elderly people, people living with disability and HIV/AIDS and other vulnerable groups.	Sensitise health workers on asking and probing questions on sensitive issues related to reproductive health, VAW/GBV and maintaining privacy for building trust and providing relevant treatment. Mobilise health professionals to identify groups at high risks in the community such as pregnant women, people living with HIV/AIDS and LGBTIQ+, elderly people, people living with disability and HIV/AIDS and other vulnerable groups who experience barriers to accessing regular health facilities and can make provisions for separate treatment for those specific groups.	Government and development partners organisations and emergency response actors
Mobilise FCHVs and other health professionals to resume door-to-door services primarily for pregnant and lactating women, without adding to increased work-burden and health risks of women and FCHVs.	Since the FCHVs are trusted by the local communities their support should be mobilised so that interventions could also include components for timely treatment of women who go into labour including managing transportation facilities and making contraceptives available locally and free of cost. This should be one of the priority areas during emergency responses.	Government and development partners organisations and emergency response actors
Roll out the Comprehensive Essential Package in line with ILOs Social Protection Floor 2012 number 202 for vulnerable and excluded groups to compliment the ongoing efforts of the GoN.	Roll out the Comprehensive Essential Package in line with ILOs Social Protection Floor 2012 number 202 for vulnerable and excluded groups to compliment the ongoing efforts of the GoN. A comprehensive rights-based approach to support women from the excluded groups. This includes a diversity of methods and approaches, ensure protection of rights and dignity of beneficiaries, non-discrimination, gender equality and will be responsive to special needs. These kind of packages consist of support such as - access to food, access to energy, access to essential supplies (soap, medicines, sanitizers, masks, sanitary napkins); access to information and communication, additional support for rural women (subsistence agriculture, livestock management, additional support like animal/poultry feed, seeds and technology for farms and kitchen garden), access to essential health services including psycho social support, trauma counselling, GBV related support; access to financial services, access to digital services; support to cash based interventions.	All level Government and development actors (bilateral, multilateral I/NGO, civil society and Private sector

<p>Recognise GBV services as essential services by rolling out the Comprehensive Essential Packages (health, legal, safe shelter psychosocial counselling, referral, and empowerment) and building the capacities of One-stop Crisis Centres and other service providers for providing services and meaningful support to the GBV survivors and others who are in need of such services by collaborating with various stakeholders including the private sector for providing such comprehensive essential packages (health, legal, safe shelter psychosocial counselling, referral, and empowerment).</p>	<p>There is enough evidence to show that VAWG and GBV increase in times of humanitarian crisis. The COVID-19 lockdown has seen a rise in increased GBV cases. Therefore, GBV comprehensive services must be seen as part of essential services that must be continued during humanitarian crisis situations and the current COVID-19 pandemic by implementing the Comprehensive Essential Package for timely treatment, relief and rehabilitation of GBV victims/survivors.</p> <p>The government should work with other stakeholders (I/NGO, private sectors and CSOs) to strengthen One-Stop Crisis Centres and build capacities of such centres and other service providers learning from successful examples in other countries and UNFPA, Nepal.</p>	<p>All level Government and development actors (bilateral, multilateral I/NGO, civil society and Private sector</p>
<p>Prioritise GBV cases for adjudication by the judiciary in dealing with impunity especially during crisis situations.</p>	<p>The current COVOD-19 lockdown has resulted in more deaths from GBV than from the Coronavirus itself. GBV cases must be dealt with the urgency that they require for promoting the rights of GBV victims/survivors to live a life free from violence. This includes ending impunity against violence by ensuring the rights of GBV victims/survivors to be protected from violence. It behoves on the state and particularly on the judiciary to deal with GBV cases by providing swift justice to deal with GBV perpetrators and not treat GBV as ordinary individual criminal cases to be dealt with at leisure.</p>	<p>All level Government, and Development partners</p>
<p>Focus on inclusion of women in health and other sectors including in the security sector to ensure gender responsiveness in COVID-19 and other humanitarian crisis responses.</p>	<p>Humanitarian crisis have differential impacts on men and women with women and people from gender and sexual minorities, those living with disabilities and other diseases, elderly people and children from vulnerable and marginalised communities suffering the most. Deliberate focus on these dimensions of humanitarian crisis is key to achieving SDG 5 on gender equality and GSDG 10 on reducing inequalities by ensuring that women are actively engaged in health, security and decision -making.</p>	<p>Federal government</p>

<p>Strengthen monitoring bodies such as the NWC, NHRC and other Commissions to monitor the implementation of GESI issues in line with the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) including the Guidance note on CEDAW and COVID-19 and call for joint action in the times of COVID-19 pandemic, statement adopted on 21 April 2020 by the CEDAW committee.</p>	<p>As state party to CEDAW, the government is obliged to implement its commitment to achieving women's empowerment and gender equality including the recommendations of the CEDAW Committee and report on its progress. Therefore, it should enhance the capacities of NWC, NHRC and other Commissions to monitor progress as well as areas that need to be improved. This can be done in collaboration with other stakeholders and actors both government and non-governmental at all levels.</p>	<p>Federal government</p>
<p>Roll out gender responsive economic stimulus packages especially for daily wage workers, vulnerable and marginalised groups to prevent them further falling into the destitution trap which forces them to accept risky jobs.</p>	<p>With loss of livelihoods and income of daily wage workers, vulnerable and marginalised groups they are on the verge of falling further into poverty and destitution. As a survival strategy they are willing to accept risky jobs and their vulnerability to trafficking has been exacerbated that can become death strategies. The government must act swiftly and roll out economic stimulus packages (ESP) as a safety net to meet their immediate cash and other daily needs. The design of policy responses and efforts to engender the ESPs should not only look at influencing short-term responses to mitigate the impact of the pandemic but also make a case for the stimulus package as a development instrument that could potentially set the stage for instituting policies that are more attuned to issues of redistribution, social justice and gender equality. This demands strategic gender responsive fiscal policy responses to divert the adverse long-term effects of the COVID 19.</p>	<p>Federal government</p>
<p>Emphasise operationalising of local collection centres for marketing of locally produced goods including agricultural products as has been practiced by the local government in Rasuwa.</p>	<p>Traditional markets such as Haat Bazaars for selling of agriculture produce and other products by the local people creates resilience especially in times of crisis. In order to ensure that locally grown vegetables and other products are not wasted, promoting sale of such items in Haat Bazzars provide the much needed income for producers and at the same time provides consumers to purchase the needed goods at affordable prices. The local governments should promote such practices by activating local collection centres to for quality assurance, control of prices and maintaining regular income of producers.</p>	<p>Provincial and Local governments</p>

Mid and Long-term recommendations		
Increase access to psychosocial counselling throughout the country for people of all ages, along with creating awareness and reducing stigma towards mental health counselling as a part of the current COVID-19 protection messaging.	<p>The government should partner with the donor community and private sector to increase the number of psychosocial counselling throughout the country for people of all ages and make it more easily accessible.</p> <p>It can use trained cohorts of psychosocial counsellors knowledgeable on GBV issues and provided services including counselling and who were previously located in the Women Development Offices (WDO) in each district.</p> <p>Similarly, there are trained social mobilisers who have worked on GBV issues and have successfully referred GBV survivors to formal GBV government response mechanisms. They can be used as critical human resources for responding to GBV, community violence and mental health issues. The government should also focus on formation/activation of the referral pathways in the community to report and manage the VAW and GBV cases including the proper management of hotlines and other services.</p>	All levels of government together with development partners
Integrate mental health and psychosocial issues in training curriculums and school text-books in partnership with government and non-government entities	<p>In order to make VAW and GBV a matter of public issue and not relegate it to the private domain, the government and non-government actors should work together towards integrating mental health and psychosocial issues as important components of training curriculum and school text-books to emphasise that VAW and GBV are gross violation of human rights.</p>	All levels of government together with development partners
Ensure government, development partners and NGOs working on disaster preparedness, response and recovery programmes include social norms change, GESI and protection issues as integral components of their work by adapting the current district disaster response plans to address these issues in health emergencies such as the COVID-19 pandemic.	<p>Adapt and expand existing social norm change programmes for example, "Sama Jodi" by Government, "Tipping point"; "Aba Mero Palo" by CARE, "Choices, Voices and Promises" with young adolescent's girls and boys by Save the Children and Rupantaran etc.) to integrate lessons on addressing GBV and promoting gender equality during emergencies, to help adolescents access alternate education, build personal resilience towards violence in face of humanitarian emergencies.</p> <p>Ensure that disaster preparedness, response and recovery programmes have components in addressing harmful practices and social norms change right from the planning and design stage – eg., addressing the norms that promote child marriage, work burden, GBV and girls education hindrance.</p>	All level Government and response actors

<p>Design future programmes to address the long-term social, political and economic impact of the COVID-19 pandemic on vulnerable and marginalised groups by ensuring universal basic income and livelihood options in public works to address care deficits which includes employment intensive social infrastructure projects and service delivery.</p>	<p>Since COVID-19 is not going to go away any time soon it will have a long-lasting impact on people's physical, psychosocial wellbeing including on their livelihoods and income. Therefore, future programmes should be designed by undertaking a gender-sensitive political economy analysis that provides a thorough understanding of the implications of the COVID-19 pandemic and to address the long-term impacts of the pandemic on vulnerable and marginalised groups. Equal access to employment opportunities could be enhanced by expanding the concept of "public works" to include employment-intensive social infrastructure projects and service delivery. This should also include projects such as auxiliary health care, care for the elderly, childcare, early childhood, and youth development activities components which will attract and employ women as well as lessen the burden of unpaid care work of women. It is also very important not to create sectoral silos in COVID-19 response work and thus GESI and protection should be integral part of the response work of the government, organisations and different projects.</p> <p>Ensure the provision of universal basic income for groups that are far below the poverty line to strengthen their social protection. Create women's farmers group and lease public land available in rural areas at less cost to support women farmers, returnee women migrant workers, women in construction sector, the entertainment sector or any informal sector. Link such groups to markets but as well as to other auxiliary services such as the ward agricultural offices, government veterinary services, local agricultural co-operatives and seed banks, cooperatives etc.</p> <p>Map out existing programmes being implemented by different donors and implement a nationwide livelihoods programme in co-ordination with the donor-funded programmes. The government should take women and minority groups leaving vulnerable jobs such as in AES as an opportunity to provide safer livelihood options through these interventions. It also can use returnee migrant workers to skill those who need skilled jobs and employ them in producing goods that can substitute imports and increase exports.</p>	<p>Government in collaboration with development partners and the private sector.</p>
<p>Collaborate with various stakeholders in scaling up local innovative approaches in agriculture and agro-based industries by linking them with current national agriculture</p>	<p>Support innovative efforts in agriculture, which would contribute to increased income of women and marginalised groups even during the pandemic. Such localised efforts should be scaled up to other municipalities. Local agro-enterprise groups consisting of women from vulnerable and excluded groups could be established and linked to local financial institutions such as co-operatives through special</p>	<p>All level government with support of development partners</p>

development and livelihoods programmes.	support programmes. Other livelihood support should include seed money, insurances and linkages to auxiliary services (such as seed banks, local agriculture and veterinary services) market systems such as by tying them up with agriculture co-operatives that exists locally. Local governments can then tie up the farmers particularly those belonging to marginalised groups with current agriculture based livelihoods support such as the proposed land bank schemes and programmes such as the Prime Minister Agricultural Modernisation Programme, President Women's Empowerment Programme and Garib Sanga Bisheswore Programme by undertaking through gender analysis.	
Ensure the meaningful participation and equitable leadership of women and marginalised social groups in disaster response and preparedness at all levels.	Actors should work to ensure meaningful participation and leadership of women. This can be done by re-enforcing the existing policies and guidelines, sensitising local leaders and building confidence of women thorough trainings, orientation and exposure and also building confidence of men that equal participation of women is not a threat for men's space. Ensure that the equal participation is ensured through all the interventions.	The government, private sector and non-government stakeholders
Enhance women's and marginalised groups access to and build their knowledge on digital technologies.	The government, private sector and non-government stakeholders could work together to improve knowledge and build confidence of women and girls in using digital technology and increasing access to digital technology as part of livelihood support interventions.	The government, private sector and non-government stakeholders
Promote initiatives that emphasise reducing women's time use through appropriate and energy saving technologies to lesson their household work burden.	Promote use of alternative energy such as improved cooking stoves, metal stoves, solar power and gas cooking stoves as relevant and prioritise restoring water supplies. This will help to reduce women's household work burden and improve their health, save water and energy resources and at the same time promote the use of technology for uplifting rural women's poverty.	All levels of government and Development partners

<p>Strengthen gender-responsive budgeting across sectors/levels in health, protection, education, agriculture, service (including tourism and hospitality sectors) and manufacturing sectors to address the economic and social needs of the most marginalised and vulnerable women especially during humanitarian crisis response and recovery.</p>	<p>Usually responses to humanitarian crisis entail meeting the immediate needs of affected people on a blanket basis thus leaving out the specific needs of the most vulnerable and marginalised. The application of gender responsive budget methodology and tools should be a mandatory practice in humanitarian crisis situations to ensure that relief materials designed to the specific needs of affected populations provide actual relief. At the same time, in order to strengthen health, protection, education, agriculture, service (including tourism and hospitality sectors) and manufacturing sectors in the long run, it will be important to apply gender responsive budgeting and auditing (GRBA) tools and methodologies to design gender responsive economic stimulus packages to ensure that it reaches the most needy, poor and vulnerable women. Gender budget audits should be a regular practice of monitoring effective implementation of all development plans and programmes including aid effectiveness in a gender responsive manner.</p>	<p>All levels of government and Development partners</p>
<p>Conduct more in-depth and broad-based analysis of macro-economic framework including trade, monetary and fiscal policies from a GESI lens for informing the government's COVID-19 socio-economic response and recovery framework that is gender transformative.</p>	<p>Crisis also provide opportunities in transforming "business as usual" to designing gender-responsive interventions. There is a need for a more in-depth and broad-based analysis of the macro-economic framework to examine the gender differential impacts of trade, monetary and fiscal policies to design gender responsive policies and programmes. The design of policy and programme responses should not only look at influencing short-term responses to mitigate the impact of the pandemic but also make a case for recovery that could potentially set the stage for instituting policies that are more attuned to issues of redistribution, social justice and gender equality. This demands strategic gender responsive fiscal policy responses to divert the adverse long-term effects of the COVID 19. It entails adequate fiscal space for investing in gender equality through inclusive fiscal policies that focus on empowering women, vulnerable and marginalised groups for achieving gender equality.</p>	<p>Federal government and Development Partners</p>

Annex 2: Research questions

The study endeavours to answer the following research questions:

- What (if any) are the gender differential impacts of COVID-19 on women, girls and other gender and sexual minorities (with specific focus on vulnerable and excluded groups) considering the pre-existing and emerging vulnerabilities?
- What (if any) are the impacts of COVID-19 on health, WASH, GBV, access to information, gender roles including care work, leadership and decision-making, livelihood and income for vulnerable populations?
- What are the available relief measures and services (quarantine package) adopted to reach these marginalized groups as part of the government's response measures?
- What are the challenges faced by these marginalized groups in accessing services including access to information, quarantine/isolation/shelter/relief, quarantine packages, psychosocial counselling for GBV?
- How are they coping with these challenges? If/if not there is a space for their voice in access to these services?

Annex 3: Demographic profile of respondents

Table 1: Demographic Information

National Level Key Informant Interview	District Level Key Informant Interview	Non-community level Key Informant Interview	Community member In-depth Interview	Community member (Survey)
No: 15 Male: 4 Female: 11	No.: 26 Male: 7 Female: 19	No.: 100 Male: 46 Female : 54	No.: 90 Male: 27 Female: 62	No.: 209 (All female)
<ul style="list-style-type: none"> • Cluster Lead • Ministry • Member of various organization (Women right based Organization) 	<ul style="list-style-type: none"> • Deputy-Mayor or Vice chairperson of Rural/Municipality • Member of District Coordination Committee • Focal person- Women & Children, District Police Office 	<ul style="list-style-type: none"> • Member of Gender Based Violence Committee • Dalit Sadashya (member in ward committee) • Dalit Mahila Sadashya (women member in ward committee) • Teacher- Principal • Ward President • Social Mobilizer • FCHVs • Women's Cooperative • Journalist • NGO/ INGOs representative 	<ul style="list-style-type: none"> • Women/ Men form Indigenous, Dalit, Muslim, Ethnic Community • Mixed Category <ul style="list-style-type: none"> ◦ Adolescent Girls/ Boys ◦ Gender and Sexual Minorities ◦ Single Women ◦ Pregnant and Lactating women ◦ Female Community Health Volunteers ◦ Women living with HIV ◦ Women with bonded labour history ◦ Male/ Female Domestic & Wage workers ◦ Women / Men involved in informal sector & small business ◦ Male Suffering from other disease apart from COVID- 19 ◦ Male Migrant Returnee ◦ Left-behind Women (from India and other third countries) ◦ Women from migrant household ◦ Women working in brick kilns, stone quarries ◦ Women/ Men with disability due to 2015 earthquake 	

Table 2: Profile of respondents (All including qual & quant)

Category	No of resp	% of resp
Male (including KII)	84	19.1
Female	356	80.9
Total Respondents by Gender	440	100%
Dalit	107	24.3
Indigenous	112	25.4
BC	142	32.8
Madhesi	61	13.9
Muslim	16	3.6
Total Respondents by Ethnic Groups in survey	440	100%
Adolescent Girl	5	1.1
Adolescent Boy	5	1.1
Women suffering from disease other than COVID 19	17	3.8
Women working in Entertainment sector	7	1.6
Single Women	20	4.5
Professional Women (FCHVs, teacher, and others) or working in formal sector	20	4.5
Pregnant and Lactating Women	26	6
Women wage workers, including home-based workers	24	5.4
Women with disabilities	12	2.7
Sexual and Gender Minorities	9	2
Domestic Workers	17	3.8
Women living with HIV/AIDS	7	1.6
Migrant returnees women	10	2.2
Women involved in informal sectors and small business	10	2.2
Women from migrant household	2	0.4
Dalit Men	2	0.4
Men suffering from other diseases	5	1.1
Men wage worker	5	1.1
Men in informal sector	3	0.6
Men with disability	3	0.6
Total survey respondents by intersectional group (community)	209	48 %
Total community interviews(qualitative)	90	-
Total non-community participants (Key Informant Interviews)	141	-
Total Collected Data	440	-

Link to [Annexes 4-9](#)



CARE Nepal
Central Office
4/288 – SAMATA Bhawan
Dhobighat (opp. DAV School)
P.O. Box: 1661, Lalitpur, Nepal
Tel: 977-1-5522800
Email: npl.carenepal@care.org



Save the Children Nepal
Country Office
Airport Gate Area, Shambhu Marg
Kathmandu, Nepal
GPO Box: 3394
Tel: 977-1-4468130/4464803
Email: post.nepal@savethechildren.org



**Ministry of Women, Children
and Senior Citizen**
Singhdurbar, Kathmandu, Nepal
Tel: 977-1-4200082, 4200408
Email: info@mowcsc.gov.np