Well-being Survey Report

An Assessment of Inequality and Vulnerability on the context of COVID-19

Nepal

Table of Contents

List of figures

List of tables

Executive summary

In the context of COVID-19, VSO implemented a Wellbeing Survey in ten of its current project districts- Sarlahi, Parsa, Banke, Lamjung, Surkhet, Dhading, Siraha, Saptari, Kapilvastu and Rupandehi to understand the interplay of four critically interrelated components: individual/group identity, gaps due to the COVID-19 crisis, access to services, and priority needs. The study was largely focused on assessing the impact of COVID-19 to people by gender, ethnicity, geography, ability, and access of services. This study is expected to support VSO's future programming and policy recommendations within the development sector with an eye to improving access of poorest, marginalised and excluded people to health, education and livelihood outcomes services as their basic rights.

The study was administered to 1319 respondents which included primary actors of the projects, their family members and community volunteers through an online questionnaire developed in Microsoft forms. Respondents comprised of 61.3% female and 38.3% male. Most of the respondents were within the age group of 18 years and below. In terms of ethnicity, Dalit, ethnic group and Madhesi covered more than half of the total respondents. Administering the short set of Washington group of questions, 2.7% of the respondents were reported to be people with disabilities.

The prominent challenge identified by the study during the COVID crisis was food shortage. More than 60% of the respondents cited food scarcity as the major problem. Not being able to go outside home and meet friends and other mental pressures were also cited as the challenges brought about by the lockdown. As food shortage was the pressing problem, the respondents managed food through support, mostly from government, individuals and organizations. They borrowed money from family and friends to cope with their challenges. An increase in the cases of gender-based violence (GBV) was also reported by 21% of the respondents. 6.2% respondents reported to have faced violence due to their gender and disability. Among them, most of them were bullied and received harsh words.

Radio was found to be the most popular source of information on COVID-19. Interpersonal communication with neighbours, family and friends were also serving as information sources during crisis situation. This trend held true across gender, location, ethnic groups and age groups.

All the services like health, education, security and livelihood were hampered by lockdown. Although the basic health services like normal treatment, ambulance services were available, the comparative rating was still low in terms of the quality of services. 22.1% of the respondents stated that there was no health service available whereas 34.4% of the respondents stated that only emergency services were available.

Education was most affected due to lockdown. Lockdown had shut the schools down and children were deprived of the education facilities. Approximately three-fourth of the

respondents stated that there were absolutely no education services available. The remaining respondents stated there are some efforts to continue the education services through radio, TV and through online medium. The limited access of people to the education services points out towards the systemic inequality as only 7% accessed remote/online learning. Siraha performed the worst in terms of education. 88.2% of the respondents in Siraha stated that there were no education services at all during the lockdown. There were no online classes and very limited access to education through radio or TV. The comparative rating showed that in contrary to 1.3% who thought the education facilities were very poor before COVID, 68.7% reported the education facilities to be very poor.

The comparative rating for the security service were also tilted towards negative although the responses were not drastic as of education and health services. People feared coming out of their homes due to the inflow of immigrants who had not undergone health checkup prior to entering in the communities. 16.7% stated that the security service was very poor while 22.1% of the respondents stated the security service to be poor. The GBV related services had faced negative perception too in the crisis situation. 26.3% of the respondents stated the GBV services to be very poor and 27.7% respondents stated the GBV services to be poor.

As the lockdown was imposed and the mobility was curtailed, the livelihood options for the people was affected. Just above half the proportion of respondents have no livelihood option available which was reflected in their rating of the livelihood services. 56.9% of the respondents stated livelihood services to be very poor after COVID which was stated by only 1.7% before COVID.

There were multiple schemes from the government and non-government agencies to help people tackle with the implications of COVID. Food distribution seems to be most prominent service provided by agencies during the crisis as 65.5% respondents stated the existence of food distribution program. 46.6% of the respondents have received at least one support from the government while 29.8% of the respondents have received at least one support from the non-government sector. In terms of services, non-government sector provided more soft support like information on COVID and psychosocial support and government sector provided food relief, hygiene kits and cash support in addition to the services provided by non-government sector.

In terms of the recommendation to the government and non-government agencies, the respondents provided urgent and short-term solution of providing relief items such as food to help them during COVID. Other suggestions included strengthening of health care systems, awareness raising, employment generation, lockdown and social distancing protocols. Although the solution posed by the respondents are short-term, the study recommends organization to work extensively in the sector of livelihood recovery and reviving education sector. As radio has been ascertained as the most popular source of information on COVID, the possibility of using it for facilitating education should be

considered. Psychosocial support has been undertaken by the non-government sector which needs to be scaled up and reached out to the wider population.

Background of the study

COVID-19, an infectious respiratory disease caused by a coronavirus first identified in late 2019, has resulted in the infection to more than eight million people and deaths of over 400,000 people across globe as of mid-June 2020. Nepal has seen more than 6,000 infections and 20 deaths during this time period[1] with cases steeply on the rise. In the context of increasing infection rates, VSO implemented this Well-Being Survey in 10 of its current project districts to understand the interplay of four critically interrelated components: individual/group identity, gaps due to the COVID-19 crisis, access to services, and priority needs. The study was largely focused on assessing the impact of COVID-19 to people by gender, ethnicity, geography, ability, and access of services. This study is expected to support VSO's future programming and policy recommendations within the development sector with an eye to improving access of poorest, marginalised and excluded people to health, education and livelihood outcomes services as their basic rights.

The study was administered in 10 project districts of VSO. VSO has been implementing Empowering a New Generation of Adolescent Girls through Education in Nepal (ENGAGE) in Sarlahi, Parsa and Banke; Sisters for Sisters' Education-II (SfS-II) in Parsa, Lamjung, Surkhet and Dhading; and SAHAJ in Siraha, Saptari, Kapilvastu and Rupandehi. Respondents include primary actors of these projects, their family members and community volunteers.

The study was administered to answer the following research questions:

- What is the situation among primary actors and community volunteers during COVID-19 pandemic?
- What services are and are not available in the community?
- How are primary actors and community volunteers coping with their challenges?
- What is the priority needs of the primary actors and community volunteers during this time?

Methodology

Due to restrictions on movement during the COVID-19 crisis, it was not possible to administer surveys face to face. In this context, VSO administered the wellbeing survey through an online questionnaire developed in Microsoft Forms. The study was led by the

[1] As of June 15, 2020

VSO Nepal programme team who supported partners and other networks to complete the survey themselves as well as administer it to primary actors and their family members.

Sampling

The sample size for primary actors and their family members was calculated using the following formula for unknown population:

Sample size (n) = P (1-P) Z^2 / d^2

n = sample size

P = prevalence of well-being

Z = confidence interval

d = margin of error

For the Well-Being Survey, a confidence interval of 95% and margin of error of 3% were used.

Therefore, the sample size was = (0.5 *0.5 * 1.96 *1.96) / (0.03 * 0.03)

n = 1,067

Adding 10% non-response in the above sample, the total sample was (106+1067) = 1,173

The study gathered 1,383 responses, which were filtered for responses by staff and cleaned for inconsistencies and errors. The cleaned data set consists of 1,319 responses of primary actors, their family members and community volunteers. A conscious effort was made to obtain information from the participants in terms of their age, ethnicity and location.

Training of enumerators

Prior to data collection, VSO Nepal provided one –day of online training on tools to M&E officers/project coordinators of their implementing partners and district team. Then, M&E officers and trained partner staff cascaded the content to community volunteers over two days. Community volunteers were trained on conducting interviews and understanding samples, and oriented to the questions in the survey. Over the course of the survey, M&E officers on staff acted as coordinators, monitoring the survey in the field and communicating challenges and updates to VSO.

Data collection

Community volunteers collected the data through phone conversations with primary actors and family members. The data was collected using Microsoft Forms. A semi-structured survey questionnaire was designed including close-ended and open-ended questions. The data was collected from respondents aged 12 years and above.

Data analysis and interpretation

After the data was collected, initial cleaning was carried out by VSO team. VSO's Knowledge for Impact team supported in the process. A consultant was hired for the analysis and interpretation of data. Data analysis was done through SPSS software, based on which the consultant carried out the report writing.

Quality assurance

The following measures were adopted during data collection to ensure high quality of data:

- Large sample size including high percentage of non-response rate was used to ensure data validation and reliability
- One-day online orientation training at district level to orient data collectors on the specific data quality requirements
- Technical support was provided by VSO online during the orientation by the district team to community volunteers
- Data from primary actors and family members was collected digitally and unique IDs were assigned to each primary actor and family member
- Monitoring of data by the district team

After data collection, the following steps were taken to ensure data quality:

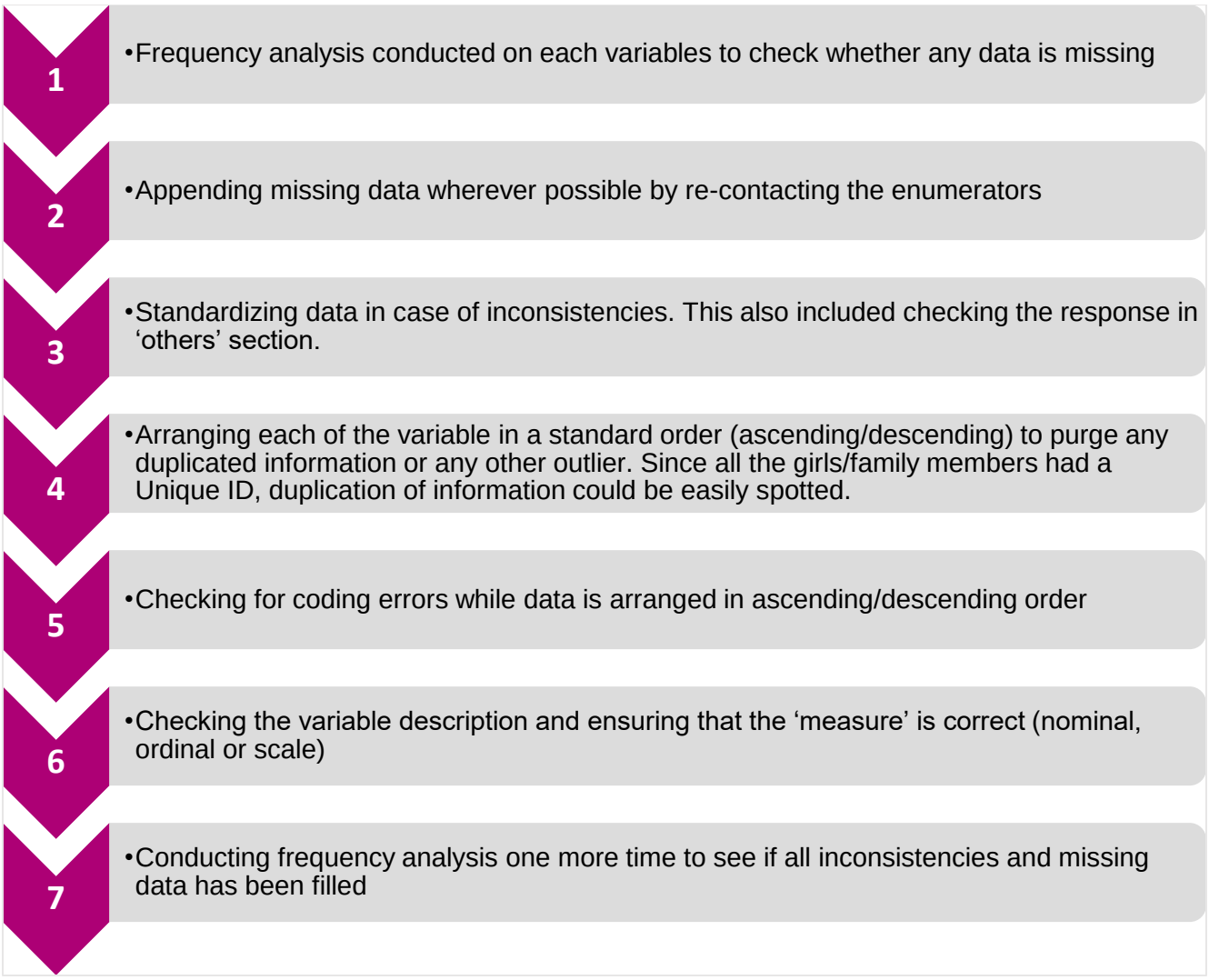


Figure 1: Steps to ensure data quality post-data collection

Ethics and safeguarding

VSO team acknowledges that this survey is highly sensitive, with distinct ethical and safety issues arising from the focus on wellbeing, stress, illness, livelihood challenges and GBVs, as well as those stemming from research with children and other vulnerable groups. For this reason, the implementation of this research has adhered to VSO's rigorous ethics and safeguarding approach to research including GDPR, which provides for participants' protection from any form of harm. Protecting children, young people and vulnerable adults from harm is must, therefore, the study has complied with the VSO policies and code of conduct.

Enumerators were oriented on the VSO safeguarding guidelines. The study team had a hotline card in place with VSO and implementing organization as the emergency contact

and also the contact information of nearest police station and women's cell if any enumerator notices the cases of referral.

Informed consent

As this survey has been carried out during the pandemic and outside mobility is restricted, enumerators have ensured the verbal consent from respondents. Consent from participants have been recorded as evidence and documentation. In case of the information from the children below 18 years of age, their parents were contacted and briefed about the process for their consent.

Risk and mitigation

Following were the risks and mitigation efforts ensured by VSO during the study.

S.N.	Risk	Mitigation
1	Embarrassment and stigma	VSO adequately trained enumerators to ask questions to minimize embarrassment. Participation in the survey was voluntary and they were allowed to withdraw their consent and discontinue the interview if they choose to. Wherever appliable, the sensitive questions were asked only ensuring that the respondents were comfortable to respond.
2	Breach of confidentiality	Enumerators were trained to ensure the confidentiality of the participants during whole process of field data collection.
3	Probing for personal information/invasion of privacy/distress	The survey has not been used to acquire personal information irrelevant to the study. During the course of survey, participants were encouraged to take their time in responding to survey questions and were allowed to skip questions if it induced distress in them. Participants were encouraged to call the violence response agency set up for the study, in case they needed professional support.

Limitations of the study

The study was carried out in the scenario of lockdown due to which the mobility was restricted and the study had to completely rely on remote data collection. This led to several limitations for the study which was beyond the ability of VSO Nepal.

- Online communication and distance monitoring are relatively new practices that had to be adopted considering the lockdown. Several meetings and orientation, first to partners and then cascading to the volunteers- all were carried out online. This limited the communication of information the way face-to-face communication would have served.

- The phone interview also limited the possibility to interviewing people with hearing difficulties and those with severe disabilities.
- In carrying out the phone interview, a call in between the phone interview led to the discontinuation of the form being filled. So, the form had to be filled again which was time consuming and tedious.
- Ensuring caste group representation was difficult because their contact numbers were not available.
- Interview with adolescent girls was primarily challenging. They had no personal phones or access to communication due to which a layer of first communicating and convincing parents was added. As parents were protective of their daughters, it took time to gain trust of parents over phone to interview their daughters which would have been relatively easier in-person.
- Similar to the limitation above, other research participants too were skeptic in the beginning for the interview over phone. It took some time to gain their trust.
- In the crisis situations, people have the tendency to expect support from external sources who seek their information. In this study too, it was challenging for the enumerators to manage expectations of support to the respondents.
- Issues concerning sexual and reproductive health are considered to be taboo in Nepali society. Therefore, it was particularly challenging to seek information related to sexuality, primarily from girls and those belonging to Muslim communities. The data, particularly related to sexual orientation is very different from the national statistics. This indicates towards the limitation in understanding of the enumerators.
- Translation is a challenge while using Microsoft Form. The data analysis had to be done manually because the questions were not numbered. It would have been easier if both numbers and questions in letters come together when downloading the results from Microsoft form or Google form.

Key findings

The People

This section illustrates the identity of 1319 respondents in terms of their location, gender, sexual orientation, age group and abilities.

Identity of the respondents

Location

The study was implemented in ten project districts of VSO. The proportion of respondents to the survey was the highest in Parsa and lowest in Surkhet comprising of 11.4% and 9.2% of the total respondents respectively. An average of 132 respondents were interviewed in each district.

Figure 2: Proportion of respondents by districts

In terms of the local units, the study covered 53 municipalities across 10 districts. The proportion of respondents was slightly higher in the rural municipalities than in urban municipalities.

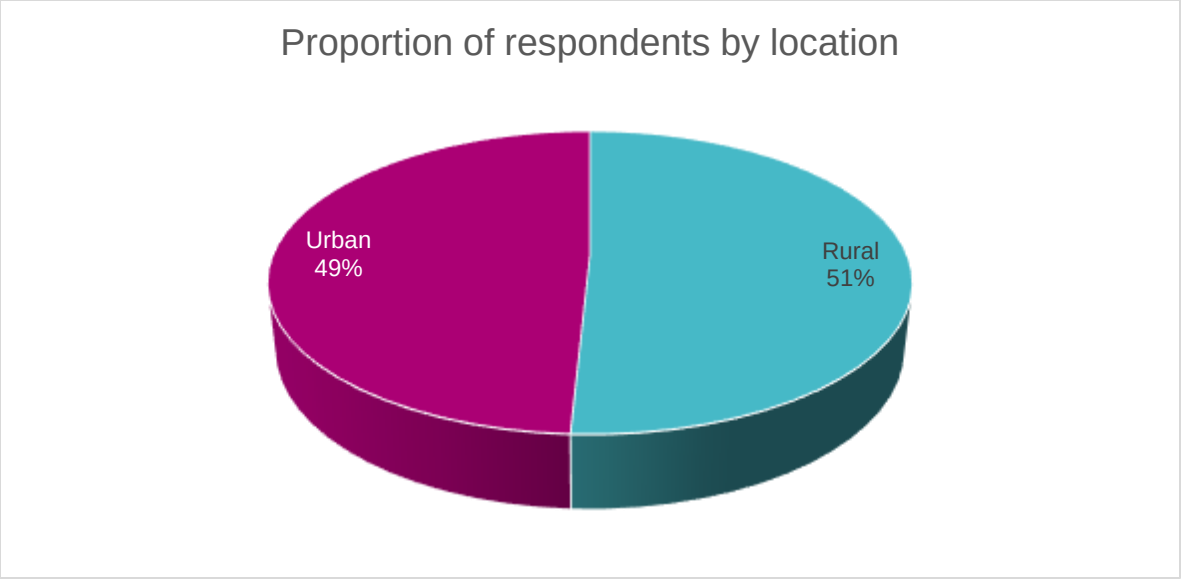


Figure 3: Proportion of respondents by rural/urban location

Gender

Female comprised a larger share in terms of participation in the survey. 61.3% of the total respondents were female while 38.3% were male. A small proportion of the respondents did not want to disclose their gender and preferred to self-describe.

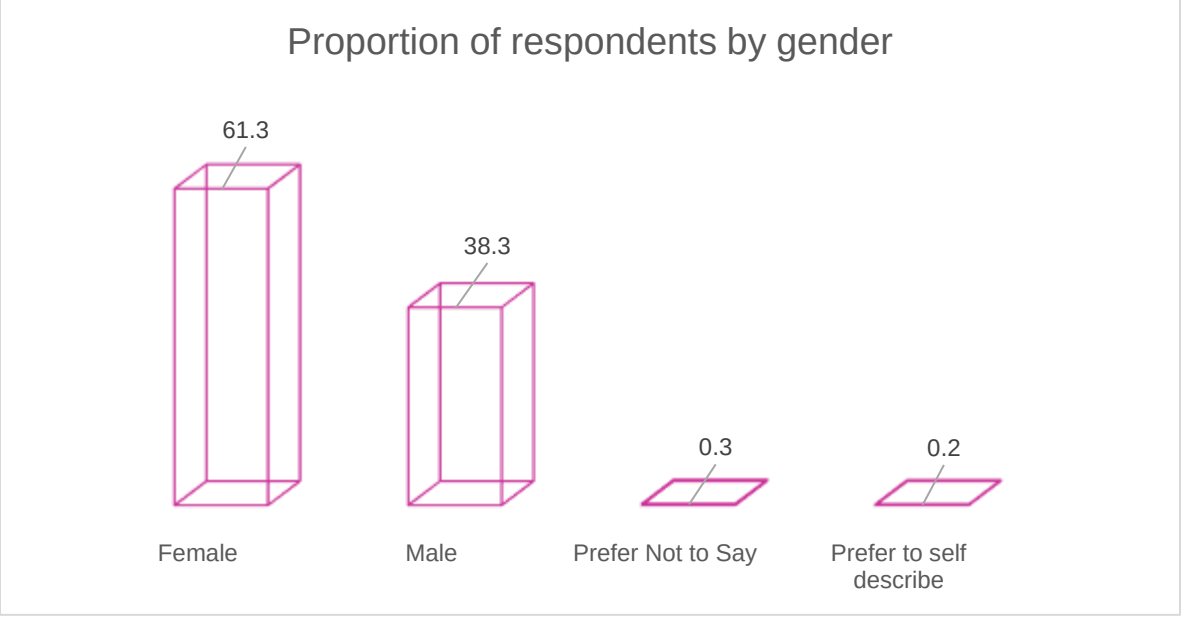


Figure 4: Proportion of respondent by gender

Age group

The respondents represent the different age groups. As two of the projects carried out-ENGAGE and SFS-II have primary actors as children, a large proportion of respondents are children below 18 years of age. Considering that project engages with family members of children, mostly their parents, the number of senior citizens aged above 60 years is only 2%.

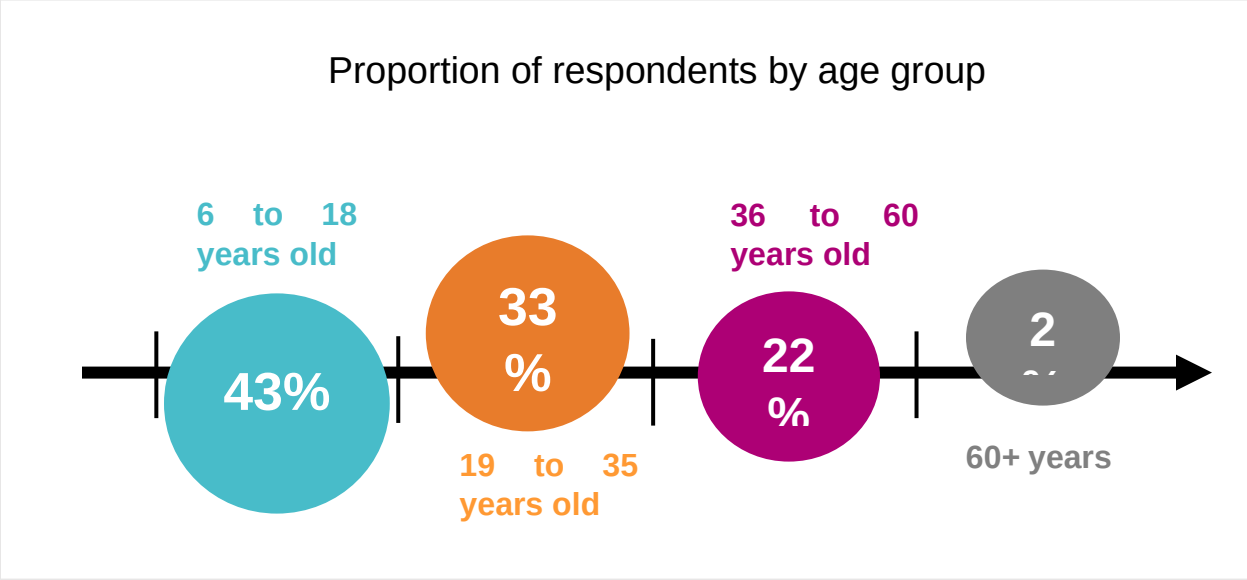


Figure 5: Proportion of respondents by age group

Ethnicity

In terms of ethnicity, Dalits across hills and Terai comprised of almost one-fourth of the total number of respondents. 24% of the total respondents were Dalits, closely followed

by the ethnic and Madhesi community representing 22% and 20% respectively. Muslims and Brahmin/Chhettri had equal representation in the study with 13% each.

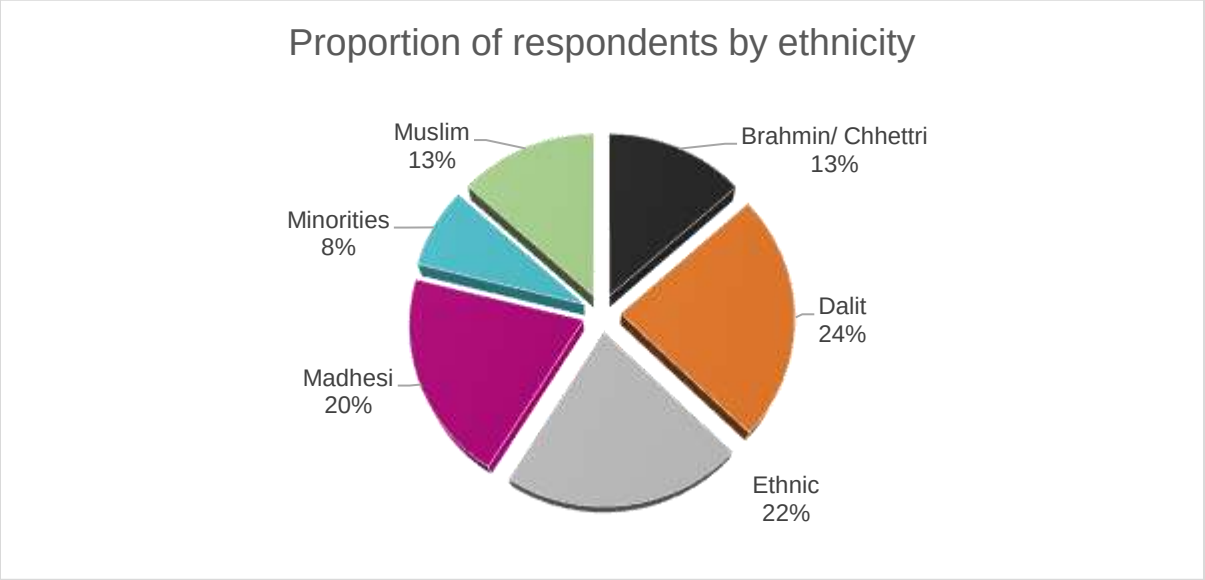


Figure 6: Proportion of respondents by ethnicity

Disability

The survey followed Washington Group of short set of questions for assessing disability. Out of the total respondents, 2.7% were reported to have disability. There were more people with single disabilities than multiple disabilities. Overall, 1.7% were stated to have single disability while 0.9% had multiple disability.

Figure 7: People with disabilities

Most of the people with disabilities had issues with walking, followed by difficulty in self-care. As the interviews were administered over phones, there were smaller proportion of

respondents in hearing and language. Following were the domains of disability which emerged during the survey.

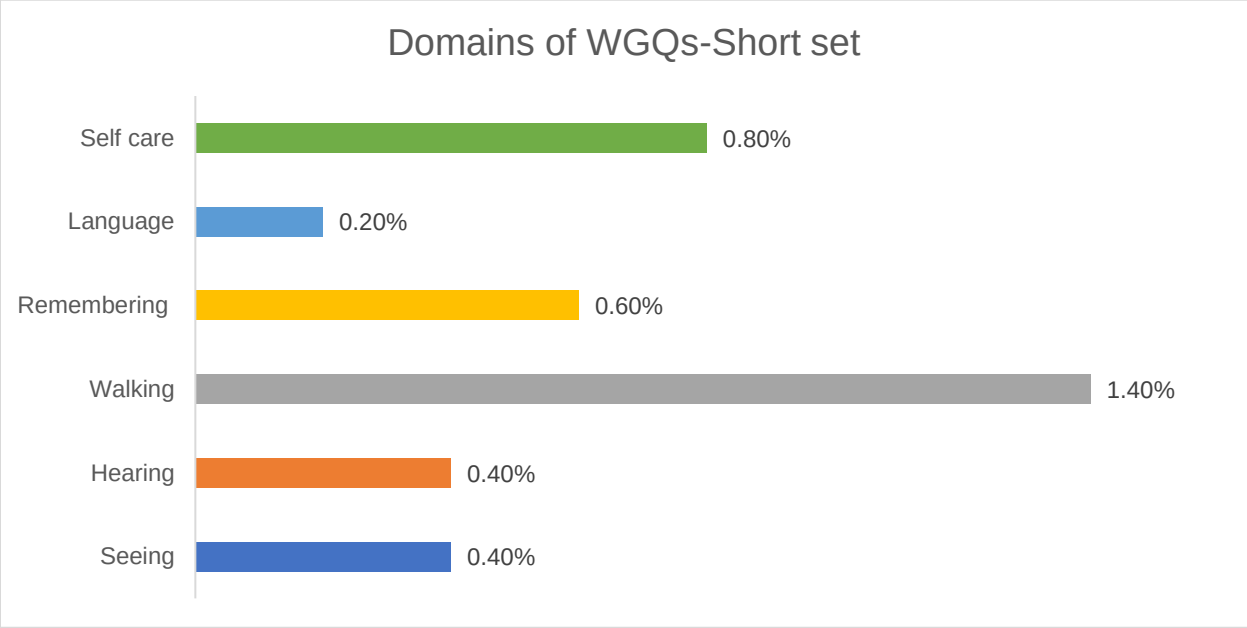


Figure 8: Domains of WGQs- short set

Key findings

Cracks due to COVID-19

This section discusses the gaps and cracks due to COVID-19. Further, the section elaborates on its interplay with the respondents' identity in terms of their location, gender, sexual orientation, age group and abilities.

Cracks due to COVID-19: Gaps

Challenge

When asked about challenges due to COVID-19, respondents laid down multiple factors which posed challenge for them during the pandemic. Food shortage was the most pronounced challenge for the people, as 62.6% respondents cited as a challenge to them during the crisis. The other challenge opined by majority of people was being able to not go outside home and meet their friends. 50.2% cited not being able to go outside home as a challenge while 47.3% respondents expressed not being able to meet their friends as one of the challenges.

A pandemic like COVID which curtails the movement of people outside homes and the one that affects their livelihood and daily living can be harsh on the mental health of otherwise busy people. The study identified that there were 47% respondents who were facing the challenge of mental pressure. Furthermore, as a result of school closure following lockdown, parents expressed the challenge of teaching children at home and engaging them inside as a major challenge.

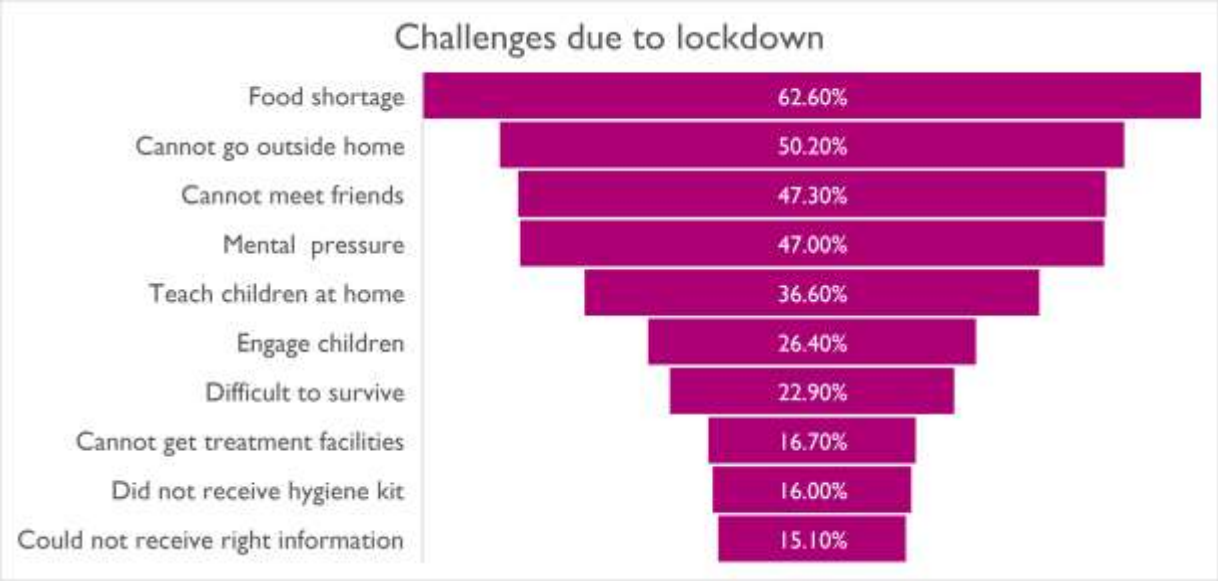


Figure 9: Challenges expressed by respondents due to lockdown

Food shortage, unable to go outside home and unable to meet friends were three most reported challenges. These challenges were compared based on the district of the respondent to identify its magnitude across districts. Shortage of food was cited the most in Sarlahi followed by Banke. Not being able to go outside home was most challenging for respondents in Kapilvastu compared to other districts while not being able to meet friends was most challenging in Surkhet.

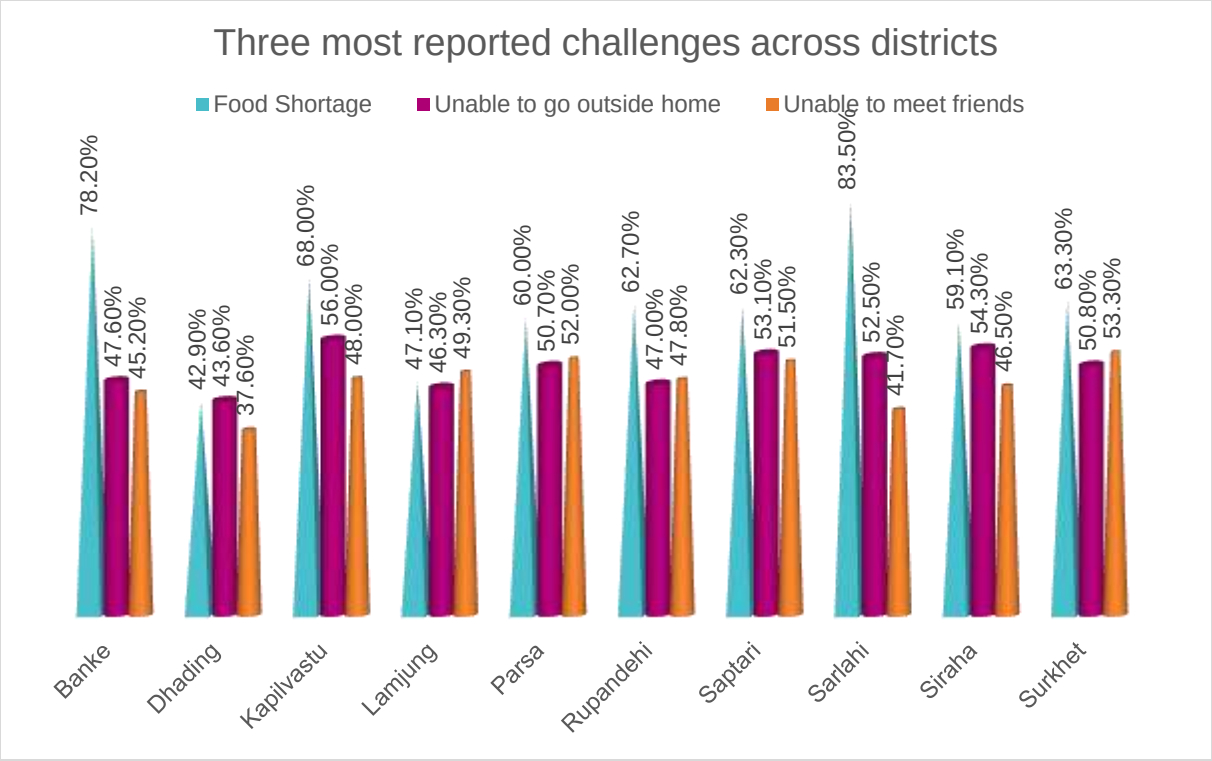


Figure 10: Comparison of three most reported challenges across districts

For the people with disabilities, the list was slightly different. Food shortage remained the most pressing challenge for them. However, the other challenge which had not emerged in the general trend, the mental pressure due to lockdown, had emerged for people with disabilities.

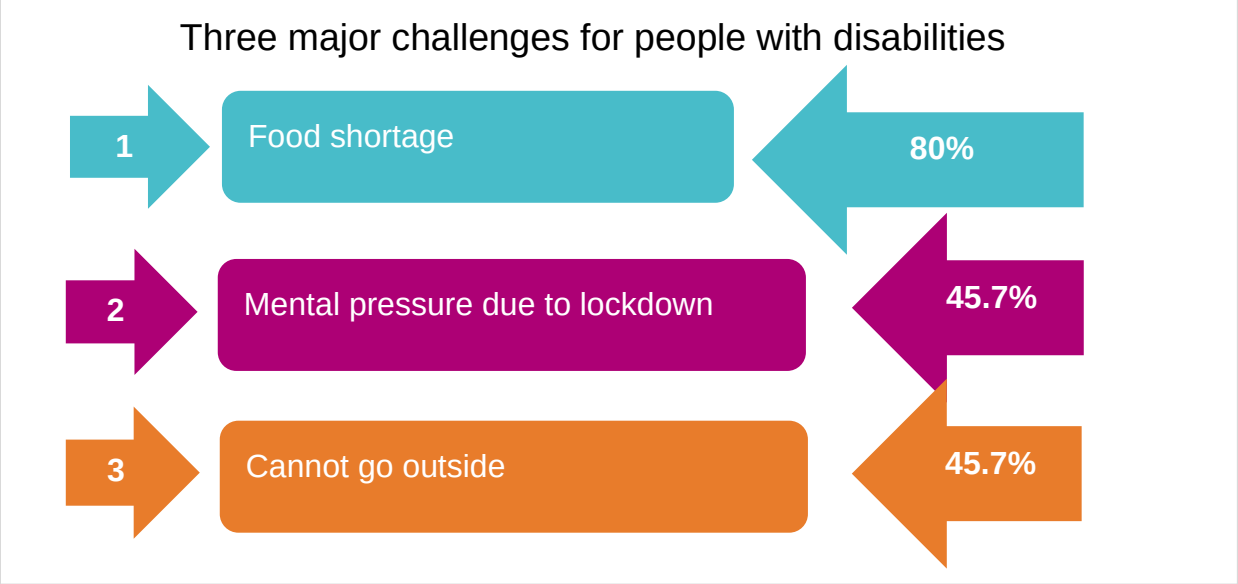


Figure 11: Three major challenges for people with disabilities

Coping with challenges

As the food shortage was the most-cited challenge by the respondents, most of the coping strategies were around tackling food shortage. The respondents managed food through the support, mostly from government, individuals and organizations. 23.6% of the respondents consumed the food supported by the government while 22.9% relied on the borrowed food from the people they know. 21.9% of the respondents did not care for hygiene of the food and consumed unhygienic food while 5.4% survived on only one meal a day. 7.7% of the respondents participated in the food for work program.

For fulfilling their need for food and for other basic needs, 36.8% of the respondent borrowed money while 5.7% respondents received cash support.

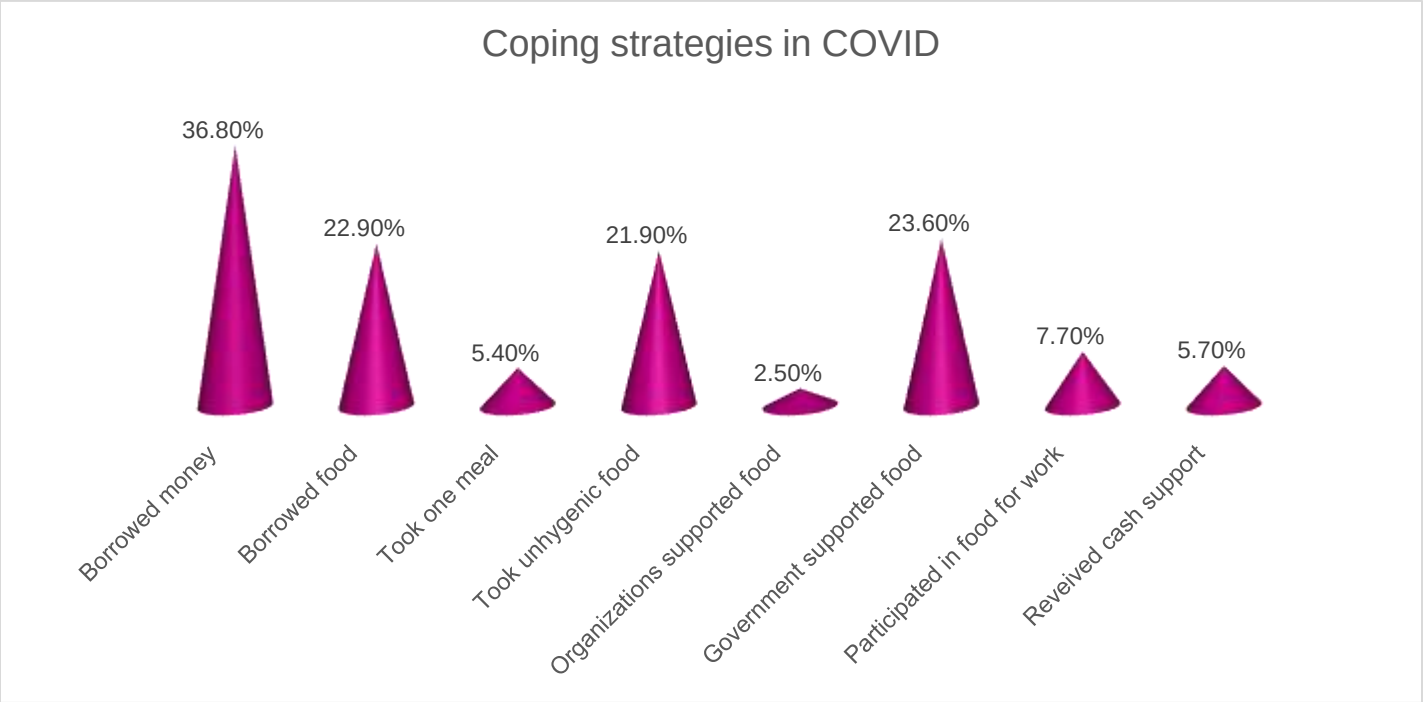
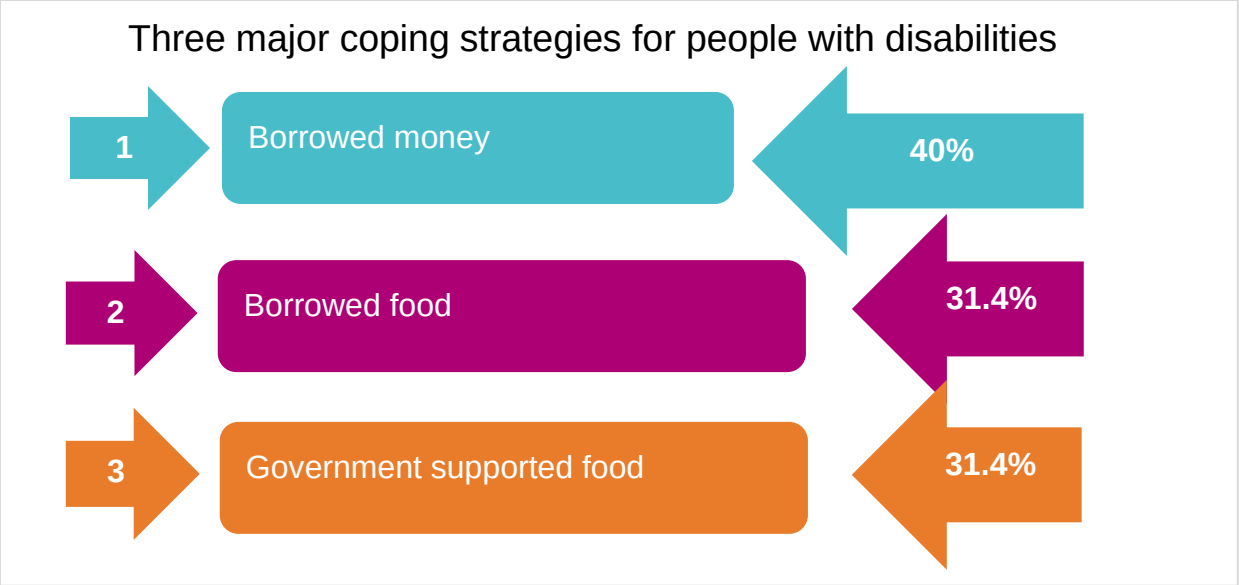


Figure 12: Coping strategies in COVID

Keeping up with the general trend, people with disabilities had borrowed money, borrowed food and survived on the food supported by government to cope with their challenges.



When asked about the duration that they can keep coping employing their strategies, almost 65% of the respondents could cope only until one month. The highest proportion of respondents, 18.2% could cope for a month while 25% could cope only for a week or less. Among the respondents who reported to cope only for a week or less, highest proportion was of the age group 6-18 years of age. Although the count of respondents was higher for female to have responded to cope for a week or less, the proportion was similar to that of male respondents. 25.1% of the female said that they could cope only for a week or less while 24.8% male reported the same. Slightly higher proportion of the respondents from ethnic group, 27.3%, have reported to cope only for a week or less. 42.9% of the people with disabilities exclaimed that they could cope with their challenges for only a week or less.

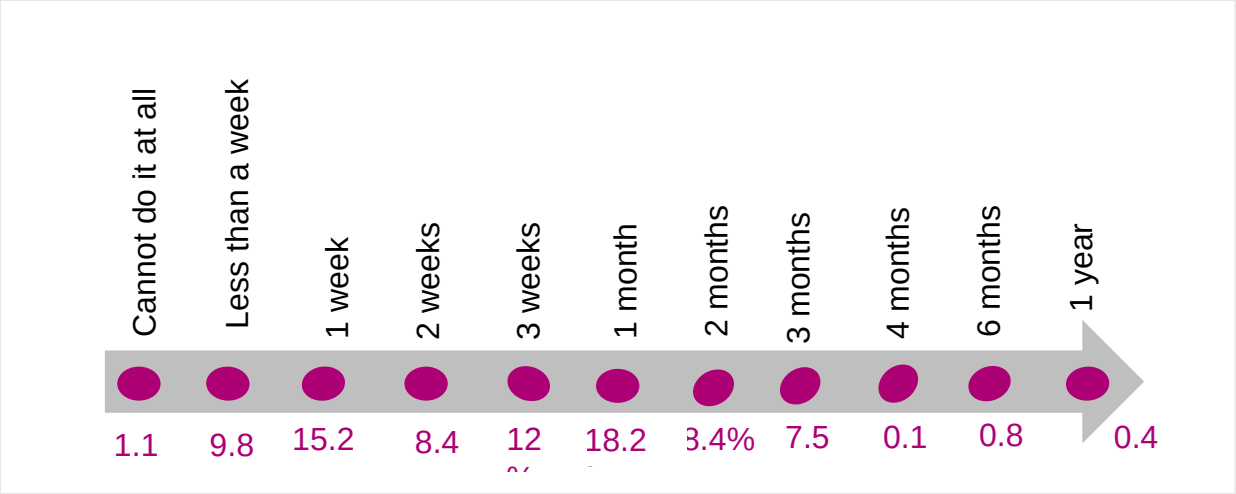


Figure 13: Time till coping strategies are expected to work

Support in coping with challenges

38.1% of the respondents have admitted to have approached others for support to help them cope with the challenges. Among them, more than half of the respondents had approached local government. 41.1% had approached neighbours and 38.5% went to their relatives for help.

In line with the aforementioned findings, local government emerged to be supportive for most of the respondents as 47.6% of the total respondents attributed local government as the stakeholder who helped them cope with the challenges. Personal relations with their relatives and neighbours proved to be helpful in garnering support coping with the challenges discussed above. 41% and 40% respondents stated relatives and neighbours to be supportive to them respectively. Just over one-fourth of respondents stated that absolutely no one had supported them in the time of crisis. Among them, Dhading was ranked the highest as 36.8% of the respondents there stated that no one had supported them closely followed by Banke who ranked second. 36.3% respondents in Banke stated that no one had supported them during crisis. Age-wise, there was not much difference. However, in terms of ethnicity, Brahmin/Chhettri were the least supported group as 34.5% of the Brahmin/Chhettri stated that no one provided them support. This was followed by ethnic community in which 30.1% were not helped by others.

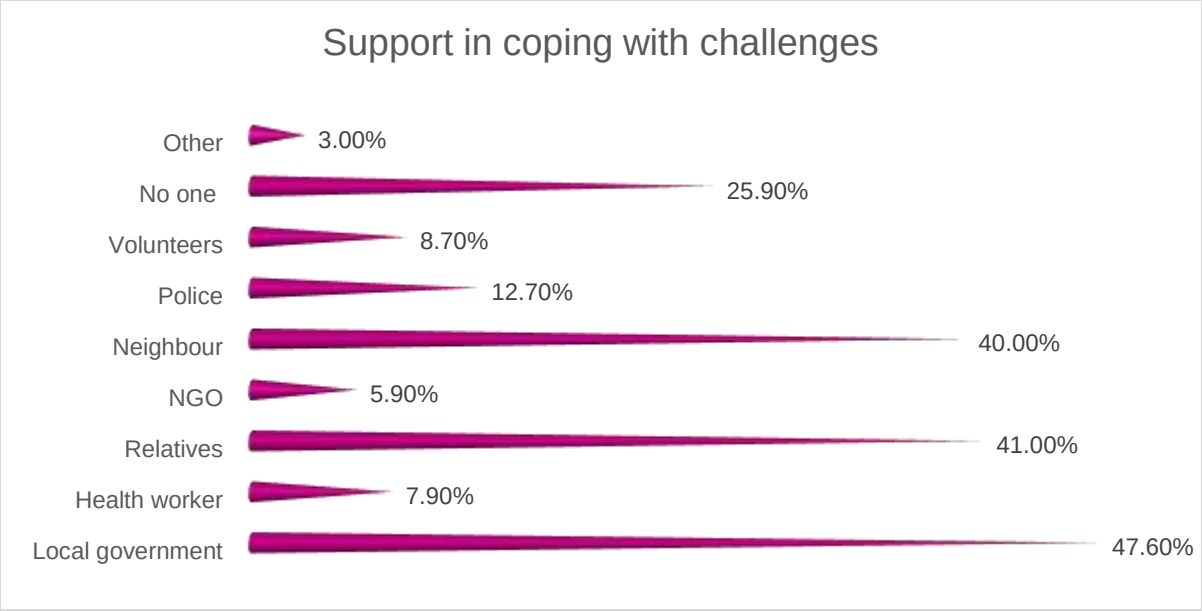
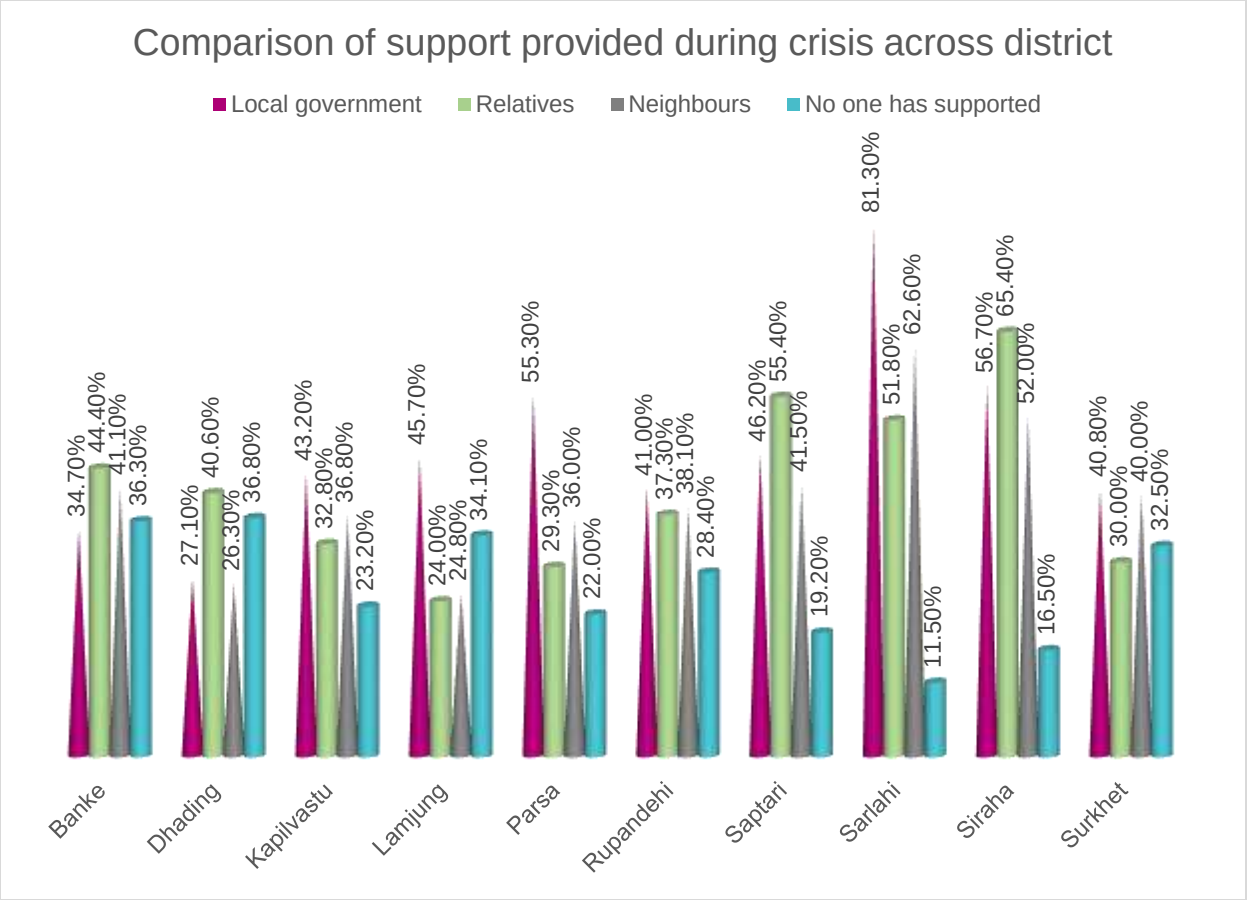


Figure 14: Stakeholders supporting in coping with challenges

The above finding was further assessed based on the districts to identify the support system functioning across districts. Local government seems to be most efficient in Sarlahi as a majority 81.3% of the respondents have cited local government as a stakeholder supporting to cope with their challenges. Contrarily, Dhading fared worst as only one-fourth of the respondents were relying on the local government. Highest proportion of respondents in Dhading, also closely followed by Banke reported that no one has supported them to cope with their challenges in this time of crisis. Social capital seems to be relatively functioning better in Siraha as most of the respondents were relying on support of relatives and neighbours during the difficult times.



Physical and mental health

In response to the question about how the respondents or their family members were feeling, 72.7% said that they or their family members were healthy. 44.4% of the respondents indicated that either them or their family members have faced trauma due to the pandemic. 13% of the respondents were feeling stressed while 12% of the respondents were scared in the context of COVID-19.

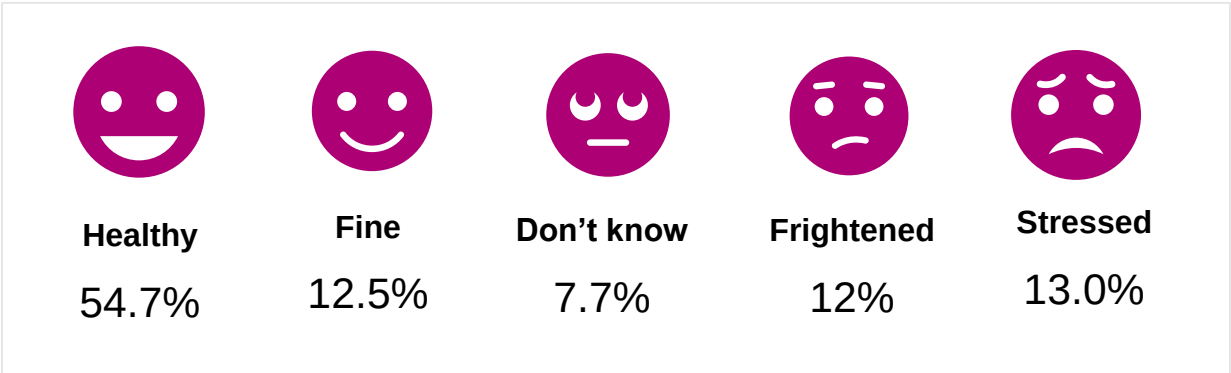


Figure 15: Physical and mental health of the respondents

Examining the cases of negative mental health further, relatively higher proportion of respondents from the age group 36-60 reported to be stressed and age group of respondents above 60 years of age reported to be frightened. Based on gender, female were found to be affected more than male. While 50.9% were stressed 69.2% were reported to be frightened. For respondents with disability, 14.3% reported to be frightened while the other 14.3% reported to be stressed. This proportion is slightly higher than the general findings.

Based on district, the highest proportion 31.5% of the respondents from Saptari reported to be frightened currently. Similarly, 25.3% of the respondents from Parsa stated that they were stressed due to the crisis. By ethnicity, people from Madhesi and minorities community reported to have negative mental health. The highest 15.5% of the Madhesi respondent reported to be frightened while 19.4% of the respondents from minority group reported to be stressed.

Gender-based violence

UNFPA issued an impact brief for COVID-19 which estimated that a lockdown for 6 months could result in 31 million gender-based violence cases globally and for every 3 months the lockdown continues, an additional 15 million cases of GBV could be expected[2]. In this context, the study assessed gender-based violence as a crack due to the pandemic. 21.1% of the total respondent asserted that the GBV has increased in their community during COVID-19. Among the respondents who said that the GBV has increased, there were a greater number of men than women. Similarly, there were more respondents from Saptari district who stated that GBV has increased in the community.

[2] https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

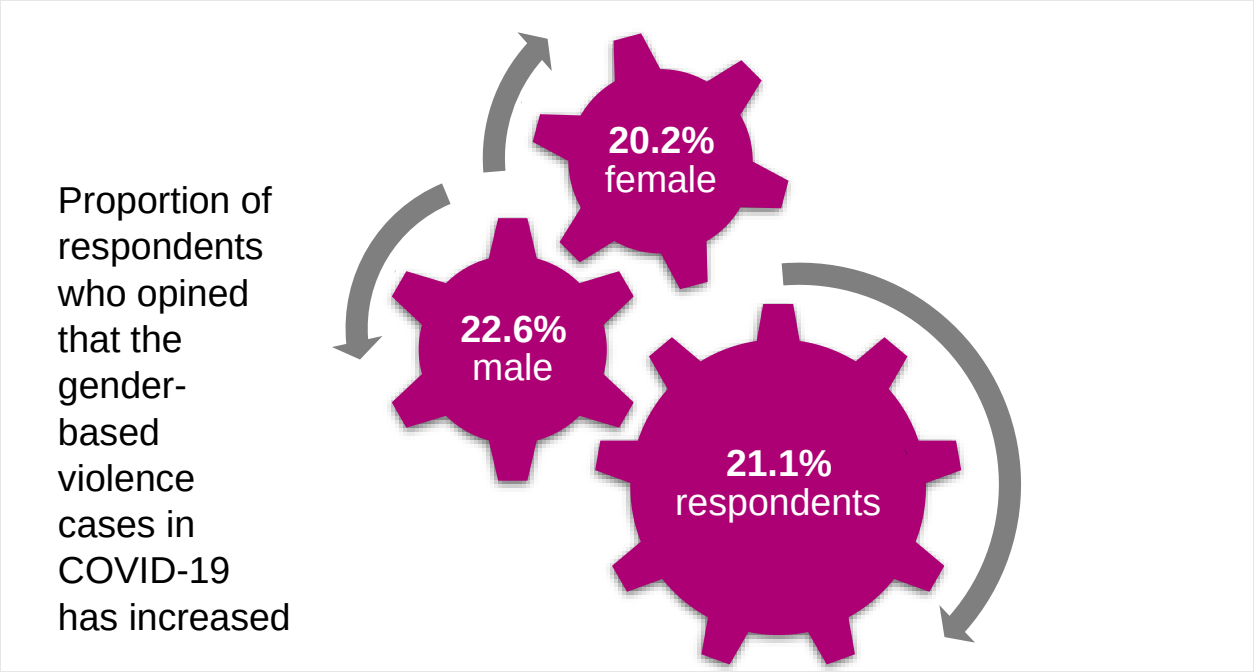


Figure 16: Proportion of respondents asserting the increase of GBV in COVID-19

In terms of ethnicity, highest proportion of respondents from Madhesi community cited the presence of gender-based violence which was closely followed by minority groups. 25.4% of the respondents among the Madhesi community stated that the GBV has increased in COVID-19. 24.3% of the respondents of minority groups stated the same. It should be noted here that the respondents have stated that the cases of violence have

increased in the communities which does not necessarily reflect the situation of violence for a particular ethnic group.

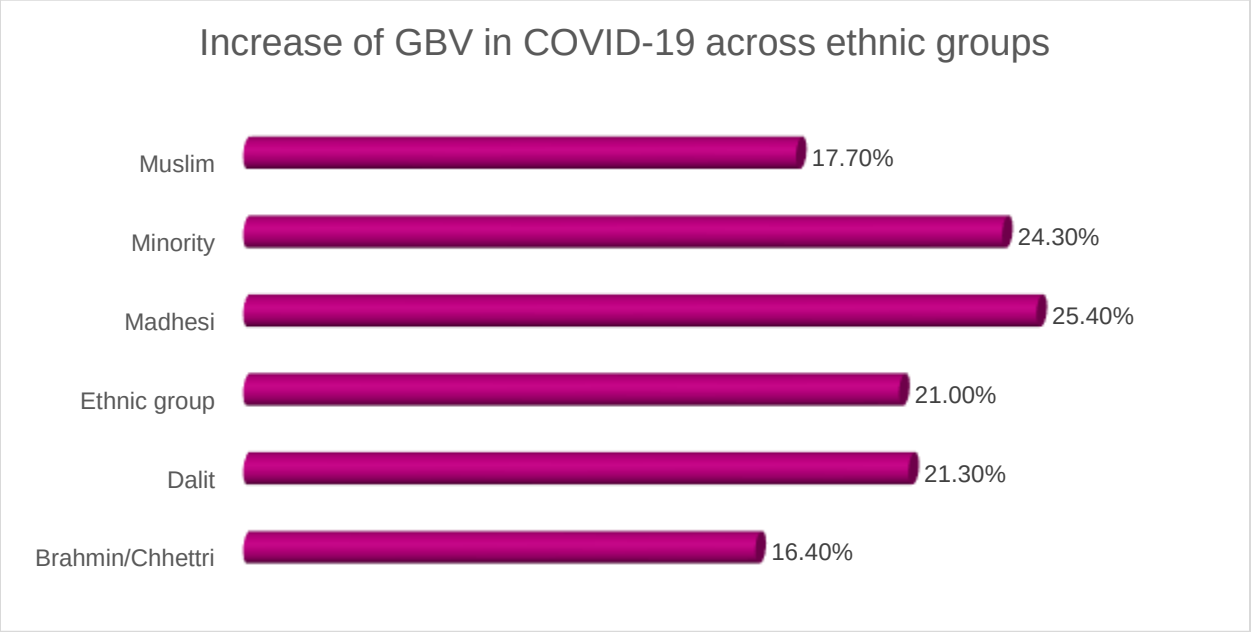


Figure 17: Increased of GBV in COVID-19 across ethnic groups

In response to the question if they had faced any forms of violence due to their gender or disability, 6.2% of the respondents had faced violence. In terms of prevalence, GBV due to gender or disability was found to be more prevalent in women than men. 6.9% female respondent reported to have suffered violence while 5.1% male respondent stated that they have faced violence. In terms of age group, the prevalence of violence was high for ages 36-60. 7.02% stated to have faced violence. Although the violence for ages 6-18 was 6.2%, the figure could be actually high because this response depends on the understanding of violence which is harder to comprehend at the relatively younger age.

In terms of district, Kapilvastu, Rupandehi and Lamjung topped the prevalence of violence as 11.2%, 10.4% and 10.3% of the respondents respectively have cited that they have faced violence due to gender or disability. By ethnicity, violence is highest in the minority groups as stated by 13.6% respondents which was followed by Dalits as stated by 8% respondents.

Violence was in higher proportion for people with disabilities, more specifically for people with multiple disabilities. Out of the total respondents with multiple disability, 41.7% stated to have faced violence. 21.7% of respondent with a single form of disability faced violence which was also much higher proportion compared to the 5.6% of the respondents without disability who faced violence.

Among the respondents who faced violence, bullying was the most stated form of violence. 40.8% among the respondents faced bullying. 32% respondents received harsh words and 27.2% did not get any support for their work from their friends and families.

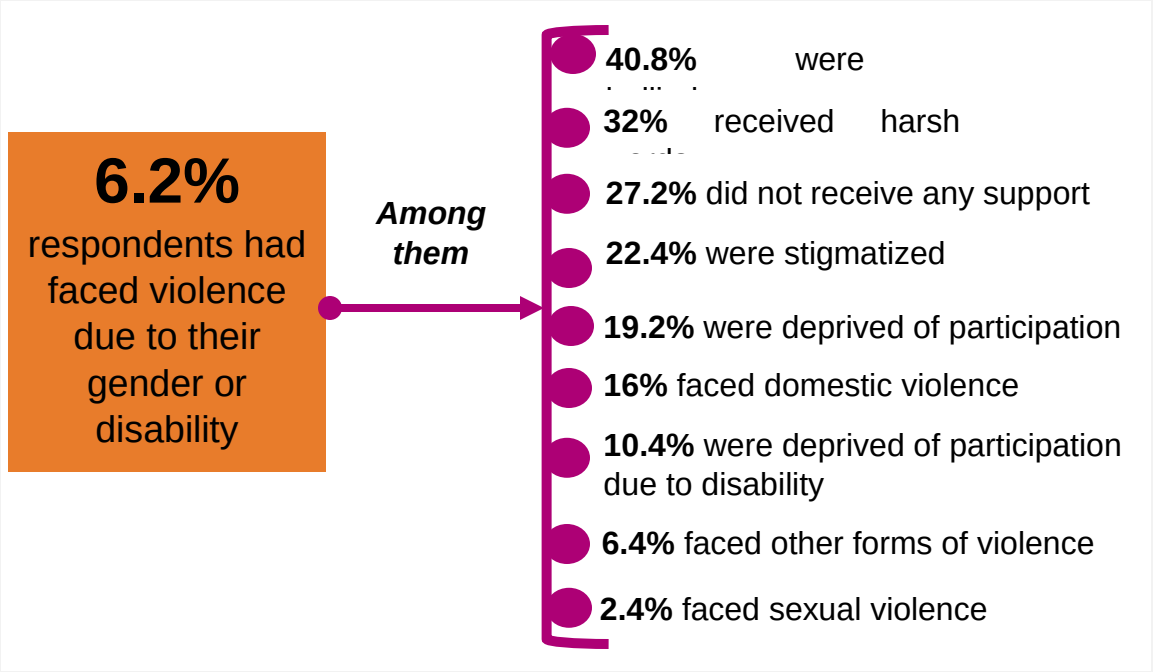


Figure 18: Forms of violence due to gender or disability

The available services for GBV and the quality of those services has been discussed in the next chapter.

Care responsibility for women

The study examined the changes in care responsibility of women due to COVID-19. Higher proportion of women stated to have faced increased care responsibility than prior to the lockdown while 24.3% have shared that their care responsibility has decreased. Among the women whose domestic workload has decreased, 42.5% were supported by the parents while 29.7% were helped by the sisters and 24.3% were helped by daughters. This indicates that the workload was shared mostly by the other women member in the household than men.

Assessing the increase in care responsibilities for women across age group, location and ethnicity, age group 6-18 were reported to have faced increased workload due to lockdown. 49.7% women reporting increase in lockdown belonged to the age group 6-18. In terms of location, more women were affected in Siraha as 13.1% of the women stating increase in workload were from Siraha. Dalit women were reportedly most overwhelmed with the increase in their care responsibility during lockdown as 24.4% of the women stating increase were Dalits.

Family decision making

Family decision-making processes for COVID-19 depicted a bright scenario as quantitative finding indicate that the decision making in the families is participatory. 91.9% of the respondents stated that all members of the family are present in the meetings and decision-making processes for COVID-19 response. Furthermore, describing the final decision making in the family, more than three-fourth of the respondents stated that all the family members discuss and make the decision. 13.1% stated that father and mother in the family make decisions while 4.5% respondents stated that only father decides.

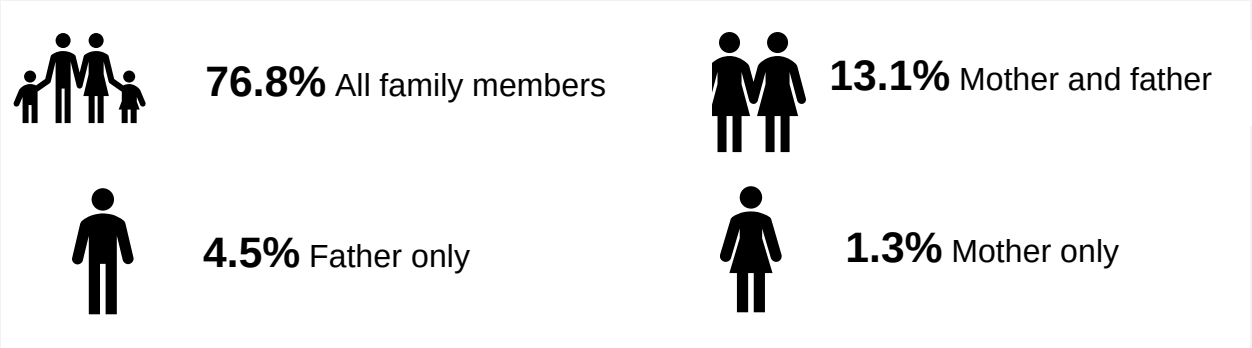


Figure 19: Household decision-making process

Source of information about COVID

Following the pandemic, government and civil society organizations have used multiple channels for disseminating the information about COVID. As a result, most of the respondents acquired the information from multiple sources rather than a single source. Only 8.49% of the respondents relied on a single source for acquiring information on COVID. In terms of communication medium, although the recent studies have shown that tendency of radio-listening on decline[3], radio still appeared to be the popular medium as 68.7% of the respondents stated it as a source of information on pandemic across all age groups. Almost half the number of respondents relying on single source appeared to have obtained information on COVID through radio.

[3] Nepal Media Landscape Survey, 2018 by Sharecast Initiative Nepal

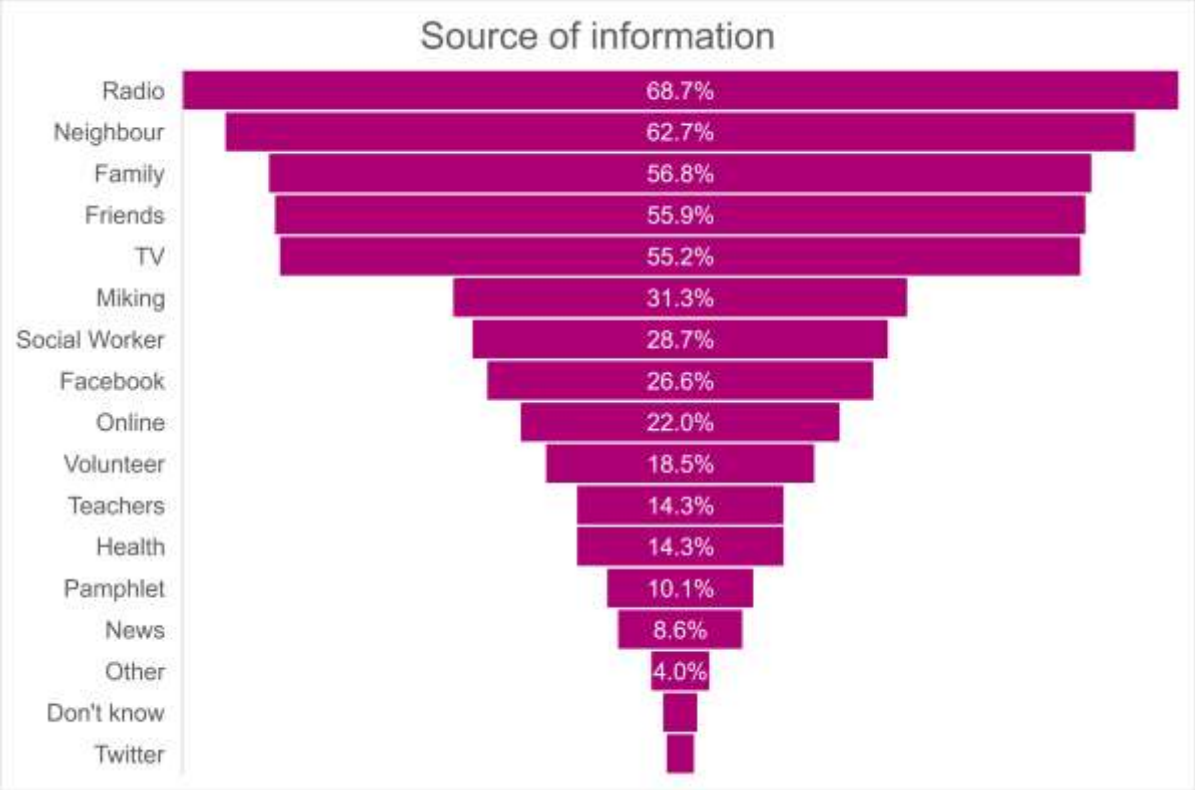


Figure 20: Source of information for COVID

Interpersonal communication appeared to be a popular information source as well for the respondents. They stated to have received their information through a neighbour, family member, friends, social worker, volunteers, teachers and health workers. A whopping 62.7%, 56.8% and 55.9% attributed a source of information to be neighbours, family and friends, respectively.

More than half of the respondents have received the information from television. Although the penetration of mobile phones and access to internet has increased over past years, media like Facebook and online news are accessed by about one-fourth of the total respondents for information on COVID.

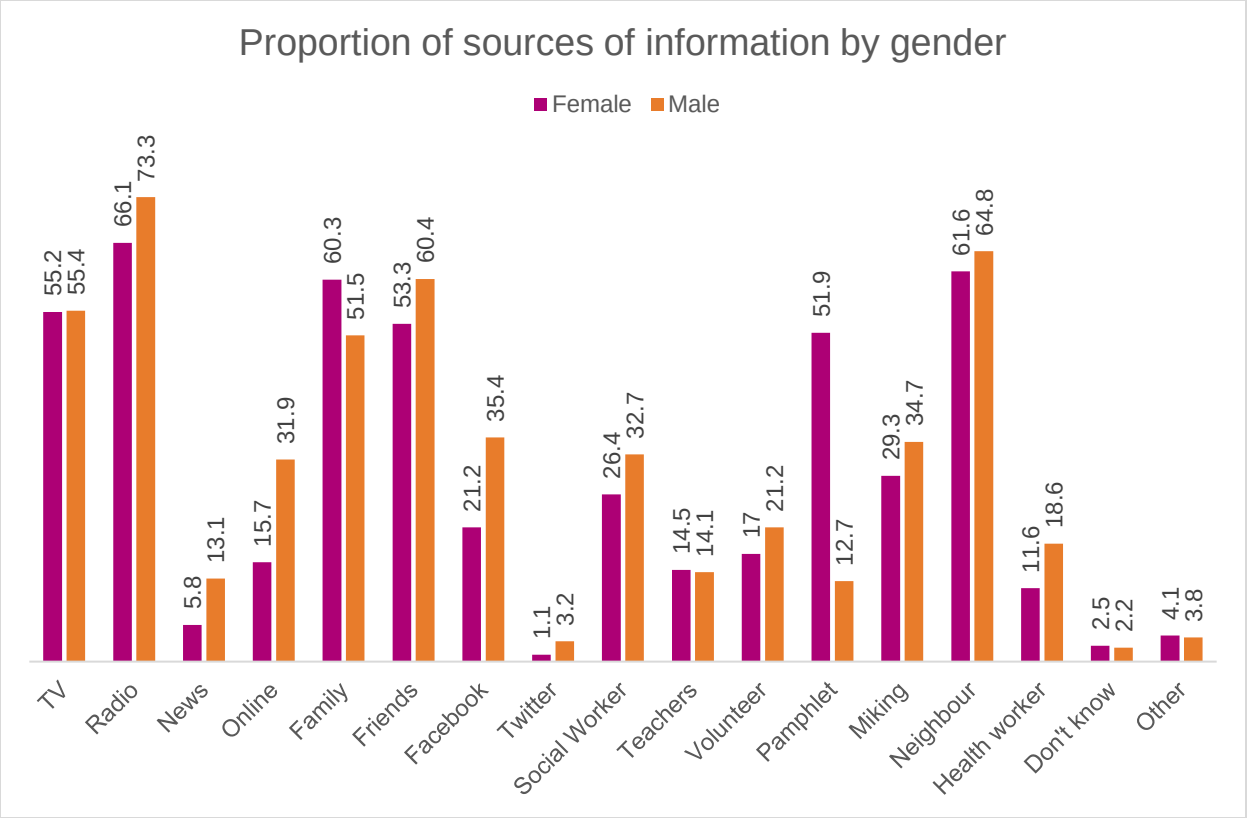


Figure 21: Proportion of sources of information by gender

Radio was a popular information source for both female and male as the highest proportion for both, 66.1% female and 73.3% male received information on COVID through radio followed by interpersonal communication with neighbours, family, friends and watching television as the most prominent ones. Comparing the access to information channel by gender, it has been seen that higher proportion of male have access to information sources than female.

The similar trend was also observed in people with disabilities. 74.3% of the respondents with disabilities obtained the information related to COVID from radio, while 60% and 45.7% received information through neighbours and family members respectively. TV was also a source of information on COVID for 34.3% of the respondents with disabilities.

The general trend of radio, interpersonal communication with neighbours and family members and TV as a source of information held accurate across all ethnic groups except Brahmins/Chhettris. For them, the second most important source of information on COVID was television after radio. Other ethnic groups were informed by neighbours and family members prior to the television.

Key findings

Access to services

This section illustrates the situation of access to various services by the respondents. Further, the section examines its interplay with the respondents' identity in terms of their location, gender, sexual orientation, age group and abilities.

Access to services

Services and quality of service available in COVID-19

Health

Listing the available health services, most of the respondents shared that the basic health services were available. 83.3% of the respondents stated that they could access to the normal treatment. Services pertinent to maternal and sexual health were also available though not in fully swing. 60.8% of the respondents stated that the family planning services were available while 37.2% agreed safe maternal health services could be accessed. Immunization service seems to be the most disrupted service as only 6.6% of the respondents stated it to be available.

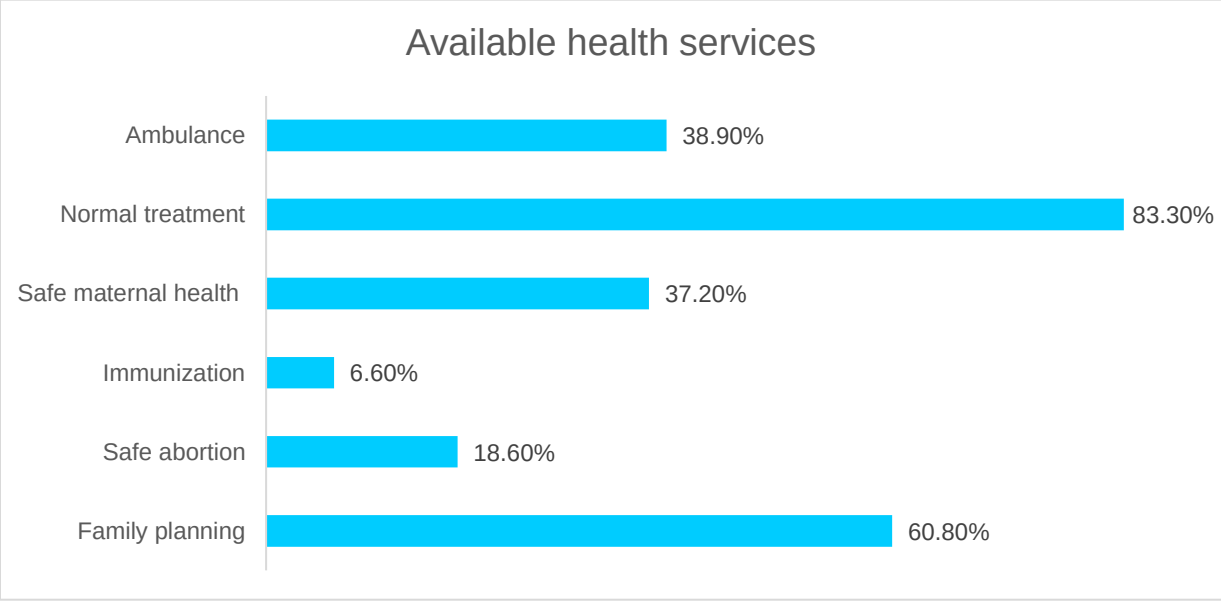


Figure 22: Available health services

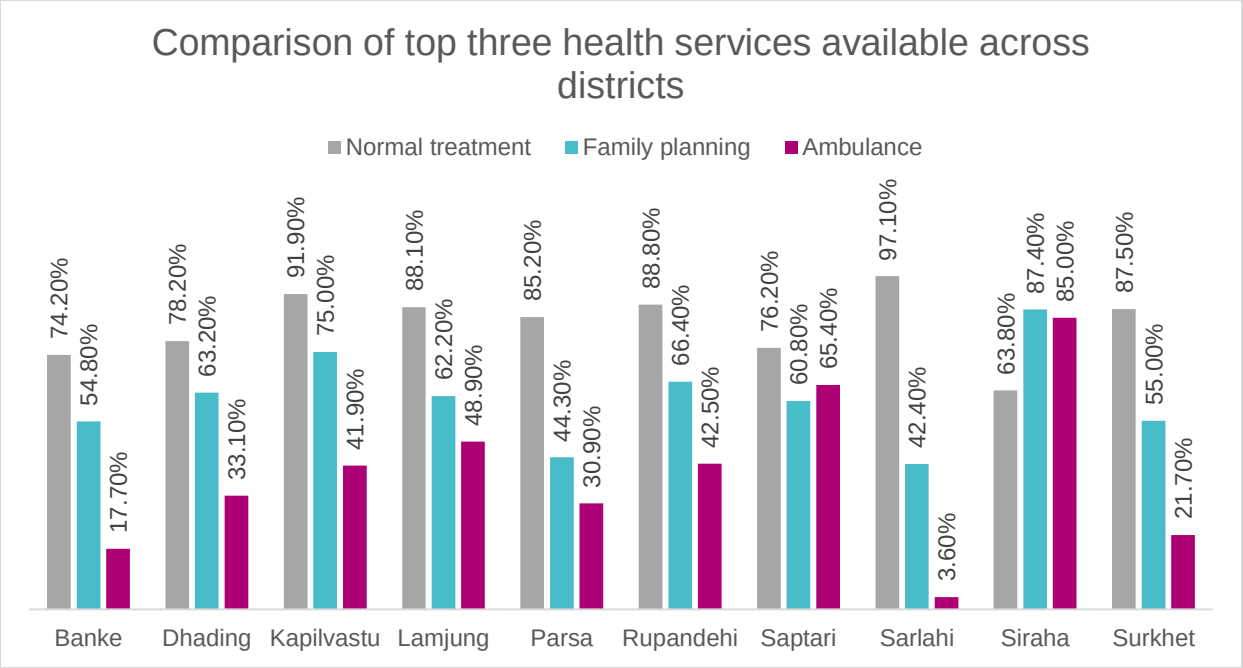


Figure 23: Comparison of top three health services available across districts

Among all the study districts, Sarlahi and Siraha showed the mixed findings. While access to normal treatment was available as stated by the majority of respondents, access to family planning and ambulance service was worse compared to other districts. Siraha, on the other hand, seems to be the worst affected compared to other districts in terms of access to normal treatment. However, it was best in access to family planning and ambulance services.

Although the services were available, in terms of rating the quality of health, it was evident that the health system had deteriorated than pacing up for tackling COVID. The responses which were tilted more towards positive in the 'before' scenario was completely changed in the 'after' scenario. Only 2.2% of the respondents opined that the health system was very poor with no health service before but as a result of COVID, 22.1% believed so. 22% of the respondents who had faith in the health system before stating that the healthcare systems were excellent with beds, PPE users and health workers was continued to believe only by 4.5%. Stating the reasons for the change, respondents cited that the adequate medicines were not available and only emergency service was available. They were not satisfied with the distance maintained by health workers during checkup and health workers were not easily available. Furthermore, health workers were skeptic to treat fever due to the fear of COVID and lack of proper safety measures.

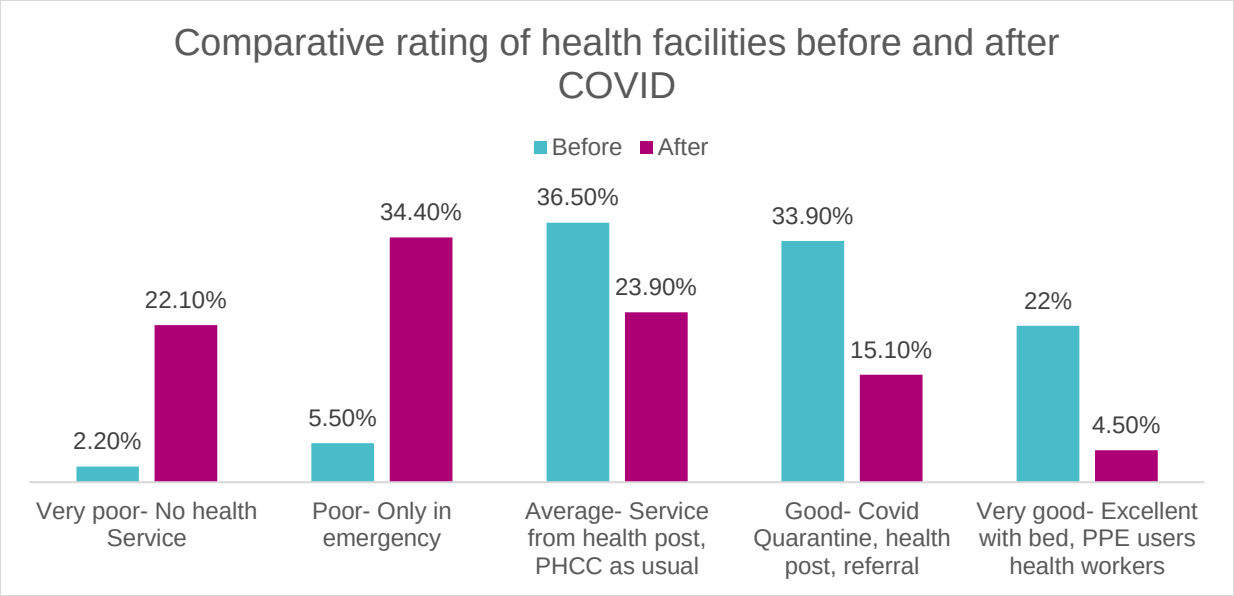


Figure 24: Comparison of health facilities before and after COVID

This trend was similar across ethnic groups. Comparing the perception of health facilities by district, Siraha has spelled out changes the most in the availability of health services. Siraha had 3.9% of the respondents stating that the health services were not available before COVID. This proportion reached to the 43.3% after COVID. This was the highest recorded change in perception by proportion. In terms of the availability of health services only in emergencies, Kapilvastu recorded the highest change. More than half of the respondents had changed their perception on the availability of health services except for emergencies. In contrary to the perception that the health services were only available before COVID by 1.6% of the respondents, 54.4% responded the same after COVID.

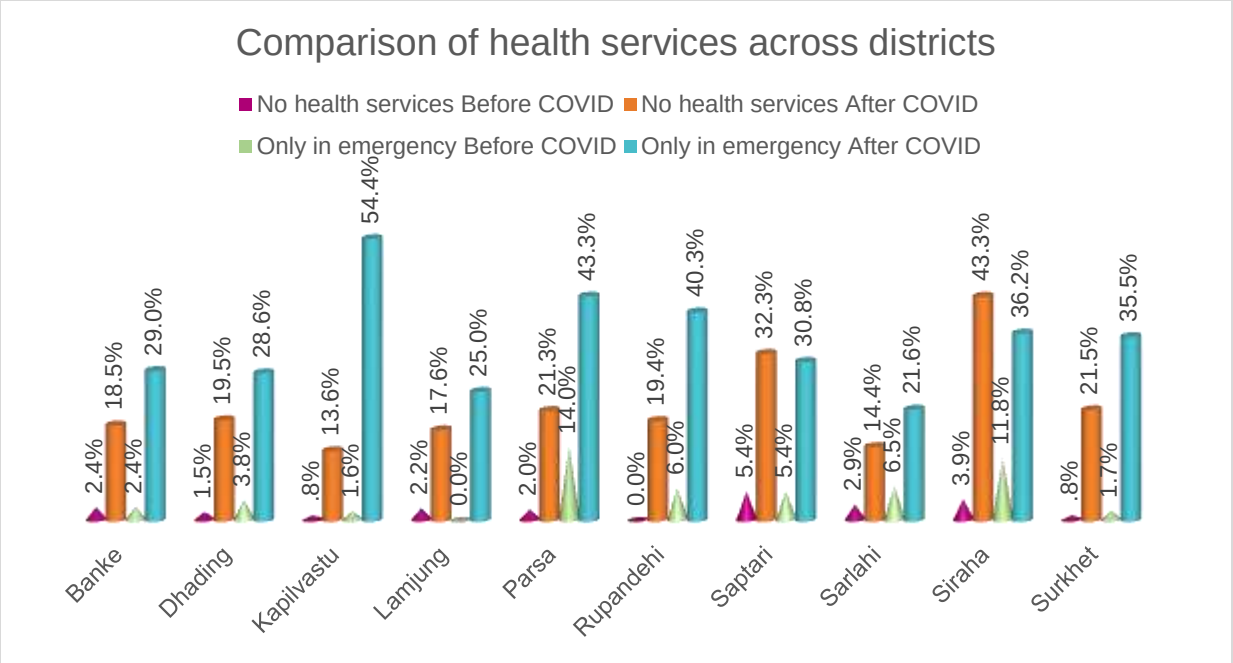


Figure 25: Comparison of health services across districts

Education

COVID had disrupted education services the most. Lockdown had shut the schools down and children were deprived of the education facilities. Approximately three-fourth of the respondents stated that there were absolutely no education services available. The remaining respondents stated there are some efforts to continue the education services through radio, TV and through online medium. The limited access of people to the education services points out towards the systemic inequality as only 7% accessed remote/online learning. The possible causes to these could be lack of access to the communication medium or lack of capacities of teachers and students to use the medium, if available.

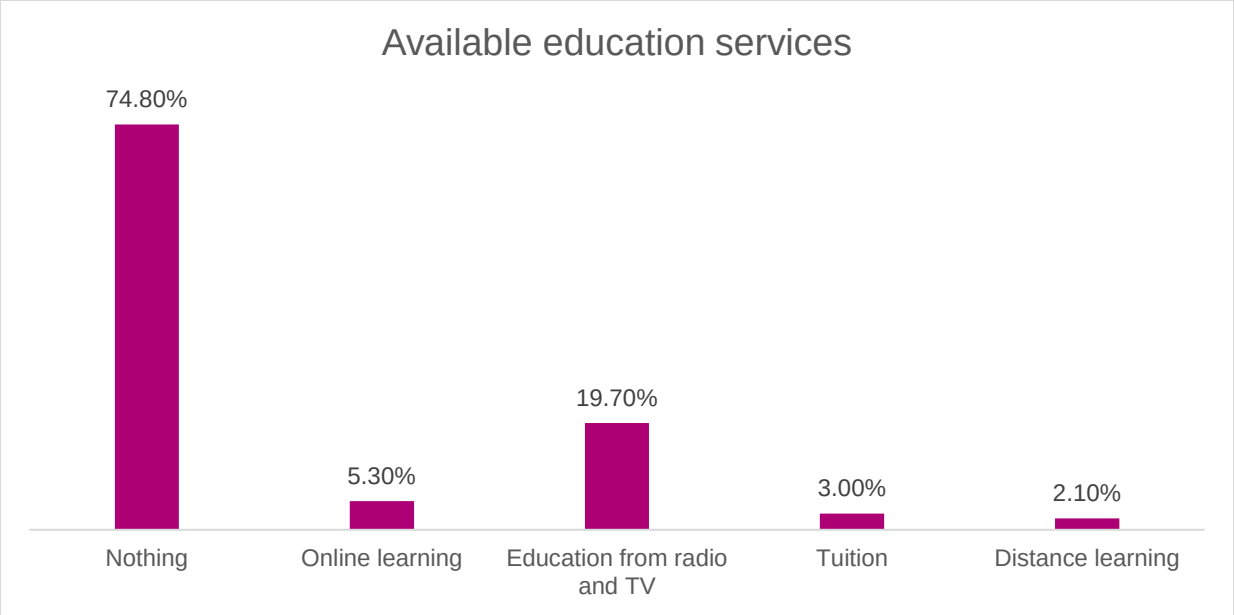
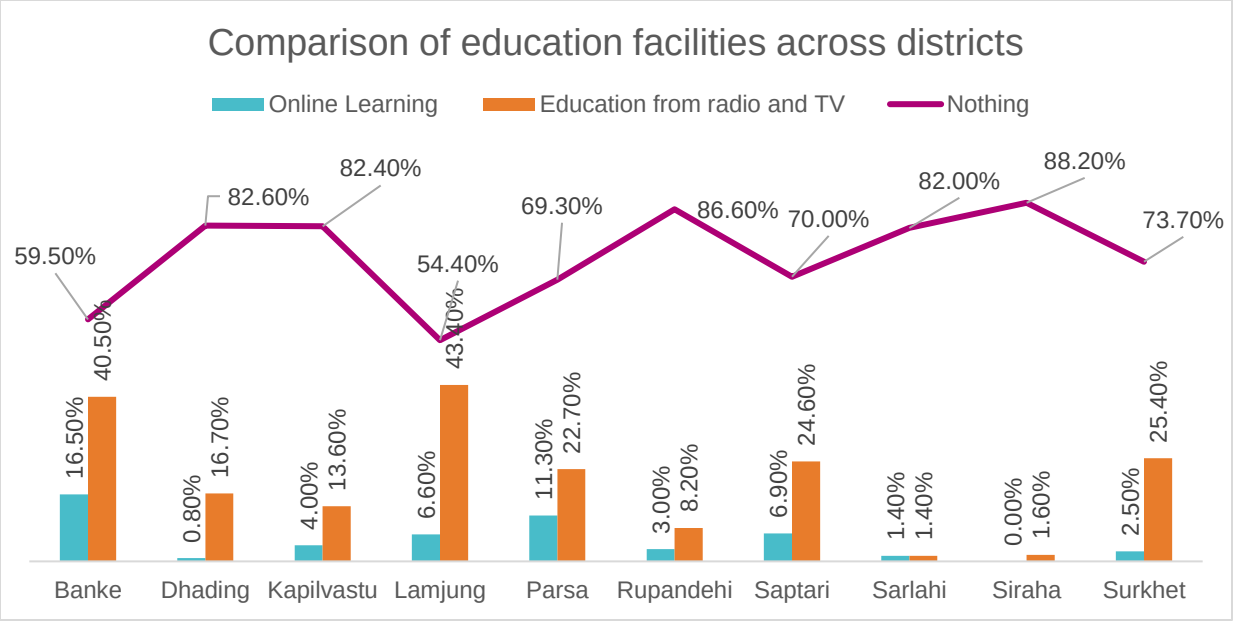


Figure 26 :Available education services

The findings disaggregated by districts depicts that Siraha fared worst in terms of education services. 88.2% of the respondents in Siraha stated that there were no education services at all during the lockdown. There were no online classes and very limited access to education through radio or TV. On the other hand, Banke and Lamjung fared comparatively better. 54.4% and 59.5% respondents in Lamjung and Banke respectively stated that there were no education services at all. The highest among all districts, 16.5% of the respondents in Banke stated the provision of online classes in their communities and the second-highest among all districts, 40.5% respondents stated the provision of education through radio and TV. In Lamjung, the highest, 43.4% respondents reported to have provision of education through radio and TV.



As the availability of education service was affected, its quality was also severely affected. Examining the trend of rating of education facilities, it can be comprehended that education services have degraded vastly during the pandemic. The rating is in the inverted trend as before COVID, majority of the respondents were happy with the education facilities while after COVID, majority of the respondents were critical of the education facilities. 40.4% of the respondents stated the education facilities to be very good before COVID but after COVID, only 2.1% stated it to be very good. Majority of the respondents, 68.7% of the total, opined that the education facilities had degraded to very poor status, the rating which was felt by only 1.3% before COVID.

Respondents laid down number of reasons to justify their rating. They reported that the educational services are closed and are not well managed due to the pandemic. The online class was inaccessible to them due to the lack of finances to ensure access to the internet and use of devices for classes. They opined that there have not been enough alternate arrangements for classrooms. The rating was similar across ethnicities and districts. Respondents were disappointed in the education facilities after COVID.

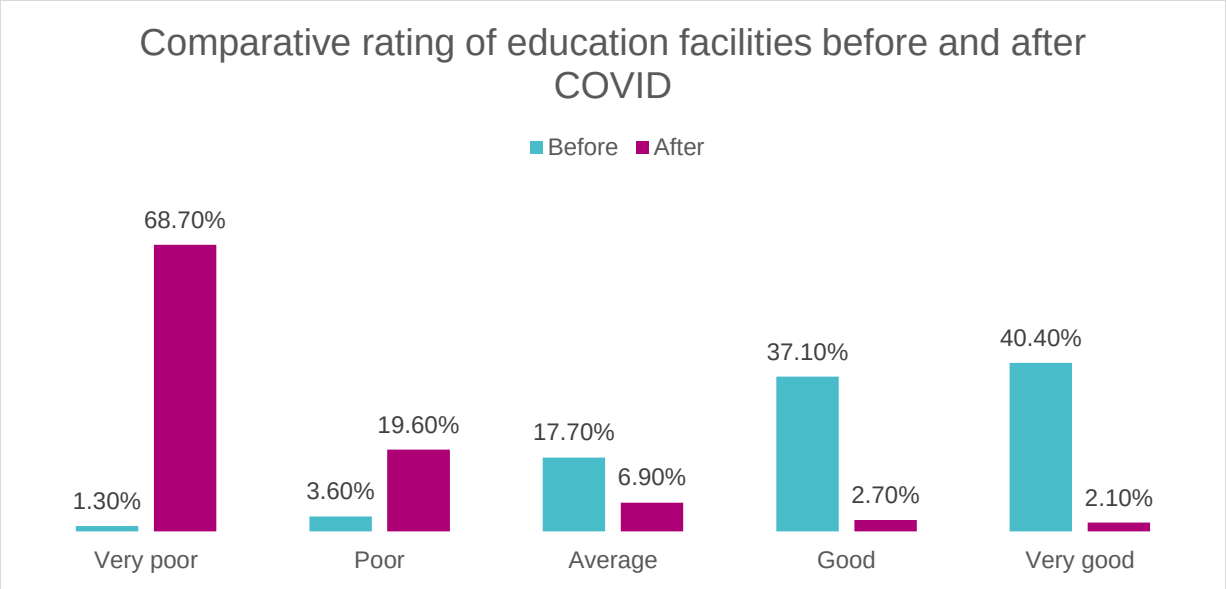


Figure 27: Comparison of education facilities before and after COVID

Security

The comparative rating for the security service were also tilted towards negative although the responses were not drastic as of education and health services. The response for security rating in the before scenario was concentrated in 'average' and 'good' section which was changed to 'average' and 'poor' section.

The respondents reported concerns in inflow of new immigrants into their villages without any surveillance or COVID testing. They feared the spread of disease in their communities due to this reason. This fear was translated in their willingness to coming out of their homes and meeting people.

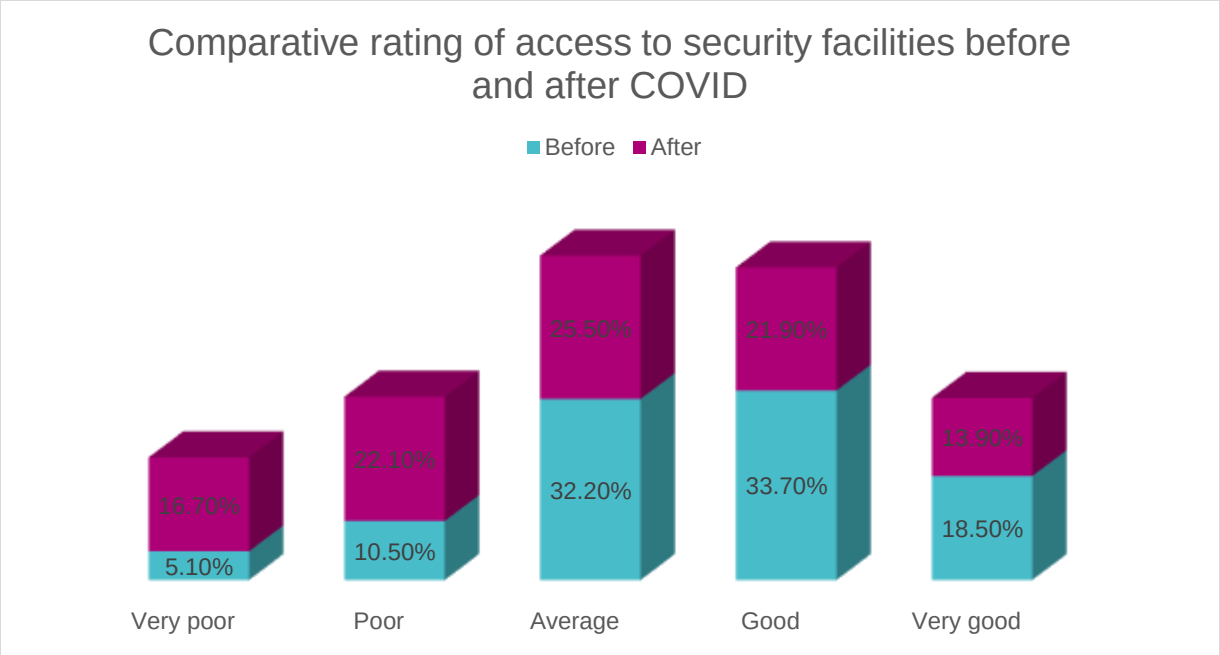


Figure 28: Comparison of security facilities before and after COVID

Service for GBV survivors

24.7% of the respondents agreed that the services for the GBV survivors were available in the community even in times of crisis. However, the quality of services was affected. Due to the lockdown, even when there are cases of GBV, the survivors are not able to report to the concerned agencies as access to the security agencies was limited. Settling of past cases and newly reported cases was halted as the issues of GBV were not in the priority for the concerned agencies. Additionally, the services provided by non-government organizations were also affected. NGOs and INGOs who used to carry out awareness raising programs had halted their awareness programs and workshops during the crisis.

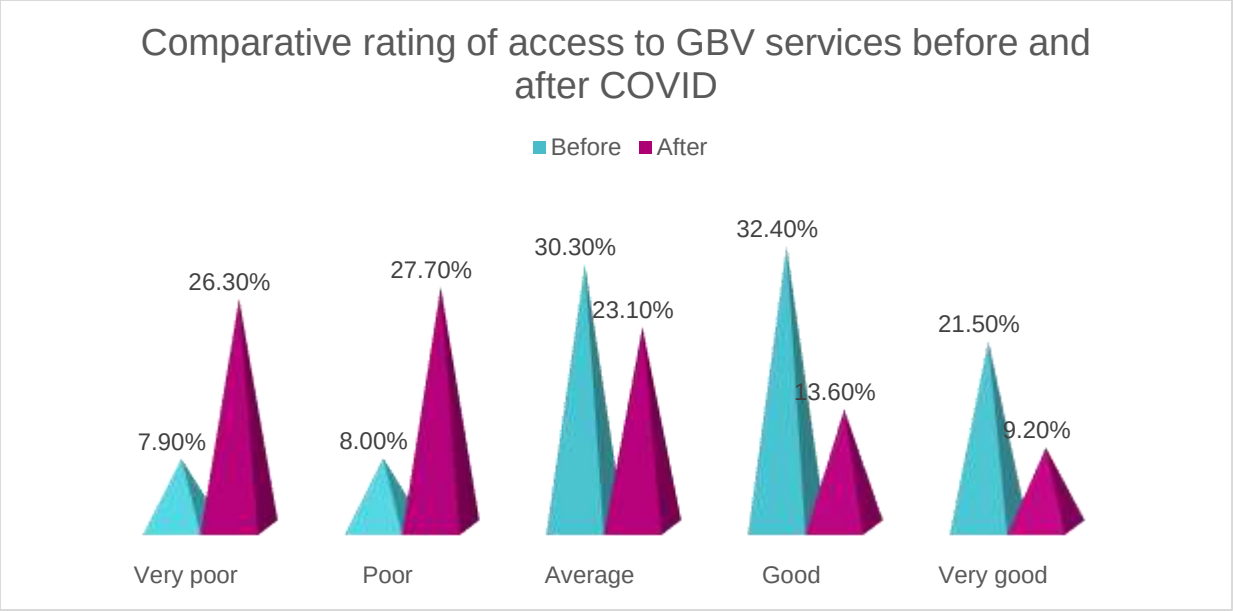


Figure 29: Comparison of GBV services before and after COVID

As the figure suggests, the negative perception towards GBV services has increased in the post-COVID scenario. More than half the proportion of the respondents across Dalits, Madhesi and minorities held negative perception about the GBV service scenario. Before COVID, the worst impression held by ethnicity was Dalits. 20.7% of the respondents thought the GBV services were 'very poor' and 'poor'.

Culminating the negative responses of 'very poor' and 'poor' as negative impression of the GBV services, Siraha fared the worst in both before and after-COVID scenario.

Table 1 : Comparison of negative responses on GBV services

Before COVID			***After COVID***		
Rank	**District**	**Proportion**	**Rank**	**District**	**Proportion**
1	Siraha	29.1%	1	Siraha	84.2%
2	Banke	24.8%	2	Saptari	60.8%
3	Sarlahi	24.4%	3	Banke	58.9%

Livelihood

As the lockdown was imposed and the mobility was curtailed, the livelihood options for the people was affected. Just above half the proportion of respondents have no livelihood option available. During COVID, 27.5% were into daily wage work while 22.4% were into agriculture and food for work. Cash for work, labour exchange and food barter were other methods employed by the respondents to manage livelihood.

Figure 30: Available livelihood options

Banke was the worst hit in terms of the livelihood options. Highest proportion of the respondents in Banke cited that their locality did not have livelihood options. Siraha and Saptari districts had more options for daily wages and provision of food for work. The livelihood option of agriculture was most cited in the hilly district of Lamjung rather than districts in Terai.

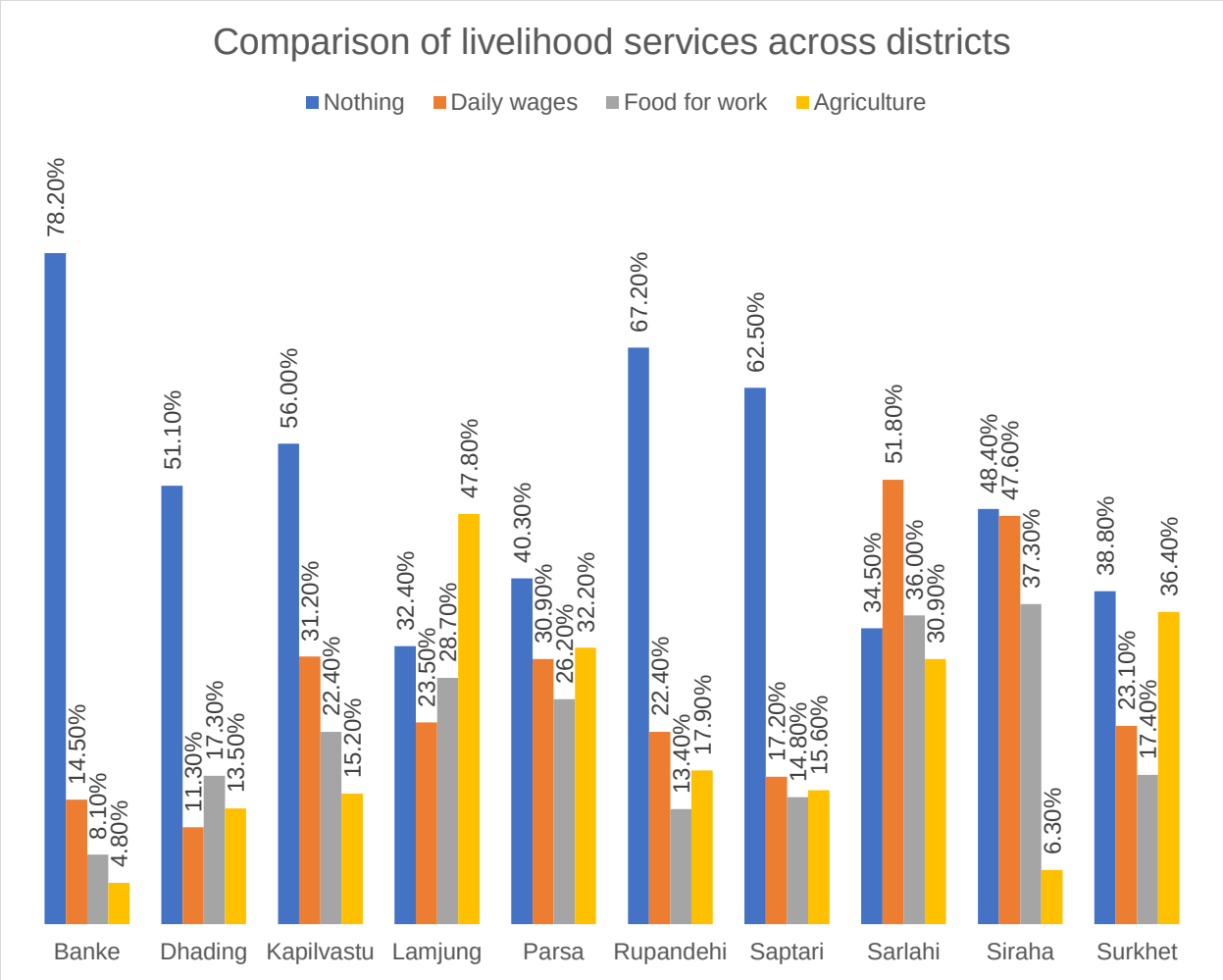


Figure 31 : Comparison of livelihood services across districts

The disruption of livelihood options was also reflected in the rating for livelihood services. More than three fourth of the respondents opined that the services to be 'very poor' and 'poor' during the times of COVID. Participants stated that they were unable to go to work or have been unemployed due to COVID crisis. Mostly the daily wage workers were facing the hard times as they were out of jobs. The people who owned businesses like manufacturing or shops were worried about recovering their losses and farmers too were not able to sell their produces in the market which caused them a loss. Respondents also expressed the fear of famine in the near future. The worries of respondents regarding livelihood options were reflected across ethnicities and districts in similar manner after COVID.

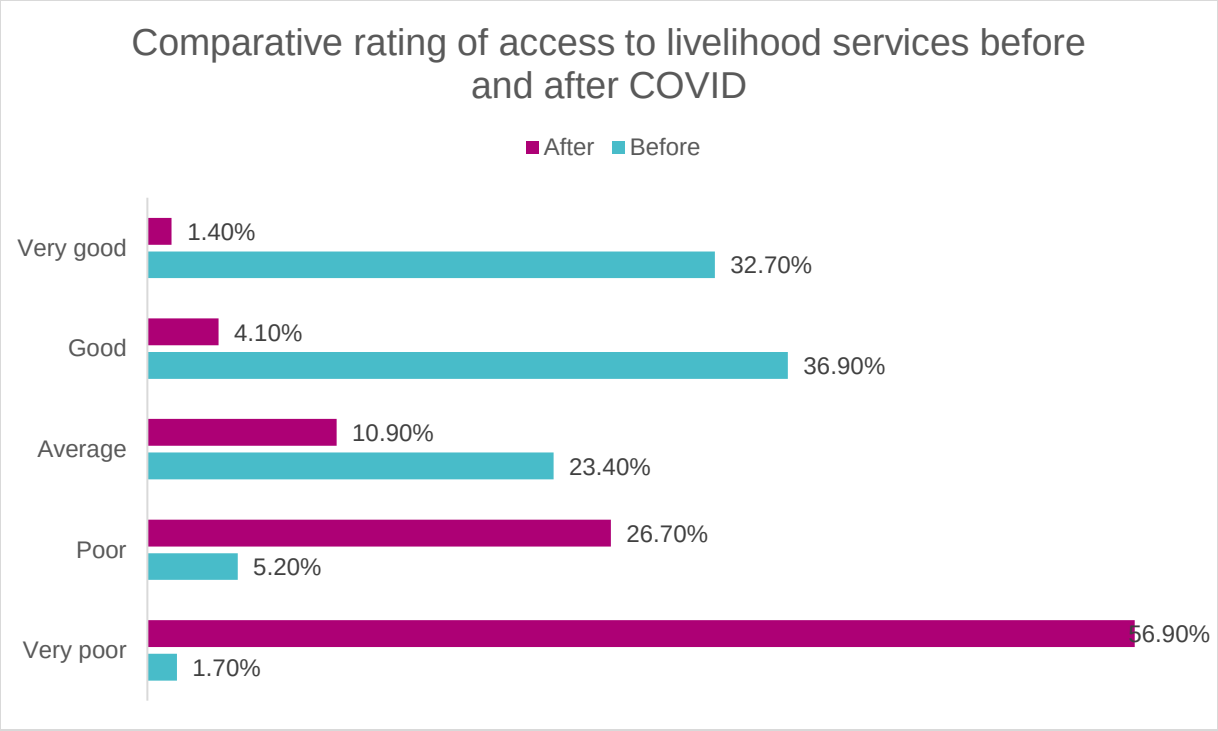


Figure 32: Comparison of livelihood services before and after COVID

Schemes from government and non-government agencies

During the time of survey, there were multiple schemes from the government and non-government agencies. Food distribution seems to be most prominent service provided by agencies during the crisis as 65.5% respondents stated the existence of food distribution program. Quarantine and COVID-19 test programs were also priority of the agencies as stated by 52% and 21.3% respondents respectively. 22.4% respondents said that neither government nor non-government agencies have come up with any programs to support in the times of COVID crisis.

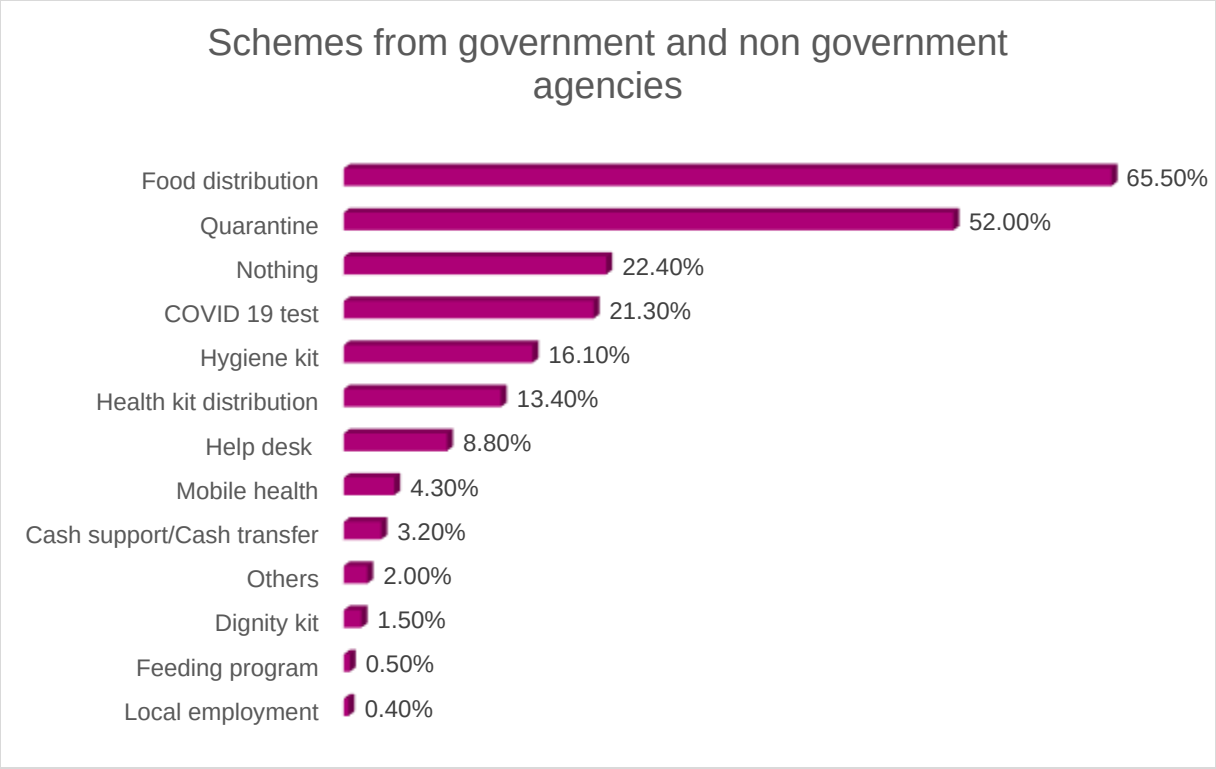


Figure 33: Schemes from government and non-government agencies during COVID

By location, the data showed similar trend of the different schemes of government and non-government which disclosed that food distribution, quarantine and COVID test were the three most popular schemes. However, the proportion of respondents stating the prevalence of the schemes were differing as per districts. 89.2% of the respondents in Sarlahi stated the presence of food distribution while 82.7% of the respondents stated the same. Quarantine in their localities were spelled out by 78.7% respondents in Siraha and 62.5% respondents in Lamjung. COVID test were however most cited in Lamjung district as 30.9% said that COVID tests were administered in their localities which was very closely followed by Saptari districts as stated by 30.8% of the respondents. In terms of the districts receiving no support, the highest proportion, 37.6% respondents in Dhading stated that they were yet to receive any schemes from the government or non-government agencies.

The respondents who have not received government and non-government support during the crisis were mostly from the ethnic groups followed by Muslim. 28% of the respondents from ethnic groups and 25.4% of respondents from Muslim communities have not been a part of government and non-government schemes.

Access to government and non-government schemes

The above section reflected on the existence of government and non-government schemes in the study location. This section further examines and compares on the access to services by the respondents.

Table 2 : Government and non-government services received by the respondents

	Government	Non-government
Access to at least one scheme	**46.6%**	**29.8%**
Among them,		
Received food or meal	72.9%	27.4%
Information on COVID	43%	63.7%
Psychosocial support	23.3%	44.8%
Hygiene kits	28.9%	11.6%
Cash support	4.5%	2.4%

Greater proportion of the respondents have received at least one scheme from the government than non-government. However, the proportion of people who got access to schemes was lower than the people who did not. Examining the nature of support, government has provided more 'hard' form of support which includes items like food, hygiene kits and cash support while I/NGOs have focused more on the soft form of support like information on COVID and psychosocial support.

Among the support provided by the government least proportion of the respondents received food distribution in Lamjung. However, they had received corona information and psychosocial support high compared to other districts. Similarly, the food support was least for Brahmin/Chhettri, however, the information on COVID and psychosocial support was high to them compared to other groups by the government.

Participation in decision-making on COVID-19 response

A mixed response was seen in terms of participation in the decision-making for COVID-19 response. 48.8% of the respondents stated that they or their family members were consulted by the government officials or other stakeholders while 39.7% stated otherwise. Out of the members who were consulted, they were consulted mostly on the issues about wearing mask, social distancing, lockdown rules, health and hygiene and quarantine.

Figure 34: Issues consulted with respondent or their families

Key findings

Priority needs

This section discusses the priority needs identified by the respondents. Further, the section weighs its interplay with the respondents' identity in terms of their location, gender, sexual orientation, age group and abilities.

Priority needs

Priority needs were drawn from the recommendations by the respondents on the most important areas that each stakeholder needs to focus on.

From Government

The priority needs for most of the respondents were immediate than long term. As the lockdown had affected their livelihood and resulted in food shortage, the focus of the respondents was on getting immediate relief which most importantly included food. 45.6% of the respondents cited provision of relief materials as the most important recommended action. The other majority demanded the strengthening of health care systems. 20% of the respondents suggested government to focus on the identification of COVID affected patients and their proper treatment.

Tackling with COVID-19 was felt at the need of the hour so 10.7% of the respondents recommend government to continue the measures of lockdown and social distancing to prevent the spread of the disease. Contrarily, 3.6% respondents advised the government to remove lockdown so that the life could go back to normal.

As COVID has affected education and livelihood of the people, respondents also suggested the government to focus on employment, livelihood and education. Furthermore, raising awareness to help protect community from the spread of the disease was also suggested by 3.3% of the respondents.

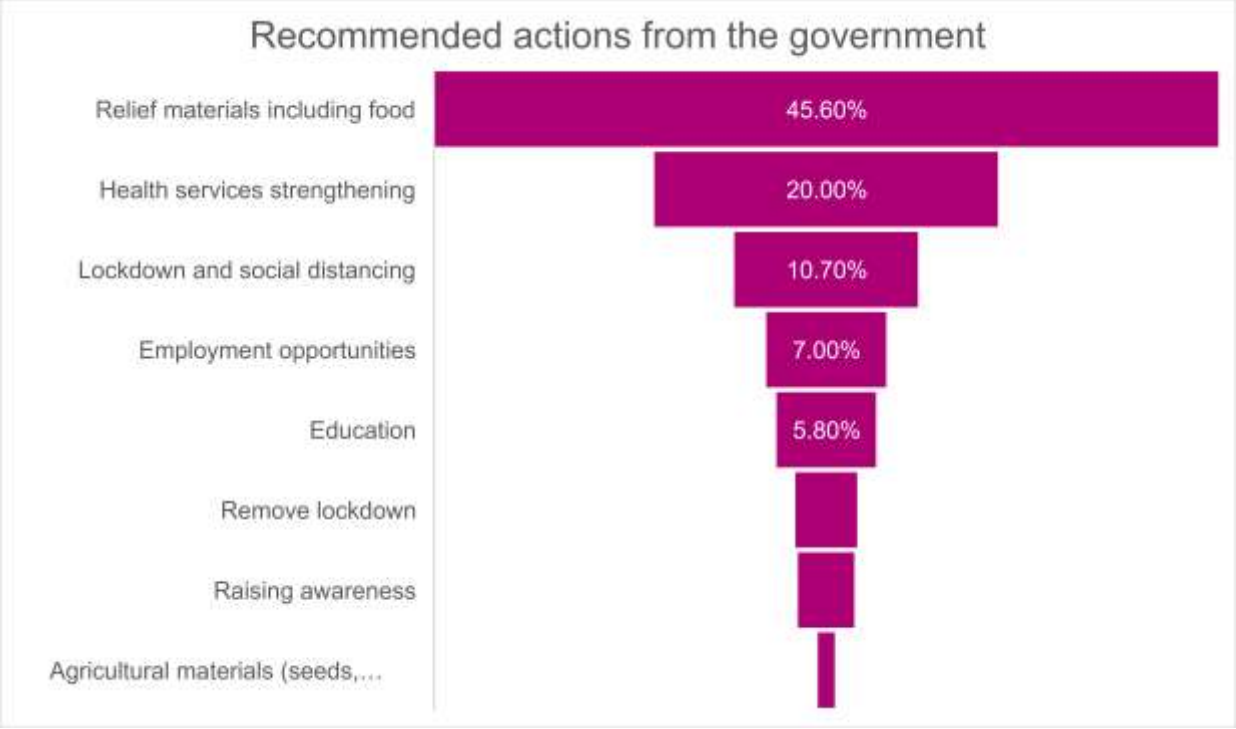


Figure 35: Priority needs from the government

Comparing the finding across district, there was no difference in the pattern of the recommended actions from the government. Majority of the respondents across all districts focused on the provision of relief materials as an expectation from the government. Particularly in Siraha, Surkhet, Sarlahi and Banke had more than half of the respondents stating relief materials as a priority need from the government. Also, for ethnicity and disability, the priority need has followed the similar trend as to the overall findings in which relief material distribution was a priority followed by strengthening of the health systems.

From non-government agencies

Like government, respondents expected support in diverse priority areas. In line with the expectations from government, 43.7% respondents recommended NGOs to focus on relief distribution, most importantly food. Strengthening of health facilities were also expected from NGOs including tests for COVID.

NGOs have been doing the awareness raising in multiple social issues. In this crisis, 13.9% respondents advised conducting the awareness raising activities in communities to prevent spread of the disease and understand it well. For the support in livelihood and employment, respondents suggested NGOs to carry out skill development trainings.

Further, strengthening education related programs, collaborating with government in their plans and programs, focusing on preventing GBV during the crisis situation and cash support were other areas which were mentioned as priorities by about 12% of the respondents.

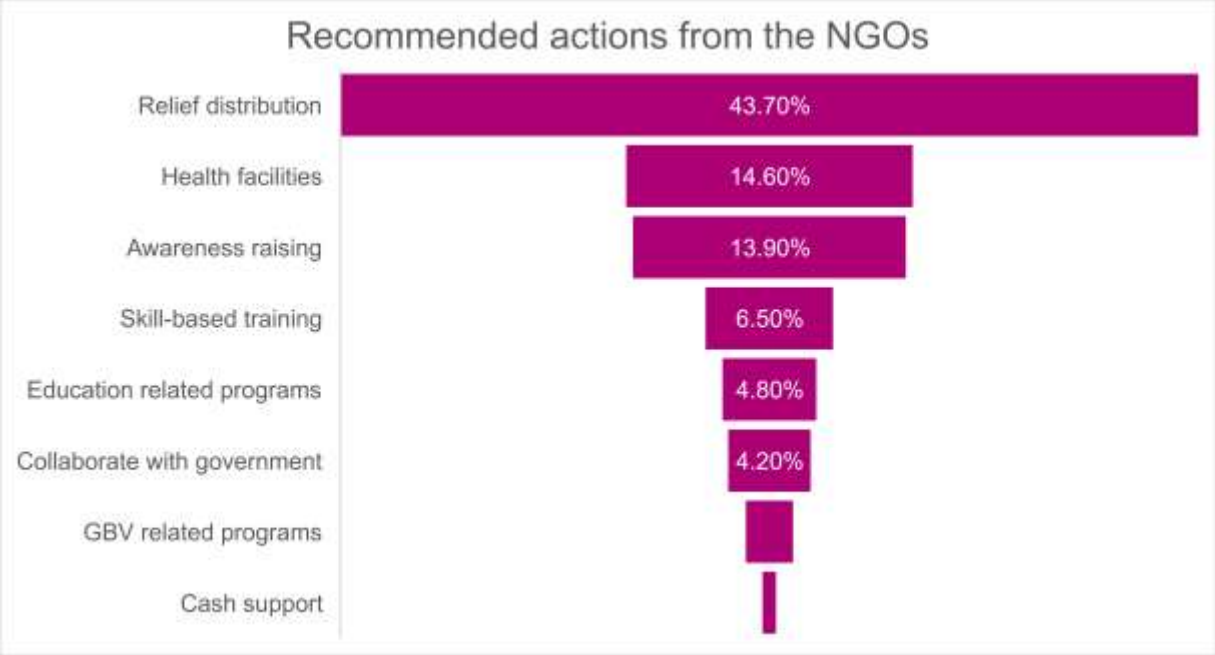


Figure 36: Priority needs from the non-government

Among the recommended actions to NGOs, relief distribution was a predominant expectation from the participants across all districts. Comparatively, it was suggested by most of the respondents in Banke followed by Sarlahi. 68.5% of the respondents in Banke and 60.4% respondents in Sarlahi have stated their priority need from NGO to be relief distribution.

Keeping up with the trend, all the ethnic groups have relief distribution as their priority need. It was the most stated expectation from NGOs by Muslims in the crisis situation. 54.3% Muslim, 49.6% Madhesi and 49% Dalit respondents have stated relief distribution as their priority need.

Conclusion and key recommendations

Conclusion and key recommendations

COVID-19 emerged as a public health crisis in 2020 but its effects were beyond health. As lockdown was imposed during the pandemic, not only health systems were pressurized but education, livelihood, gender-based violence and other socio-economic factors were equally affected. Schools were closed and the education system was stressed to look for alternatives to classroom-based education. Education system was ill-prepared in this regard. Health services suffered in the light of fear of spread of COVID. As the mobility was curtailed, livelihood options such as businesses, daily wage earners, among others were severely hampered. Food shortage, not being able to meet their family and friends, not being able to go outside homes created a mental stress in people. Some people were forced to skip meals or go without food due to the food shortage.

In this time of distress, people reached out to local government, their neighbours, friends and families and organizations for support. Government helped them through food and hygiene kits. Organizations supported people through psychosocial support and information on COVID. People also relied on information through radio, television, online platforms, among many others for knowing about the disease. Speaking of their recommendation to the government and non-government agencies, the respondents provided urgent and short-term solution of providing relief items such as food to help them during COVID. Other suggestions included strengthening of health care systems, awareness raising, employment generation, lockdown and social distancing protocols.

The most pressing challenge that emerged out in the survey was food shortage. For this reason, relief distribution, primarily food, was the most stated priority need across all districts and ethnicities. Particularly, this challenge hit Sarlahi, Banke and Kapilvastu the most. The problem of food shortage indicates towards the poverty and lack of sustainable livelihood options for the people in those locations.

Comparatively, mapping the most vulnerable, Siraha district showed the worst indicators in terms of health, education and GBV. Although other districts were taking baby steps to incorporate use of online education, Siraha had not yet begun the practice of online education and use of radio and TV for education was very limited. Also, the majority of the respondent reported health services to be very poor.

In terms of overall support from the government and non-government, Dhading was the least prioritized followed by Banke as government and non-government schemes were available comparatively lesser than other districts. In terms of ethnicities, Muslim and minorities received less support. From the government agencies, Brahmin/Chhettri received less support.

In this context, the study has emerged with following recommendations:

1. When discussing about challenges, 47% of the respondents listed mental stress as one of the major challenges due to lockdown. The issue of mental health should

be widely discussed and addressed in the community, particularly in districts where they have been marked high in the survey, with technical assistance from government and civil society organisations.

2. Although radio-listening is on declining trend, the study showed radio to be still relevant and informative for the community members. Radio, as locally convenient, can become an effective awareness building medium for social messaging and awareness raising.
3. Social capital in the form of interpersonal communication amongst neighbours, family, friends, local government officials, social workers reach out to the people, emerged as a source of information about COVID. Based on these social ties, efforts should be made by the government and organizations to relay information through these channels and reach out to the most marginalised and vulnerable families and individuals
4. Education in most locations seems to have halted due to COVID. As radio has been a good source of information and also accessible, schools and teachers could make good use of it for teaching-learning purpose. Long term solution to ensure that any pandemic in future does not affect children's education, the reach of reliable mobile phone network can be increased and access to mobile phones and internet by poor students to be planned. Teachers and students should be prepared for a distance form of teaching-learning.
5. As livelihood options have been affected, government and organizations should streamline their efforts to help people regain their food and livelihood security. This could include skill development opportunities in agriculture, manufacturing or service sector, marketing of the products or skills.
6. As the study shows that, Gender Based Violence has increased due to the pandemic, it is recommended that appropriate measures be taken to make available the services and ensure the mental health rights of the affected individuals.