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Psychosocial Impact of COVID-19 and Related Policy Provisions in Nepal

Research Report

नीति अनुसन्धान प्रतिष्ठान
Policy Research Institute

Kathmandu, Nepal

Tribhuvan University
त्रिभुवन विश्वविद्यालय

Kathmandu, Nepal

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ACRONYMS

BS	Bikram Sambat
CCMC	COVID-19 Crisis Management Centre
COVID-19	Coronavirus Disease
GESI	Gender Equality and Social Inclusion
INGO	International Non-Government Organization
MoU	Memorandum of Understanding
NCD	Non-Communicable Disease
NepJol	Nepal Journals Online
NGO	Non-Government Organization
NHP	National Health Policy
NHSS	Nepal Health Sector Strategy
PPE	Personal Protective Equipment
PRI	Policy Research Institute
TU	Tribhuvan University

नीति अनुसन्धान प्रतिष्ठान
Policy Research Institute

प.सं. :–
चनं. :–

मिति :–

Foreword

Policy Research Institute (PRI) is a think tank of the Government of Nepal. At the centre of its mandate is to undertake research on all issues of policy concern and, based on the evidence, recommend policy reforms or the enactment of new policies where there is a policy void or the reform of existing policies does not deliver. To this end, PRI conducts research on its own or in collaboration with universities and other public research institutions.

In this context, a study was undertaken through the Central Department of Anthropology of Tribhuvan University (TU) to assess the 'Psychosocial Impact of COVID-19 and Related Policy Provisions in Nepal.' Conceptualised at the end of the onslaught of the first wave of COVID-19 and undertaken during the second wave of the pandemic, the study has found different manifestations of psychosocial problems with differing effects among different groups of people. Based on the findings and conclusions of the study, relevant policy recommendations have been offered, which PRI hopes to be of use to the public health policy community in taking relevant policy decisions.

The study is one of the outcomes of the Memorandum of Understanding that PRI and TU have signed to promote institutional collaboration in research and evidence-based policymaking. In the days to come, PRI hopes to deepen and expand such collaborations in other fields and sectors of policy importance as well.

On behalf of PRI, I would like to thank Dr. Mukta S. Tamang for leading the study as Principal Investigator and my colleague Dr. Deepak Kumar Khadka, who represented PRI in the study as Co-Principal Investigator. Thanks are also due to Dr. Jiban Mani Poudel and Dr. Man Bahadur Khatri who assisted the study as Co-Principal Investigators. Dr Dambar Chemjong, Head of the Central Department of Anthropology, who was willing to institutionally collaborate, guide the study and coordinate its implementation, deserves special thanks.

I would also like to acknowledge the support of the Vice Chancellor, Rector and other office bearers of TU for creating an enabling environment for the two institutes to strategically collaborate and engage in the study the way they have done.

And last, but by no means least, I must appreciate the hard work of the members of the PRI Publication Review and Recommendation Committee – Mr Dipendra Prasad Pant, Dr. Hari Sharma, Dr. Bikram Acharya, Dr. Shobha Poudel and Dr. Mandira Lamichhane – to enhance the quality of the report by way of critical feedback and reflection.

Bishnu Raj Upreti, PhD
Executive Chairperson
July 2022

नारायणहिटी, काठमाडौं, नेपाल
फोनः ००९७७-१-४५३०५१४/४५३०५१७/४५३४९७९

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Kirtipur, Kathmandu, Nepal

Ref. No.:

Foreword

It is my privilege to write this foreword for the study on 'Psychosocial Impact of COVID-19 and Related Policy Provisions in Nepal' which is a collaborative study, undertaken between Tribhuvan University (TU) and the Policy Research Institute (PRI) policy-think tank of the Government of Nepal. As the title indicates, the study's objective is to explore COVID-19's psychosocial impacts on the people at large, review policies related to psychosocial health in Nepal, and offer recommendations to the policy community on how best to address both underlying and emergent issues. The surge of coronavirus in the country has adversely affected mental and psychosocial health affecting individuals, families as well as communities. The recommendations offered can be expected to help mitigate the problems as well as contribute to their durable solutions.

I would like to thank PRI for initiating the process of institutional collaboration between TU and PRI, leading to the Memorandum of Understanding of 07 April 2021, through which the two institutes have agreed to collaborate in evidence-based policymaking by way of policy research, academic dialogues on policy issues and development and dissemination of relevant knowledge products. This study is an outcome of the process. Three other studies are in the process of conclusion: Socio-economic Impact of COVID-19 with the Central Department of Economics; and, Electoral Systems Reform and Client Satisfaction Analysis of services offered by District Police Offices and District Administration Offices with Nepal Law Campus. I am also aware that PRI has entered into an MoU with the Institute of Engineering (TU), to undertake joint research, policy dialogues, and other processes in the area of infrastructure development. I hope to see the conclusion of these studies soon.

I would like to thank everyone– from TU and PRI – who has been part of the project in various roles, from its conceptualization to its conclusion. My appreciation goes to Dr. Dambar Chemjong, Head of the Central Department of Anthropology, who took the lead in designing and seeing through the study.

Finally, I would like to commend that the collaboration with PRI has been fruitful. I wish PRI all the best in its efforts at policy innovation while committing my full support to the process as best as I can.

Prof. Dr. Dharma Kanta Baskota,
Vice-Chancellor
July 2022

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Preface

It is my privilege to write this foreword for the publication entitled: 'Psychosocial Impact of COVID-19 and Related Policy Provisions in Nepal' which is an outcome of a collaborative research, undertaken between the Central Department of Anthropology (CDA) at Tribhuvan University (TU) and the Policy Research Institute (PRI), a policy think tank of the Government of Nepal. I am also delighted to reveal the fact that this is the first research publication in partnership between PRI, the Government of Nepal's policy institute and the Central Department of Anthropology.

In addition to teaching M.A., M.Phil., and Ph.D. level courses in anthropology, the CDA is equally involved in academic and applied research as well. The main research specialization topics that the CDA has been undertaking lately, are Social Inclusion, Governance, Climate Change, Disaster and Community Resilience. This department has already published scores of research reports and ethnographic profiles based on empirical researches and the two national surveys conducted in 2012 and 2018.

The COVID-19, a mysterious pneumonia virus-- swept across the globe beginning from December 2019. By the end of November 2020, more than 62 million people in 188 countries contracted coronavirus. As of 26 June 2021, 663,857 COVID-19 positive cases were confirmed in Nepal. By the end of June 2021, 8,975 people died of the coronavirus in Nepal. The government data shows that daily death rates during the second surge went as high as 246 a day on 19 May 2022. COVID-19, although, is primarily a physical health crisis, it has a tremendous impact on psychosocial health of the population.

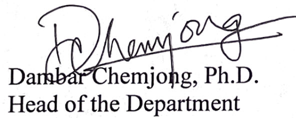
This report focusses on the psychosocial health that encompasses both cognitive process and emotional dimension in terms of individual's ability to function in the community and respond to the challenges of life constructively without oscillation of thinking and complex intensification of emotions such as anxiety, fear, frustration, anger, love, hate or joy. Disaster and pandemic often exacerbates the problem of psychosocial health. This study aims to build better understanding of psychosocial health and its determinants. In addition to this, it also reviews the policies relevant to psychosocial health with a view to help better address the problems.

We would like to commend that the Government of Nepal has formed the Policy Research Institute which as been really active in funding, managing and collaborating both the academic as well as applied researches partnering with universities including the CDA at TU.

We are grateful to Prof. Dharma Kant Baskota, Vice-Chancellor, Tribhuvan University for proving valuable support and enabling environment. We express our special thanks to Prof. Dr. Kusum Shakya, Dean, Faculty of Humanities and Social Sciences, Tribhuvan University for the necessary approval, and administrative assistance for the project.

We extend our sincere appreciation and thanks to anonymous reviewers who have meticulously reviewed the report and provided valuable comments and suggestions.

Finally, our heartfelt thanks go to the Research Associates, Bhavana Khanal, Hemraj Bhandari, Jag Bahdur Budha, Kumar Rai, Kusumlata Tiwari, Mahanta B Maharjan, Salina D. Lama, Seteman Tamang, Susma Rai, Tek Bahadur Dong and Uday Thing who took part in collecting and documenting information from the field in this challenging time amidst COVID-19 crisis. Credit is due to Prof. Yogendra Gurung and Mr. Mohan Khajum for assistance in the survey design. We also thank the staff members at the Central Department of Anthropology office for taking the very important responsibility of everyday management for the work.



Dambar Chemjong, Ph.D.
Head of the Department

Head of the Department

कार्यकारी सारांश

पृष्ठभूमि र शोध विधि

कोरोना भाइरसको ‘सिभियर अक्युट रेस्पिरेटरी सिन्ड्रोम कोरोनाभाइरस-२’ उपजातिबाट हुने कोरोना भाइरस रोग (कोभिड-१९) विश्वभर फैलिने क्रम जारी छ। २०२० नोभेम्बर को अन्त्यसम्म, १ सय ८८ देशहरूमा ६.२ करोडभन्दा बढी मानिसहरू कोरोनाभाइरसबाट सङ्क्रमित भइसकेका छन्। डेढ लाख मानिसको मृत्यु भइसकेको छ। २०२१ जुन २६ सम्म नेपालमा कोभिड-१९ का ६ लाख ६३ हजार ८ सय ५७ पोजेटिभ केसहरू पुष्टि भएका छन्। हालसम्म कोभिड-१९ बाट ८ हजार ९ सय ७५ जनाको मृत्यु भइसकेको छ। दोस्रो लहरको समयमा २०२२ मे १९ मा दैनिक मृत्यु दर एकै दिनमा २ सय ४६ सम्म पुगेको सरकारी तथ्याङ्कले देखाउँछ। कोभिड-१९ मुख्य रूपमा एक शारीरिक स्वास्थ्य सङ्कट हो तापनि यसले मानिसको मनोसामाजिक स्वास्थ्यमा ठुलो प्रभाव पारेको छ।

मनोसामाजिक स्वास्थ्यले व्यक्तिको सामाजिक सुखको सम्बन्धमा मनको अवस्थालाई बुझाउँछ। यसले सोचाइलाई उतारचढाव हुन नदिई एवम् चिन्ता, डर, निराशा, रिस, प्रेम, घृणा र आनन्दजस्ता भावनाहरूलाई जटिल किसिमले गहिरिन नदिई जीवनका चुनौतीहरूलाई रचनात्मक रूपमा सम्बोधन गर्ने र समुदायमा काम गर्ने क्षमताको हिसाबले व्यक्तिको संज्ञानात्मक प्रक्रिया र भावनात्मक आयाम दुवैलाई समेट्छ। मनोसामाजिक स्वास्थ्यलाई मानसिक स्वास्थ्यको फराकिलो विषयवस्तुभित्र बुझ्नुपर्छ। मानसिक स्वास्थ्य र मानसिक रोगलाई जैविक कारणहरूमा मात्र सीमित गर्नु हुँदैन। यी धेरै हदसम्म सामाजिक र आर्थिक तनाव, आघातात्मक अनुभव र दुर्व्यवहारपूर्ण सम्बन्धहरूको कारणले हुन्छन्। प्रकोप र महामारीले पनि अक्सर मनोसामाजिक स्वास्थ्य समस्यालाई बढाउँछ। यस अध्ययनले मनोसामाजिक स्वास्थ्य र यसका निर्धारकहरूलाई गहिरो रूपमा विश्लेषण गरेको छ। यसका अतिरिक्त, यसले समस्याहरूलाई राम्रोसँग सम्बोधन गर्न मद्दत पुऱ्याउन मनोसामाजिक स्वास्थ्यसँग सम्बन्धित नीतिहरूको समीक्षा पनि गरेको छ।

यस अनुसन्धानको समग्र उद्देश्य नेपालमा कोभिड-१९ को मनोसामाजिक प्रभावको अध्ययन गरी प्रभावित जनसङ्ख्याको हितलाई प्रवर्द्धन गर्न आवश्यक नीति सुधारहरू सिफारिस गर्नु हो।

यो अध्ययन गुणात्मक अन्तर्वार्तामा आधारित छ। सात वटै प्रदेशका ६० जिल्लाका २७४ जना सहभागीहरूसँग अन्तर्वार्ता गरी सूचना सङ्कलन गरिएको थियो। अन्तर्वार्ताहरू २०२१ अप्रिल-मे मा लिइएका थिए। व्यक्तिगत अन्तर्वार्ताको प्रारम्भिक योजनालाई बन्दाबन्दीका कारणले गर्दा फोन अन्तर्वार्तामा परिवर्तन गरिएको थियो। अन्तर्वार्ता सहभागीलाई स्नो बल विधि अपनाएर छनोट गरिएको थियो।

यस सर्वेक्षणमा कृषि पेशाका व्यक्तिहरूदेखि अनौपचारिक क्षेत्रका दैनिक ज्यालादारी मजदुर, आप्रवासी मजदुर, तलबी रोजगारहरू तथा व्यवसाय र अन्य पेशाहरूमा संलग्न व्यक्तिहरू समावेश थिए । अन्तर्वार्ताबाट सिर्जित गुणात्मक तथ्याङ्कलाई नेपाली भाषामा नोटका रूपमा रेकर्ड गरिएको थियो । सङ्कलित तथ्याङ्कको विश्लेषणका लागि अन्तर्वस्तु विश्लेषण विधि प्रयोग गरिएको थियो । अन्तर्वार्ताको लागि प्रत्येक सहभागीबाट मौखिक रूपमा सुसूचित पूर्वसहमति लिइएको थियो ।

यो अध्ययन कोभिड-१९ को सङ्कट उच्च बिन्दुमा रहेको समयमा गरिएको थियो । गुणात्मक तथ्याङ्कको लागि व्यक्तिगत अन्तर्वार्ताको मूल योजनालाई नयाँ परिस्थितिमा समायोजन गर्न फोन अन्तर्वार्तामा परिवर्तन गरिएको हो । सहज रूपमा सूचना सङ्कलन गर्न फोन कम्युनिकेसनले उल्लेख्य चुनौती खडा गऱ्यो । यी सीमितताहरूलाई ध्यानमा राख्दै, यस अध्ययनलाई गुणात्मक अन्तर्वार्ता र बयानहरूमा आधारित अन्वेषणात्मक अध्ययनको रूपमा लिनुपर्छ ।

उपलब्धिहरू

सन् २०२० देखि नेपालमा पनि कोभिड-१९ को सङ्क्रमण बढेकाले देशमा मानसिक र मनोसामाजिक स्वास्थ्य समस्याहरू थपिएका छन् । कोभिड-१९ र सम्बद्ध सङ्कटले व्यक्ति, परिवार र समुदायलाई प्रतिकूल असर पारेको छ । यो अध्ययनले मुलुकमा मनोसामाजिक स्वास्थ्य समस्या व्याप्त रहेको देखाएको छ । विभिन्न सहभागीहरूबाट सङ्कलन गरिएका बयानहरूले मनोसामाजिक समस्याहरूको पाँचवटा मुख्य अवस्थाहरूलाई औंल्याएका छन्; १) चिन्ता बढेको, २) डर र त्रास बढेको, ३) सक्रिय अवसाद, ४) एक्लिएको र एक्लोपनाको भावना बढेको, र ५) केहीमा रिस र दुर्व्यवहारपूर्ण व्यवहार बढेको । पहिल्यै कुनै स्वास्थ्य अवस्था भएकाहरूमा त उनीहरूको समस्या झन् बिग्रने सम्भावना भएको ढाँचा पनि देखिएको छ ।

मनोसामाजिक स्वास्थ्यमा सामान्यतया सामाजिक निर्धारकहरू हुन्छन् । महामारीको समयमा मनोसामाजिक स्वास्थ्य समस्याहरूको तीन प्रमुख निर्धारक वा कारणहरू हुन्छन् । अध्ययनमा सामेल अधिकांश कोभिड-१९ बाट प्रभावित सहभागीहरूले यी सबै निर्धारकहरू उल्लेख गरेका छन् । यी हुन्: पहिलो, रोजगारी र आम्दानीका स्रोतहरू गुमाउनु । दोस्रो, कष्टकर जीविकोपार्जन र ऋण । बालबालिका र अभिभावक दुवैको लागि मनोसामाजिक तनावको रूपमा तेस्रो र सबैभन्दा व्यापक रूपमा रिपोर्ट गरिएको निर्धारक चाहिँ बालबालिकाको औपचारिक शिक्षामा अवरोध हो ।

कोभिड-१९ महामारीले सिर्जना गरेको अवस्थाले मनोसामाजिक स्वास्थ्य समस्याहरू बढाउनका लागि नयाँ कारक वा निर्धारकहरू उत्पन्न गरेको छ । गुणात्मक अन्तर्वार्ताहरूले मुख्य रूपमा तनावलाई बढाउने तीन वटा कारकहरू देखाए । पहिलो भनेको सूचना महामारी (इन्फोडेमिक) हो । यो भनेको गलत सूचना, गलत सूचनाको अनुमान र षड्यन्त्र सिद्धान्तहरूसहित जानकारीको ठुलो प्रवाह हो । विभिन्न प्रकारका जानकारीको प्रवाह र सत्य तथ्य छुट्ट्याउने प्रमाणीकरणका माध्यमहरूको अभावले

मानिसहरूलाई अक्सर भ्रमित, चिन्तित र भयभीत बनाइदिएको छ । दोस्रो कारक भनेको सङ्क्रमितहरूविरुद्ध सिर्जना गरिएको कलङ्क र असहिष्णुता हो । विशेष गरी अल्पसङ्ख्यकहरू विरुद्धको असहिष्णुता व्यक्ति र समुदायका लागि बढ्दो तनावको कारण भएको छ । अन्तमा, कोभिड-१९ को सम्पर्कमा आएकाहरू र सङ्क्रमितहरूको लागि पर्याप्त स्वास्थ्य सेवामा पहुँचको अभाव मनोसामाजिक समस्याको अर्को प्रमुख स्रोत थियो ।

शक्ति सम्बन्धको तल्लो तहमा रहेका र स्रोत तथा सूचनामा सीमित पहुँच भई आफ्नो जीविकोपार्जनका लागि अनौपचारिक अर्थतन्त्रमा भर पर्ने दैनिक ज्यालादारी मजदुरहरू कोभिड-१९ र त्यसको प्रतिकूल प्रभावहरूबाट सबैभन्दा बढी प्रभावित भएका छन् । गरिब र सीमान्तकृत समुदायबाट आएका महिलाहरू कोभिड-१९ ले थपेको बोझ र लैङ्गिक हिंसाका कारण समेत प्रभावित भएका छन् ।

नेपालमा मानसिक स्वास्थ्यलाई समग्र स्वास्थ्य र सुखको प्रमुख पक्षको रूपमा मान्यता दिने दिशामा विगत केही दशकहरूमा नीतिहरूको क्रमविकास भएको छ । तर, मनोसामाजिक स्वास्थ्यसम्बन्धी नीतिहरूको सन्दर्भमा नीति उपायहरू भने अझै थप विशिष्ट बनाउन बाँकी छ । मनोसामाजिक स्वास्थ्यलाई प्रायः तृतीय विषयवस्तुको रूपमा लिइन्छ र सामान्यतया व्यापक मानसिक स्वास्थ्यको पर्यायवाचीको रूपमा प्रयोग गरिन्छ । मानसिक स्वास्थ्यलाई नीति परिदृश्यको विद्यमान ढाँचामा स्पष्ट नीतिगत किटान नगरिनु नै प्रमुख खाडल हो । नीतिहरूको समीक्षाले लिखित नीतिहरूलाई कार्यमा बदल्ने काममा पनि व्यापक खाडल रहेको देखाउँछ ।

निष्कर्ष र सिफारिसहरू

स्वास्थ्य परिणामहरूमा देखिने असमानताहरू मुख्य रूपमा सामाजिक, आर्थिक, राजनीतिक र सांस्कृतिक कारकहरूसहित सामाजिक निर्धारकहरूको प्रतिफल हो । मनोसामाजिक दृष्टिकोणले स्वास्थ्य असमानताहरू कम गर्न रोजगारी र आय, शिक्षा, आवास, पारिवारिक र सामुदायिक जीवन जस्ता सामाजिक निर्धारकहरूलाई पहिचान गर्न नीति र अभ्यासहरूको अध्ययन गरिन्छ । कोभिड-१९ जस्ता प्रकोप र महामारीबाट उत्पन्न तनाव, प्रतिकूलता र आघातले यस्तो अवस्थामा समुदायलाई गर्नुपर्ने मनोसामाजिक सहयोगको आवश्यकतालाई ह्वात्तै बढाएको छ । लैङ्गिक समानता र सामाजिक समावेशीकरण (GESI) को सिद्धान्तहरूलाई विश्वसनीय ढङ्गले अङ्गीकार गर्ने स्वास्थ्य प्रणालीभित्र प्रभावकारी कार्यान्वयनको लागि बलियो संयन्त्रको साथमा सुसङ्गत नीति उपायहरू निर्माण गर्न जरुरी छ भन्ने पनि देखाउँछ । अनुसन्धानका निष्कर्षहरू र नीति समीक्षाहरूको आधारमा जनसुखको लागि मनोसामाजिक र मानसिक स्वास्थ्य सेवा बढाउन निम्नलिखित सिफारिसहरू गरिएको छः

१. सरकारको स्वास्थ्य नीतिहरूले मानिसको बस्ने र काम गर्ने अवस्थासहित स्वास्थ्यका व्यापक निर्धारकहरूलाई सम्बोधन गर्न मानसिक र मनोसामाजिक स्वास्थ्य घटकहरूलाई एकीकृत गर्नुपर्छ । यसमा रोजगारी र आय, पारिवारिक र सामुदायिक सद्भाव, शिक्षा र सूचना,

गैरभेदभावलगायत जीवन र कामको अवस्थाको मूल्याङ्कन र सुधार समावेश हुनुपर्छ ।

२. शिक्षा, रोजगारी, न्याय प्रणालीलगायत समग्र राष्ट्रिय नीतिहरूमा मनोसामाजिक स्वास्थ्यलाई समावेश गर्ने ।

३. कमजोर जनसङ्ख्या, विशेष गरी किशोर, महिला, वृद्ध, सीमान्तकृत र अल्पसङ्ख्यक समुदायहरूलाई लक्षित गरेर मनोसामाजिक स्वास्थ्य सहायता कार्यक्रमहरू तर्जुमा गर्ने ।

४. सामुदायिक तहमा प्रशिक्षित मानव संसाधन उपलब्ध गराएर प्राथमिक स्वास्थ्य सेवामा मनोसामाजिक सहयोग हस्तक्षेपलाई समावेश गर्ने ।

५. सकारात्मक मानसिक स्वास्थ्यको लागि विद्यालय, परिवार, समुदाय र कार्यस्थलमा भेदभावरहित, दुर्व्यवहारमुक्त वातावरण स्थापना गर्न नीतिगत उपायहरू विकास गर्ने ।

६. संघीय, प्रादेशिक र स्थानीय तहमा अस्पताल, स्वास्थ्य चौकीलगायत स्वास्थ्य सेवा संस्थाहरूमा मानसिक र मनोसामाजिक स्वास्थ्य सहायताको लागि तालिम प्राप्त स्वास्थ्य कार्यदल निर्माण गर्ने ।

७. विभिन्न सरकारी विभागहरू, सरकारका तीन तहका साथै निजी क्षेत्र र गैरसरकारी संस्थाहरूबिच समन्वय सुनिश्चित गर्ने ।

८. मानसिक र मनोसामाजिक स्वास्थ्यसम्बन्धी कार्यक्रमहरू कार्यान्वयन गर्न पर्याप्त बजेट स्रोतहरू उपलब्ध गराउने ।

९. वैज्ञानिक अनुसन्धानमा आधारित मानसिक र मनोवैज्ञानिक स्वास्थ्यसम्बन्धी ज्ञानको आधार निर्माण गर्ने ।

१०. अनुभवजन्य अनुसन्धानमार्फत उपलब्ध भएका प्रमाणहरूमा आधारित गरेर गतिशील रूपमा मानसिक र मनोसामाजिक स्वास्थ्य नीतिहरू निर्माण गर्ने ।

EXECUTIVE SUMMARY

Background and Methodology

Coronavirus disease (COVID-19), caused by a strain of coronavirus, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), continues to spread across the globe. By the end of November 2020, more than 62 million people in 188 countries contracted COVID-19. The death has crossed the tragic milestone of one and half million people. As of 26 June 2021, 663,857 COVID-19 positive cases have been confirmed in Nepal. So far, 8,975 people have died of the COVID-19. The government data shows that daily death rates during the second surge went as high as 246 a day on 19 May 2022. COVID-19, although, is primarily a physical health crisis, it has a tremendous impact on the psychosocial health of the population.

Psychosocial health refers to the state of mind in relation to the social well-being of a person. Psychosocial health encompasses both cognitive process and emotional dimension in terms of an individual's ability to function in the community and respond to the challenges of life constructively without oscillation of thinking and complex intensification of emotions such as anxiety, fear, frustration, anger, love, hate or joy. Psychosocial health should be understood within the broader theme of mental health. Mental health and mental illness cannot be attributed to biological attributes alone. It is to a large extent caused by social and economic stressors, traumatic experiences and abusive relationships. Disasters and pandemics often exacerbate the problem of psychosocial health. This study aims to build a better understanding of psychosocial health and its determinants. In addition to this, it also reviews the policies relevant to psychosocial health with a view to help better address the problems.

The overall objective of this research is to study the psychosocial impact of COVID-19 and recommend necessary policy reform recommendations for promoting the well-being of the affected population.

The study is based on qualitative interviews. A total of 274 participants from 60 districts from all seven Provinces were interviewed for the information. Interviews were conducted during April-May 2021. Due to the lockdown, the initial plan for in-person interviews was changed to phone interviews. The interview participant selected rolled by following the snow ball method. The survey included varied segments of the population involved in different occupations ranging from agriculture, daily wage labourer in the informal sector and migrant labourer to

salaried jobs, business and others. Qualitative data generated through interviews were recorded as notes in the Nepali language. Method of content analysis was employed for analyzing the data collected. A verbal prior informed consent was taken from each participant for the interview.

The study was conducted during the time when the COVID-19 crisis was at its highest peak. The original plan for in-person interviews for qualitative data was changed to phone interviews to adjust to the new situation. Phone communication posed a significant challenge for collecting data smoothly. Given these limitations, this study should be taken as an exploratory study based on qualitative interviews and testimonies.

Findings

The surge of COVID-19 in the country since 2020 exacerbated the mental and psychosocial health problems in the country. The COVID-19 and associated crisis adversely impacted individuals, families and communities. This study shows that psychosocial health problem is wide spread in the country. The testimonies gathered from different participants indicates five main manifestations of psychosocial problems; 1) that it has heightened anxiety, 2) increased fear and panic, 3) activated depression, 4) increased sense of isolation and loneliness, and 5) escalated anger and abusive behaviour among some. A general pattern shows that those with pre-existing health conditions are likely to get their problem worsened.

Psychosocial health has social determinants in general. There are three major determinants or causes of psychosocial health problems during the pandemic. These three major reasons are referred to by a majority of the COVID-19-affected participants in the study. The first is the loss of employment and income sources. The second related determinant is strained livelihood and indebtedness. The third most widely reported cause of psychosocial stress for both children and parents is a disruption in the formal education of children.

The situation created by the COVID-19 pandemic generated new factors or determinants for increasing psychosocial health problems. Qualitative interviews show that there are primarily three factors that accentuated stress. The first is infodemic which refers to a massive flow of information including misinformation, disinformation speculations and conspiracy theories. The flow of different kinds of information and lack of means of verification often made people confused, anxious and fearful. The second is stigmatization and intolerance created against those who are infected. Intolerance specially against minorities has been the cause of heightened

stress for individuals and communities. Finally, the lack of access to sufficient health care for CVOID-19 contacted and infected was another major source of the psychosocial problem.

Those who are at the bottom rung of the power relations and have limited access to resources and information, especially daily wage workers who rely on the informal economy for their livelihood, are hardest hit by the COVID-19 and its resultant adverse impacts. Women coming from poor and marginalized communities were impacted due to increased burden as well as gender-based violence.

Policies have evolved over the last few decades towards the recognition of mental health as one of the key aspects of health and wellbeing in Nepal. With regard to policies on psychosocial health, the policy measures, however, are yet to be made more specific. Psychosocial health is often treated as a tertiary theme and is generally used synonymously with broader mental health. The absence of explicit policy articulation is the major gap in the existing framework of the mental health policy landscape. The policy review shows that there is also a generic gap in the translation of policy articulated into action.

Conclusion and Recommendations

Inequalities in health outcomes are the result of the social determinants - social, economic, political and cultural factors in significant ways. The psychosocial approach to health seeks the policy and practices to recognize social determinants such as employment and income, education, housing, family and community life to reduce health inequalities. Stressors, adversities and trauma inflicted by disasters and pandemics such as COVID-19 dramatically increase the need for psychosocial support to the community. It shows that there is an urgent need for building a coherent policy measure accompanied by a robust mechanism for effective implementation within the health system that takes into account the principles of Gender Equality and Social Inclusion (GESI) in good faith.

Based on the research findings and policy reviews the following recommendations are made for enhancing support in psychosocial and mental health for wellbeing:

1. The health policies of the government should integrate mental and psychosocial health components to address the wider determinants of health including the condition in which people live and work. This would involve assessment of and improvement of the living and working conditions such as employment and income, family and community harmony, education and information,

non-discrimination and others.

2. Integrate psychosocial health in overall national policies including education, employment, judicial system and others.
3. Design targeted psychosocial health support programmes to the vulnerable population, especially adolescents, women, the elderly, the marginalized and minority communities.
4. Integrate the psychosocial support intervention with primary health care by providing trained human resources at the community level.
5. Develop policy measures to facilitate a non-discriminatory, abuse-free environment in school, family, community and workspace for positive mental health.
6. Build a health workforce trained in mental and psychosocial health support at health service entities such as hospitals, health posts and others at the federal, provincial and local levels.
7. Ensure coordination among different government departments, three layers of government as well as with the private sector and NGOs.
8. Provide adequate budgetary resources for implementing the programmes related to mental and psychosocial health.
9. Build a knowledge base on mental and psychological health based on scientific research.
10. Build mental and psychosocial health policies in a dynamic way based on evidence made available through empirical research.

CHAPTER ONE
INTRODUCTION

1.1 Background

Coronavirus disease (COVID-19), caused by a strain of coronavirus, Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), continues to spread across the globe. By the end of November 2020, more than 62 million people in 188 countries contracted coronavirus. The death has crossed the tragic milestone of one and half million people (WHO, 2020a). Families are undergoing the burden of suffering from the loss of their beloved members. Not only the human cost, but COVID-19 has also seriously disrupted the economy and halted education and social life. Between January 2020 and June 2021, about 0.7 million people contacted coronavirus in Nepal. The death caused by coronavirus reached 9,000 during this period.[1]

COVID-19, although, is primarily a physical health crisis, it has a tremendous impact on the psychosocial health and well-being of the population (Fassin & Fourcade, 2021). Mental distress among people is widespread. People are afraid of getting sick, dying, or losing a family member. The fear is also heightened by what is known as infodemic – exposure to massive information including misinformation, disinformation and conspiracy theories about COVID-19 and its treatment (Saha, 2020; Zarocostas, 2020). The need for social distancing and halt of schools, offices, businesses and others have created a sense of isolation and added a burden to people, especially the elderly and children. Those families whose members already got infected, hospitalized or lost their loved ones had to go through serious stress. Many people are in economic crisis having lost or being at risk of losing their income and livelihoods. Disruption and the stressor induced by the coronavirus have started to negatively impact the social process. The case of gender-based violence including rape, suicide stigmatization and intolerance against the infected and minority population is on the rise during the period (Lohani, 2020). The secondary and often invisible effect of the COVID-19 pandemic on psychosocial health has inflicted damage on the social fabric of Nepal with a detrimental effect on the well-being of the communities (Poudel & Subedi, 2020).

A higher degree of COVID-19-related psychological distress is endured by specific population groups. The frontline health workers and wage workers in the informal

1. https://covid19.mohp.gov.np/situation-report

sector are among the first ones. In each community, the elder population and adults with pre-existing health conditions are terrified and suffered loneliness in isolation. Disruption in educational institutions has adversely affected the academic and emotional growth of children. The vulnerable and historically excluded population bears a disproportionate burnt of stress. On the whole, family anxiety, distress, abuse, and social disunity have emerged as critical challenges of our time. This humanitarian crisis and the risk of breakdown of social harmony needs to be better understood and addressed systematically.

Given the severe impact of the pandemic on psychosocial health, Nepal's citizens expect that the government, its development partners, and local authorities design an effective policy measure to address the problem. Policy Research Institute (PRI), a policy think tank of the Government of Nepal, has taken initiative to analyze the situation and review relevant policies to this end. With the support from PRI, the Central Department of Anthropology, Tribhuvan University, carried out this research to assess the psychosocial impact of COVID-19, related policy provisions and coping measures in Nepal. This study aimed to assess the psychosocial impact of COVID-19 and put forward necessary policy reform recommendations for promoting the resilient well-being of the affected population of Nepal.

1.2 Literature Review and Research Gaps

Psychosocial health refers to the state of mind in relation to the social well-being of a person. Psychosocial health encompasses both cognitive process and emotional dimension in terms of an individual's ability to function in the community and respond to the challenges of life constructively without oscillation of thinking and complex intensification of emotions such as anxiety, fear, frustration, anger, love, hate or joy. Psychosocial health should be understood within the broader theme of mental health (Frosh, 2003). Mental health has three components; biological, psychological and social. An assessment of psychosocial health involves an analysis of social factors and lived experiences that affect mental health (Martikainen, Bartley, & Lahelma, 2002; Singh-Manoux, 2003). It has a strong association with an individual's capacity for interpersonal interaction, problem-solving and decision-making.

When the mental health problems persist over time or linger for long period, they manifest in the form of mental illness or disorders. Mental illness includes various types of disorders such as depression, bipolar disorders, schizophrenia, psychosis,

dementia, eating, and personality disorders. Mental disorders are health conditions that are characterized by disruption in thinking, mood and behaviour that can cause impaired-ness in normal functioning in the community and individual lives. Mental health and mental illness to a large extent are caused by social and economic stressors, traumatic experiences and abusive relationships.

Mental health remains a much-neglect area, despite the fact that mental illnesses alone count for 18% of the current non-communicable disease burden (GON, 2014). The mental health problems include anxiety disorders, panic disorder, depression, bipolar disorder, psychic disorders, epilepsy and others. Rates of mental health problems often increase during periods of crisis, and pre-existing disorders may also resurface or be exacerbated (WHO, 2022). Although people with mental health disorders constitute a particularly vulnerable group, "stigmatization associated with mental health and pre-labelling of mental health seeker as "mad" has created an enormous barrier in identifying and addressing mental health issues" in the Nepali context (Rijal, 2018). Mental health problems cannot be reduced to biology. The social and eco-cultural contexts must be taken into consideration. The concept of psychosocial health helps to see the interconnection between the individual psyche and their socio-cultural context; their environment, interpersonal relationships, family and community. Psychosocial support is essential for maintaining good physical and mental health and provides an important mechanism for well-being and social cohesion (Misra, 2018).

Studies on psychosocial health have increased considerably in recent years in Nepal. The increased interest in research in the area of mental health and the psychosocial problem was evident when we performed a search in research databases. We searched Nepal Journals Online (NepJol) and PubMed databases with the keywords 'Diabetes', 'Cancer', 'Cardiovascular', 'Tuberculosis', 'Mental health', and 'Psychosocial.' The search in the PubMed database was conducted with the same keywords and 'Nepal' in addition.[2] In the case of NepJol, site search results were manually counted. The keywords also included major non-communicable diseases as they had a lingering impact on mental and psychosocial health. They also served as comparison variables for research output. The time period selected was 2019-2021 for the purpose of getting results during the time of COVID-19 The result is presented in the following table.

2. NepJol (https://www.nepjol.info) and PubMed (https://pubmed.ncbi.nlm.nih.gov), [Search was performed on 03 July 2021].

Table 1: Number of Research Articles Found in the Research Database (Period 2019-2021)

Database	Search Keywords and Number of Articles Found					
	Diabetes	Cancer	Cardiovascular	Tuberculosis	Mental health	Psychosocial
NepJol	>500	484	361	166	154	151
PubMed	212	374	229	134	326	125

Sources: NepJol and PubMed

A number of research-based case studies have been published on COVID-19 including its impact on psychosocial health in Nepal (Dangal, 2020; H. R. Devkota, et al., 2021; Gautam, et al., 2020; Kafle, et al., 2021; Shrestha, et al., 2020). These studies highlighted adverse or demanding circumstances created by the COVID-19 pandemic which induced unanticipated stress, and mental or emotional strain on individuals and families. These studies show that mental health problems in Nepal are often expressed in the idioms such as *chinta, dikdari, dar, udas, and jharko,* among other local concepts. They can roughly be translated to mean anxiety, uneasiness, fear/panic, depression and anger or irritation. Besides the threat of catching up coronavirus, the lockdown has caused a host of stressors by limiting mobility, access to food and material resources, child education and social interaction.

The different strata of the population; such as resource-poor women, wage workers in the informal sector, the elderly, and children experience and respond to the stressor differently. Further, if one belongs to the Dalit, indigenous communities or minority population and other vulnerable groups, the degree of the stress heightens due to their economic situation as well as the language barriers. For those who had pre-existing mental health conditions, the stressor exacerbated the problems. People generally employ multiple coping mechanisms to deal with the stressors coming from disease or fear of it, along with the stress induced by the economic downturn and social tensions.

Interest in understanding health and well-being has grown steadily in the social and behavioural sciences as well as in society generally in recent years.

Contemplation on well-being, health, and happiness has been the key part of conceptualizing the "good life" across cultures. World Health Organization (WHO) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity" (WHO, 1948), that goes beyond the absence of disease and disability as understood in the traditional medical model. Several approaches, including hedonic (Ryan & Deci, 2001), eudemonic (Lent, 2004), and Quality of Life (WHOQOL Group, 1998) have been employed to study well-being. At the time of the pandemic, disasters and eroding ethical standards, psychosocial health, and well-being need to be understood in a holistic sense.

For the purpose of this research, psychosocial health is defined as the state of mind in relation to the social wellbeing of a person. Based on the review of literature, this study aims to help address the knowledge gap in three major areas. The first is the understanding of psychosocial health in the Nepali context; the second is the impact of COVID-19 and associated stressors induced by a pandemic on psychosocial health; the third is social determinants of mental health. The understanding generated can inform the relevant policy analysis and reform.

1.3 Policy Gaps

The Constitution of Nepal established people's health as a fundamental right. Article 35 of the Constitution, for example, provides the right to every citizen for free basic health services from the State, and the right to equal access to health services. Nepal Health Sector Strategy 2015-2020 (NHSS) articulated its vision as "all Nepali citizens have productive and quality lives with the highest level of physical, mental, social, and emotional health." The health sector strategy was stated to have built upon the premise that health is an integral and indivisible part of a nation's socio-economic development (Ministry of Health and Population, 2015). Investment in health is fundamental to further national development. In line with the spirit of the Constitution of Nepal and NHSS, National Health Policy 2071 (NHP-2014) was revised in 2019 (Ministry of Health and Population, 2019). The new National Health Policy 2019 (NNHP-2019) sets out a forward-looking agenda for improving the health and well-being of all citizens of Nepal, including the elders, differently able people, single women, poor, marginalized, and vulnerable communities. The policy clearly establishes the mental, social, and emotional well-being of individuals as integral facets of human health to enable citizens to live quality lives.

NHSS sets out one of its strategic outputs (Output 3.1) as "improved access to health services, especially for unreached populations." In order to achieve this output, the strategy document outlines interventions to "update basic healthcare package by including emerging health care need like psychosocial counselling, mental health, geriatric health, oral health, standard Non-Communicable Disease (NCD) package, Ayurveda and rehabilitative services." The interventions however for improving access to health services are overtly dominated by clinical measures. Although, in another outcome (Output 7.1), "healthy behaviours and practices promoted," is articulated, the interventions designed for addressing the issues of mental, psychosocial health and well-being fall short.

The concept of an integrated umbrella policy for the health sector adopted in the past was generally expected to cover the mental health component in Nepal. A separate Mental Health Policy was adopted in 1995. Recently, the government approved the National Mental Health Strategy and Action Plan, 2077 (Ministry of Health and Population, 2020). The policy aims to create an environment in which mental health is valued and promoted, mental disorders are prevented, and persons affected by these disorders are able to exercise a full range of human rights and access high-quality, culturally-appropriate health and social care in a timely way.

Analysis of the health sector strategy and policy in Nepal shows that they have articulated a clear goal of improving the mental and psychosocial health and well-being of the population. In the light of reviews of policies related to mental health (Luitel, et al., 2015; Upadhaya, 2013), and the emerging needs of mental and psychosocial health, policy should be supported for eliminating gaps, including potential implementation issues. The reviews also indicate that if the goal with regard to psychosocial health and well-being is generic, the intervention currently envisaged is overwhelmingly focused on the curative aspect. The policy also needs to be made specific to the improvement of psychosocial health and well-being. The issue of psychosocial health would require a multi-sectorial approach linking it with education, social and economic development, and environmental policies. The policy goals and intervention logic further demand the analysis of the ways to synchronize with health sector policy on Gender Equality and Social Inclusion (GESI) (Ministry of Health and Population, 2018).

Moreover, the past policies are often designed for the normal period and only minimally conceptualized for the time of disaster or pandemic such as COVID-19. The pandemic has exacerbated anxiety, fear, and other disorders. Mental health initiatives and support after the 2015 earthquake in Nepal, however, have depicted

how natural disasters severely affect the mental health of the population and support can be extended to the affected (Jimba, et al. 2019). In response to such a situation, the Disaster Risk Reduction and Management Act 2074 Bikram Sambat (BS) in its Clause 11 stipulates one of the tasks as to “make psychosocial counselling available to the disaster-affected peoples” (Ministry of Home Affairs 2017). A review of disaster-related Acts, regulations and policies for understanding the gaps in these policy articulations and their implementation in the context of the pandemic should be given due consideration.

1.4 Research Objectives

General objective

The general objective of the research is to study the psychosocial impact of COVID-19 and recommend necessary policy reform recommendations for promoting the well-being of the affected population.

Specific objectives

Objectives related to knowledge gaps

- Identify the psychosocial impact of COVID-19,
- Identify social and emerging determinants of the mental health of the population in the context of COVID-19
- Assess the emerging phenomena induced by the COVID-19 pandemic that adversely impact mental health

Objectives related to policy recommendation and implementation

- Understand the broader landscape of the mental health policies in Nepal
- Identify policy measures articulated in various laws, regulations, strategies, plans and decisions
- Review policies related to mental and psychosocial health to offer insights on gaps and necessary reform based on the research findings and policy review.

1.5 Research Questions

- What are the psychosocial impacts of COVID-19?
- How did the new situation created by COVID-19 impact mental health?
- Who are the most vulnerable in terms of social groups and their social determinants for disproportionate impact?

- What is the policy landscape with regard to mental health?
- What are the gaps in policy measures in terms of their goal and implementation?
- What recommendation can be made to better articulate policy goals on social-psychological health and well-being and fill the gap in intervention logic and implementation?

1.6 Methodology

The study is based on qualitative interviews. A total of 274 participants from 60 districts from all seven Provinces were interviewed for the information. Except for the Bagmati province, it was planned to interview about 30 participants. In the Bagmati province, a total of 60 interviews were planned; half in urban areas of Kathmandu valley and rural districts. The theory of saturation for continuing the interview was adopted. For this, a quick assessment was made to see if the themes and narratives already shared by interviewees are repeating and if no significantly new themes and narratives are coming from newer interviewees. Such a point would be a signal of saturation of data. Nevertheless, in order to cover the participants from different backgrounds and districts, the number of participants increased in some cases.

Interviews were conducted during April-May 2021. Due to the start of the second round of the lockdown in Nepal, the initial plan for in-person interviews was changed to phone interviews. The selection of knowledgeable informants was done on the basis of the recommendation by the officials and the representatives of the local government bodies. The phone numbers of the relevant participants were obtained from local government representatives during the initial phase. The interview participant selected rolled by following snowball sampling techniques. Each interviewee was requested for name and contact for the possible participants for the next interview. Consent was taken before the start of the interview. Each phone interview lasted for about 45 minutes. Due to the phone line disturbance or disconnection, it took more time for completing the interview in many cases.

The distribution of the participants in six provinces was between 10-13 percent. Due to the larger urban population, Bagmati province has 28 percent of the share. Of the total 274 interviews, 34.3 percent interviews were conducted with female participants. The following table shows that distribution of participants by province and sex:

Table 2: Distribution of Participants by Province and Sex

Province	Number of Participants		Total (N)	Percentage
	Female	Male		
Bagmati	31	46	77	28.1
Gandaki	14	20	34	12.4
Karnali	15	15	30	10.9
Lumbini	8	25	33	12.0
Province 1	10	27	37	13.5
Province 2	9	23	32	11.7
Sudurpaschim	7	24	31	11.3
Grand Total	94 (34.3%)	180 (65.7%)	274	100.0

In terms of the composition of participants by caste and ethnicity, all social groups were included in the research. Of the total participants, 34 percent were from Adivasi Janajati, 11 percent from Dalit and 47 percent from Hill Bahun/Chhetri community. Madhesi caste and Muslim have 7 percent and 1 percent respectively. The following table shows the distribution of participants by province and caste/ethnicity.

Table 3: Distribution of Participants by Province and Social Groups

Province	Number of Participants					Grand Total
	Adivasi Janajati	Dalit	Hill Brahmin/ Chhetri	Madhesi Caste	Muslim	
Bagmati	46	2	29			77
Gandaki	20	4	10			34
Karnali		9	21			30
Lumbini	9	1	20	2	1	33
Province 1	8	5	24			37
Province 2	3	4	5	18	2	32
Sudurpaschim	6	5	20			31
Grand Total	92 (33.6%)	30 (10.9%)	129 (47.1%)	20 (7.3%)	3 (1.1%)	274

The survey included varied segments of the population involved in different occupations. The occupation included agriculture, daily wage labourer in the informal sector, migrant labourer to salaried job, business and others. However, participants who are involved in salaried jobs, businesses and students are in higher numbers than other categories. The study also took into account the level of education attained by the participants. Of the total, 56.6 percent of participants had an education of bachelor's level and above followed by 27 percent of interviewees with an education level of high school.

The following table shows the distribution of participants by occupation and education level.

Table 4: Distribution of Participants by Occupation and Education level

Occupation	Education Level					Total	Percent
	Illiterate	Basic/ Literate	Grade 8-10	Grade 11-12	Bachelor & Above		
Agriculture	4	3	1	5	3	16	5.8
Business		3	5	13	17	38	13.9
Health Worker	1	1	2	9	11	24	8.8
Household Work	1	1		3	3	8	2.9
Politician	1	4	5	17	9	36	13.1
Salaried Job			1	12	80	93	33.9
Social Work				2	6	8	2.9
Student				4	20	24	8.8
Unemployed	1				1	2	0.7
Daily Wage Worker	3	2	5	4	3	17	6.2
Migrant Labourer		1		5	2	8	2.9
Grand Total	11 (4.0%)	15 (5.5%)	19 (6.9%)	74 (27.0%)	155 (56.6%)	274	100

The researcher conducted the interview based on the Interview Guidelines provided. The guideline was designed in such a way that the participants could tell their stories

chronologically from the start of COVID-19. The participants were asked to answer the general questions on how they come to know about coronavirus, what risk they perceived, in what ways they and their families were impacted, how they responded to the situation and how they see the future scenario.

Qualitative data generated through interviews were recorded as notes in the Nepali language. In the cases where interviews were recorded, they were later transcribed. Eight Research Associates involved in the interviews conducted were responsible for the task of transcribing and finalizing the notes. For the data analysis, the method of content analysis was employed. The analysis of the data was done in three stages. The first step involved sharing the data by the Research Associates in the workshop with the whole research team. The purpose of the sharing was to identify the key themes and categories emerging in the data collected. The second step was to compile all the data for close examination for further refining the categories to be used as research findings. After the finalization of the themes and categories, the relevant information was grouped in each category. The third step involved extracting testimonies of the participants which include verbatim quotes as well as a description of the event, experiences or opinions. Selected among them were reproduced under each theme in the report as empirical material.

For the policy analysis, 20 interviews were conducted with people relevant to policy issues and concerned representatives from stakeholders. They included representatives from government health ministries, practising psychiatrists, psychosocial counsellors, health workers, community leaders and local government representatives. The participants were either involved in policymaking or knowledgeable about policy and were practising in the mental and psychosocial health-related areas. For the generation of information for the policy evaluation, questions in six areas were asked. They included information on policy background in terms of how they view the scientific ground of the policy. For example, participants were asked for their views on whether the policy goals were drawn from the conclusive review of literature from within and outside the country, what were the data based on which policies were formulated and whether existing policies examined cultural/demographic patterns relevant to mental/psychosocial health. Similarly, they were also asked about the awareness among stakeholders on policies and their provisions and whether policies were developed in consultation with stakeholders. The policy contents in terms of their vision, goal and objectives and activities were examined for assessing their relevance and coherence. Finally, the participants were asked to express their views on policy implementation.

A verbal prior informed consent was taken from each participant by informing them about their right to voluntarily respond or withdraw from the interview including consent for recording the phone interview. The study collected data from individuals on their views, perceptions and personal life experiences. In order to protect privacy and ensure no harm, all personally identifiable information is being removed or pseudonyms are used.

1.7 Limitation of the Study

The study was conducted during the time when the COVID-19 crisis was at its highest peak. At the time when we planned for field data collection, the government announced the second lockdown. Due to the impossibility of movement for an uncertain time, the research methodology had to be altered. The original plan for in-person interviews for qualitative data was changed to phone interviews to adjust to the new situation. The plan for a structured sample survey was not possible to implement. Field work for policy analysis too was constrained significantly.

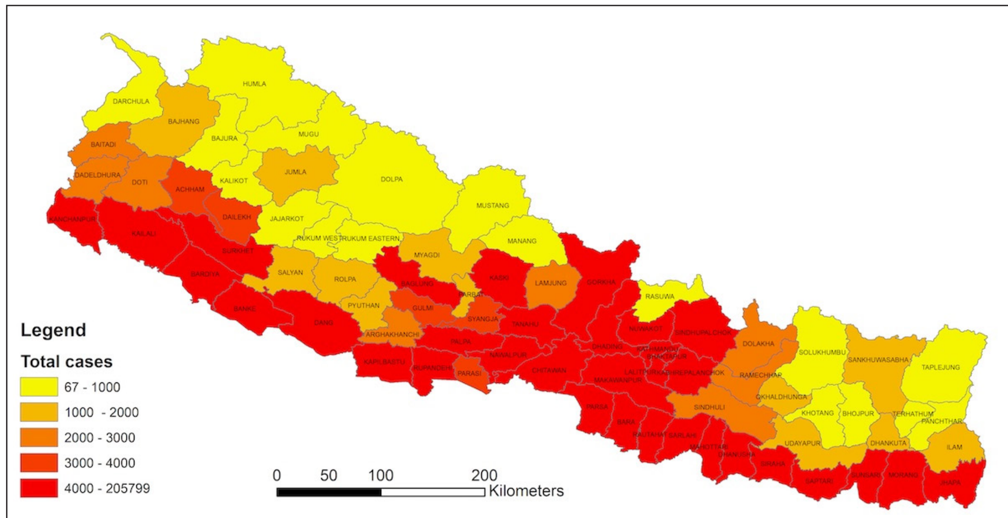
Although phone interviews were able to generate useful information to answer research questions, the interview faced a number of challenges. The weak and unreliable phone connection was a major problem. In many cases, it was difficult to get connected to the identified participants due to connection difficulties. During the interview session, the disruption of the phone line posed a significant difficulty for the smooth interview. In some cases, they had to attempt connections multiple times for an interview. Often the line was not clear enough for communication. Even more important was that the telephonic medium was not necessarily the best way for establishing rapport and a relationship of trust between the interviewer and interviewees. Given these limitations, this study should be taken as an exploratory study based on qualitative interviews and policy analyses.

CHAPTER TWO

COVID-19 PANDEMIC IN NEPAL- A SYNOPSIS

On 23 January 2020, the first case of COVID-19 was reported in Nepal which was an imported case from China. With the local transmission reported in April 2020, the first wave of COVID-19 started in the country. After about 15 months, in March 2021 the country came under the sway of a second surge. The number of positive cases spiked dramatically with a significant number of serious illnesses and deaths since then. As of 26 June 2021, 663,857 COVID-19 positive cases have been confirmed in Nepal. So far, 8,975 people have died of the coronavirus.[3] The delta variants of coronavirus were mainly responsible for the second surge. The new variants proved to be much infectious, fatal and highly transmissible. The government data shows that daily death rates during the second surge went as high as 246 a day on May 19. The lockdown started on 29 April aimed at slowing down the infection. Figure 1 shows the district-wise distribution of the cumulative numbers of COVID-19 positive cases as of 4 July 2021. The data shows a variation in the number of cases in different districts. However, it is clear that all districts are impacted by the pandemic.

Figure 1: District-wise Distribution of the Cumulative Number of COVID-19 Positive Cases in Nepal (as of 4 July 2021)



Source: Ministry of Health and Population COVID-19 Dashboard https://covid19.mohp.gov.np

3. https://covid19.mohp.gov.np/situation-report

Nepal has been hit twice by the COVID-19 pandemic with significant effects on economic, educational, social and even political aspects of society. The pandemic has impacted not only individuals' physical health but the society has witnessed various problems of psychosocial health. Previously acclaimed aspects of socially harmonious, mutually cooperative and societally integrative relationships in society seemed to be abruptly replaced by the activities that are indicative of mutual suspicion, non-cooperation and social tension (Adhikari, et al., 2021; Poudel & Subedi, 2020; Tamang, 2020). The pandemic disrupted both the processes of economic prosperity and the social well-being of the country (Sharma, et al. 2021).

The hardest hit by COVID-19 in Nepal were the poor workers involved in the informal economic sector in Kathmandu valley and urban areas elsewhere in the country. Hundreds of thousands of workers abruptly lost their jobs as soon as the government announced the lockdown (*bandabandi*) of the country in March 2020 during the first surge of the pandemic. The closing of construction sites, hotels, restaurants and factories forced hundreds of thousands of workers into a state of despair of having lost the source of making their everyday living. The weakest section of Nepali society who made their living on daily wages were literally abandoned in the street.

Those workers who immigrated to Kathmandu valley or elsewhere from different districts of the country in search of work were left with confusion about how the situation would unfold in terms of lifting of lockdown and going back to work. When it became apparent after a week or two that government continue to extend the lockdown, they realized that they should go back to their homes. The workers started their journey back home on foot on the highway. The scenes of dozens of workers walking from Kathmandu valley and other working sites to their homes were witnessed in all forms of media reports. Those heart-wrenching scenes of the workers walking on foot home with their children who often endured hunger during the hot days and dark nights exposed a lack of planning to deal with the crisis on the part of the government. Other hard-hit sectors in the economy were the entrepreneurs and investors alike when they were forced to close their businesses, many of them have faced severe consequences of their enterprises collapsing. In a nutshell, the Nepali economy seems to have taken a hard hit like many of the economies around the world.

The education sector was the second hardest hit by the lockdown following the pandemic in Nepal (Dawadi, Giri, & Simkhada, 2020; K.R. Devkota, 2021). Education system; schools, colleges, and universities were all abruptly closed

abiding by the government's announcement of lockdown thereby suspending all in-person classes and exams. As a consequence, many teachers teaching at private schools lost their jobs during the lockdown period. Most of the teachers either did not get paid or had to start teaching online with only a half-paid salary on the other. This disruption gave rise to conflicting relationships between the management of private schools and students' guardians. Many of the guardians were not ready to pay the school tuition fees for the online classes while the schools also complained that they could not pay their teachers without the tuition fees from their students. Those hit by this embroilment were the teachers who either lost their jobs or got to work on half pay despite adapting to a new (online) teaching practice that was quite demanding. The adaptation that has compelled them to adopt unfamiliar techniques created pressure on teachers (Dawadi, et al. 2020). The situation of the employees in the tourism sector and private hospitals as well as for small enterprises was the same as in the education sector (Dangol, et al., 2020).

Individuals and society are integrally interrelated in making the social system as a whole in which harmonious, integrative and cooperative relationships are desired for continuity of social structure, system and order. The COVID-19 pandemic has pushed Nepali society into a new social relationship called 'New Normal' as is the case with people of other countries. The new social norms and new ways of everyday life, such as maintaining social distance in public, getting together only in small groups, and wearing masks in public places are gradually becoming the new way of everyday life. Such an adaptation to the 'New Normal' seems to be setting the individuals and society apart, meaning that new forms of relationships are to emerge owing to the pandemic.

In fact, the Nepali people had already gone through traumatic experiences during the earthquake in 2015 as well as victims of floods and landslides. But the COVID-19 caused yet another hurt causing mental health at the individual as well as at the collective/societal level. Responses to these disasters required different approaches. During that earthquake, people had to be outside their houses for their own safety. But during COVID-19 infection surge, people have to hide inside to keep themselves safe from the pandemic. Access to digital information was helpful to those who have access but it also reduced the possibilities of in-person contacts amongst fellow members of society. It is to be noted that "humans need frequent contacts, and crisis events further stimulate a need for affiliation and intimacy" …therefore, "prolonged isolation and separation from families and their community can have profound effects on individuals even if they are not directly affected by the disease" (Saha et al., 2020:11). Besides, another difference the people witnessed was, during

the earthquake, all the Nepalese people in diaspora, and international donors/ agencies could come forward offering humanitarian support. A sense of solidarity was promoted. But during the pandemic, the whole world was crippled by COVID-19. The international community as well as the Nepalese in Diaspora couldn't come forward to provide philanthropic support as they had done during the earthquake disaster.

Amidst the growing public health crisis from the pandemic, the Government of Nepal formed the COVID-19 Crisis Management Centre – Operation (CCMC-Ops) in March 2020. The centre was launched to fight the pandemic, ensure control over the situation and deliver immediate relief in an effective and well-managed way. This high-level committee, however, was dissolved in June 2020 and the government formed a COVID-19 Crisis Management Centre (CCMC) under the coordination of the then Deputy- Prime Minister. The CCMC is comprised of four different branches; Medical Operations, Logistic Operations, Security Operations and Media and Information Technology (IT) Operations to execute their activities immediately and effectively.[4]

The second surge of the COVID-19 pandemic has created even more shock in the people. The government system was overstretched to tackle the second hit of the pandemic. Lockdown turned out to be a major solution for controlling the spread. Amidst this ongoing pandemic, Nepal was also facing shortages of essential medical supplies like personal protective equipment, testing kits, ventilators, oxygen cylinders, and most importantly the vaccine. It was heart-wrenching to witness the members of one's own family or community dying of not getting the oxygen supply when needed.

Likewise, women were more vulnerable than men in terms of facing gender-based violence, job loss and the increased workload in the domestic sphere. In terms of death, men outnumbered women, however, women experienced greater risk inadvertently in terms of social, cultural and sexual violence (Dahal et al. 2020; Paudel, et al. 2020). In terms of restricted mobility outside, women especially those women working in formal sectors had problems. As the resources are inadequate, they were under great pressure. But their situation has been overshadowed and overlooked in the larger picture of the pandemic. As Nepali society is characterized by patriarchy and existing structural inequalities across health, economy, education, and social and political relationships, the COVID-19 crisis has exposed women to a higher level of vulnerability.

4. https://ccmc.gov.np/

CHAPTER THREE

IMPACT ON MENTAL AND PSYCHOSOCIAL HEALTH

In this section, testimonies from the myriads of individuals on how they have experienced the situation that adversely impacted their mental health is presented. In particular, experience related to anxiety, fear, irritation/frustration, loneliness and depression articulated here gives glimpses into the nature and extent of the psychosocial health issues faced by the population.

3.1 Heightened Anxiety

Almost all participants expressed that the events and condition created by the pandemic have increased their *chinta*. In simple terms, this may be translated as worry. The dimension of worry, in the circumstances of the pandemic, may better be understood as anxiety. Anxiety is an emotion characterized by a feeling of stress and tension that produces worried thoughts. People who experience anxiety have recurring intrusive thoughts about impending danger, catastrophe or misfortune. The anxiety, when lingers or deepens may have physical symptoms such as sweating, trembling, dizziness or rapid heartbeat or increased blood pressure.

Anxiety during the pandemic largely stems from the mystery of the coronavirus. The new epidemic, which people came to know originated in China, but have limited information about how it spreads and transfers. Even the people who worked as health workers were uncertain about the nature of the virus. A health worker in the Lalitpur district, for example, expressed her confusion in defining coronavirus as *"ke ho ke ho?"* Another person from Dhading was aware that it is spreading fast across the globe and eventually reach their community. He thought that it must be like "*daudaha*" or the tour of officials in the past who would tax or punish the people when they reached the place. The anxiety started with the first phase of lockdown and heightened during the second phase as they could hear and see the news of more deaths.

A man from Ramechhap working as a daily wage labourer in the town of Sankhu was worried about his life and family back in the village. In his words, "When I listen and watch TV, I feel frightened. When I saw corpses in Pashupati on television, it was a little far. But what I see many corpses in Sankhu itself where I am living, I

felt coronavirus will catch everybody one day. I heard how people go to the hospital with normal coughs, and they die without their family members seeing them. I hear every day that there are 4-5 people infected in each house." He finds himself in an impending crisis to which he has no means to understand and respond.

How the level of anxiety increased over the period can be seen in the articulation of a Ward chair of the Shankarapur Municipality. He said, "Initially when we heard about the virus in Wuhan, China, we didn't assume that it could spread all over the world. We console ourselves by thinking that it is like any other virus that appeared in the past. But alarm increased as we learned that the scientists are also confused about what COVID-19 is. Our anxiety increased when the media spread confusing information about it. This made us more uncertain."

The first lockdown did not have much effect on people as the second lockdown. The second wave of the pandemic aggravated anxiety among people. A 32-year-old mother from Dhading says, "In the beginning, I was just curious about the corona, and I thought it was just the common flu or cold. I didn't think that it would come to our village. But when people started dying in a very high number before the second lockdown, I was very scared."

A farmer from Sindhupalchok, similarly expresses uncertainty in the following words, "I heard that we can get infected by air and we can get killed by the air. I had taken it very lightly last year but this year I have seen and heard people dying in hospitals because they don't get oxygen. The infected are not getting the treatment in hospitals, I think we will all die."

Anxiety not only arose due to lack of knowledge about the disease but also unavailability of the measures to tackle if one catches the virus, especially the inability of the hospitals to take care of the affected. A community leader from Bardiya District recounts, "People felt more panic in the second wave. I can feel this from the beginning. News has been broadcasted that there is no bed and no doctors in the hospital. Some hospitals have even stopped admitting corona patients. 30- 40 people are already affected in our Municipality. This has created a kind of havoc among people. Now there are no quarantine and isolation centres. People have to depend on their own."

A school teacher from the Siraha district expressed helplessness. "I do not know how to deal with this situation right now. I am worried about my health. I have a heart condition and am a diabetic patient. Its shown in the news that even the mask is not working. As per the news broadcast, there is no bed and oxygen is unavailable

in the hospital. How are you going to revive then? At the individual level, we all are trying to keep the hope but that won't be enough in the present situation."

During the pandemic, everyone looks at another person with suspicion. People are anxious in every social situation. A man from Morang for example, says "When going to the market, I see people and think if they are infected. If he came close and coughed and sneezed, I would think of him having corona. When the person comes closer to me and coughs, I am scared. Even with a normal cough, it was like having a corona."

3.2 Increased Fear and Panic

Fear is another emotion expressed by the majority of the participants accentuated by the pandemic. Fear is often used synonymously with anxiety. The testimonies suggest that there is a basic difference between fear and anxiety. Daniel-Watanabe and Fletcher (2021), suggest that the distinction between fear and anxiety may not be sharp. Nevertheless, such distinction is generally useful and informative. Fear is more immediate and has an identifiable threat which requires a short-term response. Anxiety on the other hand does not necessarily have identifiable danger and has a diffused threat. Anxiety in this sense is related to an uncertain future and indeterminate cause.

The study finds that fear has stemmed from the real threat of COVID-19 in the community but it has also originated from imagined threats and dangers. Fear has stimulated both physical and emotional responses among people from exhibiting safety behaviours to mitigate certain threats to psychological symptoms of being overwhelmed, upset, feeling out of control or a sense of impending death.

People are naturally concerned for their own and their loved ones' health and safety. The study finds that people's fear of the virus was mostly concerned with their loved ones or family members. A civil servant working in District headquarters at Darchula district expresses his fear in the following words, "Our office was open during the lockdown. There was a kind of fear when I went home from the office because my daughter is small. I used to go home in 10-15 days, I was very scared to go home. My old mother is also at home. I was scared that they would get infected because of me. Even if I was safe and secure at the office, I was always in fear and anxiety that something would happen at home."

A man from the Baitadi district shares his thoughts in terms of how he was fearful. He said, "Mentally, I was in a lot of fear. There are nephews at home, my old-age

mother, and I am worried about them more. I can be careful and protect myself, but I don't know if they can. I am a little bit anxious, stressed and scared. I wasn't only scared for myself but was scared for my family as well, so it has mentally disturbed me."

A person from Nepalgunj who has received both doses of vaccines is not out of fear and says, "I am worried I may get infected when I go somewhere. I have already received two doses of vaccines but I hear that even people who are fully vaccinated are infected. All the health workers in the nearby health post are infected. That increased my fear."

The elderly population were most scared of COVID-19. Their fear was concentrated around the theme of death. An 80-year-old man from Jhapa says, "Death of my friend scared me so much. Also, the news that says, old people, die of COVID-19 most made me feel I am near death. I feel I am now both mentally and emotionally weak. I could not even participate in his funeral. I talked to my friend when he was admitted to Kathmandu. His suffering made me very sad. My wife is worried for me and she told me to avoid such news and talk with my friend. I am worried about my wife. She is one year older than me."

A 73-year-old man from the Kaski district was in Kathmandu when the lockdown was announced. He recounts his story in the following words, "I was in Kathmandu when I first heard about COVID-19. I am an old man, and the news said that we are most prone to the virus. I was really scared when I heard that news. So I stayed in my room and didn't go out at all. I am a kidney patient as well and it further exacerbated my fear. My children were not with me and that too increased my fear and anxiety. They couldn't come to me and I couldn't go where they are."

Old people thought that death is near. They tried to come to terms with the new situation. But as an old woman from Parsa who lives in a rented house tells, she does want to die of this unknown disease. She says, "I am not scared of dying. I know my time has arrived. I heard that virus is affecting the elderly population the most. I certainly do not want pain at my last breath. I do not want to give suffering to my children, in case I get a virus. Also, my biggest concern is about acquiring the virus from a member of the family. If any of us get infected, everyone else would be at a higher risk because we are living in a rented flat with two bedrooms and a kitchen. It's a small space."

A health worker in Bara district always finds herself in danger of catching coronavirus and transmitting it to family members. She said, "I always have fear

inside me. Lots of health workers are also getting infected. I am afraid of getting infected and then transmitting it to my child and other family members. In the first wave, I worked wearing a mask and gloves with no Personal Protective Equipment (PPE). Only one PPE is sent to our health post while there are three of us. So, we did not use it for anyone. I think that the fear of getting infected will continue unless we overcome it totally."

Death has become a prominent feature in peoples' imagination as they see and hear more news about the deaths of the people. A female school teacher from Bhaktpur says, "After the second wave, the situation was very critical. There weren't many deaths in the first wave but in the second phase news of people dying increased. I feel very scared."

In addition to fear of being infected, health workers also faced the fear of attack by hostile people who think that health workers can transmit the disease. A health worker from Rautahat says, "How can I be tension-free? I am continuously living under the fear of being infected. And also had fear of getting attacked by the patients' family members. I cannot meet my family members for so many days. I get worried about them here and they get worried about me. I am the only son of my parent."

The health workers faced multiple complexities in terms of their mental and emotional states. Health workers were operating in a situation where hospitals were strained in resources, bed capacity and human resources. Amidst the risk of being infected by themselves and family members, possible stigmatization and even attack, they had to provide care to the patients.

A nurse working in a hospital in Parsa recounts the situation in the following words, "A new staff in the team hesitates to go in front of the patients. She sometimes cries seeing the severity of the condition of patients. The patients were worried about death. Their stress level was very high. There was no family member to talk to. They felt like being abandoned since their family members do not come to see them. The patients mostly get worried at night and they cry out loud due to fear. They sometimes quarrel and shout at nurses. Our staff feel helpless. Some patients run away from the ward."

A hospital staff in Rautahat who tested positive recounts her experience, "There was a widespread rumour during the pandemic that health workers in hospitals and those who are in continuous interaction with the patient are a potential source of infection. Many people believed in this rumour. Because of this belief, the health workers and their family members faced a social boycott. Even within the hospital,

my colleagues hesitated to speak with me and some even shifted their duty hours from mine. I was isolated from my family members for three months. Even after the relaxation of the pandemic, many of my colleagues fear sitting and having tea together with me. During the pandemic last year, I feared meeting my family members. Throughout the peak period of three months, I lived in the hospital quarter. I felt that it is the way to protect family members from the risk of infection."

Fear was widespread among people due to quarantine and isolation procedures and among those who were infected and admitted to hospitals. It intensified among those who feared death and also in cases where they feared loneliness as they were away from their family members. Stress-related symptoms like irritation, insomnia and emotional exhaustion were prevalent among them.

Fear in isolation centres was equally rampant. A hospital staff member in the isolation centre in the Parsa district recounts the scenario, "Last year some patients escaped from the isolation centre due to fear of dying. The isolation centre last year was not so well managed. Even the doctor responsible was reluctant to interact with people in the isolation centre. The food provided to the patient was of poor quality. This has demotivated the patient and they fear they would die there due to the carelessness of the doctor and inadequate food. The infected one had to live away from their family members till their Polymerase Chain Reaction (PCR) test turned negative. The patients feel increased panic when they see the patient next to their bed dying. They are so mentally disturbed that they do not eat sometimes, shout at nurses and doctors, cry in fear and do not sleep for many nights. They do not sometimes cooperate in the treatment as well."

A similar story was told in the quarantine centre in the Jhapa district. A non-government organization (NGO) worker who supported the quarantine centre tells, "There was no one to guide them. The people in the quarantine are so much frustrated that they quarrel with each other about a very small issue. They argue with those who come to collect the swab. They sometimes cry alone and desperately want to meet with their family members. I have noticed that many of them were angry all the time. In anger, they did a lot of disturbing activities as well. They broke the chair, windows, door locks, pipes etc. They think they will die in the quarantine centre."

Fear of being infected aggravated the mental health problems of those who already had preexisting mental disorders. A case of aggravated Obsessive Compulsive Disorder (OCD) is illustrative of this situation. A 32-year-old community leader in

the district Baitadi says, “There was an 18-year-old boy in our village who lost his mind because of COVID-19. He constantly watched TV for the news and information about coronavirus. He believed that washing hands, wearing a mask and using sanitiser will keep him alive. He built the habit of washing hands 3-4 times in an hour, took a bath 5 to 6 times a day, applied sanitiser and wear a mask even when sleeping at night.”

3.3 Symptoms of Depression

Some of the participants who lived in vulnerable social and economic conditions reported that they felt hopeless. The testimonies suggest that they are the result of the pandemic which made them have extreme feelings of sadness and pessimism. *Udas* and *nirasa* are the Nepali two terms often employed for such situations. Those who have such mental conditions tend to lose appetite, motivation, and withdrawal from social activities. These mental health conditions are symptomatic of depression and aggravated by the strained economic, social and psychological conditions during the pandemic. Suicidal thought is one of the manifestations of such a state of mind.

People who are living in poverty and experience economic insecurity are at higher risk of feeling depressed. They are also likely to be impacted by the adverse consequences of the virus due to the inability to comply with the community guidelines because of their financial and livelihood needs. These are the people who are neglected of access to proper health care, food, security and other needs and are exploited due to structural and systemic marginalization and economic inequalities. The study finds that as people are dislocated from their work and unemployed, it has brought significant impact on their psychological, social and economic wellbeing.

One of the major sources of distress is the lack of material means to live and support the family. A case from the district Bara illustrates this situation. A 40-year-old community leader from the district of Bara tells the story of a shopkeeper who took a loan from a bank. He tells the story, “Many people are in stress for not being able to repay the bank loan. Some are in a state of depression as they have lost their income but their bank interest is increasing every day. The bank is continuously following them for the loan and interest. Some of the people (family heads) of my rural municipality flew away leaving their homes while some ran away with their families to escape the loan. One person in my village committed suicide by poisoning himself since he could not bear the pressure of a loan.”

A person from Bajura who does not have food anymore says, “The market is closed. The road is closed. I do not have food. I am under a lot of stress because I do not know how to get food. Lockdown keeps extending. I am, worried about what to eat to live. I do not feel like talking to anyone anymore”

A similar story is told by a man from the district of Achham, “We are afraid that we might die of hunger than the virus. Due to the lockdown, I couldn’t go to India for work. My household runs from the income I get from work in India. I don’t have a job in my own country. I have to put food on the table for my children and family. I am more scared of my children dying of hunger than getting infected. I feel panic and depressed.”

A 38-year-old unmarried woman from the district of Kavre tested positive during the second phase of the COVID-19 pandemic. Even though she had pneumonia, fortunately, recovered after staying in the hospital for 15 days. She, however, had a lingering effect of COVID-19 on her mental health. For several months she went through a panic of being breathless. She also persistently complained that she will die. She did not want to go outside as she was scared that she will choke while alone. When asked her, she said, “Doctor says, everything it all right with my body. But I often feel short of breath. The feeling that I will die keeps in my mind. I do not know what to do.”

Stress caused by the pandemic also appears to increase anger and irritation which leads to a disruptive relationship in the family. A man from the district of Chitwan shares his experience in the following words, “My father has become even more verbally abusive and physically violent towards me and mother after the COVID-19 hit the country. After the last fight a month ago, my mother stopped speaking. She only utters a few words. I also do not want to talk anymore.”

3.4 Isolation and Loneliness

Due to prolonged lockdown in an effort to slow the spread of the virus transmission, people began to feel isolated and lonely. Humans are social beings and with the cancellation of social gatherings, and the inability to go out with friends and family, the level of boredom and tension escalated. Elderly people in the cities especially felt this isolation and affective discomfort living in a solitary situation.

A story of an old man told by his son gives a picture of the pain that an elderly person endures during the pandemic. A 90-year-old man from Nuwakot was hospitalized after a minor stroke in Kathmandu. While in hospital, he got a virus

transmitted. In a hospital, the family members were not allowed to see him. He was already living in isolation for three months at home where he could barely talk to anyone. Finally, when his youngest son was able to meet him in hospital towards the end of his life, he said, “I am alone here, I will be alone at home even if I am recovered from this disease. I am already very old, so there is no use for me going back home.” In a few days, he passed away. Family members were not allowed to touch his body nor make any religious ceremony for a funeral. Army took his body to an electronic crematory in the Pashupatinath temple area.

A young working woman from Jhapa recounts the problem of isolation in her words, “At other times, there was not much time to stay at home. In the early days of the lockdown, it was taken as an opportunity. Then it started to seem too sweet, and it became bitter. When working people stay like this for 2-3 months, their income stops and everything stops. After the income also stopped, everything stopped. Only TV and mobile were very frustrating and suffocating.” A trader from Jumla who migrates to the South and North with trading goods tells the pain of living immobile, “I am a trader who keeps travelling and doesn’t stay at one place. When I had to stay at home for about 7-8 months, I became very restless. It was very difficult to spend the days.”

A similar account is given by a middle-aged working man from Saptari. He says, “For the first few days it feels good at home together with the family members. It was more like a vacation for me. But later with the prolonged lockdown, I started feeling bored and frustrated without work. I did not expect it to be that long. After a month I felt like something must be done else this leisure is going to kill me.

Some did initiate creative work during the lockdown and avoid loneliness. For example, an educated male from Kathmandu tells his story of how he organized a virtual group to discuss the pandemic. He says, “I contacted my friends and colleague and planned for conducting an online discussion on mental health. All of them agreed since they were also feeling like me. There were no girls or women in that group because they were not as free as us. They have to perform household chores. We conducted the discussions for 20 days, where we studied the literature on mental health and self-care. This turned out to be fruitful for me; kept me engaged and I follow some coping mechanism suggested by that literature”.

But loneliness for many turned out to be difficult and led to more harmful directions. As people started losing jobs, staying unemployed at home gave rise to addictive behaviours including alcohol consumption. Most of them who drink alcohol justified drinking to relieve mental stress and for relaxation. Being intoxicated

instigated conflict, violence and nuisance in the community, as well as gender-based violence in their homes.

A man from Shankarapur the outskirt of Kathmandu says, “In the village, there are many youths who do not have employment now. They are not able to stay at home. So, they roam around, gamble and drink alcohol. Then they quarrel with family members. There is a tempo driver in the village. His work stopped after the lockdown. He returned home carrying 9,000 rupees. He ran out of money after spending on alcohol and gambling. Then he started pressuring his wife to take out a loan. After a lot of pressure from the husband, the wife applied for a loan in microfinance. As they already had a loan in microfinance, could not get a loan. Then he violently beat his wife. The incident was reported to the police and he is in custody.”

A report from the Dadeldhura district of a young man who returns from Europe resonates with the similar abuse of alcohol as a consequence of loneliness and other reasons. A community leader said, “The young people who returned to Nepal during the lockdown after working abroad were not able to find work here. Those who don’t want to do hard work or want to stay lavishly, couldn’t think properly. They were not able to get involved in agriculture so drank alcohol, got involved in quarrels and brawls.”

A community worker from Nepalgunj reports, “There was increased loneliness among the people due to prolonged lockdown. The prolonged lockdown with no option of maintaining their livelihood has resulted in frustration. This leads to much harmful behaviour and mental health issues.”

Transporting certain goods across the India-Nepal border is legally prohibited. But during the lockdown, people ventured to this due to necessity. Partly because immobility was getting unbearable and partly because of the need. A man from the Rautahat district decided to do cross-border trade of medicine. He says, “People can call it illegal, smuggling whatever they like. But I do not consider it bad. I did not have any job. I could not get any other work during the lockdown. People here could not afford to buy the goods due to price hiking in lockdown, not all people are well off or have savings. So, I worked to help them as well as myself. It was a both-way help. I had helped lots of people to get their medicine from India.”

In another instance, people expressed deep frustration with idea that lockdown is the solution to COVID-19. A wage labourer from Mahotttari complains, “The government should think about us. Only imposing the lockdown and telling us not

to go outside won't work for the poor. The relief package distributed by the ward office was not enough to run the household for 20 days. How many days would 10 kilograms of rice be sufficient to survive?"

3.5 Anger and Abuse

Multiple factors, ranging from the breakdown of family economy, helplessness and confused state of mind tended to make people susceptible to easily provoked anger, annoyance or being irritated and impatient. Moreover, depriving them of social connections made people irritated, angry and frustrated. In some cases, this has led to more abusive treatment of others both within family and community.

Personal relationships among families and friends have been reshaped during the pandemic. Family members are compelled to live closer together while friends and extended family members are gone further apart due to the social distancing protocols. As a result of the lockdown, schools and universities were closed and furthermore, the workforce was transferred to working from home. Although insignificant in number, participants reported that there were cases in which the proximity of family members had more negative than positive impacts on social relationships.

Women and girls who are already disadvantaged and vulnerable groups of people faced various kinds of abuse. Since the lockdown was imposed, there were many numbers of reports of increased violence against women due to confinement at home increasing the proximity to the perpetrator. School closures also increased the risk of violence and abuse at home for girls.

A woman activist in Bhaktapur reported the increased work burden and inaccessibility to reproductive health services during the pandemic. In her words, "Talking about the gender disparity during the lockdown, it doubled the workload on women. They had to do the chores as well as an official duty. Since I had a small family and a supportive husband I didn't have to experience such but my colleagues did. Apart from husband and kids they also had other family members whom they had to look after while being at home so, it added the extra burden. The problem women faced during that time is they couldn't get a vehicle to reach health service centres. As such, it raised the risk of unsafe abortion by taking terminating medicines from the medical without proper consultation with the expert."

A male community worker located in Jhapa similarly reports, "During the lockdown, there were more cases of domestic violence, youth violence, divorce, and rape. The

main reasons for the rising of these cases are sexual, financial and mental stress. For 2-3 months, the courts of law did not look into any case other than the special cases. Earlier, on an average, ten to twelve such cases were registered, but after the lockdown, an average of 20 cases per day were registered."

A young woman from Saptari recounts the observation, "I heard few cases of domestic violence and heard in the news as well. When everyone is free, the empty mind became Satan's house. Staying together all the time, people started having a lot of time to think. In the past, everyone was busy. There was also disagreement between husbands and wives. That took the form of violence. The reason for the dispute in the family is that all the members stayed at home. There was no work due to which the small thing triggered stress and frustration. That is the major component of violence."

3.6 Discrimination and Social Rupture

Another important impact of the pandemic is seen in the increased intolerance and rupture in the social relationship. Nepalese society is already discriminatory due to the long legacy of caste-based relationships. When the transmissible virus was spreading, the distancing requirements provided ground for differential treatment of individuals based on their cultural background, social class, educational attainment, or other socio-cultural distinction.

A school teacher in the Bara districts reports, "I have felt that social relationships have ruptured due to the pandemic. People fear each other. They do not extend their helping hands like before. The Indian migrants who came back to home places after walking for so many days is not welcomed by the family. They did not go to meet them at the border before they are taken to the quarantine centre. I personally went to the border point to meet with them and took them to their home. They were fine. They were not showing any symptoms. Restriction on marriage and other cultural activities of the people is also affecting the social relationship. The government has only allowed 25 people from both sides to be presented at the marriage ceremony. In such a situation people are wondering who to invite and who not. It will bring bitterness to the relationship. At the same time, people also could not perform or enjoy themselves like before. The pandemic has destroyed the tolerant ethos of our community."

A man from Saptari tells, how the distancing requirement has halted the social link. In his words, "Each day I am living under the fear of being infected. Everyone else in my family is disturbed by this situation. We cannot even meet our well-wishers

and talk about what we are currently feeling now. We cannot perform our cultural traditions and rituals like before. I wonder when we will finally return to normalcy."

COVID-19 has perpetuated existing negative stereotypes or assumptions, strengthening false associations between the disease and other factors, creating widespread fear, or dehumanizing those who have the disease. Stigmatization has driven people to hide the illness to avoid discrimination, avoid seeking health care and discourage people from adopting healthy behaviours.

A man from Kathmandu, who had tested COVID-19 positive tells his story, "The media has not been able to provide accurate information, experts and health workers have not been able to provide adequate information which was why, common cold was taken as corona and people were discriminated, treating them as untouchables, thought of them as people from another planet or aliens. If the person is sick then, spreading the news all over the community and looking in a negative perspective."

In addition to the economic impact on health, migrant workers are also subjected to discriminatory behaviour and stigmatization in their home communities. A returnee migrant worker from Sarlahi recounts, "My difficulty did not end after my safe return to my home. I was portrayed as the spreader of the virus by my villagers. My family was stigmatized too. Someone from my neighbourhood informed the police about my arrival. The police came to see me and quarantine me at the village quarantine centre. Even though I showed him all my documents of covid-19 tests and quarantine, the villagers wanted me to quarantine again as that would only satisfy them. With great difficulty, I dealt with that situation. This all added further stress on me and my family."

A man from Dadeldhur tells his story of discriminatory distancing in the following words, "In the beginning, we did not allow the quarantine centres for the people from India to stay in the schools or close to our community. We didn't let them walk this path. We are very scared of them bringing the virus into our community and that it may kill us. We didn't even visit them. Their own children and family didn't go near to them. A frightening situation was created."

The pandemic has also sharpened the caste discrimination in Nepal by stigmatizing Dalits; those in the communities, migrant returnees, infected ones, and also those who are recovered from the infection. There are many stories of discrimination. One told by a Dalit man in Mahottari recounts, "The deep-rooted injustice and prejudice related with the Dalit emerged once again during the outbreak that sustained their vulnerability even more. People fear passing by our settlement;

according to them we live in an unhygienic manner and are more likely to cause corona. Also, our people go to work outside every day, they believe that we would transmit this virus to them". Adding further on this he said, "We have been labelled as "untouchables" and excluded historically that has affected our both the social and economic status. They say that practice of untouchability is good for social distancing. This pandemic has been employed as justification for perpetuating old practices of untouchability. This placed us in a more precarious situation leaving the community without food and earning opportunity."

Another similar story told by a woman in Bajhang goes, "One in our community there was the first person who was infected with the virus, and then we thought now the virus is closer to us because it was about 30 minutes away from our house. In that house, there were people who came from India, they belonged to the Dalit community. We were afraid to go there because they came from India. Nobody went there or near them. A man used to fetch firewood for them. He was once suggested to go the other way."

Muslims are already a minority and disadvantaged group. They have been the subject of stigmatization and discrimination in the wake of the pandemic. They have faced social boycotts and been subjected to hate speech from non-Muslim communities as well (Sijapati, 2020). A Muslim man who was part of the group told, "The news of Muslims spreading the virus through Tablique Jamat of Delhi took the sensation. The Indian news channels were only broadcasting this news-making Muslims the culprit. Later the news in Nepal said that the Muslim assembly in Siraha was a source of the transmission."

He further said, "Slowly I noticed a change in the behaviour of people towards me in my village. One of them asked me if I had participated in any of the assemblies in Delhi or Siraha. They started wearing masks while crossing my home or while crossing me in the street or talking to me when meet. They did not say any bad words to me but they avoided me. The discriminatory behaviour further escalated when my son-in-law was put into the quarantine centre upon returning from a tour with his friends from India. People started behaving as if we all were infected. It feels very bad when people boycotted you from the society where you have grown up and lived. People called Muslims the "Corona Bomb". We fear being targeted by the Muslims unless this rumour settled down. It was very frustrating for my family to go through such avoidance. We were fearing both the virus as well as the division created in society. But the stigmatization matters more than the virus. It really makes you feel helpless especially when you are in minorities."

The unfolding story of increasing intolerance is told by another Muslim man in Udayapur, “The increased cases of corona positive in Muslim dominant district further played role in the stereotyping and stigmatization against Muslim. Birgunj, Chhapkaiya and Siripur in Parsa district have the highest Muslim populations. Chhapkaiya once had the highest corona positive case in Birgunj. Whenever we went for our “Namaz” at the Masjid, the non-Muslims informed the police. It is our culture to salat (Islamic Prayer) in the group during the month of Ramzan. But due to COVID-19, the Muslim community have formed groups of only 5-6 people avoiding larger gathering. In addition, we have been interfered with by the police many times. We could not even celebrate our festival with joy last year. We could not mix up with others for celebrations. We could not visit families and could not exchange meals and break our fast together. And this year too, I wonder how it will be since we are in the same situation of lockdown”. Adding further, he said with sadness, “The social boycott for the Muslim was high during the period and it has ruptured our social relationships with the non-Muslims.”

CHAPTER FOUR

SOCIAL DETERMINANTS OF PSYCHOSOCIAL HEALTH

The information on the impact of lockdown on the economy and its subsequent effect on psychosocial health is limited until now. Available studies have shown that the adverse impact on the socio-economic condition created by the pandemic and lockdown had a detrimental effect on the psychosocial and mental health of the population. Nepal is developing various measures to respond to the COVID-19 crisis for which such information is crucial for guiding policies and interventions. The media reports and independent research indicate that the increase in the health care cost and loss of income from various sources such as agriculture, wage labour and small trade has substantially harmed the economy (Adhikari et al, 2021; Poudel & Subedi, 2020; Shrestha, et al., 2020; Tamang, 2020).

In this section, we present the peoples' experience during the pandemic in terms of its impact on the socio-economic condition, in particular on the loss of employment, constraints on livelihood and food security and education. Abrupt loss of income and the need for a higher level of health care expenditure generate heightened stressors among the population leading to increased mental health concerns such as anxiety, depression, anger and other issues. The most vulnerable section of the society who are living on limited resources, wage labour, small trade, and marginalized groups are exposed to further marginalization as well as suffer from severe health concerns.

4.1 Loss of Employment and Income Sources

The COVID-19 crisis continues to negatively impact the livelihoods of many households due to the loss of income sources. The most vulnerable section of the society includes households that depend on informal employment, especially daily wage labourers, and small-scale producers. The other vulnerable groups include those households that depend on foreign remittance and those who have less access to social protection due to little amount of savings or limited alternative sources of income both in rural and urban settings. The lockdown of the pandemic has pushed many of these people out of their jobs; permanently or temporarily, including the formal and informal sectors of the economy. Tourism and transport turned out to be one of the hardest-hit areas.

Construction workers in Kathmandu valley and other cities were one of the main groups who suffer to a high degree during the lockdown. When the government imposed a lockdown, construction works halted abruptly. The workers were unable to return to their homes due to the unavailability of transportation. As the lockdown was announced at the beginning only for two weeks, the workers were hoping to return to work after the lockdown is released. They stayed at the construction site or in rented rooms for several weeks. As they ran out of their savings to pay for food and rent, they become restless. The employers or the government authorities have taken no steps in supporting them. The government then kept extending the lockdown. Given the uncertainty of opening up and returning to the work and emptied saving they decided to take an arduous journey of walking to their village. In addition to the loss of jobs with no savings left, they were worried about their families back home.

A construction worker who started to walk from Kathmandu to Bardia on foot via the main highway expressed the pain they endured during the journey. He says, “Nine of us who worked for the same contractor started our journey from Kalimati at the dawn. We walked for 15 days to reach our village. Walking in the scorching sun was extremely hard with our little carrying bags. We ate whatever we could buy with the meagre money left with us. The most painful time was when we were stopped by the police in different places accusing us of being a virus transmitter. In order to avoid police checkpoints and the scorching sun, we walked through the jungle during the day and road during the night.”

The people walked from east to west and west to east. A family of husband, wife and a child took their journey from a hydropower project in Dolakha to Morang. A construction worker walked from Dhading to Jajarkot. Those who worked as daily labourers as porters or rickshaw pullers or sundry helpers in the city went hungry. The absence of government intervention to help these segments of the population was one of the major gaps.

People especially from Terai and western mid-hills of Nepal seek to migrate to India for work in agriculture, manufacturing, construction industries, and mostly the informal sector. Most of the time, they travel for seasonal work. During the lockdown, they lived in camps without work in the cities they were working. When the lockdown eased, they walked for hundreds of miles toward the Nepal border. Unfortunately, many of them were stranded on the India-Nepal border.

A woman from the Bajura district observes the situation and explains that “from here many people go to work in India and from that they run their household

expenses and send their children to school. When they returned and lost their jobs and even after coming here, there was no work and no employment and there were financial problems. The agriculture here is simply not enough for feeding the family"

In rural areas, poor people are at risk of losing their prime income source as they cannot sell their agricultural products. In general, rural farmers in Nepal, do not have the capacity of storing or processing their farm products. Most of the households reported food shortages during the pandemic. The food they had in stock was insufficient to meet their needs. Food scarcity is reported most in the far-western province of the country.

Generally, those who were engaged in farming felt that they can sustain themselves in terms of food. Nevertheless, the closure of the market and transportation affected farmers from all parts of the country. A farmer from Shankarapur Municipality in Kathmandu says, "We thought there will not be much of an economic impact because farming gives us food to eat and farming has not stopped. However, lack of seed and fertilizer made it difficult to work in the fields."

Another farmer reported that farmers were desperate to get seeds and fertilizers. He added, "We really needed fertilizer and wanted to find the way. We realize that there is no other way than to resort to buying fertilizer from the black market for a painfully high price."

A man from Sindhupalchowk rented the land for farming. He expressed his worries in the following words, "I have taken other's land on lease to do farming. Only after six months, there will be a harvest. What will my family eat till then? If the landowner asks me to leave the place, then I have to. I am working by paying thirty thousand a year for the land. If the lockdown is lifted, I will be able to work but I am worried that I will die if the lockdown is not lifted."

Another area badly hit was a small business. A member of the Shauka trader community belonging to Byas village in Darchula who is engaged in cross-border trade between Nepal and Tibet says, "We earn income by doing business in Taklakot for six months. During the lockdown, we could not go to Taklakot. Almost all of the Shauka community go to Taklakot to do business. Therefore, everyone was affected financially. Later, the lockdown was eased, but the season for the business was already over in Taklakot by then. Our business is seasonal. When we were supposed to run our business, there was a nation-wide lockdown."

Tourism was another badly hit sector by the lockdown. A man from Pokhara who ran a small trekking company tells, “My business has come to a complete standstill. All my businesses have been shut down, so the economic situation is dire. Pokhara is a tourist destination in Nepal. But with no tourists, all the businessmen and hoteliers are gone. They are not in a position to pay the rent.”

A woman tourist-lodge owner in Myagdi district was worried and said, “My lodge is at the border of Mustang district. It was built exclusively for tourists. When tourists did not come due to COVID-19, my hotel is closed. I took a loan to start my business. I do not know how I am going to pay the loan.”

A family who ran a traditional tailoring business in Achham was also in a similar problem. “I have a tailoring business, and now and then also work as a daily wage earner. My tailoring business was hampered because schools were closed and new dresses could not be sewn. During the lockdown, people needed no new clothes or could not afford to buy them. So, people instead used old clothes and didn’t have to make new ones.”

In the upper part of Dolpa and Darchula, the collection and sale of yartsa gunbu, known in colloquial English as caterpillar fungus (Ophiocordyceps sinensis) was a major source of cash. A man from the Api Himal region in Darchula says, “Yartsa gunbu is the main source of income of Api Himal village municipality. At the time of lockdown, no one was able to go to pick up yartsa gunbu. That’s why there was a big financial problem. Our own production of maize and wheat is only enough to feed us for only three months.”

An entrepreneur in Dolakha who rented the land for livestock farming expresses similar apprehension and tells his story in the following words, “I rented a piece of land and took a loan from bank for running a cattle breeding business. Lockdown has had a detrimental effect on my business. I sell milk to hotels, restaurants and dairy shops. This was my source of income. During the lockdown, all the hotels and restaurants were closed, and I didn’t have any place to sell the milk. The banks pressurize me to pay the monthly installment payment. I am not even able to pay the interest to the bank. What are we supposed to do, pay the bank or eat?”

4.2 Strained Livelihood and Indebtedness

The loss of income sources and employment strained the livelihood in significant ways for the most affected population group. Generally, people in the lower-income bracket in Nepal adopt multiple strategies for securing basic necessities of livelihood

(Adhikari, et al., 2021). A combination of agriculture and animal husbandry is a basic and common strategy employed by people for food and cash. In recent decades, agriculture has become inadequate for subsistence. Wage labour inside the country is the main way of supporting families for the poorest households. Others have diversified their livelihood strategies to include small trade and outmigration has supplemented the household economy.

Because of the break in the supply chain and market activities, all of the above sources of income have been disrupted. The loss of income sources has brought two major consequences for working families. The first is that they exhausted their meagre savings in consumption during the lockdown. The second is that many of them fell into a debt trap. A 45-year-old migrant worker in India from Dadeldhura says, "I have been back for exactly one year. I haven't found any job here. All the businesses are closed due to the lockdown. There is not much farming to do. I have spent all of my savings. It was difficult for us financially, especially for those of us working in India. We go to India because of the lack of employment here in our own country."

Another worker from the Achham district says, "I work as a migrant worker in India. After returning home, I finished all my savings. I am desperately waiting for the lockdown to open so that I can return. Income from work in India is the only way that I am able to run the house. If you don't go to India for work, I cannot feed my children. This is the only option for me."

A Musahar woman living in an Integrated Model Musahar Settlement of Bardibas, Mahottari is a daily wage worker. She works as seasonal labour during the farming season and as labour at construction sites for the rest of the months. The lockdown last year made her jobless creating an economic crisis for her family. She says, "We were already indebted because of our daughter's marriage. I was working hard to repay that loan. But, suddenly everything stopped. Going without work was extremely difficult for us. We could not afford to eat without working. The support package provided by the ward was not enough. How many days would 10 killograms of rice be sufficient to survive? I had to borrow some loans again from the local landlord (Sahu- Mahajan). I took a loan of 20,000 rupees. This is a huge amount for us."

The belief that Musahars go to work in different places and hence it is more likely for them to transmit the virus to others made her jobless for so many months. Another Musaharman from the same district died of hunger in June 2020. One

family in Sarlahi had cut off all other expenses to afford the meal twice a day. A Dalit activist speaking about the economic hardship said, "*Bhasan hoina rashan deu*" meaning please give us food, not speeches.

Similarly, a street vendor from Rautahat who sells fast food in wheel carts every day on the main road of Gaur had to go without work for seven months due to the lockdown last year. His father also ran a fast food stall which is closed for several months now. Currently, they are not taking out their cart in the market because of the lockdown. He said, "I and my father went totally without work and without any income for seven months. It became very difficult to run the family. Our savings lasted just for a month. After that, we took groceries on loan from a shopkeeper. For the rest of the expenditure, we borrowed a loan. We already have a previous loan from microfinance. I and my father had planned to save money for our sister's marriage. But we could not because our work is badly affected due to the pandemic. Instead of saving we were in debt of three lakhs. If the situation would be the same this year we have no other option than dying of hunger".

A teacher in the Sunsari district who ran a private school had to bear a big loss. He opened a boarding school one year before the pandemic. For that, he took a loan of 50 lakh from the bank keeping his land as collateral. He could only run his boarding school smoothly for one year. With the COVID-19 outbreak, he had to close his boarding school. He couldn't earn anything from the boarding last year while he has to pay the interest of the 50 lakh every month. He experienced serious mental stress. He is always under stress about repaying the interest and the loan. His wife is worried about losing their land in case they could not repay the loan.

The situation however was not the same for everybody. Those who had regular salaried jobs did not suffer from loss of jobs and income. A teacher who teaches in a government school in Gorchari, Siraha, shared his experience, "I am lucky that I did not have to go through the financial hardship for meeting my family needs." He is a government teacher and he received his salary in time. A man from the Syangja district said, "No one in our family is involved in the business. The three of us brothers all are government employees. One works in the municipality and the other two in Education Department. That's probably why there weren't so many financial problems as a government employee." Salaried jobs in government and other agencies allowed the people to stay in their homes without being worried about going hungry or becoming indebted.

A complete shutdown of business has affected different classes of people differently. Loss of income resulted in debt in most of the cases if not homelessness, and hunger

for the poorer section. This situation had a significant negative impact on their mental health. The poor segment of the society expected some economic aid and home-based income-generating work that would help them to survive the situation while the middle and business class people are expecting to reduce the rate of interest for the lockdown period with no additional charges.

It is interesting to note that the village in the remote part which was relatively self-sufficient in terms of the food supply through their agriculture and limited dependence on market and wage labour suffered less from COVID-19. The living that does require mobility only within the village territory for fodder, firewood and farm work had virtually no impact from lockdown. In a village in the Baitadi district, villagers gathered for rites and rituals and other social gatherings. A farmer from high-altitude Humla village said, “Lockdown made no sense to the people in the village. There was no in and out movement from the village. The villagers have cows and farms. It is necessary to bring grass and firewood, even if they are not connected to each other, they will be connected due to work. The people of the village do not understand what it is like to have a lockdown.” A mother from a village in Baitadi said, “Even during the lockdown, we go to each other’s work in the village. People have been working together. Nobody has coronavirus here. Nothing has been affected. I do not understand why we need social distancing.”

Indebtedness was a problem for wage workers and small business entrepreneurs. The wage workers exhausted their savings after returning to their homes in a few months and then had to take a loan for living. Similarly, those who took loans for running businesses, such as auto-rickshaw, taxis, small shops, schools, farming or animal husbandry were not able to pay back the interest of the loan. All the prices during the pandemic went high. As a person from Jajarkot says, “Due to the lockdown, the people like us living in remote areas like the far west have been facing a lot of problems in food prices, and transportation. Every material’s price has been hiked.”

A man from Sindhupalchowk who ran a small shop together with his wife said, “If we had not saved money, we would have gone hungry long ago. We made a living from that money for several months. Our shop was closed for five months. The monthly rent was Rs. 12,000. In addition, we had to pay an additional sum for electricity and water. We paid a total of Rs. 65,000 for five months at once to the landlord. Then closed our shop forever.” After we finished our savings, for 15-20 days, we went to eat at relatives’ house. Now we live with borrowed money.”

A man who worked as a driver pick-up truck from the Morang district is worried about the loss of the land he used as collateral for taking a loan from a bank to buy a vehicle. He says, "The bank did not stop monthly interest during the lockdown. Due to the lockdown, I have to keep my vehicle at home. There was no transportation job to earn income. If my vehicle had a problem then garages are closed, and labourers are not available for unloading goods. The bank is harassing me on the phone to pay the debt. Two truck drivers that I know have committed suicide due to depression as the bank will confiscate their property at the failure to pay the instalments."

4.3 Disrupted Formal Education

Education is another sector having had a detrimental impact of the pandemic. Universities, colleges, and schools were closed. Exams were postponed. When the government announced online teaching, not all could afford to do that. Online teaching was a new thing to students, teachers and parents. The classes could not go as required for learning for the students. The online class required access to the internet as well as a computer. Internet is not accessible to a majority of the students, especially in rural districts. Even when the internet connection is possible, the cost was high. Access to a computer, laptop or smartphone required for online learning was expensive and many parents could not afford to buy them for their children. The classes online had multiple difficulties running regularly. Evaluating students` progress online was also difficult. Radio education was the last option for the students in remote districts.

The disruption in education had multiple impacts on the psychosocial health of families and children. Parents were worried not only about the future of their children but stressed by the need to take care of them in-house. Students lost opportunities, for being mobile and were stuck at home. This developed restlessness among the children. The impact on education, based on informants' testimonies can be summarized in four categories. The first is related to accessibility. The physical classes were closed and virtual learning was inaccessible. The second is the inefficiency of virtual learning and multiple problems related to this. The third problem relates to the additional economic burden both on part of parents and teachers. The fourth is about the loss of opportunity for the students.

On accessibility to education, a parent from the Humla district, for example, said, "Corona greatly affected my child's education. Radio programmes, and online education programmes did not run very effectively because in places like Humla

and Jumla there is no mobile phone network. Not everyone has a radio at home." This is summed up by another parent from Surkhet. He says, "All kinds of children were affected in the field of education. Radio programmes were not very effective and online education programmes also declined because such programmes were not accessible to all."

A community leader in Siraha said, "Unlike Boarding School, the distance learning system (online learning) is not possible for the Government school. There are many senior teachers in the school to whom technological knowledge for online education is new. It is equally not possible for the students since most of them are from economically poor families. They do not have all the necessary infrastructures to support online learning. Also, the Government of Nepal has not sent any directives to the government school to conduct the online class."

The problems of virtual teaching were multiple. The families, teachers and students all were not prepared for such technology. The consequence was that quality education could not be provided to children. A middle-aged parent from Nawalparasi says, "Physical classes were more effective than virtual ones. Every activity in the classroom could be monitored and students could be taught according to their level, but not in a virtual class. I think the main problem with virtual classes is that we are not ready for such technological advancement. Moreover, the family are always not available to monitor their children and we don't know whether they are actually studying or playing behind the screen. Teachers are not trained to provide virtual classes. Children upload unnecessary videos, and we don't know who the culprit behind those actions is. We don't have a laptop, so we have to use our mobile phones which are limited in nature. We are taking unpaid classes right now."

Similarly, one of the participants, who was a faculty at Tribhuvan University, said: "COVID-19 has completely ruined the School Level Education System. Our education system couldn't deal with the sudden change because of our pedagogy, teaching material and teaching system. I felt that school education should have its own organizational body to look after. But Nepal has an absolutely centralized decision-making system. Likewise, it was also difficult in the university system. Only the Master's Degree programmes were carried on with online classes in Kathmandu. Tribhuvan University is too big to manage. Another difficulty was that it compelled us to adopt an unfamiliar technique of online teaching which we needed to shift out of the blue. Private school and private college teachers were extremely affected. About the classes, I do not find online classes effective as it does not create social intimacy like an in-person class."

While many private schools have the capacity to offer Information and Communication Technology (ICT) based learning, public and government schools in mostly rural and some urban areas lack the resources and infrastructure. Local authorities lack the resources and institutional structure necessary to regulate the new requisites. Thus, the increase in demand for remote learning options has also exposed the country's digital gap between private and public schools. Also, the teachers and the school administration have indicated that they did not receive a clear idea or plan to address the problems.

A teacher from Tanahun district reflects on the difficulty of the online classes, "Although we conducted online classes during the lockdown, we were all confused as the online classroom method was new for all teachers and even the students could not take it easy. My students are all from rural areas so they have problems with the network, some don't have phones so wasn't that effective for those who didn't have the resources. Though the teachers learned something new the students did not seem to have learned well. It was easy for the students in the urban areas but for the students in the rural areas, it was difficult. Due to our large number of students and limited contact with us, we have not been able to provide education to all the students."

A mother from Baglung expresses her frustration, "Teachers themselves are ineffective due to their inexperience. Network problems, lack of access to mobile phones were other problems." She asked "Who in Magar and Dalit residents can afford to buy mobiles? So no classes and no exams!"

Online learning had other kinds of issues as well in terms of parting quality learning. Now students tended to depend upon internet resources rather than their own creativity. A mother from Kathmandu says, "In terms of education this internal evaluation, online classes are not that practice. Students are not learning instead they are going straight to Google. They are losing creativity. The uncertainty discourages them from studying." A similar observation is presented by a teacher from Parbat district. He said, "There are no more quality students in the education sector, since everyone has a mobile phone and a computer, they copy-paste rather than read and understand, now the same knowledge is no longer moral."

Online teaching seems to be least favourable to smaller grade children. A community leader from Parsa says, "Children of the smaller grades have largely forgotten what they have read. The teachers' job is going to be much tough now when the school will resume after this 2nd wave. Special attention is given to the students of the

primary grades to build up a good base and to develop reading fluency. The closer of the school for a long period of time due to the pandemic is affecting all our effort till now. We have passed all the students of that academic year because we could not complete the course in the short period of two months. The students do not know anything about the grades they passed. I wonder it would create an impact in their future."

Students faced an uncertain future, especially girls, and children from marginalized communities. Although we do not have figures, our interviews show a clear pattern that the drop-out rate has increased due to the long closure of the schools. Students from Dalit and low-income households faced the highest risk of dropout as the period of time without class increased.

For those school children who could not access online programmes or could only participate partially, the closure of the school for long-duration was a big challenge. A mother from the Mahottari district says, "The school is closed for so long. The children do not study at home. I even do not have any educated members in my family to guide them at home. They have almost forgotten everything they have studied so far. They have been promoted to upper grades however. They do not have any knowledge of the grade they studied. They have not taken any classes either. I even talked to the principal about not upgrading my children to the higher standard but the principal said that they have upgraded all the students that year. The student future should be the priority of the government."

School were opened after the relaxation of the pandemic. But the opening was confusing for many school managers. A parent from Siraha said, "After the relaxation of the pandemic situation in August, the school reopened but in several shifts and only twice a week. The school authority in coordination with the local government reopened the school by dividing the classes into shifts. It held morning classes for grades eight, nine and 10 and day classes for the students from five to seven grade. The lower grade classes remain closed to reduce the vulnerabilities of the small children. The school appointed a guard at the entrance to check if the students are wearing masks properly, they sanitize their hands and then make them sit in the class at distance. UNICEF has installed a water tanker and provided soap for hand washing. It also provided the other hygiene tools to keep the school premises clean. The municipality has provided masks and gloves for the teachers. This all supported the school to cope with the situation when it re-opened in October last year."

In some places, teachers together with parents attempted other alternative methods. A parent from Melamchi Municipality in Sindhupalchowk said, “The education sector was affected, it was shut down till August, the school did not open till later, it is not easy to teach through alternative means in the village, there is no facility of internet. We started teaching through Hello learning by taking help from our parents’ phones. After taking the parents’ number and informing them in advance, a time was fixed and the student was kept with the parents along with the book. Arrangements were made for the teacher to teach by phone. Each subject was taught routinely for 20 minutes. All teachers were given roles and responsibilities to teach their respective subjects. The German Nepal organization provided financial support. We arranged to go to each student’s home once a week to check and give feedback. We tried but the new method had several limitations.”

Despite the multiple problems, the option of online classes was a hope for many. Even with several difficulties, a student from Ramechhap reflects, “During the lockdown, we had an online class for our second semester. It kept me busy but sometimes the internet and electricity affected the class. However, it was good to be engaged in my study and finish the semester on time. During the exam also we have maintained physical distance.”

Online classes, however, appear to work better for those students who are at higher-level degrees, are committed to their learning and have no access issues. A teacher from Jhapa for example says, “We conducted online classes. In my experience, this class was also successful in my master’s degree. Regular attendance was lower during physical classes, but attendance increased in online classes. An online class is not effective at the school level at all. Only a few government school students have internet access at home.” She further reiterated, “This lockdown hampered more to some struggling private schools. It did not affect established private schools. I think, exploring different tools and materials is a positive part but it’s not effective as in-person classes. Maximum students ‘cheated’ during online classes and exams. It was a traumatic phase for students, teachers and parents of the private school.”

The increased economic burden is another effect of the pandemic and change in schooling. It has been difficult for poor households to meet the requirements to provide remote learning for their children. A parent from Parsa district who aspired to meet the need of his child for online learning expresses his economic worries in the following words, “the school where my daughters’ studies asked to clear the fee of the academic year before the final examination in the Nepali month of Chaitra.

The college where my younger brother studies also charges the fee for a whole academic year. For my younger brother's online classes, I have to connect internet at my home despite the fact that we were having difficulty meeting the most basic needs during that time. Every month I have to pay Rs. 1,200 for the internet cost."

The experience of conflict between the school management and parents also was visible during the period. One of the parents among our participants said, "I saw huge conflict between the teachers and parents. Parents were denying to pay fees as the school is not open and run physically. The teachers who are completely dependent on this profession were asking for the salary. So, it was a confusing phase. No one was wrong."A teacher from a private school in Birgunj said, "Actually, other people are having family time and vacation time but being a teacher, I had to work and put my effort double in my work. I was working under pressure but the earnings were half. That was shocking. I felt like I am having an identity crisis. There was no appreciation from the school, parents and even the government. I felt betrayed."

Students faced an uncertain future, especially girls, and children from marginalized communities. A mother from Dhading who was expecting her son to take a high school exam described her situation in the following words, "After the lockdown, the schools were closed, my eldest son's Secondary Education Examination (SEE) was cancelled. Online classes were not possible, regular classes could not be conducted. After the month of Asar, we delivered their course books to each student's house and asked them to take the exams at home and bring the answer sheets in the month of Bhadra."

For many students who aspired for obtaining an international degree, the outbreak of COVID-19 adversely impacted their study abroad plans. They were compelled to cancel their future study plans due to the pandemic and the constraints implemented by national governments on travelling internationally. There seems to be a lot of uncertainty among students and unsure what their future holds and what they should do in the light of the pandemic.

A Dalit student studying for her Bachelors in Nursing said, "When pandemic break, my research part of BNS final part was ongoing. Later, online classes started and I had to complete my research within this period without working in the field or lab. I think online classes are not effective in terms of gaining practical experience. I was unsure about my final study of Bachelor's in Nursing with the ongoing situation, I had to drop my abroad study plan for master degree."

Besides regular examinations taken by schools and universities, exams conducted by the Public Service Commission and other officer-level examinations of the Government of Nepal were also suspended, leaving many students stranded in Kathmandu, waiting for the lockdown to be lifted. Students cannot enrol in new studies or new institutes. A graduate who aspired for applying for a civil service job said, “Lockdown hampered me. I was preparing for the Loksewa exam which was supposed to be held in the month of Jestha but it was postponed three times later. It was a frustrating time full of uncertainty. Though I tried to keep myself engaged in the study I could not do well.”

A student from Mahottari who was about to complete her Bachelor’s degree describes her experience of how the younger people gradually fell into depression. She said, “I myself was depressed for quite some time. I would have completed my Bachelor’s level but due to this pandemic, my final year is on hold. It has been 1.5 years now and I am still in the same year. I have planned to apply for the job after this. But my classes are halted. I am not sure when this all is going to end.”

CHAPTER FIVE

EMERGING DETERMINANTS IN COVID-19 CONTEXT

This section presents three key emerging features in health care in the country during the pandemic. COVID-19 had several impacts on the health of the people and the health care system in the country. The three key features, in particular, are of importance in relation to the situation created by the pandemic. The first revolves around the infodemic. An infodemic refers to the abundance of information circulated to the public with regard to the pandemic that is often misleading. The second is about the increase in socially harmful behaviour such as stigmatization, segregation and intolerance to COVID-19 affected and other marginalized groups. The third is about the decreased resources and capacity for responding to the pandemic and general health care.

All of these emerging features had an impact on the psychosocial health of the communities and families. The infodemic, intolerance and the lack of proper health services when needed, created confusion, distress and panic in the mind of people which lead to the possible rupture in interpersonal and social relations.

5.1 Infodemic during the Pandemic

Infodemic or the epidemic of information refers to a rapid and far-reaching spread of both accurate and inaccurate information about something. COVID-19 infodemic consisting of the spread of fake news, misinformation and conspiracy theories has been recognized as a massive problem that undermined the health institutions and responses against COVID-19 (WHO, 2020; Zarocostas, 2020). Infodemic may not only undermine the institutions and response programmes but also may increase unnecessary anxiety and in some cases harmful negligence (Dubey, et al., 2020; WHO, 2020b). In this study, we found a sign of fear, confusion and incoherent behaviours experienced by the participants as some consequences of infodemic.

The interviews with the participants show that information and opinions with regard to coronavirus were widely available through various means including social media. In many cases, information was contradictory and confusing to the people. The lack of a method to verify the information, many took certain viewpoints as true based on their own personal judgment or hearsay. The responses from the participants

show that the infodemics are wide in at least three areas. The first is with regard to the nature of coronavirus and its transmission. The second relates to the immunity or who can and cannot get the virus. The third but most widely spread infodemics are on the prevention and cure of the coronavirus.

A 34-year migrant worker from Darchula who returned from India during the lockdown when asked when and what he heard about the coronavirus first said; "I thought of it as an invisible and mysterious monster who enters into the human body and kills instantaneously." He was in Banglore when the Indian government imposed a lockdown. He waited for several days to come back home. There were many variants of information on what coronavirus is and how it transmits to humans. All he remembers is that virus cannot be seen and it started in China and spread across the world like fire. And he further said, "there is no symptom and people suddenly die after one catches it."

Contrary to the perception of a man from Darchula, another person aged 45 from Kavre who works as a street vendor, held that coronavirus is a hoax. He said, "there is nothing called coronavirus. It is usual that people die. The idea of coronavirus came from China and America. Its purpose is to make ordinary people afraid. It is their war. The government and media are fueling the idea of corona spread." At one point the description of coronavirus as nothing but a "fatty substance" which needs to be simply "sneezed away" went viral on social media.

After hearing the news of many deaths in different countries and seeing crowded scenes in hospitals on television and on social media, people come to terms that it actually kills people and the coronavirus is real. People become obsessed with a desire to stay away from coronavirus. What do people think about the way the virus transmits itself from one human being to another? Multiple versions of the explanation were flowing through the community. The most common misinformation was that it is transmitted through the air. A businessman from Jhapa said, "I stay inside the house because I am afraid of catching the virus. With so much spread, I think the air outside now may be full of viruses. I worry about how to breathe now."

The other misinformation with regard to transmission is that the coronavirus transmits through seeing, talking or touching the people who have coronavirus. This perception made people suspect other people as possible carriers and stay away from others. As Ward chairperson of Karaiyamai Rural Municipality, Ward-1, Bara put, "I feel that social relationships have been ruptured due to the pandemic. People fear each other. They do not extend their helping hands like before. The

migrant who came after walking for so many days is not welcomed by the family and community. They are taken to the quarantine centre."

The main road to enter into a tole of Kirtipur city was obstructed so that people from outside could not enter the residents. The residents from to tole were also stopped to go outside. A similar case was found in the village in Dolakha where a barricade was created at the entrance of the village so that no one from outside enters the village. They thought that any kind of contact would transmit the disease and needs total isolation.

The idea that infected individuals are the main carriers of the virus from whom people should stay away was the strongest perception at one point during the first lockdown phase. In the Terai region, news spread about the spread of the virus by a group of Tablique Jamat. A man who worked as a Principal in a local secondary school in the Parsa district told the story of how the perception of spread has changed in the following words:

> "The news of Muslims spreading the virus through Tablique Jamat of Delhi took a sensational turn. Later news channels started to blame the Muslim assembly in Siraha as the source of the transmission. Another news tells that Zalim Mukhiya from Bara has conspired to spread the virus and has received wider attention. People in Parsa also started stigmatizing Muslims. Slowly, I noticed a change in the behaviour of people towards me in my village. One of them even asked me if I had participated in any of the assemblies in Delhi or Siraha. Slowly, everything started to change from normal to abnormal days. They started wearing a mask while crossing my home or the street. The Hindus stopped seeing and meeting me. No one asked anything when we met in the grocery shop. They did not say any bad words to me but they avoided me largely".

The other kind of misinformation about the coronavirus was that it cannot be transmitted to people in Nepal. A version of that goes that because people in Nepal are hardworking living in the pure Himalayan environment, therefore we are largely immune to the coronavirus. A middle-aged farmer from Nuwakot said, "Maybe because we are eating the food that contains much of herbal ingredients often organically grown, our body fights easily against the virus." His opinion was also filled with hope. Other person opined, "We have already developed resistance against the coronavirus." A health worker in Surkhet suggests that "it is possible that variant of coronavirus already circulated in the region before, due to which people have developed resistance against it."

Those people who thought that they are largely immune to the coronavirus refrain from accepting the recommended rules for wearing masks or social distancing. In Sindhuli village, the village ceremonies and festivals went as usual. The people who try to avoid the crowd and stay at distance are often criticized for being unsocial.

Misinformation with regard to prevention and cure was most common. There were abundant outlets that talked about the ways of prevention and cure for the coronavirus. A common opinion circulated during the period was that higher consumption of spices such as turmeric, garlic, and ginger is a way for increasing immunity and thus prevention of coronavirus. A drink made of gurjo (*Tinospora cordifolia*) plant became popular during the time. A woman in Baudha received a bundle of gurjo as a gift from her friend in Lalitpur. She heard that gurjo is the best way for keeping coronavirus away. The price of *gurjo* hiked as demand increased in the market.

Misinformation with regard to prevention that can promote harmful behaviour relates to consumption. Many received the idea that the virus is killed by alcohol as accurate. Their belief was substantiated, according to them, by the existence of alcohol content in hand sanitiser. A person in Kailali said that "I am hopeful that we will not catch coronavirus as I usually drink alcohol. I think I might increase the volume if it works."

There is no cure for coronavirus was disheartening to many. Very interestingly, this research did not come across instances where people resorted to traditional healers, priests, shamans or others. Some people thought that mask is actually bad for health as it can reduce the oxygen in the body. Similarly, there are still many people who thought that vaccine is actually more harmful than beneficial. A worker involved in transport service in Kathmandu told when asked whether he has been vaccinated; "No. I do not want a vaccine. Because I heard that people get badly sick after they take the vaccine. Some even died." He further asks, "Why should I take the vaccine that contains coronavirus?"

5.2 Stigmatization and Intolerance

The COVID-19 pandemic started with a lot of unknowns and uncertainty about it and created great fear among the mass about the infected people. Lack of knowledge on one hand and infodemic on the other caused people to resort to the extreme measures of emotional distancing manifested in stigmatization of the infected

people or people suspected of carrying the infection. The stigmatized people went through a great deal of pain, difficulty and emotional turmoil. This study has documented the cases of stigmatization and sense of intolerance and the adverse effect on the people.

The common understanding that COVID-19 is transmitted from person to person. This instigated discriminatory and intolerant actions among people in all communities. Such stigmatization affected coronavirus-infected individuals, minorities and marginalized, and also migrant workers especially those who work in India. All of them were looked upon with "suspicion" and "aversion" as they were suspected of being the virus carrier who could infect the whole community. For some individuals, whole family members were terrified of being near these people in the fear of virus transmission.

The case of a 32-year-old migrant worker from Sarlahi who returned from Saudi Arabia is an illustrious case of how he experienced stigmatization as the suspected to have been infected by the virus. With great trouble, he finally was able to get the ticket to fly back to the country as his work tenure was completed during the time. The lockdown and closure of the borders, and air travel left him in three months in isolation. When he arrived home, he was treated as a virus spreader. He recounts his experience in the following words:

> "My difficulty did not end after my safe return home. I was portrayed as the spreader of the virus by my villagers. My family was stigmatized too. Someone from my neighbourhood informed the police about my arrival. The police came to see me and quarantine me at the village quarantine centre."

The pandemic has given rise to racist attitudes, actions and behaviour. Despite the disease impacting people of all races, ethnicity and profession some specific groups were targeted in particular. The social stigma associated with the health workers and the infected makes the situation more challenging. Along with the corona-positive individuals their families, and returnees, were stigmatized and have to face social rejection.

A male COVID-19 survivor from Rautahat said, "We received the treatment received by the leprosy patient decades ago. No one used to play with my children. One school teacher stopped providing tuition classes to my children when I was taken to the isolation centre. My family members cannot even walk freely on the road, people suspected them of carrying the virus. Corona does not discriminate; I

was in isolation from every class and caste of people but people do. And believe me, it really affects you psychologically".

He further continued, "Even after my recovery, I and my family members were labelled as "not normal" by my community members. I was not happily welcomed by colleagues in the office after my recovery. They suspected me even after that and tried to avoid me as best as possible. The peon in my office did not do the necessary cleanliness of my office table and do not even come to ask for tea and water. It continued for so many days. These all behaviour disappointed me. I then left wearing a mask because people used to judge me and suspect me for not recovered fully".

The stigmatization was experienced by people in different locations. A retired forest officer, for example, tells how people view and treat when one becomes infected with the virus. He said, "Choosing home isolation was also not easy when you do not have enough members in the family. Though my wife was tested negative, she was also abandoned by our relatives and neighbours. Our maid did not come. We were left without help at home. Whenever my wife went to the market to buy the essentials, our neighbours asked her not to come outside. According to them, she was also at a higher risk of infection. It was extremely difficult for us to manage the situation."

An auto-rickshaw driver from Bahudarmai Municipality Parsa experienced discriminatory treatment as a minority. He said, "Whenever we go for our namaz at the Masjid the non-Muslims informed the police. It is our culture to *salat* (Islamic Prayer) in the group during the month of Ramzan. But due to COVID-19, our community have avoided larger gatherings by forming a small groups of 5-6 people. Despite this, we have been interfered with by the police many times. Many of my friends and neighbours did not talk with us during that period. They avoided us. We could not even celebrate our festival with joy last year."

COVID-19 also appears to have accentuated caste-based segregation. In the caste society, the Dalits are generally subjected to discriminatory behaviour as untouchables. The need for social distancing and isolation was taken as a ploy for legitimizing caste-based segregation. A Dalit student in Mahottari recounts how the so-called upper-caste community members were stigmatized during the period. She says, "People fear to pass by our settlement; according to them we live in an unhygienic manner and are more likely to cause corona. Also, our people go to work outside every day, they believe that we would transmit this virus to them."

Stigmatization of the people coming from India was one of the most common phenomena during the period. Many people from western hill districts and other parts of the country work in India as a labourer. When they were able to travel back to the country, the government had closed the border. They were forced to spend several days at the border in a crowd without proper facilities. The living on the border and subsequent quarantine organized by the government turned out to be places where further transmission could take place and people experience humiliation. A returnee from India who reached his home in Ajayameru Municipality in Dadeldhura recounts, "The attitude towards us was very negative because we were coming from India and we were looked upon as bringing corona to the community. Even when talking to us, they would speak to us from 10 meters away from the road."

The discriminatory treatment against the returnee migrants was widespread is also attested in another remark by the members back in the village. A teacher from the Baitadi district said, "There are a lot of people going to work in India from here. I was a little scared after the lockdown on April 25. I felt as though it would have been better if they had not come back home. But being a relative and a neighbour, of course, I couldn't say that. The situation was so difficult. I wish I would not have to meet any people. Even if I did meet people, I felt as if I could pass away from a distance. When we found that a person from our community was infected, we all thought that now corona is near us."

Many people who were once infected and or even recovered faced social rejection and discrimination from their relatives, neighbours and communities. Stigmatization of the infected, intolerance of minorities, caste-based segregation and negative view toward the returnee migrant are some of the key features that Nepali society experienced during the pandemic.

5.3 Insufficient Access to Healthcare

The health sector in Nepal is already crippled and with COVID-19 overwhelming the system, health care services dwindled further. There are particularly three areas that are pertinent themes emerging with regard to access to health care during the COVID-19 pandemic. The first is related to inadequate service provision. The second is about affordability to the ordinary citizens and the third is concerned about the efficacy of the service provided.

The people over the period increasingly developed a definite sense of the insufficiency of the health care service in the country. The poor management of the

quarantine, lack of human resources in the hospitals, and proper care to the patients were widely experienced by the people who experienced and observed the health care service during the period. Compounded with infodemic and associated misconceptions as well as anecdotal references, hospitals were even perceived as being the centre from where COVID-19 transmission takes place.

A person from the Bajura district, describing the situation at the quarantine centre on the India-Nepal border in western Nepal, explains the inadequacy of the service in the centre. He was on the way home from Kathmandu and spent 14 days in the quarantine centre together with the people who arrive there from India. He said, "Quarantine conditions were not so well organized. They didn't follow the health mandates. We were kept in a school, and we had to bring our own bed sheets, clothes etc. I had to make personal arrangements. The food was not up to standard and wasn't even nutritious. There was no social distancing and so it was very risky. There were no toilets or proper water taps. People coming from India were treated differently from those coming from Kathmandu. Those who came from India were discriminated."

A typical scenario when one enters the district hospital was explained by a participant from Rautahat. He had his wife tested for COVID-19 positive and got severely sick. She was admitted to the hospital where the hospital management took her to the COVID-19 ward. He recounts his observations, "The hospitals did not have enough beds, enough PPEs for the health workers, enough oxygen and even the doctors were losing hope. The hospital has set up a ventilator but it's not in use due to a lack of manpower. The hospitals do not have enough oxygen concentrators for everyone."

The situation in the cities such as Kathmandu was a bit different. For example, some public hospitals had all the necessary equipment and facilities but management was poor or even lack human resources to run the facility to serve sick people. An advocate and human rights activist from Janakpur describes the situation, "There are many hospitals with all the facilities but no manpower to run that. Who would manage that? Many ambulances are under contract while the people are deprived of the service. The hospital does not have any medicine for the treatment of COVID-19. All they could prescribe is hot water and food which was not easily available to the patient and caretaker on the hospital premise? They are living with the fear that once they will be infected, there is no option than death. And our system is proving it right. Due to lack of trust over the medical system, people are choosing home isolation, which will also increase the risk if not handled properly." A nurse working at a hospital in Parsa supports the above description and says, "The resources and

supplies at the hospital are not adequate. The equipment needed to set the isolation wards are not enough. They only received the PPEs and patient care kit after several weeks. Most importantly, the patient and doctor ratio is not in order."

During the pandemic, mistrust of the efficacy of the health services increased substantially. This was caused by several reasons, including insufficient facilities and care provided to the patients. A man from the Ramechhap district recounts his experience when he had to go to the hospital. He got sick and needed to go to the hospital but he says, "I was scared to go to the hospital even though I was ill. There was no medication for coronavirus. There is no oxygen for those who were having breathing difficulty. The doctors and nurses could do little to help the COVID-19 patient. I just sat and watch other ailing and dying people. There were not enough beds to keep the patients."

Due to a perceived lack of efficacy in the medical system, many people opted not to go to hospitals and were not even tested. A woman from the Lalitpur district who had a fever asked, "Why should I go for testing the COVID-19? I am sure that they will tell me I caught the virus. Then they will force me to stay in quarantine. If I have to go to a hospital, I will be put into a separate ward. They won't let me meet my family and children. I heard that if one dies, the army would take and no relatives are allowed even to touch."

The situation is not different in Kathmandu. Just on the outskirt of the capital city of Kathmandu, people reported that hospitals are part of the problem rather than a solution. A local community leader in Sankharapur Municipality in Kathmandu district says, "At present, about 85 percent of the villagers have symptoms of cold, fever and shortness of breath. No one has gone to the hospital, instead, they are staying at home for treatment. There are rumours that he will die if he goes to the hospital. It is rumoured that Ward Chairman of Shankharapur-4 passed away while undergoing treatment at the Medical College due to a COVID-19 infection. He was in a normal condition when he went to the hospital but it is said that due to the negligence of the hospital, he died. We have a record of one or two people passing by like that in the hospital, so we can't trust them."

Another person from the region said, "Admitting to the hospital is like going to the 'brink of death'. The ward chairman died at the hospital. Two other relatives also died. The chronically ill people have to take regular medicine. If they go to the hospital, they are just told to lie down and take medicine, and they die. So, now even if people are having fever and corona-related symptoms, they rather hide in their homes than go to any hospital."

Affordability was another major concern of the common people during the COVID-19 times. It was very difficult to get a bed in the government hospital if one gets sick. For many, the cost of treatment in the hospital itself was terrifying. A woman from Sarlahi expressed, “We do not have sufficient income to go for the treatment in case anyone gets infected. And I have heard that hospitals also do not have beds to accommodate the patient. Where will we go? Who will help us?”

A case of a private hospital can illustrate the cost involved in COVID-19 hospitalization. A man in Kathmandu had his wife test positive. The doctor recommended that she be admitted to a COVID-19 ward in a hospital. Although she did not have serious symptoms, the doctors wanted her to be in hospital for inspection. There was no other option than to admit. After 14 days, she was discharged. He was appalled when he saw the final invoice of 6 lakh and 50 thousand. He said, “It cost us almost 50,000 Rupees per day. I wonder why would they charge us so much for so little service.” According to him, this particular private hospital was supposed to be a community hospital and not among the expensive ones in the valley.

People often get agitated when sick people do not get a bed, ventilator or Intensive Care Unit (ICU), or when death is perceived to be caused by unfair treatment or mismanagement of the hospital. A man from Lumbini Province recounts the incident “In such case, the relatives of the infected physically attack health workers and hospitals. We are in a state of a health crisis. The seriousness with the cases is worsening the situation even more.”

CHAPTER SIX
THE GOVERNMENT SUPPORT AND GAPS

The Government of Nepal introduced a number of measures to contain the rapid spread of COVID-19 and to take care of those affected. The first important measure taken is on disseminating information to the public on coronavirus and ways for preventing them. The government issued messages for social distancing, hand washing and sanitization, and other ways to deal with the pandemic. The nationwide lockdown was the most extensive measure taken by the government to prevent the rapid spread of the virus during the first as well as the second phase of the COVID-19 spread. The lockdown, for the most part, was enforced successfully, with the closure of all public transport, closure of business, schools and meetings as well as international travel. Other measures taken include testing, contact tracing and management of quarantine and isolation centres. The relief support in the form of provisions of small amounts of food items and others was also part of the government response to the pandemic.

In this section, we bring testimonies of the local body representatives on what kind of measures were taken at the local level. The response also indicates strength and weakness in coordination in implementing the measures as well as challenges they faced. This is followed by responses of the participants in relation to the government support and its efficacy. Most of the participants expressed that the government measures were largely inadequate and the lockdown had a heavily adverse effect. But they also expressed that whatever was done was worthwhile.

6.1 Local Government Representatives' Perspective

A local body representative in the Saptari district explained the kind of measures they took after the pandemic hit the country. He said, "As pandemic started, we took it seriously and formed a task force immediately- a committee called DCCMC (District COVID-19 Crisis Management Centre) was formed under the leadership of Chief District Officer (CDO). The committee includes the Mayors of the district, focal health persons and security personnel. The committee made protocol for every sector to deal with the situation effectively. The committee coordinate with the local municipalities and rural municipalities further extending through wards to reach the grassroots. The team member of DCCMC including me conduct meeting every day where every member of the committee update the situation of their sector

and form planning to respond to the situation. The committee makes major decisions related to the COVID-19 and crisis in the district. We are experienced in dealing with the disaster caused by the flood and the public emergency created by this. But the pandemic is new for everyone, and its impact is also different.

A Municipality Ward chair of Bara district which had to deal with the returning labourers from India at the border told that "Last year to address the first wave of the pandemic, we turned the existing physical structure like school and college into quarantine and isolation centres and we took the full responsibility of managing the logistics. We also allowed home isolation in case the infected place met the standard of the quarantine. We did contact tracing to break the chain of infection. We established a help desk to identify the infected cases at the border point. We did screening and testing for that."

A local body member in Gokarneshowr Municipality recounted how the dead bodies were managed during the pandemic. She said, "We coordinated with the Nepal Police and Nepal Army for the effective management of the dead bodies. For this, we chose a place away from the human settlements. Last year Army performed the last rite of the dead people while this year if family members wish to do it by themselves we allowed them considering the cultural perspective. They can perform the last rite of their members by wearing the PPE kit provided by the ward, in the place selected by the municipality in the presence of the Army."

The local bodies were also able to build hospital facilities for the COVID-19 infected. A staff working at the Gaur hospital explains, "This year we do not have a quarantine centre, we have set COVID-19 hospital instead. We increased the capacity of the Gaur hospital and make it a 30-bed hospital for COVID-19 patients. We have connected oxygen cylinders to all beds and have some backup as well. We set ventilator also but could not operate it since we do not have required manpower. We are coordinating with the province for the manpower. We have transformed the Gaur Nursing Institute into a temporary COVID-19 hospital. It has the capacity of 11 beds with other necessary facilities."

A similar case was reported in the Bardiya district. The municipality chair said, "We have arranged eight more health posts for this municipality and are running the campaign of mass testing and distribution of free medicine, through rapid response teams, to those who have symptoms like fever, common cold, headache and diarrhoea."

A municipality representative in Morang explained the communication strategies and plans for health care enhancement. She said, “We are also updating people about the number of infected cases and a number of deaths in our district every day. This year we have health person like doctor, nurse and ambulance in our backup plan in case the situation worsens and more COVID-19 hospital is needed.”

There was also a host of challenges reported by the local body representative. A local body member in Surkhet said that “Last year also we partnered with many NGOs and international NGOs working in Rutahat to support the relief distribution programme. This year we are coordinating for such a programme in case the lockdown prolongs. There is no proper coordination between the three tiers of governments. The central government makes all the decisions related with the pandemic; we are only in the state of implementation.”

The challenge of coordination is also reflected in the response of one of the local leaders in the Kaski district. He says, “Constitutionally the central government an autonomous right over the disaster and risk management. They make important decisions. And on the basis of their instruction, we act on our level. We cannot form the legal framework or any policy on our own. We mainly follow the directives of the CCMC (COVID-19 Crisis Management Center). Despite the compliance, we take our own important decision for the management of the quarantine and isolation centres and distribution of the relief materials”.

Ravi, another local representative in Bara criticized the central government for not being serious about the pandemic. According to him the gathering held by the political parties at the centre and unsubstantiated remarks about COVID-19 from the head of the state have made people less serious about the pandemic. He says, “The government presence is very weak. The government must monitor if the directives and guidelines are followed strictly and properly. It should introduce a pass system for the vehicle to avoid unwanted gatherings. Although sufficient information has been provided on the pandemic, the government still have to target the rural population. According to him the local people still largely believe that they will not get infected and the corona is a ‘rich man’s disease’. The local population must be informed about the vulnerability of the pandemic highlighting the local context in the local language.”

A local body representative in the Lalitpur district expressed dissatisfaction about the role of the private sector. He suggested that in a crisis situation like this, private hospitals should be geared toward meeting humanitarian challenges going beyond

their business interest. He says, "I feel that the private sector did not support much to the government during this medical crisis. We have been continuously delivering the information through loudspeakers and FM radio. We have been telling the importance of using a mask, washing hands and maintaining distance. Those who are unable to buy the mask are provided free of cost."

A Mayor in Sarlahi explained the vital role of local bodies in the following words, "Local government is playing a crucial role in dealing with the COVID-19 virus as well as to solve the common people problem. Local governments have an understanding of the communities at the grassroots. We are offering information related with the virus. I communicate with the ward chairpersons of my municipality almost every day and take updates about the situation. We discuss this all in the DCCMC meeting and form our future plan accordingly. Considering the poor and marginalized population of my municipality, we have designed the relief package. The package included 15 kilograms of rice, 1 kilogram of dal, 1 liter of edible oil, 1 packet of salt and 5 soaps. Later we decided to distribute it to all people of our municipality since everyone was affected in one or the other way and also to avoid the protest of the people. But I am disappointed with the relief distribution programme. I received many complaints from the local people that most of our ward chairpersons distributed the relief in ethnopolitical line selecting their voters".

The mayor also expressed his disappointment towards the central government for not maintaining coordination among the three tiers of government. He said, "the central government is engaged in dirty politics in the period of health emergency in the country. I am disappointed with the central government for not providing the allowance they have promised to give to the health workers for serving in the period of emergency."

When asked what they have done for addressing the issue of mental health, a Mayor in Rautahat district said, "Last year, provincial government supported us with the Rs 15 lakh. That amount is like nothing. This year they haven't sent any budget or any logistic help to us. It seems that they do not prioritise it at all. The major work is to be done by the local government. We are the government closer to the people and they expect much from us. We allocated our remaining budget in response to the pandemic last year. This year also we have planned to allocate a considerable budget to the health sector as well as to the disaster and crisis management fund. I feel that we have done everything that we can do. The physical health of the people is not addressed adequately. In that situation even though we realize that mental health is important as well, our priority is physical health. We have not emphasized that part much."

6.2 Local Peoples' Perspective

The local community members acknowledge the support provided by the government bodies. They nevertheless felt that they were largely inadequate to meet the need of responding to the crisis. On the relief support provided by the government and other agencies, a shopkeeper in Sarlahi says, "The government only provides the relief and feels that it has addressed the poor during the pandemic. The relief they provide is not even sufficient to meet the day for 15 days. The ward last year provided us with 15 kilograms of rice, 1 kilogram of Dal, 1 litre of oil and a packet of salt. And I should tell you the rice and the lentils were not of good quality. I think they might have distributed the remaining rice and dal they had purchased to distribute as a relief package for the flood. Later Red Cross Society provided relief too. Their package was good and it included mask, sanitiser, soaps, mosquito net along with food. This year also two people from this organization came and took update about our situation. They might come with relief once again if the lockdown prolongs. The organization also spread the information about the virus through broadcasting in public through loudspeakers and posters in open spaces."

Inadequacy of support for the poor was one of the major complaints made by the local people. A student from Siraha says, "For the effective response towards the pandemic, the provincial government allocated 15 lakh to each municipality last year. But the local government engages in corruption in the name of the pandemic. It could not arrange sufficient beds in the hospital neither it had any plan to support the poor, children and pregnant women. Adding further to this, she told that even though the government has assured 100 days employment programme for the poor and unemployed it has yet not been effectively implemented."

A community leader in Kanchanpur district appreciates the government effort last year for controlling the virus. According to him, it was a very good decision to seal the border and managed the quarantine centre for the returnees and isolation centres for the infected ones. He said, "The government even did contact tracing to identify the people who had been in contact with the infected and quarantine them to minimize the risk of mass infection. The local government in coordination with some national and international organizations managed the facility of hand-washing in public places in Kanchanpur Municipality. The local government in coordination with the district police disseminated the information through loudspeakers in each ward of the municipality. But, I am disappointed that it has not been managed in the 2nd wave of the pandemic."

A migrant worker from Sarlahi expressed his disappointment towards the government for not supporting the migrant worker. According to him neither the company he worked for nor the Embassy of Nepal for Saudi Arabia helped them with the costs and pre-departure medical tests. He felt that the government should facilitate and support the safe return of migrants. Even though he felt that the testing and quarantine was a useful technique to identify and break the chain of infection, the government should have provided additional support for expenses in the case of migrant workers. Returnees themselves had to bear all expenses. He had to pay Rs. 17,000 as a quarantine cost in Kathmandu. He said, "The authority quarantined us at one hotel in Kalanki for 14 days. The hotel was not good. It had very poor sanitation and no good food. It only provided us food twice a day and each time it included "lentils, Bhat, Tarkari and Chatni only".

A story about how the government support was inadequate and how he had to look for other organizations for the Dalit community in Sarlahi is another example. He says, "Distributing a few kilograms of rice and lentils to Dalits who mostly have large family size is not enough. The ward office went to the community with just a little support. While distributing the relief they asked for the citizenship card that most of the Dalits did not have. I then coordinated with a Dalit NGO worker to support our community. He through his NGO, Dalit Sarokar Manch supported the community twice with 25 kilograms of rice, 10 kilograms of flour, 1 kilogram of chickpea, 2 kilograms of lentils, 1 litre of oil, 1 packet of salt and 4 soaps. No other organization helped our community."

The management of quarantine centres was another concern of the local people. Participants criticized the way the government managed the quarantine and testing. A local teacher from the Bara district stated, "The quarantine centre was not managed properly. One returnee from my village who had to live in the quarantine centre for 14 days told me that cleanness was very poor. There were lots of mosquitoes that could cause malaria. There is no proper testing in my village. The ward could have managed it. Even the vaccine that is said to be provided to the elderly population was not vaccinated fairly. The representatives vaccinated selecting his voters and even vaccinated their distant relatives."

Some of the participants also reported political considerations made during the relief distribution. A community member in Nawalparasi said, "The political representatives here closely monitor the relief distributed. They prioritize people who support their political party for relief distribution. They do not allow any organization and individuals to distribute the relief materials without consulting

them. They do not want other people to provide relief. They perhaps fear that if other people become popular their vote will decrease."

Irregularities are also reported by other participants. For example, a female community leader from Kailali says, "There were irregularities in the distribution of relief. Those who were supposed to receive it didn't get it. They distributed relief to their own people. The local government could not monitor it properly. Negligence and unnecessary expenditures were done by the government. In my opinion, awareness-raising programmes should be made more effective all over Nepal including in rural areas. In particular, it would be better to bring relief and financial assistance programmes for single women, the poor and the needy."

A community member in Janakpur commented on the ways the local and provincial governments could have done better. He says, "I feel that our provincial government is not serious about the pandemic. We have been struggling with this pandemic for the last 1.5 years. It's a long duration. The government could have managed the situation of its province by acting rapidly and smartly. It was only after the outbreak of the second wave that the authority said that they would repair the Manipal hospital of Dhanusha and make it well-equipped to serve the COVID-19 patients. Isn't this being irresponsive? Where were they in between? There are other hospitals with all the facilities but no manpower to run them. Who would manage the hospitals? Should not hospitals provide food free of cost to the patient and to the visitor in the hospital? The local authority has signed a contract with many ambulances but the people are not able to receive the service. They should have released a public statement about the availability of ambulance service to the public."

He further suggests, "The local government should have some economic package for the poor and deprived. Only allocating 15 lakh to COVID-19 response by the local government will not work. It even did not monitor the relief distribution process because of which there was mismanagement of relief. Lockdown was being imposed by the government without any proper plan for the poor and marginalized. There would have been less spread if the provincial government had prepared everything in time. In every meeting, the local government only blame the provincial and central government for not cooperating with them."

A migrant worker from Dadeldhura comments on the provision of jobs created by the local government, "The local government was able to do some things but they were only done for the people who were already at home and not for migrant

workers and those who were unemployed. Small works and contract works were all given to their own people. The state and federal governments have done little for us in terms of creating work."

With regard to mental health support, the participants from the cities reported that they could go to hospitals and private service providers when serious mental disorders take place in their families. In rural areas, mental health service is virtually non-existent. The issues of anxiety, depression and emotional upheavals of an individual often go unnoticed. When a serious disorder surfaces, often the community consults with faith healers holding a spirit, ghost or other malevolent forces responsible for the disorder.

CHAPTER SEVEN
POLICY REVIEW AND GAPS

During the last few decades, some positive developments in the policy landscape of the government of Nepal have emerged in terms of recognition of mental health in Nepal. Historical trajectory of policy development in Nepal shows that the first psychiatric out-patient department at Bir Hospital was established in 1961. Although hospital-based psychiatric services gradually started in other hospitals in the 1960s and 1970s, the development of mental health policies was slow. Up until the 1980s, mental illness was considered simply madness. The mentally ill people were either abandoned as the incurable (as affected by ghosts or spirits) or charged as criminals to be imprisoned in pagalkhana or mad-house (Seale-Feldman, 2020).

Alma Ata Declaration 1978 which defined health as "a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity," was a crucial milestone to include mental health as part of primary health care. It also framed health including mental health as "a fundamental human right" moving beyond the traditional idea of health programmes as disease control for the first time.

National Mental Health Strategy and Action Plan, 2077 is the latest in the government's effort to implement programmes related to mental health. The strategy and action plan demonstrated the enhanced level of policy recognition and commitment on the part of the government. It aims to make mental health a part of the primary health care system and make mental health services accessible to all. In addition to the government involvement, foreign aid-funded NGOs and programme also added to the development of mental health policies and programmes in a significant way during the last three decades.

Situation analysis for the National Mental Health Strategy and Action Plan formulation shows a stark situation in terms of mental health. For example, 18 percent of non-communicable diseases is occupied by mental illness in the country. Mental disorder causes four out of 10 disabilities. Similarly, a pilot study for National Health Survey, Nepal-2020 conducted in three pilot districts shows that among the adolescents aged between 13 to 17 years, 11.2 percent suffer from a mental health problem, 5.2 percent has anxiety-related issues and 0.7 percent have depression. Among this age group, 8.7 percent had suicidal thoughts. The report

shows that the population with the age of 18 years and above has a slightly higher rate of mental health-related problems. For example, among this age group, 13.2 percent suffer from mental health problems, 2.9 percent have anxiety, 3.4 percent have depression and 10.9 percent had suicidal thoughts. Similarly, 1.1 percent are reported to have psychosis.[5]

The 10-year-old violent conflict between the Maoist rebels and the government security forces was a traumatic experience for the community living in the conflict-affected areas which gave rise to multiple issues of mental health. The devastating 2015 earthquake similarly was another major disaster that gave significant rise to mental health problems in the affected areas. Of those who went through the trauma of the disaster, 34.2 percent had the symptom of depression, 33.8 percent had anxiety, 20.8 had alcohol abuse problems and 10.9 percent had suicidal thoughts.[6]

There has been some important research during the last two years on the impact of COVID-19. The research on the impact of COVID-19 on mental psychosocial health (H. R. Devkota, et al., 2021; Gautam, et al., 2020; Kafle, et al., 2021; Shrestha, et al., 2020), on education and children (Dangal, 2020; Dawadi, et al., 2020; K. R. Devkota, 2021) and general effect on society, economy and livelihood (Adhikari, et al., 2021; Poudel & Subedi, 2020; Tamang, 2020) are some of the important examples. Despite the increasing research interest, we still face a gap in knowledge with regard to how the coronavirus pandemic has exacerbated the situation. The testimonies collected in this study show that the pandemic has a significant adverse impact on mental health in the country can help build a better understanding of policy reform. In this section, we review the laws, policies, strategies and plans to understand the general policy landscape to address the issue of mental health. Based on the findings of our qualitative interviews with the mental health professionals as well as the community leaders and members, we also offer insights on gaps and recommendations for reform. This analysis is particularly concerned with psychosocial health within the broader rubric of mental health.

In order to understand the overall policy landscape related to mental health, a survey of related law, ordinance, policies, strategies, plans and decision were conducted. Based on the survey a total of 21 policy documents, ranging from the constitution to some specific decisions of the COVID-19 Crisis Management Centre (CCMC) were selected for review. In each of the documents, articles or clauses relevant to

5. National Health Survey, Nepal-2020 Fact Sheet. www.nhrc.gov.np

6. National Health Survey, Nepal-2020 Fact Sheet. www.nhrc.gov.np

health in general and mental health, in particular, were identified. The identified articles and clauses then were reviewed in the context of the research findings. Where ever applicable, in each of the clauses, a logical change is proposed.

The following table provides the list of policy documents reviewed:

Table 5: List of Policy Documents Reviewed

1. The Constitution of Nepal, 2015
2. 15th Plan (7.3 Health and Nutrition; Sector 7.6 Gender Equality and Women Empowerment)
3. Decisions of COVID-19 Crisis Management Centre (CCMC)
4. Ordinance for COVID-19 Crisis Management, 2078
5. Mental Health Policy, 2053 BS (1996 AD)
6. Mental Health Strategy and Action Plan, 2077
7. Mental Health Rehabilitation Programmes Guidelines, 2075
8. Community Mental Health Package Nepal, 2074
9. Multisectoral Action Plan for the Prevention and Control of Non-Communicable Diseases (2014-2020)
10. The Act Relating to Right of Person with Disability, 2074 (2017)
11. The Public Health Service Act, 2075 (2018)
12. National Health Policy, 2019
13. Public Health Regulation, 2077 (2020)
14. National Population Policy, 2014
15. Urban Health Policy, 2072 (2016)
16. National Health Insurance Policy 2071 (2014)
17. Health Insurance Act 2074 (2018)
18. National Medicines Policy, 2007 (draft)
19. National Drug Policy, 1995
20. Health Sector Gender Equality and Social Inclusion (GESI) Strategy, 2009
21. Nepal Health Sector Strategy (2015-2021)
22. Disaster Risk Reduction and Management Act 2074

The summary of the review of the policies identified in major policy documents including the constitution, national plan, act, ordinance, national policies, strategies and guidelines for provisions regarding mental health psychosocial services, instances of the finding of this survey related to those policies and logical policy change recommendations based on that is presented in Table 6.

Table 6: Summary of the Review of Policies Related to Mental Health Services as Outlined in Major Policy Documents

S N	Policies	Main Thrust	Theme Related to Psychosocial Issues and Wellbeing	Related Survey Finding	Logical Change in Policy
1.	The Constitution of Nepal, 2015	Freedom, justice, equality, and well-being; Citizens should receive free basic health services; vulnerable groups like women and children should be protected from mental violence against them.	**Article 22:** Right against torture: (1) No person who is arrested or detained shall be subjected to physical or mental torture or to cruel, inhuman or degrading treatment. **Article 35:** Right relating to health: (1) Every citizen shall have the right to free basic health services from the State; (3) Every citizen shall have equal access to health services. **Article 38:** Right of Women: (3) No woman shall be subjected to physical, mental, sexual, psychological or other	NA During the pandemic, not all citizens had free and equal access to basic health services. Gender-based violence (GBV) against women, including physical assault rape or attempt of rape, or other	NA Necessary act, rules, regulations, and plans need to be made to ensure that constitutional measure is implemented. Laws related to GBV need to be effectively implemented. Special measures should be devised for the pandemic

			forms of violence or exploitation on grounds of religion, social, cultural tradition, practice or on any other grounds. **Article 39:** Right of Children: (7) No child shall be subjected to physical, mental or any other form of torture in home, school or other place and situation whatsoever. **Various Articles:** Provision of the removal of the office bearer on the ground that he or she is unable to discharge his or her duties because of physical or mental illness.	discrimination in the domestic sphere as well as in the public quarantine were reported. Children were confined to staying home and were restricted to go to school and play in public places. There was limited alternative teaching. NA	and other disaster situations. Measures for ensuring the rights of the children during the pandemic and other disaster needs to be developed. NA
2.	15th Plan (7.3 Health and Nutrition; Sector 7.6 Gender Equality and Women Empower-ment)	**It has three objectives**: 1. To achieve balanced development and expansion of all sorts of health services at the federal, provincial, and local levels,	1. **Access to mental health services** will be expanded at all levels [Strategy 8, Working policy 4]. 2. **An emergency rehabilitation fund** will be set up at the provincial and local levels for the relief, rescue, free legal aid, psychosocial counselling, and skills development	Mental Health-related services are available mainly in the big cities/ towns but not at the rural community level. The emergency rehabilitation fund is poorly set up at the province and local levels.	Mental health-related services should be available to the community level. The government should allocate emergency rehabilitation funds at the province and local levels for relief, rescue, free legal aid,

		2. to transform the profit-oriented health sector gradually into a service-oriented sector by increasing government responsibilities and effective regulation for easily accessible and quality health services, 3. To promote a healthy lifestyle by making health service providers and service seekers more responsible for increasing the citizens' access to health services through multisectoral coordination and partnership.	programmes for survivors of violence [Sector 7.6: Gender Equality and Women Empowerment, Strategy 6, Working policy 6]		psychosocial counselling, and skills development programmes. Coordination and partnership between Government, private, and NGOs need to be strengthened.

3.	Decisions of COVID-19 Crisis Management Centre (CCMC)	A high-level COVID-19 Crisis Management Centre (headed by Deputy Prime-minister) for giving directives regarding response to the COVID-19 crisis.	There is no particular decision regarding psychosocial and mental health. Regarding the relief to the impacted people, there are the following 11 decisions. **(1) Date: 2076-12-12:** induction stove and electricity bill. **(2) Date 2076-12-16:** Approval to the relief programme of the Ministry of finance. **(3) Date: 2076-12-23:** relief distribution of essential goods to local people. **(4) Date: 2076-12-25:** Guidelines for the distribution of relief to labour and helpless people. **(5) Date: 2076-12-25:** Mobilization of players and young volunteers for relief distribution. **(6) Date: 2077-01-03:** Revision of the guidelines for relief distribution and volunteer mobilization.	No intervention with regard to psychosocial and mental health support was found. Relief distribution was not properly handled by the government agencies. Payment of 50% of salary to workers by business enterprises was not properly implemented. Free COVID-19 tests and treatment were not available for all COVID-19-affected people. NGOs and groups voluntarily mobilized themselves for relief support.	Measures to address psychosocial and mental health should be addressed by the CCMC with clear guidelines for counselling and other preventative measures in an emergency. The government should make mechanisms that facilitate proper handling of relief distribution to the poor and vulnerable people. The government should properly monitor, whether guidelines are implemented effectively or not at by the public and private sectors. Free testing should be made available at the community level.

			(7) Date 2077-04-05: relief in a penalty fee for taxi drivers for renewing a driving license. **(8) Date: 2077-09-19:** Extension of contract for 6 months. **(9) Date 2077-10-11:** Extension of contract for 6 months. **(10) Date 2077-10-15:** Payment of 50% of salary to workers by business enterprises. **(11) Date: 2078-01-04:** Free COVID-19 test and treatment.		
4.	Ordinance for COVID-19 Crisis Management, 2078	To conduct the task of prevention, control, diagnosis and treatment of COVID-19 in a unified and organized way in view of its rapid spread in Nepal.	There is no particular vision and provision for Psychosocial counselling and relief programme except for the following general provisions: **Article 7:** Central Hospital is to provide various services. (d) Telemedicine, call centre, home isolation follow-up. **Article 14:** Responsibilities of COVID-19 Crisis Management Centre (CCMC).	There was a lack of psychosocial counselling at the community level. Except in the cities, people were not able to get telephone support and home isolation follow-up.	The government should organize emergency psychosocial counselling at the community level. The concept of social distancing should be clarified as simple as common people might understand clearly.

			(f) To solve the problems related to the supply of medicine, equipment, food and essential goods, and facilitate their smooth supply. **Article 15:** COVID-19 Crisis Management Centre (CCMC) by coordinating with the Central Hospital can deploy a Rapid Response Team of health workers in the area impacted by COVID-19 for the prevention, control, diagnosis and treatment of COVID-19.	Health posts at the community level were out of medicine, equipment, and essential goods to treat COVID-19 infected patients. Rapid Response Team were not deployed in the studied areas.	The government should supply adequate medicine, equipment, and other essential goods to treat COVID-19 infected patients at the community level health support system
5.	Mental Health Policy, 2053 BS (1996 AD)	Alma Ata Declaration, Minimum local mental health support to the poor, mental health human resource, human rights, promoting public awareness	**Policy No. 4:** Generating public awareness regarding mental health, mental disorder and a mentally healthy lifestyle, with the participation of the community and health workers.	There was a poor mechanism to raise public awareness regarding mental health, mental disorder, and a mentally healthy lifestyle. Similarly, the mental health problem is still taken as a social stigma.	A new evidence-based National Mental Health Policy should be formulated following all the steps of the public policy cycle.

6.	Mental Health Strategy and Action Plan, 2077	It has 3 objectives: 1. To integrate the basic mental health service into the primary health service and to ensure free access to it. 2. To expand and make the specialized mental health service accessible to all. 3. To develop an effective partnership, coordination and collaboration among governmental, non-governmental and private sectors.	Strategies: 1. Enhancing public awareness to promote mental health and eradicate existing superstitions, misconceptions and misinformation about mental health **[Strategy 3].** 2. Protecting the fundamental human rights of persons with mental illness and psychosocial disability **[Strategy 4].**	The government and non-government organizations were actively involved to enhance public awareness to protect fundamental human rights, promote mental health, and eradicate existing superstitions, misconceptions, and disinformation, but they have limited coverage to reach out to people across the country.	The government, specifically local government should allocate a certain portion of an annual budget to raise public awareness of mental health and sustainably protect human rights. School educational curriculum must include education on mental health.

7.	Mental Health Rehabilitation Programmes Guidelines, 2075	It has two objectives: 1. To create an environment for the treatment and rehabilitation of persons with mental health and psychosocial problems and reintegrate them into the community to regain their capacity. 2. Coordination among governmental, non-governmental and private sectors to ensure the environment of effective collaboration for the	All provisions are dedicated to a mental health rehabilitation programme	Except in cities and a few district headquarters, there are no such rehabilitation centres run by the government. Few rehabilitation centres and their support for psychosocial health is limited. There is a general lack of knowledge about the services provided by the government to the targeted groups and they have limited capacity to access the services even when they are informed.	Local bodies should make arrangements for such rehabilitation programmes effectively for coordinated action including reaching out to the targeted groups.

		treatment and rehabilitation and the uniformity in service delivery and working style. **The targeted group includes:** Disabled, helpless and unclaimed persons certified by doctors as persons with mental illness or psychosocial problems needing treatment and rehabilitation services.			
8.	Community Mental Health Package Nepal, 2074	The general objective of this package is to facilitate the integration of	**Target groups:** Policymakers, public health personnel, political leaders, civil society organizations, individuals with mental health and	The training for primary health workers on mental health is limited.	The government should deploy trained health workers in each community health post for dealing

		mental health services into the primary health care delivery system of the country. The specific objectives include: 1. To define the mental health and psychosocial support service packages at different layers of primary health care system, 2. To define the minimum standard of MHPSS service at different layers of the primary health care system,	psychosocial problems and their family members. The package has the following components: Guideline documents, disorders, management, service providers, trainers, number of training days, refresher training, training contents, components of care, clinical supervision and mentoring, and referral centres. The packages include and describe activities under three strata: 1. Health administration 2. Health facility 3. Community.		with mental health problems of the people. It also requires proper monitoring of whether guidelines are implemented effectively or not in all public and private sectors.

		3. To set the standard of the training packages and manuals for training and supervision of health workers and community volunteers.			
9.	Multisectoral Action Plan for the Prevention and Control of Non-Communica-ble Diseases (2014-2020)	The goal of the multisectoral action plan is to reduce preventable morbidity, avoidable disability and premature mortality due to NCDs in Nepal. There are 4 action areas: 1. Leadership, advocacy and partnership.	It has the following strategic Approach for mental health: Improving basic minimum care of mental health services in the community and improving competency for case identification and initiating referral at the primary care level. Then, this strategic approach has the following five relevant action areas: 1. Strengthen the health system's capacity to provide essential mental health services and reduce the treatment gap.	There is a severe gap in the early detection and management of NCDs and the risk factor. Mental health is not integrated well into the health service system. Mental health and NCD screening for migrant worker is limited to specific areas but not focusing on nationwide.	Strenthenen the implementation of the programmes related to mental health in the Action Plan

		2. Health promotion and risk reduction. 3. Health systems strengthening for early detection and management of NCDs and their risk factors. 4. Surveillance, monitoring and evaluation, and research	2. Strengthen community participation through community-based approaches. 3. Integrate mental health and NCD screening for Nepali migrant workers along with infectious disease screening. 4. Implement NCD screening and mental assessment points and provide counselling and clinical services as required. 5. Strengthen information on mental health	Weak information collection and dissemination about mental health problems and treatment services available.	
10.	The Act Relating to Right of Person with Disability, 2074 (2017)	**Purpose:** to amend and consolidate laws relating to the rights of persons with disabilities in order to respect their civil, political, economic, social and cultural rights by doing away	**Article 29:** Provisions relating to rehabilitation: (1) The Government of Nepal shall rehabilitate the persons who have profound disabilities, severe disabilities, are helpless or have mental disabilities and mental or psycho-social disabilities. **Article 35:** Additional services and facilities for persons with mental or psycho-social disabilities:	Persons with a disability were most affected by COVID-19 as they were isolated from social networks and there was limited relief distribution during the pandemic.	The local government should keep up-to-date information on the persons with disabilities to support them with relief materials, and rescue during the emergency, those disabled who are lacking social support in the community.

		with discrimination against persons with disabilities and to ensure the environment that enables persons with disabilities to earn a self-reliant and respectful living by empowering persons with disabilities and getting them to have participated in the process of policy making, and development	(1) The Government of Nepal shall make provisions for the treatment of persons with mental or psycho-social disabilities in such community hospitals or health centres as chosen by them or any member of their families or their guardians. (2) The Government of Nepal shall provide free medicines and consultancy services required for persons with mental or psycho-social disabilities. (3) The Government of Nepal shall make arrangements for the treatment and rehabilitation or family reunion of persons with mental or psychosocial disabilities who have been disregarded by their families.		Psychosocial counselling should be targeted at people with disabilities.
11.	The Public Health Service Act, 2075 (2018)	**Purpose:** To make necessary legal provisions for implementing the right to get	**Article 3(4)** Every citizen shall have the right to obtain free basic health services (e) relating to mental disease. .	During the pandemic, all citizens did not have equal access to free basic heal services.	The local government should ensure access to basic health services for all citizens in coordination with the

		free basic health services and emergency health services guaranteed by the Constitution of Nepal and establishing access of the citizens to health services by making them regular, effective, qualitative and easily available	**Article 12(1):** While carrying out treatment pursuant to this Act, it shall be the duty of the concerned health worker to behave equally and respectfully towards all the service recipients. **Article 45(2):** Production, distribution, dissemination and transmission of advertisements by keeping wrong or misleading information to attract towards any materials and services that affect mental and physical health shall be prohibited. **Article 46:** The Federal, Provincial and Local levels may adopt necessary measures for controlling social and cultural superstitions that affect adversely public health	Cases reported where members of marginalized and minority communities were not able to access health services during the pandemic. Overwhelming information on COVID-19, both fake and true, caused massive confusion known as infodemic. The Federal, Provincial and Local level government has adopted certain measures to create awareness of public health.	federal, and provincial governments as well as the private sectors and NGOs. There should be a mechanism for controlling misleading information that adversely impacts mental health.
12.	National Health Policy, 2019	It has six objectives: 1. To create opportunities for all citizens	People's access to mental health and psychosocial services shall be ensured through primary hospitals by promoting the transfer of	In health posts and hospitals in most parts of rural Nepal,	The government should establish mental health and psychosocial service.

		to use their constitutional rights to health. 2. To develop, expand and improve all types of health systems as per the federal structure. 3. To improve the quality of health services and easy access. 4. To strengthen the social health protection system by integrating the most marginalized sections. 5. To promote multi-sectoral partnership and collaboration	knowledge and skills, service-oriented skills and special training [Policy 6.17.5]	mental health and psychosocial services are unavailable.	centres focusing on the rural community

		between governmental, non-governmental and private sectors to promote community involvement. 6. To transform the health sectors from profit-orientation to service-orientation			
13.	Public Health Regulation, 2077 (2020)	Rules formulated for the implementation of the Public Health Service Act 2075 (2018)	**Rule 3:** Free basic health service to all. Annex 1, List 5: Basic health service includes services for mental health which include diagnosis, treatment of symptoms, consultations and referral.	Urban, educated, rich people have received basic mental and psychosocial health services. However, rural, poor, marginalized people such as women, Dalits, Janajati, and remote areas people are lacking government-managed free mental health and psychosocial services.	The government should properly monitor, if all policies, rules, and regulations have been implemented effectively or not. The health policy should be developed by adopting a bottom-up approach.

14.	National Population Policy, 2014	**It has seven objectives** related to coordination between development and population management, right-based sexual and reproductive health and family plan-ning services, quality service delivery, management of migration and urbanization, gender equality and social inclusion in all spheres of development, effective management of statistics, research, survey and analysis, and	Establishing rehabilitation centre for HIV-AIDS victims of gender violence, persons with mental illness and disability [Strategy 8.5.8]	There are no separate rehabilitation centres for HIV-AIDS victims, men, and women, and persons with mental illness and disability.	The government should establish separate rehabilitation centres for HIV-AIDS victims, men, and women, and persons with mental illness and disabilities in different parts of the country.

		making the active population productive and entrepreneurship-oriented.			
15.	Urban Health Policy, 2072 (2016)	**Objective:** To increase the access to and utilization of basic health services for inhabitants of urban areas, particularly women, the poor and marginalized class and community.	Does not specifically mention services related to mental health and psychosocial disorder. However, these are included in the basic health service	Mental health and psychosocial disorder services are available in most the urban areas. However, there are differences in access to those services by class, gender, and educational background.	The government should properly monitor if urban health policy has been implemented effectively or not to reach the targeted people.
16.	National Health Insurance Policy 2071 (2014)	**It has three specific objectives**: 1. To increase the financial protection of the public by promoting pre-payment	**Strategy 2(2)** states that a fund will be created to ensure the participation of the poor and target group (marginalized social groups). However, no specifics are given.	The communities are not informed about financial protection and promoting pre-payment and risk pooling in the health sector. As a result, the public financial resources are not mobilized equitably and that provide quality	The government and all stakeholders should organize awareness campaigns targeting rural, marginalized and poor people.

		and risk pooling in the health sector. 2. To mobilize financial resources in an equitable manner. 3. To improve the effectiveness, efficiency, accountability and quality of care in the delivery of health care services.		mental and psychosocial health care services to improve the effectiveness, efficiency, and accountable manner.	
17.	Health Insurance Act 2074 (2018)	**Purposes:** 1. To protect the citizen's right to quality health service, to reduce the financial risk through insurance by pre-payment	**Article 7(2):** Nepal government, the federal government and local government may bear the cost equal to the premium of the insurance through a procedure.	The communities are not informed about financial protection and promoting pre-payment and risk pooling in the health sector. As a result, the public financial resources are not mobilized equitably and that provide quality mental and psychosocial	The government and all stakeholders should organize awareness campaigns targeting rural, marginalized, and poor people.

		and risk pooling in the health sector. 2. To mobilize financial resources in an equitable manner; and to ensure the citizen's access to health services by improving the effectiveness, efficiency, accountability and quality of care		health care services to improve the effectiveness, efficiency, and accountable manner.	
18.	National Medicines Policy, 2007 (draft)	**Main policies:** To maintain, safeguard and promote the health of people by ensuring access to essential and other medicines at affordable prices to all	Ensuring access to essential and other medicines at affordable prices to all; No policies related to psychotropic drugs in particular.	The mental health and psychosocial affected people were not aware of the availability of psychotropic drugs.	The government of Nepal should make psychotropic drugs easily accessible at the community level.

		irrespective of their socio-economic status or place of living; by making the country self-reliant in pharmaceutical manufacturing for human and veterinary use and to manage effectively all the pharmaceutical-related activities including production, import, export, storage, supply, sales, distribution, quality assessment, regulatory control, rational use and information flow.			

19.	National Drug Policy, 1995	**Main policy:** To maintain, safeguard and promote the health of people by making the country self-reliant on drug production; ensuring the availability of safe, effective, standard, and quality drugs at an affordable prices in quantities sufficient to cover the need of every corner of the country; and to manage effectively all the drugs-related activities including production,	There is no specific policy for psychotropic drugs and services for marginalized social groups	Marginalized, minority and disadvantaged groups among those who are affected by mental health and psychosocial problems were not aware of the availability of psychotropic drugs at the community level.	The government of Nepal should make psychotropic drugs easily accessible at the community level.

		import, export, storage, sale, supply and distribution.			
20.	Health Sector Gender Equality and Social Inclusion (GESI) Strategy, 2009	**The target group** of GESI includes the poor, vulnerable group including women, children, senior citizens, displaced people, conflict victims, the landless and victims of human trafficking, and marginalized caste and ethnic groups. The objectives of the strategy are: 1. To develop policy and	Empowerment of the poor, vulnerable group and marginalized caste and ethnic groups to seek health services and take leadership roles in service programmes [Strategy 8(a)(i)]	Despite the GESI policy adopted by the government, women are discriminated. The most marginalized, and vulnerable people are not able to take a leadership roles in the health service sector.	The government should establish a monitoring mechanism for how the GESI policy is implemented in real practice. Similarly, the government should implement a policy to end the socio-economic inequalities that exist in the country and enhance the well-being of the citizen of Nepal.

		plans for GESI in the health sector. 2. To enhance the capacity of health service providers to ensure the equitable access and use of health services by the target group using a rights-based approach. 3. To improve the health-seeking behaviour of the target group using a rights-based approach.			
21.	Nepal Health Sector Strategy (2015-2021)	It has four key strategic directions:	**A key intervention for Outcome 3** (*Equitable distribution and utilization of health services*):	The poor, less educated, marginalized, rural people do not have easy access to quality health services of psychosocial	The government should empower the poor, less educated, marginalized, rural people who do not

		1. Equitable Access to Health Services. 2. Quality Health Services. 3. Health Systems Reform. 4. Multi-sectoral Approach.	Update basic healthcare package by including emerging health care needs like psychosocial counselling, mental health, geriatric health, oral health, standard NCD package, Ayurveda and rehabilitative services. **A key intervention for Outcome 7** (*Improved Healthy Lifestyles and Environment*): Expand psychosocial, psychiatric and curative care for gender-based and sexual violence.	counselling, mental health, geriatric health, oral health, standard NCD package, Ayurveda, and rehabilitative services.	have easy access to quality health services of psychosocial counselling, mental health, geriatric health, oral health, standard NCD package, Ayurveda, and rehabilitative services.
22.	Disaster Risk Reduction and Management Act 2074, and Regulation 2076	Disaster risk reduction and management	Assessment of post-disaster pandemic and public health issues and plan for control and management based on national and international knowledge and methods. Make psychosocial counselling available to disaster-affected people. Formulating special plans and programmes for women, children, elderly, Dalit, marginalized communities, and the disabled who are vulnerable to disaster risk.	Health services in general are disrupted during the pandemic. During the pandemic, the government was not well planned for addressing the crisis situation. Policy for mental health and psychosocial support is articulated in the policy but is yet to get operationalized.	There is a need to develop a detailed policy for setting up an institutional arrangements for preparedness for mental and psychosocial support.

CHAPTER EIGHT
CONCLUSION AND RECOMMENDATIONS

Mental health in general and psychosocial health in particular is a neglected field in Nepal. Despite the fact that significant prevalence of mental health problems among the populace, mental health support is not being fully institutionalized in the country's health system. Mental health problems are often reduced to biology and focus is placed on the curative side alone. At the societal level, across the spectrum of cultural diversity in the country, people take mental illness as madness and the person with mental disorders is stigmatized and excluded from the societal processes. In addition, there is a lack of understanding that mental illness is rooted in social, economic, political and cultural contexts as much as it is a physical issue. The concept of psychosocial health helps to see the interconnection between the individual psyche and their socio-cultural context; their environment, interpersonal relationships, family and community. Psychosocial health pertains to the holistic vision of health in which a person has a positive relationship with members of the family, and community, are emotionally equipped, and have a resilient outlook towards life and society. Psychosocial support is essential for maintaining good physical and mental health and provides an important mechanism for well-being and social cohesion.

In the context of a devastating surge of coronavirus in the country since 2020, mental and psychosocial health problems have been exacerbated in the country. This study looks at the impact of the COVID-19 and associated crisis it has generated in an individual, families and communities. Based on the qualitative interviews of participants from across the seven provinces, this study shows that psychosocial health problem is widespread in the country. Psychosocial health, as this study depicts, is manifested in heightened anxiety, fear of the unknown and unpredictability, and more seriously in the deep fear of death and illness of self and the loved ones. This study also shows that there is an increased level of anger, frustrations, depression and contempt during the period of the pandemic which in turn caused disruption in interpersonal relationships. The patterned behaviour of discriminatory treatment of others, domestic violence and community conflicts are the major manifestations of such a state. Psychosocial health has social determinants, in terms of the wider social and economic situation such as loss of employment, the danger of hunger, deterioration of physical health, and economic burden among others. In order to understand psychosocial health better, this study also examines the impact

of coronavirus on general health, education and livelihood situation as its determinants. The phenomenon of infodemic, intolerance and lack of health care services during the pandemic had also caused a significant impact on increasing mental health problems. Those who are at the bottom rung of the power relations and have limited access to resources and information, especially daily wage workers who rely on the informal economy for their livelihood, are hardest hit by the coronavirus and its resultant adverse impacts.

This study also looks at the ways for improving the policy environment for addressing psychosocial health problems. In order to do this, the research team has reviewed the current law, regulation, strategies, action plans and decisions ranging from the constitutional provisions to some specific decisions of the COVID-19 Management Committee. It provides the wider landscape of the policy pertaining to mental health and suggests that policy recognition for mental health is increasing. The field study on the government support in this arena was assessed for understanding the perspectives of the stakeholders and support needs on the ground. The policy review shows that there is a generic gap in the translation of policy articulated into action. With regard to psychosocial health, the country is yet to introduce a systematic policy on psychosocial health in addition to mental health policy.

In terms of the implications of this study, there are three points that need to be made based on this exploratory research. The first is that psychosocial health is a new field in Nepal for systematic scientific study. The second is that disasters and pandemics such as coronavirus exacerbate the problem of mental and psychosocial health problems, especially among the deprived section of the community. Finally, there is an urgent need to build a coherent policy measure accompanied by a robust mechanism for effective implementation within the health system that takes into account the principles of Gender Equality and Social Inclusion (GESI) in good faith.

Policies have evolved over the last few decades towards the recognition of mental health as one of the key aspects of health and wellbeing in Nepal. However, progress made in articulating the policy measures has not yet translated into implementation. Multiple reasons can be attributed to such a generic gap in the implementation of the policies. The lack of strong leadership, weak government mechanisms, and inadequate budget allocation are among the main reasons for such a gap.

With regard to policies on psychosocial health, the policy measures are yet to be made more specific. Psychosocial health is often treated as a tertiary theme and is

generally used synonymously with broader mental health. The absence of explicit policy articulation is the major gap in the existing framework of the mental health policy landscape.

Inequalities in health outcomes are the result of the social determinants - social, economic, political and cultural factors in significant ways. The psychosocial approach to health enables the policy and practices to recognize social determinants such as employment and income, education, housing, and family and community life to reduce health inequalities. Stress and trauma caused by disasters and pandemics such as COVID-19 dramatically increase the need for psychosocial support in the community. Given the critical importance of psychosocial support in well-being and mental health, the following recommendations are made:

1. The health policies of the government should integrate mental and psychosocial health components to address the wider determinants of health including the condition in which people live and work. This would involve assessment of and improvement of the living and working conditions such as employment and income, family and community harmony, education and information, non-discrimination and others.
2. Integrate psychosocial health in overall national policies including education, employment, judicial system and others.
3. Design targeted psychosocial health support programmes for vulnerable populations, especially adolescents, women and elderly and marginalized and minority communities.
4. Integrate the psychosocial support intervention with primary health care by providing trained human resources at the community level.
5. Develop policy measures to facilitate a non-discriminatory, abuse-free environment in school, family, community and workspace for positive mental health.
6. Build a health workforce trained in mental and psychosocial health support at health service entities such as hospitals, health posts and other facilities at federal, provincial and local levels.
7. Ensure coordination among different government departments, three layers of government as well as with the private sector and NGOs.
8. Provide adequate budgetary resources for implementing the programmes related to mental and psychosocial health.

9. Build a knowledge-base on mental and psychological health based on scientific research.
10. Build mental and psychosocial health policies in a dynamic way based on evidence made available through empirical research.

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