



Nepal

**GENDER, DISABILITY AND PANDEMIC:
UNDERSTANDING INTERSECTIONAL EFFECT
ON HEALTH AND WELLBEING OF
WOMEN WITH DISABILITIES
AND THE ROLE OF LOCAL GOVERNMENT
TO BUILD A MORE RESILIENT SOCIETY**

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Gender, disability and pandemic: understanding intersectional effect on health and wellbeing of women with disabilities and the role of local government to build a more resilient society



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Project Summary

The World Risk Index 2021 assesses the disaster risk for 181 countries. This covers almost 99 percent of the world's population. Countries with low economic capacity and income tend to have higher vulnerability or lower capabilities in averting disasters. In such situations, women with disabilities often face double discrimination because of the intersectionality of multiple identities of gender and disability. It has been found that women with disabilities are socially excluded groups. They may have difficulty accessing humanitarian assistance programs, due to a variety of societal, attitudinal, environmental, and communication barriers, and are at greater risk of violence than their non-disabled peers. Women with disabilities are 'particularly vulnerable to discrimination, exploitation, and violence, including gender-based violence, but they have difficulty accessing support and services that could reduce their risk and vulnerability. Therefore, this study aimed to assess the impact of COVID – 19 pandemics and disasters on the health and well-being of people having multiple and intersecting identities and to examine the role of local government in reducing multidimensional vulnerabilities for those populations at risk.

To achieve the objective, the study examined how the intersecting effect of gender, disability, and disaster-impacted the basic healthcare needs of women with disabilities in Nepal. Marshyangdi Rural Municipality of Lamgunj, which was recently affected by natural calamities (flood and landside) along with the COVID-19 pandemic, and the Palungtar Municipality of Gorkha, which was the epicentre of the devastating earthquake of 2017 were the settings. The team visited the setting, identified 8 women having disabilities purposively, and interviewed them to explore their experiences on gender-specific barriers/vulnerabilities in relation to meeting their health needs during the pandemic and other disaster situations. As this case study intended to explore the intersectionality between gender, and disability, during the COVID-19 pandemic/ disaster and as well as seek the role of the local government, data triangulation was needed. Therefore, to take a complete picture of women with disability, data from multiple sources was necessary for the credibility, dependability, transferability, and reflexivity of the study. For this purpose, data were also collected from the local authorities, health service providers, NGO leaders, and DRR coordinators for key informant interviews (KII). Similarly, caretakers of disabled people, Disabled People's Organization, and Women's groups were also included in focused group discussions (FGDs). Similarly, Municipality, and local stakeholders participated in policy review workshops meetings. A total of 54 participants were involved in the study.

Before field visits, a desk-based review and analysis of 15 government policies (6 DRR policies; 4 National Health policies; 3 disaster-related policies; 2 gender policies) using EquiFrame¹, followed the human rights approach to policy analysis was done. Afterward, we organized participatory policy review workshops with relevant stakeholders at the local level that created a forum for dialogue between local government and other stakeholders.

The study found that women with disabilities experienced various challenges during the period of pandemics and disasters. Due to limited mobility or severe disabilities, they needed someone to accompany them to health facilities, leading to greater transport costs that negatively affected their access to health services. The layout and equipment at health facilities offering care under limited services were disability-unfriendly. Negative stereotypes against women with disabilities in society led to their exclusion from public participation forums thereby limiting their awareness of the

available services. Intersectionality of gender, poverty, and disability has affected the experiences of women with disabilities living in rural municipalities of Nepal.

This study recognized that women with disabilities faced additional risks in humanitarian crises. They were: double discrimination because of their gender and disability. The breakdown of economic structures, health care services, family and community support, educational opportunities, housing, transportation, and other infrastructures due to disaster increased the vulnerability of women with disabilities. The loss of assistive devices, caregivers, and supportive networks to protect as a result of disaster made them more dependent on others and at greater risk of exploitation. Women with disabilities in the communities experienced stigmatization and discrimination, barriers to participation, unsafe shelters, and a lack of access to services. Women with disabilities affected by disasters faced increased levels of sexual and gender-based violence in and out of the home, especially those with intellectual and mental disabilities. This was also due to factors such as stigma and discrimination, being seen as 'easy' targets, social exclusion and isolation, loss of protective/supportive mechanisms, and limited mobility. They did not have adequate access to shelter, and goods to fulfill basic needs including menstrual hygiene in humanitarian contexts. These all can result in the loss of the livelihoods of women with disabilities, which increases their poverty and makes them vulnerable to exploitation. Therefore, to reduce their vulnerabilities family, society, and community must bear responsibility. The vulnerable groups must be prioritized during disasters, and the government, especially, the local government must be responsible for building a friendly infrastructure to enhance social harmony.

On the other hand, service receivers perceived that although the local government has some programs focusing on vulnerable groups, however they are still insufficient. Similarly, the service providers and the local government found impractical policies and resource scarcity for the implementation of the program. Hence, the policies must be revised, and emphasis needs to be given to the implementation of available policies. However, there is a need to use available evidence/information about vulnerable groups, ensure participation of vulnerable groups in policy development, and this area requires further research to understand the situation of vulnerable groups.

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Background Introduction

In 2019, 95 million people were affected by 396 disasters globally, contributing to 103 million USD in economic losses; and 24.9 million individuals internally displaced.² Measures to mitigate disaster change the lives of people with leading consequences such as increased stress.³ Women and girls are particularly exposed to disaster risks and suffer higher rates of mortality, morbidity, and economic damage to their livelihoods.⁴ They have limited access to education, health, and nutrition, and are adversely and disproportionately impacted by disasters and new hazards such as the COVID-19 pandemic.² Women's and men's differential access to social and physical goods or resources is one of the key dimensions of gender inequality. Women's social positioning or the roles they are expected to take on are often supportive and reproductive, centred on the home and local community rather than the public sphere. These roles they play are generally less visible and attract less public recognition than the work in which men engage. Typically, women in poor, rural locations are expected to assume primary responsibility for their families' subsistence. Yet because they often do not earn a wage, women are frequently excluded from decisions about spending or about their children's education. The expectation that girls will help their mothers with household tasks and with caring for younger siblings means that they are more likely to be excluded from opportunities to gain an education than boys. Women earning a wage often earn less than men, leaving them more vulnerable to changes in their working environment caused by disasters.⁵

People with disabilities, representing 15% of the global population,⁶ face challenges in performing their daily life activities, in a normal social context. In the situation of disaster like this pandemic, people with disability are more likely than general people to lose their job and experience higher levels of financial crisis,⁷ experience higher risk of depression, lower life satisfaction and increased loneliness.⁸ Considering the COVID-19 pandemic, the World Health Organization (WHO) stated that additional considerations from governments, healthcare systems, disability service providers, institutional settings, communities, and actors are needed for people with disabilities.⁹

People with disabilities are already considered a marginalized group.¹⁰ they have reduced access to healthcare and community support services, among other restrictions due to the COVID-19 pandemic, which could amplify their daily difficulties. The three factors such as poor health outcomes from disabling conditions, compromised access to basic health care, and rehabilitation services, and adverse social impacts of the efforts to mitigate the pandemic, play a role to affect the people with disabilities during disaster situations.¹¹ With their dependency on services and others to meet specific needs and their increased susceptibility to COVID-19, people with disabilities are considered vulnerable during crises period.

The official census data of Nepal (2011)¹² reports a 1.94% disability rate and Nepal has ratified the UNCRPD in 2010. Disability rights are provided by the 2015 Constitution and the 2017 Rights of Persons with Disabilities Act, amongst others. However, People with disabilities experience stigma, prejudice, and marginalization which exclude them from daily life, especially in rural areas.¹³ This puts them at greater risk of violence and abuse.

People with disabilities having multiple and intersecting identities are disproportionately affected by the COVID-19 pandemic.^{14,15} UN highlighted that people with disabilities are at greater risk of contracting the coronavirus and developing more severe health conditions.¹⁶ A study suggests that

women with disabilities in particular are facing difficulties in accessing healthcare and life-saving procedures, and are at greater risk of death, injury, and long-term negative impact on their health and wellbeing at the time of disaster as they are systematically disadvantaged.¹⁷ Women and adolescent girls with disabilities are affected more by such adversities compared to their male disabled counterparts.¹⁸

Intersectionality, in this project, was primarily defined as the intersection between gender and disability identity influencing individual lives, social practices, institutional arrangements, and cultural ideologies with power outcomes that ultimately impact service used by this population and their wellbeing. The interactions that take place between and within multiple dimensions and power structures, and social systems, lead to discrimination and various forms of oppressive experiences.¹⁹ Literature informs that intersectionality between gender and disability compounds further marginalization and oppression to women with disabilities.²⁰

Nepal currently is in the midst of implementing a federal structure as defined by the new constitution 2015, with radical changes in policies and reforming the service delivery system devolving power and responsibilities significantly to Municipalities.²¹ The fear is still remaining among the public regarding the capacity of the newly formed Local governments to successfully take on their new roles as well as doubts about their 'readiness' of the service delivery system including the health system to adapt to the changes.²² With this juncture of the change, the country is facing COVID-19 pandemic along with the devastating floods in many parts of the country which has a huge impact on people's daily life.²³

In the given context, the impact of those adversities on disadvantaged and vulnerable populations such as people with disabilities was not known. The question arose, how COVID-19 pandemics together with other disasters affect those groups? How were the most vulnerable people coping with the hardships created by the pandemic/disasters? What was the experience of those populations at risk in receiving healthcare and other basic/emergency services? What was the government's new policy to support and protect the most vulnerable population during pandemics and disaster situations? How did the government, particularly the Municipalities, respond to the current situation? All these questions were unanswered. Furthermore, there was little knowledge about the combined effect of the disasters, gender, and disability in the context of healthcare and the resilience of affected populations.

There is a lack of research about the impacts of disaster on people with physical disabilities, a population that is too often forgotten in governmental decisions²⁴ which should be included in future crisis strategies and response planning. To support the needs of people with disabilities with adequate policies, it is important to understand the situation of people with disabilities, not only by the government but also by the health care providers and the general population. Hence, to minimize the long-term consequences of the pandemic, and, optimize their quality of life and social participation, it is urgent to analyse their situation. Therefore, this study intended to explore the situation of women living with disabilities to better understand and respond to their specific and unique needs in the context of crises such as pandemics or natural disasters.

Objectives

The overall objective of the project was to assess the impact of COVID – 19 pandemics and disasters on the health and wellbeing of people having multiple and intersecting identities and to examine the role of local government in reducing multidimensional vulnerabilities for those populations at risk.

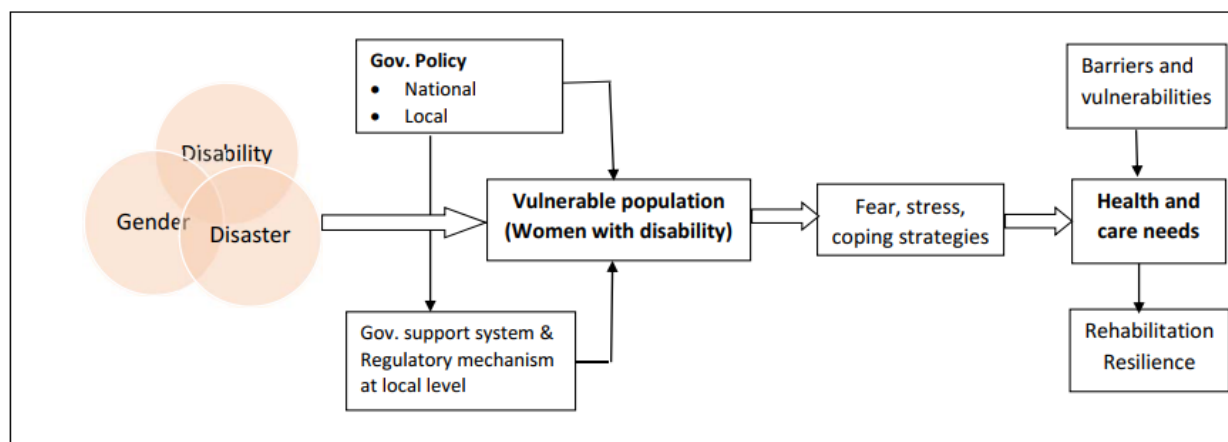
Specific Objectives:

- To identify gender-specific barriers/vulnerabilities experienced by women with disabilities in relation to meeting their health needs during pandemic and or disaster situations.
- To understand fear, stress, resilience, and coping strategies during COVID – 19 and or disaster situations of women with disabilities.
- To briefly review government policies and mechanisms (at a local level) in addressing the vulnerabilities of the population at risk (person with disabilities) during pandemic/disaster situations.
- To examine how effectively support and regulatory mechanism functions and the role of Municipalities and Rural Municipalities in the delivery of support services to populations at risk.

Concept of Disability, Gender, and Disaster

This study examined how the combination of multiple individual characteristics particularly, being female gender, with a disability, and during disaster/pandemic intersect with women’s experiences; how the current policies and government support system functioned at the local level during the period of disaster; how the women experienced the situation in relation to meeting their basic needs, and how the community moved toward resiliency. Figure 1 presents this concept:

Fig.1: Conceptual framework



Research Methods

This study adopted a case study design. This case study research examined how the intersecting effect of gender, disability, and disaster impacted on meeting the healthcare needs and wellbeing

of women with disabilities. It analyzed the government policy and mechanisms for protection and service provisions to the population at risk during disasters and pandemics. Furthermore, this study assessed the role of local government in reducing disparities and creating a resilient environment for the affected.

This study was done in Nepal, a land lock country of Southeast Asia, situated between China and India. The Gandaki province of Nepal, situated in the western region, spread over the Himalayan, Hilly, and Plain region with just about 9.06% of the total population of Nepal was the setting. From this province, Marshyangdi Rural Municipality of Lamjung district affected by flood and landside along with the COVID-19 pandemic, and the Palungtar Municipality of Gorkha District, which was the epicenter of the devastating earthquake of 2017.

As the study intended to explore lived experiences of women with a disability during COVID-19 pandemic and disaster, women having visual, and or other physical disabilities, age greater than or equals to 18 years, residing in the study settings (Gorkha and Lamjung districts) were the study population. People having different types of disabilities had unique and their own way of life experience, and because the women with a disability had to communicate/talk verbally to share their experience in this study, they were selected as the study population. The disabled women who had communication problems, severe mental and intellectual disabilities were excluded from this study.

Women with disabilities (individual/person) residing in Lamjung and Gorkha Districts for at least 12 months from the time the study was undertaken, were the sampling unit. However, this case study intended to explore the intersectionality between gender, and disability, during the COVID-19 pandemic/ disaster as well as seeking the role of the local government, data triangulation was needed. Therefore, for taking a complete picture of women with disability, data from multiple sources was necessary for the credibility, dependability, transferability, and reflexivity of the study. For this purpose, data was also collected from the local authorities, health service providers, NGO leaders, and Disaster Risk Reduction (DRR) coordinators for Key Informant Interviews (KII). Similarly, caretakers of disabled people, Disabled People's Organization, and Women's groups were also included in FGDs. Similarly, Municipality and local stakeholders participated in policy review workshops and meetings. A total of 54 participants were involved in the study 8 women with disabilities participated in In-depth Interviews (IDI), 7 participants (local leaders, development workers, and social workers) were included in KII, 20 participants participated in 3 Focus Group Discussions (FGDs), and 19 participants were included in 2 workshops.

These participants were selected through purposive and snowball techniques. By doing a field visit, the researchers identified possible participants of the study by reviewing the disability record of the local government. By taking references from local community people, and the community leader, possible participants were approached individually. By taking reference from the study participants, the next possible participants were identified, and so on till the data sufficiency was achieved.

Data Collection Procedure

We collected qualitative data through in-depth interviews with purposively selected 8 (3 from the Palungtar Municipality and 5 from the Marshyangdi Rural Municipality) women with physical disabilities to understand their experience. Similarly, interviews with 7 key informants were done. The key informants were 2 family members (Care providers) of the disabled people, 2 Female

Health Volunteers, 2 executive members of the Nepal Disabled Women Association, and 1 local level government officer (ward secretary), who serve the community people at the local level including people with disability. We conducted 2 Focused Group discussions (FGDs) in Palungtar Municipality and 1 FGD in Marshyangdi Rural Municipality. Participants of FGDs were: Disabled people who are involved in welfare organizations disabled people, local-level health workers who were directly involved in providing health services to the community generally or in disaster and pandemic situations.

To understand the key issues regarding the implication of policy at the local level, we organized participatory policy review workshops meetings with relevant stakeholders at the local level (one at Palungtar Municipality and one at Marshyangdi Rural Municipality). The workshop created a forum for dialogue between local government and other stakeholders. Involving a range of representatives from local government, community people, NGOs, disabled people's organizations, and media helped to bring them together into a dialogue and sensitize in the issue along with the data for the study.

The interviews, FGDs, and stakeholder workshops were facilitated by the PI and Co-I themselves. Interviews were conducted in the local language and were audiotaped on a digital voice recorder. Each interview took 45 to 60 minutes, and the data was collected in February 2022. To facilitate data collection, we developed an IDI guideline, a KII guideline, an FGD guideline, and a schedule of workshops meeting.

Ethical Consideration

We were acutely aware of the potential risks of engaging different stakeholders (participatory approach) in a dynamic and highly politicized environment. The project could raise disproportionate expectations among the stakeholders limiting their active participation. As the team members experienced all these potential issues in previous research/project implementation, they used this experience to devise a robust Risk Management Strategy before field implementation. The risks were further minimized by our existing relationships of trust with the key stakeholders and sharing the plan in advance, and discussing with potential stakeholders to develop a protocol.

In order to ensure COVID-19-related safety, the research team adhered to national public health measures in place to protect themselves and members of the community. Strict infection control measures were in place, and data were collected only after the release of movement restrictions by the Nepal Government. Ethical protocols were strictly adhered to, including rules and guidance on data protection. All researchers were trained on informed consent processes ahead of their entering the field, as well as local safeguarding regulations, based on national policies. The project was working with the most vulnerable people such as women with disabilities. However, we recruited only those who could give assent for the interview. Before implementation of the project, we obtained ethical approval from the Nepal Health Research Council, and the Institutional Review Committee of the Institute of Medicine, Tribhuvan University. Before enrollment of participants in the study, detailed information about the study, and their role in the study as a participant were explained and after ensuring voluntary participation, informed consent was obtained from the participants.

Data Analysis

The verbatim was transcribed, translated, and analyzed using RQDA software. An inductive approach establishing clear links between the research objectives and the summary findings was derived from the raw data and presented the results.

Findings

This study intended to assess the impact of COVID – 19 pandemics and other disasters on the health and wellbeing of people having multiple and intersecting identities and examine the role of local government in reducing multidimensional vulnerabilities for those populations at risk. From the triangulated data from different sources, in total, seven themes emerged with subthemes and codes. These themes and codes are described in accordance with the study objectives. Table 1 presents the themes, subthemes, and codes overall.

Table 2: Codes and Themes

Codes	Sub-themes	Theme			
Behave Differently		Disability-related Barriers and Its Intersection with Gender			
Negative Social Perception					
Discrimination by the Society					
Unfriendly Structures and Services					
Social Norms and Women’s Gender Ignoring Sexual Abuse		Gender Norms and Intersectionality with Disability			
Disaster, and Gender Differences					
Family and Gender Discrimination					
Disappointment	Problems experienced	Surviving During Disaster			
Disturbances in daily living					
Financial problem					
Fear and stress					
Helplessness					
Sexual Harassment					
No response					
No special provision reaching unreached					
Resource Gap					
Access and Equity			Services	Surviving During Disaster	
Local Policy Development					
Priority to the Vulnerable Group					
Satisfied with the Services			Coping Strategies		Surviving During Disaster
Steps for their Rehabilitation					
Productive Use of Disaster					
Complexities in decision making		Intersectionality of Gender, Disability, and Disaster			
Multiple Identity and Double Discrimination					
Better Services	Addressing vulnerabilities	Towards Resiliency			
Policy and Program Priority					
Priority to Vulnerable					
Welfare and Relief					
Accountability	Support Mechanism		Towards Resiliency		
Active local body in disaster					
Created Structures and Committee					

Information Flow		
Lack of Commitment		
Unclear Policy Instruction		
Claim of federal system better		
Provider's perception on federalization		
More facilities/services after federalization		
Role Duplication		
Translation of policy into action		Perception of the Federal system

Finding 1: Gender-specific barriers/vulnerabilities experienced by women with disabilities in relation to meeting their health needs during pandemic and or disaster situations.

Women with disabilities make up some of the most isolated and overlooked people. Often, they are excluded from society due to their disability. Gender, disability, and living in rural municipalities created multiple layers of discrimination. What and how were gender-specific barriers and vulnerabilities experienced by the women with disabilities are discussed under the themes of 1. Disability-related barriers and their intersection with gender; 2. Gender norms and intersectionality with disability along with the codes follow themes.

Theme 1: Disability-related Barriers and Its Intersection with Gender

1. Behave Differently

Intersectional forces such as disability along with gender impacted the ways in which impoverished women with disabilities residing in rural communities experienced discrimination, which made them more prone to violence than their able-bodied counterparts. In community with low resource settings, women with disabilities encountered many forms of violence, including caretaker abuse, forced to not use family planning, and sexual abuse. Disabled women were hatred, neglected, and dominated and were called by the given disabled identity instead of their human identity. This can be illustrated with the following verbatim of a disabled woman (P3):

“They say dundi (having no hand) and all. However, even if I am disabled, I am not as able as others. I can still do my work and earn, but you are blamed because of your disability?”

Instead of looking at the capacity and positive aspects of the women with some form of disability, they were made paralyzed mentally by perceiving them as dependent and useless beings of society. This can be illustrated by the verbatim from a participant of IDI (P6):

“People who got treatment along with me have been torn apart. They were treated with contempt by family members. When even husbands, whom we consider the dearest one, hadn’t look after them, it is so obvious that other family members won’t care.”

Persons with disabilities remained one of the most neglected sections of the society, facing discrimination and stigma and lack of access to basic rights. This marginalization was further aggravated by gender. Females having disabilities had to experience more discrimination than their disabled male counterparts. This might be due to women’s secondary status in society, which contributed to inequalities. Verbatim of an IDI participant (P1):

“People in the villages say that the daughter of so and so is like this and that, the thinking itself is different for women. People don’t presume anything even if a man is disabled but it is very difficult for a woman even if she has a very small defect.”

Societal discriminative behavior toward women with disabilities sometimes disqualify them from meeting their basic rights such as getting marriage and or a job. Additionally, we could say that society perceived that a disabled woman cannot be beautiful, not when judged according to the social scale of beauty, so a disabled woman might not be sexually attractive. This point can be justified by the feeling shared by following verbatim of the disabled women (P4):

“It would not be a problem for a disabled man to get married but it would be a problem for a woman..... they hesitate.....”

(P6): A woman who was fighting disability along with me had been married recently. She said it had just been 5-6 months. She had fallen from the tree. There was no chance of having children. She had become disabled. Her husband married another woman and left her during the time of treatment. I have seen such things also.

Additionally, if there is a disabled girl in the home, the mother suffers a lot more than having a disabled boy. Because identity in conjunction with gender identity had increased their vulnerability. Feeling shared by a mother of a disabled girl (KII participant, P9):

“I’m worried about my child not because she is a girl but because she is disabled. If my daughter..... It would not have been so painful if she was normal. Few things would have been worrying..... like where will she get married? How will her studies be? The bigger thing is that she is disabled. She doesn’t even have to go to school. Everyone dislikes and despises it.... it is like that only.”

Although disabled women are an integral part he society, looking at them as second-ranked citizens intersects with social perception, especially the negative social perception.

2. Negative Social Perception

People with disabilities were marginalized and often forced to live on the edge of society as societal perception toward the disabled person was negative, people felt that disabled people were pitied, they were incapable of meeting their daily needs. In other words, they were actually of no use to society. Feeling shared by a disabled woman (P5):

“They only say that disabled women cannot work, they are like this and that..... nothing else.....”

P6:but they badmouth behind us. They say why to look after such people. Some of them even say why take care of such disabled person?

Although people said that society itself is a root of discrimination against women with disabilities, they also have negative perception towards the woman with disabilities. They were perceived as worthless and useless which made the life of a disabled person even more complicated. One of the key informants shared (P9):

“It is known how society is. The perception of society toward the people or the woman with a disability is very different. There is an opinion that they cannot do, they don’t do anything, and nothing should be done. There is more of a negative perception.”

P3: There is a feeling of contempt for women with disability. It is not so in my case but.....shouted for not being able to do certain things and used to fight with her daily calling her disabled. Now, her husband has left her and she has come to live with her parents.

In addition, disabled people were viewed as they have no desire, or need. It was also perceived that disability is like a communicable disease that could be transmitted to others, specifically from disabled women to their children. This might be the reason why disabled women with even a small physical defect that does not impair their daily living were also disqualified by society for marriage. Perception of another key informant (P10):

“Whenever we talk about disability, there is a negative perception. There is a concept that a disabled person should not wear good... eat well... he/she will not get married.... Even if married, the child will also be born with a disability..... he/she cannot do anything. Such is the mindset. This is how society sees it.”

3. Discrimination by the Society

In addition to their extreme marginalization, women with disabilities experience violence more often, more severely, and in unique ways compared to their non-disabled counterparts. Participants of FGDs shared that there was discrimination against both women and people having disabilities. However, in some issues, gender discrimination masked the discrimination against disabled woman’s intersecting identities and vice versa. Illustration of a verbatim (P14):

“There is no discrimination on the basis of their gender, but they are discriminated against due to their disability or the discrimination between normal and disabled people.”

P6: ...they tell me to go away saying that my disease will transfer to them. And they also say, what will such a person do and earn?

This might be because the disability prevents women from meeting any of the criteria that women are judged on, making disabled women frequently unable to fulfill their expected gender roles. The inability to fit expected gender norms creates many problems for disabled women and affects their role within the household, community, and society. In addition, disabled women perceived that they are hated, and treated as untouchable, and they are not a part of society or even human beings. Experience of one of the disabled women (P6):

“...they say she has such disease; it might transmit. Why is such a girl still alive?” After listening to such things, I felt that surviving was worthless and I felt like dying.....They used to hate me there, throw the dishes that I have washed, and wash the clothes again even if I have washed them.”

This is well known that society respects a person who has the power and capacity to influence society. A person with a disability is perceived as not having the capacity to be impactful and powerful. Therefore, it can be said that discrimination against disabled women is not only because of social norms but also due to the negative perception that they are not able to perform all roles

and duties given to them as a female gender or a female of a household. Another KII participant (P15):

“There is discrimination considering that they (disabled women) cannot perform. There is an opinion that disabled people cannot do anything. This creates discrimination.”

P4: Being a single woman with disability, feelings like I cannot earn, what to do, how, to do and where to go arise. I worry about how to continue my life ahead.

Discrimination against the disabled is rooted in society and the programs that targeted women were not inclusive of women with disabilities. If disabled women could be included according to their capacity in the current women targeted programs such as skill enhancement training and income-generating activities that would be the best utilization of resources and would not create an additional burden on the government because there would not be a need of extra investment. Disabled women participated in KII (P9):

.....If disabled women are not included just because of their disability in such a program, only abled women will be there. Ok, we understand that there is no sufficient budget to bring specific programs for disabled women, but they should be included in the existing program. It would be better if women with disability were also included with the abled women. They should get a chance to participate as far as they can. Those who cannot, they cannot but those who can, should be included. For example, I can participate in any program either by listening or any other medium. So, an equal chance of participation should be given.

4. Unfriendly Structures and Services

Women with disabilities were often overlooked in many areas including service provision and delivery. In general, people with disabilities were deprived of social services for many reasons. Somewhere services were not accessible and somewhere the services were not equitable. Not having access to services not only decreased their opportunities to be educated and acquire skills but also further made them more vulnerable and marginalized. A participant in a workshop (P37)

There aren't many disabled students because they don't have the environment to go to school. The buildings and toilets are not disabled-friendly, but they are women-friendly because there is much difference between now and the time we had studied. In our time, we didn't want to go to school during menstruation because we had a different problem.

In addition, people with disabilities had not found a friendly and respectful environment in public schools and health centers/hospitals.

...After hearing such things, my son (disabled) doesn't enjoy going to school. He feels that he is despised by teachers and friends because of his disability. Yesterday also, one of his friends had teased him saying that he is disabled. So, he refused to go to school today.

Although the policy of the Nepal government has indicated that a health facility must be disabled-friendly. But in reality, they are unfriendly. Hence, the service provided in such centers cannot be inclusive to vulnerable groups. Participant in a workshop (P48):

I feel that health centers are not disable-friendly. New buildings have been built in ward number 2 and number 8. Those buildings are a bit congested. It is difficult to accommodate the normal service-seekers also. Disable people need a different kind of toilet but there is no such provision.

Theme 2: Gender Norms and Intersectionality with Disability

1. Social Norms and Women's Gender

Nepal is a patriarchal society where women have been given secondary status in decision-making which diminishes their value in society. This discriminated status generated inequalities in freedom of choice before, during, and after disasters. As experience shared by one of the KII participants (P 18):

“..... and women here are being dominated from the very beginning. Now also, it might not be the case in the city areas, but it is still the same in village areas. However, this is in decreasing trend with the increasing education. This is what I want to say.”

Women are multi-dimensionally weak. Culturally they had been given different roles, socially they had been taught to be in a manner with the given dress, the concept of beauty, and the responsibility of the family. In addition, women were considered less human and inferior to the rest of society and if disability intersects the female gender, that doubles the problem. One of the female participants of the workshops shared (P48):

“Disability means having a physical weakness. He/she is incapable of doing a few things. But a woman is multi-dimensionally weak; she is culturally weak; religiously weak and the moral perception towards her is also different. As I see it, a woman has to solve problems in every matter. But a woman indirectly suffers in many ways. It is more painful to be a woman. If we see through natural perspective also, a woman suffers a lot.”

2. Ignoring Sexual Abuse

Women with disabilities faced double discrimination with two minority identities (disability and womanhood) and thus had a double dose of discrimination and stereotyping. Due to the intersection of two grounds of discrimination, they were prone to physical, psychological, and sexual harassment and or abuse. Hence, women with disabilities had to put more effort in order to overcome physical and social obstacles, maintain their dignity, and realize their full potential. One participant (health worker) of FGD shared her experience (P26):

“.....what her family members think is to let her be pregnant again and then they would be able to hand over her to someone else. Such is the mindset. Because of this, her family members asked me not to keep the implant again and she also didn't agree.”

On the other hand it was difficult for a woman to escape/rescue herself from such sexual contempt due to disability. Verbatim of a disabled woman (P6):

.... trying to rape and constant teasing.....I have experienced it, why wouldn't I?.....people wish to do this and that and they dominate. I have experienced a lot. Before, I used to stay down there. There was a brother in a rent there. At night, when other men come, I used to open the door at the other side and called that brother and escaped.

3. Disaster, and Gender Differences

Women and men were affected differently by natural disasters, hence there existed gendered and disaster vulnerabilities. Gender was a pervasive division affecting society, and it channeled access to social and economic resources away from women and towards men. Women generally had less control over income-earning opportunities and money within their own households, together, these inequities merged to make up a complex web of female vulnerability to natural disasters. Verbatim of a disabled women participant demonstrates how women generally faced greater risks from disasters than men (P 8):

“Now even in COVID-19 condition, from doing household work to everything come under a female's responsibility. It is not that difficult for a man. Maybe it is difficult for them in their own

way, but it is not as difficult as it is for women. If men get infected by Corona, women are the ones to take care of them. So, it is difficult for women. In addition, it is much different for a woman with a disability.”

P6: if I was a man, I wouldn't have suffered. I suffered because I am a woman. Why would men suffer like me? They are bigger people.....

The social stratification of the gendered role was perceived as natural and normal hence women's vulnerability might not be looked on. However, disability was considered at risk, especially during a disaster. One of the workshop participants (a male with a disability) shared the following (P49):

“There is an obvious difference between a man and a woman. When there is a disability, it creates difficulty. When there is a storm, it is more difficult for a disabled person than for a capable one. It is obvious for a disability to be weak in every matter be it walking on the road or be it during an earthquake.”

4. Family and Gender Discrimination

Disability has a mutually destructive relationship with gender; the female gender has been paralyzed by social norms and disability causes poverty and adds to dependency. Once, a person becomes dependent on the family, discrimination starts within the family, and if the disabled is female, her vulnerability increases. One participant of FGDs shared (P17):

“.....and, in disability, regarding the discrimination between men and women, there is huge discrimination. There is a disabled man, who had an injury, and is receiving very good care because he is a man. His wife, family members, and his father has been providing him good support.

P6:a woman was fighting disability along with me had been married recently. She said it had just been 5-6 months. She had fallen from the tree.....she become disabled. Her husband married another woman and left her during the time of treatment.....

A disabled person is often left totally reliant on the kindness of family, friends, and neighbors for their survival and safety. And in the event of an emergency or disaster, they need extra support for evacuation but often their needs are ignored and neglected. If families, who are supposed to be the primary support system for people with disability, more specifically women with disability, neglected their needs and despised them, the disabled person might be unsafe in the family too and even more vulnerable during a disaster. A participant of FGDs shared (P28):

“Yes, it is different. If a woman is disabled, she is not sent to school. The services that have to be given by the home are lacking like they are not given proper clothes; they are not given bath; their clothes are not changed.”

Intersectional discrimination begins first from the family itself for women with disabilities affecting their life towards deprivation, pessimism, and isolation and perceived as an unwanted and unproductive member. Another participant of FGD (community health worker) (P 28):

“In the case of men, they can't be repressed. But she is despised... she can't do by herself, but she can see what other people do to her, and when she tries to express her things, she is not treated well by the family. I see family members despising her the most.”

Disaster increased the workload of women. It is expected that women have to keep others first in the family and put their basic needs, interests, and desire as the last priority. This further marginalizes them and vulnerable to health consequences. Experience shared by IDI participant (P1):

“Even if women are infected with COVID, must take care of the household work, and have to work inside the kitchen. Even if there are no symptoms, the body becomes weak and there is a feeling of fatigue. Every symptom faced by a man is faced by a woman as well, but women can’t stay idle because of those symptoms.”

“If a son gets ill, let’s talk about this pandemic. If a son gets infected, they are taken good care of and given nutritious food. But if a daughter falls ill, she must continue work from the day fever subsided. Daughters who are grown up must go to work. Even if the parents are supportive, society gives them a name for over-pampering a daughter.”

Finding 2: Fear, stress, resilience, and coping strategies during COVID – 19 and/or disaster situations in women with disabilities.

In the context of COVID-19 and other disasters such as earthquake and flood, women with disabilities have been left behind. They have struggled to meet their basic needs, to access needed health services including those needed both because of their gender and disability and have faced disproportionate risks of violence. What the women with disabilities experienced during the period of disaster and they overcome the situation, and the factors intersecting resiliency are described under following themes, sub-themes and codes.

Theme 1: Surviving During Disaster (Together of Disaster, Disability, and Gender)

This theme describes the problems, threats, and vulnerabilities experienced by disabled women during a disaster and/or pandemics. This theme also highlights how their basic and health care needs were addressed and how they coped with those emergencies under the following subthemes and codes.

1. Problems experienced:

Women with disabilities suffered domestic and sexual violence may be due to heightened tensions in their homes and in society as an impact of the disaster or pandemic. Women were made responsible to care for dependents with disabilities, including children, and elderly relatives, who are confined to their homes with additional caretaking responsibilities. In such conditions, women with disabilities were last on the priority list and were isolated and ignored which made them susceptible to violence.

A. Disappointment

The disabled women described the pandemic as overwhelming, describing many unknowns. They perceived threats from the novel COVID-19 pandemic, and they hurt more psychologically. Experience shared by a disabled participant (P4):

“I felt bored and scared also. I had felt about what to do, how to do it, where to go, where to die. I felt like dying either by hanging or diving.”

Women with disability lacked resiliency and faced constrained during disasters as a direct result of preexisting burdens of gender roles, disability identity, inequalities, and power deficits. When they lost support from their family in particular from their husband that made them helpless and hopeless, and this led to a sense of impending downfall as illustrated below (P5):

“My husband also doesn’t care about me and I always used to feel like dying by hanging myself. I don’t know why. Till now, he has not cared about me since I delivered a baby. I have been staying with my parents now.”

(P8): *“There is no one to support. I felt like I am alone with nowhere to go and no one to stay with.”*

Increased fear, anxiety, and mental distress due to the repeated lockdowns were a feature of all participants. Mental distress regarding food security of future was prominent for disabled women when they had no support which further increased their vulnerability during the disaster. Experience shared by a disabled woman (P7):

“Nothing was done during Corona time.....No. I didn't get anything from Municipality.yes, the food supplies were given once by the ward and once through..... sir. There are many problems for disabled women. They can't work and earn whenever needed. During floods and landslides, where to go and where to stay.....”

Women with disabilities faced disproportionate barriers to exercising their rights, they were not trusted due to their gender and disability, even in normal situations. Experience of a disabled woman (P2):

“When we go to ask for shelter with other people, they don't give us a saying that we cannot earn and so we would not be able to pay their rents. They directly say no to us. There are many such things.”

B. Disturbances in daily living

During the public health crisis of COVID-19, Nepal took drastic measures to enforce restrictions on mobility, including physical isolation to control the spread and to manage the capacity of healthcare facilities as well as economic measures. The preventive measures in the form of restrictions, and differentiated local responses, contributed to the compounding challenges such as limited access to support services which disturbed the daily life of women with disabilities. This can be illustrated by a verbatim of a disabled male participant of FGD (P21):

“Corona has affected us a lot. There was the problem of transportation. Any consumable good should be imported from the market, there is a crowd in the market. So, we could get infected from the market since it is related to our breath. There was a problem in transportation; there was a problem in earning daily wages; the social distance was to be maintained.”

The situation of the emergency was even more complicated because people with disabilities faced additional obstacles due to social structure and physical infrastructures which increased intersecting effect of the disaster situation. This can be justified by the experience of a disabled woman (P1):

“Yes, isolation. Isolation wards were not disable-friendly. The bulbs also did not provide good vision. The road was not disable-friendly. In that condition, it is already difficult for disabled people to work by themselves. On top of it, when the environment is not disabled-friendly, not only females, but all disabled people are also highly vulnerable.”

C. Fear and Stress

During the period of disasters such as floods, landside, and the COVID-19 pandemic, like other people with disability, lived with uncertainty, fear, and stress. Illustration of an FGD participant (male having a disability) (P22):

“The flood created many problems the uphill. For the extension of the roads, when the dozer starts to dig, the walls are vibrated... it has created a risk for us..... it has created great difficulty during the rainy season. We don't know what will happen tomorrow. We have a fear that we would be either swept away from below or buried from above. There is such risk.”

On the other hand, the female gender along with disability intersected to increase the vulnerability to violence, and abuse sexually during the period of disaster. Hence, fear and stress double for a woman than males, because males were perceived as stronger, capable, and powerful. Again, an illustration of a male participant (P22):

“It is easier for men. For women, there is a fear of being assaulted by some immoral men. Men are stronger and they are capable. There is no fear of getting attacked or getting assaulted by anyone for men.”

On one hand, there was the stress of intersecting effects brought together by disability and disaster as disabled people had to depend on others to fulfill their basic needs. Verbatim of IDI participant (P2):

“Things related to this COVID, I was worried about my exams like how to go to attempt the exam in this situation..... It was exactly the time for our examination. We have to keep writers for our exam. How can we attempt the exam by maintaining physical distance from the writer?”

There was fear of loss of house and stress of where and how to stay during disasters like earthquakes and disabled women had to take shelter in others' houses. Verbatim of another disabled woman (P7):

“The earthquake hit. Floods and landslides occurred. That's why our hearts panicked. Our home is completely made up of soil. The soil used to fall during the earthquake. This house is actually not mine; it is my mother's. She gave me and I stayed here. On the first day of the earthquake, we stayed in a house down there.”

Although there was fear and stress, on the other hand, there was a hope of helping hands to make their survival easier during natural calamities. This can be illustrated by the experience of one of the workshop participants (P38):

“At first, I was scared. During the earthquake, the structures collapsed. I was alone at that time. I believed our Municipality and local government would do something. Many places suffered damages but nothing happened to my house. At first, I had feared but later there were some expectations from the Municipality.”

D. Financial Problems

Disability has a destructive relationship with poverty; disability causes poverty. Having a disability makes one much more likely to fall into poverty, or to worsen existing poverty. Having a disability often requires extra medical attention or assistive devices, both of which add a heavy burden on the household income and disaster adds on it. Illustration of one FGD participant (P 35):

“The one problem they have is a financial problem. Because of their physical and mental disability, there is a lack of improvement in their economic status and hence they are not able to go for their treatment at the right place. So, mainly the matter of economic status comes there.....”

Persons with disabilities generally rely on family members for daily living. When disasters compromised their economic condition, the disabled within the family were left behind and further marginalized. This left them at high risk without access to food, essential goods, and medicine, and prevented them from carrying out basic daily activities such as bathing, cooking, or eating and poverty intersect disability. Verbatim of a participant (P15):

“When the condition of the family is not good, there is no source of income also as they cannot work by themselves. So, there is difficulty in receiving services at good facilities.”

P7:our son is also asked to be taken to Butwal for treatment. His leg will be fine if treated. We could not take him because of the lack of money. (Becomes a bit restless)

E. Helplessness

On one hand, disabled women had stress and fear of how to fulfill basic needs and how to survive during disasters such as earthquakes, floods, and the COVID pandemic, on the other, they had to depend on others to fulfill their basic needs, the effects and consequences these disasters double their fear and stress. Participants of FGDs shared that most women with disabilities are left alone in helpless and hopeless conditions. Experience shared by a participant of FGD (P32):

“Sons ofare abroad and stay with daughter-in-law. And, the old disabled with mental disabilities cases don't even receive her medicines at the time;Not able to come to us or go to higher bodies due to lack of transportation cost, due to inability to walk themselves and impossibility of taking or bringing them by others.....What else can we do?.....”

Disabled people are slipping lower and lower in the social hierarchy, they are most of the time perceived as unwanted and unproductive human resources and are silenced. They have no social security and thus are living with unmet health needs. In situations of disaster, disability often adds to and worsens their vulnerability, as the available basic health services would not be accessible to them. One instance shared by FGD participants (P 23):

“I met two elderly people. They were 86 years old. I asked them why they had not received the vaccine. They answered me that they cannot go by themselves to get the vaccine and there is no one to take them. They are not taken to the hospital even when they fall sick.”

If there is more than one woman with a disability in a family, this would be another disaster to the family. And in the situations of disaster that multiplies their vulnerabilities because disability intersects with gender, and their vulnerability increases. They are not viewed as human as they are no longer capable to take care of family, so they are left in a helpless and hopeless condition. Following verbatim of a disabled woman describes her vulnerability (P9):

“Daughter-in-law used to cook for us until she was there. Now she has gone because of the children's exam. I have an elder sister, her daughter comes sometimes to cook and gives us food. If she could not come..... It was like that during pandemic also.”

Another participant (P7):

“Yes, I don't have anyone. I had tensions like where to go, what to do, what to eat and what to wear, how to overcome, where to stay.....”

In the situation of the pandemic, the disabled persons having comorbid health conditions added stress and anxiety, because there was limited access to a health facility at the period of pandemic and they might leave without access to their regular health care (medicine). KII participant (P12):

“.....there was a problem with medications. There is a person with a disability, who has Hemophilia. If he does not take medication, it becomes really difficult, and that medication is not easily available here in the local areas and there was no transportation..... Where to go? For women, sanitary pads should be made available.”

While people fight for their right to meet a higher level of needs people living with disabilities had to struggle for the right to live during the disaster. Verbatim of a disabled woman (P9):

I am afraid of dying. What to do? Nothing is greater than being able to breathe. If there is life, it is enough even if we get to eat little.

F. Sexual Harassment

Women and girls with disabilities were particularly vulnerable to all forms of sexual violence, as well as emotional and physical abuse both inside and outside their homes. Chances of sexual harassment increased during the period of disasters like earthquakes and floods. Illustration of IDI participant (P7):

“It is unsafe for a female. We have to stay in the cottage. People take advantage of the situation. Snakes could come. There is a fear of males. There is fear of males even inside the home. In the situation where we have to stay in an open cottage with everyone, the fear increases much more.”

On one hand, disabled women had struggled to meet their basic needs, to access needed health services including those needed both because of their gender and disability, on the other they faced disproportionate risks of violence. They felt unsafe as they experience sexual violence and this risk doubles for a single woman. Such situations forced them to leave their house and roam around in search of secure shelter. Most of the disabled women felt secure in their parental homes. Another disabled woman (P6):

“When I stayed here, such people (bad intention) used to come and try to do such things (harass sexually) in the absence of my husband. But I used to beat them. When they come to do such things, I used to come out and sit there and after they are gone, I again come back here..... Yes. The husband also does not care for such things happen here. So, I went to my parents.”

Additionally, they could not exercise their bodily autonomy and experienced social barriers to fighting for justice. They could not report the contempt of sexual harassment because they were afraid of being blamed by society and questioned about their moral character. Experience shared by a woman with a disability (P6):

“If I tell, they will think so and so about me. That’s why I didn’t say anything and kept quiet.”

Being a single woman and living with a disabling condition can create additional barriers to leaving a violent domestic situation and create higher risks of sexual exploitation consequential to living with no options of insecurity, anxiety, fear, and stress. Another disabled woman (P8):

“People think that anything can be done to a single woman when there is no support for her..... Men say.”

G. Inadequate Response

Relief services were often not reached to persons with disabilities, who struggle to cover basic needs and become increasingly dependent on outside support. However, during disasters, disability welfare organizations supported people with disability. Illustration of an IDI respondent (P7):

“No, I have not received anything from the local government. National Federation for disabled had given us relief materials and medications and also some food. NAB-rehab had given me things of daily requirements like toothbrushes and toothpaste.”

Local policymakers and policy implementers shared that Municipality (local government) did not have the adequate resources and capacity to address the needs of disabled people during disaster. Still, the local government managed to rescue and support relief materials for disabled people with limited resources. Verbatim of a participant in a workshop (P46):

“.....among them, 6 houses were swept away. A house of a disabled person has also been swept away. In addition, there was a post-partum mother. The husband was disabled, and the wife was 6-months post-partum. The condition of the home was very critical. The municipality provided support as per their capacity. Ward also provided support. Reports and data on the damaged property are asked and we send the data to the provincial government, to the federal government but it is meaningless. Nothing has been done until now since the flood took place in Asadh.”

H. No Provision Reaching Unreached

It is clear that the gender, disability and structural inequalities that underpinned societies are being exacerbated, in particular for those who experience intersecting forms of discrimination and exclusion, including women with disabilities. Forms of disability contribute to vulnerability risk, so the program/service must focus on these regards. However, disabled women found no provision to reach the unreached during the disaster. Participants of FGD (P39):

“All disabilities are not visible. For example, mentally retarded patients come, how will you provide services? How will provide services if a deaf person comes? There is nothing for that.”

The equipment and facilities were often not physically accessible or located near the homes of women with disabilities, without accessible and affordable transportation options, and support for them. Women with disabilities also faced social and psychological barriers to accessing services. A disabled woman during the interview shared that (P11):

“No one does for the people who cannot speak..... There is no culture to reach the people of remote areas. The government does not search by itself, and the disabled ones are unaware and do not come forward so we lag behind.”

In such situations, disabled women had no expectations from the government, however, they wished that if the government would support the women with disability, their life would have been easier. Verbatim of a disabled woman (P9):

“I don't think the government will do anything. We wish that the government provide people like us with much and more support.”

There was no provision to reach the unreached. Disabled people could not have access to the services even if the program targeted them, because they would not have the facility to reach to receive the service, and the service itself did not reach them. This can be illustrated by the verbatim of a KII participant (Local government officer) (P13):

“But the disabled people were limited to their homes. There were no provisions to either vaccinate them at their home or to take them to the health center. Now the equality..... The state declared that everyone including women, disabled people, senior citizens, and children will be given the vaccine. But regarding the vaccination of people with disability, I think, it couldn't be seen through the vision of equity.”

During the disaster, there were no targeted services for the people with disabilities. Only the people who could reach the services could fulfill their needs, hence there was no equity and access to the services for the vulnerable people and the service was left. This can be illustrated by the following verbatim of a policy implementer of the community (P12):

“There were no such specific plans for people with disabilities only. Those who could do it by themselves fulfilled their requirements just like how abled people do and those who could not do anything or bedridden remained just like that.”

Hence, some disabled people lagged in access to basic health services. During the COVID pandemic, they had no access to vaccination that was provisioned by the Nepal government. If there was no policy, plan, or strategy to reach the service at the door of the disabled people, we can say that there was no service for the vulnerable population. Verbatim of participants in FGDs:

P21:Yes. My son (living abroad) also keeps saying that she is only left. He keeps telling us to buy the vaccine and give her.

P26: (Female and Child Health Volunteer): we cannot give her at home even if we buy the vaccine.

However, in workshops, it was claimed that some sort of priority was given to the women and disabilities, during provisioned basic relief support at the time of disaster.

.....There was a big group of people. Within that group, there were pregnant women, post-partum mothers, disabled people, etc. Teams of public representatives went there and they separated them and then only separate provisions were made for them. When we had a landslide, the health workers of the respective health post visited them daily in their temporary shelter. They didn't have a good provision of shelter. Many people had to stay in one community hall. So, the health workers used to visit them every day and they were also informed about the visiting time of the health workers and were asked to contact them if they had any problems. If anyone had a problem, they were examined and they were given the available medicines. This is how we made special provisions for women and disabled people.

I. Resource Gap

It was perceived that although there were some policies addressing people with disabilities but the inadequacy of resources to implement such policies are a big challenge to the continuity of service. Hence, resource gap intersected negatively on resiliency. KII participant (P13):

However, as per my experience, there are policies, but the problem might be because of the lack of budget. There are programs that target them but the programs that come once or twice a year wouldn't make much difference for them. For example, providing a wheelchair once is not enough. It needs repair and maintenance. Attention has not been given to such issues. It is done once given. The state should have taken care of them regularly or such an environment should have been created. Once the program is done, it is over.

Some of the participants perceived that the currently implemented federal system of the Nepal Government has contributed to increasing capital expenditure, which consequences resource scarcity in the targeted programs to the vulnerable group. KII participant (P10):

.....There are more current expenses than capital expenditures, which means we don't have a budget. Only having policies is not enough, we need a budget also. It is good that the services are provided through the local government. But, when there are no budget and human resources to implement the policies, it becomes ineffective.

Participants in workshops shared that, in addition to inadequate budget to implement policy and programs targeted to the disabled people, there were also scarce human resources to deliver provisioned services, which eventually not only delayed access to service but also compromised the quality of the delivered service. A participant in a workshop (P49):

We have a huge gap and the main reason behind this gap is human resources. Here a single person looks after both the legal section and the women and children section. It means the person

is under pressure. It can be because of the recruitment tariff and many other reasons. If I say that I have given 100% services, it would be unfair even I am not 100% satisfied.

Local service providers or the policy implementers during workshops shared that the policy and program for the disabled are not practicable to implement as it is. Because Nepal's geographic distribution is diverse (Mountain, Hill, and Plain), hence program needed in one geographic reason may be needed in the other reason. However, the Government has targeted programs to all at a blanket approach that eventually is a waste of resources that could be used wisely. Participant of KII (P14):

But the Act is the same everywhere. Both Terai and Manang have the same Act. We see problems in budgeting in health or any other sector. For that, district-level offices are established, and the provision of experts be made by them or by ourselves also. All things are set up at the federal level. Such programs are actually not needed but we have to conduct such programs for the sake of conducting a program. For example, we just conducted the elephantiasis program. We had a presentation and we had discussions. We don't know about the status of the problem of elephantiasis in Marshyangdi and who is going to find out? But we received the budget, so we did the program.

2. Services

A. Access and Equity

A person who has a severe disability might have wholly different needs compared to someone who is mildly physically disabled. Therefore, it is necessary to disaggregate our understanding of both disability and vulnerability, to better account for the specific needs and capabilities of different kinds of persons with disabilities by recognizing diversity within disabilities. However, participants felt limited access to health services for the people with disabilities and it was almost inaccessible to people with a severe form of disability. Because the services were not disabled-friendly, and the office of the local government was unaware of the status of people with disabilities. An FGD participant (P38):

One thing is that the organizations are not disable-friendly. Similarly, there is no policy to identify disabled people. We don't have accurate data on disabled people. There are no focal persons to go and enquire about their problems.....

Even the basic health services were far from the access of disabled people. That added an economic burden and left them further marginalized. If they are deprived of basic health services, they are more likely to face morbidity and mortality. Another participant of FGD (P28):

"They tend to be socially despised. During labor, for normal delivery also, they have to travel far. They have financial problems with transportation. They cannot work when they are disabled and so they don't have money. There are no services nearby, they have to go far to get the services and facilities. They tell us about these problems."

On one hand some participants were satisfied to some extent with the health services provisioned to them, and the availability and accessibility of medicines during the pandemic. The following verbatim signifies that disabled people are concerned only with meeting basic needs. FGD participant (male having a disability) (P17):

"We have been receiving the medicines sir. We are getting them easily. We receive our medicines at Khudi health post. Medicines are available there with the help of gaun-palika and Koshish. So, we have been taking the medicines."

On the other hand, some participants felt that health service provided to them during pandemic were unfriendly and unacceptable. Illustration of participants' verbatim.

P2: I had headache and fever. At the hospital also, I didn't examine, it was very difficult. They threw the medicines also. They say that Corona infected must not be touched.

P5: I was tested positive.....While measuring the temperature, it was difficult especially for blinds like me. Who would see? People were afraid to come closer to the Covid patients.....

On this ground, although there was a CORONA vaccine program launched by the government, the service was not easy to access for all disabled people. Although it was accessible to the disabled who could manage transportation to the service center. This can be illustrated by the following verbatim of a disabled (P22):

.....No, no..... We managed the vehicle ourselves at our own cost. It was communicated in the media that services will be provided at home to those who are disabled. But when I complained, they said that once a seal is broken it should be given to all and should be finished so they said it is not possible to come home. They said it is not possible even if I complained frequently.....

B. Local Policy Development

Participants also shared that there are no specific policies and programs targeting disabled women. The policies should have the inclusion of disabled people and must be more target-specific otherwise the program would not be accessible to women with disabilities. KII participant (a disabled woman working in a disabled organization) (P14):

"No new policies especially for disabled people have been made during the disaster period. That's why we said that there is no accessibility. We also advocated that such policies should be made. But it was not made. They say they will. They say that services like health services will be provided during a disaster or during Corona but they have not."

People who were responsible to implement policy and deliver services to the people at the local level felt the inadequacies of federal policy to address the needs of the vulnerable people during disaster. Hence, it must be taken as a learning opportunity and has to prepare for upcoming emergencies. Participant KII (P9):

Yes, there are policies as per my knowledge. But the policies should be specific. We should learn from the pandemic as we learn from our mistakes only. During the pandemic, the existing policies could not include disabled people. Equal policies were created but equitable policies were not created.

On the other hand, local leaders/policymakers claimed that they developed local policies and programs to address disaster-related issues locally. At the same time, they also felt the need for the capacity development of service providers. This can be illustrated by the verbatim of a Municipality Chief (P51):

We are new and we have made health regulations....we might have made it knowingly and unknowingly,addressed women with disability is..... in the beginning, when we conducted the women and children's program,.....transportation service will be free for women with disability. Regarding other things, we have not yet made any policies beyond the policy of the federal government. Regarding DRR, we have not done anything besides what is mentioned in our annual policy and programs.

There was a procedural difficulty in policy for distribution of social security allowance to the disabled people with identity cards of category ‘C’ and ‘D’. Hence, the local government made some sort of provision of disability allowance to the disabled people of those categories. Illustration of the verbatim in the workshop (P 56):

“I would like to add..... Last year we added that we could make a provision for disability care allowance. For those disabled people who are not able to come to the Municipality, we have also made a provision of providing their identity cards at their homes..... Besides disability care allowance, we have also included a policy of providing income-generating or skill-based programs for the guardian of people with disability. I think it is good.”

C. Priority to the Vulnerable Group

Accessibility barriers and lack of support have played a significant role in the marginalization of vulnerable groups. Nevertheless, during the period, the priority was given to the vulnerable groups while the delivery of the services. A participant of the FGD shared the following (P30):

.....The priority was first given to disabled people and elderly people. During that time, I think we vaccinated about 8-10 people with disability. Disabled people were targeted during the first phase of vaccination. Accordingly, we conveyed the information and gave priority to disabled and elderly people and don't keep them in a waiting line.

There was a community together to rescue people with disabilities during the period of the earthquake. A disabled mother shared that (P6):

“My daughter was 4 months old and there was no one at home at that time. I was lying in bed. My neighbors started making noise and I got up to look. All of them came and they took me and my kids. They took me Hawai ground, the airport there. They also brought all the clothes and beddings and made me lie down there.”

3. Coping Strategies

A. Satisfied with the Services

Health service providers at the local level felt that during the pandemic, health services were focused and reaching the unreached by adopting every possible approach. A participant in a workshop (P42):

“She is from the health section; I think she has missed it. During the pandemic, medicines were managed and taken home to home for people with chronic diseases like heart disease and other diseases. We had done this good work.”

During the pandemic, women with disabilities were satisfied with the health services provided to them. Probably they had no expectations from the local government, or they thought that nothing more could be done during the time of disaster. Illustration of a disabled woman (P3):

During the pandemic, I gave birth to my baby here..... The Khudi health post..... Yes, I am satisfied with everything.

The disabled women adjusted to disaster through the basic support received from the local government and they were happy with the availability of basics for survival, and they had no other demands. Verbatim of a disabled woman (P5):

Yes, they have given soaps, clothes, toothbrushes, etc. but...I don't say it is insufficient.

Health service providers were also satisfied with the provision of added services to the local health center. In their word, those were available at the time of disaster also and made some relief to not only the service recipients but also the service providers. A participant in FGD (P39):

As per my experience, there is satisfaction in the health sector.... Before...labour, what do you say it?..... a sister used to work at the health post for the whole day and she used to go to the clinic in the evening for delivery. It is not the case now. There are all services and facilities (in the health post) for delivery.....

B. Steps for their Rehabilitation

To minimize vulnerabilities from the disaster and to adjust to the situation of the disaster, the local government had taken some action for the rehabilitation of people with disabilities. A participant of FGD (P39):

..... the Mayor and the Deputy Mayor themselves met.....recommend them 2/3 types of disability cards. When we had a doctor here, many such cases used to come and our doctor used to provide them recommendations, after which I think the Municipality provided the cards.....we can provide them health-related support and refer them to higher levels if we can't.....

Although it was difficult to rescue all vulnerable groups at once, the local government acted by applying of sorting strategy to manage the disastrous effect on people having disabilities and made collaboration with local organizations to ensure available services to unreached. A KII participant (P11):

In Gorkha, like hilly areas, it was difficult to distribute relief materials as well. Coordination of different associations and organizations have been provided in some places..... Lockdown and all created difficulty to work.

The local government had done a collaboration with other organizations for DRR program. Verbatim in a workshop (P52):

.....Every year we send the report of DRR. Before we made a report with UNDP, we had developed a few maps indicating the vulnerable areas and the reasons for their vulnerability. But we have not been able to work accordingly.

C. Productive Use of Disaster

Participants shared that to adjust to the adversities of disaster, they took disaster as an opportunity to grow and used the period of the pandemic for positive and productive work. Illustration of a disabled woman (P7):

Initially, it was definitely negative..... We hear many people committing suicide also. But later... it is said that we should not panic in sadness and should not be euphoric in happiness. If we work patiently and become cautious, lockdown time can also be utilized. For those who read and create literature, lockdown provided them ample time even to write a book. If we take it positively, we can feel that lockdown has given us time for ourselves.

Finding 3: Effectiveness of the support and regulatory mechanisms and the role of Municipalities and Rural Municipalities in the delivery of support services to populations at risk.

The effectiveness of supportive and regulatory mechanism towards achieving resiliency is described under the themes of intersectionality of gender, disability, and disaster, towards resiliency with following subthemes and codes.

Theme 1: Intersectionality of Gender, Disability, and Disaster

In this theme, simultaneous interactions between different aspects of social identity such as gender, disability, disaster as well as the impact of systems and processes of intersection are explained under the following codes.

1. Complexities in Decision-making

Since there were only four categories of identity cards provided to disabled people, this procedure felt complex. Because some people with disabilities claimed the card that they received cards that they did not deserve. On the other hand, the people who had disabilities that compromised their functional ability and disabilities that had not compromised their functional ability are kept in the same categories. These complexities increased because there the provision of social security allowances given to disabled people was based on the category of the given identity card that might again impose social exclusion of the provisioned social security to the genuine one. A participant in the workshop (P52):

It might be because of the complicated procedure. Before you came, we had a discussion on whom to give disability identity cards. We can give cards to those with disabilities who can be seen, like those who can't see, who don't have legs or hands but what about the other layers who can't be seen. It is written whom to give but the debate arises there also. It depends on the decision of the person who executes.

Although all people are at risk during the disaster, the vulnerabilities of disabled people increased more than that of the others. However, the type and severity of the disability or the impact of disability on the functional ability of the individual added to the level of vulnerabilities. In addition, the geography of the residents, and insufficient infrastructures, the pre-existing barriers to exercising the rights of disabled people added to their vulnerabilities. One of the key informants (P9):

Abled people can run to save their lives. For disabled people, there are no such means. For example, wheelchairs. The wheelchairs also move easily on smooth surfaces only. It is not possible for them to move wheelchairs easily on uphill and downhill because of the lack of corresponding infrastructure. So, they are compelled to take the support from others. Hence, disabled people come to people's minds secondarily. That's why they are more vulnerable.

Due to the social construction of gender norms, women were valued less and were always the second priority, this intersecting effect increased the vulnerabilities of the female gender. Additionally, during a situation of a disaster, disability in the female gender doubles their vulnerability by adding on the risk of violence along with morbidity and mortality due to the adversities of the disaster. KII Participant (P15):

During natural disasters while the disabled ones are limited to the home, there is a high chance of violence against them by people with bad intentions. During the earthquake, able people came out of the house and stayed in tents, but disabled women stayed at home only. We heard many

such incidences. During that time, incidences of violence also happened. They can be provided safely if the family and the society remain alert and if they are given more priority.

Another KII participant (disabled women) (P12):

.....victims mostly because of their disability. It is not so for all women. It is because of the disability and being a woman is an addition to it. It is more difficult when they are women.

Gender is a social construct that creates different opportunity structures that impact the overall health of the person. If disability joins with the female sex, that doubles vulnerability. A mother with a disabled child was worried because she has a child with a disability (P13):

.....Yes, because she is disabled. If my daughter.....It would not have been so painful if she was normal. Few things would have been worrying..... like where will she get married? How will her studies be? Now she..... there's no studying. The bigger thing is that she is disabled. She doesn't even have to go to school. Everyone dislikes and despises.... It is like that only.

2. Multiple Identity and Double Discrimination

Women are always looked at with contempt everywhere. On top of it, if they are disabled, vulnerability increases. Such despise for a woman may be due to her inferior status and being economically dependent and they might be thought as easy target. Hence, the intersection of gender and disability creates multiple layers of discrimination for women. KII Participant (P14):

It is easier for a man even if he is disabled but it is difficult for a woman. There is social discriminationwomen are paid less. If we are also not able to work and earn, even we are despised.

Disability often adds to and worsens discrimination against women and negatively impacts their gender roles, furthering their perceived weakness and helplessness. The multiple identities put them at risk, especially during disasters and pandemics. A male participant with a disability in a workshop shared (P55):

It is more difficult for women, in matters like taking shelter, and staying alone; in every matter. Everyone has experienced it. This is just like a universal thing.

The associated shame surrounding disability worsens a woman's status and leads to a higher rate of discrimination. Verbatim of disabled a woman in a workshop (P53):

During disasters, we have to manage our shelter. There is a ladies' problem; we have problems with menstruation. In villages, we feel ashamed.

Theme 2: Towards Resiliency

To overcome the adversities of disasters multidimensional readiness is essential. In this theme, how participants adjusted to and overcame the effect of the earthquake, flood, and corona pandemic under the following subthemes and codes.

A. Addressing vulnerabilities

A. Better Services

Participants perceived that society is developing the capacity to recover quickly from difficulties during disasters and easing toughness brought to women with disabilities. There was a social understanding of who to keep first and how to handle the social crisis. The community was together

to fight with disaster, hence working together intersects positively the resiliency. A disabled male participant in FGD (P38):

I have seen disabled people and women being kept ahead. When I went to get the vaccine, I need not be carried; they came to me to give the vaccine.

Preventing disaster by reducing risks and enhancing protective processes was a priority of the local government. The local government supported the people with disability by providing relief materials. An IDI participant (P3):

The government has been looking after us. They have distributed relief materials. Now, we are informed. The allowance and tiffin are given.

B. Policy and Program Priority

Instead of considering the disabled and a woman as a victim of a disaster, acknowledging structural inequalities that impede women's capacities to actively build their resilience along with that of their family and community is important. This can be achieved through the development and implementation of policies. In this regard, although might not be sufficient, Nepal's government has instituted laws, policies, and procedures focusing on women and people living with disabilities. Illustration of verbatim in a workshop (P48):

Within our annual policies and programs, I don't think there are any special programs that target women with disability. We didn't have it until now. But, every year, we have been doing new programs by prioritizing the matters related to their income generation and livelihood. For example, if there is a disabled woman who can do some work and she comes in contact with the women and children section here, then we work on enhancing her livelihood. But if you ask if there's any special policy for them, then I would say we haven't made such a policy.

If policy and programs focus on promoting promote women's empowerment, they tend to develop capacities to build resilience. Participants perceived that there must be policies focusing on women with disabilities. Verbatim of a participant in FGD (P26):

If a woman becomes disabled, her physical and mental ability is destroyed. Her lifestyle for survival becomes weak. I think that's why.....the policies have been made but there are more policies on unnecessary matters like property rights.

C. Priority to Vulnerable

When women, men, and people with disabilities are affected differently by disasters, practitioners and policymakers have a responsibility to use the tools available for mitigating disaster impacts to close these gaps in the outcome. At the time of pandemic and disaster, the vulnerable population was prioritized at the community level on service delivery. Hence, the program was effective and accessible. Verbatim in an FGD (P17):

At first.....we categorize on the basis of age.....the priority was first given to disabled people and elderly people. During that time, I think we vaccinated about 8-10 people with disability.

Disaster resiliency is a multidimensional state of readiness to adjust, cope, mitigate, and accept adversities. In the disaster, at an individual level, participants were satisfied with the governmental services, they coped with the disaster, and local government hands with community organizations,

welfare organizations, and local volunteers to mitigate the effect of disaster on the health and life of people. The illustration of a disabled woman (P3):

During the pandemic, support materials have been distributed as much as possible. Not just disabled ones, those who are not disabled have also received. Hand-washing soaps, lentils, rice, salt, and oil were given.

Verbatim of a key informant (P9):

It is for all as a whole and for needy ones. There is nothing like men, women or disabled. During the pandemic, the local government provided such provisions for those who are in need.

D. Welfare and Relief

To resist the impact of the disaster, the local government worked in collaboration with different organizations, bared social responsibility, and instituted social services. At the same time, social welfare organizations joined hands to mitigate the effect of disaster focusing on vulnerable populations. Hence, the collaborative hands of social organization intersected to enhance resiliency after disaster. Verbatim of a disabled woman (P1):

National Federation for disabled had given us relief materials and medications and also some food. NAB-rehab had given me things of daily requirements like toothbrushes and toothpaste.

Illustration of a KII (P11):

After the earthquake or after what (doesn't remember), at one time, Rs 7500.00 was given per month for 3 times. They had given like that. What was the organization? I forgot now.....

On the other hand, to respond appropriately at the moment of crisis, the local government handled the disaster situation in an organized way. Verbatim of a workshop (P43):

We have a committee for all these, and we sit with the committee and discuss the programs to be done with the available budget for the year. We call it a felicitation programme but we distribute things like warm clothes, thermos, etc. within the budget.

Along with support during the disaster, continuity of the services was tried to establish for the sustainability of support through programs that would enhance the independence of the vulnerable people. Verbatim of a workshop (P52):

For the disabled, sometimes we distribute things, and sometimes, we distribute hens or goats to involve them in income generation. They cannot do other kinds of work so we distribute such things so that they can be employed and be productive through that. So, for women and disabled people, we have been regularly doing the programs every year under the limit of our budget.

Participant 48: For pregnant women, we have made the provision of eggs, milk, and warm clothes. For post-partum mothers also, similar provisions have been made. For both, we have made the provision of nutritious food including gas also.

B. Support Mechanism

A. Accountability

During the period of disaster, everybody should take responsibility for not just women but all people with disability. The family, community, and the government, all these three levels should

bear the disabled-friendly opinion to support resiliency. The local government was responsible for easing the lives of the vulnerable group. Verbatim of a disabled woman (P7):

IDI: Yes, it has. It has given rice. It has given everything. Yes, it is enough. Yes, my mother gets Rs. 12,000.00 and I get Rs. 6,400.00.....

The local government of Rural Municipalities played an important role to respond appropriately at the moment of crisis and decreasing disastrous effects. Verbatim of a key informant (P11):

Especially during the pandemic and disaster, there was especially the role of local government in the context ofgaun palika. The local government provided necessary medications to people with chronic diseases and people with disability. For those who are not able, the local government made their survival easier by providing them with food supplies also.

Along with family, the community; the intellectuals of the society, and the government; the local, provincial, and central/federal government must take responsibility for the vulnerable population during disasters. However, the local level government must be more responsible because local government is near to the people and during a crisis, it is approached first. Verbatim of a KII participant (P12):

The government should make some provisions during conditions like a pandemic. Now, there is local government. One thing is that the government should make provisions. The other thing is, at the individual level, in villages, those who work for food, have been working even during this pandemic to continue their livelihood. During disasters like floods, and landslides, the government must do. What can be done during a disaster at an individual level?

It has also been felt that although there has been policy, and protocol to address disaster, the team itself must be capable, and work in harmony with its member to console the plan into action. Illustration of a KII participant (P13):

There has been the formation of different groups. There is a Disability Coordination Committee. There are associations and organizations that look after people with disability. These all can take responsibility.

If there is no coordination and cooperation among workers, the effectiveness of the program cannot be achieved. Participants in a workshop shared following (P42):

.....The reason is political; not understanding own responsibility and not understanding the status of where he/she is. Let's say there is no institutional belongingness.

(P50): Not unacknowledged..... for example, I had money to work in the sector of women or disability. Our.....is the boss of that section here. What I meant to say is it becomes worthless if she cannot make her move even after I have executed what I have to.

B. Active local body in disaster

During the Catastrophe of floods and landslides and earthquakes, the local government became active in rescuing and rehabilitating the people who were at risk. Illustration of a participant (P 9):

Palika itself distributed the relief materials for those who could not even meet their ends. Many relief materials came from other associations and organizations like clubs also during the COVID. The local level managed to distribute relief materials to ensure that no one dies of starvation. This year, a lot of relief materials have been distributed. This place has been troubled more by flood than COVID. Where to keep people of those 30-35 houses? The landslide buried 4-5 houses up

there. Other houses were also buried. During that time also, the condition of disabled people was very miserable.

The provision of advanced health services was also managed by referring people to the higher health facility centers for the needy. Verbatim of a participant in FGD (P40):

At that time, some were taken to Aap-pipal hospital, and some were taken to higher hospitals after getting first aid in the medical. For the compensation, we have seen the mayor himself making efforts. The chief of the ward and other people visited the affected places and the Municipality itself had done whatever was needed to be done.

C. Created Structures and Committee

Disaster risk management policies were designed to maximize results, considering local conditions, and the local government created structures and committees. Illustration of workshop meeting (P46):

....then, they passed a procedure and the federal government has just created a disaster management authority. The disaster was first looked upon by the home ministry but now there is a separate authority. Just like there is an earthquake reconstruction and rehabilitation authority, there is a disaster management authority. This has been recently formed.

On the other hand, a link has been created for access to information and prompt response for future crisis or disaster situations. Verbatim of a participant (P45):

If we don't get any information about anything that has happened..... The information must come sir At present, everyone at each house knows the number of police. Almost everyone knows my phone number because we distribute our number when we go to call us whenever needed. Until now, no one complained about their problems. And we were also roaming.....

D. Information Flow

Public information on COVID-19 measures was communicated and disseminated in accessible formats and means to reach all persons with disabilities. A participant in FGD (P29):

Regarding the COVID vaccination, we are instructed to convey the information about vaccination to each people so that no one is missed and we have been doing it. We are making efforts on that; we are still doing surveillance.

(P32): They are informed through teachers of the schools, through FCHVs, public representatives, the chief, and the member of the wards. We also provide information to those who we meet.

However, some participants felt that they were misled by the news from social media which increased their anxiety levels during the period of pandemics consequently delaying resiliency. Verbatim of a disabled woman (P4):

The news was communicated from many sources...Misleading news used to come but later slowly I became used to it. I didn't watch random news. I only watched the news from authorized sources.

As women having disabilities are marginalized due to socially constructed values and belief systems, participants shared that the vulnerabilities of people with disabilities and women can be minimized by creating social awareness. Illustration of a participant (P10):

I think this is related to intelligence, literacy, and awareness. Awareness should be created regarding the family's and society's role in helping them live a respectful life. We could not even support them in the works that they are able to do.

On the other hand, local government has been launched public awareness program that might help toward resilient society. A participant in workshop (P52):

We are conducting awareness programs on gender violence, domestic violence and especially for people with disability. They are already despised. There is double problem if they have to bear violence also. The Municipality also has its 16-day campaigns. People are more aware now after federalism than before. It might also be because of the knowledge through education. Because of all these, the condition has much improved now than before.

E. Lack of Commitment

Sometimes it was also felt that there was no commitment to the delivery of service to the vulnerable population during the disaster as the provisioned service was not based on the principle of equity. A participant shared the following (P9):

The state also doesn't think specifically. Everyone does in a general way. For example, regarding the vaccination in the COVID pandemic. In one word, there would be 20, 30 or 50 disabled women. It is not a big deal. It would not be difficult to address their problem if there is a feeling of equity and the feeling that we should do something for them. But what is happening is, that the vaccine is given to only those who come for it. Even the state has not instructed to look after disabled people. It might be because of the lack of human resources also.

KII: At first, they should be the target and later the other general public should be approached. Since they are in very low number, they could be made safe first and then, later we could approach the general ones.

On the other hand, service providers at the local level were unaware of policies and procedures that direct them in service provisions to the vulnerable groups. Verbatim of a workshop (P 49):

The health-related policy has been already made here at the local level but we have not got the chance to study the policy. We have been informed that the policy has been made.

And ignorance of policy and guidelines hinders the delivery of service. Another participant (P50):

I am not much clear about that since I have not got the chance to read that. That's why I am not able to say.

F. Unclear Policy Instruction

Although there were policies to guide services, in some instances implementation of policy could not be achieved if the policies are vague and their instructions were unclear. The policy created confusion for the workers. A participant in FGD (P17):

We are the staff who do what the state instructs us to do. If we were directed to collect the data and provide vaccines to their home, we would have been compelled to do that. We are told to go and give vaccines to old people, who cannot come by themselves and whose family is not willing to bring them. Such things had come somewhere in between but it has again disappeared.

P19: There are not many disabled people..... To know exactly who has been missed we have to go for a search to get the data..... And we cannot go for data collection according to our wish. We should be instructed by higher bodies like the health section and the municipality.

Finding 4: Government policies and mechanisms in addressing the vulnerabilities of the population at risk (person with disabilities) during pandemic/disaster situations.

Along with reviewing the policies, we also collected data on the perception of people toward the federal system of government and the effectiveness of the policies at the local level. The findings are described under the following codes with the theme, perception of the federal system.

Theme 1: Perception of the Federal System

Nepal recently has changed its government from Monarchy to a federal system. In relation to the provision of services, their delivery, and access, there was a mixed opinion of disabled people with this three tier government system.

A. Claim of the federal system better

Some participants felt that the federal system of government is better for the people as the local government was made responsible. Verbatim of a participant (P9):

To make it easier for the citizens, there is a local government that has worked at the local level. So, I must say the current system is better.

The federal system is perceived better because the government has come near to people thus, they have easy access of service. Verbatim in a Workshop (P49):

Yes, we have been able to provide better service. For example, we have disabled brothers and sisters here. They had to go to Gorkha to receive services before, now they get it here. Similarly, people of Chumnuhari get the services at Chumnuhari.

The current government is perceived as accessible, and supportive, which helps to neutralize vulnerability. Another participant in a workshop (P48):

The present system has provided fast and fine services to the public. The boundary or the area was large before, now it has been reduced and it has made the work easier.

B. More facilities/services after federalization

Participants shared that the federal system has increased services to the target groups. Participant of FGD (P22):

There was nothing at all before but now, there are few. Now, a few services have been added.

P23: The present system is better for the citizens now. It was not like that before. Sanitary pads were not available before.

Women with a disability shared that the local government supported them not only during the period of disaster but also before and after the disaster too. As the government has provisioned social security allowance to the target group, which helps to ease their lives, the current government is perceived better. Verbatim of a disabled woman IDI (P5):

..... Yes, it has given rice.... has given everything. It is enough. Previously, there were no provisions for disabled people. Now, the government has done well. Before, I didn't know anyone

getting anything. For others, those who are 70 years old have received. Disable people have also received. The current system is good overall. I feel good.

Another participant KII (P10): We don't have to travel far. Everything is done here. We didn't even know the people before since we had to reach far till Gorkha. Now, it's here only. We know them a bit. They are the known faces.

The local government provisioned some target programs and made budget allocation for the program. Following are the verbatim of workshops participant (P42):

We could buy with that budget... Now, our palika has separated the budget of Rs 2,00,000.00 to buy the medicines for mental health.

P48:

.....we have our own ambulance of Gaun-palika. Our ambulance takes them to the birthing center immediately when needed and brings them back home. If our ambulance is engaged in some other work, they have to arrange their own ambulance or any vehicle but we provide the cost of transportation to go the to birthing center and to return back after delivery. We have arranged the budget for that.

P52:

After federalization, there are more facilities now than before. It is said "Ghar Ghar ma Singha Durbar" (government in each and every home). Before, people had to go to district even for small things. Now, many services are delivered through local level, through ward. But as per the emotions of federalization, the local level has not been as empowered as they should have been. There are still many things to be done.

C. Provider's Perception on Federalization

There is mixed opinion regarding federal system government of Nepal. Workers have multiple and, in some instances, contradictory views regarding present system. This signifies that this system is new, and government still have to do more. Verbatim of FGD (P26):

Before this, the Health Ministry used to look after all the health sectors. The rules and regulations then were different than now. The federal calls out province and the province call out the local government. Also, there are many differences. We have one rule at Palungtar and it is different in municipality just next to this. This is a curse. There is a difference in services provided by the staff also. For permanent staff, the salary scale is same in the entire country according to their level but the perception towards contractual staff is different. It is something here in Palungtar and something else in somewhere else. Similarly, I also see the difference in the procurement process of the medical supplies. Before, the trainings or the knowledge upgrading programs etc. used to come from the central level through district to the local level or the health post. Now, few things come from the province but there is nothing for us from the federal level.

Looking at the above verbatim, we can say that the changed system of government has created complexities in some form of services. May be for this reason, some workers felt that previous system was better than current government system. A participant in FGD shared (P18):

The previous system was good, very good. (Other participants also say the same). There used to be different respect. Now the staff has to stay under public representative. Even the doctor of the 8th level has to stay under them so the perception towards the staff has become different. Staff is considered nothing, even the general member also threatens us to snatch our job (laughs).

Workers, especially in the health sector, were dissatisfied with the current governmental system. They experienced lengthy and delayed provision of service. A participant in FGD (P21):

The previous one was better. Because the medicines used to come from the centre, from the district, and from the region. It used to come in 3 months and 6 months. Now, it has been very difficult for the local level to send medicines twice also.

P 13:

The policies and the federalism are very good in themselves. But we need to scientifically manage our budget and resources and increase the capital expenditure.

D. Role Duplication

Workers at the local level perceived that there is role confusion in this system. This might lead to service duplication or service exclusion. A participant in the workshop shared that (P49):

For example, they are already working on women and children. Instead of strengthening them, if other offices are established in the district or in the province, it just increases the conflict and the expenses only. After federalization, we were given eight rights by the constitution, but the province has been using another right duplicating ours. This has been seen because of the lack of federal law and this can be a disaster, a political disaster, or a disaster of resources. Otherwise, the federalization is better....

On the other side, it was also shared that the current three tier government has to work with the emotions of federalization, otherwise, there will be wastage of resources and will create resource scarcity. Verbatim of a participant (P42):

But if we keep adding institutions on top of existing institutions in the name of federalism, there might be economic issues. If we keep establishing unnecessary offices without enough source of income.....

P 46:

.....As per the emotions of federalization, the rights and the budgets that should have been given to us..... 70% of the total budget should be used by the local level but according to present data, we don't even get 30% of the total budget. We get limited budget but the public has high expectations of development.

E. Translation of policy into action

Participant shared that the federal government has translated policies into action. Specifically, health policies have come into action. Illustration of a verbatim (P13):

There are policies and regulations for health protection. Free health insurance is there in the policy. I don't remember all.... There are free health services in hospitals such as ticket charges. The government has also specified 80-82 medications as freely available. There is a provision of free health services, but it is also heard that free services are not available in some places. It is there in the policy, but the implementation part is difficult.

However, some participants shared that implementation of the policy is complicated and impractical. Verbatim of a participant (P33):

It has been written that a shelter will be made for single women, disabled women, and elderly people.....also a provision of providing extra Rs. 50,000.00 besides Rs. 300,000.00 for a single woman with a disability. But we cannot do it until we receive the resources from the execution level because we have not done such kind of budget management. Ultimately, it is linked to the resources. And it might also be governed by the expenditure capacity of the state.

Although the federal system brought the government to the house of people, people have still doubt about the implementation of policy. A participant in FGD:

It is heard that the state policies have allocated quotas for people with disability and have provided some relief and support but how far has it been implemented is known by the administrative sector only.

Limitations

The use of in-depth interviews, KII, FGDs, and policy review workshops facilitated an in-depth exploration of the study topic and obtained multiple views on respondents' experiences, attitudes, and beliefs within a group context. However, the research team was also unable to employ a sign language interpreter due to cost constraints and therefore we managed to interview women with mobility and visual disabilities only. Future studies should consider including women with all forms of disabilities in order to increase the knowledge base on the understanding of the intersectional effects on the health and well-being of women with the nature of their disability.

Conclusions and Recommendations

Women with disabilities experienced various challenges during the period of pandemics and disasters. When gender and disability intersect, it results in multiple layers of discrimination against disabled women living in rural communities. The breakdown of housing, transportation, and other infrastructures due to disasters such as earthquakes and flood increase the vulnerability of women and girls with disabilities. During the disaster, they must stay in common cottages or under the open sky like other non-disabled counterparts in a community and have to struggle more to fulfill their basic needs due to the unfriendly structure that makes them more vulnerable. Women with disabilities, the single women, or women who are left behind by their husbands face increased levels of sexual and gender-based violence in and out of the home, especially those with intellectual and mental disabilities. They find it harder to flee or be left behind, making them more vulnerable to violence and sexual attacks. There these vulnerable populations are in need of trainings in order to combat with their reality. The loss of assistive devices, caregivers, and supportive networks to protect as a result of disaster makes women with disabilities more dependent on others and at greater risk of exploitation and experience stigmatization, and discrimination.

In Nepal, women with disabilities experienced advantages and disadvantages when seeking services that targeted them under the recent three-tier federal government system. Due to limited mobility or severe disabilities, they needed someone to accompany them to health facilities, leading to greater transport costs that negatively affect their access to health services. The absence of someone to accompany them and the unaffordability of the high transport costs, make some disabled women forgo seeking health services despite the existence of a free program. On the other hand, the layout and equipment at health facilities offering care are disability-unfriendly. Negative stereotypes against women with disabilities in society led to their exclusion from public participation forums thereby limiting their awareness of the available policies and services.

Intersectionality of gender, poverty, disability, and disaster has affected the experiences of women with disabilities living in rural municipalities of Nepal. This is a result of interactions of gender,

and disability, with environmental factors such as disability unfriendly transportation systems, infrastructures, and societal negative attitudes. To achieve equitable services and health care for all, the service systems need to address the unique barriers that people with disabilities face when accessing services. This should entail incorporating an intersectional and gender lens to enhance the understanding of the varying degrees of vulnerabilities in accessing health care services to vulnerable groups.

The health, DRR, and gendered policies and programs are low in quality and ineffective in the sense of covering vulnerable populations. At the same time, workers at the local level are confused and unaware of the policies, and the scarce resource prevents them from providing services to the targeted vulnerable groups. Therefore, the available policies need to be revised and emphasis needs to be given to mainstreaming the vulnerable groups.

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ANNEX I: Ethical Clearance Letters



Government of Nepal
Nepal Health Research Council (NHRC)



Ref. No.: 766

1 October 2021

Dr. Hridaya Raj Devkota

Principal Investigator, Institute for Social and Environmental Research (ISER), Nepal

Ms. Mana Sharma

Principal Investigator Maharajganj Nursing Campus

Ref: Approval of research proposal

Dear Dr. Devkota and Ms. Sharma,

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

Protocol Registration No/ Submitted Date	539/2021 P 14 September 2021	Sponsor Protocol No	NA
Principal Investigator/s	Dr. Hridaya Raj Devkota Ms. Mana Sharma	Sponsor Institution	GRRIPP, Bangladesh
Title	Gender, disability and pandemic: understanding intersectional effect on health and wellbeing of women with disabilities and the role of local government to build a more resilient society		
Protocol Version No	NA	Version Date	NA
Other Documents	1. Data collection tools 2. Informed Consent Form 3. Donor agreement letter	Risk Category	Minimal risk
Co-Investigator/s	1. Prof. Chandrakala Sharma		
Study Site	1. Gorkha District and 2. Lamjung district		

Handwritten signature



Government of Nepal
Nepal Health Research Council (NHRC)



Ref. No.: 766

Type of Review	<input checked="" type="checkbox"/>	Expedited	Duration of Approval 1 October 2021 to 1 October 2022	Frequency of continuing review NA
	<input type="checkbox"/>	Full Board		
	Meeting Date: 30 September 2021			
Total budget of research	NRs 14,72,000.00			
Ethical review processing fee	NRs 44,160.00			
Investigator Responsibilities				
<ul style="list-style-type: none">• Any amendments shall be approved from the ERB before implementing them• Submit progress report every 3 months• Submit final report after completion of protocol procedures at the study site• Report protocol deviation / violation within 7 days• Comply with all relevant international and NHRC guidelines• Abide by the principles of Good Clinical Practice and ethical conduct of the research				

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

Thanking you,

Dr. Pradip Gyanwali
Member Secretary
(Executive Chief)

Annex II Instruments

In-depth Interview guiding Questionnaire

- Can you tell us your experience of the current pandemic of Coronavirus?
- How you have managed your daily requirements – living, (health) care needs?
- What challenges and difficulties are you facing due to disability in the pandemic?
- How have you felt living with this situation? – mental status (stress, sad, fear, insecure, something (-ve feeling) coming to the mind....
- How you are coping with it? What mitigates.....
- Have you had the experience of any other disasters like – Flood, earthquakes...
- If yes, could you please describe the challenges and difficulties faced at the time of disaster?
- What made you most challenging/difficult – your disability or being a woman? Could you please tell us your experiences in general and in a disaster situation?
- What challenges have you had - being a woman, and what challenges have you had with a disability? Which was more challenging for you? In your experience, what was the combined effect of being a woman and having a disability in your daily life, particularly in disaster and pandemic situations?
- How did your family and community behave you during this pandemic or at the time of disaster – any disparity/discrimination or as equal to others or more favorably?
- Were the (regular/daily) service needs accessible for you?
- What are your health (care) needs? Is/was it available for you now, during a disaster? How did you get it?
- What makes you most difficult – having a disability or being a woman?
- Think about the disaster – women – disability: How it impacts a woman with a disability.
- In your experience, can you tell us, which impacts most during a disaster – your gender or disability
- How do your family and neighbors support you? – **during and after pandemic/disaster**
- Is there any social and cultural barriers or facilitators supporting vulnerable population such as women, the disabled, children during and after disaster situation? Are there any traditions, values, and norms that prevailed in your community that influence in supporting the people in difficult situations? How do these social norms and cultural values influence you during and after the disaster?
- Have you received any sort of support from any organization? If yes, what support did you receive? – **during and after**
- How you are/were supported by the (local) government - Palika?
- Do you know any provision of the govt. to support you – in general, and or during/after disaster situation? Can you tell me what these provisions are?
- Have you received any of that support yet under those provisions?
- In your experience – what differences did you find (experience) between the previous government structure and the current changed structure and system – in terms of providing support to vulnerable populations such as people with disabilities during disaster or difficult situations.

Key Informant Interview Guiding Questionnaire

1. How do disability and gender intersect to create vulnerability during pandemic/disaster?
2. How do you think there would be access to and control over the resources including health and economic livelihood opportunities of the women with disability?
3. How the health care need of disabled women is addressed in such situations?
4. Who do you think to take the role, responsibility, and decision for the disabled women in such situations?
5. How do you think the capacity of women with a disability can be developed to respond to different barriers in such situations?
6. What are the government policies/programs for the protection of disabled people in such situations?
7. How do you think the situation can be grasped as an opportunity to build capacity for the disabled person?
8. What are the current policy/program responses to the problem/issues in these situations?
9. In your opinion, what are the challenges/problems faced by people with disability during the disaster/pandemic? In the sense of:
 - a. Program and policy
 - b. Adequacy/availability of health and other basic services
 - c. Involvement of disabled women in the decision-making process
 - d. Attitude of the people/government /community

Focused Group Discussion Guideline

1. In your opinion, what are the challenges/problems faced by the people with disability during the disaster/pandemic?
2. What are the difference of problems experienced by women with disability than that of male in such situations?
3. As a family member/care provider of people (women) with disabilities, how do you feel/experience?
4. What are the privileges and disadvantages linked to disability with female gender?
5. In your opinion, what are the challenges/problems faced by the people with disability during the disaster/pandemic? In the sense of:
 - a. Program and policy
 - b. Adequacy/availability of health and other basic services
 - c. Involvement of disabled women in decision making process
 - d. Attitude of government and community
6. How these challenges can be overcome in future similar situations?

Thanks for co-operation