



Resiliency and Empowerment in the HIV Community During COVID-19: Equity and Human Rights lenses.

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This paper examines the voices and experiences of one of the marginalised communities, Women Living with HIV (WLWH) in Nepal at the intersections of COVID-19 and structural inequality and injustice. The overarching goal of this paper is to identify impact and implications of COVID-19 on the HIV community with a focus on factors that further escalate their vulnerability to socio-economic marginalisation and mental and psychological challenges. This study was guided by Interpretative Phenomenology Analysis (IPA). For the purpose of this study two focus groups and semi structured interviews were virtually conducted with 11 Women Living with HIV (WLWH) in Kathmandu, Nepal, using a qualitative paradigm. The Psychosocial Pyramid was used to analyse the data, and through thematic analysis the data was coded and categorised from equity and human rights lenses. This community-based study uncovered that the WLWH experience of COVID-19 was further compounded by gender oppression. At a national level, the Government of Nepal imposed a lockdown as an appropriate measure to limit the spread of COVID-19, but this response failed to adequately meet the needs of marginalized populations, especially WLWH, due to a number of restrictions of the lockdown. The emergency relief program, mainly food hamper, was introduced as part of the lockdown response that did not even maintain the privacy of WLWH. It is imperative for the Government to acknowledge the challenges and vulnerability that WLWH experience from COVID-19, which are discussed in the results section, and develop integrative approaches, programs and policies in addressing these issues in the second wave of COVID and post-COVID-19.

Key words: *HIV Community, Empowerment, COVID-19, Human Rights, Equity*



Introduction

The Coronavirus 2019 (COVID-19) pandemic has had unprecedented impacts locally and globally, including on high- middle- and low-income countries, and has facilitated continued structural injustice and inequality. As of July 29th, 2020, Nepal has had 19,053 confirmed cases and 49 deaths (Nepal Coronavirus, 2020)

To prevent the virus from spreading, the Government of Nepal imposed a nationwide lockdown, effective from March 24th to July 21st, and subsequently launched an Emergency Relief Program (Food Hamper), to help meet the basic needs of those in lockdown in all 7 provinces. In response to the pandemic, the COVID-19 Crisis Management Center has worked in collaboration with government agencies and community organizations at the central, provincial, and local level. The center was involved in the procurement of necessary medical supplies, mobilization of human resources, development of quarantine facilities and other health care services, and logistic supports including transportation, food, and clothes (Nepali Sansar, 2020). According to Nepali Sansar (2020), the government spent NPR 8.39 billion in response to the COVID-19 crisis, excluding spending at the local level. At the local level, community agencies and self-help groups added additional support to better manage the crisis. These support activities mainly include distribution of food, hygiene materials, and health accessories, water sanitation, awareness campaigns, financial support, psychosocial counseling and fund raising for testing equipment. These supports better equip community members during the crisis. However, Poudel (2020) claimed that the lockdown curfews, self-isolation, social distancing and quarantine have significantly affected the overall physical, mental, spiritual and social wellbeing of the Nepalese, especially vulnerable populations such as those living with disabilities, in poverty, etc. This current community-based study examines the voices of one of the marginalized and vulnerable communities in Nepal, WLWH.

Regrettably, the COVID-19 pandemic has affected all 7 provinces encompassing 77 districts in Nepal during a time when the HIV community, mainly women living with HIV (WLWH) were voicing and publicizing their challenges and lived experiences in the media through street dramas and research (Dhungel, 2020). They have claimed that the Government of Nepal has overlooked the risk factors escalating their vulnerability to psychological and mental challenges, as well as the impacts of intersectional marginalisation for their population (Dhungel, 2020). Undoubtedly, COVID-19 has escalated the vulnerability of People Living with HIV (PLWH), mainly Women Living with HIV (WLWH) through socio-economic marginalisation and left the HIV community unsettled and disconcerted. This paper examines the subjective experiences of women living with HIV (WLWH) through COVID-19 and develops recommendations for an effective, sustainable and dignified community-based empowering post-COVID-19 response through equity and human



rights lenses. This paper aims to critically understand the voices and experiences of WLWH in Nepal at the intersections of COVID-19 and structural injustice by identifying services offered to the HIV community, specifically to WLWH, during this difficult time. This paper is organised in five sections: (1) understanding existing knowledge; (2) theoretical framework; (3) research methodology; (4) results of the study; (5) implications of the study; (6) moving forward.

1.0. Understanding Existing Knowledge

The first case of HIV/AIDS was reported in 1988 in Nepal, but the government did not take the threat seriously until the country experienced an HIV epidemic in 1996. Since then, HIV has been brought to the attention of national and international communities including International Not-for-profit Organizations (INGO), Not-for-profit Organizations, academia, health professionals and educators. As a result, the Government of Nepal developed preventive and protective approaches in responding to the HIV epidemic at a national level. Through the wide range of integrative approaches, new HIV infections in Nepal significantly decreased each year; reduced 1100 cases in 2015 to 790 cases in 2019 gave a credibility to the efforts of local government, medical bodies, INGOs and NGOs (UNAIDS, 2020; HIV/AIDS Data Hub for Asia-Pacific, 2018; National Center for AIDS and STD Control (NCASC), 2019).

Although numbers of new HIV cases have significantly decreased in recent years, survivors continue to experience stigma, discrimination and challenges in accessing public health services (USAID, 2019). There is a significant disparity between the availability and accessibility of healthcare throughout Nepal that disproportionately impacts WLWH. Resources for women are often inaccessible due to a number of factors, including physical barriers, stigma, lack of education and deeply entrenched cultural values (Devkota, Murray & Groce, 2017; Haviland et al., 2014; Liu et al., 2016). Despite the general acceptance of the importance of universal precautions in mitigating the spread of HIV/AIDS, and even in instances where women have few barriers in accessing healthcare, many healthcare providers in Nepal avoid or refuse to provide care for vulnerable populations impacted by HIV/AIDS (Jha, & Madison, 2009). Stigmatisation and discrimination against PLWH created significant barriers to accessing HIV healthcare in Nepal (Dhungel, 2020; Jha & Madison, 2009; Poudel & Baral, 2015; Regmi, van Teijlingen, Simkhada & Acharya, 2010). HIV testing, counselling and Antiretroviral Therapy (ART) are offered for free, but individuals seeking treatment incur travel costs as well as hidden costs (loss of income, potential loss of employment), which can make accessing healthcare difficult (Poudel & Baral, 2015). The government only provides CD4 (cluster of differentiation 4) test services and ART medicines, therefore patients are responsible for covering the cost of travel, food costs and medicine costs (excluding ART) and some diagnostic tests (Poudel & Baral, 2015).



In partnering with stakeholders, the Government of Nepal has focused on two critical approaches: HIV prevention and support of infected and affected people (Dhungel, 2020). Using a qualitative paradigm, the current study clearly revealed that the WLWH experienced intersectional gender oppressions including physical illness, mental and psychological wellbeing challenges, stigmatization, exclusion from property rights, experiences of disrespectful behaviours towards them in hospital settings, and violations of confidentiality and privacy in health care (Dhungel, 2020). By acknowledging these experiences, this paper discusses the additional challenges escalated by COVID -19 that PLWH experience at this difficult time.

2.0. Theoretical Framework

The study was guided by interpretative phenomenology analysis as a philosophical assumption (IPA), producing knowledge on the reality of participants at it relates to their experiences of the intersection of structural injustice and COVID-19. The IPA is a qualitative methodology that aims to provide a details and in-depth information on the lived experiences of individuals (Creswell, 1998; Smith & Osborn, 2015). Zahari and Mariny (2019) argued that IPA is a non-biased and open-minded approach that acknowledges the insiders' understandings that are embedded in their socio-cultural contexts. Smith and Osborn (2015) argued that "It [IPA] produces an account of lived experience in its own terms rather than one prescribed by pre-existing theoretical preconceptions and it recognises that this [IPA] is an interpretative endeavour as humans are sense-making organisms" (p. 41). IPA allows researchers to view the participants' world and gain an empathetic understanding of emic views, as well as their perceptions and understandings, of the phenomena/events that they interact with by building relationships and engaging in critical dialogues (Larkin, Watts & Clifton, 2006). According to Welman and Kruger (1999), "the phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of people involved" (p. 189). In this case, IPA provided the WLWH with an opportunity for systematic reflections on their own intersectional oppression and experience with COVID-19, and promoted their critical consciousness on systemic injustices, through focus groups and unstructured interviews as suggested by Larkin, Watts and Clifton (2006).

3.0. Research Methodology

In order to achieve the goals of this current research, a collaboration between the principal investigator and the Shanti Foundation, a community-based organisation supporting human trafficking survivors and PLWH in Nepal, was established. Using purposeful sampling strategies, mainly convenience and snowball sampling, the Shanti foundation recruited WLWH for their participation in this qualitative study. Using IPA, 2 focus groups and 11 unstructured interviews with participants currently living in Kathmandu, Nepal of ages ranging from 30 to 46 years old



were conducted through a virtual platform to critically understand the subjective experiences of PLWH and how their experiences were compounded by COVID-19. Lester (1999) claimed that IPA normally translates knowledge into deep information through inductive qualitative research methods such as interviews and focus groups, representing this information and participant perceptions from the perspective of the research participants. With the consent of the participants, the interviews and focus groups were audio recorded and transcribed in Nepali language, later translated into English for data analysis. Using a Psychosocial Pyramid, data was coded, categorized and then thematically analyzed from equity and human rights lenses. The following section presents the key results of the study through the use of Psychosocial Pyramid.

4.0. Results of the Study

This section presents the results of the study using a Psychosocial Pyramid (Please see the Figure 1 below). The Pyramid, consisting of 4 layers, speaks to the support systems for people's recovery and wellbeing in humanitarian agencies (IASC, 2007; IASC, 2017; UNCF, 2018). The Pyramid works to empower humanitarian actors and communities to arrange, build up and facilitate multi-sectoral responses during crisis. (IASC, 2007; 2017). Additionally, the Pyramid aims to help understand the current services available for people in need from social justice and human rights lenses and works to ensure and improve mental health and psychosocial wellbeing of those within the middle of a crisis (UNCF, 2018).

The first layer of the pyramid focuses on social consideration, at a broadest level, and in the case of this study, this layer ensures that basic services and security are delivered to the WLWH in a way that are inclusive, participatory and safe. The second layer characterizes family and community supports received by WLWH in crisis that strengthen WLWH community and their resiliency. The third layer focuses on care and supports provided by individuals and/or non-specialised workers to WLWH for maintaining and enhancing their mental health and psychological wellbeing. The fourth layer puts emphasis on specialised services provided by mental health clinicians or social service professionals to WLWH when they deal with mental and psychological health issues. Overall, multiple layers of support are required to adequately meet the issues/requirements of WLWH, who are exposed to the traumatic event, in this case, COVID-19. For the purpose of this study, multivariate services that the WLWH have received during COVID-19 in different ways will be first examined followed by the challenges experienced. For the purpose of this paper, the first two layers will be discussed individually, and the last two layers will be addressed together as the last two layers speak to health care services with a focus on mental and psychological wellbeing.

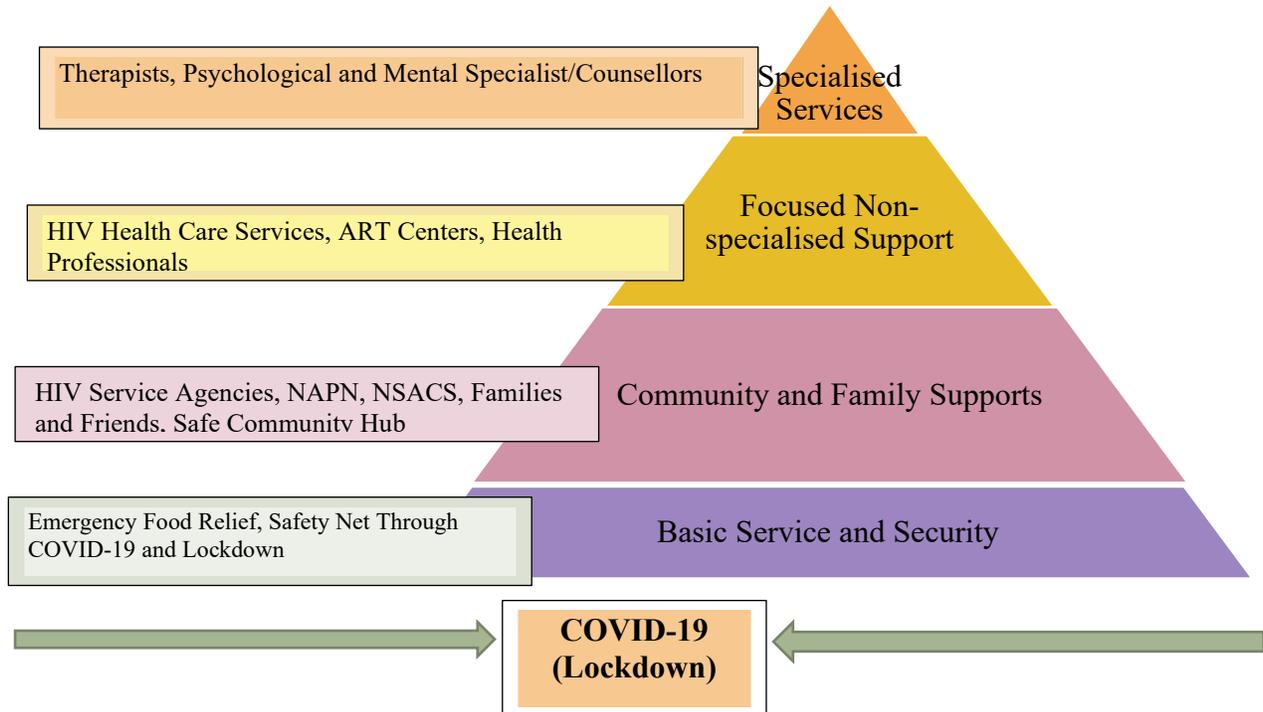


Figure 1: Intervention Pyramid for mental health and psychosocial support in emergencies. **Source:** Adopted from IASC, 2007, and modified for the presentation of this paper.

4.1. Basic Service and Security

When the lockdown was imposed on March 24th, 2020, the Government of Nepal officially committed to providing basic services and food security, through the Emergency Relief Program, to those in need. In collaboration with local government and community organisations, as part of this programs, the Food Hamper was distributed to all provinces. The contents of the hamper are varied, depending on the size of family. For a family of four, the hamper included rice (5 kg to 10 kg), lentils (5 kg), some snacks (biscuits and beaten rice), 12 eggs and 12 packets of noodles delivered twice a month. Through this study, it was recognized that there were significant limitations and barriers for the woman to access the Food Hamper program. The following section examines the limitations of Food Hamper program and its barriers especially for WLWH. They include: (1) proof of nationality; (2) lack of inclusivity; (3) food insecurity and non-nutrition; and (4) further exploitation to economic marginalisation.



4.1.1. Proof of Nationality

The government had required each individual to provide proof of nationality in order to qualify for the Emergency Food Relief Hamper that launched in all 7 provinces and 77 districts during the lockdown. Some of the residents who came to Kathmandu from other provinces did not bring their citizenship cards with them when they left their homes for Kathmandu since some came to Kathmandu for their medical health check-up and some came for family reunification. When the lockdown was enacted, these residents got trapped in Kathmandu. Moreover, some women reported that they did not have a citizenship card in the first place, since they never thought it would be required in their lives. Notably, in Nepal, once you become 18 years older, you are eligible to avail a citizenship card that is used only for employment, for entrance into post-secondary, and to vote in elections. For example, one of the participants shared;

“The people distributing the hamper would think I am not Nepali. I don’t know... Speaking Nepali language and my Nepali appearance is not good enough for them. They need proof of this and where can I bring my card especially, I am not from this community- I came to Kathmandu for my health check-up and I got stuck here. Why, why... citizenship card is needed in this crisis- I need food that is all I know.”

4.1.2. Lack of Inclusivity

The Emergency Food Relief program is a non-inclusive orientated program as the program did not consider the issues of those who have low immune systems, chronic illness, or both such as PLWH and elderly populations. To elaborate, by inviting people in a crowded public place and asking them to wait for more than 2 hours for the hamper is unreasonable, especially in a COVID-19 context. This approach undoubtedly increased the risk of spreading the virus especially to those who already have health issues. Given the situation, the women expressed apathy regarding going into the crowd to claim their food hamper, which did not provide enough food for one week. One woman condemned:

“I do not have energy to stay in a line with lots of people who I don’t even know whether they have COVID-or not. The hamper is not even sufficient for our entire family members; I have two children and you know children eat...eat all the time. I just don’t want to put myself at a risk situation by going to the public place. It would have been better if the government made some arrangements to deliver the hamper to our doors. I can go and pick up the hamper in a different time if they arrange something but... At least they can do minimum efforts for us. Who cares about us!”

4.1.3. Food Insecurity and Non-nutrition

Accessing to nutritious food is fundamental to human existence, specifically the people who have been on medications long-term such as WLWH. The food hamper was meant to be distributed twice a month, but none of the participants received the hamper more than once a month. Once participant shared her story when she went to receive the food hamper for the second time:

“you know what I was told. You behave like beggars. You already took the package two weeks ago and again you are here. We do not have anything for you until we get more hampers. Come where you finish your food given last time. Uhm.. what to say”

One of the participants reiterated and contended,

“...the hampers were not even sufficient for a week. 5 kg rice and lentils? Are you serious? How would they ask us to wait until they receive more? I don’t understand why they behaves us as if they were giving this from their own pockets- very disappointing.”

She lamented and continued,

“I have my two boys and my husband passed away a year ago and I hardly feed my children with the hampers received. I got the support once but guess what there did not give us a gas cylinder and how I would cook the rice and lentils without the gas. It seems like they really do not care about us. The hamper does not include any nutritious food and you know doctors tell us to ensure we need to get nutrition. Do the people in power and positions know what it looks like? Their lives are lives and our lives are garbage...go to hell.”

4.1.4. Further Exploitation to Economic Marginalisation

25% of the population live below the poverty line in accordance to Nepal Living Standards Survey 2010– 2011 (Central Bureau of Statistics, 2011). The link between poverty and transmissible disease is well-evident (Alsan et al., 2011). The traumatic event, COVID-19, has further increased unemployment and major economic losses in Kathmandu, particularly WLWH community. For example, the majority of WLWH in our study assert that they lost their jobs due to COVID-19 and did not receive any compensations or other financial supports from either the government or their employers. The women were involved in daily wage survival jobs, such as cleaning, washing clothes, and breaking rocks and irons, and their employers did not provide any communications during the COVID-19 crisis regarding their job security. In comparison, a single mother in the study experienced further challenges:



“I hardly read and write. The house cleaning job was perfect for me. Now I am not even able to do that job because of the lock down. I wanted to go back to my village, but this is also not possible, otherwise at least I would have food and a shelter for my children. My landlord keeps asking me to pay the rent and she is right. She needs money too. How would I pay the rent since I am not working for four months? It is easy for the Government to tell tenants not to ask us for the rent...but did they do anything for us?”

Another woman concurred and expressed her anger saying,

“With the help of some family members, I started a small grocery shop in my own community a week before the lockdown launched. I closed the store for two months although we were allowed to open the shop in mornings and evenings for two hours. My immune system is very low, and I did not want to be closer to anyone. After two months, I had to sell the shop. I was not able to pay the rent. The tenant was very...what to do...I lost Rs 2 hundred thousand. Not sure when I will pay the loan back....”

4.2. Community and Family Supports

Besides the Government of Nepal, at the local level, community agencies and self-help groups are also adding support to better manage the crisis. These support activities mainly include distribution of food, hygiene materials, and health accessories, water sanitation, awareness campaigns, financial support, psychosocial counseling and fund raising for testing equipment. These supports better equip community members during the crisis (DCA, 2020).

For the purpose of this paper, the term “community” is defined as a group of People Living with HIV (PLWH), the agencies/community-based organizations working with PLWH, and the Nepal National Centre for AIDS and STD Control (NCASC) and Association of People Living with HIV (NAPN). It is reported that WHWL have received community and family supports to varying degrees during the COVID-19 crisis, helping them to preserve their mental and psychosocial wellbeing, and also to help them sustain some small businesses. The community-based organisations including Shakti Milan Kendra and Shanti Foundation have been serving incredible roles in providing basic food such as rice, lentils and also Gas Cylinders to the PLWH, mainly WLWH who are in crisis. The women greatly appreciated the agencies for their supports, however, the food they received was not enough to sustain them and their families for one week. In addition, there are number of communities/ groups of people/religious groups and other agencies that are involved in supporting people in need, but unfortunately the women expressed hesitation to reach out to these other groups due to the fear of being discriminated against. While community and family supports are essential during difficult times, the issues and challenges the women



experienced with these supports are equally important to note during public discourses, including: (1) violations of privacy and confidentiality; and (2) donor-based service provisions.

4.2.1. Violations of Privacy and Confidentiality

When a traumatic event occurs, it is important that the government and communities come together and support people in crisis, with focus on treating everyone with respect and dignity regardless of their status. Through the assertions of the women in our study, while agencies engaged with communities in delivering and distributing food hampers, privacy and confidentiality of the WLWH were violated in multiple ways. To elaborate, a participant narrated,

“When Shanti Foundation and Shakit Milan Kendra come to support us, they take our pictures while giving the food to us and the next day our pictures are either on their websites or on their Facebooks. Where is our respect? Yes, we need food to survive but it does not mean that they have the rights to violate our privacy. The world does not need to know me as People Living with HIV.”

Another woman echoed and commented,

“Shakti Milan Kendra goes door-to door during the lockdown to deliver us the food which is greatly appreciated. But, when they come on a scooter, they have a big banner, hanging on the handle of the scooter. You know what the banner says: HIV Support agency. I just moved to a new community in which nobody knows I live with HIV and I have no more energy to face discrimination against me. Thus, I declined to receive their support. Because of the Lockdown, I cannot even go to the agency to pick up the food.”

4.2.2. Donor-based Service Provisions

NAPN has been taking initiatives to solve the immediate needs of PLWH by distributing one-time food hampers to the HIV community across the country. Their food hampers included Rs 50, rice, lentils, 12 eggs, 12 bananas, biscuits and so forth. Regrettably, the one-time food hampers are not sufficient for the four months and, in parallel, the eligibility criteria for the hampers is below 12 years and above 45 years. More than 90% of the HIV/AIDS response is funded by external sources and therefore the population living with HIV is extremely vulnerable given that resources are dependant on donor funding (Koirala, Deuba, Nampaisan, Marrone, & Ekström 2017). In responding to the women’s concerns about the criteria, the representatives of NAPN disclosed that the criteria were set up by their donors. One woman expressed her anger by saying,



“I don’t know what to say...NAPN knows that the age of PLWH is varied; most of us are not even 45 years old. Does that meant we don’t need to eat? I don’t understand the rationale of this criteria. I have not even received anything from NAPN at this point. They have not even called us yet. They left us for dying.”

Another woman concurred,

“I don’t know what NAPN and NCASC are currently doing. Where are they now? Everyone says I am super busy... busy for what? none of us received neither food hampers nor any financial supports in this group. We need NAPN and NCASC to come together and advocate for us during this difficult time. I am not even sure if we truly need the NAPN if they do nothing for us.”

4.3. Focused-Care and Specialized Care

A pandemic like COVID-19 can result in increased mental and psychological challenges, especially to marginalised and/or low-income populations through social disadvantage, such as job insecurity, housing instability, discrimination and food insecurity (Goldmann & Galea, 2014). As discussed earlier, the women were going through lots of adversities and difficulties in their lives that increased their fear and anxiety. The agencies working with populations with HIV such as NAPN delivered ART, a therapy that the WLWH needs every day. They brought this therapy to the doors of their respective members so that the women did not have to worry about accessing ART in a timely fashion. Nonetheless, the study found COVID-19 in general and the lockdown in particular made the women more vulnerable to anxiety and stress related disorders for the following reasons: (1) inaccessible and unavailability of health care; and (2) replacement of ART.

4.3.1. Inaccessible and Unavailability of Health Care

It was reported that public hospitals, especially the Teku hospital that provides most services to PLWH for free, clearly indicated that the health professionals would not treat PLWH during COVID-19. Arguably, PLWH are made more vulnerable during the COVID-19 crisis, but the Teku hospital would not see any patients regardless of if they had tested negative for COVID-19. Also, the lockdown measures had closed most transportation options, and there were no other ways for the women to go to see a doctor for their regular checkups or in emergency situations. This made the women significantly anxious and nervous regarding their health situation, for example, one participant narrated,

“I am very anxious now. I am now living in fear. I never had this feeling before even when I was diagnosed with HIV. ART would help me to fight with the virus I knew but now...if I get sick, I will



die. This is how I feel. The system makes us feel like no one cares about us, and our existence does not matter to the people in power. When a door of health services is closed for us what can we expect from others? I got a sore throat last week and my fear went really up. I got high blood pressure and panic attack just because of discrimination against us and who does that? health care professionals.”

Another participant concurred,

“I cry easily these days. I am also scared all the time. I am currently taking medications to control my blood pressure. I don’t know what I am scared of... but I am scared to talk, to eat, to go anywhere and sleep. I feel weak emotionally and physically. There is no mental health supports for us, other than food hampers from the government. I need to talk to somebody but who do I talk to ...people are scared to talk to us because we have HIV”

The government and nongovernment agencies are running several helplines to provide mental health counseling over the phone (Poudel, 2020) for those who need counseling services, however none of the women were found to be aware of or using those services. Moreover, HIV service providers claim that they have counsellors to support the women but in reality, they are not trained counsellors. During lockdown, visiting a counsellor is another challenge for the women.

4.3.2. Replacement of Antiretroviral Therapy (ART)

The WLWH brought serious health concerns with a focus on ART replacement through the critical discussions in the focus groups. The government had made the decision to change ART effective in March. Due to the lockdown, the local ART centres started bringing their services to their clients’ doors with the replacement medicines, without providing any prior information and/or any education about the new medicines replacing ART. The women in attendance expressed their serious concerns about using this medicine during this time as they heard from their peers about negative side effects of the new medicine such as diarrhea, stomach pain, fever and vomiting. One of the women shared,

“I know this decision had been made a long time ago, but they should postpone this for now. I am in fear of what will happen if I get sick after I use this medicine. Hospitals don’t want to see us, and I don’t know what to do in that situation. I am still using the old medicines but in a couple of weeks I think they will bring the new medicine.”



Another woman concurred and shared,

“I heard that NAPN has been providing online information about this change to those working in ART Centres. But not everyone has HIV in the ART centres. We have HIV and we need to know the details of this change and its potential side effects. The people from ARS centres can’t even share this information with us during this lockdown. We don’t have money to pay internet to attend zoom sessions. I have no choice about switching to the new medicine as the ART medicine will no longer be available after a few months.”

5.0. Implications of the Study

The study has significant implications, through and beyond COVID-19, for social work education, policy and practice. This study confirmed that COVID-19 and the lockdown measure further escalated the vulnerability of WLWH to social-economic marginalisation and psychological and mental challenges. As the risks to mental health rise, there is an urgent need to increase investment in psychological and mental health services and to provide services to the PLWH community free of charge. Most private health care institutions in Nepal are urban-centric and seem reluctant to show any empathy and commitment to people, mainly PLWH, during the current crisis (Singh, Sunuwar, Adhikari, Szabo & Padmada, 2020). To elaborate, in the one hand they do not have money to pay for their services in the private hospitals and in the other hand, the private hospital do not even see PLWH patients during COVID-19.

Also, education and awareness of the current services should be made available to WLWH. Assuming that everyone can read and write is dangerous and thus excludes those without these skills from accessing information from the websites of agencies and governments. Using a problem-solving approach, the Food Hampers Program was launched by the Government of Nepal and other agencies as a timely initiative to enhance food security. However, by recognising the limitations of the current program as discussed earlier, the government can revise the program to be more effective using a rights-based, rather than a victim-centered, approach during the second wave of COVID-19 and beyond. It is highly recommended that the Government of Nepal should formulate an inclusive policy while developing an Emergency Relief Programming in ways that address the voices of and advances the participations of marginalized and vulnerable communities such as WLWH in accessing the services of the program.

For the women in this study, the intersectional oppression they experienced during COVID-19 heightened their levels of stress and anxiety, and disappointingly, there was no system to help with testing and support for their mental and psychological disorders. Hence, it is incredibly important all the actors including government, psychological and counselling associations, HIV serving



agencies, and social workers come together and provide additional support the WLWH community with respect and dignity, through the maintenance of their privacy. It is ethically imperative for Government of Nepal to develop a safe communications policy to address the sharing of pictures and personal information of service users such as clients, patients, recipients, beneficiaries, interviewees and etc. on social medias without their consents. Additionally, as Chalise (2020) argued, Nepal will need to focus on strengthening the health care system country-wide to control the present and future epidemics. In parallel, community-based organizations and Government of Nepal should create a safe community hub specifically for PLWH to reduce their isolation and promote psychological and mental wellbeing. Importantly, it is recommended that participatory community-based research be conducted with PLWH, including WLWH and MLWH (Men Living With HIV), with the aim of critically understanding their experiences with a focus on psychological and mental wellbeing through COVID-19 and post-COVID-19 and compare the findings from gender-based lenses for the purpose of policy and programs development.

6.0. Moving Forward

From equity and human rights lenses, understanding resources and capacities provided to marginalised and disadvantage populations i.e. WLWH through and beyond COVID-19 and the challenges they experience during these times are critically imperative for policy and program development. Through engaging in each layer of the Psychosocial Pyramid, a wide spectrum of perspectives on the phenomenon of COVID-19 and its impacts on HIV community, mainly WLWH, was critically examined from IPA perspectives. Poverty is a social and economic trauma that directly relates to the impacts of the phenomenon of COVID-19. This study claims that the WLWH are expressively affected by COVID-19 in multitude ways, requiring additional attentions of and immediate supports by the Government of Nepal, NCASC and NAPN and other bilateral organizations, who are providing funding to NCASC, NAPN, and other agencies working in the areas of HIV and STD. Previous studies have claimed that prolonged exposure to hunger and malnutrition can trigger infections, cognitive-developmental deficit (in young children), behavioral and mental dysfunctions such as stress, suicides, and depression in both minors and adults; and can aggravate chronic conditions such as asthma, obesity, hypertension, diabetes, and hyperlipidemia (Sligamna, Laraia & Kushel, 2010). During COVID-19, the lockdown was established as an effective tool (Chalise, 2020) and the “Emergency Relief Program” was introduced, using problem-solving strategies, but this program did not adequately meet the needs of people, mainly for PWLH. The proliferation of stand-alone service i.e, Food Hamper has shown that there is no effective social protection and safety net in Nepal.

It is the fundamental responsibility and duty of each and every one of us to treat marginalised and vulnerable people such as WLWH with respect and dignity. More importantly, in response to



addressing the challenges the women identified and promoting their psychological and mental wellbeing, the Government of Nepal needs to develop some economic livelihood strategies to build capacity and skills of WLWH. Providing them with vocational trainings, free health services and free postsecondary education beyond COVID-19 is critical and their health should be treated as a priority at a national level. By developing integrative strategies in collaborations with HIV agencies, NCASC and NAPN should provide WLWH with opportunities to meet and talk to their peers on a regular basis either through a virtual platform and/or in-person and maintaining social distancing, which may work as social therapy to aid in the reduction of psychological fear of COVID-19 and other issues stemming from their fear of COVID-19 as suggested by (Chalise, 2020).

In concluding, given the precarity of this difficult period, an interdisciplinary team including health care professionals, academia, practitioners, the media and communities at large should come together and invite the WLWH communities input in responding to COVID-19 and post-COVID-19 from a social justice standpoint. Overall, due to the uncertainty associated with COVID-19, an effective and inclusive approach is required to address the issues identified in this paper.

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Rita Dhungel, from Nepali heritage, is an Assistant Professor with the School of Social Work, Community and Health Studies, MacEwan University. Dr. Dhungel strongly believes in creating a transformative and emancipatory learning environment and fostering and nurturing students' knowledge and skills, through adult learning and inquiry-based approaches. Dr Dhungel's involvement in transformative research has been widely recognized locally and internationally. Her areas of focus are Violence against women, Human Trafficking, HIV and AIDS, Mental and Psychological Wellbeing, and Immigration and Refugees.



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