

## SPECIAL SECTION

# Europasian Journal of Medical Sciences (EJMS)

### From the Desk of the Editor-in-Chief

In an earlier issue of this journal, it was announced that the *Europasian Journal of Medical Sciences (EJMS)* has established a special section as an additional feature of the journal.

Each special issue is designed to focus on a specific theme of domestic, regional, or international importance in scope. A special issue may be included periodically. For this, the editor-in-chief may invite a particular member of the editorial board or an external expert to take a lead in assuming the responsibility of soliciting, compiling, and editing the contributions to the special section. The special section is a part of the journal, but it may be published online between any two issues of the journal, or at the same time a regular issue is published.

This particular issue is the first one in this new series, and it focuses on the ongoing COVID-19 pandemic. I had the pleasure of inviting Dr. Shyam Thapa to serve as the guest editor for this section of this particular issue. This issue includes seven commentaries and a summary of the articles. These commentaries relate to various aspects of the pandemic, ranging from individual experiences to systemic issues. The underlying purpose is to try to serve humanity better during the times of the COVID-19 crisis, using these individual cases to provide a better understanding of the issues, context, innovations, failures, and successes, along with providing examples of individuals rising to the challenge. In this sense, it may be considered a part of knowledge generation from inductive to deductive processes, where applicable.

On behalf of the EJMS, I welcome suggestions and support for future special issues in the series.

#### Dr. Kapil Amgain

Editor-in-Chief, *The Europasian Journal of Medical Sciences*

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## Voices from the Field: Combating COVID-19 Pandemic in Nepal

**Shyam Thapa**

*Europasian Journal of Medical Sciences (EJMS)*

Given the ongoing COVID-19 (C-19) crisis in Nepal, this section includes some vignettes related to combatting the crisis in Nepal. When the editor-in-chief of this journal invited me to assist, I thought it would be useful to present the experiences of the actual professionals engaged in combating the pandemic in the field. This effort resulted in the collection of brief articles in the form of commentaries in this section.

The piece by Kulesh B. Thapa focuses on the response of the Kathmandu-based ambulance service. The experience clearly shows that knowledge, equipment, and supplies are essential but not sufficient for the rendering of services. The importance of contextualizing and adapting these elements to fit the local need is also vital. Thapa's story is about overcoming the obstacles and rising to the challenge; and finding a rainbow at the end of the ongoing storm.

Robin J. Bhandari is a young doctor who landed at the district hospital in Bajhang, just a few months before the pandemic started spreading across Nepal. Little did he know how challenging the situation would become during the time of a crisis of global proportion. Certainly, having worked at the emergency room (ER) during this residency had prepared him to some degree, but by his own account what he experienced was truly extraordinary. He shares his experiences of frustrations and anxieties, along with failures and successes. However, he also stresses the importance of endurance and never giving up.

Ismita Sharma shares her first-hand experience as a former patient diagnosed with COVID-19. Her story provides insights into the experience from the other side – going from being a nurse care provider to being a patient. She underscores how the system needs to be more patient-centered. As she documents, a large part of the problem may have to do with the attitudes not only of the technical providers but also those involved in organizing, managing, and rendering services. However, the author is also quick to caution that when she documented her experiences, she was experiencing the event as a corona-infected patient at a hospital, and the fact that she was a patient, along with a number of other factors may have influenced her feelings at the time. However, the bottom line remains that it is only by being aware of such issues that all may recognize them

as “real issues” and find ways of addressing them.

Rishav Koirala, a practicing psychiatrist in Kathmandu, provides us with a window into the stress and anxieties experienced by many of his patients residing in Kathmandu. Clearly, the long duration of confinement has exacerbated stress and anxiety in the minds of many citizens. At the same time, it is important to note that the stories he documents refer only to those who may have managed to get to the clinic/hospital. Without a doubt, there may be many more individuals who were not able to utilize mental health services for a variety of reasons, for example on account of not having access to services, due to lack of information, an inability access to the necessary transport, or not having the money to pay for the services being sought. The observations and stories shared by Koirala are yet another reminder that availability of and access to mental health services are important, especially during times of long-protracted confinement.

Shristi Kolakshyapati, Binita Pandey, Bindu Sharma, and Elawati KC have tried to assess the workload experienced by women during the lockdown period. For this, they obtained information from 317 women who had access to internet service and were willing to respond to the survey questions. Obviously, their survey does not include hundreds and thousands of women who did not have access to the internet, or who did not wish to participate in the survey. Still, even among those who could participate in the survey, it was found that the pandemic had put an additional burden on the women with respect to household work. The burden was expectedly higher especially among those who also held a job. The researchers note that the pandemic resulted in having the household members spending most of the time at home, which may have exacerbated the inequities in the burden of work between male and female members of the household, and between married and unmarried females in the households. This aspect needs to be taken into account when managing and organizing household activities.

In a 30-minute-long weekly program on the FM radio, Samjhana Poudel, with assistance from Sushil Sharma and others, try to bring to light innovations and social services undertaken by individuals, communities, and organizations throughout Nepal to address the challenges

and opportunities raised by the C-19 pandemic. They share with us how some people rose to the challenge to provide meals to the hungry in different locations in the Kathmandu Valley, how a woman entrepreneur in Dhangadi, in Far-Western Nepal, turned her health facility into a shelter home for Corona-infected women, and how a couple decided to dedicate their services to women in Jumla during the time of the pandemic. These are stories of unsung heroes who rose to the challenge and contributed to minimize hunger, stigma, and stress during these unprecedented times.

Bidhya Rai, a journalist, tries to assess the levels and trends in suicide and self-harm prior to and during the pandemic period nationally. The data are compiled and reported by the police. Surely, those cases that were never reported to the police are not reflected. This basic limitation aside, the data clearly indicate a rising level of suicide cases during the pandemic period. Rai also presents specific cases representing diverse communities and districts in the country. These individual cases illustrate the context of the loss of lives often triggered by the pandemic. Behind each life lost are the children and family members who have to endure and manage to pull their lives together.

The experiences shared in these articles are probably just the tip of the iceberg, and there are bound to be more heart-wrenching yet untold stories out there. But these too are no less important in our efforts to fully understanding the context, consequences, and handling of various critical situations as the pandemic has unfolded globally, and in Nepal in particular. At the same time, these are also stories not only about frustrations, anxieties, and loss of life, but also about people rising to the challenge, and providing compassion, creativity, and service during the crisis.

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Shyam Thapa, PhD, FRIPH, serves as an international editor (North America) for the *Europasian Journal of Medical Sciences (EJMS)*.

# Mobilizing Ambulance Services during the COVID-19 Pandemic in the Kathmandu Valley

**Kulesh B. Thapa**

Nepal Ambulance Service, Kathmandu

Since the COVID-19 (C-19) pandemic surfaced in Kathmandu, the Nepal Ambulance Service (NAS) has been at the forefront of transferring and carrying passengers. More specifically, NAS was designated as the principal emergency care organization by the Ministry of Population of Health of the Government of Nepal (GON). Accordingly, NAS has also been working in close collaboration with the GON's COVID-19 Crisis Management Committee (CCMC). This commentary highlights some of the main challenges faced and solutions identified in the midst of the ongoing pandemic situation in Kathmandu.

## *Nepal Ambulance Service*

NAS is operated through a non-governmental organization that has been providing emergency services for the last 10 years in the Kathmandu Valley and some major cities including Pokhara and Chitwan. The NAS is the only emergency medical service (EMS) of its kind currently in existence in Nepal; and to date it has undertaken more than 50,000 emergency transfers.

NAS currently has 10 ambulances, 35 emergency medical technicians (EMTs), and a central dispatch centre. Some of the vehicles were donated by local organizations and individual philanthropists. At the time of the 2015 earthquake in Nepal, the International Medical Corps donated five ambulances to NAS.

The Kathmandu Municipality remains a primary contributor to the core operational cost of NAS. In addition, NAS has been able to garner multiple sources of contributions to meet its operational cost. It has several patron and corporate members who contribute a fixed sum of money "for the society and by the society" on a sustained basis. NAS also charges a modest user fee on a mileage basis (for those who can afford it).

NAS has received technical assistance from Stanford Emergency Medicine International (in the USA) and the Patan Academy of Health Sciences (in Nepal). With their support, NAS was able to design and organize EMT training courses. Similarly, NAS has also received support from Regio 144 (in Switzerland) for enhancing the skills and quality of management and operational procedures. Professional staff from Regio 144 are engaged in providing continuing medical education

(CME) to NAS staff and skill-based refresher courses annually. Furthermore, nearly 150 students from Regio 144 have visited NAS to work as interns over the years. This collaboration has also resulted in some of the NAS staff also visiting the Regio 144 office for technical exchange.

## Challenges Faced and Solutions Identified

The first area of challenge was knowledge acquisition and implementation. Like much of the world, NAS did not have a C-19-specific protocol. The first stumbling block we encountered was evidence-based knowledge regarding the novel virus. Even the simple knowledge of what type of disinfectant to use became a huge issue. As we went about learning more about the virus, we focused on prioritizing the safety of our own staff, our equipment, and the passengers whom we would be transporting during the crisis. We developed a protocol for disinfecting vehicles and other related aspects. At times, some conflicting guidance coming from internationally recognized organizations (e.g., WHO or CDC) was another issue as this was a very fluid and constantly unfolding situation.

The solution for this problem came about after attending various online meetings with experts from Wuhan, discussing this issue in meetings with our government specialists, and getting long-distance opinions from various experts from all over the world who were working in this field. Following this, we developed a practical protocol for Nepal. We used this protocol for raising awareness among our staff, and repeatedly and continuously disseminated information through various mediums like classes, trainings, meetings, notices, and virtual groups.

Awareness and behaviour change were critical but not sufficient. As the pandemic continued to persist, constant monitoring and support for the availability of supplies was necessary for behaviour change. It was largely a 'learning-by-doing' scenario; and we also continued to disseminate information to various organizations through online and structured training programs. This continuous information sharing and advocacy of the use of evidence-based material helped build self-confidence and reduced the chances of pursuing rumours regarding prevention and treatment. As of this writing (August

2020), I am happy to report that all the staff of NAS remains safe and sound.

The second main area of challenge related to personal protective equipment (PPE). While we had the knowledge and skills associated with the wearing of basic PPE like gowns, gloves, eye protection and boots, wearing the full PPE and doffing had never been part of our training programs in the past. We soon realized that a one-time training given by the Government of Nepal to a few of the staff was neither effective nor properly understood. The process was found to be very cumbersome, and trying to learn using a ‘checking-the-list’ approach was not very effective. Furthermore, there were just too many participants for a hand-on-training. We needed to have every member of our staff trained and confident for the transferring of patients, and at the same time, also needed to maintain the safety of NAS staff.

By way of identifying a practical yet effective solution, we came up with a simple and easy-to-use ‘check-list’ that could be implemented in day-to-day life, and then trained and retrained the staff using this simple check-list. Additionally, we emphasized proper medical waste management. We also selected the more interested and skilled participants as instructors for the training of the other frontline field staff. We designated and trained core staff to serve as peer leaders. Some personnel representing other organisations (e.g., Red Cross, Health Ministry, and others) also participated in our quickly-improvised intensive training programs.

This method worked for us as the peer leaders upgraded their knowledge, skills, and practised within a short period of time. Soon they began to impart knowledge and skills to others, including to individuals outside NAS. Upon completing the hands-on skills training, we dedicated part of the staff for C-19 transports and kept them quarantined, with proper meals, lodging, and enough supplies and water for disinfecting of all ambulances at all hours (even water being a very precious commodity in Kathmandu).

So as not to repeat the same mistakes made by some other organizations, we were very particular regarding the number of participants per training being limited only to 12, having enough instructors for the participants (a ratio of 1:4), establishing a proper learning environment, making sure all the participants practiced, and testing them for their skills. During the training, we emphasized factors like time management, while also allowing adequate time for all the skills to be acquired (from donning and doffing to vehicle disinfection). Instead of focusing entirely on theoretical aspects, more emphasis was given to practicing skills – and in doing so, only the ‘must know’ components of the theoretical side were

imparted. This gradual and practical focus resulted in being able to train even those staff who sounded very scared and uncertain in the beginning. One staff member in particular who initially seemed somewhat reluctant ended up becoming an instructor within a short period of time, and furthermore he has been at the forefront of managing more than 100 infected patients. He practices his skills and of donning and doffing and disinfection very meticulously, and helps his colleagues learn from him. Happily, has undergone the PCR (Pulmonary Chain Reaction) test twice, and he remains safe and sound.

The third main area of challenge related to logistics. More specifically, the unavailability of PPE and other logistical factors hit our organization hard, a challenge also experienced at the same time in places throughout the world. We identified a ‘central supply and dispensing system,’ and based on the number cases we had, we calculated the amount of PPE and disinfectant that would be averagely required. Further, we asked the EMTs to fill out requisition forms and dispatched the materials from a central logistics supply room. We also appointed a full-time regular logistics coordinator for the supplies, so that there would be coordination and accountability for all the supplies and equipment. The central supply was also replenished by the Ministry of Health and Population, external donor partners, and local concerned citizens. Similarly, we also needed to approach various organizations and people for food and other supplies as well, and we had to repeatedly contact various sources for all these materials. This issue was all the more challenging as NAS was transporting the C-19 cases free of cost. At times, NAS had to purchase some of the supplies that were either not adequate or not available from philanthropists.

The fourth and final area of concern related to the stigma associated with being the frontline health workers during the pandemic. Many staff were not allowed into their rented apartments, and sometimes were also not allowed to enter the locality where they were living in. One of the EMTs, who had been living in a rented apartment in the south side of the city, was accosted by a group of youth as he was returning home one night, and told that he was no longer welcome in the community. Despite his efforts at explaining to the landlord and the youth that as a NAS staff member he was adopting all the necessary precautions, as per the NAS protocol, he was still forced to pack up and leave the apartment. Some of his other colleagues faced a similar situation of being thrown out on the street in midst of the ongoing crisis. Besides the frontline health workforce, even the ambulance was not allowed to dock in the regular docking offices.

The stigma-related avoidance, and being practically thrown out of one’s own apartment, was a source of

stress to say the least, and it also affected the functioning and morale of the other NAS staff. This warranted the time and effort of NAS officials to ensure that the staff remained supportive of each other and continued to stand together. Further, with the support and intervention of the local government, NAS was able to accommodate some of the displaced staff and also find space for keeping all of the C-19 designated ambulances. Proper hygiene and a disinfection methodology were used for the proper disposal of medical waste. All the EMTs and ambulance pilots (drivers) were stationed there so as not to have the problem of facing their landlords or the locals. Food and all other necessary materials were provided by a NAS logistics coordinator. For some time, lunch was donated by various restaurants and organizations who provided a helping hand for the initial phase of lockdown.

### **Conclusion**

Based on NAS engagement during the ongoing C-19 crisis, national and international collaboration and assistance in the area of gathering evidence-informed and evidence-based experience have expectedly proven to be critical and catalytic. At the same time, our experience also makes it clear that the development of knowledge and skills demands contextualization and adaptation. This process is important to ensure that the application of a particular intervention is effective and efficient. Our experience also shows that social stigma, induced largely by fear and anxiety, can and does happen to medical technicians and personnel. Management needs to be prepared to deal with this potential threat so that services continue functioning smoothly.

Finally, NAS engagement during the ongoing pandemic has been fraught with frustrations, challenges, and anxiety. Many of the issues that we faced and confronted on-the-ground were new to many of us. But within each of us, we knew this was a challenge that had fallen upon us, and we needed to show the best in us. The community looked to us for help, and we knew we had to rise to the challenge. I believe we did, and we are still doing so. Many lessons have been learned throughout the process, and all of us at NAS hope and feel that we have become stronger in the rendering of emergency transportation services than ever before.

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Kulesh B. Thapa, MD, DCH, is Medical Director of NAS (Nepal Ambulance Service), Kathmandu.

Acknowledgements: This note is dedicated to all the NAS staff - the real heroes of the experiences shared here. Also, on behalf of NAS and myself, I would like to thank all the individuals and organizations that provided much-needed assistance in the form of their time, kindness, or cash in our common battle with the ongoing

pandemic. I would also like to record my appreciation to Dr. Shyam Thapa who encouraged me to document my experiences for sharing with others. He was also a 'sounding-board' during the early days of addressing some of the challenges noted here.

## A Medical Officer Amidst the COVID-19 Pandemic in Far-Western Nepal

**Robin Jung Bhandari**

Bajhang District Hospital, Bajhang

After having received my MBBS degree from the School of Medicine at Kathmandu University, Bajhang was the first place where I started working as a fulltime doctor. I was seconded through the Nick Simons Institute in Kathmandu to work at the Bajhang District Hospital. I was excited about this opportunity to visit the Far-Western region of Nepal, where I had never been before.

Bajhang is a mountain district located in the Far-Western region of Nepal. It is directly north of the district of Kailali in the Terai. To the east of Bajhang lies the district of Bajura, and Darchula is located to its west. The total population of Bajhang is 195,000, with an overall female literacy rate of about 50%, considerably lower than the national average. The overwhelming majority (70%) of the inhabitants of the district are Chhetri and Thakuri, followed by Brahmin (10%). As with many other adjoining districts, one of the characteristics of Bajhang is that at least one male from most of the households leaves for seasonal employment, typically from October until March. Most of them go to various places and cities in neighboring India. Thus, there is a high level of population mobility in the form of male out-migration in the district.

I joined the hospital in mid-January (2020). It is the only hospital located in the district headquarters – Chainpur. It is a government hospital with 35 beds, along with 7 doctors and 19 nurses among other support staff. Somewhere between 80-100 patients visit the hospital daily.

This was my first time being so far away from my home and family. For the first few months, I was busy adapting to the new environment and serving the people. Gradually, I was getting familiar with the dialect, lifestyle, social norms, and traditions of this part of the country. Because the higher-level referral health facilities are far away, and mostly unreachable for the poor people, we the medical officers were expected to perform much more than we were trained for as newly graduated medical doctors. Understanding the dialect, lifestyle, social norms, and traditions, while also adapting my clinical practice to rural settings (with limited resources) was a daunting task for a verdant medical officer like me. When I shared with my friends practicing in urban settings some of the cases my colleagues and I were managing at the hospital district,

they sounded surprised. That was not unexpected; I could put myself in their situations.

As I was still at the initial phase of my job placement and trying to adapt to the new environment, the news about the COVID-19 pandemic started to hit and puzzle us. After some weeks, a complete lockdown was announced. With this, the hospital's Out-Patient Department (OPD) was also instructed to be closed; and only emergency cases were attended. We were aware that the issue of Personal Protective Equipment (PPE) was arising everywhere. However, the availability of PPEs in the immediate future in Bajhang was virtually out of question. In the initial days we used locally improvised plastic as protective materials in order to mentally feel like we were protected. Despite all those hurdles, we were still providing essential medical services as regularly as we could. This was while we still did not have access to PPE.

Amidst the initial days of confusion and uncertainty, my colleagues and I were trying to get ourselves oriented to the new pandemic environment. At the same time, I was dispatched to Dhangadi (in the district of Kailali) for the clinical management of quarantine patients there, as per the request of the Health Directorate of the Far-Western Province. As large numbers of Nepali seasonal migrant workers were beginning to return home from India and elsewhere within Nepal, there was a heightened risk of the spread of coronavirus in the province.

After nine hours of non-stop travel by a jeep, I finally reached Dhangadi. As previously informed, I went to the hostel at the training center. I could not find anybody there. The other people at the hostel seemed unwilling to interact with me. It seemed they were avoiding me. I noted the canteen also was closed without providing me with the supper. I began to feel avoided and ignored by all. I then decided to shift to a hotel in town for the night. Later, I came to realize that the people were deliberately avoiding me as I was called there to work at the COVID-19 quarantine hall. They were scared, as if they might be unintentionally infected with the coronavirus.

Despite the acerbic situation, a team was formed to work at the quarantine hall. The following day, the first ever case of COVID-19 was diagnosed in Dhangadi. Family

and contacts were segregated to keep at the specified centers. But, unavailability of PPEs, in addition to the chaotic situation even with the authorities, plus the lack of the provision of a food supply all indicated that the management was not really ready or serious about dealing with the worsening situation. The environment was full of confusion, uncertainty and anxiety. It was chaotic and mismanaged at its best. I realized that simply being a medical officer, there was little I could do by way of sorting out the evolving issues — and given the situation, I came to the conclusion that I would not be able to make a significant contribution to improving care and treatment there. Upon a mutual discussion with the authorities, I returned to Bajhang. Along the road, I sometimes felt as if I was a soldier returning home after losing a war.

Back in Bajhang now, with the pandemic going on, our responsibilities were extended beyond the district hospital. In collaboration with the District Health Office, some of my colleagues and I were assigned to assist with the screening of patients and overseeing the management of quarantine in different rural municipalities. We went to different parts of the districts to perform the Rapid Diagnostic Test (RDT), collect swabs, and observe quarantine. We had to make various public health related decisions, going beyond the usual clinical practices. Still, the swabs needed to be sent to Dhangadi for testing and results, and sometimes it took many days.

Quarantining a high-risk population is known to be an effective strategy towards breaking the chain of coronavirus. We were unable to implement a home quarantine strategy, since separate rooms were not available in most of the homes. Most of the government schools were used as quarantine centers. In some places there was a dispute with the public while allocating the quarantine center. Most of the local people were not in favor of identifying quarantine centers near their residential areas. With all the difficulties and disputes, quarantine centers were made available in most of the wards of rural municipalities. I must note that the local government played a very catalytic role in all these efforts.

With the increase in testing, the positive cases started appearing within the district. Now our major concern was the management of symptomatic cases. We adapted the strategy of keeping all asymptomatic cases at locally identified and improvised isolation centers in the villages. Only the cases needing interventions were shifted to the District Hospital, and further, only the severely symptomatic were planned to be referred out. Until this time (the end of August), we have not referred any positive cases. I recall, there was an elderly male

who was discharged from a local quarantine center after completing 21 days there. His nasopharyngeal swab report was yet to come from Dhangadi. Later we came to know that afterwards he developed acute symptoms the following day after he went home. We were later informed that he passed away. Later his swab report was confirmed to be positive for COVID-19. His contact tracing was done; all swab reports of contacts were negative. As far as I can remember, this was the first COVID-19 death in the district.

As the duration of the lockdown continued to increase, people started suffering other health issues as well. Due to the unavailability of medications, patients with chronic illnesses developed acute exacerbation and landed in the Emergency Department at the hospital. Once I attended a 16-year-old boy with diagnosis of Type 1 DM. I prescribed him an injection insulin and explained to his parents the consequences if medications were not taken. The situation became helpless as insulin was not available in the area. I suggested to him some oral antidiabetic medicines. The next morning, he was at the Emergency Department with loss of consciousness. There were several similar cases: sort of COVID-19 directly unrelated, but with indirectly related consequences.

Similarly, psychiatric issues seemed to increase among people at the quarantine hall and in the community as well. Two persons committed suicide at the quarantine centers in the district. The first person was not a positive case. Going through his suicide note, he had other conditions as well which were responsible for him committing suicide. The second person committed suicide immediately after his PCR report was found to be positive. In hindsight, his suicide was most probably due to the lack of proper counseling and evaluation of the mental status of people in quarantine.

The number of suicide attempts was also increasing at the Emergency Department. Most of them were cases of poisoning. Once I attended a case of OP (Organophosphorus) poisoning. Sadly, we were unable to save her life, but I discovered some important facts while taking her history. The deceased had some depression-like psychiatric illness. She sought help from different health centers locally. Her problems were not cured. None of the health staff who had met with her found the need for referral to a higher center for her problems (we never take psychiatric illnesses as an emergency). Due to the lockdown, she was unable to go to higher centers without a referral note. With hindsight and this bitter experience of this particular case, I have now started exploring for any psychiatric emergency conditions in my patients, and referring on time.

After the initial phase of uncertainty, and the new

experience of the strict lockdown, the situation in the interim period began to improve; and the lockdown was gradually being loosened up. The general public was trying to get a feel of a return to a 'new normal' life in the district headquarters. In all this, one could feel a sense of a tug of war between the general public, with their impatience for trying to return to a normal life, and the pandemic still galloping. These are apparently contradictory forces at work in this community, as in many places.

At the end of August (at the time of writing this), we heard the news of the pandemic wave starting to spread across the country. There have been several COVID-19 deaths reported nationally. Not surprisingly, a new tremor in the minds of people has begun to spread. As a response to this seemingly larger crisis spreading across the country, we have discharged nearly all in-patients from the hospital in preparation for accommodating coronavirus-infected patients at the hospital. Further, a proposal to establish a specialized COVID-19 hospital is in the planning. But this initiative will take time, especially due to the fear, anxiety, and uncertainty in the public at large. Additionally, the PCR test facility that was initially limited to Kathmandu, and then made available in Dhangadi, is now made available in the adjoining district – Dadeldhura. Still it is taking several days before we are able to receive the test results. Bajhang does not have a PCR test facility as yet, but is planning to establish one soon.

It has been eight months since I have been working as one of the front-line medical officers in combating the pandemic in Bajhang. It has been a roller coaster for me, and for most of my colleagues as well, along with hospital staff and the community at large. At the outset, this hospital, like many others, didn't really have any meaningful emergency plan, let alone a strategy for a COVID-19 type pandemic. But we all are learning by doing in dealing with such a pandemic of global proportions. Many lessons, some good and some not-so-good, have been learned in the process. At the personal and professional level, the experiences I have been through have been stressful at times. At the same time, I feel glad that I am here to serve as best I can, together with my colleagues. I feel this experience has made me a stronger professional moving forward. At the health service 'system' level, it has helped me understand not only the weaknesses but some of its strengths as well. I can only hope that there will be a time to do a collective review of such experiences, and utilize those towards building a stronger and more resilient system in the future.

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the Bajhang District Hospital. The views and opinions expressed are the author's own; they do not necessarily represent those of the places or professionals the author is affiliated with. The author is grateful to Dr. Shyam Thapa for his continuous support and also his encouragement for preparing this commentary.

## 'Upon being discharged from the hospital, I felt as if I was released from a prison': The experience of a coronavirus-infected Nurse

**Ismita Sharma**

Birat Medical College and Teaching Hospital, Biratnagar, Nepal

It has been four days since I was discharged (on August 8, 2020) from the COVID-19 (C-19) designated hospital in the city of Biratnagar, where I live and work. I had spent the last two weeks as a Corona-infected patient at the hospital, and upon being discharged from the hospital, I felt as if I was released from a prison.

It all started when one day when the chairman of the Birat Nursing Home, where I work, was diagnosed with a positive PCR (Pulmonary Chain Reaction) test positive result. Once this was determined, all the hospital staff who had been in contact with him were advised to undergo the test. This was on July 24, 2020.

Not surprisingly, a few of us including myself were identified in the "contact tracking". Following the testing, all of us were determined to remain in office quarantine. However, because I had a 13-month-old child, I opted to stay at my own home to quarantine. The next day I heard through the grapevine that the results were all negative. Upon hearing this, I felt elated, and started to play with my 13-month-old.

Later that same night, I received a call from the municipality office: "Your PCR test report has come out positive; because of this, you should not come into physical contact with anybody until we advise you otherwise. We will call you tomorrow morning again. In the meantime, you should also plan to have the PCR test on your child as well as other members of your family." Being a health worker myself, I didn't feel completely surprised or shocked by the message. I took some preliminary precautionary steps at the same time. But, deep in my mind I was still terrified for my family, and particularly for my 13-month-old baby.

The next day in the afternoon, the phone rang again: "You should move into isolation right away. We are planning to send an ambulance to fetch you". Even at that point, because I had not experienced any of the symptoms associated with the disease, I was somehow wishing that the initial test report was a false positive. I was no longer able to resist the phone call for me to go into isolation; and I was advised to go to the hospital directly. Accordingly, I prepared myself to go to the hospital.

In recent weeks, I had heard that Koshi Hospital had been well-prepared to manage and handle corona-infected patients. As a matter of fact, this particular hospital had been designated as the 'Birat Covid-19 Hospital'. Because of this, I decided to pick up only basic essential items for my stay at the hospital. I was in a hurry; and I packed up whatever came to my mind, but not in any leisurely or systematic way.

I had asked the ambulance to wait for me at a short distance from my house. I reached the hospital at around 3:30 pm (on 27 July). As soon as I arrived at the gate, the security guard remarked sarcastically: "Where did you bring the corona from?" This expression hit me deeply inside; as if I had committed a grave crime by having been infected with the virus. For sure, I could have responded to the guard, but I controlled myself. I did not respond. Even after having arrived at the hospital premises, it had not sunk into my mind that I was in fact a coronavirus patient. The reason for this could have been due to the fact that I had not experienced any of the known symptoms of the disease, and I was still thinking that the test result was most likely a false positive.

### *The COVID Designated Hospital*

Upon entering the hospital gate, I was kept inside the ambulance for almost an hour; and I felt somewhat suffocated. For a while, my mind was full of wishful thinking, some unknowns, curiosity, and perhaps some anxiety as well. I was wondering where I might be taken to, where the bed might be, and what procedures I might have to follow and complete. I had no idea whom I was supposed to contact and I where I was supposed to go. Obviously, there was no coordination between the municipality and hospital staff as regards receiving patients in the isolation ward. Finally, I called the metropolis office to remind them that I was still waiting at the hospital for some time.

After them acknowledging my phone call and saying 'just a minute they will receive you', the hospital gate finally opened. That was an hour and a half of my arrival at the gate. I thought, they will have my test report ready to hand it over to me. That was not the case. I asked for it, and further told them that I wished to have the test

repeated. They replied saying it was not possible, while at the same time, showing my report on a mobile phone from a distance. What could I do, but to put up with it? I took a long breath; I consoled myself that if I have to combat the disease, I will. There was nothing I could do.

I was handed over a plastic bag that contained Chawanpras, Ashwagandha, and Giloy (Ayurvedic multivitamin and oral intakes), a sanitizer, a soap, a toothbrush, soap, and one face mask. But none of the on-duty medical or other staff gave me any instruction as to where I was supposed to go, or which space was allocated for me, nor did any of them give me any guidance as to what I should or should not do. I felt like I was being dumped in an isolation ward without uttering a single word. I was surprised and completely saddened by this kind of a behavior on the part of the health workers there.

After having been brought to the hospital gate at 3:30 pm, I finally reached the ward only at 6:00 pm, and that was without any guidance. In the room where I was asked to go, I noticed that there were four sick persons (both men and women). Only one bed was empty, I figured that was probably meant for me. Obviously, both sick and asymptomatic patients like myself were planned to be kept in the same ward. Further, when I looked at the toilets, it seemed as if even a healthy person would get sick by using the facility. As I looked outside, even the premises outside the ward were still filled with heaps of garbage and waste that might not have been collected for at least 2-3 days.

After observing and seeing the situation all around me, I decided to call our CEO and complained in a polite way, stating: "I find that the system is really not set up here to function as any sort of isolation ward, despite being claimed as well planned and organized in the media. I don't even know where I am supposed to stay, or which bed I am supposed to occupy. I feel like I have been thrown in a dumpster. Could you help me to straighten out the situation?"

Most likely, the CEO was not sure if he alone would be able to resolve the situation and make improvements upon my circumstances right away. He might have experienced the management being unresponsive in the past. To make sure that the situation would receive the immediate attention it warranted, I came to know later on that the CEO had alerted the local news publisher (Makalu Khabar) about what I reported to him. Consequently, Makalu Khabar managed to publish it as a headline (with some pictures) that same evening. Happily, this action had the intended result – the management seemed more attentive to the situation from thereon.

My first-hand experience in the isolation ward also made me realize that none of the patients there were as sick as I had imagined beforehand. The overwhelming majority of the patients were asymptomatic. Additionally, the general environment of the isolation was not as good as had been previously claimed. Rather than getting a feeling of having landed at the right place for proper care and treatment, I instead became concerned that I could get sick staying at the ward. I began to feel fear and anxiety crawling inside me.

After making some noise through the system, it was only around 9:45 pm that the hospital arranged to clean a room and prepare a bed for me. While lying in the bed, I became stressed and concerned about my family again. What might my child's PCR test result be like? What about the test results of the other family members? What will they do? How will they handle? For how long? A new place, a new bed, the buzzing of mosquitoes, the smell of garbage just outside the window – all these thoughts kept me awake much of the night; and I couldn't sleep all night. I couldn't even eat the evening meal.

The next day, all my family members had undergone the PCR test. I was informed all the reports came out negative. I felt relieved; I felt as if a very heavy burden that had been weighing on my mind had been magically lifted. Despite this sense of happiness, the hospital's food and the environment were still making me impatient to return home as soon as I could. However, due to my status of being infected, I was forced to remain at the hospital until my PCR came out negative. I had to stay on until I got rid of my infection.

I reminded myself that if we try to seek positivity even within negativity, life becomes a bit more comfortable. While still being confined to the isolation ward and fighting off corona, I tried to motivate and push myself towards finding positivity within me. Gradually, I motivated (or forced!) myself to adjust to the environment. I made my own routine. I started doing yoga as part of my daily activities. Upon seeing my yoga practice, the other coronavirus-infected patients staying in the hospital also seemed motivated, and they joined in. I tried to instruct them as much as I could.

After some days, I noticed that the other patients in my situation began to talk more positively, and I could see the despair in their faces begin to change. I found a new ray of hope and confidence growing in the other patients as they began to believe they could fight off the disease, that they didn't need to be desperate, and that it was important to think more positively – and remember that the confinement is only temporary. From conversations, their self-confidence seemed to grow *by the day*.

### *Hospital Environment and Catering*

Although there were four bathrooms, only one was in working condition. At the hospital, about 55 of us were virus-infected patients, and we all had to use the same bathroom. Not surprisingly, there was often a long queue. I had to get up very early in the morning to use the facility, because if I happened to be late getting out of my bed, I had to face the consequence of standing in the line for a long time.

None of the doctors came to the ward, nor did the nurses. In some sense, it did not feel like I was in a hospital; it felt like I was confined to a prison cell with several other inmates. During my 12-day stay at the hospital, I tried to draw the attention of the management to a number of issues. Some improvements did take place, but many of the improvement practices didn't continue on a sustained basis, and the situation would quickly go back to the way it had been before. To make things even worse, some of the patients who were there as a result of being infected with coronavirus were also assigned for serving meals by going room-to-room. Similarly, other infected patients were assigned to collect information and other details from other patients.

As a principle, I know that it is good for patients not to remain idle. However, in this particular instance, coronavirus may be circulating while in the process of serving meals or interviewing the patients. Above all, when a person is sick, s/he needs some rest, and should not be trying to serve meals to other infected patients. After all, it is a communicable disease that patients in the hospital were trying to fight it off. I did not find it a particularly good practice to engage the patients simply because they still did not have any symptoms yet. I raised this issue as matter of protocol and practice. Following this, the management seemed a bit more attentive to this particular issue. Consequently, the infected patients were stopped from serving of meals or interviewing other patients. Instead, the hospital staff were assigned for these tasks.

On the positive side, I noted that at least the hospital administration had now changed the practice and assigned a separate ward for the coronavirus-infected patients to stay. Also, meals were served on time. The meals served differed according to the health status of the patients. I was happy to note, children and patients with diabetes were served special meals. However, some of the patients complained that some foods were a bit too spicy and oily. Happily, I was able to facilitate to make changes in this sphere as well.

During my isolation time at the hospital, we were all aware that the incidence of infection in the community was on the rise. More and more patients started to trickle

into the hospital. Due to the lack of space, beds were provided in the corridor of the hospital. I recall, one time a snake entered into the area where the patients were assigned. It was around 11 pm, late in the evening. Everyone panicked, many tried to run away. This incidence made many of us stay alert late into the night. The children were especially afraid, as snake bites are not so common in the Terai belt in Nepal.

Every patient inside the ward and on the corridor was consumed with the fear, anxiety, and confusion of having been a coronavirus patient. No one from among the health personnel came to talk with us by way of counseling, or providing us any guidance as to how better to maintain our health and our minds. As I think back as a patient there, it would have been really helpful if the care providers and counselors had visited us to help us keep our spirits high. As a Covid-19 designated hospital, one would expect such services as part of the preparedness plan. As patients, none of us received any information or counseling or any other forms of support. It seemed the staff who were assigned there were not really trained in such matters; instead they were there as any laypeople.

There was no Wi-Fi or TV in the isolation ward. This would have been one way to provide a substitute for counseling or new information. Furthermore, not having access to the Internet during the isolation ward made us feel like the time spent waiting there was an eternity. The term boredom is an understatement – and not having any visits from the medical or health personnel made the situation even more uncertain and depressing to many. The 12 days that I spent at the hospital ward there made me feel like I had been thrown into a prison cell, and I could sense that many others felt the same way.

On the positive side, as I began to draw the attention of the management to the situation, and noted how some of the basic issues could be improved for the mental and physical wellbeing of the patients, including myself, some improvements began to take place. For one thing, some medical doctors started to visit, to make the medical rounds, and talk with us. The other health workers seem a bit more attentive, and no longer seem to treat us like some sort of untouchables. This made me realize that some form of protest is warranted to bring about changes. I recall the saying, “if you do not ask, you may never get it.” But I guess what surprised me was that even the basic issues had to be called to attention. I wondered if our system has become just like that - very callous. If we must launch and protest even for basic things, then I am afraid we may develop a culture of agitation and protest, even for access to basic items and facilities. Wouldn't it be so nice if the State itself understood what is meant to give every citizen access

to essential health care services? I kept wondering what it really means when the constitution of the country has stipulated that basic health is the fundamental right of every citizen of Nepal. Clearly, there is a big gulf between the words on paper and the actual practice on the ground! At times, the hospital management turned a deaf ear when I tried to call attention to the basic needs of the patients in confinement, including myself. These experiences raised many issues within myself and my fellow patients; we had more questions than answers to what we were experiencing.

I felt that no matter how many ministers, mayors, and citizen representatives may have gone to the hospital in the urban municipality for monitoring visits, they most likely never tried to understand the real situation. They would take notice of whatever the hospital management preferred to show them, and whoever they might arrange to meet with the visitors. Such visitors would never have empathy for the patients who needed to be heard. It may come as another surprise to stress that even the bathroom that we, the patients, even had to clean the bathroom we were using ourselves. The hospital management simply did not care. If we did not do it ourselves, it would not even be disinfected.

### *The Behavior of Physicians*

Being a healthcare provider myself, I knew some of the doctors and nurses at the Covid-19 hospital. I knew they were mindful of my being there. This may have helped with their responses, and most likely they tried to accommodate my suggestions, and call for assistance. But the fact of the matter is that most doctors hesitated to enter the ward and wished that they didn't have to visit. Even during the times when meals or other items were being delivered, I often heard them say, "Stay away, don't come close."

For some unknown reason, even on the day I was being discharged I was not informed that my PCR test result had come out negative. I heard it informally through another source. Upon being discharged from the ward, I walked out to the main gate, but the gate remained closed. The gatekeeper had not been informed. Here again, I noticed a lapse in the management; a discharge slip could have helped.

The hospital has maintained one telephone number for registering complaints. I decided to call that very number, and was routed to a staff nurse. With some waiting, I was finally allowed to walk out. I was on the way back to my family after 12 mostly unhappy days. My family remained the source of support that keep me going; thanks to my little mobile phone; it kept me connected to my family.

The so-called COVID hospital has a huge building. The hospital receives a huge grant from the Government, however I felt the resources were not used properly. Having a huge physical space, the management could have arranged separate wards for asymptomatic and critically ill patients. However, this was not done. All types of coronavirus-infected patients were crowded in the same ward. A triaging would have helped manage the patients more efficiently. Moreover, this would have been a better practice at managing patients with a communicable disease.

The physicians at the hospital were provided with personal protective equipment (PPE) for C-19 care. With the PPE on, the doctors could visit and talk with the patients. But even with access to PPE, most of the doctors did not seem to want to even come close to the patients. They were trying hard to avoid entering into the ward. I kept wondering if they did not want to make use of the PPE --- or, if they were so afraid of us, the patients, what was the use of providing them with PPE after all?

If the government really wants to reduce the risk of corona infection, it must first expand the criteria and range of 'contact tracing' and PCR testing. I saw no reason why a protocol could not be developed and implemented whereby the asymptomatic patients could stay in home isolation with monitoring and supervision from the hospital. In my opinion, there should be no compulsion to go to the hospital. A home isolation could be provided as an option to those who have the facilities at home.

With effective and regular monitoring in-place, the home-based isolated patients could be tested after say, 10 days. This kind of triaging could also save hospital beds and costs. Furthermore, the hospital resources could be spent on the really needy critical patients, and then those most in need could get better care and services.

I also kept wondering about the behavior of the educated health workers and hospital personnel in the context of the crisis. If the hospital felt so discriminatory towards infected patients, what about the attitudes and behavior of the less educated and less informed people in the communities where we live? The lay people would most likely behave in a more discriminatory way, with a lot more suspicion and fear. They may not know how to behave and talk in a compassionate way.

Upon returning home, I did not experience any anxiety or fearful behavior from within my family members; they were aware, and they themselves had undergone the PCR test, and remained fully supportive. I returned and felt as if nothing had happened to me, and I was just as before being infected. But one individual that I knew

who had been infected previously visited a local shop to buy some regular supplies, and I was informed that the shopkeeper did not want to accept or touch the paper currency that the person handed over for payment. The shopkeeper feared that touching the money could infect him, even though the buyer had already been cleared of the infection, as I myself had been. It was rather sad to know that even the infection-free person was discriminated against. This underscores to the need to have a more effective public mass awareness. Surely, the pandemic has created a lot of suspicion, confusion, fear and anxiety in society – and it is also equally important to address these issues in effective ways.

### **Concluding Remarks**

My sense of frustration and disappointment clearly highlights the large difference in my own expectations prior to being admitted to the hospital, and what I actually observed and experienced during my stay in the hospital. Whereas for the hospital administrators, the claim of ‘being prepared to handle coronavirus-infected patients’ might have meant having allocated a ward for the infected patients, I was also expecting a management and personnel system well prepared to handle the patients from their arrival to departure to be efficient and effective. The media hype implied so. Clearly, that was not the case.

I must also note that having been employed at a private health care facility, being an actively working nurse, a young mother with a child less than one year old, and the news hype regarding how the hospital had been prepared to deal with the pandemic, were all factors that certainly could have contributed to creating a wider gulf between my expectations and reality. My own prism was certainly colored by these factors. As such, another person could have had a less critical experience than my own. Also, it is important to note that writing down my feelings immediately after being released from the hospital also worked like a form of therapy by lightening up my inner feelings of despair, anger, and frustration. Had I documented the same experiences a few weeks down the road, I am sure my own feelings would have been toned down somewhat. At the same time, being a health provider myself, and the experiences from the other side has hopefully made me more empathetic too.

Overall, my experience shows that the system, particularly the health system, could do better in many areas that would not require additional resources – and the health system needs to do so. Some of it has to do with attitudes and behavior, while other issues will require making deliberate changes in the way the health delivery system is delivered and managed. The time has come for all of us to start doing the right thing and forgo the “business as usual” attitudes. In some

ways, as distressful as my experience was, I must admit I now have a much better appreciation for how much even small issues matter to the patient at the receiving end of the service delivery. I hope this kind of first-hand experience will help make an improvement in the system. There is still a long way to go in the development of a patient-centered approach to care and treatment, but it is never too late to begin.

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## From the Desk of a Psychiatrist: Emerging Mental Health issues during the COVID-19 pandemic in the Kathmandu Valley

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In Nepal, the first strict and complete lockdown due to fear of the coronavirus was imposed beginning March 24, 2020. Since that time, a strict lockdown has been enforced multiple times and for protracted durations. Therefore, for several months, people have been living amidst fear, anxiety, and uncertainty. As I prepare this note (the last week of August 2020), this climate of fear and uncertainty continues. Due to the long and protracted period of confinement, and the adjustment to the current status of staying in, it is expected that various factors associated with mental health may rise in individuals and the communities they live in.

As part of my research and livelihood, I continue to see mental health patients at one large hospital (200 beds), one specialized hospital, and a private clinic located in three different locations in the city of Kathmandu. Since March of this year, I have probably seen around 500 patients in my clinics with varying degrees of mental-health related issues and problems. In this note, I will try to decipher what has emerged from the clinic population that I have talked with and consulted over the last several months. The patients who cared to visit my clinic are probably only the tip of the iceberg. I am sure there are still many individuals with symptoms or issues who could not come for consultation, or may have tried to ignore the problems for various reasons. This is not intended to be a representative sample or research, rather it is a summary based on what I have observed. This may also help communities and families to prepare themselves for people who may be in need.

It seems almost everyone I have met during this period has had mental stress, directly and indirectly, related to COVID-19 and associated lockdown. Among the patients, there were similar numbers of males and females; most of them were older than 40, and only few younger than 18 years old. As the public vehicles were not running during the lockdown, most of the people who visited me during these times were those who had their vehicle, or who lived close to my clinics. The patients represented mostly middle or upper socioeconomic strata.

Many of the patients expressed their fear of contracting coronavirus themselves, or a fear that one of their family members might contract coronavirus. They were also troubled by their loss of income as well as restriction

movement due to the lockdown. These stressors have led to symptoms like disturbance of sleep, irritability, restlessness, low mood, and even physical symptoms resembling coronavirus infections such as shortness of breath, dry cough, feeling feverish, etc. Many of them had excessive worries regarding coronavirus related to their job, or source of income. Anxiety symptoms were the most common symptoms encountered at these times.

The most common illnesses were acute stress reactions, generalized anxiety disorders, obsessive-compulsive disorders, and hypochondriasis. A moderate number of patients showed symptoms of depression. Many of them had a history of depression or long-term anxiety. Issues related to alcohol and other substance abuse has also increased during these times. Some of the patients have increased their drinking habits as they have been idle as well as stressed, and thus have been consuming more alcohol to pass their time, and as a coping mechanism to handle their stress. Patients related to schizophrenia and other forms of psychosis were few and their number remained unchanged.

Many of patients had an excessive fear that they would contract coronavirus from anything they touched. Hence, they feared touching anything in the hospital or even sitting down on a chair. I had to convince quite a few patients not to fear sitting down on the chair during the consultation. I recall, one was so fearful of touching the door handle that he requested me to open the door for him when he wanted to leave the clinic after the consultation. Another patient came to me with complaints of repeated dry coughs and the feeling something had gotten stuck in her throat. She initially thought that it was a symptom of coronavirus infection so she visited an ENT specialist, who then referred her to me as there were no physical findings. When I explored her symptoms, I found out that since she heard the news of the detection of patients in Nepal, she had started having anxiety symptoms. These physical symptoms were also an outcome of anxiety disorder.

Another issue the patients are facing these days is difficulty in accessing medical help due to the lockdown. Many of them, especially those outside Kathmandu, have not been able to come for follow-ups since March. One of my patients, suffering from depression, had been in my continuous care for a few years. She could not

come for follow-up due to the lockdown, and hence she had stopped her medicine. In a few days of stopping her medication, her depressive symptoms reappeared and she tried to commit suicide by ingesting poison. She was brought to the emergency room (ER) in an ambulance and was shifted to the ICU.

The spread of misinformation, as well as lack of accurate information regarding COVID-19, has also increased anxiety in many patients. An old lady came to me with complaints of disturbed sleep, palpitations, and shortness of breath. She was living alone in her house which is around a kilometer from a major hospital in Kathmandu. She had moved to her relative's place quite far from the hospital. When I asked her why she did so, she told me "I have heard that coronavirus transmits through the air and the hospital where patients with coronavirus are treated is around a kilometer from my home."

During normal times, many people were handling their stress or even symptoms of mental illness by using several coping mechanisms such as exercise, involving in outdoor activities, meeting friends and close ones, and sharing their stress. Surely, the lockdown has robbed all of us from these coping mechanisms. Several of my patients who were doing well under treatment have relapsed despite continuing their medications because they have no way to relieve their stress.

A girl in her mid-twenties had been having obsessive-compulsive symptoms for several years. She had been handling all these symptoms by herself, without any professional help by inventing her own coping mechanisms. But during the lockdown, she got confined to her house and she could not combat her symptoms and had come to me for help. She said, "This lockdown has made me helpless against my symptoms. I would go for a walk or would engage in an activity if the symptoms appeared but now, I can't do those things!"

The lockdown stress seems to have influenced people's use of alcohol as well. It seems the use of alcohol and the misuse of other illicit substances has also been on the rise. A 12-year-old girl came to me with fainting like attacks, and when explored in detail, they were symptoms of conversion/ dissociative disorder. The main stressor that had led to this improper coping mechanism was the quarrel between her parents. After probing further, it turned out that this was related to her father's increased drinking habits due to the loss of his job during the lockdown. When I explained this situation to the father he was tearful and commented, "I saw drinking as the only way to handle my stress related to finances and worries about how to sustain the family".

The cases I have seen during the pandemic period are

probably only the tip of the iceberg. Additionally, the clinics that I attend are most likely out of the reach of many poorer segment of the population. The mental-health related problems faced by the poor or the poorest segments could be many folds worse than those who could afford the hospitals where my clinics are located. Despite this limitation, it is clear that the pandemic-related stressors have risen over the last several months.

This is a time when the modality of health services has changed quite a bit all over the world, including in Nepal. The promotion of tele-health services for addressing mental health issues through the use of mobile phones and the internet has been seen as the necessity of these times and the future. Doctors have been attending a lot of calls from patients as it has been more difficult for patients to be seen at a hospital. Avoiding hospital visits for a refill of medicine is one way of reducing movement. This can only be possible if doctors provide service through phones to their patients in their free time. All should be aware that following good sleeping patterns and continuing social communications are of utmost importance to maintain psychological stability in these times. Further, doing regular meditation and exercise helps in maintaining good mental health. At the same time, avoiding excessive screen time and following a reliable source for information and news has been advised, and are of importance. Further, conscious efforts would need to be made to try to avoid the consumption of alcohol and other substances of abuse by way of avoiding stress. These are challenging times for all.

From what I have seen and observed among the hundreds of patients I have seen over the last six months, I can conclude that mental health issues have not only disturbed patients in their own individual lives, but have impacted the lives of their family members, and their working environment. Many patients channel their anger and irritation towards their family members, hence creating disharmony and quarrels in their family life. Some of them have had left their jobs, and some have also not been able to focus on their work well due to these issues. One indication is also the rising trend of the suicide rate in the country. Like many other countries around the globe, Nepal is undergoing very difficult times. Community and family support and compassion are needed more than ever.

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## Higher Workload Experienced by Women During the COVID-19 Lockdown Period

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The COVID-19 pandemic has affected all aspects of human life. In Nepal, a strict lockdown was imposed by the government starting on March 24, 2020. This resulted in all citizens having to be confined to their respective homes. Families who could afford domestic household staff and had arrangements for live-out domestic workers were then left on their own, since the commuting housemaids could not travel to and from work. In this climate of home confinement, the burden of all the household work – ranging from cooking, cleaning, washing, and managing children – most likely fell on the women in the household.

We postulated that one of the consequences of the lockdown is an increased workload for women in the household. For the purpose of assessing this hypothesis, we designed and implemented an online survey (spanning 3-5 minutes), and also conducted telephone interviews with respondents who did not have access to the internet. We collected data for eight days in early May (in 2020). We obtained a total of 317 responses from 29 districts in all seven provinces in Nepal.

The average age range of the survey respondents was 21 to 35 years. Three-fourths of the respondents were married women. Just over 50% of the women had completed a post-bachelor degree. A large percentage of them were engaged in the non-governmental (NGO) sector.

Obviously, the survey included responses only from those women who wished to respond, and had access to the internet or a telephone, and furthermore, were interested in responding to the request. Mindful of this limitation in the data obtained, we summarize the main findings that emerged from the survey below.

Nearly half (48%) of the women reported that household/care work during the lockdown has been challenging because of the increased work burden. Similarly, 47% of the respondents stated that they also had to extend their office work hours. Nearly two-thirds (65%) claimed that balancing work for both home and professional career had been a challenge. Further, the working office hours were extended for the majority of unmarried women. However, doing household work had been comparatively more challenging to married women than single women (50% v 32%). Overall, the overwhelming

majority of the women (80%) reported increasing their working hours, from one hour to more than four hours.

Nearly one in 10 women did not get any help from their family members in undertaking household chores. Consequently, they needed to increase their workload, particularly during the lockdown. Nearly half (47%) reported that they had the burden of multi-tasking. Likewise, one-third felt they had an increase in stress. They also stated that other family members were expecting all the household chores to be done by them. Some women (4%) also experienced having to spend a lot of time dealing with an abusive spouse.

Despite having had the additional burden of household chores during the lockdown, the overwhelming majority of respondents (82%) felt that they did not have any particularly bad experience, but that they had a good experience in being together with family and being confined in the house. Three out of five respondents felt that they were protected from the coronavirus by being confined to their homes. They did not have to spend time commuting to and from work, they were able to apply their discretion in managing office work from home, and they were able to balance and manage time between home and office work while at home.

The lockdown also adversely affected the health of the respondents. Nearly two in five reported having faced some kind of psychological health issues. About 31% reported having had physical health issues, and additional one in 10 reported to have experienced sexual and reproductive health issues.

The above data make it clear that the protracted lockdown period in Nepal has placed an additional burden on women, and particularly on married women. The women were multitasking as a coping mechanism to accomplish the work of both home and office during the lockdown. It is also clear that the women have felt additional stress, and have experienced additional mental and psychological health problems during the lockdown period.

Clearly, domestic work is still considered a gendered work; primarily a female's work, and married women share more burden than single women in their households. Conscious efforts, through discussions and awareness, need to be made so that domestic work such

as cooking and cleaning are not a gendered role, but rather viewed and treated as basic life skills. Such an orientation can and should begin with the family at an early age. Expectedly, a change can come about easier and faster in urban and educated households, than in the more rural and less educated households.

Communities and public entities should be engaged in addressing the inequalities and identifying strategies for reforms. It does take time for the century-old gender-based roles in the organization and management of households and community to shift, but it is never too early to begin making changes in the right direction. The data, as presented here even with its limitations, stress the areas that need attention. The current pandemic has provided the opportunity to revisit some of the areas of gender inequalities. If anything, the confinement period during the pandemic has aggravated the inequalities and inequities even more strikingly.

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## COVID-19 Kaleidoscope on the FM Radio

**Samjhana Paudel**

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Since 1991, there has been a proliferation of FM radio stations in Nepal. As of now, there are approximately 500 FM radio stations operating in the country. This represents a huge revolution that nobody could even imagine before the 1990s, when the century-old authoritarian political system was rooted out and a multiparty system was ushered in. In the midst of the COVID-19 pandemic, a Kathmandu-based private media house, Outline Media, designed a program known as, “Korona ka Kurna” (Corona Matters). It is a 30-minute-long weekly program, hosted by Samjhana Paudel and Sushil Sharma, that is broadcasted in Nepali over the FM radio.

The second session of the program was broadcasted on September 11, 2020. This particular session tried to bring in a kaleidoscope of materials from various spots around the country, presenting stories of individuals and their efforts aimed at mitigating and combating the pandemic. This article highlights three stories – stories of the unsung heroes in the ongoing pandemic.

### *I. Serving meals for the hungry in Kathmandu*

The pandemic that hit Kathmandu in March (2020) has necessitated strict lockdowns at times, meaning there were no jobs available for daily wage earners and daily laborers in particular, many of whom are from the Kathmandu Valley. This has resulted in many of these laborers not having enough money to buy food; and many have gone hungry at times.

In order to address the situation different groups have started up small initiatives to feed the hungry in Kathmandu. The Khula Manch (open stadium) in the center of the city is where people from all walks of life queue up for a hot meal every evening. Indira Rana Magar hands out pre-packed meals to those who may want to take the packed food home to share it with others.

Lila Thapa, representing the Single Women Society, has set up a Food Bank in the Budanilkatha area for the last four months. In her words, “it is a place where one who likes to donate foods, can donate; similarly, one who needs it can come and get some food.” This program is continuing on, and more and more people from both spectrums are participating in the program.

Anshu Yadav came up with the concept of “100s groups”. After realizing what was going on in the city,

he thought of the idea with the motto that no one should die of hunger or be left hungry. The idea was to serve at least one hot meal to the hungry stomachs in selected places in the Kathmandu Valley. To start with, the group planned to feed the hungry for one month, if not longer. They said that the demand has been overwhelming; and that there are hungry people who have not had any work or income for several months. As such, particularly for those relying on daily wages from manual labor jobs, the demand for services has vanished. Consequently, there have been days when they go hungry or try to survive on very little food.

The program has provided a bridge for many hungry people in the city. Still, there is no letup in sight. There have also been many ups and downs running the service. For one thing, there is a shortage of funds to buy the necessary items, and there are days when they can’t find enough people willing to chip in. The manager stated, “on certain days when we don’t find any philanthropists, we try to reach deep into our own pockets and try to serve hot meals to 600-700 hungry stomachs in Kathmandu every day”. However, each day remains full of enthusiasm and teamwork, and feeling satisfied in meeting the challenge. Yet, the group is uncertain how long they may be able to continue with their mission. It largely depends on when the strict lockdown may be lifted.

### *II. Making a space for the infected women in Dhangadi*

In Dhangadi, a metropolitan in the Terai in Far-Western Nepal, Ms. Hira Bhandari has converted her 10-year-old polyclinic facility into a holding-quarantine-isolation shelter for corona-virus infected women. As for the main motivating factor for establishing the facility, she commented, “if everyone would start discarding and avoiding people infected with the coronavirus, then where will they go and what will happen, particularly to women who are pregnant or have a young child in their laps?”

Even if there are some places that the government has tried to set up, many places do not seem “women friendly.” There have been reports of violence against the women, including rape. In consideration of these factors, Hira felt the need for a women-friendly shelter during the COVID-19 crisis.

Hira encourages the boarders to get up early and do yoga. Those with children have special places to play

with children and let them enjoy themselves. During the day, each boarder is also encouraged to sit in the sun at least 30 min, and some may try to do some walking. This is followed up by an evening with songs and sometimes dance to make the boarders come alive and forget about their disease. This also may have contributed to a more rapid recovery.

The facility provides special care, counseling and services to pregnant borders. They also receive more nutritious meals. Additionally, other women who may have a quarantine facility at their own places may not have access to medicine, care treatment, or sanitary pads. These are all provided at the facility. Hira feels that the comradery also provides much-needed self-confidence for the women. In the words of a boarder, “Once I was informed that I tested positive, I was scared as to what would happen to me, where I might be taken to, what I would do. I cried all night. But when I reached this place, I felt secured and relived of much of my stress. This place has provided all the basic things that we needed. This is a good feeling to be cared for and not avoided or boycotted by others, that could happen within a family or in the community where I come from. I feel good that I have found a place like this in this time of crisis.”

Commenting on the rewards, Hira said, “After some of the borders are free from the virus and once are ready to leave, whatever good wishes and gratitude they express, I consider that to be the best blessing I could ever get, and seeing their joyous and gracious faces makes me feel I have been successful in my mission.”

### *III. A couple doctors providing maternity services in the District of Jumla*

About a year ago, Dr. Subi Basnet, an obstetrician and gynecologist, and her husband Dr. Rabin Khatun, an anesthetist, decided to take up work at the Karnali Academy of Health Sciences (KAHS) in Jumla, a remote mountain district in Karnali Province. At that time, they left their 19-month-old daughter in care of her mother back in Kathmandu.

In the meantime, the pandemic hit. Had they wanted to, they could have gone back to Kathmandu once the pandemic began to proliferate, but they decided to stay on in Jumla. Dr Basnet says she, “did not have a second opinion as to whether she should stay back or go back to Kathmandu. This is probably because I have been happy working and living, and, above all, am satisfied with my work.”

According to them, the number of patients presenting themselves to the KAHS Hospital has increased more than two-folds in recent months. The demand for services is increasing, not decreasing. The couple is happy to see

the patients leave with smiles on their faces. During this time, the couple also even managed to do a surgery on a pregnant woman infected with coronavirus. Happily, the hospital has managed to make special spaces for infected patients.

Dr. Basnet reflects, “Sometimes, I wonder if it was perhaps a bit too early for me to leave a 19-month-old daughter back then. But, I also hope that I will be a role model for my daughter when she grows up.” While she is happy to have continued serving, the people of Jumla, especially the women needing maternity care, are thankful to have her around for them during the pandemic crisis.

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Note: The materials presented in this piece are extracted from an episode of the FM radio program, *Corona ka Kura*, hosted in Nepali by Samjhana Paudel and Sushil Sharma on behalf of Outline Media Studio ([www.outline.com.np](http://www.outline.com.np)) in Kathmandu. The additional contributors/reporters to the program were: Sabita Buda for the report on Dhangadi and Mandira Adhikari for the report on feeding the hungry.

## Rising Levels of Suicide during the COVID-19 Pandemic

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The long-protracted pandemic situation in Nepal (since March 2020) has continued to take a toll in all spheres of Nepali society. At the family and community level, impacts of the pandemic have included mental stress, anxiety, loss of work and income, and domestic violence (on account of being confined to the home), while on a larger scale, the crisis has also led to the near stalling of the national-level economy as a whole. Various newspapers have reported a higher number of suicide cases, particularly during the pandemic months. In this note, first I try to provide a review of the national level trends in suicide, and then present some specific cases from different communities in Nepal.

### National Levels and Trends

The Police Headquarters in Kathmandu compiles data on suicides reported and recorded at different police stations throughout Nepal. Obviously, these data do not include the many cases that may have been unknown or unreported for a variety of reasons. Further, these data do not include the many cases of individuals who may have attempted suicide, but that did not actually result in a suicide. These data represent the actual suicide cases. Notwithstanding these limitations, the data help us gain a picture of the levels and trends over time.

Figure 1 shows the number of cases of suicide, by male and female, for a period of 24 months, from the month of Shrawan 2075 (corresponding to mid-July 2018) through Ashad 2077 (corresponding to mid-June 2020). Several points emerge from this data.

First, during the 24 months period, a total of 12,061 suicide cases were reported. This implies an average of 502 cases per month or 17 per day. Second, the data also

clearly indicate that the number of male suicide cases are consistently higher than female cases. For every 100 female cases there are 138 male cases. Third, the incidence tends to be higher during the months April-June.

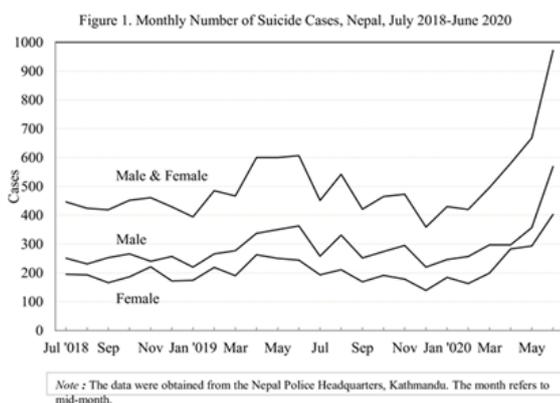
It is also obvious from the data that suicide cases rose sharply after the third week of March 2020. This coincides with the time when COVID-19 (C-19) hit Nepal and the first complete lockdown started. During the three months April-June 2020, there were a total of 2,220 cases. In contrast, there were only 1,807 cases during the same three months in the year 2019. This represents a 23% increase over the same time period in the immediately preceding year. During the three-month period in 2020, an average of about 25 cases of suicide cases were reported and recorded. The national level data, therefore, make it unequivocally clear that the number of suicide cases has risen, especially during the post-lockdown period.

### Individual Illustrative Cases

In order to go beyond the numbers and understand the context of some actual cases, below I present some specific cases. Some of these cases were reported in various local journals, while others were reported by myself during a field visit.

*Case #1, Bajhang District, Sudurpashchim Province.* On June 1, 2020, an 18-year-old male (with last name Raut) had returned from India, together with a group of 16 seasonal migrants, to his home in Khaptadchhanna in the district Bajhang. Upon return he, along with other returnees, was placed in a quarantine in the rural municipality where his home is located. Thereafter, he was sent home. In the meantime, the test result of his PCR (Pulmonary Chain Reaction) had been obtained. One day, when he was in the field attending to his buffalos, "someone informed him over the phone that his PCR result had been obtained by the local authority, and that he was infected with Coronavirus. Upon hearing this, he apparently hanged himself from a tree nearby the field where he had taken his buffalos for grazing," noted Ram Bahadur Singh, Chairman of Ward 7 where the victim lived.

*Case #2, Bajhang, Far-Western Province.* A 30-year-old person in Bajhang (Chhabispathivera rural municipality) committed suicide while still placed in quarantine at



a local school. He had returned home from India just three days before he took his own life. Several friends who knew him had mentioned some strange and unusual behavior he had displayed. “Immediately upon arrival at the quarantine he used to remark that corona is all a hoax; it is nothing but a hype, aimed at giving us trouble. Sometimes he would be in a jovial mood, while on other days, he would sit in complete silence. One day he had told us that he wanted to go to his home, and keep himself locked in a room in his own house. On the third day of his quarantine, “we came to note later in the morning that he had killed himself by hanging in the middle of the night,” remarked a 19-year-old companion who was also in quarantine. “We feel, if he had he been seen and counseled by a psychiatrist and given appropriate care, he might have been saved from killing himself”, remarked one of the three companions placed together with the victim in the quarantine location.

*Case #3, Dailekh, Karnali Province.* On June 23, 2020, Hamal, a 21-year-old person living in Dullu urban municipality in the district of Dailekh (Karnali Province) killed himself. Upon returning from seasonal employment in India, he was placed in a 14-day quarantine in the facility arranged by the municipality. He committed suicide 16 days after he was sent home. His postmortem result confirmed that he had been infected with the Corona virus. According to a friend, who is also a social worker and someone who knew the victim well, the victim had been visiting India for seasonal employment ever since he was a 12/13-year-old. His father had also been missing for 10 years, when he had left for a seasonal employment in India. The victim had complained to his friend that he had to return to his village without any money in his pocket due to Corona. On the top of this, his own mother had become an alcoholic, and thus was ostracized and stigmatized in the society. “These hard situations must have made it difficult for him to lead a life in the village, and hence he resorted to taking his own life. Most probably, he didn’t see a way out of his worsening situation,” commented the social worker who knew the victim.

*Case #4, Arghakhanchi, Lumbini Province.* BK, a 45-years-old, living in Sheetganga urban municipality, was informed on June 16 (2020) that he had tested positive in his PCR test results. He belonged to a disadvantaged and very poor family. Reportedly, he was in a deep financial situation of repaying a loan and borrowing. He was still in quarantine and could not see how he could pay off his loan to the money lender and maintain his family expenses, especially after he got sick. He was concerned about not being able to work and earn a living. He hanged himself from a tree while still in a quarantine.

*Case #5, Kathmandu, Bagmati Province.* YP Sapkota, 47, had posted on his Facebook page that he was “facing difficulty in finding enough to eat due to the strict lockdown”. He was found hanging in his kitchen at 10 pm in the evening on September 7, 2020, the same day he posted the status on his social media page.

He had been operating a hardware shop near his home. Because of the strict lockdown, his business had come almost to a close in the last six months. He was facing increasing difficulty in collecting money from his clients who had bought retailers. According to his older brother, he had to collect more than Rs 17.7 million from the market. He had recently bought a parcel of land just before the lockdown. He was very worried about the ever-sinking situation, and probably felt there was no way out of this.

*Case #6, Dhanusha District, Providence 2.* B. Yadav committed suicide two weeks after he returned home from the isolation ward at the Janakpur Province Hospital. He had been away in Rajasthan (India) for seasonal employment, but returned to his home due to COVID-19. He was confined to isolation on account of having Corona positive test results. After not finding any signs or symptoms of the virus, he was advised by the hospital to return home. Despite this, his family members felt that he was still a potential threat to the other members of his family, and barred him from entering the house. His family served him meals on tree leaves outside his home. Anil Yadav, chief of the Mithila Bihari Urban Municipality, suspected that Yadav decided to take his own life after being stigmatized by his own family members. “It was probably too much for him to take,” he opined.

*Case #7, Morang District, Province 1.* Darji, 47, lived in a homeless settlement area (sukumbasi basti) in Sundarharaicha Urban Municipality in Morang. He was supporting a family of six by doing manual work in the construction sector. In the meantime, a middleman convinced him that his wife should go to a foreign country for employment. With the expectation of a higher income and better life down the road, he took his wife to Delhi to fly out. The lockdown started within a couple of days and consequently his wife was stranded in Delhi. Back in Nepal, his job stopped due to the onset of the pandemic. His income from his work came to a full stop. He even had to sell the gas cylinder that he had in his kitchen to feed his two daughters and one son. Still, there was no sight of resuming his work. He took his own life. According to one community leader, he didn’t even have a handful of rice to place on his chest after his death. They collected money for his cremation after the postmortem.

### ***Discussion and Conclusion***

These cases are just some of the stories of hundreds of individuals who killed themselves during the pandemic period. Surely, there may be thousands more who may have tried to end their lives but did not succeed due to various reasons. The loss of life on account of desperation points to some basic steps that could be taken towards minimizing these tragedies.

Many districts in the Mid- and Far-western regions of Nepal are known to be impoverished. Even for the vast majority, who may possess some parcel of land, the land area still may not be enough to sustain the livelihood of their families. Furthermore, the productivity of the land is typically known to be low. In these situations, at least one able-bodied person from most of the households in these impoverished areas also supplements their livelihood by going to adjoining areas in India for seasonal employment. Typically, most of them return around February/March to attend to their farms. This routine cycle of going away for some months for some income and then returning to their farms for cultivation was disrupted in the first quarters of 2020.

Many who were on the way back to their homes were stopped at the border and stranded there for several weeks. Whatever money they may have managed to bring back with them had to be spent while waiting to cross the border and return to their homes. This disruptive factor not only forced the seasonal migrants spend their money while waiting to return home, but also meant that they couldn't work in their fields. Thus, this created a double burden for many.

Among those who managed to return early to their respective communities, several seasonal migrants either had to be quarantined or isolated without much family or community support. Understandably, the temporary facilities, even health facilities, were not prepared to engage and mobilize trained counselors to provide the necessary support. Furthermore, the local authorities or communities were not prepared to provide any economic or other forms of livelihood support. Consequently, many who were already vulnerable probably did not see any way out of the situation. Thus, the stories of suicide from across the country during the pandemic are largely a story of desperation and economic vulnerability pushing individuals to them to kill themselves. In addition, there appeared to be other types of mental stress and stigma associated with the pandemic. The situation becomes all the more difficult and challenging especially when trying to reach out those with little and no education.

The COVID-19 pandemic has exacerbated and compounded poverty. It has most likely made the

poor poorer and vulnerable even more vulnerable. The pandemic has, thus, hit disadvantaged citizens the hardest. These are tragedies within the larger tragedy. Also, when the head of a family is gone, it affects the wellbeing and the future of especially the children left behind. Better and more effective social protection policies and programs need to be explored and put into place. The rising trends in suicide and a few of the brief, individual stories highlighted in this article underscore these existing gaps. The challenge now is to learn from these tragedies and find solutions and approaches for moving forward.

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