Nepal
Rapid gender Analysis for Sindupalchowk

**Introduction**
Rapid Gender Analysis provides information about the different needs, capacities and coping strategies of men, women, girls and boys in a crisis. Gender analysis does this by examining the gender-relations between men, women, girls and boys. This Rapid Gender Analysis is designed to provide an overview of the gender-relations between men, women, boys and girls affected by the crisis in Sindhupalchowk District.

**Method**
This Rapid Gender Analysis uses secondary data analysis to collect data and information. It is also based on the CARE Emergency Pocketbook’s Rapid Gender Analysis tool adapted from the IASC Gender Handbook in Humanitarian Action.

The sources of information used in this initial analysis include: secondary data analysis, focus group discussions and key Informant interviews.

Dates: Primary data was collected from the 13 May 2015 to 15 May 2015

**Gender Relations in Nepal Overview:**
The overall analysis for Nepal is attached in the hyperlink below.

[Click Here](#)
Gender Relations in Sindhupalchowk Prior to the Earthquake

Gender relations between men, women, girls' and boys' in Nepal vary depending on a variety of interrelated factors including: context, caste, religion, education level, socio-economic class and urban/rural divide. Sindhupalchowk District is one of the 75 districts of Nepal, with an area of 2,542 km2. The district’s capital and coordination centre for the response effort is Chautara.

- The population of Sindhupalchowk was 287,798, according to the 2011 Census, of whom 48 percent were male and 52 percent female. The population consisted of 66,635 households, with an average household size of 4.32 people (almost 26% percent of households had more than six members).
- 24% of households are female-headed in Sindhupalchok, slightly lower than the national average of 25.73% and much lower than Gorkha where it is 37.20%. Male-headed households in which the head of the household is aged 50-70+ was 24% percent of all households).
- 4.4% of the female population in Sindhupalchowk was comprised of widows, divorced or separated women, compared to the national average of 5%. There is discrimination against single women in Nepal, especially those who have been widowed.
- Child marriage is prevalent. Among marriages recorded in Sindhupalchowk in the 2011 census, the majority involved at least one spouse aged 19 or under (see table). This is a particular area of concern, because child marriages are likely to increase post-crisis as a form of protection and as a means to ease family economic burdens. 20% of girls are married by the age of 14. While 55% of all married females (45,000) were married between age 15 and 19; which is still almost double the 27,000 boys married at that age.
- Only 12% of households reported that female members owned fixed assets (house, land or both), much lower than the national average of 25.73%. Thus 88% of the female population does not own any fixed asset, compared to national average of 79.5%.
- The 2011 census identified 2.3% of the Sindhupalchowk population as having a disability. However, the census uses self-identified disability. Due to a lack of knowledge of what qualifies as a disability and stigma around certain disabilities, these figures should be assumed to be much higher. On average, 15% of any population has a disability, and females have a higher rate of disability than males. The global average of 15% varies from context to context according to a number of variants.

In Nepal, 38.16% of all households had no toilet, while in Sindhupalchowk one third of the population did not have a toilet though this will be significantly higher post-quake.
### Sex and Age Disaggregated Data

<table>
<thead>
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<th>Sex</th>
<th>Male</th>
<th>0-4</th>
<th>5-19</th>
<th>20-59</th>
<th>60+</th>
<th>Female</th>
<th>0-4</th>
<th>5-19</th>
<th>20-59</th>
<th>60+</th>
<th>Total</th>
</tr>
</thead>
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<tr>
<td>Age group No</td>
<td>11,819</td>
<td>50,517</td>
<td>60,087</td>
<td>15,928</td>
<td>11,705</td>
<td>52,494</td>
<td>69058</td>
<td>16190</td>
<td>287,798</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% by sex</td>
<td>4.1%</td>
<td>17.5%</td>
<td>20.9%</td>
<td>5.5%</td>
<td>4.0%</td>
<td>18.3%</td>
<td>24.07%</td>
<td>5.6%</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In Sindhupalchowk there are more women and girls (52%) in the district than men and boys. This trend is common to all age brackets except ages 0-4 where there are slightly more boys than girls. This is in line with normal sex ratio at birth for Nepal. There are a total number of 66,635 households in the district. CARE estimates that there are 17,325 female-headed households in Sindhupalchowk based on the national average of 26% of female-headed households. Size of the households varies but on average there are six persons.

### Education

Men and boys in the district are significantly more literate than women and girls: 68% of males can read and write; while only 52% of females can do the same. The illiteracy rates in Sindhupalchowk are higher than the national level. Boys are more likely to be educated than girls across all forms of education from primary to post-graduate.

### Religion and Caste

59% of the Sindhupalchowk population is Hindu while 38% is Buddhist. There are four major caste groups in the district: Tamang, Chhetree, Newar, and Brahmin. There are also some 22 other castes represented in the district, and care must be taken to consider the needs of smaller caste groups, especially those of lower social status. Practitioners need to be aware of the need to consult members of minority religions such as Christians (2%), Prakriti (1%) and very small communities of Muslins, Kirati, Bon, Jain and Bahai.

### Initial Gender Recommendations

From these primary and secondary sources of information on gender relations in Sindhupalchok, the following initial recommendations are suggested to support gender-sensitive programming and gender mainstreaming, and to start developing gender-specific projects. Given the incomplete nature of this rapid gender analysis, the recommendations may change as more information becomes available.

### Overall recommendations:

- Ensure both women and men are consulted when determining priority needs and distribution mechanisms.
- Ensure women are represented in all decision-making and consultation structures. All committees being set up, either by organisations or local government, should have at least 50% women. Equal number of women and men should be in leadership positions.
- Consult with and involve women’s civil society groups and women of all ages, including those who are hard to reach or at risk such as women with disabilities.
- When moving towards early recovery stages, ensure that women are provided with livelihoods and income generation opportunities based on direct...
consultation with them and that activities are tailored to their needs, circumstances, and capacities.
- Ensure equal access to services for all religions, caste, class and ethnic groups. This is vital.

**Suggestions received from CDO, LDO, WDO and Social Worker**
- CDO of Sindhupalchowk Mr. Krishna Prasad Gyawali suggested that the resettlement plans consider reconstruction at existing housing sites and that construction should involve community members and train them to build structurally sound homes able to better withstand earthquakes.
- Local development Officer (LDO) of Sindhupalchowk Mr. Yuba Raj Kadel said relief material distribution has prioritized the poor and vulnerable as a result of close coordination with government. He said local government has been very effective and efficient in distributing relief material and has set a standard for future operations. He underscored that this has helped government receive support from the community and impacted their ownership of efforts.
- Woman Development Officer Ms. Sandhya Rajeshwori Shahi said GBV and protection have been overlooked during the relief effort and therefore a special task force and/or watch group is required immediately to monitor distribution of temporary shelters and other activities to mitigate risks to girls and women.
- Many informants underscored the important of a long-term program on GBV/Protection and SRMH. They expressed women’s right and dignity should be protected and respected by all (starting from government to the CBOs). Trafficking of girls, women and children, sexual abuses and violence could spread therefore WDO is requesting all donors to pay attention and design projects in coordination with Women and Children Welfare Ministry.

**Sector Specific Issues**

**Shelter**

Only 12% of households reported that female members owned fixed assets (house, land or both), much lower than the national average of 25.73%. Thus 88% of the female population does not own houses, in comparison to the national average of 79.5%.

According to the 2011 census, 80% of houses in Sindhupalchowk district were made of mud-bonded brick or stone while 20% were made of bonded-cement. Mud-bonded brick and stone do not absorb shock well and are more likely to be damaged or destroyed from significant impact. Therefore, there is likely significant structural damage to these homes. Due to this and fear many people are sleeping in the open, placing women and girls at risk of GBV. 85% of households in the district owned their own houses while the rest rented.

Firewood is the overwhelming cooking method in the district with 90% of households using it. This resource may be in scarce supply after the earthquake. Only 8% of households have access to Kerosene or LPG cooking and 2% of households are wired for electric cooking. Cow dung is rarely used as a fuel source but during this emergency phase it could be an interim option. In addition, in a crisis, cooking fuel and utensils are likely lost and need to be quickly replaced.

From our interviews it is clear that many people are not only concerned about rebuilding but removing the debris caused by the earthquake. Also they are concerns about where
they should settle. The government and organizations are working with local communities to either resettle them in a safer area or build more secure homes.

In Baskharka VDC

- People have started making temporary shelter near their damaged house using salvaged materials (wooden poles, CGI sheets etc.)
- People are planning to build their temporary shelters by themselves.
- Single women, poor and other marginalized groups have been prioritized by the distribution committee of the village, however single women who are living with extended families will have challenges accessing the limited resources in the household.
- Reconstructing houses before monsoon is the big challenge therefore everyone appealed that they should be provided shelter to protect themselves and their existing food and the crops that will be harvested within a month (such as potatoes, onions, wheat).
- CGI sheets are being requested by almost everyone in the community.

**Suggested gender-sensitive responses:**

See Overall recommendations, above. In addition:

- Provide women, girls and other at-risk groups with materials to construct their own shelters and when possible in-person construction support. This should mitigate the risk of theft of goods, exchanging sexual favours for support with construction, and attack if collecting shelter materials.
- Ensure that female headed households, children headed households, people with disabilities, unaccompanied children etc, are provided with shelter in a safe location and shelter that meets their personal needs and circumstances.
- Conduct community mapping exercises to ensure rebuilt neighbourhoods and homes for the displaced are in a location that is both safe and comfortable for them.
- Provide safe-fuel and cost-effective cooking options to households that will mitigate the risk of harm from cooking to homes and the cost of cooking.
- Work with GBV actors to prioritise and provide shelter support to GBV survivors.
- Ensure that our shelter vulnerability criteria includes GBV, child protection, age, disability, sexual orientation and gender identity, class, caste, religion and other discriminatory issues present in Nepalese society.
- Ensure there is adequate supply of sleeping materials for everyone so sharing isn’t necessary. When there are not enough material women and girls (or possibly boys and men) could go without or participate in transactional relationships.
- Ensure the content of NFI kits is culturally appropriate and includes male and female clothing, for different ages and body sizes, including underwear. Use information volunteers to engage with the community and raise awareness on individual entitlements: the quality and variety of the items they should receive; place, day and time of distribution. Clothes distributions should be conducted in market-style distributions so people can choose the right types and sizes of clothes for them. Separate distributions for men and women should be considered.
- Use male and female volunteers to identify households where purdah or other harmful traditional practices are practiced. Identification of widows, female-headed households, child-headed households and people with a disability or impairment is also advised. These groups (along with other groups mentioned in this document) have mobility and access issues either because of physical restrictions or due to gender norms. This should be addressed by ensuring identification in a non-stigmatising way, and house-hold
distributions until an alternative, context-appropriate solution can be found. Information volunteers may be able to support distributions where distribution teams do not have the bandwidth to be able to conduct household level distributions. This will further ensure that we are delivering a community driven response. If community members are given the responsibility of distributions, they should do this in pairs and be given a quick overview of PSEA policies before engaging and before a more formal training can be given after the acute phase of the emergency has passed.

- Provide solar lighting as part shelter kits (preferably two lamps or torches, with spare batteries) that can be used both within and outside the home. Lighting dramatically reduces the risk of injury and harm.
- Organise for fuel for cooking and heating to be collected in groups through the information volunteer programme for both safety reasons regarding gender but also because people are fearful of landslides and another earthquake. Women and girls are at increased risk of sexual violence if collecting fuel on their own. Ideally, smokeless fuel will be distributed, to decrease health risks to women, as well as mitigate the risk of sexual violence, and the burden of collecting fuel.
- Include toilets within the home whenever possible so women do not have to travel to relieve themselves.

**Sexual Reproductive Maternal Health**

According to the Global Development Index (GDI), women’s life expectancy at birth is 69.6 years (2013 figures). The maternal mortality rate in Nepal is 170 per 100,000 births, this is very high and it is expected to be even higher at the district level, however specific data is not available. The national fertility rate is 2.4 births per women, with rural women usually having about one child more than urban women.

50% of the reproductive age population in Nepal do not use any form of family planning method, while 47% use modern family planning methods, and 3% use traditional family planning methods. Data on fertility rate and use of contraceptive in the district is not available. Family planning method supplies may be disrupted during this crisis and could result in unplanned pregnancy.

As 72% of all women in Sindhupalchowk are married by age 19, maternal complications and maternal and child mortality in the district is likely to be higher because statistically young women face greater risk of complications from pregnancy and childbirth than women in their twenties.

Breastfeeding is common in Nepal. Nationally 70% of children less than 6 months old are exclusively breastfed. This practice should be encouraged and the health of breastfeeding women a priority.

The national rate of vaccination of one-year-old children is reasonably high with vaccinations for common diseases reaching 88% of the population. Given the increased risk of infection post-disaster, consideration should be given to identifying and vaccinating children and adults still at risk of preventable transmission.

There have been teams of medical doctors visiting some of the VDC’s, however the focus has been general medical services and particularly treating those injured. This is of course important but long-term care should not be neglected. This is likely to occur during the crisis phase and limited health facilities while reconstruction is taking place. We have received feedback from communities that families are sending pregnant women and lactating women to the nearest cities where they have relatives in order to be safe and
receive care.

**Suggested gender-sensitive responses:**

See Overall recommendations, above. In addition:

- Ensure continued supply of family planning services to both men and women of reproductive ages. Make sure contraceptive supply chain still in place.
- Focus SRMH information and services on young women/men because so many are married before the age of 19.
- Use Female Community Health Volunteers (FCHV) Program members to provide women with SRMH information.
- Support district health authorities to strengthen their services to address SRMH needs.
- Ensure access for all by actively engaging women and men from the community and the health workforce, including those who belong to vulnerable groups, equally and at all levels in the design and management of health service delivery, including the distribution of supplies.
- Ensure on-going and coordinated health service delivery strategies that address the health needs of women, girls, boys and men. For instance:
  - Provide Minimum Initial Service Packages (MISP) so that women and men and adolescent girls and boys have access to priority SRMH services in the earliest days and weeks post-quake, comprehensive SRMH services, including GBV-related services, as the situation stabilises.
- Ensure prevention of and response to GBV as described in the IASC Guidelines on Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, including treatment, referral and support mechanisms for GBV Survivors, ensure linkage with GBV actors.

**WASH**

At national level, 93% of the population had access to safe and clean drinking water prior to the earthquake. In Sindhupalchowk more than two-thirds (70%) of households are supplied with piped or tapped water. A further 25% of households use spout water and 5% use an uncovered well. Due to gender norms, women and girls may take on the responsibility of collecting water. Appropriate measures should be taken to ensure their safety.

Almost 24,000, or more than a third of households in Sindhupalchowk, don’t have their own toilet, while 38% of households nationally don’t have a toilet. Of those in Sindhupalchowk with a toilet, 18,000 do not have a flushing toilet.

During this time in particular, and always, there is a risk of water borne disease and illness associated with lack of appropriate sanitation facilities. This will affect women, men, boys and girls differently and this situation should be monitored closely and using a gender lens.

The isolation of women during menstruation period is still practiced by some communities in Nepal. This practice increases women’s risks to rape, physical violence and other GBV. It also limits women’s mobility and access to services, resources and opportunities. For those in Sindhupalchowk that continue with this practice, the current crisis increases the vulnerability/danger of women forced to practice it. Therefore, efforts should be geared towards identifying communities in the district that continue with this practice.
In Baskharka VDC

- There is significant debris.
- Distribution pipes and taps of drinking water are broken.
- Most latrines are cracked and due to fear people are not using them now and practicing open defecation despite many VDCs declared open defecation free earlier.
- Children are practicing open defecation while some young girls and boys are using their neighbours facilities.
- 95% houses built by stones, mud and wood are damaged completely. Latrines that were adjoining with the houses or located far were also damaged and were found constructed with the same materials.
- 5% latrines are left in the village but have some cracks.

**Suggested gender-sensitive responses:**

See Overall recommendations, above. In addition:

- Work with community to repair or rebuild their latrines.
- Communicate with community that using structurally sound latrines is safe and the best health option.
- Ensure water points, latrines and bathing facilities set up/being used for those without a home are sex-disaggregated and universally accessible.
- Ensure that menstrual hygiene items are locally and culturally appropriate. Get specific information for your locations to plan for procurement.
- Ensure that hygiene promotions activities encourage hand washing (which was not prevalent before the crisis) and work with the district health official and FCHV who have had success in this to address the issue.
- Ensure all facilities are centrally located, lockable and lighted in order to mitigate the risk of sexual violence.
- Include a hook in latrines so girls and women can hang their purse and not be forced to place it on the floor. This dramatically improves use by women.
- Although cloth sanitary pads are most common in many parts of Nepal make sure waste baskets are available to use for disposable pads. Otherwise they will fill up and clog latrines.

**Food Security**

Results of the Nepal Demographic Health Survey showed that nationally, 41% of children under five years of age were stunted and 29% underweight. 46% of children between the ages of 6-59 months were anemic. 18% of women were malnourished, while 14% were overweight or obese.

It is important to note the following:

- Pregnant and lactating women and infants require additional nutrition, than the average person. Dietary supplements to their health may be difficult to get due to mobility, poverty and discriminatory gender norms. There is anecdotal evidence to suggest women and girls are given less to eat than men and boys.
- Lack of food and resources to buy food will impact on families and have a deep impact especially on female-headed households, as well as those who have limited mobility (age and disability).
- Women and girls (and to a lesser extent boys and men) may enter into exchanges
for food and resources. These may be exploitative. In all crises we must assume and believe that sexual exploitation and abuse and all forms of SGBV are happening at a heightened rate.

- For a large number of women, especially in rural areas their livelihood is linked to home based activities, such as agriculture and livestock. The earthquake has affected these livelihood options and without prompt action to restore them or offer alternatives girls and women will be more vulnerable to trafficking.
- Some food stocks stored before the earthquakes are covered by debris and either unable to be eaten or recovered.
- Food distribution has taken place in the district but most people interviewed said they had enough to eat for a month including rice, lentils, oil, salt and beaten rice.
- The economy is largely dependent on agriculture and remittances received from family members working outside the district or country. Men usually work as labourers and women as domestic help. Some respondents said women have gone to Gulf countries to work as domestic help. This information however needs to be verified.

**Suggested gender-sensitive responses:**
See Overall recommendations, above. In addition:

- Ensure livelihood opportunities are prioritised for families and particularly girls and women to minimise the increased risk of trafficking.
- Ensure that the physical and safety risks associated with collecting food assistance are minimised and that access is universal.
- Ensure that the weight and size of food packages are manageable for women, girls and other at-risk groups and if not organize porter services.
- Use community mobilisers/volunteers to engage with community, identify those who are unable to collect food, and organise for household/individual distribution.
- Use community mobilisers/volunteers to address gendered access and control issues surrounding food and nutrition in the household.

**Gender Based Violence**
Girls marry much younger than boys in the district and marriage of girl children is common. In the district 20% of girls are married by the age of 14, while 55% of all married females (45,000) were married between age 15 and 19; almost double the 27,000 boys married at that age. At the national level 74.5% of girls are married by the age of 19 and only 16.32% of girls are married by age 14. It should be noted that in the current crisis, child marriages are likely to increase as a form of protection and as a means to ease economic burdens on families.

It is only after age 20 that the number and percentage of married men exceeds females. Around 30,000 men married between the ages of 20-29, along with 21,000 females of a similar age. In the district 72% of all married women were married by the age of 19. Only 47% of married men were married by that age.

All humanitarian personnel should assume and believe that GBV, and in particular sexual violence, is taking place and is a serious and life threatening protection issue, regardless of the presence or absence of concrete and reliable evidence. This often difficult to believe for humanitarian actors in an environmental emergencies, however, due to the breakdown in normal social protection mechanisms, GBV (and in particular sexual violence) increases,
disproportionately affecting women and girls.

Survivors of GBV may not have access to services, or know where existing services are. This places survivors at particular risk of death, injury and other health risks such as HIV contraction, STI contraction and pregnancy - all of which could be prevented if individuals know where to access the appropriate care.

From the later acute phase of a crisis onwards, other types of GBV are likely to increase. Intimate partner violence may increase as gender roles are challenged and frustrations increase, the already endemic issue of child marriage may escalate as poverty takes hold and families rely on this practice to reduce the economic burden of girl children on the household and the burden to protect the girl.

During this crisis we should take into account raised during focus groups and informant interviews:

- Extended family living outside in open area suffer from a lack of private space
- Few safe space for adolescent girls
- Maintaining hygiene is difficult for women and a girls when (and boys and men) when there is little private space
- No child friendly space therefore difficult to handle small and school going children
- More than 90% people feel insecure and have little hope
- Women’s need and dignity often overlooked by men and boys, because shelter, and food security take precedence over creating women’s space, privacy and protection. Almost all (100%) women expressed in the focus group that no one considered their privacy issues (menstruation, changing of cloths, breast feeding, talking on feminine issue, sickness etc.)
- Sexual violence/abuse has not been reported and women fear that it is a particular risk for girls
- Women are concerned the elderly, but have not expressed their fear to authorities.
- Due to labour migration of men, women (wives) in the village bear all livelihood responsibilities including children, livestock, agriculture, households and more.

**Suggested mainstreamed gender and protection responses:**

See Overall recommendations at the start of the Initial recommendation section, above. In addition:

- Mainstream GBV guidelines into sectoral responses.
- Share the GBV referral pathways put out by the GBV sub-cluster with team leaders, sector leaders to be further distributed with all staff, partner staff and volunteers
- Provide orientation on how to share information on GBV and referrals and what to do when they interact with a survivor.
- Use community mobilisers and volunteers to deliver information about GBV mitigation and the health impacts (in particular) of certain forms of GBV. Make sure to include child marriage: we should strive to prevent an escalation of child marriage.

For more information: emergencygender@careinternational.org

Updated May 20, 2015
- Inform the community on where to receive appropriate services and why it is important to do so (prevention of HIV contraction, emergency contraception and STI prophylaxis) within 72 hours.
- Be aware that schools are closed at least till the end of May, and this will increase the child-care burdens on women and older girls.
- Boys and girls are at heightened risk of participating violence in humanitarian settings due to a lack of rule of law, lack of information, restricted decision-making power and their level of dependence. This frustration can manifest itself as violence.
- Be aware that children are more easily exploited and coerced than adults, and are often taken advantage of by people in authority.
- Be aware that proximity to armed forces, overcrowded camps, and separation from family members all contribute to an increased risk of exposure to violence.
- Coordinate with GBV and child protection actors, agencies.
- Collect and analyse key gender and protection concerns on a weekly basis. This will be used to inform our humanitarian programming. This information will also be made available to the Gender Task Force and the Protection cluster for them to address issues where appropriate.

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1 A lot of the information in this section has been taken from http://cbs.gov.np/wp-content/uploads/2012/11/National%20Report.pdf
2<http://en.wikipedia.org/wiki/Sindhupalchowk_District>
3 Nepal Census 2011