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The role of local government in tackling a global pandemic: A lesson from Nepal

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Cover image: A health worker carries COVID-19 test samples to the laboratory in Sukraraj hospital, Teku, Nepal in 2021. © Save the Children

Abstract

This paper critically analyses the scope of leadership in Nepal at the local government level when tackling the wider impacts of COVID-19, with a particular focus on health service delivery in line with World Health Organisation (WHO) frameworks. In-depth interviews with 66 representatives from local governments (LG) in the Madhesh and Sudurpaschim provinces were conducted, along with analysis of routine data from health management information systems. We found that Maternal Child Health (MCH) services at local health institutions were largely unimpacted, stocks of essential medicine were available, and the LGs exhibited determination and capability in getting to grips with the crisis, despite inadequate knowledge and resources. Nevertheless, there was sizeable shrinkage in the utilisation of services, which triggered public health concerns of a different nature, the LGs were inadequately prepared in regards to the capacity and availability of human resources, and there were explicit gaps in terms of coordination among all three tiers of government and a lack of role clarity that delayed the response to the pandemic at the local level. Our recommendations include continued investment in local MCH services, capacity building for local leaders with a focus on human resource management in emergency contexts, and the simplification of public procurement processes, particularly during crises, enabling LGs and other local actors to expediate procurement and improve response times.

Leadership relevance

This paper highlights the role of Nepalese local government leadership in emergency management and explores its readiness to respond to disaster, especially given the new governance structures implemented by this emerging democracy. Further, the paper provides insights for low-and-middle income countries by identifying potential opportunities and areas of improvement when responding to disaster at a local government level.

Introduction

The COVID-19 pandemic triggered a seismic health emergency in every nook and cranny of the world. Even countries with robust health mechanisms struggled to manage the sudden spike in the demand for intensive care units. Likewise, the unavailability of critical yet basic equipment like personal protective equipment, ventilators, and the surge in workload experienced by health professionals, further strained already struggling health systems (Ferrara & Albano, 2020). Consequently, when the COVID-19 pandemic struck low-and-middle-income economies like Nepal, it became vividly clear that countries with feeble health systems would battle to cater for the overwhelming demand for health care in such a context.

Nepal reported its first case of COVID-19 on January 23, 2020 and since then more than one million people have been infected, and more than 12,000 deaths attributed to COVID-19 in the country (Worldometer, 2022b). An early countrywide lockdown was enacted by the government of Nepal on March 24, 2020 to curb the rapid transmission of COVID-19, curtailing both national and international travel, forcing the closure of public facilities including schools, suspending most commercial activities, and closing borders with neighbouring countries (CRISIS24, 2020). Although the government announced that basic and emergency health services would be provided in an uninterrupted manner, there were reports of disruptions to basic services like immunisation in some parts of country during the lockdown (Mathema, n.d.).

This crisis of unprecedented magnitude was the first of its kind since the country adopted its new constitution in late 2015 and embraced the spirit of federalism[1]. Following the adoption of the new constitution, Nepal transitioned from a unitary to federal system, mandating the creation of seven provinces and 753 local governments (Government of Nepal, 2015). The new constitution clearly articulates that health is the fundamental human right of every citizen in the country (Government of Nepal, 2015). As such, the management of any type of emergency situation, including a pandemic, comes under the purview of the federal government of Nepal. In such emergency cases, the federal government develops and coordinates rapid plans, policies, and programs with support from the provincial governments and the local government bodies.

Against the backdrop of such recent constitutional and structural change, this newly formed government structure was forced to encounter a large-scale health crisis. This paper aims to critically analyse the role of leaders of the new local government bodies in addressing the COVID-19 pandemic, especially from the perspective of health service delivery in line with World Health Organisation (WHO) frameworks (World Health Organisation, 2007).

This paper aims to critically analyse the role of leaders of the new local government bodies in addressing the COVID-19 pandemic.

Methodology

A qualitative study was adopted to achieve the research objectives. In addition to qualitative interviews, data from the Nepalese Health Management Information System (HMIS) was analysed to supplement the findings from qualitative data. The researchers also undertook a desk review in order to study the relevant policies, guidelines, protocols, and institutional arrangements in place for an effective health system delivery.

This study focused on two provinces of Nepal—Madhesh and Sudurpaschim—chosen because of their high numbers of COVID-19 incidences as well as the local presence of World Vision International Nepal (WVI Nepal). Five districts (two from Madhesh Province and three from Sudurpaschim Province) were also selected. Within each district, two rural municipalities were nominated, resulting in a total of 10 rural municipalities. In-depth interviews were conducted among health service providers, ward officers, health coordinators, and social protection officers at a local level, and two representatives working in health and social protection from the Ministry of Social Development were interviewed at the provincial level. In addition, we conducted two interviews with representatives from the Ministry of Health and Population and the Ministry of Federal Affairs and General Administration at the federal level, and four people from International Non-Governmental Organisations were also interviewed as part of the data collection. A total of 66 in-depth interviews (IDIs) were conducted using IDI guidelines. The interview questions were drafted using WHO's tools for Health System Assessment for Crisis Management (World Health Organisation, 2012), as well as the assessment framework for health systems in decentralised contexts from the World Bank (Berman & Bitran, 2011).

Trend analysis for secondary data was conducted using STATA 16. All the IDIs were transcribed and translated to English. Back translation was also conducted to ensure the consistency of the content and information.

[1] The 2015 constitution was a federal restructure of the governance framework, and was welcomed by Nepalese society as opening up the possibilities for better governance in the country.

Coding was conducted and themes generated based on the codes. All the respondents were informed about the objectives and benefits of the study and verbal consent was obtained prior to the study. Further, voluntarism was ensured throughout the study and no personal identifiers were used anywhere in the report.

Background

In a broader sense, health systems comprise of "all organisations, institutions, resources, people and actions" and consist of different stakeholders such as patients, families, communities, health ministries, health providers and health financing bodies, all of which have interconnecting roles and functions with the primary purpose of improving health (World Health Organisation, 2012). The WHO states that an effective interaction between the six fundamental building blocks of a health system (comprising of service delivery, the health workforce, health information systems, access to essential medicines (logistics), financing, and leadership/governance) provide the enabling environment required to attain equitable and sustained health outcomes (World Health Organisation, 2007).

Lack of equilibrium among any of the aforementioned building blocks can cause a disruption of health systems and reduce health outcomes. The public health predicament triggered by the COVID-19 pandemic in Nepal, for example, led to the disruption of the demand and supply aspects of healthcare service delivery. Supplies of some critical medicines ran out, crucial healthcare logistics failed, there were inadequate levels of skilled health personnel, as well as ineffective coordination amongst different tiers of government bodies. Our analysis explored all six facets of health systems through both primary and secondary research.

Service delivery analysis

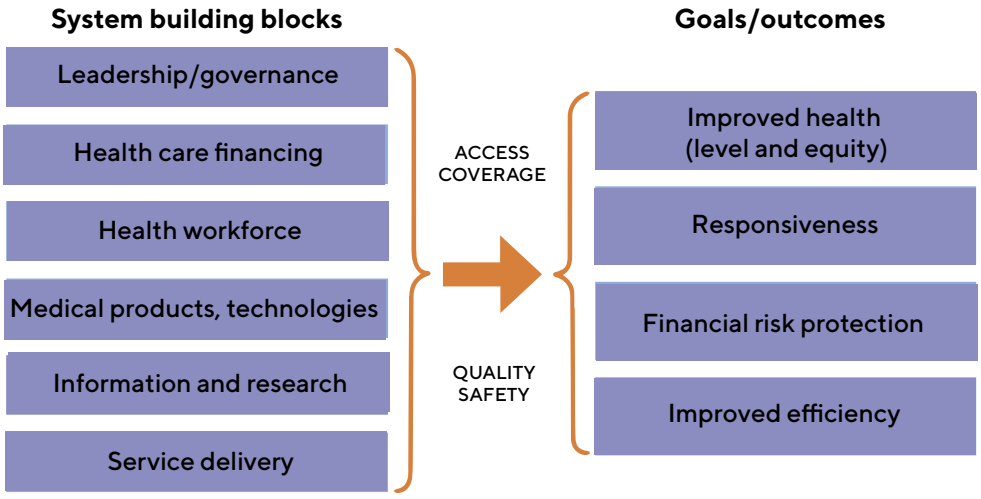
Data from November 2019 to March 2020 was extracted from the Health Management Information System (HMIS) and analysed to assess the continuation of service delivery before and during the onset of COVID-19. Service delivery components included antenatal care (ANC) visits by pregnant women, health facility (HF) delivery, family planning (FP), and immunisation.

Overall, antenatal care visits by pregnant women decreased by 25% after the onset of the COVID-19 in Nepal.

Overall, ANC visits by pregnant women decreased by 25% after the onset of the COVID-19 in Nepal. Likewise, HF delivery reduced by 26%. There was also a noticeable reduction of the government incentives distributed to expectant mothers for the four ANC visits that are recommended by the WHO in its antenatal care protocols. The Four ANC visits incentive reduced by 31% and the transport incentive reduced by 34% in Madhesh Province, while a 1% reduction was noted in the Four ANC visits incentive scheme and a 8% reduction in the transportation incentive in Sudurpaschim Province.

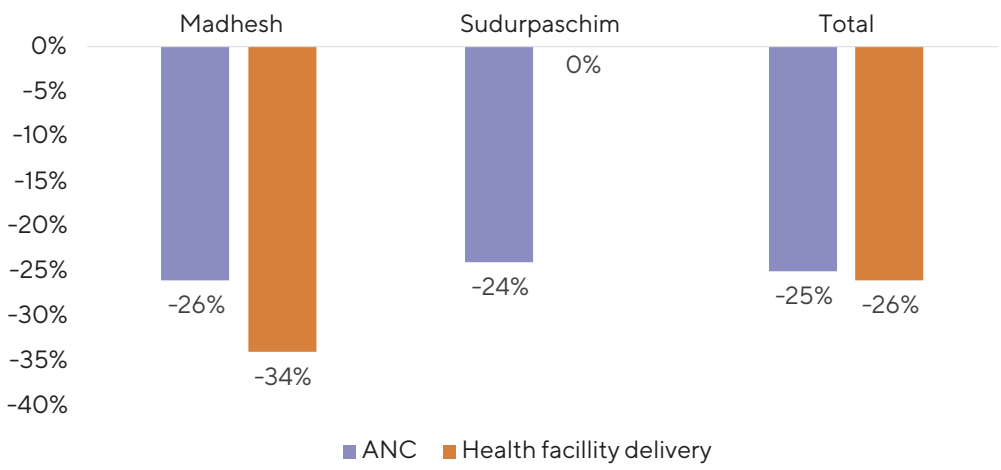
In total, the distribution of incentives for the Four ANC program reduced by 21%, while transportation incentives reduced by 27%, as shown in Figure 3.

Figure 1: The WHO Health System Framework



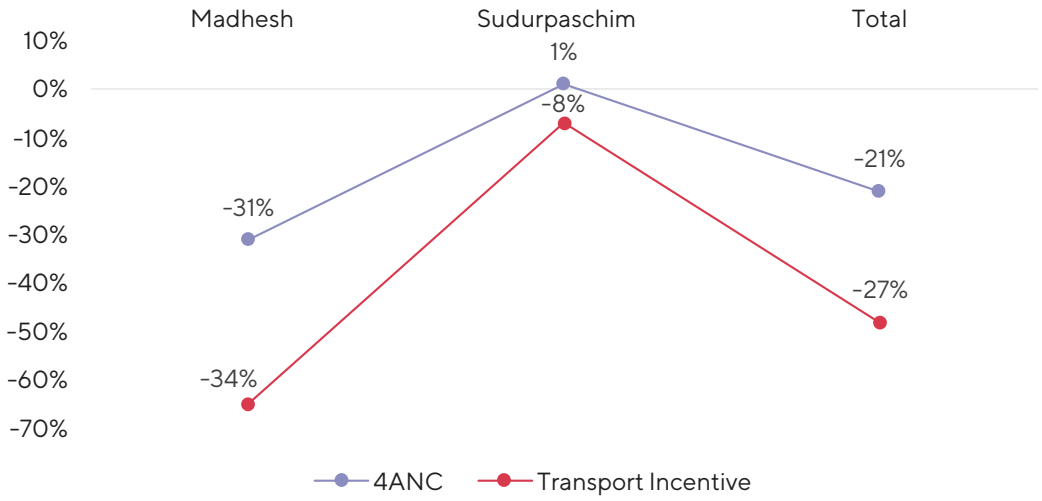
Source: World Health Organisation, 2007

Figure 2: Antenatal care visits and Health facility delivery during COVID-19



Source: Nepal HMIS

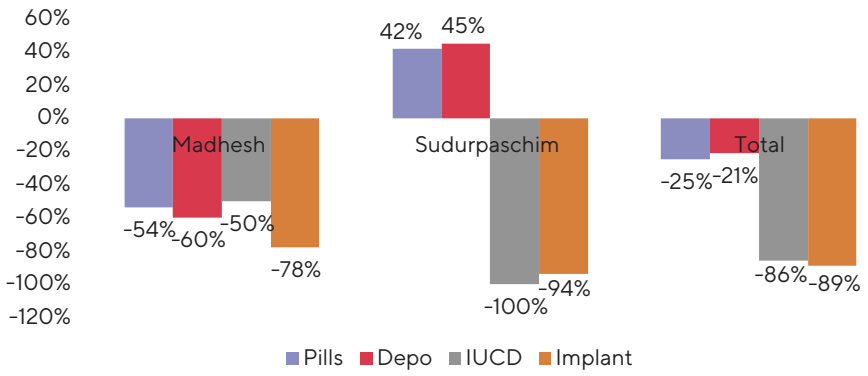
Figure 3: Four ANC and Transport Incentive distribution



Source: HMIS (Before Nov 2019- Feb 2020; After COVID: March 2020-June 2020)

To assess the continuation of Family Planning services, we collected data related to new users using contraceptive measures before and after the pandemic. It should be noted that the use of the contraceptive pill and hormonal contraceptive injections (known as depo) are the most prevalent forms of temporary contraception in Nepal (Ministry of Health and Population (MoHP), 2017). In Madhesh province, new users for both pills and depo reduced by 54% and 60% respectively, while in Sudurpaschim, there was a significant surge in the use of both bills and depo among new users (42% and 45% respectively). In total, the use of the pill diminished by a quarter whereas the uptake for depo decreased by 21% (as illustrated in Figure 4).

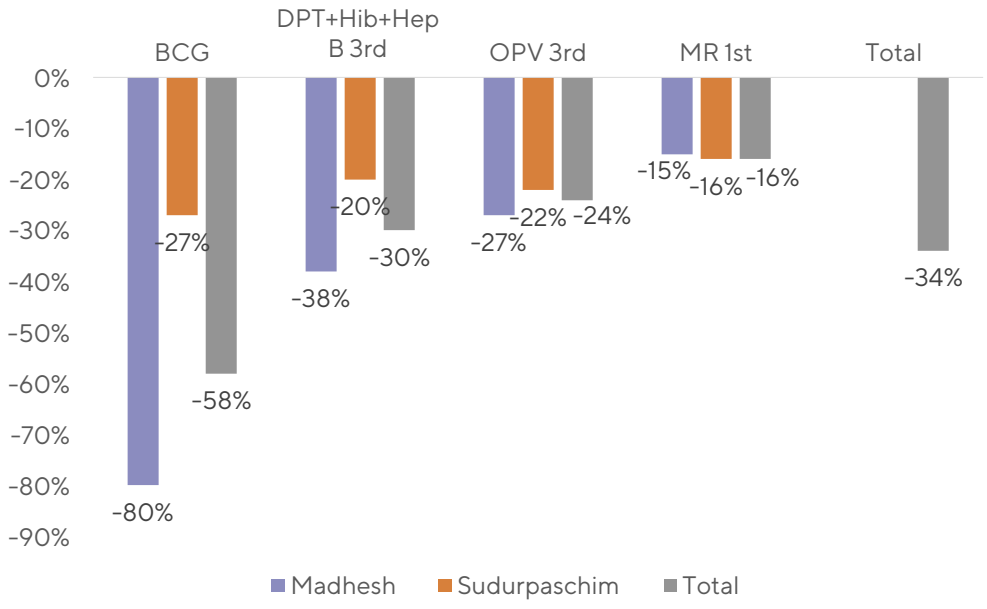
Figure 4: New users of Family Planning services during COVID-19 period



Source: HMIS (Before Nov 2019- Feb 2020; After COVID: March 2020-June 2020)

Regular immunisation related services were also impacted in the months of March and April 2020. After comparing the immunisation uptake prior to COVID-19 and during the pandemic, we can see that the Bacillus Calmette-Guerin (BCG) inoculation rate declined in both the provinces surveyed. In Madhesh province, the uptake of BCG immunisation decreased by 80% during the pandemic. Madhesh Province also witnessed a 38% decline in the uptake of the third dose of the pentavalent vaccine (DPT+hib+Hepatitis B). The rate in the inoculation of the same vaccine in Sudurpaschim province reduced by one fifth. Similarly, the uptake of the first dose of Measles Rubella vaccine in Madhesh and Sudurpaschim Provinces shrunk by 15% and 16% respectively. In terms of the uptake of the third dose of Oral Polio Vaccine (OPV), Madhesh Province saw a decrease of more than a quarter (27%) in comparison to a decline of 22% in Sudurpaschim Province (shown in Figure 5).

Figure 5: Immunisation coverage during COVID-19



Source: HMIS (Before Nov 2019- Feb 2020; After COVID: March 2020-June 2020)

Discussions with interviewees revealed several reasons for these declines, both official and social:

> "In the month of April and May of 2020, our local government mandated us to temporarily suspend the immunisation program as there was scarcity of vaccines. Moreover, we also halted the regular growth monitoring program in the month of March and it has not been restarted as of today. Having said that, other regular services are being continued here!"—M1SP

> "In the early days of the COVID-19 pandemic, the footfall of service seekers significantly decreased because they felt unsafe to visit health facilities"—M5SP

Human resources

The workforce in the healthcare sector comprises of both clinical and non-clinical personnel engaged in public and individual healthcare. They play critical roles in an effective healthcare delivery process. During the study, almost half of the local government personnel interviewed stated that they lacked enough health personnel to provide health services when the pandemic was impacting local communities. Moreover, not even a single local government official interviewed had a robust human resource management plan in place to quickly identify the pool of potential health professionals and recruit them, or to mobilise volunteers. Furthermore, one of the interviewees from local government stated that they had to use the same health personnel in quarantine and isolation centres alongside the usual health facility due to the shortage of health workers.

Not even a single local government official interviewed had a robust human resource management plan in place to quickly identify the pool of potential health professionals and recruit them, or to mobilise volunteers.

> "The number of trained health personnel are inadequate and there is no provision of contingency human resource plan. Moreover, there is no database in relation to the availability of skilled health professionals. Furthermore, the local government also do not have a plan in place to leverage the internal resources for the purpose of human resource management during the crisis of such magnitude"—M10

In many cases, health personnel were hired on the basis of temporary contractual agreements in order to mitigate disruptions to health services when existing health service providers were infected (although few of the contracted temporary staff were able to work in special COVID-19 hospitals that had facilities like Intensive Care Units or ventilators). Hospital administrators were briefed by provincial governments to demand additional budget for hiring human resources on the basis of these temporary contracts. The provincial governments also provided clear instructions to on-board required doctors and technical teams on a temporary basis as per the need during the COVID-19 predicament. Such human resource management practices are still prevalent in some of the provinces.

The Federal Government delegated responsibility for the provision of training programs related to counselling and Case Investigation and Contact Tracing (CICT) to the provincial governments (Ministry of Health and Population, 2020). Thereafter, the provincial governments provided training programs to the local governments. During the time of pandemic, additional specialised trainings related to critical care were organised by the federal government, both in face-to-face format, and virtual mode, depending on the nature of the training and the needs of health personnel. It should be noted that the practice of virtual training was a relatively new concept in Nepal, however, during the COVID-19 situation such training methods were common. Some respondents in this study commented that the virtual trainings were ineffective, while other government officers responsible for conducting such trainings stated that they did not have adequate budget and resources and mostly played a facilitator role during the pandemic.

> "The virtual training sessions provided by the government agencies were not as effective as the one we used to take on in-person format. Many of the participants were using Zoom meeting for the first time, and most of them even did not know the mute functionality in the virtual tool, leading to lot of disturbances during the training. To be frank, I could not hear even a single point that was shared in the training!"—M7SP

Logistics and equipment

In the initial days of the pandemic, local governments did not have access to enough Personal Protective Equipment (PPE) for health workers. During our interviews, local health service delivery personnel mentioned that they instead followed social distancing rules, used masks, disposable gloves, and sanitisers while delivering health services. The study participants

stated that the key reason behind the shortage of PPE was the cumbersome and time-consuming government public procurement process.

The study participants stated that the key reason behind the shortage of PPE was the cumbersome and time-consuming government public procurement process.

As the pandemic progressed, the federal government used epidemiological modelling to anticipate the number of probable cases in Nepal and develop scenario planning in order to address the shortage of critical health equipment including PPE. As per the findings from such modelling, a logistics plan was devised, and procurement processes were made agile in order to more quickly source critical materials.

Nevertheless, local officials were critical of the processes:

> "The health office provided us with PPE, RDT kits and sanitisers during the pandemic. But the amount of such materials was not enough for us to perform our duties in such a risky situation"—M4

"Our purchase process is very lengthy and complicated. Law has provision of procurement during emergency situations but there are many hurdles in the process, which makes purchase difficult"—FG1

> "Our procurement process is time consuming and highly cumbersome. Although there is a legal provision spelled out for the emergency situation, there are many legal and procedural bottlenecks in the execution part, that makes the procurement process very frustrating!"—FG1

During the interviews, the majority of the participants from local government stated that they had sufficient amounts of essential medicines at their disposal, and that they did not encounter any challenges in managing them. A few participants said that the amount of medicinal stock they had ran low at times, but they coordinated with health offices for medicine and other required logistical support to ensure that health service delivery was uninterrupted. Only one representative from one of the local governments interviewed commented that they were unable to access adequate amounts of medicine for their health facilities, adding that outpatient department (OPD) patients had to purchase their own medicine.

> "We struggled to cater the medicinal needs of some of the health facilities. We supplied the medicine stocks that we received from health offices, but the amount was not sufficient. As such, the patient taking OPD services had to buy medicines from private pharmacies on their own"—M1

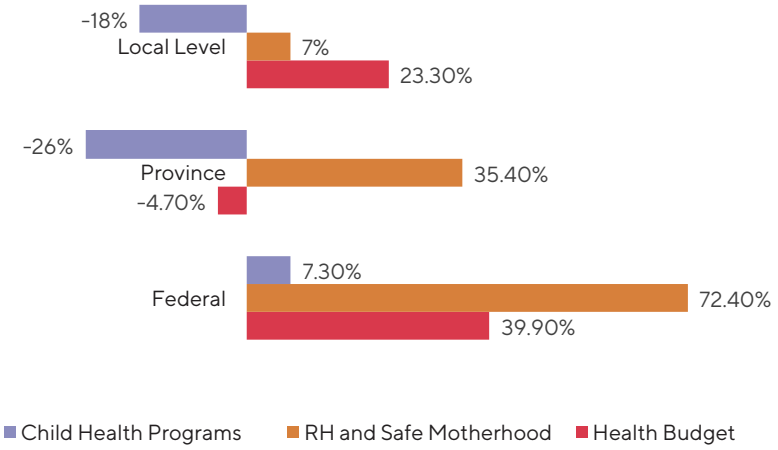
Budget

The total national budget for the 2020-21 fiscal year (FY) was Rs.1,272 billion, a decrease of 3.8% in comparison to FY 2019-20. However, the proportion of budget allocated to the health sector on 2020-21 surged by 39.9% to Rs.115 billion in contrast to FY 2019-20 when the total budget allocated for the sector was just Rs.82 billion (Ministry of Finance, 2020; Ministry of Finance, n.d.). The budget for reproductive health and safe motherhood (which includes safe motherhood programs, family planning, safe abortion services and infertility management), increased by 72.4%. The budget for child health programs (which include immunisation programs, child treatment services, management of childhood illness, child curative services, and nutritional programs) increased by 7.3%.

At the provincial level, total health budgets (an aggregate of conditional and provincial health budgets) reduced by 4.7% in FY 2020-21. The total budget for reproductive health and safe motherhood services at this level of government increased by 35.4%, while the budget for child health programs reduced very significantly by 26.4% from FY 2019-20 to FY 2020-21. In 2021-21, the total health budget at the local level increased by 23.3%, while the budget for reproductive health and safe motherhood increased by 7.2% and the budget for child health programs reduced by 17.5%. However, decreases in budgets at the provincial and local levels could be due to the lack of detailed budget breakdown for maternal and child health programs, and therefore these declines should be interpreted with caution.

The budgetary requirements for health service management surfaced at the end of the last quarter of FY2019-20. As there was no specific budget allocated for COVID-19 management at the local level, most study participants stated that they experienced challenges while managing the funds needed for the COVID-19 situation. In contrast, the majority of the representatives from provincial and local governments acknowledged that there was a provision for unallocated budget in the Red Book (the Nepalese Government's national budget current account), and that this budget could be leveraged under different situations as required. This budget line, in addition to the transfer of money from under other areas, was used to help manage

Figure 6: Health budgets at federal, provincial and local level during COVID-19



Source: Redbook (Federal, Province, Local Level) for FY2019-20 and FY 2020-21

the COVID-19 situation (although the fund was not sufficient considering the magnitude of the crisis). In order to address the lack of adequate budget for health service delivery that was triggered by COVID-19, many local governments transferred budget allocated to infrastructure development.

"Last year, around 40 to 42 million Nepali Rupees were accumulated at province level by transferring budget from other headings to COVID-19 management. In addition, the local government used undivided budget for the purpose of COVID-19 response measures!"—M1

"As the budget previously allocated for infrastructure projects could not be utilised in the COVID-19 context, we transferred the budget for the pandemic management in the last FY"—M5

Although local governments denied that the budget of other health programs was compromised due to budget allocation for COVID-19 management, provincial and federal government representatives did mention that the budgets for other health programs were affected to a certain extent.

"The government has formed a separate fund for COVID-19 management. Lot of health programs in the last fiscal year were compromised and we re-channelled funds. We also mobilised the fund reserved for pandemic preparedness in our annual work plan and budget"—FG1

Although the budget for COVID-19 management was not sufficient in 2019-20 fiscal year, in the following fiscal year, 6% of the total health budget was dedicated to COVID-19 management. This was included in the Red Book of the federal, provincial as well as local governments (Ministry of Finance, n.d.). This COVID-19 fund was established mainly for capacity building, equipment purchases, surveillance, allowances for health personnel, research and other COVID-19 related management. Furthermore, additional budget was allocated in 2020-21 to establish a 50-bed hospital in each province and 300 bed hospitals at the federal level, with the vision of better managing infectious disease outbreaks (Shrestha et al., 2021).

Health Information Management System

It is imperative to continuously update Health Management Information Systems (HMIS) on a regular basis to ensure an effective and functioning health system. However, there are always inherent risks during this process. The key challenges during the pandemic to properly updating the HMIS included a lack of adequate human resources as well as the surge in workload among the existing health personnel. Nevertheless, the majority of the study participants stated that the impact of COVID-19 on the reporting process in HMIS and Logistic Management Information Systems (LMIS) was very limited or non-existent. There were only few interviewees who stated that the reporting of HMIS and LMIS was impacted due to the pandemic.

"All the staffs were busy in quarantine and isolation, so, from Chaitra to Ashar, our HMIS and LMIS data entry was disturbed"—M2

> "Each of us were occupied in managing quarantine and isolation facilities because of which our regular data entry process in LMIS and HMIS during the month of May and June were impacted due to COVID-19 related workload and commitments"—M2

The federal government and the provincial governments started Information Management Units (IMU) in some of the hospitals. The purpose of the IMUs was to record the case details of COVID-19 that required reporting. CICT teams were also formed at all local levels, however, the teams are no longer functioning (Government of Nepal Ministry of Health and Population, 2022).

Leadership and governance

Due to its topography and climatic conditions, Nepal is one of the most disaster-prone countries in the world. Hazards include floods, landslides and earthquakes (Dangal, n.d.). Even prior to the outbreak of the COVID-19 pandemic, local level disaster risk management committees were in place in most of the local government units. A few of these committees also had a Rapid Response Team (RRT), which take a major role during disasters. After the rampant prevalence of COVID-19, some local governments transformed their RRT committees into COVID-19 Crisis Management Committees (CCMC), while other local governments formed new CCMCs to respond the crisis. Local CCMCs coordinated with the district level CCMCs, while the district CCMCs coordinated with provincial level CCMCs. Provincial level CCMCs then coordinated with the federal government.

The study participants informed us that the CCMCs were formed under the leadership of the local mayor or chairperson of the local government and were in line with guidance issued by the federal government. CCMC members also included a ward chairperson of the local government, security personnel, and staff from the health departments of the local government. The ward chairpersons were responsible for supporting quarantine and isolation management while the security personnel ensured safety and set up quarantine and isolation centres. The health section staff were responsible for the management of medicine and the supplies required for healthcare services. Similarly, the ward sent information to the municipality/rural municipality (known as Palika in Nepalese) regarding the number of people entering their ward from the borders, which helped to manage relief distribution. The overarching responsibility of this committee was to make decisions regarding the effective and efficient management of COVID-19, which mainly included quarantine and isolation management.

Mixed responses were received from respondents regarding the coordination mechanism between the three tiers of government and their effectiveness in COVID-19 management. The majority of the respondents mentioned that they were in constant communication with each other and were working in coordination. Nonetheless, a few local government representatives complained that they did not receive any support from their province and also pointed out the lack of coordination at other levels of government.

"Coordination of three governments was not seen. Only the federal and local governments were involved in the management of COVID-19 pandemic"—M3

As COVID-19 is a new type of infectious disease, scientific information has been constantly evolving, requiring frequent updates to guidelines. These frequent changes in the guidelines and a lack of clarity about the roles and responsibilities of the three tiers of the government were reported by the majority of the respondents as hindering the effective management of pandemic. Major changes in the guidelines were usually related to the requirements for testing the COVID-19 positive patients after isolation. This led to conflict in the community on some occasions. Further, although local government officials mentioned that they regularly monitored health facilities, provincial and federal government interviewees stated that there were a few weaknesses in monitoring.

> "We did deploy teams from the federal level to monitor if guidelines are there and if they are being followed/complied with or not, and if not being complied with, then why, and to provide coaching for compliance. But we have not documented these monitoring findings. Documentation is our weak side"—FG1

Conclusion and recommendations

COVID-19 is the first emergency crisis faced by Nepal since federalism in 2015. This study explored opportunities and challenges faced by local governments in delivering health and social protection services in the first year of the pandemic. Maternal and child health service availability at health facilities was relatively unaffected but a drop in service utilisation was noted due to challenges with accessibility.

Local governments were unprepared in terms of human resource management particularly in regard to staff levels, capacity building, motivation and well-being. Most of the local governments had adequate essential medicines in stock and did not face any difficulty in managing them, however there was a scarcity of PPE in the beginning, as is quite understandable in an

unprecedented situation like this. The lengthy public procurement process was one of the challenges when trying to manage this inadequacy.

Local governments also struggled to secure and manage available funds for COVID-19 as the pandemic took them by surprise toward the last quarter of FY 2019-20, however they managed by allocating funds from other areas, as well as by using the provision of unallocated budget.

In terms of leadership and governance, local governments demonstrated capacity and willingness to manage the crisis despite limited resources and knowledge. Lack of clarity in roles and coordination among the three tiers of government is a clear area for improvement.

In terms of leadership and governance, local governments demonstrated capacity and willingness to manage the crisis despite limited resources and knowledge.

Our recommendations, which are applicable to any other disease outbreak, are broadly categorised as follows:

- Continued investment in interventions that support and enhance accessibility and utilisation of MCH services, especially given a recent UNICEF report projected maternal mortality in Nepal to increase by 16.7%, with 16,531 additional unintended pregnancies and a 31.7% increase in unsafe abortion in one year alone (Guttmacher Institute and CREHPA, 2017).

- Tailored capacity building for local leaders with a focus on human resource management, and other governance related issues like budget allocation, and collaboration, with an emphasis on emergency contexts. This capacity building can be done before, during and after emergencies.

- Continuous engagement with the federal government on the simplification of public procurement processes, particularly during crises, enabling local governments and other local actors to expediate procurement and improve response times.

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