Update-5

Isolation and Management of Individuals Infected with COVID-19 at Local Level

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Around mid-May, the daily identification rate of individuals infected with COVID-19 was very low. Since only a small number of infections were being identified, their isolation and treatment at designated hospitals was possible. But, after widening the scope of testing around the end of May, more than 100 infections were being identified every day. On July 3, 2020, a total of 740 individuals with the infection were identified, registering the highest single-day total so far.[1] With more cases of infections identified than what designated hospitals could accommodate, the isolation of individuals with infections was a challenge. Hospital beds were fully occupied by individuals with infections, most of whom exhibited no symptoms.

As the rate of daily infections increased, the pressure of individuals requiring isolation also increased. The number of individuals being kept under isolation peaked at 10,341 on June 30, 2020. After that date, the number of individuals being discharged from isolation centers after being cured significantly outpaced the number of new individuals requiring isolation. The federal government issued a revised testing guidelines for COVID-19 on June 2, 2020 which stated that no tests were required for confirmed cases who have completed 14 days of isolation with no symptoms. It also stated that no tests were required for symptomatic cases who have completed 14 days of isolation and spent at least three days without symptoms.[2] After this directive, a large number of individuals with COVID-19 infections who had been kept under local government managed isolation centers were sent home without administering a second test.[3] Thus, as the number of individuals returning home after staying in isolation centers outpaced the number of new infections, the number of individuals in isolation at district and local levels gradually decreased. But this number, which had reduced to about 5,000 around the end of July, is now steadily increasing. More individuals showing COVID-19 symptoms have been identified. When the scope of testing decreased, the rate of identifying infections had also decreased; now, as the scope of testing expands, the rate of infections being identified is also increasing (See Figure 1).

On June 29, 2020, the federal government issued the 'Health Standards Related to Isolation of Individuals with COVID-19 Infection, 2020' stating minimum standards to be followed for management of isolation centers at the local level and standards to be followed in home isolation. The federal government issued directives making it possible to establish isolation centers at the local level and for people to opt for home isolation.[4] Directives on the standards for the operation and management of isolation centers were also issued by provincial governments in line with the federal directives. This reduced the pressure of asymptomatic individuals or individuals with mild symptoms at designated COVID-19 hospitals, the presence of whom would have hampered the treatment of patients with serious conditions.

Province 2 has registered the highest number of infections among all provinces. Province 5 and Sudurpaschim Province are second and third respectively. Province 1, Bagmati Province, Gandaki Province and Karnali Province have seen the rate of infection rise relatively slowly. Although Bagmati Province had fewer cases of infection than Province 1

[1] Government of Nepal, Ministry of Health and Population, Situation Report #145

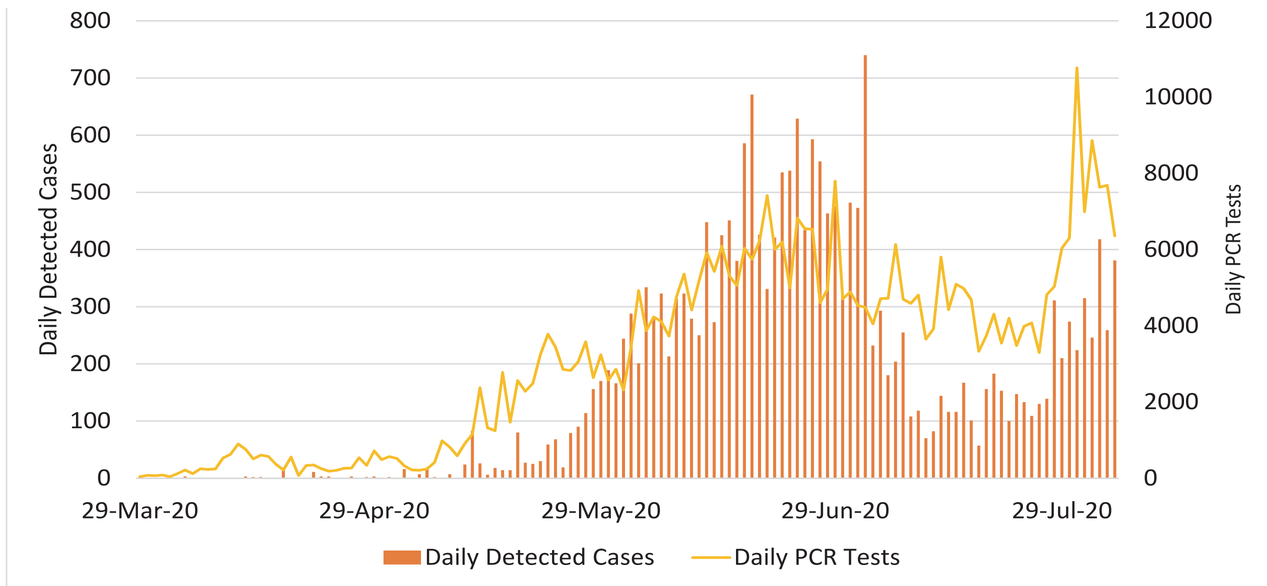
[2] Government of Nepal, Ministry of Health and Population, National Testing Guidelines for COVID-19, approved on June 2, 2020.

[3] On June 17, 2020, the World Health Organization issued its revised directives regarding discharging individuals with the COVID-19 infection from isolation. It appears that the federal government used those directives as the basis for this decision. https://www.who.int/news-room/commentaries/detail/criteria-for-releasing-covid-19-patients-from-isolation

[4] The National Testing Guidelines for Covid-19 issued by the Ministry of Health and Population on June 2, 2020, may be considered an example.

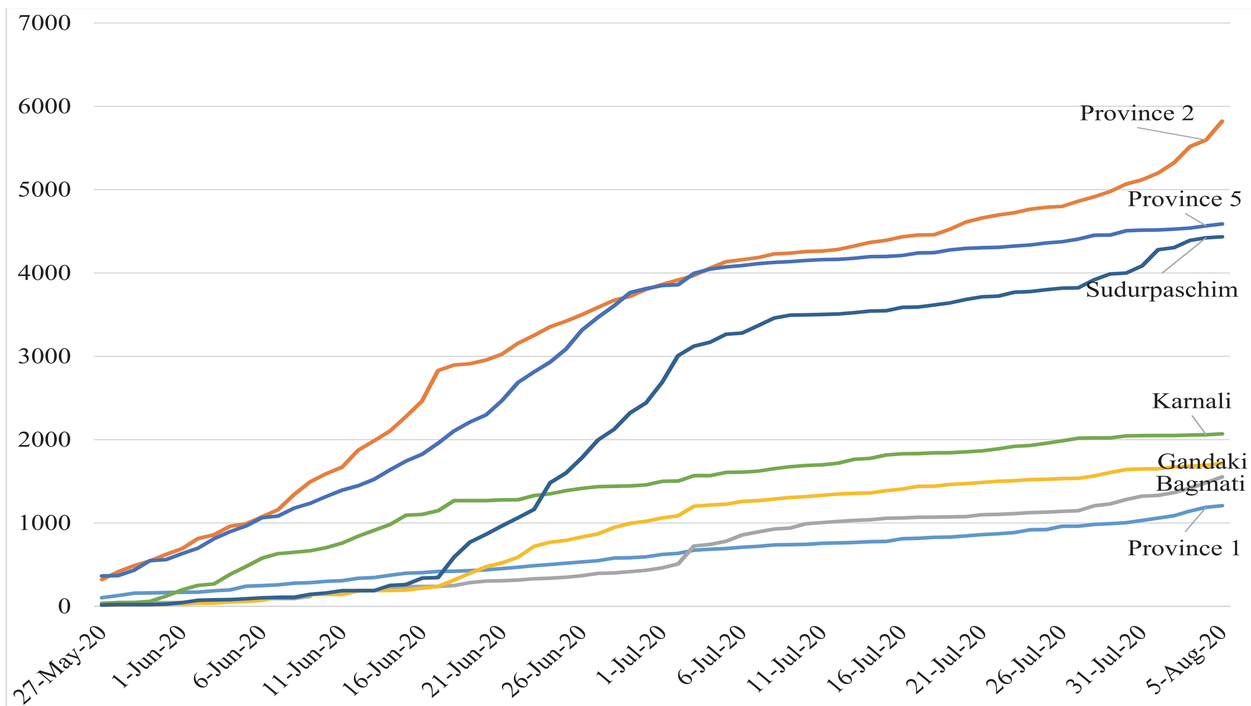
until July 2, 2020, the number of infected individuals is increasing (See Figure 2). As the number of infected individuals increases, it appears that they will also face challenges in isolation management.

Figure 1: Number of daily PCR tests and confirmed infections



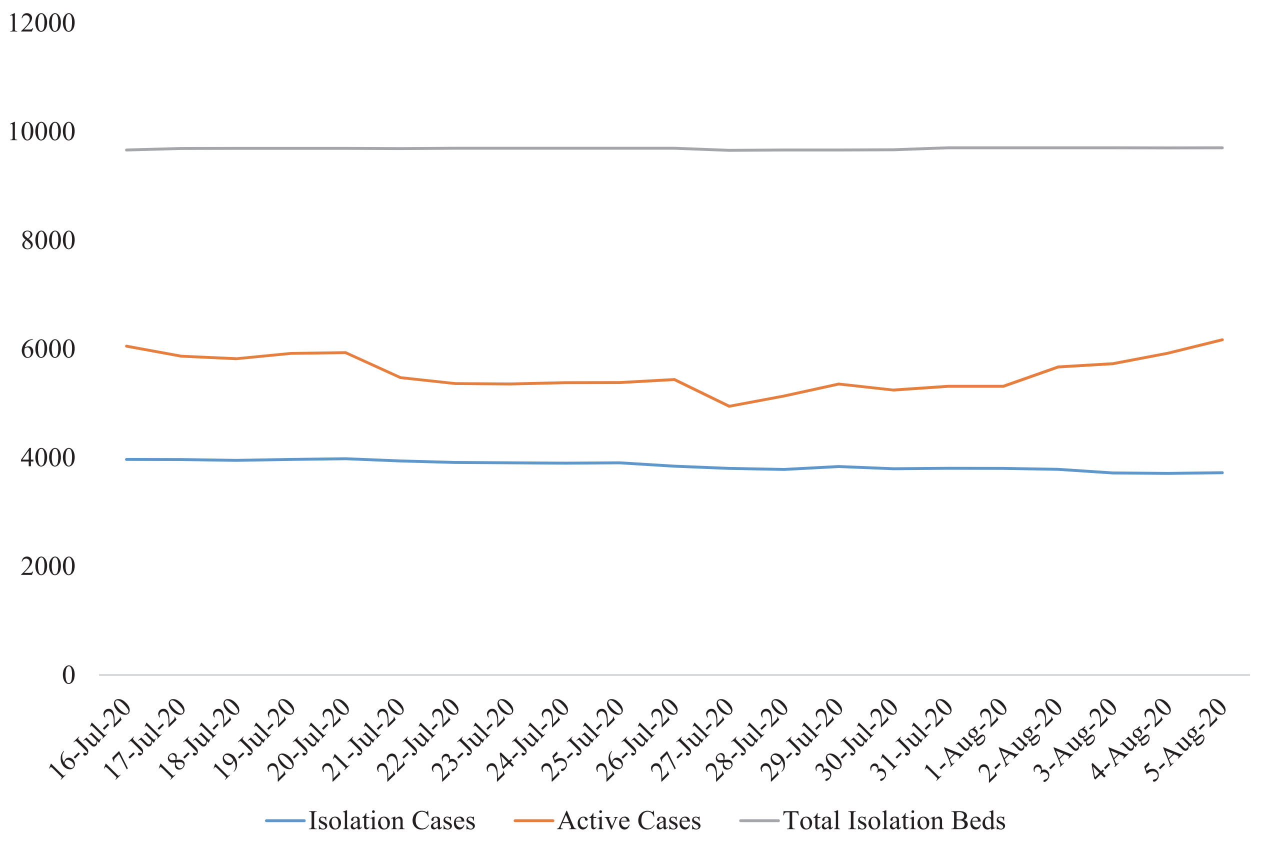
Source: Government of Nepal, Ministry of Health and Population, Status Reports 49–178; https://covid19.ndrrma.gov.np/timeline/

Figure 2: Total number of infections at the province-levels



Source: https://covid19.ndrrma.gov.np/timeline/

Figure 3: Isolation bed capacity and number of individuals under isolation



Source: https://covid19.ndrrma.gov.np/timeline/

This Democracy Resource Center Nepal (DRCN) study on the management of isolation centers was done in the context of the rapid rise in the number of infections.[5] Districts with relatively high rates of infections (Dailekh in Karnali Province, Kailali in Sudurpaschim Province, Rautahat in Province 2, Kapilvastu and Palpa in Province 5 and Nawalparasi-East in Gandaki Province) and some local units in those districts were selected for this study. Telephone conversations were carried out around mid-July with district-level stakeholders, elected representatives, officials, health coordinators, physicians, health workers, journalists and representatives of organizations at the local level in these districts. Statistics and information were also collected through media monitoring.

[5] In its previous updates, DRCN had discussed the various challenges associated with the management of the large number of citizens returning from India, their quarantine management, the slow rate of testing, and challenges in expanding laboratory facilities. Seeing how difficult it had been for local units to manage quarantine facilities, it had already been estimated that it would be additionally difficult for them to manage isolation centers.

1. Establishment and management of isolation centers

It has been very challenging for local governments to establish and manage isolation centers. When it became difficult for designated COVID-19 hospitals to manage the increasing rate of infections, local governments were immediately required to isolate any new confirmed case of COVID-19 infection. They did not get the time to prepare separate buildings to isolate infected individuals, or to make other essential preparations. They utilized available infrastructure to hurriedly create isolation facilities. They converted

existing quarantine facilities into isolation facilities. Most of these isolation facilities, created in schools and other public buildings, could not meet the standards issued by the Government of Nepal.[6] In districts and local units with relatively low rates of infections, the treatment and management of individuals with infection was being carried out in isolation facilities established in hospitals and other health facilities.

As shown in Figure 3, isolation centers across the country have a total capacity of around 10,000 beds. According to the latest statistics, only 4,000 beds have individuals with COVID-19 infections. Yet, the number of active infections is between 5,000 and 6,000. DRCN was told that the difference of around 1,000 individuals were in self-isolation at their homes. However, it appears that it has not been possible to monitor individuals under home-isolation and whether they are following the rules of isolation.

Nearly 800 individuals with COVID-19 were identified in Dailekh. Local schools and public buildings had to be converted into isolation facilities overnight which made it difficult to adhere to the stipulated standards.[7] According to a Dailekh District Coordination Committee (DCC) official, existing infrastructure like schools were being used as isolation facilities after ensuring as much compliance as possible with the standards issued by the Government of Nepal. The official accepted that most isolation centers lacked essential facilities like ventilators with supervising physicians, an ambulance and oxygen supply. Many other districts and local units also experienced this problem. A representative of the District Health Office in Palpa said that there were about 350 isolation beds across Palpa district. He asserted that some isolation centers differed from others in terms of resources, but none of them met the standards prepared by the Government of Nepal. The chief district officer of the district said, “We had kept 31 individuals at a quarantine facility. When we tested them, 30 individuals showed they carried the infection. We converted the quarantine center into an isolation center and transferred the individual without infection to another quarantine facility.”

The infection was identified in nearly 170 individuals in Yashodhara Rural Municipality of Kapilvastu. Initially, when the number of infections was between 15 and 20, infected induviduals were being sent to the COVID-19 hospital in Butwal. But when the COVID-19 hospital informed that it could no longer accommodate new individuals with the infection due to increased pressure, an immediate decision was made to convert the rural municipality’s quarantine facilities, being operated out of three community schools, into isolation centers. In terms of physical infrastructure and facilities available, these isolation centers were no different from quarantine facilities. Because many quarantine facilities had been converted into isolation centers without any additional safety provisions or essential services, there was an increased risk of COVID-19 infections spreading from such centers into communities. DRCN was told that relatives bringing meals to patients at a few isolation centers in Kapilvastu did not practice physical distancing, nor did they practice any other precautions.

[6] As per the government issued guidelines, the minimum standards to be followed in such isolation centers include adequate physical infrastructure for maintaining physical distancing among infected individuals; adequate human resources, medical officers and health professionals, security persons as per the number of infected individuals in the isolation facility; regular health check-up and maintenance and updating health profile of individuals; availability of required medicines, instruments for health check-up, oxygen cylinders, oximeter as per the number of infected individuals; regular cleanliness, waste disposal and garbage management; regular communication with nearest COVID-19 hospital and ambulance on standby; and management of visitors and safety measures. Most of the isolation facilities established in districts and local units lacked most of these resources.

[7] Provisions exist that at an isolation center there must be at least two meters of physical distance maintained between individuals; that as much as possible single cabins should be provided for patients; that there should be separate entrances, toilets, bathrooms, hand-washing stations for security personnel and other employees; that medical officers (one per 50 individuals with the infection) and security personnel should be present; that two nurses or paramedics should be available per 25 individuals with the infection; and that the necessary medications, equipment, oxygen cylinders, masks, personal protection shields, an ambulance and at least three medical check-ups daily should be available.

Case Study 1: Challenges faced by Dailekh

With large numbers of Nepalis arriving from India, Narayan Municipality in Dailekh had to manage the stay of over 200 individuals at a quarantine facility with only 100 beds. As the rate of people arriving increased, all school buildings were converted into quarantine facilities. Swab samples were collected after individuals had stayed under quarantine for over 14 days, and sent to Surkhet for testing. Test results were not received even after a week. People who had been staying under quarantine began protesting over the delay in receiving test results. When the district COVID-19 Crisis Management Center (CCMC) informed the federal government about the challenges it faced, it received directives to conduct Rapid Diagnostic Tests (RDT) on individuals not exhibiting any symptoms. Four individuals tested positive with the RDT, they were isolated, while the remaining individuals were sent home. But after a few days when the Polymerase Chain Reaction (PCR) test results arrived, the infection was seen in 30 individuals. When it was apparent that individuals who had already gone home were carrying the infection, the CCMC decided to return them for isolation. Immediately, seven isolation centers were established across Narayan Municipality where individuals who returned from their homes were kept along with new cases of identified infections. They were kept for an additional 14 days. Ambulances were kept at standby to transport individuals to the Health Service Office or Province Hospital if their health status deteriorated. However, even these isolation centers lacked adequate facilities.

DRCN was told that some individuals with the infection experienced psychological stress because they had to stay at isolation centers lacking even the minimum facilities. Some infected individuals were scared that they may not get timely access to a hospital if their health conditions deteriorated, and that they may even die from a lack of treatment. Individuals with the infection staying at isolation centers without a supervising physician and necessary safety and treatment resources felt unsafe. An individual at an isolation center in Narayan Municipality of Dailekh, feeling unsafe, repeatedly requested to be taken to the isolation unit at a hospital. He had felt safe only after being taken to the special COVID-19 hospital in Surkhet.[8] There were similar examples from the isolation center in Yashodhara Rural Municipality as well.

Local governments are managing isolation centers with the human resources available to them. Some have hired additional employees on contract. According to the medical superintendent at the District Hospital in Gaur of Rautahat, more than 40 employees, including a few physicians, were hired on contract for isolation management. But in Dailekh, isolation management was carried out using available employees and health workers. According to a physician at the Health Services Office in Dailekh, the eight to 10 doctors available across the district were deployed at the isolation centers. He said, "We reach all 11 local units as necessary. Local governments contact us if there are serious cases, and we coordinate to bring the patient to the district headquarters. If treatment is not possible here, we send them to the COVID-19 hospital in Surkhet." Similarly, in Gauriganga Municipality of Kailali, the public health inspector informed that a five member team led by a medical officer was providing services at the isolation center working on 15-day shifts.

In Palpa, isolation centers were managed by deploying available human resources in shifts. However, there were not enough specialist physicians available. The deputy mayor of Rampur Municipality in Palpa said that while there were enough of other health workers, there were not specialist physicians in adequate numbers. At district-level isolation centers, however, some specialized services were also available. The chief district officer at Dailekh informed DRCN that an isolation center with 31 beds, including three high care units, was established at the District Health Services Office. However, even district-level

[8] http://annapurnapost.com/news/156725

isolation centers lacked health facilities like ventilators and intensive care units.

Gauriganga Municipality was forced to build a local isolation center after Covid-19 patients it had sent to the Seti and Mahakali hospitals found it difficult to get a bed. Due to the shortage of beds, patients were frantically taken from one designated hospital to another. A total of 1,149 PCR tests carried out in local units confirmed 142 cases of the infection. All of them were kept at the municipality's isolation center for 14 days and discharged after nobody showed any symptoms. A health worker told DRCN that three individuals had been allowed to self-isolate at their homes after getting them to sign a commitment document. In Dailekh, a few individuals were allowed to self-isolate at their homes, but without having them sign any commitment documents.[9] Some local governments were found to be using local hotels as isolation facilities. Lamkichuha Municipality in Kailali converted a local 25-bed hotel into an isolation center.

The deputy mayor of Chandrapur Municipality in Rautahat said, "We had panicked when hundreds of infections were being identified each day, but we were able to address the challenge to some extent with the help of elected local representatives, employees, health workers and security personnel." Local governments feel that the situation has eased up a bit in recent days as individuals with infections have returned home after staying at isolation centers for 14 days or more. A physician at the District Health Services Office in Dailekh says, "As the number of people entering Nepal decreased, the number of people staying at quarantine facilities also decreased. The number of confirmed infections is low because the rate and scope of testing is also low, and isolation centers are emptying out." The health coordinator at Yashodhara Rural Municipality told DRCN that all three isolation centers in the local unit were empty after all individuals staying there returned home after completing their 14-day stay.

[9] Karnali Province had issued a list of rules that was to be compulsorily followed by individuals under home isolation. On it, the consent to the rules was the first point.

2. Inter-municipal coordination in isolation management

Limitations in physical infrastructure, administrative capacity and resources made it difficult for local governments to tackle the challenges posed by a global pandemic like COVID-19 on their own. Since local governments are autonomous within the federal structure, it has been easier for them to coordinate with each other and make decisions. They have mutually coordinated with each other to establish and manage isolation centers which are expensive. Toward the beginning of the lockdown, in Rautahat, Brindaban, Gujara, Gadhimai and Chandrapur municipalities had implemented the decision to establish a common quarantine facility. Later, as the number of infections increased, these municipalities cooperated in the establishment of isolation centers (See Case Study 2).

Case Study 2: Isolation Center in Rautahat

There are 11 isolation centers across Rautahat with a total capacity of 470 beds. Of them, only the isolation center in Chandrapur Municipality and the District Hospital at Gaur were established for this specific purpose. The remaining centers are municipality and rural municipality quarantine facilities later converted into isolation centers.

The Convention Hall situated at Shahid Park in Chandrapur-2 was converted into an isolation center through the common efforts of Chandrapur, Brindaban, Gujara and Gadhimai municipalities. The 40-bed isolation center was built with NPR 2.5 million from Chandrapur Municipality and NPR 1.5 million each from Brindaban, Gujara and Gadhimai municipalities. According to the Public health inspector who is in charge of the isolation center, the municipalities agreed to establish the isolation center there because, in comparison to other local units, Chandrapur Municipality had the necessary physical infrastructure where it would be easier to get assistance and supply the necessary health workers. The isolation center was established along the East-West Highway and there are private and government hospitals nearby making it easier to

transport individuals with infections to hospitals if the need arises.

The isolation center, which is located far from settlements, has four sections with seven air-conditioned rooms. The deputy mayor of Chandrapur Municipality claimed that it was the most well managed and well-appointed isolation center in the entire district. The isolation center contains beds arranged with adequate physical distance between them, an adequate number of temporary toilets, clean drinking water, health check-ups, hygiene, internet and other essential services along with games like chess and ludo. If the health of anyone deteriorates and they need to be taken to a hospital, there is an ambulance on the ready. Individuals staying under isolation have access to meals and snacks. Expenses are being managed through a common fund into which all four local governments have contributed. Five health workers, including two physicians working at the local hospital, two health assistants and a health inspector, have been deployed at the isolation center. The health inspector at the isolation center said, “All necessary medications, PPE and nebulizer are available here, but there is no ventilator.”

DRCN was also told that although most cases of the infection had been found along the southern part of the district, most isolation centers in the region had not been well managed. Most local governments had converted schools into quarantine facilities, and when the rate of infection increased the same space were converted into isolation centers. But since such isolation centers lacked even a basic bed, individuals with the infection were living on mattresses spread on the floor. Sanitary facilities were inadequate, basic hygiene was lacking, and there was an increased risk of the infection spreading. The medical superintendent at Gaur Hospital accepted the fact that necessary facilities were lacking because erstwhile quarantine facilities had been converted into isolation centers.

In Palpa, Rampur Municipality and Nisdi Rural Municipality are operating a 50 bed isolation center. In Nawalparasi-East, a five bed isolation center was prepared in Midpoint Community Memorial Hospital in Danda of Kawasoti Municipality. But, as the number of infections increased greatly, the center was shifted to the Community Naturopathy Hospital in Rajahar of Devchuli Municipality. The facility hosted 220 individuals with the infection, around mid-July 138 patients were receiving treatment. The mayor of Devchuli Municipality said that eight local units in the district had pooled together their resources to manage expenses. According to him, each municipality had contributed NPR 800,000 while each rural municipality had contributed NPR 700,000.

Many local governments across the country have established common isolation centers because it not only lowers the cost associated with establishing them, but also reduces operational cost. Inter-municipal coordination had also helped with the deployment of the limited human resources available. In Dang, Gadhawa, Rajpur and Lamahi municipalities have established a special isolation center at the Rapti Pravidhik Shikshalaya of Rapti Rural Municipality, a technical skills school. Alongside deploying their available employees, participating local government have also mobilized a common fund toward this end, with each local government contributing NPR 1.5 million to the fund.

3. Management of budgets and resources

Local governments built isolation centers in accordance with the directives from the federal Ministry of Health and Population by mobilizing available resources and human resources. Although provincial governments had provided some funds to establish and operate district-level isolation centers, local governments had gathered the resources required at the local level on their own. Most often, local governments had first exhausted their Disaster Management Funds before reallocating budgets from various other development projects towards the establishment and operation of isolation centers.

The medical superintendent of the District Hospital in Gaur of Rautahat district said, “The provincial government had sent us about NPR 5.5 million. The federal government sent personal protection equipment. But the biggest challenge we face is regarding the management of operational costs. We have about NPR 5.5 million worth of invoices remaining to be cleared. We have asked the provincial government, and we have received a positive response.”

According to the mayor of Gauriganga Municipality, a COVID-19 fund was established in fiscal year 2019-20 and funds allocated for disaster management was transferred into it along with budgets for a few other municipal projects. The target for the fiscal year 2020-21 is to create a fund amounting to NPR 10.05 million. The deputy mayor of Chandrapur Municipality said that although the federal government provided some assistance toward purchasing beds and the provincial government made some test kits available, the main fiscal burden associated with the isolation center is born by the local government.

In cases when the health of individuals infected with COVID-19 deteriorated, many of the isolation centers did not have an ambulance, ventilators and oxygen supply. In some local units, DRCN was told that the situation had become additionally difficult because ambulances available on rent had shown reluctance in carrying patients. The head of a health office in Palpa said that when an elderly patient requiring dialysis tested positive with COVID-19 and was referred to the special COVID-19 hospital, the hospital was reluctant in admitting the patient.

Eight local units in Nawalparasi-East were collectively managing finances of a common isolation center. Around mid-July, the provincial government provided about NPR 5.7 million to the isolation center situated in Devchuli Municipality as compensation for expenses incurred to that date. The District Hospital in Gaur also received financial assistance from the provincial government toward the management of the isolation center there.

Local governments have deployed available human resources in an appropriate manner even in these adverse circumstances. But, a challenge that has appeared in this context is the issue of financial incentives. According to the public health inspector at Gauriganga Municipality, the local government has not been able to provide additional benefits to health workers. He said, “We provided an additional daily stipend of NPR 500 for first two months, but we have not been doing so now. We have asked the Accounts Section for the 50 percent risk allowance that was supposed to come from the federal government, but we are being told that there are no funds for that. We had provided free ambulance service to infected individuals. There have been complications in paying for it, so it seems we will have to adjust it in the forthcoming budget.” According to the deputy mayor of Chandrapur Municipality, a decision was taken to divide health workers into four categories according to risks faced and provide benefits accordingly, but no monetary benefits have been provided so far. She said that the risk allowance would be disbursed soon as the Municipality had kept this issue in mind while allocating budgets for the current fiscal year.

Both Rampur Municipality in Palpa and Devchuli Municipality in Nawalparasi-East reported that they are providing incentive pay amounting to between 25 and 100 percent of monthly salaries. Rampur Municipality had been providing a daily allowance of NPR 1,200 to frontline and laboratory workers. Representatives of both municipalities said that other employees on contract like those who managed waste, municipal police, drivers and others were receiving up to 50 percent of their monthly wages as incentives.

4. Retest and discharge of individuals with the infection

Individuals kept under isolation were being sent home after 14 days, in some places after administering additional tests and, in some other places, without

additional testing.[10] Controlling the spread of COVID-19 has been affected by a slow rate of testing and the lack of easy access to laboratories. Even local governments that have wanted to discharge and send individuals home only after additional testing have been failing to do so owing to a lack of easy access to laboratories. In Rautahat, individuals under isolation are tested for a second time after staying under isolation for 10 to 12 days, and are discharged only after the results are received. But the long lag between sending samples for testing and receiving their results is also affecting the prevention of the spread of the infection. In many cases, it took longer than two weeks for the test results to be received. This has forced individuals with the infection to continue to stay under isolation for many more days than necessary.[11] A physician at Gaur Hospital informed DRCN that some individuals staying under isolation had been administered as many as three additional PCR tests before being discharged home.

In Dailekh, individuals not exhibiting any symptom had been discharged without additional testing after 14 days under isolation. In Birendranagar of Surkhet, individuals under isolation had protested when attempts were made to discharge them home without additional testing. The public health inspector at Gauriganga Municipality said that about 140 individuals with the infection had been sent home without additional testing. According to a representative of the District Health Services Office in Palpa, although attempts were made to send people home only after ascertaining that they were free of the infection, people had to be sent home without additional tests because laboratories had refused to administer additional rounds of tests. In Yashodhara Rural Municipality, the municipal health coordinator said that although a decision was taken to send people home after additional testing, they were discharged before the results of additional tests were received because of the delay in test results. Of them, 14 individuals returned positive results but they were not sought for and brought back to isolation centers. They were directed to self-isolate at their homes. The standards related to isolation requires local governments to obtain and record the daily health status of individuals with the infection through phone calls and SMS, however, the practice appears to have been absent. Thus, the possibility has increased that, on the one hand, individuals with infections would lack any monitoring and, on the other hand, the infection would spread with the arrival of such individuals into their communities. It was also suspected that the infection had spread in Dailekh and Birgunj of Parsa after individuals with infections reached their communities after being discharged from isolation centers.[12]

5. Role of district-level institutions

Representatives of various organizations, security institutions, the CCMC, the DCC, the District Administration Office, and the District Health Office claim that there has been necessary coordination in quarantining, testing and isolation management. But representatives of local governments say that the coordination has not been effective, and that a disproportionate burden of COVID-19 prevention and control has fallen upon them. Initially, when the rate of infection was low, individuals with the infection were being taken to designated COVID-19 hospital through coordination at the district and provincial levels. But according to an employee at Yashodhara

[10] The National Testing Guidelines for Covid-19 issued by the Ministry of Health and Population on June 2, 2020, states that individuals with confirmed COVID-19 infection shall not require additional testing after 14 days under quarantine if they did not show any symptom, and that they may be sent home without further testing. And for individuals showing symptoms, it allows for them to be sent home without further testing if they complete 14 days of isolation and do not show further symptoms over an additional three days. But when a writ petition was filed at the Supreme Court against the decision to send home individuals at isolation centers without further testing, the Supreme Court issued an interim order prohibiting the implementation of the decision. The Court has issued an order requiring additional PCR testing to ascertain that individuals staying at isolation centers are free of the infection before they may be discharged home.

[11] Lack of timely tests of individuals under quarantine required them to stay under quarantine for longer periods. https://www.democracyresource.org/wp-content/uploads/2020/06/COVID-19_Update-4_30June2020-web-version.pdf

[12] https://ekantipur.com/news/2020/07/23/159550838188874808.html

Rural Municipality, when the rate of infections increased, local governments were forced to manage isolation centers on their own, and the necessary assistance from district-level institutions was not received. “Neither did anyone come to monitor [the isolation center], nor did they provide any assistance. We somehow managed the stay of all individuals with the infection. We sent them home after 14 days, but without additional testing. It would have been very difficult to manage if anyone had developed any health-related complication,” the employee said. DRCN was told that in Dailekh, the District Administration Office had coordinated the identification of individuals with the infection and of isolation centers through committees and subcommittees representing the local governments within the district along with the DCC and other organizations.[13] In cooperation with the relevant local governments, these committees and subcommittees collected details about citizens arriving from elsewhere, managed quarantine facilities, conducted contact tracing, and also assisted in keeping individuals with the infections under isolation. However, since testing could not be done on time, cases of the infection were identified only after individuals had reached their homes from quarantine and isolation facilities. These committees and subcommittees then assisted with returning individuals with the infection to isolation centers and in identifying other individuals who had come in contact with such individuals.

DRCN found that the monitoring and supervision of these isolation centers were not effective. Monitoring and supervision may have weakened due to the risk of the infection spreading. However, in a few isolation centers at the Palpa district headquarters were being observed by representatives of the District Administration Office, the CCMC, the DCC, the District Health Office and World Health Organization. DRCN was also told that the isolation center in Chandrapur Municipality received periodic monitoring visits.

6. Conclusion

As the rate of people arriving from elsewhere into districts and local units decreased, the number of people staying at quarantine facilities also decreased. At isolation centers, too, the number of people arriving was lower than those being discharged home. This decreased the pressure on many isolation centers established at the local level. It is suspected that individuals with infections are returning into their communities because of the inability to identify them in time and the failure to contain them at isolation centers. The fact that the access to laboratories or the scope of testing has not increased may also have resulted in the failure to identify actual individuals with the infection. However, with the recent increase in the scope of testing, the rate of infection has also increased. Therefore, it can be concluded that the decision a few weeks ago by the federal government to decrease the scope of testing was erroneous.

The federal government should have utilized the period after the lockdown as an opportunity for necessary preparation to expand the scope of testing, isolating individuals with the infection, identifying other individuals who had come in contact with them, establishing well-managed isolation centers, upgrading hospital facilities, etc. But the expected achievements have not been made in this regard. The fact that the management of isolation and quarantine facilities has been ineffective appears to have resulted in the infection reaching the community-level. Examples of individuals who were sent home before receiving their test results but were subsequently identified as carrying the infection show that the infection may reach horrific proportions. On top of that, the possibility of the infection getting out of control also exists since the lockdown ended in the country. Because of these reasons, the task of identifying individuals with the infection and the management of isolation centers appears additionally challenging. Since there is no

[13] DRCN was told that the District Administration Office had been coordinating with the district-level COVID-19 Crisis Management Center, COVID-19 Outbreak Reduction Committee, COVID-19 Prevention, Control and Management Safety Committee/Sub-committee, Rapid Response Team, Market Monitoring Committee, COVID-19 Command Post and other committees and sub-committees.

sign that COVID-19 will be brought under control anytime soon, it is imperative for local, provincial and federal governments to create long-term policies and programs aimed at identifying individuals with the infection, contact tracing, isolation and treatment. If the scope of testing is widened, isolation centers are upgraded to meet stipulated standards, and individuals with the infection are isolated in time from their communities, it may be possible to slow the rate of spread of COVID-19.

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