

**Update-6**

# **The Federal, Provincial and Local Governments in COVID-19 Prevention, Control and Treatment**

**October 19, 2020**

**DEMOCRACY**  

---

**RESOURCE CENTER**



## The Federal, Provincial and Local Governments in COVID-19 Prevention, Control and Treatment

Nearly two months after the first case of COVID-19 was confirmed, the second COVID-19 infection was identified in Nepal on March 23, 2020. Immediately, on March 24, the Government of Nepal decided to impose a nationwide lockdown. Since then, all three levels of government have actively engaged in the prevention, control and treatment of COVID-19. They also play central roles in the process of quarantine management, testing, isolation and treatment. The additional rights afforded to the three levels of governments by federalism made it easier for provincial and local governments to respond to COVID-19 with greater autonomy. Yet, a multitude of challenges persist. Health experts estimate that the infection has reached the community-level in the Kathmandu Valley and various districts of the country.<sup>1</sup> It is against this context that this report discusses the policies adopted by the three levels of government toward preventing, controlling and treating COVID-19. It goes on to evaluate the implementation of such policies along with the challenges and shortcomings in coordination between them.

### Preparedness for infection control

Each of the three levels of government failed to take the spread of the COVID-19 infection seriously and make appropriate preparations by creating policies essential for its control and treatment. In the winter of 2019, COVID-19 had been identified in China and was spreading to other countries. It is natural that a pandemic originating in one country eventually reaches other countries in this globally connected

world. Therefore, risk assessments should have been done in a timely manner and preparations made with commensurate urgency. Yet, in Nepal, even two months after the first case was identified, facilities for testing COVID-19 had not been extended beyond the federal capital. The absence of such facilities was because of delays in the import of healthcare material. The Prime Minister and his ministers expressed skepticism regarding COVID-19 and made light of its effects on public health.<sup>2</sup> The head of the federal government itself took the disease lightly. The Prime Minister went so far as to declare in the parliament that COVID-19 could be treated like any other ordinary seasonal flu. Officials at the highest institution related to public health – the Ministry of Health and Population – were not professionals possessing knowledge of healthcare services. It was natural for the minister to be from a political background, but since even the Secretary of the Ministry wasn't from a health background, the administrative leadership failed to take effective steps after briefing political leadership on the possible negative fallout of taking the disease so lightly.

Local levels established quarantine facilities, but they were not well-managed owing to a lack of resources. They soon proved inadequate for citizens returning home in large numbers. They played a role in separating individuals suspected of carrying the infection from local communities. But, in some cases, quarantine facilities themselves became infection hotspots. A lack of management and coordination was seen even within the limited efforts made in the prevention, control and treatment of COVID-19. Because of this, there were difficulties in testing for the virus, and quarantine and isolation facilities became ill-managed. Consequently, effective treatment of the infected wasn't possible. There was a lack of healthcare material, but in parallel, there was also a failure to prepare healthcare workers by providing them the necessary knowledge and skills.

<sup>1</sup> Dhaukakoti, Prakash. 2020. v.s. Rajdhanima Samudayamai Sankraman, Tara Contract Tressing Huna Sakena. <https://www.nayapatrikadaily.com/news-details/50019/2020-08-27>; accessed September 10, 2020.

<sup>2</sup> Swasthkhobar. 2020. v.s. Nepaliko Rog Pratirodhatmak Kshamata Badhi Chha Kasale Bhaneko? Gaganko Prashnama Pradhanmantriko Jawaf – Maile Bhaneko. <https://swasthyakhabar.com/story/32977>; accessed September 10, 2020.

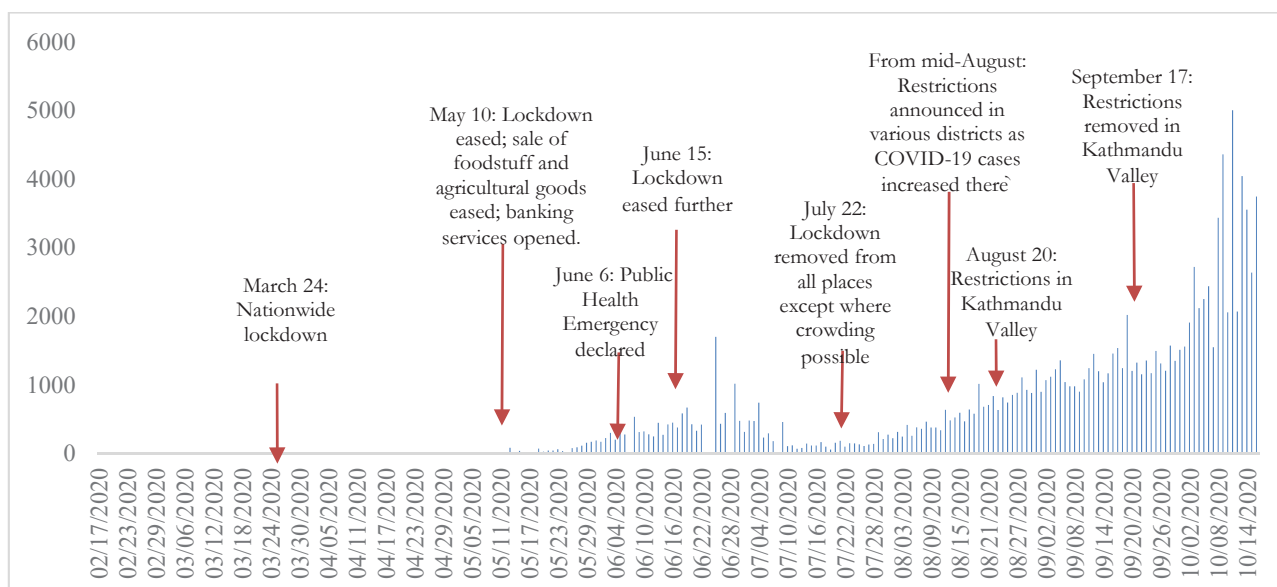
## Lockdown/Restrictions: Rushed decisions taken without necessary preparation

A nationwide lockdown was imposed in the third week of March, with the stated purpose of controlling the spread of the infection, identifying individuals suspected of carrying the infection, and making necessary preparations for their treatment. The lockdown proved effective in disrupting the transmission of the infection. But, even at that time, voices had been raised saying that instead of a blanket lockdown across the country, lockdowns should be enforced only in specific places in consultation with experts. After four months, when

such decisions rather than having a decisive role in decision-making.<sup>3</sup>

The fact that lockdowns and restrictions were imposed without clear planning or preparation meant that, alongside the spread of COVID-19 infections, the economic crisis also deepened further. In places with a low risk of the infection spreading, economic activities could have been permitted to continue after enforcing health standards. But, a nationwide lockdown resulted in the closure of all economic activities. The worst effect of this was experienced by laborers dependent upon daily wages for their

Figure 1: Status of confirmed daily infections



Source: Data related to daily infections have been taken from Our World in Data, and data on lockdowns and curfews have been taken from reliefweb.int

the lockdown was lifted, restrictions were again issued in more than 50 districts and local units. It was found that such restrictions were imposed or removed at the discretion of administrative officers with limited or no consultation with experts. An ex-Minister of Health and Population expressed the opinion that since restrictions imposed by district administrations are a matter of public security, it is natural for chief district officers to be involved, but the role of district administrative offices should be limited to the implementation of

livelihood. Local governments tried to provide relief materials to them in the form of cash and kind. But, an absence of beneficiary lists, limited quantity of available relief material, political and other biases, and cumbersome processes requiring official documents restricted the reach of these relief efforts. Since most people who are dependent upon daily wages for their

<sup>3</sup> Opinion shared by ex-Health Minister and member of Federal Parliament Gagan Thapa through his personal Twitter handle on September 9, 2020.

livelihood are also temporary migrants, there was a lack of the necessary documentation among them. Although laborers waited for a few days to receive relief, when they realized that both work and relief weren't so easily forthcoming they chose instead to walk hundreds of kilometers back to their places of origin.

The federal government wasn't found to have paid much attention to supplying the necessary healthcare equipment, increasing the rate and scope of testing, training healthcare workers, establishing well-appointed isolation centers, or managing hospitals after declaring the lockdown. According to the Health Sector Emergency Response Plan issued by the Ministry of Health and Population in the third week of April 2020, there were a total of 1,595 Intensive Care Unit (ICU) beds and 840 ventilators available across the country. Although it was apparent that it was essential to increase the number of available ICU beds and ventilators, this wasn't treated as a priority by the government. Because of this, it was found that citizens with serious COVID-19 infections had a difficult time finding treatment facilities.<sup>4</sup>

The lockdown ended without added strictness in public health standards at a time when the infection was spreading leading to COVID-19 spreading even more rapidly. The movement of people naturally increased with the end of the lockdown. There was no strictness in enforcing public health standards in public transport, business activities and various offices. People continued to travel unimpeded to and from spots where the infection was spreading. No institution thought it necessary to monitor whether or not people arriving from outside were observing quarantine. Kathmandu and other cities with dense populations like Biratnagar, Kalaiya, Birgunj, Bharatpur and Nepalgunj saw a rapid rise in the spread of COVID-19. In districts where the rate of infection increased, the district administration offices were given the responsibility of imposing restrictions.

<sup>4</sup> Poudel, Arjun. 2020. Valley has run out of intensive care beds and ventilators for Covid-19 patients. Available at <https://kathmandupost.com/health/2020/10/06/valley-has-run-out-of-intensive-care-beds-and-ventilators-for-covid-19-patients>; accessed September 30, 2020.

## **Arrival of Nepalis from India and their management**

Nepalis who were residing in India for employment began entering Nepal in large numbers from the last week of May. Some attempts were made for the safe management of Nepali citizens returning from India, but people were returning home in numbers far exceeding expectations. This meant that their management couldn't be effective and increased the risk of the infection spreading. When lockdowns were imposed on both sides of the Nepal-India border, people continued to surreptitiously come and go across the border. A lockdown was also imposed in India and Nepalis there lost their livelihoods while the rate of infection was also on the rise. When the lockdown in India was eased and transportation resumed, a large number of Nepali citizens suddenly returned home. Their arrival wasn't well managed, because of which the infection spread.

Tensions arose between Nepal and India after Nepal issued a new geopolitical map which included Limpiyadhura. Since the disputed territory falls in Sudurpashchim Province and Uttarakhand of India, the effect of the row fell mostly upon people traveling between those two territories. According to the chief district officer of a hilly district in Sudurpashchim Province, the Indian administrators who, before the territorial dispute, were prompt with responses regarding Nepali citizens stuck on the Indian side of the border, began tarrying with their responses when coordinating issues related to Nepali citizens stuck at the Indian border for long periods.

Local administrations along the border sent Nepali citizens who entered from India to quarantine facilities without administering tests and on transportation vehicles without appropriate or adequate safety precautions. Local governments also failed to calculate the exact number of their citizens who were abroad and accordingly prepare quarantine facilities in anticipation of their return. In the first phase, many local governments established a limited number of quarantine facilities. But, when their citizens began to return, they rushed to add new quarantine facilities.

Hundreds of people were forced to share kitchens, toilets and bathing facilities. When groups of people were kept in such quarantine facilities with very poor hygiene, the quarantine facilities became the main place for the spread of the infection.

### **Lack of healthcare material: Effect on treatment**

There was a delay in the supply of medicines, healthcare equipment and personal protection equipment (PPE) used to treat COVID-19. When such material were supplied after a considerable delay, the fact that they were of poor quality led to a further decline in the morale of healthcare professionals. This had an effect on healthcare services.

The Health Services Department under the federal government, along with provincial governments, was responsible for ensuring the supply of the medicines, healthcare equipment, gloves, sanitizer and personal protection equipment used to treat COVID-19. The first attempt made by the federal government to purchase material became controversial resulting in the cancellation of the agreement made with the firm selected to supply the material. Thereafter, the Nepal Army was given the responsibility of supplying healthcare material. However, the Nepal Army also failed to supply the material on time. Consequently, health institutions faced a severe lack of equipment and safety material required to treat COVID-19. An atmosphere of fear was created among healthcare workers because they were forced to operate amid a lack of PPEs. They had to be wary even when people with fevers or other illness approached them. People with illnesses couldn't avail treatment in time. Given the lack of personal protection equipment, technicians were unable to follow proper protocols while collecting swab samples from individuals with suspected cases of COVID-19. Experts warned that collecting swab samples in this manner may result in false results being shown by the tests.

### **Access to treatment of COVID-19 and other patients**

Federal and provincial governments failed to manage hospitals for the treatment of people with COVID-19 infections. Although they passed decisions to build COVID-19 hospitals, the implementation of the decision was delayed because of a lack of physical infrastructure and healthcare human resources. The decision to treat COVID-19 and other illnesses at the same hospital facilities combined with the failure to make alternative arrangements for citizens to easily access healthcare services meant that regular patients and visitors to these hospitals were deprived of treatment. There was an increase in cases of patients dying from being denied timely treatment. This is a common problem in the Nepali context where policies, plans and programs appear very attractive, but their implementation is ever effective or timely. Although the Province 2 government passed a decision to use the Kalaiya Hospital in Bara and Jaleswor Hospital in Mahottari as COVID-19 hospitals, the failure to arrange for the necessary infrastructure resulted in the hospitals not being brought into use in time. Individuals from Bara, Rautahat and Sarlahi districts with the infection were brought to Narayani Hospital in Parsa for treatment. In Lumbini Province, the decision to utilize the Armed Police and Nepal Army hospitals as COVID-19 hospitals saw delays in implementation. The Crisis Management Committee in Province 1 decided in June to increase the number of beds in isolation facilities to 800, but this decision had not been implemented by mid-October. Because of this, problems arose in the treatment of individuals with COVID-19 infections.

With the rise in the number of infections, the government, in the first week of August 2020, decided all the private and public hospitals to allocate 20 percent of their beds for the COVID-19 patients. The provision of not arranging for separate buildings, additional healthcare workers or medical equipment for COVID-19 patients appeared to be a risky decision. Due to this decision, many hospitals began treating non-COVID and COVID patients which increased the possibility of healthcare workers and



other patients getting infected.<sup>5</sup> Psychological fear resulted in fewer people seeking treatment at hospitals where COVID-19 patients were being treated. It is the federal and provincial government's duty to designate separate COVID-19 hospitals by coordinating with private hospitals and medical colleges. But, the federal government and all the provincial governments issued directives that 20 percent of available beds at every hospital and 33 percent of beds in medical colleges had to be designated toward COVID-19 treatment.<sup>6</sup> But, the fact that government hospitals, which were most accessible to the average citizens, were now being used as COVID-19 hospitals meant that patients with other ailments and chronic illnesses were deprived of treatment. For example, at least three patients died when the Narayani Hospital in Parsa was converted into a COVID-19 hospital, depriving patients of timely dialysis services. There were also multiple incidents where patients who had reached the hospital were refused admission by using COVID-19 as an excuse to deprive them of timely treatment, because of which patients lost their lives.<sup>7</sup>

Studies have shown that maternal and infant mortality rates have climbed dramatically above pre-pandemic levels because pregnant and delivering women have been deprived of timely access to healthcare institutions because of COVID-19.<sup>8</sup> Hospitals refused to admit expectant women out of suspicion that they

may be infected with COVID-19, and when infections had been confirmed, because COVID-19 dedicated hospitals refused admission, pregnant women had to be administered oxygen under home isolation.

### Testing: Limited laboratories, restricted scope

The delay in increasing laboratory capacity slowed the rate of testing, and results were delayed. This not only created difficulties in quarantine and isolation management, the infection also spread further. In the initial stage, Rapid Diagnostic Tests (RDT) were prioritized as they were cheaper and quicker to return results than Polymerase Chain Reaction process (PCR). But as reasons to suspect its reliability increased, pressure was created to stop RDTs. From the very beginning, physicians and epidemiologists were stressing upon the need for widespread testing to determine the actual status of the spread of the infection. Because of a lack of reagents in the country, the first COVID-19 tests were carried out abroad. Three months later, the second test was carried out in Nepal. By October, 2020, tests that were initially possible only in Kathmandu have been expanded to over 50 government and private laboratories across the country. However, there does not seem to be a correspondence between the increased need to carry out testing and the rate of expansion of laboratory capacity. In the first few months, in comparison to the need for testing, the rate of expansion of laboratory capacity was very slow.

There was a need to establish COVID-19 testing laboratories at the main check-points along the Nepal-India border. This was also a demand of the people and local governments along the border. However, both the federal government and the provincial governments ignored this demand. Therefore, in densely populated cities along the main entry points into Nepal from India like Birgunj, Biratnagar and Nepalgunj, COVID-19 infections became widespread. Since sample swabs were being collected in numbers far larger than the

<sup>5</sup> Khanal, Sabina. 2027 v.s. COVIDka ra Aru Birami Ekai Thau Rakhera Upachar Garda Birma Sankraman Phailiyo. [www.thahakhabar.com/news/106807/?fbclid=IwAR1k27GkzttKnGn7b9CJ4uIBBUYJY2gHJhI5bmBpNhImbnm\\_4p37YiCo1og](http://www.thahakhabar.com/news/106807/?fbclid=IwAR1k27GkzttKnGn7b9CJ4uIBBUYJY2gHJhI5bmBpNhImbnm_4p37YiCo1og); and, Rai, Bibek. 2027 v.s. 12 Jana Sathilai Corona Bhaisakyo, Samparkama Aayekalai Diutima Khatainchha. [www.setopati.com/social/215179/?fbclid=IwAR1k27GkzttKnGn7b9CJ4uIBBUYJY2gHJhI5bmBpNhImbnm\\_4p37YiCo1og](http://www.setopati.com/social/215179/?fbclid=IwAR1k27GkzttKnGn7b9CJ4uIBBUYJY2gHJhI5bmBpNhImbnm_4p37YiCo1og); accessed September 20, 2020.

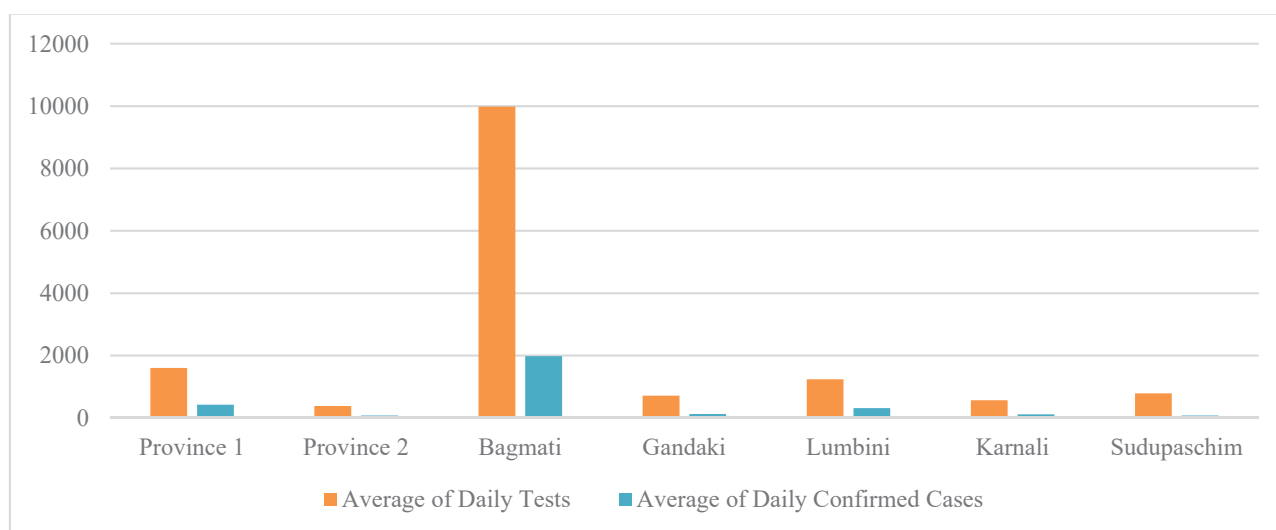
<sup>6</sup> Onlinekhabar. 2027 v.s. Sabai Aspatalma Corona Sankramitnali Rakhne Tayari. <https://www.onlinekhabar.com/2020/08/888522>; accessed September 10, 2020.

<sup>7</sup> Budhathoki, Kishor. 2027 v.s. Sat Ota Aspatal Puryaunda pani Upachar Napayera Garvawatile Tyagin Pran. <http://annapurnapost.com/news/165326>; accessed September 10, 2020.

<sup>8</sup> KC, Ashish, et al. 2020. Effect of the COVID-19 pandemic response on intrapartum care, stillbirth, and neonatal mortality outcomes in Nepal: a prospective observational study. *The Lancet*

*Global Health* 8(10): e1273–e1281. DOI: [https://doi.org/10.1016/S2214-109X\(20\)30345-4](https://doi.org/10.1016/S2214-109X(20)30345-4).

Figure 2: Average number of daily tests and confirmed infections at the provincial level



Source: Daily updates, Government of Nepal, Ministry of Health and Population (Oct 9 - 16, weekly average)

testing capacity of laboratories, there was a delay in receiving results. There were even examples of people staying at quarantine facilities waiting for up to two weeks for the result of their tests. This delay in receiving results and the subsequent needlessly extended stay in quarantine facilities increased the risk of infection in such facilities. Local governments also faced new fiscal burdens in addition to the difficulty of managing quarantine facilities.

Facing a lack of testing material, the availability of testing kits was made the basis for testing. Timely supply of the viral transport medium (VTM) necessary for PCR testing hadn't been possible. Testing was interrupted repeatedly in cities like Birgunj, Nepalgunj and Biratnagar, where there were high rates of infection, due to a lack of VTM kits. People who had been contacted through contact-tracing programs didn't receive timely tests due to the lack of testing kits. Even in places where high rates of infection were seen, testing was dictated solely by the availability of testing kits. On the basis of availability, people staying at quarantine and isolation facilities being operated by local governments were administered a miniscule number of tests before large numbers of individuals were allowed to go home. Difficulties arose in controlling the spread of the infection because of the

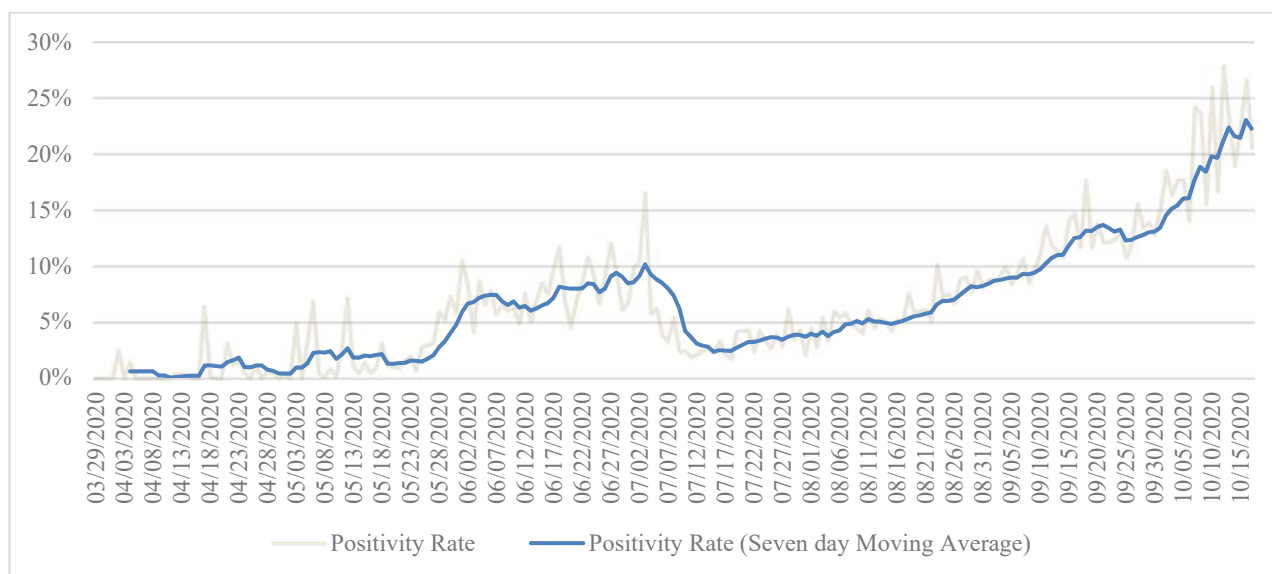
irregularity in testing and because many people staying under quarantine were released without further testing.

The government has pointed to the high cost of PCR testing as an excuse to make the scope of testing narrower.<sup>9</sup> This policy deprived asymptomatic infected individuals of testing services, and increased the possibility of the infection increasing unchecked. According to the government's standards, an asymptomatic person can be sent home without further testing after spending 14 days in quarantine or under isolation. Experts were saying that releasing asymptomatic individuals in quarantine or under isolation without additional testing would increase the risk of the infection spreading.<sup>10</sup>

<sup>9</sup> According to the standards prepared by Nepal Government's Ministry of Health and Population, individuals staying under quarantine but exhibiting no symptoms require no testing. Similar provisions have been created for individuals in isolation who aren't showing symptoms. For individuals with confirmed infections and exhibiting symptoms, they may be released from isolation if they don't show symptoms for three consecutive days following a 14-day isolation period.

<sup>10</sup> Onlinekhabar. 2077 v.s. Janaswasthya Bigyako Chetawani: Lakshan Nadekhiyeka Sankramitlai Ghar Pathaunu Mahabhul. <https://nepalkhabar.com/society/35951>; accessed September 10, 2020.

Figure 3: Rate of confirmed infections in daily testing



Source: Daily updates, Government of Nepal Ministry of Health and Population

The World Health Organization holds that the appropriate rate of testing can be calculated on the basis of the total rate of infections confirmed against the total number of tests administered. This idea holds that infection confirmation rates between 3 percent and 12 percent can be accepted as adequate testing. Although the rate of infection confirmation in Nepal remained under 10 percent until mid-September, the rate has now climbed up to 25 percent, as shown by Figure 3. Therefore, it is apparent that there is far less testing than the required benchmark, and therefore the scope of testing needs to be expanded. Representatives at the local level were of the opinion that the state was seeking to abdicate its responsibility by restricting the scope of testing. Because the state had adopted such a policy, asymptomatic individuals with the infection were deprived of the opportunity to get tested. In Nepal, many of the people with the infection are asymptomatic. By mid-September of 2020, nearly 99.6 percent of the infected individuals were asymptomatic. However, in recent days there has been an increase in the number of people exhibiting symptoms. Even individuals exhibiting symptoms had to jump through many hoops to get tested for COVID-19, or appeal to

people in positions of power to access PCR tests.<sup>11</sup> It is clear that there are many challenges to bringing the spread of COVID-19 under control because the testing standards adopted by the government have been impractical.

### Local governments burdened with responsibilities exceeding their capacities to address them

According to the Constitution, the responsibility of preventing, controlling and treating communicable diseases is of the federal government, with the provincial and local governments extending the necessary support to it. It appears that controlling the spread of the infection became difficult because local governments were given responsibilities exceeding their capacities without being given adequate or necessary resources and counsel.

<sup>11</sup> KC, Durgalal. 2077 v.s. PCR Parikshan Garauna Rakshamantriko Sorsa. <https://ekantipur.com/news/2020/09/05/159928498454698864.html>; accessed September 10, 2020.



Local governments had to bear more responsibilities than what the physical, fiscal and human resources available to them made possible. Apart from the duties designated to them by the federal government, local governments also had to bear the responsibility of conducting tests, managing additional healthcare material and equipment, and managing isolation facilities. When these responsibilities exceeded their capacities, the management aspect suffered. In addition to this, local governments were given the responsibility of collecting data, distributing relief material, operating health desks and fever clinics, sanitizing marketplaces, managing quarantine facilities, contact-tracing, and managing isolation facilities.

During the first phase, local governments purchased the healthcare material and equipment necessary for health institutions within their local units when the federal and provincial governments failed to supply an adequate amount of healthcare material. Apart from the healthcare material, when it became apparent that testing would be affected due to a lack of testing kits, local governments purchased RDT kits and VTM kits. Birgunj Metropolitan City, Biratnagar Metropolitan City, Narayan Municipality, etc., even bought their own PCR testing machines when the rate of infections grew rapidly.

Although it was decided that all three levels of government will establish quarantine facilities, most of them were established and managed by local governments utilizing their own resources. Such facilities, created using the limited resources available to local governments, were not able to meet the standards set by the federal government. Most local governments utilized existing educational institutions as quarantine facilities. The most effective method for controlling the spread of COVID-19 is to eliminate crowding and maintain physical distance between individuals. The quarantine standards specify that there must be one toilet per 6 occupants of the facility, and that there must be bathing facilities. Apart from schools that operate hostels, showers and bathing facilities are rarely found in other educational institutions. Although attempts at maintaining physical distance were made at the

quarantine facilities established by local units, there was a compulsion to share water taps, toilets and canteens.

The establishment, management and operation of quarantine and isolation facilities were also challenging from a human resources standpoint. The quarantine standards require the presence of one MPH or MD (Community Medicine), a medical officer, and a paramedic for every hundred occupants to supervise each eight-hour shift. Some district-level hospitals in rural areas don't even have medical officers available. There is a lack of healthcare workers at the local level since the employees' integration process. On top of that, local governments were also operating health desks and fever clinics. This added to the workload of healthcare workers at the local level. Therefore, the local governments were in no shape to supply the healthcare workers stipulated by the standards. Quarantine facilities built without maintaining physical distancing and operating in the absence of adequate healthcare workers and physical infrastructure emerged as COVID-19 infection hotspots.

As the number of individuals with the infection increased, and as isolation beds at facilities operated by the federal and provincial governments proved inadequate, local governments were forced to take the lead in operating isolation facilities. Since the same facilities that were utilized as quarantine facilities were converted into isolation centers, the problems that were encountered before continued to be seen. Most local governments were forced to operate isolation centers without physicians, oxygen or an ambulances. There were also a few exceptional cases where three or four local governments collectively operated quarantine facilities in order to address the lack of fiscal, physical and human resources. Such isolation centers enjoyed a relatively more robust management.

### **Absence of coordination and collective effort among the three levels of government**

The fact that federalism is in its initial stages of implementation effected COVID-19 prevention,

control and treatment. Although the Constitution states that the three levels of government should operate under the principles of coordination, cooperation and coexistence, that wasn't evident in practice. A lack of coordination and collective effort among the three levels of government was visible with regard to COVID-19 prevention, control and treatment. Decisions taken by the federal and provincial governments couldn't be implemented in a timely manner, while local governments were forced to operate under a situation of duress. Local governments abandoned any dependence upon the federal and provincial governments to buy necessary material, and during moments of crisis, manufactured their own Personal Protective Equipment (PPE). The latter practice by local governments may be taken as a positive aspect of the federal system.

There was also confusion about which of the three levels of government was supposed to do what. Around the first week of April, 2020, the Government of Nepal published the implementation plan for each of the three levels of government. But, nothing happened according to it. When local governments, facing the highest threat of infection, didn't receive necessary assistance from the federal and provincial governments, they took on the initiative to supply medicines, and manage testing and treatment. Local governments held the opinion that the federal and provincial governments took decisions without consulting them, and treated local governments merely as units through which to implement their decisions. When federal and provincial governments ignored the valid demands of local governments in the course of controlling and treating COVID-19, local governments faced problems in the prevention, control and treatment of COVID-19.

Local governments with important check-points along the border with India, like Biratnagar, Birgunj and Nepalgunj, requested the federal and provincial governments to strictly monitor cross-border movement and to establish PCR testing laboratories at the border. But, as their demands were not addressed expediently, infections spread in those cities. The federal government authorized Birgunj Metropolitan City to bear the cost of operating the Gandak Hospital in contravention of provisions stipulating

that the federal government would manage the cost of providing treatment to COVID-19 patients.<sup>12</sup> When the federal government passed the decision that individuals staying under quarantine could be sent home without additional testing, many individuals staying under quarantine at the local level had protested the provision, putting local governments in a difficult position. After the responsibility of declaring curfews and restrictions was handed over to the chief district officers, the absence of coordination with the provincial and local governments created problems between the three levels of government in controlling the spread of the infection.<sup>13</sup>

The division of responsibilities between the Social Development Ministry, Provincial Health Directorate and Province Health Supply Management Center remained unclear and confusing. Consequently, policy formation and health material supply were affected. Healthcare workers under the provincial governments felt that these entities tried to avoid their responsibilities by pointing to each other when it came to creating the necessary policies and directives and in supplying healthcare material needed for the prevention and control of COVID-19.

## Conclusion

It appears that the three levels of governments did not show the expected sensitivity to taking well planned and effective steps necessary to prevent, control and treat COVID-19 infections even as the pandemic was spreading across the globe and made its presence known in Nepal. The federal government appears to have been especially negligent. Because of the initial skepticism toward the disease, which resulted in delays in preparation to confront it, the rate of infection increased. Although, when the second infection was

<sup>12</sup> Annapurna Post. 2077 v.s. Sankramansanga Judhdai Mophasalka Mahanagar. <http://annapurnapost.com/news/164463>; accessed September 9, 2020.

<sup>13</sup> Neupane, Tufan. 2077 v.s. Nishedhagyasangai Sanghiyatako Anautho Abhyas: Pradesh ra Sthaniya Sarkarbhandha CDO Shaktishali. <https://www.himalkhabar.com/news/117529>; accessed September 9, 2020.

confirmed, a lockdown to restrict the movement of people was initiated, each of the three levels of government's preparations aimed at controlling the spread of infection, and testing and treating individuals with the infection seemed inadequate. Nepali citizens returning from India should have been confined to quarantine facilities along the border and tested for the infection – this couldn't happen. They reached their villages and homes without testing, and were forced to stay in quarantine facilities established by their local governments. This put other passengers in the vehicles in which they traveled and other people staying with them at the quarantine facilities in additional risk of contracting the infection.

Recently, the scope of testing was narrowed in order to save testing kits, and treatment facilities have not

been increased to keep pace with the increase in the rate of infections. People have been deprived of access to testing and treatment. Although lockdowns and restrictions have been imposed or lifted without any corresponding preparation, nobody seems to have paid any attention toward strictly enforcing health standards. The three levels of government failed to clearly divide responsibilities between them to collectively carry out efforts to prevent, control and treat COVID-19 infections in a coordinated manner. Consequently, cities and urban areas with high population density, like the national capital Kathmandu, are facing severe levels of COVID-19 infections. A situation has been created for which our existing healthcare system is not capable of handling.



This study has received financial and technical support from The Asia Foundation. All conclusions and analyses in this report are based on the DRCN study and may not necessarily represent the opinions of the supporting institution.