

Review Article

COVID-19 in Nepal: Governance and its Implication on Public Health Measures

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ABSTRACT

COVID-19, the pandemic caused by SARS- CoV-2 has affected more than 220 countries including Nepal, costing millions of lives around the globe. Despite the government's effort to contain the virus by initiating several public health measures, the exponential growth of COVID-19 cases has been noted in due course. Our review is focused on preventive health measures and the role of government in implementation, in the context of Nepal. We found that while the government did enact some policy and guidelines in response to COVID-19, the response was lacking in timely execution, coordination and monitoring, and was not in compliance with human rights principles.

Key Words: COVID-19; Government response; Nepal; Public health measures

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INTRODUCTION

The COVID-19 infection has been declared a public health emergency on 30th Jan 2021 World health organization (WHO).¹The response to the COVID-19 public health emergency is highly dependent on coordination and cooperation between different actors involved, for example, the government, civil society, the health personnel, as well as the public at large. Most importantly, responding to such an emergency requires good governance.

A report published by the Southeast European University in partnership with the UNDP defines good governance (in health) as “the enhancement of the leadership and stewardship functions and the improvement of management support systems of both the central and local governments in terms of their collective responsibility for the overall performance of the health system.”² Additionally, good governance involves “setting up the policies and the systems for transparency and accountability, mustering the political will to enforce the rules, and providing the right

incentives to ensure positive behaviors of players in the health system.”²

Proper-functioning leadership/governance is one of the six core components of public health systems, according to the framework by WHO (other components include service delivery, health workforce, health information systems, access to essential medicines, and financing).³ In fact, governance forms the basis for the “policy and regulation” of the rest of the components. Thomas R. Frieden provides another set of six elements for effective public health program implementation in which also situates good governance as a pillar that is essential for the facilitation of other elements (that include innovation, partnership, management, technical package, and communication).⁴

Public health measures which include social isolation, Quarantine, isolation and contact tracing, effective risk communication are effective measures of infectious disease prevention. This strategy

is also endorsed by WHO, in its COVID-19 prevention strategy. A large systematic review was conducted by Ayouni I. et. al to evaluate the implemented public health interventions to control the spread of the outbreak of COVID-19, by using worldwide data published up to March 16, 2021.⁵ These revealed public health measures are the most effective intervention in the control of COVID-19 infection.

Initially, COVID-19 cases were low in Nepal. As the number of tests increased so did the case detection and a rapid surge is noted, especially when the pandemic hit hard in India. Several public health measures have been applied to contain the pandemic in Nepal but effectiveness is only seen nationwide lockdown and others were found not effective. This prompted us to do this review which assesses the COVID-19 situation and public health initiatives in Nepal and the role of the Government in its implementation.

COVID-19 SITUATION IN NEPAL

The first case of COVID-19 in Nepal was detected on January 23, 2020. Estimated prevalence by 31st May 2020 was 2.25% (n=1572) (95% CI: 2.15–2.37%) with 0.5% case-fatality rate (CFR).⁶ Following the second confirmed case, which was reported outside Kathmandu valley Government of Nepal declared a nationwide lockdown from 24 March to July 2020.

A study conducted by Pokhrel A et al⁷ estimated the effective reproduction number (R) of COVID-19 in Nepal from March 24 to June 1, 2020. R measures the expected number of secondary infectious cases produced by a primary infectious case. This measurement is used to determine the potential for epidemic spread in a susceptible population. They found a median R-value of 1.48 (SD: 0.21), with a minimum of 0.58 and a maximum of 3.71. This signifies that the outbreak then was not yet under control.⁷ The same study also showed the covid-19 growth trend for two time periods, while strict social distancing (March 23, 2020, to May 01, 2020) versus when increased individuals mobility, Google monitored (May 1 to June 09) and showed increased mobility is attributed to the increased case growth rate (0.03 to 0.13) with decreased case doubling time (22 days to 5 days).⁷ Thus the study has concluded that the lockdown has played a significant role in the containment of the virus but the outbreak then was not controlled yet and predicted a possible second wave. This is further supported by the study of Kusum Sharma et al which also assessed the first lockdown scenario of Nepal. The study has also revealed that the covid-19 case distribution was higher in the southern part of the country, which shares porous borders with India.⁸

Covid situation update of the World Health Organization (WHO) showed that after July 2020 (when the lockdown was loosened) covid cases along with the case fatality rate (CFR) increased significantly.⁹ As of November 2020, the CFR reached 0.6% (with 2, 24,077 confirmed cases and 1361 deaths) and subsequently reached more than 1% CFR by March 2021 (with 276980 confirmed cases and 3,027 deaths).⁹ This massive surge coincided with the abrupt increase of covid cases in India. Following this situation, the Nepali government issued another nationwide lockdown which started from April 29 and continued up to July 2021. As of June 2021, 33, 29,687 tests were performed and identified 668221 confirmed cases and 9051 deaths accounting for 1.35% CFR.⁹ Expert opinion says that this unprecedented soaring second wave of the pandemic may be attributed to “our

own cases, those being imported from India and the rise of the more contagious UK strain”.¹⁰

GOVERNMENT'S RESPONSE IN IMPLEMENTING PUBLIC HEALTH MEASURES

On 1st March 2020, the Government of Nepal (GoN) formed a High-Level Coordination Committee for the Prevention and Control of COVID-19 (HLLCC) and initiated the first nationwide lockdown as of 24 March. This was accompanied by a suspension of all international flights, a closed-off border, as well as suspension of visas on arrival for incoming travelers from countries highly affected by COVID-19. All promotional activities related to Visit Nepal 2020 program were postponed. This initiative is very praiseworthy as it helped to contain the virus in the early phase of the pandemic. The idea that lockdown was beneficial in containing the virus is supported by the study by Pokhrel et al.⁵

The GoN also initiated public health measures like establishing a health desk at Tribhuvan International Airport (TIA) and other checkpoints in the bordering area, starting an entry and exit screening, educating people regarding risk factors and prevention of COVID-19 through different mass media, building quarantine and isolation centers and guidelines, contact tracing mechanism to identify covid cases. Despite the nationwide lockdown and initiation of the above-mentioned public health measures, the COVID-19 cases in Nepal over time demonstrate an increasing trend.

Although the health desk was established in TIA as soon as the outbreak occurred in Wuhan, China, health personnel were deployed by the GoN only in the second week of January 2020. This rendered the health desk non-functional without fulfilling its objective.¹¹ This organizational mishap was highlighted in national media at the time. The director at the Epidemiology and Disease Control Division (EDCD) had expressed their concern by stating that “since there are no health workers at the health desk, incoming passengers are not being screened for possible diseases.”¹¹

The WHO declared Covid-19 as a Public Health Emergency of International Concern global emergency on 30th January and requested all countries to be prepared for the prevention of COVID-19. Even after the WHO's emergency declaration, COVID-19 preparedness of Nepal was unsatisfactory in providing logistic supplies for case detection such as thermal scanners, reagents for COVID-19 detection, etc.¹² In such a situation where there is no proper screening and difficulty of diagnosis, early detection is not possible. Such scarcity of logistic supplies may very well be the reason that the first case of COVID-19 was only detected on the 23rd of January 2020- and prior cases may have been missed.

Health sector Emergency Response plan (HSERP) Nepal was formulated on 7th May 2020 with the main objective to prepare and strengthen the health system response capable of minimizing the adverse impact of this pandemic.¹³ To carry out the plan, the Case Investigation and Contact Tracing Team (CICTT) composed of multi-disciplinary personnel were formed at all local levels. The plan suggested forming the team with members from the public health, laboratory, nursing, local council, administration, and security. Despite this, contact tracing is not being properly

carried out in Nepal. According to the report published by the United Nations Resident and Humanitarian Coordinator for Nepal, “registration, health screening and antigen RDT testing of all entrants to Nepal through land border points of entry (PoE) health desks is inadequate, as is community-level surveillance, case investigation, and contact tracing, severely impacting the ability to monitor and control the spread of the virus in Nepal.”¹⁴

As per HSERP quarantine guidelines, institutional quarantine has been made mandatory for international travelers either by air or ground, for those unfeasible for home-based quarantine, and for those violating home-based quarantine (as decided by the local authority). Local governments were responsible for institutional quarantine facilities provincial governments are for isolation facilities. Guidelines for requirements in quarantine/isolation facility numbers and logistics were also made and all centers across the country are required to abide by guidelines.

Since its inception, local governments and provincial governments have doubted the feasibility of implanting the guidelines due to the limitation of budget and other logistical constraints.¹⁵ These doubts manifested themselves in reality when many quarantine centers were not able to fulfill the basic standards set by the WHO that require individuals in quarantine to be provided with health care, financial, social, and psychosocial support along with basic needs including food, water, and other essentials.

Furthermore, a report prepared by the monitoring team of Nepal Bar Association, Federation of Nepal Journalist, NGO Federation Nepal, and Nepal Human right commission disclosed that in many quarantine centers in Nepal, people are exposed to a risky environment for acquiring infections.¹⁶ This portrays how the government failed to utilize its powers under the Infectious Disease Control Act of 1964, under which orders and directions regulating lockdown measures had been promulgated. The act provides that, “where any infectious disease develops or spreads or is likely to spread on the human beings throughout Nepal or any part thereof, Government of Nepal may take necessary action to root out or prevent that disease and may issue necessary orders applicable to the general public or a group of any persons.”¹⁷

VIOLATION OF THE RIGHT TO HEALTH CARE

Article 35 of the Nepali constitution provides for the right to health care which reads: “Every citizen shall have the right to seek basic health care services from the state and no citizen shall be deprived of emergency health care.”¹⁸ A report made by the international commission of jurists (ICJ) claims that Nepal has violated the right to health as many quarantine centers are without health personnel, thus depriving the access of health care services among persons in quarantine when needed.¹⁹

Scholars and media outlets have reported on the shortage of personal protective equipment (PPE) crucial for the safety of health workers and medical personnel. A nationwide survey conducted in April 2020 by Shrestha et al on covid preparedness in hospitals of Nepal demonstrated that an overwhelming percentage of doctors they surveyed claimed the hospitals were ill-prepared for the pandemic and that PPE equipment was inadequate (according to 94.7% of the respondents).²⁰ Furthermore, an impact study on health services utilization in Province 2 using a qualitative research approach found that during the first three months after a lockdown was imposed in March 2020, the shortage of PPE

(even gloves and masks) made health care workers halt maternal and general health care services due to fear of the spread of infection.²¹ Maternal health care service is one of the basic health care services that are meant to be free for all citizens under the Public Health Act Service Act of 2018.²² The suspension of maternal and general health care services due to a scarcity of PPE itself upholds a situation where the right to health of the public is neglected. While there were some improvements in the PPE supply in the later months with donated gear entering the country, early proactive intervention into the situation of PPE shortage could have been highly beneficial for not only the safety of health professionals but also the patients that they deal with. There was a delay in acquiring PPE for various reasons, one of which was the flippant change of authorities for the procurement of PPE designated by the government in light of allegations of corruption.²³ This delay created insecurity among medical personnel, consequently hampering the level of health care received by the public.

CONCLUSIONS

COVID-19 cases are surging up in Nepal. As of June 2021, the number of tests is performed 33, 29,687, confirmed cases are 668221 and 9051 number deaths, accounting for 1.35% CFR. An increased surge occurred especially when the pandemic hit hard in India. To contain the pandemic, GON initiated Several public health measures. Among them nationwide lockdown is found most effective. It is also noted that the lifting of the first lockdown in Nepal occurred when infectious cases were still prevalent. This would not have been a problem if other public health measures were effectively implemented. In our case, besides lockdown, other public health measures are not effective. This might have caused a negative role in containing the virus. Additionally, although policies and guidelines do exist, their implementation is lacking. This may be due to a lack of coordination and monitoring mechanisms. Furthermore, delayed decision-making and lack of commitment of government have created a delay in the execution of preventive measures.

Orders and directions regulating lockdown and quarantine measures in Nepal have been promulgated under the Infectious Disease Control Act of 1964. This act does not require the mandatory implementation of the right to health. This made the government less liable and accountable in the implementation of preventive health measures following the human rights principles. Instead of the infectious disease act 1964, if Nepal has promulgated the order and directions regulating public health measures based on the public health service act, then the right to health must have been exercised more properly.

Recommendations

Considering the infectious and mutant nature of the COVID-19 viruses, in a country like Nepal where the health system is fragile, effective implementation of public health measures will give the best long-term solution for prevention. Bhutan is a fitting example of a south-Asian nation that has been able to keep the least number of COVID-19 cases and deaths with effective implementation of public health measures. In April 2021, the GON declared that all seven provinces in the country were in the community transmission phase. Community transmission refers to “countries/areas/territories experiencing larger outbreaks of local

transmission without any known contact with another confirmed case of viral infection or recent travel history to or from a country badly affected by a pandemic.” In this situation, no one is safe until everyone is safe. The best preventive strategy in such a situation is vaccinating the entire population, but this is not reasonable to expect in Nepal in the near future. Hence, another best possible

alternative until we acquire enough vaccines is only through the effective implementation of public health measures at all levels. This demands a strong commitment from the government. With an increasing trend in COVID-19 cases and the death rate, an impending threat of a more disastrous situation can be predicted if public health measures are further neglected.

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