Understanding health system resilience to respond to COVID-19: a case study of COVID-19 policy response and health workforce management in Nepal

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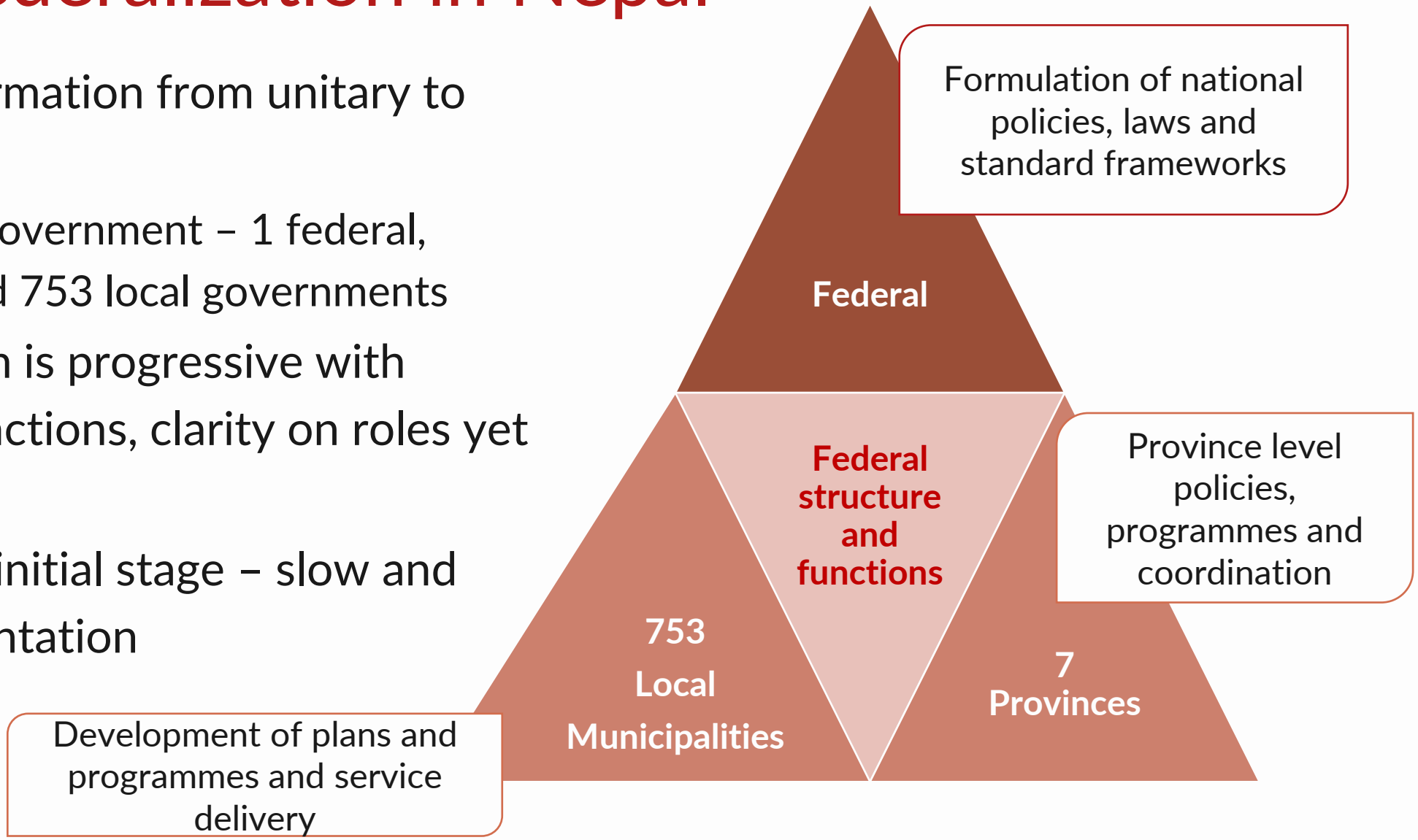
Context: Federalization in Nepal

- Political transformation from unitary to federal system
  - Three tiers of government – 1 federal, 7 provinces and 753 local governments
- While federalism is progressive with defined core functions, clarity on roles yet fully realised
- Federalism is in initial stage – slow and patchy implementation

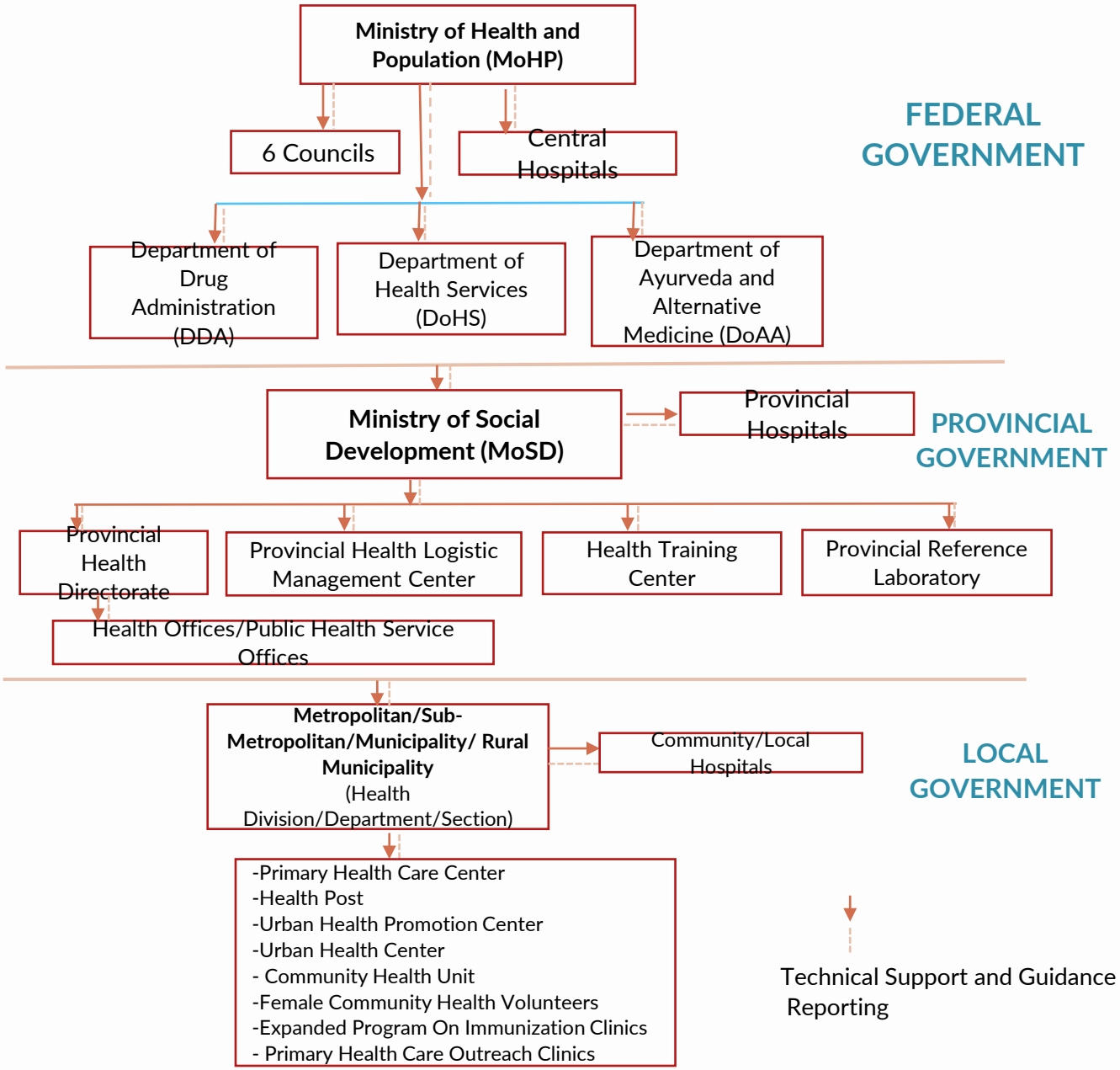


Health System in Federalized Context and COVID-19

- **Federal level** - MoHP and its departments provide stewardship to develop national health policies and regulatory frameworks including management of pandemic

- **Province level** – MoSD in coordination with PHD and different centres to develop province level health policies and plans, and perform coordination functions

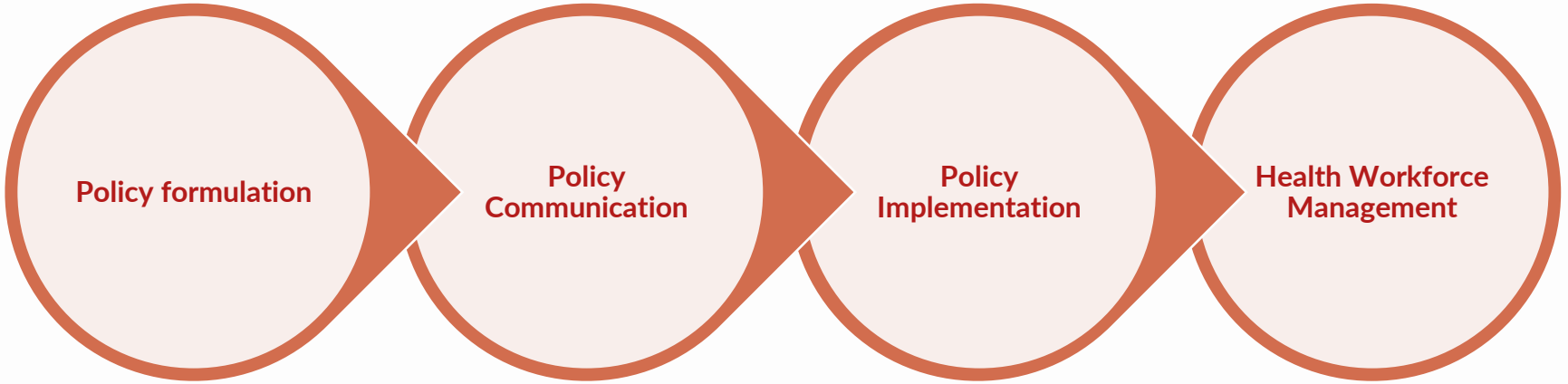
- **Local level** - Power has devolved to local governments (municipalities), responsible for delivery of basic health services and other public health programmes



Research Questions

Our study aimed to answer the following research questions:

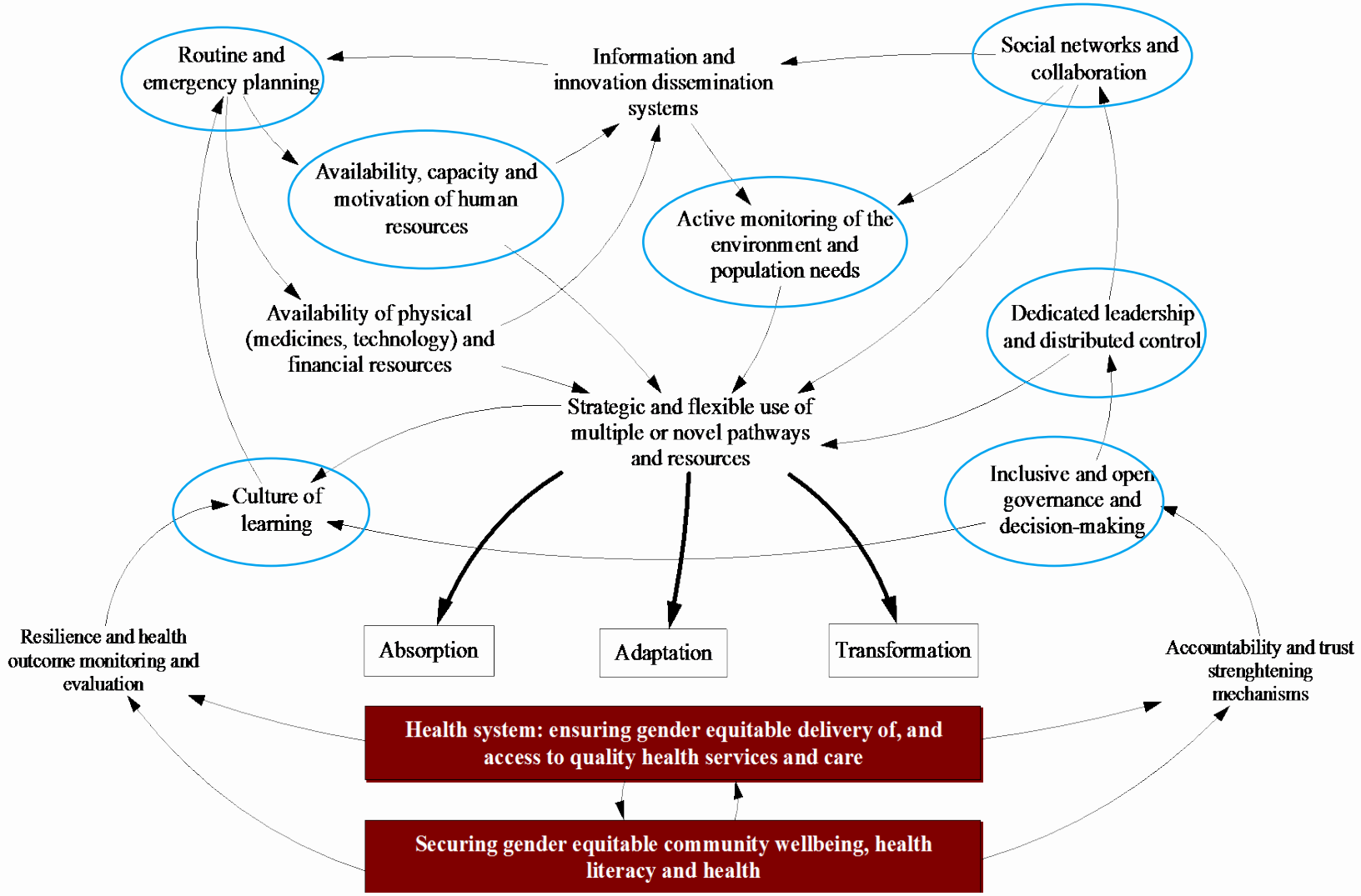
- What were the health sector policy responses to COVID-19 at the three tiers of governments?
- How were the processes of policy formulation, communication and implementation executed at three levels, particularly in relation to health workforce?
- What health workforce management mechanisms were adopted at the local level in response to COVID-19, in addition to delivery of routine quality health services?



Resilience Framework – ReBUILD for Resilience

- To understand how the health system has developed resilience in the form of absorption, adaptation and transformation

- Key elements of the framework explored were:
  - Inclusive and open decision-making;
  - Monitoring and feedback loops;
  - Inter-sectoral collaborations, networking and coordination;
  - Communication strategies;
  - Human resources management including motivation;
  - Decision space at local level



Methodology

- A cross-sectional exploratory case study, using mixed-methods
  - i) Document review (policies, strategies and directives introduced in response to COVID-19) - from January to December 2020
  - ii) Key-informant interviews – 22 KIIs
- Data collection at three levels – federal, province (Lumbini) and local governments (2 municipalities of Kapilvastu district)
- Coding of the transcripts were done using Nvivo software
- Framework analysis using key issues and themes – indexing, charting, mapping and interpretation

Level	Informants	M1	M2
Local (16)	HWs	3	3
	Municipality Health Coordinator	1	1
	Mayor	1	1
	Ward chair	1	1
	FCHVs	2	2
Province (4)	MoSD	1	
	PHD	1	
	EDP	1	
	District hospital (Doctor)	1	
Federal (2)	MoHP	1	
	EDP	1	
	Total	**22**	

COVID-19 Policies Development

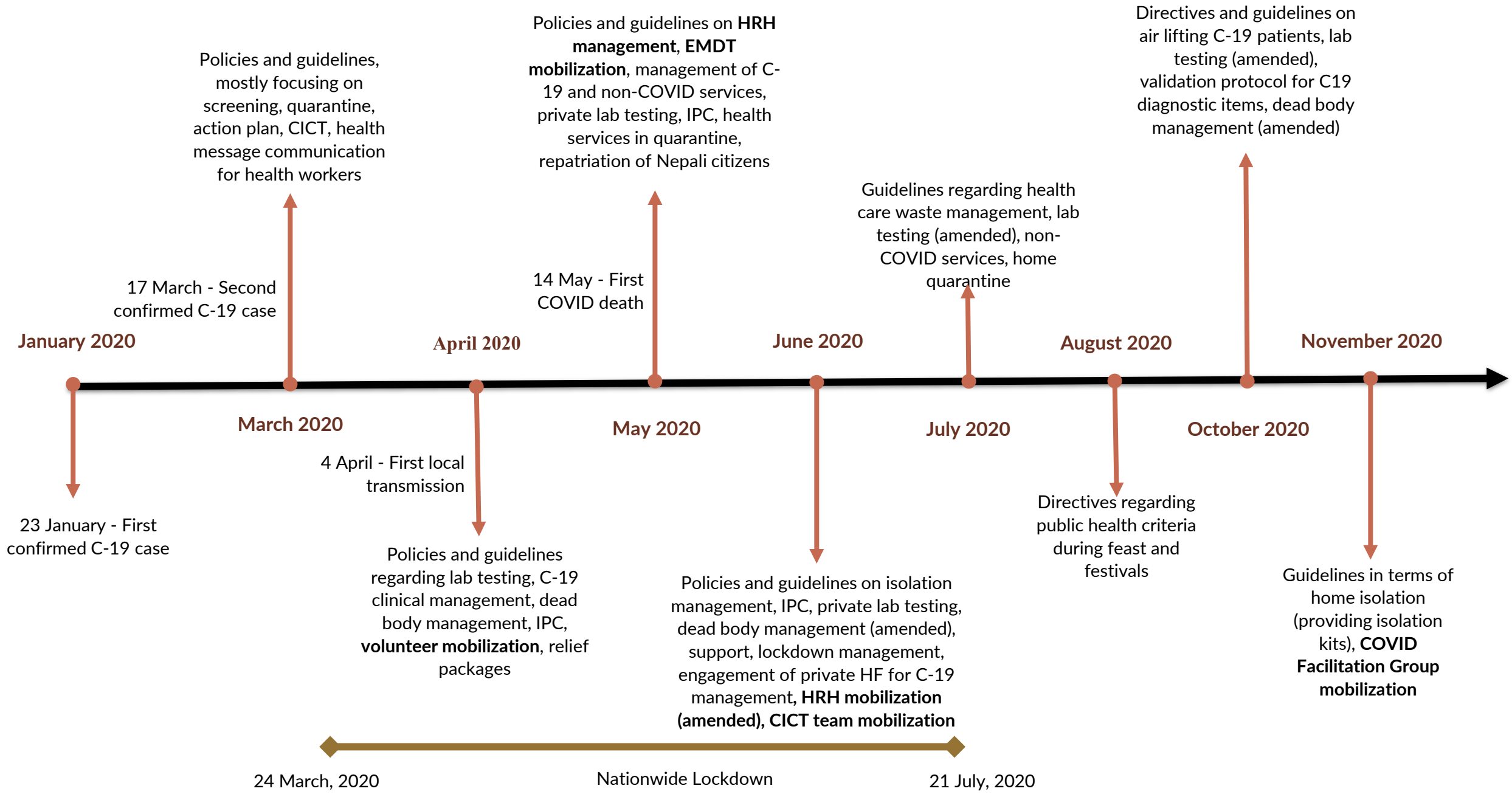


Figure. Timeframe of COVID-19 policies and guidelines from Jan-Dec 2020

Policy Formulation Process

- Federal government mainly engaged in COVID-19 policy formulation; few policies developed at province level while the local levels were implementing those policies
- Policies based on global learning, mainly from WHO recommendations and also learnings from local context
  - However robust use of evidence was less practiced, weak mechanism and structure for evidence generation and review
- Limited consultation with provincial and local governments, largely virtual – leading to less contextualization of the policies
- Less coherence between policies, emerging evidence, available resources and implementation arrangements including HR management

Policy Communications

- Top-down approach: No focused/targeted communications – communication to different levels of government, health workers (HWs) and to public done in a same manner
- Due to poor communication - provincial and local level governments less aware about updates and changes in policies - confusion to operate routine services that affected delivery
- Municipalities communicated policies to HWs via phone, not in a written form – HWs reported ineffective to understand the policies
- HWs reported – lack of proper understanding of protocols and guidelines, mostly relied on social media and websites to get updated about policies and learnings, HWs with limited access to internet were poorly informed

Channels:

- Daily press briefing
- Daily situation reports
- Website notices
- Social media
- Emails
- Existing cluster meetings with provinces held every two weeks

COVID-19 Response Structure and Actors

COVID-19 Response Structure and Actors

- Multisector collaboration at all levels with involvement of:
  - Different ministries (Ministry of women, child and senior citizen sector, Ministry of Internal Affairs and Law, Ministry of Economic Affairs and Planning etc.),
  - EDPs (WHO, World Bank, UN agencies etc.)
  - I/NGOs,
  - Private sectors,
  - Drug association,
  - Medical colleges
  - Technical experts to MoHP (doctors, public health experts, epidemiologists, economist etc.)
  - Nepal Army representatives, etc.
- Technical management by Ministry of Health and Population and COVID Crisis Management Centre (CCMC)
- Community participation low at all levels

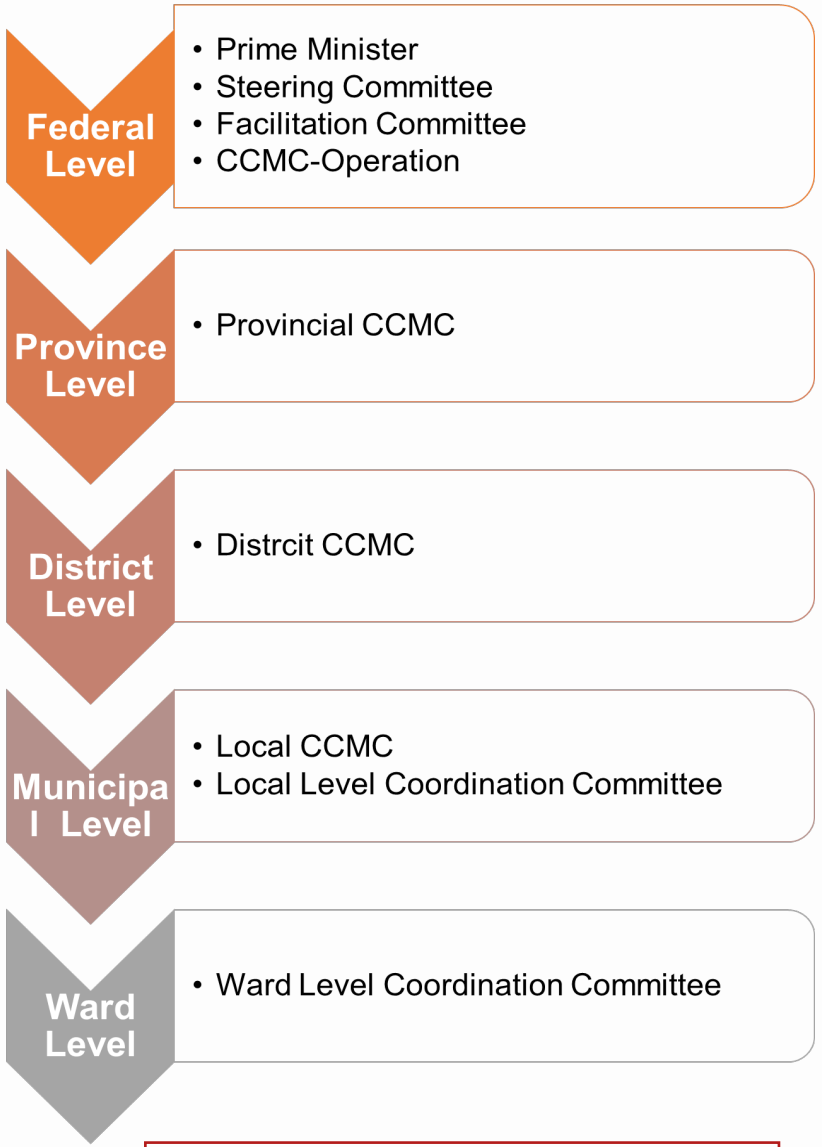


Figure: Overall COVID-19 management and response structure at all levels

Policy Implementation

- Local governments responsible for policies implementation
- Monitoring and supervision visits by municipalities to health facilities – but less frequently in one municipality and not at all in the other municipality
- Weak mechanism to ensure consistency in understanding of policies and protocols, one-way process of dissemination
- Consistent implementation of policies affected by several factors:
  - Lack of clarity - ineffective and untimely communications
  - Lack of training/orientation to HWs
  - Unavailability of logistics
  - Irregular monitoring and supervision

Decision space at local level

- Planning and undertaking of COVID-19 activities

- Budget allocation for COVID-19 response
  - Local governments allocated their own funds for COVID-19 management, although supported by federal government
  - Funding used in:
    - Relief packages, used in better quarantine management,
    - PPE and other protective items etc for HWs
    - Initiated COVID-19 health insurance to health workers

- Flexibility of contextualization of federal and provincial policies into local context

HRH management at local level

Health workforce related policies - highlights

- Mobilization: of existing human resources and recruitment of new short-term staff for COVID-19 management
- Working hours: 10 hours per day which was amended stating management as per necessity
- Motivation packages: incentive, risk allowance and insurance to HWs
- Protection of physical and mental health: Provisions of PPE and safety items, and monitoring and necessary actions of stigma and discrimination
- Capacity strengthening: majority of documents mentioned about organizing training and capacity development activities in coordination with development partners
- Monitoring and supervision: of HR and volunteers

Health workforce – situation and gaps

- Already insufficient number of HWs and unfulfilled sanctioned positions - also affected by staff adjustment process at federal and local levels
- Same HWs delivering COVID-19 and routine services including health services in quarantine and isolation centres
- This raised issue of IPC and affected delivery of routine services *(as health facilities had to be shut down when higher demand for HWs in quarantine centres)*
- Further aggravated when HWs working in quarantine and isolation centres got infected
- All resulted in heavy workload and longer working hours for HWs

Health workforce mobilization strategies

- Dedicated COVID-19 and non-COVID hospitals through out the country
- For the management of Dedicated COVID-19 hospitals
  - At the federal level - fresh medical graduates were deployed in COVID-19 dedicated hospitals
  - At local level - transfer of HWs (within health facilities of same municipality)
- Some international organizations/EDP deployed their staff to the hospital (district) to support in COVID-19 management
- No policy on mobilising HWs from private sectors
- No GESI considerations reflected in national policies – however, local health facilities management seemed sensitive and where possible did consider gender, pregnancy status and age of HWs

Motivation and support to health workers

1. Incentives and sanctions

Policy provision:

Risk allowance

Health insurance

Appreciation/ rewards

Issues:

Untimely allowance

Differences in allowance between municipalities – low motivation among HWs

2. Leave and holidays

Policy provision:

Leave and holidays

Issues:

Due to staff shortage and surging cases – no leave, holidays and weekends

3. Physical safety and protection

Policy provision:

PPE sets and other safety items

Issues:

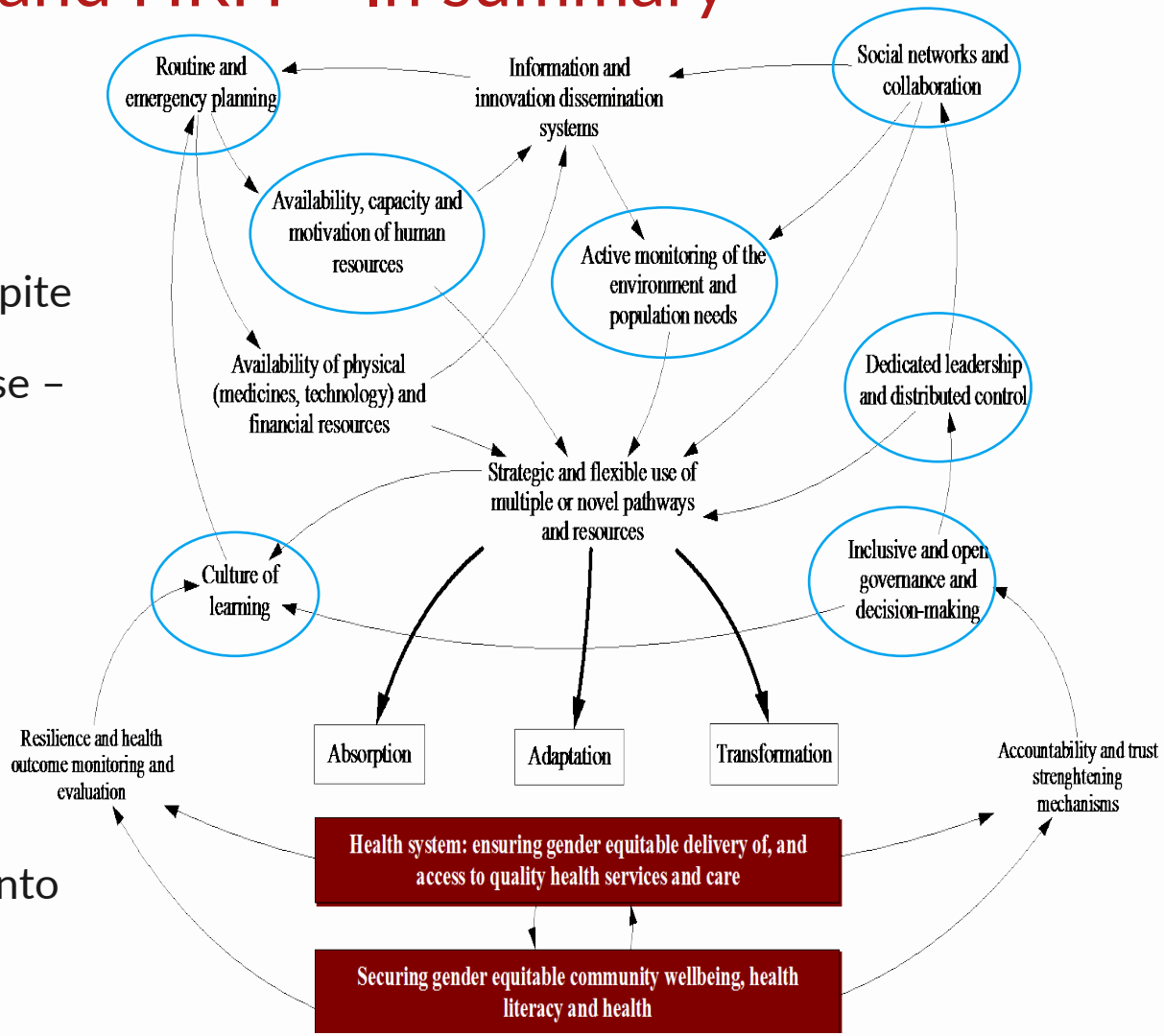
Shortages of protective items

Mental safety, stigma and discrimination: HWs' experience

- Fear of COVID-19 among HWs because of insufficient information and orientation
  - No supporting programmes organized by local governments or the health facilities
  - Province organized psychosocial counselling only to HWs mobilized in isolation centers
- HWs faced social stigma and discrimination in initial phase in the form of
  - restriction to use community tap water, toilet, shopping,
  - blocked road to restrict entry into the community,
  - neighbours threatening to leave job, hatred etc.
- Later federal government released directives for actions against such acts – reactive mgmt. and with time this is not a problem now

COVID19, Health System Resilience and HRH – In summary

- Absorption:
  - Evidence to policy – global, national and local
  - Health system gradually progressing to cope with the pandemic
  - Demonstrated commitment and dedication by HWs despite several challenges
  - Engagement of local governments in COVID-19 response – CICT formation, treatment and management
- Adaptation:
  - Revision/adaptation of policies and guidelines
  - Redeployment of HR in areas of need
  - Recruitment and adjustment of staff
  - Engagement of multisector including private sector
  - HR in federal context – who manages whom?
- Transformation:
  - Designated and non-designated COVID-19 hospitals
  - Transformation of hotels, community halls, schools etc into quarantine and isolation centres



Key message

- Rapid policy development – inclusiveness seems challenging leading to ownership issues
- Policy communication – not always as intended but use of different platforms lead to consistent understanding
- Implementation – balance between policy choices and implementation capacity across three level is crucial
- Enabling conditions for human resource management – whose responsibility in federal context
- Contextualization, reflection, revision and communication – ongoing process which is tiresome but vital to continue

ReBUILD FOR RESILIENCE

Thank you !

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