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Research for resilient health systems
in fragile and shock-prone settings

Health sector policy responses and health workforce management during COVID-19 in Nepal: Lessons for building resilient health systems – a policy brief

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Key points

1. Formulation of evidence-informed policy must include evidence from the local context.
2. Communication approaches need to be targeted with more effort to reach provincial and local level audiences – at system, health facility and community.
3. The effectiveness of policy communication should be monitored at all levels.
4. Gender, equity and justice needs to be reflected in COVID-19 policies and actions.
5. Health workforce policies should consider investment in:
   a. Updating systems that provide an account of all cadres of human resources in the country
   b. Developing strategies to mobilize the health workforce in emergencies and shocks
   c. Supporting the physical safety and mental well-being of the health workforce
   d. Training and motivation by recognizing their efforts and contribution
   e. Provision of balanced incentive packages for the health workforce during emergencies.

Background

When the COVID-19 pandemic started, implementation of Nepal's federalised structures across three tiers of government (federal, seven provincial and 753 local/municipal) was in its initial stages. While core functions of the three tiers of government have been defined, clarity on roles, execution of authorities and structures were yet to be fully realised. There have been calls to strengthen capacities at different tiers, especially the local governments (also known as municipalities of different types), which are responsible for providing basic health services.[1] Within this context, municipalities were further challenged to respond to COVID-19 pandemic, while keeping basic healthcare delivery intact.

This study focuses on one of the key components of the COVID-19 response in Nepal: health workforce management in order to address the surge in demand for services. The study describes the health sector policy response to COVID-19 with specific attention to policies that directly or indirectly affected health workforce, and to determine the **processes of policy formulation, communication and implementation** at the three tiers of governments, also exploring the dynamic interactions between them.

Study approach

We adopted a cross-sectional exploratory case study design, using mixed methods.

A document review of all policies, strategies and directives introduced in response to COVID-19 in Nepal from January-December 2020 was carried out. A total of 90 policy documents directly and indirectly related to the health workforce were reviewed.

Qualitative data were collected through 23 key informant interviews at federal, provincial and municipal levels, including policymakers, technical experts, provincial and local managers, frontline health workers and development partners from January to March 2021.

Two municipalities in Lumbini province were purposively selected for data collection. Data were analyzed using a thematic framework analysis approach, and results were summarized under different thematic areas. The analysis adapted and applied a resilience framework developed by the ReBUILD for Resilience project.

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Key findings

Policy formulation process

Key actors in policy development

Pandemics or any emergency management are primarily the responsibility of federal government,[2] which was effectively leading the formulation of COVID-19 policies and guidance with key roles for the Ministry of Health and Population (MoHP) and COVID-19 Crisis Management Committee (CCMC). Only a few policies were developed at provincial level, while the local governments were primarily implementing policies developed at federal and provincial levels. Inter-sectoral coordination was evident during policy formulation at federal level, with the participation of concerned line ministries, sectors including Nepali army, armed police force, development partners, individual experts etc.

However, routine vertical consultations with sub-national governments for policy formulation was minimal and when done, were largely virtual, primarily with provincial governments. Thus, some policies were regarded as less relevant or feasible by local government stakeholders in study sites. For example, local governments faced difficulty in mobilizing Case Investigation and Contact Tracing Teams (CICTTs) as the public health professionals envisioned to lead the teams[3] were not available at local level. Furthermore, the federal decision to mobilize a fixed number of CICTT in each municipality regardless of population size and geography was another challenge.[4] Despite having decision space to formulate locally tailored policies in line with federal policies, in practice local governments were mostly reliant on federal and provincial guidance; and contextualization of policies were done rarely at local levels because of limited technical capacity.

Evidence-informed policy formulation

Formulation of COVID-19 policies was generally based on global learning, mainly considering WHO interim recommendations. Even without a dedicated professional team and defined mechanisms for evidence generation, the federal government adopted evidence and global learning in the development of policies and guidelines. However, local information gathering, for example on needs in terms of resources such as HRH, logistics, health infrastructure was done on an ad-hoc basis rather than based on comprehensive and systematic local evidence.

"While formulating the policies, local problems need to be addressed.
The national level policies are made at federal level that do not match with our local context.
Our local level is not much developed.
There are lots of difficulties such as human resources and financing."
Male Elected Representative, Municipality2

Gender, equity and justice in policies

Gender, equity and justice (GEJ) was not well reflected in COVID-19 policies and guidelines. For instance, policies on quarantine and isolation management did not precisely include gender and equity components. As the issues of sexual harassment started being visible through media and other sources in isolation and quarantine centres, policy documents were revised making necessary amendments with the provision of separate living areas including toilets and bathrooms for men and women and the provision of female security personnel at women's isolation centres;[5,6] and arrangement of essential health services for children, elderly people, pregnant and lactating mothers[7,8].

"There was a communication gap. Federal level formulated the guidelines but never informed us about that. We have to search in Facebook, we knew [about the guidelines] through other mediums. We only operated and managed by exploring [about the guidelines] through other mediums and self-search."
Male PHD, Lumbini Province

Policy communication and interaction

Communication approaches

MoHP led policy communications using various communications forms and channels such as the MoHP website, COVID-19 portal, daily situation report, press releases and daily visual briefing, social media platforms, for policy communication to sub-national governments, health workers and the public. These multiple channels were all top-down and communication was not focused on specific audiences. Orientation or interaction for communicating policies - from federal to sub-national governments and from local government to health workers and community people was rarely happening. As a result, provincial and local governments remained less aware of policies and relevant updates released by the federal government.

Effectiveness of policy communication

At the health facility level, health workers were not often informed about policies from the municipality and when they were communicated this was done verbally over phone rather than in written form, which health workers felt to be less effective and inhibited their understanding. Since the policy communication process was less coherent and mostly ad-hoc, and because nobody came forward to explain policies and guidelines to health workers, there were varied levels of understanding and interpretation of policies among health workers. Furthermore, digital communication of policies was hampered by a lack of computer and Internet access. There was no monitoring mechanism at any level to ensure consistency in understanding and implementation of information delivered to health workers.

Health workforce management

Availability of a trained health workforce

Nepal already had a chronic shortage of health workers (17 doctors and 50 nurses per 100,000 population).[9] This shortage was compounded by COVID-19 because of the need for additional services like case investigation and contact tracing, health screening at border entry points, quarantine management and health communication.

"It was very difficult for us to manage due to a lack of health workers.
We had to do double triple duty.
Talking about our struggle, we could not even eat properly."
Female health worker, Municipality1

Health staffing shortages were apparent in both study municipalities due to government's 'staff adjustment' process to support decentralisation. The recruitment and reallocation of staff was paused due to COVID-19. As a result, none of the health facilities in either municipality had dedicated health workers to support both routine service delivery and COVID-19 service delivery. This was particularly difficult as COVID-19 cases surged, and the health workforce shortage was aggravated when health workers themselves started to get infected with COVID-19.

"We did not receive the COVID-19 related training that came from national and governmental level. We self-learned about critical care, how to manage COVID-19 cases and how to use PPE by watching videos or were taught by others."
Male health worker, District Hospital, Kapilvastu

Physical and mental safety of the health workforce
Due to a shortage of Personal Protective Equipment (PPE) during the initial stage of COVID-19 in both municipalities, health workers had limited or no protection. Municipality governments then started procuring PPE. Consequently, infection and COVID-19 related deaths among health workers exacerbated the health worker shortage (see box below).

Compromised health and safety of health workforce: Updated evidence in context
There were 40 deaths reported among health workers due to COVID-19 between 16 July 2020 to 15 July 2021 which included 14 doctors, nine nurses and 17 other health workers.

Source: National Joint Annual Review, 2020/2021

To ensure the mental health and safety of the health workforce, Government guidelines made hospitals responsible for providing counselling services to health workers involved directly in COVID-19 treatment and their families,[10] though this did not happen in the study sites. In the initial phase of the pandemic, health workers were stigmatized and discriminated against at community level and had difficulty in using community tap water, public toilets and visiting markets, which was widely covered in mass media too. Later, as a reactive response, the federal government responded to the situation by releasing directives for actions against such stigmatising behaviour. With time, the level of community awareness and understanding of COVID-19 improved, which resolved the problem of social discrimination of health workers.

Motivation and support to the health workforce
Most of the COVID-19 policies and guidelines included the orientation and training of health workers, e.g. on use of PPE, infection prevention and control, case investigation and contact tracing and specimen collection. However, there were substantial delays in delivering these trainings which impacted on the efficient delivery of health services. The federal government also released special policies on risk allowances and health insurance[11,12]. However, the uneven (between municipalities) and delayed distribution of risk allowances (due to late budget disbursement) demotivated the frontline health workforce. In spite of a national policy to increase holidays for staff working intensively, the provincial government cut all holidays during the pandemic due to staff shortages and rising case numbers. On a positive note, province and local governments rewarded health workers for dedicated engagement in service delivery during the pandemic and also provided rewards in form of badges, medals and verbal appreciation.

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Conclusion and recommendations

- Engagement of national and sub-national governments and sectoral stakeholders in policy development processes is crucial in order to formulate contextually tailored evidence-informed policies and to create ownership of the documents at all levels.
- A monitoring mechanism needs to be established, particularly by local government, to ensure a clear and consistent understanding of policies by all targeted audiences.
- A policy or guideline regarding the mobilization of the health workforce at the time of emergency should be in place in addition to strong leadership and commitment from provinces and municipalities for the management, redeployment, training and task reallocation of the health workforce.
- Capacitating the health workforce with timely and emerging information, provision of balanced incentive packages, recognition of efforts and physical and mental protection to enable their continued and positive responses are areas to be paid attention.
- Greater consideration of GEJ should be given in COVID-19 related policy documents and implementation, and while mobilizing the health workforce in emergencies.

Resources

The full report of this study and other resources from ReBUILD for Resilience can be accessed on the consortium's website.

References

1. Vaidya A, Simkhada P, Simkhada B. The Impact of Federalization on Health Sector in Nepal: New Opportunities and Challenges. J Nepal Health Res Counc. 2020;17(4):558–9.

2. Gautam G, Khanal K and Bondurant T. An analysis of the health sector functions of all three levels of government as per Functional Analysis and Assignments and relevant policies. 2020.

3. Ministry of Health and Population. Case Investigation and Contact Tracing Team (CICTT) Mobilization Guideline 2077. 2020.

4. Epidemiology and Disease Control Division. SOP for Case Investigation and Contact Tracing of COVID-19. 2020.

5. Health Emergency Operation Center. Health Standards for COVID-19 Infected in Isolation, 2077. 2020.

6. Ministry of Health and Population. COVID-19 Cases Isolation Management Guidelines. 2020.

7. Ministry of Federal Affairs and General Administration. Guidelines for operation and management of quarantine. 2020.

8. Ministry of Health and Population. Management of health services for people in quarantine. 2020.

9. Ministry of Health and Population, World Health Organisation, Nepal Health Sector Support Programme. Human Resources for Health Nepal Country Profile. 2013.

10. Ministry of Health and Population. Guidelines for the Management of Health Workers and Other Staff Directly Involved in the Treatment of COVID-19 Patients, 2077. 2020.

11. Ministry of Health and Population. Directions on management of risk allowance to human resources engaged in treatment of COVID-19 infection - 2077. 2020.

12. Ministry of Federal Affairs and General Administration. Regarding implementation of decision of Government of Nepal (To all local levels). 2020.

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HERD International is a national research and development organisation in Nepal. Its vision is to promote health and well-being by generating quality evidence, and informing policy, strategies and practice.

ReBUILD for Resilience examines health systems in fragile settings experiencing violence, conflict, pandemics and other shocks. Its aim is to produce high-quality, practical, multidisciplinary and scalable health systems research which can be used to improve the health and lives of many millions of people.

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