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COVID-19 as a challenge to Nepal's newly-federalised health system: capacities, responsibilities,

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Abstract

Objective: The aim of this study is to explore how Nepal's newly federalized health system responded to the COVID-19 pandemic, using this as a basis for drawing wider lessons for health policymakers in Nepal.

Method: An exploratory qualitative method was used, involving Key Informant Interviews with 145 health system stakeholders from diverse locations and all three levels of government. The resulting transcripts were thematically analysed using NVIVO software.

Finding: We found significant differences in perceptions between the local and higher levels of government. At the local level, major themes identified included: i) a good ability to enact an initial response based on locally-available resources and capacities; ii) a consequent raising of the profile of health amongst local governments; iii) a feeling that they had not received the necessary support from higher levels of government. At the higher levels of government, we found: i) doubts about the capabilities of local governments to manage a health crisis; and ii) uncertainty about the roles and responsibilities of Provincial governments.

Discussion: The newly-federalized health system understandably struggled to function effectively during the pandemic. However, this was not only the result of resource deficiencies or bureaucratic weaknesses. The performance of the system was also in part undermined by the continuation of a centralized mindset, especially amongst high ranking policy makers and senior officials, which was at odds with the theoretically devolved nature of decision-making under the federalized system.

Conclusion: The study shows that, even outside the exceptional circumstances of the pandemic, there is a need for a change in mindset amongst Federal-level policymakers, from a command and control mentality towards supporting and empowering the lower levels in order to deliver a robust and functional federal health system.

Keywords: Federalisation, Health System, Governance, COVID-19, Nepal

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What We Already Know:

Constitution of 2015 introduced federalism with 3 tiered government structure thus decentralizing all service sectors including the heath system with several transitional challenges moving to a new system.

What This Article Adds:

1. The health system's response to COVID-19, a pandemic response experience, that demonstrated both strengths and weaknesses that need to be examined.

2. This experience with the COVID-19 response can provide valuable insights to policymakers into the future challenges Nepal may face in fully implementing a federalized health system.

1. Introduction

Nepal's transition to a federal republic in 2015 aimed to decentralize decision-making and improve public service delivery, but it faced significant challenges [1] [2] [3]. The health sector underwent major changes, moving from a centralized system to a three-tiered structure [4]. However, the Constitution's lack of clarity on government functions resulted in power struggles, impacting federalism's successful implementation and the health system's effectiveness.

The COVID-19 pandemic coincided with Nepal's health system restructuring, adding complexity to the federal transition [5][6][9]. Unfortunately, the Constitution did not address pandemic management or define authority division during health emergencies. The pandemic not only posed a health challenge but also tested the newly-established federal health system's crisis response. This study aims to explore stakeholders' perspectives on the challenges and lessons learned during the COVID-19 response and identify potential improvements for Nepal's new federal health system. The questions this study aims to answer are:

1. What were the strengths and weaknesses of the health system’s response to COVID-19?
2. What can we learn from this experience about the future challenges for Nepal’s move to a fully federalised health system?

2. METHODS

2.1 Study design and setting

This study employs an exploratory qualitative research design [10] and is part of a broader investigation into health system federalization in Nepal (REFERENCE REMOVED FOR ANONYMITY). It focuses on COVID-related issues and lessons learned from stakeholders, utilizing methods from the main study.

Semi-structured Key Informant Interviews (KIIs) were conducted to ensure a diverse representation of participants from different levels of the health system, including Federal, Provincial, Municipal,

Ward, and health center levels. The sample covered all three tiers of government, including the federal government, three out of seven provincial governments, four urban/rural municipalities, and eight wards (service delivery level). The study sites were selected to encompass five dimensions reflecting Nepal's diversity: ecological zones, ethnic population, rural/urban settings, socioeconomic status, and the level of health services.

The Ethical Approval for the study is received from Nepal Health Research Council (NHRC) Ethical Review Board (ERB). The ERB reference number is 354/2020.

2.2 Study participants

Between March and August 2021, 145 KIIs were conducted with stakeholders at all levels, including elected representatives, civil servants, health service providers, and NGO representatives, focusing on Nepal's federal health system and COVID-19 experiences. Informed written consent was secured from participants with privacy ensured and no financial incentives provided.

2.3 Data collection

Interview checklists and topic guides based on the WHO's six health system building blocks were developed in consultation with research scientists and health sector experts. They were also informed by the available literature on health system decentralization in Nepal and other countries. The checklists and guides were tested, amended, and then implemented.

Nepali-speaking senior researchers, assisted by research associates, conducted the interviews, ensuring consent was obtained and notes were taken. Interviews were audio recorded, and efforts were made to build rapport with participants while maintaining objectivity and considering the power dynamic between researchers and participants. All interviews were conducted in Nepali.

2.4 Data analysis

Audio recordings were transcribed in Nepali and translated to English by a local Nepali researcher/translator. Three Nepal-based researchers verified the recordings. Verbatim transcripts, field notes, and interview descriptions were analyzed using NVivo software. An inductive analysis was performed [11,12] creating an initial list of nodes based on multiple interviews. Data was double coded, organized into themes, and reconciled for differences in interpretation and labeling. Two additional researchers reviewed the nodes, ensuring accuracy and discussion with Principal Investigators

3. FINDINGS

The study provided some revealing findings on Nepal's newly federalized health system's response to the COVID-19 pandemic. The results obtained from the study are presented through the two overarching themes, first with several lessons learned from COVID-19 response at the local level and second with the perspectives of the higher level stakeholders.

3.1 Local experiences: Lessons learned from the COVID-19 response

There are three main lessons identified by local level participants in respect of their experience of Nepal's COVID-19.

3.1.1 Local level governments were the key responders during the pandemic and were able to autonomously mount a response within their resource constraints

Using their executive powers, local level governments responded quickly to the pandemic by taking the required decisions and initiating emergency measures, as their capacity allowed. They made use of the resources at hand, including financial, local infrastructure, and manpower available to them. Their choices were based on local needs, were generally in-line with WHO recommendations at the time, and took into account local conditions.

An official from the health section of a Rural Municipality government in Mugu (a rural area in the Far West of the country) explained how necessary financial and material resources were obtained:

> *"We managed by diverting the budget we had allocated for other programs for the prevention of infection. We conducted meetings with different organizations who helped us with masks, soap and other materials."* (Mugu-210418-33-M-Health Coordinator)

Similarly, a ward chairperson in the same region described how his ward reallocated funding.

> *"We invested almost 8-9 lakhs [around $6-7,000 USD] on Covid management. We did PCR tests and referred some patients to Jumla."* (Mugu-210415-24-RM-Chairman)

In addition to providing protective equipment and testing services, local governments also used their financial resources to supply essential supplies to households during lockdown:

> *"We also supplied 1 sack of rice, 2 iodine salt, 1 pack of cooking oil etc. to each house during the lockdown."* (Mugu-210419-41-M-Ward Chairperson)

As well as locally-available financial resources, human resources were also mobilized:

"We mobilized the municipality's resources to provide information about COVID-19, and also mobilized FCHVs [Female Community Health Volunteers]." Parasi_R_-210727-2-Health Staff

"We regularly provided health education. Everyone was told to maintain social distance and to wash their hands regularly. We suggested people wear a mask and maintain social distance - and yes, they followed the advice as well." Mugu-210418-37-M-Staff Nurse

Local governments also took the lead in establishing and managing quarantine and isolation centres. One local politician from Parasi described the process:

"Last year, the local government established several quarantine centers in different places. Our health workers have also been providing health services in different isolation centers as well. if the local government was not available then we might not have been able to control COVID 19 infections. So, they played an important role in implementing control measures." (Parasi _R_ -210728- 4 elected member)

3.1.2 COVID-19 highlighted to local governments the importance of health, and helped unlock local level resource allocation

Due to the COVID-19 experience, municipal governments began prioritizing the health sector in their fiscal plans, utilizing the authority granted by the new constitution. Previously focused on infrastructure investments, this shift was viewed positively by health system workers. Alongside budget allocations, local governments improved monitoring and enhanced health service delivery.

"Giving priority to health, we are now allocating a budget of around 1 core [approx. $75,000USD] for COVID 19 management so that we can utilize the budget for to prevent future disaster. We also have increased the number of health workers compared to the past." (Parasi_R_-210730-3-Elected Official)

A local health workers in Sindhupalchok reported an increased prioritisation of health:

COVID-19 emphasized the significance of health as a multisectoral priority. Local governments are now encouraged to prioritize the health sector in their fiscal plans and budgets." (Sindhupalchok-210310-8-RM-HP Incharge)

Officials from Kathmandu and Parasi similarly felt that the local leadership has increased the priority of health services after the experience of COVID.

"COVID has made them understand what health is. During the past 2 years - due to COVID – awareness amongst the leadership has increased. I thank Corona very much. Corona has helped bring health a little further forward." (Kathmandu _S_-210727-1-Health Post Staff)

"Health should be a priority, and now it is happening. COVID has made us realise its importance, not only here but in every place." (Parasi_R_-210729-2-Admin Staff)

3.1.3 Stakeholders at the local level did not feel adequately supported by the higher levels

Local governments actively responded but faced capacity limitations. The pandemic response lacked a national strategy, relying on ad hoc actions. As it continued, local governments increasingly depended on higher levels, revealing gaps in the federal health system. Higher-level responses were criticized for being slow and insufficient.

For example, when specialised equipment such a PCR machines, antigen test kits, and viral transport media were needed locally, the response from the Province was seen as too slow:

> *"We lack a PCR machine in this district. Materials like VTM, Antigen test kits, etc., are supplied by the Province, not us [at municipal level]. We can only procure certain items, distributed to address local needs."* (Sindhupalchowk-210814-56-M-Senior Public Health Officer)

The Federal government, meanwhile, was seen as having been slow in disseminating COVID management guidelines to the local level:

> *"Lately delivered guidelines from the central level caused confusion for local management of COVID-19. The local level, lacking technical expertise, effectively handled the pandemic using local resources.""* (Parasi_R_-210729-3-EDP Staff)

At the time of the interviews, there were concerns about the insufficiency of vaccines being sent to the local levels from the Federal government. A member of staff at an urban health centre told us:

> *"I do not have a clear idea about what is going on. The main thing that is making the news is COVID vaccination, but as vaccination has stopped, it has become an issue. "Can we protect ourselves with the amount of vaccines provided?" People are raising such questions now."* (Kathmandu-210329-1-UHC Staff)

A local-level official said that the vaccination programme had been conducted without any co-ordination with the municipality, he said:

> *"Our role during COVID 19 has been very crucial. But now the vaccination program has been conducted without coordination with the municipality."* (Kathmandu-210418-1-Local Govt. Official)

3.2 Perceptions at the higher levels: What Federal and Province health stakeholders think

COVID-19 was a challenging test for Nepal's new federal health system, with similar struggles in other countries. Local-level officials and health service providers praised local government actions. Problems were linked to inadequate support from higher levels and coordination issues. However, Federal and Provincial stakeholders held different views, showing dismissiveness towards local government capabilities and discontent with unclear roles and perceived neglect at the Province level by the Federal government.

3.2.1 Doubts about the capabilities of local governments

There were significant doubts expressed by participants at both the Federal and Province levels about the technical expertise of local governments in relation to health. One Federal level official, for example, said:

> *"At the local level there is relatively little or no expertise in health. In health, quality matters ... So, it's not easy. Having power, authority is one thing. But operationalizing that at the local level is quite challenging."* (Federal- 210316-1-HF Expert)

Similarly, a senior Province-level official reported:

> *"Local governments lack expertise to run health services effectively. believe granting full rights to the Provincial government could lead to better results."*(Surkhet-210409-16-Province-Senior Health Administrator)

The federal structure was often unfavorably compared to the past centralized governance system, where key decisions were made by the central government and implemented by District Health Offices, which now operate under Municipal governments in the federal system

A staff member from Department of Health Services (DoHS) at the (Federal) Ministry of Health and Population highlighted:

> *"I am still saying that, despite our health system being in the federal structure, the central level should have governing power right down to the grassroots level. We were doing well under the past structure."* (Federal-210314-1-DoHS Official)

Similarly, a senior official at the Ministry of Health and Population argued:

> *"We have had a long debate on whether we do or do not need Districts. In times like this – during a pandemic - it is not possible to go to all 753 units [municipalities]. The argument that we needed Districts has now been proven."* (Federal-210324-1-MoHP Official)

Amongst some, such as this Ministry official, there was a desire to rethink the entire move to a federal structure:

"Federalism adds complexity. We should reconsider the need for three tiers of government. Provinces are stuck in the middle, and the local level has been procuring health materials recklessly (Federal-210312-1-MoHP Official)

3.2.2 The unclear role of Provincial governments

This comment about Provincial governments "hanging in the middle" resonated with the responses of interviewees at Province level, although their preferred solution was to more fully empower Provinces rather than disband them:

"For better services, the Federal government should delegate responsibilities to the Provincial level. In this current situation [the COVID-19 pandemic], we do not see any activities or have any responsibility at the Provincial level." (Bagmati-210903-2-Health staff)

"The Province level is coordinating with all levels - Federal level and local - but what can we do when the Federal level itself is bypassing the province level?" (Lumbini-210804-1-Health Staff)

4. DISCUSSION

The COVID-19 pandemic impacted Nepal's health system during its federal restructuring, affecting service delivery and emergency response. Despite capacity constraints, local governments demonstrated prompt pandemic response and resource reallocation, while frustration with higher-level authorities persisted. The federal level maintained a centralized mindset, leading to inadequate support for local levels and coordination challenges. Future epidemic preparedness may be hindered without strategic direction and clarity on roles. Nepal's relatively young federalized health system requires a shift to a collaborative mindset through capacity building and defined roles and resources. The pandemic highlighted strengths and weaknesses in the health system, offering lessons for improvement. However, the study acknowledges its limitation in capturing only stakeholder views in policymaking and service provision. To strengthen the health system, a collaborative approach is essential. [13][14].

5. CONCLUSION

The pandemic highlighted limitations in the newly federalized health system, and stakeholder perspectives need adaptation. To benefit from federalism, clear roles and trust-based relationships among key players are crucial. A change is needed from an outlook of "command and control" to one of "support, strengthen and empower".

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