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HEALTH AND SOCIAL PROTECTION SERVICES AT LOCAL LEVEL

LESSONS FROM COVID-19 FIRST SURGE IN NEPAL

Oxford Policy Management

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Executive summary

COVID-19 led to health emergency situation of an unprecedented magnitude across the globe. Strong health systems of the most developed countries also struggled to cope with the increasing demand for intensive care generated due to COVID-19 infection. Countries with poor health system were unable to comprehend its own coping mechanisms. For Nepal, this was the first large scale crisis since establishment of federalism in 2015 and eventually the country entered into an early lockdown on 24 March, 2020. Stringent restrictions on movement and economic activities resulted in disruption of health services and loss of jobs, particularly affecting people living on daily wages.

Studies that have put the local governments into perspective and tried to understand the opportunities and challenges faced in addressing the pandemic, have been very few. This was important especially as Nepal transitions from multiparty democracy to federalism. In this context, this study was undertaken to understand how the local governments addressed the crisis particularly in two sectors: health and social protection services and to understand the challenges in doing so. The findings from this study is expected to support the local governments in preparing for the remaining of the pandemic as well as crisis of similar magnitude in days to come.

Study design: This study adopted qualitative methods with desk review and in-depth interviews between November – December 2020. Desk review was conducted to understand policies, guidelines, protocols, and institutional arrangements for delivery of health service and social protection services. The study was conducted purposively in Province 2 and Sudurpaschim province, spanning 10 rural/municipalities and including 66 key informant interviews.

Findings: This study explored opportunities and challenges in ***health system***, looking at all the six components of the system based on World Health Organization health system framework. Maternal and child health service availability at health facilities was relatively unaffected but a drop in service utilization was noted due to challenges in accessibility. The local governments were unprepared in terms of human resource management particularly with regard to quantity, capacity building, motivation and well-being. Most of the local governments had adequate essential medicines in stock and did not face any difficulty in managing them, however there was scarcity of PPE in the beginning as is quite understandable in an unprecedented situation like this. The lengthy public procurement process was one of the challenges when trying to manage this inadequacy. The local governments struggled to manage funds for COVID -19 as the pandemic hit by surprise toward the last quarter of FY 2019/20 but they managed from other headings as well as using the provision of undivided budget in the Red Book*. In terms of leadership and governance, the local governments demonstrated capacity and willingness to manage crisis at their end despite limited resources and knowledge. Lack of clarity in roles and coordination among three tiers of government is a clear area for improvement.

In ***social protection***, the pandemic did not have much impact on distribution of social security allowance, however programmes relating to Prime Minister

* Red Book is the term used by the Ministry of Finance/Government of Nepal for the document *Byaya Anumanko Bibabran Arthik Barsha 20..../20....* that provides budget details of all programs in a given nepali fiscal year,

Employment Program (PMEP) were disrupted. Challenges to accessing social security allowance (SSA) by recipients were related to overcrowding at banks, long queues and distance and also dissatisfaction in beneficiary selection. In-kind distribution including food commodities and hygiene materials were also reported as social protection mechanisms in almost all Palikas with one Palika also distributing small amount of cash, however, not much was done to support the returnee migrants. The study did not find any evidence on employment opportunities at local level, therefore, returnee migrants and those who lost their jobs were not able to benefit from PMEP. Gaps still remains in overall understanding of social protection, legal and institutional framework which governs all programmes relating to social protection, monitoring and evaluation of programmes relating to social protection, and overall service delivery mechanism.

Recommendation: Maternal and child ***health services*** were available during the lockdown, however, emphasis should be on providing means and ways for vulnerable groups to access and utilize these services when needed. The local governments should have a human resource management plan and invest in capacity building, motivation, safety and well-being of health workers while they continue to work in the frontline in any emergency context. This may be applicable to COVID-19 pandemic as it may be prolonged crisis as well as any other forms of crisis. While essential medicines were adequate during this period, public procurement process should be simplified for emergency procurement during crisis management. Provision of undivided budget in Red Book, managing from other budget headings and even internal management proved helpful to the local governments in this crisis, but more rigorous and scientific basis of budget allocation would support the local governments to remain prepared for a prolonged crisis like COVID-19 and even similar emergency situations in future. The federal and province governments should strengthen capacity of the local governments by providing clear guidance and coordination. I/NGOs should also support the local governments with timely support.

A clear framework for ***social protection*** including legal and institutional framework, service delivery mechanism and monitoring and evaluation system is urgently required for a common understanding at all levels. The local governments should make social protection beneficiary selection participatory, inclusive and transparent. Considering the vulnerability of social protection beneficiaries and pandemic situation, local government should ease the process of receiving SSA. Given, there was no evidence of dedicated support to returnee migrants, the federal government would take necessary approach to encourage participation of returnee migrants. There are ample opportunities for both the local governments and development partners to plan relief support to returnee migrants.

The local governments should devise means to make social protection program more transparent. Periodic monitoring should be conducted by Ministry of Home Affairs (MoHA) and Ministry of Women, Children and Senior Citizens (MoWCSC) regarding the distribution of SSAs, online registration of beneficiaries and selection of beneficiaries until a universal framework is developed by National Planning Commission (NPC). Further research is required to understand how SSAs and PMEP impacted livelihood of beneficiaries and returnee migrants, if any.

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List of abbreviations

ARI	Acute Respiratory Infection
ANC	Ante-natal Care
BCG	Bacillus Calmette-Guerin
CAO	Chief Administrative Officer
CB-IMCI	Community Based Integrated Management of Neonatal and Childhood Illness
CICT	Case Investigation and Contact Tracing
COVID	Corona Virus Disease
CCMC	COVID-19 Crisis Management Committee
DoNIDCR	Department of National Id and Civil Registration
DTCO	District Treasury Controller Office
EDP	External Development Partner
ESC	Employment Service Centres
FP	Family Planning
FY	Fiscal Year
HMIS	Health Management Information System
ICU	Intensive Care Unit
IMU	Information Management Unit
KII	Key Informant Interview
MoHP	Ministry of Health and Population
MoFALD	Ministry of Federal Affairs and Local Development
MoF	Ministry of Finance
MoLESS	Ministry of Labour Employment and Social Security
MoSD	Ministry of Social Development
MoWCSC	Ministry of Women Children and Senior Citizens
NPC	National Planning Commission
NPR	Nepalese Rupee
OPM	Oxford Policy Management
OPV	Oral Polio Vaccine
PCR	Polymerase Chain Reaction
PHEOC	Provincial Health Emergency Operation Centres
PPE	Personal Protective Equipment
PMEP	Prime Minister Employment Programme
PNC	Post-natal Care
RRT	Rapid Response Team
SSA	Social Security Allowance
WHO	World Health Organisation

BACK-GROUND

Corona Virus Disease-19, also known as COVID-19 is a zoonotic infection caused by novel coronavirus, causing Severe Acute Respiratory Syndrome (SARS-CoV-2), first diagnosed in China in December 2019 (WHO, 2020). COVID-19 rapidly spread out of China across the globe and was declared a pandemic by the WHO in March 2020. Severity of infection varies from asymptomatic to critical condition and even death, causing more severe infection in old age and people with other morbidities (Bulut C, 2020). As of 19th February 2021, over 110 million people have been infected with 2.5 million deaths globally (Worldometers, 2021). COVID-19 is primarily a health crisis, but the pathway between the pandemic and global trade disruptions is now very clear, and the crisis has negatively affected social determinants of health as well as social protection services (Barlow P, 2021).

1.1 Health

COVID-19 has led to a health emergency across the globe. Strong health systems of the developed countries also faced challenges to cope with the increasing demand for intensive care generated due to COVID-19 infection. Shortage of logistics including personal protective equipment and ventilators, and excessive workload on health professionals, all posed challenges to the health systems (Ferrara & Albano, 2020). As the COVID-19 pandemic negatively affected the developed nations before the lower-middle-income countries, it was only obvious to assume that the countries with weaker health systems, such as Nepal, would struggle to keep up with the healthcare demands. This was further supported by the epidemiological modelling (White, et al., 2020). In 2020, spread of COVID-19 infection in Nepal was slow with first positive case reported on 23rd January 2020, followed by second positive case on 23rd March. An early nationwide lockdown was imposed by the Government on 24th March 2020 to limit the spread of COVID-19 infection. As preventive interventions, national and international travel were suspended, schools and services encouraging mass gathering were closed, ban on public gatherings, and closure of borders with neighbouring countries were immediately made effective. This came at a cost of disruption of normal day to day life, also impacting the health services delivery and access, in addition to overall socio-economy of the country, primarily affecting people living on daily wage income and migrant labours returning home (UN-Nepal, 2020). Despite government's commitment for uninterrupted basic and emergency health services, there were reports of disruption of the health services such as immunization in some parts of the country during the initial phase of the lockdown (Mathema, 2020). (Roberton, et al., 2020).

In Nepal, the Federal Government led the COVID-19 response through High-level Committee on COVID-19 and COVID-19 Crisis Management Center (CCMC), both headed by Deputy Prime Minister and Minister for Defence. The management of emergency situations such as an infectious disease pandemic falls under the jurisdiction of the federal government with support and coordination from provincial and local Governments. Additionally, steering committee led by the Secretary of the Ministry of Health and Population and clusters were formed at the Federal and Provincial level (UN-Nepal, 2020). The guidelines for COVID-19 management, quarantine and isolation management, COVID-19 dead body management, and guidance for reproductive, maternal, neonatal and child health (RMNCH), was formulated by the federal government and implemented all three tiers of the government. The testing capacity was increased from a single COVID-19 diagnostic laboratory at Nepal Public Health Laboratory in Kathmandu to 83 laboratories in both private and public sector across all seven provinces (MoHP, 2021).

The quarantine and isolation centers started reaching capacity with increasing number of migrant workers returning from India through open borders in April/May, further posing challenges to manage the centers locally. . After nearly three months, the Government of Nepal relaxed the lockdown measures on 11 June 2020 which was completely lifted on 21 July 2020. International travel restrictions

were still in place and borders remained closed in addition to closure of schools (Sharma, et al., 2020). Furthermore, the Local Governments managed the COVID-19 situation by using range of measures including sealing of areas with high cases of infection to locking down entire Palika or districts based on circumstances. However, number of infected cases peaked in October 2020 when daily test positivity rate reached 15 percent, much higher than the baseline of five percent recommended by the World Health Organization (Bhattarai M, 2020).

Intensive care unit (ICU) occupancy also peaked resulting in scarcity of ICU beds and ventilators (Poudel, 2020). To cater to the increase in demands for PCR tests, the federal government started coordinating with private health facilities. Home isolation for asymptomatic COVID-19 positive people was promoted and contact tracing was encourage with contacts to also opt for PCR test and home isolation. The development and humanitarian actors present in the country assisted in management of COVID-19 situation by working closely with the g. They also contributed directly by donating personal protective equipment, setting up contactless hand washing facilities in public places and healthcare facilities, and distributing relief packages to people who were in immediate needs including those without livelihood support and returnee migrants.

The Constitution of Nepal (2015) recognizes health as the fundamental right of every citizen, to enact which, Acts and policies, such as the Public Health Service Act 2018, the Rights to Safe Motherhood and Reproductive Health Act 2018, Immunization Act 2016 and the National Health policy 2019 have been endorsed. Ensuring equitable access to basic and emergency healthcare is the responsibility of all the three levels of Government (Thapa, et al., 2019). The Public Health Service Act 2018 clearly states the Federal Government has the right to declare a state of emergency in case of infectious disease outbreak affecting more than one Province, while the local Government can declare a state of emergency based on local circumstances (GoN, 2018). Rapid response team and emergency physicians group has to extend health services during health emergency situations as per the law (GoN, 2018).

The federal government announced the continuation of basic and emergency healthcare services and directives for the same were also given to povincial and local Governments. The Health Sector Emergency Response Plan (HSERP) was prepared by the federal government to manage COVID-19 pandemic situation based on the resources available in the country, including hospital-based interventions, public health and social measures, human resource management, and logistics and fund management. Probable situations were categorized in four levels to understand the point at which the health systems would start stretching and response plans were formulated accordingly (MoHP, 2020). A total of 194 hospitals, 26,930 hospital beds (both public and private), 1,595 ICU beds and 840 ventilators and 111 hospitals were designated in country to run COVID-19 clinics, and 28 hospitals to treat COVID-19 cases (MoHP, 2020). An epidemiological modelling to forecast positive case loads, and analisis of tentative time-period of infectious cases to peak was also conducted. Based on these findings, logistics purchase plan was also formulated. Testing capacity of labs were increased and made available in all seven provinces, national guidelines for testing, quarantine and isolation was

formulated and implemented across the country, and toll-free helpline call center and mobile application to provide information on COVID-19 were established. The Government started providing COVID-19 vaccination nationwide for health workers and frontline workers from 27 January 2021 while still continuing the non-pharmaceutical interventions of social distancing, hand hygiene and mandatory use of masks in public places.

1.2 Social Protection

Social protection can be referred to as public interventions including sector (policies, frameworks, guidelines and regulations), individual programmes and delivery systems (database and payment mechanism), which mainly focuses on addressing the existing deprivation and vulnerabilities of the impoverished as well as protecting those who are at risk of potential shocks and vulnerabilities such as dependent, marginalised, disabled, informal workers, indigenous population and so on (O'Brien, et al., 2018) (World Vision , 2020). There are several interventions relating to social protection namely social assistance, social insurance, labour market intervention and social care. However, this study has referred to social protection as social assistance (specifically social security allowances and other relief support during a disaster) and labour market intervention (specifically Prime Minister Employment Programme[1]) as these interventions significantly relates to the aim of this study.

Social assistance mainly includes non-contributory cash, vouchers or in-kind transfers and social security allowances (SSA)[2] whereas labour market intervention includes provision of employment and skill development activities, creation of job opportunities as well as ensuring occupational health and safety standards. Department of National Id and Civil Registration (DoNIDCR) which is managed and controlled by Ministry of Federal Affairs and Local Development (MoFALD) is responsible for administering the SSA (World Bank , et al., 2020) whereas Ministry of Labour Employment and Social Security (MoLESS) is responsible for administering PMEP.

Whilst the COVID-19 pandemic has directly affected the wellbeing of many Nepalese population, the preventive measures adopted to contain the pandemic has indirectly affected many sectors and the overall economy of the country. The impact of COVID-19 pandemic on Nepalese economy is widely evident (IIDS, 2020) (World Bank, 2020) (SAWDF Nepal, 2020). Analysts suggest that the COVID-19 crisis will lead to 10 percent increase in prevalence of extreme poverty, which was already high before the crisis (International Policy Centre for Inclusive Growth , 2020). With increase in prevalence of extreme poverty, the population who are dependent upon others are likely to be further impoverished. Those dependent population include people below 15 years (29.6 percent of total population) and above 60 years of age (7 percent of total population) (CBS, 2019). In addition, the population who needs

[1] Prime Minister Employment Programme (PMEP) was implemented by GoN in 2019 envisioning a minimum employment of 100 days of work to the registered unemployed in Public Works Programmes (PWPs). This programme focuses on providing short term employment while prioritising the vulnerable population.

[2] Social security allowances are those allowances that are defined under social security act

special protection as defined by the state including Dalit, socially backward women, indigenous people, person with disabilities, marginalised and oppressed or citizens of backward regions are at a great risk of further impoverishment.

The COVID-19 pandemic is estimated to mostly impact informal workers (World Bank, 2020) and vulnerable people (Poudel & Subedi, 2020) (Reliefweb , 2020). The pandemic is estimated to make 15,880 people jobless (SAWDF Nepal, 2020), of which many are likely to be informal workers, temporary workers, internal migrants and day labourers (UNDP, 2020). However, the exact number of people losing jobs might be higher than 15,880 while assessing the year round figure.

According to a report on COVID-19 labour market impact in Nepal, 5.7 million workers are in informal labour market and 1.4 million are home based workers. A significant number of Nepalese population who were working abroad have returned back to Nepal (Reliefweb, 2020) (Aryal & Shrestha, 2020). It is important to consider that workers in the informal sector often lack social protection coverage.

Considering the vulnerability of above mentioned population groups, government should take an effective approach for providing those population groups with the social protection in terms of social assistance and adopting adequate labour market interventions (GoN, 2015)[3].

[3] It has been mentioned under Part 3: Fundamental Rights and Duties (40: Rights of Dalit; 41: Rights of Senior Citizens; 42: Right to Social Justice; 43: Right to Social Security; 51(h): Policies relating to basic needs of the citizens; 51(i): Policies relating to labour and employment; 51(j): Policies relating to social justice and inclusion

Rationale of the study 1.3

Government of Nepal braced itself for response with external and internal support from donors, international non-government organizations, national organizations, private sector, civil society and individuals. Political will to address the pandemic was strong and Nepal's previous experience from Koshi flood response (2008) and Nepal earthquake response (2015) favored the country's response capacity. The Public Health Service Act 2075(2018) and Health Sector Emergency Response Plan 2020 provided the foundation for early response.

The first few months of response faced criticisms in the inability to ramp-up testing as thousands of migrant workers from India returned home; lack of quality quarantine centers; and the overwhelming health system providing inpatient supports for infected population. The media channels consistently reported lack of management of quarantine centers causing deaths, delay in confirmatory tests sometimes even so after the patient has died, instances of gender based violence in quarantine centers, to quote some. On 14 June 2020, Nepal Health Research Council conducted hospital based assessment to identify country level preparedness and readiness. Thereafter, individual organizations published small scale assessment, secondary impact of lockdown and the prolonged economic crisis particularly to the most vulnerable population.

Until end of 2020, studies that put local government into perspective to understand the opportunities and challenges local government faced in addressing the pandemic were very few, hence, this study aims to fill that gap. The study has beenundertaken

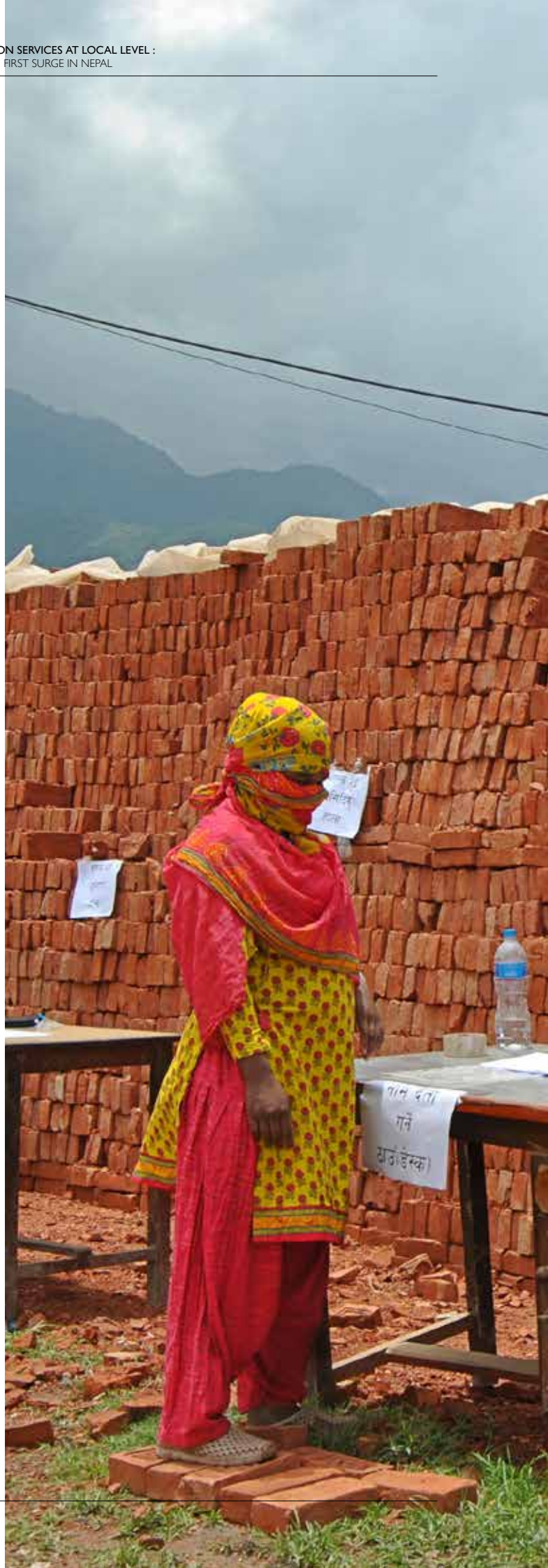
with an objective to comprehend how local governments in the federal structure addressed the crisis particularly in two sectors: health and social protection services and what were the challenges in doing so. The findings from this study is expected to support local government in preparing for the remaining of the pandemic as well as crisis of similar magnitude in days to come.

1.4 Objective of the study

General Objective:
The objective of this study is to understand opportunities and challenges of local governments in delivering health and social protection services during COVID-19 first surge.

Specific objective:

- To understand how local governments responded in health, explained from within the WHO health systems framework perspective
- To understand the role and coordination mechanism of local governments with province governments, federal government, and I/NGOs during response.
- To understand the response of local governments in social protection service delivery, in particular understand accessibility of vulnerable groups to relief programmes, in relation to food, cash and voucher programmes and PMEP
- To understand response of local governments in addressing returnee migrants and their livelihoods.
- To make short and long term recommendations to local government in preparedness for ongoing pandemic and similar crisis in future



METHO-DOLOGY

2.1 Study design

This study adopted qualitative methods to achieve the study objectives. Desk review and interviews were the primary methods of data collection. An in–depth desk review was conducted to understand policies, guidelines, protocols, and institutional arrangements for delivery of health service and social protection services. The source of secondary data was health management information system (HMIS) records at health facilities, government annual program 2076/77, relevant documents from rural/ municipalities between March/April 2020 – June/July 2020. Key Informant Interviews (KIIs) were conducted with the service providers, the local ggovernment representatives, and concerned ministries at province and federal government to understand the implementation and responses of both health services as well as social protection programmes. WHO's tool for health systems assessment in crisis situation as well as the tool used for World Bank's assessment of health systems in decentralized context were contextualized and used to collect information on health systems. Tools to collect information for social protection were developed and tested before its implemention in the field.

2.2 Sample and study site

This study was conducted in two provinces: Province 2 and Sudurpaschim, which were purposively selected as i) these were program implementation districts of World Vision International (WVI) Nepal and ii) these provinces were experiencing high number of COVID-19 cases with an influx of returnee migrants in the early phase of lockdown. Further, five districts were selected: two in Province 2 and three in Sudurpaschim province. In each district, two rural/municipalities were selected therefore 10 rural/ municipalities in total were selected as sample for the study. Details of selection is provided in annex.

At service user level, two health service user, two social protection service users, one exit client interview for health, two exit client for social protection were interviewed. At the local government rural/municipality level, one health service provider, one ward officer, one health coordinator and one social protection officer each were interviewed. At province government level, two personnel each for health and social protection from Ministry of Social Development were interviewed. At federal level, 1 personnel from MoHP and 1 personnel from MOFAGA were interviewed. 4 personnel from INGOs were interviewed. A total of 66 KIIs were conducted for the purpose of this study.

2.3 Data collection tools and techniques

Data collection was conducted between November and December 2020. Semi structured questionnaire for health was developed based on WHO's tools for Health system assessment for crisis management and World Bank's assessment of health systems in decentralized context. Questionnaires and checklists for social protection were developed based on the objectives of the study, literature review, pre-test and feedback from the data collectors and supervisors. Census and Survey Processing System (CSPro) was used to develop Computer-Assisted Personal Interviewing (CAPI) for exit client and follow up interviews. Interview was conducted using CAPI.

Follow-up and exit-client[4] interviews were mostly conducted remotely (telephonically). Exit-client interview was conducted with the current service users while for those who missed scheduled medical appointments a separate follow-up interviews were conducted. In certain instances where contact number of service users were not available, list of detail address was provided by the service facility, which allowed field researchers to visit the houses of service users to conduct face-to-face exit-client and follow-up interviews. All interviewers provided consent for the interview.

2.4 Data Analysis

Data from desk review was analysed using trend analysis. Data from qualitative interviews were analysed thematically. Data that required quantitative analysis was entered into STATA 16. All the KIIs were transcribed from mothertongue to English language to maintain consistency of the content and information. Particular attention was paid to the conceptual equivalence to the original language during translation. Content analysis of the qualitative data was conducted by the qualitative expert. The data was read and re-read, and initial ideas noted. Initial codes were generated, and data was organized into meaningful groups. This was followed by careful coding of interest features and verbatim analysis of qualitative data was done.

[4] Exit clients are those health service users or beneficiaries who received the service at the time interviewer went to HFs/Palika/Ward for collecting the data on that particular day.

Limitations 2.5

- Sample size is small so care should be taken to generalize findings
- Exit client interview and follow up interview were retrospective in nature so recall bias is possible
- Gap in understanding of social protection interventions among respondents, limited social security to social security allowance and cash or in-kind transfers only.
- Absence of designated institution and legal framework for social protection resulted in data collection and also limited the coherence in response.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1,400
Oxygen Cylinders handover to the Government of Nepal
Friday, 21 May 2021
1,225 sets of Personal Protective Equipment (PPE); 1,012 units of Pulse Oximeters; 1,012 units of IR
thermometers; 20 units of Oxygen concentrators and 25 beds also handed over together with 1,400 Oxy
Cylinders.
World Vision

FINDINGS

3.1 Health

Background characteristics

In order to understand perspectives of health service users, exit-client interview was conducted with current service users while follow-up interviews were conducted with those who missed their scheduled medical appointment. Health services include reproductive health and safe motherhood (ante-natal care, institutional delivery, post-natal care (PNC), and family planning services) and child health include (community based integrated management of neonatal and childhood illness (CB-IMNCI) and immunization services).

Out of 34 exit-client interview respondents, eight (8) respondents were 0-5 years (parents of children responded for their children) and 26 were in 18-35 years age group (as shown in Figure 1). Services for which exit-client respondents visited the health facility were as follows: four (4) for immunization, eight (8) for childhood illness, eight (8) for ANC visit, five (5) for institutional delivery, and nine (9) for family planning services (as shown in Table 1).

FIGURE 1: NUMBER OF RESPONDENTS FOR EXIT-CLIENT AND FOLLOW-UP INTERVIEW BY THEIR AGE

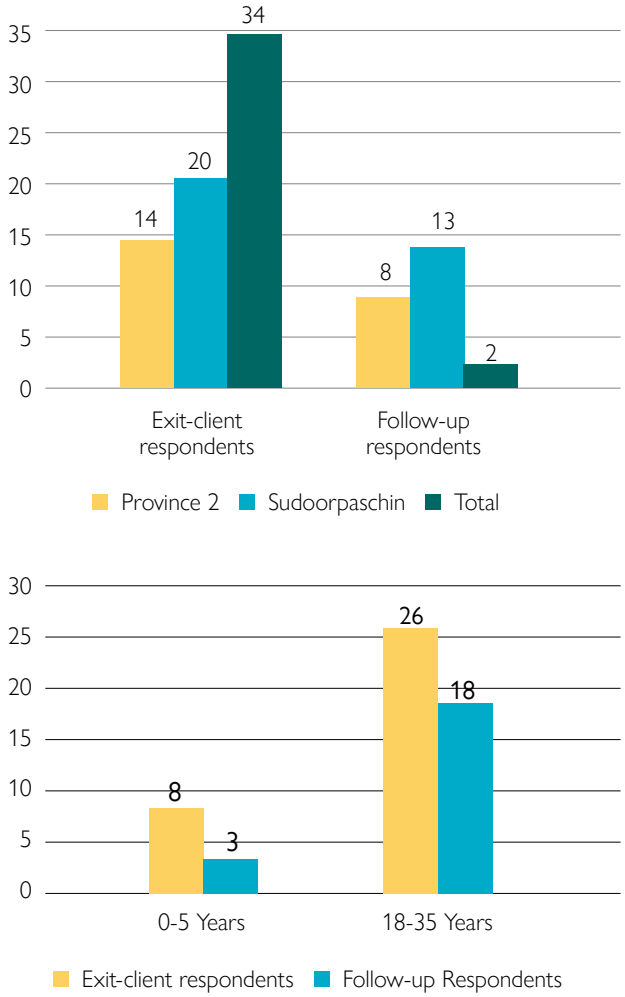
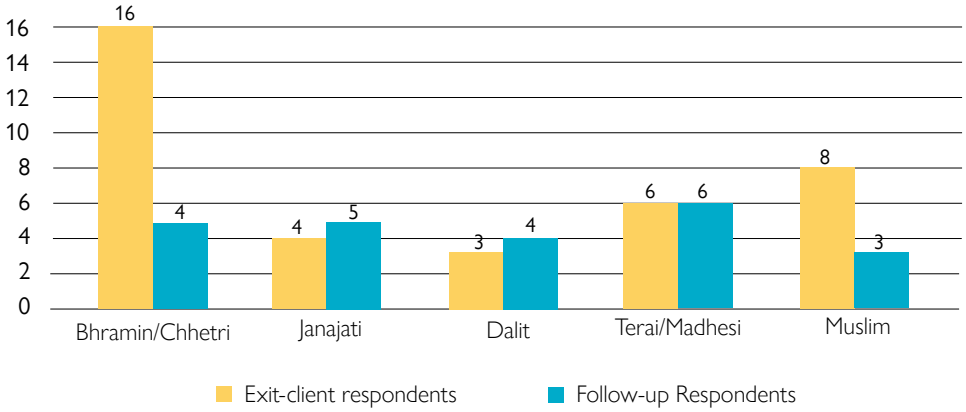


TABLE 1: NUMBER OF RESPONDENTS FOR EXIT-CLIENT AND FOLLOW-UP INTERVIEWS BY THE TYPE OF HEALTH SERVICE

TYPE OF HEALTH SERVICE	EXIT CLIENT INTERVIEW		FOLLOW UP INTERVIEW	
	Province 2	**Sudurpaschim Province**	**Province 2**	**Sudurpaschim Province**
Reproductive Health and Safe Motherhood[5]	10	13	8	10
Child Health Programme[6]	4	7	-	3
Total	14	20	8	13

[5] Reproductive Health and Safe Motherhood: includes ANC, PNC, Institutional Delivery, Family Planning Services
[6] Child Health Programme: Immunization, Childhood Illnesses, Growth Monitoring

FIGURE 2: DISTRIBUTION OF RESPONDENTS BY CASTE/ETHNICITY



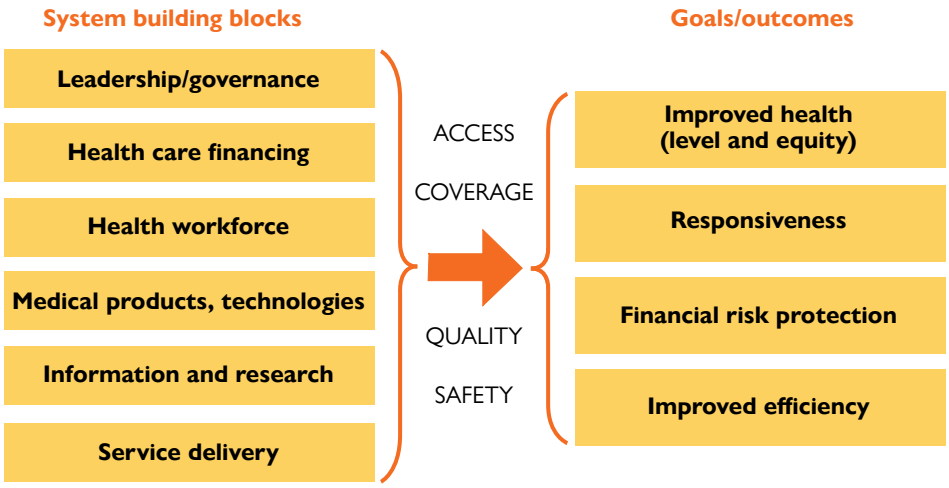
Out of 21 follow-up interview respondents, three (3) respondents were 0-5 years and 18 were in 18-35 years age group (as shown in Figure 1). Health services missed by follow-up respondents were as follows: three (3) for childhood illness, two (2) for ANC, five (5) for delivery, six (6) for PNC, and five (5) for family planning services (as shown in Table 1).

Based on caste/ethnicity, majority of the respondents of the exit-client interview were Brahmin/Chhetri (47%), followed by and Terai/Madhesi (18%) and Muslim (15%). For follow-up interviews, most common caste/ethnicity of respondents included Terai/Madhesi (29%), Brahmin/Chhetri and Janajati (24% each).

3.1.1 Health Systems

Federal system of the government replaced the unitary government in Nepal with the promulgation of constitution in 2015, with three levels of Government, a federal Government, seven Provinces and 753 local Governments. At the federal level, Ministry of Health and Population (MoHP) disseminates and manages healthcare services with three departments; department of health services, department of drug administration and department of ayurveda and alternative medicine, councils and central hospitals. At the provincial level, Ministry of Social Development disseminates healthcare services with the help of Provincial Health Directorate, Health Office and provincial hospitals. The local government is mainly responsible for providing basic healthcare services at the community level through the health division of the metropolitan and sub-metropolitan municipality, and urban and rural municipality. At the local level, community hospitals, primary health care (PHC) centers, health post, female community health volunteers, immunization clinics and PHC outreach clinics provide health services. The federal government, further provides technical support and guidance to the provincial and local government in addition to monitoring and providing conditional grants for uninterrupted health service provision.

Health systems consists of "all organizations, institutions, resources, people and actions", including patients, families, communities, ministries of health, health providers and health financing bodies, which have interconnecting roles and functions with primary purpose of improving health (WHO, 2010) (GAVI, 2013). According to WHO, interaction between the six building blocks of health systems, which includes, service delivery,



Source: Everybody's business : strengthening health systems to improve health outcomes : WHO's framework for action; World Health Organization; 2007

health workforce, health information systems, access to essential medicines (Logistics), financing, and leadership/ governance enables a country to achieve equitable and sustained health outcomes (WHO, 2010).

Imbalance in any one of the components can result in disruption of health systems resulting in poor health outcomes. Unprecedented circumstances arising due to COVID-19, could lead to disruptions from either supply or demand side of healthcare service delivery, stock out of essential medicines or other healthcare logistics, shortage of human resource due to work overload or infection in healthcare workers or poor coordination among different levels of governments. This analysis explored all six components of health systems, based on desk review and interviews.

Service delivery

To assess the continuation of service delivery, information from HMIS was collected from Mangsir (November/ December 2019) to Chaitra (March/ April 2020) 2076 and Baisakh (April/ May 2020) to Asar (June/July 2020) 2077; patient inflow to the health facility before and after the onset of COVID-19 pandemic in Nepal was also compared.

Service delivery components include: ANC, institutional delivery, PNC family planning, CBIMNCI, immunization and growth monitoring.

Pregnant women visiting health facilities for ANC visits since the beginning of lockdown in COVID-19 period in comparison to four months before the onset of COVID-19, reduced by 26 percent in Province 2 and by 24 percent in Sudurpaschim. The coverage of ANC visits for all ten Palikas reduced by 25 percent in the same time period (as shown in Figure 3). The coverage of ANC visits reduced slightly in the month of Chaitra 2076 (March/April 2020) in Samsi and Mellekh, and in Haripurwa, Tikapur, Ghodaghodi, Purwichauki, and Safebagar in the month of Baisakh 2077 (April/ May 2020). Besides these municipalities, ANC visits remained unaffected in other municipalities (as shown in Table 2). None of the health facilities were reported to be closed in any months since the onset of COVID-19 or during the period of lockdown.

The coverage of institutional delivery since the onset of COVID-19 reduced by 34 percent in Province 2 with no change in the overall coverage of institutional delivery in Sudurpaschim. In total,

TABLE 2: NUMBER OF PREGNANT WOMEN ATTENDING FOUR (4) ANC VISITS BEFORE AND AFTER THE ONSET OF COVID-19

Municipality	Before COVID	After COVID
Haripurwa M	33	37
Chandranagar RM	58	43
Samsi RM	32	11
Ekdara RM	26	19
Tikapur M	33	23
Ghodaghodi M	70	50
Dipayal Silgadhi M	15	11
Phurwichauki RM	7	6
Safebagar M	16	12
Mellekh RM	18	19
Total	**308**	**231**

TABLE 3: NUMBER OF INSTITUTIONAL DELIVERIES CONDUCTED BEFORE AND AFTER THE ONSET OF COVID-19

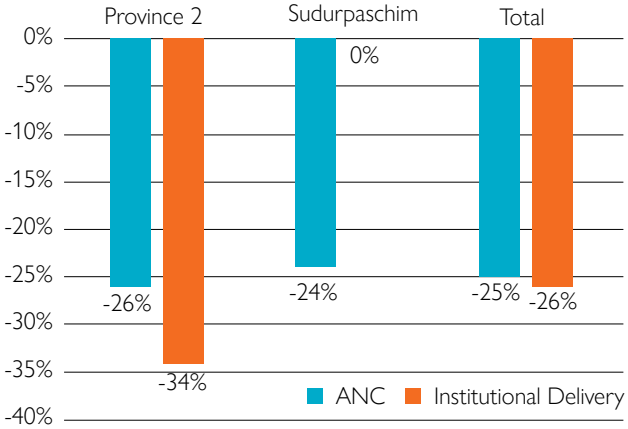
Municipality	Before COVID	After COVID
Haripurwa M	75	80
Chandranagar RM	51	48
Samsi RM	110	78
Ekdara RM	98	16
Tikapur M	23	19
Ghodaghodi M	38	38
Dipayal Silgadhi M	16	7
Phurwichauki RM	7	12
Safebagar M	4	8
Mellekh RM	14	18
Total	**436**	**324**

Source: HMIS (Before COVID: Mangsir-Falgun 2076; After COVID: Chaitra 2076-Asar2077)

institutional delivery for all ten Palikas reduced by 26 percent (as shown in Figure 3). Institutional delivery reduced in Samsi once in Chaitra 2076 (March/April 2020) and again in Shrawan 2077 (July/August 2020) during the second phase of lockdown but remained normal in between. In Ghodaghodi, institutional delivery reduced only in Jestha 2077 (May/June 2020) while in Dipayal Silgadhi, institutional delivery reduced in two consecutive months, Chaitra 2076 (March/April 2020) and Baisakh 2077 (April/May 2020) but became normal thereafter. Institutional delivery in other municipalities appeared to be unaffected during the COVID-19 crisis situation (as shown in Table 3).

The ANC and transport incentive for institutional delivery was distributed in nine (9) out of 10 health facilities. Both incentives have not been distributed in Samsi municipality from before COVID-19 till data collection for this assessment due to backlog of incentive distribution from previous fiscal year (shown in Table 4). Incentive distribution for 4 ANC visits reduced by 33 percent and transport incentive distribution reduced by 36 percent in Province 2 in before and after COVID-19 period. Similarly, incentive distribution for 4 ANC visits decreased by three (3) percent and travel incentive reduced by 10 percent in Sudurpaschim in the same period. In total, incentive distribution for 4 ANC visits reduced by 21 percent and travel incentive reduced by 27 percent (as shown in Figure 3).

FIGURE 3: COVERAGE OF ANC VISITS AND INSTITUTIONAL DELIVERY IN THE COVID-19 PERIOD



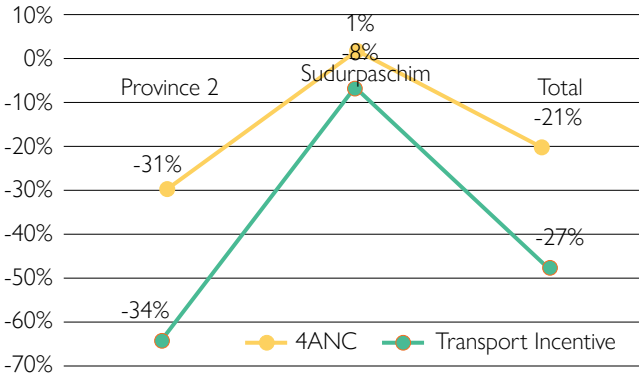
Source: HMIS. (Before COVID: Mangsir-Falgun 2076; After COVID: Chaitra 2076-Asar2077)

TABLE 4: INCENTIVES DISTRIBUTED TO WOMEN FOR 4 ANC VISITS AND TRAVEL FOR INSTITUTIONAL DELIVERY IN BEFORE AND AFTER COVID-19 PERIOD

Municipality	4ANC incentive recipient		Transport incentive eligible		Transport incentive recipient	
	Before COVID	After COVID	Before COVID	After COVID	Before COVID	After COVID
Haripurwa M	50	28	75	80	75	80
Chandranagar RM	51	38	51	48	51	48
Samsi RM	0	0	0	0	0	0
Ekdara RM	26	19	98	16	98	16
Tikapur M	23	19	23	19	23	19
Ghodaghodi M	25	27	38	38	38	38
Dipayal Silgadhi M	16	7	16	7	16	7
Phurwichauki RM	7	8	7	12	7	12
Safebagar M	4	8	1	11	1	11
Mellekh RM	14	17	28	15	28	15

Source: HMIS (Before COVID: Mangsir-Falgun 2076; After COVID: Chaitra 2076-Asar2077)

FIGURE 4: INCENTIVES DISTRIBUTED TO WOMEN FOR 4 ANC VISITS AND TRAVEL FOR INSTITUTIONAL DELIVERY BEFORE AND AFTER COVID-19 PERIOD

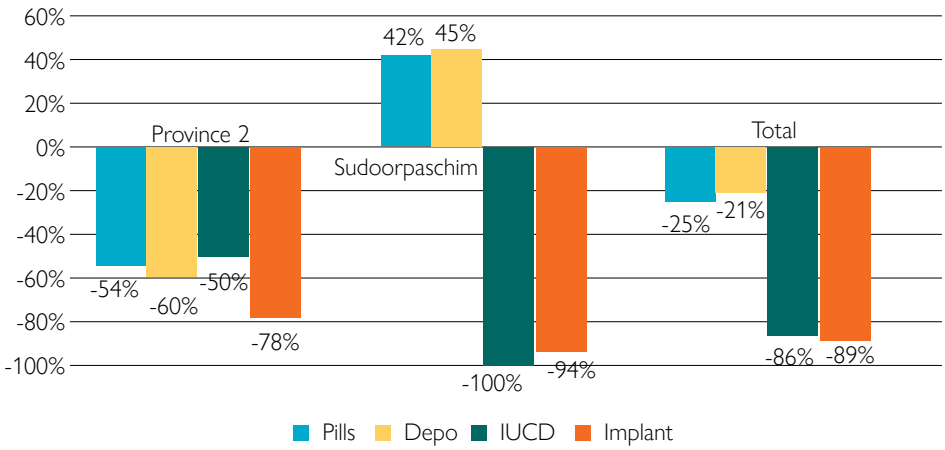


Source: HMIS

To assess continuation of Family Planning (FP) services, information on new service users for contraceptive pills and depo was collected from before and after the onset of COVID-19, as pills and depo are the most commonly used modality of modern contraceptives in Nepal. In Province 2, new users for both pills and depo reduced by 54 percent and 60 percent respectively while in Sudurpaschim, the new users for both pills and depo increased by 42 percent and 45 percent respectively. In total, use of pills reduced by 25 percent and depo reduced by 21 percent (as shown in Figure 4).

The immunization services were disrupted to some extent in the month of Chaitra (March/April 2020) in most of the Palikas. When comparing the immunization uptake in the study Palikas before and after onset of COVID-19, Bacillus Calmette-Guerin (BCG) uptake reduced the most in both Provinces. However, in Province 2, 80 percent reduction was seen after COVID-19 in comparison to before COVID-19 time period (due to shortage of BCG syringe in the Province). This syringe shortage occurs repeatedly in Province 2 which was confirmed by both Palika and provincial authorities during the KII. Yet concrete steps to prevent this recurring problem has not been taken so far. Uptake of 3rd dose of penta (DPT+Hib+Hep B) vaccine reduced by 38 percent in Province 2 and

FIGURE 5: NEW USERS OF FAMILY PLANNING SERVICES BEFORE AND AFTER COVID-19 PERIOD

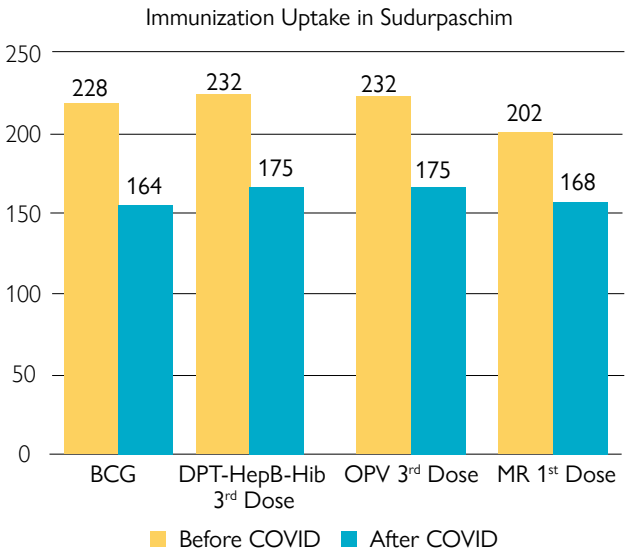


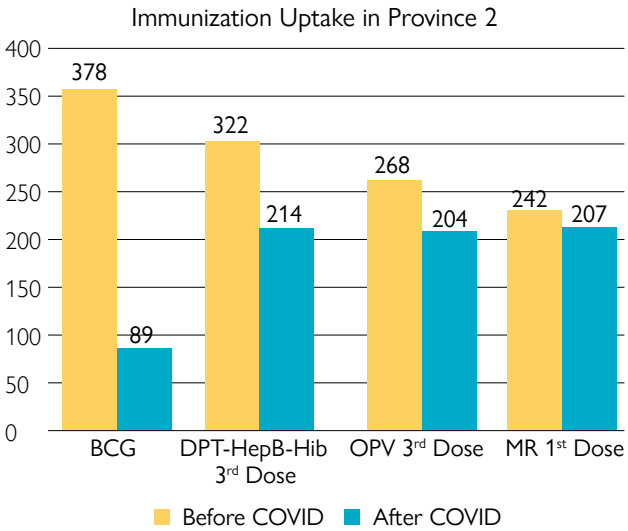
Source: HMIS

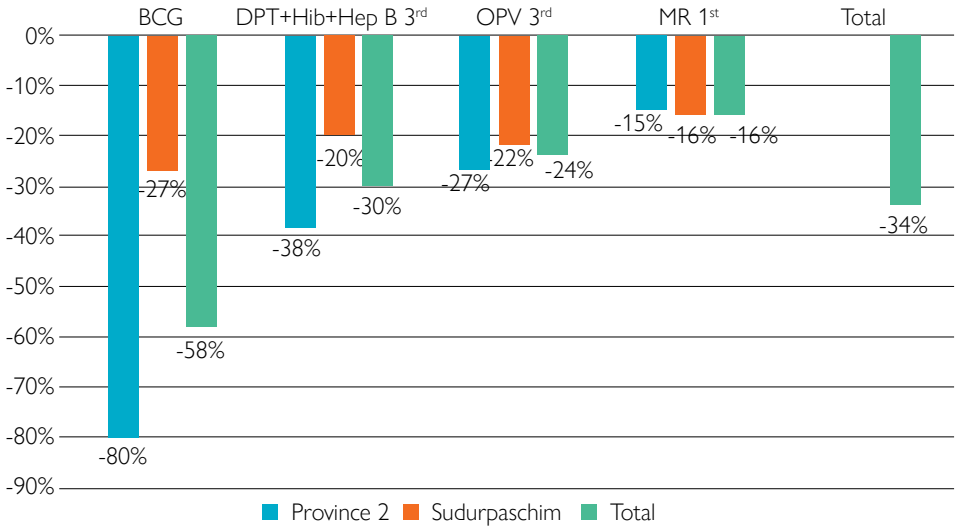
20 percent in Sudurpaschim, while uptake of 1st dose of MR reduced by 15 percent in Province 2 and by 16 percent in Sudurpaschim. Reduction of 27 percent was observed for Oral Polio Vaccine (OPV) 3rd dose uptake in Province 2 in comparison to 22 percent in Sudurpaschim (as shown in Figure 5). Immunization service was not disrupted in Dipayal Silgadhi, Purwichauki and Mellekh, even during the lockdown period. Uptake of immunization started improving from Asar 2077 (June/July 2020) onwards in almost every Palika.

Children in 2-59 months age group receiving treatment for acute respiratory infection (ARI)/pneumonia reduced by 66 percent since the onset of COVID-19 in comparison to previous four months in almost all the Palikas of both Provinces. This could either be attributed to COVID-19 or due to reduced number of cases of infection due to change in season from winter to summer. Children in the same age group receiving treatment for diarrhoea/dehydration in the same time period reduced by 11 percent (as shown in Figure 6). Reduction in treatment for diarrhoea/dehydration reduced by 23 percent in Province

FIGURE 6: REDUCTION IN COVERAGE OF IMMUNIZATION DURING FOUR MONTHS SINCE THE ONSET OF COVID-19







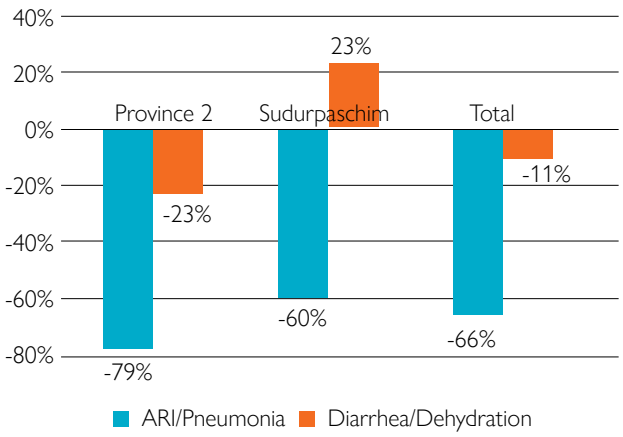
Source: HMIS (Reduction in immunization coverage during Chaitra2076 to Asadh 2077 in comparison to Mangsir to Falgun 2076)

2 while the coverage increased in Sudurpaschim by 23 percent since the onset of COVID-19. This reduction in treatment for diarrhoea/dehydration can be due to people accessing treatment from local pharmacies due to ease of proximity and travel restrictions.

Growth monitoring for children in both provinces was disrupted for children of all age groups (0-11 months and 12-23 months), during the COVID-19 crisis period. In Province 2, growth monitoring for 0-11 months children reduced by 51 percent and for 12-23 months children, by 62 percent. Growth monitoring was not conducted in the health facility of Haripurwa and Ekdara from Chaitra 2076 (March/April 2020) to Asar 2077 (June/July 2020) and in Chandranagar from Baisakh (April/May 2020) to Asar 2077 (June/July 2020) for both age group children. In Sudurpaschim, growth monitoring reduced by 76 percent in 0-11 months children and 61 percent in 12-23 months children (as shown in Figure 7). Growth monitoring was not conducted in the health facility of Ghodaghodi and was disrupted in Tikapur from Baisakh (April/May 2020) to Asar 2077 (June/July 2020) while the service in the health facilities of other Palikas also reduced since the onset of COVID-19.

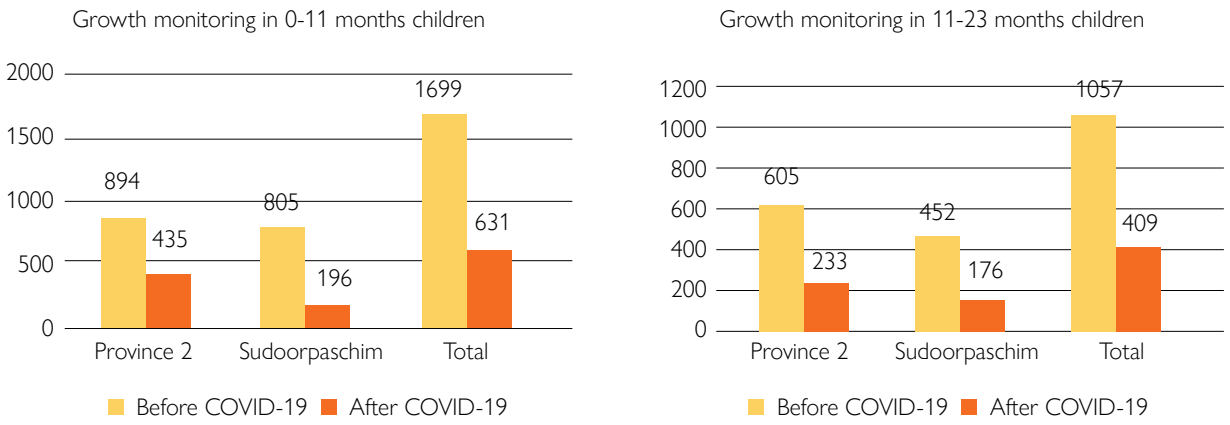
Almost all of the local governments mentioned that the delivery of basic health services has not been affected by the COVID-19 pandemic and they have been ensuring that the health facilities are not closed.

FIGURE 7: REDUCTION IN COVERAGE OF TREATMENT FOR ARI/ PNEUMONIA AND DIARRHOEA/DEHYDRATION IN CHILDREN OF 2-59 MONTHS AGE



Source: HMIS (Before COVID: Mangsir-Falgun 2076; After COVID: Chaitra 2076-Asar2077)

FIGURE 8: REDUCTION IN GROWTH MONITORING OF CHILDREN UNDER 2 YEARS OF AGE



Source: HMIS (Before COVID: Mangsir-Falgun 2076; After COVID: Chaitra 2076-Asar

"If the clients came, we didn't send them back without treatment. We prevented crowd and provided services by maintaining adequate distance." **M8SP**

"We did not stop health services but changed the modalities while providing them. Before COVID-19, the OPD services were provided indoors but they have been shifted outdoors in order to maintain social distance." **M5SP**

"The guidelines from the higher authority including Ama Surakshya program instructed us not to stop any services, rather use preventive measures like using PPE while providing services. Even before receiving this guideline, we were continuously delivering health services." **M8SP**

"As we didn't receive a clear guideline whether to continue or discontinue MR campaign, we continued it using preventive approaches in the Province." **PG3**

Yet, disruptions were observed in the delivery of a few health services in some places.

"Swab collection was done in all seven wards and it disrupted laboratory services twice or thrice a month when the staff working in the lab went for swab collection." **M8SP**

"The lab service was disrupted as the only lab assistant available in health post was asked to provide lab services in quarantine (swab collection)." **M5SP**

Immunization was also halted for a short duration of time in some Palikas due to lack of supplies and in others due to lack of clear guidelines on continuation of immunization services. In some Palikas, the delivery cases had been referred to higher centers due to fear of COVID-19 transmission in absence of Personal Protective Equipment (PPE). Few also mentioned that programs specific to their Palika like group ANC were also affected.

"In the month of Baishak and Jestha, the Palika instructed us to stop immunization program due to lack of vaccine supply. We also stopped growth monitoring program from Chaitra and it has not resumed yet. The remaining services are being provided continuously." **M1SP**

"The programs that were to be conducted in groups were affected by COVID-19. Group ANC, that were being conducted in collaboration with Nyaya Health got delayed by a few days but were continued later." **M10C**

"In initial period, the client flow decreased because people didn't feel safe visiting the health facility." **M5SP**

"The women believed that they should not visit the health facilities to avoid COVID-19 transmission and maternal health services were affected. Later, awareness raising activities were conducted to bring them to health facilities." **M5SP**

"In the FCHV meeting, we decided to inform the health service seekers not to visit the health facility for general illness. May be the flow decreased because of the same. General OPDs decreased rather than maternal and child health services." **M5SP**

The inflow of clients to take health services also decreased for some time during the initial days of lockdown as people feared contracting COVID-19from the health facility.

Few of the Palikas indicated that they disseminated messages to the public not to visit health facility in case of minor ailments. This too could have decreased the flow.

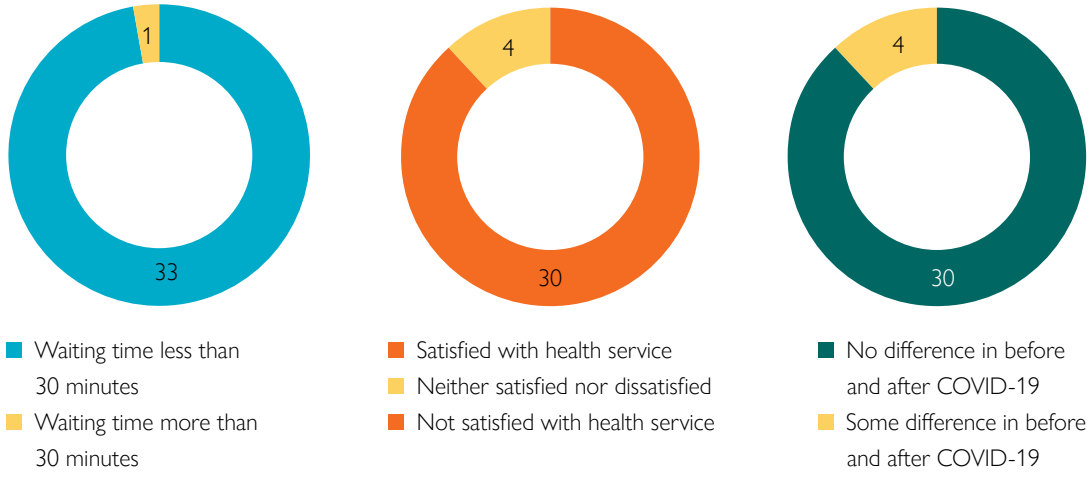
Among the total of 34 respondents for exit-client interview of health service users, all of them received health services in less than 30 minutes of waiting time except for one who had to wait for more than 30 minutes to receive health service. Most of the respondents (30) were satisfied with the health service they received while 4 had neutral response, neither satisfied nor dissatisfied. Most of the respondents () did not find any difference in health service provided before and after onset of COVID-19 pandemic. Four (4) respondents mentioned difference in service delivery provided before and after onset of COVID-19 pandemic, reason for which included outpatient department (OPD) service being conducted outside the health facility, and having to wear masks, wash hands and use sanitizers (as shown in Figure 8). However, none of the respondents mentioned difference in the quality of health service delivery.

Out of 21 respondents for follow-up of healthcare services who missed their scheduled appointment during the month of Chaitra 2076 (March/April 2020) to Asar 2077 (June/July 2020), seven (7) respondents sought health services from other health facility than their regular health facility. Out of the seven (7) five (5) received health service from other public health facilities while two (2) received health services from a private health facility. The remaining 14 (out of 21 follow-up respondents) did not take health service from any health facility. Out of 21 respondents, only four

"Previously OPD service was provided from inside the health facility now it is outside." **M6HEC1**

"Previously we used to come as it is nowdays health staff told us to wear mask, wash hand and put sanitizer." **M9HEC1**

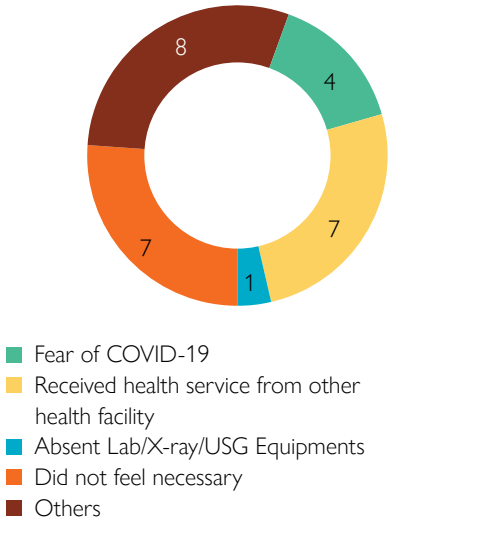
FIGURE 9: WAITING TIME, CLIENT SATISFACTION AND DIFFERENCE IN HEALTH SERVICE DELIVERY BEFORE AND AFTER COVID-19 PERIOD



Source: Exit-client Interview of Health Service Users

(4) mentioned fear of COVID-19 as a reason for not taking follow-up health service. However, one respondent who mentioned fear of COVID-19, still went to another health facility to obtain health service, while seven (7) did not feel necessary to go for their scheduled healthcare. The other eight (8) respondents did not attend their follow-up visits due to either family restrictions or busy schedule owing to household responsibilities (as shown in Figure 9).

FIGURE 10: REASONS FOR MISSING FOLLOW-UP HEALTH CHECKS

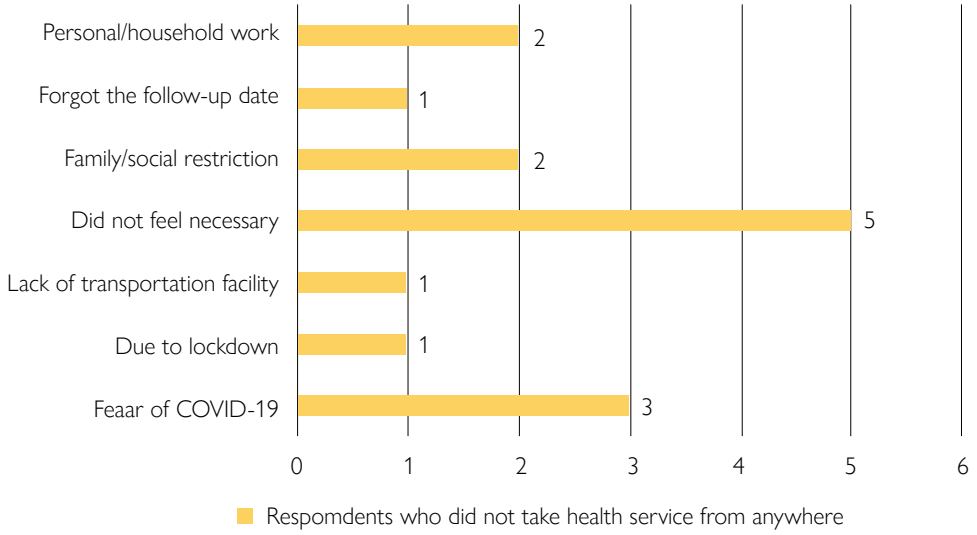


Source: Follow-up Interview of Health Service Clients

Among the 14 respondents who did not take health service from any health facility, three (3) did not visit the health facility due to fear of COVID-19, and one (1) each due to lockdown and lack of transportation. Five (5) respondents missed their health service follow-up as they did not feel it was necessary (as shown in Figure 10). None of the respondents mentioned closure of health facility as a reason for not attending their scheduled health appointment.

Among the seven (7) respondents who received health service from health facility other than their regular health facility, four (4) went to a health post (2) and a public hospital (2) while three (3) went to the private hospital. Reason for visiting other health facilities was most commonly due to lack of trained human resource or appropriate equipment, but none of them mentioned closure of health facility or COVID-19 as a reason for visiting other health facilities.

FIGURE 11: REASON FOR NOT TAKING HEALTH SERVICE FROM ANYWHERE BY FOLLOW-UP RESPONDENTS



Source: Follow-up Interview of Health Service Clients

Services that were interrupted, resumed soon after the federal government issued the guideline to deliver those services using safety measures. Provision of hazard allowance to the health service providers working in COVID-19 context was also announced by the federal government. Furthermore, the federal and provincial government also stated that they were communicating and coordinating with the local government regularly to understand their needs and address them in a timely manner to ensure continuous delivery of health services.

Nevertheless, the federal and provincial governments acknowledged that some services might have been disrupted due to various issues in the initial phase of the lockdown.

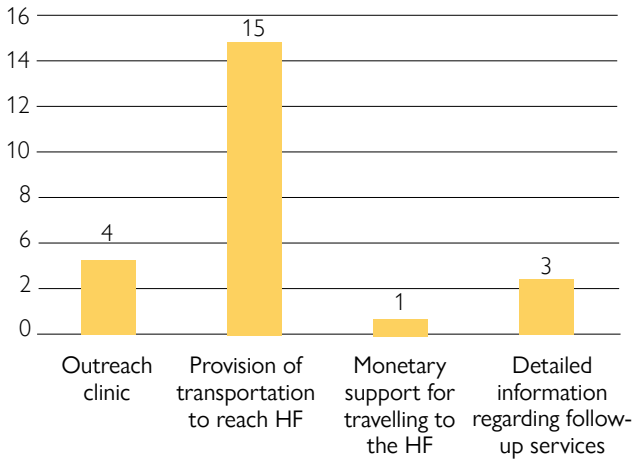
"Health Minister communicated regularly with Social Development minister of all 7 Provinces to seek information about the problems faced, kind of support required, and mechanisms were established accordingly. It has been continued till date." **FG1**

"COVID-19 did overwhelm our health system. It did hamper non-COVID healthcare. We should have used public health approach to contain the pandemic while we used lockdown, an administrative approach, which led to communication gap and resulted in assumptions that health facilities too are closed. We had problem with communication and information management." **FG1**

"When we assessed that there might be more delivery cases in the hospital as compared to the hospital's capacity, we informed other health facilities to be ready for additional deliveries but due to miscommunication, it was understood that we were disrupting the delivery of safe motherhood program when in fact, we were trying to manage additional cases." **PG2**

Prolonged lockdown during the COVID-19 crisis also resulted in disruption of transportation in addition to financial constraints due to lack of livelihood for many. However, only four (4) out of 21 respondents of the follow-up for health services received any form of support from the Palika or I/NGO. Among these four (4) respondents, one (1) respondent received transportation

FIGURE 12: TYPE OF SUPPORT THAT WILL ENCOURAGE PEOPLE TO GO TO HEALTH FACILITY FOR FOLLOW-UP SERVICES



Source: Follow-up Interview with Health Service Clients; HF: Health Facility

to the health facility from the Palika, and two (2) received financial support from the Palika while only one (1) received in-kind support from the I/NGO. Apart from these supports, none of the respondents mentioned any other factor that enabled them to seek health service. Most of the respondents of health service follow-up believed provision of transportation would have encouraged them to go to the health facility for follow-up healthcare (as shown in Figure 11). Similarly, most of the respondents suggested provision of transportation will help improve health service during emergency situations, while a few of them believed outreach clinic and providing detailed information regarding follow-up services will improve health service during emergency situations (as shown in Figure 12).

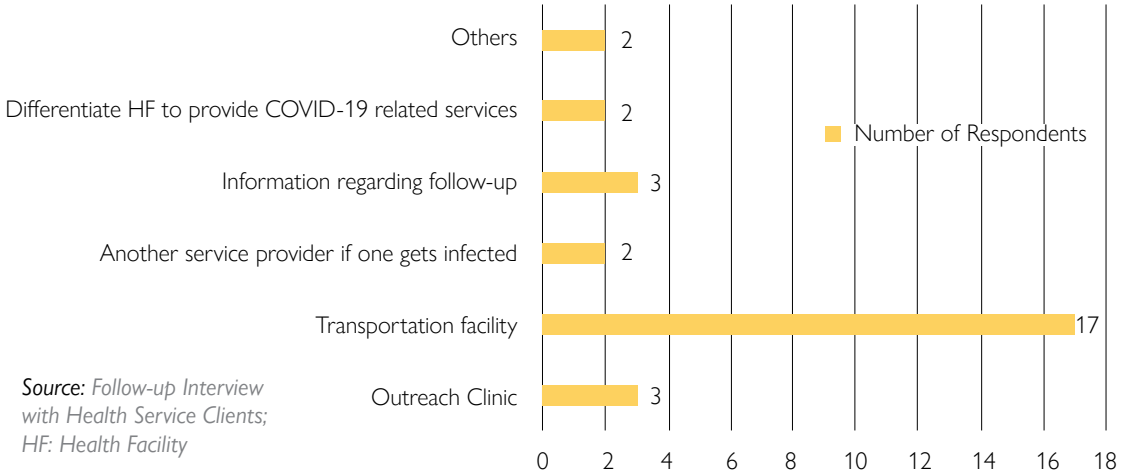
***Aama Programme*[7]:** All the health facilities mentioned that they have been providing the Aama Programme incentive though some could not provide it on time. This delay was mainly due to the lockdown and delay in release of the budget to the Palika.

"The women delivering at our health facility have received all the incentives including 4 ANC incentive and travel incentive. We have not cut off for any of the incentives." **M8SP**

"We were not able to distribute the Aama incentive at the time of discharge. The mother had to wait 15-20 days to receive it as the budget in first quarter was not released on time." **M1SP**

"Travel incentive under Aama programme has been delayed because during the lockdown, it was difficult for us to get the cash from the bank as banks were closed." **M5SP**

FIGURE 13: SUGGESTIONS TO IMPROVE HEALTH SERVICE DURING EMERGENCY SITUATIONS



Source: Follow-up Interview with Health Service Clients; HF: Health Facility

[7] Aama Programme is Government of Nepal's maternity incentive scheme which provides cash incentive to contribute as transport cost to reach health facility plus cash incentive after completion of four antenatal care visits.

"We were not able to distribute Aama incentive at the time of discharge. Two hundred and eighty-five mothers who delivered last year have not received the incentive till date due to absence of CAO. We have requested the Palika to manage budget but they have not taken any action." **M3SP**

"It is not difficult to contact the beneficiaries of Aama Program. We know where they live and if one beneficiary receives the incentive, she will disseminate the information to all. Nobody will be left out." **M7SP**

However, a few mentioned that they were not able to pay Aama incentive from before the onset of pandemic due to delay in release of funds and other administrative issues such as absence of CAO and problems with budget management by the Palika. These issues have not been addressed in spite of repeated requests as per the respondents.

Few health facilities further stated that they knew the beneficiaries and provided the incentive when they were available. However, this could not be ascertained as it was beyond the scope of this study.

Health Workers COVID-19 Allowance: It is important to keep the health workers motivated to continue working in difficult and unfavourable circumstances such as COVID-19. Allowances to work in such difficult circumstances can act as a motivating factor. However, health service providers did not receive allowances in many places which could have potentially acted as a barrier to health service delivery in some local level health facilities as acknowledged by the key informants.

"The federal government promised hazard allowance to health service providers but asked the local government to manage it from the budget they already had. It didn't send extra fund as hazard allowance and hence the health service providers might have been demotivated and the services might have been disrupted in a few places." **PG3**

"The federal government talked about the hazard allowances through media, but they have not provided allowances to us." **M4**

"When the HP in-charge was mobilized in the quarantine center, Palika provided 60 % allowance to the quarantine staff and the 40% allowances to all the staffs including sweeper providing services in the health post for two months." **M8SP**

Only a few health facilities mentioned that hazard allowance was being provided for a certain period of time depending upon where they worked during the pandemic.

The source of the budget for the hazard allowance could have been from the Palika's internal budget. In one of the provinces, the Provincial Health Directorate and Ministry of Social Development mentioned that they took the guardianship of the health workers and announced that they would provide the allowances even if they don't receive it from the federal government.

Pre-Hospital Handling/Triaging of Cases: The federal government has developed an isolation guideline as per which the COVID-19 cases are classified as asymptomatic or symptomatic with mild, moderate (community-based isolation) or severe status. The asymptomatic and mild cases can be managed at home while the moderate cases need to be sent to the community-based isolation centre and severe cases

are to be sent to hospital isolation. The same guideline is followed by the provincial government and circulated to the local government through the health offices in each district.

The respondents mentioned that there was no specific mechanism for pre-hospital handling of cases. As majority of the cases are kept in home isolation at present, the COVID-19 positive patients are asked to wear masks, use sanitizers and isolate themselves at home from other people. If the severity of the infection increases and they need to be taken to the hospitals, majority of the Palika manage ambulance service, provide PPE to the drivers and transport them.

Quarantine Management: The local governments are mainly responsible for quarantine and isolation management, which was set up in the schools within their Palikas. The budget for the set up was provided in most of the cases by the federal and provincial level. A few local governments mentioned that they used additional funds from their internal revenue sources to fund the establishment and management of quarantine and isolation centers based on need. The local governments which used their own resources to support additional expenditure of quarantine and isolation centers, mentioned that they had to ask people to stay in home quarantine when they ran out of funds.

Few Local Governments also mentioned that they provided certain amount of money to people to enable them to quarantine themselves at homes.

Few quarantine centres were also managed by province governments when the flow of immigrant labours returning home from neighbouring India was higher than the capacity of the local government. Some health offices working on quarantine management mentioned that lack of testing kits also hindered the effective management of quarantine centres.

Few Palikas mentioned that there were conflicts in the communities when the decision was made to establish a quarantine centre in their locality.

"We were providing food and shelter to the people in quarantine centres with our own budget but we ran out of funds after some period. We were unable to afford the quarantine, didn't receive any support from federal and provincial government and hence requested the people to stay in home quarantine." **M2**

"After some period of running quarantine centres, we were unable to afford the quarantine. So, we provided NPR. 200 per day to each person whose total was NPR. 2800 when they stayed there for fourteen days." **M1**

"We were told that the people entering the borders have to be quarantined, tested and let go to their destination but we lacked the kits and had to allow them to leave after keeping them in the centres for more than 28 days. The test was conducted after 45 days when they had met tons of people." **HO2**

"During the establishment phase, we faced a great difficulty to establish the quarantine centers. The locals disagreed and protested against the establishment of quarantine centers. We got pressure from district to establish the quarantine center in any way but wherever we tried to establish one, there were protests. Later, a representative from the province visited the Palika and the community gave us permission to establish a quarantine centre under the condition that only the people of respective wards would be kept in the center and others would be sent to their respective wards." **M4C**

However, they were able to manage the situation with great hardships, and in some cases with the help from the provincial government.

Regarding the quality of quarantine centres, majority of the respondents accepted that despite of trying their best, the optimum standards were not met in most of the centres . Further, few health offices mentioned that they could not monitor the quality of quarantine centres managed by the local government as they only had authority to provide technical support when required while the right and responsibility to maintain the quality was vested upon local governments.

"There is no sufficiency of team members for COVID-19 management. We need more human resources." **M7**

"The human resource for health is insufficient and there haven't been any provisions of back up. There isn't a data base of skilled human resource. There isn't even a plan with the Palika for the mobilization of internal resource for human resource management." **M10**

"The same health service providers working in the health posts worked in the quarantine centres. They did their duty in the quarantine turn by turn and there wasn't any provision of isolating the health workers for some days though they were exposed to positive cases due to insufficient human resource." **M6**

Human Resource

Human resource in healthcare includes both clinical and non-clinical staff involved in public as well as individual healthcare, that plays an important role in healthcare delivery. In the pandemic situation, health workers, who are the backbone of health systems, require an additional training to manage the new evolving circumstances. They also are at increased risk themselves in the pandemic situation. A robust human resource management plan in this pandemic situation is essential to ensure availability of enough manpower at all times in every part of the country for smooth health service delivery. Almost half of the local governments mentioned not having sufficient human resource to deliver health services during the pandemic. None of the Palikas had a concrete human resource management plan in place to either recruit human resource or mobilize volunteers during the emergency situation.

One of the Local Government mentioned that the same human resource was working in the quarantine and isolation centres as well as the health facilities under their jurisdiction sue to lack of manpower.

Human resources were hired on contract basis by the provinces to avoid disruption of services in case the health service provider got infected. Hospital administrations were also informed to demand budget for human resource and hire them on contract on need basis. This practice for human resource management is still prevalent in a few provinces. Some of the contract staffs are working in the COVID-19 special hospitals which has intensive care unit (ICU) and ventilator facilities. The provincial government had also informed the hospitals under their jurisdiction to request any funds required for COVID-19 response along with rationale. Furthermore, the federal government has also sent instructions to recruit a temporary team of doctors and technicians on emergency basis, based on need, to cater to the healthcare needs emerging due to COVID-19 crisis.

"Not only human resource, we had informed the hospitals that they would have to fulfil the procedure but could demand budget for any resource they would require for COVID-19 response along with the rationale and we would approve them." **PG2**

"We distributed resources to run 5 bedded hospital in 649 local levels immediately and tried our best to manage the deficit resource at the local level as it is the main problem and implementation isn't. We even sent instructions to recruit team of doctors and technicians for 3 months on emergency basis." **M7SP**

"In case of requirement of additional human resource and medical support, we had coordinated with the private hospitals and informed that in case of huge influx of cases that the Government health facilities can't manage, we would provide them financial support and technical assistance, if required and those hospitals would have to operate like the public ones." **PG2**

Further, few of the provincial governments also mentioned that they have already coordinated with the private hospitals to support COVID-19 response in case of need.

Training of Human Resource:

As per the federal government, they provide counselling and Case Investigation and Contact Tracing (CICT) training to the provincial government, while the provincial governments cascades these trainings to the local governments. Specialized trainings such as training for critical care have been conducted by the federal government, both face-to-face, as well as remotely, depending on the type of training and human resources to be trained. The concept of virtual training is very new in Nepal but in the COVID-19 context, it was conducted based on the existing circumstances and need. However, a few respondents mentioned that the virtual trainings were not effective.

Majority of the health service providers mentioned that they did not receive adequate training for the management of COVID-19.

Furthermore, the health offices mentioned that they do not have budget for training and hence, they only bear the role of facilitation.

Only one training centre mentioned to have started providing training on COVID-19 management for past few months, after many months have already passed since the onset of

"Virtual trainings were not effective as the communication was one-way and the trainers could not ensure whether the trainees had learnt what was being explained to them." **HO2**

"We didn't receive any training during the COVID-19 pandemic but now, we have received orientation from the women development section recently, regarding women and COVID-19." **M8SP**

"I did not find zoom training effective. People were using zoom app for the first time and some people could not mute themselves causing a lot of disturbances and I could not understand anything at all." **M7SP**

"We didn't receive any trainings. I learnt how to use PPE sets by watching YouTube tutorial." **M10SP**

"We don't have separate budget for training programs and we are only responsible for supporting the implementation of planned activities. Hence, we did not provide any trainings but supported the trainings organized by the Provincial Health Directorate." **HO1**

pandemic. Since dead body management is conducted by the army, hence, no training has been organized for this purpose for the health workers till date.

Discrimination Against the Health Workers: Discrimination as well as appalling treatment of health service providers by community was observed in the initial phase of the pandemic (Shrestha RM, 2020). Fear in the community against the health workers was palpable due to general belief that the health workers might transmit COVID-19 in the community and, therefore, avoided them. In one of the districts, the community people attacked the health service providers with stones when they were visiting the quarantine centres as well as collecting swabs. In another district, people staying in quarantine centres were unhappy with the quality of the centres, due to overcrowding and poor toilet facilities and hence swore on the health workers. Additionally, in the initial days of the pandemic, due to limited number of testing labs, results of samples collected from suspected cases or people living in quarantines would take very long. This had resulted in few episodes of aggressive behaviour from some people.

Though inhumane treatment was not mentioned by the health service providers, a few mentioned that there had been a few cases of discrimination against them or their colleagues.

To mitigate the stigma surrounding health workers and the risk common people perceived health workers can pose to others in the community, some Palikas conducted campaigns to raise awareness. Apart from a few awareness campaigns, no other intervention or support was mentioned by any of the key informants to support the health workers.

"When we worked in the field, our own health worker friends said that we should not go home. But how long would I stay in isolation? I felt uncertain and went home." **M6**

"Community people asked us to stay far as we were working in the health facility and quarantine." **M8SP**

"I have not faced any discrimination but one of the shopkeepers denied to provide a recharge card to one of our health workers. He told her that she could transmit the virus as she works at the health facility and that he would not want to see her in his shop again." **M7SP**

"As we worked in the health facilities, not only our neighbours but also our family members were afraid but they didn't treat us bad." **M9SP**

"Due to fear of COVID-19 transmission, people didn't even provide drinking water to the health workers. Palika conducted a few awareness raising campaigns to reduce such discriminations." **M10**

Logistics

All local governments mentioned about inadequate PPE to provide services to the public during the initial days of the pandemic. In the absence of complete sets of PPE, they mentioned that they maintained social distancing, used masks, gloves and sanitizers and delivered the services.

This inadequacy of PPE was acknowledged by the federal government.

The main reason for the inadequacy was mentioned to be the lengthy public procurement process. However, to address the issue of logistics insufficiency, the federal government conducted an Epidemiological Modelling to forecast the number of probable cases the country should expect. Based on the findings

"We received PPE, RDT kits and sanitizers from the health office during the pandemic but those were not t provided in adequate quantity." **M4**

"At the beginning, we only had 10-12 PPE sets. With the same PPE, we had to run the fever clinic and check up the patients in the quarantine. The same PPE was being used by the staffs, alternatively by sanitizing it." **M6**

"Initially, we had issues in logistics management, such as lack of PPE which led to protests from doctors, but we did good coordination in logistics management." **FG1**

"Our purchase process is very lengthy and complicated. Law has provision of procurement during emergency situations but there are many hurdles in the process, which makes purchase difficult." **FG1**

"Later after we formulated rapid action plan, did projections based on epidemiological modelling, and linked public purchase with procurement plan, we did not have problem in logistics management." **FG1**

"We were unable to provide sufficient amount of medicines to health facility. Once health office supplied some medicine to us, but it was not sufficient and hence, some clients had to purchase medicine on their own." **M**

from this modelling, logistics plan was formulated, and the purchase was made. This assisted in fulfilling the logistics requirement.

Pertaining to the clause of public procurement during emergencies, the Local and the Provincial Governments mentioned that they were procuring emergency medicines and other logistics following the same clause and there has not been any stock-out situation of these supplies in the later phase of the pandemic.

Stock-Out of Essential Medicine:
Most of the local governments mentioned having adequate essential medicines in their stock and did not face any difficulty in managing them. A few of them mentioned that when they had low stock of medicines, they coordinated with the health offices for medicines and other logistics to ensure health service delivery to the public. Yet, one of the local government mentioned that they were not able to provide sufficient medicines to the health facilities and the patients visiting the OPD had to buy medicines on their own.

Budget

Total national budget for the fiscal year (FY) 2020/21 reduced by 3.8 percent (from 1,532 billion Nepali rupees (NPR) in FY 2019/20 to 1,474 billion NPR), however, health budget has increased by 39.9 percent to 115 billion NPR in FY 2020/21 from 82 billion NPR in FY 2019/20. The budget for Reproductive Health and Safe Motherhood, (which includes Safe Motherhood Programme, Family Planning, Safe Abortion Services and Infertility Management), increased by 72.4 percent. The budget for the Child Health Programmes, (which includes Immunization Programme, Children Treatment Service, Management of Childhood Illness, Child Curative Services, Nutritional Programme) has increased by 7.3 percent.

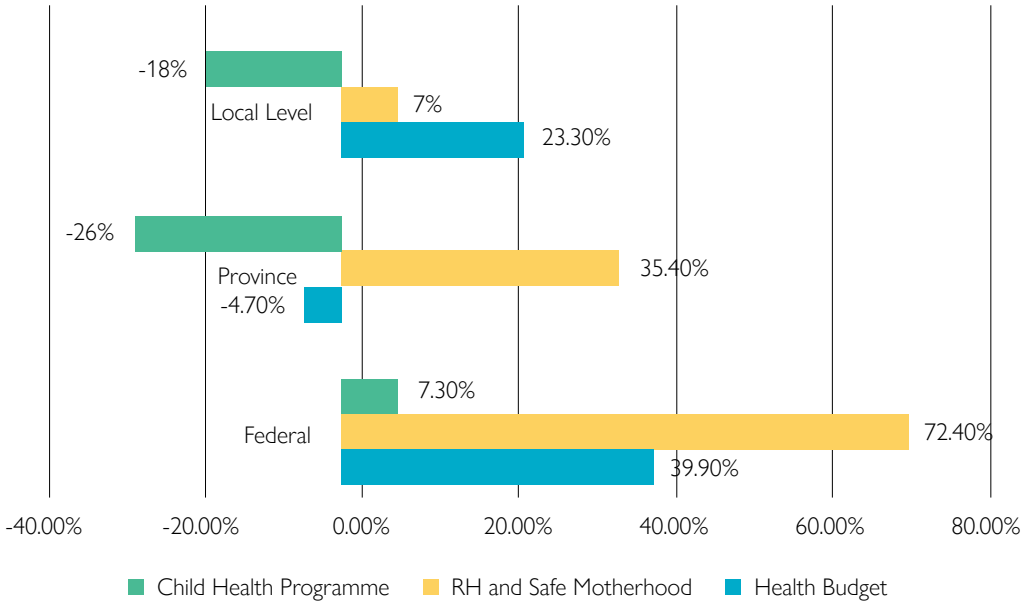
At the provincial level, total health budget (aggregate of conditional and provincial health budget) has reduced by 4.7 percent in FY 2020/21. Total budget (aggregate of conditional and provincial health budget) for the reproductive health and safe motherhood has increased by 35.4 percent while the budget for the child health programmes has reduced significantly by 26.4 percent from FY

2019/20 to FY 2020/21. The total health budget (aggregate of conditional and local budget) at the local level has increased by 23.3 percent. The budget for the reproductive health and safe motherhood at the local level has increased by 7.2 percent and the budget for the child health programmes has reduced by 17.5 percent in FY 2020/21. Decrease in budget for provincial and local level could be due to lack of detailed budget breakdown for maternal and child health programmes and therefore requires to be interpreted with caution.

The total health budget for Province 2 has increased by 192 percent and by 91 percent for Sudurpaschim Province in the FY 2020/21. In Province 2, out of four Palikas, the health budget increased only in Samsi by 3 percent, while health budget in other two Palikas reduced; Chandranagar decreased by 10 percent, Ekdara reduced by 42 percent in FY 2020/21 while the health budget for Haripurwa was not available. Similarly, in Sudurpaschim Province, health budget increased in four Palikas; Ghodaghodi by 106 percent, Dipayal Silgadhi by 33 percent, Safebagar by 148 percent and Mellekh by 44 percent, while health budget decreased in two Palikas; Tikapur reduced by 35 percent and Purwichauki by 59 percent (as shown in Figure 14). However, the difference in budget (between the two fiscal years, FY 2019/20 and FY 2020/21) could be due to the difference in the headings under which the budget is allocated or because the budget allocation is at the last quarter of current Nepali fiscal year and yet to be completed. Therefore, budget allocation should be interpreted with caution.

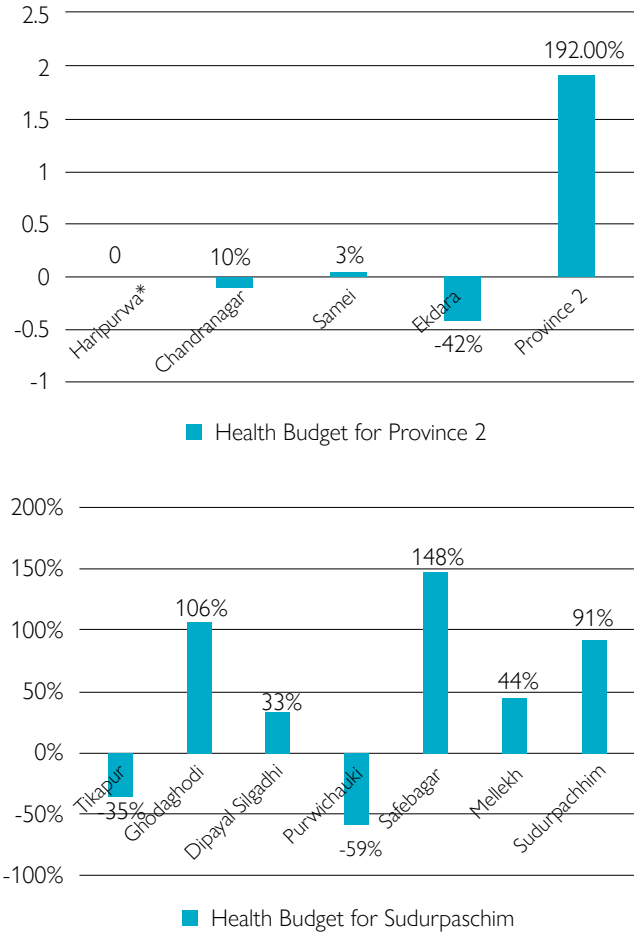
In Province 2, the budget for the reproductive health and safe motherhood program has increased in only one Palika, Ekdara by 15 percent, and reduced in the other two Palikas; Chandranagar by 16%, Samsi by 5%, while budget for Haripurwa was not available. In Sudurpaschim, the budget

FIGURE 14: HEALTH BUDGET AT FEDERAL, PROVINCIAL AND LOCAL LEVEL FOR HEALTH, REPRODUCTIVE HEALTH AND FAMILY PLANNING, AND CHILD HEALTH PROGRAMMES



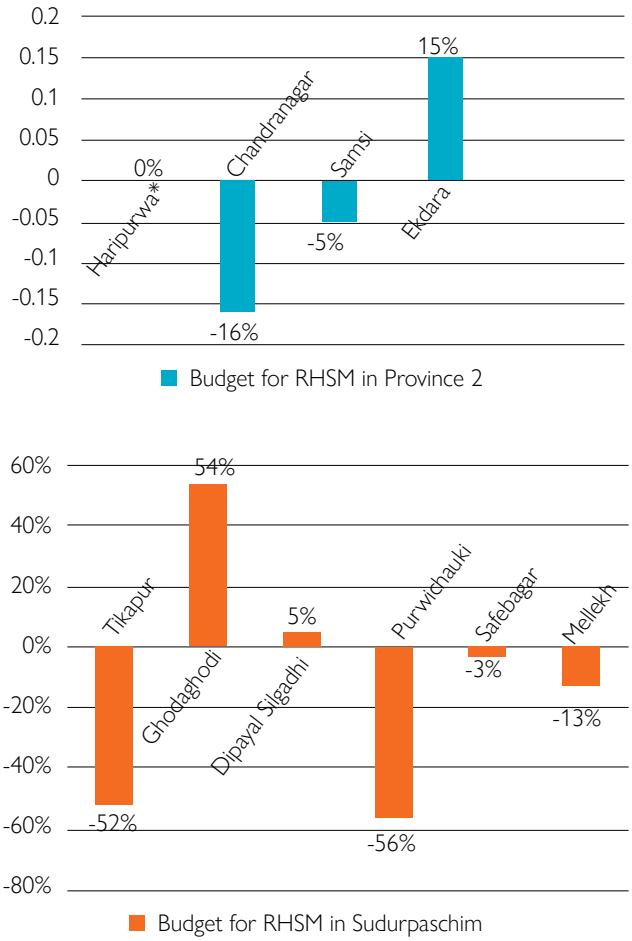
Source: Redbook (Federal, Province, Local Level) for FY2019/20 and FY 2020/21

FIGURE 15: PALIKA LEVEL HEALTH BUDGET FOR PROVINCE 2 AND SUDURPASCHIM



Source: *Redbook FY 2019/20-FY 2020/21. *Budget for Haripurwa not available*

FIGURE 16: PALIKA LEVEL BUDGET FOR REPRODUCTIVE HEALTH AND SAFE MOTHERHOOD (RHSM) IN PROVINCE 2 AND SUDURPASCHIM

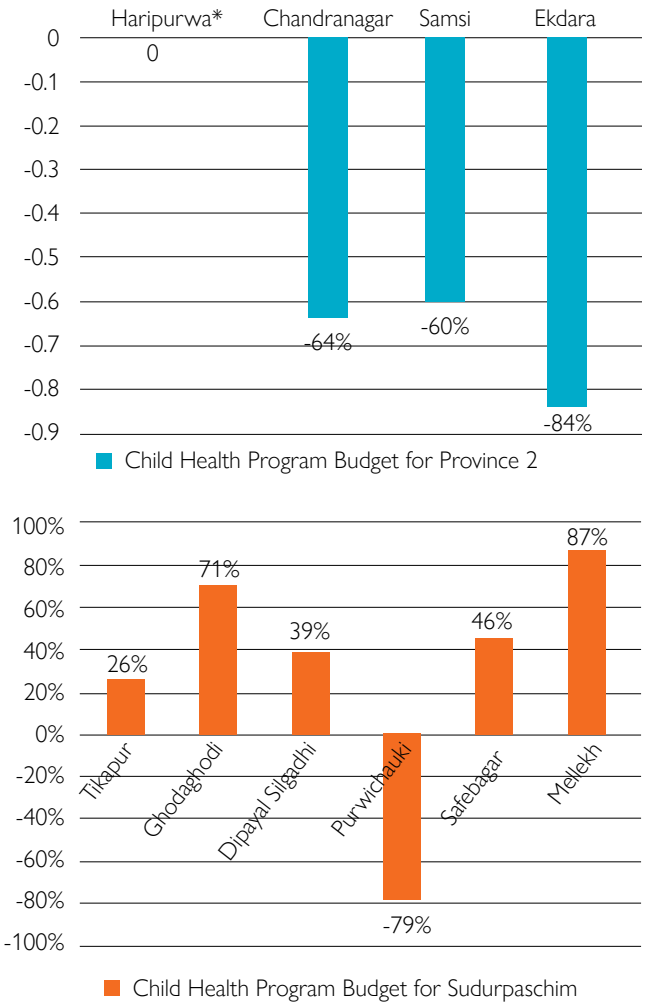


Source: *Redbook. *Budget for Haripurwa is not available*

for the reproductive health and safe motherhood has increased in two Palikas; Ghodaghodi by 52 percent and Dipayal Silgadhi by 5 percent. While, it has reduced in four of the Palikas; Tikapur by 52 percent, Purwichauki by 56 percent, Safebagar by 3 percent and Mellekh by 13 percent (as shown in Figure 15).

The child health program budget for Province 2 reduced in three Palikas; Chandranagar by 64 percent, Samsi by 84 percent, Ekdara by 60 percent in FY 2020/21, while budget for Haripurwa was not available. In Sudurpaschim, the budget for the child health program increased in five Palikas; Tikapur by 26 percent, Ghodaghodi by 71 percent, Dipayal Silgadhi by 39 percent, Safebagar by 46 percent, Mellekh by 87 percent, but reduced in Purwichauki by 79 percent in the FY 2020/21. In the FY 2019/20, large budget was allocated for the nutrition program by the government as well as by UNICEF in the Palikas of Province 2 as well as Purwichauki of Sudurpaschim which has been removed in the budget for the current FY 2020/21. This reduction is reflected as reduction of budget for the child health programs in FY 2020/21 (as shown in Figure 16).

FIGURE 17: PALIKA LEVEL BUDGET FOR CHILD HEALTH PROGRAM IN PROVINCE 2 AND SUDURPASCHIM



Source: *Redbook. *Budget for Haripurwa is not available.*

***"Budget is allocated under the heading of 'emergency/crisis' fund in the Palika in the AWPB itself every year. Depending upon the situation, the fund is mobilized."* M1**

***"Last year, 40-42 crores were collected in the province through transfer of budget from other budget headings for COVID-19 management. Also, the Palikas had undivided budget, which was used for COVID-19 response."* M1**

***"The budget allocated for development of infrastructure could not be completely utilized due to the pandemic which were transferred for COVID-19 management in the last fiscal year."* M5**

The budgetary needs for health service management due to COVID-19 crisis occurred towards the last quarter of the fiscal year 2019/20. There was no dedicated budget allocated for COVID-19 management at that point of time. Majority of the respondents mentioned that it was difficult to manage funds (acquisition/reallocation) required for COVID-19 management. However, most of the representatives at the provincial and local level also stated that there is a provision of undivided budget in the redbook which can be used under any heading depending on the need. This fund, as well as the budget headings for which were transferred to COVID-19 management were mobilized, though this may not have been sufficient. Infrastructure development was largely halted due to the COVID-19 restrictions. Due to this reason, many Palikas also transferred the budget dedicated for infrastructure development towards COVID-19 management based on the need.

Apart from COVID-19, one of the Palikas also mentioned that political conflict acted as a major hindrance in planning and budgeting.

Although local governments denied that the budget of other health programs was compromised due to budget allocation for COVID-19 management, the provincial and federal governments mentioned that the budget for other health programs were affected to a certain extent.

However, the governments at all the levels mentioned that budget for essential health care services, such as, immunization and safe motherhood were not affected due to COVID-19 management. Rather, allocation

"Due to political conflict, no work is being carried out in the Palika at present. We have sent letters to ward offices multiple times, asking them to send us the proposed plans. new have not received any response so far and that's a very sad thing. More than COVID-19, we have been affected by the political conflict." **M1**

"The government has formed a separate fund for COVID-19 management. Lot of health programmes in the last fiscal year were compromised and we re-channelized those funds. We also mobilized the fund reserved for pandemics preparedness in our annual work plan and budget." **FG1**

"When the budget is required in a great amount in one sector and is deficit, the budgeting in the other sector is obviously compromised." **PG3**

in health has increased by certain amount in some Palikas. The budget for infrastructure development was compromised to some extent as well owing to the COVID-19 budgetary requirements in the previous fiscal year.

According to the federal government, financial resources are the main constraint at the local level in COVID-19 management but not implementation. Hence, additional funds were transferred to the local governments by the federal government, to run five bedded hospitals at the local level for COVID-19 management.

Although the budget for COVID-19 management was not sufficient in the previous fiscal year, in the current fiscal year, FY 2020/21, six (6) percent of total health budget has been dedicated for COVID-19 management. This has been included in the red book of the federal, provincial as well as the local governments[8]. This COVID-19 fund has been established mainly for capacity building, equipment purchase, surveillance, allowance for health personnel, research and other COVID-19 related management. Furthermore, additional budget has been allocated in the current fiscal year 2077/78 to establish 50 bedded hospital in each province and 300 bedded hospital at the federal level with the vision of infectious disease outbreak management (Shrestha, et al., 2020).

Information System

It is important to continue updating the HMIS (health management information system) regularly. However, there always is a risk of disruption to updating HMIS in the pandemic situation due to increased workload on the existing manpower. Most of the respondents mentioned that there had been no impact of COVID-19 on the reporting of HMIS and LMIS (logistics management information system). However, a few revealed that reporting of HMIS and LMIS was affected to some extent.

"This year, we have deducted some budget of other development sectors and invested in health." **M7C**

"We distributed resources to run 5 bedded hospital in 649 local levels immediately and tried our best to manage the deficit resource at the local level as it is the main problem and implementation isn't. We even sent instructions to recruit team of doctor and technicians for 3 months on emergency basis." **FG1**

"All staff were busy in quarantine and isolation, so, from Chaitra to Ashar, our HIMS and LIMS data entry was disturbed." **M2**

[8] Redbook FY 2020/21

"No COVID-19 patients have gone missing in the Palika and such situation will not occur, most probably. The ward chairpersons are actively involved right now for ensuring this." **M9**

"The community people were not convinced about the severity of COVID-19. When we requested them not to enter the health post, take the medicine from window, maintain physical distancing, they did not followed the instructions as they had not seen the signs and symptoms of COVID-19. It would have been better if all three tiers of government coordinated in curtailing these hoax messages." **M7SP**

"People have been claiming that the virus can never enter their community because of their belief. One person came from India and his daughter-in-law and grandson got infected. When we told him about it, he kept on saying that the doctors provided them fake report." **M7SP**

Information Management Unit (IMU) has been initiated in some of the hospitals through which details of COVID-19 cases need to be reported. Case investigation and contact tracing (CICT) team had been formed in all of the Palikas but they are not functional at present as it became difficult to identify the contacts accurately and manage them with increased cases of the pandemicAlthough there have been reports of people going missing after testing positive for COVID-19 from some parts of the country, local governments seemed to be confident that none of the positive cases have gone missing so far.

Although majority of the health service providers mentioned that the community people were afraid of COVID-19 transmission and took safety measures as much as possible, one of the respondents mentioned that people considered COVID-19 as hoax and were reluctant to follow the measures when visiting the health facility.

Even when few people got infected, there were complaints that the health facilities were faking the reports.

Leadership/Governance

COVID-19 Crisis Management Committee : Provincial health emergency operation centres (PHEOC) have been formed at the provincial level which coordinates with the federal and local level for the management of COVID-19 and its reporting. Disaster management committees existed in most Palikas before the onset of COVID-19 pandemic. Some of them also had rapid response teams (RRT), major responsibilities of which were to respond to any disaster. With the onset of pandemic, some Palikas transformed the RRT committee into COVID-19 crisis management committee (CCMC), while some Palikas formed a new committee. CCMC coordinates with the district crisis management committee at the district level, which further coordinates with provincial crisis management committee at the province level and ultimately coordinating with the federal government.

As per the respondents, CCMC has been formed under the chairmanship of mayor/chairperson of the Palika, complying with the guidelines issued by the federal government. The CCMC includes the ward chairpersons, security personnel and health section staffs as members of the committee. The roles and responsibilities have been fixed for every member of the committee. The ward chairpersons are responsible for supporting quarantine and isolation management while the security personnel are involved in ensuring

the safety and setting up quarantine and isolation centres. The health section staffs are responsible for the management of medicines and supplies required in the healthcare services. Similarly, the ward sends information to the Palika regarding the number of people entering their ward from the borders, which then manages the relief distribution. The overarching responsibility of this committee is to make decisions regarding the effective and efficient management of COVID-19, which mainly includes quarantine and isolation management.

Guidelines and Provision for Declaring State of Emergency: The Public Health Service Act 2075 (2018) clearly states that the local government can declare a state of emergency in case of infectious disease outbreak at the local level. However, the key informants from the provincial and local governments mentioned that they do not have any provision to declare a state of emergency at provincial or local level, indicating lack of information. The federal government utilized their authority by calling nationwide lockdown to limit the spread of COVID-19 infection. Furthermore, the federal government also revealed that they have developed a systematic emergency response plan. This emergency plan has categorized the pandemic situation in the country in four categories and has clearly mentioned that the existing health system will be overwhelmed with more than 5,000 positive cases requiring hospital care. Furthermore, a state of emergency will have to be declared if more than 10,000 people require hospital care. These guidelines were communicated by the federal government to the provincial and the local governments. Based on this plan, the concept of home isolation was promoted when the number of positive cases started rising rapidly. The concept of home isolation is being followed by the provincial as well as the local level. However, the federal government also mentioned that the public were not happy with the concept of home isolation initially.

"We formulated guidelines to keep symptomatic and asymptomatic cases in institutional isolation centers in the beginning but when the number of cases cross 5,000, we would start home isolation." **FG1**

"Home isolation was not acceptable to many people in the beginning but it is how we managed the pandemic. At a point when we had 46,000 positive cases, had we kept all of them in hospitals, our health system would have crumbled, people would have been dying on the streets." **FG1**

"Earlier, there was no coordination between the Palika and the district health office. When the cases started decreasing and almost reached zero, the meeting was conducted on how to handle the situation. Even the quarantine centers had already been dismissed when supports arrived." **M6**

Coordination Mechanism for COVID-19 Management: There are health offices in each districts within the province which coordinate with the Palikas. The health offices also coordinated with the health coordinators of each Palika within their district and explained the COVID-19 situation and their roles and responsibilities on COVID-19 management.

The federal government developed guidelines for isolation and quarantine management and also announced lockdown to contain the pandemic which was followed by the provincial and the localgovernment. The provincial government acted as a linkage between

the federal and the local level to communicate the guidelines, provide technical support to the local level for the implementation and setting up of isolation and quarantine centres, in addition to managing the borders through the health office and the provincial health directorate. The provincial government also supplied medicines, equipment, RDT/PCR kits and PPE sets to the local government. The local governments supported strict implementation of lockdown. The set up of health desks at borders, managed the returnee migrants in quarantine centres, tested them and managed their isolation, whenever necessary. However, only few Palikas reported receiving support for COVID-19 management albeit not on time.

Mixed responses were received regarding the coordination mechanism between the three tiers of the government and their effectiveness in COVID-19 management. Majority of the respondents mentioned that they were in constant communication with each other and were working in coordination. Nonetheless, few local governments complained that they did not receive any support from the province and also pointed out the lack of coordination from other level of Governments.

As COVID-19 is a new type of infectious disease, scientific information has been evolving over the time requiring frequent updates in the guidelines. These frequent changes in the guidelines and lack of clarity on the roles and responsibilities of the three tiers of the government was reported by majority of the respondents. This hindered the effective management of pandemic to a certain extent. Major changes in the guidelines were related to the requirements for testing the COVID-19 positive patients after staying in isolation for a few days. This led to conflict in the community on some occasions.

"Coordination of three tiers of the government was not seen. Only the federal and local Governments were involved in the management of COVID 19 pandemic." **M3**

"Sometimes, the community people questioned us why we were sending the people back to their home without doing PCR test. The untested people were not accepted by the community. They were not allowed to stay outside of their homes. If anyone saw the patient on the road, they would complain that the corona is spreading." **M6**

"Guidelines were made but I think they were not communicated well. As a result, they did not reach appropriately to all the levels. We informed them that there was no need to test an individual after he/she completes 14 days of their days of infection in isolation but repeated tests have been performed." **FG1**

Even the people who don't exhibit signs and symptoms or have not been referred for testing by health service providers are being tested if they wish to get tested and they don't need to pay any charge." **PG2**

"We have been communicating with all of the provincial Governments through PHEOC, which further communicates with the local Government." **FG1**

"At the time of crisis, a command system is required where one has to obey the other, but this was not the case due to federalism. We faced great challenges in coordination. We were not able to communicate policies and guidelines very well; provincial and local governments couldn't understand them appropriately and some even denied to follow the federal guidelines. This made us think if centralized system is better than federal structure for responding to situations like this." **FG1**

This same conflict could also have led to repeated testing in some other Palikas. This issue related to guidelines for testing was also acknowledged by the federal government, main reason for which was mentioned to be lack of clarity in communicating the guidelines to the local governments.

Furthermore, one of the respondents mentioned that they were providing polymerase chain reaction (PCR) testing service free of cost even when someone was asymptomatic but desired to be tested for COVID-19.

Apart from the issues related to communication of guidelines, the federal government mentioned that they have been trying their best to coordinate well with the province and the local level.

The federal government further mentioned that the challenges they faced in responding to the pandemic made them think whether the unitary system of governance would have been better in handling the pandemic situation rather than the federal system of governance.

The provincial government also agreed with the federal government that they have been making great attempts to coordinate well with local government but there could be other factors leading to their dissatisfaction. They also acknowledged that the level of coordination during the pandemic situation had never been experienced before since federalism.

Monitoring: The local government mentioned that they have been regularly monitoring the health facilities but the provincial and federal government stated that there have been few weaknesses in monitoring.

"The local levels are receiving support from us, but their expectations might be higher and they may not be clear on the demarcation of roles and responsibilities of three tiers of Government." **PG2**

"There hadn't been such perfect coordination between the three tiers of the government since federalism as observed in the COVID-19 response. The federal, provincial and local Government, all were coordinating with each other and making decisions, especially in the matters related to quarantine management and case reporting." **PG2**

"We did deploy teams from federal level to monitor if guidelines are there and if they are being followed/complied or not, if not being complied then why is it not being complied and to provide coaching for compliance. But we have not documented these monitoring findings. Documentation is our weak side." **FG1**

"When we were working for the management of COVID-19, I/NGOs were working from home. This might have been their protocol, but it seemed like they didn't even exist." **HO1**

Role of International/Non-Government Organisations in COVID-19 Management : Majority of the local governments complained that they did not receive adequate support from I/NGOs during the initial phases of COVID-19.

However, support from the I/NGOs started coming for the management of COVID-19 in the form of donating PPE sets, sanitizers, relief materials etc., in the later phase. Some even supported in risk communications by disseminating information about COVID-19 preventive measures.

"We published booklets and pamphlets for COVID-19 awareness. PPE sets, gloves, masks, sanitizers and thermometers were supplied to those working in the frontline like health workers, office assistants, media workers and police. We also distributed relief package to 300 to 400 households of Dalit, women and poor." **M7DP**

"We were not directly involved in quarantine and isolation management but provided hazard allowances to the health workers involved in delivering services in those centres." **M6DP**

"We made the community people aware about hand hygiene and taught them the hand washing techniques. We distributed food and supplies to the quarantine centres. After the quarantine centres were dismissed, we sanitized the schools." **M7DP**

"A few organizations working here have supported the management of drinking water and sanitation in the quarantine centres. They have arranged water tank and installed taps there." **M2C**

"Similar to health services provided through our health facilities, one organization has been providing services related to chronic diseases like hypertension, COPD, mental health problems as well as ANC, PNC and USG by visiting the community during COVID-19." **M10C**

Some Local Governments also acknowledged receiving support from the I/NGOs for drinking water and sanitation services in the quarantine centres. While few other local governments also mentioned that a few NGOs started supporting the delivery of basic health services in the later phase.

Strengths and gaps of COVID-19 management based on the findings

Based on the six building blocks of the health systems, there were certain strengths and gaps identified in the health systems readiness of the local governments in the COVID-19 context, on the basis of the findings of this assessment.

Strengths:

- All the local governments continued providing emergency and basic health services in the crisis situation occurring due to COVID-19 in spite of the lack of PPEs in the initial stage.
- Local government managed human resource to cater to the healthcare needs of the people by utilizing the available health workers. Additionally, new team of health workers was hired to meet the increasing demand due to COVID-19 in some Palikas.
- Availability of logistics and stock was managed efficiently by making emergency purchase based on the need to avoid stock-outs.
- Except for few disruptions, the HMIS and LMIS reporting continued, in addition to COVID-19 reporting.
- Spread of hoax message was also managed effectively in most of the Palikas.
- In terms of the budget, some Palikas utilized funds from the internal revenue to manage the additional budgetary requirements for quarantine and isolation center management.
- Both the federal and provincial governments extended support to the local governments to ensure continuation of the health services, and quarantine and isolation center management, although this was insufficient and often incoherent.

Gaps:

- Lack of support from the local governments to access the health services, such as provision of transportation facilities was an

important barrier in accessing health services by the health service users. Provision of transportation services and outreach clinics during the lockdown period would have encouraged health service users to continue their follow-up health services.

- Poor communication of COVID-19 guidelines resulted in the disruption of immunization and nutrition programmes during the initial stage of lockdown which could have been prevented.
- Although there was no incidence of scarcity of human resource, human resource management plan which is useful in emergency situations to meet additional needs and prevent unforeseen scarcity, was not formulated by any of the Palikas. This also resulted in same health professionals working in both quarantine centers and health facilities in some Palikas.
- Remote modalities of training to the health workers was often of poor quality and inadequate, for which quality assessment was not conducted. Conducting quality assessment and feedback mechanism would have assisted in making the training programmes more effective.
- Although local governments managed funds for COVID-19 management there were confusion managing funds in the beginning. Support and capacity building of local governments to better utilize the resources for emergency situation management would be useful for future emergency situation management.
- Poor coordination mechanism between the three tiers of the governments and poor communication of guidelines and protocols was an obvious gap that often times resulted in confusion. Furthermore, the top-down approach in the management and decision making process of the emergency situation without active engagement of the local governments by the federal government emerged as yet another critical gap.

Social Protection 3.2

The purpose of this study is to analyse the understanding of social protection at three tiers of the government, understand the accessibility of vulnerable groups to social assistance and employment opportunities (specifically PMEP) and understand the approaches taken by local governments to address the vulnerability of returnee migrants. To answer the questions as mentioned in the objectives of the study, this section will initially present the background characteristics of beneficiaries who were surveyed as a part of the study which will be followed by the understanding of social protection at the three tiers of government, legal and institutional frameworks, budgeting, adequacy of the social protection interventions at the local level, accessibility to social protection schemes, impact of social protection interventions at the local level, barriers in availing benefits of social protection interventions, social protection interventions during COVID-19 pandemic and impact of COVID-19 pandemic on interventions relating to social protection. Finally, the process of monitoring and evaluating interventions relating to social protection will be briefly mentioned.

Background Characteristics of Beneficiaries

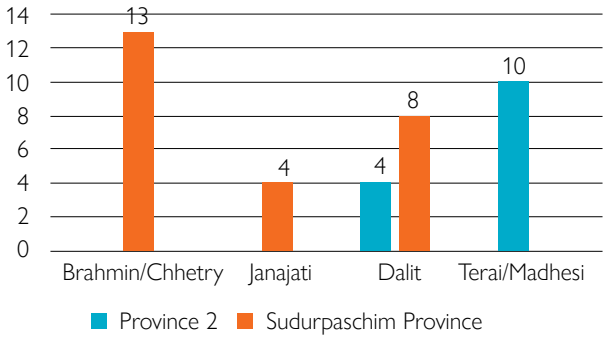
TABLE 5: BACKGROUND CHARACTERISTICS OF BENEFICIARIES ACCORDING TO THE TYPES OF SOCIAL PROTECTION SCHEMES

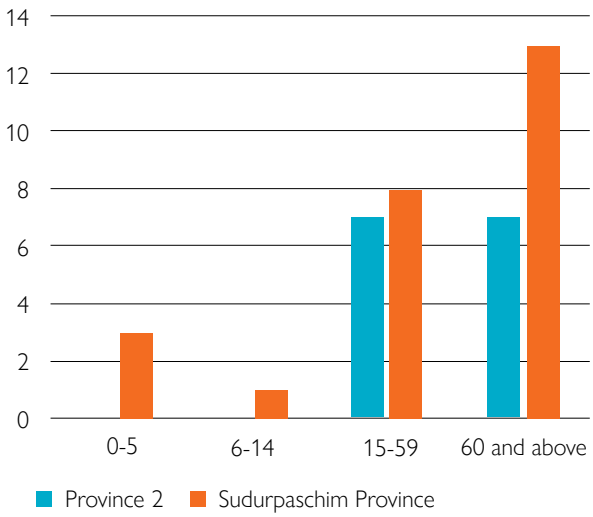
Characteristics of beneficiaries	Categories	Exit client interview		Follow up interview		Total
		Province 2	Sudurpaschim Province	Province 2	Sudurpaschim Province	
Types of social protection schemes	Senior citizen allowance	3	9	4	1	17
	Single women allowance	1	6	2	2	11
	Disability allowance	3	-	1	1	5
	Other social security allowances	-	2	-	1	3
	Other social protection schemes	-	3	-	-	3
Total		7	20	7	5	39

As shown in table 5 above, senior citizen allowance comprises of highest number of beneficiaries (17) which is followed by single women allowance (11), disability allowance (5), other social security allowances (3) and other social protection schemes (3). Other social security allowance includes endangered indigenous people allowance, single women allowance and child protection allowance whereas other social protection schemes includes PMEP, in-kind support received during lockdown and cash or in-kind support for flood victims. Table 1 presents that this study included a total of 39 beneficiaries.

Figure 18 above presents the distribution of beneficiaries who were surveyed in this study according to age and caste/ethnicity. Age range was disaggregated in accordance with eligibility criteria for receiving SSAs (specifically child protection and senior citizen allowance) and dependent age

FIGURE 18: BACKGROUND CHARACTERISTICS OF BENEFICIARIES ACCORDING TO AGE AND CASTE/ETHNICITY





group (population below 14 years of age and above 60 years of age). Out of total 39 beneficiaries, 20 beneficiaries are 60 years or above (seven (7) from Province 2 and 13 from Sudurpaschim Province), 15 beneficiaries are between 15 to 59 years of age (seven (7) from Province 2 and eight (8) from Sudurpaschim Province), one beneficiary from Sudurpaschim Province is between 6 to 14 years of age and three of the total beneficiaries are below five years of age.

Approximately 59 percent of total beneficiaries are within dependent age group, whereas 41 percent are within working age population. Those beneficiaries who falls into working age population (15-59 years) are beneficiaries of PMEP, disability allowance, single women allowance, endangered indigenous people allowance, social assistance during COVID-19 pandemic and social assistance for victims of flood. Additionally, majority of the beneficiaries are from Brahmin/Chettri ethnicity (13), followed by Dalit (four (4) from Province 2 and eight (8) from Sudurpaschim Province), Terai/Madhesi (10), and Janajati (4).

Understanding of Social Protection

Semi structured interviews were conducted with the key informants from National Planning Commission (NPC) and Ministry of Women Children and Senior Citizens (MoWCSC) at the federal level, MoSD at the provincial level, and CAO and local leaders at the local level to assess the understanding of social protection within different levels of government. It was found that there is a gap in understanding social protection at the three tiers of the government. According to the KII conducted at the MoWCSC, social protection is understood to include social assistance, social insurance and labour market policies. In contrast, according to NPC's understanding, social protection includes social care services and shelter in addition to social assistance, social insurance and labour market intervention. Additionally, at the provincial level, the understanding of social protection was found to be limited around provision of social security allowances to single women, senior citizens and people with disability, and protection of women and children against violence and abuse. Most importantly, it was indicated that the MoSD has not been able to do much regarding social protection. Moreover, local governments are seen to implement programmes as planned by the federal and provincial governments while having limited understanding regarding social protection.

Legal and Institutional Framework

The interviews with the representatives at federal, provincial and local governments has reflected a gap in universal legal and institutional framework as well as service delivery mechanisms relating to social protection in Nepal. According to KII with NPC, there are 13 ministries that are implementing about 85 schemes relating to social protection as per their own institutional framework and service delivery mechanism. Similarly, different sections at respective Palikas were found to be implementing different programmes relating to social protection. For instance, programmes relating distribution of relief materials were said to be implemented by disaster management section, programmes regarding provision of skill-based trainings are being provided through women development section and programmes relating to provision of scholarship through education section.

"There is lack of clarity within the ministries regarding the understanding of social protection. Me as well did not have a clear idea regarding the social protection before. We were not sure if our schemes come under social protection or not. When we looked through the schemes, we found out that different schemes were related to social protection which we thought was not related to social protection before. For instance, programme relating to employment generation such as PMEP." **FG3**

"News is filled with the cases of rapes and kidnappings. This shows that people are not safe. So, I feel that social protection related services have not been provided as effectively as they should have been." **PG4**

"The legal and institutional framework regarding social protection is not consistent as different ministries of the government are involved in providing social protection and the government lacks universal legal and institutional framework concerning social protection. The legal framework is dispersed and is also connected with provincial level." **FG3**

"Not being able to determine the actual contribution of EDPs has been a significant problem. I am still trying to track the budget directed towards social protection." **FG3**

Budgeting

The representatives from the federal government stated that around 13% of the total national budget has been allocated towards social protection. However, it is difficult to track the support received from external development partners (EDPs) regarding social protection as it was informed that they tend to do the agreement with Ministry of Finance (MoF) directly without coordinating with MoWCSC.

As programmes relating to social protection are dispersed across the ministries at the federal level and at the provincial and the local level, it is difficult to assess the total expenditure made towards social protection. This finding links with the gap in universal legal and institutional framework regarding social protection as the budget for programmes relating to social protection are disbursed across the government ministries. There is no single document that reflects the overall budget allocated and expenditures made towards social protection.

As per the findings from the desk review and KII, the budget for SSAs are sent to local level (Palika and/or bank situated at the local level) from the MoF at the federal level in accordance with Line Ministry Budget Information System (LMBIS) (DoNIDCR, 2021). A total of 386 local levels are using banking system for distribution of SSAs (see DoNIDCR's website for futher details) (DoNIDCR, 2021). Budget allocated towards SSAs are not reflected in Palikas' budget where banking systems are being used. In contrary, budget allocated towards SSAs are reflected in Palikas' budget where banking systems have not been used yet. Those Palikas not using banking system for distribution of SSAs distributes the budget allocated to their respective wards at the local level which further distributes to beneficiaries respectively. All our study Palikas were found to be using banking system for distributing SSAs to beneficiaries. Therefore, the budget allocated towards SSAs could not be analysed in this study as it was not reflected in Palikas' budget.

Most importantly, according to KII with NPC and MoWCSC, no plan was found to have been formulated with regard to making SSAs financially sustainable in the long run while considering the limited resources within the country.

The budget allocated by the local level for implementing PMEP is presented in the table below.

TABLE 6: BUDGET ALLOCATED TOWARDS PMEP AT RESPECTIVE PALIKAS

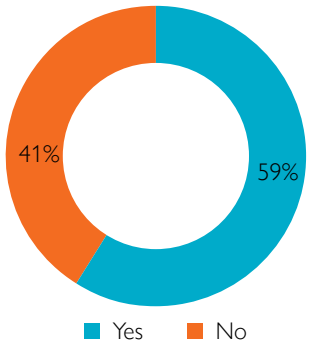
Name of the municipality	Province	Budget allocated in FY 2077/78
Haripurwa M	2	*Budget has not been passed by the Palika yet
Chandranagar RM	2	5,936,000
Samsi RM	2	5,923,000
Ekdara RM	2	5,923,000
Tikapur M	Sudurpaschim	5,944,000
Ghodaghodi M	Sudurpaschim	5,929,000
Dipayal Silghadi M	Sudurpaschim	5,893,000
Phurwichauki RM	Sudurpaschim	5,891,000
Safebagar M	Sudurpaschim	5,621,000
Mellekh RM	Sudurpaschim	5,891,000

As shown in table 6 above, the budget allocation towards PMEP is similar (approximately NRs 5.8-5.9 million) in all the municipalities with Safebagar municipality allocating a bit lower i.e. about NRs 5.6 million than other municipalities. It was found that the major budget headings including daily wages for the employees and salary of employment coordinator under PMEP are similar across the Palikas resulting in overall similarity in budget allocation towards PMEP. Awareness regarding foreign employments, administration cost for running employment service centres (ESC) and strengthening ESCs are among other activities under PMEP. Other activities specifically focusing on returnee migrants with regards to PMEP have not been conducted while looking at the budget allocation towards activities under PMEP.

Adequacy of the Programme at the Local Level

As shown in figure 19, out of the 27 exit clients who were surveyed in this study, 16 of them i.e. 59 percent thinks that the current social protection schemes or amount provided to them by the government are adequate whereas 11 of them i.e. 41 percent thinks that those schemes or amounts are not adequate. Out of 16 respondents who thinks those schemes or amount are adequate, more than half of them (59 percent) reports that it supports to cover their daily expenses. In contrast, out of the 11 respondents who think that schemes or amount are not adequate for them, 55 percent suggested the amount provided is not enough while considering the current inflation.

FIGURE 19: RESPONSE REGARDING ADEQUACY OF SOCIAL PROTECTION SCHEMES



"I came to know about the service from my neighbour and went to Palika, but the Palika staff said that relief amount is Rs 8,990 which is rather small as I belong to the family whose house was completely destroyed." **M5SPEC5**

"Some programmes have criterias for the selection of beneficiaries. If we have such kind of criteria, we send the letters to the ward accordingly and call the beneficiaries. If there are no such criteria and if the program is focused for the specific target group, we coordinate with the ward members and select the beneficiaries." **M4C**

Accessibility to Social Protection Schemes

To understand the accessibility social protection schemes, this section will present findings regarding identification and selection of beneficiaries, process of informing beneficiaries about the social protection schemes, involvement of local people in planning and implementation of programmes relating to social protection and awareness regarding current social protection schemes.

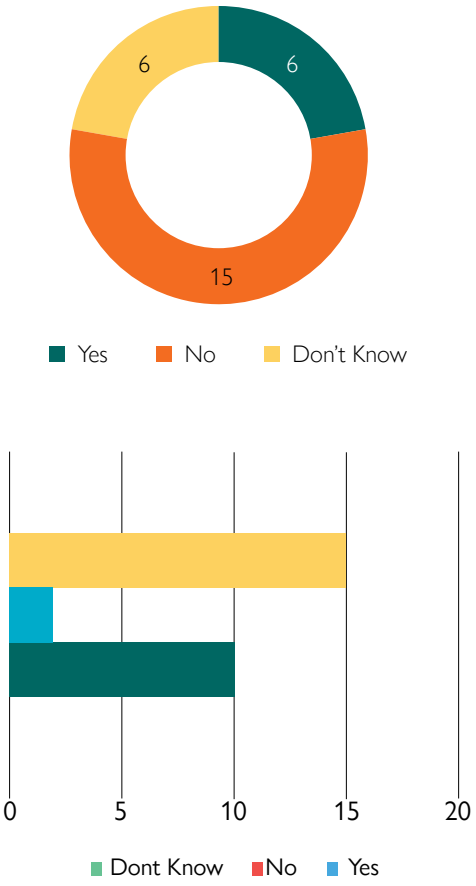
Identification and Selection of Beneficiaries: Local governments including the Palika and ward plays a fundamental role in identification and selection of beneficiaries targeted by social protection. Primarily, ward recommends the Palika for enrolling the eligible people as beneficiaries based on the eligibility criteria for social security allowance and doctor's recommendation for disability allowance. Consequently, the Palika makes the final decision regarding the selection of beneficiaries and provision of social security allowances.

It was found that the representatives at respective Palikas were found to be confident regarding proper and unbiased selection of beneficiaries.

"While selecting people with disabilities for the allowance, the ward chairperson is also invited. We obtain the recommendation of both ward chairperson and doctor. The main basis for evaluation is doctor's recommendation for this allowance while for the rest, the recommendation of the ward is major." **M3C**

"People's representatives should avoid disputable selection of beneficiaries. If the wrong beneficiaries were selected, programs would have become disputable, however, no one has reported that so far." **M3C**

FIGURE 20: PROBLEM IN IDENTIFICATION AND SELECTION OF BENEFICIARIES AND RESPONDENT'S PERSPECTIVES REGARDING SELECTION OF BENEFICIARIES



They reported that no complaints have been received till the date regarding the selection and identification of the beneficiaries.

Figure 20 above (pie chart) shows that the majority (15 out of 27) of the respondents from the exit client interview, who are currently receiving the service relating to social protection schemes, reported no problem in identification and selection of beneficiaries. On the other hand, six (6) of them reported that there is a problem and six (6) were not sure about that and reported that they were not aware about that.

As shown in the chart in figure 20, most of the respondents (15 out of 27) who are currently receiving the social protection service reported that they did not know whether the right people are selected as beneficiaries or not, 10 respondents noted that the right people are selected as beneficiaries whereas two of them suggested otherwise i.e. the right people are not selected.

Those who expressed dissatisfaction about the process of identification and selection of beneficiaries of social security allowance reported existance of political biasness in the process and nepotism in selection for PMEP.

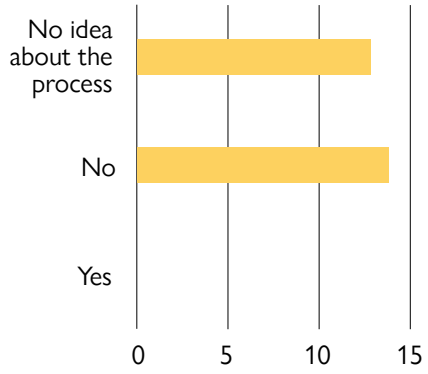
Information about the service to beneficiaries: It was found that most of the beneficiaries know about of the social protection schemes from the government authorities or their relatives. The beneficiaries were least likely to know about services from the radio, television and newspaper notice. However, according to KIIs with the representatives from local and federal government, representatives mentioned that local means of communication such as local FM and television channels are used to inform beneficiaries about the social protection schemes. Additionally, they also noted that the ward members, ward representatives and local representatives play an important role in informing the beneficiaries about the programme. Few Palikas mentioned a Katuwal (messenger) as well as an office assistant (peon), who is responsible for informing the community about social protection schemes.

"There is a bias in classification of people with disability as per government's rule- people in their favour gets full allowance." **M4SPEC4**

"There is no problem in being selected for social security allowances, but there is nepotism while selecting beneficiaries for other development works". **M7SPEC3**

"The peon of the ward is mobilized for disseminating the door to door information regarding social protection programs." **M4L**

FIGURE 21: RESPONSE REGARDING INVOLVEMENT OF LOCAL PEOPLE IN PLANNING AND IMPLEMENTATION



Involvement of local people in planning and implementation

Figure 21 shows that out of 27 exit clients who were surveyed in this study, none of them reported the involvement of local people in planning and implementation of programmes relating to social protection, 14 of them informed that they were not involved and 13 of them reported that they were not aware about the process of involving local people in planning and implementation of programmes relating to social protection. Out of 14 respondents who noted that local people were not involved in planning and implementation of programmes, nine (9) suggested that local people should be involved in the process to understand the real problem, while six (6) suggested that local people should be involved to make the policies and programmes more effective.

TABLE 7: AWARENESS AMONG THE EXIT CLIENTS REGARDING THE SERVICES RELATING TO SOCIAL PROTECTION SCHEMES

Name of the services	Count	Percent
Senior citizen allowance	25	93
Single women allowance	17	63
Disability allowance	6	22
Endangered indigenous people allowance	4	15
Child protection allowance	9	33
No idea	2	7

Awareness Regarding Provision of Services Relating to Social Protection Schemes

As shown in Table 7, only two (7 percent) of the total respondents were not aware about any social protection schemes. Exit clients were mostly aware of the senior citizen allowance (93 percent) followed by single women allowance (63 percent), child protection allowance (33 percent), disability allowance (22 percent) and endangered indigenous people allowance (15 percent).

Impact of Social Assistance Programmes

Most of the respondents (14) informed that the current social protection programmes specifically social security allowances were helpful in covering their family expenses. Nine (9) of the total 27 exit client respondents suggested that they received more care and attention from family members and relatives after they started receiving the allowances. Four (4) of them mentioned that the social assistance programmes have helped in increasing the access and use of community assets and basic social services and three (3) of them noted that it has helped to increase social participation.

Majority of the follow-up interviewees mentioned that the allowances were helpful in covering their household expense. FSome reported that they are being treated properly by their family members and relatives after they started receiving the allowance, it has been helpful to cover their personal and treatment expenses and they feel good to receive such kind of support from the government.

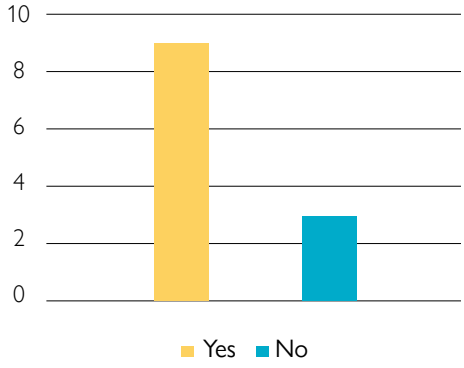
FIGURE 22: IMPACT OF SOCIAL ASSISTANCE PROGRAMMES AT INDIVIDUAL AND THE COMMUNITY LEVEL[9]

[9] As this figure comprise of multiple response from a single respondent, caution should be taken while interpreting its figures

Barriers to accessing Social Protection services

Out of the 12 service users who were asked whether they faced any barriers in receiving the service relating to social protection or not, majority (9) of them said yes which is as shown in figure 22. Out of the nine (9) respondents who said yes, three (3) of them informed that it was difficult for them to receive the social security allowance from the bank as the bank was overcrowded, three (3) of them informed that they have to travel a long distance to receive the social security allowance, one of them mentioned that they have to stay in queue for a long period of time, one of them mentioned that the respondent was left out as the respondent did not have a son, and one of them noted delay in receiving the service.

FIGURE 23: BARRIERS TO AVAILING SOCIAL PROTECTION



"As I am getting old It is very difficult for me to travel 7 or 8 kilometres to reach up to the bank and stay about two or three hours in a queue." **M2SPFC2**

"The ward chairperson left me out from receiving service relating to social protection as I don't have a son and I only have four daughters." **M1SPFC2**

"Daughter-in-law is found to be receiving the allowance on behalf of her father-in-law who is already dead." **M7SPEC2**

"It took me around one year to receive the service even after I completed all the processes." **M8SPEC1**

"Bank is not providing money in a timely manner, but according to ward officials they have been sending the money on time, this year we got money on the last week of Asar. I assume that bank is keeping our money to get interest." **M5SPEC2**

"Around 10 institutions came here and took the picture of our house telling that they will provide some relief but none of them came back and provided any help. Finally, Palika provided NPR 8,990 instead of NPR 15,000 for the house which was completely destroyed. Palika staff said that the money was deducted as per the higher level decision." **M5SPEC5**

"Government officials selected the beneficiaries who were not eligible and updated their name in the list of eligible beneficiaries." **M2SPEC2**

In contrast to follow-up service users, majority of the exit client respondents were found to be positive about the provision of social protection schemes informing that services were easily accessible, and information provided by the government staff at the local level were clear and useful. However, few of them suggested that there is delay in updating the service as well as while receiving the money. Additionally, exit client respondents expressed some concerns regarding delay in receiving the service, service being provided to ineligible people and process being tedious. Moreover, one of the representatives from the Palika mentioned that the bank is not well equipped to provide the service relating to distribution of social security allowances.

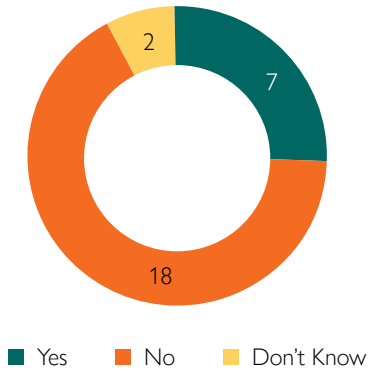
With regards to difficulty faced by the exit clients in complying with the conditions set forth by the government before receiving the service, majority of the respondents (20 out of 27; 70 percent) informed that they faced no difficulty in complying with the conditions and six (6) (22.22 percent) out of 27 respondents were positive on the process of compliance. However, similar to the response from follow-up service users, two out of the total respondents informed that they have to travel a long distance to receive the service and one of them informed that they have to queue at a bank for long hours to receive the service. The follow-up service users also indicated to personal reasons, delay in releasing the budget, problem in an online registration system and fear of COVID-19 infection as the reasons behind not receiving the service.

According to the key informant at MoSD, there have been complaints regarding delays and errors in issuing identity card which is essential for receiving allowance from the Palikas. Lack of adequate knowledge amongst staff at the local level regarding categorisation of beneficiaries as per the type of allowance, was pointed out to be the reason behind delays and errors.

"We need to get updates from ward or Palika frequently which is atedious process, and it takes our entire day for receiving service from the bank." **M5SPEC1**

"It was not only me who is having problem with online registration, there are about 20 to 25 people who have the same problem as me. I hope to receive my money soon." **M2SPFC2**

FIGURE 24: SOCIAL PROTECTION SUPPORT DURING COVID-19 PANDEMIC



Social Protection during COVID-19 Pandemic

This section will specifically mention social protection programmes during COVID-19 pandemic rather than overall social protection programmes. For example, social assistance i.e. cash or in-kind transfers and labour market intervention i.e. employment opportunities provided during COVID-19 pandemic (March 2020-July 2020). Out of the 27 exit client respondents, 18 did not receive any support either cash transfers or in kind during COVID-19 pandemic, seven (7) received support and two (2)were not aware as shown in figure 24. Those who received the support informed that they received in-kind transfers which included food commodities and soaps.

It was found that all the municipalities from Province 2 (Haripurwa municipality, Chandranagar rural municipality, Samsi rural municipality and Ekdara rural municipality) and Sudurpaschim province (Tikapur municipality, Ghodaghodi municipality, Dipayal Silgadhi municipality, Purwichauki rural municipality, Safebagar municipality and Mellekh rural municipality) distributed food commodities to the impoverished. In addition to food commodities,

"In some of the Palikas, the positions sanctioned in women and child development section have not been fulfilled and the coordinator of health or education section have been made responsible for providing social security allowances. They don't have an idea regarding categorization of disability, leading either to delay in providing identity cards to beneficiaries or to improper categorization." **PG4**

Haripurwa municipality provided NPR. 300 to poor households, Tikapur, Ghodaghodi and Dipayal Silgadhi municipalities distributed soaps to poor households, and Purwichauki rural municipality distributed masks to every households situated in that municipality. Apart from poor households, relief materials as mentioned above was provided to students living in rented houses and informal workers in Tikapur municipality, and informal workers in Ghodaghodi municipality, Dipayal Silgadhi municipality and Purwichauki rural municipality. Moreover, Chandranagar rural municipality, Samsi rural municipality, Tikapur municipality, Ghodaghodi municipality, Dipayal Silgadhi municipality and Purwichauki rural municipality distributed relief materials to a total of 2240, 1283, 3746, 3649, 1662 and 1225 beneficiaries respectively. Details of this can also be seen in a table presented in Annex 1.

"During the pandemic, our organization coordinated with the local government and ward-level for the selection of the beneficiaries and provided them with the relief packages. We also conducted awareness programmes regarding hygiene and sanitation." **M7DP**

"We are planning to focus on skill development program while managing the traditional skills by coordinating with the local government primarily focusing on Dalit, women and poor people." **M7DP**

"Many people have lost their employment and it is easier for us to generate employment in the agriculture sector so that people will be self-dependent. We think that self-dependency leads towards the prosperity. Therefore, we have separated more budget on agriculture." **M8C**

The support from non-governmental organisations working in the Palikas were focused on distribution of PPE sets, masks, gloves and sanitizers as well as raising awareness about COVID-19 infection and preventive approaches. Some organisations were also involved in the distribution of relief materials to people who lost their jobs due to the pandemic and some of the development partners working in the Palikas are planning to support income generating activities and skill development activities as a part of the recovery from impact of COVID-19 pandemic.

Nevertheless, according to key informants from the provincial governments, there were concerns regarding management of the support provided by the development partners. Additionally, adequate information and records are not available regarding the support provided by the development partners.

It was found that a significant number of people returned back from abroad after the pandemic which resulted in increase in unemployment. To address the problem of rise in unemployment specifically amongst returnee migrants, few Palikas were found to have increased the budget allocation towards agriculture sector and skills development significantly in order to create employment opportunities for them. For instance, in Samsi, there was 143.7 percent increase in budget

allocation towards agriculture sector (from NPR 4,145,000 in FY 2076/77 to NRs 10,100,000 in FY 2077/78), in Dipayal Silgadhi, the budget increased by 102.1 percent (from NRs 3,014,000 in FY 2076/77 to NRs 6,091,000 in FY 2077/78) and in Safebagar, the budget increased by 127.4 percent (from NRs 3,371,000 in FY 2076/77 to NRs 7,665,000 in 2077/78).

It was also observed that Dipayal Silgadhi municipality was planning to provide employment to the youths who lost their jobs while targeting women, specifically Dalit women, and including them in workshops and meetings relating to agricultural skills development, sewing and weaving, cottage and agricultural industries. Even though the federal government highlighted the significance of providing immediate cash transfers and creating job opportunities for people who lost their jobs due to the impact of COVID-19 pandemic, not many programmes were planned and implemented to support those people. In terms of expectation from the beneficiaries, the exit clients and follow up service users suggested that government should provide door to door service for the provision of SSAs, provision of employment for unemployed people and timely distribution of SSA. In addition, there were also some expectation regarding distribution of masks, sanitisers and food commodities to poor people.

"There aren't any programmes to address the returnee migrants in particular. There is a PMEP at the local level where they can register and those who are interested can work as per their skills, but other plans have not been formulated so far." **FG2**

"Programmes have not been planned for providing employment opportunities to the people returning back from abroad. The majority of them were from India who, I think have returned back." **PG4**

TABLE 8: IMPACT OF COVID-19 PANDEMIC IN DISTRIBUTION OF SOCIAL SECURITY ALLOWANCE

Impact of COVID-19 pandemic	Name of the municipalities
Delay in the distribution of social security allowance	Haripurwa municipality, Chandranagar rural municipality, Samsi rural municipality, Tikapur municipality, Ghodaghodi municipality, Dipayal Silgadhi municipality, Purwichauki rural municipality
Delay in the process of renewal resulting in delay in distribution of social security allowance	Ekdara rural municipality
No impact at all	Safebagar municipality and Mellekh rural municipality

Impact of COVID-19 Pandemic

Table 8 shows that except in Safebagar municipality and Mellekh rural municipality, there were delays in distribution of SSAs in all other municipalities. With regards to that, there was a delay in distribution of SSA in the third quarter (Chaitra to Asar 2076/77) in Tikapur, Ghodaghodi and Dipayal Silgadhi municipalities, and in Purwichauki rural municipality. Additionally, in Ekdara rural municipality, there was a delay in distribution of SSA because of delay in renewal process.

As shown in table 10 in annex section, there was no impact of COVID-19 pandemic on PMEP in Province 2, however, PMEP had not been conducted yet there. In Chandranagar and Samsi rural municipality, PMEP

was not conducted as there was a delay in releasing the budget from the Palika. As municipal assembly was not conducted in Haripurwa municipality, PMEP had not been conducted there either. Similarly, PMEP had not been conducted in Ekdara rural municipality as Palika did not have a staff to implement the programme. Additionally, process of selection of beneficiaries had been carried out only in Chandranagar rural municipality.

In contrast to Province 2, there was an impact of COVID-19 pandemic in most of the municipalities in Sudurpaschim Province except for Tikapur municipality. As Tikapur municipality usually conducts the PMEP in 2nd quarter (Mangsir to Falgun) of the fiscal year (FY), the programme is yet to be conducted, however, beneficiaries are being selected in the municipality. In Ghodaghodi and Dipayal Silgadhi municipalities, PMEP had to be stopped because of COVID-19 pandemic and it has been planned for Jestha. In Safebagar municipality and Mellekh rural municipality, small group of workers were formed rather than large groups who were mobilised every alternate week. In Purwichauki rural municipality, the budget for PMEP was transferred to budget for COVID-19 pandemic as a result of which PMEP could not be conducted there.

According to interviews with the key informants at the local level, it was found that number of developmental projects and programmes relating to it were hindered due to the pandemic and preventive measures adopted to control the pandemic.

There were hindrances in the programmes relating to provision social security allowance and PMEP. For instance, in some Palikas the pandemic delayed the distribution of SSAs.

"Various development projects could not be conducted this year as our prime focus got shifted to COVID-19 management and health sector." **M7C**

"More than health related programs, the impact of COVID-19 was observed in the social security sector. PMEP could not be conducted for a long time and we resumed it later with smaller groups and proper social distancing measures." **M9C**

"The allowances which was supposed to be distributed in Jestha was distributed in the month of Asar due to the pandemic." **M6C**

The exit client respondents noted that risk of infections, closure of the ward office and lockdown imposed as a result of COVID-19 pandemic caused challenges in availing the services relating to social security allowance and PMEP. Additionally, similar to the response from the Palika representatives, exit client respondents also informed that there was a delay in distributing social security allowances. The delay in renewal of social security allowance card was also found. In contrary, few respondents informed that the ward officials provided door to door service for providing SSAs. A representative from one of the Palikas also mentioned that they had to divert the budget allocated to other sectors including agriculture, education, transportation and infrastructural development to procure equipment and supplies such as PPEs, masks, sanitizers and gloves for control and management of COVID-19 pandemic.

Monitoring Programmes Relating to Social Protection

As per the interview conducted with the representatives from local, provincial and federal level, there

exists a gap in monitoring and evaluation of programmes relating to social protection. The mechanism for monitoring has not been established yet at the federal level. At the local level, there is a lack of defined monitoring mechanism. According to the KII conducted at the federal level, monitoring is done by just looking at allocated budget and expenditures made on programmes relating to social protection. At the local level, Mayor and CAO get involved in process of monitoring was observed, however, clear procedure on this was not defined. Additionally, some representatives from the Palikas mentioned that the mechanism for monitoring was disrupted due to COVID-19 pandemic.

As informed by the key informant at the NPC, after the federal structure, the local government has a significant role in the implementation of programmes planned by federal, provincial or local government. Although majority of the programmes are planned by federal and provincial government, they do not play any part in implementing those programmes. Hence, effective implementation and monitoring of programmes relating to social protection has been a great challenge.

With regards to impact assessments and evaluation to assess the implementation of the programmes relating to social protection, no studies of such kind were conducted by the government at the federal level. A few development partners recommended that the Government should also focus on monitoring and evaluating the distribution of social security allowances and its impact of livelihood of the beneficiaries.

"Monitoring visits used to be conducted monthly but they were disrupted for around three months and now, are being conducted as usual." **M10C**

"Due to COVID-19 the frequency of monitoring has decreased. We are unable to do monitoring frequently." **M6C**

"A lot of money from the federal government is sent to local governments for implementing PMEP (Prime Minister Employment Programme). There is difficulty in assessing whether the work is done at the local level or not and monitor if the activities are being conducted in accordance with government's will." **FG2**

"The local, provincial and federal governments should conduct monitoring visits the effectiveness of social protection programme. They should focus on the status of target people, after getting the services- how they have been living and whether there are any signs of improvement in their status." **M5DP**

No, we have not conducted any studies. In 2012, Asian Development Bank (ADB) conducted one study. We only knew about that study while we were designing the framework. No study was conducted after that. **FG2**

DISCUS-SION

4.1 Health

In emergency situations basic and regular healthcare services are often neglected due to shift in priority, affecting the supply aspect of the basic healthcare. This study assessed all six components of the health systems, from the WHO health systems framework perspective, and findings are discussed in the following sections.

Service delivery at health facilities was relatively unaffected as both service providers and service users mentioned that health facilities remained open during the pandemic. Further analysis of HMIS data shows that although services were available, ANC utilization reduced by 25 percent and institutional delivery reduced by 26 percent comparing data before and after lockdown in the study area. Similar reduction was seen in uptake of treatment for childhood illnesses. Major barriers were fear of COVID-19 and lack of transportation. Several studies during the same time have also shown that institutional delivery reduced by 52.4% (KC, et al., 2020) and 31.8 percent (Jha, et al., 2020) during the pandemic. Globally, similar results were seen during the Ebola outbreak, when coverage of antenatal visits, delivery at the health facility, postnatal care, and family planning services declined in the affected countries in Africa and the underlying causes were fear of contracting Ebola virus, distrust towards health systems and rumours about the source of Ebola infection (Roberton , et al., 2020). This strongly suggests that while services are made available during emergency, it is equally important to provide means for accessibility and utilization of services for women and children.

Local governments were unprepared in terms of ***human resource*** management for the pandemic. None of the rural/municipalities had a human resource plan to recruit or mobilize existing resources. The system was stretched as the same health workforce was mobilized both at health facilities and quarantine centres. Health workers faced scarcity of PPE in the initial days of the pandemic but this did not deter them from providing quality health services as most of the service users were satisfied with the quality of care provided at the health facility and waiting time was less than 30 minutes in almost all the cases. Health workers at the local level received training on CICT and critical care through virtual means, but they did not find this effective and overall health workers said they were not adequately trained to manage the pandemic. Health workers also feared discrimination from community as there were reports of stigmatization and mistreatment of health workers from across the country due to fear of contracting COVID-19 from health workers, (Shrestha RM, 2020). Hazard allowance for health workers working in the frontline, as announced by the federal government, was not provided in most of the Palikas. Health professionals have been lauded globally for their effort and work in COVID-19 management, risking their own life to perform their duty of saving others' life, however, this spirit and appreciation appeared to be lacking in Nepal, both in the community and in the governance (Shrestha RM, 2020). This clearly suggests that government should invest in capacity building, motivation, safety and well-being of health workers while they continue to work as frontliners in any emergency context.

Most of the local governments mentioned having adequate ***logistics*** of essential medicines in their stock and did not face any difficulty in managing them. As is understandable for a pandemic like this, there was scarcity of PPE in the beginning and health workers maintained social distancing, used masks, gloves and

sanitizers on order to deliver services. The main reason for any inadequacy in the beginning was the lengthy public procurement process. But pertaining to the clause of public procurement during emergencies, local government procured emergency medicines and other logistics in the later phase of the pandemic. I/NGOs also extended their support by donating PPEs, infrared thermometers, relief materials to the community, generating awareness about prevention methods and hand hygiene, installing contactless water dispensers and providing soaps for handwashing, assisting with providing sanitation and drinking water services at the quarantine centers, and in some occasions supporting with basic health service delivery as well.

Local governments struggled to manage ***funds*** for COVID -19 as the pandemic hit by surprise toward the last quarter of FY 2019/20 but they managed from the provision of undivided budget in the government's Red Book which can be used under any heading depending on need as well as other budget headings, which were transferred to COVID-19 response, although this was not sufficient. Also, many Palikas transferred budget dedicated for infrastructure development towards COVID-19 management as many infrastructure works were disrupted, but not from health programs.

Budget for COVID-19 management was not sufficient in FY 2019/20, but in FY 2020/21, six percent of total health budget has been dedicated for COVID-19 management and has been included in the Red Book of the federal, provincial as well as the local governments[10]. This particular budget is specified for capacity building, equipment purchase, surveillance, allowance for health personnel, research and other COVID-19 related management. Furthermore, there is additional budget for construction of a 50 bedded hospital in each province and 300 bedded hospital at the federal level. Given severe limitations in financing in FY 2019/20, there is clear budget allocation for COVID-19 management in FY 2020/21 at all levels, nevertheless, more rigorous and scientific basis of budget allocation would support local government to remain prepared for future, in case of a prolonged pandemic like COVID-19.

Despite the unprecedented nature of the pandemic, local governments demonstrated ***leadership*** in dealing with the crisis from the limited resources and knowledge available at the given time. Some rural/municipalities had pre-existing Disaster Management Committees while others had Rapid Response Teams (RRT), and these turned into COVID-19 Crisis Management Committee (CCMC) at the local level. This committee led by Mayor/ Chairperson, coordinated with district, province and ultimately federal levels and also I/NGOs in the municipality. Support with technical guidelines and supplies like RDT kits, PCR and PPE trickled down from federal to province to local government. Local governments supported strict implementation of lockdown, set up health desks at borders and managed test, isolate and support of returnee migrants as necessary. Some of the major challenges local governments faced were, frequent change in guidelines, in particular, testing and lack of clarity of roles and responsibility among all three tiers of government. Key informants from province and federal level opined that this was the first large scale crisis that required intensive tiered coordination since the coutry adopted federalism ,and perhaps the previous system was better. Indeed COVID-19 is the first national emergency since the implementation of federal

[10] Red Book FY 2020/21

system of governance in Nepal five years ago with which major power and control was limited to federal government (Karki, 2020). Majority of the local governments stated that they did not receive adequate support from I/NGOs during the initial phase of COVID-19 but received support like PPE sets, sanitizers, relief material, risk communication in the late phase.

The Public Health Service Act (2018) clearly states that the local government can declare a state of emergency in case of infectious disease outbreak at the local level but key informants in this study stated otherwise, indicating need for clear and common understanding. Local government shows capacity and willingness to address any forms of crisis. This should be strengthened through clear guidance and coordination from province and the federal government and timely support from I/NGOs.

4.2 Social Protection

Accessibility to SSAs and PMEP

There is a gap in overall understanding of social protection and a universal legal and institutional framework regarding social protection at three tiers of the government. This might to some extent limit the overall accessibility to programmes relating to social protection. For instance, government institutions who are responsible for providing services related to social protection will only provide or advocate for those services which they are familiar with. This can obscure the implementation of other interventions relating to social protection apart from social security allowances and PMEP. In addition to the gap in understanding and universal legal and institutional framework regarding social protection, there is no defined monitoring and evaluation system. Hence, arguments can be made regarding the effectiveness of social protection programmes at local, provincial and federal level. Although it is suggested that social protection schemes have helped vulnerable peoples across Nepal, there is no evidence regarding its positive impact on the livelihoods of those people.

As provision of social security allowances and PMEP to the beneficiaries are mainly guided by the Social Security Act and act relating to PMEP, overall service delivery mechanism was found to be positive. However, there were concerns regarding political bias and nepotism in the beneficiaries selection process. This points out that vulnerable people who require social protection could have been missed out from the provision of SSAs and PMEP. This also links with the issue regarding a gap in well-defined monitoring and evaluation system.

Most importantly, it was found that local people are left out of planning and implementation of social protection programmes. This can create a significant gap in felt and real needs of the vulnerable people eventually creating challenges in accessibility.

There are several specific barriers in accessing SSAs by vulnerable groups during COVID-19 pandemic. First, vulnerable people must travel a long distance and queue for a long period of time to receive SSAs. This might hinder vulnerable people, specifically senior citizens and people with disabilities, from receiving SSAs. Second, overcrowding at banks which further increases the risk of COVID-19 infection amongst vulnerable groups such as senior citizens. Third, there are delays in distribution of SSAs, process of renewal and in issuing identity card to the beneficiaries. All of which will eventually impact the livelihood of the vulnerable people and their families as SSAs are the only source of income for most of the vulnerable groups. Fourth, the lockdown restricted the vulnerable

groups to access SSAs from the bank. Although few Palikas provided door to door service (SSAs) during COVID-19 pandemic, the service was not provided in all Palikas. Thus, beneficiaries from those Palikas where door to door service was not provided might have been deprived of SSAs.

Overall, even though the social protection schemes have helped a lot of vulnerable groups while supporting them in their day to day lives, several barriers mentioned above hindered its accessibility to vulnerable groups. There was not much impact due to COVID-19 pandemic as SSAs are distributed quarterly, however, barriers relating to governance and service delivery mechanism existing from before the pandemic caused problems regarding the accessibility of vulnerable groups to social protection schemes. Moreover, as beneficiaries of SSAs are likely to be increased, not having a sustainable roadmap can create further problems with regards to provision of social security to vulnerable groups.

Social protection schemes to support returnee migrants

In PMEP, there was no allocation made towards activities targeted to support returnee migrants apart from regular PMEP activities. It is important to consider that regular PMEP activities were also hindered during the pandemic. Additionally, in Province 2, PMEP had not been conducted yet due to several reasons including delay in releasing budget from the Palika, delay in conducting municipal assembly and lack of designated staff to implement the PMEP. In Sudurpaschim province, PMEP was not conducted effectively as they had to form small group of workers due to the risk of transmission of infection and budget for PMEP was transferred to budget for control and prevention of COVID-19 pandemic. Moreover, apart from provision of 100 days of work, the PMEP programmes were limited to activities focused on raising awareness regarding foreign employment rather than creating employment opportunities. This suggests that not much was done by the local government to support returnee migrants in terms of provision of employment.

Food commodities were distributed to the impoverished by most of the Palikas. Additionally, few Palikas distributed soaps and one Palika also distributed small amount of cash i.e. NPR 300 to poor households. Moreover, development partners within the local level focused on distribution of PPE sets, masks, gloves and sanitisers. Nevertheless, it is not sure whether the returnee migrants benefitted from these immediate cash or in-kind transfers.

Overall impact on social protection mechanism due to COVID-19 pandemic

As shown in the table above, this study found four major problems relating to social protection mechanism (SSA and PMEP) as a result of COVID-19 pandemic. First, in regard to receiving SSAs from the bank, there is a high risk of transmission of COVID-19 infection due to overcrowding and long queues at the bank. It is important to consider that SSAs are distributed to vulnerable population who are also vulnerable to the risk of COVID-19 infection.

Second, COVID-19 pandemic has disrupted the distribution of SSAs and the implementation of PMEP to some extent. It was found that there were delay in distribution of SSAs, delay in process of renewal as well as closure of government offices. This can impact the livelihood of those people who are entirely dependent on SSAs. Additionally, it was found that PMEP had to be stopped in Ghodaghodi and

TABLE 9: PROBLEMS RELATING TO SOCIAL PROTECTION MECHANISM DUE TO COVID-19 PANDEMIC

Problems relating to COVID-19 pandemic	Remarks
Receiving SSAs from the bank	• Risk of transmission of COVID-19 infection: • Overcrowding • Beneficiaries have to stay in a queue for a long period of time
Impact on distribution of SSA and implementation of PMEP	• Delay in distribution of SSA • Delay in process of renewal • Closure of government offices due to lockdown measures • PMEP had to stopped (Ghodaghodi and Dipayal Silgadhi) • PMEP's budget transferred to COVID-19 budget (Phurwichauki)
Monitoring and evaluation	• Disruption in monitoring due to the risk of infection due to COVID-19 pandemic • No any studies (for example, impact assessments) are conducted
Reporting by development partners to local governments regarding the support that are being provided at local level	• Adequate information and records regarding the support provided by the development partners are not available at the municipal office

Dipayal Silgadhi and PMEP's budget was transferred to COVID-19 budget in Phurwichauki. With low employment opportunities, increase in number of returnee migrants and no specific social protection schemes or programmes (other than PMEP) targeted towards those population groups, there is lack of available support to address the vulnerability of those population groups which can eventually impact their livelihood as well as their family's health and well-being.

Third, it was found that there were disruptions in monitoring and evaluation of distribution of SSAs and implementation of PMEP. Without periodic monitoring and evaluation, real barriers for effective distribution of SSAs and implementation of PMEP can be obscured which can hinder the programme implementation and management and can eventually impact the livelihood of vulnerable population. Additionally, it was found that no studies, such as impact assessment, were conducted to assess the impact of social protection measures to support the vulnerable population groups at local levels across Nepal. Therefore, it is difficult to find out the barriers, impact (positive and negative) and thus to conclude that SSAs and PMEP are helpful to address the vulnerability of the population groups.

Fourth, few Palikas' representatives mentioned that they did not have adequate information regarding the support provided by development partners at the local level during the COVID-19 pandemic. This can have several implications such as programmes being redundant, loss of economy and resources, and lack of secondary data which can be helpful in conducting further research.

Whilst abovementioned problems are superficial, there are various other issues that might not be apparent initially but can further aggravate these problems. Those various other issues, which has been mentioned above, include gap in understanding of social protection, missing universal legal and institutional framework regarding social protection, political bias and nepotism while selecting beneficiaries, lack of involvement of local people in planning and implementation of programmes relating to social protection and lack of programmes to support returnee migrants.

CONCLU-SION

Health

This study explored opportunities and challenges faced by the local governments in delivering health and social protection services in the first year of the pandemic. Maternal and child health services availability at health facilities was relatively unaffected but a drop in service utilization was noted due to challenges in accessibility. The local governments were unprepared in terms of human resource management particularly with regard to quantity, capacity building, motivation and well-being. Most of the local governments had adequate essential medicines in stock and did not face any difficulty in managing them, however there was scarcity of PPE in the beginning as is quite understandable in an unprecedented situation like this. The lengthy public procurement process was one of the challenges when trying to manage this inadequacy. The local governments struggled to manage funds for COVID -19 as the pandemic hit by surprise toward the last quarter of FY 2019/20 but they reallocated from other headings as well as using the provision of undivided budget in the Red Book. In terms of leadership and governance, the local governments demonstrated capacity and willingness to manage crisis at their end despite limited resources and knowledge. Lack of clarity in roles and coordination among the three tiers of government is a clear area for improvement.

Social Protection

Although the COVID-19 pandemic did not have much impact on distribution of SSAs, there was a major impact on PMEP as the programmes relating to PMEP were halted. With regards to accessibility of vulnerable groups in receiving SSAs, several institutional barriers and barriers relating to service delivery mechanism remains. In-kind transfers i.e. food commodities and hygiene materials were distributed in almost all Palikas with one Palika also distributing small amount of cash, however, not much was done to support the returnee migrants. Additionally, not much was done to create employment opportunities at the local level. Consequently, returnee migrants and those who lost their jobs were not able to benefit from PMEP. Moreover, gaps still remain in overall understanding of social protection, legal and institutional frameworks which govern all programmes relating to social protection, monitoring and evaluation of programmes relating to social protection, and overall service delivery mechanism.

RECOMMENDATIONS

Health

Recommentations for Federal Government and Province Government

- Any new and updated guidelines, in this case such as COVID-19 guidelines, should be communicated to the local governments clearly and on timely manner to avoid confusion
- Public procurement processes should be simplified so that the local governments are able to make emergency procurement for crisis management
- Support and build capacity of the local governments in the areas of planning and budgeting so that the local governments remain prepared for crisis situations like COVID-19 pandmeic and similar others in future

Recommendations for the local governments

- Essential and basic health services were available during lockdown and this should be continued.
- The local governments should provide means and ways, particularly transporation and outreach services in communities for vulnerable groups to access and utilize the health services durign crisis situations.
- The local governments should have a human resource management plan for emergencies and invest in capacity building, motivation, safety and well-being of health workers while they continue to work in the frontline in any crisis context.
- The local governments should plan and prepare budget guidelines for emergency contexts including building own capacity as well as seeking support from the province and federal government, as required
- The local governments should develop coordination mechanism with the federal government, province government and I/NGOs for better preparedness and response

Recommentations for the development partners

- In crisis situations, I/NGOs should support the local government as quickly as possible and not delay support
- I/NGOs should proactively develop coordination plan with the local government for emergency preparedness and response

Social Protection

Recommendations for the province and federal government

- The federal government, specifically NPC, should develop a clear framework for social protection including its understanding, legal and institutional framework, service delivery mechanism and monitoring and evaluation system. This should be done in consultation with different ministries at the federal level including MoWCSC, MoHA, MoF and other relevant ministries, provincial governments (specifically MoSD), and local governments as programmes relating to social protection are dispersed across the ministries.

- MoLESS should follow up with the local governments regarding the implementation of PMEP while taking necessary approaches to encourage the participation of returnee migrants.
- Periodic monitoring should be conducted by MoHA and MoWCSC regarding the distribution of SSAs, online registration of beneficiaries and selection of beneficiaries until a universal framework is developed by the NPC.
- Further research should be conducted specifically focusing on accessibility to SSAs and PMEP, as well as its impact on the livelihood of beneficiaries.

Recommendation for Local Government

- Local government should involve local people including vulnerable groups in planning and implementation of programmes relating to social protection. All potential stakeholders including beneficiaries, MoWCSC, MoHA, MoF, MoSD and NPC should ensure the inclusion of local people in planning and implementation of programmes relating to social protection.
- The local governments should ease the process for receiving the social security allowance specifically considering the vulnerability of the beneficiaries (senior citizens and people with disabilities).
- The local governments should incarese awareness regarding social distancing, masking and sanitising specifically amongst the vulnerable population and in the places which can be crowded such as public institutions and banks.
- The local governments should make sure that the preventive measures are adhered to prevent the risk of infection amongst the vulnerable groups.
- The local governments should implement the PMEP in full swing while adhering to preventive measures to control the spread of COVID-19 and considering the participation of returnee migrants.
- The local governments should provide immediate relief support to the most vulnerable returnee migrants. The development partners should empower local people to get involved in planning and implementation of programmes relating to social protection and help to ensure their participation.
- The local governments should make every programmes relating to social protection fully transparent by publishing it in the local government's website and newspapers, broadcasting in local radio and television programmes and through community health workers or community groups.

Recommendation for the development partners

- INGOs should help the local governments to maintain a digital registry including a detail of beneficiaries of SSAs and PMEP.
- Support the local governments to implement PMEP effectively and support the employees of PMEP by making sure they are using personal protective equipment.
- Provide immediate support (cash or in-kind) to returnee migrants who are most vulnerable.
- Cooperate fully and report to the local governments while implementing any activities relating to social protection to avoid redundancy and to use the resources efficiently.

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ANNEX


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ANNEX B: HEALTH

Characteristics of exit-client and follow-up interview respondents

TABLE 10: CHARACTERISTICS OF EXIT-CLIENT AND FOLLOW-UP INTERVIEW RESPONDENTS

Back-ground	Categories	Exit client interview			Follow up interview		
		Province 2	Sudurpaschim Province	Total	Province 2	Sudurpaschim Province	Total
Service type	ANC check up	3	5	**8**	1	1	**2**
	PNC visit		1	**1**	6		6
	Delivery	3	2	**5**		5	**5**
	Immunization	1	2	**3**			
	Family planning	4	5	**9**	1	4	**5**
	Child illness (IMNCI)	3	5	**8**		3	**3**
Total		14	20	34	8	13	21
Caste Ethnicity	Bhramin/ Chhetry	1	15	**16**		5	**5**
	Janajati	2	2	**4**		5	**5**
	Dalit	1	2	**3**	1	3	**4**
	Terai/Madhesi	5	1	**6**	6		6
	Muslim	5		**5**	1		1
Age	0-5	3	5	**8**		3	**3**
	15-49	11	15	**26**	8	10	**18**

Total number of exit clients by type of service and municipality

TABLE 11: TOTAL NUMBER OF EXIT CLIENTS BY TYPE OF SERVICES AND MUNICIPALITY

Municipality	ANC check-up	PNC check-up	Deliv-ery	Vacci-nation	Family planning	Child illness-es like diar-rhoea and pneumonia	Treat-ment of disease	Fol-low-up
Haripurwa M	1		1			1		
Chandranagar RM	1				3			
Samsi RM	1		2	1				
Ekdara RM					1	2	1	
Tikapur M	1			1			1	
Ghodaghodi M					2		1	
Dipayal Slighadhi M	1				1	1	1	
Purwachauki RM	2			1		2		
Safebagar M	1		1		1			
Mellekh RM		1	1	1	1			2
Total	8	1	5	4	9	6	4	2
Valid cases – 34								

Total number of follow up clients by type of service and municipality

TABLE 12: TOTAL NUMBER OF FOLLOW UP CLIENTS BY TYPE OF SERVICE AND MUNICIPALITY						
Municipality	**ANC check-up**	**PNC check-up**	**Delivery**	**IMNCI (FB/CB)**	**Family planning**	**Total**
Haripurwa M		2				2
Chandranagar RM		2				2
-Samsi RM	1	2			1	**4**
Tikapur M			1	3		4
Ghodaghodi M			2		1	**3**
Dipayal Slighadhi M			1		2	**3**
Purwachauki RM			1			1
Safebagar M					1	**1**
Mellekh RM	1					1
Total	**2**	**6**	**5**	**3**	**5**	**21**

Use of safe motherhood services before and after COVID-19 pandemic

TABLE 13: USE OF SAFE MOTHERHOOD BEFORE AND AFTER COVID-19 PANDEMIC				
Municipality	**4ANC visit**		**Institutional Delivery**	
	Before COVID	**After COVID**	**Before COVID**	**After COVID**
Haripurwa M	33	37	75	80
Chandranagar RM	58	43	51	48
Samsi RM	32	11	110	78
Ekdara RM	26	19	98	16
Tikapur M	33	23	23	19
Ghodaghodi M	70	50	38	38
Dipayal Silgadhi M	15	11	16	7
Phurwichauki RM	7	6	7	12
Safebagar M	16	12	4	8
Mellekh RM	18	19	14	18
Total	**308**	**231**	**436**	**324**

Monthly count of pills (new user) before and after COVID-19 by municipality

TABLE 14: MONTHLY COUNT OF PILLS (NEW USER) BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	2	4	4	1	1	0	1	1	11	3
Chandranagar RM	0	0	0	0	0	0	0	0	0	0
Samsi RM	12	10	4	2	9	9	0	0	28	18
Ekdara RM	0	5	7	5	0	1	4	0	17	5
Tikapur M	0	2	1	2	2	3	7	1	5	13
Ghodaghodi M	1	1	0	2	0	0	1	1	4	2
Dipayal Silgadhi M	6	3	3	0	4	1	0	3	12	8
Phurwichauki RM	1	0	0	0	3	3	0	0	1	6
Safebagar M	0	0	0	0	0	0	1	0	0	1
Mellekh RM	0	2	0	0	2	2	0	0	2	4
Total	**22**	**27**	**19**	**12**	**21**	**19**	**14**	**6**	**80**	**60**

Monthly count of depo user before and after COVID-19 by municipality

TABLE 15: MONTHLY COUNT OF DEPO USER BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	4	5	6	3	2	3	3	3	18	11
Chandranagar RM	5	4	3	6	0	0	0	4	18	4
Samsi RM	12	19	10	24	3	4	0	1	65	8
Ekdara RM	4	5	8	8	9	5	8	6	25	28
Tikapur M	9	1	7	5	4	7	4	7	22	22
Ghodaghodi M	6	7	2	2	3	1	3	6	17	13
Dipayal Silgadhi M	11	7	2	5	1	9	20	27	25	57
Phurwichauki RM	2	0	1	0	0	1	2	6	3	9
Safebagar M	0	0	1	0	0	0	0	0	1	0
Mellekh RM	1	1	2	1	1	1	1	2	5	5
Total	**54**	**49**	**42**	**54**	**23**	**31**	**41**	**62**	**199**	**157**

Monthly count of IUCD new user before and after COVID-19 by municipality

TABLE 16: MONTHLY COUNT OF IUCD NEW USER BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	0	0	0	0	0	0	0	0	0	0
Chandranagar RM	0	0	1	0	1	0	0	0	1	1
Samsi RM	0	1	0	0	0	0	0	0	1	0
Ekdara RM	0	0	0	0	0	0	0	0	0	0
Tikapur M	0	0	0	0	0	0	0	0	0	0
Ghodaghodi M	0	5	0	0	0	0	0	0	5	0
Dipayal Silgadhi M	0	0	0	0	0	0	0	0	0	0
Phurwichauki RM	0	0	0	0	0	0	0	0	0	0
Safebagar M	0	0	0	0	0	0	0	0	0	0
Mellekh RM	0	0	0	0	0	0	0	0	0	0
Total	**0**	**6**	**1**	**0**	**1**	**0**	**0**	**0**	**7**	**1**

Monthly count of Implant new user before and after COVID-19 by municipality

TABLE 17: MONTHLY COUNT OF IMPLANT NEW USER BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	0	0	0	0	0	0	0	0	0	0
Chandranagar RM	14	5	10	10	11	0	0	0	39	11
Samsi RM	0	0	7	5	0	0	0	0	12	0
Ekdara RM	0	7	4	1	1	1	0	1	12	3
Tikapur M	0	0	0	49	6	0	1	0	49	7
Ghodaghodi M	21	53	0	12	0	0	0	0	86	0
Dipayal Silgadhi M	0	0	0	0	0	0	0	0	0	0
Phurwichauki RM	0	0	1	0	0	0	0	0	1	0
Safebagar M	0	0	0	0	0	0	0	0	0	0
Mellekh RM	0	0	1	1	0	0	0	1	2	1
Total	**35**	**65**	**23**	**78**	**18**	**1**	**1**	**2**	**201**	**22**

Immunisation before and after COVID-19 by municipality

TABLE 18: IMMUNISATION BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	BCG		DPT-HepB-Hib 3rd		OPV 3rd		MR 1st (9-11 Months)	
	Before COVID	After COVID	Before COVID	After COVID	Before COVID	After COVID	Before COVID	After COVID
Haripurwa M	61	0	44	24	45	22	33	29
Chandranagar RM	95	0	76	53	76	43	61	33
Samsi RM	102	21	58	30	58	30	66	48
Ekdara RM	101	52	121	78	61	80	63	79
Tikapur M	19	16	23	29	28	29	19	18
Ghodaghodi M	163	100	157	92	157	92	130	101
Dipayal Silgadhi M	29	23	27	35	27	35	31	33
Phurwichauki RM	17	11	13	14	13	14	20	9
Safebagar M	1	13	14	17	14	17	6	6
Mellekh RM	18	17	21	17	21	17	15	19
Total	**606**	**253**	**554**	**389**	**500**	**379**	**444**	**375**

Monthly count of total cases <= 28 days before and after COVID-19 by municipality

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	0	0	0	0	0	0	0	0	0	0
Chandranagar RM	0	0	0	0	0	0	0	0	0	0
Samsi RM	2	0	2	0	0	0	0	0	4	0
Ekdara RM	119	28	53	14	92	60	57	40	214	249
Tikapur M	4	3	0	1	0	0	0	0	8	0
Ghodaghodi M	4	2	1	3	0	0	0	0	10	0
Dipayal Silgadhi M	0	0	1	0	0	0	0	0	1	0
Phurwichauki RM	1	0	0	0	0	0	0	0	1	0
Safebagar M	0	1	0	0	2	1	0	2	1	5
Mellekh RM	0	0	0	0	0	0	0	0	0	0
Total	**130**	**34**	**57**	**18**	**94**	**61**	**57**	**42**	**239**	**254**

Monthly count of total ARI Pneumonia 2-59 months before and after COVID-19 by municipality

TABLE 19: MONTHLY COUNT OF TOTAL ARI PNEUMONIA 2-59 MONTHS BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	3	2	2	5	2	2	1	1	12	6
Chandranagar RM	6	0	0	0	0	0	2	0	6	2
Samsi RM	7	3	10	7	1	0	0	0	27	1
Ekdara RM	9	5	2	2	1	0	1	2	18	4
Tikapur M	4	4	1	1	0	0	0	0	10	0
Ghodaghodi M	7	4	2	1	2	0	0	0	14	2
Dipayal Silgadhi M	17	5	13	2	0	9	9	6	37	24
Phurwichauki RM	28	6	5	13	6	10	1	3	52	20
Safebagar M	5	1	3	1	0	2	0	0	10	2
Mellekh RM	0	1	2	3	3	1	0	0	6	4
Total	**86**	**31**	**40**	**35**	**15**	**24**	**14**	**12**	**192**	**65**

Monthly count of total Diarrhoea 2-59 months before and after COVID-19 by municipality

TABLE 20: MONTHLY COUNT OF TOTAL DIARRHOEA 2-59 MONTHS BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	0	15	5	6	8	8	10	12	26	38
Chandranagar RM	5	6	6	6	2	2	4	0	23	8
Samsi RM	19	17	12	11	6	0	2	0	59	8
Ekdara RM	5	10	7	3	24	8	6	11	25	49
Tikapur M	0	0	0	0	0	0	0	0	0	0
Ghodaghodi M	5	3	4	5	3	2	0	1	17	6
Dipayal Silgadhi M	3	2	3	3	7	4	7	10	11	28
Phurwichauki RM	0	1	2	7	0	5	4	0	10	9
Safebagar M	0	1	0	2	0	1	1	0	3	2
Mellekh RM	0	1	0	2	3	1	3	2	3	9
Total	**37**	**56**	**39**	**45**	**53**	**31**	**37**	**36**	**177**	**157**

Monthly count of Growth Monitoring 0-11 months before and after COVID-19 by municipality

TABLE 21: MONTHLY COUNT OF GROWTH MONITORING 0-11 MONTHS BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	0	75	0	35	0	0	0	0	110	0
Chandranagar RM	35	32	48	62	32	0	0	0	177	32
Samsi RM	21	49	55	65	75	106	20	0	190	201
Ekdara RM	43	30	24	31	0	0	0	0	128	0
Tikapur M	39	51	41	34	18	0	0	0	165	18
Ghodaghodi M	20	28	35	20	0	0	0	9	103	9
Dipayal Silgadhi M	22	22	24	29	26	19	12	24	97	81
Phurwichauki RM	9	2	6	14	4	14	4	2	31	24
Safebagar M	1	0	2	1	0	10	0	1	4	11
Mellekh RM	27	3	11	11	6	9	8	10	52	33
Total	**217**	**292**	**246**	**302**	**161**	**158**	**44**	**46**	**1057**	**409**

Monthly count of Growth Monitoring 12-23 months before and after COVID-19 by municipality

TABLE 22: MONTHLY COUNT OF GROWTH MONITORING 12-23 MONTHS BEFORE AND AFTER COVID-19 BY MUNICIPALITY

Municipality	2076					2077			Before COVID	After COVID
	Mangsir	Poush	Magh	Falgun	Chaitra	Baisakh	Jestha	Asar		
Haripurwa M	0	75	0	35	0	0	0	0	110	0
Chandranagar RM	35	32	48	62	32	0	0	0	177	32
Samsi RM	21	49	55	65	75	106	20	0	190	201
Ekdara RM	43	30	24	31	0	0	0	0	128	0
Tikapur M	39	51	41	34	18	0	0	0	165	18
Ghodaghodi M	20	28	35	20	0	0	0	9	103	9
Dipayal Silgadhi M	22	22	24	29	26	19	12	24	97	81
Phurwichauki RM	9	2	6	14	4	14	4	2	31	24
Safebagar M	1	0	2	1	0	10	0	1	4	11
Mellekh RM	27	3	11	11	6	9	8	10	52	33
Total	**217**	**292**	**246**	**302**	**161**	**158**	**44**	**46**	**1057**	**409**

Health Budget at Federal Level

TABLE 23: HEALTH BUDGET AT FEDERAL LEVEL				
Budget heading	**Federal**			
	2019/20 (2076/77)		**2020/21 (2077/78)**	
	Allocation	**Expenditure**	**Allocation**	**Expenditure**
Total Budget (in Million)	1,532,967	1,073,350	1,474,645	
Health Sector Budget (in Million)	82,273	66,683	115,062	
Reproductive Health and Safe Motherhood (in Million)	744	565	1,282	
Child Health Programmes	3,058	2,324	3,281	
COVID-19 Prevention and Control (in Million)	5,701	4,798	7,150	

Health Budget at Provincial Level

TABLE 24: HEALTH BUDGET AT PROVINCIAL LEVEL								
Budget heading	**Province***							
	2019/20 (2076/77)				**2020/21 (2077/78)**			
	Conditional		**Province**		**Conditional**		**Province**	
	Allocation	**Expenditure**	**Allocation**	**Expenditure**	**Allocation**	**Expenditure**	**Allocation**	**Expenditure**
Total Budget (in Million)	117,456	93,876	140,307	100,658	102,985		161,221	
Health Sector Budget (in Million)	4,878	4,146	7,955	6,364	4,530		7,703	
Reproductive Health and Safe Motherhood (in Million)	860	731	91		1,188		100	
Child Health Programmes	1,509	1,282	231		1,026		254	

Health Budget at Local Level

TABLE 25: HEALTH BUDGET AT LOCAL LEVEL								
Budget heading	**Local****							
	2019/20 (2076/77)				**2020/21 (2077/78)**			
	Conditional		**Local**		**Conditional**		**Local**	
	Allocation	**Expenditure**	**Allocation**	**Expenditure**	**Allocation**	**Expenditure**	**Allocation**	**Expenditure**
Total Budget (in Million)	14,299	12,165	402,307	321,846	24,542		431,505	
Health Sector Budget (in Million)	21,230	18,045	7,502	5,117	25,411		10,000	
Reproductive Health and Safe Motherhood (in Million)	2,497	2,123	1,021	697	2,399		1,374	
Child Health Programmes	1,166	991	339	231	825		417	

ANNEX C: SOCIAL PROTECTION

Type of social security allowances

TABLE 26: TYPE OF SOCIAL SECURITY ALLOWANCES WITH AMOUNT

S.N.	Type of SSA	Amount
1.	Senior Citizen Allowance (Dalit)	2000
2.	Senior Citizen Allowance (Single Women)	2000
3.	Senior Citizen Allowance (above 70 years)	3000
4.	Senior Citizen Allowance (area specified)	2000
5.	Disability Allowance "Ka" Category	3000
6.	Disability Allowance "Kha" Category	1600
7.	Widow allowance (Financial support)	2000
8.	Endangered Indigenous People Allowance	3000
9.	Child Protection Allowance (Child Nutrition Allowance)	400

Source: https://donidcr.gov.np/Home/SocialSecurity

Social assistance during COVID-19 pandemic

TABLE 27: SOCIAL ASSISTANCE SUPPORT DURING COVID-19 PANDEMIC BY NAME OF MUNICIPALITIES, SUPPORT RECEIVED, TARGET POPULATION AND TOTAL NUMBER OF BENEFICIARIES

S.N.	Name of municipalities (M)	Province	Support received	Target population	Total number of beneficiaries
1.	Haripurwa M	2	Food commodities and cash	Impoverished households	-
2.	Chandranagar RM	2	Food commodities	Impoverished households	2240
3.	Samsi RM	2	Food commodities	Impoverished households	1283
4.	Ekdara RM	2	Food commodities	Impoverished households	-
5.	Tikapur M	Sudurpaschim	Food commodities and soaps	Impoverished households, students staying in the rent and informal workers	3746
6.	Ghodaghodi M	Sudurpaschim	Food commodities and soaps	Informal workers and impoverished households	3649
7.	Dipayal Silgadi M	Sudurpaschim	Food commodities and soaps	Informal workers and impoverished households	1662
8.	Purwichawki RM	Sudurpaschim	Food commodities and masks	Food commodities to impoverished households and masks to all families	1225
9.	Safebagar M	Sudurpaschim	Food commodities	Impoverished households	-
10.	Mellekh M	Sudurpaschim	Food commodities	Impoverished households	-

-Data not available at the municipal office

Impact of COVID-19 pandemic on PMEP at study Palikas

TABLE 28: IMPACT OF COVID-19 PANDEMIC ON PMEP AT MUNICIPALITES WHERE THE STUDY WAS CONDUCTED

Municipality	Impact	Remarks
Haripurwa M	No	As municipal assembly was not conducted, PMEP has not been conducted this year and no beneficiaries has been selected yet.
Chandranagar RM	No	As there was a delay in releasing the budget from the Palika, PMEP has not been conducted this year. Although selection beneficiaries have been done.
Samsi RM	No	As there was a delay in releasing the budget from the Palika, PMEP has not been conducted this year.
Ekdara RM	No	As Palika does not have a staff, PMEP has not been conducted this year.
Tikapur M	No	As Tikapur M usually conducts the PMEP in 2nd quarter (Mangsir-Falgun), PMEP program has not been conducted this year. The programme will be conducted in 2nd Quarter. However, beneficiaries are being selected. There was no impact of COVID-19 last year.
Ghodaghodi M	Yes	PMEP programme began in Chaitra last year, however, it had to be stopped and the rest of the programme will be conducted on Jestha. Currently, beneficiaries are being selected.
Dipayal Silgadhi M	Yes	PMEP programme began in Chaitra last year, however, it had to be stopped and the rest of the programme will be conducted on Jestha. Currently, beneficiaries are being selected.
Purwichauki RM	Yes	As the budget for PMEP was transferred to budget to COVID-19 budget, PMEP program could not be conducted in last fiscal year (FY). It is yet to be conducted in this FY.
Safebagar M	Yes	As there was a risk of transmission of infection, small groups were formed instead of large groups. Additionally, groups were mobilised in alternative weeks to control the spread of COVID-19 infection. This year PMEP is being conducted.
Mellekh RM	Yes	As there was a risk of transmission of infection, small groups were formed instead of large groups. Additionally, groups were mobilised in alternative weeks to control the spread of COVID-19 infection. This year PMEP is being conducted.

Sample palikas and tools to be implemented for health and sp

Province	District	Palikas	Number of Tools to be implemented for Health								Tools for Both	Number of Tools to be implemented for Social Protection						
			Health Facility checklist	Follow up on Service users (Semi structured interview)	Exit client checklist	KII Service Provider	KII health coordinator	KII with provincial health directorate	KII with provincial MoSD-Health	KII with federal government (MoHP)	KII local government representatives Health & SP	Follow up service users SP Semi structured interview	Exit Client SP	KII with Ward officers	KII with SP personnel at palika	KII with I/NGOs working in the local area	KII with MoSD-SP	KII with Federal government MoFAGA
Province 2	Sarlahi	Haripurwa	1	2	2	1	1	1	1	1	1	2	2	1	1	1	1	1
		Chandranagar	1	2	2	1	1				1	2	2	1	1			
	Mohattari	Samsi	1	2	2	1	1				1	2	2	1	1	1		
		Ekdara	1	2	2	1	1				1	2	2	1	1			
Province 7	Kailali	Tikapur	1	2	2	1	1				1	2	2	1	1	1		
		Ghodaghodi	1	2	2	1	1	1	1		1	2	2	1	1		1	
	Achham	Mellekh	1	2	2	1	1				1	2	2	1	1	1		
		Danphebagar	1	2	2	1	1				1	2	2	1	1			
	Doti	Dipayal Silgadhi	1	2	2	1	1				1	2	2	1	1	1		
		Purbichauki	1	2	2	1	1				1	2	2	1	1			
Total			**10**	**20**	**20**	**10**	**10**	**2**	**2**	**1**	**10**	**20**	**20**	**10**	**10**	**5**	**2**	**1**

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