Covid-19 experiences and activities in Nepal

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This paper begins with a report of the personal experiences by the author, a COVID-19 focal person from the Health Office Kathmandu, Nepal, and how this office has met the crisis created by the pandemic. The second part details overall nursing experiences during the COVID-19 response.

PART I: HEALTH OFFICE KATHMANDU

With a population of nearly two million people, Kathmandu is the largest city and capital of Nepal, located in Kathmandu District with ten municipalities and one metropolitan city.1 The first COVID-19 case was reported on January 23, 2020, in Kathmandu, Nepal, from a student returning from Hubei China.2 The second case appeared two months later, on March 17, 2020, in a person returning to Nepal from France. The first community transmission was detected on April 4, 2020. From the month of May 2020, new case identification has been greatly increased due to the increased capacity of testing as well as community transmission in parallel.

As the news of China’s declaration of COVID-19 as a pandemic spread across the world, it became obvious that the threat of the virus transmission in Nepal would increase because of the shared northern border of Nepal with China. The only international airport in Nepal is in Kathmandu, and the district is densely populated with much movement of people inside and outside the country. Thus, Kathmandu was highly vulnerable to the virus transmission. As a result, the Government of Nepal as well as the Health Office Kathmandu began actively working for the prevention and management of this threat. The first step was to assign a Public Health Nurse Officer as the focal person for COVID-19 management. I was that person and was chosen because I was a trained EpiNurse (epidemiology nurse) with skills in disaster management. I was also appointed as an executive member of the District COVID-19 Crisis Management Committee (DCCMC) of Kathmandu district, which had become active in the prevention and control of COVID-19.

A Rapid Response Team (RRT) was formulated at the district and municipal levels, after which various programs of disease prevention, control, and management were conducted. Initially these included carrying out awareness programs for department chiefs of all the municipalities of the Kathmandu district, local level health workers, female community health volunteers, and mothers’ groups. Similarly, we mobilized school health nurses to conduct awareness programs for students, teachers, and parents to prevent, control and manage COVID-19 using banners, pamphlets, posters, social and mass media. We also listed different resources: the number of hospital beds including Intensive Care Units (ICU) and ventilators, numbers of available ambulance services, available human resources, suggestions for quarantine and isolation centers, and possible high-risk areas. Similarly, the Health Office Kathmandu coordinated with all the stakeholders such as municipalities, hospitals, and external developmental partners to plan for the possible spread of the virus.

After detection of the first case in Kathmandu, the government and Health Office Kathmandu started to work immediately. The Health Office helped to established health desks at national and international entry and exit points for screening of suspected COVID-19 cases and collection of samples for polymerase chain reaction (PCR) testing (Fig. 1). All suspected and confirmed cases were quarantined and isolated. Nurses were key health workers here. We helped in establishment of central- and municipal-level quarantine and isolation centers. One of
my responsibilities as the COVID-19 focal person was to lead in capacity building programs, orientation, and the training and on-site coaching for district level officers, local leaders, public health volunteers, rapid response teams (RRT), and Case Investigation and Contact Tracing (CICT) teams. I was also responsible for COVID-19 case management, holding center and ambulance management, sample collection, waste management, Infection Prevention and Control (IPC), logistic management, and coordination with different sectors (Fig. 2). Much of our work involved recording, reporting, monitoring, and supervision. We also wrote COVID-19 related guidelines, protocols, and reports as per need.

Significantly, nurses comprised most of the management team in the Kathmandu district, with only a few other health personnel available. We had to manage around 2000 cases per day, do case investigations and tracing of all positive cases, and help in sample collections for all the suspected cases. Nurses also established call centers to provide health services for those who were in home isolation, and we organized psychological counselling for COVID-19 patients and their families. We also had to do regular monitoring, supervision, and logistical support for quarantine sites, isolation centers, health desks, holding centers, hospitals, and entry points (Fig. 3). We conducted training sessions for ambulance drivers regarding how to handle COVID-19 patients and how to use Personal Protective Equipment (PPE) sets and how to disinfect the ambulance.

As an EpiNurse, I had experiences in prevention and management of patients with communicable diseases and vector-borne diseases, and thus I decided to work on COVID-19 issues. Many health care professionals were afraid, and most knew little about the disease. Thus, I became the focal person of the Kathmandu district for the prevention and management of COVID-19. This was in addition to my regular job description of managing reproductive health programs, other disasters, the Early Warning and Reporting System (EWARS), and school health nurse programs. The job also included implementation of a minimum service standard in all health facilities in the district; and implementation of sanitation, infection prevention, waste management, and capacity building of health workers. Assessment, planning, implementation, and evaluation of public health programs were important, as well as monitoring and supervision of governmental and non-governmental health facilities, coordination with different sectors, district health information management, facilitation of information to volunteers and health related students, and the responsibility of being an information officer.

One of the first tasks I carried out was capacity building of health workers regarding COVID-19 prevention and management. This included orientation.
programs for DCCMC, RRT, local leaders, public health volunteers, school health nurses, and the case management team (Fig. 4). This also included training in case investigation and contact tracing; sample collection; IPC and waste management; setting up meetings among DCCMC, local leaders, and municipality chiefs; and onsite coaching as per need. At the same time, I was responsible for devising an awareness program that included district level orientation about COVID-19 to health department chiefs of all municipalities and Kathmandu metropolitan city officials. Education and communication materials were distributed through different mass and social media outlets. In carrying out capacity building and awareness programs, we faced various challenges, which included no budgets and lack of standard guidelines and protocols.

My position involved other duties. One responsibility was the supervision and monitoring of entry points of the Kathmandu district, providing logistical support as needed. This was very challenging because of the scarcity of PPEs, thermal guns, and other necessary equipment and supplies. It was also difficult to visit entry points because of strict lockdowns and lack of transportation facilities to get to the entry areas. Thus, I had to coordinate with many different stakeholders. Alongside the central and local governments, I also was responsible for the management of quarantine and isolation centers (Fig. 5). Duties included regular supervision and monitoring along with providing help for disinfection and other logistics. The greatest challenge was the lack of support from the local community because of fear of the virus, making it very difficult to convince them of the need to establish such centers.

The government of Nepal decided to rescue its citizens who were facing difficulty in foreign countries due to lockdown, but it had to do so without transmission of the virus. Thus, special holding centers were established in different places of the Kathmandu district. The responsibility of health checkups, counselling, and screening for COVID-19 was given to the Health Office Kathmandu. Due to limited number of health workers in the office, however, we requested school health nurses of Bagmati province to work in the holding centers. This, too, was challenging because of the lack of trained human resources, lack of logistical supply systems, limited transportation, lack of budgets, and fear of infection by the workers. Despite these challenges, the nursing team showed great dedication and hard work and effectively served 150,000 people.

One of the most challenging tasks was the management COVID-19 positive cases. We mobilized RRT, the CICT team, public health volunteers, school nurses, and ward leaders to provide health services and proper counselling to these patients. In a single day, we had to manage more than 2,000 cases, often having to call in 200 people in a day, which means each member of CICT team often having to call 200 people per day due to insufficient staff. This proved to be mentally tiring for the nurses, but we put in extra effort without additional incentives.

Case management was difficult because of inadequate isolation and hospital beds, few ambulance services, lack of oxygen supply, few adequately educated critical care staff, little knowledge about the disease, and social stigma. Initially patients infected with COVID-19 were sought like fugitives and brought to hospitals after tracing them. As a nurse, I had to make difficult decisions. For
example, I remember a case when a nurse tested positive but was reluctant to go to the hospital. She was adamant that she would quarantine herself at home. At that time, however, the government of Nepal had no provision for home quarantine due to high social stigmatization in the community. As a result, I counselled her for four hours and eventually was successful in convincing her to go to the hospital for isolation. There were others who had COVID-19, such as pregnant and postnatal women who did not want to be hospitalized. Again, we counselled them for many hours to get them to the hospital, which was a very painful situation for us.

Nepal’s COVID-19 policies are changing frequently as more is learned about the disease in real-time. This often creates uncertainty and misinformation among the people. At the initial stage, for example, testing and tracing proceeded smoothly when the procedures were free of cost, yet the situation became more confusing when the government stopped free testing and treatment. Nepal is a developing country, does not have the resources to provide treatment for free all. Free services are only for those people who are poor, vulnerable, marginalized and unable to afford health services. The disease has made it clear that, in a country such as Nepal, it has been necessary to make clear policy regarding health care service. Proper rules are needed as to who gets free health services and who must pay. There should be better assessment processes for categorizing the status of testing and treating people. Thus, while making decisions, policymakers must consider the larger picture rather than short-term issues.

Due to the high number of cases and the shortage of ambulances, we created an ambulance service dedicated specifically for COVID cases. This required providing orientation to ambulance drivers regarding infection prevention and control and safe transportation of the patients. All drivers were provided with PPE sets and disinfectants.

Building on all the logistical problems associated with COVID-19 management, I was assigned to direct the dispersion of masks, gloves, visors, goggles, caps, gowns, boots, sanitizers, PCR test kits, thermal guns, health kits, and oxygen supplies. We also had to set up logistical systems to manage caring for the dead, handling the shortage of PPEs, dealing with increased black marketing, and managing not getting supplies from outside the country due to lockdown. Indeed, worldwide demand was high, and supply was low. To tackle these challenges, I had to coordinate daily with different stakeholders, especially to decrease black marketing of supplies.

Other responsibilities included preparation of COVID-19 guidelines, protocols, and reports. Because of the stigma and discrimination in the community, however, it was very difficult to get complete information of patients and their contacts due to barriers such as phone switch-offs, wrong information, incorrect phone numbers and addresses, and duplication of reports. Receiving information from all eleven municipalities and the metropolitan city, province, and federal governments also proved difficult. And reporting formats were changing frequently by different concerned authorities, which made it challenging to accomplish work on time.

In Nepal, the first phase of COVID-19 vaccination programs began on January 27, 2021. For the vaccination program we have listed the target groups (health workers, cleaning /waste management staffs, ambulance drivers, geriatric home personnel, prisoners, mortuary teams, female community health volunteers, etc.) who were eligible to get the vaccine in first phase. At the same time, we had selected twelve tertiary level hospitals for vaccination centers, each with an assigned vaccine coordinator and Adverse Event Following Immunization (AEFI) coordinator. Prior to the vaccination campaign, an orientation program was conducted for the vaccinators and AEFI teams. Due to the lack of standard cold chain facilities, which were needed to preserve and store the vaccine, we had to supply vaccines to all centers every day in the early morning and record and report our practices each evening. Managing crowds was very difficult because people who were not in the target groups were also demanding the vaccines.

**PART II: NURSES’ ISSUES AND PROBLEMS**

The burden of work for nurses in Nepal has been huge. I have often had to be on duty day and night. Sometimes I received calls for help from patients in the middle of night, with some stating they would die on the road if I did not attend them. Thus, there have been many challenges. In addition to transportation problems and social stigmatization, nurses have faced conflicts within their own families due to long working hours. In Nepal, most nurses are female, and they have many responsibilities trying to blend professional roles, household work, and childcare. Due to these burdens, nurses, including myself, have faced misunderstanding and arguments in our families, which have exacerbated during the COVID-19 pandemic. Some of my family members discouraged me from working in COVID-19 management because I had a daughter who was under two years old. I usually went to my office early in the
morning and returned home after 10:00 p.m., and thus had limited time to spend with her. Family members also feared that I might spread COVID-19 at home. One of the most painful moments I experienced was a brutal two-wheeler accident while visiting isolation centers. I was injured badly, and the physician advised me to rest for a few days. As a focal person, however, the burden of work was very high so, I did not have an option to take rest. Indeed, taking rest in this crisis was not my priority because we were in the battlefield of COVID-19. Although people in my community did not express being uncomfortable with me as I led the mothers’ groups in my residential area, they did express concern when they had not seen me for some time when I went for field visits. They asked questions like, was I was quarantining or isolating after infection?

We know we are not alone, as COVID-19 has affected all dimensions of human life across the world. Yet the developing nation of Nepal has been severely affected. A growing number of confirmed cases and casualties have occurred in recent days. The country is in a very vulnerable situation due to low health literacy among the general people, poor housing and overcrowding in urban areas, a fragile health system with a shortage of adequately qualified frontline health care personnel, and poor diagnostic capability of laboratories.

In this deadly pandemic, the frontline health care workers, especially nurses, are leading the battle against the virus. Yet the nursing profession in Nepal, with its focus on general and public health nursing, does not have any specialization and training in disaster nursing. Nurses are still regularly performing duties in their respective health facilities and hospitals. They carry out reproductive health services, manage COVID and non-COVID-19 cases in hospitals or isolation centers, and work in entry and exit portals of airports and borders. Some are working in risk communication and information management or logistics management, management of vaccines, case management and investigation and contact tracing. Others are taking the responsibility of district disaster management as a focal person, and many are working as counselors and health promoters in various areas of the country.

Because nurses are engaged in the care of COVID-19 patients due to close contact in the first phase of the pandemic, high numbers of nurses have been infected with the virus. As noted above, the government of Nepal has prioritized nurses and other health care workers in the first phase of the national vaccination campaign. Nurses received the first dose of the vaccine in January 2021 and completed the second dose in April. Unfortunately, the second wave of COVID-19 started in April 2021, creating an even more devastating situation by increasing the infection rate and mortality in the country. All the hospitals were filled completely with COVID-19 patients, and nurses’ duties increased even more. Whereas typically the nurse-patient ratio in Nepal is very low, during the pandemic one nurse had to see twenty to thirty patients each. During the second wave, this number increased even more.

Being in the nursing profession in a developing country like Nepal is difficult. In addition to family conflicts, nurses face many issues such as low salary, excessive workload, and little to no incentives and motivation during the time of pandemic. In addition, we are facing various physical and psychological violence while performing our duties. In the last week of May 2021, for example, relatives of a deceased patient attacked nurses and doctors in the Bheri Hospital of Banke district, leaving them injured; and four of the health workers jumped from the first floor to save their lives. This situation is repeated frequently, with incidents of violence growing daily. As nurses face physical and psychological violence, our motivation declines as we are victims of harsh words from the people around us. As an example, the stigma that follows nurses has led some landlords to prevent nurses from entering their rented homes. Indeed, stigma is a major reason for mental health outcomes such as stress, anxiety, fear, and insomnia. Indeed, one study revealed that the prevalence of anxiety among nursing staff was 43.6%.

Nurses are ready to work hard, but the fear of contagion, stigmatization, and social isolation is demoralizing. We have requested every stakeholder to support the health worker in combating this deadly pandemic together. Despite overwork and low salary, nurses remain ready to save lives and make our country healthier and happier. We have the capability to fight against the pandemic. Our hope is that the government of Nepal will take quick steps to save lives from this deadly virus as people continue to die from lack of beds, oxygen, or availability of intensive care units. The health care environment in hospitals and health care centers—from patients to health workers, including nurses—should be addressed. We are hopeful the day will come when the government of Nepal will understand the importance of nurses and will address all the issues regarding our profession. Last, but not least, the Nepalese people should get quality health care so that no one will die because of lack of access to proper facilities and quality health services.

On the positive side, health care systems at the central
and local levels are changing in post-COVID Nepal. In the past, local level authorities were more focused on construction of physical infrastructure such as roads. Because of COVID-19, however, officials now realize that health is equally important, and greater allocation of funds has resulted for the health care sector. This is now happening at the central level, as authorities are investing in preparedness programs; and at local levels, where aid packages for non-communicable diseases like chronic obstructive pulmonary disease, diabetes mellitus, cancer, cardiovascular disease and mental health problems have increased.

Finally, I am grateful and honored that my hard work has paid off. The Kathmandu District COVID-19 Crisis Management Centre has acknowledged my contribution and recommended me for the President Award, and I received it (the Prabal Janasewa Shree Chaturth Medal and Certificate) by Rt. Honorable President of Federal Democratic Republic of Nepal, Mrs. Bidya Devi Bhandari (Fig. 6). This is one of the highest civilian awards of Nepal, having been awarded to personalities from different walks of life in recognition of their exemplary contribution to the country. The award was presented at a special ceremony organized by the Ministry of Home Affairs at the office of the President residence.

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