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Human Resources for Health Strategic Plan 2011-2015

Draft

Strengthening Health Systems-Improving Services

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ACRONYMS

AA	Anaesthesia Assistant
AHP	Allied Health Professional
AHW	Auxiliary Health Worker
AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Clinic
ANM	Auxiliary Nurse Midwife
ASRH	Adolescent Sexual and Reproductive Health
AWPB	Annual Work Plan and Budget
BCC	Behaviour Change Communication
BME	Bio-Medical Equipment Training
BOR	Bed Occupancy Rate
BPKIHS	B.P. Koirala Institute of Health Sciences
CCF	Country Coordination and Facilitation
CEOC	Comprehensive Emergency Obstetric Care
CME	Continuing Medical Education
CPD	Continuing Professional Development
CPR	Contraceptive Prevalence Rate
CSO	Community Service Organisations
CTEVT	Council of Technical Education and Vocational Training
DHO	District Health Officer
DPHO	District Public Health Office
DoCPR	Department of Civil Personnel Records
DoHS	Department of Health Services
EDP	External Development Partner
EHCS	Essential Health Care Services
EPI	Expanded Programme on Immunisation
FCHV	Female Community Health Volunteers
FP	Family Planning
FY	Fiscal Year
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HA	Health Assistant
HDI	Human Development Index
HFOMC	Health Facility Operations and Management Committee
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
HP	Health Posts
HR	Human Resources
HRH	Human Resources for Health
HRP/M/D	HRH Planning, Management and Development
HRM	Human Resource Management
HuRIS	Human Resource Information System
INGO	International Non-Governmental Organisation
IST	In-Service Training
IT	Information Technology
LATH	Liverpool Associates in Tropical Health
M&E	Monitoring and Evaluation

MBBS	Bachelor of Medicine Bachelor of Surgery
MCH	Maternal Child Health
MCHW	Maternal and Child Health Worker
MD	Medical Doctor
MDG	Millennium Development Goal
MDGP	Medical Doctors-General Practice
MISP	Minimum Initial Service Package
MMR	Maternal Mortality Rate
MNCH	Maternal Neonatal Child Health
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
MoLD	Ministry of Local Development
MoU	Memorandum of Understanding
NCDs	Non-communicable Diseases
NDHS	National Demographic and Health Survey
NGO	Non-Governmental Organisation
NHSP	Nepal Health Sector Programme
NHSP-IP	Nepal Health Sector Programme-Implementation Plan
NHTC	National Health Training Centre
NRs	Nepali Rupees
NSI	Nick Simons Institute
O&M	Operations and Management
OPD	Out Patient Department
ORC	Outreach Clinics
OT	Operation Theatre
OTTM	Operation Theatre and Technical Management
PIS	Personnel Information System
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PSC	Public Service Commission
PST	Pre-Service Training
PPP	Public Private Partnership
RHTC	Regional Health Training Centre
SAS	Safe Abortion Service
SBA	Skilled Birth Attendants
SLTHP	Second Long-Term Health Plan
SHPs	Sub Health Posts
STS	Service Tracking Survey
SWAP	Sector Wide Approach
TB	Tuberculosis
TC	Technical Committee
TIS	Training Information System
ToR	Terms of Reference
TU-IOM	Tribhuvan University Institute of Medicine
TWG	Technical Working Groups
UN	United Nations
UNDP	United Nations Development Programme
USD	US Dollars
VDC	Village Development Committee

VHW	Village Health Worker
WHO	World Health Organisation

Exchange Rate December 2011

Rs 100 = USD 1.2

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BACKGROUND

There is a diverse range of factors that influence the Human Resources for Health (HRH) situation in Nepal. On the demand side expanding health service needs; new and emerging diseases, infrastructural development, infrastructural development, population and changes in the distribution of population, and new technologies are important factors influencing the demand for human resources. Supply side factors that influence the availability of health workers include the number and type of health workers produced through the education and training system, labour market dynamics, private and Non-Governmental Organisation (NGO) participation in service delivery, and the flow and movement of health workers.

Other developments, including national legislation and global initiatives will have an influence on HRH policies and plans, such as the Millennium Development Goals (MDGs), the World Health Organisation (WHO) Global Code of Practice on the International Recruitment of Health Personnel[1] and Global Policy Recommendations on 'Increasing access to health workers in remote and rural areas through improved retention'[2], National Health Policy 1991, Civil Service Act 1993, Health Services Act 1997, the 20-year Second Long-Term Health Plan (SLTHP) for FY 1997-2017, Local Self-Governance Act 1998, the 2003-2017 Strategic Plan for Human Resources for Health, the Nepal Health Sector Programme (NHSP) 2004 – 2010, Good Governance Act 2007, Interim Constitution, 2007, the Three Year Plan (2010/11 – 2012/13)[3] and the NHSP-2 2010 – 2015[4]. In addition the evolving decentralisation and federalism processes will have implications for future HRM policies and systems.

In developing the HRH Strategic Plan these developments, opportunities and challenges have been taken into consideration. The Plan provides an analysis of the current HRH situation in Nepal and presents strategies and activities for addressing current and future HRH issues and challenges.

[1] (http://www.who.int/hrh/migration/code/practice/en/)
[2] WHO (2010). Global Policy Recommendations - Increasing access to health workers in remote and rural areas through improved retention. WHO, Geneva.
[3] Government of Nepal National Planning Commission (2010). Three Year Plan Approach Paper (2010/11 - 2012/13)
[4] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme - Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

DEVELOPMENT OF THE PLAN

The NHSP-2 identifies a number of HRH challenges and constraints that are affecting the delivery of health services and the achievement of health outcomes. It proposes a range of strategies and issues to address these challenges in the 5-year plan period. It recommends that the staffing projections made in the 2003 Strategic Plan for HRH[5] be reassessed in light of the evolving political, policy and health environment.

In 2010 the Ministry of Health and Population (MoHP) established a Country Coordination and Facilitation (CCF) mechanism and began work on developing a new HRH Strategic Plan (2011-2015) to address some of the long-standing HRH problems. The MoHP adopted the 2009 Global Health Workforce Alliance's CCF principles and process to guide the development process.[6]

At the start-up workshop with key MoHP officials and other stakeholders in November 2010 five key HRH problem areas and issues were identified:

- Shortages of HRH as a result of imbalances between supply and demand
- Maldistribution of staff, especially in remote and rural areas
- Poor staff performance, including productivity, quality, and availability
- Fragmented approaches to human resource planning, management and development
- HRH Financing

Workshop participants agreed that these would be the priority areas to be addressed through the new HRH Strategic Plan. A Technical Committee (TC) and five Technical Working Groups (TWGs) (see Annex 1 for membership) were formed to coordinate and develop the HRH Strategic Plan. Participants agreed that a longer-term Health Workforce Plan and HRH projections would be developed once more comprehensive information on the health workforce were available. The Workforce Plan will be developed during Year I of the implementation of the HRH Strategic Plan.

Participants agreed a road map to guide the Plan development process. This included further data collection and analysis by the five TWGs and consultations with the Technical Committee and the wider CCF membership.

In March 2011 the TWGs reported on progress to a meeting of the TC, chaired by the Secretary, Dr Mishra.[7] The process of developing the Plan was endorsed and the following feedback provided:[8]

[5] Ministry of Health (2003). NEPAL Strategic Plan for Human Resources for Health 2003-2017.
[6] Country Coordination and Facilitation (CCF) - Principles and Process on human resources for health (HRH) for an integrated health workforce response
[7] Bista, B. G. (2011). Human Resources for Health: the process of developing HRH strategic plan - status reporting (4 March 2011), NHSSP.
[8] Ministry of Health and Population (2011). Milestone 7: Periodic Review on the development of the HR Plan (Draft) Martineau, T. and Bista, B.G.

- The Plan will be for four years, from mid 2011 to mid 2015, to coincide with the end of the Nepal Health Sector Programme (NHSP - 2)
- Both public and private sectors should be included in the Plan, but it should be clear which strategies relate to which sectors[9]
- There will be a mixed set of planning assumptions, not based only on population[10]
- While the problem analysis may have led to a different structure of strategies, these should be clearly related to the common HR areas of recruitment, retention, training, etc.
- The HRH plan should be fully aligned with NHSP-2, which already includes a number of HR strategies and other service delivery related strategies that need to be supported by the HRH Strategic Plan.

Following the meeting of the TC, the TWGs undertook further work to consolidate, prioritise and cost the strategies and activities in the Plan.[11]

The MoHP adopted a multi-stakeholder process for the development of the Plan. The draft Plan was disseminated to stakeholders for review and was revised several times to incorporate staekholders comments and feedback. It was disseminated internally within the MoHP and then to other government ministries and agencies, External Development Partners (EDPs) and CCF members (Annex 3 provides a list of stakeholders consulted). The MoHP will continue to maintain these multisectoral and collaborative approaches throughout the implementation and review cycles of the Plan.[12]

As set out in the CCF principles, the HRH situation analysis contained in this HRH Strategic Plan is based on an analysis of information that was available mainly on the public health workforce and an examination of trends within the political, socio-economic, legal and organisational context. Information on the private and NGO sectors was not available at the time of developing the Plan but data will be collected and these data and the findings of the 2011 Service Tracking Survey and other surveys will help to produce a more comprehensive overview and profile of the entire heath workforce. This new information will also inform the development of the Annual Work Plan and Budget (AWPB) for 2013 and onwards.

A more comprehensive profile will be critical for determining future HRH requirements and for developing a Health Workforce Plan. Gender and social inclusion data will be considered to ensure that HR planning, management and development decisions take cognizance of marginalised groups. The HRH Information System (HuRIS) will be strengthened to provide a more reliable source and repository for HR information and will enable planners and

[9] E.g. retention strategies might only be targeted at the public sector, whereas the staffing projections will cover the whole sector.

[10] These might include population growth (this has increased 35% between 1991 and 2008, while the number of health workers has increased only by 3.4%.); facility plans (upgrading of health and sub-health posts and PHCCs to community hospitals), changes in serviced delivery (e.g. the introduction of 24/7 services in some facilities), creation or absorption of new types of posts (e.g. anaesthetist assistants); and probably the absorption of contract staff to permanent positions.

[11] HRH Workshop Report June 25/26 2011

[12] Country Coordination and Facilitation for Human Resources for Health. Institution Capacity Building. 12th - 15th July 2010, Cairo, Egypt

managers undertake more effective workforce planning and monitoring of the HRH situation.

The MoHP will translate and prioritise the strategies and activities contained in the HRH Strategic Plan into costed time bound interventions that will be included in the Annual Work Plan and Budget (AWPB).

A Monitoring and Evaluation (M&E) Plan will be developed for the implementation of the Plan that is aligned with the targets and indicators contained in the NHSP-2 and other review and monitoring mechanisms. Indicators will be disaggregated, gender sensitive and inclusive and M&E information used to modify strategies and activities and to inform the design of subsequent plans and interventions.

This Section 1 discusses the context and process of developing the HRH plan. Section 2 describes the current health status and contextual factors in the health environment. It highlights key health polices and plans that are influencing the management and development of HRH. The HRH situation analysis in **Section 3** identifies and examines key HR issues, functions and challenges, including recruitment, deployment, attrition, and training.

Section 4 presents the outputs, strategies and activities that will be implemented to address identified HRH issues and challenges, to achieve agreed outputs and support the implementation of the NHSP-2. The Plan adopts a 4-year timeframe, from mid 2011 to 2015, in order to align it to the NHSP-2 timeframe; however the outputs and strategies are not time-bound and they could continue to guide the development and implementation of HRH plans, strategies and activities beyond this initial four-year period.

Finally, **Section 5** presents issues related to the implementation of the Plan such as risk analysis, implementation arrangements, M&E systems and budgeting and resource mobilisation strategies.

INTRODUCTION

According to the preliminary results of the Population Census of 2011, the population of Nepal is 26.6 million with the annual growth rate of 1.40%. Based on the estimates of the 2007 population the age structure of population is 0-14 years: 38.7%; 15-64 years: 57.6% and 65 years and over: 3.7%. The median age was 20.3 years (male 20.1 years and female 20.4 years).[13] In 2001, 84.1% of the population lived in rural areas and 14.2% in urban areas, but the rate of urbanisation has been increasing rapidly in recent years. _Nepal's Human Development Index is 0.428 with a rank of 138 out of 177 countries[14] and in 2010/11 Nepal has a gross national income of US $ 261 per capita[15]. Twenty percent of its 27 million people live below the national poverty line.

Nepal is broadly divided into three horizontal ecological belts, namely, Mountain, Hill, and Terai. Vertically it is divided into five development regions and administratively into 75 districts, which are further divided into smaller administrative units known as Village Development Committees (VDCs) and municipalities. The VDCs and municipalities are further divided into wards.[16] At the district level, departmental or ministry offices oversee plans and programmes for that sector. The District Health Officer is responsible for all health activities of the district including the organisation and management of district hospital, PHCs, HPs and SHPs.

NATIONAL AND HEALTH POLICY FRAMEWORKS

Nepal has a fairly comprehensive framework of health policies, strategies and plans in place. The main components of the framework are: the National Health Policy 1991; Second Long-Term Health Plan (1997-2017); Ninth Five Year Plan (1997-2002); Medium-Term Expenditure Framework; Nepal Health Sector Programme, Tenth Plan (Poverty Reduction Strategy Paper) 2002-2007; and Health Sector Strategy – an Agenda for Reform 2004.

The Interim Constitution of Nepal 2007

Nepal has made a political commitment for the health of the people at the highest level by declaring 'Basic health a fundamental right of its people' in the Interim Constitution of Nepal 2007. The right to health is stated in 9 out of 31 proposed fundamental rights in the constitution.

13 WHO Country Office for Nepal (2007). Health System in Nepal: Challenges and Strategic Options
14National Planning Commission/UNDP (2011). Millennium Development Goal Needs Assessment for Nepal 2010
15 Economic Survey, 2010/11 published by Ministry of Finance
16Population Division, Ministry of Health and Population (2011). Nepal Demographic and Health Survey 2011 Preliminary Report

The National Health Policy 1991

The National Health Policy (1991) provides a framework to guide health sector development. It aims to extend the primary health care system to the rural population so that they can benefit from modern medical facilities and services from trained health care providers.[17]

20-year Second Long-Term Health Plan (SLTHP) 1997-2017

The Ministry of Health and Population's (MoHP) 20-year Second Long-Term Health Plan (SLTHP) for FY 1997-2017 guides health sector development for the overall improvement of the health of the population. It is based on Primary Health Care principles and aims to improve the health status of the most vulnerable groups.[18] It defines a cost-effective package of Essential Health Care Services (EHCS) to address the most essential health needs of the population. It aims to provide technically competent and socially responsible health personnel in appropriate numbers for quality healthcare throughout the country, particularly in under-served areas.[19]

Free Health Care Policy

As guided by the Interim Constitution Government is providing essential health care services (emergency and inpatient services) free of charge to poor, destitute, disabled, senior citizens and FCHVs in 25-bedded district hospitals and Primary Health Care Centre (PHCCs), and to all citizens at Sub Health Post (SHP)/ Health Post (HP) and PHC level. In order to implement the Free Health Care Policy effectively, the MoHP has introduced operational guidelines based on the new budget policy.

Three Year Plan

The Three Year Plan (2010/2011-2012/2013) seeks to establish the right of the citizen to free basic health care services. Public health issues - preventive, promotional and curative health services - will be implemented as per the principles of primary health services.[20]

The Nepal Health Sector Programme (NHSP)

The MoHP's 'Health Sector Reform Strategy; an agenda for reform 2004' is being implemented through the Nepal Health Sector Programme. The NHSP is a sector wide programme focused on performance results and health policy reforms implemented under a Sector Wide Approach (SWAP), with an agreed set of performance indicators and policy reform milestones for the programme duration. The policy reform milestones are outlined in the Nepal Health Sector Programme Implementation Plan (NHSP-IP).

There are eight outputs in the National Health Sector Programme. Three are related to strengthening health service delivery and five are designed to improve institutional capacity

[17] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010
[18] WHO Country Office for Nepal (2007). Policy Papers on Health, Nepal
[19] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010 p.13
[20] Government of Nepal National Planning Commission (2010). Three Year Interim Plan (2010/11 - 2012/13)

and management, including human resource management.[21] The MoHP is currently implementing the second Plan, the NHSP-2 (2010-2015).

The Health Services Act (1997)

The Health Services Act (1997) makes provisions for the management of health workers employed by the MoHP and provides guidance on the recruitment, deployment, promotion, and discipline of health workers. Since its enactment, the Act has had a number of amendments and the Act appears to have a degree of flexibility that make it responsive to a dynamic and evolving health system and to a diverse and multicultural health workforce. The Act is currently in the process of amendment.

HEALTH FINANCING

The Government consistently increased the health sector's budget during the period covered by NHSP-IP1, from NRs. 6.5 bn in 2004-5 to NRs. 17.8 bn in 2009-10. Government spending on health is high compared to other SEAR countries and as a result fiscal space for further budget expansion is very limited.

In 2009/10 the health sector share of the overall government budget was 6.24% (Rs. 17.84 bn), rising to 7.24% in 2011. There has been an increasing shift of funds to the 75 districts and a corresponding reduction to the centre. In 2009 districts received about half of the total health budget directly or indirectly from central funds.

Of the total health sector budget, Rs. 13.42 bn (75.20%) was allocated for the execution of programmes under the Department of Health Services, of which Rs. 12.9 bn (96.52%) was allocated to the recurrent budget, while only 3.48% was was allocated to the capital budget. The External Development Partners' contributions comprised 50.53% of the total budget under Department of Health Services (DoHS).

Over the past three years, the allocation of the health development budget for child and maternal health has increased significantly and Nepal is on track to achieve Millennium Development Goal (MDG) 4, 5 and 6.[22] However the substantial gains achieved in reducing child and maternal mortality will be difficult to sustain without continued external support.

Despite the considerable improvements in the provision of health services and increased funding allocations to districts, public expenditure on health continues to be mainly based on central Government financing and delivery of services. The MoHP has had little opportunity to achieve the vision outlined in the NHSP-IP 2004-2010 of a more efficient and effective decentralised health sector, with greater utilisation of private providers to deliver services. NHSP-2 includes plans to achieve improved governance and accountability to

[21] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010 p. 19
[22] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p. 22

sustain Government and External Development Partner (EDP) support, and make the best use of limited resources.[23]

The MoHP is currently developing a Health Financing Strategy and the budget emphasis is on improving accessibility to health services, especially by remote and vulnerable groups and on the health of children and pregnant mothers.[24] According to the DoHS 2011 Annual Report,[25] more funds will be provided to the social welfare sectors, including health and the present health budget will be increased. Further budget expansion to finance health workforce expansion plans will very much depend on the fiscal space available.

DECENTRALISATION

Nepal is currently transitioning from a unitary system of governance to a federal system and planning is underway for transferring power from the centre to the sub national government. The political and constitutional imperative of provincial autonomy in Nepal's proposed federalist system will be fully supportive of devolving responsibility for health service provision.

The broad objective underlying decentralisation is to bring government closer to the people to empower them and to make service delivery more effective, efficient and equitable. Decentralised health management will help to improve health service delivery with increased level of downward accountability, community ownership and wider coverage giving better access to local people, especially the poor and excluded groups.

The MoHP has already submitted preliminary ideas for the future organisation of the health sector under a federal state. Issues such as the provision and location of services and the role of the central MoHP in a federal state have been highlighted and will need further discussion and consideration. There has already been some progress with the decentralisation and devolution of authority from the centre to the sub-national levels. During 2004/2005 the Ministry handed over 1,433 health and sub-health posts and PHCCs in 29 districts to local health management committees. Semi-autonomous status has been granted to 52 of the 88 public hospitals although the extent of their autonomy varies. In FY 2009/2010 about 58% of the MoHP budget was allocated directly to district programmes.

A 'Strengthening of Local Health Governance Programme' designed and developed by MoHP is being piloted in 7 districts. It includes provisions for providing formula based health grants to district and below, an increased role for local government units and other innovative approaches. This programme is being implemented in collaboration with MLD, concerned District Development Committees and some EDPs. Based on experiences and lessons learned pilot districts will be further expanded in the plan period.

[23]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010
[24] WHO Country Office for Nepal (2007). Health System in Nepal: Challenges and Strategic Options
[25]Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010

According to the DOHS Annual Report 2009/2010 (2066-2067), decentralisation and regionalisation will continue to be strengthened and peripheral units will be made more autonomous.[26] District Health Offices (DHOs) will be given more responsibility for the planning and management of health services from district to village levels. Increased local autonomy will be accompanied by changes in the financing, management and governance of health sector institutions.[27] Management structures and system will continue to evolve, as the political process of federalisation is being agreed and adopted.

[26] Ministry of Health and Population (2011) Department of Health Services Annual Report 2009-2010

[27] Ministry of Health and Population Government of Nepal (2010) Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

HEALTH GOALS AND OUTCOMES

The goal of the NHSP-2 is to improve the health and nutritional status of the Nepali population, especially for the poor and excluded. The three objectives set out in the NHSP-2 results framework are:

1. To increase access to and utilisation of quality essential health care services;
2. To reduce cultural and economic barriers to accessing health care services and harmful cultural practices in partnership with non-state actors; and
3. To improve the health system to achieve universal coverage of essential health services.

Table 1 below shows the main health indicators such as life expectancy by sex, mortality by sex, by age (infant, maternal, under-five), HIV/AIDS prevalence rate and safe drinking water access.

TABLE 1 HEALTH INDICATORS

MDG/Impact Indicator	Achievement						Target
	1991	**1996**	**2001**	**2006**	**2009**	**2010**	**2015**
Life expectancy at birth				62	66	67.3	
Infant mortality (per 1,000 live births)	106	78.5	64	48	41	41	32
Under-5 mortality rate (per 1,000 live births)	158	118.3	91	61	50	50	38
Maternal mortality rate (per 1,000 live births)	539	539	415	281	229	229	134
Immunisation coverage					81	82	90
HIV prevalence among pregnant women aged 15-24 years	NA	NA	NA	NA	NA	0.49	0.35
Malaria annual parasite incidence (per 1,000)	NA	0.54	0.40	0.28	NA	0.15	Halt and reverse trend
Prevalence rate associated with TB (per 100,000 population)	N/A	N/A	N/A	N/A	N/A	244	210
% with access to safe drinking water	N/A	N/A	N/A	N/A	N/A	80.4	73
% with access to sanitation	N/A	N/A	N/A	N/A	N/A	43.0	53.0
% Births attended by skilled health workers (MDG indicator)	N/A	N/A	N/A	19%	33%	36	60.0
% Births in a Health Facility	N/A	N/A	N/A	18	N/A	28	N/A
% PW receiving at least 1 ANC visit	N/A	N/A	N/A	N/A	N/A	87.4	N/A

Source: NHSP II; DoHS Annual Report, 2009-2010; Nepal Demographic and Health Survey 2006 & 2011 and MDG Need Assessment, 2010.

HEALTH STATUS

In spite of the transitional situation, political instability and other challenges, Nepal is likely to achieve six of the eight MDGs by 2015. There has been steady improvement in health outcomes and impact and in equality of access during the first NHSP (2004-10). Nepal met or exceeded nearly all of the outcome and service output targets that were set for 2004-10, and is on track to meet the child and maternal mortality MDGs.[28] In 2010 Nepal received an award from the UN for progress towards MDG 5 and GAVI award for progress in child survival (MDG 4).

Essential Health Care Services (EHCS), available and provided by the HPs, SHPs and PHCCs are free to all. At district hospitals, outpatient, inpatient and emergency services, including medicines, are free of charge to poor, vulnerable, and marginalised groups, and 40 essential medicines are free of charge to all. Institutional deliveries in government hospital and facilities are free of charge to all women.

There was a 35% increase in new outpatient contacts in 2007-8, and increased utilisation by poor and disadvantaged groups following the introduction of free services at PHCCs, health and sub-health posts, and targeted free services at district hospitals. During NHSP-2, several services will be added to the existing EHCS package to further address reproductive and child health problems, communicable and non-communicable diseases, and improve the health status of Nepal's citizens, especially the poor and excluded.

Increasing skilled attendance at delivery is an intervention for reducing maternal mortality. Increasing percentage of deliveries attended by health workers at the national and the regional levels is a positive sign of the effectiveness of programme interventions through the demand and supply side financing. This increase in the percentage of delivery by health personnel could also be explained by the revision of the target population.[29]

The proportion of births attended by a skilled provider over the last five years has nearly doubled, from 19% in 2006 to 36%, while the proportion of babies delivered in a health facility has increased from 18% in 2006 to 28% in 2010. [30]

However there are a number of health issues that continue to cause concern, such as the prevalence of hunger and stunting and the large number of poor and deprived people in Nepal.[31] The delivery of quality health service in remote areas remains a challenge[32] and the health of excluded and very poor populations has not improved as expected. Mortality and

[28]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010
[29] Ministry of Health and Population (2011). Department of Health Services Annual Report 2066/67 (2009-2010) p. 113
[30]Population Division, Ministry of Health and Population (2011). Nepal Demographic and Health Survey 2011 Preliminary Report
[31]Government of Nepal National Planning Commission (2010). Three Year Plan Approach Paper (2010/11 - 2012/13)
[32]Government of Nepal National Planning Commission (2010). Three Year Plan Approach Paper (2010/11 - 2012/13)

morbidity rates, especially among women and children, are high. Nepal still has a significant challenge to meet the MDG target of 60% births attended by a skilled provider.

Many of the health problems are exacerbated by under-utilisation of resources; shortages of adequately trained personnel; underdeveloped infrastructure; poor public sector management; and weak intra- and inter-sectoral co-ordination.[33]

Table 2 below shows the main causes of morbidity and mortality in Nepal.

TABLE 2 MAIN CAUSES OF MORBIDITY AND MORTALITY

Main causes of morbidity	**Main causes of mortality**
Acute Respiratory Infection	Neonatal Deaths
Gastritis	Cancer
Enteric Fever	Suicide
Chronic Bronchitis	Tuberculosis
Cancer	Diabetes
Accidents and Injury	

Source: MoHP 2011

However, the NHSP-2 will continue to build on the successes of the first NHSP and will address the remaining constraints, including HRH constraints, to increasing access and utilisation of essential health care services. There will be a particular focus on tackling disparities between the wealthier population and the poor, vulnerable and marginalised populations.[34]

[33] http://www.mohp.gov.np Country Profile 2009

[34] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

SERVICE DELIVERY STRUCTURES AND MECHANISMS

The government health service operates at national, regional, zonal, district levels and below (e.g. PHCCs, health posts, sub-health posts), as well as at community level. Ayurvedic services are provided at all levels of the health system.

Table 3 below shows the number and location of public and private hospitals, PHCCs/Health Centres, HPs and SHPs providing health services, supported by approximately 50,000 Female Community Health Volunteers (FHCVs). Table 4 shows the increase in the number and type of government facilities since 1991.

TABLE 3 PUBLIC AND PRIVATE HEALTH FACILITIES AND INSTITUTIONS

SN	Facility	Number		Available beds
		Rural	Urban	
1	Public Hospitals	16	79	7637
2	Public PHC	214	0	642
3	Public HP/SHP	3816	0	0
3	Private for profit Hospitals	12	93	4621
4	Medical Colleges	0	20	10576
5	Mission Hospitals	6	2	612
	Total	4064	194	24088

Source: MoHP 2010

TABLE 4 NUMBER OF HEALTH FACILITIES IN THE PUBLIC SECTOR 1991-2011

Health Institutions	**1991**	**2001**	**2004**	**2009**	**2010**	**2011**
Regional TB Centre	1	1	1	1	1	1
Centres (e.g. HIV/AIDS, NHTC)	n/a	4	5	5	5	5
Specialty /Tertiary/Central Hospitals	7	8	13	13	13	13
Ayurvedic, Homeo and Unani Hospitals	4	4	4	4	4	4
Regional and Zonal hospitals	n/a	3	10	11	13	15
Ayurvedic Clinics	82	275	275	288	288	288
District Hospitals	65	67	65	65	65	65
Rural Hospitals	n/a	n/a	1	2	2	3
Primary Health Centres	33	193	205	213	214	214
Health Posts	351	701	679	679	682	1204
Sub Health Posts	n/a	3129	3129	3158	3158	2636
Out Reach Clinics	n/a	30780	30780	30071	30071	30071
Total	543	35161	35162	34505	34511	34514

Source: MOHP 2011 and DOHS Annual Report 2001-02, 2008/09

REFERRAL SYSTEM

The health referral system was designed to ensure that the majority of the population receive public health and minor treatment in places accessible to them and at a price they can afford. The SHP and HP are the first contact points for basic health service, as well the point for community-based activities, such as (Primary Health Care) PHC Outreach clinics and Expanded Programme on Immunisation (EPI) clinics. Referrals are made to each level above the SHP and HP to PHCC, and to district, zonal and regional hospitals, and to specialty tertiary care centres in Kathmandu. Logistical, financial, supervisory, and technical support is provided from the centre to the periphery.[35]

During the timeframe of the NHSP-2, the referral system will be strengthened to ensure the rural population is referred to well-equipped and appropriately staffed institutions. Some HPs will be upgraded and converted to PHCCs. Improvements will be made in the organisation and management of health facilities at the central, regional and district levels.. The referral system will be strengthened through the improved utilisation of non-state hospitals (particularly of medical colleges) for referral with partnership approach.

PUBLIC PRIVATE PARTNERSHIP

There are a number of successful public private partnerships operating in the health sector, e.g. service delivery, production and training of health professionals, etc. Partnerships between public/government entities, private/commercial entities and civil society have a contribution to make in improving the health of the poor by combining the different skills and resources of various organisations in innovative ways. Public agencies can benefit from working in collaboration with the private sector in areas where the sector lacks expertise and experience.[36]

In Nepal there is as yet no formal mechanism for public private partnerships in the health sector, but a white paper on Public Private Partnership (PPP) has been drafted and circulated. The Government is committed (e.g. NHSP-2 and the Three Year Plan Approach Paper 2010/11 - 2012/13) to developing and strengthening policies and mechanisms to promote and regulate the participation of private, governmental, non-governmental, community and co-operative organisations in the provision of health services. The private sector and NGOs will be encouraged to produce and train health professionals to meet health sector needs and to provide health services in rural and remote areas.

[35] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010

[36] WHO public-private partnerships for health http://www.who.int/trade/glossary/story077/en/

HEALTH SERVICE PROVIDERS

The principal agency for the management of health care delivery and provision of health services is the MoHP, through the Department of Health Services DoHS, headed by the Director General. The MoHP administers services through Regional Health Directorates and District Health Offices. There are over 1,300 health management boards/committees responsible for the management of hospitals and other health facilities.

The private for profit and not-for-profit sectors health provide health services through 17 NGO run hospitals, 17 eye hospitals, 87 private hospitals and nursing homes, 39 pharmaceutical industries of Nepali origin and 240 foreign-based pharmaceutical companies, 40 diagnostic laboratories and research centres and two radiotherapy facilities.[37]

Government health providers

Government facilities provided curative services to 60% of the population in 2007-8. Over 85% of clients received services from health posts, sub-health posts and outreach clinics, about 10% from PHCCs, and the remaining 5% from hospitals. In 2007/08 a total of 706,128 people received treatment through 291 government Ayurvedic Centres at national, regional and district levels,

Private/for-profit health service providers

The private sector has expanded over the years and includes private pharmacies, private hospitals, nursing homes, private practitioners, and private training institutions. In 2010 it was estimated that the sector employed around 20,000 health workers in its facilities[38].

Private hospitals are mainly located in urban areas and are used predominantly by the richest. Private sector pharmacies are widespread, providing examinations as well as treatment, and are a major recipient of out-of-pocket spending by all income groups. Roughly 50% of the acute illness patents go to private practitioners for their treatment. However, the sector remains underutilised; the NHSP-2 suggests that private health facilities could be better utilised by the government sector e.g. production and training of health professionals and as practicum sites for medical students.[39] The Nepal Medical Council will be responsible for coordinating these issues.

There are 18 privately run medical colleges, and the private sector produces almost 90% of the medical doctors (MBBS) in the country, and a similar share of staff nurses.[40] During the timeframe of the NHSP-2, the Government is planning to improve the regulation of the private health training institutions in order to sure that production meets requirements.

[37]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

[38] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

[39]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

[40]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p. v

NGO/non-profit health providers

The not-for-profit sector includes mission hospitals, I/NGOs, community organisations, cooperatives, and trust and philanthropic organisations. This sector is more broadly involved in partnering with the Government of Nepal (GoN) in delivering EHCS and public health services. Although the contracting out of service provision and the management of facilities has progressed slowly, there are partnerships with NGOs in many areas, including the management of government hospitals, and the provision of family planning, safe motherhood, TB, and HIV/AIDS services.[41] No definitive information is currently available on the numbers of health staff employed by NGOs and other non-profit health providers.

FUTURE SERVICE DELIVERY PLANS AND PRIORITIES

The government recognises that the health problems and health needs of the population in the future will differ from those faced under the first NHSP-IP. The MoHP is already exploiting many of the most cost-effective interventions for reducing mortality and morbidity. Further reductions in neo-natal, child and maternal deaths will require a functioning health system able to respond to emergencies 24/7 and the ability to reach currently underserved populations. Tackling the problem of malnutrition will require a multi-sectoral approach. In this regard, a committee formed by National Planning Commission under the chairmanship of VC of NPC is expected to mitigate this problem.

The burden of disease is changing, and the population will increasingly demand quality curative services for non-communicable diseases. The percentage of aged population is increasing and consequently there is an increasing demand for service delivery. This is an area where public private partnerships and alternative financing mechanisms may have more of a role to play. At the same time, technology will continue to change, and developments that have made it possible for FCHVs to treat problems that were previously the province of physicians will continue to be made.

During NHSP-2 EHCS will be scaled up, and maintaining and further strengthening coverage is a priority. Further increases are planned in the coverage of several programmes such as expanded population and family planning, safe motherhood and child health and mother and child nutrition. The Skilled Birth Attendants (SBA) training strategy will be implemented; training 5,000 by 2012, and reaching full coverage (7,000) by 2015. The existing communicable disease programmes will be maintained and the response to Non-Communicable Diseases (NCDs) and injuries will be expanded as a response to the growing burden of road traffic accidents. Emergency capacity will be strengthened in facilities near to major highways. Mental health services will be added to the EHCS package to address the increasing number of suicides among women of reproductive age.

[41]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

The government will also consider various options to improve physical access to facilities, including new investment in health and sub-health posts where justified, more frequent outreach clinics, options for relocating existing facilities, and contracting services and PPPs to provide services. During NHSP-2 all sub-health posts will be upgraded to health posts that will have birthing units. An additional Health Assistant (HA) will be posted to the HPs and the existing Maternal and Child Health Worker (MCHW) position) will be upgraded to Auxilliary NurseMidwife(ANM).

SECTION 3 HRH SITUATION ANALYSIS

INTRODUCTION

The Human Resources for Health (HRH) Strategic Plan 2011-2015 has been produced with the best information that was available on the HRH situation at the time (from November 2010 to December 2011). The Situation Analysis that follows is based on a review and analysis of issues and challenges in the documentation, on the outputs of the TWGs and other stakeholder inputs. Information from the MoHP Human Resource Information System (HuRIS) and from the government's Personnel Information System (PIS) was also reviewed and used.

At the time this Plan was being developed (up to December 2011) the information available on government health workers was not completely up to date. Only limited information was available on health workers employed by the private and NGO sectors. As a result much of the analysis and commentary contained in this Plan covers only government/public health sector facilities, providers and employees. However more comprehensive information may soon be available through the Service Tracking Survey (STS) undertaken by the MoHP in late 2011 and other recent HRH data gathering initiatives.

The analysis of the public sector health workforce is based on different primary and secondary data sources and datasets; as a result there are gaps and in some cases considerable inconsistencies in the findings. The use of different classifications and categorisations also make it difficult to compare staffing levels and trends over time. This Plan contains specific strategies and activities aimed at improving HRH information systems and processes in the MoHP, in the professional councils, training institutions and other private sector organisations. The findings of current and future HRH studies will help to enrich and strengthen the HRH evidence base and will provide more reliable information for HRH decision-making.

GUIDING POLICIES, PLANS AND STRATEGIES

The MoHP recognises that a competent and motivated workforce is required to provide quality health services, achieve health goals and outcomes and the objectives of the NHSP-2 (i.e. increase access to and utilisation of quality essential health care services). In 2003 the MoHP developed the Strategic Plan for Human Resources for Health (2003-2017) and in

collaboration with its partners has undertaken a number of interventions to improve the planning, management and development of HRH.

However the Government, the MoHP and the EDPs recognise that there are still a number of HRH challenges that need to be overcome. The NHSP–2 recommends that a more scientific and robust assessment of HRH requirements is needed to inform workforce planning for the public and private sectors, and in 2008 WHO proposed that 'to move forward there is an immediate need to review the policy & the strategic plan & update it'.

As described in Sections 1 and 2 there are various policies, plans and programmes that affect the HRH situation. Some of the key plans are discussed below:

The Health Services Act 1994

The major policy document governing the employment of health sector staff is the Health Services Act 1994.[42] This was created to provide more flexibility in the employment of health staff ("in order to make the health service more competent, vigorous, service-oriented and responsible") than the Civil Service Act 1992, which covers most government employees including those on secondment to MoHP from other ministries (e.g. Ministry of General Administration, Ministry of Finance). Five amendments have been made to this Act, the most recent being in January 2010. Amongst many other things the Health Services Act provides the rules on transfer, deputation and promotion. The Act allowed for a change from a rank system of post to a grade system.

An important policy decision outwith the Health Service Act was to allow local contracting, partly to deal with staffing shortages and partly in line with the decentralisation of management to facility level.

The 2003-2017 Strategic Plan for Human Resources for Health

The 2003-2017 Strategic Plan was intended to (a) specify the direction and growth of human resource growth, (b) outline human resource objectives for the medium term, and (c) identify short-term policy actions for the MoHP. It includes future human resource requirements and supply and examines their implications for training and training institutions. The Plan, which was formally adopted, projects a 71% increase in the public sector workforce by 2017.[43]

NHSP-2004-2010

During NHSP-2004-2010 a range of interventions were implemented to address HRH challenges. These included:

[42] Nepal Law Commission (2010). Nepal Health Service Act, 2053 (1997) - with updates. Available at: http://www.lawcommission.gov.np/index.php/ne/acts-english/doc/654/raw

[43] Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery. Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

- A two-year compulsory service scheme for physicians who studied under the government's scholarship scheme. To date 280 medical doctors in the scheme have joined the Department of Health Services to work in peripheral health facilities.
- 2,100 maternal and child health workers working in sub-health posts were enrolled in an 18-month ANM course and after graduation were posted at their respective duty stations.
- Vacant posts of Maternal Child Health (MCH) workers and ANMs were filled by contractual services in many districts.
- Incentive packages to retain doctors, nurses and technicians were developed and introduced.
- A one-year biomedical equipment technician course was developed to improve the biomedical equipment maintenance system and 90 technicians graduated.

- A Policy on SBA and a long-term plan were formulated and in-service training of SBAs started.[44]
- Training of all health personnel including FCHVs in integrated management of childhood illness (IMCI).

NHSP-2 2010-2015

The NHSP-2 notes that 'a competent, motivated health workforce forms the core of a high-quality, effective and efficient health system'.[45] It acknowledges that there was some improvement n the HRH situation during the NHSP-2004-2009, but recognises that there are still HRH challenges to overcome. These include:

- Health worker shortages, e.g. only two-thirds of positions for doctors and nurses are filled and there are skills shortages in specialised areas, such as anaesthesia.
- Deployment and retention of essential health workers, especially in rural and remote areas.
- Fragmented HR management and incomplete HR information.
- Improving the skills of the health workforce.
- Poor staff attendance and motivation affecting productivity and the quality of services.
- Participation of Dalits and other highly excluded groups in the health workforce.

The NHSP-2 recommends that HRH requirements to support the delivery of EHCS and other health programmes are reassessed in the context of an evolving health, social, economic, and political environment. Some of the key changes that have occurred in the health environment are identified as progress made on achieving the health-related MDGs, the introduction and expansion of free health care, the expansion in the private health sector,

[44] Ministry of Health and Population/ RTI (2009) Human Resource Strategy Option for Safe Delivery. Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

[45] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

the growing supply of doctors and nurses for the global labour market, and evolving decentralisation of the health sector.

It proposes specific interventions to overcome the challenges and these have been grouped around key HRH areas and are summarised and presented in Table 5 below.

TABLE 5 NHSP-2 PROPOSED HRH INTERVENTIONS

HRH Area	Intervention
Recruitment	• Procedures in place to contract obstetricians, anaesthesiologists, paediatricians, gynaecologists, MDGPs, medical officers, physiotherapists, nurses, ANMs and other diagnostic support staff • Staff recruited from marginalised groups and allocated to underserved areas • Deployment of 5,000 additional FCHVs and replacement of 2,000 who will retire/leave
Training and capacity development	• Pre-service and in-service training strengthened • Refresher training for all providers at district hospitals and below • Production of multi-skilled workforce to provide more integrated services • Expansion of SBA training • Training of 5,000 additional FCHVs • New training curricula and courses • Provision of career development opportunities • Re-evaluation of the role of the National Health Training Centre • Analytical capacity at the MoHP strengthened
Productivity and performance	• Performance incentives piloted and evaluated • Continued payment of provider incentives for safe delivery • Replacement of village health worker cadre with AHWs • Teams posted to district hospitals • Legal framework for anaesthesia assistants established
Public private partnership	• Use of private sector to provide specialised services to rural areas. • Partnership developed with the Ministry of Local Development and with municipalities

Source: NHSP 2010

A rapid assessment of HR planning, management and development capacity, conducted in 2010 found the characteristics of HRH to be as follows:[46]

[46]Nepal Health Sector Support Programme (2010). Draft Capacity Assessment for Health Systems Strengthening. An assessment of capacity building for health systems strengthening and the delivery of the NHSP-2 results framework. Martineau, T (LATH) and Subedi H. N.

- Supply of most cadres increasing (e.g. institutions for training staff nurses have increased from 6 in 1991 to 103 in 2010), but staffing projections done in 2003 are no longer valid.
- Inequity in access to health workers is worsening, despite the increase in supply, due to the difficulty in attracting and retaining staff in remote areas, even though innovations such as local contracting are showing promise.
- Expansion of training, much of which is now provided by the private sector, has not been accompanied by maintenance and development of standards. This has implications for the quality of service delivery.
- There is a lack of accurate data on staffing, especially for non-government employers.

STAFFING LEVELS

Government data sources estimate that of the current 78,000 civil servants employed by the government, approximately 31,500 (40%) are employed in the MoHP.

Data from the Medical Council or 2010 indicate that there were 12,194 Nepali medical doctors and 4,752 non-Nepali medical doctors registered in Nepal as shown in Table 6. Of the 12,194 Nepali doctors registered, 2000 were consultants and specialists. Table 7 below shows the number, sex and type of specialists registered. The greatest number of specialists is in the areas of obstetrics and gynaecology (237), general surgery (232), followed by internal medicine (195), and paediatrics (182). One third of all the specialists registered are female, with the majority in the areas of obstetrics and gynaecology and paediatrics.

TABLE 6 REGISTERED MEDICAL DOCTORS (AS OF DECEMBER 2010)

Category	Registration (National)	Registration (foreign)	Total
MBBS	10194	n/a	10194
Consultant	2000	n/a	2000
Not identified	n/a	4752	4752
Total	12194	4752	16946

SOURCE: NEPAL MEDICAL COUNCIL 2010

TABLE 7 MEDICAL SPECIALIST REGISTERED WITH NEPAL MEDICAL COUNCIL

S.N	Subject	Male	Female	Total
1	General Practice	80	26	106
2	E.N.T	51	13	64
3	Psychiatry	38	5	43
4	Anesthesiology	89	31	120
5	Radiology and Imaging	84	12	96
6	Pediatrics	133	49	182
7	Nephrology	5	3	8
8	Master in Dental Surgery (MDS)	52	39	91
9	T.B. and Respiratory	7	1	8
10	Community Medicine Public Health	33	10	43
11	Pharmacology	13	1	14
12	Obs+Gynae	71	166	237
13	M.S (General Surgery)	222	10	232
14	Orthopedics	160	1	161
15	Cardiology	69	5	74
16	Ophthalmology	61	45	106
17	Internal Medicine	177	18	195
18	Clinical Pathology	38	38	76
19	Dermatology + Venereology	39	23	62
20	Neurology	14	3	17
21	Gastroenterology	14	2	16
22	Urology	14	0	14
23	Surgical Oncology	14	0	14
24	Forensic Medicine	6	0	6
25	Microbiology	7	4	11
26	Nuclear Medicine	4	0	4
	Total	1495	505	2000

Source: Nepal Medical Council 2010

Table 8 shows that there were 33,733 Nepali and 684 non-Nepali nurses with permanent registration in 2011. Over half (51%) of the total number registered were ANMs.

TABLE 8 REGISTERED NURSES (AS OF JULY 2011)

Category	Nurse	ANM	Total	Foreign nursing	Grand total
Permanent registration	16299	17424	33733	684	34417
Total	16299	17424	33733	684	34417

Source: Nepal Nursing Council 2011

Table 9 below shows that there were 47,987 Health Professionals registered in 2011, 5,514 of which had temporary registration. The table also shows the level of the qualification they have attained, with the majority having attained a Level 3 qualification. Table 10 provides more information on the types of health professionals that have permanent registration.

TABLE 9 REGISTERED HEALTH PROFESSIONALS (AS OF JULY 2011)

Category	Level 1 (Bachelor)	Level 2 (PCL)	Level 3 (TSLC)	Total
Permanent registration	1619	4232	36622	42473
Temporary registration	611	1003	3900	5514
Total	2230	5235	40522	47987

Source: Nepal Health Professional Council 2011

TABLE 10 HEALTH PROFESSIONALS WITH PERMANENT REGISTRATION (AS OF JULY 2011)

No.	Discipline	Level		
		Level 1 Bachelor & above	Level 2 PCL	Level 3 TSLC
1.	Public Health	654	–	–
2.	Health Education	45	9	–
3.	Medicine	–	2780	29301
4.	Medical Microbiology	20	–	–
5.	Diag. Health Lab	544	536	5828
6.	Diag. Radiography	98	164	43
7.	Diag. Radiotherapy	4	9	–
8.	Diag. Cytrology	2	–	–
9.	Diag. Hematology	7	–	–
10.	Diag. Biochemistry	20	–	–
11.	Ayurved	6	191	1046
12.	Homeopathy	44	10	–
13.	Unani	12	–	–
14.	Acupuncture	12	1	11
15.	Physiotherapy	86	74	35
16.	Community Based Rehabilitation	1	–	–
17.	Prosthetic & Arthritic	2	1	–
18.	Dental Assistant	–	37	356
19.	Naturopathy	7	–	1
20.	Yoga	8	–	1
21.	Ophthalmology	40	390	–
22.	Operation Theatre and Allied Health Sciences	–	30	–
23.	Clinical Psychology	2	–	–
24.	Speech and Hearing	5	–	–
Sub Total		**1619**	**4232**	**36622**
Total		**42473**		

Source: Nepal Health Professional Council 2011

The data presented above indicate that the production and stock of most cadres of health workers is adequate to meet the service delivery needs of the country; the problem is attracting and retaining them in the public health sector, especially in remote and rural

government facilities. There are acute shortages of doctors, specialists and nurses, especially staff nurses,[47] in district hospitals and PHCCs. Recent data presented in Table 11 below indicates that of the 12,194 Nepali medical doctors registered (see Table 6 above) in Nepal in 2011, there are 8,335 working in the country, 1,447 in the public sector and 6,888 in the private sector.

TABLE 11 DOCTORS IN THE PUBLIC AND PRIVATE SECTORS IN 2011

Cadre	Public sector		Private-for-profit sector	Total
	Scholarship	Sanctioned and filled posts		
Doctors	335	1112	6888	8335

Source: HuRIC 2010 and DOHS 2010

A significant number of health workers are employed in the private and NGO sectors; estimated to be 20,000 in 2010, while others are working outside the sector and the country.

Table 12 below shows that in 2011 the MoHP has 27,316 employees, of whom 20,179 are technical and 7,137 are administrative and support.. In addition there are also approximately 50,000 FCHVs, who support the delivery of health service

TABLE 12 HUMAN RESOURCES FOR HEALTH IN THE PUBLIC AND PRIVATE SECTOR 2011

Cadre	Public sector		Private-for-profit sector	Private-not-for-profit	Other	Total
	Scholarship	Sanctioned				
Doctors	335	1112	6888	n/a	n/a	8335
Nurses	0	6553	n/a	n/a	n/a	6553
Paramedics	0	7559	n/a	n/a	n/a	7559
Public health workers	0	4289	n/a	n/a	n/a	4289
FCHVs	0	0	n/a	n/a	48549	48549
Alternative medicine	0	666	n/a	n/a	n/a	666
Other health workers, incl admin	0	7137	n/a	n/a	n/a	7137
Total	**335**	**27316**	**6888**		**48549**	**83088**

Source : Huric 2010 and DOHS 2010

[47] 2011 MoHP Service Tracking Study. Preliminary findings

According to the Department of Health Services 2009/10 Annual Report, a total of 1,348 additional Paramedics/Allied Health Professional (AHP) posts were created and filled during 2008/09 and a similar number were added during 2009/10 to upgrade sub-health posts to health posts. In addition there were 586 ANMs and 40 staff nurses recruited on local contracts to support 24-hour delivery services in PHCCs and HPs in 2009/10.[48] These numbers have yet to be incorporated into the HuRIS[49] and are not reflected in the 2011 figures presented in Table 12 above.

Staffing has not kept pace with population growth, which grew at a rate of 45% between 1991 and 2011, compared to an increase in staffing of only 3.4% in the same period (about 10% of the population growth rate). The sanctioned post system is used by the government sector to manage and control staffing levels in the sector and for some cadres there are insufficient sanctioned posts available to absorb the health workers produced and to meet demand. This system is not sufficiently flexible and/or responsive to allow the sector to periodically realign and readjust staffing levels in line with population growth, health service needs, training output and a changing disease burden.[50] There is also inadequate numbers of sanctioned posts for staff that have upgraded their skills and qualifications e.g. those who have trained as SBAs.

Table 13 below shows that Nepal currently has 0.042 doctors per 1,000/population ratio and 0.25 nurses per 1,000/population ratio. These ratios are based on an estimated 2011 population of 26.6 million and use the 2011 staffing data that were available for the public sector doctor (1,112) and nursing (6,553) cadres. This represents a total ratio of 0.29 health workers per 1,000/population, which is significantly less than the WHO recommendation of 2.3 per 1,000/population and low compared to selected countries in the region.

TABLE 13 RATIO OF DOCTORS AND NURSING/MIDWIFERY STAFF TO 1,000 POPULATION IN NEPAL AND THE REGION

Country	Doctor	Date	Nursing & Midwifery	Date
Bhutan	0.24	*2011*	1.09	*2011*
Bangladesh	0.26	*2004*	0.14	*2004*
Nepal	0.04	*2011*	0.23	*2011*
India	0.06	*2005*	0.80	*2004*

Sources: WHO Global Health Atlas 2011, WHO 2006 and MoHP HuRIS and PIS

However the picture for doctors changes dramatically when the number of doctors in the private sector is included in these calculations. For example if the number of doctors employed in the country (see Table 11) of 8,335 is used, the ratio would be almost 0.31 doctors per 1,000/population, which is higher than that of Bangladesh, but is still much lower than the WHO recommendation.

[48] Ministry of Health and Population (2011) Department of Health Services Annual Report 2009-2010 p.96
[49] Ministry of Health and Population (2011) Department of Health Services Annual Report 2009-2010
[50] WHO Country Office for Nepal (2007) Policy Papers on Health, Nepal

As is evident from the data presented in the Tables above, the availability of adequate numbers of skilled health workers in the public sector is one of the most critical bottlenecks in scaling up needed health interventions in the health sector. This is rooted in the weaknesses inherent in the structures, systems and capacity used to plan, manage and develop the health workforce and as a result of the migration of health professionals to other sectors and countries.

The situation is expected to become more serious as new and expanded health programmes come on stream during the NHSP-2, and as the population grows and the demand for health services and utilisation increases. The MoHP TWG formed to examine and analyse imbalances between supply and demand identified several reasons for the shortages and non-availability of some cadres of staff[51]. These include the lack of up-to-date HRH information; unregulated training institutions that are not producing sufficient numbers of the types of health workers that are needed to meet service delivery demands; weak HR planning systems and capacity; obsolete staffing norms and standards; ill-informed deployment decisions; lack of performance incentives; as well as health worker migration.

The 2011 MDG Assessment Report found that frequent transfers, study leave, deputation, training workshops and high patient load, including unfilled sanctioned posts, are key factors affecting the availability of staff.[52]

VACANCIES/SHORTAGES IN PUBLIC SECTOR FACILITIES

According to the NHSP-2, two-thirds of the public sector's sanctioned positions for doctors and nurses are filled and 82% of posts are filled at PHCCs and district hospitals.[53] Vacancy rates are particularly high for skills that are most needed, and are most acute in remote and rural areas..

In 2008 WHO highlighted the shortage of qualified doctors and midwives and indicated that a third of PHCCs had no doctors.[54] It suggested that doctors 'prefer to join private services in urban settings or migrate to developed countries'.

Table 14 shows shortages across the different cadres in 2007/08 and indicates that there were shortages across the board, but these were most acute for doctors.

[51] Ministry of Health and Population (2011). Milestone 7: Periodic Review on the development of the HR Plan (Draft) Martineau, T. & Bista, B. Nepal Health Sector Support Programme
[52] National Planning Commission/UNDP (2011). Millennium Development Goal Needs Assessment for Nepal 2010
[53] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p. vi
[54] WHO HRH NEPAL http://www.nep.searo.who.int/en/Section10.htm 2008

TABLE 14: MOHP SANCTIONED AND FILLED POSTS IN 2007/08

Position	Sanctioned	Filled	Vacant	% of filled positions	% Share
Medical doctor	1,062	816	246	76.84	4.34
Nursing staff including ANMs	5,935	5,307	628	89.42	24.25
Paramedics	10,642	9,212	1,430	86.56	43.48
Other	6,838	6,394	444	93.51	27.94
Total	24,477	21,729	2,748	88.77	100.00

Source: Annual Report, DoHS, 2007/08, cited in NHSP-2

The NHSP-2 highlights shortages in other areas. There are only 1,000 of the 7,000 trained SBAs needed; 90 Medical Doctors - General Practice (MDGPs) are needed but only 34 are available; as well as chronic shortages of anaesthetists, psychiatrists, radiologists, radiographers, and anaesthesia assistants. In addition, there is a shortage of health systems management personnel, such as procurement specialists, health legislation experts, epidemiologists, health economists, health information specialists, HR managers, hospital managers, and health governance experts.

A study conducted in 2009/10 by the MoHP on Obstetric Morbidity and Related Care Seeking Behaviour, focusing on maternal health and family planning services, found that less than 80% of the sanctioned posts were filled in the surveyed health facilities.[55] Of the filled posts about 10% of the staff were not available during the time of survey. Essential equipment and drugs were also lacking in most of the health facilities.[56]

The 2011 MDG Assessment found shortages of SBAs and specialised TB staff. It recommends that vacant posts, particularly at the district level, be filled immediately and priority given to candidates from local communities.[57]

In order to fill critical posts the MoHP is employing a number of obstetricians, gynaecologists, MDGPs, medical officers, nurses and ANMs on short-term contracts.[58] Preliminary findings from the 2011 Service Tracking Study indicate that in the 16 regional, zonal and district hospitals surveyed, administrative staff make up the greatest number of contracted staff, followed by ANMs. At PHCC level, it is administrative staff, AHWs and ANMs who are on contracts and a similar situation was found in the HPs and SHPs surveyed. The NHSP-2 recommends that multi-year contracts be provided for staff providing obstetric, gynaecological, paediatric, physiotherapy, and other diagnostic support services.

[55] Ministry of Health and Population (2011). Department of Health Services Annual Report 2066/67 (2009-2010) pp. 127-130
[56] Ministry of Health and Population (2011). Department of Health Services Annual Report 2066/67 (2009-2010) pp. 127-130
[57] National Planning Commission/UNDP (2011). Millennium Development Goal Needs Assessment for Nepal 2010
[58] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010 p.96

WORKFORCE CHARACTERISTICS

Recruitment and attraction

Attracting specific health cadres into the public health sector is a challenge, as seen in the data presented above and the high vacancy rates that exist in government facilities. On the other hand there is a shortage of some sanctioned posts in the public sector. So there are twin challenges of increasing the number of sanctioned posts for the health workforce and then attracting trained health workers to fill these posts. The TWGs identified a number of reasons for the problems related to attraction and recruitment. These included a lack of information on vacancies and shortages; weak and unwieldy recruitment systems; insufficient sanctioned posts; financial constraints to creating new posts; unwillingness of graduates to consider public sector jobs; and more attractive employment conditions offered by private and NGO employers.

Anecdotal evidence suggests that there is a pool of unemployed graduates; e.g. one estimate is that there are between 200-300 trained ANMs available in the labour market. The MoHP has conducted a number of Operations and Management (O&M) surveys and identified new positions required to deliver services. For example the Family Health Division in the MoHP has identified that 28 MDGP, 12 Gynaecologist and 40 Anaesthesia Assistant (AA) posts will need to be created to improve the provision of CEOC services. These posts have not yet been approved. The MoHP is also seeking approval to create 330 new specialist positions.[59] Posts will need to be sanctioned and funded to ensure that the MoHP can recruit and deploy the staff required.

It is increasingly being recognised that MDGPs are the most appropriate doctor cadre for rural areas,[60] and an increase in the numbers recruited and deployed to rural areas is expected. The creation of positions for hospital managers and recruitment of managers is also a priority to ensure that HRH and other resources are effectively managed in the delivery of services.

In order to by-pass and avoid the often lengthy procedures for creating new posts and for recruiting staff, a policy decision was made outwith the Health Services Act, to allow for local recruitment. This has resulted in an unknown – but reportedly quite large – number of staff being employed that are not on the formal payroll. A current constraint with this practice is that contracts can only be given for 12 months and it takes up to 5 months to negotiate a follow-on contract, seriously affecting continuity.

Those hired on one year contracts often work for less time than this, sometimes for as little as 6 months, because of delays with the contracting and budget approval processes. In some cases health workers are taking leave from their full time jobs to take up contract posts and their availability depends on the amount of leave they can take; practices that are creating shortages and distortions elsewhere in the system. The short-term nature of the contracts

[59] Reported by the Personnel Administration Division

[60] The Nick Simons Institute has developed a scholarship system for MDGP doctors, and according to the NSI Report on Five Years of Progress 2006-11 the MOHP recently asked the NSI to 'rapidly and widely scale up' the Rural Staff Support Programme.

and the high turnover of contract staff is already causing considerable disruption of services. Strategies and activities related to this are included in Output 2 in Section 4 of this Plan.[61]

The MoHP is planning to initiate multi-year contracting to address some of these issues and the NHSP recommends that multi-year contracts be provided for obstetric, gynaecological, paediatric, physiotherapy, and other diagnostic support services.[62] The Health Facility Operations and Management Committees (HFOMCs) are also responsible for the recruitment and management of contract staff and strategies and activities to review and strengthen their roles and responsibilities have been developed.

The 2008 Nepal Safe Delivery Survey examined the willingness of private medical and nursing students to work for government.[63] None of the students surveyed intended to join the public health service; the majority was planning to continue their studies abroad. More than half of the nursing students (57%) wanted to work for the private or NGO sector after graduation. The reason they gave for their unwillingness to join the public sector included the following: poor physical facilities, lack of equipment/supplies, poor working environment, lack of opportunities for upgrading knowledge, and lack of security (personal safety) and non-availability of staff quarters.

Distribution

The data indicate that sufficient stocks of most categories of health workers are being produced. The greatest challenge to the availability of health workers in government facilities is the way in which staff are deployed and distributed. For example, out of a national stock of 8,335 medical doctors, only 1,112 are working in sanctioned government posts. Two-thirds are working in the Kathmandu valley or in other cities.[64] The 2008 Nepal Safe Delivery Field Survey reported that key Maternal Neonatal Child Health (MNCH) staff such as specialist doctors (e.g. obstetrician/gynaecologists, anaesthesiologists and MDGPs), and staff nurses were not equitably distributed.

Table 15 and Table 16 below present 2008 information on government health facilities by development region and geographic terrain.

TABLE 15 DISTRIBUTION OF GOVERNMENT HEALTH FACILITIES BY DEVELOPMENT REGION

Development Region	Regional Hospital	Zonal Hospital	District Hospital	PHCC	Health post	Total
Eastern	0	3	14	50	142	**209**
Central	1	3	12	67	170	**253**
Western	1	1	16	42	144	**204**
Mid Western	1	1	13	29	133	**177**

[61] Ministry of Health and Population Government of Nepal. (2010) Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p.65

[62] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p.65

[63] Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken, MD, and DrPH Prof. Ishwar Bahadur Shrestha

[64] Ministry of Health and Population Government of Nepal (2010), Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

Far Western	0	2	7	20	89	**118**
Total	**3**	**10**	**62**	**208**	**678**	**961**

Source: Ministry of Health and Population (2009)

Table 16 below shows that the hill region has the highest number of health facilities overall. The mountain region has no zonal or regional hospital.

TABLE 16 DISTRIBUTION OF HEALTH FACILITIES IN THE PUBLIC SECTOR BY GEOGRAPHIC REGION, 2008

Geographic region	Regional hospital	Zonal hospital	District Hospital	PHCC	Health post	Total
Mountain	0	0	16	20	149	**185**
Hill	2	1	32	101	364	**500**
Terai	1	9	14	87	165	**276**
Total	**3**	**10**	**62**	**208**	**678**	**961**

Source: Ministry of Health and Population (2009)

Maldistribution has been a major concern over the years in the health sector and the deployment of health personnel to the rural and remote areas of the country remains a challenge. These areas are generally under-staffed and absenteeism is a growing problem. A significant number of sanctioned posts, especially for skilled and specialist staff, are vacant in these areas. A 2009 review of the skills mix revealed that only 4.2% of the health workforce were doctors; 12% were nurses, excluding ANMs; nearly half (47%) were paramedics; and almost one-third (28%) were support staff.[65] Private sector health facilities tend to be located in the urban areas resulting in greater numbers of health workers in these areas. Transfers systems and practices are also causing distortions in the distribution of health workers.[66]

Although there are more health care providers in urban areas, these are mainly private providers and are less accessible to poor urban populations who have as poor, or worse, health status than rural populations. Public health facilities in urban areas are few, of low quality and poorly staffed. An urban health policy and strategy is being developed, which will help to address the gap in health services for the rapidly growing urban population.

The MoHP TWG that was formed to work on this HRH issue identified several reasons for maldistribution. These included lack of informed and transparent deployment and transfer decisions, lack of standardised procedures for placement and transfer, poor working environment, insufficient incentives to attract and retain staff in remote and rural areas and other personal, professional and economic reasons.[67]

Effective deployment procedures will ensure that staff with the right skills are posted to the facilities where they are needed and where they can use their skills. The 2008 Nepal Safe Delivery Field Survey found that a large number of MDGPs and staff nurses were posted to

[65] HuRIC, 2008
[66] HRH Workshop Report June 25/26 2011
[67] Ministry of Health and Population (2011). Milestone 7: Periodic Review on the development of the HR Plan (Draft) Martineau, T. & Bista, B. (2011). Nepal Health Sector Support Programme

facilities that did not require their qualifications and skills.[68] For example MDGPs or (Medical Doctors) MD (Ob/Gyn) who have specialist skills were posted as medical officers, and staff nurses with anaesthesia training were working in the general wards.[69] In 2011 as part of its follow up of AAs in the field, the Nick Simons Institute (NSI) collected data on the status of Comprehensive Emergency Obstetric Care (CEOC) services and HRH availability at government district hospitals. They made contact with 79 of the 91 AAs trained. Out of the 79 contacted, only 49 were still working and using their skills. One of the main reasons given by those who were not working was the fact that there was no doctor in the facility to conduct operations.[70]

There are various initiatives in place to promote more equitable distribution of the health workforce. For example the Health Services Act encourages staff to serve rural areas by providing additional career development and incentive packages to those who take up a rural posting.[71] The 2011 DoHS Annual Plan indicates that career development and opportunities for higher education will be made available for doctors and health workers who are willing to work in villages and rural areas.[72]

There are approximately 50,000 Female Community Health Volunteers (FCHVs) deployed in the mountain regions and remote districts, partly to compensate for the shortage of professional health workers, and it is expected that during the NHSP-2 that this number will increase by 5,000.[73]

Health workforce attrition and retention

Skilled and motivated health workers in sufficient numbers in the right place, at the right time are critical to deliver effective health services and improve health outcomes. The shortage of qualified health workers in remote and rural areas impedes access to health-care services for a significant percentage of the population; it slows progress towards attaining the MDGs and challenges the aspirations of achieving health for all.

One of the main causes of shortages is the inability of the government to attract and retain health workers facilities at district level and below, especially medical doctors and nurses. There are a number of reasons for this, including supply, attrition and distribution factors.

The NHSP-2 suggests that doctors are migrating to the private and NGO health sectors within the country and others are leaving the country altogether. Professional councils are being approached for letters of good standing by staff wanting to work abroad,[74] but it is not clear how many of these actually leave. There were significant number of specialists in

[68]Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha
[69]Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha
[70] NSI (2011) Nepal MoHP CEOC Service vs Human Resource Provision
[71] Interview with MoHP official
[72]Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010
[73] Ministry of Health and Population Government of Nepal (2010) Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010
[74]Ministry of Health and Population (2011) Human Resource Information System Assessment. Blair G., LATH

obstetrics, gynaecology and paediatrics registered with the Medical Council, yet many of these posts are vacant in the government health facilities.

Table 17 below shows the data that are available on the main causes of attrition among public health workers. The main cause of attrition in 2009 and 2010 from the data presented was 'voluntary' followed by 'age'.

TABLE 17 PUBLIC SECTOR STAFF IN SANCTIONED POSTS, APPOINTMENTS AND RESIGNATIONS

Demographics	2006	2007	2008	2009	2010	2011
Number of Staff at the start of the year	24,539	24,774	24,906	24,945	25,189	25,313
New Appointments	235	132	39	244	124	13
Retirement at the start of the year	44	57	87	165	314	472
Other losses:						
Voluntary	9	12	40	85	61	9
Forced With Facility	2	1	1	2	0	0
By Age	1	16	30	58	80	31
By Service Period	1	0	0	0	0	0
Deceased	0	0	7	4	17	4
Pending Transfer Employees	0	0	0	0	0	21
Forced Without Facility	0	1	0	0	0	0
Pending Retired Employees	0	0	0	0	0	12
Total Exit	13	30	78	149	158	77
Actual Staff at the end of the year/till date	24,717	24,819	24,780	24,875	24,841	24,777

Source: HuRIS, MoHP 2011

A number of studies have been conducted to determine the most effective retention strategies in Nepal. In a 2008 survey to ascertain the expectations of medical graduates of the government health system the key priorities were academic support for post-graduate training, followed by financial incentives, career advancement support, allowances, better diagnostic facilities, and security.[75]

Health worker performance

A motivated nursing work force is essential to a well functioning health system and motivated employees are likely to be more productive. There is evidence that there is a range of monetary and non-monetary incentives (e.g. recognition, appreciation, opportunities for career advancement, etc.) that can be used to improve performance and influence heath worker's behaviours. The fairness of the rewards offered also affects the manner in which individuals view their jobs and the organization, and the amount of effort

[75] Health Sector Reform Support Programme (2008). Costing Study on Incentives Packages for Nepal's Health Care Professionals

they expend in accomplishing tasks. Other factors such as low levels of skills and knowledge also affect performance and productivity in the health sector.

The skill mix that exists currently in many government health facilities, where doctors and nurses are in the minority, does not allow for the delivery of quality health care. The NHSP-2 recommends that the skills of existing health workers must be further developed and vacant positions of unskilled staff be upgraded to semi-skilled.[76]

Motivation and performance are closely linked. A study of the factors affecting the motivation of health workers included the following: opportunities for training and further study, salary and incentives, personal factors (such as safety, communication), staff quarters, supportive community, recruitment conditions and career development opportunities, good working environment, team work and supportive staff, appreciation and recognition of work and supportive supervision.[77] The findings also indicated that poor career prospects and a lack of sanctioned posts were key demotivators for MDGPs in district hospitals.

Poor staff performance negatively affects the delivery of health services and has impacted on the utilisation of services and the achievement of the MDGs and the National Health Indicators. While the root causes and the true extent of poor performance need to be further substantiated through in-depth analysis, the TWG working on this area identified the following causes:

Skills related factors

- Poor quality basic education
- Weak in-service training systems, approaches and programmes
- No personal investment or prioritisation by the sector in skills development

Environmental factors

- Lack of HRH policies and strategy.
- Weak Human Resource Management (HRM) and performance management systems and non-compliance with procedures and regulations.
- Lack of career pathways.
- Ineffective procedures for deployment and transfer.
- Inadequate physical working environment, including infrastructure, equipment and supplies and transport.
- Bureaucratic decision making practices.
- Health worker focus on private practice.
- Insufficient recognition of social values, gender issues, social inclusion.
- Economic and political instability.
- Political and social pressure to misuse power.

[76] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p.84

[77] Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

- Ineffective communication /coordination between HRH related stakeholders.

Financial/motivational issues

- Low remuneration for levels of skills and expertise.
- Limited allowances.
- Lack of performance based monetary incentives.
- No reward or recognition for good performance.

In 2008 the Nepal Safe Delivery Field Survey reported that there was a lack of SBA skills among all relevant cadres. Despite a concerted effort to train ANMs as SBAs, the NHSP 2 identifies the need for an additional 7000 SBAs. More recent studies indicate that clients are not satisfied with health worker attitudes and behaviours, e.g. the Rapid Assessment of Aama Programme, Social audit of Aama Programme and the Study on Obstetric Morbidity and Related Care Seeking Behaviour in Nepal.

The MoHP has been working in collaboration with National Health Training Centre (NHTC) and other stakeholders to improve in-service training and the skills of providers to enhance the quality of care provided. Reviews have already been conducted for maternal health and safe motherhood services and training courses have been strengthened to address the gaps identified.

With support from the NSI, the MoHP and NHTC have conducted training needs assessments, which have lead to the creation and adoption of new training courses (e.g. Mid Level Practicum, AA, SBA and Biomedical Technician training) for critical health workers, such as mid level workers and SBAs, and a distance Continuing Medical Education (CME) course for doctors has also been introduced. [78] However, the impact of this initiative has yet to be evaluated. Preliminary findings from the 2011 Service Tracking Study indicate that ANMs and AHWs were the cadres that received the most training of all cadres in the facilities survey.[79]

Other essential health workers will be identified and further training needs assessment conducted to determine how gaps can be addressed. Over the time frame of the NHSP 1,000 MCHWs will be upgraded to ANMs and over 1,200 Village Health Worker (VHW) positions will be upgraded to AHWs. Skills of care providers and support staff at health and sub-health posts, PHCCs and district hospitals will be updated through in-service refreshing training, coaching and onsite support.[80]

Productivity

Low productivity is identified as another key HRH challenge in the NHSP-2. For example, 2006/07 data from Health Management Information Systems (HMIS) indicates that paramedics' clinical consultations per day were as low as 6 at HPs and SHPs. Daily output per

[78] NSI (2011) Five Years of Progress 2006-2011

[79] Service Tracking Study 2011 Preliminary findings

[80] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p. 83

physician varied between regions. On average, a physician located in a district hospital in the Terai Region saw 18 outpatients and 3 inpatients per day, nearly twice as many as physicians located in the mountain districts. A doctor in a referral hospital saw on average only 10 outpatients and 3 inpatients daily.[81] It was recognised that factors beyond the control of the staff, such as the availability of drugs, affect patient demand and productivity. However, the findings provide evidence of low productivity and demonstrate that there were sufficient numbers of staff available at that time to increase utilisation and coverage.

Staff need equipment and supplies to do their work. The 2008 Nepal Safe Delivery Survey[82] found that all ten of the district hospitals visited by the survey team lacked the equipment critical for safe delivery and in some cases equipment was not being fully utilised by the staff.[83]

As mentioned above some staff do not have enough opportunities to use their skills, and there is an inappropriate skills mix in some facilities which also affects productivity and the delivery of quality health care. During the NHSP-2, health provisions will be made to integrate vertical programme supervisors (Family Planning [FP], EPI, TB/Leprosy, disease control, etc.) as public health supervisors and provide them with training to increase their effectiveness.

Transfers also affect the composition and productivity of teams by removing key team members, particularly for the management of delivery complications. For example when one member of an MNCH team, which can include an AA, MDGP and Operation Theatre (OT) nurse, is transferred, caesarean sections cannot be provided.

Effective management systems and capacity are needed at the facility level to support staff performance and productivity. In 2007, WHO proposed that the roles of health system managers needed to be redefined, with more emphasis given to developing managers' competencies and skills for inter-sectoral coordination and partnership building.[84]

In 2011, NSI, in conjunction with NHTC, conducted a study to assess the management and leadership training needs of hospital managers. Its preliminary findings suggest that a cadre of managers needs to be created, equipped with appropriate competencies through pre- and in-service training and CPD and supported through an enabling working environment to improve the management of hospitals and the delivery of services. The study proposes that initially a programme of in-service management and leadership development be run as a pilot with selected hospital management teams.[85] Management and leadership capacity will also be critical as the federalisation process continues and authority for HRM and health facility performance is further decentralised and devolved to the sub-national levels.

[81] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme - Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010

[82] Ministry of Health and Population/RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

[83] Ministry of Health and Population/RTI (2009) Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

[84] WHO Country Office for Nepal (2007). Health System in Nepal: Challenges and Strategic Options

[85] NSI (2011) Hospital Management Training A Summary Report

Absenteeism

Absenteeism is another problem that affects health worker productivity. The 2008 Nepal Safe Delivery Field Survey[86] found that that a significant number of doctors, nurses and paramedics were not present in their workplace at the time of the survey. The situation was worse in the most remote districts. The 2009/10 MoHP study on Obstetric Morbidity and Related Care Seeking Behaviour found that 10% of the staff deployed were not available during the time of the survey.[87]

Authorised absence, such as deputation, leave, study leave and training were cited as the main causes of absenteeism among doctors and staff nurses. Preliminary findings from the 2011 Service Tracking Survey indicate that deputation is greatest among VHWs and Lab Staff in the hospitals, among HAs and VHWs in PHCCs and among Auxiliary Health Workers (AHWs), HAs, and VHWs in HPs.

Table 18 below provides information on causes of authorised and unauthorised ('disobedience') absenteeism in 2008. The negative figures for MDGPs and ANMs may be due to the fact that staffing is greater than the number of sanctioned posts.

TABLE 18 ABSENTEEISM OF HEALTH WORKERS AND ITS CAUSES IN GOVERNMENT HEALTH FACILITIES IN 2008

Staff category	Filled posts	Presently working	No. absent	% absent	Cause of absenteeism			
					Leave	Study/training	Deputation	Disobedience
Regional/Zonal Hospital								
Anaesthesiologist	8	6	2	25	50	0	50	0
Obs/Gyne	11	6	5	45	20	0	60	20
Paediatrician	13	13	0	-	-	-	-	-
MGDP	4	5	-1	-	-	-	-	-
Medical Officer	102	98	4	4	25	50	25	0
Staff Nurse	328	284	44	13	7	39	32	23
ANM	57	69	-12	-21	0	0	100	0
Total	523	481	42	87	102	89	267	43
District Hospital								
Paediatrician	1	0	1	1	0	0	100	0
Medical Officer	11	10	1	10	0	0	100	0
Staff Nurse	44	36	8	18	12	50	25	13
ANM	23	23	0	0				
Total	84	74	10	12	10	40	40	10
Primary Health Care Centre								
Medical Officer	6	4	2	33	0	100	0	0
Staff Nurse	10	7	3	30	0	67	0	33
ANM	41	39	2	5	0	0	100	0
Total	57	50	7	12	0	57	29	14
Health Post								
ANM	14	14		0				

Source: MoHP 2009

[86] Ministry of Health and Population/RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

[87] Ministry of Health and Population (2011). Department of Health Services Annual Report 2066/67 (2009-2010) pp. 127-130

PERFORMANCE MANAGEMENT SYSTEMS

There is a performance management system in operation in the civil service and some sectors and ministries such as Ministry of Finance (MoF) and MoGA are implementing it. It is the responsibility of each sector to implement and adapt the system to its needs. A recent report suggest that the system of performance based incentives in place in MoGA is having very positive results on performance, particularly with staff working on the PIS, evidenced through improved and updated information systems.[88]

One of the strategies proposed in the National Planning Commission's Three-year Plan (2010/11 - 2012/13) is to make 'the implementation of the performance based employee reward and punishment policy effective', and employee's performance evaluation less subjective.[89]

A performance management system has not yet been implemented within the MoHP. But the NHSP-2 indicates that performance-based and retention-based payment systems will be introduced during the plan period. Incentive packages for care providers will be developed and piloted and operations research will be used to observe the impact on performance and retention.

Regular monitoring, supervision, facilitation, onsite support and technical backup will help to increase the efficiency of HRH in service delivery. There are plans for further devolution and delegation of authority for case and resource management to the lower levels. A focus on the deployment of teams of health workers as opposed to posting individual health workers will also be adopted to ensure the optimum skills mix to deliver quality services.

BASIC AND PRE-SERVICE TRAINING

Nepal has numerous government and private sector pre-service health training institutions. The training of health workers is overseen by the professional councils and much of the lower level training is overseen by the Council for Technical Education and Vocational Training (CTEVT)[90].

In 2011 there are 16 medical colleges offering the MBBS programme, 2 offering the MBBS and BDS programmes and a further three offering only the BDS programme. These colleges are listed in Table 19.

[88] Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH
[89] Government of Nepal National Planning Commission (2010). Three Year Plan Approach Paper (2010/11 - 2012/13)
[90] See http://www.ctevt.org.np/about_ctevt.asp

TABLE 19 MEDICAL COLLEGES (2011)

No.	Programme	College MBBS program:
1.	MBBS	TU Institute of Medicine, Maharajgunj
2.		Manipal College of Medical Science, Pokhara
3.		Bharatpur Medical College, Chitwan
4.		Nepal Medical College, Jorpati
5.		Kathmandu Medical College, Sinamangal
6.		Nepalgunj Medical College, Nepalgunj
7.		KU School of Medicine Science, Kavre
8.		National Medical College, Birgunj
9.		Janaki Medical College, Janakpur
10.		Nobel Medical College, Biratnagar
11.		KIST Medical College, Gwarko
12.		Lumbini Medical College and Research Centre, Palpa
13.		Chitwan Medical College, Chitwan
14.		Patan Medical Science Academy, Lalitpur
15.		Gandaki Medical College, Pokhara
16.		National Academy of Medical Science, Bir Hospital (conducting a Post Graduate Program).
17	**MBBS and BDS**	BP Koirala Institute of Health Sciences, Dharan
18		Universal College of Medical Science, Bhairahawa
19	**BDS**	People's Dental College, Naya Bazaar
20		MB Kedia Dental College, Birgunj
21		Kantipur Dental College, Basundhara

In 2008/09 there was an annual intake of 1,240 students into the Medical Colleges and 241 students receiving scholarships. After graduation, scholarship holders are required to work for two to five years in a government health facility. However few graduates are willing to remain in government health service and prefer to work in the private health sector or abroad.

As shown in Table 20 the annual intake to nursing schools is about 1,300. Many of the teaching hospitals do not have a nursing school, which makes it harder to retain nursing graduates in the government facilities. In 2009 the Council of Technical Education and Vocational Training (CTEVT) of the Ministry of Education (MoE) and its affiliated campuses was training approximately 1,000 ANMs annually every year.

TABLE 20 ANNUAL INTAKES TO NURSING TRAINING PROGRAMMES 2007/8

Name of the Institution	Annual Intake
TU – IOM and its affiliated campuses	270
BPKIHS	40
Kathmandu University	40
Council of Technical Education and Vocational Training (CTEVT)	960
Total	1,310

Source: MoHP 2009

According to the 2008 Nepal Safe Delivery Field Survey, nurses prefer private sector employment and to work in teaching hospitals rather than lower-level facilities. Currently the annual nursing output is insufficient to meet requirements for safe delivery in government health facilities.

The Nepal Health Professional Council 2010 data indicate that there are 78 institutes and colleges offering Technical SLC, 63 institutions offering Proficiency Certificate Level, while 29 offer Bachelor Degrees & higher qualifications abroad.[91]

The government is providing training opportunities in disciplines that are critical for service delivery, such as general medicine (MDGPs), anaesthesiolog, (AAs), and radiology but it is finding it difficult to fill the places that are available.

Anecdotal evidence suggests that the quality of basic and pre-service training, particularly in private sector training institutions, needs to be improved. Outputs from the private sector training institutions may also be contributing to an oversupply of doctors. Many of those produced seek employment in the private sector and outside the country.

Some of the health workers produced by these institutions do not have the skills required to provide quality services. They often have to be retrained and/or receive intensive in-service training to enable them to provide the services for which they were trained. The TWG working on this area recommended the following interventions to improve the situation: the MoHP in collaboration with the professional councils and the MoE needs to regulate training; revision and development of curricula; skills development for teaching staff and improved quality of instructional approaches. The MoHP plans to work with the Ministry of Education, universities, teaching institutions and the professional councils to regulate training to ensure that the staff it requires are being produced, and to improve the quality of training.

IN-SERVICE TRAINING

The National Health Training Centre is responsible for developing and providing in-service training, upgrading and specialised training for public health workers, for the development of curricula and the training of trainers. The NHTC liaises with the Planning Division of the MoHP to identify the training needs of the different health programmes and provides training programmes in line with the 2004 National Health Training Strategy and as directed by periodic plans.

NHTC has provided basic training for ANMs, upgrading training for AHWs and ANMs, and reproductive health training. It also provides clinical and non-clinical training. The NHTC oversees 5 Regional Training Centres and training is provided through a network of the central NHTC, 6 regional training centres, one sub-regional training centre, 30 district training facilities, and 14 training health posts. There are also 18 clinical training sites attached to regional and zonal hospitals for clinical competency based training. The training

[91] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010

teams provide technical as well as managerial inputs for national, regional, district and community level training programmes.[92]

During the NHSP-2, training will be decentralised to the district level to enable districts to plan and implement training relevant to their needs and to minimise the training burden at the central level. Existing training and capacity building packages will be reviewed, revised, and used to support the Ministry's pilot initiative 'Strengthening Local Health Governance Programme'.

The SBA In-Service Training Strategy (2006 2012) aims to provide competency-based in-service training in SBA to all eligible current and newly recruited ANMs, staff nurses, and doctors who work in government facilities, and to increase the number of SBA training sites. It estimates that over 5,000 SBAs will need to be trained by 2012 to reach the target of 60% SBA assisted births in 2015.[93] Additional SBA training sites will be established and SBA skills incorporated into pre-service training curricula for medical officers and nurses. By 2010, 2,535 SBAs had been trained.

Training will be provided to continue to improve SBA and MNCH skills of health workers. Training will be provided to MCHWs to enable them to upgrade to ANMs and to approximately 1,200 Village Health Worker (VHW) who will upgrade to AHWs. Other planned training interventions, such as management and leadership development training programmes are also planned.

The NHTC has a Training Information System (TIS) that is an Oracle-based system. It is not fully utilised currently due to capacity constraints and a paper-based system is being used instead. NHTC plans to add additional fields and forms and is currently working with a pilot district to help them capture their training provided locally. It is also intended to link TIS and HuRIS.[94] Strengthening the TIS will help with the monitoring of training interventions and reduce the need for individual training databases for different projects and programmes.[95] It was reported that health workers sometimes attend the same course twice and that investment in training is being lost because trained staff are being posted to facilities and posts where they cannot use the skills they have acquired through the training. With a link between TIS and a personnel database (either HuRIS or PIS), this problem may be avoided.

The NHSP-2 proposes that the role of the NHTC be re-evaluated. It also recommends that there should be more integrated approaches to the delivery and monitoring of training to enhance quality and minimize cost. It proposes the formation of a National Health Training Coordination Committee to promote intersectoral training coordination and cooperation.

There are few districts with training facilities, and many are conducting training without the necessary training infrastructure. Uncoordinated training is also contributing to absenteeism

[92] Ministry of Health and Population (2011). Department of Health Services Annual Report 2009-2010 pp. 225-226
[93] Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha
[94] Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH
[95] Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH

and affecting the availability of essential health workers. The 2011 MDG Assessment Report indicates that staff in remote districts has not received adequate training on new developments related to maternal health and were not competent to manage complicated maternal cases.[96]

An assessment of training capacity in the health sector in Nepal was conducted in mid-2011.[97] The focus of the assessment was in-service training and CPD. Findings indicate that the government is committed to training and has allocated financial and human resources for training interventions. Private sector providers are contracted to provide training and there are a number of 'best practices' training approaches being adopted in Nepal, e.g. workplace based training.

However the assessment also highlighted a number of areas that needed to be improved and strengthened. Much of the training was found to be is 'supply driven' and not based on individual and/or organisational needs and requirements. Training in topics such as management, human resources, data management, finance, etc. is not provided. Many of the training approaches used are classroom based and practical elements are weak. Training providers are not regulated and the quality of some providers is poor. Overall a more systematic and coordinated approach was recommended. This Assessment recommended ways in which the in-service training and CPD system could be strengthened, and identified a number of priority areas for action.[98] These include:

- Establishing a systematic and coordinated approach to in-service training and CPD through the development of structures, strategies and plans aligned with the HRH Strategic Plan and in collaboration with stakeholders.
- Ensuring continuous improvements in training approaches through scaling up good practices and revision of training materials in line with GESI principles.
- Strengthen institutions' ability to provide training and CPD, and strengthen contracting mechanisms and guidelines.
- Improve current regulation mechanisms by promoting national and international partnerships and making CPD a requirement for re-registration with professional councils.

[96] National Planning Commission/UNDP (2011). Millennium Development Goal Needs Assessment for Nepal 2010
[97] Ministry of Health and Population (2011). Training Capacity Assessment and Strategy Development. Elliot, L., LATH
[98] Ministry of Health and Population (2011). Training Capacity Assessment and Strategy Development, Elliot L, LATH

HR FUNCTIONS, SYSTEMS AND CAPACITY

The functions related to the HRP/M/D in the public sector are carried out by multiple actors in a number of government organisations and agencies, including the MoE, Public Service Commission (PSC), Ministry of Finance, MoGA, the professional councils and in many different units within the MoHP and DoHS. While there is logic to the allocation of these functions, making the overall system work requires very effective coordination and communication.

Within the MOHP no single department has overall responsibility of HRH, responsibility is spread across three divisions (see Table 21). These include the Personnel Administration Division, responsible for recruitment, posting and promotion of health workers; the Human Resource and Financial Management Division, concerned with human resource planning and HR development; and the Policy, Planning and International Cooperation Division, responsible for fellowship and scholarship programmes. Another three units under the MoHP - namely the Department of Health Services, Department of Ayurveda and Department of Drug Administration - also perform a number of HR functions.

Both Joint Secretaries have HR in their remit and since they are of the same rank, which is also equal to that of the Director of NHTC, neither is in a position to set the agenda for NHTC. In addition, both Joint Secretaries are employed by the Ministry of General Administration (under the Civil Service Act) and are subject to frequent transfer between ministries.

TABLE 21: UNITS OF THE MOHP INVOLVED IN PLANNING, MANAGEMENT AND/OR DEVELOPMENT OF HRH

Joint Secretary Human Resources and Finance Division	Joint Secretary Personnel Administration Division	Policy, Planning and International Cooperation Division
Human Resource Development Section (includes HuRDISH)	Personnel Administration Section	International Support, Scholarships, International Cooperation Coordination Section
	Promotion Section	
	Acts, Regulations Consultation Section	

Source: MoHP 2010

The Administration of the DOHS and the Regional and District Office deal with posting and the transfer of staff according to grades as shown in Table 22 below.

TABLE 22: POSTING AND TRANSFER AUTHORITY BY LEVEL OF INSTITUTION

Institutional level	Grades
DOHS	6-7
Regional office	4-5
District office	1-4

Source: MoHP 2010

The PSC is responsible for recruitment and promotion of approximately 80,000 government staff, including those employed by the MoHP. It manages a quota system for recruitment as part of positive discrimination policy to improve social inclusion. Its Regional and Zonal offices have delegated authority.[99] As part of a 3-year reform programme the PSC is streamlining its procedures with support from the ADB-supported e-governance project

The role of MoGA is to regulate and manage the civil service as prescribed by the government's rules and regulations and management of pension entitlements.[100] It oversees the structures and staffing (establishment) of government departments and keeps records of civil servants. MoGA seconds administrative staff to other ministries.

Professional councils, namely the Medical Council, the Nursing Council and the Pharmacy Council, are responsible for registration, licencing and accreditation of training institutions. They register new graduates, oversee the training curriculum and approve new training institutions.

Because there are multiple actors, with sometimes opposing interests, involved in the HR functions, approaches to HR planning, management and development can be fragmented and poorly coordinated. Many of the staff responsible for HR are employed by MoGA and can be transferred at any time, leading to a high turnover of staff.[101]

However there have been improvements in the planning, management and development of HRH, and some systems and practices are effective, as evidenced by the award Nepal received from the UN for progress towards MDG 5. Other initiatives and interventions have been undertaken, including the establishment of structures and development of plans which provide strategic oversight and directions for HRH, e.g. the establishment of the Country Coordination Facilitation (CCF) mechanism; the Strategic Plan for Human Resources for Health (2003-17) provides direction for HRH interventions and the NHSP-2 has made provisions for strengthening HRH planning, management and development. Systems and procedures are being strengthened to address staffing shortages and performance issues; e.g. contracting arrangements have been established for doctors after completion of scholarships, arrangements have been developed for staff to cover for those on study and leave, and a proposal for a performance based incentive scheme for doctors has been submitted to the MoF for approval.

An assessment of the capacity for HR planning, management and development was conducted in 2010.[102] It noted that the CCF would provide a forum for improved stakeholder collaboration and communication, and that the new HRH Strategic Plan would provide a more strategic direction for HRH interventions. However, it also confirmed that HRH structures and systems in the MoHP and across government were fragmented and

[99] See http://www.psc.gov.np/engintroduction.php
[100] See http://www.moga.gov.np/beta/index.php#
[101] Information based on interview with MoHP
[102] Nepal Health Sector Support Programme (2010). Draft Capacity Assessment for Health System Strengthening. An assessment of capacity building for health systems strengthening and the delivery of the NHSP-2 results framework. Martineau, T (LATH)and Subedi H. N.

incomplete. There was a low skill base in strategic HR planning and management, and there were no structures in place for coordinating HRH across the health sector and for aligning staffing requirements with the rapidly expanding supply from training.

HR information systems

Two major HR databases exist with data on the health workforce employed by the government The HuRIS is the MoHP's information system, which maintains information on staff employed in the health sector only. The MoGA has a hard-copy file database for all government employed staff that was recently overhauled and updated for health employees. It also manages the PIS, which is housed within the Department of Civil Personnel Records (DoCPR). The PIS is the repository for HR information for the whole of the public service and is used for managing pensions. The DoCPR keeps records and information of the 87,000 government employees (with the exception of teachers, police, paramilitary and armed forces).

It was originally planned that the HuRIS would include other government sectors (e.g. police, army) and the private sector, but this has not yet happened. The HuRIS contains detailed job related information on each individual, including job history, training and personal details but is slow and offers limited information because it is dependent on largely voluntary self declared information inputs. Though HuRIS is capable of forecasting the retirement and replacement of staff, the data are incomplete and could not be used as a reliable planning and management system. The major problems appear to be with regular updating of the system at district level, due to poor internet connectivity in some locations and high turnover of trained operators, especially at district and institutional levels. Professional councils also hold data on key professionals for which they are responsible. However, the validity of these data is also uncertain and the systems do not monitor, for example, training and education for all members.

There are limited data available in the MoHP to provide evidence of the main HRH problems and challenges, and to identify which cadres are the most affected. There is a lack of accurate and comprehensive routine workforce information at the national level and there are no readily available and up-to-date figures showing flows and trends in the main staff groups, such as doctors and nurses, over the last decade. Many of the reports cited above are using data on staffing that is three years old or older.[103]

A survey in 2008 demonstrated the lack of consistency in staffing data collected in the field and the Human Resource Information Centre (now referred to as HuRIS). It raised concerns about the quality of the information for human resource planning, training, and management.[104] This was echoed a year later in the NHSP-2 when it was noted that 'the present human resource information system HuRIS is not up-to-date and is believed to

[103]Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH

[104] Ministry of Health and Population/ RTI (2009). Human Resource Strategy Option for Safe Delivery Riitta-Liisa Kolehmainen-Aitken and Ishwar Bahadur Shrestha

contain only three-fourths of the total personnel'.[105] HuRIS will need to be strengthened to ensure that it can generate and provide up-to-date and reliable information for managing human resources. The MoHP has developed tools and will begin collecting, compiling and maintaining data on both the private-for-profit and private-not-for profit/NGO sectors. [106]

In 2011 an assessment of the Human Resource Information System was conducted.[107] Its findings and recommendations are presented and discussed below.[108]

National statistics on staff numbers are not being collected and reported on a routine basis, making it difficult to monitor and track staff movements. Job classifications are inconsistent, which makes identifying trends in staffing difficult, due to classification of staff categories. The MoHP tends to get national workforce data from regions rather than use HuRIS, because of its unreliability. Because the HuRIS information on new entries and resignations is incomplete, it cannot be used to monitor staff flows, particularly staff losses/attrition.

The PIS is currently being upgraded and the database is being validated to develop it into a fully functioning HuRIS and paperless process for HR administration. If the PIS can produce accurate workforce reports and meet the needs of the MoHP given the current investment in its upgrading, a decision may need to be made as to whether efforts should continue to be made to strengthen and improve the HuRIS. However, HuRIS may still be needed as the MoHP role in HR planning is envisioned to increase significantly, with the production of a large number of reports on a routine basis. This includes an annual report of HR information, which should also be published on the MoHP website.[109]

Regions, Districts and Hospitals produce workforce reports on sanctioned and filled posts and vacancies, which are used to plan and monitor recruitment. Staff in 73 out of 75 districts have been trained in entering data into HuRIS, but some of those trained have been transferred and their replacements are untrained and therefore do not use the system.[110] Workforce information that is available at region and district levels should be submitted to the MoHP on a regular basis to enable the MoHP compile annual workforce reports, including reports on sanctioned and filled posts and vacancies for the main staff groups. Additional staff should be trained in the analysis of workforce information and the use of Excel's spreadsheet and graphics functions.

Systems and procedures will be needed to ensure that routine workforce information is collected on a regular basis. This will need to be well institutionalised before the workforce planning exercise is conducted. Workforce information should be updated each year and a time series produced to show changes year by year. In order to monitor initiatives aimed at improving the retention of essential staff in rural areas, recruitment and vacancy figures

[105]Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010
[106] Ministry of Health and Population (2011). Milestone 7: Periodic Review on the development of the HR Plan (Draft) Martineau, T. & Bista, B. (2011). Nepal Health Sector Support Programme
[107] Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH
[108] Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH
[109]Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH
[110]Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH

should be monitored on a regular basis. Data on staff losses (e.g. resignations, retirement, etc.) and age profiles should be collected by staff group, on an annual basis and published for MoHP planning and budgeting cycle purposes. An annual report on all HR Information should be produced. The training information system is currently being strengthened and expanded, and once it is fully functional data on the number of newly qualified staff graduating for each profession should be collected annually.

PROJECTING HRH REQUIREMENTS AND WORKFORCE PLANNING

To support improved workforce planning a Health Workforce Plan will be developed in Year 1 and will provide short, medium and long term HRH projections. The Workforce Plan will establish a more complete HRH profile for the health sector, identify HRH shortages and skills gaps and provide strategies for closing the gaps between future demand for HRH and the current workforce. Capacity will be developed to in workforce planning and the processes and systems institutionalised. The MoHP will monitor, review and adjust the Plan on an annual basis

The first step in developing the Health Workforce Plan will be to update and validate current HRH data and to continue to strengthen the collection, analysis and capturing of routine workforce information. Systems and capacity to maintain and monitor these data (particularly HRH stocks and flows) will be improved and reliable data will be available to policy makers, decision makers and managers for HR decision-making. This will provide a more firm foundation on which the MoHP can undertake a more comprehensive workforce planning exercise across the whole health sector.

The MoHP will ensure that future HRH requirements are informed by service delivery needs; and that existing and future data are used to adjust and amend the projections e.g. data from the HuRIS, the government's PIS, and the findings of the Service Tracking Survey and other surveys and studies.

Free health services and the abolition of user fees in district hospitals and the resultant increase in the utilisation of services will be taken into account when determining future requirements. Greater involvement and partnership with the private sector in the delivery of health services is envisaged, and the additional HRH that will be available through such partnerships will be considered when future HRH requirements are being determined.

Other factors and developments such as infrastructural development and upgrading of health and sub-health posts, GESI, the provisions and amendments of the Health Services Act,[111] budget allocations and constraints, new health programmes and decentralisation will also be considered.

[111]A recent amendment proposed to the Health Service Act states that '45% of the posts to be filled by open competition shall be set aside and be filled up by having separate competition between women, Adiwasi/Janjati (ethnicity), Madhesi, Dalit, disabled and backward groups. It also states that the employees may form trade unions under the provision of this Act.

The MoHP will also determine the methodology to be used for the workforce planning exercise. Currently the recruitment and deployment of HRH are controlled by a sanctioned post system, and workforce planning is based on facility-based staffing standards in which there are fixed numbers of sanctioned posts for each category of staff per level of health facility. Alternative approaches to determining staffing pattern and norms that take into account local needs and/or facility workloads will be explored.

A recent assessment of the HuRIS suggests that workforce demand, unlike other HR information, can be more subjective in nature. There are tensions between what would be professionally ideal and what is economically affordable, and these can only be resolved through a process of stakeholder consultations.[112]

Workforce demand is sometimes based on activity ratios that link the number of staff to the volume of work e.g. 'nurses per occupied bed'. However, the ratios need to be agreed, usually using international comparisons as a starting point, suitably adjusted for degree of complexity and other contextual factors. For example, surgeon numbers are determined by the number of operations undertaken, the acuity of patients and the complexity of the procedures. Demand exercises will be undertaken with inputs from members of the health professions who are actively engaged in clinical work.[113]

Recent plans and various new health initiatives and programmes call for the recruitment and deployment of additional staff for the MOHP as shown in the Table 23 below.

[112]Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH

[113]Ministry of Health and Population (2011). Human Resource Information System Assessment. Blair G., LATH

TABLE 23 PROPOSED HRH REQUIREMENTS

Source	Cadre	Quantity	Additional Information
NHSP-2	SBA	7000	Current supply of SBAs is 1,000, 34 MDGPs are available Chronic shortage of anaesthetists, psychiatrists, radiologists, radiographers, anaesthesia assistants). To be provided over the 5 years of the NHSP-2
	MDGPs	90	
	Anaesthetists	44	
	Radiologists	55	
	Physiotherapists,	20	
	Physiotherapy Assistants	70	
	Psychiatrists	56	
	Radiographers	100	
	AAs	62	
	ANMs/Rahat	1000	An additional 1,000 ANMs (200 per year) will be recruited from the Dalits and other excluded groups as Rahat to HPs in underserved areas
	Doctors, 3 nurses, and support staff	Not specified	The number of community hospitals is expected to increase and additional doctor, 3 nurses, and support staff will be required to run these community hospital on a 24/7 basis.
	HAs	3,100	3,100 SHPs will be upgraded to HPs during NHSP-2. Each new HP will require an additional HA
	Mobile Teams	Not specified	Mobile teams will be organised to provide specialist services to remote areas.
NHSP-2	Health system related staff	7 procurement specialists 3 health legislation experts 7 epidemiologists 7 health economists 3 health governance experts Unspecified number of health information specialists, HR managers, hospital managers	There is a shortage of human resources related to health systems management—procurement specialists, health legislation experts, epidemiologists, health economists and health governance experts
The National SBA Policy (2006)			Identifies maternal health staffing requirements for health posts and sub-health posts

Source	Cadre	Quantity	Additional Information
2008 Nepal Safe Delivery Field Survey	Staff to provide Maternal and Child Health Services		Required mainly at district and community levels
DoHS Annual Report 2066/67 (2009/2010)	ANMs Vaccinators		Insufficient number of SBAs - create ANM posts for health facilities in remote hill and mountain districts Increase number of SBA training sites Alternative provision of vacant post of vaccinators (Fill vacant post or contract out locally) Reallocate existing Immunisation staff at different levels
FHD/MOHP O&M Survey Report 2011	MDGPs, Gynaecologists & Anaesthesia Assistants for CEOC services	28 MDGPS 12 Gynaecologists 40 Anaesthesia Assistants	O&M survey conducted by FHD/MOHP for 40 districts for the creation of posts for MDGP/Gynaecologist and Anaesthesia Assistant for CEOC service
MoHP O & M Survey	Specialists	330	
2011 MDG Assessment Report	Staff to provide Maternal and Child Health, Malaria and TB services		Additional staff required to provide maternal and child health services and to support the delivery of malaria and TB services.

It may be appropriate to undertake the workforce planning incrementally. It could be undertaken as a pilot in a particular region or selected district.

In December 2011 the MoHP developed preliminary projections for key cadres as shown in Table 24. Notes, which provide an explanation of how the figures were calculated are given below the Table.

TABLE 24 PRELIMINARY PROJECTIONS 2011

No.	Cadres	Posts	Existing No.	Additional No. Required	Remarks
1.	Medical Doctors	1.1 Specialists: 9th, 10th and 11th level		330	
		1.2 8th Level MBBS Doctors 1.2.1 Physiotherapists 1.2.2 Pathologists 1.2.3 Ophthalmologists		479 15 13 15	
		1.3 BDS Doctors		80	
2.	**Staff Nurses/Nurses**	(a) For 1204 HP with BC (b) For 2636 upgraded HP (c) For 240 PHCs (d) For District level and above	1203	8690 2408 5272 240 770	Including for proposed birthing centres
3.	**Health Assistants (HA)**		1244	3536	
4.	**Auxiliary Health Workers (AHW)**	AHW VHW	4923 3958	n/a	VHWs upgraded to AHWs
5.	**ANMS**	ANM MCHW	1781 3307	n/a	MCHW upgraded to ANM Staff nurses are proposed instead of ANMs
6.	**Paramedics**		7648		
6.1		Lab Technicians (LT)		435	
6.2		Radiographers		355	
6.3		Anesthetist Assistants		141	
6.4		Physiotherapy Assistants		28	
6.5		Ophthalmic Assistants		65	
6.6		Psychiatrists		28	
		Total		**14210**	

Notes:

1.1 This number is based on the negotiation between MoHP & NMA in 2010 about increasing the number of sanctioned posts of specialist doctors.

1.2 The 479 posts of MBBS Doctor are proposed for Central level hospital (3 for 13 central hospitals; 2 for 15 regional/zonal hospitals; 2 for 65 District Hospital; 2 for 20 Rural hospital; and 1 for 240 PHCs;

1.2.1 This post is proposed for regional/zonal hospitals.

1.2.2 This post is proposed for central level hospitals

1.2.3 This post is proposed for regional/zonal hospitals.

1.3 One BDS Doctor post is proposed for 15 regional/zonal hospitals and 65 district level hospitals

2. The 8690 nurses posts are proposed on the basis of 2 for 1204 HPs (with BC); 2 for 2,636 upgraded SHPs; 1 for 240 PHCs; 3 for 20 Rural hospital; 4 for 65 District Hospitals; 10 for 11 zonal hospitals; 20 for 4 regional hospitals; and 20 for 13 central hospitals

3. One each for the upgraded SHPs, and one third of AHWS.

4. This post has not been proposed. Only HAs are proposed.

5. Staff Nurse posts are proposed instead of ANMs.

6.1 435 Lab Technician (LT) posts are proposed as follows: 1 for 240 PHCs; 1 for 20 Rural Hospitals; 2 for 65 District Hospitals; and 3 for 15 regional/zonal hospitals

6.2.355 Radiographer posts are proposed as follows: 1 for 240 PHCs; 1 for 20 Rural Hospitals; 1 for 65 District Hospitals; 2 for 15 regional/zonal hospitals

6.3. 141 Anesthetist Assistant posts are proposed as follows: 1 for 20 Rural Hospitals; 1 for 65 District Hospitals, 2 for 15 regional/zonal hospitals and 2 for 13 central hospitals

6.4. 28 Physiotherapy Assistant posts are proposed as follows: 1 for regional/zonal hospitals, 1 for central level hospitals

6.5 65 Ophthalmic Assistant posts are proposed for all District hospitals

6.6-28 Psychiatrists posts are proposed as follows: 1 for central level hospitals and 1 for regional/zonal hospitals

Robust information systems in the MoHP will be required to support and maintain the workforce planning process. Adjustments will be made based on monitoring data related to service delivery requirements and demands, health system developments, disease burden, new technologies, population trends, etc.. The MoHP will plan, manage, and monitor the development, deployment and utilisation of the workforce to meet service delivery requirements and standards.

SECTION 4 AIM, OUTPUTS, STRATEGIES & ACTIVITIES

AIM OF THE HRH STRATEGIC PLAN

The overall aim of the HRH Strategic Plan is: 'to ensure the equitable distribution of appropriately skilled human resources for health (HRH) to support the achievement of health outcomes in Nepal and in particular the implementation of NHSP-2'.

In order to contribute to this aim, the main focus of the specific **strategies** and **activities** will be to support the achievement of the following four **outputs**:

1. Appropriate supply of health workers for labour market needs
2. Equitable distribution of health workers
3. Improved health worker performance
4. Effective and coordinated HR planning, management and development across the health sector

The HRH Strategic Plan is a four-year plan, aligned to the remaining timeframe of the NHSP-2, covering the period from 2011 to 2015. The strategies and activities contained in the Plan have been designed to build on the achievements of the first NHSP (2004-2010) and to support the implementation of the HRH strategies contained in the NHSP-2. It responds to the HRH situation analysis conducted by the TWGs that were formed to support the development of the Plan. It responds to the issues, challenges and findings contained in assessments and surveys such as the 2008 Nepal Safe Delivery Field Survey, the 2010 assessment of HR planning, management and development capacity, the 2011 MDG Assessment Report, the 2011 assessments of the MoHP HR information systems and in-service training capacity. It aims to support the health sector in its efforts to develop a 'comprehensive and balanced package of measures ….to support improvements in health system performance'.

This section presents the outputs, strategies and activities to be undertaken and achieved over the timeframe of the HRH Strategic Plan. A broad mix of strategies and approaches is required to improve the current situation and address the challenges that exist. Many of the strategies and activities in this section focus on HRH challenges in the government sector because limited information was available on the private and NGO sectors when this Plan was being developed. However, there are studies currently being conducted and others being planned that will provide additional information on the other sectors so that a more comprehensive profile of the health sector can be produced.

The HRH Strategic Plan includes strategies and activities to strengthen capacity, structures and systems for improved stakeholder collaboration and coordination of HRH across the sector and HR functions so that HRH are effectively managed and developed. There are strategies and activities to strengthen the attraction, recruitment, deployment and retention of essential cadres, and to strengthen pre-service and in-service training to improve health worker skills and performance. Strategies and practices will have a gender and social inclusion perspective. Marginalised groups will be trained and retained in the health sector

to provide services across the sector, but especially to underserved populations. Strategies to strengthen public-private partnerships and to improve the involvement and participation of the private and NGO sectors in the provision of services are also included in the Plan.

Some of the strategies and activities contained in the Plan relate to the whole sector; but most focus on the MoHP and government health workers. Activities that have been prioritised for inclusion in a costed Year 1 Implementation Plan are indicated and these will be further developed into sub-activities**. Annex 2** presents more detailed activities and sub-activities for each of the strategies.

OUTPUT 1: APPROPRIATE SUPPLY OF HEALTH WORKERS FOR LABOUR MARKET NEEDS

STRATEGY 1.1 IMPROVE HR PLANNING FOR HEALTH SECTOR

RATIONALE

HR information systems (HuRIS) and leadership and HR planning capacity will be strengthened to ensure that relevant, reliable and up-to-date information on HRH across the sector is available for HR Planning and the development of a Workforce Plan.

The MoHP will focus on updating and validating current HRH data and ensuring that routine workforce information is collected and analysanalysed on a regular basis for the government sector in the first instance. Systems and capacity will be strengthened to maintain and monitor these data (e.g. using data to monitor and manage entries and exits from the MoHP) and mechanisms put in place to make this information available to policy makers, decision makers and managers. A gender and social inclusion perspective will be adopted in the design of data collection tools and the analysis of data.

Once the government system is functioning in the MoHP and data available on government sector employees, the MoHP will begin collecting and analysing information on the private and NGO sectors. There are a number of ongoing initiatives and others planned that will contribute to the information gathering and analysis processes and support the development of a more comprehensive profile of HRH across the sector. An annual Service Tracking Survey, which includes a module on human resources, was conducted in 2011 Save the Children is also currently compiling a situation analysis of HRH and the MoHP is planning to compile a national HR profile in 2012.. These initiatives may also include supporting other organisations, such as NGOs, private health providers, and the professional councils to strengthen their information systems.

All of these initiatives will contribute to establishing an improved evidence base for HRH in the country. The information generated will also support the MoHP to undertake a more comprehensive workforce planning exercise across the whole health sector (including the private and NGO sectors). Workforce monitoring information will be available to help managers and decision makers to plan and review the impact of HR policies and interventions. Monitoring historic trend information will show how staff numbers have changed over a period of time and how this compares with utilisation levels, case loads and

total population. The availability of information on recruitment, distribution, age profiles, staff losses (e.g. resignations, retirement, etc.) will help to inform planning and management decisions, including retention and performance issues. The HuRIS will be strengthened to manage and maintain these HR data and to generate reports that will support HR planning and management processes. Linkages and networking between the HuRIS and other government information systems, such as the PIS and the TIS will also be strengthened.

ACTIVITIES

- Strengthen leadership and capacity in HR planning, including the HR Division in MoHP, Department of Health Services, and staff at regional and district levels (Year 1 and ongoing)
- Strengthen HR information systems and capacity within the MoHP to generate reliable and up-to-date information on HRH firstly in the public sector and thereafter in the private and NGO sectors, for routine and strategic HR planning and management (Year 1)
- Improve availability and use of disaggregated HRH and training information (e.g. gender, caste, ethnicity, cadre, facility, geographical area) for HR planning and management (Year 1 and ongoing)
- Collect and analyse information on service needs across the health sector (Year 1)
- Produce Health Workforce Plan (by June 2012) that will determine HRH requirements (numbers, skills, gender, etc.) and supply to meet service delivery needs across the sector over the short, medium and long term (Year 1)
- Develop capacity and establish and institutionalise planning mechanisms
- Put HURIS online and provide training to relevant field staff (year 1 and ongoing)

STRATEGY 1.2 IMPROVE RECRUITMENT AND DEPLOYMENT PROCESSES AND ENSURE THEY ARE EFFECTIVE AND TIMELY

RATIONALE

The timely recruitment and deployment of essential health workers is a challenge in the health sector. There are various factors that affect the effective functioning of the recruitment and deployment systems, including: a lack of information on vacant positions and shortages, weak systems to implement and enforce recruitment and deployment policies and processes, and financial constraints and lengthy procedures to establish and sanction additional government posts for critical and scarce staff.

The PSC is responsible for the selection of permanent staff, and the MoHP will work more closely with the PSC to ensure that recruitment procedures are strengthened. Procedures will be streamlined, and GESI principles adopted to ensure that available staff are attracted into the health sector and are more equitably distributed. The findings and recommendations of the O&M surveys that have been conducted will be reviewed and progress and/or bottlenecks in having the posts approved and created will be assessed. Information will be collected on the numbers and types of unemployed health workers available and plans developed to fast track their entry into the health sector. Information and communication systems will be improved to ensure that recruitment information is more widely disseminated and targets graduates.

Frequent transfers are impacting on staff utilisation and productivity, especially on team work when a team member is transferred. The implementation of the transfer policy will be reviewed to ensure that transfers are not causing staff shortages, maldistribution, underutilisation, and/or impacting on team working and productivity. It will also be reviewed for its gender implications.

It is increasingly recognised that MDGPs are the most appropriate medical doctor cadre for rural areas[114] and more focused efforts will be made to increase the numbers recruited and deployed to rural areas. It is also critical to ensure that sufficient numbers of positions are available and/or created for hospital and health facility managers. Management and other health systems expertise is available in the country, and staff with appropriate skills will be recruited to ensure that the available HRH and other resources are effectively managed in the delivery of health services.

Female Community Health Volunteers (FCHVs) support and promote the utilisation of health services. A FCHV Fund has been established to support the activities of the volunteers. An electronic database has been developed and is used at the central as well as district levels for the planning and implementation of the FCHV programme.[115] Further studies could be conducted to assess their impact on service delivery and health outcomes.

The NHSP indicates that multi-year contracts will be provided for obstetric, gynaecological, paediatric, physiotherapy, and other diagnostic support services.[116] To ensure that these health workers and others required can be recruited as efficiently as possible, contracting procedures will be streamlined and strengthened and multi-year contracting initiated. Local recruitment/contracting procedures and practices will be reviewed to ensure that they are transparent and equitable, and that appropriately skilled staff are being appointed and deployed. Where local contracting is taking place, priority will be given to the recruitment of local staff and candidates from marginalised communities who have the required skills.

Mechanisms to monitor and manage the quality and performance of contract staff will also be strengthened. Other employment arrangements and contracting options will be explored. For example the contracting function could be outsourced to another agency such as an NGO or a private organisation, which would also have responsibility for managing the performance of the contract staff. The role of the HFOMCs in the recruitment process and the management of contract staff will also be reviewed.

Existing systems and practices will be reviewed through systems audits to identify a) whether the recruitment and deployment practices are complying with policies and procedures, including GESI principles, and b) where the bottlenecks are.

ACTIVITIES

- Assess current recruitment and deployment processes and systems, identify problems and bottlenecks, including GESI related issues and use findings to streamline and strengthen systems (Year 1 and ongoing)
- Review and strengthen contracting systems and practices (Year 1 and ongoing)

[114] The Nick Simons Institute has developed a scholarship system for MDGP doctors; according to the NSI Report on Five Years of Progress 2006-11 the MOHP recently asked the NSI to 'rapidly and widely scale up' the Rural Staff Support Programme.
[115] Ministry of Health and Population (2011). Department of Health Services Annual Report 2066/67 (2009-2010) pp. 119- 120
[116] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p.65

(including introduction of multi-year contracting)

- Review O&M studies and identify and advocate for priority vacancies/positions to be filled
- Management and other health systems posts created to improve the management of hospitals and other health facilities and overall health systems, e.g. HR planning, management and development, health economics, procurement, logistics, etc.
- Use Health Workforce Plan to guide recruitment and posting of staff according to job requirements (Year 1 and ongoing)
- Determine number of trained unemployed health workers available for work and implement procedures to attract, recruit and deploy
- Review and assess experience with local recruitment/contracting to ensure that systems and processes are transparent and equitable, and that appropriately skilled staff are being hired before expanding its use (Year 1 and ongoing)
- Explore and practice alternative recruitment and employment arrangements (including introduction of multi-year contracting)
- Review and document the role and contribution of FCHVs to delivery of health services (Year 1)

STRATEGY 1.3 IMPROVE ATTRACTIVENESS OF JOBS FOR INCREASED RECRUITMENT AND RETENTION

RATIONALE

All employers need to ensure that they have robust systems and procedures in place to attract, recruit and retain adequate numbers of staff with the appropriate skills to fill vacant and new posts in facilities at all levels. Strategy 2.2 below provides more details on issues and activities related to retention and making jobs and postings in the rural areas more attractive. Employers need information on the labour market and need to understand health worker job preferences and job seeking behaviour. Employers can use this information to improve the attractiveness of jobs in the health sector, especially in the government health sector, which may include reviewing the conditions of service, remuneration and other incentives (e.g. recognition and rewards, career development training opportunities, etc.).

The MoHP will improve its understanding of the reasons health workers leave - not just the cadres, but also the different health workers within those cadres - in order to better target attraction and retention strategies. Attrition rates and trends will be monitored and the information used to develop the most appropriate strategies differentiated according to health worker cadre, gender specific needs, the job and the service needs of the location and/or facilities.

ACTIVITIES

- Information (disaggregated) collected and reviewed on job preference and job seeking behaviour
- Labour market information reviewed regularly
- Develop/improve GESI sensitive policies to manage retention (Year 1 and ongoing)

STRATEGY 1.4 ENSURE BASIC AND PRE-SERVICE EDUCATION AND TRAINING IS IN LINE WITH REQUIREMENTS FOR THE HEALTH SECTOR

RATIONALE

The MoHP will work closely with the MoE to ensure that the training and education systems for health professionals are aligned and informed by MoHP plans and programmes. They will work in collaboration with the Professional Councils to regulate and support training institutions/providers to enable them to produce adequate numbers of health workers with the relevant and appropriate skills and knowledge to deliver quality health services. They will explore innovative ways to improve the quality and relevance of health training systems such as the models and approaches discussed at a recent workshop for health training stakeholders facilitated by the MoHP e.g. 'adopt a district' model.

Producing for requirements will also reduce oversupply and will help to refocus training investments on less qualified staff and on staff with the skills needed at district levels and below. Many of highly qualified staff currently produced do not have skills that are relevant and appropriate for the lower levels of the health system. Greater synergy will be fostered between basic and pre-service training systems and in-service training and CPD systems so that the investment in health training and development produces health workers with appropriate and relevant skills and knowledge.

Mechanisms and processes to regulate and assure the quality of training institutions and providers will be reviewed and strengthened. Memoranda of Understanding (MoUs) and/or formal service agreements will be signed with private training institutions, training curricula and programmes will be reviewed and standardised, and systems put in place to assure the quality of their outputs. The MoHP will support and strengthen the Health Professional Councils to enable them play a greater role in the accreditation, review and regulation of health training institutions.

The TIS is currently being strengthened and expanded and when it is fully functional, it will produce data on the numbers of newly qualified staff graduating for each profession annually. Aligned with information on service delivery needs, this will help to inform training plans and programmes. The TIS is currently being strengthened; once it is fully functional data on the number of graduated for each profession should be collected annually. Information on Pre-Service Training (PST), In-Service Training (IST) and Continuing Professional Development (CPD), such as information on numbers and types of training programmes provided by government and private institutions and providers, curricula and programme content, number and capacity of facilities, numbers and types of teaching staff, current and projected intakes and outputs will be required to strengthen the planning and coordination of human resource development systems.

The MoHP will continue to invest significant resources in pre-service and in-service training programmes over the timeframe of the NHSP-2 and this Plan, and it will be important to ensure that these investments produce a health workforce equipped with the skills that will help them to improve performance, deliver quality services and achieve health outcomes. Supportive supervision and post training follow up will be improved to support health

workers use and apply their skills and to assess the relevance and appropriateness of the skills and knowledge acquired. The training will be evaluated to assess the impact on performance and service provision and the findings used to improve the design and content of further training programmes.

ACTIVITIES

- Data collected on current projected production and potential for increase/decrease of specific cadres assessed
- Strengthen mechanisms for communication and collaboration between MoHP and MoE and establish inter-ministerial fora (to include MoHP, MoE, National Planning Commission, MoF, PSC, etc.) to coordinate and address production and regulatory issues
- Work with the MoE to expand or contract training, informed by service delivery needs e.g. MDGPs, Hospital Managers, establishment of more rural based training sites/institutions, etc.
- Improve accreditation and regulation of pre-service training institutions to ensure an adequate supply of appropriately skilled and knowledgeable health workers and assure the quality of the training provided (Year 1 and ongoing)
- Strengthen mechanisms to follow up and support health workers after training and to evaluate the impact of the training on performance.

OUTPUT 2 EQUITABLE DISTRIBUTION OF HEALTH WORKERS

STRATEGY 2.1 REVIEW CURRENT DISTRIBUTION TRENDS AND PROCESSES AND ENSURE DEPLOYMENT SYSTEMS RESULT IN EQUITABLE DISTRIBUTION OF HEALTH WORKERS

RATIONALE

There are various types of workforce distribution problems, but the focus in this Plan is on rural versus urban distribution. However the needs of urban populations and issues related to the quality of urban health services will need attention in the coming years. These will be addressed in part by the upcoming urban health strategy. A good starting point for improving workforce distribution deployment systems and practices would be a review of WHO's recent guidelines on staffing remote areas to see what interventions may be relevant and feasible in the Nepal health context.[117]

The equitable distribution of staff depends on the availability of good data to determine where the vacancies and greatest HRH needs are. More comprehensive and up-to-date data on the distribution of health workers, both in terms of numbers and skills, across the different sectors and geographical regions of the country will be collected. A better understanding of the skills mix required at the different levels of the health system will ensure that the staff available are posted to facilities where their skills are needed and can

[117] World Health Organization (2010). Increasing access to health workers in remote and rural areas through improved retention. Global policy recommendations

be fully utilised. The remote area policies and systems that are in place in the health sector will be reviewed and deployment processes mapped out to get a better understanding of what should happen, what does happen in practice and what is the effect on staff distribution.

Criteria for placement and transfer will be developed and utilised, and the predictability of rotations established to ensure transparent implementation. Training institutions will encourage applications from students from remote areas and marginalised groups; establishing a quota system may help with this.

ACTIVITIES

- Review regulation and enforcement of remote area policies and systems and identify barriers (Year 1 and ongoing)
- Collect, analyse and update distribution data of sanctioned and filled posts disaggregated by location, cadre, gender, caste, and ethnicity (Year 1)
- Introduce corrective action to address barriers and strengthen policies and systems

STRATEGY 2.2 MAKE JOBS/POSTINGS IN RURAL AND REMOTE AREAS MORE ATTRACTIVE TO RETAIN HEALTH WORKERS

RATIONALE

This strategy builds on Strategy 1.3, but with a particular focus on jobs in rural areas. The MoHP has implemented and adopted a number of strategies to improve the distribution and retention of health workers. The bonding of scholarship doctors and the withholding of licenses until they have served out the bonding period has been an effective strategy in increasing the number of junior doctors deployed and retained in the rural and remote areas.

Various studies have been conducted to examine the reasons for shortages in rural and remote areas. For example, are there sufficient numbers and types being produced; are the health workers produced entering the public health service; if they do enter, how long are they staying; if they leave do they join the private or NGO health sector or do they leave the sector and/or the country? If there is a distribution problem, is it because of insufficient information to indicate where the vacancies and needs are and where staff are not posted; is it because the transfer and deployment systems are ineffective; are staff posted but unwilling to go and do not report? Further analysis is needed to determine the causes and to develop the most appropriate strategies to address attrition and retention problems.

Other studies have examined issues such as staff satisfaction, motivation and incentives. The findings of these studies and other international research[118] on retention suggest that the best results are achieved by choosing and implementing a bundle of contextually relevant interventions.[119]

[118] WHO (2010). Increasing access to health workers in remote and rural areas through improved retention. Global policy recommendations

[119] See findings of the 2008 Nepal Safe Delivery Field Survey; the MoHP/NSI 2010 Mid-term Assessment of the Rural Staff Support Programme; the (2008) Health Sector Reform Support Programme Costing Study on Incentives Packages for Nepal's Health Care Professionals; and various MoHP O&M Surveys.

Piloting different bundles of interventions with different health worker cadres will help to determine the most effective bundle to use to attract and retain staff required. Interventions could include career development and advancement opportunities, creating an enabling work working environment, provision of adequate supplies and equipment, and other factors such as good leadership and HR management, team work and clear job roles and plans.

The impact of interventions and bundles already in operation will be studied and the evidence and findings generated better utilised to inform new strategies and interventions.[120] More information may be needed on the incentive structure that influences an individual's choice of job and location, e.g. studies and/or research on the 'push' and 'pull' factors that affect different categories of staff.

Studies to determine migratory patterns and trends among the different health worker cadres and the push and pull factors that influence external and internal migration will also be conducted. The findings will inform the design of interventions to reduce internal migration and movement between the government, private, and NGO sectors and help achieve a better public-private mix. Female health workers face also constraints to working in remote areas because of gender related issues (e.g. family responsibilities, etc.) and these constraints will be addressed through supportive interventions.

The availability of more comprehensive information, disaggregated by sex, cadre, age, caste and ethnicity through the HuRIS and other information systems, will enable employers to develop more targeted and differentiated retention packages (monetary and non-monetary incentives) to make postings more attractive and help to retain staff in underserved areas.

Any future expansion and/or scale up of these initiatives must be well managed and coordinated, to ensure that they do not distort distribution imbalances even further. Any incentives and allowances provided will be linked to absence management and will be performance based.

The functioning of the HFOMCs will be strengthened so that they can support initiatives to improve the working environment and to address some of the factors identified as being key to retaining staff such as security.

ACTIVITIES

- Review, revise, implement and monitor career benefits related to rural posting and transfers (linked to 1.1 and 1.3)
- Identify push and pull factors, disaggregating these for women, people from different social groups, income status and locations
- Review existing retention schemes across the sector, including the private and NGO sectors, and identify the most appropriate and effective schemes and incentives (Year 1 and ongoing)
- Use findings of review to develop retention policy and schemes
- Research on critical HRH areas focusing on remote areas and link to planning process

[120] MoHP/Nick Simmons Institute (2010) Mid-term Assessment of the Rural Staff Support Programme

- Improve working environment to attract and retain staff in collaboration with HFOMCs

STRATEGY 2.3 PREPARE AND SUPPORT STAFF BETTER FOR WORKING AND LIVING IN REMOTE AREAS

RATIONALE

All new employees and those being transferred to remote areas will receive adequate orientation before they are posted. This will build on and add to the information provided during their pre-service training. They will be given information on the location and facility they will be posted to. Safety and security issues for female staff will also be considered. In the more remote facilities, new staff will be linked up with senior staff members who can support and mentor them. Local district health office and the HFOMCs will also support the health workers deployed to their areas. Pre-service training curricula will be reviewed and revised to include this type of information to better prepare health workers for living and working in rural areas.

ACTIVITIES

- Provide job and posting orientation after recruitment for different cadres (Year 1 and ongoing).
- Strengthen mechanisms to ensure that health workers posted to remote areas receive regular supportive supervision and mentoring support

STRATEGY 2.4 IMPROVE WORKERS' LIVING AND SOCIAL CONDITIONS IN REMOTE LOCATIONS

RATIONALE

Health workers are likely to be more willing to go and remain in remote areas that have adequate living and social conditions. Studies conducted in Nepal indicate that factors such as housing, schooling, transport, security, etc. are important to attract and retain health workers.

The NSI Rural Staff Support Programme is focusing on many of these issues with varying degrees of success. Recent programme assessments indicate that improving communications and providing opportunities for health workers in rural areas to network with each other have been very effective in retaining MDGPs. The findings also suggest that working closely with the local government and the community has addressed many of the greatly security issues. It will also be important that infrastructural development and construction and renovation plans for health facilities include improvements for staff housing.

Some of the things required to improve living and working conditions in remote areas are not within the control or remit of the MoHP, e.g. schooling and security, and will require liaison with other government agencies at central and local levels. Further federalisation and decentralisation may lead to improved transport and schooling, and districts may have greater control over the allocation of resources to address some of these issues.

ACTIVITIES

- Review policy and practice related to the following areas:
    - Improved security
    - Access to schools
    - Improved housing
    - Communications (inc internet)
    - Transport
- Strengthen functioning of health facility/hospital management committees (e.g. local level resource mobilisation for improving living and social conditions for health workers)

STRATEGY 2.5 COMPULSORY SERVICE TO IMPROVE RURAL SERVICE PROVISION

RATIONALE

As proposed in Strategy 2.3 above, staff will need to be better prepared and supported for working and living in remote areas. There are increasing numbers of young doctors working out their scholarship bonds in rural and remote government facilities. The MoHP will work in collaboration with the Ministry of Education to strengthen mechanisms to adequately support and mentor these scholarship doctors; new graduates and junior staff posted to remote areas will be linked up with senior and more experienced health workers. Improved communications and opportunities for networking with other junior doctors will be provided. Strategies such as posting newly recruited doctors to larger facilities in less remote areas for a short period before they begin their rural posting will also be explored. This would allow them to gain more practical experience and work under the mentorship and supervision of more experienced staff.

When policies and procedures are in place for compulsory service, the MoHP, in collaboration with the professional councils will ensure compliance through withholding registration and/or further postgraduate training opportunities until the agreed period has been served.

ACTIVITIES

- Review compulsory service experiences and assess impact on deployment and retention of junior doctors (e.g. scholarship and new entrants), specialists and other senior staff in peripheral health facilities (Year 1 and ongoing)
- Use findings of review to develop and pilot the introduction of incentive packages (e.g. career development, post graduate training, etc.) to attract, motivate and retain scholarship doctors.

STRATEGY 2.6 CONTINUE AND IDENTIFY NEW AREAS FOR TASK SHIFTING AND ALTERNATIVE STAFFING IN CLINICAL AREAS (E.G. ANAESTHESIA, ULTRASOUND ETC.)

RATIONALE

Decisions for task shifting should be based on the following:

- an analysis of key shortages
- what can feasibly and safely be done by cadres to whom it is proposed that tasks be shifted
- whether the decision is a short-term or long-term solution to the shortage

The analysis and review undertaken will also identify specialist staff that have been posted to generalist positions and are not fully utilising their skills.

ACTIVITIES

- Review and conduct analysis of key shortages and scarce skills (Year 1 and ongoing)
- Conduct workload and job analysis for all health professional jobs/posts

STRATEGY 2.7 USE NGOS AND PRIVATE HEALTH PROVIDERS FOR SERVICE DELIVERY IN MOST DIFFICULT AREAS

RATIONALE

The feasibility of this strategy needs to be further explored in the context of PPP, and will require consultations with the NGO and private health sectors. There has some progress to date with PPP, and this is an area that requires further analysis and refinement. Greater participation and investment by the private sector in the public health sector will be encouraged. For example, where private training institutions are using government health facilities as practicum sites for their students, they could be encouraged to ensure that posts are filled and to invest in infrastructure and other areas.

Gaps in service delivery in difficult areas will be identified, services that NGOs and private providers could provide identified, and the most appropriate type of partnership agreed and formalised.

More information will be obtained on the strategies used by the NGO and private sectors to attract and retain staff in difficult areas. The HFOMCs, local health training institutions and other organisations such as women's groups, representative organisations and youth clubs will also be better utilised to provide services.

ACTIVITIES

- Prepare modalities for PPPs and expand PPPs for the management of district hospitals (Year 1 and ongoing)
- Ensure Community Service Organisations (CSO) and HFOMCs participation in social auditing process

OUTPUT 3: IMPROVED PERFORMANCE OF HEALTH WORKERS

STRATEGY 3.1 PROVIDE STAFF WITH LEADERSHIP AND CLEAR DIRECTION

RATIONALE

The MoHP has also identified that the leadership and management capacity of hospitals managers and management teams needs to be improved and strengthened. The EDPs are planning to use performance-based contracts with selected hospitals, and the management of these contracts and the achievement of the agreed performance standards and targets will require a certain level of management expertise.

In 2011, NSI, in conjunction with NHTC, conducted a study to assess the management and leadership training needs of hospital managers. Its preliminary findings suggest that a cadre of managers needs to be created, equipped with appropriate competencies through pre- and in-service training and CPD, and supported through an enabling working environment to improve the management of hospitals and the delivery of services. The study proposes that initially a programme of in-service management and leadership development be run as a pilot with selected hospital management teams.[121]

Management and leadership capacity will also be critical as the federalisation process continues and authority is further decentralised and devolved to the sub-national levels.

While the attrition and retention of staff is often the key focus of plans and interventions, the MoHP will ensure that equal attention is given to managing the performance of the staff that are available and working in health facilities. Facility managers and those responsible for the management of HRH will be equipped with the skills and tools to do this effectively. The MoHP will introduce performance-based and retention-based payment systems. Incentive packages for care providers will be developed and piloted, and operations research will be used to observe the impact on performance. Findings will inform the scale up of these schemes to other geographical areas.

An assessment of how work plans are used at institutional and facility levels will help to determine the extent to which they are guiding the work of individuals and teams. The findings of the review will be used to establish procedures and mechanisms to support the development of work plans linked to performance management and appraisal systems. Managers and staff will be supported and trained on how to develop, implement, monitor and evaluate work plans. Work plans will be reviewed on a regular basis and mechanisms put in place to facilitate stakeholder meetings at all levels (HFOMC, VDC, Municipality, District, Region and National) to review performance.

Recent experiences of developing and/or updating job descriptions e.g. for MDGPs, SBAs, maternal health service jobs, etc. will also be reviewed. The results of the review will be used to revise, update or develop job descriptions for each post and health facility. Performance-based indicators for each individual and health facility will be developed and introduced and these will be linked to incentives where there is critical shortage of staff.

[121] NSI (2011). Hospital Management Training. A Summary Report

The review and development of job descriptions, job plans and performance based indicators will enhance the functioning of the performance management system. An open appraisal system will be implemented to support measure and monitor staff performance and development.

Greater involvement of HFOMCs in performance management processes will be encouraged and facilitated. They will also play a role reducing absenteeism, generating extra resources for facilities and staff, and enhancing the quality of services provided by improving relations between providers and the community.

ACTIVITIES

- In collaboration with organisations such as NSI, design and develop an in-service leadership and management programme and pilot in Year 1 with hospital management teams
- Annual work plans for institution and individuals developed, implemented and monitored. (Year 1 and ongoing)
- Review/develop job descriptions for staff at all levels in collaboration with facility managers.
- Update/develop and introduce performance appraisal/management system for each individual and health facility in line with service delivery programmes (link with performance based incentives where there is critical shortage of HRH)
- Strengthen the implementation of performance appraisal/management systems to make them more objective

STRATEGY 3.2 STRENGTHEN SKILLS/CAPACITY OF HEALTH WORKERS TO DO THEIR JOBS

RATIONALE

An assessment of the overall training and CPD capacity in the health sector was undertaken in August 2011.[122] It identifies a number of good practices and approaches already in place that could be scaled up. It recommends that the capacity of regulatory bodies be improved and more systematic approaches to the regulation, management and provision of in-service training and CPD be adopted. It also proposes that CPD be made a requirement for registration with the professional councils

The NHSP-2 indicates that there will be a substantial number of health workers trained throughout the plan period. The MoHP plans to upgrade and update the skills of providers to enhance the quality of care. Over 1,000 MCHWs will be upgraded to ANMs, and there are over 1,200 vacant positions for VHWs that will be upgraded to AHWs. Skills of care providers and support staff at health and sub-health posts, PHCCs and district hospitals will be updated through in-service refreshing training, coaching and onsite support.[123]

The MoHP and NHTC have been working to improve in-service training and ensure that health workers have the skills and capacity to do their jobs well. Reviews have already been conducted for maternal health and safe motherhood services and training courses have been strengthened to address the gaps identified. With support from the NSI, the MoHP and NHTC have conducted training needs assessments, which have lead to the creation and

[122] Ministry of Health and Population (2011). Training Capacity Assessment and Strategy Development. Elliot, L., LATH

[123] Ministry of Health and Population Government of Nepal (2010). Nepal Health Sector Programme- Implementation Plan II (NHSP-IP 2) 2010 – 2015 Final Draft 18 March 2010 p. 83

adoption of new training courses (e.g. Mid Level Practicum, AA, SBA and Biomedical Technician training) for critical health workers, such as mid level workers and SBAs, and has introduced a distance CME course for doctors to address the skills gaps identified.[124] Other essential health workers will be identified and further training needs assessment conducted to determine how gaps can be addressed.

A more strategic long term perspective on human resource development in the health sector will be adopted to ensure that health workers at all levels have the necessary technical, clinical, management and supervisory skills and knowledge to deliver quality services. The development of the Health Workforce Plan (as described in Strategy 1.1) will help to identify the types of health workers that will be required, which will in turn inform the design and content of training programmes and curricula.

As described in Strategy 1.4, pre-service training will be strengthened to ensure that health workers have a strong knowledge base to begin with and that basic training supports good performance. Providers of in-service training and CPD, including NHTC, will be assessed and strengthened to ensure that the training they provide produces appropriately skilled and knowledgeable health workers. A priority activity will be the assessment of the NHTC capacity and the development of a revised Strategic Plan for the institution.

Training curricula will be reviewed and revised based on systematic reviews of the desired skills set for different cadres, Revisions will also be in line with GESI principles so that health workers can recognise and respond to issues of women, the poor and the excluded. Regulation and contracting mechanisms and guidelines will be strengthened. Training sites will be assessed and monitored and additional sites created to ensure that all health workers have equal access to professional development and skills enhancement opportunities. The number and quality of teaching staff and teaching approaches and methodology will also be reviewed and strengthened. These initiatives will be linked to and support the interventions proposed in Strategy 3.1 above.

As much as possible IST and CPD initiatives will utilise approaches such as on-the-job training, mentoring, coaching and distance learning to ensure that training does not lead to increased absenteeism and disruption of services. Distance learning approaches and options will be considered for staff development, to avoid taking essential health workers away from already understaffed facilities.

ACTIVITIES

- Review, assess and strengthen institutional pre-service and in-service training capacity to provide education, training and CPD that supports service delivery and quality performance
- Provide relevant in-service training courses and CPD to upgrade and update skills of providers and enhance the quality of care (especially of specialist, doctor and senior nursing cadres)
- Review the working/opening hours for public health facilities at district level and below
- Strengthen contracting and accreditation mechanisms and capacity of Professional Councils to enforce and monitor compliance (Year 1 and ongoing)

[124] NSI (2011) Five Years of Progress 2006-2011

- Establish mechanisms and develop criteria and tools to measure, monitor and evaluate training outcomes, training quality and impact and transfer of learning and skills to job and performance

STRATEGY 3.3 ENSURE EFFECTIVE REWARD AND SANCTION SYSTEMS IN PLACE

RATIONALE

This will involve a policy and systems review. The performance appraisal form (Ka SA MU form) will be reviewed and updated. A transparent and open performance evaluation system, aligned with public sector developments and reforms, will be established and appraisals conducted on an ongoing and regular basis (e.g. every 6 or 12 months). Health workers will be involved in the design of reward and sanction systems; unless these systems are perceived as being fair, they will not have the desired motivational effect on behaviour. Performance criteria will also be GESI sensitive. Performance based incentives are being used in other ministries and could be adapted and tailored for the health sector

ACTIVITIES

- Link rewards and sanctions, especially promotion within grade to performance
- Mechanisms in place for health workers to provide feedback on the perceived fairness of reward and punishment systems.
- Pilot performance based incentive system (Year 1 and ongoing)
- Ensure Regional Directorates are providing supportive supervision and monitoring the health work force in their regions.
-

STRATEGY 3.4 REDUCE STAFF ABSENCE FROM ASSIGNED POSTS

RATIONALE

A review will be conducted of the systems currently in place to manage absence. A qualitative study involving staff and managers will provide more understanding of how the current system is working. A monitoring system for both transfers and deputation will also be developed. Strengthening the planning and coordination of training will help to reduce absence as a result of training.

ACTIVITIES

- Improve planning and management of transfers and deputations (kaaj) (Year 1 and ongoing)
- Strengthen absence management mechanisms (Year 1 and ongoing)
  Implement alternative arrangements for staff that are on the leave or on deputation for long periods.

STRATEGY 3.5 ENSURE STAFF AT ALL LEVELS HAVE AN ENABLING WORK ENVIRONMENT

RATIONALE

Staff are more likely to perform well when there is an enabling work environment, including having the necessary equipment and tools (e.g. medical diagnostic and Information Technology (IT) equipment, infrastructure, furnishings, etc.) to do their jobs. If this increases job satisfaction, an added benefit might be improved retention (linked to activities in Strategy on retention)

ACTIVITIES

- Identify which factors in the work environment affect staff performance most (Year 1 and ongoing)
- Liaison with relevant departments and agencies (e.g. logistics and supplies departments) to provide an enabling environment

STRATEGY 3.6 STRENGTHEN TEAM WORK APPROACHES

RATIONALE

Effective team work will improve the quality and coverage of health services and is an effective mechanism where there is understaffing and a high workload. A review of current team work practices will be conducted, including an examination of the impact of transfers on team work. Producing case studies of good and effective team work practices would be a useful first step in addressing this issue. Team work will also ensure that there is an appropriate skills mix to deliver a specific package of services in the facilities e.g. CEOC sites and Birthing Centres

ACTIVITIES

- Review successful team work practices and document (Year 1 and ongoing)
- Disseminate good practice case studies to facility managers

OUTPUT 4 EFFECTIVE AND COORDINATED HR MANAGEMENT AND DEVELOPMENT ACROSS THE HEALTH SECTOR

STRATEGY 4.1 APPROPRIATE HR POLICIES IN PLACE

RATIONALE

Some of the current HR and HR related policies might no longer be relevant or appropriate for the management of today's health workforce. They will be reviewed to determine which are still valid and/or which are not being effectively implemented. The international and national policy and regulatory environment will be scanned regularly and HR policies and systems reviewed and modified accordingly. Various amendments have been made to the Health Service Act and the National Health Policy is currently being revised and updated. HR policies will be aligned with other policy frameworks, e.g. Health Service Act, National Health Policy, GESI strategy and other new and evolving international and national health policies, legislation and regulations.

The ability of HR decision makers and managers to implement and resource the strategies in the Plan and to achieve the agreed outputs will require a supportive policy and regulatory environment. Implementation plans will be aligned with and supported by national and health policy frameworks, e.g. the authority to increase recruitment, improve distribution, increase production will need to be resourced, mandated and sanctioned.

ACTIVITIES

- Review existing national, health and HR policies, identify gaps and revise as necessary (Year 1)
- Identify and promote organisational culture needed to support implementation of revised policies and systems

- Introduce licencing examinations for all health professionals.
- Create mechanisms for re-licensing

STRATEGY 4.2 APPROPRIATE ORGANISATIONAL STRUCTURES, SYSTEMS AND CAPACITY DEVELOPED TO SUPPORT THE HR FUNCTIONS

RATIONALE

A rapid assessment of HR-related departments found that there was a fragmented structure and a lack of capacity to effectively perform the functions, including the management of HR information.[125] Organisational structures at all levels will be identified and strengthened to coordinate, manage and perform HR functions. These structures will have appropriately skilled staff with the tools necessary to effectively perform the functions. The structure and capacity of the professional councils will be also be strengthened to conduct licensing and accreditation and maintain and monitor professional standards. These structures and competencies will be critical as health care services are decentralised and authority for HR recruitment, deployment and other management decisions is devolved to district levels and below.

HR systems, processes and practices for recruitment and deployment, promotion, managing staff absence, contracting and transfers and other HR functions will be reviewed. The gaps identified through these reviews will provide the entry points for support interventions. GESI responsibilities of HR staff also need to be identified, and capacity and skills developed to ensure that GESI principles are observed and adopted. Strategies and activities to support the strengthening of the HuRIS for workforce planning are included under Strategy 1.1 above.

A standard HR framework will be adapted to review the HR functions, including the HuRIS. Previous capacity assessment exercises conducted in the MoHP and their findings will be reviewed and built on. As the form of federalisation becomes known, the organisational structures performing the HR functions and the capacity of HR and management staff at sub-national levels will need to be reviewed and modified and/or strengthened

ACTIVITIES

- Review existing structures, systems and capacity using HR functions framework to identify gaps and overlaps, including from a GESI perspective (Year 1)
- Develop proposals and plans for strengthening structures, systems and capacity
- Strengthen leadership capacity and governance structures and promote greater engagement and involvement of policy makers and senior management in HR planning, management and development (linked to Outputs 1-3)
- Prepare for restructuring required as part of federalisation

[125] Nepal Health Sector Support Programme (2010). Draft Capacity Assessment for Health System Strengthening. An assessment of capacity building for health systems strengthening and the delivery of the NHSP-2 results framework. Martineau, T (LATH) and Subedi H. N.

STRATEGY 4.3 EFFECTIVE COORDINATION MECHANISMS IN PLACE AT ALL LEVELS WITHIN THE HEALTH SYSTEM

RATIONALE

HRH has a diverse set of stakeholders and actors with sometimes opposing interests, which makes it difficult to achieve an agreed and coordinated approach. There are a multiplicity of government and private sector agencies, institutions and stakeholders currently responsible for HRH and different HR functions. The fragmentation and weak coordination of the HR functions within the MoHP is contributing to weak and inefficient HR practices and reduces the sector's ability to maintain a strategic perspective.

The CCF, a high-level multi stakeholder committee established in November 2010 to oversee the development of the HRH Strategic Plan will have a coordinating and oversight role. It will be strengthened and supported to enhance policy dialogue and promote stakeholder collaboration and establish formal and informal linkages across the sector, at both strategic and technical levels.

Robust coordinating structures and mechanisms will be put in place to improve partnership, communication, collaboration, and coordination between all the actors and agencies (including the private and NGO sectors, MoHP departments and programmes, other government agencies, donors, consumers, etc.). This will improve oversight and accountability for the planning, management and development of the health workforce.

The CCF will be aligned with existing coordination structures and mechanisms in the MoHP. The Committee will be composed of representatives from the key stakeholder groups (including GESI) and will promote and encourage policy dialogue across the sector at both strategic and technical levels.

The CCF Committee will also be responsible for coordinating the monitoring, evaluation and the revision of the Plan. It will support the development of annual HRH implementation plans at all levels and their incorporation into the MoHP's AWPB process. It will also support the mobilisation and allocation of adequate funding for the implementation of the Plan from government, donors, and other agencies.

Sub committees or technical working groups will be established to coordinate and monitor specific HRH strategies and interventions, such as workforce planning, training, HRIS, HRM (e.g. recruitment, distribution, retention, and performance management), monitoring and evaluation, etc.

ACTIVITIES

- Obtain more clarity on underlying causes of fragmentation and weak coordination **(Year 1)**
- Strengthen the CCF to function as a high level HRH Coordinating Committee at national level **(Year 1)**
- Mechanisms reviewed and in place between MoHP and other health providers to supplement the delivery of health service

INTRODUCTION

It will be extremely challenging to address all of the HRH issues and challenges highlighted in this Plan. The effort needs to be well coordinated and carried out by people with appropriate skills and experience. Strengthening HRM systems will be particularly important to complement the investment in scaling up numbers of staff to ensure the best return on the investment. The MoHP will ensure that there are robust human resource policies, capacity, structures, and systems to manage and develop their human resources and to enhance productivity in the health sector. Other arrangements such risk analysis processes, implementation arrangements and mechanisms, monitoring and evaluation systems and budgeting and resource mobilisation strategies will be developed to give the Plan the best chance of success.

Factors in the external environment will impact on HRH and the performance of the health sector during the time frame of this Plan. These risks will be managed to reduce the negative impact. The implementation of the Plan will be coordinated, supported and regularly monitored, reviewed and evaluated in order to assess progress, modify and adjust strategies and activities and develop subsequent plans and interventions. Finally, the 4 Year Strategic Plan, Annual Implementation Plans and the proposed Health Workforce Plan will be costed and resources mobilised. These are discussed in greater detail below.

RISKS AND ASSUMPTIONS

HRH cannot be considered in isolation from the socioeconomic, political, legal, and health context, and there are factors in the external environment that could impact on HRH and the performance of the health sector during the time frame of this Plan.

This Plan contains strategies and activities to address current and future challenges and to achieve the overall aim and stated outputs. However well-designed the strategies might be, there are factors beyond the control of the MoHP, which may hinder the achievement of the aims and outputs. Some of these risks, which can be stated more positively as explicit assumptions, can be managed to reduce the negative impact. As part of managing the HR strategy, the MoHP will regularly check whether the assumptions remain true. If the assumptions are found not to hold true, some redesign of the strategies may be required.

The following are some of the assumptions for the successful accomplishment of this plan:

- Partners and collaborators are willing to fund and support the HRH Strategic Plan.
- MoHP and senior management in other government departments are willing to participate in the development, approval and review of policies, systems and practices to facilitate the implementation of the HRH Strategic Plan.
- Health sector partners responses and actions to address HRH issues are coordinated and strategic.

- Private sector involvement leads to improved coverage and access to health services.
- MoHP staff and senior management from other key government Ministries support the implementation and monitoring and evaluation of the Plan. This support will translate into required resource allocation.

Some of the risks and assumptions will be managed within the HRH Strategic Plan to reduce the negative impact. Others will be acknowledged and monitored. Table 18 below provides a sample table that will be populated in Year 1 as part of the planning and development process for this HRH Strategic Plan. In it the risks are restated as assumptions, which supports the link between the strategies and their respective outputs.

TABLE 25 EXAMPLE OF ASSUMPTIONS ASSOCIATED WITH THE STRATEGIES

Output/Strategy	Assumptions/Risks	Strategy
Appropriate supply of health workers for labour market needs	All key stakeholders are and continue to be included in the planning process Regular review meetings, monitoring and evaluation inform decisions and action taken HR information systems are strengthened and enhance flows of data between the centre and the regions/districts	Improve HR Planning for Health Sector Improve MoHP recruitment and deployment processes, and ensure they are effective and timely Improve attractiveness of jobs for increased recruitment and retention

IMPLEMENTATION ARRANGEMENTS

There is a common danger that the plan remains simply that – a Plan. It is therefore important that the strategies and activities are reviewed and revised on a regular basis to ensure the greatest chance of implementation. Strategies and long-term plans must be set out with clear priorities.

The implementation of the Strategic Plan will take place at various levels of the health care delivery system. Emerging HRH issues will be reviewed regularly as part of the annual health sector review process. The MoHP and CCF will oversee the implementation of the broad strategies, provide strategic guidance to interpret the strategies and activities into annual costed action plans that are included in AWPB, ensure that the Plan is reviewed during the Joint Annual Review (JAR), and make recommendations for the broad direction for subsequent years. The participation of officers and managers at regional, district and facility levels and staff from the training institutions in the implementation will also be critical.

ANNUAL IMPLEMENTATION PLANS

The MoHP, the CCF and other stakeholders will translate and prioritise the strategies and activities contained in the HRH Strategic Plan into more detailed annual implementation plans. The activities and indicative sub-activities for each of the strategies are presented in **Annex 2**. These have been costed and a draft budget for the implementation of the Plan

over the 4 years has been developed. Priority activities will be further refined and captured in the 2012 AWPB.

MONITORING AND EVALUATION OF THE PLAN

The implementation of the Plan will be monitored, reviewed and evaluated on an annual basis as part of the Joint Annual Review process. This will provide opportunities for reflecting on the purpose, strategies, and outputs of the Plan and for reviewing the quality of the outcomes. Strategies and activities will be modified and adjusted and new plans developed.

The implementation and monitoring of the strategies in the Plan will require further information gathering and analysis, in particular, for the development of the proposed Health Workforce Plan (see Strategy 1.1) scheduled for Year 1. This will need to be supported by relevant and reliable HRH information systems. Basic and post-basic training plans will also be linked to these projections.[126]

A Monitoring and Evaluation Plan and HR indicators aligned with NHSP-2 indicators will be developed. Monitoring the implementation of the HRH Strategic Plan will be done at three levels: the national, regional and district levels. At the national level, the CCF will coordinate the development of Annual Implementation Plans and oversee the monitoring of the implementation of the Plan. The approved HRH Strategic Plan and the Annual Implementation Plans will be disseminated widely and posted on the MoHP website.

M&E data will be collected and analysed regularly and used to prepare quarterly and annual reports on HRH. These reports will be disseminated to senior management and M&E information shared with policy makers and managers. At the regional and district levels the monitoring of the Implementation Plan will be integrated into the existing routine health planning and monitoring systems.

COSTING AND FINANCING THE HRH STRATEGIC PLAN AND HEALTH WORKFORCE PLAN

The HRH Strategic Plan includes cost for implementing each of the HRH strategies. (See Annex 4) The Health Workforce Plan will include the numbers and types of staff that will be needed to deliver health services over the longer term. It will also include the cost of increasing to the production, recruitment and upgrading of these staff over the next 4 years.

Financing to train and employ these additional staff will need to be mobilised. There are a number of human resource programmes already supported by external development partners. A strategy for marketing the plan and attracting additional funds will be developed. The fact that there is a comprehensive and integrated strategy for human resources will make this area more attractive to funders.

[126] 2011 ToR for HRIS Consultancy

Annex 1 Technical Working Groups (TWG) Membership

TWG-I: Shortage of HRH Staff- Imbalance between supply and demand and proposed member of technical working group are:

- Mr. Krishna Karki Under Secretary, MoHP (Member Secretary)
- Mrs. Ishwori Devi Shrestha, Nursing In-charge, MoHP
- Dr. Mukanda Panthi – registrar
- Dr. T.P. Thapa – Kist Medical College (private sector)
- Dhan Prasad Paudel, Ragistar – public Health council
- Mr. Parsuram Shrestha – Sr. Public Health
- MoE Representative (Higher & technical Education)
- Dr. Maureen Dariang - NHSSP

Note: Mr. Karki has been serving as the care taker Member Secretary due to the transfer of Mr. Prem Raj Giri who was named as the Member Secretary at the beginning.

TWG-II: Mal-distribution of staff - especially in remote and rural areas and proposed member of technical working group are:

- Mr Krishna Karki , Under Secretary, MoHP (Member Secretary)
- Dr. Angel Magar
- Dr. Ganga Shakya - NHSSP
- Dr. Mark Zimmerman, Nick Simons Institute
- Ms. Anita Lama – Medical Council
- Representative from Ministry of General Administration

TWG-III: Poor staff performance (productivity, quality, and availability) and proposed member of technical working group are:

- Mr. Kabi Raj Khanal - Under Secretary, MoHP (Member Secretary)
- Ms. Pramila Dewan – Nursing association
- Mr. BinodThapa - CTEVT
- Dr. Senendra Upreti – Director, Curative Division
- Mr. Hom Nath Subedi - NHSSP
- Dr. Choplal Bhusal – Nepal Research Council
- ,Bhwaniprasad Shrestha - MoGA
- Representative from Merlin

TWG-IV: Fragmented approach to human resource planning, management and development, and proposed member of technical working group are:

- Mr. Ram Chandra Khanal – Sr. Public Health Administrator, MoHP (Member Secretary)
- Dr B R Marasini – Senior Health Administrator
- Ms. Janaki K.C. – Nursing association
- Dr. Kedar Baral PAHC
- Lila Paudel – section officer
- Tulsi Shrestha _ under secretary
- Dr. Shyam Mani
- Dr. Anjani Kumar Jha
- Pan Bdr. Chettri
- Dr R. K. Tuladhar (PHS)
- Mr. Krishna Sharma, NHSSP

TWG-V: HRH Financing and proposed member of technical working group are:

- Mr Shiva Simkhada - Under Secretary (Account Section), MoHP (Member Secretary)
- Suresh Tiwari - NHSSP
- Devi Prasain - NHSSP
- Representation from EDP
- Dr. Badri Raj Pandey
- Mr. Mohan Thapa – Account Officer
- Dr. Devendra Gyewali
- Nirmal HariAdhikari (MoF)

Annex 2

STRATEGIES, ACTIVITIES AND SUB-ACTIVITIES

OUTPUTS:

1. Appropriate supply of health workers for labour market needs
2. Equitable distribution of health workers
3. Improved health worker performance
4. Effective and coordinated HR planning, management and development across the health sector

Activities	Sub-activities
OUTPUT 1: APPROPRIATE SUPPLY OF HEALTH WORKERS FOR LABOUR MARKET NEEDS	
Strategy 1.1 Improve HR Planning for Health Sector	
Strengthen leadership and capacity in HR planning including the HR division in MoHP, Department of Health Services, and staff at regional and district levels (**Year 1 and ongoing)**	Assess HR planning capacity and use findings to develop a Capacity Improvement Plan Implement capacity improvement plan e.g. coaching, mentoring, TA support, on/off the job training, external training courses, etc.
Strengthen HR information systems and capacity within the MoHP to generate reliable and up-to-date information on current HRH available in the public sectors (and thereafter the private and NGO sectors for routine and strategic HR planning and management (year 1)	Review and strengthen MoHP HR information system (HuRIS) at all levels and update database (may include provision of IT equipment, software, capacity development interventions, etc.) Agree recommendations of 2011 HRIS assessment to be implemented Coordinate efforts of other stakeholders (e.g. Save the Children, WHO) to generate information on the private and NGO sectors and provide a more comprehensive profile of HRH across the sector Assess training information management systems (TIMS) Strengthen training information management systems (TIMS) Network and link HuRIS to other information systems e.g. HMIS, PIS, professional councils, MoHP departments, District and regional facilities and offices, and private/NGO service providers
Improve availability and use of disaggregated HRH and training information (e.g. gender, caste, ethnicity, cadre,	Collect, analyse, and maintain disaggregated HR information for the whole health sector on a

facility, geographical area) for HR planning and management (Year 1 and ongoing)	regular basis. Orientation for policy makers and department/programme heads and HR managers to access and use HRH information for advocacy, policy formulation and decision making
Collect and analyse information on service delivery needs (Year 1)	Use service delivery data (HMIS) to support the development of a medium to long term Health Workforce Plan and to accurately determine HRH requirements
Produce Health Workforce Plan (by June 2012) that will determine HRH requirements (numbers, skills, gender, etc.) and supply to meet service delivery needs across the sector over the short, medium and long term (Year 1)	Develop sector wide HR profile with disaggregated data on sex, age, caste/ethnicity, regional identity, cadre/post, workplace, training, etc. Identify MoHP and other employers' plans for service change/expansion. Conduct Labour Market study drawing on most recent census data Conduct workload and job analysis for existing and new health professional jobs/posts and define optimum staffing norms for service delivery needs Review and explore other factors that will influence HRH requirements e.g. decentralisation, infrastructural development /expansion, provisions of the Health Services Act, specific service needs to address barriers of women, poor and excluded, GESI, free health services, other health/national policies and regulations, etc. Establish drafting team and build capacity of members to determine HRH requirements based on analysis of needs and other factors and develop, monitor and update long term Health Workforce Plan. Establish HRH requirements for the health sector for the short, medium and long term Develop mechanisms to cost new HRH requirements. Identify finances potentially available (fiscal space) and mobilise any additional funds required. Prepare budgets for expanded health workforce e.g. salaries with justification and evidence Service needs to address barriers of women, poor and excluded to access health services identified Facilitate stakeholder consultations to get agreement on Workforce Plan and HRH projections and requirements

Establish ongoing HR planning mechanisms and capacity	Update and maintain database so that it can generate up-to-date and reliable disaggregated data and reports Provide mentoring and coaching support to HuRIS staff HuRIS and TIMS used to update HRH profile on an annual basis and to adjust HRH requirements and projections
Strategy 1.2 Improve MoHP recruitment and deployment processes and ensure they are effective and timely	
Assess current recruitment and deployment processes and systems, identify problems and bottlenecks, including GESI related issues and use findings to streamline and strengthen systems (Year 1 and ongoing)	Conduct assessment/systems audit of currentincluding checking that recruitment systems and deployment processes accommodate need for gender equality and social inclusion Use findings to develop systems strengthening interventions (may include equipment, capacity development interventions, advocacy, etc.) Amend Health Service Act, if necessary to facilitate provision of posts and the production, recruitment and promotion of public health sector workers Use HuRIS generated information to identify sanctioned filled and vacant positions and new/additional posts and recruit and deploy/post staff accordingly Make informed, transparent and timely requests to the Public Service Commission to recruit to fill vacant positions Advertise and/or make information available on vacancies and jobs through Public Service Commission (PSC) at least once a year. Ensure PSC recruitment criteria includes technical, human and conceptual GESI sensitive skills (linked to job descriptions) Provide induction/ orientation/training linked to job responsibilities for all categories. Promote team working and deploy teams to ensure appropriate skills mix in facilities
Review and strengthen contracting systems and practices	Conduct study of contracting procedures and practices (study to examine what type/age/sex/ of hw is on contract, location of post, duration of contract, administration/management of contracts, etc) Introduce multi-year contracting for essential and scarce cadres (Year 1 and ongoing)

	Improve procedures for the management of contracted staff and administration of contracts (Year 1 and ongoing)
Review O&M studies	Review recommendations and advocate for priority vacancies/positions to be filled
Use Health Workforce Plan to guide recruitment and posting of staff according to job requirements (Year 1 and ongoing)	Use job descriptions, service delivery requirements and information on local context to guide advertising, selection, recruitment and deployment of health workers Review and update the existing assessment systems for selection and appointment of staff Use distribution data to determine location of vacant posts and skills mix required and use information to make deployment decisions
Determine number of trained unemployed health workers available for work and implement procedures to attract, recruit and deploy	Conduct study (including review of training supply data and employment figures) and disseminate findings. Target unemployed health workers through special advertisements and provide free refresher/reorientation training
Review and assess experience with local recruitment/contracting to ensure systems and processes are transparent and equitable and appropriately skilled staff are being hired before expanding its use (Year 1 and ongoing)	Assess role and responsibility of HFOMCs and other groups (e.g. women's group, youth clubs etc.) in local recruitment Conduct review and use findings for scale up or for design of more appropriate strategies
Explore alternative recruitment and employment arrangements	Conduct review and use findings to pilot outsourcing of recruitment function for contracting and management of specific cadres to private or NGO agencies
Review and document role and contribution of FCHVs for potential expansion or use with other cadres (Year 1)	Conduct study to examine role and impact of FCHVs
Strategy 1.3 Improve attractiveness of jobs for increased recruitment and retention	
Information (disaggregated) collected and reviewed on job preference and job seeking behaviour	Conduct study forfor health workers in public, private and NGO sectors and use findings to inform the design of attraction and retention strategies
Labour market information reviewed regularly	Collect and analyse labour market data and update database, HuRIS and HRH profile
Develop/improve GESI sensitive policies to manage retention (Year 1 and ongoing)	Collect and analyse data to inform GESI policies to support attraction and retention strategies for these groups
Strategy 1.4 Ensure pre-service training is in line with requirements for the health sector	
Data collected on projected production and potential for increase/decrease of specific cadres assessed	Collect and analyse data on production from public, private and NGO training institutions and providers Establish and maintain TIMS
Expand or contract pre-service training, informed by service delivery needs e.g. training of MDGPs, Hospital	Develop National Health Pre-service Training Strategy and annual implementation plans linked

Managers, assessment/establishment of more rural based training sites/institutions, etc.	to and informed by Health Workforce Plan Year 1
Improve accreditation and regulation of pre-service training institutions to ensure an adequate supply of skilled and knowledgeable health workers and assure the quality of the training provided (Year 1 and ongoing)	Map stakeholders (e.g. professional council and associations) and determine their roles and responsibilities for the accreditation, regulation and monitoring of health training institutions Strengthen capacity of Professional Councils to regulate and monitor training institutions Review and strengthen accreditation and regulation procedures and guidelines in consultation with relevant bodies Monitor enforcement of guidelines and regulations of pre-service training
Strengthen mechanisms to follow up and support health workers after training and to evaluate the impact of the training on performance.	Review current mechanisms Strengthen or develop post training follow up and impact evaluation instruments/tools
OUTPUT 2 EQUITABLE DISTRIBUTION OF HEALTH WORKERS	
Strategy 2.1 Review current situation and experiences and ensure deployment systems result in equitable distribution of health workers	
Review regulation and enforcement of remote area policies and systems and identify barriers (Year 1 and ongoing)	Conduct policy and systems audit to identify bottlenecks
Collect, analyse and update distribution data of sanctioned and filled posts by location, cadre, gender, caste, and ethnicity (Year 1)	Identify underserved and remote populations and areas (e.g. caste, ethnicity, gender) Collect and analyse data and update profile and HRH database and use to make deployment decisions Deployment based on defined needs (population, geography, disease burden, etc.) Monitor distribution trends
Use findings to strengthen systems	Take corrective action to address barriers and strengthen policies and systems
Strategy 2.2 Make jobs/postings in rural areas more attractive	
Review, revise, implement and monitor career benefits related to rural posting and transfer (linked to Strategies 1.1 and 1.3)	Identify career benefits and use information for the development of attraction, training and retention strategies
Identify push and pull factors, disaggregating these for women, people from different social groups, income status and locations	Collect and analyse data on push and pull factors Gender specific issues identified and addressed
Review existing retention schemes across the sector, including the private and NGO sectors and identify the most appropriate and effective schemes and incentives	Conduct study and use findings to design retention strategies

(Year 1 and ongoing)	Develop policies and procedures to attract and retain scarce staff e.g. career development opportunities for MDGPs posted to underserved and remote areas Explore possibilities of staff rotation to fill gaps Monitor impact on retention
Use findings of review to develop retention policy and schemes	Identify and provide targeted retention measures for remote areas Identify and provide retention measures for selected cadres/ posts
Research on critical HRH gaps focusing on remote areas and link to planning process	Conduct evaluation and use findings to determine appropriate package of allowances Monitor impact on retention
Improve working environment to attract and retain staff in collaboration with HFOMCs	Study to identify factors that improve working environment Use findings to improve working environment Monitor impact on attraction and retention
Strategy 2.3 Prepare and support staff better for working and living in remote areas	
Provide job and posting orientation after recruitment for different cadres (Year 1 and ongoing).	Design orientation programmes to include training in relevant skills areas for specific cadres e.g. new entrants and scholarship doctors, health systems management training, clinical training in SBA, CAC, ER Management, etc. and to provide information on workplace (link to Output 3 on performance) Include information and training on working in rural areas in pre-service training curriculam
Strengthen mechanisms to ensure that health workers posted to remote areas receive regular supportive supervision and mentoring support	Review and strengthen support supervision and mentoring systems and practice in collaboration with service delivery programmes (link to performance management and in-service training/CPD) Identify and provide gender specific support
Strategy 2.4 Improve workers living and social conditions in remote locations	
Review policy and practice related to the following areas: • Improved security • Access to schools • Improved housing • Communications (inc internet) • Transport	Review polices and advocate with relevant departments, agencies and local governance groups to improve these areas

Strengthen functioning of health facility/hospital management committee (e.g. local level resource mobilization) to support living and social conditions for health workers)	Identify roles and responsibilities and strengthen functioning (e.g. may include capacity development interventions, supplies, equipment, financial support to hold meetings, etc.) Collaborate with local government, VDCs, community groups, etc. to initiate improvements
Strategy 2.5 Compulsory service to improve rural service provision	
Review compulsory service experiences and assess impact on deployment and retention of junior doctors (e.g. scholarship and new entrants) and specialists and other senior staff in peripheral health facilities (Year 1 and ongoing)	Conduct review and impact assessment Use findings to inform attraction and retention studies (linked to Strategies 2.1 to 2.4) Use findings to inform decisions about expanding the scheme or adopting other approaches (Year 1 and ongoing)
Strategy 2.6 Continue and identify new areas for task shifting and alternative staffing in clinical areas (e.g. anaesthesia, ultrasound etc.)	
Review and conduct analysis of key shortages and scarce skills (Year 1 and ongoing)	Review conducted and data analysed and findings used to update HRH profile and inform and update health workforce planning
Conduct ongoing workload and job analysis for existing and new health professional jobs/posts	Data collected and analysed on an annual basis and used to update Health Workforce Plan and HR projections Review and update job descriptions/ToRs for new jobs and responsibilities Pilot introduction of job descriptions for specific cadres/jobs
Strategy 2.7 Use NGOs and private health providers for service delivery in most difficult areas	
Prepare modalities for PPP and expand PPPs for the management of district hospitals (Year 1 and ongoing)	Conduct review of existing PPP initiatives Use findings to expand and scale up Identify additional providers to provide services in remote locations Identify appropriate package of incentives to encourage private providers to provide services in underserved and remote areas MoHP develop and implement robust monitoring and supervision systems
Ensure CSO and HFOMCs participation in social auditing process	Social audits conducted in collaboration with CSO & HFOMCs
Output 3: Improved performance of health workers	
Strategy 3.1 Provide staff with leadership and clear direction	
Design and develop in collaboration with NSI an in-	Design and develop materials for programme and

service leadership and management programme and pilot in Year 1 with hospital management teams	pilot in district hospitals Follow up, evaluate and scale up
Annual work plans for institutions/facilities and individuals developed, implemented and monitored. (Year 1 and ongoing)	Assess resource (HR, infrastructure and skills) requirements to deliver mandated quality health services (including identifying existing strength and gaps) Provide training to facility managers to develop, resource implement, monitor and evaluate work plans and individual capacity development plans (linked to performance management and appraisal). Develop career development pathways–linked to capacity development plans Incorporate gender and inclusion aspects in the workplan Implement planned activities and monitor regularly
Review/develop job descriptions for staff at all levels in collaboration with facility managers.	Review existing job descriptions and identify gaps Revise/update and /develop and endorse job descriptions. Provide health workers with facility work plan during induction process and orient health-workers on the job descriptions.
Update/develop performance appraisal/management system in line with service delivery programmes and public sector systems (link with performance based incentives where there is critical shortage of HRH)	Review existing public sector performance management systems annually. Adapt/develop tools and systems Provide feedback to heath workers on performance through supervision and appraisal systems
Pilot the implementation of performance appraisal/management systems.	Design Operations Research Study and identify facilities/staff to conduct study to monitor and evaluate impact of performance management systems Conduct study and examine all aspects of performance management system including development and use of job descriptions and workplans, implementation of annual appraisals, capacity improvement plans, feedback mechanisms, use of social audit/client satisfaction measurement tools, etc. and disseminate findings
Strategy 3.2 Strengthen skills/capacity of health workers to do their jobs	
Review, assess and strengthen institutional training capacity to provide pre-service and in-service education, training and CPD that supports service delivery and quality performance	Develop tool for assessment of Training Institutions (Year 1) Conduct capacity assessment of NHTC (Year 1) to cover the following areas:

	• Infrastructure - teaching facilities and staff and student accommodation; • Staffing levels - number and skills of tutors/teaching staff • Training curricula and materials • Number and quality of practicum sites, • Instructional approaches (theory/practical, classroom/practicum sites, etc) • Student population (including information on entry requirements, student selection, intakes, attrition, nationality/ethnicity of students, numbers and types of graduates produced, destination of graduates post training) • Training information systems • HR systems and practices (recruitment, retention and professional development of teaching staff), • Financial resources Stakeholder consultations to review findings and identify short, medium and long term interventions. Revise and update the 2004 NHTC strategy and develop Capacity Improvement Plan (Year 1) and develop Training Implementation Plans on an annual basis Map and assess capacity of other existing pre-service and in-service training institutions and develop Institutional Capacity Improvement Plans (to include training standards, protocols and guidelines) and Implementation Plans on an annual basis Develop a National In-Service Training (IST) & CPD Strategy and prepare in-service training and CPD plans on an annual basis (Linked to National Pre-service Training Strategy) Review and strengthen contracting mechanisms for training providers and institutions Establish and maintain a training information management system (TIMS) to maintain and monitor numbers, names of trainees, training programme undertaken, training provider, making it mandatory for all staff to report training taken (e.g. information documented during performance appraisal process))

Provide relevant in-service training courses and CPD sessions to upgrade and update skills of providers and enhance the quality of care	Identify critical cadres on an annual basis (based on HRH profile and Workforce Plan included and costed in Strategy 1.1) and conduct Training Needs Assessment as per proposed National IST/CPD Strategy and Annual Implementation Plan Design and deliver in-service training programmes and CPD for selected cadres informed by findings of TNA and National IST/CPD Strategy Review training approaches and design and introduce new and innovative approaches for the delivery and content of on the job training and mentoring (e.g. distance and tele-medicine programmes/work based learning) Strengthen competencies and skills of health workers to respond to GESI related issues Develop mechanisms and implement induction/orientation/training for all health workers Conduct TNA and provide in-service training to locally recruited health workers based on need and job responsibilities
Strengthen contracting and accreditation mechanisms and capacity of Professional Councils to enforce and monitor compliance (Year 1 and ongoing)	Review, revise/develop quality assurance, regulation and accreditation procedures and guidelines for training institutions and monitor compliance Strengthen capacity of professional councils (included in Strategy 1.4) Improve current regulation mechanisms by making CPD a requirement for re-registration
Measure, monitor and evaluate training outcomes, training quality and support transfer of learning and skills to job and performance	Develop tools and mechanisms to conduct monitoring and evaluation of trainers and training institutions Promote continuous improvements in training approaches
Strategy 3.3 Ensure effective reward and sanction systems in place	
Link reward and sanctions, especially within grade, to performance	Review and update existing performance appraisal form (Ka SA MU form) based on portfolio based evaluation Review/revise/develop promotion criteria that is sensitive to gender and inclusion issues Department heads and managers conduct annual performance appraisals and appraisal information is documented and used for promotion decisions Sanction discriminatory behaviour towards

	women, poor and the excluded
Mechanisms in place for health workers to provide feedback on the perceived fairness of reward and punishment systems.	Develop tools and mechanisms for health workers to provide feedback on reward and punishment system Establish a process of feedback from HFOMC regarding behaviour of health workers
Pilot performance based incentive system **(Year 1 and ongoing)**	Identify and agree performance indicators and targets/outcomes Identify and select pilot facilities (e.g. 5 facilities per region per annum) Determine and cost incentives to be provided Monitor and evaluate impact on performance
Strategy 3.4 Reduce staff absence from their assigned posts	
Improve planning and management of transfers and deputations (kaaj) (Year 1 and ongoing)	Review current practice of staff transfers and deputation and identify the gaps Ensure managers enforce and comply with rules and regulations for deputation and transfer Establish policy provisions to improve planning and management of transfers and deputations including the following provisions: • targeted training and recruitment of health workers from remote rural districts • compulsory service with provision of appropriate support and incentives for selected health workers (e.g. new graduates MBBS, Nurses, and paramedics and other key cadres) in underserved and remote areas to avoid frequent transfer and deputation • attractive financial incentives (e.g. hardship allowance, non-practice allowance, housing allowance, family transport support and annual leave) to reduce absence • devolve authority to regional health offices to recruit, deploy and manage health workers • priority given to health workers willing to transfer to post in home town and/or district and same location postings for spouses • Reward and sanction for violating HR management rules and regulations on staff transfer and deputation. Identify gender specific constraints and adopt innovative ways to address them so that women employees can work comfortably Develop and implement monitoring systems to ensure managers enforce and comply with rules

	and regulations for deputation and transfer e.g. develop, maintain and implement a roster for transfer of staff before/or at the time of recruitment. Monitor and document impact of transfers on team working (Year 1 and ongoing).
Strengthen absence management mechanisms (Year 1 and ongoing)	Review current levels of staff absenteeism, identify gaps and develop and agree mechanisms to minimise. Establish systems and procedures for the management of absence for meetings, workshops & training e.g. document staff movement and scheduling for meetings, workshops, etc. Introduce distance and tele-medicine programmes/work based learning for staff working in underserved and remote areas Implement mechanisms and procedures to improve participation of political, social and union/associations pressure/influence in HRM (especially in areas of transfer, deputation, study leave, etc.)
Strategy 3.5 Ensure staff at all levels have an enabling work environment	
Identify which factors in the work environment affect staff performance most (Year 1 and ongoing)	Identify factors through consultations with health workers, facility managers and other stakeholders
Liaison with relevant departments and agencies (e.g. logistics and supplies departments) to provide an enabling environment	Conduct political and social mobilisation to create enabling environment (e.g. social security, better accommodation, incentives for family and career opportunities and/or posting in accessible facility) at the health facility to reduce absence and maximise retention of health workers
Strategy 3.6 Strengthen team working approaches	
Review successful team working practices and document (Year 1 and ongoing)	Conduct review in selected facilities
Disseminate good practice case studies to facility managers	Produce case study and disseminate
OUTPUT 4 EFFECTIVE AND COORDINATED HR MANAGEMENT AND DEVELOPMENT ACROSS THE HEALTH SECTOR	
Strategy 4.1 Appropriate HR policies in place	
Review existing national, health and HR policies, identify gaps and revise as necessary (Year 1)	Map and synthesize key policies Review policies on recruitment, transfer, promotion, leave, and working environment, considering the following: GESI related issues, maternity leave, paternity leave, child care, breast feeding, flexible working, etc.

	Amend/revise policies as required ensuring GESI aspects are considered and gender specific responsibilities of women recognised
Identify and promote organisational culture needed to support implementation of revised policies and systems	Assess organisational culture strengths and gaps Identify issues experienced by women staff and staff of excluded communities Conduct sessions/dialogue to discuss working environment aspects within teams Establish process for regular discussions for a positive working environment
Strategy 4.2 Appropriate organisational structures, systems and capacity developed to support the HR functions	
Review existing structures, systems and capacity using HR functions framework to identify gaps and overlaps, including from a GESI perspective (Year 1)	Review impact of existing organisational structures and staffing on HR functions and identify the gaps Conduct a GESI audit of the organisational structures, systems and staff Carry out audit of selected systems and processes in central MoHP (linked to Outputs 1, 2 and 3) Conduct capacity assessment of HR staff in central MOHP to carry out HR functions Explore the option of establishing a HRH Management Division at MoHP that will incorporate all existing HR related functions in the MoHP
Develop proposals and plans for strengthening structures, systems and capacity	Use findings to determine key HR functions and appropriate structures/staffing Review staffing needs of new/revised structures and recruit new staff if necessary, with due consideration given to sex, caste/ethnicity and diversity Develop capacity improvement plan and interventions e.g. coaching, mentoring, on/off the job training programmes for existing staff Identify HR systems strengthening initiatives e.g. information systems (Linked to Strategies in Output 1) Identify tools required for staff to perform HR functions
Strengthen leadership and governance structures and promote greater engagement and involvement of policy makers and senior management in HR planning, (linked to Outputs 1-3)	Map and assess capacity and role of governance structures in HRH Strengthen the leadership capacity of policy

	makers and senior managers in the MoHP and health facilities Strengthen HR systems and processes are ensure that are transparent and efficient
Prepare for restructuring required as part of federalisation	Review and assess devolution/decentralisation of authority to regions, districts and health facility committees and boards for HR planning, management and development Use findings to develop Capacity Improvement Plans for all levels
Strategy 4.3 Effective coordination mechanisms in place at all levels within the health System	
Obtain more clarity on underlying causes of fragmentation and weak coordination (Year 1)	Map and consult HRH stakeholders to assess causes of fragmentation and coordination
Strengthen the CCF to function as a high level HRH Coordinating Committee at national level and the formation of sub committees at regional level for resolving HRH issues **(Year 1)**	Support and facilitate regular /monthly meetings of CCF Review and revise ToR for CCF Review composition for CCF Orient CCF on GESI issues Identify specific responsibilities of CCF on GESI CCF establishes sub committees at central, regional and lower levels for implementation and monitoring of HRH Strategic Plan (Year 1)
Mechanisms reviewed and in place between MoHP and other health providers to supplement the delivery of health services	Mechanisms agreed and in place for the coordination of stakeholders HRH inputs and investments, including donors, the private sector and other government sectors and agencies Mechanisms in place to mobilize community support for HRH

Annex 3

Stakeholders that received and/or reviewed the draft HRH Plan

Name	Title	Ministry/Organisation/Agency
Dr Praveen Mistra	Population Secretary	MoHP
Mr Pratap Kumar Pathak	Secretary	Ministry of General Administration (MoGA)
Mr. Tilak Ram Sharma	Joint Secretary Human Resource and Financial Management Division & Chair of HRH Technical Committee	MoHP
Mr. Surya Prasad Acharya	Joint Secretary Personnel Administration Division	MoHP
Dr Lava Deo Aawasthi	Joint Secretary	Ministry of Education
Mr Atma Ram Pandey	Joint Secretary	National Planning Commission
Dr Bal Krishna Suvedi	Chief, Policy Planning and International Cooperation Division	MoHP
Mr Parshu Ram Shrestha	Director General,	DoHS
Mr. Kabiraj Khanal	Under Secretary, Human Resource Development Section	MoHP
Mr. Shiva Prasad Shimkhada	Under Secretary Finance Division, & Core Team Member	MoHP
Mr. Tulsi Bdr. Shrestha	Under Secretary	Department Of Health Service
Mr Radha Krishna Pradhan	Under Secretary	National Planning Commission
Dr.Senendra Raj Upreti	Chief	Curative Division, MoHP
Dr Babu Ram Marasani		MoHP
Mr Santosh Dahal		MoHP
Professor Ghanim Al-sheikh	HRH Consultant	GHWA
Dr Tirtha Rana	Public Health and Nutrition Specialist	Consultant
Dr Muhammad Mahmood Afzal	Technical Officer Head of Country Facilitation Team	Global Health Workforce Alliance, WHO
Health Services Academy	Health Services Academy	Pakistan
Merlin		Merlin
Latika Maskey Pradhan	Program Manager	AUSAid, Australian Embassy
Dr Sharad Onta		Institute of Medicine.
Mr. Ram Chandra Khanal	Senior Public Health Administrator	MoHP
Mr. Parshu Ram Shrestha	Senior Public Health Administrator	Department Of Health Service
Mr. Khagendra Prasad Rijal	Section Officer	HuRIC Unit, MoHP
Mr. Arjun Prasad Poudel	Account Officer	MoHP
Mr. Shovakar Neupane	Section Officer	MoE
Ms. Anita Lama	Pra.a	Nepal Medical Council

Prof. Trilok Pati Thapa	Principal	KIST Medical College
Mr. Arjun Bhadur Singh	Director	National Health Training Center
Dr. Muknda Raj Panthi	Registrar	NAMS
Mr. Dhan Prasad Poudel	Registrar	NHPC
Mr. Sabin Kumar sharma	Computer Programmer	HuRIC Unit, MoHP
Mr. Gauri Bhadur Thapa	Dietician Supervisor	NPHF
Mr. Sharad Banta		
Mr. Tirtha Rana	Consultant	
Ms. Ishwori Devi Shrestha		MoHP
Dr. Amit Bhandari	Health Advisor	DFID Nepal
Dr Bert Voetberg	Lead Health Specialist	World Bank
Dr Frank Paulin	WRO	WHO Nepal
Dr Mark Zimmerman	Executive Director	Nick Simons Institute
Ms. Takma K.C		Nepal Nursing Council
Ms. Daya Laxmi Joshi Baidhya	President	Nepal Nursing Council
Ms. Pramila Dewan	President	Nepal Nursing Association
Mr. Laxman Prasad Ghimire		MoHP
Dr. Giridhari Sharma Paudel	Planning, Monitoring and System Strengthening Specialist	Western Regional Health Directorate, Pokhara
Dr. Bisho Raj Khanal	Regional Director	MoHP, Pokhara
Dr. Buddhi B. Thapa	Medical Superintendent	Western Regional Hospital Pokhara
Mr. Ramesh Adhikari	District Health Officer	MoHP, Kaski, Pokhara
Dr Nancy Gerein	International Lead	NHSSP
Mr Greg Whiteside	QA Advisor	NHSSP
Mr. Tomass Lievens	Health Economist	OPM
Dr Suresh Tawari	Health Financing Advisor	NHSSP
Ms. Chaya Jha	GESI Advisor	NHSSP
Mr Ramchandra Man Singh	Health Systems Governance Advisor	NHSSP
Mr Sitaram Prasai	GESI Advisor	NHSSP
Mr Ajit Pradhan	M&E Research Advisor	NHSSP
Dr Maureen Dariang	EHCS Advisor	NHSSP
Dr Ganga Shakya	MNH Advisor	NHSSP
Mr Hom Nath Subedi	Equity and Access Advisor & Core Team Member	NHSSP
Mr Krishna Sharma	Head of Admin and Finance	NHSSP
Dr Devi Prasad Prasai	Consultant, Demand side Financing	NHSSP
Mr Bal Govinda Bista	National HR Consultant	LATH/NHSSP
Dr Shiva Adhikari	Associate Professor of Economics (Health),	Tribhuvan University/LATH/NHSSP Costing Consultant
Dr Angel Magar	Consultant/Core Team Member	WHO

Annex 4

Outputs/Strategies	Estimated Cost					
	2012	**2013**	**2014**	**2015**	**Total**	**Percent**
1. Appropriate supply of health workers for labour market needs	**104012675**	**40241350**	**23796125**	**23496125**	**191546275**	**0.2242**
Strategy 1.1 Improve HR Planning for Health Sector	44776850	30143325	18577850	18577850	112075875	0.1312
Strategy 1.2 Improve MoHP recruitment and deployment processes and ensure they are effective and timely	32644675	4382675	3287675	2987675	43302700	0.0507
Strategy 1.3 Improve attractiveness of jobs for increased recruitment and retention	295000	0	0	0	295000	0.0003
Strategy 1.4 Ensure pre-service training is in line with requirements for the health sector	26296150	5715350	1930600	1930600	35872700	0.0420
2. Equitable distribution of health workers	**93804752**	**78366102**	**56018502**	**54343502**	**282532858**	**0.3307**
Strategy 2.1 Review current situation and experiences and ensure deployment systems result in equitable distribution of health workers	1160000	0	0	0	1160000	0.0014
Strategy 2.2 Make jobs/postings in rural areas more attractive	24622852	13194202	13194202	11519202	62530458	0.0732
Strategy 2.3 Prepare and support staff better for working and living in remote areas	6934500	6184500	0	0	13119000	0.0154
Strategy 2.4 Improve workers living and social conditions in remote locations	10854450	10354450	2522900	2522900	26254700	0.0307
Strategy 2.5 Compulsory service to improve rural service provision	10854450	10354450	2522900	2522900	26254700	0.0307
Strategy 2.6 Continue and identify new areas for task shifting and alternative staffing in clinical areas (e.g. anaesthesia, ultrasound etc.)	0	0	0	0	**0**	0.0000
Strategy 2.7 Use NGOs and private health providers for service delivery in most difficult areas	39378500	38278500	37778500	37778500	153214000	0.1793
3. Improved health worker performance	**104091113**	**91023063**	**80320663**	**80320663**	**355755500**	**0.4164**
Strategy 3.1 Provide staff with leadership and clear direction	19376750	17676750	7474350	7474350	52002200	0.0609
Strategy 3.2 Strengthen skills/capacity of health WORKERS TO do their jobs	41745112.5	32860513	32460513	32460513	139526650	0.1633
Strategy 3.3 Ensure effective reward and sanction systems in place	35758500	35758500	35758500	35758500	143034000	0.1674
Strategy 3.4 Reduce staff absence from their assigned posts	5813450	3330000	3330000	3330000	15803450	0.0185
Strategy 3.5 Ensure staff at all levels have an enabling work environment	968600	968600	968600	968600	3874400	0.0045
Strategy 3.6 Strengthen team working approaches	428700	428700	328700	328700	1514800	0.0018
4. Effective and coordinated HR planning, management and development across the health sector	**9927350**	**5148900**	**5148900**	**4283900**	**24509050**	**0.0287**
Strategy 4.1 Appropriate HR policies in place	2837500	2037500	2037500	2037500	8950000	0.0105
Strategy 4.2 Appropriate organisational structures, systems and capacity developed to support the HR functions	5015950	1237500	1237500	555000	8045950	0.0094
Strategy 4.3 Effective coordination mechanisms in place at all levels within the health System	2073900	1873900	1873900	1691400	7513100	0.0088
Total	**311835890**	**214779415**	**165284190**	**162444190**	**854343683**	1.0000