



Deployment of
**Health
Care
Workers**
in Government District
Hospitals in Nepal

N I C K S I M O N S I N S T I T U T E (2 0 0 6)

Executive Summary

Nepal's Health Ministry and its supporting agencies need reliable data concerning the deployment of workers in the government system. In 2006, we conducted an assessment of health care workers in 23 government district hospitals in the West, Mid-west, and Central Regions (34% of Nepal's District Hospitals). We determined "actual" staffing patterns for upper level workers (doctor and staff nurse) and mid-level workers (health assistants, community medical assistants, and auxiliary nurse midwives), as compared to the Health Ministry's Human Resource Development Information System (HuRDIS) data. In addition, we assessed whether the staff were employed centrally by the Ministry or locally, as well as the locations of the staff workers' homes.

1. Health Ministry human resource data (HuRDIS) were close to the staffing patterns found by our team, with HuRDIS actually underestimating "actual" staffing by 7%. In the case of doctors, however, we found that 30% were absent even while they were "in post" on paper.
2. Of the 284 upper- and mid-level staff members who were present, only 11% were employed by a local organization. Excluding Lamjung Hospital (a model of decentralized health care) from the total, this figure comes down to only 5%. Fourteen of the 23 hospitals had no local employees at these levels. Apart from Lamjung, no doctors were local employees.
3. Forty-eight percent of upper and mid-level staff had permanent local homes. This figure ranged from 10% for doctors to 70% for auxiliary health workers.
4. Much work remains to be done in converting government district hospitals to local management, a process which could be facilitated by the large number of staff living locally.

Introduction

The Government of Nepal's Ministry of Health and Population (MoHP) identifies lack of access to quality health care in rural areas as a priority issue (3, 4). The MoHP Strategic Plan for Human Resources for Health (2003-17) calls for expansion of the pool of health care workers by nearly 50,000 over this period, especially in the case of mid-level workers (5). The government and external development partners well recognize the problem of huge urban-rural gaps in staffing.

The Nick Simons Institute (NSI) is an organization with a mission to train and support health care workers for rural Nepal. NSI functions in partnership with a network of quality health care institutions across the country; these hospitals both train workers and provide support to government institutions in more remote districts. In regard to this work, NSI must measure the deployment of

health care workers in the field – both for a baseline and to assess impact of its interventions.

The Human Resource Development Information System (HuRDIS) is Nepal's Health Ministry system (supported by the German organization GTZ) for tracking government health care workers. HuRDIS records data for all medical workers in all levels of government health care. In developing its strategic plan, NSI needed to assess the reliability of these government figures. NSI hypothesized that the government's HuRDIS tabulation would overestimate staffing, i.e. that many workers would be 'in post' on paper, but not in reality. In addition, NSI was interested in determining how many district hospital workers were employed outside the central government system (by local development committees) and how many of the total number of staff were local (i.e. with homes near the hospital). NSI supports the Health Ministry's plan to delegate management of its health

care institutions to local committees, and we wanted to determine the extent of the decentralization process within district hospitals.

During the summer of 2006, we sent a team to visit government district hospitals throughout Nepal. The research was two-pronged: this report concerns health care worker deployment; in a separate project, we specifically studied MDGP doctors. Our team visited 23 of Nepal's 68 district hospitals to assess staffing patterns. Because NSI was initially considering supporting government facilities in the Western Region (where our partner Tansen Mission Hospital is located), we concentrated on this region and added hospitals in the Mid-West and two in the Central Region.

We conducted this study after consultation with, and with the written permission of, the Director General of Health Services of Nepal's Health Ministry.

Study Methods

Our team consisted of a medical doctor and a medical student. Both were included in developing the assessment tool, which was a matrix of health care worker presence against a timeline of the previous 12 months. We assessed the upper and mid-level cadres – doctor, staff nurse (SN), health assistant (HA), auxiliary health worker (AHW), and auxiliary nurse midwife (ANM). [In the government system, senior auxiliary health worker (SAHW) and health assistant occupy the same post. For the purpose of this study, we refer to this post simply as "HA."] At each hospital, our team interviewed two senior staff and recorded the actual staffing patterns of these cadres of worker over the last year.

In addition, we determined current presence in the hospital, employment authority (under local committee or centrally by Ministry), and location of each health care worker's permanent home. Our team entered this data on a single form for the particular hospital, and then confirmed it in the second interview with senior hospital staff.

This study took place during July and August 2006. We also received the concurrent staffing list as recorded by HuRDIS – which tells the number of government posts of each cadre that are sanctioned (approved) and filled (on the job). We compared the HuRDIS data with our study data.



Results

During the months of July and August 2006, our team visited the following 23 government district hospitals:

Western Region: Arghakanchi, Baglung, Gorkha, Kapilvastu, Lamjung, Manang, Mustang, Myagdi, Nawalparasi, Palpa, Parbat, Rupandehi, Syangja, Tanahu (14) [Of 15 district hospitals, we only missed Gulmi District, due to a large landslide blocking the road.]

Mid-Western Region: Bardia, Dailekh, Dang, Jumla, Pyuthan, Salyan, Surkhet (7)

Central Region: Dhading, Sindhupalchowk (2)

Table 1 | Numbers of Health Workers in 23 Nepal District Hospitals

CADRE	HuRDIS “Filled”	Summer 06 Study “Present”		
		Govt. Employee	Local Employee	Total Employee
Doctor	50	35	4	39
Staff Nurse	69	68	0	68
Health Assistant	17	35	0	35
Aux. Health Worker	50	58	13	71
Aux. Nurse Midwife	49	56	15	71
Total	235	252	32	284

In the 23 district hospitals, among the cadres of doctor, staff nurse, health assistant, auxiliary health worker and auxiliary nurse midwife, our study found a total of 284 staff currently present and in post. Of this number, 252 (88.7%) were employed centrally by the Ministry of Health, while 32 were employed by the local development committee (LDC) or hospital development committee (HDC). The HuRDIS system only records Health Ministry staff, but not locally employed staff. Table 1 compares the HuRDIS figures for “filled” posts with the actual “present” figures as ascertained by our study team. The critical comparison here is between HuRDIS “Filled” and Summer Study “Present - Govt. Employee”.

Overall, we found that the government’s HuRDIS figures underestimated the number of workers present in these district hospitals, with 7.2% more ‘present’ than recorded in central records. Of the 23 hospitals, 14 hospitals had more staff present than on record, 2 had the same number, and 7 had more on record than were present. For ANMs and AHWs, there were more staff present than on record, but this did not hold for the higher level staff: nurses were about the same, and doctors had 15 more on record than the number who were actually present.

Table 1 also shows that only 32 (11%) of all staff were employed by a local committee, the greater proportion being under the central Ministry of Health. This indicates a low amount of decentralization of district hospital staff. Even this figure was inflated by the presence of Lamjung Hospital in the total. Of the total 32 locally-employed staff, 18 were employed by Lamjung and all 4 of the locally-employed doctors worked there. Looking at all the hospitals excluding Lamjung, we found that only 5.8% of all workers are locally employed, and no doctors, staff nurses, or health assistants worked locally. Tabulated by number of hospitals, we found that 14 of the 23 hospitals studied had no locally employed staff (i.e. all their upper-mid level staff were employed centrally by the Ministry of Health).

Table 2 | Numbers of Local Health Workers “Present”

CADRE	Local	% Local	Total Employee
Doctor	4	10	39
Staff Nurse	24	35	68
Health Assistant	14	40	35
Aux. Health Worker	50	70	71
Aux. Nurse Midwife	44	62	71
Total	136	48%	284

We also studied the home location of all staff present at the hospitals. (Some of these staff were locally employed, while others were employed by the Health Ministry centrally.) Table 2 shows counts of workers who have homes in their hospitals’ districts.

In spite of having a low number of district hospital staff under local employment, a relatively high number of these upper/mid-level staff are local citizens. Of all staff whom we found present, nearly half (48%) have a home in the district where they are working. This proportion is low for doctors, of whom only 10% have local homes, and increases for lower level staff; 70% of all AHWs live in the vicinity of their workplaces.

Table 3 | Numbers of staff present for full 12 months of year

CADRE	Total Employee	Present for 12 months	%
Doctor	39	22	56
Staff Nurse	68	55	81
Health Assistant	35	31	89
Aux. Health Worker	71	68	96
Aux. Nurse Midwife	71	65	92
Total	284	241	85%

Among the 284 staff members who were present at the time of our visit to their hospital, we recorded their reported presence during the 12 months prior to our study. Overall, a high proportion (85%) were present for the full period. This was not the case for doctors, however. Among those “present” in post, only 56% had spent the entire 12 months on site.



Discussion

Programs intended to improve access to rural health care workers require human resources data that is reliable and current. GTZ worked with the Nepal Health Ministry to create a system for monitoring the number of health care workers in government institutions. To assess this system's reliability, we traveled to 34% of Nepal's district hospitals and conducted interviews regarding staffing patterns.

Our study was a 'spot-check' of government staffing. As such, it was random, both in time and in location. It is possible that staffing patterns may be different in other districts of Nepal, though we see no reason why this should be. In addition, we not only took a single point in time, but also conducted a survey of staffing over the previous 12 months for each cadre of upper and mid-level worker. The study hinges upon the credibility of the senior staff members who provided the information, though we also corroborated it during the day that our team spent at the hospital. Eighty-five percent of staff members who were recorded as being present at the time of the interview were reported to be present for the full 12 months of the year.

We expected that the actual staffing patterns would be lower than the government/HuRDIS data for health care workers in post. In fact, overall, the HuRDIS figures were fairly close to the actual figures, and tended to underestimate the number of government employees present. For doctors, however, of the 50 who were recorded to be 'in post', only 39 (78%) were actually present at the time of the assessment. In addition, of those doctors who were present, only 56% had been present on a full-time basis throughout the previous 12 months. Although this indicates that doctors tend to leave their post more frequently than other staff, even these figures are not as low as we had expected. In general, with the exception of the doctor cadre, we found that the HuRDIS figures gave a fairly good approximation of staffing patterns.

Both the Health Ministry's Health Sector Reform Strategy (2002) and Health Sector Implementation Plan (2004) emphasize the need to work towards "decentralized management" of government health care institutions. Otherwise there are bound to be inefficiencies in a centrally-placed Ministry that manages many diverse institutions spread across a remote country. Quite simply,

local people should be able to manage their own local institutions more effectively. While this decentralization process has progressed well at the health post level, we wanted to determine the extent of local management at district hospitals. The present government system allows for health care staff to be under the employ of the central government or under a local committee. As an important measure of decentralization, we examined the number of upper and mid-level staff who were employed by a local development committee or by a hospital development committee/board. While there are other measures of decentralization – such as financial or governance autonomy – local control of staff is crucial to rural staff retention.



We found that the level of local employment of upper and mid-level staff was low: only 11% of all staff who were present in the hospitals were employed by a local committee. This figure was inflated by the presence of Lamjung Hospital, which – with 18 of its 22 staff being under a local development board – is indeed a model of decentralization. Not counting Lamjung, only 5% of staff members are locally employed (in the other 22 hospitals). Fourteen of our study hospitals did not have even one locally employed staff in the cadres of worker that we assessed. We cannot infer from this that district hospital staff all have their

homes in other districts. According to our study, 48% of upper and mid-level staff had permanent homes close to the hospital. We can conclude, however, that the government – along with private partners – has some work to do in developing communities (and local committees) so that they can take some management responsibility for their hospitals.

The highest level of workers – doctors – were the least likely to be employed locally. Apart from Lamjung, no hospitals in our survey had a doctor under the employment of the local management committee. Doctors were also the least likely member of staff to have a permanent home in the area of the hospital, with only 10% reported to live locally. This is, in part, due to the transitory nature of government doctors. Junior doctors are posted for limited periods and then leave to do post-graduate training. Up until now, there has been limited effort to recruit local people to serve as doctors in particular rural areas. Likewise, the General Practice doctor who remains long-term in one rural location is an exception. GP doctors are relatively few in number, and their support is such that only a few remain many years in one place.

References

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