Situational Analysis of Human Resource For Health

In Public and Private Sectors in Nepal

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Executive summary

Adequate number of competent and highly motivated human resource are prerequisites for effective functioning of health system. The World Health Report 2006 states that a minimum of 2.3 health worker per 1,000 population is needed to meet the health related MDGs. The objectives of the study was to review existing global and national HRH related polices, plan, identify gaps and to recommend for better synergy in fostering healthy public private partnership for health manpower production in health sector in Nepal. The study was purely descriptive qualitative conducted in public and private teaching hospitals and relevant stakeholders of five development region of Nepal.

Nepal health related policies and documents clearly state the problems of deployment and retention of health sector staff especially in remote areas in Nepal's health system. The market has supplied sufficient quantity human resources for health, regardless of quality and working attitude. However, there is still shortage of critical human resources for service delivery due to brain drain and better opportunities in foreign countries. Nepal still lacks good recruitment policy. Even though there are health man power production policies some of the private health institutions are producing substandard health work force. This is the result of lack of proper control mechanism in the country. The population of Nepal has increased by 35% between 1991 and 2008, while the number of health workers has increased only by 3.4% in public sector. The aging population has also increased. Thus, if HRH development is not scaled up it will be difficult to meet the demand of its growing population unless the existing workforce is significantly increased in public sector and are fully mobilized. The shortages of human resources in rural areas are a universal problem and affect both developing countries and developed countries equally although their impacts on the developing and poorer countries are more devastating.

The public sector can contribute to service delivery in coordination with public sectors; however the coordination between these two sectors is very weak. Hence government should have strong policy and coordinated bodies and public private partnership should be adopted. It is also essential to have clear guideline for public private partnership in HRH production and absorption, considering equal opportunities incentives to marginalized population in public and private sectors.

Table of Contents

List of Tables

ABBREVIATION

ANM	Auxiliary Nurse Midwife
BNMT	Britain Nepal Medical Trust
BPKIHS	B.P. Koirala Institute of Health Science
CMA	Community Medical Assistant
CTEVT	Council for Technical Education & Vocational Training
EHCS	Essential Health Care Services
HA	Health Assitant
HMIS	Health Management Information System
HP	Health Post
HR	Human Resource
HRH	Human Resources for Health
HuRDIS	Human Resource Development Information System
IDI	In-depth Interview
IOM	Institute of Medicine
MCH	Maternal and Child Health
MDG	Millennium Development Goal
MDGP	Medical Doctor General Practitioner
MNCH	Maternal Neonatal and Child Health
MoHP	Ministry of Health and Population
NAMS	National Academy of Medical Science
NGO	Non-Governmental Organization
NPHF	Nepal Public Health Foundation
PAHS	Patan Academy of Health Sciences
PHCC	Primary Health Care Centre
PRSP	Poverty Reduction Strategy Paper
SBA	Skilled Birth Attendants
SEAPHEIN	South East Asian Public Health Educational Institutes Network
SLTHP	Second Long Term Health Plan
WHA	World Health Assembly
WHO	World Health Organization

Terms of Reference

The study on the status of public – private partnership in promoting human resources for health, was commissioned by Britain Nepal Medical Trust (BNMT) and undertaken by Nepal Public Health Foundation (NPHF) research team along with the researchers of BNMT, to meet the following objectives:

1. To review global Human Resource for Health (HRH) policies and practices related to HRH specific to developing countries.
2. To review the existing national HRH related policies, plan, guidelines and strategies including recent efforts of the Ministry of Health and Population (MoHP) on HRH.
3. To analyze the gaps in existing policies and implementation plans.
4. To review and analyze the trends in production and utilization (absorption) of various categories of health professionals by both public and private sector and how do they fit in the overall framework of HRH.
5. To critically assess HRH pull and push factors with evidence sought from both public and private sectors (recruitment, deployment, incentives).
6. To provide recommendations for better synergy and fostering healthy public-private partnership in Nepal for health sector in Nepal.

CHAPTER 1

INTRODUCTION

Human resource for health (HRH) is defined as "people primarily engaged in actions with the intent of enhancing health".[1]They include various categories of health professionals ranging from doctors, nurses, mid-level health professionals of different specialty of health sciences, public health professionals and researchers. The community health workers and volunteers are also very important human resources for health. While the provision of sufficient number of different types and categories of health workforce with identified task is important, enabling healthy work environment for their proper utilization ensuring is a pre-requisite for better functioning of the health system.[2]

Human resource for health is among the important building blocks of the health care system. Along with the issue of ill-distribution, there are other pertinent issues faced by developing and least developed countries related to HRH such as inadequate HRH production, lack of appropriate knowledge and skills, and inadequate public health orientation to name few. Ensuring adequate number of competent and motivated staff for poor functioning of a high quality and efficient health system is the central task of the health workforce management. It takes substantial time to build up a qualified health workforce. Many countries in the South Asia region lack the means to train adequate number of health workforce. Furthermore, teaching methods and materials tend to inadequate for the production of health workforce capable to address the complex emerging health problems. Private schools have evolved as a HRH production industry, largely outside the national regulatory framework and are often guided by commercial interest. Quality control has been a serious issue in production of human resources in South Asian countries. Lack of standardization in training quality and lack of adequate provision for continuing education have deprived many health care workers from acquiring updated and appropriate level of expertise, skills and positive attitudes to respond to the growing needs of the service user's. [3,4,5,6]

Therefore effective human resource which equals to better management strategies are greatly needed to achieve better HRH production health outcomes and better access to health care. This demands a continuous periodic assessment of its status and revision of its policy to keep it relevant with the changing demands of time and also to address new challenges emerging from the epidemiologic transition of health and diseases of a particular country.[4]

In Nepal, prevention and control of communicable diseases remains an unfinished agenda whereas and non-communicable on the other hand represent more than half the

burden of disease because of changing environment and life styles. This mixed epidemiologic transition and the new emerging diseases, like H1N1, Avian Flu, HIV/AIDS, Dengue etc, require more epidemiologists and public health experts to intervene any health problem at the population level. The existing HR situations of Nepal present a mixed scenario of over production with underutilization, and in some cases, insufficient production that falls far short of actual need being met. Nepal Safe Delivery Field Survey conducted in 2008 had identified major HRH challenges and constraints that were impacting on the effective delivery of MCH services and poor functioning of referral system. These include inconsistencies between central and field staffing, incomplete HR data, centralized and weak HRH systems, facility based staffing standards, misdistribution of key MNCH staff such as specialist doctors (Obstetrician/Gynaecologist, Anaesthesiologists, and MDGP), staff nurse, lack of SBA skill among all relevant cadres, and attracting and retaining sufficient numbers of trained staff in public health facilities, especially in rural and remote areas.[7]

Another notable feature in human resource development in the country is that the private sector has emerged as a substantial force in HRH production and utilization which needs to be acknowledged and properly coordinated with the public sectors engaged in HRH production and utilization to maximize the gains. [8,9]Hence, this study aims to review global and national HRH policies, guidelines, strategies and practices to critically appraise and identify the gaps at both HRH production and utilization and provide possible recommendations for healthy public private partnership in health sector in Nepal.

CHAPTER 2

METHODOLOGY

This study was conducted with an aim to review existing national HRH related policies, plans, guidelines and strategies, identify gaps and make recommendation for better synergy and fostering of healthy public private partnership Nepalese sector.

2.1 Study Design

The study was designed as a qualitative study. However, quantitative information was also collected from the literature and analyzed. Data for the study was collected from four development regions of Nepal representing both public and private institutions. Data collection covered the major districts of Nepal namely: Kailali, Banke, Kathmandu, Sunsari, Dhankuta and Morang.

This study was conducted for four months from September through December 2011 with series of in built activities.

2.2 Data collection technique, data sources and process

The study commenced with consultation meetings with the relevant stakeholders interested in development of human resources for health in Nepal. Outcome of these meetings contributed to formulate the outlines and modality of study.

Literature review: A list of potential public and private organizations was prepared, where documents could be available. These individual institutions were visited and relevant documents related to human resource demand, production and distribution were obtained after consulting the concerned activities of the institutions. Then, desk review was done to analyze existing global and national policies, strategies and plans related to HRH.

Different public and private sectors in Kathmandu were visited in order to obtain related documents and a consultation was done with the Human Resource head of the respective organizations.

To verify the information collected from reviewed documents, a meeting was held at Nepal Public Health Foundation, in Kathmandu with representatives from The Britain Nepal Medical Trust, Institute of Medicine and other relevant institutions. The findings of the literature review was shared and discussed for further review and analysis.

Data sources: At first public and private organizations and institutions, involved and concerned with HRH representing different development regions of the country were identified. These institutions are responsible for planning at the national level, production of human resources for health, consumption, and monitoring quality of their performances. Heads of these institutions were consulted in order to obtain consent for data collection from these institution (names of these institutions and organizations are annexed).

Development of tools: Interview guidelines were developed for in-depth interviews with the respondents to obtain qualitative information. Formats were used to collect quantitative data from the respondents. Separate sets of tools were developed for different types of respondents, as variety of information was expected from the different categories of the respondents representing public and private institutions, professional councils and planners. These tools were drafted in consultation with consultants and Technical Team of BNMT. They were pre-tested and finalized in a meeting with content and HRH experts.

Data collection: Pre-identified institutions in different districts were contacted and informed about the study. After receiving consents from the heads of the institutions, dates for the interviews were fixed. On the assigned dates, researchers visited the district for data collection. Prior to the interviews, the researchers explained the objectives and approaches of the study to each person being interviewed.

2.1 Data Management and Analysis

The qualitative data obtained were recorded in tape at the time of data collection. The tape recorded interviews were transcribed and categorized into appropriate topics/sub-topics and domains. During the content analysis, each of the topics was described and interpreted. Some of the heart-touching views expressed by the respondent were quoted in the form of verbatim. The contents were also verified with recorded voice of IDI participants. Triangulation, relevancy, consistency, accuracy and scientific proceedings of data were checked.

2.2 Quality Assurance of Data

Quality assurance of the data was maintained by timely supervision of field worker by supervisors and direct involvement of consultants in designing interviews. Apart from that, principal investigator and consultant had also supervised the work of enumerators and facilitators.

2.3 Ethical Consideration

The research participants were explicitly explained about the objectives and methods of the study. Anonymity of the responses and confidentiality of the respondent's identity was ensured. As the risk to the participants was minimum, benefits of the study was explained. Use of study findings was clarified to the research participants. Written informed consent from the participants was obtained prior to commencing the interviews. The participants were also informed about their interviews being tape recorded.

CHAPTER 3

RESULTS AND FINDINGS

Findings of the study are organized in two categories. In the first category, findings about the global situation of human resources for health are presented. These findings are from the literature reviews. In the second category findings about the HRH situation in Nepal is presented. The HRH situation in Nepal is further divided into the HRH policies, strategies and plans, and current production and distribution of HRH in Nepal.

3.1 GLOBAL POLICIES AND PRACTICES RELATED TO HRH

The World Health Report 2006 reveals the pivotal role played by health professionals in achieving health outcomes of member countries. But it also sounded the alarm that, without sufficient numbers of adequately trained and supported health workers, there is low probability of meeting the health-related Millennium Development Goals (MDGs) (WHO, 2006). Therefore a refocus on human resource management in health care and more research is desirable to develop new policies.[1]

3.1.1 Deficit in human resources for health: uneven distribution

More than 57 countries, specifically developing and least developed countries are experiencing a critical deficit in the area of health workforce. About 46.6% of WHO Member States report to have less than 1 physician per 10,000 populations. Though Europe and North America together have only 21% of the world population, 45% of the world's allopathic doctors, and 61% of nurses' work there. South East Asia region with 26% of world population only has 20.2% of total allopathic doctors and 7.9% of nurses. Sub-Saharan Africa faces the greatest challenges of deficit of HRH. The region has 11% of the world's population and carries 25% of the global disease burden, but has the most acute shortage of human resources which can be termed as work force crisis.

The shortages of human resources in rural areas are a universal problem and affect both developing countries and developed countries equally although their impacts on the developing and poorer countries are more devastating. At the country level, imbalances are even more prominent. There are also some countries like Mali and Democratic Republic of Congo, where despite the overproduction of health workers, with medical

unemployment in urban areas, chronically suffer with shortages in rural areas; a situation similar to Nepal.[1, 10, 11]

The World Health Report 2006 recognized the centrality of the health workforce for the effective operation of country health systems and outlined proposals to tackle a global shortage of 4.3 million health workers. The World Health Report 2006 demonstrates that a minimum of 2.3 health workers per 1000 population is needed to meet health related MDGs. There is increasing evidence that this shortage is interfering with efforts to achieve international development goals, including those contained in the Millennium Declaration and those of WHO's priority programmes. The situation is more acute in countries which shoulder the highest disease burden, their health system does not function properly and they have an unacceptably low population health workforce ratio.[1]

The shortage of qualified staff in Africa has been aggravated by the increasing emigration of health workers to a number of developed countries. Countries like Ghana have more doctors working overseas (60%) than in their country. In Zimbabwe, only 360 physicians out of the 1200 trained in the 1990s remained in their country. These health professionals are supporting the health care delivery and serving the developed countries. The developed countries in response to their own staff shortages have actively drained highly skilled health professionals without re-investing in the health systems of the source countries especially those in Africa. Kenya's public health system is short of 5000 nurses yet 6000 of its nurses are looking for a job in the developed countries.[12]

3.1.2 Human Resource for Health: a less prioritized agenda

Human resources for health and health systems in developing countries have been under funded for decades due to harsh economic policies like structural adjustment. The situation has been exacerbated by conflict, the HIV pandemic, weak institutional capacity and the failure of donors to invest in recurrent expenditures like staff salaries. This chronic under-investment has led to collapsing health systems, appalling and unsafe working conditions for health professionals and unfair distribution of health professionals between rich and poor countries.[1, 7]

The health workforce crisis in developing countries derives principally from inadequate educational opportunities for health workers and a lack of relevance of their training to community health care practice. Additional contributing factors include: inadequate compensation for their working conditions, the deteriorating health of the workforce in many developing countries, urban/rural workforce imbalance, and migration of the workforce from developing to developed countries.[13]

It has also been pointed out that the human resources for healthcare provision have been neglected by governments, donors, international organizations and development policy-makers.[5]Too often the priorities are set globally with no involvement of the most vulnerable populations. Health sector reforms have not yet ensured that adequate resources, management and decision-making powers are decentralized and accountability mechanisms are weak or nonexistent. Such issues have made providing health care in any developing country an enormous challenge for most health workers.
South-East Asia region has only five percent of public health schools in the world. Weak incentive and management policies and practices, insufficient incentive systems and effective management policies and practices have lead to attrition and low productivity of the health workforce. The global and regional policies on HRH and the alliances for HRH have tried to address these issues.[14]

3.1.3 Evolution of global HRH policies and alliances

In growing recognition of this imbalance in HRH, WHO has begun to highlight the problem and develop consensus policy and strategies to address this burgeoning problem. In 2002, the 55th World Health Assembly had requested the Secretariat " to accelerate development of an action plan to address the ethical recruitment and distribution of skilled health care personnel, and the need for sound national policies and strategies for training and management of human resources for health". In 2004, WHA passed Resolution WHA57.19 on the challenge posed by the international migration of health personnel; in 2006 it passed Resolution WHA59.23 on rapid scaling up of health workforce production; and also Resolution WHA 59.27 on strengthening nursing and midwifery.[14]The year 2006 is important not only for WHA resolution but it brought out the World Health Report 2006: "working together for health" highlighting the role of human resources for health development, and launched Global Health Workforce Alliance in May 2006 to bring together and mobilize the key stakeholders in global health for human resource development.[1] Regional alliances such as Asia-Pacific Action Alliance on Human Resources for Health (AAAH) and South East Asia Public Health Educational Institutes Network (SEAPHEIN) are some of the notable initiatives in this direction.

3.2 HUMAN RESOURCE FOR HEALTH SITUATION IN NEPAL

As mentioned earlier, this section of findings is organized into two parts. The first part is findings based on literature review which describes the HRH policies, strategies and plans. The second part consists of information about existing situation of production of HRH, distribution of health service facilities and health workers in different regions of the

country, gaps and other issues. The second part is the findings obtained from the literature and in-depth interviews with the research participants. The qualitative findings of this study are presented based on the information obtained from various health institutions both from the private and public sector. These institutions provide health care services and are involved in human resources development and monitoring the quality of health workers in Nepal. The public health institutions involved in this study serve the public and produce human resources for health through the government health service network and system. The private health institutions provide services to the public and produce human resources and are seen as private investment for profit.

Altogether 25 participants representing various institutions were interviewed. Nearly one third (7) of the interviews were conducted in Kathmandu followed by 6 interviews in Biratnagar, 6 in Nepalgunj, 2 in Dhangadhi, 2 in Dharan and 2 in Dhankuta.

3.2.1 National policies and plans related to HRH in Nepal

As Nepal is signatory of important global policies related to Human Resources for Health and is making steady progress in meeting health related MDGs, it can be hoped that with periodic assessment and revision of HRH policy particularly in relation to public-private partnership in HRH, Nepal will be able to tune its HRH management in accordance with the changing need of the country's health challenges.

Several national policy documents deal with HRH, some in passing and others in more details. A brief review of these documents is undertaken in this section.

National Health Policy, 1991[15]

The National Health Policy was adopted in 1991 (2048 BS) to bring about improvements in the health conditions of the people of Nepal through extending access and availability of primary health care system. The primary objective of the National Health Policy is to extend the primary health care system to the rural population so that they benefit from modern medical facilities and the services from trained health care providers. The National Health Policy addresses the Human Resources for Health (HRH) for ensuring technically competent human resources for all health facilities. The policy has provided the directive to expand and strengthen training centers and academic institutions to produce competent human resources and meet the national requirements.

Second Long Term Health Plan, 1997-2017[16]

A 20-year Second Long-Term Health Plan (SLTHP) for FY 2054-2074 (1997-2017) had been developed with an aim to guide health sector development for the overall improvement of the health of the population; particularly those whose health needs are often not met. The SLTHP has focused on improving the health status of women and children, the rural population, the poor, the underprivileged, and the marginalized. The plan has spelled out the need for redirecting resources from high-cost, low-impact interventions to the low-cost high –impact essential health care services (EHCS).

Addressing the disparities in healthcare and taking into account gender sensitivity and equitable community access to quality health care services, the SLTHP provided a guiding framework to develop technically competent and socially responsible health personnel in appropriate numbers for quality healthcare throughout the country, particularly in under-served areas. In the area of human resource development, together with other programmes, the main thrust of the SLTHP was to ensure co-ordination among public, private and NGO sectors and development partners. The SLTHP opened the door wide to the private sector for training Human Resource for Health.

10th Five year plan 2002-2007[17]

The 10th five year plan is in line with the Poverty Reduction Strategy Paper (PRSP) 2002. Emphasizing on the critical importance of the health sector for human development, for improving living standards in rural areas and mainstreaming marginalized groups and communities, this document has highlighted the interdependence of health and development. The 10th five year plan during its period reinforced the directive of SLTHP to privatize health profession education and producing Human Resource for Health. It also outlined the importance of retention of trained staff in rural areas for services.

Nepal Health Sector Programme-Implementation Plan (2004-2009) NHSP-IP[18]

NHSP-IP was an important document that guided the national health activities for five years. Among three program outputs and eight sector outputs envisioned in the document, one of them was human resource development. The Human Resource Development has focused mainly in to five key areas. They are;

1. Locate HRD unit in an appropriate MoHP structure and reform it
2. Improve personnel management system in an effective way
3. Improve co-ordination and quality of in-service training
4. Provide training in newly identified areas of training needs
5. Improve co-ordination between the Ministry of Education (MoE), MoHP and CTEVT for pre-service education.

Three Year Interim Plan (2007/2008 – 2009/2010)[19]

The Three Year Interim Plan has provided the directives to establish the right of the citizen to free basic health care services, and addressing public health issues as per the principles of primary health care. It has also indicated the need to ensure that the human, financial and physical resources provided by the government, private sector and NGOs would be managed effectively for improving the quality of health care services.

Strategic Plan for Human Resources for Health, 2003-17[4]

The Ministry of Health and Population (MoHP) introduced new policies and operational mechanisms to improve the ability of the Ministry to manage the deployment, utilization, development and careers of its staff (MOHP, 2003). The MoHP has recently realized the importance of improving skills of human resources and to increase efficiency of the system. One of the steps forward in this direction has been the relatively recent upgrading of Maternal and Child Health Workers (MCHWs) by providing Auxiliary-Nurse Mid-wife (ANM) training in 500 VDCs. The plan is to place ANMs in all VDCs.

The Strategic Plan for human resources for health intended to

1. Specify the direction and growth of human resources growth
2. Outline human resources objectives for the medium term
3. Identify short –term policy action for the MoHP

It includes future human resources 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.[20] However, these staffing projections are no longer valid for a health sector that is now providing free health care, has an expanding private sector and producing an increasing supply of doctors nurses for the national and global labor market. Unfortunately, the strategic plan has not informed annual planning and there has been no formal review of progress

against the plan. Since the time this plan was endorsed, several other strategies have been developed which have important implications for human resources.

The National SBA Policy (2006)[21]

The National SBA policy identifies maternal health staffing requirements for health post and sub-health posts. The SBA In-services training Strategy (2006) aims to provide competency-based In-service SBA training to all eligible current and newly recruited ANMs, Staff nurses, and Doctors who work in MoHP facilities. The Government of Nepal aims to achieve 60% of the deliveries attended by SBAS by 2012. Until now 2,535 SBAs are trained, which is much lower than the requirement.

Nepal Health Sector Programme- II (2010-2015)[20]

The NHSP –II is the most recent document that guides health activities until 2015. It identifies key issues and challenges facing the health sector and outlines various strategies to address them. It recognizes that a competent, motivated health workforce forms the core of a high-quality, effective and efficient health system. NHSP-II identified development and retention of health worker and ensuring the delivery of quality services as the major challenges of HRH. Some of other challenges identified by NHSP-II are: shortage of health workers e.g. only 2/3 of positions for doctors and nurses were filled. There were skilled workforce shortages in specialized areas, such as Anaesthesia. Fragmented HR management and incomplete HR information were some other problem areas. The NHSP-II explicitly pointed out to poor staff attendance, weak motivation affecting productivity and quality of services and low participation of Dalits and other excluded groups in the health workforce as problems to be addressed.

3.2.2 Production and distribution of HRH

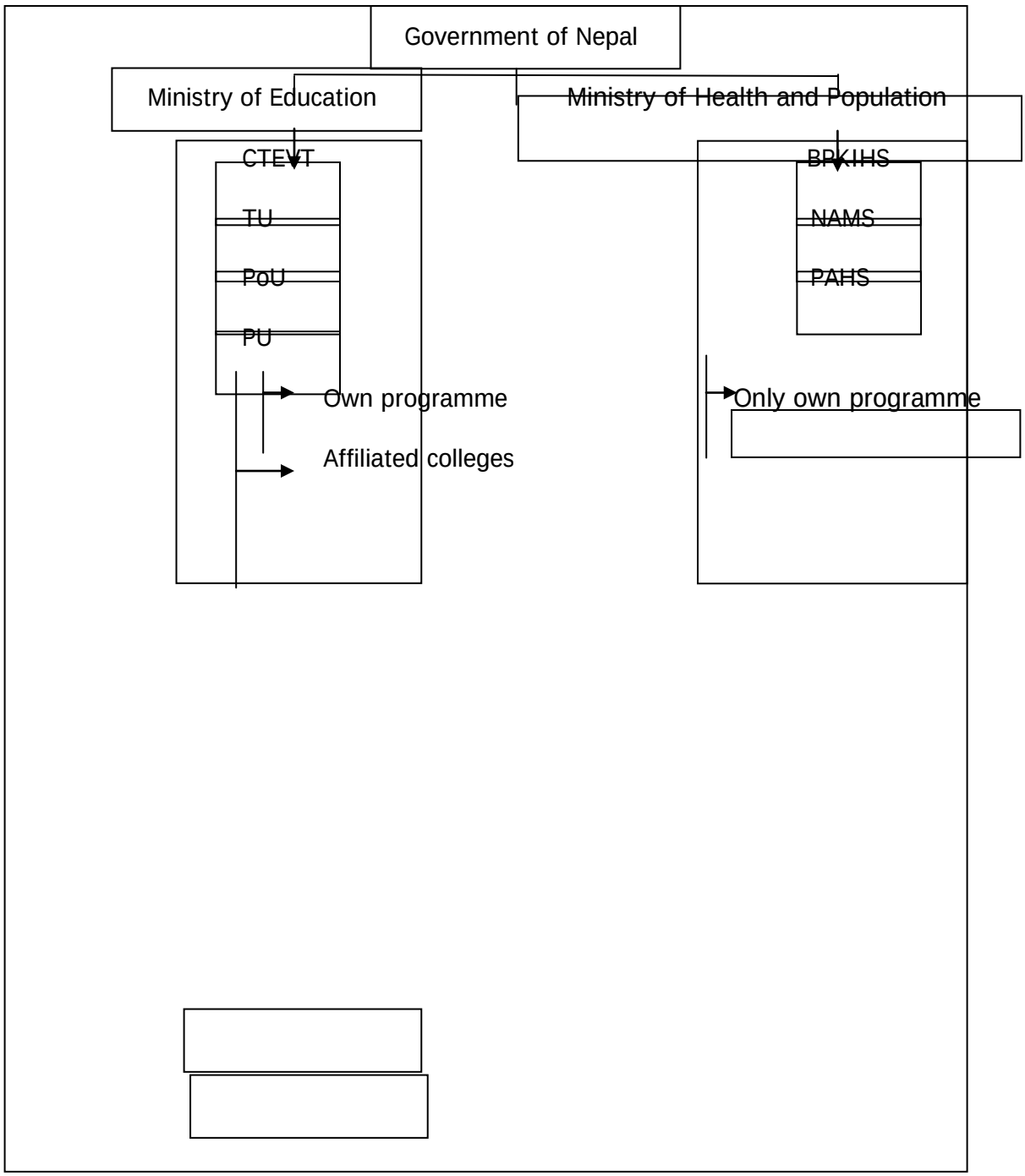
This section describes the sanctioned and fulfilled posts for health workers in public sector, regional and ecological distribution of health service facilities, and HRH production situation in Nepal.

HRH Production in Nepal

Human Resource for Health is formally produced in Nepal through different mechanisms under the Ministry of Education and Ministry of Health and Population. Under the Ministry of Education, HRH production takes place through Council of Technical and Vocational Training (CTEVT), Tribhuvan University (TU), Pokhara University (PoU) and Purbanchal

University (PU). In addition, Sanskrit University produces HRH in traditional systems. Under the ministry of Health and Population, HRH of different categories are produced by BP Koirala Institute of Health Sciences (BPKIHS), National Academy of Medical Sciences (NAMS) and Patan Academy of Health Sciences (PAHS).

CTEVT is responsible for the production and quality control of mid- level human resources for health, like ANM, Staff Nurse, Health Assistants, Community Medical Auxiliary, Pharmacists and others. CTEVT mainly provides license to private institutions and colleges to produce mid level HRH with exception of few of their own training program. Universities have their own training program and are affiliated to private colleges for the production of graduates and post graduate specializing in HRH. The institutions under the Ministry of Health and Population have their own training programmes of different level and do not affiliate with private colleges. Universities and institutions under the Ministries are autonomous authorities although they are legally under the line Ministries.


Government of Nepal
Ministry of Education
Ministry of Health and Population
CTEVT
TU
PoU
PU
BPKIHS
NAMS
PAHS
Own programme
Affiliated colleges
Only own programme

As shown in the table below, large numbers of different categories of human resources for health is produced every year in Nepal. These numbers are far bigger than the capacity of public sector consumption alone. Visibly, there are a large number of private health institutions that are involved in training of different specialty and level of HRH. There are few more categories of HRH being trained in Nepal, but not all are included in the table, like Bachelor in Optometry, Bachelor in Audiology, etc although their numbers are smaller. Similarly, training on super specialty courses has been initiated in Nepal. Despite such numbers of production, very few are found to serve the total population of Nepal.

Table 1: Production of different categories of HRH in Nepal

Category of Health workers	Number of campus	Total quota	Per year production(Estimated)	Total production up to Sept 2011
Medical College (medical Doctor)	20	100 to 150	2500	11052
Staff Nurse	98	40	3920	16219
Health Assistant	47	40	1880	2780
CMA	80	40	3200	29301
ANM	47	40	1880	17434
Lab Technician	42	30	1260	1080
Lab Assistant	32	40	1260	5828
Pharmacy college	35	30	1050	875
Public health	16	40	640	654
Radiographer	15	30	450	305
Ayurved worker	10	40	400	1253

Source: Field survey Oct, 2011

In Nepal, public and private academic institutions are producing different categories of Human Resources for Health. The public academic institutions are under Tribhuvan University and Ministry of Health and Population. The private sector should be licensed by the Council for Technical and Vocational Training (CTEVT) or be affiliated to one or another University. The categories of health workers include different levels and different specialties: Paramedics in various disciplines, Undergraduate in Medical, Public Health, Nursing, Pharmacy, Oral Health, and other para-clinical areas, post graduate in clinical, public health, nursing and other different specialties.

All the middle level health workers like Health Assistants, Staff Nurses, Auxiliary Nurse Midwife (ANM) Community Medical Assistant (CMA), Dental Therapist, Lab Technician, Pharmacy Assistants are exclusively produced by private sector licensed and certified by CTEVT. Graduates in Medicine, Public Health, Nursing and other disciplines are produced largely by private academic institutions affiliated to one or another University and in small proportion by public academic institutions. Post graduates in clinical specialty, Public Health, Nursing, Pharmacy and other health science disciplines are mainly produced by public sector. PhD programmes in public health and Nursing are exclusively in public institutions.

Thus, in Nepal, majority of health workers are produced by the private sector. For example, out of about 2,500 medical doctors produced in Nepal every year, public academic institutions produce only slightly more than 200 medical graduates.

Nonacademic public health institutions are not directly involved in the production of health manpower but provide opportunities and space to medical doctors, nurses, paramedics and lower level health workers to learn skills through internship and on the job training programs.

Sanctioned and fulfilled positions in public sector

In the fiscal year 2010/011, there were a total of 24,477 sanctioned posts of health workers in the health facilities. Among them, 88% of positions are filled and 12% are vacant. Slightly more than three fourth sanctioned posts of doctors are filled, while nearly 90% of nursing staff are filled among the sanctioned posts (Table 2).

Table 2: Human resources for health under MoHP in Nepal (2010/011)

Position	Sanctioned	Filled	Vacant	% of filled position
Medical Doctor	1,062	816	246	76.84
Nursing staff including ANMs	5,935	5307	628	89.42
Paramedics	10,642	9,212	1,430	86.56
Other	6,838	6,94	4,44	93.51
Total	24,477	21,729	2,748	88.77

Source: Human Resource for Health Strategic Plan, 2011-2015.

From more recent data obtained from the HuRIS in September 2011, out of total of 31, 628 sanctioned posts for the main staff categories of doctor, nurses, paramedics/professional allied medicine, administrative and support staffs and Ayurvedic

and traditional medicine, 21,970 are filled and about 30% (9658) are vacant (Table 2). Altogether, about 12% of the total sanctioned positions are vacant (Table 3).

Table 3: Sanctioned versus filled posts

Position	Sanctioned	Filled	Vacant post
All HRH including administrative staff	31,628	21,970	9,658

Sources : HURIS Sep. 2011

Regional and ecological distribution of health facilities in public sector

The regional and ecological distribution of health service facilities in public sector is not even. Distribution of health service facilities is concentrated in the central region and adversely skewed to the mid and Far Western regions (Table 4).

Table 4: 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
Far Western	0	2	7	20	89	118
Total	3	10	62	208	678	961

Source: Ministry of Health and Population (2009)

In the Eastern and Far Western development regions, there are no regional hospitals. However, Teaching Hospital of BPKIHS, provides a good range of health services in the Eastern region. Such additional facility is not available in the Far Western region. Several districts do not have district hospitals yet. Highest number of district hospitals resides in Western and Eastern region while central region have highest number of PHCCs and HPs. Ecologically, more number of regional, districts hospitals, PHCCs and HP are located in hilly region (Table 5).

Table 5: Distribution of health facilities in the public sector by geographic region

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)

3.2.3 Gaps in human resources for health in Nepal

Nepal shares similar scenario with other least developed countries in terms of problems related to HRH. It suffers from over production and underutilization in some areas while in others there is absolute shortage of skilled human resources. Unlike Africa, however, where most of the countries have an absolute shortage of HRH due to brain drain, mortality from AIDS epidemic and reduced training capacity, [10, 22] the situation in Nepal can be best described as relative shortage. Nepal has adequate capacity and producing enough number of health workers of different categories and specialties with few exceptions. However, most of the human resources are concentrated in urban areas and outside the government sector, away from the places where their need is acutely felt. As expressed in policies, health system has not yet been able to ensure HRH availability for the services to the people living in the rural, difficult terrain, with low socio-economic conditions.

Though Nepal produces an adequate number of doctors and nurses there are still absolute shortage of qualified midwives. Out of a national stock of 8771 medical doctors, 1,062 have been working in sanctioned government posts and about 300 have been working in government posts under the Ministry's scholarship programme. The health sector constitutes about one-fourth of total personnel of the public sector. The existing skills mix revealed that only 4% of total health care providers are doctors, 12% nurses, excluding ANMs, 47% paramedics, 0.92% public health officers, and 3.1% traditional health care providers (HuRIC, 2008). There is currently a high number of unskilled support staff (28% of the total workforce). This poses a challenge to the health system to reduce the volume of unskilled and semi-skilled labor as a percentage of the total workforce.[20]

Mismatch between health needs and HRH development

The population of Nepal has increased by 35% between 1991 and 2008, while the number of health workers has increased only by 3.4% in public sector. The aging population has also increased. Thus, if HRH development is not scaled up it will be difficult to meet the demand of its growing population unless the existing workforce is

significantly increased in public sector and are fully mobilized. Health facility surveys showed that only 64-80% of posted medical doctors were available at the time of the surveys. Availability of nurses was 68-81% and for paramedics, 81-92%. The situation is worse in the most remote districts. Productivity of health workers is yet another serious issue. As reported in HMIS, paramedics' clinical consultations per day in health posts and sub health posts are as low as 6 person (HMIS, 2006/07), which is even lower when considering their involvement in both preventive and curative services.

Choices between public and private sector: There is an increasing attraction for the health workers to work in private or NGO sector after graduation. Among the nursing students, 57% expressed their desire to work for the private or NGO sector after graduation. In the public sector, there is a limitation on the availability of funds for human resource development, and it accounts for 8-10% of total salary. Apparently, monitoring of human resource between public and private sector constrained affairs.

Choices between rural and urban areas: as perceived by most of the informants involved in HRH production and quality control, there is an increasing trend for the health workers particularly among the doctors to work in large cities. These health professionals are willing to work with less salary in the cities than going to the remote areas with higher remunerations. One of the responding key informants, representing professional council expressed the view as

> ***"… 80% of the population are in rural area while 80% health related human resources are in urban area…… there is no need based distribution of human resources in health… it needs to be addressed immediately and carefully…"***

Recruitment Policy

In the public sector, according to the level of health institutions - Regional, Zonal, District and Peripheral level institutions) - public health institutions have provisions for consultants, medical officers, nurses and paramedics assigned to work whilst all the sanctioned posts are not filled and sanctioned numbers are also not sufficient to serve the population they need to serve.

For recruitment, public health sectors follow the government policy, rules and regulations. Additionally, these institutions recruit health workers following the regulation of Health Facility Development Board, which is formed in most of the regional and zonal hospitals. Academic institutions in public sector are autonomous and formulate their own recruitment policy and rule, which are approved by the government. The private academic institutions have more liberal policy of recruitment. They use their affiliate University guidelines for the selection criteria and number of human resources. However, these institutions often recruit HRH on need basis. Although these health institutions have their own documented recruitment policy and has to be followed, but in practice majority of the private institutions recruit the necessary health workers in ad hoc basis with mutual agreement.

Problem of Retention of Human Resources in Health sector

Retention of human resources is one of the chronic problems of health systems especially in remote areas. Almost all the respondents expressed that the main reason for them to choose an urban setting is due to the facilities available at urban areas. The reasons for weak retention of human resources in both public and private sectors are lack of proper job environment in the remote districts, absence of provision of quality education and schools to children, opportunity for further study. Lack of well-equipped quality infrastructure to enhance skills, low salary scale compared to private sectors, frequent transfer, limited scholarship programs for doctors, lack of career development opportunities all contribute to the internal migration of HRH to mostly to urban dwellings. Many health workers perceive that even existing policies and regulations putting place to address some of these problems are not properly implemented. Sometimes, working environment fostering weak team spirit, non cooperation of support staff is responsible to amplify the problems. The consultants in public institution from the Eastern region clearly reflected their views as

> *"…. I am a surgeon. If the government compelled me to go to remote area I could easily go there to serve people, however government should have provision of treatment if I was to fall ill and guarantee for my immediate treatment if I became victim of any illness at the right time in the very place…"*
>
> *"…. I am interested to work at remote areas, if my children get equal opportunity to have quality education as children from urban areas……".*

Perception of most of the respondents is that if medical doctors enter the public sector and go to the remote district, their objective is to grab an opportunities of post graduate study. Their intention is not to serve the people and contribute to improvement of the system. It is equally true that, as expressed by the informants, there is weak linkage of central level offices with peripheral level resulting in non-recognition of health workers working in far districts. Posting in difficult districts is also seen as punishment to the health workers by the system. These factors have adversely affected the deployment and retention of health workers.

Private sector is not free from these problems. There is practically no opportunity for further study, job security is not assured, social respects and recognition is less satisfactory for the health workers. They have few opportunities to participate in trainings, seminars and workshops compared to those from the public sectors. A participant of study from a medical college in Western Nepal stated that retention problem is mainly of nursing staffs. The participants further added 'nurses are more career oriented and their intention is to go for abroad study'. Hence, they do not like to

work in remote areas because of lack of language learning centers as well as less number of nursing colleges to work part time and earn extra money.

Quality of existing HRH in Nepal

Quality of HRH is imperative due to sensitivity of their work and responsibility. Competency of HRH is perceived as deteriorating over the years. This situation is largely a result of poor quality of training institutions, which rarely maintain the standard of faculty, infrastructure and other facilities. There are few training institutions complying with the norm and standard of regulating authority and producing quality health workforce. The condition is comparatively worse in private training institutions. The responding representatives of quality control authorities expressed that they are aware of the situation. However, improving the situation was much more difficult than it seemed. As most of the respondents reflected, majority of the private institutions lack qualified and adequate faculty required for training. The faculties are not recruited on the basis of qualifications and experiences but rather on the basis of acquaintances. These institutions are widely believed to establish as investment for profit. Their commitment to produce quality HRH was questionable. One of the representatives of quality control authorities expressed the bitter feeling in the following words:

> ***"… these days people are running private nursing college in two rooms, without any hospital practical exposure……. How could we expect quality nursing products from those institutes? ……. ."***

In comparison to private sectors, public sectors faculty is fulfilled and health workers are also trained and qualified.

In order to address the problem of quality of nurses, Nepal Nursing Council is planning to conduct license exam to qualify registered nurses. Currently, there is a provision of license examination for the medical doctors conducted by Nepal Medical Council.

Perception towards brain drain of HRH

Brian drain of human resources especially for doctors and nurses are a big problem in Nepal which needs to be addressed urgently. According to the Nepal Nursing Council, unemployment and no vacancy announcement by Civil Service Commission are the main reasons identified for nurses to go abroad. They get both opportunities to earn money and have higher education.

"……We are producing human resources for health not only for Nepal, these days we are more aware towards international market demand of health manpower, hence we are heading towards production of manpower for international market as well…"

One of the authorities of professional council, Kathmandu

Reasons of flourishing private sectors and their contribution to public sectors

In Nepal, private sectors are flourishing very rapidly. This development has both positive and negative implication. On one hand the positive aspect is that they produce abundant number of health workforce required to serve large number of growing population, even to the extent of supplying to the global market. On the other hand their quality is seriously compromised as compared to government colleges. This increase in the number of private sectors in production side appears to be commercially driven and is creating a big problem of over production within the national boundaries. Even though the government of Nepal has adopted public private partnership approaches, the approaches is not functioning well due to lack of proper controlling mechanisms in the country.

Strengths and Weakness of Public and Private sectors Health Institutions

In Nepal, more than 80% of the population lives in rural areas. However, 80% of HRH are concentrated in urban areas. Over production and underproduction of different categories of health workers to meet the requirement and lack of proper human resource planning are the major weakness in managing HRH in Nepal. Though there are different HRH policies, rules and regulation, their implementation is very poor. There is no proper controlling mechanism. Low supervision and monitoring in the rural areas and lack of accountability and dedicated human resources are also the major challenges to address the issues of HRH. Job security, low paid salary in few private institutions in the name of earning money, no training, promotion and ranking are the identified weakness of private sector in retaining human resources. However, even though the employees are facing such problem they are forced to work to earn their livelihood. In contrast, public sectors have wider networks, well established job description, trained manpower, promotion and ranking system. Dedication and accountability of health worker towards their job and transferring acquired knowledge and skill are major things that need to be considered.

CHAPTER 4

DISCUSSION

A competent, motivated health workforce forms the core of a high-quality, effective and efficient health system. Nepal's health policy and strategy documents over the past several decades have repeatedly identified issues regarding the deployment and retention of health sector staff as a major problem facing Nepal.

The Human Resource Development Strategic Plan 2003 needs to be revisited in the context of the health-related MDGs, free health care, and health system development. The new projection of human resources by categories and sub categories is imperative to support EHCS and beyond EHCS service delivery. The government of Nepal, Ministry of Health and Population has taken a commendable step in this direction by bringing out draft of Human Resources for Health Strategic Plan 2011-2015 for discussion.

The market has supplied sufficient human resources for health. However, there is still a shortage of critical human resources for service delivery. For example, 7,000 trained SBAs are needed but the current supply is only 1,000, 90 MDGPs are needed but only 34 are available and there is a chronic shortage of other clinical and non-clinical human resources: Anesthetists, Psychiatrists, Radiologists, Radiographers, Anesthesia Assistants, Physiotherapist/ Physiotherapy Assistant, Optometric Technician/Ophthalmic Assistant, and Dental Assistants. In addition, there is a shortage of human resources related to health systems management—procurement specialists, health legislation experts, epidemiologists, health economists and health governance experts.

There also appears to be a sufficient national stock of medical doctors in some of the key specialties related to the health MDGs. For example, the Medical Council in September 18, 2011 registered 8771 MBBS, 917 BDS & 1302 specialist's doctors registered. The problem is one of poor distribution of doctors and specialists nationwide.

1. As the findings of field study suggest, the retention of medical doctors and nurses remains a major concern. There is a lack of evidence on the average length of stay of care providers at any delegated health institution. Health workforce migration and retention

2. Health workers leave their home countries looking for better working conditions and career opportunities abroad.
3. They leave rural areas for urban settings.
4. The result: increasingly inequitable access to health care, within and between countries.

Poor career prospects and lack of sanctioned posts were serious de-motivators for retaining General Practice Specialist doctors (MDGPs) in district hospitals. Limited staff housing, few opportunities for continuing education, and lack of network problem for communication were de-motivating factors for all rural health workers. There is very low participation of marginalized population like Dalits in the health workforce at both policy and service delivery levels groups in the health workforce at both policy and service delivery levels. Increasing their participation still remains a challenge.

Purchasing services and regulating the private sector will require procurement specialists, health legislation experts, health economists, and health governance experts.

The main reasons for health care professionals not willing to work in public health institution are poor physical infrastructures, lack of equipment/supplies, poor working environment, lack of opportunities for upgrading knowledge, and lack of security (personal safety, non-availability of staff quarters)

In spite of these challenges, Nepal has consistently advanced in human resource trainings, thanks primarily to the innovative approach in health sciences education. Over the years Nepal experimented with different kinds of mid-level health workers such as Health Assistants, Auxiliary Health Workers, Assistant Nurse Midwife, Village Health Workers and Maternal and child health workers and succeeded in developing a functional tier of health professional at different level of health care delivery system. Even the doctors were trained in community oriented medical education system; the Institute of Medicine being one of the first lots of community oriented medical colleges in the world. The curriculum of all these different levels of health workers were heavily community oriented and field based. This character is the community oriented medical education was retained in other public medical colleges such as BPKIHS and PAHS, as well as all the private medical college, at least in paper. On this basis, the Institute of Medicine built solid structures of Public Health education starting from Bachelors of Public Health and developing into MPH and PhDs.

CHAPTER 5

CONCLUSION AND RECOMMENDATION

Globally, HRH is deficit in developing countries largely due to mobility of health workers from these countries to developed countries. Human resource development is a less prioritized agenda.

In Nepal, policy has sufficiently addressed the issues of human resource development and utilization. However, there is a gap in implementation of the policy. Plans and strategies to mobilize the health workers in remote and rural areas are still inadequate.

Nepal has adequate infrastructure and capacity to produce HRH to meet the national needs due to involvement of private sector with larger share; majority of medical, nursing and public health training institutions are operated by private sector.

The private sectors can make a big difference in the public sectors by producing HRH and delivering services to general population in proper coordination with public sectors working in their own area. Coordination between the public and private sector is weak, which is resulted in weak partnership between two sectors.

A clear strategy to produce need based HRH to meet the national demand should be worked out.

A strategy for deployment and retention of HRH in remote areas is urgently needed.

Monitoring the quality production of HRH should be reemphasized by strengthening quality control authorities.

A mechanism to coordinate and building effective partnership between public private institutions should be in place.

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ANNEX 1

Table 6: Name of the institutions which were used for the study purpose

S.N	Name of institutions under study	Type of Institutes
1.	National Planning Commission, Kathmandu	Public sector
2.	Seti Zonal Hospital, Dhangadi	Public sector
3.	Nepalgunj Medical College, Teaching Hospital, Nepalgunj	Private sector
4.	Nepalgunj Nursing Campus	Public sector
5.	Bheri Zonal Hospital, Nepalgunj	Public sector
6.	CTEVT, Sanothimi	Public Sector
7.	Dhulikhel Hospital, Dhulikhel	Private sector
8.	Nepal Nursing Council, Kathmandu	Public sector
9.	Nepal Medical Council, Kathmandu	Public sector
10.	Nepal Health Professional Council, Kathmandu	Public sector
11.	National Academy for Medical Sciences, Kathmandu	Public sector
12.	Patan Academy of Health Sciences, Lalitpur	public sector
13.	Ministry of Health and Population	Public sector
14.	Koshi Zonal Hospital, Biratnagar	Public sector
15.	Nobel Medical College, Teaching Hospital, Biratnagar	Private sector
16.	BP Koirala Institute of Health Sciences, Dharan	Public sector
17.	Regional Health Directorate, Eastern Region, Dhankuta	Public sector

ANNEX 2

In Depth Interview
(MoHP, Patan Academy of health sciences, TUTH, Bir Hospital, Nursing Campus, etc)

I am _____employed by Nepal public Health Foundation, as interviewer to collect data for research on Human Resource for Health, a comprehensive assessment of public private partnership in various aspects of HRH in the country, a project supported by Britain Nepal Medical Trust (BNMT), with ways to move forward. Dr. Mahesh Maskey at Nepal Public Health Foundation is the principal investigator on this research which will take place for three months. I and the research team assures you that the information provided will be kept confidential and also the answer records will be out of reach for other unrelated person except those who will analyze them.
In addition, choosing to participate or not to participate will not affect your job or job related evaluations in any way. You may stop participating in the discussion at any time that you wish without any implication.
Name or the Interviewee: _____
Signature: _____
Date: _____

Interview questionnaire

1. What types of HRH are produced in your organization?
2. What types of HRH are functioning at your organization?
3. Do you have recruitment policy in your organization?
4. What are the factors affecting retention of HRH in your institution?
5. Is there a performance based reward system of staffs at your organization?
    a. Is current remuneration of HRH sufficient for livelihood?
    b. Salary/allowance per month/year- specially for Doctor & Nurse
    c. Other incentives
6. What percentages of HRH produced by our institution are employed by public sector and private sector?

7. In your opinion, what are the major strength/ weakness of public sector & private sectors in relation to HR recruitment, HR retention, HR motivation towards their work?
8. What do you think is the reason for private sector to have flourished in Nepal so rapidly? How do they contribute to public health sector?
9. Is there an imbalance between supply & demand of Human Resources in Health (HRH) in Nepal? If so what could be the causes in your opinion.
10. What can be done to improve Human Resources in Health (HRH) situation in Nepal?

In Depth Interview
(Nepal Health Professional council, NMC, NNC, CTEVT)

I am _____employed by Nepal public Health Foundation, as interviewer to collect data for research on Human Resource for Health, a comprehensive assessment of public private partnership in various aspects of HRH in the country, a project supported by Britain Nepal Medical Trust (BNMT), with ways to move forward. Dr. Mahesh Maskey at Nepal Public Health Foundation is the principal investigator on this research which will take place for three months. I and the research team assures you that the information provided will be kept confidential and also the answer records will be out of reach for other unrelated person except those who will analyze them.

In addition, choosing to participate or not to participate will not affect your job or job related evaluations in any way. You may stop participating in the discussion at any time that you wish without any implication.

Name or the Interviewee: _____

Signature: _____

Date: _____

Interview questionnaire

1. What types of HRH are functioning at your organization?
2. Do you have recruitment policy in your organization?
3. What are the factors affecting retention of HRH in your institution
4. What is the quality of HRH in Nepal?
    a. Skill
    b. Attitude towards work
5. What is your view towards the brain drain HR in foreign country?
6. What can be done from policy level to stop brain drain?
7. How you identify the pool of human resources?
8. In your opinion, what are the major strength/ weakness of public sector & private sectors in relation to HR recruitment, HR retention, HR motivation towards their work?
9. What are the causes/effects of mal-distribution of health staff
10. What can be done to improve the day-to-day management and supervision of HRH?
11. What do you think is the reason for private sector to have flourished in Nepal so rapidly? How do they contribute to public health sector?
12. Is there an imbalance between supply & demand of Human Resources in Health (HRH) in Nepal? If so what could be the causes in your opinion.
13. What can be done to improve Human Resources in Health (HRH) situation in Nepal?

In Depth Interview
(Private Health institutions)

I am _____employed by Nepal Public Health Foundation, as interviewer to collect data for research on Human Resource for Health, a comprehensive assessment of public private partnership in various aspects of HRH in the country, a project supported by Britain Nepal Medical Trust (BNMT), with ways to move forward. Dr. Mahesh Maskey at Nepal Public Health Foundation is the principal investigator on this research which will take place for three months. I and the research team assures you that the information provided will be kept confidential and also the answer records will be out of reach for other unrelated person except those who will analyze them.
In addition, choosing to participate or not to participate will not affect your job or job related evaluations in any way. You may stop participating in the discussion at any time that you wish without any implication.
Name or the Interviewee: _____
Signature: _____
Date: _____

Interview questionnaire

1. What types of HRH are produced in your organization?
2. What types of HRH are functioning at your organization?
3. Do you have recruitment policy in your organization?
4. What are the factors affecting retention of HRH in your institution
5. Is there a performance based reward system of staffs at your organization?
    a. Is current remuneration of HRH sufficient for livelihood?
    b. Salary/allowance per month/year- specially for Doctor & Nurse
    c. Other incentives
6. What percentages of HRH produced by our institution are employed by public sector and private sector?

7. In your opinion, what are the major strength/ weakness of public sector & private sectors in relation to HR recruitment, HR retention, HR motivation towards their work?
8. Why human resources/patient are attracted towards private sector rather than public sectors?
9. What can be done to improve the day-to-day management and supervision of HRH?
10. What do you think is the reason for private sector to have flourished in Nepal so rapidly? How do they contribute to public health sector?
11. Is there an imbalance between supply & demand of Human Resources in Health (HRH) in Nepal? If so what could be the causes in your opinion.
12. What can be done to improve Human Resources in Health (HRH) situation in Nepal?

Thank You!!!