Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal

4 Human Resources for Health Management from Central to District Level in Nepal

A Report of Operational Research

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Preface

Ministry of Health and Population has committed, through its second Nepal Health Sector Programme Implementation Plan (2010-2015), to improve the health and nutritional status of the people by providing them equal opportunity to receive quality health care services free of charge or at affordable cost thereby contributing to poverty alleviation. The ministry promotes access to and utilisation of essential health care and other health services, emphasising services to women, children, and poor and excluded. The plan and programmes are focused to changing risky life styles and behaviours of most at-risk populations through behaviour change and communication interventions.

The health sector requires competent and motivated health workforce to achieve the stipulated goals and targets of the health plan and the programmes. Nepal health sector is facing critical human resources for health (HRH) crisis for service delivery. Deployment and retention, production of skill mix human resources and their equitable distribution, availability, productivity, performance and accountability of the human resources for health are some of the major issues to be addressed by the health system. On the other hand, non-communicable diseases, accident and injuries and other new emerging diseases will require more epidemiologists and public health experts. A scientific and robust strategic plan for managing HRH both in public and private sectors, maintaining equilibrium in supply and demand, delivering efficient services to people so as to achieve MDGs, is now a prime concern for the Ministry.

The Ministry of Health and Population has prepared a HRH Strategic Plan (2011-2015) aiming to ensure the equitable distribution of appropriately skilled human resources for health to support the achievement of health outcomes in Nepal and in particular the implementation of Nepal Health Sector Progamme-2 (NHSP-2). The HRH Strategic Plan has given main focus to achieve the appropriate supply of the heath workers, equitable distribution of them, improved health workers performance, effective and coordinated HR planning, management and development across the health sectors.

Both the NHSP-2 and HRH Strategic Plan has highlighted the need of operational researches to find out the bottlenecks of health system in terms of policy implementation and HRH management there by to recommend the appropriate actions to strengthen the health system.

This operational research carried out by Society for local Integrated Development Nepal (SOLID Nepal) and Merlin with financial support from the European Commission and Ladham Trust helps to generate empirical evidence highlighting the key gaps and existing challenges in six key areas : a) Distribution and skill mix of HRH, b) Training, recruitment , placement and retention, c) performance and accountability, d) HRH management, e) working conditions and f) Civil Society Organisation's engagement . This will definitely support MoHP for further human resources planning and its effective implementation.

The MoHP would like to thank SOLID Nepal, Merlin, the European Union and Ladham Trust for carrying out this research. There is great appreciation to all research and logistics teams for their efficient work and to the research participants, for their valuable contribution to the research study.

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Foreword

It is my great pleasure to introduce this report on the *Barriers to Effective Policy Implementation and Management of Human Resources for Health in Nepal*. This report was the result of a comprehensive piece of nationally representative operational research, conducted by Society for Local Integrated Development (SOLID) Nepal in partnership with Merlin Nepal, which encompassed all Nepal's development regions and ecological belts. That research and, subsequently, this report were made possible with the financial assistance of the European Union and the Ladham Trust.

Every man, woman, youth and child has the right to enjoy the highest attainable standard of physical and mental health. The practical realisation of this right, however, has one significant precondition: To enjoy the highest attainable standard of health, every individual must first have access to suitably qualified and motivated health workers. While fundamental, this requirement remains a major challenge in many countries, particularly those which have significant geographical, economic and/or human resource constraints.

The Nepal Health Sector Programme – Implementation Plan II (NHSP-IP II, 2010-2015) mentions that Nepal has experienced a 35% growth in population since 1991, however the public workforce only increased by 3% during the same period, and approximately 25% of the total health workforce are unskilled. While having an adequate number of qualified health workers physically in place is obviously vital to ensuring access to quality healthcare, so too is the distribution and mix of those health workers, the quality and appropriateness of their training, their workplace performance and accountability, the effectiveness of their management structures and their working conditions. All of these contributing factors were assessed and analysed as part of this operational research.

SOLID and Merlin also recognise the proactive role civil society organisations (CSOs) can play in regard to human resources for health. As such, the current and potential roles of CSOs were considered throughout this research.

It is our hope that this publication will not only provide a holistic picture of the current health worker situation in Nepal, but also present all stakeholders engaged in Nepal's health sector with tangible recommendations which will, in turn, facilitate every Nepali accessing their right to the highest attainable standard of health.

More information on the importance of health workers and the challenges they face can be found on Merlin's Hands Up for Health Workers campaign site: **www.handsupforhealthworkers.org.**

Catherine Whybrow
Country Director
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स्थानीय एकीकृत विकास समाज नेपाल
Society for Local Integrated Development Nepal

Acknowledgements

It is our immense pleasure to bring forth the series of reports of operational research entitled "Barrier to Effective Policy Implementation and Management of Human Resources for Health in Nepal" under the project "Support to Health Workforce through Civil Society Engagement". This operational research highlighted six crucial thematic areas of Human Resources for Health (HRH) in Nepal: 1) Distribution and skill mix of health workforce; 2) Recruitment, training, placement and retention of health professionals with an emphasis on public-private partnership; 3) Health workforce performance and accountability; 4) HRH management from central to district level; 5) Working conditions of health workforce; and 6) Role of civil society in HRH.

We would like to express our heartfelt thanks to the secretary of Ministry of Health and Population, Dr. Prabin Mishra for his steady and constructive support from the very beginning of the project. We highly acknowledge the senior officials from the ministry namely Dr. Baburam Marasini, *Senior Public Health Administrator;* Ram Chandra Khanal, *Senior Public Health Administrator* and Kabiraj Khanal, *Undersecretary* for their support in each and every step of the operational research especially for thorough review of the research findings and providing substantial inputs. Our sincere thanks also go to other officials in the ministry and its departments for their valuable supports.

It will be a true injustice if we do not acknowledge Mr. Raghu Ghimire, an *HRH expert in Nepal* for his selfless reviewing of the reports and providing valuable feedbacks in all the reports. We are also indebted to Prof Dr. Chop Lal Bhusal, *Chairman;* Dr Shanker Pratap Singh, *Member Secretary,* Nepal Health Research Council for their encouragement and guidance in the research processes. Dr Rajendra BC, a well known researcher has also contributed a lot to refine and make the research meaningful. Thank you Dr BC.

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ACRONYMS

AHW	Auxiliary Health Worker
ANM	Auxiliary Nurse Midwife
CBOs	Community Based Organizations
CDR	Central Development Region
CHD	Child Health Division
CMA	Community Medical Assistant
CSOs	Civil Society Organizations
DDC	District Development Committee
DHO	District Health Office/Officer
DoHS	Department of Health Services
DPHO	District Public Heath Office/Officer
EC	European Commission
EDCD	Epidemiology and Disease Control Division
EDR	Eastern development Region
EPI	Expanded Programme on Immunisation
FCHV	Female Community Health Volunteer
FGD	Focus Group Discussion
FHD	Family Health Division
FWDR	Far-Western Development Region
GTZ	Gesellschaft für Technische Zusammenarbeit
HA	Health Assistant
HFOMC	Health Facility Operation and Management Committee
HP	Health Post
HR	Human Resource
HRD	Human Resource Development
HRH	Human Resources for Health
HuRDIS	Human Resource Development Information System
HuRIC	Human Resource Information Centre
HuRIS	Human Resource Information System
I/NGO	International Non Governmental Organization
KII	Key Informant Interview
KU	Kathmandu University
LCD	Leprosy Control Division
LMD	Logistics Management Division
LSGA	Local Self Governance Act
MCHW	Maternal and Child Health Worker
MD	Management Division
MoHP	Ministry of Health and Population
MWDR	Mid-Western Development Region
NCASC	National Centre for AIDS and STD Control
NGO	Non-Governmental Organization
NHEICC	National Health Education, Information and Communication Centre
NHP	National Health Policy
NHRC	Nepal Health Research Council

NHSP IP	Nepal Health Sector Programme Implementation Plan
NHSSP	Nepal Health Sector Support Programme
NHTC	National Health Training Centre
NPHL	National Public Health Laboratory
NTC	National Tuberculosis Centre
PHC	Primary Healthcare Centre
PHCP	Primary Health Care Project
PHCRD	Primary Health Care Revitalization Division
PSC	Public Service Commission
RHD	Regional Health Directorate
SHP	Sub Health Post
TU	Tribhuvan University
VDC	Village Development Committee
VHW	Village Health Worker
WDR	Western Development Region
WHO	World Health Organization

GLOSSARY

Ecological Belts	Nepal is made up of three ecological belts running laterally across the country: the Mountain belt in the northern highlands, Hill in the central belt, and Tarai lowland plains in the southern belt.
Basic-level HWs	Basic-level HWs have received Technical School Level Certificates (TSLC). They are trained for 12-18 months, primarily through affiliated institutions of CTEVT and are able to provide basic services in their trained areas.
Deputation	Secondment of personnel, irrespective of the numbers of sanctioned posts, for a given period of time.
Development Regions	For administrative purposes, Nepal is divided up into five Development Regions: Eastern Development Region (EDR), Central Development Region (CDR), Western Development Region (WDR), Midwest Development Region (MDR), and Far Western Development Region (FWDR).
HRH	Human Resources for Health (HRH) include those 'engaged in actions whose primary intent is to enhance health' (1).
Mid-level HWs	Mid-level health workers have attended a three-year training course (Proficiency Certificate-Level or Diploma-Level courses). They perform a curative, preventative, and diagnostic function, and are responsible for supervising the basic-level HWs. They are produced primarily by affiliated institutions of CTEVT, and by Tribhuvan University (TU), Kathmandu University (KU) and B.P. Koirala Institute of Health Sciences (BPKIHS).
Paramedical	Paramedical staff are a section of the health workforce representing basic and mid-level technical categories, including Health Assistants, Auxiliary Health Workers, Laboratory Technicians, Laboratory Assistants, Radiographers, Anaesthetic Assistants, Ophthalmic Assistants, Physiotherapy Assistant.
Sanctioned posts	Sanctioned posts are posts that have been centrally approved by the MoHP within health institutions.
Skill mix	The 'combination of different health workers that produce a given level of healthcare' (2).

NEPALI HEALTH STAFF ACRONYMS

AHW Auxiliary Health Worker: AHWs are trained for one year after secondary school. They are the Sub-Health Post in-charge and also service providers in the HP, PHC and Hospitals. Their main role is to provide promotive and preventive care in the community and refer to primary healthcare facilities.

ANM Auxiliary Nurse Midwife: ANMs are based at Health Posts to conduct maternal and child health care services. They are trained for 18 months and like the MCHW, the ANM's main job is to conduct antenatal clinics, provide TT immunization, nutrition education, conduct normal deliveries, recognize danger signs and refer women to for more specialized care. ANMs provide Safe Motherhood services, Basic Emergency Obstetric Care and Family Planning services.

FCHV Female Community Health Volunteers: FCHVs are grassroots level health volunteers based in their respective Wards, who are selected by the Mothers' Groups and trained for 18 days on basic healthcare. They are responsible for conducting Mother's group meetings and delivering health messages to the Mothers and distributing pills, condoms, polio drops, oral rehydration salts and Vitamin A. The government provides training and refresher training to them.

HA Health Assistant: HAs are based in Health Posts as the Health Post In-charge, holding a Proficiency Certificate in Medical Science (General Medicine). They perform promotive, curative and preventative roles and are responsible for supervising the Health Post staff and Sub-Health Posts in their area. HAs report to the District Public Health Office (DPHO)/ DHO at district level.

MCHW Maternal and Child Health Worker: MCHWs are selected mainly from the local VDC. MCHWs are based in Sub-Health Posts to provide maternal and child health services, after receiving six months' training. MCHWs conduct antenatal clinics, provide TT immunization, post natal clinic nutrition education, and conduct normal deliveries. They also provide counseling to couples on family planning and provide Family Planning services. They are also responsible for conducting EPI clinics and PHC/ORCs.

SBA Skilled Birth Attendant: "An accredited health professional, such as a midwife, doctor or nurse, who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period and in the identification, management and referral of complications in women and newborns (3)."

VHW Village Health Worker: VHWs are the community level government employee with six months' initial training. Together with MCHWs, they conduct outreach clinics in their villages, and are involved in immunization of children under the age of one year. In addition, they distribute contraceptive pills, condoms and refer clients for other methods of family planning. They supervise FCHVs and attend Mother's group meetings. They also provide health education in the village.

EXECUTIVE SUMMARY

Introduction: Nepal faces considerable challenges in Human Resources for Health (HRH) management, which is characterised by top-down decision-making. This report is part of an operational research project which aims to facilitate the improved delivery of healthcare in Nepal through strengthened human resources for health (HRH) policy development and implementation by enhancing civil society engagement. The report analyses the Ministry of Health and Population (MoHP) Human Resources for Health Management system in Nepal. It examines the main gaps in the human resources management system in the health sector and makes recommendations for viable mechanisms to strengthen the system.

Methodology: A cross-sectional descriptive study was conducted using mixed method with observation checklist. Fifteen districts representing eco-developmental regions of Nepal were selected using multi-stage cluster sampling method. Out of 404 sample, 747 health workforce from 375 health institutions were interviewed (<10% non-response rate) using the Probability Proportionate to Size method as per WHO guideline. Further, secondary review was carried out for triangulation of findings.

Key Findings: The recruitment process is complex, requiring multiple levels of authorisation. The combination of a lengthy legal selection process and administrative delays lead to posts being vacant for a long time, and results in numerous positions being filled on a temporary or daily wage basis at the local level. Furthermore, there are contradictions between the Health and Civil Service Acts which has resulted in the cancellation of advertisements for specific jobs.

The transfer system, in-service training and rewards and punishment systems are criticised as unsystematic, highly centralised and politicised, with allegations of nepotism and corruption. In-eligible transfers are taking place, resulting in the irregular and unplanned nature of transfers. There is a mismanagement of candidate selection for in-service training, with 61 percent of respondents claiming that this process is impartial and biased. The system to upgrade a particular post, based on the duration of service period, is in place. However, the employee must work in the same position with same responsibilities. And although there is a disciplinary process in cases of misconduct by employees, it is rarely used. Health Workers are dissatisfied with these systems, which they claim are based on political influence rather than policy. This causes demotivation among Health Staff and results in unsystematic health worker records at the Personnel Administrative Section of the DoHS. The failure to decentralize the management of these systems at the required levels exacerbates these inequities.

The decentralisation process has been met with varying degrees of success. Though different policies and guidelines emphasise decentralisation, the MoHP still suffers from over centralised planning and budgeting. There are pertinent issues related to the decentralisation of the health service delivery system that need to be addressed: top down planning and management, lack of coordination, lack of resources and weak institutional capacity.

There are administrative constraints in the function and validation of the Human Resources Information System (HuRIS). Lack of technical competencies due to migration of trained personnel, unwillingness of staff to update the records on time and under/over reporting, are common problems within the system. Despite training being given to all 75 districts, the information is most commonly being updated at the central level.

Conclusion: Although Health legislation and policy is well developed and unbiased, the pervasion of nepotism in promotion, transfer, in-service training leads to inequitable systems, decentralisation is only partial and thus ineffective, and the information system is cumbersome, out of date and not being used effectively as a management tool.

TABLE OF CONTENTS

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I INTRODUCTION

1.1 Background

There has been an increased focus in recent years on effective human resource management (HRM) (4) in healthcare, which is fundamental to any sustainable solution to health system performance (5). In the context of some of the poorest countries of the world, where health systems are severely undermined by the lack of staff to deliver health services, effective HRM is crucial for improving maternal and child health outcomes and contributing towards progress in meeting the Millennium Development Goals (6). Research has shown that there is a positive correlation between people management and performance, and that the relationship is cumulative (5). Research has also highlighted the importance of three broad areas as the building blocks of HRM, which are needed to maximise workforce productivity and performance:

1. 'Employees with the necessary ability
2. Adequate motivation for them to apply their abilities
3. Opportunity for them to apply 'discretionary behaviour' (5)

Yet in many low and lower-middle income countries, such as Nepal, poor HRH planning and management, including the absence of reliable information and management databases, undermines the building blocks of HRM and slows progress to achieving national and international goals (7).

Nepal faces considerable challenges in HRH management, which is characterised by top-down decision-making (8) despite the fact that amendments to policy have emphasised the empowerment of local government to regulate and monitor local development agencies (9). Furthermore, the implementation of the Human Resource Information System (HuRIS), which was established to facilitate HR planning and management at all levels, is used primarily for administration rather than proactive management. This research report therefore examines the main gaps in the current HR planning and management system in Nepal, and recommends viable mechanisms to strengthen the system. how human resource management can either facilitate or provide major constraints to meeting the objectives of health sector reform (5).

1.2 Aims and Objectives

This report is part of an operational research project which aims to facilitate the improved delivery of healthcare in Nepal through strengthened human resources for health (HRH) policy development and implementation by enhancing civil society engagement. The overall objective of the report is to analyse the Ministry of Health and Population (MoHP)/ Department of Health Services (DoHS), Human Resources for Health Management system in Nepal. The specific objectives of this particular research paper are as follows:

1. To identify the MoHP provision and practice of HRH planning and decision-making and administrative management processes from central to district level.
2. To explore gaps in the HRH management mechanism in the public sector of Nepal and formulate recommendations for improvements in HRH policy and strategic plans.

CHAPTER II METHODOLOGY

A cross-sectional descriptive study, using both qualitative and quantitative research methods, was conducted in 15 districts of Nepal to obtain comprehensive information on the Human Resources for Health (HRH) situation in the country.

2.1 Primary Data Collection and Analysis

2.1.1 Quantitative methods

2.1.1.1 Sample Design

A multi-stage cluster sampling method was used to select a representative sampling frame for this study (see Appendix 1). Of the 75 districts in Nepal, 15 districts were selected, one from each of the three ecological belts (Mountain, Hill and Tarai) and each of the five development regions (Far-Western, Mid-Western, Western, Central and Eastern) using a random sampling method.

Table 1: Selected Districts for Research Study, Nepal 2011

Development Region / Ecological Belt	Far-western	Mid-western	Western	Central	Eastern
Mountain	Darchula	Mugu	Manang	Rasuwa	Sankhuwasabha
Hills	Doti	Pyuthan	Palpa	Lalitpur	Panchthar
Tarai	Kailali	Bardiya	Kapilvastu	Dhanusha	Jhapa

The sampling frame consisted of 5146 health institutions in the selected 15 districts, including Government Hospitals (Regional, Zonal or District), Primary Health Centres, Health Posts, Sub-health Posts, Ayurvedic Centres, Non-governmental and Private health outlets. A total of 404 health institutions were then selected using the Probability Proportionate to Size (PPS) method, based on the size of health institution by available HRH, as per WHO guidelines (10) (see Appendix 2). Out of the selected health institutions, data was collected from 375 health facilities. A total of 29 health facilities were not included in the study due to the unavailability of staff, demonstrating a response rate of 93 percent (see Appendix 3).

2.1.1.2 Research participants

Research participants were service providers including Doctors, Specialists, Nurses, Midwives, Public Health Workers, Health Assistants, Auxiliary Health Workers, Laboratory Technicians, Radiographers and Pharmacists.

2.1.1.3 Data collection tools and processes

An interviewer-administered questionnaire was carried out by Public Health graduates trained as enumerators with 747 health workers from the 375 selected health institutions in 15 districts, selected on the basis of WHO guidelines (10). Self-appraisal forms were also completed by 54 doctors, 218 nurses and 324 paramedical staff from within the sampling frame, with the exclusion of 20 respondents due to lack of complete information. An observation checklist was also carried out by research supervisors in 256 health facilities, in keeping with WHO standards of observing at least one third of health facilities from the sampling frame (10).

2.1.1.4 Data analysis

Quantitative data was entered into a computer software system (EpiData 3.1) by trained data entry personnel. In order to validate the data, 10 per cent was randomly cross-checked. After editing and cleaning, the data was transferred onto a statistical software package (SPSS 17.0) for analysis.

2.1.2: Qualitative Methods

2.1.2.1 Research Participants

Based on availability, a total of 645 participants were selected for the qualitative study, which aimed to support quantitative research findings (see Appendix 4). Participants were selected from the following groups: service providers, as in section 2.1.1.2, and also inclusive of Female Community Health Volunteers (FCHVs), Maternal and Child Health Workers (MCHW); service users, such as exit-patients of health service outlets; members of Government Health Institutions including District Public Health Office, District Health Office, District Development Committee, and Village Development Committee; Professional Associations; Civil Society organisations and people working in the field of advocacy, civil rights, media and social campaigns; local leaders, social workers and school teachers.

2.1.2.2 Data Collection Tools and Processes

Key data collection tools included Focus Group Discussions (FGDs) and Key Information Interviews (KIIs), conducted by Public Health graduates. A series of 74 FGDs were held, with at least one group of service providers, service users and facility groups in each district. Purposive sampling was used to select 29 informants to take part in semi-structured KIIs. A consultation workshop was also held with MoHP and other key stakeholders to discuss findings and recommendations of the report.

2.1.2.3 Data Analysis

Qualitative data was transcribed and translated into English, and was then analysed according to different thematic areas based on the relevant research objectives. The data was then triangulated with quantitative and secondary data findings.

2.2 Secondary Data Collection and Analysis

A review of the literature on national and international research papers on HRH management and the functioning mechanism of HuRDIS was carried out. The review also included key national MoHP health Policies, Plans and Acts (9, 11-19). Key findings from the secondary data were triangulated with both qualitative and quantitative data.

2.3 Validity and Reliability

1. A standard statistical tool was used to determine the sample size and sampling strategy to reduce systematic error in the design phase of the study, based on WHO Standards.
2. Internal consistency reliability was ensured in quantitative data analysis by obtaining Cronbach's Alpha on key variables (>0.85).
3. To avoid questionnaire information bias, questionnaires were pre-tested in three districts, and feedback from the pre-test was incorporated into the final questionnaire design to improve validity and reliability.
4. To avoid interviewer information bias, interviewers, who were Public Health graduates, were trained for two days on data collection tools and methods according to WHO standard protocols.
5. Regular supervision visits were carried out, with appropriate feedback ensured from the central level during the collection of data.
6. Triangulation of primary and secondary data ensured consistency of the research data.

2.4 Ethical Issues

Ethical approval for this study was obtained from the Nepal Health Research Council (NHRC), and researchers adhered to national NHRC standard operating procedures and ethical guidelines for health research. Informed consent was obtained from each respondent, and confidentiality in terms of information disclosed and identity of respondents was ensured.

CHAPTER III HRH PLANNING AND MANAGEMENT

Overall sectoral policy, planning and management of healthcare in Nepal is prepared and regulated by the Ministry of Health and Population (MoHP), which includes one separate division for Human Resource Development under the Human Resources and Financial Management Division (see Appendix 5). Under the MoHP, the Department of Health Services (DoHS) coordinates all administrative activities of health service delivery under its administration department in Nepal, such as logistics, training, public awareness and quality enhancement (see Appendix 6).

This chapter outlines policy and practice in relation to HRH planning and management, which have been researched specifically through data collection and analysis in the following areas:

- Recruitment process
- Transfer
- Opportunities for in-service training and study
- Rewards and punishments system

3.1 Recruitment

3.1.1 Existing Policy Overview

Rules and regulations regarding permanent, temporary and daily wage contracts are set out in the Civil Service Act 1993 (13) and the Nepal Health Service Act 1997 (16). The Public Service Commission (PSC), an independent constitutional body, is responsible for permanent recruitment, while the MoHP and its department has authority for temporary and daily wage recruitment. The MoHP manages officer level recruitment (20), while the Regional Health Directorate (RHD) manages below the officer level (see Details of positions and categories in Appendix 7). In the health sector, while the PSC recruits all level of health staff and the department, regional and district authorities of the Ministry of Health and Population (MoHP) are responsible for their deployment (21). The Health Service Act 1997 defines recruitment of temporary posts of up to six months, with the consent of the PSC (16), and the Ministry of General Administration should be informed within seven days of the appointment. Article 8B of the Nepal Health Service Act 1997 restricts appointments regarding daily wage recruitment (16).

Furthermore, the Civil Service Act 1997 has specific inclusion quotas for women, different ethnic groups, and disadvantaged groups (13). However, the Health Service Act does not yet include these quotas.

3.1.2 Gaps in Policy and Practice

Several major challenges to the recruitment planning and management process have been identified and detailed below. There are contradictions between the Health and Civil Service Acts which has resulted in the cancellation of advertisements for specific jobs, namely Public Health Officers and Health Education Officers. This decision was taken by the Supreme Court in 2008 following a dispute regarding the lack of quotas in the Health Service Act.

Since then, these specific positions have remained vacant under the MoHP. One of the MoHP officials stated that the government has been very slow to update and amend the Acts. There are contradictions among various acts, which affect candidates who are seeking jobs and promotions. Although the Health Act is specific about recruitment procedures, evidence shows that there is a discrepancy between the policy and its implementation.

The recruitment process is complex, requiring multiple levels of authorisation. Key informant interviews with DoHS officials revealed that there were often considerable delays in informing the PSC of vacancies, which resulted in longer gaps in filling vacant position. It was suggested that this was due to the lack of accountability through a clear follow-up system. Timeframes for each recruitment step are set out in the Public Service Act. For example, the advertisement period is 21 days, with an additional week including a fee for late applications. Moreover, the PSC can advertise once a year for officer level and maximum two times for non-officer level positions (22). (see Table 2).

Table 2: Recruitment of HRH Time Line as per the PSC Calendar Implanted from July 2011, Nepal

Level of HRH	Vacancy Notice out	Written exam	Result notice out	Interview and final selection
4th Level	April	June	October	September
5th Level	February	May	August/September	September
6th, 7th and 8th Level	November	February	May/April	April
9th and 11th Level	October	January	May/April	April

Source: *Public Service Commission, Nepal*

The MoHP must inform the PSC within seven days of a position becoming vacant (13). Furthermore, selection of candidates occurs only at specific times in the year, regardless of when a position comes vacant. The combination of a lengthy legal selection process and administrative delays lead to posts being vacant for a long time.

The complications involved in permanent recruitment (coordination, communication and decision making) result in numerous positions being filled on a temporary or daily wage basis. The survey revealed that out of the 747 health workers, nearly one third (30.57%) of health workers were on temporary, contract or daily wage appointments which has the positive impact in terms of filling recruitment gaps for short-term periods, with additional human resources. There has been VDC/ DDC budgetery support and support from I/NGOs for additional staff members. For example, in Kailali District of the FWDR, 54 health workers were recruited with the above mentioned support, rather than the allocated sanctioned positions. Similarly this is also supported by the DHO in Darchula, who reported that 28 ANMs and two laboratory assistants were locally

recruited by the respective Village Development Committees in local health facilities. However, local recruitment also has negative implications in that HWs were ineligible for the same benefits as permanent members of staff, such as insurance, dismissal and notification period, training, promotion and other non-financial incentives (13).

3.2 Transfer

3.2.1 Existing Policy Overview

Employees are eligible for transfer once they have worked for at least one year in the most remote area or at least two years in a remote area (16). The nature of transfers should therefore serve as a means to provide health workers with experience in different parts of the country, and guarantee that HR needs are met in all regions. The authority to make transfers is delegated among central, regional and district levels, as per the Health Service Act according to where the transfer is taking place (16).

3.2.2 Gaps in Policy and Practice

The transfer system has been criticised as unsystematic and highly politicised, with allegations of nepotism and corruption. Health workers expressed their dissatisfaction around the transfer of staff based on political influence rather than based on policy. This caused demotivation due to the fear of being transferred from one place to another, regardless of the policies in place. Moreover, it resulted in unsystematic health worker records at the Personnel Administrative Section of the DoHS (16), as stated by the MoHP's HRD Unit Officer.

Survey data highlighted that the transfer management system was not functioning according to the regulations set out in the Health Service Act. Out of 82 respondents that were in-eligible for transfer, 22 percent were transferred despite their in-eligibility (see Table 3).

Table 3: Number and Percentage of Respondents Who Transferred from Another District

Category	Region	Percentage of in-eligible transfers	
		Percent	Number
Ecological Belts	Mountain	28.6	14
	Hill	12.9	31
	Tarai	27.0	37
Development Regions	EDR	29.2	24
	CDR	38.5	13
	WDR	0.0	6
	MWDR	25.0	16
	FWDR	8.7	23
Rural Urban Localities	Rural	22.9	48
	Urban	20.6	34
Service Categories of HRH	Doctors	26.1	23
	HA/AHW	10.5	19
	Technicians	25.0	8
	Nurses/ANMs	25.0	32
Total		**22.0**	**82**

Source: *HRH Field Survey 2011*

Health workers have mentioned they are usually not aware of where they will be transferred to. Spouses are often not transferred to the same district, despite this being set out in the Health Service Act (13). Moreover, there is a consensus between the trade unions and MoHP whereby the MoHP cannot transfer the central committee members of trade unions without their consent as mentioned in Labour Act and Civil Service Act and rules. This causes feelings of resentment and demotivation among health workers.

The failure to decentralise the management of the transfer system at the required levels exacerbates this unfairness. A Regional Health Director claimed that there was frequent interference from central level, with the list of transfers often being developed and coerced by the central authorities. The irregular nature of transfers could also be ascribed to the instability of government, as the initial task of the new government was to transfer positions. This was emphasised by one key informant, who stated that "... since there is no stable government, every time a new minister comes into the position, his/her main task would be transferring..." Within this scenario, dissatisfaction of the irregular and unplanned transfer is experienced, making the health worker more irresponsible and unaccountable. Moreover, the DoHS Annual Report 2066/67 (23) also highlighted that irregular and unplanned transfer is one of the identified constraints in health sector.

3.3 In- service Training and Study

3.3.1 Existing Policy Overview

The Nepal Health Service Act and Civil Service Act outline that scholarships for study, international training or study tours should be available for employees based on higher marks for educational qualifications, seniority, experience of service in geographical region and work performance evaluation. There is also a bond system for those who have gone for study, training or study tour (16).

The MoHP accords high priority for the development of competent human resources for health through various training activities (23). The National Health Training Centre (NHTC) has been established as an apex body for human resource development under the MoHP to coordinate all the training programmes of the country, and operates training systems following the National Health Training Strategy 2004 (23). The NHTC develops annual training plans in coordination with the Department of Health Services (DoHS), Regional Health Directorates (RHDs), Sub/Regional Training Centres and District Health Offices (DHOs). The programmes include Initial and Basic Training, Upgrading Training, Specialised Training, In-service Refresher Training and Orientation Programmes (23).

The NHTC provides input to policies, plans and activities of MoHP to be addressed through training to contribute in achieving national goals and targets (23). Each DHO makes a list of employees who need training in different categories. The DHO nominates the appropriate candidate for the particular training, once the NHTC or its sub/regional centre sends an invitation letter to the respective DHO according to the NHTC's training plan. Nomination is normally based on the relevancy in terms of job responsibility and needs.

3.3.2 Gaps in Policy and Practice

The NHTC training plan has been criticised as *unsystematic, top down and not needs based.* Similar training components are carried out each year, without an effective training needs assessment, by merely increasing the number of training events. The NHTC claimed that each district has a team of five to seven competent trainers to conduct locally identified training (23). Yet these teams have not been active for nearly a decade.

There were significant competency gaps in health workers' clinical skills in all six tested areas, which were less than minimum acceptable score of 60 percent (24). This was in part due to the inconsistency between what health workers learn during their academic qualifications and what they learn during in-service training. One of the key informants of MoHP mentioned *"There seems a difference between the academic course and in our training curriculum."*

Moreover, there's seems to be an issue of repetition of training topics. One of the DPHOs said that *"repeated topics and programme related training are not required, as they consumed not only time but also expended unnecessary budget."* The DHO further suggested that training should be needs-based rather than only objective oriented.

There is mismanagement in selecting appropriate candidates for in-service training. One of the training focal persons of the district highlighted the systematic lack of updated records on staff who had received training, which resulted in repetition of training and oversight. As a result, many employees were working but did not receive required training or repetitions of the same training. Only 51 percent of health workers had received in-service trainings (see Table 4).

Table 4: Percentage Distribution of HRH According to Training or Orientation Immediate After Recruitment (N= 747)

Characteristics		Induction Training	General Orientation	Only Introduction to People and Place	In-Service Training	Intern/ Apprentice	Others
Ecological Belts	Mountain	38.2	65.2	62.9	41.6	24.7	2.2
	Hill	51.0	67.1	81.5	56.2	27.7	2.0
	Tarai	44.8	62.5	73.6	49.5	23.4	4.3
Development Regions	EDR	47.6	68.5	78.6	43.5	14.9	1.8
	CDR	53.3	75.3	85.7	53.3	28.6	3.8
	WDR	35.6	54.8	76.0	51.9	23.1	3.8
	MWDR	39.7	50.0	60.3	55.1	26.9	5.1
	FWDR	47.6	61.0	61.9	55.2	37.1	1.9
Categories of HRH	Doctors	46.5	71.8	81.7	43.7	32.4	4.2
	HA/AHW	42.6	62.4	73.7	49.8	22.9	2.5
	Technicians	38.0	44.0	74.0	46.0	28.0	4.0
	Nurses/ANMs	54.3	71.1	75.6	56.9	25.9	3.6

Source: *HRH Field Survey 2011*

The data also showed that the selection of candidates for training lacked transparency and consistency. Out of total 747 respondents, nearly one third (32.3%) of the respondents replied that their managers assessed their training needs on an ad hoc basis, and 40.6 percent replied that their training needs had never been assessed (see Table 5).

Table 5: Percentages Distribution of Respondents According to the Monitoring for Further Study and Training by Different Background Characteristics.

(N= 747)		Monitoring	Sometimes Monitoring	Usually no Monitoring	Total
Ecological Belts	Mountain	18.4	31.7	50	120
	Hill	32.2	32.2	35.5	273
	Tarai	26.3	32.5	41.3	354
Development Regions	EDR	26.4	33	40.7	197
	CDR	28.7	33.9	37.5	192
	WDR	26.7	31	42.2	116
	MWDR	18.8	31.7	49.5	101
	FWDR	32.6	30.5	36.9	141
Service Categories of HRH	Doctors	27.6	21.3	51.3	80
	HA/AHW	18.6	33	48.4	376
	Technicians	28.5	32.1	39.2	56
	Nurses/ANMs	40.4	34.9	24.6	235

Source: *HRH Field Survey 2011*

According to the Health Service Act, each international training and study placement should be decided by the MoHP at Secretary and Minister Level. There is also a scholarship committee which recommends nominees for international scholarship (for study). One training focal point at the DPHO stated that due to the centralised management of international training and study opportunities, there was a greater likelihood of inequities in the decision-making process particularly in rural areas. The perception towards discrimination when selecting candidates for international training and the study tour was analysed. The majority (61%) of health workers perceived the process as frequently discriminatory. The perception of discrimination was higher in mountain regions (44.2%) compared with Hill and Tarai. Among service categories, nearly half of the paramedics and doctors (50% and 45% respectively) reported discrimination.

3.4 The Reward and Punishment System

3.4.1 Existing Policy Overview

Rewards and sanctions are specified in the Nepal Health Service Act 2053. Salary increments, upgrading positions and promotions are the rewards for the employee that provisions are mentioned under health service act (16). There are separate clauses of reward in the act referencing *"five grade salary increments"* accompanied by a letter of

appreciation and a decision made by Head of the Department. The assessment of performance evaluation is prescribed for both reward and punishment. The assessment of work efficiency is the criteria for the promotion of the employee (16).

The provision for the punishment to employee also stated in the act under Chapter 10 *"Punishment and Appeal"* (16). For this, there are two types of punishment mandated i.e. ordinary and special. Censure, withholding of promotion for certain periods and demoting to the basic scale of the post fall under ordinary. Similarly, in special cases an employee may lose his/her job and may or may not be able to serve in the government service in the future (16).

In addition, another way of rewarding has been practiced in the Nepal Civil Service, including the health system, for the past few years though it is not stated in any Acts. One of the RHDs stated: *"The recent practice of recognizing health personnel based on extraordinary works has been started."* In addition, he further mentioned that the districts are ranked by the Department of Health Services (DoHS) based on their annual achievements at regional and at national level, and the top three districts are awarded with an appreciation letter.

Upgrade in the position is one of the rewards for the employee. In health system of Nepal, existing upgrading system is based on the service period; however, the employees are compelled to work in the same position with same responsibilities. It is due to the impractical provision of current health service act which is prepared without proper plan as the government couldn't increase the sanctioned positions in line with the provision of upgrades. An employee of Sankhuwasabha stated her frustration, saying that although she has upgraded from 4th level to 6th level, she is still doing the same 4th level tasks.

3.4.2 Gaps in Policy and Practice

The system of promotion decision is based on numerous factors including length of service and educational qualifications. In addition, the reward of 'five grade salary increment' is a complicated process that has to be decided by head of the department; based on a recommendation from their line manager.

Pre-approval from the PSC is mandatory before taking disciplinary action, and in practices such cases are rare. The initiation of the process is also no guarantee of completion, as political contacts may intervene at any number of levels.

Fair distribution of reward and punishment makes staff more accountable. In the government sector, this system has very low significance and is not based on objective standards. One of the DPHOs mentioned *"study, international exposure and transfer in urban areas are main attractions. Only those, who have good approaches at ministry level, will attain them"* This perception of unfairness causes frustration and demotivation among health staff.

The government also provides a cash prize annually to certain best performers from the civil service which includes health personnel too. Though there are clear selection criteria, this provision is not sufficient for numbers of health staff. One of the strategies proposed in the current three year plan (2010/11-2012/13) is to make an effective employee's reward and punishment policy (19). Therefore, the current policy is not being enforced.

CHAPTER IV STRATEGIES AND TOOLS FOR HRH PLANNING AND MANAGEMENT

4.1 Decentralization as a Management Strategy

4.1.1 Existing Policy Overview

Article 195(g) of the Local Self Governance Act (LSGA) 1999 (9) stipulates that plans and allocation processes must be participatory and locally accountable: *"The plan on human resource development in various sectors is to be formulated by the local people themselves"* (9). The institutional development of local bodies should be ensured through the delegation of authority to the District Development Committee (DDC).

Nepal introduced one of the world's most progressive legislations for decentralisation in the 1980s, devolving primary responsibility of development from the central level to elected local authorities (25). As per the Long Term Health Plan 1997, decentralisation included devolution of HRH management to Regional Health Directorates, District Health Offices and relevant health committees, which were established to supervise and manage human resource functions in their respective catchment areas. Decentralisation should promote community participation and should be supported by coordination with the MoHP and relevant ministries (26).

The Local Governance Act (1999) handed over the authority of health institution management, mobilisation of local resources, management of essential medicines and equipment, supervision and monitoring of programme activities and human resource function to local bodies (11). Between 2004 and 2010, a total of 1,433 health institutions in 28 districts were handed over to local community management (11). While the committees have the responsibility to oversee and monitor the functioning of health staff, they have no responsibility for the recruitment and dismissal of staff, which remains under the MoHP at central and regional level.

4.1.2 Gaps in Policy and Practice

The decentralisation process has been met with varying degrees of success. Though different policies and guidelines emphasise decentralisation, the MoHP still suffers from over centralised planning and budgeting, poor financial and information management (27), a personnel system too dependent on informal criteria, poor staff motivation and poor supervising practices, lack of coordination between local actors and weak institutional capacity of local organisation. There are some pertinent issues related to the decentralisation of the health service delivery system that need to be addressed: Top down planning and management, lack of coordination, lack of resources and weak institutional capacity (21).

4.1.3 Top-down mode of planning and management

Despite the fact that the Health Service Act (16) delegates responsibility for the transfer of certain levels of employees to the regional level, in practice this is often influenced by authorities at central level. Although the Regional Director (RD) has authority to carry out transfers of staff, decisions are often based on pressure from the central level. In some cases a list is often prepared by the MoHP and sent to the DoHS: "We are just forced to do what MoHP asks." The use of scare tactics to enforce political will are in no way reflective of the 'empowerment' of local actors, as envisaged in the Local Governance Act (1999).

Human Resources planning remains at DoHS and MoHP level, such that regional and district health plans are simple aggregations of centrally sanctioned budgets. Regional and district health offices are not directly involved in priority setting nor are adequate budgets made available to respond to local public health emergencies and natural disasters (28).

During a KII with one DHO, concerns were raised around the gap between HR policy and practice: "Though the agenda of HR planning and decision-making should be forwarded from the lower level, nothing as such has been done." However, in practice, the MoHP suffers from a highly centralised planning and management system, where there is no space for district authorities to discuss and provide input into national-level action plans (29), leading to unmet needs of the population.

4.1.4 Lack of coordination between local actors

A barrier to the effective implementation of the decentralised system is the lack of coordination between local actors. The system is highly dependent on the working relationship between different actors at the local level. This is illustrated by the conflict caused due to the lack of elected bodies at the VDC. It was observed that one of the new VDC secretaries, who assumed this position on an interim basis, had been raised to a more senior position above the in-charge of the local health institutions. This had caused conflict, particularly from the perspective of the in-charge, who was not satisfied with the new level of responsibilities taken on by the VDC secretary.

Recruitment through the decentralization process is also a challenge, as it also depends on the working relationship between the local government at district level and local development agencies. One DHO in the Hill region stated that the VDCs achieved success in recruiting 22 ANMs and other paramedical staff through their support from the DDC. However, he stressed that the ability to hire additional staff locally was dependent on good coordination with local bodies in the district, and this working relationship should be managed with caution.

An additional challenge is also the lack of coordination with civil society, due to an unclear definition of role of civil society. The NHSP-IP II has recognised the role of civil society organisations and individuals: *"There is the need to actively engage citizens and communities in holding the service providers accountable to local people"* (17). However, in practice, there is the need to initiate an open policy process where stakeholders' views are valued and CSOs are involved in health planning and policy processes, including Joint Annual Reviews (JARs). Regular organisation of public hearings at different levels of health governance will also help strengthen voice and accountability (30).

4.1.5 Roles of local bodies and lack of resources

The Local Self-governance Act (LSGA) (9) mandates that local government bodies should manage and supervise the Sub or Health Posts (S/HP), local committees and Village Development Committee (VDC). Bodies like Health Facility Operation and Management Committee (HFOMC) should control resources and management of S/HP. However, the roles of the local bodies (VDCs and DDCs) have not been clearly defined, which has resulted in the lack of provision of required resources in the management of S/HPs. Furthermore, VDCs receive a central government grant of which 25 per cent is earmarked for social services including health (31). In addition, VDCs can generate additional resources to cover the services (31). However, no additional central government funds accompany the new arrangements under SHP handover.

4.1.6 Weak institutional capacity of local organisations

The Health Facility Operation and Management Committees (HFOMC) are responsible for overseeing the health service and mobilising local resources at the local level (11). The

Table 6: Percentage of Health Management Committees Available in Health Institutions

Types of Institutions	Total Surveyed Institutions	Available Health Facility Management Committee	
		No	%
Hospital	16	12	75
PHC	17	17	100
Health Post	52	51	98
Sub-Health Post	208	195	94
Ayurvedic Centre	22	12	55
Total	315	287	91

Source: *HRH Field Survey 2011*

In terms of capacity to manage health services, the role of local Health Facility Operation and Management Committees (HFOMCs) has been questioned. A key informant from the Hill belt stated that the HFOMC was found to be weak and that the head of the committee was never present in the management meetings to answer concerns from the community. He emphasised his frustration, in that when taking a written complaint to the district level, he had not received a response from the District Health Office. Important issues raised by the community, such as the absence of health workers in the health facilities, were therefore left unanswered. Reasons for the ineffective management of the HFOMCs were examined in secondary data and FGDs, suggesting that their decision-making authority and accountability have not been revised to take into consideration their new responsibilities in the handover of local health institutions, and thus they suffer from a severe lack resources.

These findings show the importance of resource management, institutional capacity building and more effective monitoring and supervision by the DHO of local bodies and forums to increase communication between the different local actors (32).

4.2 Human Resource Information System (HuRIS)

The Human Resource Information System (HuRIS) is a database management system that was established in 1994 with support by PHCP-GTZ (27), and was formally known as HuRDIS. This system is in place to provide reliable, relevant up-to-date and complete information for the management of human resources for health (33). The HuRIS was initially housed under the Department of Health Services, but later was transferred to the Ministry of Health and Population. The HuRIS system includes information on the number and distribution of health workers, and tracks their career information (34). It is one of the administrative tools for monitoring and supervision of health workers which should provide reliable, up to date, adequate, timely and complete information for the management of human resource for health (33).

The template of HuRIS includes detailed information about health workers' person and professional history. It requires only simple statistical competencies for analysing and maintaining up to date information. The government is planning to keep a comprehensive record on the human resources in the health sector by 2012, to address the increasing disparity in the deployment of health professionals and to project the future need for the country (35).

Similar management systems have been implemented on a global scale with differing levels of success. In Kenya, a detailed implementation timeframe has been laid out in the Health Sector Strategic Plan and relevant data is collected based on specific outcomes and indicators. Also, as part of the National Rural Health Mission in India, an electronic management information system network linking all districts of the country is being set up. This includes the collection of data related to deployment and management, which is used to monitor coverage, motivation and competencies of health workers (5).

4.2.1 Gaps in the System

The Human Resource Information System should be used as an ***authentic administrative tool for planning, decision making and implementing agencies.*** The system should cover each and every health institution of the government sector and other non-government sector's health institutions and health workers. However, evidence points to a fragmented system with incomplete data. Very few standard reports seem to be produced currently by the unit responsible for HuRIS (36). Due to the fact that HuRIS is not updated at the local level, it is not up to date with the most recent figures.

So far, the MoHP has the record of only government-employed health staff, which, experts say is not accurate or updated. One of the MoHP officials said *"We lack data even on the staff at the Civil Hospital and the Army Hospital, let alone the mushrooming private hospitals."* Basic training for updating HuRIS data to Statistical Officers/Computer Operators in all 75 District/Public Health Offices has been completed, however, only 3 or 4 districts are updating their system from district level.

Table 7 shows an example of incomplete and unmatched HuRIS data on sanctioned

posts, appointment, retirement, promotion and training from 2006 to 2012. For example, the number of staff at the start of the year is different with the number of actual staff at the end of previous year. The figure for new appointments, retirement training seems to be misreported, and is not representative of the national level.

Table 7: HuRIS Data on Sanctioned Posts, Appointment, Retirement, Promotion and Training from 2006 to 2011

Characteristics	2006	2007	2008	2009	2010	2011
Number of Staff at the start of the year	**24540**	**24775**	**24907**	**24946**	**25191**	**25316**
New Appointments	235	132	39	245	125	14
Retirement at the start of the year	44	57	87	165	314	472
Voluntary	9	12	40	85	61	9
Forced With Facility	2	1	1	2	0	0
Forced Without Facility	0	1	0	0	0	0
By Age	1	16	30	58	80	32
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
Pending Retired Employees	0	0	0	0	0	12
Total Exit	13	30	78	149	158	78
Promotion	2230	1986	237	481	117	11
Training	191	199	62	62	35	1
Actual Staff at the end of the year	**24718**	**24820**	**24781**	**24877**	**24844**	**24780**

Source: *HuRIS; Last Update January 2012*

There are certain constraints in the function and validation of the system. The lack of technical competencies, unwillingness of staff to update the records on time and under/over reporting due to insufficient staff for monitoring at central level are common problems within the system. The responsibilities of the HuRIS focal point at the district level have not been included in their ToR, resulting in priorities being given to other tasks. Moreover, frequent transfers of trained staff causes problems with regards to updating the system at district and regional levels. HuRIS in Nepal is non-functional and has not been maintained properly. Despite training being given to all 75 districts, mostly the information is being updated from central level, and displays factual disparities. There is also confusion regarding financial support, how and who is going to provide it, so that the system can be sustained and the required training maintained.

One of the RHDs emphasised the nature of HuRIS as *"HuRIS only exists at the central level, which is dysfunctional. They are not able to keep updated records through HuRDIS…it is only being used to penalise or promote selected staff, and is updated based on individual interest."* He also mentioned that the system is prone to misreporting, as even his own profile incorrectly showed that he had taken part in international training.

CHAPTER V CONCLUSIONS AND RECOMMENDATIONS

This report has examined Human Resources for Health Management from Central to District level, focusing on recruitment, transfer, the reward and punishment system and in-service training. It has also explored HRH management tools and strategies, including the challenges involved in the decentralisation of the health system and the effective implementation of the Health Information System (HuRIS). The report has found that although Health legislation and Policy is well developed and unbiased, weak management systems lead to inequitable promotion and transfer systems. While the government is committed to a decentralised system, this is not fully realised within MoHP HRH management and the central service cannot manage to effectively track personnel and ensure appropriate performance management activities such as training, promotion and transfer.

On the basis of qualitative and quantitative findings, the following summary of major findings is presented below.

5.1 HRH Planning and Management

Conclusions

- The ***recruitment process*** is complex, requiring multiple levels of authorisation. The combination of a lengthy legal selection process and administrative delays lead to posts being vacant for a long time. Furthermore, there are ***contradictions between the Health and Civil Service Acts*** which has resulted in the cancellation of advertisements for specific jobs.
- The complication involved in permanent recruitment (coordination, communication and decision making) results in ***numerous positions being filled on a temporary or daily wage basis*** at the local level, with nearly one third (30.57%) of Health Workers on temporary, contract or daily wage appointments.
- The transfer system, in-service training and rewards and punishment system have been criticised as ***unsystematic, top down and highly politicised.*** Key informants recommended that greater decentralisation would improve the management of those systems. There is mismanagement in the nomination of candidate for in-service training and further study opportunities. It often conducted with an ad hoc basis without having training need assessment and found lacks of updated records.
- The system is in place to upgrade a particular post of health services, based on the duration of service period; however, the study found that employee must work in the same position with same responsibilities without updated terms of references.

Recommendations

- ***Strengthen the recruitment system timelines:*** the Public Service Commission Act should be revised, to make the recruitment timeline more flexible and efficient, so that postings of positions are available more frequently. The MoHP from Central to District levels should monitor adherence to the process. A roster of health professionals could be recruited and placed at District level, to make sure that if a post is vacant, an alternative member of staff can be identified at any time during the year.
- ***Local hiring should be encouraged and resourced:*** until the recruitment system is strengthened, the MoHP should ensure that the DHO and RHD are provided with sufficient budget for temporary and daily wages recruitment, which should include a strong element of capacity building. CSOs can assist in lobbying for appropriate funds for local recruitment as well as monitoring the implementation of the local budge.
- On a national level, ***a transfer plan should be prepared and shared*** through HuRIS so that each employee has access to the information about forthcoming transfers, as based on the rules and regulations set out in the Health Service Act. This would address both the perceived unfairness of the current system and the need to meet the HRH needs in all parts of the country.
- ***The Health Service Act should be fully in line with the Civil Service Act:*** a revision by the MoHP should identify and correct discrepancies, such as the provision of specific inclusion of quota for women and disadvantaged groups.
- A ***monitoring system on HuRIS to improve the recruitment process*** should be in place to ensure that the reporting of vacancies and potential vacancies at local level is initiated in a timely manner, with adequate planning. ***More personnel are needed*** at MoHP central level to regularly monitor the system at district level. To improve HuRIS, the ***responsibility of updating the system should be included in the ToR of the focal person at district level***. Since the regular update is main concerning of the system, the D/PHO should regularly monitor the focal person's performances.
- ***The Performance appraisal system should be strengthened*** to include a verification mechanism that staff have completed and passed required in-service ***training, to be updated on HuRIS.*** The higher authorities should monitor that training has been delivered as recommended. Accountability for the equitable access and allocation of training places needs to be both assigned and monitored.
- ***The Human Resources Information System (HuRIS) should incorporate information on training*** in terms of needs, plans, availability and should be used as a tracker of training undertaken by each single HW and as the force as a whole. Each district as well as at central level will have ease of access to information about training and study which will facilitate monitoring.
- For international training and study opportunities, a ***quota should be available for those who are working in different places (separate urban and rural) and for different categories of the health workers.*** Nominations should be based on the recommendation of the line manager, combined with performance indicators. It is also important that the bond system is fully operational, enabling follow up of candidates who go abroad for

training.

- The quotas for the upgrading staff, along with the job descriptions and available posts should be updated to reflect the reality of the HR needs of the Nepalese health system.

5.2 Strategies and Tools for HRH Planning and Management

Conclusions

- The decentralisation process has been met with varying degrees of success. Although a decentralisation policy is in place, it is not operational. District authorities do not have sufficient budget or authority, resulting in central authorities taking on too many activities, which limit their ability to regulate.
- There are some pertinent issues related to the decentralisation of the health service delivery system that need to be addressed: top down planning and management, lack of coordination, lack of resources and weak institutional capacity (31).
- There are certain administrative constraints in the function and validation of the Human Resources Information System (HuRIS), which is ineffectively managed to produce the required information.

Recommendations

- The successful implementation of decentralisation requires ***a broader context of institutional capacity building and resource management,*** and underlines the need for their consideration during implementation processes, and further investigation.
- Most of the health institutions are in the process of devolution or decentralization. The MoHP should ***hand over authority for planning and budgeting*** and enhance its capacity of effective monitoring and supervision along with technical support.
- ***Local bodies should be made accountable*** for planning, monitoring and HR record keeping through participation in human resources planning and decision making. The responsibility and authority at local level should allow for bottom-up planning. The appropriate environment for further discussion and adjustments with local authorities (i.e. health management committee, mother groups, district health office, district development committee, village development committee) needs to be created by the Ministry of Health and Population from central to lower level.
- ***Improve communication between local authorities and local development bodies*** in HRH planning and decision-making, through monthly working groups involving VDC, DDC and CSOs (including HFOMC, Mothers' Groups etc). The purpose of these meetings would be discussions and adjustments to human resources at local level.
- ***Strengthen communication between the MoHP and local authorities,*** so that planning and decision-making of human resources for health takes into account the local needs.

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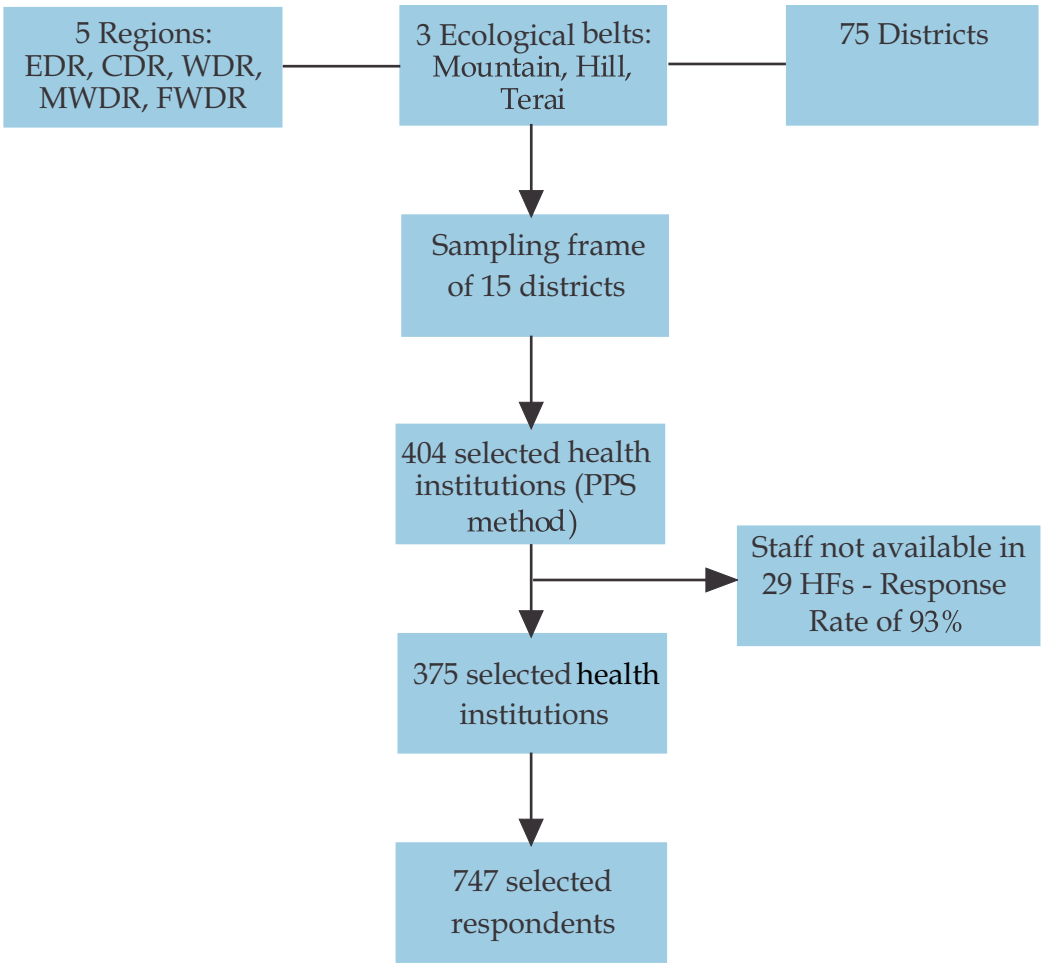
APPENDICES

Appendix 1: Sampling Method



Appendix 2: Derivation of Sample Size

Major features of sample determination:

1. Total Institutions = 5146

2. Total Hospitals, PHC/HC and HP = 1000

3. Proportion of Targeted Health Facilities = 1000/5146= 0.194

4. The formulae for calculating the sample size

$$n= Z^2_{1-\alpha/2} *p*(1-p)*deff*(1+nr)/d^2$$

Where:

$Z^2_{1-\alpha/2}$ = 5% level of significance=1.96

p = proportion of the targeted coverage of health institutions

Note: Since all categories of health workforce are found in District Hospital, Primary Health Care Centres/ Health centres and Health Posts, the total number of these institutions (1000) is divided by the total health institutions (5146) in the country to calculate the proportion.

deff = Design effect, which is set as to minimize sampling variability caused by cluster sampling

The design effect set for this sample determination is 1.5

nr = Non response rate, which is an estimated rate for the non-response of respondents and it is set as 10 percent (0.1) in this sample selection.

d = Allowable error, which is usually considered as 0.05 that indicates its range from 14.4 to 24.4 percent.

The equation for deriving the sample size is given as below.

$$n= Z^2_{1-\alpha/2} *p*(1-p)*deff*(1+nr)/d^2$$

or $n= (1.96)^2*0.194*1.5*(1+0.1)/0.05^2$

or n= (3.84*0.16*1.5*1.1)/0.025

or n= 1.01/0.025

or n= 404

Appendix 3: Total Number of Institutions by Districts, Ecological Belts and Development Region

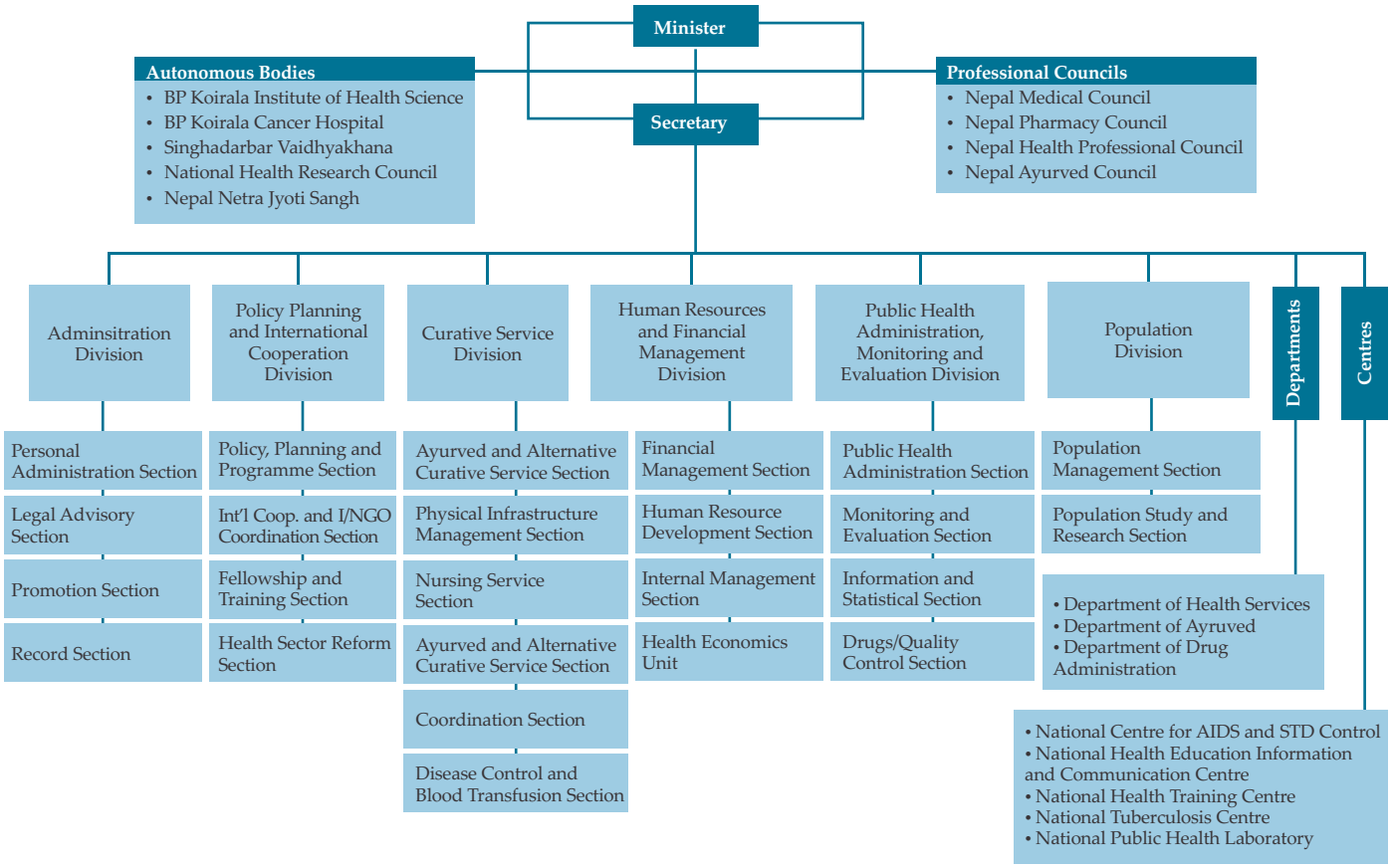
SN	Development Region	Ecological Belt	District	Selected Number of Institutions							
				District Hospital	PHCC/HC	Health post	Sub-Health Post	I/NGO - Clinic	Private Institution	Ayurvedic	Total Institution
1	Far-Western	Mountain	Darchula	1	1	5	10	0	0	1	18
2	Far-Western	Hills	Doti	1	1	4	16	1	0	3	26
3	Far-Western	Tarai	Kailali	1	2	3	13	2	1	2	24
4	Mid-western	Mountain	Mugu	1	1	1	4	2	0	0	9
5	Mid-western	Hills	Pyuthan	1	1	5	14	0	1	1	23
6	Mid-western	Tarai	Bardiya	1	1	3	9	6	0	1	21
7	Western	Mountain	Manang	1	0	2	1	0	0	1	5
8	Western	Hills	Palpa	1	1	4	23	1	0	3	33
9	Western	Tarai	Kapilbastu	1	1	3	27	1	0	1	34
10	Central	Mountain	Rasuwa	1	1	3	2	2	1	1	11
11	Central	Hills	Lalitpur	2	1	4	12	17	5	1	42
12	Central	Tarai	Dhanusa	1	2	4	37	2	0	3	49
13	Eastern	Mountain	Sankhuwasaba	1	1	4	10	1	1	2	20
14	Eastern	Hills	Panchthar	1	1	4	12	1	0	0	19
15	Eastern	Tarai	Jhapa	1	2	3	18	9	6	2	41
	Selected number of institutions by ecological belts										
1	Mountain			5	4	15	27	5	2	5	63
2	Hills			6	5	21	77	20	6	8	143
3	Tarai			5	8	16	104	20	7	9	169
	Selected number of institutions by development region										
1	Far-Western Development Region			3	4	12	39	3	1	6	68
2	Mid-Western Development Region			3	3	9	27	8	1	2	53
3	Western Development Region			3	2	9	51	2	0	5	72
4	Central Development Region			4	4	11	51	21	6	5	102
5	Eastern Development Region			3	4	11	40	11	7	4	80
	Total			**16**	**17**	**52**	**208**	**45**	**15**	**22**	**375**

Source: *HRH Field Survey 2011*

Appendix 4: Qualitative Data Collection

District	Focus Group Discussions (FGD)							Key Informant Interviews (KII)				Grand Total of Participants
	Management Group		Service Providers		Service Users		Total # of FGD	Management Group	Service Provider	Service User	Total # of KII	
	# of FGD	# of Participants	# of FGD	# of Participants	# of FGD	# of Participants						
Sankhuwasabha	1	9	1	10	1	12	-	-	-	-	-	-
	1	6	-	-	-	-	-	-	-	-	-	-
	1	12	-	-	-	-	-	-	-	-	-	-
Total	3	27	1	10	1	12	5	0	1	0	1	50
Panchthar	-	-	1	8	1	10	-	-	-	-	-	-
	-	-	1	13	1	6	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
	-	-	-	-	1	7	-	-	-	-	-	-
Total	0	0	2	21	4	32	6	0	1	0	1	54
Jhapa	1	7	1	6	1	8	-	-	-	-	-	-
	-	-	1	10	-	-	-	-	-	-	-	-
	-	-	1	6	-	-	-	-	-	-	-	-
Total	-	7	3	22	1	8	5	1	1	0	2	39
Dhanusha	1	7	1	12	1	8	-	-	-	-	-	-
	-	--	-	-	1	10	-	-	-	-	-	-
Total	1	7	1	12	2	18	4	1	1	0	2	39
Lalitpur	-	-	1	4	1	9	-	-	-	-	-	-
	-	-	-	-	1	7	-	-	-	-	-	-
Total	0	0	1	4	2	16	3	1	1	1	3	23
Rasuwa	1	7	1	7	1	7	-	-	-	-	-	-
Total	1	7	1	7	1	7	3	0	1	0	1	22
Palpa	1	8	1	8	1	8	-	-	-	-	-	-
	1		1	7	1	9	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
Total	2	8	2	15	3	26	7	1	1	0	2	51
Manang	-	-	1	7	1	10	-	-	-	-	-	-
Total	0	0	1	7	1	10	2	1			1	18
Kapilvastu	1	8	1	7	1	7	-	-	-	-	-	-
	1	6			1	6	-	-	-	-	-	-
Total	2	14	1	7	2	13	5	0	1	0	1	35
Mugu	1	14	-	-	1	8	-	-	-	-	-	-
Total	1	14	0	0	1	8	2	0	0	0	0	22
Pyuthan	1	6	1	7	1	9	-	-	-	-	-	-
	1	7	-	-	1	11	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
Total	2	13	1	7	3	29	6	0	3	0	3	52
Bardiya	1	6	1	8	1	8	-	-	-	-	-	-
	-	-	1	8	1	9	-	-	-	-	-	-
	-	-	1	7	-	-	-	-	-	-	-	-
Total	1	6	3	23	2	17	6	1	2	1	4	50
Doti	1	8	1	9	1	11	-	-	-	-	-	-
	1	8	1	6	1	8	-	-	-	-	-	-
Total	2	16	2	15	2	19	6	0	1	1	2	52
Darchula	1	16	1	7	1	17	-	-	-	-	-	-
	1	8	-	-	1	15	-	-	-	-	-	-
Total	2	24	1	7	2	32	5	0	4	0	4	67
Kailali	1	9	1	6	1	6	-	-	-	-	-	-
	1	6	1	6	1	6	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
	-	-	-	-	1	9	-	-	-	-	-	-
	-	-	-	-	1	12	-	-	-	-	-	-
Total	2	15	2	12	5	42	9	0	1	1	2	71
Grand Total	20	158	22	169	32	289	74	6	19	4	29	645

Appendix 5: Organization Chart of MoHP, Nepal



Source: *NHSP IP II (2010-2015), NepalNHSP IP II (2010-2015), Nepal*

Appendix 6: Organization Chart of Department of Health Services Central to Periphery Level

MINISTRY OF HEALTH AND POPULATION

DEPARTMENT OF HEALTH SERVICES

CENTRAL LEVEL	**HOSPITALS - 8**	**DIVISIONS – 7**		**CENTERS - 5**	
	CENTRAL HOSPITALS	FHD	MD	NHTC	NTC
		LCD	EDCD	NPHL	NCASC
		CHD	LMD	NHEICC	
		PHCRD			
REGIONAL LEVEL	**REGIONAL HEALTH DIRECTORATE - 5**				
	REGIONAL HOSPITAL - 3	**SUB-REGIONAL HOSPITAL - 2**	**REGIONAL TRAINING CENTRE - 5**	**REGIONAL MEDICAL STORE - 5**	**REGIONAL TB CENTER**
ZONAL LEVEL	**ZONAL HOSPITAL – 10**				
DISTRICT LEVEL	**DISTRICT PUBLIC HEALTH OFFICE -15**	**DISTRICT HOSPITAL - 65**		**DISTRICT HEALTH OFFICE - 60**	
ELECTORAL CONSTITUENCY LEVEL	**PRIMARY HEALTH CARE CENTRE/ HEALTH CENTRE - 208**				
VDC, MUNICIPALITY LEVEL - 3973	**HEALTH POST - 1204**			**SUB-HEALTH POST - 2636**	
COMMUNITY LEVEL	**FCHV - 48,489**		**PHC/ORC CLINIC - 13,180**		**EPI OUTREACH CLINIC - 16,474**

Source: *DoHS 2009/10, Annual Report, MoHP*

FHD	Family Health Division
LCD	Leprosy Control Division
CHD	Child Health Division
PHCRD	Primary Health Care Revitalisation Division
MD	Management Division
EDCD	Epidemiology and Disease Control Division
LMD	Logistic Management Division
NHTC	National Health Training Centre
NTC	National Tuberculosis Centre
NCASC	National Centre for AIDS and STD Control
NPHL	National Public Health Laboratory
NHEICC	National Health Education, Information and Communication Centre
FCHV	Female Community Health Volunteer
PHC/ORC	Primary Health Care Outreach Clinic
EPI	Expanded Programme on Immunisation

Appendix 7: Level and Positions of Health Cadres as Mentioned in Nepal Health Service Act 1997

Position Categories	Level	Name of the Positions
Basic Level	Level 1st	Not Existing
	Level 2nd	Not Existing
	Level 3rd	Village Ayurved Health Workers, Village Health Workers, Maternal and Child Health Worker
	Level 4th	ANM, Baidhya (Ayurved), Microscopist Assistant, CMA, Junior Medical Recorder Supervisor
	Level 5th	Staff Nurses, Dental Supervisor, Ayurved Assistant, Health Education Technician, Microscopist, HA, Senior AHW, Medical Recorder Supervisor Pharmacy Supervisor/ Quality Control Supervisor Physiotherapy Assistant, Radiography Supervisor, ECG Technician
Senior	Level 5th	Senior Staff Nurses/Dental Supervisor/Ayurved Assistant/Health Education Technician/Microscopist/Health Assistant/AHW/Medical Recorder/Pharmacy Supervisor/ Quality Control Supervisor/Physiotherapy Assistant, Radiography Supervisor/ECG Technician and others
Officer	Level 6th	Staff Nurse Officer, Health Education Technician Officer, Lab Technician Officer, Senior AHW Officer, Medical Recorder Supervisor/ Inspector Pharmacy Supervisor Officer, Physiotherapy Officer, Radiography Inspector, Radiotherapy Officer, Medical Physician Inspector, ECG Technician Officer, Dental Surgeon
	Level 7th	Medical Officer, Sister, Dental Surgeon, Officer Kaviraj, Homeopathy Medical Officer, Integrated Medical Officer
	Level 8th	Medical Officer
	Level 9th	Consultants, Forensic Medical Officer, Medical Superintendent, Health Education Trainer Administrator, Deputy Chief Medical Technologist, Public Health Administrator
	Level 10th	DPHOs, Senior PH Administrators, Medical Superintendent, Chief Medical Officers, Senior Consultants, Senior Homeopathy Doctor, Senior Hospital Nursing Administrator, Senior Community Nursing Administrator and others
	Level 11th	Chief Consultant, Hospital Director, Chief Medical Technologist, DGs of DoDA, DoA, Directors, Division Chiefs, Regional Directors, KTM DPHO, Deputy DG and so on
	Level 12th	Director General of DoHS, Chief PPICD, Secretary of MoHP

Source: *Health Service Act 1997 with amendment*

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