A staff support programme for rural hospitals in Nepal

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Problem District hospitals in Nepal struggle to provide essential services such as caesarean sections.

Approach Retention of health workers is critical to the delivery of long-term, quality health-care services. To promote retention and enhance performance in rural public hospitals, the Government of Nepal and the Nick Simons Institute progressively implemented a rural staff support programme in remote hospitals. After competitive selection for a compulsory-service scholarship and training, family practice doctors who could do basic surgery, orthopaedics and obstetrics were hired under a binding three-year contract in each participating hospital. Comfortable living quarters and an Internet connection were provided for the resident doctors; in-service training for all staff and capacity development for each hospital’s management committee were provided.

Local setting Nepal’s mountainous landscape, poverty and inequitable rural/urban distribution of health workers pose barriers to adequate health care.

Relevant changes Between 2011 and 2015 family practice doctors were maintained in all seven programme hospitals. All hospitals became providers of comprehensive emergency obstetric care and served more patients. Compared with hospitals not within the programme, deliveries increased significantly (203% versus 71% increase, respectively; \( P = 0.002 \)). The programme recently expanded to 14 hospitals.

Lessons learnt A package of human resource supports can improve the retention of doctors and the use of remote hospitals. Factors contributing to the success of this programme were compulsory-service scholarship, central personnel management, performance-based incentives and the provision of comfortable living quarters.

Introduction

In remote areas, an absence of doctors and nurses leads to poor health outcomes for local populations.1 To increase access to health-care workers, the World Health Organization recommends interventions in four areas – education, regulatory, financial and professional/personal.1 To support retention, WHO and other organizations have called for bundled programmes that take into account health workers’ expectations.2–4 Retention programmes that enhance workers’ competence, responsiveness and productivity have also been recommended.5

Studies on retention of health-care workers in low- or middle-income countries tend to focus on compulsory government service6 or on salary incentives.7,8 Few studies have reported on bundled programmes or used patient volumes as outcome variables for such programmes.9,10

Here we describe a bundled programme for human resource support in Nepal.

Local setting

In Nepal, the mountainous landscape, poverty (the annual gross domestic product per capita is 300 United States dollars, US$) and an inequitable rural/urban distribution of health workers pose barriers to adequate health care.9,10 Eighty-three percent of 28 million Nepalese live in rural areas. These areas are served by 15-bed public district hospitals,11 which are expected by the Nepalese Government to provide emergency operations. However, in 2006, only 10 of 64 (16%) district hospitals were able to perform caesarean sections, due to absent, low-performing or mismatched health-care workers.12

The support programme

To address low retention of health-care workers and poor performance in district hospitals, the Nepalese Government partnered in 2006 with the Nick Simons Institute – a non-governmental organization working to improve health care in rural areas by supporting Nepalese health-care workers. The partnership developed a rural staff support programme, based on international consensus about retention factors1,3 and stakeholder consultations.

The central component of the rural staff support programme was recruiting one or two family practice doctors per programme hospital. These physicians are post-graduate doctors trained in medical universities in Nepal – to provide primary care as well as basic surgery, orthopaedics and obstetrics. To recruit these doctors, we first negotiated with the medical university for three to six seats per year in the post-graduate family practice programme. Then we advertised in newspapers for junior doctors with at least two years of working experience and who had either been raised in or who had previously worked in rural areas. We chose 15 to 20 applicants to take an entry exam. Three to six applicants with the best results were offered a scholarship for the three-year post-graduate programme and binding contracts for a subsequent three years of service in a programme hospital. Doctors who chose to leave the programme early incurred a financial penalty twice the scholarship, which varied from US$ 20 000

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Submitted: 5 February 2015 – Revised version received: 2 October 2015 – Accepted: 5 October 2015 – Published online: 2 November 2015


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Lessons from the field

Abstracts in العربية, Français, Русский и Español at the end of each article.
Table 1. Overview of the rural staff support programme, Nepal, 2007–2015

<table>
<thead>
<tr>
<th>Support</th>
<th>Description</th>
<th>First phase assessment (2010)</th>
<th>WHO policy recommendation category*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Original</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical coordination by family practice doctor</td>
<td>Employ two family practice doctors past their scholarship commitment</td>
<td>Most critical component to increasing hospital use</td>
<td>A1, B4, C1, D2, D6</td>
</tr>
<tr>
<td>Comfortable quarters</td>
<td>Build new and renovate existing doctors’ quarters</td>
<td>Appreciated, but staff also requested the same improvements for all staff quarters</td>
<td>D1</td>
</tr>
<tr>
<td>Communication</td>
<td>Provide reliable Internet access in quarters and hospital office</td>
<td>Important component for reducing sense of isolation</td>
<td>D1, D5</td>
</tr>
<tr>
<td>Continuing medical education</td>
<td>Train multiple levels of staff – via in-service courses and on-the-job trainings</td>
<td>Encouraging to all staff; special value for quality of delivery service</td>
<td>A5, D3</td>
</tr>
<tr>
<td>Community governance</td>
<td>Participate in and build capacity of local hospital management committee</td>
<td>Variable ownership by different local committees</td>
<td>D2</td>
</tr>
<tr>
<td>Capital items</td>
<td>Procure equipment or do small building projects to improve clinical services</td>
<td>Important for starting medical procedures, such as operations</td>
<td>D2</td>
</tr>
<tr>
<td><strong>Discontinued (2007–2011)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s education support</td>
<td>Assist two primary schools located near to the hospital</td>
<td>Discontinued: no trickle down to hospital performance</td>
<td>D1</td>
</tr>
<tr>
<td>Connection with larger hospital</td>
<td>Partner smaller programme hospital with a mentor hospital in the region</td>
<td>Discontinued: larger hospitals too busy to assist district hospitals</td>
<td>D6</td>
</tr>
<tr>
<td><strong>Added (2011–2015)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Connection with district</td>
<td>Develop training and referral linkage with smaller district health posts</td>
<td>The programme should evolve towards district-wide support</td>
<td>–</td>
</tr>
<tr>
<td>Continuous quality improvement</td>
<td>Initiate and monitor an ongoing cycle of self-assessment and interventions</td>
<td>Performance improvement should affect service quality and not just utilization</td>
<td>D2</td>
</tr>
</tbody>
</table>

WHO: World Health Organization.
* The categories of WHO improved retention policy recommendation are as follow: A: education; B: regulatory; C: financial; D: professional/personal.

30 000. Once posted in the programme hospital, the doctors received salaries three times higher than the usual basal government rate, not including other government benefits. To facilitate an effective hospital team, the programme also provided personal, professional and management support for all staff working in the hospital (Table 1).

The programme was implemented stepwise: In 2007, three hospitals started the programme and in 2009, they were fully operational when scholarship doctors began to graduate from their training programmes. In 2011, four more hospitals joined the programme. All seven hospitals (Bajhang, Kalikot, Doti, Salyan, Kapilvastu, Gulmi and Dolakha) were rural, some were in extremely mountainous regions, and all their districts were below the national Human Development Index mean of 0.471. 

In 2008, we hired one centrally-located nurse coordinator for the programme team. This nurse administered the programme and provided counseling to doctors and nurses posted in the remote hospitals. She shared success stories with other hospitals, the government, the local newspaper and published these in the institute’s annual reports. When the programme grew to seven hospitals, we hired a second nurse coordinator.

In 2010, we did a detailed evaluation. Hospital staff mostly appreciated the Internet access, hospital equipment stipends and renovations of staff quarters. However, two components did not produce the expected outcomes. The children’s education component assisted certain schools, yet many staff chose to send their children to other schools. Efforts to connect these small rural hospitals with a larger hospital failed because staff in the larger hospitals were too busy with their own work to develop useful support relationships with staff working in the programme hospitals. These two components were therefore replaced with two new components in 2011 – connection with district health posts and continuous quality improvement (Table 1). We also interviewed a small number of relatives of outpatients and inpatients to assess community satisfaction.

In 2011 we added a job description for the family practice doctors and a performance-based incentive, which was a lump sum of maximum 20% of the total salary. The lump sum depended on a doctor evaluation score. For example, if the doctor scored 80%, he or she got 80% of the maximum lump sum. In each hospital, we also introduced and monitored a self-administered quality improvement tool designed to address equipment and management gaps that affected patient care.

The institute bore all programme costs. The programme cost was US$ 66 387 per hospital per year – 49.2% (US$ 32 667) for doctors’ scholarships and salaries, 45.3% (US$ 30 073) for other programme activities and 5.5% (US$ 3651) for central management. This cost was approximately 50% more than a parallel, government scheme that provided emergency obstetric services.
Lessons from the field
Rural hospital support programme in Nepal
Mark Zimmerman et al.

through one-year doctor contracts in 28 district hospitals.15

Programme outcomes
All doctors reported that they settled uneasily into their new workplaces: they felt isolated, both geographically from their homes and professionally from the medical hierarchy of their training hospitals. Nevertheless, the programme was able to continuously post at least one family practice doctor in each of the seven hospitals.

Five out of the programme’s first 20 doctors chose to pay off their bond before fully completing their service period. As of 2013, three of these five doctors continued to work in rural hospitals for other organizations.

All seven programme hospitals became providers of emergency obstetric care and doctors did between 10 and 50 caesarean sections per year in each hospital.

We used changes in hospital use as a proxy indicator for community satisfaction and quality of care. We collected data on numbers of outpatient visits, admissions, deliveries and caesarean sections. Comparing patient use before (2006–2007) and after (2012–2013) implementing the programme, all programme hospitals showed increases in all four indicators. Mean annual admissions and outpatient visits per hospital almost doubled, from 832 to 1592, and from 10 585 to 21 341, respectively. Mean deliveries per hospital per year tripled, from 152 to 462. The mean annual increase in caesarean sections was 23.4 per year; from 1.4 to 24.8.

We compared use data between programme hospitals and district hospitals not within the programme. The 34 control hospitals with complete data also showed increased use between 2006 and 2013. Mean annual admissions, outpatient visits and deliveries per hospital increased approximately 1.5 times, from 1231 to 1770, from 13 065 to 19 299, and from 298 to 511, respectively. The mean annual increase in caesarean sections increased from 2.1 to 24.5. When compared to the control hospitals – using a non-parametric rank test – programme hospitals had greater improvements in the number of deliveries ($P = 0.002$) and caesarean sections ($P = 0.056$). Admissions ($P = 0.151$), and outpatient visits were not significantly increased ($P = 0.544$; Fig. 1).

In the evaluation and during regular hospital visits, staff strongly requested that the programme be continued in their hospital. Though staff other than

Fig. 1. Changes in hospital use ranks in control and rural staff support programme hospitals, Nepal, 2007–2013

RSSP: rural staff support programme.
Notes: Control and programme hospitals’ ranks were compared using a Wilcoxon Rank Sum test. The mean rank is indicated with a plus sign (+) and the horizontal bar indicates the median rank. The box represents the 25th and 75th percentiles of the indicator and the whiskers extend to largest or smallest values, excluding outliers. Seven rural staff support programme hospitals and 34 control hospitals were included in the analysis.

doctors appreciated the programme, they complained that they were not being compensated for having to treat more patients.

Lessons learnt

To improve performance in poorly functioning rural public hospitals, we created a staff support and programme based on three principles – personalized management, bundled support and programme evaluation and revision.

We recruited and deployed family practice specialists who were capable of providing a range of services. We added several comfort and professional supports to a bundle that we revised after evaluation to improve the programme. The use of and types of surgical services available in the programme hospitals increased (Box 1). Compared with control hospitals, all programme hospitals showed a higher increase in deliveries; all hospitals were converted into continuous providers of emergency obstetrics services; and the changes in hospital services all met with community satisfaction. While a parallel government-contracted doctor programme provided discontinuous service,1 the rural staff support programme maintained a continuous supply of family practice doctors to each hospital.

The main challenge of the programme was to motivate – and ensure effective collaboration between – family practice doctors and their government medical superintendents. We had to overcome the preconceptions that rural hospitals had always been, and would likely remain, dysfunctional. This challenge was addressed by the programme’s long-term commitment and its responsiveness to each hospital’s unique situation. Another challenge was the medical superintendents themselves, who varied widely in both their desire to upgrade their own hospitals and their management capacity. We addressed this challenge by giving them control over the equipment and training budgets and giving them credit for the programme gains.

In 2013, during the sixth year of the programme, the Nepalese government asked that the programme be expanded to 25 more district hospitals. However, limited numbers of scholarship doctors meant that only four hospitals in 2013 and three in 2015 could join the programme, resulting in a total of 14 functioning programme hospitals. The programme plans to expand to 18 hospitals. In 2015, the Nepalese health ministry, using its own budget, instituted a similar programme to recruit, bond and deploy 40 family practice doctors per year in public hospitals.

A compulsory-service scholarship programme for doctors that includes staff and living supports could be a viable model in other countries that face problems in delivering health-care services in remote areas.

Acknowledgements

We thank Robert B Gerzoff.

Competing interests: MZ, SS, BS, KS and BH were employed by the Nick Simons Institute for all or part of the programme’s implementation.

Box 1. Summary of main lessons learnt

- Continuous doctor retention in remote, previously understaffed hospitals can be attained through a combination of compulsory service scholarship, improved living quarters, personal counselling and moderately higher salaries, including performance-based incentives.
- Programme success depends on the performance of the individual doctor – which in turn depends on both the doctor’s personal qualities – such as courage and motivation – and a range of hospital factors.
- Hospital staff found Internet access, new equipment and comfortable quarters especially helpful.

Lessons from the field

The HDFA model for comprehensive transformation of rural hospitals in Nepal

The Rural hospital support programme in Nepal Mark Zimmerman et al. 2016

Rural hospital support programme in Nepal

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Резюме

Программа поддержки персонала для сельских больниц в Непале

Приросты: Районные больницы Непала испытывают трудности при оказании важнейших услуг населению, таких как выполнение родов, а также недостаточное финансирование. В период с 2011 по 2015 год врачи, проводившие лечебные процедуры, получали только 71% от запланированной зарплаты, а для руководителей комитета каждой больницы проводились курсы повышения квалификации. Местные условия Непала — гористая страна, в которой нищета и неравномерное распределение медицинских сотрудников в городской и сельской местности создают препятствия для нормального оказания медицинских услуг.

Осуществленные переменны: В период с 2011 по 2015 год врачи проводили большую часть своих процедур, и в результате пациенты получали более качественные услуги. Всем больницам были обеспечены интернет-соединения, что позволило врачам проводить более эффективно.

Выводы: Комплекс мер по поддержке кадров способствует удержанию врачей на их рабочем месте, а также улучшает показатели обращений в больницы, расположенные в отдаленной местности.
Un programa de apoyo al personal para los hospitales rurales de Nepal

**Situación** Los hospitales de distrito en Nepal tienen dificultades para proporcionar servicios básicos como cesáreas. Los hospitales de distrito en Nepal tienen dificultades para distribuir el personal de salud y mejorar el rendimiento en los hospitales públicos rurales, el Gobierno de Nepal y el Instituto Nick Simons aplicaron de forma progresiva un programa de apoyo al personal rural en hospitales remotos. Tras una selección competitiva para una beca de servicio obligatorio y formación, se contrató en cada hospital participante a médicos de familia que pudieran llevar a cabo una cirugía básica, ortopédicas y obstetricia con un contrato vinculante de tres años. Se proporcionó una cómoda residencia y conexión a internet a los médicos residentes y también formación en el servicio para todo el personal y desarrollo de capacidades para el comité de gestión de cada hospital.

**Marco regional** En Nepal, el paisaje montañoso y la pobreza pueden mejorar la retención de médicos y el uso de hospitales remotos. Entre 2011 y 2015 se mantuvieron médicos que no se encontraban en el programa, el número de partos aumentó significativamente (aumentó del 203% frente al 71%, respectivamente; P = 0,002). Recientemente, el programa se extendió hasta los 14 hospitales.

**Cambios importantes** Los factores que contribuyeron al éxito de este programa fueron la beca de servicio obligatorio, la gerencia central de recursos, los incentivos basados en el rendimiento y la provisión de una residencia cómoda.

**Enfoque** La retención del personal sanitario es indispensable para suministrar servicios médicos de calidad a largo plazo. Para promover la retención y mejorar el rendimiento en los hospitales públicos rurales, el Gobierno de Nepal y el Instituto Nick Simons aplicaron de forma progresiva un programa de apoyo al personal rural en hospitales remotos. Los hospitales de distrito en Nepal tienen dificultades para distribuir el personal de salud y mejorar el rendimiento en los hospitales públicos rurales, el Gobierno de Nepal y el Instituto Nick Simons aplicaron de forma progresiva un programa de apoyo al personal rural en hospitales remotos. Las medidas para mejorar la retención de médicos y el uso de hospitales remotos son relevantes para el mundo y las lecciones aprendidas pueden adaptarse a diferentes contextos. La retención de personal de salud en los hospitales rurales es esencial para brindar servicios de salud de calidad a las comunidades rurales en Nepal. La implementación de programas de apoyo al personal para los hospitales rurales se puede replicar en otros países con sistemas de salud similares.

**Resumen** Un programa de apoyo al personal para los hospitales rurales de Nepal. Situación: Los hospitales de distrito en Nepal tienen dificultades para proporcionar servicios básicos como cesáreas. Enfoque: La retención del personal sanitario es indispensable para suministrar servicios médicos de calidad a largo plazo. Cambios importantes: Entre 2011 y 2015 se mantuvieron médicos de familia en los siete hospitales del programa. Los hospitales se volvieron proveedores de atención obstétrica de emergencia integral y atendieron a más pacientes. En comparación con otros hospitales que no se encontraban en el programa, el número de partos aumentó significativamente (aumentó del 203% frente al 71%, respectivamente; P = 0,002). Recientemente, el programa se extendió hasta los 14 hospitales. Lecciones aprendidas: Un paquete de apoyo a los recursos humanos puede mejorar la retención de médicos y el uso de hospitales remotos. Los factores que contribuyeron al éxito de este programa fueron la beca de servicio obligatorio, la gerencia central de recursos, los incentivos basados en el rendimiento y la provisión de una residencia cómoda.