

Human Resource for Health in Nepal

Analysis of Policies and Practices



THE BRITAIN NEPAL MEDICAL TRUST

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Abbreviations

ANM	Auxiliary Nurse Midwife
AHW	Auxiliary Health Worker
BNMT	Britain Nepal Medical Trust
CSOs	Community and Social Organisations
CTEVT	Council for Technical Education and Vocational Training
DDC	District Development Committee
DHMC	District Health Management Committee
DoHS	Department of Health Services
EDCD	Epidemiology and Disease Control Division
FCHV	Female Community Health Volunteers
GESI	Gender and Social Inclusion
HA	Health assistant
HF	Health Facility
HFMC	Health Facility Management Committee
HI	Health Institutions
HP	Health Post
HR	Human resources
HRH	Human resources for Health
HRM	Human Resources Management
HuRIS	Human Resource Information System
KII	Key informants interviews
LSGA	Local Self Governance Act
MDGs	Millennium Development Goals
MoE	Ministry of Education
MoF	Ministry of Finance
MoGA	Ministry of General Administration
MoHP	Ministry of Health and Population
NAC	Nepal Ayurveda Council
NDVS	National Development Volunteer Service
NHPC	Nepal Health professional Council
NHSPIP	National Health Sector Programme implementation plan
PAR	Performance Appraisal Review
SHP	Sub Health Post
VDC	Village Development Committee
VHW	Village Health Workers
WB	World Bank
WHO	World Health Organisation

Executive summary

This report is prepared primarily on the basis of document review and with limited primary information as well as interviews with key informants. This assessment is a part of larger project being implemented by BNMT, called “Human Resources for Health mainstreamed in health systems, through strengthened advocacy capacity of CSO’s”, and aims to highlight some of the underlying issues around human resource for health.

The health sector is a major employer in all countries. Nepal employ approx. 28,000 (one third of total public service employment) under Ministry of Health and Population. Wage costs (salaries, bonuses and other payments) account for between 65% - 80% (85 – 90% of HR budget in Nepal) of the recurrent health expenditure. Unequal distribution of available health workforce, inappropriate skill mix, training, motivation and deployment, and wages and incentives are among the major concern in human resource management. The additional emerging challenges many developing countries face are ‘health workers flight to rich countries’ and inequitable distribution of health workforce. Kampala Declaration (The Agenda for Global Action 2008) is an endeavour towards addressing these HR problems globally and locally. It is built around six fundamental and interconnected strategies based on previous actions and commitments.

In Nepal, Health Services Act 1979 and Civil Service Act are the major legal documents governing the employment of health sector staff. Health Service Act is different and more ‘tailor made’ to suit health sector than the umbrella Civil Service Act 1992 which covers most government employees including those on secondment to MoHP from other ministries (e.g. Ministry of General Administration, Ministry of Finance). Clearly, not all staff working in MOHP are governed by a single act and some HR functions are carried out by different divisions.

The existing skills mix revealed that only 4% of total health care providers are doctors, 12% nurses, excluding ANMs, 47% paramedics, 0.92% public health officers, and 3.1% traditional health care providers (HuRIS, 2008). However, the skill mix at the selected district level appeared relatively better in terms of %age of different category of staff, except the doctors.

Facility survey (MoHP 2009) indicated a better picture of staffing at HP and SHP level than at hospitals and PHC level. Unfilled positions at higher level of health institutions are a concern, particularly in the case of the position of

doctors. Clearly, the effort of MoHP in attracting doctors in rural health institutions is partially successful.

The Health Act along with other Acts (e.g. LSGA 1998) has allowed for local recruitment of human resources to meet the acute shortage and specific need at the district (local) level. Now in absence of other suitable mechanism, many staffs are employed under Procurement Act which is designed to regulate procurement of goods and services. Though the local employment apparently has been in practices for some time now, but frequent and adequate use of such provision appears to be in recent days only. Data from selected districts shows that majority of employment were within last five years. Among the sources that employ the local staff in the health institutions, Village Development Committee and Health Facility Management Committee together employ over 70% of staff. It is important to sustain and systematise this practices while at the same time, proper documentation and recording of such practices is needed.

Doctors appeared the least employed locally. Among others, administrative staff constitutes 36% of local employment. The reasons for such high demand (or supply) of administrative staff in the local health facilities is not clear. It is therefore worthwhile to explore the role, responsibility and workload of locally employed staff in order for informing an appropriate resource distribution process. Task analysis is also important especially of the admin staff in local health facilities particularly in those areas where client load is very low. Some health institutions are getting support from national volunteer system as well. There are however certain areas that is not yet fully addressed through this practice. There is no proper record of such recruitment at central level as they are out of formal pay roll. Though this practice certainly has ameliorated some the shortage in HR situation at local level, it is difficult to make an assessment whether this practice has been able to address some of the critical issues like, skill mix, quality of service and issue of retention particularly of medical doctors.

Absenteeism is most complicated situation as expressed by many, both at Ministry of Health and at DHO level. Even when position is filled, absenteeism from work is widely reported during the field work in 10 BNMT districts. A study in 23 district hospital recorded that while overall presence of staff for full 12 month were over 85%, but doctors were present only 56% of their time in the district. Data from selected districts health facilities indicates that most common reasons for absenteeism is secondment, training and away from work without any reasons. When staffs are nominated for training they often continue to be away for much longer than the training period for which they

were nominated. In on average lab staff and paramedics are highest absent category at the district level with 74 and 65 days of absence in 2011 respectively.

Transfer has been a major workload and a subject for political manoeuvring both at Department of Health and at Ministry of Health. This is also a major reason for high turnover of the staff. It eats up considerable time of senior officials for expediting the transfer requests as well as in entertaining and responding to the requests from staff as well as from political peoples from all levels. Data from selected facility indicated that transfer seeking tendency is very high among the staff in the first five years of their service.

The reasons for seeking transfer, as almost all interviewed staff cited, was to be in hometown or to be with family members (91%). Government has policy to support staff seeking transfer near or at the hometown and for working couple, posting at the same district. While this is very encouraging and pro staff policy, its success also appeared partial.

There is an extensive performance appraisal system in place to all civil servants including health professionals. But use of performance appraisal is very limited. It is used only at the time of promotion to calculate the total final score. There is no mechanism to review and analyse the performance appraisals to inform managers and policy makers. Since such documents are treated confidential, is not available for academic research and analysis either. Besides, there is no individual job description against which performance of an individual could be measured, nor can the individual be made accountable to specific task. This has not only affected the motivation of the staff, but also is a HR management issue.

Opportunity for training is often considered an incentive or reward for good work and a strong motivational factor. But health staffs often complain that nomination for training is biased and preferred to those who are near and dear to the boss. Management and administration is a large part of mid-level health care providers' job responsibilities but most are weak or have not received any training. The budget analysis indicated that other than the salary line items, the budget in HR related items (training) has sharp upward trend from previous years. There is no explanation on such sharp and sudden rise in training related cost from the year 2008/09 to 2009/10.

The role and achievements of FCHVs are well appreciated and recognised. Despite recognition and appreciation of their important and crucial role in health care delivery, FCHVs are struggling to secure a "better space" at health

system. Nonetheless, it is extremely important to continue motivating them and acquiring their services.

Recommendations

1. There is a need to review the policy and the strategy – which is already progressing in the Ministry of Health and is expected to be ready soon. The HR unit in the ministry needs strengthened it to make more functional not only to manage the day to day affairs but also to implement and monitor new strategy.
2. It is recommended to develop a policy and a framework within HR strategy that allows the local authority to plan, recruit and document human resources at local level in a more systematic manner addressing the critical HR needs.
3. It has been widely recognised that health workers are required to engage in routine management responsibilities for which they are not prepared or trained. Organisations working in the district (e.g. BNMT), in collaboration with ministry of health should explore the possibility of designing and organising management trainings.
4. A mechanism needs to be put in place to monitor the absenteeism and remedial action at the district and facility level. Potentially, HFMC should be able to do this. For this as well as for better engagement of HFMC some training and or a hand book to HFMC would be useful.
5. Despite recognition and appreciation of their important and crucial role in health care delivery, FCHVs are struggling for secure a “better space” in the health system. Nonetheless, it is extremely important to continue motivating them and acquiring their services.
6. A method to make the PAR more scientific and achievement based is should be instituted to address some of the grievances regarding motivation, opportunity for training and promotion.

1. Background

BNMT along with its implementing partners is implementing a project to improve Human Resources for Health (HRH) in Nepal with the support of European Union. The overall objective of the project is to advocate for prioritizing Human Resources for Health (HRH) in planning, programming, implementation, monitoring and delivery of health services.

The project aims to increase commitment at the policy and program level for effective provision and mobilization of HRH. The project targets policy /decision makers including civil society organisations to create awareness and seek commitment on the importance of HRH. It also seek to strengthen the capacity of civil societies, health professional associations, health care providers, committee members of health management committees and local governance bodies at the local level for advocating for adequate provision and mobilisation of HRH.

In order to prepare a base for strong evidence based advocacy, the project has envisaged conducting series of desk reviews and research activities both at the national and district level. This assignment is part of the process and has included extensive review of Nepal Health Sector Programme 2 (NHSP 2) and relevant documents on Strategic Plan for Human Resources, Second Long Term Health Plan and other important health policy documents to draw conclusion regarding human resources in health.

2. Objectives and methodology

Objectives

This review is expected to enhance understanding on the state of the HRH policy and situation in the country. It also helps to identify gaps in implementation. Some of the specific objectives of the review are as follows:

- To review global policies and practices related to HRH specific to developing countries as appropriate
- To review the existing national HRH related policies, plans, guidelines and strategies including recent effort of the MoHP on HRH
- To analyse the gaps in existing policies and implementation of plans
- To review and analyse the past five years trend on budget allocated for HRH at national level and at project district level
- To review trend on strategies and status of human resource planning, recruitment, deployment, incentives, transfers and retention with gender disaggregated data.
- To provide recommendations for improvement of HRH situation at national and district level.

Methodology

The methodology primarily consisted of document review, Key Informants Interview (KII) with selected officials at Ministry of health and at programme districts. Information related to deployments, absenteeism, and resource availability and spending trend was also collected from selected districts where BNMT has programmes.

For the purpose of collecting information and keeping track of information, a matrix with key study areas and key questions and tools to collect views and data was developed with joint consultation with HR team at BNMT (matrix available in Annex 2).

Limitation and challenges

During the period of this assessment, MOHP has also initiated the development of new human resource strategy for Health in the country. Therefore key officials related to HR either were too occupied to the strategy process or were little reluctant to share or pre-empt the strategy or information that may affect strategy development process. However, the officials met were very cooperative.

Financial information was not available other than what was published in different document; therefore the specific trend analysis regarding HR spending in the country was not possible. In those cases where information was available, was not adequately detailed or kept in the format that would hardly allow easy extraction of HR related spending. Moreover, the officials both at the district and centre are little reluctant to share or show the financial or spending information.

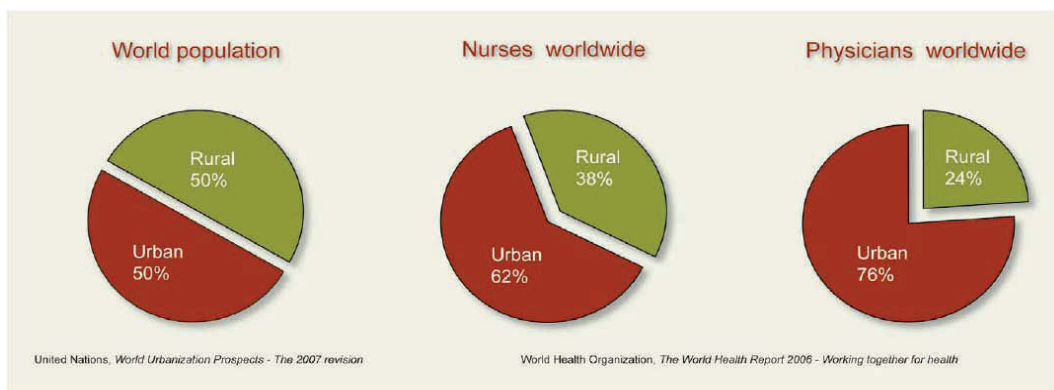
The supplementary information on HR collected from BNMT programme districts also were incomplete for the same reasons as mentioned above. Therefore the information and analysis based on district information needs to be used cautiously; **it should be used as indicative information rather than conclusive data.**

3. Conceptual framework for HRH

World

The health sector is a major employer in all countries. The International Labor Organization reckons that 35 million persons are currently employed in the health sector worldwide. While health expenditure claims an increasingly important share of national budget, wage costs (salaries, bonuses and other

payments) account for between 65% and 80% (Nepal: 85 – 90% of HR budget) of the recurrent health expenditure (WHO 2008). The growing inequality in health indicator among the population and shortage of health workers are major concern in many developing countries. The problem is further exacerbated by the unequal distribution of available health workforce; inappropriate skill mix; training, motivation and deployment, and wages and incentives. The emerging challenges many developing countries face are 'health workers flight to rich countries' and inequitable distribution of health workforce.



WHO has emphasised the need to have sufficient numbers of health workers to achieve the basic objectives of the Millennium Development Goals (MDGs). It has suggested that a minimum of 2.3 doctors, nurses, and midwives 30 per 1,000 people should be a basic numerical target (WHO World Health Report 2006). The Kampala Declarations (2008) takes into account of the current HR situation from global perspectives and has come up with agenda for global action as follows;

The six interconnected strategies

1. Building coherent national and global leadership for health workforce solutions
2. Ensuring capacity for an informed response based on evidence and joint learning
3. Scaling up health worker education and training
4. Retaining an effective, responsive and equitably distributed health workforce
5. Managing the pressures of the international health workforce market and its impact on migration
6. Securing additional and more productive investment in the health workforce

Dimension of HR management

Coverage: the extent to which the allocation of the workforce corresponds to needed services and of geographical access

Productivity: the ratio of outputs relative to inputs, such as number of consultations by provider etc.

Technical quality: the extent to which services have a positive impact on health status

Sociocultural quality: the extent to which services are acceptable to users and meet their expectations.

Organization stability: the use of the workforce so as to guarantee the viability of services and their capacity to adapt to changing needs

(Source: WHO 2008)

The Agenda for Global Action is built around six fundamental and interconnected strategies, based on previous actions and commitments. It is a synthesis that specifically highlights challenges and the need for change which reflects the essential continuum of planning, training, deployment and retention. Its purpose is to translate political will, commitments, leadership and partnership into effective actions (World Health Organization - acting as the host organization for, and secretariat of, the Global Health Workforce Alliance, 2008).

Nepal

Health Services Act 1979 and Civil Service Act are the major legal documents governing the employment of health sector staff. Strategic Plan for Human Resource for Health (2003 – 2017) is another major policy document that: a) specify the direction of growth of development of HR; b) specifically outline HR objectives for the medium term which provides a frame-work for short term plan development; and c) identify short term action and in particular policy action which are needed for MOH to proceed towards medium term future (HRH Strategic Plan 2003). Health system and need have expanded exponentially but HR situation and number of positions has not changed for more than 10 years.

Of the total civil service employment in Nepal, **Ministry of Health is the largest employer and constitutes about one-third (approx. 28,000) of total personnel of the public sector.** There are different categories of staff in Ministry of Health under different acts and rules. In other words, **not all staff working in MOHP are governed by a single act.** Data from private sector employment is not available, but keeping in view of increasing number of private health institutions and hospitals, the employment of health personnel could be quite high.

Current approaches in human resources suggest a number of weaknesses: a reactive and ad hoc attitude towards problems of human resources; dispersal

of accountability within human resources management (HRM); a limited notion of personnel administration that fails to encompass all aspects of HRM; and finally the short-term perspective of HRM (MoHP 2009).

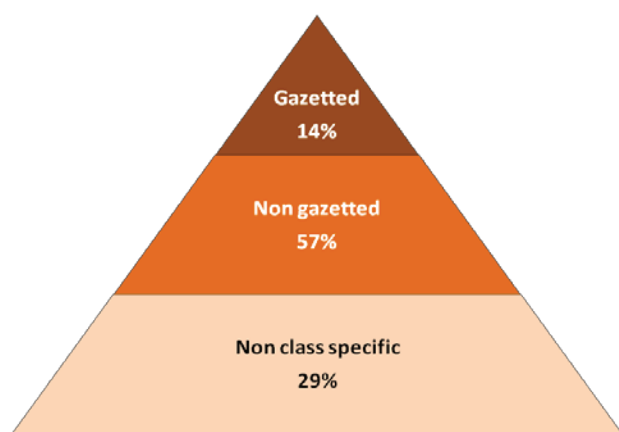
4. Findings:

4.1 National status of HRH

Health Services Act 1979 and Civil Service Act are the major legal documents governing the employment of health sector staff. Health Service Act is different and more ‘tailor made’ to suit health sector than the umbrella Civil Service Act 1992 which covers most government employees including those on secondment to MoHP from other ministries (e.g. Ministry of General Administration, Ministry of Finance). Five amendments have been made to this act, the most recent being in January 2010. Amongst many other things the Health Services Act provides the rules on transfer, deputation and promotion. The Act allowed for a change from a rank/class system of post to a grade system.

The Ministry of Health and Population in Nepal has recognized that the human resource development strategic plan of 2003 needs to be revisited in the context of the health-related MDGs, free health care, health system development (NHSP IP – 2). The MoHP Strategic Plan for Human Resources for Health (2003-17) calls for expansion of the pool of health care workers by nearly 50,000 over this period, especially in the case of midlevel workers.

Figure 1: Composition of HR in MoHP



It is also highlighted (NHSP IP-2, 2009) that the population of Nepal has increased by 35% between 1991 and 2008, while the number of health workers has increased only by 3.4%. But keeping in view the considerable number of health workers and doctors from private colleges, the overall situation of health workers in the country has certainly improved. Despite this, MoHP is facing difficulties to meet the HR demand in government

health facilities.

Moreover, many of the recommendations and strategic direction suggested in previous strategy have not been fully achieved for obvious reasons like rapid changes in the national context after post conflict period. **Therefore it will be necessary to review the recommendations and carry over those that are most relevant in the current changing context.**

Composition of HR in Ministry of health revealed that there are nearly one third non class specific positions. Government has policy to gradually abolish non class specific job either through upgrading the position or not fulfilling once it gets vacant (Figure 1).

It was reported by a senior official at the MoHP that, on one hand, appointment takes much longer because of administrative procedure (seeking approval from Public Service Commission, advertisements, etc). On the other, even after the recruitment, **the retention of medical doctors and nurses remains a major concern.** Moreover, now quite a staffs are employed under Procurement Act which is designed to regulate procurement of goods and services. Though buying service provision in the Act is more suitable for acquiring services that is “non-regular” in nature (i.e. short term technical support, advisors and consultancies and activities of one off nature like training etc), but in absence of other suitable employment provision to meet acute shortage of staff, this provision is widely used to recruit staff for work responsibility of regular nature like day to day services at hospitals, laboratory, administrative work and so on. This practice is quite widespread particularly where there is donor supported programmes. FHD is allocating fund for all 75 districts for ANM/SN recruitment locally and fund to recruit senior doctors for CS to run Comprehensive Emergency Obstetric Care services. The advantage and disadvantage of this act regarding staff recruitment is widely debated.

We are employed through a ‘bidding’ process like a contractor. In the bidding process those who propose low salary will have higher chance of getting selected. Therefore quality is comprised and we do not see any future and are not motivated either. Most of the opportunity for training is also given to regular staff. We feel exploited – ***a staff from a far west hospital***

Among other limitations, procurement act does not allow for multiyear contract/employment. Along with this and complicated procedure coupled with delay fund disbursement makes it difficult recruit and retain staff for longer period. **For recruiting staff for long term or for work of regular nature this has been serious obstacle, therefore multiyear recruitment provision should be included in the act.**

There is a lack of evidence on the average length of stay of care providers in the assigned position. Health facility survey (2009) showed that only 64-80% of posted medical doctors were available at the time of the surveys. Availability of nurses was 68-81% and for paramedics, 81-92%. The situation is worse in the remote districts.

The existing skills mix revealed that only 4% of total health care providers are doctors, 12% nurses, excluding ANMs, 47% paramedics, 0.92% public health officers, and 3.1% traditional health care providers (HuRIC, 2008). There is currently a high number of unskilled support staff (28% of the total workforce), which poses a challenge to the health system to reduce the volume of unskilled and semi-skilled labour as a percentage of the total workforce (MoHP, 2004). On one hand, it is often argued that this skills mix hardly allows for delivering quality health care (NHSP IP – 2, pp 66), on the other there is continuing debate on what should be the skill mix or what is the right proportion of health care provider that should be available at various health facilities. While may agree that such mix should be based on population and disease pattern, exact formula to calculate the mix is yet to come.

Table 1: Skill mix

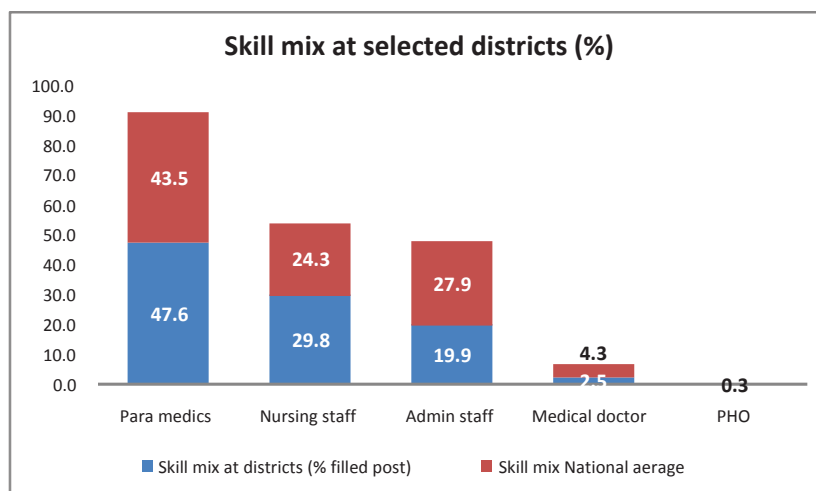
Position	Sanctioned	Filled	Vacant	% filled	Share%
Medical doctor	1,062	816	246	76.84	4.34
Nursing staffs including ANMs	5,935	5,307	628	89.42	24.25
Paramedics	10,642	9212	1,430	86.56	43.48
Other	6,838	6,394	444	93.51	27.94
Total	24,477	21,729	2,748	88.77	100.00

(Source: MoHP 2010)

However, the skill mix at the district level (selected district with BNMT programme) appeared relatively better in terms of %age of different category of staff except the doctors. National average for public health officer is not available, but paramedics and nursing staff perform both clinical and public health related activities.

Reportedly, Ayurvedic health care providers also complement and supplement the modern care in many districts. The nature and magnitude of such practices is not available, but given the basic education of Ayurvedic colleges where knowledge of allopathic medicine is also given, there is possibility of such services.

Figure 2: Skill mix at selected BNMT districts¹



MoHP facility survey indicated that absentees and lack of coordination between health facility and DHO in approving the leave of staff are major concern in human resource management at the district/facility level. Information from BNMT districts also reaffirmed the problem of absenteeism.

Female Community Health Volunteers

Nearly 50,000 FCHVs in the countries have played a vital role mainly in maternal and child health. The role and achievements of this cadre of volunteers are well appreciated and recognised. Therefore, NHSP -2 aims to create balance between compensating the women for the real financial and time costs that they incur in carrying out their duties, without losing the spirit of voluntary service to the community. The success of the FCHV programme has resulted in more responsibilities being given to FCHVs. Training and recognition for the importance of their work are strong motivating forces for many. Despite recognition and appreciation of their important and crucial role in health care delivery, FCHVs are struggling for a “secure space” at health system. **Nonetheless, it is extremely important to continue motivating them and acquiring their services.**

¹ Data source: DHO information from Kalikot, Kailali, Achham, Nawalparasi and Sindhupalchok, collected by BNMT staff

Table 2: Issues in human resource management

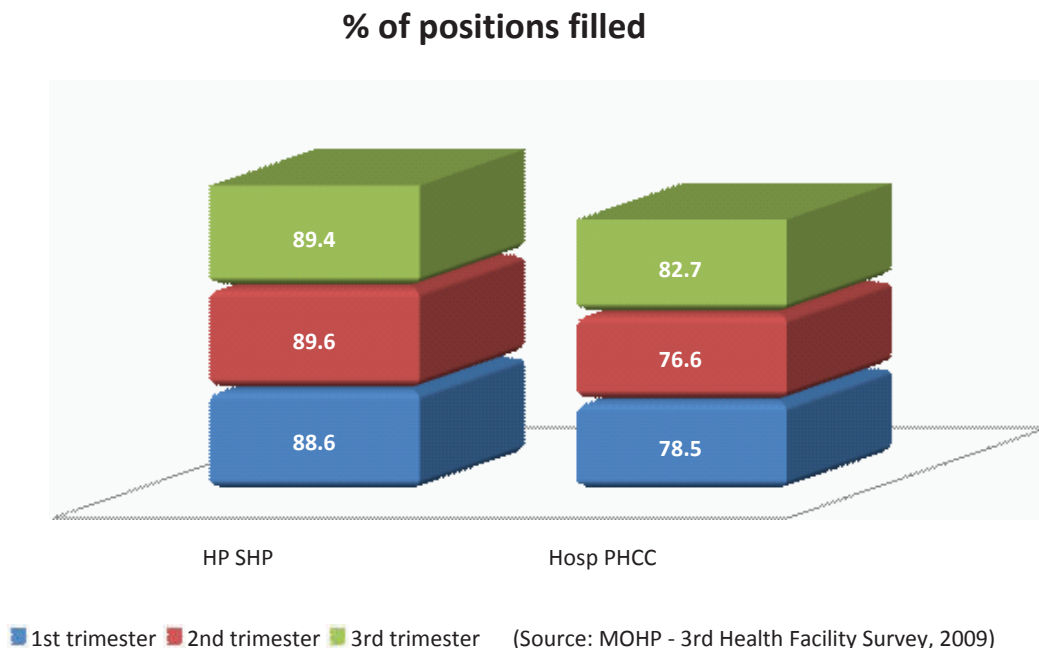
Problems	Frequency (n=168)
Insufficient technical staff due to absenteeism without notice and seconding	41
Lack of coordination between health facilities and the DPHO for approving the leave of subordinate staff	5
Regional and political pressure to transfer, second, or contract with staff	0
Lack of motivation among staff	0

(Source: MOHP, Third Facility survey 2009)

Facility survey (2009) indicated a better picture of staffing at HP and SHP level than at hospitals and PHC level. At HP and SHP level 88 – 89% of position is filled whereas in the same period 76 – 82% was filled at Hospital and PHC level (Table 2). **Unfilled positions at higher level of health institutions is of concern, particularly that of doctors. Clearly, the effort of MoHP in attracting doctors in rural health institutions is partially successful.**

Institution upgrade policy is now being implemented i.e. upgrading SHP to HP, but HR is not well thought out and incomplete – ***an official in Ministry of Health***

Figure 3: Position filled (%) at health facility



4.2 Work division for HR function

In the Ministry three divisions play important roles in HR management: Personnel Administration Division, HR and Finance Division including HuRIS, and Planning Division (for training and scholarship planning/nomination/execution). The central and key role of Personnel Administration Division in the Ministry of Health is well documented. Other divisions (and regional directors) also perform some HR functions, particularly the training and projection of HR for that particular division. The training function appeared widely distributed and all major division are running their programme specific training. Given the huge size of human resources in the ministry and not all HR is governed by a single act/rule, such division and dispersal of HR function is inevitable, what is most important is coordination and harmonisation of such functions (Table 3).

Personal Administration Division is responsible to keep record of all staff including the record of their academic qualifications and trainings received. Such record is expected to provide critical information while designing the training and other HR development activities as well as while nominating staff for national and international training. **This personnel information is important to avoid double or multiple training to some or no training**

to other. But it is not clear how this function is carried out in the Ministry. Harmonisation process and mechanism of HR functions of different division is also not clear.

Table 3: HR functions of different Divisions

Divisions/ sections	Function related to HR
	<p>Full HR related functions managed through specific units (Personal administration unit, promotion unit, records unit and legal unit)</p> <ul style="list-style-type: none">• Policy development, need projection and HR development strategy as well as documentation and record keeping of HR in health, HR information collection, data processing, analysis, and distribution as well as use and publication• Study and research on HR and policy advice on HR production, mobilization and management, Training need assessment, Strengthening training information system• Health system governance and performance• Plan and organize trainings on population aspects <ul style="list-style-type: none">• Coordination of HR projection, identification and mobilization of HR required for hospital through Hospital Development Committee• HR demand, supply and projection planning for HR required for nursing services• Research, study and analysis on standard of nursing services, HR mobilization terms and conditions of services• Prepare plans for up grading nursing services, training, motivation and career development• Coordination on mobilization of nursing staff <ul style="list-style-type: none">• Appointment, posting, transfer and termination• Staff nomination for internal and international training• Personal record keeping and updating• Training and orientation on disaster management <ul style="list-style-type: none">• Record keeping and staff mobilization

- Performance appraisal of staff
 - Appointment, posting, transfer, promotion and termination of staff
 - Nomination for internal and international training, staff motivation
 - Personal record keeping and updating it regularly
 - Position creation and coordination with Public Service Commission, Civil service records
-
- Develop training policy and plan
 - Conducting training (various areas)

Source: MoHP (2068), Annual plan, budget and progress report

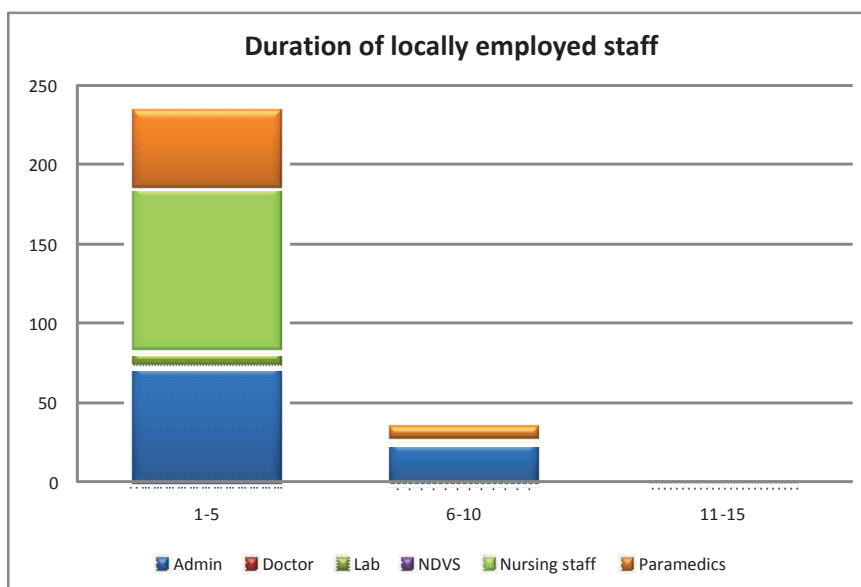
Clearly, there is a need to strengthen the Personnel Administration Division and HURIS so that it can better perform coordinating and harmonising functions. Moreover, NHTC is mandated to develop training policy and plan as well as conduct trainings, a need of direct link and coordination with HR section in the Ministry is apparent.

4.3 Local recruitment policy and practices

The Health Act is restrictive for local employment in the sanctioned post. Other acts (e.g. LSGA 1998) have allowed for flexibility in local resource allocation which is used for recruitment of human resources to meet the acute and specific need at the district (local) level. There is general view that such provision has not only allowed recruiting health personnel at local level at most competitive salary, but also has addressed some of the factors that delays the recruitment from central level. This is further supplemented and complemented subsequent guidelines that have made it mandatory for local governance body to allocate funds to health and social sector. Based on this act and other guidelines, DDCs and VDCs are allocating their resources to 'health' where such allocation is used to meet among other things the acute shortage of health staff in local health institutions. The procedure followed and time taken to employ staff at local level is not known, but it can be assumed that since the decision is made locally, lengthy bureaucratic hassles in central recruitment is overcome at local level.

Though local employment has apparently been in practice for some time now, frequent and adequate use of such provision appears more in recent days as indicated by the Figure 4, where majority of employment were within last five year. **It is important to sustain and systematise this practice while at the same time, proper documentation and recording of such practices is needed.**

Figure 4: Duration of locally employed staff



Source: (data from selected health institutions (total 122) from Achham, Dang, Doti, Kailali, Kalikot, Nawalparasi, Panchthar and Sindhupalchok)

Those who have received government scholarship for MBBS study are now working at different hospitals as part of their 'bond' in receiving government scholarship. It is additional post (not part of regular or permanent post) created specifically for newly graduated doctors. About 200 such doctors are working, but there is no data how many of them continue with government after completion of the bond period.

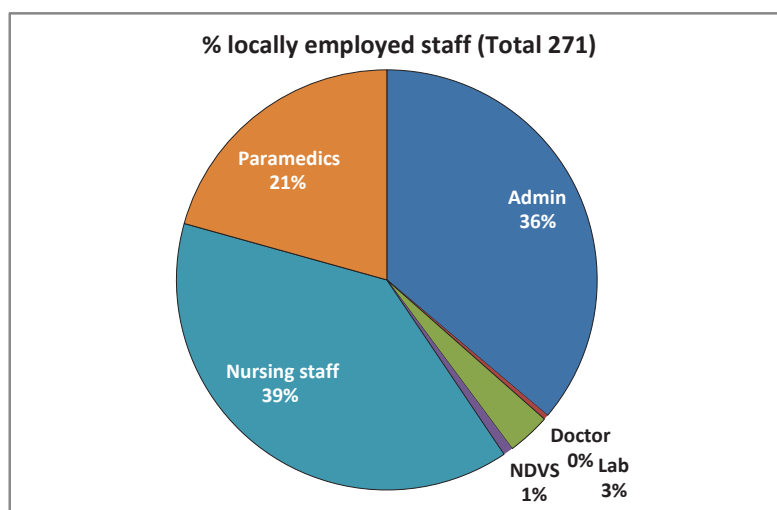
Production of human resource is under Ministry of Education, they sign the bond with the students. After completion of the study, such bond holders are directed to Ministry of Health for employment, but other than for Doctor, there is no any arrangement in MoHP to employ the bond holder. As result, many bond holders either seeking employment elsewhere or unemployed.

Nursing staff (staff nurse, ANMs, MCHWs) are among the highest category of locally employed staff (39%) followed by Administrative staff (36%). Paramedics (HA, AHWs, VHWs) are the third highest category of locally employed staff (Figure 5). It is not clear the reasons for such high demand (or supply) of administrative staff in the local health facilities. **It is therefore worthwhile to explore the role, responsibility and workload of locally employed staff in order for developing an appropriate resource distribution. Task analysis is also important especially of the admin**

staff in local health facilities particularly in those areas where client load are very low. Some HIs are getting support from national volunteer system as well.

In a personal interview with an official, it was indicated that pressure to recruit more nursing staff locally is largely due to government employed nursing staff not performing to their best level.

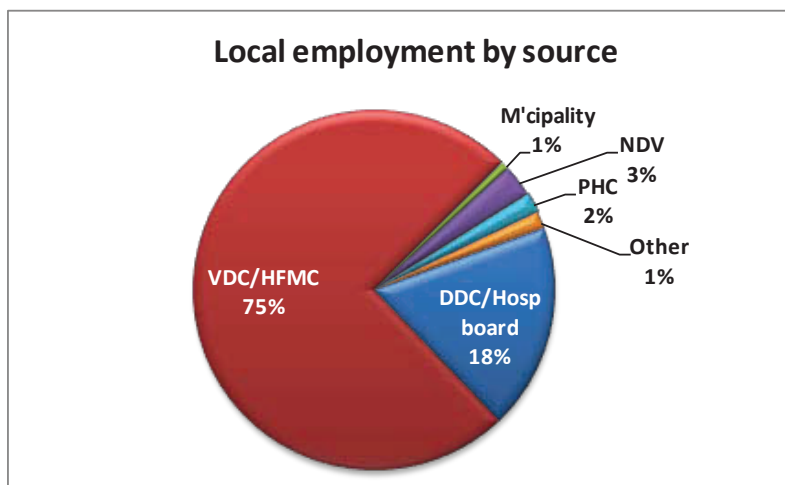
Figure 5: Locally employed staff category (%)²



There are however certain areas that is not yet fully addressed through this practice. There is no proper record of such recruitment at central level as they are out of formal pay roll. Though this practice certainly has ameliorated some the shortage in HR situation at local level, it is difficult to make an assessment whether this practice has been able to address some of the critical issues like, skill mix, quality of service and issue of retention particularly of medical doctors.

Figure 6: Employment by source

² Source: Data from Panchthar, Nawalparasi, Kailali, Kalikot, Dang, Sindhupalchok, Achham, and Doti – representing 271 staff from various health facilities (Hospital, PHC, Ayurvedic facility, HP/SHPs)



Doctors appeared the least employed locally. Doctors were also the least likely member of staff to have a permanent home in the area of the hospital, with only 10% reported to live locally (NSI 2006). **Clearly, the current practice and effort to locally employ health worker need careful**

adjustment to attract doctors in local health institutions. According to NSI (2006) study, 48% of upper and mid-level staff had permanent homes close to the hospital. Therefore it was concluded that the government – along with private partners – has some work to do in developing communities (and local committees) so that they can take some management responsibility for their hospitals at the district hospital.

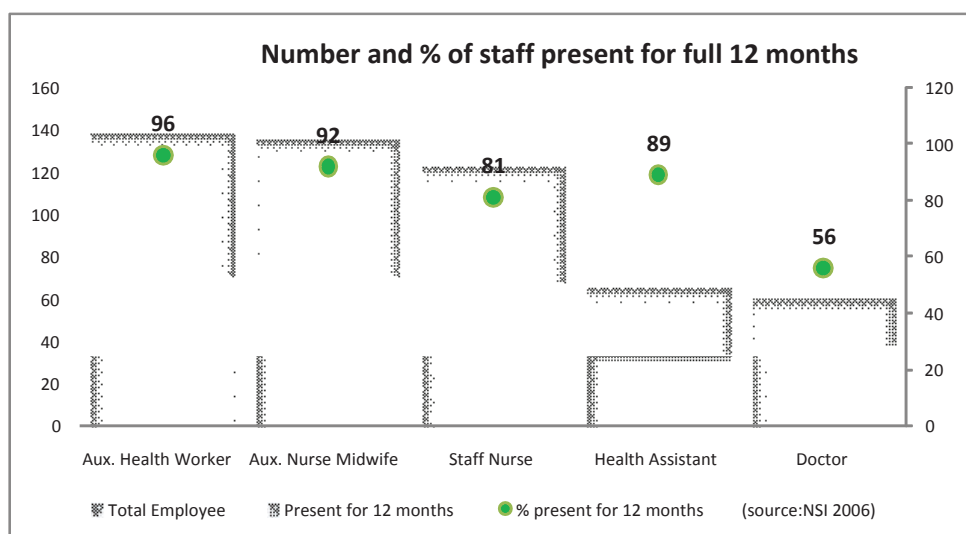
Among the sources that employ the local staff in the health institutions, VDC and HFMC together employs over 70% of staff. Nearly 20% are employed together by Hospital Development Board and DHOs. Clearly, most HFMC and Hospital Board get support from VDC and DDC apart from some resources from some fee or other services. **Evidently, resources and availability of certain level of human resources (nursing and paramedics, for example) appeared not a major issue at the local level. What is necessary is a policy and a framework that allows the local authority to plan and recruit human resources at local level in more systematic manner in addressing the critical HR needs.**

4.4 Absenteeism

Absenteeism is most complicated situation as expressed by many both at Ministry of Health and at DHO level. Even when position is filled, absenteeism from work is widely reported during the field work in 10 BNMT districts. It was also reported from one of the district (Dang) that staffs in HP/SHP have arranged to work in turn i.e. few staff stay full time for certain period (2-3 weeks) when rest of the staff go away for personal work. And those who stayed back go away for personal work when other who was away returns back. This cycle is repeated in turn. This self-arrangement seems working unabated in those areas where client load is low as it is neither complained by

the clients nor picked up by DHO supervision system. Apart from regular annual leave and other normal available holidays, staffs are often seconded (*kaaj*) elsewhere using political or other connection without proper notice to DHO or personnel section in the Ministry of Health and Population. This is extremely complicated situation and is quite rampant at all levels. There is no any record of such movement of staff neither in DHO nor in the MOHP. A study of 23 district hospitals recorded that while overall presence of staff for full 12 months were over 85%, but doctors were present only 56% of their time in the district (NSI 2006)³.

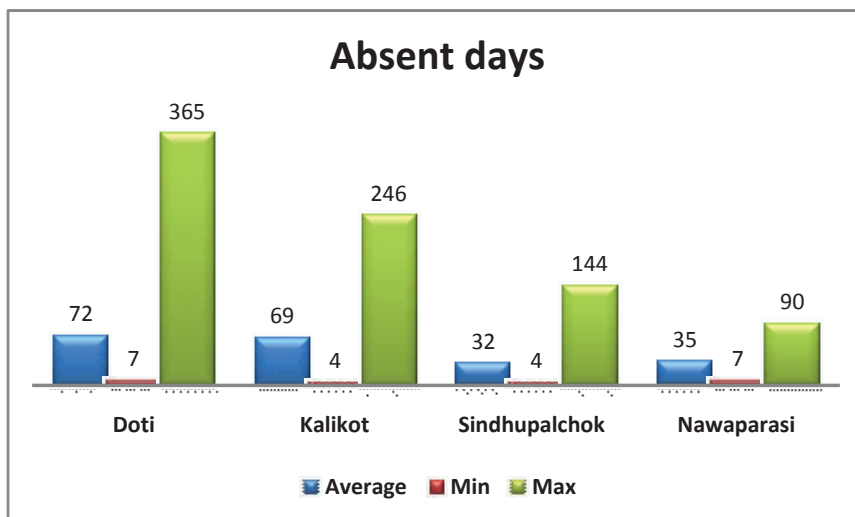
Figure 7: Number of staff present for full 12 months



As discussed in earlier section, nearly 90% of positions are filled at HP/SHP level and about 80% are filled at hospital and PHC level, but often staff are absent for various reasons like leave, sick leave and seconded elsewhere (*Kaaj*). **Data from selected districts indicate as well as reaffirm that remote districts have more absentees than in the less remote districts (Figure 8).**

³ Nick Simons Institute (2006), Deployment of Health Care Workers in Government District Hospital, Nick Simons Institute, Jhamsikhel, Kathmandu, Nepal

Figure 8: Absent days in selected districts

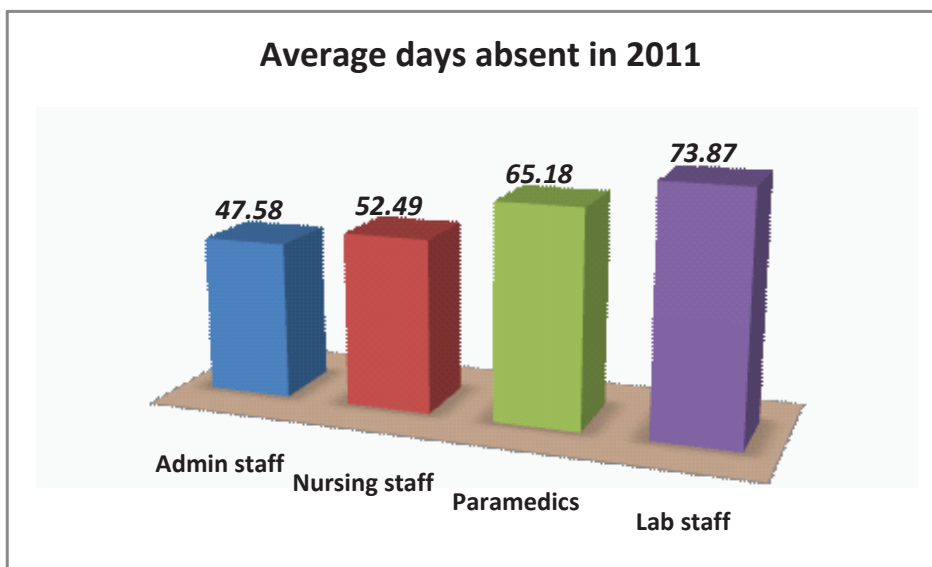


Source/method: Four districts Doti, Kalikot, Sindhupalchok and Nawalparasi (total reporting HIs 46 and 234 staff of all categories) calculated on the basis of 280 days as working days in a year.

In Doti district for example certain staffs are away for more than a year either in *Kaaj* (secondment) or away from work without any specific reasons. In Nawalparasi district the overall absenteeism situation is better for obvious reasons. The most common reasons for long absence from work are away for training and or just away from work with no obvious reasons.

It is also interesting to observe (data from selected districts/health institutions) that average absenteeism is highest among the lab staff i.e. almost 74 average working days absent in 2011 followed by paramedics (all categories combined) who were absent for 65 days in on average in the same period. Admin and nursing staff are relatively less absent than other categories (Figure 9).

Figure 9: Average days absent in 2011⁴



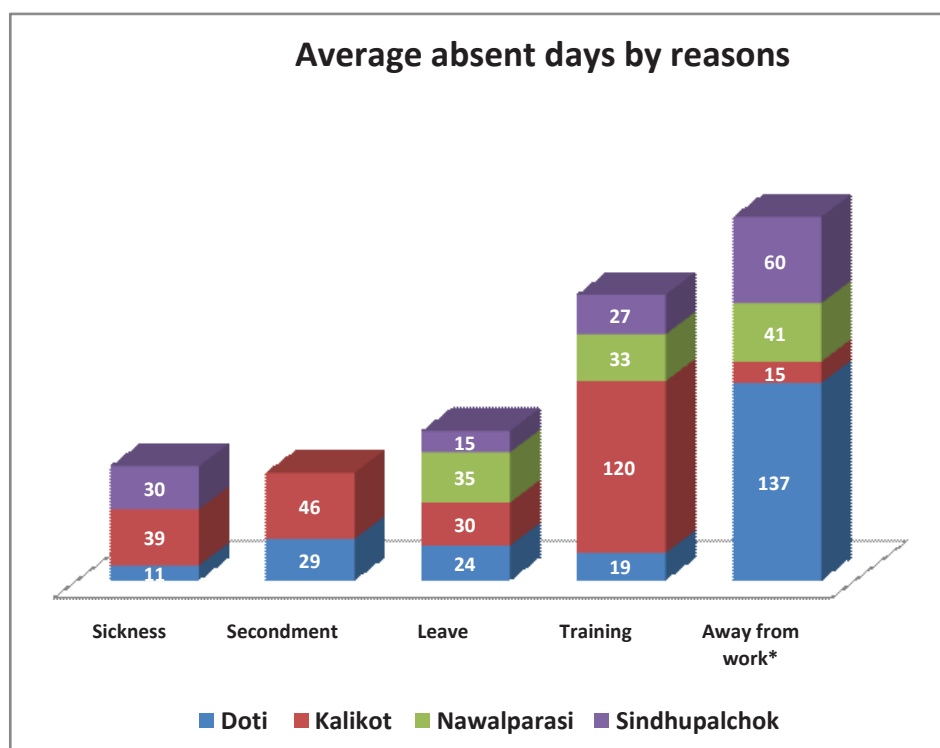
During interview with some DHOs in the districts, it was told that when staffs are nominated for training, they often continue to be away for much longer than the training period for which they were nominated and obtain official extension from higher authority (Regional director, Department or Ministry) for this extended period which is not communicated to district in time. Too many uncoordinated trainings from different divisions is also one of the main reasons of absenteeism. Because of these practices not only the HR data updating is virtually impossible, but also impossible to take official action for such absentees. Sometime when staff gets their *kaaj* extended, they manage to get transfer while still in *kaaj*, and this information comes very late to the districts. This case is also reported from central level that data of *kaaj* and transfer often come very late to HR unit for updating the records. Officials in the Ministry though are discouraging this practice, but tendency is still high because of all sorts of influences used for personal benefit.

In quarterly review meeting at Chautara, in a HP zero achievement against the set target was reported (staff being away most of the time), but attendance record submitted for salary release show full attendance of all staff – **a case reported from Sindhupalchok district**

Data from selected districts health facilities indicates that most common reasons for absenteeism is secondment, training and away from work without any reasons (Figure 10).

⁴ Data source and method: Weighted average based on number of districts and reporting staff in each category. See Annex 1 for detail data.

Figure 10: Absent days by reasons



Note: Data from Doti, Kalikot, Sindhupalchok and Nawalparasi (total reporting HIs 46 and 234 staff) calculated on the basis of 280 days as working days in a year. Number of staff and health institutions reporting absenteeism data varies and not proportionate (refer to Annex 1: Additional data), therefore average reported days varies.

4.5 Transfer

Transfer has been a major workload and political manoeuvring both at Department of Health and at Ministry of health level and also a major reason for high turnover of the staff. It eats up considerable time of senior officials both in taking official decision as well as entertaining and responding to the requests from staff and from political peoples.

Transfer is inextricably linked with *kaaj* as the first step of transfer. When formal transfer is not possible, staffs are put in *kaaj* for longer period against policy – which is later changed to proper transfer. As reported, this is often done to avoid unnecessary pressure and influence.

Data from selected facility indicated that transfer seeking tendency is very high among the staff who are within 5 year of service i.e. 60 months (Figure 11).

But the staffs who have already served longer in the current position normally did not seek transfer. One of the reasons could be that they might have found right place and are quite content in the current posting in terms of the location.

Figure 11: Staff seeking transfer⁵

Staff seeking transfer (%) n=164		
Months in current position	301-360	0.61
	241-300	0.61
	181-240	1.83
	121-180	6.71
	61-120	17.68
	1-60	71.34
	Unknown	1.22

The reasons for seeking transfer for almost all staff cited to be in hometown or to be with family members (91%). Government has policy to support staff seeking transfer near or at the hometown or if couple, posting at the same district. While this is very encouraging and pro staff policy, its success also appeared only partial as indicated by the data. In absence of a comprehensive national or district data on transfer, further analysis in terms of frequency of transfer, overall %age of health staff seeking transfer, meeting the need of staff in transfer and its effect on work performance is not possible to make in the

current assessment.

4.6 Performance appraisal and motivation

There is an extensive performance appraisal system in place to all civil servants including health professional. All permanent employees are required to undergo yearly performance appraisal system with the supervisor (often the chief of the office). This is a two way process where both staff and supervisor can share their views regarding performance and score. Despite its

⁵ Source of data Achham, Dang, Doti, Kailali, Kalikot, Nawalparasi, Panchthar, Sindhupalchok, district with 164 staff (Paramedics 98, Nursing staff 48, Doctor 6, Lab 5, Ayurved 5 and Admin 6) reporting the data

comprehensiveness, the PAR is very subjective and is not based on performance measurement indices or targets. As a result, the PAR has remained a ritual task.

But use of performance appraisal is very limited. It is used only at the time of promotion to calculate the total score. **There is no mechanism to review and analyse the performance appraisals to inform managers and policy makers. Since such documents are to be treated confidential by rule, is not available for academic research and analysis either.**

Recently, during promotion to Joint Secretary Level (5 positions) from Undersecretary Level, some 60 performance appraisals of eligible candidates were reviewed. It was noticed that out of 60, 53 had received 'excellent' grading. This show level of 'seriousness' of supervisor (or lack of it) while grading the performance. Supervisor often do not want to be called 'bad' by not giving higher grade during performance appraisal

Opportunity for training/scholarship is being used as an incentive or a reward for good work and a strong motivational factor as well as for skills development. But health staffs often complain that nomination for training is biased and preferred to those who are near and dear of the boss. Motivation of health staff varies considerably depending on level and positions they work. For example, a married couple working in a health post appeared very happy and motivated largely because they were posted together in the same place. To some, training has been a motivating factor. **Generally, discussion with field staff clearly indicates a mix level of motivation among the health care providers.**

In order to maintain high performance standard and keep staff motivated, accountability and performance based incentive is very critical – ***an official at Ministry of Health***

Moreover, health service is classified into different group i.e Anaesthesia group, lab group, administration group etc. where career path and incentives rule are not the same. **Besides, there is no individual job description against which performance of an individual could be measured, nor can the individual be made accountable to specific task. This has not only affected the motivation of the staff, but also is an HR management issue.**

There are advantage and disadvantage of having local staff at the local health institution including district hospital.

Performance of local staff is often questioned – as they become part of local politics and try to influence normal working procedure including decision of Health Management Facility or District Health Management Committee. Moreover, they do not easily accept ‘outsider’ as their boss.

If they do not become part of local politics they face number of pressure and threat for transfer – a case reported by one of the district where BNMT has HR programme – ***a case reported from Dang district***

4.7 Budget analysis

Financial and budgetary data is not readily available. There is no mechanism to collect and analyse the financial information both at centre and at district levels. District authorities are often reluctant to share financial information. Moreover the method of data keeping is such that extracting desire set of information is almost impossible.

Data from MOHP budget analysis shows that of the total HR budget (which is 16 - 19% of total MOHP budget), 85 -90% are allocated to salary and allowances. HR development related cost (post basic training, training and other HR support cost etc) is not available – though it is an established practice that programme related training or HR development cost are included in the respective divisions and in the programmes. **It is essential that post basic training and other management training are provided to health workers in order to improve their management and HR related functions.**

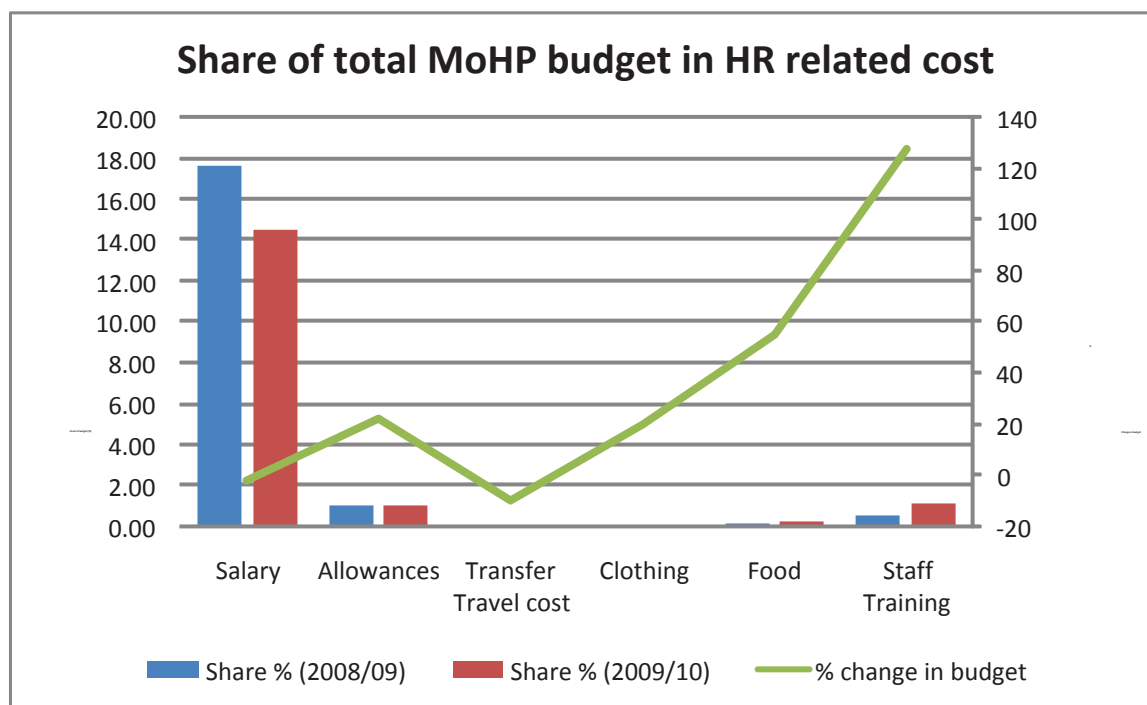
Management and administration is a large part of mid level health care providers’ job responsibilities. **The assessment of management knowledge showed a weakness in basic management principals as well as a lack of understanding of how to correct problems in such areas as public relations, resources or personnel issues within a health post (NIS 2007, P 21)**

The budget analysis also indicated that other than salary line items, the budget in other HR related items has sharp increase from previous years. There is no explanation on such sharp and sudden rise in training related cost

from the year 2008/09 to 2009/10 (Figure 12), despite the fact that most of technical and programmatic trainings are budgeted under respective programme budget.

Region and District do have delegated authority for many HR and finance related functions – but do not exercise such authority and look for central guidance. This is general problem of the bureaucracy not just in health sector

Figure 12: Share of MoHP budget in HR related cost



It is very difficult to ascertain the budget allocation policy in trainings for civil servants where it is specified that 5% of training budget from each ministry/department/units to be allocated for human resource development related activities (Civil Servant Training Policy 2058)

Enforcing law and maintaining discipline is major problem in HR management at district level because of unionisation and political party lobbying – ***an officer at Sindhupalchok district***

5. Discussions and recommendation

Ministry of health is largest employer and constitutes about one-third (approx. 30,000) of total personnel of the public sector. There are different category of staff in Ministry of Health under different acts and rules. In other words, **not all staff working in MOHP are governed by a single act.** Current approaches in human resources suggest a number of weaknesses: a reactive, ad hoc attitude towards problems of human resources; dispersal of accountability within human resources management (HRM); a limited notion of personnel administration that fails to encompass all aspects of HRM; and finally the short-term perspective of HRM (MoHP 2009).

Recommendation 1

As there are many unachieved strategic direction in HR Strategy 2003, there is a need to review of the policy and the strategy – which is already progressing and is expected to be ready soon. The HR (HuRDIS and Personnel Administration) unit in the ministry needs strengthened to make it more functional not only to manage the day to day affairs but also to implement and monitor the HR new strategy as well as coordination and harmonization among other divisions who also do have some HR functions.

A comprehensive strategy must include ensuring a quality pre-service education as well as in-service training in the clinical skills of curative medicine (NSI 2007) the largest and most concerning performance gap is in the area of maternity care.

Recommendation 2

It is recommended that a policy and a framework within the HR strategy that allows the local authority to plan and recruit human resources at local level in more systematic manner addressing the critical HR needs, be developed. As such, a mechanism to document, record and update information on local recruitment needs to be in place. It is expected that new HR strategy will take into account of this. Since the current procurement act is more suitable for procurement of goods and services, it is necessary to review/amend the provision regarding recruitment of staff.

Recommendation 3

It has been widely recognised that health workers are required to engage in routine management responsibilities for which they are not prepared or trained. Therefore many would not be able to fulfil basic management responsibility. Management training to health workers particularly to the newly appointed doctors and public health officers is essential. Organisations working

in the district (e.g. BNMT), in collaboration with Ministry of Health should explore the possibility of designing and organising management trainings.

Recommendation 4

Despite recognition and appreciation of their important and crucial role in health care delivery, FCHVs are struggling for secure a position at health system. **Nonetheless, it is extremely important to continue motivating them and acquiring their services.**

Recommendation 5

A mechanism needs to be put in place to monitor the absenteeism and for remedial action at the district and facility level. Potentially, HFMC should be able to do this. For this as well as for better engagement in HR at local level, some training and or a hand book to HFMC would be useful. Emphasis should be on adapting existing MoHP hand book.

Recommendation 6

A method to make the PAR more scientific and achievement based is should be instituted to address some of the grievances regarding motivation, opportunity for training and promotion. It should be more open and made available for managers to make management decision as well as for academic analysis/research.

6. References

- Govt. of Nepal (1999), Nepal Health Service Rules, 2055 (1999), Nepal Law Commission <http://www.lawcommission.gov.np/>
- MoGA (2011), Governance Bulletin June/July 2011, Vol-15, Ministry of General Administration Kathmandu
- MoGA, Civil servant National Training Policy 2058
- MoHP (2003), Strategic Plan for Human Resource for Health (2003 – 2017), Ministry of Health, Kathmandu
- MoHP (2009), Health Care Policy, Third Trimester Health Facility Survey Report (HSRSP Report No. 2.17-12-09)
- MoHP (2010), HR capacity assessment report (unpublished), Ministry of Health, Kathmandu
- MoHP (2010), Nepal health sector programme implementation Plan ii (NHSPIP - 2) 2010 – 2015, Ministry of Health and Population, Kathmandu
- MOHP/RTI/CARE (December 2009). Assessing Implementation of Nepal's Free
- Nick Simons Institute (2007), Measuring the Quality of Rural Based Government Mid-level Health Care Workers, A clinical Assessment August 2007 (www.nsi.edu.np)
- Seble Frehywot, a Fitzhugh Mullan, a Perry W Paynea & Heather Rossa (2010), Bulletin of World Health Organisation 2010; 88: 364–370
- Shah M (2009), Health manpower development in Nepal: A historical perspective, Kathmandu University Medical Journal (2009), Vol. 7, No. 3, Issue 27, 325-327.
- Shakya. R (Dr.) (2009), Why Civil Service Reforms fail? – A Case of Nepal, Administration and Management Review Volume 21, No.2, August, 2009
- WHO (2008), Kampala Declaration and agenda for global action

WHO (2010), The WHO Global CODE of Practice on the International Recruitment of Health Personnel, Sixty-third World Health Assembly - WHA63.16

WHO (2010), WHO Global Code of Practice on the International Recruitment of Health Personnel Sixty-third World Health Assembly - WHA63.16 May 2010

7. Annexes

Annex 1: Additional data

A. Absenteeism reported by

Districts	# of HIs	staff	Sickness	Leave	Training	Secondment	Away from work
Kalikot	18	84	1	65	2	72	23
Doti	19	92	84	2	65	83	7
Sindhupalchok	4	46	1	39	28		2
Nawalparasi	5	12		4	5		3
Total	46	234	86	110	100	155	35

B. Reasons for seeking transfer

Staff category	Better place	Further Study	Home town	Physical problem	Unknown	Children education	Grand Total
Admin			6				6
Ayurved			5				5
Doctor		2	2		2		6
Lab			5				5
Nursing staff		1	42			1	44
Paramedics	1	2	90	1	3	1	98
Grand Total	1	5	150	1	5	2	164
%	0.61	3.05	91.46	0.61	3.05	1.22	100.00

Absenteeism by category (detail data for figure 9)

Method used: Weighted average

Admin staff				
Row Labels	Count of Total absent	Sum of Total absent	simple avg	
Doti	16	1026	64.1	
Kalikot	24	1422	59.3	
Sindhupalchok	6	86	14.3	

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Achham	12	168	14.0
Weighted avg.	47.58		37.9
Nursing staff			
Row Labels	Count of Total absent	Sum of Total absent	simple avg
Doti	31	1544	49.8
Kalikot	19	1225	64.5
Nawalparasi	4	200	50.0
Sindhupalchok	14	507	36.2
Achham	21	1107	52.7
Weighted avg.	52.49		50.6
Lab staff			
Row Labels	Count of Total absent	Sum of Total absent	Simple avg
Doti	3	113	37.67
Kalikot	2	298	149.00
Sindhupalchok	1	66	66.00
Achham	2	106	53.00
Weighted avg.	73.87		
Paramedics			
Row Labels	Count of Total absent	Sum of Total absent	Simple avg
Doti	42	3992	95.05
Kalikot	34	2346	69.00
Nawalparasi	7	212	30.29
Sindhupalchok	23	768	33.39
Achham	49	2630	53.67
Weighted avg.	65.18		56.27

Annex 2: Key questions and tools to collect data

Review of Existing Policies, HRH database and Identification of gaps

Key areas, key question and Tools for assessing existing situation and gap in policies and practices in Human Resource Management in Health Care Delivery at public sector. It may not be possible to get answer to all Key questions during the current work; however it will be useful to make effort in collecting as much information as possible along these lines.

Key areas	Key Questions	Source of information	Tools
Policy environment	<ol style="list-style-type: none"> 1. What is the HR Policy as part of National health policy 2. How does the policy takes into account of international policy, commitments, guidelines and best practices – instruments, 3. How policy address issue of recruitment, deployment, and retention of Health workforce 4. How the HR is developed and deployed in addressing to emerging health problems (NCD, traditional vs modern health service), work load 	<ol style="list-style-type: none"> 1. Health Policy; NHSP-2; Report of Administrative Reform Commission; Health Service Act 2. WHO Documents, HSS guidelines (Health workforce is one of the building block) 3. MLD/LCGDP documents (report from Kopila) 4. MOWSC – women involved in health sector – training plan....National Plan of Action Zero 	<ol style="list-style-type: none"> a. Document Review b. Questionnaire, checklist (KII)

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Key areas	Key Questions	Source information	of Tools
	(by geographical area, urban/rural) 5. What are the gaps	tolerance for GBV	
Personnel system	1. Does health workforce plan exists 2. What is the staffing pattern (gender equity, geographical and ethnic balance) 3. How recruitments, hiring and deployment is done (some time NGO employ health staff in HP) 4. How Performance Appraisal is conducted, how the information is used (reward/punishment, transfer, promotion, training and skill development, mentoring and support) 5. Job description – is it available to all? How it is developed, how the performance is ensured 6. How training and other HRD issues/need is addressed (i.e. new and emerging issues in health not	1. HRH Plan (MoHP), NHSP 2, Health Act, Health Facility Survey report 2. HURIS data 3. In depth Interview with key officials 4.	a. Document review b. Questionnaire, check list

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Key areas	Key Questions	Source information	of Tools
	<p>informed/trained to field health workers)</p> <p>7. Follow up of training – how it is done?</p> <p>8. कार्य सम्पादन मुल्याङ्कन फारम, How it is used. Any data analysed so far?</p>		
Work environment and conditions	<p>1. Workplace safety regulation</p> <p>2. Job satisfaction – how it is assessed and addressed</p> <p>3. Home district deployment (rule is if both husband and wife are working – they are to be posted in same district)</p> <p>4. Career development opportunity and plan – does it exist? If so in what way it is put into practice?</p> <p>5. How private practice is affecting health delivery at public facilities</p>	<p>1. Policy documents; regulations</p> <p>2. KII</p>	<p>a. Document review</p> <p>b. Questionnaire, check list</p>
HR Information system	<p>1. How is the system designed, what kind of information it collects, analyse and use</p> <p>2. How the HR Information is used (purpose, frequency)</p>	<p>1. HR manuals (?), guidelines, policy documents</p> <p>2. KII</p>	

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Key areas	Key Questions	Source information	of Tools
	3. What are the strengths and weakness of current HuRIS system		
HR financing	1. How Budget and expenditure are made for HR, in relation to overall health spending 2. Is HR financing adequate? Are there any gaps 3. How Local Government (DDC, VDC) allocate financing for Human Resources, what category is funded by local authority 4. Actual spending in HR budget by category (doctor, nurses, HA/AHWs, Admin)	1. National Health Accounts; budget book, expenditure records 2. DDC/VDC budget and expenditure record 3. KII, District data	a. Document review b. DDC/VDC/ DHO records from selected districts c. Questionnaire and check lists
Additional	1. How FCHVs are considered in HR for health		

Annex 3: People met

Kaviraj Khanal	-	Ministry of Health
Dr Naresh Pratap KC	-	Family Health Division, Dept of Health Services
Mr. Ramchandra Man Singh		NHSSP/DFID
Homnath Subedi	-	NHSSP/DFID
Dr. Rajendra Konju	-	Dhulikhel Hospital
Dilip Lama	-	Acct. DHO Sindhupalchok
DHOs and other health staff at BNMT working districts		