Improving government district hospitals through an integrated programme of health worker environmental support in Nepal

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**Challenges**
Training itself is not sufficient to meet the goal of an improved rural health workforce. The ‘push-pull’ factors affecting retention of health workers in remote locations in Nepal has been well documented. Even well-trained workers depend on an enabling work environment to be productive. Studies relating to retention of health workers tended to focus on single environmental factors or to advocate short-term interventions.

In 2006, the Nepal National Health Training Center and the Nick Simons Institute saw the need for a staff support programme that would be comprehensive, ongoing, and dynamic. They sought to design a programme, learn from experience, and continue to refine it as they rolled it out.

**Project description**

The two organizations set out to identify three government district hospitals in which to pilot the Rural Staff Support Program (RSSP). Their criteria were: (1) underutilization; (2) adequate infrastructure; (3) location in remote and economically deprived areas; and (4) existence of motivated hospital support committees.

The RSSP included:

- **Communication**: providing a VSAT satellite dish, computers, and internet bandwidth, so as to reduce isolation
- **Continuing Medical Education**: based on the hospital’s identified needs, the programme sent staff on in-service courses, most under the NHTC. NSI also developed a distance continuing medical education (CME) programme on CD ROM for doctors to conduct self-study at home.
- **Community Governance**: supporting the hospital committee in assuming a higher level of autonomy and facilitating team-building exercises and visits to model rural hospitals.
- **Connection with Larger Hospital**: linking the district hospital with a larger hospital in the region; the programme conducted interaction meetings on a yearly basis and facilitated short-term staff exchange.
- **Children’s Education**: supporting the education of staff children, through two methods: a teacher training program to improve local schools, and a small education allowance for staff who have children aged 5-16 years.
- **Capital Stipend**: based on the hospital’s yearly assessed needs, the programme provided a modest stipend to ‘fill gaps’ in the hospital’s equipment.

RSSP’s ‘7 Cs’ were administered by a single programme officer located in NSI, who worked closely with the district hospital’s medical superintendent and with the NHTC.

In September 2007, some components such as VSAT communication had immediate impact; the committees became more active, staff control panels were set up. Other aspects came more slowly: the children’s education programme and the MDGP scholarship programme both had long development lags; the CORE programme sent staff to training in stages. The most marked change occurred with provision of the general practitioners (GP) to the hospital. Once communities became aware that operations and other procedures were being done, patient flow increased in all areas. In the districts where the GP has been the longest, the programme has had the most success. In the districts without a GP, the results have been more modest.

An improved programme, based on findings from a mid-term assessment, is likely to expand to new district hospitals, but this number is still to be decided.

**Outcomes**

The programme’s main success indicators are (1) an increase in patient utilization; (2) increased C-section capability; and (3) provision of training by the district hospital for remote district staff.

**Conclusions**

Nepal’s Rural Staff Support Program has made a good start at enhancing the performance of remote health care workers through a diverse package of environmental supports. While the programme was essential at the start, it needs to be part of an ongoing process of trial, refinement, and scaled-up implementation.