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Role of Civil Society in Human Resources for Health Management in Nepal

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ABSTRACT

Background: The policy document of Nepal has spelled out commitment to involving civil society organisations (CSOs) in improving human resources for health (HRH). However, lack of empirical evidences, it is very hard to figure out exact situation about the roles and engagement of CSOs in HRH management.

Methods: A cross-sectional descriptive study was conducted using both quantitative and qualitative methods. Out of 404 sample health institutions, 747 health workforce from 375 health institutions were interviewed (<10% non-response rate) using the probability proportionate to size method as per World Health Organization (WHO) guidelines.

Results: Nearly 75% respondents had opined that the political parties were supporting the health institutions in the grassroots. It was found that the support from the CSO was better in Hill (54.9%) compared to Terai (46.9%) and Mountain (46.7%). The support was significantly different between rural (CI: 0.5063-0.591) and urban (CI: 0.3055-0.4363) ($p < 0.05$, CI 95%). Mean index score of effectiveness of CSOs was found highest in Hills (0.3036) followed by Mountains (0.2669) and Terai (0.2589). Effectiveness of CSOs was found positively correlated with feeling of security by health workers and social prestige.

Conclusions: The roles of civil society in HRH management still need to be recognized and well documented ensuring their active participation in formulation and implementation of policies, strategies and planning related to HRH for effective and quality healthcare services in Nepal.

Keywords: civil society; human resources for health; Nepal; roles.

INTRODUCTION

Civil society has been defined as the general public representing the social domain that is not part of the state or the market; or the arena of un-coerced collective action around shared interests, purposes and benefits.[1,2] It consists of mutual and public benefit related organisations such as non-governmental organisations, community groups, women's organisations, faith-based organisations, professional associations, trade unions, self-help groups, coalitions and advocacy groups.[3,4]

Current national health policies and strategies of Nepal illustrate the government's commitment to involving civil society organisations in improving human resources for health (HRH) through the decentralisation of health service delivery and the handover of these facilities to the health facility operation and management committees (HFOMCs).[5-8] In this study, the HFOMCs, political parties, non-governmental organizations (NGOs), youth groups, mother groups and other local level organisations are considered the envoys of civil societies.

The overall objective of this study is to analyse the role of civil society engagement in human resources for health in enhancing the health service delivery in Nepal.

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METHODOLOGY

Study design

A cross-sectional descriptive study, using quantitative research method was conducted to obtain comprehensive information on the Human Resources for Health (HRH) situation of the country.

Sample Design for primary data collection

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

Table 1. Selected districts for research study, Nepal 2011.

Ecological Belt \ Development Region	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 5,146 health institutions in the selected 15 districts, including government hospitals (regional, zonal or district), primary health centers, 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.[9] 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, resulting a response rate of 93 percent.

Structured questionnaire was administered to 747 health workers (doctors, nurses, midwives, public health workers, health assistants, auxiliary health workers, laboratory technicians, radiographers, and pharmacists etc.) from the 375 selected health institutions in 15 districts, following the WHO guidelines.[9] 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.

Data analysis

Quantitative data was entered into a computer software system (Epi Data 3.1) by trained data entry personnel. In order to validate the data, 10% was randomly crosschecked. After editing and cleaning, statistical package for social sciences (SPSS) v16.0 was used for analysis.

Validity and Reliability

To ensure valid and reliable research, WHO standard statistical tools were used to determine the sample size and to reduce systematic error in the design phase of the study. Internal consistency reliability was ensured in quantitative data analysis by obtaining Cronbach's Alpha on key variables (>0.85). To avoid questionnaire information bias, pre-testing was done in three districts, and feedback from the pre-test was incorporated into the final questionnaire design to improve validity and reliability. Similarly, interviewers were also trained using WHO standard protocols. Triangulation of primary and secondary data ensured consistency of the research data.

Ethical approval

Ethical approval for this study was obtained from the Nepal Health Research Council (NHRC). Researchers adhered to national NHRC standard operating procedures and ethical guidelines for health research. Prior to the interview, informed consent taken and confidentiality of participants ensured at every step of the research by maintaining the anonymity.

RESULTS

Out of total 747 respondents, 297 (39.76%) were male and 450 (60.24%) were female health workers. The mean age of respondents was 35.33 years (SD ±9.58 years). Most of the respondents were currently married 522 (69.88%) followed by never married 154 (20.62%), separated 64 (8.57%) remaining were married but not cohabitation (0.67%) and widow/widower (0.27%). Ethnic distribution of respondents showed that most of the respondents were Hill High Castes 436 (58.37%) followed by Hill Janajati 134 (17.94%). Majority of respondents were from Terai belt 354 (47.39%) followed by Hill belt 273 (36.55%) and Mountain 120 (16.06%). Similarly, respondents from rural setting were 534 (71.49%) and urban setting was 213 (28.51%).

This study used the designations of health workers under Ministry of Health and Population (MoHP) based on the Nepal Health Service Regulation 1999[10] (Table 2). The designations of respondents showed that about one-third (31.59%) of the respondents were gazetted with 25.70% third class officers. Similarly, 68.49% of the respondents were non-gazetted (NG) level with 47.26% NG fifth level and 20.21% NG fourth level. Among total respondents, 80 (10.71%) were doctors, 376 (50.33%) were health assistant/community medical assistant (HA/CMA) paramedical, 235 (31.46%) were nurses/auxiliary nurse midwives (ANMs) and remaining 56 (7.50%) were technicians (medical laboratory and radiography) (Table 3).

Table 2. Classification of the designations of health workforce.

Class according to Civil Service	Level in Health Services	Designations of Health Workforce
Non-gazetted 3rd	3rd	Village Health Worker (VHW)/Maternal and Child Health Worker (MCHW)
Non-gazetted 2nd	4th	Auxiliary Health Worker (AHWs)/ Auxiliary Nurse Midwive (ANMs)
Non-gazetted 1st	5th	Health Assistant (HA)/ Staff Nurse (SN)/S. AHW/ Sr.ANM etc.
Gazetted 3rd	6th	Public Health Inspector (PHI), Hospital Nursing Inspector (HNI) etc.
Gazetted 3rd	7th	Public Health Officer (PHO), Nursing Officer, Health Ediucation Instructor (HEI) etc.
Gazetted 3rd	8th	Medical Officer (MO)/Sr. PHO/Sr. HNO etc.
Gazetted 2nd	9th	Sr. Medical Officer/ Medical Consultant/ Public Health Administrator (PHA)/ Nursing Administrator etc.
Gazetted 2nd	10th	Sr. Medical Consultant, Medical Superintendent, Sr. PHA etc.
Gazetted 1st	11th	Chief Consultants Physicians/Surgeon, Directors, Chief PHA etc.
Gazetted 1st	12th	Director General, Chief Expert

Source: Nepal Health Service Regulation 1999 (2nd Amendment 2005)

Table 3. Distribution of respondents according to health institutions.

SN	Type of Institutions	Number	Percentage
1	Hospital	106	14.19
2	Primary Healthcare Center (PHCC)	52	6.96
3	Health Post (HP)	121	16.20
4	Sub-Health Post (SHP)	276	36.95
5	Ayurvedic Centers/ Ausadhalaya	35	4.69
6	Private Clinic/Hospital	55	7.36
7	I/NGO Clinic/Hospital	102	13.65

Source: HRH Field Survey 2011/SOLID Nepal

Support from CSOs to health institutions

Support from the CSO was found better in Hill (54.9%) compared to Terai (46.9%) and Mountain (46.7%) among the ecological belts. Among the development regions, supports in western development region (WDR) excelled (61.2%) others, followed by (51.5%) in mid-western development region (MWDR), (51.3%) eastern development region (EDR), and (45.4%) far western development region (FWDR) and finally the central development region (CDR) (43.8%) at the lowest position. When observed the level of supports by urban rural difference the rural area was found better (54.9%) (CI: 0.5063-0.591) compared to urban (37.1%) (CI: 0.3055-0.4363) in supports rendered by the CSOs. The statistical analysis of urban-rural support of CSOs was significantly different (CI: 95%; p= <0.05) (Table 4).

Supports from Political Parties and Common People

Altogether three fourth of the respondents (74.3%) had opinion that the political parties were supporting the health institutions in the grassroots. The urban areas had obtained less supports compared to their rural counterparts. The PHCs, Health Post and Sub-Health Posts excelled in obtaining supports from the political leaders and local communities in total.

Reward to the Health Personnel by CSOs

Rewards provided to the health workers by CSOs is an important indicator to show the relationship between them. Altogether, 7.5% of respondents were aware of the rewards system. In general, more than 92% of interviewed health workers were not aware that local communities rewarded Health Workers for their good services (Figure 1). A communication gap between the HRHs and local civil society is suggested by this situation- almost all HRHs had no idea about the local communities' rewards systems. It indicated the need for rethinking in the tradition of 'expression of thanks' in the oriental societies.

Table 4. Support from CSOs to health institutions with respect to their localities.

Locality	Number	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Min	Max
					Lower Bound	Upper Bound		
Rural	534	0.5487	0.49809	0.02155	0.5063	0.591	0	1
Urban	213	0.3709	0.48418	0.03318	0.3055	0.4363	0	1
Total	747	0.498	0.50033	0.01831	0.4621	0.5339	0	1
Analysis of Variance			Sum of Squares	df	Mean Square		F	Sig.
Between Groups			4.813	1	4.813		19.71	< 0.05

Source: HRH Field Survey 2011/SOLID Nepal

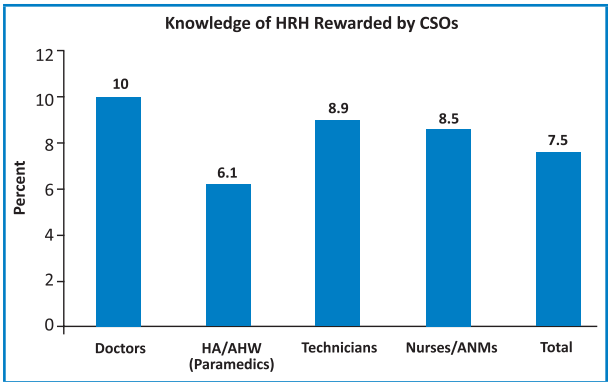

Figure 1. Knowledge on HRH rewarded by CSOs.

Source: HRH Field Survey 2011/SOLID Nepal

Role of CSOs from Health workers perspectives

Almost four out of five (79.0%) health workers opined that the roles of civil societies in their workplace were just satisfactory. However, nearly one out of five (17.3%) had perceived that the CSOs in local level were excellent. This figure indicates that CSOs have some meaningful representations in the community level health services, which further needs to be re-strengthened and functional as supportive agencies to the health institutions. A very few health workers (3.7%) thought that behaviour of the CSOs was unacceptable (Table 5).

Table 5. Index of effectiveness of civil society and perception of social behaviors of CSOs.

Index of Effectiveness of Civil Society	Perception towards Social Behaviour of CSOs					
	Excellent		Satisfactory		Not Acceptable	
	Number	%	Number	%	Number	%
Low	26	11.2	198	85.0	9	3.9
Medium	46	16.8	214	78.1	14	5.1
High	57	23.8	178	74.2	5	2.1
Total	129	17.3	590	79.0	28	3.7

Source: HRH Field Survey 2011/SOLID Nepal

Effectiveness of CSOs and perception of HRHs towards the social life in the work place

A clear-cut positive direction was observed between the effectiveness of CSOs and perception of HRHs towards the social life in the work place. This positivity indicated that in the areas where the CSOs had high effectiveness, the health workers had perceived as good places to live in and work. Its statistical association examined with Gamma coefficients showed a positive association (0.259) with 99.9% level of significance (Table 6).

Effectiveness of CSOs and feeling of security by Health Worker

The analysis of effectiveness of Civil Society and feeling of safety at workplace showed that altogether 77.5% of health workers felt safe. Further analysis showed that 85% of health workers felt safe among the health workers residing in area with high effectiveness of CSOs and the feeling of safety was lower (69%) among the health workers residing in area with low effectiveness of CSOs (Table 7).

Table 6. Index of effectiveness of civil society and social life in work place of HRH.

Index of Effectiveness of Civil Society	Social Life in Work Place				Row Total
	Not Good		Good		
	Number	%	Number	%	
Low	49	21.03	184	78.97	233
Medium	51	18.61	223	81.39	274
High	24	10.00	216	90.00	240
Column Total	124	16.60	623	83.40	

Statistical Examination of Ordinal Scale Variables

Ordinal by Ordinal	Value	Asymp. Std. Error(a)	Approx. T(b)	Approx. Sig.
Gamma (γ)	0.259	0.074	3.360	0.001
No. of Valid Cases	747			

Source: HRH Field Survey 2011/SOLID Nepal

Table 7. Index of effectiveness of civil society and feeling of safety at workplace.

Index of Effectiveness of Civil Society	Feeling of Safety at Workplace						Row Total (N)
	Safe		Indifferent		Unsafe		
	Number	%	Number	%	Number	%	
Low	162	69.50	43	18.50	28	12.00	233
Medium	213	77.70	28	10.20	33	12.00	274
High	204	85.00	18	7.50	18	7.50	240
Column Total	579	77.50	89	11.90	79	10.60	747

Source: HRH Field Survey 2011/SOLID Nepal

Feeling of safety and retention of HRH at workplace

The feeling of safety was found interrelated to the retention of HRH in working place. A cross examination of effectiveness of CSOs with feeling of safety was performed to identify the median months spent by respondents in each category. It was revealed that who had experienced the workplace as 'safe' one; there was a median of 72 months of the stay for HRH where the CSOs had high effectiveness. Same was sharply reduced to 36 for both low and medium level of effectiveness of CSOs though the feeling of safety was the same or 'safe' (Figure 2).

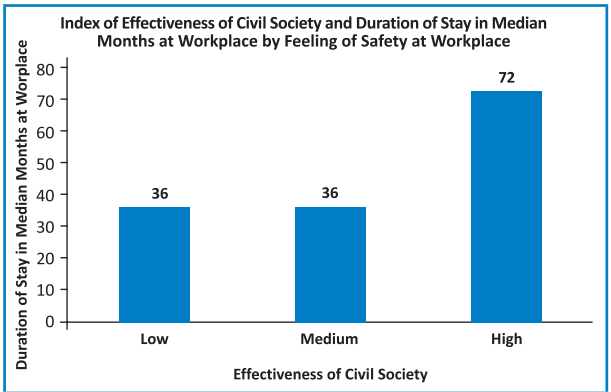

Figure 2. Index of effectiveness of civil society and duration of stay in median months at workplace by feeling of safety at workplace.

Source: HRH Field Survey 2011/SOLID Nepal

DISCUSSIONS

The above findings indicated that the civil society organizations were more supportive in rural areas rather than in urban areas. The modernization and urbanization were found to have been negatively affecting or weakening the interrelationships between civil society organizations and the health institutions. However, the growing individualism, modernization, and isolation of health institutions from the common populace in urban areas might have been attributed to such a poor level of supports by the civil society organizations in urban areas. Researchers have shown that CSOs are observed to have 'role modelled' successfully in community resource mobilization strategies, including traditional individual or group insurance, prepayment plans, or community-based funds earmarked for health care.[11,12] Similarly, CSOs interventions in urban Philippines were found to have improved service provision, immunization rates, increased use of oral rehydration solution and reduced child malnutrition rates.[13] This study found that the CSOs have some supportive roles in the community for better healthcare services; their roles need to be specified and strengthened further.

Though nearly three quarters of rural health care workers were getting supports from political parties, but their role in policy formulation were not notable. Studies have suggested that consultative decision making processes and participatory intervention methodologies in CSO interventions could have integrated community knowledge, evidence, views and values and enhanced community involvement in health systems and health policy.[14] The study revealed that there was a positive relation in between effectiveness of CSOs and feeling of security at workplace hence prolonging their stay. The effectiveness of CSOs were found high in the rural Hills, and in the far-western Nepal. However, this study indicates that the CSOs need to be further re-strengthened and functional as supportive agencies to the health institutions.

CONCLUSIONS

The CSOs have been playing creative roles in the rural Hills and in the far-west Nepal with their remarkable engagement in the health system. Feeling of security by rural staff, and their prolonged retention at workplaces were interlinked with the effectiveness of CSOs. However, there are very less documentation about the involvement of CSOs at local level as well as at national level. Hence, the study recommends that the roles of civil society in HRH management still need to be recognised and well documented in policy documents to seek their active participation in formulation and implementation of policies, strategies and planning related to HRH for effective and quality healthcare services in Nepal.

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