Vacant hospitals and under-employed nurses: a qualitative study of the nursing workforce management situation in Nepal

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It is vital for all healthcare systems to have a sufficient number of suitably trained health professionals including nurses at all levels of health services to deliver effective healthcare. An ethnographic, qualitative method was chosen for this study, which included open-ended, in-depth interviews with a range of stakeholders including student nurses, qualified nurses, nurse managers and lecturers, and the human resource co-ordinator in the Ministry of Health and Population. Available records and policy documents were also analysed. Study findings suggest that there is a severe mal-distribution of the nursing workforce in rural and urban healthcare centres in Nepal. Although there is an oversupply of newly qualified nurses in hospitals in Kathmandu, the staffing situation outside the valley is undesirable. Additionally, the turnover of junior nursing staff remains high in major urban hospitals. Most qualified nurses aspire to work in developed countries, such as the UK, North America, Australia and New Zealand. Between 2000 and 2008, as many as 3000 nurses have left Nepal for jobs in the developed west. There is no effective management strategy in place to retain a nursing workforce, particularly in rural Nepal. This article concludes by proposing some suggestions for a nursing workforce retention policy to address this critical issue.

Keywords Nursing, Human Resources for Health (HRH), nursing workforce, oversupply of nurses, international migration, Nepal

KEY MESSAGES

- Currently, the health service in Nepal faces a serious mal-distribution of nursing workforce. Although there are no or very few nurses in rural posts, urban centre hospitals are over crowded with surplus nurses. There is an urgent need to make rural nursing posts attractive.

- Nepal is training more nurses than the country’s capacity to employ them. Presently, nursing education is focused on meeting international training standards and preparing nurses for the global market. Nepal’s domestic nursing workforce needs have been ignored, and this area demands urgent policy attention.

- Nursing staff turnover in urban centre hospitals remains high. There is a need to develop and implement a national level nursing workforce management plan.

- This article proposes two strategies to better manage the under-employed nursing workforce in urban hospitals with specific focus on ways to make rural posts more attractive.
Introduction

Nurses are frontline service providers in most healthcare systems globally. An adequate staffing level with a stable workforce brings many benefits to health services: staff, organizations and the people who are being cared for (Buchan 2010). It is vital for a nation to have a sufficient number of appropriately qualified nurses and a stable nursing workforce at all levels of the health service for effective healthcare service delivery. However, a mal-distribution of nurses and other healthcare professionals at various levels—rural–urban, regional, national and international—has created a serious challenge in the provision of essential health services, particularly for many low-income countries (Kingma 2006; WHO 2006; Connell et al. 2007; El-Jardali et al. 2013). This led the World Health Organisation (WHO) to declare a global crisis of Human Resources for Health (HRH) in 2006 (WHO 2006).

As in many low-income countries such as Malawi, Ghana, the Philippines and Kenya, nursing jobs in rural areas in Nepal has been chronically undesirable (Justice 1986; Baird 2005; Adhikari and Grigulis 2013). Deployment and retention of nurses, doctors and other healthcare professionals, particularly in rural areas, has been a major challenge for the government since the establishment of the health service in 1954 (Justice 1986; NSI 2006). Evidence suggests that there are some remote districts where there are no positions sanctioned for healthcare professionals, including nurses (Martineau and Subedi 2010). The vast majority of rural positions has ghost workers (absen-tees), because the incidence of those staff who are supposed to be in rural areas arranging ‘Kaj’ (secondment) and living and working in urban centres is all too common.

Paradoxically, since the late 1990s, there has been a phenomenal increase in health professionals’ education capacity in Nepal, but jobs have not been created in par with the increased numbers of new graduates. As a result of this, since the beginning of the new millennium hospitals and nursing homes in urban areas, such as the Kathmandu valley, have not been able to absorb all the new graduates. Many newly graduated nurses and doctors have remained either un-employed or under-employed in urban healthcare institutions. The preliminary result of a study conducted by the Centre for Technical Education and Vocational Training (CTEVT) in early 2011 suggested that some new nurse graduates had accepted unpaid voluntary work in healthcare institutions in Kathmandu and remained unpaid for between 6 and 9 months after graduation.1 As it is very important for all new nurse graduates to maintain their clinical competencies and continue to learn new skills and gain further experience, even working as an unpaid volunteer is very valuable for them. This work experience becomes an important asset when applying for a permanent post.

Clearly, there is a massive rural–urban mal-distribution of health professional staffing in Nepal. Unfortunately, there is neither comprehensive health workforce data available to accurately illustrate the situation nor a clear national policy guideline in place for the recruitment, deployment and retention of health professionals in rural areas (Martineau and Subedi 2010). There has been some effort by the non-governmental organizations (NGOs) to attract nurses and other categories of healthcare professionals in some rural areas, but it has been a temporary and patch work solution.

Although the education and workforce management situation for health professionals—for doctors, nurses and allied health professionals—appears to be very similar in Nepal, the nursing situation, illustrated in this article, provides a fresh perspective. The paper begins by highlighting how nursing has become an increasingly attractive profession for Nepali women and examines the growth of education institutions to cater for the increased demand for more training places. The discussion then moves on to the nursing in the labour market and the complexity of the workforce management situation. The main argument is that there is an urgent need to develop and implement a proper nursing workforce management strategy. Management should start with educating enough numbers of the right type of nurses needed for rural healthcare services and prioritize meeting Nepal’s domestic needs first. The paper concludes by proposing some practical nursing workforce management initiatives to address this critical issue.

Method

This article is based on two studies on nurse education and the nursing workforce management situation in Nepal. The first was a doctoral study, conducted between the summer of 2006 and the autumn of 2009, which looked at the nurse education situation in Nepal and the migration experience of Nepali nurses to the UK. A range of qualitative research methods including observation, open-ended and in-depth interviews with key informants, and a review of relevant records and policy documents were used. In Nepal, research information was gathered from various healthcare institutions including nursing colleges under Tribhuvan University (TU) and the Institute of Medicine (IoM); from private nursing colleges run under the CTEVT the Ministry of Health and Population (MoHP); from the Nepal Nursing Council (NNC—the professional regulatory body) and the Nurses Association of Nepal (NAN—nurses’ professional trade union organization). Interviews and informal discussion were conducted with various stakeholders: nurse lecturers (n = 20), senior nurse managers (n = 3), CTEVT Divisional Directors (n = 2), HRH co-ordinator at the MoHP (n = 1), NNC Board Member (n = 1), NAN Board Member (n = 1), a group of nursing students (n = 20), a recently returned nurse from the UK (n = 1) and Nepali migrant nurses in the UK (n = 21).

A follow-up study was conducted to supplement the doctoral study. This was designed to track down the hospitals in Nepal where Nepali nurses, who had migrated to the UK and participated in the doctoral study, had trained and worked. In September–October 2010, the researcher visited six major tertiary care hospitals in Kathmandu and hospital matrons were interviewed. The purpose was to explore how these hospitals had been affected by international nurse migration and if these hospitals had developed and implemented any workforce management and nurse retention strategies.

Interviews were tape-recorded and later transcribed and translated into English. Data were analysed using qualitative analytical methods, primarily consisting of reading and rereading the transcripts, production of analytical memos and the
gradual building of analytical themes and insights (Silverman 2012). Data analysis started in the early stages of the research fieldwork and continued until the end.

Findings presented in this article are the result of long-term engagement and interaction with research participants in Nepal during the process of data collection and interpretation—a process commonly described as ‘immersion’ by ethnographers. This iterative immersion results in the research findings being constantly cross-checked by reading and rereading the interview records and ethnographic notes, and repeatedly listening to the interviews (Handwerker 2001).

Appropriate ethical permission was obtained from the study participants according to the procedures laid down by the University of Edinburgh, which was home to these studies. Participants were contacted by telephone first, and a suitable time for them was arranged. Participants chose their own free time and the researcher travelled to agreed locations. Apart from some public figures, most of the research informants have been anonymized to protect their identity.

**Result and discussion**

As this article is about the nursing workforce situation in Nepal, it is important to examine first the development of nursing education—the process of nursing workforce preparation.

In Nepal, the first nursing education programme began in 1956 with the help of the WHO, and it was run under the Ministry of Health. Three years later in 1959, the second programme was set up by the United Mission to Nepal—an organization established and run by newly arrived Christian missionaries (Owen-Fleming and Fleming 1990; NAN 2003; Maxwell and Sinha 2004). Until the mid-1980s there were only two staff nurse education programmes in the country training only 50 staff nurses a year.2

Nepal’s National Education System, including nursing education was revamped in the 1970s. The IoM was established in 1972 under the auspices of TU. Thereafter nursing education was moved to IoM which came under the Ministry of Education. The IoM became solely responsible for offering all types of health professionals’ education until the early 1990s. Nursing education within the IoM has always been heavily subsidized by the government and supported by foreign aid and technical assistance.

The nurse education curriculum has been revised several times since its establishment and adapted to match Nepal’s current National Health Plan. For example, the idea of Health for All (HFA) by 2000, through the core principles of Primary Health Care, was implemented in the 1980s. Subsequently the curriculum was revised to match the ideas of HFA, and it became the main driving force to deliver appropriate, accessible and affordable healthcare to all people of Nepal, including to those in remote areas.3

Later in the mid-1980s Nepal adopted a neo-liberal economic policy which was designed and prescribed by the International Monetary Fund to tackle the budget deficits. As in many other countries globally, the idea of private sector involvement in healthcare was considered one of the ways to expand health professionals’ education and health service provision in the country and to reach rural areas to meet the HFA goals. In order to involve and mobilize the private sector effectively, and to expand capacity for healthcare professionals’ education, the CTEVT was established in 1989. The CTEVT was to co-ordinate and regulate all private sector nursing (and other technical training) programmes in the country.

After the establishment of the CTEVT in 1989, the private sector stepped in and thereafter the number of nursing and other technical training programmes started to grow rapidly. Mainly since the early 1990s, nurse education programmes started to receive an increasing numbers of applicants. Many new nurse education programmes were set up to cater for the growing demand for training places. For example, the number of staff nurse education programmes grew from just six in 1996, to over three dozen in 2006, and then to 103 in September 2010 (Fig. 1).

Within this increased education capacity, new types of nursing degree programmes have been set up. Currently in early 2013 there are six levels of nursing education available in Nepal, from Auxiliary Nurse Midwife (ANM) to Ph.D. level. A brief outline of each of these is provided in the Appendix.

**Nursing and its growing attraction**

Since the 1990s, nursing has become an increasingly attractive profession for women in Nepal. Since the new millennium, enrolment in nurse education has been almost synonymous with preparing for a career which will facilitate migration to developed countries. In order to see how student nurses themselves view nursing as a profession, examining their reasons for choosing a nursing career and what they see themselves doing after graduation, in the summer of 2007 the researcher met a group of 20 first year B.Sc. nursing students in one nursing college in Kathmandu. While discussing why the students chose nursing as a career, the vast majority of them revealed the main attraction as being that nursing would allow them to migrate abroad. Here are some of the student nurses’ first-hand accounts, written by the students themselves in English.

One student gave her reason for joining nursing:

‘‘. . . my sister is a nurse and is now working in Reading UK. I see my sister has a good career so I want to do the same.’’

Another student wrote:

‘‘. . . in my opinion 80 per cent nurses take this as the first choice of career because of international job opportunities.’’

Another student stated:

‘‘. . . respect for the profession is increasing; it is not like in the past.’’

The list of students’ reasons for enrolling on the B.Sc. nursing programme is lengthy. What is clear is that these students saw their future opportunities abroad. They had, at least at the time of our interaction, no intention of working in rural Nepal. Although there has been a rapid growth of nurse education institutions in recent years, and there is a surplus of qualified
nurses (in the urban centres) in the country, the total pool of qualified nurses remains relatively small. In 2010, an estimated total of just over 1700 staff nurses were produced in Nepal each year. According to the NNC, by 31 January 2013 there were just under 40 000 nursing professionals registered with the NNC Register (Registered Nurses \(n = 19\,098\); ANMs \(n = 19\,851\); Foreign trained nurses \(n = 739\)) for the country’s total population of almost 29 million (NNC 2013).

The figures for the nursing workforce presented earlier do not accurately reflect how many nurses are actively working in Nepal, how many have retired, and how many have already left Nepal to work abroad. Those who are no longer actively practising in Nepal but are working abroad are also included in the NNC Register. There is no proper recording system for nurses currently working in Nepal and the number of nurses moving from public to private healthcare services is also not known. Neither the number of nurses approaching retirement in the near future nor indeed the age profile of Nepal’s nursing workforce is available.

Nursing labour market and workforce situation

Although comprehensive workforce data are vital for workforce planning (Diallo 2004), as in many countries globally, there are no systemic data available to show the total nurse employment capacity in public and private sector healthcare services in Nepal. However, there are three main types of employers for nurses: the government-funded healthcare service; private health service providers and international and national non-governmental organizations (INGOs).

The government of Nepal had just over 11 600 nursing positions in total in 2011 (MoHP 2011). The majority of rural positions is for ANMs. Staff nurses and positions above that level are mostly urban hospital based.

Additionally, since the 1990s, there have been increasing numbers of new private hospitals opening up in the country. Most are in urban centres such as Kathmandu, Pokhara, Biratnagar, Bhairahawa and Nepalgunj and their nursing staff employment capacity is not known. Apart from these service sectors, nursing professionals are employed by an ever increasing number of nursing education institutions, private universities and colleges. Again the total number of nurses involved in the nursing education sector (full-time or part-time) is not known. A significant number of nurses I interacted with during the research fieldwork worked in more than one teaching institute, and moonlighting teaching has been a growing phenomenon in the country since 2000. Some senior nurses hold several posts: full-time positions plus moonlight teaching, and are simultaneously doing private consultancies (Adhikari 2008).

As well as government and private healthcare provision, there are various INGOs, NGOs and charities involved in health service provision. These organizations play key roles and are major stakeholders in health. Because most INGOs/NGOs offer their employees relatively better working terms and conditions, they usually attracted the most experienced and better qualified healthcare professionals, including nurses. Again, their capacity to employ nurses is not known, but appeared to be relatively small. Overall, it is not possible to obtain comprehensive figures for nurse employment capacity in various sectors in Nepal.

Currently, there are three major concerns with nursing workforce planning and management in Nepal. Firstly, there is a severe rural–urban mal-distribution with absenteeism in rural areas and oversupply of nurses in urban hospitals. Secondly, there is a fast staff-turnover, even in hospitals and nursing colleges in urban centres. Thirdly, Nepal has been losing nurses to international migration (Adhikari 2011).

The shortage of all categories of health workers, including nurses, in rural hospitals is a chronic problem. The HRH Coordinator at the MoHP shared his views, stating:

"...less than 50 per cent staff nurses present at the district level, and there is an oversupply of nurses in Kathmandu while some district hospitals have no staff nurse in place."

Healthcare staff absenteeism has always been too common in Nepal (Justice 1986; NSI 2006). As a result, many district hospitals have no nurse (or doctor or other category health professional) present. Healthcare professionals regularly arrange Kaj (secondment) in Kathmandu and other urban centres in order to avoid working in rural and remote posts.

Oversupply of nurses in Kathmandu valley hospitals

Although Kathmandu and other major urban centres have always been the much preferred place for most healthcare professionals, oversupply of nursing staff (and doctors) in Kathmandu is a new phenomenon. This has been noted mainly after an increasing number of private nursing institutions started educating nurses from the late 1990s. In early 2011, more than half of the 110 staff nurse education institutions (each training between 35 and 60 nurses per year) were located in the Kathmandu valley. The Kathmandu valley has not just become a centre for education but has also been seen as a stepping-stone for international migration. Most of the migration facilitation agents (also known as International Education Consultancies) are also based in Kathmandu. Additionally, there are many other modern up-to-date facilities such as good schools for children available in Kathmandu, which are very attractive to health professionals. Consequently, if a newly qualified nurse cannot find a paid job, she would be prepared to even take up a voluntary post until she finds her way into an urban-based job or a way out of Nepal.
In autumn 2010, a matron in a government hospital in Kathmandu shared her everyday experience this way:7

‘...newly qualified nurses can find no job for months. Four of them came to see me this morning, as they [newly qualified nurses] come to see me every day. I told them ‘now, I say Namaskar. I cannot give you any job even to work as unpaid volunteer.’ There were four newly qualified nurses looking for voluntary posts, they came to see me just this morning. Like this, newly qualified nurses come to see me almost every day, looking for voluntary [unpaid work] or any job.’

The matron also suggested that many other medical and allied healthcare professionals face similar challenges with finding jobs in Kathmandu and many end up volunteering in any healthcare institution.

For new nurse graduates, the idea of volunteering in hospitals started only after the new millennium as the nursing workforce supply began to exceed demand. Some of the teaching hospitals in the Kathmandu valley started giving opportunities to new graduates to work as volunteers for a few months until positions became available. This gave the hospital free nurses, and the nurses, the opportunity to practise new clinical skills. Here is an example of a practice adopted by a government funded hospital to illustrate how this volunteering system worked in 2010.

In autumn 2010, the practice of employing a volunteer nurse at a government-funded hospital was this: a new graduate would lodge an application to become a volunteer, and usually he/she would be given an initial 3-month appointment. During this time the nurse would work as if they were permanent staff, so she would have the opportunity to continue her nursing practice and learn new skills. She would also get to know the system and the hospital staff would get to know her better. If this worked out for both parties, she would then have the chance to move one step closer to proper employment via the daily-wage scheme. When a position becomes vacant to work as a daily-wage member of staff, she would be able to apply again for a new post. After working in the daily-wage scheme for at least another 3 months the next step would be to secure a temporary contract. When a temporary contract becomes available, the nurse would transfer to that scheme. After a certain number of years as a short-term contract nurse she would be able to apply for a permanent position there. This process appeared to be similar for doctors and other healthcare graduates. In this way there would always be a new pool of health professionals waiting to move up into more secure position, and ultimately into permanent posts in this hospital.

This practice of volunteering was quite common in some other private hospitals and nursing homes in Kathmandu, and an increasing number of medical graduates face similar challenges with securing a job in other major urban centres. Many nurses, doctors and allied health professionals would try more than one hospital before they secured a voluntary placement or a temporary contract. The job market for new graduates in the health sector in the Kathmandu valley has become extremely competitive and new graduates constantly have to ‘shop’ for better jobs. As a result, staff turnover appeared to be very frequent in most hospitals. Unfortunately evidence suggests that frequent staff turnover can have negative healthcare outcomes, with longer hospital stays for patients and increased costs related to new recruitment (Aiken et al. 2004). As we have seen in the nursing students’ statement quotes earlier that most of the young nurses wanted to move abroad, this situation may be inevitable.

The trend of Nepali nurses making international career moves started around 2000. As highlighted earlier, nursing is becoming increasingly attractive as this opens up international opportunities for a younger generation of women. It is estimated that between 2000 and 2008, around 3000 Nepali nurses migrated to the developed west, with the most desired destination countries being the USA, UK, Australia, New Zealand and Canada. At the time of these studies (until 2010), there were just over 10 000 staff nurses who had graduated from nursing colleges; therefore, this represents almost 30% of Nepal’s total nursing workforce. Available records of nurses who intended to migrate were much higher than this, as not all who wish to migrate internationally are able to make the move (Adhikari 2011). A Nepali nurse, who graduated in the late 1990s and has been working in Britain since 2005, informed the researcher that 18 out of 30 of her classmates from staff nurse training had already migrated abroad.8

The nursing workforce planning and management situation

A follow-up study in September–October 2010 investigated the measures and strategies some hospitals have considered for retaining nurses in Nepal and reducing frequent staff turnover, and revealed that there was no workforce planning and nurse retention strategies in place. Nursing managers in hospitals in Kathmandu suggested that there is no lack of nurse candidates for junior nursing positions; if one leaves today they can hire a new nurse tomorrow. As already noted earlier, there was a large pool of newly qualified nurses looking for jobs.

As of the summer 2013, there are no national policy guidelines on pay systems in the country, in either the public or the private healthcare sector. Labour market competition makes the situation very favourable to employers. Working terms and conditions on offer in private sector institutions are less attractive than in the government-run hospitals. The government-funded healthcare services, or the MoHP, to date employ the largest proportion of the nursing workforce in Nepal, but the nursing management situation within this system appears very complex. Lack of professional leadership, a volatile political situation and bureaucratic interference act as barriers to health workforce management within the state-funded healthcare institutions.

There used to be a nursing division in the MoHP, which was responsible for nursing workforce management. As part of restructuring of the national health system, the nursing division was dissolved in 1993. At this point, the national healthcare management system was decentralized to a regional level and a nursing focal point was created in the MoHP. During research fieldwork period, this focal point had two senior nursing positions, with very limited management capacity. One senior nursing officer at this focal point retired in the early 2000s and the position remained vacant until 2010. Because of the
country’s unstable political situation and frequent changes in the key government positions (the Health Minister, Secretary of Health and Directors of various divisions within the MoHP), there has been no stable line management, and no sustained and long-term HRH planning. There has been no full-time and regular nurses’ representation at policy level.

During research field work in 2006–10, nurses working under the Ministry of Health spoke at length of low-morale and job dissatisfaction. They had many pressing professional issues, including the lack of professional representation at policy level in the ministry. A senior nurse at the Nursing Focal Point at the MoHP stated:

“...if you are making any policy recommendation or any suggestion [from this research] to the MoHP, please tell them that we want our Nursing Division back. Doctors have their own Division which deals with their professional issues, but there is no responsible section in the MoHP for nurses. Who is going to do anything for nurses? We feel demoralised; there is no senior policy level position for us. There is no hope for our future and job promotion.”

Decentralization seemed progressive at the time but this did not happen as intended. Nepal’s health service policy still remains completely centralized and staffing and vacancies for management level positions are decided at the central level. The HRH Coordinator within the MoHP, in the autumn of 2008, commented:

“...there is no clear policy on health service administration, so these [existing policy guidelines] are constantly manipulated/interpreted by individuals at policy level. Because of a lack of clear policy and bureaucratic incompetence, some key nursing positions have been vacant for a long time.”

Nurses working in the Western Regional Hospital in Pokhara and also in government hospitals in Kathmandu all agreed that the line of nursing management within the MoHP was not clear. Nurses expressed concerns about retirement and pensions, and professional development. They felt that there needs to be strong nurse leadership to take nurses’ issues to the policy level. The HRH Coordinator at the MoHP was in agreement, as he explained:

“...leadership is lacking in nursing—there is no nurse qualified to take this responsibility. There are numerous bureaucratic hurdles to go through here. After we cross all the bureaucratic hurdles of advertising to fill the vacant positions, we presently, at least, do not have a recruitment problem. We do receive plenty of good candidates and we can recruit the number we need. But there is a problem with deployment. The majority of nurses with good academic records, who work within the MoHP in Nepal but there is nobody responsible for any performance evaluation of nurses in the country, at least within the government system. There is no praise or incentive for good work nor any caution for poor performance. So, we nurses feel demoralised and we are here without any authority. I am here as contact person but I have no authority for anything else.”

Lack of supervision, work evaluation, rewards, incentives and promotion opportunities were mentioned as further key factors. A senior nurse in post in the Focal Point for Nurses in the MoHP said:

“...I act as a contact person [at the focal point] for all the nurses who work within the MoHP in Nepal but there is nobody responsible for any performance evaluation of nurses in the country, at least within the government system. There is no praise or incentive for good work nor any caution for poor performance. So, we nurses feel demoralised and we are here without any authority. I am here as contact person but I have no authority for anything else.”

Some of the above examples illustrate how newly qualified nurses had little interest in government positions, but preferred to live and work in the Kathmandu valley and then seek other opportunities locally and internationally. Those in the district hospitals were left without any support from the centre. Further, because of bureaucratic problems, there is no efficient, clear mechanism to recruit staff and fill rural vacancies. In summary, there is generally little attraction in working outside Kathmandu, mainly due to the poor salary, a lack of incentives or reward system, and a lack of proper job evaluation. Promotion possibilities seem poor, if one does not have an afno manche connection at the policy level.

Concluding remarks

The situation discussed earlier is not unique to Nepal’s health sector. Health professionals’ absenteeism (Belta et al. 2013), unplanned and unco-ordinated education leading to under-employment (Choy 2003; Adhikari 2011), a lack of comprehensive data on health professionals’ distribution (Diallo 2004; Kingma 2006; WHO 2006) and poor workforce planning at government level are the main issues faced by a vast majority of countries globally (Kingma 2006; WHO 2006; Humphries et al. 2009). However, the Nepal case study offers a fresh perspective for the health services that are seriously affected by mal-distribution of HRH.

Evidently, the rural–urban imbalance in healthcare worker distribution in Nepal is extreme. This imbalance has always been there since the establishment of a modern health service in the mid-1950s, and has not improved to date despite the recent increase in nurse training capacity (Martineau and Subedi 2010; B Marasini, unpublished data). There are two main reasons for this rural–urban imbalance: firstly, the faulty nurse (and health professional) education systems and poor HRH planning and management.

The nurse education system is faulty because the programmes appear to focus on bringing nurse education to an international
standard, but ignore addressing Nepal’s specific domestic needs. One such example is that the main driver of curriculum change recently in Nepal has been the international nursing labour market and international nursing skills need (Adhikari 2011). Recent changes in the nurse education curriculum to include the care of the elderly and psychiatric nursing modules, added during a nursing curriculum revision in 2007, reflect this. There is a greater focus on meeting international standards of nursing education, and raising professional standards, in order that Nepali nurses can be employed in a global market. During the follow-up visit to Nepal in 2010, the researcher was asked by an education authority if she thought nurse education in Nepal meets western standards and if Nepali nurses can find jobs in the international market, or if they needed to make further improvements, seeking feedback for their training standards and business. Presently, the education standard is measured by how many graduates from a particular institution have been successful in securing international nursing jobs. The recent increase in nurse production has had hardly any impact on the provision of the nursing workforce needed for rural healthcare services in Nepal. Instead it has become a profitable private sector business (Adhikari 2010; Martineau and Subedi 2010).

Secondly, the reason for vacant hospitals in rural Nepal is that the government has not been able to recruit, deploy or retain health professionals including nurses there. Evidently the difficulty in deploying nurses in rural areas is an old phenomenon. Justice (1986) noted this fact in the 1980s and little has changed. Working in rural Nepal has always been the least desired option for the urban born, bred and educated nurses and all other health professionals. A younger generation of nurses have flooded the small labour market in Kathmandu and other urban centres. This situation becomes more complex because there is a lack of nursing leadership in policy making positions and a volatile political situation leading to frequent changes of government. If the government and other major stakeholders ignore this critical issue now, the nursing workforce crisis will deepen.

In order to address some of the issues around the nursing workforce discussed earlier, this article suggests some management strategies for the health sector in Nepal. Firstly, education should focus on Nepal’s domestic needs. As the WHO report (2006) suggests, countries with a shortage of healthcare workers can take measures such as training healthcare workers to meet local needs, as well as planning and implementing staff retention strategies.

The second point is that there is a pressing need to set up national pay and employment structures within the healthcare sector in Nepal, covering both the government and the non-government sector. There has been regular media exposure about institutions in which nurses are exploited. Pay differentials in government sector, private and INGO sectors are very high. As seen earlier, some staff nurses work without any salary and others who gain lucrative INGO jobs can earn up to 20,000 NRS (£180) per month. Addressing this issue would help retain experienced nurses. Also, newly qualified nurses deserve to be valued and not exploited in a competitive labour market. This would ultimately improve nurse retention in the country. It would be at least one step forward in a positive direction.

Thirdly, there is an opportunity to tap into the pool of under-employed nurses (and doctors), and recruit them for rural health services, through the provision of incentives. Research evidence suggests one of the main reasons nurses make international moves is for further studies and professional advancement (Kingma 2006; Adhikari 2010, 2011). One way to make rural posts attractive could be by offering further education opportunities for those who have served in rural district hospitals for a certain number of years. Alternatively some sort of compulsory posting in rural areas could be rewarded with bonus points [enhanced accreditation or certificates] from the NNC for those who have served in rural areas. This would certainly attract more nurses in under-served areas.

Finally, as global nursing workforce experts suggest, nursing workforce management initiatives should involve all major stakeholders (Buchan and Calman 2005; Humphries et al. 2009). Nursing workforce management initiatives in Nepal should involve the nursing professional regulatory body, the NNC. Currently, there is no co-ordination or any kind of partnership between health workforce producers and employers (B Marasini, unpublished data). The government has been unable to regulate the private nursing education market. Also, there is a need for all stakeholders to support and collaborate with Nepal’s government to improve and strengthen the HRH situation. Such multi-sectoral collaboration is urgently needed in nursing workforce management. From the discussion earlier, it has been very clear that there is a lack of nursing leadership and representation for the nursing profession at the policy level. The government should pay attention to these concerns.

There have been some international donor supported initiatives in health service delivery in rural Nepal. Much effort has been towards training community health volunteers, but so far there has been very little or no attention paid to how to mobilize unemployed or under-employed health professionals to serve in rural areas. Now it is time for donor agencies and the foreign aid departments of migrant nurses’ destination countries to pay urgent attention to the HRH situation in Nepal and support the Nepali government to retain its valuable nursing workforce in rural areas. Such measures have already been suggested to international donors and actions have been taken to improve health worker retention in sub-Saharan countries with some degree of positive outcome (Eastwood et al. 2005). There is increased evidence that retention of the health workforce has been a low-priority not only in Nepal but also many health systems globally (Humphries et al. 2009; Buchan 2013). Now is the time to act and make rural posts attractive and worthwhile for this pool of under-employed nurses, before they flock abroad.

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Authorship
R.A. designed both research projects on which this paper is based. R.A. collected and analysed the data on Nepali nurse migration to the UK and nursing workforce management situation in Nepal, and drafted this manuscript.

Endnotes
1 Interview with the CTEVT, director, Kathmandu, 16 August 2011.
2 Community Medical Assistants, ANMs and Health Assistants programmes were gradually set up in the 60s to prepare health workers to work in rural healthcare settings. All programmes were initially under the Ministry of Health.
3 Primary healthcare initiative was also supported by foreign donors with financial and technical assistance.
4 Interview with the HRH Coordinator, MoHP, Kathmandu, on 23 November 2008.
5 Interview with Matron in a Government hospital in Kathmandu, November 2010.
6 Migrant Nepali nurses I interviewed in Britain were from all walks of life, some with almost 30 years of clinical, management and specialist nursing experience and some were new graduates.
7 Interview with a senior nurse level 10, in the MoHP October 2007. This nurse took early retirement in the summer of 2009. In autumn 2009, when the researcher visited the nursing focal point in the MoHP, no nurse was in post.
8 Interview with HRH Coordinator, HR Department in the MoHP, Kathmandu on 23 November 2008.
9 Interview with Nursing Officer in MoHP in autumn 2007.

References

Appendix: By the academic year of 2012–13, six levels of nurse education from ANM to Ph.D. in Nursing were available in Nepal

(1) The ANM. ANM training started in the late 1960s, with the aim of preparing a nursing workforce to work in rural
health posts proving Maternal and Child Health Services. There were only five ANM programmes in the country in the early 1980s, all under the TU. After the programme was taken over by the CTEVT in the early 1990s, the number increased to 50, and all are run privately. Over half of the 50 programmes are in Kathmandu valley, and many trained ANMs remained unemployed.

(2) The Proficiency Certificate Level in Nursing (PCL) or Staff Nurse. Prior to the establishment of CTEVT in 1989, there were six staff nurse campuses in Nepal (under the purview of the state). They trained a total of just over 250 nurses per year. Then, the idea was to train enough staff nurses for the district centre hospitals and other government hospitals throughout the country. This number started to grow in the 1990s. Although exact figures are not available, and NNC record (in early 2011) suggested that about 110 programme, each training between 35 and 60 staff nurses a year and 101 were registered under the CTEVT. Many of the new programmes are run privately, under the purview of the CTEVT. There were unregistered training colleges opening each year and a few have been closed during the initial study period.

(3) Bachelor of Science in Nursing (B.Sc. Nursing). In 2013, there were 40 programmes in the country that have received university affiliation to run the B.Sc. in nursing programme: eight in the TU, IOM; 21 are affiliated with Purbanchal University; eight are affiliated with Kathmandu University; one is run by BP Koirala Institute of Health Sciences (BPKISH) in Dharan and further two are affiliated with Pokhara University. These are very new programmes in the country; a vast majority of them were opened in the past few years.

(4) Bachelor in Nursing (B.N.). The route to this level of training is after 3 years of PCL training and 2-year post-registration clinical experience. This degree used to be run by TU, having started in 1976. Currently post-liberalization, there are 40 programmes, 11 under the Institute of Medicine; 23 affiliated with Purbanchal University; four with Kathmandu University; one with BPKISH and one in the Bir Hospital nursing campus in Kathmandu.

(5) Masters in Nursing (M.N.). In 2013, there are five M.N. programmes available in Nepal: four are under the TU, IOM, one in BPKIHS. This is aimed at those who want to teach, for which plenty of opportunities are emerging.

(6) Ph.D. in Nursing: Programme began in 2011 with two candidates per year by TU IOM, in Maharajgunj Nursing Campus in Kathmandu.