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Maternal Health in Nepal: Exploring the Role of MDGPs in Scaling Up Emergency Obstetric and Neonatal Care Services

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Abstract
Introduction: Availability of skillful human resource for providing safe motherhood and newborn health services at all levels of the health system, particularly at the community level is crucial to achieve MDGs 4 and 5 in Nepal. We need to have specialists trained in anesthesiology, obstetrics/gynecology and pediatrics to expand the coverage at district level hospital - the first referral point from primary level health facility. This clearly emphasizes the potential of a specialist general practitioner, MDGP, in providing EmOC services in all seventy five districts of Nepal where coverage can not be ensured by other related specialists currently and in near future.

Methodology: Desk review of relevant documents was done and information was gathered by literature search including internet search particularly Google Nepal, and Pubmed.

Results and discussion: There is improving trend of decreasing maternal mortality in Nepal but coverage of births attended by Skilled Birth Attendants is still very poor. There is not only shortages of health workers but also imbalance in mix of staff and geographic distribution together with low level of motivation, little incentive and poor career advancement that are responsible for current human resource crisis. District hospitals can be best staffed with MDGPs, assisted by nurses trained as SBAs and Anesthesia Assistants to deliver the range of essential services at rural setting particularly Comprehensive Emergency Obstetrics and Neonatal Care. Government policy, particularly frequent transfer, and lack of clear career path and problem of children’s education are the major issues related to recruitment and retention of MDGPs in Govt. system. A holistic approach is necessary to review the policy related to MDGPs recruitment and retention and explore their potential in strengthening EmONC services in Nepal.

Key Words
MDGP, Nepal, EmONC services

Introduction
Nepal is a landlocked and one of the least developed countries in the world, with 42% of its 23.2 million populations living below the poverty line. The geographical terrain and limited resources make the provision of health services to all very difficult and challenging. In addition, socio-cultural factors particularly the low status of women prohibits them from seeking appropriate health services including maternity services.

Functioning capacities of existing health facilities offering specialist maternal, newborn and child health services including quality Emergency Obstetric Care services in the country is limited. The issue of appropriate human resource for safe motherhood and newborn health services remains a major challenge. Availability of skilled and competent health care providers with midwifery skills at all levels of the health system; particularly

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at the community level is crucial to achieve MDGs 4 and 5. There is a need to have provision of specialists trained in anesthesiology, obstetrics/gynecology and pediatrics to expand the coverage at district level hospital - the first referral point from primary level health facility. This clearly emphasizes the vital role that a specialist general practitioner, MDGP, can play in providing EmOC services in all seventy five districts of Nepal as they are trained to suit the need of people living in rural setting. To provide the essential Obstetric and Neonatal care for the management of pregnancy and childbirth-related complications in women and newborn, it is high time to consider expansion of the role and potential of specialist general practitioner, MDGPs.

Maternal Health Scenario in Nepal

The maternal mortality ratio (MMR) of Nepal is among the highest in the world. The latest 2006 Demographic and Health Survey revealed a Maternal Mortality Ratio of 281 per 100,000 live births, which is considered to be slightly underestimation of data if compared to data reported by WHO (830 per 100,000 live births) but definitely shows improving trend in achieving MDG 5. For each maternal death, 30 women suffer from significant disability related to pregnancy and childbirth. The proportion of all births assisted by a health worker, both at home and in an institution has slightly increased, from 11% in 2001 to 19% in 2006; similarly, the practice of delivering in health facility has increased marginally from 9% in 2001 to 18% in 2006. According to the 1998 Maternal Mortality and Morbidity Study, the majority of women, who died as a result of pregnancy, childbirth or the postpartum period, did so at home (67.4%). Approximately 11% of deaths occurred on the way to the health facility and about 21% in a health facility (14.4% in a hospital, 4.5% in a private clinic and 2.3% in a primary health centre (PHC). The majority of maternal deaths (62.1%) take place post partum and postpartum haemorrhage was the number one cause of direct maternal death (46.3%), followed by obstructed labour (16.3%), eclampsia (14.3%) and puerperal sepsis (11.8%).

Policy/Strategy Background

National Safe Motherhood Policy, developed by, Ministry of Health, Government of Nepal in 1998 and updated in July 2006, emphasize on increasing the accessibility, availability and utilization of maternal health care services and strengthening technical capacity of service providers at all levels. Despite a good policy, there is gross disparities in access and service utilization by women in rural versus urban areas, poor versus non poor women and often between different regions of Nepal. The National Safe Motherhood Plan 2002-17 developed a long-term vision to scale up the coverage of maternal and newborn health care at all levels of health care delivery system by strengthening the technical capacity of maternal health care providers at all levels of the health care system through training. The National Safe Motherhood Training Strategy, 2002 focused on strengthening pre-service and in-service training institutions to ensure that all health care providers have appropriate skills of skilled birth attendant. The proportion of births assisted by Skilled Birth Attendants is the key Millennium Development indicator for assessing progress towards maternal mortality reduction. WHO suggests that in countries where the Maternal Mortality Rate is very high, the goal should be at least 40% of all births assisted by skilled birth attendants by 2005, 50% by 2010 and 60% by 2015. National SBA policy and strategy, 2006 recommends the realistic and achievable national target for the proportion of births attended by a skilled attendant of 60% by 2015. Currently in Nepal, only 19 percent of women are attended by a health worker during delivery, and not all of these health workers qualify as SBAs.

The National SBA Policy is very well incorporated in the Nepal Health Sector Programme-Implementation Plan 2004-2009. SBA Strategy is focused to ensure skilled care at every birth,
The rapid expansion of accredited SBA training sites and capacity building of trainers for ensuring quality training. Apart from having a medium and long-term strategy, a short-term strategy involves reviewing and updating of the existing of midwifery refresher, BEOC training, curriculum of doctors and MDGPs to include components of basic and advanced core skills of SBA. Long-Term (Pre-service) Measures will be targeted to develop a new cadre of Professional Midwife as a crucial human resource for safe motherhood.

Human Resources for Maternal and Newborn Health
Providing sufficient number of skilled providers, especially at the community level, is a major challenge faced by Nepal as many other countries of South East Asia. In order to ensure attainment of the MDGs on maternal and child health, it is not only essential that the adequate numbers of human resources for Safe Motherhood with the right skills and competency is available, but an enabling environment is also a prerequisite. A functioning health system means having a proper infrastructure, essential equipment, drugs and supplies, referral networks, quality of care and regular monitoring mechanism together with a legal and regulatory framework, appropriate human resource deployment and distribution, retention policies, standards and protocols, job descriptions, performance appraisal, supervision mechanisms, continuing education and re-licensing mechanisms etc.

The Strategy for Human Resources for Health 2003-2017 has identified shortages of health workers and imbalances in mix of staff as well as in geographic distribution, unclear job definitions, inadequate supervision, limited and uncontrolled staff development and career management, low levels of individual and organisational productivity and performance and little incentive to improve performance as major cause for human resource crisis. The Current MDGP Program in Nepal

In the setting of rural Nepal, it seems that the best solution to get district hospitals staffed with MDGPs, assisted by nurses, who have been upgraded to nurse-midwives and Anaesthesia Assistants, in order to deliver the range of essential services particularly Comprehensive Emergency Obstetrics and Neonatal Care. The MDGP training for Nepal was established in 1982, by Calgary University, Canada, and currently, this training takes place at IoM (Tribhuvan), UMN (United Mission to Nepal) Patan Hospital and UMN Tansen Hospital. It is a three-year structured training, focussed on life-saving skills and covers Medicine and Surgery, Obstetrics/Gynaecology, Paediatrics and Anaesthesia, as well as Emergency Medicine and a few others. Obst & Gyne training for the MDGP is of 24 weeks duration and includes normal and complicated pregnancy, normal delivery, assisted vaginal delivery, Caesarean Section etc. including competency based hands on training. This duration is more than the one of 17 weeks recommended for medical officers for training in CEmONC. This training also includes Paediatrics, which is also of 24 weeks duration, of which 4 weeks is devoted to Neonatology. These residents are also posted to a district hospital for two months for training in the more remote parts of the country. In 2002, training similar to the MDGP training at IoM was started at BPKIHS, Dharan but it is called Medical Doctorate in Family Medicine.

Opportunities and Challenges
There is good evidence from the Safe Motherhood districts (NSMP AND WRLH projects) that even in low-resource settings with very low rates of facility deliveries, increases in the availability, quality, and utilization of emergency obstetric care can be achieved and utilization of services goes up with the availability of surgeons who can provide CEmOC (MDGPs in these projects). Similarly, GPs were providing effective obstetric services including effective management of emergencies and Caesarean section (6.4%) in the rural areas including as
reported by Prasad et al in International Conference at Melbourne, Australia, 2002.\textsuperscript{15}

All together, since 1982 some seventy MDGPs have been trained, but less than half of them work in the government service. According to the latest information, of the around 50, who are said to be currently available, only 12 work in the so called Safe Motherhood districts, i.e. those districts where CEmONC is introduced. However, Dr. Bruce Hayes, himself a MDGP from Australia, conducted a study in 2001 and found that 70\% of all of Nepal’s MDGP graduates were working outside the Kathmandu valley long-term.\textsuperscript{16}

MDGP curriculum contains most of the skills of advanced SBA needed to ensure an adequate delivery of CEmONC at the level of the district hospital. However, currently there are some problems at MOHP in nominating candidates for MDGP training to fulfill the requirement of MDGPs for coverage of seventy five districts. In addition, financial support given to trainees is inadequate. Moreover, MDGPs have got too little career perspectives to motivate the young graduates to go for post graduation in this specialty. They get transfer to zonal, regional and central hospitals but transfers may be too often and not always desired, interfering with continuity of care.

Considering the amount of work load at first referral point in all specialties including EmOC, it is reasonable to have at least two MDGPs per district hospital. It is possible that number of Ob./Gyn consultants will increase in future to take over the responsibility of EmOC throughout the country but there deployment and retention at district level can still be a problem and can not be guaranteed. Moreover, MDGPs can still attend all obstetric emergencies at first entry and refer subsequently to obstetricians if available for further management.

There is tremendous growth of number of medical colleges in Nepal and very soon, every year almost thousand new doctors will be produced. Unless there is clear policy to deploy and retain these doctors to serve the need of rural community, Nepal will suffer a missed opportunity to use its own human resource. It is suggested by Dr. Mark Zimmerman that the vision should be provision of quality care for the majority rather highest quality for few.\textsuperscript{17} At district hospital setting; it is unlikely that there will be a team of obstetricians, anesthesiologists and pediatricians to provide CEmONC in near future. Rather various cadres of SBAs will include MDGPs, Nurse Midwives and anesthesia assistants.

There is further need to modify education system so as to make it more community based that helps in retaining these doctors in the community as reported in Kenya, by Simeon Mining , Arthur Kaufman.\textsuperscript{18} Finding of an interview based study reported by Hayes, B., Gupta, S. (2003) regarding recruitment and retention issues for MDGPs in Nepal suggests that Place of growing up appeared significant in determining the location of work. Health assistant background and undergraduate rural exposure appeared non-significant. Lack of support staff, and facilities were the greatest difficulties faced in rural areas. Government policy, particularly frequent transfer, and lack of clear career path and children’s education were the major issues. Lack of specialist support, lifestyle issues and continuing medical education appeared non-significant.\textsuperscript{19}

\textbf{The Way Forward}

Nick Simon Institute conducted a conference in March 2006 in which national and international experts developed a consensus on building up the GP profession in Nepal. Recommendations from the conference regarding recruitment of MDGPs were (1) to adopt a selective admissions policy with rural background being number one criteria, (2) awarding scholarships for post graduate MDGP doctors (3) Raise the profile of GP in medical
schools and raise their status in the community, (4) improve the standing of MDGPs in the government system, create MDGP posts in different institutions, and give MDGPs the same opportunities as other specialists, (5) GP should be a full academic specialty in MBBS courses (Undergraduate training) (6) consider separate MD entry track - selective admission and establish multiple pathways for training with a common final national exam. (7) Develop rural training sites with GP supervision/mentoring for training and (8) developing National organization as single governing body of GPs. Similarly, to improve retention of GPs in the health system, recommendations were (1) Government career ladder should put GPs on equal footing with other specialists - clear and transparent criteria for promotion and there should be a common career ladder for MDGP in government, NGO and private hospitals, (2) Establish a system to rotate doctors to rural locations and improve Govt. system of Human Resource Development, (3) Develop career alternatives that extend beyond MDGP- GP with special interest in (WSI) without losing their core of being a GP. The GP Career should be individually tailored and flexible allowing diversification to meet the varying needs of the nation, (4) Ongoing support- Improving hospital infrastructure, Developing community support, addressing professional isolation, Providing financial incentives and better education for children. They advised an integrated approach that included (1) Lobbying government to give GPs full privileges in the government career ladder, (2) Support of families, (3) Continuing medical education, and (4) Inclusion of GP training in medical school curricula. There could be a role for “on the job training”, and residents undertaking the final common examination qualifying as MDGP doctors. Such a role would involve the challenges of mixing public/private/not for profit institutions and matching people and places.

Conclusion
A holistic approach is necessary to address the complex interacting factors that impact on GP recruitment and retention. General Practice Association of Nepal (GPAN) could be the most obvious organization to develop into such an academic governing body and a powerful lobby representing GPs at a national and international level. There should be close collaboration of professional organizations such as GPAN, NESOG (Nepal Society of Ob./Gyn), NEPAS (Nepal Pediatric Society) and SAN (Society of Anesthesiologists in Nepal) to identify and delegate roles and responsibilities of professionals in order to address compelling health needs of the country including Maternal health in Nepal. The community needs to acknowledge and value its doctors and GP doctors in rural communities should be an agent of change.

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