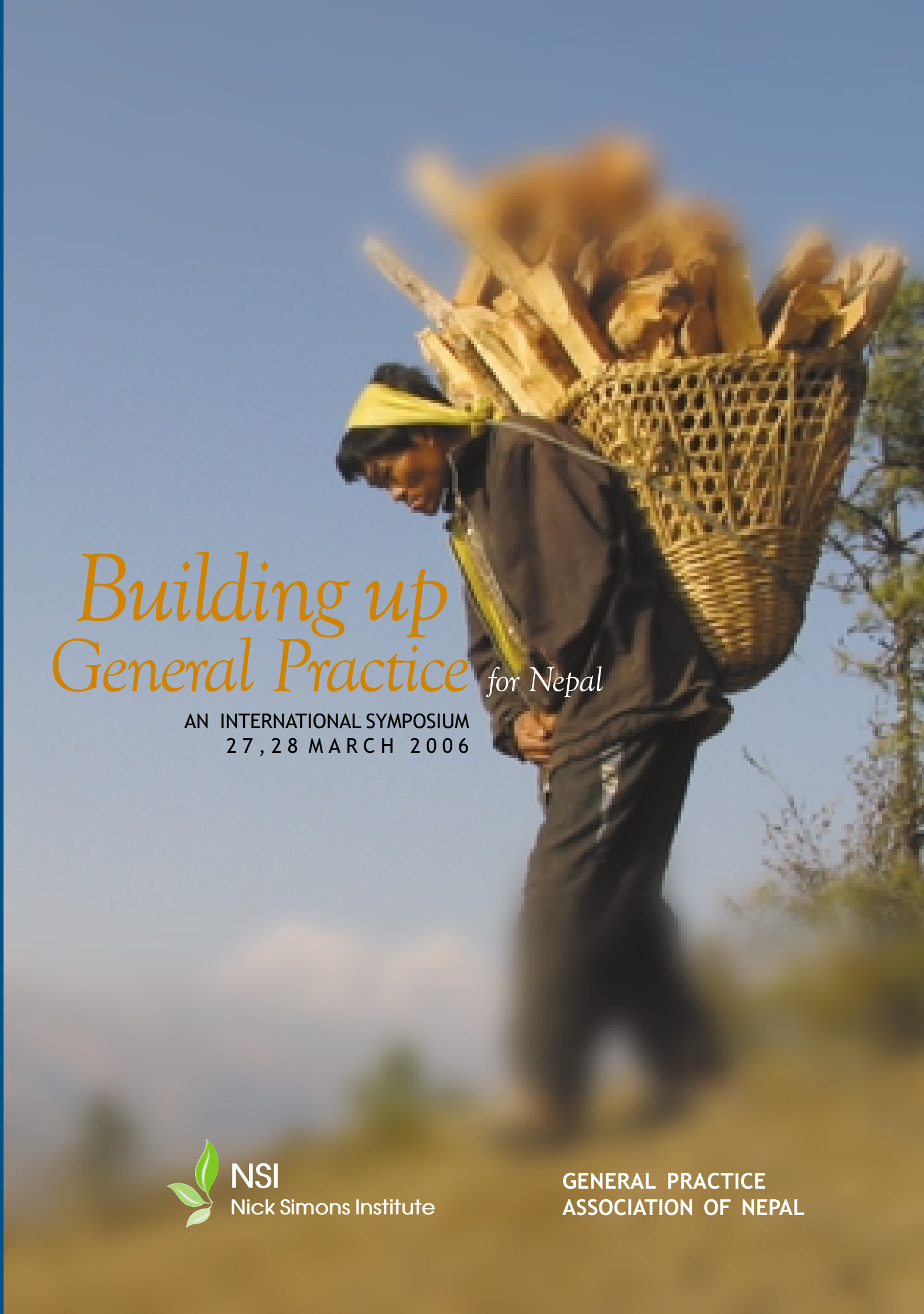


Building up General Practice for Nepal

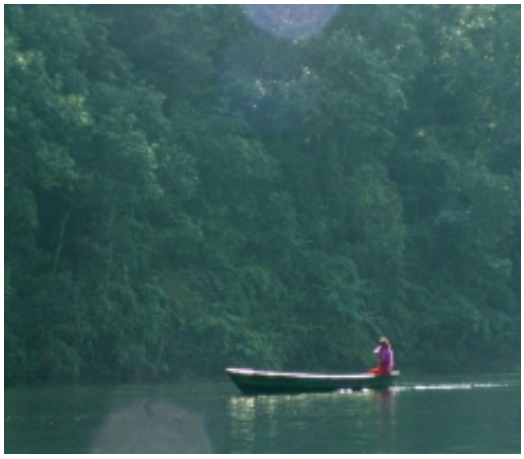
AN INTERNATIONAL SYMPOSIUM
27, 28 MARCH 2006

NSI
Nick Simons Institute

GENERAL PRACTICE
ASSOCIATION OF NEPAL

"You must
be the change
you want to see
in the world."

Mahatma Gandhi



International Faculty

Dr. P.T. Jayawickramarajah World Health Organization Regional Office for South-East Asia with extensive experience in medical educational planning in Nepal - gave an international perspective on Family Practice. He stressed that the future of family medicine lies in developing a strategy to transform and renew the speciality to meet the needs of people and society in a changing environment.

Dr. Waris Qidwai Associate Professor Department of Family Medicine, Aga Khan University, Karachi presented on the situation in Pakistan and the challenges they faced with a clear message of the need for a holistic and collaborative approach to these issues of recruitment and retention.

Dr. Preethi Wijegoonewardene President College of General Practitioners of Sri Lanka gave an overview of the Sri Lankan experience of the evolution of general practice, particularly highlighting the challenges of public/private mix and the development of the College of General Practitioners.

Dr. Khwanchai Visithanon Bureau of Policy and Strategy, Ministry of Public Health, Thailand shared some of the Human Resources in Health principles used in Thailand, emphasising the importance of a life cycle approach to the needs of doctors to promote rural primary care service.

Dr. Max Watson formerly of Tansen Mission Hospital, now Consultant Palliative Medicine UK Lecturer Queens University Belfast National Cancer Research Institute UK Partnership in International Medical Education shared from his experience in Nepal and UK that having a Doctor assigned to your community may be a right, but having a good Doctor working in your community over a period of years needs community commitment to care for him/her well.

National Consultants

Dr Dibya Sri Malla	Dean	National Academy of Medical Sciences
Dr Hemang Dixit	Director	Kathmandu Medical College
Dr Ramesh Adhikari	Dean	Institute of Medicine
Dr. Trilok Thapa	Asst.Dean	Institute of Medicine
Dr Gopal Acharya	Chief Medicine	Institute of Medicine
Dr Owen Lewis	Chief Family Med	BPKIHS
Dr Gyanendra Malla	MDGP/Asst. Prof	BPKIHS
Dr Druba Singh	MDGP/Asst. Prof	Bir Hospital/NAMS
Dr. Indira Basnet	Consultant	Support for Safer Motherhood Program
Mr Raghu Ghimire	Consultant	GTZ / Ministry of Health
Dr Nanda Lal Sikarni	MDGP	Sindhupulchok District hospital
Dr Bedanidhi Katiwada	MDGP	ADRA Jhapa
Dr Santosh Giri	MDGP/Asst. Prof	Kathmandu University Medical School
Dr Manohar Joshi	MDGP	Lumbini Zonal Hospital
Dr Lawrie McArthur	MDGP	Tansen Mission Hospital
Dr Arbin Joshi	MDGP	Tansen Mission Hospital/Okhaldhunga
Dr Raju Shakya	MDGP	Tansen Mission Hospital
Dr Olak Jirel	MDGP	HDCS
Dr Bharat Yadav	MDGP/Assoc. Prof	Patan Hospital/NAMS
Dr Bruce Hayes	Prof/GPCoordinator	Patan Hospital/NAMS
Dr Katrina Butterworth	MDGP/Assoc. Prof	Patan Hospital/NAMS
Dr. Paul Johnson	Former GP Organizer	Patan Hospital

About the Symposium

There continues to be a worldwide shortage of general practitioners - doctors with the necessary skills to work in rural and remote areas. Furthermore, in a country like Nepal, the majority of the population (about 85%) live in rural areas. There is a large disparity in health measures. Life expectancy in Kathmandu is about 74 while it is as slow as 37 in some areas and averages 59 in the country. The major detriment comes from lack of resources (including trained medical personnel) and poverty.

This symposium, sponsored by the Nick Simons Institute (NSI) and General Practitioners' Association of Nepal (GPAN) addressed 2 main issues and brought forward concrete action plans. Recognising that a General Practitioner(GP) is a key human resource for Nepal and especially rural Nepal:

- What can be done to recruit GPs to serve rural Nepal, so as to impact the health of rural Nepalis?
- What can be done to retain them in the most needed posts?

We invited 5 international experts in the field of health care distribution to give their perspectives on what is happening in other countries. They came from Thailand, Pakistan, Sri Lanka, India, and one from the U.K. who had worked in Nepal. Twenty local consultants representing Government of Nepal, academic institutions, INGOs, and MDGPs working in a range of rural and urban settings also participated in this 2-day process.

The symposium was a workshop in which the consultants developed a strategy for building up General Practice in Nepal. This brochure details the findings and leads us into the work that awaits us in the future. Thank you.

Dr. Katrina Butterworth
Course Organizer
Patan Hospital

Building up General Practice for Nepal

Day 1 - Monday 27 March

Keynote Addresses

Dr. Jayawickramrajah, Dr. Waris Qidwai, Dr. Preeti

Initial Recruitment issues

- Literature/international perspective (Dr Waris)
- Nepal perspective (Dr Hemang Dixit)
- Discussion / Small group work
  - Formualations of proposals

Undergraduate training/

- Using rural district hospital for training/GP input to training
- Literature/ international perspective (Dr Max Watson)
- Local perspective (Dr Owen Lewis)
- Discussion / Small group work
  - Formulation of proposals

Day 2 - Tuesday 28 March

Keynote Address - Dr. Visithanon

Career path for Family physicians

- International perspective (Dr Jayavikramraja)
- Local perspective (Dr Manohar Joshi)
- Discussion/Small Group work

Support for the rural physician

- International perspective (Dr Preethi Wijegoonewardene)
- Local perspective (Dr Olek Jirel)
- Discussion / Small group work

Plenary Session

Consensus Building

The symposium invited a select group of experts and practitioners to come to the table to share perspectives from a range of different viewpoints. International experts reflected the experiences of 5 different South Asian countries. Local consultants came from government and mission, rural and urban, academics and practice. In addition, some non-GP doctors seasoned the mix. The organizers provided a forum that moved through a number of stages:

(1) A questionnaire was sent to all participants, as well as to 15 other GPs. The replies were summarized in a document sent to all participants before the symposium.

(2) A team conducted extensive literature search, and the annotated bibliography was compiled and distributed.

(3) The symposium followed a pattern of international lecture, local lecture, discussion, and break-out small group work.

(4) Results from small groups were brought back in plenary sessions.

(5) The discussions that follow in this brochure are the distillation of this work.

(6) The Symposium participants agreed on an action plan.

Recruitment/ Training Summary

SELECTION

Adopt a selective admissions policy - with rural background being the number one criteria.

Conference participants expressed strong feeling that rural/peripheral communities should be involved in the process of selecting people they want as their doctor. This has been successfully done with other health professionals. It would be important to try to balance possible bias with criteria set by the institute with community involvement. Criteria might include needed academic abilities and aptitudes such as staying-power, team working, communication skills and realism. There were different viewpoints about the value or problems associated with the use of interview/ aptitude testing for this. It's important to identify motivated students.

Nepal government should apply this principle to its bonded seats (120 MBBS seats/year).

Award scholarships for postgraduate MDGP doctors.

Put greater emphasis on providing scholarships for Post Graduate MDGP programmes ~ thereby doctors can be selected who have already shown a commitment to serve in rural areas. Generally, the conference felt that bonding was unhelpful. This is partly due to the lack of government postings for bonded students to fit into. A loan system was proposed (with repayment schedule) as one alternative.

Rural/peripheral communities should be involved in the process of selecting people they want as their doctor.

Pilot the scholarship scheme in an area with full community support.

It was suggested that this system of rural nomination should be piloted in an area where the community is fully aware of the process. We could also trial community support for Training in areas where there is a positive attitude towards GPs eg Surkhet, Tansen (where they have already seen good GP role models and experienced benefit)

PROMOTING GENERAL PRACTICE

Raise the profile of GP in medical schools.

GPs should visit medical schools to raise awareness and provide role models.

Raise stature in the community.

Use radio/TV programmes to raise awareness. GPs should also be involved in high schools, for example during career days. **Recognize excellent service and commitment by awarding a "Rural GP of the Year".**

Improve the standing of MDGPs in the government system.

Create MDGP posts in different institutions, and give MDGPs the same opportunities as other specialists to be promoted. Participants frequently expressed the need for government advocacy work.

UNDERGRADUATE TRAINING

GP should be a full academic specialty in MBBS courses

There should be a core Family Medicine curriculum made compulsory in all medical schools (including private ones). For this to happen we need to press the NMC. All satellite training centres should have good communication and internet access. Faculty should be paid to visit peripheral sites. A good connection with the centre is essential if students are not to feel isolated.

GPs should be teaching specific skills such as communication, patient-centred practice, psychosocial medicine, population and whole patient care. Initially we would need to use visiting GP faculty until a cadre of Family Medicine teachers could be built up with the ultimate aim of a Family Medicine Department in all schools. GPs could be used in problem-based learning.

All satellite training centres should have good communication and internet access. Faculty should be paid to visit peripheral sites. A good connection with the centre is essential if students are not to feel isolated.

Use rural sites for training

Lobby the NMC to instigate a compulsory rural component of undergraduate training (Possibly up to 6 months - extending as facilities develop). Training sites may be government or NGO hospitals. All universities (and established rural training centres) should develop rural satellite training centres with health teams (BPKIHS model). This would facilitate more rapid expansion of rural training and address the medical schools' "social" responsibility.

It is essential that rural experiences are positive experiences for students. There should be adequate facilities with appropriate referral and less emphasis on high tech medicine. At the same time, rural sites must have adequate communications linkage with the center.

Provide training and recognition of GP teachers

Provide training for GP teachers (preferably MDGP but could be any specialty), certify them and provide rewards for teaching (financial and/or academic recognition, social recognition eg "best rural teacher/doctor award")

Regularly update this training eg every 3 years. Consider a system of reaccreditation.

It is important to match the doctors and the training site. Doctors trained as trainers should not be arbitrarily moved to another non-training site.

Connection with the centre

All satellite training centres should have good communication and internet access. Faculty should be paid to visit peripheral sites. A good connection with the centre is essential if students are not to feel isolated.

Develop a fully Rural medical school

Conference participants seriously discussed the possibility of developing an "Institute of Rural Medicine" - specifically aimed at producing rural

doctors. This would be further down the track as it would require significant development of trainers and facilities.

Develop rural training sites with GP supervision/ mentoring for training.

POSTGRADUATE TRAINING

Consider separate MD entry track - selective admission.

The current practice of a common exam for all postgraduate courses discourages those wanting to take up General Practice. A separate entrance exam for MDGP programmes with possibly aptitude testing and interviews was recommended. There was some disagreement about how valid such techniques would be.

Participants felt that work in smaller rural hospitals or in NGO hospitals (not currently recognized for entry to postgraduate study programmes) should be reconsidered for MDGPs. This needs to change so that doctors working in any rural hospital are recognized for scholarships.

Establish multiple pathways for training with a common final national exam.

In order to rapidly increase the number of GP doctors to the required level we need to expand the number of sites of training and have multiple possible routes for training. For this to happen we recommend:

1. Make nationally agreed core competencies for Family medicine (WHO has developed core curriculum for SE Asia 2003)
2. Once these are developed, introduce some flexibility in curriculum design to reflect changing societal needs and disease patterns. Regular review of curriculum is important.
3. A common National MDGP examination is vital.
4. Establish a national body to oversee quality.

Develop rural training sites with GP supervision/mentoring for training. A rural candidate who works for several years training in a big city is transformed into an urban doctor. Rural training sites should be regularly evaluated for the quality of education given. As more GP tutors become available the time spent in a rural setting should be gradually lengthened. (Literature supports longer time) Ongoing support and mentoring are essential.

There could be a role for "on the job training", and residents undertaking the final common examination qualifying as MDGP doctors.

NATIONAL ORGANIZATION AS SINGLE GOVERNING BODY OF GPs

This was a recurring theme over both days of the symposium: We need a single governing body to be the umbrella organization to oversee areas such as - the core competencies set for a GP curriculum, accreditation of a common national exam, the quality of training provided in different institutions, CME of graduates and other doctors working in rural areas.

Such a role would involve the challenges of mixing public/private/ not for profit institutions and matching people and places. This could take the politics out of placements and emphasize the importance of stability.

General Practice Association of Nepal (GPAN) was frequently mentioned as the most obvious organization to develop into such an academic governing body. As a single, united body it could become a powerful lobby representing GP's at a national and international level.

CAREER/PROMOTION PROSPECTS

Government career ladder should put GPs on equal footing with other specialists.
This is essential if General Practice is going to flourish in Nepal. A plan should be set from undergraduate training to retirement with options built in for ongoing training in areas of special interest, sabbatical leave and support.

Important to create more MDGP posts in each level of institution - district (eg DHO), zonal, regional and central (eg ED Chief) with clear and transparent criteria for promotion. Criteria for promotion should be a mix of performance related work and time. There should be a common career ladder for MDGP in government, NGO and private hospitals.

Establish a system to rotate doctors to rural locations.
We don't want to produce two classes of doctor, one urban and one rural, but it would be good to have a rotation system. A long term fixed posting in a rural area (2-3 yrs) - gives continuity of service.

A career plan should be set from undergraduate training to retirement.

Participants expressed the need to have a locum system whereby rural doctors could take annual leave and study leave as well as sabbaticals was expressed. There would need to be some kind of body to coordinate locum cover. Locum reliefs could be MDGP doctors normally working in urban areas who were willing to work for up to three months per year rurally. Doctors who worked as locums should be accredited and recognized by the government.

Health Ministry must improve its system of Human Resource Development.
There needs to be a Human Resource Development department at the Ministry of Health to manage and to monitor career development of MDGP doctors. This department could ensure matching of doctors with communities, skills with available resources and examining "losses" in the system.

To do this we need to develop an advocacy group which might include GPAN, SSMP or other INGO's plus NSI. Using the example of Thailand we should formulate guidelines based on the "lifecycle needs" of MDGP doctors in Nepal. This guideline could be provided to the MoH. Care should be taken that one strategy doesn't conflict with another. "Big change without adequate planning and capacity building leads to disaster."

ONGOING PROFESSIONAL DEVELOPMENT OF GPs

Develop career alternatives that extend beyond MDGP.
GP with special interest in (WSI) without losing their core of being a GP.

There should be provision for doctors to choose an area in which they wish to gain extra expertise through further training. This could be formal (qualification) or informal (needs based).

We recommend that MDGP doctors should have to work in rural areas for at least 2 -3 years before being allowed (or given preference) to pursue

a special interest in a variety of fields (eg rural medicine, surgery, obstetrics, public health, administration, HIV/AIDS, academic teaching). Scholarships might be available for such extra training.

There must be some national standards for GP/USG, GP/Surgery, GP/ObGyne etc. Also, further training should lead to further recognition in terms of an increased salary and promotion.

GPs are all rounders with varying interest. The GP Career should be individually tailored and flexible allowing diversification to meet the varying needs of the nation. Explore industrial medicine, health promotional work, teaching/clinical supervision, research.

Provide regular CME (Continuing Medical Education).

There is a need for an organization to be responsible for CME eg GPAN or NSI. Doctors participating in CME should receive some kind of recognition that they are keeping up to date. For this to happen there needs to be coordination between Ministry of Health and the Ministry of Education. Training could be short course/ onsite/ informal. Distance education using paper methods or internet, broad band could also be developed. CME must be locally derived and relevant – not just taken from the West. CME materials should be based on a needs analysis, looking at the skill mix required and tailoring to a rural or urban setting.

CME should also include the rest of the health care team.

GP doctors in rural communities must be engines of change.

SUPPORT ONCE IN POST

Improve hospital infrastructure.

A Primary care facility should be well resourced with a medical record system and connection with peers. It was suggested that there could be decentralization of resources to the Hospital Development Committee (eg Dhading). Each HDC should be capacity built to be supportive and active, creating ideas for income generation and motivating doctors to work. There would need to be some kind of umbrella organization to supervise and act as an arbitrator if there were problems with inappropriate community pressure for personal gain on this committee.

Another suggestion was that Doctors set up a "business" and contract out their services to rural hospitals. The equipment would be owned by the doctors and would follow them. The doctor would also hire his/her own team of nurses and support staff. For this to work, during MDGP training the doctor should learn resource mobilization and staff mobilization

Develop community support.

The community needs to value its doctors and not abuse them. There are several good examples (in Ilam, Butwal, Australia and Pakistan) of how involving the community in the choosing of a doctor, providing clearly defined roles and responsibilities to the doctor and then supporting them has worked well.

Infrastructure provision and support for children's education are the most significant issues.

Hospitals should also be looking to build up the whole community by addressing general infrastructure needs eg water and sanitation, road access etc. A challenge for GP doctors in rural communities is to be engines of change.

Combat professional isolation.

There should be at least 2-3 doctors, plus other support staff in each rural hospital. The Ministry of Health needs to coordinate staffing with hospital size and equipment.

Each MDGP doctor should be assigned a mentor, preferably a senior GP doctor with experience in rural areas. Feeling "valued" (Social recognition) by colleagues (eg. "GP of year") is important. The formation of "rural clubs" would also help to address the issue of social isolation.

Provide better education for children.

There should be some method of support for doctor's children education (and also other staff children). This might be providing good schooling in the rural area or giving scholarships to boarding schools.

Provide financial incentives.

An adequate and fair pay scale is essential. It should also be possible to diversify beyond salary (public) and fee paying (private) and increase private/public provisions. A superannuation/pension fund would be important. There could also be allowances for travel, study, sabbatical (after 5 years), remote place allowance.

Generate the evidence for what support works in the Nepal setting

The international literature is not clear on what is most effective in retention and there needs to be Nepal-specific research. Infrastructure provision and support for children's education are probably the most significant issues in Nepal from the surveys done of MDGPs to date. There needs to be action from this deductive reasoning and then review effectiveness. We could visit doctors who have been successfully retained in rural areas, and investigate factors that have kept them there and see if we can replicate this in other places.

Need to set up a research group to start reviewing and collecting this evidence.

GP SUPPORT AGENCY

Develop an agency to facilitate GP support at all levels.
GPAN/ NSI could form an advocacy group to develop such an organization. This organization could coordinate CME, locum services and could help match doctors with communities according to community need and the skill mix available. Such an agency has worked well in Australia (South Australian rural doctors workforce agency), keeping doctors in rural areas.

NEED FOR A SINGLE NAME

The current situation of there being "General Practitioners" and "Family Medicine" or "Family Physicians" is confusing for both doctors and the general public. Doctors in Nepal, and the academic institutions should sit down and agree on one name. The overall view of the symposium was that MDFM (MD in Family Medicine) would be the best name to improve morale and provide a professional identity. Also, "Family Medicine" is more common in South Asia (India) A decision should be made soon, after consulting more generally with those involved. GPAN would be a suitable forum for this discussion.

SUMMARY

- A holistic approach is necessary to address the complex interacting factors that impact on GP recruitment and retention.
- We need to collaborate with each other (unity amongst the GPs in Nepal) and with other developed and developing countries.
- A need exists to establish an integrated career pathway of education and training for rural practice, beginning at the pre-undergraduate level and continuing through undergraduate medical education to specific rural practice vocational training followed by appropriate continuing and university graduate education, practice structures and family supports.

Action Plan

The Symposium recommends that the multiple recommendations listed above be crystallized into **eight areas** for immediate action.

1. Create a GP Advocacy Group.

There is a need for an advocacy group for GPs that can go to the government and lobby for key changes in career structure as discussed during the symposium.

GPAN would be the lead group, with support from NSI and from SSMP. Dr Malla from NAMS and Dr Ramesh Adhikari from IOM would also support such an advocacy group.

At present the government is reviewing its policy with regard to MDGP doctors. The advocacy group needs to go and find out what is happening. Human resource management at the MoH needs to be strengthened, so that the correct number of health workers are trained in the correct way and are then adequately supported in their work.

Drs. Pratap Prasad, Manohar Joshi, Bharat Yadav, and Olak Jirel
With support from GPAN, and NSI providing facilities

2. Encourage GPAN to take a leading role.

GPAN needs to promote itself amongst doctors as an organization worth supporting. An increase in its membership will increase its capacity for advocacy and raise its profile. GPs themselves need to drive this.

To develop into an Independent College, GPAN would need a band of committed senior GPs who are able to give time and energy to this purpose.

Dr Manohar Joshi of GPAN is willing to bring this to the next GPAN meeting.

3. Bring together the three current academic bodies for training GPs.

The three academic bodies, NAMS, IOM and BPKHIS need to get together and decide on a common name (in conjunction with GPAN), common intake/entry exam process, develop common core competencies for a national GP curriculum and a possible common final exam.

Dr. Owen Lewis and Dr. Bruce Hayes to organize meetings in Kathmandu

4. Choose a brand name.

A survey should be done of GPs in Nepal, consulting them on what they would like to be called (eg General Practitioners, Family doctors etc). Once a name has been chosen it would need to be endorsed by the senate. GPAN would take this forward to the senate.

Advocacy group should take a lead. NSI will fund survey and provide staff.

5. Form a research group.

Need for a group to take forward research, building up an evidence base for proposed changes to enhance GP recruitment and retention.

Bruce Hayes agreed to lead this group. Other members were: Owen Lewis, Santosh Giri, Arbin Joshi, Manohar Joshi and Lawrie McArthur. This group will make proposals for research and send them to NSI for possible funding.

NSI study in summer 2006 on GP deployment factors

6. Raise awareness in the public of GP.

NSI investigating production of a radio soap opera on rural doctor

7. Investigate setting up a continuing medical education program.

NSI in conjunction with GPAN could develop a continuing medical education (CME) programme with urban and rural streams. The structure and format of CME should allow academic recognition and further career development.

Setting up a mentoring system (involving current training institutes) could help facilitate good CPD.

Dr. Bruce Hayes to begin investigating. NSI available for funding.

8. Dialogue with undergraduate course directors about MDGP component.

In the long term NMC should be approached to make a compulsory Family Medicine component for all medical schools.

Letter from GPAN/NSI out of this symposium to support Family Medicine in all Undergraduate curriculum. This would support letter already sent by Owen and Mary Lewis.

In the short term a group of experienced GPs sponsored by NSI could make themselves available as visiting faculty to raise awareness of Family medicine in medical schools. Bruce Hayes is available to coordinate this.

About GPAN

The General Practice Association of Nepal was established in 1990 and was the first specialty chapter under the Nepal Medical Association. It provides support to MDGPs across Nepal, especially in the areas of Continuing Medical Education and Government advocacy. In 2006 Dr. Manohar Gupta (of Institute of Medicine) is the GPAN President.

About NSI

Nick Simons Institute is an organization with a mission to train and support health care workers for rural Nepal. NSI reaches beyond training, and is developing rural retention programs, as well as generally advocating for the status of the rural health care worker. NSI is a staunch supporter of the concept of the MDGP as 'Captain' of the rural health care team. The NSI headquarters are in Jhamsikhel, Patan.