

Editorial

Beyond the Bedside: Integrating Health Advocacy into Medical Education in Nepal

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BACKGROUND

In Nepal, healthcare delivery is shaped by the interplay of geographic barriers, resource constraints, and social inequities. Although national indicators point to progress, they often mask the persistent challenges faced by rural populations. A typical example is illustrated in the following scenario: *'A pregnant woman in the last trimester of her pregnancy experiences complications indicating a possible high-risk pregnancy. She lives in a small village in the mountains of mid-*

western Nepal. The nearest health post is a 30-minute walk but lacks a doctor and specialized equipment to handle high-risk pregnancies. The nearest primary health centre is a further 1 hour away and lacks the equipment and expertise to handle high-risk pregnancy. The nearest hospital capable of handling her case is a three-hour jeep ride away along a mud road that becomes nearly impassable during the rainy season.'

This scenario still holds true in many parts of rural Nepal. There have been significant improvements in several healthcare indicators in Nepal. Maternal mortality decreased from 553 to 142 per 100,000 live births during 2000–2023. Similarly neonatal mortality dropped from 40 to 17.2 per 1000 live births during 2000–2022 [1]. Nepal has performed better than many countries in these mortality improvements when adjusted for economic growth [2]. Significant disparities in education, employment, and lifestyle habits connected with income persist; urban poor lacked education and employment. The same may also be true in

rural Nepal. Factors such as a person's ecological region, and province of residence, gender and age predict an increased risk of health conditions such as being overweight/obese, pre-hypertension, pre-diabetes, and diabetes [3].

During the last three decades there has been a significant increase in the number of medical colleges in the country. An article, however, mentions that the training provided does not prepare students for serving rural Nepal. Students do spend time in rural communities; however, the training does not equip them to work independently in rural areas, handle administrative responsibilities, interact with and be a member of rural communities, and live in rural Nepal [4]. Social determinants of health (SDH) continue to be neglected in the Nepalese curriculum. Knowledge of SDH should be incorporated into healthcare policies and into the curriculum [5]. Brain drain is a major problem among medical graduates. A recent article mentions the number of physicians seeking to emigrate may be more than the number of new graduates, neutralizing national investment in medical education. The physician-to-population ratio ranges from 1:850 in urban Kathmandu to a catastrophic 1:150,000 in remote districts, with vacancy rates greater than 62% for general practitioners in the public health system nationwide [6]. This editorial will mainly focus on medical advocacy and empowering medical students to be advocates for patient and community health.

Defining Medical Advocacy in the Nepalese Context

Health advocacy has been defined as 'actions that promote social, economic, educational, and political changes that reduce the threats to human health and well-being that a

physician identifies through their professional work [7]. Advocacy operates at the level of the patient, the community, and the health system. At the patient level, individual patients (regardless of caste, gender, or geography and other demographic characteristics) should receive equitable care through the healthcare system. At the community level, it involves identifying local health determinants and mobilizing resources to address them. At the systemic and policy level, the physician's professional standing should be used to influence the structures that generate illness in the first place, especially social determinants of health.

The CanMEDS framework developed by the Royal College of Physicians and Surgeons of Canada is critical for the Nepalese context precisely because it clarifies what advocacy is and what it is not. Advocacy is not partisan political activism, but a professional responsibility grounded in patient and community need. Globally, competency frameworks (notably CanMEDS and the WHO's health workforce recommendations) have mentioned advocacy as an important role of the physician. Despite considerable time and labour devoted to defining health advocacy and designing objectives for the role, advocacy teaching and assessment lag that of other physician competencies even in high-income countries [7]. In South Asia, and Nepal where medical education is focused on biomedical content and is examination-driven, curricula do not integrate social determinants of health, despite growing evidence of the importance of these for future practice and their vital influence on population health outcomes [8].

The 2015 constitution enshrines health as a fundamental right. Decentralization of health services and the Federal set up mean all three

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levels of government (Federal, Provincial and Local), have a role in healthcare provision and advocacy efforts must be focused on localized health needs rather than a single central authority [9]. There has been substantial progress in mental health, universal health coverage and one health. The Nepalese diaspora is becoming active in the health sector and in advocacy. A Diaspora Research Grants platform, a centralized project bank for health sector needs, and a Research, Evidence Synthesis and Diaspora Engagement Unit within the Ministry of Health and Population are proposed to be established [10].

Why Nepal Demands Advocacy Trained Physicians?

Nepal faces a twin burden of both communicable and non-communicable diseases (NCDs). Non-communicable diseases now account for over two-thirds of deaths, driven by urbanization, ageing, and lifestyle shifts. Workforce shortages, healthcare disparities, and out-of-pocket payments continue to be major challenges [11]. Geographic barriers and the difficult terrain limit access to healthcare. As mentioned previously, brain drain is a major issue and the distribution of health workers in the public system is a concern, with huge variations between ecological zones (Mountain, Hill, and Terai) and among the seven federal states. Remote hill and mountain areas face a severe shortage of health personnel [12]. Adivasis/janajatis and dalits fall ill more frequently, rely more on local healers for treatment, and resort (often unwillingly) to government health facilities for treatment of illness. A study mentions that they experience more treatment failures and incur high expenses per episode of illness

when they seek medical help from private health facilities [13]. There are barriers for women and girls to access healthcare services, but rural telemedicine may reduce these barriers [14].

Doctors regarded as trusted and respected members of communities and should support communities improve living conditions and social determinants of health. They have an important role in health advocacy. The traditional medical curriculum may not equip doctors with the skills for healthcare advocacy.

The Current State of Medical Education in Nepal

The emphasis continues to be on biomedicine and the focus on passing examinations. Most medical schools in Nepal have not embraced the social accountability principle that directs schools to partner with communities and governments for improved health outcomes [15]. Learning of SDH is also limited. The priority areas for health advocacy in Nepal are universal health coverage and healthcare financing, [16] strengthening the system to provide mental health care, [17] antimicrobial resistance, gender-based violence and sexual assault, reproductive and sexual health, the social determinants of health, access to healthcare and climate change and health among others. Among the key advocacy skills for Nepalese medical students are:

Recognizing and Addressing Social Determinants of Health: Students must learn to see illness in its social context. Nepalese medical education is predominantly urban-based, hospital- and biomedically oriented, and does not adequately prepare graduates to serve the rural underserved population [18].

Communication and Relationship-Building Across Social Difference: Advocacy in Nepal's pluralistic society requires skilled communication across linguistic, ethnic, and caste divides. Medical students should develop this skill [18].

Community Needs Assessment: Students need practical tools to identify and document unmet health needs at the population level. Community diagnosis programmes have been in place for a long time, but students rate themselves lowest in identifying resources and collaborating for system change [19]. This is an especially important skill in the Nepalese context.

Navigating and Mobilizing Health Systems: In Nepal, brain drain is a major problem and doctors remaining in the country tend to concentrate in urban areas. Practitioners who remain in Nepal should be able to navigate and strengthen a fragmented health system.

Policy Literacy and Civic Engagement: The topics of equity, policy, and advocacy are all intertwined, and medical students must complete their undergraduate training with an understanding of how each of these impacts the other in the Nepalese context [20].

Reflective Practice and Professional Identity: To develop as a health advocate, students must acquire multiple skill sets in an incremental fashion, and this requires structured reflection on professional identity [21]. These are not commonly addressed in Nepal's hierarchical education system.

Facilitators and Barriers to Teaching Advocacy: Factors influencing advocacy mentioned in a recent article were divided into those operating at the level of patients, resources, social position, and social norms [22]. Learners were more likely to advocate

for patients with whom they developed a sense of connection and who seemed more like them. They were also more likely to advocate for patients with fewer resources and for those whom they felt most needed their help. Knowledge of available resources and collaboration with other professionals was also helpful. Continuity in the learning environment and progressing through the course may also facilitate advocacy. However, as students progressed, they were more comfortable with advocacy but had less time available to be involved. Social norms also had a strong influence.

In the United States, medical students recognized that involvement in health policy and/or advocacy is a duty of physicians. They acknowledged physicians' voices were well respected in society. They could identify social determinants of health but felt unprepared to address needs. The barriers mentioned to future involvement in advocacy included intimidation, self-doubt, and scepticism of the impact. Advocacy education was offered in a US medical school, and the respondents offered recommendations for improvement in teaching these skills, including simulation, earlier integration in the course, and teaching on health-related laws and policies [23].

Among possible barriers to teaching advocacy in Nepalese medical schools are the following.

Curricular Marginalisation of Non-Clinical Competencies: Advocacy as a physician competency encompassing health equity, social determinants, policy engagement, and community empowerment is largely absent from Nepal's MBBS curriculum as an explicit, assessed domain.

Faculty Capacity Deficits: There is a critical shortage of well-trained faculty, and

institutional policies create disincentives for hiring and retaining them [24]. Advocacy requires faculty who are themselves trained in health policy, social determinants, and community engagement, and this may be absent in Nepalese medical colleges.

Pedagogical Culture: Hierarchy, Rote Learning, and Passivity: Medical education in South Asia and Nepal is authoritarian with hierarchical faculty-student relationships and an emphasis on rote learning and may be poorly suited to disciplines like public health and advocacy, which require open discourse, interdisciplinary cooperation, inquisitiveness, and creative problem-solving [24].

Dominance of Clinical Medicine over Social and Community Orientations: Within medical colleges, the dominance of clinical medicine over public health is pervasive, and this extends to advocacy teaching. Resources, prestige, and faculty attention are channelled toward biomedical and clinical content, and other disciplines may be marginalized.

Examination-Driven Learning and the Assessment Ecology: Nepal's examination system rewards factual recall, not competencies like advocacy, community engagement, or policy literacy. Performance is based exclusively on rote recall and agreement with the teacher's opinions.

Brain Drain, Institutional Orientation, and Learner Goals: Many self-financing students, especially those in private colleges, have their goals firmly set on postgraduate entrance examinations and establishing urban practices or emigrating to developed nations [4]. A large proportion of the Institute of Medicine (IOM) graduates (36.1%) were working abroad after graduation [25]. Students have little perceived utility for advocacy skills in their professional trajectories.

Absence of Role Models and Institutional Advocacy Culture: The absence of public debates over Ministry of Health and Population health policies, the lack of systemic change driven by graduates, all reflect a culture where physician advocacy is not modelled, rewarded, or expected.

Structural and Resource Constraints: Inadequate library resources, insufficient internet and computing infrastructure, and unavailability of basic office support handicap medical colleges, leaving little room and resources for innovation in competency areas like advocacy.

Assessing Advocacy: Assessing advocacy as a competency in the curriculum is also challenging.

What Advocacy Education Could Look Like in Nepal?

In Nepal, community diagnosis programmes can be expanded. Students should spend more time in rural communities. At the Patan Academy of Health Sciences (PAHS), community-based learning experience has been integrated into the curriculum [26]. Case-based learning using real Nepalese health equity scenarios will also be useful. Partnerships with NGOs, other organizations, and local governments will be helpful. To develop advocacy among medical students, institutions must invest in structured, experiential faculty development programmes to ensure role-modelling by faculty. These will enable faculty leadership, strengthen institutional academic missions, and better prepare medical students to meet society's evolving needs [27].

Advocacy can be integrated into community medicine and public health modules and into clinical ethics teaching. A needs assessment is

important before developing an advocacy curriculum. Learner, faculty, institutional, and community needs should be assessed. The curriculum should be vertically integrated through the programme. The preclinical years should focus on awareness and knowledge, while the clinical years should focus on skill development and application. Elective/senior years should offer immersive advocacy experiences.

Community-based participatory learning, legislative simulation and role-play, narrative medicine and storytelling by patients, interprofessional learning, and reflective journals and portfolios are important learning strategies.

Assessment strategies should be aligned with Miller's pyramid. At the 'Knows' level, written examinations or multiple-choice questions on policy frameworks, social determinants of health concepts, and advocacy history integrated into existing assessment will be useful. At the 'Knows how' level, a policy brief or advocacy letter with a structured marking rubric assessing evidence use, clarity of argument, stakeholder awareness, and proposed action is recommended. At the 'Shows how' level, OSCE stations involving a patient with a clear social determinant can be used. The 'Does' level requires portfolio evidence of real-world advocacy activity with structured supervisor sign-off and reflective commentary.

Call to Action

Medical educators should embed advocacy explicitly, not incidentally, and demonstrate these in their daily professional life. The regulators, the Nepal Medical Council and the Medical Education Commission, should consider advocacy as a competency to be

developed by a MBBS graduate. Students should recognize their role as agents of health equity, not just disease management. Among specific recommendations are for the Medical Education Commission to mandate advocacy as a core competency, provide faculty development in advocacy, integrate advocacy into community medicine rotations, address problem with the maldistribution of doctors and other health workers both within and outside the country, institutionalize student-lead advocacy, incorporate advocacy in curriculum reviews, embed advocacy in postgraduate and licensing examinations and align advocacy with Nepal's health adaptation planning cycle.

Conclusions

Revisiting the case scenario at the start of this viewpoint, a physician trained in advocacy would have handled the patient differently. Let us examine the differences.

Immediate (Week 1):

The physician would ensure safe referral for this patient with documented logistics, transport contact, written danger signs in the local language, and direct hospital notification.

Month 1-2:

The physician will audit all high-risk pregnancies from this catchment over the past year. Document access barriers, transport costs, and any adverse outcomes. Quantify the burden.

Month 2-3:

Present findings to health post and primary health centre staff, frontline community health volunteers, and local government

health committee and propose different solutions.

Month 3–6:

Implement capacity building including training for primary health centre staff, secure basic equipment, establish phone consultation protocol with hospital.

Month 6+:

Advocate formally to the District Health Office for conditional cash transfers for transport and road improvement as a budget priority.

As highlighted at the beginning of the editorial, Nepal's health challenges are social and political as much as clinical; and the country's doctors must be trained accordingly. Advocacy training would support the creation of a generation of Nepalese physicians who move fluidly between stethoscope (clinical care) and advocacy.

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