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Institutional Capacity Assessment of National Health Training Centre

Executive Summary

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Strengthening Health Systems-Improving Services

INSTITUTIONAL CAPACITY ASSESSMENT OF NATIONAL HEALTH TRAINING CENTRE

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LATH
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IN TROPICAL HEALTH

Acronyms

AHW	Auxiliary Health Worker
AWPB	Annual Work Plan and Budget
DDA	Department of Drug Administration
DHO	District Health Officer
DPHO	District Public Health Officer
DoHS	Department of Health Services
EDP	External Development Partners
FHD	Family Health Division
GAVI	Global Alliance for Vaccines and Immunisation
GESI	Gender Equality and Social Inclusion
GoN	Government of Nepal
HR	Human Resources
HURIS	Human Resource Information System
ICT	Information and Communication Technology
JHPIEGO	Johns Hopkins Program for International Education in Gynaecology and Obstetrics
JSI	John Snow International
MoHP	Ministry of Health and Population
NASC	Nepal Administrative Staff College
NFHP	Nepal Family Health Project
NHSP-2	Nepal Health Sector Programme (Phase 2)
NSI	Nick Simons Institute
PPICD	Policy, Planning and International Cooperation Division
RHTC	Regional Health Training Centre

SBA	Skilled Birth Attendant
TMIS	Training Management Information System
TOR	Terms of Reference
TOT	Training of Trainers
TWG	Training Working Group
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development

INSTITUTIONAL CAPACITY ASSESSMENT OF NATIONAL HEALTH TRAINING CENTRE

EXECUTIVE SUMMARY

The purpose of this assignment is to assess the institutional capacity of the NHTC to perform its current mandate and an expanded role, and to identify options and specific recommendations for improving its capacity. The assignment was carried out from 9-25 July 2012 and a second phase is planned to take this work forward when the Ministry has made a decision on the key recommendations in this report.

The NHTC was recognised as an "apex body" for health training in the National Health Training Strategy of 2004, which envisaged NHTC would oversee and coordinate all the Ministry of Health and Population's training (both pre-service and in-service) and provide all in-service training for the divisions and centres of the DoHS, as well the Departments of Drug Administration and Ayurveda in the MoHP. The NHTC's specific responsibilities set out in this document are wide ranging and they have continued to grow since 2004, even though it has yet to fulfil its original mandate effectively. Today, the NHTC has a critical role to play in developing the skills of service providers and managers throughout the government health system in order to achieve the ambitious service delivery targets of NHSP-2.

Methodology

The methodology for the assessment agreed with the TWG relied on individual semi-structured interviews, a field visit to Biratnagar and Dhankuta RHTC, and a review of key documents. A gender equality and social inclusion (GESI) dimension to the assessment was incorporated after the assignment had started with the agreement of the Director of NHTC. The preliminary findings and options for improvement were presented and discussed at a national stakeholder forum. The feedback was used to prepare this final report.

Findings

<u>In-Service Health Training System</u>

The NHTC operates at the heart of a wider in-service health training system which is illustrated in Figure 2 in section 3. It carries out training directly though the RHTCs or, more frequently, by "contracting" training to external training providers who are usually individual specialists working in the government and non-government health systems. NHTC's main clients (or potential clients) are the divisions and centres of the DoHS. It is well supported technically by a number of external partners to deliver specialised training funded by donor agencies. The main weakness of the system is that most divisions and centres, with the exception of the FHD, do not coordinate their in-service training through the NHTC. They have their own training budgets which they manage directly, which leads to parallel training activities carried out by the NHTC and the divisions/centres, which often compete for the same

participants. This results in in-service providers being taken away from their jobs for several weeks or even months at different occasions during the year.

Environmental Threats

The consultants identified a number of environmental threats which impair NHTC's effectiveness, namely: (a) restricted cadre system; (b) frequent staff transfers; (c) training as a personal incentive; (d) vertical donor funded training; and (e) late budget releases. These are discussed in section 3 of this report. The restricted cadre system, which reserves all professional posts exclusively for the health sub-group, is a binding constraint. Indeed it is the main determinant of the internal capacity weaknesses within the NHTC. The financial incentives attached to training are also a concern since they distort the motivations of trainees to undertake training, which may undermine its application on the job.

Mandate and Functions

The NHTC has a very wide mandate indeed for a training institution. It has been explicitly entrusted with eight of the nine training and development functions, namely policy development, training needs analysis, planning and budgeting, curriculum design, delivering training, evaluation and quality assurance. The only function it has not been formally assigned is contracting out training, although it is doing this extensively. Unsurprisingly, the NHTC is not presently carrying out all of these functions. It performs no policy development work or quality assurance, and only a limited amount of training needs analysis for individual programmes. And significantly, few of its programmes are conducted by in-house trainers; over 75% are contracted out.

However, NHTC has adapted in a practical way to the wide range of functions mandated and the limited skills and experience it possesses. It has done this firstly, by utilising the skills of qualified specialist trainers within the health system and secondly, by delegating key tasks to the supporting partners with whom they have formed collaborative relationships.

Capacity Weaknesses

Why is this? Put simply, the NHTC has been asked to do far too much with the type of personnel who have been deployed there. The specific capacity weaknesses in the NHTC and the wider training role within the Ministry can be summarised as follow:-

- *Staffing:* Although 70% of the 100 staffs at NHTC are deployed in RHTCs, there are only 16 technical officers in the regions (three per centre) capable of conducting training. All this training is paramedical; professional training has to be contracted out. The ratio of female to male officers is 1:6.5. Diversity among staff is also low with one social group predominating. And less than half of the staffs in RHTCs have any technical training which is a small proportion for a dedicated training centre. Almost 60% of staffs are in supporting roles;

- *Skills:* The training professionals at the RHTCs have worked as either health education officers or health assistants before joining the NHTC. They are qualified to either certificate or diploma level. The NHTC as a whole lacks any meaningful skills in training needs analysis, monitoring or training follow-up. Staffs have acquired skills on the job in curriculum design and training administration, but these skills need to be significantly enhanced. Many staffs, however, have undergone a training of trainers programme. Only two staffs had received training in GESI mainstreaming;

- *Processes:* The Ministry and the NHTC lack effective processes for conducting training needs analysis, quality assurance, planning training, curriculum design and evaluation. The most significant weaknesses are the first two mentioned. There is no established process for analysing the training needs of the whole public sector health system, which would derive skill deficits from an analysis of performance gaps. Nor does the Ministry have any quality assurance procedures, including the formal accreditation of training programmes, trainers and trainees, curriculum review, resource materials and facilities, and the monitoring of trainers' performance at the point of delivery;

- *Facilities and resources:* The RHTC training rooms are inadequately decorated and poorly equipped and, in our view, are unsuitable and unattractive venues for quality training. The regional centre at Pokhara is better furnished and equipped than the others, but the present facility falls short of the standards needed to cater for international participants. Further, the RHTCs are not co-located with a clinical training site at a hospital; participants must therefore be transported elsewhere for practical training.

The location of the NHTC within the structure of the MoHP/DoHS is not an issue which needs to be addressed. The NHTC currently sits under the DoHS which is an appropriate structural arrangement for serving the needs of its divisions and centres.

Options

Future role of NHTC

Before deciding where NHTC's capacity needs to be strengthened, we need to ask first what its future role should be. In section 4, three options are presented (the current situation, a training institute, and a training management body) and the advantages and disadvantages of each are discussed. The present role (option 1) is not tenable for two main reasons. Firstly, NHTC is trying to be a training institute without having a core group of professional trainers. Secondly, most of the training which NHTC offers

is supply driven because it has its own budget and it can therefore decide what courses it runs without reference to the DoHS.

The real choice lies between options 2 and 3, the conventional training institute and the training management body. The main advantage of having a training institute (including the RHTC network) is that it provides a readily available source of training for core (and continuing) courses which can be delivered in a classroom setting. However, it is unlikely that most of the specialised in-service health training could be conducted in a classroom because it should ideally be delivered at the workplace or at a training site (which replicates the workplace.) The advantage therefore of having specialised trainers and purpose-built classroom facilities may not be practical or efficient. The main disadvantage of the training institute option is that, on its own, it is not legitimate for this type of organization to perform either the policy development or, most important, the quality assurance function, which conflicts with the responsibility for training delivery.

The advantage of NHTC becoming a training management body is that it could legitimately perform all of the core functions, with the exception of training delivery. A training management body would enable the necessary expertise to be pooled in a single entity serving the needs of the technical divisions and the district health offices. The main disadvantage is that this body will not have a permanent in-house training capability. That said, our view is that this is not a significant concern, since much of professional training can be delivered by specialists currently working in the public health system. This is a more flexible way of conducting training, which avoids the high overhead costs of maintaining a large staff of permanent trainers. For some specialised areas, such as management training, expertise can be contracted out to specialist institutions, the private sector or NGOs.

On balance, therefore, our view is that option 3, the training management body, is the most appropriate solution for the Ministry. It would perform essential functions which are not currently being performed and which cannot legitimately be performed by a training institute. At present, it is more critical for the Ministry to establish and capacitate such an entity than to develop permanent in-house capability to design and deliver training. Option 2, the training institute, is not a viable solution. It cannot address the urgent requirement to put in place a capability for analysing training needs, developing training plans or assuring the quality of training for the system as a whole.

<u>International training and autonomy</u>

A case can be made for establishing an International Training Centre at the RHTC site in Pokhara. Nepal's public health system has some relevant success stories which it may legitimately choose to share with health professionals in the region. The organization responsible for delivering training would need to be run along business lines with substantial autonomy, similar to that enjoyed by NASC, to guarantee high quality training responsive to the needs of overseas clients. Our view is that the present NHTC is not ready to use its autonomous status effectively, principally because it has virtually no in-house professional training expertise. Accordingly, spawning a completely new organization is the preferred option for pursuing the market for international training.

The form of autonomy which NASC has been granted by Act of Parliament is discussed in section 4 of the main report. Although such autonomy would be welcomed, it is not appropriate for NHTC since it exists primarily to serve the MoHP and the DoHS. In contrast, NASC provides training services for all Ministries and Departments of the GoN. It is therefore beholden to none of them and, for this reason, it does not report to any particular Ministry. Should the Ministry decide to retain NHTC as a fully-fledged training institute (option 2), it would be inappropriate to grant it similar autonomy to NASC, since it would have incentives to sell training to the private sector and donor agencies. This would undermine the training services it provides to its primary client, namely the Ministry. As a training institute, the NHTC should therefore be accountable to the Ministry/DoHS, not to its own Board.

Options for developing capacity

Because it is argued that the Ministry needs to carry out all the training and development functions (not just training delivery), this report takes a broad view of what should be done generally in the MoHP/DoHS to strengthen training and development. The main options are as follows:

- First, a critical mass of competent training and development professionals is needed who would be responsible for the overall management of training for the Ministry/DoHS. They should be able to analyse training needs, prepare training plans, administer and evaluate training, and have the skills to mainstream gender equality and inclusion aspects into these functions;

- Second, the Ministry should establish processes, routines and methodologies for analysing training needs and preparing training plans. The plans should be aligned with the annual planning and budgeting process of the Ministry, and they should incorporate a bottom-up element which allows DPHO/DHOs to identify their local priorities;

- Third, a small number of master trainers are needed responsible for quality assuring all the Ministry's training (and external training), whether it is delivered by the Ministry's own staff or external contractors. They should be able to conduct training of trainer programmes, review curricula and monitor training at the point of delivery;

- Fourth, the Ministry should integrate within the curriculum development process an explicit consideration of alternative training methods. There should be a shift away from classroom based training towards more cost-effective on-job methods which avoid taking staffs away from their workplaces for long periods of time.

Recommendations and Next Steps

Looking ahead, the Ministry should be thinking broadly about the different training roles for which it requires capacity, not just the needs of the NHTC. In the short-term, the Ministry definitely requires a training management body rather than a training centre or institute. The full recommendations are set out in section 5 of the report. The key recommendations are as follow:

- NHTC should become a training management body responsible for managing and quality assuring all training carried out for the Ministry. The precise location within the structure and its relationship to the present HR function would be determined in Phase 2;
- If the Ministry wishes to carry out international training, it should consider establishing a separate and independent institute for this purpose operating along business lines. NASC is one such model, although the task may also be privatised;
- NHTC should be staffed by socially diverse professional training managers and a few master trainers, some of whom should have skills in mainstreaming GESI. The precise numbers and skills would be determined in Phase 2;
- GESI should be integrated into the core functions and process of NHTC, including human resource management policies, planning and budgeting, curriculum design, and monitoring and reporting;
- The Ministry should create a pool of accredited trainers, coaches and mentors, comprised largely of its own staffs;
- Capacity to undertake GESI mainstreaming should be strengthened as a core competency through orientations and advanced training for selected trainers in both training design and delivery.

In Phase 2 the consultants propose to develop a "road map" to transition the current structures to the proposed structures. This will depend on the Ministry's prior decision to convert the NHTC from a training institute to a training management body which, in our view, is the priority at the present time. However, in addition to the road map, an in-service health training strategy is strongly, even urgently required, and the GoN is encouraged to invite supporting partners who possess the necessary expertise to undertake this critical task.

To read the full version of this Institutional Capacity Assessment, please see the NHSSP website: www.NHSSP.org.